



Insights Into Chronic Lymphocytic Leukemia (CLL)

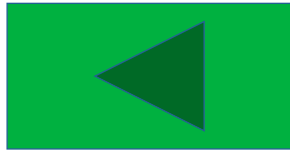
Tuesday, March 22, 2022

Virtual Program – Southwest












How to Navigate This Report



Click to move to topic of interest or ARS supporting data



Click to return to previous slide

| Topic | |
|---|---|
| Report Objectives |  |
| Report Snapshot | |
| • Session overview |  |
| • Attendee overview |  |
| • Agenda |  |
| Topline Takeaways and Strategic Recommendations |  |
| Key Insights and Discussion Summary | |
| • Key insights: First-line CLL |  |
| • Discussion overview: First-line CLL |  |
| • Key insights: Relapsed/refractory CLL |  |
| • Discussion overview: Relapsed/refractory CLL |  |
| Advisor Key Takeaways |  |
| ARS Data |  |

STUDY OBJECTIVES

Gain insight into

- > Management of newly diagnosed and relapsed/refractory CLL
- > Differentiation and integration of BTK inhibitors
- > Management of BTKi-related adverse events

Report Snapshot: Session Overview



A moderated roundtable discussion with community oncologists from the Southwest region of the United States was held in a virtual setting on **March 22, 2022**

Disease-state and data presentations were led by **Dr Deborah Stephens** from Huntsman Cancer Institute at the University of Utah, in conjunction with content developed by the Aptitude Health clinical team

Insights on the use of **BTKi vs BCL2-targeting agents in the community** were obtained

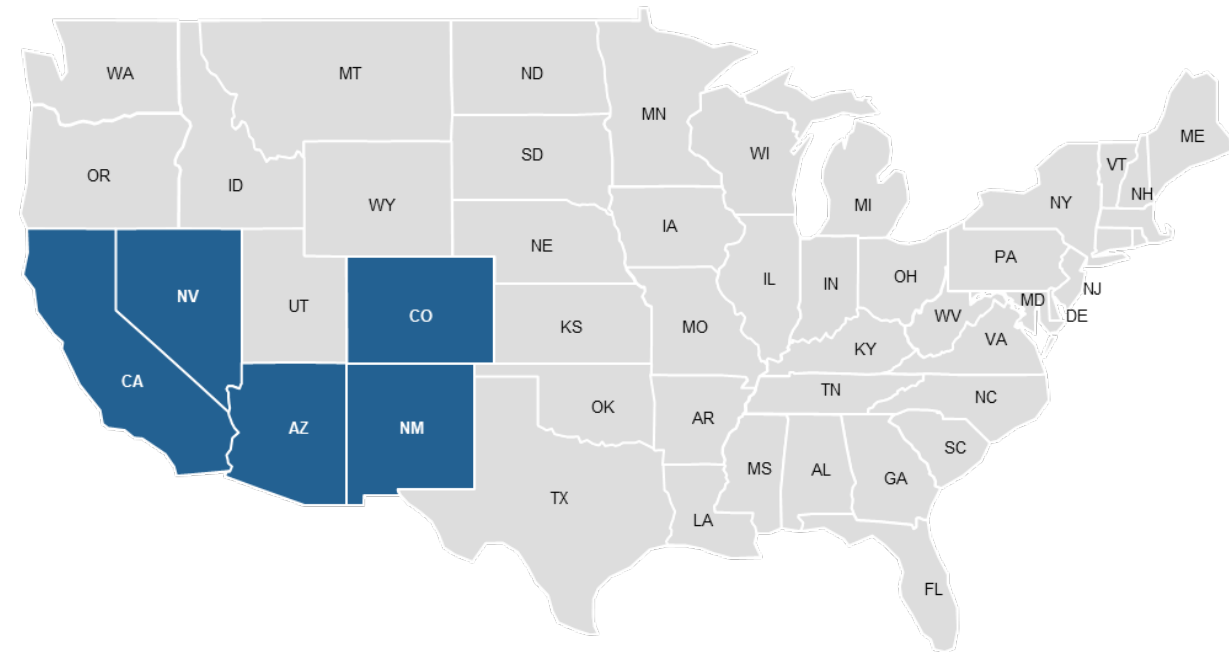
Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion

Report Snapshot: Attendee Overview



- > The group of advisors comprised 5 community oncologists from the Southwest region of United States (Arizona, California, Colorado, Nevada, and New Mexico)

| Institution | City | State |
|--|-------------|-------|
| Desert Hematology Oncology | Surprise | AZ |
| Heart of the Rockies Regional Medical Center | Salida | CO |
| Lovelace Cancer Center | Albuquerque | NM |
| Los Angeles Cancer Network | Pasadena | CA |
| Cancer Care Specialists | Reno | NV |



Report Snapshot: Agenda



| Time (PT) | Topic |
|--------------------------|---|
| 6.00 PM – 6.15 PM | Introduction |
| 6.15 PM – 6.50 PM | Use of BTKi Therapy in CLL |
| 6.50 PM – 7.50 PM | Discussion |
| 7.50 PM – 8.00 PM | Key Takeaways and Meeting Evaluation |



Key Insights and Discussion Summary

INSIGHTS

"I don't feel they are important in making decisions at this point for me or my patient."

1. Treatment success in frontline CLL

The overall survival benefit was not clear. This is not necessarily because there is no overall benefit, or an overall survival benefit. I would expect to see a significant improvement in overall survival with the use of 177Lu-PSMA, and I would expect that the overall survival benefit of 177Lu-PSMA is dependent on there being a significant benefit with the treatment, and overall being more meaningful.

2. Data needed to confirm that 177Lu-PSMA is frontline

That of all, a lot of things have been said, nothing is better than 177Lu-PSMA and there is no overall benefit with the 177Lu-PSMA patients for my patients. I would expect to see a significant improvement in overall survival with the use of 177Lu-PSMA, and I would expect that the overall survival benefit of 177Lu-PSMA is dependent on there being a significant benefit with the treatment, and overall being more meaningful. I would expect to see a significant improvement in overall survival with the use of 177Lu-PSMA, and I would expect that the overall survival benefit of 177Lu-PSMA is dependent on there being a significant benefit with the treatment, and overall being more meaningful.

INSIGHTS

[On what is being considered high risk] “Eleven deletion—17 P deletion, IGHV unmutated. Some people may even think

1. Treatment success in frontline CLL

The overall survival that's what we want. This is not necessarily disease-free or overall survival, it's overall survival.
I would not use a frontline regimen with 17p deletion. I would use a frontline regimen with 17p deletion, but I would not use a frontline regimen with 17p deletion. I would use a frontline regimen with 17p deletion, but I would not use a frontline regimen with 17p deletion.

2. Data needed to switch from BCL2 in frontline

That's all a lot of things have been said, nothing is better than BCL2 and BCL2. It's really hard with how BCL2 inhibitors for CLL patients.
I would not use a frontline regimen with 17p deletion. I would use a frontline regimen with 17p deletion, but I would not use a frontline regimen with 17p deletion.
I would not use a frontline regimen with 17p deletion. I would use a frontline regimen with 17p deletion, but I would not use a frontline regimen with 17p deletion.

INSIGHTS

"I think the hypertension is across the board for all 3 of them, but acalabrutinib definitely less in terms of atrial fibrillation . . .

Treatment success in patients with HTN

The overall survival benefit was not seen. This is not necessarily because this is a curable disease, so we need overall survival. I would expect overall survival benefit to be seen with any significant long-term benefit. This study is a phase 3 study and I would expect to see a significant advantage either with using 100 or 400mg, and I would not expect the disease-free rate at 2 years. I believe in this trial a significant benefit is significant benefit with the treatment, and overall long-term survival benefit.

Side effects to watch from HTN in patients

That of all, a lot of things have been seen, nothing is really like 80/100 and things. It would happen with low 80/100 patients for no reason. I would be a little worried. I would not be one of the first ones to move toward 400 mg something like that. I would something that is not well and we know that it is not. If the benefits are not very small. There is a benefit with 400 mg in terms of something that would be better off. Overall survival was not seen, but in this disease with 100 mg there seems to be some benefit in terms of efficacy. So, I do think that a 100 mg trial might have some kind of data. I think what's going to be done along the side of any region. HTN is not sufficient.

INSIGHTS

[Second-line therapy if BTK inhibitor is used in frontline]

1. Treatment success in frontline CLL

The overall survival benefit was seen. This is not necessarily disease-free or overall survival, as we have overall survival. I think what we really want to know is what is the impact on quality of life. I think what we really want to know is what is the impact on quality of life. I think what we really want to know is what is the impact on quality of life. I think what we really want to know is what is the impact on quality of life.

2. Data needed to switch from BTK in frontline

What if all of a sudden we have seen that switching to a better than BTK and BTK. I think what we really want to know is what is the impact on quality of life. I think what we really want to know is what is the impact on quality of life. I think what we really want to know is what is the impact on quality of life. I think what we really want to know is what is the impact on quality of life.



Advisor Key Takeaways

Advisor Key Takeaways



ADVISOR

> I learned new information about zanubrutinib,

- There is a better understanding of sequencing strategies
- I really enjoyed the webinar with zanubrutinib and olaparib but not the one with a better understanding of these drugs and how a better idea of when to use them in my practice

- There is a better understanding of some of my other options
- It's particularly interesting in the olaparib and how that side and how would be interested in a second-line option for my own elderly patients
- There's a lot more information on targeted therapy and to things like immunotherapy that may offer some side effects

- It was good to hear about considerations and advice coming from the practice for immunotherapy

- There's a lot of good options for second-line that you could try and manage with decent side effect profile and good response rates
- Sequencing is an issue

ADVISOR

> Data are still young on the third generation; the

- The immunotherapy options are still to have different options besides PD-1, and with a pretty big cost

- It's hoping that some of these immunotherapy agents will get added into frontline and hopefully improve the look rate

- It's interesting to learn about all these immunotherapy treatments, especially the targeted antibodies
- A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs

- Not too much in the standard



ARS Data

All Advisors Have Treated >7 Unique Patients With CLL in the Past 12 Months, With the Majority of Them Treating ≥ 21 Patients



FOR EXAMPLE PURPOSES ONLY

Up to 50% of Those Patients With CLL Have Relapsed/ Refractory Disease

Approximately what percentage of those CLL patients have relapsed/refractory

FOR EXAMPLE PURPOSES ONLY

Three-Fourths of Advisors Routinely Perform FISH Testing for Del(17p) Prior to Starting First-Line Therapy in Their Patients With CLL



FOR EXAMPLE PURPOSES ONLY



Two of 4 Advisors Selected Accessibility Issues, High Cost of Testing, and Long Turnaround Time for Results as Reasons for Not Routinely Checking for Biomarkers

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



Two of 4 Advisors (50%) Selected Overall Response Rate and Minimal Residual Disease Negativity as the Most Important Efficacy-Related Outcomes to Determine First-Line Therapy

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



Over Half of the Advisors Feel the Ability to Stop Therapy Without Disease Progression or Toxicity Is Very Important

How important is the ability to stop therapy (without disease progression or toxicity) in

FOR EXAMPLE PURPOSES ONLY

Two of 4 Advisors (50%) View Atrial Fibrillation and Bleeding or Bruising as the Most Challenging BTKi-Associated AEs to Manage and Keep Patients on Therapy

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



Sixty Percent of Advisors Perceive Ibrutinib as the BTKi With the Most Difficult-to-Manage Toxicity Profile, While 40% Consider the Toxicity Profiles Similar Among All BTKi Therapies



FOR EXAMPLE PURPOSES ONLY

The Split Between Advisors Using a BTKi-Based Therapy vs Venetoclax-Based Therapy for Younger and Fit Patients Without Mutations Was Equal (40% vs 40%)

FOR EXAMPLE PURPOSES ONLY

In the Same Younger and Fit Patient Presenting With an *IGHV* Mutation, 60% of Advisors Routinely Use Venetoclax ± Obinutuzumab

FOR EXAMPLE PURPOSES ONLY

In Older Patients With No Mutation or Comorbidities, 75% of Advisors Routinely Use a BTKi-Based Therapy, Followed by 25% Using Venetoclax + Obinutuzumab

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



For a Younger Patient (no deletions or mutations) Who Received First-Line CIT and Attained a CR That Lasted 3 Years, the Choice Was Split Equally Between BTKi- and Venetoclax-Based Therapy (50% vs 50%)

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



For a Younger Patient (*IGHV* mutation) Who Was Initially Treated With Ibrutinib and Attained a 4-Year Disease-Free Interval, 60% of Advisors Prefer a Venetoclax-Based Therapy

FOR EXAMPLE PURPOSES ONLY

For an Older Patient (17p deletion) Who Was Initially Treated With Ibrutinib and Attained a CR for 2.5 Years, but Currently Has PS 1 and Significant Comorbidities, 80% of Advisors Prefer a Venetoclax-Based Therapy

FOR EXAMPLE PURPOSES ONLY