Exploring Key Issues Affecting the Care of Patients with BRAF-Mutant Metastatic Colorectal Cancer

A CME/MOC-Accredited Virtual Event

Thursday, September 9, 2021
5:00 PM – 6:00 PM ET

Faculty
Scott Kopetz, MD, PhD

Consulting Clinical Investigator
Wells A Messersmith, MD

Moderator
Neil Love, MD

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Faculty

Scott Kopetz, MD, PhD
Professor and Deputy Chair
Department of Gastrointestinal Medical Oncology
The University of Texas
MD Anderson Cancer Center
Houston, Texas

Consulting Clinical Investigator

Wells A Messersmith, MD
Professor and Head, Division of Medical Oncology
Associate Director for Translational Research
University of Colorado Cancer Center
Aurora, Colorado

Moderator

Neil Love, MD
Research To Practice
Miami, Florida

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Commercial Support

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Dr Love — Disclosures

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Dr Messersmith — Disclosures

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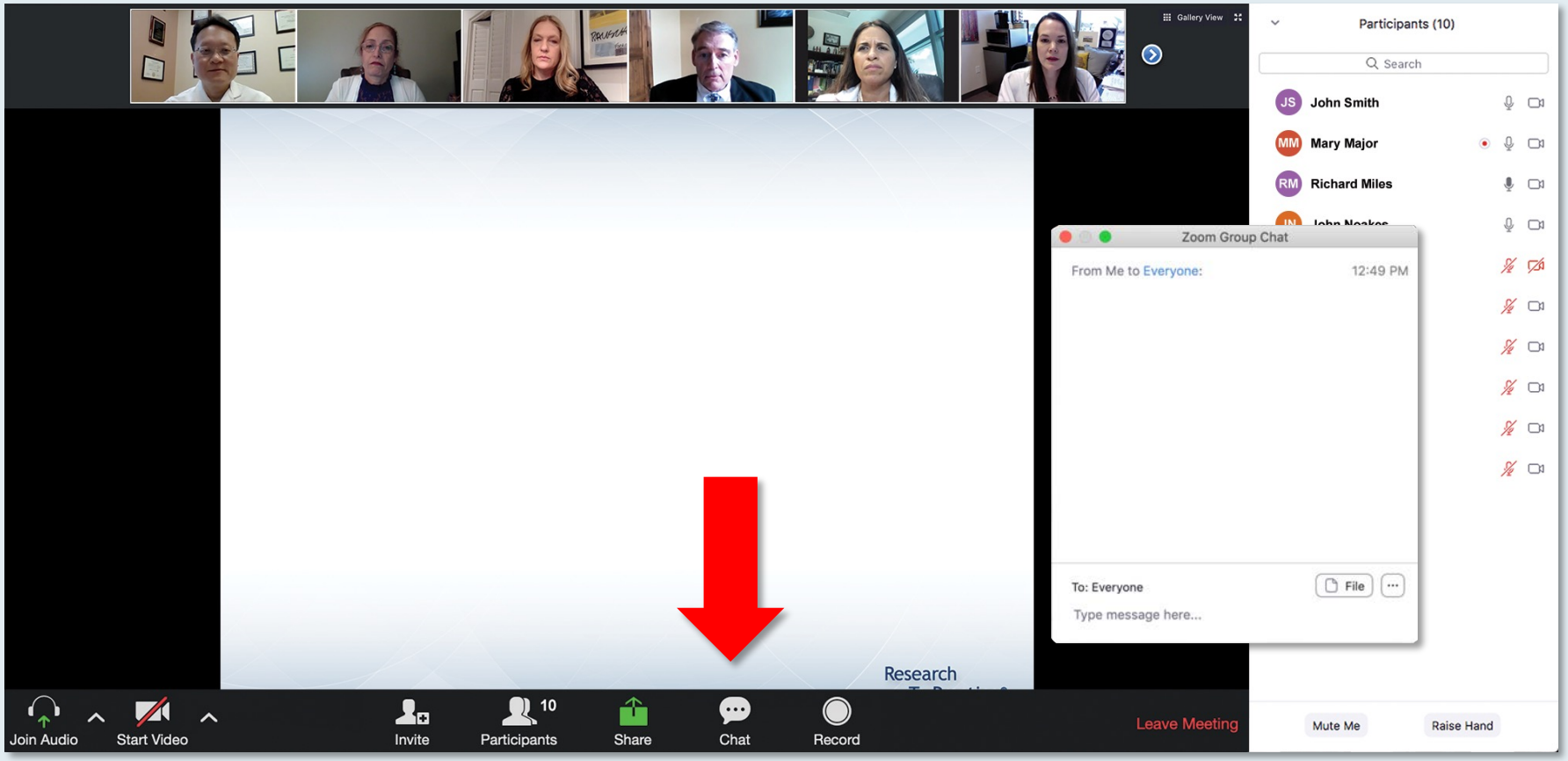
We Encourage Clinicians in Practice to Submit Questions



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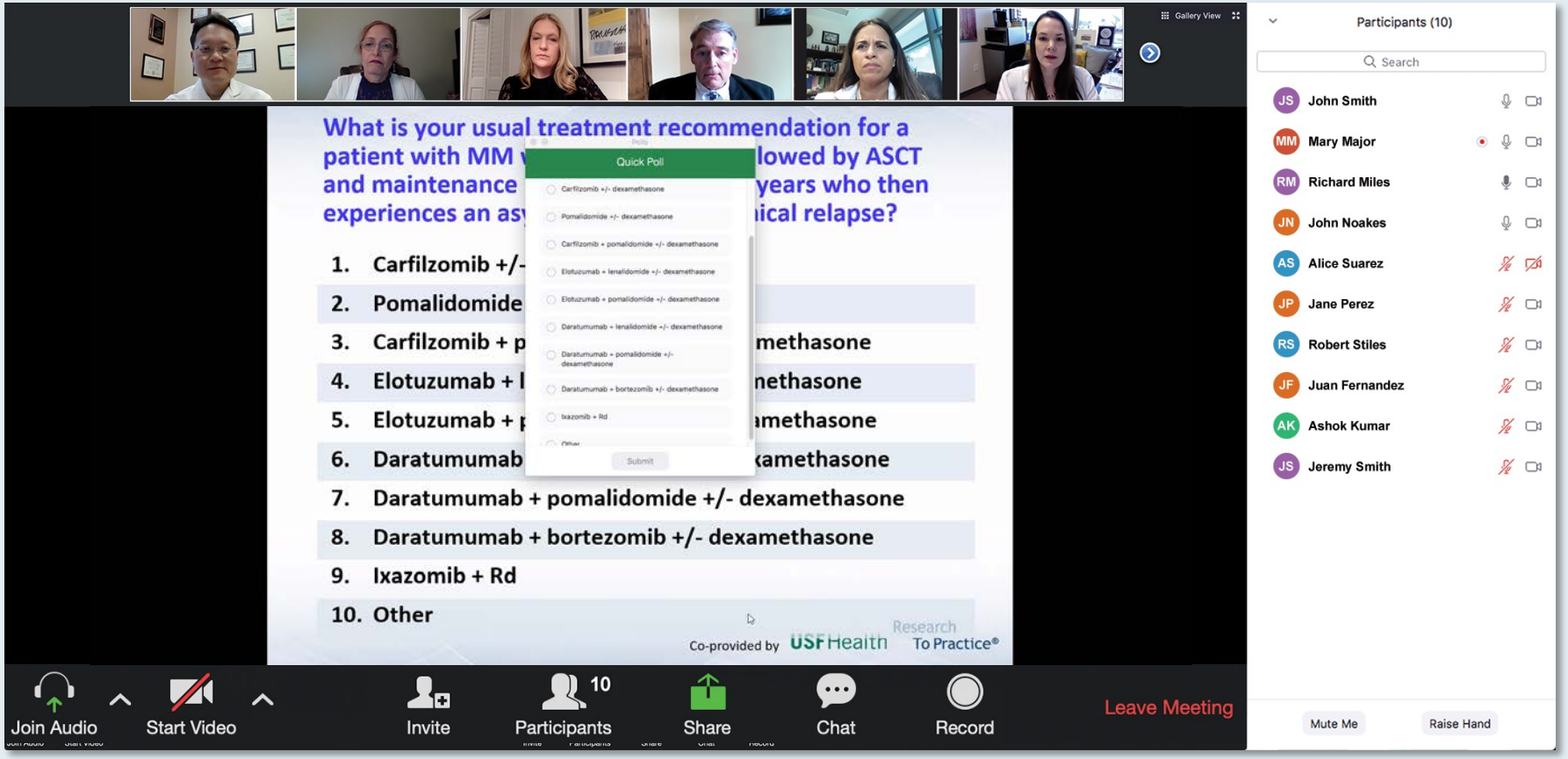

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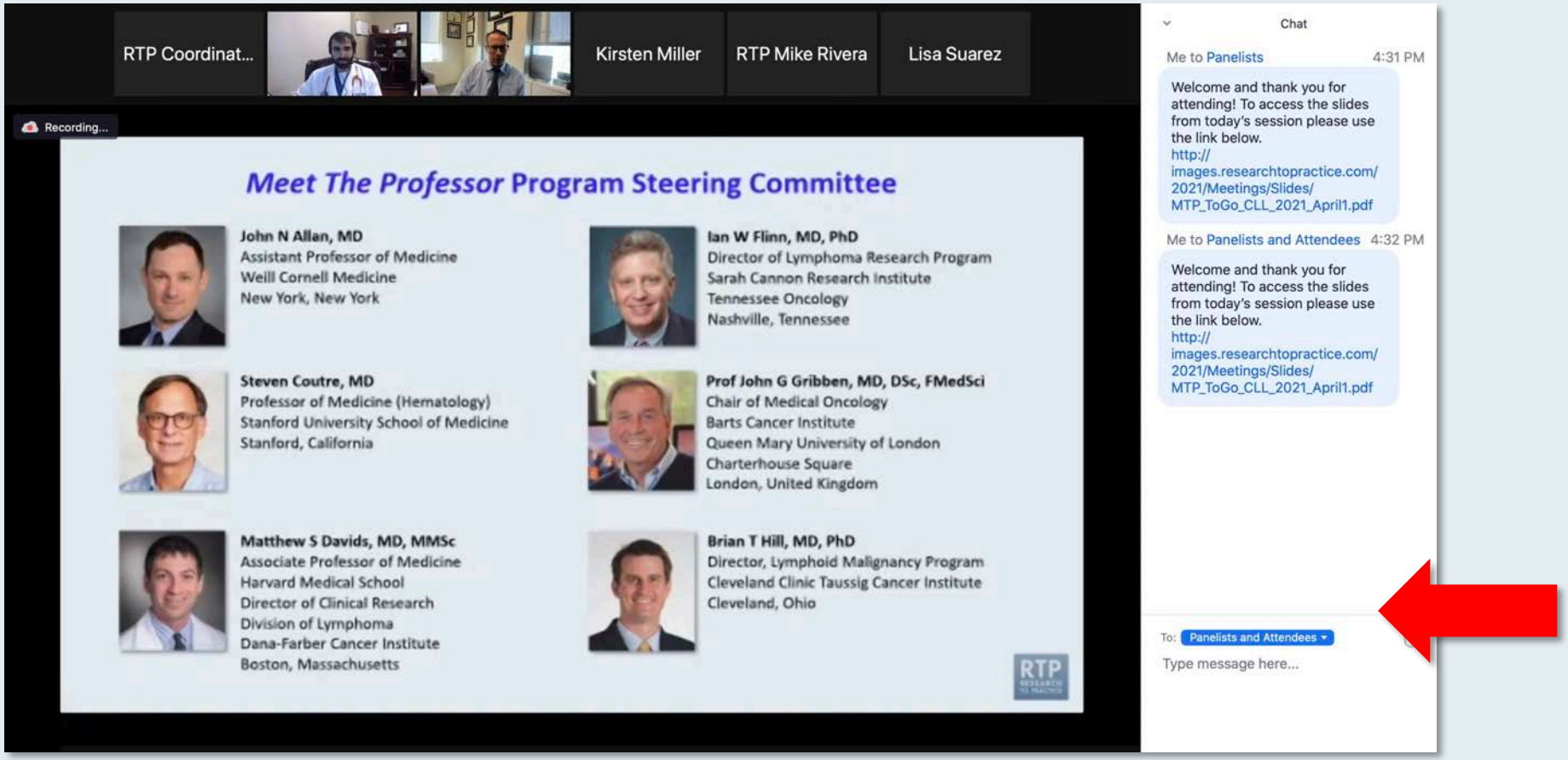

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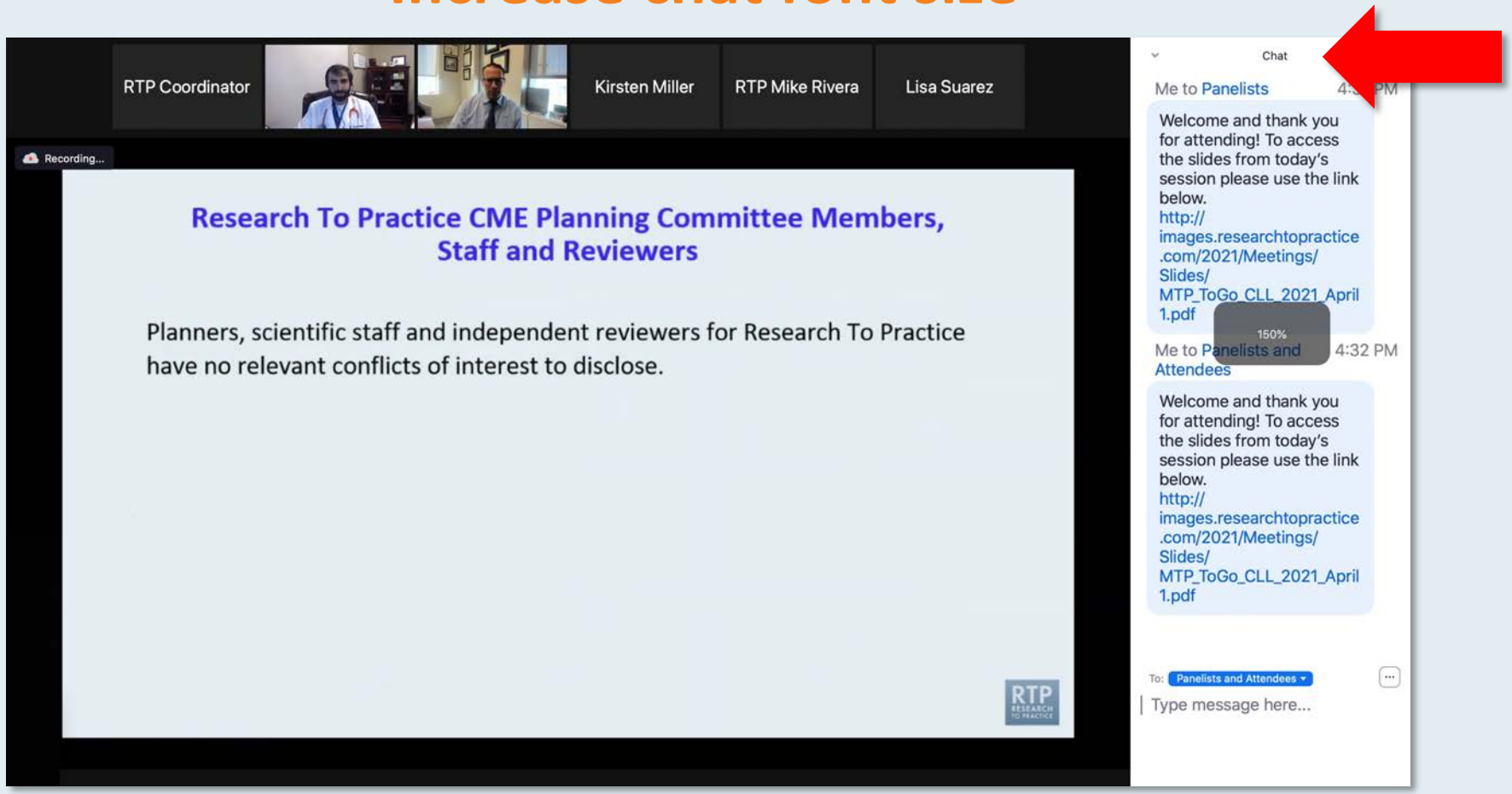

Press Command (for Mac) or Control (for PC) and the + symbol.
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Key Presentations on Gastrointestinal Cancers from the 2021 ASCO Annual Meeting

DR KRISTEN CIOMBOR

VANDERBILT-INGRAM CANCER CENTER

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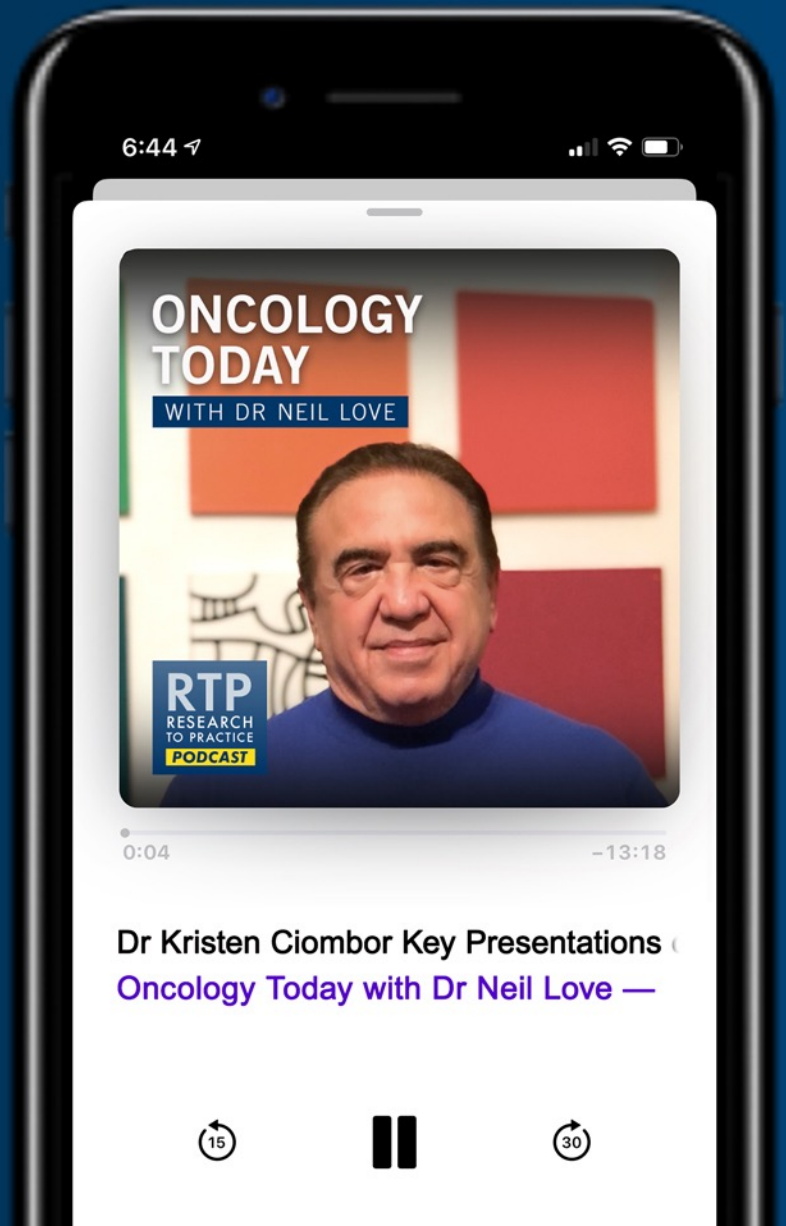

Expert Second Opinion: Investigators Discuss Available Clinical Research in the Care of Patients with Non-Small Cell Lung Cancer and Validated Targets Beyond EGFR

A Live Webinar Held as a Satellite CME/MOC Symposium During the IASLC 2021 World Conference on Lung Cancer Worldwide Virtual Event

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5:45 AM – 6:45 AM MDT / 7:45 AM – 8:45 AM ET

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Heather Wakelee, MD

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What Urologists Want To Know: Addressing Current Questions and Controversies in the Management of Bladder Cancer

A Virtual CME Satellite Symposium During the American Urological Association (AUA) 2021 Annual Meeting

Monday, September 13, 2021
11:00 AM – 12:30 PM ET / 8:00 AM – 9:30 AM PT

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Ashish M Kamat, MD, MBBS
Guru Sonpavde, MD
Robert Svatek, MD

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Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with Renal Cell Carcinoma

Tuesday, September 14, 2021
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Wednesday, September 22, 2021
5:00 PM – 6:00 PM ET

Faculty

Sara M Tolaney, MD, MPH

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Neil Love, MD

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Thank you for joining us!

CME credit information will be emailed to each participant within 3 business days.

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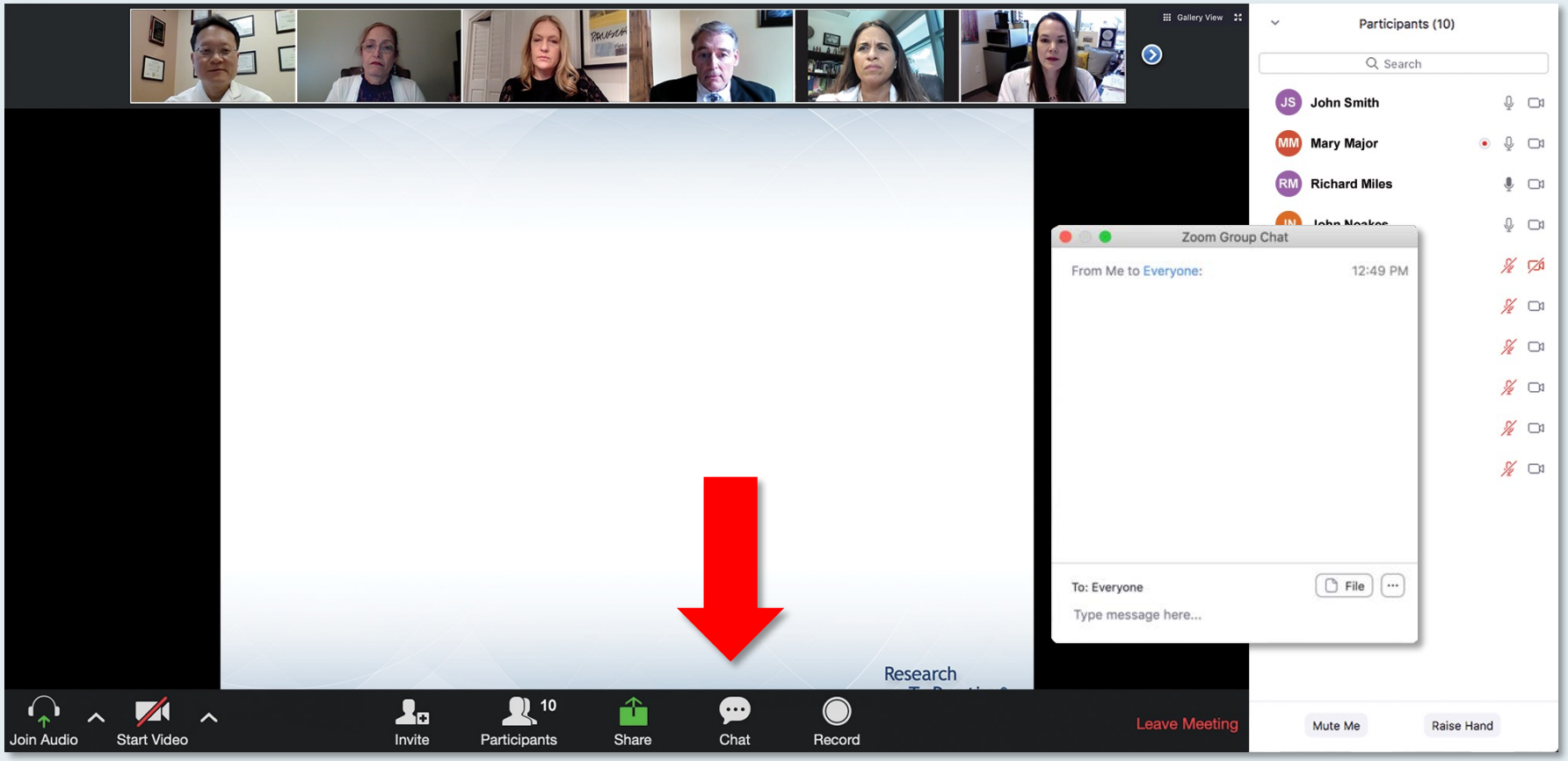

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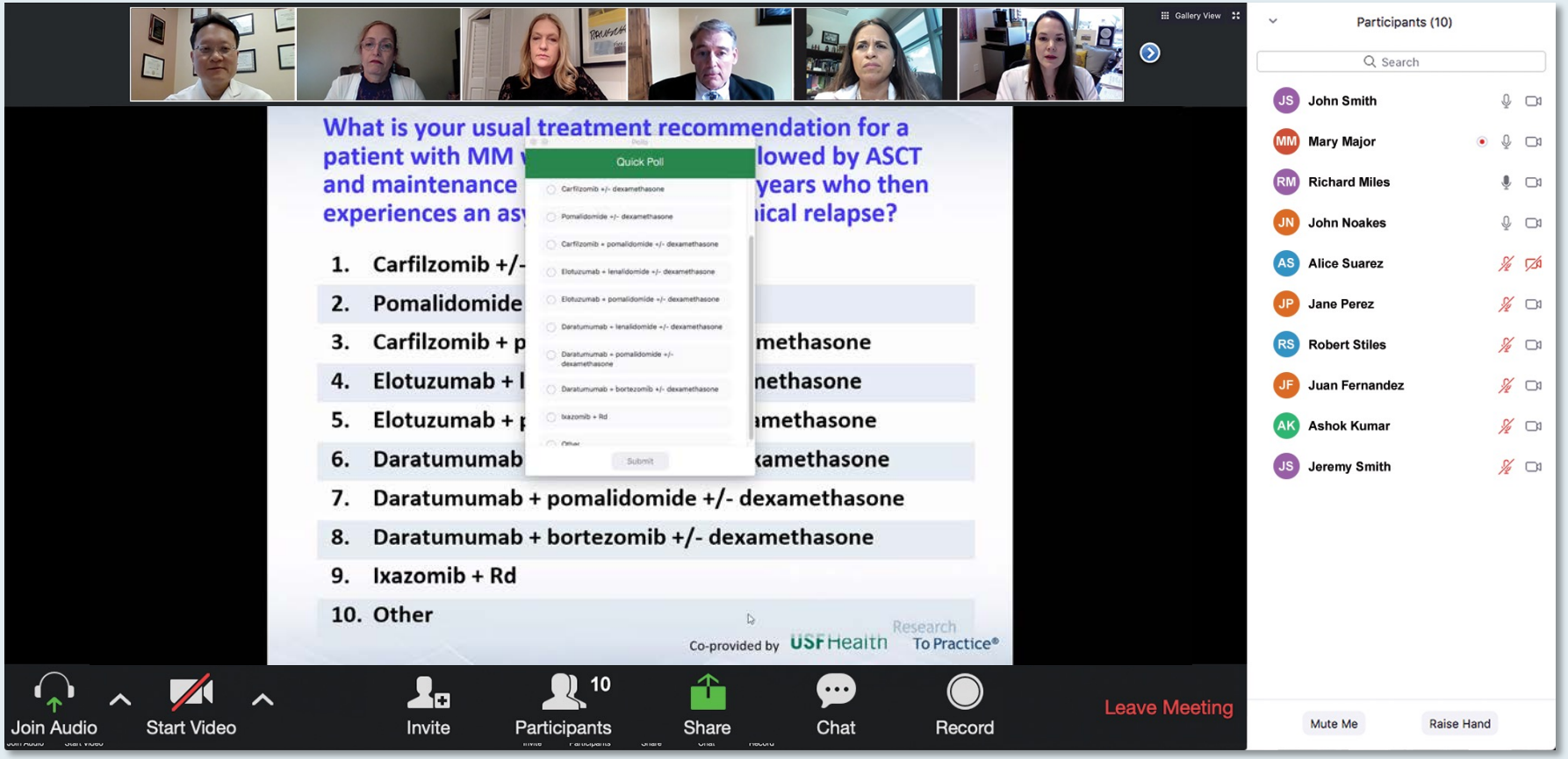

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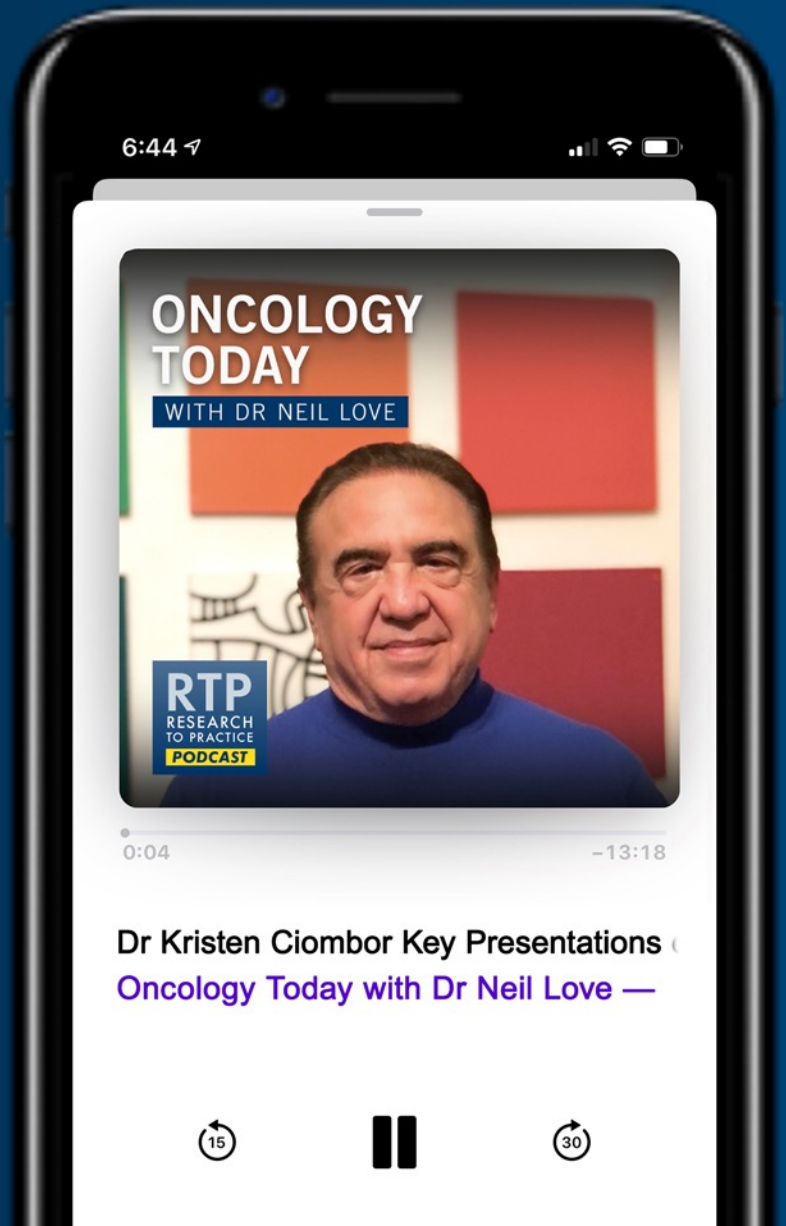

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Agenda

Introduction

Case 1: A 48-year-old woman with BRAF V600E-mutant metastatic colorectal cancer (mCRC) receives panitumumab/encorafenib after disease progression on FOLFOX/bevacizumab

Case 2: A 44-year-old nurse practitioner with BRAF V600E-mutant mCRC and lung metastases receives cetuximab/encorafenib

Case 3: A 45-year-old woman with BRAF-mutant mCRC experiences rapid disease progression on FOLFOX/bevacizumab and is switched to panitumumab/encorafenib

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Colorectal cancer in younger people

Dr Wells A Messersmith

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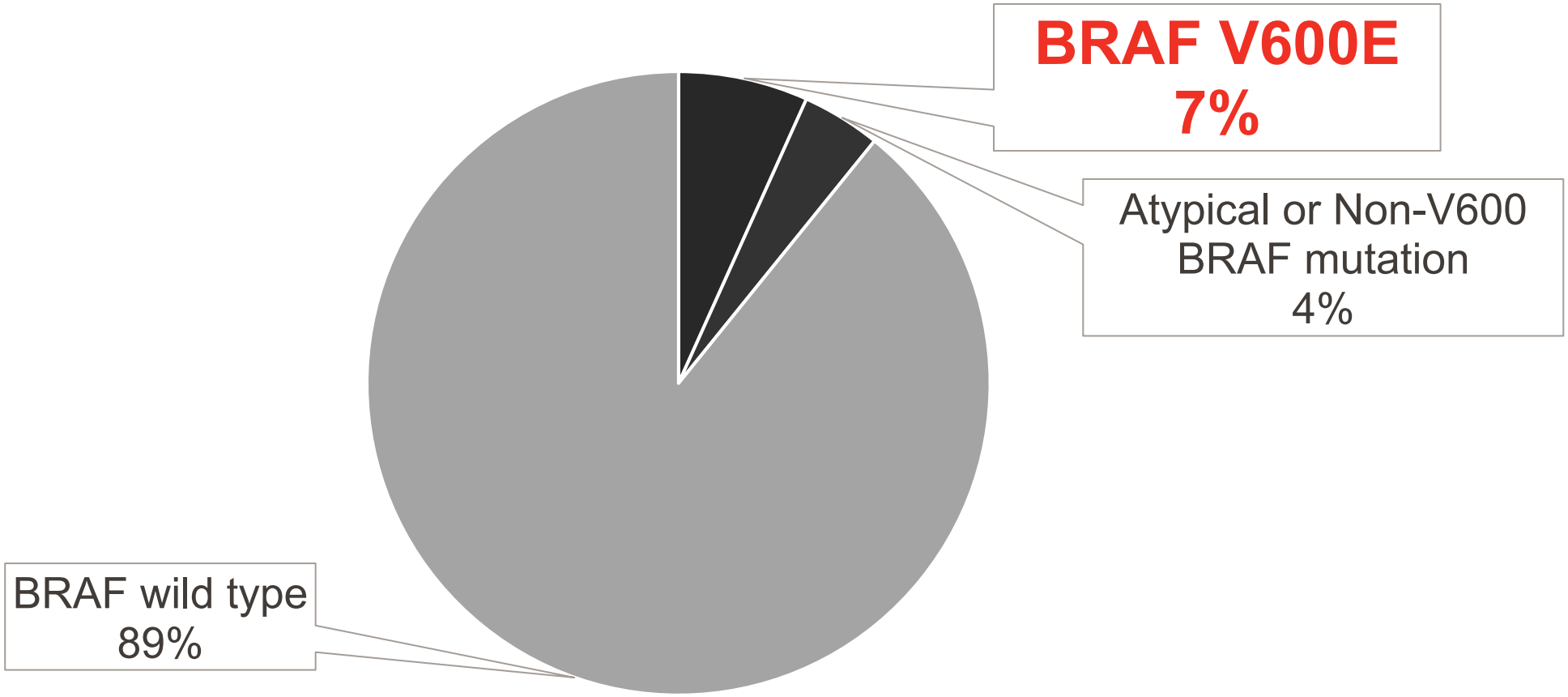
What is your usual first-line treatment recommendation for a 60-year-old patient with left-sided, MSS, pan-RAS wild-type, BRAF V600E-mutant metastatic colorectal cancer (mCRC)?

1. FOLFOX/CAPOX
2. FOLFOX/CAPOX + bevacizumab
3. FOLFOXIRI
4. FOLFOXIRI + bevacizumab
5. FOLFIRI
6. FOLFIRI + bevacizumab
7. Chemotherapy + EGFR antibody
8. Other

For a patient with BRAF V600E-mutant mCRC to whom you would administer BRAF-targeted therapy, what would be your preferred treatment?

1. Irinotecan + vemurafenib + EGFR antibody
2. Dabrafenib + trametinib + EGFR antibody
3. Encorafenib + binimetinib + EGFR antibody
4. Encorafenib + EGFR antibody
5. Other

“BRAF Mutations”: V600E and Atypical/Non-V600E mutations

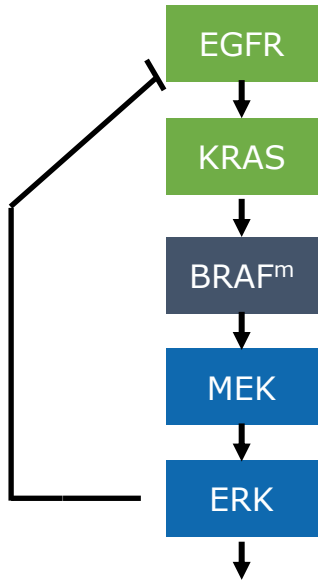


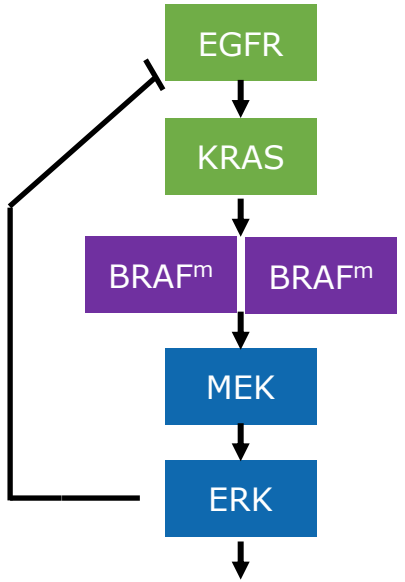
Cbioportal; referencing Cancer Cell ‘18

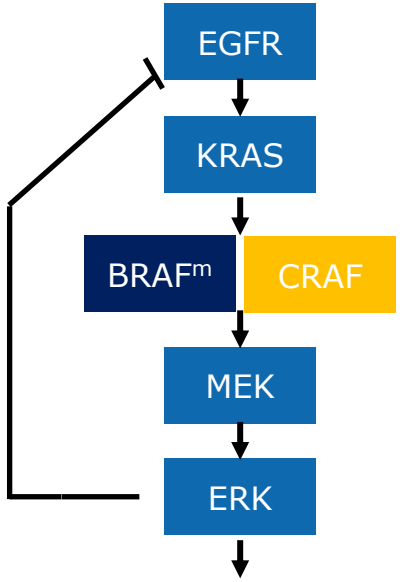
Courtesy of Scott Kopetz, MD, PhD

Understanding Class II and Class III Non-V600E *BRAF*^{mut}

	BRAF V600E Class I	Class II BRAF	Class III BRAF
Structure	BRAF monomer	BRAF dimers	BRAF/CRAF dimers
RTK (EGFR) Dependency	No	No	Yes
Kinase activity	High	High/Intermediate	Low
EGFRi sensitivity	No	Unlikely	Likely
Potential Strategy	BRAF, MEK, EGFR	RAF dimer inhibitors	RTK, MAPK combinations



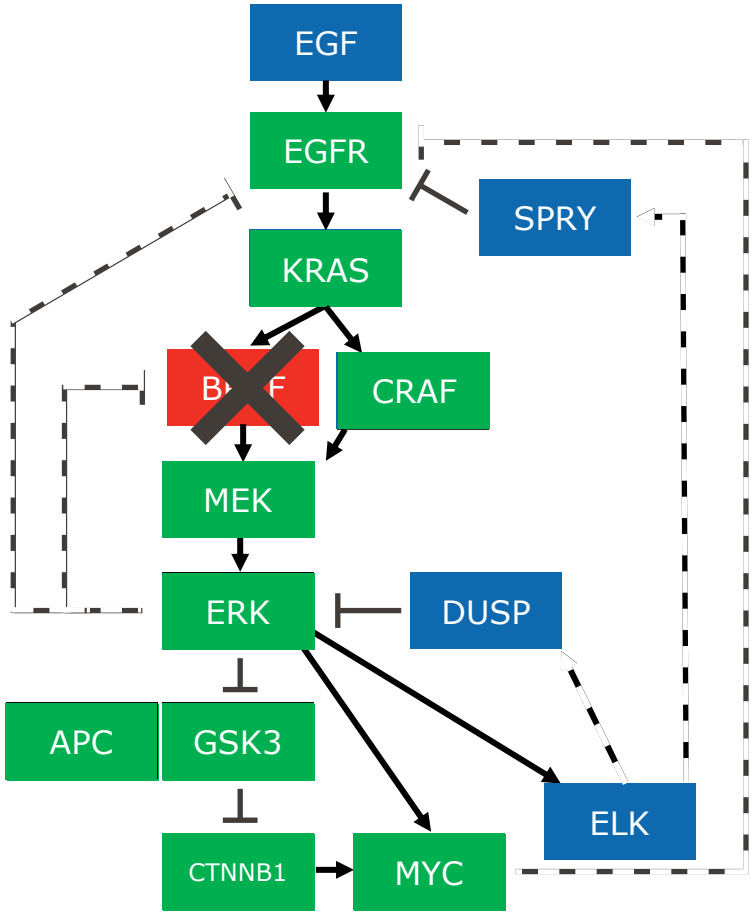




Yao et al Nature '17

Courtesy of Scott Kopetz, MD, PhD

Targeting BRAF: Adaptive Resistance



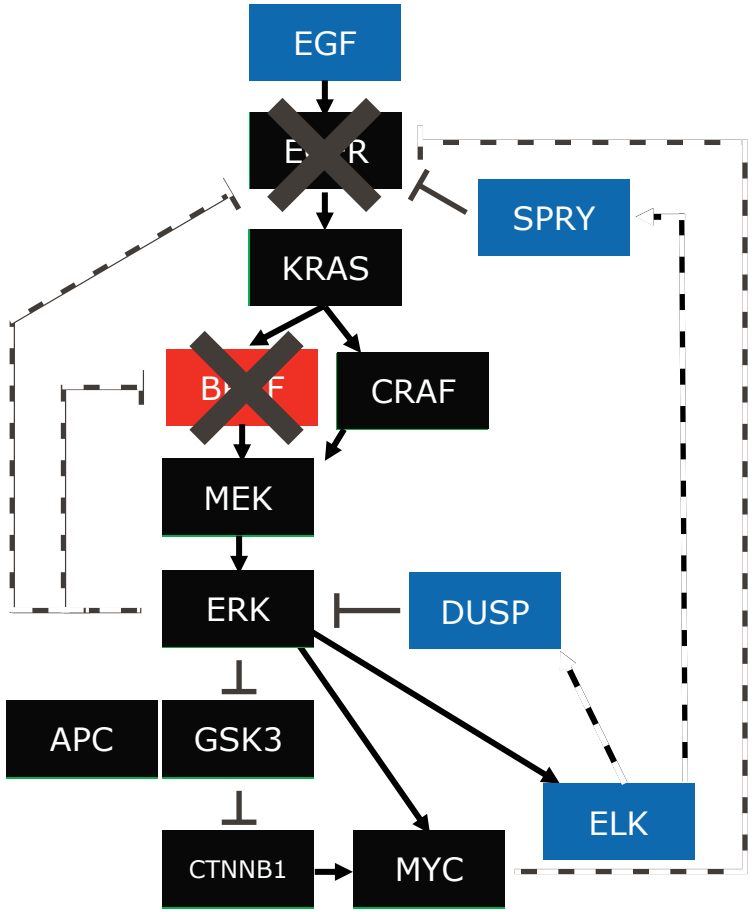
Homeostatic regulation is a critical and nearly universal feature of biological systems

Growth pathways like MAPK have a number of such feedback networks established

Inhibition of a single node in the pathway results in a rapid compensation in the signaling to restore homeostasis

Courtesy of Scott Kopetz, MD, PhD

Targeting BRAF: Adaptive Resistance



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Case Presentation: A 48-year-old woman with BRAF V600E-mutant mCRC receives panitumumab/encorafenib after disease progression on FOLFOX/bevacizumab

Dr Wells Messersmith

- Presents with loose stool, RUQ pain → CT: Multiple liver lesions → Biopsy: Adenocarcinoma
- Colonoscopy: Mass at proximal transverse colon
- CAPOX/bevacizumab (GI toxicity) switched to FOLFOX/bevacizumab, with excellent response
- Liver resection, with insufficient future liver remnant → Portal vein embolization, right hepatectomy
- Primary resection (ypTisN1b, with 3/19 lymph nodes involved)
- Molecular testing: MSS, BRAF V600E mutation, RAS wildtype, TMB-low, PIK3CA mutation

Question

- What do you do when you start a patient on FOLFOX/bevacizumab and then you discover the patient has a BRAF V600E mutation?

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Determination of sidedness for transverse colon lesions

Dr Wells A Messersmith

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Case Presentation: A 48-year-old woman with BRAF V600E-mutant mCRC receives panitumumab/encorafenib after disease progression on FOLFOX/bevacizumab (continued)

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Questions

- ***How do you feel about the level of aggressiveness in a patient like this? Is the biology of the disease so aggressive that we shouldn't be doing liver resection, or should we be aggressive if they have a good response?***

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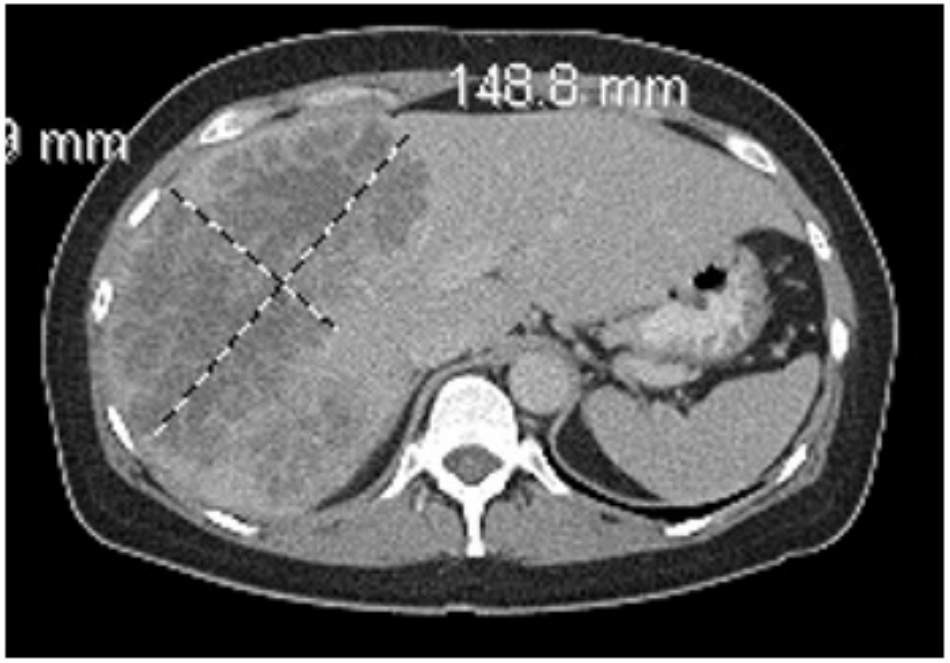
Case Presentation: A 48-year-old woman with BRAF V600E-mutant mCRC receives panitumumab/encorafenib after disease progression on FOLFOX/bevacizumab (continued)

Dr Wells Messersmith

Liver lesions at baseline



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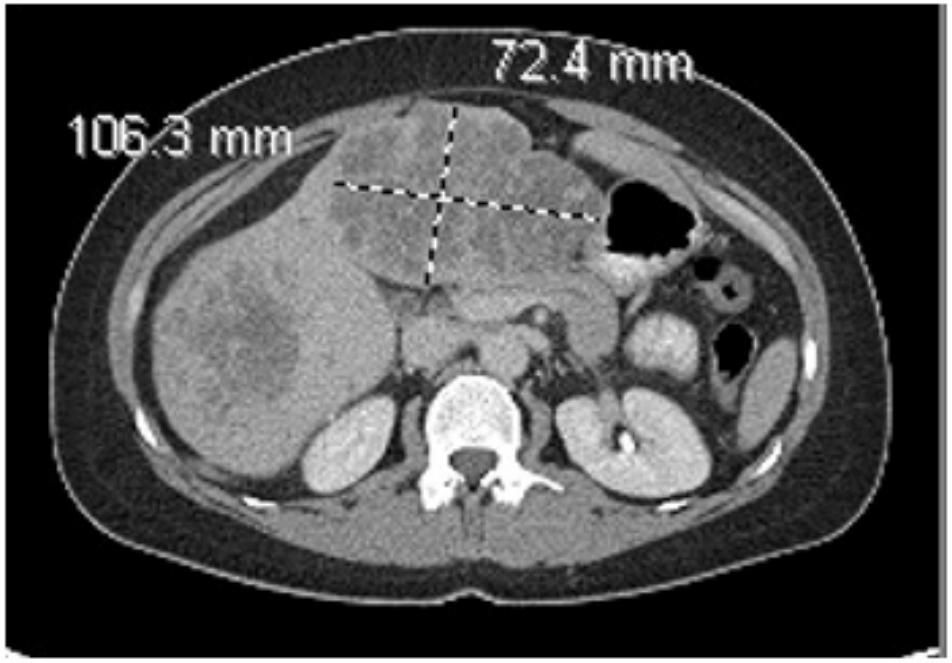

baseline

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- ***After 6 months patient feeling well but CEA beginning to rise***

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- ***PET/CT: Recurrence***
- ***Panitumumab/encorafenib, with moderate rash and minor response***

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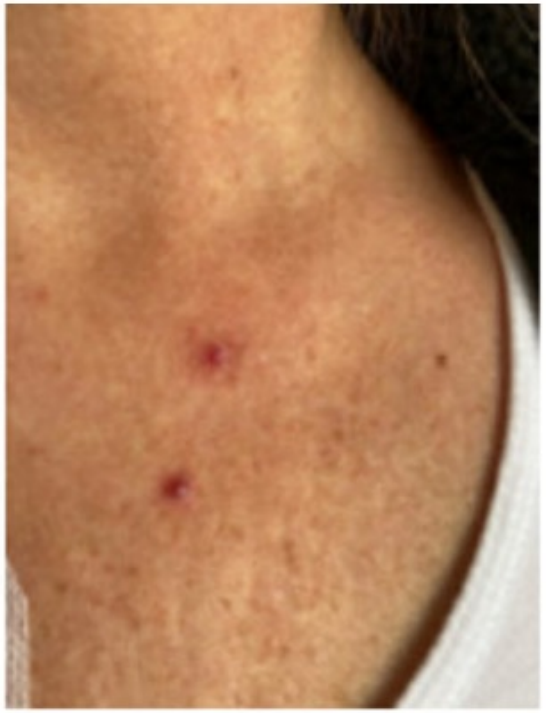
Case Presentation: A 48-year-old woman with BRAF V600E-mutant mCRC receives panitumumab/encorafenib after disease progression on FOLFOX/bevacizumab (continued)

Dr Wells Messersmith

Skin toxicity on encorafenib/panitumumab therapy



Pustules on neck

RTP RESEARCH TO PRACTICE

Agenda

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Case 1: A 48-year-old woman with BRAF V600E-mutant metastatic colorectal cancer (mCRC) receives panitumumab/encorafenib after disease progression on FOLFOX/bevacizumab

Case 2: A 44-year-old nurse practitioner with BRAF V600E-mutant mCRC and lung metastases receives cetuximab/encorafenib

Case 3: A 45-year-old woman with BRAF-mutant mCRC experiences rapid disease progression on FOLFOX/bevacizumab and is switched to panitumumab/encorafenib

Case Presentation: A 44-year-old nurse practitioner with BRAF V600E-mutant mCRC and lung metastases receives cetuximab/encorafenib

Dr Wells Messersmith

- Presents with abdominal pain
- CT: Thickening in mid-sigmoid colon and LLL pulmonary nodule (PET-positive)
- Colonoscopy: Sessile serrated adenoma/polyp “with at least high-grade dysplasia”
- Simultaneous colon and lung surgery (pT3 pN2a pM1a colon adenocarcinoma, 0.4-cm lung metastasis)
- MSS
- Adjuvant FOLFOX x 6 months

Case Presentation: A 44-year-old nurse practitioner with BRAF V600E-mutant mCRC and lung metastases receives cetuximab/encorafenib (continued)

Dr Wells Messersmith

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- Adjuvant FOLFOX x 6 months
- ***Molecular testing completed but report not read or placed in clinical notes***
- ***Undergoes second lung resection → Referred for 2nd opinion***
- ***Molecular testing report located: BRAF V600E mutation***

RTP RESEARCH TO PRACTICE

Case Presentation: A 44-year-old nurse practitioner with BRAF V600E-mutant mCRC and lung metastases receives cetuximab/encorafenib (continued)

Dr Wells Messersmith

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- MSS
- Adjuvant FOLFOX x 6 months
- Molecular testing completed but report not read or placed in clinical notes
- Undergoes second lung resection → Referred for 2nd opinion
- Molecular testing report located: BRAF V600E mutation
- ***Cetuximab/encorafenib, with a nice response, some acneiform rash***

Question

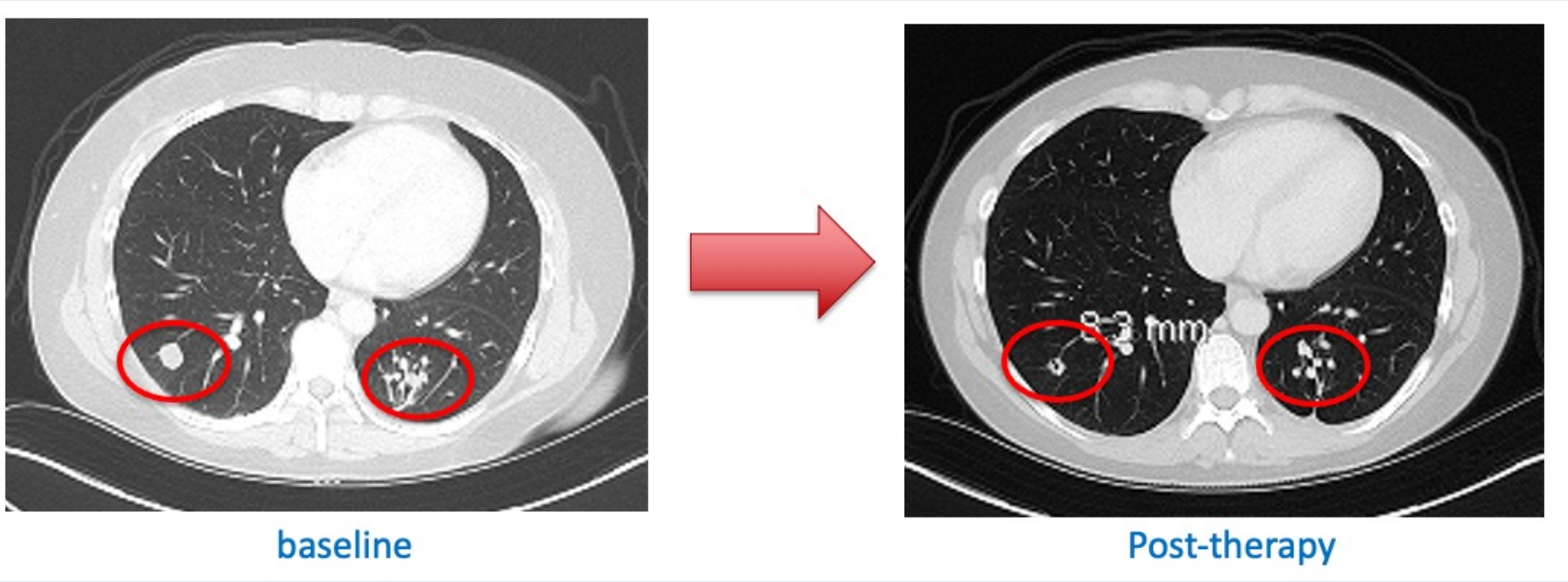
- ***Should we go after the lung lesions in this patient?***

RTP RESEARCH TO PRACTICE

Case Presentation: A 44-year-old nurse practitioner with BRAF V600E-mutant mCRC and lung metastases receives cetuximab/encorafenib (continued)

Dr Wells Messersmith

CT scan after cetuximab/encorafenib therapy



BEACON CRC Study Design

Results of Safety Lead-In led to the introduction of an additional primary endpoint of ORR and an interim OS analysis to allow for early assessment

Patients with *BRAF*^{V600E} mCRC with disease progression after 1 or 2 prior regimens; ECOG PS of 0 or 1; and no prior treatment with any RAF inhibitor, MEK inhibitor, or EGFR inhibitor

Safety Lead-in

ENCO + BINI + CETUX
N = 30

Encorafenib 300 mg PO daily
Binimetinib 45 mg PO bid
Cetuximab standard weekly dosing

A separate Safety Lead-in cohort of n=7 in Japan was enrolled subsequently. Results will be reported at a later time.

Phase 3

R 1:1:1

- **Triplet therapy**
  ENCO + BINI + CETUX
  n = 205
- **Doublet therapy**
  ENCO + CETUX
  n = 205
- **Control arm**
  FOLFIRI + CETUX, or irinotecan + CETUX
  n = 205

Overall Survival

Primary Endpoints:

Triplet vs Control

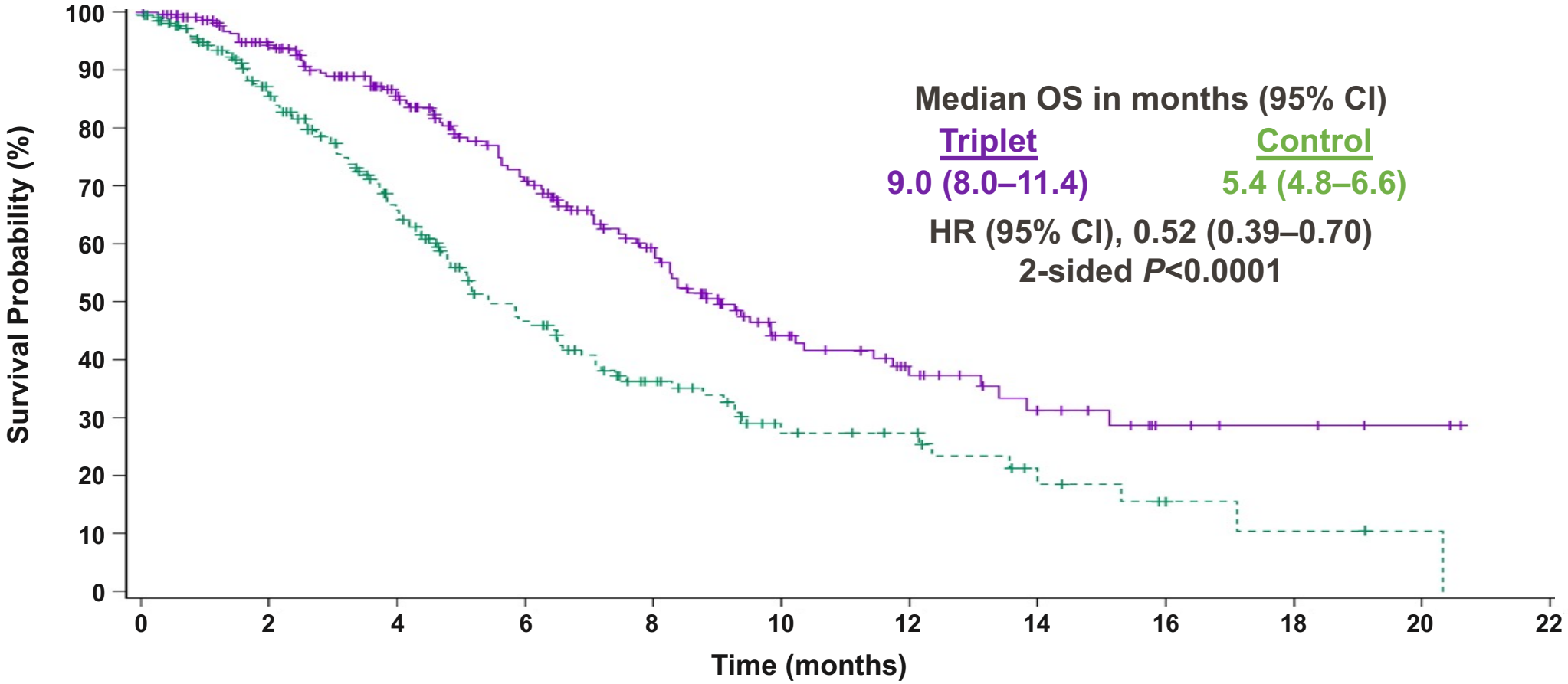
- **OS**
- **ORR**
  (Blinded Central Review)

Secondary Endpoints: Doublet vs Control OS & ORR, PFS, Safety

Randomization was stratified by ECOG PS (0 vs. 1), prior use of irinotecan (yes vs. no), and cetuximab source (US-licensed vs. EU-approved).

Courtesy of Scott Kopetz, MD, PhD

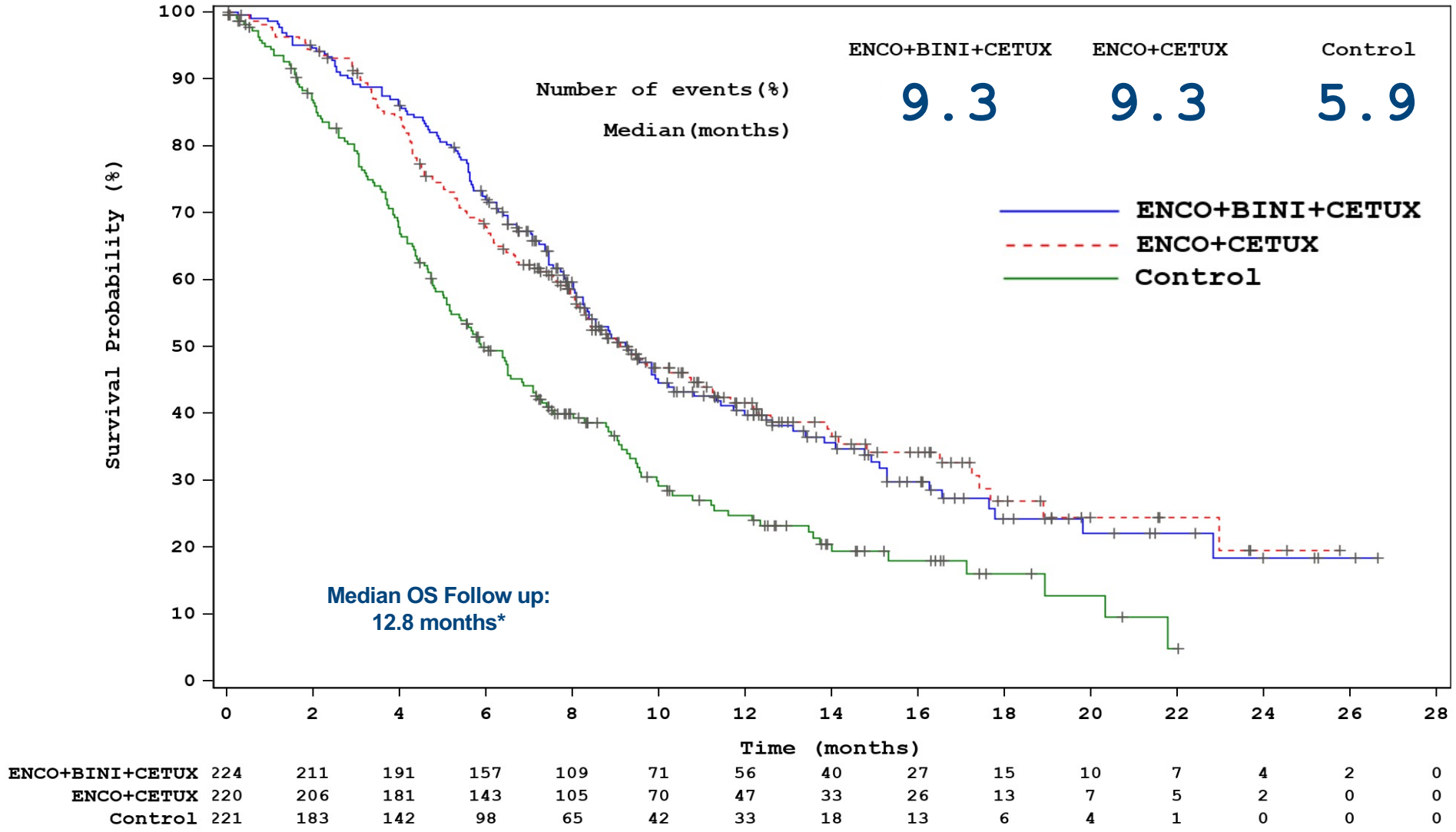
BEACON CRC: Primary Endpoint - Overall Survival: Triplet vs Control



Courtesy of Scott Kopetz, MD, PhD

Kopetz et al NEJM '19

BEACON CRC: However, OS is not improved with addition of MEKi



Courtesy of Scott Kopetz, MD, PhD

Kopetz et al NEJM '19

BEACON CRC: Objective Response Rate (first 331 randomized patients)

Confirmed Response by BICR	Triplet N=111	Doublet N=113	Control N=107
Objective Response Rate	**26%**	**20%**	**2%**
95% (CI)	(18, 35)	(13, 29)	(<1, 7)
p-value vs. Control	<0.0001	<0.0001	
Objective Response Rate			
1 prior line of therapy	**34%**	**22%**	**2%**
>1 prior line of therapy	14%	16%	2%
Best Overall Response			
Complete Response	4%	5%	0
Partial Response	23%	15%	2%
Stable Disease	42%	54%	29%
Progressive Disease	10%	7%	34%
Non Evaluable by RECIST	22%	19%	36%
Clinical progression or adverse event[a]	14%	17%	16%
Insufficient information to assess response[b]	8%	2%	20%

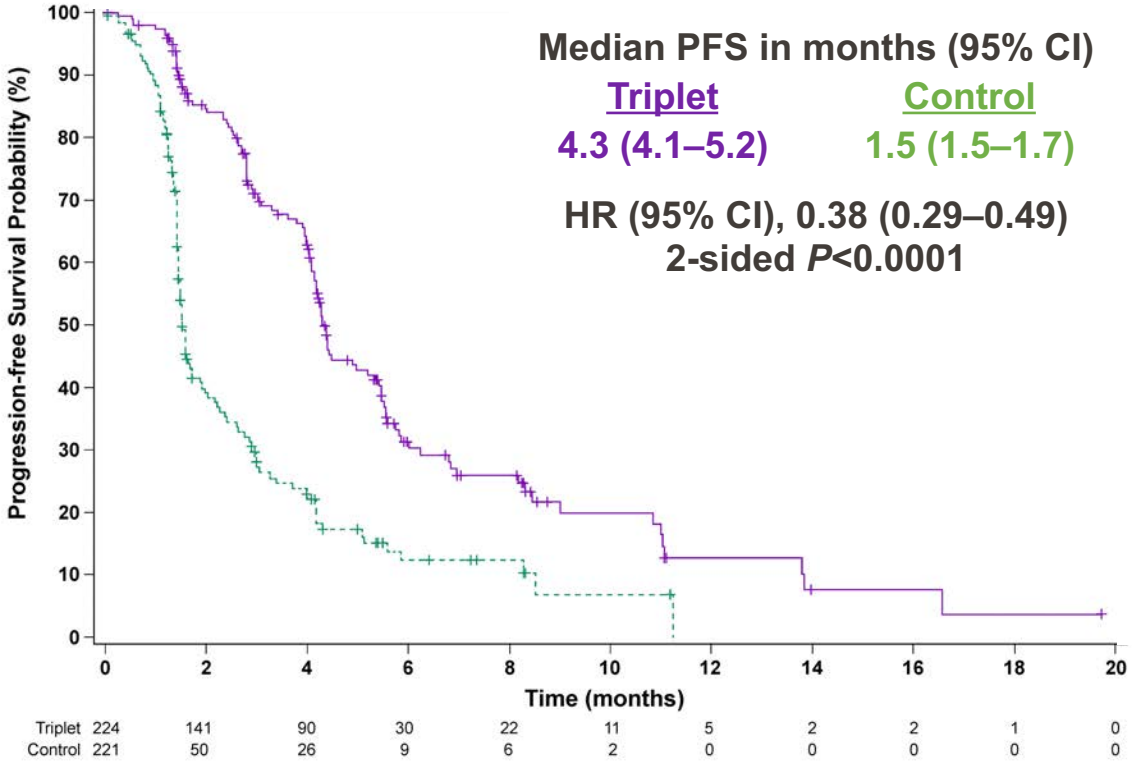
BICR=blinded independent central review.
a. Includes patients considered not evaluable by central assessment with clinical progression or radiological progression by local assessment or discontinuation due to adverse event.
b. Includes patients who were untreated, withdrew consent, had stable disease < 42 days, had no baseline scans, or had no post-baseline scans without evidence of clinical progression or adverse event as the reason for missing scans.

Courtesy of Scott Kopetz, MD, PhD

Kopetz et al NEJM '19

BEACON CRC: Progression-Free Survival

Triplet vs Control

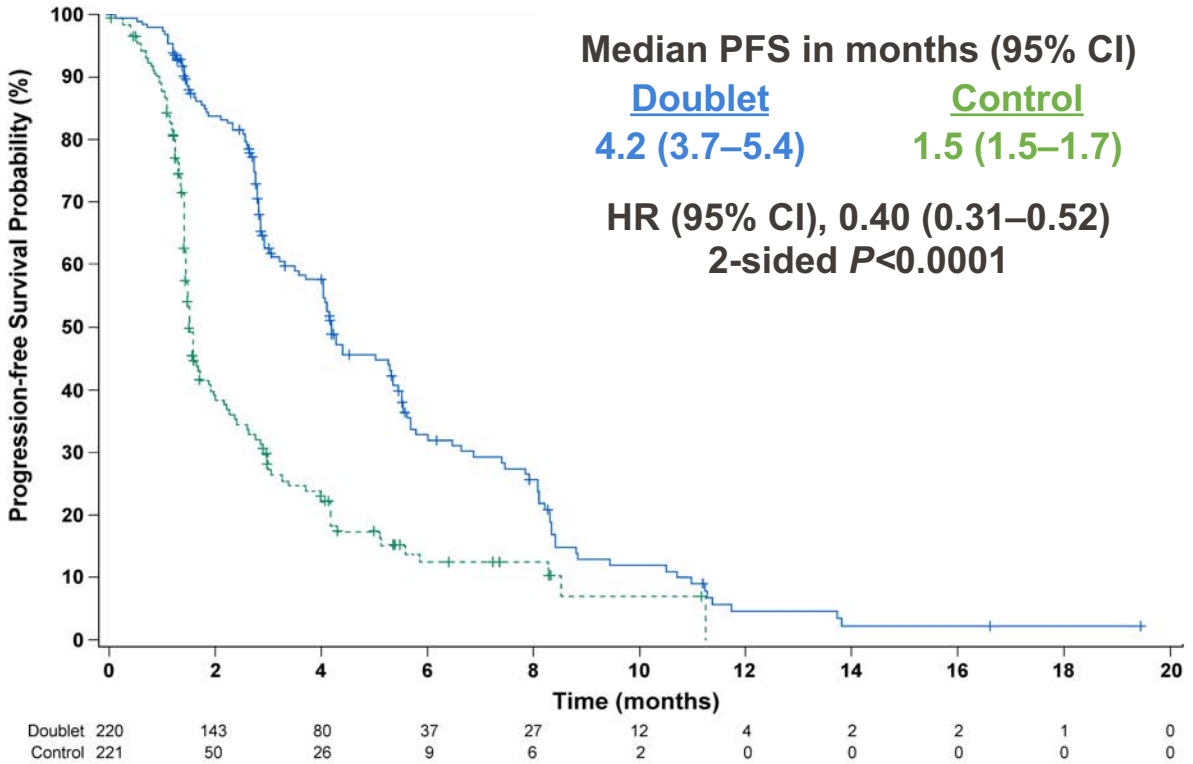


Median PFS in months (95% CI)

Triplet	Control
4.3 (4.1–5.2)	1.5 (1.5–1.7)

HR (95% CI), 0.38 (0.29–0.49)
2-sided *P*<0.0001

Doublet vs Control



Median PFS in months (95% CI)

Doublet	Control
4.2 (3.7–5.4)	1.5 (1.5–1.7)

HR (95% CI), 0.40 (0.31–0.52)
2-sided *P*<0.0001

*PFS by BICR (blinded independent central review).

Courtesy of Scott Kopetz, MD, PhD

Kopetz et al NEJM ‘19

FDA Approves New Dosing Regimen for Cetuximab

Press Release – April 6, 2021

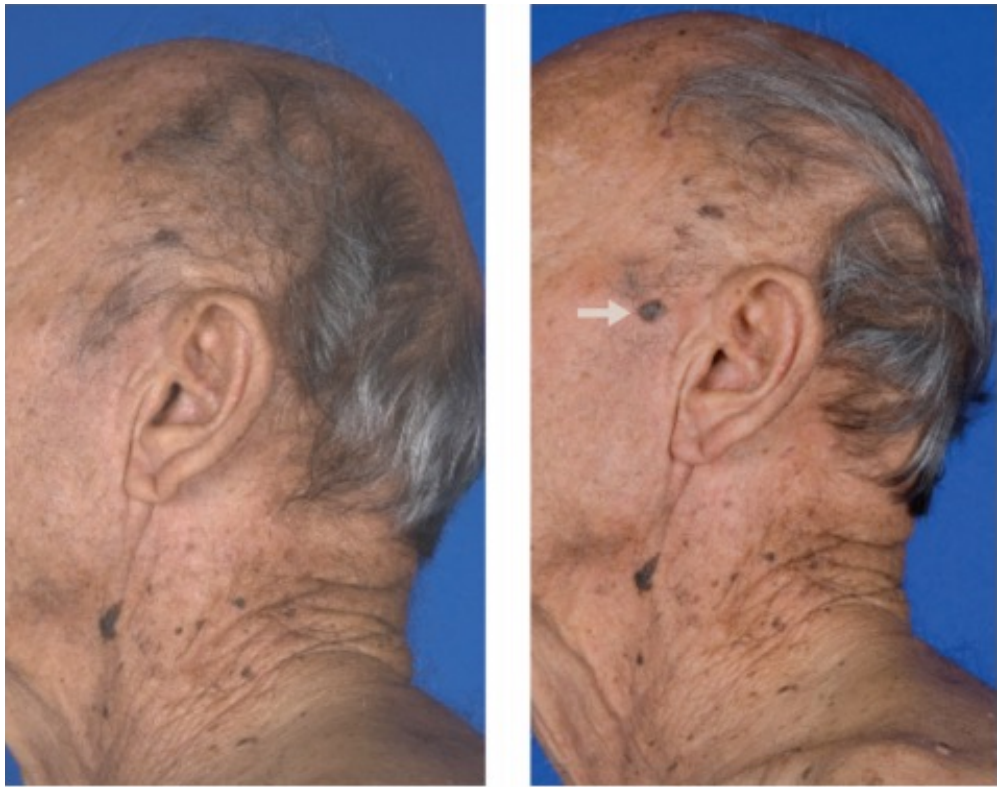
"On April 6, 2021, the Food and Drug Administration approved a new dosage regimen of 500 mg/m^2 as a 120-minute intravenous infusion every two weeks (Q2W) for cetuximab for patients with K-Ras wild-type, EGFR-expressing colorectal cancer (mCRC) or squamous cell carcinoma of the head and neck (SCCHN).

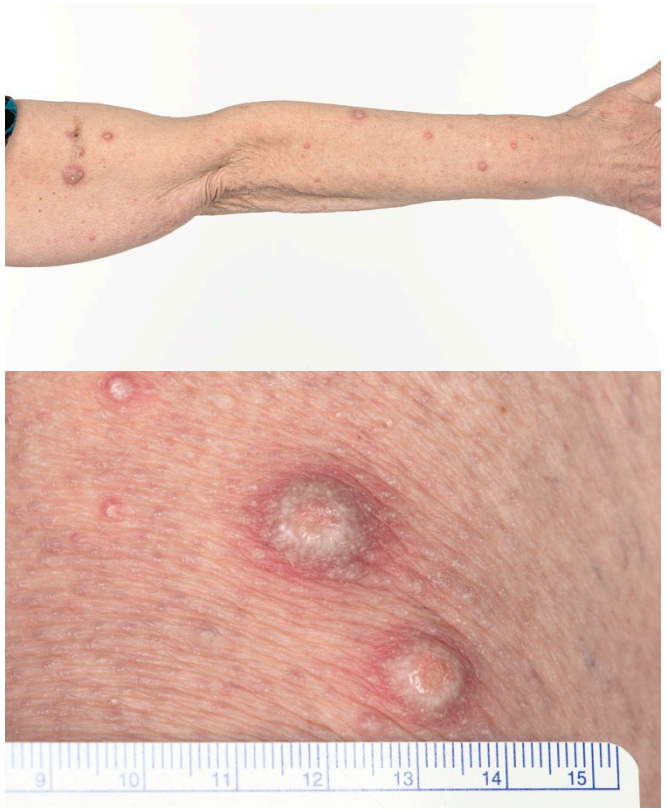
The approval was based on population pharmacokinetic (PK) modeling analyses that compared the predicted exposures of cetuximab 500 mg Q2W to observed cetuximab exposures in patients who received cetuximab 250 mg weekly. The application was also supported by pooled analyses of overall response rates, progression-free survival, and overall survival (OS) from published literature in patients with CRC and SCCHN, and OS analyses using real-world data in patients with mCRC who received either the weekly cetuximab or Q2W regimens. In these exploratory analyses, the observed efficacy results were consistent across dosage regimens and supported the results of the population PK modeling analyses.

The most common adverse reactions (incidence ≥25%) to cetuximab are cutaneous adverse reactions (including rash, pruritus, and nail changes), headache, diarrhea, and infection."

https://www.fda.gov/drugs/drug-approvals-and-databases/fda-approves-new-dosing-regimen-cetuximab

Keratoacanthomas





Courtesy of Scott Kopetz, MD, PhD

Kopetz et al JCO ‘15

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Case Presentation: A 45-year-old woman with BRAF-mutant mCRC experiences rapid disease progression on FOLFOX/bevacizumab and is switched to panitumumab/encorafenib

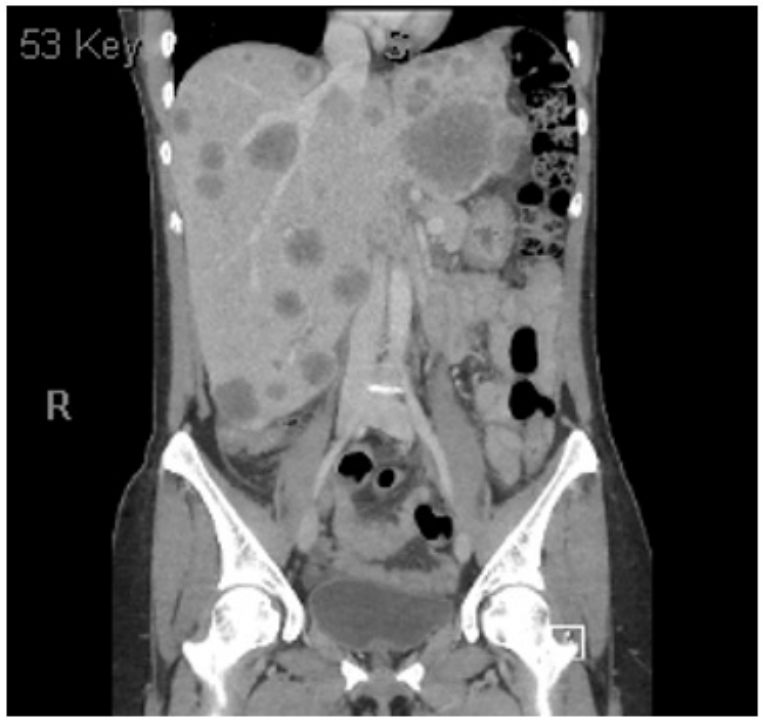
Dr Wells Messersmith

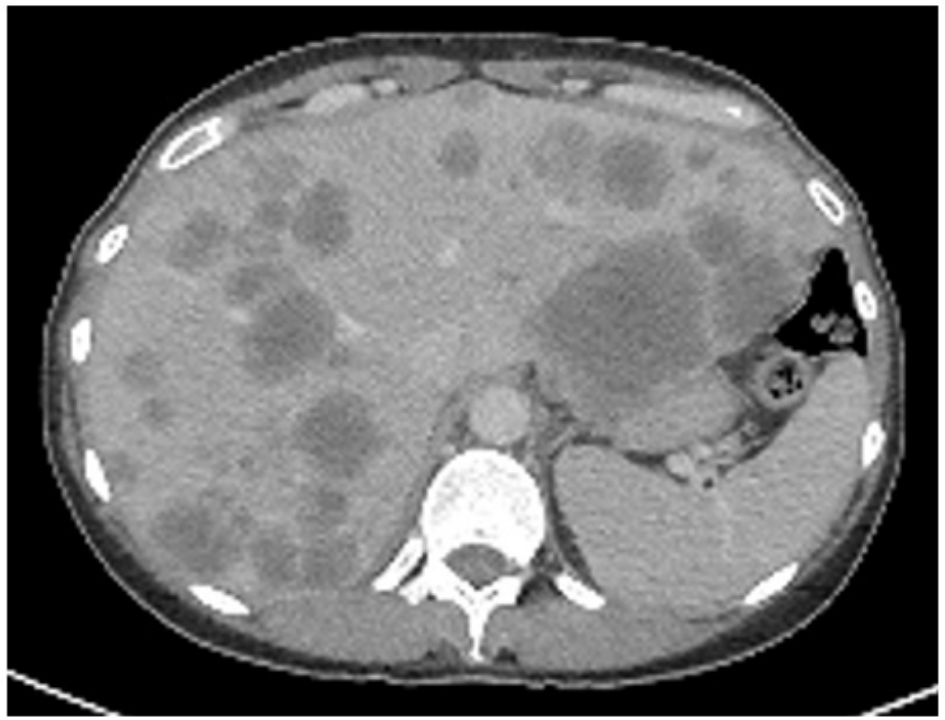
- Presented with abdominal pain, nausea and vomiting
- Imaging shows multiple diffuse hepatic masses measuring up to 6.2 cm
- Diagnosed with metastatic poorly differentiated carcinoma, compatible with colorectal primary; MMR proficient
- FOLFOX/bevacizumab → rapid progression and new nodules detected in the lung
- Encorafenib/panitumumab with initial good clinical response and radiographic response
- Rapid clinical progression 1 month later and she was admitted to local hospice with liver failure

Case Presentation: A 45-year-old woman with BRAF-mutant mCRC experiences rapid disease progression on FOLFOX/bevacizumab and is switched to panitumumab/encorafenib (continued)

Dr Wells Messersmith

Baseline scans

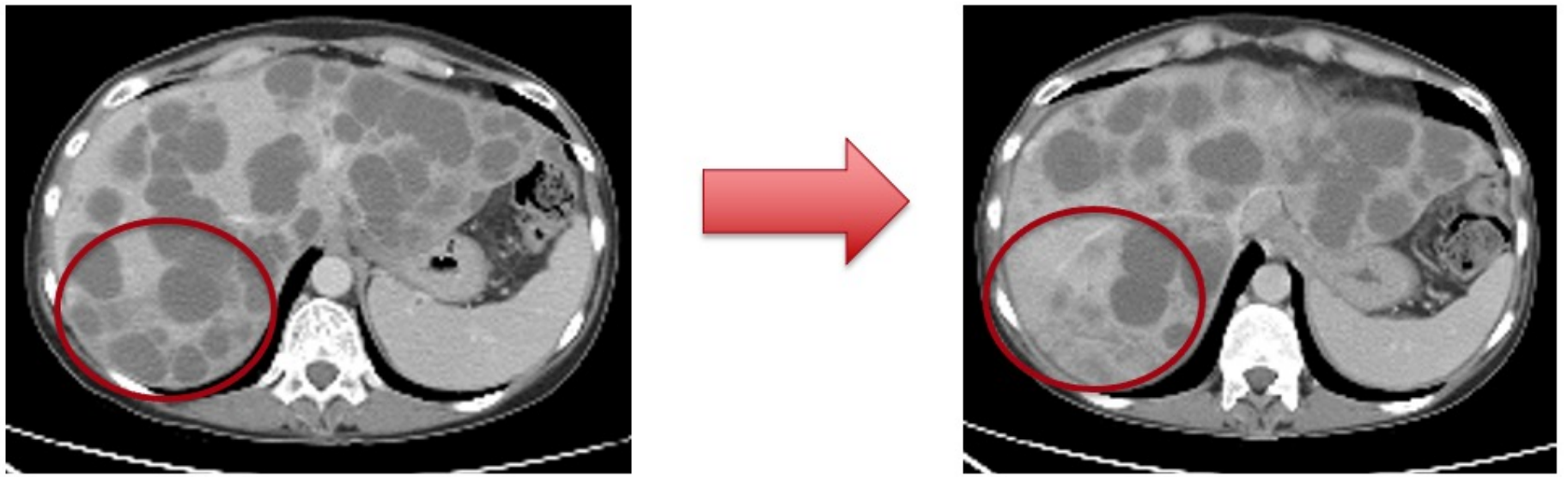




Case Presentation: A 45-year-old woman with BRAF-mutant mCRC experiences rapid disease progression on FOLFOX/bevacizumab and is switched to panitumumab/encorafenib (continued)

Dr Wells Messersmith

Before and after encorafenib/panitumumab therapy



baseline

Post-therapy

Targeting of BRAF resistance mutations or resistance pathways

Dr Wells A Messersmith

RTP RESEARCH TO PRACTICE

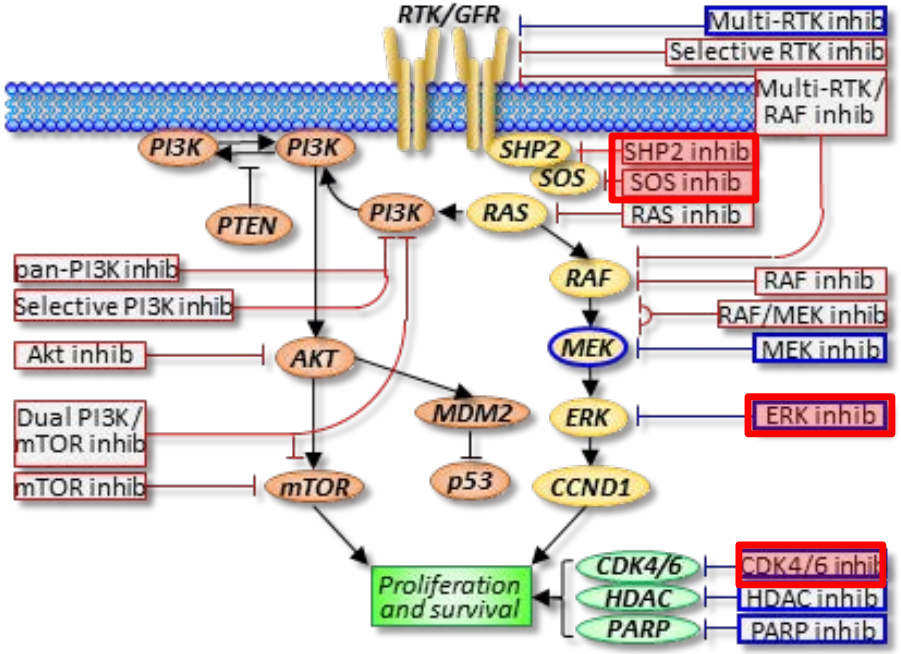
Future role of immunotherapy in the management of BRAF-mutant mCRC

Dr Wells A Messersmith

RTP
RESEARCH
TO PRACTICE

Potential Implications of BEACON CRC Study: Next Steps for BRAF

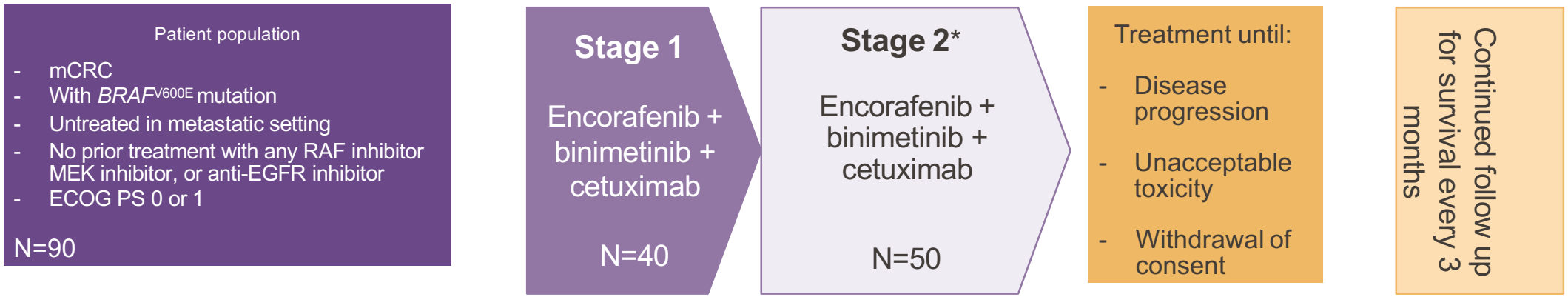
- MEK inhibition improves depth of response, but **not** duration of benefit/OS, at least with BEACON regimen
- Early administration may result in better outcomes
- Further understanding of signaling at progression are needed, including clinical approaches to modulate resistance



Courtesy of Scott Kopetz, MD, PhD

ANCHOR Study in First Line

The ANCHOR CRC trial in 1st-line treatment of *BRAF*^{V600E} metastatic colorectal cancer (mCRC)



*Stage 2 may be initiated as soon as the 40 patients from Stage 1 are treated and a confirmed response is observed in at least 12 patients.

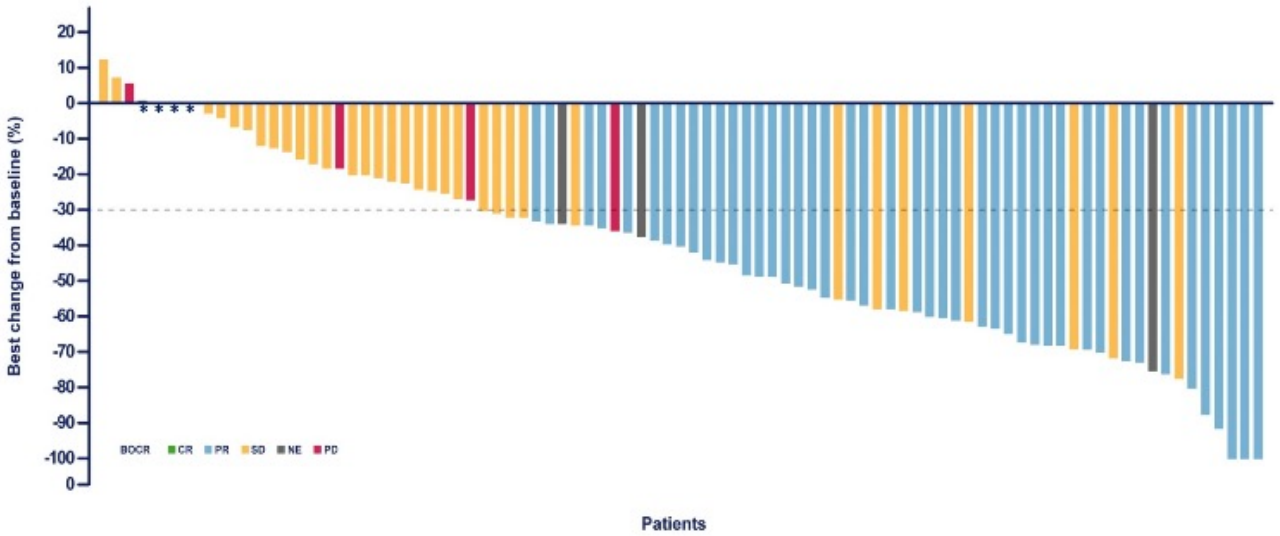
- **Primary Objective**
  - Confirmed ORR of encorafenib + binimetinib + cetuximab by local assessment
- **Main Secondary Objectives**
  - Efficacy: cORR by central radiologist assessment, time to response (TTR), duration of response (DoR), PFS – *all locally and centrally assessed*- and OS
  - Safety: AEs and SAEs, labs, physical examination, vital signs, ECG, LVEF, dermatologic and ophthalmic examinations
  - QoL: EORTC QLQ-C30, EQ-5D-5L, PGIC

Courtesy of Scott Kopetz, MD, PhD

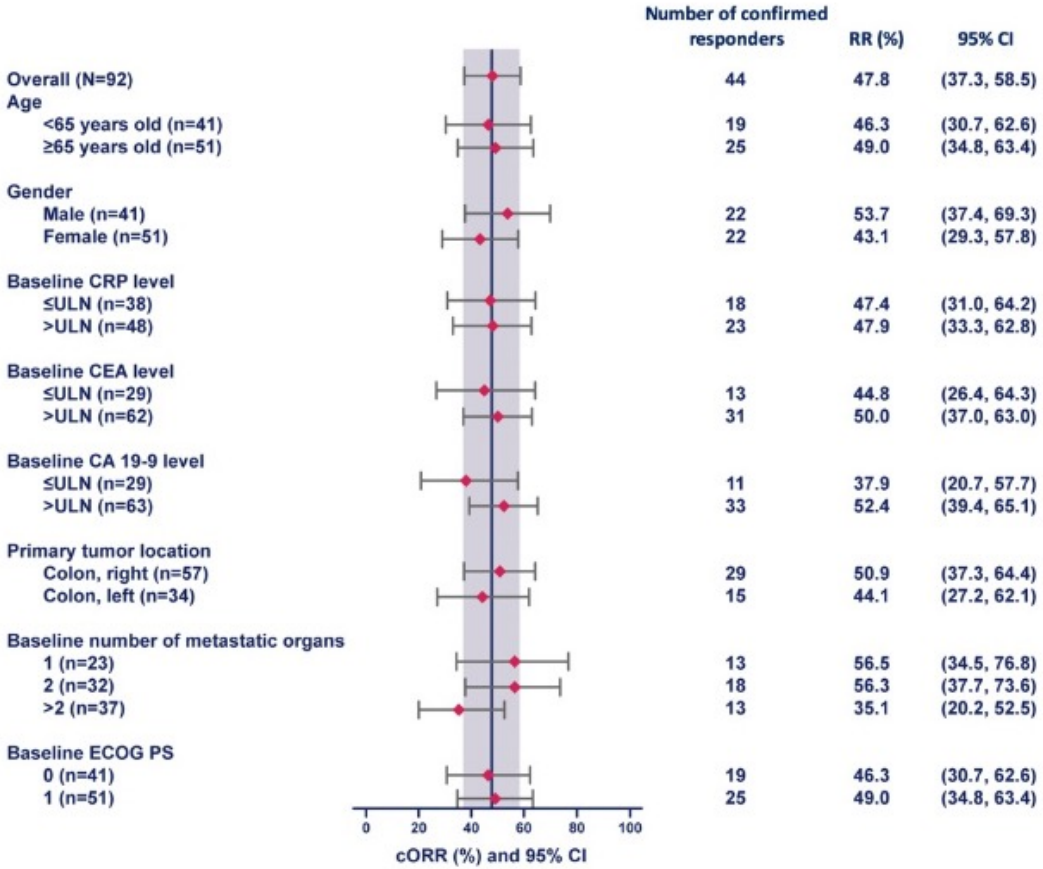
ANCHOR CRC

Primary Endpoint: cORR (investigator assessed)

Investigator's assessment, patients evaluable for efficacy (N=92#)



"The study met its primary endpoint, as the observed cORR was 47.8% with a lower limit of the 95% CI of 37.3%, exceeding the pre-specified rate of at least 30% required to reject the null hypothesis"



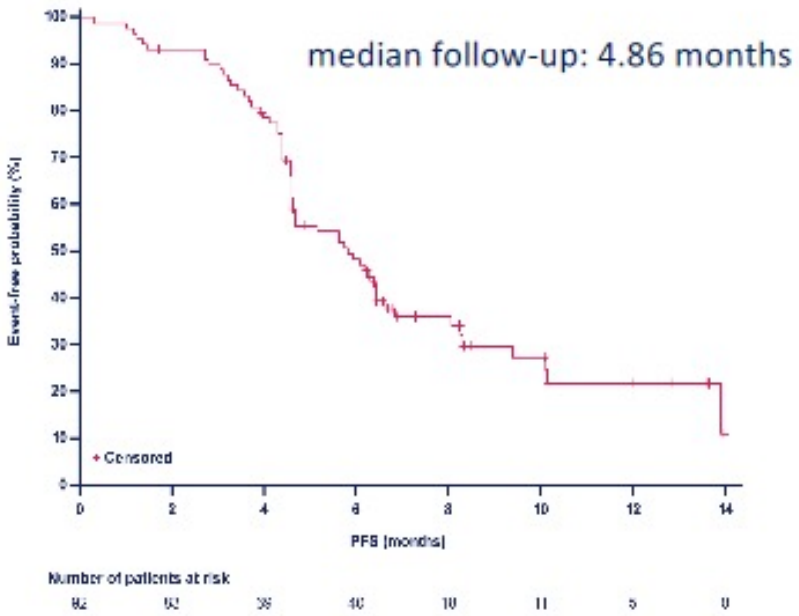
No meaningful differences in cORR in subgroup analysis

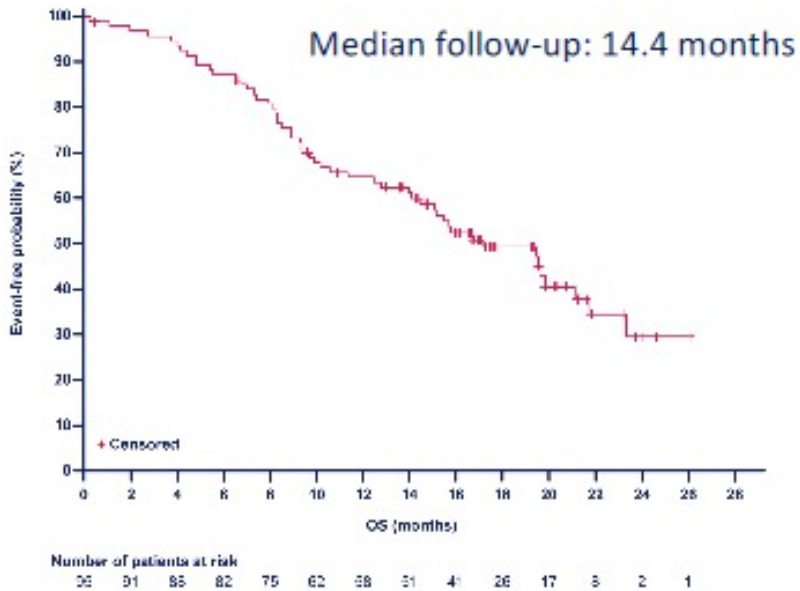
Van Cutsem E et al. Abstract O-10.ESMO GI 2021

Courtesy of Scott Kopetz, MD, PhD

ANCHOR CRC

Secondary Endpoints: PFS / OS





E/C/B	N	Number of events	Median (months - 95% CI)
OS	N=95	52 (54'7%)	17'2 (14'1-21'1)
PFS	N=92	61 (66'3%)	5'8 (4'6-6'4)

Courtesy of Scott Kopetz, MD, PhD

First Line Trial for $BRAF^{V600E}$: BREAKWATER Trial

Safety Lead-in

- Patients with *BRAF* V600E mutant mCRC with 0 -1 prior regimens in the metastatic setting

Encorafenib + Cetuximab + mFOLFOX6
N=30
Encorafenib + Cetuximab + FOLFIRI
N=30

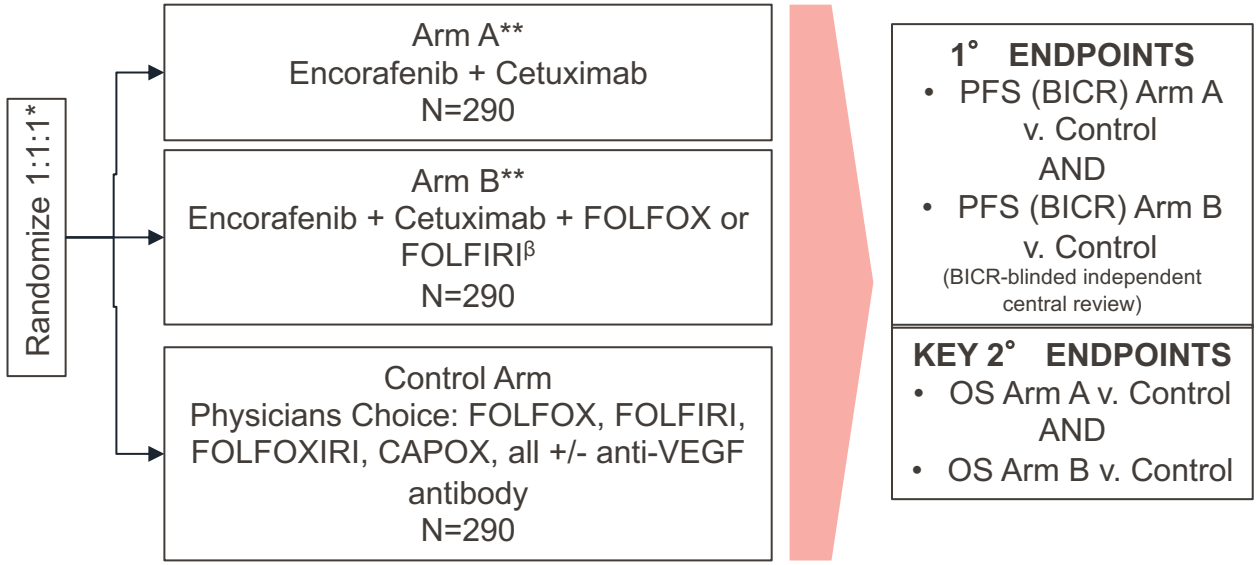
Doses:
Encorafenib- 300 mg PO QD
Cetuximab- 500 mg/m^2 IV Q2W
FOLFOX- full doses IV Q2W
FOLFIRI- full doses IV Q2W

ENDPOINTS

- Incidence of DLTs, Adverse events, dose modifications/discontinuations due to AEs
- PK including drug-drug interactions

Phase 3

- Patients with *BRAF* V600E mutant mCRC and no prior systemic therapy in the metastatic setting



*Stratified by: ECOG PS 0 v. 1, Region US/Canada v. Western Europe v. ROW

**Same dosing as SLI; βFOLFOX or FOLFIRI based on SLI results

Courtesy of Scott Kopetz, MD, PhD

NCT04607421

Faculty Case Appendix

Case Presentation – Dr Kopetz: A 65-year-old man with cecal adenocarcinoma

65 yo M who presented after screening colonoscopy demonstrated cecal adenocarcinoma.

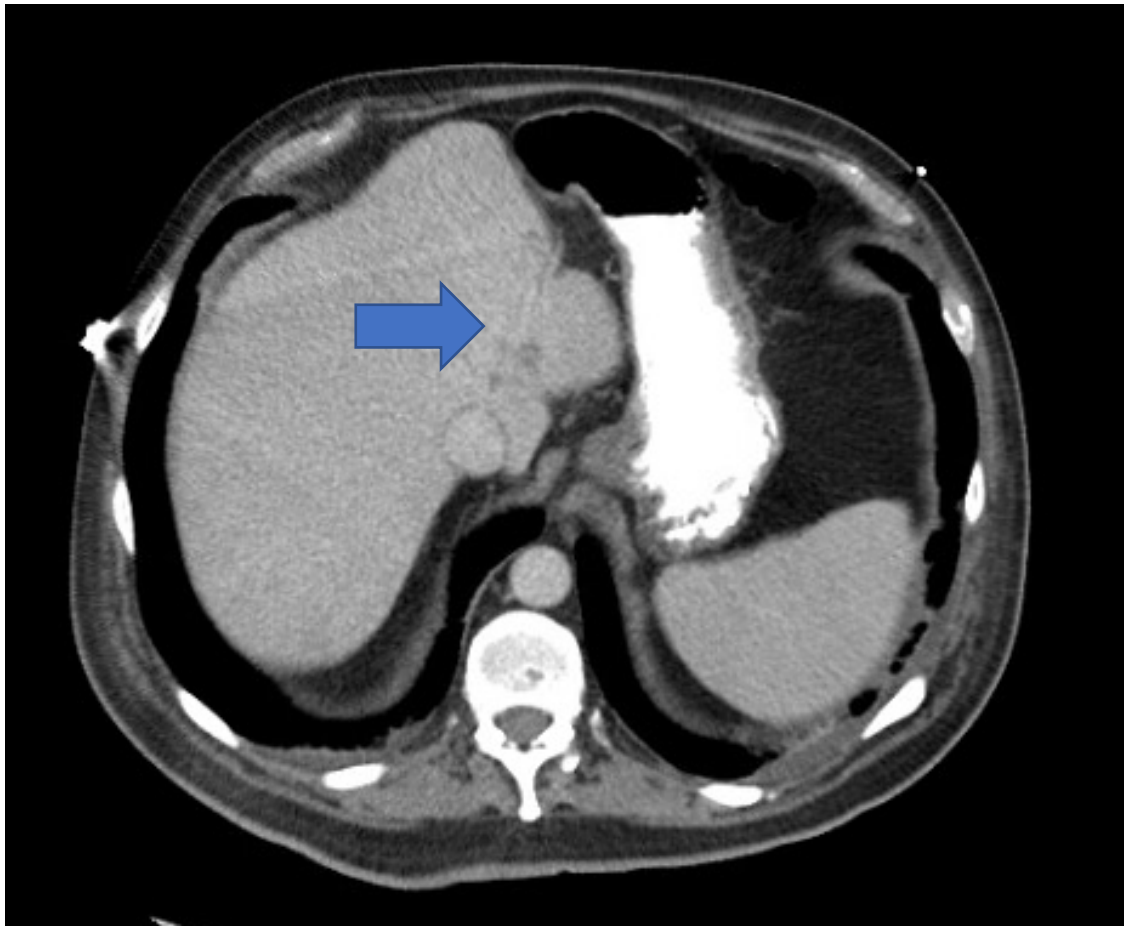
Indeterminant liver lesion on CT C/A/P imaging.

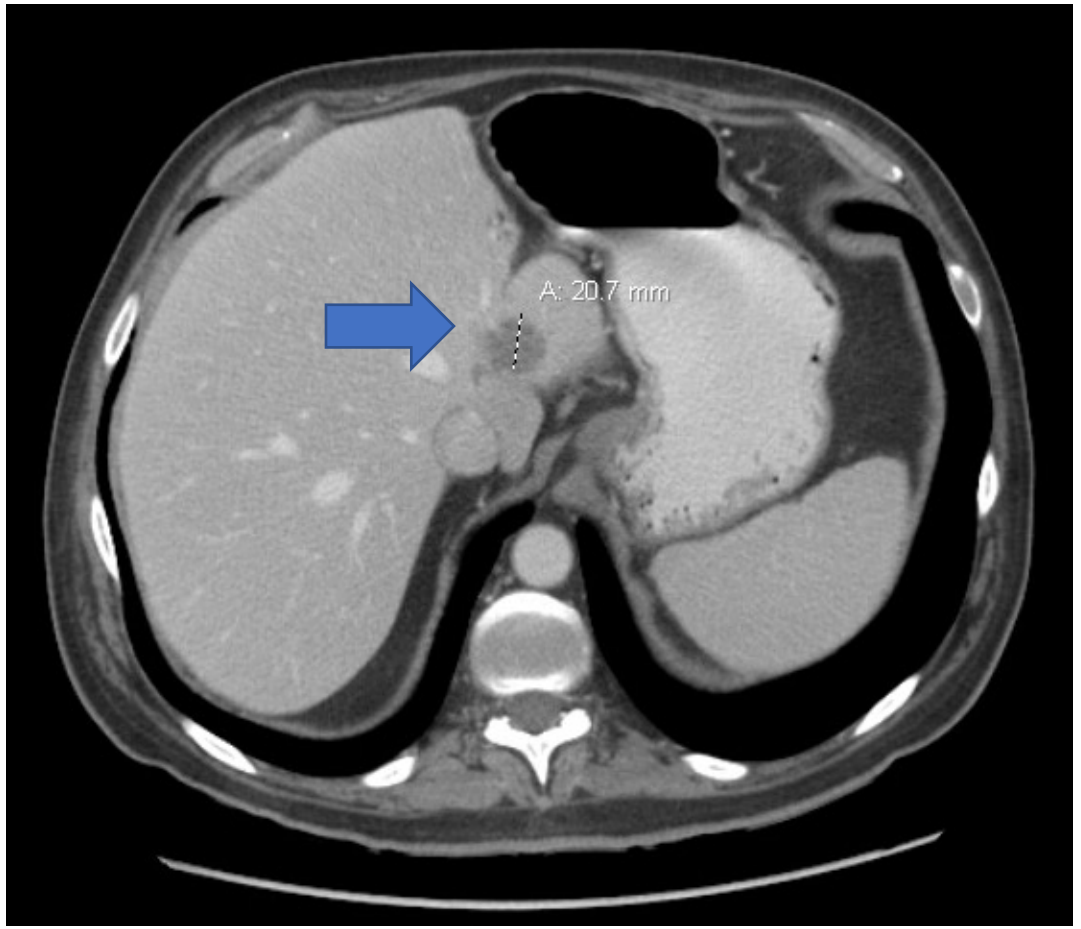
Surgery was performed with right hemicolectomy. T4a N2 (21 of 23 LN involved) with perineural invasion seen.

Presented to clinic for evaluation 3 weeks post-op.

Repeat CT C/A/P performed.

Case Presentation – Dr Kopetz: A 65-year-old man with cecal adenocarcinoma (continued)





Case Presentation – Dr Kopetz: A 65-year-old man with cecal adenocarcinoma (continued)

ctDNA was performed for rapid molecular profiling:

AKT1	CCND1	ESR1	HRAS	MAPK3	NPM1	RB1
ALK	CCND2	EZH2	IDH1	MET	NRAS	RET
APC	CCNE1	FBXW7	IDH2	MLH1	NTRK1	ROS1
AR	CDK4	FGFR1	JAK2	MPL	NTRK3	SMAD4
ARAF	CDK6	FGFR2	JAK3	MTOR	PDGFRA	SMO
ARID1A	CDKN2A	FGFR3	KIT	MYC	PIK3CA	STK11
ATM	CTNNB1	GNA11	KRAS	NF1	PTEN	TERT
BRAF	DDR2	GNAQ	MAP2K1	NFE2L2	PTPN11	**TP53**
BRCA1	EGFR	GNAS	MAP2K2	NOTCH1	RAD51	TSC1
BRCA2	ERBB2	HNF1A	MAPK1	NOTCH2	RAF1	VHL

BRAF^{V600E} identified

FINDINGS:

Copy Number Variations
None identified

Somatic Mutations

Gene	Standardized Nomenclature (HGVS)	Location	DNA change	Protein change	COSMIC ID	Computed VAF†
APC	NM_000038.5(APC):c.2983dupT p.C995fs	Exon 16	Duplication	Frameshift		1.0%
APC	NM_000038.5(APC):c.4393_4394dupAG p.S1465fs	Exon 16	Duplication	Frameshift		0.9%
BRAF	NM_004333.4(BRAF):c.1799T>A p.V600E	Exon 15	SNV	Missense	COSM476	2.3%
TP53	NM_000546.5(TP53):c.404G>T p.C135F	Exon 5	SNV	Missense	COSM10647	1.7%

Case Presentation – Dr Kopetz: A 65-year-old man with cecal adenocarcinoma (continued)

Question from patient: Am I a candidate for surgical resection of liver met?

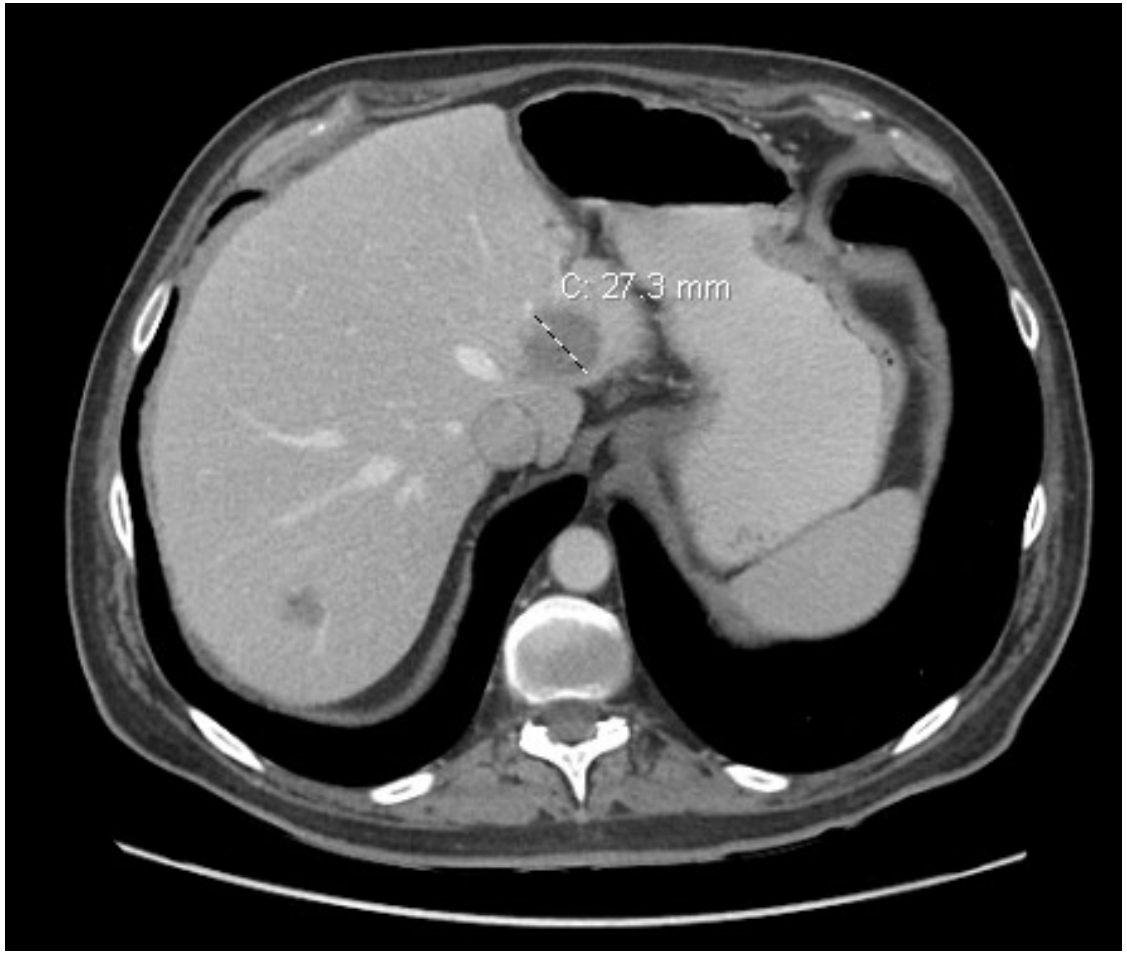
Answer: No, due to BRAF V600E mutation, high nodal burden, short interval from surgery, slow recovery from primary resection

Initiated on FOLFOX + B

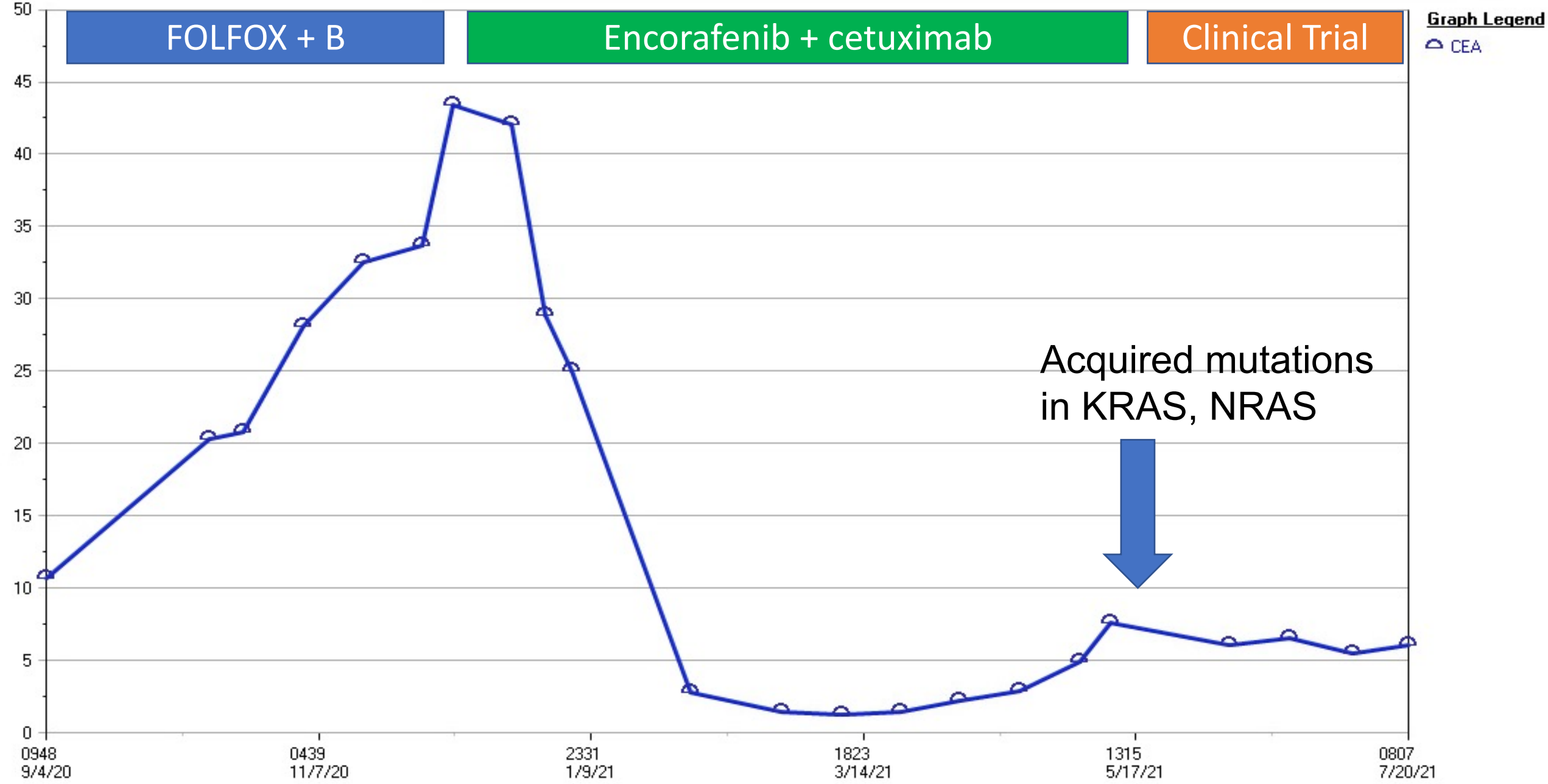
3-month scan performed with progression

Initiated on encorafenib + cetuximab

Response and 6 months of disease control



Case Presentation – Dr Kopetz: A 65-year-old man with cecal adenocarcinoma (continued)



Case Presentation – Dr Kopetz: A 68-year-old man with BRAF V600E Stage III colon cancer

68 yo M with PMH of hypertension, no relevant family history

Last colonoscopy at the age of 56 without findings

Presented with anemia, and colonoscopy demonstrated moderately differentiated adenocarcinoma in ascending colon

Imaging tests demonstrated no evidence of distant disease with peritumoral LNs up to 8 mm in size

Underwent R hemicolectomy

- T3 primary tumor
- 2 LN involved with disease, out of 28 LNs sampled (N1)
- No PNI
- Microsatellite stable by IHC

Case Presentation – Dr Kopetz: A 68-year-old man with BRAF V600E Stage III colon cancer (continued)

He presents to medical oncology office 4 weeks after resection

- Uneventful recovery, and approaching baseline functional status
- PS is 1 but expected to return to 0 shortly
- Retired, but active volunteering in the community. Stationary bike 4 times per week and walks his two small dogs daily. Enjoys traveling but is willing to adjust travel plans based on recommendations
- His daughter has read online about the poor prognosis of BRAF V600E

Patient is interested in adjuvant therapy, and is asking about what regimen and duration is recommended

Case Presentation – Dr Kopetz: A 68-year-old man with BRAF V600E Stage III colon cancer (continued)

In summary: 68yo T3N1 Stage III colon cancer with MSS, BRAF V600E

Which of the following would you recommend?

- FOLFOX x 6 months
- FOLFOX x 3 months
- 5-FU x 6 months
- CAPOX x 3 months
- CAPOX x 6 months

Case Presentation – Dr Kopetz: A 71-year-old woman with BRAF-mutant mCRC

71 yo F presents with right upper quadrant pain, prompting CT scan in local ER.

Imaging demonstrated bilateral lung metastases, and mild ascites with radiographic concern for peritoneal disease. Thickening in the descending colon.

Biopsy of a lung lesion demonstrated moderately differentiated adenocarcinoma, CK20+, CK7-, CDX2+, consistent with GI primary.

Colonoscopy confirmed adenocarcinoma in sigmoid colon, nonobstructing.

Case Presentation – Dr Kopetz: A 71-year-old woman with BRAF-mutant mCRC (continued)

Patient initiated on treatment with FOLFOX + Bevacizumab.

Molecular testing was returned with the following alterations:

- APC, TP53, ARID1A, NF1 mutations
- **BRAF D594 mutation (Class III)**
- No KRAS, NRAS mutations
- TMB is low (3)
- Microsatellite stable
- No HER2 amplification or overexpression
- No fusions detected

Case Presentation – Dr Kopetz: A 71-year-old woman with BRAF-mutant mCRC (continued)

Which of the following regimens would you recommend as a next line of therapy?

- FOLFIRI + Cetuximab
- FOLFIRI + Bevacizumab, followed by TAS-102 or Regorafenib
- FOLFIRI + Bevacizumab, followed by Irinotecan + Cetuximab
- Encorafenib + Cetuximab

Expert Second Opinion: Investigators Discuss Available Clinical Research in the Care of Patients with Non-Small Cell Lung Cancer and Validated Targets Beyond EGFR

A Live Webinar Held as a Satellite CME/MOC Symposium During the IASLC 2021 World Conference on Lung Cancer Worldwide Virtual Event

Friday, September 10, 2021
5:45 AM – 6:45 AM MDT / 7:45 AM – 8:45 AM ET

Faculty

D Ross Camidge, MD, PhD
Alexander E Drilon, MD
Justin F Gainor, MD

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Thank you for joining us!

CME credit information will be emailed to each participant within 3 business days.