MIC | METRO INFUSION CENTER

Pembrolizumab (Keytruda)

Name: _____
DOB: _____
Diagnosis/Code: _____ / _____
Cancer Stage: _____

Weight: _____ **lb** _____ **kg**

☐ Call for weight change greater than 10% from weight listed on order

☐ No dose modifications required for any weight change

BSA: N/A
Mg/Kg dosing

Patient Clearance: **Attach treatment Consent Form** ☐

Patient will be seen by Oncology Provider prior to every _____ cycle and cleared for treatment (Metro staff will also review symptoms prior to each treatment)

Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/_____days

Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:

Will be done at referring office (Name and phone# of who to expect labs from):

☐ CMP with each treatment ☐ CBC with each treatment

☐ Other:

Dosing Guidelines/Parameters: ***Provider must select parameters that will trigger a call from the Infusion staff***

☐ Hold and call provider for ANC: /Platelet:

☐ Hold and call for LFT's 3x or ULN and/or Bilirubin 1.5x ULN

☐ Hold and call for creatinine 1.5x ULN

☐ No hold parameters

Hydration Orders:

☐ Not required

Premedication and Antiemetic orders:

☐ Not required (very low emetogenic potential)

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE		ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ Pembrolizumab (Keytruda)	Flat Dosing	200mg		IVPB	Over 30 minutes	☐ Every 3 weeks
☐ Pembrolizumab (Keytruda)	Flat Dosing	400 mg		IVPB	Over 30 minutes	☐ Every 6 weeks
☐ Pembrolizumab (Keytruda)	_____mg/kg	_____mg		IVPB	Over 30 minutes	☐ Every _____ weeks

Date of intended first treatment at Metro Infusion Center: _____

Subsequent treatment may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Other:

Administer using non-pyrogenic, low-protein binding in-line filter (0.2 micron to 5 micron in-line or add-on filter.)

Oral cancer treatment patient is taking: _____

Call referring provider for:

1. Rash
2. Elevated LFT's or creatinine as outline above
3. Severe fatigue or weight loss
4. Allergic reaction – will plan for premeds with subsequent cycles
5. Other reasons to call:

Diarrhea of 6/day
Severe SOB; pulse oximeter less than 90%
Neurologic changes

Date:

Referring Provider: _____ _____ Phone# _____

SIGNATURE REQUIRED **PRINTED NAME REQUIRED**

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: Intake@metroinfusioncenter.com or fax to (866)507-1164.

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