NHS England interim treatment changes during the COVID-19 pandemic

The aim of the interim treatment changes is to allow for greater flexibility in the management of cancer during COVID-19 pandemic to ensure clinicians have additional treatment options through this time.

These interim treatment regimens are based on clinical opinion from members of the Chemotherapy Clinical Reference Group and specialised services cancer pharmacists and endorsed by NHS England and NHS Improvement. Each interim treatment changed has been clinically assessed against the following criteria:

a) the treatment is less immunosuppressive and thereby mitigates a patient's likelihood of contracting COVID-19 or becoming seriously ill from COVID-19 **or**
b) the treatment can be administered at home or in a setting that reduces the patient's exposure to COVID-19 **or**
c) the treatment is less resource intensive and makes better use of clinical capacity **and**
d) the treatment is feasible; that is, it is not likely to require significant service change or additional training **and**
e) there is likely to be adequate capacity in the relevant sector (such as home care providers) to deliver the treatment.

The responsibility for using these interim treatment regimens lies entirely with the prescribing clinician, who must discuss the risks and benefits of interim treatment regimens with individual patients, their families and carers.

All patients who start on an interim treatment during the COVID-19 pandemic should be allowed to continue the treatment until they and their clinician jointly decide it is appropriate to stop or to switch to a different treatment.

The interim treatment changes will remain in place for the remainder of financial year 2020/21 to support patient access during the COVID-19 pandemic.

Any interim treatment change listed below that is currently subject to an ongoing NICE technology appraisal will be superseded by the final appraisal document, which receives interim funding from the Cancer Drugs Fund, should this be published during the COVID-19 pandemic. In the case of a negative decision in an ongoing NICE technology appraisal, the interim treatment option will be withdrawn on publication of the final guidance.

Where a PAS (patient access scheme) is operational for any of the drugs listed below, it is expected that the PAS will continue to apply to all supplies and preparations as per the conditions of a simple discount PAS. The 'all supplies and

preparations' requirement includes any off-label uses. There are no arrangements that require the operational NHS to do anything additional.

These interim treatment changes do not constitute NICE guidance. When using this table, bear in mind that some regimens may not have a UK marketing authorisation for the use listed (for further information, see the General Medical Council's guidance on prescribing unlicensed medicines).

Indication	Treatment changes
General	• Give prophylactic daily granulocyte-colony stimulating factor (G-CSF) or a biosimilar PEGylated G-CSF to prevent neutropenic fever and reduce admissions (for example, for patients on chemotherapy regimens with a greater than 10% risk of neutropenic fever) • After an assessment of the risks and benefits to the patient, consider stopping: – later-line palliative treatment to reduce the need for admission – adjuvant therapy for low-risk patients, for example those with breast, lung or colorectal cancer, to reduce the need for immune-suppressive therapy
Acute myeloid leukaemia (AML)	• Allow the use of venetoclax with either low dose cytarabine or azacitidine instead of standard induction chemotherapy for newly diagnosed acute myeloid leukaemia, to reduce need for prolonged in-patient admission and reduce risk of neutropenia. • Use of gilteritinib for relapsed/refractory FLT3+ acute myeloid leukaemia was superseded on 16 July 2020 by NICE's final appraisal document and availability is governed by usual funding processes
Bladder cancer	• Give atezolizumab as first-line immunotherapy instead of chemotherapy to reduce the number of admissions and reduce the risk of neutropenia
Breast cancer	• Suspend treatment with adjuvant bisphosphonates to reduce inpatient visits • Reduce the course of adjuvant trastuzumab treatment from 12 months to 6 months • Give pertuzumab plus trastuzumab for neo-adjuvant therapy, adjuvant therapy, locally recurrent or metastatic disease without chemotherapy to reduce the risk of neutropenia

Indication	Treatment changes
	• Switch to oral capecitabine from intravenous taxanes with anti-HER2 therapies for metastatic disease to reduce the risk of neutropenia • Substitute albumin-bound paclitaxel (Abraxane) for paclitaxel or docetaxel to reduce toxicity and potential for admission • Use of atezolizumab for triple negative metastatic breast cancer instead of chemotherapy was superseded on 22 May 2020 (see TA639) and availability is governed by usual funding processes
Colorectal cancer	• Allow intermittent treatment with chemotherapy regimens that contain cetuximab or panitumumab to reduce the need for immunosuppressive treatment • Give nivolumab as immunotherapy instead of chemotherapy for the treatment of metastatic colorectal cancer with high levels of micro-satellite instability and/or deficient mis-match repair to reduce the number of admissions and reduce the risk of neutropenia • Option to give encorafenib and cetuximab for BRAF positive metastatic disease instead of chemotherapy to reduce risk of immunosuppression **[added 3 August 2020]**
Endometrial cancer	• Option to give nivolumab instead of chemotherapy for microsatellite instability-high tumours to reduce toxicity of treatment **[added 3 August 2020]**
Gestational or placental site trophoblastic tumour	• Option to give pembrolizumab first-line or subsequent line instead of combination chemotherapy (change of sequence) to reduce the number of admissions and reduce the risk of neutropenia
Head and neck cancer	• Option to give pembrolizumab as first-line immunotherapy instead of chemotherapy for head and neck cancers originating from outside the oral cavity to reduce the number of admissions and reduce the risk of neutropenia
Lung cancer (non-small cell)	• Stop maintenance pemetrexed in combination with pembrolizumab to reduce treatment toxicity and risk of neutropenia • Allow pembrolizumab to be given as a single agent as a first-line treatment for squamous or non-squamous non-small cell lung cancer and a PDL-1 score of less than 50% to reduce treatment toxicity and risk of neutropenia

Indication	Treatment changes
	• Allow durvalumab be given 4 weekly in patients eligible for durvalumab following treatment with chemo-radiotherapy to reduce the number of hospital visits • Switch to carboplatin and paclitaxel from day 8 treatments such as gemcitabine and carboplatin and cisplatin and vinblastine • Option to give osimertinib as first-line therapy to delay the need for subsequent chemotherapy • Option to give dabrafenib plus trametinib for BRAF positive metastatic disease instead of chemotherapy to reduce risk of immunosuppression **[added 3 August 2020]**
Lung cancer (small cell)	• Stop first-line chemotherapy for stage 4 small cell lung cancer after 4 cycles to reduce hospital admission and risk of neutropenia
Lymphoma (Hodgkin)	• Option to give brentuximab earlier in treatment pathway to replace salvage chemotherapy, to reduce toxicity of treatment and number of admissions needed for intensive treatment • Option to give nivolumab earlier in treatment pathway – after brentuximab to replace salvage chemotherapy – to reduce admission time and reduce risk of neutropenia
Lymphoma (non-Hodgkin)	• Suspend rituximab maintenance to avoid patients attending hospital • Suspend obinutuzumab maintenance to avoid patients attending hospital • Allow the use of polatuzumab (in combination with bendamustine and rituximab) for diffuse large B-cell lymphoma as bridging therapy for patients approved for CAR-T therapy, both before and after apheresis • Switch intravenous rituximab to subcutaneous rituximab in follicular lymphoma patients receiving rituximab with lenalidomide to reduce the time patients spend in hospital • Allow option to give oral ibrutinib (with or without rituximab) first-line instead of intravenous chemotherapy in patients with mantle cell lymphoma to reduce toxicity of treatment and number of admissions required
Melanoma	• Give oral therapy as first-line treatment for BRAF-positive patients in preference to immunotherapy to reduce admission for intravenous therapy

Indication	Treatment changes
	• Stop immunotherapy doublet (ipilimumab and nivolumab) and switch to single agent nivolumab or pembrolizumab to reduce toxicity
Mesothelioma	• Option to give nivolumab monotherapy instead of second line chemotherapy to reduce risk of immunosuppression **[added 3 August 2020]**
Myeloma	• Allow oral pomalidomide with dexamethasone as second- or third-line therapy instead of intravenous treatments in patients previously treated with lenalidomide to reduce the need for chemotherapy and reduce admissions and risk of neutropenia • Allow first-line lenalidomide and dexamethasone for transplant eligible myeloma patients in preference to regimens that need more hospital attendances and parenteral administrations to reduce toxicity of treatment and number of admissions needed for treatment • Allow second-line ixazomib with lenalidomide and dexamethasone for patients who are neither refractory to previous proteasome inhibitor-based treatment nor to lenalidomide-based treatment if contained within the first line of therapy already received **[amended 3 August 2020]**
Neuroendocrine tumours	• Give oral temozolomide and capecitabine instead of intravenous streptozocin and 5-fluorouracil to reduce toxicity and admissions for treatment
Ovarian cancer	• Give olaparib or other poly-ADP-ribose polymerase (PARP) inhibitors instead of chemotherapy plus maintenance PARP at first relapse for BRCA-positive PARP-naive patients to reduce admissions and risk of neutropenia • Option to give trametinib for advanced low grade serous ovarian carcinoma as oral alternative to intravenous chemotherapy and to reduce risk of immunosuppression **[added 3 August 2020]**
Prostate cancer	• Option to give enzalutamide with androgen deprivation therapy for patients with newly diagnosed metastatic disease instead of docetaxel to reduce toxicity and potential for admission • For patients who are intolerant of enzalutamide, give the option of switching treatment to abiraterone
Renal cell cancer	• Stop first-line immunotherapy using nivolumab with ipilimumab in intermediate and poor risk groups, and switch to either first-line single agent

Indication	Treatment changes
	nivolumab or use oral therapy as first-line and nivolumab with ipilimumab as second-line therapies to reduce toxicity • Use first- and second-line oral tyrosine kinase inhibitors and switch nivolumab from second to third line to delay use of intravenous immunotherapy (hospital visits)
Upper gastrointestinal cancers (oesophageal, gastric, small bowel, biliary tract, pancreatic)	• Option to give nivolumab instead of chemotherapy for microsatellite instability-high tumours to reduce toxicity of treatment **[added 3 August 2020]**