



Doctor's Order Sheet

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



CC7910 0611 11 2025

Allergies:	<input type="checkbox"/> No Known
Date: <u>DD/MONTH/YYYY</u> Planned Administration Date: <u>DD/MONTH/YYYY</u>	
Cycle <u> </u> of <u> </u> Cycle Duration: 21 days Date of previous cycle: <u>DD/MONTH/YYYY</u>	
MAY PROCEED WITH DOSES AS WRITTEN IF:	
<ul style="list-style-type: none">• 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.• LFTs and Bilirubin assessed.• Creatinine clearance assessed.	
PREMEDICATIONS (FOR HOSPITAL PHARMACY):	
<input type="checkbox"/> ondansetron 8 mg PO on day 1	
<input type="checkbox"/> dexamethasone 8 mg PO on day 1	
<input type="checkbox"/> 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.

Doctor's Order Sheet

**OXALIplatin 130 - capecitabine
1000 - pembrolizumab 2 mg/kg –
Kanjinti™ (trastuzumab) 6/8 mg/kg**
Regimen Cycles 2+ (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) 6 mg/kg X weight (kg) = _____ mg
IV in 250 mL normal saline over 60 minutes on day 1
Cycles 3 onwards can be administered over 30 minutes if no adverse reaction

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: _____

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