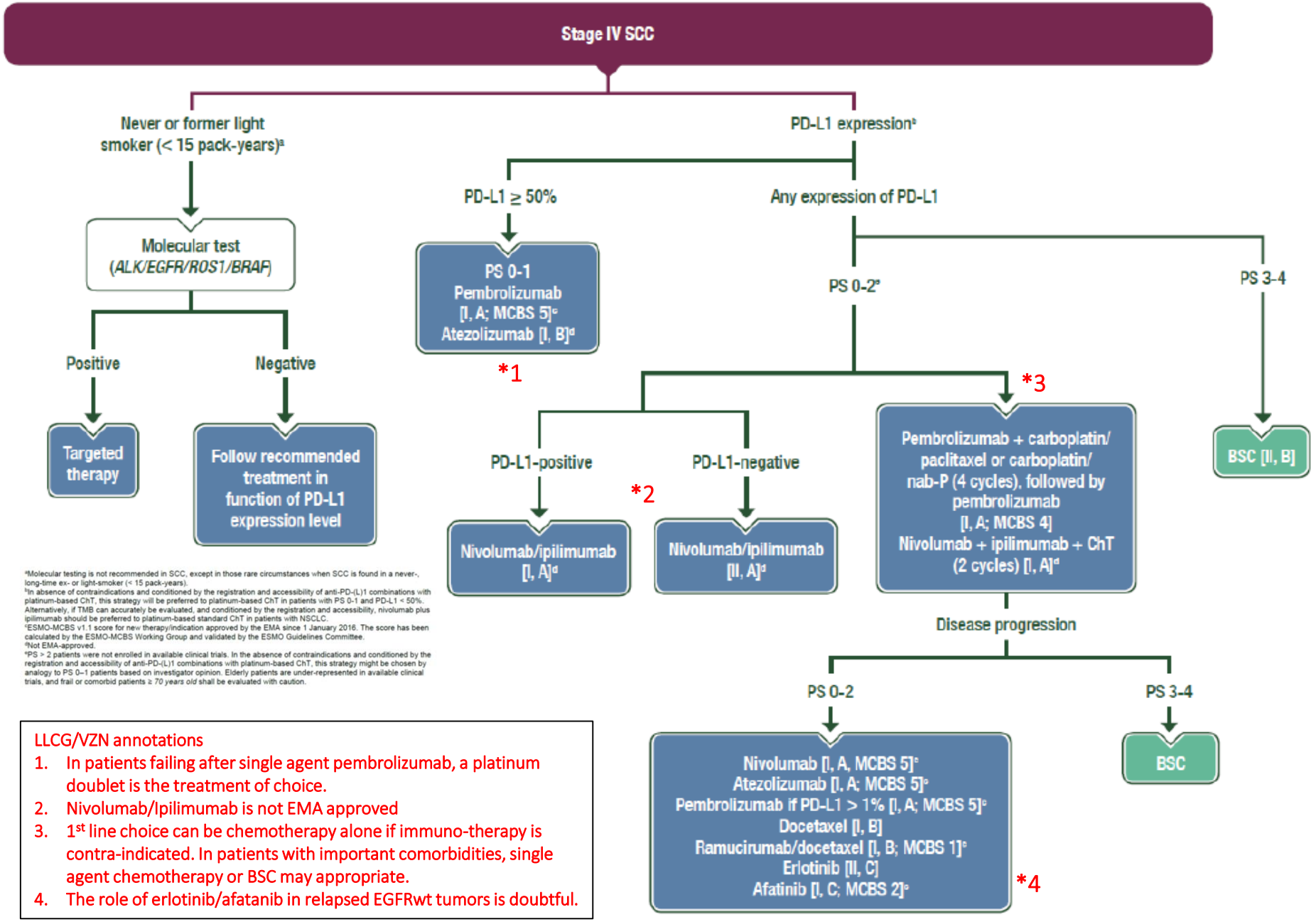

[a]Molecular testing is not recommended in SCC, except in those rare circumstances when SCC is found in a never-, long-time ex- or light-smoker (< 15 pack-years).
[b]In absence of contraindications and conditioned by the registration and accessibility of anti-PD-(L)1 combinations with platinum-based ChT, this strategy will be preferred to platinum-based ChT in patients with PS 0-1 and PD-L1 < 50%. Alternatively, if TMB can accurately be evaluated, and conditioned by the registration and accessibility, nivolumab plus ipilimumab should be preferred to platinum-based standard ChT in patients with NSCLC.
[c]ESMO-MCBS v1.1 score for new therapy/indication approved by the EMA since 1 January 2016. The score has been calculated by the ESMO-MCBS Working Group and validated by the ESMO Guidelines Committee.
[d]Not EMA-approved.
[e]PS > 2 patients were not enrolled in available clinical trials. In the absence of contraindications and conditioned by the registration and accessibility of anti-PD-(L)1 combinations with platinum-based ChT, this strategy might be chosen by analogy to PS 0–1 patients based on investigator opinion. Elderly patients are under-represented in available clinical trials, and frail or comorbid patients ≥ *70 years old* shall be evaluated with caution.

LLCG/VZN annotations

1. In patients failing after single agent pembrolizumab, a platinum doublet is the treatment of choice.
2. Nivolumab/Ipilimumab is not EMA approved
3. 1st line choice can be chemotherapy alone if immuno-therapy is contra-indicated. In patients with important comorbidities, single agent chemotherapy or BSC may appropriate.
4. The role of erlotinib/afatanib in relapsed EGFRwt tumors is doubtful.