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Insights Into Management and Treatment Options for Acute Myeloid Leukemia (AML)

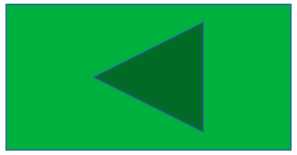
July 20, 2021

Speaker and Chair: Elias Jabbour, MD

MD Anderson Cancer Center

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



Click to return to previous slide

Contents

CASES

Report Objectives

MEETING OBJECTIVES
Gain advisors' perspectives on existing and emerging treatments for newly diagnosed and relapsed/refractory AML

Report Snapshot: Session Overview

A moderated roundtable discussion was held with community oncologists from 7 locations throughout the United States, in a virtual setting on **July 20, 2021**

Disease state and data presentations were led by **Elias Jabbour, MD,** from MD Anderson Cancer Center in conjunction with content developed by the Aptitude Health clinical team

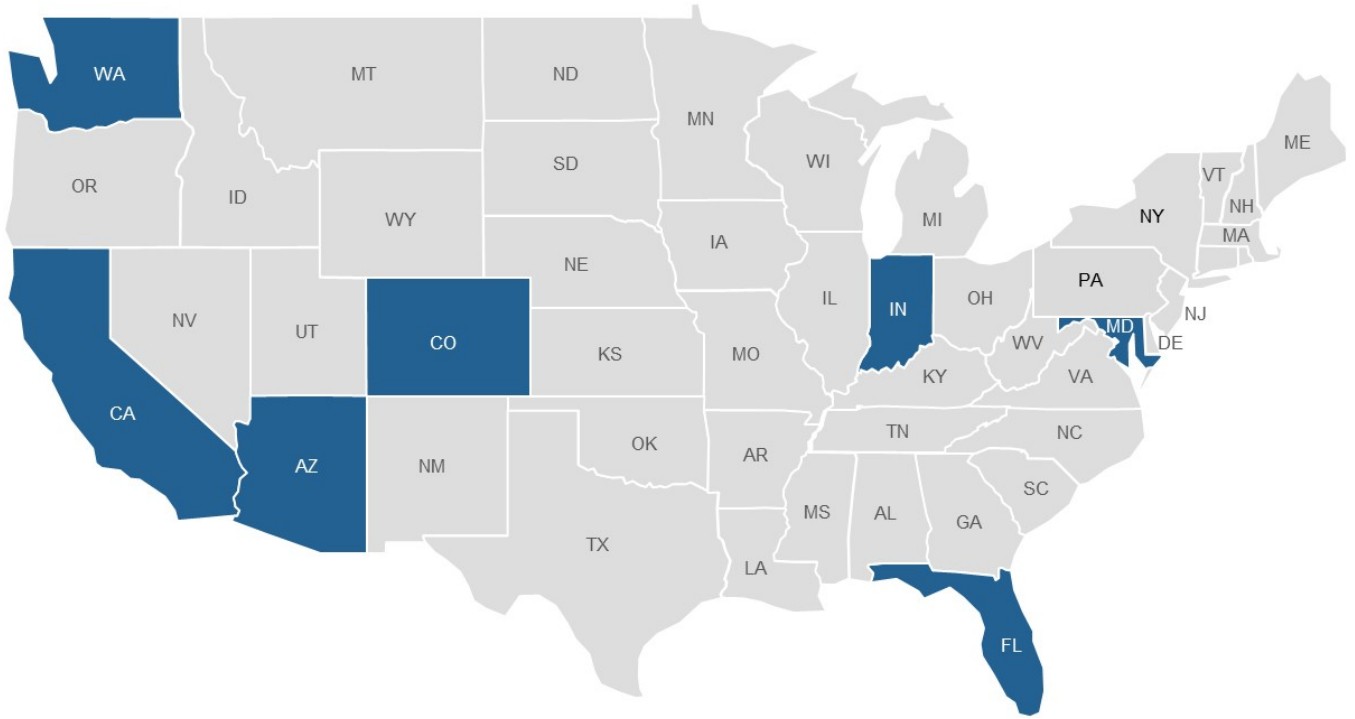
Insights were obtained on physicians' preferred therapy choices; targeted therapies including *FLT3*-, *IDH1/2*-, and BCL2-targeting agents, Hedgehog pathway inhibitors; and maintenance therapies

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

Report Snapshot: Attendee Overview

> The group of advisors was composed of 10 community oncologists from 7 states across the US

INSTITUTION	CITY	STATE
Sutter Alta Bates Summit Medical Center	Berkeley	CA
Community Hospital St. Catherine Hospital	Munster East Chicago	IN
Virginia Mason Medical Center	Mercer Island	WA
Broward Health Coral Springs	Tamarac	FL
Chesapeake Oncology Hematology Associates	Annapolis	MD
Mid Florida Cancer Centers	Orange City	FL
David Walsh Center	Sterling	CO
Cancer Treatments Centers of America	Phoenix	AZ
Northern Hematology Oncology	Thornton	CO
Pacific Shores Medical Group	Long Beach	CA



Report Snapshot: Agenda

Time (CT)	Topic
6.00 PM – 6.15 PM (15 min)	**Introduction and ARS Questions** • Program overview • ARS questions
6.15 PM – 7.25 PM (70 min)	**First-Line Treatment of AML** • Overview of current data • Reaction and discussion
7.25 PM – 7.35 PM (10 min)	Break
7.35 PM – 8.45 PM (70 min)	**Management of Relapsed/Refractory AML and Promising Strategies in AML** • Overview of current data • ARS questions • Reaction and discussion
8.45 PM – 9.00 PM (15 min)	**Key Takeaways and Meeting Evaluation**

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Topline Takeaways and Strategic Recommendations

Meeting Objectives Were Achieved: Topline Takeaways

OBJECTIVE	PROCESS	INSIGHTS
> Learn community	Through ARS questions and	> Most of these advisors treat their older, frail, and unfit AML patients,

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Key Insights and Discussion Summary

Key Insights: Management and Treatment Options for AML

REPORT OBJECTIVES

- Learn community oncologists' treatment paradigms for frontline/newly diagnosed AML
- Understand advisors' current approaches to treating relapsed/refractory AML
- Understand community oncologists' decision-making in their choice of therapy on the basis of patient type/prior therapy

Key Insights: Management and Treatment Options for AML

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Advisors may or may not admit patients to local hospitals for induction with venetoclax, but noted that venetoclax is not always readily available at these centers

- In these circumstances, it is common to have the venetoclax prescription filled as an outpatient and tell the patient, a member of their family, or other caregiver to bring this medication to the hospital
  - One advisor noted that their facility does keep 2–3 days of venetoclax on hand as startup medication until a regular venetoclax supply can be obtained at a local pharmacy
- Some advisors do release their AML patients from the hospital following initial venetoclax treatment if they are medically stable, and will continue these patients on venetoclax on an outpatient basis

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CASES

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Several advisors said they prefer to remain strict in reaching the entire 28 days of venetoclax dosing while addressing treatment-related adverse events (AEs) such as myelosuppression as they arise

Other advisors are more flexible in their initial treatment cycle (and subsequent) with venetoclax, noting it is not uncommon for them to interrupt or dose-reduce venetoclax to mitigate AEs and wait for BM to recover

- Several advisors also noted they commonly use growth factors to address myelosuppression, but that pegfilgrastim (Neulasta®) can be difficult to obtain at community practices, due to financial coverage or high copays

After the initial cycle with venetoclax, advisors employ varying dosing strategies ranging from 7 to 14 days, to keep patients on this therapy while also ensuring AEs are manageable

- A few advisors said they also adjust their dosing strategy for azacitidine to facilitate managing AEs

Several advisors noted their good experience with venetoclax, with some patients able to stay on this regimen for long periods of time (up to ~1.5–2 years)

- Most physicians noted they have observed minimal numbers of patients with infections while on this regimen

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CASES

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Discussion: Management and Treatment Options for AML

INSIGHTS FROM DISCUSSION

[Regarding younger and fit patients] "I usually will have them visit with a transplanter at the get-go."

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

Discussion: Management and Treatment Options for AML

INSIGHTS FROM DISCUSSION

"We have some venetoclax in the hospital, and we [get] patient prescriptions within 2 or 3 days . . . and we bring it from the clinic to the hospital the next day when I round."

Discussion: Management and Treatment Options for AML

INSIGHTS FROM DISCUSSION

"We hold treatment, wait for the counts to recover. I don't give [venetoclax] continuous."

"Usually when they become neutropenic, [I and] up stopping the venetoclax, watching, and usually doing

- Treatment success in frontline DLBCL
- Data needed to switch from BCIC in frontline

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Advisor Key Takeaways

Advisor Key Takeaways

ADVISOR		ADVISOR	
1	> Will consider using some FLAG regimens in their AML > 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	> Eager to see new data with targeted therapies (FLT3i [illegible] > For relapsed/refractory patients it's nice to have different options besides R-ICE 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

ADVISOR		ADVISOR	
1	> Views the newer therapies currently under > 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	> Use antifungal medications in newly diagnosed AML patients (when using venetoclax) > For relapsed/refractory patients it's nice to have different options besides R-ICE 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
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Audience Response System (ARS) Data

Advisors Have a Variety of Risk-Stratifying Considerations for Their AML Patients, Relying Slightly More on Comorbidities and Genomic Factors

*One advisor did not respond.

Nearly Half of the Advisors (43%) Said Poor-Risk Patients Comprise Approximately One-Fifth of Their Total AML Patients

What percentage of your AML patients fall into the poor-risk category? (N = 7*)

*Three advisors did not respond.

For the Largest Proportion of the Advisors (58% = 29% + 29%), AML Patients at Least 75 Years Old Make Up Approximately One-Third to One-Half of Their Total AML Patient Population

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*Three advisors did not respond.

These Advisors Have Significant Proportions of AML Patients Who Are Younger but Cannot Tolerate Intensive Chemotherapy Because of Comorbidities

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*Three advisors did not respond.

The Advisors Routinely Test for Expected AML-Associated Molecular Markers/Mutations

*One advisor did not respond.

All the Advisors Send Their Molecular and Genetic Testing Panels to an External Lab

*One advisor did not respond.

The Largest Proportion of the Advisors (80%) Receive Their Molecular and Genetic Test Results Within the Second Week After Sending Specimens for Testing

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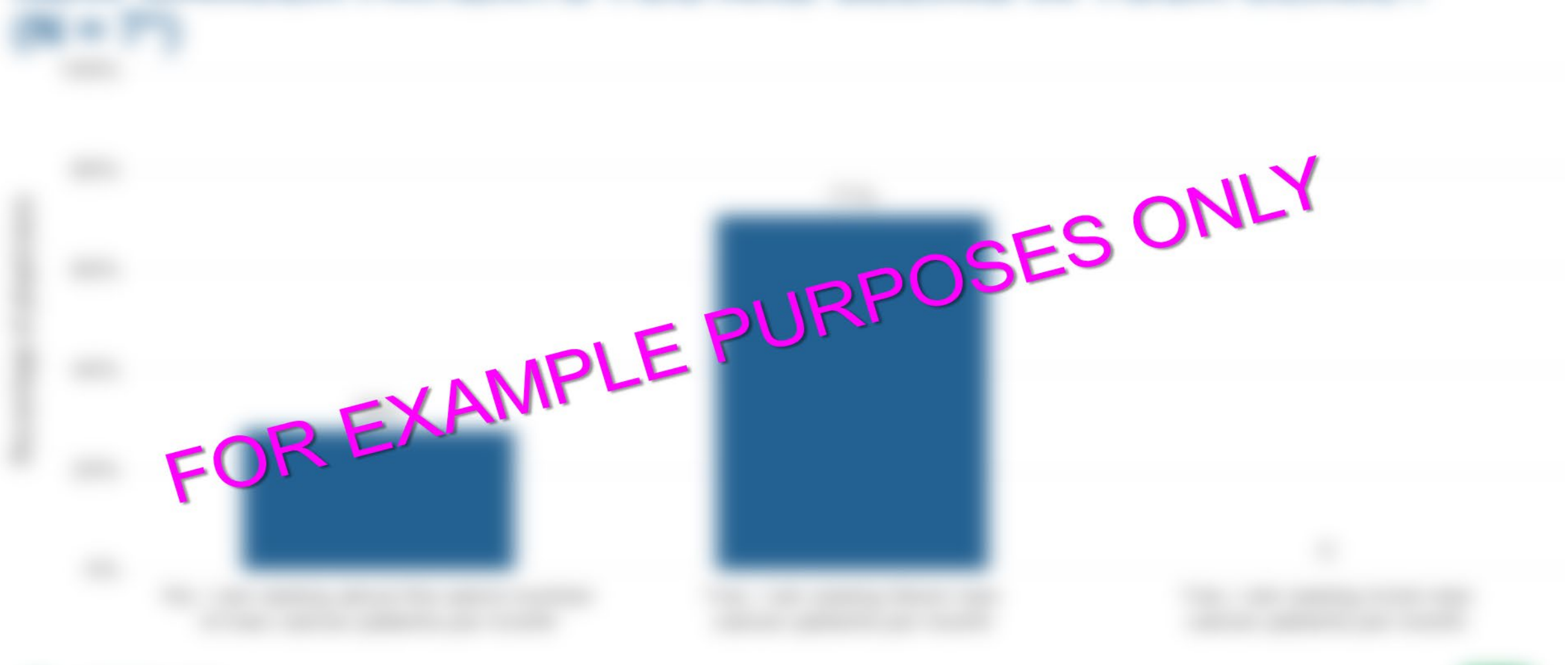
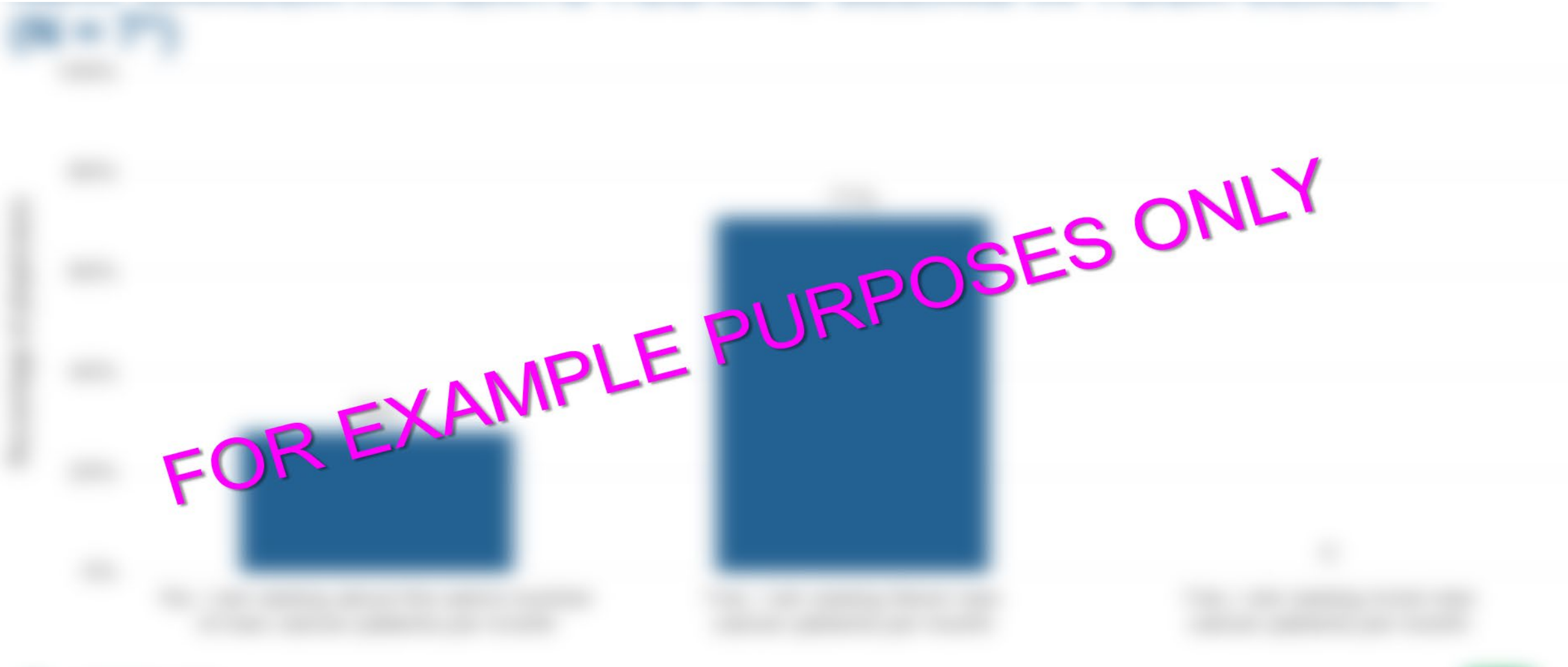


The Great Majority of Advisors (88%) Sometimes Begin Treatment for Their Newly Diagnosed AML Patients Before Receiving Molecular and Genetic Test Results



*Two advisors did not respond.

Most of the Advisors (56%) Chose Standard 7+3 Chemotherapy + a CD33-Targeting Agent for a Younger, Fit AML Patient Who Is CD33 Positive

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*One advisor did not respond.

For a Younger CD33-Positive Patient Who Cannot Accept Intensive Chemotherapy Due to Comorbidities, Over Half of the Advisors (56%) Chose Venetoclax (± HMA or LDAC) for Induction

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*One advisor did not respond.

For an Older CD33-Positive Patient With Good Performance Status and No *FLT3* Mutation, the Majority of the Advisors Chose Venetoclax (± HMA or LDAC) for Induction

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*One advisor did not respond.

For an Intermediate-Risk Older Patient With Poorer PS and *IDH1* Mutation, Advisors Were Split on Whether to Choose Venetoclax (± HMA or LDAC) or Single-Agent *IDH1*-Targeting Agent

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*One advisor did not respond.

More Than Three-Fourths of Advisors (78%) Use the Prescribed Daily Dose Ramp-up When Initiating Therapy With Venetoclax

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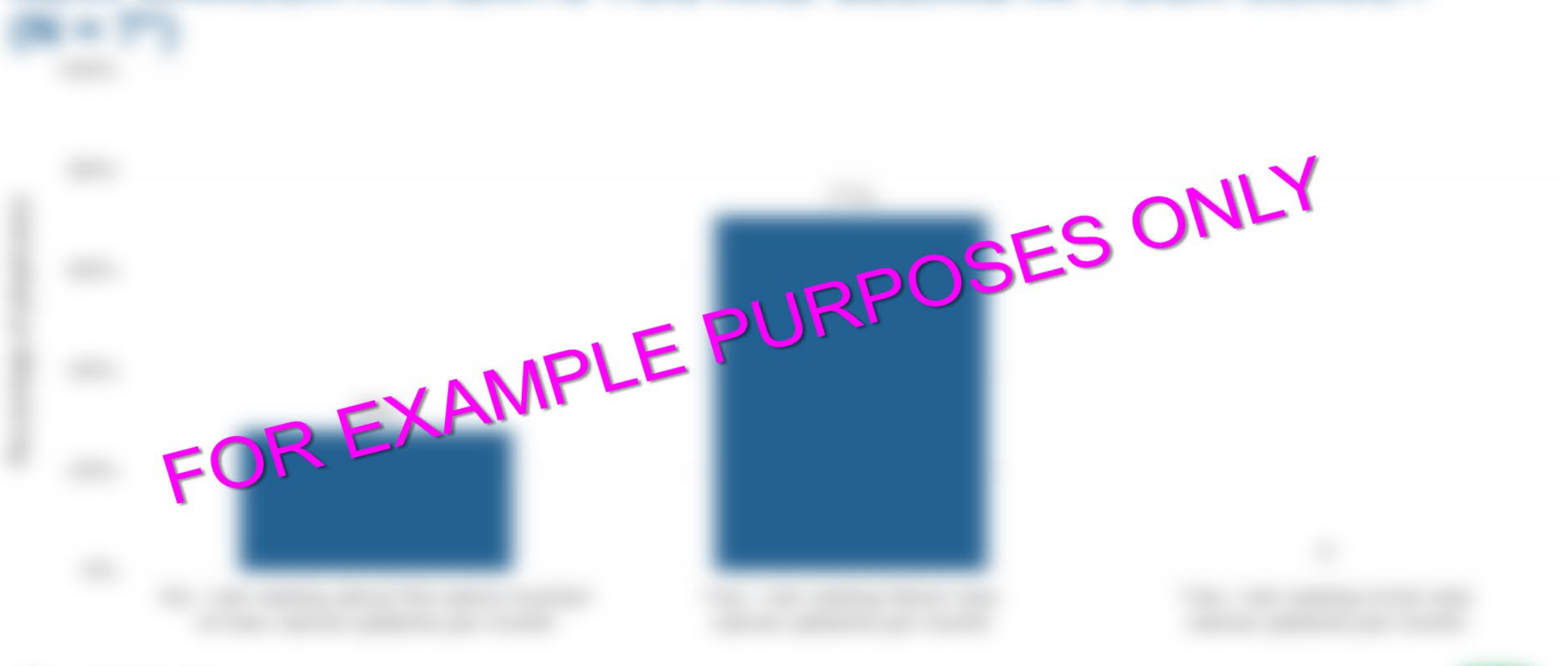
*One advisor did not respond.

All Advisors Who Use Prophylactic Antifungal Medications With Venetoclax Modify the Venetoclax Dose When These Agents Are Used Concomitantly



*Two advisors did not respond.

All Advisors Retest for Biomarkers on Relapse; Nearly All (88%) Do a Full-Panel Repeat

*Two advisors did not respond.

The Majority of Advisors (75%) Selected *FLT3* and *IDH1/2* as the Most Important Mutations to Test for on Relapse

*Two advisors did not respond.

The Largest Proportion of Advisors (43%) Would Refer a Relapsed Patient, Following Induction Chemotherapy and HiDAC Consolidation, for Bone Marrow Transplant Evaluation and Possible Reinduction

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Percentage

*Three advisors did not respond.

For a Patient Who Showed Significant Blasts After Anthracycline-Based Induction, Half of the Advisors Would Next Treat With FLAG-IDA

*Two advisors did not respond.

For an Older AML Patient Who Relapsed at 12 Months but Acquired an *IDH2* Mutation, the Largest Proportion of Advisors (50%) Would Treat This Patient With Single-Agent *IDH2* Inhibitor

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*Two advisors did not respond.

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