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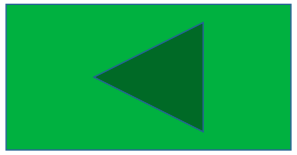
# Insights Into Hepatocellular Carcinoma (HCC)

Virtual Platform

March 15, 2022

# How to Navigate This Report

Click to move to topic of interest or ARS supporting data



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# Report Objectives

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## STUDY OBJECTIVES

To gain advisors' perspectives on

- Current treatment practices regarding therapy of unresectable advanced HCC
- Current treatment practice attitudes toward recently introduced and upcoming agents

# Report Snapshot: Session Overview

A moderated roundtable discussion was held with community oncologists from Massachusetts and New York in a virtual setting on **March 15, 2022**

Disease state and data presentations were led by **Dr Tanios Bekaii-Saab** from the **Mayo Clinic** in **Phoenix, Arizona**, in conjunction with content developed by the Aptitude Health clinical team

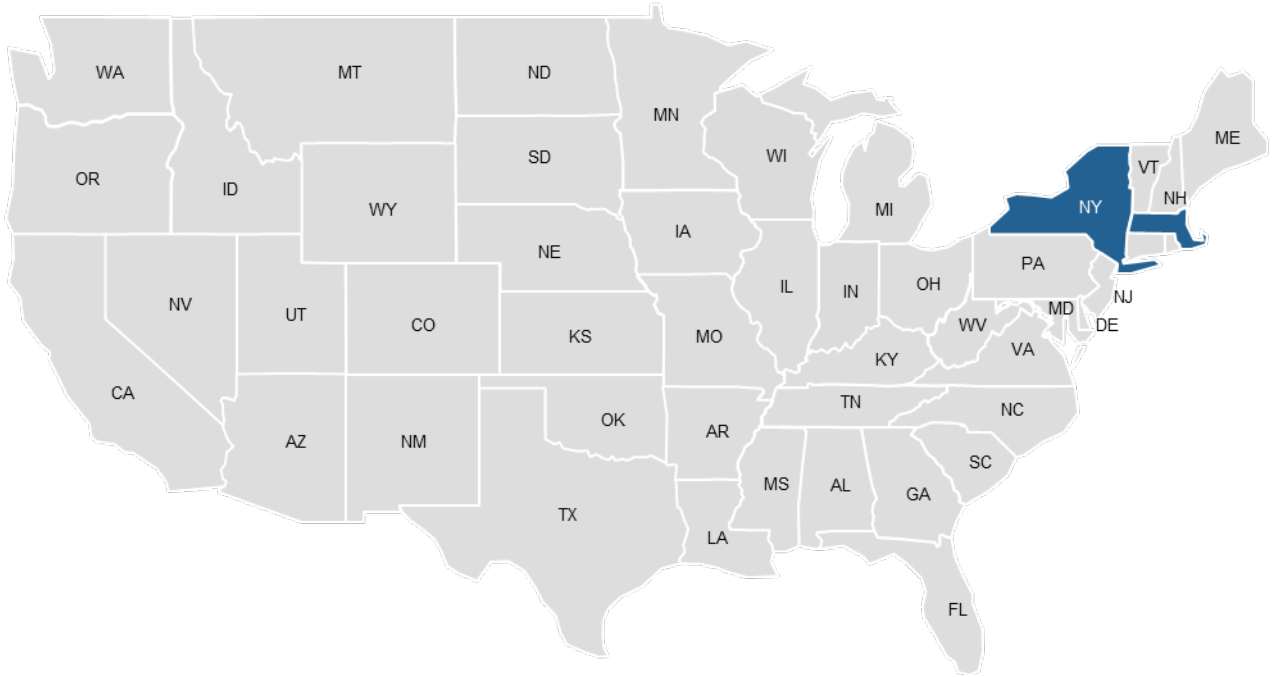
Insights were obtained on current treatment practices and attitudes toward new therapeutics for unresectable advanced HCC

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 8 community oncologists from New York and Massachusetts

| INSTITUTION | CITY | STATE |
|---|---|---|
| Westchester Medical Center | Hawthorne | NY |
| Vantage Oncology Group | Flushing | |
| New York Cancer & Blood Specialists | Greenlawn | |
| Northwell Health Cancer Institute | New Hyde Park | |
| Northwell Health Cancer Institute at Lenox Hill Hospital | New York | |
| New York Cancer & Blood Specialists | Port Jefferson | |
| New York Cancer & Blood Specialists | Bronx | |
| Southcoast Health | Fall River | MA |



# Report Snapshot: Agenda

| Time (ET) | Topic |
|---|---|
| 6.00 PM – 6.15 PM (15 min) | Introduction |
| 6.15 PM – 7.20 PM (65 min) | First-Line Treatment of Advanced HCC |
| 7.20 PM – 7.30 PM (10 min) | Break |
| 7.30 PM – 8.45 PM (75 min) | Second-Line and Subsequent Therapy for Advanced HCC |
| 8.45 PM – 9.00 PM (15 min) | Key Takeaways and Meeting Evaluation |

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# Key Insights and Discussion Summary

# Discussion: First-Line Treatment in Advanced HCC

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## INSIGHTS AND DATA

*"I think it [STRIDE regimen] has a role in patients with high risk of bleeding and esophageal bleed. But besides*

- [illegible]

[illegible]

- [illegible]

[illegible]

# Discussion: First-Line Treatment in Advanced HCC

## INSIGHTS AND DATA

*"I tend to do NGS on all patients with stage IV."*

- Treatment success in frontline DLBCL

"My overall survival, that's what we need. This is not metastatic disease, this is curable disease, so we need overall survival."

"...cure without any significant long-term toxicity. ...I think when I define success, I would rather use a landmark endpoint rather than using OS or PFS, and I would say what's the disease-free rate at 2 years. I definitely do think OS is important if there is significant toxicity with the treatment, and people dying from competing comorbidities."

- Data needed to switch from SOC in frontline

"First of all, a lot of things have been tried, nothing is better than R-CHOP, and frankly, I'm pretty happy with how R-CHOP performs for my patients."

"I would be a late adopter. I would not be one of the first ones to move based on PFS or anything like that. I want something that's tried and true and we know how well it works."

"If the toxicities are not very severe, I think a hazard ratio of 0.85 or better would be something that I would be looking at."

"Overall survival data, that's ideal, but in this disease state OS is hard to come by, so you do have to use some surrogates of efficacy. So, I do think that a 2- or 3-year event-free survival kind of story is likely what's going to start driving my use of any regimen. ...PFS is not sufficient."

# Discussion: First-Line Treatment in Advanced HCC

## INSIGHTS AND DATA

*"I'm really excited about HIMALAYA as an alternative in the first-line setting. . . .The drugs being used are similar*

- [illegible]
- [illegible]

# Discussion: First-Line Treatment in Advanced HCC

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## INSIGHTS AND DATA

*"In terms of COSMIC, I haven't yet figured out how I'm going to incorporate it. I don't think it's that easy to tolerate."*

- [illegible]

- [illegible]

# Discussion: Second-Line and Subsequent Therapy in Advanced HCC

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## INSIGHTS AND DATA

*"I think it's a combination of factors. Patient performance status, radiological evidence, and alpha-fetoprotein. If it's*

- Treatment success in frontline (S,BC),

- Data needed to switch from SOC in frontline

# Discussion: Second-Line and Subsequent Therapy in Advanced HCC

## INSIGHTS AND DATA

*"I have a lot of comfort using [sorafenib] and I find the GI stuff is less than the other ones, and as long as you*

- [illegible]

- [illegible]

# Discussion: Second-Line and Subsequent Therapy in Advanced HCC

## INSIGHTS AND DATA

*"I think durva is going to be my preferred agent just because now there's clear data to support it once it's*

- [illegible]

[illegible]

- [illegible]

[illegible]

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# Advisor Key Takeaways

# Advisor Key Takeaways

| ADVISOR | | ADVISOR | |
|---|---|---|---|
| 1 | > Atezo + bev first line and wind up with cabo as a | 5 | > I am rethinking second-line options, and also figuring |
| 1 | > I have a better understanding of sequencing therapies<br>> 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-ICE and auto or going to CAR T |
| 2 | > I have a better understanding of some of my relapse options<br>> 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<br>> 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<br>> 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<br>> Sequencing is an issue | 8 | > Still R-CHOP is the standard |

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# ARS Data

# Advisors Treat a Significant Number of Advanced HCC Patients


*Two advisors did not respond.

# Atezolizumab + Bevacizumab Is the Preferred First-Line Systemic Therapy for 75% of Advisors


*Two advisors did not respond.

# Proven Efficacy Is the Primary Driver for First-Line Therapy Selection Among Advisors


*Two advisors did not respond.

# Thirty-Three Percent of Advisors Use EGD in >50% of Their Patients Before Commencing Therapy


*Two advisors did not respond.

# All Advisors (100%) Have Used Atezolizumab + Bevacizumab as First-Line Therapy in at Least 1 Patient


*Two advisors did not respond.

# Most Advisors Would Use Atezolizumab + Bevacizumab as First-Line Treatment Post-radiation for an Elderly Man With Advanced HCC

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*One advisor did not respond.

# Preference for Second-Line Therapy in Unresectable HCC Varied Significantly, Although Lenvatinib Was Selected by More Than One-Third of the Advisors

# Proven Efficacy and Impact on Quality of Life Are the Primary Drivers for Second-Line Therapy Selection Among Advisors, Followed by Personal Expertise With the Regimen

# Advisors Selected Lenvatinib (57%) as Preferred Second-Line Treatment for an Adult Male With Advanced HCC Whose Disease Progressed After Atezolizumab + Bevacizumab

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*One advisor did not respond.

# Twenty-Nine Percent of Advisors Do Not Consider AFP Level When Determining Second-Line Therapy


*One advisor did not respond.

# Seventy-Five Percent of Advisors Have Used Cabozantinib in the Second-Line Setting

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