



CASES

INSIGHTS INTO PROSTATE CANCER

Saturday, March 27, 2021

Community Insights From Puerto Rico

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STUDY OBJECTIVES

- > To gain advisors' perspectives on current treatment practices and management of patients with nmCRPC and mCSPC

REPORT SNAPSHOT: SESSION OVERVIEW



A moderated roundtable discussion with community oncologists and urologists in Puerto Rico was held virtually on **March 27, 2021**

Disease state and data presentations were led by **Dr Jorge A. Garcia** from University Hospitals Seidman Cancer Center, Cleveland, USA, and discussions were moderated by **Dr Freddy Mendez** from Puerto Rico

Insights were obtained on current treatment practices and management of patients with nmCRPC and mCSPC 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 11 community urologists and oncologists from Puerto Rico
 - Attendees of the roundtable represented community oncologists and urologists* from Ponce, San Juan, Caguas, Toa Baja, and Fajardo

| Institution | City | Country |
|---|----------|---------|
| VA Hospital-San Juan Vet Center | San Juan | PR |
| Advanced Hematology Oncology Group of Puerto Rico | San Juan | PR |
| Centro de Hematología y Oncología Médica Integral | San Juan | PR |
| Centro de Medicina Oncologica de Puerto Rico | San Juan | PR |
| University of Puerto Rico, Humacao Campus | Ponce | PR |

*Three advisors came from their own private practice.

REPORT SNAPSHOT: AGENDA



| Time (EST) | Topic |
|---------------------|--|
| 8.00 AM – 8.15 AM | Introduction and ARS Questions <ul style="list-style-type: none">• Program overview• ARS questions |
| 8.15 AM – 8.45 AM | Management of Nonmetastatic Castration-Resistant Prostate Cancer (nmCRPC) Overview of current data <ul style="list-style-type: none">• When and how to screen?<ul style="list-style-type: none">– Role of imaging and PSA monitoring• Role of genetic testing on patient management and therapy choice• When and how to treat? Optimal integration of androgen receptor inhibitors<ul style="list-style-type: none">– Apalutamide– Darolutamide– Enzalutamide |
| 8.45 AM – 9.25 AM | Moderated Discussion |
| 9.25 AM – 9.35 AM | Break |
| 9.35 AM – 10.05 AM | Management of Metastatic Castration-Sensitive Prostate Cancer (mCSPC) <ul style="list-style-type: none">• ARS questions• Overview of current data<ul style="list-style-type: none">– Androgen deprivation therapy (ADT)<ul style="list-style-type: none">• Optimal treatment regimen and monitoring• Optimal combination therapy with ADT (<i>What, when, and how to use?</i>)<ul style="list-style-type: none">– Docetaxel– Abiraterone– Second-generation antiandrogens<ul style="list-style-type: none">• Apalutamide• Enzalutamide |
| 10.05 AM – 10.45 AM | Moderated Discussion |
| 10.45 AM – 11.00 AM | Key Takeaways and Meeting Evaluation |



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Topline Takeaways and Strategic Recommendations

MEETING OBJECTIVES WERE ACHIEVED: TOPLINE TAKEAWAYS



OBJECTIVES

PROCESS

INSIGHTS

- Understand patient experience for stroke care and address using a new approach to training for LACS.
- Gain insight on how patient address different address concerns and community needs.
- Address the perception of addressing in the LACS setting compared with other therapeutic approaches (LACS T therapy and telemedicine), including therapy delivery and monitoring.

Through LACS sessions and community discussions, community members shared their testing processes and challenges they experience.

- Addressers are open to trying new approaches, primarily with good feedback and in training, with some open to adopting new things with good feedback (e.g. LACS T or LACS T therapy).
- Addressers in community practice typically have some, but not all, resources (e.g. telemedicine, LACS T, telemedicine, LACS T, telemedicine, LACS T, telemedicine).
- All addressers generally have positive experiences with telemedicine in terms of efficacy and usability. However, some currently use it only as a bridge to LACS T, and some are looking for LACS T. All addressers are excited about supporting therapy.



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Key Insights and Discussion Summary

How and when is mCRP assessed by community urologists and does it impact use of abiraterone in the prostate setting?

mCRP is mainly assessed at complete response (CR) by either molecular PCR, mCRP or multiplex flow. Abiraterone is used to treat mCRP+ patients in the prostate by about half of the urologists (50%).

- mCRP is assessed at CR by half of urologists (50%). The other reports assess mCRP at CR and 3 months from induction, and every 3 months thereafter (25%). Only a few reports (10%) assess mCRP monthly.
 - The most common approach is performed either by the pathologists in the hospital setting, or by the urologist themselves, depending on the hospital.
 - Most of the urologists were aware of the importance of sending the first sample of home response approach for mCRP assessment.
- mCRP assessment methods mostly used by the urologists are molecular PCR (20%) and mCRP (20%). The multiplex flow is used by 20% of urologists.
 - Although mCRP is considered more precise in detecting mCRP when compared with PCR, its use is limited by the cost, which is considered still too expensive by most urologists.
- Generally, when patients are mCRP+ following induction, the induction therapy is extended, followed by abiraterone.
 - However, at least 3 urologists are using abiraterone to reduce mCRP negatively after induction in patients or after completion of abiraterone. The remaining urologists would refer their patients to hospital departments.

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- mCRP is assessed at CR by half of urologists (12%). The other reports assess mCRP at CR and 3 months from induction, and every 3 months thereafter (12%). Only a few reports (17%) assess mCRP monthly.
 - The most common approach is performed either by the pathologists in the transplant centers, or by the urologists themselves, depending on the hospital.
 - Most of the urologists were aware of the importance of sending the first sample of urine response samples for mCRP assessment.
- mCRP assessment methods mostly used by the urologists are molecular PCR (12%) and mCRP (12%). The multiplex flow is used by 20% of urologists.
 - Although mCRP is considered more precise in detecting mCRP when compared with PCR, its use is limited by the cost, which is considered still too expensive by most urologists.
- Generally, when patients are mCRP+ following induction, the induction therapy is extended, followed by abiraterone.
 - However, at least 3 urologists are using abiraterone to reduce mCRP negatively after induction in patients or after consolidation of patients. The remaining urologists would refer their patients to transplant departments.

INSIGHTS

[Monitoring] “. . . Every 3 months, and depending on the response I may adjust the times.”

1. Treatment success in prostate (PSA),

The overall survival that's been seen with this is not necessarily disease-free survival. It's overall survival. So we need overall survival. I would not use a treatment approach with that using AR or ARN, and I would not start the disease-free rate at 1 year. I believe as time goes on, there is a significant benefit with the treatment, and overall being that something is measurable.

2. Data needed to confirm from PSA in prostate

That's all a lot of things have been that, getting a better than 100% and that's, it's really hard with that 100% number for the patients. I would not use ARN. I would not be one of the first ones to move toward ARN or anything like that. I want something that's been seen and that we know that we can do.

If the benefits are not very obvious, there is a benefit with ARN or better would be something that I would be looking at.

Overall survival data, that's what we're looking at. ARN is a benefit coming to us, so we have to use some surrogate of efficacy. So, I do think that's a lot of things that we need to see. I think what's going to start driving the use of ARN. ARN is not sufficient.

How and when is mCSPC assessed by community oncologists and does it impact use of abiraterone in the frontline setting?

mCSPC is mainly assessed at complete response (CR) by either radiologic (CR), mCSPC or radiologic free. Abiraterone is used to treat mCSPC patients in the frontline by about half of the addressers (CR).

- mCSPC is assessed at CR by half of addressers (CR). The other reports assess mCSPC at CR and 3 months from induction, and every 3 months thereafter (CR). Only a few reports (17%) assess mCSPC monthly. 
 - The most common approach is performed either by the pathologists in the management centers, or by the addressers themselves, depending on the hospital.
 - Most of the addressers were aware of the importance of sending the first sample of tumor response samples for mCSPC assessment.
- mCSPC assessment methods mainly used by the addressers are radiologic (CR) (CR) and mCSPC (CR). The radiologic free is used by 20% of addressers. 
 - Although mCSPC is considered more precise in selecting mCSPC when compared with CR, its use is limited by the cost, which is considered not too expensive by most addressers.
- Generally, when patients are mCSPC following induction, the induction therapy is extended, followed by consolidation.
 - However, at least 3 addressers are using abiraterone to reduce mCSPC regularly after induction in addressers or after consolidation of addressers. The remaining addressers would refer their patients to management departments.

How and when is mCSPC assessed by community oncologists and does it impact use of abiraterone in the frontline setting?

mCSPC is mainly assessed at complete response (CR) by either radiologic (73%), mCSPC or radiologic free. Abiraterone is used to treat mCSPC patients in the frontline by about half of the addressors (50%).

- mCSPC is assessed at CR by half of addressors (50%). The other reports assess mCSPC at CR and 2 months from induction, and every 2 months thereafter (25%). Only a few reports (17%) assess mCSPC monthly.
 - The most common approach is performed either by the pathologist in the hospital setting, or by the addressor themselves, depending on the hospital.
 - Most of the addressors were aware of the importance of sending the first sample of tumor response samples for mCSPC assessment.
- mCSPC assessment methods mostly used by the addressors are radiologic (73%) and mCSPC (25%). The radiologic free is used by 25% of addressors.
 - Although mCSPC is considered more precise in selecting mCSPC when compared with FCR, its use is limited by the cost, which is considered still too expensive by most addressors.
- Generally, when patients are mCSPC following induction, the induction therapy is extended, followed by consolidation.
 - However, at least 3 addressors are using abiraterone to reduce mCSPC regardless of whether it is assessed or after consolidation of addressors. The remaining addressors would refer their patients to hospital departments.

How and when is mCSPC assessed by community oncologists and does it impact use of abiraterone in the frontline setting?

mCSPC is mainly assessed at complete response (CR) by either radiologic (73%), mCSPC or radiologic free. Abiraterone is used to treat mCSPC patients in the frontline by about half of the addressors (50%).

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 - The most common approach is performed either by the pathologists in the management centers, or by the addressors themselves, depending on the hospital.
 - Most of the addressors were aware of the importance of sending the first sample of tumor response samples for mCSPC assessment.
- mCSPC assessment methods mostly used by the addressors are radiologic (73%) and mCSPC (20%). The radiologic free is used by 20% of addressors.
 - Although mCSPC is considered more precise in selecting mCSPC when compared with rFSR, its use is limited by the cost, which is considered still too expensive by most addressors.
- Generally, when patients are mCSPC following induction, the induction therapy is extended, followed by consolidation.
 - However, at least 3 addressors are using abiraterone to reduce mCSPC regardless of whether it is assessed or after consolidation of addressors. The remaining addressors would refer their patients to management departments.



Advisor Key Takeaways

ADVISOR KEY TAKEAWAYS*



ADVISOR

> It was good to hear that the way we are practicing is within

- There is a better understanding of sequencing therapy
- I really enjoyed the webinar with professional and educational but not I have a better understanding of these drugs and have a better idea of when to use them in my practice

- There is a better understanding of some of my other options
- It's particularly interesting in the educational and how that will and then would be interested in a second line option for my own office practice
- There is a lot more information for treatment therapy and to things the professional that they offer with the office

- It was good to hear about considerations and clearly coming from the practice for immunomodulators

- There is a lot of good options for second line that just ICD 1 and management with second line other profile and good response rate
- Appreciating it all

ADVISOR

> I found the comparisons between different studies very interesting. also the different patient profiles included in

- The immunomodulators, adding the need to have different options besides ICD 1 and with or going to ICD 1

- The finding that some of these immunomodulators agents will get added into practice and hopefully improve the outcomes

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

- Not too much in the standard

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ARS Data – Introductory ARS Questions

PARTICIPANT DEMOGRAPHICS

The majority of advisors see between 50 and 150 patients each week

Every month, 11%–20% of the advisors' patients seen have prostate cancer

FOR EXAMPLE PURPOSES ONLY

ALMOST ALL THE ADVISORS' PATIENT POPULATIONS COMPRISE 1%–20% OF PATIENTS WITH nmCRPC SEEN EACH MONTH



FOR EXAMPLE PURPOSES ONLY

ALMOST TWO-THIRDS OF ADVISORS DO NOT REFER THEIR nmCRPC PATIENTS FOR GENETIC TESTING

FOR EXAMPLE PURPOSES ONLY

ALMOST HALF OF THE ADVISORS CONSIDER RISE IN PSA THE MOST IMPORTANT FACTOR TO CHANGE TREATMENT IN nmCRPC PATIENTS

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.

IN nmCRPC PATIENTS WITH A PSADT <6 MONTHS, ALMOST HALF OF THE ADVISORS WOULD ADD A SECOND-GENERATION ANTIANDROGEN TO ADT

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.

ALMOST ALL THE ADVISORS BELIEVE SECOND-GENERATION ANTIANDROGENS IMPROVE MFS, OS, AND QOL



FOR EXAMPLE PURPOSES ONLY

THE MAJORITY OF THE ADVISORS THINK ALL 3 SECOND-GENERATION ANTIANDROGENS HAVE EQUAL ACTIVITY IN nmCRPC

FOR EXAMPLE PURPOSES ONLY

*Three advisors did not respond.

> A 60-year-old man was previously diagnosed with grade 3 localized prostate

...

THE MAJORITY OF THE ADVISORS WOULD RECOMMEND ADT + APALUTAMIDE FOR THIS PATIENT

FOR EXAMPLE PURPOSES ONLY

> A second-generation antiandrogen was added, and the patient was stable for 40

• [Blurred text]

ALMOST ALL THE ADVISORS WOULD RECOMMEND A BONE SCAN AT THIS POINT

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



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ARS Data – Management of
mCSPC

FOR THE MAJORITY OF ADVISORS, 1%–10% OF THEIR PATIENTS SEEN EACH MONTH HAVE mCSPC

FOR EXAMPLE PURPOSES ONLY

THE MAJORITY OF ADVISORS HAVE TREATED BETWEEN 1–5 PATIENTS WITH ENZALUTAMIDE IN THE LAST 3 MONTHS



FOR EXAMPLE PURPOSES ONLY

THE MAJORITY OF ADVISORS HAVE TREATED BETWEEN 1–10 PATIENTS WITH APALUTAMIDE IN THE LAST 3 MONTHS



FOR EXAMPLE PURPOSES ONLY

ALMOST HALF OF THE ADVISORS ARE VERY OR SOMEWHAT UNFAMILIAR WITH THE DATA FROM THE TITAN TRIAL

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.

THE MAJORITY OF ADVISORS ARE VERY OR SOMEWHAT UNFAMILIAR WITH THE DATA FROM THE ENZAMET TRIAL

FOR EXAMPLE PURPOSES ONLY

ALL THE ADVISORS ARE VERY OR SOMEWHAT UNFAMILIAR WITH THE DATA FROM THE ARCHES TRIAL

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.

ONE-THIRD OF THE ADVISORS THINK THAT ALL 3 DRUGS ARE EQUALLY TOLERATED

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.

> Patient case: mCSPC

Mr. Jones, 65-year-old male, presents with a 3-month history of weight loss, fatigue, and back pain. He has a 20-pack-year smoking history and a history of hypertension. Physical examination is unremarkable. Laboratory studies show hemoglobin 10 g/dL, hematocrit 30%, and ferritin 100 ng/mL. Imaging shows a lytic lesion in the T12 vertebral body. Biopsy of the lesion shows metastatic adenocarcinoma. Immunohistochemistry is positive for CK7, CK20, and CD56. The patient is started on docetaxel and prednisone.

- Bone metastases: lytic lesions, T12 vertebral body metastasis with compression and fracture. No other metastatic abnormalities seen. PSA 12 ng/mL.

TWO-THIRDS OF ADVISORS WOULD RECOMMEND ADT + AN ANTIANDROGEN FOR THIS PATIENT

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.