

BC Cancer Protocol Summary for Treatment of Hodgkin Lymphoma and Anaplastic Large Cell Lymphoma with Brentuximab Vedotin

Protocol Code

LYBRENTUX

Tumour Group

Lymphoma

Contact Physician

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ELIGIBILITY:

Patients must have:

- Not been previously treated with brentuximab vedotin, and
- Advanced stage Hodgkin lymphoma
 - relapsed after high dose chemotherapy and autologous stem cell transplant or, if transplant ineligible due to age or co-morbid conditions, have relapsed after standard ABVD or equivalent
 - for consolidation treatment after response to high dose chemotherapy and autologous stem cell transplant, use LYBV protocol
- Advanced stage anaplastic large cell lymphoma
 - have relapsed after primary chemotherapy or after high dose chemotherapy and stem cell transplant or, if transplant ineligible due to age or co-morbid conditions, have relapsed after primary chemotherapy with CHOP or equivalent
- Primary cutaneous anaplastic large cell lymphoma (pcALCL) treated with at least one prior systemic or radiation therapy, or
- CD30-expressing mycosis fungoides (MF) ($\geq 10\%$ CD30-positive malignant cells or lymphoid infiltrate) treated with at least one prior systemic therapy

EXCLUSIONS:

Patients must not have:

- CD30-expressing Sézary syndrome, or
- Other subtypes of CD30-expressing cutaneous T-cell lymphoma

TESTS:

- Baseline: CBC & Diff, platelets, [creatinine](#), [total bilirubin](#), ALT
- Baseline required, but results do not have to be available to proceed with first treatment; results must be checked before proceeding with cycle 2: HBsAg, HBcoreAb, [HBsAb](#)
- Before day 1 of each treatment cycle: CBC & diff, platelets
- If clinically indicated: creatinine, ALT, [total bilirubin](#)
- [If clinically indicated: HBV viral load, HBsAg \(see protocol \[SCHBV\]\(#\)\)](#)

PREMEDICATIONS:

- If past brentuximab vedotin drug reactions:
 - diphenhydramine 50 mg PO 30 minutes prior to brentuximab vedotin
 - acetaminophen 650 mg to 975 mg PO 30 minutes prior to brentuximab vedotin

SUPPORTIVE MEDICATIONS:

Moderate risk of hepatitis B reactivation. If HBsAg or HBcoreAb positive, start hepatitis B prophylaxis as per BC Cancer Protocol Summary for Hepatitis B Virus Reactivation ([SCHBV](#)).

TREATMENT:

Drug	Dose	BC Cancer Administration Guideline
brentuximab vedotin	1.8 mg/kg on Day 1*	IV in 100 mL NS over 30 minutes

Repeat every 21 days. Maximum 16 cycles. Discontinue if definite progression at any time.

*The dose for patients weighing greater than 100 kg should be calculated based on a weight of 100 kg.

DOSE MODIFICATIONS:

1. Hematological:

ANC (x10 ⁹ /L)		Platelets (x10 ⁹ /L)	Brentuximab vedotin
greater than or equal to 0.6	and	greater than or equal to 50	100%
less than 0.6	or	less than 50	Delay until recovery

2. Peripheral Neuropathy:

Toxicity	Dose Modification
Grade 1	100%
Grade 2 or 3	Hold until neuropathy improves to grade 1 or baseline, then decrease dose to 1.2 mg/kg
Grade 4	Discontinue brentuximab vedotin

PRECAUTIONS:

- Neutropenia:** Fever or other evidence of infection must be assessed promptly and treated aggressively.
- Extravasation:** Brentuximab vedotin causes pain and may, rarely, cause tissue necrosis if extravasated. Refer to BC Cancer Extravasation Guidelines.
- Thrombocytopenia:** Support with platelet transfusion may be required.
- Hepatitis B Reactivation:** See [SCHBV](#) protocol for more details.
- Peripheral neuropathy:** Brentuximab treatment causes peripheral sensory neuropathy. Cases of peripheral motor neuropathy have also been reported. Brentuximab-induced peripheral neuropathy is cumulative. Monitor patients for symptoms of neuropathy, such as hypoesthesia, hyperesthesia,

paresthesia, discomfort, a burning sensation, neuropathic pain or weakness and institute dose modifications accordingly.

6. **Infusion reactions:** Infusion-related reactions, including anaphylaxis, have occurred with brentuximab. Monitor patients during infusion. If an infusion reaction occurs, stop the infusion. See BC Cancer Hypersensitivity Guidelines.
7. **Tumor lysis syndrome:** Patients with rapidly proliferating tumor and high tumor burden are at risk of tumor lysis syndrome and these patients should be monitored closely.
8. **Progressive multifocal leukoencephalopathy (PML):** JC virus infection resulting in PML and death has been reported in brentuximab-treated patients. Consider the diagnosis of PML in any patient presenting with new-onset signs and symptoms of central nervous system abnormalities. Hold brentuximab if PML is suspected.
9. **Stevens-Johnson syndrome:** Stevens-Johnson syndrome has been reported with brentuximab. If Stevens-Johnson syndrome occurs, discontinue brentuximab vedotin.
10. **Acute pancreatitis** including fatal outcomes, has been reported in patients who have received brentuximab vedotin. Consider the diagnosis of acute pancreatitis for patients who present with new or worsening abdominal pain. Hold brentuximab vedotin if suspected pancreatitis and discontinue if confirmed.

Call Dr. Laurie H. Sehn, Dr. Kerry Savage or tumor group delegate at (604) 877-6000 or 1-800-663-3333 with any problems or questions regarding this treatment program.

REFERENCES:

1. Chen R, Gopal AK, Smith SE, et al. Five-year survival and durability results of brentuximab vedotin in patients with relapsed or refractory Hodgkin lymphoma. *Blood* 2016;128:1562-6.
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3. Moskowitz CH, Nademanee A, Masszi T, et al. Brentuximab vedotin as consolidation therapy after autologous stem-cell transplantation in patients with Hodgkin's lymphoma at risk of relapse or progression (AETHERA): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet* 2015;385:1853-62.
4. Pro B, Advani R, Brice P, et al. Brentuximab Vedotin (SGN-35) in patients with relapsed or refractory systemic anaplastic large-cell lymphoma: results of a phase II study. *J Clin Oncol* 2012;30:2190-6.
5. Prince HM, Kim YH, Horwitz SM, et al. Brentuximab vedotin or physician's choice in CD30-positive cutaneous T-cell lymphoma (ALCANZA): an international, open-label, randomised, phase 3, multicentre trial. *Lancet* 2017;390(10094):555-566. doi:10.1016/S0140-6736(17)31266-7