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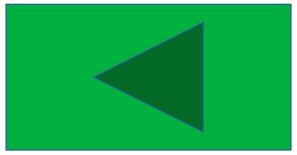
Insights Into Ovarian Cancer

Tuesday, July 27, 2021

Virtual Program – East

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



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Report Snapshot: Session Overview

A moderated roundtable discussion with academic oncologists from Massachusetts and New York was held virtually on **July 27, 2021**

Disease state and data presentations were led by **Thomas Herzog, MD,** from the University of Cincinnati, in conjunction with content developed by the Aptitude Health clinical team

Insights were obtained on the use of **genetic testing and use of PARP inhibitors in advanced ovarian cancer**

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 oncologists
  - Attendees of the roundtable represented academic centers in Massachusetts and New York

INSTITUTION	NUMBER OF ATTENDEES	CITY	STATE
Dana-Farber Cancer Institute	5	Boston	MA
Massachusetts General Hospital	2	Boston	MA
Icahn School of Medicine at Mount Sinai	2	New York	NY
NYU Langone Medical Center	1	New York	NY

Report Snapshot: Agenda

Time (EST)	Topic
5.30 PM – 5.45 PM	Introduction and ARS Questions • Program overview • ARS questions
5.45 PM – 6.55 PM	Molecular Testing in Advanced Ovarian Cancer • Overview of current data • Reaction and discussion
6.55 PM – 7.10 PM	*Break*
7.10 PM – 8.20 PM	First-Line and Maintenance Therapy Options • ARS questions • Overview of treatment options • Reaction and discussion
8.20 PM – 8.30 PM	Key Takeaways and Meeting Evaluation

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Topline Takeaways and Strategic Recommendations

Meeting Objectives Were Achieved: Topline Takeaways

OBJECTIVES

- 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

PROCESS

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

INSIGHTS

- 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

Discussion: Molecular Testing in Advanced Ovarian Cancer (1/3)

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INSIGHTS

"I usually send for both germline testing and the somatic testing at the same time to do it in parallel, ideally during

- [illegible]

- [illegible]

Discussion: Molecular Testing in Advanced Ovarian Cancer (2/3)

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INSIGHTS

"I routinely send my patients for both germline testing and their tumor sample, whether it's from primary debulking

- Treatment success in frontline (1L/BC)

- Data needed to switch from 3CIC in frontline

Discussion: Molecular Testing in Advanced Ovarian Cancer (3/3)

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INSIGHTS

"The biggest decision is which tissue to do it on, so I can get the best possible result. That is always, to me, a little

- Treatment success in frontline (1L/IFC)

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

"... 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..."

- Data needed to switch from SOC in frontline

"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."

Discussion: First-Line and Maintenance Therapy Options

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INSIGHTS

"I rarely use [bevacizumab] in the upfront setting. It has to be an extraordinary case. Usually present with bilateral

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

Discussion: First-Line and Maintenance Therapy Options

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INSIGHTS

"I've actually used that tagline [for niraparib], 'The only PARP inhibitor with the convenience of once-daily and tailored

- [illegible]

- [illegible]

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Advisor Key Takeaways

Advisor Key Takeaways*

ADVISOR		ADVISOR	
1	> Understanding how other advisors decide primary > I have a better understanding of sequencing therapies > I really wasn't that familiar with ponatinib and telaglenastat but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> Understanding treatment patterns of advisors from > 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 telaglenastat 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 ponatinib 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

One advisor did not provide key takeaways.

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ARS Data

For 67% of Advisors, >30% of the Gynecologic Cancer Patients They See Each Month Have Ovarian Cancer

What proportion of your gynecologic cancer patients whom you see per month have ovarian cancer? (N = 9*)

*One advisor did not respond.

All Advisors Test >75% of Their Patients for Germline *BRCA* Mutations

What percentage of your first-line ovarian cancer patients receive germline *BRCA* mutation testing? (N = 10)

Most Advisors (70%) Test >75% of Their Patients for Germline *BRCA* Mutations

What percentage of your first-line ovarian cancer patients receive tumor (somatic *BRCA*) testing? (N = 10)

Sixty Percent of Advisors Reported That >50% of Their Patients Receive HRD Testing

What percentage of your first-line ovarian cancer patients receive homologous recombination deficiency (HRD) testing? (N = 10)

Testing for *BRCA* Then Reflexing to HRD Is the Most Common Way Advisors Sequence Their Testing

Do you typically sequence or concurrently test for *BRCA* and HRD? (N = 9*)

*One advisor did not respond.

Archival Tissue Is the Most Commonly Used Sample Type for HRD Testing

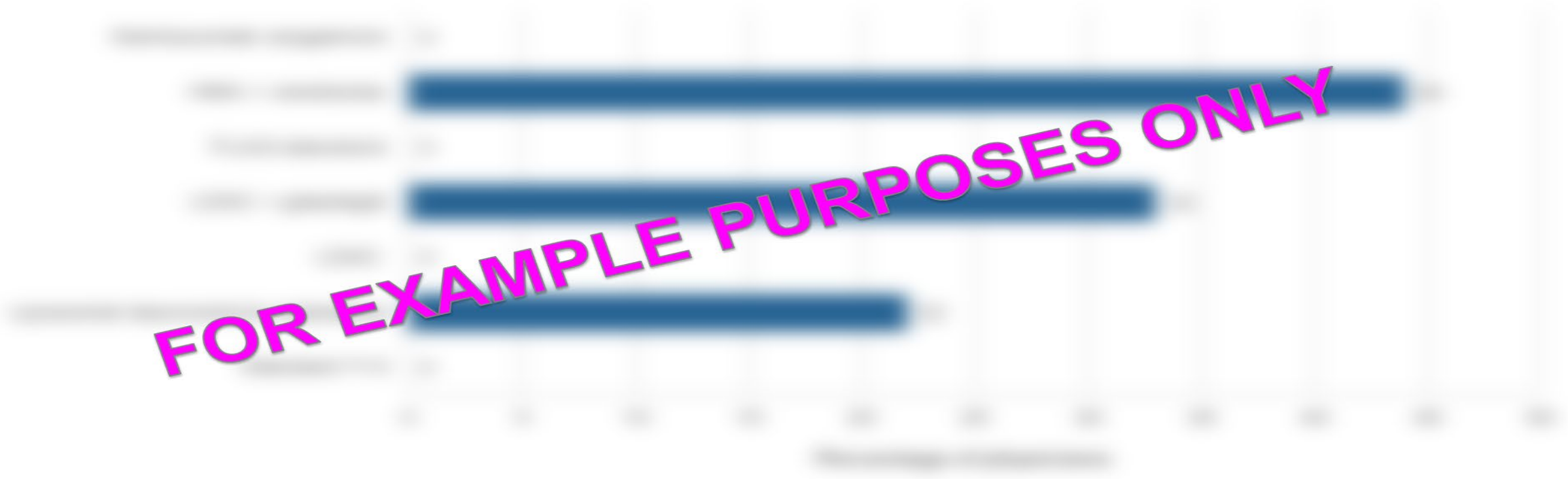
Which of the following sample types are you using for HRD testing? Please select all that apply. (N = 10)

Most Advisors Reported Their HRD Testing Includes Both HRR Mutations and Genomic Instability

Does your HRD test include homologous recombination repair (HRR) mutations and genomic instability via tumor tissue? (N = 10)

All Advisors Use Foundation Medicine for HRRm Testing, in Addition to Other Testing Partners

Which commercially available gene assays do you currently use for HRRm testing? Please select all that apply. (N = 10)



Half of the Advisors Receive Their HRD Testing Results During Induction Treatment

When do you typically receive your HRD test results? (N = 10)

Wait Time for Results and Acquiring Adequate Tissue Samples Are the Top 2 Challenges Advisors Face When Ordering HRD Testing

What are the main challenges with ordering HRD testing for patients with advanced

*One advisor did not respond.

Most Advisors (67%) Reported Only 1%–25% of Their Patients Receive Bevacizumab as Part of Frontline Therapy

What proportion of your patients receive bevacizumab as part of frontline therapy?
(N = 9*)

*One advisor did not respond.

Most Advisors (67%) Have Prescribed Niraparib for Only 1–5 Patients in the Past 3 Months

Approximately how many ovarian cancer patients have you treated with niraparib (Zejula) over the past 3 months? (N = 9*)

*One advisor did not respond.

Fifty-Six Percent of Advisors Have Prescribed Olaparib for 6–10 Patients in the Past 3 Months

Approximately how many ovarian cancer patients have you treated with olaparib (Lynparza) over the past 3 months? (N = 9*)

*One advisor did not respond.

Forty-Four Percent of Advisors Believe the Available PARP Inhibitors Are Too Similar to Decide Which Has the Most Favorable Safety Profile

Which of the following PARPi has the most favorable safety profile in ovarian cancer?

*One advisor did not respond.

Most Advisors Reported That Approval for Olaparib Maintenance From SOLO-1 Has Had the Biggest Impact on Their Practice

Which recent approval for primary maintenance has had the biggest impact on your

*One advisor did not respond.

Adverse Events Are the Most Common Reason Advisors Would Choose PARPi Monotherapy Maintenance Over Bevacizumab-Olaparib in a Patient With a g*BRCA1/2* Mutation Who Received Bevacizumab in Primary Therapy

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What is the primary reason you might choose PARP inhibitor monotherapy over bevacizumab + olaparib for a patient with a **g*BRCA1/2*** mutation who received bevacizumab-containing primary therapy? (N = 10)

Olaparib Is the Most Used Approach in First-Line Maintenance for Newly Diagnosed *BRCA*m Advanced Ovarian Cancer Patients

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What do you anticipate being your most commonly used approach to first-line maintenance in your patients with newly diagnosed *BRCA*m advanced ovarian cancer? (N = 9*)

*One advisor did not respond.

Niraparib Is the Most Used Approach in First-Line Maintenance for Newly Diagnosed HRD-Positive/*BRCA*wt Advanced Ovarian Cancer Patients

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What do you anticipate being your most commonly used approach to first-line maintenance in your patients with newly diagnosed HRD-positive/*BRCA*wt advanced ovarian cancer?
(N = 9*)

Niraparib or Watch-and-Wait Are the Most Used Approaches in First-Line Maintenance for Newly Diagnosed HRD-Negative/*BRCA*wt Advanced Ovarian Cancer Patients

What do you anticipate being your most commonly used approach to first-line maintenance in your patients with newly diagnosed HRD-negative/*BRCA*wt advanced ovarian cancer? (N = 9*)

*One advisor did not respond.

For an Advanced Ovarian Cancer Patient With Optimal Debulking, 33% of Advisors Each Would Test for *BRCA* and HRD Concurrently, or *BRCA* Then Reflex to HRD

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Patient case: 54 y/o with stage IIIC epithelial ovarian cancer s/p primary optimal debulking surgery including TH, BSO,

*One advisor did not respond.

If the Patient Presents With a g*BRCA* Mutation, Most Advisors Would Prescribe Carboplatin-Paclitaxel

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Patient Case, Continued: Germline testing revealed a g*BRCA* mutation. What therapy would you recommend for primary treatment? (N = 10)

After Carboplatin-Paclitaxel Primary Therapy, Olaparib Monotherapy Is the Preferred Maintenance Regimen for This Patient

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Patient case, continued: 54 y/o with stage IIIC epithelial ovarian cancer s/p optimal debulking surgery with no gross residual macroscopic disease. Germline testing revealed a g*BRCA* mutation. She was treated with carboplatin-paclitaxel and had a CR with normalization of CA125 and negative exam. What posttreatment strategy would you

*One advisor did not respond.

If the Patient Was Treated With Carboplatin-Paclitaxel-Bevacizumab Instead, Bevacizumab-Olaparib Would Then Be the Preferred Maintenance Regimen

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Assume the patient with a *gBRCA* mutation was given carboplatin-paclitaxel-bevacizumab as primary therapy. What would you offer now as maintenance therapy? (N = 10)

If the Prior Patient Was *BRCA1/2*wt and HRP Instead, Most Advisors Would Prescribe Bevacizumab Monotherapy as Primary Therapy

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If this patient was ***BRCA1/2*wt** and **HRP**, what would you offer as maintenance therapy after carboplatin-paclitaxel-bevacizumab primary therapy? (N = 9*)

*One advisor did not respond.