INSIGHTS INTO CHRONIC LYMPHOCYTIC LEUKEMIA DURING THE COVID-19 PANDEMIC

Wednesday, May 20, 2020

HOW TO NAVIGATE THIS REPORT

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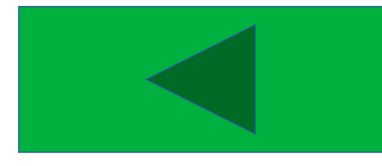

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STUDY OBJECTIVE

To gain advisors' perspectives on the following

- Management of newly diagnosed and relapsed/refractory chronic lymphocytic leukemia (CLL) during the COVID-19 pandemic

REPORT SNAPSHOT

- A moderated roundtable discussion focusing on treatment of CLL in the context of the COVID-19 pandemic was held online on May 20, 2020
- Disease state and data presentations were developed in conjunction with Dr. Nitin Jain, and Dr. Roy Chemaly from MD Anderson Cancer Center
- The group of advisors comprised 10 community oncologists
- Insights on the following CLL therapies were obtained: acalabrutinib, ibrutinib, zanubrutinib, obinutuzumab, rituximab, venetoclax, duvelisib, idelalisib, FCR, BR
- Data collection was accomplished through use of audience response system questioning and in-depth moderated discussion

Topline Takeaways

TOPLINE TAKEAWAYS

First-Line Therapy

Ibrutinib is commonly prescribed across all CLL patient types in the frontline setting. The

Participant Demographics

PARTICIPANT DEMOGRAPHICS

How many cancer patients with COVID-19 have you seen? (n = 9*)

How many CLL patients with COVID-19 have you seen? (n = 9*)

FOR EXAMPLE PURPOSES ONLY

PARTICIPANT DEMOGRAPHICS

How many unique patients with CLL are you currently following? (n = 8*)

What percentage of your CLL patients have del(17p) and/or TP53 mutations? (n = 8*)

Key Insights

FIRST-LINE THERAPY (1/2)

Topic	Insights and Data
Treatment Drivers	**In the frontline setting, advisors prescribe ibrutinib across all types of CLL patients. Usage of CIT is seen in younger patients and increases in patients with *IGHV* mutations. Usage of Venetoclax (+ obinutuzumab) is minimal in the**

FIRST-LINE THERAPY (2/2)

Topic	Insights and Data
Response Monitoring and	**Most advisors do not monitor MRD in their practice and are not very clear on when to do MRD testing** • During discussion, most advisors indicated that they do not routinely check MRD in their practice but some expect to

QUOTES – FIRST-LINE CLL

“Well, I generally don't necessarily think about

“I personally haven't given Venetoclax yet.”

“I've been treating most everybody first-

MANAGEMENT OF RELAPSED/REFRACTORY DISEASE (1/2)

Topic	Insights and Data
Treatment	**Following CIT in the frontline setting, most advisors report choosing BTK inhibitors for second-line**

MANAGEMENT OF RELAPSED/REFRACTORY DISEASE (2/2)

Topic	Insights and Data
Treatment	• Almost all advisors except one preferred venetoclax-based therapy (monotherapy or with obinutuzumab

QUOTES – RELAPSED/REFRACTORY CLL

“I wouldn't go back to chemo immunotherapy

“I will generally do more ibrutinib than

Advisor Key Takeaways

KEY TAKEAWAYS (1/2)

Dr 1	Dr 4
• Lot of options in CLL which we may not have had previously	• When I see a new CLL patient, will think about sequencing right

KEY TAKEAWAYS (2/2)

Dr 7	Dr 9
• MRD is very interesting. I just don't know how to incorporate that at	• I'm going to start thinking and discussing with especially those

ARS Data

First Line CLL

ON A SCALE OF 1–5 (1 IS VERY LITTLE, 5 IS A GREAT DEAL) HOW MUCH DOES EACH OF THE FOLLOWING PATIENT CHARACTERISTICS IMPACT YOUR FIRST-LINE THERAPY CHOICE FOR YOUR CLL PATIENTS? (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*1 advisor did not respond

WHICH OF THE FOLLOWING EFFICACY-RELATED OUTCOMES DO YOU CONSIDER MOST IMPORTANT WHEN DETERMINING FIRST-LINE THERAPY FOR YOUR CLL PATIENTS? (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*1 advisor did not respond

HOW IMPORTANT IS THE ABILITY TO STOP THERAPY (WITHOUT DISEASE PROGRESSION OR TOXICITY) IN YOUR FIRST-LINE THERAPY CONSIDERATION? (n = 8*)

FOR EXAMPLE PURPOSES ONLY

*2 advisors did not respond

WHAT FIRST-LINE REGIMEN DO YOU ROUTINELY USE FOR A 50-YEAR-OLD PS 0 PATIENT WITH NO MAJOR COMORBIDITIES (WITHOUT *DEL[17P]/TP53* MUTATION OR IGHV MUTATION)? (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*1 advisor did not respond

WHAT FIRST-LINE REGIMEN DO YOU ROUTINELY USE FOR A 50-YEAR-OLD PS 0 PATIENT WITH NO MAJOR COMORBIDITIES (WITHOUT DEL[17P]/TP53 MUTATION; IGHV MUTATION POSITIVE)? (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*1 advisor did not respond

WHAT FIRST-LINE REGIMEN DO YOU ROUTINELY USE FOR A 50-YEAR-OLD PS 0 PATIENT WITH NO MAJOR COMORBIDITIES (POSITIVE FOR DEL[17P]/TP53 MUTATION; IGHV MUTATION NEGATIVE)? (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*1 advisor did not respond

WHAT FIRST-LINE REGIMEN DO YOU ROUTINELY USE FOR A 75-YEAR-OLD PS 0 PATIENT WITH NO MAJOR COMORBIDITIES (WITHOUT DEL[17P]/TP53 MUTATION OR IGHV MUTATION)? (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*1 advisor did not respond

A 57-YEAR-OLD PATIENT WITH CLL (NO 17P DELETION OR TP53 MUTATION) HAS BEEN ON VENETOCLAX + OBINUTUZUMAB AS A FRONTLINE COMBINATION FOR THE PAST 8 MONTHS WITH ADEQUATE TOLERANCE AND NO TOXICITIES. HIS PHYSICIAN CHECKED THE MRD STATUS USING 6-COLOR FLOW AND THAT CAME BACK NEGATIVE. AT THIS

FOR EXAMPLE PURPOSES ONLY

*2 advisors did not respond

Relapsed/Refractory CLL

WHAT IS YOUR PREFERRED SECOND-LINE THERAPY IN A 55-YEAR-OLD PS 0 CLL PATIENT WHO RECEIVED FCR OR OTHER CIT AS FIRST-LINE THERAPY AND ATTAINED A CR THAT LASTED 3 YEARS? PATIENT HAS NO 17P DELETION OR TP53 MUTATION, AND IGHV MUTATIONAL STATUS IS UNKNOWN. (n = 8*)

FOR EXAMPLE PURPOSES ONLY

*2 advisors did not respond

WHAT IS YOUR PREFERRED SECOND-LINE THERAPY IN A CLL PATIENT WHO IS 55 YEARS OF AGE, WAS TREATED WITH IBRUTINIB FRONTLINE THERAPY, AND ATTAINED A 4-YEAR DISEASE-FREE INTERVAL? PATIENT HAD NO EVIDENCE OF 17P DELETION AND/OR TP53 MUTATION, AND HE HAD MUTATED IGHV STATUS. (n = 8*)

FOR EXAMPLE PURPOSES ONLY

*2 advisors did not respond

A 75-YEAR-OLD PATIENT WITH 17P-DELETED CLL WAS TREATED WITH IBRUTINIB MONOTHERAPY AND ATTAINED A CR FOR 2.5 YEARS, THEN PROGRESSED. PATIENT'S RENAL FUNCTION SHOWS A GFR OF 50 ML/MIN AND HIS PS IS 1. HE HAS A HISTORY OF HYPERTENSION AND TYPE 2 DIABETES THAT IS WELL CONTROLLED. YOUR

FOR EXAMPLE PURPOSES ONLY

*2 advisors did not respond

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