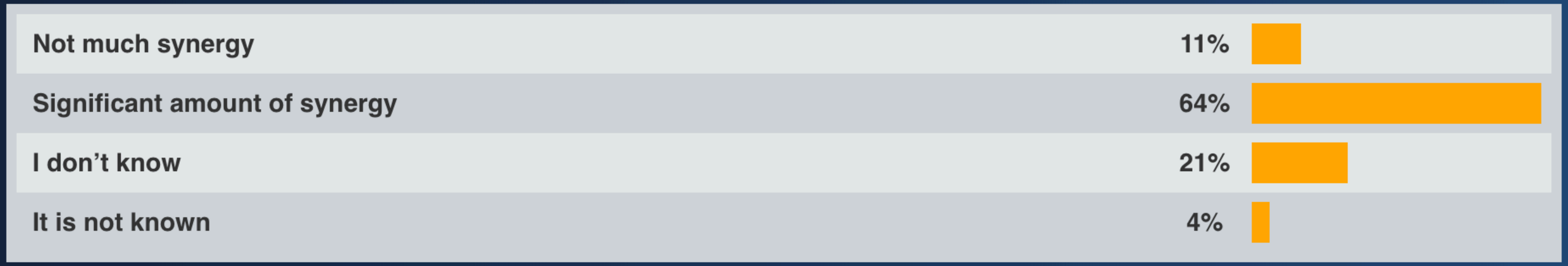
To what extent do you believe the benefits observed with durvalumab in the PACIFIC trial reflect some type of synergy with chemoradiation therapy?

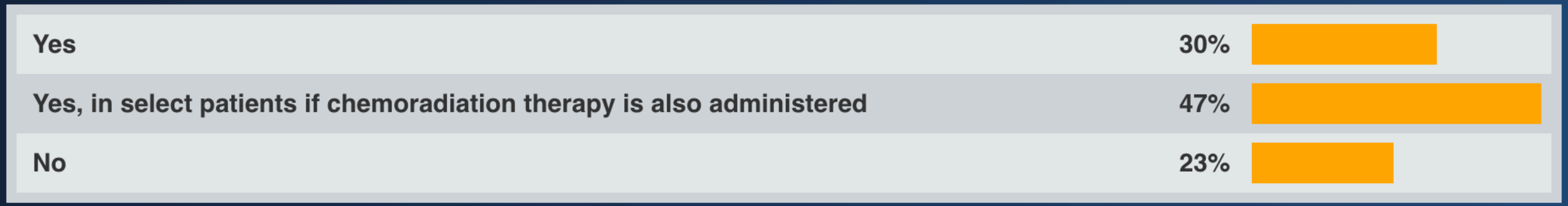


The PACIFIC trial evaluating consolidation durvalumab in unresectable Stage III non-small cell lung cancer (NSCLC) is the first randomized Phase III data set supporting the use of adjuvant/consolidation (micrometastatic) checkpoint inhibitor therapy in a solid tumor.

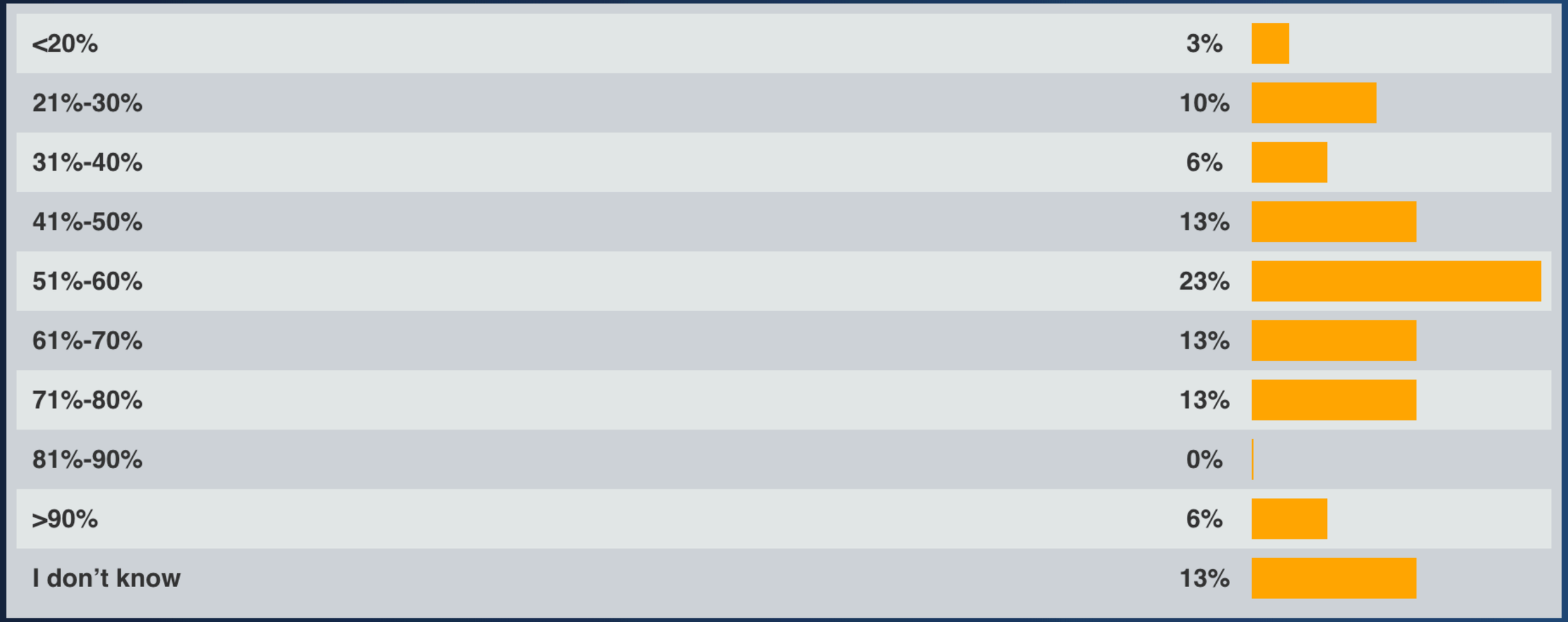
Should durvalumab generally be recommended as consolidation treatment after chemoradiation therapy for unresectable Stage IIIA and IIIB NSCLC?

Should durvalumab be recommended as consolidation treatment for an older, frail patient who is unable to tolerate chemotherapy and receives radiation therapy only for unresectable Stage III NSCLC?

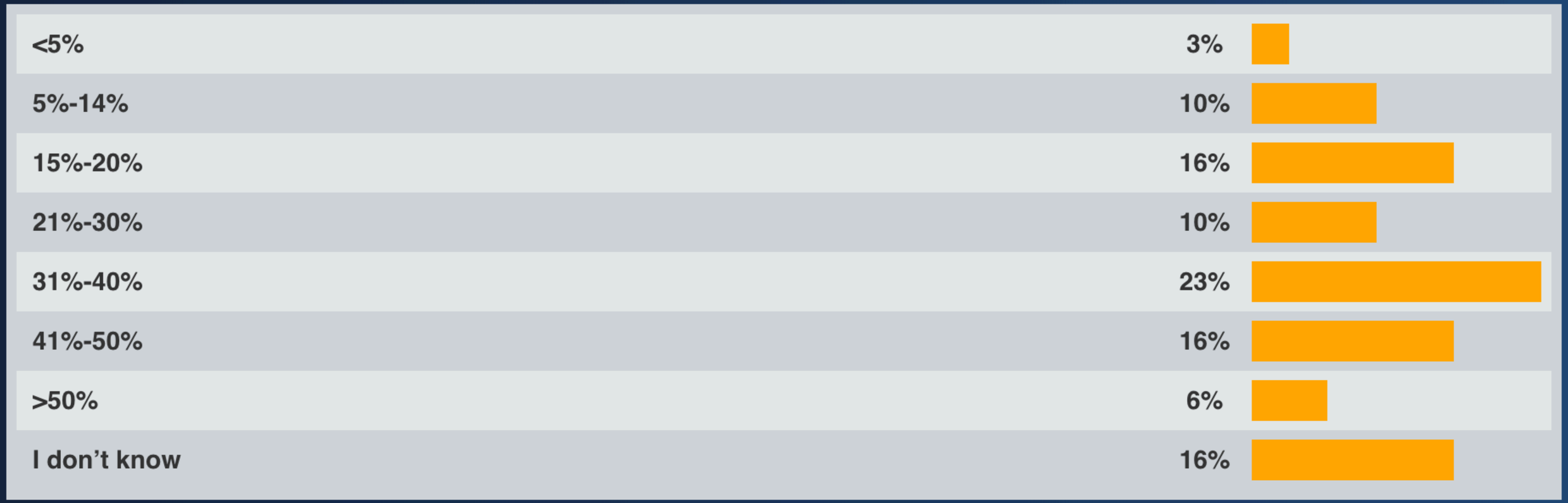
Should durvalumab be recommended as consolidation treatment for a patient with locally advanced NSCLC who underwent surgical excision as part of initial treatment?



A 70-year-old former smoker is about to undergo chemoradiation therapy for Stage III NSCLC. The patient has asked you to estimate the chances that he or she will experience disease progression within 18 months with no further treatment beyond chemoradiation therapy. How would you respond?

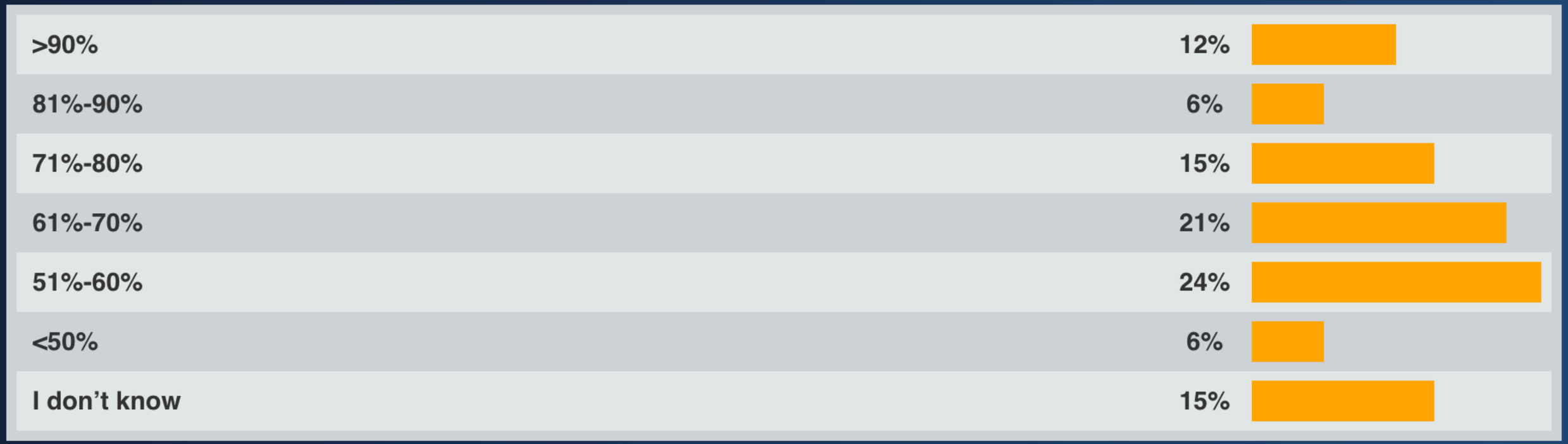


If the patient in the previous scenario received consolidation durvalumab, what would you estimate to be the absolute reduction in the risk that he or she will experience disease progression within 18 months compared to chemoradiation therapy alone?



What do you believe is the optimal duration of consolidation durvalumab for a patient with locally advanced NSCLC who is responding and tolerating therapy well?

Based on data from the PACIFIC trial, what would you estimate to be the likelihood that a patient who is started on durvalumab consolidation for unresectable locally advanced NSCLC will be able to complete 1 year of therapy, assuming there is no recurrence?



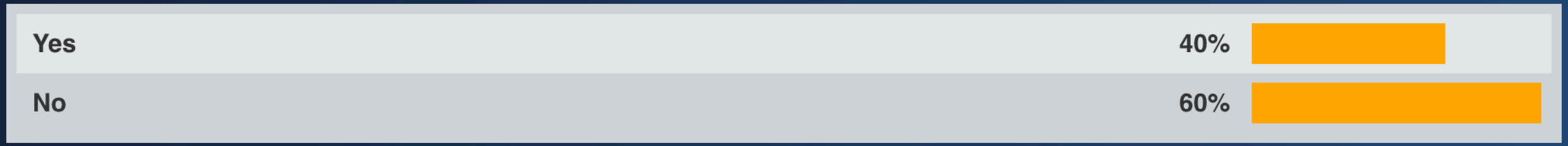
The risk of Grade 3/4 toxicities with checkpoint inhibitors is…

In the Phase III PACIFIC study of durvalumab consolidation for unresectable Stage III NSCLC, pneumonitis occurred in both treatment arms with similar rates of Grade 3/4 events, and most events were Grade 1-2.

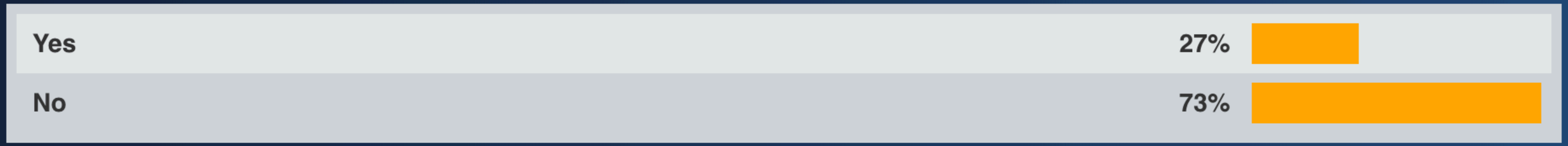
In the PACIFIC study, among patients who experienced pneumonitis, the time to onset was similar among those who received durvalumab versus those who received placebo.

In the PACIFIC study, there was no difference in durvalumab treatment exposure based on the presence or absence of pneumonitis.

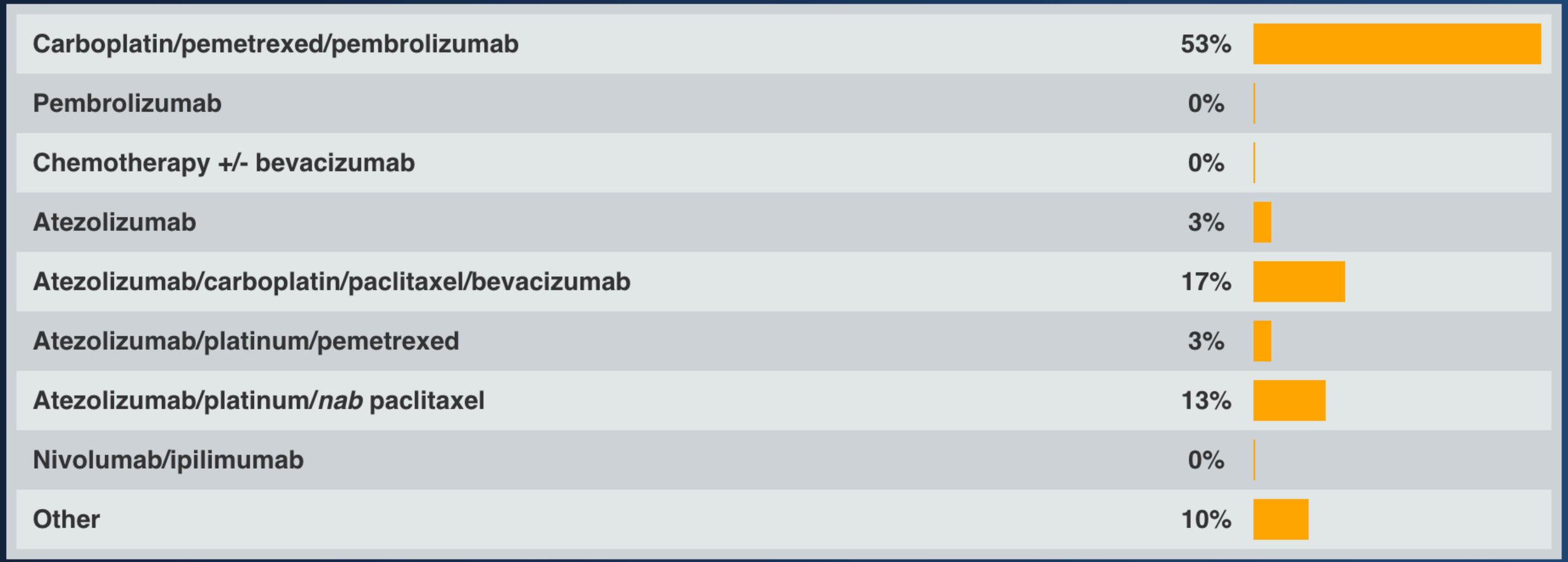
Outside of a protocol setting, would you generally offer durvalumab as consolidation treatment after chemoradiation therapy to a patient with locally advanced NSCLC and Crohn's disease that is well controlled on infliximab?



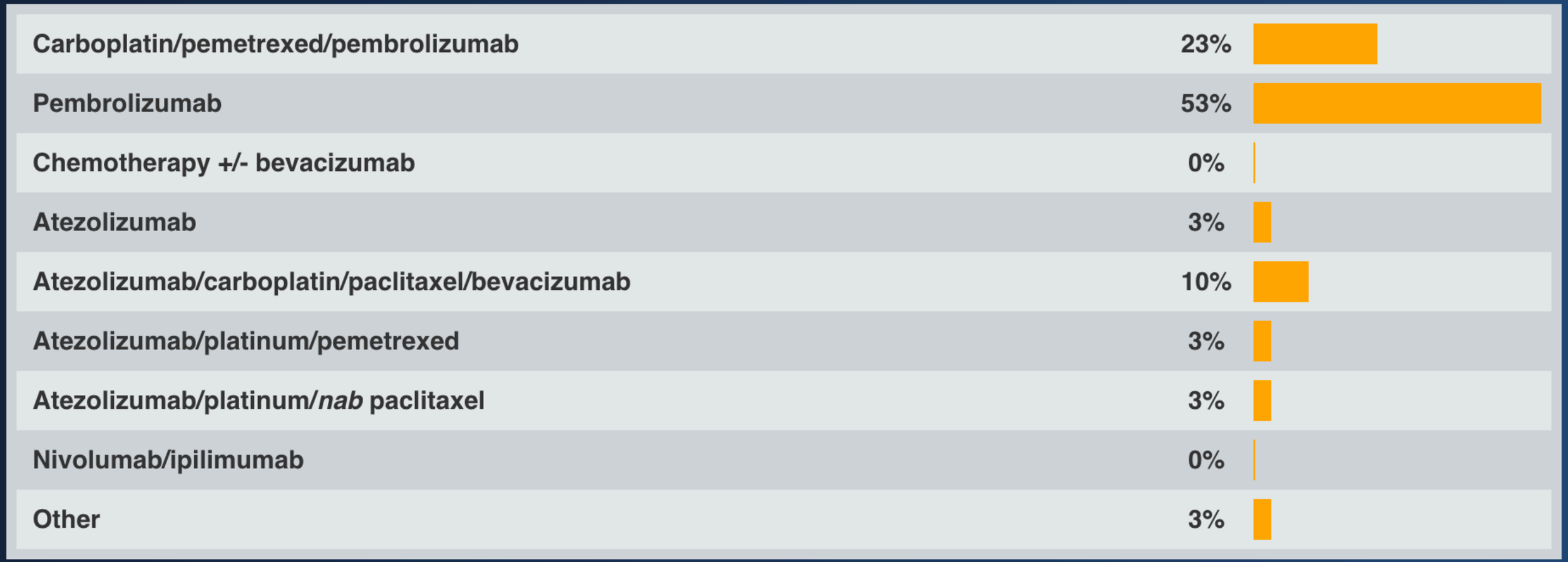
Outside of a protocol setting, would you generally offer durvalumab as consolidation treatment after chemoradiation therapy to a patient with locally advanced NSCLC who has undergone a kidney transplant?



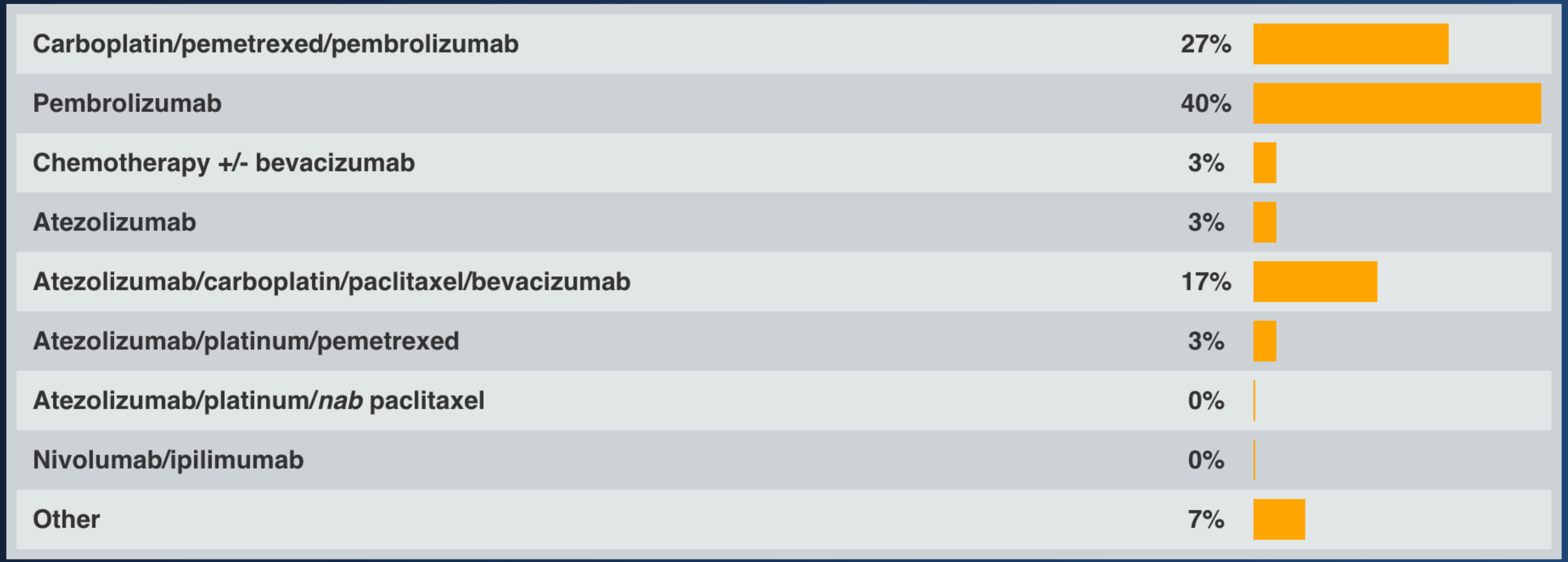
What is the optimal treatment for a 65-year-old patient with metastatic nonsquamous NSCLC and no identified targetable tumor mutations with a PD-L1 TPS of 10%?



What is the optimal treatment for a 65-year-old patient with metastatic nonsquamous NSCLC and no identified targetable tumor mutations with a PD-L1 TPS of 50%?

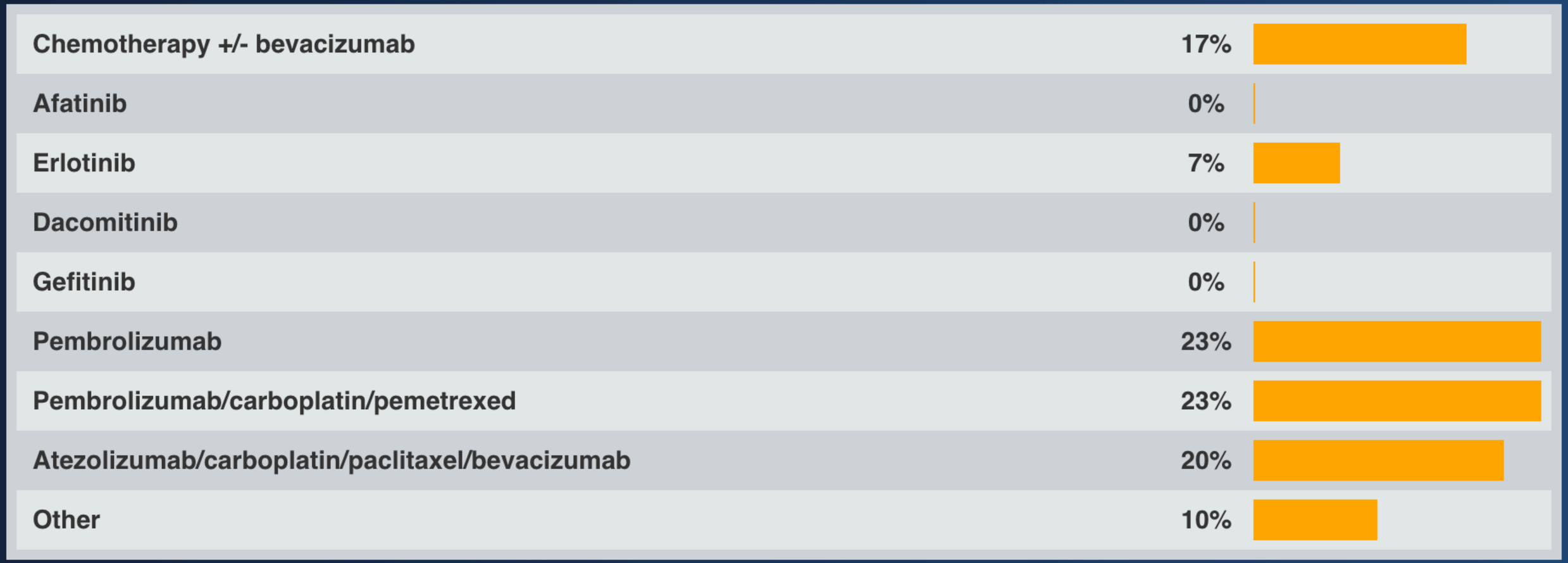


What is the optimal treatment for a 65-year-old patient with metastatic nonsquamous NSCLC and no identified targetable tumor mutations with a PD-L1 TPS of 90% and significant disease-related pulmonary symptoms?

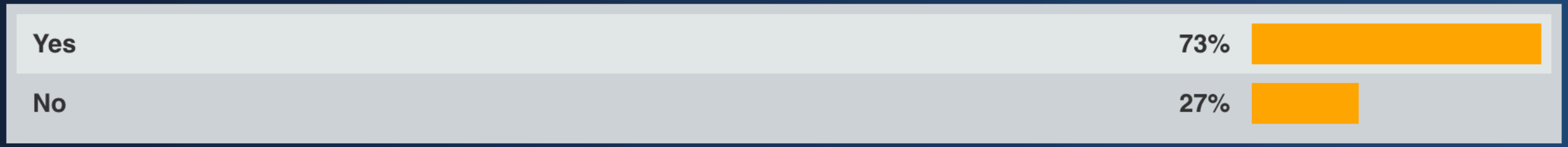


In general, when do you believe checkpoint inhibitors should be introduced into the treatment algorithm for a patient with metastatic NSCLC with an EGFR tumor mutation and a PD-L1 TPS of 50%?

A patient with metastatic nonsquamous NSCLC with an EGFR activating tumor mutation and a PD-L1 TPS of 50% responds to first-line osimertinib for 18 months and then experiences disease progression with no targetable secondary mutations. What is your most likely next systemic therapy?

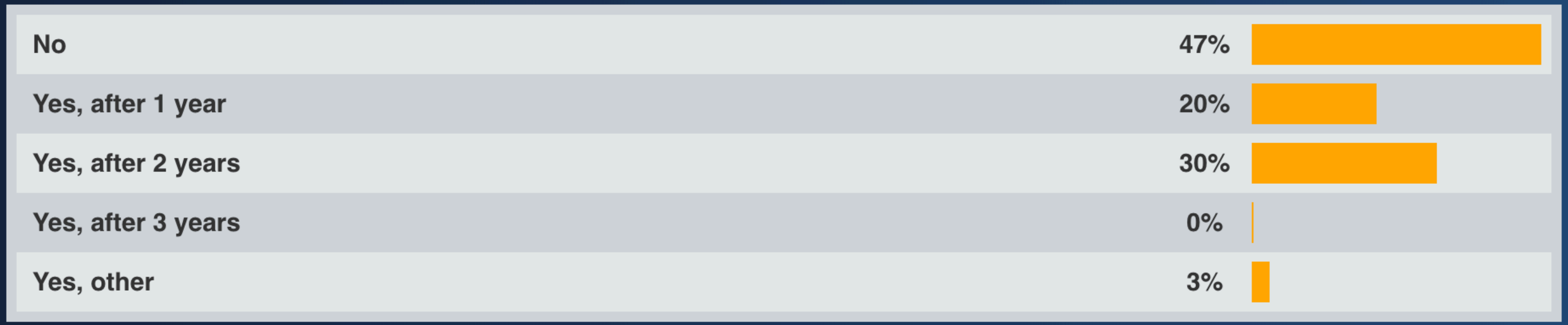


A patient with locally advanced NSCLC receives chemoradiation therapy followed by durvalumab consolidation but then develops metastatic disease 18 months later. Would you likely rechallenge with an anti-PD-1/PD-L1 antibody at some point in their treatment course?



Based on your own clinical experience and the available data, do you believe hyperprogression is an actual clinical phenomenon?

Would you discontinue treatment with a PD-1/PD-L1 antibody for a patient with metastatic NSCLC who is responding and tolerating therapy well?



Preliminary single-arm trials have reported pathologic complete response rates of greater than 25% to neoadjuvant treatment with an anti-PD-1/PD-L1 antibody in patients with muscle-invasive urothelial bladder cancer.

Do you believe current data support the use of tumor mutation burden as a factor in clinical decision-making for patients with NSCLC?

Do you believe there is general concordance between liquid and tissue biopsy to assess tumor mutational burden?

Early data suggest a negative correlation between clinical benefit from an anti-PD-1/PD-L1 antibody and the use of certain antibiotics shortly before or after first administration.