

Keytruda (Pembrolizumab)

Provider Order Form rev. 2/6/2026



PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, Recent Labs, TB/Hep B

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code: C43 C34 C34.9 C45.0 C44.2 C81 C85.2 C67 C18 C16.9 C15.9 C53 C22 C24 C4A.9
 C64 C54.1 C44.92 C50 Other: _____
Description: _____
 NKDA Allergies: _____ Weight (lb/kg) _____
Patient Status: New to Therapy New to Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

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

NURSING

- TB Status and date (list results and attach clinicals)

 Hep B Status and date (list results and attach clinicals)

 Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI
 Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

- CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 Other: _____
 Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

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

THERAPY ADMINISTRATION

- Keytruda (Pembrolizumab) IV infusion
- **Dose:** 200 mg 400 mg
 Other: _____
 - **Frequency:** Every 3 weeks Every 6 weeks
 Other: _____
 - **Route:** Intravenous
 - Administer per Prescribing Information**
 - Flush with 0.9% sodium chloride after infusion complete
 - Refills: Zero/ for 12 months/ Other: _____
 - (if not indicated order will expire one year from date signed)
- To ensure a brand name product is dispensed, the prescriber must
handwrite "Brand Medically Necessary" on the prescription form. If not
indicated, Redeemer Infusion is authorized to administer a generic or
biosimilar.*

SPECIAL INSTRUCTIONS

Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

Provider Name (Print)

Provider Signature

Date