



Insights Into Prostate Cancer

September 13, 2025

Chicago, IL

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Report Snapshot



Disease state and data presentations were led on **September 13, 2025**, by **Ulka Vaishampayan, MD**, from the University of Michigan, with content developed in conjunction with the Aptitude Health scientific team



The objectives of the meeting were to gain advisors' perspectives on the following

- > Use/barriers to use of androgen receptor (AR) inhibitors and potential radioligand therapies for management of metastatic hormone-sensitive prostate cancer (mHSPC)
- > Use/barriers to use of radioligand therapy for management of metastatic castration-resistant prostate cancer (mCRPC)
- > Perceptions of evolving clinical data and their impact on therapy choice in mHSPC and mCRPC



Data collection was accomplished through use of **audience response system (ARS)** questioning and **moderated discussion**



Insights on the management of prostate cancer were obtained from **15 community oncologists** from the Midwest region

Report Snapshot: Session Agenda



Time	Topic
9.00 AM – 9.15 AM (15 min)	Introduction <ul style="list-style-type: none">> Program overview> Round-robin introductions
9.15 AM – 10.25 AM (10-min ARS; 25-min presentation; 35-min discussion)	Management of mHSPC <ul style="list-style-type: none">> ARS questions> Overview of current data> Reaction and discussion
10.25 AM – 10.35 AM (10 min)	Break
10.35 AM – 11.45 AM (10-min ARS; 25-min presentation; 35-min discussion)	Management of mCRPC <ul style="list-style-type: none">> ARS questions> Overview of current data> Reaction and discussion
11.45 AM – 12.00 PM (15 min)	Key Takeaways and Meeting Evaluation

Report Snapshot: Attendee Overview

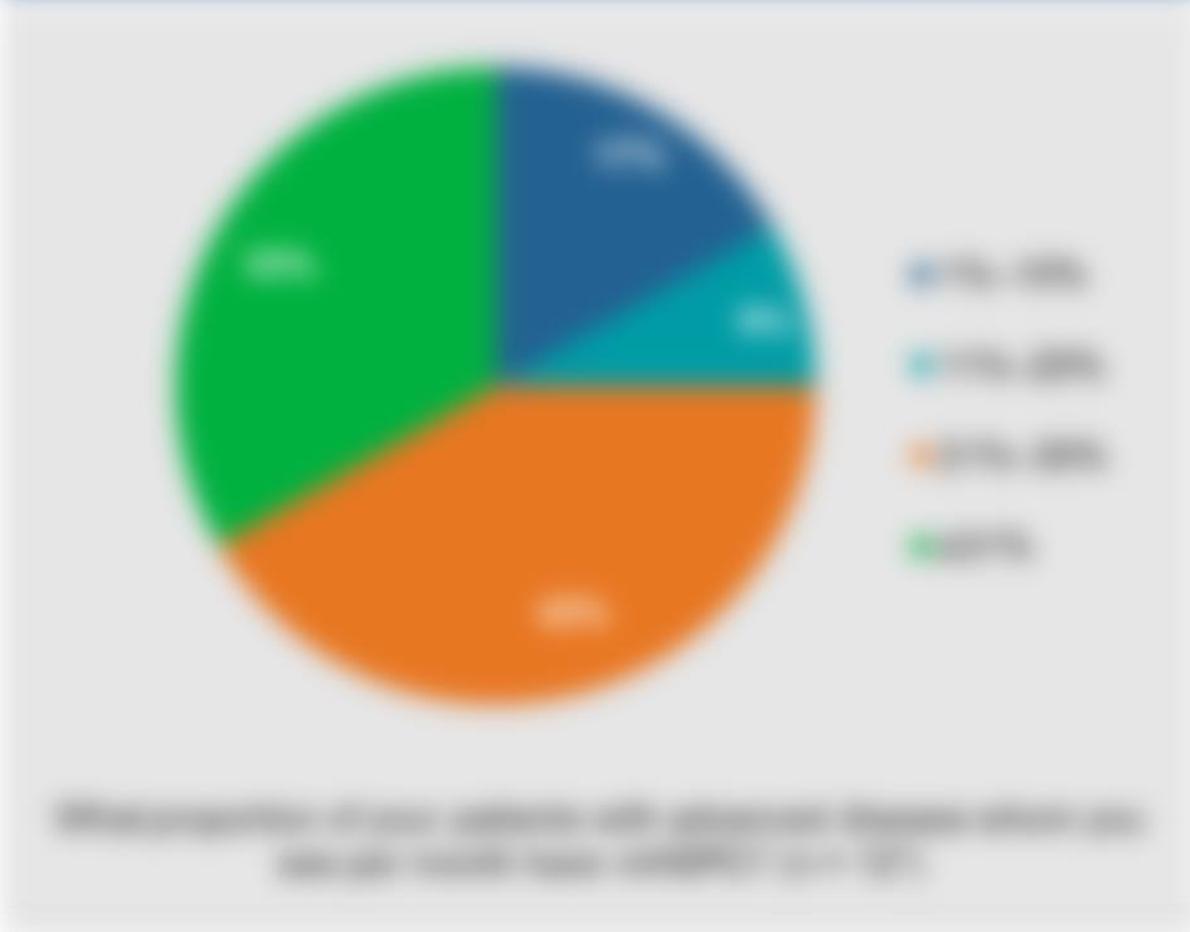
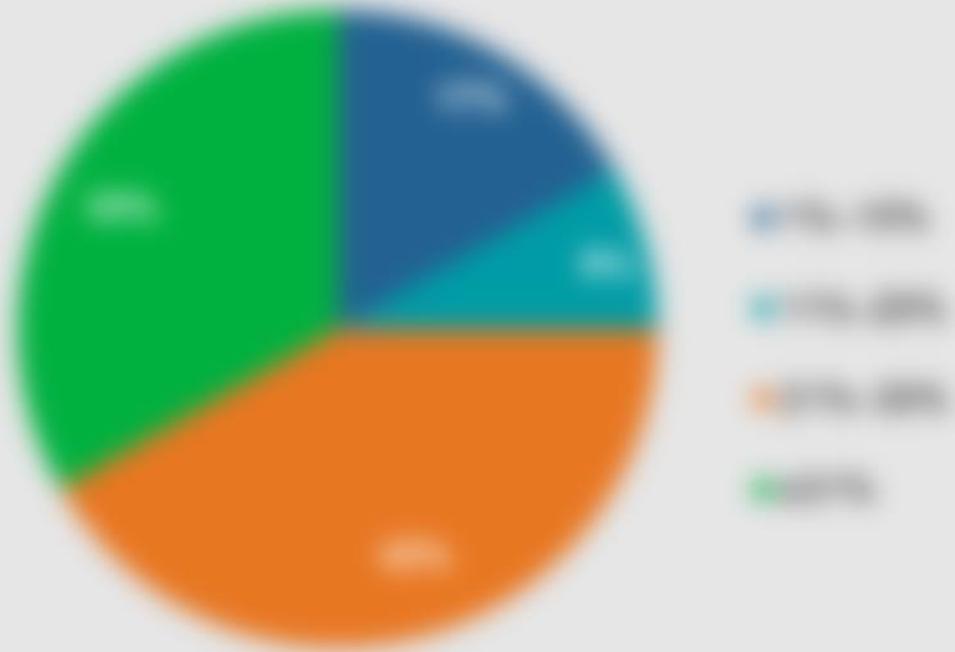


Report Snapshot: Attendee Demographics (1/2)

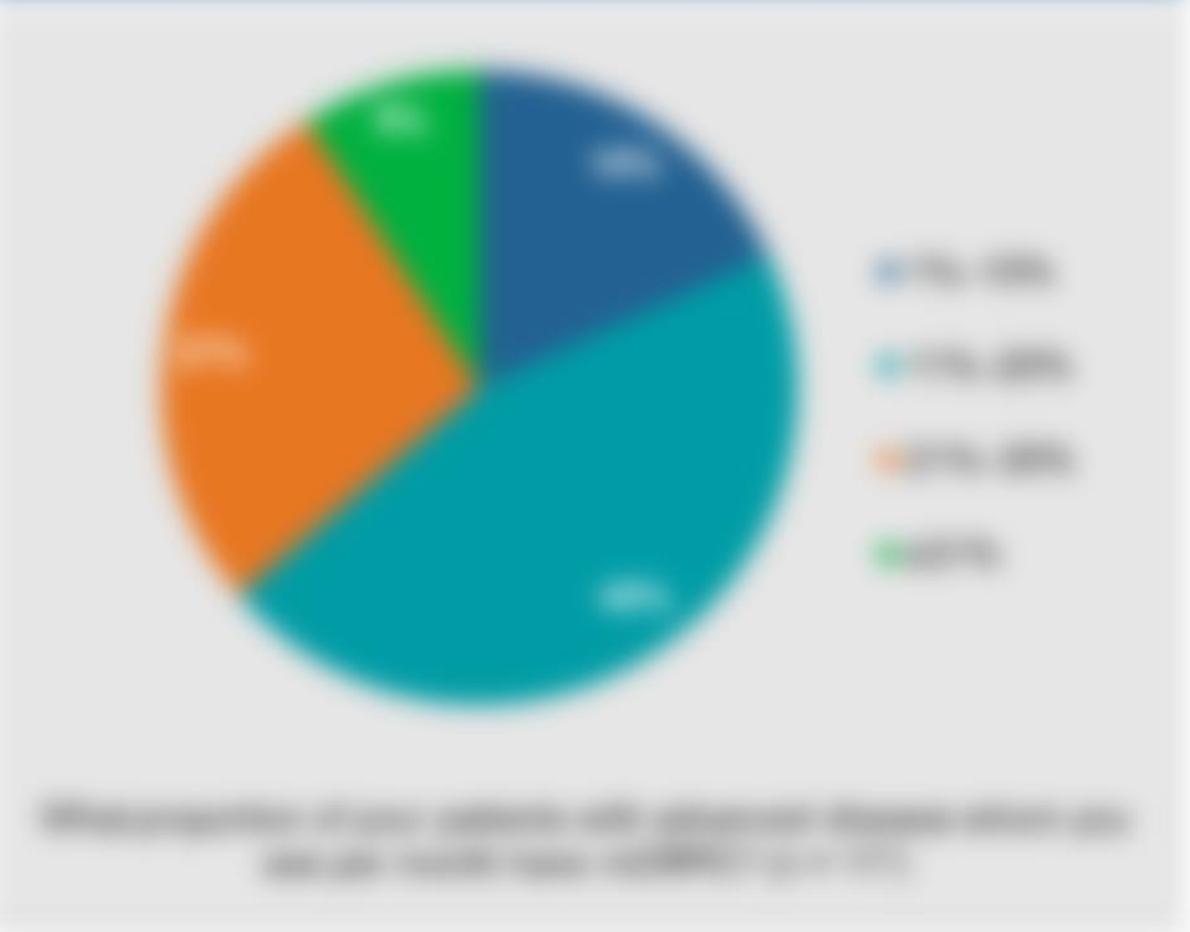
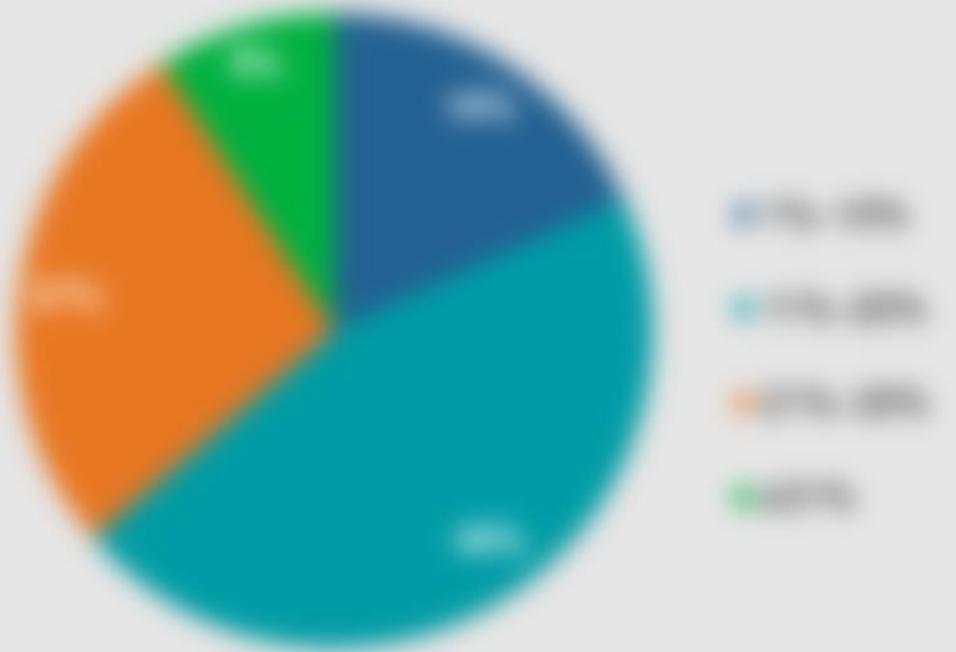


Report Snapshot: Attendee Demographics (2/2)

Demographic breakdown of attendees by gender



Demographic breakdown of attendees by education level



Scope of the Report



Scope of the Report

- 1. **Executive Summary**
This section provides a high-level overview of the findings and recommendations of the report.
- 2. **Introduction**
This section outlines the purpose of the report, the scope of the study, and the methodology used.
- 3. **Findings**
This section details the results of the study, including key observations and data points.

Topline Takeaways



Key Message	Topline Takeaway
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**Detailed Insights and
Strategic Recommendations**

Objective 1: Detailed Insights



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Some urologists start ADT or AR therapy independently, while others refer patients to oncologists for systemic management of care

Objective 1: Supportive Quotes From Discussion (1/4)



Case	Supportive Statements
<p>Dr. [Name] [Title] [Institution]</p>	<p>"I think the [ill-negative patients with chronic disease, fully disease, where you really are worried about getting a response and you wouldn't be able to use the [drug], that's probably the patient I would think about it for."</p> <p>"I think even though the [drug] may warrant you to be at least 8 months from your last [treatment-based therapy], it probably does make [drug] if you're between 8 and 12 months, or approved to using [drug] again."</p> <p>"I think the [treatment] for age, but for [drug], I thought that age actually crossed the [threshold] for our age for [treatment] [drug]."</p> <p>"[Supportive statement]</p>
<p>Dr. [Name] [Title] [Institution]</p>	<p>"I used [treatment] and very well tolerated. And also in [drug] [treatment], it's a [treatment] [treatment] [treatment]. But you can use it [treatment] [treatment] [treatment]. So I have used it and modified the dose of [treatment] [treatment], and it's very well tolerated."</p> <p>"The [treatment] on the [treatment], I actually had the [treatment] [treatment] [treatment] for a patient, not because of [treatment] [treatment], but also, the [treatment] [treatment] [treatment] [treatment], and also had really really [treatment] [treatment], required [treatment] [treatment]. And in the [treatment] [treatment], I gave her these 2 [treatment] and said you're really, you're high risk for [treatment] [treatment] because of your existing [treatment] [treatment]. So it's probably a better [treatment] for you. And then I also offered [treatment] [treatment], and she ultimately chose [treatment]. And I just got her [treatment], and they look amazing. The [treatment] [treatment] have decreased. So I was a [treatment], but I think I was the right choice, together."</p>

Objective 1: Supportive Quotes From Discussion (2/4)



Topic	Relevant Statements
Proposition on CBZ/PA/MSK	<p>"Look, but the data speaks, hazard ratio of 0.58 and 95% confidence interval is 0.41 to 0.71. And look at the Kaplan-Meier curve. They're separating ... they're separating ... which you showed us."</p> <p>"And then when you brought up the depressive results for their control arm, I think we had this study open and what was remarkable, at least to our site, was there was a significant difference between control groups of 48% and 52% and that I was a lot amount of patients, the amount of all of the patients had depression. So we actually didn't have a lot amount that was not eligible for CBZ/PA/MSK because of that. I wonder if that's something that just sort of I guess, concentrated the 48% population for this, and maybe patients did better. I don't know if that was discussed at all in the."</p> <p>"I mean, there's very impressive results. The data will get into the major collection of the study, which is that the CBZ/PA/MSK regimen is an interpretable once you get to the maintenance phase. And I mean there are ongoing studies about doing sort of an induction with followed by maintenance. So I think that's what we really needed to see. Today's I think, well, interpreted in general, but it's a lot of monitoring, the drug every 8 weeks, more or less, to look for SJS and that's just a lot of patients, especially in long responders. Sometimes I don't average them for 8 months or do that within for 8 months. So it just is like the intensity has increased, for sure."</p> <p>"I think the other factor with the control arm doing better than CBZ/PA/MSK is the volume of patients that did not get institutional or performance, because half of the patients were de novo. That means the other half had therapy for breast cancer in the past. That's probably not something we see."</p>

Objective 1: Supportive Quotes From Discussion (3/4)



Topic	Supportive Statements
Proposition on GLP1RA	<p>"Well, for the data overall, hazard ratio of 0.58 and 95% confidence interval 0.48 to 0.71. And look at the Kaplan-Meier curve. They're separating ... they're separating well ... what you showed us."</p> <p>"And then when you brought up the regression results for their control arm, I think we had the study open and what was remarkable, at least to our site, was there was a significant difference between control groups of GLP1RA and oral. And I was a bit surprised of patients, the amount of all of the patients had discontinuation. So we actually didn't have a lot of patients that were not eligible for GLP1RA because of that. I wonder if that's something that just sort of I guess, concentrated the GLP1RA population for this, and maybe patients do better. I don't know if that was discussed at all in the."</p> <p>"I mean, they're very impressive results. So you will get into the major outcomes of the study, which is that the GLP1RA/RA regimen is an interpretable once you get to the maintenance phase. And I mean there are ongoing studies about doing sort of an induction plus following maintenance. So I think that's what we really needed to see. GLP1RA, I think, well, interested in general, but it's a lot of monitoring, the drug every 2 weeks, more or less, to look for GLP1RA that there's just a lot of patients, especially in long responders. Sometimes I don't manage them for 8 months or do that either for 8 months. So it just is like the intensity has increased, for sure."</p> <p>"I think the other factor with the control arm doing better than GLP1RA/RA is the volume of patients that did not get discontinued or perforated, because half of the patients were de novo. That means the other half had therapy for several years in the past. There's probably not something we see."</p>

Objective 1: Supportive Quotes From Discussion (4/4)



ID	Relevant Statements
Dr. [Name] (MD) and [Name] (MD) (Interview)	<p>I think the self-negative patients with chronic disease, really disease, where you really are worried about getting a response and you wouldn't be able to use the [Drug], that's probably the patient I would think about it for.</p> <p>I think even though the [Drug] may wanted you to be at least 8 months from your last immunosuppressant-based therapy, I'd probably favor more [Drug] if you're between 8 and 12 months, or approved to using [Drug] again.</p> <p>I think the treatment for age, but for [Drug], I thought that age actually crossed the barrier for our age for using [Drug].</p> <p>[Supportive statement]</p>
Dr. [Name] (MD) (Interview)	<p>I used [Drug] and very well tolerated. And also in [Drug] studies, it's a disease treatment [Drug]. But you can use it in other immunosuppressant treatment. So I have used it and modified the dose of immunosuppressant sometimes, and it's very well tolerated.</p> <p>The use of [Drug] in the literature, I actually had the come up interestingly recently for a patient, not because of [Drug] itself, but also, she actually came through her [Drug] and she had really really pulmonary involvement, required supplemental oxygen. And in the literature, I gave her these 2 options and said you're really you're high risk for [Drug] because of your existing pulmonary needs. So it's probably a better treatment for you. And then I also offered [Drug], and she ultimately chose [Drug]. And just get her that week, and they had amazing. Her oxygen requirements have decreased. So it was a risk but I think it was the right choice, together.</p>

Objective 1: Strategic Recommendations



Work with experts to develop guidelines to address what supporting decisions is needed to meet current, while continuing to share information with the Board about what is being done.

- Develop guidelines early on supporting decision making
 - Develop clear evidence-based supporting frameworks to help the Board understand the impact of the Board's decisions on the patient's health and the organization's financial and operational performance.
- Work with experts to determine feasibility of how the organization will support the Board's decisions to patients with the disease, when evidence-based therapy may not be available.
- As data from the Board's decisions continues to evolve, highlight key data outcomes to both the current and future Board decisions, as the information will be valuable to inform the patient's decision making.
- Develop strong relationships with the Board's single agent arm of the Board's decisions.
- Provide resources or monitoring to help with the Board's decisions in the long term, to encourage effective communication managing the disease.

Objective 2: Detailed Insights

Objective 2: Detailed Insights

Key Takeaway: Address practice efficacy, safety, and quality of life with vildagliptin (VILDA) + metformin (MET) with discussion on the most preferred (VILDA) + MET combination. Address currently practice treatment based regimens for second line therapy in the absence of affordable metformin, but they noted a preference for vildagliptin + metformin in patients with HbA1c > 9.0% and metformin in the case of HbA1c < 9.0%. Address how VILDA + MET competing and were optimistic regarding its future incorporation in vildagliptin + MET, though concerns remain regarding real time use and testing costs.

When discussing 1L disease, address emphasis that safety, toxicity management, quality of life, and efficacy influence guide treatment decisions.

- Metformin is the most preferred (VILDA) + MET, with half of address recommending discussion that this has choice, while 40% of address said it depends on the patient.
 - Address point to efficacy results and toxicity profiles as the leading reasons behind their choice of (VILDA) + MET. Physicians also consider VILDA + MET as their preference.
- According to address, vildagliptin is more appealing for frail patients, while sitagliptin remains effective for higher risk disease.

Following progression on first line vildagliptin plus sitagliptin, most address would recommend treatment plus vildagliptin for a patient with vildagliptin + MET in the absence of any affordable metformin.

- During discussion, address noted that they typically use vildagliptin for their patients with HbA1c > 9.0%, citing that it came first as their most preferred for its selection over vildagliptin.
- Address discussed using single agent treatment for their patients with HbA1c < 9.0%.

Address found the data from VILDA + MET and VILDA + MET highly compelling and expressed interest in the VILDA + MET and VILDA + MET trials to expand the arsenal of available treatments for vildagliptin + MET.

- Physicians cite real time use and the potential cost of repeated HbA1c testing as challenges for incorporation of VILDA + MET, but they remain optimistic and noted that many patients desire additional testing.
 - One address raised a question on how to proceed for patients who test positive for HbA1c > 9.0% at low clinic frequency.

Objective 2: Supportive Quotes From Discussion (1/4)



Topic	Relevant Statements
Description of evidence	<p>"This is a landmark trial. It came in JAMA. Primary outcome. Also in New England Journal of Medicine."</p> <p>"We are doing something better than what we've been doing in all metabolic disease. I think it's a practice-changing trial. It's very, very important. The question is, how often you will do it? 2 weeks every 2 months, every 4 months. Other thing, HbA1c number. If you found it's a very high number as compared to 200% number, I will treat with HbA1c number really because that's a worse number as compared to 200% number. When you can get a little bit. But I think this is a very important trial, which you showed us, and it's a practice-changing. But I don't think commitment is available in all part. The commitment with your 2 weeks. I think it should be implemented in patient care after 4 months and every 2 to 4 months, check for 200% number, and change the treatment."</p> <p>"I think the question comes, are we using around the way? Is it a best time for this also? I think that was another discussion."</p> <p>"Do we have a number that is better as 200% alteration or those that were detected? So, we screened about 1,000 patients or maybe 200 patients. Obviously, at the time, they detected the low 200% alteration get randomized after the 4 months? Was that a year? Do we know?"</p> <p>"I was skeptical because of the potential for adverse effect. But this trial as well that checking every 2 to 4 months certainly is going to increase the cost of what we're doing. But this trial is the quality of life measure actually not at changed by what a little bit. Although I can see what you're saying about the psychological impact. But I don't think that to explain it other than clinical benefit is important, so."</p>

Objective 2: Supportive Quotes From Discussion (2/4)



Topic	Supportive Quotes
Topic 1	[Blurred text]
Topic 2	[Blurred text]

Objective 2: Supportive Quotes From Discussion (3/4)



ID	Supportive Quotes
[Blurred]	[Blurred]
[Blurred]	[Blurred]

Objective 2: Supportive Quotes From Discussion (4/4)



Topic	Relevant Statements
Prevalence of MDD	<p>"This is a landmark trial. It came in JAMA... Primary outcome... Also in the English Journal of Medicine."</p> <p>"We are doing something better than what we've been doing in all mental health... I think it's a practice-changing trial. It's very, very important. The question is, how often you will do it? 2 months every 2 months, every 4 months. Other thing, PHQ-9 number. If you found it's a very high number as compared to DSM-5 number, I will treat with PHQ-9 number every 2 months. If you found it's a lower number as compared to DSM-5 number, then you can wait a little bit. But I think this is a very important trial, which you should do, and it's a practice-changing. But I don't think commitment is available in all you. The commitment with your clinician. I think it should be implemented in patient care after 2 months and every 2 to 4 months, check for DSM-5 number, and change the treatment."</p> <p>"I think the question comes, are we only around the city? Is it a local trial too also? I think that was another discussion."</p> <p>"Do we have a number that is better as DSM-5 alternative in those that were detected? So, we screened about 1,000 patients or maybe 200 patients. Obviously, at the time, they detected the two DSM-5 alternative got confirmed. Was that 2 months? Was that a year? Do we know?"</p> <p>"I was skeptical because of the potential for adverse effects. But this trial as well that checking every 2 to 4 months certainly is going to increase the cost of what we're doing. But this trial is the quality of life measure actually not at all changed by either a little bit. Although I can see what you're saying about the psychological impact. But I don't think that is really a better than clinical benefit is important, so."</p>

Objective 2: Strategic Recommendations



Strategic Recommendations

1. **Recommendation 1: [Faded text]**

- [Faded text]
- [Faded text]

2. **Recommendation 2: [Faded text]**

- [Faded text]

Objective 3: Detailed Insights

Section 1: Introduction

Section 2: Key Findings

- 1. The first finding is that...
- 2. The second finding is that...
- 3. The third finding is that...

Section 3: Recommendations

- 1. It is recommended that...
- 2. It is recommended that...
- 3. It is recommended that...

Section 4: Conclusion

Section 5: Appendix

- 1. Appendix A: Data Table
- 2. Appendix B: Additional Notes

Objective 3: Supportive Quotes From Discussion (1/3)

Case	Supportive Quotes
[Blurred Case Name]	[Blurred Supportive Quotes]

Objective 3: Supportive Quotes From Discussion (2/3)



Case	Supportive Quotes
Case 1: [Illegible]	[Illegible text]
Case 2: [Illegible]	[Illegible text]

Objective 3: Supportive Quotes From Discussion (3/3)



Topic	Supportive Quotes
[Faded text]	[Faded text]

Objective 3: Strategic Recommendations



Strategic Recommendations

The following recommendations are based on the findings of the assessment and are intended to support the organization in achieving its strategic objectives. These recommendations are based on the findings of the assessment and are intended to support the organization in achieving its strategic objectives.

- Recommendation 1:** [Blurred text]
- Recommendation 2:** [Blurred text]



Attendee Key Takeaways



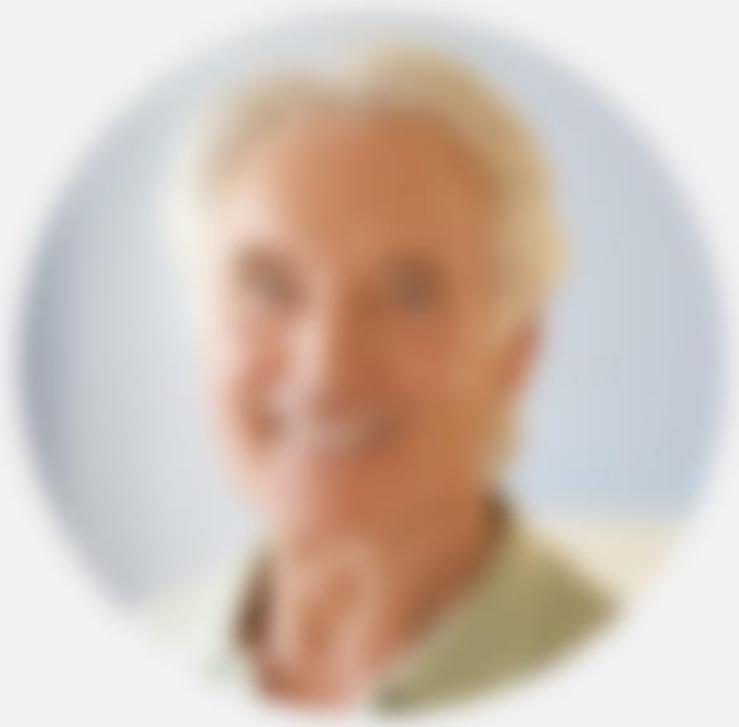
ARS Data

The Majority of Advisors Refer >50% of Their Patients With mHSPC for Genetic Testing



While 47% of Advisors Do Not Encounter Any Barriers to AR Inhibitor Use in Treating mHSPC, Another 47% Reported Delays in Authorization as a Key Impediment



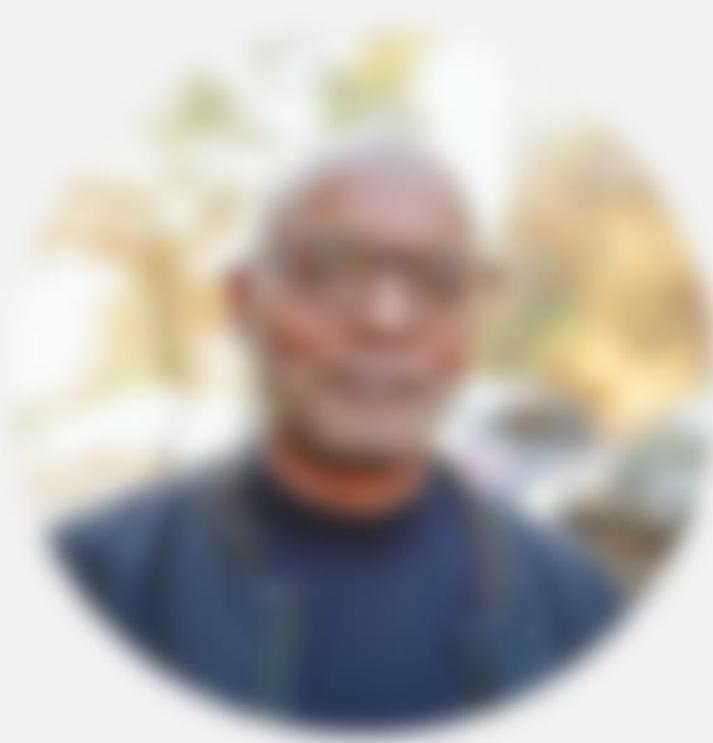


What would be your preferred therapy for a patient with metastatic breast cancer with the following characteristics?

- ER+ and HER2+ breast cancer, PD-L1+ positive
- Symptomatic disease
- ECOG PS 1
- High volume synchronous metastases
- No known significant genetic mutations/alterations

Nearly All Advisors Selected Triplet Therapy With Darolutamide for Treatment of a Patient With High-Volume mHSPC

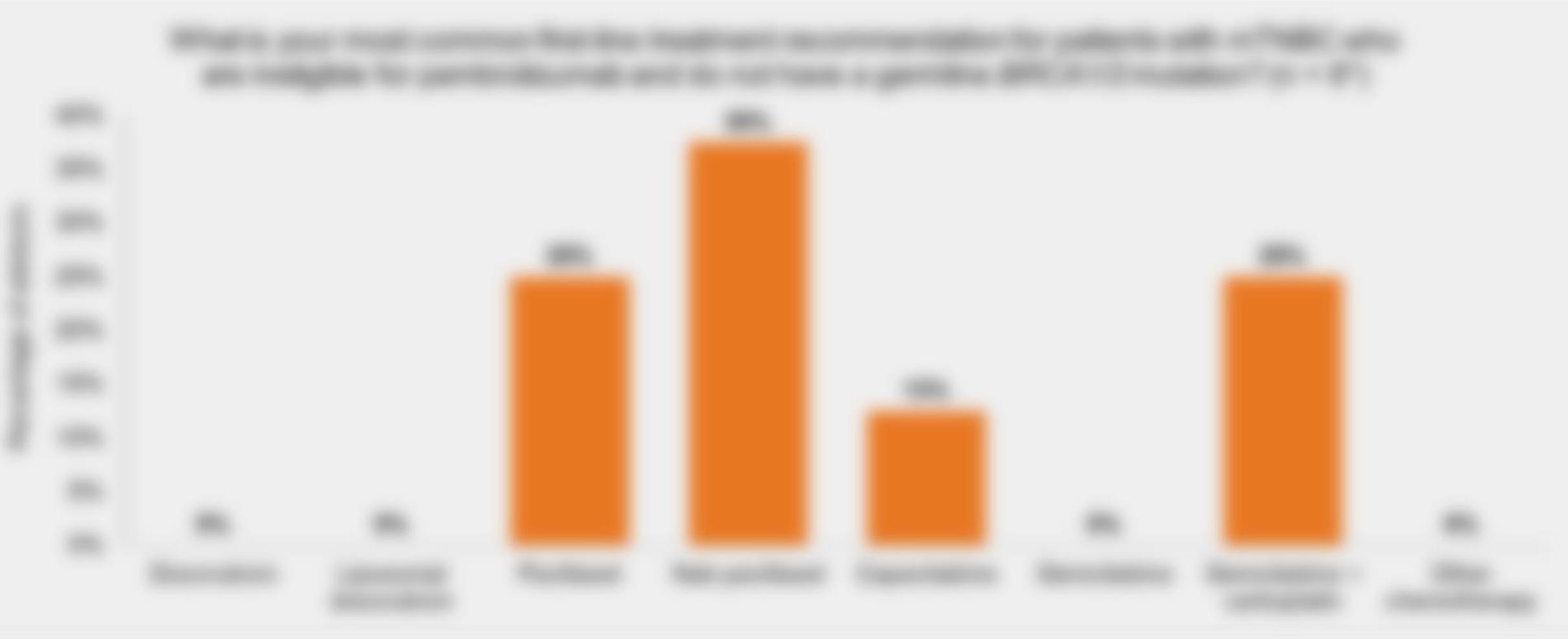




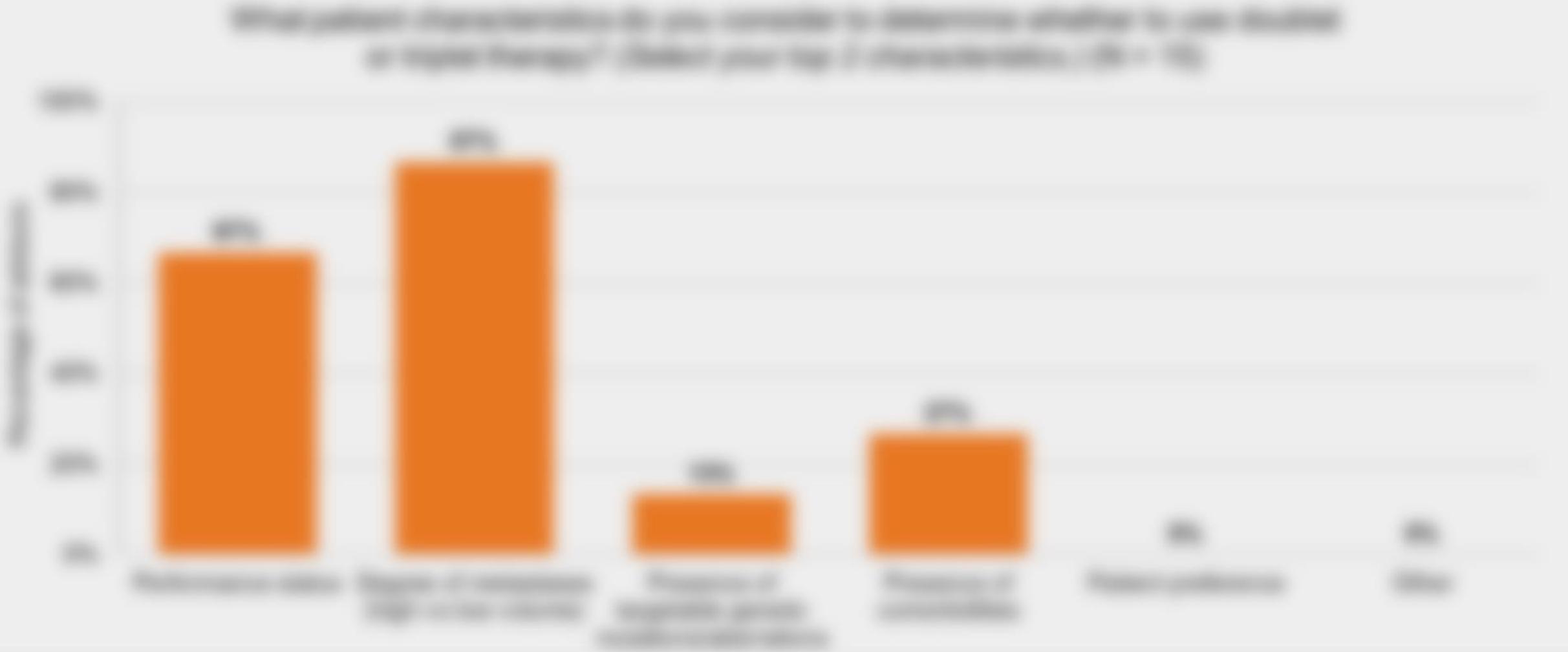
What would be your preferred therapy for a patient with metastatic, with the following characteristics?

- Bone and lymph node metastases, PSMA-PET positive
- Mildly symptomatic disease
- ECOG PS 1
- Low volume synchronous metastases
- No known significant genetic mutations/alterations

The Preferred Treatment for a Patient With Low-Volume mHSPC Was Doublet Therapy With Either Darolutamide (33%), Apalutamide (20%), or Enzalutamide (13%)



Degree of Metastases, Followed by Patient Performance Status, Are Top Factors in Determining Treatment Intensification



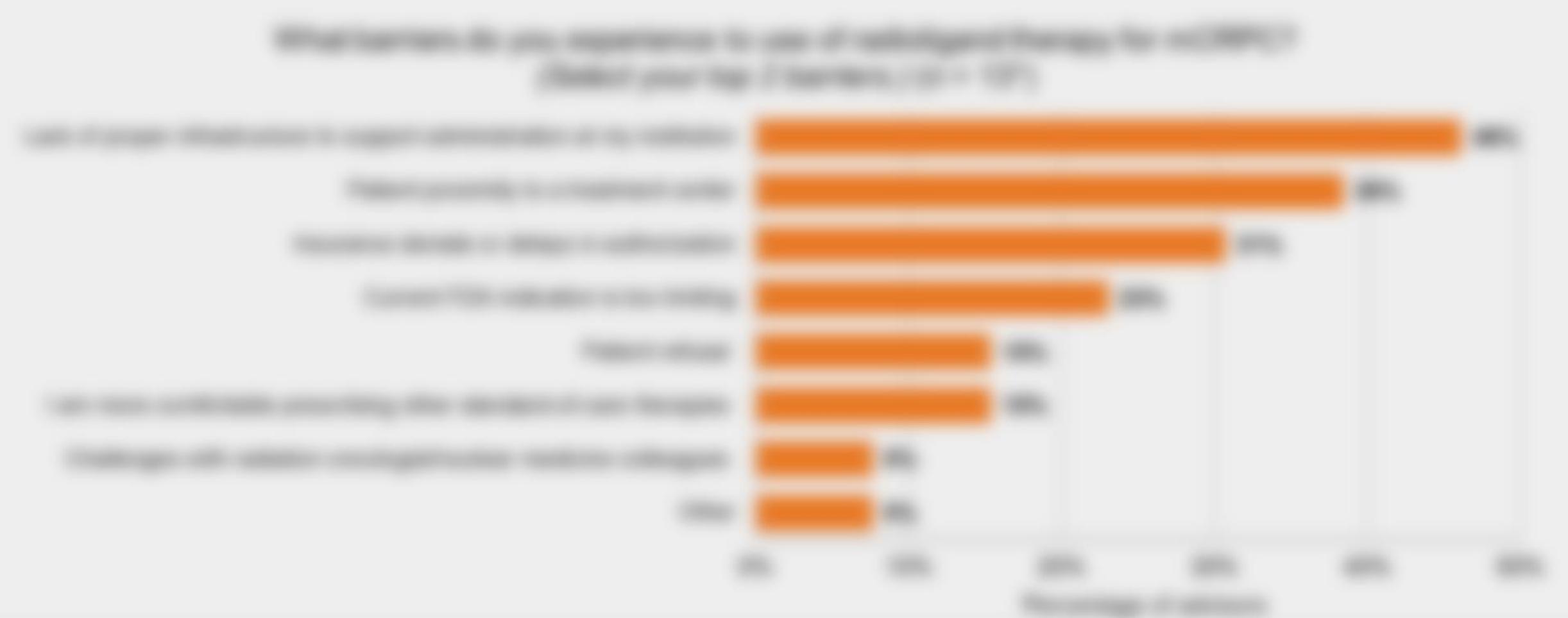
Nearly All Advisors Refer the Majority of Their Patients With mCRPC for Genetic Testing



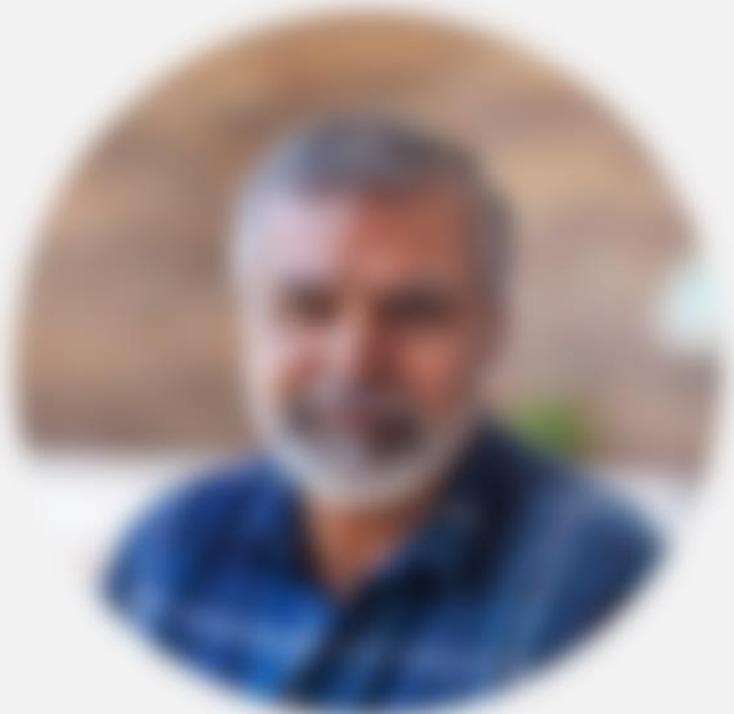
While Over Half of Advisors Have Access to Multiple Treatment Service Lines, Only 15% Can Access a Hot Lab/Theranostics Department at Their Institution



Lack of Proper Infrastructure, Patient Proximity to Treatment Centers, and Insurance Issues Are The Most Frequent Hurdles to Use of Radioligand Therapy for mCRPC

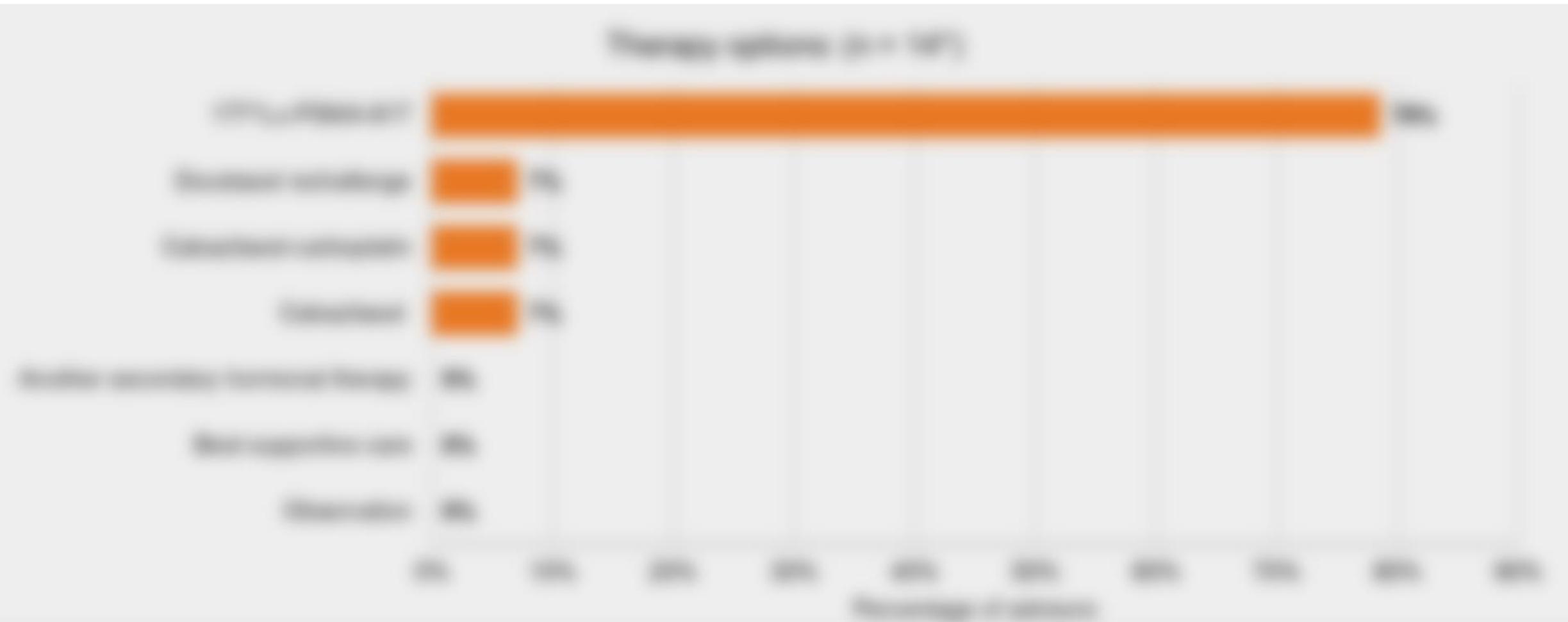


Patient Case 3

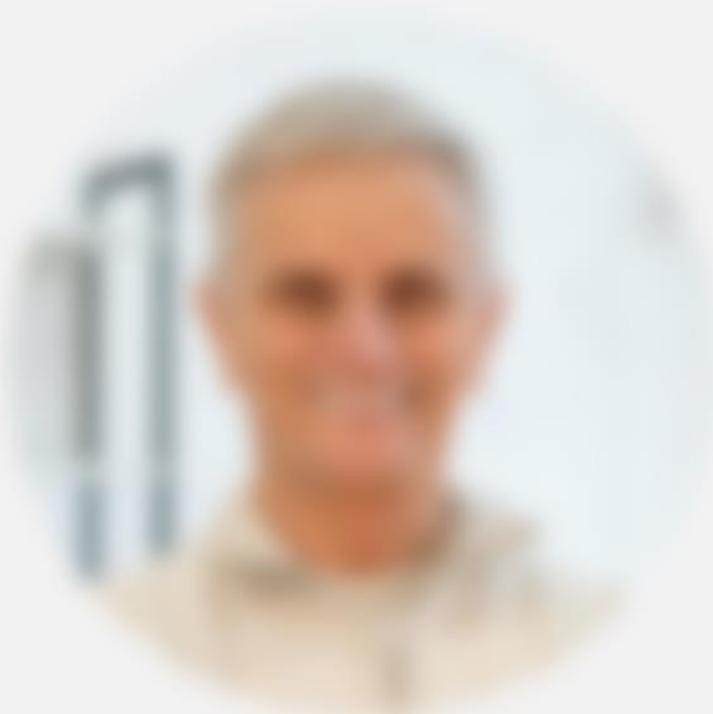


- What would be your preferred therapy for a patient with mCRPC, with the following characteristics?
- 1. Bone and visceral lung metastases, PSMA PET positive
 - 2. Symptomatic disease
 - 3. PSMA PET +
 - 4. Prior ADT + AR targeted therapy (enzalutamide) + docetaxel
 - 5. Unknown genetic mutations

Over Three-Quarters of Advisors Selected ¹⁷⁷Lu-PSMA-617 Treatment for a Symptomatic Patient With mCRPC Who Received Prior Triplet Therapy (with enzalutamide)



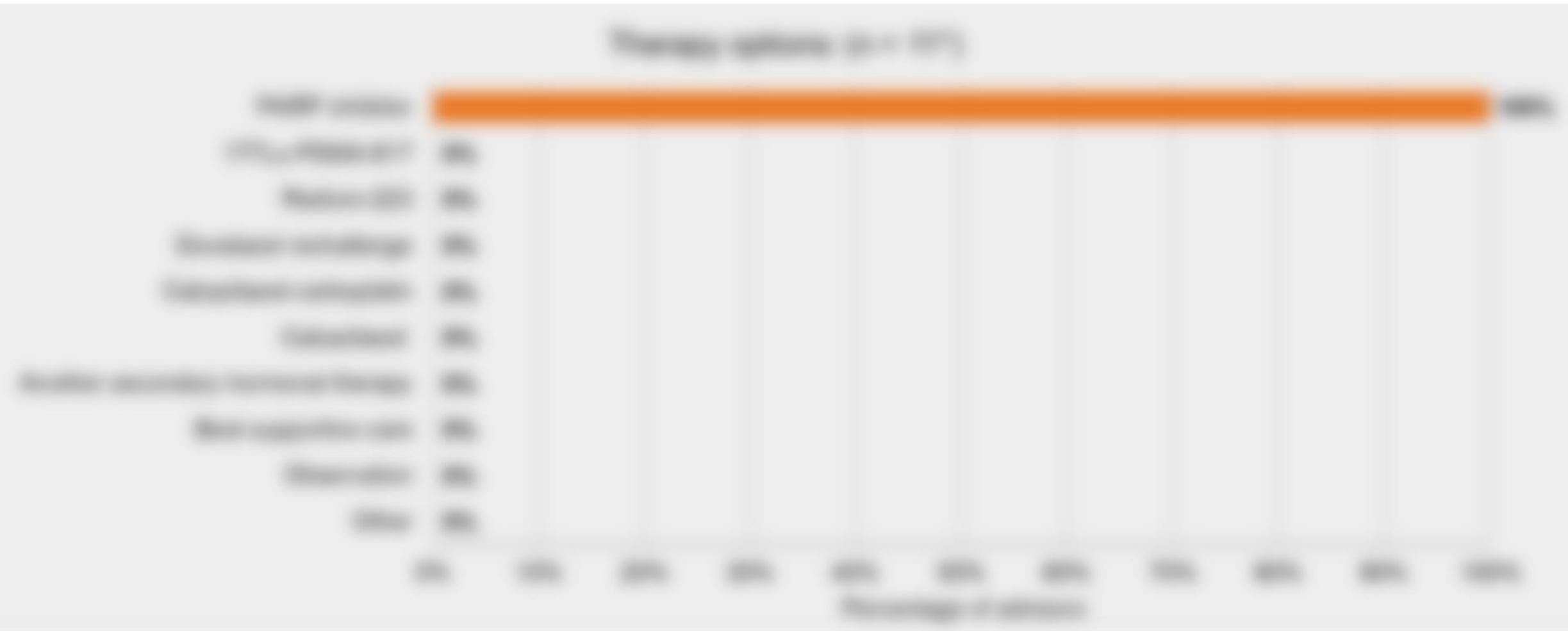
Patient Case 4



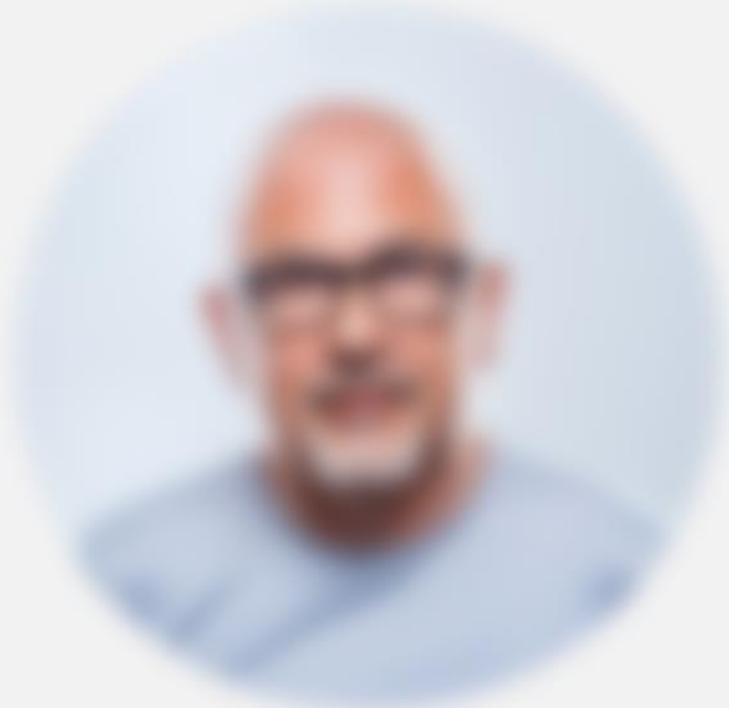
What would be your preferred therapy for a patient with mSCLC, with the following characteristics?

- Male and lymph node metastases, PDMS-PD1 positive
- Mildly symptomatic disease
- ECOG PS 1
- Prior chemotherapy and radiation
- Known BRCA mutation

All Advisors Preferred a PARP Inhibitor for a Mildly Symptomatic Patient With mCRPC and Known *BRCA* Mutation, Who Previously Received Enzalutamide + Docetaxel



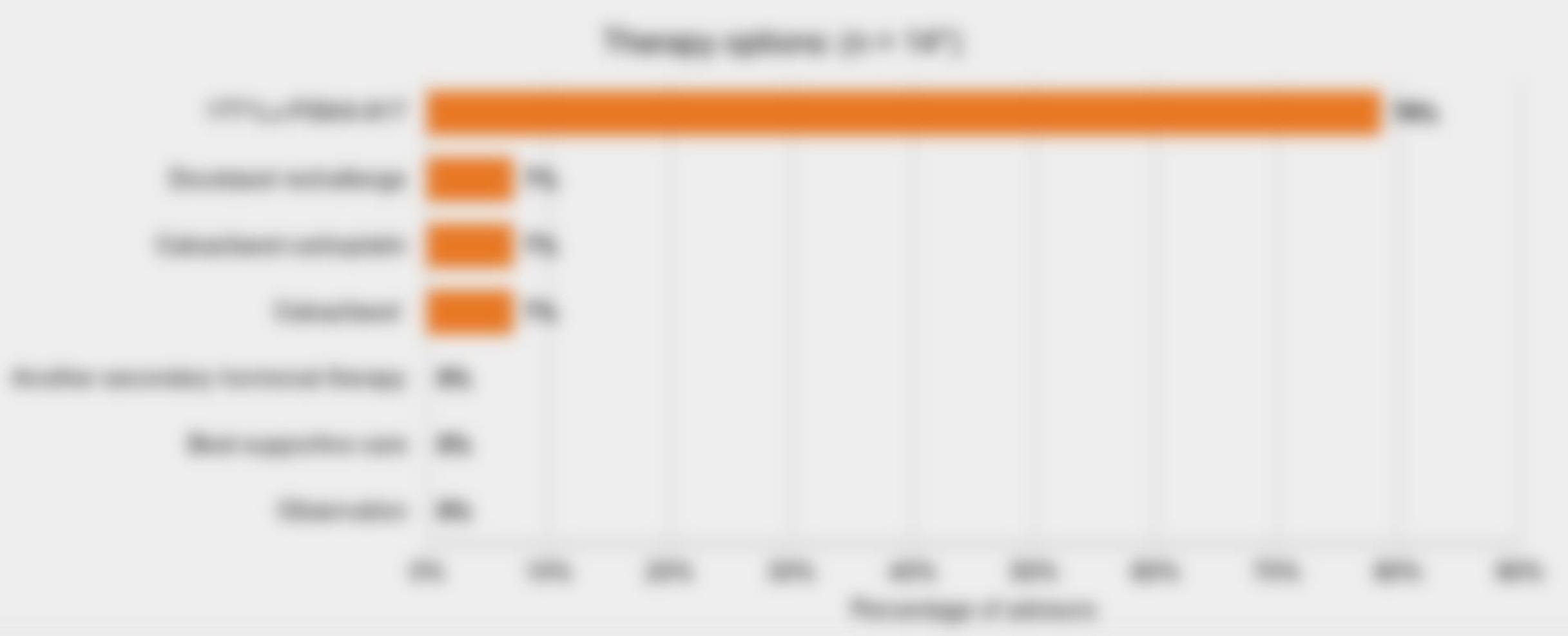
Patient Case 5



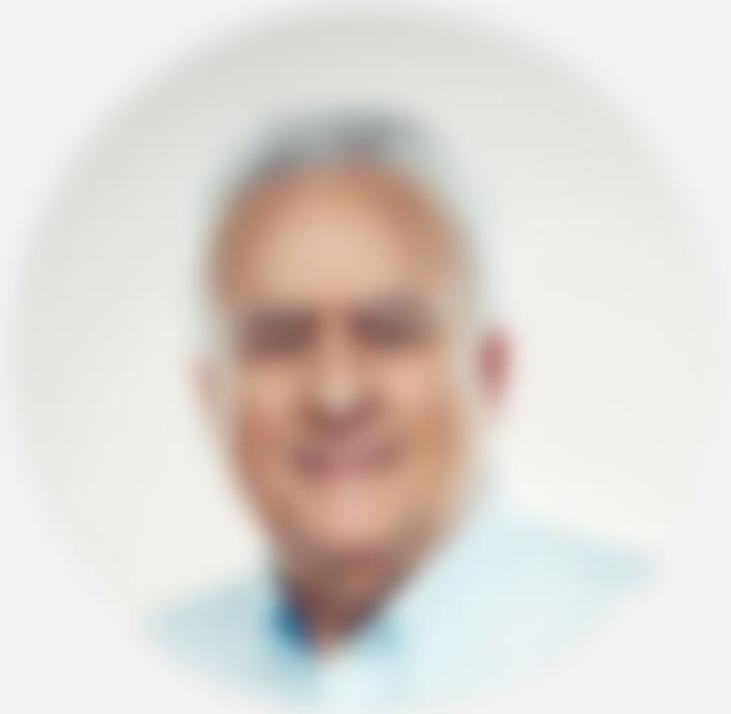
What would be your preferred therapy for a patient with mCRPC, with the following characteristics?

- Bone metastases, PSMA-PET positive
- Asymptomatic
- ECOG PS 0
- Prior ADT (optimal therapy)
- No extensive genetic mutations

64% of Advisors Favored ¹⁷⁷Lu-PSMA-617 Treatment for a Patient With Asymptomatic mCRPC and Prior AR-Targeted Therapy; Another 14% Preferred Docetaxel

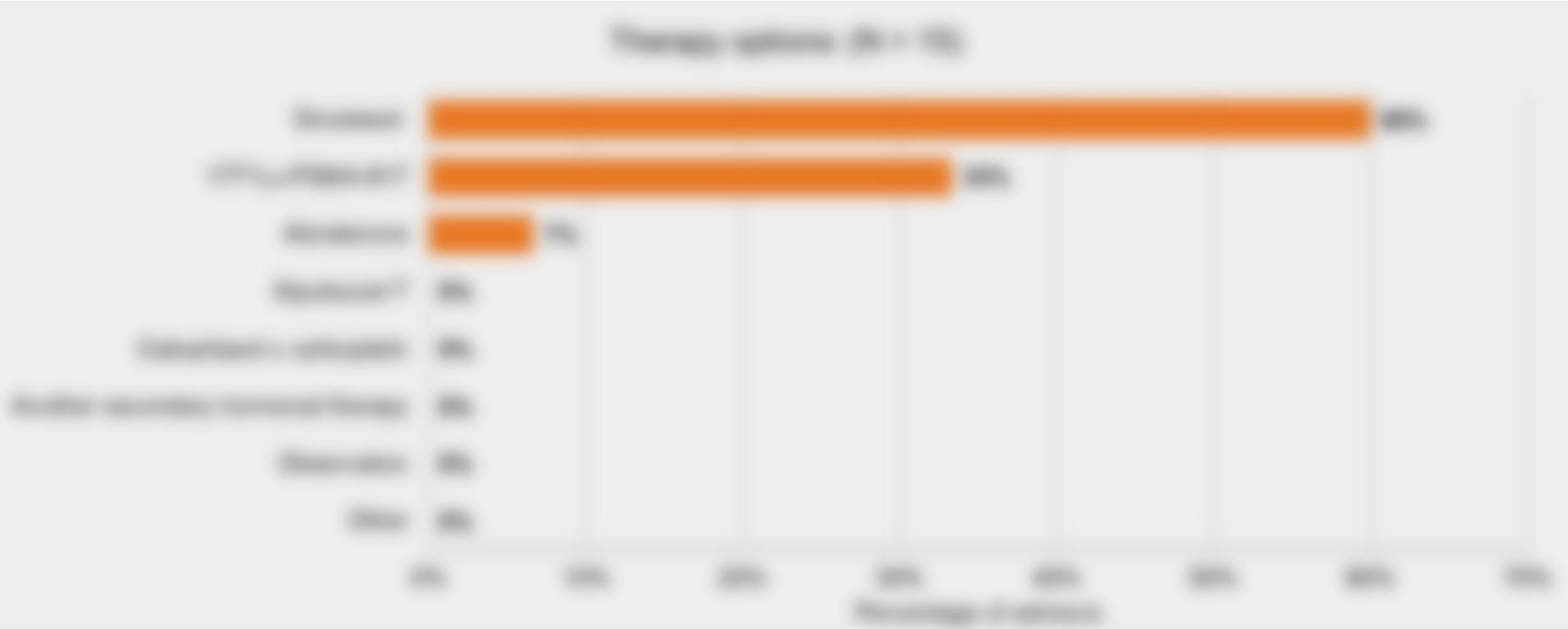


Patient Case 6



- What would be your preferred therapy for a patient with mCRPC, with the following characteristics?
- Bone and visceral metastases, PSMA-PET positive
 - Symptomatic disease
 - ECOG PS 1
 - Prior ADT + AR targeted therapy (enzalutamide)
 - No actionable genetic mutation

Although the Majority of Advisors Chose Docetaxel Treatment for a Symptomatic Patient With Prior Doublet Therapy (with enzalutamide), 33% Preferred ¹⁷⁷Lu-PSMA-617





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