KEYTRUDA Qlex™
pembrolizumab + berahyaluronidase alfa-pmph
Subcutaneous Injection | 165 mg + 2,000 units/mL

Horizon Infusions

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____

*Include recent labs and last 2 office visit notes

Choose Location _____

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 (_____) **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