

# 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: \_\_\_\_\_

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  1000mg PO  
 Cetirizine (Zyrtec) 10mg PO  
 Loratadine (Claritin) 10mg PO  
 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