CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CAPOX pembrolizumab Regimen:

OXALIplatin 130 - capecitabine 1000 - pembrolizumab 2 mg/kg

(Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: CAPOX pembrolizumab 2 mg/kg
Adult Chemotherapy - Medical Oncology
Unresectable or metastatic esophageal carcinoma or HER-2 negative gastro-esophageal junction adenocarcinoma

CC4410 0251 10 2022

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY _____ Planned Administration Date: DD/MONTH/YYYY _____

Cycle_____ of _____ **Cycle Duration: 21 days** Date of previous cycle: DD/MONTH/YYYY _____

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.2 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, otherwise notify Medical Oncologist
- Creatinine Clearance **greater than** 50 mL/minute, otherwise notify Medical Oncologist
- LFT's and Bilirubin assessed

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **ondansetron 8 mg PO** on day 1

☐ **dexamethasone 8 mg PO** on day 1

☐ Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CAPOX pembrolizumab Regimen:

OXALIplatin 130 - capecitabine 1000 - pembrolizumab 2 mg/kg

(Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: CAPOX pembrolizumab 2 mg/kg
Adult Chemotherapy - Medical Oncology
Unresectable or metastatic esophageal carcinoma or HER-2 negative gastro-esophageal junction adenocarcinoma

CC4410 0251 10 2022

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 2 mg/kg** X weight (kg) = _____**mg (maximum dose 200 mg)**

IV in 50 mL normal saline over 30 minutes on day 1

☐ **OXALIplatin 130 mg/m²** X BSA = _____**mg**

☐ Dose modification: **OXALIplatin 130 mg/m²** X BSA - _____% = _____**mg**

IV in 500 mL D5W over 120 minutes on day 1

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **capecitabine 1000 mg/m²** X BSA = _____**mg**

☐ Dose modification: **capecitabine 1000 mg/m²** X BSA - _____% = _____**mg**

PO bid with food on days 1 to 14

This prescription is NOT eligible for medication management by a pharmacist.

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____