

Meet The Professor

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

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Co-Leader, Kidney Cancer Program

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Commercial Support

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Dr Love — Disclosures

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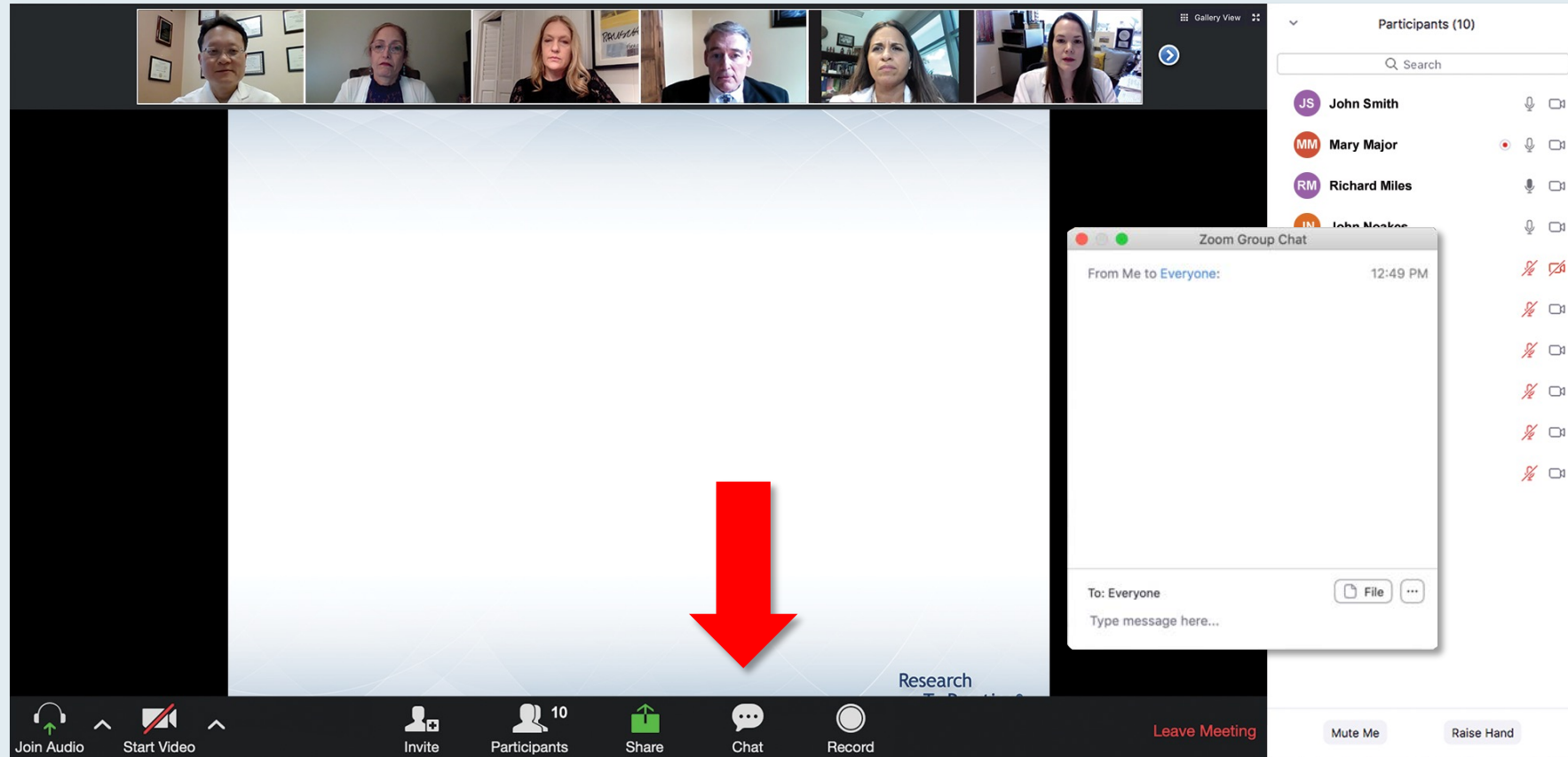
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Dr Hammers — Disclosures

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We Encourage Clinicians in Practice to Submit Questions



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

Familiarizing Yourself with the Zoom Interface

Expand chat submission box

The screenshot shows a Zoom meeting interface. At the top, there are video thumbnails for participants: RTP Coordinat..., Kirsten Miller, RTP Mike Rivera, and Lisa Suarez. Below the thumbnails is a slide titled "Meet The Professor Program Steering Committee" with six members listed:

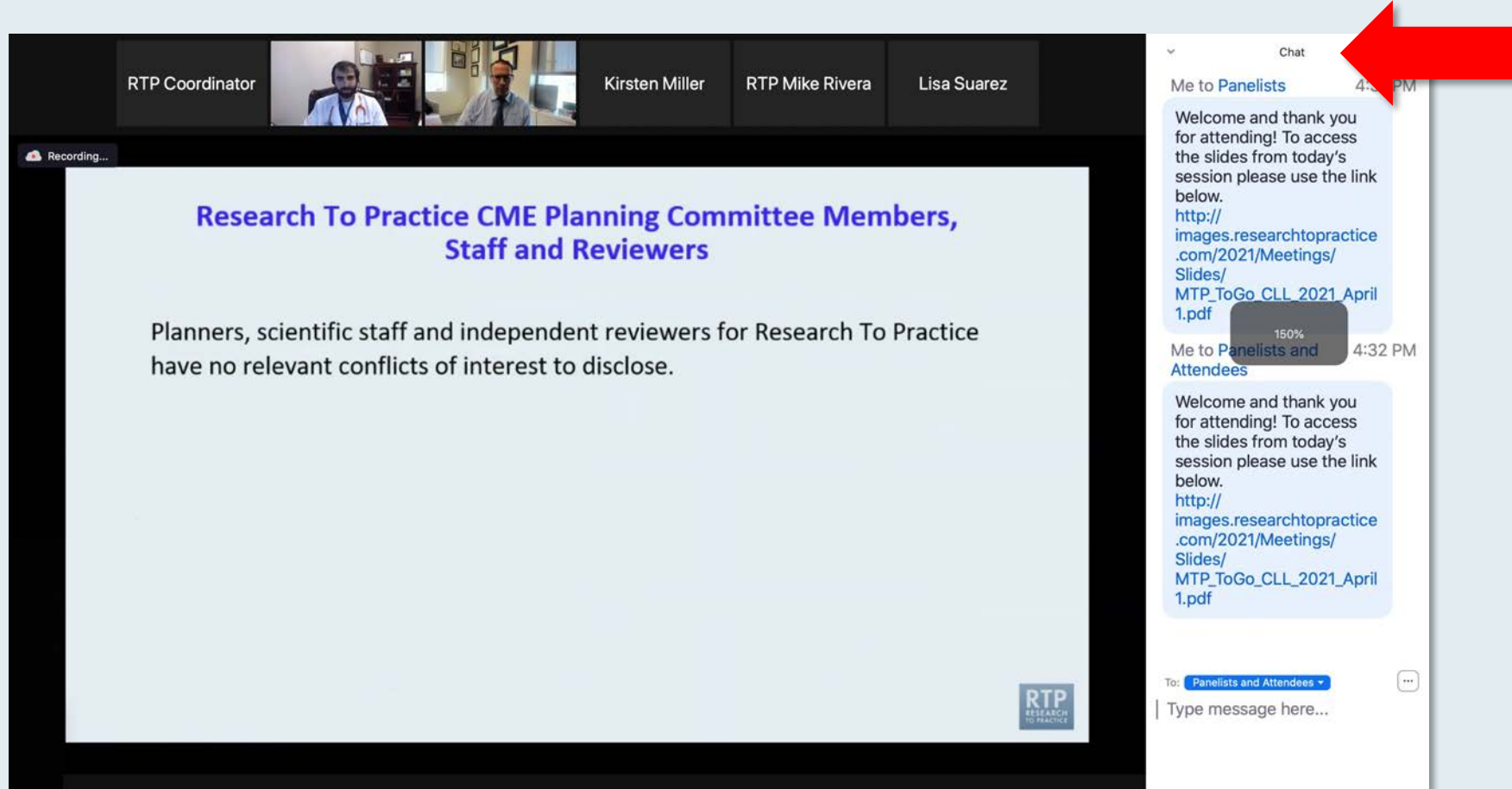
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Drag the white line above the submission box up to create more space for your message.

Familiarizing Yourself with the Zoom Interface

Increase chat font size



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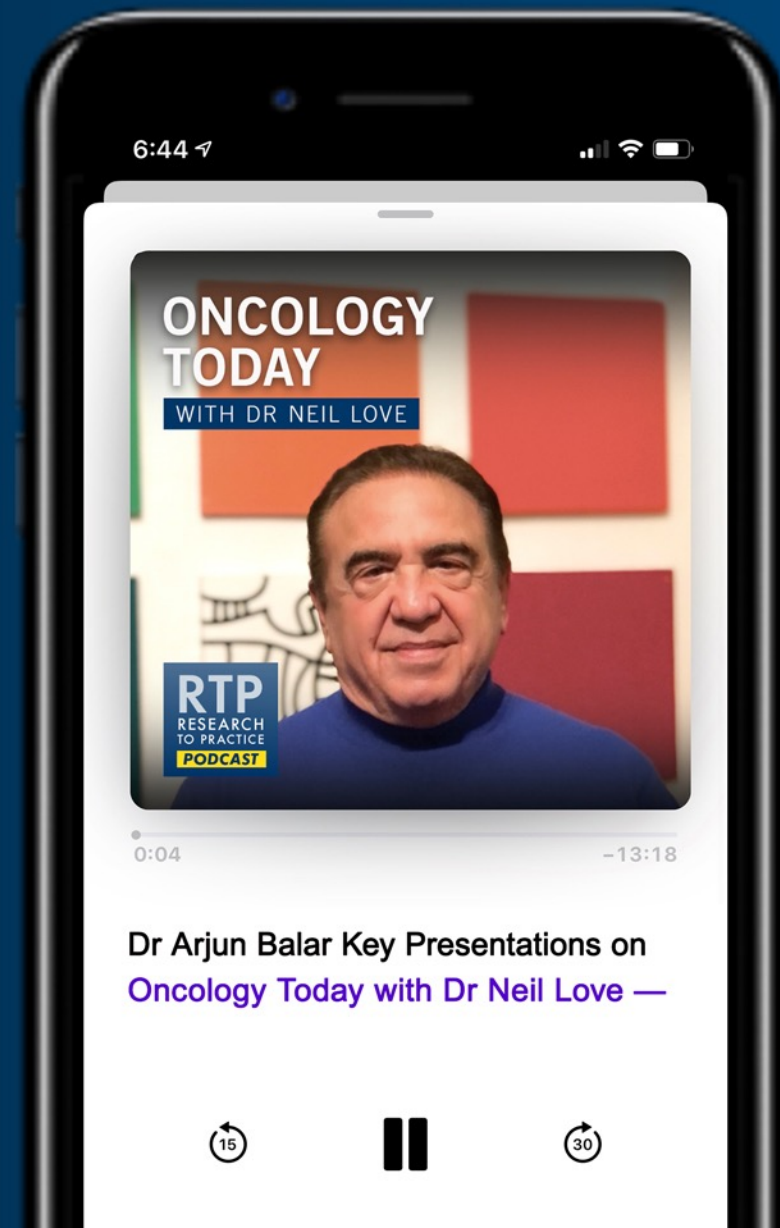
ONCOLOGY TODAY

WITH DR NEIL LOVE

Key Presentations on Genitourinary Cancers from the 2021 ASCO Annual Meeting



DR ARJUN BALAR
NYU PERLMUTTER CANCER CENTER



Identifying, Managing and Mitigating Therapy-Related Adverse Events in Patients with Chronic Lymphocytic Leukemia and Mantle Cell Lymphoma

A CME/MOC-Accredited Virtual Event

Monday, October 4, 2021

5:00 PM – 6:00 PM ET

Faculty

**Richard R Furman, MD
Lindsey Roeker, MD**

Consulting Cardiologist

Daniel J Lenihan, MD

Moderator

Neil Love, MD

Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with ER-Positive Breast Cancer

Wednesday, October 6, 2021
5:00 PM – 6:00 PM ET

Faculty

Virginia Kaklamani, MD, DSc

Moderator

Neil Love, MD

Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with Advanced Gastrointestinal Cancers

**Friday, October 8, 2021
12:00 PM – 1:00 PM ET**

Faculty

Eileen M O'Reilly, MD

Moderator

Neil Love, MD

Meet The Professor

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

Monday, October 11, 2021

5:00 PM – 6:00 PM ET

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Elizabeth R Plimack, MD, MS

Moderator

Neil Love, MD

Recent Advances and Future Directions in Oncology: A Daylong Multitumor Educational Webinar in Partnership with Florida Cancer Specialists

A CME-MOC/NCPD Accredited Virtual Event

Saturday, October 23, 2021

9:30 AM – 4:30 PM ET

Faculty

Tanios Bekaii-Saab, MD
Kristen K Ciombor, MD, MSCI
Brad S Kahl, MD
Mark Levis, MD, PhD
Mark D Pegram, MD

Daniel P Petrylak, MD
Noopur Raje, MD
David Sallman, MD
Lecia V Sequist, MD, MPH

Additional faculty to be announced.

Moderator

Neil Love, MD

Thank you for joining us!

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

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Dallas, Texas

Meet The Professor Program Participating Faculty



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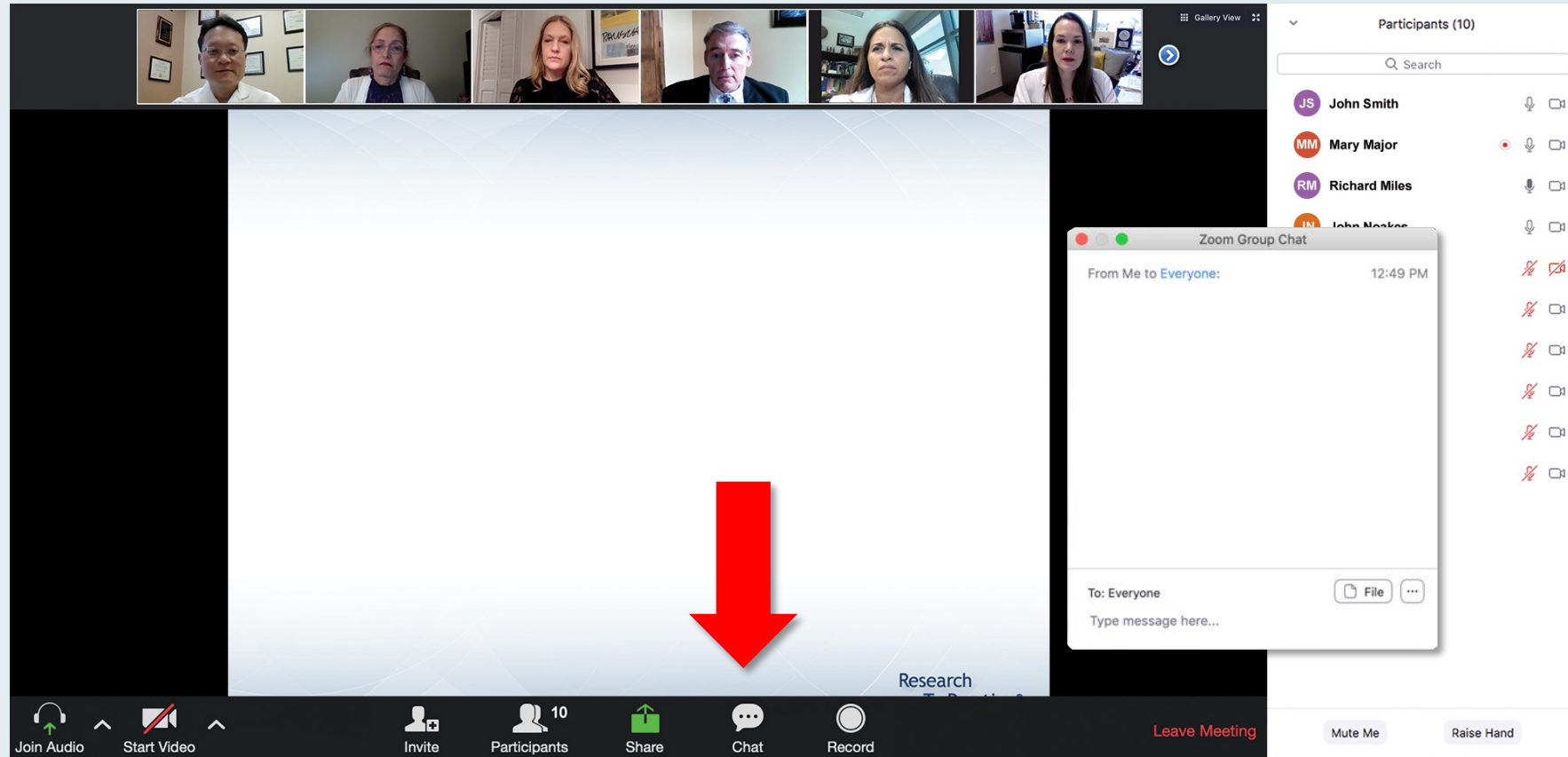


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Research To Practice
Miami, Florida

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Recent Advances and Future Directions in Oncology: A Daylong Multitumor Educational Webinar in Partnership with Florida Cancer Specialists

Module 1: Breast Cancer – 9:30 AM – 10:20 AM

Module 2: Lung Cancer – 10:30 AM – 11:20 AM

Module 3: Gastrointestinal Cancers – 11:30 AM – 12:20 PM

Module 4: Genitourinary Cancers – 12:30 PM – 1:20 PM

Module 5: CLL and Lymphomas – 1:30 PM – 2:20 PM

Module 6: Multiple Myeloma – 2:30 PM – 3:20 PM

Module 7: AML and MDS – 3:30 PM – 4:20 PM

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Medical Oncologist
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Meet The Professor with Dr Hammers

MODULE 1: Case Presentations

- Dr Plimack: A 69-year-old man with metastatic clear cell RCC
- Dr Kumar: A 53-year-old woman with metastatic RCC with rhabdoid features
- Dr Kodali: A 34-year-old man with widespread peritoneal carcinomatosis and papillary RCC
- Dr Jonasch: A 30-year-old man with von Hippel-Lindau disease
- Dr Glynn: An 81-year-old man with metastatic RCC

MODULE 2: ESMO 2021 Review and Journal Club with Dr Hammers

MODULE 3: Beyond the Guidelines

MODULE 4: Key Data Sets

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Case Presentation – Dr Plimack: A 69-year-old man with metastatic clear cell RCC



Dr Elizabeth Plimack

- Age 58: S/p bilateral partial nephrectomies for Stage I ccRCC
- Ten years later: Small lung metastases biopsy-confirmed ccRCC – Slow growth trajectory
- Pazopanib x 1 year
 - Dose holds/adjustments for diarrhea
 - Discontinued for fatigue while responding
- Cabozantinib x 6 months
 - Dose reduced, then discontinued due to poor tolerance in the setting of PD due to subtherapeutic dosing
- Ipilimumab/nivolumab
 - LFT abnormalities, hepatitis → Hospitalization and steroids

Question

- In this patient who had initially an excellent response to ipilimumab and nivolumab, had immune-mediated hepatitis as an adverse effect of that treatment, now with progression having been off that treatment, would anyone rechallenge this patient with nivolumab versus switching to alternate therapy?

Case Presentation – Dr Plimack: A 69-year-old man with metastatic clear cell RCC (continued)



Dr Elizabeth Plimack

- Age 58: S/p bilateral partial nephrectomies for Stage I ccRCC
- Ten years later: Small lung metastases biopsy-confirmed ccRCC – Slow growth trajectory
- Pazopanib x 1 year
 - Dose holds/adjustments for diarrhea
 - Discontinued for fatigue while responding
- Cabozantinib x 6 months
 - Dose reduced, then discontinued due to poor tolerance in the setting of PD due to subtherapeutic dosing
- Ipilimumab/nivolumab
 - LFT abnormalities, hepatitis → Hospitalization and steroids
- ***Re-challenged with nivolumab but PD after 6 months***
 - ***No recurrent hepatitis***

Case Presentation – Dr Kumar: A 53-year-old woman with metastatic RCC with rhabdoid features



Dr KS Kumar

- PMH: Hailey-Hailey skin disorder (benign pemphigus)
- Left clear cell RCC, with 3-4 small, bilateral pulmonary nodules
- Radical nephrectomy, clear cell RCC with 10-15% rhabdoid features
- Double IO therapy planned

Questions

- In light of the rhabdoid differentiation, would you administer double IO therapy, or would you go with a TKI/IO combination regimen?
- Would you treat the pulmonary nodules or observe those for now since they are quite small?
- Is there a contraindication to IO therapy in patients with non-autoimmune pemphigus?
- Am I making a mistake by not treating her immediately, or should I treat her right away?

Case Presentation – Dr Kodali: A 34-year-old man with widespread peritoneal carcinomatosis and papillary RCC



Dr Dhatry Kodali

- Father and sister RCC at a young age
- S/p radical nephrectomy and periaortic dissection for T3aN0 clear cell RCC
- Surveillance → Recurrent ascites, with negative cytology
- Laparoscopy: Widespread peritoneal carcinomatosis, papillary RCC
- Awaiting germline genetic testing results

Questions

- Do you see a role for combination therapy for this patient?
- Is there a difference between hereditary and sporadic RCC, especially when there is doubt between clear cell or papillary, or mixed kind in terms of first-line therapy?

Case Presentation – Dr Kodali: A 34-year-old man with widespread peritoneal carcinomatosis and papillary RCC (continued)



Dr Dhatry Kodali

- Father and sister RCC at a young age
- S/p radical nephrectomy and periaortic dissection for T3aN0 clear cell RCC
- Surveillance → Recurrent ascites, with negative cytology
- Laparoscopy: Widespread peritoneal carcinomatosis, papillary RCC
- Awaiting germline genetic testing results
- **Nivolumab/cabozantinib**

Case Presentation – Dr Jonasch: A 30-year-old man with von Hippel-Lindau disease

- Began surveillance in his early 20s
- PMH: hemangioblastoma, small renal cell mass

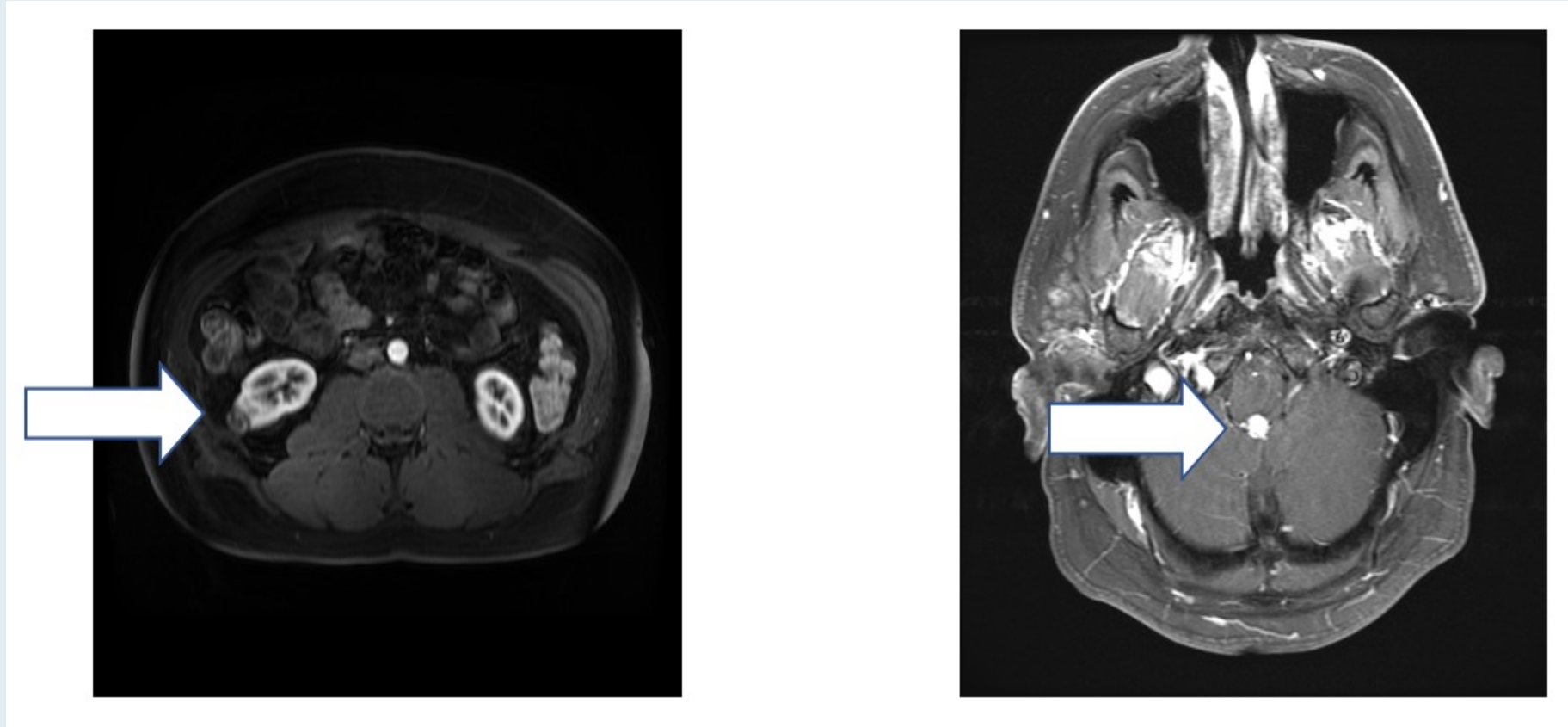


Dr Eric Jonasch

Case Presentation – Dr Jonasch: A 30-year-old man with von Hippel-Lindau disease (continued)



Dr Eric Jonasch



Case Presentation – Dr Glynn: An 81-year-old man with metastatic RCC



Dr Philip Glynn

- 8/2019: Progressive weight loss, anemia
- CT: Left renal lesion, with involvement of renal vein → surgical resection, T3N0
- 8/2020 radiographic assessment: Pulmonary nodularity → biopsy-proven mRCC
- Pembrolizumab/axitinib
- 2/2021 radiographic assessment: Mild-to-moderate improvement in pulmonary nodules

Question

- In 2021, with the availability of the cabozantinib/nivolumab regimen, would you have made a different selection for initial treatment, or would you have gone with pembrolizumab/axitinib?

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ESMO 2021 Review

- Choueiri TK et al. **Pembrolizumab (pembro) vs placebo as adjuvant therapy for patients (pts) with renal cell carcinoma (RCC): Patient-reported outcomes (PRO) in KEYNOTE-564.** ESMO 2021;Abstract 653O.
- Derosa L et al. **Antibiotic (ATB) therapy and outcome from nivolumab (N) in metastatic renal cell carcinoma (mRCC) patients (pts): Results of the GETUG-AFU 26 NIVOREN multicentric phase II study.** ESMO 2021;Abstract 657MO.
- Rini BI et al. **Randomized, open-label, 3-arm phase III study comparing MK-1308A + lenvatinib and pembrolizumab (pembro) + belzutifan + lenvatinib versus pembro + lenvatinib as first-line (1L) treatment for advanced clear cell renal cell carcinoma (ccRCC).** ESMO 2021;Abstract 717TiP.
- McDermott DF et al. **Phase II study of belzutifan (MK-6482), an oral hypoxia-inducible factor 2 α (HIF-2 α) inhibitor, plus cabozantinib for treatment of advanced clear cell renal cell carcinoma (ccRCC).** ESMO 2021;Abstract 656MO.

ESMO 2021 Review

- Vasudev NS et al. **Nivolumab in combination with alternatively scheduled ipilimumab in first-line treatment of patients with advanced renal cell carcinoma: A randomized phase II trial (PRISM)**. ESMO 2021;Abstract LBA29.
- Choueiri TK et al. **Phase III CLEAR trial in advanced renal cell carcinoma (aRCC): Outcomes in subgroups and toxicity update**. ESMO 2021;Abstract 660P.
- Motzer RJ et al. **Conditional survival and 5-year follow-up in CheckMate 214: First-line nivolumab + ipilimumab (N + I) versus sunitinib (S) in advanced renal cell carcinoma (aRCC)**. ESMO 2021;Abstract 661P.
- Procopio G et al. **A phase II prospective trial of frontline cabozantinib in metastatic collecting ducts renal cell carcinoma: The BONSAI trial (Meeturo 2)**. ESMO 2021;Abstract 654MO.

Journal Club with Dr Hammers

- Choueiri TK et al; KEYNOTE-564 Investigators. **Adjuvant pembrolizumab after nephrectomy in renal-cell carcinoma.** *N Engl J Med* 2021;385(8):683-94.
- Patel V et al. **Acute interstitial nephritis, a potential predictor of response to immune checkpoint inhibitors in renal cell carcinoma.** *J Immunother Cancer* 2020;8(2):e001198.
- Singla N et al. **Improved survival after cytoreductive nephrectomy for metastatic renal cell carcinoma in the contemporary immunotherapy era: An analysis of the National Cancer Database.** *Urol Oncol* 2020;38(6):604.e9-17.
- Rini BI et al. **Characterization and management of treatment-emergent hepatic toxicity in patients with advanced renal cell carcinoma receiving first-line pembrolizumab plus axitinib. Results from the KEYNOTE-426 trial.** *Eur Urol Oncol* 2021;[Online ahead of print].

Journal Club with Dr Hammers

- Gorin MA et al. **Neoadjuvant nivolumab in patients with high-risk nonmetastatic renal cell carcinoma.** *Eur Urol Oncol* 2021;[Online ahead of print].
- Harrison MR et al. **Active surveillance of metastatic renal cell carcinoma: Results from a prospective observational study (MaRCC).** *Cancer* 2021;127(13):2204-12.
- Gul A et al. **Salvage ipilimumab and nivolumab in patients with metastatic renal cell carcinoma after prior immune checkpoint inhibitors.** *J Clin Oncol* 2020;38(27):3088-94.
- Hannan R et al. **Phase II trial of stereotactic ablative radiation (SAbR) for oligoprogressive kidney cancer.** ASCO 2021;Abstract 4564.
- McGregor BA et al. **Cabozantinib (C) in combination with nivolumab (N) and ipilimumab (I) (CaNI) for advanced renal cell carcinoma with variant histology (aRCCVH).** ASCO 2021; Abstract TPS4592.
- Plimack ER et al. **A phase 1b/2 umbrella study of investigational immune and targeted combination therapies as first-line therapy for patients with advanced renal cell carcinoma (RCC).** ASCO 2021;Abstract TPS4594.

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Optimizing Front-Line Decision-Making for Advanced RCC

Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient with a history of nephrectomy for clear cell renal cell carcinoma (RCC) who on routine follow-up 3 years later is found to have asymptomatic bone metastases (PS 0)?

1. Nivolumab/ipilimumab
2. Avelumab/axitinib
3. Pembrolizumab/axitinib
4. Pembrolizumab/lenvatinib
5. Nivolumab/cabozantinib
6. Tyrosine kinase inhibitor (TKI) monotherapy
7. Anti-PD-1/PD-L1 monotherapy
8. Other

Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient with a history of nephrectomy for clear cell renal cell carcinoma (RCC) who on routine follow-up 3 years later is found to have asymptomatic bone metastases (PS = 0)?



Dr Choueiri

**Nivolumab/
cabozantinib**



Dr Motzer

**Nivolumab/
cabozantinib**



Dr Hutson

**Nivolumab/
cabozantinib**



Dr Plimack

**Pembrolizumab/
axitinib**



Dr Jonasch

**Nivolumab/
cabozantinib**



Prof Powles

**Pembrolizumab/
lenvatinib**



Dr McDermott

Nivolumab/ipilimumab



Dr Rini

**Pembrolizumab/
lenvatinib**

Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient who presents with clear cell RCC with multiple painful bone metastases and hemoglobin (Hb) of 11.4 g/dL (PS 1)?

1. Nivolumab/ipilimumab
2. Avelumab/axitinib
3. Pembrolizumab/axitinib
4. Pembrolizumab/lenvatinib
5. Nivolumab/cabozantinib
6. TKI monotherapy
7. Anti-PD-1/PD-L1 monotherapy
8. Other

Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient who presents with clear cell RCC with multiple painful bone metastases and hemoglobin (Hb) of 11.4 g/dL (PS = 1)?



Dr Choueiri

**Nivolumab/
cabozantinib**



Dr Motzer

Nivolumab/ipilimumab



Dr Hutson

**Nivolumab/
cabozantinib**



Dr Plimack

**Pembrolizumab/
lenvatinib**



Dr Jonasch

**Nivolumab/
cabozantinib**



Prof Powles

**Pembrolizumab/
axitinib**



Dr McDermott

**Pembrolizumab/
lenvatinib**



Dr Rini

**Pembrolizumab/
lenvatinib**

In general, which first-line therapy would you recommend for a 65-year-old patient who presents with metastatic clear cell RCC and for whom the use of immune checkpoint inhibitors is contraindicated?

1. Sunitinib
2. Pazopanib
3. Cabozantinib
4. Axitinib
5. Other

In general, which first-line therapy would you recommend for a 65-year-old patient who presents with metastatic clear cell RCC and for whom the use of immune checkpoint inhibitors is contraindicated?



Dr Choueiri

Cabozantinib



Dr Motzer

Cabozantinib



Dr Hutson

Cabozantinib



Dr Plimack

Pazopanib



Dr Jonasch

Sunitinib



Prof Powles

Pazopanib



Dr McDermott

Cabozantinib



Dr Rini

Cabozantinib

In general, how would you compare the efficacy of tivozanib to that of commercially available tyrosine kinase inhibitors (TKIs; eg, axitinib, cabozantinib, lenvatinib) in patients with relapsed metastatic RCC?



Dr Choueiri

I don't know (likely same as axitinib)



Dr Motzer

I don't know



Dr Hutson

Efficacy is about the same



Dr Plimack

Efficacy is about the same



Dr Jonasch

Efficacy is about the same



Prof Powles

Efficacy is about the same



Dr McDermott

Efficacy is about the same



Dr Rini

Efficacy is about the same

In general, how would you compare the tolerability of tivozanib to that of commercially available TKIs (eg, axitinib, cabozantinib, lenvatinib) in patients with relapsed metastatic RCC?



Dr Choueiri

Tivozanib is more tolerable



Dr Motzer

Tivozanib is more tolerable



Dr Hutson

Tivozanib is more tolerable



Dr Plimack

Tivozanib is more tolerable



Dr Jonasch

Tivozanib is more tolerable



Prof Powles

Tolerability is about the same



Dr McDermott

Tivozanib is more tolerable



Dr Rini

Tivozanib is more tolerable

Sequencing of Therapy for Patients with Relapsed/Refractory RCC; Novel Approaches under Investigation

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear-cell RCC who receives first-line ipilimumab/nivolumab and experiences disease progression after 12 months?

1. Sunitinib
2. Pazopanib
3. Cabozantinib
4. Axitinib
5. Avelumab/axitinib
6. Pembrolizumab/axitinib
7. Nivolumab/cabozantinib
8. Other

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear cell RCC who receives first-line ipilimumab/nivolumab and experiences disease progression after 12 months?



Dr Choueiri

Cabozantinib



Dr Motzer

Axitinib



Dr Hutson

Cabozantinib



Dr Plimack

**Pembrolizumab/
axitinib**



Dr Jonasch

Cabozantinib



Prof Powles

Cabozantinib



Dr McDermott

Cabozantinib



Dr Rini

Axitinib

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear-cell RCC who receives first-line pembrolizumab/axitinib and experiences disease progression after 12 months?

1. Sunitinib
2. Pazopanib
3. Cabozantinib
4. Sorafenib
5. Lenvatinib/everolimus
6. Nivolumab/ipilimumab
7. Nivolumab/cabozantinib
8. Other

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear cell RCC who receives first-line pembrolizumab/axitinib and experiences disease progression after 12 months?



Dr Choueiri

Cabozantinib



Dr Motzer

Cabozantinib



Dr Hutson

Cabozantinib



Dr Plimack

Cabozantinib



Dr Jonasch

Cabozantinib



Prof Powles

Cabozantinib



Dr McDermott

Cabozantinib



Dr Rini

Cabozantinib

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear cell RCC who receives first-line nivolumab/cabozantinib and experiences disease progression after 12 months?

 Dr Choueiri	Lenvatinib + everolimus	 Dr Motzer	Lenvatinib + everolimus
 Dr Hutson	Lenvatinib + everolimus	 Dr Plimack	Lenvatinib + everolimus
 Dr Jonasch	Lenvatinib + everolimus	 Prof Powles	Axitinib
 Dr McDermott	Nivolumab/ipilimumab	 Dr Rini	Axitinib

Meet The Professor with Dr Hammers

MODULE 1: Case Presentations

- Dr Plimack: A 69-year-old man with metastatic clear cell RCC
- Dr Kumar: A 53-year-old woman with metastatic RCC with rhabdoid features
- Dr Kodali: A 34-year-old man with widespread peritoneal carcinomatosis and papillary RCC
- Dr Jonasch: A 30-year-old man with von Hippel-Lindau disease
- Dr Glynn: An 81-year-old man with metastatic RCC

MODULE 2: ESMO 2021 Review and Journal Club with Dr Hammers

MODULE 3: Beyond the Guidelines

MODULE 4: Key Data Sets



Nivolumab plus ipilimumab versus sunitinib for first-line treatment of advanced renal cell carcinoma: extended 4-year follow-up of the phase III CheckMate 214 trial

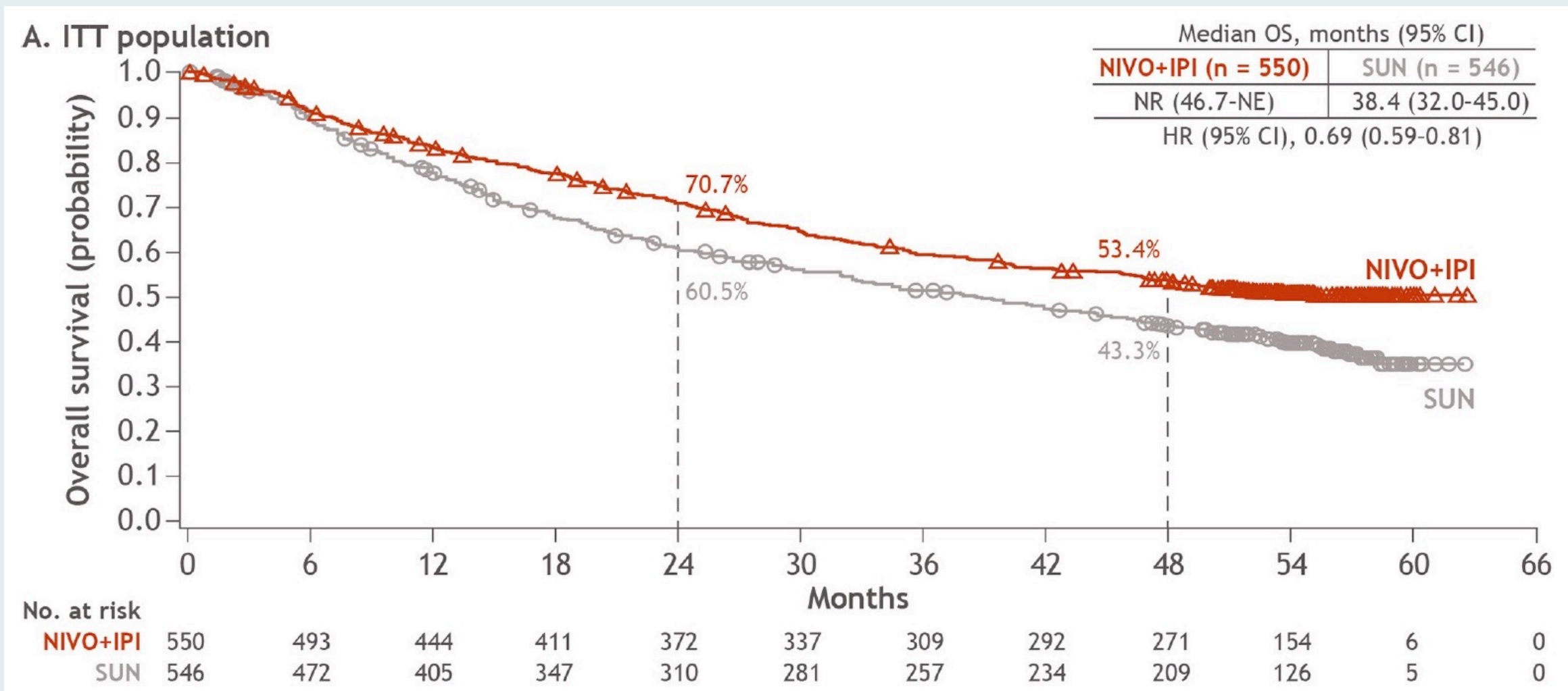
Laurence Albiges ¹, Nizar M Tannir,² Mauricio Burotto,³ David McDermott,^{4,5} Elizabeth R Plimack,⁶ Philippe Barthélémy,^{7,8} Camillo Porta ⁹, Thomas Powles,^{10,11} Frede Donskov,¹² Saby George,¹³ Christian K Kollmannsberger,¹⁴ Howard Gurney,^{15,16} Marc-Oliver Grimm,¹⁷ Yoshihiko Tomita,¹⁸ Daniel Castellano,¹⁹ Brian I Rini,²⁰ Toni K Choueiri,²¹ Shruti Shally Saggi,²² M Brent McHenry,²³ Robert J Motzer²⁴

ESMO Open 2020;5(6):e001079.

CheckMate 214: Overall Response and Best Response Rate per IRRC at 4 Years Minimum Follow-Up in ITT Population

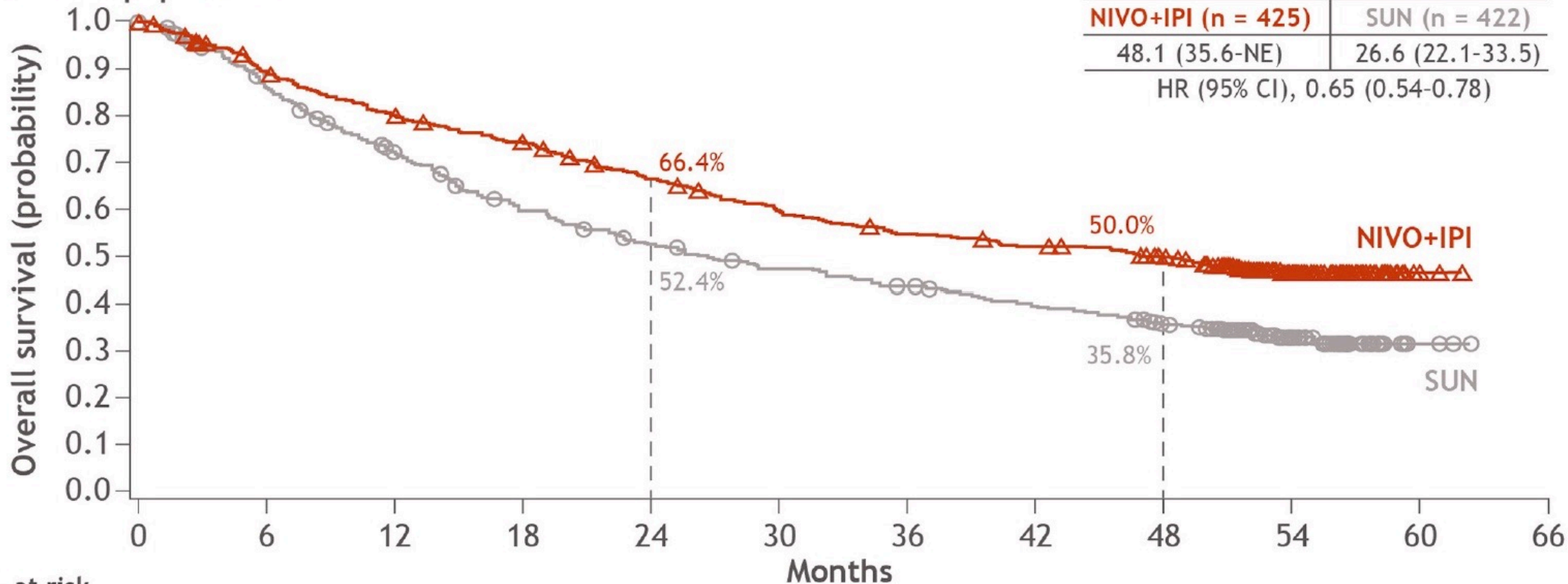
	Intent-to-Treat		Intermediate/Poor Risk		Favorable Risk	
	Nivo + Ipi (n = 550)	Sunitinib (n = 546)	Nivo + Ipi (n = 425)	Sunitinib (n = 422)	Nivo + Ipi (n = 125)	Sunitinib (n = 124)
Confirmed ORR	39.1%	32.4%	41.9%	26.8%	29.6%	51.6%
CR	10.7%	2.6%	10.4%	1.4%	12.0%	6.5%
PR	28.4%	29.9%	31.5%	25.4%	17.6%	45.2%
Stable disease	36.0%	42.1%	30.8%	44.3%	53.6%	34.7%
Progressive disease	17.6%	14.1%	19.3%	16.8%	12.0%	4.8%
Ongoing response	65.1%	52.0%	65.2%	49.6%	64.9%	56.3%

CheckMate 214: Overall Survival (ITT)



CheckMate 214: Overall Survival (Intermediate/Poor Risk)

B. I/P-risk population



No. at risk

	0	6	12	18	24	30	36	42	48	54	60	66
NIVO+IPI	425	372	332	306	270	241	220	208	193	86	3	0
SUN	422	353	291	237	206	184	169	151	133	66	3	0

N Engl J Med 2021;384(9):829-41

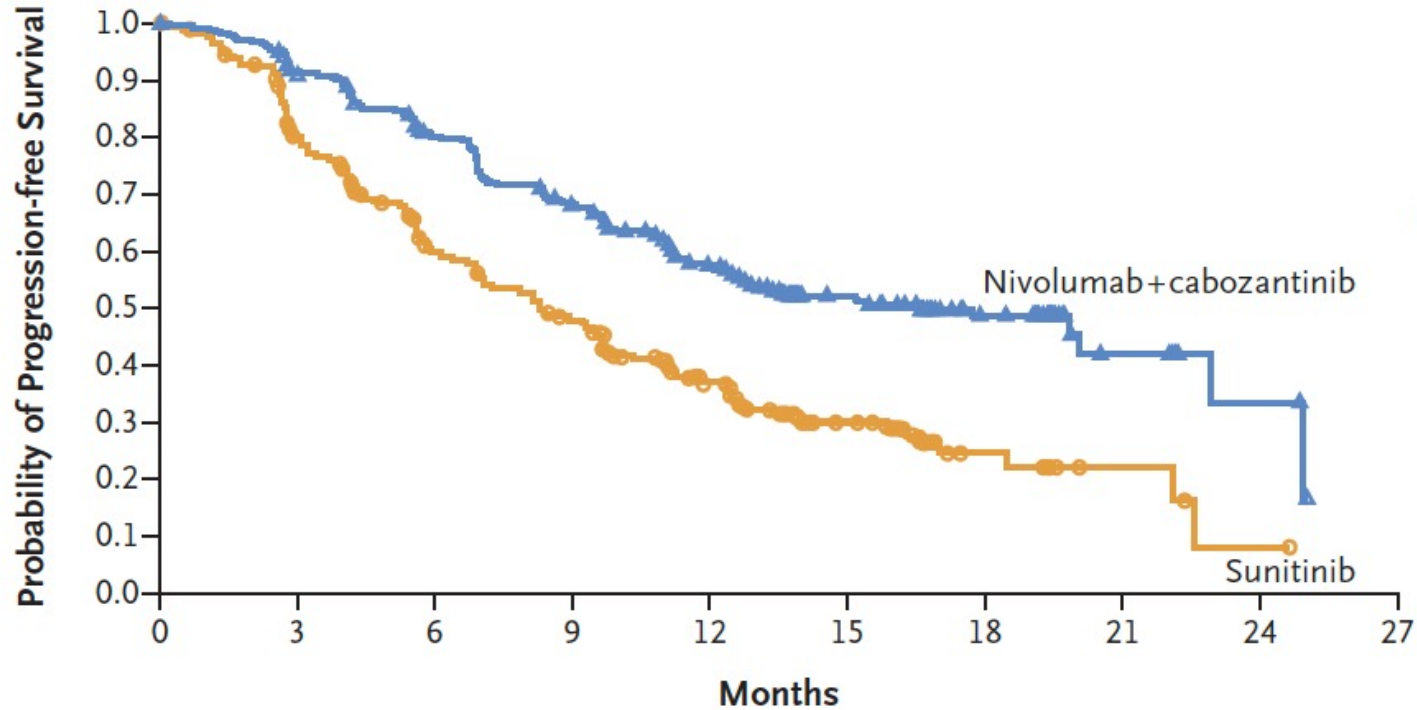
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Nivolumab plus Cabozantinib versus Sunitinib for Advanced Renal-Cell Carcinoma

T.K. Choueiri, T. Powles, M. Burotto, B. Escudier, M.T. Bourlon, B. Zurawski, V.M. Oyervides Juárez, J.J. Hsieh, U. Basso, A.Y. Shah, C. Suárez, A. Hamzaj, J.C. Goh, C. Barrios, M. Richardet, C. Porta, R. Kowalyszyn, J.P. Feregrino, J. Żołnierek, D. Pook, E.R. Kessler, Y. Tomita, R. Mizuno, J. Bedke, J. Zhang, M.A. Maurer, B. Simsek, F. Ejzykowicz, G.M. Schwab, A.B. Apolo, and R.J. Motzer, for the CheckMate 9ER Investigators*

CheckMate 9ER: Progression-Free Survival



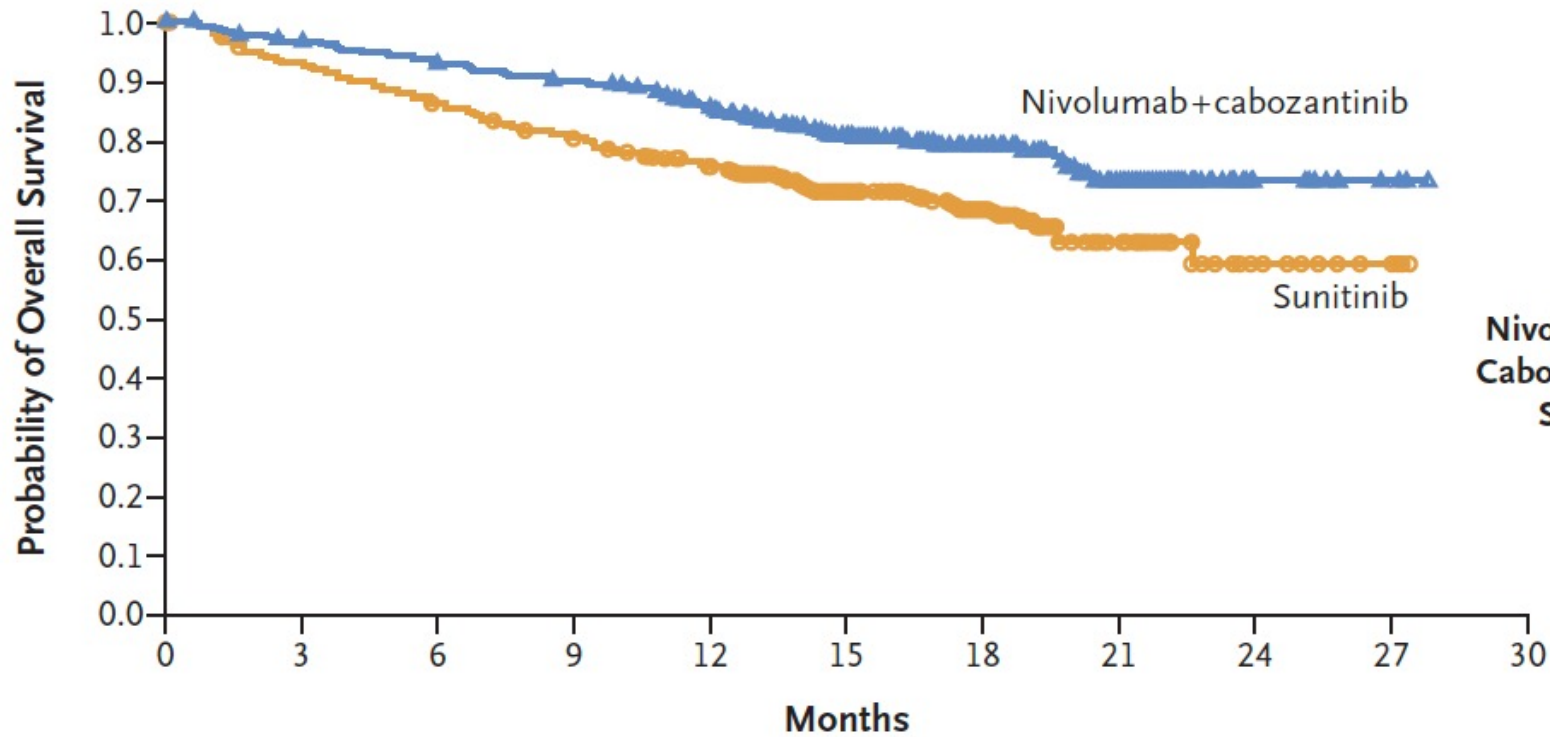
	No. of Patients	Median (95% CI) mo
Nivolumab+ Cabozantinib	323	16.6 (12.5–24.9)
Sunitinib	328	8.3 (7.0–9.7)

Hazard ratio for disease progression or death, 0.51 (95% CI, 0.41–0.64)
P<0.001

No. at Risk

	0	3	6	9	12	15	18	21	24	27
Nivolumab+cabozantinib	323	279	234	196	144	77	35	11	4	0
Sunitinib	328	228	159	122	79	31	10	4	1	0

CheckMate 9ER: Overall Survival



	No. of Patients	Median (95% CI) mo
Nivolumab+ Cabozantinib	323	NR (NE)
Sunitinib	328	NR (22.6–NE)

Hazard ratio for death, 0.60 (98.89% CI, 0.40–0.89)
P=0.001

No. at Risk

Nivolumab+cabozantinib	323	308	295	283	259	184	106	55	11	3	0
Sunitinib	328	296	273	253	223	154	83	36	10	3	0

ABSTRACT 4509: NIVOLUMAB PLUS CABOZANTINIB IN PATIENTS WITH NON-CLEAR CELL RENAL CELL CARCINOMA: RESULTS OF A PHASE 2 TRIAL



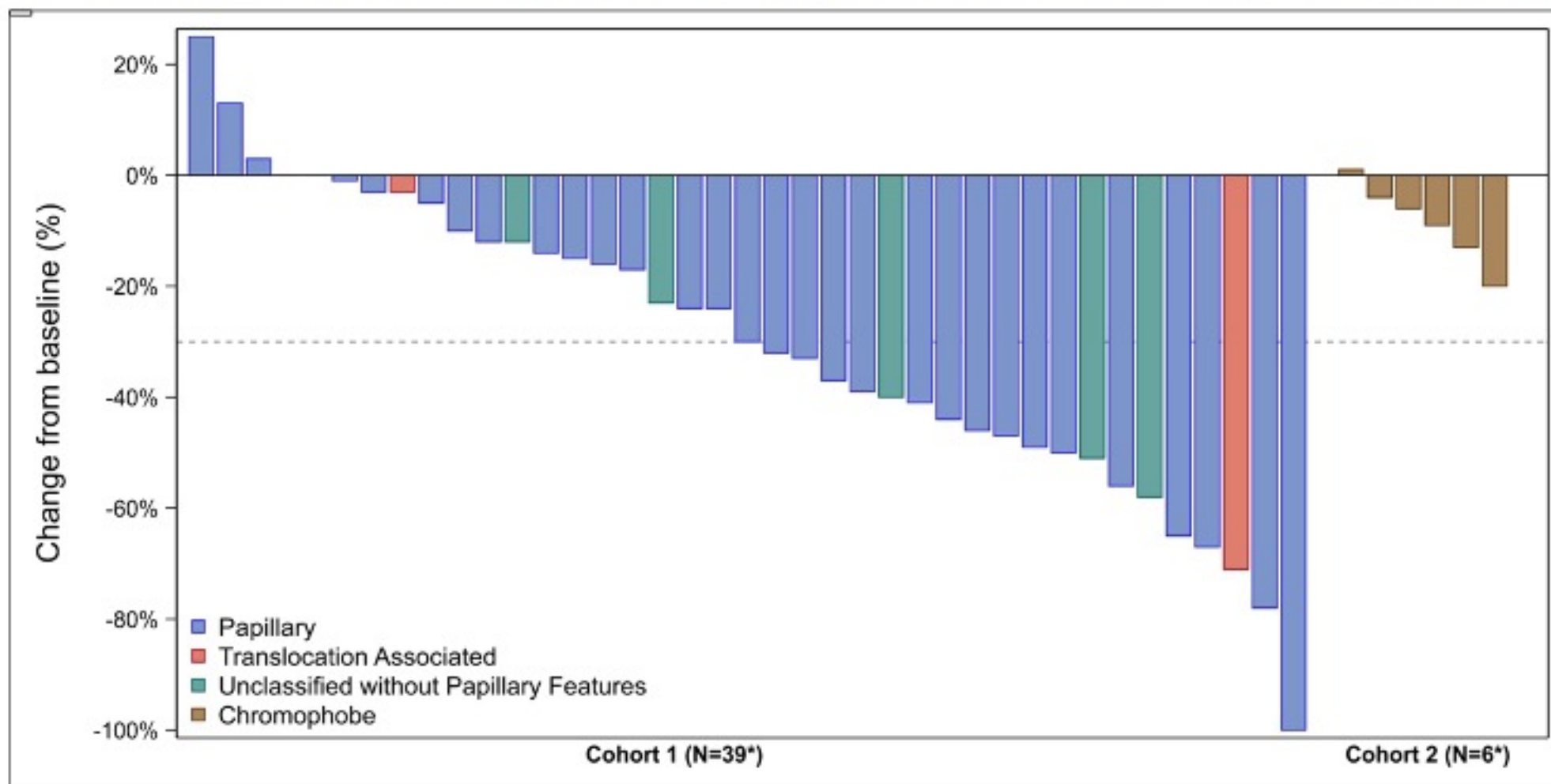
Memorial Sloan Kettering
Cancer Center™

Chung-Han Lee, Martin H Voss, Maria Isabel Carlo, Ying-Bei Chen, Ed Reznik, Andrea Knezevic, Robert A Lefkowitz, Natalie Shapnik, Diana Tassone, Chloe Dadoun, Mark Zucker, Neil J. Shah, Colette Ngozi Owens, Deaglan Joseph McHugh, David Henry Aggen, Andrew Leonard Laccetti, Ritesh Kotecha, Darren R. Feldman, Robert J. Motzer

June 6, 2021

Corresponding Author Contact:
Dr. Chung-Han Lee
leec4@mskcc.org

Maximum Change in Target Lesions by Histology

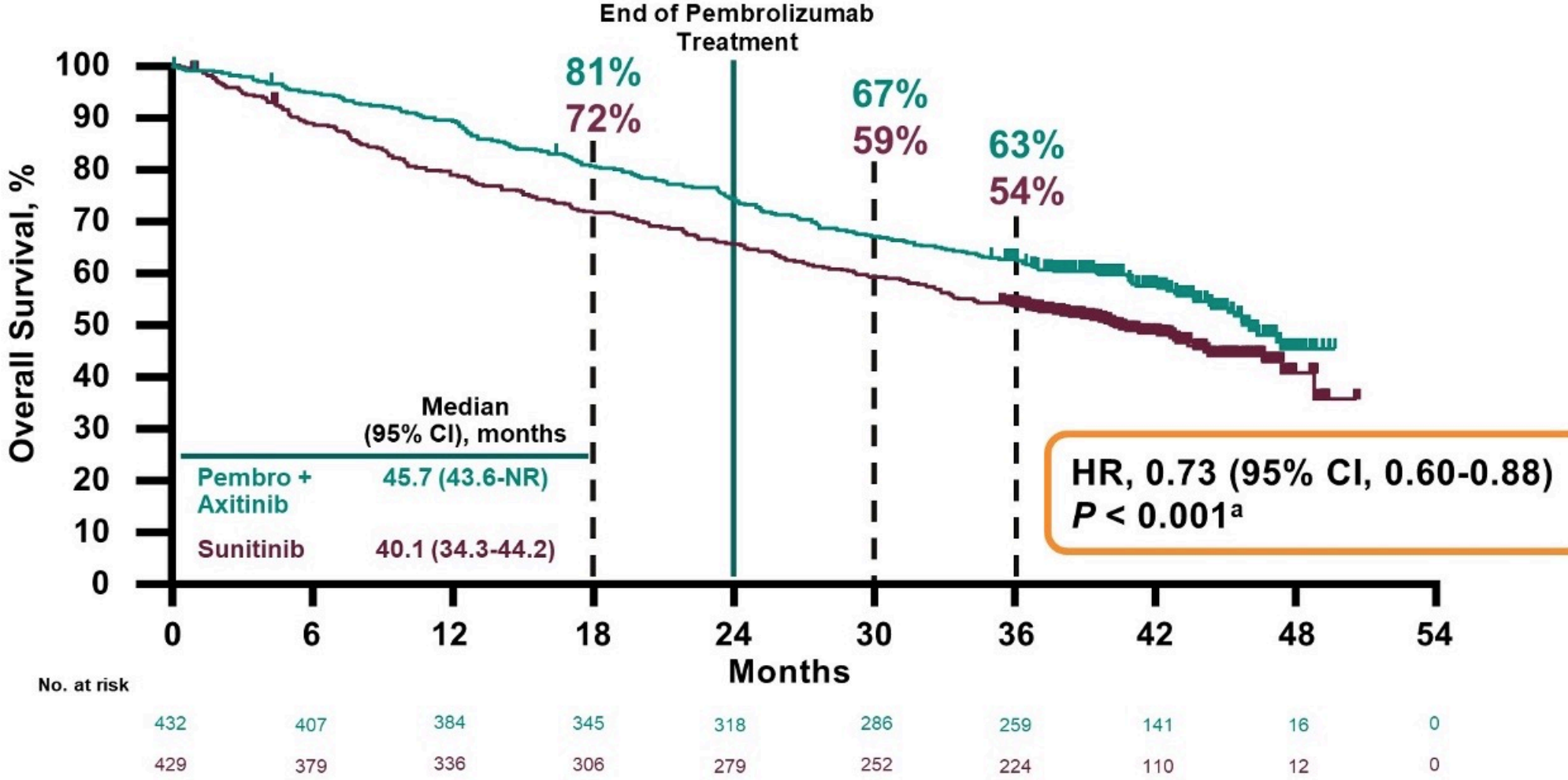


Pembrolizumab Plus Axitinib Versus Sunitinib as First-Line Therapy for Advanced Clear Cell Renal Cell Carcinoma: Results From 42-Month Follow-Up of KEYNOTE-426

B. I. Rini¹; E. R. Plimack²; V. Stus³; T. Waddell⁴; R. Gafanov⁵; F. Pouliot⁶; D. Nosov⁷; B. Melichar⁸; D. Soulieres⁹; D. Borchiellini¹⁰; I. Vynnychenko¹¹; R. S. McDermott¹²; S. J. Azevedo¹³; S. Tamada¹⁴; A. Kryzhanivska¹⁵; C. Li¹⁶; J. E. Burgents¹⁶; L. R. Molife¹⁷; J. Bedke¹⁸; T. Powles¹⁹

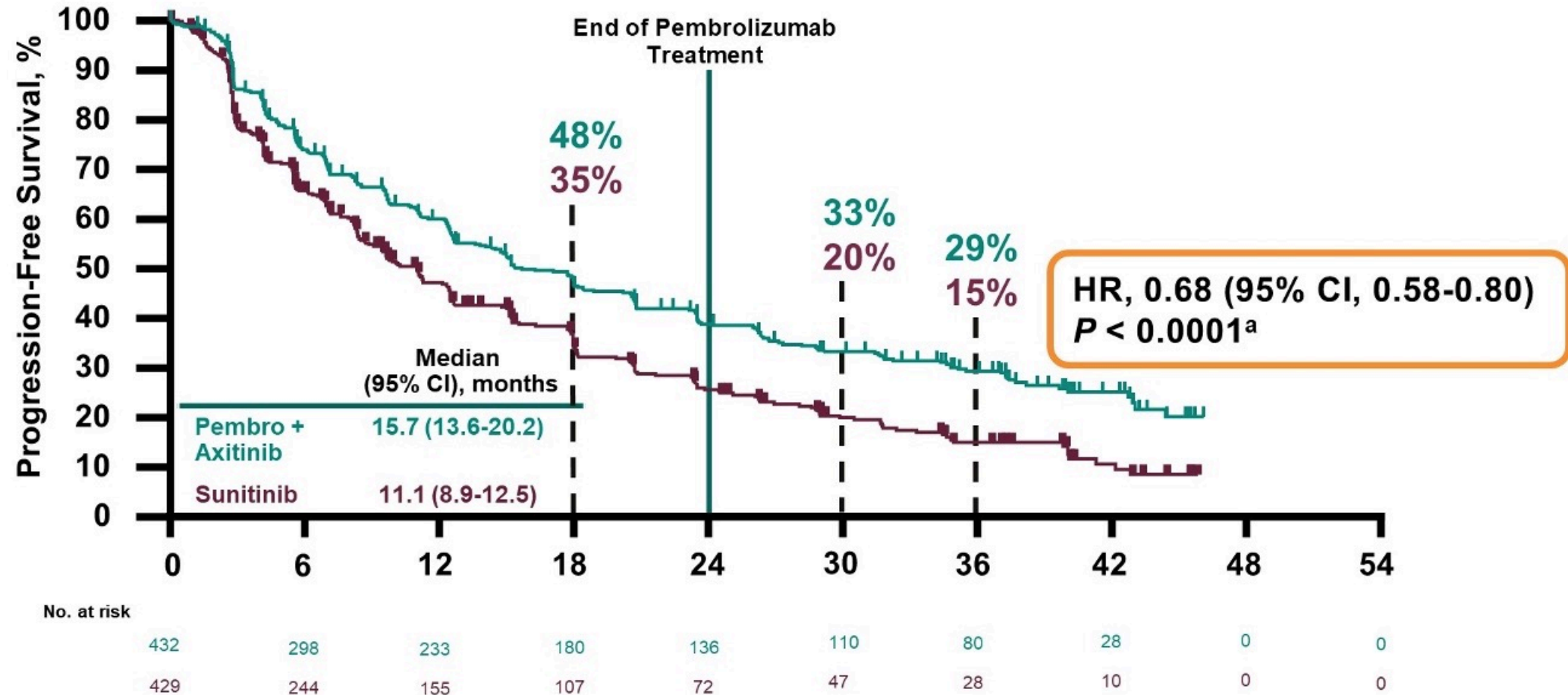
¹Vanderbilt-Ingram Cancer Center, Nashville, TN, USA; ²Fox Chase Cancer Center, Philadelphia, PA, USA; ³Dnipropetrovsk Medical Academy of Ministry of Health of Ukraine, Dnipro, Ukraine; ⁴The Christie NHS Foundation Trust, Manchester, United Kingdom; ⁵Russian Scientific Center of Roentgenradiology, Moscow, Russia; ⁶CHU of Québec and Laval University, Québec City, QC, Canada; ⁷Central Clinical Hospital With Outpatient Clinic, Moscow, Russia; ⁸Palacky University Medical School and Teaching Hospital, Olomouc, Czech Republic; ⁹Centre Hospitalier de l'Universitaire de Montréal, Montréal, QC, Canada; ¹⁰Centre Antoine Lacassagne, Université Côte d'Azur, Nice, France; ¹¹Sumy State University, Sumy Regional Oncology Center, Sumy, Ukraine; ¹²Adelaide and Meath Hospital and University College Dublin, Dublin, Ireland; ¹³Hospital de Clínicas de Porto Alegre, Porto Alegre, Brazil; ¹⁴Osaka City University Hospital, Osaka, Japan; ¹⁵Ivano-Frankivsk National Medical University, Ivano-Frankivsk, Ukraine; ¹⁶Merck & Co., Inc., Kenilworth, NJ, USA; ¹⁷MSD UK, London, United Kingdom; ¹⁸Eberhard Karls Universität Tübingen, Tübingen, Germany; ¹⁹Barts Health NHS Trust and the Royal Free NHS Foundation Trust, Barts Cancer Institute, and Queen Mary University of London, London, United Kingdom

OS in the ITT Population



^aBecause superiority of pembrolizumab + axitinib was shown at the first interim analysis, no alpha was allocated to OS; only nominal *P* values are reported. Data cutoff: January 11, 2021.

PFS in the ITT Population



^aBecause superiority of pembrolizumab + axitinib was shown at the first interim analysis, no alpha was allocated to PFS; only nominal P values are reported. Data cutoff: January 11, 2021.

ORIGINAL ARTICLE

Updated efficacy results from the JAVELIN Renal 101 trial: first-line avelumab plus axitinib versus sunitinib in patients with advanced renal cell carcinoma

T. K. Choueiri^{1*}, R. J. Motzer², B. I. Rini^{3†}, J. Haanen⁴, M. T. Campbell⁵, B. Venugopal⁶, C. Kollmannsberger⁷, G. Gravis-Mescam⁸, M. Uemura⁹, J. L. Lee¹⁰, M.-O. Grimm¹¹, H. Gurney¹², M. Schmidinger¹³, J. Larkin¹⁴, M. B. Atkins¹⁵, S. K. Pal¹⁶, J. Wang¹⁷, M. Mariani¹⁸, S. Krishnaswami¹⁹, P. Cislo²⁰, A. Chudnovsky²¹, C. Fowst¹⁸, B. Huang¹⁹, A. di Pietro²² & L. Albiges²³

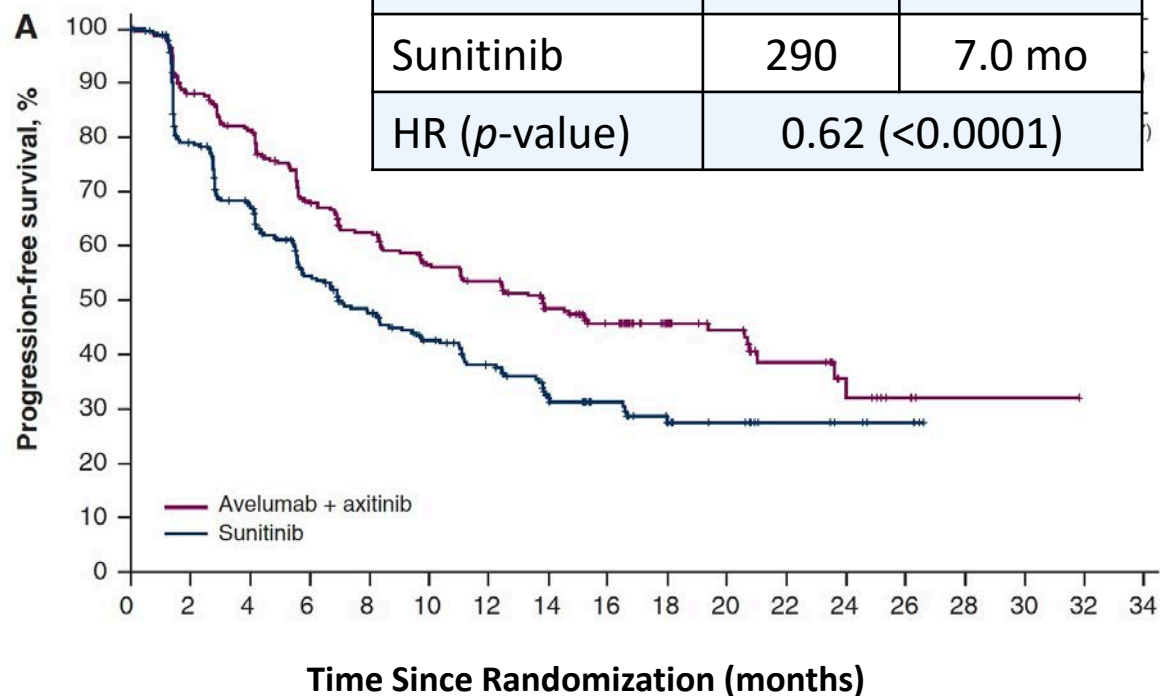
JAVELIN Renal 101: Overall Response and Best Response Rate in the PD-L1-Positive and Overall Populations

	PD-L1-positive		Overall	
	Avelumab + axitinib (n = 270)	Sunitinib (n = 290)	Avelumab + axitinib (n = 442)	Sunitinib (n = 444)
Confirmed ORR	55.9%	27.2%	52.5%	27.3%
CR	5.6%	2.4%	3.8%	2.0%
PR	50.4%	24.8%	48.6%	25.2%
Stable disease	27.0%	41.4%	28.3%	43.7%
Progressive disease	11.5%	22.4%	12.4%	19.4%
Ongoing response	55.6%	53.2%	54.3%	50.4%

JAVELIN Renal 101: PFS in the PD-L1-Positive and Overall Populations

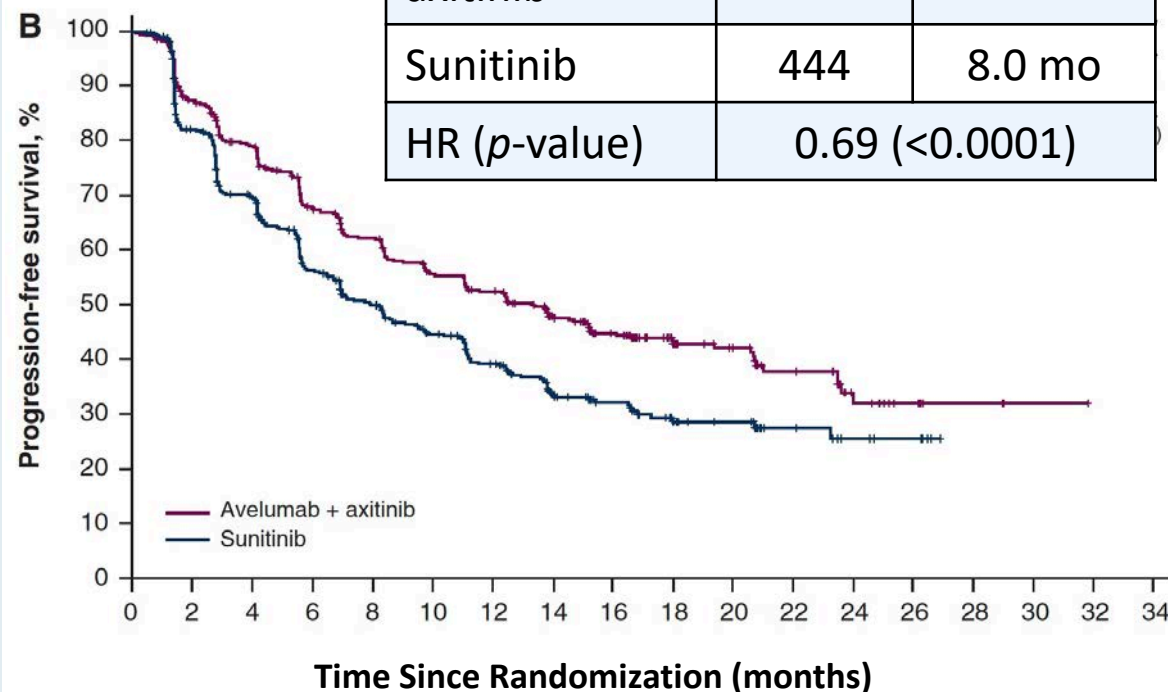
PD-L1 \geq 1% Population

	N	mPFS
Avelumab + axitinib	270	13.8 mo
Sunitinib	290	7.0 mo
HR (<i>p</i> -value)	0.62 (<0.0001)	



Overall Population

	N	mPFS
Avelumab + axitinib	442	13.3 mo
Sunitinib	444	8.0 mo
HR (<i>p</i> -value)	0.69 (<0.0001)	



FDA Approves Lenvatinib with Pembrolizumab for Advanced RCC

Press Release – August 10, 2021

“The Food and Drug Administration approved the combination of lenvatinib plus pembrolizumab for first-line treatment of adult patients with advanced renal cell carcinoma (RCC).

The efficacy of this combination was investigated in CLEAR (Study 307/KEYNOTE-581; NCT02811861), a multicenter, open-label, randomized phase 3 trial in patients with advanced RCC in the first-line setting. Patients were enrolled regardless of PD-L1 tumor expression status.

The recommended dosages for patients with advanced RCC are lenvatinib 20 mg orally once daily with pembrolizumab 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks or 400 mg administered as an intravenous infusion over 30 minutes every 6 weeks up to 2 years, until disease progression or until unacceptable toxicity.”

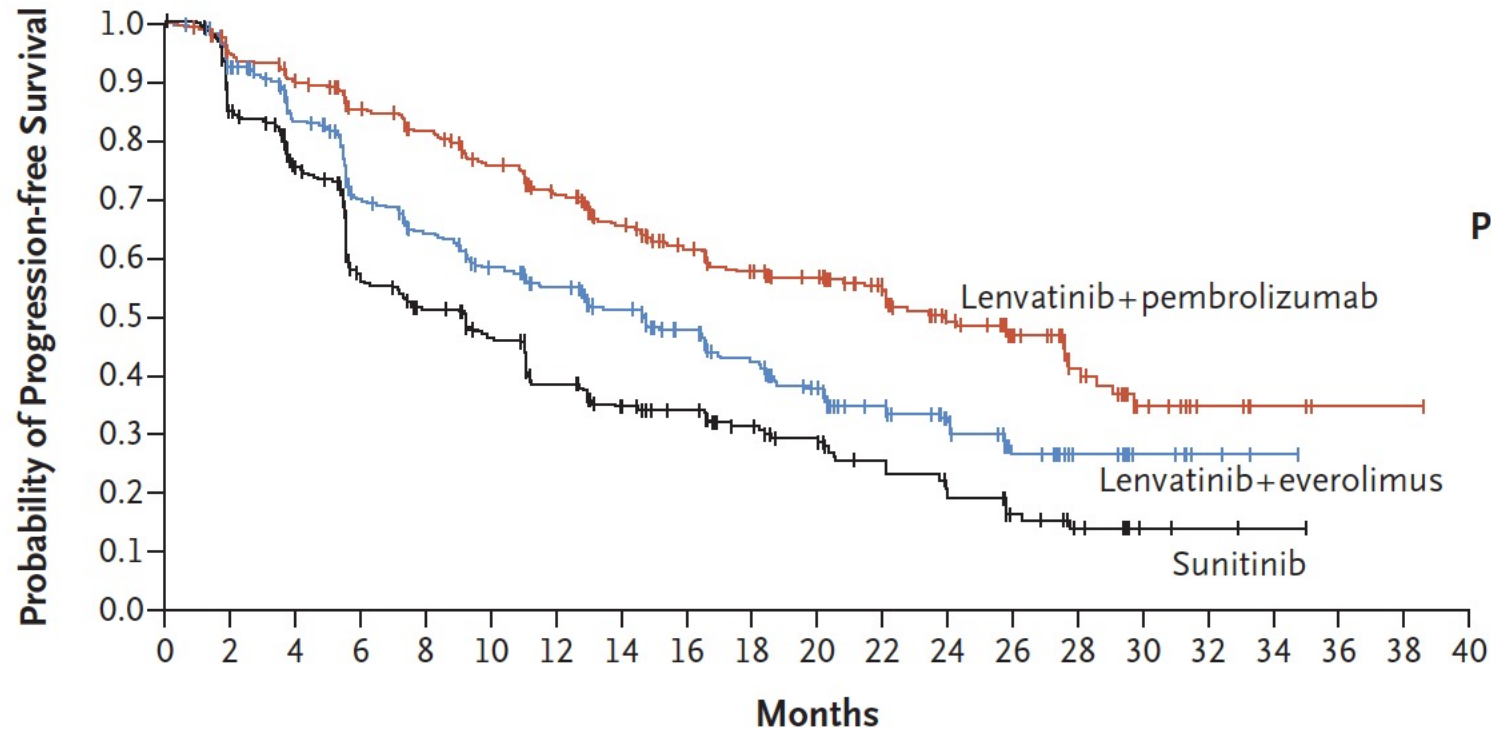
ORIGINAL ARTICLE

Lenvatinib plus Pembrolizumab or Everolimus for Advanced Renal Cell Carcinoma

R. Motzer, B. Alekseev, S.-Y. Rha, C. Porta, M. Eto, T. Powles, V. Grünwald, T.E. Hutson, E. Kopyltsov, M.J. Méndez-Vidal, V. Kozlov, A. Alyasova, S.-H. Hong, A. Kapoor, T. Alonso Gordo, J.R. Merchan, E. Winquist, P. Maroto, J.C. Goh, M. Kim, H. Gurney, V. Patel, A. Peer, G. Procopio, T. Takagi, B. Melichar, F. Rolland, U. De Giorgi, S. Wong, J. Bedke, M. Schmidinger, C.E. Dutcus, A.D. Smith, L. Dutta, K. Mody, R.F. Perini, D. Xing, and T.K. Choueiri, for the CLEAR Trial Investigators*

N Engl J Med 2021;[Online ahead of print].

CLEAR: Progression-Free Survival



	Median Progression-free Survival (95% CI) <i>mo</i>
Lenvatinib+ Pembrolizumab	23.9 (20.8–27.7)
Lenvatinib+ Everolimus	14.7 (11.1–16.7)
Sunitinib	9.2 (6.0–11.0)

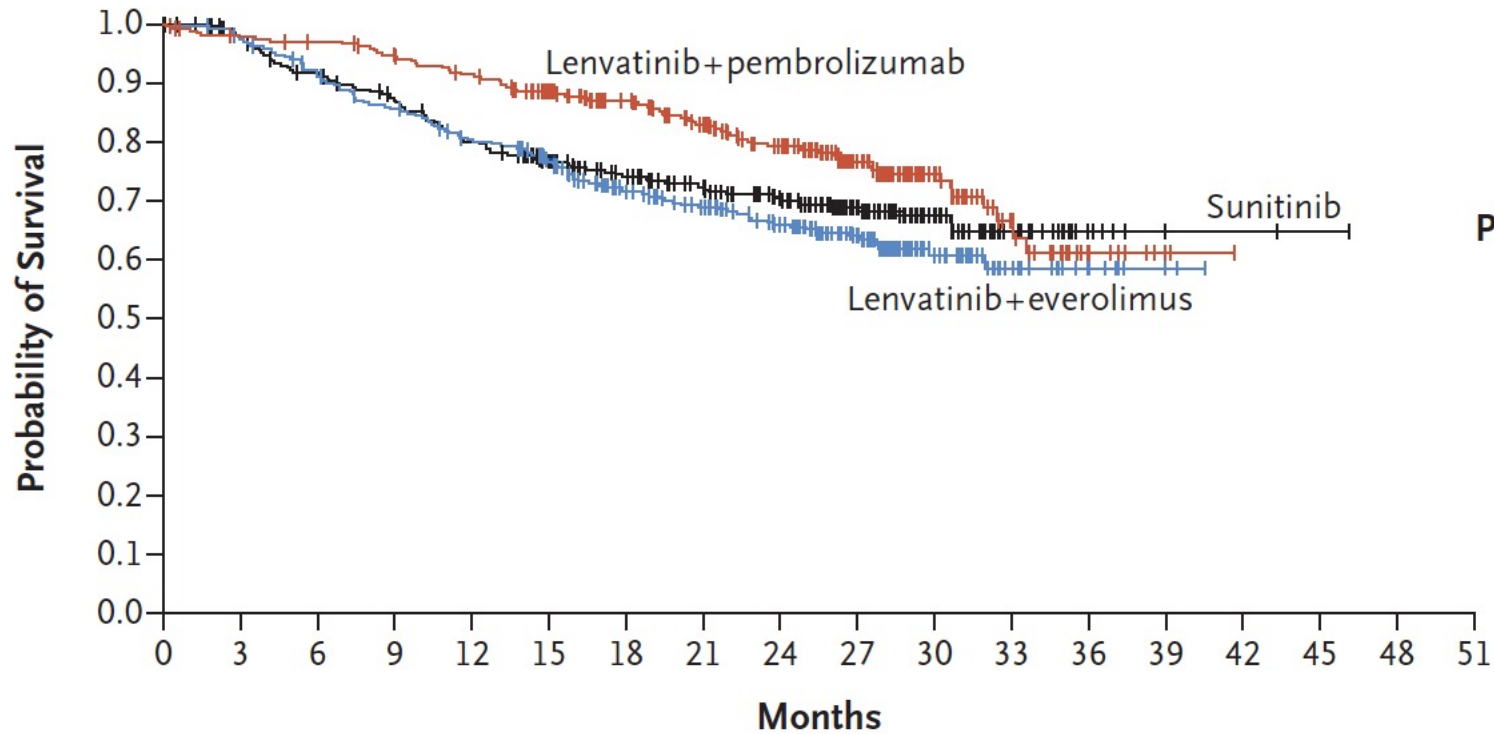
Hazard ratio for disease progression or death (lenvatinib+ pembrolizumab vs. sunitinib), 0.39 (95% CI, 0.32–0.49); P<0.001

Hazard ratio for disease progression or death (lenvatinib+ everolimus vs. sunitinib), 0.65 (95% CI, 0.53–0.80); P<0.001

No. at Risk

Lenvatinib+pembrolizumab	355	321	300	276	259	235	213	186	160	136	126	106	80	56	30	14	6	3	1	1	0
Lenvatinib+everolimus	357	305	259	207	185	163	149	125	105	85	70	53	37	20	13	7	3	1	0		
Sunitinib	357	262	218	145	124	107	85	69	62	49	42	32	25	16	9	3	2	1	0		

CLEAR: Overall Survival



	Median Overall Survival (95% CI) <i>mo</i>
Lenvatinib+ Pembrolizumab	NR (33.6–NE)
Lenvatinib+ Everolimus	NR (NE–NE)
Sunitinib	NR (NE–NE)

Hazard ratio for death (lenvatinib+ pembrolizumab vs. sunitinib), 0.66 (95% CI, 0.49–0.88); P=0.005

Hazard ratio for death (lenvatinib+ everolimus vs. sunitinib), 1.15 (95% CI, 0.88–1.50); P=0.30

No. at Risk

Lenvatinib+pembrolizumab	355	342	338	327	313	280	253	222	188	129	66	26	10	2	0		
Lenvatinib+everolimus	357	346	321	299	277	246	205	183	154	109	46	22	8	2	0		
Sunitinib	357	332	307	289	264	236	207	186	160	112	60	25	7	2	2	1	0

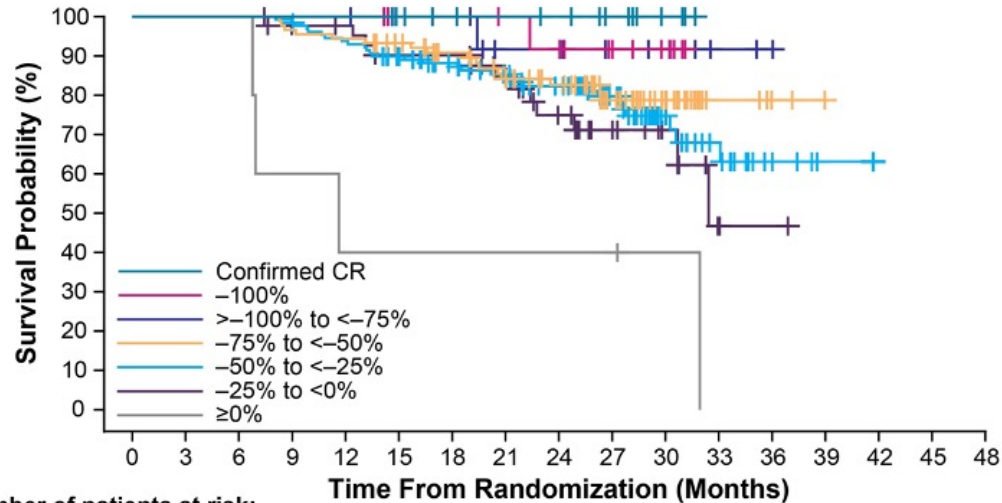
ANALYSIS OF THE CLEAR STUDY IN PATIENTS WITH ADVANCED RENAL CELL CARCINOMA: DEPTH OF RESPONSE AND EFFICACY FOR SELECTED SUBGROUPS IN THE LENVATINIB-PLUS-PEMBROLIZUMAB AND SUNITINIB TREATMENT ARMS

Viktor Grünwald¹, Thomas Powles², Evgeny Kopyltsov³, Vadim Kozlov⁴, Teresa Alonso Gordo⁵, Masatoshi Eto⁶, Thomas Hutson⁷, Robert Motzer⁸, Eric Winquist⁹, Pablo Maroto¹⁰, Bhumsuk Keam¹¹, Giuseppe Procopio¹², Shirley Wong¹³, Bohuslav Melichar¹⁴, Frederic Rolland¹⁵, Mototsugu Oya¹⁶, Karla Rodriguez-Lopez¹⁷, Kenichi Saito¹⁸, Alan Smith¹⁹, Camillo Porta²⁰

¹University Hospital Essen, Essen, Germany; ²The Royal Free NHS Trust, London, England, UK; ³State Institution of Healthcare “Regional Clinical Oncology Dispensary”, Omsk, Russia; ⁴State Budgetary Health Care Institution “Novosibirsk Regional Clinical Oncology Dispensary”, Novosibirsk, Russia; ⁵Hospital Universitario Ramón y Cajal, Madrid, Spain; ⁶Kyushu University, Fukuoka, Japan; ⁷Texas Oncology, Dallas, TX, USA; ⁸Memorial Sloan Kettering Cancer Center, New York, NY, USA; ⁹Western University, London, Ontario, Canada; ¹⁰Hospital de la Santa Creu i Sant Pau, Barcelona, Spain; ¹¹Seoul National University Hospital, Seoul, Korea; ¹²Fondazione IRCCS Istituto Nazionale dei Tumori di Milano, Milan, Italy; ¹³Western Health, VIC, Australia; ¹⁴Palacký University Medical School and Teaching Hospital, Olomouc, Czech Republic; ¹⁵Centre René Gauducheau Centre de Lutte Contre Le Cancer Nantes, Saint-Herblain, France; ¹⁶Keio University School of Medicine, Tokyo, Japan; ¹⁷Merck & Co., Inc., Kenilworth, NJ, USA; ¹⁸Eisai Inc., Woodcliff Lake, NJ, USA; ¹⁹Eisai Ltd., Hatfield, England, UK; ²⁰San Matteo University Hospital Foundation, Pavia, Italy.

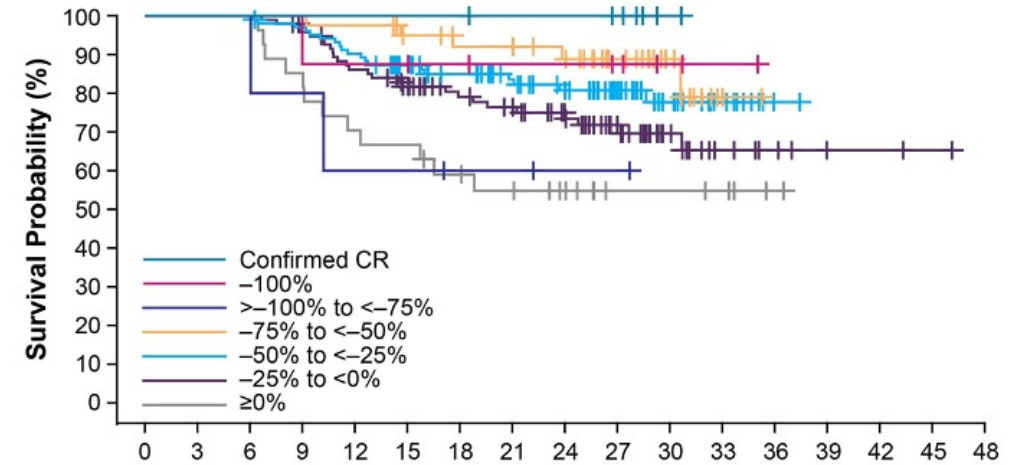
CLEAR: 6-Month OS Analysis by Depth of Response

Lenvatinib plus Pembrolizumab



Number of patients at risk:	Time From Randomization (Months)																
	0	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48
Confirmed CR	16	16	16	16	14	12	11	10	7	3	0	0	0	0	0	0	0
-100%	20	20	20	20	17	14	12	11	8	5	0	0	0	0	0	0	0
>-100% to <-75%	16	16	16	13	13	9	9	6	5	2	1	0	0	0	0	0	0
-75% to <-50%	89	86	84	78	70	61	54	37	20	5	2	0	0	0	0	0	0
-50% to <-25%	129	128	120	108	96	88	76	53	23	14	5	1	0	0	0	0	0
-25% to <0%	44	40	39	35	35	29	21	13	8	2	1	0	0	0	0	0	0
≥0%	5	3	2	2	2	2	2	2	1	0	0	0	0	0	0	0	0

Sunitinib



Number of patients at risk:	Time From Randomization (Months)																
	0	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48
Confirmed CR	7	7	7	7	7	7	6	6	5	1	0	0	0	0	0	0	0
-100%	8	8	7	7	6	5	5	4	2	1	0	0	0	0	0	0	0
>-100% to <-75%	5	4	3	3	2	2	1	1	0	0	0	0	0	0	0	0	0
-75% to <-50%	40	40	39	35	32	32	28	19	10	2	0	0	0	0	0	0	0
-50% to <-25%	103	99	92	80	71	61	53	39	21	9	1	0	0	0	0	0	0
-25% to <0%	96	90	80	71	60	56	47	34	17	9	5	2	2	1	0	0	0
≥0%	27	23	19	18	15	13	10	5	5	4	1	0	0	0	0	0	0

Among patients treated with lenvatinib plus pembrolizumab, all those who had a complete response were alive at 2 years; survival rates were similar for patients who had more than 75% reduction in target lesions.

Tumors assessed by Independent Review Committee per RECIST v1.1

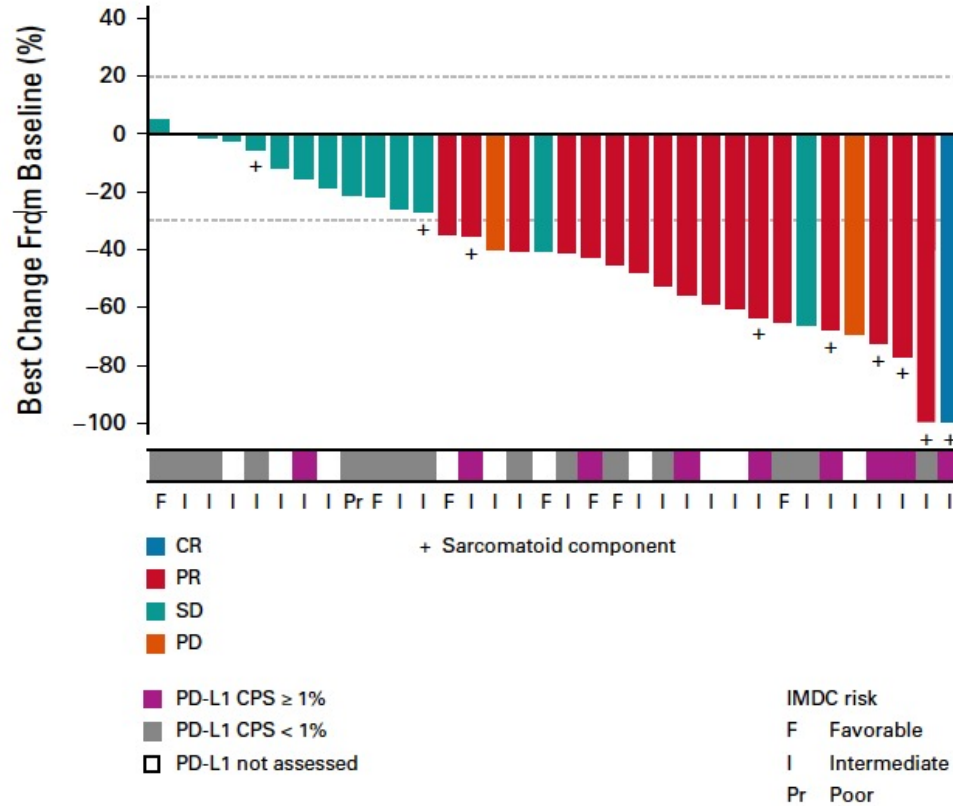
Cabozantinib in Combination With Atezolizumab for Advanced Renal Cell Carcinoma: Results From the COSMIC-021 Study

Sumanta K. Pal, MD¹; Bradley McGregor, MD²; Cristina Suárez, MD³; Che-Kai Tsao, MD⁴; William Kelly, DO⁵; Ulka Vaishampayan, MD^{6,7}; Lance Pagliaro, MD⁸; Benjamin L. Maughan, MD⁹; Yohann Loriot, MD¹⁰; Daniel Castellano, MD¹¹; Sandy Srinivas, MD¹²; Rana R. McKay, MD¹³; Robert Dreicer, MD¹⁴; Thomas Hutson, DO¹⁵; Sarita Dubey, MD¹⁶; Scott Werneke, PhD¹⁷; Ashok Panneerselvam, PhD¹⁷; Dominic Curran, MBChB¹⁷; Christian Scheffold, MD¹⁷; Toni K. Choueiri, MD²; and Neeraj Agarwal, MD⁹

J Clin Oncol 2021;[Online ahead of print].

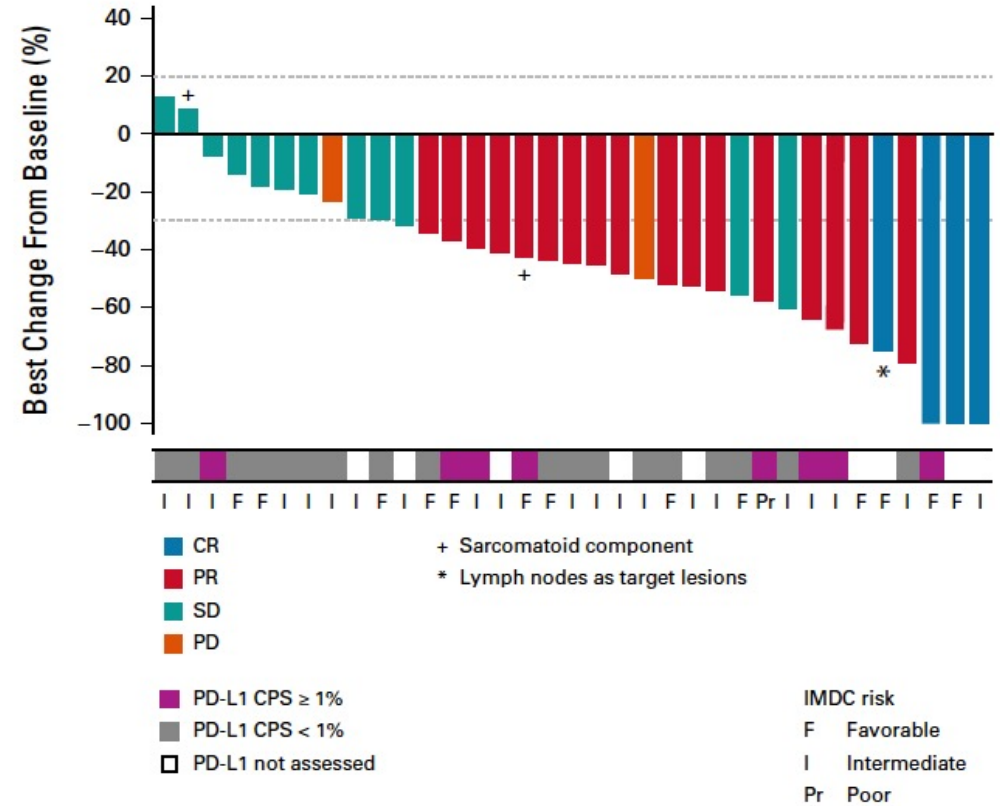
COSMIC-021: Cabozantinib/Atezolizumab for Previously Untreated Advanced ccRCC

Cabozantinib 40mg + Atezolizumab (n = 34)



ORR: 53%
mPFS: 19.5 mo

Cabozantinib 60mg + Atezolizumab (n = 35)



ORR: 58%
mPFS: 15.1 mo

Select Ongoing Phase III Clinical Trials for Previously Untreated Metastatic RCC

Study acronym	Target accrual	Randomization	Primary endpoint	Estimated primary completion
COSMIC-313	840	<ul style="list-style-type: none"> Cabozantinib + nivolumab + ipilimumab (4 doses) → cabozantinib + nivolumab Placebo + nivolumab + ipilimumab (4 doses) → placebo + nivolumab 	PFS	Nov 2021
PDIGREE	1,046	<p>After induction nivolumab/ipilimumab</p> <ul style="list-style-type: none"> Pts with CR → Nivolumab <ul style="list-style-type: none"> Pts with non-CR or non-PD, <i>randomized</i> → Nivolumab → Nivolumab + cabozantinib Pts with PD → Cabozantinib 	OS	Sept 2021

Sequencing of Therapy for Patients with Relapsed/Refractory RCC; Novel Approaches under Investigation

FDA Approves Tivozanib for Relapsed or Refractory Advanced RCC

Press Release: March 10, 2021

“On March 10, 2021, the Food and Drug Administration approved tivozanib, a kinase inhibitor, for adult patients with relapsed or refractory advanced renal cell carcinoma (RCC) following two or more prior systemic therapies.

Efficacy was evaluated in TIVO-3 (NCT02627963), a randomized (1:1), open-label, multicenter trial of tivozanib versus sorafenib in patients with relapsed or refractory advanced RCC who received two or three prior systemic treatments, including at least one VEGFR kinase inhibitor other than sorafenib or tivozanib.

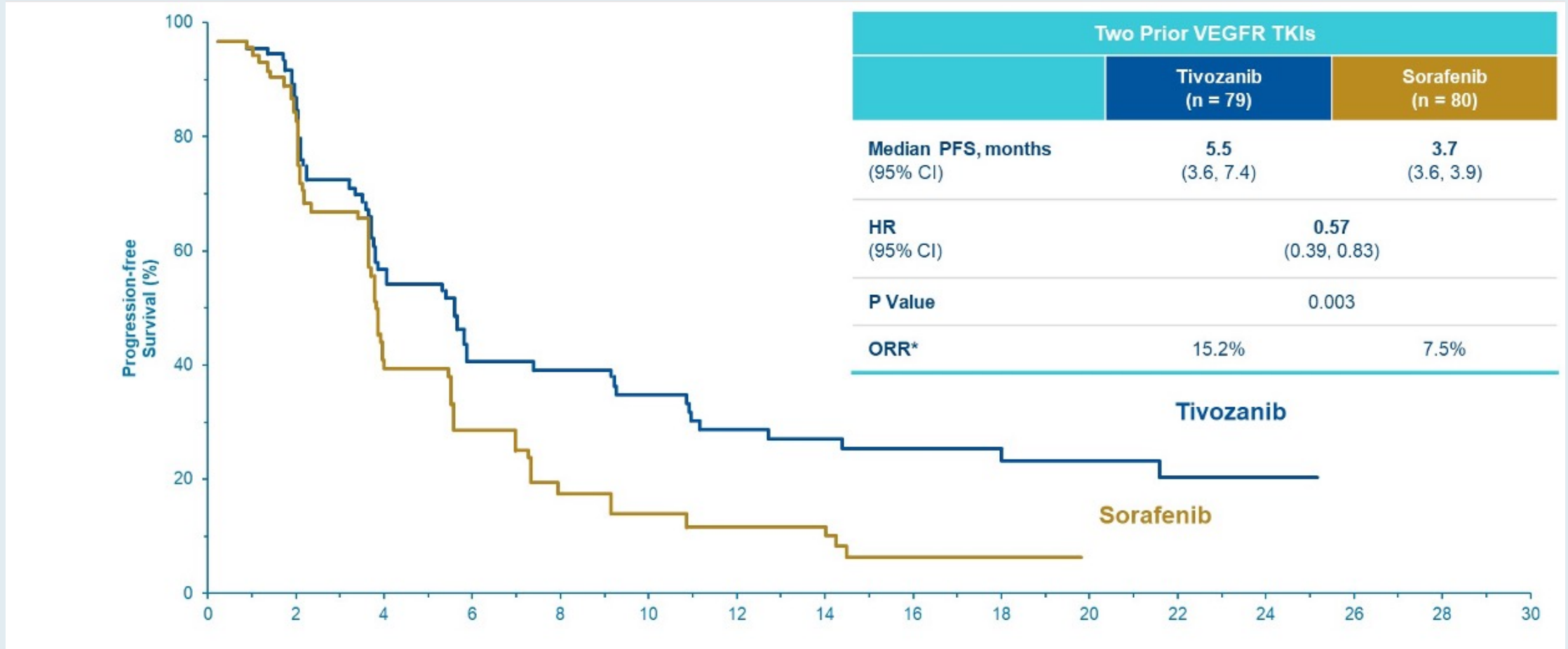
The recommended tivozanib dose is 1.34 mg once daily (with or without food) for 21 consecutive days every 28 days until disease progression or unacceptable toxicity.”

Tivozanib in Patients with Advanced Renal Cell Carcinoma (aRCC) Who Have Progressed After Prior Treatment of Axitinib: Results from TIVO-3

Rini BI et al.

Genitourinary Cancers Symposium 2021;Abstract 278.

TIVO-3: Progression-Free Survival and ORR in Patient Subgroup with 2 Prior TKIs



TIVO-3: Tivozanib After Axitinib

RCC Population	N (subjects)		mPFS (months)		HR	ORR	
	<u>Tivo</u>	<u>Sor</u>	<u>Tivo</u>	<u>Sor</u>		<u>Tivo</u>	<u>Sor</u>
ITT	175	175	5.6	3.9	0.73	18%	8%
3 rd Line Any Prior Axitinib	47	46	5.5	3.9	0.71	16%	6%
4 th Line Any Prior Axitinib	36	43	5.5	3.6	0.64	11%	10%
3 rd and 4 th Line Any Prior Axitinib	83	89	5.5	3.7	0.68	13%	8%

TIVO-3: Durability of Response and Updated Overall Survival of Tivozanib versus Sorafenib in Metastatic Renal Cell Carcinoma (mRCC)

Verzoni et al.

ASCO 2021;Abstract 4546.

“Tivozanib demonstrated clinically meaningful and statistically significant improvement in ORR and DoR with similar OS to sorafenib in patients with highly relapsed or refractory mRCC”

- *Median DoR was 20.3 months with tivozanib, twice that observed with sorafenib*

FDA Approves Belzutifan for Cancers Associated with von Hippel-Lindau Disease

Press Release – August 13, 2021

“The Food and Drug Administration approved belzutifan, a hypoxia-inducible factor inhibitor for adult patients with von Hippel-Lindau (VHL) disease who require therapy for associated renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastomas, or pancreatic neuroendocrine tumors (pNET), not requiring immediate surgery.

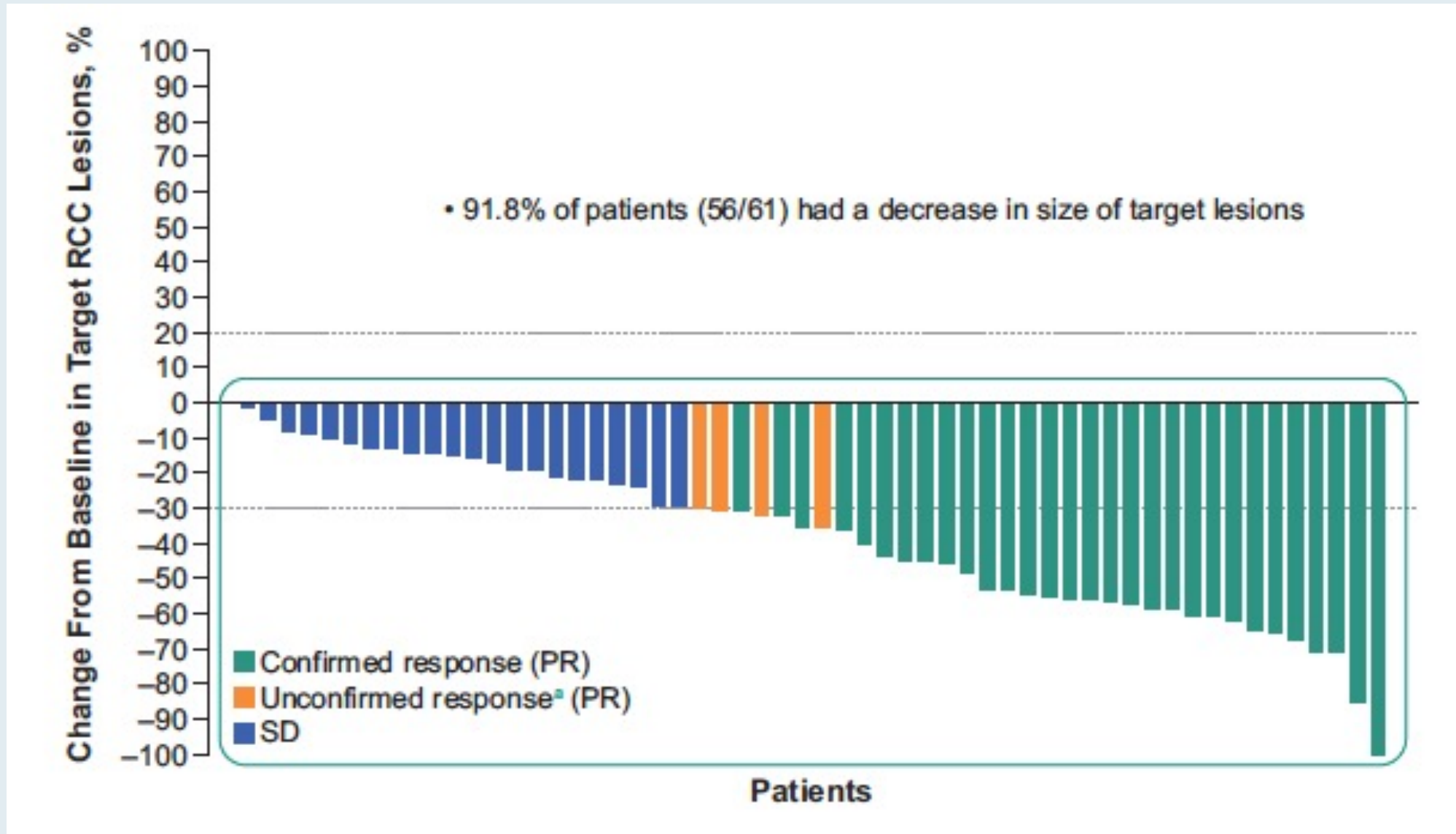
Belzutifan was investigated in the ongoing Study 004 (NCT03401788), an open-label clinical trial in 61 patients with VHL-associated RCC (VHL-RCC) diagnosed based on a VHL germline alteration and with at least one measurable solid tumor localized to the kidney. Enrolled patients had other VHL-associated tumors, including CNS hemangioblastomas and pNET. Patients received belzutifan 120 mg once daily until disease progression or unacceptable toxicity.”

Phase 2 Study of Belzutifan (MK-6482), an Oral Hypoxia-Inducible Factor 2 α (HIF-2 α) Inhibitor, for Von Hippel-Lindau (VHL) Disease-Associated Clear Cell Renal Cell Carcinoma (ccRCC)

Srinivasan R et al.

ASCO 2021;Abstract 4555.

Maximum Change from Baseline in Sum of Target RCC Lesions



Genitourinary Cancers Symposium 2021;Abstract 272.

Phase 2 Study of the Oral Hypoxia-Inducible Factor 2 α Inhibitor Belzutifan (MK-6482) in Combination With Cabozantinib in Patients With Advanced Clear Cell Renal Cell Carcinoma

Toni K. Choueiri¹; Todd M. Bauer²; David F. McDermott³; Edward Arrowsmith⁴; Ananya Roy⁵; Rodolfo Perini⁵; Donna Vickery⁵; Scott S. Tykodi⁶

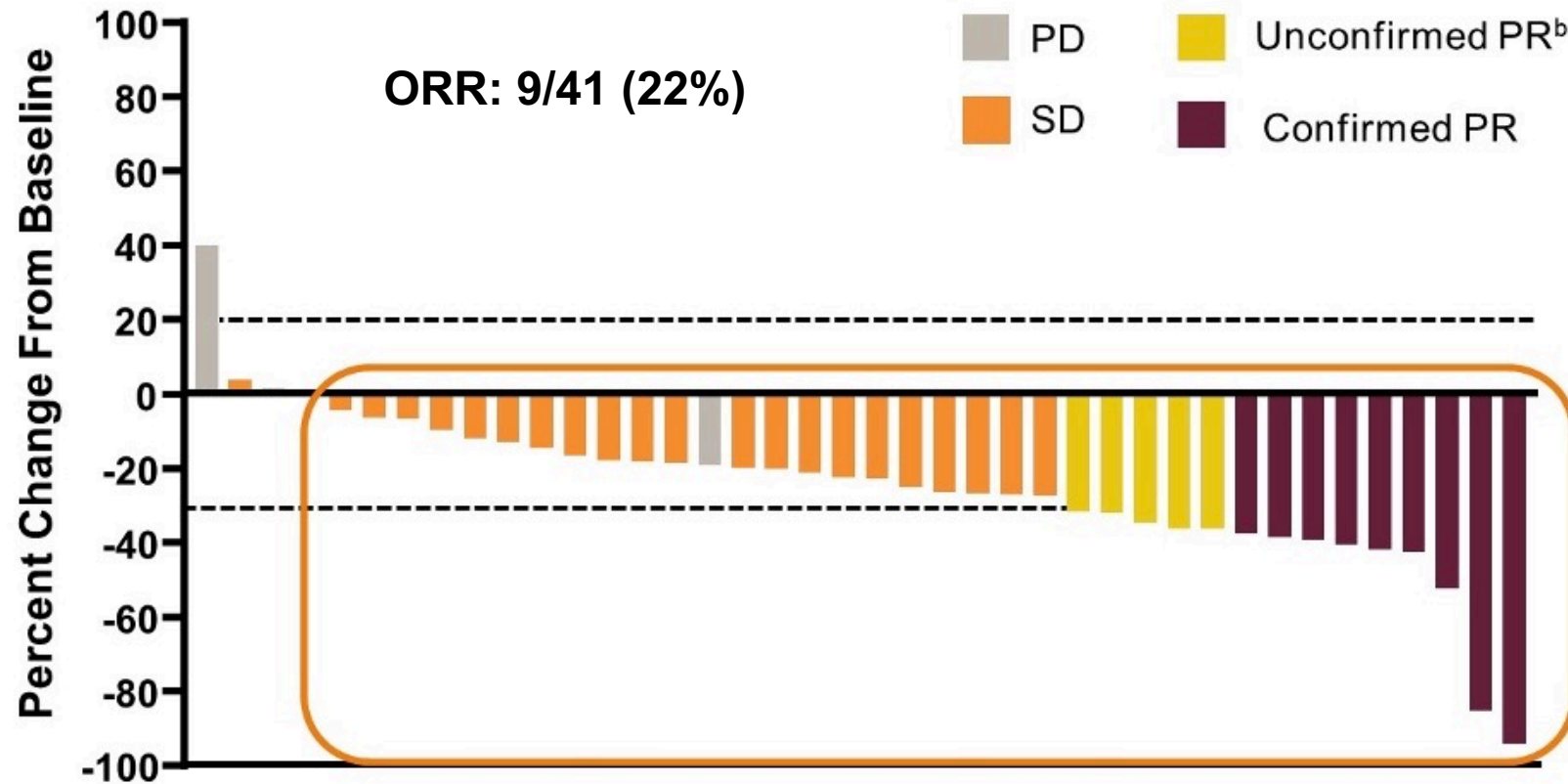
¹Dana-Farber Cancer Institute, Boston, MA, USA; ²Sarah Cannon Research Institute/Tennessee Oncology, Nashville, TN, USA;

³Beth Israel Deaconess Medical Center, Boston, MA, USA; ⁴Tennessee Oncology, Chattanooga, TN, USA;

⁵Merck & Co., Inc., Kenilworth, NJ, USA; ⁶University of Washington and Fred Hutchinson Cancer Research Center, Seattle, WA, USA

Best Tumor Change from Baseline

- 36 of 41 patients (88%) experienced a reduction in target lesion size^a



Summary of Adverse Events

n (%)	N = 52	n (%)	N = 52
Any grade treatment-emergent AE	52 (100)	Deaths due to a treatment-emergent AE	1 (2) ^c
Any grade treatment-related AE	51 (98)	Deaths due to a treatment-related AE	0 (0)
Related to belzutifan	51 (98)	Belzutifan dose reduced ^d	10 (19)
Related to cabozantinib	51 (98)	Cabozantinib dose reduced ^e	25 (48)
Grade 3-5 treatment-emergent AEs	35 (67)	Discontinued any drug due to a treatment-emergent AE	8 (15)
Grade 3 ^b treatment-related AEs	31 (60)	Discontinued belzutifan ^f	6 (12)
Related to belzutifan	17 (33)	Discontinued cabozantinib ^g	8 (15)
Related to cabozantinib	28 (54)		
Serious treatment-emergent AEs	16 (31)		
Serious treatment-related AEs	7 (13)		
Related to belzutifan	4 (8)		
Related to cabozantinib	4 (8)		

Treatment-Related Adverse Events

Treatment-Related AEs in ≥15% of Patients	Safety Analysis Set N = 52			
	Any Grade		Grade 3	
	Event, n	n (%)	Event, n	n (%)
Any	742	51 (98)	60	31 (60)
Anemia	92	40 (77)	8	6 (12)
Fatigue	67	35 (67)	10	6 (12)
Hand-foot syndrome	56	28 (54)	1	1 (2)
Diarrhea	49	23 (44)	2	2 (4)
Hypertension	52	23 (44)	15	12 (23)
Nausea	24	18 (35)	1	1 (2)
ALT increased	48	17 (33)	7	3 (6)
AST increased	34	17 (33)	2	2 (4)
Decreased appetite	22	15 (29)	1	1 (2)
Dysgeusia	19	12 (23)	1	1 (2)
Headache	12	10 (19)	0	0 (0)
Hypophosphatemia	18	9 (17)	2	2 (4)
Stomatitis	10	8 (15)	0	0 (0)

- There were no grade 4/5 treatment-related AEs
- Of all 742 AEs, 92% were grade 1 or 2 in severity
- Treatment-related hypoxia, considered an on-target AE for belzutifan, occurred in 2 patients (4%) (both were grade 3 AEs)

^aAll patients who received ≥1 dose of treatment. Data cutoff: October 15, 2020.

Identifying, Managing and Mitigating Therapy-Related Adverse Events in Patients with Chronic Lymphocytic Leukemia and Mantle Cell Lymphoma

A CME/MOC-Accredited Virtual Event

Monday, October 4, 2021

5:00 PM – 6:00 PM ET

Faculty

**Richard R Furman, MD
Lindsey Roeker, MD**

Consulting Cardiologist

Daniel J Lenihan, MD

Moderator

Neil Love, MD

Recent Advances and Future Directions in Oncology: A Daylong Multitumor Educational Webinar in Partnership with Florida Cancer Specialists

A CME-MOC/NCPD Accredited Virtual Event

Saturday, October 23, 2021

9:30 AM – 4:30 PM ET

Faculty

Tanios Bekaii-Saab, MD
Kristen K Ciombor, MD, MSCI
Brad S Kahl, MD
Mark Levis, MD, PhD
Mark D Pegram, MD

Daniel P Petrylak, MD
Noopur Raje, MD
David Sallman, MD
Lecia V Sequist, MD, MPH

Additional faculty to be announced.

Moderator

Neil Love, MD

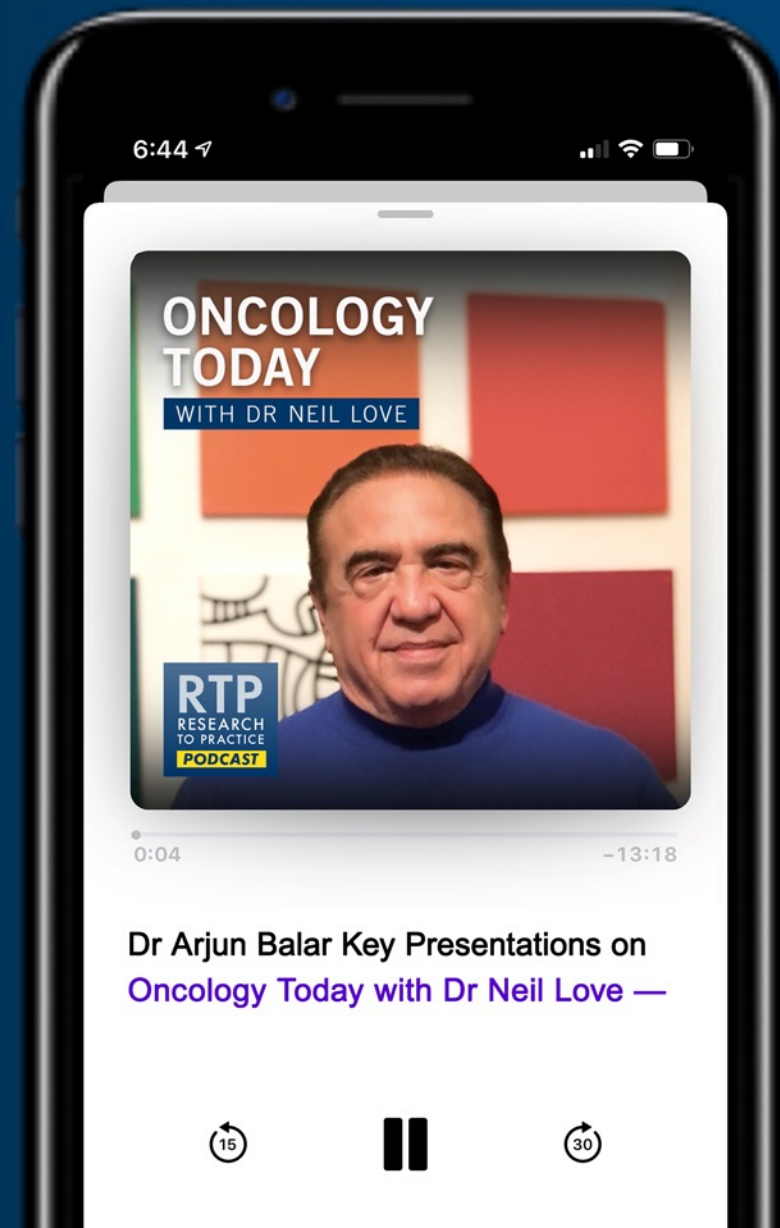
ONCOLOGY TODAY

WITH DR NEIL LOVE

Key Presentations on Genitourinary Cancers from the 2021 ASCO Annual Meeting



DR ARJUN BALAR
NYU PERLMUTTER CANCER CENTER



Thank you for joining us!

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