

Regimen Monograph

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A - Regimen Name

PEMB(MNT) Regimen

Pembrolizumab (Maintenance)

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.

Rationale and Uses For maintenance treatment of 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, after completing platinum and fluoropyrimidine-based chemotherapy + pembrolizumab

(Refer to the 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](#))

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B - Drug Regimen

After completing platinum and fluoropyrimidine-based chemotherapy + PEMB, as maintenance treatment:

pembrolizumab ¹	2 mg /kg	IV (max 200 mg)	Day 1, q21 days
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OR

pembrolizumab ¹	4 mg /kg	IV (max 400 mg)	Day 1, q42 days
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¹Dosing based on NDFP funding criteria.

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C - Cycle Frequency

2 mg/kg dosing: REPEAT EVERY 21 DAYS

4 mg/kg dosing: REPEAT EVERY 42 DAYS

Until disease progression or unacceptable toxicity to a maximum of 2 years (35 doses given q3 weeks or 18 doses given q6 weeks) including doses given with initial chemotherapy + PEMB, whichever comes first

Refer to NDFP form for funding criteria for retreatment.

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D - Premedication and Supportive Measures

Antiemetic Regimen: Minimal

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

Other Supportive Care:

- Avoid the use of corticosteroids or immunosuppressants before starting treatment.

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.

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E - Dose Modifications

Doses should be modified according to the protocol by which the patient is being treated.

Dosage with toxicity

Healthcare professionals should also consult the most recent pembrolizumab product monograph for additional information.

There are no dose reductions for pembrolizumab. Doses are either delayed or discontinued with toxicity.

Summary of Principles of Management or immune-related adverse effects (irAEs)

- Immune-related adverse effects (irAEs) are different in their presentation, onset and duration compared to conventional chemotherapy. Patient and provider education is essential.
- Initial irAE presentation can occur months after completion of treatment and affect multiple organs.
- Dose escalation or reduction is not recommended.
- If no other cause can be identified (such as infection), any new symptom should be considered immune-related and prompt treatment initiated.

- Organ-specific system-based toxicity management is recommended.

Refer to CCO's [Immune Checkpoint Inhibitor Toxicity Management Guideline](#) for detailed descriptions of Immune-related toxicities and their management.

Management of Infusion-related Reactions:

Also refer to the CCO guideline for detailed description of [Management of Cancer Medication-Related Infusion Reactions](#).

Grade	Management	Re-challenge
1 or 2	<ul style="list-style-type: none"> • Stop or slow the infusion. • Manage the symptoms. <p>Restart:</p> <ul style="list-style-type: none"> • No specific recommendations can be made at this time. 	<ul style="list-style-type: none"> • Consider re-challenge with close monitoring and pre-medications (antipyretic and H1-receptor antagonist).
3 or 4	<ul style="list-style-type: none"> • Stop the infusion. • Aggressively manage symptoms. 	<ul style="list-style-type: none"> • Discontinue permanently (do not re-challenge).

Hepatic Impairment

Refer to CCO's [Immune Checkpoint Inhibitor Toxicity Management Guideline](#) for detailed descriptions for immune-related hepatitis management.

Impairment	Pembrolizumab Dose
Mild (bilirubin 1 - 1.5 x ULN or AST > ULN)	No dose adjustment necessary
Moderate (bilirubin >1.5 - 3 x ULN and any AST) to severe (bilirubin > 3 x ULN and any AST)	Caution; no data

Renal Impairment

Refer to CCO's [Immune Checkpoint Inhibitor Toxicity Management Guideline](#) for detailed descriptions for immune-related nephritis management.

CrCl (mL/min)	Pembrolizumab Dose
≥ 60	No dose adjustment necessary
30 to 59	No dose adjustment necessary
< 30	Caution; no data

Dosage in the Elderly

No dosage adjustment is required. No differences in safety or efficacy were reported between patients aged 65 and older and younger patients.

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F - Adverse Effects

Refer to [pembrolizumab](#) drug monograph(s) for additional details of adverse effects.

Common (25-49%)	Less common (10-24%)	Uncommon (< 10%), but may be severe or life-threatening
<ul style="list-style-type: none"> Fatigue 	<ul style="list-style-type: none"> Diarrhea (may be severe) Rash / pruritus Nausea / vomiting Musculoskeletal pain 	<ul style="list-style-type: none"> Myocarditis Colitis Anemia Hemolytic anemia Myelosuppression ± infection, bleeding Hepatitis Pancreatitis Sclerosing cholangitis Infusion-related reaction Hemophagocytic lymphohistiocytosis Sarcoidosis Graft loss - solid organ transplant recipients Hyper / hypothyroidism Hyperglycemia Hypopituitarism / hypophysitis Adrenal insufficiency Encephalitis Guillain-Barre syndrome Myositis, myasthenia Eye disorders Nephritis / nephrotoxicity Pneumonitis Vasculitis Vogt-Koyanagi-Harada syndrome Stevens-Johnson syndrome Toxic epidermal necrolysis

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G - Interactions

Refer to [pembrolizumab](#) drug monograph(s) for additional details.

- Pembrolizumab is not expected to have pharmacokinetic drug-drug interactions as it is not metabolized by drug metabolizing enzymes.
- Use of systemic corticosteroids or immunosuppressants should be avoided prior to starting pembrolizumab because of potential interference with efficacy. They can be used to treat immune-mediated reactions after starting the drug. Corticosteroids may be used as premedication (e.g. antiemetic) when given with chemotherapy.

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H - Drug Administration and Special Precautions

Refer to [pembrolizumab](#) drug monograph(s) for additional details.

Administration

- Dilute in 0.9% sodium chloride or D5W to final concentration of 1 to 10 mg/mL; mix by gentle inversion.
- Administer over 30 minutes using sterile, non-pyrogenic, low protein-binding 0.2 to 5 micron in-line or add-on filter.
- Do not co-administer other drugs through the same infusion line.
- If a planned dose is missed, administer as soon as possible. Adjust the schedule to maintain the prescribed dosing interval.
- Vials should be stored under refrigeration (2 to 8°C). Do not freeze.

Also refer to the CCO guideline for detailed description of [Management of Cancer Medication-Related Infusion Reactions](#).

Contraindications

- Patients who have a hypersensitivity to this drug or any of its components.

Warnings/Precautions

- Patients with active infection, autoimmune disease, conditions that require systemic immunosuppressive therapy (i.e. transplant patients) and a history of pneumonitis, severe immune-mediated adverse reactions with ipilimumab or severe hypersensitivity to other monoclonal antibodies, etc. were excluded from clinical studies.
- Pembrolizumab may cause serious immune-mediated reactions affecting multiple organ systems, including GI, hepatic, renal, respiratory, endocrine and others. Use with caution and monitor closely in patients with pre-existing conditions such as colitis, hepatic impairment, respiratory or endocrine disorders, such as hypo or hyperthyroidism or diabetes mellitus.
- Patients with ECOG performance status ≥ 2 were excluded from clinical trials.
- Use of a PD-1 or PD-L1 blocking antibody with a thalidomide analogue plus dexamethasone is not recommended outside of controlled clinical trials, due to increased mortality reported.

Pregnancy/Lactation

- This regimen is not recommended for use in pregnancy. Adequate contraception should be used by patients and their partners while on treatment and after the last treatment dose. Recommended methods and duration of contraception may differ depending on the treatment. Refer to the drug monograph(s) for more information.
- Breastfeeding is not recommended during this treatment and after the last treatment dose. Refer to the drug monograph(s) for recommendations after the last treatment dose (if available).
- Fertility effects: Unknown

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I - Recommended Clinical Monitoring

Treating physicians may decide to monitor more or less frequently for individual patients but should always consider recommendations from the product monograph.

Recommended Clinical Monitoring

- Liver function tests; Baseline, before each dose and as clinically indicated; frequent with severe toxicity
- Renal function tests; Baseline, before each dose and as clinically indicated; frequent with severe toxicity
- Thyroid function tests; Baseline, before each dose and as clinically indicated
- Electrolytes; Baseline, before each dose and as clinically indicated
- Blood glucose; Baseline, before each dose and as clinically indicated
- CBC; Baseline and as clinically indicated
- Clinical toxicity assessment for infusion-related and immune-mediated reactions, fatigue, ocular, endocrine, skin, GI, neurologic, musculoskeletal, cardiac and respiratory effects; At each visit
- Grade toxicity using the current [NCI-CTCAE \(Common Terminology Criteria for Adverse Events\) version](#)

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J - Administrative Information

Approximate Patient Visit	0.75 hour
Pharmacy Workload (average time per visit)	19.75 minutes
Nursing Workload (average time per visit)	40.75 minutes

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K - References

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

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):759-71.

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

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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.

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.

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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