



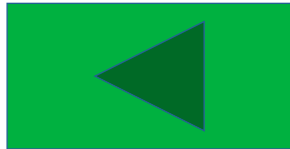
Insights Into Maintenance Therapy in Acute Myeloid Leukemia (AML)

February 24, 2024

How to Navigate This Report



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Topic

Report Objectives 

Report Snapshot

- Session overview 
- Attendee overview 
- Agenda 

Topline Takeaways and Strategic Recommendations 

Key Insights and Discussion Summary 

Advisor Key Quotes 

Advisor Key Takeaways 

Audience Response System (ARS) Data 

MEETING OBJECTIVES

Gain advisors' perspectives on frontline and maintenance therapy for AML and factors that guide treatment choices

REPORT OBJECTIVES

- > Learn advisors' perspectives regarding the use of oral and injectable hypomethylating agents (HMAs) as maintenance therapy in AML
- > Understand how the presence of mutations affects treatment decisions
- > Learn how physicians assess patient fitness and eligibility for intensive chemotherapy (IC)

Report Snapshot: Session Overview



A moderated roundtable discussion was held with 11 oncology healthcare providers in Arizona and California on **February 24, 2024**

Disease state and data presentations were co-chaired by **Elias Jabbour, MD**, and **Naval Daver, MD**, from MD Anderson Cancer Center in Houston, TX, with content developed in conjunction with the Aptitude Health clinical team

Insights were obtained on advisors' perspectives on existing treatments and maintenance therapy for AML and factors that guide treatment choices

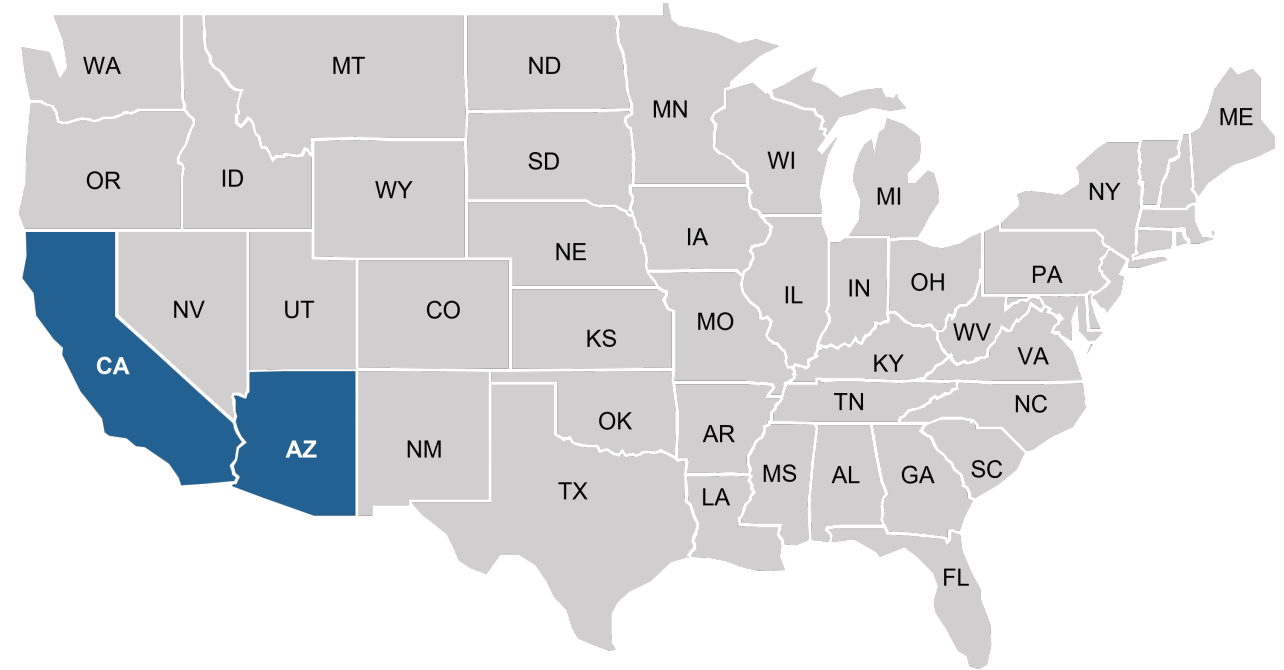
Data collection was accomplished through audience response system (ARS) questions and in-depth moderated discussion

Report Snapshot: Attendee Overview



> The group of advisors was composed of 11 oncologists from Arizona and California

Institution	City	State
Keck Medicine of USC	Newport Beach	CA
Loma Linda University Medical Center	Loma Linda	CA
University of California, Irvine	Irvine	CA
University of California, Irvine	Orange	CA
Riverside Medical Center	Irvine	CA
University of California San Diego Health	San Diego	CA
City of Hope	Phoenix	AZ
Cancer Transplant Institute at HonorHealth	Scottsdale	AZ
Mayo Clinic	Phoenix	AZ
Desert Hematology Oncology	Surprise	AZ
Arizona Oncology	Tucson	AZ



Report Snapshot: Attendee Demographics (1/2)

Do you generally directly treat patients with AML, or do you refer them to a tertiary center? (*Select all that apply.*) (N = 11)

FOR EXAMPLE PURPOSES ONLY

Report Snapshot: Attendee Demographics (2/2)

How many unique patients with AML do you personally treat per month? (N = 11)



What percentage of your patients with AML are eligible for intensive induction chemotherapy? (N = 11)



Report Snapshot: Agenda



Time (MT)	Topic
1.00 PM – 1.15 PM	Introduction and Baseline ARS Questions
1.15 PM – 1.55 PM	First-Line Therapy in AML
1.55 PM – 2.55 PM	Maintenance Therapy in AML
2.55 PM – 3.05 PM	Break
3.05 PM – 3.50 PM	Patient Case-Based Discussion
3.50 PM – 4.00 PM	Key Takeaways and Meeting Evaluation



Advisor Key Quotes From Discussion

INSIGHTS

“We do [maintenance therapy] because not all my leukemia patients go to transplant. They don’t get transplanted

- Phase 1 study of [drug] in [disease]**
 - Experts believe the combination of [drug] and [drug] is possible to use here, and these combinations can potentially be helpful
- Phase 2 study of [drug] in [disease]**
 - The regimen is seen as effective, working well, and broadly applicable to many patients
- Phase 3 study of [drug] in [disease]**
 - This approach is seen as a great option for a patient population in which going to transplant is difficult. It is seen as effective and safe
- Phase 4 study of [drug] in [disease]**
 - Experts believe the combination of [drug] and [drug] is safe. However, they would like to see phase 3 data to confirm its safety in this setting
- Phase 5 study of [drug] in [disease]**
 - The [drug] regimen is seen as useful in the specific patient population with [disease]. It was noted to be effective, very safe, and well-tolerated. Some of the responses were seen clearly, very quickly

INSIGHTS

“Yes, depending on whether they have a target. I do not do routine maintenance therapy [if they are deployed and

- Immunotherapy phase 1 study - (NCT01858281) Study 001**
 - Experts believe the inclusion of multiple phenotypes is possible in real time, and these combinations can potentially be targeted
- Phase 1 study of nivolumab and ipilimumab in melanoma - (NCT01824505) Study 001**
 - The approach is seen as effective, working with nivolumab, applicable to many patients
- Phase 1 study of nivolumab and ipilimumab in melanoma - (NCT01824505) Study 001**
 - The approach is seen as a great option for a patient population in which going immunotherapeutic is difficult. It is seen as effective and safe
- Phase 1 study of nivolumab and ipilimumab in melanoma - (NCT01824505) Study 001**
 - Experts believe the combination of nivolumab + ipilimumab with nivolumab is safe. However, they would like to see phase 2 data to confirm its safety in this setting
- Phase 1 study of nivolumab and ipilimumab in melanoma - (NCT01824505) Study 001**
 - The nivolumab approach is seen as better in the specific patient population with advanced disease. It was noted to be effective, very safe, and well-tolerated. Some of the responses were seen with fairly low doses



Advisor Key Takeaways

Advisor Key Takeaways (1/2)



ADVISOR

> HiDAC dosage of 3 am/m² should not be given

- There is a better understanding of sequencing therapy
- There is a better understanding of the role of the different drugs and how to use them in the future

- There is a better understanding of some of the latest options
- It is particularly important to be up-to-date and keep the skills and the mind open to a continuous update for the new drugs coming
- There is a lot more evidence for targeted therapy and to change the paradigm that they offer more side effects

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

- There is a lot of good options for second line that just (L1) and treatment with lower side effect profile and good response rate
- Immunology is an issue

ADVISOR

> The benefit of quiz + intensive chemotherapy even in

- The immunotherapy setting the need to have different options besides T-102 and also to get to (L1)

- The hope is that some of these immunotherapy agents will get added into frontline and hopefully improve the outcomes

- It is 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

- The (L1) is the standard

Advisor Key Takeaways (2/2)



ADVISOR

> Learned the great efficacy of venetoclax and intensive

- There is a better understanding of sequencing therapy
- There is a better understanding of the combination and
- There is a better understanding of the combination and how
- There is a better understanding of the combination and how

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ADVISOR

> The benefit of maintenance is in the MRD-positive patient

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Audience Response System (ARS) Data

About 45% of Advisors Use IC Regardless of the Presence of Mutations, While the Remaining Prefer a Targeted Therapy in the Presence of Mutated *FLT3* or *IDH1*

FOR EXAMPLE PURPOSES ONLY

The Majority of Advisors Prefer Transplant After a Patient With AML Receives IC ± Consolidation and Has CR/CRi



FOR EXAMPLE PURPOSES ONLY

While More Than Half the Advisors Prefer Transplant, 30% Would Administer an Additional Consolidation Cycle After a Patient With AML Receives IC ± Consolidation, Has Morphologic CR/CRi, but Is Positive for MRD

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.

For Most Advisors, Up to 40% of Their Patients With AML, After Having CR/CRi Post-IC, Do Not Go on to Transplant



FOR EXAMPLE PURPOSES ONLY

Worsening Performance Status Was Cited as the Most Common Reason a Patient Does Not Proceed to Transplant After Receiving IC

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.

Oral Azacitidine Is the Most Preferred Option for Maintenance Therapy in Patients With AML After IC

FOR EXAMPLE PURPOSES ONLY

About Three-Quarters of Advisors Always Measure MRD in Their Patients With AML After IC and Consolidation, While the Rest Measure It Sometimes

FOR EXAMPLE PURPOSES ONLY

Although Advisors Were Divided on Whether to Use MRD for Treatment Decision-Making or as a Prognostic Indicator, There Was a Slight Tendency Toward Favoring Its Use for Guiding Treatment Decisions

FOR EXAMPLE PURPOSES ONLY

For a 65-Year-Old Patient in Remission After IC (without consolidation) With No Specific Mutation, 40% of Advisors Would Choose Maintenance Therapy With Oral Azacitidine (14-day cycles), While 40% Selected More Consolidation Cycles

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.

For a 65-Year-Old Patient With AML in Remission After IC (with consolidation) and Who Is MRD Negative, 45% of Advisors Would Choose Oral Azacitidine



FOR EXAMPLE PURPOSES ONLY

For a 65-Year-Old Patient in Remission After IC (with consolidation) Who Has Been on Oral Azacitidine and Shows Signs of Progression, 73% of Advisors Would Perform Cytogenetic and Molecular Profiling

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US 5901-B Peachtree Dunwoody Road
Suite 415, Atlanta, GA 30328, US

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

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

[aptitudehealth.com](https://www.aptitudehealth.com)

