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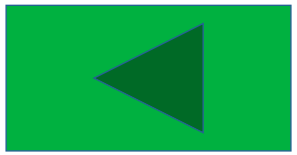
Insights Into Advanced Endometrial Cancer (aEC)

Friday, October 13, 2023

Insights From Community Oncologists in the Northeastern US

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



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Report Snapshot: Session Overview

A moderated roundtable discussion was held with oncologists from the Northeastern US in Philadelphia, PA, on **October 13, 2023**

Session moderation and data presentations were led by **Dr Bhavana Pothuri,** from NYU Langone Health, with content developed in conjunction with the Aptitude Health clinical team

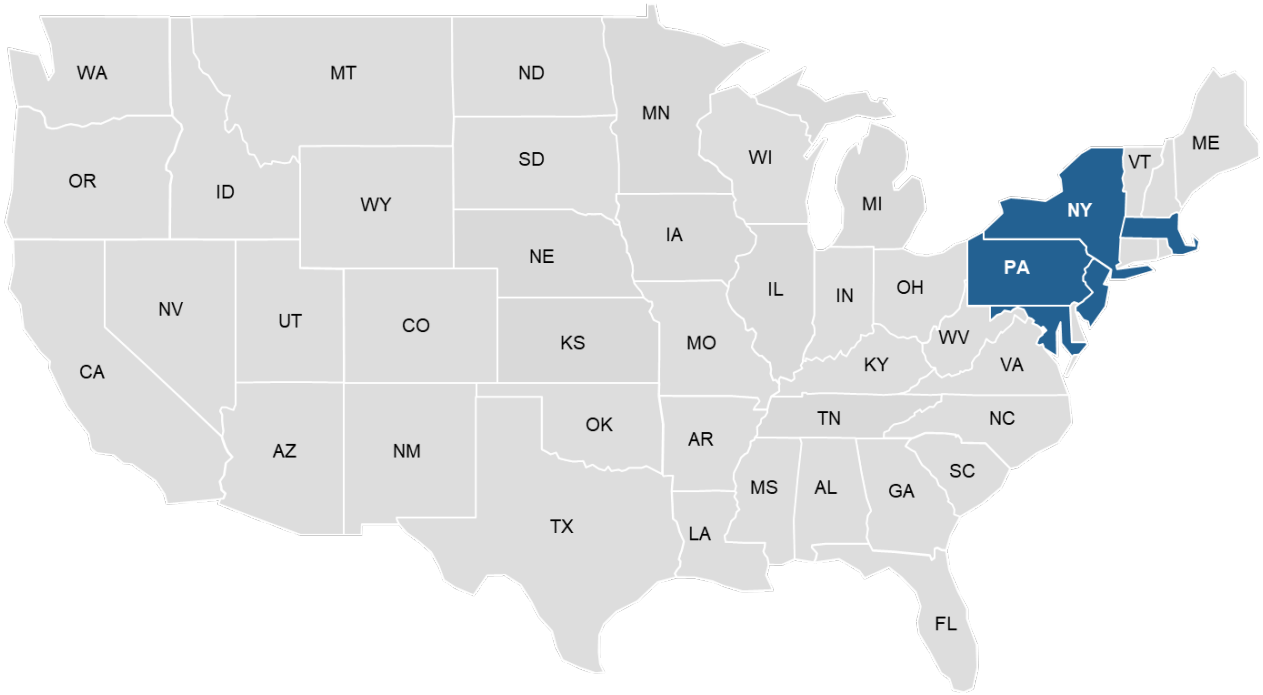
Insights were obtained on the use of **evolving treatment landscape of aEC** in the community setting

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 13 oncologists from the Northeast region of the United States
  - Attendees of the roundtable represented community oncologists from Pennsylvania, New York, Massachusetts, New Jersey, and Maryland

Institution	City	State
Allegheny Oncology Network	Natrona Heights	PA
Chesapeake Oncology Hematology Associates	Annapolis	MD
New York Oncology Hematology	Hudson	NY
Lahey Medical Center	Peabody	MA
Cancer Care Associates of York	York	PA
Rowan Virtua	Stratford	NJ
Hackensack Meridian Health	South River	NJ
Jefferson Health	Sewell	NJ
Greater Washington Oncology Associates	Silver Spring	MD
Advanced Care Oncology & Hematology Associates	Englewood	NJ
Regional Cancer Care Associates	Riverdale	NJ
NYU Medical Oncology Associates	New York	NY
UPMC Western Maryland	Cumberland	MD



Participant Demographics

Approximately how many patients with aEC who had not received a prior systemic therapy have you treated in the past 12 months? (n = 11*)

Approximately how many patients with aEC who had received 1 prior systemic therapy have you treated in the past 12 months? (n = 12†)

*Two advisors did not respond; † One advisor did not respond.

Report Snapshot: Agenda

Time (ET)	Topic
2.00 PM – 2.15 PM	**Introduction** • Program overview
2.15 PM – 3.45 PM	**Frontline Treatment of aEC** • ARS questions • Overview of current first-line data • Reaction and discussion
3.45 PM – 4.00 PM	**Break**
4.00 PM – 4.50 PM	**Treatment of Recurrent aEC** • ARS questions • Overview of current R/R data • Reaction and discussion
4.50 PM – 5.00 PM	**Key Takeaways and Meeting Evaluation**

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Discussion

Frontline Treatment of aEC

Discussion: Frontline Treatment of aEC (1/7)

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INSIGHTS AND DATA

“MSI, MMR status, it looks very important. You [now] have options of chemotherapy backbone with Pembro or the

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Discussion: Frontline Treatment of aEC (2/7)

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INSIGHTS AND DATA

"The only nuance I'll add is for early stage, I do send off Signatera liquid tumor assays. It is just in general, more for

- [redacted]

[redacted]

- [redacted]

[redacted]

Discussion: Frontline Treatment of aEC (3/7)

INSIGHTS AND DATA

"I don't think it makes a difference, honestly. I think it's a Coke or Pepsi. I think it's different studies, different duration of follow-up.

- Treatment success in frontline (N,EC)

"Pt 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 3 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 (N)C 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."

have proof of survival with what you treat frontline vs if you have a proof, I think this makes a difference. OS is still important."

Discussion: Frontline Treatment of aEC (4/7)

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INSIGHTS AND DATA

"I think it's a great, very impressive study."

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

Discussion: Frontline Treatment of aEC (5/7)

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INSIGHTS AND DATA

	“Oh yeah, myeloma and lymphoma, so it’s approved [in other malignancies]. . . . Yeah, very tough.”

Discussion: Frontline Treatment of aEC (6/7)

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INSIGHTS AND DATA

"So I guess the question I'd have is, I have that patient who has finished the chemoimmunotherapy, MSS, and has TP53

Discussion: Frontline Treatment of aEC (7/7)

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INSIGHTS AND DATA

Segmenting

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Discussion

Treatment of Recurrent aEC

Discussion: Treatment of Recurrent aEC

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INSIGHTS AND DATA

"I think you have used immunotherapy in the first line, you are done without immune therapy, so you will not use it in the

- [illegible]

[illegible]

- [illegible]

[illegible]

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Advisor Key Takeaways

Advisor Key Takeaways (1/2)

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ADVISOR	ADVISOR
> SIENDO trial and the efficacy of selinexor	> 4 subtypes: POLE, dMMR, copy number low, p53
1	5
2	6
3	7
4	8

Advisor Key Takeaways* (2/2)

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ADVISOR		ADVISOR	
1	> Dostarlimab + chemotherapy in front line vs > 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	> Data for the use of immunotherapy + chemotherapy in > 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

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ARS Data

Nearly Three-Quarters of Community Oncologists Had Treated 1–5 Patients With aEC Who Had Not Received a Prior Systemic Therapy With a Chemotherapy + Immunotherapy Combination in the Past Year

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In the past 12 months, approximately how many patients with aEC who had not received a

*Two advisors did not respond.

Nearly Two-Thirds of Advisors Perform IHC Testing (MMR, p53, and HER2), NGS Testing (*TP53*, MMR), and Receptor Testing for ER and/or PR in Their Patients With aEC

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Which of the following do you perform in your patients with aEC?

*Two advisors did not respond.

Most Advisors Perform Comprehensive Molecular Analysis in Their Patients With aEC Who Have Received 1 Prior Systemic Therapy; Nearly a Third Do Not Perform Molecular Analysis in This Population

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Which of the following do you perform in your patients with recurrent aEC

*Two advisors did not respond.

Almost All Community Oncologists Perform NGS in 76%–100% of Their Patients With aEC

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In what percentage of your patients with aEC do you perform NGS? (n = 10*)

*Three advisors did not respond.

All Advisors Typically Receive Their NGS Results in More Than 11 Days, With the Majority Reporting an Average Turnaround Time of 11–15 Days

On average, what is the typical turnaround time to receive the results from NGS

*One advisor did not respond.

Patient Case

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- A 62-year-old woman presents with abnormal uterine bleeding. Following an initial

After Seeing the RUBY and NRG-GY018 Data, All Community Oncologists Would Recommend a Chemotherapy + Immunotherapy Combination for a pMMR, *TP53*wt Patient With aEC

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Which of the following systemic therapies would you now recommend?

*One advisor did not respond.

Patient Case (cont.)

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- The same 62-year-old patient is treated with carboplatin + paclitaxel. One year

Over Two-Thirds of Advisors Would Recommend Lenvatinib + Pembrolizumab in a pMMR, *TP53*wt Patient With aEC Experiencing Progression 1 Year After Completion of Carboplatin + Paclitaxel

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You would now recommend: (N = 13)

Nearly All Advisors Believe NCCN Guideline Recommendations Have the Greatest Impact on Their Treatment Decisions in Patients With aEC

Which of the following have the greatest impact on your treatment decision in your

*One advisor did not respond.

Prior to the Program, Nearly Half the Advisors Were Not Familiar With the SIENDO Study

What do you see as the most impressive finding from the long-term follow-up of the

*One advisor did not respond.

The Majority of Advisors Said the Greatest Benefit to Using Selinexor in Their Patients With aEC Is Its Efficacy in a Patient Population With an Unmet Need (*TP53*wt)

What do you see as the greatest benefit to selinexor use in patients with aEC? (N = 13)

Three-Quarters of Advisors Indicated That Managing and Monitoring for AEs Associated With Selinexor Is the Greatest Barrier to Its Use in Patients With aEC

What do you see as the greatest barrier to selinexor use in patients with aEC? (N = 13)

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US 5901-C Peachtree Dunwoody Road NE
Suite 200, Atlanta, GA 30328, US

EU Wilhelmina van Pruisenweg 104
2595 AN The Hague, the Netherlands

UK 6th Floor, 2 Kingdom Street
London, W2 6BD, United Kingdom

aptitudehealth.com