Table 1. Final list of consensus statements.

Statement no.	Statement	Level of evidence[a]	Evidence	% agreement (voted "1" or "2")[b]	Consensus achieved in
General principles of treatment					
1	For treatment-naïve CLL patients who do not meet the iwCLL 2018 criteria for initiation of therapy, a watchful waiting approach is recommended.	I	CLL12, iwCLL guidelines 2018	100.0%	Round 1
2	Besides FISH testing for del(17p), it is important to evaluate *TP53* and *IGHV* mutational status to guide appropriate treatment choices.	N.A.	iwCLL guidelines 2018, NCCN CLL/SLL guidelines version 3.2023, ESMO guidelines, ERIC recommendations	100.0%	Round 1
3	In general, and where equally available, novel targeted agents are preferred over CIT. CIT may be a reasonable option for patients who are fit, *IGHV*-mutated, without del(17p) or *TP53* mutation after appropriate counselling on increased risk of acute haematological toxicity, infection and small increased risk of secondary myeloid malignancies. *Note: applies to all subpopulations; subpopulation-specific statements included under respective sections*	I	CLL14, E1912, ELEVATE-TN, Alliance A041202, ECOG ACRIN	100.0%	Round 1
4	In general, where novel agents are to be used, the choice between continuous (e.g. BTKi therapy) or time-limited therapy (e.g. V+O or upcoming combinations) should be based on careful consideration of factors including genomic alterations, side-effect profile, patient preferences, comorbidities and medications, logistics and cost, as well as physician judgement.	N.A.	NCCN CLL guidelines version 3.2023	100.0%	Round 1
5	Where continuous treatment is selected, second-generation BTKis (acalabrutinib or zanubrutinib) may be preferred to first-generation BTKis (ibrutinib) based on their side effect profile. Where acalabrutinib is selected, it can be used alone or combined with obinutuzumab. *Notes:* *This statement applies to the following subpopulations:* *- patients with del(17p) or TP53 mutation* *- unfit, IGHV-mutated patients without del(17p) or TP53 mutation* *- IGHV-unmutated patients without del(17p) or TP53 mutation*	II	ELEVATE-TN, SEQUOIA, NCCN CLL/SLL guidelines version 3.2023, ESMO guidelines 2020 *Note: No head-to-head comparisons in the TN setting.*	100.0%	Round 1

Table 1. Final list of consensus statements. (Cont'd)

Statement no.	Statement	Level of evidence[a]	Evidence	% agreement (voted "1" or "2")[b]	Consensus achieved in
Treatment in patients with del(17p) or *TP53* mutation					
6	Novel targeted agents (within either continuous or time-limited treatment regimens) are recommended for patients with del(17p) or *TP53* mutation; the choice of novel agent(s) should be based on careful consideration of factors including patient preferences, side effect profile, comorbidities and medications, logistics and cost, as well as physician judgement.	I	iLLUMINATE, CLL14	100.0%	Round 1
7	For time-limited treatment for young patients with del(17p) or *TP53* mutation, a BTKi+BCL2 inhibitor combination may be considered, accepting heightened risks of hypertension and low but not insignificant risk of cardiac arrhythmia. *Note: The only currently approved combination is I+V in Singapore, Europe and Canada. More evidence on other BTKi+BCL2i combinations are expected as survival data from ongoing trials mature (e.g. A+V±O: AMPLIFY, Z+V: SEQUOIA).*	I	CAPTIVATE	100.0%	Round 1
8	Time-limited V+O combination is less preferred for patients with del(17p) or *TP53* mutation, but may be an option for patients preferring time-limited treatment, after careful counselling of higher risk of progression after time-limited treatment.	I	CLL14, CLL14 follow-up	100.0%	Round 1
Treatment in *IGHV*-mutated patients without del(17p) or *TP53* mutation					
9	Recommended treatment options for fit, *IGHV*-mutated patients without *TP53* mutation, del(17p) are single agent BTKi (first gen), FCR [patients with no del(11q)], V+O or BTKi+BCL2 inhibitor combination, the choice of which should be based on careful consideration of factors including patient preferences, side effect profile, comorbidities and medications, logistics and cost, as well as physician judgement, after appropriate counselling on high rates of haematological toxicity, infection, and small increased risk of secondary myeloid malignancies.	I	CLL8, CLL13 (GAIA), RESONATE-2, ECOG, ALLIANCE, E1912 and E1912 long-term follow-up	87.5%	Round 1
10	If CIT is selected, FCR is the preferred CIT regimen in fit patients without *TP53* mutation, del(17p) or del(11q) and *IGHV* mutated.	I	CLL10, CLL8 and follow-up data	100.0%	Round 2

Table 1. Final list of consensus statements. (Cont'd)

Statement no.	Statement	Level of evidence[a]	Evidence	% agreement (voted "1" or "2")[b]	Consensus achieved in
12	If time-limited treatment is selected, V+O or I+V is the preferred treatment option in unfit, *IGHV*-mutated patients without del(17p), or *TP53* mutation.	I	CLL14	100.0%	Round 1
13	After V+O or I+V, the next preferred time-limited treatment options for unfit, *IGHV*-mutated patients without del(17p), or *TP53* mutation include B+R, Clb+O, single-agent rituximab, single-agent obinutuzumab or single-agent chlorambucil.	I	RO5072759 [GA101], CLL14, GAGE, CLL5, Rituximab Phase II trial, NCCN CLL/SLL guidelines Version 3.2023	100.0%	Round 2
Treatment in *IGHV*-unmutated patients without del(17p) or *TP53* mutation					
14	Novel targeted agents (continuous or time-limited) are recommended for *IGHV*-unmutated patients without *TP53* mutation, or del(17p); the choice of novel agent(s) should be based on careful consideration of factors including patient preferences, side effects, comorbidities and medications, logistics and cost, as well as physician judgement.	I	RESONATE-2, ELEVATE-TN, SEQUOIA, CLL 14 and follow-up data, GLOW	100.0%	Round 1
15	If time-limited treatment is selected, V+O or I+V combination is preferred for *IGHV*-unmutated patients without del(17p) or *TP53* mutation.	I	CLL14	100.0%	Round 1

[a] Level of evidence: I — Evidence from at least 1 large randomised, controlled trial of good methodological quality (low potential for bias) or meta-analyses of well-conducted randomised trials without heterogeneity; II — Small randomised trials or large randomised trials with a suspicion of bias (low methodological quality) or meta-analyses of such trials or of trials with demonstrated heterogeneity
[b] Level of agreement: 1 — "accept completely", 2 — "accept with minor changes"
A: acalabrutinib; B: bendamustine; BCL2: B-cell lymphoma 2; BTKi: Bruton's tyrosine kinase inhibitor; C: cyclophosphamide; CIT: chemoimmunotherapy; Chl: chlorambucil; CLL: chronic lymphocytic leukaemia; ESMO: European Society for Medical Oncology; ERIC: European Research Initiative on CLL; F: fludarabine; FISH: fluorescence in situ hybridisation; I: ibrutinib; IGHV: immunoglobulin heavy chain gene; iwCLL: International Workshop on Chronic Lymphocytic Leukaemia; O: obinutuzumab; R: rituximab; R1: Round 1; R2: Round 2; SLL: small lymphocytic lymphoma; TN: treatment-naïve; TP53: tumour protein p53; V: venetoclax; Z: zanubrutinib