MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

KEYTRUDA® (pembrolizumab) ORDER FORM

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

(- Required Fields)*
_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

KEYTRUDA® ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ________________________________

Dosing: _____ 200 mg IV every 3 weeks

OR

_____ 400mg IV every 6 weeks

Physician Signature* ________________________________

Date*(Order is Valid for One Year) ____________________
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

**Please list diagnosis below:

_____ ____________________________

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

Last Infusion/Injection Date: ____________________

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ Complete Metabolic Panel (CMP)

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ________________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

--------Colorado--------
___ Lakewood

--------Florida---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

------Oklahoma--------
___ Tulsa

--------Texas-----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 9/2021