

Doctor's Order Sheet
**pembrolizumab 4 mg/kg -
Kanjinti (trastuzumab) 6 mg/kg
Regimen**

Name: _____

HCN: _____

Date of Birth: _____

ARIA Protocol Name: pembrolizumab 4mg/kg Kanjinti (trastuzumab) 6mg/kg maintenance

Adult Chemotherapy - Medical Oncology

Metastatic or inoperable locally advanced gastric, gastroesophageal junction or esophageal adenocarcinoma



CC7330 0553 04 2025

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

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:

- CBC with differential assessed.
- Creatinine clearance assessed.
- LFTs and Bilirubin assessed
- Thyroid function assessed

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

pembrolizumab 4 mg/kg X weight (kg) = _____ **mg** (Cap dose at 400mg)

IV in 50 mL normal saline over 30 minutes on day 1. Administer with 0.2 or 0.22 micron low protein binding in-line filter

Kanjinti® (trastuzumab) 6 mg/kg X weight (kg) = _____ **mg**

IV in 250 mL normal saline over 30 minutes on days 1 and 22

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.