KEYTRUDA® (PEMBROLIZUMAB) PRESCRIBER ORDER FORM

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Keytruda® (Pembrolizumab) Prescription

Keytruda® (Pembrolizumab) refill as directed x 1 year

- ☐ Infuse 200 mg IV over 30 minutes once every 3 weeks.
- ☐ Infuse 400 mg IV over 30 minutes once every 6 weeks.
- ☐ Other: _____

Ancillary Orders

Anaphylaxis Orders

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Pre-Medication Orders

- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for fever or mild discomfort.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions.
- ☐ Other: _____

IV Flush Orders

☐	Peripheral:	0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
☐	PICC and Central Tunneled/ Non-Tunneled:	0.9% Sodium Chloride 5 to 10 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin 10 unit/mL) 5 mL *or* (100 unit/mL) post-use. For maintenance, heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.
☐	Implanted Port:	0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.
☐	Valved Catheters:	0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, 0.9% Sodium Chloride 5 to 10 mL at least weekly.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.
Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	

City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to:

