



Clinical Commissioning Policy: Glucarpidase for the urgent treatment of methotrexate- induced renal dysfunction

Reference: NHS England B15/P/a

NHS England

Clinical Commissioning

Policy:

Glucarpidase for the urgent treatment of methotrexate-induced renal dysfunction

First published: January 2015

Prepared by NHS England Specialised Services Clinical Reference Group for Chemotherapy

Published by NHS England, in electronic format only.

NHS England INFORMATION READER BOX**Directorate**

Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference: 02666

Document Purpose	Policy
Document Name	Glucarpidase for the urgent treatment of methotrexate-induced renal dysfunction
Author	NHS England
Publication Date	January 2015
Target Audience	Foundation Trust CEs , Medical Directors, Directors of Nursing, NHS England Regional Directors, NHS England Area Directors, Directors of Children's Services, NHS Trust CEs

Additional Circulation List

Description	NHS England will commission Glucarpidase for the urgent treatment of methotrexate-induced renal dysfunction in accordance with the criteria outlined in this document. This policy document outlines the arrangements for funding of this treatment for the population in England.
--------------------	--

Cross Reference	N/A
------------------------	-----

Superseded Docs (if applicable)	N/A
---	-----

Action Required**Timing / Deadlines**
(if applicable)

Contact Details for further information	NHS England Skipton House 80 London Road London SE1 6LH
--	---

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Contents

Policy Statement	5
Equality Statement	5
Plain Language Summary	5
1. Introduction	6
2. Definitions	6
3. Aim and objectives	6
4. Epidemiology and needs assessment.....	7
5. Evidence base.....	7
6. Rationale behind the policy statement.....	9
7. Criteria for commissioning	9
8. Patient pathway	9
9. Governance arrangements.....	9
10. Mechanism for funding.....	10
11. Audit requirements	10
12. Documents which have informed this policy.....	10
13. Links to other policies.....	10
14. Date of review	10
References.....	10

Policy Statement

NHS England will commission Glucarpidase for the urgent treatment of methotrexate-induced renal dysfunction in accordance with the criteria outlined in this document.

In creating this policy NHS England has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population in England.

Equality Statement

Throughout the production of this document, due regard has been given to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

Plain Language Summary

Methotrexate is a medicine used to treat a variety of cancers and autoimmune conditions. Acute renal dysfunction (kidney injury) is a life-threatening complication that can occur with high doses of methotrexate. When this occurs large amounts of methotrexate remain in the blood causing the side effects that have a high risk of death. Glucarpidase is a medicine that removes methotrexate from the blood.

1. Introduction

Methotrexate is an antifolate drug that is used alone or in combination with other drugs to treat a variety of cancers and autoimmune conditions (e.g. rheumatoid arthritis). It is administered over a wide dose range, which can be as low as 20 mg/m² (milligrams per square metre) for maintenance therapy or between 1G/m² and 12G/m² (grams per square metre) when used as high dose therapy.

Acute renal dysfunction is a life-threatening complication that is caused by the precipitation of methotrexate, and its metabolites, in the renal tubules. Renal dysfunction delays the renal clearance of methotrexate, leading to elevated plasma concentrations of the drug and the potential for additional methotrexate toxicities including myelosuppression, mucositis, hepatitis, and dermatitis.

Patients receiving high-dose methotrexate therapy are treated with aggressive hydration and alkalinization to improve the solubility of methotrexate, and with leucovorin, a folate that can counteract the effects of methotrexate. With this regimen, in combination with close patient monitoring, the incidence of methotrexate nephrotoxicity decreases from about 10% to approximately 1% to 2%. Despite the reduced incidence of methotrexate-induced toxicity, cases of severe and fatal nephrotoxicity still occur.

Glucarpidase is an orphan medicine, not licensed in the UK. It was licensed in the US in early 2012 for the treatment of patients with toxic levels of methotrexate in their blood due to kidney failure. Glucarpidase reduces methotrexate levels by >98% within 15 minutes of administration. It is a recombinant form of the bacterial enzyme carboxypeptidase G2, and works by rapidly hydrolyzing methotrexate into inactive non cytotoxic metabolites. These are not eliminated by the kidney, providing an alternative clearance route in patients who have acute kidney injury and delayed renal elimination.

Glucarpidase is intended for use by paediatric and adult oncology and haematology consultants for treating adults and children receiving high-dose methotrexate chemotherapy who develop a significant deterioration in renal function after the start of the high dose methotrexate, have toxic plasma methotrexate levels and are at risk of life-threatening methotrexate-induced toxicities.

It is very unlikely that in any given year Glucarpidase will be used for more than 20 patients. However, when it is required, it is needed urgently without time to seek funding approval through the Individual Funding Request route. Determining a national commissioning position in advance of its use would allow clinicians to manage patients appropriately in full knowledge of funding streams

2. Definitions

This policy reviews the use of the medicine Glucarpidase for the treatment of patients with toxic levels of methotrexate in their blood due to kidney injury.

3. Aim and objectives

This policy aims to: develop a national commissioning policy for glucarpidase in the management of methotrexate induced renal dysfunction. The objectives are to: provide a consistent approach to funding and minimise the need for individual

funding requests.

4. Epidemiology and needs assessment

Sales data from Clinigen (distributor for the UK) suggest demand for this product will be very low in the region of 5 to 10 patients a year (adults/paediatrics).

Glucarpidase is needed for use by paediatric and adult oncology/ haematology patients who develop a significant deterioration in renal function after the start of high dose methotrexate, have toxic plasma methotrexate levels and are at risk of life-threatening methotrexate-induced toxicities.

5. Evidence base

A number of uncontrolled phase II single arm studies and case reports have been published previously (1-3). However, more recently a pooled analysis of efficacy data from four multicenter single-arm compassionate-use clinical trials using protocols from 1993 to 2007 was published (4).

Of 476 patients with renal toxicity and delayed methotrexate elimination who were treated with intravenous glucarpidase for rescue after high-dose methotrexate, 169 patients had at least one preglucarpidase (baseline) plasma methotrexate concentration greater than 1 $\mu\text{mol/L}$ and one postglucarpidase methotrexate concentration measurement by high-performance liquid chromatography and were included in the efficacy analysis; renal recovery was assessed in 436 patients who had at least one recorded preglucarpidase and postglucarpidase serum creatinine concentration measurement.

Efficacy was defined as rapid and sustained clinically important reduction (RSCIR) in plasma methotrexate concentration, with a concentration of 1 $\mu\text{mol/L}$ or lower at all postglucarpidase determinations. Median age of efficacy-evaluable patients was 20 years (range 5 weeks-84 years). Osteosarcoma (36%), non-Hodgkin lymphoma (27%), and acute lymphoblastic leukemia (20%) were the most frequent underlying diagnoses. Median preglucarpidase serum methotrexate was 11.7 $\mu\text{mol/L}$. At the first (median 15 minutes) through the last (median 40 hours) postglucarpidase measurement, plasma methotrexate concentrations demonstrated consistent 99% median reduction. RSCIR was achieved by 83 (59%) of 140 patients. A total of 64% of patients with renal impairment greater than or equal to Common Terminology Criteria for Adverse Events grade 2 recovered to grade 0 or 1 at a median of 12.5 days after glucarpidase administration.

The authors concluded that Glucarpidase caused a clinically important 99% or greater sustained reduction of serum methotrexate levels and provided noninvasive rescue from methotrexate toxicity in renally impaired patients.

Paediatric patients

Experience with glucarpidase in children has been published in abstract (5). From November 1993 through June 2009, 232 paediatric patients experiencing renal toxicity and delayed elimination of methotrexate (methotrexate) were treated with glucarpidase (50 units/kg intravenously) in compassionate use trials conducted in

the United States and Europe.

Of the 232 paediatric patients, 89 were < 12 years; the youngest was 5 weeks. Fifty-four percent were male. Forty-seven percent were treated for osteogenic sarcoma, 31% for ALL, 18% for non-Hodgkin lymphoma, and 4% for other malignancies. The median pre-glucarpidase methotrexate concentration was 34 $\mu\text{mol/L}$. Seventy percent of patients received a single dose of glucarpidase, 28% received 2 doses, and 2% received 3 doses.

Sixty-seven patients had methotrexate concentrations determined by central laboratory HPLC assay. At the first measurement (median 15 minutes post-glucarpidase; range: 10 - 30 minutes) serum methotrexate concentration was reduced by $\geq 95\%$ in 91% of patients. Eighty-four percent of patients had a $\geq 95\%$ reduction at the last measurement (median 48 hours post-glucarpidase).

In the 201 patients with pre-glucarpidase renal impairment measured as NCI Common Terminology Criteria for Adverse Events (CTCAE) Grade 2 or higher, 75% recovered to Grade 0 or 1 after a median of 10 days post-glucarpidase. Glucarpidase was well-tolerated overall, but side effects included paresthesia (2.2%), flushing (1.7%), headache (1.3%), burning sensation (1.3%), and feeling hot (1.3%). Thirteen patients died during the follow-up period of causes unrelated to glucarpidase, as judged by the treating physician.

Glucarpidase is the treatment recommendation within the UKALL2011 (trial for acute lymphoblastic leukaemia and lymphoma (EudraCT no. 2010-020924-22)) when a child has: raised Methotrexate levels at specified time points post high dose Methotrexate infusion, serum creatinine rises $>100\%$ within 24 hours of infusion, delayed excretion when plasma methotrexate levels plateau.

Alternative treatments

There are no other drugs currently used for the same indication. Haemodialysis is a possible option if renal failure occurs. However, this must be repeated continuously or daily, in order to reduce the methotrexate level to non-toxic concentrations.

The use and efficacy of dialysis-based methods of methotrexate removal in patients with HD- methotrexate -induced renal dysfunction has been reviewed (6). The review included 49 patients from 30 publications. The most frequently used single methods reviewed were haemodialysis (n=10), high-flux haemodialysis (n=9) and charcoal haemoperfusion or charcoal haemofiltration (n = 7) with 16 patients treated with multiple modalities. Dialysis-based methods were used for up to 14 days. Peritoneal dialysis alone resulted in only a minimal decrease in plasma methotrexate concentrations. The use of other single-modality methods of methotrexate removal resulted in a median decrease in plasma methotrexate concentration of 52% (range, 26 - 82%). High-flux haemodialysis resulted in the greatest decrease in plasma methotrexate concentrations (median 75.5%; range 42 - 94%) within the shortest period of time (median 4 hours; range 4 - 12 hours). Only 3 patients had a $> 90\%$ decrease in methotrexate concentration with the use of single method in one dialysis session. However a major limitation on the use of dialysis-based methods is the marked rebound in plasma methotrexate

concentrations that can occur when the dialysis is stopped. Rebound increases in the post-dialysis plasma methotrexate concentration were in the range of 10 - 221% of the post-procedure methotrexate level and 90 - 100% of the pre-procedure methotrexate level.

6. Rationale behind the policy statement

There is level 2+ evidence, from published uncontrolled studies, that glucarpidase increases the elimination of methotrexate and reduces the risk of severe methotrexate toxicities in patients with renal impairment.

Indirect comparison with reported elimination rates using alternative treatments, particularly haemodialysis, suggests that glucarpidase is more effective and less invasive.

7. Criteria for commissioning

Before patients receive high-dose methotrexate, there should be formal checks to ensure the patient has normal renal function and there is good hydration/alkalinisation of urine. Before using glucarpidase, all other supportive measures must have been optimised, such as use of fluids and folinic acid. Glucarpidase will be routinely funded for the treatment of adults and children receiving high-dose methotrexate chemotherapy (doses > 1 g/m²) who develop a significant deterioration in renal function after the start of the high dose methotrexate, have toxic plasma methotrexate levels and, despite rescue measures, are at risk of life threatening methotrexate induced toxicities.

A significant deterioration in renal function is regarded as a serum creatinine that is at least 1.5 times the upper limit of normal and rising, or the presence of oliguria.

Defining a toxic methotrexate level is complicated by the regimen used and the time at which the level is tested. However, patients must have a dangerously high blood methotrexate level that is rising despite all standard rescue measures. For children treated on UKALL 2011, this level is defined in the guidance in the protocol.

The recommended dose and schedule for glucarpidase is as a single intravenous injection of 50 Units/kg. Multiple doses are not permitted under this policy.

8. Patient pathway

Glucarpidase has been used on a small number of occasions in NHS England to urgently treat toxic methotrexate levels that have occurred during cancer chemotherapy. It may be used in any patient receiving high-dose methotrexate therapy who develops significant renal dysfunction, has a toxic level of methotrexate and who is at risk of life-threatening complications.

9. Governance arrangements

Glucarpidase is an orphan drug that is not licensed in the UK. It is supplied on a named patient basis.

Use of glucarpidase will be subject to internal governance arrangements within

Acute Providers.

10. Mechanism for funding

Methotrexate chemotherapy is funded by NHS England. Glucarpidase is proposed for NHS England funding. This may be considered on a 'notification' basis but approval of a commissioning policy should not then require individual 'prior approval' or a funding decision.

Glucarpidase is manufactured by Protherics UK and distributed by Clinigen on a named patient basis in packs of 2 vials containing 1000 units/vial at a cost of £26,900 (including VAT). This would be the average cost for patients weighing 40kg or less. For patients between 40-80kg, the cost would be £53,800 (including VAT).

11. Audit requirements

Collation of patient details and outcome by Acute Trust and reported to the NHS England Area Team.

12. Documents which have informed this policy

Yorkshire and the Humber Specialised Commissioning Group. Draft Commissioning Policy: Glucarpidase for the urgent treatment of methotrexate-induced renal dysfunction. September 2012.

13. Links to other policies

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

14. Date of review

This policy will be reviewed in April 2016 unless information is received which indicates that the proposed review date should be brought forward or delayed.

References

1. Buchen S, Ngampolo D, Melton RG, Hasan C, Zoubek A, Henze G, et al. Carboxypeptidase G2 rescue in patients with methotrexate intoxication and renal failure. *British journal of cancer*. 2005;92(3):480-7.
2. Schwartz S, Borner K, Müller K, Martus P, Fischer L, Korfel A, et al. Glucarpidase (Carboxypeptidase G2) Intervention in Adult and Elderly Cancer Patients with Renal Dysfunction and Delayed Methotrexate Elimination After High-Dose Methotrexate Therapy. *The Oncologist*. 2007;12(11):1299-308.
3. Widemann BC, Balis FM, Kim A, Boron M, Jayaprakash N, Shalabi A, et al. Glucarpidase, Leucovorin, and Thymidine for High-Dose Methotrexate-Induced

Renal Dysfunction: Clinical and Pharmacologic Factors Affecting Outcome. *Journal of Clinical Oncology*. 2010;28(25):3979-86.

4. Widemann BC, Schwartz S, Jayaprakash N, Christensen R, Pui CH, Chauhan N, et al. Efficacy of Glucarpidase (Carboxypeptidase G2) in Patients with Acute Kidney Injury After High-Dose Methotrexate Therapy. *Pharmacotherapy*. 2013.

5. Howard SC, Widemann BC, Chauhan N, Daugherty C, King TR, Jayaprakash N, et al., editors. Pediatric clinical trial and compassionate use experience with glucarpidase for methotrexate toxicity. *American Society of Pediatric Hematology Oncology*; 2012 May 9-12; New Orleans, Louisiana.

6. Widemann BC, Adamson PC. Understanding and managing methotrexate nephrotoxicity. *Oncologist*. 2006;11(6):694-703.