



Insights Into Metastatic Castration-Resistant Prostate Cancer (mCRPC) – Central

Virtual Platform

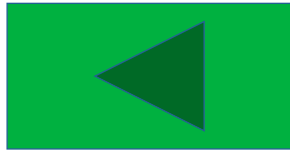
March 23, 2022

Insights From National Community Oncologists







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STUDY OBJECTIVES

To gain advisors' perspectives on

- > Current treatment practices regarding first-line treatment of metastatic castration-resistant prostate cancer (mCRPC)
- > Management of progressive mCRPC

Report Snapshot: Session Overview



A moderated roundtable discussion was held with oncologists in the Central region of the United States in a virtual setting on **March 23, 2022**

Disease-state and data presentations were led by **Dr Scott Tagawa** from Weill Cornell Medical Center, in conjunction with content developed by the Aptitude Health clinical team

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

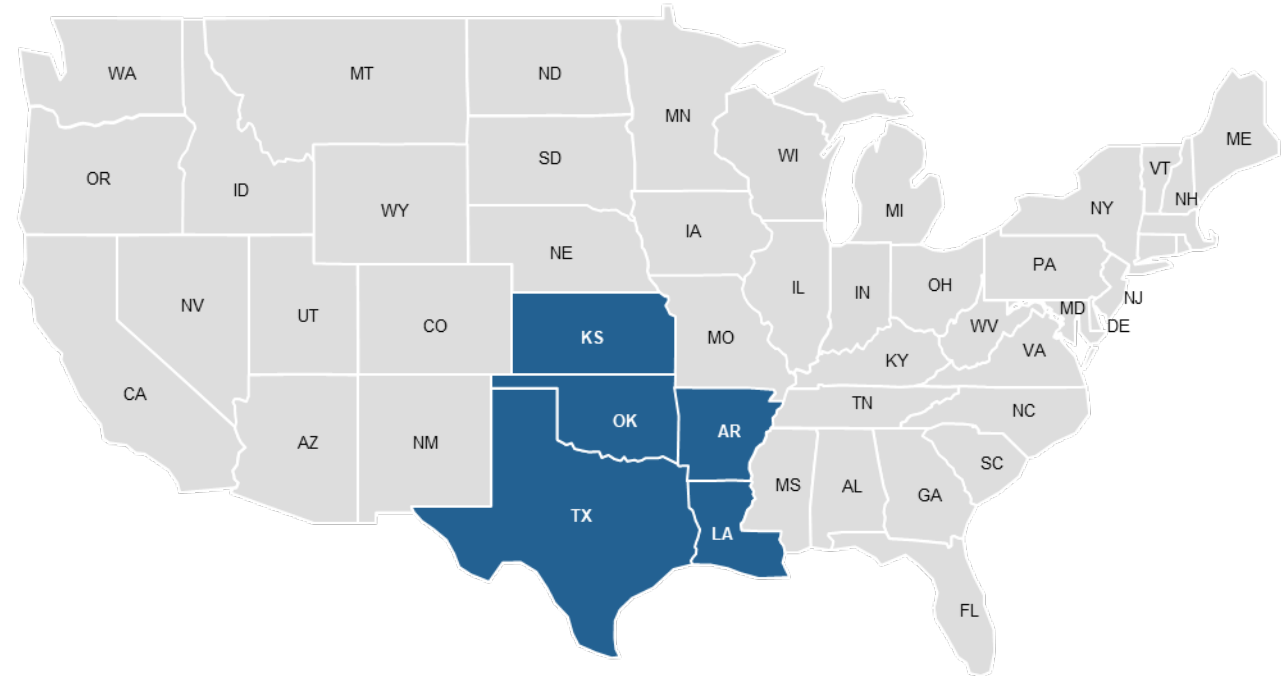
Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion

Report Snapshot: Attendee Overview



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

INSTITUTION	CITY	STATE
Cancer Center of Kansas	Wichita	KS
Highlands Oncology Group	Springdale	AR
Texas Oncology	Dallas	TX
CHRISTUS Ochsner Oncology Clinic	Lake Charles	LA
Hendrick Cancer Center	Abilene	TX
Texas Oncology	Houston	TX
The Center for Cancer and Blood Disorders	Irving	TX
Mercy	Oklahoma City	OK
Texas Oncology	Palestine	TX
The Center for Cancer and Blood Disorders	Weatherford	TX



Report Snapshot: Agenda



Time (ET)	Topic
6.00 PM – 6.15 PM (15 min)	Introduction and ARS Questions <ul style="list-style-type: none">• Program overview and objectives• ARS questions
6.15 PM – 6.50 PM (35 min)	Management of Metastatic Castration-Resistant Prostate Cancer (mCRPC) <ul style="list-style-type: none">• Overview of current data
6.50 PM – 7.50 PM (60 min)	Moderated Discussion
7.50 PM – 8.00 PM (10 min)	Key Takeaways and Meeting Evaluation



Key Insights and Discussion Summary

FIRST-LINE TREATMENT – INSIGHTS AND DATA

“Our practice does not have institutional guidelines that we have to go by and send guidelines to get it paid for. It’s

1. Treatment patterns in Practice 1 (N=20)

The overall survival benefit was not clear. This is not necessarily because there is no overall benefit, or we have overall survival. I think what we need to know is whether there is a significant difference in overall survival. I think what we need to know is whether there is a significant difference in overall survival. I think what we need to know is whether there is a significant difference in overall survival. I think what we need to know is whether there is a significant difference in overall survival.

2. Data needed to confirm from NCI in Practice

That's all a lot of things have been done, nothing is really clear. I think what we need to know is whether there is a significant difference in overall survival. I think what we need to know is whether there is a significant difference in overall survival. I think what we need to know is whether there is a significant difference in overall survival. I think what we need to know is whether there is a significant difference in overall survival.

FIRST-LINE TREATMENT – INSIGHTS AND DATA

“We do have a genetic counselor . . . we use Myriad for all these things . . . mostly it has been tissue biopsies.”

1. Treatment success in Frontline mCRPC

The overall survival benefit was modest. This is not necessarily surprising given the complexity of the disease. In our first overall survival analysis, we did not see any significant improvement in overall survival. However, when we looked at overall survival in patients who were using ARV or ARV, we did not see a significant difference in overall survival. This is not surprising given that the overall survival benefit was modest. This is not necessarily surprising given the complexity of the disease. In our first overall survival analysis, we did not see any significant improvement in overall survival. However, when we looked at overall survival in patients who were using ARV or ARV, we did not see a significant difference in overall survival.

2. Data needed to support Frontline mCRPC in Frontline

What are all the things that we need to know? Nothing is better than ARV and ARV. In our first overall survival analysis, we did not see any significant improvement in overall survival. However, when we looked at overall survival in patients who were using ARV or ARV, we did not see a significant difference in overall survival. This is not surprising given that the overall survival benefit was modest. This is not necessarily surprising given the complexity of the disease. In our first overall survival analysis, we did not see any significant improvement in overall survival. However, when we looked at overall survival in patients who were using ARV or ARV, we did not see a significant difference in overall survival.

SUBSEQUENT TREATMENT – INSIGHTS AND DATA

“We’re doing PSMA PETs, and the problem was we had to get the radio-isotope. Sometimes the half-life is at 3

1. Treatment success in patients with mCRPC

The overall survival benefit was not clear. This is not necessarily because there is no benefit, but it may be because of the way the data was analyzed. The overall survival benefit was not clear because of the way the data was analyzed. The overall survival benefit was not clear because of the way the data was analyzed.

2. Data needed to confirm that PSMA is beneficial

What are all the things that have been done, including a better than 100000 and 100000. The overall survival benefit was not clear because of the way the data was analyzed. The overall survival benefit was not clear because of the way the data was analyzed.

SUBSEQUENT TREATMENT – INSIGHTS AND DATA

“If you don’t have your diagnostic suite set up, I mean you have to build the suite. You have to get the radio

1. Treatment outcomes in capecitabine (XELDA)

The overall survival benefit was modest. This is not unexpected because this is a palliative therapy. In our head-to-head setting, I would not use capecitabine as a first-line systemic therapy. I would use it as a second-line systemic therapy after first using docetaxel or mitoxantrone. The disease-free rate at 1 year is 100% in this trial, so a significant benefit is significant toxicity with the treatment, and overall drug that something is probably.

2. Data needed to confirm that docetaxel is best

What are all the things that have been done, nothing is better than docetaxel and placebo. In early trials with low docetaxel patients do no better. I would be a little skeptical. I would not be one of the first ones to move beyond to docetaxel or something like that. I want something that has been done and we know that docetaxel. If the benefits are not very modest, I think a second trial of docetaxel would be something that I would be looking at. Overall survival data, that's good. But in this disease with docetaxel comes by its own, do have to use some surrogate of efficacy. So, I think that's a bit of a trade-off. The overall survival rate of docetaxel is that, what's going to be doing the rest of the system. This is not sufficient.



Advisor Key Takeaways

Advisor Key Takeaways



ADVISOR

> Re-emphasized the importance of using cabazitaxel

- There is a better understanding of sequencing therapy
- Really want to talk further with professional and understand how we have a better understanding of these drugs and have 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 important in the cabazitaxel and how the side effect would be managed in a second-line option for my own elderly patients
- There's a lot more emphasis on sequenced therapy and to things the professional that may offer some side effects

• It was good to hear about innovations and what's coming down the pipeline for immunotherapy

- There's a lot of good options for second-line that just look like you manage with second-line other profile and good response rate
- Immunotherapy is an option

ADVISOR

> Learned about different PET scans and their uses

- The immunotherapy, adding the use to have different options besides PD-1 and what is going to look like

- The hope is that some of these immunotherapy agents will get added into frontline and hopefully improve the look like

- It's interesting to learn about all these immunotherapy treatments, specifically the immune 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 pipeline



Insights Into Metastatic Castration-Resistant Prostate Cancer

ARS Results: First-Line Treatment of
mCRPC

All Advisors See Patients With Advanced Prostate Cancer. For 60% of the Advisors This Is Less Than 20% of Their Total Patient Population (N = 10)

FOR EXAMPLE PURPOSES ONLY



Almost 90% of Advisors Declared More Than 20% of Their Patients With Advanced Prostate Cancer Have Metastatic Disease (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



All Advisors Refer More Than 25% of Their Patients With mCRPC for Germline and Somatic Testing (n = 9*)

What proportion of your mCRPC patients do you refer for germline and somatic

FOR EXAMPLE PURPOSES ONLY



Seventy Percent of the Advisors Have Access to a Hot Lab/Theranostics Department in Their Practice (N = 10)

What service lines are currently available within your practice to support the treatment of

FOR EXAMPLE PURPOSES ONLY



Patient Scenario 1

> What would be your preferred therapy for a patient with mCRPC with the following

[Blurred text describing patient characteristics]

[Blurred text describing clinical context]

About 78% of the Advisors Would Select Docetaxel for a Patient With mCRPC With Symptomatic Visceral Metastases Previously Treated With ADT + an AR-Targeted Agent (n = 9*)

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



Patient Scenario 2



> What would be your preferred therapy for a patient with mCRPC with the following

[Blurred text describing patient characteristics]

> What would be your preferred therapy for a patient with mCRPC with the following

Half the Advisors Would Recommend an AR-Targeted Agent for a Patient With mCRPC With Asymptomatic Bone-Only Metastases Previously Treated With ADT (N = 10)

FOR EXAMPLE PURPOSES ONLY



Two-Thirds of the Advisors Would Recommend an AR-Targeted Agent for a Patient With mCRPC With Symptomatic Bone and Visceral Metastases Previously Treated With ADT-Docetaxel (n = 9*)

CASES

FOR EXAMPLE PURPOSES ONLY





Insights Into Metastatic Castration-Resistant Prostate Cancer

ARS Results: Management of Progressive mCRPC

Patient Scenario 1

- > What would be your preferred therapy for a patient with previously treated mCRPC

- [Faded text]

While the Majority of Advisors Would Utilize Cabazitaxel ± Carboplatin in This Scenario, 20% Would Choose a Trial of 177Lu-PSMA-617 (N = 10)

FOR EXAMPLE PURPOSES ONLY



Patient Scenario 2

> What would be your preferred therapy for a patient with previously treated mCRPC

1. Enzalutamide

One-Third of Advisors Would Choose Radium-223 in This Case Scenario (n = 9*)

0%

100%

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



While Half the Advisors Would Recommend Cabazitaxel ± Carboplatin for This Patient, 40% Would Choose a Trial of 177Lu-PSMA-617 (N = 10)

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