Keytruda Prescription / Enrollment Form Date: _____	Y Medical Associates **Fax Referral To: 855-838-0623** **Phone: 800-447-7558**	YMedical ASSOCIATES

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS (ICD-10)

Diagnosis (ICD-10): _____

PRE-SCREENING

Coexisting Medical Conditions:

☐ Organ Transplant ☐ Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)
☐ Immune Disorders (Lupus, Crohn's Disease, Ulcerative Colitis) ☐ Thyroid Disorders
☐ Other: _____

PRESCRIPTION ORDERS

Premeds

Premedication to be given 30 minutes prior to infusion:

☐ Acetaminophen PO PRN: ☐ 325mg ☐ 500mg ☐ 650mg
☐ Diphenhydramine PRN: ☐ 25mg IVP ☐ 50mg IVP ☐ 25mg PO ☐ 5 0mg PO **OR** ☐ Alternate oral antihistamine: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mgs ☐ Fexofenadine 180mgs

☐ Methylprednisolone PRN ☐ 125mg IVP ☐ 40mg IVP OR ☐ ____mg PO

☐ Others/Miscellaneous: _____

☐ Epinephrine pen Auto-Injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis

Medication

Keytruda: ☐ 200mg or ☐ 400mg every ☐ 3 weeks or ☐ 6 weeks in ☐ 0.9% Sodium Chloride injection, USP or ☐ 5% Dextrose Injection, USP over 30 minutes through an IV line containing 0.2µ to 5µ inline or add on filter.
OR

☐ Pediatric Dose: Keytruda 2mg/kg, up to 200mg, every 3 weeks in 0.9% Sodium Chloride Injection, USP or 5% Dextrose Injection, USP over 30 minutes through IV line containing line containing 0.2µ to 5µ inline or add on filter.

Flushing Protocol:
☐ NaCl 0.9% 5-10ml IV before and after infusion
☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral/PICC access and PRN
☐ Heparin 100units/m 3-5ml IV after infusion for Port IV access and PRN
☐ All infusion supplies necessary to administer the medication

Skilled nurse to assess, teach, and administer prescribed medication and admit for services.

Lab Monitoring:
☐ Liver Function Tests: ALT, AST, Bilirubin
☐ Renal Function Tests: ☐ BUN ☐ CrCl
☐ CBC:
☐ Other: _____

By signing below, I certify that above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

_____ _____ _____ _____
Dispense as Written Date Substitution Allowed Date