

Doctor's Order Sheet
**capecitabine 1000 -
pembrolizumab 4 mg/kg**
Regimen: Cycles 1-4

ARIA Protocol Name: Pembrolizumab 4 mg/kg Capecitabine 1000 mg/m²
Adult Chemotherapy - Medical Oncology
Adjuvant Breast Cancer Therapy



CC7280 0548 04/2025

Name: _____

HCN: _____

Date of Birth: _____

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** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $75 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS:

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

pembrolizumab 4 mg/kg X weight (kg) = _____ mg (cap dose at 400 mg)
IV in 50 mL normal saline over 30 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 day 1 to day 14 and day 22 to 35

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.