Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
BONE-B (1 of 6) External request: Submission from Merck & Co., Inc., (4/29/20) requesting the inclusion of the updated dosing recommendations for pembrolizumab, either 200 mg every 3 weeks or 400 mg every 6 weeks administered as a 30-minute intravenous (IV) infusion until disease progression, unacceptable toxicity, or up to 24 months for the treatment of adult patients with microsatellite instability-high (MSI-H) bone cancer, to BONE-B (page 1 of 6) in the NCCN Bone Cancer Guidelines.	Based on a review of the data and discussion, the panel consensus supported the inclusion of pembrolizumab, as a footnote, either 200 mg every 3 weeks or 400 mg every 6 weeks administered as a 30-minute intravenous (IV) infusion until disease progression, unacceptable toxicity, or up to 24 months as an option for the treatment of adult patients with microsatellite instability-high (MSI-H) bone cancer. This is a category 2A, preferred recommendation. See Submission for references.	20	0	0	8
BONE-B (1 of 6) External request: Submission from Merck & Co., Inc., (3/20/20) requesting that the updated publication by Marabelle, be added as a reference to support pembrolizumab as a treatment option for patients with MSI-H bone cancer (page BONE-B 1 of 5) in the NCCN Bone Cancer Guidelines.	Based on a review of the data and discussion, the panel consensus supported the inclusion of the updated publication by Marabelle, to be added as a reference to support pembrolizumab as a treatment option for patients with MSI-H bone cancer. See Submission for reference.	20	0	0	8
BONE-B (1 of 6) Internal request: Comment to consider the inclusion of pazopanib as an option for metastatic and widespread disease for chondrosarcoma.	Based on a review of the data and discussion, the panel consensus supported the inclusion of pazopanib for metastatic and widespread disease for chondrosarcoma. This is a category 2A, other recommended recommendation. • Chow W, Frankel P, Ruel C, et al. Results of a prospective phase 2 study of pazopanib in patients with surgically unresectable or metastatic chondrosarcoma. Cancer 2020;126:105-111.	20	0	0	8

NCCN Guidelines for Bone Cancer V.1.2021 – Follow-Up on 06/12/20

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
BONE-B (1 of 6) External request: Submission from Agios Pharmaceuticals, Inc. (3/30/20) Recommend the addition of ivosidenib to the chondrosarcoma guidelines as a treatment option for patients with chondrosarcoma (any tumor grade) who received prior surgery, systemic therapy, or radiotherapy and have an *IDH1* mutation.	Based on a review of the data and discussion, the panel consensus supported the inclusion of ivosidenib (for susceptible *IDH1* mutations) for Chondrosarcoma as follows: • Conventional (Grades 1-3). This is a category 2A, useful in certain circumstances recommendation. • Dedifferentiated chondrosarcoma. This is a category 2A, useful in certain circumstances recommendation.	20	0	0	8
BONE-B (2 of 6) Internal request: The 2019 CTOS presentation suggest VIDE is inferior to VCD/IE for Ewing sarcoma. Should it remain category 1?	Based on a review of the data and discussion, the panel consensus supported the continued listing of VIDE (vincristine, ifosfamide, doxorubicin and etoposide) with a change in category from a category 1, other recommended regimen to a category 2A, other recommended regimen for first-line therapy and primary therapy for metastatic disease for Ewing sarcoma.	12	0	5	11
BONE-B (2 of 6) Internal request: Suggest adding cabozantinib under second-line systemic therapy options for Ewing sarcoma and osteosarcoma (BONE-B, 3 of 6) (relapsed/refractory or metastatic disease). External request: Submission from Exelixis, Inc. (4/15/20). Respectfully request that the NCCN Bone Cancer Guidelines Panel consider the inclusion of cabozantinib as a second-line systemic therapy options for Ewing sarcoma (relapsed/refractory or metastatic disease) and osteosarcoma (relapsed/refractory or metastatic disease).	Based on a review of the data and discussion, the panel consensus supported the inclusion of cabozantinib for Ewing sarcoma and osteosarcoma as follows: • Second-line therapy (relapsed/refractory or metastatic disease. This is a category 2A, other recommended regimen.	20	0	0	8

Guideline Page and Request	**Panel Discussion/References**	Institution Vote			
		YES	**NO**	**ABSTAIN**	**ABSENT**
BONE-B (2 of 6) Internal request: Listing the regimen, irinotecan ± temozolomide ± vincristine could be interpreted that the combination of just irinotecan and vincristine is appropriate/preferred for Ewing sarcoma.	The Panel consensus was to remove the ± between irinotecan ± temozolomide and present the regimen as follows: irinotecan + temozolomide ± vincristine for second-line systemic therapy options for Ewing sarcoma. This is a category 2A, preferred recommendation.	20	0	0	8
BONE-B (2 of 6) Internal request: Consider removal of ifosfamide/etoposide as a preferred regimen for second-line systemic therapy options for Ewing sarcoma (relapsed/refractory or metastatic disease).	The Panel consensus was to remove ifosfamide/etoposide as a preferred regimen for second-line systemic therapy options for Ewing sarcoma (relapsed/refractory or metastatic disease).	20	0	0	8
BONE-B (3 of 6) Internal request: Consider moving sorafenib and everolimus from preferred regimens for osteosarcoma for second-line therapy (relapsed/refractory or metastatic disease) to other recommended regimens.	The Panel consensus was to move sorafenib and everolimus from preferred regimens for osteosarcoma for second-line therapy (relapsed/refractory or metastatic disease) to other recommended regimens.	20	0	0	8
BONE-B (3 of 6) External request: Submission from BTG International Inc. (12/18/19). We propose that the following recommendation be made as a footnote to mentions of high-dose methotrexate for osteosarcoma. In the event a patient receiving high-dose methotrexate experiences delayed elimination due to renal impairment, glucarpidase is strongly recommended in the context of a rising serum creatinine if the 36-hour plasma methotrexate level is above 30 µM, 42-hour level is above 10 µM, or 48-hour level is above 5 µM. Optimal administration of glucarpidase is within 48 to 60 hours from the start of methotrexate infusion.	Based on the review of the data and discussion, the panel did not use the language proposed in the submission. However, the panel supported adding the following language as a footnote to all mentions of high-dose methotrexate for osteosarcoma, *In the event a patient receiving high-dose methotrexate experiences delayed elimination due to renal impairment, glucarpidase is strongly recommended*.	0	20	0	8