



Insights Into Management of Diffuse Large B-Cell Lymphoma (DLBCL)

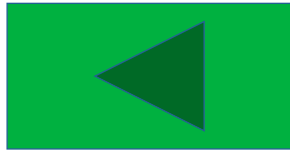
March 31, 2022

Insights From Southwest Region







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STUDY OBJECTIVE

To gain the perspectives of advisors on drivers of treatment decisions in the management of diffuse large B-cell lymphoma (DLBCL)

Report Snapshot: Session Overview



A moderated roundtable discussion was held with community oncologists from the Southwest United States in a virtual setting on **March 31, 2022**

Disease-state and data presentations were led by **Dr Elizabeth Brém** from the University of California, Irvine, and **Dr Keren Sturtz** from the National Cancer Institute in conjunction with content developed by the Aptitude Health clinical team

Insights were gathered on the use of **polatuzumab in the management of DLBCL** in the community setting

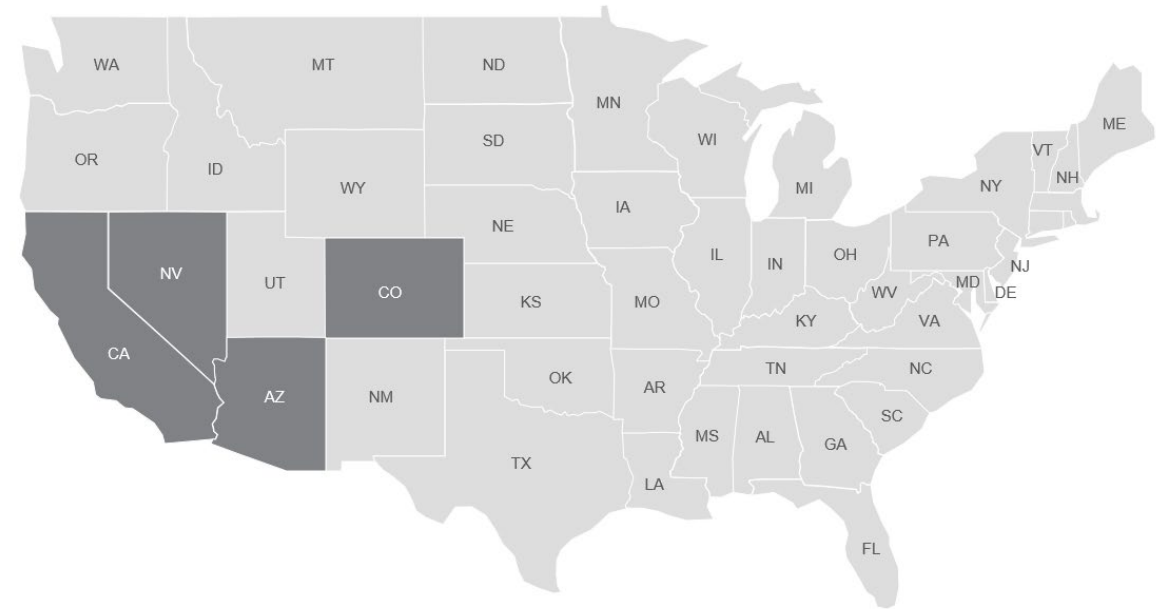
Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion

Report Snapshot: Attendee Overview



- > The group of advisors comprised 12 community oncologists from the Southwest United States
 - Attendees of the roundtable represented community oncologists from Arizona, California, Colorado, and Nevada

INSTITUTION	CITY	STATE
Banner – University Medical Center	Tucson	AZ
Desert Hematology Oncology Medical Group	Surprise	AZ
Ironwood Cancer & Research Centers	Phoenix	AZ
Loma Linda University Medical Center	Loma Linda	CA
City of Hope	Huntington Beach	CA
Kaiser Permanente Riverside Medical Center	Riverside	CA
City of Hope	West Covina	CA
Los Angeles Cancer Network	Pasadena	CA
Kaiser Permanente Riverside Medical Center	Riverside	CA
Northern Hematology Oncology National Jewish Health	Thornton	CO
OptumCare Cancer Center	Las Vegas	NV
Comprehensive Cancer Centers of Nevada	Las Vegas	NV



Report Snapshot: Agenda



Time (PT)	Topic
6.00 PM – 6.15 PM (15 min)	Introduction and ARS Questions <ul style="list-style-type: none">• Program overview• ARS questions
6.15 PM – 7.00 PM (20-min presentation; 25-min discussion)	Initial Treatment of DLBCL <ul style="list-style-type: none">• Overview of current first-line data<ul style="list-style-type: none">– Factors guiding first-line therapy– Current role of maintenance therapy– Overview of recent congress updates• Reaction and discussion
7.00 PM – 7.15 PM (15 min)	Break
7.15 PM – 8.50 PM (35-min presentation; 60-min discussion)	Treatment of Relapsed/Refractory DLBCL <ul style="list-style-type: none">• ARS questions• Overview of current relapsed/refractory data<ul style="list-style-type: none">– Factors guiding second-line and subsequent therapy– Current role of CAR T-cell therapy– Options after ≥ 2 therapies– Overview of recent congress updates• Reaction and discussion
8.50 PM – 9.00 PM (10 min)	Key Takeaways and Meeting Evaluation



Key Insights and Discussion Summary

DLBCL – INSIGHTS AND DATA

Call of origin's role for *"Personally, I haven't really been using it to make treatment decisions as much."*

1. Treatment success in frontline DLBCL

The overall survival benefit was not clear. This is not necessarily because there is no overall benefit, or we need overall survival. I think overall survival is a bit of a weak endpoint. I think overall survival is a bit of a weak endpoint. I think overall survival is a bit of a weak endpoint. I think overall survival is a bit of a weak endpoint. I think overall survival is a bit of a weak endpoint.

2. Data needed to confirm front DLBCL in frontline

What are all the things that have been done? Making a table that is DLBCL and DLBCL. It would be good to have DLBCL patients for the patients. I would be a bit of a weak endpoint. I would be a bit of a weak endpoint. I would be a bit of a weak endpoint. I would be a bit of a weak endpoint. I would be a bit of a weak endpoint.

DLBCL – INSIGHTS AND DATA

“If a patient has aggressive disease and fewer comorbidities, I prefer CAR T.”

1. Treatment success in frontline DLBCL

The overall survival benefit was not seen. This is not necessarily because this is a curable disease, or we were underpowered.
I would not use a frontline approach other than using CH or R2, and I would not start the disease free rate of 1 year. I believe as there is a significant trend of significant toxicity with the treatment, and people dying from something else.

2. Data needed to switch from CH or R2 to frontline

What if all a lot of things have been done, nothing is better than R2/CH and R2. It would have to have R2/CH patients for no reason.
I would be a little bit more. I would not be one of the first ones to move based on R2 or anything like that. I want something that's been done and we know that R2 works.
If the benefits are not very clear, I think a higher rate of R2 or better would be something that I would be looking at.
I think overall, there's still, but in this disease, with CH or R2, it's hard to come by, so you do have to use some surrogate of efficacy. So I do think that a lot of people would be surprised that it's not really going to start doing the rate of any longer. R2 is not sufficient.

Discussion: Management of DLBCL



DLBCL – INSIGHTS AND DATA

"I think apart from CAR T, TAFB seems to be the best treatment for 2L R/R DLBCL and not POLA as long as they

1. Treatment outcomes in frontline DLBCL

The overall survival benefit was not seen. This is not unexpected because this is a highly aggressive cancer and most patients have relapsed within 2 years. The overall survival benefit was not seen in this trial. This is not unexpected because this is a highly aggressive cancer and most patients have relapsed within 2 years. The overall survival benefit was not seen in this trial. This is not unexpected because this is a highly aggressive cancer and most patients have relapsed within 2 years.

2. Data needed to confirm front DLBCL in frontline

What if all of the things that were done were not done? Making a better than 50% survival and better. The overall survival benefit was not seen. This is not unexpected because this is a highly aggressive cancer and most patients have relapsed within 2 years. The overall survival benefit was not seen in this trial. This is not unexpected because this is a highly aggressive cancer and most patients have relapsed within 2 years.

DLBCL – INSIGHTS AND DATA

“If you look at all 3 drugs, POLA, TAFK, and LONCA in the relapsed/refractory setting, you're going to look at

the overall survival that's what we want. This is not necessarily disease-free or overall response, so we want overall survival. I think what you're going to see here is that you're going to see a significant improvement in overall survival with the treatment, and overall survival is something that's important to patients. I think you're going to see a significant improvement in overall survival with the treatment, and overall survival is something that's important to patients.

That's all a lot of things that have been done, nothing is better than B2201 and B2202. It's really hard to see B2201 patients for no reason. I think you're going to see a significant improvement in overall survival with the treatment, and overall survival is something that's important to patients. I think you're going to see a significant improvement in overall survival with the treatment, and overall survival is something that's important to patients.



Advisor Key Takeaways

Advisor Key Takeaways (1/2)



ADVISOR	ADVISOR
<ul style="list-style-type: none"> > I will think about using CAR T earlier • There is a better understanding of sequencing therapy • I really want to talk to the oncologist and understand how to have a better understanding of these drugs and have a better idea of when to use them in my practice 	<ul style="list-style-type: none"> > Early relapse you go with CAR T as second line and then late relapse you go with auto transplant • The sequencing strategy is not to have different options besides CAR T and auto or going to CAR T
<ul style="list-style-type: none"> • There is a better understanding of some of my clinical options • It's particularly important in the relapsed and how that will and how would be considered to a second line option for my own clinical practice • There's a lot more emphasis to sequenced therapy and to things the oncologist that may offer some side effects 	<ul style="list-style-type: none"> • The feeling that some of these immunotherapy agents will get added into practice and hopefully improve the look like
<ul style="list-style-type: none"> • It was good to hear about innovations and what's coming down the pipeline for immunotherapies 	<ul style="list-style-type: none"> • It's interesting to learn about all these immunotherapy treatments, especially the specific antibodies • 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's a lot of good options for second line that just CAR T and transplant with decent side effect profile and good response rates • Sequencing is an issue 	<ul style="list-style-type: none"> • CAR T is not the standard

Advisor Key Takeaways (2/2)



ADVISOR	ADVISOR
<ul style="list-style-type: none">> It was interesting to see the upcoming treatments that are in the pipeline and see what's coming upThere is a better understanding of immunotherapyReally want to see how well immunotherapy will workThere is a better understanding of these drugs and how a better idea of when to use them in the pipeline	<ul style="list-style-type: none">> These data sort of solidify referring early for CAR T.The immunotherapy, especially the ones to have different options besides T cell, and what is going to come next
<ul style="list-style-type: none">There is a better understanding of some of the newer optionsIt's particularly interested in the immunotherapy and how that will work and how much we can expect to see in the pipeline for the next several yearsThere is a lot more information on targeted therapy and the things the immunotherapy that may offer some side effects	<ul style="list-style-type: none">It's hoping that some of these immunotherapy agents will get added into frontline and hopefully improve the outcomes
<ul style="list-style-type: none">It was good to hear about immunotherapy and what's coming down the pipeline for immunotherapy	<ul style="list-style-type: none">It's interesting to learn about all these immunotherapy treatments, especially the targeted antibodiesA lot of options coming up in the future. The only issue will be to learn how to improve these drugs
<ul style="list-style-type: none">There is a lot of good options for second line that just CAR T and immunotherapy with decent side effect profile and good response ratesImmunotherapy is an issue	<ul style="list-style-type: none">It's interesting to see the pipeline



ARS Data

Over Half the Advisors Currently Follow 7–15 Unique DLBCL Patients



How many unique patients with DLBCL are you currently following? (N = 12)

FOR EXAMPLE PURPOSES ONLY

Over Half the Advisors Did Not Use Ibrutinib to Treat Their DLBCL Patients in the Past Year

How many patients with DLBCL have you treated with ibrutinib in the past year? (N = 12)

FOR EXAMPLE PURPOSES ONLY

Most Advisors Reported Treating Between 1–5 of Their DLBCL Patients With Lenalidomide in the Past Year



How many patients with DLBCL have you treated with lenalidomide in the past year? (N = 12)

FOR EXAMPLE PURPOSES ONLY

Presence of Double- or Triple-Hit Disease Features and Performance Status Have the Greatest Impact on Advisors' Treatment of DLBCL

FOR EXAMPLE PURPOSES ONLY

Over 80% of the Advisors Do Not Use Maintenance Therapy in DLBCL

Do you use maintenance therapy in DLBCL? (n = 11*)



- > A 63-year-old man presents with a 4-week history of progressive back pain.

A 63-year-old man presents with a 4-week history of progressive back pain. Imaging reveals an T11-con retroperitoneal mass. A core needle biopsy is obtained and is read as DLBCL, non-GCB by Hans methods. IHC for bcl-2 and myc show high expression (>90%) for each. FISH testing for bcl-2 and myc are both negative. FISH for bcl-6 is positive. PET imaging reveals widespread pathologic adenopathy with involvement of mediastinal, retroperitoneal, and mesenteric nodes. There are also 2 PET-avid mass lesions in the liver, and 1 lesion in the left kidney. The SUV_{max} is 28. Ki67 is 90%. There is no apparent marrow involvement by PET. The LDH is elevated at 2x the ULN. His PS is 1 and there are no significant comorbidities.

Half the Advisors Gave the Patient a CNS IPI Score of 4

His CNS IPI score is: (n = 8*)

100%

FOR EXAMPLE PURPOSES ONLY

*Four advisors did not respond.

R-CHOP Was the Most Common Chemotherapy Backbone Choice for This Patient

Which chemotherapy backbone would you recommend to this patient? (N = 12)

FOR EXAMPLE PURPOSES ONLY

Advisors Who Would Include CNS Prophylaxis Would Primarily Choose IT MTX

I would include the following CNS prophylaxis: (N = 12)

FOR EXAMPLE PURPOSES ONLY

The Majority of Advisors Would Not Recommend ASCT Consolidation for This Patient

Assuming patient achieves a CR to frontline therapy, would you recommend ASCT consolidation? (N = 12)



Over Half the Advisors Would Recommend R-ICE Followed by ASCT If the Patient Relapsed After Frontline R-CHOP

The patient relapses 1 year after completing frontline therapy with R-CHOP. Biopsy

FOR EXAMPLE PURPOSES ONLY

For a Transplant-Ineligible Relapsing Patient, CAR T-Cell Therapy and Tafasitamab ± Lenalidomide Are the Most Preferred Treatment Regimens

FOR EXAMPLE PURPOSES ONLY

Two-Thirds of the Advisors Identified Polatuzumab Vedotin as a CD79b-Targeting ADC

Which of the following best describes the mechanism of action of polatuzumab vedotin? (n = 11*)

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.

Most Advisors Identified Tafasitamab as a CD19-Targeting ADC or CD19-Directed Cytolytic Antibody

Which of the following best describes the mechanism of action of tafasitamab? (n = 11*)

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.

Three-Fourths of the Advisors Identified Loncastuximab Tesirine as a CD19-Targeting ADC

Which of the following best describes the mechanism of action of loncastuximab tesirine?

FOR EXAMPLE PURPOSES ONLY

Three-Fourths of the Advisors Have Treated 1–5 Patients With R/R DLBCL With Polatuzumab Vedotin in the Past Year



How many patients with DLBCL (R/R) have you treated with polatuzumab vedotin in the

FOR EXAMPLE PURPOSES ONLY



Over 40% of the Advisors Have Treated Patients With R/R DLBCL With Tafasitamab Since Its Approval



How many patients with DLBCL (R/R) have you treated with tafasitamab since its

FOR EXAMPLE PURPOSES ONLY

Over 90% of Advisors Have Treated or Referred 1–5 Patients With DLBCL for CAR T-Cell Therapy in the Past Year



How many patients with DLBCL have you treated with or referred for CAR T-cell therapy in

FOR EXAMPLE PURPOSES ONLY



For Two-Thirds of the Advisors, >50% of Their Patients Referred for CAR T-Cell Therapy Were Reinfused With the Actual Cellular Product

FOR EXAMPLE PURPOSES ONLY

Patients Progressing Before Receiving CAR T, Manufacturing Turnaround, and Obtaining Institutional Approval Were Chosen by Over 80% of Advisors as the Top Barriers to Broader Use of CAR T-Cell Therapy

FOR EXAMPLE PURPOSES ONLY

Nearly Half the Advisors Selected Insurance Declining Referral to the Site That Is Most Convenient to Their Patient as the Top Barrier for Referring Patients for CAR T-Cell Therapy

FOR EXAMPLE PURPOSES ONLY

The Majority of Advisors Have Access to Axicabtagene Ciloleucel and Tisagenlecleucel for Their Patients at Their Practice or at Their Referral Institution

FOR EXAMPLE PURPOSES ONLY

None of the Advisors Know Beforehand Which CAR T-Cell Therapy Their Referral Patients Will Receive

When referring patients for CAR T, do you know beforehand which CAR T-cell therapy your patient will receive? (N = 12)

