**Planning of Bevacizumab therapy for patients under the care of the Cambridge NF2 service for COVID-19**

In light of the current COVID-19 epidemic, there is a need for us to define how we manage patients who are currently receiving Bevacizumab therapy for NF2 under the Specialised commissioning framework. We need to balance issues around patient safety and hospital capacity, both for provision of surgical services and delivery of the systemic therapy. It is also important that we adhere as much as possible to a single consensual statement.

We know that the side effect profile of Bevacizumab for most of our patients is very favourable, with patients encountering minimal side effects. There is also no evidence that Bevacizumab directly increases the risk of infection or has any form of immunosuppressive effect. Furthermore, we know that Bevacizumab is being used to avoid surgical interventions in our patient cohort, which is relevant in the light of all non-emergency surgery being cancelled.

We are aware that short treatment breaks may result in worsening of hearing function, but that in the majority of patients, this loss is reversible if the break in treatment is less than 3 months.

We know that the risk of severe COVID-19 infection or death is low for the majority of our patient cohort, who are under the age of 50. However, we do also have a cohort of patients who are at increased risk of needing hospitalised largely due to neurological comorbidities of their NF2 but also through complications of Bevacizumab therapy. Case record reviews from Wuhan show hypertension is a significant finding in patients requiring hospitalisation or ventilation.

Finally, we must acknowledge that our capacity to deliver Bevacizumab treatment may fall through staff absence, or lack of availability of infusion chairs. Reducing activity will help under such circumstances.

**The following changes are to be implemented:**

No new Bevacizumab starts unless therapy is being given to avoid urgent surgery.

Patients currently on induction phase of treatment (5mg/kg 2w) should be encouraged to switch to 7.5mg/kg 3w to complete induction unless there are treatment related side effects that necessitate lower doses per treatment. The same overall dose intensity is achieved.

Maintenance therapy is continued for patients under the age of 50 and with KPS>70 as resources allow. The KPS threshold is to include treatment related morbidity (esp hypertension)

An appropriate discussion of risk and benefit should be held with patients over 50 or KPS<70 and the default position as a group is that **we do not recommend treatment.** This is due to the age-dependent baseline risk of adverse outcome with COVID-19 infection and the increased risk of attending hospital for blood tests, clinical review and infusions. An acceptable form of risk mitigation is to offer 2 monthly infusions at 5mg/kg.

All maintenance patients with stable imaging and symptoms should be considered for a temporary switch to 2 monthly infusion schedules, at 5mg/kg as we have used successfully in the past.

In each case, a discussion should be held with the patient explaining the motivation for the change in management, and documentation should always include details of both standard management plans and COVID-19 based plans for future reference.