Clinical Priorities Advisory Group Summary Report

Agenda item	3.6
Date of Meeting	11/05/2026-13/05/2026
Title of the Proposition	Dabrafenib for BRAFV600E mutation positive histiocytic neoplasms where standard care has failed (all ages)
Unique Reference Number	2268
Programme of Care	Cancer
Clinical Reference Group	Chemotherapy
Service/treatment status	retained

Action requested

Support the adoption of the policy proposition

Recommended its relative prioritisation.

Summary of the proposition:

Dabrafenib is recommended to be available off-label as a routine commissioning treatment option for BRAFV600E mutation positive histiocytic neoplasms where standard care has failed within the criteria set out in the policy proposition. This policy proposition is for all ages in line with the findings from the evidence review.

Chemotherapy services are considered suitable and ready for delegation, therefore it is expected that responsibility will transfer to Integrated Care Boards in future.

Clinical Panel recommendation:

The Clinical Panel recommended that the policy proposition progress as a routine commissioning policy.

Assurances

The committee is asked to receive the following assurance:		
1.	The Deputy Director of Clinical Effectiveness confirms the proposition has completed the appropriate sequence of developmental and governance steps.	
2.	The Deputy Director of Cancer Programme confirms the proposition is supported by the following documentation (please tick the box where applicable)	
	Draft Clinical Commissioning policy proposition	☒
	Evidence Review	☒
	Public Health Evidence Report	☐
	Evidence to Decision Making (EtD) Summary	☒
	Equalities and Heath Inequalities Assessment (EHIA)	☒
	Prior Approval Form	☒
	Engagement Report	☒
	13Q Assessment and Patient & Public Voice Assurance	☒
	Clinical Panel Report	☒
	Policy Working Group membership	☒
	Other (please state if required)	☐
3.	The Deputy Director of Finance (Specialised Commissioning) confirms that the Impact Assessment has reasonably estimated a) the incremental cost and b) the budget impact of the proposal.	
4.	The Director of Clinical Commissioning (Specialised Commissioning) confirms that the Service and Operational Impact Assessments have been completed.	

5.	The Deputy Director of Quality and Nursing (Specialised Commissioning) confirms that the proposed quality indicators have been adequately defined (where applicable).

Evidence Review Summary

In people with BRAF^{V600E} mutation positive histiocytic neoplasms where standard care has failed, what is the clinical effectiveness and safety of oral dabrafenib with or without best supportive care compared with best supportive care alone?

Outcome	Evidence statement
Clinical Effectiveness	
Critical outcomes	
Disease response **Certainty of evidence:** Very low	This outcome is important to patients because it can reflect the benefits the treatment may have for a patient. This can be important to control the symptomatic burden of the disease and/or reflect subgroups who may configure additional response benefits, allowing the treatment protocol to be individualised. In total, one retrospective cohort study, one prospective case series and two retrospective case series provided evidence relating to disease response in patients with BRAF^{V600E} mutation positive histiocytic neoplasms. The cohort study compared dabrafenib following first-line chemotherapy with second-line chemotherapy following first-line chemotherapy. Disease response was evaluated using the International LCH Study Group Criteria[1], the LCH Disease Activity Score (DAS),[2] and the PET Response Evaluation Criteria in Solid Tumours (PERCIST)[3]. At 1 month: • One cohort study (Wang et al 2022) reported a *statistically significant lower* DAS in those that received dabrafenib compared with those that received second-line chemotherapy (2.5 v 8.5, p=0.002). The same cohort study also showed a *statistically significant difference* in those reporting to be AD/better on the LCH Study Group Criteria at one month between those that received dabrafenib (n=12, 100%) and those receiving second-line chemotherapy (n=3, 37.5%; p=0.004). **(VERY LOW)** • One prospective case series (Shi et al 2021) reported that 86.4% of those on dabrafenib (n=19) were AD/better at one month follow-up. No statistical comparison was reported. **(VERY LOW)** During follow-up: • One prospective case series (Shi et al 2021) reported that amongst the group receiving dabrafenib over 12 months, the proportion with an AD/better score decreased from 86.4% at one month follow-up (n=19) to 64.3% at nine

[1] International LCH Study Group Criteria, Disease State: non-active disease (NAD); active disease (AD)/better; AD/intermediate; AD/worse

[2] LCH disease activity score (DAS) is a 15 domain scale with scores ranging from 0-35 (35 being very poor health). Scores 0-2 are considered low, 3-6 moderate and ≥7 high

[3] Modified PET Response Criteria in Solid Tumours (PERCIST): up to 5 lesions were selected, SUVs were normalized for body weight, and the FDG avidity of each lesion was calculated as $SUV_{max\ lesion} - SUV_{max\ liver\ background} = SUV_{corrected\ for\ background}$, or simply "SUV." For brain lesions, brain background was used *in lieu* of liver background. Values less than zero were treated as 0, which allowed the FDG avidity of a lesion to be considered as the excess avidity above background. Complete metabolic response (CMR) was defined as all lesions decreased to or below background; partial metabolic response (PMR) was defined as a 50% or greater decrease from baseline in the sum SUV of all target lesions; progressive metabolic disease (PMD) was defined as a 50% or greater increase from the nadir in the sum of SUV all target lesions or the appearance of new evaluable lesions; stable metabolic disease (SMD) was when the response did not meet other criteria

Outcome	Evidence statement
	months follow-up (n=9). The results were not compared statistically. **(VERY LOW)** • One retrospective case series (Bhatia et al 2018) reported that for 11 adults with ECD and ECD/LCH achieved either partial or complete metabolic response on dabrafenib treatment (total cases=11, PMR=8, CMR=3); dabrafenib treatment ranged from four to 43 months; median not reported. No statistical analyses were reported. **(VERY LOW)** At the end of treatment: • One retrospective case series (Yang et al 2021) reported that at the end of dabrafenib treatment, 65% of patients were AD/better (n=13), 10% AD/stable (n=2), 5% AD/mixed (n=1) and 20% AD/worse (n=4). The DCR rate[4] in those treated with dabrafenib was 75%. No statistical comparison was reported. **(VERY LOW)** • One prospective case series (Shi et al 2021) reported that at 12 months follow-up and treatment completion, 100% of the patients still taking dabrafenib were classed as AD/better (n=11). **(VERY LOW)** **For patients that had first-line chemotherapy followed by oral dabrafenib, compared to patients that had first-line chemotherapy followed by second-line chemotherapy, one cohort study provided very low certainty evidence of a statistically significant improvement in disease state after one month of daily dabrafenib treatment compared to two cycles of second-line chemotherapy. One case series provided very low certainty non-comparative evidence that during dabrafenib treatment, all patients reached partial or complete metabolic response; no statistical analyses were conducted. Two case series provided very low certainty non-comparative evidence that at the end of treatment with dabrafenib, a higher proportion of patients were classed as AD/better and AD/stable than AD/worse; the data were not statistically compared.**
Overall survival **Certainty of evidence:** Very low	Overall survival is important to patients as individuals with refractory histiocytic neoplasms have a high mortality rate due to progression of cancer. Improved survival is an important marker of effective treatment. In total, one retrospective cohort study and one retrospective case series provided evidence relating to overall survival in children with $BRAF^{V600E}$ mutation positive histiocytic neoplasms. The cohort study compared dabrafenib following first-line chemotherapy with second-line chemotherapy following first-line chemotherapy. • One cohort study (Wang et al 2022) reported that during follow-up (median: 28.9 months, range 10.0 to 60.8 months), no patients died in either the dabrafenib group or the chemotherapy comparator group. **(VERY LOW)** • One retrospective case series (Yang et al 2021) reported that during 30.8 months of follow-up (range 18.9 to 43.6 months), no patients died. **(VERY LOW)** **One cohort study provided very low certainty evidence of no difference in mortality following dabrafenib treatment compared with second-line chemotherapy; the groups were not compared statistically. One case series, non-comparator data, provided very low certainty evidence of low mortality rates in patients with $BRAF^{V600E}$ mutation positive histiocytic neoplasms treated with dabrafenib.**
Progression free survival **Certainty of evidence:**	This outcome is important to patients because it represents the time for which their disease is not progressing. Stable disease might represent longer survival and disease stability may result in patients experiencing fewer symptoms from the disease itself. It can be determined sooner than overall survival outcome measures. In total, one retrospective cohort study and one prospective case series provided evidence relating to progression free survival in children with $BRAF^{V600E}$ mutation

[4] DCR: disease control rate; the percentage of all patients AD/better and AD/stable at the end of treatment

Outcome	Evidence statement
Very low	positive histiocytic neoplasms. The cohort study compared dabrafenib following first-line chemotherapy with second-line chemotherapy following first-line chemotherapy. *Progression free survival (PFS) rate* • One cohort study (Wang et al 2022) reported a *statistically significant higher* PFS in those that received dabrafenib (74% ± 12.5%) compared with those that received second-line chemotherapy (14.6% ± 13.5%) at four years follow-up (p=0.034). **(VERY LOW)** • One prospective case series (Shi et al 2021) reported a PFS of 47.9% (95% CI 31.3% to 64.5%) at 2 years and a PFS of 63.9% (95% CI 51.7% to 76.1%) at one year in those treated with dabrafenib. **(VERY LOW)** **One cohort study provided very low certainty evidence of statistically significant improvement in progression free survival when comparing those that had first-line chemotherapy followed by oral dabrafenib to patients that had first-line chemotherapy followed by second-line chemotherapy. One case series provided very low certainty non-comparative evidence that at the end of two years, patients with BRAF^{V600E} mutation positive histiocytic neoplasms treated with dabrafenib had a progression free survival rate of almost 50%.**
Important outcomes	
Quality of life **Certainty of evidence:** Very low	Quality of life is important to patients as it provides an indication of an individual's general health, their self-perceived well-being and their ability to participate in activities of daily living. Measurement of quality of life can help inform patient-centred decision making and inform health policy. **No evidence was identified for quality of life.**
Relapse rate **Certainty of evidence:** Very low	This outcome is important to patients because it can indicate that their condition may not be adequately controlled by their current treatment, impacting on quality of life and patient treatment decisions. In total, one retrospective cohort study, one prospective case series and one retrospective case series provided evidence relating to relapse rate in children with BRAF^{V600E} mutation positive histiocytic neoplasms. The cohort study compared dabrafenib following first-line chemotherapy with second-line chemotherapy following first-line chemotherapy. • One cohort study (Wang et al 2022) reported that during follow-up (median: 28.9 months, range 10.0 to 60.8 months), three patients in the dabrafenib group (n=12, 25.0%) and six patients in the chemotherapy comparator group (n=8, 75.0%) had disease progression or relapse; the difference between the groups was *not statistically significant*. **(VERY LOW)** • One prospective case series (Shi et al 2021) reported that during 14.0 months of follow-up (range 4.8 to 37.7 months), seven patients had disease relapse or progression (n=7, 31.8%). **(VERY LOW)** • One retrospective case series (Yang et al 2021) reported that during 30.8 months of follow-up (range 18.9 to 43.6 months), 50% of the children suffered relapse or LCH progression following cessation of dabrafenib treatment (10 of 20). **(VERY LOW)** **One cohort study provided very low certainty evidence of no statistically significant difference in relapse / progression rate following dabrafenib treatment compared with second-line chemotherapy. Two case series, non-comparator data, provided very low certainty evidence of relapse rates of 32% and 50% in children with BRAF^{V600E} mutation positive histiocytic neoplasms, specifically LCH, treated with dabrafenib.**
Symptom alleviation	This outcome is important to patients because reduction of symptoms directly improves the patient's quality of life. This outcome is both a key indicator of the effectiveness of treatment and provides an insight into the patient's perception of the effectiveness of treatment.

Outcome	Evidence statement
Certainty of evidence: Very low	**No evidence was identified for symptom alleviation.**
Organ specific disease response **Certainty of evidence:** Very low	This outcome is important to patients as objective measures of functioning of affected organs. Given the progressive nature of pulmonary and neurodegenerative histiocytosis, disease activity results might not be expected to return to normal following treatment, however, stabilisation may indicate treatment has successfully limited disease progression. One retrospective cohort study and one retrospective case series provided evidence relating to organ specific disease response in children with $BRAF^{V600E}$ mutation positive histiocytic neoplasms. The cohort study compared dabrafenib following first-line chemotherapy with second-line chemotherapy following first-line chemotherapy. *MAS-HLH disease: recovery time of temperature, haemoglobin and platelets* • One cohort study (Wang et al 2022) reported *statistically significant fewer* days until reduction of fever to normal body temperature in those children treated with dabrafenib (n=12, median 2.0 days) compared with those treated with second-line chemotherapy (n=8, median 18.0 days; p<0.001). **(VERY LOW)** • The same study reported *statistically significant fewer* days until normal levels of haemoglobin were reached in those children treated with dabrafenib (n=12, median 7.0 days) compared with those treated with second-line chemotherapy (n=8, median 30.5 days; p<0.001). **(VERY LOW)** • The cohort study also reported *statistically significant fewer* days until normal levels of platelets were reached in those children treated with dabrafenib (n=12, median 7.0 days) compared with those treated with second-line chemotherapy (n=8, median 27.0 days; p<=0.013). **(VERY LOW)** *Liver and Spleen* • One cohort study (Wang et al 2022) reported *statistically significant smaller* spleen size following one month of dabrafenib therapy (n=12) compared with those treated with second-line chemotherapy (n=8) for two rounds (p=0.047). **(VERY LOW)** • One retrospective case series (Yang et al 2021) stated that five patients showed improvement in all lesions except hepatic cirrhosis following a median of 11.4 months of dabrafenib treatment (range 3.1 to 19.2 months). Two additional patients with symptoms of hepatosplenomegaly and liver damage (but no cirrhosis-related manifestations) reported a reduction in symptoms. Clinical measurements were not reported. **(VERY LOW)** *Pituitary* • One retrospective case series (Yang et al 2021) stated that seven patients with pituitary lesions showed no further progression of disease following a median of 11.4 months of dabrafenib treatment (range 3.1 to 19.2 months). One of three patients with diabetes insipidus had an improvement of symptoms. Clinical measurements were not reported. **(VERY LOW)** **One cohort study provided very low certainty evidence of a statistically significant shorter time to improvement for the key disease markers of MAS-HLH (temperature, haemoglobin levels and platelet levels) in those treated with dabrafenib compared with those treated with second-line chemotherapy. The same study also provided very low certainty evidence of a statistically significantly smaller spleen size following one month of dabrafenib therapy compared with those receiving second-line chemotherapy. One case series provided very low certainty narrative evidence of improvements in liver, spleen and pituitary disease following dabrafenib therapy.**
Safety	
Adverse events	These outcomes are important to patients because they will impact on their treatment choices, recovery and could have long term sequelae if they are irreversible. They reflect the tolerability and adverse effects of the treatment. From a service delivery

Outcome	Evidence statement
Certainty of evidence: Very low	perspective, they reflect the additional demands placed on the health system to manage the adverse consequences of the treatment. In total, one retrospective cohort study, one prospective case series and two retrospective case series provided evidence relating to safety in patients with $BRAF^{V600E}$ mutation positive histiocytic neoplasms. The cohort study compared dabrafenib following first-line chemotherapy with second-line chemotherapy following first-line chemotherapy. *Number of adverse events (AEs)* • One cohort study (Wang et al 2022) reported fewer adverse events in those children treated with dabrafenib (4, 33.3%) compared with those treated with second-line chemotherapy (12, 92.3%); the groups were not statistically compared. **(VERY LOW)** • One retrospective case series (Yang et al 2021) reported 17 AEs in nine patients over a median of 11.4 months of dabrafenib treatment (range 3.1 to 19.2 months). None of the AEs were reported to be severe. **(VERY LOW)** • One retrospective case series (Bhatia et al 2018) reported AEs in eight out of 11 adults over a range of 4 to 43 months of treatment with dabrafenib. One patient reported Grade 3 fever; all other AEs were Grade 1 or 2. **(VERY LOW)** *Specific AEs* • One cohort study (Wang et al 2022) stated that the primary AEs for dabrafenib patients were skin-related toxicity (75%), diarrhoea, vomiting, fatigue, joint pain and transient myocardium enzyme rising; whilst the most common AEs for those receiving second-line chemotherapy were myelosuppression and pancytopenia. **(VERY LOW)** • One retrospective case series (Yang et al 2021) reported that over a median of 11.4 months of dabrafenib treatment (range 3.1 to 19.2 months) the most common AE was maculopapular rash with eight events (47.1%). **(VERY LOW)** • One prospective case series (Shi et al 2021) reported that during 14.0 months of follow-up (range 4.8 to 37.7 months), 13 children had skin toxicity due to dabrafenib treatment (56.5%). **(VERY LOW)** • One prospective case series (Bhatia et al 2018) reported skin toxicities to be the most common (panniculitis, keratoacanthoma, keratosis pilaris and skin; n=4) followed by fever (n=3), fatigue (n=2) and arthralgia (n=2) during dabrafenib treatment (range 4 to 43 months; median not reported). **(VERY LOW)** **One cohort study provided very low certainty evidence that there were fewer adverse events in those treated with dabrafenib compared with those treated with second-line chemotherapy; the groups were not statistically compared. The most common adverse event reported across all included studies was skin-related. These studies provide very low certainty evidence that many patients reported adverse events during dabrafenib treatment; however, most were not severe.**

Abbreviations
AD: active disease; AE: adverse events; CI: confidence interval; CMR: complete metabolic response; DAS: Disease Activity Score; DCR: disease control rate; ECD: Erdheim-Chester Disease; LCH: Langerhans cell histiocytosis; MAS-HLH: Macrophage activation syndrome-hemophagocytic lymphohistiocytosis; n: number; ORR: objective response rate; PERCIST: Modified PET Response Criteria in Solid Tumours; PFS: progression free survival; PMR: partial metabolic response; v: versus

In people with $BRAF^{V600E}$ mutation positive histiocytic neoplasms where standard care has failed, what is the cost effectiveness of oral dabrafenib with or without best supportive care compared with best supportive care alone?

Outcome	Evidence statement

Cost effectiveness	**No evidence was identified for cost effectiveness.**

From the evidence selected, are there any subgroups of patients that may benefit from oral dabrafenib with or without best supportive care more than the wider population of interest?

Outcome	Evidence statement
Subgroups	Subgroup results by risk organ (RO) group[5] from one retrospective case series reported the critical outcomes, disease response and progression free survival. Subgroup analysis was pre-planned in the cohort. **Disease Response** • One case series (Yang et al 2021) reported a higher treatment response following dabrafenib therapy in those from RO+ve group (n=14, 78.6%) compared to those that were RO-ve (n=6, 33.3%). The results were *not statistically significant.* (p=0.122) **Progression free survival** • One retrospective case series (Yang et al 2021) showed *no statistically significant difference* in the 2-year progression free survival rate in those in the RO+ve group compared to those in the RO-ve group after dabrafenib treatment (X^2=0.062, p=0.804). **One retrospective case series compared outcomes in paediatric patients treated with dabrafenib therapy stratified by risk organ group (RO+ve and RO-ve) and reported no statistically significant difference in the effectiveness of dabrafenib in terms of disease response or progression free survival.**
Abbreviations: **n: number; RO: risk organ group; RO+ve: risk organ positive, LCH disease involved risk organs; RO-ve: risk organ negative, LCH disease did not involve risk organs**	

From the evidence selected, what dose of dabrafenib was used in the research studies?

Outcome	Evidence statement
Dabrafenib dose	Evidence about dabrafenib dose came from one retrospective cohort study, one prospective case series and two retrospective case series. • One cohort study (Wang et al 2022) treated children with poorly controlled LCH and MAS-HLH with oral dabrafenib at a dose of 2 mg/kg, twice daily for 12 months. • The two additional case series (Shi et al 2021 and Yang et al 2021), used the same dosing regimens for their paediatric patients with LCH: oral dabrafenib, 2 mg/kg, twice daily. • One retrospective case series (Bhatia et al 2018) treated adults with ECD or ECD/LCH with oral dabrafenib at the following doses (all twice daily): 50mg, 75mg, 100mg, 150mg. Treatment ranged from 4 to 43 months and was ongoing for n=9 patients at the time of follow-up; median follow-up time was not reported. **One retrospective case series treated adult patients with ECD or ECD/LCH with oral dabrafenib at doses ranging from 50mg, twice daily to 150mg, twice daily. Three studies of paediatric patients with LCH, used an oral dabrafenib dose of 2 mg/kg (twice daily).**
Abbreviations	

[5] The authors do not further define this group.

ECD: Erdheim-Chester Disease; LCH: Langerhans cell histiocytosis; MAS-HLH: Macrophage activation syndrome-hemophagocytic lymphohistiocytosis; mg: milligram; kg: kilogram; n: number

Patient Impact assessment

Patient Impact Summary

The condition has the following impacts on the patient's everyday life:

- **mobility:** patients with histiocytic neoplasms may experience spontaneous fractures occur in the skull, spine and long bones that acutely compromise mobility. Many patients experience chronic skeletal pain that has a major long-term impact upon mobility. In addition, patients are often hospitalised for weeks at a time or spend many hours sitting through long chemotherapy cycles. This can have profound impact on their mobility and physicality after a prolonged hospital stay.
- **ability to provide self-care:** patients with severe forms of histiocytic neoplasms may become entirely dependent on others for all forms of personal care, including washing and dressing, due to fatigue and pain associated with the disease, as well as loss of muscle mass from multiple lines of treatment, often including corticosteroids and prolonged hospital admissions.
- **undertaking usual activities:** patients that have not achieved stable disease activity can have severe problems in carrying out their usual activities, including working, due to extreme fatigue, chronic pain associated with disease and the consequences of chemotherapy.
- **experience of pain/discomfort:** patients with histiocytic neoplasms often experience long term skeletal pain or discomfort, in addition to extreme fatigue side effects of chemotherapy.
- **experience of anxiety/depression:** patients with histiocytic neoplasms can be severely anxious or depressed. This can be caused by multiple factors including direct neurocognitive impairment due to nervous system involvement, chronic skeletal pain, long term analgesic use and the stress and uncertainty associated with lived experience of a rare disease.

  Children may experience loss of schooling/education/lack of developmental progression due to long and/or multiple hospital admissions/ attendances. Adults may become unable to work, and often experience difficulties with relationships and progressive social isolation

Further details of impact upon patients:

Histiocytic neoplasms can cause a wide range of symptoms and affect patients of all ages from neonates to adults. Many of the symptoms severely impair quality of life. In young children, speech and language development, educational attainment, growth, and development may be delayed. In older adults, employment, relationships, and social activities are often very restricted by chronic ill-health. Chronic pain, respiratory, renal, and neuropsychiatric impairment are the major culprits in life-limiting effects of the disease.

Many patients have a delayed diagnosis which adds to the distress and anxiety they experience as part of the disease process. As chemotherapy is the mainstay of treatment, this has a huge impact on patients' lives. Young children will often be kept out of school, due to the lethargy and discomfort caused by chemotherapy and for protection during periods of bone marrow suppression. This can significantly impact on their development

and puts a huge strain on parents who have to stay home with their child every day. Meanwhile adults may have to take significant time off work, or give up work entirely, which again places huge financial strains on their lives.

Despite protective measures, patients undergoing chemotherapy will often end up in and out of hospital with infections and side effects of chemotherapy. Patients suffer loss of hair, dentition and suffer from a range of skin-related problems, which can be particularly distressing for young patients and family members to observe. (www.histiouk.org)

Further details of impact upon carers:

Those living with and caring for people with histiocytic neoplasms might be providing help with medication, hospital appointments, or emergency attendances and hospitalisations, and this requires a lot of organisation and time whilst trying to balance other responsibilities such as employment or childcare. Carers of people with severe histiocytic neoplasms often reduce their working hours or give up work to provide care.

Additionally, having an unwell sibling can be hugely detrimental to the development and wellbeing of other siblings. Their unwell sibling may require more time and attention which can often be very difficult for other young children to understand. They may also suffer from the trauma of watching a sibling struggle with the side effects of both the disease and the side effects of chemotherapy treatment.

The unpredictability of the disease relapsing can mean that planning life is challenging. There are often mixed emotions associated with this including guilt, bitterness, and sadness. This affects carers' mental health and the relationship between carers and patients. These challenges are only more substantial for carers of people with severe disease and limited treatment options, who live with more uncertainty and morbidity.

Considerations

Equality and Health Inequalities Impact Assessment (EHIA)	
Summary of any potential impacts of the proposal	This policy proposition aims to provide a treatment option for patients of all ages who are currently experiencing the consequences of histiocytic neoplasms. It is not thought to adversely impact on any other individuals from protected characteristic groups. As a policy commissioned nationally, this aims to potentially promote equity of access and treatment across the country, thereby reducing the variation of outcomes for people with histiocytic neoplasms.
13Q Assessment	
PPVAG outcome	No consultation required

Were PPVAG assured of the level of stakeholder testing?	Yes

Rare Disease Advisory Group

Yes

Committee members supported the policy proposition and supported NHS England's drive to secure product that was suitable for neonates.

Pharmaceutical

Yes

This clinical commissioning policy proposition recommends dabrafenib as a treatment option for $BRAF^{V600E}$ mutation positive histiocytic neoplasms where standard care has failed. The recommendation is outside of the marketing authorisation for dabrafenib so use is off-label and Trust policy regarding unlicensed medicines should apply. Dabrafenib is on the NHS Payment Scheme Annex A, that is, it is an excluded drug.

National Programme of Care

The proposal received the full support of the Cancer National Programme of Care Assurance Group.