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INSIGHTS INTO CHRONIC LYMPHOCYTIC LEUKEMIA

July 2020

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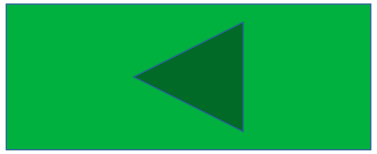

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STUDY OBJECTIVE

- To gain perspectives of advisors from the southeast region of the United States on the management of newly diagnosed and relapsed/refractory chronic lymphocytic leukemia (CLL)

REPORT SNAPSHOT

- A moderated roundtable discussion focusing on treatment of CLL was held online on July 8, 2020
- Disease state and data presentations were developed in conjunction with Dr Matthew Davids from Dana-Farber Cancer Institute
- The group of advisors comprised 9 community oncologists from the southeast region of the United States
  - Community oncologists were invited from Alabama, Georgia, Florida, South Carolina, Tennessee, and Virginia
  - Attendees of the roundtable represented community oncologists from Georgia and Florida
- 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

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Topline Takeaways

TOPLINE TAKEAWAYS

First-Line Therapy

Ibrutinib is commonly prescribed with or without rituximab across all CLL patient types in the first-line

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Participant Demographics

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*)

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Key Insights

FIRST-LINE THERAPY (1/2)

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

FIRST-LINE THERAPY (2/2)

Topic	Insights and Data
Response monitoring and	**Most advisors are currently not utilizing MRD to assess patient response in their practice and are not very clear on how to incorporate MRD testing into clinical practice**

QUOTES – FIRST-LINE CLL (1/2)

“If they [younger patients] are mutated, I would still

QUOTES – FIRST-LINE CLL (2/2)

“In the older patients, again, we go by patients'

MANAGEMENT OF RELAPSED/REFRACTORY DISEASE (1/2)

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

MANAGEMENT OF RELAPSED/REFRACTORY DISEASE (2/2)

Topic	Insights and Data
Treatment	• 3/4 of the advisors preferred venetoclax with obinutuzumab for an older patient (17p deletion), previously

QUOTES – RELAPSED/REFRACTORY CLL

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"Well, I think now learning more about the

"I like the fact that it's [venetoclax] a limited

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Advisor Key Takeaways

KEY TAKEAWAYS (1/2)

Dr 1 • Need to check the mutations up front	**Dr 4** • In private practice, MRD is not something that all of us are

KEY TAKEAWAYS (2/2)

Dr 7	Dr 9
• Thinking about early transplant in the relapsed setting	• I think FCR in first-line is still a viable option

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ARS Data

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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)

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WHICH OF THE FOLLOWING EFFICACY-RELATED OUTCOMES DO YOU CONSIDER MOST IMPORTANT WHEN DETERMINING FIRST-LINE THERAPY FOR YOUR CLL PATIENTS? PLEASE SELECT YOUR TOP 2. (N = 9)

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

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)

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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)

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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)

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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)

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PATIENT CASE

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- A 57-year-old patient with CLL (no 17p deletion or *TP53* mutation) has been on

AT THIS STAGE YOUR PREFERRED APPROACH IS: (N = 9)

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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 = 7*)

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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*)

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PATIENT CASE

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- A 75-year-old patient with 17p-deleted CLL was treated with ibrutinib monotherapy

- Bone marrow report states "15% plasma cells consistent with plasma cell myeloma" with normal cytogenetics and FISH that shows del(17p)

YOUR PREFERRED SECOND-LINE THERAPY IS: (N = 8*)

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