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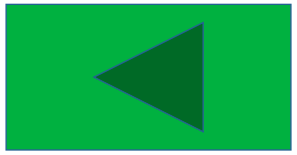
Insights Into Ovarian Cancer

Wednesday, September 30, 2021

Virtual Program – OneOncology Network Physicians

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



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Report Objectives

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STUDY OBJECTIVES
Gain perspectives of community oncologists from OneOncology Network on the therapeutic management of advanced ovarian cancer with regard to testing and treatment selection

Report Snapshot: Session Overview

A moderated roundtable discussion with OneOncology Network community oncologists in New Jersey, New York, Tennessee, and Texas was held virtually on **September 30, 2021**

Disease state and data presentations were led by **Shannon Westin, MD,** from University of Texas, MD Anderson Cancer Center, in conjunction with content developed by the Aptitude Health clinical team

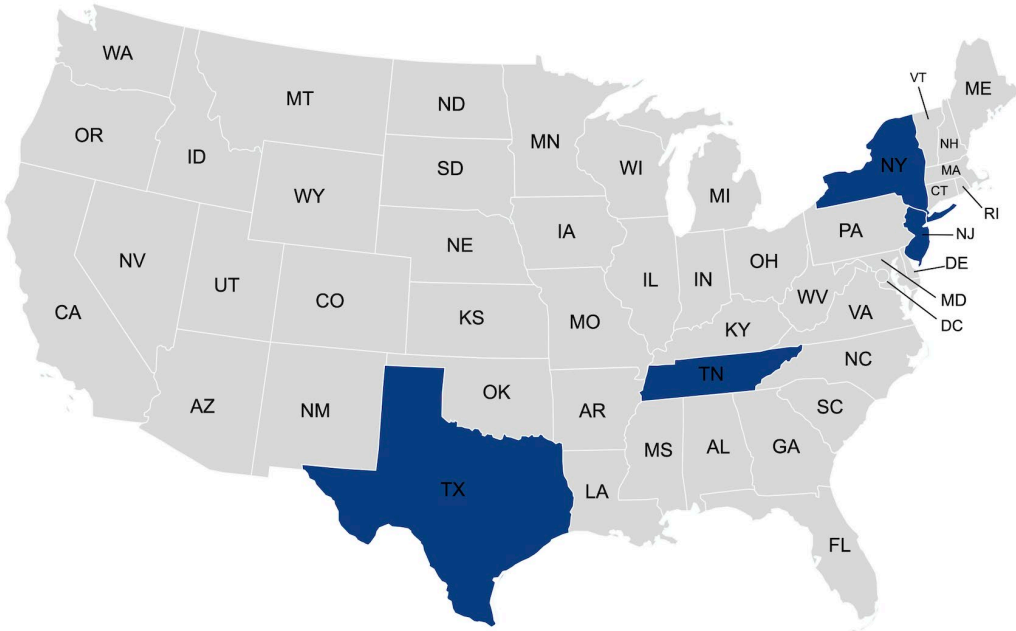
Insights were obtained on the use of **genetic testing and use of PARP inhibitors in advanced ovarian cancer**

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

Report Snapshot: Attendee Overview

- The group of advisors comprised 10 oncologists
  - Attendees of the roundtable represented OneOncology Network community oncologists in New Jersey, New York, Tennessee, and Texas

Institution	Number of Attendees	City	State
Astera Cancer Center	1	Somerset	NJ
The Center for Cancer and Blood Disorders	1	Edison	NJ
New York Cancer & Blood Specialists	1	Patchogue	NY
New York Cancer & Blood Specialists	1	Port Jefferson Station	NY
Tennessee Oncology	1	Murfreesboro	TN
The Center for Cancer and Blood Disorders	4	Fort Worth	TX
The Center for Cancer and Blood Disorders	1	Irving	TX



Report Snapshot: Agenda

Time (EST)	Topic
6.00 PM – 6.15 PM	Introduction and ARS Questions
6.15 PM – 7.25 PM	Molecular Testing in Advanced Ovarian Cancer
7.25 PM – 7.40 PM	*Break*
7.40 PM – 8.50 PM	First-line and Maintenance Therapy Options
8.50 PM – 9.00 PM	Key Takeaways and Meeting Evaluation

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Key Insights and Discussion Summary

Discussion: Molecular Testing in Advanced Ovarian Cancer (1/2)

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INSIGHTS

"I personally test both at the same time whenever possible…if a patient has gone down the line, has unfortunately

- Treatment success in frontline (1L/BC)

- Data needed to switch from 3C/2C in frontline

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

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INSIGHTS

"So it's an open discussion with the patient. And I strongly believe that BRCA1 and 2 are the main drivers there.

- Treatment success in frontline (1L/BC)

- Data needed to switch from 3C/C in frontline

Discussion: HRD Results Before Front Line and Maintenance Treatment Decision setting

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INSIGHTS

"I always start with Avastin if their genetic testing comes back with BRCA or HRD, I can propose PAOLA so I can talk

- [illegible]

- [illegible]

Discussion: First-line Therapy Options

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INSIGHTS

"...it's hard to do a cross-trial comparison, in ICON7 versus PAOLA. It's hard to, and on top of the PAOLA, it'd been

- Treatment success in frontline OLBCL

"...the 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 BOC 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: Maintenance Therapy Options

INSIGHTS

"…, about PARP versus *bev[acizumab]*…part of it is a patient factor. Can they come in and get an infusion regularly? Do

- Treatment success in frontline OLBCL

"

- Data needed to switch from SOC in frontline

"

Discussion: First-line and Maintenance Therapy Options

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INSIGHTS

"I favor to use a PARP inhibitor…the majority of the benefits from PARP inhibitors tends to be right after using

- Treatment success in frontline DLBCL

"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 3 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 0.65 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*

ADVISOR	
➢ Low-risk group of patients that benefitted from the [illegible]	➢ For patients that you're concerned about, consider the strategy [illegible]
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
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
3	➢ It was great to hear about innovations and what's coming down the pipeline for relapsed/refractory
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
5	➢ For relapsed/refractory patients it's nice to have different options besides R-CE and auto or going to CAR T
6	➢ I'm hoping that some of these second-line agents will get added onto frontline and hopefully improve the cure rate
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
8	➢ Still R-CHOP is the standard

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ARS Data

For One-third of Advisors, More Than 30% of the Gynecologic Cancer Patients They See Each Month Have Ovarian Cancer

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Most Advisors (78%) Test >75% of Their Patients for Germline *BRCA* Mutations

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*One advisor did not respond.

Half of Advisors Test >75% of Their Patients for Tumor (somatic *BRCA*) Mutations

Most (70%) Advisors Reported That >50% of Their Patients Receive HRD Testing

Test for *BRCA* and HRD Concurrently Is the Most Common Way Advisors Sequence Their Testing

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*Three advisors did not respond.

Archival Tissue and Fresh Biopsy are the Most Commonly Used Sample Type for HRD Testing

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

*One advisor did not respond.

Most Advisors (40%) Use Foundation Medicine for HRRm Testing, in Addition to Other Testing Partners

*One advisor did not respond.

Most Advisors (70%) Receive HRD Testing Results During Induction Treatment

*One advisor did not respond.

Awareness/Education on HRD or Genomic Instability Markers and Acquiring Adequate Tissue Samples are the Top Challenges Advisors Face When Ordering HRD Testing

(such as LOH)

*Three advisors did not respond.

Most Advisors (80%) Reported At Least 26% or More of Their Patients Receive Bevacizumab as Part of Frontline Therapy

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Most Advisors (60%) Have Prescribed Niraparib for 1–5 Patients in the Past 3 Months

Most (70%) Advisors Have Prescribed Olaparib for Only 1–5 Patients in the Past 3 Months

Most Advisors (60%) Believed that One Available PARP Inhibitor Had a More Favorable Safety Profile Over Another

Most Advisors (56%) Reported That Approval for Olaparib Plus Bevacizumab Maintenance From PAOLA-1 Had the Biggest

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*One advisor did not respond.

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

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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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Bevacizumab Monotherapy was Reported as the Most Used Approach in First-line Maintenance for Newly Diagnosed HRD-Negative/*BRCA*wt Advanced Ovarian Cancer Patients

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FOR EXAMPLE PURPOSES ONLY

For an Advanced Ovarian Cancer Patient With Optimal Debulking, 40% of Advisors Each Test for *BRCA* Then Reflex to HRD or Comprehensive NGS, Then Reflex to HRD

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

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After Olaparib Monotherapy for Primary Therapy, Bevacizumab-Olaparib and Niraparib are 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

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

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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 **BRCA1/2wt and HRP**, what would you offer as maintenance therapy after carboplatin

Adverse Events is 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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One advisor did not respond.

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