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# Insights Into Renal Cell Carcinoma

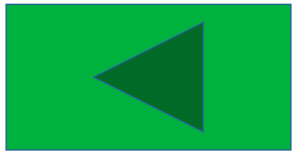
Virtual Platform

February 23, 2022

Insights From Southwest Community Oncologists

# 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 was held with oncologists across the Southwest region of the United States in a virtual setting on **February 23, 2022**

Disease state and data presentations were led by **Dr Rana McKay** from UC San Diego and moderated by **Dr Sushil Bhardwaj** from the Good Samaritan Regional Medical Center, in conjunction with content developed by the Aptitude Health clinical team

Insights were obtained on **first-line and subsequent therapies for advanced RCC** in the community and impact on patient management

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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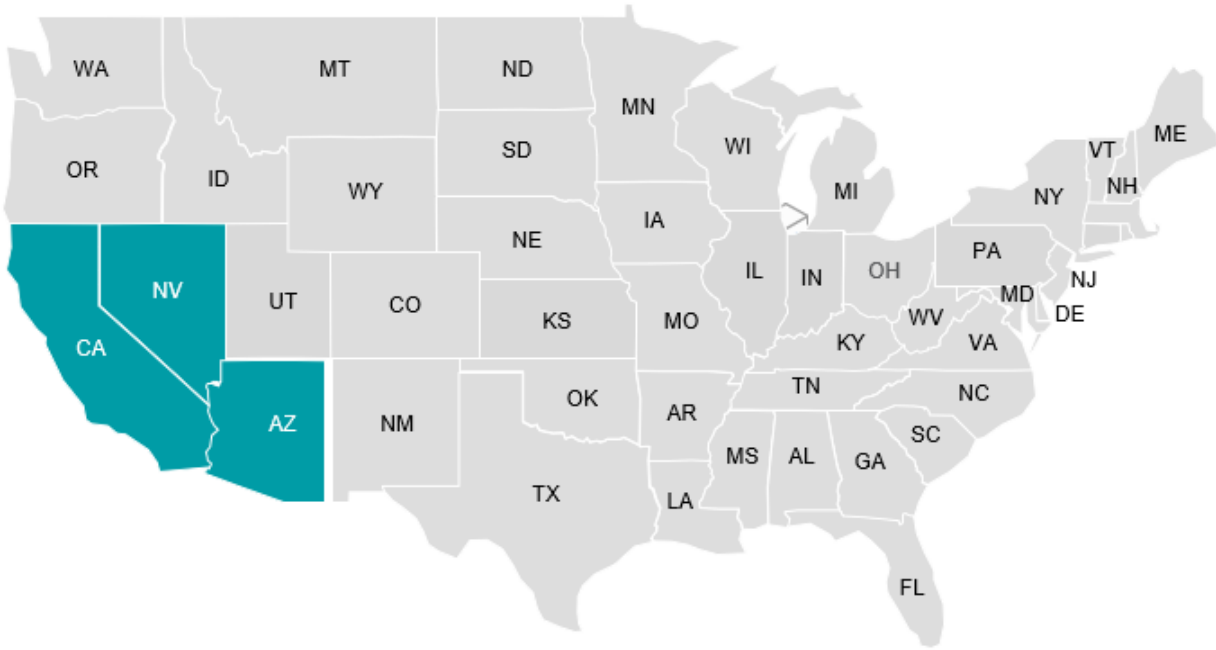
> The group of advisors comprised 10 oncologists from the Southwest region of the United States

| INSTITUTION | CITY | STATE |
|---|---|---|
| Arizona Center for Cancer Care | Scottsdale | AZ |
| Desert Hematology Oncology | Surprise | AZ |
| Comprehensive Cancer Centers of Nevada | Las Vegas | NV |
| Loma Linda University | Loma Linda | CA |
| Ventura County Hematology Oncology Specialists | Ventura | CA |
| Palo Verde Cancer Specialists | Phoenix | AZ |
| Cancer and Blood Specialty Clinic | Los Alamitos | CA |
| Ironwood Cancer & Research Centers | Mesa | AZ |
| Kaiser Permanente | San Diego | CA |
| Keck Medicine of USC | Huntington Beach | CA |



# Report Snapshot: Agenda

| Time (ET) | Topic |
|---|---|
| **6.00 PM – 6.15 PM (15 min)** | **Introduction and ARS Questions**<br>• Program overview<br>• Introductions<br>• ARS questions |
| **6.15 PM – 7.25 PM (70 min)** | **First-Line Therapy in Advanced RCC**<br>• Overview of current data<br>• Reaction and discussion |
| **7.25 PM – 7.35 PM (10 min)** | **Break** |
| **7.35 PM – 8.45 PM (70 min)** | **Subsequent Management for Advanced RCC**<br>• ARS questions<br>• Overview of current data<br>• Reaction and discussion |
| **8.45 PM – 9.00 PM (15 min)** | **Key Takeaways and Meeting Evaluation** |

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# Key Insights and Discussion Summary

# Discussion: First-Line Treatment of Advanced RCC (1/4)

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## FIRST-LINE TREATMENT – INSIGHTS AND DATA

*"I definitely go by the risk status, high risk, intermediate, and low risk. And so for my low-risk patients, kind of*

- Treatment success in frontline (1L/2L)

- Data needed to switch from 1L/2L in frontline

# Discussion: First-Line Treatment of Advanced RCC (2/4)

## FIRST-LINE TREATMENT – INSIGHTS AND DATA

*"I have [used cabozantinib] in combination but not as a single agent."*

- [illegible]

- [illegible]

# Discussion: First-Line Treatment of Advanced RCC (3/4)

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## FIRST-LINE TREATMENT – INSIGHTS AND DATA

*"I think most of my patients can tolerate axitinib + pembro frontline. I've used that quite a bit. And then my*

- Treatment success in frontline (N-IRC)

- Data needed to switch from N3C in frontline

# Discussion: First-Line Treatment of Advanced RCC (4/4)

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## FIRST-LINE TREATMENT – INSIGHTS AND DATA

*"[On CheckMate 9ER data] I mean, it demonstrated statistically significant improvement in overall survival across*

- Treatment success in frontline (N-IRC)

"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 N-IO in frontline

"First of all, a lot of things have been tried, nothing is better than N-CHOP, and frankly, I'm pretty happy with how N-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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# Key Insights: Treatment of Advanced Renal Cell Carcinoma

Subsequent Management of Advanced RCC

# Discussion: Subsequent Management in Advanced RCC (1/4)

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## SUBSEQUENT TREATMENT – INSIGHTS AND DATA

*"I scan them every 3 months with the full-body scans. If the patient has a new mass, of course that's the clear sign*

- Treatment success in frontline (1L/2L)

"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 3L/2L in frontline

"First of all, a lot of things have been tried, nothing is better than IO+VEGF, and frankly, I'm pretty happy with how IO+VEGF 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."

# Discussion: Subsequent Management in Advanced RCC (2/4)

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## SUBSEQUENT TREATMENT – INSIGHTS AND DATA

*"I think lenvatinib is very effective, but the dose is a little bit something that I get hesitant."*

- [illegible]

[illegible]

- [illegible]

[illegible]

# Discussion: Subsequent Management in Advanced RCC (3/4)

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## SUBSEQUENT TREATMENT – INSIGHTS AND DATA

*General comments:*

*"My go-to combination is the pembro + axi and cabo + nivo."*

- Treatment success in frontline (N,IRC):

[redacted]

- Data needed to switch from N/C in frontline:

[redacted]

# Discussion: Subsequent Management in Advanced RCC (4/4)

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## SUBSEQUENT TREATMENT – INSIGHTS AND DATA

*After cabo-nivo:*

*"If my first line is cabo + nivo, then the available second line is tivo."*

- Treatment success in frontline (N,IMC)

- Data needed to switch from (N)IC in frontline

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# Advisor Key Takeaways

# Advisor Key Takeaways

| ADVISOR | | ADVISOR | |
|---|---|---|---|
| 1 | > Combination therapy (TKI + IO) is promising<br>> I have a better understanding of sequencing therapies<br>> I really wasn't that familiar with pralsetinib and tebentafusp but now I have a better understanding of these drugs and have a better idea of when to use them in my practice | 5 | > Data about lenvatinib + pembro and second-line cabozantinib is good<br>> 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<br>> I'm particularly interested in the tebentafusp and hope that tafa and Rev would be tolerated for a second-line option for my very elderly patients<br>> 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<br>> 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<br>> Sequencing is an issue | 8 | > Still R-CHOP is the standard |

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# Insights Into Renal Cell Carcinoma

## ARS Results: First-Line Treatment of Advanced RCC

# About 70% of the Advisors Have Used Single-Agent TKI to Treat RCC Patients as a First-Line Therapy in the Past Year (N = 10)

# All Advisors Have Used Axitinib + Pembrolizumab to Treat RCC Patients as a First-Line Therapy in the Past Year (N = 10)

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# About 80% of the Advisors Have Used Cabozantinib + Nivolumab as a First-Line Therapy in the Past Year (N = 10)

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FOR EXAMPLE PURPOSES ONLY

# About 33% of the Advisors Have Used Lenvatinib + Pembrolizumab as a First-Line Therapy in the Past Year (n = 9*)

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*One advisor did not respond.

# Only 11% of the Advisors Have Used Axitinib + Avelumab as a First-Line Therapy to Treat RCC Patients in the Past Year (n = 9*)


*One advisor did not respond.

# 80% of the Advisors Have Used Ipilimumab + Nivolumab as First-Line Therapy for RCC in the Past Year, but the Majority Have Only Limited Use (N = 10)

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# Overall Survival Was Cited as the Main Driver for Selection of First-Line Therapy (N = 10)

# Half of the Advisors Believe Hepatic Metastases Carry the Worst Prognosis in Metastatic Kidney Cancer Patients (N = 10)

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# Patient Case 1

- A 58-year-old man diagnosed with RCC 4 years ago underwent radical

# Most Advisors Would Recommend IO + TKI (most frequently axi-pembro) as First-Line Treatment for This Low-Risk Patient (N = 10)

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# Patient Case 2

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- A 70-year-old man was initially found to have a 6-cm mass in his left kidney with

# Most Advisors Would Recommend IO + TKI (nearly half with axi-pembro) as First-Line Treatment for This Intermediate-Risk Patient (n = 9*)

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*One advisor did not respond.

# Patient Case 2, Continued

- Assume the same 70-year-old man (6-cm mass in his left kidney; clear cell

# Half of the Advisors Would Recommend TKI (cabozantinib) as Next-Line Treatment for This Intermediate-Risk Patient (N = 10) Who Previously Received Pembro as Adjuvant Therapy

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# Patient Case 3

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- A 68-year-old woman presents with severe fatigue, blood in her urine, and pain in

# Most Advisors Would Recommend IO + TKI (most frequently axi-pembro) as First-Line Treatment for This High-Risk Patient (N = 10)

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# Insights Into Renal Cell Carcinoma

ARS Results: Subsequent Management of Advanced RCC

# The Majority of the Advisors Prefer Cabozantinib as Second-Line Therapy for Advanced RCC (n = 9*)


*One advisor did not respond.

# Proven Efficacy Was the Most Frequently Cited Driver for Selection of Second-Line Therapy (N = 10)

# Patient Case 2, Continued

- The 70-year-old male with past nephrectomy and metastatic RCC (liver and lymph

# Most of the Advisors Would Recommend Cabozantinib as the Next Line of Therapy for This Patient (N = 10)

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What would you recommend for this patient now?

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