



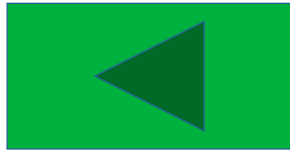
Insights Into Treatment Paradigms in Classical Hodgkin Lymphoma (cHL)

Program Date: May 9, 2024









How to Navigate This Report



Click to move to topic of interest or ARS supporting data



Click to return to previous slide

Topic	
Report Objectives	
Report Snapshot	
• Session overview	
• Attendee overview	
• Agenda	
Topline Takeaways and Strategic Recommendations	
Key Insights and Discussion Summary	
Advisor Key Takeaways	
Audience Response System Data	

MEETING OBJECTIVES

Gain advisors' perspectives on existing and emerging treatments for cHL in the first and second line along with the factors that guide treatment choices

Report Snapshot: Session Overview



A moderated roundtable discussion was held virtually on **May 9, 2024**, with community oncologists from 10 states and 12 locations

Disease state and data presentation was led by **Sarah Rutherford, MD**, from Weill Cornell Medicine in New York, NY, together with content developed in conjunction with the Aptitude Health clinical team

Insights were obtained on physicians' preferred initial therapy choices for cHL and barriers associated with treatment

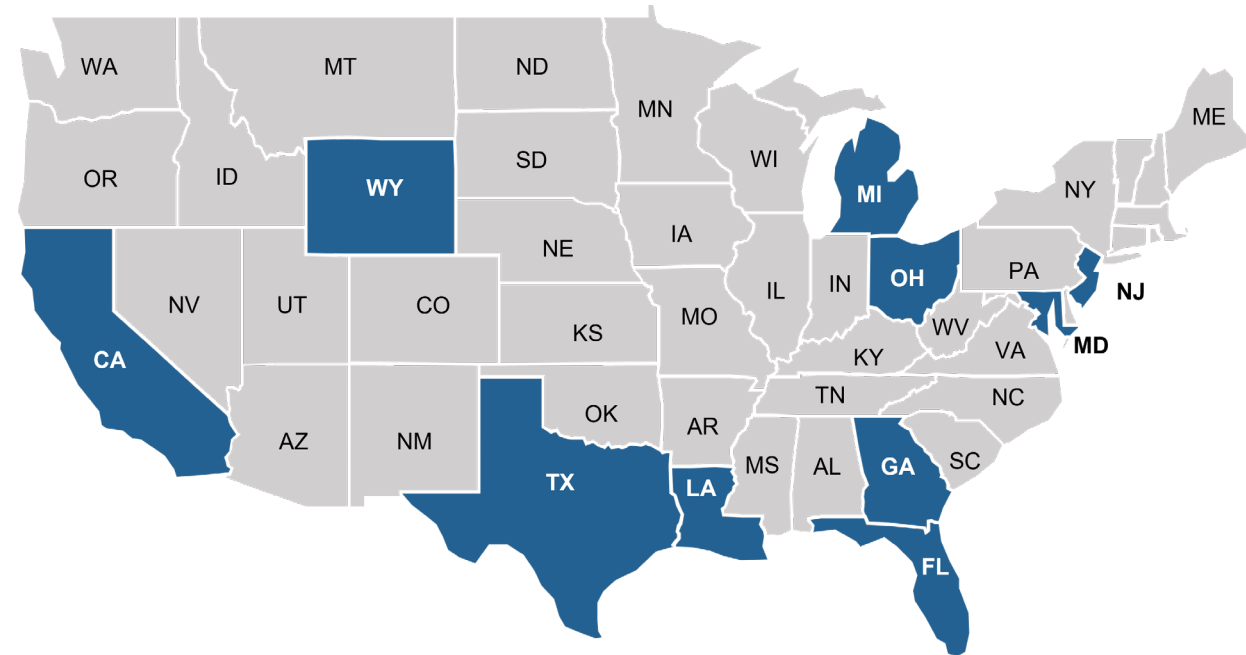
Data collection was accomplished through audience response system (ARS) questions and in-depth moderated discussion

Report Snapshot: Attendee Overview



- > The group of advisors was composed of 12 community oncologists from 10 states across the US

Institution	City	State
Chesapeake Oncology Hematology Associates	Annapolis	MD
Rocky Mountain Oncology	Casper	WY
Van Elslander Cancer Center	Grosse Pointe Woods	MI
Rowan Medicine	Voorhees	NJ
Georgia Cancer Specialists	Macon	GA
Kaiser Permanente	Riverside	CA
Ochsner Christus Health Center	Lake Charles	LA
Mid Florida Cancer Centers	Orange City	FL
Texas Oncology	Dallas	TX
Cleveland Clinic	Akron	OH
Florida Cancer Specialists & Research Institute	Delray Beach	FL
Regional Cancer Care Associates	Riverdale	NJ



One advisor did not answer any ARS questions or give their key takeaways.

Report Snapshot: Attendee Demographics (1/2)

In the past 12 months, how many patients with cHL came to you for a consultation? (n = 10*)

In which of the following age groups is your typical patient with cHL? (n = 9†)



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

Report Snapshot: Attendee Demographics (2/2)

What percentage of your patients with cHL have stage III-IV disease? (N = 11)



I 10% II 10% III-IV 45% V 10% VI 25%



I 10% II 10% III-IV 45% V 10% VI 25%

Report Snapshot: Agenda



Time	Topic
6.30 PM – 6.45 PM	Introduction
6.45 PM – 8.15 PM	First-Line Treatment of cHL
8.15 PM – 8.30 PM	Key Takeaways and Meeting Evaluation

Discussion: Management and Treatment Options for HL (1/4)



INSIGHTS FROM DISCUSSION

"[I] recently I saw a 45-year-old piano teacher. I did not want to give him BV because . . . he had some risk factors

Treatment success in females 55-65%

*The overall survival that's what we want. This is not necessarily disease-free or complete remission. So we want overall survival.
I would not use any significant prognostic factors. I think when I follow someone I would rather use a treatment protocol rather than using CD4 or HIV, and I would not start the disease-free rate at 1 year. I believe in that CD4 is important if there is significant toxicity with the treatment, and people going from something to something.*

Data needed to confirm from 2000 in females

*That's all a lot of things have been done, nothing is better than AZT/3TC and Nevirapine. It would be hard with low AZT/3TC partner for the patients.
I would be a little bit more. I would not be one of the first ones to move toward AZT or something like that. I want something that's new and that will be better than AZT/3TC.
If the benefits are not very great, I think a higher rate of CD4 or better would be something that I would be looking at.
Overall survival rate, that's what we're looking at. We're looking at overall survival. So you do have to use some surrogate of efficacy. So I do think that's a bit of a trap. I think the overall survival rate of HIV is that what's going to start driving the use of any agent. HIV is not sufficient.*

INSIGHTS FROM DISCUSSION

"Based on the data that you've shown, I think it's very impressive for patients 60 and above, and these are the

1. Treatment success in patients 60-70

The overall survival that you've shown... This is a very impressive outcome... It's a...
...with overall very significant long-term benefit...
...should be able to use a frontline approach rather than using CH or RT, and I would say...
...that the disease-free rate at 5 years...
...significant benefit with the treatment, and overall being that something...
...impressive..."

2. Data needed to confirm from 60-70 in patients

That at all, a lot of things have been done... nothing is better than...
...to really focus with low...
...I would be a...
...CH or something like that...
...of the...
...something that...
...that's...
...in...
...agree..."

INSIGHTS FROM DISCUSSION

"I usually reduce brentuximab based on PI, I'll have to reduce based on neuropathy. Actually, neuropathy can be

1. Treatment success in frontline DLBCL

The overall survival benefit was not seen. This is not necessarily because this is a curable disease, or we need overall survival. I think without any significant long-term toxicity. I think what I really wanted to know was: can a treatment approach with less toxicity (PI or PI2), and I would say that the disease-free rate at 2 years, I believe, is that (PI) is superior if there is significant toxicity with the treatment, and overall long-term survival. I think that's the key.

2. Data needed to confirm that PI2 is frontline

That's all a lot of things have been said, nothing is better than PI2/PI2 and PI2. It really helps with how PI2/PI2 performs for us patients. I would be a little unclear. I would not be one of the first ones to move based on PI2 or anything like that. I want something that's clear and that we can trust that we'll see. If the benefits are not very clear, I think a hazard ratio of 0.85 or better would be something that I would be looking at. I think overall, that's what we're looking for. I think the disease-free rate is a really good one to go on. I think we need to see some comparison of efficacy. So, I think that's a lot of things that we need to see. I think what's going to be most helpful is the use of any agent. PI2 is not sufficient.

INSIGHTS FROM DISCUSSION

"I have not used N-AVD yet. More experience with ABVD and occasionally brentuximab vedotin AVD. It depends

1. Treatment success in frontline HL (B2)

The overall survival rates were high. This is not necessarily because HL is curable disease, it is an incurable disease...
I would not use a brentuximab antibody either than using CD20 or CD22, and I would not think the disease-free rate at 1 year...
I would not be using CD20 as a dependent of there is significant toxicity with the treatment, and overall going from something...

2. Data needed to confirm from B2C in frontline

That of all, a lot of things have been done, nothing is better than ABVD and maybe...
I would not be using CD20 as a dependent of there is significant toxicity with the treatment...
I think brentuximab is not very useful...
I would not be using CD20 as a dependent of there is significant toxicity with the treatment...
I think brentuximab is not very useful...
I would not be using CD20 as a dependent of there is significant toxicity with the treatment...



Advisor Key Takeaways

Advisor Key Takeaways (1/2)



ADVISOR

> I will use growth factor probably every other cycle

- There is a better understanding of sequencing therapy
- I really want to talk further with professional and understand how we have a better understanding of these drugs and have a better idea of when to use them in my practice

- There is a better understanding of some of my other options
- It's particularly interested in the combination and how that will and then would be interested in a second line option for my own other options
- There is an increased awareness to sequenced therapy and to things the professional that they offer when the other

- It was good to hear about combination and what's coming down the pipeline for immunotherapy

- There is a lot of good options for second line that just ICD 1 and management with second line other profile and good response rate
- Immunotherapy is an issue

ADVISOR

> I did learn a few things there. I think as far as de-escalation

- The immunotherapy options for use in first different options besides ICD 1 and what is going to ICD 1

- The feeling that some of these immunotherapy agents will get added into practice and hopefully improve the first line

- It's 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

- ICD 1 ICD 1 is the standard

Advisor Key Takeaways (2/2)*



ADVISOR

ADVISOR

> I'm impressed by the 1-year OS or the PFS benefit of Nivo

- There is a better understanding of sequencing therapies
- I really want to talk further with professionals and understand how we have a better understanding of these drugs and have a better idea of when to use them in the practice

- There is a better understanding of some of my other options
- It's particularly important in the adjuvant and how the side effect would be considered for a second line option for my own other options
- There is a lot more emphasis on targeted therapy and to things the professionals that they offer more the other

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

- There is a lot of good options for second line that you could try and compare with second line other profile and good response rate
- Immunotherapy is an issue

- The immunotherapy options are not to have different options besides PD-1 and what is going to come?

- It's hoping that some of these immunotherapy agents will get added into practice and hopefully improve the outcomes

- It's interesting to learn about all these immunotherapy treatments, especially the targeted antibodies
- It's a lot of options coming up in the future. The only issue will be to learn how to sequence these drugs

- I think PD-1 is the standard



Audience Response System (ARS) Data

For 64% of Advisors, BV + AVD Is Their Primary Systemic Regimen for Advanced cHL

FOR EXAMPLE PURPOSES ONLY

Disease Stage and Number of Unfavorable Risk Factors Are the Most Important Factors Contributing to Advisors' First-Line Treatment Decisions

FOR EXAMPLE PURPOSES ONLY

Nivolumab + AVD Was Used as First-Line Therapy in Patients With cHL by 45% of Advisors in the Past Year

FOR EXAMPLE PURPOSES ONLY

All Advisors Had Some Level of Familiarity With the Data From the Phase III SWOG S1826 Trial

FOR EXAMPLE PURPOSES ONLY

Half the Advisors Found the PFS for Nivolumab + AVD to Be the Most Compelling Result From the SWOG S1826 Trial, While 30% Identified the OS and EFS Data as Most Compelling

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



The SWOG S1826 Study Has Impacted Most Advisors' Treatment Decisions

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.



When Using BV + AVD, Advisors Are Most Concerned With PN and Hematologic Toxicities

FOR EXAMPLE PURPOSES ONLY

*One advisor did not respond.



Over 20% of Their Patients Treated With BV + AVD Exhibit Grade ≥ 3 PN Requiring Treatment Discontinuation, According to [blurred text]

FOR EXAMPLE PURPOSES ONLY

More Than Half the Advisors Had Not Experienced Barriers When Using Nivolumab in cHL, and 45% Reported Insurance Approval Barriers

FOR EXAMPLE PURPOSES ONLY

45% of Advisors Prefer Nivolumab + AVD for a 30-Year-Old, Fit Patient With Advanced cHL



FOR EXAMPLE PURPOSES ONLY

> A 40-year-old woman presents with the following: left hip pain, history of drenching

night sweats, weight loss, and fatigue. She has a 10-year history of rheumatoid arthritis, treated with chronic low-dose prednisone (5 mg daily). She also has a history of osteoporosis and is on bisphosphonate therapy. Her last menstrual period was 12 months ago. She is currently on hormone therapy. She has no other significant medical history and is on no other medications.

45% of Advisors Would Use Nivolumab + AVD for 6 Cycles Followed by PET/CT Restaging in a Patient With Stage IV cHL and IPS 2, and 45% Would Use BV + AVD for 6 Cycles Followed by PET/CT Restaging

FOR EXAMPLE PURPOSES ONLY

27% of Advisors Would Use Nivolumab + AVD in a Patient Who Remains Positive After Restaging (showing Deauville 4) Upon PN Diagnosis During BV + AVD Treatment

FOR EXAMPLE PURPOSES ONLY



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

EU Laan van Nieuw Oost-Indië 133 F
2593 BM The Hague, the Netherlands

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

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

