

Patient Information

First Name, Last Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Address: _____ City, State, Zip: _____

Phone: _____ ☐ Cell _____ SSN# _____

☐ Allergies _____ Weight: _____ lbs or _____ kgs

Prescribing Physician Information

Referring Practice: _____

Practice Address: _____ City, State, Zip: _____

Prescriber Name: _____ Prescriber NPI: _____

Nurse/Key Contact: _____ Phone: _____

Fax: _____ Email: _____

Treatment Location: Choose One ☐ Location Nearest Patient's Address: _____

Insurance & Required Documentation *Please attach insurance card, front and back*

☐ Patient demographics ☐ Current medication list and H&P ☐ Insurance card / information

☐ Progress notes supporting diagnosis ☐ CMP, CBC and TSH within last 3 months

Diagnosis *Provider must specify*

ICD-10 Code (required): _____ ICD-10 Description: _____

Keytruda Administration

☐ 200 mg every 3 weeks ☐ 400 mg every 6 weeks Last Infusion Date: _____

☐ Peripheral IV ☐ Implanted Port ☐ Other vascular access: _____

☐ Patient is on concurrent chemotherapy: _____

Standing Orders & Laboratory Orders

☐ Administer per Infuse One protocols. **Laboratory orders completed before infusion**

Lab source name and phone: _____ ☐ CBC w/diff every: _____ ☐ CMP every: _____

☐ Other: _____

Pre-Medications

☐ Acetaminophen: ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO ☐ Cetirizine 10 mg PO ☐ Loratadine 10 mg PO

☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV ☐ Hydrocortisone 100 mg IV

☐ Methylprednisolone: ☐ 40 mg ☐ 125 mg IV ☐ Other: _____

Labs / Special Instructions *Please include frequency*

Authorization & Signature

I authorize Infuse One and its clinical representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Infuse One.

Provider Phone Line:
833-881-6048

Please be sure to attach all of the following:

- Patient demographics
- Patient medical insurance card copied front and back
- Patient pharmacy card copied front and back (if they have one)
- Most recent chart notes, diagnostic testings, and labs.
- Proof of patient being concurrently treated with any other biologics

Physician Signature: _____
Date: _____