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

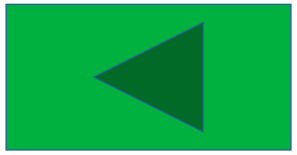
Virtual Platform

March 23, 2022

Insights From National Community Oncologists

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

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

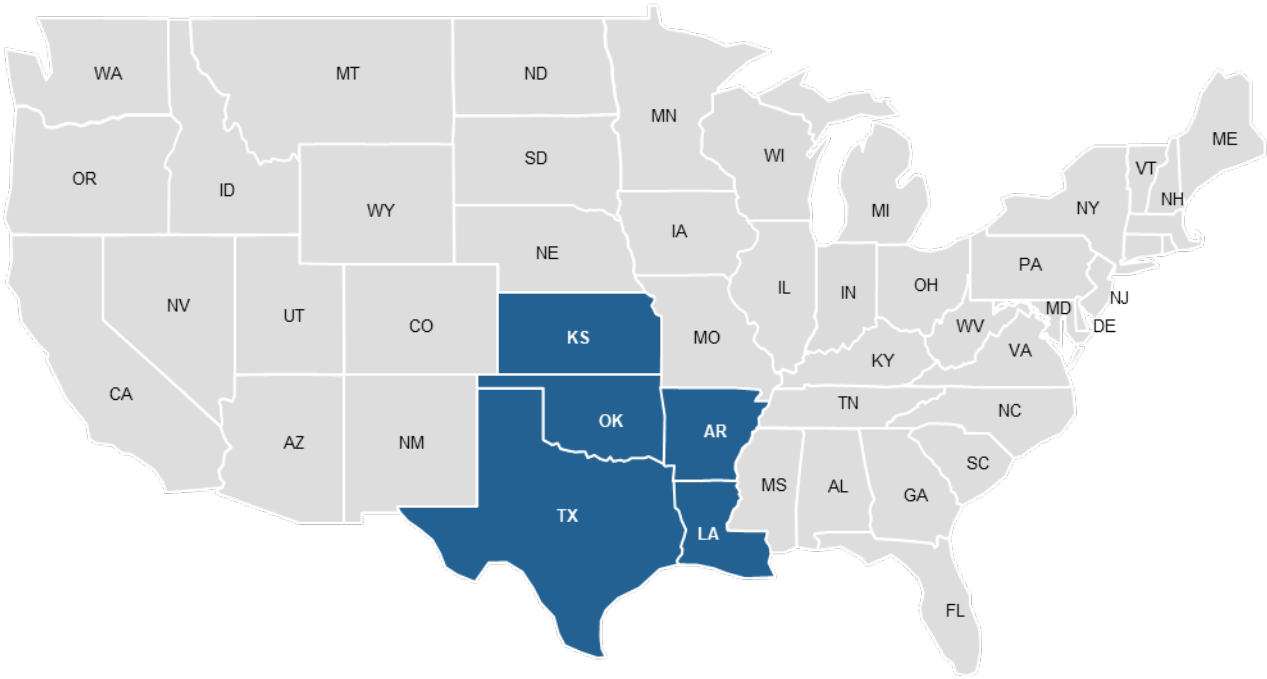
Insights were obtained on **first-line and subsequent therapies for mCRPC** in the community and their impact on patient management

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** • Program overview and objectives • ARS questions
6.15 PM – 6.50 PM (35 min)	**Management of Metastatic Castration-Resistant Prostate Cancer (mCRPC)** • 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**

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Key Insights and Discussion Summary

Discussion: First-Line Treatment of mCRPC (1/3)

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FIRST-LINE TREATMENT – INSIGHTS AND DATA

First-line treatment preferences	*"Mostly, it's like a clinical decision in my opinion and we go with docetaxel for a fast response, but I think this might be just a reflex action . . . maybe there is more to it, but I've seen patients respond very well to docetaxel, especially when you are wanting faster response, especially with visceral mets."* *"My approach differs for each and every patient, but generally, like if I see a high burden of disease . . . for instance, I had a patient recently. He had visceral disease, severe bony metastatic disease. I gave him 6 cycles of docetaxel, and he had a complete response, so his bone scans and CT scans were completely clean. He is currently on abiraterone and prednisone along with Lupron shots every 3 months, and he is doing fine, and his PSA remains undetectable. . . . If I have a patient who is robust and who has a good performance status, I tend to start with all the treatments that I can."* *"Androgen suppression is my first step as well . . . then regarding other therapies . . . I try to sequence them, so of course, like the back ones there."*
Factors affecting first-line treatment choice	*"It kind of depends what they got in the first line, once they become castrate-resistant."* *"I try to look at the performance status of the patient and if I need to get a quick response, I will use chemotherapy. If the patient has multiple sites of disease, or has visceral crisis, or if the patient is like, recently I had a patient with almost cord impingement in the hospital, so for that patient, I started on docetaxel first line, and he responded actually beautifully. I'm not able to get newer generations like abiraterone in the hospital, but if the patient is clinically stable, and PSA is rising slowly, and we have time, then I try to do hormonal therapy first."* *"If someone has a low PSA and liver mets, they're going to respond to chemotherapy faster than they would on the first line Abi or Enza, but it's not necessarily quicker for chemo . . ."*

Discussion: First-Line Treatment of mCRPC (2/3)

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FIRST-LINE TREATMENT – INSIGHTS AND DATA

Role of guidelines in decision-making	*"Our practice does not have institutional guidelines that we have to go by and send guidelines to get it paid for. It's really about just the drug getting covered. Usually, if it's covered by NCCN, we are able to get it paid for."* *"We have internal pathways in our group. We try and utilize them, and we have to stay compliant with the internal pathways as well. Of course, I mean, guidelines are there, and we initially come up with the plan ourselves and then try to see if the pathways align with it."* *"I mostly go to NCCN."* *"We use NCCN. NCCN has to be category 2A or less, to be or beyond we don't approve . . . like to follow the guidelines 2A and below, so you don't end up just adding new partner or somebody out of training trying to go to extreme like phase I study, phase II study, or making treatment like that. So, this will make it homogeneity."*
NGS and mutation testing	*"We have a cancer geneticist with us [to do germline testing]."* *"They do [send it to a genetic counselor], but then they send it out to Myriad, so it's typically where they go to for germline."* *"We, in our practice, have collaboration with UT Southwestern, even though I do satellite clinics as well in remote locations . . . they can do a virtual Zoom meeting and they can send the kits to home, and they can collect the saliva sample and ship it out, and that gets tested,"* *"No [we don't have less than 80% of patients with advanced prostate cancer that are getting Germline], for sure as a standard of care, you should be doing those Germline testing nowadays . . . sometimes I do like a Guardant . . . sometimes sequence Guardant360 liquid biopsy."*

Discussion: First-Line Treatment of mCRPC (3/3)

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FIRST-LINE TREATMENT – INSIGHTS AND DATA

NGS and mutation testing (cont)	*"We do have a genetic counselor . . . we use Myriad for all these things . . . mostly it has been tissue biopsies."* *"We would love to get tissue. Unfortunately, a lot of times, there's no accessible lymph nodes or visceral disease and so, we're stuck with liquid biopsies."* *[On asking has anyone used PSMA as a biomarker for CRPC?]* *"We've used it too . . . I haven't used it just for pure biomarker, I use it to help me plan my treatments."*
Current treatment of progressive disease	*"The patients who have progressed on docetaxel or chemotherapy, if you are looking for other options, then I think that would be good at the metastatic or CRPC setting . . . use it [177Lu-PSMA-617] as a prognostic and treatment option."* *"In my experience, it has been very difficult to give cabazitaxel post docetaxel. I think you never get a patient who would be able to tolerate that and mostly these are, obviously patients who are in their 70s and late 80s. So, use of cabazitaxel is kind of very limited in my opinion."* *"Some patients are younger, and I had used [cabazitaxel] quite a few times in younger patients or older fit patients."*

Discussion: Management of Progressive mCRPC (1/2)

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SUBSEQUENT TREATMENT – INSIGHTS AND DATA

Access to radiopharmaceuticals	*"We're doing PSMA PETs, and the problem was we had to get the radio-isotope. Sometimes the half-life is at 3 hours, but the product is 1 hour, and so you need to be close to either a cyclotron or a radio pharmacy that can generate the dose for you."* *"We do PET scans in our department, but [the problem is access to radiopharmaceuticals] . . . we live in the Midwest, in Wichita, Kansas, and the closest stock around us is located at 100 miles, so we don't have [radio pharmacy that can generate the dose for us] and the local cyclotron doesn't do those yet . . ."* *"We urologists give it [radium] in our account and we have radiation therapy staff affiliated with the hospital where we work at, so it is not done in our house, but it's given through . . . many of the patients had radium."* *"We give radium in our clinic, so our radiation oncologist helps administer that, but we have treated several patients."* *"[On selecting patients] Usually they have mainly bone-only disease if they have already progressed on either enzalutamide or abiraterone, and if they only have bone-only disease before I try to do chemo, I'll do the radium for them."* *"The radiation oncologist does it . . . if the patient meets the criteria, bone-only mets, no visceral mets then it is; I would say we give it a lot."*

Discussion: Management of Progressive mCRPC (2/2)

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SUBSEQUENT TREATMENT – INSIGHTS AND DATA

Barriers to adoption of 177Lu-PSMA-617	*"If you don't have your diagnostic suite set up, I mean you have to build the suite. You have to get the radio license approved with your radio-oncologist and then you have to get approved through the insurance and a lot more logistical challenges as opposed to that I think the availability challenge."* *"One of the issues is like, in our practice, medical oncologists, urologists, do hold on to the patient longer, so often we don't see them in the RAD, and they become pancytopenic and they want us to do bone marrow biopsy - - when they are really pancytopenic."* *"I think the patient selection in this regard, the patient-population who are candidates for this, are kind of limited and the time when they come to us, I agree with Dr Mattar. They have been held by their urologist or someone else for a long time, so by the time they come to us, it's kind of pretty delayed and too late for them to go to this."*

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Advisor Key Takeaways

Advisor Key Takeaways

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ADVISOR		ADVISOR	
1	> Re-emphasized the importance of using cabazitaxel before other hormone inhibitor in younger or older fit patients	6	> Learned about different PET scans and their uses > Looking forward to use radionuclides as the data are very promising
2	> Will certainly use the radio ligand, hopefully in next 2–3 weeks when it is commercially available > In the future, it will move to castrate-sensitive setting, and might actually replace external beam radiation as a potential modality, and hopefully less side effects	7	> Enjoyed the presentation > Nice overview of the current treatment options > Will review the radiopharmaceuticals a bit more closely after this presentation
3	> Likes the data on the different radiopharmaceuticals, cabazitaxel, and ADTs > Helped clear confusion in selection for castrate-resistant or castrate-sensitive setting	8	> Data presented in an easy way to understand
4	> Moving in the direction of more radiopharmaceuticals in the care of prostate cancer > Patients with aggressive small-cell disease will benefit the most from any new treatment modality which is coming in	9	> Prostate cancer progresses much slower than science and the field of medicine > Patients are living longer and have more options > Good to review new data, look forward to utilizing it
5	> New data with the lutetium is the biggest takeaway > Just received intimation regarding its FDA approval, reviewing the data is very helpful		

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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)

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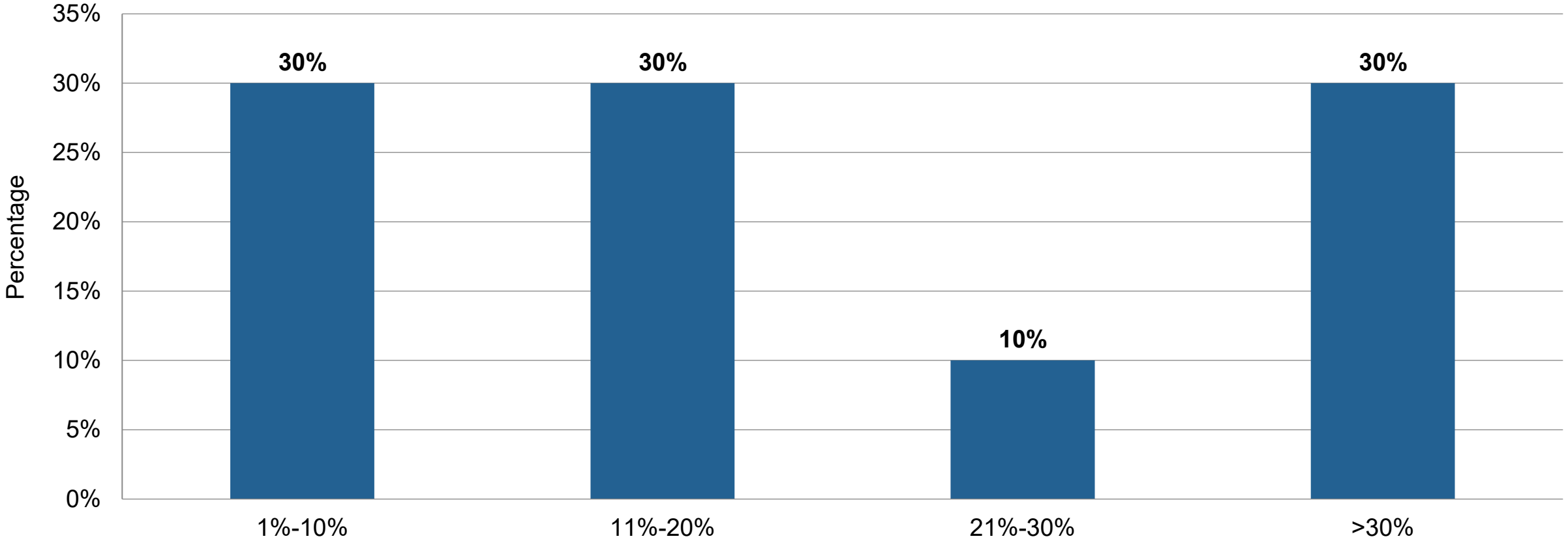
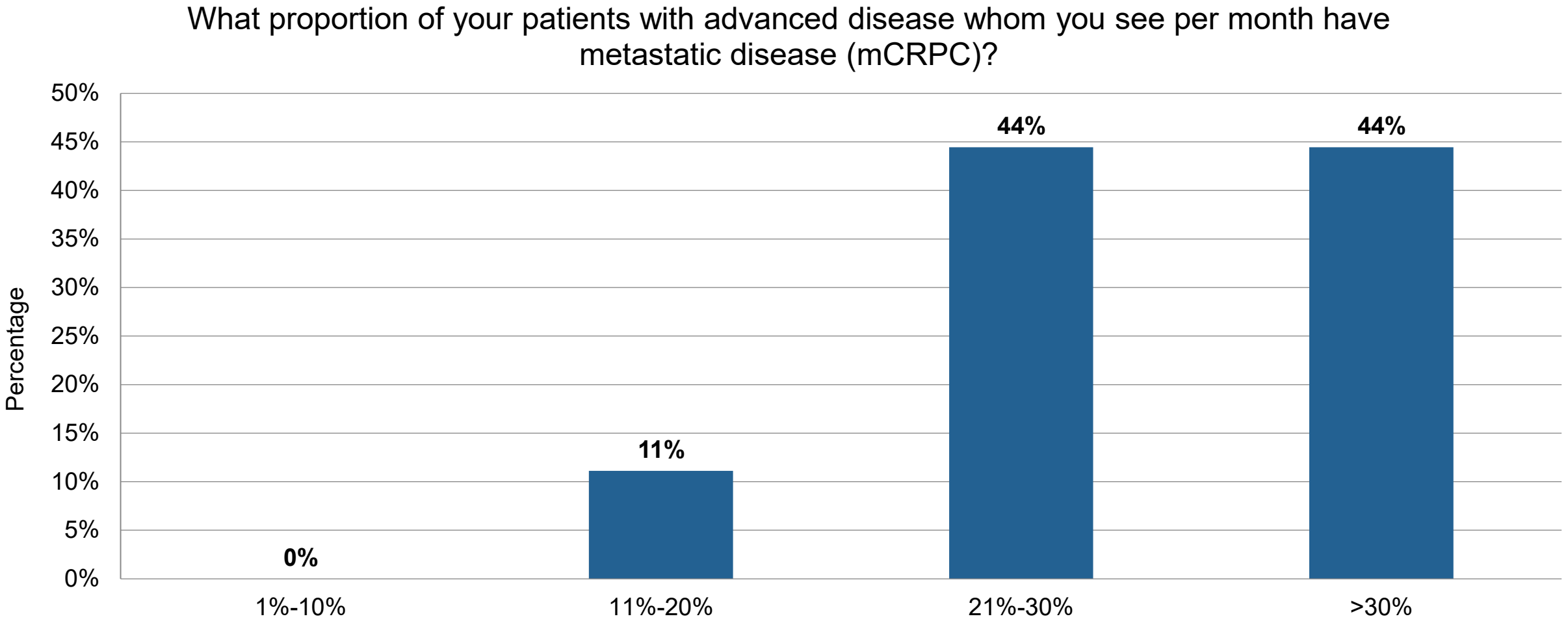
What percentage of your **TOTAL** patients whom you see per month have advanced prostate cancer?

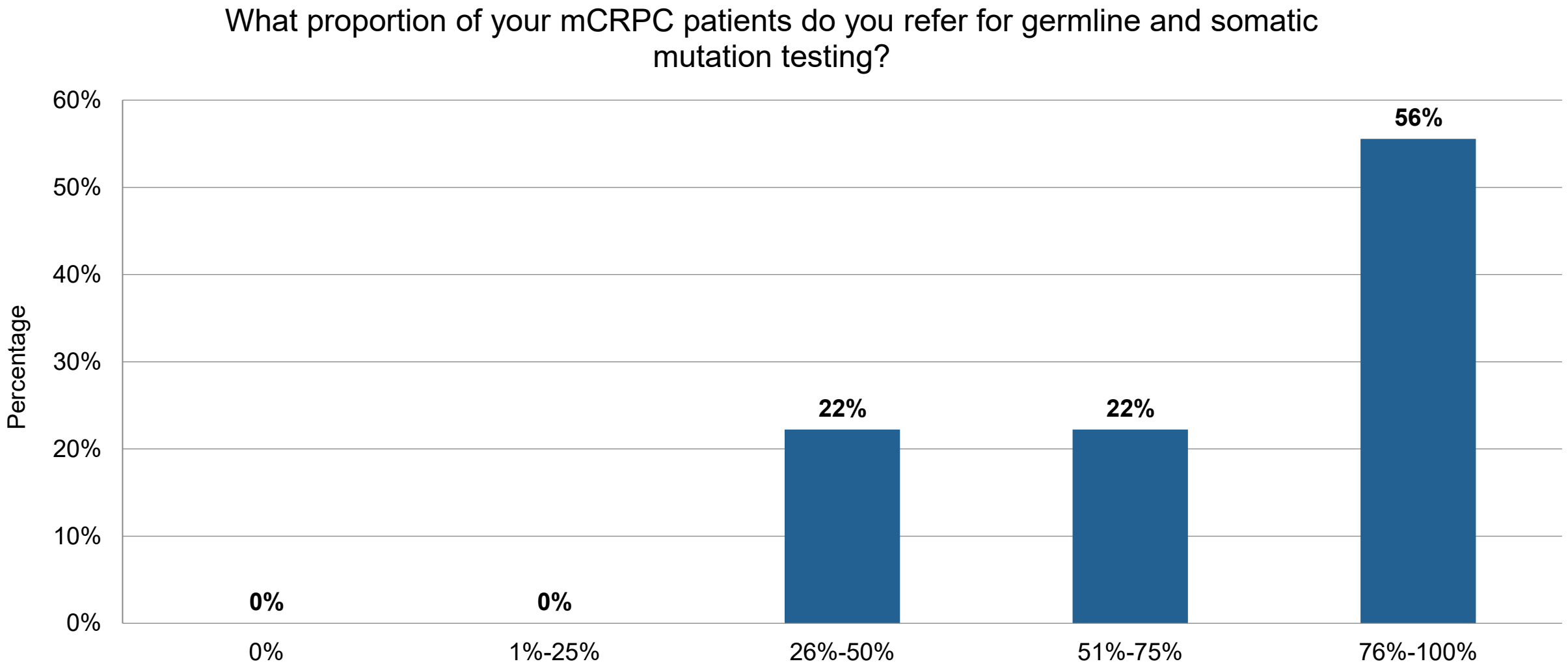


Almost 90% of Advisors Declared More Than 20% of Their Patients With Advanced Prostate Cancer Have Metastatic Disease (n = 9*)



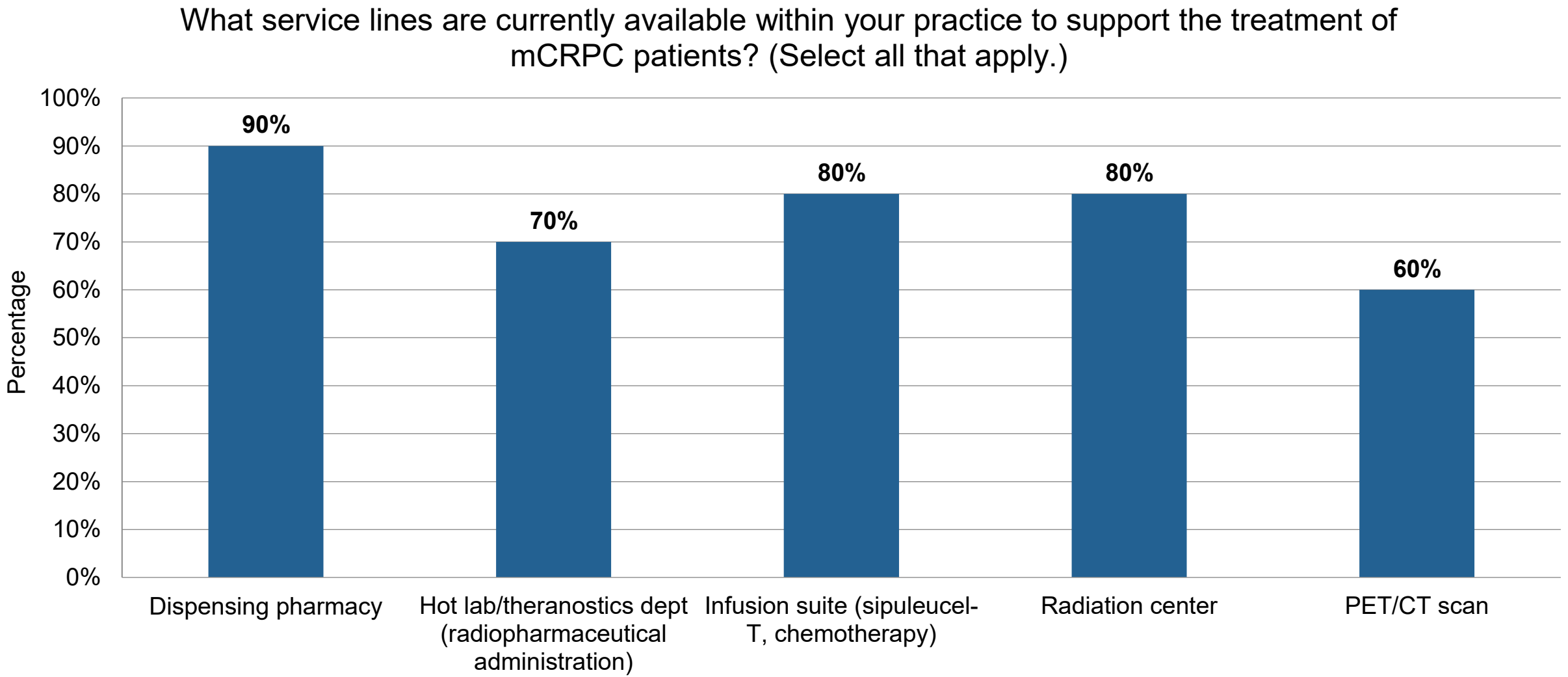
*One advisor did not respond.

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



*One advisor did not respond.

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



Patient Scenario 1

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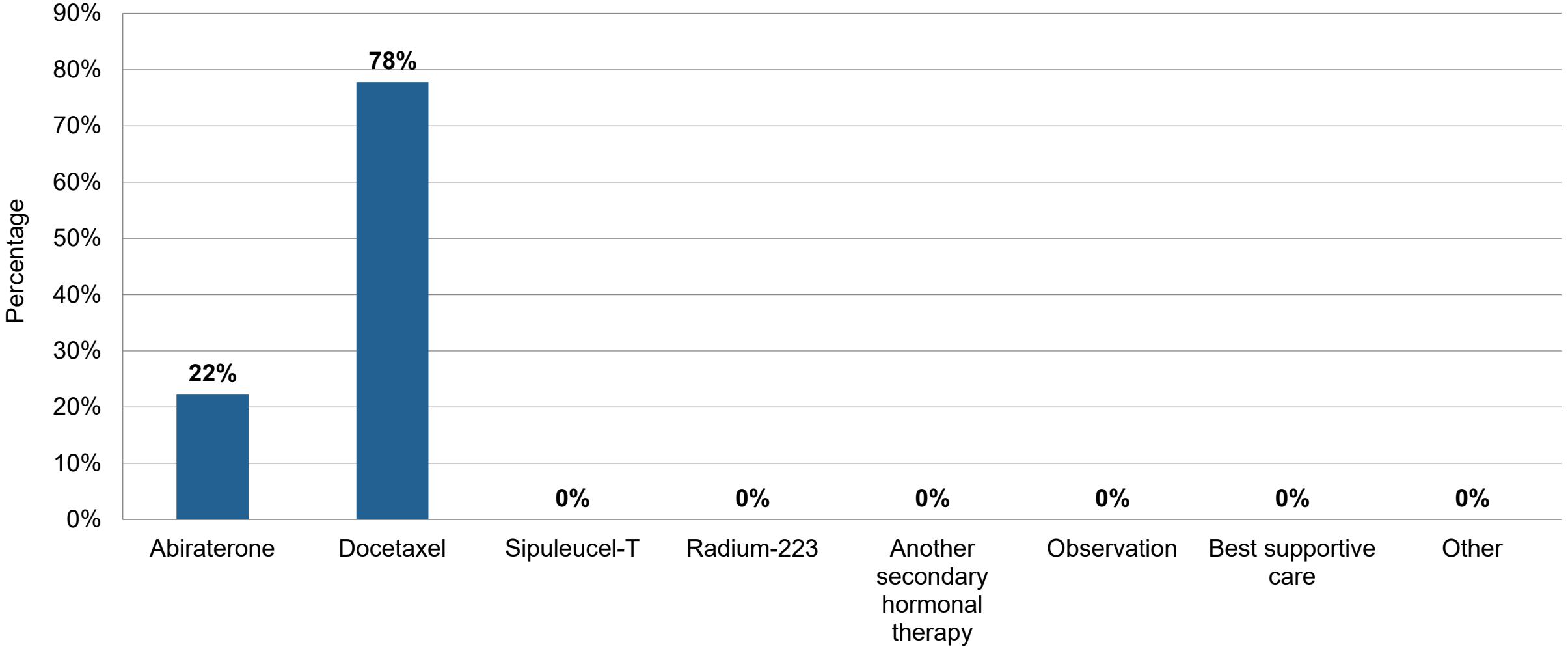
- What would be your preferred therapy for a patient with mCRPC with the following characteristics?
  - Visceral metastases
  - Symptomatic disease
  - ECOG 1
  - Received prior ADT + AR-targeted therapy (enzalutamide)
  - Unknown genetic mutations

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*)



*One advisor did not respond.

Patient Scenario 2

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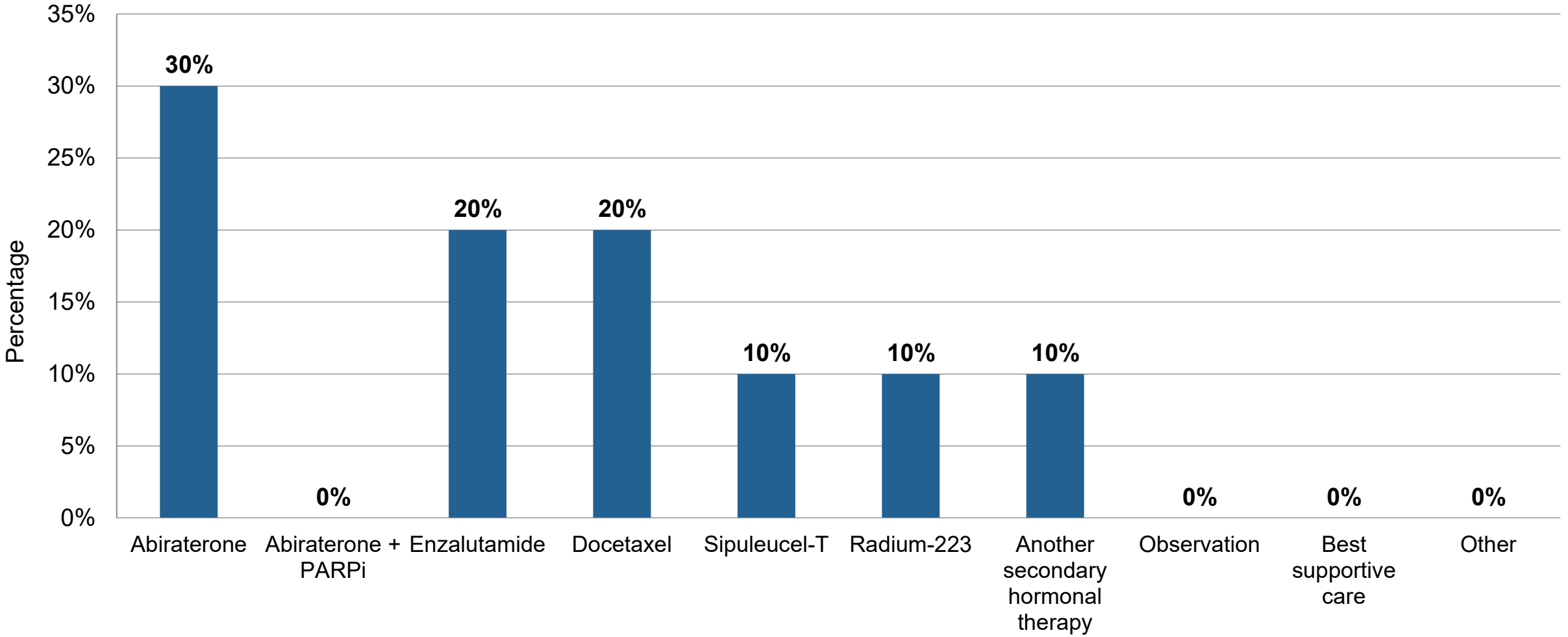
- What would be your preferred therapy for a patient with mCRPC with the following characteristics?
  - Bone-only metastases
  - Asymptomatic disease
  - ECOG 0
  - Received prior ADT
  - Unknown genetic mutations

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)



Patient Scenario 3

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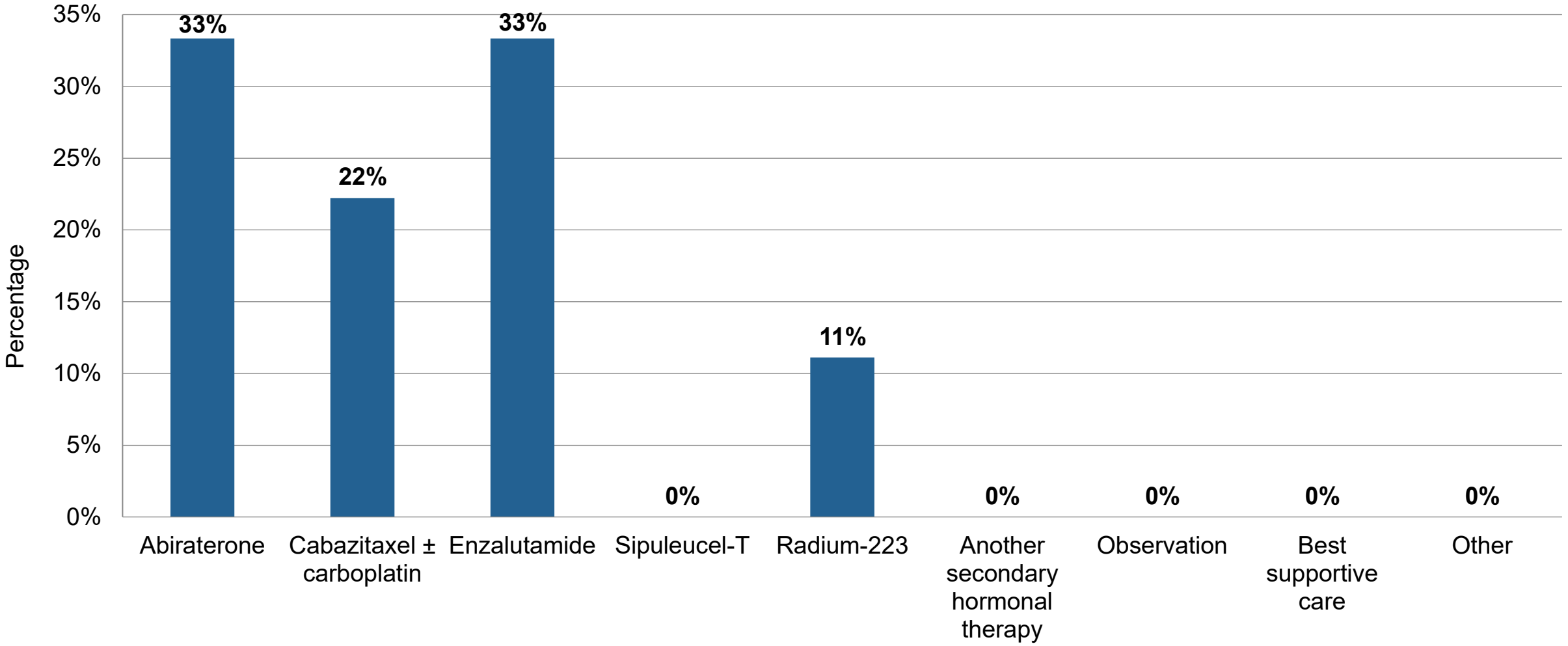
- What would be your preferred therapy for a patient with mCRPC with the following characteristics?
  - Bone and visceral metastases
  - Symptomatic disease
  - ECOG 2
  - Received prior ADT and docetaxel
  - Unknown genetic mutations

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*)



*One advisor did not respond.

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ARS Results: Management of Progressive mCRPC

Patient Scenario 1

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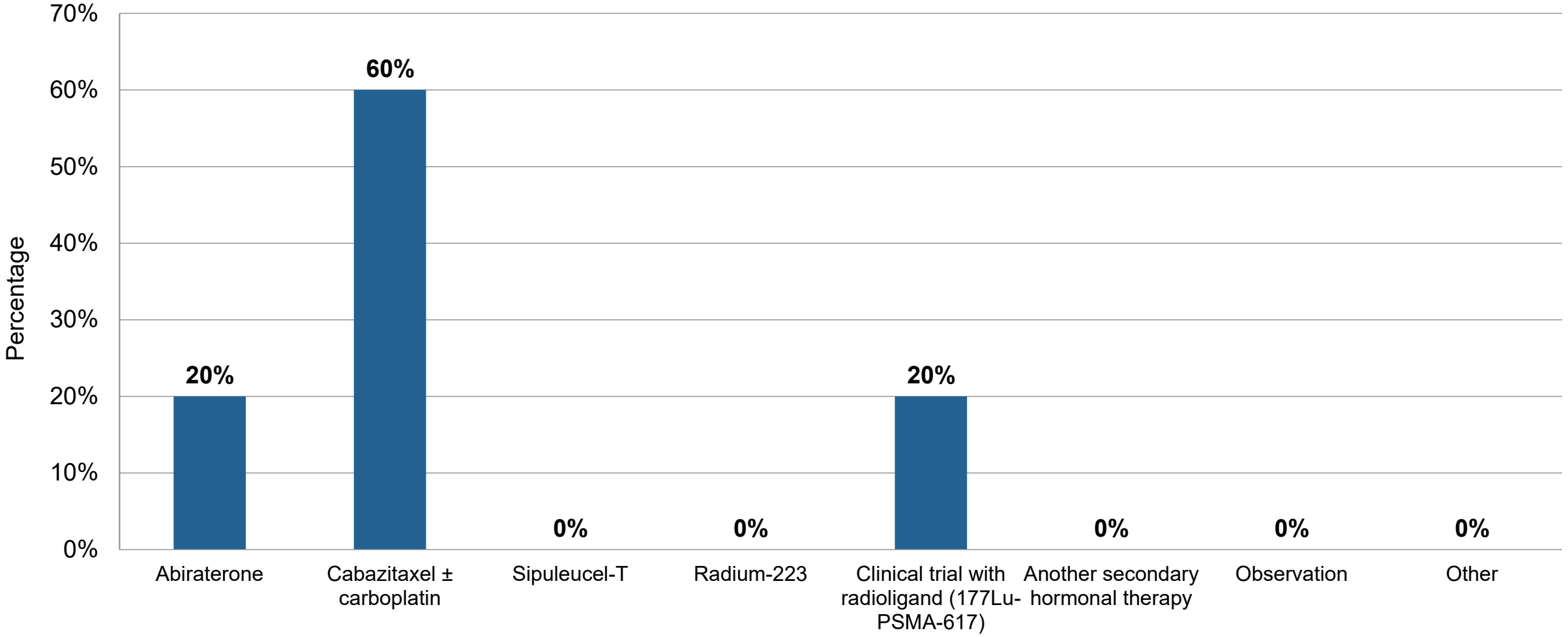
- What would be your preferred therapy for a patient with previously treated mCRPC with the following characteristics?
  - Visceral metastases
  - Symptomatic disease
  - ECOG 1
  - Prior ADT + AR-targeted therapy (enzalutamide)
  - Prior docetaxel therapy
  - Unknown genetic mutation

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



Patient Scenario 2

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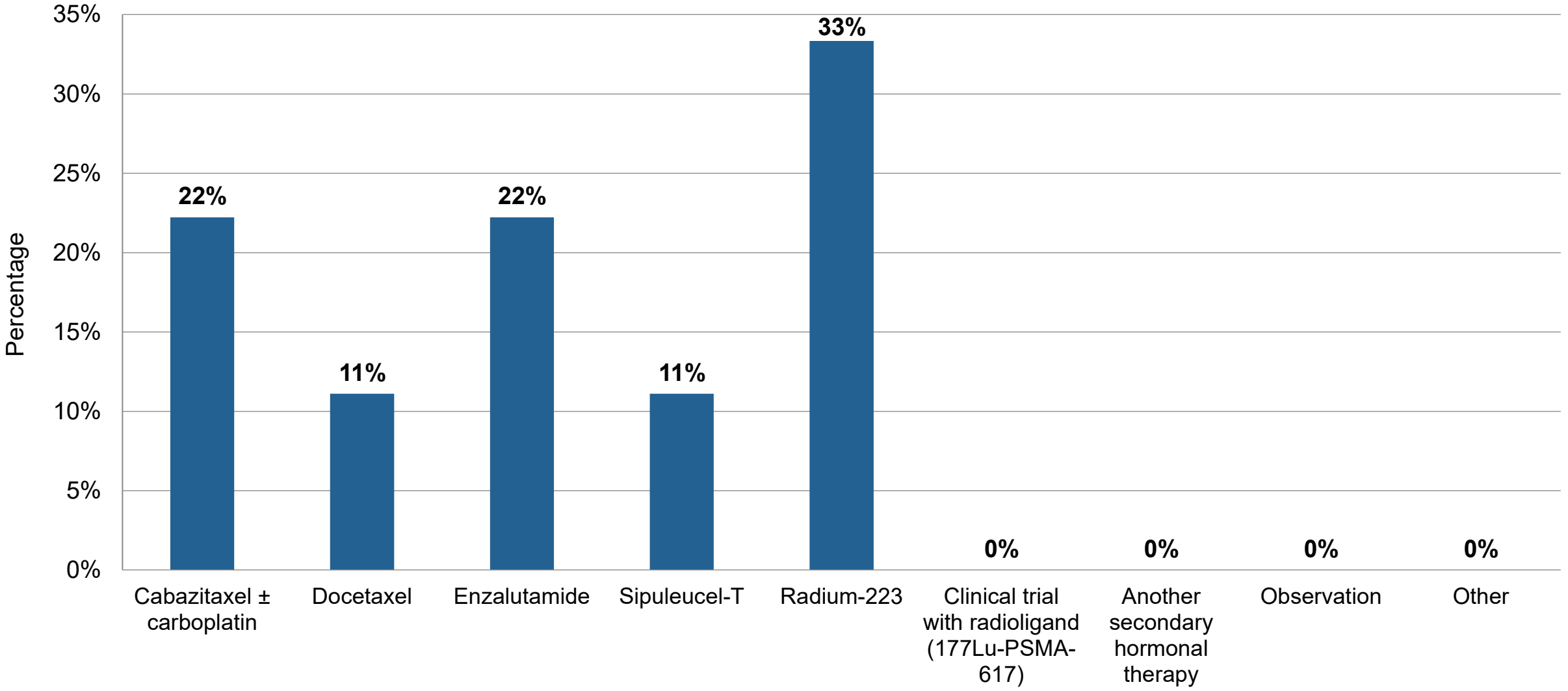
- What would be your preferred therapy for a patient with previously treated mCRPC with the following characteristics?
  - Bone-only metastases
  - Asymptomatic disease
  - ECOG 0
  - Received prior ADT
  - Received prior abiraterone
  - Unknown genetic mutations

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



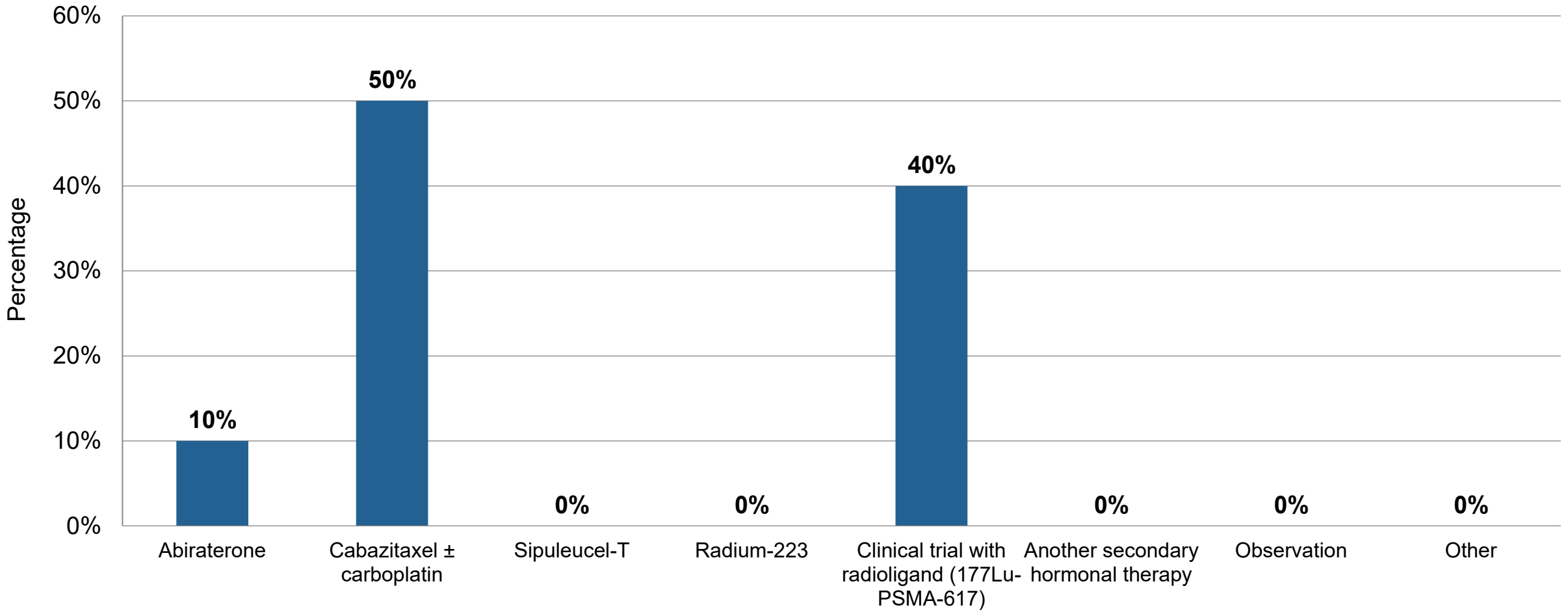
*One advisor did not respond.

Patient Scenario 3

CASES

- What would be your preferred therapy for a patient with mCRPC with the following characteristics?
  - Bone and visceral metastases
  - Symptomatic disease
  - ECOG 2
  - Received prior ADT and docetaxel
  - Received prior enzalutamide
  - Unknown genetic mutations

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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