Indication	For first line treatment of Child-Pugh A locally advanced or metastatic hepatocellular carcinoma. NB Patients can receive sorafenib if lenvatinib has been discontinued within 3 months of starting treatment because of unmanageable toxicity and there has been no disease progression whilst on lenvatinib OR if a patient has received atezolizumab/bevacizumab as 1st therapy.
Treatment Intent	Palliative
Frequency and number of cycles	Repeat every 28 days Continue until progressive disease, unacceptable toxicity or patient choice.
Monitoring Parameters pre-treatment	• At each cycle monitor FBC, U&Es and LFTs. • Thyroid function should be checked if patients develop symptoms suggestive of hypothyroidism or hyperthyroidism • Monitor BP every 2 weeks for the first 8 weeks and then at each cycle thereafter or as clinically indicated. • ECG and electrolyte monitoring (magnesium, potassium, and calcium) baseline in patients at risk of QT prolongation and then as clinically indicated. • ECHO: for at risk patients at baseline, then every 6/12. • Hypoglycaemia has been reported, monitor glucose levels in diabetic patients closely. • **Hepatic impairment:** No dose adjustment is required in patients with mild to moderate (Child Pugh A or B) hepatic impairment. No data is available in severe (Child Pugh C) hepatic impairment. • **Renal impairment:** No dose adjustment is required in mild, moderate or severe renal impairment. No data is available in patients requiring dialysis d/w consultant. • **Dose Modification:** When dose reduction is necessary the dose should be reduced to 400mg sorafenib once daily (see section 4.2 of SpC). • **Adverse reactions:** o If skin rash occurs d/w consultant (may require dose interruption or dose reduction) o QT interval prolongation: Use with caution in patients who have, or may develop prolongation of QTc, such as patients with a congenital long QT syndrome, patients treated with a high cumulative dose of anthracycline therapy, patients taking certain anti-arrhythmic medicines or other medicinal products that lead to QT prolongation, and those with electrolyte disturbances such as hypokalaemia, hypocalcaemia, or hypomagnesaemia. o The use of VEGF pathway inhibitors in patients with or without hypertension may promote formation of aneurysms and/or artery dissections. This risk should be carefully considered in patients with risk factors such as hypertension or history of aneurysm. • **<u>Common drug interactions (for comprehensive list refer to BNF/SPC)</u>:** CYP3A4 inducers (e.g. phenytoin, carbamazepine, rifampicin, barbiturates, St John's Wort) and neomycin can decrease efficacy. Concentration of P-glycoprotein substrates (e.g. digoxin, quinidine, loperamide) may be increased. Warfarin anticoagulant effect may be enhanced. • For oral self-administration: refer to local Trust policy on oral anti-cancer medicines and supply Patient Information Leaflet.
References	SPC accessed online 22.09.20 bluteq form accessed online KMCC proforma UGI-023v6

NB For funding information, refer to CDF and NICE Drugs Funding List

Repeat every 28 days

TTO	Drug	Dose	Route	Directions
Day 1	**SORAFENIB**	**400mg**	PO	BD. Without food or with a low or moderate fat meal. If the patient intends to have a high-fat meal, sorafenib tablets should be taken at least 1 hour before or 2 hours after the meal. The tablets should be swallowed with a glass of water. (available as 200mg tablets)
	Loperamide	2mg-4mg	PO	Take 4mg (2 capsules) initially, then 2mg (1 capsule) after each loose stool when required. Maximum 16mg (8 capsules) a day. Dispense 30 capsules with cycle 1 and then only if required.