



Insights Into Acute Myeloid Leukemia (AML)

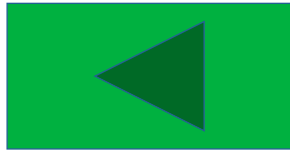
March 1, 2022

Virtual Session

How to Navigate This Report



Click to move to topic of interest or ARS supporting data



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Topic

Report Objectives



Report Snapshot

- Session overview
- Attendee overview
- Agenda



Topline Takeaways and Strategic Recommendations



Key Insights and Discussion Summary

- Key insights: Testing and its impact
- Key insights: Current AML data
- Key insights: First-line and R/R
- Discussion
 - Testing and its impact
 - First-line AML
 - Relapsed/Refractory AML



Advisor Key Takeaways



ARS Data



Report Snapshot: Session Overview



A moderated roundtable discussion with community oncologists from the Southwest region of the United States was held online on **March 1, 2022**

Disease state and data presentations were led by **Dr Elias Jabbour** from MD Anderson Cancer Center, in conjunction with content developed by the Aptitude Health clinical team

Insights on the practical management of first- and second-line AML using **venetoclax, ivosidenib, and other targeted approaches** were obtained

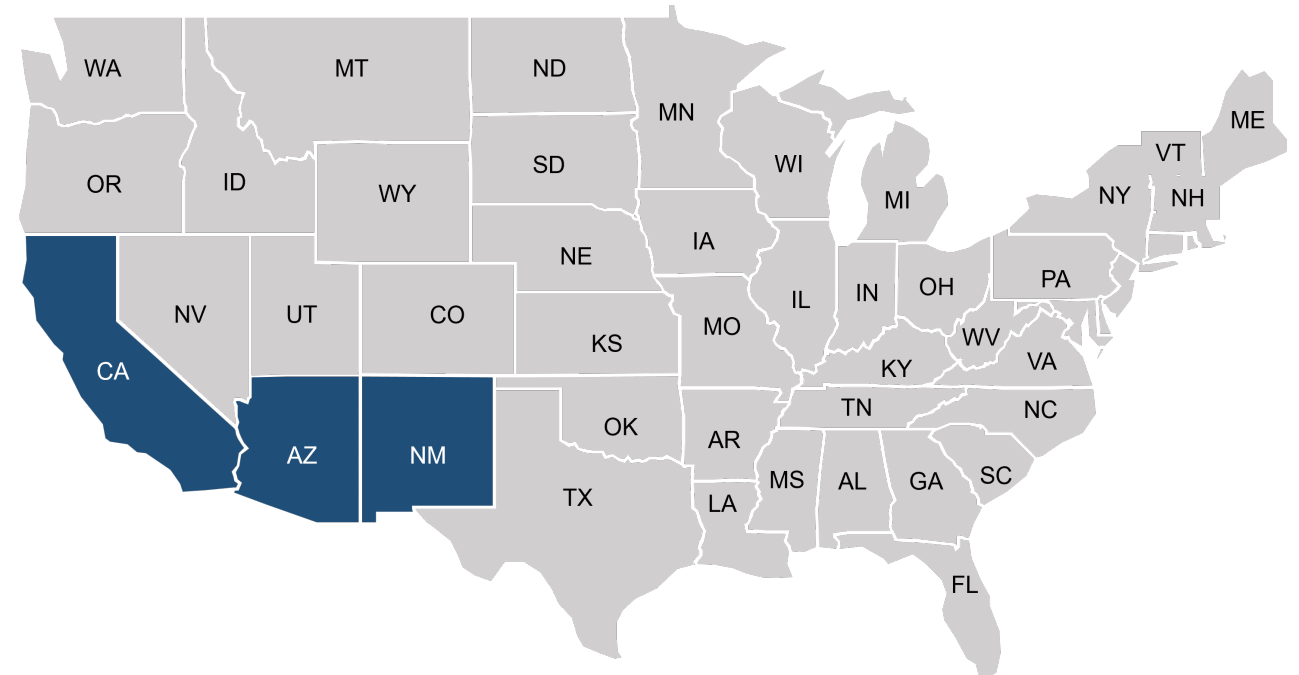
Data collection was accomplished through use of audience response system (ARS) questioning and in-depth moderated discussion

Report Snapshot: Attendee Overview



- > The group of advisors comprised 9 community oncologists from the Southwest region of the United States
 - Attendees of the roundtable represented community oncologists from California, Arizona, and New Mexico

Institution	City	State
Los Angeles Cancer Network	Pasadena	CA
Ironwood Cancer & Research Centers	Phoenix	AZ
Kaiser	Irvine	CA
Desert Hematology Oncology	Peoria	AZ
UC San Diego Health	Temecula	CA
Kaiser	Riverside	CA
Lovelace Cancer Center	Albuquerque	NM
Pacific Shores/City of Hope	Huntington Beach	CA
Cancer & Blood Specialty Clinic	Los Alamitos	CA



Report Snapshot: Attendee Demographics (1/2)



What proportion of your patients with hematologic malignancies whom you see per month have AML? (n = 8*)

How many unique patients with AML (newly diagnosed or otherwise) do you personally manage per month? (n = 8*)



*One advisor did not respond.

Attendee Demographics (2/2)

What percentage of your AML patients are 75 years or older? (n = 8*)



What percentage of your AML patients are under 75 years old, but have comorbidities that prevent use of intensive induction chemotherapy? (n = 8*)



Report Snapshot: Agenda



Time (EST)	Topic
6.00 PM – 6.15 PM	Introduction and ARS Questions <ul style="list-style-type: none">• Program overview• ARS questions
6.15 PM – 7.35 PM	First-Line Treatment of AML <ul style="list-style-type: none">• Overview of current data• Reaction and discussion
7.35 PM – 7.45 PM	<i>Break</i>
7.45 PM – 8.45 PM	Management of Relapsed/Refractory AML and Promising Sequencing Strategies in AML <ul style="list-style-type: none">• ARS questions• Overview of current data• Reaction and discussion
8.45 PM – 9.00 PM	Key Takeaways and Meeting Evaluation

INSIGHTS

“We do NGS, multiple myeloma NGS. We do that from the get-go from the bone marrow. We just send it out . . .

1. Treatment success in frontline MM

The overall survival that we see is what we would expect. This is not necessarily disease-free or overall survival, so we have overall survival. I would expect any significant improvement in overall survival with a treatment approach other than using IM or IMiD, and I would expect that the disease-free rate at 1 year, I believe, is that IM is important if there is significant toxicity with the treatment, and people going from something to something.

2. Data needed to confirm from IMiD in frontline

That's all a lot of things have been done, nothing is better than IMiD and IMiD. It's really hard with how IMiD performs for my patients. I would be a little bit more. I would not be one of the first ones to move toward IMiD or something like that. I would something that's been done and we know that IMiD is better. If the benefits are not very much, I think a hazard rate of IMiD or better would be something that I would be looking at. Overall survival data, 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 think that's a bit of a trade-off between overall survival and efficacy. I think what's going to start driving the use of IMiD is that IMiD is not sufficient.

INSIGHTS

"I typically try to get up to the 400 mg of venetoclax, but again, that's difficult in many of our patients, so I either

1. Treatment success in frontline MDS

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2. Data needed to switch from MDS to frontline

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Discussion: Relapsed/Refractory AML

INSIGHTS

"It wasn't so bad [experience with ivosidenib]. I didn't see the differentiation syndrome. It's mostly GI problems,

1. Treatment success in frontline MDS

The overall success rate is very low. This is not necessarily because the disease is so bad, but because we are using a low-dose, low-intensity regimen. If we had used a more aggressive regimen, we might have seen a better overall success rate. For example, if we had used a regimen like that used in the study, we might have seen a success rate of 15-20%. I believe that this is a reflection of the fact that the disease is very aggressive and needs very high-intensity therapy.

2. Data needed to confirm that MDS is frontline

That's all a lot of things have been said, nothing is better than 5-azacitidine and venetoclax. It's really hard to see 5-azacitidine as the best option. I would like to see a study that compares the two regimens to see if one is more effective. We are currently doing that. I am currently doing that with a high-dose, high-intensity regimen. If the results are not very good, then a success rate of 10-15% is really good for something that is really hard to do. I think that we need to see a study that compares the two regimens to see if one is more effective. We are currently doing that. I am currently doing that with a high-dose, high-intensity regimen. If the results are not very good, then a success rate of 10-15% is really good for something that is really hard to do. I think that we need to see a study that compares the two regimens to see if one is more effective.



Advisor Key Takeaways

Advisor Key Takeaways (1/2)



ADVISOR

> I think the FLAG + IDA with the venetoclax in the upfront

- There is a better understanding of sequencing therapy
- There is a better understanding of the role of venetoclax in the upfront setting
- There is a better understanding of the role of FLAG + IDA in the upfront setting

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- It was good to hear about considerations and advice coming from the practice for immunotherapy

- There is a lot of good options for upfront therapy that can be used in combination with venetoclax and other agents
- Sequencing is an issue

ADVISOR

> It seems like the venetoclax is becoming the backbone of a

- The immunotherapy options are still in the pipeline and we are going to see a lot of options

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

- It was interesting to learn about all these immunotherapy treatments, specifically 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 standard is the standard

Advisor Key Takeaways (2/2)



ADVISOR

ADVISOR

> FLAG + IDA + ven with a higher IDA dose that you

- Have a better understanding of sequencing through
- Have a better understanding of how to use the combination and
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ARS Data

Most Advisors Routinely Do Comprehensive Molecular Testing



In addition to cytogenetics, which of the following molecular markers do you routinely test for in your newly diagnosed AML patients? (Select all that apply.) (n = 8*)

FOR EXAMPLE PURPOSES ONLY



Most Advisors Send Their Samples Out for Molecular/Genomic Testing

When it comes to molecular/genomic testing (n = 7*):

FOR EXAMPLE PURPOSES ONLY

Most Advisors Wait Between 1 And 2 Weeks to Get Results From Molecular/Genomic Testing

When it comes to genomic/mutational testing, the turnaround time to get the final results is:



One in 4 Advisors Always Starts Frontline Therapy Before Getting Genomic/Mutational Test Results

In general, the following statement describes me best (n = 8*):

FOR EXAMPLE PURPOSES ONLY

In the Past Year, 3 of 4 Advisors Have Used a Hypomethylating Agent (HMA) as a Monotherapy in Their AML Patients

In the past year, in how many AML patients have you used a hypomethylating agent (HMA) as monotherapy? (n = 8*)

FOR EXAMPLE PURPOSES ONLY

HMA Monotherapy Is Perceived as Tolerable, Easy to Use, With Favorable Availability and Accessibility



What are the reasons you use HMA monotherapy as induction therapy in your elderly/unfit AML patients? *Please select all that apply.* (n = 7*)

FOR EXAMPLE PURPOSES ONLY

All Advisors Have Some Experience Using Venetoclax in Their AML Patients in the Past Year

In the past year, in how many newly diagnosed AML patients have you used a venetoclax-based regimen? (n = 6*)

FOR EXAMPLE PURPOSES ONLY

OS Benefit, Remission Rates, and Positive Clinical Experience Contribute to the Use of Venetoclax in Elderly/Unfit Patients

In your opinion, what are the reasons for you to choose venetoclax-based regimens in your elderly/unfit AML patients? *Please select all that apply.* (n = 8*)

FOR EXAMPLE PURPOSES ONLY

Most Advisors See AML Patients Who Harbor an *IDH1* Mutation; However, These Patients Make Up Only 1%–10% of Their Total Patient Population

What percentage of your AML patients harbor an *IDH1* mutation? (n = 7*)

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.



Most Advisors Prefer Venetoclax for a 77-Year-Old PS 0 Patient With Intermediate-Risk AML (CD33 Positive, FLT3 Negative, IDH1 Positive)

What induction regimen do you recommend for a 77-year-old PS 0 patient with intermediate-risk AML (CD33 positive, FLT3 negative, IDH1 positive)? (n = 7*)

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.



Half of the Advisors Were Not Familiar With the AG120 Trial Data

On a scale of 1–5, how familiar were you, before today, with the patient populations followed in the AG120 trial? (1 = Not at all familiar, 5 = Extremely familiar) (n = 8*)

FOR EXAMPLE PURPOSES ONLY

Sixty-Three Percent of Advisors Were Familiar With the VIALE-A Trial Data

On a scale of 1–5, how familiar were you, before today, with the patient populations followed in the VIALE-A trial? (1 = Not at all familiar, 5 = Extremely familiar) (n = 8*)

FOR EXAMPLE PURPOSES ONLY

For a Patient Who Was Receiving HMA Alone for MDS, but Their Disease Progressed to AML (*IDH1* positive), Most Advisors Would Add Venetoclax to HMA

How would you treat a patient who was receiving HMA alone for MDS but their disease progressed to AML? Genetic testing reveals they are *IDH1* positive. (n = 7*)

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.



All Advisors Would Induce With Venetoclax for a 70-Year-Old PS 2 Patient With Intermediate-Risk AML (*IDH1* positive)

What induction regimen do you recommend for a 70-year-old PS 2 patient with intermediate-risk AML and *IDH1* mutation revealed by NGS? (n = 7*)

FOR EXAMPLE PURPOSES ONLY

The Most Valuable Resources for Current AML-Related Information Are the NCCN Guidelines and UpToDate

Please select up to 3 real-time resources you most often use for AML-related information.
(n = 7*)

FOR EXAMPLE PURPOSES ONLY

*Two advisors did not respond.



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