Nivolumab (OPDIVO)
National Drug Monograph
March 2016
VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

The purpose of VA PBM Services drug monographs is to provide a focused drug review for making formulary decisions. Updates will be made when new clinical data warrant additional formulary discussion. Documents will be placed in the Archive section when the information is deemed to be no longer current.

FDA Approval Information

**Description/Mechanism of Action**
Nivolumab is a monoclonal antibody that binds to the programmed-death 1 (PD-1) receptor on T-cells, blocking its interaction with its ligands PD-L1 and PD-L2 releasing PD-1 mediated pathway inhibition of the immune system resulting in anti-tumor responses. In combination with ipilimumab, another immune system checkpoint inhibitor, in melanoma results in greater T-cell function and better responses than either agent alone.

**Indication(s) Under Review in this document (may include off label)**
- Unresectable or metastatic melanoma:
  - As a single agent for BRAF V600 wild-type unresectable or metastatic melanoma.
  - As a single agent for BRAF mutation-positive unresectable or metastatic melanoma.
  - In combination with ipilimumab in patients for patients with unresectable or metastatic melanoma.
- Metastatic non-small cell lung cancer with progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving nivolumab.
- Patients with advanced or metastatic renal cell carcinoma with a clear cell component who received prior anti-angiogenic therapy.

**Dosage Form(s) Under Review**
- Injection 40 mg/4 mL
- Injection 100 mg/10 mL

**REMS**
- ✗ REMS  ❌ No REMS  □ Postmarketing Requirements
  *See Other Considerations for additional REMS information*

**Pregnancy**
Based on its mechanism of action and data form animal studies, nivolumab can cause fetal harm when administered to a pregnant woman.
*See Special Populations for additional information*

**Executive Summary**

**Efficacy**
- In metastatic melanoma in previously treated patients, higher objective response rates and durable response versus chemotherapy. In treatment naïve patients, single agent nivolumab superior to dacarbazine for overall survival in BRAF wild-type. In treatment naïve BRAF mutated, nivolumab and nivolumab/ipilimumab superior to ipilimumab for progression free survival. Note that in a subgroup analysis of BRAF mutated tumors, the HR for PFS crossed 1 for the analysis of nivolumab versus ipilimumab.
- In non-small cell lung cancer in previously treated patients, nivolumab superior to docetaxel for overall survival in both non-squamous and squamous disease.
- In renal cell cancer after 1-2 prior antiangiogenic therapies, nivolumab was
superior to everolimus for overall survival.

Safety

- Immune-related toxicities are rare but potentially serious. Early recognition and prompt treatment are key to resolution.
- Common adverse events: Melanoma (≥20%): rash (single agent); rash, pruritus, headache, vomiting, colitis (in combination with ipilimumab)
  NSCLC (≥20%): fatigue, musculoskeletal pain, decreased appetite, cough, Constipation
- While the overall percentage of patients with a grade 3 or 4 adverse event is over 20% in most clinical trials, the incidence of each grade 3 or 4 events is small.
- Discontinuation rates for adverse events was generally less than in the comparator arm.

Other Considerations

<table>
<thead>
<tr>
<th>Outcome in clinically significant area</th>
<th>Effect Size</th>
<th>Potential Harms</th>
<th>Net Clinical Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma Previously Treated (vs chemo): ORR 31.7%; PFS 4.7 mos; OS not available</td>
<td>Melanoma Previously Treated: PFS HR 0.82 (99%CI 0.32-2.05)</td>
<td>Single agent melanoma: Grade 3 or 4 in 42% Combination with ipilimumab in melanoma: Grade 3 or 4 in 69% NSCLC nonsquamous: Grade 3 or 4 in 47% NSCLC squamous: Grade 3 or 4 in 7% Renal Cell: Grade 3 or 4 in 19%</td>
<td>Melanoma Previously Treated: Negative Melanoma Treatment Naïve: Moderate Melanoma Treatment naïve + ipilimumab: Moderate NSCLC (nonsquamous): Moderate NSCLC (squamous): Substantial Renal Cell: Substantial</td>
</tr>
<tr>
<td>Melanoma Treatment naïve (vs dacarbazine): OS NR vs 10.8 mos; PFS 5.1 vs 2.2 mos</td>
<td>Melanoma Treatment naïve: OS HR 0.42 (99%CI 0.25-0.73); PFS HR 0.43</td>
<td>NSCLC nonsquamous: OS HR 0.73 (99%CI 0.39-0.89)</td>
<td>Melanoma Treatment naïve: Moderate</td>
</tr>
<tr>
<td>Melanoma Treatment naïve + ipilimumab: PFS 11.5 vs 6.9 mos (NI vs N); OS not available</td>
<td>Melanoma Treatment naïve + ipilimumab: PFS (NI vs I) HR 0.42; (N vs I) HR 0.57 (NI vs N) HR 0.74 (99.5%CI 0.60-0.92)</td>
<td>NSCLC (nonsquamous): OS HR 0.59 (95%CI 0.44-0.79)</td>
<td>Melanoma Treatment naïve + ipilimumab: Moderate</td>
</tr>
<tr>
<td>NSCLC (nonsquamous): OS 9.2 vs 6.0</td>
<td>Renal Cell (vs everolimus): OS 25 vs 19.6 mos</td>
<td>Renal Cell: OS HR 0.73 (98.5%CI 0.57-0.93)</td>
<td>NSCLC (squamous): Moderate</td>
</tr>
</tbody>
</table>
| Renal Cell: OS 25 vs 19.6 mos | **Background**

Purpose for review

The purposes of this monograph are to (1) evaluate evidence of safety, tolerability, efficacy, cost, and other pharmaceutical issues that would be relevant to evaluating nivolumab for possible addition to the VA National Formulary; (2) define its role in therapy; and (3) identify parameters for its rational uses in the VA.

**Issues to be determined:**

- Evidence of need?
- Does nivolumab offer advantages to currently available alternatives?
- Does nivolumab offer advantages over current VANF agents?
- What safety issues need to be considered?
- Does nivolumab have specific characteristics best managed by the non-formulary process, prior authorization, criteria for use?

### Other therapeutic options

#### Unresectable or metastatic melanoma

<table>
<thead>
<tr>
<th>Formulary Alternatives</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cisplatin</td>
<td>If not used 1st line and not the same class as 1st line (with vinblastine, dacarbazine, IL-2 and interferon; high incidence of toxicity).</td>
</tr>
<tr>
<td>Carboplatin</td>
<td>If not used 1st line and not the same class as 1st line</td>
</tr>
<tr>
<td>Vinblastine</td>
<td>If not used 1st line and not the same class as 1st line (see cisplatin)</td>
</tr>
<tr>
<td>Carmustine</td>
<td>If not used 1st line and not the same class as 1st line</td>
</tr>
<tr>
<td>Imatinib</td>
<td>If c-KIT mutation positive</td>
</tr>
<tr>
<td>Paclitaxel</td>
<td>If not used 1st line and not the same class as 1st line</td>
</tr>
<tr>
<td>Dacarbazine</td>
<td>If not used 1st line and not the same class as 1st line (see cisplatin)</td>
</tr>
<tr>
<td>Carboplatin/paclitaxel</td>
<td>If not used 1st line and not the same class as 1st line</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-formulary Alternative (if applicable)</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pembrolizumab</td>
<td>PD-L1 blocker; 1st line or 2nd line</td>
</tr>
<tr>
<td>Ipilimumab</td>
<td>Single agent or in combination with nivolumab</td>
</tr>
<tr>
<td>Dabrafenib</td>
<td>BRAF mutation positive; 1st line or 2nd line if not used in 1st line; single agent or in combination with trametinib (preferred)</td>
</tr>
<tr>
<td>Vemurafenib</td>
<td>BRAF mutation positive; 1st line or 2nd line if not used in 1st line</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>Limited to good PS and centers experienced with administering in ICU</td>
</tr>
<tr>
<td>High-dose Interleukin-2</td>
<td>Protein-bound paclitaxel</td>
</tr>
</tbody>
</table>

#### Non-small cell lung cancer after progression on platinum therapy

<table>
<thead>
<tr>
<th>Formulary Alternatives</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erlotinib</td>
<td>With or without EGFR mutation; indirect comparison better OS with nivolumab after chemotherapy</td>
</tr>
<tr>
<td>Gemcitabine infusion</td>
<td>PS 0-2</td>
</tr>
<tr>
<td>Docetaxel</td>
<td>PS 0-2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-formulary Alternative (if applicable)</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pembrolizumab</td>
<td>PD-L1 blocker; approved only for tumors expressing PD-L1</td>
</tr>
<tr>
<td>Pemetrexed</td>
<td>Non-squamous histology</td>
</tr>
<tr>
<td>Ramucirumab</td>
<td>With docetaxel</td>
</tr>
</tbody>
</table>

#### Unresectable or Metastatic Renal Cell Carcinoma after antiangiogenic therapy

<table>
<thead>
<tr>
<th>Formulary Alternatives</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bevacizumab</td>
<td>Phase II data for use after cytokine therapy; limited data on use after TKI therapy</td>
</tr>
</tbody>
</table>
Nivolumab Monograph

Updated March 2016
Updated version may be found at www.pbm.va.gov or PBM INTRANet
| CheckMate 069 \nBristol-Myers Squibb | Unresectable or metastatic treatment naive with measurable disease | N=142  
N=95 nivolumab + ipilimumab  
N=47 ipilimumab | N=142  
N=95 nivolumab + ipilimumab  
N=47 ipilimumab | 0-1  
Nivolumab 1 mg/kg IV every 3 weeks X 4 doses plus ipilimumab 3 mg/kg IV every 3 weeks X 4 doses  
Then maintenance nivolumab 3mg/kg IV every 2 weeks | Primary response:  
Nivolumab: 7.6%  
Dacarbazine: 1% |  
Until progression (treatment after progression permitted if clinical benefit seen and no substantial adverse effects) |  
Nivolumab 1 mg/kg IV every 3 weeks X 4 doses plus ipilimumab 3 mg/kg IV every 3 weeks X 4 doses  
Then maintenance nivolumab 3mg/kg IV every 2 weeks | Complete response:  
Nivolumab: 7.6%  
Dacarbazine: 1% |  
Med duration of response:  
Nivolumab=NR  
Dacarbazine=6 mos |
| | Male: 64  
Male 66%  
ECOG 0: 83%  
BRAF mut: 24% | Male 66%  
ECOG 0: 83%  
BRAF mut: 24% |  
Same dose schedule with nivolumab placebo in both the combination and maintenance phase | 
| | | | \[0.25-0.73;  
P<0.001\] | OS 1 yr: 72.9 vs 42.1%  
PD-L1 pos:HR 0.30  
PD-L1 neg: HR 0.48 | 
| CheckMate 067 \nBristol-Myers Squibb | Unresectable or metastatic No prior treatment Measurable disease Tissue available for PD-L1 biomarker analysis Known BRAF mutation status | N=945  
N=316 nivolumab  
N=314 combination  
N=315 ipilimumab | N=945  
N=316 nivolumab  
N=314 combination  
N=315 ipilimumab | 0-1  
Nivolumab 3 mg/kg IV every 2 weeks (plus ipi placebo)  
Nivolumab 1 mg/kg IV every 3 weeks plus ipilimumab 3 mg/kg IV every 3 weeks X 4 doses; then maintenance nivolumab 3mg/kg IV every 2 weeks | Objective response rate:  
Nivo: 43.7%  
Combo: 57.6%  
Ipi: 19% | \(\text{PD-L1 negative:} \quad \text{Nivo: 41.3%}  
\text{Combo: 54.8%}  
\text{Ipi: 17.8%} \) | \(\text{PD-L1 positive:} \quad \text{Nivo: 72.1%}  
\text{Combo: 71.3%}  
\text{Ipi: 21.3%} \) |
| | Age: 65  
Male: 65%  
ECOG 0: 73%  
PD-L1 pos: 23.6%  
BRAF mut: 31.5% | Age: 65  
Male: 65%  
ECOG 0: 73%  
PD-L1 pos: 23.6%  
BRAF mut: 31.5% | 
| | | | 
| | | | \(\text{PD-L1 pos:HR 0.30}  
\text{PD-L1 neg: HR 0.48} \) | 
| | | | Results not yet available | 

Updated March 2016  
Updated version may be found at [www.pbm.va.gov](http://www.pbm.va.gov) or [PBM INTRAnet](http://www.pbm.va.gov)
In patients with metastatic melanoma that was previously treated, including patients with BRAF wild type and V600 mutations, nivolumab produced higher overall response rates versus investigator’s choice of chemotherapy.

The responses in the nivolumab arm were durable as the median duration of response has not been reached versus a duration of response of 3.6 months for chemotherapy. This pattern of durable responses is similar to other immunotherapies. The results of the overall survival analysis are not yet available.

In treatment naïve patients with unresectable or metastatic melanoma without BRAF mutation, nivolumab was superior versus dacarbazine in overall survival with a median overall survival not yet reached versus 10.8 months with dacarbazine. The survival advantage was irrespective of PD-L1 expression.

In treatment naïve patients with unresectable or metastatic melanoma with a BRAF mutation, PFS was improved in patients receiving nivolumab or nivolumab plus ipilimumab versus ipilimumab itself. The PFS in the combination arm was also improved compared to nivolumab. PFS in patients whose tumors express PD-L1 was the same in the combination or nivolumab arm and was better than the ipilimumab arm. PFS was better in the combination arm versus nivolumab or ipilimumab in patients whose tumors did not express PD-L1. The results of the co-primary outcome of overall survival are not yet available.

Note that in a subgroup analysis of BRAF mutated tumors, the HR for PFS crossed 1 for the analysis of nivolumab versus ipilimumab.

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**Table 2. Non-small cell lung cancer**

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Pts</th>
<th>ECOG PS</th>
<th>Treatment</th>
<th>Response (%)</th>
<th>PFS months</th>
<th>OS months</th>
</tr>
</thead>
<tbody>
<tr>
<td>CheckMate 057³</td>
<td>Stage IIIB or IV or recurrent after radiation or surgery And recurrence or progression on 1 prior platinum based doublet If EGFR mutation pos or ALK translocation allowed additional line of TKI therapy. Maintenance therapy allowed (continuation or switch therapy)</td>
<td>N=582</td>
<td>0-1</td>
<td>Nivolumab 3 mg/kg IV every 2 weeks</td>
<td>Objective response rate: 19 vs 12%</td>
<td>2.3 vs 4.2 HR 0.92 (95%CI 0.77-1.1; P=0.39)</td>
<td>8% vs 19%</td>
</tr>
<tr>
<td>Bristol-Myers Squibb</td>
<td></td>
<td>N=292 Nivolumab N=290 Docetaxel</td>
<td>Nivolumab 3 mg/kg IV every 2 weeks</td>
<td>Objective response rate: 19 vs 12%</td>
<td>2.3 vs 4.2 HR 0.92 (95%CI 0.77-1.1; P=0.39)</td>
<td>8% vs 19%</td>
<td>N=71 nivolumab patients continued therapy beyond initial progression; 23% had a nonconventional pattern of benefit OS 1 yr: 51% vs 39%</td>
</tr>
<tr>
<td>Squamous</td>
<td>Stage IIIB or IV</td>
<td>N=272</td>
<td>0-1</td>
<td>Nivolumab 3</td>
<td>Objective</td>
<td>3.5 vs 2.8</td>
<td>Primary</td>
</tr>
</tbody>
</table>

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WT=wild type; ECOG=Eastern Cooperative Oncology Group; PS=Performance Status; PD-L1=Programmed Death Ligand 1; PFS=Progression Free Survival; ITT=intention to treat; NR=not reached; HR=hazard ratio; OS=overall survival
**Nivolumab Monograph**

**Updated March 2016**

Updated version may be found at www.pbm.va.gov or PBM INTRANet

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**Table 3. Renal Cell Carcinoma**

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Pts</th>
<th>ECOG PS</th>
<th>Treatment</th>
<th>Response (%)</th>
<th>PFS months</th>
<th>OS months</th>
</tr>
</thead>
<tbody>
<tr>
<td>CheckMate</td>
<td>Advanced or metastatic renal-cell carcinoma with a clear cell component 1-2 previous antiangiogenic therapies</td>
<td>N=821</td>
<td>N=406 Nivolumab N=397 Everolimus</td>
<td>Nivolumab 3mg/kg IV every 2 weeks</td>
<td>Objective response rate: 25 vs 5% Odds ratio 5.98 Complete response: 1% vs &lt;1% Duration of response: 12 vs 12 mos</td>
<td>4.6 vs 4.4</td>
<td>Primary 25 vs 19.6</td>
</tr>
<tr>
<td>Bristol-Myers Squibb</td>
<td>N=406 Nivolumab N=397 Everolimus</td>
<td>Age: 62</td>
<td>Male: 77% White: 86% MSKCC risk group Favorable: 35% Intermediate: 49% Poor: 16% 1 prev therapy: 72%</td>
<td>Everolimus 10 mg orally daily</td>
<td></td>
<td></td>
<td>HR 0.88 (95%CI 0.75-1.03; P=0.11)</td>
</tr>
</tbody>
</table>

MSKCC=Memorial Sloan Kettering Cancer Center; KPS=Karnofsky Performance Status; PD-L1=Programmed Death Ligand 1; PFS=Progression Free Survival; HR=hazard ratio; OS=overall survival

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- In patients with previously treated non-squamous non-small cell lung cancer, nivolumab increased overall survival compared to standard docetaxel therapy.
- The overall survival advantage was seen at 12 months and 18 months.
- Objective response, improved PFS and improved overall survival were not associated with PD-L1 expression.
- In patients with previously treated squamous non-small cell lung cancer, nivolumab increased overall survival compared to standard docetaxel therapy.
- The overall survival advantage was also seen at the 12 month mark.
- The median duration of response has not yet been reached.
- Objective response, improved PFS and improved overall survival were not associated with PD-L1 expression.
- Subjects who received adjuvant or neoadjuvant platinum-doublet chemotherapy (after surgery and/or radiation therapy) and developed recurrent or metastatic disease within 6 months of completing therapy were eligible. However, patients with recurrent disease > 6 months after adjuvant or neoadjuvant platinum based chemotherapy also needed to subsequently progress during or after a platinum doublet regimen given to treat the recurrence to be eligible for nivolumab.

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**EGFR=epidermal growth factor receptor; ALK=anaplastic lymphoma kinase; ECOG=Eastern Cooperative Oncology Group; PS=Performance Status; PD-L1=Programmed Death Ligand 1; PFS=Progression Free Survival; HR=hazard ratio; OS=overall survival**
estimate for overall survival favored nivolumab in multiple subgroups, but the confidence intervals crossed 1 for the following groups: favorable MSKCC score, 2 previous antiangiogenic regimens, patients in western Europe and rest of the world, Age <65 years old, and female sex.

- Quality of life scores, Functional Assessment of Cancer Therapy Kidney Symptom Index-Disease-Related Symptoms (FKSI-DRS), in the nivolumab group increased (improved) over time (weeks 32-104) and differed significantly from the scores in the everolimus treated patients which decreased (worsened) over time.
- There was a numerical overall survival advantage for nivolumab irrespective of PD-L1 expression, however for those with PD-L1 1% or greater the 95% confidence interval crossed 1 which did not occur in those with PD-L1 <1%.

### Potential Off-Label Use

- Ovarian carcinoma
- Relapsed/refractory Hodgkin’s Lymphoma (CheckMate 039)
- Glioblastoma Multiforme
- Hepatocellular Carcinoma
- Bladder/urothelial cancer
- Head and Neck Cancer
- Colorectal carcinoma
- Gastric cancer
- Triple negative breast cancer
- Non-Hodgkin’s lymphoma
- Esophageal cancer
- Adjuvant melanoma
- Nivolumab + chemo in NSCLC
- Nivolumab + ipilimumab in Renal Cell Cancer
- Nivolumab + ipilimumab in NSCLC

### Safety

(for more detailed information refer to the product package insert)

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boxed Warning</td>
</tr>
<tr>
<td>Contraindications</td>
</tr>
<tr>
<td>Warnings/Precautions</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
| | Immune-mediated endocrinopathies:  
| | o Hypophysitis: withhold for moderate or severe and permanently discontinue if life-threatening  
| | o Adrenal insufficiency: withhold for moderate and permanently discontinue for severe or life-threatening  
| | o Thyroid: monitor for changes and initiate hormone replacement if needed |
| | Immune-mediated nephritis and renal dysfunction: withhold for moderate or severe and permanently discontinue for life-threatening elevation in serum creatinine. |
| | Immune-mediated rash: withhold for severe and permanently discontinue for life-threatening |
| | Immune-mediated encephalitis: withhold for new-onset moderate or severe neurologic signs or symptoms and permanently discontinue for immune-mediated encephalitis |
| | Embryofetal toxicity: can cause fetal harm. Advise of potential risk to fetus and use effective contraception |

### Safety Considerations

- Immune-mediated reactions are the most significant safety concerns for this drug. Like with other immune-
modulators, early recognition and initiation of treatment are key.

### Adverse Reactions

#### Common adverse reactions
- Melanoma (≥20%): rash (single agent); rash, pruritus, headache, vomiting, colitis (in combination with ipilimumab)
- NSCLC (≥20%): fatigue, musculoskeletal pain, decrease appetite, cough, constipation
- Renal cell (≥20%): asthenic conditions, cough, nausea, rash, dyspnea, diarrhea, constipation, decreased appetite, back pain, arthralgia

#### Death/Serious adverse reactions
- Melanoma (2% - <5%): abdominal pain, hyponatremia, increased aspartate aminotransferase, increased lipase. (≥10%): rash
- Melanoma in combination with ipilimumab: colitis, diarrhea not treated with steroids, increased ALT, pneumonitis, AST increase, pyrexia; in at least 20%: rash, pruritus, headache, vomiting, colitis.
- NSCLC (at least 2%): pneumonia, pulmonary embolism, death due to limbic encephalitis
- Renal cell (at least 2%): acute kidney injury, pleural effusion, pneumonia, diarrhea, hypercalcemia

#### Discontinuations due to adverse reactions
- Melanoma (single): 6.8 vs 11.7%
- Melanoma (combination): 52.1% vs 24.3% (ipi); 36.4% vs 14.8% (ipi) vs 7.7% (nivolumab)
- NSCLC: 3-5% vs 10-15% (docetaxel)
- Renal cell: 16% vs 19% (everolimus)

### Drug Interactions

#### Drug-Drug Interactions
- No pharmacokinetic drug-drug interaction studies

### Risk Evaluation

As of October 1, 2015

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentinel event advisories</td>
</tr>
<tr>
<td>• None</td>
</tr>
<tr>
<td>• Sources: ISMP, FDA, TJC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Look-alike/sound-alike error potentials</th>
<th>NME Drug Name</th>
<th>Lexi-Comp</th>
<th>First DataBank</th>
<th>ISMP</th>
<th>Clinical Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nivolumab 40mg/4mL, 100mg/10mL vial</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Nebivolol Nimodipine Natalizumab</td>
<td></td>
</tr>
<tr>
<td>Opdivo</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Ovide Optiray Forfivo</td>
<td></td>
</tr>
</tbody>
</table>

Sources: Based on clinical judgment and an evaluation of LASA information from three data sources (Lexi-Comp, First Databank, and ISMP Confused Drug Name List)

### Other Considerations

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Updated March 2016
Updated version may be found at [www.pbm.va.gov](http://www.pbm.va.gov) or [PBM INTRANet](http://www.pbm.va.gov/PBMINTRANet)
Melanoma Treatment naïve + ipilimumab: PFS 11.5 vs 6.9 mos (NI vs N); OS not available
NSCLC (nonsquamous) (vs docetaxel): OS 12.2 vs 9.4 mos
NSCLC (squamous) (vs docetaxel): OS 9.2 vs 6.0
Renal Cell (vs everolimus): OS 25 vs 19.6 mos

**Effect Size**

Melanoma Previously Treated: PFS HR 0.82 (99%CI 0.32-2.05)
Melanoma Treatment naïve: OS HR 0.42 (99%CI 0.25-0.73); PFS HR 0.43
Melanoma Treatment naïve + ipilimumab: PFS (NI vs I) HR 0.42; (N vs I) HR 0.57 (NI vs N) HR 0.74 (99.5%CI 0.60-0.92)
NSCLC (nonsquamous): OS HR 0.73 (95%CI 0.59-0.89)
NSCLC (squamous): OS HR 0.59 (95%CI 0.44-0.79)
Renal Cell: OS HR 0.73 (98.5%CI 0.57-0.93)

**Potential Harms**

Single agent melanoma: Grade 3 or 4 in 42%
Combination with ipilimumab in melanoma: Grade 3 or 4 in 69%
NSCLC nonsquamous: Grade 3 or 4 in 47%
NSCLC squamous: Grade 3 or 4 in 7%
Renal Cell: Grade 3 or 4 in 19%

**Net Clinical Benefit**

Melanoma Previously Treated: Negative
Melanoma Treatment Naïve: Moderate
Melanoma Treatment naïve + ipilimumab: Moderate
NSCLC (nonsquamous): Moderate
NSCLC (squamous): Substantial
Renal Cell: Substantial

**Definitions**

**Outcome in clinically significant area:** morbidity, mortality, symptom relief, emotional/physical functioning, or health-related quality of life

**Effect Size:** odds ratio, relative risk, NNT, absolute risk reduction, relative risk reduction, difference in size of outcomes between groups, hazard ratio

**Potential Harms:** Low risk (Grade 3 or 4 toxicity in <20%) versus High risk (Grade 3 or 4 toxicity in ≥20%)

**Net Clinical Benefit:** Substantial (high benefit with low risk of harm), moderate (high benefit with high risk of harm), minimal (low benefit with low risk of harm), negative (low benefit with high risk of harm)

**Dosing and Administration**

- Refer to the package insert for full dosing information and recommended dose modifications
- Melanoma (single agent): Nivolumab 3mg/kg as an intravenous infusion over 60 minutes every 2 weeks until disease progression or unacceptable toxicity.
- Melanoma in combination with ipilimumab: Nivolumab 1mg/kg as an intravenous infusion over 60 minutes, followed by ipilimumab on the same day, every 3 weeks for 4 doses. Subsequent doses of nivolumab is 3 mg/kg as an intravenous infusion over 60 minutes every 2 weeks until disease progression or unacceptable toxicity.
- NSCLC: Nivolumab 3mg/kg as an intravenous infusion over 60 minutes every 2 weeks.
- Renal cell carcinoma (clear cell): Nivolumab 3 mg/kg as an intravenous infusion over 60 minutes every 2 weeks.

**Special Populations (Adults)**

**Comments**

**Elderly**

- No differences in safety or efficacy in 2nd line single-agent trial in melanoma (35% >65 yrs old and 15% ≥75 yrs old)or 2nd line single agent trial in non-squamous NSCLC (37% >65 yrs old and 7% ≥75 yrs old). In combination with ipilimumab, too few patients >65 yrs old to evaluate for efficacy and safety.

**Pregnancy**

- Risk summary: Based on mechanism of action and animal data, nivolumab can cause fetal harm when given to a pregnant female. In animals given nivolumab from onset of organogenesis through delivery there was an increased incidence of abortion and premature infant death. Nivolumab is an immunoglobulin G4 and human IgG4 is known to cross placenta and can be transmitted from mother to fetus. There is no available human data.

**Lactation**

- Risk Summary: It is not known if nivolumab is present in breast milk. Because drugs, including antibodies are excreted in breast milk and due to the potential serious adverse reactions in nursing infants from nivolumab, women should be advised to stop breastfeeding during therapy with nivolumab.

**Females and Males of Reproductive**

- Advise females of reproductive potential to use effective
Nivolumab Monograph

Projected Place in Therapy

- Metastatic melanoma: Current FDA approved choices for therapy for metastatic melanoma that is refractory to ipilimumab and/or BRAF inhibition if BRAF V600 mutation positive, include dacarbazine and interleukin-2, both providing limited benefit and considerable toxicity. For front-line therapy, FDA approved drugs include dacarbazine, interleukin-2, interferon, ipilimumab, pembrolizumab and TKIs for tumors with actionable mutations: vemurafenib, dabrafenib, trametinib, and cobimetinib.
- Lung cancer is one of the top 2 cancers in the VA.
- In non-squamous non-small cell lung cancer that has progressed on a platinum based chemotherapy regimen, there are a number of drugs available for use in this setting. Subsequent therapy in the context of platinum failure does not depend on the tumor molecular profile.
- In squamous non-small cell lung cancer that has progressed on 1 prior platinum based chemotherapy, choices for subsequent therapy are more limited.
- In patients with renal cell carcinoma with a clear cell component, therapy following antiangiogenic therapy is everolimus, an mTOR inhibitor.
- The overall quality of the evidence for nivolumab is high. Some caveats including the lack of availability of overall survival data for previously treated patients with melanoma and in treatment naïve patients with melanoma and a BRAF mutation until sometime in 2016. The quality of data in non-small cell lung cancer is also high, but there is some question about choosing the right patients especially in the non-squamous setting. In renal cell with clear cell component, there are more limited choices with good data for 2nd or 3rd line therapy after antiangiogenic therapy. The quality of data with nivolumab is high and an FDA indication in this setting is expected shortly.
- On ongoing question in this class is choosing the best patients for therapy. Although PD-L1 expression has been tested in clinical trials there is no validation of the staining method and therefore no standardized method for measurement. There is also no standard interpretation of the correct cut-point for declaring PD-L1 expression positivity: in clinical trials in this class of drugs 1%, 5%, 10% and 50% have all been utilized. There are other biomarkers that may become important in the future with predicting which patients are more likely to respond (e.g. tumor-infiltrating lymphocytes and DNA mismatch-repair deficiency).
- Place in therapy should generally follow the current FDA indications until we have more detailed information on using biomarkers to delineate subpopulations to treat or not treat.


Updated March 2016
Updated version may be found at www.pbm.va.gov or PBM INTRAnet

### Appendix A: GRADEing the Evidence

#### Designations of Quality

<table>
<thead>
<tr>
<th>Quality of evidence designation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>High</strong></td>
<td>Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes (2 consistent, higher-quality randomized controlled trials or multiple, consistent observational studies with no significant methodological flaws showing large effects).</td>
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<tr>
<td><strong>Moderate</strong></td>
<td>Evidence is sufficient to determine effects on health outcomes, but the number, quality, size, or consistency of included studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes (1 higher-quality trial with &gt; 100 participants; 2 higher-quality trials with some inconsistency; 2 consistent, lower-quality trials; or multiple, consistent observational studies with no significant methodological flaws showing at least moderate effects) limits the strength of the evidence.</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higher-quality studies, important flaws in study design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.</td>
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</tbody>
</table>

## Appendix B: Approval Endpoints (use for oncology NMEs)

### Table 1. A Comparison of Important Cancer Approval Endpoints

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Regulatory Evidence</th>
<th>Study Design</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Survival</td>
<td>Clinical benefit for regular approval</td>
<td>• Randomized studies essential • Blinding not essential</td>
<td>• Universally accepted direct measure of benefit • Easily measured • Precisely measured</td>
<td>• May involve larger studies • May be affected by crossover therapy and sequential therapy • Includes noncancer deaths</td>
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<tr>
<td>Symptom Endpoints (patient-reported outcomes)</td>
<td>Clinical benefit for regular approval</td>
<td>• Randomized blinded studies</td>
<td>• Patient perspective of direct clinical benefit</td>
<td>• Blinding is often difficult • Data are frequently missing or incomplete • Clinical significance of small changes is unknown • Multiple analyses • Lack of validated instruments</td>
</tr>
<tr>
<td>Disease-Free Survival</td>
<td>Surrogate for accelerated approval or regular approval*</td>
<td>• Randomized studies essential • Blinding preferred • Blinded review recommended</td>
<td>• Smaller sample size and shorter follow-up necessary compared with survival studies</td>
<td>• Not statistically validated as surrogate for survival in all settings • Not precisely measured; subject to assessment bias, particularly in open-label studies • Definitions vary among studies</td>
</tr>
<tr>
<td>Objective Response Rate</td>
<td>Surrogate for accelerated approval or regular approval*</td>
<td>• Single-arm or randomized studies can be used • Blinding preferred in comparative studies • Blinded review recommended</td>
<td>• Can be assessed in single-arm studies • Assessed earlier and in smaller studies compared with survival studies • Effect attributable to drug, not natural history</td>
<td>• Not a direct measure of benefit in all cases • Not a comprehensive measure of drug activity • Only a subset of patients with benefit</td>
</tr>
<tr>
<td>Complete Response</td>
<td>Surrogate for accelerated approval or regular approval*</td>
<td>• Single-arm or randomized studies can be used • Blinding preferred in comparative studies • Blinded review recommended</td>
<td>• Can be assessed in single-arm studies • Durable complete responses can represent clinical benefit • Assessed earlier and in smaller studies compared with survival studies</td>
<td>• Not a direct measure of benefit in all cases • Not a comprehensive measure of drug activity • Small subset of patients with benefit</td>
</tr>
<tr>
<td>Progression-Free Survival (includes all deaths) or Time to Progression (deaths before progression censored)</td>
<td>Surrogate for accelerated approval or regular approval*</td>
<td>• Randomized studies essential • Blinding preferred • Blinded review recommended</td>
<td>• Smaller sample size and shorter follow-up necessary compared with survival studies • Measurement of stable disease included • Not affected by crossover or subsequent therapies • Generally based on objective and quantitative assessment</td>
<td>• Not statistically validated as surrogate for survival in all settings • Not precisely measured; subject to assessment bias particularly in open-label studies • Definitions vary among studies • Frequent radiological or other assessments • Involves balanced timing of assessments among treatment arms</td>
</tr>
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</table>

*Adequacy as a surrogate endpoint for accelerated approval or regular approval is highly dependent upon other factors such as effect size, effect duration, and benefits of other available therapy. See text for details.