

Doctor's Order Sheet  
**FOLFOX pembrolizumab Regimen:**  
**OXALIplatin 85 - leucovorin 400**  
**- fluorouracil 400 - fluorouracil**  
**2400 - pembrolizumab 4 mg/kg (Part I)**

Name: \_\_\_\_\_  
 HCN: \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

**ARIA Protocol Name:** FOLFOX pembrolizumab 4 mg/kg  
 Adult Chemotherapy - Medical Oncology  
 Unresectable or metastatic esophageal carcinoma or HER-2 negative gastro-  
 esophageal junction adenocarcinoma



CC4420 0252 10 2022

**Allergies:**  No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY  
 Cycle      of      **Cycle Duration: 42 days** Date of previous cycle: DD/MONTH/YYYY

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- ANC **greater than or equal to**  $1.2 \times 10^9/L$  and platelets **greater than or equal to**  $75 \times 10^9/L$ , otherwise notify Medical Oncologist
- Creatinine clearance assessed.
- LFTs and Bilirubin assessed

**PREMEDICATIONS (FOR HOSPITAL PHARMACY):**

- ondansetron 8 mg PO** on day 1, 15 and 29  
 **dexamethasone 8 mg PO** on day 1, 15 and 29  
 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: \_\_\_\_\_

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

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**FOLFOX pembrolizumab Regimen:**  
**OXALi<sub>platin</sub> 85 - leucovorin 400**  
**- fluorouracil 400 - fluorouracil**  
**2400 - pembrolizumab 4 mg/kg (Part II)**

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**ARIA Protocol Name:** FOLFOX pembrolizumab 4 mg/kg  
 Adult Chemotherapy - Medical Oncology

Unresectable or metastatic esophageal carcinoma or HER-2 negative gastro  
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Weight: \_\_\_\_\_ kg      Height: \_\_\_\_\_ cm      Body Surface Area (BSA) = \_\_\_\_\_

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

- pembrolizumab 4 mg/kg** X kg = \_\_\_\_\_ mg (maximum dose 400 mg)  
 IV in 50 mL NS over 30 minutes on day 1
  
- OXALi<sub>platin</sub> 85 mg/m<sup>2</sup>** X BSA = \_\_\_\_\_ mg  
 Dose modification: **OXALi<sub>platin</sub> 85 mg/m<sup>2</sup>** X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg  
 IV in 500 mL D5W over 2 hours on day 1, 15 and 29
  
- leucovorin 400 mg/m<sup>2</sup>** X BSA= \_\_\_\_\_ mg  
 IV in 250 mL D5W over 2 hours on day 1, 15 and 29
  
- fluorouracil 400 mg/m<sup>2</sup>** X BSA= \_\_\_\_\_ mg  
 Dose modification: **fluorouracil 400 mg/m<sup>2</sup>** X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg  
 IV push on day 1, 15 and 29
  
- fluorouracil 2400 mg/m<sup>2</sup>** X BSA= \_\_\_\_\_ mg  
 Dose modification: **fluorouracil 2400 mg/m<sup>2</sup>** X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg  
 IV in D5W continuously over 46 hours on day 1, 15 and 29

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Authorized Prescriber's Signature: \_\_\_\_\_ ID #: \_\_\_\_\_

Nurse's Name: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_

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