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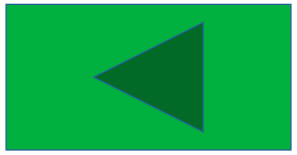
# Insights Into Acute Myeloid Leukemia (AML)

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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# Report Snapshot: Session Overview

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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

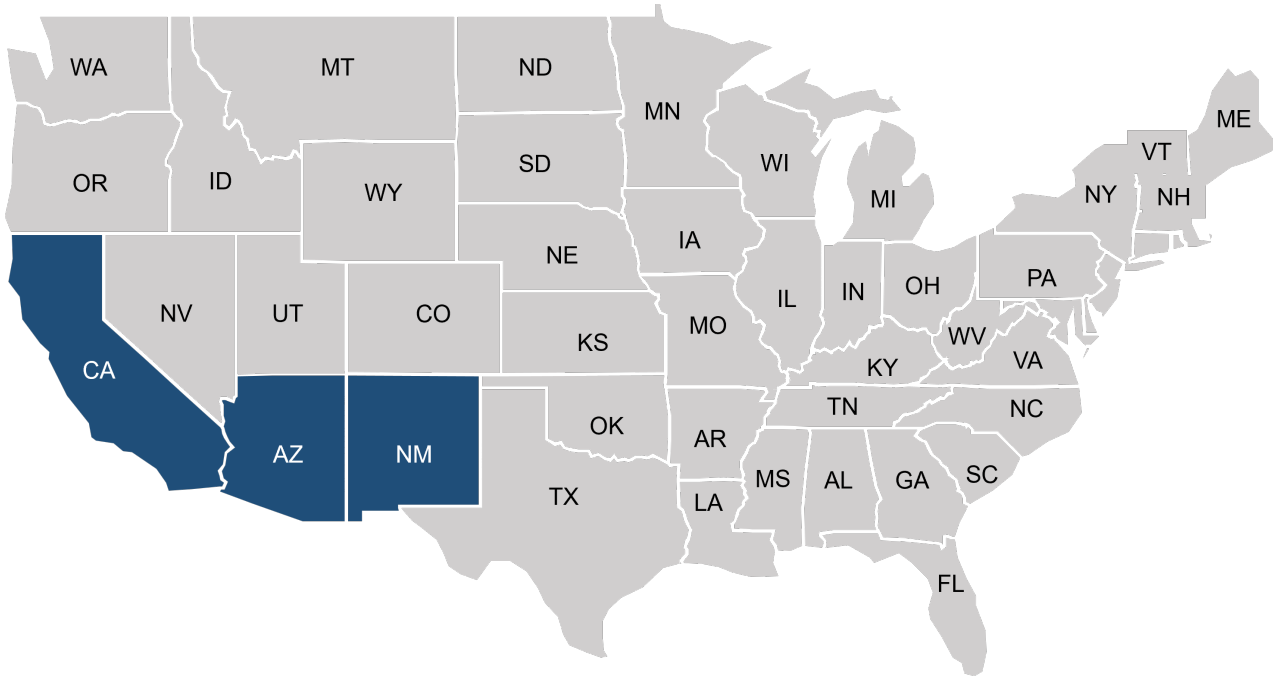
Insights on the practical management of first- and second-line AML using **venetoclax, ivosidenib, and other targeted approaches** were obtained

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

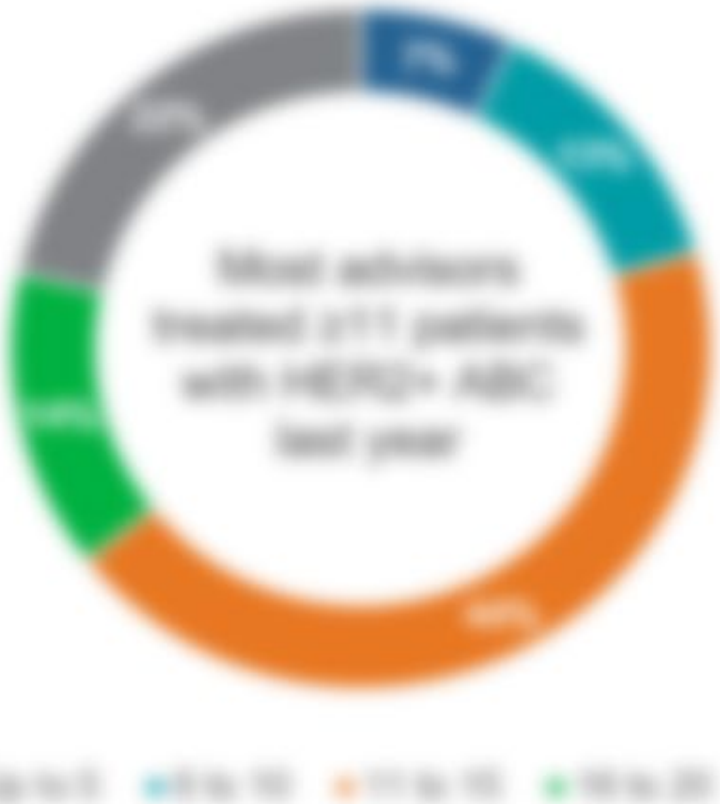
| Institution | City | State |
|---|---|---|
| Los Angeles Cancer Network | Pasadena | CA |
| Ironwood Cancer & Research Centers | Phoenix | AZ |
| Kaiser | Irvine | CA |
| Desert Hematology Oncology | Peoria | AZ |
| UC San Diego Health | Temecula | CA |
| Kaiser | Riverside | CA |
| Lovelace Cancer 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*)**

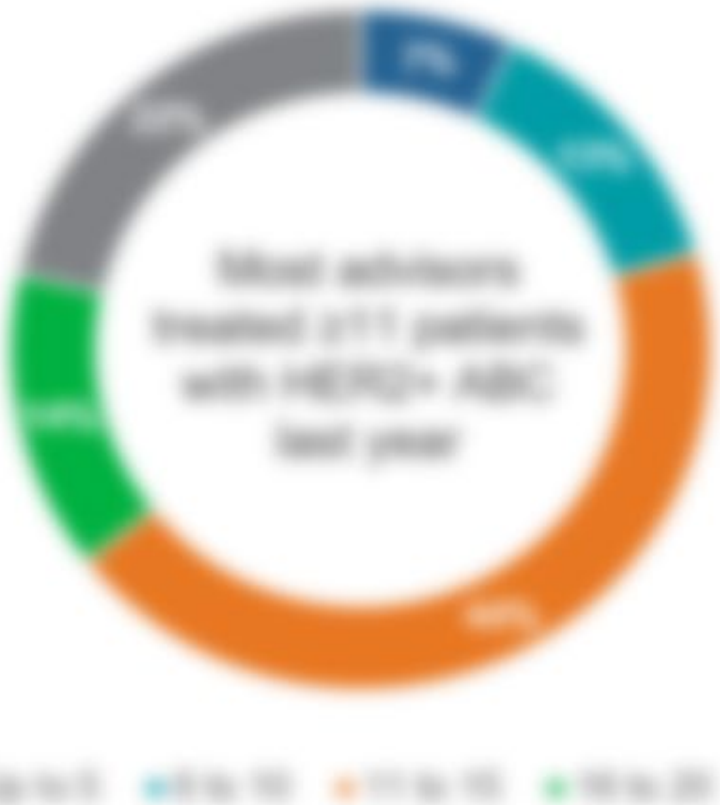


*One advisor did not respond.

# 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*)**



*One advisor did not respond.

# Report Snapshot: Agenda

| Time (EST) | Topic |
|---|---|
| **6.00 PM – 6.15 PM** | Introduction and ARS Questions<br>• Program overview<br>• ARS questions |
| **6.15 PM – 7.35 PM** | First-Line Treatment of AML<br>• Overview of current data<br>• Reaction and discussion |
| **7.35 PM – 7.45 PM** | *Break* |
| **7.45 PM – 8.45 PM** | Management of Relapsed/Refractory AML and Promising Sequencing Strategies in AML<br>• ARS questions<br>• Overview of current data<br>• Reaction and discussion |
| **8.45 PM – 9.00 PM** | Key Takeaways and Meeting Evaluation |

# Discussion: Testing and Its Impact

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

- Treatment success in frontline DLBCL

- Data needed to switch from SOC in frontline

# Discussion: First-Line AML

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*"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*

- Treatment success in frontline DLBCL

[redacted]

- Data needed to switch from SOC in frontline

[redacted]

# Discussion: Relapsed/Refractory AML

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

- [illegible]

- [illegible]

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# Advisor Key Takeaways

# Advisor Key Takeaways (1/2)

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| ADVISOR | ADVISOR |
| --- | --- |
| > I think the FLAG + IDA with the venetoclax in the upfront | > It seems like the venetoclax is becoming the backbone of a |
| 1 | 5 |
| 2 | 6 |
| 3 | 7 |
| 4 | 8 |

# Advisor Key Takeaways (2/2)

| ADVISOR | | ADVISOR | |
|---|---|---|---|
| 1 | > I have a better understanding of sequencing therapies<br>> 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 | > FLAG + IDA + ven with a higher IDA dose that you |
| 2 | > I have a better understanding of some of my relapse options<br>> 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<br>> 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<br>> 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<br>> Sequencing is an issue | 8 | > Still R-CHOP is the standard |

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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*)


*One advisor did not respond.

# Most Advisors Send Their Samples Out for Molecular/Genomic Testing

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


*Two advisors did not respond.

# 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 advisor did not respond.

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

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


*One advisor did not respond.

# 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*)


*One advisor did not respond.

# 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*)


*Two advisors did not respond.

# 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*)


*Three advisors did not respond.

# 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*)


*One advisor did not respond.

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

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


*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)

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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*)


*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*)



*One advisor did not respond.

# 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*)



*One advisor did not respond.

# 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

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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*)



*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*)


*Two advisors did not respond.

# 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*)


*Two advisors did not respond.

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