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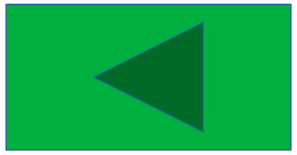
Insights Into Treatment Paradigms in Classical Hodgkin Lymphoma (cHL)

Program Date: May 9, 2024

How to Navigate This Report

Click to move to topic of interest or ARS supporting data



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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

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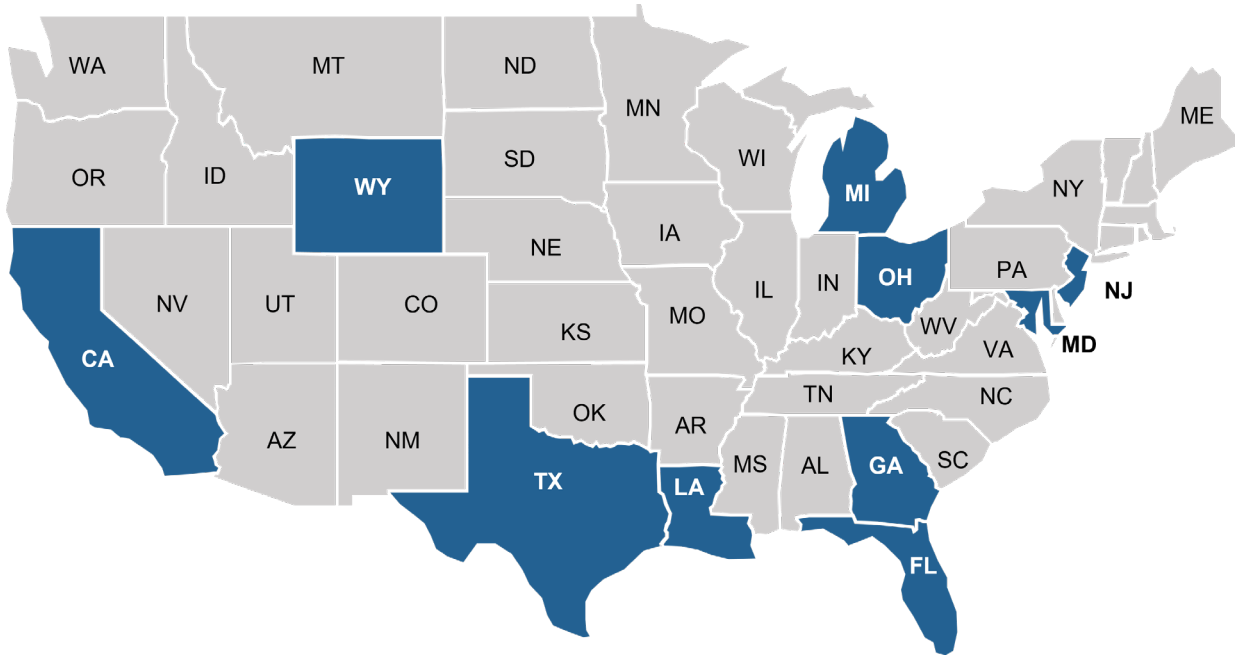
> The group of advisors was composed of 12 community oncologists from 10 states across the US

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)

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)

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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

Discussion: Management and Treatment Options for HL (2/4)

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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

- Treatment success in frontline (N,BV)

- Data needed to switch from BV in frontline

Discussion: Management and Treatment Options for HL (3/4)

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INSIGHTS FROM DISCUSSION

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

- [illegible]

- [illegible]

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

INSIGHTS FROM DISCUSSION

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

- Treatment success in frontline (A,BV)

[illegible]

- Data needed to switch from (A)C in frontline

[illegible]

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Advisor Key Takeaways

Advisor Key Takeaways (1/2)

ADVISOR		ADVISOR	
1	> I will use growth factor probably every other cycle > 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 did learn a few things there. I think as far as de-escalation > For relapsed/refractory patients it's nice to have different options besides R-CE 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	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'm impressed by the 1-year OS or the PFS benefit of Nivo 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

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Audience Response System (ARS) Data

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

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

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*One advisor did not respond.

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

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

*Two advisors did not respond.

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

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*One advisor did not respond.

The SWOG S1826 Study Has Impacted Most Advisors' Treatment Decisions

*Two advisors did not respond.

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

*One advisor did not respond.

Over 20% of Their Patients Treated With BV + AVD Exhibit Grade ≥3 PN Requiring Treatment Discontinuation, According to Most Physicians

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

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

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Patient Case

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

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

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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

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