

Pembrolizumab (Keytruda)

Provider Order Form rev. 6/11/2026



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name:	DOB:	Patient Phone:	
Patient Address:	Patient Email:		
Allergies:	<input type="checkbox"/> NKDA	Weight (lbs/kg):	Height (in/cm):
Sex: <input type="checkbox"/> M / <input type="checkbox"/> F	Date of Last Infusion:	Next Due Date:	Preferred Location:

DIAGNOSIS (Please provide ICD-10 code in space provided)

Urothelial Cancer:	Melanoma:	Triple-Negative Breast Cancer:
Renal Cell Carcinoma (RCC):	Non-Small Cell Lung Cancer (NSCLC):	
Other:	Description:	

THERAPY ADMINISTRATION & DOSING

- Administer pembrolizumab (Keytruda) 200 mg IV in 100ml of 0.9% NS or D5W
- Administer pembrolizumab (Keytruda) 400 mg IV in 100ml of 0.9% NS or D5W
- Administer pembrolizumab (Keytruda) _____ mg IV
*Refer to PI for most up to date dosing information

FREQUENCY

Every _____ weeks

LABORATORY ORDERS

- CBC w/ diff at each dose every: _____
- CMP at each dose every: _____
- Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

- Tylenol 500mg / 650mg PO
- Loratadine 10mg PO
- Pepcid 20mg PO / IVP
- Benadryl 25mg / 50mg PO / IVP
- Solumedrol 40mg / 125mg IVP
- Other: _____

NURSING

- Hold infusion and notify provider for:
 - History of hypersensitivity
 - Pregnancy
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name:	Preferred Contact Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including confirmation of diagnosis, treatment failures, or contraindications

Required Labs: LFTs, Renal function, pregnancy test

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.
Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.