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INSIGHTS INTO PROSTATE CANCER

Saturday, March 27, 2021

Community Insights From Puerto Rico

HOW TO NAVIGATE THIS REPORT

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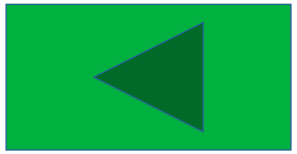
Click to move to topic of interest or ARS supporting data



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REPORT OBJECTIVES

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

REPORT SNAPSHOT: SESSION OVERVIEW

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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

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- 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 • Program overview • ARS questions
8.15 AM – 8.45 AM	**Management of Nonmetastatic Castration-Resistant Prostate Cancer (nmCRPC)** Overview of current data • When and how to screen? – 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 – 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)** • ARS questions • Overview of current data – Androgen deprivation therapy (ADT) • Optimal treatment regimen and monitoring • Optimal combination therapy with ADT (*What, when, and how to use?)* – Docetaxel – Abiraterone – Second-generation antiandrogens • 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

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OBJECTIVES	PROCESS	INSIGHTS
• 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

KEY INSIGHTS: MANAGEMENT OF nmCRPC

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

MRD is mainly assessed at complete response (CR) by either molecular PCR, NGS or multicolor flow. Blinatumomab is used to treat MRD+ patients in the frontline by about half of the advisors (1/2)

- MRD is assessed at CR by half of advisors (50%). The other experts assess MRD at CR and 3 months from induction, and every 3 months thereafter (38%). Only a few experts (13%) assess MRD monthly.
  - The bone marrow aspirate is performed either by the pathologists in the transplant centers, or by the advisors themselves, depending on the hospital.
  - None of the advisors were aware of the importance of sending the first sample of bone marrow aspirate for MRD assessment.
- MRD assessment methods mostly used by the advisors are molecular PCR (38%) and NGS (38%). The multicolor flow is used by 25% of advisors.
  - Although NGS is considered more precise in detecting MRD when compared with PCR, its use is limited by the cost, which is considered still too expensive by most advisors.
- Generally, when patients are MRD+ following induction, the induction therapy is extended, followed by consolidation.
  - However, at least 1 advisors are using blinatumomab to induce MRD negativity after induction (1 advisor) or after consolidation (2 advisors). The remaining advisors would refer their patients to transplant departments.

KEY INSIGHTS: MANAGEMENT OF nmCRPC

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DISCUSSION: MANAGEMENT OF nmCRPC

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INSIGHTS

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

- [illegible]

[illegible]

- [illegible]

[illegible]

KEY INSIGHTS: MANAGEMENT OF mCSPC

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KEY INSIGHTS: MANAGEMENT OF mCSPC

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DISCUSSION: MANAGEMENT OF mCSPC

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INSIGHTS

Definition and monitoring

[Defining mCSPC] ". . . We use bone scan."

- [illegible]

"[illegible] overall survival, that's what we need. This is not metastatic disease, this is curable disease, so we need overall survival."

"[illegible] cure without any significant long-term toxicity. I think when I define success, I would rather use a landmark endpoint rather than using OS or PFS, and I would say what's the disease-free rate at 2 years. I definitely do think OS is important if there is significant toxicity with the treatment, and people dying from competing comorbidities."

- [illegible]

"First of all, a lot of things have been tried, nothing is better than R-CHOP, and frankly, I'm pretty happy with how R-CHOP performs for my patients."

"I would be a late adopter. I would not be one of the first ones to move based on PFS or anything like that. I want something that's tried and true and we know how well it works."

"If the toxicities are not very severe, I think a hazard ratio of 0.85 or better would be something that I would be looking at."

"Overall survival data, that's ideal, but in this disease state OS is hard to come by, so you do have to use some surrogates of efficacy. So, I do think that a 2- or 3-year event-free survival kind of story is likely what's going to start driving my use of any regimen. PFS is not sufficient."

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Advisor Key Takeaways

ADVISOR KEY TAKEAWAYS*

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ADVISOR	
> It was good to hear that the way we are practicing is within	> I found the comparisons between different studies very interesting, also the different patient profiles included in
1	5
2	6
3	7
4	8

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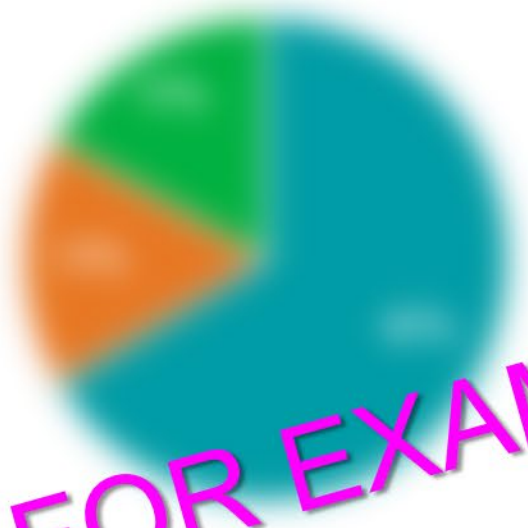
ARS Data – Introductory ARS Questions

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



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

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*Two advisors did not respond.

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

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*Three advisors did not respond.

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

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*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

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*Two advisors did not respond.

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

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*Two advisors did not respond.

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

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*Three advisors did not respond.

PATIENT CASE

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- 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

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*Three advisors did not respond.

PATIENT CASE (CONT.)

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

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

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*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

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FOR EXAMPLE PURPOSES ONLY

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

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*One advisor did not respond.

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

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*One advisor did not respond.

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

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FOR EXAMPLE PURPOSES ONLY

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*Two advisors did not respond.

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

CASES

FOR EXAMPLE PURPOSES ONLY

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

CASES

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.

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

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*Two advisors did not respond.

PATIENT CASE

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- Patient case: mCSPC

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

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*Two advisors did not respond.