Keytruda



InfusionForHealth.com Ph: 888-777-1945 | Fax: 805-852-2636

PROVIDERS: Please include the following to expedite the order. Most Recent Office Visit Note, Medication List. Insurance Info. Pathology Reports, Imaging Retated to diagnosis, and any current/concurrent treatment. CBC, CMP. Thyroid Panel PATIENT INFORMATION Patient Name: Patient Contact Number: DOB: Allergies: Weight: Diagnosis: Diagnosis: Diagnosis: Diagnosis: Diagnosis: DA449 COTICE Address: Contact Person: Contact Email: The following medications will be administered per prescribing information: No Premeds Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: Diphenhydramine Di	Date:	Ph: 888-777-1945 Fax: 805-852-2636 ate: Treatment Location:							
Patient Name: Patient Contact Number: DOB: NPI: Date: NPI: Phone: Fax: Weight: Diagnosis: C43.9 C34.90 C44.42 C81.1 C85.23 Contact Person: Contact Email: The following medications will be administered per prescribing information: No Premeds Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: Diphenhydramine 25mg 50mg PO IV Other N/A Acteaminophen 325mg 50omg 650mg PO Other N/A Normal Saline Bolus 250mL 50omL IV Other N/A Normal Saline Bolus 250mL 50omL IV Other N/A PEMBROLIZUMAB (KEYTRUDA) Administer via IV infusion: 200 mg every 3 weeks 400 mg every 6 weeks 2 mg/kg (up to 200mg) every 3 weeks for pediatrics To ensure that a brand name product be dispensed the prescriber must handwrite 'Brand Medically Necessary' on prescription form. If not indicated, Infusion Fiealth is authorized to administer generic or biosimilar.	Most Recent Office Visit Note, Medication List, Insurance Info, Pathology Reports, Imaging Related to diagnosis,								
Patient Contact Number: DOB:	PATIENT INFORMATION			PRESCRIBER INFORMATION					
DOB: Altergies: Phone: Phone: Fax: Office Address: Contact Person: Contact Email: The following medications will be administered per prescribing information: No Premeds Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: Diphenhydramine Sepand Soomg PO Other N/A Acetaminophen Sepand Soomg Soomg PO Other N/A Methylprednisolone Japand Japand Japand N/A Normal Saline Bolus Sooml Sooml Joon Administer via IV infusion: 200 mg every 3 weeks 2 mg/kg (up to 200mg) every 3 weeks for pediatrics To ensure that a brand name product be disponsed the prescriber must handwrite 'Brand Medically, Necessary' on prescription form. If not indicated, Infusion Fealth is authorized to administer generic or biosimilar.	Patient Name:			Prescriber's Name:					
Allergies: Weight: lbs / kg Height: Office Address: Diagnosis: C43.9 C34.90 C44.42 C81.1 C85.23 Contact Person: Other Dx/ICD10: Contact Email: The following medications will be administered per prescribing information: No Premeds Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: Diphenhydramine 25mg 50mg PO IV Other N/A Acetaminophen 325mg 50omg 650mg PO Other N/A Methylprednisolone 40mg 125mg IV Other N/A Normal Saline Bolus 250ml 500ml IV Other N/A Cetirizine 10mg PO Other N/A PEMBROLIZUMAB (KEYTRUDA) Administer via IV infusion: 200 mg every 3 weeks 400 mg every 6 weeks 2 mg/kg (up to 200mg) every 3 weeks for pediatrics To ensure that a brand name product be dispensed, the prescriber must handwrite 'Brand Medically Necessary' on prescription form. If not indicated. Infusion for Health is authorized to administer generic or biosimilar.	Patient Contact Number:			Signature:					
Weight:lbs / kg Height:	DOB:			NPI:		Date:			
Weight:	Allergies:			Pho	ne:		Fax:		
Diagnosis: C43.9 C34.90 C44.42 C81.1 C85.23 Contact Person: Other Dx/ICD10: Contact Email: The following medications will be administered per prescribing information: No Premeds Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: Diphenhydramine 25mg 50mg PO IV Other N/A Acetaminophen 325mg 50omg 650mg PO Other N/A Methylprednisolone 40mg 125mg IV Other N/A Normal Saline Bolus 250mL 500mL IV Other N/A Cetirizine 10mg PO Other N/A PEMBROLIZUMAB (KEYTRUDA) Administer via IV infusion: 200 mg every 3 weeks 400 mg every 6 weeks 2 mg/kg (up to 200mg) every 3 weeks for pediatrics To ensure that a brand name product be dispensed the prescriber must handwrite Brand Medically Necessary* on prescription form. If not indicated. Infusion for Health is authorized to administer generic or biosimilar.				Offic	ce Address	Si			
Other Dx/ICD10: The following medications will be administered per prescribing information: No Premeds Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: Diphenhydramine	<u> </u>				tact Perso	n:			
Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: Diphenhydramine				Con	tact Email	:			
Acetaminophen 325mg 500mg 650mg PO Other N/A Methylprednisolone 40mg 125mg IV Other N/A Normal Saline Bolus 250mL 500mL IV Other N/A Cetirizine 10mg PO Other N/A PEMBROLIZUMAB (KEYTRUDA) Administer via IV infusion: 200 mg every 3 weeks 400 mg every 6 weeks 2 mg/kg (up to 200mg) every 3 weeks for pediatrics To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar. Lab Orders: CBC, CMP Thyroid Panel Other:	 □ No Premeds Center will use Hypersensitivity protocol established by Infusion for Health and P.I. Additional: 								
Methylprednisolone									
□ Normal Saline Bolus □ 250mL □ 500mL □ IV □ Other □ N/A □ Cetirizine □ 10mg PO □ Other □ N/A PEMBROLIZUMAB (KEYTRUDA) Administer via IV infusion: 200 mg every 3 weeks □ 400 mg every 6 weeks 2 mg/kg (up to 200mg) every 3 weeks for pediatrics To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar. Lab Orders: □ CBC, CMP □ Thyroid Panel □ Other: □	·		PC	J	IV /				
Cetirizine									
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☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment. ☐ Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the	☐ Prior to first appoint☐ Please check this boclearance and/or insur	ment Other Frequency: ox if you DO NOT authorize Infusion ance authorization prior to treatm	on for nent.	r Heal	th to order	and draw labs	indicated for		

prescribing provider for an insurance company that denies authorization for treatment.

Revised 08/11/23