



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Pembrolizumab and berahyaluronidase alfa-pmph (KEYTRUDA QLEX™) Injection

Flat dosing/no dose calculations

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 TSH 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 parametersHydration Orders: Not requiredPremedication and Antiemetic orders: Not required (list emetogenic potential)**Treatment orders:**

| DRUG | DOSE CALCULATION Flat dosing | DOSE | SOLUTION AND VOLUME | ROUTE | RATE | FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES |
|---|---------------------------------|--|---------------------|----------------------|----------------|--|
| <input type="checkbox"/> pembrolizumab and berahyaluronidase alfa-pmph (KEYTRUDA QLEX™) | Flat Dose | 395 mg pembrolizumab/4,800 units berahyaluronidase | 2.4ml | SQ- Abdomen or Thigh | Over 1 minute | Every 3 weeks |
| <input type="checkbox"/> pembrolizumab and berahyaluronidase alfa-pmph (KEYTRUDA QLEX™) | Flat Dose | 790 mg pembrolizumab/9600 units berahyaluronidase | 4.8ml | SQ- Abdomen or Thigh | Over 2 minutes | Every 6 weeks |
| <input type="checkbox"/> pembrolizumab and berahyaluronidase alfa-pmph (KEYTRUDA QLEX™) | | | | | | |

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: _____

Oral cancer treatment patient is taking: _____

Call referring provider for:

- | | |
|--|--|
| 1. Rash | Diarrhea of 6/day |
| 2. Elevated LFT's or creatinine as outline above | Severe SOB; pulse oximeter less than 90% |
| 3. Severe fatigue or weight loss | Neurologic changes |
| 4. Other reasons to call: | |

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: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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