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CASES

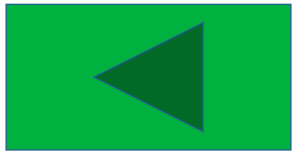
Insights Into Acute Lymphoblastic Leukemia (ALL)

Monday, March 6, 2023

Virtual Program – Northwest

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



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Report Objectives

STUDY OBJECTIVE
Gain advisors' perspectives on current treatment practices and management of patients with ALL in the frontline setting

Report Snapshot: Session Overview

A moderated roundtable discussion was held with oncologists from the Northwest region of the US in a virtual setting on **March 6, 2023**

Disease state and data presentations were led by **Dr Elias Jabbour** from MD Anderson Cancer Center, in conjunction with content developed by the Aptitude Health Clinical Team

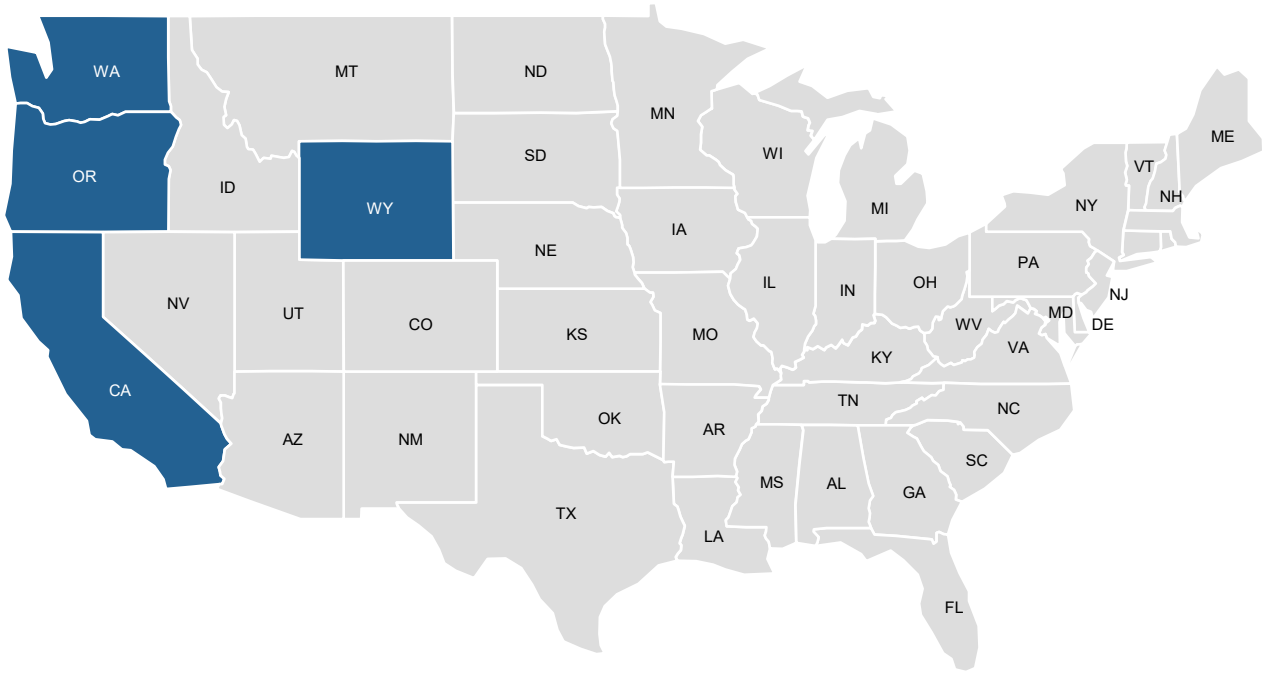
Insights were obtained on **current approaches to treatment and management of Ph– and Ph+ ALL**, including MRD assessment and monitoring, in the community setting

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

Report Snapshot: Attendee Overview

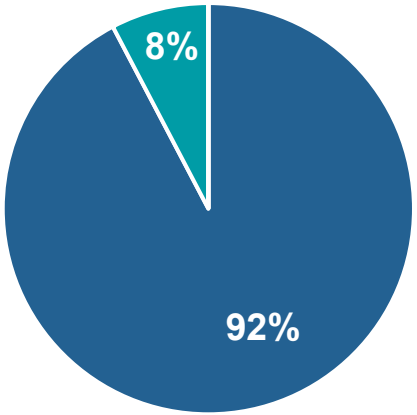
> The group of advisors comprised 14 oncologists from the Northwest region of the US: California, Oregon, Washington, and Wyoming

INSTITUTION	CITY	STATE
Sutter Alta Bates Comprehensive Cancer Center	Berkeley	CA
Enloe Specialty Physicians	Chico	CA
cCARE	Fresno	CA
John Muir Health Cancer Medical Group	Pleasant Hill	CA
Summit Health	Bend	OR
Providence Regional Cancer Partnership	Everett	WA
The Everett Clinic	Everett	WA
UW Medicine/Valley Medical Center	Renton	WA
Swedish Cancer Institute	Seattle	WA
Multicare Regional Cancer Center	Tacoma	WA
North Star Lodge	Yakima	WA
Rocky Mountain Oncology	Casper	WY



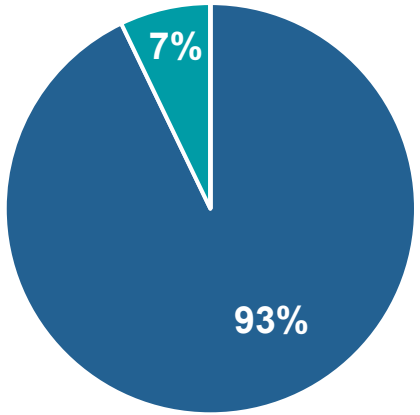
Report Snapshot: Attendee Demographics

Approximately how many newly diagnosed ALL patients have you treated in the past 12 months? (n = 13*)



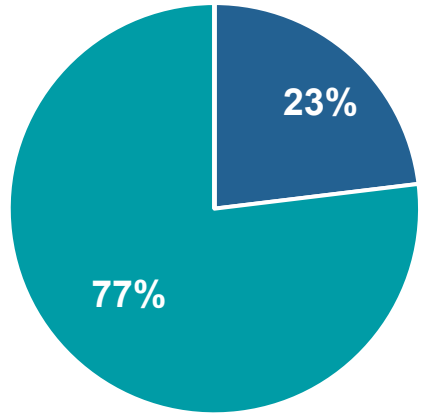
■ ≤5 patients ■ 6–10 patients ■ 11–15 patients ■ 16–20 patients ■ ≥21 patients

Approximately how many of your newly diagnosed ALL patients in the past 12 months were Ph–? (N = 14)



■ ≤5 patients ■ 6–10 patients ■ 11–15 patients ■ 16–20 patients ■ ≥21 patients

Approximately how many of your newly diagnosed ALL patients in the past 12 months were Ph+? (n = 13*)



■ 0 patients ■ 1–3 patients ■ 4–6 patients ■ 7–9 patients ■ ≥10 patients

Nearly all advisors (92%) had managed ≤5 newly diagnosed ALL patients in the last 12 months

- A few advisors (23%) reported that all their patients had Ph– disease, while the others (77%) noted that 1–3 of their patients had Ph+ disease

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*One advisor did not respond.

Report Snapshot: Agenda

Time (PT)	Topic
6.00 PM – 6.15 PM (15 min)	Introduction
6.15 PM – 7.25 PM (70 min)	Management Options in Ph– ALL
7.25 PM – 7.40 PM (15 min)	Break
7.40 PM – 8.50 PM (70 min)	Management Options in Ph+ ALL
8.50 PM – 9.00 PM (10 min)	Key Takeaways and Meeting Evaluation

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Key Insights and Discussion Summary

Insights Into ALL

Discussion: Ph– ALL (1/3)

MANAGEMENT OF Ph– ALL – INSIGHTS AND DATA

"All of my currently 3 patients are getting blinatumomab in one form or another."

- [illegible]

[illegible]

- [illegible]

[illegible]

Discussion: Ph– ALL (2/3)

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MANAGEMENT OF Ph– ALL – INSIGHTS AND DATA

Impressions of *"I think it is definitely challenging the standard of care."*

- [illegible]

- [illegible]

Discussion: Ph– ALL (3/3)

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MANAGEMENT OF Ph– ALL – INSIGHTS AND DATA

"It depends. Their age, how long the time to relapse, during maintenance or not. But most likely if they just had an MRD+ relapse, then it is different from say a florid relapse. So far, we've been using vin for just MRD+ relapse. If it is more

- Treatment success in frontline DLBCL

- Data needed to switch from BCR in frontline

Discussion: Ph+ ALL

MANAGEMENT OF Ph+ ALL – INSIGHTS AND DATA

"We've started to use it. I have more experience with imatinib and dasatinib."

- [illegible]

[illegible]

- [illegible]

[illegible]

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Advisor Key Takeaways

Insights Into ALL

Advisor Key Takeaways (1/2)

ADVISOR		ADVISOR	
1	> Blina combined with the intensity-reduced > 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	> I think for community practice oncologists, we need to know more > 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 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	> The ponatinib vs dasatinib data was very impactful > I have a better understanding of sequencing therapies > I really wasn't that familiar with ponatuzumab and telisotamab 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 telisotamab 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 ponatuzumab 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

Insights Into ALL

The Clinical Factors Most Strongly Impacting Advisors' Choice of TKI in Frontline Ph+ ALL Are Efficacy, Followed by Toxicity and Comorbidities

Which of the following clinical factors most influence(s) your choice of TKI in frontline

In Ph+ ALL, TKI-Based Regimens Are the Most Prevalent Induction Regimens – Hyper-CVAD Combinations Are the Most Common, Followed by Combinations With Corticosteroids or Multiagent Chemotherapy

Which of the following induction regimens have you used in Ph+ ALL in the past 12

Half of the Advisors Decide on a Case-by-Case Basis Whether to Refer Their Ph+ ALL Patients for Postremission Therapy

For postremission therapy in Ph+ ALL: (N = 14)

In Ph+, MRD+ ALL, Blinatumomab ± TKI Is the Most Common Postremission Therapy

Which of the following postremission therapies have you used in Ph+, **MRD+** patients in the past 12 months? (*Select all that apply.*) (N = 14)

In Ph+, MRD– ALL, TKI Monotherapy Is the Most Prevalent Postremission Therapy

Which of the following postremission therapies have you used in Ph+, **MRD–** patients in the past 12 months? (*Select all that apply.*) (N = 14)

In Ph–, MRD+ ALL, Blinatumomab Is the Most Used Consolidation Therapy

Which of the following consolidation therapies have you used in Ph–, **MRD+** patients in the

In Ph–, MRD– ALL, the Most Prevalent Consolidation Therapies Are Chemotherapy, Followed by Blinatumomab

Which of the following consolidation therapies have you used in Ph–, **MRD–** patients in the past 12 months? (*Select all that apply.*) (n = 13*)

Most Advisors (71%) Would Recommend Blinatumomab for an Older Patient Who Achieved MRD Negativity at CR1 After Induction With a BFM Regimen

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A 68-year-old man is newly diagnosed with B-cell ALL (*BCR-ABL1* negative). He is induced with a BFM

If the Same Patient Was MRD+ at CR1, Nearly All Advisors (92%) Would Recommend Treatment With Blinatumomab

Consider the previous case, but upon CR1, the patient is MRD+. What would you recommend? (n = 13*)

The Most Common Time Point in Treatment Where Persistent MRD Positivity Would Change Advisors' ALL Management Is End of Induction

At what point in treatment would persistent MRD positivity lead you to change ALL patient

The Biggest Challenges Advisors Face in Ordering MRD Testing Are Lack of Reimbursement, Patient Aspiration Refusal, or Pathologists/Practices Not Offering the Assessment

What challenges do you face in ordering MRD testing? (*Select all that apply.*) (n = 13*)

The Clinical Factors Most Strongly Impacting Advisors' Choice of First Salvage Are Comorbidities, Followed by Ph Chromosome Status and Response to Initial Therapy

Which of the following clinical factors most influence(s) your choice of therapy in the first-relapse setting? (*Select your top 3.*) (n = 13*)

Nearly All Advisors (92%) Would Recommend Blinatumomab for a Young Patient Who Relapsed at the End of Consolidation

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A 35-year-old female patient presents with a history of pre–B-ALL diploid cytogenetics and is C*RLF2* negative. She was induced with R–hyper-CVAD and achieved CR with MRD negativity. She was found to have relapsed ALL at

Approximately Half of the Advisors (54%) Would Prescribe a Total of 4 Cycles of Blinatumomab for This Patient, While Others (46%) Would Move to Transplant After 2 Cycles of Blinatumomab

The patient was reinduced with blinatumomab and achieved CR2 at day 28. MRD was also negative at day 42. The patient is now receiving cycle 2 of blinatumomab and tolerating it well. Your next plan

Most Advisors (92%) Reported Being Not Familiar (71%) or Only Somewhat Familiar (21%) With the ECOG-ACRIN E1910 Trial

How familiar are you with the ECOG-ACRIN E1910 trial? (N = 14)

Advisors Showed Low Baseline Knowledge of the ECOG-ACRIN E1910 Data

Which of the following are outcomes from the ECOG-ACRIN E1910 trial?
(*Select all that apply.*) (n = 13*)

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