NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Keytruda (Pembrolizumab) Order Form – J9271

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Please list any premeds needed here:_____

Please indicate Pembrolizumab Dose:

(unless otherwise specified, dose will be administered over 30 mintues):

☐ **200mg every 21 days**

☐ **400mg every 42 days**

Orders valid through ____/____/_____

* **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____