Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
ORPH-2 Internal request: Institutional review comment to expand the indications for primary therapy with RT + systemic therapy/RT to make it an option for patients with stage T1, N1, p16-negative oropharyngeal cancer.	Based on the data in the noted reference and discussion, the panel consensus was to expand the indications for primary therapy with RT + systemic therapy/RT to include stage T1, N1, p16-negative oropharyngeal cancer. RT + systemic therapy is an option for T1-2, N1 disease only. This is a category 2B recommendation. Reference: Denis F, Garaud P, Bardet E, et al. Final results of the 94-01 French Head and Neck Oncology and Radiotherapy Group randomized trial comparing radiotherapy alone with concomitant radiochemotherapy in advanced-stage oropharynx carcinoma. J Clin Oncol 2004;22:69-76.	12	7	0	8
ORPHPV-1 Internal request: Panel comment to include systemic therapy/RT as an adjuvant therapy option for stage T1-2, N0-1, p16 (HPV)-positive oropharyngeal cancer, for those with extranodal extension (ENE) with or without a positive margin following surgery.	The panel consensus was to include systemic therapy/RT as an adjuvant therapy option if there is extranodal extension with or without a positive margin following surgery for stage T1-2, N0-1, p16 (HPV)-positive oropharyngeal cancer. This is a category 2A recommendation.	21	0	0	6
ORPHPV-1 Internal request: Panel comment to consider the addition of systemic therapy/RT as an adjuvant therapy option for stage T1-2, N0-1, p16 (HPV)-positive oropharyngeal cancer, for those with a positive margin following surgery.	The panel consensus was to include systemic therapy/RT as an adjuvant therapy option if there is a positive margin following surgery for stage T1-2, N0-1, p16 (HPV)-positive oropharyngeal cancer. This is a category 2A recommendation.	19	2	0	6
ORPHPV-1 Internal request: Panel comment to consider the addition of systemic therapy/RT as an adjuvant therapy option for stage T1-2, N0-1, p16 (HPV)-positive oropharyngeal cancer, for those with other risk features (excluding ENE or a positive margin) following surgery.	The panel consensus was to include systemic therapy/RT as an adjuvant therapy option if there are other risk features (excluding ENE and/or a positive margin) following surgery for stage T1-2, N0-1, p16 (HPV)-positive oropharyngeal cancer. This is a category 2B recommendation.	14	7	0	6

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
ORPHPV-2 Internal request: Panel comment to include systemic therapy/RT as an adjuvant therapy option for clinical stage T3-4, N0-1, p16 (HPV)-positive oropharyngeal cancer, for those with ENE and/or positive margin, or other risk features following surgery.	The panel consensus was to include systemic therapy/RT as an adjuvant therapy option if there is ENE and/or a positive margin, or other risk features following surgery for stage T3-4, N0-1, p16 (HPV)-positive oropharyngeal cancer. This is a category 2A recommendation.	21	0	0	6
ORPHPV-3 Internal request: Panel comment to include systemic therapy/RT as an adjuvant therapy option for those with ENE and/or positive margin, or other risk features following surgery for p16 (HPV)-positive oropharyngeal cancer, clinical stage any T, N1 (single node >3 cm, or 2 or more ipsilateral nodes ≤6 cm), or N2-3.	The panel consensus was to include systemic therapy/RT as an adjuvant therapy option for ENE and/or a positive margin, or as an option to consider in the presence of other risk features, following surgery for p16 (HPV)-positive oropharyngeal cancer, if clinical stage any T, N1 (single node >3 cm, or 2 or more ipsilateral nodes ≤6 cm), or N2-3. This is a category 2A recommendation.	21	0	0	6
NASO-2 Internal request: Institutional review comment to reassess the inclusion of induction chemotherapy followed by chemo/RT as a primary therapy option for nasopharyngeal cancer, stage T1, N1-3; or T2-4, any N.	Based on the discussion and noted reference, the panel consensus supported the continued listing of induction chemotherapy followed by chemo/RT as a primary therapy option for nasopharyngeal cancer, stage T1, N1-3; or T2-4, any N. This recommendation changed from a category 3 to a category 2A. Reference: Sun Y, Li WF, Chen NY, *et al.* Induction chemotherapy plus concurrent chemoradiotherapy versus concurrent chemoradiotherapy alone in locoregionally advanced nasopharyngeal carcinoma: a phase 3, multicentre, randomised controlled trial. *The Lancet. Oncology* 2016; 17(11)**:** 1509-1520.	18	3	0	6
GLOT-6 Internal request: Institutional review comment to clarify the adjuvant therapy options for patients with ENE and/or positive margin and options for those with other adverse features, after surgery for T4a, any N cancer of the glottic larynx.	The panel consensus was to include the following adjuvant therapy options for patients with for T4a, any N cancer of the glottic larynx: • If ENE and/or positive margin: Systemic therapy/RT (category 1) • If other adverse features: RT or consider systemic therapy/RT or observation for highly selected patients	21	0	0	6

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
ETHM-3 Internal request: Institutional review comment to clarify the adjuvant therapy options after primary surgery if diagnosed after incomplete resection with no residual disease on physical exam, imaging and/or endoscopy.	For those diagnosed after incomplete resection with no residual disease on physical exam, imaging and/or endoscopy, the panel consensus was to include systemic therapy/RT following primary surgery as an adjuvant therapy option to consider in the presence of adverse features. This is a category 2B recommendation.	21	0	0	6
MAXI-3 Internal request: Panel comment to consider removing the following footnote for T3-4a, N0 maxillary sinus tumors: “For surgical resection, consider preoperative RT or preoperative systemic therapy/RT in select patients (category 2B).”	The panel consensus was to remove the following footnote with preoperative recommendations for T3-4a, N0 maxillary sinus tumors: “For surgical resection, consider preoperative RT or preoperative systemic therapy/RT in select patients (category 2B).”	21	0	0	6
ADV-1 External request: Submission from Foundation Medicine to review data for inclusion of hybrid capture based NGS in the evaluation of patients with advanced head and neck cancers to inform the use of currently approved genomically matched therapies or counsel patients on the option of an appropriately matched clinical trial. (Also on ADV-3, OCC-1, and SALI-2)	Based on the data in the references noted in the submission, the panel consensus did not support the addition of these specific recommendations into the Guidelines. See Submission for references	1	19	0	7

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
SALI-4 Internal request: Institutional review comment to consider assessment of androgen receptor and HER2 status if appropriate based on histology.	Based on the data in the noted reference and discussion, the panel consensus was to include the following footnote on the assessment of AR and HER2 status: "Check androgen receptor (AR) status and HER2 status prior to treatment for distant metastases." Based on the data in the noted reference and discussion, the panel consensus was to include androgen receptor therapy (eg, leuprolide, bicalutamide) as a recurrence therapy option for patients with AR positive, metastatic disease. This is a category 2A recommendation. Based on the data in the noted reference and discussion, the panel consensus was to include trastuzumab as a recurrence therapy option for patients with HER2 positive, metastatic disease. This is a category 2B recommendation. Reference: Fan CY, Wang J, Barnes EL. Expression of androgen receptor and prostatic specific markers in salivary duct carcinoma: an immunohistochemical analysis of 13 cases and review of the literature. Am J Surg Pathol 2000; 24(4): 579-586.	21 18 17	0 3 5	0 0 0	6 6 4
CHEM-A (1 of 5) Internal request Institutional review comment to consider including weekly cisplatin as an option for use with concurrent radiation following induction chemotherapy for cancers of the lip, oral cavity, oropharynx, hypopharynx, glottic larynx, supraglottic larynx, ethmoid sinus, maxillary sinus, and occult primary tumors.	Based on the discussion, the panel consensus was to include weekly cisplatin as an option for use with concurrent radiation following induction chemotherapy for cancers of the lip, oral cavity, oropharynx, hypopharynx, glottic larynx, supraglottic larynx, ethmoid sinus, maxillary sinus, and occult primary tumors. This is a category 2B recommendation.	11	9	0	6
CHEM-A (2 of 5) Internal request: Institutional review comment to consider removing gemcitabine/vinorelbine from the systemic therapy options for recurrent, unresectable, or metastatic nasopharyngeal cancer.	Based on the discussion, the panel consensus was to remove gemcitabine/vinorelbine from the systemic therapy options for recurrent, unresectable, or metastatic nasopharyngeal cancer due to limited clinical use in this setting.	21	0	0	6

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
CHEM-A (2 of 5) Internal request: Institutional review comment to review the data for the use of cisplatin/gemcitabine for recurrent, unresectable, or metastatic nasopharyngeal cancer.	Based on the discussion and noted reference, the panel consensus supported the continued listing of cisplatin/gemcitabine as an option for recurrent, unresectable, or metastatic nasopharyngeal cancer. This recommendation changed from a category 2A to a category 1. References: Zhang L, Huang Y, Hong S, Yang Y, Yu G, Jia J et al. Gemcitabine plus cisplatin versus fluorouracil plus cisplatin in recurrent or metastatic nasopharyngeal carcinoma: a multicentre, randomised, open-label, phase 3 trial. Lancet 2016; 388(10054): 1883-1892.	21	0	0	6
CHEM-A (2 of 5) External request Submission from Merck & Co., Inc., to review the data for inclusion of pembrolizumab as a systemic therapy treatment option for unresectable or metastatic microsatellite instability high (MSI-H) or deficient mismatch repair (dMMR) solid tumors that have progressed following prior treatment and have no satisfactory alternative treatment options.	Based on the data in the references noted in the submission, the panel consensus was not to make changes to the current recommendations. See Submission for references	3	11	5	8