NHS England interim treatment options during the COVID-19 pandemic

These interim treatment options 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 change has been clinically assessed against the following criteria:

a) the treatment is less immunosuppressive and thereby mitigates a patient's likelihood of becoming seriously ill during the coronavirus pandemic **or**
b) the treatment can be administered at home or in a setting that reduces the patient's exposure to the coronavirus **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 options will remain in place for the remainder of financial year 2020/21 to support patient access during the COVID-19 pandemic.

Any interim treatment option listed below that is currently subject to an ongoing NICE technology appraisal will be superseded by the final appraisal document, which receives interim funding from the Cancer Drugs Fund, should this be published during the COVID-19 pandemic. In the case of a negative decision in an ongoing NICE technology appraisal, the interim treatment option will be withdrawn on publication of the final guidance.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

If you have any queries about the interim treatment options, please email NHS England (england.cdfteam@nhs.net).

These interim treatment options 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).

Current interim treatment options

Indication	Interim treatment options
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 and in the event of high rates of coronavirus infection, 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 immunosuppressive therapy
Acute myeloid leukaemia (AML)	• Option to use 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
Bladder cancer	• Option to use atezolizumab as first-line immunotherapy instead of chemotherapy to reduce the number of admissions and reduce the risk of neutropenia
Breast cancer	• Consider reducing the duration of adjuvant trastuzumab monotherapy from 12 months to 6 months. Note this may be less effective than standard therapy for patients at higher risk of recurrence, and for such patients it is only suitable if they are willing to accept potentially lower efficacy to reduce risk of COVID-19 in the event of high rates of coronavirus infection

Indication	Interim treatment options
	• Consider giving pertuzumab plus trastuzumab for neo-adjuvant therapy, adjuvant therapy, locally recurrent or metastatic disease without chemotherapy to reduce the risk of neutropenia in patients seeking less immunosuppression. Note this is less effective than standard therapy and so is only suitable for patients willing to accept lower efficacy to reduce risk of COVID-19 in the event of high rates of coronavirus infection • Option to switch to oral capecitabine from intravenous taxanes with anti-HER2 therapies for metastatic disease to reduce the risk of neutropenia • Option to substitute albumin-bound paclitaxel (Abraxane) for paclitaxel or docetaxel to reduce toxicity and potential for admission
Colorectal cancer	• Option to give intermittent treatment with chemotherapy regimens that contain cetuximab or panitumumab to reduce the need for immunosuppressive treatment • Option to 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
Endometrial cancer	• Option to give nivolumab instead of chemotherapy for microsatellite instability-high tumours to reduce toxicity and risks of treatment
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
Lung cancer (non-small cell)	• Option to stop maintenance pemetrexed in combination with pembrolizumab to reduce treatment toxicity and risk of neutropenia • Option to give pembrolizumab 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 • Allow durvalumab to be given 4-weekly in patients eligible for durvalumab following treatment with

Indication	Interim treatment options
	chemo-radiotherapy to reduce the number of hospital visits • Option to give dabrafenib plus trametinib for BRAF positive metastatic disease instead of chemotherapy to reduce risk of immunosuppression
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)	• Consider suspending rituximab maintenance to avoid patients attending hospital in the event of high rates of coronavirus infection • Consider suspending obinutuzumab maintenance to avoid patients attending hospital in the event of high rates of coronavirus infection • Option to switch intravenous rituximab to subcutaneous rituximab in follicular lymphoma patients receiving rituximab with lenalidomide to reduce the time patients spend in hospital • 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
Mesothelioma	• Option to give nivolumab monotherapy instead of second line chemotherapy to reduce risk of immunosuppression
Myeloma	• Option to give 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 • Option to give 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

Indication	Interim treatment options
	• Option to give lenalidomide as second-line treatment in patients with multiple myeloma previously not treated with a first-line bortezomib-containing regimen • Option to give 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
Neuroendocrine tumours	• Option to give oral temozolomide and capecitabine instead of intravenous streptozocin and 5-fluorouracil to reduce toxicity and admissions for treatment
Ovarian cancer	• Option to give olaparib, niraparib or rucaparib (poly-ADP-ribose [PARP] inhibitors) instead of chemotherapy plus maintenance PARP inhibitor at first relapse for BRCA-positive PARP-naive patients to reduce admissions and risk of neutropenia in the event of high rates of coronavirus infection • Option to give trametinib for advanced low grade serous ovarian carcinoma as oral alternative to intravenous chemotherapy and to reduce risk of immunosuppression
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	• Option to delay use of first-line nivolumab with ipilimumab to second or subsequent line of therapy. This is to allow intermediate and poor risk groups patients to choose oral therapy options to reduce toxicity and potential for admission • Option to delay use of second-line nivolumab to third-line or subsequent line therapy. This is to allow intermediate and poor risk groups patients to choose oral therapy options to reduce toxicity and potential for admission
Upper gastrointestinal cancers (oesophageal,	• Option to give nivolumab instead of chemotherapy for microsatellite instability-high tumours to reduce toxicity of treatment

Indication	Interim treatment options
gastric, small bowel, biliary tract, pancreatic)	

Interim treatment options that have been removed by NHS England or have been superseded by NICE technology appraisal committee decisions

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Acute myeloid leukaemia (AML)	• Use of gilteritinib for relapsed/refractory FLT3+ acute myeloid leukaemia was superseded on 16 July 2020 (see TA642) and availability is governed by usual funding processes
Breast cancer	• 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 • Option to suspend treatment with adjuvant bisphosphonates to reduce inpatient visits was removed by NHS England on 21 September 2020
Colorectal cancer	• Option to give encorafenib and cetuximab for BRAF positive metastatic disease instead of chemotherapy to reduce risk of immunosuppression was superseded on 20 November 2020 by NICE's final appraisal document. Availability is governed by usual funding processes
Head and neck cancer	• Option to give pembrolizumab as first-line immunotherapy instead of chemotherapy for head and neck cancers to reduce the number of admissions and reduce the risk of neutropenia was superseded on 22 October 2020 (see TA661). Availability is governed by usual funding processes
Lung cancer (non-small cell)	• Option to give osimertinib as first-line therapy to delay the need for subsequent chemotherapy was superseded on 11 September 2020 (see TA654) and availability is governed by usual funding processes • Advice to switch to carboplatin and paclitaxel from day 8 treatments such as gemcitabine and carboplatin and cisplatin and vinblastine was removed by NHS England on 6 November 2020 because clinicians are able to make this choice for

	individual patients within the commissioned pathway
Lung cancer (small cell)	• Advice to stop first-line chemotherapy for stage 4 small cell lung cancer after 4 cycles to reduce hospital admission and risk of neutropenia was removed by NHS England on 6 November 2020 because clinicians are able to make this choice for individual patients within the commissioned pathway
Lymphoma (non-Hodgkin)	• 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, was superseded on 20 August 2020 (see TA649) and availability is governed by usual funding processes
Melanoma	• Advice to use oral therapy as first-line treatment for BRAF-positive patients in preference to immunotherapy to reduce admission for intravenous therapy was removed by NHS England on 6 November 2020 because clinicians are able to make this choice for individual patients within the commissioned pathway • Stop immunotherapy doublet (ipilimumab and nivolumab) and switch to single agent nivolumab or pembrolizumab to reduce toxicity was removed by NHS England on 21 September 2020 because clinicians are able to make this choice for individual patients within the commissioned pathway