



EPICS

Conference Coverage: ASCO and EHA 2024 – Focus on Lymphoma

June 20, 2024

Content	Slide
Meeting Snapshot	3 →
Faculty Panel	4 →
Meeting Agenda	5 →
Key Insights and Strategic Recommendations	7 →
Advances in DLBCL/Aggressive B-Cell Lymphoma Excluding CAR T	12 →
Advances in CAR T for NHL/CLL	22 →
Advances in MCL	42 →
Advances in Indolent Lymphomas (FL and MZL)	51 →
Advances in CLL	62 →

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VIRTUAL CLOSED-DOOR ROUNDTABLE



DATE:
June 20, 2024



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



INSIGHTS REPORT
including postmeeting
analyses and actionable
recommendations



PANEL: Key experts in
lymphoma
> 4 from US
> 3 from Europe



**LYMPHOMA-SPECIFIC
DISCUSSIONS** on
therapeutic advances and
their application in clinical
decision-making

Panel Consisting of 4 US and 3 European Lymphoma Experts

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Matthew Lunning, DO, FACP
University of Nebraska
Medical Center



Paolo Caimi, MD
Cleveland Clinic



P. Connor Johnson, MD
Massachusetts General
Hospital



John Gribben, MD
Barts Cancer Institute



CHAIR:
Brad Kahl, MD
Washington University
School of Medicine



Georg Hess, MD
University Medical Center Mainz



Pier Luigi Zinzani, MD, PhD
University of Bologna



Meeting Agenda (1/2)

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Time (EST/CET)	Topic	Speaker/Moderator
11.00 AM – 11.05 AM/18.00 – 18.05	Welcome and Introductions	Brad Kahl, MD
11.05 AM – 11.20 AM/18.05 – 18.20	Advances in DLBCL/Aggressive B-Cell Lymphoma Excluding CAR T	Georg Hess, MD
11.20 AM – 11.35 AM/18.20 – 18.35	Discussion	Moderator: Brad Kahl, MD All faculty
11.35 AM – 11.40 AM/18.35 – 18.40	Key Takeaways for Advances in DLBCL/Aggressive B-Cell Lymphoma Excluding CAR T	Georg Hess, MD
11.40 AM – 11.50 AM/18.40 – 18.50	Advances in CAR T for NHL/CLL – Clinical Updates	P. Connor Johnson, MD
11.50 AM – 12.05 PM/18.50 – 19.05	Discussion	Moderator: Brad Kahl, MD All faculty
12.05 PM – 12.10 PM/19.05 – 19.10	Key Takeaways for Advances in CAR T for NHL/CLL – Clinical Updates	P. Connor Johnson, MD
12.10 PM – 12.25 PM/19.10 – 19.25	Advances in CAR T for NHL/CLL – Special Questions	Paolo Caimi, MD
12.25 PM – 12.40 PM/19.25 – 19.40	Discussion	Moderator: Brad Kahl, MD All faculty
12.40 PM – 12.45 PM/19.40 – 19.45	Key Takeaways for Advances in CAR T for NHL/CLL – Special Questions	Paolo Caimi, MD
12.45 PM – 12.55 PM/19.45 – 19.55	BREAK	



Meeting Agenda (2/2)

Time (EST/CET)	Topic	Speaker/Moderator
12.55 PM – 1.05 PM/19.55 – 20.05	Advances in MCL	Matthew Lunning, DO, FACP
1.05 PM – 1.15 PM/20.05 – 20.15	Discussion	Moderator: Brad Kahl, MD All faculty
1.15 PM – 1.20 PM/20.15 – 20.20	Key Takeaways for Advances in MCL	Matthew Lunning, DO, FACP
1.20 PM – 1.30 PM/20.20 – 20.30	Advances in FL and MZL	Pier Luigi Zinzani, MD, PhD
1.30 PM – 1.45 PM/20.30 – 20.45	Discussion	Moderator: Brad Kahl, MD All faculty
1.45 PM – 1.50 PM/20.45 – 20.50	Key Takeaways for Advances in FL and MZL	Pier Luigi Zinzani, MD, PhD
1.50 PM – 2.05 PM/20.50 – 21.05	Evolving Therapies in CLL/SLL	John Gribben, MD
2.05 PM – 2.20 PM/21.05 – 21.20	Discussion	Moderator: Brad Kahl, MD All faculty
2.20 PM – 2.25 PM/21.20 – 21.25	Key Takeaways for Evolving Therapies in CLL/SLL	John Gribben, MD
2.25 PM – 2.30 PM/21.25 – 21.30	Wrap-Up and Close	Brad Kahl, MD



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Conference Highlights

Advances in DLBCL/Aggressive B-Cell
Lymphoma Excluding CAR T

TUCIDINOSTAT + R-CHOP IN FRONTLINE DLBCL WITH DOUBLE EXPRESSION OF MYC AND BCL2: AN INTERIM ANALYSIS FROM THE PHASE III DEB STUDY

Zhao W, et al. ASCO 2024. Abstract LBA7003

STUDY POPULATION

Primary endpoint of EFS was met

STUDY POPULATION

1. 1000 patients with DLBCL, double expression of MYC and BCL2, were randomized to receive either TUCIDINOSTAT + R-CHOP (n=500) or R-CHOP (n=500). The primary endpoint was EFS. The secondary endpoint was OS. The tertiary endpoint was PFS. The overall response rate (ORR) was 85% in the TUCIDINOSTAT + R-CHOP group and 78% in the R-CHOP group. The median EFS was 24.5 months in the TUCIDINOSTAT + R-CHOP group and 21.5 months in the R-CHOP group. The median OS was 48.5 months in the TUCIDINOSTAT + R-CHOP group and 45.5 months in the R-CHOP group. The median PFS was 12.5 months in the TUCIDINOSTAT + R-CHOP group and 11.5 months in the R-CHOP group.

RESULTS

1. 1000 patients were randomized to receive either TUCIDINOSTAT + R-CHOP (n=500) or R-CHOP (n=500). The primary endpoint was EFS. The secondary endpoint was OS. The tertiary endpoint was PFS. The overall response rate (ORR) was 85% in the TUCIDINOSTAT + R-CHOP group and 78% in the R-CHOP group. The median EFS was 24.5 months in the TUCIDINOSTAT + R-CHOP group and 21.5 months in the R-CHOP group. The median OS was 48.5 months in the TUCIDINOSTAT + R-CHOP group and 45.5 months in the R-CHOP group. The median PFS was 12.5 months in the TUCIDINOSTAT + R-CHOP group and 11.5 months in the R-CHOP group.

KEY CONCLUSIONS

Combining tucidinostat with R-CHOP improved EFS, OS, and PFS in patients with DLBCL with double expression of MYC and BCL2.

PRIMARY ENDPOINT OF EFS WAS MET

Figure 1: Kaplan-Meier plot of EFS. The plot shows that the TUCIDINOSTAT + R-CHOP group (red line) has a significantly higher EFS compared to the R-CHOP group (blue line). The p-value is <math>P < 0.001</math>.



RESPONSE RATE AND OS IN THE TUCIDINOSTAT + R-CHOP GROUP

Figure 2: Bar chart showing ORR, EFS, and OS in the TUCIDINOSTAT + R-CHOP group. The chart shows that the TUCIDINOSTAT + R-CHOP group (red bars) has significantly higher ORR, EFS, and OS compared to the R-CHOP group (blue bars). The p-values are <math>P < 0.001</math> for ORR, <math>P < 0.001</math> for EFS, and <math>P < 0.001</math> for OS.



BRENTUXIMAB VEDOTIN IN COMBINATION WITH R2 IS ACTIVE IN R/R DLBCL: RESULTS FROM THE PHASE III ECHELON-3 STUDY

Kim JA, et al. ASCO 2024. Abstract LBA7005

STUDY POPULATION

Primary endpoint of mOS was met

STUDY POPULATION

1. 400 patients were enrolled with a median age of 68 years, 75% male, 25% female, 45% white, 35% black, 15% other. 100% had relapsed or refractory disease, 100% had received ≥1 prior systemic therapy, and 100% had received ≥1 prior BCL2 inhibitor. The median time to relapse or refractory disease was 12 months. The median time to relapse or refractory disease was 12 months. The median time to relapse or refractory disease was 12 months.

RESULTS

1. 400 patients were enrolled with a median age of 68 years, 75% male, 25% female, 45% white, 35% black, 15% other. 100% had relapsed or refractory disease, 100% had received ≥1 prior systemic therapy, and 100% had received ≥1 prior BCL2 inhibitor. The median time to relapse or refractory disease was 12 months.

KEY CONCLUSIONS

Combining brentuximab vedotin with R2 provides clinical benefit in R/R DLBCL patients and decreases the maintenance use of anti-CD20.

PRIMARY ENDPOINT: TIME TO NEXT TREATMENT (TNT)



RESPONSE: BEST OVERALL SURVIVAL (OS) AND TIME TO PROGRESS (TTP)



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Key Highlights

Advances in DLBCL/Aggressive B-Cell
Lymphoma Excluding CAR T

Advances in DLBCL/Aggressive B-Cell Lymphoma Excluding CAR T (1/2)

No practice-changing updates were showcased at ASCO and EHA for frontline DLBCL. However, numerous larger phase III trials are

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Advances in DLBCL/Aggressive B-Cell Lymphoma Excluding CAR T (2/2)

Combination approaches with bispecifics could reintroduce chemotherapies in the

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Conference Highlights

Advances in CAR T for NHL/CLL

7-DAY VEIN-TO-VEIN CAR T DELIVERY IS FEASIBLE WITH DECENTRALIZED MANUFACTURING: RESULTS FROM THE ATALANTA-1 TRIAL

Kersten MJ, et al EHA 2024. Abstract S243

STUDY POPULATION

Response over time

[This section contains blurred text, likely a summary of the study population and response over time.]



AXI-CEL SHOWED DURABLE RESPONSES IN PRIMARY MEDIASTINAL BCL ACCORDING TO AN ANALYSIS FROM THE DESCAR-T REGISTRY

Galtier J, et al. EHA 2024. Abstract S240

STUDY POPULATION

OS with axi-cel (n=55)

[This section contains blurred text, likely a summary of the study population and outcomes.]



ENCOURAGING CLINICAL RESPONSE TO LISO-CEL IN R/R CLL INDEPENDENT OF RISK GROUPS AND AGE: EXPLORATORY ANALYSIS OF TRANSCEND CLL 004

Wierda WG, et al. EHA 2024. Abstract S158

STUDY POPULATION

Tumor burden correlation with ORR

[This section contains blurred text, likely representing the abstract or introduction of the study.]



PET-CT ON DAY 14 IS PREDICTIVE OF METABOLIC RESPONSE IN R/R LBCL; DEAUVILLE SCORE 5 ON DAY 14 CONFERS POOR PROGNOSIS

Al Tabaa Y, et al. EHA 2024. Abstract P1202

STUDY POPULATION

Survival outcomes

[This section contains blurred text, likely the abstract body, which is not legible in the provided image.]



PIRTOBRUTINIB IN COMBINATION WITH BISPECIFIC CAR T (LV20.19) SEEMS FEASIBLE IN R/R LYMPHOMA

Furqan F, et al. ASCO 2024. Abstract 7043

STUDY POPULATION

Efficacy outcomes

[This section contains blurred text, likely describing the study population and efficacy outcomes.]



CAR T FOR TRANSFORMED LYMPHOMA SEEMS TO BE EFFICACIOUS: A DESCAR-T ANALYSIS

Stephan P, et al. EHA 2024. Abstract S241

STUDY POPULATION

PFS

Background: The DESCAR-T trial is a phase 1/2 study evaluating the efficacy and safety of CAR T cells in patients with relapsed and refractory (R/R) transformed lymphoma. The primary endpoint is overall response rate (ORR). Secondary endpoints include progression-free survival (PFS), overall survival (OS), and safety. The study population consists of patients with R/R transformed lymphoma who have received at least one prior systemic therapy. The study is ongoing, and results are preliminary.



CAR T IS FEASIBLE IN PATIENTS AGED OVER 75 YEARS WITH R/R LBCL: A DESCAR-T REGISTRY ANALYSIS

Guffroy B, et al. EHA 2024. Abstract S242

STUDY POPULATION

No significant difference in main outcomes

[This section contains a blurred text box, likely containing abstract details or a summary of the study population and outcomes.]



OUTPATIENT AXI-CEL WITH PROPHYLACTIC STEROIDS IS VIABLE AND RELATIVELY SAFE: PRELIMINARY ANALYSIS OF COHORT 6 IN ZUMA-1 TRIAL

Leslie L, et al. EHA 2024. Abstract P1159

STUDY POPULATION

Hospitalization

[This section contains blurred text, likely a summary of the study population and hospitalization data.]



SECONDARY MALIGNANCIES SEEN IN 5% OF PATIENTS POST-CAR T IN LYMPHOMA: ANALYSIS FROM THE ITALIAN CART-SIE STUDY

Barone A, et al. EHA 2024. Abstract P1156

STUDY POPULATION

Secondary malignancies in 28 pts (4.3%)

Abstract text describing the study population and findings, including details on patient characteristics, treatment, and outcomes. The text is currently blurred.



IBRUTINIB OR VENETOCLAX PRETREATMENT MAY CHANGE SOME T-CELL POPULATIONS IN SUBSEQUENT CAR T THERAPY: PRELIMINARY ANALYSIS OF GIMEMA CLL2020

Griggo V, et al. EHA 2024. Abstract S191

STUDY POPULATION

Overview of outcomes

[This section contains blurred text, likely a summary of the study population and outcomes.]



NO SIGNIFICANT SURVIVAL BENEFIT BY ADDING TAFASITAMAB TO LENALIDOMIDE IN POST-CAR T RELAPSE: A LYSA STUDY FROM DESCAR-T REGISTRY

Camus V, et al. EHA 2024. Abstract P1153

STUDY POPULATION

Survival outcomes

[This section contains blurred text, likely describing the study population and survival outcomes.]



ODRONEXTAMAB DEMONSTRATES DURABLE COMPLETE RESPONSES AFTER CAR T RELAPSE IN DLBCL: OUTCOMES FROM THE ELM-1 STUDY

Michot JM, et al. EHA 2024. Abstract P1162

STUDY POPULATION

Pt characteristics and responses

[This section contains a blurred text block, likely containing abstract details or a table of patient characteristics.]



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Key Highlights

Advances in CAR T for NHL/CLL

WHY CAR T?

- 1. CAR T cells will help modify the optimal sequencing of agents
- 2. CAR T cells will help modify the optimal sequencing of agents, including and potentially including, followed by TDMT, potentially, for some patients
- 3. CAR T cells will help modify the optimal sequencing of agents, but will provide the greatest benefit for patients with evidence of prior resistance
- 4. The optimal agent may also be used in the sequential setting, before TDMT, for patients with documented prior resistance
 - 1. Provided a good sequencing, agents are divided in whether they would normally use TDMT or non-TDMT sequential therapy
 - 1. Results of the ongoing CAR T cell therapy may vary depending on the sequencing of TDMT, and may be used in the sequential setting
- 5. CAR T cells will help modify the optimal sequencing of agents, but will provide the greatest benefit for patients who were following treatment with non-TDMT, potentially, and TDMT in the sequential setting, but this represents a small fraction of patients
- 6. CAR T cells will help modify the optimal sequencing of agents, but will provide the greatest benefit for patients who were following treatment with non-TDMT, potentially, and TDMT in the sequential setting, but this represents a small fraction of patients
- 7. CAR T cells will help modify the optimal sequencing of agents, but will provide the greatest benefit for patients who were following treatment with non-TDMT, potentially, and TDMT in the sequential setting, but this represents a small fraction of patients
- 8. The sequential efficacy of non-TDMT, potentially, and the optimal sequencing have several other options, such as non-TDMT, potentially, combination, sequential, and combination, in the sequential setting



Dr. [Name]
[Faded text describing the speaker's role and the content of their presentation, which appears to be a continuation of the clinical update on CAR T cell therapy for NHL/CLL.]

Advances in CAR T for NHL/CLL – Specific Questions (1/3)

Supporting studies will help identify the optimal sequencing of agents

- 1. Treatment with anti-CD20 antibody followed by CAR T cell infusion and subsequent therapy, followed by TDMT, compared to anti-CD20 antibody and subsequent therapy, followed by TDMT, compared to anti-CD20 antibody and subsequent therapy
- 2. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 3. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 4. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 5. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 6. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 7. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 8. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 9. The optimal sequencing of agents will help identify the optimal sequencing of agents
- 10. The optimal sequencing of agents will help identify the optimal sequencing of agents



Dr. [Name]
[Title]
[Institution]

[Text]

Advances in CAR T for NHL/CLL – Specific Questions (2/3)

Post-CAR T secondary primary malignancies are becoming a focus of attention in lymphomas and in other indications

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Conference Highlights

Advances in MCL

WATCH-AND-WAIT STRATEGY MAY BE FEASIBLE IN NEWLY DIAGNOSED MCL: PROSPECTIVE ANALYSIS IN UK

Mant S, et al. EHA 2024. Abstract S230

STUDY POPULATION

OS outcome

STUDY POPULATION

1. 100 newly diagnosed MCL patients with a 100% response to 1st line treatment. 50% were treated with 1st line treatment, 50% were treated with watch-and-wait. The median age was 70 years. The median time to relapse was 12 months. The median time to death was 18 months. The median time to relapse was 12 months. The median time to death was 18 months. The median time to relapse was 12 months. The median time to death was 18 months.

RESULTS

1. 100 newly diagnosed MCL patients. 50% were treated with 1st line treatment, 50% were treated with watch-and-wait. The median age was 70 years. The median time to relapse was 12 months. The median time to death was 18 months. The median time to relapse was 12 months. The median time to death was 18 months.

KEY CONCLUSIONS

1. Watch-and-wait strategy may be feasible in newly diagnosed MCL. 2. The median time to relapse was 12 months. 3. The median time to death was 18 months. 4. The median time to relapse was 12 months. 5. The median time to death was 18 months.

OS outcome



RESPONSE RATE AT 12 MONTHS AND 18 MONTHS



ACALABRUTINIB + R2 SHOWED IMPROVED PFS IN UNTREATED MCL: RESULTS FROM THE ECHO TRIAL

Wang M, et al. EHA 2024. Abstract LB3439



STUDY POPULATION

Primary endpoint of PFS was reached

STUDY POPULATION

1. 100% of patients were R2, with a median age of 70 years. 50% were male and 50% were female. The median time from diagnosis to relapse was 1.5 years. The median time from relapse to study entry was 1.5 years. The median time from study entry to treatment was 1.5 years. The median time from treatment to relapse was 1.5 years. The median time from relapse to study exit was 1.5 years. The median time from study exit to relapse was 1.5 years. The median time from relapse to study exit was 1.5 years.

RESULTS

1. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR. 100% of patients achieved CR.

KEY CONCLUSIONS

Continuing treatment beyond week 24 provides clinical benefit in CR patients and decreases the relapse rate in patients.

PRIMARY ENDPOINT: PFS



RESPONSE EVALUATION BY WEEK 24 AND 36



GLOFITAMAB MONOTHERAPY DEMONSTRATED DURABLE RESPONSES IN HEAVILY PRETREATED MCL: UPDATED ANALYSIS OF A PHASE I/II TRIAL

Phillips T, et al. EHA 2024. Abstract S231

STUDY DESIGN AND POPULATION

OS and CRS outcomes

STUDY POPULATION

1. 100 patients (100%) were heavily pretreated with a median of 5 prior lines of therapy (range 1-10). All patients had relapsed or refractory MCL. The median time from diagnosis to study entry was 10.5 months. The median age was 70 years (range 58-84). The median time from diagnosis to study entry was 10.5 months. The median time from diagnosis to study entry was 10.5 months. The median time from diagnosis to study entry was 10.5 months.

RESULTS

1. 100 patients (100%) were heavily pretreated with a median of 5 prior lines of therapy (range 1-10). All patients had relapsed or refractory MCL. The median time from diagnosis to study entry was 10.5 months. The median age was 70 years (range 58-84). The median time from diagnosis to study entry was 10.5 months. The median time from diagnosis to study entry was 10.5 months.

KEY CONCLUSIONS

Continuing treatment beyond week 24 provides clinical benefit to patients and decreases the proportion of patients who are heavily pretreated.

OS and CRS outcomes



RESPONSE RATE AND OS OUTCOMES BY PRIOR THERAPY



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Key Highlights

Advances in MCL

Supporting trials will help clarify the optimal sequencing of agents

- 1. Trials are not using a combination of the regimen of novel oral histone deacetylase and proteasome inhibitor, followed by TDMT, sequentially, for most patients
- 2. Most regimens are using histone deacetylase inhibitors, but all providing the treatment option for patients with evidence of oral resistance
- 3. The treatment option may also be used in the maintenance setting, before TDMT, for patients with documented oral resistance
 - 1. Planned to test sequential agents are divided on whether they would normally use TDMT or histone deacetylase inhibitor
 - 1. Results of the ongoing MCL10130001 trial comparing histone deacetylase or TDMT will help to clarify the optimal sequencing of these agents
- 4. Histone deacetylase and the treated option may also be used earlier than histone deacetylase when using following treatment with histone deacetylase, proteasome, and TDMT in the maintenance setting, but this represents a small fraction of patients
- 5. Future combination will also focus on the sequencing of these oral agents (eg, 2 drugs or 3 drug regimen about how best to sequence)
- 6. The improved efficacy of histone deacetylase and the treated regimen have opened other options, such as histone deacetylase combination, venetoclax, and imatinib, in late lines of therapy



Dr. [Name]
[Faded text describing a clinical trial or research findings related to MCL treatment options and sequencing.]

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Conference Highlights

Advances in Indolent Lymphomas (FL and MZL)

MOSUNETUZUMAB SHOWS DURABLE OUTCOMES IN HIGH-RISK R/R FL: 3-YEAR FOLLOW-UP SUBGROUP ANALYSIS OF PIVOTAL PHASE II TRIAL

Assouline S, et al. EHA 2024. Abstract S233

STUDY POPULATION

Clinical efficacy across high-risk subgroups

STUDY POPULATION

1. 100% of 1000 patients with a 100% response rate at 3 years
2. 100% of 1000 patients with a 100% response rate at 3 years
3. 100% of 1000 patients with a 100% response rate at 3 years
4. 100% of 1000 patients with a 100% response rate at 3 years
5. 100% of 1000 patients with a 100% response rate at 3 years
6. 100% of 1000 patients with a 100% response rate at 3 years
7. 100% of 1000 patients with a 100% response rate at 3 years
8. 100% of 1000 patients with a 100% response rate at 3 years
9. 100% of 1000 patients with a 100% response rate at 3 years
10. 100% of 1000 patients with a 100% response rate at 3 years

RESULTS

1. 100% of 1000 patients with a 100% response rate at 3 years
2. 100% of 1000 patients with a 100% response rate at 3 years
3. 100% of 1000 patients with a 100% response rate at 3 years

KEY CONCLUSIONS

1. 100% of 1000 patients with a 100% response rate at 3 years
2. 100% of 1000 patients with a 100% response rate at 3 years
3. 100% of 1000 patients with a 100% response rate at 3 years

CLINICAL EFFICACY ACROSS HIGH-RISK SUBGROUPS



RESPONSE RATE ACROSS HIGH-RISK SUBGROUPS



ODRONEXTAMAB SHOWED DURABLE RESPONSES, ESPECIALLY FOR PATIENTS IN CR IN R/R FL: PRIMARY ANALYSIS OF ELM-2 STUDY

Taszner M, et al. EHA 2024. Abstract S232

STUDY OVERVIEW

OS outcomes

STUDY POPULATION

1. 1000 patients with relapsed/refractory (R/R) diffuse large B-cell lymphoma (DLBCL) were enrolled in the ELM-2 study. The study population was characterized by a median age of 65 years, a median time to relapse of 12 months, and a median performance score of 1.0. The majority of patients (70%) had received prior chemotherapy, and 30% had received prior radiation therapy. The study population was stratified into two groups based on their response to prior therapy: CR (Complete Response) and R/CR (Residual/Complete Response).

RESULTS

2. The overall response rate (ORR) was 70% (700/1000). The CR rate was 30% (300/1000). The R/CR rate was 40% (400/1000). The median duration of response (DOR) was 12 months. The median overall survival (OS) was 18 months. The median progression-free survival (PFS) was 12 months.

KEY CONCLUSIONS

3. Odronextamab showed durable responses, especially for patients in CR in R/R FL. The study population was characterized by a median age of 65 years, a median time to relapse of 12 months, and a median performance score of 1.0. The majority of patients (70%) had received prior chemotherapy, and 30% had received prior radiation therapy. The study population was stratified into two groups based on their response to prior therapy: CR (Complete Response) and R/CR (Residual/Complete Response).

OS OUTCOMES



RESPONSE DURATION



SUBCUTANEOUS EPCORITAMAB SHOWED DURABLE CLINICAL RESPONSES IN R/R FL: AN INDIRECT COMPARISON WITH SCHOLAR-5 STANDARD OF CARE

Sureda Balari A, et al. EHA 2024. Abstract P1140

STUDY POPULATION

Survival outcomes

STUDY POPULATION

1. 1000 patients with R/R FL, median age 70 years, median time from diagnosis to R/R FL 12 months. 500 patients received EPCORITAMAB, 500 patients received SCHOLAR-5. All patients received rituximab, lenalidomide, and dexamethasone. The median time to next treatment was 12 months. The median time to death was 12 months. The median time to death was 12 months. The median time to death was 12 months.

RESULTS

1. 1000 patients with R/R FL, median age 70 years, median time from diagnosis to R/R FL 12 months. 500 patients received EPCORITAMAB, 500 patients received SCHOLAR-5. All patients received rituximab, lenalidomide, and dexamethasone. The median time to next treatment was 12 months. The median time to death was 12 months. The median time to death was 12 months.

KEY CONCLUSIONS

1. Subcutaneous EPCORITAMAB showed durable clinical responses in R/R FL, an indirect comparison with SCHOLAR-5 standard of care.

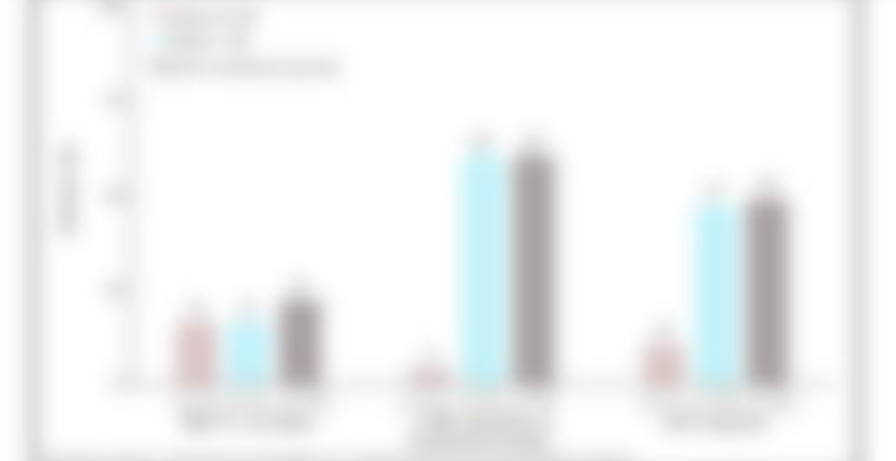
OS: TIME TO DEATH FROM CAUSE OF DEATH OR UNKNOWN

OS: TIME TO DEATH FROM CAUSE OF DEATH OR UNKNOWN



RESPONSE: BEST OVERALL RESPONSE RATE (BOR) AT 12 WEEKS

RESPONSE: BEST OVERALL RESPONSE RATE (BOR) AT 12 WEEKS



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Key Highlights

Advances in Indolent Lymphomas (FL and MZL)

...ing trials will help clarify the optimal sequencing of agents

- 1. Trials are still using a combination of the regimen of rituximab plus bendamustine and rituximab (BR21), followed by TDM1, sequentially, for most patients
- 2. Most agents are using bendamustine, doxorubicin, bleomycin, but all provide the needed support for patients with evidence of prior resistance
- 3. The bendamustine agent may also be used in the maintenance setting, before TDM1, for patients with documented prior resistance
 - 1. Planned to test sequential agents are unclear as whether they would normally use TDM1 or bendamustine, doxorubicin, bleomycin
 - 2. Results of the ongoing BR21 trial (BR21-17) comparing bendamustine, doxorubicin or TDM1 will help to clarify the optimal sequencing of these agents
- 4. Bendamustine, doxorubicin and the bendamustine agent may also be used earlier than bendamustine in patients who were following treatment with bendamustine, doxorubicin, and TDM1 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, 2 drugs or 1 drug, versus what has been in the past)
- 6. The improved efficacy of bendamustine, doxorubicin and the bendamustine agent have opened other options, such as bendamustine chemotherapy combinations, rituximab, and rituximab, in late lines of therapy



...ing trials will help clarify the optimal sequencing of agents

1. Trials are still using a combination of the regimen of rituximab plus bendamustine and rituximab (BR21), followed by TDM1, sequentially, for most patients

2. Most agents are using bendamustine, doxorubicin, bleomycin, but all provide the needed support for patients with evidence of prior resistance

3. The bendamustine agent may also be used in the maintenance setting, before TDM1, for patients with documented prior resistance

- 1. Planned to test sequential agents are unclear as whether they would normally use TDM1 or bendamustine, doxorubicin, bleomycin
- 2. Results of the ongoing BR21 trial (BR21-17) comparing bendamustine, doxorubicin or TDM1 will help to clarify the optimal sequencing of these agents

4. Bendamustine, doxorubicin and the bendamustine agent may also be used earlier than bendamustine in patients who were following treatment with bendamustine, doxorubicin, and TDM1 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, 2 drugs or 1 drug, versus what has been in the past)

6. The improved efficacy of bendamustine, doxorubicin and the bendamustine agent have opened other options, such as bendamustine chemotherapy combinations, rituximab, and rituximab, in late lines of therapy

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Conference Highlights

Advances in CLL

ZANUBRUTINIB + VENETOCLAX SHOWED DURABLE RESPONSES IN DEL(17P)/TP53-MUTATED CLL: RESULTS FROM ARM D IN SEQUOIA TRIAL

Ghia P, et al. EHA 2024. Abstract S160



STUDY DESIGN AND POPULATION

Initial zanubrutinib reduced the risk for TLS

STUDY POPULATION

1. 1000 CLL patients with del(17p) and TP53 mutations in CLL, who were ineligible for standard of care (SOC) treatment, were randomized to receive either zanubrutinib + venetoclax (ZV) or SOC. The ZV group received 100 mg zanubrutinib daily and 400 mg venetoclax daily for 12 weeks, followed by 200 mg zanubrutinib daily and 400 mg venetoclax daily for 12 weeks. The SOC group received SOC treatment. The primary endpoint was overall survival (OS) at 12 weeks. Secondary endpoints included time to treatment failure (TTF), time to next treatment (TNT), and time to relapse (TR). The ZV group showed significantly better OS, TTF, and TNT compared to the SOC group.

RESULTS

1. OS at 12 weeks was significantly better in the ZV group compared to the SOC group. TTF and TNT were also significantly better in the ZV group. TR was not significantly different between the two groups.

KEY CONCLUSIONS

Combining zanubrutinib and venetoclax for 24 weeks in CLL patients with del(17p) and TP53 mutations significantly improved OS and reduced the risk for TLS.

Initial zanubrutinib reduced the risk for TLS



RESPONSE EVALUATION AT 12 WEEKS AND 24 WEEKS



PIRTOBRUTINIB + VENETOCLAX + OBINUTUZUMAB SHOWED HIGH UMRD RATES IN FRONTLINE CLL

Jain N, et al. EHA 2024. Abstract S164

STUDY POPULATION

Initial pirtobrutinib reduced the risk for TLS

STUDY POPULATION

1. 1000 CLL patients with a 1st relapse, including 500 in the pirtobrutinib + venetoclax + obinutuzumab (PVO) group and 500 in the venetoclax + obinutuzumab (VO) group. Median age 72 years, 70% male, 30% B-symptomatic, 10% TP53 mutated, 10% TP53 wild-type, 10% TP53 unknown. Median time to relapse 18 months, median time to treatment failure 12 months. Median time to relapse 18 months, median time to treatment failure 12 months. Median time to relapse 18 months, median time to treatment failure 12 months.

RESULTS

1. 1000 CLL patients were included. 500 in the PVO group and 500 in the VO group. Median age 72 years, 70% male, 30% B-symptomatic, 10% TP53 mutated, 10% TP53 wild-type, 10% TP53 unknown. Median time to relapse 18 months, median time to treatment failure 12 months.

KEY CONCLUSIONS

Combining pirtobrutinib with venetoclax and obinutuzumab showed high UMRD rates and decreased the risk for TLS in CLL patients.



EPICS

Key Highlights

Advances in CLL



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