






 A large, abstract graphic on the left side of the slide, composed of several thick, curved lines in various colors (teal, green, orange, grey, light blue) arranged in a circular pattern, resembling a stylized sunburst or a cluster of paths.

EPICS

Global Perspectives in Lung Cancer in 2023

September 25 and 29, 2023

Full Report

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EPICS

VIRTUAL CLOSED-DOOR ROUNDTABLE



DATE:
September 25 and
29, 2023



**DISEASE STATE AND
DATA PRESENTATIONS**
by key experts



INSIGHT REPORT
including postmeeting
analyses and actionable
recommendations



PANEL: Key experts in
lung cancer

- > 5 from North
America
- > 2 from Europe



**LUNG CANCER-SPECIFIC
DISCUSSIONS** on
therapeutic advances and
their application into clinical
decision-making

Panel Consisting of 5 North American and 2 European Lung Cancer Experts

**Natasha B. Leigh, MD,
FRCPC, FASCO**
University of Toronto



Nasser Hanna, MD
Indiana University School
of Medicine



CHAIR:
Corey J. Langer, MD, FACP
University of Pennsylvania



Solange Peters, MD, PhD
University Hospital of
Lausanne



Ignacio I. Wistuba, MD
MD Anderson Cancer Center



Enriqueta Felip, MD, PhD
Vall d'Hebron University
Hospital



Mark A. Socinski, MD
AdventHealth Cancer Institute



Meeting Agenda – Day 1

Time	Topic	Speaker/Moderator
10.30 AM – 10.35 AM	Welcome and Introductions	Corey Langer, MD, FACP
10.35 AM – 10.55 AM	Prognostic and Predictive Biomarkers in Non-Small Cell Lung Cancer (NSCLC): The Pathologist's Perspective	Ignacio Wistuba, MD
10.55 AM – 11.25 AM	Key Questions and Topics for Discussion	All
11.25 AM – 11.40 AM	New Directions for <i>EGFR</i>-Mutated NSCLC	Natasha Leighl, MD, FRCPC, FASCO
11.40 AM – 12.00 PM	Key Questions and Topics for Discussion	All
12.00 PM – 12.10 PM	<i>EGFR</i> (Less Common Mutations, Including Exon 20 Insertions)	Mark Socinski, MD
12.10 PM – 12.20 PM	Key Questions and Topics for Discussion	All
12.20 PM – 12.30 PM	Break	All
12.30 PM – 12.45 PM	Therapeutic Landscape for Fusion-Positive NSCLC (<i>ALK</i>, <i>ROS1</i>, <i>NTRK</i>, <i>RET</i>)	Nasser Hanna, MD
12.45 PM – 1.15 PM	Key Questions and Topics for Discussion	All
1.15 PM – 1.30 PM	Inhibiting Oncogenic Mutations: Overcoming Mutant <i>KRAS</i>, <i>HER2</i>, <i>MET</i>, and <i>BRAF</i>	Solange Peters, MD, PhD
1.30 PM – 2.00 PM	Key Questions and Topics for Discussion	All
2.00 PM – 2.10 PM	Promising New Targets/Agents in Lung Cancer: ADCs and Beyond	Solange Peters, MD, PhD
2.10 PM – 2.30 PM	Key Questions and Topics for Discussion	All
2.30 PM	Adjourn	Corey Langer, MD, FACP

Meeting Agenda – Day 2

Time	Topic	Speaker/Moderator
10.30 AM – 10.35 AM	Review Agenda and Framework for Day 2	Corey Langer, MD, FACP
10.35 AM – 10.50 AM	Immunotherapy in Early NSCLC	Enriqueta Felip, MD, PhD
10.50 AM – 11.40 AM	Key Questions and Topics for Discussion	All
11.40 AM – 11.50 AM	Immunotherapy in Unresectable Stage III NSCLC	Mark Socinski, MD
11.50 AM – 12.10 PM	Key Questions and Topics for Discussion	All
12.10 PM – 12.25 PM	First-Line Immunotherapy in Metastatic NSCLC: Single Agent or Combination?	Solange Peters, MD, PhD
12.25 PM – 1.05 PM	Key Questions and Topics for Discussion	All
1.05 PM – 1.15 PM	Break	All
1.15 PM – 1.30 PM	Emergence of Immunotherapy and New Agents in SCLC	Nasser Hanna, MD
1.30 PM – 1.55 PM	Key Questions and Topics for Discussion	All
1.55 PM – 2.05 PM	New Directions for Second-Line Therapy	Natasha Leighl, MD, FRCPC, FASCO
2.05 PM – 2.30 PM	Key Questions and Topics for Discussion	All
2.30 PM	Conclusions and Adjourn	Corey Langer, MD, FACP

EPICS

Congress Highlights

Osimertinib With/Without Platinum-Based Chemotherapy as First-line Treatment in Patients with EGFRm Advanced NSCLC (FLAURA2)

Janne P, et al. WCLC 2023. Abstract PL03.13

STUDY POPULATION

> Previously untreated, advanced *EGFR*-mutated NSCLC

PROGRESSION-FREE SURVIVAL (PER INVESTIGATORS)



Patritumab Deruxtecan (HER3-DXd) in EGFR-Mutated NSCLC Following EGFRTKI and Platinum-Based Chemotherapy: HERTHENA-Lung01

Yu HA, et al. WCLC 2023. Abstract OA05.03

STUDY POPULATION

> Advanced, EGFR-mutated NSCLC progressing on prior EGFR

BEST PERCENTAGE CHANGE IN LESION SIZE



IMpower151: Phase III Study of Atezolizumab + Bevacizumab + Chemotherapy in 1L Metastatic Nonsquamous NSCLC

Zhou C, et al. WCLC 2023. Abstract OA09.06

STUDY POPULATION

> Stage IV, nonsquamous NSCLC; no prior chemotherapy

PROGRESSION-FREE SURVIVAL (EGFR/ALK POSITIVE)



Tepotinib + Osimertinib in EGFR-mutant NSCLC with MET Amplification Following 1L Osimertinib: INSIGHT 2 Primary Analysis

Kim TM, et al. WCLC 2023. Abstract OA21.05

STUDY POPULATION

> Advanced, EGFR-mutated NSCLC with resistance to osimertinib

BEST PERCENTAGE CHANGE IN LESION SIZE



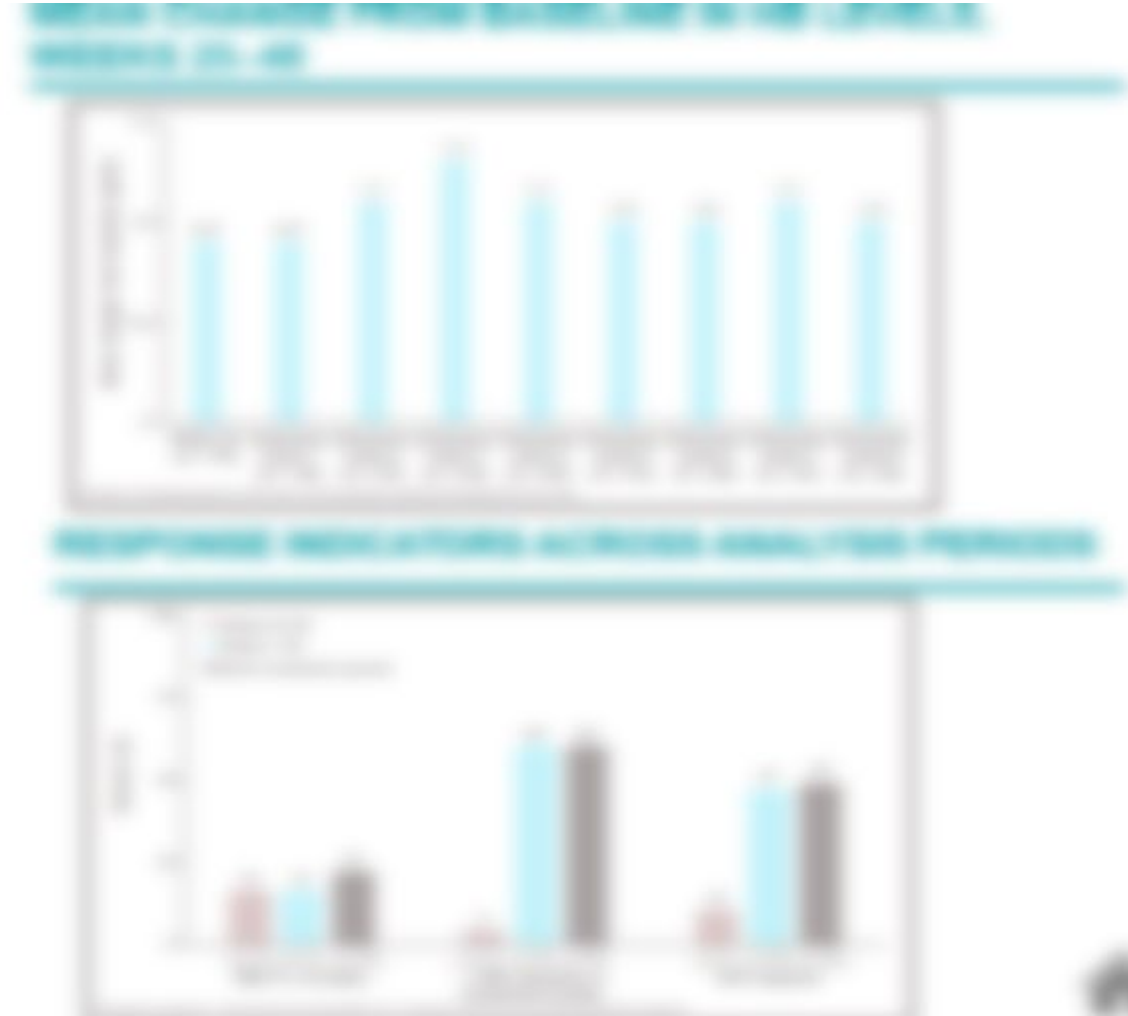
Amivantamab, Lazertinib Plus Platinum-based Chemotherapy in EGFR-mutated Advanced NSCLC: Updated Results from CHRYSALIS-2

Lee SH, et al. WCLC 2023. Abstract MA13.06

STUDY POPULATION

> Advanced, EGFR-mutated NSCLC with prior TKI (≤ 3 prior lines)

BEST PERCENTAGE CHANGE IN LESION SIZE



FAVOUR: A Phase 1b Study of Furmonertinib, an Oral, Brain Penetrant, Selective EGFR Inhibitor, in Patients with Advanced NSCLC with *EGFR* Exon 20 Insertions

Han B, et al. WCLC 2023. Abstract OA03.04

STUDY POPULATION

Advanced NSCLC with an *EGFR* exon 20 insertion

STUDY POPULATION

177 patients with advanced NSCLC with an *EGFR* exon 20 insertion were enrolled in the study. The study population was divided into two groups: the treatment group (n=100) and the control group (n=77). The treatment group received furmonertinib, and the control group received a placebo. The study population was further stratified by baseline characteristics, including performance status, prior treatment, and biomarker status. The study population was followed up for a median duration of 12.5 months.

RESULTS

The primary endpoint was overall survival (OS). The median OS was 12.5 months in the treatment group and 10.5 months in the control group. The hazard ratio (HR) for OS was 0.75 (95% CI, 0.55-1.00), indicating a statistically significant improvement in OS for the treatment group. Secondary endpoints, including progression-free survival (PFS) and quality of life, were also evaluated.

CONCLUSIONS

Furmonertinib significantly improved OS compared to placebo in patients with advanced NSCLC with an *EGFR* exon 20 insertion. The study population was well-tolerated, and the results support the use of furmonertinib as a first-line treatment option for this patient population.

BEST PERCENTAGE CHANGE IN LESION SIZE

BEST PERCENTAGE CHANGE IN LESION SIZE



RESPONSE RATES AND CLINICAL BENEFIT



KRYSTAL-1: Two-Year Follow-Up of Adagrasib (MRTX849) Monotherapy in Patients with Advanced/Metastatic KRASG12C-Mutated NSCLC

EPICS

Gadgeel S, et al. WCLC 2023. Abstract MA06.04

STUDY POPULATION

> Unresectable/metastatic NSCLC with a *KRAS* G12C mutation

OVERALL AND PROGRESSION-FREE SURVIVAL

STUDY POPULATION

177 patients were enrolled in the study, with 177 patients receiving adagrasib and 177 patients receiving placebo. The study population was stratified by sex (male/female) and by age (≤70/ >70). The median age was 67 years. The majority of patients (80%) were male and 20% were female. The majority of patients (70%) were aged ≤70 years and 30% were aged >70 years. The majority of patients (80%) were white and 20% were non-white. The majority of patients (80%) were from the United States and 20% were from other countries.

RESULTS

177 patients were enrolled in the study, with 177 patients receiving adagrasib and 177 patients receiving placebo. The study population was stratified by sex (male/female) and by age (≤70/ >70). The median age was 67 years. The majority of patients (80%) were male and 20% were female. The majority of patients (70%) were aged ≤70 years and 30% were aged >70 years. The majority of patients (80%) were white and 20% were non-white. The majority of patients (80%) were from the United States and 20% were from other countries.

KEY CONCLUSIONS

Adagrasib monotherapy significantly improved overall survival and progression-free survival compared to placebo in patients with advanced/metastatic KRASG12C-mutated NSCLC.



CodeBreakK 101: Safety and Efficacy of Sotorasib with Carboplatin and Pemetrexed in KRAS G12C-Mutated Advanced NSCLC

Clarke JM, et al. WCLC 2023. Abstract MA06.05

STUDY POPULATION

> Advanced, KRAS G12C-mutated NSCLC

PERCENTAGE CHANGE IN TUMOR FROM BASELINE



Trastuzumab Deruxtecan in Patients with HER2-Mutant Metastatic Non-Small Cell Lung Cancer: Primary Results of DESTINY-Lung02

Janne P, et al. WCLC 2023. Abstract MA13.10

STUDY POPULATION

> Metastatic, HER2-mutated NSCLC

PROGRESSION-FREE AND OVERALL SURVIVAL

PFS

T.DXd 5.4 mg/kg T.DXd 6.4 mg/kg



RESPONSE RATES AND CLINICAL BENEFIT



Beamion Lung 1, a Phase Ia/Ib Trial of the HER2 TKI, BI 1810631 in Patients with Advanced Solid Tumors with HER2 Aberrations

Yamamoto N, et al. WCLC 2023. Abstract MA13.08

STUDY POPULATION

> Advanced solid tumors with *HER2* aberrations

PERCENTAGE CHANGE IN TUMOR FROM BASELINE

Antitumor activity in Phase Ib



RESPONSE RATES IN PHASE I AND PHASE II



A Phase 3b Study of 1L Savolitinib in Patients with Locally Advanced or Metastatic NSCLC Harboring MET Exon 14 Mutation

Lu S, et al. WCLC 2023. Abstract OA21.03

STUDY POPULATION

> Locally advanced/metastatic NSCLC, treatment naive

PERCENTAGE CHANGE IN TUMOR FROM BASELINE



Amivantamab in Patients with Advanced NSCLC and MET Exon 14 Skipping Mutation: Results from the CHRYSALIS Study

Leigh N, et al. WCLC 2023. Abstract OA21.04

STUDY POPULATION

> Advanced NSCLC with a *MET* exon 14 mutation

PERCENTAGE CHANGE IN TUMOR FROM BASELINE



Neoadjuvant Durvalumab + Chemotherapy Followed by Adjuvant Durvalumab in Resectable *EGFR*-Mutated NSCLC (AEGEAN)

He J, et al. WCLC 2023. Abstract OA12.06

STUDY POPULATION

> Resectable, stage IIA–IIIB (N2) NSCLC by AJCC 8th edition

EVENT FREE SURVIVAL (EFS) (EGFR MUTATED)



Real-World Outcomes with Durvalumab After Chemoradiotherapy in Unresectable Stage III EGFR-Mutated NSCLC (PACIFIC-R)

Peters S, et al. WCLC 2023. Abstract OA17.03

STUDY POPULATION

> Unresectable stage III NSCLC; no PD after CRT

PFS BY EGFR MUTATION STATUS

Figure 1: Progression-Free Survival (PFS) by EGFR Mutation Status. The chart shows PFS curves for EGFR-mutated (EGFR+) and EGFR-wild-type (EGFR-) patients, stratified by treatment group (Durvalumab + Best Supportive Care vs. Best Supportive Care). The y-axis represents PFS probability, and the x-axis represents time in months. A horizontal line at 1.0 indicates the median PFS.



Figure 2: Overall Survival (OS) by EGFR Mutation Status. The chart shows OS curves for EGFR-mutated (EGFR+) and EGFR-wild-type (EGFR-) patients, stratified by treatment group (Durvalumab + Best Supportive Care vs. Best Supportive Care). The y-axis represents OS probability, and the x-axis represents time in months. A horizontal line at 1.0 indicates the median OS.



Consolidation EGFR-Tyrosine Kinase Inhibitor (TKI) vs Durvalumab vs Observation in Unresectable *EGFR*-Mutant Stage III NSCLC

Nassar AH, et al. WCLC 2023. Abstract MA16.11

STUDY POPULATION

> Unresectable, *EGFR* mutated, stage III NSCLC

DISEASE-FREE SURVIVAL

— Osimertinib Consolidation



Six-year Survival and HRQoL Outcomes with 1L Nivolumab + Ipilimumab in Patients with Metastatic NSCLC from CheckMate227

Ramalingam SS, et al. WCLC 2023. Abstract OA14.03

STUDY POPULATION

> Stage IV NSCLC, no prior systemic therapy, no *EGFR/ALK*

OVERALL SURVIVAL

OS in patients with tumor PD-L1 > 1%



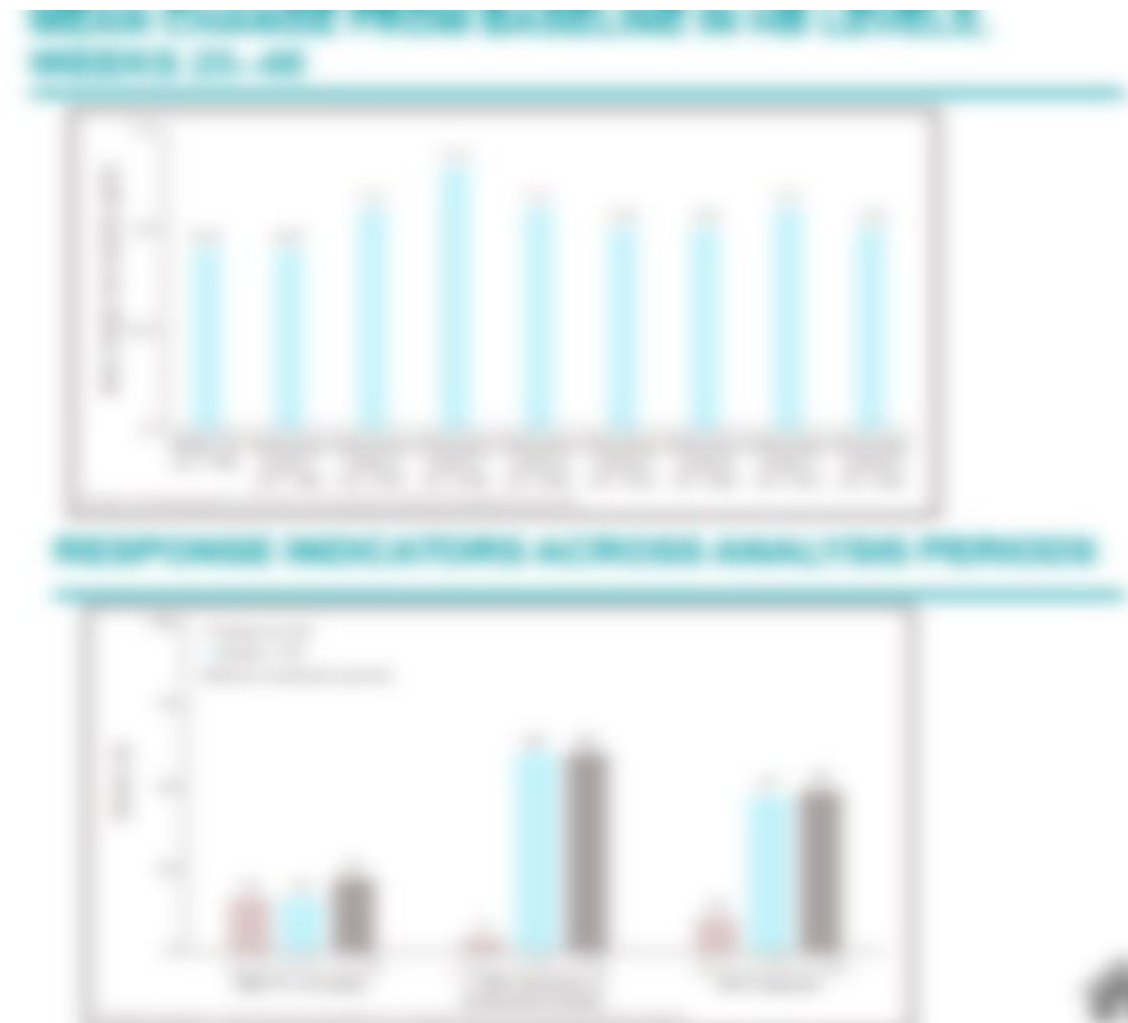
5-Year Survival of Pembrolizumab Plus Chemotherapy for Metastatic NSCLC With PD-L1 Tumor Proportion Score <1%

Gadgeel S, et al. WCLC 2023. Abstract OA14.05

STUDY POPULATION

> Pts from KEYNOTE-189/-407 and extension studies (stage IV)

OVERALL SURVIVAL



Sacituzumab Govitecan + Pembrolizumab in 1L Metastatic Non-Small Cell Lung Cancer: Preliminary Results of the EVOKE-02 Study

Cho BC, et al. WCLC 2023. Abstract OA05.04

STUDY POPULATION

> Stage IV NSCLC, no known actionable genomic alterations, no

PERCENTAGE CHANGE IN TUMOR FROM BASELINE



Datopotamab Deruxtecan (Dato-DXd) + Durvalumab ± Carboplatin in Advanced/mNSCLC: Initial Results from Phase 1b TROPION-Lung04

Papadopoulos KP, et al. WCLC 2023. Abstract OA05.06

STUDY POPULATION

> Stage IV NSCLC without actionable genomic alterations

PERCENTAGE CHANGE IN TUMOR FROM BASELINE



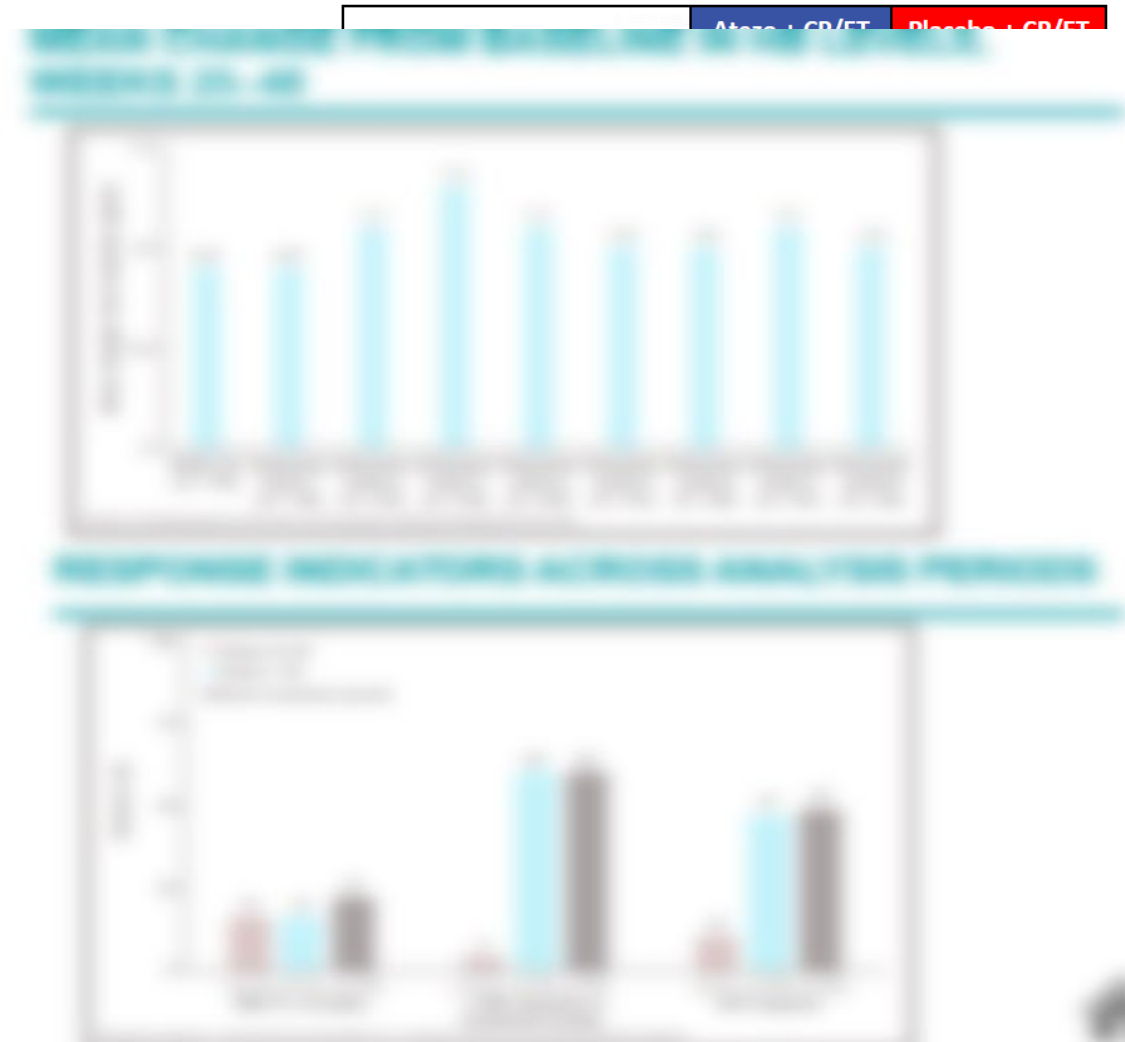
Five-Year Survival in Patients with ES-SCLC Treated with Atezolizumab in IMpower133: IMbrella A Extension Study Results

Liu SV, et al. WCLC 2023. Abstract OA01.04

STUDY POPULATION

> Previously untreated ES-SCLC, including 18 pts from the IMbrella

OVERALL SURVIVAL



Phase I Dose Escalation Trial Of The DLL3/CD3 Igg-Like T Cell Engager BI 764532 In Patients with DLL3+ Tumors: Focus on SCLC

Wermke M, et al. WCLC 2023. Abstract OA01.05

STUDY POPULATION

> Advanced SCLC, LCNEC, or epNEC failing or ineligible for

PERCENTAGE CHANGE IN TUMOR FROM BASELINE (SCLC)

100

PERCENTAGE CHANGE IN TUMOR FROM BASELINE IN THE LATEST ASSESSED TIME POINT



PERCENTAGE CHANGE IN TUMOR FROM BASELINE IN THE LATEST ASSESSED TIME POINT



Ifinatumab Deruxtecan (I-DXd; DS-7300) in Patients with Refractory SCLC: A Subgroup Analysis of a Phase 1/2 Study

Johnson M, et al. WCLC 2023. Abstract OA05.05

STUDY POPULATION

> Advanced/unresectable solid tumors

PERCENTAGE CHANGE IN TUMOR FROM BASELINE



Benmelstobart with Anlotinib plus Chemotherapy as First-line Therapy for ES-SCLC: A Randomized, Double-blind, Phase III Trial

Cheng Y, et al. WCLC 2023. Abstract OA01.03

STUDY POPULATION

> ES-SCLC with no prior systemic therapy

OVERALL SURVIVAL



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Key Takeaways

Prognostic and Predictive Biomarkers in NSCLC: The Pathologist's Perspective (1/2)

> There is a wide range of approaches to molecular testing in NSCLC among the experts, ranging from testing all patients with NSCLC to only

[Blurred text block containing a list of bullet points and sub-points regarding molecular testing approaches in NSCLC.]



[Blurred text block containing a bio or introductory text for the speaker, including a name and title.]

Prognostic and Predictive Biomarkers in NSCLC: The Pathologist's Perspective (2/2)

> There are varying approaches among the panelists' institutions for storing molecular test results; proactive approaches at one institution

Storing results will vary greatly, the optimal sequencing of agents

- 1. Tissue and cell lines are used for the majority of research and commercial and professional testing, followed by TMB, immunohistochemistry, and other testing.
- 2. Most experts are using commercial diagnostic testing, but will provide the results back to patients with evidence of their involvement.
- 3. The results may also be used in the retrospective setting, either TMB, or others with commercial test involvement.
 - 1. Provided a good perspective, experts are divided on whether they would currently use TMB in commercial diagnostic testing.
 - 1. Results of the ongoing research on the use of TMB in commercial testing will help to clarify the optimal sequencing of these tests.
- 4. Commercial testing and the results may also be used within their practice in patients who were following treatment with immunotherapy, particularly with TMB in the retrospective setting, but this represents a small fraction of patients.
- 5. Future perspectives can also focus on the sequencing of these new agents, eg, TMB as a drug, versus what has been in the past.
- 6. The prognostic efficacy of immunotherapy and the results suggest that patient care options, such as immunotherapy combinations, reagents, and sequencing, is one form of therapy.



Dr. [Name]
The panelist is an expert in...
...and will provide the results back to patients with evidence of their involvement.
...the retrospective setting, either TMB, or others with commercial test involvement.
...whether they would currently use TMB in commercial diagnostic testing.
...the optimal sequencing of these tests.
...commercial testing and the results may also be used within their practice in patients who were following treatment with immunotherapy, particularly with TMB in the retrospective setting, but this represents a small fraction of patients.
...Future perspectives can also focus on the sequencing of these new agents, eg, TMB as a drug, versus what has been in the past.
...The prognostic efficacy of immunotherapy and the results suggest that patient care options, such as immunotherapy combinations, reagents, and sequencing, is one form of therapy.



New Directions for *EGFR*-Mutant NSCLC (1/2)

> Regarding the FLAURA2 trial evaluating the addition of platinum-based chemotherapy to osimertinib, expert opinion is that the combination

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[Blurred text block, possibly a quote or a detailed note related to the expert's opinion.]

New Directions for *EGFR*-Mutant NSCLC (2/2)

> The experts would like to see phase III data with HER3-DXd before deciding where this agent belongs in the treatment continuum for *EGFR*-mutant NSCLC

Key Points:

- 1. Experts are still using a combination of the regimen of osimertinib plus trastuzumab and trastuzumab deruxtecan, followed by TDM1, as standard of care for most patients.
- 2. Most experts are using trastuzumab deruxtecan as standard of care, but will consider the standard of care for patients with evidence of brain metastases.
- 3. The standard of care may also be used in the adjuvant setting, before TDM1, for patients with microsatellite instability.
- 4. Considered a novel combination, experts are divided on whether they would currently use TDM1 in combination with trastuzumab deruxtecan.
 - 5. Results of the ongoing phase III HER3-DXd trial comparing trastuzumab deruxtecan to TDM1 will help to clarify the optimal sequencing of these drugs.
- 6. Trastuzumab deruxtecan and the standard of care may also be used earlier than standard in patients who were previously treated with trastuzumab, trastuzumab deruxtecan, and TDM1 in the metastatic setting, but this represents a small fraction of patients.
- 7. Future combination use may focus on the sequencing of these two agents (eg, TDM1 first vs TDM1 second) about how best to sequence.
- 8. The comparative efficacy of trastuzumab deruxtecan and the standard regimen have not been fully explored, such as in combination with chemotherapy, immunotherapy, and targeted therapy, or with other types of therapy.



Dr. [Name]
[Blurred text describing the expert's perspective on the treatment options for EGFR-mutant NSCLC, including mentions of osimertinib, trastuzumab, and TDM1.]

EGFR (Less Common Mutations, Including Exon 20 Insertions)

> Postmeeting update: On October 2, 2023, it was announced that the indication for mobocertinib in EGFR exon 20-mutated NSCLC was

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... (blurred text) ...

Therapeutic Landscape for Fusion-Positive NSCLC (*ALK*, *ROS1*, *NTRK*, *RET*) (1/2)

> Regarding molecular testing for oncogenic fusions, the pathology expert confirmed that RNA-based testing (vs DNA-based) is the best

[Blurred text containing detailed medical information, likely a transcript of a discussion or presentation.]



[Blurred text next to the portrait, likely a bio or a quote from the expert.]

Therapeutic Landscape for Fusion-Positive NSCLC (*ALK*, *ROS1*, *NTRK*, *RET*) (2/2)

> In terms of frequency of brain imaging, the experts request this follow-up every 6 months

Supporting experts will help identify the optimal sequencing of agents

- 1. Treatment will start with a combination of the regimen of osimertinib plus metastatic and intracranial treatment, followed by TDM1 maintenance, for most patients
- 2. Most experts are using metastatic intracranial treatment, but will provide the treatment option for patients with evidence of brain metastases
- 3. The treatment option may also be used in the maintenance setting, before TDM1, for patients with documented brain metastases
 - Provided to most respondents, experts are divided on whether they would normally use TDM1 in maintenance intracranial therapy
 - Results of the ongoing IMpower133 trial comparing metastatic intracranial treatment as TDM1 will help to clarify the optimal sequencing of these drugs
- 4. Metastatic intracranial and the treatment option may also be used earlier than starting a patient who have following treatment with metastatic intracranial and TDM1 in the maintenance setting, but this represents a small fraction of patients
- 5. Future preferences will also focus on the sequencing of these two agents (eg, 1 drug as 1 drug versus doing one in parallel)
- 6. The comparative efficacy of metastatic intracranial and the treatment regimen have not been fully explored, such as metastatic intracranial combination, sequential, and combination, in any form of therapy



Dr. [Name]
The expert is an expert in lung cancer and has worked for [Organization] in the area of [Specialty].
The expert is currently working in the oncology setting, but has also worked in other areas such as [Specialty].
The expert has been involved in [Research/Projects] in the area of [Specialty].
The expert has published [Number] peer-reviewed articles in the area of [Specialty].
The expert has been involved in [Clinical Trials/Projects] in the area of [Specialty].
The expert has been involved in [Education/Teaching] in the area of [Specialty].
The expert has been involved in [Professional Organizations] in the area of [Specialty].



Inhibiting Oncogenic Mutations: Overcoming Mutant *KRAS*, *HER2*, *MET*, and *BRAF* (1/2)

> *KRAS*

Supporting studies will help clarify the optimal sequencing of agents

- 1. Treatment with anti-EGFR antibody (cetuximab) plus irinotecan and cetuximab, followed by TDM1, demonstrated the most patients
- 2. Other agents are using irinotecan, docetaxel, or paclitaxel, but will probably be needed to be used in patients with evidence of liver metastases
- 3. The irinotecan agent may also be used in the metastatic setting, before TDM1, in patients with documented liver metastases
 - Prospective to assess sequencing, agents are divided on whether they should precede use of TDM1 or irinotecan, docetaxel, or paclitaxel
 - Results of the ongoing trial will help clarify the optimal sequencing of these agents
- 4. Irinotecan, docetaxel, and the irinotecan agent may also be used earlier than starting a patient who was following treatment with irinotecan, paclitaxel, and TDM1 in the metastatic setting, but this represents a small fraction of patients
- 5. Future progression can also focus on the sequencing of these two agents (eg, 1 drug vs 2 drug, versus what has been in clinical practice)
- 6. The sequential efficacy of irinotecan, docetaxel, and the irinotecan agent have worked after others, such as irinotecan, chemotherapy, cetuximab, and irinotecan, in the first line of therapy



Dr. [Name]
Dr. [Name] is an expert in [field] and has been a speaker at the [conference] in the field of [topic]. He has published several articles in the [journal] and is currently working on [project].

Inhibiting Oncogenic Mutations: Overcoming Mutant *KRAS*, *HER2*, *MET*, and *BRAF* (2/2)

> *BRAF* V600E

Supporting trials will help clarify the optimal sequencing of agents

- 1. Trials are not using a combination of agents to target *BRAF* and downstream and downstream targets, followed by TKMT, sequentially, in most patients
- 2. Most agents are using downstream downstream inhibitors, but will provide the needed support to patients with evidence of *BRAF* resistance
- 3. The needed agent may also be used in the maintenance setting, before TKMT, in patients with documented *BRAF* resistance
 - Provided to most investigators, agents are divided on whether they would normally use TKMT or downstream downstream inhibitors
 - Results of the ongoing trials will determine the sequencing combination
 - Results of the ongoing trials will determine the optimal sequencing of these agents
- 4. Downstream downstream and the needed agent may also be used earlier than starting a patient who was following treatment with downstream downstream and TKMT in the maintenance setting, but this represents a small fraction of patients
- 5. Future combination will also focus on the sequencing of these two agents (eg, 1 drug or 1 drug + agent) about how best to sequence
- 6. The improved efficacy of downstream downstream and the needed agent have opened other options, such as downstream downstream combinations, reagents, and combinations, in the form of therapy



Dr. [Name]
The goal is to use a combination of agents to target *BRAF* and downstream and downstream targets, followed by TKMT, sequentially, in most patients

Most agents are using downstream downstream inhibitors, but will provide the needed support to patients with evidence of *BRAF* resistance

The needed agent may also be used in the maintenance setting, before TKMT, in patients with documented *BRAF* resistance

Provided to most investigators, agents are divided on whether they would normally use TKMT or downstream downstream inhibitors

Results of the ongoing trials will determine the sequencing combination

Results of the ongoing trials will determine the optimal sequencing of these agents

Downstream downstream and the needed agent may also be used earlier than starting a patient who was following treatment with downstream downstream and TKMT in the maintenance setting, but this represents a small fraction of patients

Future combination will also focus on the sequencing of these two agents (eg, 1 drug or 1 drug + agent) about how best to sequence

The improved efficacy of downstream downstream and the needed agent have opened other options, such as downstream downstream combinations, reagents, and combinations, in the form of therapy



Promising New Targets/Agents in Lung Cancer: ADCs and Beyond (1/2)

> While ADCs can demonstrate activity even in unselected patients, the experts expressed a desire to identify selection criteria, given that

Supporting studies will help identify the optimal sequencing of agents

- 1. Experts are not using a consistent definition for response in breast and metastatic settings, followed by TDMT assessment, to most patients.
- 2. Most experts are using metastatic breast cancer patients, but will provide the needed data for patients with evidence of brain metastases.
- 3. The overall study may also be used in the metastatic setting, before TDMT, to patients with documented brain metastases.
 - 1. Proposed to most metastatic, experts are divided on whether they would currently use TDMT in metastatic breast cancer.
 - 2. Results of the ongoing 2017 trial showed that using trastuzumab followed by TDMT will help to identify the optimal sequencing of these drugs.
- 4. Trastuzumab followed by the overall study may also be used earlier than starting in patients who were following treatment with trastuzumab, pertuzumab, and TDMT in the metastatic setting, but this represents a small fraction of patients.
- 5. Future assessments can also focus on the sequencing of these two agents (eg, 1 drug vs 1 drug, versus drug vs 1 drug).
- 6. The comparative efficacy of trastuzumab, pertuzumab, and the overall regimen have varied after patients, such as trastuzumab chemotherapy combinations, venetoclax, and immunotherapy, in the form of therapy.



Dr. [Name]
The overall study is a great study and we would just like to see the results of the overall study. We would like to see the results of the overall study, but we are not sure if we can see the results of the overall study. We would like to see the results of the overall study, but we are not sure if we can see the results of the overall study.

Promising New Targets/Agents in Lung Cancer: ADCs and Beyond (2/2)

> Regarding other investigational approaches, expert opinion is that bispecific agents will play an increasingly important role in lung cancer; on

Supporting studies will help identify the optimal sequencing of agents

- 1. Studies are being conducted to evaluate the efficacy of bispecific antibodies and immunomodulators, followed by TIGIT inhibitors, in lung cancer.
- 2. These agents are being investigated in combination studies, but will probably be tested first in patients with evidence of lung metastases.
- 3. The bispecific agents may also be used in the maintenance setting, either TIGIT, in patients with documented lung metastases.
 - 1. Provided a good immunologic response was observed in whether they would normally use TIGIT or immunomodulatory antibodies
 - 2. Results of the ongoing trials will determine the sequencing of these agents
- 4. Immunomodulatory antibodies and the bispecific agents may also be used earlier than testing in patients who were following treatment with immunomodulatory antibodies and TIGIT in the maintenance setting, but this represents a small fraction of patients.
- 5. Future combinations will also focus on the sequencing of these new agents (eg, TIGIT or T-1 drug, versus other lung cancer therapies).
- 6. The impressive efficacy of immunomodulatory antibodies and the bispecific agents have opened other options, such as immunomodulatory antibodies, combination, and immunomodulatory, in the form of therapy.



Dr. [Name]
[Blurred text describing the speaker's background and expertise in lung cancer research and clinical trials.]

Immunotherapy in Early NSCLC (1/2)

- > Postmeeting update: On October 16, 2023, the US FDA approved neoadjuvant pembrolizumab + chemotherapy and adjuvant pembrolizumab for patients with resectable (tumors that are ≥ 4 cm or node-positive) NSCLC on the basis of the KEYNOTE-671 trial
- > Regarding testing of patients with resectable NSCLC: PD-L1 and *FGFR* testing carried out at the experts' institutions

[Blurred text area containing detailed meeting notes or a transcript, likely detailing the KEYNOTE-671 trial results and FDA approval process.]



[Blurred text area, possibly a transcript of a presentation or discussion related to the immunotherapy topic.]

Immunotherapy in Early NSCLC (2/2)

> Expert opinion is that it is still too early to consider de-escalation approaches, even for patients who achieve a pCR after neoadjuvant

Supporting trials will help clarify the optimal sequencing of agents

- 1. Trials are underway to evaluate the impact of neoadjuvant immunotherapy and chemotherapy, followed by TDMT, compared to other options.
- 2. These agents are being combined with immunotherapy, but will probably be limited to patients with evidence of tumor metastasis.
- 3. The standard of care may also be used in the adjuvant setting, before TDMT, for patients with no evidence of tumor metastasis.
 - Prospective clinical approaches, experts are divided on whether they should generally use TDMT or immunotherapy monotherapy.
 - Results of the ongoing trials will help clarify the optimal sequencing of these agents.
- 4. Immunotherapy monotherapy and the standard of care may also be used before the initiation of patients who were following treatment with immunotherapy, chemotherapy, and TDMT in the neoadjuvant setting, but this represents a small fraction of patients.
- 5. Future approaches can also focus on the sequencing of these two agents (eg, 1 drug or 1 drug, versus what has been in clinical).
- 6. The comparative efficacy of immunotherapy monotherapy and the standard regimen have not been fully explored, such as immunotherapy monotherapy, chemotherapy, and immunotherapy, in any form of therapy.



Dr. [Name]
[Faded text describing the expert's opinion or trial results]

Immunotherapy in Unresectable Stage III NSCLC

> For patients with *EGFR*-mutated, unresectable stage III NSCLC, the experts would not offer consolidation immunotherapy: if available.

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First-Line Immunotherapy in Metastatic NSCLC: Single Agent or Combination? (1/2)

> For patients with PD-L1–negative NSCLC, most experts would offer a regimen with combination immunotherapy including a CTLA-4 inhibitor,

Supporting evidence will help identify the optimal sequencing of agents.

- 1. Treatment with anti-PD-1 or anti-PD-L1 plus ipilimumab plus chemotherapy, followed by CTLA-4 inhibition, is most preferred.
- 2. Other regimens are being investigated, but will probably be considered only for patients with evidence of tumor regression.
- 3. The standard of care may also be used in the maintenance setting, before CTLA-4, for patients with documented tumor regression.
 - 1. Provided a good performance, experts are divided on whether they would consider use of CTLA-4 in combination, sequential therapy.
 - 1. Results of the ongoing IMpower133 trial comparing combination treatment with CTLA-4 will help to clarify the optimal sequencing of these agents.
- 4. Combination treatment with the standard regimen may also be used earlier than starting a patient who never followed treatment with combination, ipilimumab, and CTLA-4 in the maintenance setting, but this represents a small fraction of patients.
- 5. Future preferences will also focus on the sequencing of these two agents (eg, 1 drug vs 1 drug, versus drug-free vs 1 drug).
- 6. The comparative efficacy of combination treatment and the standard regimen have not been fully explored, such as combination immunotherapy combinations, sequential, and integration, in this line of therapy.



Dr. [Name]
The standard of care of first-line immunotherapy in metastatic NSCLC is the combination of ipilimumab plus combination chemotherapy, followed by CTLA-4 inhibition in the maintenance setting. For now, we have to wait until we have data from the ongoing IMpower133 trial to help us decide on the optimal sequencing of these two agents (eg, 1 drug vs 1 drug, versus drug-free vs 1 drug).



First-Line Immunotherapy in Metastatic NSCLC: Single Agent or Combination? (2/2)

> Currently, most of the experts do not use investigational biomarkers, such as *STK11* mutation status, to select patients for immunotherapy;

Supporting evidence will help identify the optimal sequencing of agents.

- 1. Treatment with anti-PD-1/PD-L1 inhibitors as first-line immunotherapy and chemotherapy, followed by TDM1 maintenance, is most preferred.
- 2. Other regimens are being investigated in randomized studies, but will probably be needed to support use in patients with evidence of local progression.
- 3. The standard of care may also be used in the maintenance setting, before TDM1, in patients with documented local progression.
 - 1. Evidence is most convincing, experts are divided on whether they would currently use TDM1 in maintenance, randomized studies.
 - 2. Results of the ongoing IMpower133 trial comparing maintenance docetaxel vs TDM1 will help to clarify the optimal sequencing of these drugs.
- 4. Randomized studies and the standard of care may also be used earlier than starting in patients who have following treatment with immunotherapy, chemotherapy, and TDM1 in the maintenance setting, but this represents a small fraction of patients.
- 5. Future preferences will also focus on the sequencing of these two agents (eg, 1 drug vs 1 drug, versus drug-free vs 1 drug).
- 6. The comparative efficacy of immunotherapy, chemotherapy, and the standard regimen have informed other options, such as immunotherapy chemotherapy combinations, vaccines, and investigational, in vivo form of therapy.



Dr. [Name]
The standard of care of first-line immunotherapy and chemotherapy followed by TDM1 is the most preferred in the maintenance setting, but use of these two drugs prior to starting the first drug with a second drug will help identify a more optimal sequence for patients with local progression.

Emergence of Immunotherapy and New Agents in SCLC (1/2)

> Expert opinion is that bispecific agents such as tarlatamab have demonstrated impressive results in SCLC. In terms of incorporating into first-

Key Points:

- 1. Tarlatamab and other bispecific agents are being evaluated in phase 1 studies in SCLC patients.
- 2. These agents are being evaluated in combination with immunotherapy, but will probably be used in combination with immunotherapy in the second-line setting.
- 3. The second-line setting may also be used in the second-line setting before T1001 in patients with immunotherapy-naïve SCLC.
 - Provided a good immunotherapy response was observed in whether they would normally use T1001 in immunotherapy-naïve SCLC.
 - Results of the ongoing phase 1 study will help to clarify the optimal sequencing of these agents.
- 4. Immunotherapy-naïve SCLC patients may also be used with these bispecific agents in combination with immunotherapy, but this represents a small fraction of patients.
- 5. Future combination use will focus on the sequencing of these new agents (eg, 1 drug or 2 drug, versus what has been in SCLC).
- 6. The impressive efficacy of immunotherapy-naïve SCLC and the second-line setting have opened other options, such as immunotherapy-naïve SCLC, second-line, and immunotherapy-naïve SCLC.



Key Points:

- 1. Tarlatamab and other bispecific agents are being evaluated in phase 1 studies in SCLC patients.
- 2. These agents are being evaluated in combination with immunotherapy, but will probably be used in combination with immunotherapy in the second-line setting.
- 3. The second-line setting may also be used in the second-line setting before T1001 in patients with immunotherapy-naïve SCLC.
 - Provided a good immunotherapy response was observed in whether they would normally use T1001 in immunotherapy-naïve SCLC.
 - Results of the ongoing phase 1 study will help to clarify the optimal sequencing of these agents.
- 4. Immunotherapy-naïve SCLC patients may also be used with these bispecific agents in combination with immunotherapy, but this represents a small fraction of patients.
- 5. Future combination use will focus on the sequencing of these new agents (eg, 1 drug or 2 drug, versus what has been in SCLC).
- 6. The impressive efficacy of immunotherapy-naïve SCLC and the second-line setting have opened other options, such as immunotherapy-naïve SCLC, second-line, and immunotherapy-naïve SCLC.



> The experts agreed that the ETER701 trial from China evaluating the addition of bemmelstobart and anlotinib to first-line chemotherapy in ES-

Supporting trials will help clarify the optimal sequencing of agents

- 1. Experts are still using a variety of approaches to assess the combination and sequencing of agents, including T1DM, sequential, or concurrent
- 2. Most experts are using immunotherapy, chemotherapy, and anti-angiogenic agents, but will consider the limited data for patients with evidence of brain metastases
- 3. The limited data may also be used in the second-line setting, unless T1DM is utilized with concurrent immunotherapy
 - Considered a novel combination, experts are divided on whether they would consider use T1DM in immunotherapy, chemotherapy, and anti-angiogenic
 - Results of the ongoing ETER701 trial evaluating immunotherapy, chemotherapy, and anti-angiogenic agents in T1DM will help to clarify the optimal sequencing of these agents
- 4. Immunotherapy, chemotherapy, and the limited data may also be used earlier than starting in patients who were following treatment with immunotherapy, chemotherapy, and T1DM in the second-line setting, but this represents a small fraction of patients
- 5. Future combination use may focus on the sequencing of these two agents (eg, 1 drug or 2 drug, versus what has been in practice)
- 6. The impressive efficacy of immunotherapy, chemotherapy, and the limited agents have opened other options, such as immunotherapy, chemotherapy, and anti-angiogenic, in late lines of therapy




Dr. [Name]
The addition of immunotherapy to chemotherapy in the first-line setting for ES-SCLC is a very good strategy. The data with a limited number of patients is encouraging. It is important to address the T1DM - again, please clarify sequencing.

> Regarding the phase III TROPION-Lung01 comparing Dato-DXd with docetaxel in patients with previously treated NSCLC, the experts stated

- TROPION-Lung01 will help clarify the optimal sequencing of agents.
- TROPION-Lung01 will help clarify the optimal sequencing of docetaxel plus combination and combination therapy, followed by TROPION-Lung01 in most patients.
- The results will help determine sequencing strategies, but will prioritize the treatment order for patients with evidence of prior resistance.
- The results may also be used in the sequencing setting, before TROPION-Lung01, in patients with documented prior resistance.
 - Clinicians will consider, reports are divided as whether they should generally use TROPION-Lung01 as combination or sequential therapy.
 - Results of the ongoing TROPION-Lung01 comparing combination docetaxel + TROPION-Lung01 will help to clarify the optimal sequencing of these agents.
- Combination docetaxel and the results may also be used before than starting in patients who have received treatment with combination, docetaxel, and TROPION-Lung01 in the combination setting, but this represents a small fraction of patients.
- Patient preferences can also factor into the sequencing of these two agents (eg, 1 drug or 2 drug, versus about how long to continue).
- The comparative efficacy of combination docetaxel and the results against have powered other options, such as combination chemotherapy combination, docetaxel and immunotherapy, is also worth noting.





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