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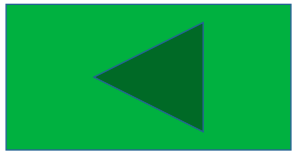
INSIGHTS INTO LUNG CANCER

Thursday, June 24, 2021

Virtual Program – Southeast

HOW TO NAVIGATE THIS REPORT

Click to move to topic of interest or ARS supporting data



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REPORT SNAPSHOT: SESSION OVERVIEW

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A moderated roundtable discussion with community oncologists from the Southeast region of the United States was held virtually on **June 24, 2021**

Disease state and data presentations were led by **Dr Stephen Liu** from Georgetown University and **Dr Keren Sturtz** from the SCL Health Medical Group, in conjunction with content developed by the Aptitude Health clinical team

Insights on the management of ***RET* rearrangement-positive NSCLC** and **current use of treatment options in the community** 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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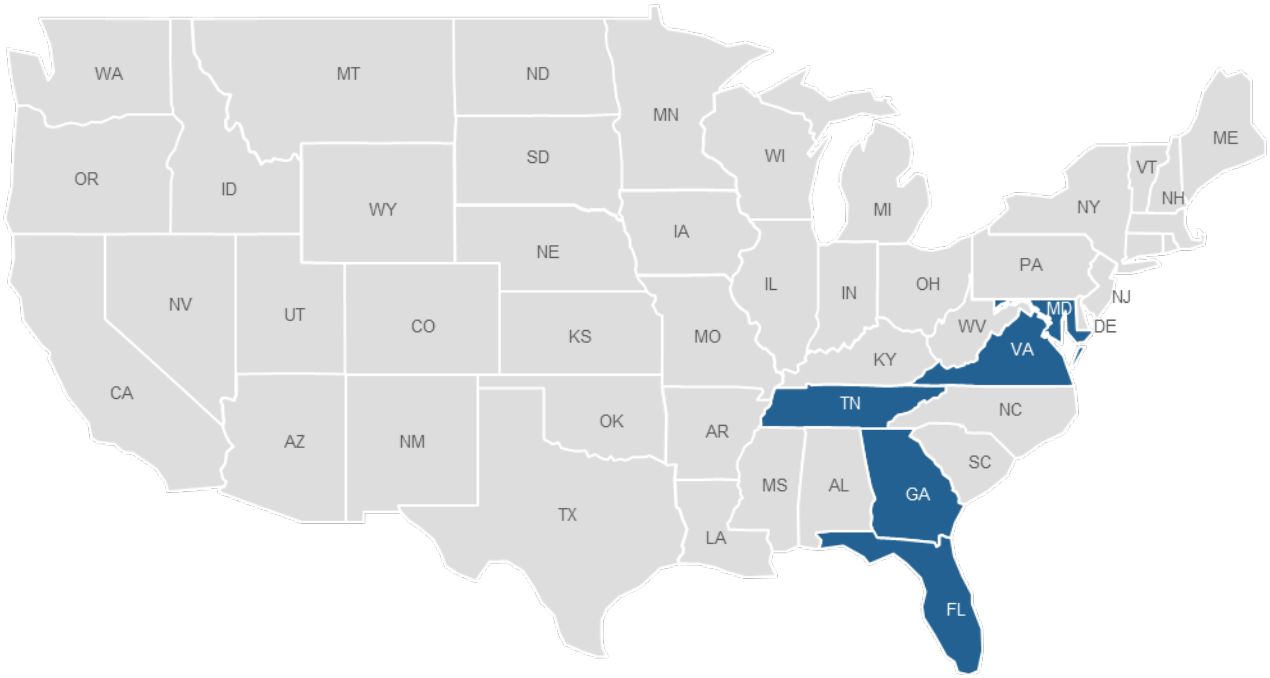
- The group of advisors comprised 10 community oncologists from the Southeastern United States
  - Attendees of the roundtable represented community oncologists from Florida, Georgia, Maryland, Tennessee, and Virginia

INSTITUTION	CITY	STATE
Florida Cancer Specialists	New Port Richey	FL
Hematology Oncology Associates of the Treasure Coast	Port St. Lucie	FL
Sylvester Comprehensive Cancer Center	Fort Lauderdale	FL
Harbin Clinic	Rome	GA
Northwest Georgia Oncology	Marietta	GA
The Southeast Permanente Medical Group	Atlanta	GA
Chesapeake Oncology Hematology Associates	Annapolis	MD
Greater Washington Oncology Associates	Silver Spring	MD
West Cancer Center	Memphis	TN
Virginia Cancer Institute	Mechanicsville	VA



PARTICIPANT DEMOGRAPHICS

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Approximately how many patients with *RET* fusion-

Approximately how many patients with PD-L1–positive

*One advisor did not respond.

REPORT SNAPSHOT: AGENDA

Time (EST)	Topic
6.00 PM – 6.15 PM	Introduction and ARS Questions • Program overview • ARS questions
6.15 PM – 7.25 PM	Treatment of *RET* Rearrangement-Positive Advanced NSCLC • Overview of current data • Reaction and discussion
7.25 PM – 7.35 PM	*Break*
7.35 PM – 8.45 PM	Treatment of PD-L1 Expression-Positive Advanced NSCLC • ARS questions • Overview of current data • Reaction and discussion
8.45 PM – 9.00 PM	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
• 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 R/R 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 ORR • 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: BIOMARKER TESTING IN ADVANCED NSCLC

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REPORT OBJECTIVE

> Determine the role of biomarker testing in NSCLC

DISCUSSION: *RET*-POSITIVE ADVANCED NSCLC

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INSIGHTS

"I test everybody that I can possibly test."

- Treatment success in frontline OLIGO

- Data needed to switch from SOC in frontline

DISCUSSION: PD-L1–POSITIVE ADVANCED NSCLC

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INSIGHTS

"Everybody seems to get hypothyroid. I've had 2 get hyperthyroid in a month's time. Although I do like the PD-L1

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Advisor Key Takeaways

ADVISOR KEY TAKEAWAYS (1/2)

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ADVISOR		ADVISOR	
1	> 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	> I would definitely use a RET drug first, then > For relapsed/refractory patients it's nice to have different options besides R-CE 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)

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ADVISOR		ADVISOR	
1	> I did learn more about the RET fusion drugs and I > 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	> I think it's time to move to next gen sequencing rather > 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

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ARS Data

MOST ADVISORS (89%) REPORTED THAT >3/4 OF THEIR PATIENTS WITH mNSCLC RECEIVE BIOMARKER TESTING

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*One advisor did not respond.

NEW PATIENTS WITH mNSCLC TYPICALLY DO NOT ALREADY HAVE BIOMARKER TEST RESULTS AT FIRST VISIT

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*One advisor did not respond.

BIOMARKER TEST RESULTS ARE UNLIKELY FOR FIRST-LINE PATIENTS WITH mNSCLC

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*One advisor did not respond.

ABOUT 1/3 OF ADVISORS WORK WITH A PATHOLOGIST FOR BIOMARKER TESTING

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*One advisor did not respond.

MOST PATIENTS UNDERGO TISSUE; REFLEX TO LIQUID BIOPSY FOR BIOMARKER TESTING

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*One advisor did not respond.

IN PATIENTS WITH INSUFFICIENT TISSUE, MOST ADVISORS WOULD RECOMMEND LIQUID BIOPSY

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*One advisor did not respond.

ALL BUT 1 ADVISOR SAID THEY WOULD WAIT FOR BIOMARKER TEST RESULTS BEFORE MAKING TREATMENT DECISIONS IN mNSCLC

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*One advisor did not respond.

MOST ADVISORS RECOMMEND LIQUID BIOPSY IF BIOMARKER RESULTS ARE QNS

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*One advisor did not respond.

THE MAIN CHALLENGES TO BIOMARKER TESTING ARE INSUFFICIENT TISSUE SAMPLE AND LENGTH OF TIME TO RECEIVE RESULTS

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*One advisor did not respond.

ADVISORS WOULD INCREASE BIOMARKER TESTING IN PATIENTS WITH mNSCLC IF TURNAROUND TIME AND TISSUE AVAILABILITY WERE IMPROVED

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*One advisor did not respond.

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Treatment of *RET*-Positive Advanced NSCLC

ARS RESPONSES

ALL THE ADVISORS HAVE TREATED ≤3 PATIENTS WITH *RET*-POSITIVE NSCLC

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*One advisor did not respond.

ONLY 2 ADVISORS HAVE TREATED PATIENTS WITH mNSCLC WITH SELPERCATINIB

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*One advisor did not respond.

NONE OF THE ADVISORS HAVE TREATED PATIENTS WITH PRALSETINIB FOR mNSCLC

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*One advisor did not respond.

ADVISORS WERE UNSURE WHICH THERAPY HAS BETTER ACTIVITY IN *RET* FUSION-POSITIVE mNSCLC

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*One advisor did not respond.

MOST ADVISORS WOULD SWITCH TO A RET INHIBITOR ONLY AFTER INITIAL SYSTEMIC THERAPY STOPS WORKING

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*One advisor did not respond.

MOST ADVISORS WOULD CHOOSE A *RET*-TARGETED THERAPY OVER IMMUNOTHERAPY REGIMENS FOR A PATIENT WITH STAGE IV ADENOCARCINOMA OF THE LUNG WITH *KIF5B-RET* FUSION AND PD-L1 EXPRESSION 75%

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*One advisor did not respond.

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Treatment of PD-L1–Positive Advanced NSCLC

ARS RESPONSES

MOST ADVISORS ORDER PD-L1 TESTING FOR PATIENTS WITH NSCLC

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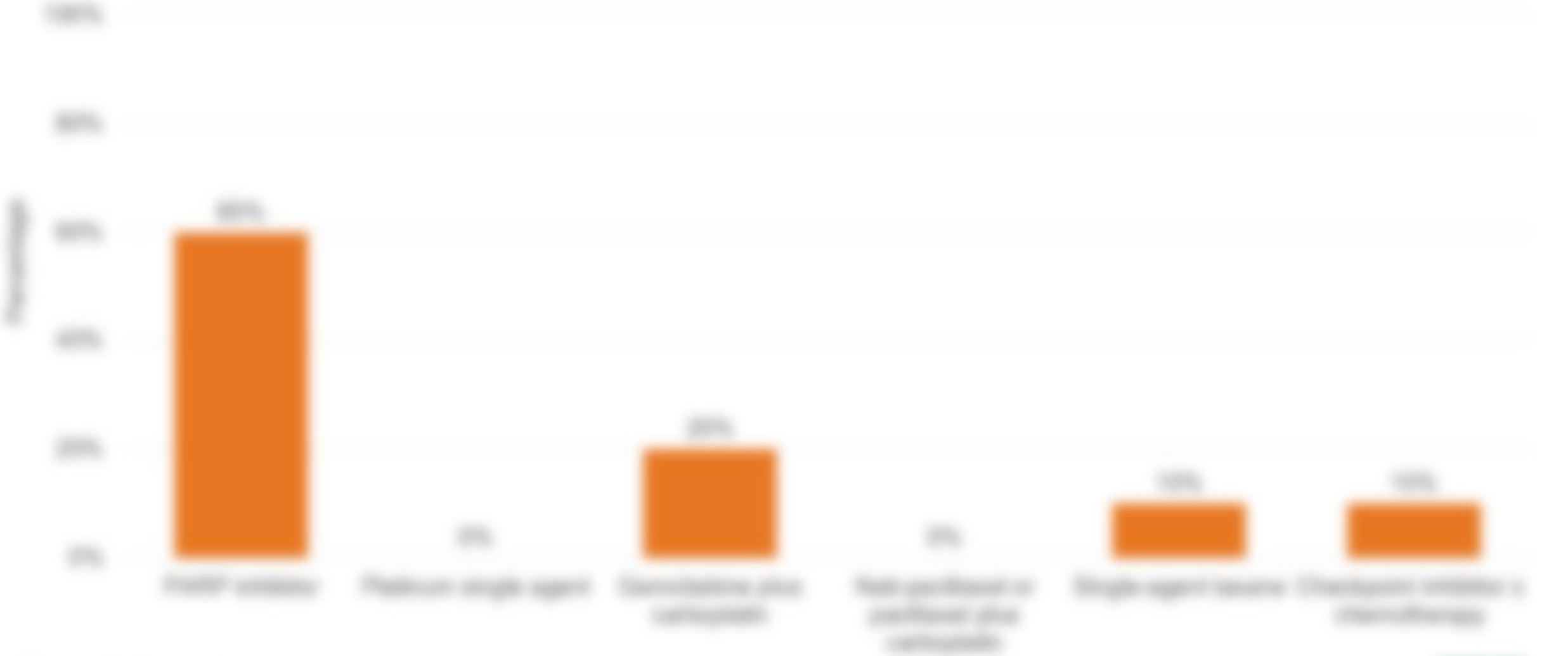

ALL BUT 1 ADVISOR HAD AT LEAST 13 PATIENTS WITH PD-L1–POSITIVE NSCLC IN THE LAST YEAR

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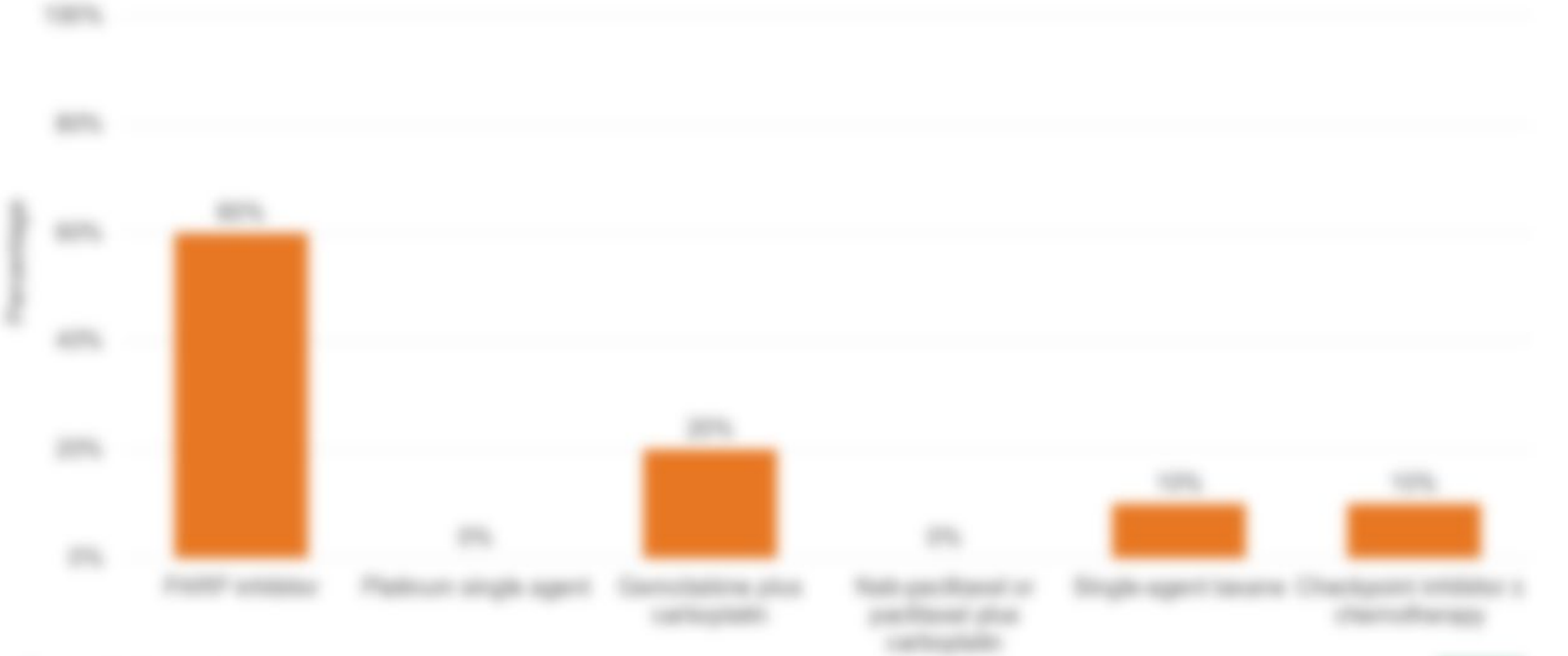

TWO-THIRDS OF ADVISORS TREATED NSCLC PATIENTS WITH NIVOLUMAB IN THE PAST YEAR

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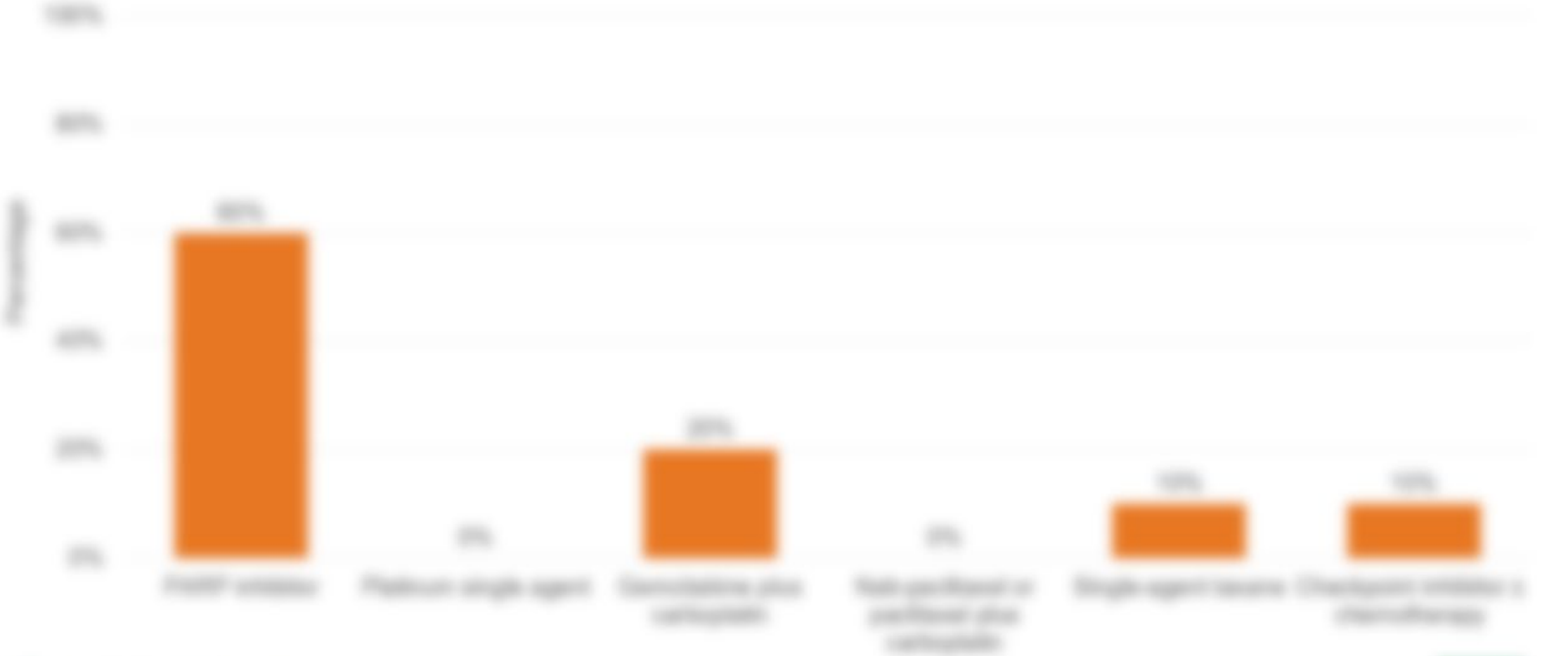

ALL ADVISORS HAVE TREATED AT LEAST 6 NSCLC PATIENTS WITH PEMBROLIZUMAB IN THE PAST YEAR

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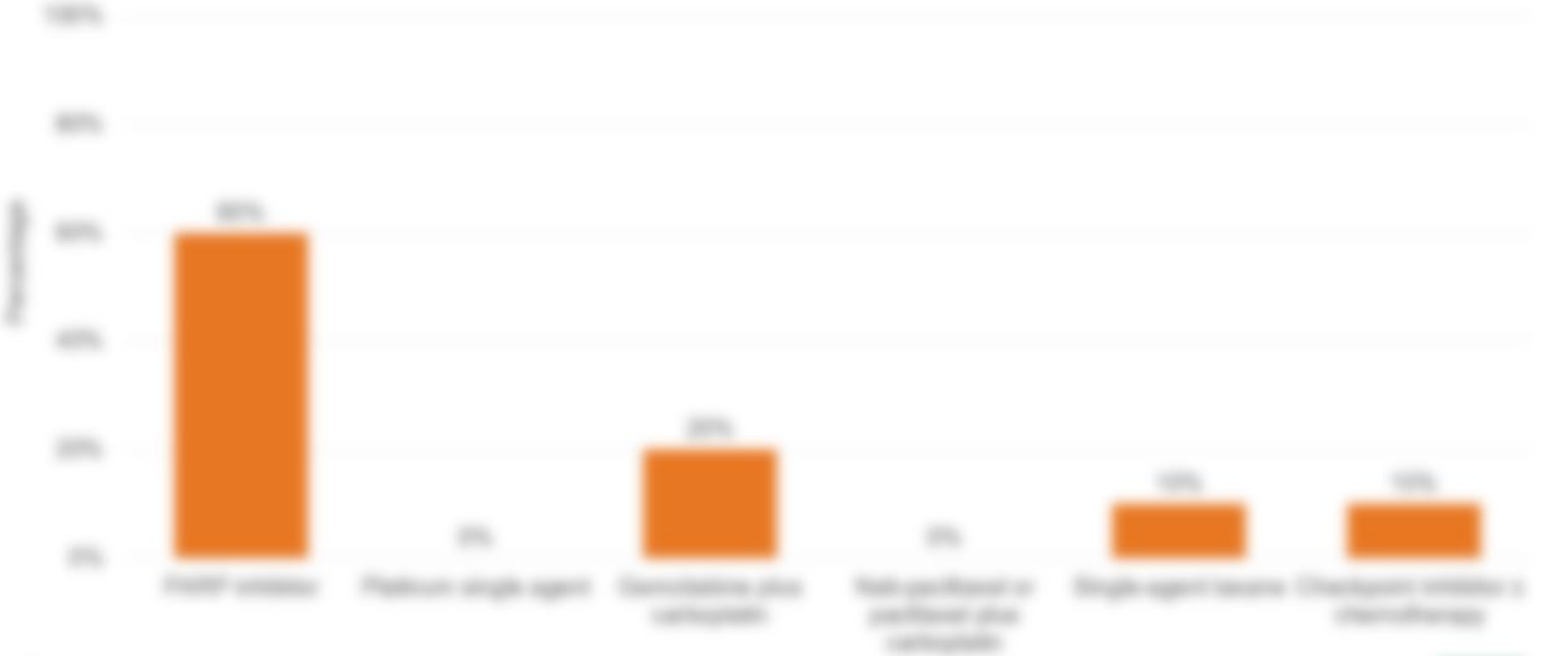

ALL ADVISORS HAVE TREATED 5 OR FEWER NSCLC PATIENTS WITH ATEZOLIZUMAB IN THE PAST YEAR

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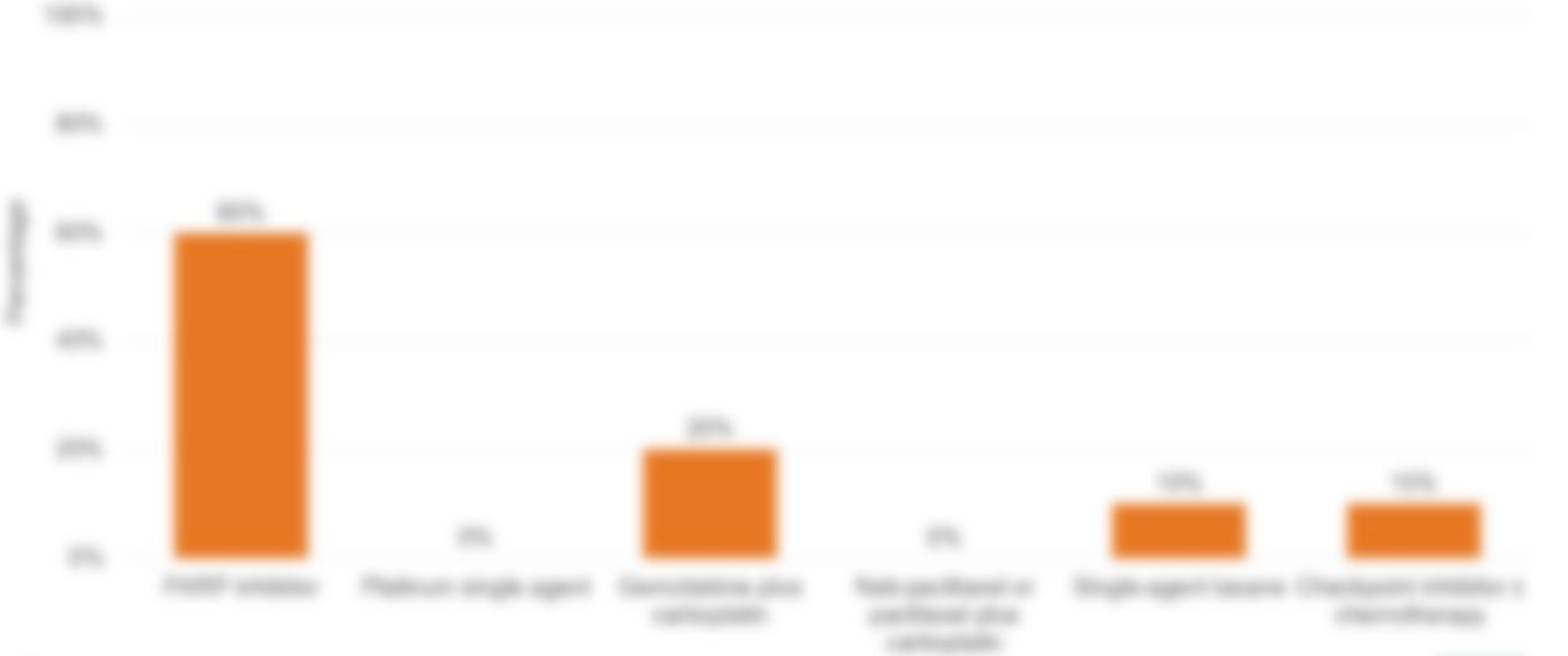

NONE OF THE ADVISORS HAVE TREATED NSCLC PATIENTS WITH CEMIPLIMAB IN THE PAST YEAR

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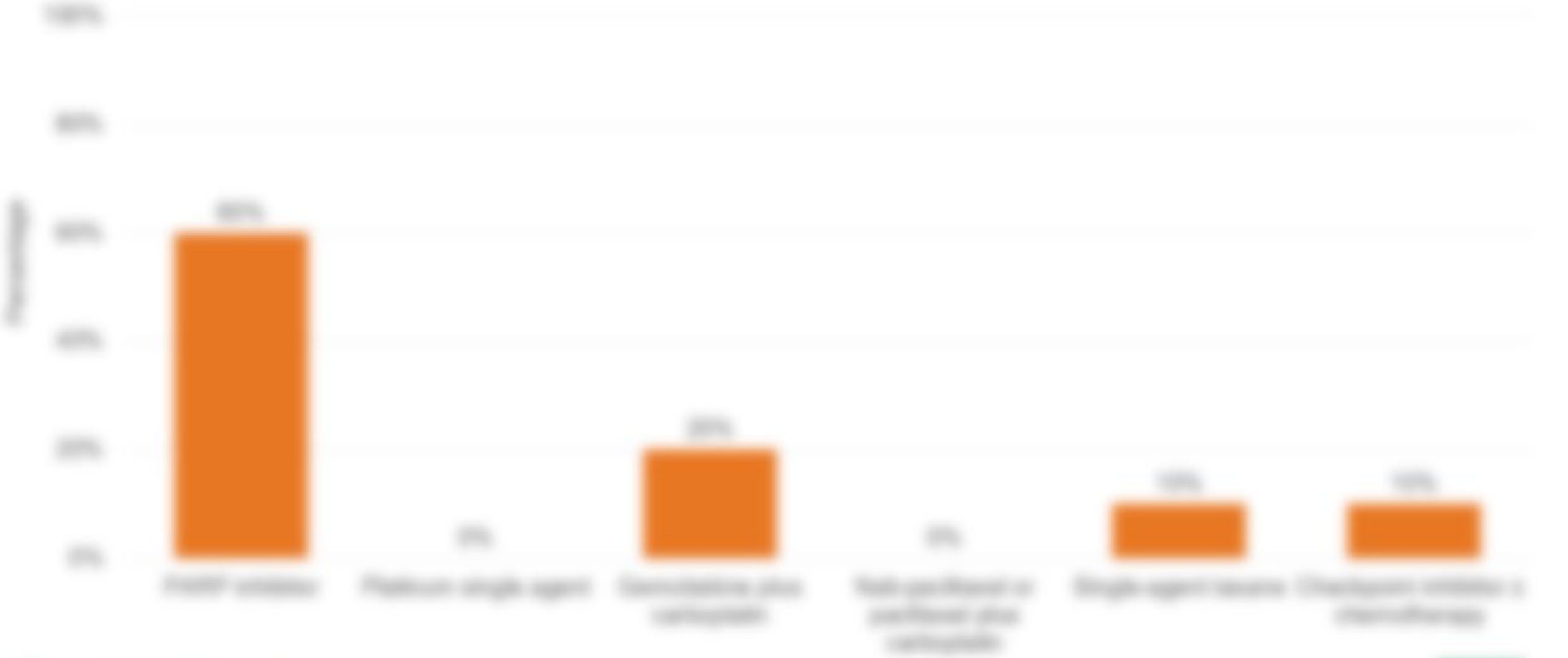

MOST ADVISORS FELT THE LISTED IMMUNOTHERAPIES HAVE COMPARABLE ACTIVITY AS MONOTHERAPY IN PATIENTS WITH PD-L1–POSITIVE mNSCLC

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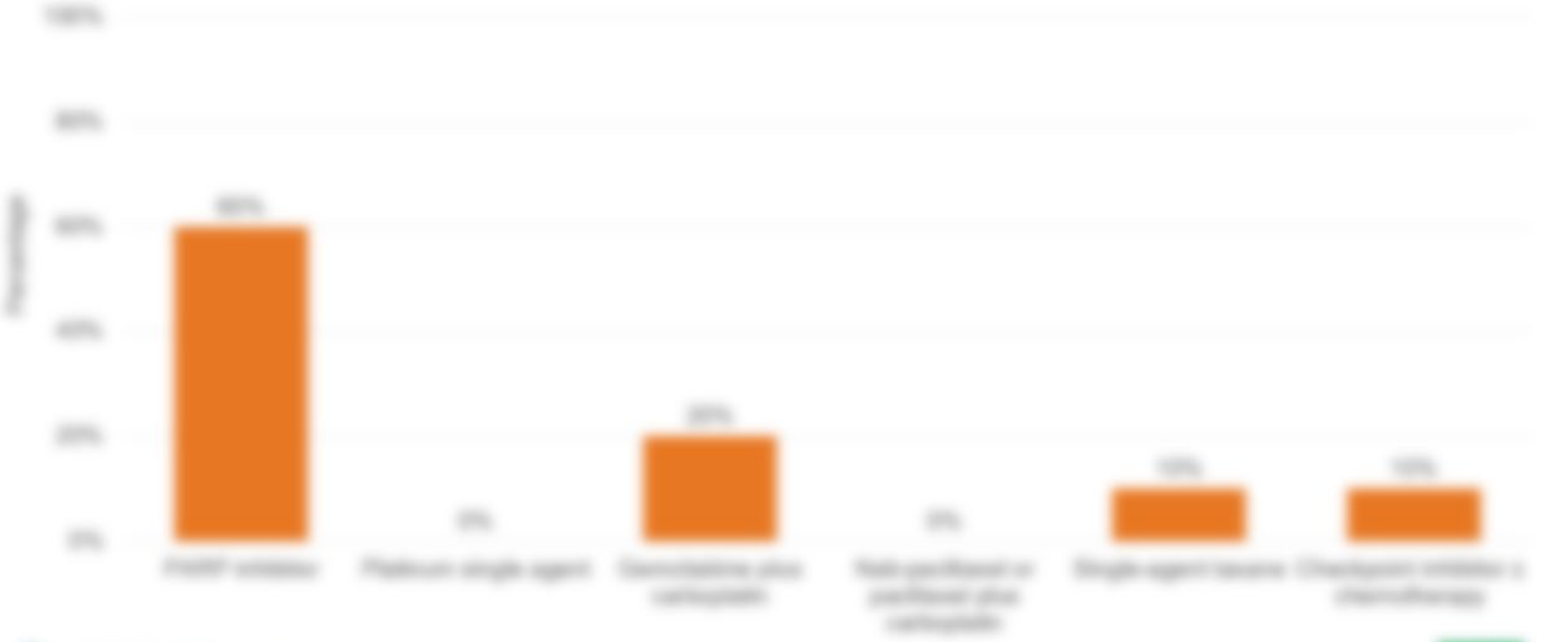

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A 75-YEAR-OLD MALE WITH BRAIN METASTASIS UNDERWENT BRONCHOSCOPY FOR BAL OF RML AND BIOPSY OF LEVEL 11 LN. TUMOR PROVED (+) FOR ADENOCARCINOMA, SOLID PATTERN TTF1 (+). TISSUE WAS SENT FOR MOLECULAR TESTING AND PD-L1 PROFILING. HE RECEIVED DENOSUMAB AND SRS TO THE BRAIN LESION. ALL ADVISORS WOULD WAIT FOR THE TESTING BEFORE DETERMINING THEIR APPROACH TO TREATMENT.

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OVER THE PROCEEDING 2–3 WEEKS, PAIN IMPROVED BUT DID NOT RESOLVE. HE NOTED EPISTAXIS AFTER DENOSUMAB, WHICH SPONTANEOUSLY RESOLVED. APPETITE REMAINED INTACT. THERE WERE NO SEQUELAE POST-SRS. PD-L1 TESTING RETURNED (+) AT 80%. ALL MOLECULAR MARKERS, INCLUDING *ALK*, *EGFR*, *ROS1*, ETC, WERE (–). MOST ADVISORS WOULD TREAT THIS PATIENT WITH PEMBROLIZUMAB.