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Insights Into Non-small Cell Lung Cancer (NSCLC)

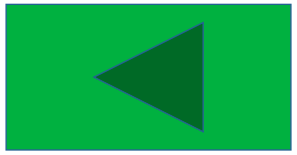
Philadelphia, PA

August 20, 2022

Insights From Community Oncologists in the Northeast Region of the US

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



Click to return to previous slide

Contents

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Report Objectives

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STUDY OBJECTIVES

- Gain perspectives of advisors from the Northeast region of the United States on the following
  - Molecular testing practices in stage III NSCLC
  - Current use of immunotherapies in stage III NSCLC

Report Snapshot: Session Overview

A moderated roundtable discussion was held with community oncologists from the Northeast region of the United States in Philadelphia, PA, on **August 20, 2022**

Disease-state and data presentations were led by **Narjust Duma, MD,** from Dana-Farber Cancer Institute, and moderated by **Keren Sturtz, MD,** from Intermountain Cancer Center, in conjunction with content developed by the Aptitude Health clinical team

Insights were acquired on the management and current use of treatment options for ***EGFR*-mutant NSCLC** 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

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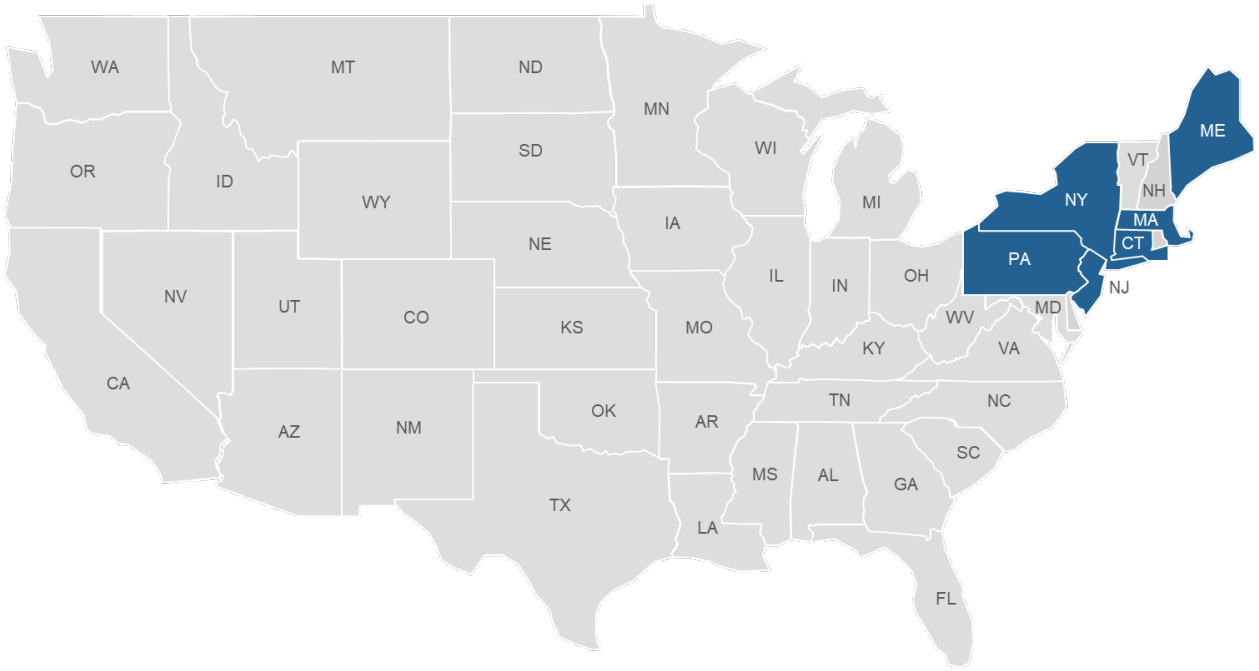
> The group of advisors comprised 13 community oncologists from the Northeast region of the United States

INSTITUTION	CITY	STATE
Penn State Health/Hershey Medical Center	Reading	PA
Lahey Clinic Medical Center	Burlington	MA
Ocean Hematology and Oncology	Lakewood	NJ
York Oncology	York	ME
Penn Medicine	Cherry Hill	NJ
Kenneth R. Hoffman, MD, MPH and Associates	Teaneck	NJ
Penn Medicine	Voorhees	NJ
Nuvance Health	Danbury	CT
Roswell Park Hematology and Oncology of Niagara	Niagara Falls	NY
Alliance Cancer Specialists	Horsham	PA
Pottstown Hospital	Pottstown	PA
Hematology-Oncology Associates of Central New York	Syracuse	NY
Penn Hematology Oncology—South Jersey Division	Cherry Hill	NJ



Report Snapshot: Agenda

Time (ET)	Topic
9.15 AM – 9.30 AM	Introduction
9.30 AM – 10.45 AM	Molecular Testing and Management of *EGFR*-Mutant NSCLC
10.45 AM – 10.55 AM	*Break*
10.55 AM – 12.00 PM	Immunotherapy in Resectable and Stage III Unresectable NSCLC
12.00 PM – 12.15 PM	Key Takeaways and Meeting Evaluation

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Key Insights and Discussion Summary

Discussion: Biomarker Testing Practices

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INSIGHTS

	"The problem for some patients who are admitted to the hospital and we do the biopsy and that need something, chest tube,
• Treatment success in frontline DLBCL	[illegible]
• Data needed to switch from BOC in frontline	[illegible]

Discussion: Biomarker Testing Practices

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INSIGHTS

"What we're doing for anyone that comes in the office with a diagnosis is sending off liquid from the beginning, and then it's sort of

- Treatment success in frontline DLBCL

- Data needed to switch from BCC in frontline

Discussion: *EGFR*-Mutant Advanced NSCLC

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INSIGHTS

"I think it really comes down to what does the patient and the family want, and do they have enough time for the drug to work?"

- Treatment success in frontline DLBCL

[redacted]

- Data needed to switch from BCC in frontline

[redacted]

Discussion: *EGFR*-Mutant Advanced NSCLC

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INSIGHTS

Have any of you have given amivantamab yet?

- Treatment success in frontline (1L)/2L

[redacted]

- Data needed to switch from 3C/C in frontline

[redacted]

Discussion: Immunotherapy in Resectable and Stage III Unresectable NSCLC

INSIGHTS

	Questions/concerns from advisors regarding NADIM II and use of carboplatin-paclitaxel
[illegible]	[illegible]
[illegible]	[illegible]

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Advisor Key Takeaways

Advisor Key Takeaways (1/2)

ADVISOR		ADVISOR	
1	> The small cell transformation was something I really	5	> NGS for all lung cancer patients > Neoadjuvant chemo IO for early lung cancer
1	> I have a better understanding of sequencing therapies > I really wasn't that familiar with polatuzumab and tafasitamab but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> For relapsed/refractory patients it's nice to have different options besides R-CD. 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 tafasitamab 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 polatuzumab 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	> With the durva data, I would probably stop sequencing > I have a better understanding of sequencing therapies > I really wasn't that familiar with polatuzumab and tafasitamab but now I have a better understanding of these drugs and have a better idea of when to use them in my practice	5	> Impressed by the data and will do a formal presentation > 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 tafasitamab and hope that tafa and Rev would be interested for a second-line option for my very elderly patients > There's a lot more enthusiasm for targeted therapy and for things like polatuzumab 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

One advisor did not provide key takeaways.

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ARS Data

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Molecular Testing Practices and Management of *EGFR*-Mutant NSCLC

ARS Responses

More Than Half of Advisors Have Treated ≤3 Patients With *EGFR*-Mutant mNSCLC in the Past 6 Months; 8% of Advisors Have Treated ≥13 Patients

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The Majority of Advisors (62%) Perform Biomarker Testing at Diagnosis for All of Their Patients

Advisors Seem to Be Less Consistent With Testing Their Patients at Progression Compared With Testing at Diagnosis, With a Quarter of Advisors Performing Biomarker Testing for Only Up to 25% of Their Patients Upon Progression

*One advisor did not respond.

All Advisors Reported Using Next-Gen Sequencing for Their Patients; Other Methods Used Include IHC, FISH, and RT-PCR

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When Testing for *EGFR* Mutation Status, All Advisors Test for Exon 19 Deletion and Exon 20 Insertion; Most Also Test for *T790M, S768I, L861Q, G719X, and L858R* Mutations

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41% of Advisors Collaborate With a Pathologist to Obtain Biomarker Testing

46% of Advisors Reported Testing for Tissue and Liquid at the Same Time, With 38% Testing Only Tissue and Reflexing to Liquid Biopsy When Appropriate

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Three-Fourths of Advisors Wait for Biomarker Test Results Before Making Treatment Decisions in mNSCLC

*One advisor did not respond.

The Main Challenges of Biomarker Testing for Most Advisors Are Insufficient Tissue Sample (54%) and Time to Obtain Results (31%)

The Majority of Advisors Feel Shorter Turnaround Time and Improved Tissue Availability Would Increase Utilization of Biomarker Testing

Scenario 1

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- A 49-year-old Asian-American female never-smoker presents with dyspnea on

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.

More Than Three-Fourths of Advisors Feel There Is ≥60% Chance of This Patient Having an *EGFR* Mutation

For a Young Patient With Exon 19 Mutation, All the Advisors Would Choose to Treat With Osimertinib

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The patient's tumor returns positive for exon 19 mutation. Which of the following agents

*One advisor did not respond.

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Immunotherapy in Resectable and Stage III Unresectable NSCLC

ARS Responses

About 40% of Advisors Have Used Immunotherapy in Up to 50% of Their Patients With Neoadjuvant NSCLC

*Three advisors did not respond.

About 75% of Advisors Reported Using Adjuvant Immunotherapy in Less Than 25% of Their Patients

*One advisor did not respond.

45% of Advisors Have Used Immunotherapy in All Their Patients With Stage III NSCLC

*Two advisors did not respond.

42% of Advisors Feel Pembrolizumab Has the Best Activity in NSCLC; Equally, 42% of Advisors Feel There Is No Difference in the Activity Among Various Immunotherapies

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*One advisor did not respond.

Half of Advisors Perform Biomarker Testing in Over 50% of Their Patients With Stage III NSCLC

*One advisor did not respond.

Half of the Advisors Test for PD-L1 in Over 50% of Their Patients With Stage III NSCLC

*One advisor did not respond.

Half of the Advisors Have Seen Between 4–8 Patients in the Last Year; Half Have Seen ≥9 Patients

*One advisor did not respond.

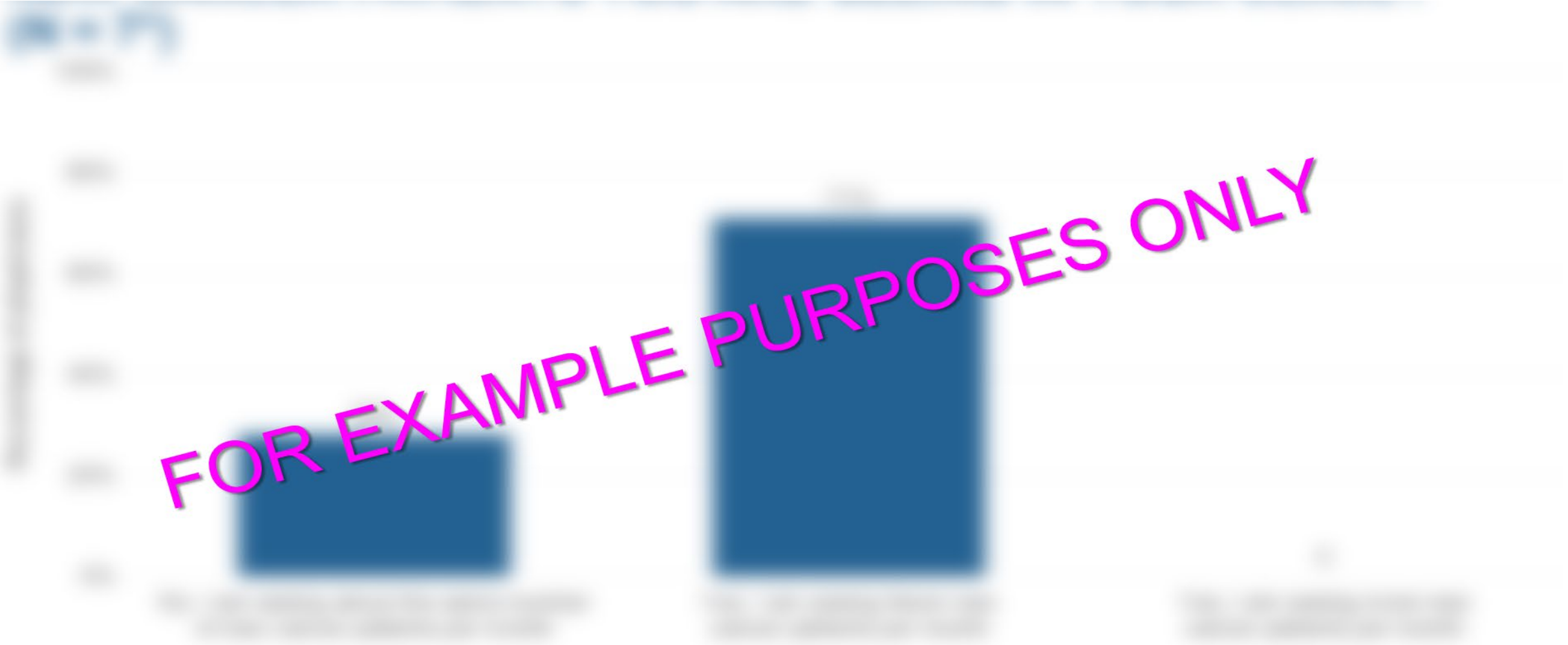
58% of Advisors Have Treated ≥6 Stage III NSCLC Patients With Immunotherapy in the Past Year

*One advisor did not respond.

42% of Advisors Have Treated 6–10 Stage III NSCLC Patients With Durvalumab in the Past Year

*One advisor did not respond.

Three-Fourths of Advisors Said They May Consider Using Immunotherapy in a Patient With Local Relapse Who Had Previously Received Immunotherapy in the Adjuvant or Neoadjuvant Setting



*One advisor did not respond.

Three-Fourths of Advisors Would Test or Request a PD-L1 Test for All Patients With NSCLC but No Targetable Mutations

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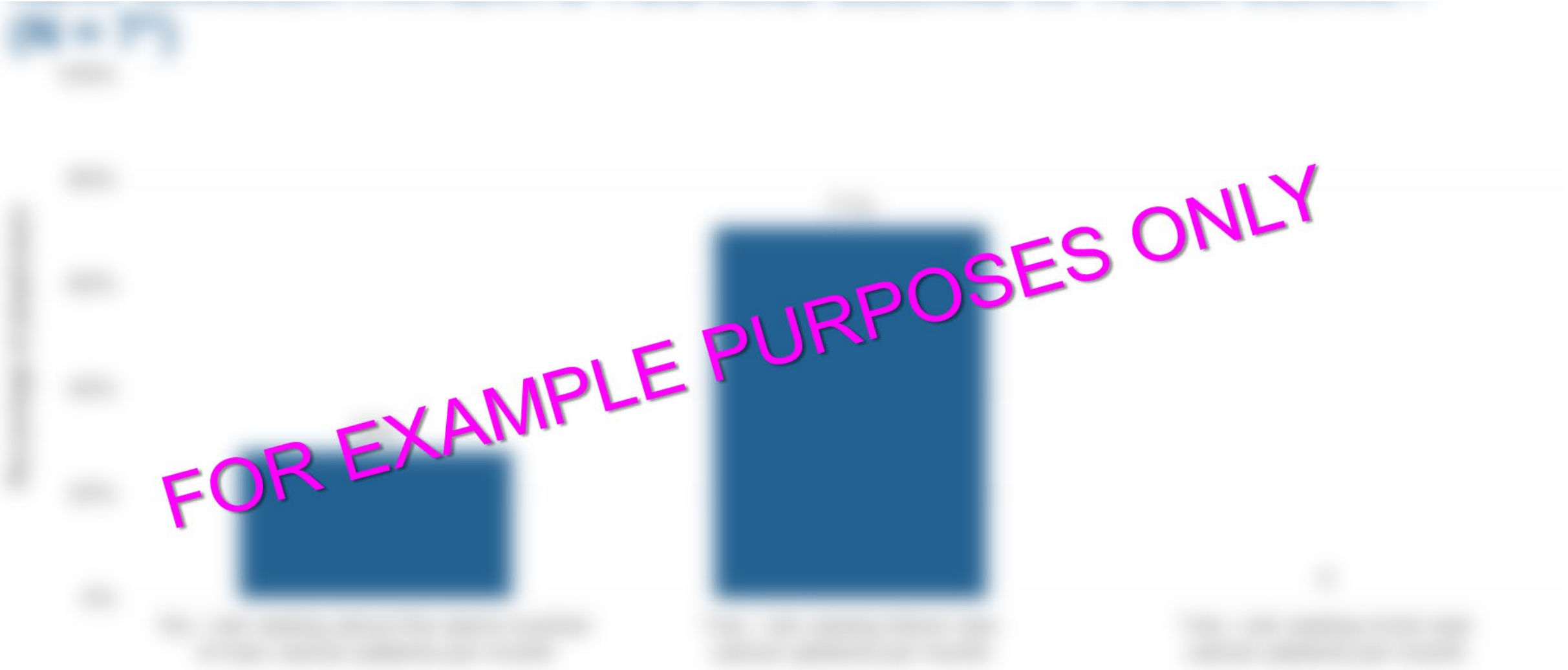
*One advisor did not respond.

For an Elderly Patient With 10% PD-L1 Status, 69% of Advisors Would Prefer Starting Durvalumab 3 Weeks After Completion of cCRT



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