

Regimen Monograph

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A - Regimen Name

CAPECISP+PEMB Regimen

Capecitabine-CISplatin-Pembrolizumab

CAPE+PEMB Regimen

Capecitabine-Pembrolizumab

Disease Site Gastrointestinal
Esophagus
Gastric / Stomach

Intent Palliative

Regimen Category **Evidence-informed :**

Regimen is considered appropriate as part of the standard care of patients; meaningfully improves outcomes (survival, quality of life), tolerability or costs compared to alternatives (recommended by the Disease Site Team and national consensus body e.g. pan-Canadian Oncology Drug Review, pCODR). Recommendation is based on an appropriately conducted phase III clinical trial relevant to the Canadian context OR (where phase III trials are not feasible) an appropriately sized phase II trial. Regimens where one or more drugs are not approved by Health Canada for any indication will be identified under Rationale and Use.

This **Regimen Abstract** is an **abbreviated** version of a Regimen Monograph and contains only top level information on usage, dosing, schedule, cycle length and special notes (if available). Information in regimen abstracts is accurate to the extent of the ST-QBP regimen master listings, and has not undergone the full review process of a regimen monograph. Full regimen monographs will be published for each ST-QBP regimen as they are developed.

**Rationale and
Uses**

First-line treatment in patients with locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-negative esophageal adenocarcinoma or squamous cell carcinoma, gastric adenocarcinoma or gastroesophageal junction (GEJ) adenocarcinoma.

(Refer to NDFP eligibility form for detailed funding criteria.)

**Supplementary
Public Funding**

[pembrolizumab](#)

New Drug Funding Program (Pembrolizumab - First-line Treatment of Advanced HER2-negative Esophageal, Gastric, and Esophagogastric Junction Carcinoma) ([NDFP Website](#))

[capecitabine](#)

ODB - General Benefit (capecitabine) ([ODB Formulary](#))

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B - Drug Regimen

Cycles 1 to 6:

pembrolizumab ^{1,2}	2 mg /kg	IV (max 200 mg)	Day 1
CISplatin	80 mg /m ²	IV	Day 1
capecitabine [^]	1000 mg /m ²	PO	BID Days 1 to 14

([^]Total dose 2000 mg/m²/day)

Cycles 7 and onwards:

pembrolizumab ¹	2 mg /kg	IV (max 200 mg)	Day 1
capecitabine ^{^,†}	1000 mg /m ²	PO	BID Days 1 to 14

([^]Total dose 2000 mg/m²/day)

[†]May continue with PEMB(MNT) if capecitabine is discontinued. Refer to PEMB(MNT) regimen for details.

¹Dosing based on NDFP funding criteria. Alternative pembrolizumab dosing schedule is 4 mg/kg IV (max 400 mg) q6 weeks.

²Give pembrolizumab before chemotherapy when given on the same day.

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C - Cycle Frequency

REPEAT EVERY 21 DAYS

For 6 cycles of CAPECISP+PEMB[^], followed by CAPE+PEMB[^] for up to 2 years (including initial CAPECISP+PEMB cycles), unless disease progression or unacceptable toxicity.

[^]If chemotherapy is discontinued after at least 1 cycle due to intolerance, pembrolizumab may be continued as single agent (PEMB(MNT)) for up to 2 years, unless disease progression or unacceptable toxicity.

Refer to NDFP form for funding criteria for retreatment.

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D - Premedication and Supportive Measures

Antiemetic Regimen: High (Cycles 1-6)
Low – No routine prophylaxis; PRN recommended (Cycles 7+)

- Also refer to [CCO Antiemetic Recommendations](#).

Screen for hepatitis B virus in all cancer patients starting systemic treatment. Refer to the [hepatitis B virus screening and management](#) guideline.

Pembrolizumab Premedication (prophylaxis for infusion reactions):

- Routine pre-medication is not recommended.
- May consider antipyretic and H1-receptor antagonist in patients who experienced a grade 1-2 infusion reaction.

Other Supportive Care:

- Avoid the use of corticosteroids or immunosuppressants before starting pembrolizumab treatment.
- Standard regimens for Cisplatin premedication and hydration should be followed. Refer to local guidelines.
- Topical emollients (e.g. hand creams, udder balm) therapy may ameliorate the manifestations of hand-foot syndrome in patients receiving capecitabine.
- Supportive care should be provided, including loperamide for diarrhea.

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J - Administrative Information

Approximate Patient Visit

CAPECISP+PEMB 4 hours

CAPE+PEMB 0.5 hour

Pharmacy Workload (average time per visit)

CAPECISP+PEMB 40.337 minutes

CAPE+PEMB 22.05 minutes

Nursing Workload (average time per visit)

CAPECISP+PEMB 54.833 minutes

CAPE+PEMB 45 minutes

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K - References

Canada's Drug Agency. Reimbursement Recommendation: Pembrolizumab (Keytruda). Canadian Journal of Health Technologies. October 2024.

Capecitabine drug monograph. Ontario Health (Cancer Care Ontario).

Cisplatin drug monograph. Ontario Health (Cancer Care Ontario).

Kang YK, Kang WK, Shin D, et al. Capecitabine/cisplatin versus 5-fluorouracil/cisplatin as first-line therapy in patients with advanced gastric cancer: a randomised phase III noninferiority trial. *Ann Oncol* 2009;20(4):666-73.

pCODR reimbursement review (pembrolizumab: esophageal carcinoma, gastroesophageal junction adenocarcinoma). February 2022.

Pembrolizumab drug monograph. Ontario Health (Cancer Care Ontario).

Rha SY, Oh DY, Yañez P, et al. Pembrolizumab plus chemotherapy versus placebo plus chemotherapy for HER2-negative advanced gastric cancer (KEYNOTE-859): a multicentre, randomised, double-blind, phase 3 trial. *Lancet Oncol* 2023 Nov;24(11):1181-95. doi: 10.1016/S1470-2045(23)00515-6.

Sun JM, Shen L, Shah MA, et al. Pembrolizumab plus chemotherapy versus chemotherapy alone for first-line treatment of advanced oesophageal cancer (KEYNOTE-590): a randomised, placebo-controlled, phase 3 study. *Lancet* 2021 Aug 28;398(10302):759-771.

January 2025 Updated Rationale and Uses, Supplemental Public Funding, Drug Regimen, and Cycle Frequency sections

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L - Other Notes

DPD Deficiency Testing and Guidance:

Patients should be tested for DPD deficiency before starting treatment with capecitabine. Refer to the [DPD Deficiency Guidance for Clinicians](#) for more information.

In patients with unrecognized DPD deficiency, acute, life-threatening toxicity may occur; if acute grade 2-4 toxicity develops, treatment should be stopped immediately and permanent discontinuation considered based on clinical assessment of the toxicities.

Antidote for Capecitabine Overdose:

Uridine triacetate is a prodrug of uridine and is a specific antidote for treating capecitabine overdose or severe early onset toxicities. If available, consider administering as soon as possible (i.e. within 96 hours) for suspected overdose. If not available, treatment is symptomatic and supportive.

For usage approval and supply, contact Health Canada's [Special Access Program](#) (SAP) (Phone: 613-941-2108. On-call service is available for emergencies).

The recommended dosing and administration for **uridine triacetate** in patients ≥ 18 years is:

- 10 grams (1 packet of coated granules) orally every 6 hours for 20 doses in total, without regards to meals.
- Granules should not be chewed. They should be mixed with 3 to 4 ounces of soft foods such as applesauce, pudding or yogurt.
- The dose should be ingested within 30 minutes of preparation, followed by at least 4 ounces of water.
- Refer to the prescribing information on dose preparation for NG-tube or G-tube use.

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M - Disclaimer

Regimen Abstracts

A Regimen Abstract is an abbreviated version of a Regimen Monograph and contains only top level information on usage, dosing, schedule, cycle length and special notes (if available). It is intended for healthcare providers and is to be used for informational purposes only. It is not intended to constitute or be a substitute for medical advice, and all uses of the Regimen Abstract are subject to clinical judgment. Such information is provided on an “as-is” basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information’s quality, accuracy, currency, completeness, or reliability, and Cancer Care Ontario disclaims all liability for the use of this information, and for any claims, actions, demands or suits that arise from such use.

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Regimen Monographs

Refer to the [New Drug Funding Program](#) or [Ontario Public Drug Programs](#) websites for the most up-to-date public funding information.

The information set out in the drug monographs, regimen monographs, appendices and symptom management information (for health professionals) contained in the Drug Formulary (the “Formulary”) is intended for healthcare providers and is to be used for informational purposes only. The information is not intended to cover all possible uses, directions, precautions, drug interactions or adverse effects of a particular drug, nor should it be construed to indicate that use of a particular drug is safe, appropriate or effective for a given condition. The information in the Formulary is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. All uses of the Formulary are subject to clinical judgment and actual prescribing patterns may not follow the information provided in the Formulary.

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Some Formulary documents, such as the medication information sheets, regimen information sheets and symptom management information (for patients), are intended for patients. Patients should always consult with their healthcare provider if they have questions regarding any information set out in the Formulary documents.

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