



# Insights Into Myelofibrosis (MF)

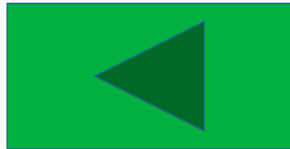
December 2021 – April 2022

Virtual Programs Across Multiple Regions

# How to Navigate This Report

















Click to move to topic of interest or ARS supporting data



Click to return to previous slide

---

Topic	
Report Objectives	
Report Snapshot	
• Session overview	
• Attendee overview	
• Agenda	
Topline Takeaways and Strategic Recommendations	
Key Insights and Discussion Summary	
• Key insights: Current management in myelofibrosis	
• Discussion overview: Current management in myelofibrosis	
• Key insights: Current management in myelofibrosis	
• Discussion overview: Current management in myelofibrosis	
• Key insights: Emerging paradigms in myelofibrosis	
• Discussion overview: Emerging paradigms in myelofibrosis	
Advisor Key Takeaways	
ARS Data	
Addendum	

## STUDY OBJECTIVES

- > Gain perspectives of advisors from various regions of the United States on the following
  - Current management and treatment practices regarding therapy of MF
  - Unmet needs and emerging paradigms in the treatment landscape of MF

# Report Snapshot: Session Overview



A series of moderated roundtable discussions with community oncologists from various regions across the US were held virtually from **December 2021 – April 2022**

Disease state and data presentations were led by

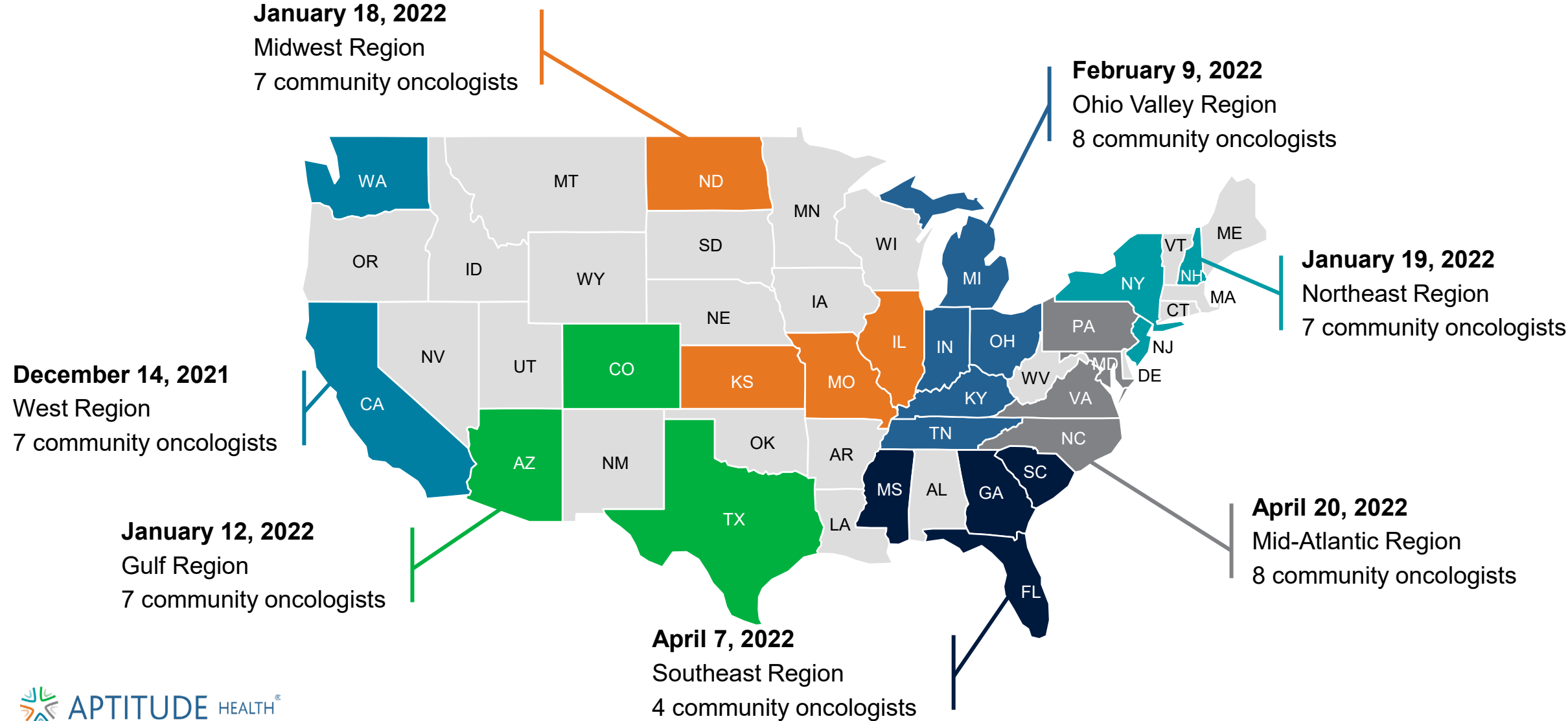
- **Dr Prithviraj Bose** from MD Anderson Cancer Center
- **Dr Ruben Mesa** from Mays Cancer Center
- **Dr John Mascarenhas** from Mount Sinai
- **Dr Kristen Pettit** from University of Michigan
- **Dr Elias Jabbour** from MD Anderson Cancer Center

in conjunction with content developed by the Aptitude Health clinical team

Insights on the use of **current and new therapies for MF in the community** were obtained

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

# Series of 7 Moderated Roundtable Discussions Including 48 Oncologists Between December 2021 and April 2022



# Report Snapshot: Attendee Overview



> The group of advisors comprised 48 community oncologists from across the United States

Program	Institution	City	State
Dec 14 (West)	Contra Costa Oncology	Walnut Creek	CA
	Cancer & Blood Specialty Clinic	Los Alamitos	CA
	Sutter Alta Bates Summit Medical Center	Berkeley	CA
	Los Angeles Cancer Network	Pasadena	CA
	North Star Lodge Cancer Center	Yakima	WA
	LA Cancer Network	Los Angeles	CA
	Kaiser Permanente	Riverside	CA
Jan 12 (Gulf)	The Center for Cancer and Blood Disorders	Benbrook	TX
	The Center for Cancer and Blood Disorders	Fort Worth	TX
	Hendrick Health	Abilene	TX
	Texas Oncology	Houston	TX
	National Jewish Health Northern Hematology Oncology	Thornton	CO
	Texas Oncology	Palestine	TX
	Cochise Oncology	Tucson	AZ
Jan 18 (Midwest)	Loyola University Medical Center	Maywood	IL
	Cancer Center of Kansas	Wichita	KS
	Sanford Health	Fargo	ND
	St. Luke's Hospital	Chesterfield	MO
	Washington University School of Medicine	St. Louis	MO
	Cancer Treatment Centers of America	Chicago	IL
Jan 19 (Northeast)	Rutgers Cancer Institute of New Jersey	New Brunswick	NJ
	New York Cancer & Blood Specialists	Elmhurst	NY
	Foundation Hematology/Oncology	Nashua	NH
	Medical Diagnostic Associates	Summit	NJ

Program	Institution	City	State
	Minniti Center for Medical Oncology and Hematology	Sewell	NJ
	AdvantageCare Physicians Valley Stream	Valley Stream	NY
	Hematology-Oncology Associates of CNY	Syracuse	NY
Feb 9 (Ohio Valley)	Cleveland Clinic Cancer Center	Mansfield	OH
	Commonwealth Cancer Center	Danville	KY
	Henry Ford Health System	Detroit	MI
	Singh Arora Oncology Hematology, PC	Flint	MI
	UH Seidman Cancer Center at UH Parma Medical Center	Parma	OH
	Tennessee Oncology	Shelbyville	TN
	Fort Wayne Medical Oncology and Hematology	Fort Wayne	IN
Zangmeister Cancer Center	Columbus	OH	
Apr 7 (Southeast)	Florida Cancer Specialists	Tampa	FL
	Carolina Blood and Cancer Care Associates	Lancaster	SC
	Singing River Cancer Center	Gulfport	MS
	Suburban Hematology Oncology	Lawrenceville	GA
Apr 20 (Mid-Atlantic)	Cancer Care Associates of York	York	PA
	Henry B. Fox, MD	Chevy Chase	MD
	Allegheny Health Network	Forbes	PA
	Virginia Cancer Institute	Mechanicsville	VA
	Atrium Health Levine Cancer Institute	Charlotte	NC
	NovaCure Consultants	Alexandria	VA
	Greater Washington Oncology Associates	Rockville	MD
Allegheny Health Network Cancer Institute	Pittsburgh	PA	

# Report Snapshot: Agenda



Time	Topic
6.00 PM – 6.15 PM	Introduction and ARS Questions <ul style="list-style-type: none"><li>• Program overview</li></ul>
6.15 PM – 7.00 PM	Current Management and Emerging Challenges in MF <ul style="list-style-type: none"><li>• ARS questions</li><li>• Moderated discussion</li></ul>
7.00 PM – 7.45 PM	Unmet Needs and Emerging Paradigms, New and Emerging Pathways <ul style="list-style-type: none"><li>• ARS questions</li><li>• Moderated discussion</li></ul>
7.45 PM – 8.00 PM	Key Takeaways and Meeting Evaluation





# Key Insights and Discussion Summary

Compiled from 7 programs

## INSIGHTS

*"I think it's very useful, frankly. Because it's of practical importance."*

1. Treatment success in frontline JAK2i

The overall survival benefit was clear. This is not necessarily disease-free survival, but overall survival, so we need overall survival. I think overall survival is a better endpoint than using CR or PRF, and I would say that the disease-free rate at 3 years is actually a better CR as a response. There is significant toxicity with the treatment, and overall doing that something.

2. Data needed to justify front-line JAK2i

That's all a lot of things have been said, nothing is better than Ruxitinib and Echin. It's really hard to say Ruxitinib performs for my patients. I would be a little bit more. I would not be one of the first ones to move toward CR or anything like that. I want something that's clear and that we can see that we're doing. If the benefits are not very clear, then a hazard ratio of 0.85 or better would be something that I would be looking at. I think overall data, that's clear, but in this disease, with CR as a response, you do not do have to use some surrogate of efficacy. So, I do think that a CR or better than that survival rate of data is that, what's going to start driving the use of any agent. CR is not sufficient.

## INSIGHTS

*"I usually use a ramp-up strategy, so I typically start out with 10 mg BID. Then I try, most important, like everybody*

1. Treatment success in frontline JAK2i

The overall success rate is what we want. This is not necessarily disease-free, this is overall success, so we want overall success. I would not use a treatment approach other than using JAK2i as first-line, and I would not start the disease-free rate as a goal. I believe as first-line a response rate is important mostly with the treatment, and overall going from something unmanageable to something manageable.

2. Data needed to confirm front-line JAK2i

That's all a lot of things have been said, nothing is better than R20331 and Ruxitinib. It would be good to have R20331 evidence for my patients. I would be a little skeptical. I would not be one of the first ones to move beyond an R20331 or something like that. I want something that has been used and we know that it works. If the benefits are not very strong, then a higher rate of R20331 or better would be something that I would be looking at. Overall success rate, that's what we're looking for. In this disease, with JAK2i, we have to have to use some surrogate of efficacy. So, we have to have a JAK2i or better than the overall rate of success. I think what's going to start driving the use of any agent. JAK2i is not sufficient.

## INSIGHTS

*"It's a much-needed drug in that thrombocytopenic patient, because we really don't have good options. I look very*

1. Treatment success in thrombocytopenic patients

The overall success rate is very high. This is not necessarily because the disease is curable, but because we have a very effective drug. I think the overall success rate is high because we have a very effective drug. I think the overall success rate is high because we have a very effective drug. I think the overall success rate is high because we have a very effective drug.

2. Data needed to support the use of this drug in thrombocytopenic patients

There are a lot of things that we need to know. We need to know if the drug is safe and effective. We need to know if the drug is safe and effective. We need to know if the drug is safe and effective. We need to know if the drug is safe and effective. We need to know if the drug is safe and effective.



## Advisor Key Takeaways

Compiled from 6 programs (42 advisors)\*

# Advisor Key Takeaways (West Region) (1/2)



## ADVISOR

> I think the most important takeaway is one of the new

- There is a better understanding of sequencing therapies
- I really want to see how well combination and individual therapies work. There is a better understanding of these things and how a better idea of when to use them in my practice

- There is a better understanding of some of the newer options
- It's particularly important in the subcutaneous and oral that will and then would be important for a second-line option for my own patients, patients
- There is a lot more emphasis on targeted therapy and to things like combination that may offer more side effects

- It was good to hear about innovations and what's coming down the pipeline for immunotherapy

- There is a lot of good options for second-line that you can't get with standard care. There are some options that are good response rate
- Immunology is an issue

## ADVISOR

- The immunotherapy options are still to have different options besides PD-1/PD-L1 and what is going to come next

- It's hoping that some of these second-line agents will get added into frontline and hopefully improve the first-line

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

- CAR T-cell is the standard

# Advisor Key Takeaways (West Region) (2/2)



## ADVISOR

## ADVISOR

> The overall survival data associated with reduced

- Have a better understanding of sequencing therapy
- Have a better understanding of how to use immunotherapy
- Have a better understanding of when to use immunotherapy

- Have a better understanding of some of the newer options
- Be particularly interested in the immunotherapy and how that will be used in combination with other therapies
- Have a good understanding of targeted therapy and how to use it in combination with other therapies

- It was good to hear about immunotherapy and what's coming down the pipeline for immunotherapy

- There's a lot of good options for immunotherapy that you can use in combination with other therapies and have good response rates
- Immunotherapy is an option

- The immunotherapy options are not to have different options besides PD-1 and anti-CTLA-4

- Be happy that some of these immunotherapy agents will get added into frontline and hopefully improve the outcomes

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

- PD-1/CTLA-4 is the standard

# Advisor Key Takeaways (Gulf Region)



## ADVISOR

> I think the meeting was very important, especially to

- There is a better understanding of upcoming therapies
- I really enjoyed the meeting with pharmaceutical and
- I think there was a better understanding of these drugs and how a better idea of when to use them in the practice
- There is a better understanding of some of the newer options
- It's particularly important in the subcutaneous and oral that will and they would be interested in a subcutaneous option for my own clinical practice
- There is a lot more emphasis on weight therapy and to things like subcutaneous that may offer more side effects
- It was good to hear about innovations and already coming down the pipeline for immunomodulators
- There is a lot of good options for disease like that just like T1 and treatment with disease with other profile and good response rate
- Responding to an issue

## ADVISOR

> Pacritinib data was quite promising, especially with the platelets <50,000

- The immunomodulatory pathway is not to have different options besides IVIG and with a getting to 2007
- In hoping that some of these newer drug agents will get added into practice and hopefully improve the care of
- Very interesting to hear about all these immunomodulatory 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
- IVIG is still the standard



# Advisor Key Takeaways (Northeast Region) (1/2)



## ADVISOR

> Cytopenic vs proliferative myelofibrosis, categorizing

- There is a better understanding of sequencing therapy
- There is a better understanding of the relationship between the different subtypes of MF and the different clinical presentations
- There is a better understanding of the different clinical presentations of MF

- There is a better understanding of the different clinical presentations of MF
- There is a better understanding of the relationship between the different subtypes of MF and the different clinical presentations
- There is a better understanding of the different clinical presentations of MF

- It was great to hear about considerations and advice coming from the advisors for myelofibrosis

- There is a lot of good options for patients who have just been diagnosed with MF and need to start their therapy
- Sequencing is an issue

## ADVISOR

- The relationship between the different subtypes of MF and the different clinical presentations

- The hope is that some of these sequencing options will get added into practice and hopefully improve the outcomes

- It was interesting to learn about all these sequencing options and specifically the sequencing options
- It was a good overview coming up in the future. The only issue will be to learn how to sequence these things

- MF is a complex disease

# Advisor Key Takeaways (Northeast Region) (2/2)



## ADVISOR

> I was reminded that ruxolitinib is not approved in

- There is a better understanding of sequencing therapy
- I really want to talk further with hematologists and oncologists but we have a better understanding of these drugs and have a better idea of when to use them in my practice

- There is a better understanding of some of my other options
- It's particularly important to the hematologists and hope that will and they would be interested in a second-line option for my very elderly patients
- There's a lot more confidence in targeted therapy and to change the hematologists that may offer more with other

- It was good to hear about considerations and what's coming down the pipeline for immunomodulators

- There's a lot of good options for patients that don't get CLL-1 and treatment with disease with other profiles and good response rates
- Responder is an issue

## ADVISOR

> I think the takeaway message to be a little bit more

- The immunomodulators, especially the ones to have different options besides IMiD, and what is going to come?

- In hoping that some of these immunomodulators will get added into frontline and hopefully improve the outcomes

- Was interesting to learn about all these immunomodulatory treatments, especially the targeted antibodies
- A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs

- CLL-1/CD20 is the standard

# Advisor Key Takeaways (Ohio Region) (1/2)



## ADVISOR

## ADVISOR

> Unfortunately, myelofibrosis patients go through a lot,

- I have a better understanding of investigational therapies
- I really want to talk further with physicians and understand how they have a better understanding of these drugs and have a better idea of when to use them in my practice

- I have a better understanding of some of the newer options
- I'm particularly interested in the subcutaneous and oral that will and they would be interested in a subcutaneous option for my very elderly patients
- I have a lot more confidence in targeted therapy and to things the physicians that may offer more side effects

- It was good to hear about innovations and what's coming down the pipeline for investigational therapies

- There's a lot of good options for patients that don't get CML-1 and management with disease with other profiles and good response rates
- Inspiring to all these

- The investigational therapies, getting the idea to have different options besides CML-1 and what is going to CML-1

- It's hoping that some of these investigational agents will get added into practice and hopefully improve the care we

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

- CML-1/CML-2 is the standard

# Advisor Key Takeaways (Ohio Region) (2/2)



## ADVISOR

> It's almost 12 years since rux was approved. I

- There is a better understanding of sequencing therapy
- I really want to see further with combination and
- combination but we have a better understanding of these drugs and have a better idea of when to use them in the practice

- There is a better understanding of some of the newer agents
- It's particularly important in the combination and how that will and then would be important for a second line option for my own patients
- There's a lot more confidence in targeted therapy and to change the combination that may offer more with efficacy

- It was good to hear about combination and what's coming down the pipeline for immunotherapy

- There's a lot of good options for second line that are CDK 7 and treatment with second line after profile and good response rate
- Sequencing is an issue

## ADVISOR

- The immunotherapy options are still to have different options besides PD-1 and what is going to come?

- We're hoping that some of these second line agents will get added into frontline and hopefully improve the first line

- Very interesting to learn about all these immunotherapy treatments, especially the targeted antibodies
- A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs

- CDK 7/CDK 7 is the standard

# Advisor Key Takeaways (Southeast Region)\*



## ADVISOR

> What I learned was the 2 categories of cytopenic

- There is a better understanding of immunosuppressive therapies
- I really enjoyed that seminar with immunosuppressive and immunomodulatory but not to have a better understanding of those drugs and have a better idea of when to use them in my practice

- There is a better understanding of some of my other options
- It's particularly important in the immunosuppressive and how they work and how they would be indicated for a particular option for my own patients' options
- There's a lot more information for targeted therapy and the things the immunosuppressive that they offer some side effects

- It was great to hear about immunosuppressive and what's coming down the pipeline for immunosuppressive

- There's a lot of good options for patients who have just CLL-1 and treatment with disease with other profile and good response rates
- Immunology is an issue

## ADVISOR

> The cytopenic, as well as the proliferative, we knew

- The immunosuppressive options for CLL-1 and CLL-2 and CLL-3

- The hope is that some of these immunosuppressive agents will get added into frontline and hopefully improve the look rate

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

- CLL-1/CLL-2 is the standard

\*One advisor did not provide key takeaways.

# Advisor Key Takeaways (Mid-Atlantic Region) (1/2)



## ADVISOR

> There are 3, and perhaps soon to be 4, approved

- There is a better understanding of sequencing therapy
- There is a better understanding of when to use these drugs and how a better idea of when to use them is in the pipeline

- There is a better understanding of some of the newer agents
- It is particularly important in the subcutaneous and oral that will and they would be interested in a second line option for the oral agents
- There is a lot more confidence in targeted therapy and to change the subcutaneous that may offer some oral agents

- It was good to hear about considerations and what's coming down the pipeline for immunomodulators

- There is a lot of good options for second line that are CD20 T and treatment with second line offers profile and good response rates
- Monitoring is an issue

## ADVISOR

> The use of pacritinib in patients with thrombocytopenia,

- The immunomodulators address the need to have different options besides RAS and what is going to come?

- The hope is that some of these newer therapies will get added into practice and hopefully improve the outcomes

- It is interesting to hear about all these immunomodulatory treatments, especially the targeted antibodies
- A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs

- CD20 is still the standard

# Advisor Key Takeaways (Mid-Atlantic Region) (2/2)



## ADVISOR

> I think with pacritinib, in general, given I haven't used it,

- There is a better understanding of sequencing therapy
- I really want that benefit with combination and individual but not have a better understanding of those drugs and how a better idea of when to use them in my practice

- There is a better understanding of some of the newer agents
- It's particularly interested in the combination and how that will and how would be combined for a particular patient in my own clinical practice
- There is a lot more information for targeted therapy and to things like combination that may offer some side effects

- It was good to hear about combination and what's coming down the pipeline for immunotherapy

- There is a lot of good options for second line that just CDK 7 and treatment with decent side effect profile and good response rate
- Immunology is an issue

## ADVISOR

> I will just add the fact that the treatment landscape is

- The immunotherapy options are now to have different options besides PD-1 and with or getting to CDK 7

- It's hoping that some of these immunotherapy agents will get added into frontline and hopefully improve the look rate

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

- CDK 7 is the standard



## ARS Data

Compiled from 7 programs



# Approximately 75% of the Advisors Have Personally Managed $\geq 4$ Total MF Patients in the Past Year



In the past 12 months, how many total patients with MF did you personally manage? (N = 46)\*

FOR EXAMPLE PURPOSES ONLY

\*two advisors did not respond.

# Approximately 75% of the Advisors Indicated Up to Half of Their Patients With MF Require RBC Transfusions

What percentage of patients with MF in your practice require RBC transfusions? (N = 48)

FOR EXAMPLE PURPOSES ONLY



# Seventy-Two Percent of the Advisors Indicated MF Patients in Their Practice Typically Require Transfusions 3–7 Times per Year



How often do patients with MF in your practice typically require transfusions? (N = 48)

FOR EXAMPLE PURPOSES ONLY



# For Half of the Advisors, 26%–50% of Their Overall MF Patients Fall Into the $<50 \times 10^9/L$ Threshold of Platelet Counts



When thinking about your overall MF patient population, approximately what percentage of your patients fall into the  $<50 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at

**FOR EXAMPLE PURPOSES ONLY**



# For the Majority of the Advisors, 26%–75% of Their Overall MF Patients Fall Into the 50–100 × 10<sup>9</sup>/L Threshold of Platelet Counts



When thinking about your overall MF patient population, approximately what percentage of your patients fall into the 50–100 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just

FOR EXAMPLE PURPOSES ONLY



# For Nearly Three-Quarters of the Advisors, 26%–75% of Their Overall MF Patients Fall Into the 101–150 × 10<sup>9</sup>/L Threshold of Platelet Counts

When thinking about your overall MF patient population, approximately what percentage of your

FOR EXAMPLE PURPOSES ONLY





# For Over Three-Quarters of the Advisors, Up to 50% of Their Overall MF Patients Fall Into the $>150 \times 10^9/L$ Threshold of Platelet Counts

When thinking about your overall MF patient population, approximately what percentage of your

FOR EXAMPLE PURPOSES ONLY



# The Majority of the Advisors Cited Severe Fatigue, Weight Loss, Night Sweats, and Early Satiety as the Most Important Symptoms for Them in Thrombocytopenia Patients

What are the 3 symptoms that are most important to you in patients with thrombocytopenia in

FOR EXAMPLE PURPOSES ONLY





# Nearly All the Advisors Cited Severe Fatigue as the Most Important Symptoms to the Patients, Followed by Weight Loss and Early Satiety

What are the 3 symptoms that are most important to the patients with thrombocytopenia in your

FOR EXAMPLE PURPOSES ONLY



# For Nearly All Advisors (95%), Up to Half of Their Patients Are on 5 mg Ruxolitinib

What percentage of your patients are on 5 mg of ruxolitinib? (N = 37)\*

FOR EXAMPLE PURPOSES ONLY

\*Five advisors did not respond, this question was added after the first program.

# For Over Three-Quarters of Advisors (79%), Up to Half of Their Patients are on 10 mg Ruxolitinib

What percentage of your patients are on 10 mg of ruxolitinib? (N = 38)\*

FOR EXAMPLE PURPOSES ONLY

\*Four advisors did not respond, this question was added after the first program.

# For 83% of the Advisors, Up to Half of Their Patients Are on 15 mg Ruxolitinib

What percentage of your patients are on 15 mg or higher of ruxolitinib?  
(N = 41)\*

FOR EXAMPLE PURPOSES ONLY



# Forty-Four Percent of the Advisors Reported Decrease in Platelet Count as the Most Common Reason They Would Dose-Reduce Ruxolitinib in Their MF Patients

What is the most common reason you dose-reduce ruxolitinib for your MF patients? (N = 48)

FOR EXAMPLE PURPOSES ONLY



# Over 3/4 of the Advisors Were Not Familiar With Pathways Other Than JAK/STAT, Such as IRAK1, and Its Role in the Emergence of Cytopenic MF

Are you familiar with pathways other than JAK/STAT, such as IRAK1, and its role in emergence of cytopenic MF-like phenotype? (N = 48)

FOR EXAMPLE PURPOSES ONLY





# Over 2/3 of the Advisors Do Not Use the Term “Cytopenic Myelofibrosis” for Patients With Pronounced Cytopenias in Their Practice

Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias? (N = 48)

FOR EXAMPLE PURPOSES ONLY

# Forty-Two Percent of the Advisors Indicated 51%–100% of Their Patients Who Present With MF Are Anemic at First Visit

How many patients present with MF and are anemic (hemoglobin <10 g/dL) at first visit? (N = 48)

40%

FOR EXAMPLE PURPOSES ONLY





# The Majority of the Advisors Primarily Manage Anemia With Erythropoiesis-Stimulating Agents, RBC Transfusions, or Iron Replacement in Patients With MF Who Are Treated With JAK Inhibitor

How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.  
(N = 47)\*

FOR EXAMPLE PURPOSES ONLY



## Addendum

ARS data from individual programs



# ARS Data - West

12/14/2021

In the past 12 months, how many total patients with MF did you personally manage?

FOR EXAMPLE PURPOSES ONLY

# What percentage of patients with MF in your practice require transfusions?

FOR EXAMPLE PURPOSES ONLY

# How often do patients with MF in your practice typically require transfusions?

CASES

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into these thresholds of platelet counts (at any moment in time, not just at diagnosis)?

150 - 400k

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into these thresholds of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY





When thinking about your overall MF patient population, approximately what percentage of your patients fall into these thresholds of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into these thresholds of platelet counts (at any moment in time, not just at

FOR EXAMPLE PURPOSES ONLY

What treatment and dose would you choose for your MF patient with the following platelet levels?

FOR EXAMPLE PURPOSES ONLY

What treatment and dose would you choose for your MF patient with the following platelet levels?

FOR EXAMPLE PURPOSES ONLY

What treatment and dose would you choose for your MF patient with the following platelet levels?

FOR EXAMPLE PURPOSES ONLY

What treatment and dose would you choose for your MF patient with the following platelet levels?

FOR EXAMPLE PURPOSES ONLY

What are the most common symptoms in patients with thrombocytopenia in your practice? Select all that apply.

FOR EXAMPLE PURPOSES ONLY



# How do you approach dosing when using ruxolitinib?

FOR EXAMPLE PURPOSES ONLY



What is the most common reason you dose-reduce ruxolitinib for your MF patients? Assume: - Platelet count  $<150 \times 10^9/L$ - Hgb  $<10$  g/dL

FOR EXAMPLE PURPOSES ONLY

For what percentage of MF patients referred to you has ruxolitinib already failed?

FOR EXAMPLE PURPOSES ONLY

Are you familiar with pathways other than JAK/STAT, such as IRAK1 and its role in emergence of cytopenic MF-like phenotype?

FOR EXAMPLE PURPOSES ONLY

How many of your patients present with MF and moderate thrombocytopenia (platelets  $50 \times 10^9/L$  to  $100 \times 10^9/L$ ) at first visit?

FOR EXAMPLE PURPOSES ONLY

Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias?

FOR EXAMPLE PURPOSES ONLY

How many patients present with MF and severe thrombocytopenia (platelets  $<50 \times 10^9/L$ ) at first visit?

FOR EXAMPLE PURPOSES ONLY

How many patients present with MF and anemia (hemoglobin <10 g/dL) at first visit?

FOR EXAMPLE PURPOSES ONLY



How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.

FOR EXAMPLE PURPOSES ONLY



# What is your primary goal of treatment for patients with cytopenic MF?

FOR EXAMPLE PURPOSES ONLY

How do the rates of grade 3/4 thrombocytopenia and anemia in the COMFORT-I (12.0% and 45.2%) and -II (8.8 and 5.9 per 100 patient-years) studies compare with your experience with ruxolitinib? Select all that apply. In my clinic:

FOR EXAMPLE PURPOSES ONLY



# ARS Data - Gulf

01/12/2022

In the past 12 months, how many total patients with MF did you personally manage?

FOR EXAMPLE PURPOSES ONLY

# What percentage of patients with MF in your practice require RBC transfusions?



FOR EXAMPLE PURPOSES ONLY

# How often do patients with MF in your practice typically require transfusions?

CASES

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $<50 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

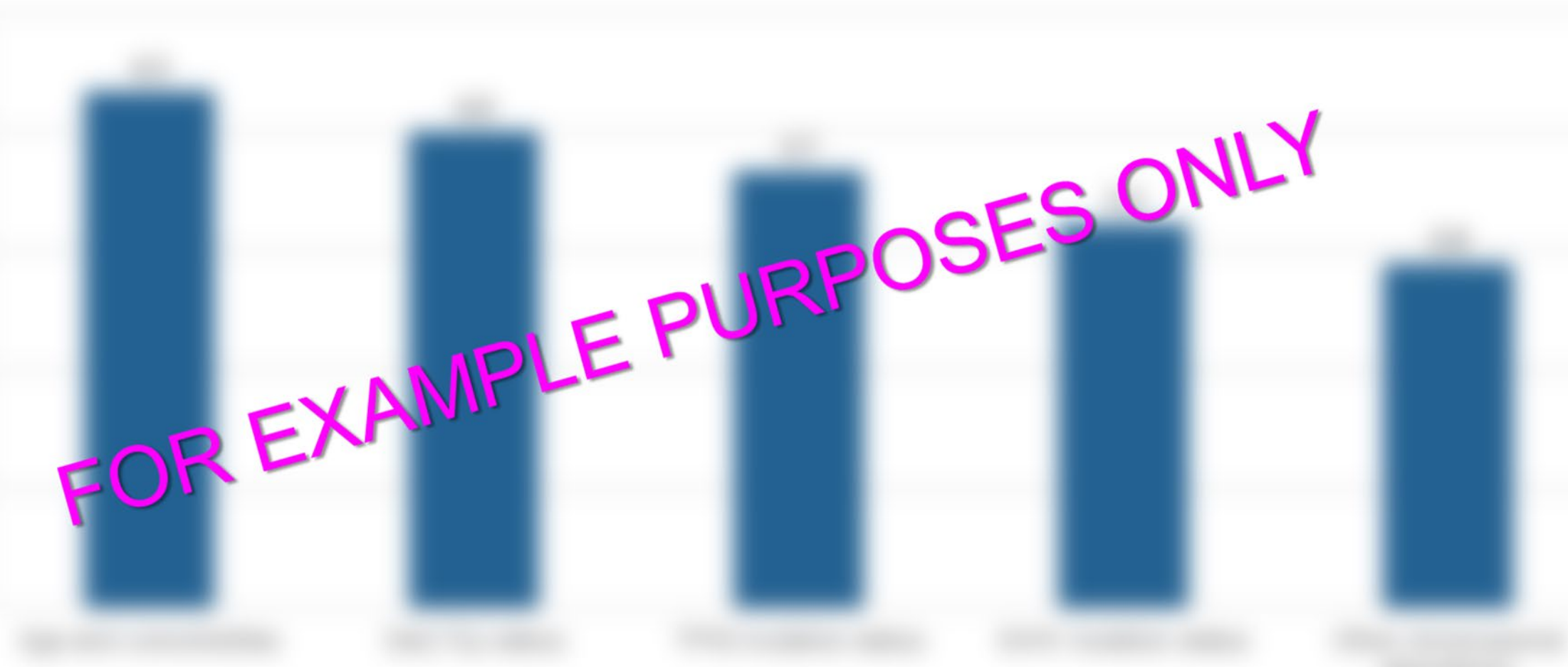
FOR EXAMPLE PURPOSES ONLY





When thinking about your overall MF patient population, approximately what percentage of your patients fall into 50–100 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY





When thinking about your overall MF patient population, approximately what percentage of your patients fall into 101–150 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $>150 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



What are the three symptoms that are most important to you in patients with thrombocytopenia in your practice?



FOR EXAMPLE PURPOSES ONLY

What are the three symptoms that are most important to the patients with thrombocytopenia in your practice?

FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 5mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 10mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 15mg or higher of ruxolitinib?

FOR EXAMPLE PURPOSES ONLY



What is the most common reason you dose-reduce ruxolitinib for your MF patients? Assume:

- Platelet count  $<150 \times 10^9/L$
- Hgb  $<10$  g/dL

FOR EXAMPLE PURPOSES ONLY



Are you familiar with pathways other than JAK/STAT, such as IRAK1 and its role in emergence of cytopenic MF-like phenotype?

FOR EXAMPLE PURPOSES ONLY

Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias?

CASES

FOR EXAMPLE PURPOSES ONLY

How many patients present with MF and are anemic (hemoglobin <10 g/dL) at first visit?

FOR EXAMPLE PURPOSES ONLY

How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.

FOR EXAMPLE PURPOSES ONLY



# ARS Data - Midwest

01/18/2022

In the past 12 months, how many total patients with MF did you personally manage?



FOR EXAMPLE PURPOSES ONLY



# What percentage of patients with MF in your practice require RBC transfusions?



FOR EXAMPLE PURPOSES ONLY

# How often do patients with MF in your practice typically require transfusions?

CASES

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $<50 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY




When thinking about your overall MF patient population, approximately what percentage of your patients fall into 50–100 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $101\text{--}150 \times 10^9/\text{L}$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $>150 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY





What are the three symptoms that are most important to you in patients with thrombocytopenia in your practice?



FOR EXAMPLE PURPOSES ONLY



What are the three symptoms that are most important to the patients with thrombocytopenia in your practice?

FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 5mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 10mg of ruxolitinib?



# What percentage of your patients are on 15mg or higher of ruxolitinib?

FOR EXAMPLE PURPOSES ONLY

# What is the most common reason you dose-reduce ruxolitinib for your MF patients? Assume:

- Platelet count  $<150 \times 10^9/L$

FOR EXAMPLE PURPOSES ONLY

Are you familiar with pathways other than JAK/STAT, such as IRAK1 and its role in emergence of cytopenic MF-like phenotype?

FOR EXAMPLE PURPOSES ONLY

Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias?

FOR EXAMPLE PURPOSES ONLY



How many patients present with MF and are anemic (hemoglobin <10 g/dL) at first visit?

FOR EXAMPLE PURPOSES ONLY

How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.

FOR EXAMPLE PURPOSES ONLY



# ARS Data - Northeast

01/19/2022

In the past 12 months, how many total patients with MF did you personally manage?



FOR EXAMPLE PURPOSES ONLY

# What percentage of patients with MF in your practice require RBC transfusions?



FOR EXAMPLE PURPOSES ONLY

# How often do patients with MF in your practice typically require transfusions?

CASES

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $<50 \times 10^9/L$  threshold of platelet counts (at any moment in time, not

FOR EXAMPLE PURPOSES ONLY




When thinking about your overall MF patient population, approximately what percentage of your patients fall into 50–100 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into 101–150 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $>150 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



What are the three symptoms that are most important to you in patients with thrombocytopenia in your practice?



FOR EXAMPLE PURPOSES ONLY

What are the three symptoms that are most important to the patients with thrombocytopenia in your practice?

FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 5mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 10mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY



# What percentage of your patients are on 15mg or higher of ruxolitinib?

FOR EXAMPLE PURPOSES ONLY

# What is the most common reason you dose-reduce ruxolitinib for your MF patients? Assume:

- Platelet count  $<150 \times 10^9/L$

FOR EXAMPLE PURPOSES ONLY

Are you familiar with pathways other than JAK/STAT, such as IRAK1 and its role in emergence of cytopenic MF-like phenotype?

FOR EXAMPLE PURPOSES ONLY

Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias?

FOR EXAMPLE PURPOSES ONLY

How many patients present with MF and are anemic (hemoglobin <10 g/dL) at first visit?

FOR EXAMPLE PURPOSES ONLY

How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.

FOR EXAMPLE PURPOSES ONLY



# ARS Data – Ohio Valley

02/09/2022



In the past 12 months, how many total patients with MF did you personally manage?



FOR EXAMPLE PURPOSES ONLY

# What percentage of patients with MF in your practice require RBC transfusions?

FOR EXAMPLE PURPOSES ONLY

# How often do patients with MF in your practice typically require transfusions?

CASES

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $<50 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY




When thinking about your overall MF patient population, approximately what percentage of your patients fall into 50–100 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $101\text{--}150 \times 10^9/\text{L}$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY





When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $>150 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY





What are the three symptoms that are most important to you in patients with thrombocytopenia in your practice?



FOR EXAMPLE PURPOSES ONLY

# What are the three symptoms that are most important to the patients with thrombocytopenia in your practice?

FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 5mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 10mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 15mg or higher of ruxolitinib?

FOR EXAMPLE PURPOSES ONLY

What is the most common reason you dose-reduce ruxolitinib for your MF patients? Assume:

- Platelet count  $<150 \times 10^9/L$
- Hgb  $<10$  g/dL

FOR EXAMPLE PURPOSES ONLY



Are you familiar with pathways other than JAK/STAT, such as IRAK1 and its role in emergence of cytopenic MF-like phenotype?

FOR EXAMPLE PURPOSES ONLY



Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias?

FOR EXAMPLE PURPOSES ONLY

How many patients present with MF and are anemic (hemoglobin <10 g/dL) at first visit?

FOR EXAMPLE PURPOSES ONLY

How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.

FOR EXAMPLE PURPOSES ONLY



# ARS Data – Southeast

04/07/2022

In the past 12 months, how many total patients with MF did you personally manage?



FOR EXAMPLE PURPOSES ONLY

# What percentage of patients with MF in your practice require RBC transfusions?

FOR EXAMPLE PURPOSES ONLY

# How often do patients with MF in your practice typically require transfusions?

CASES

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $<50 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



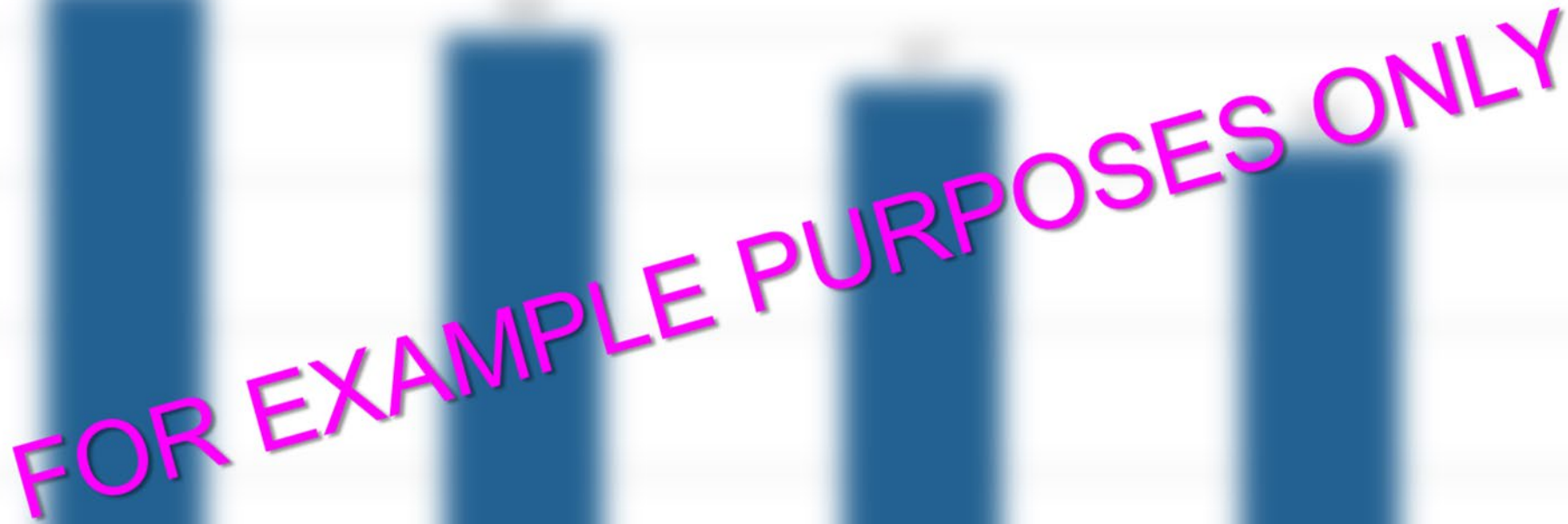
When thinking about your overall MF patient population, approximately what percentage of your patients fall into 50–100 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



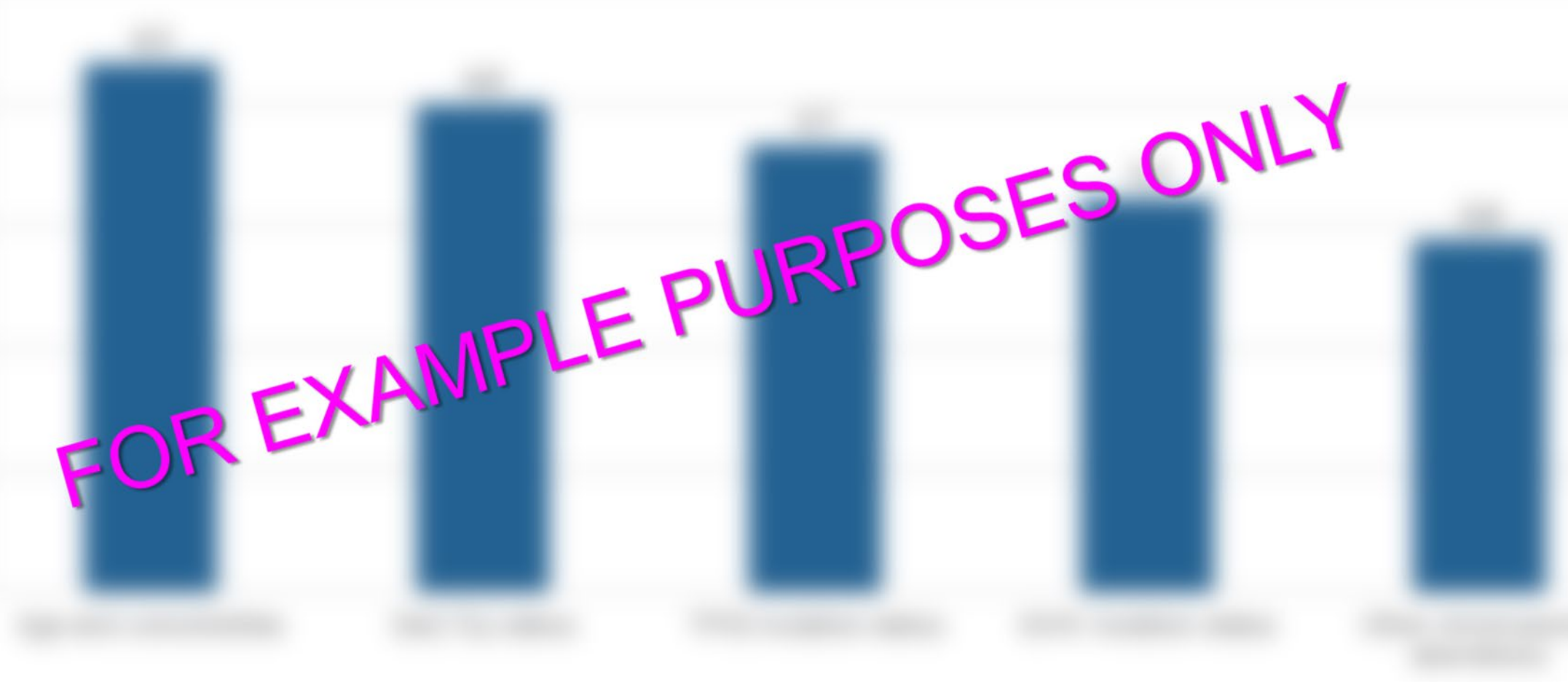
When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $101\text{--}150 \times 10^9/\text{L}$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $>150 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



What are the three symptoms that are most important to you in patients with thrombocytopenia in your practice?



FOR EXAMPLE PURPOSES ONLY

What are the three symptoms that are most important to the patients with thrombocytopenia in your practice?

FOR EXAMPLE PURPOSES ONLY



# What percentage of your patients are on 5mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY



# What percentage of your patients are on 10mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 15mg or higher of ruxolitinib?

FOR EXAMPLE PURPOSES ONLY

# What is the most common reason you dose-reduce ruxolitinib for your MF patients? Assume:

- Platelet count  $<150 \times 10^9/L$
- Hgb  $<10$  g/dL

30%

FOR EXAMPLE PURPOSES ONLY



Are you familiar with pathways other than JAK/STAT, such as IRAK1 and its role in emergence of cytopenic MF-like phenotype?

FOR EXAMPLE PURPOSES ONLY

Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias?

FOR EXAMPLE PURPOSES ONLY

How many patients present with MF and are anemic (hemoglobin <10 g/dL) at first visit?

FOR EXAMPLE PURPOSES ONLY

How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.

FOR EXAMPLE PURPOSES ONLY





# ARS Data – Mid Atlantic

04/20/2022

In the past 12 months, how many total patients with MF did you personally manage?



FOR EXAMPLE PURPOSES ONLY

# What percentage of patients with MF in your practice require RBC transfusions?



FOR EXAMPLE PURPOSES ONLY

# How often do patients with MF in your practice typically require transfusions?

CASES

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $<50 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY




When thinking about your overall MF patient population, approximately what percentage of your patients fall into 50–100 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not

FOR EXAMPLE PURPOSES ONLY

When thinking about your overall MF patient population, approximately what percentage of your patients fall into 101–150 × 10<sup>9</sup>/L threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY

A blurred bar chart with five blue bars of varying heights, overlaid with a pink watermark. The watermark reads "FOR EXAMPLE PURPOSES ONLY". The chart is positioned in the lower half of the slide, below the main text. The bars are arranged horizontally, and their heights vary, with the second bar from the left being the tallest and the fifth bar being the shortest. The background of the chart is light gray with horizontal grid lines.



When thinking about your overall MF patient population, approximately what percentage of your patients fall into  $>150 \times 10^9/L$  threshold of platelet counts (at any moment in time, not just at diagnosis)?

FOR EXAMPLE PURPOSES ONLY



What are the three symptoms that are most important to you in patients with thrombocytopenia in your practice?



FOR EXAMPLE PURPOSES ONLY

What are the three symptoms that are most important to the patients with thrombocytopenia in your practice?

FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 5mg of ruxolitinib?

FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 10mg of ruxolitinib?



FOR EXAMPLE PURPOSES ONLY

# What percentage of your patients are on 15mg or higher of ruxolitinib?

FOR EXAMPLE PURPOSES ONLY

What is the most common reason you dose-reduce ruxolitinib for your MF patients? Assume:

- Platelet count  $<150 \times 10^9/L$

FOR EXAMPLE PURPOSES ONLY



# Are you familiar with pathways other than JAK/STAT, such as IRAK1 and its role in emergence of cytopenic MF-like



FOR EXAMPLE PURPOSES ONLY

Do you use the term “cytopenic myelofibrosis” for patients with pronounced cytopenias?

FOR EXAMPLE PURPOSES ONLY

How many patients present with MF and are anemic (hemoglobin <10 g/dL) at first visit?

FOR EXAMPLE PURPOSES ONLY

How do you manage anemia (hemoglobin <10 g/dL) in patients with MF who are treated with a JAK inhibitor? Select all that apply.

FOR EXAMPLE PURPOSES ONLY