

## Niraparib (gynae)

### Indication

Treatment of relapsed, platinum sensitive high grade serous epithelial ovarian, fallopian tube or primary peritoneal cancer in patients who have responded to the most recent course of platinum based chemotherapy if they:

- have a documented germline BRCA mutation and have had 2 (and only 2) courses of platinum based chemotherapy

or

- have had a BRCA test that shows they do not have a germline BRCA mutation and have had 2 or more courses of platinum based chemotherapy.

(NICE TA784)

Maintenance treatment in patients with high grade epithelial stage III or IV ovarian, fallopian tube or primary peritoneal carcinoma who are in response following first line chemotherapy

(NICE TA673 - CDF)

### ICD-10 codes

Codes with a pre fix C48, 56, 57

### Regimen details

Starting dose is based on patient weight and platelet count to reduce risk of thrombocytopenia:

Weight  $\geq 77$ kg **and** platelets  $>150 \times 10^9/L$

Drug	Dose	Route
Niraparib	300mg OD	PO

Weight  $<77$ kg **or** platelets  $<150 \times 10^9/L$

Drug	Dose	Route
Niraparib	200mg OD*	PO

\*dose may be escalated to 300mg on subsequent cycles if no significant toxicity.

### Cycle frequency

4 weeks

### Number of cycles

Continuous until disease progression or unacceptable toxicity.

### Administration

Niraparib is available as 100mg capsules. Patients should be advised to take the dose at approximately the same time each day. The capsules should be swallowed whole with water and should not be crushed or chewed.

Administration at bedtime may reduce nausea.

If a dose is missed, it should be omitted and the next dose taken as planned.

### Pre-medication

Nil

### Emetogenicity

This regimen has mild emetic potential.

### Additional supportive medication

Antiemetics if required.

Laxatives if required.

### Extravasation

N/A

### Investigations – pre first cycle

Investigation	Validity period
FBC	14 days
U + Es (including creatinine)	14 days
LFTs	14 days
CA 125	28 days
Blood pressure*	Baseline
Pregnancy test (women of child bearing potential)	Baseline

\* Blood pressure should be adequately controlled prior to commencing treatment.

### Investigations – pre subsequent cycles

Investigation	Validity period
FBC*	Weekly
U + Es (including creatinine)	Monthly
LFTs	Monthly
CA 125	3 monthly
Blood pressure	Monitor weekly for the first 2 months, then monthly thereafter

\* Haematological toxicity is common during the initial phase of treatment. FBC should be monitored weekly at the start of treatment or following dose escalation until stable dose for 4 weeks, then monthly for 10 months, then every 2-3 months.

### Standard limits for administration to go ahead

If blood results not within range, authorisation to administer **must** be given by prescriber/ consultant

Investigation	Limit
Neutrophils	> $1.0 \times 10^9/L$ – see below
Platelets	> $100 \times 10^9/L$
Haemoglobin	> 80g/L
CrCl	≥ 30 mL/min
Bilirubin	See below
ALT/AST	See below

### Dose modifications

Adverse reactions should initially be managed by maximal supportive measures. If the patient recovers within 28 days, treatment may be recommenced at the same dose. Treatment interruptions are required for haematological toxicities and treatment resumed on recovery, usually at a lower dose level (see below). If the reaction persists beyond 28 days, treatment should be discontinued.

If the adverse reaction recurs then the dose should be reduced as below:

Dose level	Niraparib dose
Full dose	300mg OD
First dose reduction	200mg OD
Second dose reduction	100mg OD

If further dose reduction beyond 100mg daily is required, discontinue Niraparib.

#### • Haematological toxicity

Haematological adverse reactions have been observed with Niraparib, especially during the initial phase of treatment.

#### Platelets:

Platelet level		Management
< 100 x 10 <sup>9</sup> /L	First occurrence	Withhold (maximum of 28 days) and monitor weekly FBC Once resolved resume at same dose or with one dose reduction (clinician decision). If platelets < 75 x 10 <sup>9</sup> /L at any time resume with reduced dose on recovery.
	Second occurrence	Withhold (maximum of 28 days) and monitor weekly FBC Once resolved resume with reduced dose.

If platelet count dose not recover within 28 days or if thrombocytopenia persists despite dose reduction to 100mg OD, discontinue treatment.

If platelets < 10 x 10<sup>9</sup>/L consider platelet transfusion. On recovery resume with reduced dose.

#### Neutrophils and haemoglobin:

If neutrophils < 1.0 x 10<sup>9</sup>/L and/or haemoglobin < 80g/L:

- Withhold (maximum of 28 days) and monitor weekly FBC until neutrophils ≥ 1.5 x 10<sup>9</sup>/L and haemoglobin ≥ 90g/L.
- Once resolved resume with reduced dose.
- If counts do not recover within 28 days or if the dose has been reduced to 100mg OD discontinue treatment.

**If counts do not recover, consider myelodysplastic syndrome (MDS) or acute myeloid leukaemia (AML). Permanently discontinue treatment and refer to haematology.**

#### • Renal impairment

No dose adjustment is necessary for patients with mild (CrCl < 90 - ≥ 60 mL/min) to moderate (CrCl < 60 - ≥ 30 mL/min) renal impairment. There is no data in patients with severe renal impairment or end stage renal disease undergoing haemodialysis therefore use with caution.

#### • Hepatic impairment

ALT/AST		Bilirubin	Niraparib dose
>ULN	and	≤ULN	No dose adjustment needed
Any	and	1-1.5 x ULN	No dose adjustment needed
Any	and	1.5-3 x ULN	Recommend starting dose of 200mg OD
Any	and	3 x ULN	No data, use with caution. Consultant decision

- **Other toxicities**

**Hypertension**

Hypertension and hypertensive crisis have been reported in patients taking niraparib. Blood pressure should be adequately controlled prior to commencing treatment. Blood pressure should be monitored as above. Hypertension should be controlled adequately using standard antihypertensive treatment, with a dose reduction of Niraparib, if necessary. Treatment should be discontinued in case of hypertensive crisis or if medically significant hypertension cannot be adequately controlled with antihypertensive therapy.

**Adverse effects - for full details consult product literature/ reference texts**

- **Serious side effects**

Myelodysplastic syndrome and AML (approx. 0.5% increase over placebo)  
Myelosuppression

- **Frequently occurring side effects**

Nausea and vomiting  
Abdominal pain  
Diarrhoea  
Dyspepsia  
Hypertension  
Urinary tract infections  
Myelosuppression  
Insomnia  
Anxiety, depression  
Fatigue  
Stomatitis

- **Other side effects**

Peripheral oedema  
Decreased appetite  
Deranged LFTs  
Rash

**Significant drug interactions – for full details consult product literature/ reference texts**

Caution is recommended when niraparib is used concomitantly with medicinal products where their active products are **metabolised by CYP3A4**-dependent mechanisms, particularly those with a narrow therapeutic range (e.g. ciclosporin, tacrolimus, alfentanil, ergotamine, pimozone, quetiapine, and halofantrine).

Caution is recommended when niraparib is used concomitantly with medicinal products where their active products are **metabolised by CYP1A2**-dependent mechanism, particularly those with a narrow therapeutic range (e.g. clozapine, theophylline, and ropinirole).

Caution is recommended when niraparib is combined with **substrates of BCRP** (irinotecan, rosuvastatin, simvastatin, atorvastatin, and methotrexate).

Increased plasma concentrations of co-administered medicinal products that are **substrates of MATE 1 and MATE 2** (e.g. metformin) cannot be excluded.

Caution is recommended when niraparib is combined with active substances that undergo an uptake transport by OCT1 such as metformin.

### Additional comments

Women of childbearing potential should not become pregnant while on treatment and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of childbearing potential prior to treatment. Women of childbearing potential must use effective contraception during therapy and for 1 month after receiving the last dose of niraparib.

---

### References

- Summary of Product Characteristics Niraparib (Tesarro) accessed 12 August 2021 via [www.medicines.org.uk](http://www.medicines.org.uk)
- National Institute for Clinical Excellence (TA784) accessed 29 June 2022 via [www.nice.org.uk](http://www.nice.org.uk)
- National Institute for Clinical Excellence (TA 673) accessed 12 August 2021 via [www.nice.org.uk](http://www.nice.org.uk)
- Oza AM, editor Quality of Life in Patients with Recurrent Ovarian Cancer (OC) Treated with Niraparib: Results from the ENGOT-OV16/NOVA Trial. ESMO; 2017; Madrid, Spain.
- Mirza. M.R., et al Niraparib Maintenance Therapy in Platinum-Sensitive, Recurrent Ovarian Cancer December 1, 2016. N Engl J Med 2016; 375:2154-2164
- Gonzalez-Martin A., et al. Niraparib in Patients with Newly Diagnosed Advanced Ovarian Cancer. N Engl J Med 2019; 381:2391-2402

---

Written/reviewed by: Dr Axel Walther (Consultant Medical Oncologist, UHBW NHS Trust)

Checked by: Kate Gregory (Lead Pharmacist for SACT protocols, SWAG Cancer Alliance)

Authorised by: Dr J Braybrooke (Consultant Oncologist, UHBristol NHS Trust, SW Clinical Network)

Date: August 2021

---