

KEYTRUDA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ M05.____ (Rheumatoid Arthritis w/ RF) ☐ M06.____ (Rheumatoid Arthritis w/o RF)

☐ L40.5 (Arthropathic Psoriasis) ☐ Other: _____ ☐

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

TB/PPD test: ☐ Positive ☐ Negative HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT

KEYTRUDA (pembrolizumab)

Premedication Protocol: (Not Usually Indicated)

Route: Intravenous infusion

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Dose: ☐ 500mg (<60kg) ☐ 750mg (60-100kg)

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ 1000mg (>100kg) ☐ Other: _____ mg ☐ Other: _____

Frequency:

Sig: _____

☐ Induction: Once in weeks 0, 2, and 4

☒ Center will use anaphylactic and hypersensitivity protocol established by Restore Health

☐ Maintenance: Every 4 weeks

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Signature: _____

Date: _____

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