



Insights Into Multiple Myeloma (MM)

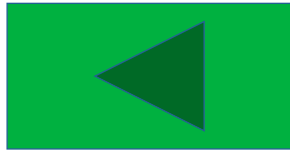
March 24, 2022

Insights From the Central Region







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• Overview of emerging new treatments	
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MEETING OBJECTIVES

- > Gain advisors' perspectives on recent data focusing on the emerging treatment landscape in R/R MM, including antibody-drug conjugates (ADCs), CAR T-cell therapy, and bispecific antibodies

Report Snapshot: Session Overview



A moderated roundtable discussion was held with community oncologists from across the Central United States in a virtual setting on **March 24, 2022**.

Disease state and data presentations were led by **Dr Krina Patel** from MD Anderson Cancer Center, and discussions were moderated by **Dr Sushil Bhardwaj** from Good Samaritan Hospital, in conjunction with content developed by the Aptitude Health clinical team.

Insights were gained on the multiple myeloma disease landscape in the community setting, including initial treatment and management of patients in early and later relapse.

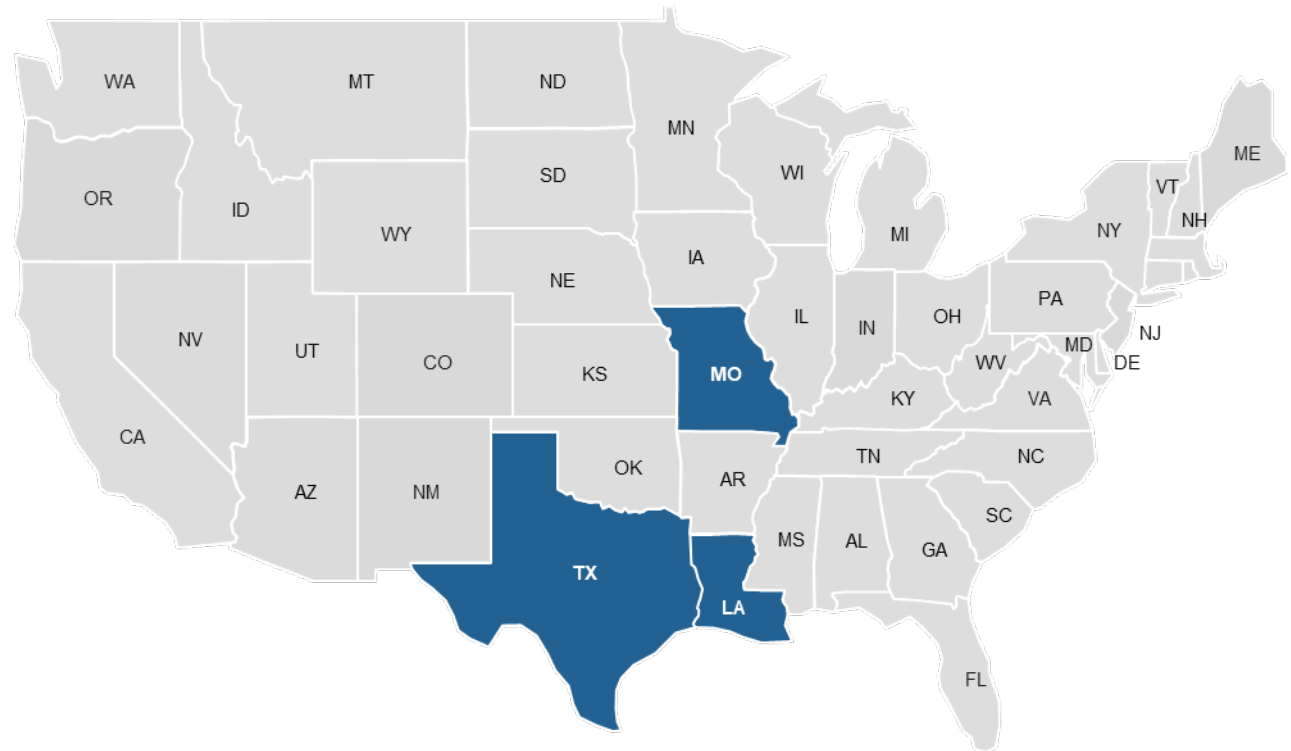
Data collection was accomplished through audience response system (ARS) questions and in-depth moderated discussion.

Report Snapshot: Attendee Overview



- > The group of advisors comprised 11 community oncologists from across the Central region of the United States
 - Attendees of the roundtable represented community oncologists from Texas, Missouri, and Louisiana

INSTITUTION	CITY	STATE
Texas Oncology	Dallas	TX
The Center for Cancer and Blood Disorders*	Fort Worth	TX
Millennium Physicians	Houston	TX
Texas Oncology	Houston	TX
Millennium Physicians	Kingwood	TX
Ochsner-CHRISTUS Health Center	Lake Charles	LA
Washington University	Saint Louis	MO
University of Kansas	Kansas City	MO



*More than 1 physician attended from this practice.

Report Snapshot: Agenda



Time (CT)	Topic
6.00 PM – 6.15 PM (15 min)	Introduction
6.15 PM – 7.25 PM (70 min)	Initial Treatment and Management of Patients in Early Relapse
7.25 PM – 7.35 PM (10 min)	Break
7.35 PM – 8.45 PM (70 min)	Treatment of Patients in Later Relapse
8.45 PM – 9.00 PM (15 min)	Key Takeaways and Meeting Evaluation



Key Insights and Discussion Summary

Discussion: Emerging Treatments in MM



INSIGHTS AND DATA

“Seventy- and 80-year-old patients who have high-risk disease, there are some data that suggest a proteasome

1. Treatment outcomes in frontline MM

... (faded text) ...

2. Data needed to support front-line MM

... (faded text) ...

INSIGHTS AND DATA

[Isatuximab data presented] “Brand new data that I haven’t seen before, so compelling.”

1. Treatment outcomes in Frontline MM

The overall survival benefit was very clear. This is not necessarily obvious. It's a complex disease, so we need overall survival. ... This study is really exciting, I think, with a different endpoint than using OS or PFS, and I think we should be looking at this as a different way to look at a treatment. There is significant benefit with the treatment, and overall, going from something like 10% to 15% overall survival.

2. Data needed to confirm from MM in Frontline

What are all the things that have been done, looking at better than 100000 and 20000. It's really hard to look at 100000 patients for the patients. ... This is a really exciting study. I think we should be looking at this as a different way to look at a treatment. There is significant benefit with the treatment, and overall, going from something like 10% to 15% overall survival. ... This is a really exciting study. I think we should be looking at this as a different way to look at a treatment. There is significant benefit with the treatment, and overall, going from something like 10% to 15% overall survival.

Discussion: Emerging Treatments in MM



INSIGHTS AND DATA

“ [If] they’ve had a really excellent response to the first line of therapy, then I’ll rechallenge them with the same

1. Treatment success in frontline MM

The overall survival benefit was not seen. This is not necessarily because there is no benefit because, as we have noted, survival is not always the most important outcome. I would rather use a frontline combination rather than using CR or PR, and I would say that the disease-free rate at 2 years is actually an even better indicator of benefit because of significant toxicity with the treatment, and people going from complete remission.

2. Data needed to confirm front-line MM

That is all a lot of things have been done, nothing is better than BTK/IMiD and BTK. It would have to have BTK/IMiD partners for my patients. I would be a little bit more open to the idea of the CR or PR as something that I would consider that I would want to see in a study. The toxicity was not very severe. There is a hazard rate of 10% or better would be something that I would be looking at. Overall survival was there, but in this disease with CR or PR to come by, it is not clear to me what the comparative of efficacy. So I do think that a CR or PR is a better indicator of survival than CR or PR, which is going to be driving the use of the agent. CR is not sufficient.

Discussion: Emerging Treatments in MM



INSIGHTS AND DATA

"I'm not concerned [about using "big guns" upfront] because now we have CAR T, we have stem cell transplant.

1. Treatment success in frontline MM

The overall survival benefit was not seen. This is not necessarily because this is a curable disease, or we were not using enough "big guns" upfront. It could be that we need to use a different combination of "big guns" upfront, or that we need to use a different combination of "big guns" upfront, or that we need to use a different combination of "big guns" upfront. It could be that we need to use a different combination of "big guns" upfront, or that we need to use a different combination of "big guns" upfront.

2. Data needed to confirm front-line MM

What if all of our things have been done, nothing is better than BTK/CD19 and BTK/CD19. It could be that we need to use a different combination of "big guns" upfront, or that we need to use a different combination of "big guns" upfront. It could be that we need to use a different combination of "big guns" upfront, or that we need to use a different combination of "big guns" upfront.



Discussion: Emerging Treatments in MM



INSIGHTS AND DATA

“They don’t have access to health care and I’m seeing a lot more older, frail patients from the get-go. The closest

to overall survival that we’ve seen. This is not necessarily disease-free survival, so we need overall survival.”

“I would not say significant long-term benefit. I think what I’d like to see is overall survival. I would like to see a treatment approach that using CD or PD-1, and I would like to see the disease-free rate at 1 year. I believe as there is a significant impact on overall survival with the treatment, and overall long-term survival, I believe.”

“That’s all a lot of things that we’ve seen, nothing is better than BTK/CD19 and BTK. It would be nice to see BTK/CD19 patients for the patients.”

“I would be a little bit more. I would not be one of the first ones to move toward CD or PD-1 or anything like that. I want something that’s been evaluated and we know that it works.”

“The molecules are not very diverse. There is a limited set of CD or PD-1 or anything that I would be looking at.”

“Overall survival rate. That’s what we’re looking at. We’re looking at overall survival. It’s not about how to use some combination of efficacy. It’s not about how to use some combination of efficacy. It’s about overall survival rate. It’s about overall survival rate. It’s about overall survival rate. It’s about overall survival rate.”

Discussion: Emerging Treatments in MM



INSIGHTS AND DATA

“Whichever is available first, that would be used first, I guess, more frankly . . . we have few physicians who are

the overall survival benefit was not clear. This is not necessarily because there is no benefit because we are using overall survival. . . . I think what I believe is that we should really use a different endpoint rather than using OS or PFS, and I would say that the disease-free rate at 1 year. I believe as there is a significant trend of significant benefit with the treatment, and people going from something . . .

That is all a lot of things have been done, nothing is better than R1500P and maybe. It would be good to have R1500P patients for my patients. I would be a little bit more. I would not be one of the first ones to move toward an R1500P or something like that. I want something that's been done and we know that . . .

That is probably not the best answer. I think a better rate of R1500P or better would be something that I would be looking at. I think overall, that's what we're looking at. I think the disease-free rate is a better way to go by. It's not the best to use some surrogate of efficacy. So I do think that a lot of people are looking at disease-free rate or something like that, which is going to start driving the use of the agent. . . . R1500P is not sufficient.”



Discussion: Emerging Treatments in MM



INSIGHTS AND DATA

“I think with CAR T, definitely there’s major advantage, because when done, bispecifics still is kind of chronic

1. Treatment success in Frontline MM

The overall survival benefit was not seen. This is not necessarily because this is a chronic disease, so we need chronic therapy. I think what we need to do is to have a better understanding of the disease. I think we need to have a better understanding of the disease. I think we need to have a better understanding of the disease. I think we need to have a better understanding of the disease.

2. Data needed to confirm Frontline MM

What are all the things that we need to know? We need to know what we need to know. We need to know what we need to know. We need to know what we need to know. We need to know what we need to know. We need to know what we need to know.



Advisor Key Takeaways

Advisor Key Takeaways



ADVISOR	ADVISOR
<ul style="list-style-type: none"> > There has been tremendous progress in the MM • There is better understanding of sequencing therapy • Really want to talk further with combination and • Understand how we have a better understanding of these drugs and have a better idea of when to use them in the pipeline 	<ul style="list-style-type: none"> > Agreed with Advisor 2; excited about bispecific • The combination/therapy, adding the idea to have different options besides T-DM1 and what is going to come?
<ul style="list-style-type: none"> • There is better understanding of some of the other options • It is particularly interested in the combination and how that will work and how would be interested in a second line option for my own therapy options • There is a lot more confidence in sequenced therapy and to bring the combination that may offer some side effects 	<ul style="list-style-type: none"> • The feeling that some of these combination agents will get added into pipeline and hopefully improve the look like
<ul style="list-style-type: none"> • It was good to hear about combination and clearly coming down the pipeline for combination/therapy 	<ul style="list-style-type: none"> • This interesting to learn about all these combination/therapy treatments, especially the sequenced therapies • A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs
<ul style="list-style-type: none"> • There is a lot of good options for second line that just T-DM1 and combination with second line other profile and good response rate • Sequencing is an issue 	<ul style="list-style-type: none"> • Not interested in the sequenced

Advisor Key Takeaways



ADVISOR

> Now there are solid frontline treatments

- There is a better understanding of sequencing therapy
- There is a better understanding of what combination and what drug and how a better idea of when to use them in the pipeline

- There is a better understanding of some of the newer options
- It's particularly interesting in the combination and how the data and how much we understand for a particular option for the new therapy options
- There is a lot more confidence in sequenced therapy and to bring the combination that may offer some side effect

- It was good to hear about innovations and already moving down the pipeline for investigational therapy

- There is a lot of good options for sequenced therapy and good response rates
- Sequencing is an issue

ADVISOR

> DVRd is more widely used than initially thought and needs to revisit their use of the regimen

- The investigational therapy still need to have different options besides DVRd and what is going to come next

- It's hoping that some of these investigational agents will get added into frontline and hopefully improve the outcomes

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

- DVRd is the standard



ARS Data

Experience Varied, but 87% of Advisors See at Least 4% or More Patients With Hematologic Malignancies in Their Practice



FOR EXAMPLE PURPOSES ONLY

*Three advisors did not respond.

Answers Were Split Across Options, With 72% of Advisors Stating $\geq 25\%$ of Patients Are Transplant Eligible



FOR EXAMPLE PURPOSES ONLY

All Advisors Selected RVD as the Most Common Induction Regimen for Their Transplant-Eligible Patients



FOR EXAMPLE PURPOSES ONLY



Nearly Two-Thirds of Advisors Selected RvD as the Most Common Induction Regimen for Their Transplant-Ineligible



FOR EXAMPLE PURPOSES ONLY

Seventy-Three Percent of Advisors Would Choose RVd for an Elderly Patient With Practically No Comorbidities, With Bone Fractures but Normal Renal Function



FOR EXAMPLE PURPOSES ONLY

Nearly Three-Quarters of Advisors Think Efficacy Is the Most Important Factor in Choosing R/R Patient Therapy



FOR EXAMPLE PURPOSES ONLY

All Advisors Selected a Daratumumab-Based Treatment Regimen for First Relapse (DPd, DRd, or KDd)



FOR EXAMPLE PURPOSES ONLY



Although Answers Were Divided, 72% Chose Daratumumab Combination Therapies (DPd, DRd, or KDd) for This Patient in First Relapse After ASCT

FOR EXAMPLE PURPOSES ONLY

Advisors' Answers Again Varied for the Best Approach to Treat a 70-Year-Old Patient With Comorbidities After Bone Progression, 2 Years Post-ASCT, With 44% Choosing DPd



FOR EXAMPLE PURPOSES ONLY

A Lack of Uniformity Was Observed in Treatment Selection for a Patient Refractory to a CD38-Targeted Agent



FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



Seventy Percent of Advisors Think CAR T Therapies Will Have the Greatest Impact on the MM Treatment Landscape, Followed by 30% for Bispecific Antibodies



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Eighty-Two Percent of Advisors Need to Refer a Patient to Another Institution to Utilize CAR T Therapy; 9% Have Access in Their Center

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