Thank you for joining us.
The program will commence momentarily.

Recent Advances in Medical Oncology: Targeted Therapy for Lung Cancer

Wednesday, July 15, 2020

5:00 PM – 6:30 PM ET

Faculty

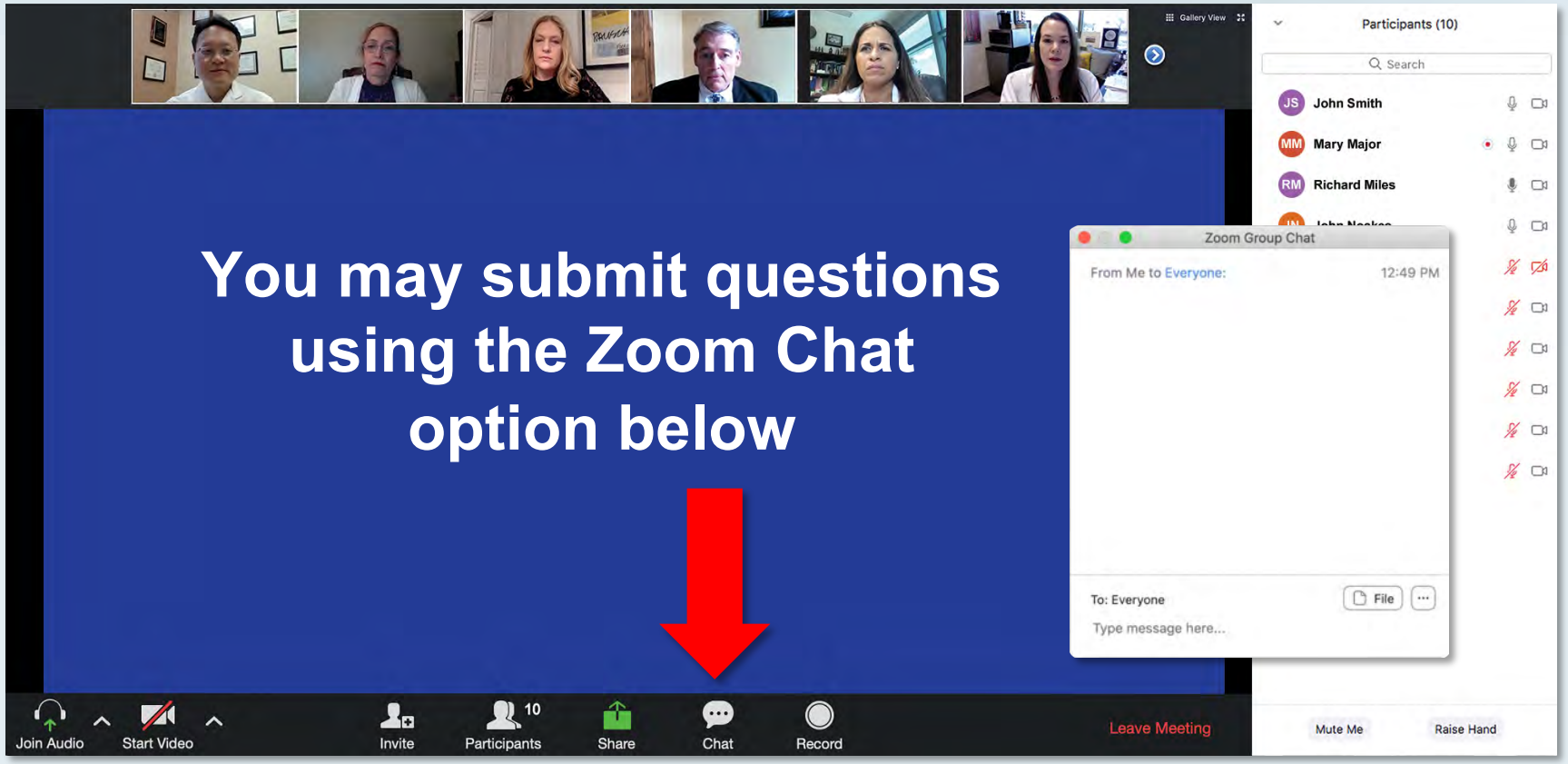
Alexander E Drilon, MD
Professor Solange Peters, MD, PhD
Suresh S Ramalingam, MD

Moderator

Neil Love, MD

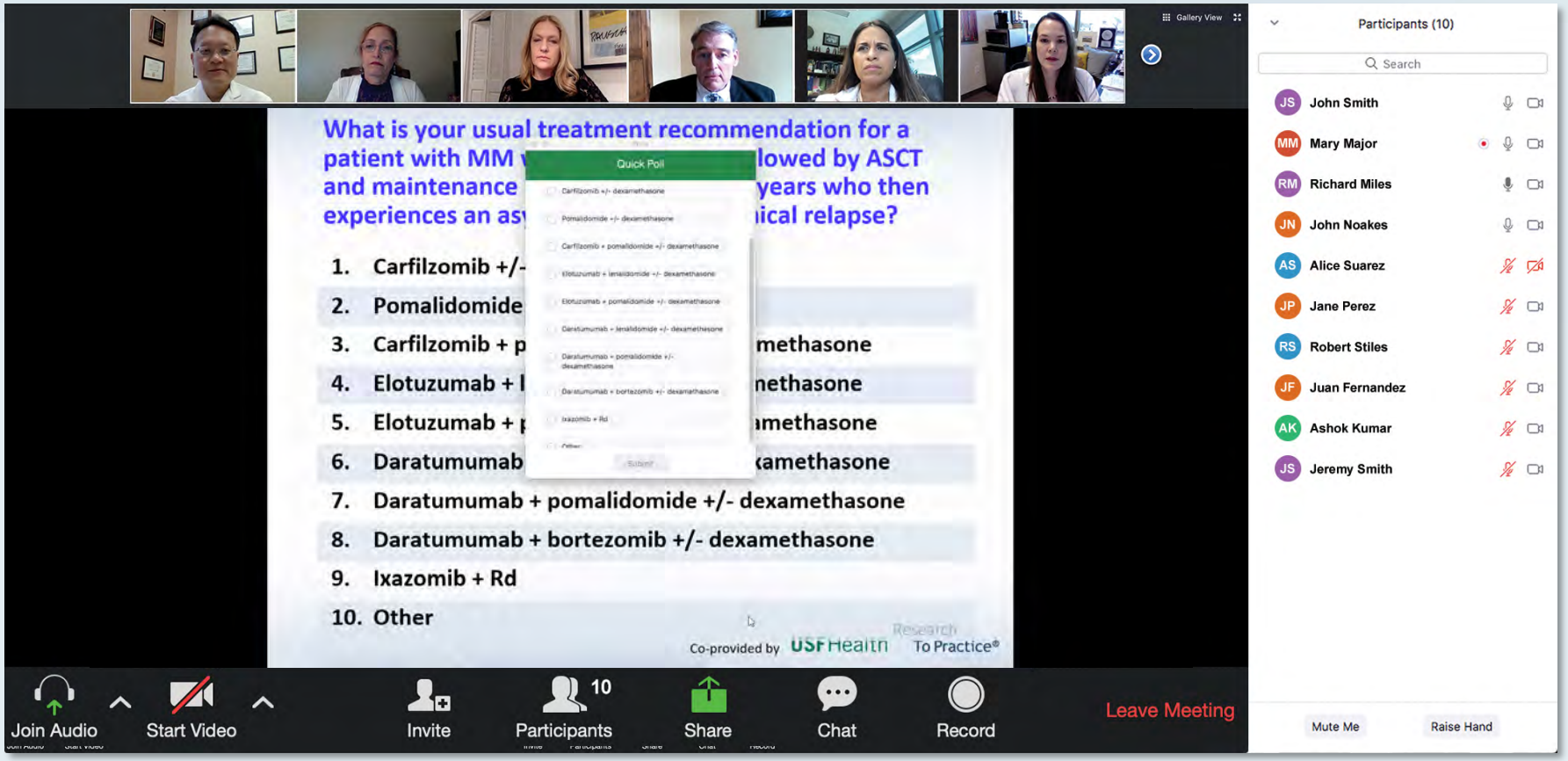
RTP RESEARCH TO PRACTICE

Dr Love and Faculty Encourage You to Ask Questions



Feel free to submit questions **now before** the program commences and **throughout the program.**

Familiarizing yourself with the Zoom interface
How to answer poll questions



When a poll question pops up, click your answer choice from the available options. Results will be shown after everyone has answered.

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Dr Love — Disclosures

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Upcoming Live Webinars

Thursday, July 16, 2020
8:00 AM – 9:00 AM ET

Clinical Investigator Perspectives on the Current and Future Management of Multiple Myeloma

Faculty
Sagar Lonial, MD

Moderator
Neil Love, MD

Monday, July 20, 2020
5:00 PM – 6:00 PM ET

Recent Advances in Medical Oncology: Triple-Negative Breast Cancer

Faculty
Joyce O'Shaughnessy, MD
Hope S Rugo, MD

Moderator
Neil Love, MD

Upcoming Live Webinars

Tuesday, July 21, 2020
12:00 PM – 1:00 PM ET

MEET THE PROFESSORS Clinical Investigators Discuss Existing and Emerging Treatment Strategies for Patients with Ovarian, Cervical and Endometrial Cancer

Faculty
Joyce F Liu, MD, MPH
David M O'Malley, MD

Moderator
Neil Love, MD

Wednesday, July 22, 2020
5:00 PM – 6:00 PM ET

Recent Advances in Medical Oncology: Melanoma

Faculty
Michael B Atkins, MD
Professor Georgina Long, BSc, PhD, MBBS
Jason J Luke, MD

Moderator
Neil Love, MD

Upcoming Live Webinars

Thursday, July 23, 2020
12:00 PM – 1:00 PM ET

MEET THE PROFESSOR
Current Questions and Controversies in the Management of Lung Cancer

Faculty
Joel W Neal, MD, PhD

Moderator
Neil Love, MD

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Suresh S Ramalingam, MD

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Faculty

Alexander E Drilon, MD
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Head, Medical Oncology
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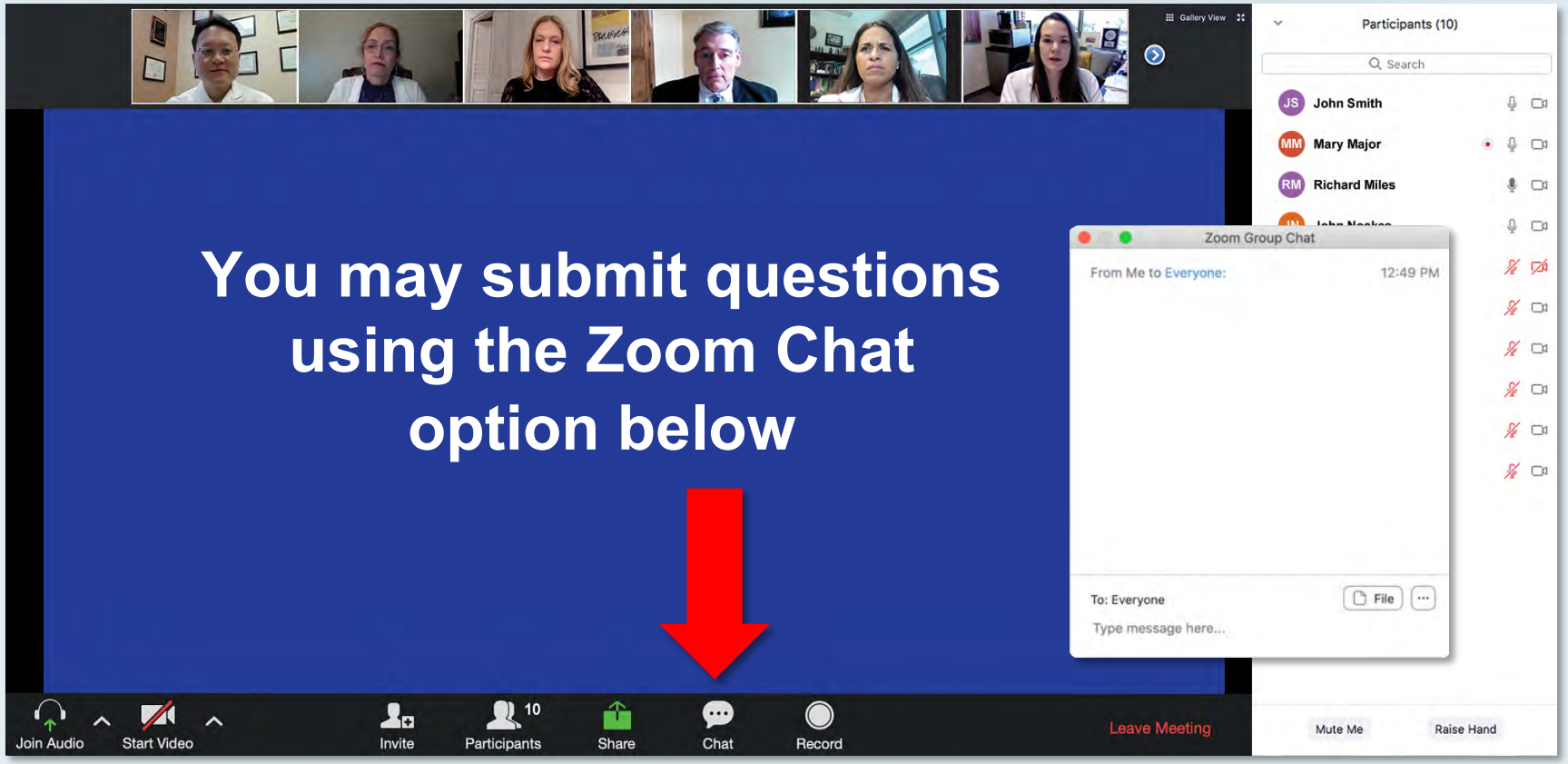
Dr Love and Faculty Encourage You to Ask Questions



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ONCOLOGY TODAY

WITH DR NEIL LOVE

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Clinical Investigator Perspectives on the Current and Future Management of Multiple Myeloma

A Meet The Professor Series

Thursday, July 16, 2020
8:00 AM – 9:00 AM ET

Sagar Lonial, MD
Chair and Professor
Department of Hematology and Medical Oncology
Anne and Bernard Gray Family Chair in Cancer
Chief Medical Officer
Winship Cancer Institute
Emory University School of Medicine
Atlanta, Georgia

Co-provided by USF Health RTP RESEARCH TO PRACTICE

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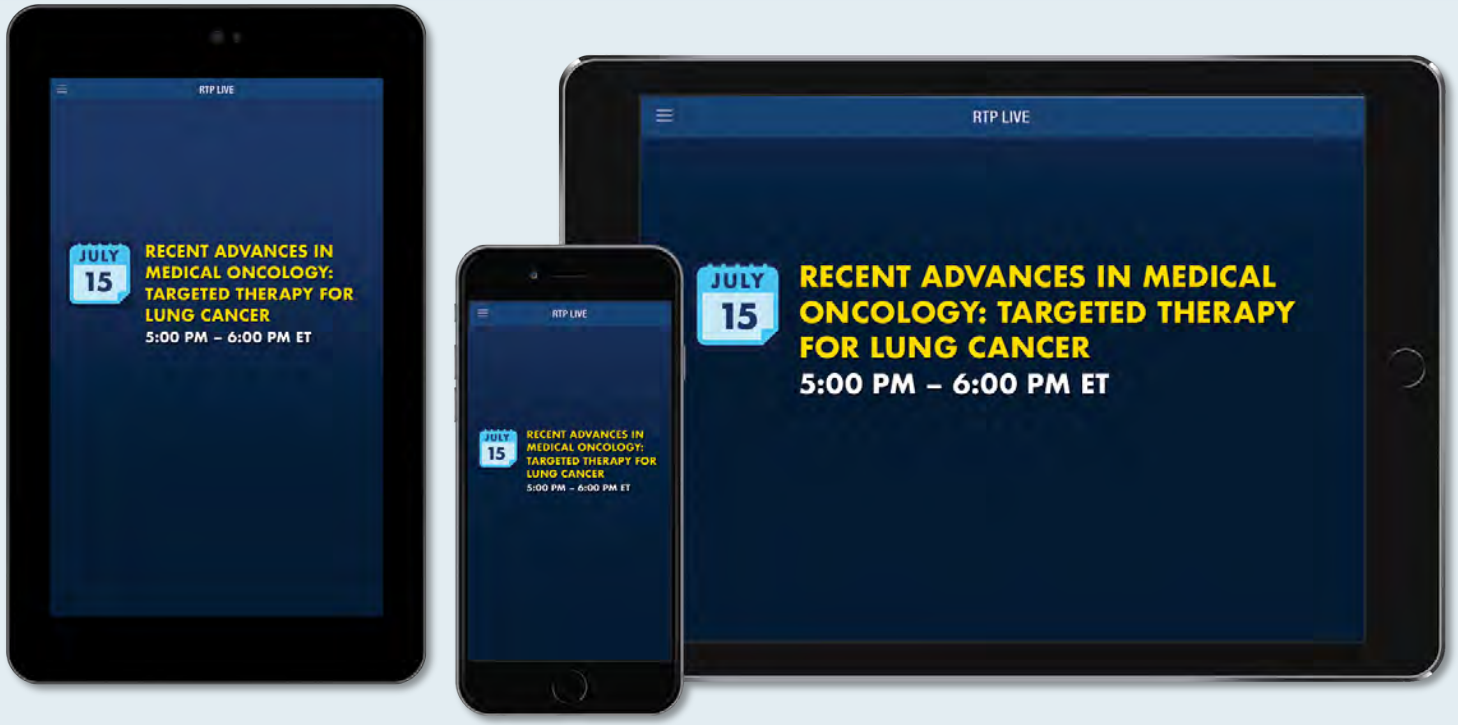

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San Francisco, California

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Tom and Julie Wood Family Foundation
Professor of Lung Cancer Clinical Research
Indiana University
Indianapolis, Indiana

Corey J Langer, MD
Director of Thoracic Oncology
Abramson Cancer Center
Professor of Medicine
Perelman School of Medicine
University of Pennsylvania
Philadelphia, Pennsylvania

Agenda

MODULE 1: EGFR Mutation-Positive NSCLC

MODULE 2: NSCLC with ALK Rearrangements

MODULE 3: RET Fusion-Positive Disease

MODULE 4: Targeting MET in MET Exon 14-Altered Disease

MODULE 5: HER2-Mutant NSCLC

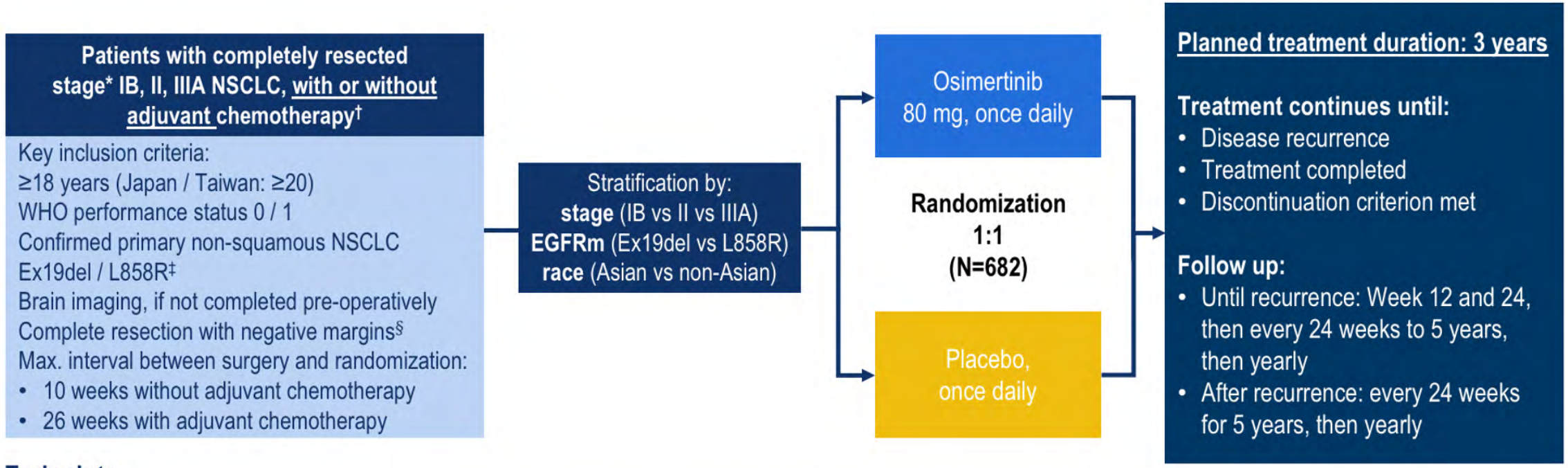
MODULE 6: NSCLC with ROS1 Rearrangements

MODULE 7: Other Targetable Genetic Abnormalities

MODULE 1: Management of EGFR Mutation-Positive NSCLC

- **Key Relevant Data Sets**
- **Questions and Cases from Investigators**
- **Faculty Cases – Dr Ramalingam**
  - 71-year-old woman with metastatic adenocarcinoma of the lung and an EGFR L858R mutation
  - 62-year-old man with metastatic adenocarcinoma of the lung and an EGFR Exon 20 insertion mutation

ADAURA: Design



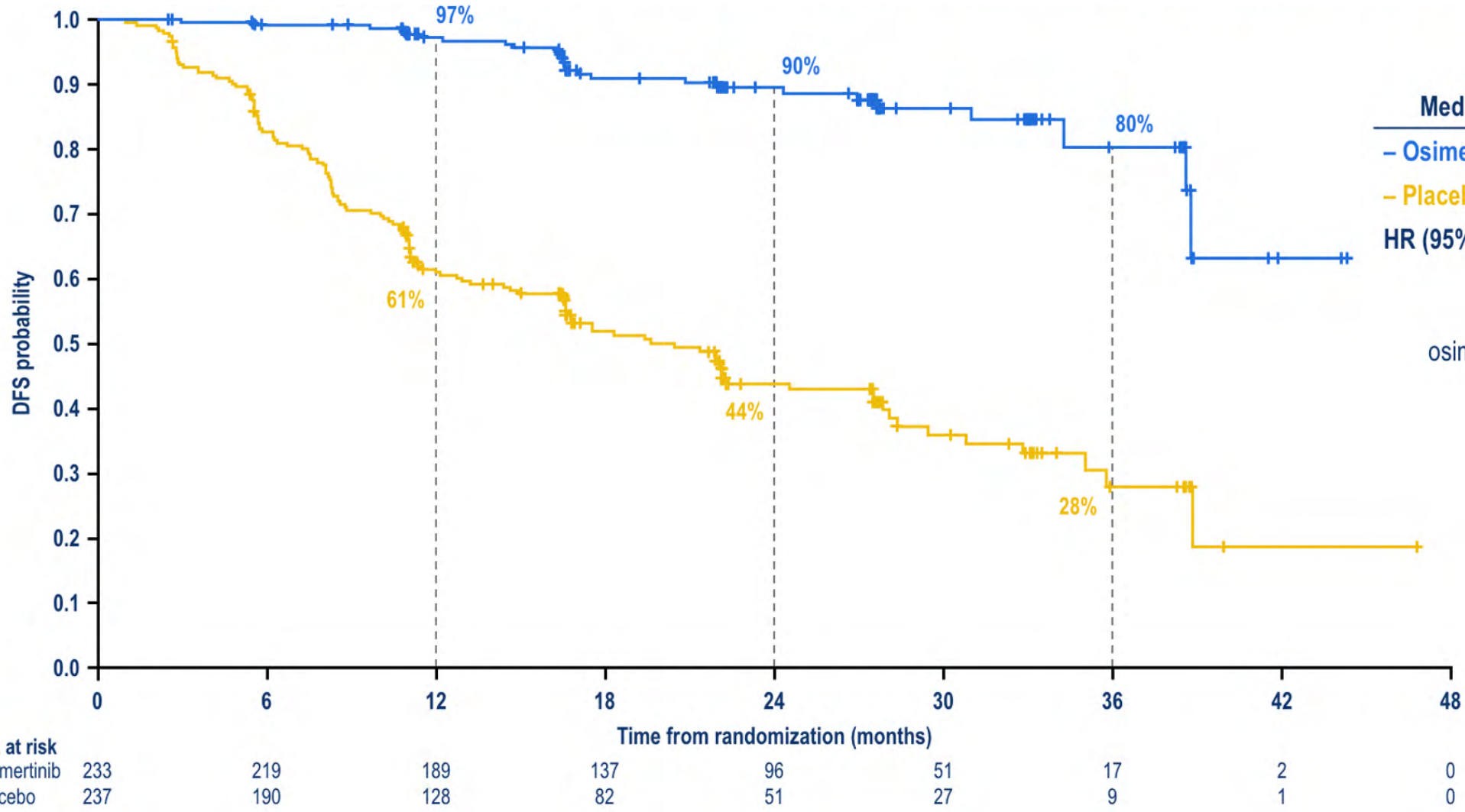
Endpoints

- **Primary**: DFS, by investigator assessment, in stage II/IIIA patients; designed for superiority under the assumed DFS HR of 0.70
- **Secondary**: DFS in the overall population¶, DFS at 2, 3, 4, and 5 years, OS, safety, health-related quality of life

- **Following IDMC recommendation, the study was unblinded early due to efficacy; here we report an unplanned interim analysis**
- **At the time of unblinding the study had completed enrollment and all patients were followed up for at least 1 year**

Herbst RS et al. ASCO 2020;Abstract LBA5.

ADAURA Primary endpoint: DFS in patients with stage II/IIIA disease



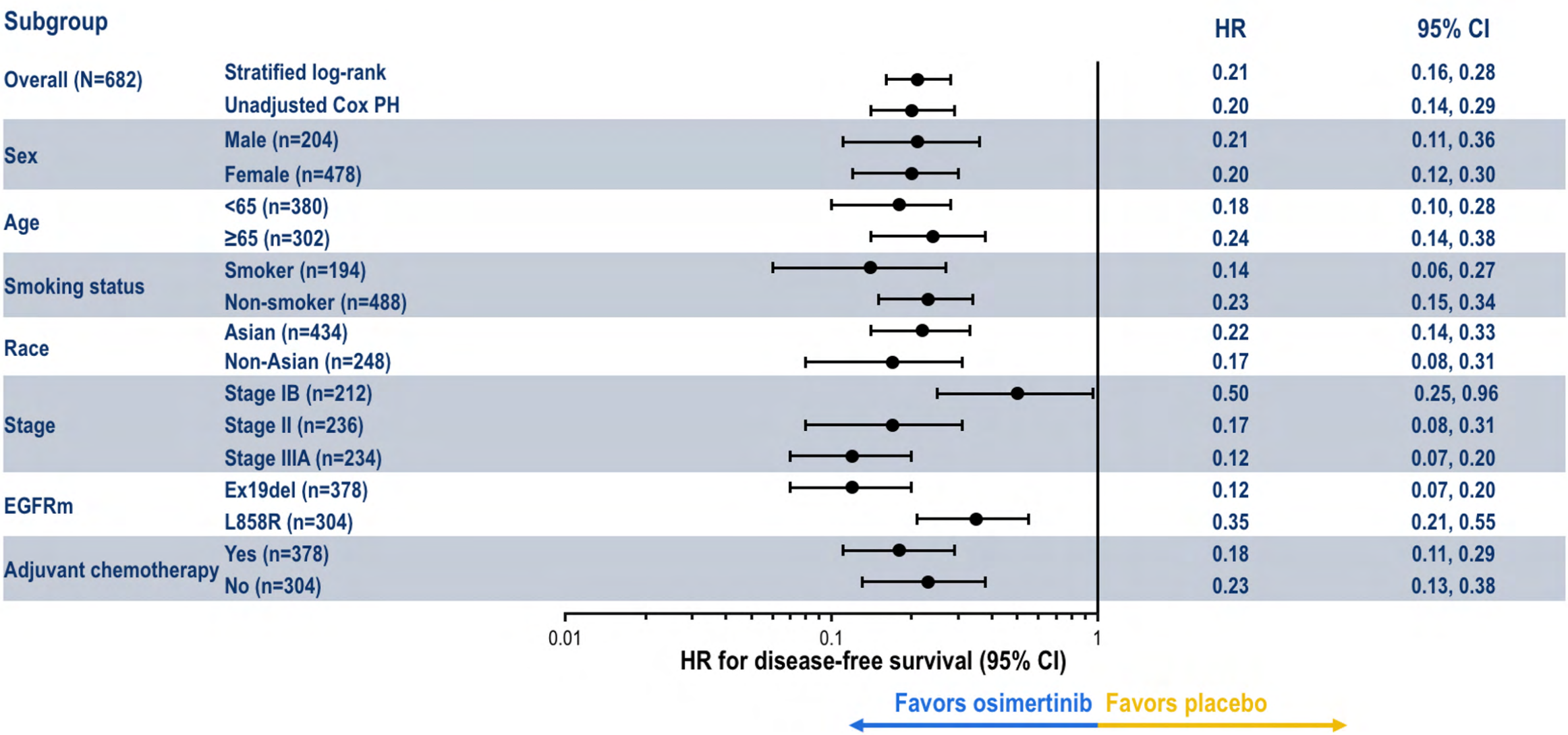
Median DFS, months (95% CI)	
– Osimertinib	NR (38.8, NC)
– Placebo	20.4 (16.6, 24.5)
HR (95% CI)	**0.17 (0.12, 0.23); p<0.0001**

Maturity 33%:
osimertinib 11%, placebo 55%

Herbst RS et al. ASCO 2020;Abstract LBA5.

Courtesy of Suresh Ramalingam, MD

ADAURA DFS across subgroups in the overall population



Herbst RS et al. ASCO 2020;Abstract LBA5.

Courtesy of Suresh Ramalingam, MD

RELAY: Study Design[1,2]

Key inclusion criteria
- Stage IV NSCLC
- *EGFR* mutation-positive (Ex19del or Ex 21 L858R)
- ECOG PS 0-1

Key exclusion criteria
- Known *EGFR* T790M mutation
- Prior treatment with EGFR TKI or chemotherapy
- Brain metastases

Phase 3[a]
N=449

RANDOMIZE 1:1

- **Ramucirumab 10 mg/kg Q2W + Erlotinib 150 mg/day**
- **Placebo Q2W + Erlotinib 150 mg/day**

Treatment until progression or unacceptable toxicity

Primary end point: Progression-Free Survival

Stratification factors
- *EGFR* status (exon 19 deletion vs. exon 21 L858R)
- Sex
- Region (East Asia vs. other)
- EGFR testing method (therascreen®/cobas® vs. other)

[a]Phase 3 enrollment began after confirmation of dose and schedule in Phase 1b[2]

1. Garon EB et al. *Clin Lung Cancer* 2017; 2. Reck M et al. *Clin Lung Cancer* 2018

Clinicaltrials.gov NCT02411448

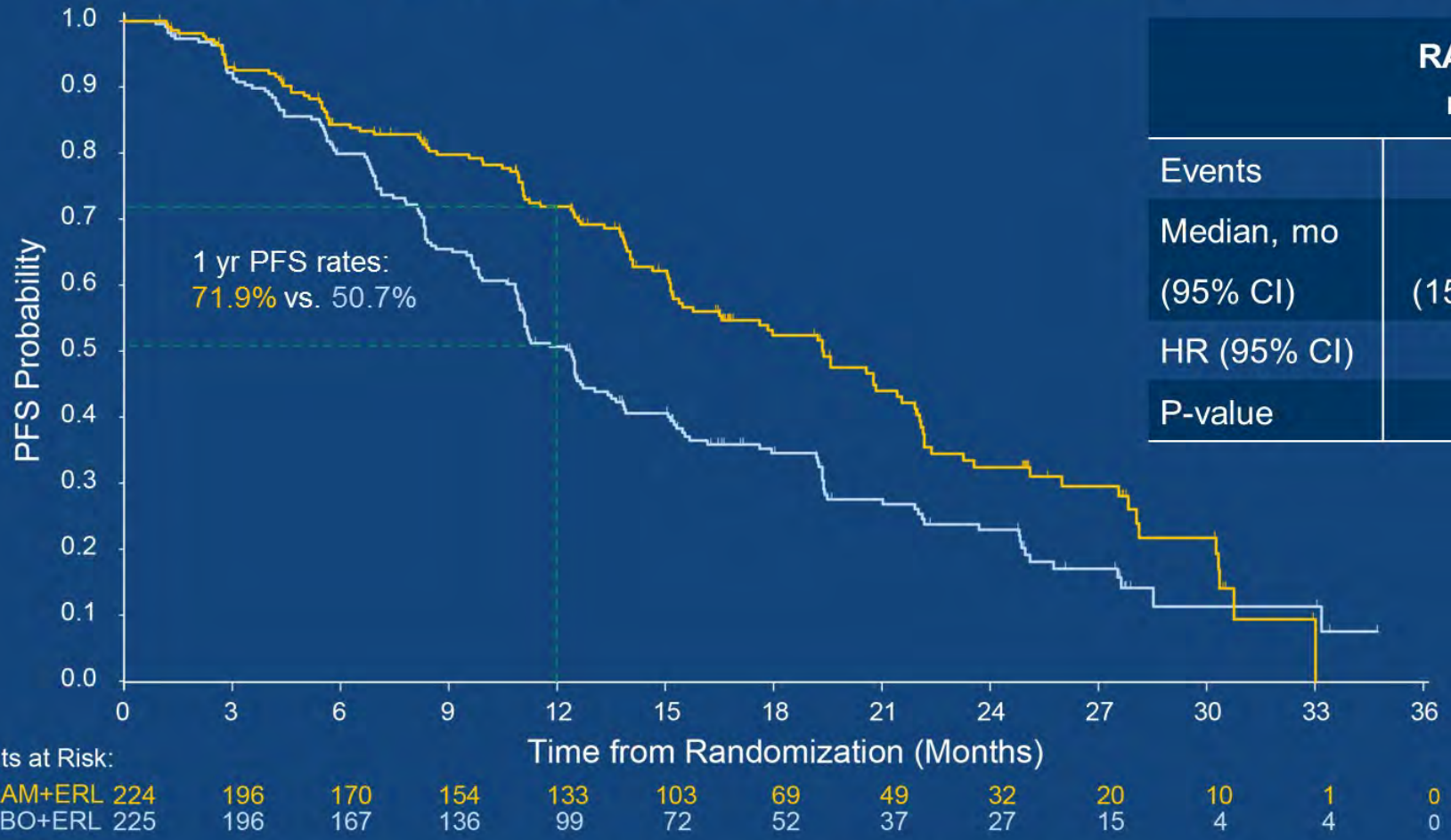
PRESENTED BY: Prof. Kazuhiko Nakagawa, MD, PhD
Kindai University Faculty of Medicine, Osaka, Japan

Courtesy of Suresh Ramalingam, MD

Winship Cancer Institute | Emory University

Nakagawa K et al. ASCO 2019;Abstract 9000. Presented By Kazuhiko Nakagawa at 2019 ASCO Annual Meeting

RELAY Primary Endpoint: PFS (Investigator-Assessed)



	RAM+ERL n=224	PBO+ERL n=225
Events	122	158
Median, mo	**19.4**	**12.4**
(95% CI)	(15.4–21.6)	(11.0–13.5)
HR (95% CI)	**0.591** (0.461, 0.760)	
P-value	<0.0001	

Consistent PFS benefit by independent, blinded central review (HR 0.671, 95% CI 0.518 – 0.869; p=0.0022)

PRESENTED AT: 2019 ASCO ANNUAL MEETING #ASCO19

PRESENTED BY: Prof. Kazuhiko Nakagawa, MD; Kindai University Faculty of Medicine, Osaka, Japan

Courtesy of Suresh Ramalingam, MD

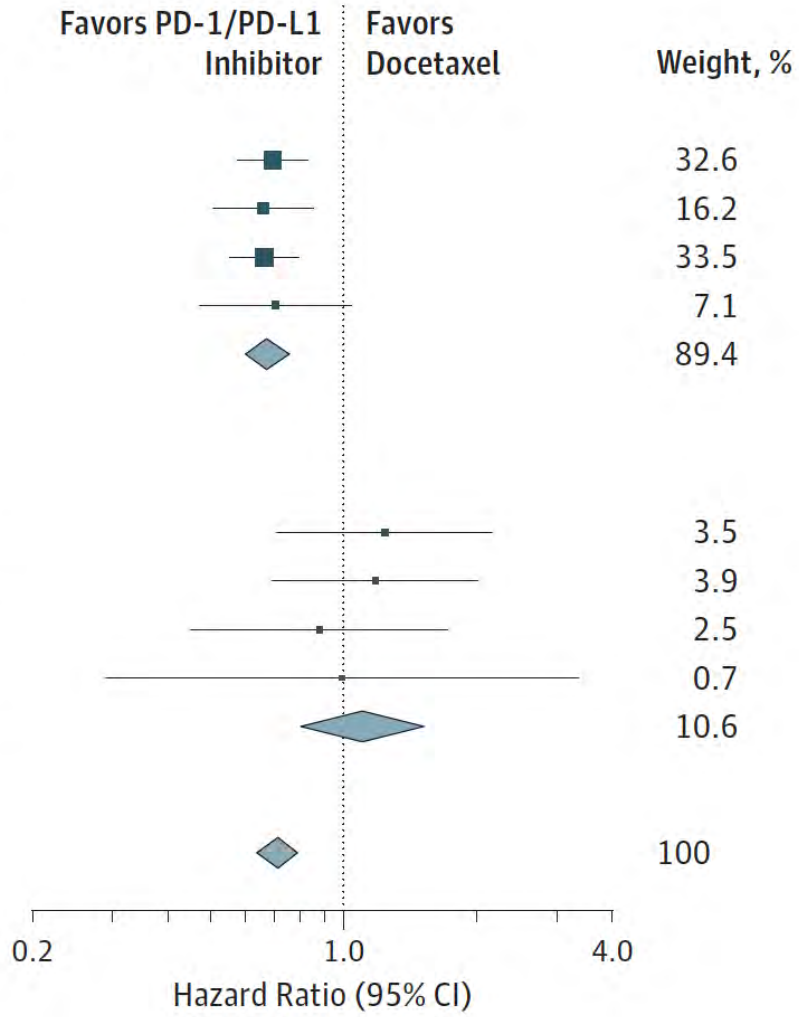
Winship Cancer Institute | Emory University

Nakagawa K et al. ASCO 2019;Abstract 9000.

Presented By Kazuhiko Nakagawa at 2019 ASCO Annual Meeting

Meta-Analysis Comparing Overall Survival: Efficacy of PD-1/PD-L1 Inhibitors vs Docetaxel in EGFR^{MT} and EGFR wild-type NSCLC

Trial	Hazard Ratio (95% CI)
EGFR wild-type	
OAK	0.69 (0.57-0.83)
CheckMate 057	0.66 (0.51-0.85)
Keynote 010	0.66 (0.55-0.79)
POPLAR	0.70 (0.47-1.04)
Subtotal	0.67 (0.60-0.75)
Heterogeneity: $\chi^2_3 = 0.18$, $P = .98$; $I^2 = 0\%$	
Test for overall effect: $z = 6.94$ ($P < .001$)	
EGFR mutated	
OAK	1.24 (0.71-2.18)
CheckMate 057	1.18 (0.69-2.02)
Keynote 010	0.88 (0.45-1.72)
POPLAR	0.99 (0.29-3.40)
Subtotal	1.11 (0.80-1.53)
Heterogeneity: $\chi^2_3 = 0.69$, $P = .88$; $I^2 = 0\%$	
Test for overall effect: $z = 0.61$ ($P = .54$)	
Total	0.71 (0.64-0.79)
Heterogeneity: $\chi^2_7 = 8.90$, $P = .26$; $I^2 = 21\%$	
Test for overall effect: $z = 6.37$ ($P < .001$)	
Test for subgroup differences: $\chi^2 = 8.03$, $P = .005$; $I^2 = 87.6\%$	



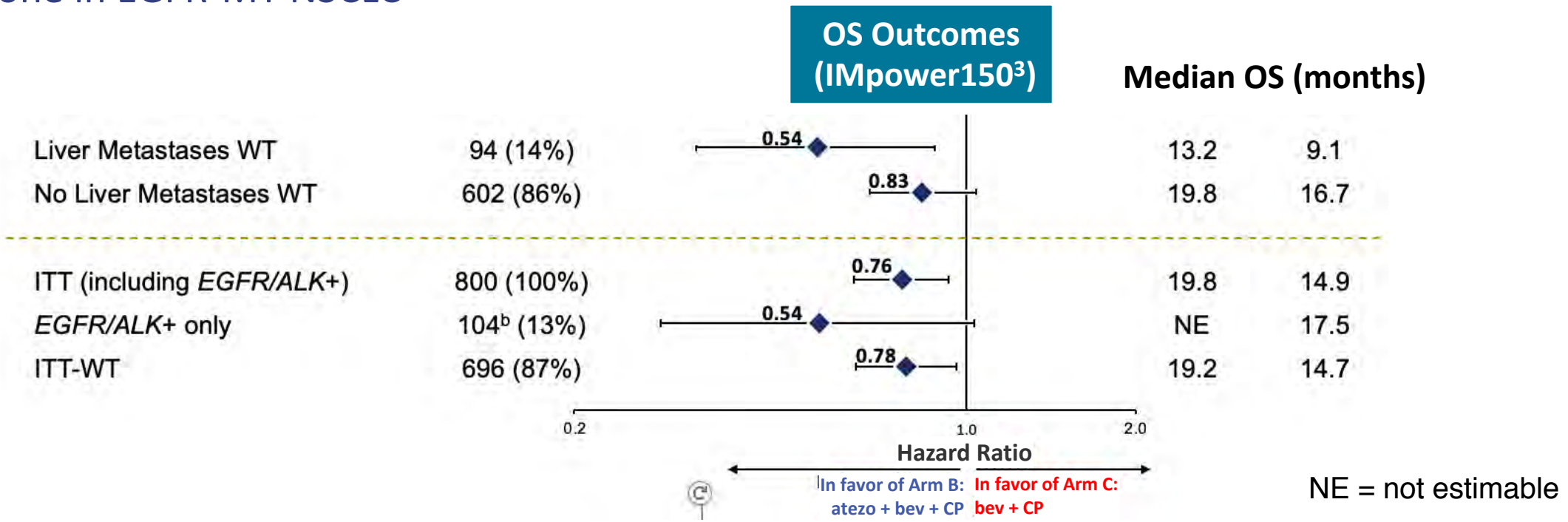
Lee et al. JAMA Oncology 2018;4(2):210-216.

Courtesy of Suresh Ramalingam, MD

Winship Cancer Institute | Emory University

What About Chemo + IO for EGFR-MT NSCLC?

- Post-hoc analysis from IMpower150[1]
  - Suggestion of improved efficacy with chemo + Bevacizumab + Atezolizumab
- Results from IMpower130 failed to demonstrate benefit with chemo + Atezo versus chemo alone in EGFR-MT NSCLC[2]



NE = not estimable

[1] Socinski et al, NEJM, 2018;378(24):2288-2301; [2] West H et al. Lancet Oncol 2019;20(7):924-937; [3] Socinski MA et al. ASCO 2018;Abstract 9002.

Courtesy of Suresh Ramalingam, MD
Winship Cancer Institute | Emory University

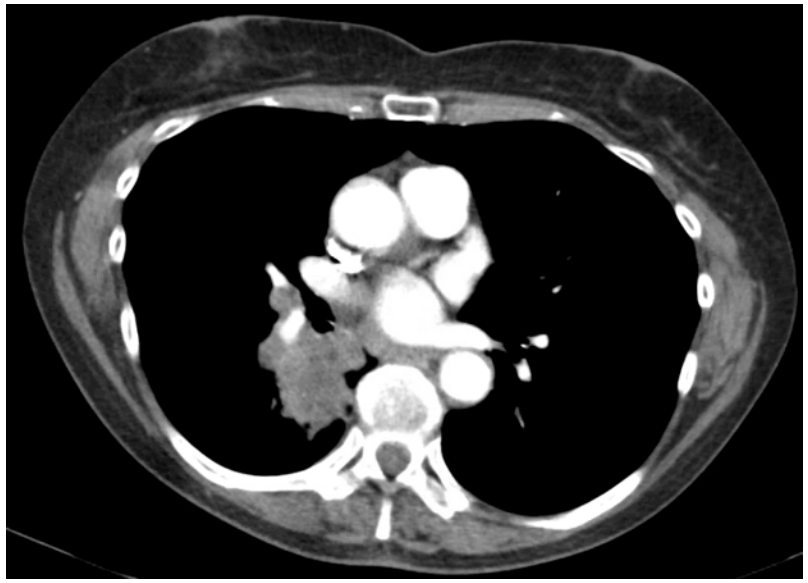
Case Presentation -- Dr Ramalingam: 71-year-old woman with metastatic adenocarcinoma of the lung and an EGFR mutation

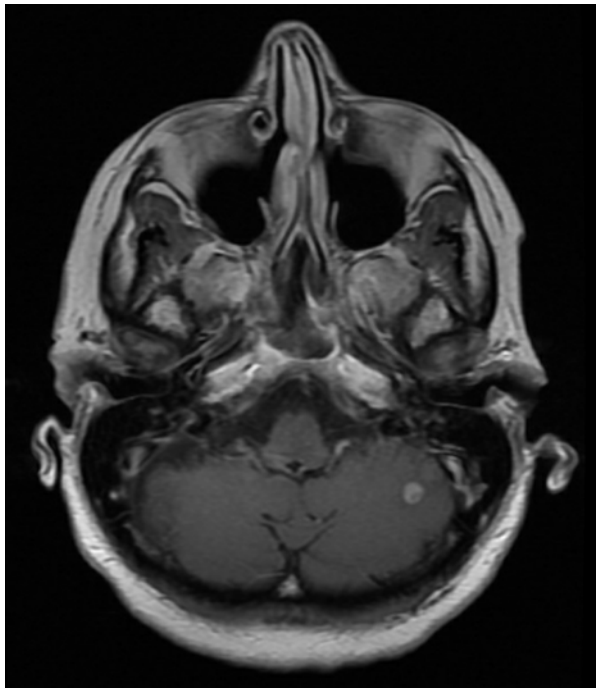
- 71 year old woman
- Never-smoker, no other medical illnesses
- Presented with persistent cough
- CT chest demonstrated right lower lobe lung mass
- Biopsy- adenocarcinoma
- EGFR L858R mutation
- Staging revealed multiple bilateral pulmonary nodules and brain metastasis (sub-cm)
- Started on osimertinib in October 2019

Courtesy of Suresh Ramalingam, MD

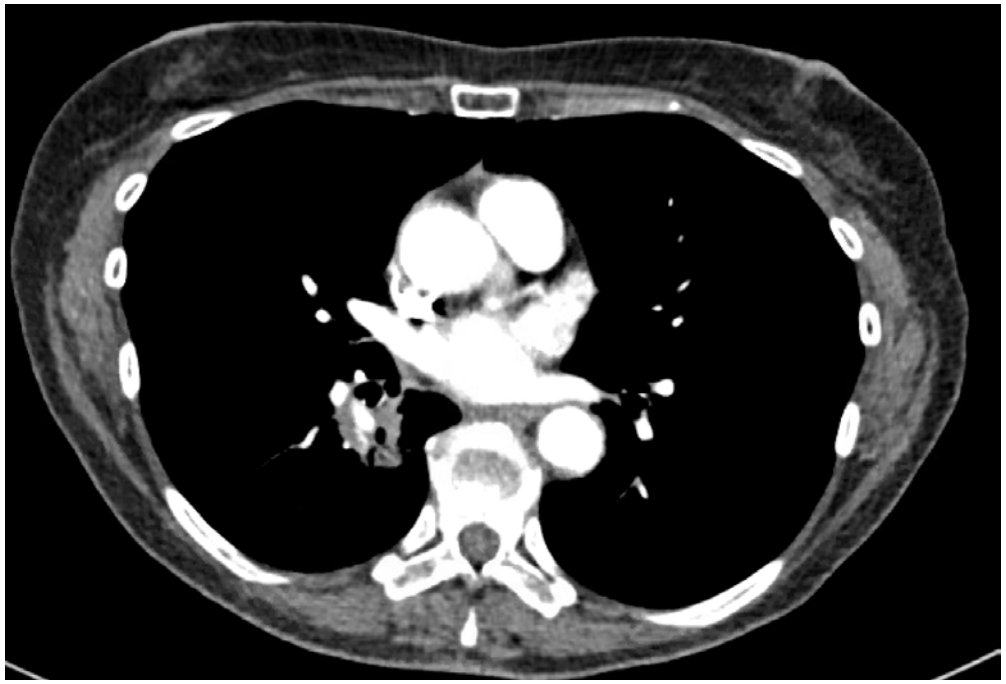
Winship Cancer Institute | Emory University

Case Presentation -- Dr Ramalingam: 71-year-old woman (cont)





Sept 2019



Jan 2020

Courtesy of Suresh Ramalingam, MD

Regulatory and reimbursement issues aside, what would be your likely systemic treatment for a high-functioning physician who presents with nonsquamous NSCLC with bone metastases, 25 brain metastases and an exon 21 L858R mutation?

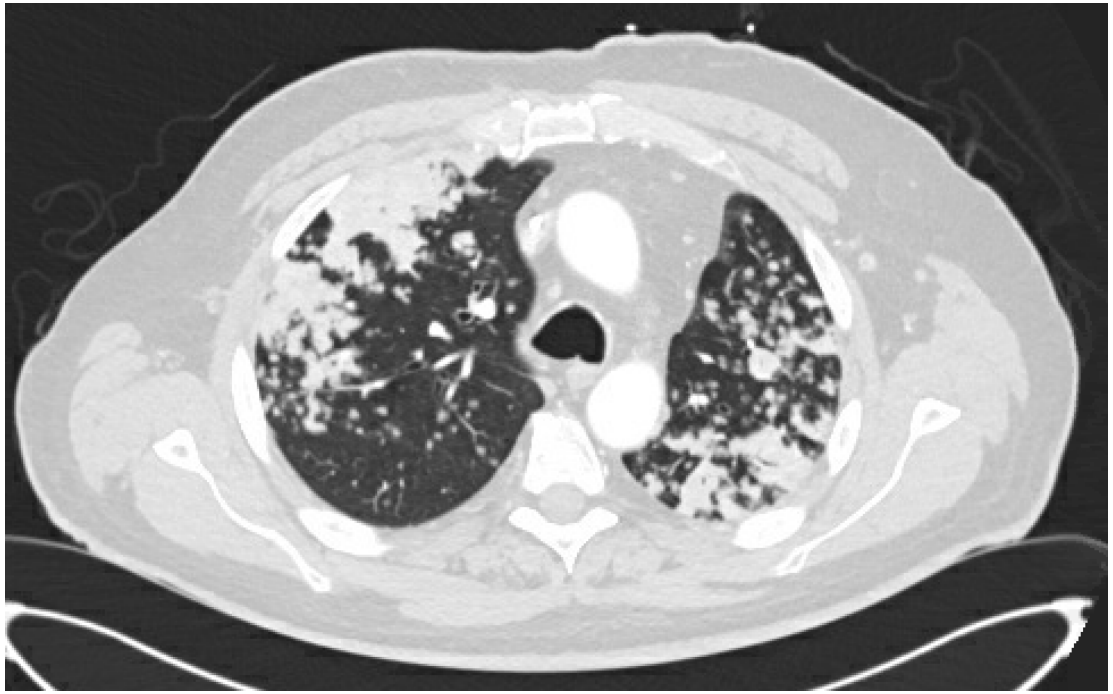
a. Osimertinib
b. Osimertinib/chemotherapy
c. Osimertinib/bevacizumab
d. Osimertinib/ramucirumab
e. Other

Challenging Questions and Cases

Challenging Questions and Cases

Case Presentation – Dr Ramalingam: 62-year-old man with metastatic adenocarcinoma of the lung and an EGFR Exon 20 insertion mutation

- 62/M
- Diagnosed with stage 4 adenocarcinoma in 2017
- No extra-thoracic disease
- EGFR Exon 20 insertion mutation
- Carboplatin-pemetrexed- 13 months (Stable disease)
- Enrolled to ECOG-ACRIN 5162
  - Osimertinib 160 mg/d
  - Best response stable disease
  - Duration of benefit- 20 months



Courtesy of Suresh Ramalingam, MD

Winship Cancer Institute | Emory University

Regulatory and reimbursement issues aside, what adjuvant systemic therapy would you recommend for a 59-year-old nonsmoker with a 2.9-cm Stage IB nonsquamous NSCLC with lymphovascular invasion and an EGFR exon 19 deletion?

a. Osimertinib
b. Chemotherapy
c. Chemotherapy followed by osimertinib
d. Other
e. None

Challenging Questions and Cases

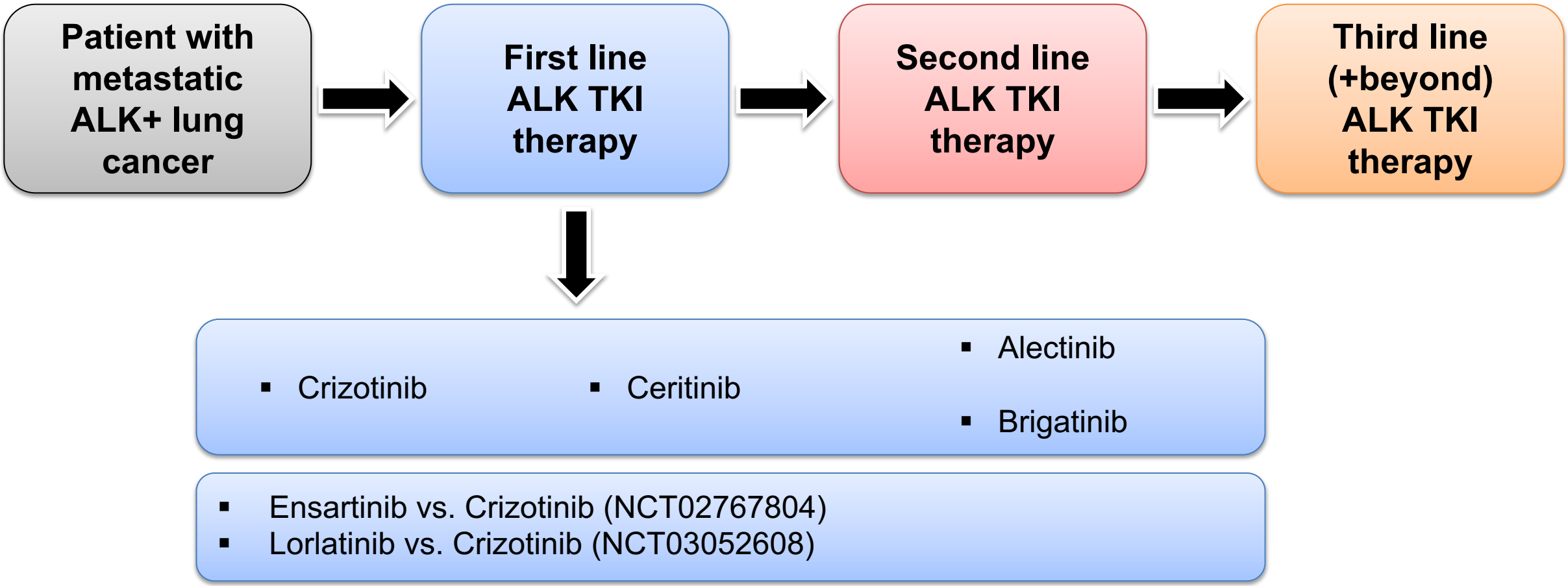
Challenging Questions and Cases

Challenging Questions and Cases

MODULE 2: Management of ALK Rearrangements

- **Key Relevant Data Sets**
- **Questions and Cases from Investigators**
- **Faculty Case – Professor Peters**
  - A 59-year-old patient with adenocarcinoma of the lung and an ALK rearrangement

First line therapy for ALK+ lung cancer in 2018



Modified from Lovly, AACR 2018

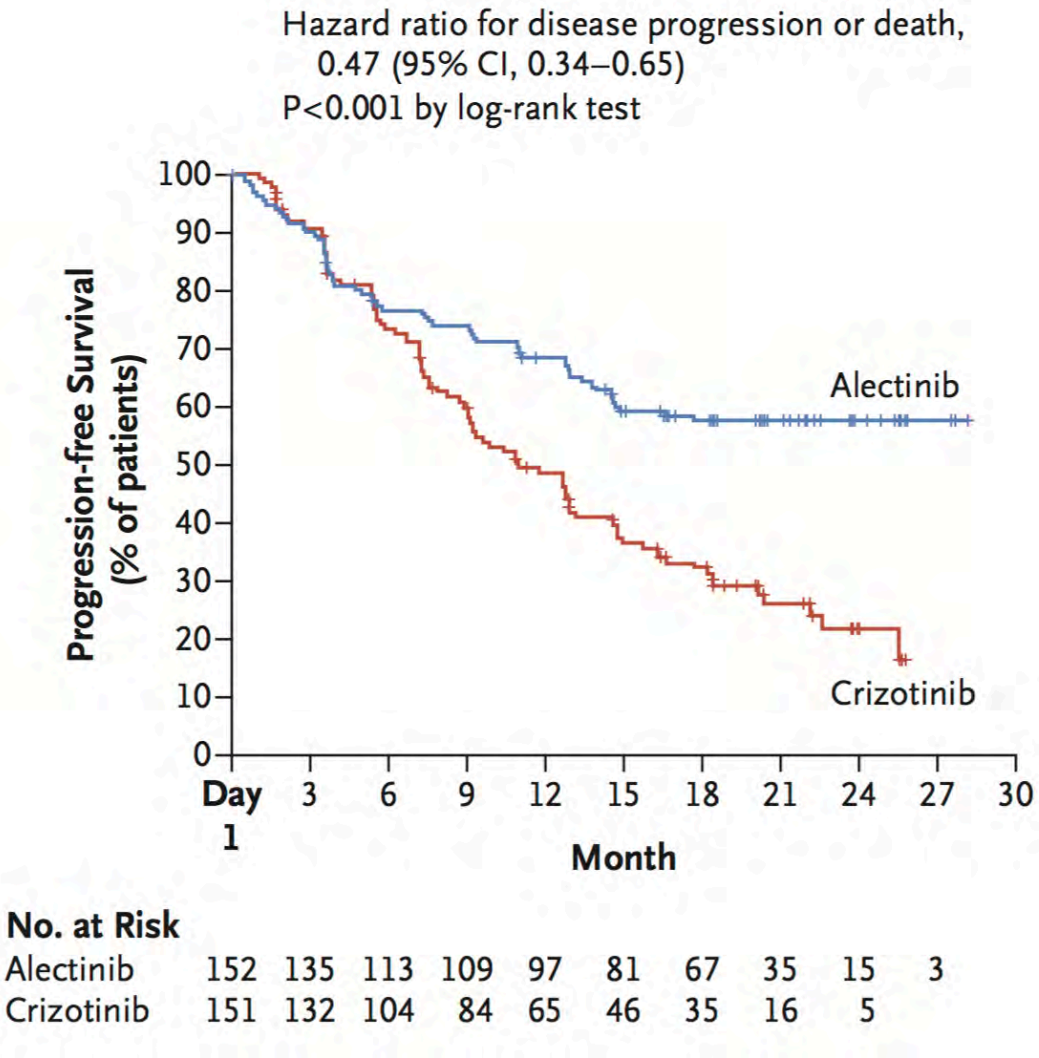
Courtesy of Solange Peters, MD, PhD

ALEX trial: alectinib frontline against crizotinib

ORIGINAL ARTICLE

Alectinib versus Crizotinib in Untreated *ALK*-Positive Non–Small-Cell Lung Cancer

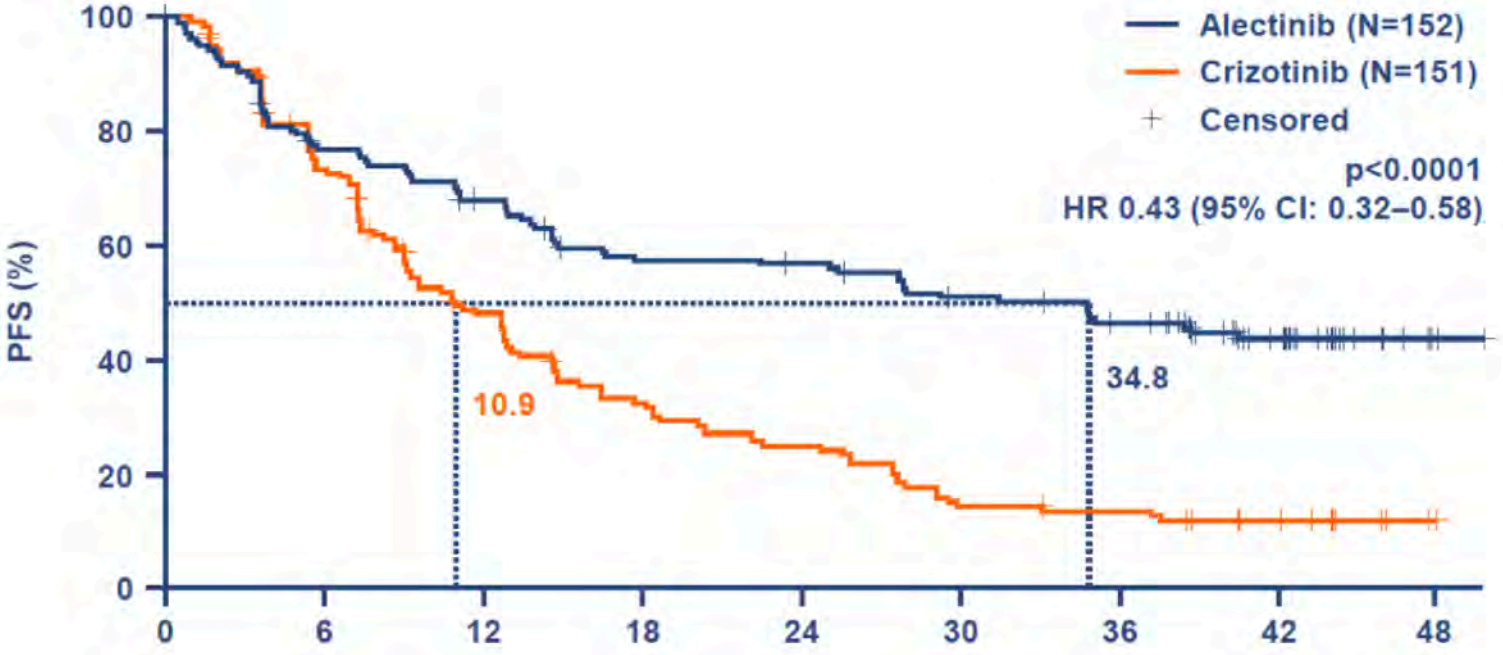
Solange Peters, M.D., Ph.D., D. Ross Camidge, M.D., Ph.D., Alice T. Shaw, M.D., Ph.D., Shirish Gadgeel, M.D., Jin S. Ahn, M.D., Dong-Wan Kim, M.D., Ph.D., Sai-Hong I. Ou, M.D., Ph.D., Maurice Pérol, M.D., Rafal Dziadziuszko, M.D., Rafael Rosell, M.D., Ph.D., Ali Zeaiter, M.D., Emmanuel Mitry, M.D., Ph.D., Sophie Golding, M.Sc., Bogdana Balas, M.D., Johannes Noe, Ph.D., Peter N. Morcos, Pharm.D., and Tony Mok, M.D., for the ALEX Trial Investigators*



Courtesy of Solange Peters, MD, PhD

Peters S, et al. *N Engl J Med* 2017;377:829-38.

ALEX trial: Final PFS alectinib frontline against crizotinib



	Alectinib	Crizotinib
mPFS, mo	34.8	10.9
HR (95% CI)	0.43 (0.32–0.68)	
ORR, %	72.4	60.9

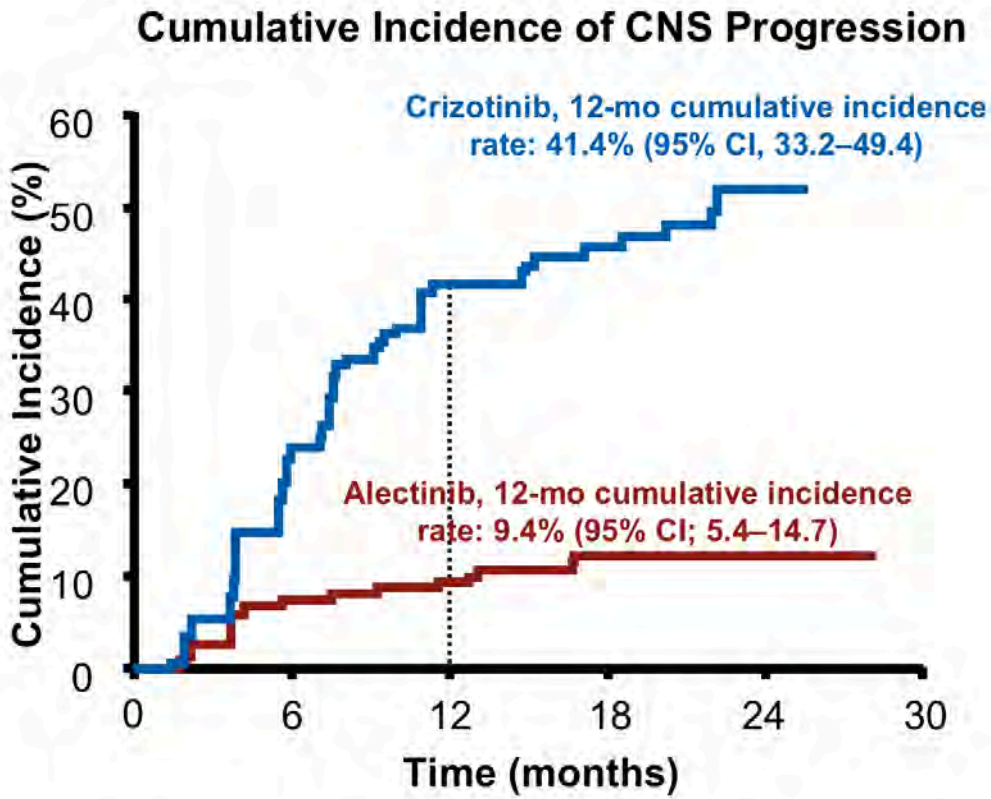
Peters S, et al. *N Engl J Med* 2017;377:829-38
Mok, ESMO 2019

Courtesy of Solange Peters, MD, PhD

ALEX: CNS Activity

- Competing risk of CNS progression, non-CNS progression, and death based on first event was analyzed

CNS Progression, no Previous Systemic PD	Alectinib (n = 152)	Crizotinib (n = 151)
Pts with event, n (%)	18 (12)	68 (45)
Cause-specific HR (95% CI)	0.16 (0.10–0.28)	
P value	< .0001	

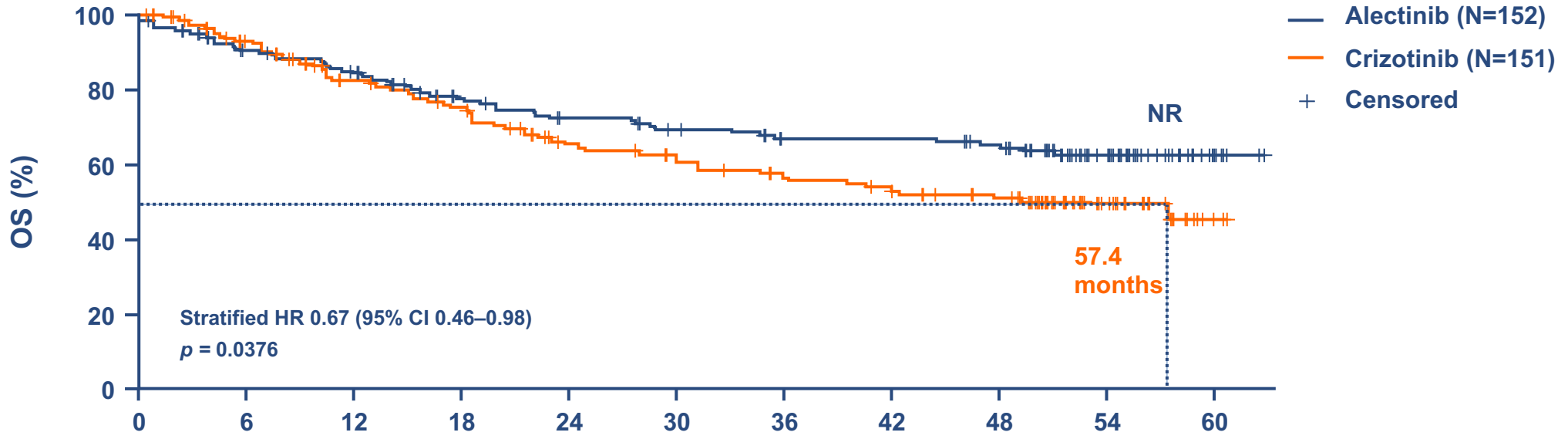


Courtesy of Solange Peters, MD, PhD

Peters S, et al. *N Engl J Med* 2017;377:829-38.

ALEX: 5-year Overall survival data

OS in the ITT population



No. patients at risk:

Alectinib	152	142	131	127	120	111	103	98	94	94	88	87	81	81	81	80	77	62	46	23	8
Crizotinib	151	141	128	116	104	100	93	84	73	71	67	63	60	59	55	51	48	35	18	12	3

OS data remain immature, with 37% of events recorded (stratified HR 0.67, 95% CI 0.46–0.98)

Median OS was not reached with alectinib vs 57.4 months with crizotinib (95% CI 34.6–NR)

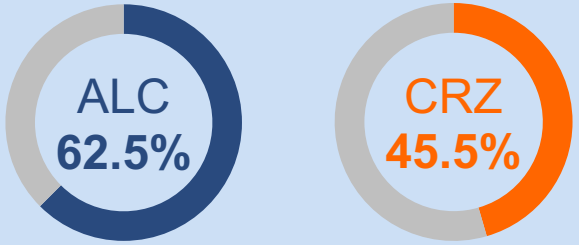
NR = not reached

Peters S et al. ASCO 2020;Abstract 9518.

Courtesy of Solange Peters, MD, PhD

Summary: updated OS and safety findings from the global ALEX study

5-year survival rate:
62.5% with alectinib (ALC) vs
45.5% with crizotinib (CRZ):



OS data remain immature at this updated analysis:

37% of events recorded in the ITT population

(stratified **HR 0.67**
95% CI 0.46–0.98)

No new safety signals were observed with alectinib with almost 3 times longer median treatment duration than crizotinib

Patients that had access to other ALK TKIs after first-line alectinib or crizotinib:

38.1%
after first-line alectinib

53.5%
after first-line crizotinib

This is the first global randomized study of a next-generation ALK TKI to demonstrate a clinically meaningful improvement in OS vs crizotinib in treatment-naïve *ALK*+ NSCLC

Courtesy of Solange Peters, MD, PhD

Mok T, et al. Ann Oncol 2020; in press

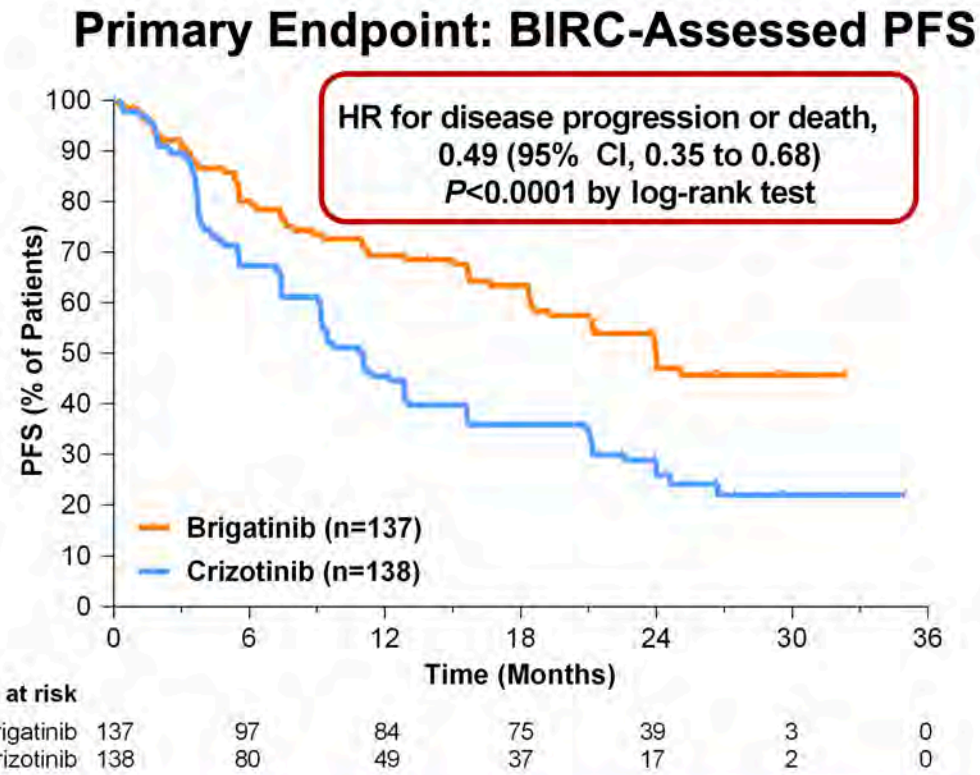
ALTA-1L trial: PFS by independent review

ORIGINAL ARTICLE

Brigatinib versus Crizotinib in *ALK*-Positive Non–Small-Cell Lung Cancer

D.R. Camidge, H.-R. Kim, M.-J. Ahn, J.C.-H. Yang, J.-Y. Han, J.-S. Lee, M.J. Hochmair, J.Y.-C. Li, G.-C. Chang, K.H. Lee, C. Gridelli, A. Delmonte, M.R.G. Campelo, D.-W. Kim, A. Bearz, F. Griesinger, A. Morabito, E. Felip, R. Califano, S. Ghosh, A. Spira, S.N. Gettinger, M. Tiseo, N. Gupta, J. Haney, D. Kerstein, and S. Popat

- Same benefit in patients with our without prior chemotherapy
- Independent radiological review
- Interim analysis



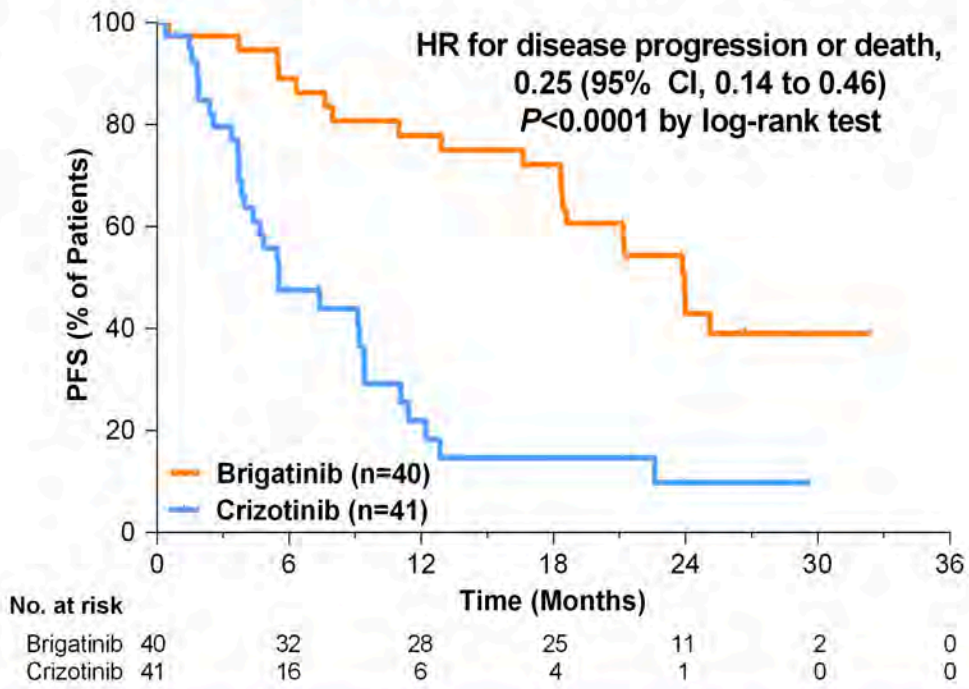
Treatment	No. (%) of Patients With Events	Median PFS (95% CI)	2-Year PFS, % (95% CI)
Brigatinib (n=137)	63 (46)	24.0 mo (18.5–NR)	48 (39–57)
Crizotinib (n=138)	87 (63)	11.0 mo (9.2–12.9)	26 (18–35)

Courtesy of Solange Peters, MD, PhD

Camidge, NEJM 2018; ESMO Asia 2019

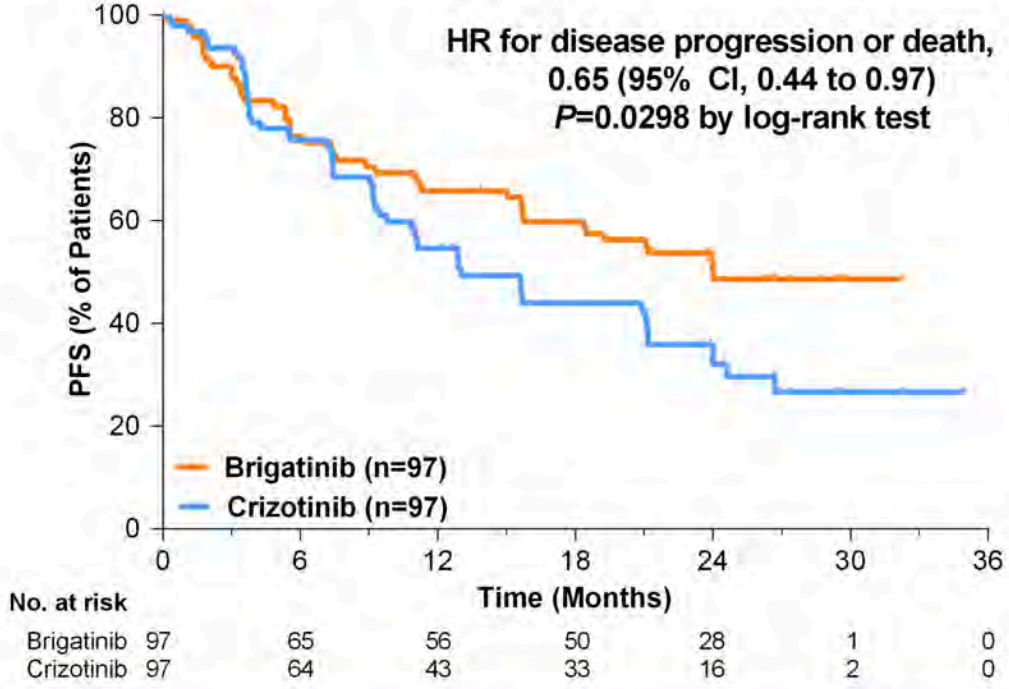
ALTA-1L: PFS with/without brain metastasis

Patients With Any Brain Metastases at Baseline



Treatment	No. (%) Patients With Events	Median PFS (95% CI)	2-Year PFS, % (95% CI)
Brigatinib (n=40)[a]	20 (50)	24.0 mo (18.4–NR)	43 (25–59)
Crizotinib (n=41)[a]	30 (73)	5.6 mo (3.8–9.4)	10 (2–25)

Patients Without Brain Metastases at Baseline



Treatment	No. (%) Patients With Events	Median PFS (95% CI)	2-Year PFS, % (95% CI)
Brigatinib (n=97)[a]	43 (44)	24.0 mo (15.7–NR)	50 (39–61)
Crizotinib (n=97)[a]	57 (59)	13.0 mo (9.5–21.1)	32 (22–43)

[a] Per investigator assessment

Courtesy of Solange Peters, MD, PhD

Camidge, ESMO Asia 2019.

The obvious competition
Intracranial activity alectinib vs brigatinib

Intracranial Efficacy	ALTA-1L		ALEX	
	Brigatinib	Crizotinib	Alectinib	Crizotinib
Measurable Brain Metastases (N)	18	21	21	22
ORR % (95% CI)	78 (52,94)	26 (10,48)	81 (58,95)	50 (28,72)
Any brain metastases (N)	47	49	64	58
HR (95% CI) for PFS with any BM	0.25 (0.14–0.46)		0.40 (0.25–0.64)	

Courtesy of Solange Peters, MD, PhD

Caution should be exercised when making cross-trial comparisons due to differences in study design and patient baseline characteristics.
Adapted from Blackhall F. WCLC 2018; Camidge DR, et al. *N Engl J Med* 2018;379(21):2027-39. Peters S, et al. *N Engl J Med* 2017;377:829-38.

ALKi TOXICITIES

CERITINIB

NAUSEA
DIARRHEA
VOMITING
ALT, AST, GAMMA-GT
ALP

ALECTINIB

ALT, AST, GAMMA-GT
OEDEMA
FATIGUE
MYALGIA
LUNG TOXICITY
(LATE ONSET)

BRIGATINIB

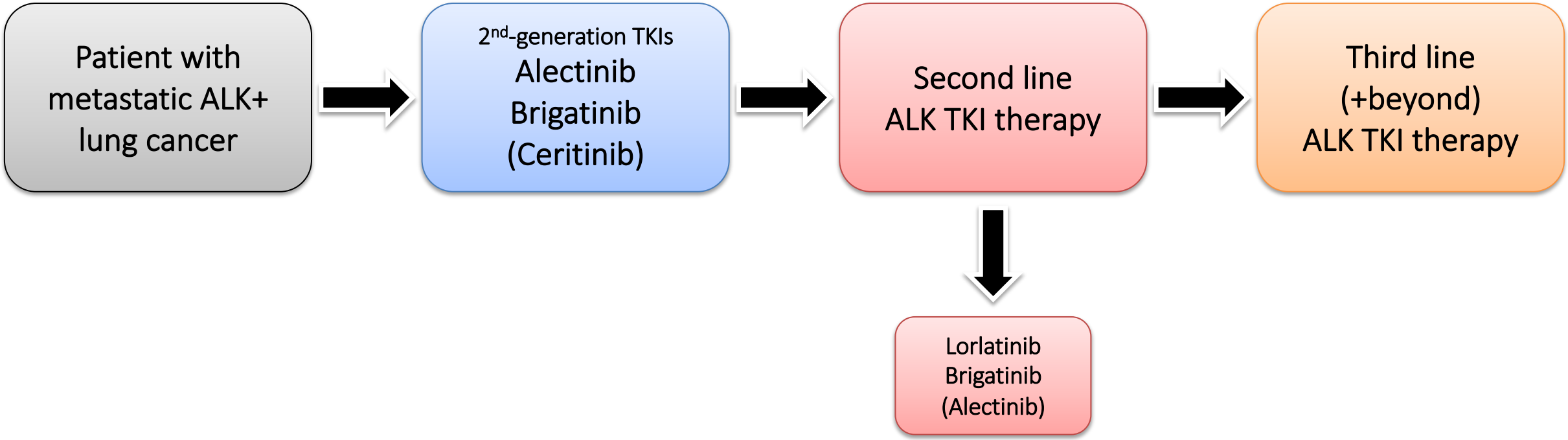
CPK
HYPERTENSION
LIPASE
AMYLASE
DIARRHEA

LUNG TOXICITY
(EARLY ONSET)

Courtesy of Solange Peters, MD, PhD

Second line therapy for ALK+ lung cancer, after a 2nd-generation ALK TKI

Much less data in this scenario…



Can we bring resistance biomarker selection into the sequence of ALK TKIs in lung cancer?

Courtesy of Solange Peters, MD, PhD

Modified from Lovly, AACR 2018

Challenging Questions and Cases

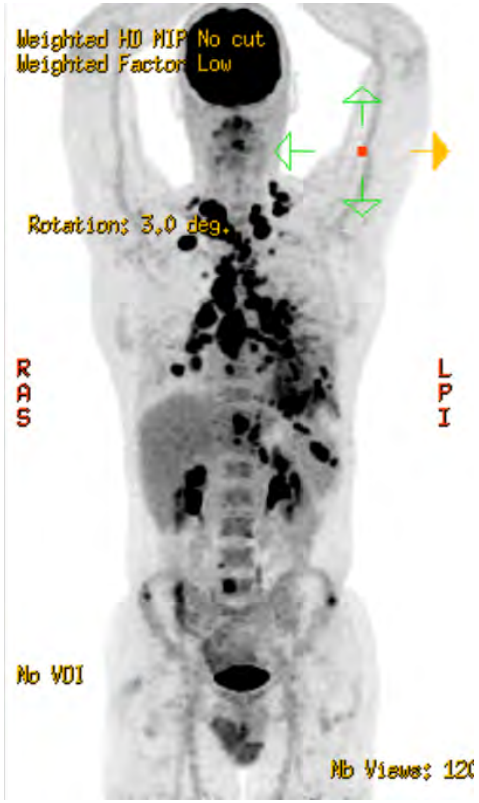
Which of the following ALK inhibitors is likely to be the most efficacious and tolerable as first-line treatment for a patient with metastatic nonsquamous NSCLC with an ALK rearrangement?

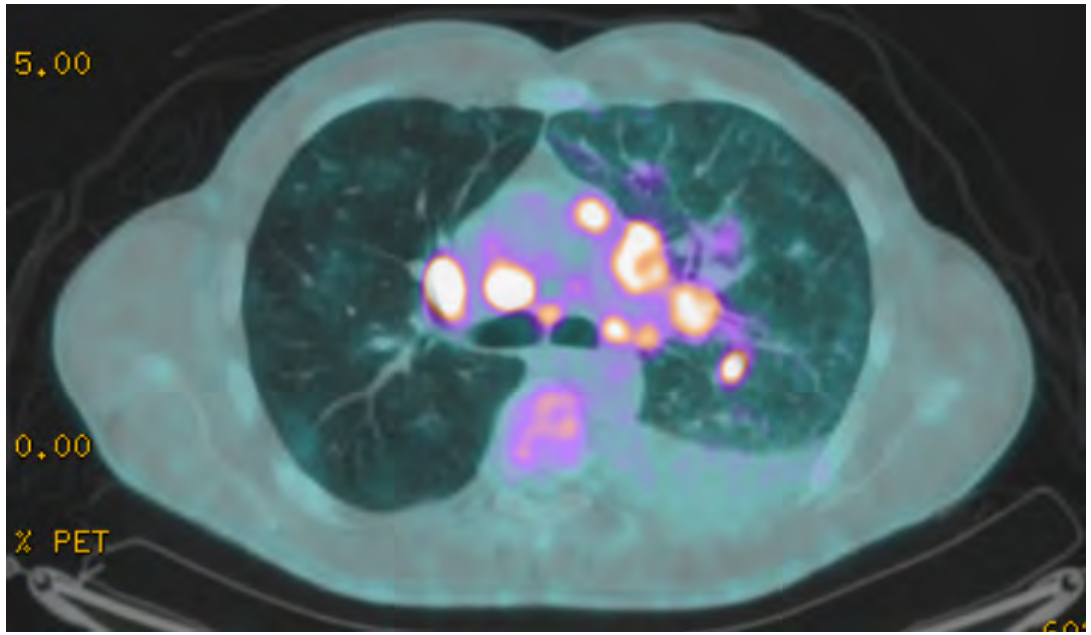
a. Alectinib
b. Brigatinib
c. Ceritinib
d. Any of the above — it is a coin-flip
e. I don’t know

Challenging Questions and Cases

Case Presentation – Professor Peters: A 59-year-old patient with adenocarcinoma of the lung and an ALK rearrangement

- Patient was born in 1971, excellent general state, never smoker
- Very sportive – progressive limitations in running performances
- Progressive cough and fatigue
- Family doctor asks for a CT scan, then a PET/CT, early 2015

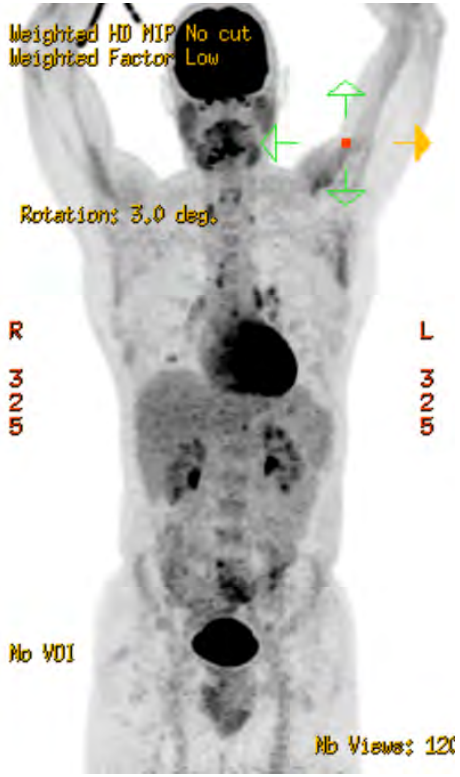


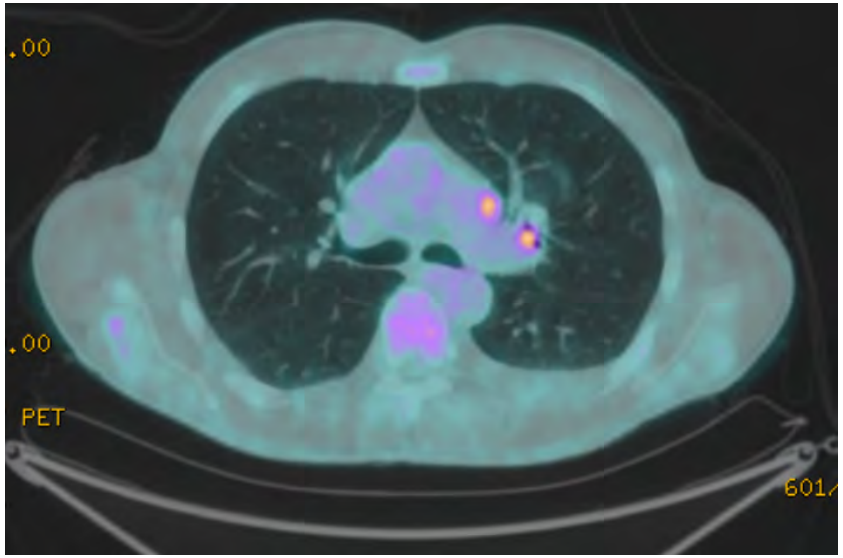


Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 59-year-old patient
-- Supraclavicial node biopsy

- Adenocarcinoma, solid & acinar, TTF-1 positive, EGFR WT
- IHC positive for ALK
- No brain lesions at MRI
- Emergency crizotinib introduction for rapidly worsening general symptoms. PET-CT after 6 weeks

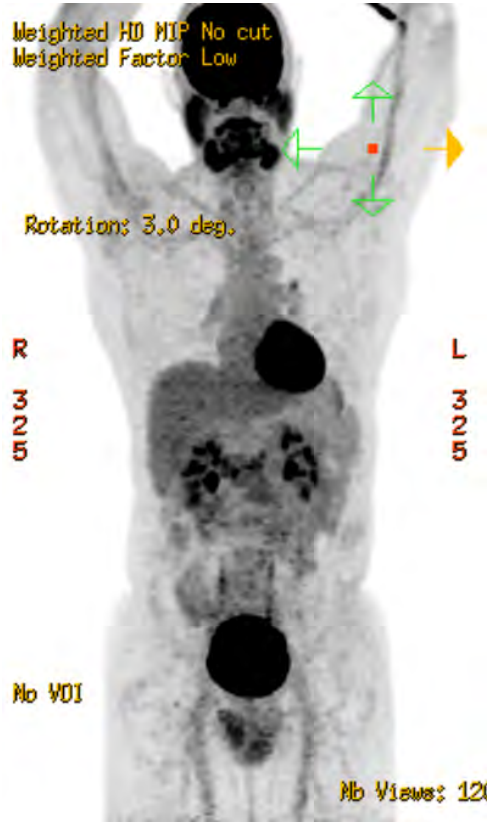


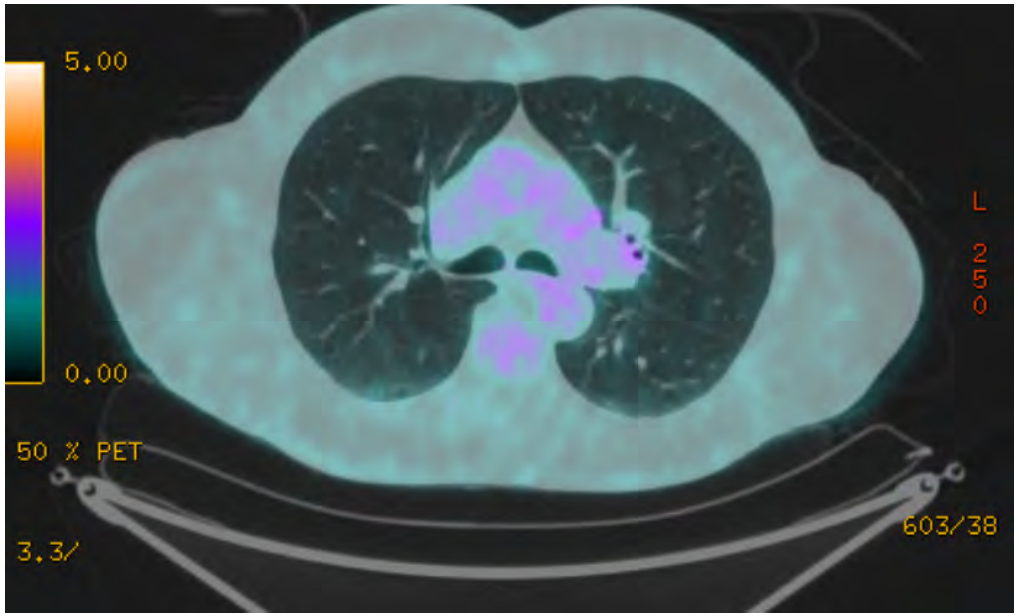


Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 59-year-old patient
-- After 9 months

- CR, no brain lesion at MRI
- Resuming a normal life, despite some nausea grade 1 and visual disturbances, running, and working 100%

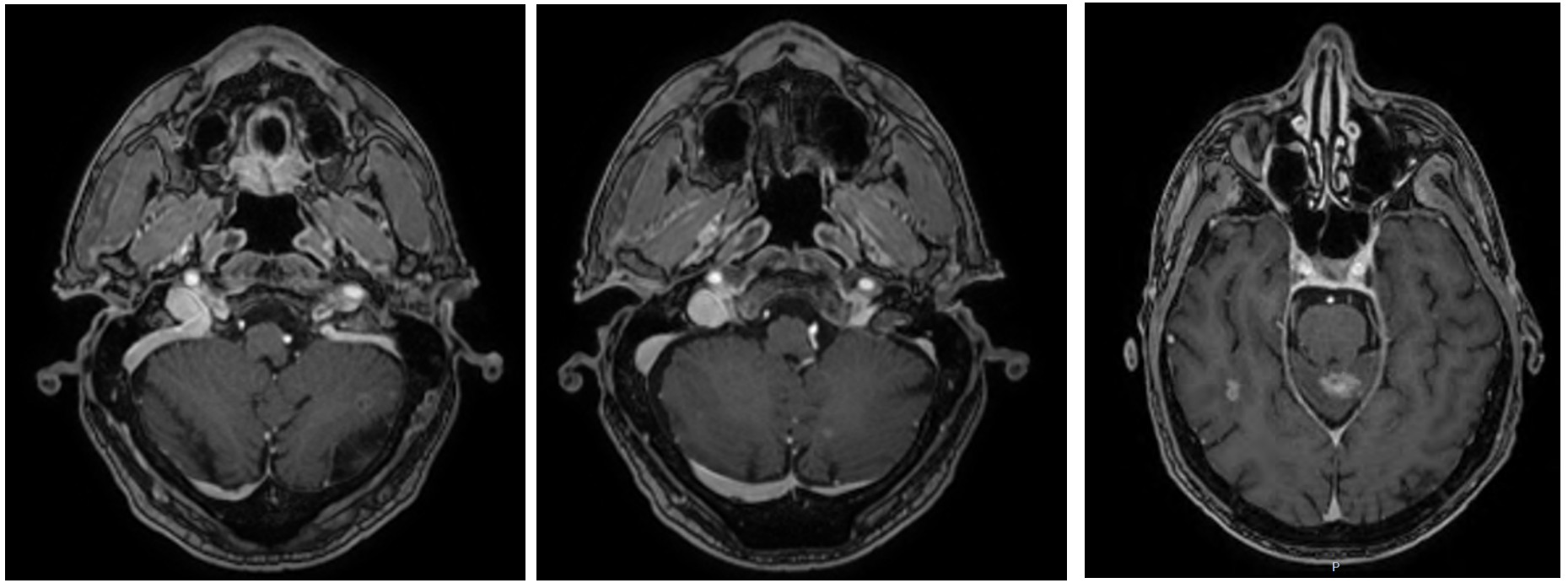




Courtesy of Solange Peters, MD, PhD

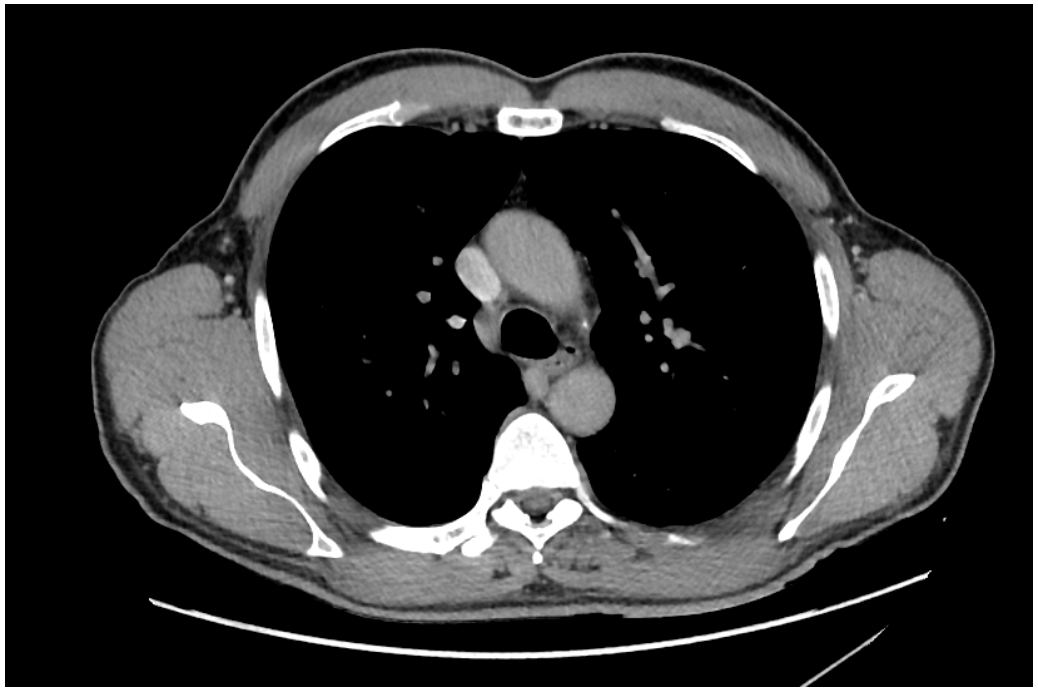
Case Presentation – Professor Peters: A 59-year-old patient
-- After 18 months

- No significant general symptoms
- Experiences some episodes of dizziness after running
- PET/CT: persistence of a CR.
- But…



Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 59-year-old patient
-- At Disease Progression

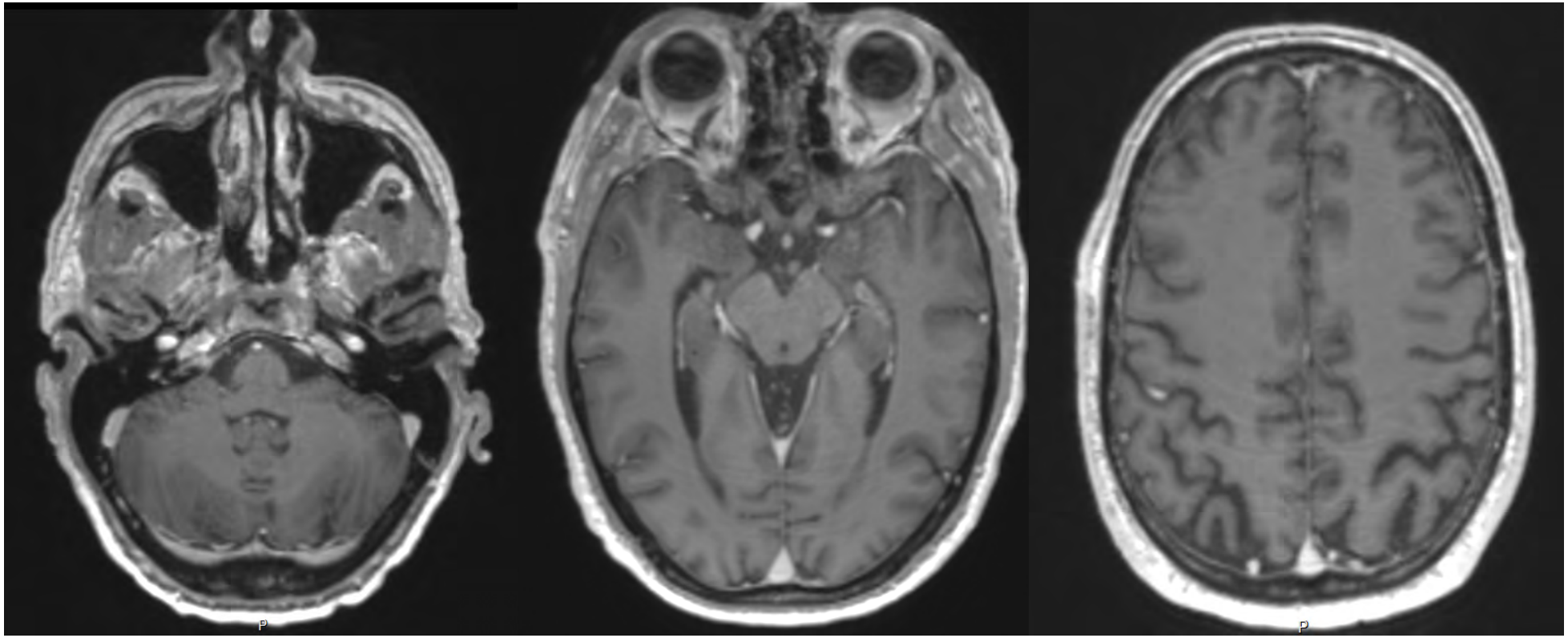


- No systemic relapse
- Introduction of Alectinib 600 mg bid
- Complete disappearance of dizziness and fatigue in 4 weeks

Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 59-year-old patient
-- Today, > 5 years later

- Complete remission, working 100%
- Teaching sport again, despite some fluctuating myalgia and significant photosensitivity

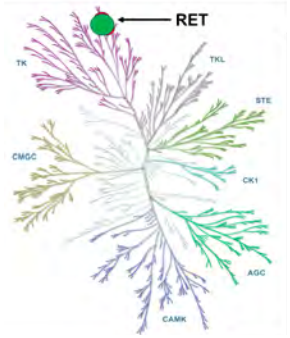


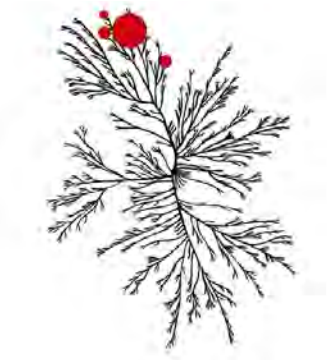
Courtesy of Solange Peters, MD, PhD

MODULE 3: RET Fusion-Positive Disease

- **Key Relevant Data Sets**
- **Questions and Cases from Investigators**
- **Faculty Case – Dr Drilon**
  - 33-year-old woman with adenocarcinoma of the lung and an EML4-RET fusion mutation and a TP53 frameshift mutation

Selective RET inhibitors are active in *RET* fusion-positive NSCLC





	Selpercatinib (LIBRETTO-001)	Pralsetinib (ARROW)
ORR		
Treatment naïve	85% (70-94, n=39)	66% (46-82, n=29)
Platinum pretreated	64% (54-73, n=105)	55% (45-66, n=92)
-Intracranial ORR	91% (59-100, n=11)	(not reported)
Median PFS		
Treatment naïve	not reached (14-NE)	17 months (14-NE)
Platinum pretreated	(not reported)	(not reported)

*both by independent review and in intent-to-treat population; NE – not evaluable

Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Goto et al, ASCO 2020; Gainor et al, ASCO 2020

Selective RET inhibitors are well tolerated

	Selpercatinib (n=531)	Pralsetinib (n=354)
Treatment-related AEs, any grade		
AST/ALT Increase	26%	31%
Anemia/Leukopenia/Neutropenia	-	22%
Hypertension	24%	20%
Dry mouth	33%	11%
Diarrhea	22%	14%
Fatigue	18%	12%

Goto et al, ASCO 2020; Gainor et al, ASCO 2020

Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Case Presentation – Dr Drilon: 33-year-old woman with adenocarcinoma of the lung and an EML4-RET fusion mutation

- Patient presented with cough and dyspnea. Computed and positron-emission tomography imaging revealed a hypermetabolic 4.8-cm right lower lobe mass, mediastinal and hilar adenopathy, and osseous metastases involving L1, the sacrum, and the left anterolateral sixth rib.
- MRI of the brain showed three sub-centimeter enhancing foci in the right precentral gyrus, right parietal lobe, and left temporal lobe. Endobronchial biopsy of an R4 lymph node revealed adenocarcinoma with signet ring cell features
- Tumor cells were positive for TTF-1 and negative for p40 by immunohistochemistry
- NGS identified an EML4-RET fusion in addition to a TP53 frameshift mutation.
- Patient was treated with the investigational anti-RET multikinase inhibitor agerafenib (RXDX-105).
- Although a confirmed PR was initially achieved (a near-complete response in her brain metastases), her course was marked by isolated asymptomatic intracranial progression requiring multiple radiation treatments.

Guo R et al. JCO Precis Oncol 2019;[Epub ahead of print].

Courtesy of Alexander E Drilon, MD

Case Presentation – Dr Drilon: 33-year-old woman (cont)

- A year after initiating therapy, she underwent stereotactic radiosurgery (21 Gy) to five new enhancing sub-centimeter parenchymal metastases.
- Seven months later, she developed further intracranial progression requiring 42 Gy of stereotactic radiosurgery to seven additional lesions. Given absence of extracranial disease progression, agerafenib (RXDX-105) was continued.
- Four months later, the patient developed symptomatic progression of brain metastases and new leptomeningeal disease.
- She presented with left facial, tongue, and upper extremity tingling and worsening neck pain. These symptoms were deemed to be secondary to leptomeningeal disease that was identified radiologically in the right hemisphere, predominantly in the right parietal lobe, recognizing that nonradiologically apparent disease was likely present in other areas
- Multiple brain metastases had also increased. The total volume of radiologically significant intracranial metastases was 20.1 cm^3
- Patient declined lumbar puncture; a brain biopsy to potentially determine the mechanism of resistance to agerafenib (RXDX-105) was not deemed safe. Extracranial imaging again showed no evidence of disease

Guo R et al. JCO Precis Oncol 2019;[Epub ahead of print].

Courtesy of Alexander E Drilon, MD

Case Presentation – Dr Drilon: 33-year-old woman (cont)

- Given that the patient was highly symptomatic with progressive symptoms, a single-patient use protocol of selpercatinib was approved by the FDA and institutional review board
- Imaging assessments were performed every 8 weeks
- A clinical response to therapy was achieved within the first week of therapy, with improvement and subsequent resolution of the patient's neurologic symptoms. This was accompanied by a confirmed radiologic response to therapy.
- A partial response in the brain was achieved at follow-up imaging assessment at 16 weeks and confirmed by subsequent imaging
- In addition, selpercatinib therapy achieved complete resolution of leptomeningeal enhancement. Volumetric assessment revealed a continued decrease in the total volume of significant intracranial disease, with a maximal shrinkage of 65% at 5 months
- The patient continues to receive selpercatinib at 10.8 months, with ongoing radiologic disease control and no neurologic symptoms. She reports only grade 1 fatigue. There continues to be no evidence of extracranial disease

Guo R et al. JCO Precis Oncol 2019;[Epub ahead of print].

Courtesy of Alexander E Drilon, MD

For a patient with metastatic nonsquamous NSCLC with a RET rearrangement and a TPS of 10%, in what line of therapy should targeted treatment (eg, selpercatinib, pralsetinib) be used?

a. First line
b. Second line
c. Third line
d. Fourth line and beyond

Challenging Questions and Cases

MODULE 4: Targeting MET in MET Exon 14-Altered Disease

- **Key Relevant Data Sets**
- **Faculty Case – Dr Drilon**
  - 72-year-old woman with adenocarcinoma of the lung and a MET exon 14 alteration

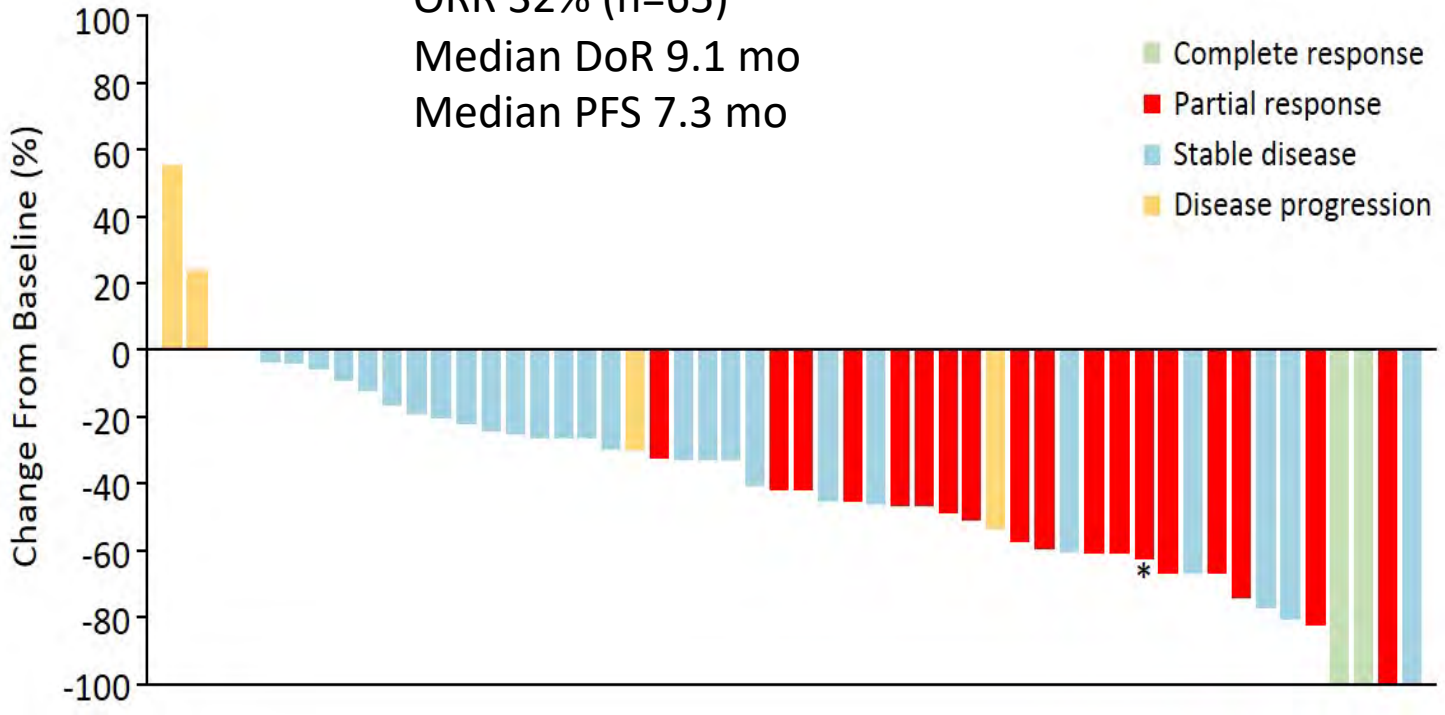
Targeting MET in *MET* exon 14-altered lung cancers

Type Ia Multikinase

Type Ib Selective and More Potent

Capmatinib
Tepotinib
Savolitinib

<u>Crizotinib</u>
ORR 32% (n=65)
Median DoR 9.1 mo
Median PFS 7.3 mo



Drilon et al, Nature Med 2019

Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Activity and safety of selective MET inhibitors

	Capmatinib (GEOMETRY)	Tepotinib (VISION)
ORR		
Overall	(not reported)	46% (36-57, n=99)
Treatment naïve	67% (48-84, n=28)	44% (29-60, n=43)
Second line	48% (30-67, n=31)	48% (30-66, n=33)
Median PFS		
Overall	(not reported)	8.6 months
Treatment naïve	9.7 months	(not reported)
Second line	8.1 months	(not reported)
Adverse events		
Peripheral edema	84%	63%

Groen et al ASCO 2020 (second-line), Wolf et al ASCO 2019 (treatment-naïve), Paik et al NEJM 2020

Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

For a patient with metastatic nonsquamous NSCLC with a MET exon 14 skipping mutation and a TPS of 10%, in what line of therapy should targeted treatment (eg, capmatinib, tepotinib) be used?

a. First line
b. Second line
c. Third line
d. Fourth line and beyond

Case Presentation – Dr Drilon: 72-year-old woman with adenocarcinoma of the lung and a MET exon 14 alteration

- 72 year-old woman who was diagnosed with a stage 1A T1N0M0 adenocarcinoma 8 years ago (started with an incidental nodule in the LUL on CXR). Recurred in the ipsilateral hilar and mediastinal nodes the next year – treated with concurrent chemoradiation.
- Two years later was found to have new hepatic and abdominal lymph nodes on surveillance imaging. A liver biopsy showed recurrent adenocarcinoma. Carbo/pem x 5 given, but remarkable for substantial fatigue and pancytopenia requiring transfusion. During this time, sequencing returned with a MET exon 14 alteration.
- The patient was treated on PROFILE 1001 with crizotinib. She had a confirmed complete response with therapy that lasts up to today (5 years into therapy). No major tolerability issues except for mild fatigue.

Courtesy of Alexander E Drilon, MD

MODULE 5: HER2-Mutant NSCLC

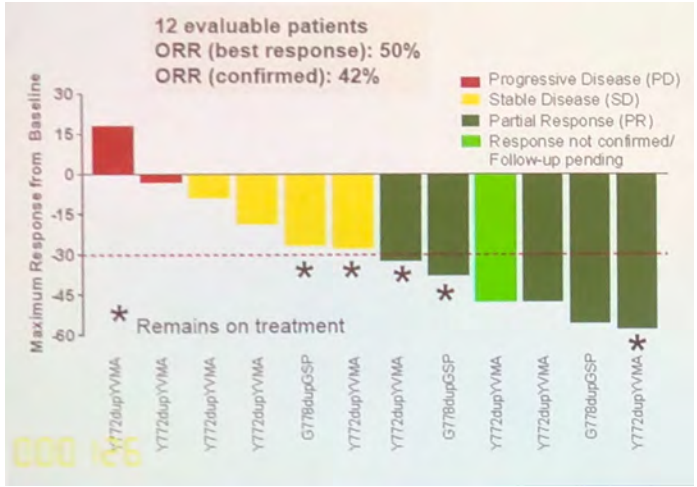
- Key Relevant Data Sets
- Questions and Cases from Investigators

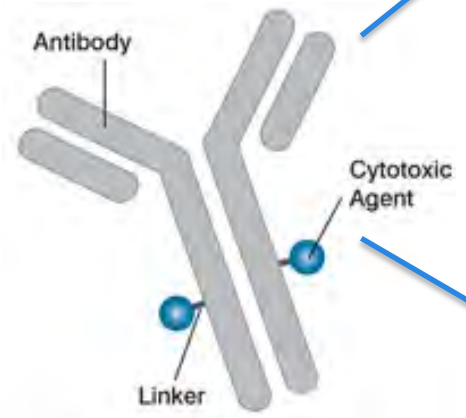
Targeted therapy is active in *HER2*-mutant NSCLC

HER2 TKIs

Afatinib, Neratinib, Dacomitinib, Lapatinib: ORR 0-13%

Poziotinib: ORR 42%
median PFS 5 mo

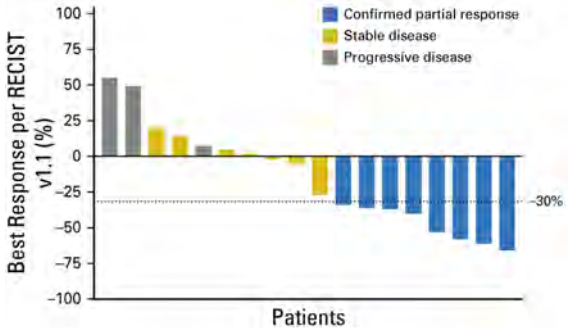




HER2 ADCs

Ado trastuzumab Emtansine (T-DM1)
ORR 44%
median PFS 5 mo
NCCN guidelines

Trastuzumab deruxtecan



Li et al, JCO 2018; Tsurutani et al, WCLC 2018; Heymach et al, WCLC 2018

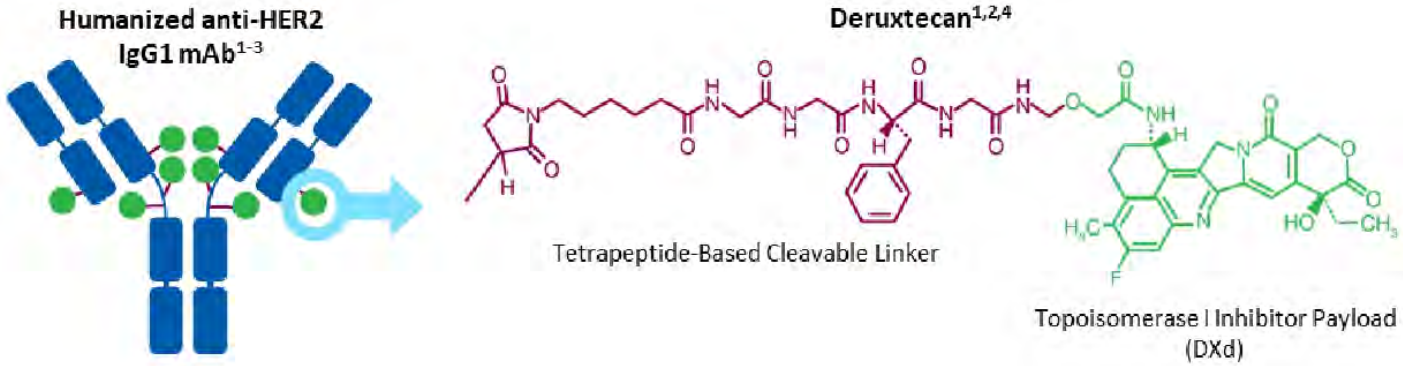
Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Trastuzumab deruxtecan: DESTINY-Lung01 phase 2 study

T-DXd is an ADC with 3 components:

- A humanized anti-HER2 IgG1 mAb with the same amino acid sequence as trastuzumab
- A topoisomerase I inhibitor payload, an exatecan derivative
- A tetrapeptide-based cleavable linker



	Patients (N = 42)
Age, median (range), years	63.0 (34-83)
< 65 years, %	59.5
Female, %	64.3
Region, % Asia / North America / Europe	35.7 / 31.0 / 33.3
ECOG performance status 0 / 1, %	23.8 / 76.2
HER2 mutation, %	
Kinase domain	90.5
Extracellular domain	4.8
Not reported	4.8
Presence of CNS metastases, %	45.2

Median prior lines of treatment: 2 (range, 1-6)

Prior Treatment, %	Patients (N = 42)
Platinum-based therapy	90.5
Anti–PD-1 or –PD-L1 inhibitor	54.8
Docetaxel	19.0

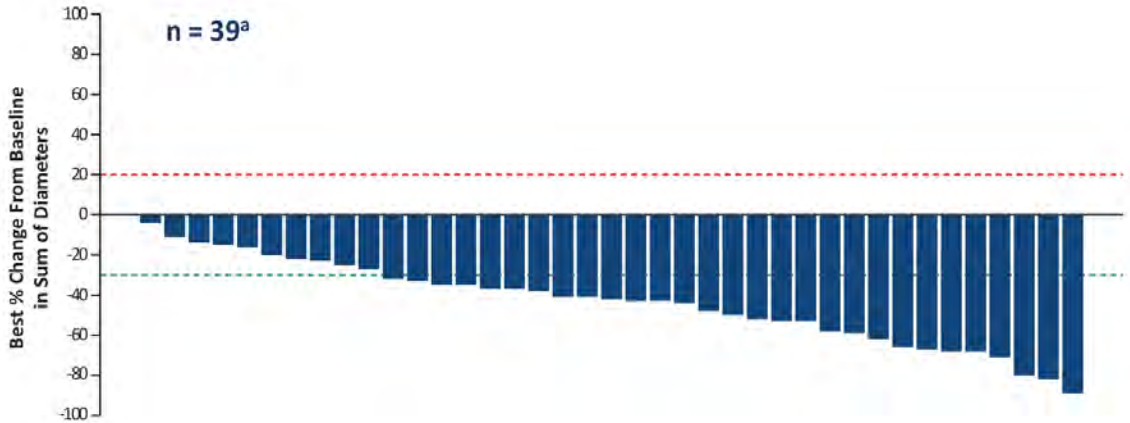
3 patients received prior poziotinib, 2 received afatinib, and 1 received mobocertinib

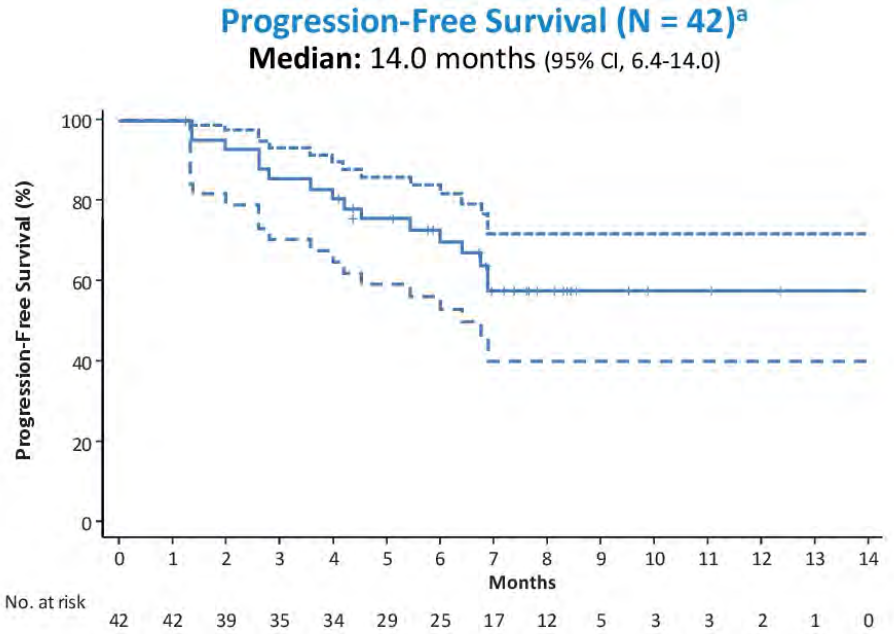
Smit et al, ASCO 2020

Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Trastuzumab deruxtecan is active in *HER2*-mutant NSCLCs





	Patients (N = 42)
Confirmed ORR by ICR	**61.9% (n = 26)** (95% CI, 45.6%-76.4%)
CR	2.4% (n = 1)
PR	59.5% (n = 25)
SD	28.6% (n = 12)
PD	4.8% (n = 2)
Not evaluable	4.8% (n = 2)
Disease control rate	90.5% (95% CI, 77.4%-97.3%)
Duration of response, median	Not reached (95% CI, 5.3 months-NE)
PFS, median	14.0 mo (95% CI, 6.4-14.0 months)

Most common AEs: nausea (>70%), alopecia/anemia/neutropenia (>40%)

	All Patients (N = 42)					
n (%)	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Any Grade/ Total
Interstitial lung disease	0[a]	5 (11.9)	0	0	0	5 (11.9)

- Median time to onset of investigator-reported ILD was at 86 days (range, 41-255 days)
- 4 patients had drug withdrawn and 1 had drug interrupted
- All patients received steroid treatment
- 2 patients recovered, 1 recovered with sequelae, 1 was recovering, and 1 had not recovered by data-cutoff
- No grade 5 ILD was observed in this cohort

Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Smit et al, ASCO 2020

Regulatory and reimbursement issues aside, what would be your preferred first-line treatment for a patient with metastatic nonsquamous NSCLC with a HER2 mutation and a TPS of 10%?

a. Carboplatin/pemetrexed/pembrolizumab
b. Atezolizumab/carboplatin/*nab* paclitaxel
c. Atezolizumab/carboplatin/paclitaxel
d. Ipilimumab/nivolumab
e. Trastuzumab deruxtecan
f. T-DM1
g. Neratinib
h. Other

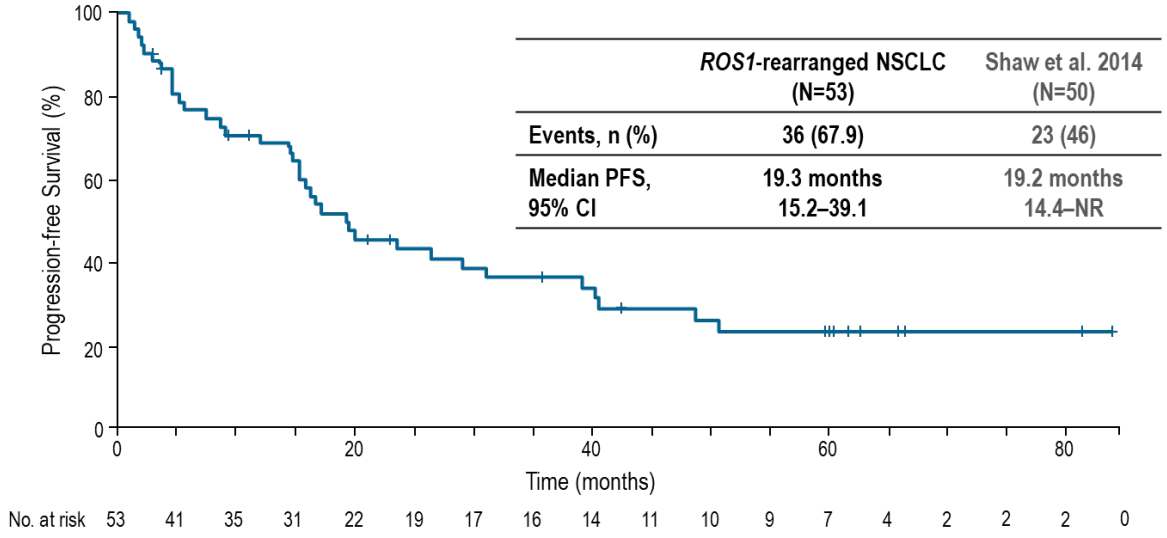
Challenging Questions and Cases

MODULE 6: Management of ROS1 Rearrangements

- **Key Relevant Data Sets**
- **Questions and Cases from Investigators**
- **Faculty Case – Professor Peters**
  - 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

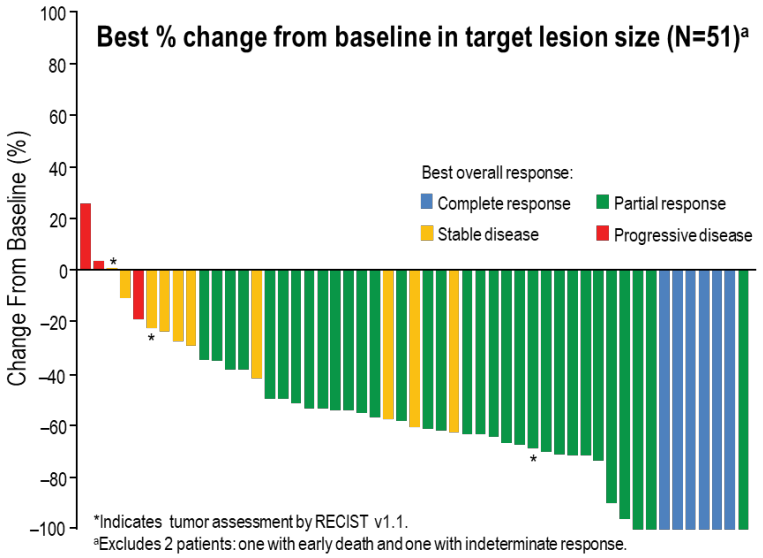
Focusing on ROS-1: Crizotinib

UPDATED PROGRESSION-FREE SURVIVAL



	ROS1-rearranged NSCLC (N=53)	Shaw et al. 2014 (N=50)
Events, n (%)	36 (67.9)	23 (46)
Median PFS, 95% CI	19.3 months 15.2–39.1	19.2 months 14.4–NR

UPDATED ANTITUMOR ACTIVITY



	ROS1-rearranged NSCLC (N=53)	Shaw et al. 2014 (N=50)
BOR, n (%)		
CR	6 (11.3)	3 (6)
PR	32 (60.4)	33 (66)
SD	10 (18.9)	9 (18)
PD	3 (5.7)	3 (6)
NE[a]	2 (3.8)	2 (4)
ORR, %	71.7	72
95% CI	57.7–83.2	58–84
Median TTR, wks	7.9	7.9
Range	4.3–103.6	4.3–32.0
Median DOR[b], mos	24.7	17.6
95% CI	15.2–45.3	14.5–NR

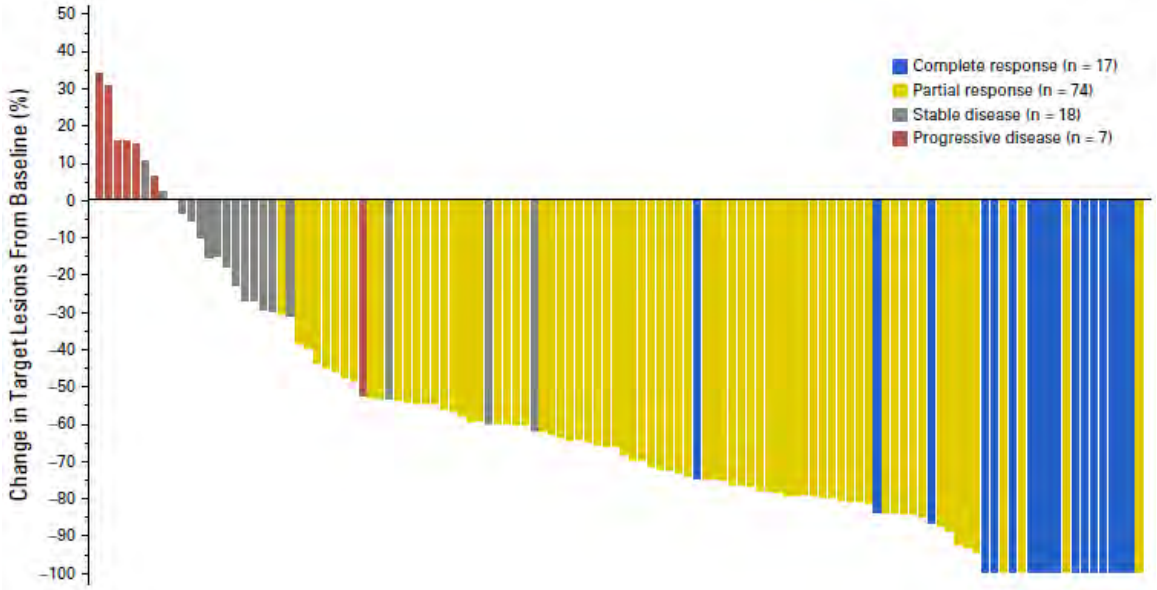
[a]Responses could not be evaluated in 2 patients because of early death or indeterminate response.
[b]Estimated using the Kaplan-Meier method.

Courtesy of Solange Peters, MD, PhD

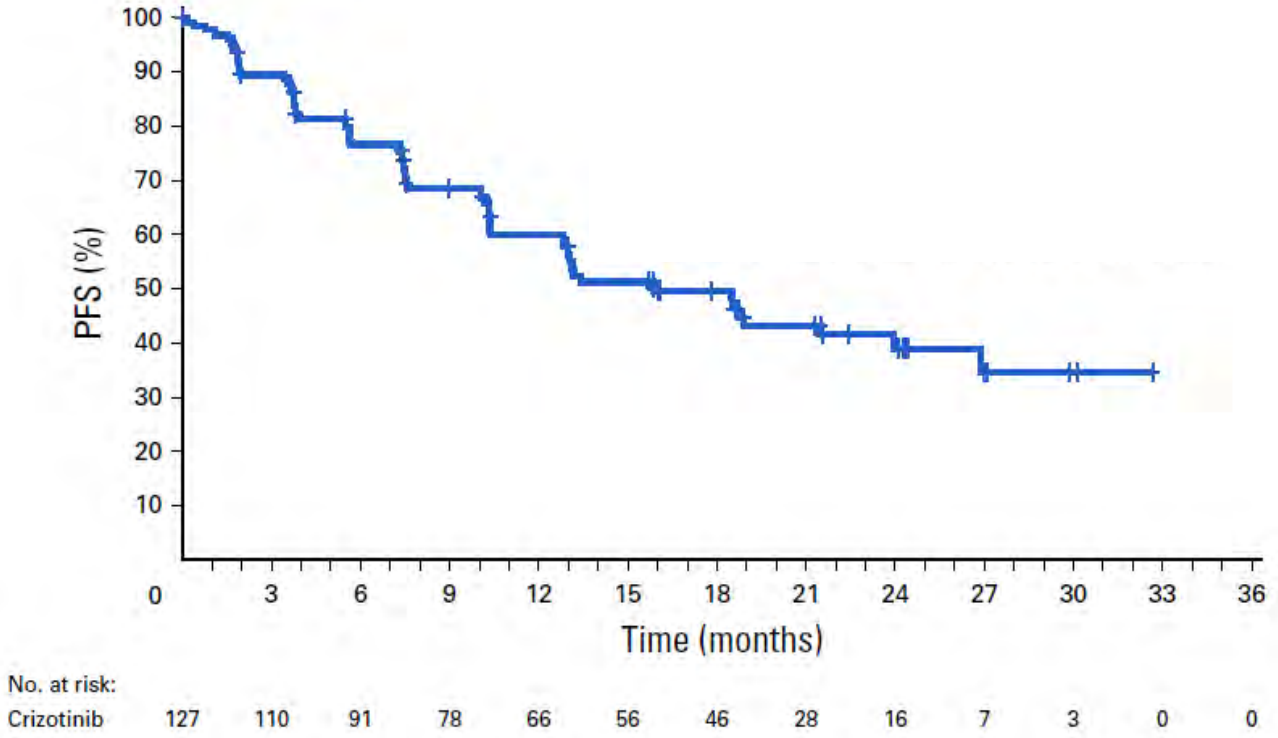
Shaw et al 2019 Crizotinib in ROS1-rearranged advanced non-small-cell lung cancer (NSCLC): updated results, including overall survival, from PROFILE 1001 N Engl J Med. 2014 Nov 20;371(21):1963-71

Phase II study of Crizotinib in East Asian Patients

ORR: 71.7 %



Median PFS, 15.9 months
(95% CI, 12.9 to 24.0 months)

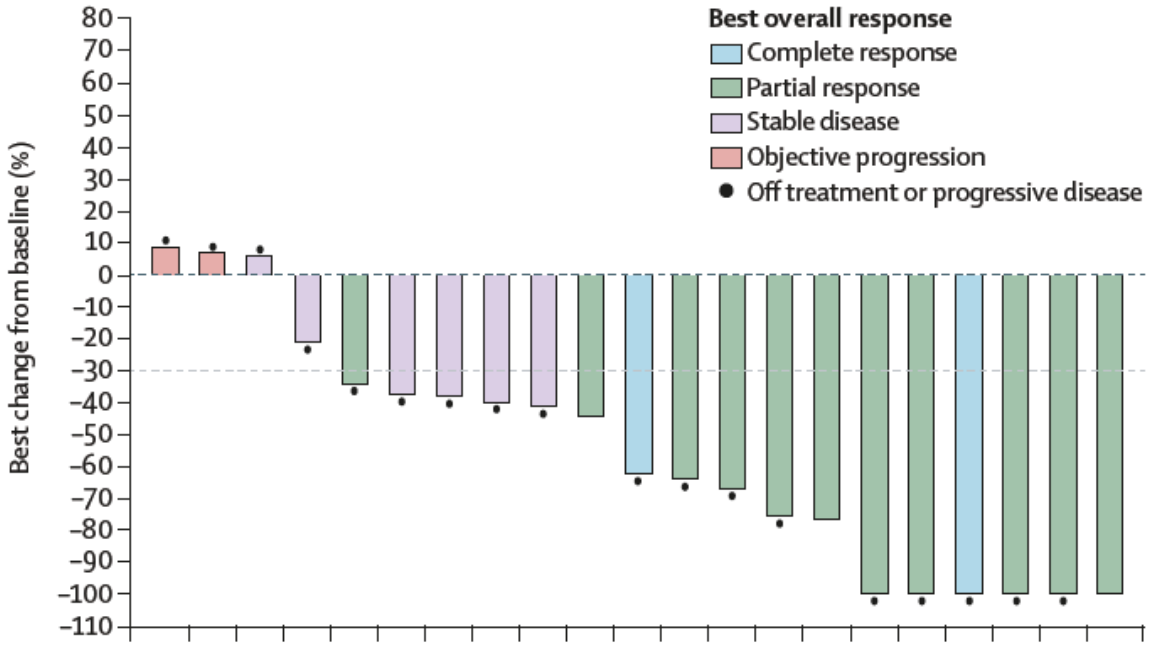


Courtesy of Solange Peters, MD, PhD

Wu et al 2018. Phase II Study of Crizotinib in East Asian Patients With ROS1-Positive Advanced Non–Small-Cell Lung Cancer J Clin Oncol. 2018 May 10;36(14):1405-1411

Lorlatinib multicenter, open-label, single-arm, phase 1–2 trial

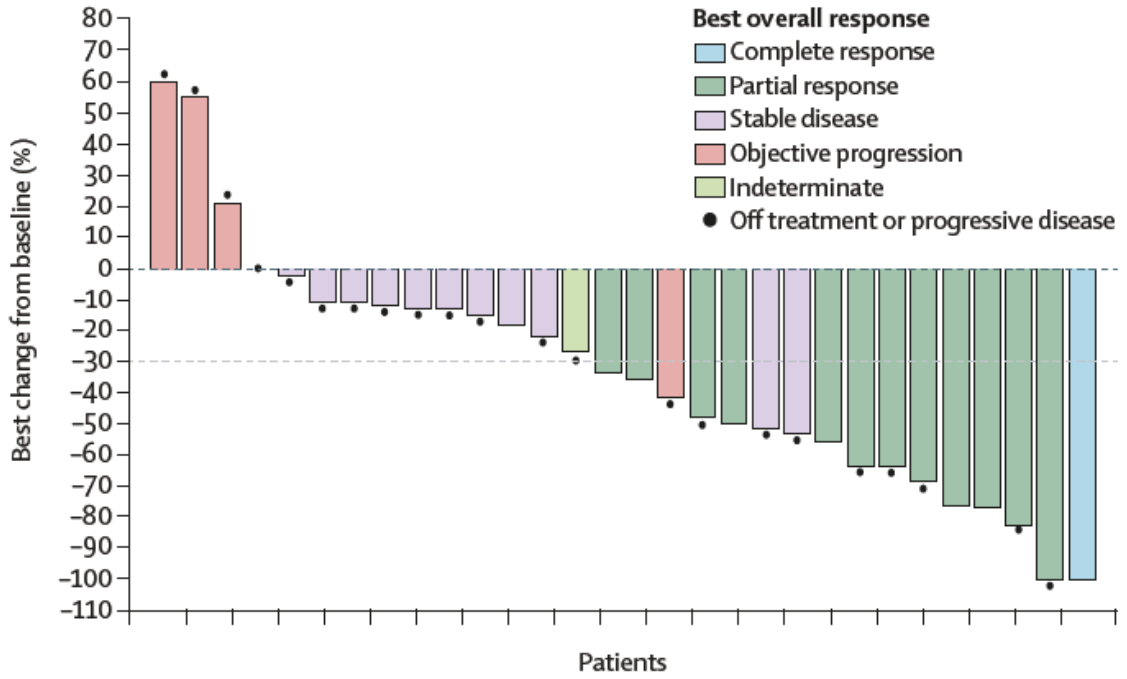
ROS1-TKI naïve pts (n=21)



ORR, %: 62 (38–82)

mDoR, month: 25.3 (7.5–31.9)

Crizotinib pretreated pts (n=40)



ORR: 35% (21-52)

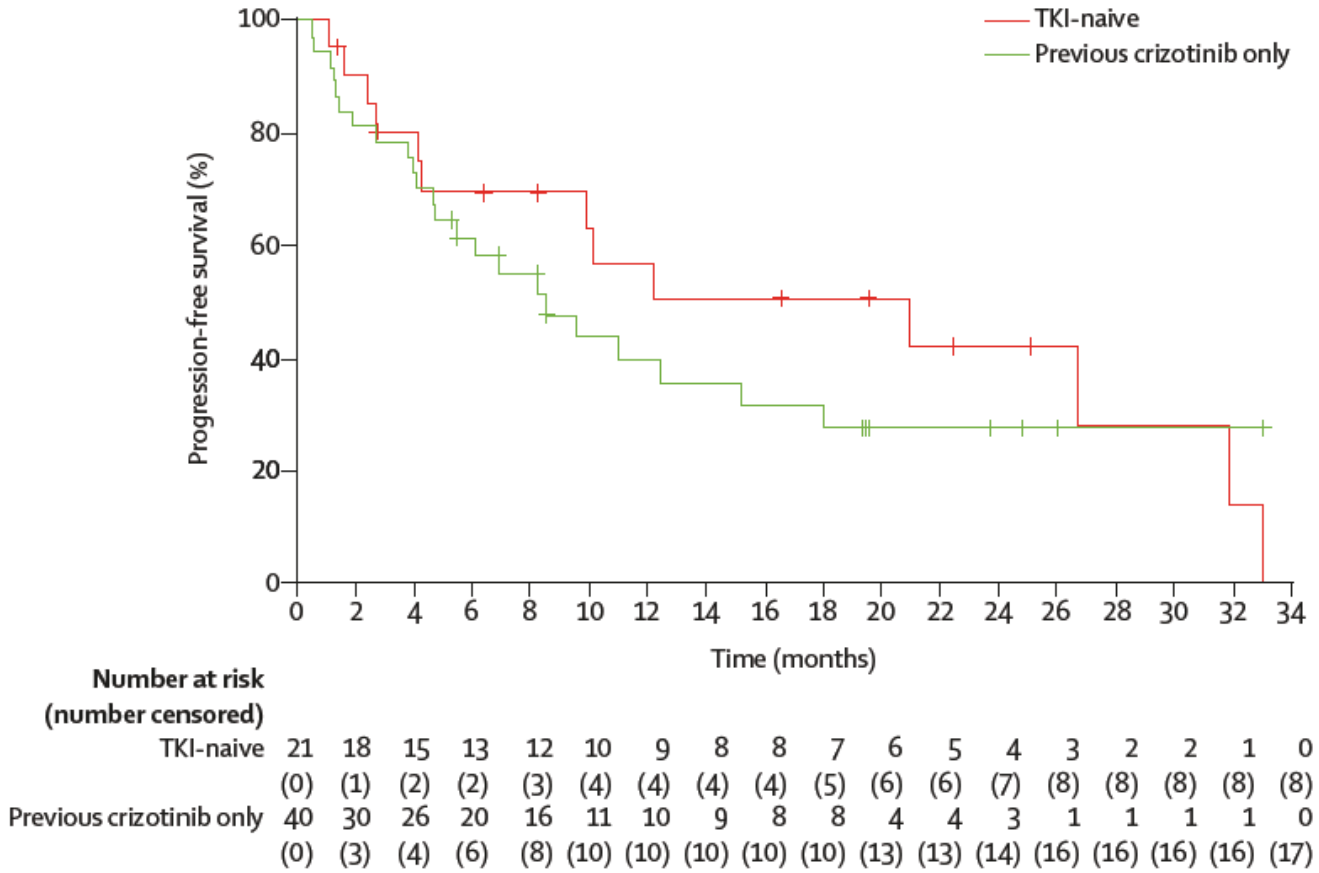
mDoR, month: 13.8 (9.7–NR)

Shaw et al 2020 Lorlatinib in advanced ROS1-positive non-small-cell lung cancer: a multicentre, open-label, single-arm, phase 1–2 trial Lancet Oncol. 2019 Dec;20(12):1691-1701. doi: 10.1016/S1470-2045(19)30655-2. Epub 2019 Oct 25.

Courtesy of Solange Peters, MD, PhD

Lorlatinib is not approved for ROS1+NSCLC by any HA

Overall efficacy of Lorlatinib



	TKI-naïve (n=21)	Prior crizotinib only (n=40)
Events, n (%)	13 (62)	23 (58)
mPFS, months (95% CI)	21.0 (4.2–31.9)	8.5 (4.7–15.2)

Shaw et al 2020 Lorlatinib in advanced ROS1-positive non-small-cell lung cancer: a multicentre, open-label, single-arm, phase 1–2 trial Lancet Oncol. 2019 Dec;20(12):1691-1701. doi: 10.1016/S1470-2045(19)30655-2. Epub 2019 Oct 25.

Courtesy of Solange Peters, MD, PhD

Lorlatinib is not approved for ROS1+NSCLC by any HA

Intracranial efficacy of Lorlatinib

CNS metastases were present at baseline in 39 (57%) of 69 patients;
19 (49%) of whom had received previous brain-directed radiotherapy

	TKI-naïve	Prior crizotinib only
INTRACRANIAL	CNS metastases were measurable and non-measurable	
No. of patients with baseline CNS metastases	11	24
Best overall intracranial response, n		
Complete response	5 (45%)	9 (38)
Partial response	2 (18%)	3 (13)
Stable disease	2 (18%)	6 (25)
Objective progression	2 (18%)	2 (8)
Indeterminate	0	4 (17)
Confirmed intracranial ORR, n	7 (64%)	12 (50)
95% CI	31–89	29–71
Duration of intracranial response, months		
Median (95% CI)	NR (5.7–NR)	NR (11.0–NR)

- 6 TKI-naïve patients had measurable BL CNS metastases and 4 (67%) achieved intracranial responses

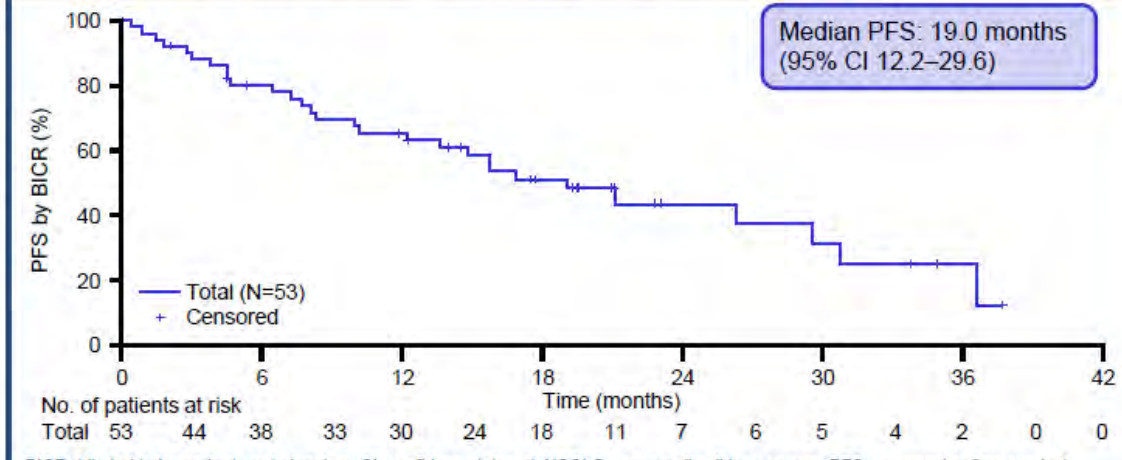
Shaw, Lancet Oncol. 2019.

Courtesy of Solange Peters, MD, PhD

Lorlatinib is not approved for ROS1+NSCLC by any HA

Integrated analysis of STARTRK-2, STARTRK-1 and ALKA-372-001: Entrectinib in ROS1-fusion positive NSCLC (TKI-naive)

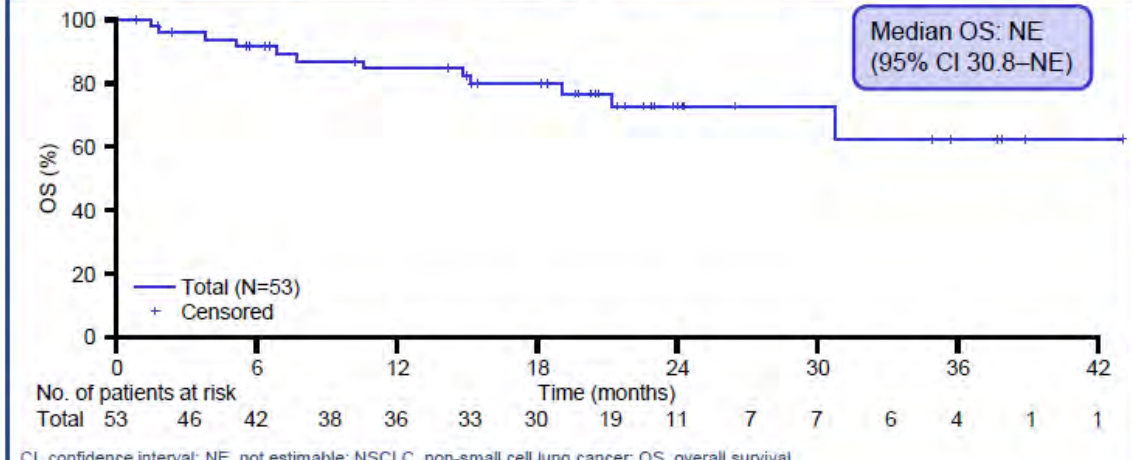
Figure 2. PFS per BICR in patients with *ROS1*+ NSCLC



BICR, blinded independent central review; CI, confidence interval; NSCLC, non-small cell lung cancer; PFS, progression-free survival

Responders, n (%)	*ROS1*+ NSCLC (n=53)
ORR, % (95% CI)	79.2 (65.9–89.2)
Complete response	5 (9.4)
Partial response	37 (69.8)
Stable disease	1 (1.9)
Progressive disease	4 (7.5)
Non complete/partial response	2 (3.8)
Missing/unevaluable	4 (7.5)

Figure 3. OS in patients with *ROS1*+ NSCLC



CI, confidence interval; NE, not estimable; NSCLC, non-small cell lung cancer; OS, overall survival

Table 3. IC ORR per BICR in *ROS1*+ NSCLC with baseline CNS disease

Responders, n (%)	*ROS1*+ NSCLC with baseline CNS disease (n=20)
ORR, % (95% CI)	55.0 (31.5–76.9)
Complete response	4 (20.0)
Partial response	7 (35.0)
Stable disease	0
Progressive disease	3 (15.0)
Non complete/partial response	4 (20.0)
Missing/unevaluable	2 (10.0)

CNS disease status determined by BICR
BICR, blinded independent central review; CI, confidence interval; CNS, central nervous system; NSCLC, non-small cell lung cancer
ORR, objective response rate

De Braud, ESMO 2019;Abstract 4178.

Courtesy of Solange Peters, MD, PhD

Entrectinib in ROS1-fusion positive NSCLC (TKI-naive)

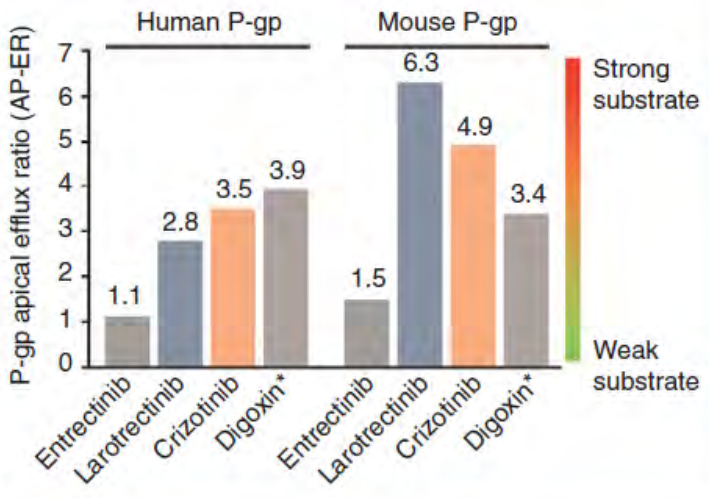


Fig. 2 In vitro P-gp AP-ER of entrectinib, larotrectinib, and crizotinib in LLC-PK1 cells stably transfected with human or mouse P-gp. Graphical representation of AP-ER (see Table 1) for entrectinib, larotrectinib, and crizotinib in human and mouse P-gp models. Based on this novel AP-ER model, entrectinib was shown to be a weak P-gp substrate, whereas larotrectinib and crizotinib were strong P-gp substrates. *Digoxin is an in vitro benchmark P-gp substrate, used as a control for the assay. AP-ER was calculated from $P_{app}^{A\rightarrow B}$ and $P_{app,inh}^{A\rightarrow B}$ (Equation 3). AP-ER, apical efflux ratio; P-gp, P-glycoprotein.

Table 2 Mean concentrations ($n = 4$) of entrectinib, crizotinib and larotrectinib in plasma, CSF and brain from rats after single i.v. bolus followed by i.v. infusion

Parameters	Entrectinib		Crizotinib		Larotrectinib	
	5 h	6 h	5 h	6 h	4 h	5 h
Plasma concentration, nM ± SD	1260 ± 430	1400 ± 109	477 ± 53.7	489 ± 47.9	330 ± 46.3	332 ± 82.2
δ plasma concentration at SS, nM (SD)	140 (109–430)		12 (47.9–53.7)		2 (46.3–82.2)	
Brain concentration, nM ± SD	567 ± 71.2	843 ± 186	390 ± 12.1	477 ± 131	21.4 ± 3.74	23.0 ± 5.60
δ brain concentration at SS, nM (SD)	276 (71.2–186)		87 (12.1–131)		1.6 (3.74–5.60)	
CSF concentration, nM ± SD	0.99 ± 0.2	0.81 ± 0.2	1.1 ± 0.36	0.78 ± 0.18	3.16 ± 0.76	3.56 ± 0.87
Unbound plasma concentration ($C_{u,p}$), nM[a]	4.0	4.5	27	28	115	116
Unbound brain concentration ($C_{u,b}$), nM[b]	0.28	0.42	0.94	1.1	9.9	11
Measured CSF/$C_{u,p}$ ratio	0.25	0.18[c]	0.041	0.028[d]	0.027	0.031[e]

[a] $C_{u,p}$ value initially calculated as product of mean plasma concentration by plasma F_u, and later determined using equilibrium dialysis in vitro.
[b] $C_{u,b}$ value was initially calculated as the product of mean brain concentration by brain F_u, and later determined using kinetic LIMBA.
[c] SS not reached after 6 hours.
[d] Near SS after 6 hours.
[e] Near SS after 5 hours.
δ, difference in concentrations between two different time points; CSF, cerebrospinal fluid; $C_{u,b}$, unbound drug concentration in brain; $C_{u,p}$, unbound drug concentration in plasma; F_u, unbound fraction; i.v., intravenous; LIMBA, lipid membrane binding assay; SD, standard deviation; SS, steady state.

Fischer, Neuro-Oncology 2020

Courtesy of Solange Peters, MD, PhD

Resistance on Crizotinib and ROS1 inhibitor in clinical trials

The activity of ROS1 inhibitors* against known crizotinib-resistant ROS1 mutations

	Gatekeeper	αC helix		Solvent front	
	L2026M	S1986Y/F	G2032R	D2033N	L1951R
Crizotinib	No	No	No	No	No
Ceritinib	Yes	No	No	No	No
Brigatinib	Yes	Unknown	No	No	No
Lorlatinib	Yes	Yes	Yes/No	Yes	Unknown
Entrectinib	No	Unknown	No	Unknown	Unknown
Repotrectinib	Yes	Unknown	Yes	Yes	Unknown
Cabozantinib	Yes	Unknown	Yes	Yes	Yes

This table is based on the available preclinical data, not all of which have been validated in the clinic. Of note, preclinical data for the activity of lorlatinib against G2032R has been mixed (and thus indicated as 'Yes/No'); clinical activity remains to be determined

* Ceritinib, Brigatinib, Lorlatinib, Repotrectinib, and Cabozantinib are not approved for ROS1+NSCLC by any health authority and Entrectinib is only FDA approved.

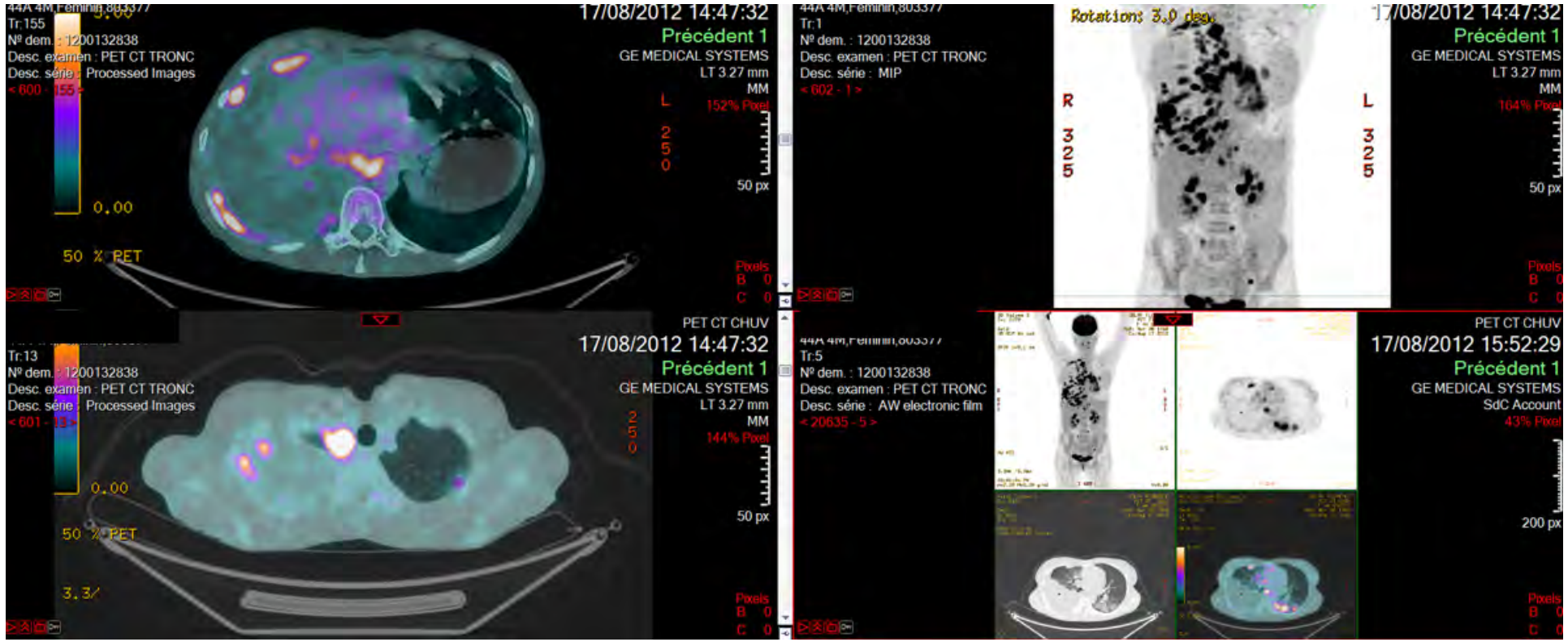
Lin et al 2017 Recent Advances in Targeting ROS1 in Lung Cancer J Thorac Oncol. 2017 Nov;12(11):1611-1625.

Courtesy of Solange Peters, MD, PhD

Challenging Questions and Cases

Case Presentation – Professor Peters: A 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

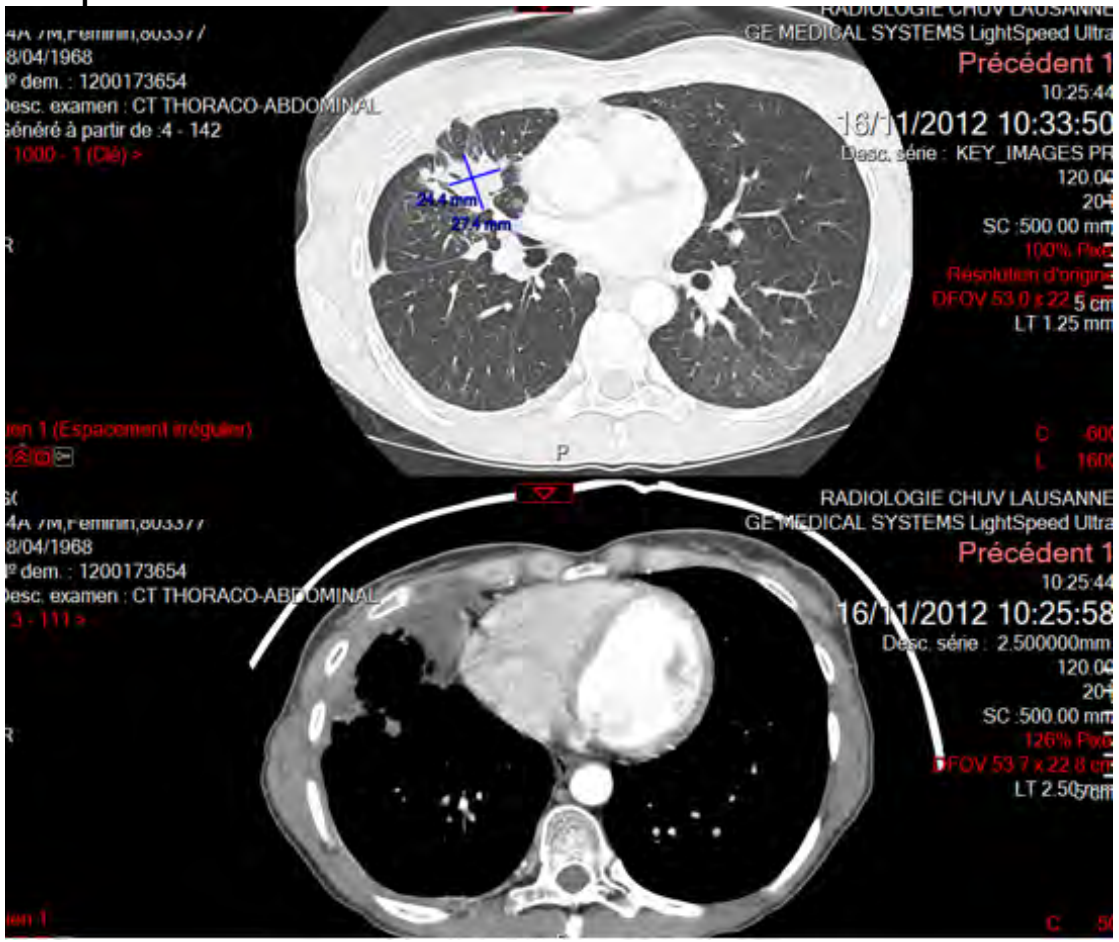
- 44 years old. Never smoker
- 08.2012: 1st diagnosis of stage IV right lung adenocarcinoma
- cT3 cN2 cM1b (pleural metastases and abdominal lymph nodes), 7th edition TNM
- Bronchoscopy and EBUS: No EGFR/HER2/KRAS mutations, no ALK rearrangement



Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

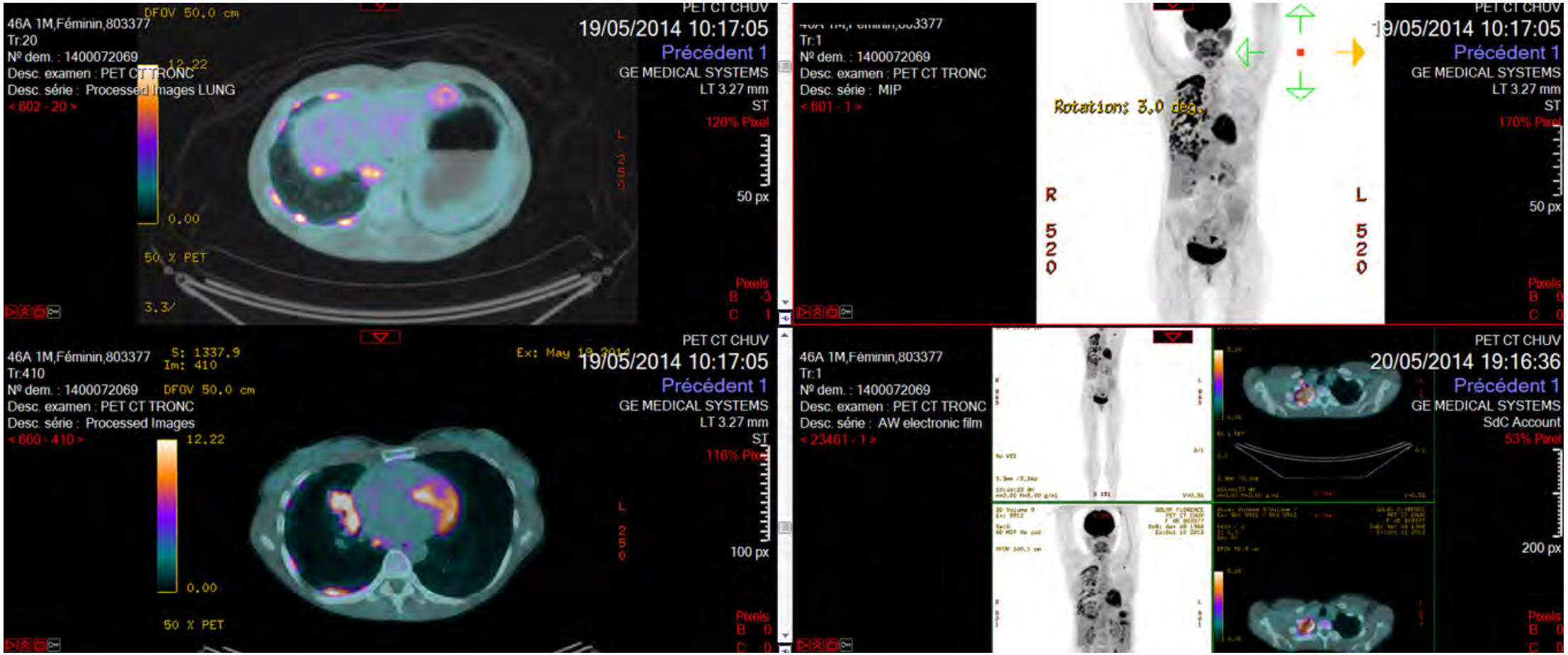
- 08.2012 to 2014: 1st line chemotherapy: 4 cycles of carboplatin/ pemetrexed-bevacizumab followed by 23 cycles of maintenance with
- Pemetrexed/bevacizumab
- PR as best response



Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

05.2014: PD (lung progression)

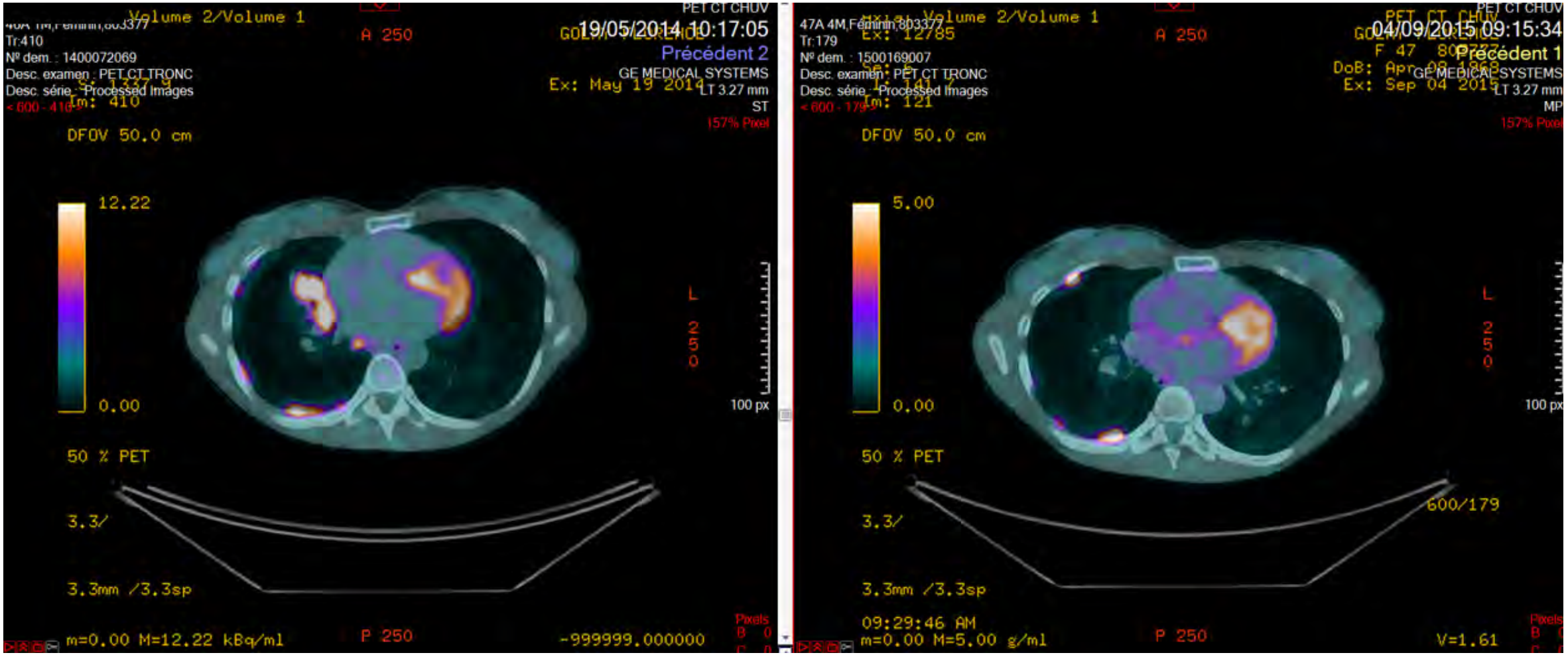


✓ ROS-1 rearrangement diagnosed by IHC (testing still in development then) confirmed by RT-PCR

Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

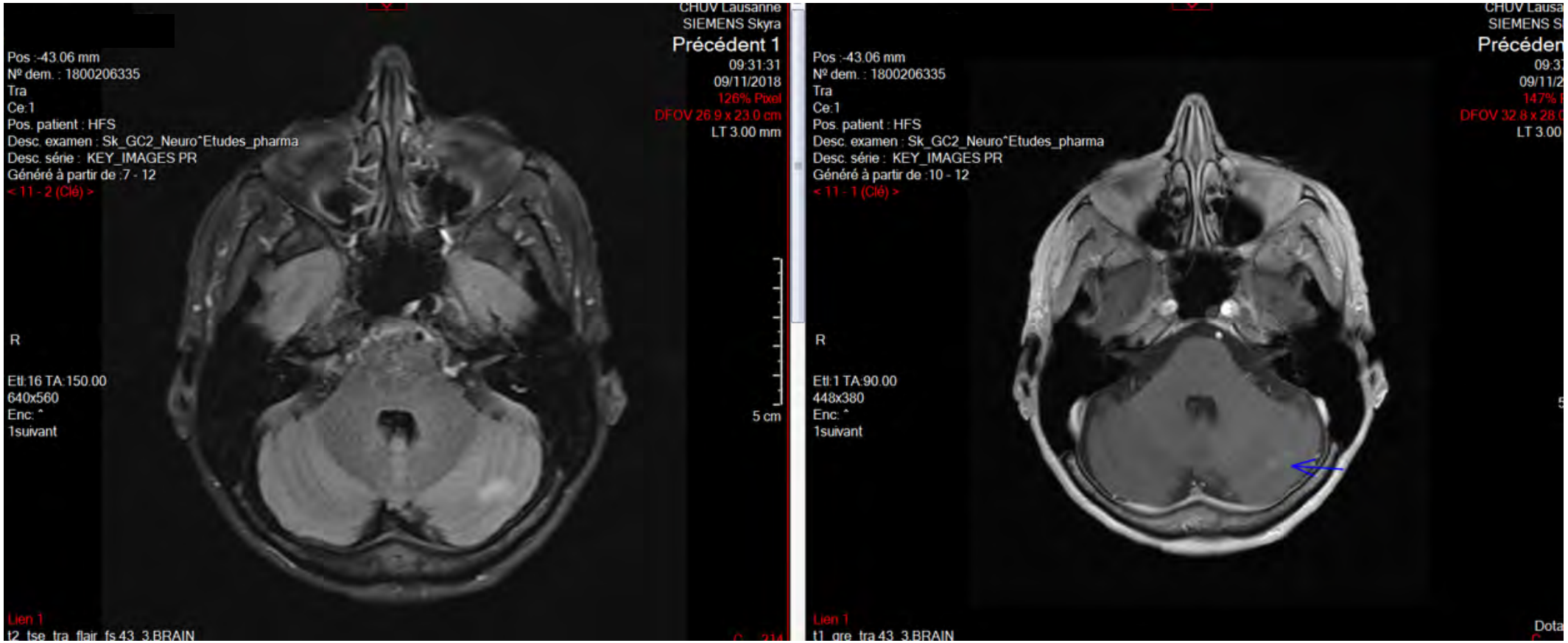
- 06.2014 to 05.2016: 2nd line with crizotinib 250 mg bid
- PR as best response



Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

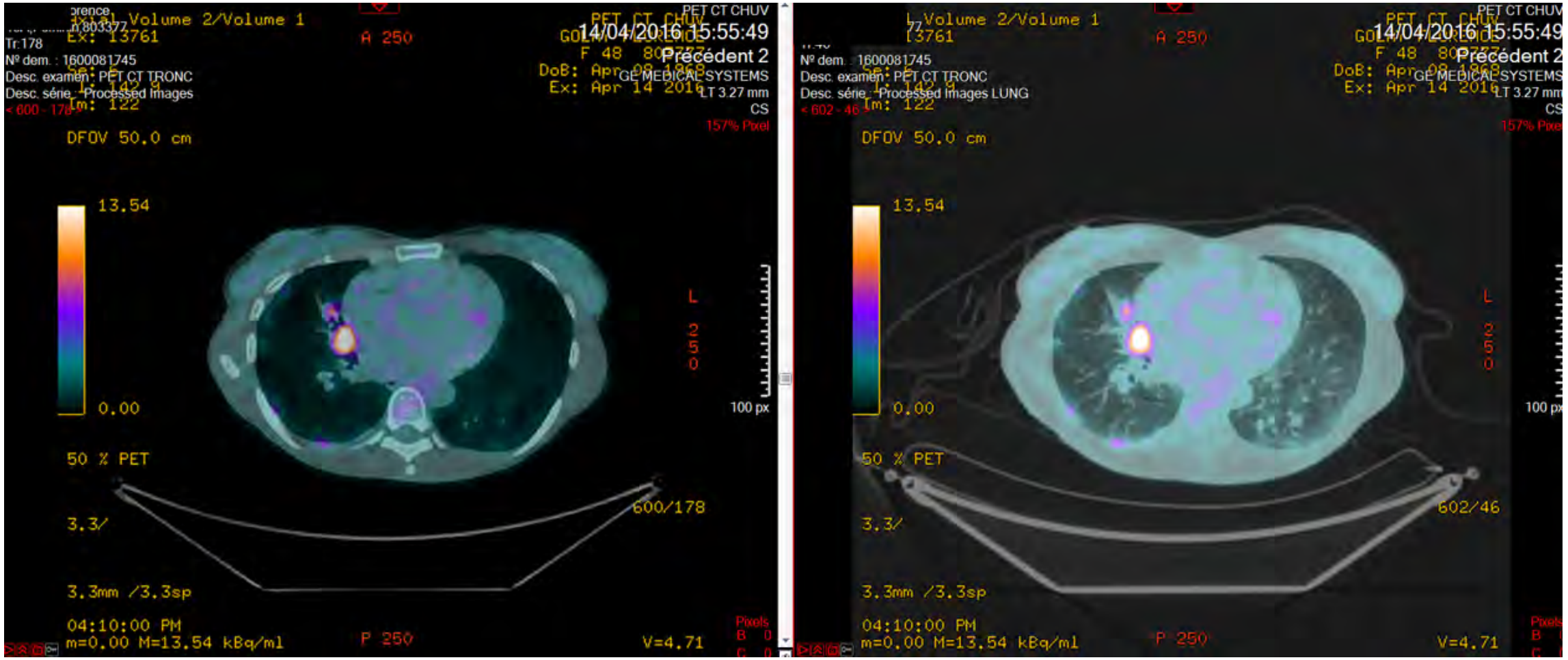
10.2015: CNS progression: SBRT
Continuation of crizotinib



Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

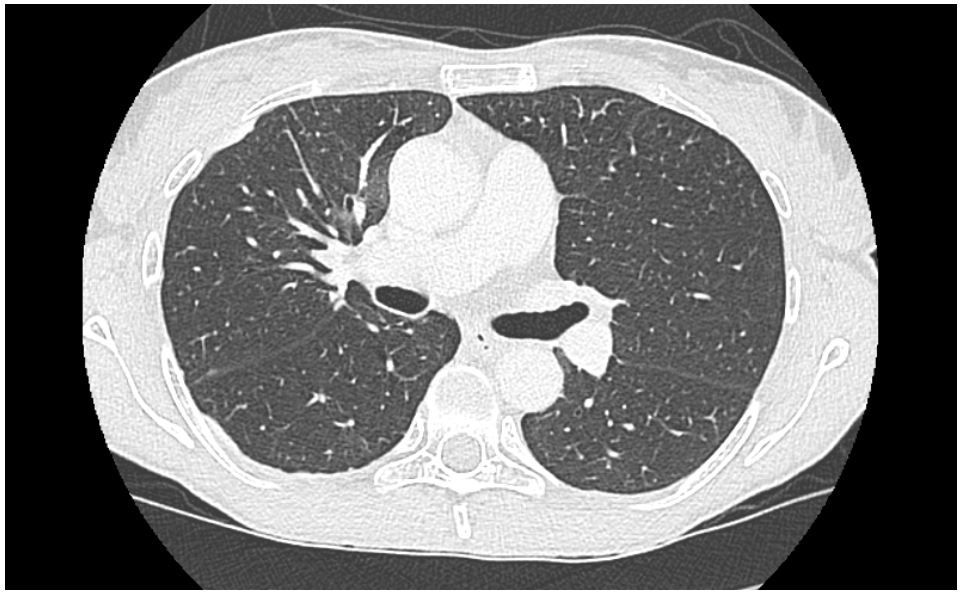
04.2016: PD (lung progression)



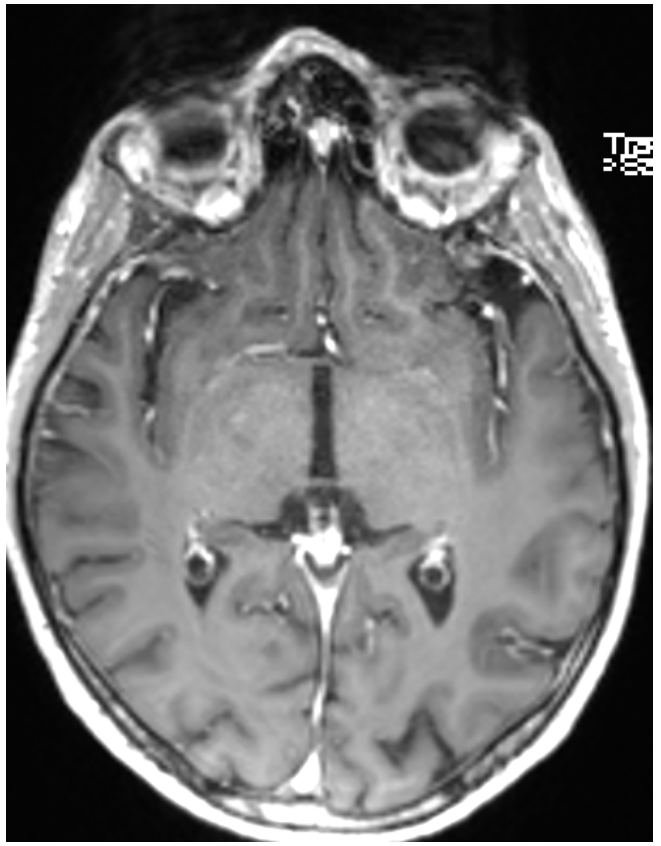
Courtesy of Solange Peters, MD, PhD

Case Presentation – Professor Peters: A 44-year-old with adenocarcinoma of the lung and a ROS1 rearrangement

- Since 08.2016: 3rd line lorlatinib and CR (best response)
  - Some mood changes (anxiety) and weight gain, severe hypercholesterolemia (grade 3)
  - Dose lowered to 75 mg/d
  - Improvement to grade 1



June 2020



Courtesy of Solange Peters, MD, PhD

MODULE 7: Other Targetable Genetic Abnormalities

- **Key Relevant Data Sets**

TRK inhibitors are active in TRK fusion-positive cancers

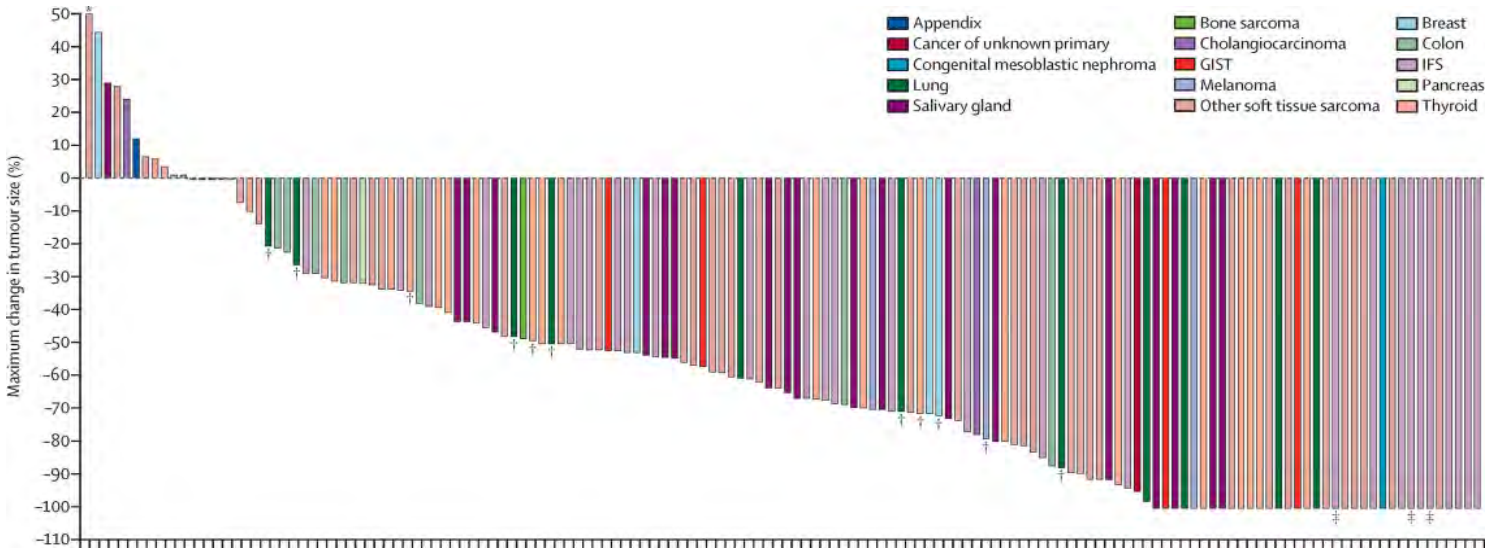
Larotrectinib

ORR 79%

(95% CI 72-85%, n=159)

Median DoR 35.2 months

Median PFS 28.3 months



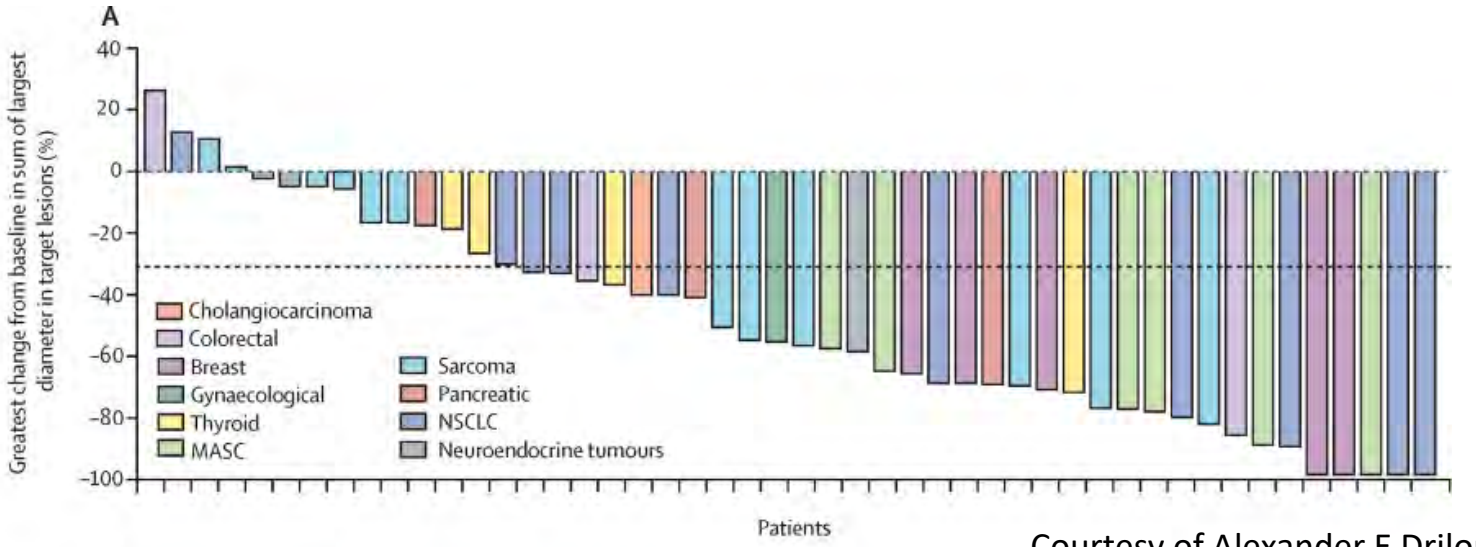
Entrectinib

ORR 57%

(95% CI 43-71%, n=54)

Median DoR 10 months

Median PFS 11 months



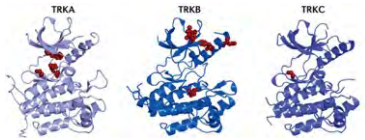
Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Second-generation TRK inhibitors can address on-target resistance

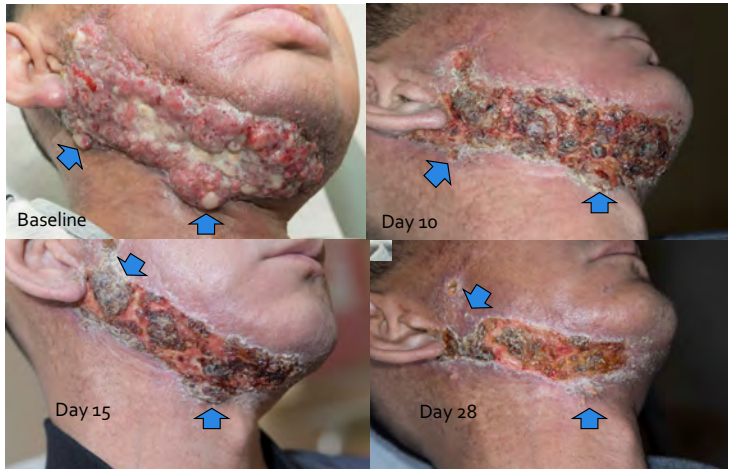
1st gen drug → 2nd gen drug

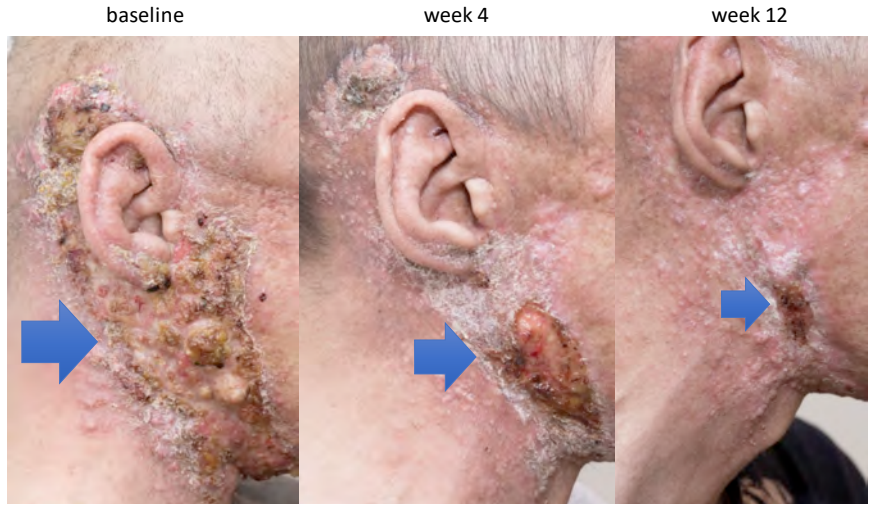
Larotrectinib → **Selitrectinib**



1st gen drug → 2nd gen drug

Entrectinib → **Repotrectinib**



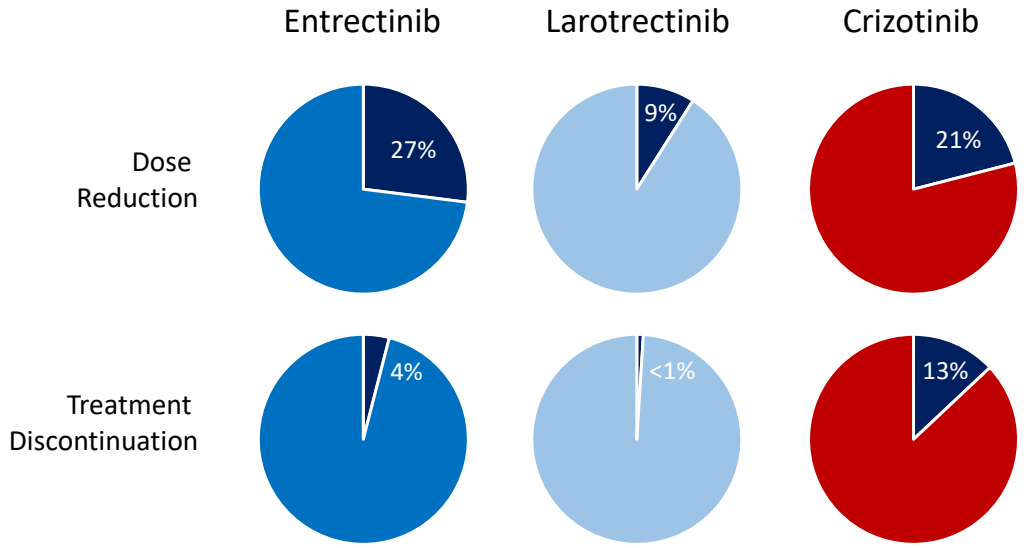


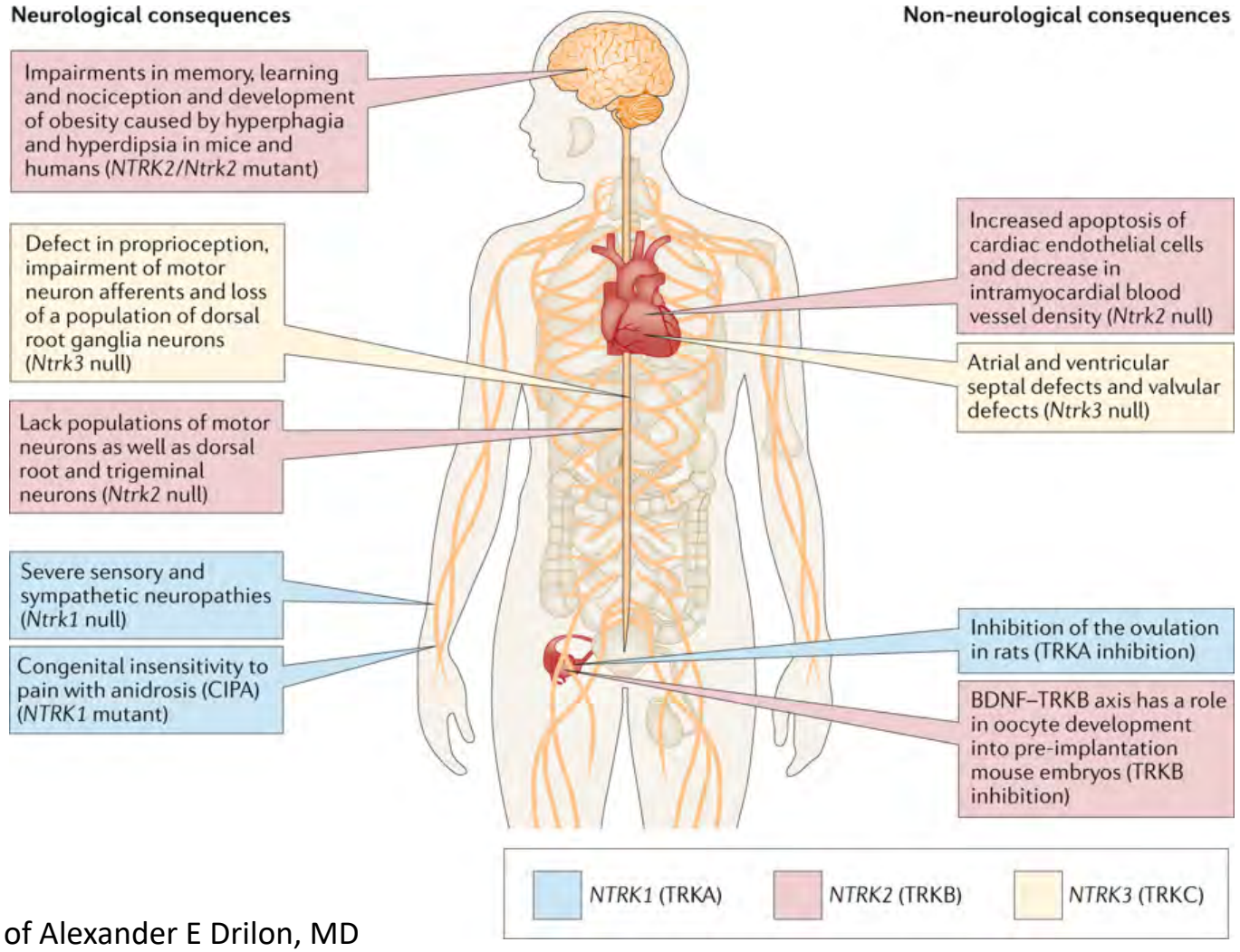
Courtesy of Alexander E Drilon, MD

Drilon et al, Cancer Discov 2017; Drilon et al, Cancer Discov 2018

Memorial Sloan Kettering Cancer Center

TRK inhibitors have favorable overall safety profiles and occasional unique adverse events

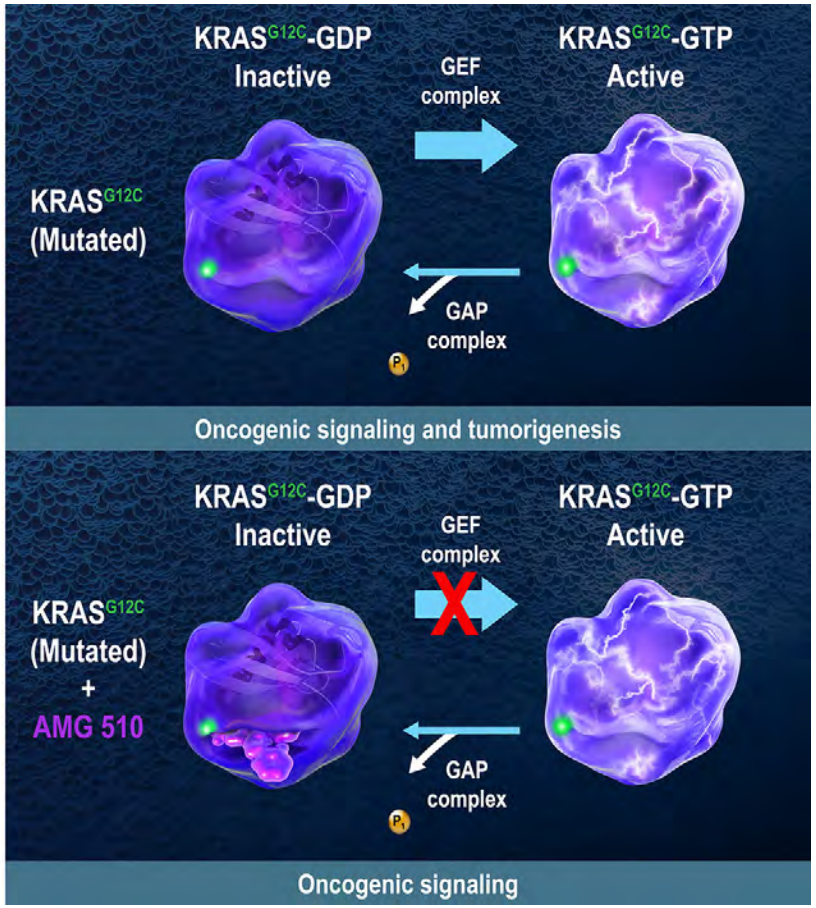




Drilon, Annals Oncol 2019, Cocco et al, Nat Rev Clin Oncol 2018

Courtesy of Alexander E Drilon, MD

Mutant-selective direct inhibitors: *KRAS* G12C-mutant NSCLC



Li et al, IASLC N Am Conf Lung CA 2019

Courtesy of Alexander E Drilon, MD

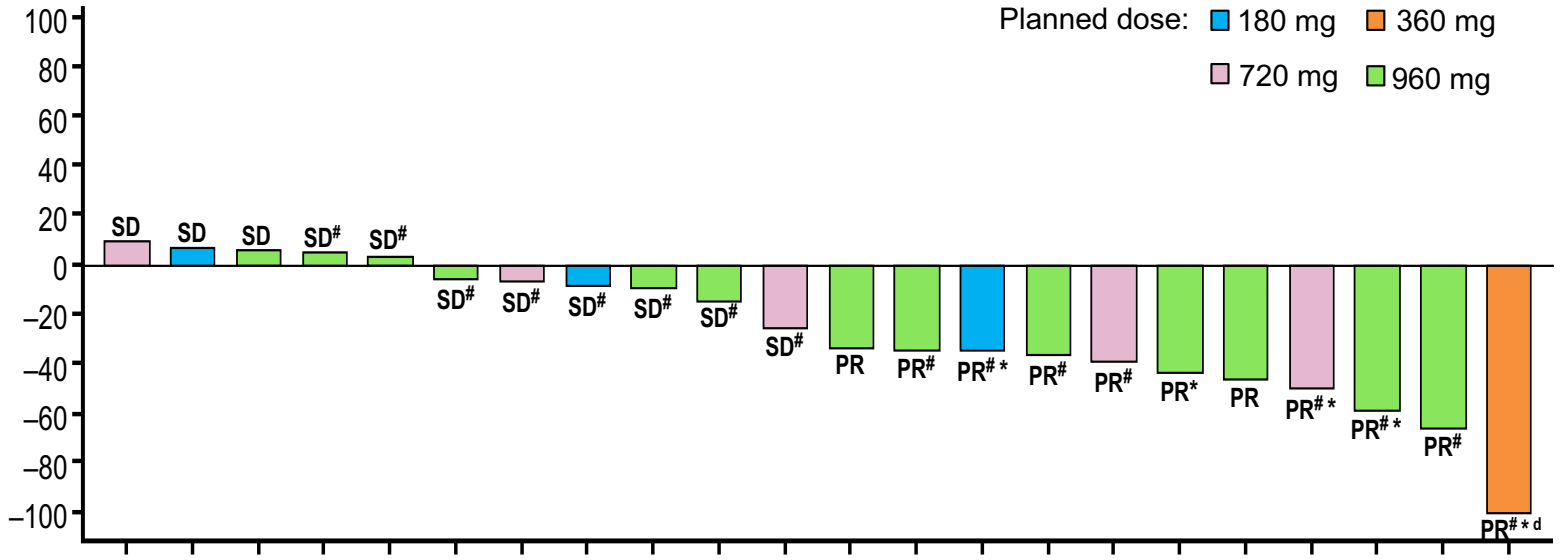
Memorial Sloan Kettering Cancer Center

Mutant-selective direct inhibitors: *KRAS* G12C-mutant NSCLC

Sotorasib
(AMG-510, n=23)

ORR 48%

PR 48%
SD 48%
PD 4%

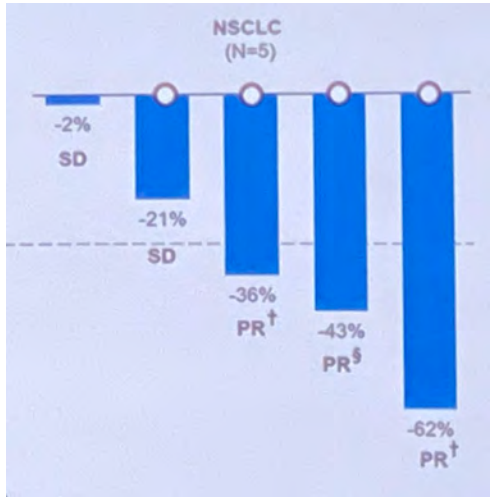


No DLTs or AEs leading
to Tx discontinuation

MRTX849

3/5 PRs

(n=5)



Li et al, IASLC N Am Conf Lung CA 2019; Janne et al, EORTC-AACR-NCI 2019

Courtesy of Alexander E Drilon, MD

Memorial Sloan Kettering Cancer Center

Clinical Investigator Perspectives on the Current and Future Management of Multiple Myeloma

A Meet The Professor Series

Thursday, July 16, 2020
8:00 AM – 9:00 AM ET

Sagar Lonial, MD
Chair and Professor
Department of Hematology and Medical Oncology
Anne and Bernard Gray Family Chair in Cancer
Chief Medical Officer
Winship Cancer Institute
Emory University School of Medicine
Atlanta, Georgia

Co-provided by USF Health RTP RESEARCH TO PRACTICE

Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 days.