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

March 31, 2022

Insights From Southwest Region

How to Navigate This Report

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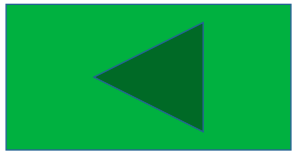

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Report Objectives

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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

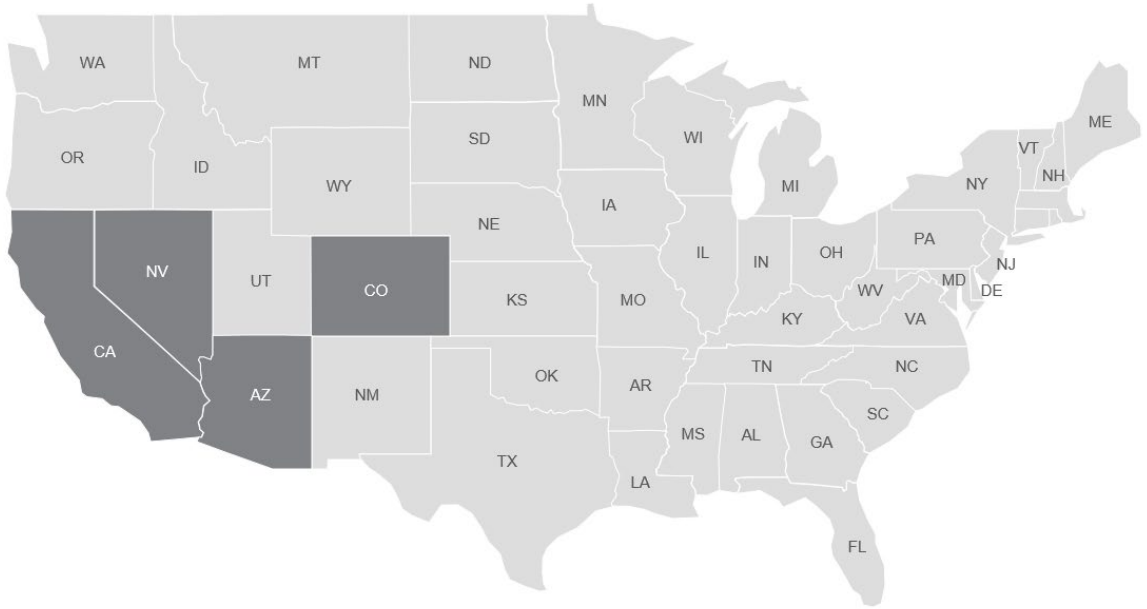
Insights were gathered on the use of **polatuzumab in the management of DLBCL** in the community setting

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 • Program overview • ARS questions
6.15 PM – 7.00 PM (20-min presentation; 25-min discussion)	Initial Treatment of DLBCL • Overview of current first-line data – 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 • ARS questions • Overview of current relapsed/refractory data – 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

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Key Insights and Discussion Summary

Discussion: Management of DLBCL

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DLBCL – INSIGHTS AND DATA

Cell of origin's role for

"Personally, I haven't really been using it to make treatment decisions as much."

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

Discussion: Management of DLBCL

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DLBCL – INSIGHTS AND DATA

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

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

Discussion: Management of DLBCL

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DLBCL – INSIGHTS AND DATA

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

- Treatment success in frontline DLBCL

- Data needed to switch from BCC in frontline

Discussion: Management of DLBCL

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DLBCL – INSIGHTS AND DATA

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

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

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Advisor Key Takeaways

Advisor Key Takeaways (1/2)

ADVISOR		ADVISOR	
1	> I will think about using CAR T earlier > I have a better understanding of sequencing therapies > I really wasn't that familiar with pomalidomide and selinexor but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> Early relapse you go with CAR T as second line and then late relapse you go with auto transplant > For relapsed/refractory patients it's nice to have different options besides R-ICE and auto or going to CAR T
2	> I have a better understanding of some of my relapse options > I'm particularly interested in the selinexor and hope that selly and Xpo would be tolerated for a second-line option for my very elderly patients > There's a lot more enthusiasm for targeted therapy and for things like pomalidomide that may offer lesser side effects	6	> I'm hoping that some of these second-line agents will get added onto frontline and hopefully improve the cure rate
3	> It was great to hear about innovations and what's coming down the pipeline for relapsed/refractory	7	> Very interesting to learn about all these relapsed/refractory treatments, specifically the bispecific antibodies > A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs
4	> There's a lot of good options for second line than just CAR T and transplant with decent side effect profile and good response rates > Sequencing is an issue	8	> Still R-CHOP is the standard

Advisor Key Takeaways (2/2)

ADVISOR		ADVISOR	
1	> It was interesting to see the upcoming treatments that are in the pipeline and see what's coming up > I have a better understanding of sequencing therapies > I really wasn't that familiar with [illegible] and [illegible] but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> These data sort of solidify referring early for CAR T. > For relapsed/refractory patients it's nice to have different options besides R-ICE and auto or going to CAR T
2	> I have a better understanding of some of my relapse options > I'm particularly interested in the [illegible] and hope that tafa and Rev would be tolerated for a second-line option for my very elderly patients > There's a lot more enthusiasm for targeted therapy and for things like proteasomals that may offer lesser side effects	6	> I'm hoping that some of these second-line agents will get added onto frontline and hopefully improve the cure rate
3	> It was great to hear about innovations and what's coming down the pipeline for relapsed/refractory	7	> Very interesting to learn about all these relapsed/refractory treatments, specifically the bispecific antibodies > A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs
4	> There's a lot of good options for second line than just CAR T and transplant with decent side effect profile and good response rates > Sequencing is an issue	8	> Still R-CHOP is the standard

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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)

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)

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

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

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

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

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

Patient Case Study

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> 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 11-cm 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 (>80%) 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 3× 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*)

*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)

Advisors Who Would Include CNS Prophylaxis Would Primarily Choose IT MTX

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

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

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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*)

*One advisor did not respond.

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

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

*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?

*One advisor did not respond.

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

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

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

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

*One advisor did not respond.

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

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

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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

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

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)