Published specialist guideline.
This guideline passed independent clinical review and pharmacy verification; reviewer identities are retained privately. It is written for specialist healthcare professionals and supersedes v2.0. Access and regulatory positions move: check the current SmPC, the live NICE or SMC position and your local commissioning route before treating. Two literature corrections remain unresolved and are marked at every point their figures are used. Evidence and access cut-off 2026-07-30; published 31 July 2026.

An independent three-track audit on 30 July 2026 corrected several factual errors during preparation of this revision, including two where an earlier working copy wrongly withdrew a correct v2.0 statement. Those corrections were included in the exact candidate that passed independent clinical review and pharmacy verification, and in the bytes published on 31 July 2026.

Every statement of marketing authorisation, HTA recommendation and commissioning status below must be re-checked against the official source before you treat, prescribe or promise a route. Where a v2.0 statement could not be reproduced against the live source on 30 July 2026, the change is marked with a **changed since v2.0** block giving

the reason.

Publication model: England access framework with separate devolved-nation notes. United Kingdom and non-United Kingdom positions are demarcated throughout: blocks headed **outside the United Kingdom** describe evidence or regulatory status in other jurisdictions and *never* establish a route to treatment for a patient in the United Kingdom.

MCL v2.1 quick reference

One-page quick reference

The tables that follow this summary give the reasoning. This one is the compressed form, intended to be printed and taken to clinic or MDT. Certainty and access are recorded separately and deliberately: they answer different questions and they frequently disagree.

Certainty A to E and access class R1 to R5 are defined immediately below. Priority P1 to P4 is the practical instruction. Access positions change: confirm every access statement against the live source before treating.

Setting
Option
Certainty
England access
Priority
First line, transplant-suitable
Cytarabine induction, ASCT, rituximab maintenance 3 years

R3 guideline-supported
P1
TRIANGLE ibrutinib regimen

R4 licensed, company scheme
P3
Rituximab maintenance in a TRIANGLE pathway

R3
P2
Obinutuzumab substituted for rituximab

R5 no licence

P4
First line, older or transplant-ineligible
Bendamustine–rituximab, then maintenance ≥2 years

R1 routine — policy 17088P, off-label
P1
VR-CAP

R1 routine — TA370
P2
R-BAC
C
R3 guideline-supported
P2
Acalabrutinib with bendamustine–rituximab

R4 licensed, company scheme
P3
Adding bortezomib to BR, or lenalidomide to maintenance

—
P4
Ibrutinib with BR (SHINE), or ibrutinib–rituximab (ENRICH)

R5 no route
P4
TP53-mutated
Trial referral

R3
P1
Anti-CD20 with BTK and BCL2 inhibition, first line
C
R5 no licence
P4
MRD-guided cessation

R5
P4
Relapsed or refractory
Ibrutinib or zanubrutinib after exactly one line

R1 routine — TA502, TA1081
P2
Brexucabtagene autoleucel after ≥2 lines incl. BTKi
C
R2 CDF — review remitted after appeal
P2
Pirtobrutinib after covalent BTKi
C
R4 licensed, no route
P3
Lisocabtagene maraleucel
C
R4 licensed, no route
P3
Lenalidomide monotherapy
C
R4 licensed, no route
P3
Ibrutinib with venetoclax

R5 no MCL licence
P4
Glofitamab — GLOBRYTE trial
C
R5 trial only
P4
Sonrotoclax — CELESTIAL-RRMCL trial
C
R5 trial only
P4
Allogeneic HCT after CAR-T failure

R3 specialist decision
P3
THREE LINES TO CARRY IN YOUR HEAD

Bendamustine–rituximab is routinely commissioned in first line and is *off-label* — NHS England policy 17088P says so itself. Commissioning and licensing are not the same thing and can point in opposite directions.

The two first-line company schemes divide on transplant eligibility, in opposite directions: acalabrutinib–bendamustine–rituximab is licensed for patients **not** eligible for ASCT, the TRIANGLE regimen for those who **are**.

Brexucabtagene autoleucel is the only cellular therapy with an England route, TA677 managed access remains live, while the post-managed-access review remains unresolved following remittal. Confirm before you promise.

Discuss allogeneic transplantation *before* CAR-T, at covalent BTK-inhibitor progression. Remission status at transplant drives the outcome, and a patient who has already failed CAR-T is usually neither in remission nor fit enough.