



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 minutes):

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: _____