# NIRAPARIB (Zejula) (first line maintenance)

## INDICATION (ICD10) C56

*Check the most recent Blueteq eligibility criteria before prescribing. Blueteq registration required. (www.england.nhs.uk/publication/national-cancer-drugs-fund-list/)* (NIR3) (NIR4)

1. Niraparib monotherapy (not being administered concurrently with maintenance bevacizumab) as maintenance treatment in patients with high grade epithelial stage III or IV predominantly high grade serous or high grade endometrioid or high grade clear cell ovarian, fallopian tube or primary peritoneal carcinoma who are in response following a minimum of 4 cycles platinum-based FIRST line chemotherapy (not previously received any PARP inhibitor) has no evidence of progressive disease on the post-treatment scan or a rising CA125 level, AND who DO NOT HAVE a deleterious or suspected deleterious BRCA1 or BRCA2 germline and/or somatic BRCA mutation, PS 0 or 1. (TA673)
2. Niraparib monotherapy (not being administered concurrently with maintenance bevacizumab) as maintenance treatment in patients with high grade epithelial stage III or IV predominantly high grade serous or high grade endometrioid or high grade clear cell ovarian, fallopian tube or primary peritoneal carcinoma who are in response following a minimum of 4 cycles platinum-based FIRST line chemotherapy (not previously received any PARP inhibitor) has no evidence of progressive disease on the post-treatment scan or a rising CA125 level, AND who HAVE a deleterious or suspected deleterious BRCA1 or BRCA2 germline and/or somatic BRCA mutation, PS 0 or 1. (TA673)

## REGIMEN

First line maintenance will commence maintenance niraparib monotherapy within 12 weeks from the date of the first day of the last cycle of 1st line chemotherapy.

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| Days 1 to 28 | **NIRAPARIB** | 200mg* | oral | once daily |

*Starting dose is 200mg daily unless the patient weighs ≥77Kg and has a platelet count ≥150 in which case the recommended starting dose is 300mg daily.

## CYCLE FREQUENCY AND NUMBER OF CYCLES

Daily for 28 days continuously until progression or toxicity (patients in continued complete remission when it would be an appropriate time to discontinue maintenance niraparib therapy and that this time was likely to be after approximately 3 years of maintenance treatment).
A first formal medical review as to whether maintenance treatment with niraparib should continue or not will be scheduled to occur at least by the start of the third 4-weekly cycle of treatment for 1st line maintenance the second 4-weekly cycle of treatment for 2nd or subsequent line maintenance.

## ADMINISTRATION

Available as 100mg tablets
Swallow whole with or without food, preferably at night

## ANTI-EMETICS

Minimal risk all days

## EXTRAVASATION AND TYPE OF LINE / FILTERS

Not applicable

## INVESTIGATIONS

Blood results required before SACT administration

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| FBC, U&E including $Mg^{++}$ (>0.4) and LFTs<br>Neutrophils x $10^9$/L ≥1.0 provided patient is well<br>Platelets ≥100x$10^9$/L | Baseline, weekly for the first month then monthly for 10 months then periodically |
| Blood pressure | baseline then weekly for 2 months then monthly for the first year then periodically |
| Serum creatinine | baseline and every cycle |
| CA125 | baseline and every 3rd cycle |
| Virology | before cycle 1 if not previously checked |
| Weight | baseline and every cycle |

## MAIN TOXICITES AND ADVERSE REACTIONS

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| Niraparib | Arthralgia<br>Cardiac disorders<br>Diarrhoea, constipation<br>Hypertension<br>Infections<br>Photosensitivity |

## INTERACTIONS WHICH MAY REQUIRE DOSE MODIFICATIONS

**(not exhaustive list check SPC/BNF/Stockleys)**

| | |
|---|---|
| Niraparib | - |

## DOSE MODIFICATIONS

It is recommended to first interrupt the treatment (but no longer than 28 consecutive days) to allow recovery from the adverse reaction and then restart at the same dose. In the case that the adverse reaction recurs, it is recommended to interrupt the treatment and then resume at the lower dose.

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| Starting dose | 200mg | 300mg |
| First dose reduction | 100mg/day | 200mg/day |
| Second dose reduction | Discontinue | 100mg/day |

If further dose reduction below 100mg/day is required, discontinue niraparib.

**Haematological**

Niraparib

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| Haematologic adverse reaction requiring transfusion or GCSF | • For patients with platelet count ≤100, platelet transfusion should be considered. If there are other risk factors for bleeding such as co-administration of anticoagulation or antiplatelet medicinal products, consider interrupting these substances and/or transfusion at a higher platelet count.<br>• Resume niraparib at a reduced dose. |
| Platelet count ≤100 | First occurrence:<br>• Withhold niraparib for a maximum of 28 days and monitor blood counts weekly until platelet counts return to ≥100.<br>• Resume niraparib at same or reduced dose based on clinical evaluation.<br>• If platelet count is <75 at any time, resume at a reduced dose.<br>Second occurrence:<br>• Withhold niraparib for a maximum of 28 days and monitor blood counts weekly until platelet counts return to ≥100.<br>• Resume niraparib at a reduced dose.<br>• Discontinue niraparib if the platelet count has not returned to acceptable levels within 28 days of the dose interruption period, or if the patient has already undergone dose reduction to 100mg once daily. |
| Neutrophil <1.0 or haemoglobin 8g/dL | • Withhold niraparib for a maximum of 28 days and monitor blood counts weekly until neutrophil counts return to ≥1.5 or haemoglobin returns to ≥9g/dL.<br>• Resume niraparib at a reduced dose.<br>• Discontinue niraparib if neutrophils and/or haemoglobin have not returned to acceptable levels within 28 days of the dose interruption period, or if the patient has already undergone dose reduction to 100mg once daily. |
| Confirmed diagnosis of myelodysplastic syndrome or acute myeloid leukaemia | Permanently discontinue niraparib. |

**Non-haematogical**

Niraparib

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| ≥Grade 3 toxicity where prophylaxis is not considered feasible or adverse reaction persists despite treatment | First occurrence:<br>• Withhold niraparib for a maximum of 28 days or until resolution of adverse reaction.<br>• Resume niraparib at a reduced dose (200mg/day).<br>Second occurrence:<br>• Withhold niraparib for a maximum of 28 days or until resolution of adverse reaction.<br>• Resume niraparib at a reduced dose (100mg/day). |
| ≥Grade 3 toxicity lasting more than 28 days while patient is administered niraparib 100mg/day | Discontinue treatment |

**Hepatic impairment**
Niraparib
No dose adjustment is needed in patients with mild hepatic impairment AST >ULN and total bilirubin ≤ULN or any AST and bilirubin> 1.0–1.5xULN.
Patients with moderate hepatic impairment any AST and bilirubin >1.5-3xULN the recommended starting dose of niraparib is 200mg once daily.
No data in patients with severe hepatic impairment (any AST and bilirubin >3xULN); use with caution in these patients.

**Renal impairment**
Niraparib
No dose adjustment is necessary for patients with mild to moderate renal impairment.
No data in patients with severe renal impairment or end stage renal disease undergoing haemodialysis; use with caution in these patients.

**REFERENCES**
1. CDF

Assessments

| | Pre | Cycle 1 | Cycle 2 | Cycle 3 | Cycle 4 | Ongoing |
|---|---|---|---|---|---|---|
| Clinical assessment | X | | Pre cycle | | Pre cycle | Every cycle |
| SACT assessment (PS and toxicities) | X | X | X | X | X | Every cycle |
| FBC | X | X | X | X | X | weekly for the first month then monthly for 10 months then periodically |
| U&E, calcium & LFT | X | X | X | X | X | weekly for the first month then monthly for 10 months then periodically |
| CA125 | X | | | X | | Every 3rd cycle |
| CT scan | X | | | | | At cycle 6, Inform consultant team if not booked |
| Informed consent | X | | | | | Verbal each cycle |
| Height | X | | | | | |
| Weight recorded | X | X | X | X | X | Every cycle |