Pembrolizumab 200mg Monotherapy

This regimen supercedes NCCP Regimen 00347 Pembrolizumab 2mg/kg Monotherapy as of September 2018 due to a change in the licensed dosing posology.

INDICATIONS FOR USE:

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>ICD10</th>
<th>Regimen Code</th>
<th>*Reimbursement Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-line treatment of metastatic non-small cell lung carcinoma (NSCLC) in adults whose tumours express PD-L1 with a ≥50% tumour proportion score (TPS) with no EGFR mutations or ALK translocations.</td>
<td>C34</td>
<td>00455a</td>
<td>ODMS 01/04/2018</td>
</tr>
<tr>
<td>First line monotherapy for the treatment of advanced (unresectable or metastatic) melanoma in adults</td>
<td>C43</td>
<td>00455b</td>
<td>ODMS June 2016</td>
</tr>
<tr>
<td>For the treatment of ipilimumab-refractory patients with unresectable or advanced metastatic melanoma</td>
<td>C43</td>
<td>00455c</td>
<td>ODMS June 2016</td>
</tr>
<tr>
<td>As monotherapy for the treatment of adult patients with relapsed or refractory classical Hodgkin lymphoma (cHL) who are transplant-ineligible and have failed brentuximab vedotin</td>
<td>C81</td>
<td>00455d</td>
<td>ODMS 12/11/2018</td>
</tr>
</tbody>
</table>

*If the reimbursement status is not defined the indication has yet to be assessed through the formal HSE reimbursement process.

TREATMENT:

The starting dose of the drugs detailed below may be adjusted downward by the prescribing clinician, using their independent medical judgement, to consider each patient's individual clinical circumstances. Pembrolizumab is administered once every 21 days until disease progression or unacceptable toxicity develops.

For patients who achieve a satisfactory objective response according to the treating clinician’s judgement and who have no signs of progression at 24 months of treatment, the discontinuation of the treatment should be taken into consideration.

Atypical responses (i.e., an initial transient increase in tumour size or small new lesions within the first few months followed by tumour shrinkage) have been observed. It is recommended to continue treatment for clinically stable patients with initial evidence of disease progression until disease progression is confirmed.

Facilities to treat anaphylaxis MUST be present when pembrolizumab is administered.

<table>
<thead>
<tr>
<th>Day</th>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Diluent &amp; Rate</th>
<th>Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pembrolizumab</td>
<td>200mg</td>
<td>IV infusion</td>
<td>100ml 0.9% NaC</td>
<td>lover 30minutes using a low-protein binding 0.2 to 5 micrometre in-line or add-on filter.</td>
</tr>
</tbody>
</table>

Pembrolizumab is diluted to a final concentration ranging from 1-10mg/ml
ELIGIBILITY:
- ECOG Status 0-1
- Adequate haematological, hepatic and renal function
- First line Non-Small Cell Lung Cancer
  - Histologically or cytologically confirmed stage IV NSCLC with no sensitizing EGFR mutations or ALK translocations
  - Confirmation of PD-L1 tumour proportion score of 50% or greater by a validated test
  - No previous systemic therapy for metastatic disease
- Melanoma
  - No more than one previous systemic treatment for advanced disease
- Classical Hodgkin Lymphoma
  - Consider the benefit of treatment with pembrolizumab versus the risk of possible GVHD in patients with a history of allogeneic HSCT

EXCLUSIONS:
- Hypersensitivity to pembrolizumab or any of the excipients.
- Has received prior therapy with an anti-PD-1 or anti-PD-L1 antibody
- History of serious autoimmune disease
- Untreated brain metastases
- Any medical condition that requires immunosuppressive doses of systemic corticosteroids or other immunosuppressive medication(s) (defined as >10mg prednisolone/daily (or steroid equivalent, excluding inhaled or topical steroids)
- History of interstitial lung disease
- Any active clinically significant infection requiring therapy

PRESCRIPTIVE AUTHORITY:
The treatment plan must be initiated by a Consultant Medical Oncologist or Consultant Haematologist experienced in the treatment of haematological malignancies

TESTS:
Baseline tests:
- FBC, renal and liver profile
- Glucose
- Thyroid function tests.
- Virology Screen: Hepatitis B (HBsAg, HBcoreAb) and Hepatitis C
- NSCLC: PD-L1 expression using a validated test method

Regular tests:
- FBC, renal and liver profile prior to each cycle
- Glucose prior to each cycle
- TSH every 3 to 6 weeks.

Disease monitoring:
Disease monitoring should be in line with the patient’s treatment plan and any other test/s as directed by the supervising Consultant.
DOSE MODIFICATIONS:

- Any dose modification should be discussed with a Consultant.
- Management of immune-related adverse reactions may require withholding of a dose or permanent discontinuation of pembrolizumab therapy and institution of systemic high-dose corticosteroid.
- Dose reduction is not recommended.
- Guidelines for withholding of doses or permanent discontinuation are described below in Table 1.
Table 1: Guidelines for withholding or discontinuation of pembrolizumab

<table>
<thead>
<tr>
<th>Immune-related adverse reaction</th>
<th>Discontinuation</th>
<th>Treatment Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pneumonitis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade ≥ 3, or recurrent Grade 2</td>
<td>Permanently discontinue</td>
<td>Withhold*</td>
</tr>
<tr>
<td><strong>Colitis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 2 or 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 4 or recurrent Grade 3</td>
<td>Permanently discontinue</td>
<td>Withhold*</td>
</tr>
<tr>
<td><strong>Nephritis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 2 with creatinine &gt; 1.5-3 x ULN</td>
<td>Permanently discontinue</td>
<td>Withhold*</td>
</tr>
<tr>
<td>Grade ≥ 3 with creatinine &gt; 3 x ULN</td>
<td>Permanently discontinue</td>
<td>Withhold*</td>
</tr>
<tr>
<td><strong>Endocrinopathies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic hypophysitis with Grade &gt; 3 hyperglycaemia (Glucose &gt;250mg/dL or &gt;13.9 mmol/L) or associated with ketoacidosis</td>
<td>Permanently discontinue</td>
<td>Withhold*</td>
</tr>
<tr>
<td>Hyperthyroidism Grade ≥ 3</td>
<td>Withhold*</td>
<td></td>
</tr>
<tr>
<td>For patients with Grade ≥ 3 endocrinopathy that improved to Grade 2 or lower and is controlled with hormone replacement, if indicated, continuation of pembrolizumab may be considered after corticosteroid taper, if needed. Otherwise treatment should be discontinued. Note: Hypothyroidism may be managed with replacement therapy without treatment interruption</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With AST or ALT &gt; 3-5 x ULN or total bilirubin &gt; 1.5-3 x ULN</td>
<td>Permanently discontinue</td>
<td>Withhold*</td>
</tr>
<tr>
<td>With AST or ALT &gt; 5 x ULN or total bilirubin &gt; 3 x ULN</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
<tr>
<td>In case of liver metastasis with baseline Grade 2 elevation of AST or ALT, hepatitis with AST or ALT increases ≥50% and lasts ≥1 week</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
<tr>
<td><strong>Skin reactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 3 or suspected Stevens-Johnson syndrome (SJS) or toxic epidermal necrolysis (TEN)</td>
<td>Permanently discontinue</td>
<td>Withhold*</td>
</tr>
<tr>
<td>Grade 4 or confirmed SJS or TEN</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
<tr>
<td><strong>Other immune-related adverse reactions</strong></td>
<td>Based on severity and type of reaction (Grade 2 or Grade 3)</td>
<td>Permanently discontinue</td>
</tr>
<tr>
<td>Grade 3 or 4 myocarditis</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
<tr>
<td>Grade 3 or 4 encephalitis</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
<tr>
<td>Grade 3 or 4 Guillain-Barre syndrome</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
<tr>
<td>Grade 4 or recurrent Grade 3</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
<tr>
<td><strong>Infusion related reactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade ≥ 3</td>
<td>Permanently discontinue</td>
<td></td>
</tr>
</tbody>
</table>

NCI-CTCAE v 4.0 *Until adverse reactions recover to Grade 0-1

The information contained in this document is a statement of consensus of NCCP and ISMO or IHS professionals regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult these documents is expected to use independent medical judgement in the context of individual clinical circumstances to determine any patient’s care or treatment. Use of these documents is the responsibility of the prescribing clinician, and is subject to HSE’s terms of use available at: [http://www.hse.ie/eng/Disclaimer](http://www.hse.ie/eng/Disclaimer).

This information is valid only on the day of printing, for any updates please check: [www.hse.ie/NCCPchemoregimens](http://www.hse.ie/NCCPchemoregimens).
Pembrolizumab should be permanently discontinued:
- For Grade 4 toxicity except for endocrinopathies that are controlled with replacement therapy
- If corticosteroid dosing cannot be reduced to ≤10mg prednisolone or equivalent per day within 12 weeks
- If treatment-related toxicity does not resolve to Grade 0-1 within 12 weeks from last dose of pembrolizumab.
- If any event occurs a second time at Grade ≥ 3 severity.

Renal and Hepatic Impairment:
Table 2: Dose modification of pembrolizumab in renal and hepatic impairment

<table>
<thead>
<tr>
<th>Renal Impairment</th>
<th>Hepatic Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild/Moderate</td>
<td>No dose adjustment required</td>
</tr>
<tr>
<td>Severe</td>
<td>Has not been studied</td>
</tr>
</tbody>
</table>

SUPPORTIVE CARE:
EMETOGENIC POTENTIAL: Minimal (Refer to local policy).
PREMEDICATIONS: Not usually required
OTHER SUPPORTIVE CARE: Not usually required

ADVERSE EFFECTS / REGIMEN SPECIFIC COMPLICATIONS
The adverse effects listed are not exhaustive. Please refer to the relevant Summary of Product Characteristics for full details.
This medicinal product is subject to additional monitoring. Healthcare professionals are asked to report any suspected adverse reactions.

- Immune-mediated adverse reactions: Most immune-related adverse reactions occurring during treatment with pembrolizumab are reversible and managed with interruptions of pembrolizumab, administration of corticosteroids and/or supportive care. Immune-related adverse reactions have also occurred after the last dose of pembrolizumab. For suspected immune-related adverse reactions, adequate evaluation to confirm aetiology or exclude other causes should be ensured. Based on the severity of the adverse reaction, pembrolizumab should be withheld and corticosteroids administered. Upon improvement to Grade ≤ 1, corticosteroid taper should be initiated and continued over at least 1 month. Based on limited data from clinical studies in patients whose immune-related adverse reactions could not be controlled with corticosteroid use, administration of other systemic immunosuppressants can be considered. Pembrolizumab may be restarted within 12 weeks after last dose of pembrolizumab if the adverse reaction remains at Grade ≤ 1 and corticosteroid dose has been reduced to ≤ 10 mg prednisone or equivalent per day. Pembrolizumab must be permanently discontinued for any Grade 3 immune-related adverse reaction that recurs and for any Grade 4 immune-related adverse reaction toxicity, except for endocrinopathies that are controlled with replacement hormones.
Specific guidelines for management of Immune Mediated Adverse Events are available.

- **Infusion-related reactions:** Severe infusion-related reactions have been reported in patients receiving pembrolizumab. For severe infusion reactions, infusion should be stopped and pembrolizumab permanently discontinued. Patients with mild or moderate infusion reaction may continue to receive pembrolizumab with close monitoring; premedication with antipyretic and antihistamine may be considered.

**DRUG INTERACTIONS:**

- No formal pharmacokinetic drug interaction studies have been conducted with pembrolizumab. Since pembrolizumab is cleared from the circulation through catabolism, no metabolic drug-drug interactions are expected.
- The use of systemic corticosteroids or immunosuppressants before starting pembrolizumab should be avoided because of their potential interference with the pharmacodynamic activity and efficacy of pembrolizumab. However, systemic corticosteroids or other immunosuppressants can be used after starting pembrolizumab to treat immune-related adverse reactions.
- Current drug interaction databases should be consulted for more information.

**ATC CODE:**
Pembrolizumab – L01XC18

**COMPANY SUPPORT RESOURCES/Useful Links:**
Please note that this is for information only and does not constitute endorsement by the NCCP

**HCP Guide**

**Patient Alert Card**

**REFERENCES:**

The information contained in this document is a statement of consensus of NCCP and ISMO or IHS professionals regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult these documents is expected to use independent medical judgement in the context of individual clinical circumstances to determine any patient's care or treatment. Use of these documents is the responsibility of the prescribing clinician. and is subject to HSE’s terms of use available at http://www.hse.ie/eng/Disclaimer

This information is valid only on the day of printing, for any updates please check www.hse.ie/NCCPchemoregimens

| NCCP Regimen: Pembrolizumab 200mg Monotherapy | Published: 21/03/2018 | Version number: 3 |
| Tumour Group: Lung/Skin Melanoma/Lymphoma | Review: 09/11/2020 | |
| NCCP Regimen Code: 00455 | ISMO Contributor: Prof Michaela Higgins, Dr. Giuseppe Gullo, Dr Deirdre O’Mahony | Page 6 of 7 |
NCCP Chemotherapy Regimen

Tumour Group: Lung/Skin Melanoma/Lymphoma
NCCP Regimen Code: 00455

Published: 21/03/2018
Review: 09/11/2020
Version number: 3

Version | Date       | Amendment                                                                 | Approved By                      |
---------|------------|---------------------------------------------------------------------------|----------------------------------|
1        | 21/03/2018 |                                                                            | Prof Michaela Higgins             |
2        | 04/09/2018 | Change in licensed dosing posology for melanoma. Standardisation of treatment table to 100ml NaCl 0.9%. Clarification on the use of systemic steroids in exclusion criteria | Prof Michaela Higgins Dr Giuseppe Gullo |
3        | 08/11/2018 | Inclusion of indication for Hodgkin Lymphoma. Updated treatment section and inclusion/ exclusion criteria | Dr Deirdre O’Mahony               |

Comments and feedback welcome at oncologydrugs@cancercontrol.ie.

1 ODMS – Oncology Drug Management System
CDS – Community Drug Schemes (CDS) including the High Tech arrangements of the PCRS community drug schemes
Further details on the Cancer Drug Management Programme is available at; http://www.hse.ie/eng/services/list/S/cancer/profinfomedonc/cdmp/

The information contained in this document is a statement of consensus of NCCP and ISMO or IHS professionals regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult these documents is expected to use independent medical judgement in the context of individual clinical circumstances to determine any patient’s care or treatment. Use of these documents is the responsibly of the prescribing clinician. and is subject to HSE’s terms of use available at http://www.hse.ie/eng/Disclaimer

This information is valid only on the day of printing, for any updates please check www.hse.ie/NCCPchemoregimens