Inside the Issue: Integrating Targeted and Immunotherapy into the Management of Localized Non-Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Thursday, September 21, 2023
5:00 PM – 6:00 PM ET

Faculty

Jamie E Chaft, MD
John V Heymach, MD, PhD

Moderator

Neil Love, MD

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Faculty

Jamie E Chaft, MD
Associate Attending Physician
Thoracic Oncology Service
Memorial Sloan Kettering Cancer Center
New York, New York

Moderator
Neil Love, MD
Research To Practice

John V Heymach, MD, PhD
Professor and Chair
Thoracic/Head and Neck Medical Oncology
The University of Texas MD Anderson Cancer Center
Houston, Texas

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Dr Love — Disclosures

Dr Love is president and CEO of Research To Practice. Research To Practice receives funds in the form of educational grants to develop CME activities from the following companies: AbbVie Inc, Adaptive Biotechnologies Corporation, ADC Therapeutics, Agios Pharmaceuticals Inc, Alexion Pharmaceuticals, Amgen Inc, Array BioPharma Inc, a subsidiary of Pfizer Inc, Astellas, AstraZeneca Pharmaceuticals LP, Aveo Pharmaceuticals, Bayer HealthCare Pharmaceuticals, BeiGene Ltd, BeyondSpring Pharmaceuticals Inc, Blueprint Medicines, Boehringer Ingelheim Pharmaceuticals Inc, Bristol Myers Squibb, Celgene Corporation, Clovis Oncology, Coherus BioSciences, CTI BioPharma Corp, Daiichi Sankyo Inc, Eisai Inc, Elevation Oncology Inc, EMD Serono Inc, Epizyme Inc, Exact Sciences Corporation, Exelixis Inc, Five Prime Therapeutics Inc, Foundation Medicine, G1 Therapeutics Inc, Genentech, a member of the Roche Group, Genmab US Inc, Gilead Sciences Inc, Grail Inc, GSK, Halozyme Inc, Helsinn Healthcare SA, ImmunoGen Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, administered by Janssen Scientific Affairs LLC, Jazz Pharmaceuticals Inc, Karyopharm Therapeutics, Kite, A Gilead Company, Kronos Bio Inc, Legend Biotech, Lilly, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, MEI Pharma Inc, Merck, Mersana Therapeutics Inc, Mirati Therapeutics Inc, Natera Inc, Novartis, Novartis Pharmaceuticals Corporation on behalf of Advanced Accelerator Applications, Novocure Inc, Oncopeptides, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Puma Biotechnology Inc, Regeneron Pharmaceuticals Inc, R-Pharm US, Sanofi, Seagen Inc, Servier Pharmaceuticals LLC, SpringWorks Therapeutics Inc, Stemline Therapeutics Inc, Sumitomo Dainippon Pharma Oncology Inc, Taiho Oncology Inc, Takeda Pharmaceuticals USA Inc, TerSera Therapeutics LLC, Tesaro, A GSK Company, TG Therapeutics Inc, Turning Point Therapeutics Inc, Verastem Inc, and Zymeworks Inc.

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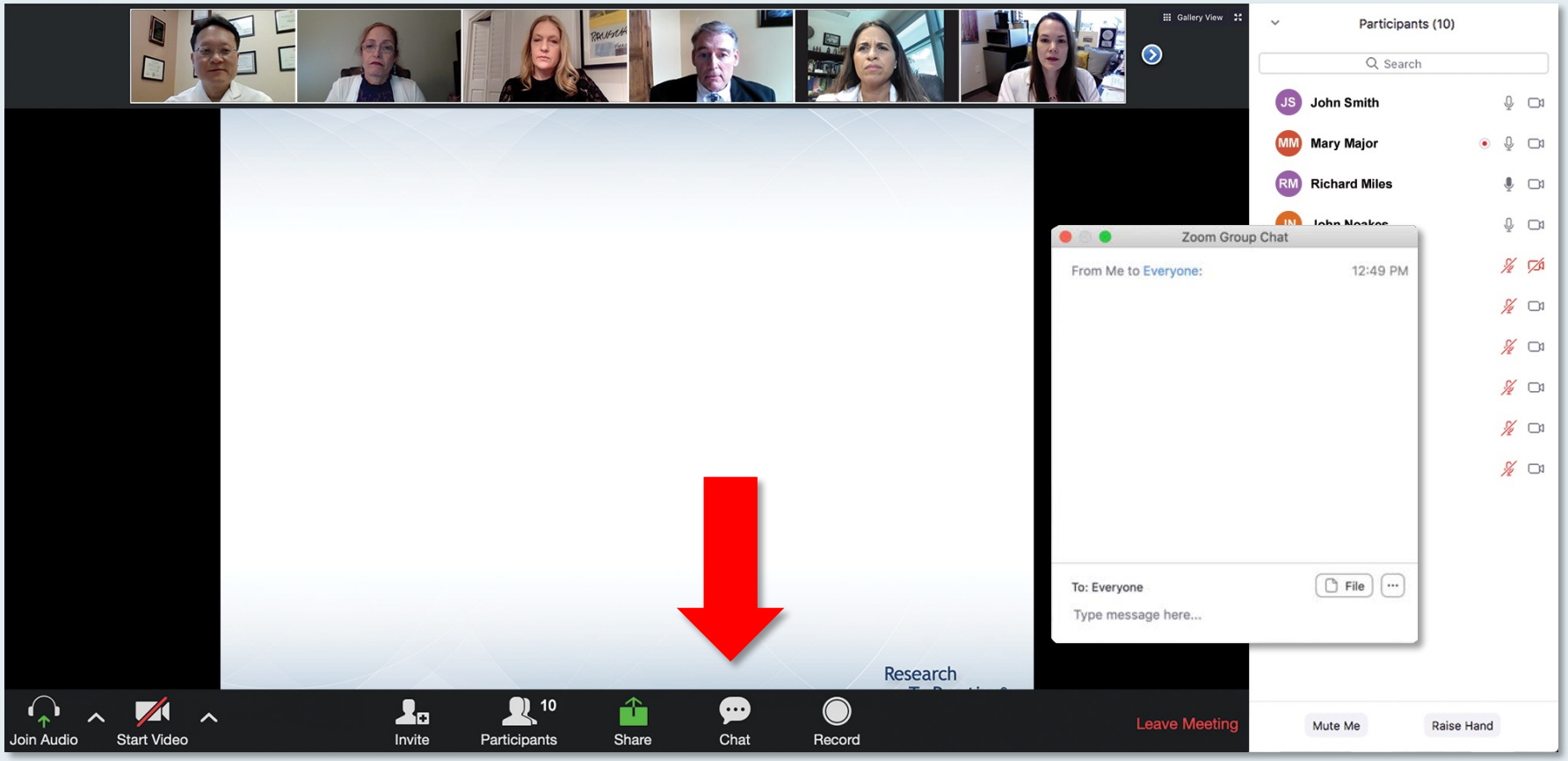

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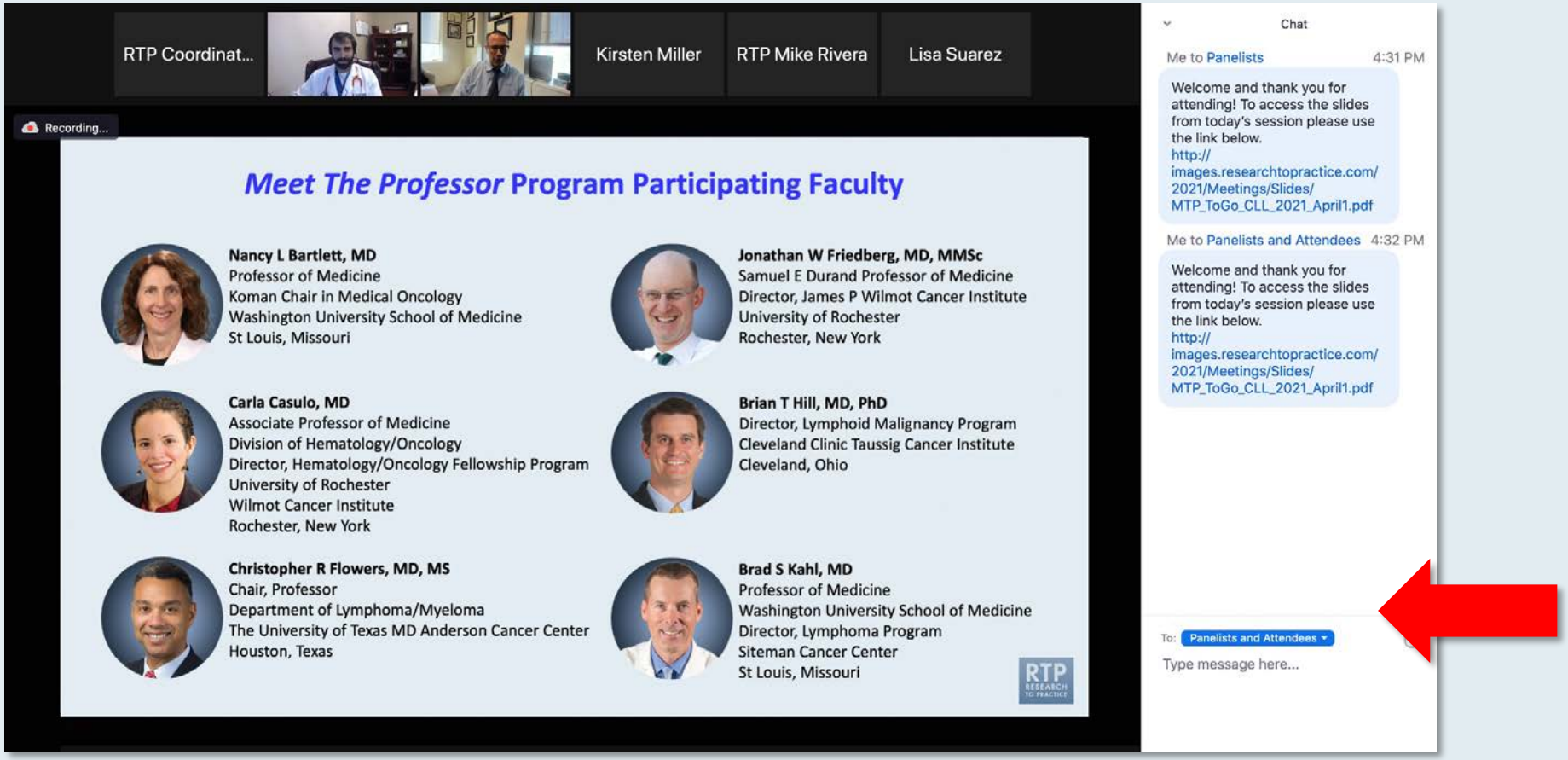

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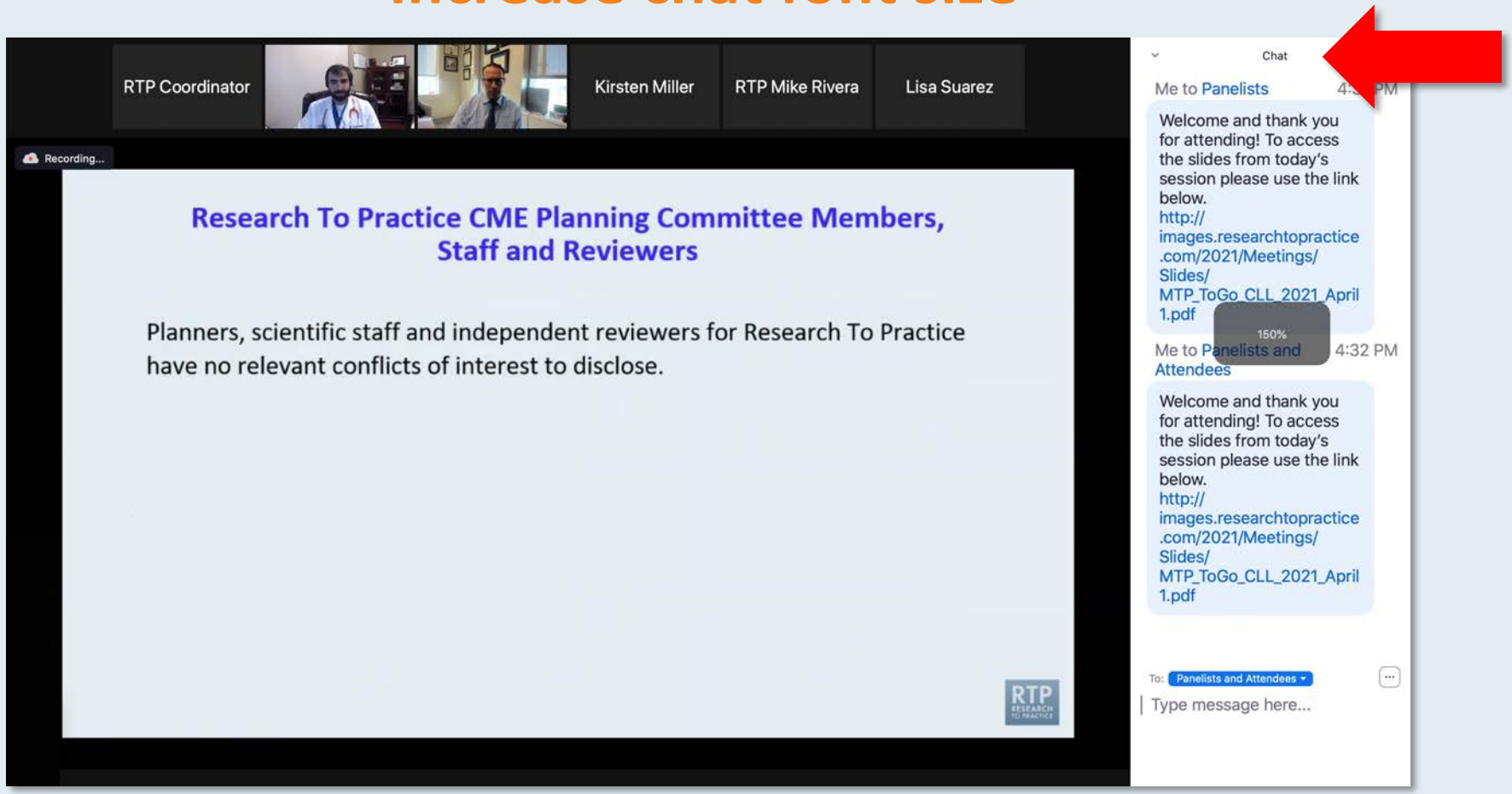

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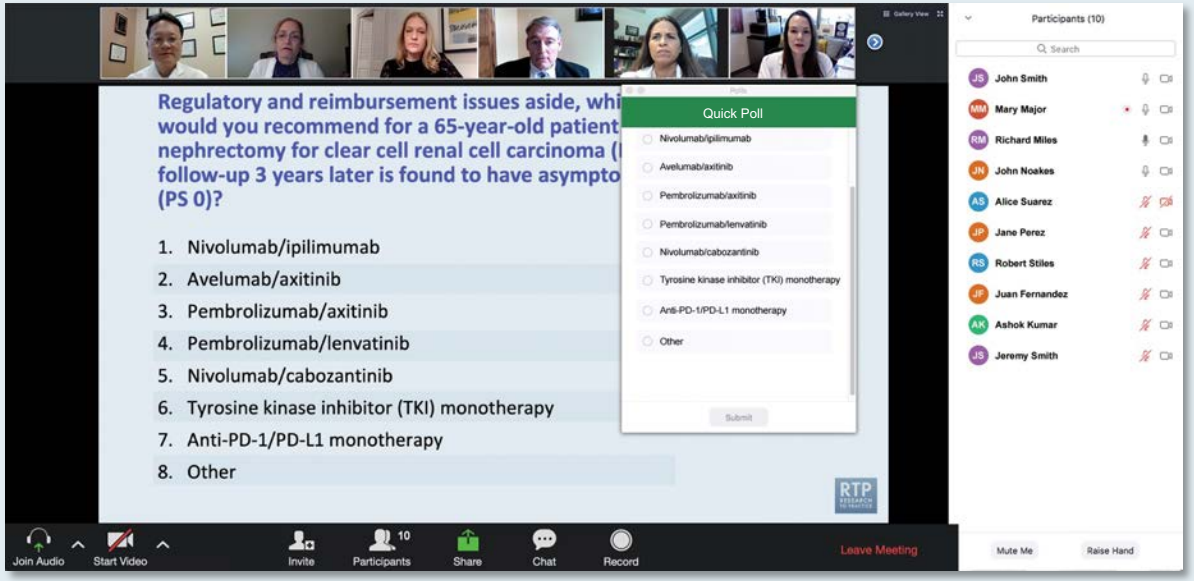

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WITH DR NEIL LOVE

Special Edition — Key Presentations on Lung Cancer from the 2023 American Society of Clinical Oncology (ASCO) Annual Meeting

DR MATTHEW GUBENS

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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What Clinicians Want to Know About the Management of Relapsed/Refractory Mantle Cell Lymphoma

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Tuesday, October 3, 2023
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Anna C Pavlick, DO, MBA

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Lymphoma

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Thank you for joining us!

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

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Survey Participants

Mark Awad, MD, PhD
Clinical Director, Lowe Center for Thoracic Oncology
Dana-Farber Cancer Institute
Assistant Professor of Medicine
Harvard Medical School
Boston, Massachusetts

Ramaswamy Govindan, MD
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Director, Section of Oncology
Anheuser-Busch Endowed Chair in Medical Oncology
Washington University School of Medicine
St Louis, Missouri

Patrick Forde, MD
Co-Director, Division of Upper Aerodigestive Malignancies
Associate Professor of Oncology
Johns Hopkins University
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Heather Wakelee, MD, FASCO
Professor of Medicine
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Stanford Cancer Institute
President, International Association for the Study of Lung Cancer (IASLC)
Stanford, California

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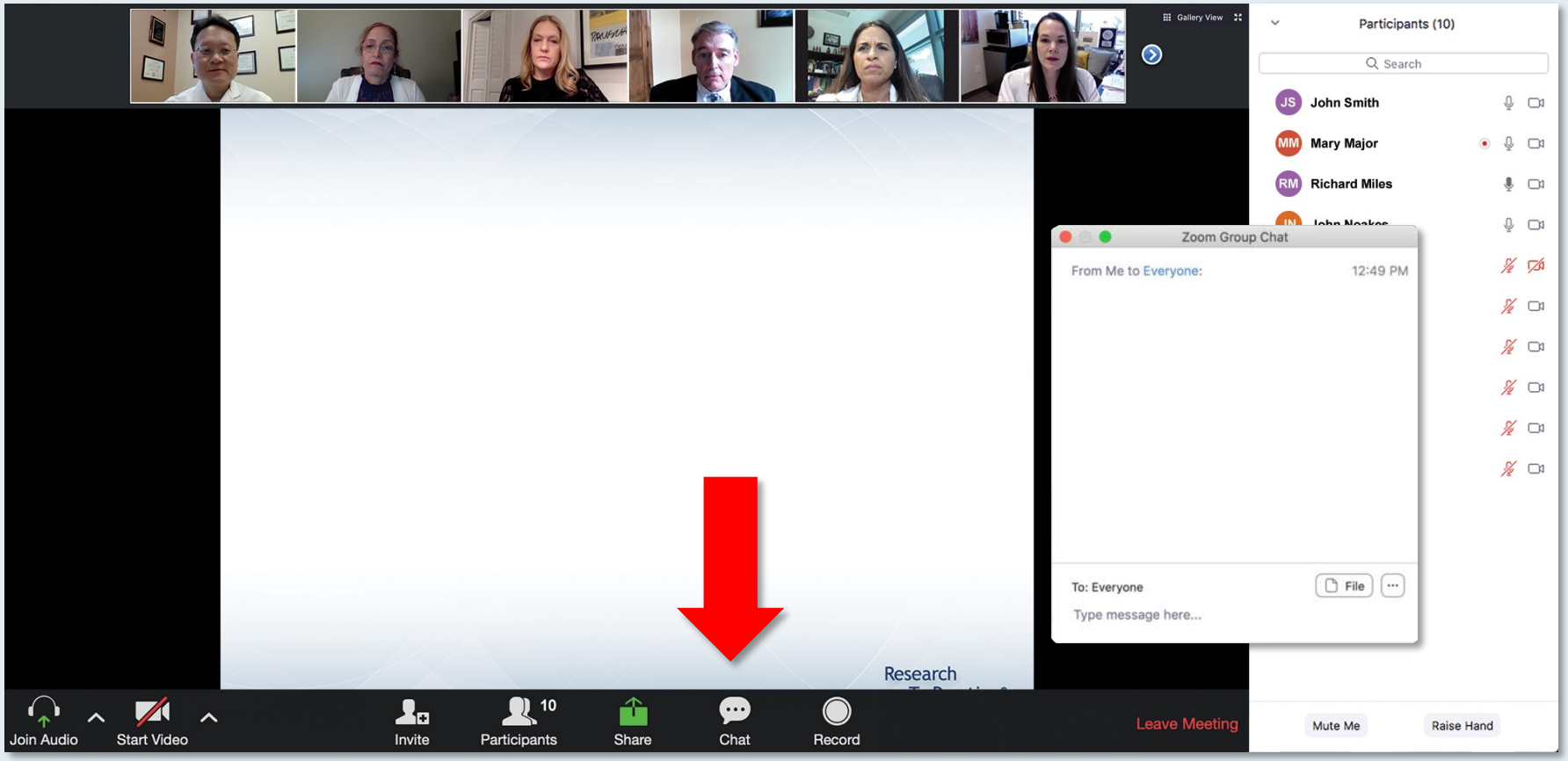

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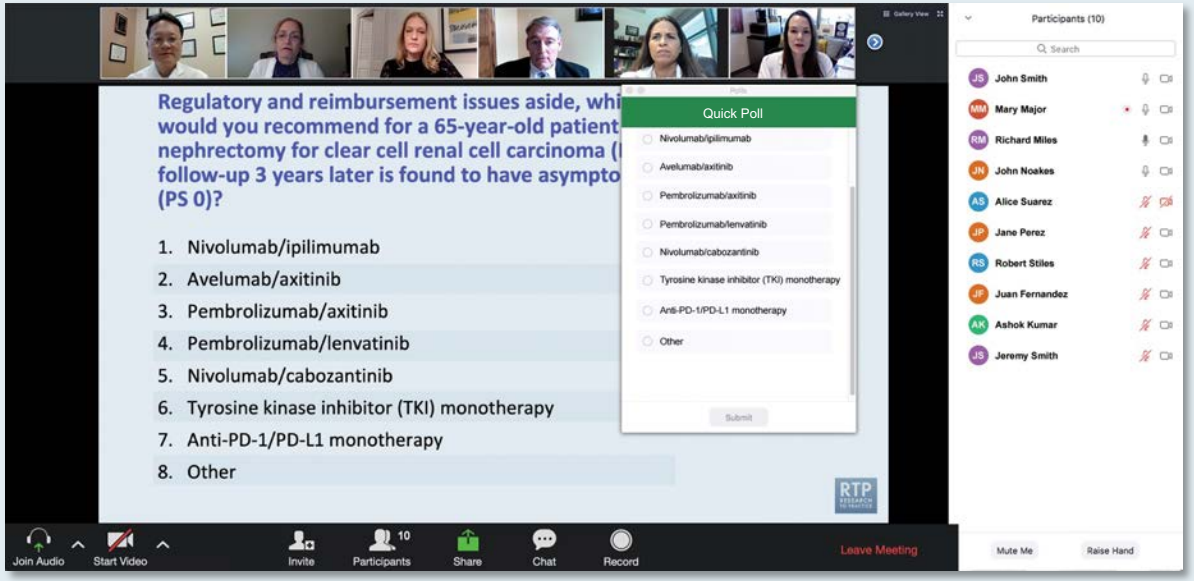

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John Heymach MD, PhD
Chair, Thoracic/Head and Neck Medical Oncology
David Bruton, Jr. Chair in Cancer Research
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Sept. 15, 2023

Memorial Sloan Kettering Cancer Center

The Evolving Role of Neoadjuvant Therapy for Localized Non-Small Cell Lung Cancer

September 18, 2023
Jamie Chaft
www.MSKCC.org

Memorial Sloan Kettering Cancer Center

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Key Data Sets

John V Heymach, MD, PhD

- Felip E et al. Adjuvant atezolizumab after adjuvant chemotherapy in resected stage IB-IIIA non-small-cell lung cancer (IMpower010): A randomised, multicentre, open-label, phase 3 trial. *Lancet* 2021 October 9;398(10308):1344-57.
- Felip E et al. Overall survival with adjuvant atezolizumab after chemotherapy in resected stage II-IIIA non-small-cell lung cancer (IMpower010): A randomised, multicentre, open-label, phase III trial. *Ann Oncol* 2023 July 17;[Online ahead of print].
- Paz-Ares L et al. Pembrolizumab (pembro) versus placebo for early-stage non-small cell lung cancer (NSCLC) following complete resection and adjuvant chemotherapy (chemo) when indicated: Randomized, triple-blind, phase III EORTC-1416-LCG/ETOP 8-15 – PEARLS/KEYNOTE-091 study. *Annals Oncology* 2022;33(4):451-3.
- O'Brien M et al. Pembrolizumab versus placebo as adjuvant therapy for completely resected stage IB-IIIA non-small-cell lung cancer (PEARLS/KEYNOTE-091): An interim analysis of a randomised, triple-blind, phase 3 trial. *Lancet Oncol* 2022 October;23(10):1274-86.

Key Data Sets

John V Heymach, MD, PhD (continued)

- Chang JY et al. Stereotactic ablative radiotherapy with or without immunotherapy for early-stage or isolated lung parenchymal recurrent node-negative non-small-cell lung cancer: An open-label, randomised, phase 2 trial. *Lancet* 2023 September 9;402(10405):871-81.
- Wu Y-L et al. Osimertinib in resected EGFR-mutated non-small-cell lung cancer. *N Engl J Med* 2020;383:1711-23.
- Tsuboi M et al. Overall survival with osimertinib in resected EGFR-mutated. *N Engl J Med* 2023 July 13;389(2):137-47.
- Solomon BJ et al. ALINA: A phase III study of alectinib versus chemotherapy as adjuvant therapy in patients with stage IB-IIIA anaplastic lymphoma kinase-positive (ALK+) non-small cell lung cancer (NSCLC). ASCO 2019;Abstract TPS8569.

Key Data Sets

Jamie E Chaft, MD

- Girard N et al. Neoadjuvant nivolumab (N) + platinum-doublet chemotherapy (C) for resectable NSCLC: 3-y update from CheckMate 816. ELCC 2023;Abstract 84O.
- Wakelee H et al. KEYNOTE-671: Randomized, double-blind, phase 3 study of pembrolizumab or placebo plus platinum-based chemotherapy followed by resection and pembrolizumab or placebo for early stage NSCLC. ASCO 2023;Abstract LBA100.
- Wakelee H et al. Perioperative pembrolizumab for early-stage non-small-cell lung cancer. *N Engl J Med* 2023 August 10;389(6):491-503.
- Heymach JV et al. AEGEAN: A phase 3 trial of neoadjuvant durvalumab + chemotherapy followed by adjuvant durvalumab in patients with resectable NSCLC. AACR 2023;Abstract CT005.
- Forde PM et al. nivolumab plus chemotherapy in resectable lung cancer. *N Engl J Med* 2022 May 26;386(21):1973-85.
- NeoADAURA: A study of osimertinib with or without chemotherapy versus chemotherapy alone as neoadjuvant therapy for patients with EGFRm positive resectable non-small cell lung cancer. NCT04351555

Agenda

INTRODUCTION: Patient Involvement in (Neo)Adjuvant Treatment Decisions

MODULE 1: Targetable Treatment in Localized Disease

MODULE 2: Immunotherapy in Localized Disease

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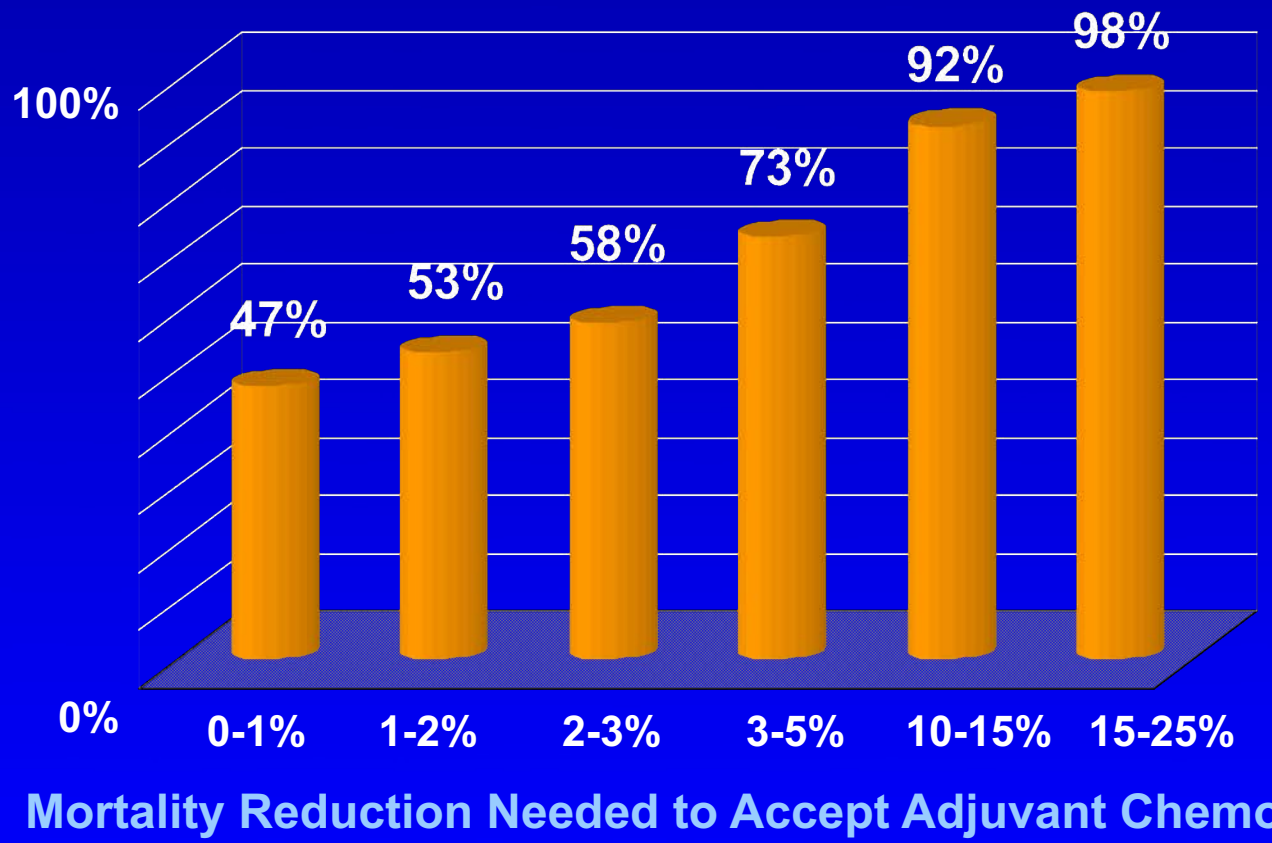
HOW WELL DO WE COMMUNICATE WITH OUR PATIENTS?

A Survey of Patients Who Received Adjuvant Chemotherapy for Colorectal Cancer

Neil Love, MD; Carma Bylund, PhD; Neal J Meropol, MD; John Marshall, MD; Steven A Curley, MD; Lee M Ellis, MD; Axel Grothey, MD; Heinz-Josef Lenz, MD; Leonard B Saltz, MD; Melanie Elder, BBA; Kathryn Ault Ziel, PhD; Douglas Paley, BA; Ginelle Suarez, BS; Erin Wall, BS

Australian Breast Cancer Patient Preference Study

What benefit would you require to receive chemotherapy?



Sources: J Natl Cancer Inst Monogr 2001;30:146-52. Williams CJ, editor. Introducing new treatments for cancer: Practical, ethical and legal problems. London (UK): Wiley; 1992. p 447–58. Simes J, Coates AS. Intl Cancer Institute Monograph 2001;30:146-52.

Trade-Off Situations Presented After Review of Audio Program

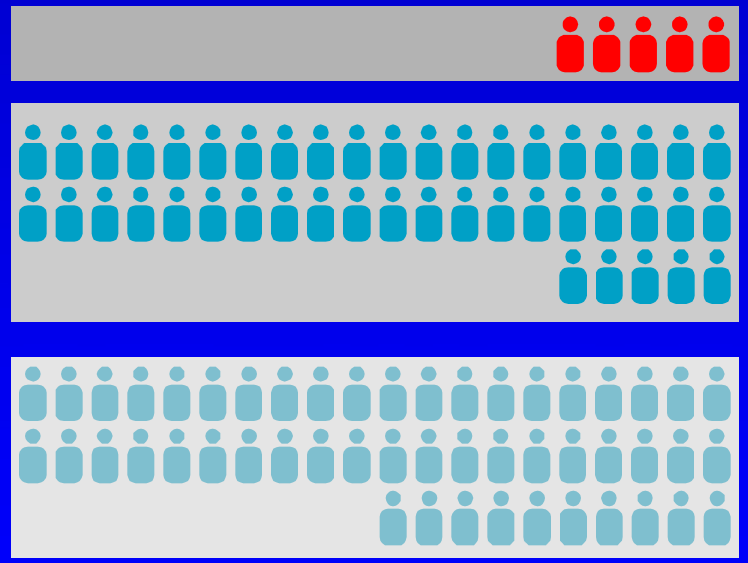
	Recurrence Risk		
Scenario	Baseline	With Chemotherapy	Absolute Benefit
1	50%	49%	1%
2	20%	19%	1%
3	20%	17%	3%
4	50%	45%	5%
5	20%	15%	5%
6	50%	40%	10%

Graphic Presentation of Scenarios

Scenario 4

- **Baseline recurrence risk: 50%**
- **Risk with chemotherapy: 45%**

Would you receive treatment again?

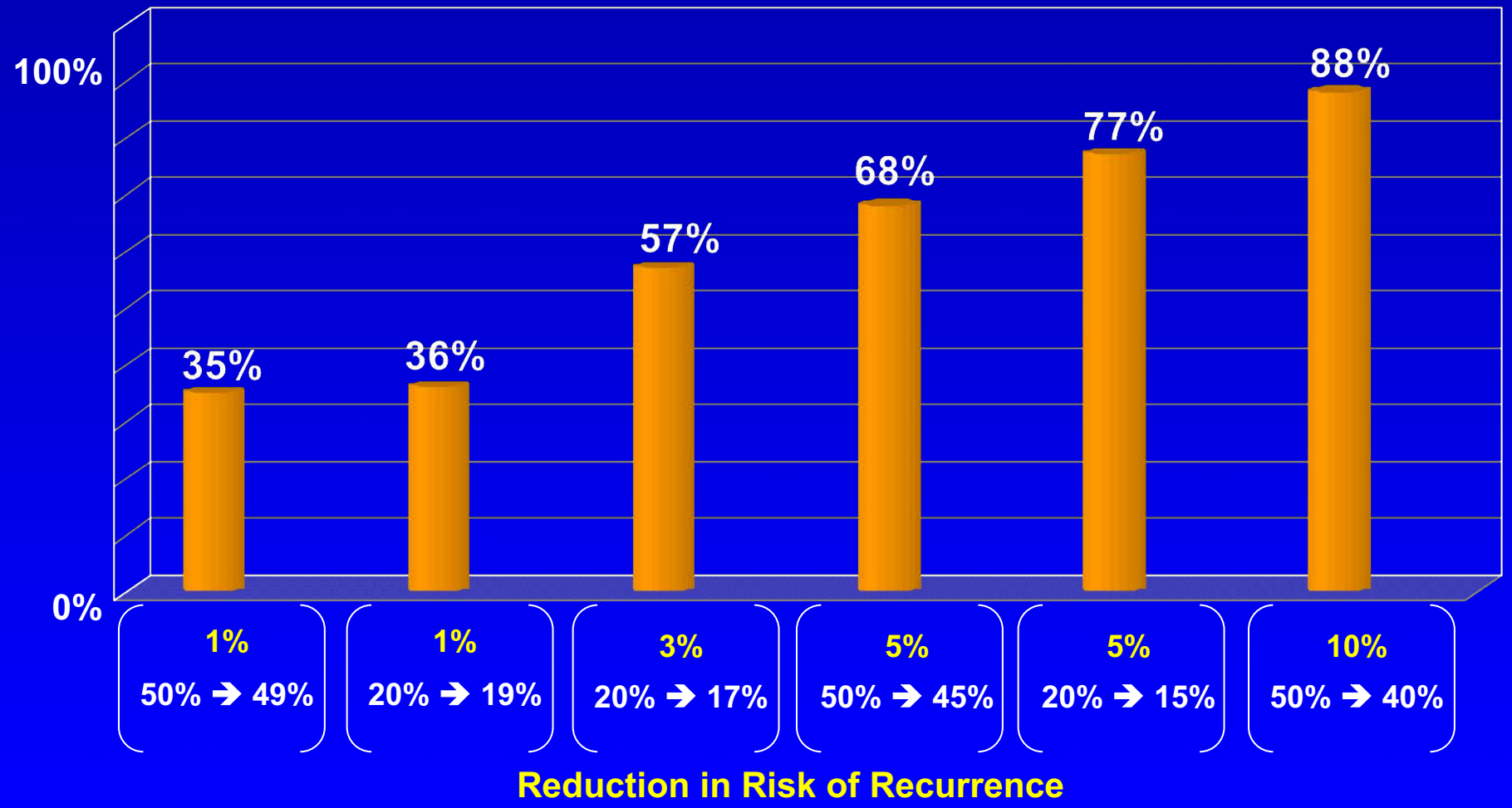


5 ← **Patients cured because of adjuvant chemotherapy**

45 ← **Patients whose cancer would return even though they received adjuvant chemotherapy**

50 ← **Patients who were already cured without adjuvant chemotherapy**

Percent of Patients Who Would be Treated Again for Various Reductions in Risk of Recurrence



Survey of 150 patients with colorectal cancer: 2006

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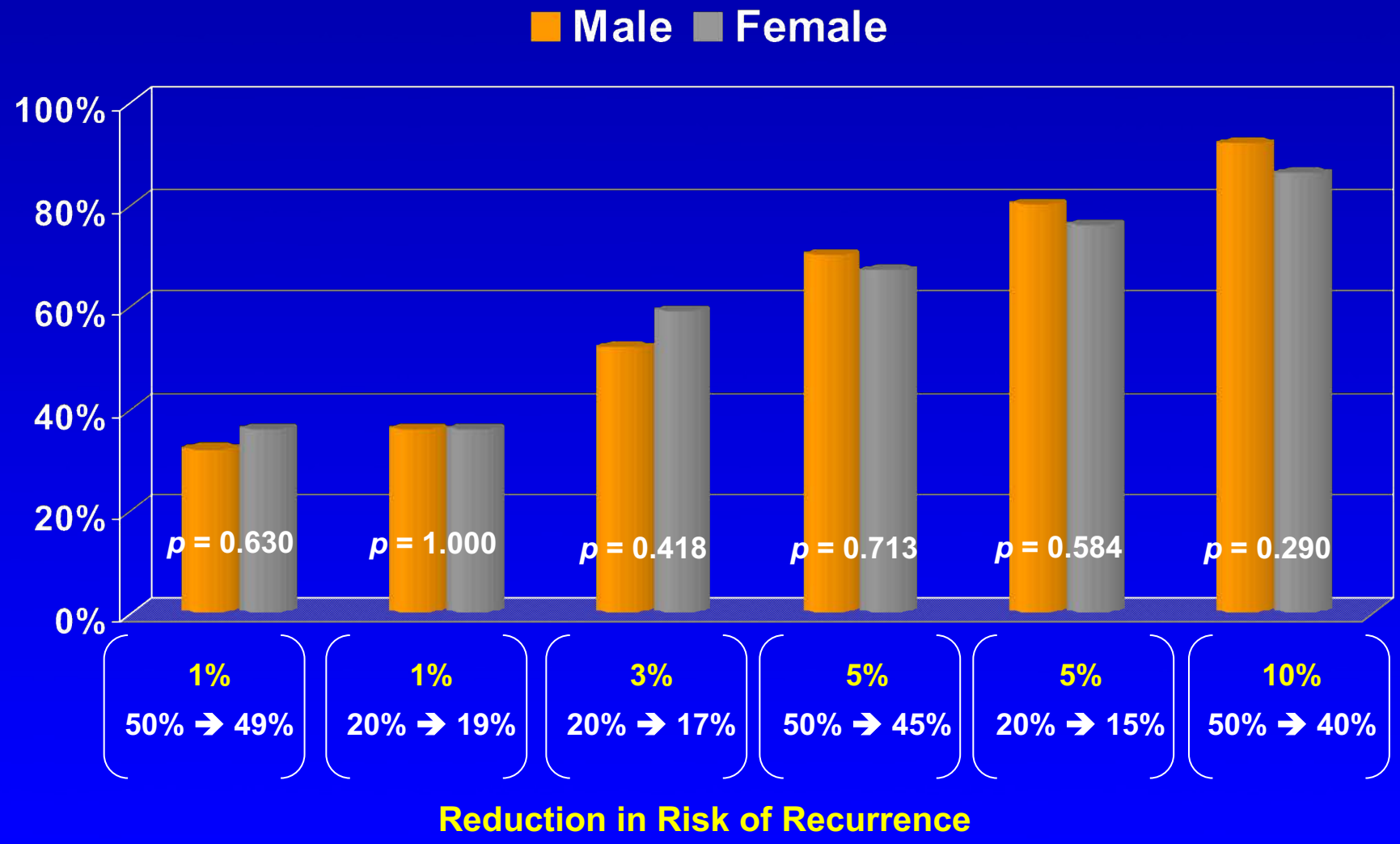
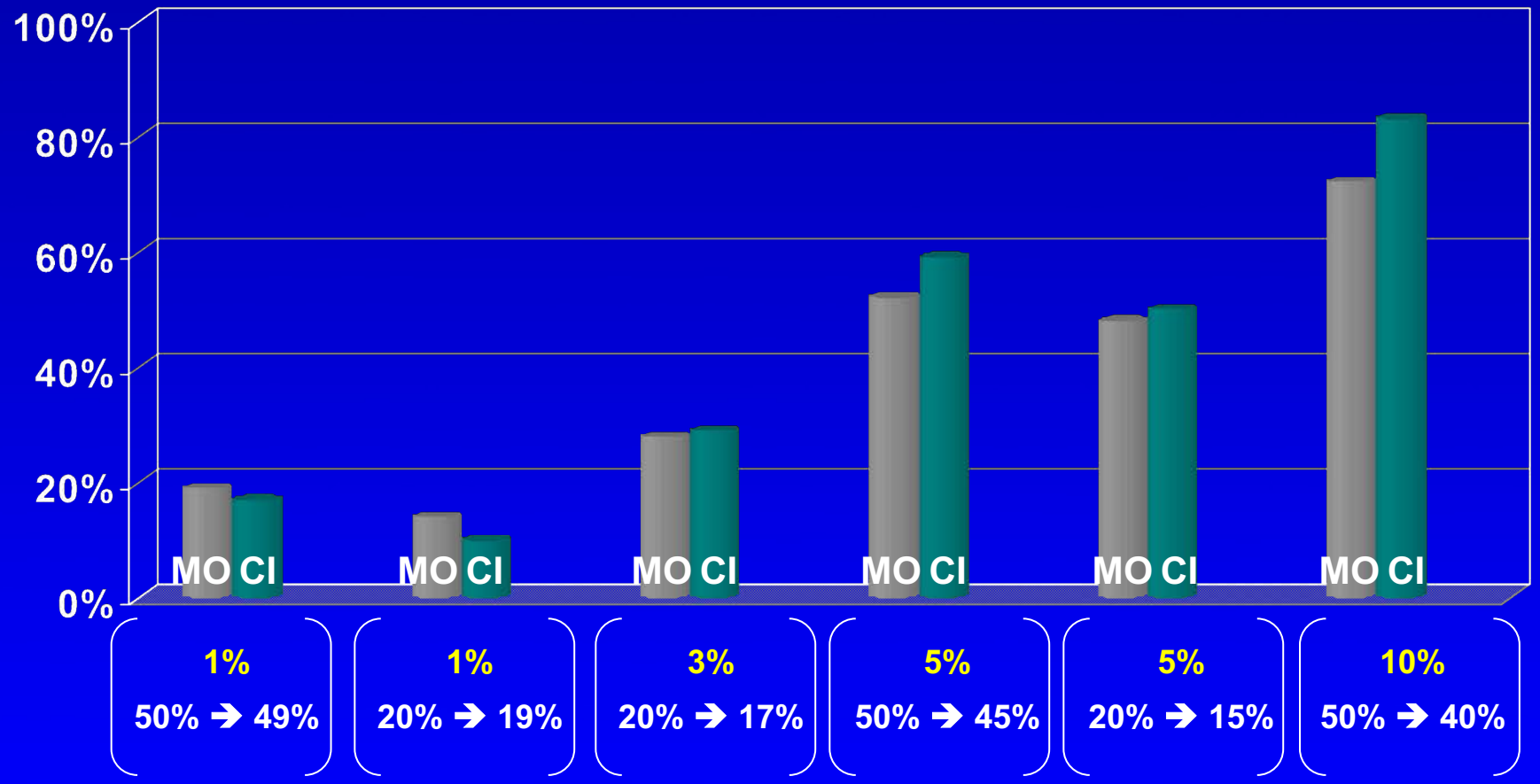


Male: n = 50; female: n = 100

Predictions of Patient Trade-Offs
(Medical Oncologists and Clinical Investigators)



Survey of 150 practicing oncologists: 2006

RTP CRC Patient Project Findings Publicized Nationally

Study: Doctors out of sync with cancer patients' wishes

By Liz Szabo
USA TODAY

ORLANDO — A new study sheds light on the hardships that cancer patients are willing to endure in the hope of a cure — as well as the communication gap between patients and their doctors.

In a study of 150 patients presented Sunday at the 2007 Gastrointestinal Cancers Symposium, researchers found that many colorectal cancer patients were willing to undergo chemotherapy, even when the potential benefit was very small.

Researchers posed a hypothetical question to patients who had already been treated with surgery and drugs: Would they again have chemo — which can cause diarrhea, nausea and crushing fatigue — if it cut the risk of relapse by 1%? About 35% said they would.

Doctors weren't very good at judging patients' responses, the survey shows. Of 150 interviewed, only 19% of doctors and 17% of researchers thought patients would agree, says Neil Love, the study's lead author and president of a Miami medical education company called Research to Practice.

It's easy to understand why doctors and patients don't always communicate well, says Neal Meropol, director of gastrointestinal cancer at Philadelphia's Fox Chase Cancer Center. Overwhelmed patients may not be able to concentrate during office visits, especially when dealing with technical medical terms.

The study revealed other communication gaps, Love says. About 60% of patients say they weren't given the chance to join a clinical trial. Yet 81% wished they had gotten such information.

Leonard Saltz, a co-author and colorectal cancer researcher at New York's Memorial Sloan-Kettering Cancer Center, noted that the study had important limitations. Patients who answered the survey may be more positive about chemo than others. "They had already had chemo and lived to tell about it, so they are probably already leaning in that direction," Saltz says.

Love now plans to interview patients before they have chemo. Sanofi-Aventis, which makes cancer drugs, paid for the survey.

www.usatoday.com

USA TODAY

Life

SECTION D

Monday, January 22, 2007

Would you say yes to chemotherapy?

Most doctors underestimated patients' willingness to take harsh therapies in exchange for a greater chance of remaining cancer-free.

▒ = Patients who said yes
□ = Doctors who predicted patients would say yes

Would you get chemo if it cut your risk of relapse from 50% to ...		Yes	
	49%	35%	19%
	45%	68%	52%
	40%	88%	72%

Source: Neil Love, 2007 Gastrointestinal Cancers Symposium

RTP RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, in general, which adjuvant treatment would you recommend for an otherwise healthy 65-year-old patient with Stage IIA nonsquamous NSCLC with an EGFR exon 19 deletion and a PD-L1 TPS of 50%? What would you estimate to be the approximate risk of recurrence if the patient *did* versus *did not* receive adjuvant therapy?

	Adjuvant treatment	Risk of recurrence	
		Without treatment	With treatment
 Dr Chaft	Osimertinib	45%	15%
 Dr Heymach	Chemotherapy → osimertinib	30%	10%
 Dr Awad	Chemotherapy → osimertinib	35%	20%
 Dr Forde	Chemotherapy → osimertinib	40%	10%
 Dr Govindan	Chemotherapy → osimertinib	30%	20%
 Dr Wakelee	Chemotherapy → osimertinib	70%	20%

TPS = tumor proportion score

Regulatory and reimbursement issues aside, which of the following would you most likely recommend as adjuvant therapy for a patient with completely resected Stage IIB lung adenocarcinoma and an EGFR-activating mutation? What would you estimate to be the approximate risk of recurrence if the patient *did* versus *did not* receive adjuvant therapy?

	Adjuvant treatment	Risk of recurrence	
		Without treatment	With treatment
 Dr Chaft	Chemotherapy → osimertinib	60%	30%
 Dr Heymach	Chemotherapy → osimertinib	45%	12%
 Dr Awad	Chemotherapy → osimertinib	40%	25%
 Dr Forde	Chemotherapy → osimertinib	50%	15%
 Dr Govindan	Chemotherapy → osimertinib	50%	30%
 Dr Wakelee	Chemotherapy → osimertinib	70%	20%

Regulatory and reimbursement issues aside, in general, which adjuvant treatment would you recommend for an otherwise healthy 65-year-old patient with Stage IIA nonsquamous NSCLC and a PD-L1 TPS of 50%? What would you estimate to be the approximate risk of recurrence if the patient *did* versus *did not* receive adjuvant therapy?

	Adjuvant treatment	Risk of recurrence	
		Without treatment	With treatment
 Dr Chaft	Carboplatin-based chemotherapy → atezolizumab	45%	20%
 Dr Heymach	Carboplatin-based chemotherapy → atezolizumab	45%	30%
 Dr Awad	Cisplatin-based chemotherapy → pembrolizumab	35%	20%
 Dr Forde	Cisplatin-based chemotherapy → atezolizumab	40%	10%-15%
 Dr Govindan	Cisplatin-based chemotherapy → atezolizumab	30%	25%
 Dr Wakelee	Cisplatin-based chemotherapy → atezolizumab	70%	25%

Regulatory and reimbursement issues aside, in general, which adjuvant treatment would you most likely recommend for an otherwise healthy 65-year-old patient with completely resected Stage IIB adenocarcinoma of the lung and a PD-L1 TPS of 50%? What would you estimate to be the approximate risk of recurrence if the patient *did* versus *did not* receive adjuvant therapy?

	Adjuvant treatment	Risk of recurrence	
		Without treatment	With treatment
 Dr Chaft	Cisplatin-based chemotherapy → atezolizumab	60%	30%
 Dr Heymach	Carboplatin-based chemotherapy → atezolizumab	60%	25%
 Dr Awad	Cisplatin-based chemotherapy → pembrolizumab	40%	25%
 Dr Forde	Cisplatin-based chemotherapy → atezolizumab	50%	25%
 Dr Govindan	Cisplatin-based chemotherapy → pembrolizumab	50%	30%
 Dr Wakelee	Cisplatin-based chemotherapy → atezolizumab	70%	30%-35%

Agenda

INTRODUCTION: Patient Involvement in (Neo)Adjuvant Treatment Decisions

MODULE 1: Targetable Treatment in Localized Disease

MODULE 2: Immunotherapy in Localized Disease

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TO PRACTICE

Case Presentation – Dr Heymach: targeted therapy

- 51-year-old non-smoker, mother of 5, found to have LUL mass in 2021
  - PS 0, exercises diligently, highly active and motivated.
- After resection found to have stage II lung adeno (T2N1M0), PD-L1<1%.
- On sequencing found to have RET fusion.

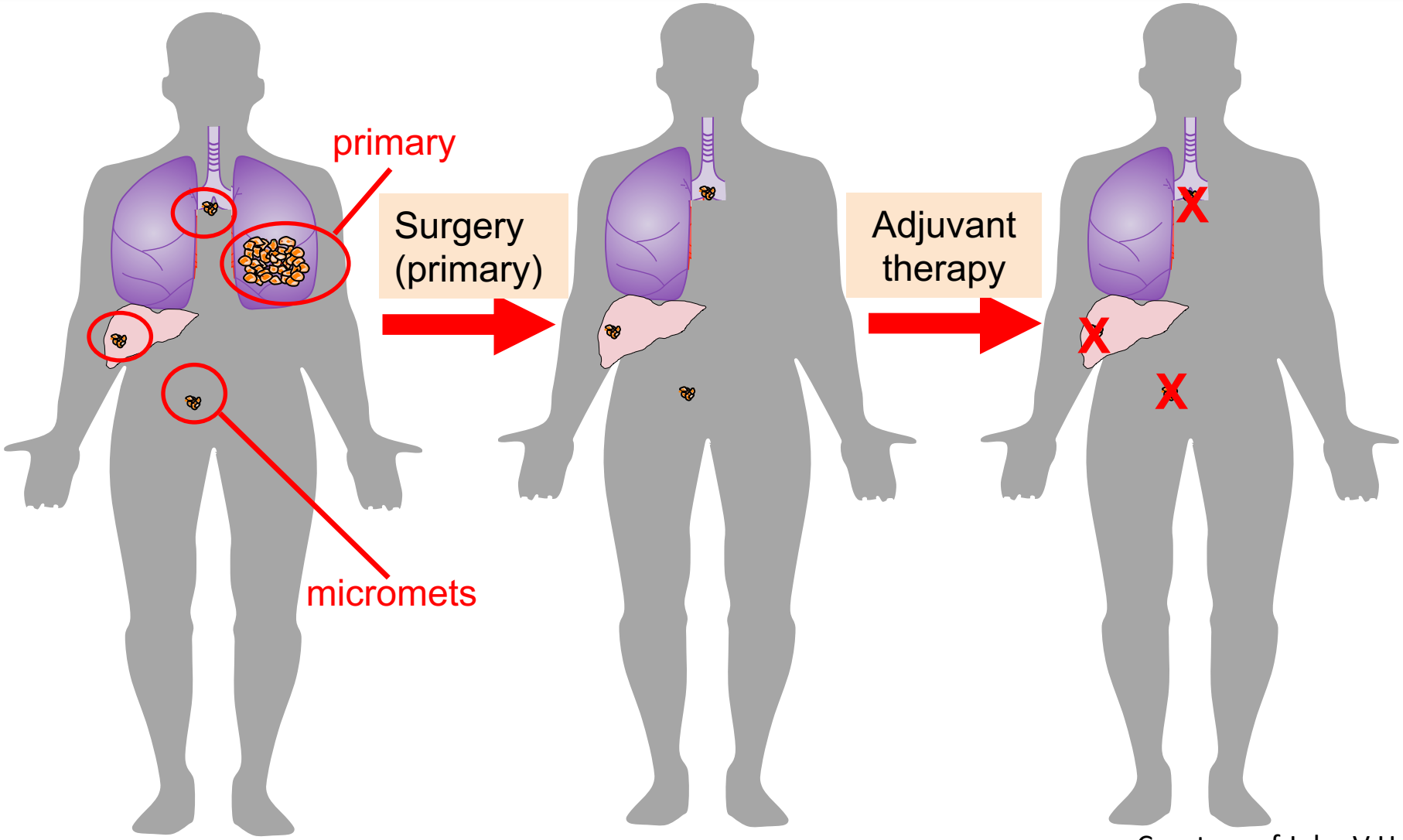
Case Presentation – Dr Heymach: targeted therapy (continued)

- Patient requests adjuvant selpercatinib but SOC is discussed with patient, chemo is offered.
- Patient reluctantly completes 4 cycles of cis/pemetrexed uneventfully.
- She requests ctDNA monitoring.
- After 1-year ctDNA is positive and solitary liver metastasis observed.
- Liver met resected and (sort of) adjuvant selpercatinib started.
- Patient remains recurrence free July 2023.

Have you recommended or would you recommend targeted therapy in the adjuvant setting for a patient with NSCLC and …?

	An EGFR mutation	An ALK rearrangement	A RET rearrangement
 Dr Chaft	Yes	Yes	No
 Dr Heymach	Yes	Yes	Yes
 Dr Awad	Yes	Yes	No
 Dr Forde	Yes	Yes	No
 Dr Govindan	Yes	No	No
 Dr Wakelee	Yes	Yes	No

The primary goal of adjuvant treatment is to eliminate micrometastatic disease



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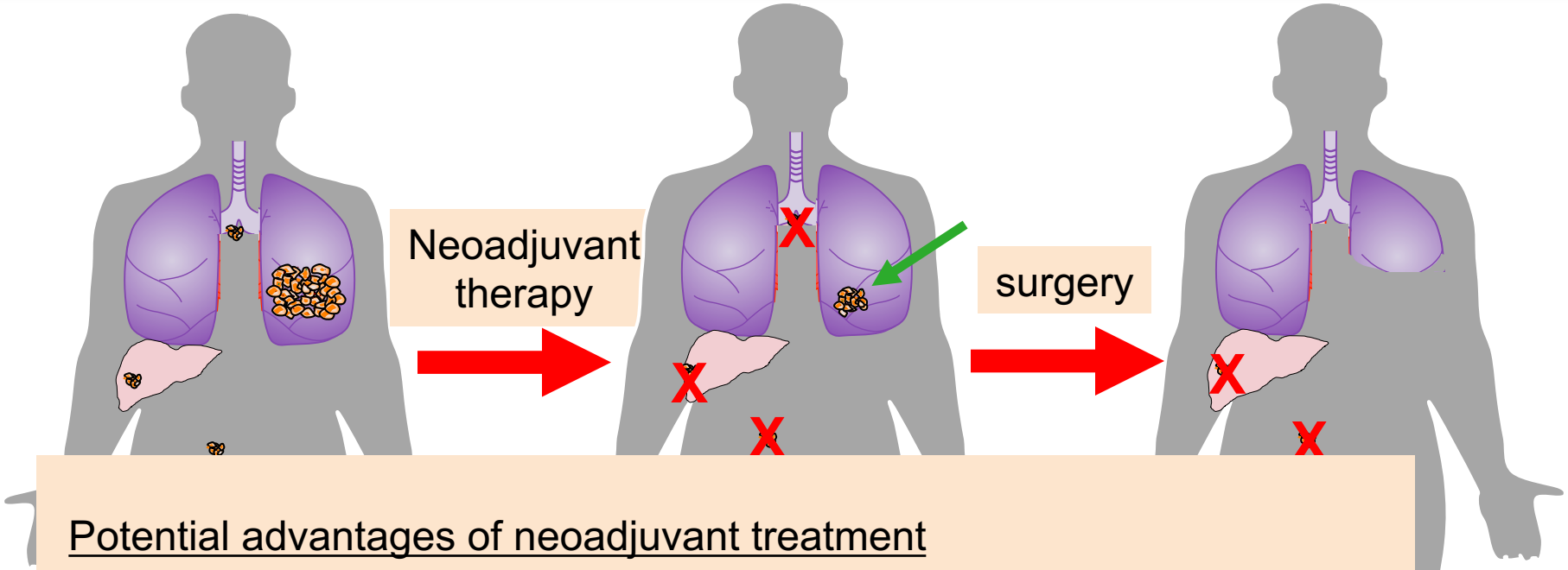
Courtesy of John V Heymach, MD, PhD

Neoadjuvant treatment can “downstage” the primary tumor, potentially making surgery less morbid and clearing mediatinum



Potential advantages of neoadjuvant treatment

- Analysis of tumor response (MPR, pCR)
- Enhance anti-tumor immunity when more tumor antigens are present
- Earlier treatment of micromets and increased compliance

Potential advantages of adjuvant treatment

- More rapid removal of tumor
- No need for profiling prior to surgery

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Making Cancer History®

Courtesy of John V Heymach, MD, PhD

Overview

Cisplatin-based chemo

Adj osimertinib

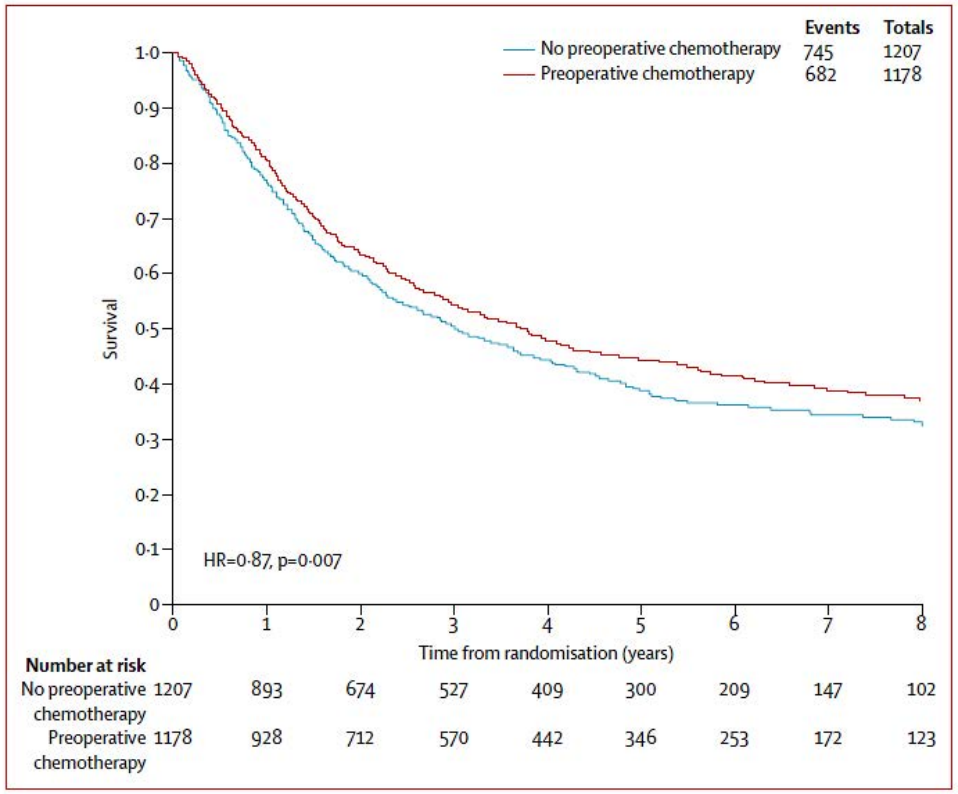
Adj atezo
Adj pembro

Neoadj chemo-nivo

*Periop chemo-pembro

*Adj alectinib

*Periop chemo-durva



*Positive trial readouts with anticipated FDA approvals

Neoadj therapy meta-analysis equivalent
HR to adjuvant therapy 0.87

Courtesy of Jamie E Chaft, MD

ADAURA study design: Adjuvant osimertinib for resectable EGFR mutant NSCLC

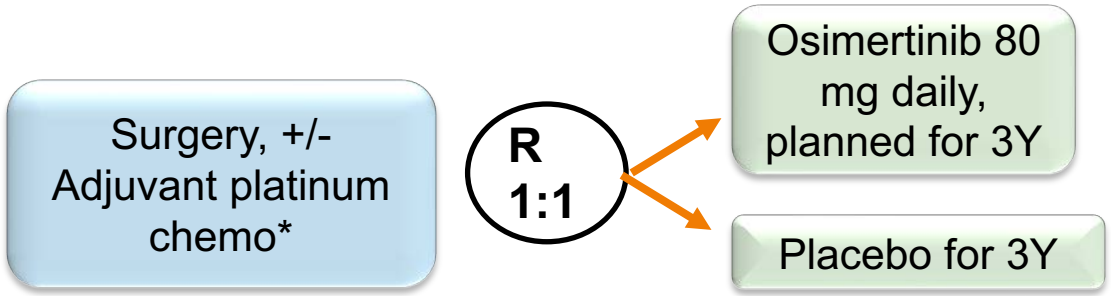
N=682

Key eligibility

- Stage IB-IIIA
- EGFRm (Ex19del, L858R)
- Complete resection with negative margins
- Max. interval between surgery and randomization: 10weeks (w/o adjuvant), 26w (w/adjuvant)

Stratification:

- Stage (IB vs II vs IIIA)
- EGFRm (Ex19del vs L858R)
- race (Asian vs non-Asian)



Primary endpoint : DFS, by investigator assessment, in stage II/IIIA patients; designed for superiority under the assumed DFS HR of 0.70

Secondary endpoints include: OS; DFS in the overall population; DFS at 2, 3, 4, and 5 years; safety, health-related QOL

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center Making Cancer History®

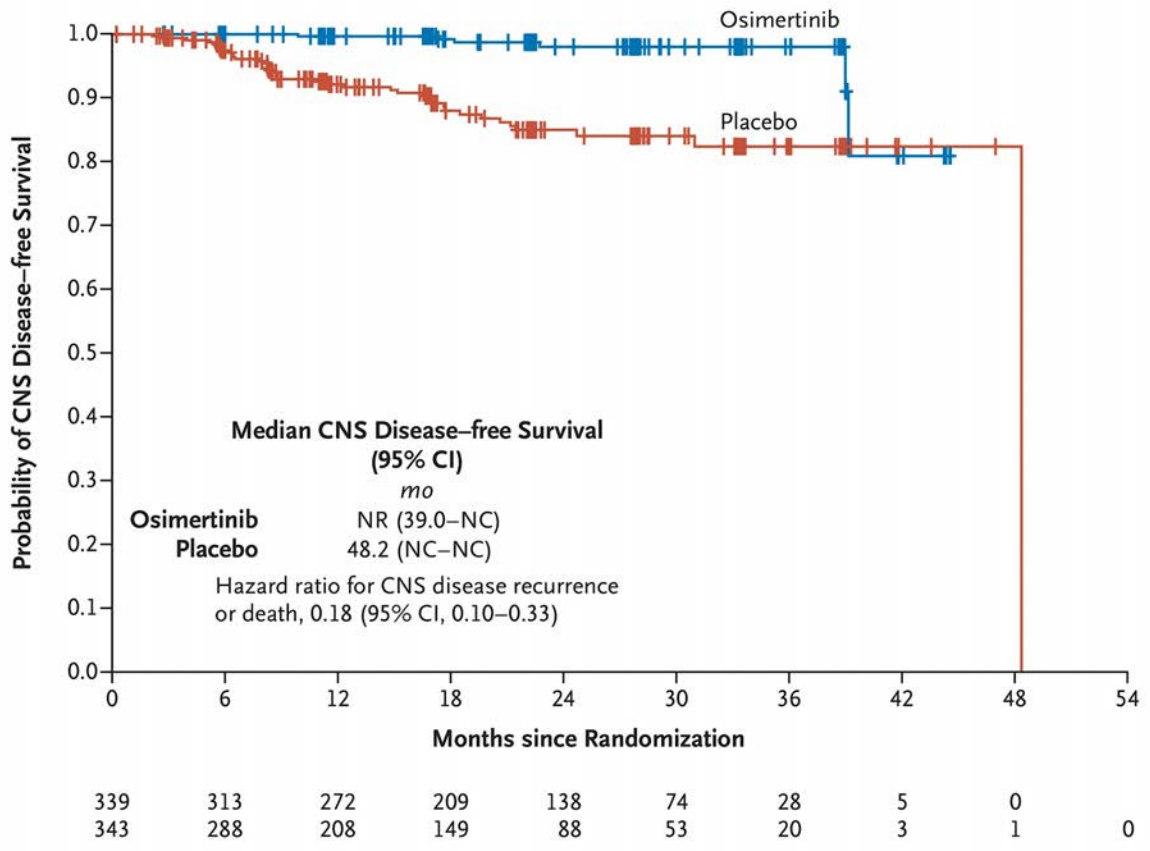
Wu Y-L et al. N Engl J Med 2020;383:1711-1723

Courtesy of John V Heymach, MD, PhD

ADAURA: Adjuvant osimertinib for resectable EGFR mutant NSCLC – CNS DFS

CNS DFS

HR 0.18 (95% CI 0.10-0.33)



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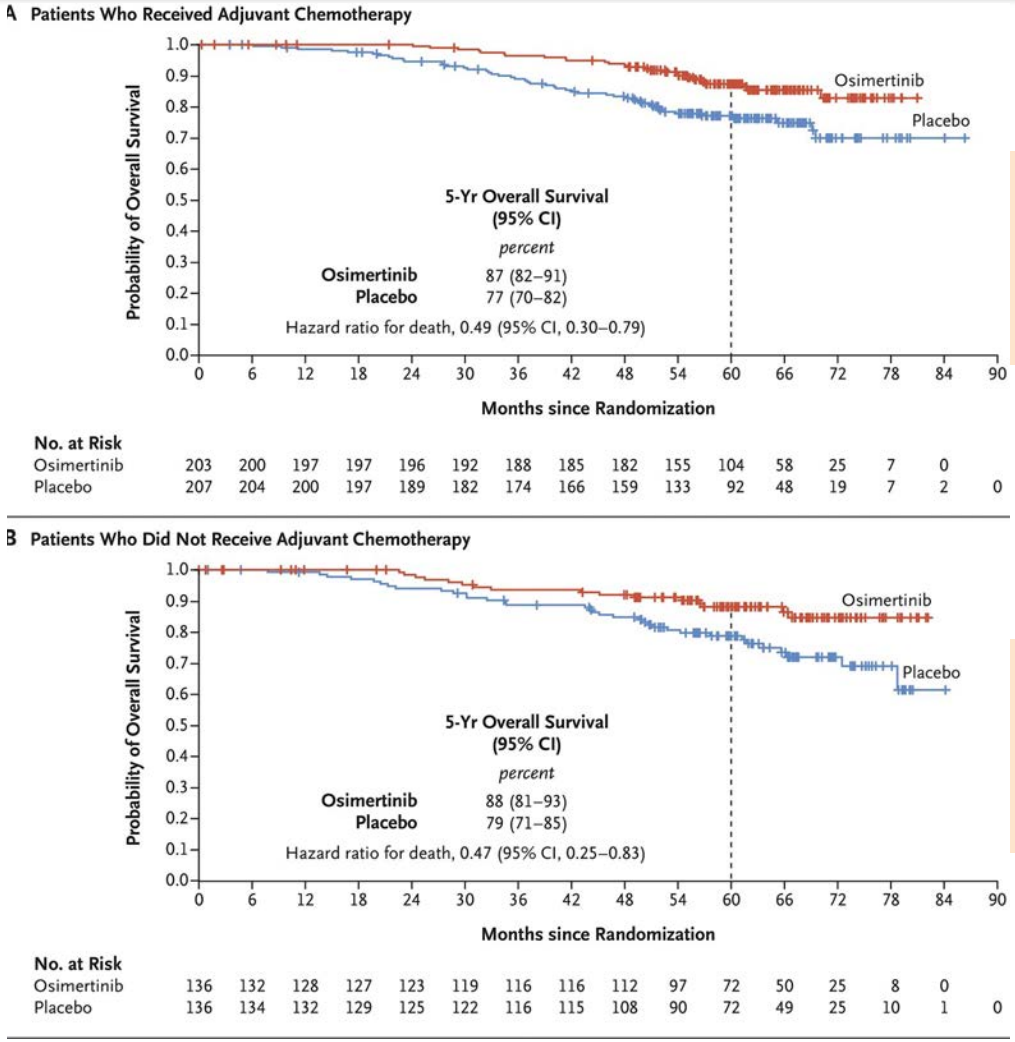
Wu Y-L et al. N Engl J Med 2020;383:1711-1723

Courtesy of John V Heymach, MD, PhD

ADAURA: OS benefit among those who did or did not receive adjuvant chemotherapy



Received adjuvant chemo
HR 0.49 (95% CI, 0.30-.79)

Did not receive adjuvant chemo
HR 0.47 (95% CI, 0.25-.83)

Tsuboi M et al. N Engl J Med 2023;389:137-147

Courtesy of John V Heymach, MD, PhD

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ALINA study design: Adjuvant alectinib for resectable ALK mutant NSCLC

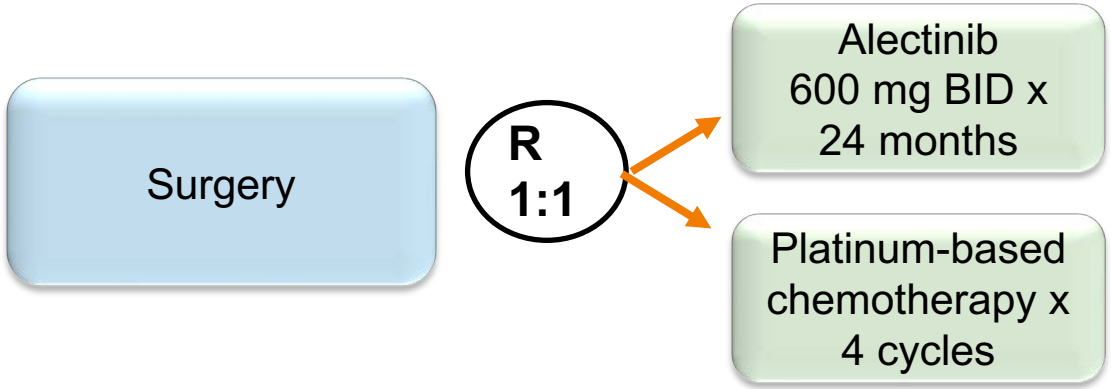
N=257

Key eligibility

- Stage IB-IIIA (>4cm)
- ALK fusion
- Complete resection with negative margins

Stratification:

- Stage (IB vs II vs IIIA)
- race (Asian vs non-Asian)



Primary endpoint : DFS, by investigator assessment

Secondary endpoints include: OS; safety; PK

Press release Sept. 1, 2023: Alectinib met its primary endpoint at prespecified interim analysis with a “statistically significant and clinically meaningful improvement in DFS as adjuvant therapy “

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Solomon et al, Proc ASCO 2019

Courtesy of John V Heymach, MD, PhD

What do you predict will be the hazard ratio for disease-free survival in the Phase III ALINA study evaluating alectinib versus platinum chemotherapy for patients with completely resected Stage IB to IIIA NSCLC and ALK alterations?

 Dr Chaft	0.2
 Dr Heymach	0.15 – 0.2
 Dr Awad	0.3
 Dr Forde	0.18
 Dr Govindan	0.4
 Dr Wakelee	0.2

RTP RESEARCH TO PRACTICE

Adjuvant therapy for resectable NSCLC: the bottom line

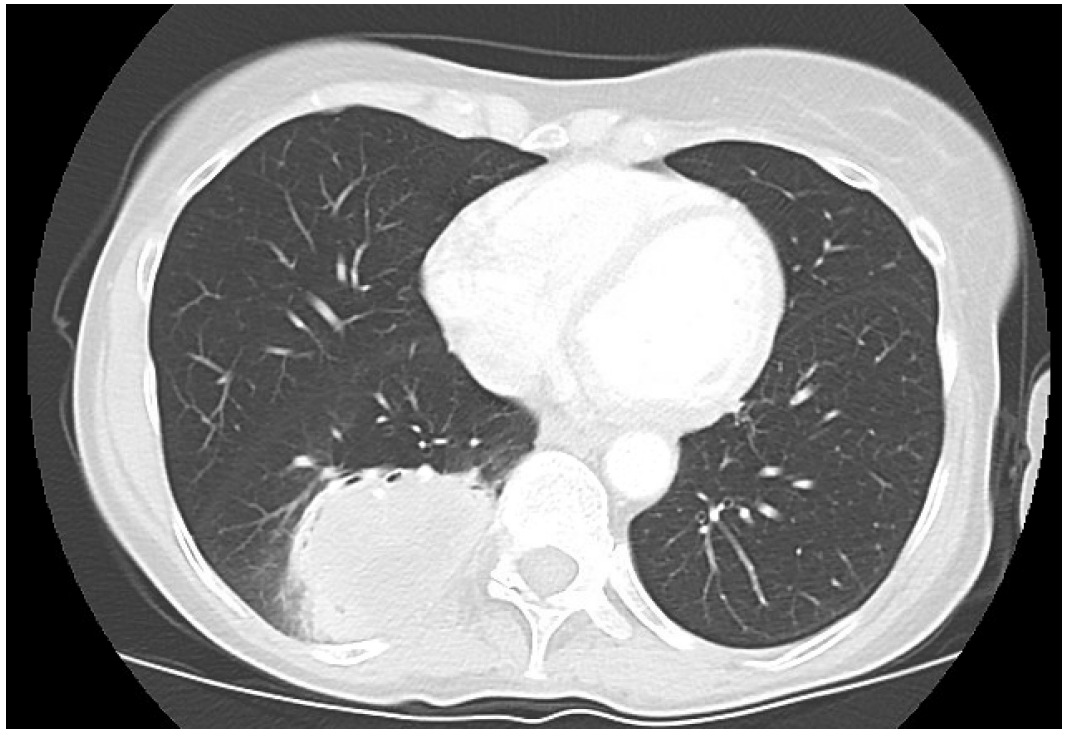
Targeted therapy

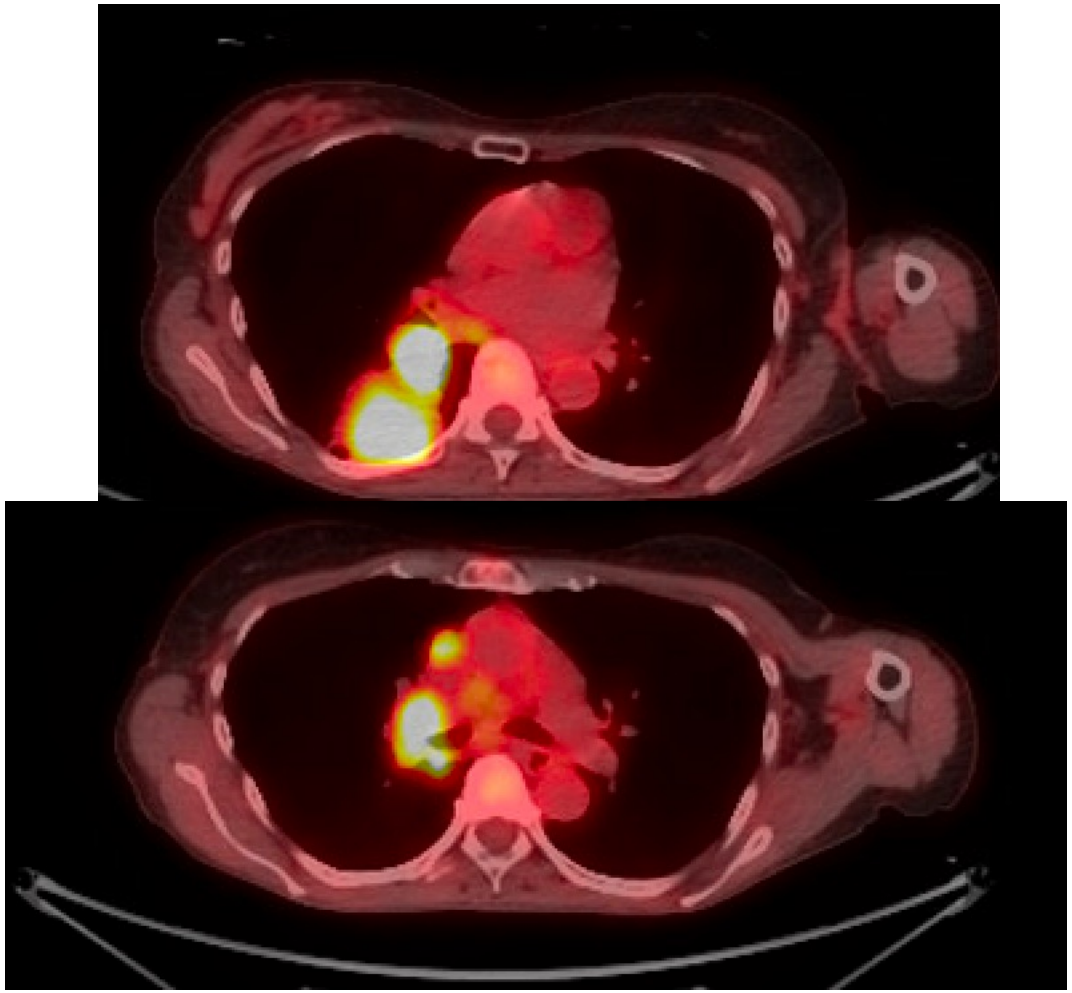
- ADAURA: Adjuvant Osimertinib x 3y improves DFS and OS
- ALINA: Alectinib improves DFS in ALK+ (press release)
- All resectable patients need profiling (EGFR/ALK minimum)

Courtesy of John V Heymach, MD, PhD

Case Presentation – Dr Chaft: osimertinib

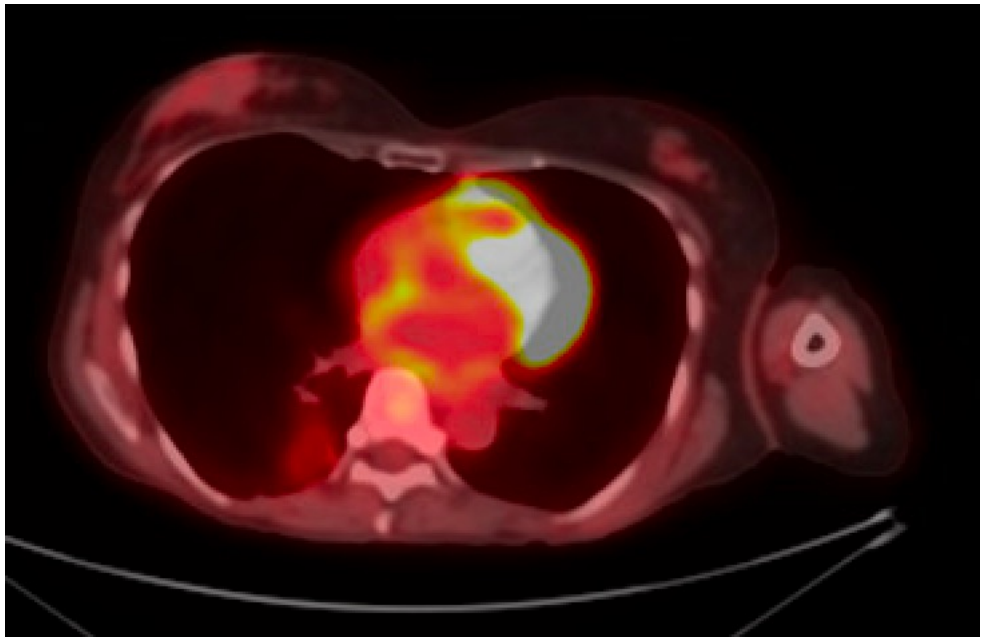
- 60-year-old female never smoker with a cT3N2 (hilar and level 7+) adenocarcinoma
- EGFR Exon 19 indel

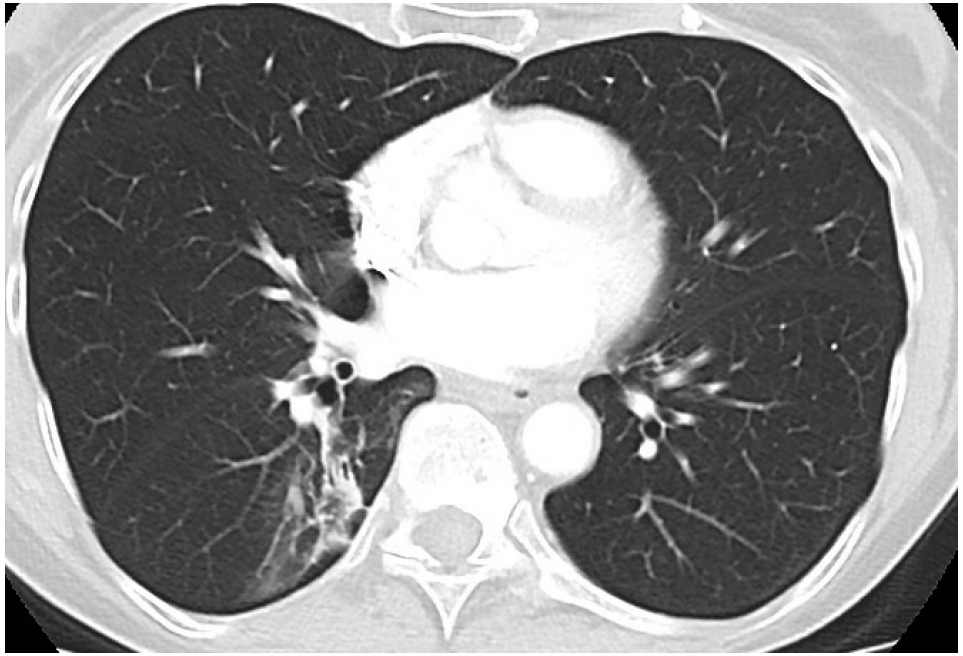




Case #3 T3N2

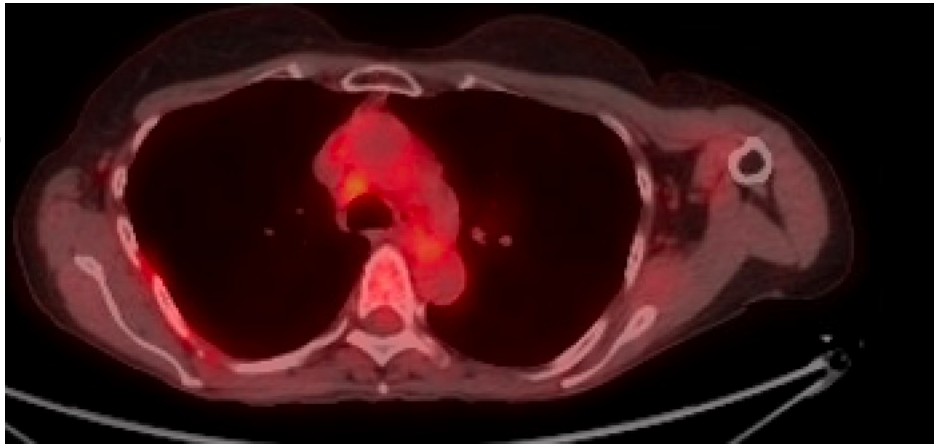
- Declined study (requires core bx)
- Refused chemo
- Treated with osi with near CR





Case #3 Path

- Went outside for resection – frozen section level 3+ so surgeon wedged out primary and sampled a few nodes but didn't complete dissection. ypT1aNo
- Returned to us – restaging with some mild adenopathy
- Complete resection done
  - No residual viable nodal disease
- Intolerant of adj chemo
- Resumed osi



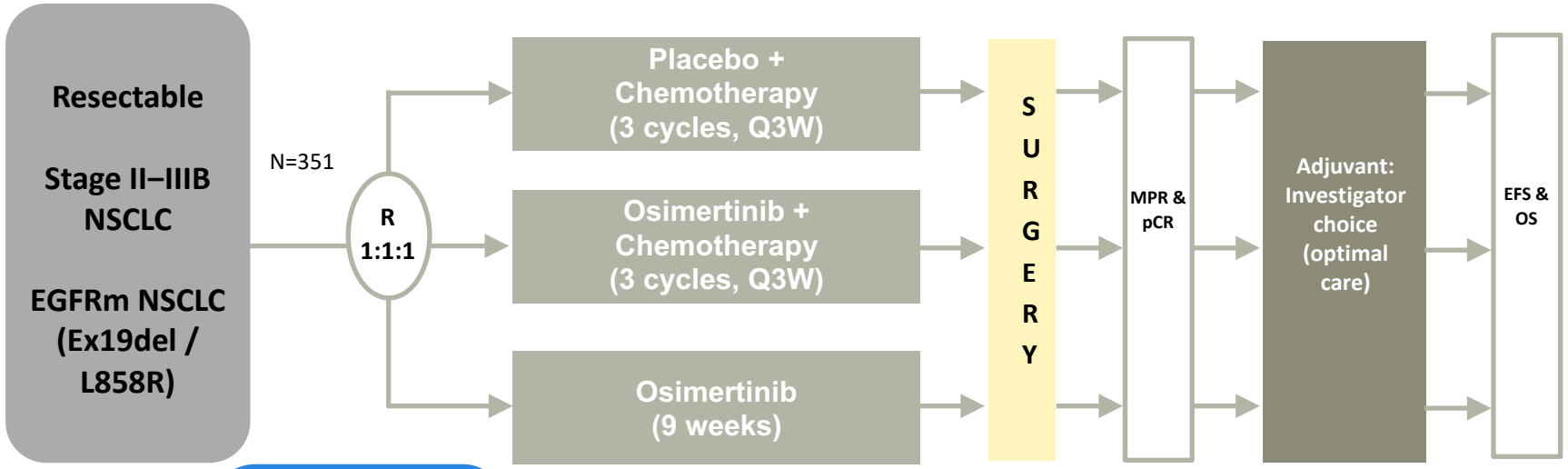
Neoadjuvant TKI

- Rationale is great, however very small datasets available
- Most data show failure to achieve high pCR rate
- Post-op chemo often poorly tolerated
- What about combination therapy?

Courtesy of Jamie E Chaft, MD

NeoADAURA (NCT 04351555)

Phase III, Randomized, Controlled, Multicenter Study of Neoadjuvant Osimertinib



Stratification:

Stage II/III
Non-Asian/ Chinese/ other Asian
Ex19del/L858R

Double-blind treatment arms:

1. Placebo + pemetrexed 500 mg/m² plus carboplatin AUC5 mg/ml.min or cisplatin 75 mg/m²
2. Osimertinib 80 mg qd + pemetrexed 500 mg/m² plus carboplatin AUC5 mg/ml.min or cisplatin 75 mg/m²

Open-label (sponsor-blind) treatment arm:

3. Osimertinib 80 mg qd

Adjuvant therapy at investigator's discretion:

- Up to 5 years
- Osimertinib will be offered for up to 3 years

Courtesy of Jamie E Chaft, MD

To approximately how many patients with localized NSCLC have you administered adjuvant osimertinib?

 Dr Chaft	20
 Dr Heymach	10
 Dr Awad	8
 Dr Forde	10
 Dr Govindan	10
 Dr Wakelee	10

RTP RESEARCH TO PRACTICE

Approximately what proportion of patients with localized NSCLC will experience toxicity during treatment with osimertinib that requires dosing to be held? What is the primary toxicity patients experience that leads to withholding dosing?

	Chance of holding dose	Primary toxicity
 Dr Chaft	5%	Pulmonary
 Dr Heymach	20%	Diarrhea
 Dr Awad	15%	GI toxicity
 Dr Forde	30%	Skin
 Dr Govindan	30%	Diarrhea, fatigue
 Dr Wakelee	5%	Pulmonary

For how long do you typically continue adjuvant osimertinib for a patient with localized NSCLC who is tolerating therapy well? What variables, if any, affect your decision about duration of therapy?

 Dr Chaft	Indefinitely for Stage III, 3-5 years for Stage II
 Dr Heymach	3 years
 Dr Awad	3 years, starting to discuss indefinite treatment if patients are tolerating treatment well
 Dr Forde	Indefinitely, will discuss at 3 years
 Dr Govindan	3 years
 Dr Wakelee	Discuss indefinite treatment

Approximately what proportion of patients do you expect to complete your intended duration of adjuvant osimertinib?

 Dr Chaft	90%
 Dr Heymach	70%
 Dr Awad	80%
 Dr Forde	70%
 Dr Govindan	60%
 Dr Wakelee	75%

To what degree do you believe adherence is an issue among patients receiving adjuvant osimertinib for localized NSCLC?

 Dr Chaft	Somewhat
 Dr Heymach	Somewhat
 Dr Awad	Somewhat
 Dr Forde	Somewhat
 Dr Govindan	Somewhat
 Dr Wakelee	Somewhat

RTP RESEARCH TO PRACTICE

Do you generally hold adjuvant osimertinib for patients undergoing surgical procedures?

 Dr Chaft	No
 Dr Heymach	Yes, starting day before and continuing for 3-4 days after
 Dr Awad	Yes, for about a week before/after major surgery
 Dr Forde	Yes, if any history of thrombocytopenia on receiving osimertinib will hold if surgeon prefers
 Dr Govindan	No
 Dr Wakelee	No

RTP RESEARCH TO PRACTICE

For a patient with an EGFR mutation who does not wish to receive chemotherapy, in which situations, if any, would you be comfortable administering adjuvant osimertinib alone?

 Dr Chaft	I feel comfortable administering adjuvant osimertinib in all situations if a patient refuses chemotherapy
 Dr Heymach	Particularly for older patients or patients with renal issues
 Dr Awad	All situations (about one third of patients on ADAURA didn't get chemo)
 Dr Forde	Patients are informed of the survival benefit with chemotherapy; if they wish to proceed without it then will prescribe osimertinib alone
 Dr Govindan	I feel comfortable administering adjuvant osimertinib in all situations if a patient refuses chemotherapy
 Dr Wakelee	In most situations, but would discuss chemo for Stage III especially

RTP RESEARCH TO PRACTICE

Is there a clinical scenario in which you would use chemotherapy with osimertinib as first-line treatment for a patient with metastatic NSCLC with an EGFR mutation?

 Dr Chaft	Yes, for symptomatic brain metastases per the FLAURA2 data
 Dr Heymach	Yes
 Dr Awad	No
 Dr Forde	Yes, I discuss FLAURA2 data with patients with very bulky disease, brain metastases or exon 21 mutation
 Dr Govindan	No
 Dr Wakelee	Yes, for patients with L858R mutation and high disease burden

Which of the following best describes your reaction to the recently reported final overall survival analysis of the Phase III ADAURA trial evaluating adjuvant osimertinib for patients with completely resected Stage IB to IIIA NSCLC with EGFR mutations?

 Dr Chaft	Results were similar to what I expected
 Dr Heymach	Results were slightly more positive than I expected
 Dr Awad	Results were slightly more positive than I expected
 Dr Forde	Results were much more positive than I expected
 Dr Govindan	Results were similar to what I expected
 Dr Wakelee	Results were slightly more positive than I expected

Regulatory and reimbursement issues aside, what would you most likely recommend as consolidation treatment for a patient with locally advanced NSCLC who has completed chemoradiation therapy and is found to have …?

	An EGFR-activating mutation	A RET fusion
 Dr Chaft	Osimertinib	2 cycles of chemotherapy
 Dr Heymach	Osimertinib	Selpercatinib
 Dr Awad	Osimertinib	Durvalumab
 Dr Forde	Osimertinib	Durvalumab
 Dr Govindan	Durvalumab	Durvalumab
 Dr Wakelee	Osimertinib	Additional pemetrexed

Outside of a clinical trial setting, would you employ neoadjuvant targeted therapy for a patient with NSCLC and a documented genomic alteration (eg, EGFR mutation)?

 Dr Chaft	Yes, for a patient with N2+ or large tumor
 Dr Heymach	Yes, when downstaging would be helpful, eg, to avoid pneumonectomy
 Dr Awad	No
 Dr Forde	No
 Dr Govindan	No
 Dr Wakelee	Yes, I have rarely administered osimertinib

Agenda

INTRODUCTION: Patient Involvement in (Neo)Adjuvant Treatment Decisions

MODULE 1: Targetable Treatment in Localized Disease

MODULE 2: Immunotherapy in Localized Disease

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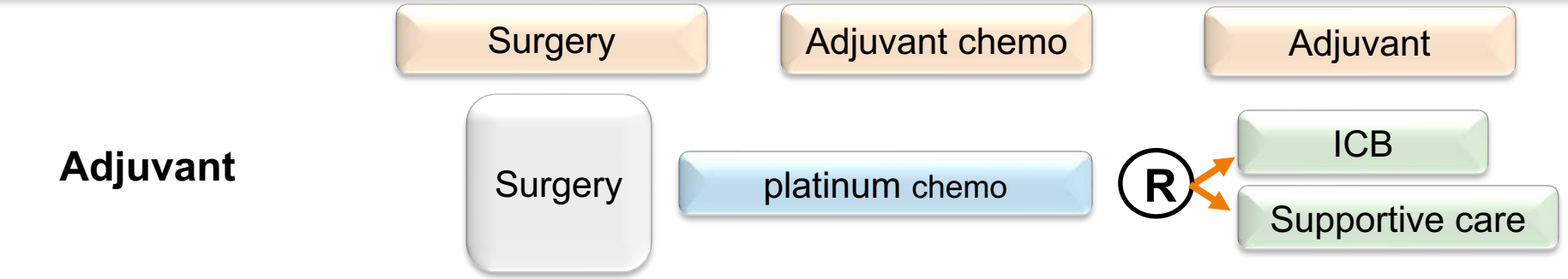
Randomized studies of adjuvant ICB for resectable NSCLC



IMpower010	N=1280 1 EP: DFS II-IIIA, PDL1>1%, then all II-IIIA, then IB-IIIA 2 EP: Incidence of toxicity	**Primary results:** HR=0.66 for II-IIIA PD-L1 TC ≥1% HR=0.79 for all Stage II-IIIA	R → atezo; Supportive care
PEARLS/KN-091	N=1177 1 EP: DFS IB-IIIA, ≥50% 2 EP; OS, OS in ≥50% and ≥1%	**Primary results:** HR=0.76 for all IB-IIIA (P=.0014, 95% CI 0.63-0.91) HR=0.82 for PDL1 ≥50% (*P* = 0.14 95% CI, 0.57-1.18)	R → pembrolizumab; Supportive care
ANVIL	N=901 1 EP: DFS, OS 2 EP: Incidence of toxicity		R → nivolumab; Supportive care
BR.31	N=1360 1EP: DFS PD-L1 TC ≥25% 2EP: OS, DFS in other groups		R → durvalumab; Supportive care

Felip, Lancet 2021; Paz-Ares, et al. *Annals Oncology*. 2022;33(4):451

Courtesy of John V Heymach, MD, PhD

What about IO after definitive RT? The I-SABR RP2 study for early-stage or isolated lung parenchymal recurrent node-negative NSCLC

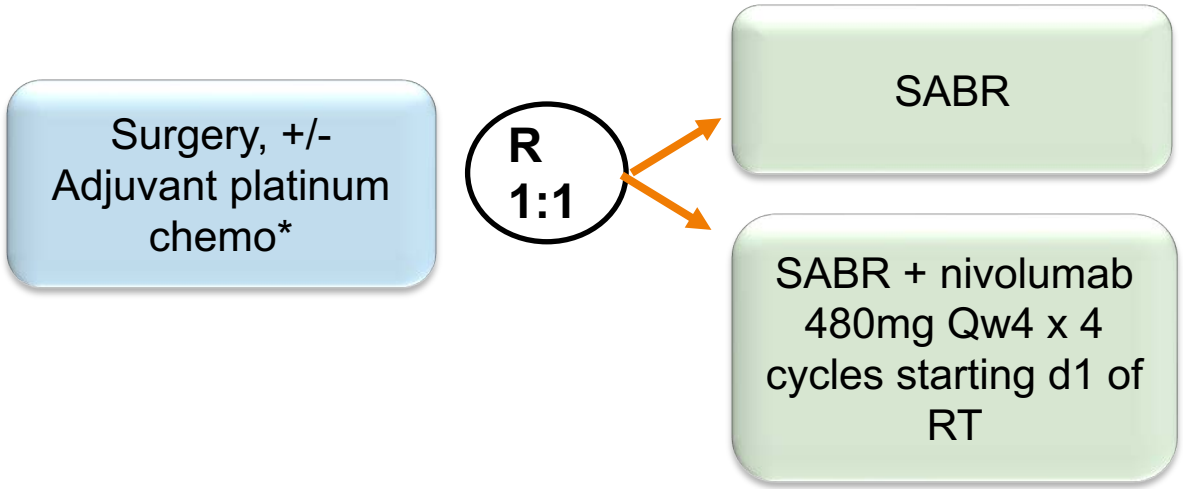
N=156 randomized

Key eligibility

- Stage IA-IIB, AJCC 8th ed. Or isolated parenchymal recurrence (node-negative)
- Medically inoperable or refused surgery

Stratification:

- ECOG PS (0–1 vs 2), tumor size (≤3 cm vs >3 to 5 cm vs >5 to 7 cm), histology (squamous vs non-squamous), and lung cancer history (primary vs recurrent disease)

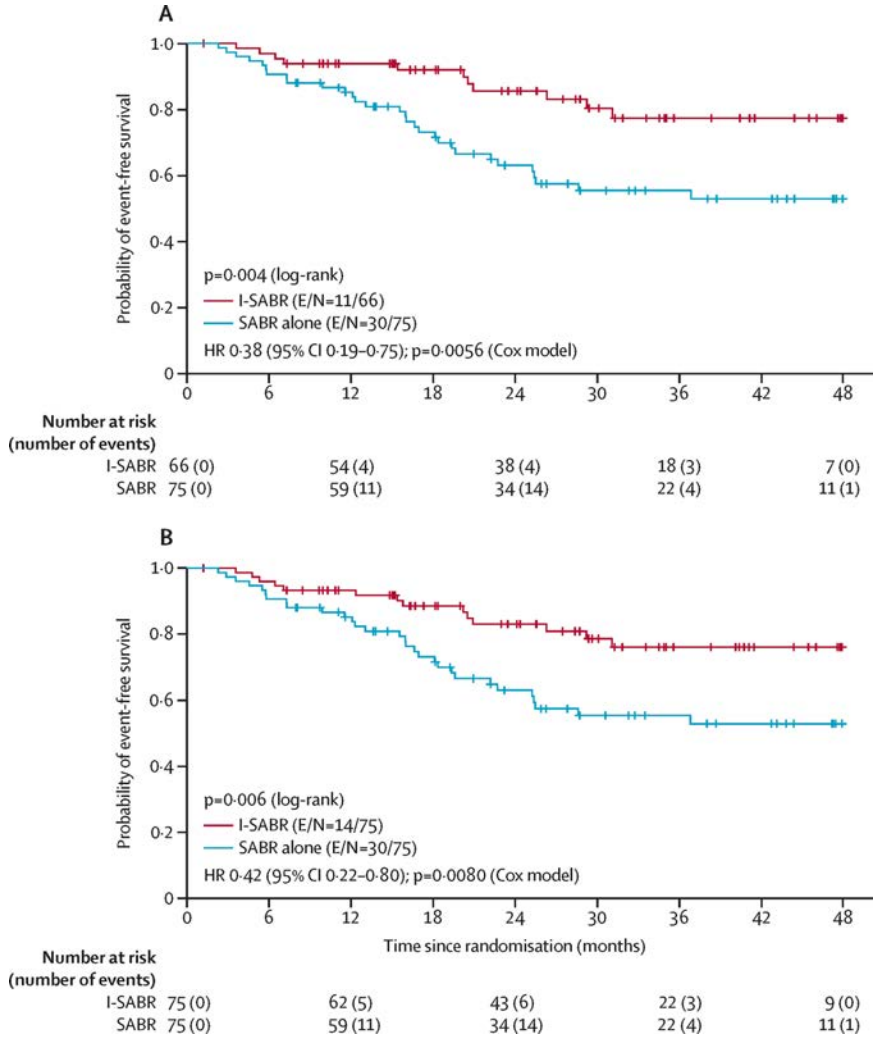


Primary endpoint : 4Y EFS (events include recurrence, new primary, or death), both ITT and treatment per-protocol

Chang et al, Lancet 2023

Courtesy of John Heymach MD, PhD

I-SABR RP2 study for early-stage or isolated lung parenchymal recurrent node-negative NSCLC: primary results



Per protocol treated
HR 0.38 (95% CI 0.19-.75; p=.0056)

ITT population
HR 0.42 (95% CI 0.22-.80; p=.006)

Chang et al, Lancet 2023

Courtesy of John Heymach MD, PhD

Adjuvant therapy for resectable NSCLC: the bottom line

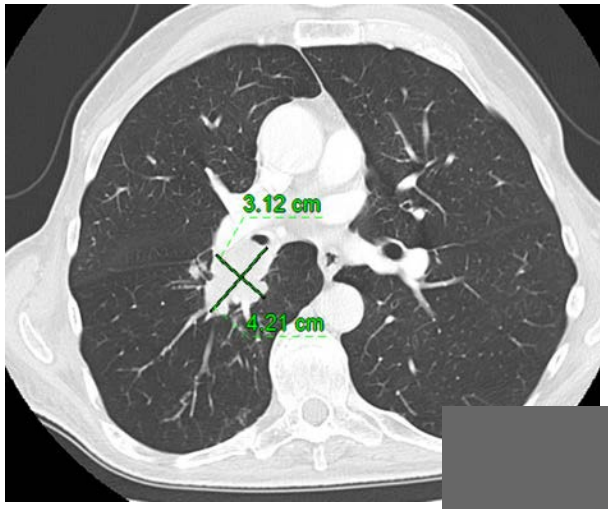
ICB

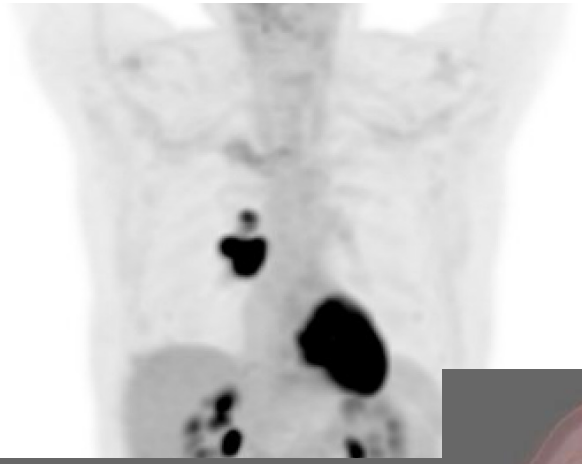
- Adjuvant ICB improves outcomes in resectable NSCLC in overall population although benefit generally greater in higher PD-L1 levels
- Pembro approved stages IB-IIIA (any PD-L1), atezo in PD-L1 >1%
- Initial results suggest adjuvant nivolumab improves EFS after SABR

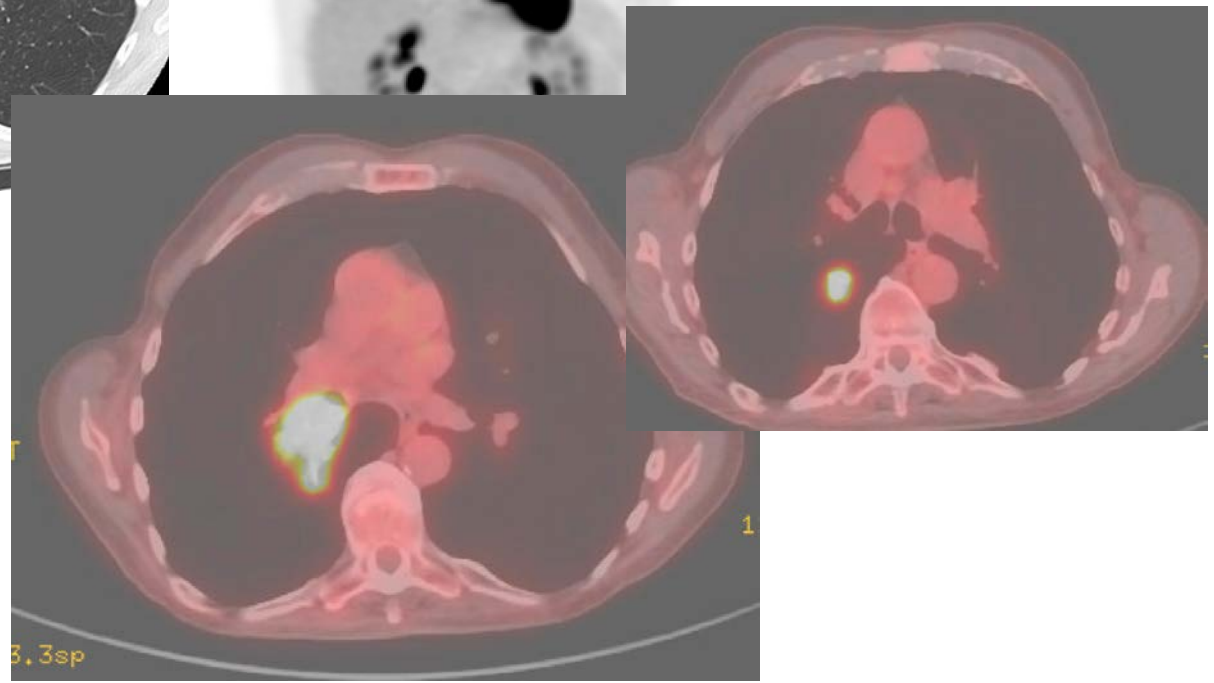
Courtesy of John V Heymach, MD, PhD

Case Presentation – Dr Chaft: cT2aN1, Stage IIB

70-year-old male former smoker presents with cough





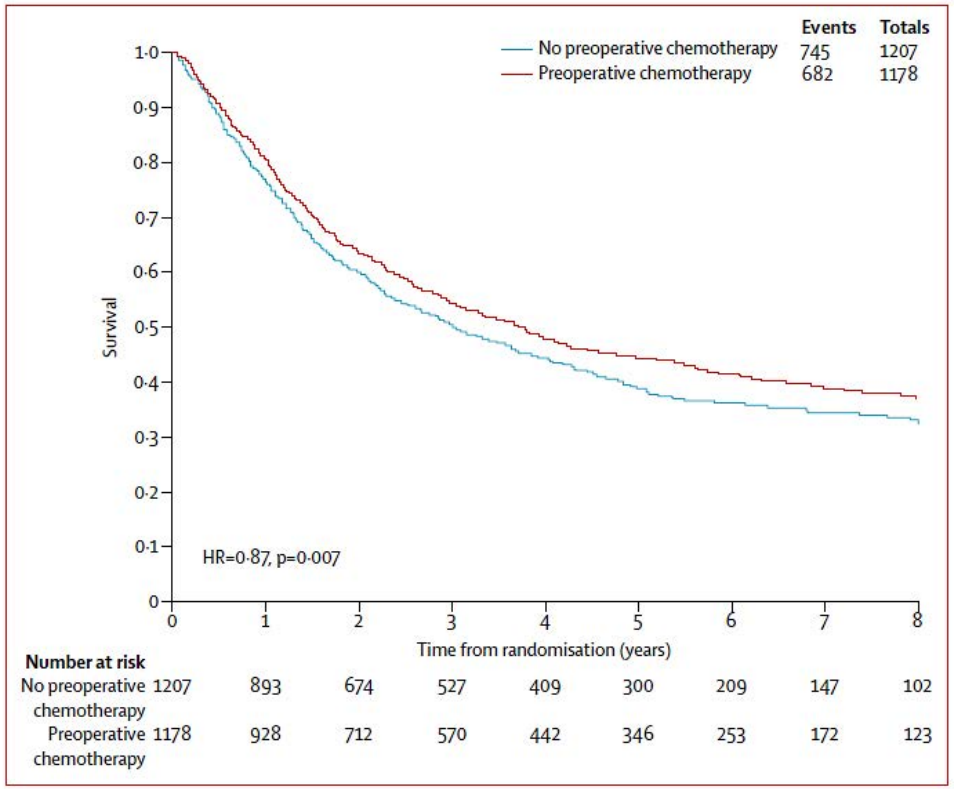


Bronch bx: (primary tumor, LN not accessible):

NSCLC, favor squamous cell, PD-L1 60%

Why Induction?

- Regression from the hilum may enable lesser resection
- Prehabilitation
- *In vivo* treatment efficacy assessment

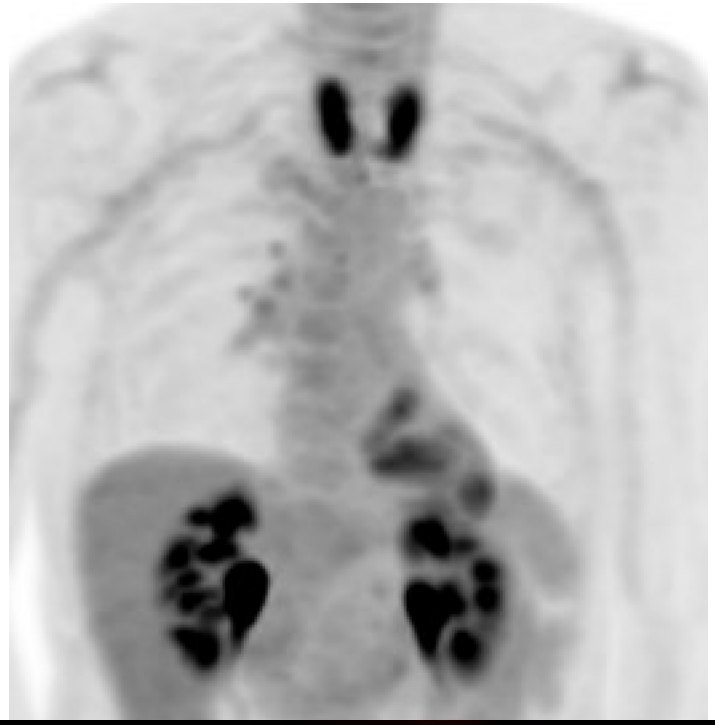


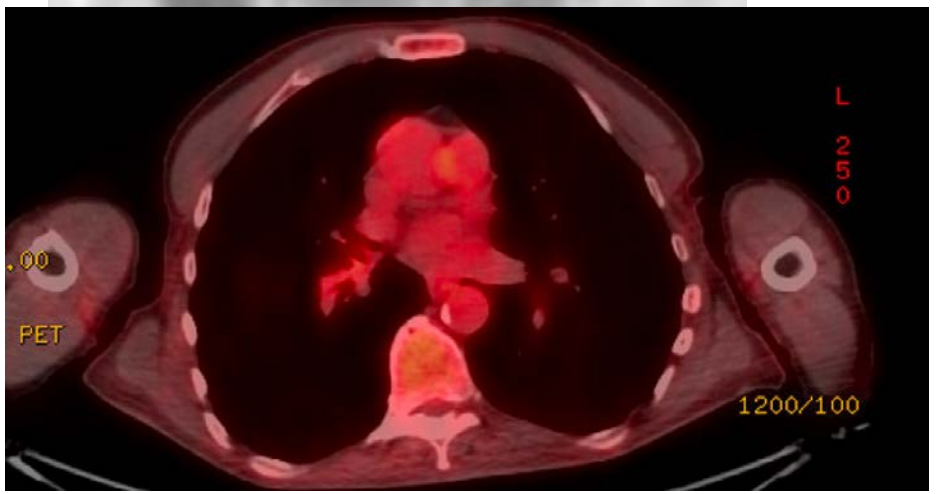
Courtesy of Jamie E Chaft, MD

Memorial Sloan Kettering Cancer Center

Post-treatment evaluation

- CT PR after 2 cycles
- Scintigraphic PR
- Notably thyroiditis
- Severe hypothyroidism on labs
- No AI





How do I follow these folks?

CT Chest w/con after 2 cycles
PET/MR brain with endo labs (on the day of scans, so results in your hand when pt returns) after 3rd cycle

Courtesy of Jamie E Chaft, MD

Case #1 Summary

- Nice radiographic response to chemo-IO
- Surgery delayed to manage IO induced hypothyroidism
  - Induction of anesthesia when severely hypothyroid can lead to vascular collapse
- Pt went to the OR last week, path report pending
- He will need continued endo lab follow-up

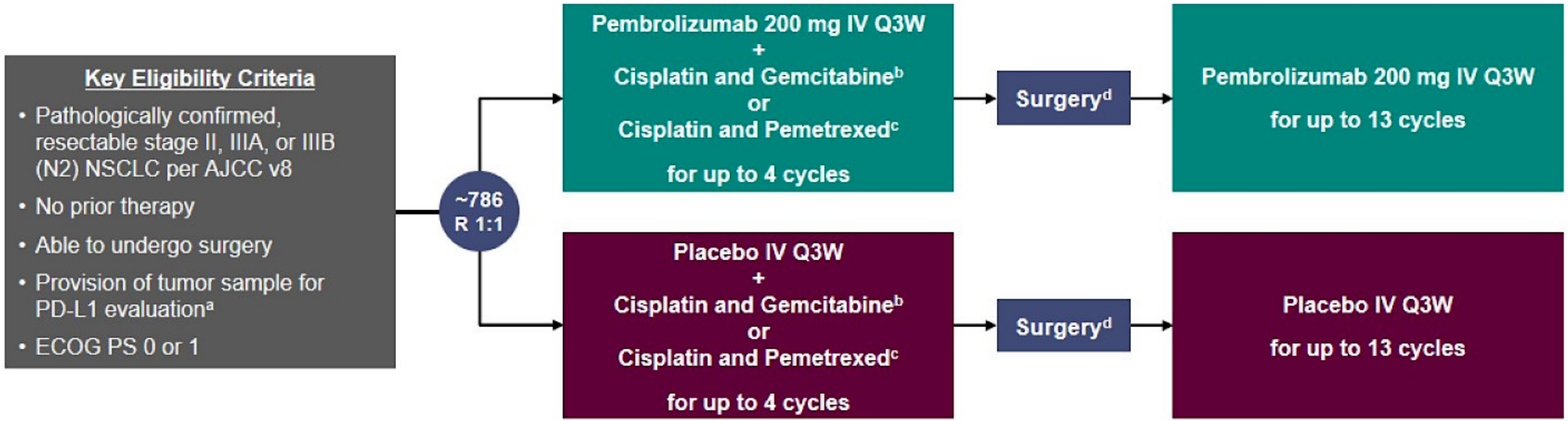
Case #1 Outcomes to query

CM-816 didn't prespecify adjuvant therapy

- What if he has a pCR, any more therapy needed?
- What if he doesn't have a pCR?
- Who is going to follow his endocrinopathies?
- When is he safely out of the window of developing a new IRAE?

I will watch… if carbo/pacli/nivo didn't do the trick, gem monotherapy or more IO play no role without more data

KEYNOTE-671 Study Design
Randomized, Double-Blind, Phase 3 Trial



Stratification Factors
- Disease stage (II vs III)
- PD-L1 TPS[a] (<50% vs ≥50%)
- Histology (squamous vs nonsquamous)
- Geographic region (east Asia vs not east Asia)

Dual primary end points: EFS per investigator review and OS

Key secondary end points: mPR and pCR per blinded, independent pathology review, and safety

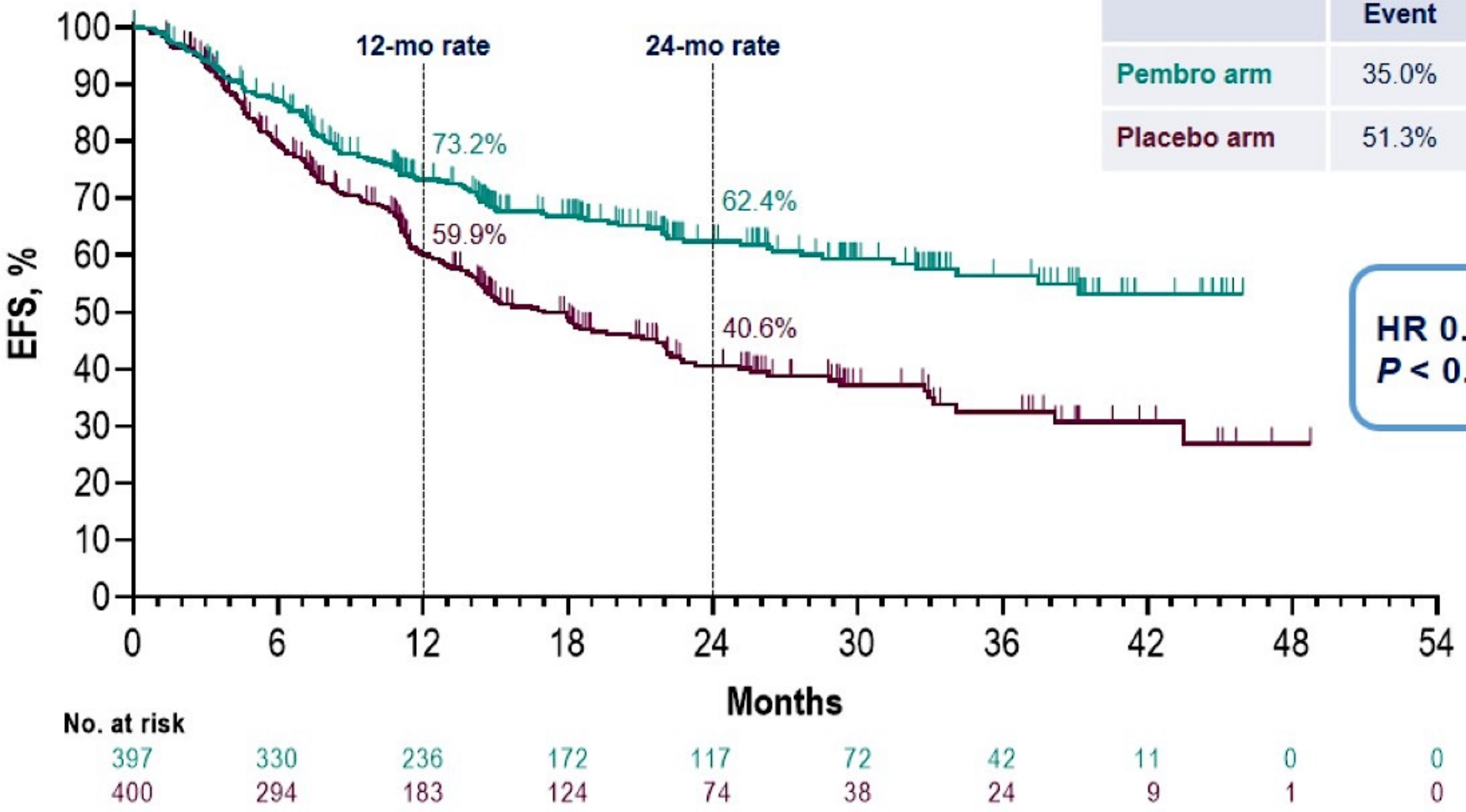
[a] Assessed at a central laboratory using PD-L1 IHC 22C3 pharmDx. [b] Cisplatin 75 mg/m^2 IV Q3W + gemcitabine 1000 mg/m^2 IV on days 1 and 8 Q3W was permitted for squamous histology only. [c] Cisplatin 75 mg/m^2 IV Q3W + pemetrexed 500 mg/m^2 IV Q3W was permitted for nonsquamous histology only. [d] Radiotherapy was to be administered to participants with microscopic positive margins, gross residual disease, or extracapsular nodal extension following surgery and to participants who did not undergo planned surgery for any reason other than local progression or metastatic disease. ClinicalTrials.gov identifier: NCT03425643.

Courtesy of Jamie E Chaft, MD

N Engl J Med 2023 Aug 10;389(6):491-503.

KEYNOTE-671: Event-Free Survival

	Pts w/ Event	Median (95% CI), mo
Pembro arm	35.0%	NR (34.1-NR)
Placebo arm	51.3%	17.0 (14.3-22.0)



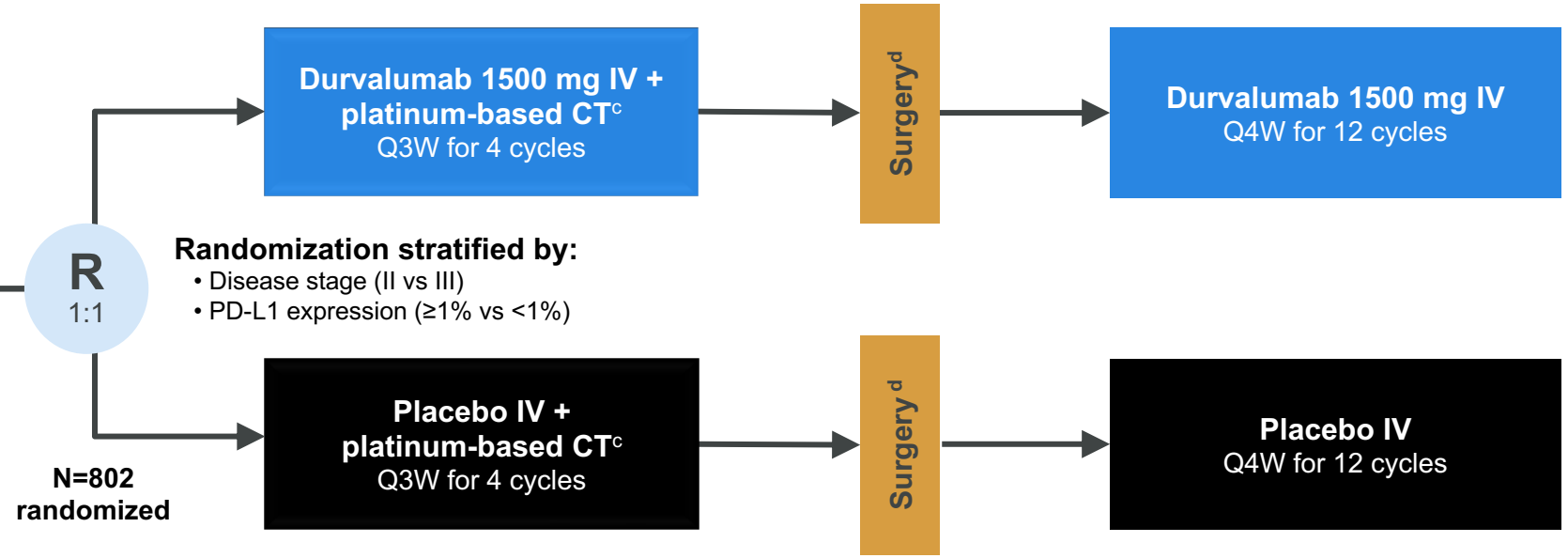
HR 0.58 (95% CI, 0.46-0.72)
***P* < 0.00001**

EFS defined as time from randomization to first occurrence of local progression precluding planned surgery, unresectable tumor, progression or recurrence per RECIST v1.1 by investigator assessment, or death from any cause. Data cutoff date for IA1: July 29, 2022 (median follow-up, 25.2 mo [range, 7.5-50.6]).

AEGEAN: Study Design

Study population

- Treatment-naïve
- ECOG PS 0 or 1
- Resectable NSCLC[a] (stage IIA–IIIB[N2]; AJCC 8th edition)
- Lobectomy, sleeve resection, or bilobectomy as planned surgery[a]
- Confirmed PD-L1 status[b]
- No documented *EGFR/ALK* aberrations[a]



Endpoints: All efficacy analyses performed on a modified population that excludes patients with documented EGFR/ALK aberrations[e]

Primary:

- pCR by central lab (per IASLC 2020)
- EFS using BICR (per RECIST v1.1)

Key secondary:

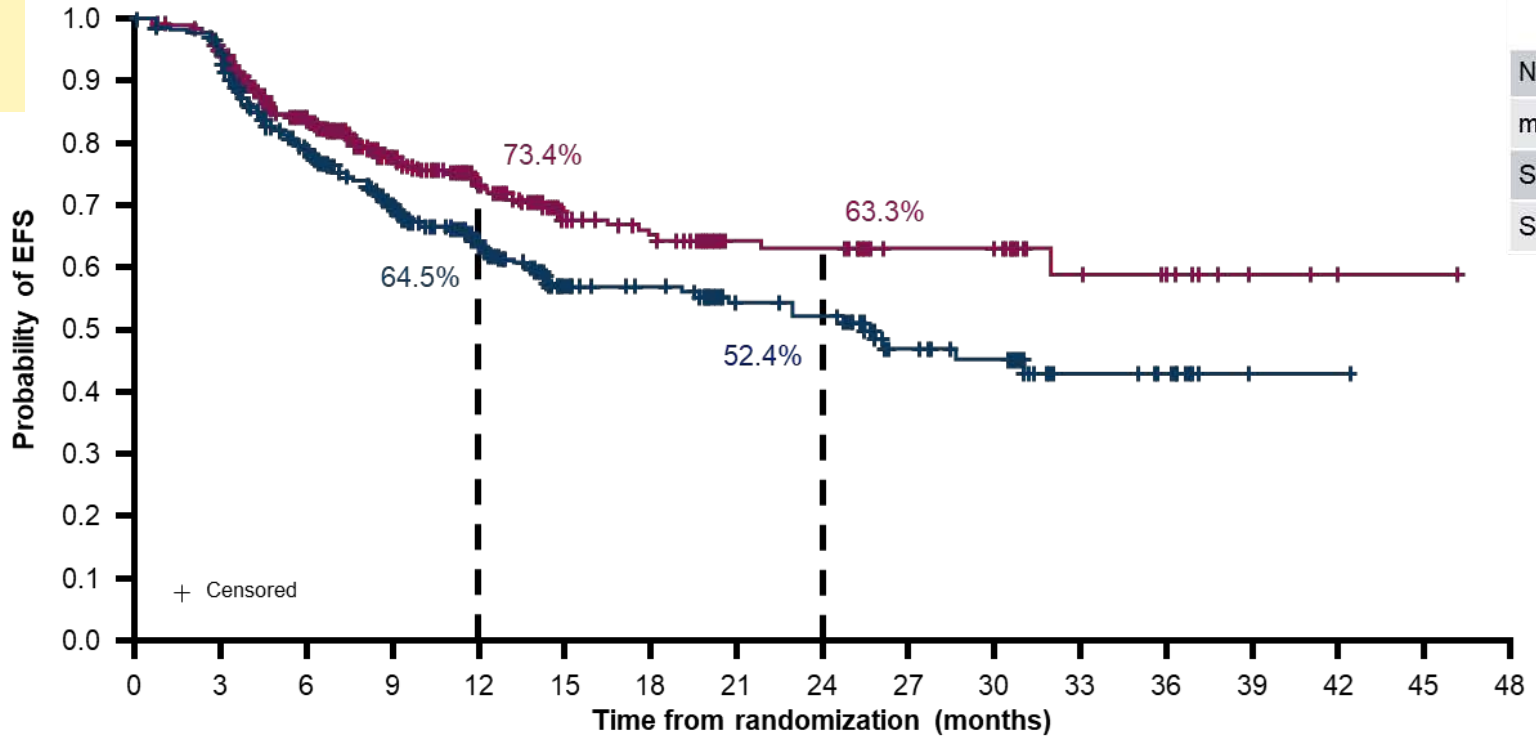
- MPR by central lab (per IASLC 2020)
- DFS using BICR (per RECIST v1.1)
- OS

Heymach, J. AACR April 2023.

Courtesy of Jamie E Chaft, MD

Memorial Sloan Kettering Cancer Center

AEGEAN: EFS



No. at risk:																	
D arm	366	336	271	194	140	90	78	50	49	31	30	14	11	3	1	1	0
PBO arm	374	339	257	184	136	82	74	53	50	30	25	16	13	1	1	0	0

	D arm	P arm
No. events / no. patients (%)	98/366 (26.8)	138/374 (36.9)
mEFS, months (95% CI)	NR (31.9–NR)	25.9 (18.9–NR)
Stratified HR* (95% CI)	0.68 (0.53–0.88)	
Stratified log-rank P-value	0.003902	

Median follow-up (range) in censored patients: 11.7 months (0.0–46.1)

EFS maturity: 31.9%

Heymach, J. AACR April 2023.

Courtesy of Jamie E Chaft, MD

Memorial Sloan Kettering Cancer Center

Take home messages on Neoadjuvant Therapy

- Induction IO likely more effective than adjuvant IO
- Predictive biomarker testing remains important
  - not IO for all
- Personalized medicine needs to be employed in the perioperative setting too
  - Disease characteristics (location, hemoptysis, obstruction)
  - Tumor biology (PD-L1 genomics)
  - Pt characteristics (comorbidities)
  - Pt preference (without comparative data between pre/postop)

Courtesy of Jamie E Chaft, MD

In which specific clinical situations do you or would you administer adjuvant chemotherapy followed by an anti-PD-1/PD-L1 antibody?

 Dr Chaft	Stage II/III resected, PD-L1-positive, EGFR/ALK/ROS/RET/HER2-negative
 Dr Heymach	Only if resected prior to seeing me, or unwilling to wait for neoadjuvant; otherwise, I prefer neoadjuvant
 Dr Awad	In a situation such as this: Some surgeons take patients straight to surgery without discussing neoadjuvant therapy, or they discover that the pathologic stage is actually II (eg, was clinical Stage I going into surgery)
 Dr Forde	Upstaged from clinical Stage I to higher pathologic stage at surgery, candidate for adj chemo; I tend to recommend adj IO only for patients with PD-L1 ≥50% but discuss and have used with 1%-49%
 Dr Govindan	All patients with NSCLC who would be candidates for lobectomy
 Dr Wakelee	Select resected Stage II, and all resected Stage III especially with high PD-L1; but not to patients with a driver mutation that is nonresponsive to IO

RTP RESEARCH TO PRACTICE

Think of the last patient to whom you administered adjuvant chemotherapy followed by an anti-PD-1/PD-L1 antibody. What was their …?

	Age	Sex	Disease stage	PD-L1 status
 Dr Chaft	65	Female	IIB	50%
 Dr Heymach	67	Male	IIB	50%
 Dr Awad	66	Female	IIB	1%
 Dr Forde	52	Female	IIIA	30%
 Dr Govindan	67	Male	II	Positive
 Dr Wakelee	73	Male	II	30%

Do you have a preferred choice of agent when recommending adjuvant immunotherapy for a patient with localized NSCLC?

 Dr Chaft	Yes, atezolizumab
 Dr Heymach	Yes, atezolizumab for PD-L1-positive, pembrolizumab for PD-L1-negative
 Dr Awad	Yes, pembrolizumab
 Dr Forde	Yes, atezolizumab
 Dr Govindan	No preference
 Dr Wakelee	Yes, atezolizumab

Does PD-L1 level affect your preference of adjuvant immunotherapy for localized NSCLC?

 Dr Chaft	Yes, PD-L1 high: atezolizumab, PD-L1 low: either, PD-L1-negative: pembrolizumab
 Dr Heymach	Yes, atezolizumab for PD-L1-positive, pembrolizumab for PD-L1-negative
 Dr Awad	Yes, more likely to omit it if PD-L1-negative if there may be a contraindication (eg, history of autoimmune disease)
 Dr Forde	Yes, the consistency of the atezolizumab data across PD-L1 strata is reassuring and I tend to favor it
 Dr Govindan	No
 Dr Wakelee	Yes, atezolizumab if PD-L1 high, and I question the benefit of adjuvant IO in those with negative PD-L1

For a patient who does not wish to receive chemotherapy, in which situations, if any, would you be comfortable administering an adjuvant anti-PD-1/PD-L1 antibody alone?

 Dr Chaft	PD-L1 high or PD-L1 low and smoker or TMB high
 Dr Heymach	PD-L1-positive
 Dr Awad	I would still explain the benefit of chemotherapy, but if they do not want it, I would use adjuvant IO alone for Stage II/III, regardless of PD-L1 level
 Dr Forde	I am hesitant to recommend adjuvant IO alone but will consider if the pt is insistent they will not take chemo and the tumor is PD-L1 positive, ideally 50%+
 Dr Govindan	Smokers with PD-L1 of 50% or greater
 Dr Wakelee	No positive data with this; I'd be very hesitant but would discuss with a patient with very high tumor PD-L1 (no driver mutation) who absolutely refused chemo

TMB = tumor mutational burden

Based on your clinical experience and knowledge of available data, what would you estimate is the likelihood that a patient receiving 1 year of adjuvant immunotherapy will experience an immune-related adverse event?

 Dr Chaft	30%
 Dr Heymach	20%
 Dr Awad	25%
 Dr Forde	15%
 Dr Govindan	40%
 Dr Wakelee	50%

Approximately what proportion of patients receiving adjuvant immunotherapy for localized NSCLC complete treatment?

 Dr Chaft	50%
 Dr Heymach	70%
 Dr Awad	75%
 Dr Forde	60%
 Dr Govindan	80%
 Dr Wakelee	60%

RTP RESEARCH TO PRACTICE

Based on your clinical experience and knowledge of available data, what are the top 3 side-effect issues patients experience when receiving adjuvant immunotherapy for localized NSCLC?

 Dr Chaft	Pruritus/rash, hypothyroidism, arthralgias
 Dr Heymach	Thyroiditis, pneumonitis, colitis
 Dr Awad	Arthralgias, fatigue, hypothyroidism
 Dr Forde	GI upset, thyroid function abnormalities, skin rash
 Dr Govindan	Thyroid dysfunction, rash, asymptomatic pneumonitis
 Dr Wakelee	Thyroid dysfunction, rash, arthralgias

Do you believe that a correlation exists between autoimmune toxicity and treatment benefit among patients receiving immune checkpoint inhibitors?

 Dr Chaft	Yes
 Dr Heymach	Yes
 Dr Awad	Yes
 Dr Forde	Yes
 Dr Govindan	Yes
 Dr Wakelee	Yes

RTP RESEARCH TO PRACTICE

Please describe 3 situations in which you considered adjuvant immunotherapy for a patient with a potential contraindication (eg, prior autoimmune disease). What was the nature of the contraindication, what did you ultimately decide and how did the patient respond? Patient 1

 Dr Chaft	Controlled Crohn's disease, resected Stage IIA SCC, PD-L1-negative received adjuvant carboplatin/paclitaxel, no IO
 Dr Heymach	Minor skin autoimmune (psoriasis, inactive)
 Dr Awad	Recently active ulcerative colitis, PD-L1-negative, decided not to use adjuvant IO; currently receiving just adjuvant chemotherapy
 Dr Forde	History of Graves disease, discussed with endocrinologist and they felt reasonable to proceed, patient fared well and is without recurrence
 Dr Govindan	Lupus, discussed adjuvant IO but ultimately the patient did not receive this treatment
 Dr Wakelee	Mild rheumatoid arthritis, discussed and treated with adjuvant IO, patient fared okay

SCC = squamous cell carcinoma

Please describe 3 situations in which you considered adjuvant immunotherapy for a patient with a potential contraindication (eg, prior autoimmune disease). What was the nature of the contraindication, what did you ultimately decide and how did the patient respond? Patient 2

 Dr Chaft	Resected Stage IIIA KRAS G12C+/KEAP1-/STK11-, PD-L1 100% and concurrently resected thymoma received adjuvant cisplatin/pemetrexed, no IO
 Dr Heymach	High risk for relapse with history of RA (but RA history was soft — may have been osteoarthritis)
 Dr Awad	Interstitial lung disease, PD-L1-negative, just received chemotherapy. Possible disease recurrence
 Dr Forde	Vague history of lupus, never treated, rheumatology consult felt it was not lupus and patient received adjuvant IO without issues
 Dr Govindan	Organ transplant, discussed adjuvant immunotherapy but ultimately the patient did not receive this treatment
 Dr Wakelee	History of inflammatory bowel disease, discussed but patient decided against treatment

RTP RESEARCH TO PRACTICE

Please describe 3 situations in which you considered adjuvant immunotherapy for a patient with a potential contraindication (eg, prior autoimmune disease). What was the nature of the contraindication, what did you ultimately decide and how did the patient respond? Patient 3

 Dr Chaft	Resected Stage IIIA N1 KRAS G12C+ LCNEC, PD-L1 90%, RA on prednisone and biologics, received adjuvant carboplatin/paclitaxel and atezolizumab
 Dr Heymach	History of possible Crohn's, inactive, patient really motivated for treatment
 Dr Awad	Remote h/o Crohn's colitis, not recently active, PD-L1 TPS 60%, currently faring well on adjuvant pembrolizumab
 Dr Forde	Resected Stage IIB NSCLC, PD-L1 80%; history of "uveitis" and on steroid eye drops for years. Referred to ophthalmology, diagnosis of Fuchs heterochromic uveitis (late sequala of childhood rubella), ruled not a contraindication to IO and patient received adjuvant IO without any issues
 Dr Govindan	Multiple sclerosis with optic neuritis, discussed adjuvant immunotherapy but ultimately the patient did not receive this treatment
 Dr Wakelee	Paraneoplastic polymyalgia rheumatica which drastically improved after resection of Stage IIB NSCLC. We felt risk of IO was very high for a flare of her PMR

LCNEC = large cell neuroendocrine carcinoma of the lung; RA = rheumatoid arthritis

In which specific clinical situations do you or would you administer neoadjuvant chemotherapy combined with an anti-PD-1/PD-L1 antibody?

 Dr Chaft	Clinical Stage II/III, medically operable and technically resectable NSCLC without actionable oncogene driver mutation and without pre-existing autoimmune disease
 Dr Heymach	All EGFR and ALK wild-type patients with tumors larger than 4 cm
 Dr Awad	All patients with Stage II/III resectable NSCLC (EGFR/ALK negative) who are otherwise eligible for chemotherapy and immunotherapy
 Dr Forde	ECOG PS 0-1, limited comorbidities, resectable clinical Stage II/IIIA NSCLC without an EGFR mutation or ALK alteration
 Dr Govindan	Locally advanced node-positive NSCLC who would be candidates for lobectomy
 Dr Wakelee	Stage III without driver mutation, many but not all Stage II

RTP RESEARCH TO PRACTICE

Think of the last patient to whom you administered neoadjuvant chemotherapy combined with an anti-PD-1/PD-L1 antibody. What was their …?

	Age	Sex	Disease stage	PD-L1 status
 Dr Chaft	65	Male	IIB	30%
 Dr Heymach	69	Female	IIIA	20%
 Dr Awad	72	Male	IIIA	40%
 Dr Forde	81	Male	IIB	0%
 Dr Govindan	45	Female	IIIA	Positive
 Dr Wakelee	52	Male	IIIA	10%

In general, for a patient with localized non-small cell lung cancer (NSCLC) to whom you have made the decision to administer an anti-PD-1/PD-L1 antibody in the neoadjuvant setting, what do you consider to be the optimal approach?

 Dr Chaft	Neoadjuvant chemotherapy/nivolumab → resection
 Dr Heymach	Neoadjuvant chemotherapy/pembrolizumab → resection → adjuvant pembrolizumab
 Dr Awad	Neoadjuvant chemotherapy/nivolumab → resection
 Dr Forde	Neoadjuvant chemotherapy/nivolumab → resection
 Dr Govindan	Neoadjuvant chemotherapy/nivolumab → resection
 Dr Wakelee	Neoadjuvant chemotherapy/nivolumab → resection

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Does PD-L1 level affect your preference of neoadjuvant immunotherapy for localized NSCLC?

 Dr Chaft	Yes, but strictly to determine whether to administer; PD-L1 level does not affect my choice of agent
 Dr Heymach	No
 Dr Awad	Not exactly, though I am more optimistic for using chemoimmunotherapy for cancers that are PD-L1-positive
 Dr Forde	Yes, benefit of (neo)adjuvant IO is likely greater for PD-L1-positive disease; I tend to favor neoadjuvant chemotherapy/nivolumab for PD-L1-negative as it is a shorter course of therapy
 Dr Govindan	No
 Dr Wakelee	Yes, the concurrent with chemo approach is favored for those with low or no PD-L1 expression in my opinion, so lean towards neoadjuvant

IO = immunotherapy

What Clinicians Want to Know About the Management of Relapsed/Refractory Mantle Cell Lymphoma

A CME/MOC-Accredited Virtual Event

Tuesday, September 26, 2023
5:00 PM – 6:00 PM ET

Faculty

Toby A Eyre, MBChB, DipMedEd, MRCP, MD
Brad S Kahl, MD

Moderator

Neil Love, MD

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Thank you for joining us!

Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us. The survey will remain open for 5 minutes after the meeting ends.

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

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