Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
ME-1, ME-3, ME-B External request: Submission from Castle Biosciences, Inc (05/30/18) to consider inclusion of the DecisionDx-Melanoma test in the guidelines as a prognostic test that provides stratification according to metastatic risk for cutaneous melanoma patients to help inform management decisions by changing footnote d to read "Gene expression profiling to differentiate melanomas at low (Class 1) versus high (Class 2) risk for metastasis may provide additional information on individual risk of recurrence beyond standard clinical and pathological staging, which may inform management decisions." Also for ME-3 and ME-B footnote c.	Based on a review of data and discussion, the panel did not support making the proposed footnote change. References: • Zager JS, Gastman BR, Leachman S, et al. Performance of a prognostic 31-gene expression profile in an independent cohort of 523 cutaneous melanoma patients. BMC Cancer 2018;18:130. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29402264. • Hsueh EC, DeBloom JR, Lee J, et al. Interim analysis of survival in a prospective, multi-center registry cohort of cutaneous melanoma tested with a prognostic 31-gene expression profile test. J Hematol Oncol 2017;10:152. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28851416.	0	25	1	2
ME-3, ME-4, ME-5, ME-7, ME-13, ME-14 Internal request Institutional review and panel member comments to remove interferon alfa as an adjuvant treatment option for melanoma due to changes in clinical practice across NCCN institutions. For each of the adjuvant treatment settings, the panel voted on whether to retain interferon alfa as an option.	Based on discussion of clinical practice at NCCN Institutions, panel consensus supported removing interferon alfa as an option in the following settings:				
	• Adjuvant treatment option for patients with newly-diagnosed stage IB (T2a) or II (>1 mm thick, any feature, N0). (ME-3)	9	18	0	1
	• Adjuvant treatment for newly-diagnosed stage III melanoma (sentinel node positive) (ME-4)	3	16	8	1
	• Adjuvant treatment for newly-diagnosed Stage III (clinically positive node[s]), after wide local excision and complete therapeutic lymph node dissection. (ME-5)	1	21	4	2
	• Adjuvant treatment for newly-diagnosed Stage III (clinical satellite or in-transit) with no evidence of disease after surgery (ME-7)	2	21	4	1
	• Adjuvant treatment for local satellite and/or in-transit recurrence in patients who have no evidence of disease after surgery (ME-13)	1	21	5	1
	• Adjuvant treatment for completely resected nodal recurrence (ME-14)	1	21	5	1

Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
ME-4, ME-5, ME-6, ME-8, ME-9, ME-10, ME-12, ME-14 External request: Submission from Novartis Pharmaceuticals Corporation (5/30/18) to consider modifying the guidelines and compendium based on the pivotal trials and FDA-approved labeling for dabrafenib and trametinib in patients with resected stage III or metastatic stage IV BRAF V600-mutant melanoma as follows: Include a bullet for mutational testing to confirm BRAF status as part of the workup for stage III and IV melanoma.	The panel noted that BRAF testing is already recommended for stage IV in footnote ii on ME-8, ME-9, ME-10, ME-12, ME-14, and ME-15. The panel voted on whether to include BRAF testing in the footnotes for stage III and higher. Based on review of the data and discussion, panel consensus supported adding footnote "s" on ME-4, ME-5, and ME-6 to include BRAF testing. References: • Long GV, Hauschild A, Santinami M, et al. Adjuvant Dabrafenib plus Trametinib in Stage III BRAF-Mutated Melanoma. N Engl J Med 2017;377:1813-1823. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28891408.	22	0	0	6
ME-4: External request: Submission from Bristol-Myers Squibb (12/21/17) requesting to change the recommendation of Category 1 (preferred adjuvant immunotherapy regimen) designation of "Nivolumab for resected Stage IIIB/C" to "Nivolumab".	Based on a review of data and discussion, the panel consensus supported including nivolumab as an adjuvant treatment option (category 2A) for all patients with resected stage III melanoma, with footnotes to indicate the specific study population in which adjuvant nivolumab was tested, and to say that adjuvant treatment may not be beneficial for very low risk patients. Based on the vote above, the panel revised the adjuvant treatment option for Stage III sentinel node positive disease as follows: "Nivolumab ~~for resected stage high-risk IIIB/C~~ ~~(category 1)~~…" with the following language in footnotes: • Footnote v: "In patients with very-low-risk stage IIIA disease (non-ulcerated primary, SLN metastasis <1 mm), the toxicity of adjuvant therapy may outweigh the benefit." • Footnote x: "Adjuvant nivolumab is a category 1 option for patients with AJCC 7th Edition stage IIIB/C disease." • Footnote y: "Randomized clinical trials testing adjuvant anti-PD-1 therapy included patients with sentinel node-positive disease at high risk: those with ulcerated primary (nivolumab, pembrolizumab) or an SLN metastasis >1 mm (pembrolizumab)." Reference: • Weber J, Mandala M, Del Vecchio M, et al. Adjuvant Nivolumab versus Ipilimumab in Resected Stage III or IV Melanoma. N Engl J Med 2017;377:1824-1835. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28891423.	21	0	6	1

Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
ME-4, ME-5 Internal request: Institutional review comment to reconsider the data regarding high-dose ipilimumab versus nivolumab for adjuvant treatment of stage III disease. Panel voted on whether to retain high-dose adjuvant ipilimumab as a first-line adjuvant treatment option for patients with (1) newly-diagnosed stage III sentinel node positive disease, and (2) newly-diagnosed stage III disease with clinically positive node[s], after wide local excision and complete therapeutic lymph node dissection.	Based on a review of data and discussion, panel consensus was to remove "high-dose ipilimumab for SLN metastasis >1 mm (category 1)" as an adjuvant treatment option for Stage III sentinel node positive disease.(ME-4) Based on a review of data and discussion, panel consensus was to remove "high-dose ipilimumab (category 1)" as an adjuvant treatment option for newly-diagnosed Stage III (clinically positive node [s]), after wide local excision and complete therapeutic lymph node dissection. Reference: • Weber J, Mandala M, Del Vecchio M, et al. Adjuvant Nivolumab versus Ipilimumab in Resected Stage III or IV Melanoma. N Engl J Med 2017;377:1824-1835. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28891423.	8 6	14 16	5 1	1 5
ME-5, ME-14 External request: Submission from Novartis Pharmaceuticals Corporation (5/30/18) to consider modifying the adjuvant treatment algorithms for adjuvant therapy to show locoregional options **or** systemic options rather than the current version that shows locoregional options first, followed by systemic options.	Based on discussion, panel consensus supported revising the algorithm by removing the arrow from "Locoregional option" that pointed to "Systemic options." The recommendation was changed to "Locoregional option **and/or** Systemic options."	22	0	0	6

Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
Multiple pages: External request: Submission from Merck & Co (04/15/18) to add pembrolizumab as an adjuvant treatment option for patients with resected, high-risk stage III melanoma as a category 1 recommendation. **ME-5, ME-7, ME-13, ME-14, ME-15** Internal request: Institutional review comment and panel member request to consider adding pembrolizumab as an adjuvant treatment option for recurrent or metastatic melanoma.	Based on a review of data from the submission and discussion, the panel consensus was to include pembrolizumab as an adjuvant treatment option for patients with resected, high-risk stage III melanoma. Based on a review of data and discussion, panel consensus supported adding pembrolizumab as a treatment option in the following settings:				
	• Adjuvant treatment for newly-diagnosed stage III (sentinel node positive) disease, with the following text in footnotes: (ME-4) o Footnote y: "Randomized clinical trials testing adjuvant anti-PD-1 therapy included patients with sentinel node-positive disease at high risk: those with ulcerated primary (nivolumab, pembrolizumab) or an SLN metastasis >1 mm (pembrolizumab)." o Footnote v: "In patients with very-low-risk stage IIIA disease (non-ulcerated primary, SLN metastasis <1 mm), the toxicity of adjuvant therapy may outweigh the benefit."	18	0	9	1
	• Adjuvant treatment for newly-diagnosed Stage III (clinically positive node [s]), after wide local excision and complete therapeutic lymph node dissection (ME-5)	20	0	7	1
	• Adjuvant treatment for newly-diagnosed Stage III (clinical or microscopic satellite/in-transit) with no evidence of disease after surgery. (ME-7)	20	0	7	1
	• Adjuvant treatment for local satellite and/or in-transit recurrence in patients who have no evidence of disease after surgery (ME-13)	18	1	7	2
	• Adjuvant treatment for completely resected nodal recurrence (ME-14)	20	0	7	1
	• Adjuvant treatment for resected stage IV distant metastatic disease (for patients with now evidence of disease after resection) (ME-15)	19	2	6	1
	Reference: • Eggermont AMM, Blank CU, Mandala M, et al. Adjuvant Pembrolizumab versus Placebo in Resected Stage III Melanoma. N Engl J Med 2018;378:1789-1801. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29658430.				

Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
ME-5, ME-14 Internal request: Institutional review and panel member comments to remove biochemotherapy as an adjuvant treatment option for melanoma based on clinical practice across NCCN Institutions.	Based on discussion of clinical practice at NCCN Institutions, panel consensus supported removing biochemotherapy as an option in the following settings: • Adjuvant treatment for newly-diagnosed Stage III (clinically positive node [s]), after wide local excision and complete therapeutic lymph node dissection. (ME-5) • Adjuvant treatment for completely resected nodal recurrence (ME-14)	0 2	22 20	4 5	2 1
ME-8, ME-9, ME-10, ME-12, ME-15 External request: Submission from Illumina, Inc (05/18/18) requesting to change footnote regarding workup as follows: "…Obtain tissue **for NGS-based testing** to ascertain alterations in BRAF, and in the appropriate clinical setting, KIT from either biopsy of the metastasis (preferred) or archival material if the patient is being considered for targeted therapy."	Based on a review of data and discussion, the panel did not support making the proposed change to footnote "ll". See Submission for references.	1	26	0	1
ME-12 External request: Submission Illumina, Inc request (05/18/18) to change the bullet point under "Common Follow-up Recommendations for All Patients" as follows: "Consider referral to a genetics counselor **for NGS-based germline testing panels** of p16/CDKN2A ~~mutation testing~~ in the presence of 3 or more invasive melanomas, or a mix of invasive melanoma, pancreatic cancer, and/or astrocytoma diagnoses in an individual or family. Testing for other ~~genes~~ **germline mutations** that can harbor melanoma-predisposing mutations (eg. CDK4, TERT, MITF, and BAP1) may be warranted."	Based on a review of data and discussion, the panel did not support making the proposed change to the bulleted statement in "Common Follow-up Recommendations for All Patients". See Submission for references	0	26	0	2

Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
ME-14, ME-15 Internal comment: Panel member request to consider high-dose ipilimumab as an adjuvant treatment option for patients with prior exposure to anti-PD-1 agents.	Based on a review of data and discussion, panel consensus supported retaining high-dose ipilimumab as an adjuvant treatment option for completely resected nodal recurrence, but clarified it is to be used only for patients with exposure to prior anti-PD-1 agents. (ME-14) Based on a review of data and discussion, panel consensus supported adding "High-dose ipilimumab if prior exposure to anti-PD-1 agents" as an adjuvant treatment option for patients with resected stage IV distant metastatic disease (with no evidence of disease after resection).(ME-15) References: • Weber J, Mandala M, Del Vecchio M, et al. Adjuvant Nivolumab versus Ipilimumab in Resected Stage III or IV Melanoma. N Engl J Med 2017;377:1824-1835. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28891423. • Eggermont AM, Chiarion-Sileni V, Grob JJ, et al. Prolonged Survival in Stage III Melanoma with Ipilimumab Adjuvant Therapy. N Engl J Med 2016;375:1845-1855. Available at: https://www.ncbi.nlm.nih.gov/pubmed/27717298.	23 21	0 1	3 4	2 2
ME-A (1 of 2) External request Submission from DermTech (5/31/18) to review the enclosed data for inclusion of non-invasively obtained gene expression and mutation risk factors to support clinicians in their biopsy decisions and efforts to rule out primary cutaneous melanoma. For ME-A page 1 add a new header "Molecular Risk Factors" and recommend molecular risk factors, ideally assessed non-invasively, be considered to help guide biopsy decisions and rule out primary cutaneous melanomas. Not to be used on clinically frank melanomas or as a screening tool. Useful also when surgical biopsies are not feasible.	Based on a review of data and discussion, the panel did not support making the proposed changes to the guidelines due to insufficient data. See submission for References	0	26	0	2

Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
ME-H (1 of 6) External request Submission from Bristol-Myers Squibb (03/06/18) request to add the following footnote: "FDA-recommended dosing for single-agent nivolumab is 240 mg IV every 2 weeks or 480 mg IV every 4 weeks administered over 30 minutes. FDA-recommended dosing for nivolumab/ipilimumab combination therapy is nivolumab 1 mg/kg administered as an intravenous infusion over 30 minutes, followed by ipilimumab 3 mg/kg on the same day, every 3 weeks for 4 doses; then single-agent nivolumab 240 mg IV every 2 weeks or 480 mg IV every 4 weeks administered over 30 minutes until disease progression or unacceptable toxicity." **ME-4, ME-5, ME-7, ME-13, ME-14, ME-15** External request Submission from Bristol-Myers Squibb (03/06/18) request to add the following footnote: "FDA-recommended dosing of single agent nivolumab for adjuvant treatment of melanoma is 240mg IV every 2 weeks or 480 mg IV every 4 weeks administered over 30 minutes until disease recurrence or unacceptable toxicity for up to 1 year."	Based on a review of data and discussion, the panel did not support the inclusion of the recommended footnote(s). See Submission for References.	4	22	0	2
ME-H (1 of 6) External request Submission from Amgen, Inc request (2/28/18) to review recently released data regarding talimogene laherparepvec (T-VEC) in combination with ipilimumab vs ipilimumab alone in patients with advanced, unresectable melanoma.	Based on a review of data and discussion, the panel consensus was to include Ipilimumab/intralesional injection with T-VEC as a second-line or subsequent systemic therapy option for distant metastatic or unresectable disease. This is a category 2B recommendation. • Chesney J, Puzanov I, Collichio F, et al. Randomized, open-label phase II study evaluating the efficacy and. safety of talimogene laherparepvec in combination with ipilimumab versus ipilimumab alone in patients with advanced, unresectable melanoma. J Clin Oncol 2018;36:1658-1667.	14	7	4	3

Guideline Page and Request	Panel Discussion/References	Vote			
		YES	NO	ABSTAIN	ABSENT
ME-H (1 of 6) External request Submission from Amgen, Inc request (2/28/18) to review recently released data on the use of T-VEC in combination with pembrolizumab in patients with advanced, unresectable melanoma.	Based on a review of data and discussion, the panel did not support the inclusion T-VEC/pembrolizumab an option for patients with advanced, unresectable melanoma. Reference: • Ribas A, Dummer R, Puzanov I, et al. Oncolytic Virotherapy Promotes Intratumoral T Cell Infiltration and Improves Anti-PD-1 Immunotherapy. Cell 2017;170:1109-1119 e1110. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28886381.	4	19	3	2