



**CASES**

# **INSIGHTS INTO MANAGEMENT OF DLBCL**

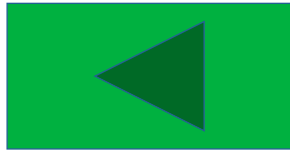
February 22, 2021

Insights From Southwest Region

# HOW TO NAVIGATE THIS REPORT



Click to move to topic of interest or ARS supporting data



Click to return to previous slide

# CONTENTS



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Topic	
Report Objectives	
Report Snapshot	
<ul style="list-style-type: none"><li>• Session overview</li><li>• Attendee overview</li><li>• Agenda</li></ul>	
Topline Takeaways	
Key Insights and Discussion Summary	
<ul style="list-style-type: none"><li>• Management of DLBCL</li><li>• DLBCL discussion overview</li></ul>	
Advisor Key Takeaways	
ARS Data	

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## STUDY OBJECTIVE

- > To gain perspectives of advisors on drivers toward treatment decisions in the management of diffuse large B-cell lymphoma (DLBCL)

# REPORT SNAPSHOT: SESSION OVERVIEW



A moderated roundtable discussion was held with community oncologists from the southwestern United States in a virtual setting on **February 22, 2021**

Disease state and data presentations were led by **Dr John Burke** from Rocky Mountain Cancer Centers and **Dr Keren Sturtz** from SCL Health Medical Group in conjunction with content developed by the Aptitude Health clinical team

Insights were gathered on the use of **polatuzumab in the management of DLBCL** in the community setting

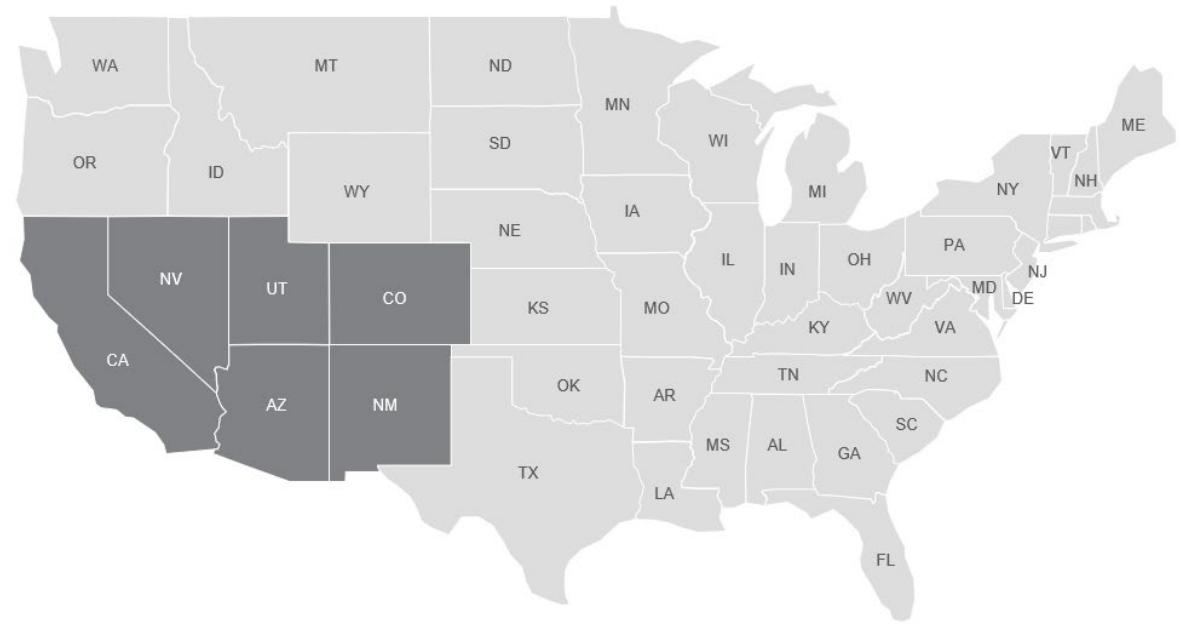
Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion

# REPORT SNAPSHOT: ATTENDEE OVERVIEW



- > The group of advisors comprised 14 community oncologists from the southwestern United States
  - Attendees of the roundtable represented community oncologists from Arizona, California, Colorado, New Mexico, Nevada, and Utah

INSTITUTION	CITY	STATE
Arizona Center for Cancer Care	Scottsdale	AZ
Cochise Oncology	Sierra Vista	AZ
Ironwood Cancer & Research Centers	Chandler	AZ
Ironwood Cancer & Research Centers	Glendale	AZ
City of Hope	Colton	CA
Kaiser Permanente Riverside Medical Center	Riverside	CA
Kaiser Permanente Riverside Medical Center	Riverside	CA
Kaiser Permanente Riverside Medical Center	Riverside	CA
OC Blood and Cancer Care	Huntington Beach	CA
Denver Health Medical Center	Denver	CO
Heart of the Rockies Regional Medical Center	Salida	CO
Lovelace Cancer Center	Albuquerque	NM
Intermountain Healthcare Nevada	Las Vegas	NV
University of Utah and Intermountain Healthcare	Salt Lake City	UT



# REPORT SNAPSHOT: AGENDA



Time (PST)	Topic
5.00 PM – 5.15 PM (15 min)	Introduction and ARS Questions <ul style="list-style-type: none"><li>• Program overview</li><li>• ARS questions</li></ul>
5.15 PM – 6.00 PM (20-min presentation; 25-min discussion)	Initial Treatment of DLBCL <ul style="list-style-type: none"><li>• Overview of current first-line data</li><li>• Reaction and discussion</li></ul>
6.00 PM – 6.15 PM (15 min)	Break
6.15 PM – 7.50 PM (35-min presentation; 60-min discussion)	Treatment of Relapsed/Refractory DLBCL <ul style="list-style-type: none"><li>• ARS questions</li><li>• Overview of current relapsed/refractory data</li><li>• Overview of ASH updates</li><li>• Reaction and discussion</li></ul>
7.50 PM – 8.00 PM (10 min)	Key Takeaways and Meeting Evaluation



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**Topline Takeaways and  
Strategic Recommendations**





# MEETING OBJECTIVES WERE ACHIEVED: TOPLINE TAKEAWAYS



## OBJECTIVE

## PROCESS

## INSIGHTS

*[Faded text describing objectives]*

*[Faded text describing process]*

*[Faded text describing insights]*

 CASES Key Insights and  
Discussion Summary



## DLBCL – INSIGHTS AND DATA

1. Treatment success in frontline DLBCL

DLBCL is a highly curable lymphoma. The overall survival (OS) for DLBCL is approximately 70% at 5 years. This is a significant improvement over the 50% OS seen in the 1980s. The improvement is due to the use of rituximab, a monoclonal antibody that targets CD20, a protein found on the surface of B cells. Rituximab is used in combination with chemotherapy, such as CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) or R-CHOP. The addition of rituximab to CHOP (R-CHOP) has been shown to significantly improve OS compared to CHOP alone. The improvement in OS is most pronounced in patients with stage I and II disease, but it is also seen in patients with stage III and IV disease. The overall survival rate for DLBCL is approximately 70% at 5 years, which is a significant improvement over the 50% OS seen in the 1980s. The improvement is due to the use of rituximab, a monoclonal antibody that targets CD20, a protein found on the surface of B cells. Rituximab is used in combination with chemotherapy, such as CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) or R-CHOP. The addition of rituximab to CHOP (R-CHOP) has been shown to significantly improve OS compared to CHOP alone. The improvement in OS is most pronounced in patients with stage I and II disease, but it is also seen in patients with stage III and IV disease.

2. Data needed to confirm that R-CHOP is frontline

The data needed to confirm that R-CHOP is the standard of care for DLBCL is the results of the R-CHOP trial. This trial compared R-CHOP to CHOP in patients with DLBCL. The results of the trial showed that R-CHOP significantly improved OS compared to CHOP. The improvement in OS was most pronounced in patients with stage I and II disease, but it was also seen in patients with stage III and IV disease. The overall survival rate for DLBCL is approximately 70% at 5 years, which is a significant improvement over the 50% OS seen in the 1980s. The improvement is due to the use of rituximab, a monoclonal antibody that targets CD20, a protein found on the surface of B cells. Rituximab is used in combination with chemotherapy, such as CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) or R-CHOP. The addition of rituximab to CHOP (R-CHOP) has been shown to significantly improve OS compared to CHOP alone. The improvement in OS is most pronounced in patients with stage I and II disease, but it is also seen in patients with stage III and IV disease.



## Advisor Key Takeaways

# ADVISOR KEY TAKEAWAYS



## ADVISOR

## ADVISOR

- Have a better understanding of sequencing therapy
- Really want to talk to the provider with confidence and understand the use of each a better understanding of these drugs and have a better idea of when to use them in my practice

- Have a better understanding of some of my other options
- I'm particularly interested in the combination and how the side effects would be managed in a secondary option for my own therapy options
- There's a lot more confidence in sequenced therapy and to things the combination that may offer more side effects

- It was good to hear about combination and what coming from the provider for immunotherapy

- There's a lot of good options for second line that just ICD 1 and managed with second line other profile and good response rate
- Sequencing is an issue

- The immunotherapy options the use to have different options besides ICD 1 and what is going to ICD 1

- In hoping that some of these immunotherapy agents will get added into practice and hopefully improve the look up

- Was interesting to learn about all these immunotherapy treatments, especially the specific antibodies
- A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs

- ICD 1 ICD 1 is the standard

# ADVISOR KEY TAKEAWAYS

## ADVISOR

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- There is a better understanding of assessing the value of the business and how to value it
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- There is a better understanding of the value of the business and how to value it

- There is a better understanding of some of the value drivers
- There is a better understanding of the value drivers and how to value the business
- There is a better understanding of the value drivers and how to value the business

- It is good to have a better understanding of the value drivers and how to value the business

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**CASES**

**ARS Data**



# OVER 85% OF THE ADVISORS CURRENTLY FOLLOW $\geq 7$ UNIQUE DLBCL PATIENTS

How many unique patients with DLBCL are you currently following? (n = 13\*)

FOR EXAMPLE PURPOSES ONLY

# MOST ADVISORS HAVE TREATED 1–10 OF THEIR DLBCL PATIENTS WITH IBRUTINIB IN THE PAST YEAR

FOR EXAMPLE PURPOSES ONLY

# MOST ADVISORS HAVE TREATED 1–5 OF THEIR DLBCL PATIENTS WITH LENALIDOMIDE IN THE PAST YEAR

FOR EXAMPLE PURPOSES ONLY

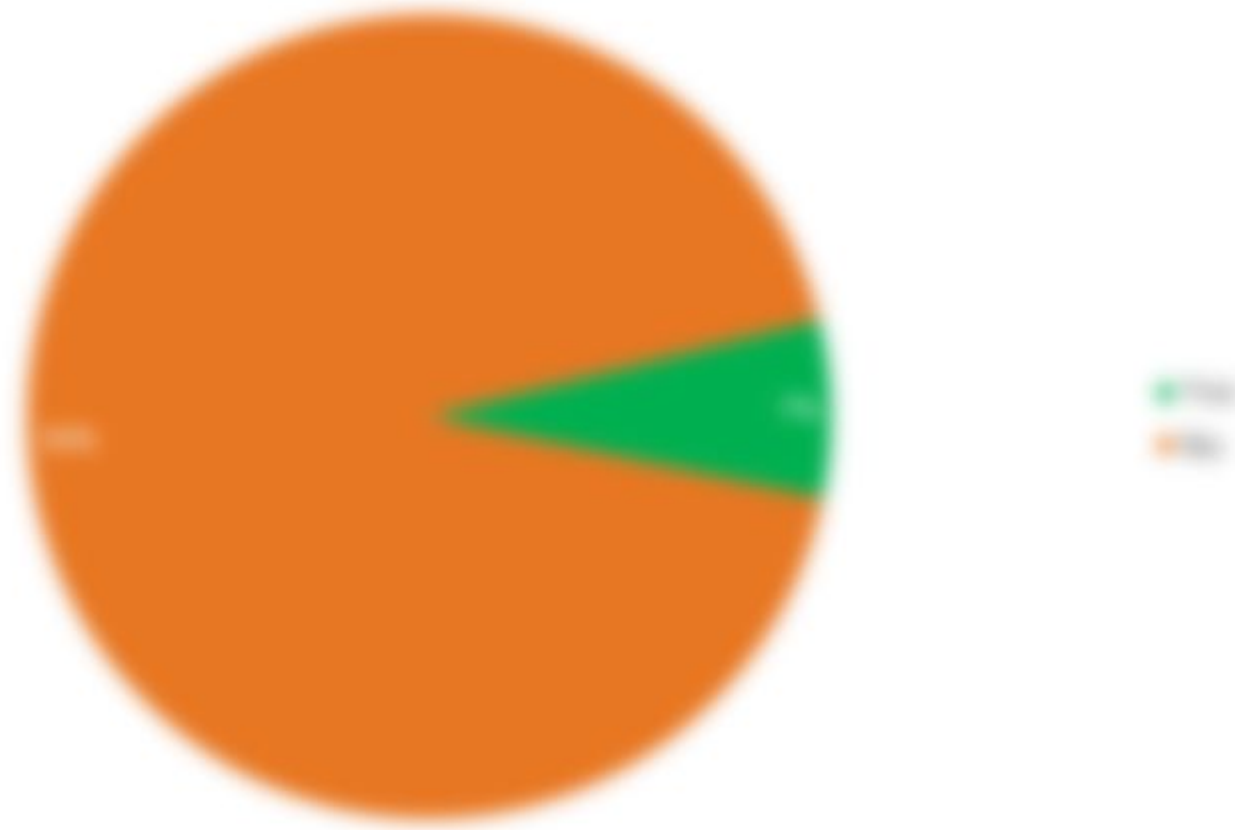
# PRESENCE OF DOUBLE- OR TRIPLE-HIT FEATURES AND PATIENT'S PERFORMANCE STATUS HAVE THE GREATEST IMPACT ON TREATMENT CHOICE IN DLBCL

FOR EXAMPLE PURPOSES ONLY

\*Two advisors did not respond.

# ALMOST NONE OF THE ADVISORS USE MAINTENANCE THERAPY IN DLBCL

Do you use maintenance therapy in DLBCL? (N = 14)



A 63-year-old man presents with a 4-week history of progressive back pain. Imaging reveals an 11-cm retroperitoneal mass. A core needle biopsy is obtained and is read as DLBCL, non-GCB by Hans methods. IHC for bcl-2 and myc show high expression (>90%) for each. FISH testing for bcl-2 and myc are both negative. FISH for bcl-6 is positive. PET imaging reveals widespread pathologic adenopathy with involvement of mediastinal, retroperitoneal, and mesenteric nodes. There are also 2 PET-avid mass lesions in the liver, and 1 lesion in the left kidney. The  $SUV_{max}$  is 28. Ki67 is 90%. There is no apparent marrow involvement by PET. The LDH is elevated at 3x the ULN. His PS is 1 and there are no significant comorbidities.

# HALF OF THE ADVISORS SELECTED THIS PATIENT'S CNS IPI SCORE AS 4



FOR EXAMPLE PURPOSES ONLY

\*Two advisors did not respond.

# MOST ADVISORS WOULD RECOMMEND R-EPOCH TO THIS PATIENT

FOR EXAMPLE PURPOSES ONLY

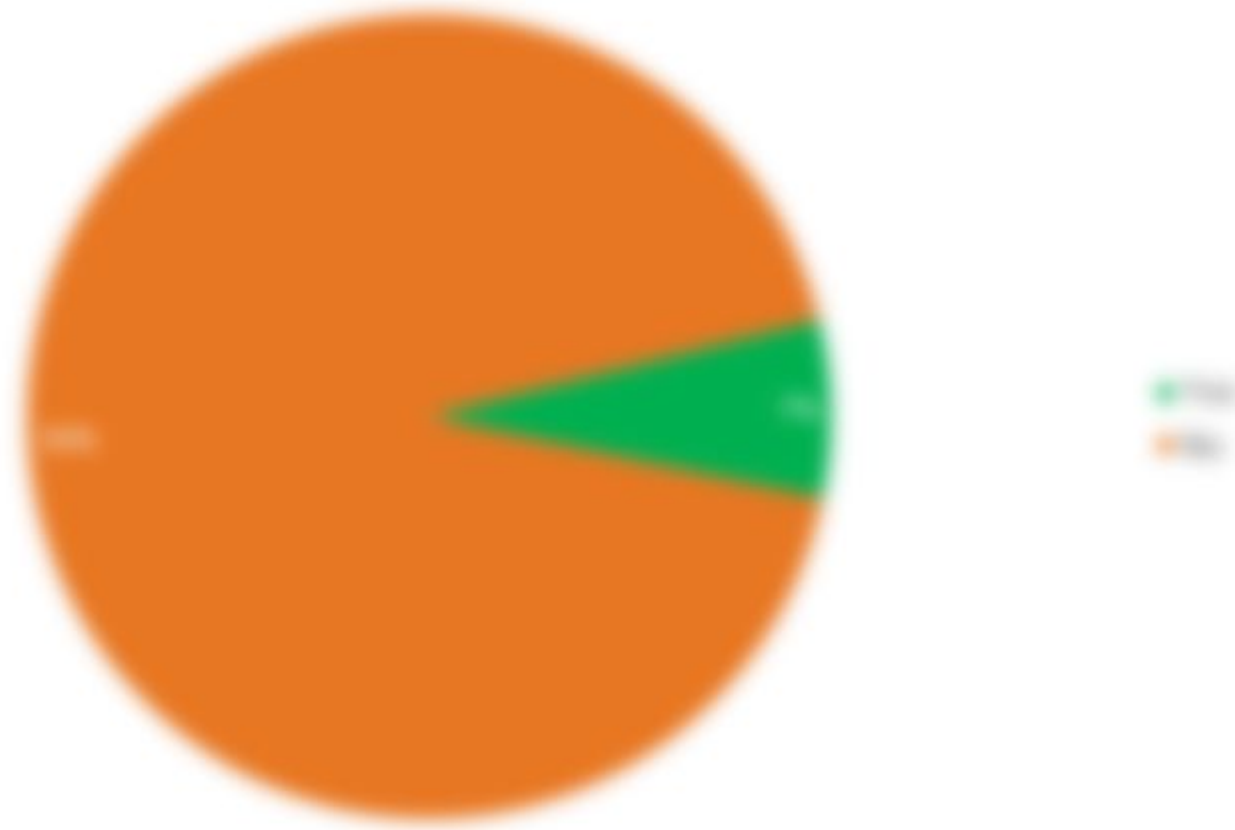


# FOR CNS PROPHYLAXIS, HALF OF THE ADVISORS WOULD INCLUDE IT MTX

FOR EXAMPLE PURPOSES ONLY

# MOST ADVISORS WOULD NOT RECOMMEND ASCT CONSOLIDATION

Assuming patient achieves a CR to frontline therapy, would you recommend ASCT



# FOR A PATIENT RELAPSING AFTER FRONTLINE R-CHOP, MORE THAN HALF OF THE ADVISORS WOULD RECOMMEND R-ICE FOLLOWED BY ASCT

FOR EXAMPLE PURPOSES ONLY

\*Two advisors did not respond.



# VARIED TREATMENT SELECTION FOR A TRANSPLANT-INELIGIBLE PATIENT, WITH TAFASITAMAB + LENALIDOMIDE AND POLATUZUMAB ± BENDAMUSTINE ± RITUXIMAB THE TOP 2 PREFERRED REGIMENS OF THE ADVISORS

FOR EXAMPLE PURPOSES ONLY

\*Two advisors did not respond.



# MOST ADVISORS IDENTIFIED POLATUZUMAB VEDOTIN AS A CD79B-DIRECTED ANTIBODY-DRUG CONJUGATE

FOR EXAMPLE PURPOSES ONLY

# LESS THAN HALF OF THE ADVISORS HAVE TREATED 1–5 OF THEIR DLBCL PATIENTS WITH POLATUZUMAB VEDOTIN IN THE PAST YEAR



FOR EXAMPLE PURPOSES ONLY



# ALMOST 3/4 OF THE ADVISORS HAVE NOT TREATED ANY OF THEIR DLBCL PATIENTS WITH TAFASITAMAB SINCE ITS APPROVAL



FOR EXAMPLE PURPOSES ONLY



# MOST ADVISORS HAVE TREATED OR REFERRED 1-5 OF THEIR DLBCL PATIENTS FOR CAR T-CELL THERAPY IN THE PAST YEAR

FOR EXAMPLE PURPOSES ONLY





# HALF OF THE ADVISORS REPORTED THAT >50% OF THEIR PATIENTS REFERRED FOR CAR T THERAPY WERE REINFUSED WITH THE ACTUAL CELLULAR PRODUCT



FOR EXAMPLE PURPOSES ONLY

# APPROPRIATE PATIENT SELECTION AND PATIENTS' PROGRESS BEFORE RECEIVING CAR T ARE THE TOP 2 BARRIERS TO BROADER USE OF CAR T-CELL THERAPY

FOR EXAMPLE PURPOSES ONLY

\*Two advisors did not respond.

# ONE-THIRD OF ADVISORS INDICATED INSURANCE REFUSAL OF THE MOST CONVENIENT CENTER AS THE MAIN BARRIER TO REFERRING PATIENTS FOR CAR T-CELL THERAPY



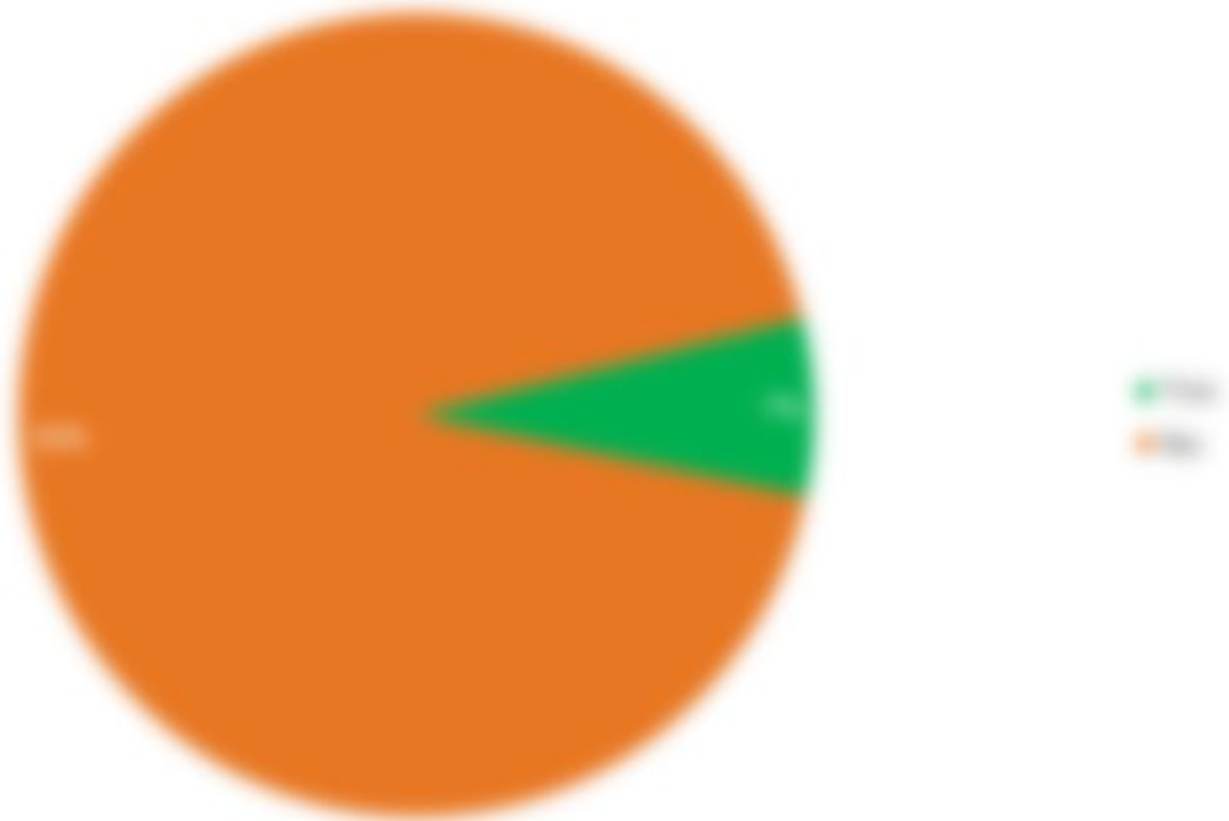
FOR EXAMPLE PURPOSES ONLY

# MOST ADVISORS ARE CURRENTLY ABLE TO ACCESS AXICABTAGENE CILOLEUCEL, FOLLOWED BY TISAGENLECLEUCEL



FOR EXAMPLE PURPOSES ONLY

# ABOUT 80% OF THE ADVISORS DO NOT KNOW BEFOREHAND WHICH CAR T-CELL THERAPY THEIR PATIENT WILL RECEIVE



\*One advisor did not respond.

**MOST ADVISORS AGREE THAT BRIDGING CHEMOTHERAPY CAN BE ADMINISTERED WHILE WAITING FOR CAR T; HOWEVER, OVER 40% BELIEVE IT MAY INCREASE THE RISK OF ADVERSE EVENTS DURING THE PREINFUSION PERIOD**

**FOR EXAMPLE PURPOSES ONLY**

\*One advisor did not respond.

