Best of Oncology
An ASCO Direct™ Conference

Update on Hematologic Malignancies

PRESENTED BY

Michael R. Bishop, MD, FACP, FASCO

University of Chicago

Update of Hematologic Malignancies

Disclosures

Membership on a Advisory Board or Consultant: KITE/Gilead, Novartis, CRISPR Therapeutics, Autolus Therapeutics, Bristol-Meyer-Squibb/JUNO Therapeutics, Chimeric Therapeutics, in8bio, Galapagos, Incyte, Iovance Biotherapeutics

Speakers Bureau: AstraZeneca, BMS, Kite/Gilead, Servier, Abbvie, Incyte, GenMab, ADC Therapeutics

Discussion of off-label drug use: N/A

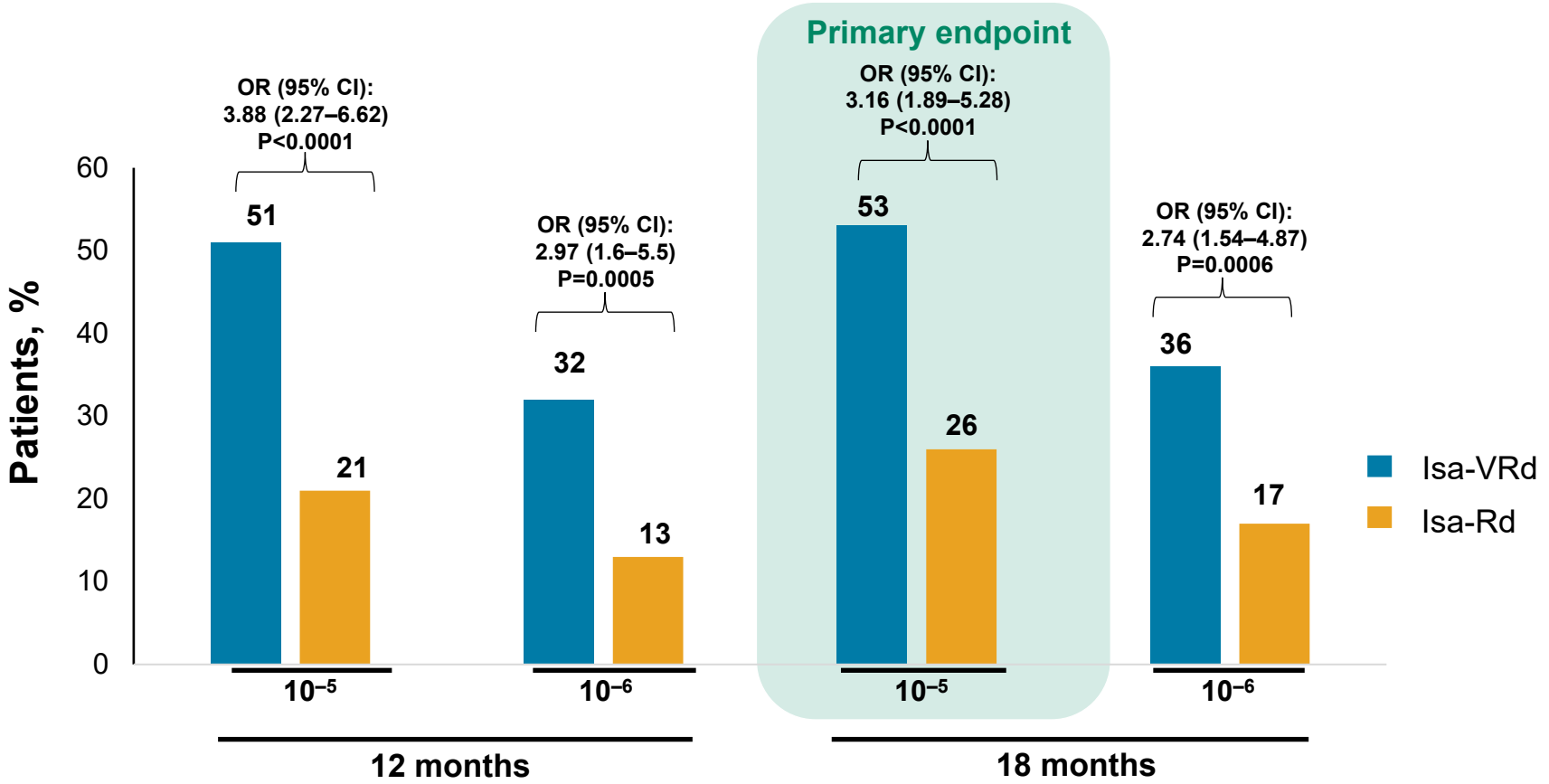
Multiple Myeloma

2024 ASCO® ANNUAL MEETING

Isatuximab Plus Lenalidomide and Dexamethasone with Weekly Bortezomib versus Isatuximab Plus Lenalidomide and Dexamethasone in Newly Diagnosed Transplant Ineligible Multiple Myeloma. The BENEFIT (IFM 2020-05) Study

Xavier Leleu[1] and Cyrille Hulin[2], Lambert Jerome[3], Arthur Bobin[1], Aurore Perrot[4], Lionel Karlin[5], Roussel Murielle[6], Lydia Montes[7], Brieuc Cherel[8], Thomas Chalopin[9], Borhane Slama[10], Marie-Lorraine Chretien[11], Kamel Laribi[12], Claire Dingremont[13], Christophe Roul[14], Clara Mariette[15], Sophie Rigaudeau[16], Claire Calmettes[17], Mamoun Dib[18], Mourad Tiab[19], Laure Vincent[20], Jacques Delaunay[21], Alberto Santagostino[22], Margaret Macro[23], Emmanuelle Bourgeois[24], Frederique Orsini-Piocelle[25], Julie Gay[26], Benoit Bareau[27], Noemie Bigot[3], François Vergez[28], Pierre Lebreton[29], Reza Tabrizi[30], Agathe Waultier-Rascalou[31], Laurent Frenzel[32], Ronan Le Calloch[33], Emilie Chalayer[34], Thorsten Braun[35], Florence Lachenal[36], Selim Corm[37], Celine Kennel[38], Rakiba Belkhir[39], Jean-Sebastien Bladé[40], Bertrand Joly[41], Valentine Richez-Olivier[42], Helene Demarquette[43], Daniela Robu-Cretu[44], Laurent Garderet [45], Muriel Newinger-Porte[46], Amine Kasmi[47], Bruno Royer[48], Olivier Decaux[49], Bertrand Arnulf[48], Karim Belhadj[50], Cyrille Touzeau[51], Mohamad Mohty[52], Salomon Manier[53], Philippe Moreau[51], Hervé Avet-Loiseau[28], Jill Corre[28], **Thierry Facon**[53]

BENEFIT (IFM 2020-05) Study Primary Endpoint: MRD(–)* Rate at 18 months – ITT population



Isa-VRd resulted in deep response rates, with a significant improvement in the MRD at 12 and 18 months, and at 10^{-5} and 10^{-6} in the ITT population

*MRD was assessed on the basis of IMWG recommendations.[1]
CI, confidence interval; Isa, isatuximab; ITT, intent-to-treat; MRD–, minimal residual disease negativity; NGS, next generation sequencing; OR, odd ratio; R, lenalidomide; V, bortezomib.
1. Kumar S, et al. *Lancet Oncol* 2016;17:e328–e346.

2024 ASCO® ANNUAL MEETING

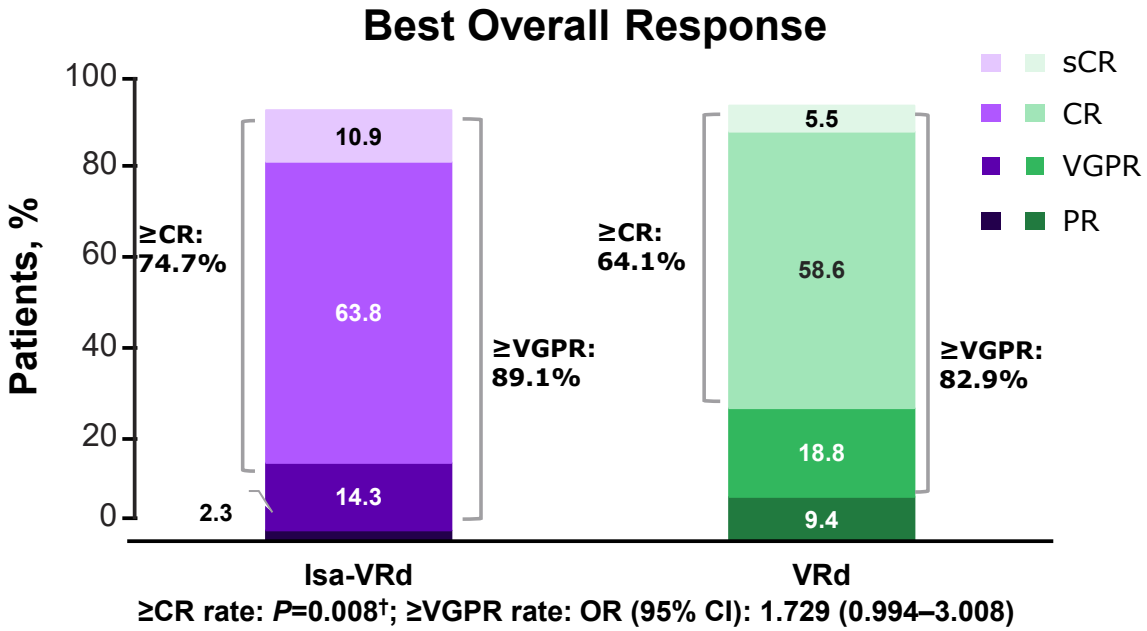
IMROZ

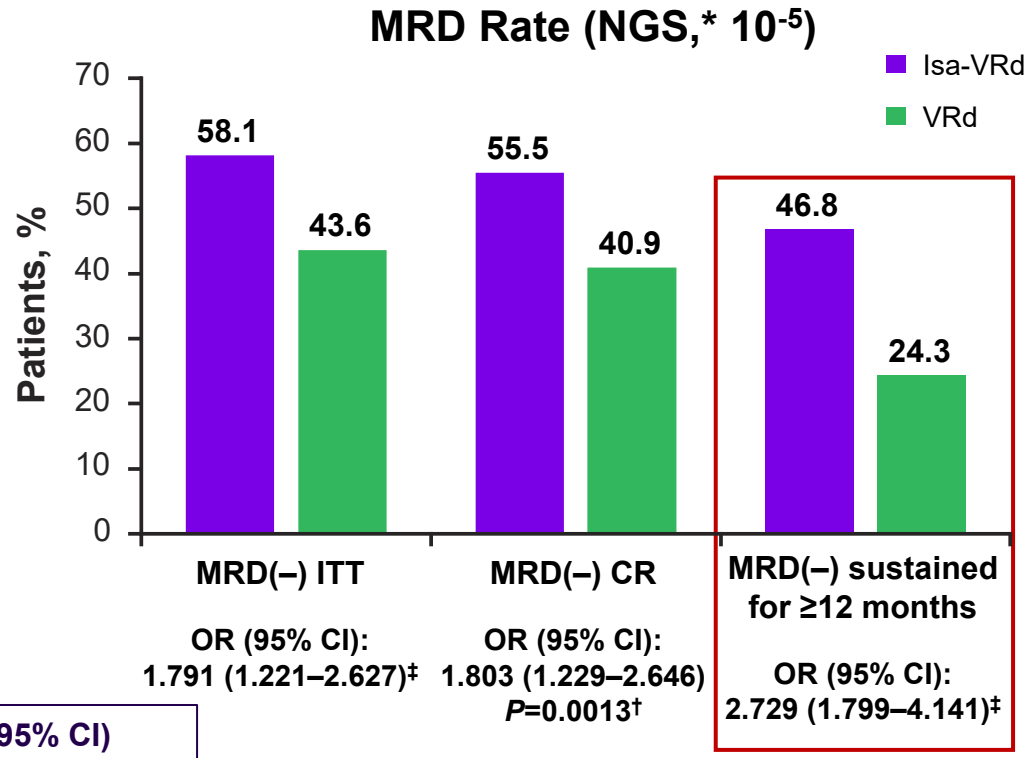
Phase 3 Study Results of Isatuximab, Bortezomib, Lenalidomide, and Dexamethasone (Isa-VRd) versus VRd for Transplant-Ineligible Patients with Newly Diagnosed Multiple Myeloma (IMROZ)

Thierry Facon,[1] Meletios-Athanasios Dimopoulos,[2] Xavier Leleu,[3] Meral Beksac,[4,5] Ludek Pour,[6] Roman Hajek,[7] Zhuogang Liu,[8] Jiri Minarik,[9] Philippe Moreau,[10] Joanna Romejko-Jarosinska,[11] Ivan Spicka,[12] Vladimir Vorobyev,[13] Michele Cavo,[14] Hartmut Goldschmidt,[15] Thomas Martin,[16] Salomon Manier,[17] Marie-France Brégeault,[18] Sandrine Macé,[18] Christelle Berthou,[18] Robert Z. Orlowski[19]

[1]Department of Haematology, University of Lille, and French Academy of Medicine, Paris, France; [2]Department of Clinical Therapeutics, National and Kapodistrian University of Athens, Greece; [3]Service d'Hématologie et Thérapie Cellulaire, CHU and CIC Inserm 1402, Poitiers Cedex, France; [4]Department of Hematology, Ankara University, Ankara, Turkey; [5]Istinye University Ankara Liv Hospital, Ankara, Turkey; [6]Department of Internal Medicine, Hematology and Oncology, University Hospital Brno, Brno, Czech Republic; [7]Department of Hemato-Oncology, University Hospital Ostrava and Faculty of Medicine, University of Ostrava, Ostrava, Czech Republic; [8]Shengjing Hospital of China Medical University (Huaxiang Br), Shenyang, China; [9]Department of Hemato-Oncology, University Hospital Olomouc and Faculty of Medicine and Dentistry, Palacky University Olomouc, Olomouc, Czech Republic; [10]Department of Hematology, University Hospital Hôtel-Dieu, Nantes, France; [11]Department of Lymphoid Malignancies, Marie Sklowdoska-Curie National Research Institute of Oncology, Warszawa, Poland; [12]Charles University and General Hospital in Prague, Prague, Czech Republic; [13]SP Botkin Moscow City Clinical Hospital, Moscow, Russia; [14]IRCCS Azienda Ospedaliero-Universitaria di Bologna, Istituto di Ematologia "Seràgnoli," Università di Bologna, Bologna, Italy; [15]Department of Internal Medicine V, University of Heidelberg, Heidelberg, Germany; [16]Department of Hematology, University of California at San Francisco, San Francisco, California, USA; [17]Department of Hematology, University Hospital Center of Lille, Lille, France; [18]Sanofi, R&D, Vitry-sur-Seine, France; [19]Department of Lymphoma and Myeloma, The University of Texas MD Anderson Cancer Center, Houston, Texas, USA.

Clinical Response





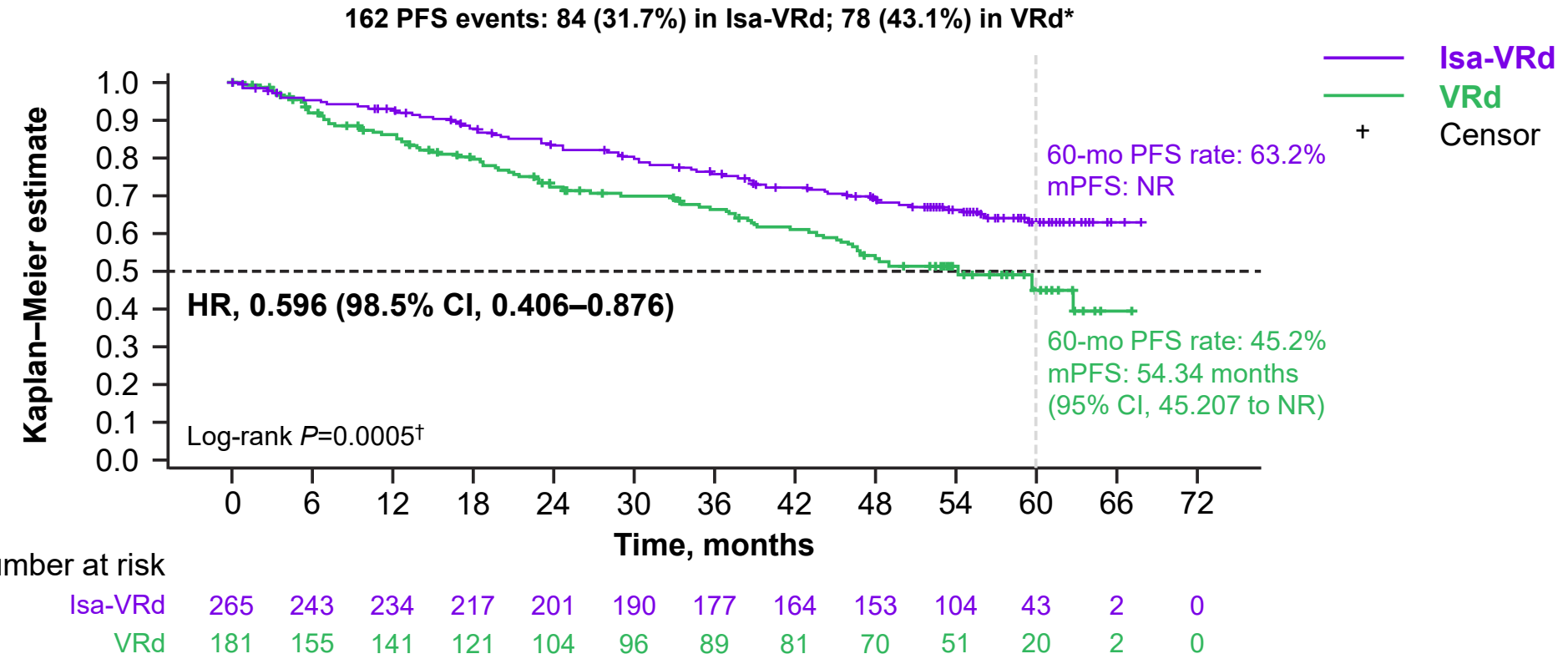
Time to MRD(–), median (95% CI)
Isa-VRd: 14.72 (11.53–24.08) months
VRd: 32.79 (17.51–45.11) months

Isa-VRd resulted in deep response rates, with a significant improvement in the MRD(–) CR rate, as well as higher rates of MRD(–) and sustained MRD(–) for ≥12 months at any point in the ITT population

*Adaptive Biotechnologies clonoSEQ®. †Stratified Cochran-Mantel-Haenszel test. One-sided significance level is 0.025. ‡*P* value not reported; not a key secondary endpoint.
MRD–, minimal residual disease negativity.

Primary endpoint met: Interim PFS analysis - IRC assessment in ITT population

IMROZ



At a median follow-up of 5 years (59.7 months), Isa-VRd led to a statistically significant reduction in the risk of progression or death by 40.4%

*Cutoff date for PFS analysis: September 26, 2023 (median follow-up, ~5 years). †Nominal one-sided *P* value.
NR, not reached.

Daratumumab (DARA) + Bortezomib/Lenalidomide/ Dexamethasone (VRd) with DARA-R (D-R) Maintenance in Transplant-Eligible Patients with Newly Diagnosed Multiple Myeloma (NDMM): Analysis of Minimal Residual Disease (MRD) in the PERSEUS Trial*

*ClinicalTrials.gov Identifier: NCT03710603; sponsored by EMN in collaboration with Janssen Research & Development, LLC.

Paula Rodriguez-Otero[1], Philippe Moreau[2], Meletios A Dimopoulos[3], Meral Beksac[4], Aurore Perrot[5], Annemiek Broijl[6], Francesca Gay[7], Roberto Mina[7], Niels WCJ van de Donk[8], Fredrik Schjesvold[9], Michel Delforge[10], Hermann Einsele[11], Andrew Spencer[12], Sarah Lonergan[6], Diego Vieyra[13], Anna Sitthi-Amorn[13], Robin Carson[13], Joan Bladé[14], Mario Boccadoro[15], Pieter Sonneveld[6]

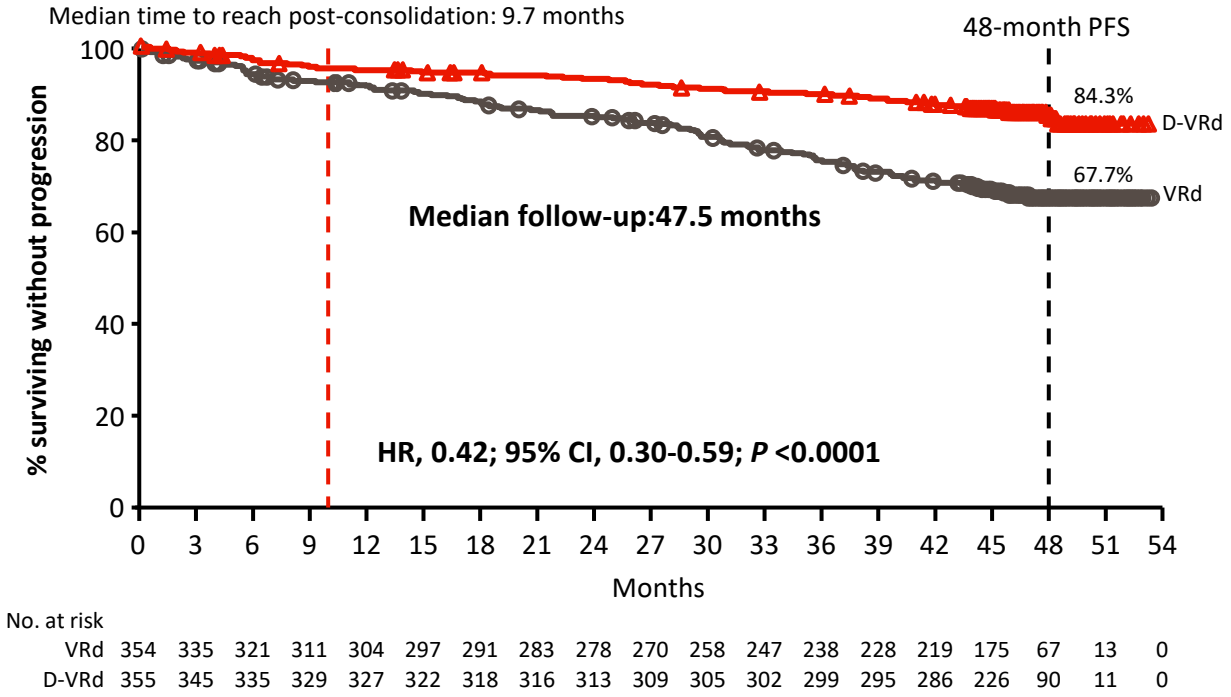
[1]Department of Hematology, Cancer Center Clínica Universidad de Navarra, Pamplona, Navarra, Spain; [2]Hematology Department, University Hospital Hôtel-Dieu, Nantes, France; [3]National and Kapodistrian University of Athens, Athens, Greece; [4]Ankara University, Ankara, Turkey; [5]CHU de Toulouse, IUCT-O, Université de Toulouse, UPS, Service d'Hématologie, Toulouse, France; [6]Department of Hematology, Erasmus MC Cancer Institute, Rotterdam, The Netherlands; [7]Division of Hematology 1, AOU Città della Salute e della Scienza di Torino, and Department of Molecular Biotechnology and Health Sciences, University of Torino, Torino, Italy; [8]Department of Hematology, Amsterdam University Medical Center, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands; [9]Oslo Myeloma Center, Department of Hematology, and KG Jebsen Center for B-cell Malignancies, University of Oslo, Oslo, Norway; [10]University of Leuven, Leuven, Belgium; [11]Department of Internal Medicine II, University Hospital Würzburg, Würzburg, Germany; [12]Malignant Haematology and Stem Cell Transplantation Service, Alfred Health-Monash University, Melbourne, Australia; [13]Janssen Research & Development, LLC, Spring House, PA, USA; [14]Hospital Clínic de Barcelona, Institut d'Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), University of Barcelona, Barcelona, Spain; and GEM/PETHEMA; [15]Myeloma Unit, Division of Hematology, University of Torino, Azienda Ospedaliero-Universitaria Città della Salute e della Scienza di Torino, Torino, Italy

Presented by P Rodriguez-Otero at the American Society of Clinical Oncology (ASCO) Annual Meeting; May 31-June 4, 2024; Chicago, IL, USA

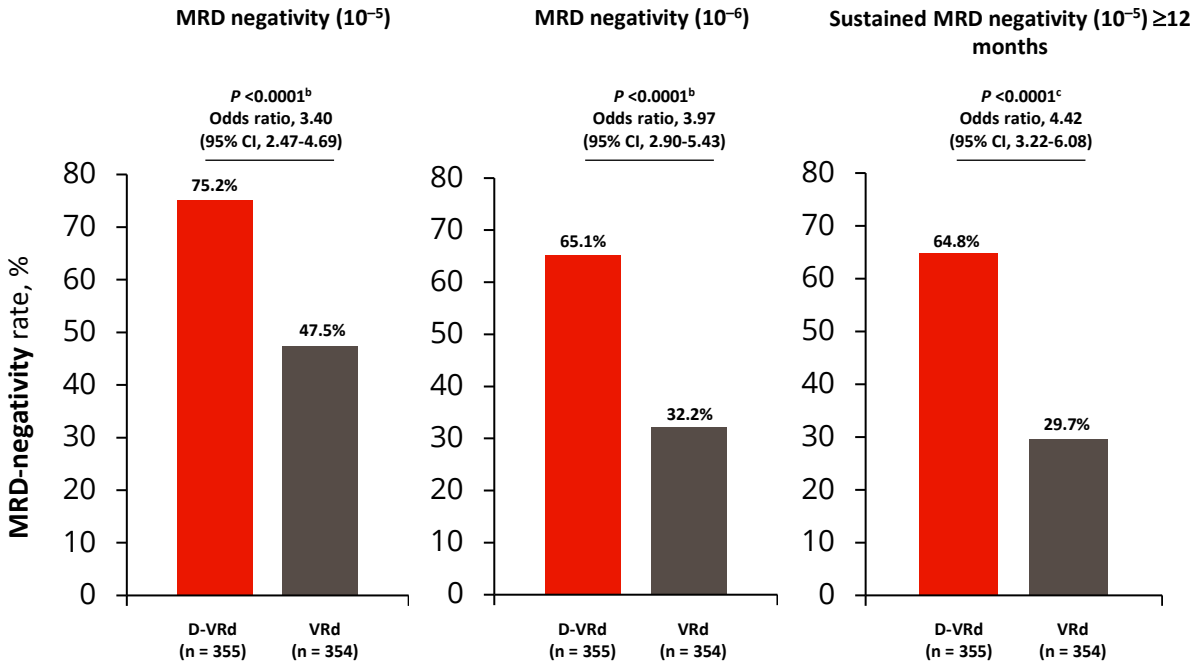
Abstract #7502

PERSEUS Primary Analysis: D-VRd Followed by D-R Maintenance Significantly Improved PFS and Depth of Response Versus VRd Followed by R Maintenance[1]

Progression-free Survival



Overall and sustained MRD-negativity rates[a]



58% reduction in the risk of progression or death in patients receiving D-VRd

Deep and durable MRD negativity achieved with D-VRd

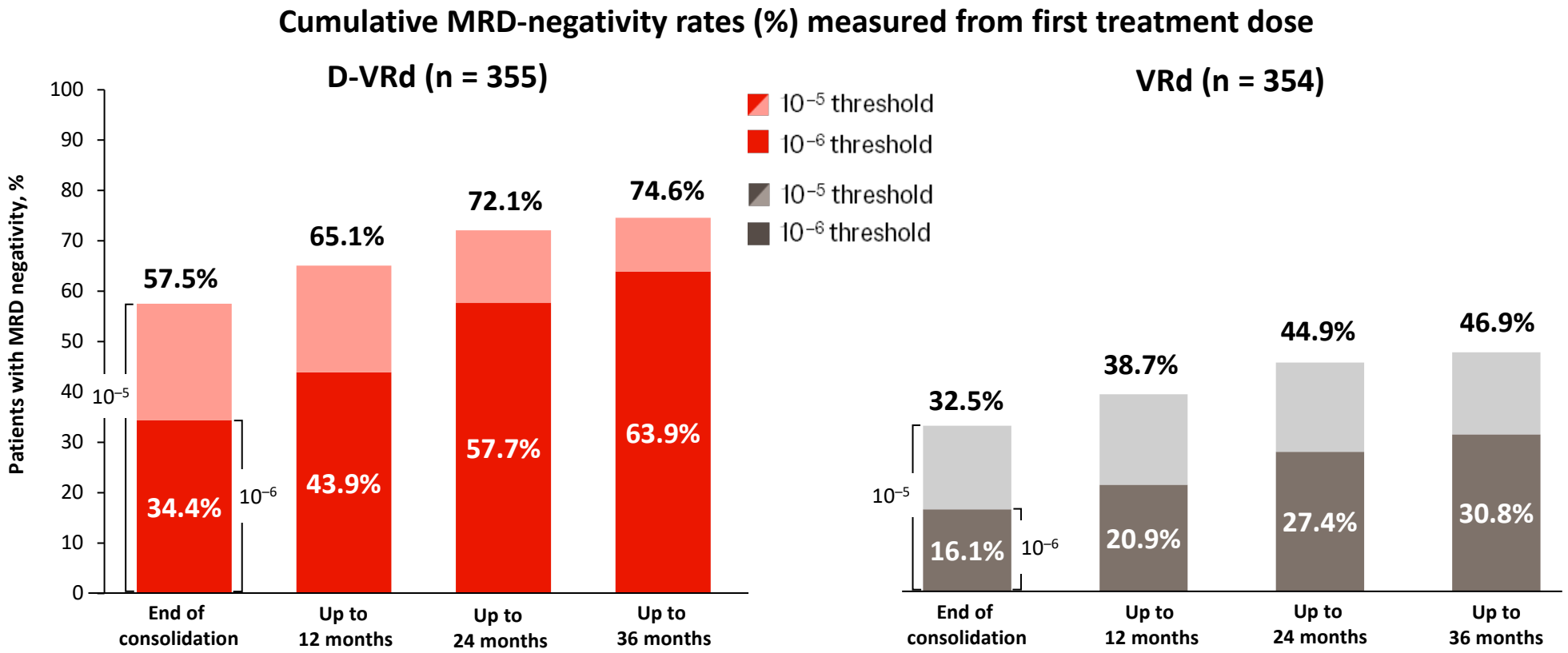
HR, hazard ratio; CI, confidence interval. [a]MRD-negativity rate was defined as the proportion of patients who achieved both MRD negativity and ≥CR. MRD was assessed using bone marrow aspirates and evaluated via NGS (clonoSEQ assay, version 2.0; Adaptive Biotechnologies, Seattle, WA, USA). [b]*P* values were calculated with the use of the stratified Cochran–Mantel–Haenszel chi-square test.
[c]*P* value was calculated with the use of Fisher's exact test.

1. Sonneveld P, et al. *N Engl J Med*. 2024;390(4):301-313.

Abstract #7502

Presented by P Rodriguez-Otero at the American Society of Clinical Oncology (ASCO) Annual Meeting; May 31-June 4, 2024; Chicago, IL, USA

PERSEUS: MRD Negativity Rates 10^{-5} and 10^{-6} (ITT)



- D-VRd + D-R doubled the rates of deeper MRD negativity at 10^{-6} versus VRd + R
- MRD negativity at 10^{-6} increased by approximately 30% during maintenance with D-R

MRD-negativity rate was defined as the proportion of patients who achieved both MRD negativity and ≥CR in the ITT population. Patients who were not evaluable or had indeterminate results were considered MRD positive. *P* values were calculated using the stratified Cochran–Mantel–Haenszel chi-square test. *P* <0.0001 for all comparisons of D-VRd versus VRd.

Abstract #7502

Presented by P Rodriguez-Otero at the American Society of Clinical Oncology (ASCO) Annual Meeting; May 31-June 4, 2024; Chicago, IL, USA

2024 ASCO® ANNUAL MEETING

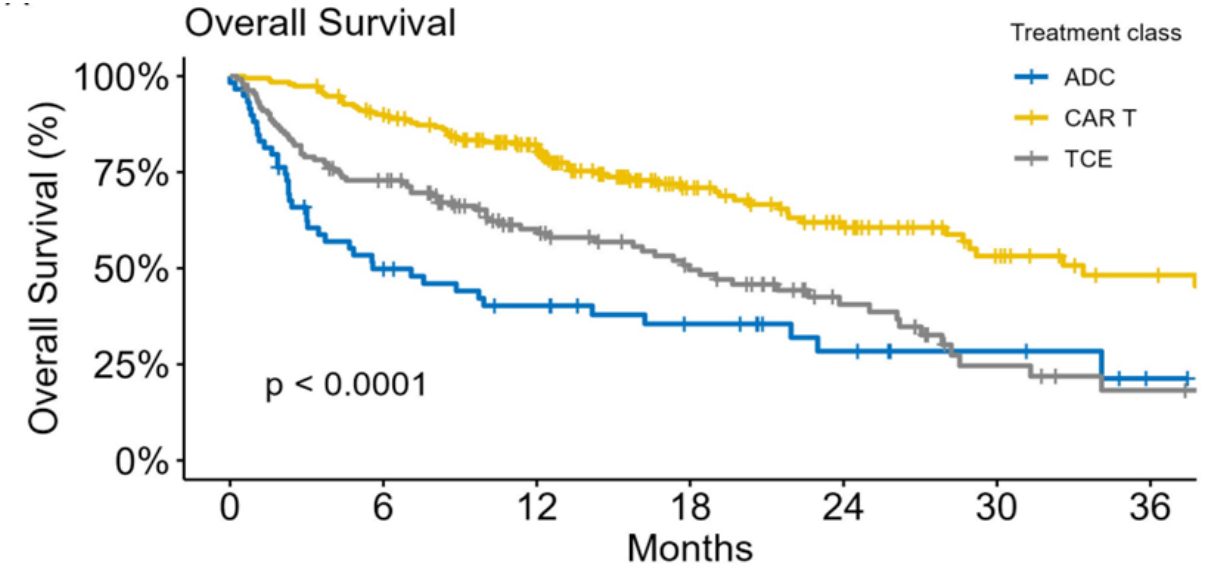
Class Comparison of BCMA-Directed Therapies in Relapsed Multiple Myeloma

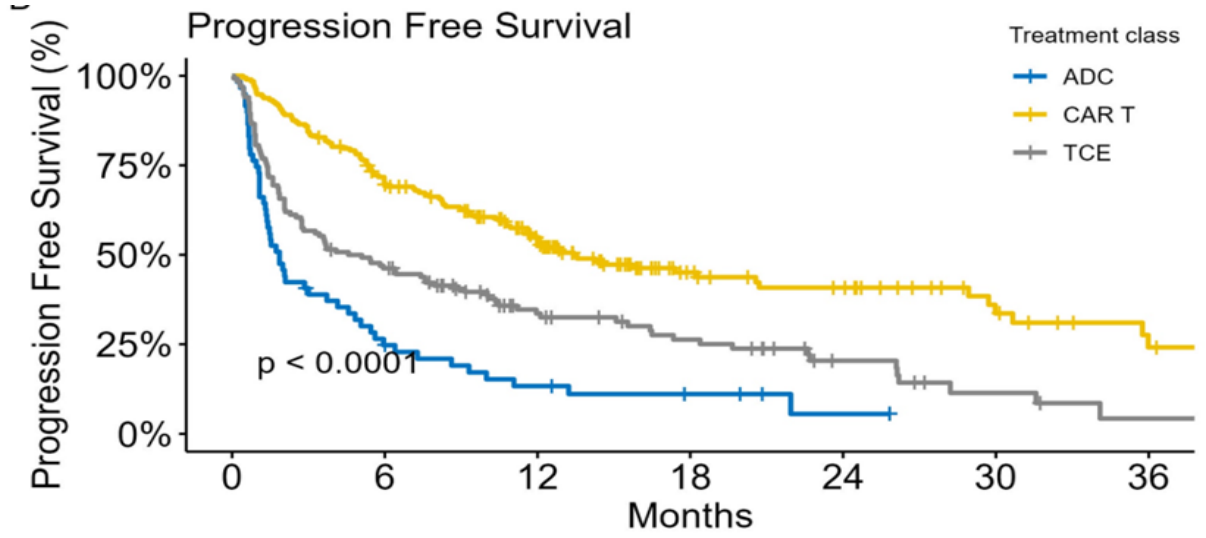
Dr Matthew J Rees[1], Dr Aytaj Mammadzadeh[1], Dr Abiola Bolarinwa[1], Dr Mohammed E Elhaj[1], Dr Arwa Bohra[1], Dr Radhika Bansal[1], Dr Sikander Ailawadhi[2], Dr Ricardo Parrondo[2], Dr Saurabh Chhabra[3], Dr Suzanne Hayman[1], Dr Angela Dispenzieri[1], Dr Francis Buadi[1], Dr David Dingli[1], Dr Rahma Warsame[1], Dr Prashant Kapoor[1], Dr Morie Gertz[1], Dr Eli Muchtar[1], Dr Taxiarchis Kourelis[1], Dr Wilson Gonsalves[1], Dr S. Vincent Rajkumar[1], Dr Yi Lin[1], **Dr Shaji Kumar**[1]

1. Division of Hematology, Mayo Clinic, Rochester, MN, USA.
2. Division of Hematology, Mayo Clinic, Jacksonville, FL, USA
3. Division of Hematology, Mayo Clinic, Phoenix, AZ, USA

Class Comparison of BCMA-Directed Therapies in Relapsed Multiple Myeloma

- **Median OS:**
  - CAR-T = 33.4 m
  - TCE = 18 m
  - ADC = 5.6 m
- **Median PFS:**
  - CAR-T = 13.4 m
  - TCE = 4.6 m
  - ADC = 1.9 m
- CAR-T produced superior PFS and OS
- This remained significant on multivariable analysis adjusted for age, EMD/PCL, double-hit HRCA, prior BCMA-directed therapy, and the number of LOTs in the preceding 1-year





CAR-T: chimeric antigen receptor T cells; TCE: T-cell engager; ADC: antibody drug conjugate

Chronic Myeloid Leukemia

Timothy P. Hughes
Tim.Hughes@sahmri.com

ASC4FIRST, A Pivotal Phase 3 Study of Asciminib vs Investigator-Selected Tyrosine Kinase Inhibitors in Newly Diagnosed Patients with Chronic Myeloid Leukemia: Primary Results

Timothy P. Hughes, Andreas Hochhaus, Naoto Takahashi, Ghayas C. Issa, Richard A. Larson, Felice Bombaci, Jianxiang Wang, Dong-Wook Kim, Dennis Dong Hwan Kim, Jiri Mayer, Yeow-Tee Goh, Philipp Le Coutre, David J. Andorsky, Shruti Kapoor, Tracey McCulloch, Kamel Malek, Lillian Yau, Sophie Ifrah, **Jorge E. Cortes**

This study is sponsored by Novartis Pharmaceuticals Corporation. For more information, please refer to https://www.clinicaltrials.gov/study/NCT04971226.

Late Breaking Abstract #6500

Oral presentation at: 2024 ASCO Annual Meeting; May 31-June 4, 2024; Chicago, Illinois, and virtual.

ASC4FIRST, a head-to-head study comparing asciminib vs all standard-of-care TKIs in newly diagnosed patients with CML

NCT04971226

Key inclusion criteria

- Newly diagnosed Ph+ CML-CP with ***no*** prior TKIs[a]
- Age ≥18 years

Prerandomization TKI selection

- The TKI a patient will take if randomized to the investigator-selected (IS-TKI) arm
- Selected by the physician in consultation with the patient

Stratification by:

- Prerandomization TKI selection (IMA or 2G TKI)
- ELTS risk category (high, intermediate, low)

R 1:1

N=405

Asciminib (ASC) 80 mg QD

- Imatinib stratum: **ASC^{IMA}**
- 2G TKI stratum: **ASC^{2G}**

All IS-TKIs at label doses

- Imatinib stratum: **IS-TKI^{IMA}**
- 2G TKI stratum: **IS-TKI^{2G}**

End of study: LPFT + 5 years[b]

Data cutoff: Nov. 28, 2023

Primary endpoints:

- MMR at week 48 for asciminib vs all investigator-selected TKIs
- MMR at week 48 for asciminib vs investigator-selected TKI within the imatinib stratum

ASC, asciminib; ELTS, EUTOS long-term survival score; EUTOS, European Treatment and Outcome Study; IMA, imatinib; LPFT, last person first treatment; Ph, Philadelphia chromosome; QD, once daily; R, randomized.

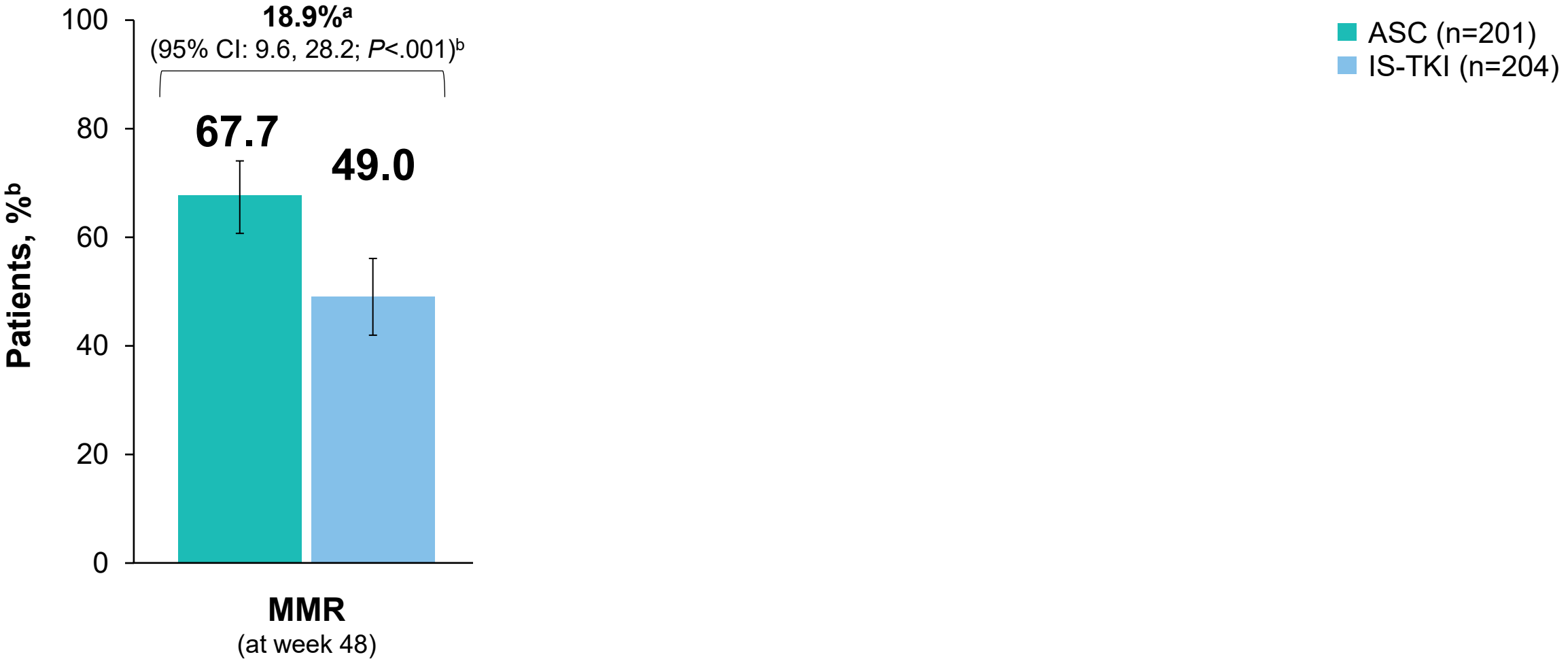
[a] Either imatinib, bosutinib, dasatinib, or nilotinib is allowed for up to 2 weeks prior to randomization. Treatment with other TKIs prior to randomization was not permitted.

[b] Patients will remain on study for 5 years after the last patient first dose, unless they have discontinued early due to treatment failure, disease progression, pregnancy, intolerance, or investigator or patient decision.

LBA #6500

Oral presentation at: 2024 ASCO Annual Meeting; May 31-June 4, 2024; Chicago, Illinois, and virtual.

MMR rate at week 48 was superior with asciminib vs all IS-TKIs, meeting the first primary endpoint



IRT, interactive response technology. Error bars represent 95% CIs.

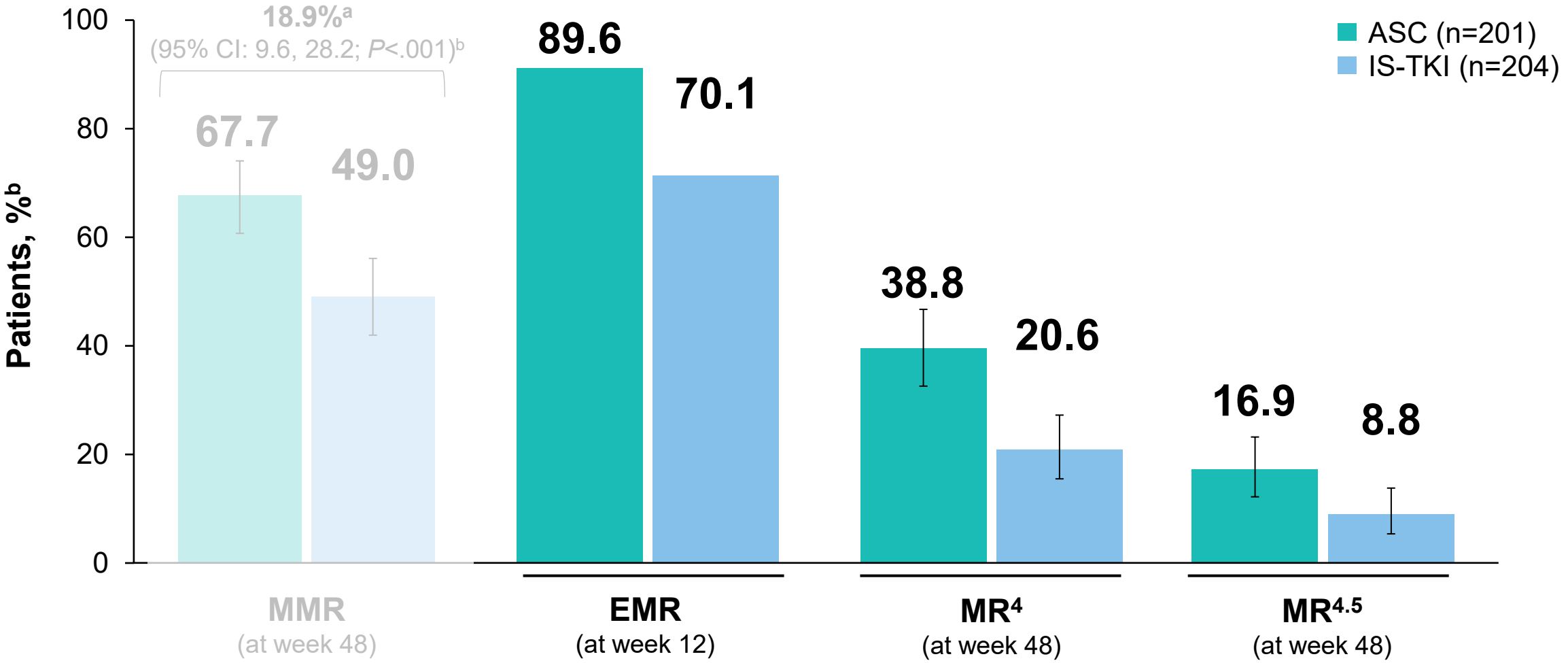
[a] The common treatment difference and its 95% CI are estimated using the Mantel-Haenszel method after stratifying for (a) pre-randomization selected TKI, and (b) baseline ELTS risk groups (both IRT data).

[b] Adjusted 1-sided p-value calculated based on the graphical gatekeeping procedure. The null hypothesis is rejected if the adjusted p-value is ≤0.025.

Oral presentation at: 2024 ASCO Annual Meeting; May 31-June 4, 2024; Chicago, Illinois, and virtual.

LBA #6500

A higher proportion of patients achieved early and deep molecular responses with asciminib vs all IS-TKIs



IRT, interactive response technology; MMR, major molecular response; EMR, early molecular response; MR, molecular response
Error bars represent 95% CIs.
[a] The common treatment difference and its 95% CI are estimated using the Mantel-Haenszel method after stratifying for (a) pre-randomization selected TKI, and (b) baseline ELTS risk groups (both IRT data).
[b] Adjusted 1-sided p-value calculated based on the graphical gatekeeping procedure. The null hypothesis is rejected if the adjusted p-value is ≤0.025.

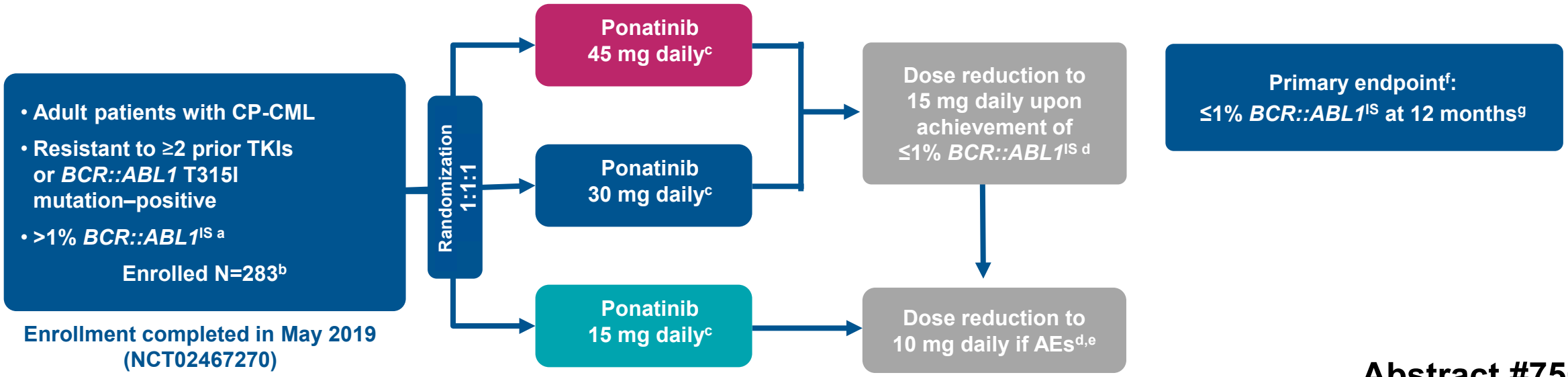
Late Breaking Abstract #6500

Oral presentation at: 2024 ASCO Annual Meeting; May 31-June 4, 2024; Chicago, Illinois, and virtual.

Ponatinib in Patients with Chronic-phase Chronic Myeloid Leukemia and the T315I Mutation: 4-year Results from OPTIC

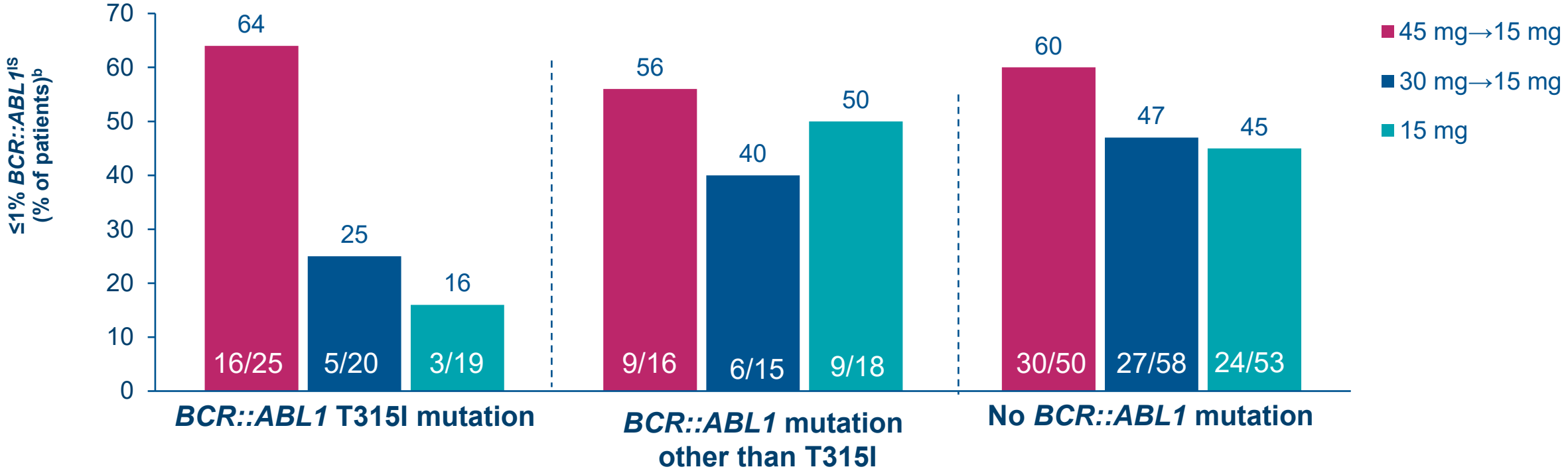
Michael Deininger, MD, PhD,[1] Jane Apperley, MD,[2] Christopher Kevin Arthur, MD,[3] Charles Chuah, MD,[4] Andreas Hochhaus, Dr. med.,[5] Hugues de Lavallade, MD, PhD,[6] Jeffrey Lipton, MD, PhD,[7] Elza Lomaia, MD, PhD,[8] James McCloskey, MD,[9] Lori Maness, MD,[10] Michael Mauro, MD,[11] Beatriz Moraghi, MD,[12] Carolina Pavlovsky, MD,[13] Gianantonio Rosti, MD,[14] Philippe Rousselot, MD, PhD,[15] Maria Undurraga Sutton, MD,[16] Xiaowei Ren, PhD,[17] Alexander Vorog, MD,[17] Hagop Kantarjian, MD,[18] **Jorge Cortes, MD**[19]

[1]Versiti Blood Research Institute, Milwaukee, WI, USA; [2]Imperial College London, London, UK; [3]Royal North Shore Hospital, St. Leonards, Australia; [4]Singapore General Hospital, Duke-NUS Medical School, Singapore; [5]Universitätsklinikum Jena, Jena, Germany; [6]King's College Hospital NHS Foundation, London, UK; [7]Princess Margaret Cancer Centre, Toronto, Ontario, Canada; [8]Almazov National Medical Research Centre, St. Petersburg, Russia; [9]The John Theurer Cancer Center at Hackensack Meridian Health, Hackensack, NJ, USA; [10]University of Nebraska Medical Center, Omaha, NE, USA; [11]Memorial Sloan Kettering, New York, NY, USA; [12]Hospital Jose Maria Ramos Mejia, Buenos Aires, Argentina; [13]Fundaleu, Buenos Aires, Argentina; [14]IRCCS Istituto Romagnolo per lo Studio dei Tumori (IRST) "Dino Amadori", Meldola (FC), Italy; [15]Centre Hospitalier de Versailles University de Versailles Saint-Quentin-en-Yvelines, Paris, France; [16]Hospital del Salvador, Santiago, Chile; [17]Takeda Development Center Americas, Inc., Lexington, MA, USA; [18]The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [19]Georgia Cancer Center at Augusta University, Augusta, GA, USA



Abstract #7501

Ponatinib in T315I Mutation CML (OPTIC): ≤1% *BCR::ABL*^{IS} Response Rates by Baseline Mutation Status by 48 Months[a]



- ≤1% *BCR::ABL1*^{IS} (MR2) response rate by 48 months was highest in the 45-mg cohort
- The difference in response between dosing cohorts was highest for patients with T315I

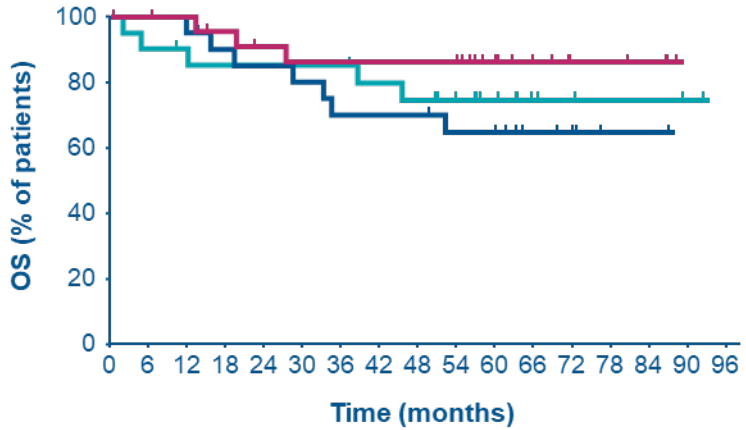
[a]Analysis conducted in the ITT population; [b]Number of patients with ≤1% *BCR::ABL1*^{IS} is counted on cumulative basis by each time point, and a patient with response is counted only once. Percentages are based on the number of patients in each cohort as denominator.
ITT, intent-to-treat

Abstract #7501

Ponatinib in T315I Mutation CML (OPTIC): OS by Mutation Status and Dosing Cohort

BCR::ABL1 T315I Mutation

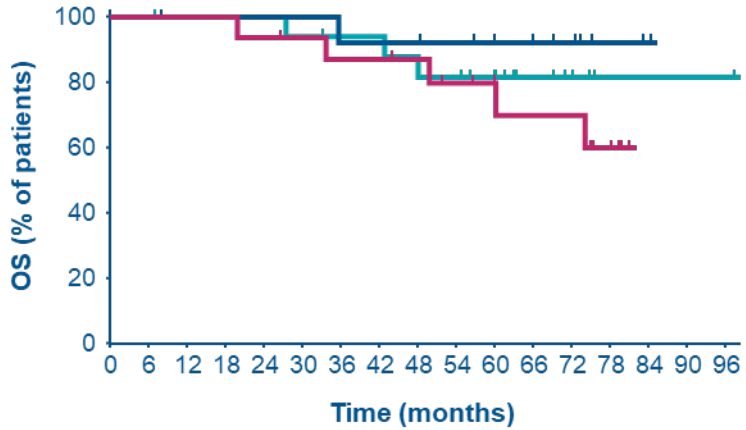
	No. (%) of patients with events	Median OS, months (95% CI)	4-year OS, % (95% CI)
45 mg→15 mg (n=25)	3 (12)	NE (NE–NE)	86 (63–95)
30 mg→15 mg (n=21)	7 (33)	NE (34.6–NE)	70 (45–85)
15 mg (n=21)	5 (24)	NE (45.6–NE)	75 (50–89)



No. at risk																
45 mg→15 mg	25	24	23	21	19	18	18	18	18	18	12	8	5	5	4	0
30 mg→15 mg	21	21	20	18	17	16	14	14	14	11	11	5	4	1	1	0
15 mg	21	19	18	17	17	17	17	15	14	12	8	4	3	2	2	1	0

BCR::ABL1 Mutation other than T315I

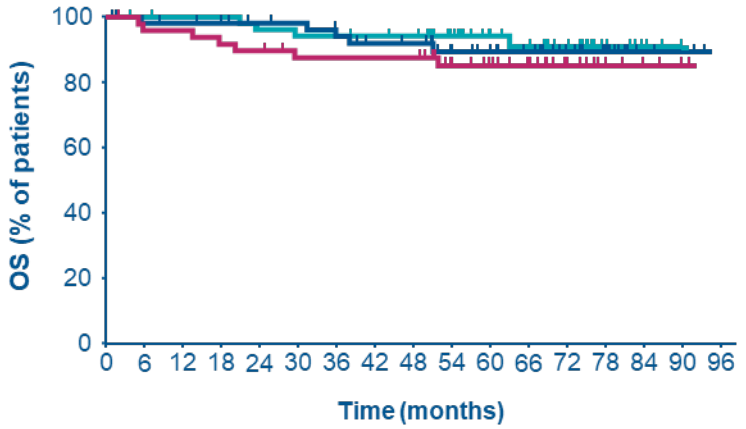
	No. (%) of patients with events	Median OS, months (95% CI)	4-year OS, % (95% CI)
45 mg→15 mg (n=16)	5 (31)	NE (49.8–NE)	87 (57–97)
30 mg→15 mg (n=15)	1 (7)	NE (NE–NE)	92 (57–99)
15 mg (n=18)	3 (17)	NE (NE–NE)	82 (53–94)



No. at risk																
45 mg→15 mg	16	16	16	16	15	14	13	13	12	10	9	7	7	4	0	
30 mg→15 mg	15	14	13	13	13	13	12	12	12	11	9	8	5	2	1	0
15 mg	18	18	17	17	17	16	15	15	14	13	10	6	4	1	1	1	1

No *BCR::ABL1* Mutation

	No. (%) of patients with events	Median OS, months (95% CI)	4-year OS, % (95% CI)
45 mg→15 mg (n=51)	7 (14)	NE (NE–NE)	88 (75–94)
30 mg→15 mg (n=58)	5 (9)	NE (NE–NE)	92 (80–97)
15 mg (n=54)	4 (7)	NE (NE–NE)	94 (83–98)



No. at risk																
45 mg→15 mg	51	47	47	45	44	41	41	41	41	32	27	21	13	6	4	2	0
30 mg→15 mg	58	55	54	53	49	48	45	42	41	33	29	25	19	13	3	2	0
15 mg	54	53	52	52	49	48	48	47	46	39	30	27	21	10	4	1	0

- Median OS was not reached at the 4-year analysis regardless of mutation status across all dosing cohorts

Abstract #7501

Update of Hematologic Malignancies

Lymphoma

Glofitamab Monotherapy in Patients with Heavily Pretreated Relapsed/Refractory (R/R) Mantle Cell Lymphoma (MCL): Updated Analysis from a Phase I/II Study

Abstract #7008

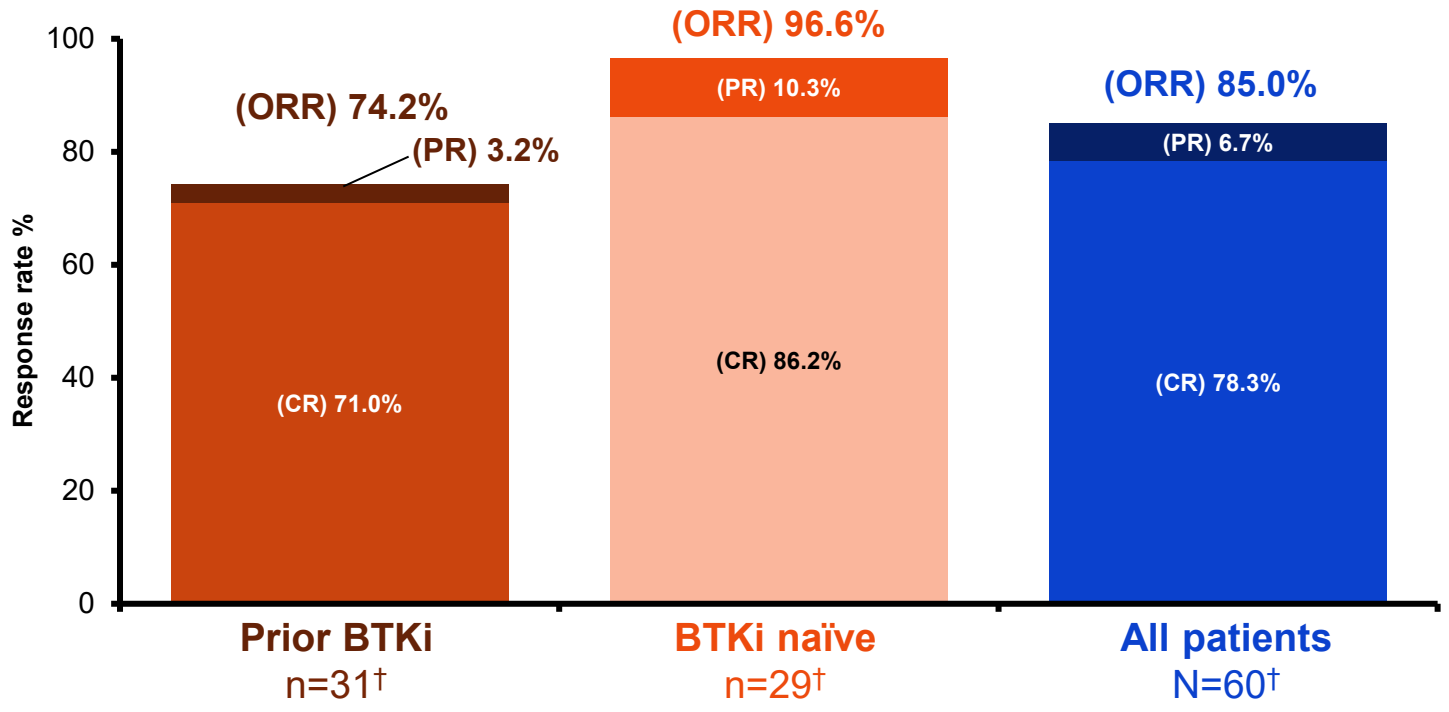
Tycel Phillips,[1] Carmelo Carlo-Stella,[2] Franck Morschhauser,[3] Emmanuel Bachy,[4] Michael Crump,[5] Marek Trněný,[6] Nancy L. Bartlett,[7] Jan Zaucha,[8] Tomasz Wrobel,[9] Fritz Offner,[10] Audrey Filézac de L'Etang,[11] James Relf,[12] David J. Carlile,[12] Ben Byrne,[12] Estefania Mulvihill,[11] Linda Lundberg,[11] **Michael Dickinson**[13]

[1]City of Hope National Medical Center, Duarte, CA, USA; [2]Humanitas University and IRCCS Humanitas Research Hospital, Milano, Italy; [3]Centre Hospitalier Universitaire de Lille, France; [4]Hospices Civils de Lyon and Université Claude Bernard, Pierre-Bénite, France; [5]Princess Margaret Cancer Centre, Toronto, ON, Canada; [6]Charles University, Prague, Czech Republic; [7]Siteman Cancer Center, St. Louis, MO, USA; [8]Medical University of Gdańsk, Gdańsk, Poland; [9]Wroclaw Medical University, Wroclaw, Poland; [10]Dept Hematology Universitair Ziekenhuis, Gent, Belgium; [11]F. Hoffmann-La Roche Ltd, Basel, Switzerland; [12]Roche Products Ltd, Welwyn Garden City, United Kingdom; [13]Peter MacCallum Cancer Centre, Melbourne, Australia

Presented at the 2024 American Society of Clinical Oncology (ASCO) Annual Meeting | May 31 – June 4, 2024

Glofitamab Monotherapy in R/R MCL: Response Rates

Response Rates* in Patients with R/R MCL



- Median time to first response among responders (n=51): **42 days** (95% CI: 42.0–45.0)

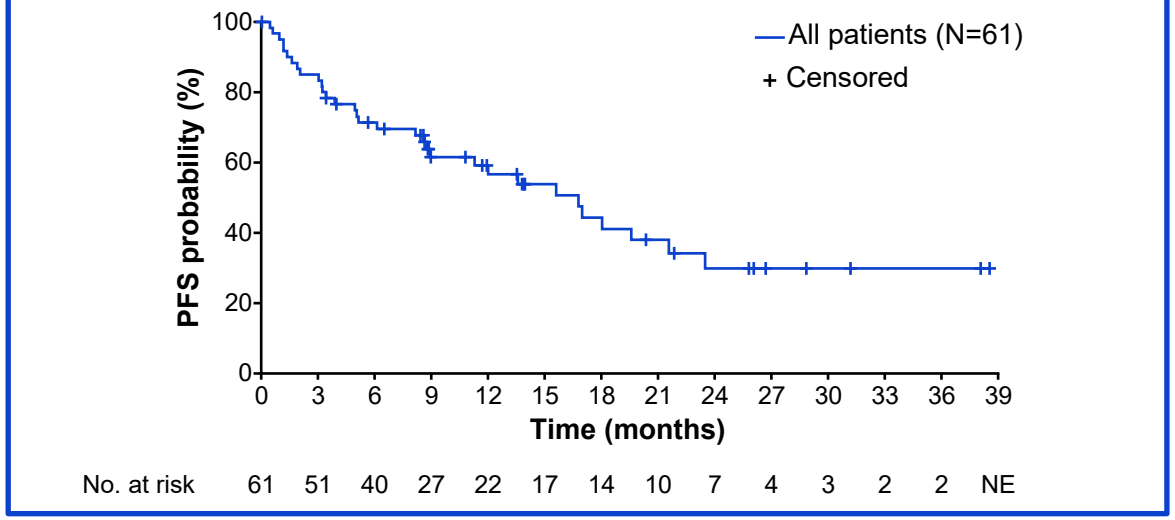
High CR and OR rates were observed in the overall population and in both BTKi-naïve patients and those with prior BKTi therapy

Clinical cut-off date: September 04, 2023.
*Investigator-assessed. †Efficacy evaluable population.
CI, confidence interval; ORR, overall response rate; PR partial response.

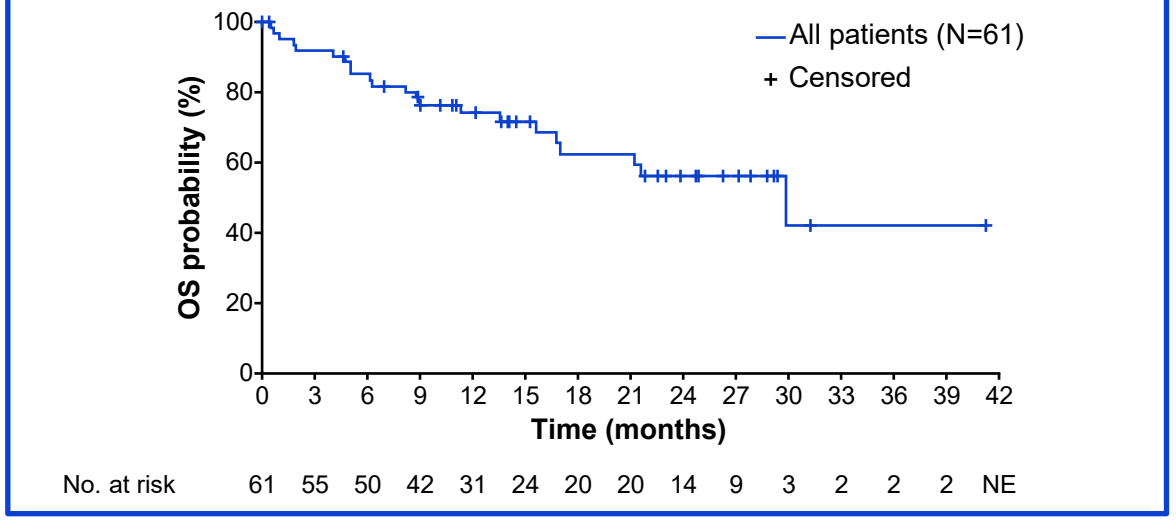
Abstract #7008

Glofitamab Monotherapy in R/R MCL: Time-to-event endpoints

PFS



OS†



	Prior BTKi n=32*	All patients N=61*
Median PFS follow-up, months (95% CI)	26.1 (13.5–31.2)	19.6 (11.9–26.1)
Median PFS, months (95% CI)	8.6 (3.4–15.6)	16.8 (8.9–21.6)
15-month PFS rate, % (95% CI)	33.0 (14.8–51.1)	54.0 (40.1–67.8)

	Prior BTKi n=32*	All patients N=61*
Median OS follow-up, months (95% CI)	24.7 (13.6–28.8)	21.8 (14.0–24.9)
Median OS, months (95% CI)	21.2 (9.0–NE)	29.9 (17.0–NE)
15-month OS rate, % (95% CI)	55.0 (36.5–73.6)	71.4 (59.3–83.5)

Clinically significant PFS and OS at 15 months were achieved with fixed-duration glofitamab

Clinical cut-off date: September 04, 2023.
*ITT population. †At the time of analysis, 22 patients had died, the majority due to PD (n=7) or COVID-19 (n=7); other causes of death were pneumonia (n=1), septic shock (n=1), cardiac arrest (n=1), and unknown/other (n=5). All patients who died due to COVID-19 had achieved a CR.
OS, overall survival; PD, progressive disease; PFS, progression-free survival.

Abstract #7008

MAYO CLINIC

Benefit of Rituximab Maintenance after First-line Bendamustine-Rituximab in Mantle Cell Lymphoma

Yucai Wang[1], Melissa C. Larson[1], Anita Kumar[2], Brian T. Hill[3], David A. Bond[4], Brad S. Kahl[5], Alexey Danilov[6], Reid W. Merryman[7], Natalie S. Grover[8], Aung Tun[9], Sabarish Ayyappan[10], Georgios Pongas[11], Craig A. Portell[12], Javier L. Munoz[13], Patrick M. Reagan[14], Muhamad Alhaj Moustafa[15], Priyanka A. Pophali[16], I. Brian Greenwell[17], Jonathon B. Cohen[18], Peter Martin[19]

[1]Mayo Clinic, Rochester, MN; [2]Memorial Sloan-Kettering Cancer Center, New York, NY; [3]Cleveland Clinic, Cleveland, OH; [4]Ohio State University, Columbus, OH; [5]Washington University in St. Louis, St, Louis, MO; [6]City of Hope, Duarte, CA; [7]Dana Farber Cancer Institute, Boston, MA; [8]University of North Carolina, Chapel Hill, NC; [9]University of Kansas Medical Center, Kansas City, KS; [10]University of Iowa, Iowa City, IO; [11]University of Miami, Miami, FL; [12]University of Virginia, Charlottesville, VA; [13]Mayo Clinic, Phoenix, AZ; [14]University of Rochester, Rochester, NY; [15]Mayo Clinic, Jacksonville, FL; [16]University of Wisconsin, Madison, WI; [17]Medical University of South Carolina, Charleston, SC; [18]Emory University, Atlanta, GA; [19]Weill Cornell Medicine, New York, NY

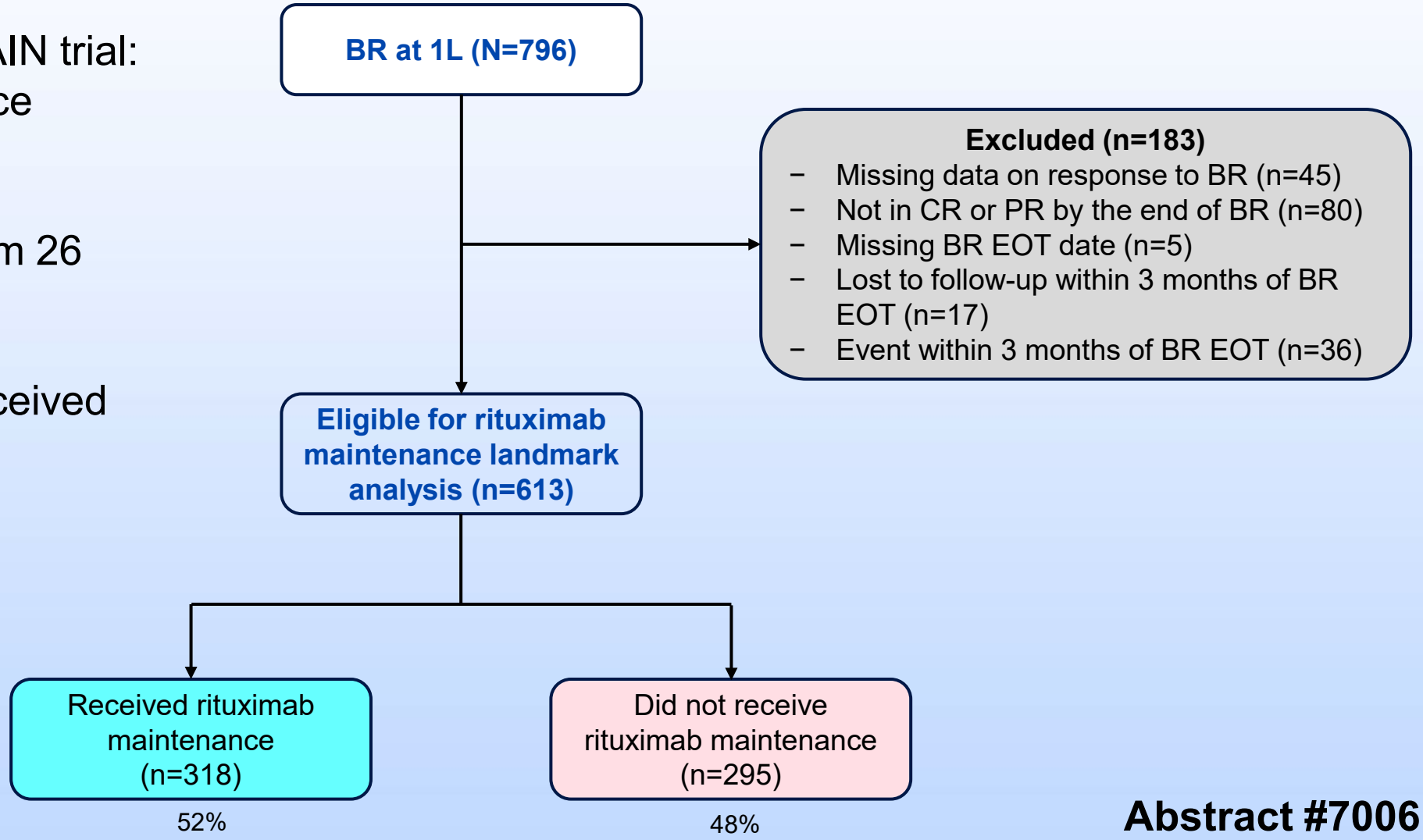
ASCO 2024
June 1, 2024

MAYO CLINIC

Abstract #7006

Rituximab Maintenance after FL BR in MCL

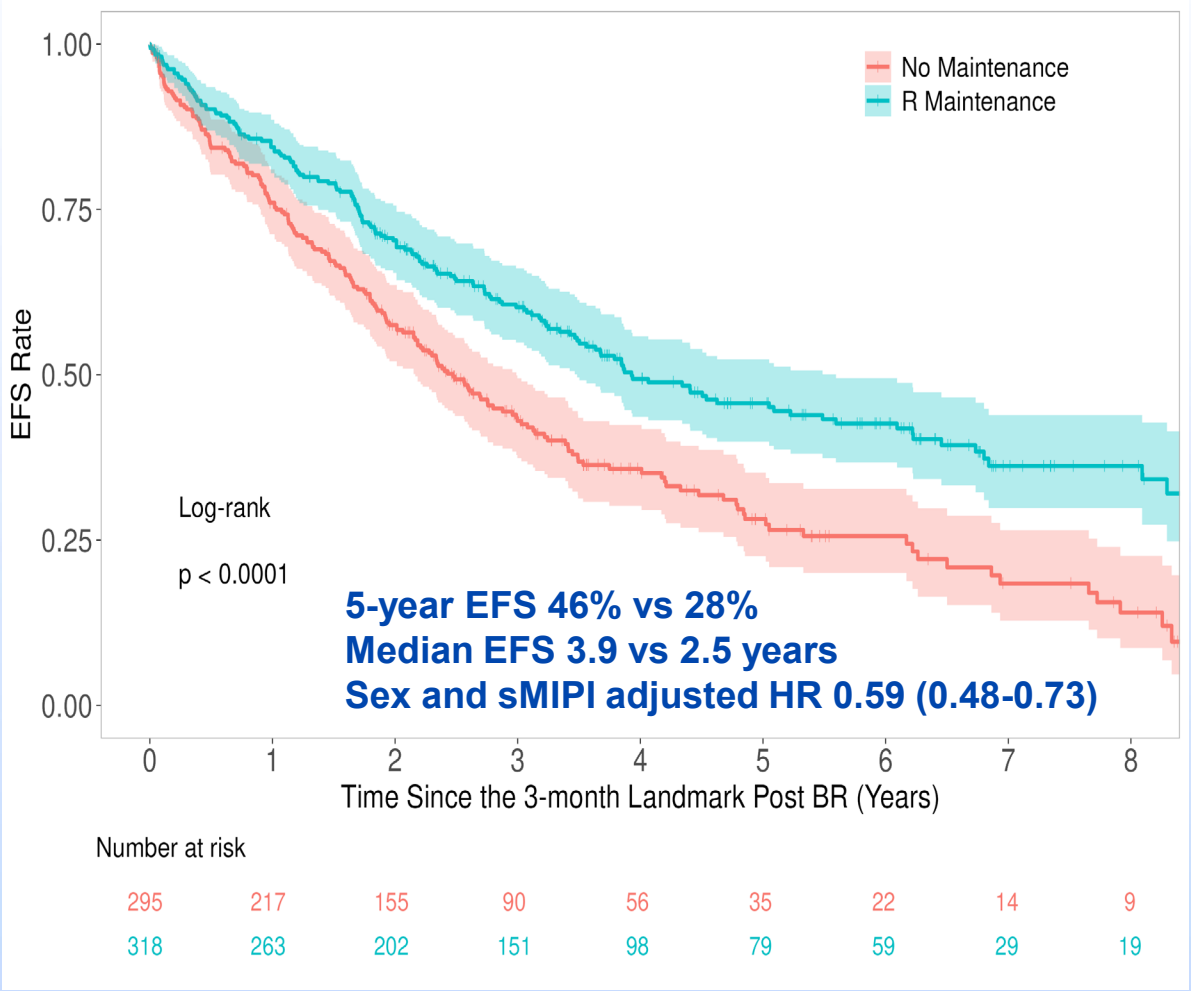
- StiL NHL7-2008 MAINTAIN trial: No benefit of maintenance rituximab after FL BR
- Observational cohort from 26 US academic centers
- N = 796 patients who received 1L BR in 2007-2020



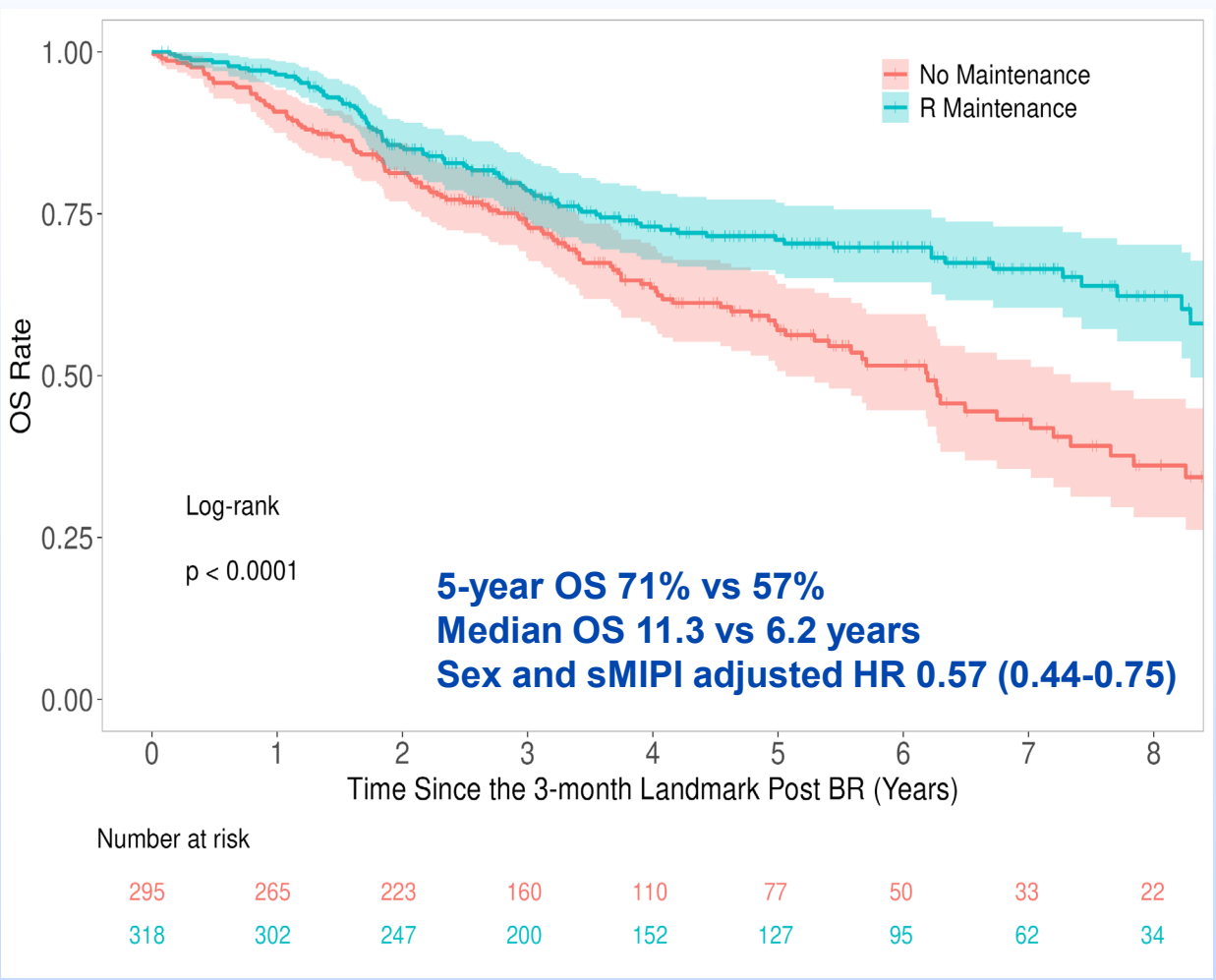
Abstract #7006

Rituximab Maintenance after FL BR in MCL

EFS by Rituximab Maintenance



OS by Rituximab Maintenance



MAYO CLINIC

Abstract #7006

Ibrutinib Combined with Venetoclax in Patients with Relapsed/Refractory Mantle Cell Lymphoma: Primary Analysis Results from the Randomized Phase 3 SYMPATICO Study

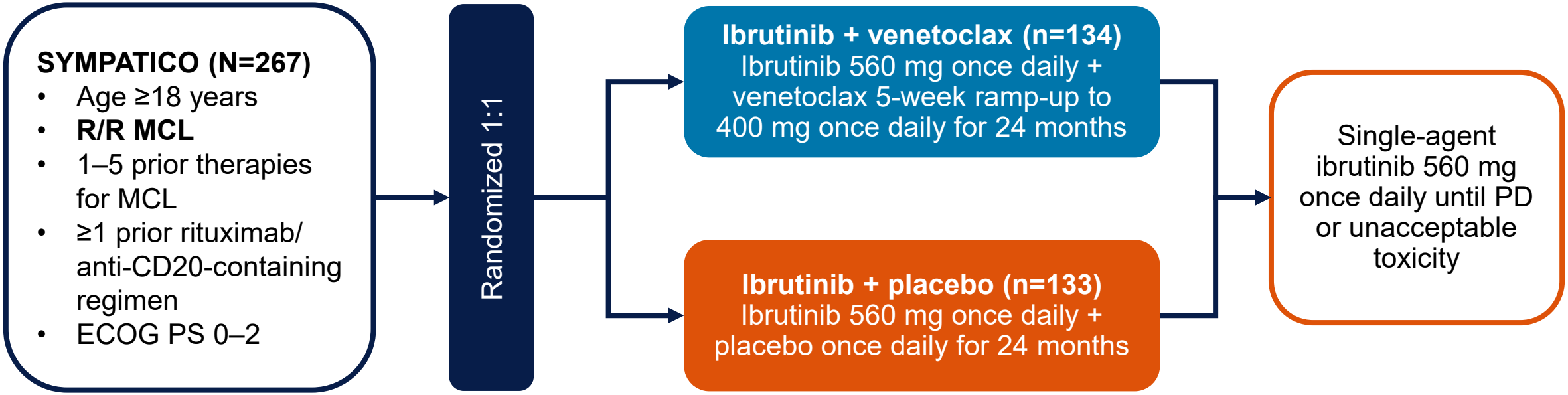
Michael Wang, MD[1], Wojciech Jurczak, MD, PhD[2], Marek Trneny, MD[3], David Belada, MD[4], Tomasz Wrobel, MD, PhD[5], Nilanjan Ghosh, MD, PhD[6], Mary-Margaret Keating, MD[7], Tom van Meerten, MD, PhD[8], Ruben Fernandez Alvarez, MD[9], Gottfried von Keudell, MD, PhD[10], Catherine Thieblemont, MD, PhD[11], Frederic Peyrade, MD[12], Marc Andre, MD[13], Marc Hoffmann, MD[14], Edith Szafer-Glusman, PhD[15], Jennifer Lin, MS, MA[15], James P. Dean, MD, PhD[15], Jutta K. Neuenburg, MD, PhD[15], Constantine S. Tam, MD, MBBS[16]

[1]Department of Lymphoma and Myeloma, The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [2]Maria Skłodowska-Curie National Research Institute of Oncology, Kraków, Poland; [3]General University Hospital in Prague, Prague, Czech Republic; [4]4th Department of Internal Medicine - Haematology, Charles University, Hospital and Faculty of Medicine, Hradec Králové, Czech Republic; [5]Wrocław Medical University, Wrocław, Poland; [6]Levine Cancer Institute, Atrium Health, Charlotte, NC, USA; [7]Queen Elizabeth II Health Sciences Centre, Halifax, Nova Scotia, Canada; [8]Universitair Medisch Centrum Groningen, Groningen, Netherlands; [9]Hospital Universitario de Cabueñes, Asturias, Spain; [10]Beth Israel Deaconess Medical Center, Boston, MA, USA; [11]Université de Paris, Assistance Publique-Hôpitaux de Paris, Hôpital Saint-Louis, service d'hémato-oncologie, Paris, France; [12]Centre Antoine Lacassagne, Nice, France; [13]CHU UCL Namur Mont-Godinne, Yvoir, Belgium; [14]University of Kansas Cancer Center, Westwood, KS, USA; [15]AbbVie, North Chicago, IL, USA; [16]Peter MacCallum Cancer Centre, Alfred Health and Monash University, Melbourne, Victoria, Australia

Abstract #7007

SYMPATICO Study Design

- SYMPATICO (NCT03112174) is multinational, randomized, double-blind, placebo-controlled, phase 3 study



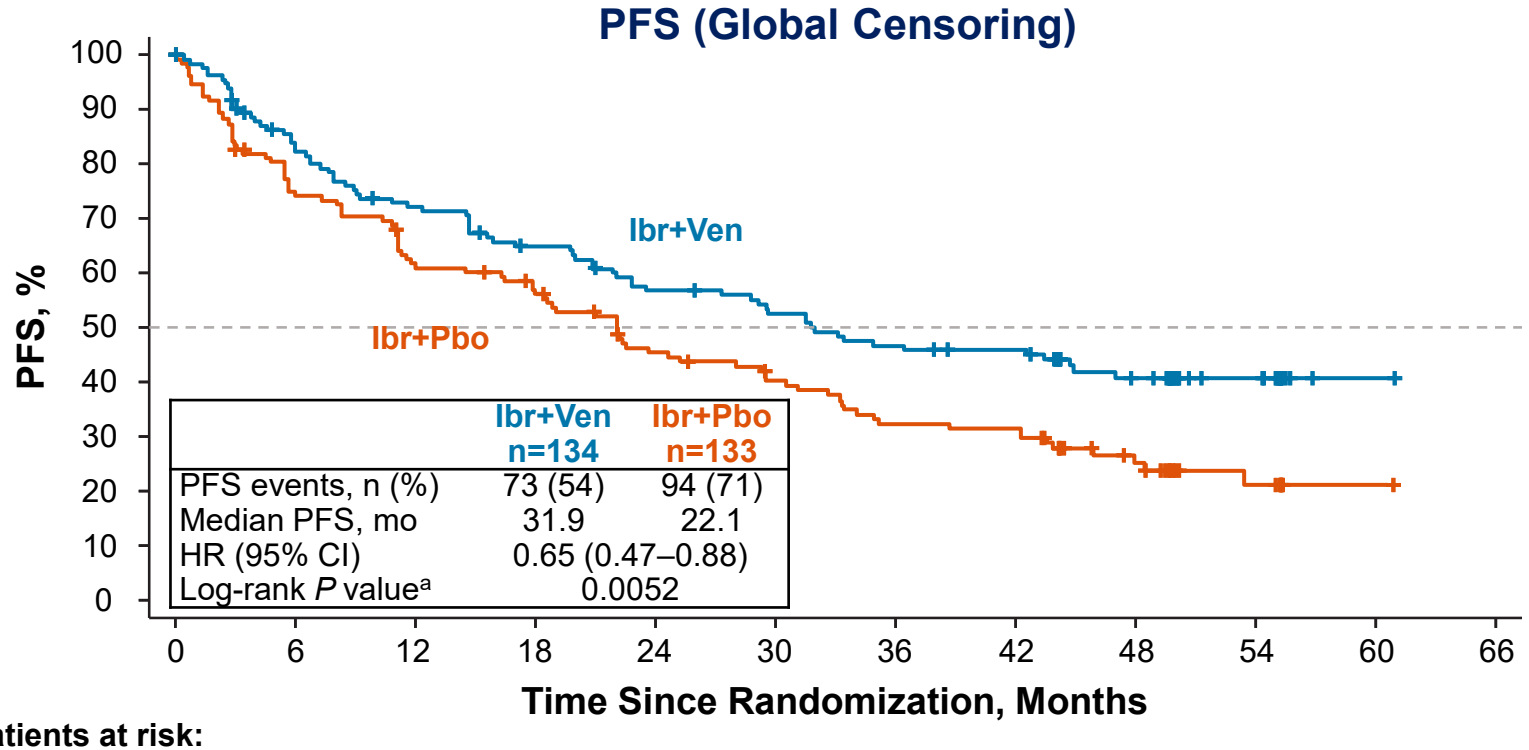
Stratification: ECOG PS, prior lines of therapy, TLS risk[a]

- **Primary endpoint:**
  - **PFS by investigator assessment using Lugano criteria**
- **Secondary endpoints (tested hierarchically in the following order):**
  - CR rate by investigator assessment
  - TTNT[b]
  - OS (interim analysis)
  - ORR by investigator assessment

CR, complete response; ECOG PS, Eastern Cooperative Oncology Group performance status; PD, progressive disease; PFS, progression-free survival; ORR, overall response rate; OS, overall survival; TLS, tumor lysis syndrome; TTNT, time to next treatment.

[a]Increased TLS risk was defined as at least 1 lesion >10 cm, or at least 1 lesion >5 cm with circulating lymphocytes >25,000 cells/mm^3, and/or creatinine clearance <60 mL/min. [b]For hierarchical testing per US FDA censoring, TTNT was tested after OS.

Primary Endpoint: Investigator-Assessed PFS Was Significantly Improved With Ibrutinib + Venetoclax Versus Ibrutinib + Placebo



Patients at risk:

Ibr+Ven	134	107	91	80	69	63	56	53	34	15	1	0
Ibr+Pbo	133	96	79	70	54	46	37	36	18	8	1	0

Median PFS, mo	Global Censoring[b]				US FDA Censoring[c]			
	Ibr+Ven n=134	Ibr+Pbo n=133	HR (95% CI)	Log-rank *P* value[a]	Ibr+Ven n=134	Ibr+Pbo n=133	HR (95% CI)	Log-rank *P* value[a]
Investigator assessment	31.9	22.1	0.65 (0.47–0.88)	0.0052	42.6	22.1	0.60 (0.44–0.83)	0.0021
IRC assessment	31.8	20.9	0.67 (0.49–0.91)	0.0108	43.5	22.1	0.63 (0.45–0.87)	0.0057

HR, hazard ratio; Ibr, ibrutinib; Pbo, placebo; Ven, venetoclax.

[a]*P* values were determined by stratified log-rank test (stratification factors: prior lines of therapy [1–2 vs ≥3] and TLS risk category [low vs increased risk]). [b]Censoring at last non-PD assessment for patients without PD or death. [c]Censoring at last non-PD assessment for patients without PD or death, with subsequent anticancer therapy, or missing ≥2 consecutive visits prior to PD or death.

Randomized Phase II/III Study of R-CHOP +/- Venetoclax in Previously Untreated Double Expressor Lymphomas: Results from Alliance A051701

Jeremy S. Abramson, Susan Geyer, Levi Pederson, Sharmila Giri, Eric D. Hsi, Richard F. Little, Steven Gore, Daniel Landsburg, Hua-Jay Cherng, Brad Kahl, Neha Mehta-Shah, Shira Dinner, Jonathan W. Friedberg, Nancy L. Bartlett, **John P. Leonard**

Abstract #7012

Alliance A051701: Efficacy

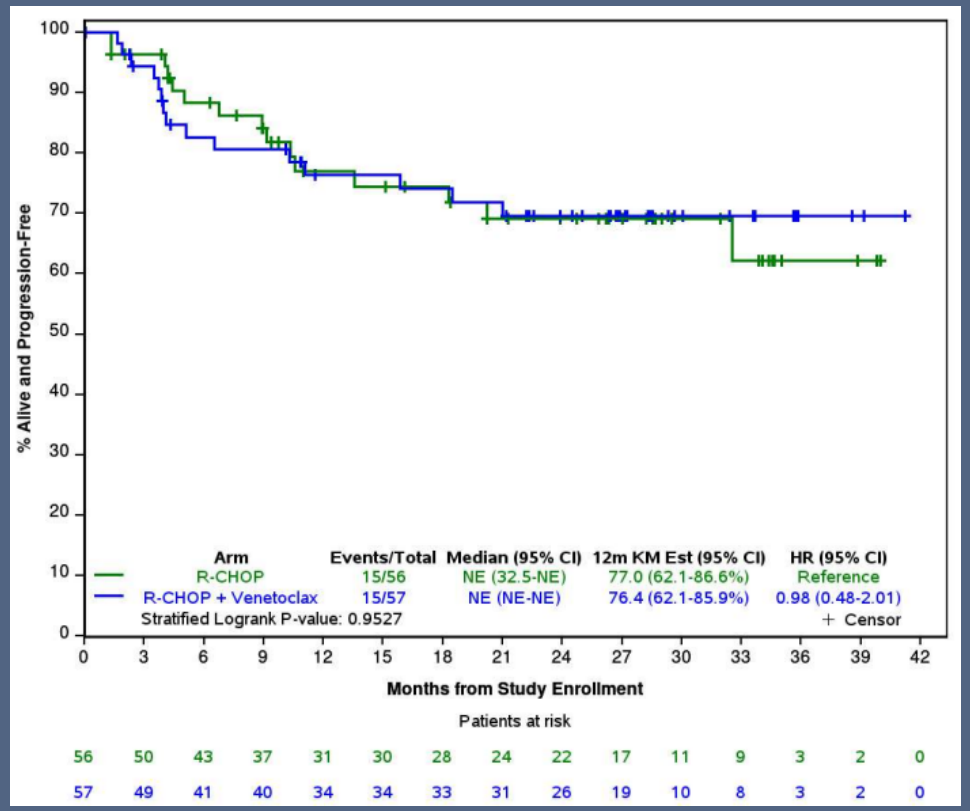
Abstract #7012

Best response by PET/CT, n (%)	R-CHOP N=56	R-CHOP-venetoclax N=57
ORR	51 (96)	50 (98)
CR	41 (77)	44 (86)
PR	10 (19)	6 (12)
PD	2 (4)	1 (2)
Missing	3	6

p=0.999

Progression-free survival

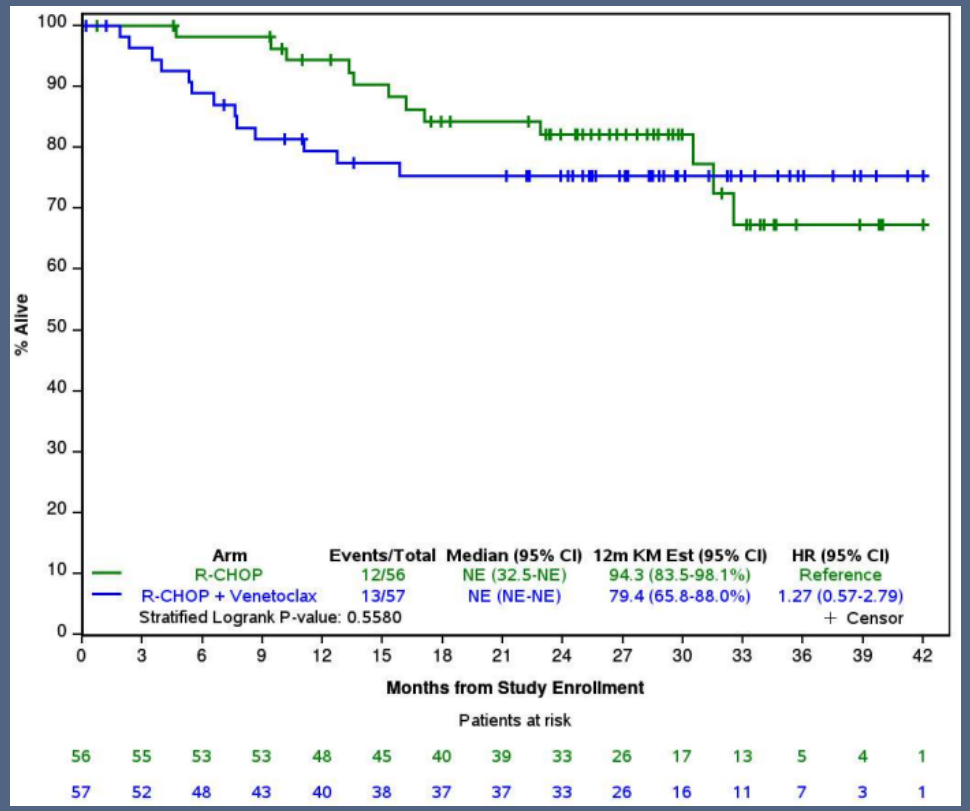
PFS HR=0.98
p=0.95



median follow-up 26.4 months

Overall survival

OS HR=1.27
p=0.56



median follow-up 28.4 months

ALLIANCE FOR CLINICAL TRIALS IN ONCOLOGY

Abstract 7010

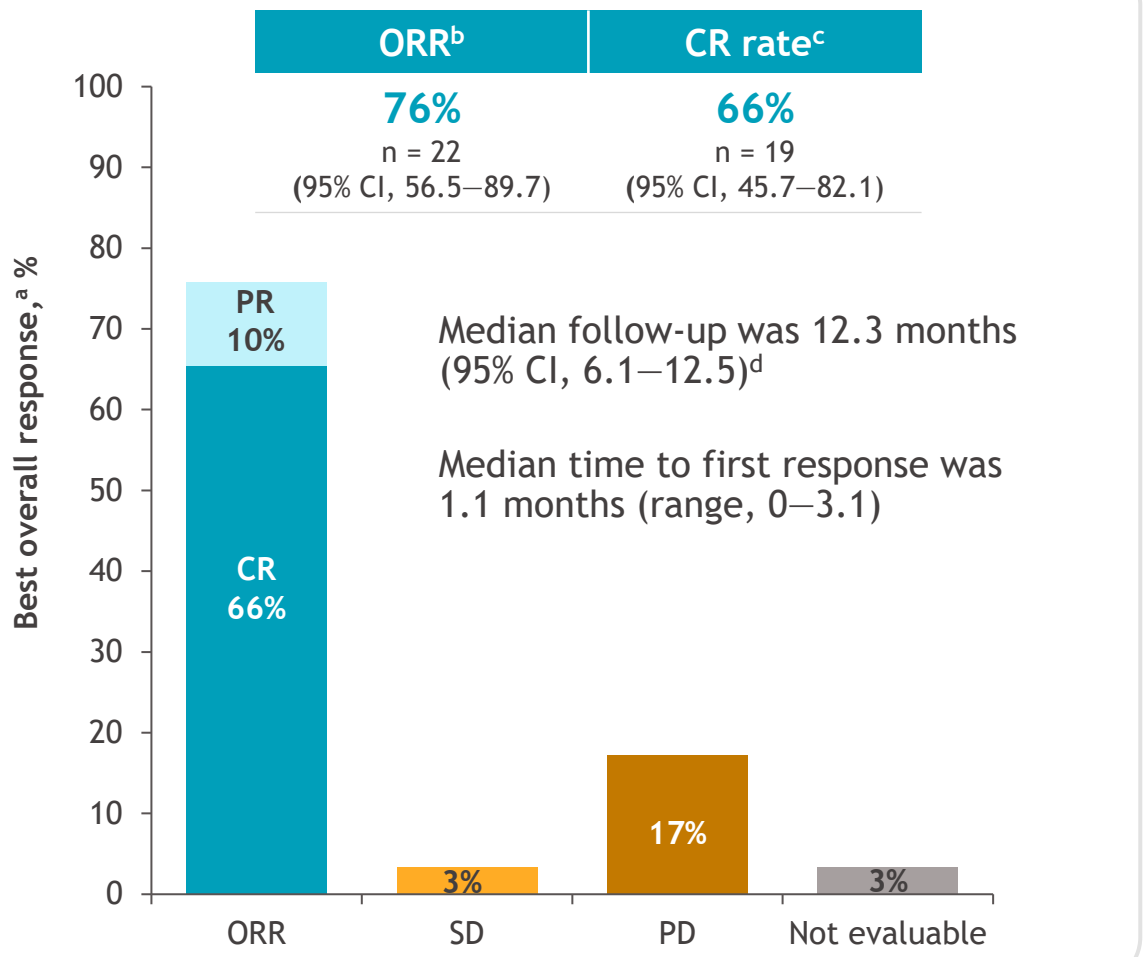
2024 ASCO® ANNUAL MEETING

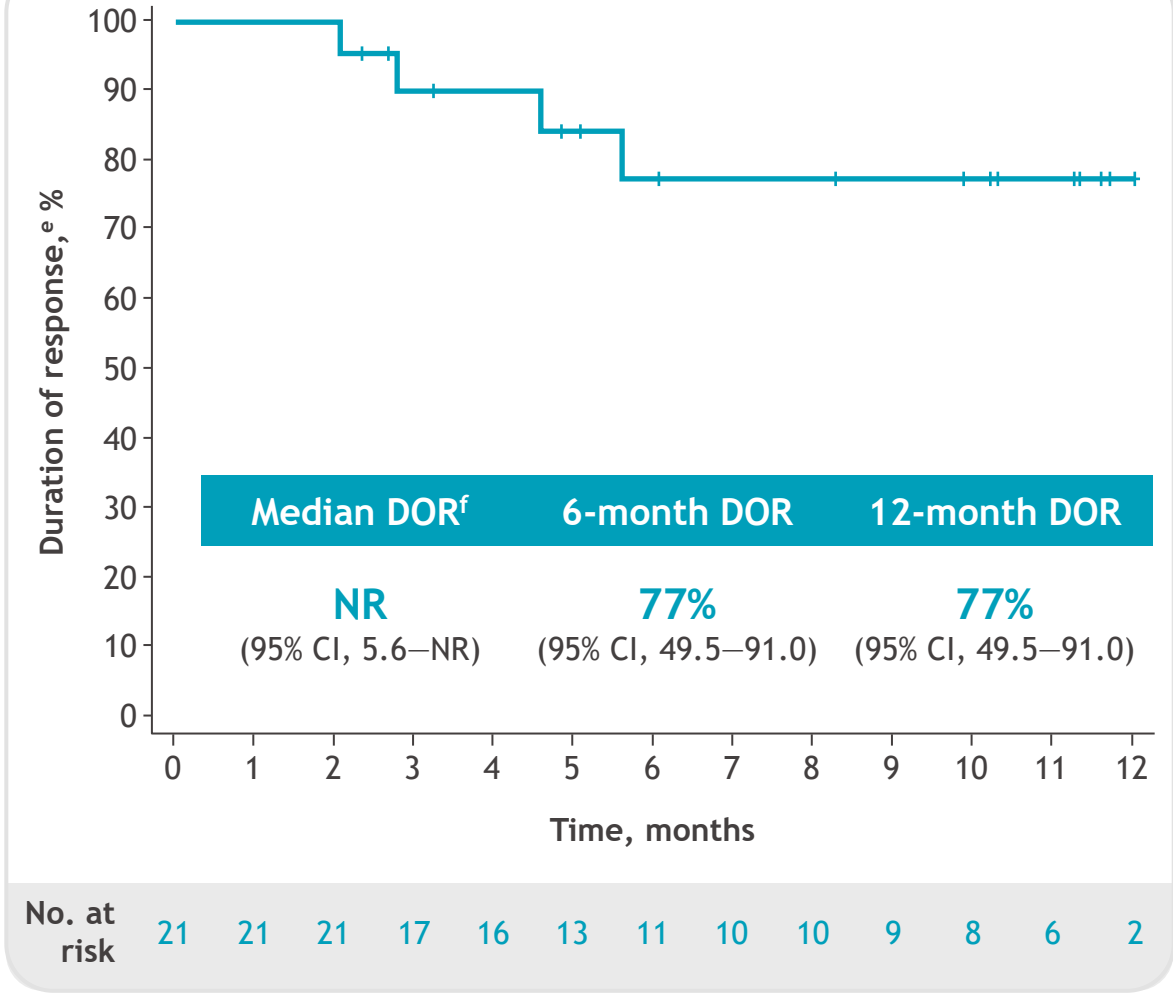
Real-world Outcomes of Lisocabtagene Maraleucel in Patients with Richter Transformation from the Center for International Blood and Marrow Transplant Research (CIBMTR)

Allison Winter, MD,[1] Sushma Bharadwaj, MD,[2] Alex F. Herrera, MD,[3] Chaitanya Iragavarapu, MD,[4] Abu-Sayeef Mirza, MD, MPH,[5] M. Lia Palomba, MD,[6] Sagar S. Patel, MD,[7] Mecide Gharibo, MD,[8] David Bernasconi, MSc,[9] Tracy Krimmel, MSN, DNP,[8] Fei Fei Liu, GDCE, MBA,[8] Debasmita Roy, PhD,[8] Marcelo C. Pasquini, MD, MS[10]

[1]Cleveland Clinic Taussig Cancer Institute, Cleveland, OH, USA; [2]Stanford University School of Medicine, Stanford, CA, USA; [3]City of Hope Medical Center, Duarte, CA, USA; [4]University of Kentucky College of Medicine, Lexington, KY, USA; [5]Moffitt Cancer Center, Tampa, FL, USA; [6]Memorial Sloan Kettering Cancer Center, New York, NY, USA; [7]Huntsman Cancer Institute at the University of Utah, Salt Lake City, UT, USA; [8]Bristol Myers Squibb, Princeton, NJ, USA; [9]Celgene, a Bristol-Myers Squibb Company, Boudry, Switzerland; [10]Center for International Blood & Marrow Transplant Research, Medical College of Wisconsin, Milwaukee, WI, USA

CIBMTR Liso-cell in Richter Transformation: ORR, best overall response, and DOR





[a]Among evaluable patients (n = 29); [b]Continued complete remission + CR + PR; [c]Continued complete remission + CR; [d]Estimated using the reverse Kaplan-Meier method; [e]Responders with available DOR data; [f]Median follow-up was 9.9 months (95% CI, 4.9–11.3).
NR, not reached; SD, stable disease.

2024 ASCO® ANNUAL MEETING

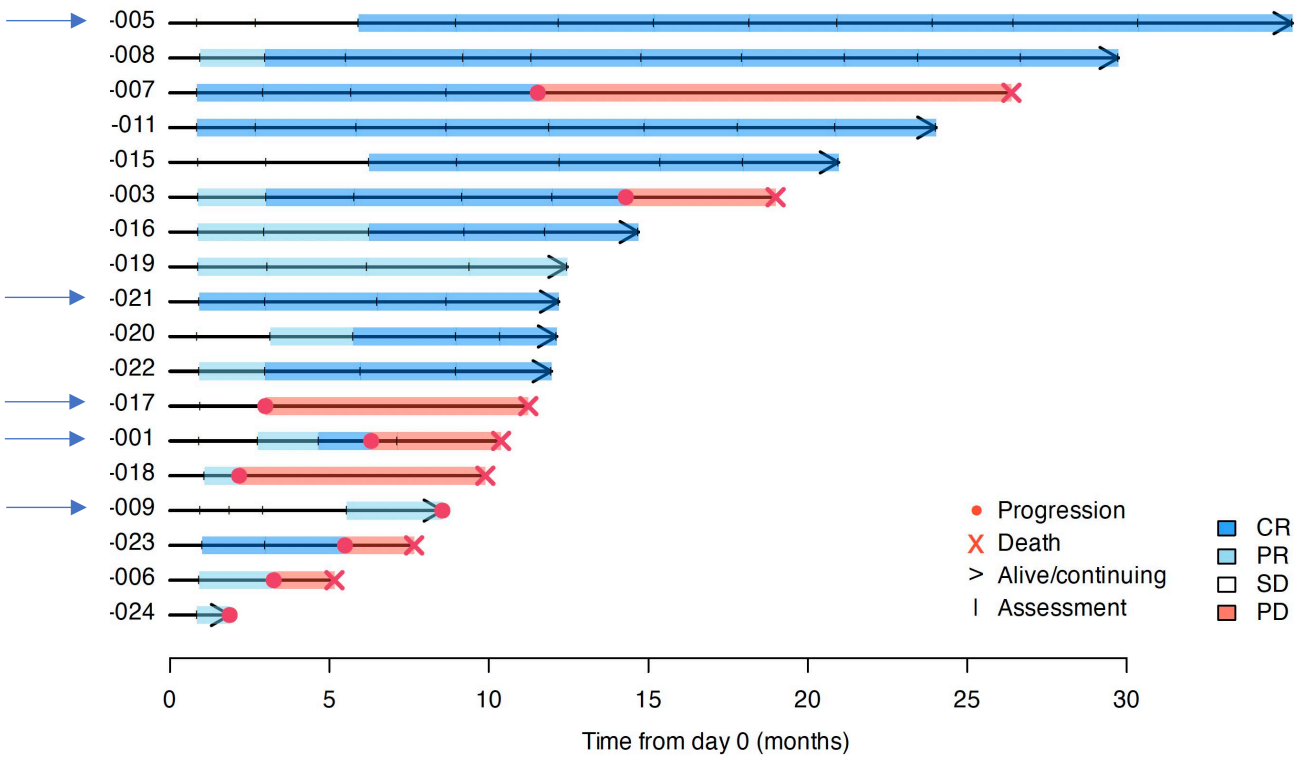
A Pilot Study of Axicabtagene Ciloleucel in Relapsed/Refractory Primary and Secondary Central Nervous System Lymphomas (PCNSL & SCNSL)

L Nayak, UN Chukwueke, S Hogan, C Meehan, R Redd, E Lee, AI Kim, LN Gonzalez Castro, JR McFaline Figueroa, IC Arrillaga-Romany, M Murakami, R Huang, U Gerdemann, J Kaminski, D Mao, S Filosto, M Mattie, S Poddar, P Armand, LS Kean, **CA Jacobson**

Dana-Farber Cancer Institute; Boston Children's Hospital; Mass General Brigham; Kite, A Gilead Company

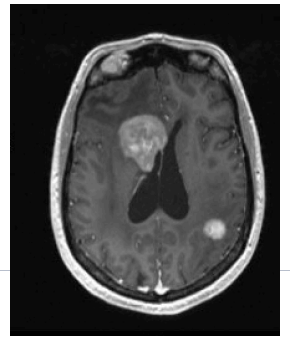
Pilot Study of Axi-cel in R/R PCNSL & SCNSL: Efficacy

Abstract #2006

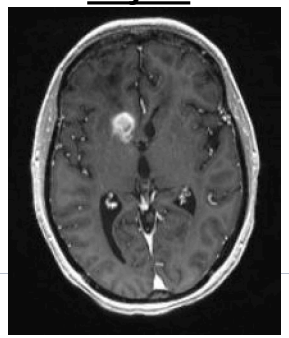


- Median f/u: 24 months
- ORR: 17/18 (94%)
  - uCR/CR: 12/18 (67%)
  - PR: 5/18 (28%)
- Median time to best response : 3 months (1-6)

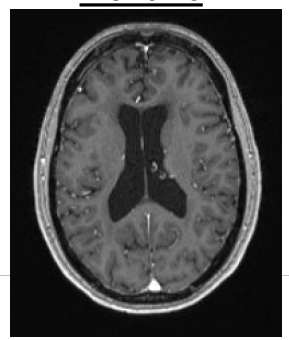
Baseline



Day 28



Month 6



Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma

Outcomes in High-risk Subgroups After Fixed-Duration Ibrutinib + Venetoclax for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma: Up To 5.5 years of Follow-up in the Phase 2 CAPTIVATE Study

William G. Wierda, MD, PhD,[1] Ryan Jacobs, MD,[2] Paul M. Barr, MD,[3] John N. Allan, MD,[4] Tanya Siddiqi, MD,[5] Alessandra Tedeschi, MD,[6] Thomas J. Kipps, MD, PhD,[7] Susan M. O'Brien, MD,[8] Xavier C. Badoux, MBBS, FRACP, FRCPA,[9] Andrea Visentin, MD, PhD[10] Masa Lasica, MBBS, FRACP, FRCPA,[11] Dennis Carney, MBBS, FRACP, FRCPA,[12] Anna Elinder Camburn, MBChB, FRACP, FRCPA,[13] Javier De la Serna, MD,[14] Edith Szafer-Glusman, PhD,[15] Cathy Zhou, MS,[15] Anita Szoke, MD,[15] James P. Dean, MD, PhD,[15] Paolo Ghia, MD, PhD,[16,17] Constantine S. Tam, MBBS, MD[18]

[1]The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [2]Levine Cancer Institute, Charlotte, NC, USA; [3]Wilmot Cancer Institute, University of Rochester Medical Center, Rochester, NY, USA; [4]Weill Cornell Medicine, New York, NY, USA; [5]City of Hope National Medical Center, Duarte, CA, USA; [6]ASST Grande Ospedale Metropolitano Niguarda, Milan, Italy; [7]University of California San Diego Moores Cancer Center, La Jolla, CA, USA; [8]UC Irvine, Chao Comprehensive Cancer Center, Orange, CA, USA; [9]Ministry of Health, Kogarah, NSW, Australia; [10]University of Padova, Padova, Italy; [11]St Vincent's Hospital Melbourne, Melbourne, VIC, Australia; [12]Peter MacCallum Cancer Centre, Melbourne, Australia; [13]North Shore Hospital, Auckland, New Zealand; [14]Hospital Universitario 12 de Octubre, Madrid, Spain; [15]AbbVie, North Chicago, IL, USA; [16]Università Vita-Salute San Raffaele, [17]IRCCS Ospedale San Raffaele, Milan, Italy; [18]Alfred Hospital and Monash University, Melbourne, VIC, Australia

2024 ASCO Annual Meeting; May 31–June 4, 2024; Chicago, IL, USA

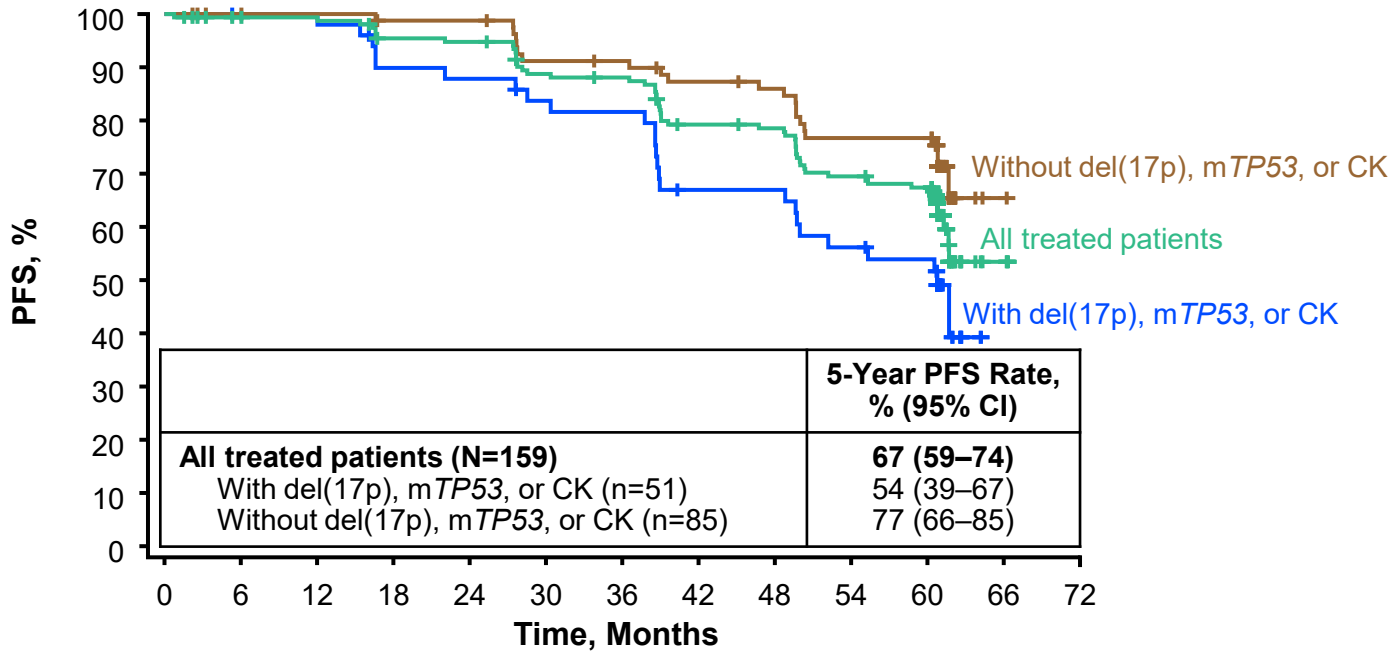
Abstract #7009

CAPTIVATE FD Cohort: Overall Median PFS Was Not Reached With Up to 5.5 Years of Follow-Up

Abstract #7009

- Median time on study: 61.2 months (range, 0.8–66.3)

PFS in All Treated Patients and by del(17p), m*TP53*, or CK Status



Patients at risk

All treated patients	159	153	152	144	143	132	130	115	113	100	96	3	0
With del(17p), m*TP53*, or CK	51	50	50	44	43	40	39	31	31	26	24	0	
Without del(17p), m*TP53*, or CK	85	82	81	79	79	72	71	67	65	58	58	1	0

	With feature		Without feature	
High-risk feature	**n**	**5-Year PFS rate, % (95% CI)**	**n**	**5-Year PFS rate, % (95% CI)**
del(17p)/m*TP53*	27	41 (21–59)	129	73 (64–80)
CK[a]	31	57 (37–72)	102	72 (61–80)
del(11q)[b]	11	64 (30–85)	74	79 (67–87)

CK, complex karyotype; m*TP53*, mutated *TP53*; PFS, progression-free survival. [a]Defined as ≥3 chromosomal abnormalities by conventional CpG-stimulated cytogenetics; [b]Excluding patients with del(17p)/mutated *TP53* or CK.

CAPTIVATE FD Cohort: Overall Median PFS Was Not Reached With Up to 5.5 Years of Follow-Up

Abstract #7009

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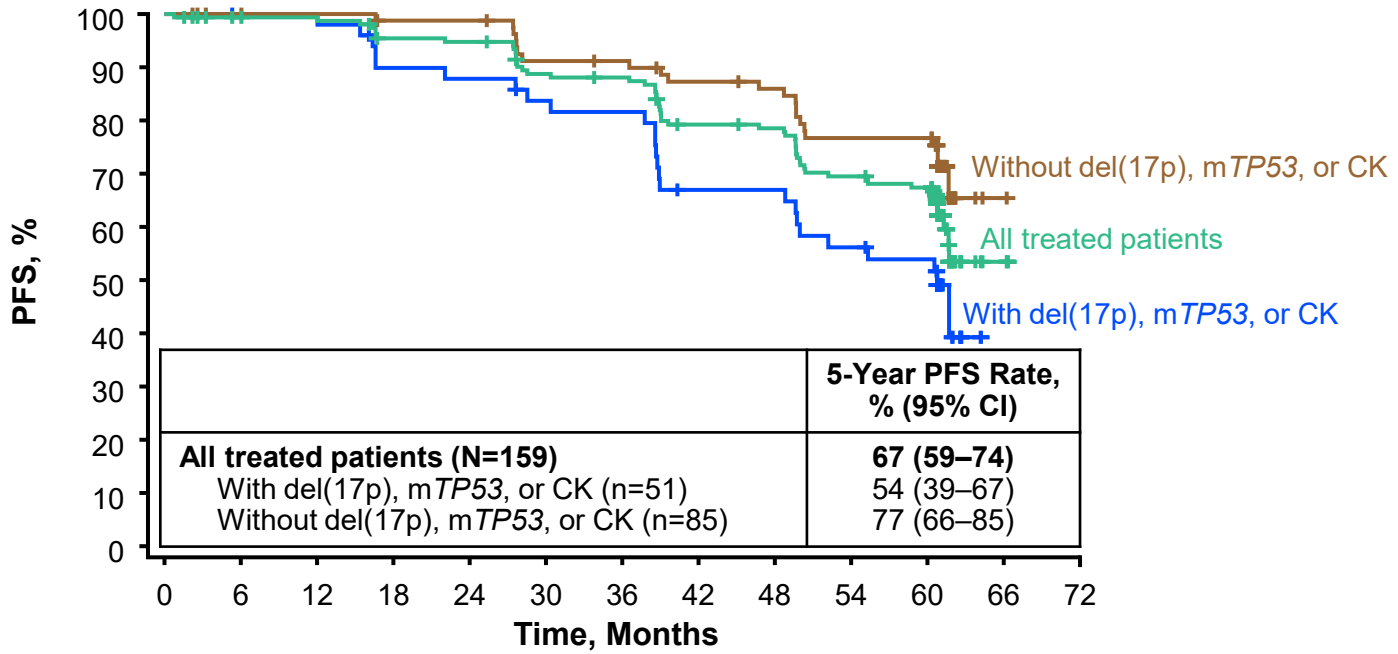
PFS in All Treated Patients and by del(17p), m*TP53*, or CK Status



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	With feature		Without feature	
High-risk feature	**n**	**5-Year PFS rate, % (95% CI)**	**n**	**5-Year PFS rate, % (95% CI)**
del(17p)/m*TP53*	27	41 (21–59)	129	73 (64–80)
CK[a]	31	57 (37–72)	102	72 (61–80)
del(11q)[b]	11	64 (30–85)	74	79 (67–87)

CK, complex karyotype; m*TP53*, mutated *TP53*; PFS, progression-free survival. [a]Defined as ≥3 chromosomal abnormalities by conventional CpG-stimulated cytogenetics; [b]Excluding patients with del(17p)/mutated *TP53* or CK.

Myelodysplastic Syndrome

2024 ASCO® ANNUAL MEETING

Preliminary safety and efficacy of oral azacitidine in patients with Low-/Intermediate-risk myelodysplastic syndromes: phase 2 results from the ASTREON trial

Guillermo Garcia-Manero,[1] Karen W. L. Yee,[2] Francisca Hernandez,[3] Matteo Giovanni Della Porta,[4,5] Stefania Paolini,[6] Seo-Yeon Ahn,[7] Valeria Santini,[8] Pierre Fenaux,[9] Takahiro Suzuki,[10] Mikkael A. Sekeres,[11] Jun He,[12] Jerry Li,[12] Ronit Barkalifa,[12] Carlos E. Vigil,[12] Thomas Prebet,[12] Daniel Lopes de Menezes,[13] Joseph Burnett,[12] Rami S. Komrokji,[14] Aristoteles Giagounidis[15]

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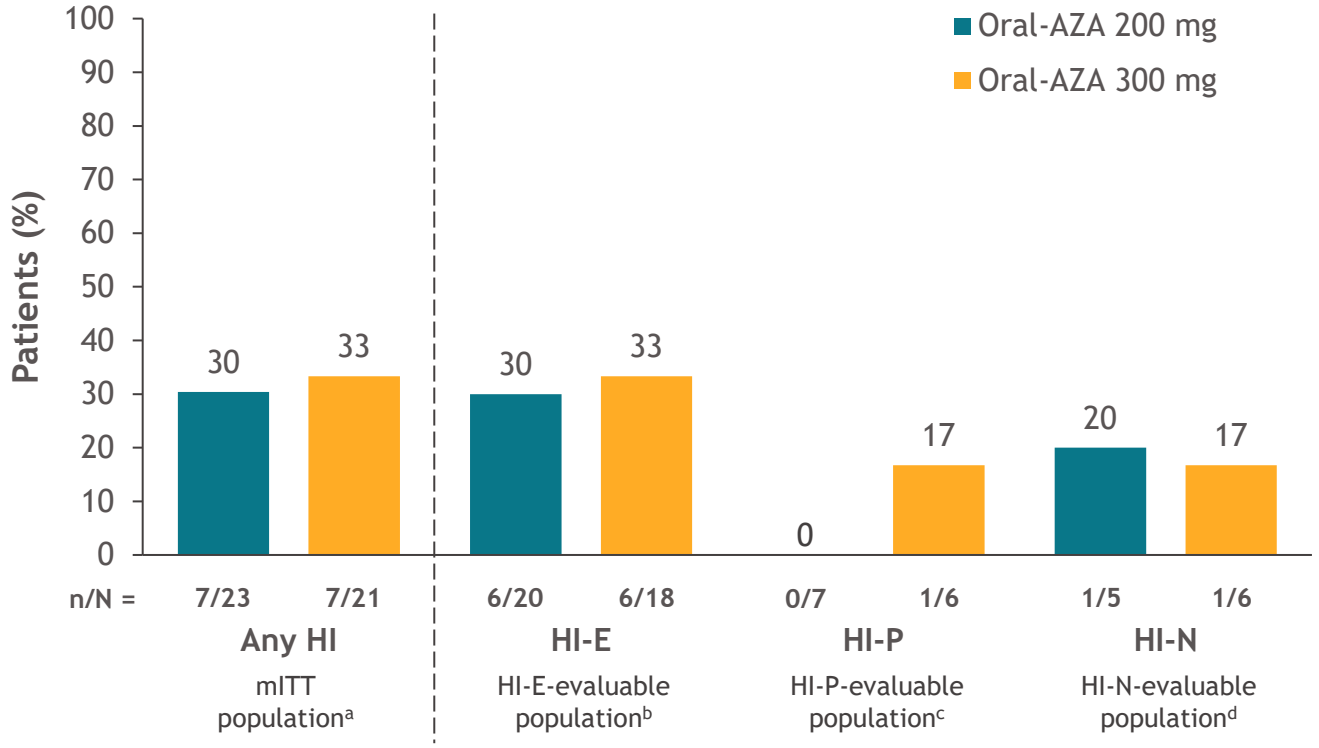
Abstract #6509

Oral Azacitine in Low/Int-Risk MDS (ASTREON): Hematologic responses per IWG 2006 criteria[1]



	Oral-AZA 200 mg (N = 23[a])	Oral-AZA 300 mg (N = 21[a])
Best hematologic response within 6 cycles, n (%)		
CR	0	0
PR	1 (4)	1 (5)
mCR	3 (13)	1 (5)
Stable disease	17 (74)	19 (91)
Treatment failure	0	0
Disease progression	2 (9)	0
Best OR (all cycles), n (%)		
CR	0	0
PR	1 (4)	1 (5)
mCR	3 (13)	1 (5)
mCR with HI	1/3 (33)	1/1 (100)
Any HI	6 (26)	6 (29)
Other[e]	13 (57)	13 (62)

Additional response data are still being evaluated. Percentages may not sum to 100 due to rounding.

[a]mITT population is defined as all patients who received ≥ 75% of the cycle 1 Oral-AZA dose and had ≥ 1 post-baseline efficacy assessment. [b]Patients in the mITT population with baseline Hb < 11 g/dL or baseline Hb ≥ 11 g/dL and baseline RBC-TD with > 1 RBC unit transfused within 56 days. [c]Patients in the mITT population with baseline platelets < 100 × 10^9/L. [d]Patients in the mITT population with baseline ANC < 1.0 × 10^9/L. [e]Patients meeting none of the specified response criteria.

CR, complete remission; HI, hematologic improvement; HI-E, HI-erythroid response; HI-N, HI-neutrophil response; HI-P, HI-platelet response; mCR, marrow CR; mITT, modified intent-to-treat; OR, overall response; PR, partial remission.

1. Cheson BD, et al. *Blood* 2006;108:419-425.

Abstract #6509

Myelofibrosis

Updated Safety and Efficacy Data From the Phase 3 MANIFEST-2 Study of Pelabresib in Combination With Ruxolitinib for JAK Inhibitor Treatment-Naïve Patients With Myelofibrosis

Raajit K. Rampal,[1] Sebastian Grosicki, Dominik Chraniuk, Elisabetta Abruzzese, Prithviraj Bose, Aaron T. Gerds, Alessandro Vannucchi, Francesca Palandri, Sung-Eun Lee, Vikas Gupta, Alessandro Lucchesi, Stephen Oh, Andrew Kuykendall, Alberto Alvarez Larran, Ruben Mesa, Jean-Jacques Kiladjian, Moshe Talpaz, David Lavie, Morgan Harris, Sarah-Katharina Kays, Anna-Maria Jegg, Manlei Wu, Barbara Brown, Claire Harrison*, **John Mascarenhas***

*Both authors contributed equally

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Rampal R, et al. Presented at ASCO 2024: Oral 6502.

MANIFEST-2: Randomized, Double-Blind, Active-Control Ph3 Study

Study population

JAKi-naïve patients with MF (N=430)
(primary or post-ET/PV)

- DIPSS Int-1 or higher
- Splenomegaly (≥450 cm^3) by CT/MRI
- TSS ≥10 (≥3 for two symptoms, MFSAF v4.0)

Double-blind randomization (1:1)

1:1 randomization stratified by:

- DIPSS risk category: Int-1 vs Int-2 vs high
- Platelet count: >200 × 10^9/L vs 100–200 × 10^9/L
- Spleen volume: ≥1800 cm^3 vs <1800 cm^3

Treatment arms

Pelabresib 125 mg* PO QD Day 1–14 + **Ruxolitinib** Per label with a 5-mg BID lower starting dose† Day 1–21

21-day cycles

Placebo PO QD Day 1–14 + **Ruxolitinib** Per label with a 5-mg BID lower starting dose† Day 1–21

Primary endpoint

- SVR35 at Week 24

Key secondary endpoints

- Absolute change in TSS from baseline at Week 24
- TSS50 at Week 24

Safety

- AEs of all grades and serious AEs

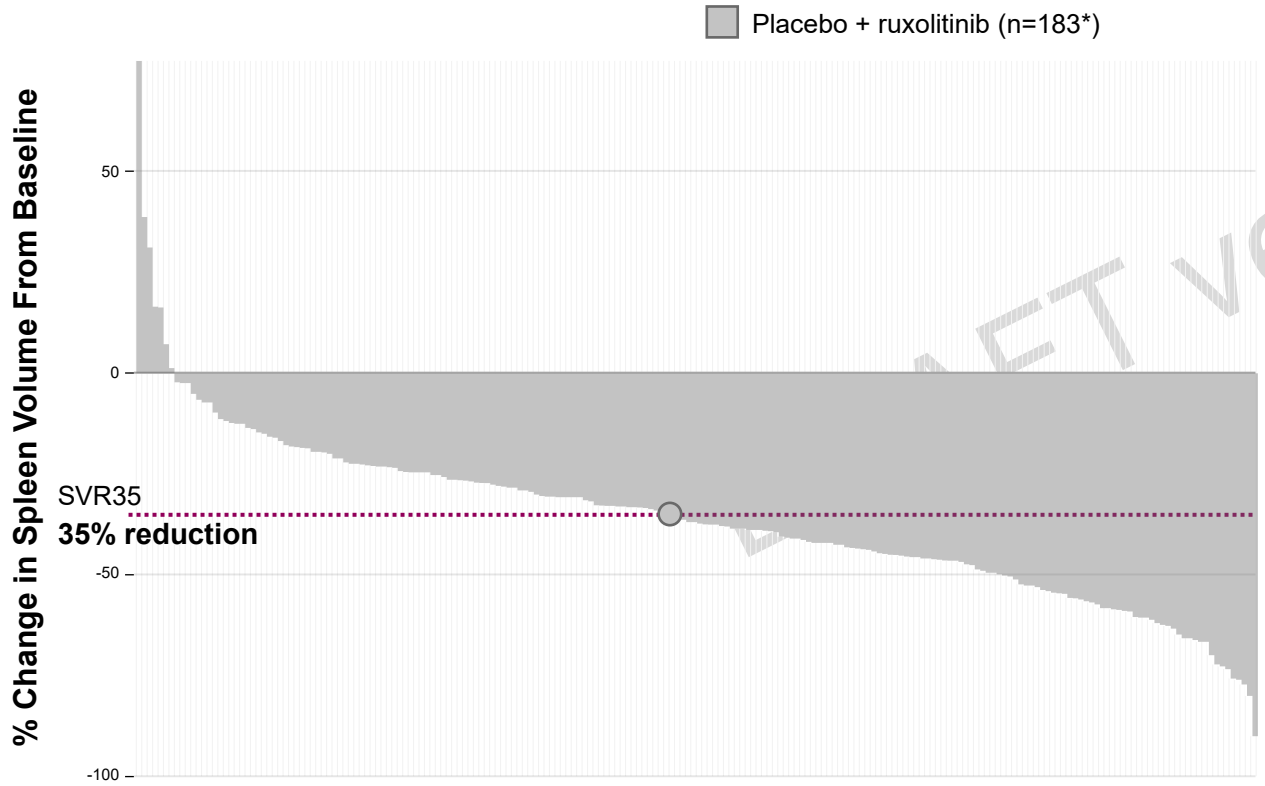
*The starting dose for pelabresib was 125 mg QD and protocol-defined dose modifications based on AEs and treatment response allowed a dose range between 50 mg and 175 mg QD; †Ruxolitinib was started at 10 mg BID (baseline platelet count 100–200 × 10^9/L) or 15 mg BID (baseline platelet count >200 × 10^9/L) with a mandatory dose increase by 5 mg BID after one cycle and a maximum dose of 25 mg BID per label.
AE, adverse event; BID, twice daily; CT, computed tomography; DIPSS, Dynamic International Prognostic Scoring System; ET, essential thrombocythemia; Int, intermediate; JAKi, Janus kinase inhibitor; MF, myelofibrosis; MFSAF, Myelofibrosis Symptom Assessment Form; MRI, magnetic resonance imagining; PO, orally; PV, polycythemia vera; QD, once daily; SVR35, ≥35% reduction in spleen volume; TSS, total symptom score; TSS50, ≥50% reduction in total symptom score.
Harrison CN, et al. *Future Oncol*. 2022;18(27):2987-2997; Rampal R, et al. Presented at ASH 2023. [Oral 628].

Rampal R, et al. Presented at ASCO 2024: Oral 6502.

Pelabresib (CPI-0610) is an investigational new drug and has not been approved by any regulatory authority

MANIFEST-2 Study Met its Primary Endpoint: SVR35 at Week 24

SVR35 response at Week 24 was significantly greater in patients treated with pelabresib + ruxolitinib vs placebo + ruxolitinib



ITT population

		Placebo + ruxolitinib (N=216)
SVR35 at Week 24		35.2%

Mean % change in spleen volume at Week 24†		-30.6 (n=183)
95% CI		-33.7, -27.5

Data cut off: August 31, 2023. Spleen volume assessed by central read.
*Waterfall plots represent patients who have baseline and Week 24 data. †Patients without Week 24 assessment are considered nonresponders.
ITT, intent-to-treat; SVR35, ≥35% reduction in spleen volume.

Rampal R, et al. Presented at ASCO 2024: Oral 6502. Data first presented at ASH 2023

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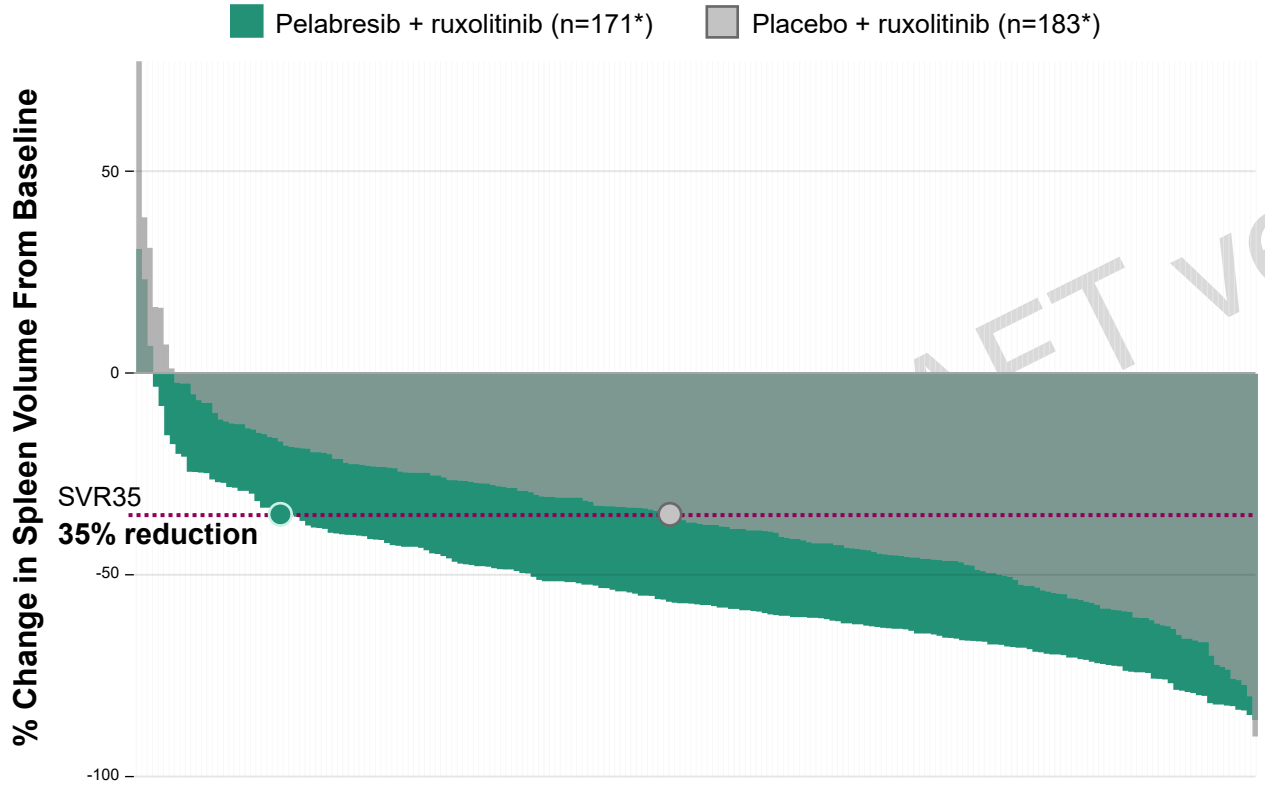

ITT population

	Pelabresib + ruxolitinib (N=214)	Placebo + ruxolitinib (N=216)	p-value
SVR35 at Week 24	65.9%	35.2%	<0.001
Difference† (95% CI)	30.4 (21.6, 39.3)		
Mean % change in spleen volume at Week 24‡	-50.6 (n=171)	-30.6 (n=183)	NA§
95% CI	-53.2, -48	-33.7, -27.5	

Data cut off: August 31, 2023. Spleen volume assessed by central read.
*Waterfall plots represent patients who have baseline and Week 24 data. †Calculated by stratified Cochran–Mantel–Haenszel test. ‡Patients without Week 24 assessment are considered nonresponders. §SVR35 at any time and percentage change in spleen volume at Week 24 are exploratory endpoints.
CI, confidence interval; ITT, intent-to-treat; SVR35, ≥35% reduction in spleen volume.

Rampal R, et al. Presented at ASCO 2024: Oral 6502.

Update of Hematologic Malignancies

Thank you

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