### CSLL-D

**Internal request:**
Panel discussion to include “lenalidomide” with or without rituximab as appropriate for the treatment of CLL.

Based on the noted references, the panel consensus was to add lenalidomide either with or without rituximab as an option for:
- CLL without del (11q) or del (17p) and CLL with del (11q)
  - First-line therapy, age ≥ 70 y or younger patients with co-morbidities
  - Relapsed/refractory therapy, short response for both “age ≥70 y” and “for age <70 y or older patients without significant co-morbidities.”
- CLL with del (11q)
  - Relapsed/refractory therapy

**References**

**Vote**
- Yes: 26
- No: 1
- Abstain: 0

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### Internal request:
Panel discussion comment to change “bendamustine with rituximab” to “bendamustine with or without rituximab.”

After panel discussion, the consensus was to change bendamustine with rituximab to bendamustine with or without rituximab as a treatment option for CLL without del (11q) or del (17p) and CLL with del (11q) cases for both first-line therapy and relapsed or refractory therapy to allow for the option of bendamustine monotherapy which reflects the available data.

**Vote**
- Yes: 27
- No: 0
- Abstain: 0
### Follicular Lymphoma

**FOLL-B:**

**Internal request:**
Panel discussion comment to remove “RFND (rituximab, fludarabine, mitoxantrone, dexamethasone)” as a first-line therapy option.

The panel discussion and consensus was to remove RFND as a first-line therapy due to availability of other standard first-line treatment options, and potential concerns for stem cell toxicity with this regimen in patients who may undergo autologous transplant in the future.

The panel discussion and consensus was to remove radioimmunotherapy as a first-line therapy due to the availability of other standard first-line treatment options. Radioimmunotherapy was retained as a first-line option for elderly patients.

Based on the panel discussion, the consensus was to remove BVR regimen as a treatment option for second-line and extended dosing due to limited data to support its use in follicular lymphoma.

Based on the noted references and panel discussion, the consensus was to add single agent rituximab as an option for second-line and subsequent therapy.


**External request:**
Submitted by Celgene Corporation to recommend the use of lenalidomide (with or without rituximab) as a treatment option for second-line and subsequent therapy.

Based on the noted references and panel discussion, the consensus was to add lenalidomide with or without rituximab as a treatment option for second-line and subsequent therapy.

<table>
<thead>
<tr>
<th>Guidelines Page and Request</th>
<th>Panel Discussion</th>
<th>References</th>
<th>Vote</th>
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<tbody>
<tr>
<td>Follicular Lymphoma</td>
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<tr>
<td>FOLL-B:</td>
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<td>rituximab) as a suggested treatment regimen in the guidelines for follicular lymphoma (grade 1-2) as second line and subsequent therapy with a Category 2A recommendation.</td>
<td>second-line and subsequent therapy.</td>
<td>presentation]. Proceedings of the 48th Annual Meeting of the American Society of Clinical Oncology (ASCO) 2012; June 1-5; Chicago, IL; USA.</td>
<td>Yes 23 No 0 Abstain 0</td>
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<tr>
<td>Mantle Cell Lymphoma</td>
<td>The panel discussion and consensus was to add the complete CALGB 59909 regimen to include treatments 3 through 5.</td>
<td>Damon LE, Johnson JL, Niedzwiecki D, et al. Immunochemotherapy and autologous stem-cell transplantation for untreated patients with mantle-cell lymphoma: CALGB 59909. J Clin Oncol 2009;27:6101-6108.</td>
<td>19 0 4</td>
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<td>MANT-A: Internal request: Add all treatment steps to the CALGB 59909 regimen which includes: Treatment 3: etoposide, cytarabine, rituximab; Treatment 4: carmustine, etoposide, cyclophosphamide/ autologous stem cell rescue; Treatment 5: rituximab maintenance.</td>
<td>The panel consensus was to clarify rituximab maintenance as a category 1 recommendation for patients treated with CHOP + rituximab followed by consolidation with rituximab maintenance.</td>
<td>Kluin-Nelemans HC, Hoster E, Hermine O, et al. Treatment of older patients with mantle-cell lymphoma. N Eng J Med 2012;367:520-531.</td>
<td>19 0 4</td>
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<tr>
<td>Internal request: Clarify rituximab maintenance as a category 1 recommendation for the following treatment option, “CHOP + rituximab followed by consolidation with rituximab maintenance (375 mg/m2 every 8 wks until progression).”</td>
<td>The panel discussion and consensus was to add the complete CALGB 59909 regimen to include treatments 3 through 5.</td>
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<td>External request: Submitted by Genentech, Inc to consider the recently presented data on rituximab plus FC for the treatment MCL.</td>
<td>The panel consensus was that FC + rituximab is already included in the NHL Guidelines for the appropriate indications.</td>
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### Lymphoblastic Lymphoma

**BLAST**
Due to the creation of the NCCN Guidelines for Acute Lymphoblastic Leukemia (ALL), all regimens were removed from the Lymphoblastic Lymphoma section. The LL Guidelines are now directed to the ALL Guidelines.

### AIDS-Related B-cell Lymphomas

**AIDS-2 Internal request:**
Panel discussion comment to remove “CDOP (cyclophosphamide, liposomal doxorubicin, vincristine, prednisone) + rituximab” as a treatment option for AIDS-related diffuse large B-cell lymphoma, lymphoma associated with Castleman’s disease, and primary effusion lymphoma.

Based on panel discussion and results of the AMC 047 trial that suggested that this regimen may be inferior to EPOCH-containing therapy in patients with AIDS-related NHL, the consensus was to remove CDOP-R as a treatment option for AIDS-related diffuse large B-cell lymphoma, lymphoma associated with Castleman’s disease, and primary effusion lymphoma.


### Peripheral T-Cell Lymphoma

**TCEL-B Internal request:**
Panel discussion comment to add “dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)” as a treatment option for first-line and second-line therapy.

Based on data in the noted references and panel discussion, the consensus was to add dose-adjusted EPOCH as a treatment option for first-line and second-line therapy.

- Peng YL, Huang HQ, Lin XB, et al. [Clinical outcomes of patients with peripheral T-cell lymphoma (PTCL) treated by EPOCH regimen].
### Internal request:
Panel discussion comment to review the NCCN category for pralatrexate for second-line therapy for candidates for transplant.  

**Other:**
“Denileukin diftitox” was removed as a second-line therapy option as it is no longer commercially available.  

Based on discussion, the panel consensus resulted in a change from a category 2B to a category 2A recommendation for pralatrexate for second-line therapy for candidates for transplant.  

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### Mycosis Fungoides/Sezary Syndrome

**MFSS-A**

**Other:**
“Denileukin diftitox” was removed as a systemic therapy option as it is no longer commercially available.  

### Adult T-cell Leukemia/Lymphoma

**ATLL-C**

**Internal request:**
Panel discussion comment to add “CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide and prednisone)” as a suggested chemotherapy option.  

Based on panel discussion, the consensus was to add CHOEP as an option for chemotherapy.  

| 21  | 5  | 0  |

### Extranodal NK/T-cell Lymphoma, nasal type

**NKTL-B**

**Other:**
“Asparaginase” was replaced with “pegaspargase” in all associated regimens as “asparaginase” is no longer
commercially available.

### Posttransplant Lymphoproliferative Disorder

**PTLD-A**

**Internal request:**
Panel discussion comment for frail patients who cannot tolerate anthracycline to add: “RCEPP (rituximab, cyclophosphamide, etoposide, prednisone, procarbazine)” and “RCEOP (rituximab, cyclophosphamide, etoposide, vincristine, prednisone)”.

Based on panel discussion, the consensus was to add both “RCEPP (rituximab, cyclophosphamide, etoposide, prednisone, procarbazine)” and “RCEOP (rituximab, cyclophosphamide, etoposide, vincristine, prednisone)” for frail patients who cannot tolerate anthracycline.

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### Other

**External request:**
Submitted by BTG International Inc. to review the data for inclusion of (glucarpidase) for the treatment of toxic plasma methotrexate (MTX) concentrations in NHL patients receiving high-dose methotrexate therapy and who have delayed methotrexate clearance due to impaired renal function.

The panel discussion resulted in a statement being added to the Supportive Care for NHL page: “Consider use of glucarpidase if significant renal dysfunction and methotrexate levels are >10 microM beyond 42-48 h. Leucovorin remains a component in treatment of methotrexate toxicity and should be continued for at least 2 days following glucarpidase administration. However, be aware that leucovorin is a substrate for glucarpidase, and therefore should not be administered within two hours prior to or following glucarpidase.”

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**External request:**
Submitted by Genentech, Inc to consider updating the NCCN Guidelines with results from the recently presented Phase III RATE Trial, which evaluated the safety of accelerated infusions of Rituxan in patients with previously untreated diffuse large B-cell lymphoma (DLBCL) and follicular NHL.

After discussion, the panel consensus was not to make a change to the guidelines regarding accelerated rituximab infusion.

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<td><strong>External request:</strong></td>
<td>The panel consensus was that bendamustine + rituximab is already included in the NHL Guidelines for the appropriate indications.</td>
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<tr>
<td>Submitted by Genentech, Inc to consider the recently presented data on the use of rituximab plus bendamustine for the treatment of indolent NHL for updating purposes.</td>
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