

# Keytruda (pembrolizumab)

Provider Order Form rev. 1/2/2026



## PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Other

Email Address: \_\_\_\_\_ Address: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height (in): \_\_\_\_\_

☐ NKDA Allergies: \_\_\_\_\_ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

Patient Preferred Location: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code & description)

Primary Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

Please find all billing codes here: <https://www.keytrudabillingcodes.com/keytruda/>

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel depending on medication), signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

### Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO

☐ Cetirizine (Zyrtec) 10mgPO

☐ Loratadine (Claritin) 10mgPO

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### Lab Orders

Required: CMP within last 3 months

☐ Other: \_\_\_\_\_

**Keytruda (pembrolizumab)** (Select one):

☐ Infuse 200 mg IV over 30 minutes once every 3 weeks.

☐ Infuse 400 mg IV over 30 minutes once every 6 weeks.

☐ Other: \_\_\_\_\_

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.

**Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ \_\_\_\_\_ (Prescription valid for one year, unless otherwise indicated)

**Special Instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PROVIDER INFORMATION

Provider Full Name: \_\_\_\_\_ Provider NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Provider Name (Print)

Provider Signature

Date

E: [Referrals@americaninfusioncare.com](mailto:Referrals@americaninfusioncare.com)

[Americaninfusioncare.com](http://Americaninfusioncare.com)

Greater Houston Area F: 832.510.7824 P: 832.800.3213  
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454  
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213  
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454