KEYTRUDA® (PEMBROLIZUMAB) PRESCRIBER ORDER FORM

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

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: ______________________________

Dose will be rounded to closest 100 mg vial, where applicable, for weight-based dosing.

Ancillary Orders

Pre-Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
☐ Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.

☐ Other: ______________________________

IV Flush Orders

☐ Peripheral:	NS 2 to 3 mL pre-/post-use.
☐ PICC and Central Tunneled/Non-Tunneled:	NS 5 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:	NS 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:	NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, NS 5 to 10 mL at least weekly.

Lab Orders

☐ No labs ordered at this time.

☐ Other: ______________________________

Skilled nurse to assess and administer and/or teach self-administration where appropriate 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:**	

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