Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
Submission request from The Bladder Cancer Advocacy Network (BCAN) (07/27/20) • Managing common side effects, such as those experienced by patients having BCG treatments, are not addressed, and should be. There is an NCCN patient guideline for managing IO side effects that could be referenced if you feel it is appropriate. Many bladder cancer patients experience *recurrent urinary tract infections* as a side effect during their treatment journey and well into survivorship.	Based on the discussion, the panel consensus was to not include language about managing common side effects, such as those experienced by patients having BCG treatments as proposed in the submission. However, the panel suggested that this could be considered for inclusion in the NCCN Guidelines for Patients with Bladder Cancer.	0	24	0	7
• Clinical Trials – the message on page 5 is important, but is lost as a footnote and not positioned as a treatment option in the remaining document. Please consider listing clinical trials as a viable treatment option throughout, or *somehow making the recommendation more prominent than a mere footnote*.	Based on the discussion, the panel consensus was to not include additional clinical trial language beyond the current recommendations for clinical trials in the Guidelines.	0	24	0	7
• Clearly assessing patient goals of care as an element of the guidelines, would help bridge the divide between treating a tumor and treating the patients living with the disease. Perhaps adding a statement to the introduction will help to highlight this for clinicians.	Based on the discussion, the panel consensus was to not include language assessing patient goals of care in the Guidelines as this is general knowledge in the care of patients. The panel suggested that this could be considered for inclusion in the NCCN Guidelines for Patients with Bladder Cancer.	0	24	0	7
• The current document does not address environmental or occupational risk factors (including those for military personnel or first responders) that may be significant in disease development or progression. [Smoking is listed as risk factor on BL-1, *Veterans and Agent Orange: Update 2014* changed the categories of association with exposure to the herbicides sprayed in Vietnam for three health effects. Bladder cancer was moved from “inadequate or insufficient”	Based on the discussion, the panel consensus was to not include language about agent orange in the Guidelines. However, the panel suggested that this could be considered for inclusion corresponding Discussion section and in the NCCN Guidelines for Patients with Bladder Cancer.	0	24	0	7

evidence of association up to “limited or suggestive” evidence of association. The VA has yet to make a formal statement about bladder cancer as a presumptive condition as a result of Agent Orange exposure though. Current VA Burn Pit Registries are attempting to document the impact of this environmental/occupational exposure on the health of veterans of modern warfare.]					
• Urinary diversion options are not fully highlighted in the radical cystectomy segments. Continent Cutaneous Pouch or CCP (Indiana Pouch) and Neobladder are not mentioned anywhere in the document. [Radical cystectomy first appears on page BL-5. Also on BL-7, BL-B. Ileal conduit is mentioned one time on BL-H. CCP is nowhere in the document and neobladder is also not included. All three are viable urinary diversion options and should be explained to patients.]	Based on the discussion, the panel consensus was to not include language about urinary diversion options in the Guidelines. However, the panel suggested that this could be considered for inclusion in the NCCN Guidelines for Patients with Bladder Cancer.	0	24	0	7
• Bladder preservation (using trimodal therapy) is neither included nor explained as a viable treatment option in most of the recommendations. [Bladder preservation is first mentioned in the footnotes of BL-5 and 7. Trimodality therapy does not show up until BL-B. It is not offered as an actual treatment option anywhere. Bladder preserving options are included in the Treatment of Non-Metastatic Muscle-Invasive Bladder Cancer: AUA/ASCO/ASTRO/SUO Guideline (2017) Chang SS et al. J Urol. 2017;198:552-559.]	Based on the discussion, the panel consensus was to include clarifying language as of “bladder preservation” to the recommendation concurrent chemoradiotherapy on BL-5**.**	24	0	0	7
• Best supportive care – starts on BL-6 and is mentioned throughout, yet it is not defined. NCCN has numerous (12) guidelines on supportive care, including palliative care. We recommend at least mentioning them early in the document.	Based on the discussion, the panel consensus to include a link to the NCCN Guidelines for Palliative Care for each mention of best supportive care.	24	0	0	7

[Pain, Antiemesis, and Palliative Care are three examples that can be mentioned/linked]. • Recently approved treatment options focusing on genetic mutations present a need for patients to understand and consider genomic testing to allow for more treatment or clinical trial options, should they experience disease progression. This first appears on page BL-8 and should be suggested earlier in disease staging.	Based on the discussion, the panel consensus was to not include further language about genomic testing options in the Guidelines. However, the panel suggested that this could be considered for inclusion in the NCCN Guidelines for Patients with Bladder Cancer.	0	24	0	7
BL-3, BL-4, BL-G 2 of 7 and 3 of 7 Submission from Merck and Co., Inc. (04/09/20) to consider We respectfully request 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 locally advanced or metastatic urothelial carcinoma (UC), including cancers that are microsatellite instability-high (MSI-H), to BL-G (pages 2 and 3 of 7) in the NCCN Bladder Cancer Guidelines. • until persistent or recurrent high-risk non-muscle invasive bladder cancer (NMIBC), disease progression, unacceptable toxicity, or up to 24 months for the treatment of adult patients with high-risk Bacillus Calmette-Guerin (BCG)-unresponsive NMIBC, including cancers that are MSI-H, to pages BL-3 and BL-4 in the NCCN Bladder Cancer Guidelines.	Based on the discussion, the panel consensus did not support the inclusion of updated dosing recommendations for pembrolizumab. Dosing recommendations are not included in the guidelines for other regimens. However, the dosing will be included in the NCCN Chemotherapy Order Templates.	0	24	0	7
BL-8, BL9, BL-10 External request Submission request from Foundation Medicine, (08/28/20): Update footnote “z” to read “recommend	Based on a review of the data and discussion, the panel consensus was not to make changes to the current recommendations.	0	24	0	7

comprehensive genomic profiling (CGP) via a validated NGS-based assay for patients diagnosed with advanced bladder cancer to inform the use of currently available biomarker driven therapies and define/refine clinical trial options". This update would reinforce the language on pages MS-24 and MS-25 supporting the use of molecular testing at diagnosis to determine eligibility for FDA-approved therapies as well as screen for clinical trial eligibility.					