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CASES

INSIGHTS INTO METASTATIC BREAST CANCER

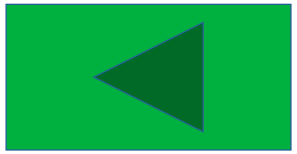
March 1, 2021

Community Insights From Oncologists in the Southwest US

HOW TO NAVIGATE THIS REPORT

CASES

Click to move to topic of interest or ARS supporting data



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REPORT OBJECTIVES

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STUDY OBJECTIVES

- To gain perspectives on community oncology treatment practices in HR+, HER2+, and TN mBC
- To gain insight into the influence of recent data and approvals on community treatment practices

REPORT SNAPSHOT: SESSION OVERVIEW

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A moderated roundtable discussion was held with community oncologists from across the Southwest region of the United States in a virtual setting on **March 1, 2021**

Disease state and data presentations were led by **Dr Mark Pegram** from Stanford Cancer Center and discussions moderated by **Dr Keren Sturtz** from Sackler School of Medicine, in conjunction with content developed by the Aptitude Health Clinical Team

Insights on the **treatment and management of breast cancer patients in the community** setting were obtained

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

REPORT SNAPSHOT: ATTENDEE OVERVIEW

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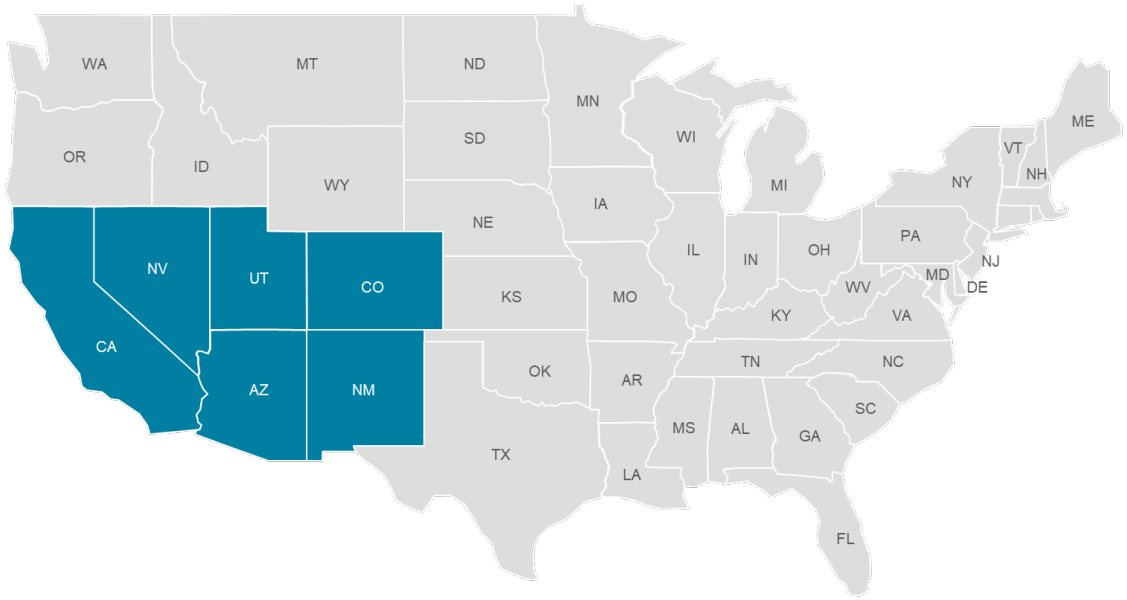
- The group of advisors comprised 14 community oncologists from across the United States
  - Attendees of the roundtable represented community oncologists from California, Nevada, Utah, Arizona, Colorado, and New Mexico

INSTITUTION	CITY	STATE
Ironwood Cancer & Research Centers	Chandler	AZ
Ironwood Cancer & Research Centers	Phoenix	AZ
Private practice	Huntington Beach	CA
Cancer & Blood Specialty Clinic	Los Alamitos	CA
Private practice	Los Angeles	CA
Kaiser Permanente Riverside Medical Center	Riverside	CA
Riverside Medical Center	Riverside	CA
Southern California Permanente Medical Group	San Diego	CA
Pacific Shores Medical Group	Ventura and Long Beach	CA
Denver Health Medical Center	Denver	CO
Heart of the Rockies Regional Medical Center	Salida	CO
Lovelace Cancer Center	Albuquerque	NM
Cancer Care Specialists	Reno	NV
Utah Cancer Specialists	Salt Lake City	UT



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PARTICIPANT DEMOGRAPHICS (1/2)

Approximately how many patients with HR+ ABC have you treated in the last year? (N = 13)*

Approximately how many patients with HER2+ ABC have you treated in the past year? (N = 14)

* One advisor did not respond.

PARTICIPANT DEMOGRAPHICS (2/2)

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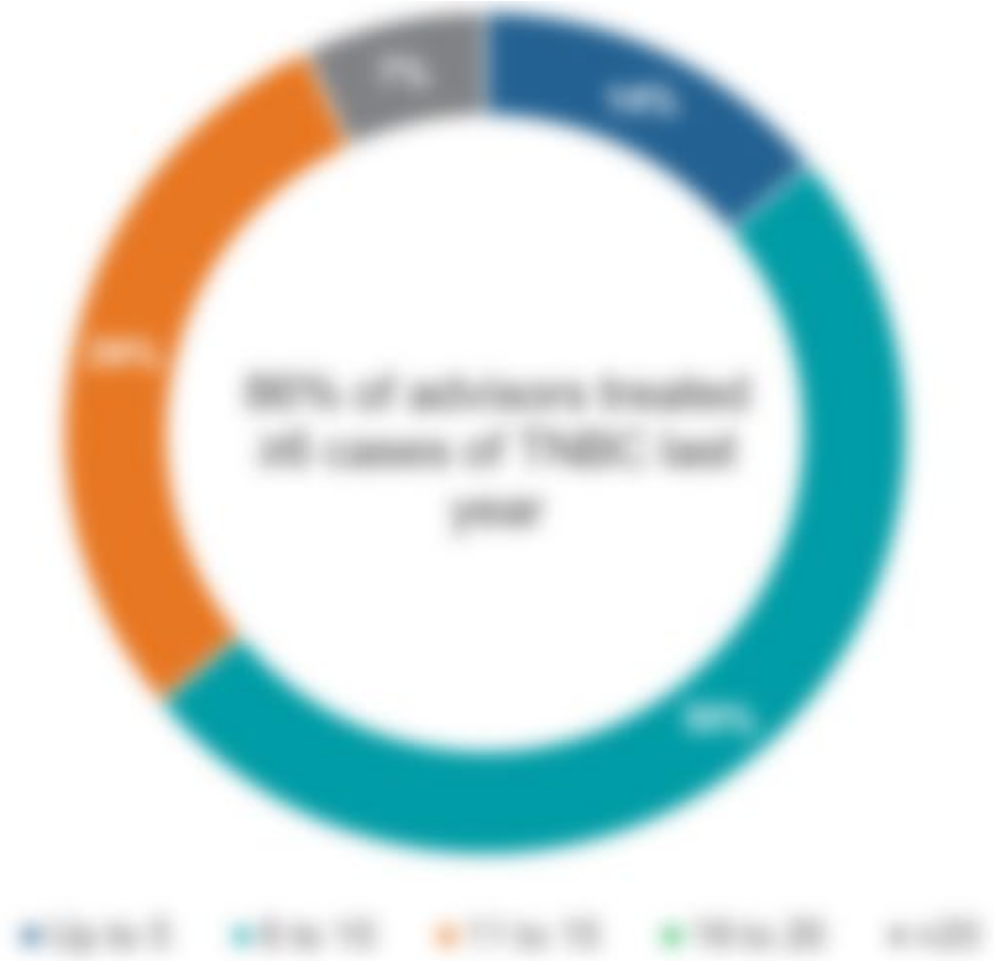
Approximately how many patients with triple-negative ABC have you treated in the past year? (N = 14)



REPORT SNAPSHOT: AGENDA

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Time (PST)	Topic
5.00 PM – 5.15 PM (15 min)	Introduction
5.15 PM – 5.45 PM (30 min)	Treatment of HR-Positive Advanced Breast Cancer
5.45 PM – 6.15 PM (30 min)	Moderated Discussion
6.15 PM – 6.35 PM (20 min)	Treatment of HER2-Positive Advanced Breast Cancer
6.35 PM – 7.00 PM (25 min)	Moderated Discussion
7.00 PM – 7.10 PM (10 min)	Break
7.10 PM – 7.30 PM (20 min)	Treatment of Triple-Negative Advanced Breast Cancer
7.30 PM – 7.50 PM (20 min)	Moderated Discussion
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

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OBJECTIVE	PROCESS	INSIGHTS
[illegible]	[illegible]	[illegible]

- Understand physicians' expectations for clinical trial data before trying a new regimen in frontline for DLBCL
- Gain insights into R/R patient referral patterns between academic and community practices
- Assess the perception of polatuzumab in the R/R setting compared with other therapeutics (especially CAR T therapy and tafasitamab), including therapy selection and sequencing

Through AIRS questions and moderated discussions, community oncologists described their testing practices and challenges they experience

- Advisors are open to trying new regimens, primarily with good OS benefit data in frontline, with some open to adopting new therapy with good hazard ratio (0.80 or better) or EFS
- Advisors in community practice typically treat older, less mobile, transplant-ineligible patients and refer out young, fit, transplant-eligible patients
- All advisors generally have positive opinions/experiences with polatuzumab in terms of efficacy and tolerability; however, some currently use it only as a bridge to CAR T, and some in patients ineligible for CAR T. All advisors are unsure about sequencing therapies

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Key Insights and Discussion Summary

DISCUSSION: HR+ ABC (1/3)

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HR+ mBC 1L – INSIGHTS AND DATA

"You know, ER+ typically the main thing is symptoms. If they are very symptomatic, like liver mets, bone mets, very painful

- Treatment success in frontline (3L)BCL

- Data needed to switch from SOC in frontline

DISCUSSION: HR+ ABC (2/3)

CASES

HR+ mBC 1L – INSIGHTS AND DATA

"So far, I have been doing Ibrance for the majority of my patients. I do see the data maybe a little bit better with . . . abemaciclib. My fear is that it's

- [illegible]

- [illegible]

DISCUSSION: HR+ ABC (3/3)

CASES

HR+ mBC 2L and Beyond – INSIGHTS AND DATA

"I usually switch them to fulvestrant + AI or with everolimus, depending on the disease burden, again."

- Treatment success in frontline (3L/4L)

- Data needed to switch from SOC in frontline

DISCUSSION: HER+ ABC (1/2)

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HER2+ mBC – INSIGHTS AND DATA

"I use the PTH, pertuz/tras/tax. I mean that's pretty straightforward."

- Treatment success in frontline DLBCL

- Data needed to switch from BCIC in frontline

DISCUSSION: HER+ ABC (2/2)

HER2+ mBC – INSIGHTS AND DATA

"I would much rather give my patients tucat second line and skip T-DM1 all together and then be ready for Enhertu in the

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

DISCUSSION: TNBC (1/2)

CASES

TNBC – INSIGHTS AND DATA

"As soon as the data from 522 came out, I started using pembro in the neoadjuvant setting because of the CR rates and sort of translating

- [illegible]

[illegible]

I

- [illegible]

[illegible]

DISCUSSION: TNBC (2/2)

TNBC – INSIGHTS AND DATA

"Of course I am doing the germline testing. But actually, pretty much with each subsequent line of treatment I do try to get a

- Treatment success in frontline (N,BC)

- Data needed to switch from SOC in frontline

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Advisor Key Takeaways

ADVISOR KEY TAKEAWAYS (1/2)

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ADVISOR		ADVISOR	
1	> The biology behind some decisions that we've had > I have a better understanding of sequencing therapies > I really wasn't that familiar with polatuzumab and tafasitamab but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> For ER+ disease, we have multiple choices that will be > For relapsed/refractory patients it's nice to have different options besides R-CD and auto or going to CAR-T
2	> I have a better understanding of some of my relapse options > I'm particularly interested in the tafasitamab and hope that tafa and Rev would be tolerated for a second-line option for my very elderly patients > There's a lot more enthusiasm for targeted therapy and for things like polatuzumab that may offer lesser side effects	6	> I'm hoping that some of these second-line agents will get added onto frontline and hopefully improve the cure rate
3	> It was great to hear about innovations and what's coming down the pipeline for relapsed/refractory	7	> Very interesting to learn about all these relapsed/refractory treatments, specifically the bispecific antibodies > A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs
4	> There's a lot of good options for second line than just CAR-T and transplant with decent side effect profile and good response rates > Sequencing is an issue	8	> Still R-CHOP is the standard

ADVISOR KEY TAKEAWAYS (2/2)*

CASES

ADVISOR		ADVISOR	
1	> CDK4/6 inhibitors, I use Kisqali because it is the only > I have a better understanding of sequencing therapies > I really wasn't that familiar with ide/elucumab and tel/belamab but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> I still haven't figured out which CDK4/6i's I like > For relapsed/refractory patients it's nice to have different options besides R-CD. and auto or going to CAR-T
2	> I have a better understanding of some of my relapse options > I'm particularly interested in the tel/belamab and hope that tels and Rev would be tolerated for a second-line option for my very elderly patients > There's a lot more enthusiasm for targeted therapy and for things like ide/elucumab that may offer lesser side effects	6	> I'm hoping that some of these second-line agents will get added onto frontline and hopefully improve the cure rate
3	> It was great to hear about innovations and what's coming down the pipeline for relapsed/refractory	7	> Very interesting to learn about all these relapsed/refractory treatments, specifically the bispecific antibodies > A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs
4	> There's a lot of good options for second line than just CAR-T and transplant with decent side effect profile and good response rates > Sequencing is an issue	8	> Still R-CHOP is the standard

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ARS Data

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Treatment of HR+ ABC

ARS RESULTS

CASE 1 (HR+ ABC)

CASES

- A 58-year-old woman presents with de novo T3N1M1 grade 2 ER+/PR+/HER2–

MOST ADVISORS WOULD USE A CDK4/6i AND LETROZOLE; 61% WOULD USE PALBOCICLIB AS THE CDK4/6i

CASES

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*One advisor did not respond.

CASE 1 (HR+ ABC) CONT.

CASES

- The patient is treated with letrozole + palbociclib, in addition to zoledronic acid.

MOST WOULD USE A FUL + CDK4/6i REGIMEN, AND NONE WOULD SWITCH FROM ET TO CAPECITABINE

CASES

*One advisor did not respond.

CASE 1 (HR+ ABC) CONT.

CASES

- What if instead of progression only in bone after 30 months on letrozole +

APPROXIMATELY ONE-HALF OF THE ADVISORS WOULD SWITCH TO CHEMOTHERAPY, AND HALF WOULD USE FULVESTRANT-BASED APPROACHES

CASES

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*One advisor did not respond.

CASE 2 (HR+ ABC)

CASES

- A 65-vear-old obese woman has had ER+/PR+ bone-onlv MBC for 10 years

92% OF ADVISORS WOULD USE AN ET + CDK4/6i IN LATE-LINE HR+ mBC IF CDK4/6i WAS NOT USED PREVIOUSLY

CASES

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*Two advisors did not respond.

CASE 3 (HR+ ABC)

CASES

- A 55-year-old postmenopausal woman has been on adjuvant anastrozole for 4

71% OF ADVISORS WOULD USE FUL + CDK4/6i FOR MILDLY SYMPTOMATIC LIVER METS AFTER PROGRESSION ON ADJUVANT AI

CASES

FOR EXAMPLE PURPOSES ONLY

MOST ADVISORS SELECT CDK4/6i's BASED ON EFFICACY, TOXICITY, AND THEIR FAMILIARITY WITH THE AGENT

CASES

MOST ADVISORS DO NOT ANTICIPATE CHANGING THEIR PRESCRIBING PATTERNS FOR CDK4/6i's IN THE NEXT 12–18 MONTHS

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Treatment of HER2+ ABC

ARS RESULTS

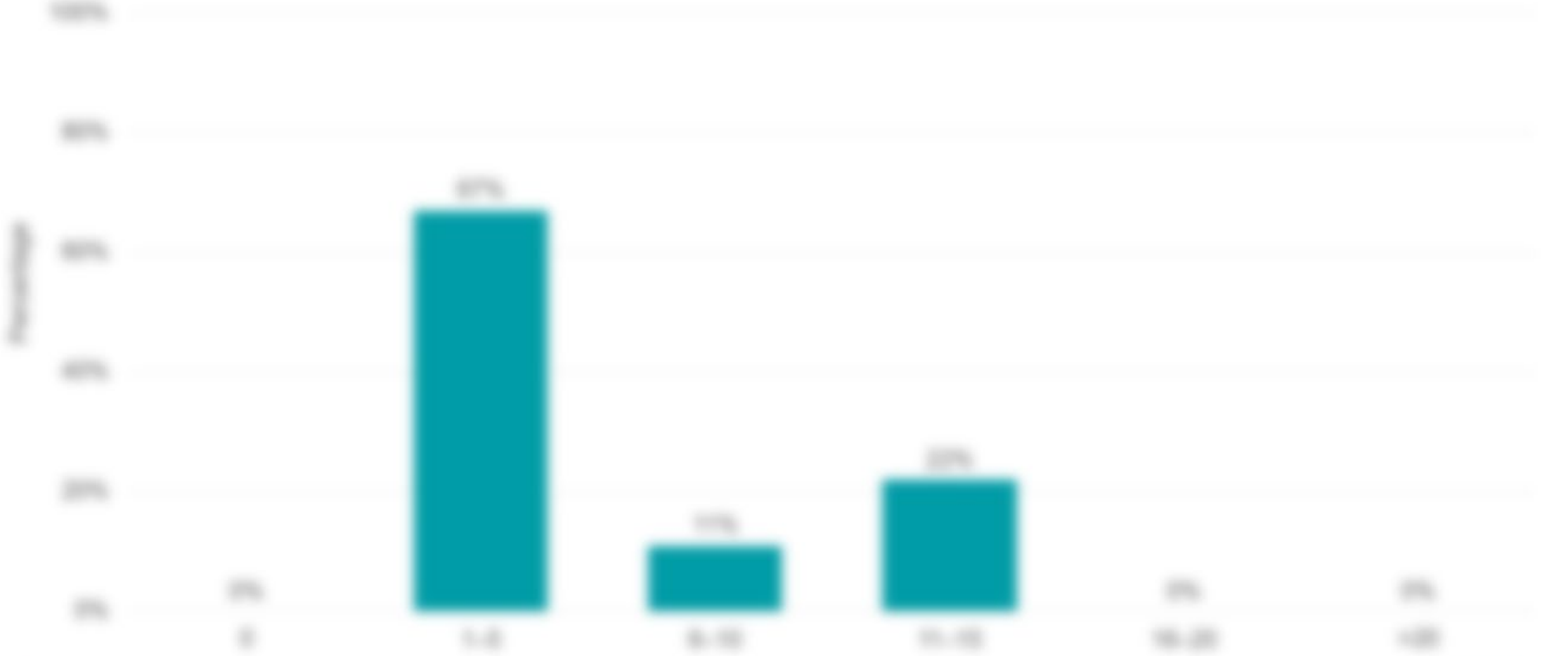
CASE 1 (HER2+ ABC)

CASES

- A 55-year-old postmenopausal woman presents with ER+/PR–/HER2+ bone-only

MOST ADVISORS WOULD USE HTP FOR 1L TREATMENT OF BONE-ONLY HR+/HER2+ mBC

CASES



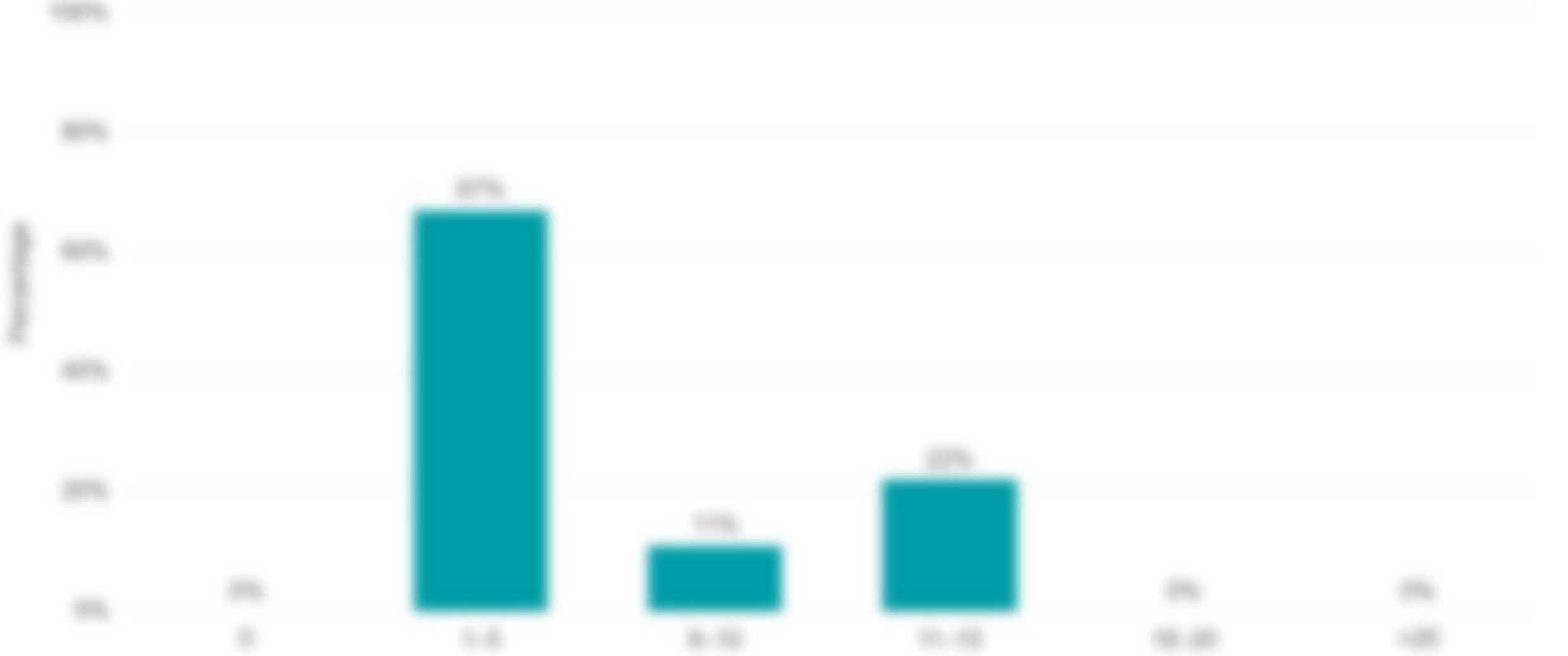
CASE 1 (HER2+ ABC) CONT.

CASES

- She is treated with 6 cycles of docetaxel plus trastuzumab plus pertuzumab and

IN A PATIENT WITH BONE-ONLY METASTASES FROM HR+/ HER2+ mBC, MOST ADVISORS USE HP + AI

CASES



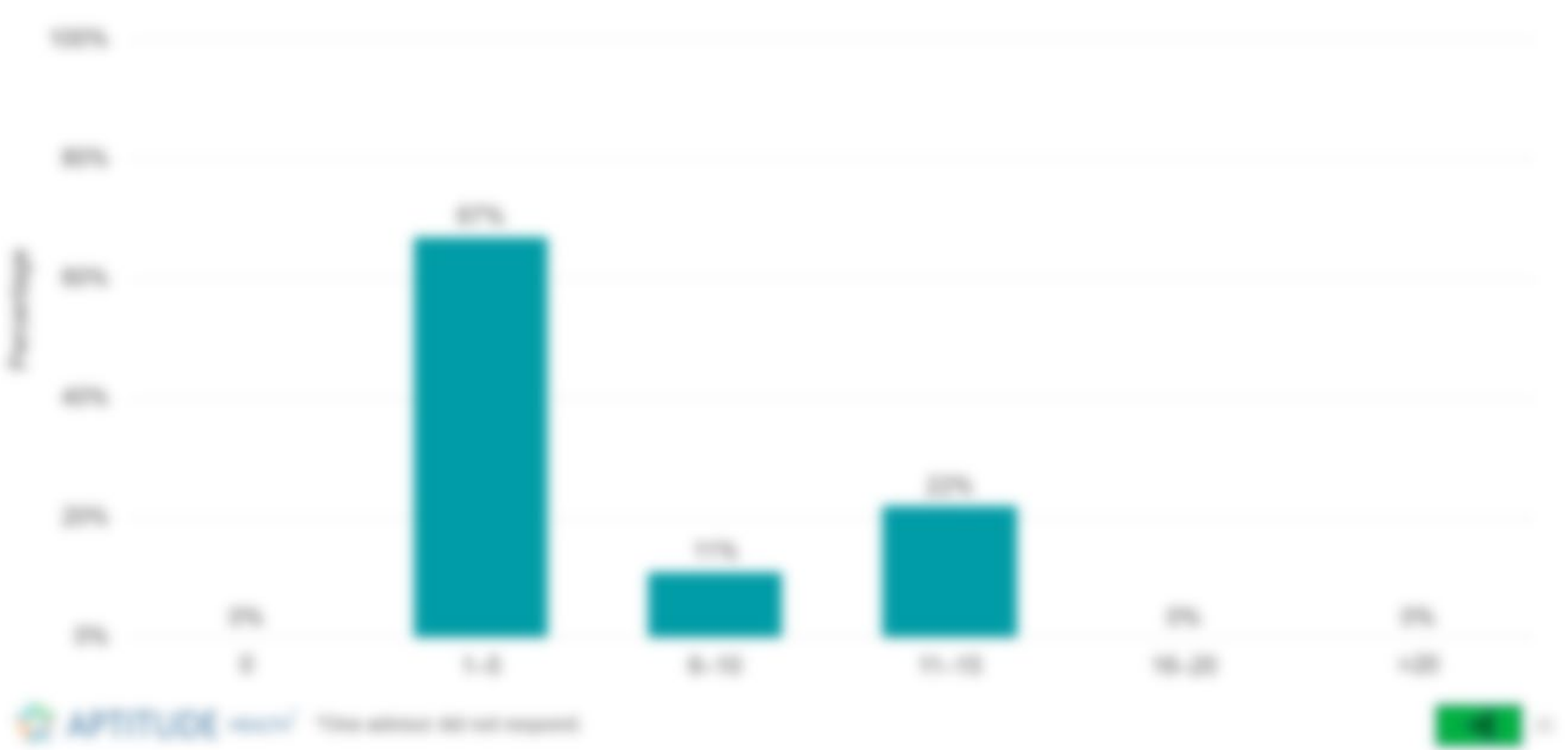
CASE 1 (HER2+ ABC) CONT.

CASES

- Following 6 cycles of taxane plus trastuzumab plus pertuzumab for her de novo

64% OF ADVISORS WOULD USE T-DM1 FOR 2L HR+/HER2+ mBC

CASES



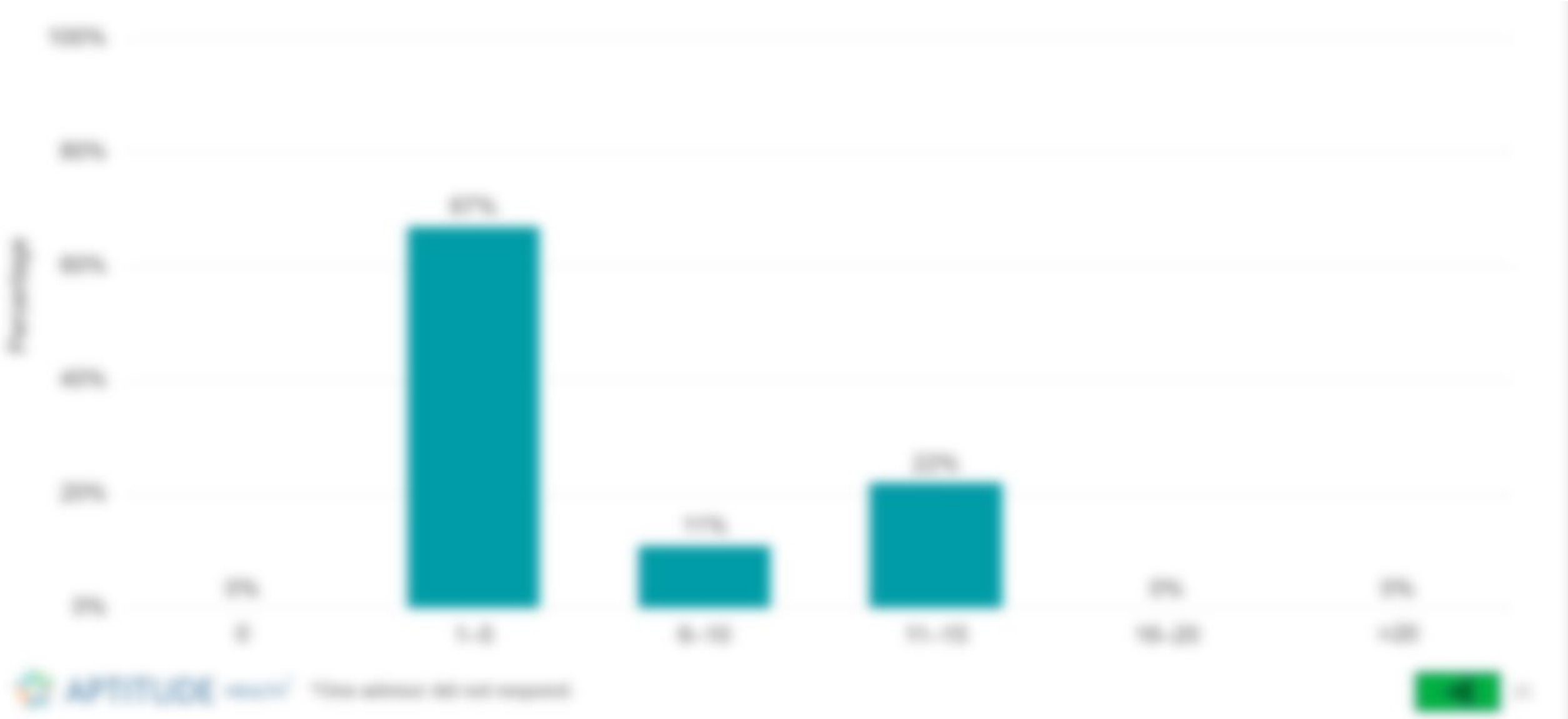
CASE 1 (HER2+ ABC) CONT.

CASES

- She receives treatment with T-DM1 followed at disease progression with

64% OF ADVISORS WOULD SELECT T-DXd FOR HR+/HER2+ mBC WITH MILDLY SYMPTOMATIC LIVER METS AFTER PROGRESSION ON T-DM1 AND TRASTUZUMAB-CAPECITABINE

CASES



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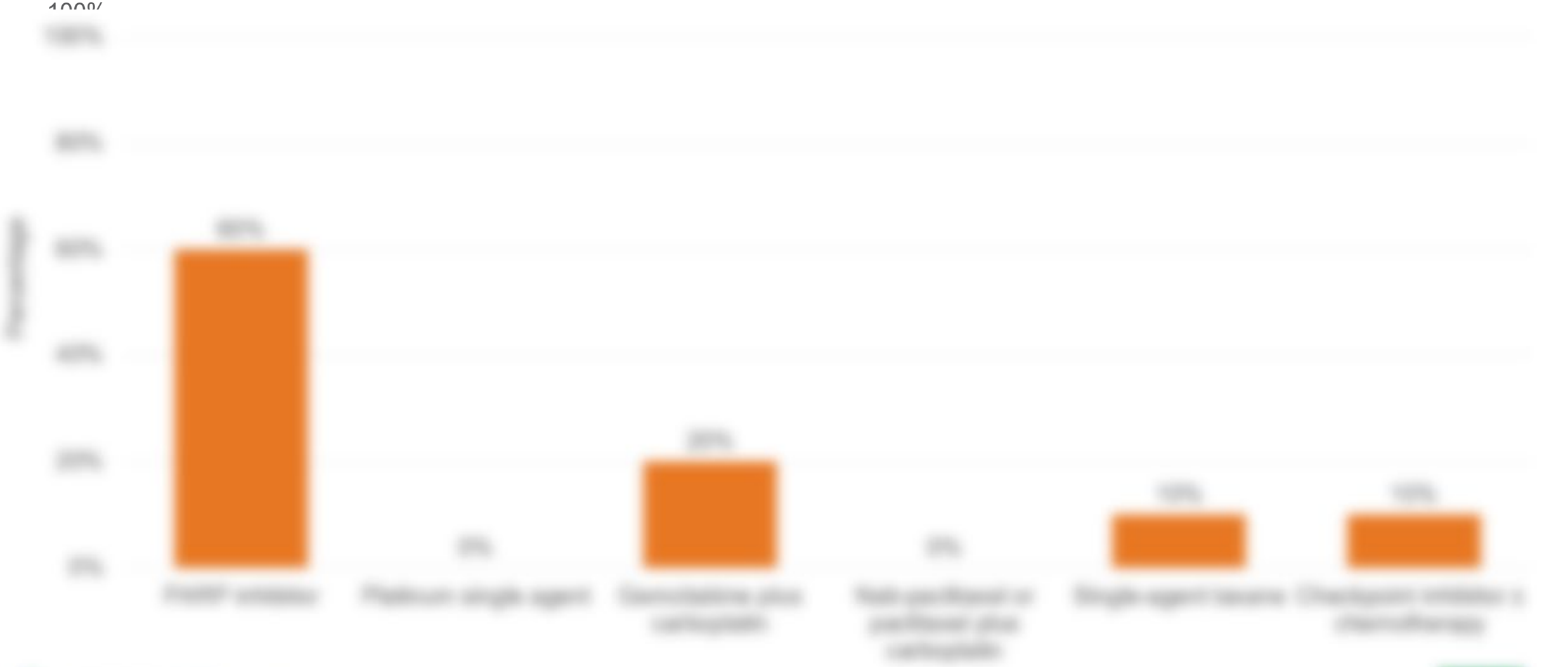
Treatment of mTNBC

ARS RESULTS

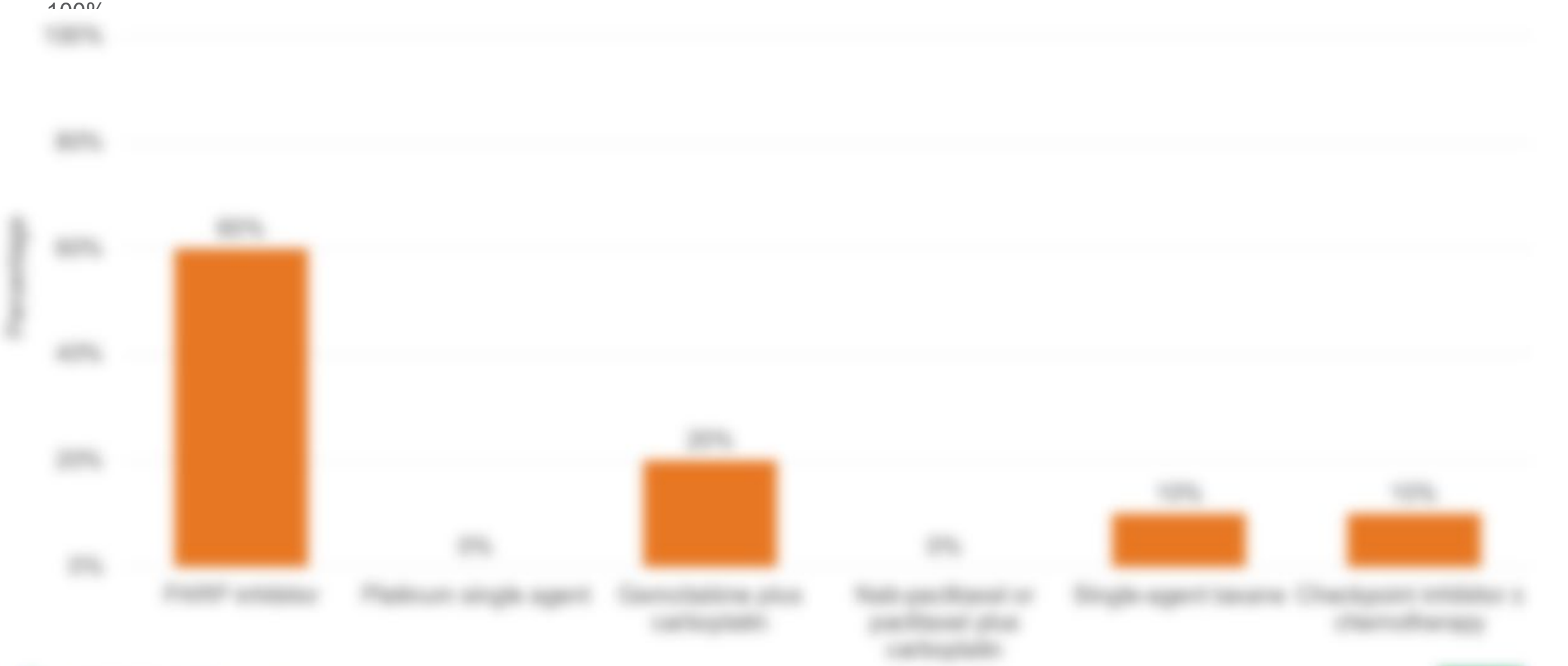
MOST ADVISORS HAD USED A PARP INHIBITOR IN ≤5 PATIENTS IN THE PAST YEAR

CASES



MOST ADVISORS WOULD USE AN IMMUNE CHECKPOINT INHIBITOR PRIOR TO CHEMOTHERAPY OR A PARP INHIBITOR

CASES



CASE 1 (TNBC)

CASES

- A 51-vear-old woman with no familv historv of breast cancer who had mastectomv

MOST ADVISORS PERFORM MULTIGENE GERMLINE PANEL TESTING IN PATIENTS WITH RECURRENT TNBC

CASES

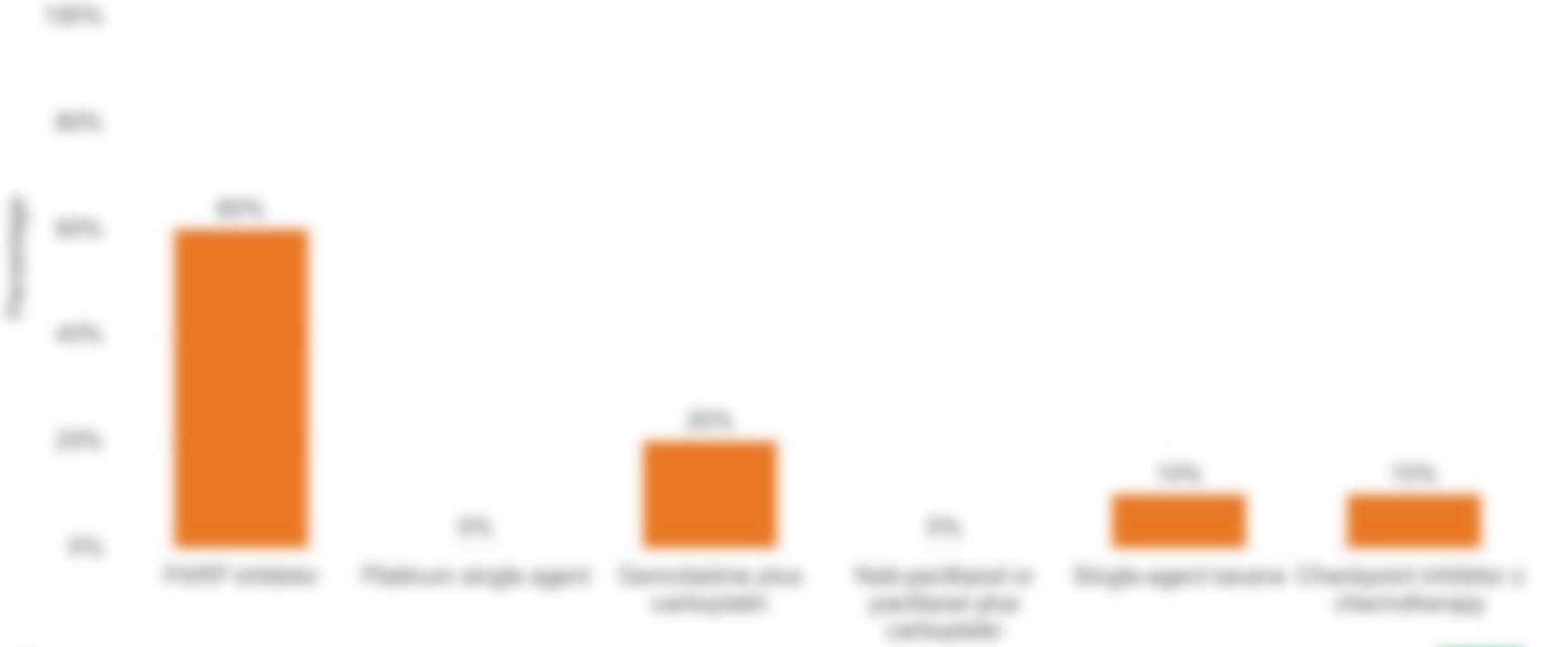
CASE 1 (TNBC) CONT.

CASES

- Situation A: She is found to have a deleterious *BRCA1* mutation

ONLY 46% OF ADVISORS WOULD USE A PARP INHIBITOR IN A PATIENT WITH RECURRENT m*BRCA1* TNBC, AND 30% WOULD USE A PT

CASES



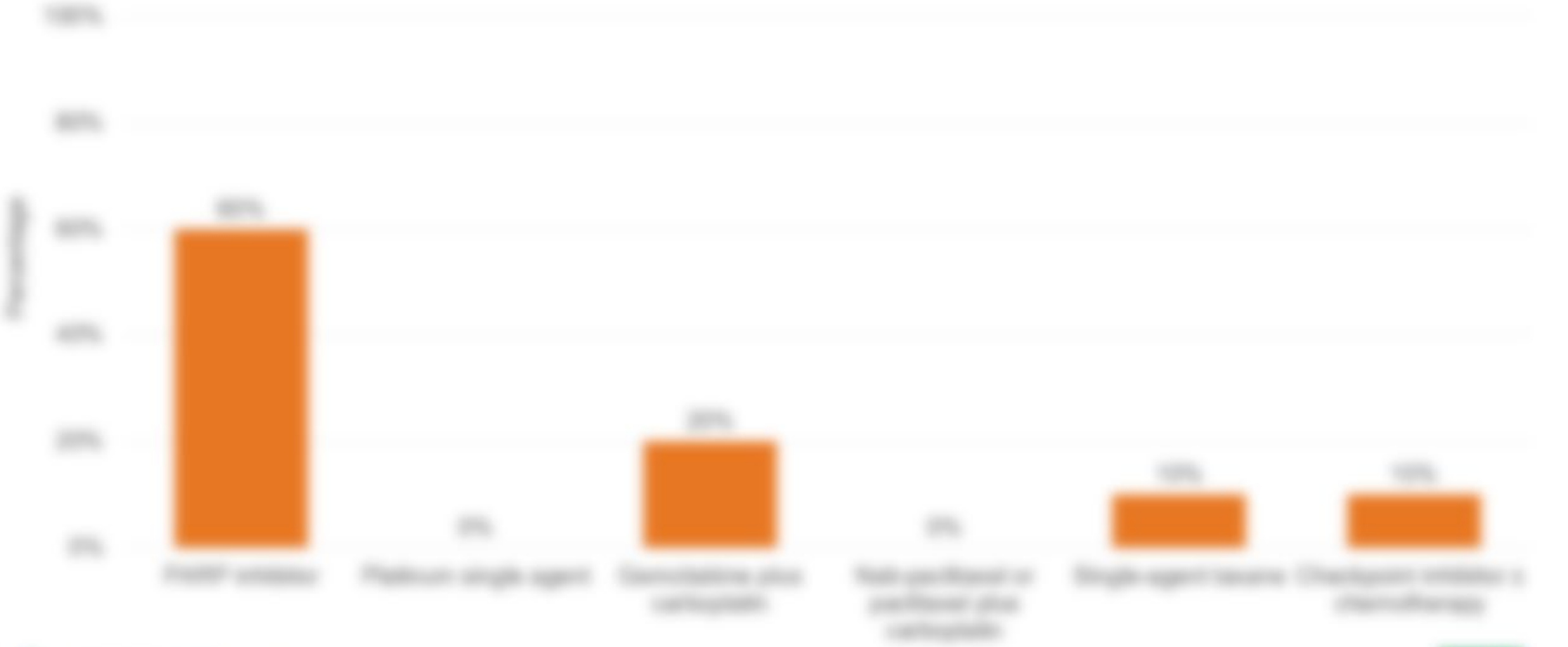
CASE 1 (TNBC) CONT.

CASES

- Situation B: She is found to NOT have a deleterious *BRCA1* mutation

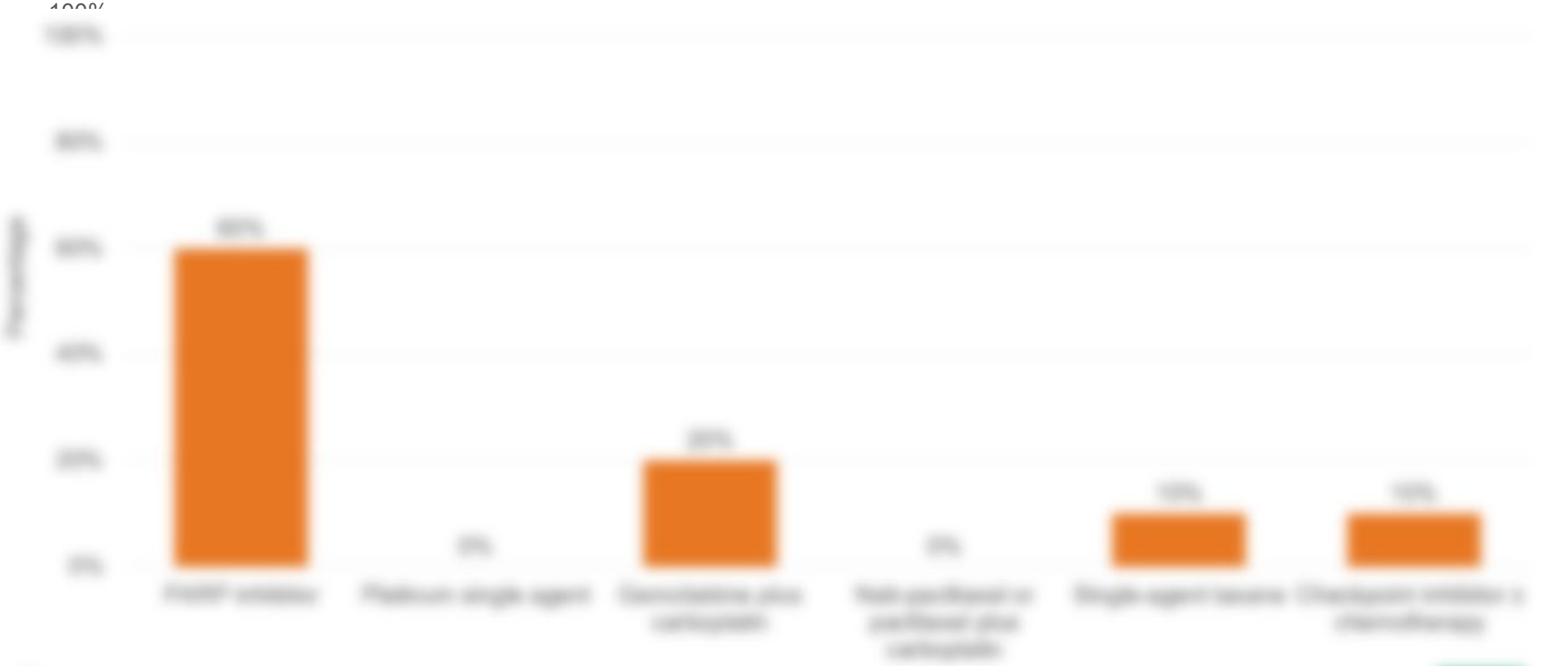
IN THE ABSENCE OF A DELETERIOUS GERMLINE *BRCA1* MUTATION, MOST ADVISORS WOULD USE AN IMMUNE CHECKPOINT INHIBITOR + CHEMOTHERAPY

CASES



MOST ADVISORS WOULD PERFORM GERMLINE MUTATION TESTING IN ER+/HER2– mBC PATIENTS <50 YEARS OLD

CASES



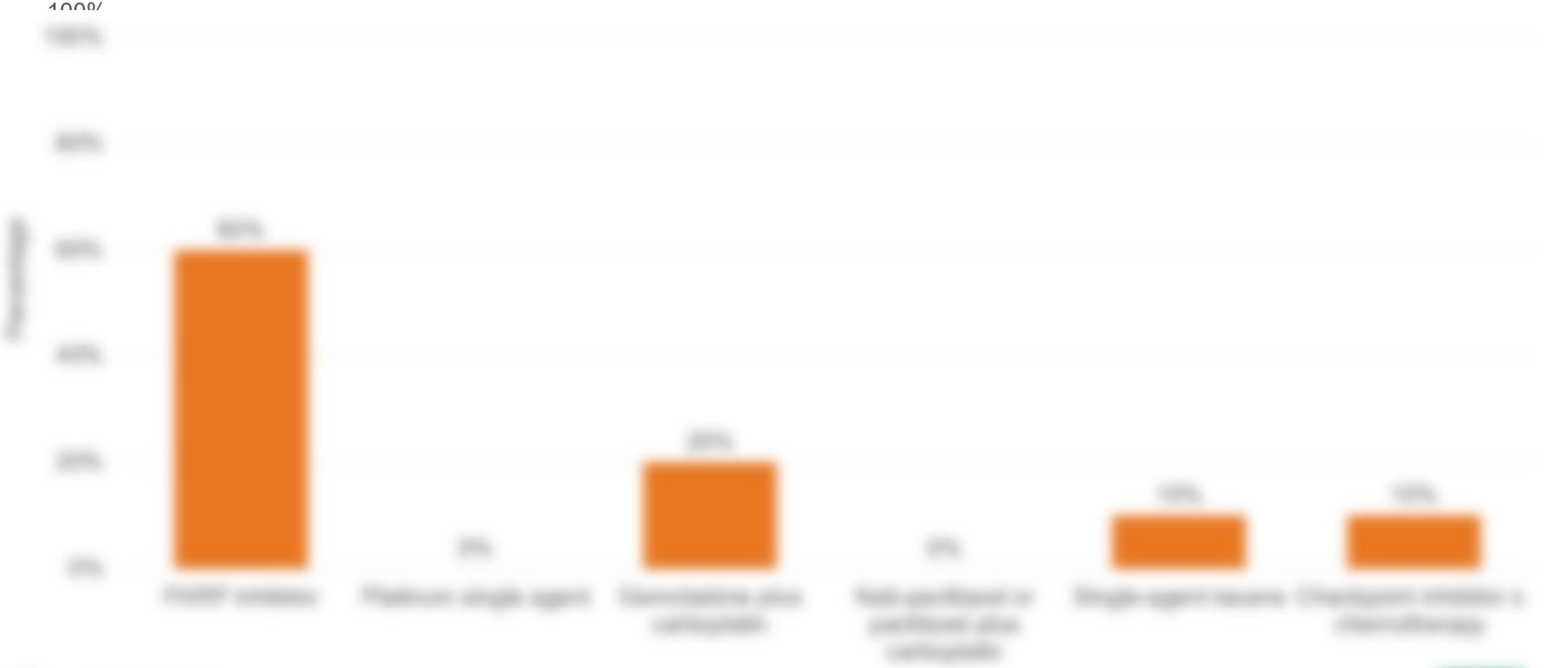
CASE 2 (TNBC)

CASES

- A 75-year-old woman presents with biopsy-proven metastatic blastic bone and LN-

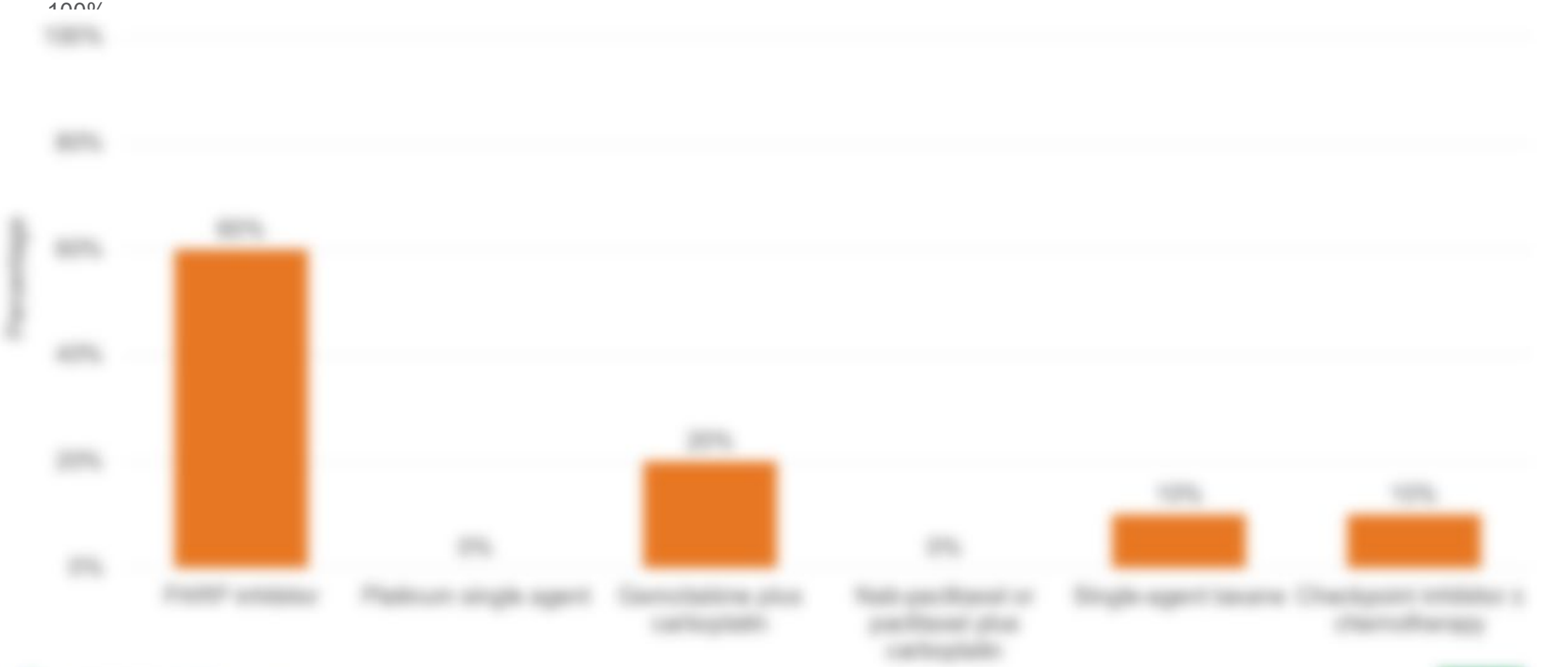
MOST ADVISORS DO NOT ORDER AR IHC FOR TNBC

CASES



MOST ADVISORS WOULD USE ANDROGEN BLOCKADE FOR TNBC WITH HIGH AR EXPRESSION

CASES



CASE 3 (TNBC)

CASES

- A 39-vear-old woman with T2N1 TNBC underwent bilateral mastectomv then dose-

IN A CHEMOTHERAPY-TREATED PATIENT WITH ASYMPTOMATIC LIVER METS FROM TNBC, MOST ADVISORS WOULD USE A PD-(L)1 INHIBITOR PLUS CHEMOTHERAPY

CASES