NCCP Chemotherapy Regimen

Nivolumab Monotherapy 480mg -28 days

This regimen supersedes NCCP Regimen 00349 Nivolumab Monotherapy as of May 2018 and Regimen 00573 as of Nov-2019 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>As monotherapy for the treatment of advanced (unresectable or metastatic) melanoma in adults</td>
<td>C43</td>
<td>00484a</td>
<td>ODMS 9/10/2017</td>
</tr>
<tr>
<td>As monotherapy for the treatment of advanced renal cell carcinoma (RCC) after prior therapy in adults.</td>
<td>C64</td>
<td>00484b</td>
<td>ODMS 9/10/2017</td>
</tr>
<tr>
<td>As monotherapy for the adjuvant treatment of adults with melanoma with involvement of lymph nodes or metastatic disease who have undergone complete resection</td>
<td>C43</td>
<td>00484c</td>
<td>Reimbursement not approved</td>
</tr>
<tr>
<td>As monotherapy is indicated for the treatment of adult patients with relapsed or refractory classical Hodgkin lymphoma (cHL) after autologous stem cell transplant (ASCT) and treatment with brentuximab vedotin.</td>
<td>C81</td>
<td>00484d</td>
<td>ODMS</td>
</tr>
<tr>
<td>As monotherapy for the treatment of squamous cell cancer of the head and neck in adults progressing on or after platinum-based therapy.</td>
<td>C76</td>
<td>00484e</td>
<td>ODMS</td>
</tr>
<tr>
<td>As monotherapy for the treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC) after prior chemotherapy in adults.</td>
<td>C34</td>
<td>00484f</td>
<td>ODMS</td>
</tr>
</tbody>
</table>

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.

Nivolumab is administered once every 28 days until disease progression or unacceptable toxicity develops.

For adjuvant melanoma therapy, the maximum treatment duration with nivolumab is 12 months.

Patients should be monitored continuously (at least up to 5 months after the last dose) as an adverse reaction with nivolumab may occur at any time during or after discontinuation of therapy

If a patient needs to be switched from the 480mg every 4 weeks schedule to the 240mg every 2 weeks schedule (See NCCP Regimen 00483 - Nivolumab Monotherapy 240mg-14 days), the first 240mg dose should be administered four weeks after the last 480mg dose.

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Diluent &amp; Rate</th>
<th>Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nivolumab</td>
<td>480mg</td>
<td>IV infusion</td>
<td>Infuse over 60 minutes through a sterile, non-pyrogenic, low protein binding in-line filter with a pore size of 0.2-1.2 micrometre</td>
<td>Ongoing every 28 days to progression or toxicity</td>
</tr>
</tbody>
</table>

Nivolumab must not be administered as an intravenous push or bolus injection.

Nivolumab can be infused directly as a 10mg/mL solution or can be diluted to as low as 1mg/mL with sodium chloride 9mg/mL (0.9%) solution for injection or glucose 50mg/mL (5%) solution for injection.

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ELIGIBILITY:

- Indications as above
- ECOG status
  - **ECOG 0-2:**
    - Advanced melanoma
    - RCC
  - **ECOG 0-1:**
    - Adjuvant melanoma
    - cHL
    - Head and Neck
    - NSCLC
- Aged 18 years or above
- Adequate haematological, hepatic and renal function
- Nivolumab is not recommended during pregnancy and in women of childbearing potential not using effective contraception unless prescribing consultant deems clinical benefit outweighs the potential risk. Effective contraception should be used for at least 5 months following the last dose of nivolumab.
- **Renal cell carcinoma**
  - Histologic confirmation of advanced or metastatic renal-cell carcinoma.
  - Have received one or more prior lines of systemic therapy including at least one prior anti-angiogenic tyrosine kinase inhibitor.
- **Head and Neck**
  - Histologically confirmed recurrent or metastatic squamous cell carcinoma of the head and neck (SCCHN) (oral cavity, pharynx, larynx), that is not amenable to local therapy with curative intent (surgery or radiation therapy with or without chemotherapy).
  - Tumour progression or recurrence within 6 months of last dose of platinum-based therapy in the adjuvant (ie, with radiation after surgery), primary (ie, with radiation), recurrent, or metastatic setting.
- **Non small cell lung cancer (NSCLC)**
  - Subjects must have experienced disease recurrence or progression during or after one prior platinum-containing doublet chemotherapy regimen for advanced or metastatic disease.
- **Adjuvant melanoma**
  - Stage IIIIB/C or Stage IV (AJCC 7th Edition) histologically confirmed melanoma that has been completely surgically resected

CAUTION:

Use with caution in:

- Patients with clinically significant autoimmune disease

EXCLUSIONS:

- Previous treatment with an anti-PD1 monoclonal antibody
- Symptomatic CNS metastases

NCCP Regimen: Nivolumab Monotherapy
480mg-28 days

Published: 21/05/2018
Review: 06/11/2021
Version number: 6

Tumour Group: Genitourinary/ Melanoma/ Lymphoma/Lung/Head and Neck
NCCP Regimen Code: 000484

ISMO Contributor: Prof. G. Gullo, Dr. D. O’Mahony, Dr. R Bambury, Dr. Fergal Kelleher, Prof Maccon Keane

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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)
- Symptomatic interstitial lung disease
- Any active clinically significant infection requiring therapy
- **Adjuvant melanoma:**
  - Uveal melanoma
- **Head and neck**
  - Patients with carcinoma of the nasopharynx or salivary gland as primary tumour site.

**PRESCRIPTIVE AUTHORITY:**

The treatment plan must be initiated by a Consultant Medical Oncologist or by a Consultant Haematologist working in the area of haematological malignancies.

**TESTS:**

**Baseline tests:**
- Blood, renal and liver profile
- Glucose
- TFTs
- Hepatitis B (HBV sAg) and Hepatitis C (HCV RNA)
- Serum cortisol (ideally a morning sample)

**Disease specific baseline test:**
- **Adjuvant and advanced Melanoma**: Determination of BRAF status

**Regular tests:**
- FBC, renal, liver profile and glucose prior to each cycle
- TFTs prior to each cycle

**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.

**Non small cell lung cancer (NSCLC)**
- Patients should be assessed for progression prior to commencing their 8th cycle.

**DOSE MODIFICATIONS:**

- Any dose modification should be discussed with a Consultant
- Dose escalation or reduction is not recommended. Any dose modification should be discussed with a Consultant.

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Management of immune-related adverse reactions may require withholding of a dose or permanent discontinuation of nivolumab therapy and institution of systemic high-dose corticosteroid.

If immunosuppression with corticosteroids is used to treat an adverse reaction, a taper of at least 1 month duration should be initiated upon improvement. Rapid tapering may lead to worsening or recurrence of the adverse reaction. Non-corticosteroid immunosuppressive therapy should be added if there is worsening or no improvement despite corticosteroid use. Nivolumab should not be resumed while the patient is receiving immunosuppressive doses of corticosteroids or other immunosuppressive therapy.

Guidelines for withholding of doses or permanent discontinuation are described in Table 1 below.

**Table 1: Recommended Treatment Modifications for Nivolumab**

<table>
<thead>
<tr>
<th>Immune-related adverse reaction</th>
<th>Severity</th>
<th>Treatment Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immune-related pneumonitis</td>
<td>Grade 2 pneumonitis</td>
<td>Withhold dose(s) until symptoms resolve, radiographic abnormalities improve, and management with corticosteroids is complete</td>
</tr>
<tr>
<td></td>
<td>Grade 3 or 4 pneumonitis</td>
<td>Permanently discontinue treatment</td>
</tr>
<tr>
<td>Immune-related colitis</td>
<td>Grade 2 diarrhoea or colitis</td>
<td>Withhold dose(s) until symptoms resolve and management with corticosteroids, if needed, is complete</td>
</tr>
<tr>
<td></td>
<td>Grade 3 diarrhoea or colitis</td>
<td>Withhold dose(s) until symptoms resolve and management with corticosteroids is complete</td>
</tr>
<tr>
<td></td>
<td>Grade 4 diarrhoea or colitis</td>
<td>Permanently discontinue treatment</td>
</tr>
<tr>
<td>Immune-related hepatitis</td>
<td>Grade 2 elevation in aspartate aminotransferase (AST), alanine aminotransferase (ALT), or total bilirubin</td>
<td>Withhold dose(s) until laboratory values return to baseline and management with corticosteroids, if needed, is complete</td>
</tr>
<tr>
<td></td>
<td>Grade 3 or 4 elevation in AST, ALT, or total bilirubin</td>
<td>Permanently discontinue treatment</td>
</tr>
<tr>
<td>Immune-related nephritis and renal dysfunction</td>
<td>Grade 2 or 3 creatinine elevation</td>
<td>Withhold dose(s) until creatinine returns to baseline and management with corticosteroids is complete</td>
</tr>
<tr>
<td></td>
<td>Grade 4 creatinine elevation</td>
<td>Permanently discontinue treatment</td>
</tr>
<tr>
<td>Immune-related endocrinopathies</td>
<td>Symptomatic Grade 2 or 3 hypothyroidism, hyperthyroidism, hypophysitis, Grade 2 adrenal insufficiency</td>
<td>Withhold dose(s) until symptoms resolve and management with corticosteroids (if needed for symptoms of acute inflammation) is complete. Treatment should be continued in the presence of hormone replacement therapy as long as no symptoms are present</td>
</tr>
<tr>
<td></td>
<td>Grade 3 diabetes</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Grade 4 hypothyroidism</th>
<th>Permanently discontinue treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 4 hyperthyroidism</td>
<td></td>
</tr>
<tr>
<td>Grade 4 hypophysitis</td>
<td></td>
</tr>
<tr>
<td>Grade 3 or 4 adrenal insufficiency</td>
<td></td>
</tr>
<tr>
<td>Grade 4 diabetes</td>
<td></td>
</tr>
</tbody>
</table>

**Immune-related rash**

<table>
<thead>
<tr>
<th>Grade 3 rash</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 4 rash</td>
</tr>
<tr>
<td>Steven-Johnsons syndrome (SJS) or toxic epidermal necrolysis (TEN)</td>
</tr>
</tbody>
</table>

- Withhold dose(s) until symptoms resolve and management with corticosteroids is complete
- Permanently discontinue treatment
- Permanently discontinue treatment

**Other adverse reactions**

<table>
<thead>
<tr>
<th>Grade 3 (first occurrence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 3 myocarditis</td>
</tr>
<tr>
<td>Grade 4 or recurrent Grade 3; persistent Grade 2 or 3 despite treatment modification; inability to reduce corticosteroid dose to 10mg prednisone or equivalent per day</td>
</tr>
</tbody>
</table>

- Withhold dose(s)
- Permanently discontinue treatment
- Permanently discontinue treatment

Toxicity grades are in accordance with National Cancer Institute Common Terminology Criteria for Adverse Events Version 4.0 (NCI-CTCAE v4).
Renal and Hepatic Impairment:

Table 2: Dose modification of nivolumab in renal and hepatic impairment

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

Nivolumab must be administered with caution in patients with
- moderate (total bilirubin >1.5x to 3x ULN and any AST) or
- severe (total bilirubin >3 x ULN and any AST) hepatic impairment

SUPPORTIVE CARE:

EMETOGENIC POTENTIAL: Minimal (Refer to local policy).

PREMEDICATIONS: Not usually required

OTHER SUPPORTIVE CARE: No specific recommendations

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.

- Cardiac adverse events and pulmonary embolism: Patients should be monitored for cardiac and pulmonary adverse reactions continuously, as well as for clinical signs, symptoms, and laboratory abnormalities indicative of electrolyte disturbances and dehydration prior to and periodically during treatment.
- Immune related adverse reactions:

<table>
<thead>
<tr>
<th>Adverse reaction</th>
<th>Withhold/ discontinue</th>
<th>Recommended action -1” occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immune-related pneumonitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 2 (symptomatic)</td>
<td>Withhold</td>
<td>Initiate corticosteroids at a dose of 1mg/kg/day methylprednisolone (equivalents) Upon improvement, nivolumab may be resumed after corticosteroid taper</td>
</tr>
</tbody>
</table>

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### Immune-related colitis

Patients should be monitored for diarrhea and additional symptoms of colitis, such as abdominal pain and mucus or blood in stool. Infectious and disease-related aetiologies should be ruled out. Cytomegalovirus (CMV) infection/reactivation has been reported in patients with corticosteroid-refractory immune-related colitis. Consider if patient has persistent colitis despite appropriate colitis therapy.

<table>
<thead>
<tr>
<th>Grade 2 diarrhea or colitis</th>
<th>Withhold</th>
<th>Initiate corticosteroids at a dose of 0.5 to 1mg/kg/day methylprednisolone (equivalents) Upon improvement, nivolumab may be resumed after corticosteroid taper</th>
</tr>
</thead>
<tbody>
<tr>
<td>If worsening or no improvement occurs despite initiation of corticosteroids</td>
<td>Permanently discontinue</td>
<td>Increase corticosteroid dose to 1 to 2mg/kg/day methylprednisolone (equivalents)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade 3 diarrhea or colitis</th>
<th>Withhold</th>
<th>Initiate corticosteroids at a dose of 1 to 2mg/kg/day methylprednisolone (equivalents) Upon improvement, nivolumab may be resumed after corticosteroid taper</th>
</tr>
</thead>
<tbody>
<tr>
<td>If worsening or no improvement occurs despite initiation of corticosteroids</td>
<td>Permanently discontinue</td>
<td>Increase corticosteroid dose to 1 to 2mg/kg/day methylprednisolone (equivalents)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade 4 diarrhea or colitis</th>
<th>Permanently discontinue</th>
<th>Initiate corticosteroids at a dose of 1 to 2mg/kg/day methylprednisolone (equivalents)</th>
</tr>
</thead>
</table>

### Immune-related hepatitis

Patients should be monitored for signs and symptoms of hepatitis such as transaminase and total bilirubin elevations. Infectious and disease-related aetiologies should be ruled out.

<table>
<thead>
<tr>
<th>Grade 2 transaminase or total bilirubin elevation</th>
<th>Withhold</th>
<th>Persistent elevations in these laboratory values should be managed with corticosteroids at a dose of 0.5 to 1mg/kg/day methylprednisolone equivalents. Upon improvement, nivolumab may be resumed after corticosteroid taper</th>
</tr>
</thead>
<tbody>
<tr>
<td>If worsening or no improvement occurs despite initiation of corticosteroids</td>
<td>Permanently discontinue</td>
<td>Increase corticosteroid dose to 1 to 2mg/kg/day methylprednisolone (equivalents)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade 3 or 4 transaminase or total bilirubin elevation</th>
<th>Permanently discontinue</th>
<th>Initiate corticosteroids at a dose of 1 to 2mg/kg/day methylprednisolone (equivalents)</th>
</tr>
</thead>
</table>

### Immune-related nephritis or renal dysfunction

Patients should be monitored for signs and symptoms of nephritis and renal dysfunction. Most patients present with...

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**NCCP Regimen: Nivolumab Monotherapy**
480mg-28 days  
**Published:** 21/05/2018  
**Review:** 06/11/2021  
**Version:** 6

**Tumour Group:** Genitourinary/ Melanoma/ Lymphoma/Lung/Head and Neck  
**NCCP Regimen Code:** 000484  
**ISMO Contributor:** Prof. G. Gullo, Dr. D. O’Mahony, Dr. R Bambury, Dr. Fergal Kelleher, Prof Maccon Keane  
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asymptomatic increases in serum creatinine. Disease-related aetiologies should be ruled out.

| Grade 2 or 3 serum creatinine elevation | Withhold | Initiate corticosteroids at a dose of 0.5 to 1mg/kg/day methylprednisolone (/equivalents) Upon improvement, nivolumab may be resumed after corticosteroid taper |
| If worsening or no improvement occurs despite initiation of corticosteroids | Permanently discontinue | Increase corticosteroid dose to 1 to 2mg/kg/day methylprednisolone (/equivalents) |
| Grade 4 serum creatinine elevation | Permanently discontinue | Initiate corticosteroids at a dose of 1 to 2mg/kg/day methylprednisolone (/equivalents) |

**Immune-related endocrinopathies**

Patients should be monitored for clinical signs and symptoms of endocrinopathies and for hyperglycaemia and changes in thyroid function (at the start of treatment, periodically during treatment, and as indicated based on clinical evaluation). Patients may present with fatigue, headache, mental status changes, abdominal pain, unusual bowel habits, and hypotension, or nonspecific symptoms which may resemble other causes such as brain metastasis or underlying disease. Unless an alternate etiology has been identified, signs or symptoms of endocrinopathies should be considered immune-related.

**Symptomatic hypothyroidism**

| Withhold | Thyroid hormone replacement should be initiated as needed |

**Symptomatic hyperthyroidism**

| Withhold | Antithyroid medication should be initiated as needed Corticosteroids at a dose of 1 to 2mg/kg/day methylprednisolone equivalents should also be considered if acute inflammation of the thyroid is suspected. Upon improvement, nivolumab may be resumed after corticosteroid taper, if needed. Monitoring of thyroid function should continue to ensure appropriate hormone replacement is utilised. |

**Life-threatening hyperthyroidism or hypothyroidism**

| Permanently discontinue |

**Symptomatic Grade 2 adrenal insufficiency**

| Withhold | Physiologic corticosteroid replacement should be initiated as needed. |

**Severe (Grade 3) or life-threatening (Grade 4) adrenal insufficiency**

| Permanently discontinue | Monitoring of adrenal function and hormone levels should continue to ensure appropriate corticosteroid replacement is utilised |

**Symptomatic Grade 2 or 3 hypophysitis**

| Withhold | Hormone replacement should be initiated as needed. Corticosteroids at a dose of 1 to 2mg/kg/day methylprednisolone (/ equivalents) should also be considered if acute inflammation of the pituitary gland is suspected. Upon improvement, nivolumab may be resumed after corticosteroid taper, if needed. Monitoring of pituitary function and hormone levels should continue to ensure appropriate hormone replacement is utilised |

**Life-threatening (Grade 4) hypophysitis**

| Permanently discontinue | Monitoring of pituitary function and hormone levels should continue to ensure appropriate hormone replacement is utilised |

**Symptomatic diabetes**

| Withhold | Insulin replacement should be initiated as needed. Monitoring of blood sugar should continue to ensure appropriate insulin replacement is utilised |

**Life-threatening diabetes**

| Permanently discontinue |

**Immune-related skin adverse reactions**

**Grade 3 rash**

| Withhold | Severe rash should be managed with high-dose corticosteroid at
Grade 4 rash | Permanently discontinue | a dose of 1 to 2mg/kg/day methylprednisolone equivalents. Rare cases of toxic epidermal necrolysis (TEN) some of them with fatal outcome have been observed. If symptoms or signs of Stevens-Johnson Syndrome (SJS) or TEN appear, nivolumab treatment should be discontinued and the patient referred to a specialised unit for assessment and treatment. If the patient has developed SJS or TEN with the use of nivolumab, permanent discontinuation of nivolumab is recommended. Caution should be used when considering the use of nivolumab in a patient who has previously experienced a severe or life-threatening skin adverse reaction on prior treatment with other immunestimulatory anticancer agents.

Other immune-related adverse reactions
For suspected immune-related adverse reactions, adequate evaluation should be performed to confirm aetiology or exclude other causes. Based on the severity of the adverse reaction, nivolumab should be withheld and corticosteroids administered. Upon improvement, nivolumab may be resumed after corticosteroid taper. Nivolumab must be permanently discontinued for any severe immune-related adverse reaction that recurs and for any life-threatening immune-related adverse reaction.

Infusion reactions
- Mild or moderate infusion reaction: Caution
  - May receive nivolumab with close monitoring and use of premedication according to local treatment guidelines for prophylaxis of infusion reactions
- Severe or life-threatening infusion reaction: Discontinue infusion
  - Administer appropriate medical therapy

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

ATC CODE:
Nivolumab – L01XC17

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:
https://www.hpra.ie/img/uploaded/swedocuments/f58c69f8-7bab-4188-a8d8-bca03e1beb1b.pdf
REFERENCES:


<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Amendment</th>
<th>Approved By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21/05/18</td>
<td></td>
<td>Prof. G. Gullo, Dr. D. O’Mahony, Dr. R Bambury, Dr. L Bacon, Dr E Hanrahan</td>
</tr>
<tr>
<td>2</td>
<td>05/02/2019</td>
<td>Updated thyroid function testing</td>
<td>Prof Maccon Keane</td>
</tr>
<tr>
<td>3</td>
<td>09/10/2019</td>
<td>Inclusion of caution for use in patients with a clinically significant history of auto-immune disease</td>
<td>Dr Deidre O’Mahony, Dr. S. Cuffe. Dr E Hanrahan</td>
</tr>
<tr>
<td>4</td>
<td>06/11/2019</td>
<td>Inclusion of adjuvant melanoma indication</td>
<td>Prof Maccon Keane</td>
</tr>
</tbody>
</table>

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Tumour Group: Genitourinary/ Melanoma/ Lymphoma/Lung/Head and Neck NCCP Regimen Code: 000484 ISMO Contributor: Prof. G. Gullo, Dr. D. O’Mahony, Dr. R Bambury, Dr. Fergal Kelleher, Prof Maccon Keane

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Version number: 6

Tumour Group: Genitourinary/ Melanoma/
Lymphoma/Lung/Head and Neck
NCCP Regimen Code: 000484

Prof Maccon Keane

Comments and feedback welcome at oncologydrugs@cancercontrol.ie.

1 Post 2012 indication. Not reimbursed through the ODMS or Community Drug Schemes (including the High Tech arrangements of the PCRS community drug schemes). Please check https://www.hse.ie/eng/services/list/5/cancer/profinfomedonc/cdmp/new.html for the most up to date reimbursement approvals.

ODMS – Oncology Drug Management System
CDS – Community Drug Schemes (CDS) including the High Tech arrangements of the PCRS community drug schemes

The administration of nivolumab 480mg once every 28 days is an unlicensed dosing posology for this indication in Ireland. Patient’s should be informed of this and consented to treatment in line with the hospital’s policy on the use of unlicensed medication and unlicensed or “off label” indications. Prescribers should be fully aware of their responsibility in communicating any relevant information to the patient and also ensuring that the unlicensed or “off label” means of administration has been acknowledged by the hospital’s Drugs and Therapeutics Committee, or equivalent, in line with hospital policy.

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

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