KEYTRUDA® (PEMBROLIZUMAB) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

