

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____

Choose Location _____

*Include recent labs and last 2 office visit notes

Name	DOB	
Phone	Other Phone	
Email	SSN	
Allergies	Weight	Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name	NPI#	
License #	TIN#	DEA#
Address		
City	State	Zip
Office Contact	Email	
Phone	Fax	

DIAGNOSIS INFORMATION _____

ICD 10 Code _____ **Required Labs: CMP/CBC/TSH/T4 within last 3 months**

PRESCRIPTION INFORMATION (valid for 12 months)

KEYTRUDA Qlex

- ☐ 395mg pembrolizumab/4,800 units berahyaluronidase SQ over one minute every 3 weeks
- ☐ 790mg pembrolizumab/9,600 units berahyaluronidase SQ over 2 minutes every 6 weeks
- ☐ Other _____
- ☐ Vital signs per HI Protocol
- ☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS

- ☐ Acetaminophen _____ mg
- ☐ Fexofenadine (Allegra) 180mg (or other non-sedating antihistamine)
- ☐ Diphenhydramine (Benadryl) _____
- ☐ Methylprednisolone (Solu-Medrol) _____
- ☐ Prednisone _____ mg PO
- ☐ Other _____

POST-MEDICATIONS

- ☐ Acetaminophen _____ mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

REQUIRED LABS

- | | | |
|--|--|--|
| ☐ CBC w/ Diff | ☐ Each infusion | ☐ Other frequency _____ |
| ☐ CRP | ☐ Each infusion | ☐ Other frequency _____ |
| ☐ CMP | ☐ Each infusion | ☐ Other frequency _____ |
| ☐ ESR | ☐ Each infusion | ☐ Other frequency _____ |
| ☐ Hepatic Panel | ☐ Each infusion | ☐ Other frequency _____ |
| ☐ Renal Panel | ☐ Each infusion | ☐ Other frequency _____ |
- ☐ Quantiferon TB Gold, annually, last completed(date): _____
- ☐ Other (specify): _____

Provider Signature _____

Date _____

Fax Referrals to:

Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586