

Patient Information

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
			Last infusion date (if applicable): _____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

Provider Information

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

ICD-10 CODE

Medication Order

Keytruda (pembrolizumab)	Dose:	Frequency:
	200mg IV	Every 3 weeks
	400mg IV	Every 6 weeks
	Other: _____	

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs: Liver enzymes, creatinine, thyroid function	Insurance Card (front and back)
Current Medications	History/Progress Notes

Pre-Medication Order

acetaminophen (Tylenol)	500mg	650mg	1000mg PO	diphenhydramine (Benadryl)	25mg	50mg /	PO	IV
cetirizine (Zyrtec)	10mg PO			methylprednisolone (Solu-Medrol)	40mg IV	125mg IV		
loratadine (Claritin)	10mg PO			hydrocortisone (Solu-Cortef)	100mg IV			
Other: _____								
Dose: _____			Route: _____			Frequency: _____		

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____ Provider Name	_____ Provider Signature	_____ Date
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Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order