CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

OXALIplatin 130 - capecitabine 1000 - pembrolizumab 2 mg/kg – Kanjinti™ (trastuzumab) 8/6 mg/kg

Regimen Cycle 1 (Part I)

Name

HCN:

Date of

ARIA Protocol Name: CAPOX pembro 2 mg/kg Kanjinti (trastuzumab)
Adult Chemotherapy - Medical Oncology
Locally advanced or metastatic HER-2 positive gastric or gastroesophageal junction (GEJ) adenocarcinoma

CC7900 0610 11 2025

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.
- LFTs and Bilirubin assessed.
- Creatinine clearance 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: _____

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Doctor's Order Sheet

OXALIplatin 130 - capecitabine 1000 - pembrolizumab 2 mg/kg – Kanjinti™ (trastuzumab) 8/6 mg/kg

Regimen Cycle 1 (Part II)

Name

HCN

Date of

ARIA Protocol Name: CAPOX pembro 2 mg/kg Kanjinti (trastuzumab)
Adult Chemotherapy - Medical Oncology
Locally advanced or metastatic HER-2 positive gastric or gastroesophageal junction (GEJ) adenocarcinoma

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 2 mg/kg** X weight (kg) = _____ **mg** (Cap dose at 200mg)
IV in 50 mL normal saline over 30 minutes on day 1

☐ **Kanjinti™ (trastuzumab) 8 mg/kg** X weight (kg) = _____ **mg**
IV in 250 mL normal saline over 90 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: _____