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Insights Into Urothelial Carcinoma (UC) – Midwest

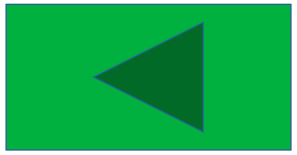
Insights From Community Oncologists in the Midwestern US

Saturday, August 26, 2023

Chicago, IL

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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MEETING OBJECTIVES
> Gain advisors' perspectives on recent clinical data focusing on the evolving treatment landscape in UC, including frontline treatment approaches and subsequent management of advanced UC

Report Snapshot: Session Overview

A moderated roundtable discussion was held with oncologists from the Midwest region of the US on **August 26, 2023**

Disease-state and data presentations were led and moderated by **Dr Sushil Bhardwaj,** with disease-state and data presentations by **Dr Jorge A. Garcia,** from Case Western Reserve University in Cleveland, OH, in conjunction with content developed by the Aptitude Health clinical team

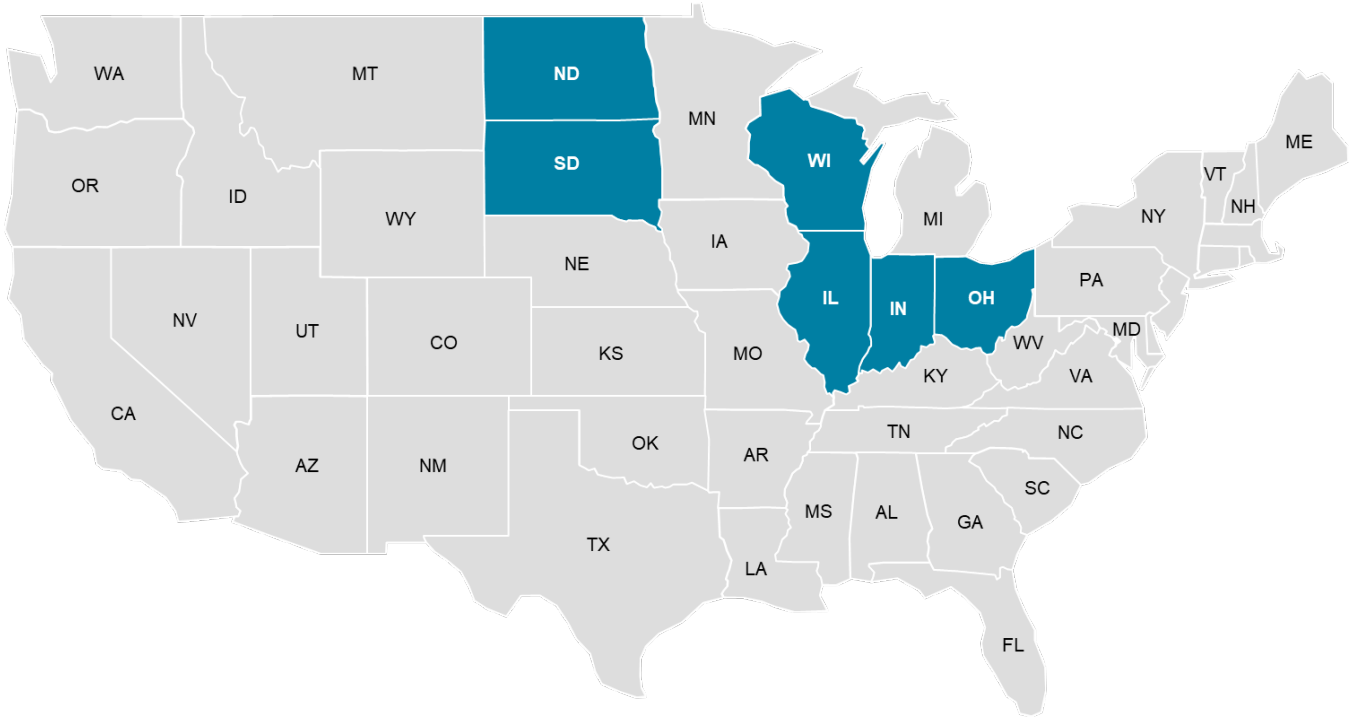
Insights were gained on the **UC treatment landscape** in the community setting, including **frontline treatment approaches and subsequent management of advanced UC**

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

Report Snapshot: Attendee Overview

- The group of physicians comprised 12 oncologists from the Midwest United States
  - Attendees of the roundtable represented community oncologists from Illinois, Indiana, Wisconsin, North Dakota, South Dakota, and Ohio

Institution	City	State
Prairie Lakes Healthcare System*	Watertown	SD
Edward Hines, Jr VA Hospital	Maywood	IL
Northwest Cancer Centers	Crown Point	IN
Sanford Health	Fargo	ND
Aspirus Cancer Care	Medford	WI
Advocate Medical Group	Chicago	IL
Zangmeister Cancer Center	Columbus	OH
OhioHealth Physician Group	Delaware	OH
Illinois Cancer Specialists	Elgin	IL
Lima Memorial Hospital	Lima	OH
Northwest Oncology & Hematology	Rolling Meadows	IL



*Two advisors from this institution attended.

Report Snapshot: Attendee Demographics (1/2)

How many unique patients with UC have you treated in the past 12 months? (N = 12)

What percentage of your patients with UC have metastatic disease? (n = 11*)

*One advisor did not respond.

Report Snapshot: Attendee Demographics (2/2)

What percentage of your patients with UC are cisplatin ineligible? (N = 12)

Agenda

Time (CT)	Topic
1.15 PM – 1.30 PM (15 min)	**Introduction** • Program overview • Baseline ARS questions
1.30 PM – 3.00 PM (40-min presentation; 50-min discussion)	**First-Line Therapy for Advanced UC** • Overview of current data • Reaction and discussion
3.00 PM – 3.10 PM (10 min)	**BREAK**
3.10 PM – 4.00 PM (20-min presentation; 30-min discussion)	**Second-Line and Subsequent Management of Advanced UC** • ARS questions • Overview of current data • Reaction and discussion
4.00 PM – 4.15 PM (15 min)	**Key Takeaways and Meeting Evaluation**

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Key Insights and Discussion Summary

Discussion: Management of Locally Advanced and Metastatic UC (1/7)

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INSIGHTS AND DATA

"You have to decide whether they're cisplatin eligible or not eligible, because performance status, renal function, cardiac

- [illegible]

- [illegible]

Discussion: Management of Locally Advanced and Metastatic UC (2/7)

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INSIGHTS AND DATA

"If they're cisplatin eligible, definitely they get cisplatin, gemcitabine and cisplatin, followed by avelumab maintenance,

- Treatment success in frontline (N,BC)

"It's 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 0.65 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: Management of Locally Advanced and Metastatic UC (3/7)

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INSIGHTS AND DATA

"I was aware of these data. . . . I think cisplatin-ineligible patients, we can use this protocol, which has shown equally

- [illegible]

- [illegible]

Discussion: Management of Locally Advanced and Metastatic UC (4/7)

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INSIGHTS AND DATA

"I'm definitely using avelumab in the maintenance setting. The problem I have so far is basically the length of time of

- [redacted]

- [redacted]

Discussion: Management of Locally Advanced and Metastatic UC (5/7)

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INSIGHTS AND DATA

"After EV, and this particular patient had a good response to sacituzumab. He did have neutropenia, required

- Treatment success in frontline (N-BIC)

"It's 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 BCIC in frontline

"First of all, a lot of things have been tried, nothing is better than N-CHOP, and frankly, I'm pretty happy with how N-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 0.65 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: Management of Locally Advanced and Metastatic UC (6/7)

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INSIGHTS AND DATA

"When I use gem-cis or gem-carbo followed by 2 years avelumab, not only it's an experience, but I know what I

- [illegible]

- [illegible]

Discussion: Management of Locally Advanced and Metastatic UC (7/7)

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INSIGHTS AND DATA

"I have diligently checked all my patients for mutations, but have not found a single FGFR mutation, I have not. So

- [illegible]

[illegible]

- [illegible]

[illegible]

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Advisor Key Takeaways

Advisor Key Takeaways (1/2)

ADVISOR	ADVISOR
> 1L in cisplatin or platinum ineligible patients, EV plus	
1	6
2	6
3	7
4	8

Advisor Key Takeaways* (2/2)

	ADVISOR		ADVISOR
1	> 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	> 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

> EV and pembro data, it give us another choice for first-

> EV plus pembro in cisplatin ineligible. The data is pretty

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Audience Response System (ARS) Data

All the Advisors Mentioned Patient Performance Status as the Most Important Factor to Consider Before Selecting a 1L Therapy

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The Top Reasons Advisors Select a Specific 1L Therapy Are, in Order: Better Clinical Efficacy, Good Tolerability Profile, and Having Prior Experience With Therapies

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The Majority of Advisors (83%) Prefer Gemcitabine + Cisplatin Followed by Avelumab Maintenance as the 1L Regimen for Cisplatin-Eligible Patients With Metastatic Disease

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More Than Half the Advisors (58%) Prefer Gemcitabine + Carboplatin Followed by Avelumab Maintenance as the 1L Regimen for Cisplatin-Ineligible Patients With Metastatic Disease; the Rest Prefer Pembro + EV

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The Majority of Advisors (67%) Indicated 31%–60% of Their Patients With UC Achieved Stable Disease After Receiving 1L Gemcitabine + Carboplatin Therapy

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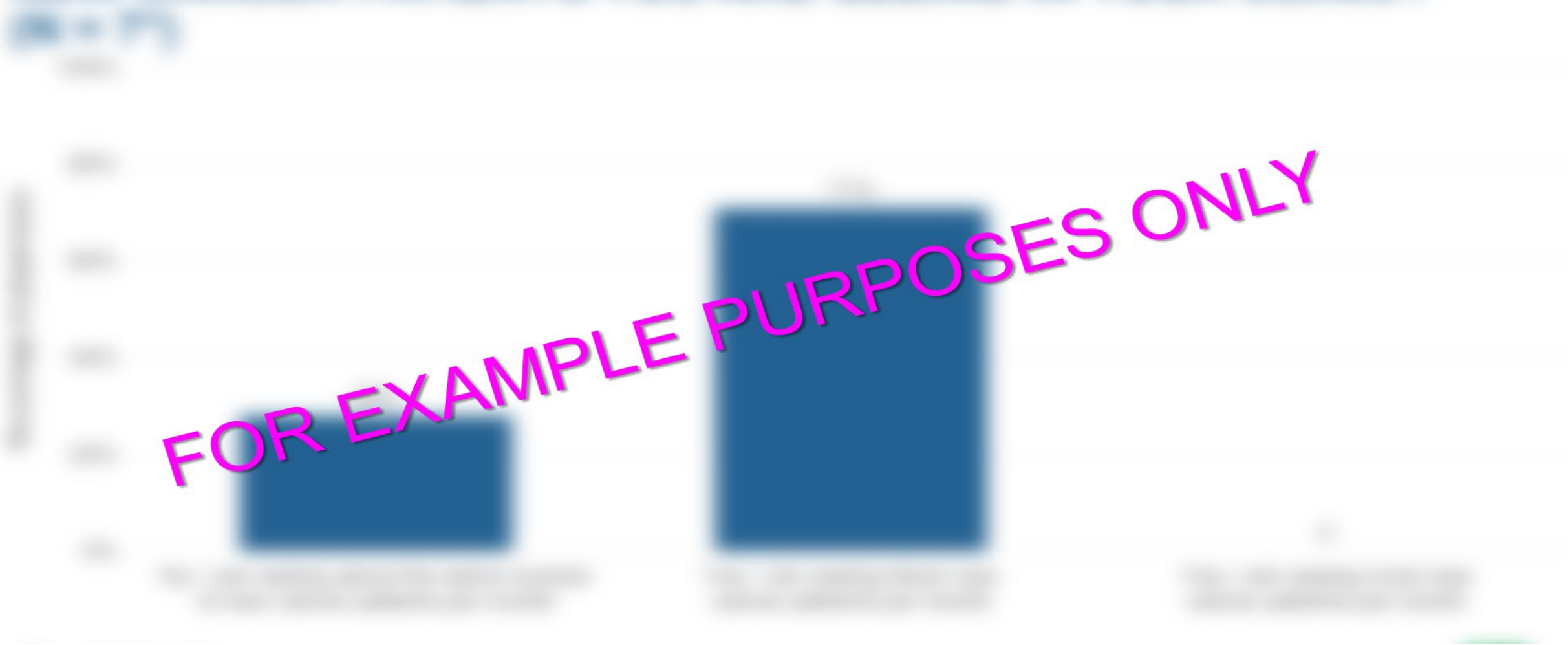
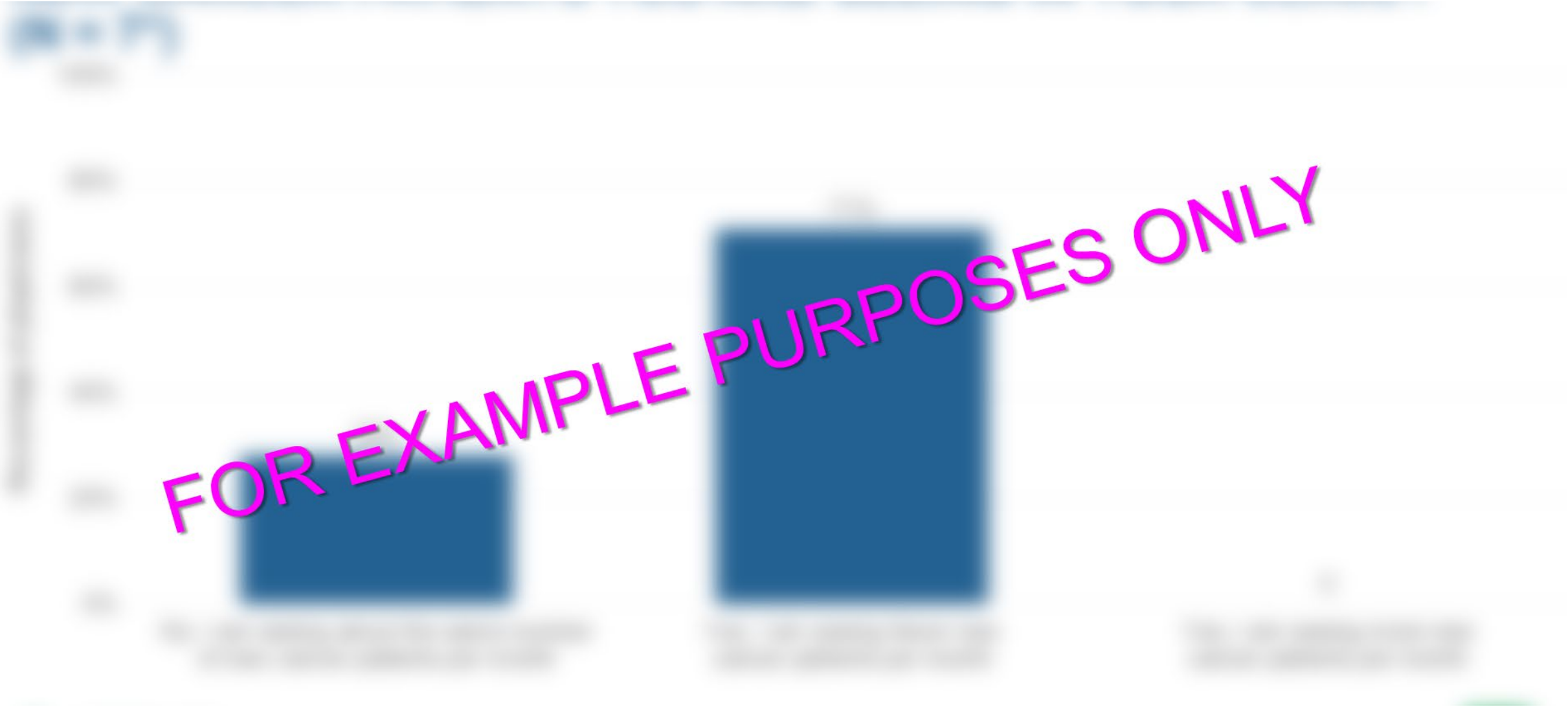


Only a Third of Advisors Had Prior Experience With Pembro + EV in Their Practice



Patient Case 1

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- A 70-year-old man is diagnosed with metastatic UC with metastasis to the lymph

More Than Half the Advisors (58%) Would Use Gemcitabine + Carboplatin Followed by Avelumab Maintenance Therapy for This Case, While the Rest (42%) Would Select Pembro + EV

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According to Advisors, Prior Therapies Received (100%), Followed by Patient Comorbidities (75%) and Specific Tumor Molecular Alterations (66%), Are the Most Important Factors That Impact Later-Line Therapy Choices

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Three-Quarters of Advisors Had Prior Experience With EV in the 3L Setting

Have you had any prior experience with enfortumab vedotin in the third-line setting? (N = 12)

Two-Thirds of Advisors Currently Use EV in Pretreated mUC, While the Remaining Third Indicated They Will Incorporate It Into Their Treatment Algorithm in Appropriate Patients

More Than 90% of Advisors Would Choose EV for a Patient With Metastatic UC Which Progressed After Platinum-Based CT and Avelumab Maintenance

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*One advisor did not respond.

Disease Progression (100%), Followed by Adverse Events (83%) and Impaired Organ Function (75%), Are the Main Reasons Mentioned by Advisors for Therapy Discontinuation

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Patient Case 2

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- A 71-year-old man is diagnosed with muscle-invasive bladder cancer following an episode

All Advisors Recommended EV + Pembrolizumab for a Patient With mUC That Progressed 14 Months After 4 Cycles of Neoadjuvant Gemcitabine + Cisplatin for MIBC Without Undergoing Surgery

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