Trifluridine/Tipiracil (Lonsurf®, TAS-102) chemotherapy

For the treatment of metastatic colorectal cancer in adult patients previously treated with, or not candidates for treatment with, fluoropyrimidines, oxaliplatin, irinotecan, anti-VEGF therapy, and, if RAS wild-type, anti-EGFR therapy

**Trifluridine/Tipiracil (Lonsurf®)**

- **35 mg/m² PO BID on Days 1-5 and Days 8-12**  *Based on Trifluridine component*
- Maximum 80mg per dose.
- Also known as TAS-102
- Compassionate programme, contact DAF for enrolment.
- Outpatient prescription; Trade name: Lonsurf® 15 film-coated tablets (15 mg trifluridine/6.14 mg tipiracil), Lonsurf® 20 film-coated tablets (20mg trifluridine/8.19 mg tipiracil).
- Use multiple strengths / tablets to acquire required dose

**Dose adjustments:**
- Initial doses are 35mg/m² Reduce dose by 5mg/m² for each dose reduction level. (i.e. 1 dose level reduction= 30mg/m², 2 dose level reductions = 25mg/m², 3 dose level reductions = 20mg/m².) Discontinue treatment if doses need to be reduced below 20mg/m².
- **Hepatic impairment:**
  - Mild impairment (T.Bili less than or equal to ULN and AST greater than ULN OR if T.Bili is 1- 1.5 x ULN and any AST): no adjustment of starting dose is required.
  - Moderate impairment (T.Bili 1.5 to 3 x ULN and any AST): use of Trifluridine/Tipiracil not recommended
  - Severe impairment (T.Bili greater than 3 x ULN, any AST): use of Trifluridine/Tipiracil not recommended
- **Renal Impairment:**
  - If CrCl greater than or equal to 60 mL/min, no adjustment to starting dose required.
  - If CrCl is 30-59 mL/min, no starting dose adjustment required, but monitor closely for haematological toxicity and adjust dose accordingly.
  - If CrCl is below 30 mL/min, no data is available and use of Trifluridine/Tipiracil not recommended

**Age:**
- Starting dose adjustment not needed for elderly patients.
- Higher incidences of grade 3-4 myelosuppression, grade 3 anemia and grade 3-4 thrombocytopenia were seen in patients greater than 65 years.
- Limited efficacy and safety data available in those greater than 75 years.

**TESTS:**
- Baseline and at each visit: WBC HB PLT ANC Cr Urea T.Bili ALT GGT AlkPhosphatase
- Baseline and as clinically indicated: Proteinuria (by dipstick)
- Day 15 (Recommended): WBC HB PLT ANC

**ANTIEMETIC TAKE-HOME REGIMEN:**

**Level A - Day 1**
- Prochlorperazine 10 mg PO q4-6h prn

**TOXICITIES:**

**Hematologic:**
- Cycle 1 – Do not start 1⁰ treatment cycle until ANC greater than or equal to 1.5 x 10⁹/L or PLT are greater than or equal to 75 x 10⁹/L and non-hematological toxicities are less than or equal to 1.
- For cycles 2+: If PLT below 50 x 10⁹/L or ANC below 0.5 x 10⁹/L, causing 1 week or less delay to start of cycle, hold treatment. If counts recover by Day 8, restart® at same dose level within the cycle, or restart** at same dose with next cycle.
- If PLT below 25 x 10⁹/L or ANC below 0.5 x 10⁹/L, causing greater than 1 week delay to start of cycle, hold treatment and restart** next cycle at 1 dose level lower.
- If febrile neutropenia, hold treatment and restart** next cycle at 1 dose level lower.
- ** Restart treatment when PLT greater than or equal to 75 x 10⁹/L and ANC greater than or equal to 1.5 x 10⁹/L

**Non-Hematologic:**
- For Non-hematologic Grade 3 or 4 toxicities (excluding Grade 3 nausea/vomiting controlled by anti-emetics or diarrhea responding to anti-diarrheal therapy) hold treatment and restart next cycle at 1 dose level lower.

**Interstitial Lung Disease / Pneumonitis (treatment related):**
- Hold and investigate. If confirmed, permanently discontinue treatment.

**SUGGESTED ACTIONS:**

- Taken with a glass or water, within one hour of completing morning and evening meals
- Do not make up for any missed doses
SPECIAL PRECAUTIONS:

- Contains lactose. Carefully consider use in patients with hereditary lactase, glucose or galactose disorders
- Caregivers should use gloves when handling
- Patients who have received prior radiotherapy may be at higher risk of hematological adverse effects
- Embryotoxic and fetotoxic, probable excretion in breast milk

Bibliography


