



CASES

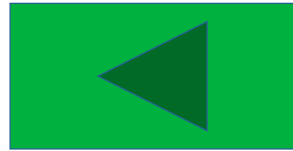
INSIGHTS INTO ACUTE LYMPHOBLASTIC LEUKEMIA (ALL)

Monday, August 24, 2020

HOW TO NAVIGATE THIS REPORT



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Report Snapshot



Key Insights



ARS Data – Introduction



ARS Data – Management of First-Line Therapy



ARS Data – Management of Relapsed Disease



Advisor Key Takeaways

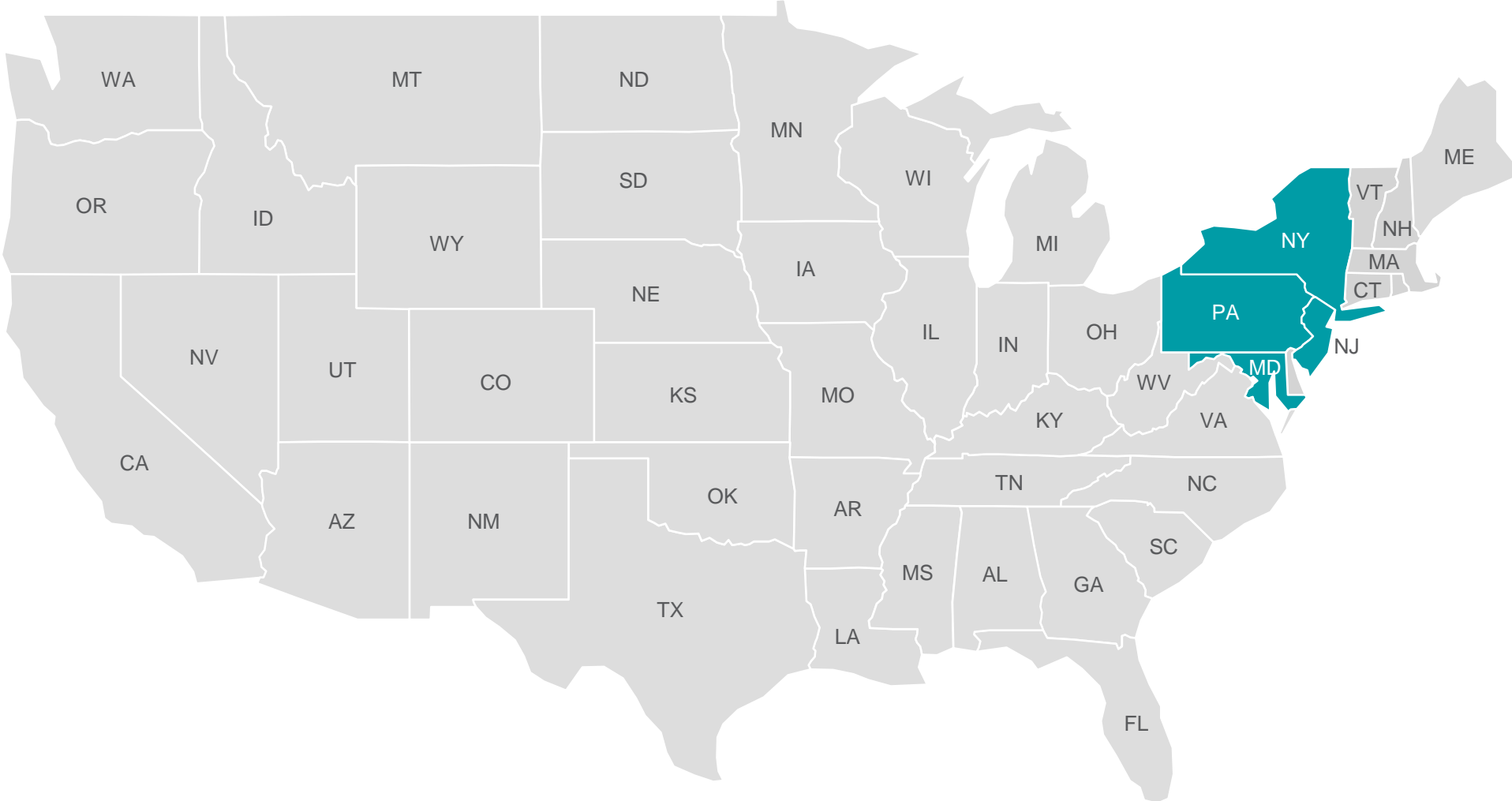


STUDY OBJECTIVES



- > To gain advisors' perspectives on the current treatment practices regarding adult and adolescent and young adult (AYA) acute lymphoblastic leukemia (ALL)

NORTHEAST CASES



- > A moderated roundtable discussion focusing on treatment of ALL for adults and AYA was held online on August 24, 2020
- > Disease state and data presentations were developed in conjunction with Dr Elias Jabbour from MD Anderson Cancer Center
- > The group of advisors comprised 9 community oncologists from the Northeast region of the United States
 - Attendees of the roundtable represented community oncologists from Maryland, New Jersey, New York, and Pennsylvania
- > Insights on the following therapies were obtained: blinatumomab, ponatinib, inotuzumab ozogamicin, liposomal vincristine, and chimeric antigen receptor (CAR) T-cell therapy
- > Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion



Key Insights

CURRENT TREATMENT PRACTICES
REGARDING ADULT AND AYA ALL

Management of First-Line Therapy

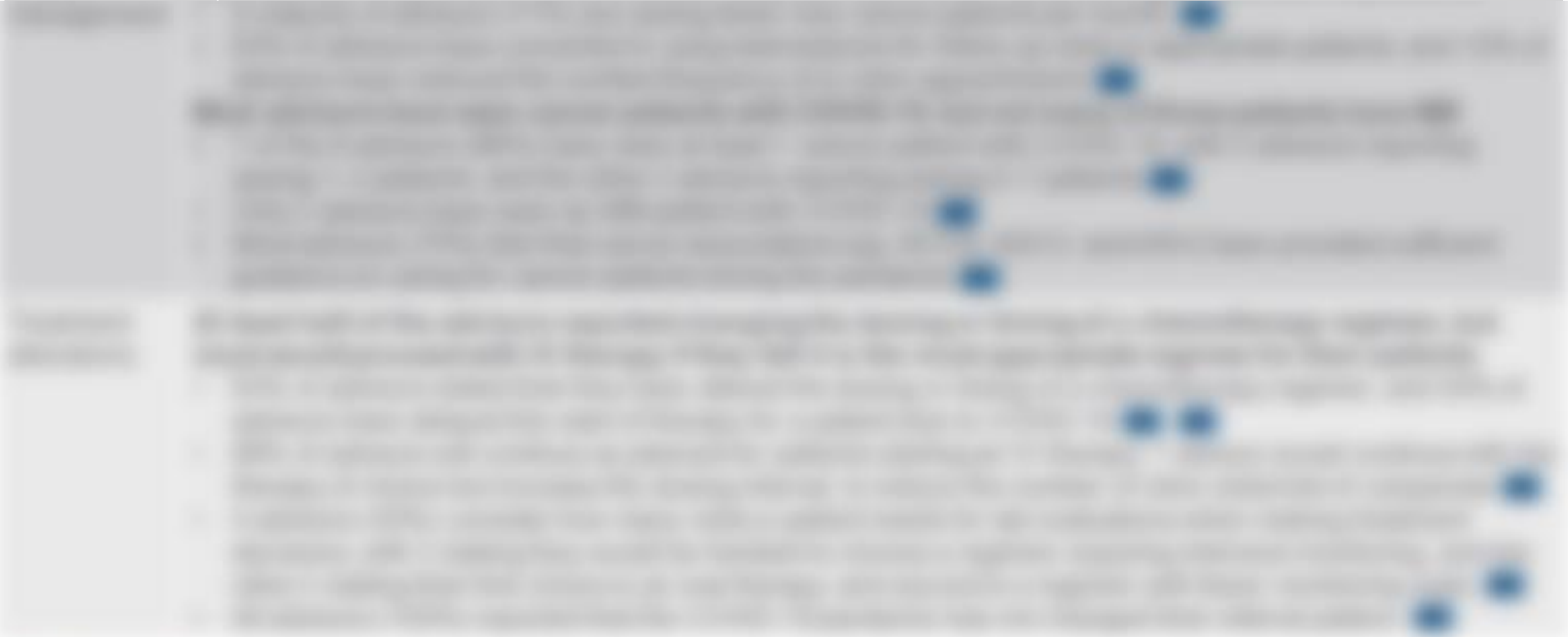
- Hyper-CVAD–based regimens are preferred for adult patients, with inclusion of a tyrosine kinase

Management of Relapsed Disease

- Nearly all advisors correctly understood that blinatumomab improves survival compared with

MANAGEMENT OF FIRST-LINE THERAPY (1/3)

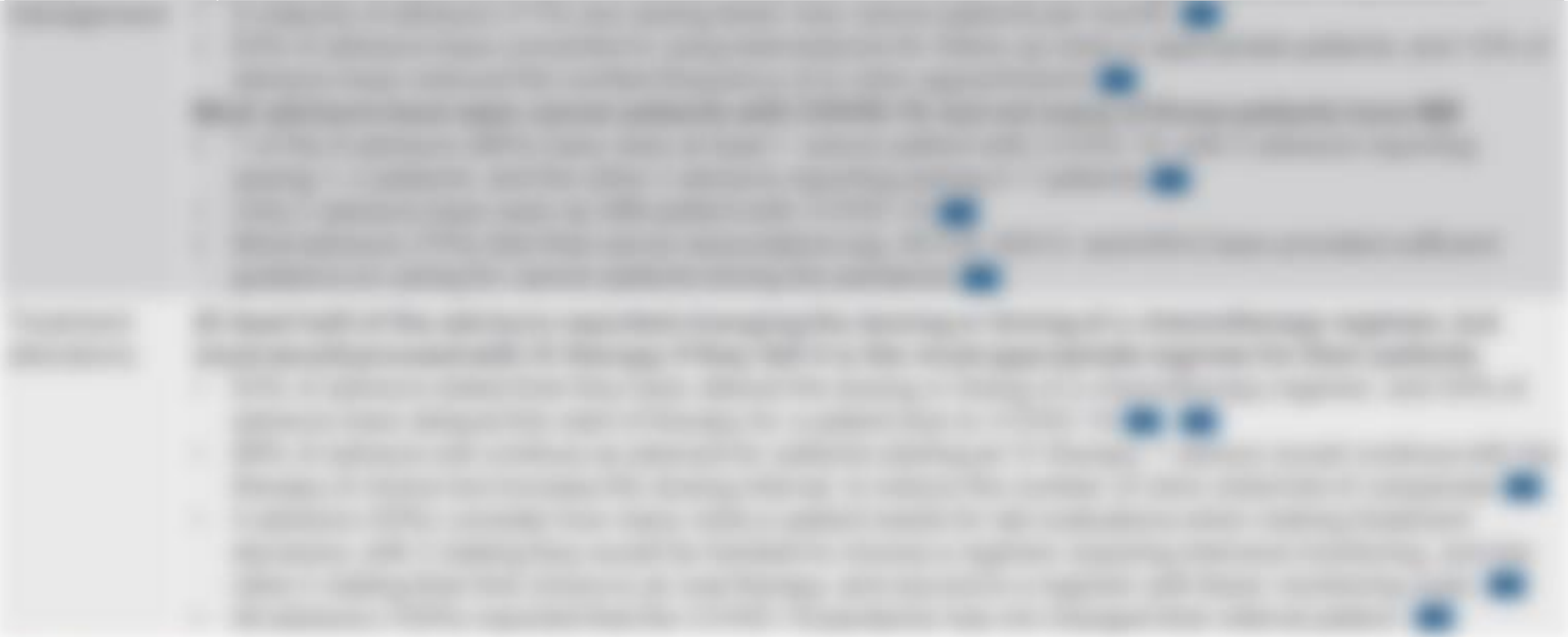
Topic	Insights and Data
Adult treatment	The majority of advisors prefer hyper-CVAD–based regimens for adult ALL patients (55%, Ph+; 67%, Ph–)



MANAGEMENT OF FIRST-LINE THERAPY (2/3)




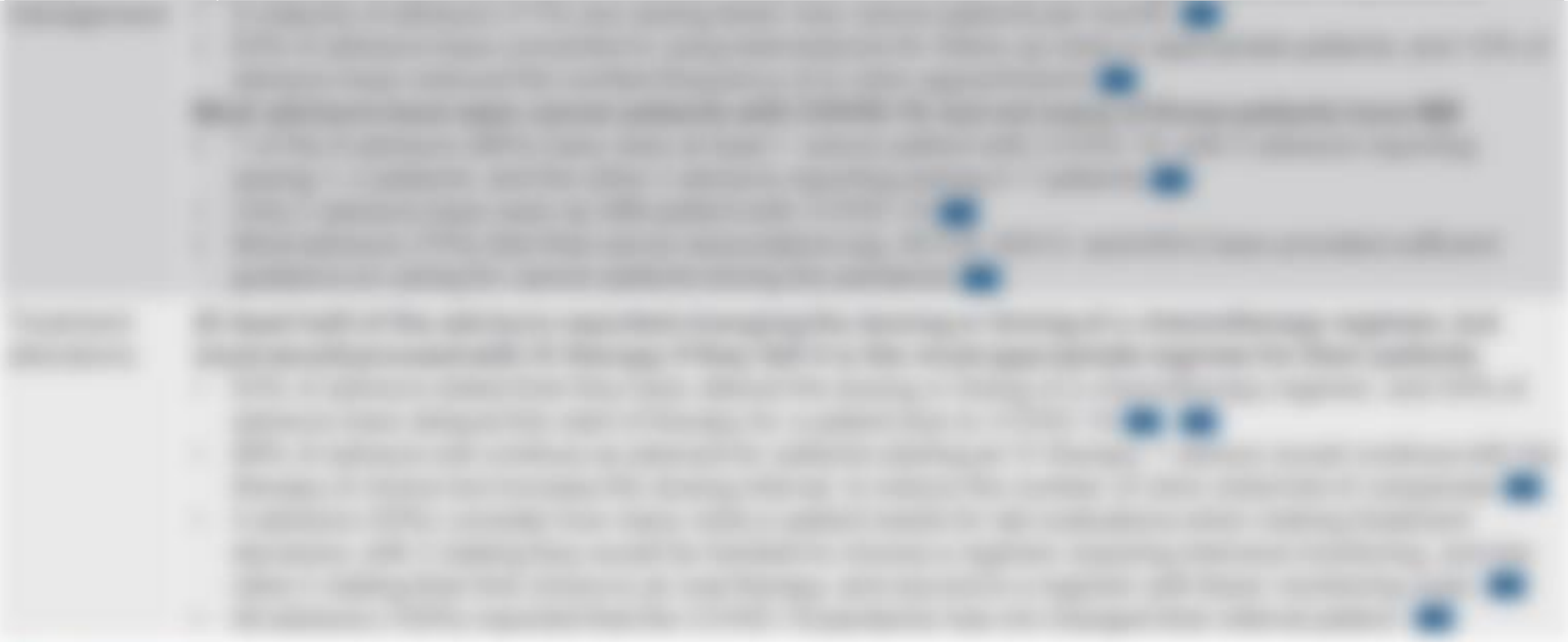
Topic	Insights and Data
AYA treatment	The majority of advisors (67%) reported that AYA patients with ALL should be treated with pediatric-inspired



MANAGEMENT OF FIRST-LINE THERAPY (3/3)



Topic	Insights and Data
Impact of MRD	The majority of advisors reported assessing for MRD using methods that vary across advisors' institutions 



QUOTES – MANAGEMENT OF FIRST-LINE THERAPY



“The last time I took care of an ALL patient was probably in my

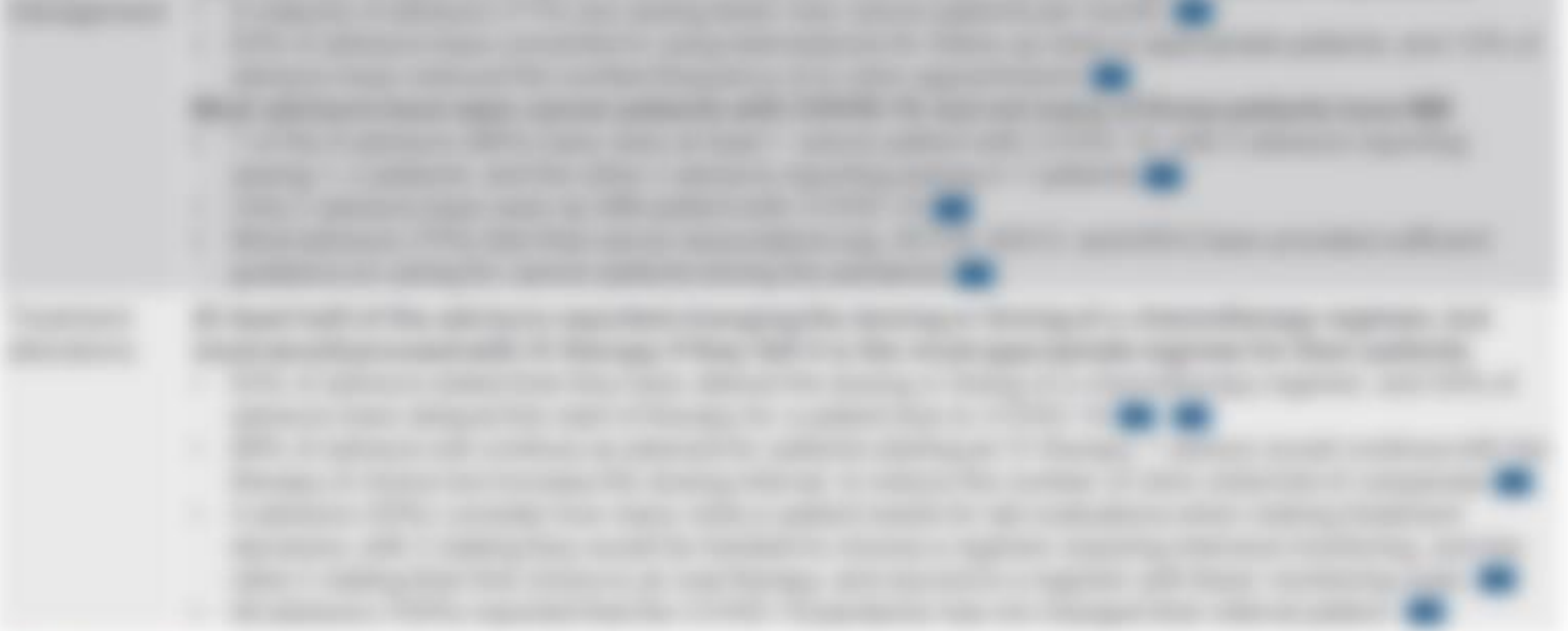
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MANAGEMENT OF RELAPSED DISEASE (1/3)



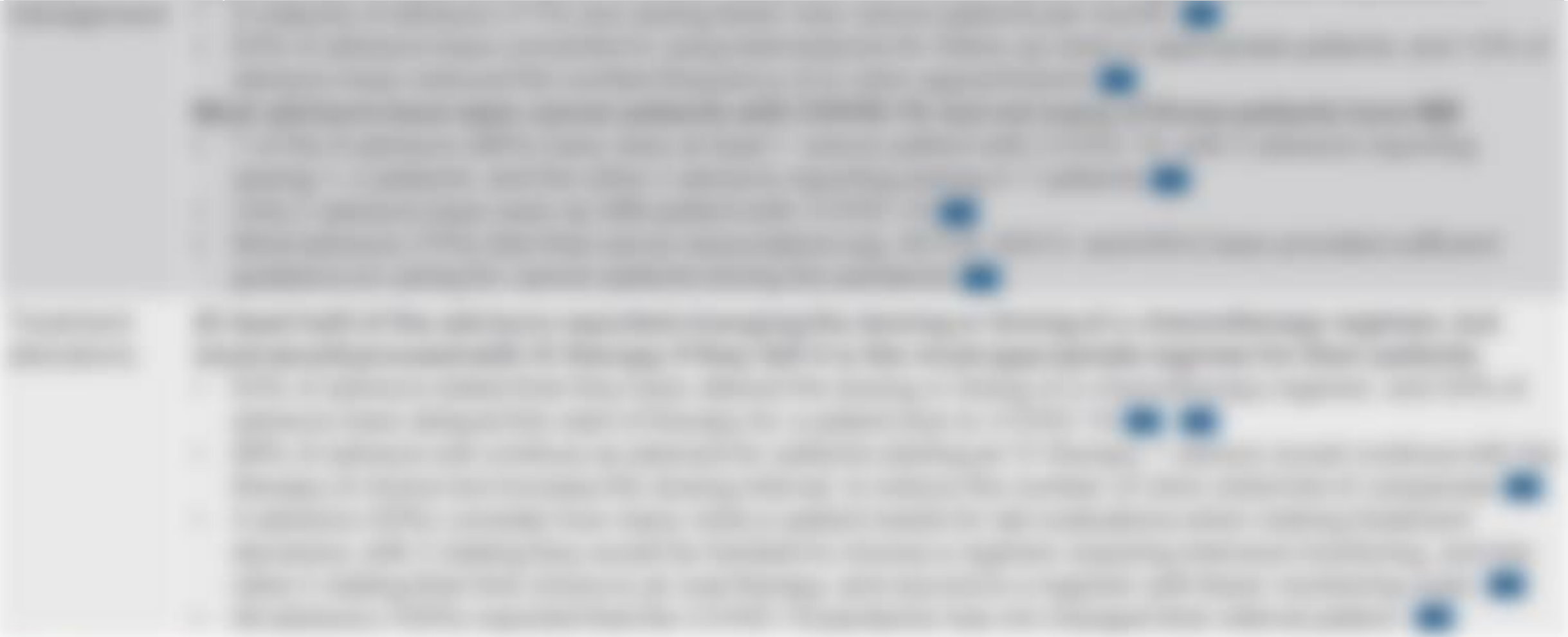
Topic	Insights and Data
Treatment	Most advisors refer their patients with R/R ALL to academic centers



MANAGEMENT OF RELAPSED DISEASE (2/3)




Topic	Insights and Data
Blinatumomab	While most advisors are aware of the survival benefit of blinatumomab in R/R ALL, the majority have never



MANAGEMENT OF RELAPSED DISEASE (3/3)



Topic	Insights and Data
45-year-old	Advisors overwhelmingly (89%) chose hyper-CVAD plus rituximab as induction therapy for this patient 

[This section contains a blurred screenshot of a presentation slide, likely detailing the clinical case and treatment outcomes for the 45-year-old patient mentioned in the table above.]

QUOTES – MANAGEMENT OF RELAPSED DISEASE



“[With blinatumomab], we had some elevated LFTs that we

“Agents like blinatumomab have changed the prognostic landscape of ALL treatment”

[Blurred text block]

[Blurred text block]





CASES

ARS Data – Introductory ARS Questions

HOW MANY NEW ALL PATIENTS DO YOU SEE PER YEAR? (N = 8)*

FOR EXAMPLE PURPOSES ONLY

*One participant did not respond.

IN HOW MANY UNIQUE ALL PATIENTS HAVE YOU EVER USED LIPOSOMAL VINCRIStINE (MARQIBO)? (N = 9)



FOR EXAMPLE PURPOSES ONLY

IN HOW MANY UNIQUE ALL PATIENTS HAVE YOU EVER USED INOTUZUMAB OZOGAMICIN (BESPONSA)? (N = 9)

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FOR EXAMPLE PURPOSES ONLY



IN HOW MANY UNIQUE ALL PATIENTS HAVE YOU EVER USED BLINATUMOMAB (BLINCYTO)? (N = 9)



FOR EXAMPLE PURPOSES ONLY



HOW DO YOU DEFINE AYA ALL? (N = 9)

FOR EXAMPLE PURPOSES ONLY



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ARS Data – Management of First-Line Therapy

MY PREFERRED INDUCTION REGIMEN FOR ADULT PH+ ALL PATIENTS IS: (N = 9)

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FOR EXAMPLE PURPOSES ONLY



MY PREFERRED INDUCTION REGIMEN FOR ADULT PH- ALL PATIENTS IS: (N = 9)

FOR EXAMPLE PURPOSES ONLY

> Fifty-nine-year-old male patient with no PMH presents with severe back pain for 2

2

HOW WOULD YOU TREAT HIM? (N = 9)

FOR EXAMPLE PURPOSES ONLY

THE PATIENT ACHIEVES A CR AND IS MRD-. HE HAS A MATCHED UNRELATED DONOR. WHAT WOULD YOU NOW

FOR EXAMPLE PURPOSES ONLY

HOW DO YOU ASSESS FOR MINIMAL RESIDUAL DISEASE (MRD)? (N = 9)

FOR EXAMPLE PURPOSES ONLY

WHEN DO YOU ASSESS FOR MRD? (N = 9)

FOR EXAMPLE PURPOSES ONLY

IN PATIENTS WITH POSITIVE MRD TREATED WITH BLINATUMOMAB (SELECT ALL THAT APPLY):

FOR EXAMPLE PURPOSES ONLY

IN GENERAL, HOW DO YOU TREAT AYA PATIENTS? (N = 9)

FOR EXAMPLE PURPOSES ONLY

> Twenty-four-year-old female patient with no PMH presents with fatigue, and easy

■ [Blurred text]

HOW WOULD YOU TREAT HER? (N = 9)

FOR EXAMPLE PURPOSES ONLY

PATIENT CASE (CONTINUED)

> Day 28 bone marrow assessment confirms CR. MRD is detected by flow

■ Bone marrow assessment shows 100% remission with complete remission (CR) and no detectable residual disease (MRD) by flow cytometry.

WHAT DO YOU RECOMMEND NEXT? (N = 9)

FOR EXAMPLE PURPOSES ONLY

PATIENT CASE (CONTINUED)

> The patient received further consolidation therapy. MRD assessment at 12 weeks

MRD assessment at 12 weeks post-therapy showed a negative result, indicating a complete response to treatment.

WHAT DO YOU RECOMMEND NEXT? (N = 9)

FOR EXAMPLE PURPOSES ONLY



CASES

ARS Data – Management of Relapsed Disease

WHEN COMPARED WITH SOC IN PATIENTS WITH RELAPSED/ REFRACTORY ALL, BLINATUMOMAB IMPROVES OS. (N = 9)

CASES

FOR EXAMPLE PURPOSES ONLY



WHEN COMPARED WITH SOC IN PATIENTS WITH RELAPSED/ REFRACTORY ALL, INOTUZUMAB OZOGAMICIN (SELECT ALL

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FOR EXAMPLE PURPOSES ONLY



> Forty-five-year-old male presents with fever and fatigue. CBC reveals: Hgb = 9

WBC = 12.5 x 10⁹/L (12,500/mm³) with 85% neutrophils, 10% lymphocytes, and 5% monocytes. Platelets = 150 x 10⁹/L (150,000/mm³). ESR = 45 mm/hr. Urinalysis is normal. Renal function is normal. No splenomegaly or lymphadenopathy. No evidence of infection on chest X-ray and CT scan. No evidence of malignancy on PET-CT scan. No evidence of autoimmune disease on ANA, ANCA, and rheumatoid factor. No evidence of endocrine disease on TSH, free T4, and prolactin. No evidence of liver disease on ALT, AST, ALP, and GGT. No evidence of renal disease on BUN and creatinine. No evidence of bone marrow disease on bone marrow biopsy. No evidence of infection on blood cultures and PCR for CMV, EBV, and HHV-8. No evidence of malignancy on bone marrow biopsy. No evidence of autoimmune disease on ANA, ANCA, and rheumatoid factor. No evidence of endocrine disease on TSH, free T4, and prolactin. No evidence of liver disease on ALT, AST, ALP, and GGT. No evidence of renal disease on BUN and creatinine. No evidence of bone marrow disease on bone marrow biopsy.

WHAT IS YOUR PLAN FOR INDUCTION THERAPY? (N = 9)

FOR EXAMPLE PURPOSES ONLY

PATIENT CASE (CONTINUED)

> The patient was treated with R-hyper-CVAD and achieved a CR with MRD

■ Bone marrow relapse after 7th cycle with hyper-CVAD. MRD was detected at 10⁻⁴ level. Patient was treated with salvage therapy and achieved a CR with MRD.

WHAT WOULD BE YOUR SALVAGE APPROACH? (N = 9)

FOR EXAMPLE PURPOSES ONLY

PATIENT CASE (CONTINUED)

> The patient received reinduction with augmented hyper-CVAD. On day 28 he

■ [Blurred text]

WHAT WOULD YOU NOW RECOMMEND? (N = 9)

FOR EXAMPLE PURPOSES ONLY

PATIENT CASE (CONTINUED)

- > The patient received a MUD-SCT after 3 cycles of augmented hyper-CVAD.

- > [Blurred text]

WHAT WOULD YOU NOW RECOMMEND? (N = 9)

FOR EXAMPLE PURPOSES ONLY

> Thirty-five-year-old female with history of pre-B ALL diploid cytogenetics and

■ [Faded text]

YOUR NEXT PLAN WOULD BE: (N = 9)

FOR EXAMPLE PURPOSES ONLY

PATIENT CASE (CONTINUED)



> Patient was reinduced with blinatumomab and achieved CR2 at day 28. MRD

■ [Faded text]

YOUR NEXT PLAN WOULD BE: (N = 9)

FOR EXAMPLE PURPOSES ONLY



Advisor Key Takeaways

ADVISOR KEY TAKEAWAYS



Dr 1

- Importance of MRD methodology

Dr 6

- Possibility of administering blinatumomab in the community