

# Oncology Clinical Pathways Follicular Lymphoma

March 2025 – V1.2025



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# Follicular Lymphoma – Presumptive Conditions

VA automatically presumes that certain disabilities were caused by military service. This is because of the unique circumstances of a specific Veteran's military service. If a presumed condition is diagnosed in a Veteran within a certain group, they can be awarded disability compensation.

## Atomic Veterans – Exposure to Ionizing Radiation

- Lymphomas, other than Hodgkin's disease

## Gulf War and Post 9/11 Veterans

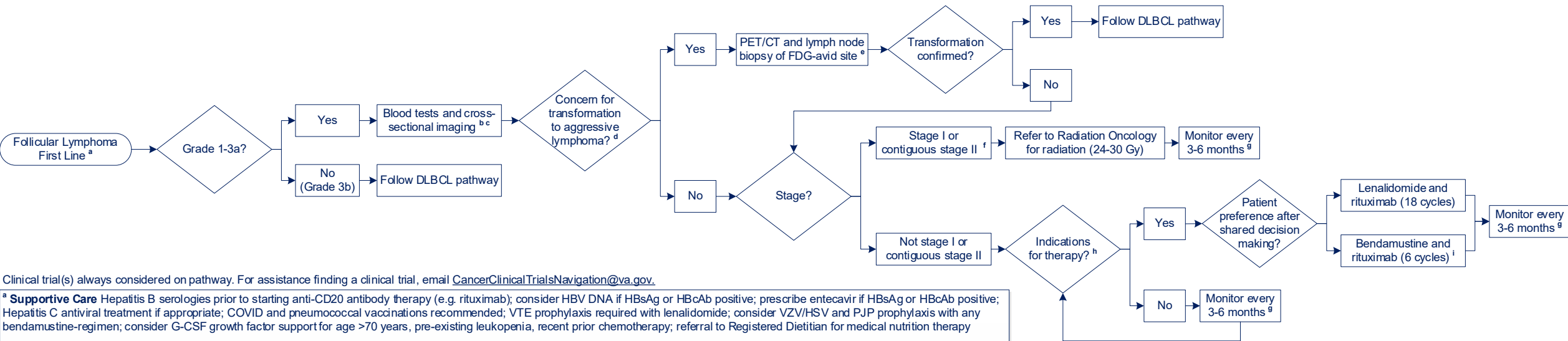
If the patient served on or after Sept. 11, 2001, in Afghanistan, Djibouti, Egypt, Jordan, Lebanon, Syria, Uzbekistan, or Yemen or if the patient served in the \*Southwest Asia theater of operations, or Somalia, on or after Aug. 2, 1990, specific conditions include:

- Lymphoma of any type

\* The Southwest Asia theater of operations refers to Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations.

For more information, please visit [U.S. Department of Veterans Affairs - Presumptive Disability Benefits \(va.gov\)](https://www.va.gov/presumptive-disability-benefits/)

# Follicular Lymphoma – First Line



Clinical trial(s) always considered on pathway. For assistance finding a clinical trial, email [CancerClinicalTrialsNavigation@va.gov](mailto:CancerClinicalTrialsNavigation@va.gov).

<sup>a</sup> **Supportive Care** Hepatitis B serologies prior to starting anti-CD20 antibody therapy (e.g. rituximab); consider HBV DNA if HBsAg or HBcAb positive; prescribe entecavir if HBsAg or HBcAb positive; Hepatitis C antiviral treatment if appropriate; COVID and pneumococcal vaccinations recommended; VTE prophylaxis required with lenalidomide; consider VZV/HSV and PJP prophylaxis with any bendamustine-regimen; consider G-CSF growth factor support for age >70 years, pre-existing leukopenia, recent prior chemotherapy; referral to Registered Dietitian for medical nutrition therapy

<sup>b</sup> **Cross-Sectional Imaging** CT neck, chest, abdomen, and pelvis with IV contrast or FDG-PET/CT; PET/CT preferred if Stage I-II

<sup>c</sup> **Blood Tests** CBC with differential, CMP, uric acid, LDH, HBsAg, HBsAb, HBcAb, HCV antibody, HIV

<sup>d</sup> **Clinical Suspicion for Transformation to Aggressive Lymphoma** may include features such as rapid enlargement of an individual lymph node, PET/CT with high FDG uptake, very elevated LDH, and/or significant B- symptoms/weight loss not attributed to other causes; a pathological diagnosis is needed for confirmation

<sup>e</sup> **Biopsy** of lymph node; excisional preferred; ancillary/molecular test as appropriate based on discussion with hematopathology

<sup>f</sup> **Stage** bone marrow biopsy and PET/CT should be performed to confirm limited stage

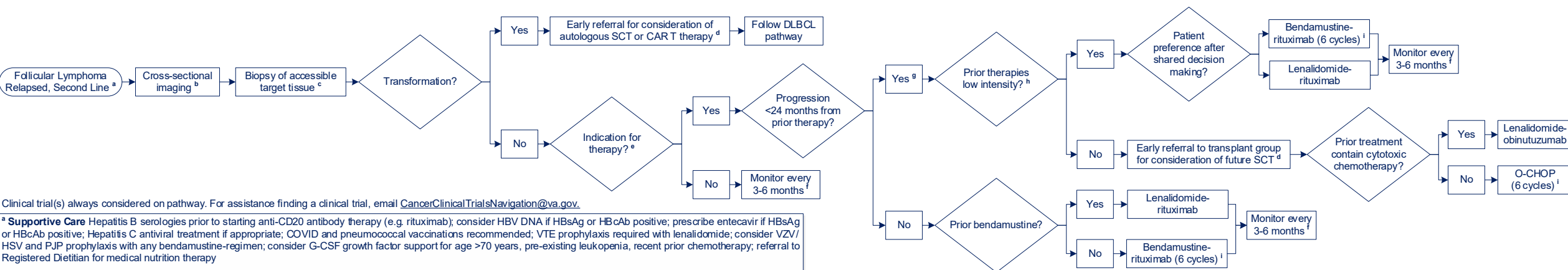
<sup>g</sup> **Surveillance** initially q3 months, then spaced to Q6-12 months, consisting of physical exam and labs; surveillance imaging is not recommended for asymptomatic patients

<sup>h</sup> **Indications** local symptoms due to nodal disease, reduced organ function due to nodal disease, B-symptoms (fever, weight loss, night sweats), cytopenias (Hgb < 10 g/dL, platelets <100,000/mm<sup>3</sup>), or an increase in disease tempo; radiation therapy (2 Gy x 2) can be helpful for symptomatic sites

<sup>i</sup> **Maintenance Rituximab** dosed every 8 weeks for a total of 24 months improves progression free survival without improved overall survival and increases the risks of infection including COVID; may be considered but only after weighing risks and benefits with the patient and evaluating response

**DLBCL** Diffuse Large B-Cell Lymphoma

# Follicular Lymphoma – Relapsed, Second Line



Clinical trial(s) always considered on pathway. For assistance finding a clinical trial, email [CancerClinicalTrialsNavigation@va.gov](mailto:CancerClinicalTrialsNavigation@va.gov).

**a Supportive Care** Hepatitis B serologies prior to starting anti-CD20 antibody therapy (e.g. rituximab); consider HBV DNA if HBsAg or HBcAb positive; prescribe entecavir if HBsAg or HBcAb positive; Hepatitis C antiviral treatment if appropriate; COVID and pneumococcal vaccinations recommended; VTE prophylaxis required with lenalidomide; consider VZV/HSV and PJP prophylaxis with any bendamustine-regimen; consider G-CSF growth factor support for age >70 years, pre-existing leukopenia, recent prior chemotherapy; referral to Registered Dietitian for medical nutrition therapy

**b Cross-Sectional Imaging** CT neck, chest, abdomen, and pelvis with IV contrast or FDG-PET/CT; PET/CT preferred if there is concern for transformation

**c Biopsy** may include lymph node or any organ with appearance of involvement based on cross-sectional imaging; excisional biopsy is preferred; FNA is not appropriate

**d Referral for Cellular Therapy** (stem cell transplant, CAR T therapy) requires pre-transplant evaluation and review through TRACER

**e Indications** local symptoms due to nodal disease, reduced organ function due to nodal disease, B-symptoms (fever, weight loss, night sweats), cytopenias (Hgb < 10 g/dL, platelets <100,000/mm<sup>3</sup>), or an increase in disease tempo; discussion with stem cell therapy team as appropriate; radiation therapy (2 Gy x 2) can be helpful for symptomatic sites

**f Surveillance** initially q3 months, then spaced to Q6-12 months, consisting of physical exam and labs; surveillance imaging is not recommended for asymptomatic patients

**g Patients with Progression** may have poor prognosis regardless of prior therapies; a clinical trial is recommended

**h Low Intensity Therapies** include XRT, single agent anti-CD20 antibody, and/or chlorambucil

**i Maintenance Anti-CD20 Antibody (e.g., rituximab, obinutuzumab)** dosed every 8 weeks for a total of 24 months improves progression free survival without improved overall survival and increases the risks of infection including COVID; may be considered but only after weighing risks and benefits with the patient and evaluating response

**DLBCL** Diffuse Large B-Cell Lymphoma

**O-CHOP** Obinutuzumab, Cyclophosphamide, Vincristine, Doxorubicin, Prednisone

**R-CHOP** Rituximab, Cyclophosphamide, Vincristine, Doxorubicin, Prednisone



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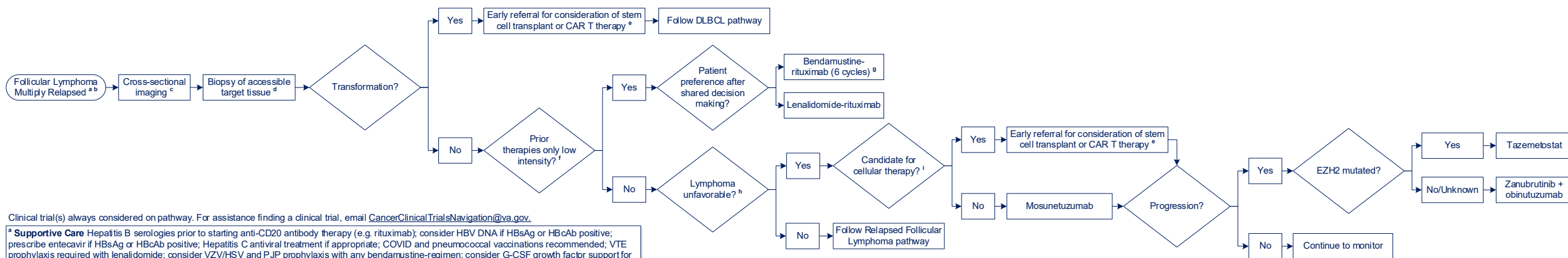
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# Follicular Lymphoma – Multiply Relapsed



Clinical trial(s) always considered on pathway. For assistance finding a clinical trial, email [CancerClinicalTrialsNavigation@va.gov](mailto:CancerClinicalTrialsNavigation@va.gov).

<sup>a</sup> **Supportive Care** Hepatitis B serologies prior to starting anti-CD20 antibody therapy (e.g. rituximab); consider HBV DNA if HBsAg or HBcAb positive; prescribe entecavir if HBsAg or HBcAb positive; Hepatitis C antiviral treatment if appropriate; COVID and pneumococcal vaccinations recommended; VTE prophylaxis required with lenalidomide; consider VZV/HSV and PJP prophylaxis with any bendamustine-regimen; consider G-CSF growth factor support for age >70 years, pre-existing leukopenia, recent prior chemotherapy; referral to Registered Dietitian for medical nutrition therapy

<sup>b</sup> **Radiation therapy** (2 Gy x 2) can be helpful for symptomatic sites

<sup>c</sup> **Cross-Sectional Imaging** CT neck, chest, abdomen, and pelvis with IV contrast or FDG-PET/CT; PET/CT preferred if there is concern for transformation

<sup>d</sup> **Biopsy** may include lymph node or any organ with appearance of involvement based on cross-sectional imaging; excisional biopsy is preferred; FNA is not appropriate

<sup>e</sup> **Referral for Cellular Therapy** (stem cell transplant, CAR T therapy) requires pre-transplant evaluation and review through TRACER

<sup>f</sup> **Low Intensity Therapies** include XRT, single agent anti-CD20 antibody, and/or chlorambucil

<sup>g</sup> **Maintenance Rituximab** dosed every 8 weeks for a total of 24 months improves progression free survival without improved overall survival and increases the risks of infection including COVID; may be considered but only after weighing risks and benefits with the patient and evaluating response

<sup>h</sup> **Unfavorable** defined as relapsed after anti-CD20 antibody, cytotoxic chemotherapy, and lenalidomide, or progression <24 months from all prior treatments

<sup>i</sup> **Candidate for Cellular Therapy** defined as ECOG performance status 0-1, few or controlled comorbidities, younger age (typically <70 years), patient and caregiver willing to relocate to cell therapy site if needed



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# Follicular Lymphoma – Molecular Testing Table

Eligibility	Test Category	Test Type	Recommended Vendors	NPOP Coverage	Specimen Type
Clinical or Pathological Features Suspicious for Pediatric-Type Follicular Lymphoma	IHC	IHC for BCL2 and BCL6	Local VA or locally contracted vendor	No	Bone Marrow Biopsy, Lymph Node Biopsy, Blood
	FISH	FISH for t(14;18), BCL6, IRF4 or IGH rearrangements, 1p36	Local VA or locally contracted vendor	No	Bone Marrow Biopsy, Lymph Node Biopsy, Blood
Clinical or Pathological Features Suspicious for Large B-Cell Lymphoma with IRF4 Rearrangement	IHC	IHC for BCL2, BCL6, CD10 and MUM1	Local VA or locally contracted vendor	No	Bone Marrow Biopsy, Lymph Node Biopsy, Blood
	FISH	FISH for IRF4/MUM1 cryptic rearrangement with IGH	Local VA or locally contracted vendor	No	Bone Marrow Biopsy, Lymph Node Biopsy, Blood
Multiply Relapsed Follicular Lymphoma	Molecular	<i>EZH2</i> mutation analysis	Tempus	Yes	Bone Marrow Biopsy, Lymph Node Biopsy, Blood
			Foundation	Yes	