Inside the Issue: Novel Agents, Approaches and Strategies in the Management of Higher-Risk Myelodysplastic Syndromes

A CME/MOC-Accredited Live Webinar

Tuesday, July 11, 2023
5:00 PM – 6:00 PM ET

Faculty

Guillermo Garcia-Manero, MD
David Sallman, MD

Moderator

Neil Love, MD

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Faculty

Guillermo Garcia-Manero, MD
McCredie Professor of Medicine
Chief, Section of MDS
Vice Chair, Department of Leukemia
The University of Texas
MD Anderson Cancer Center
Houston, Texas

David Sallman, MD
Associate Member
Malignant Hematology
Moffitt Cancer Center
Tampa, Florida

Moderator
Neil Love, MD
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Commercial Support

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Dr Love — Disclosures

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Dr Garcia-Manero — Disclosures

No relevant conflicts of interest to disclose.

Dr Sallman — Disclosures

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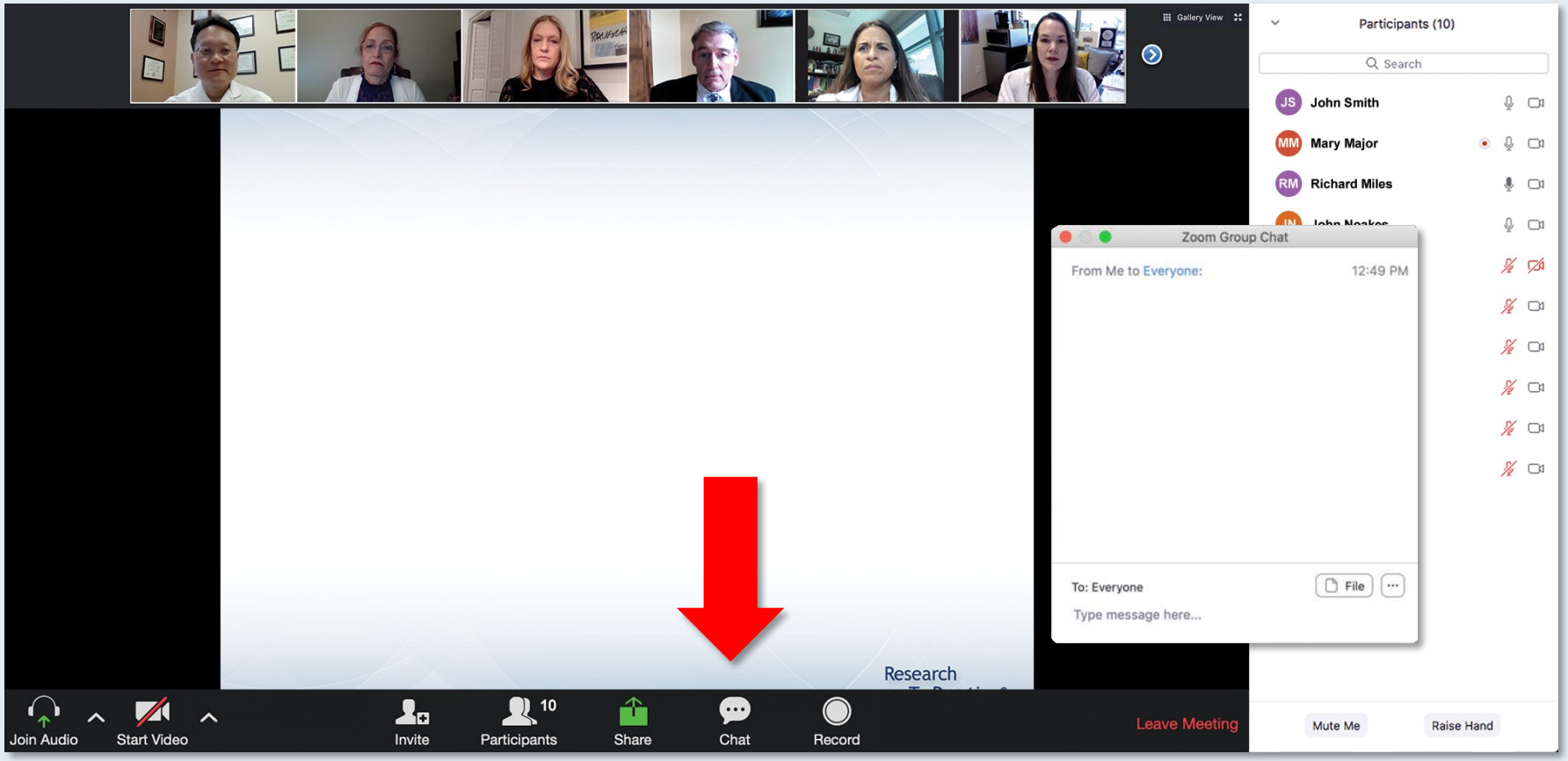

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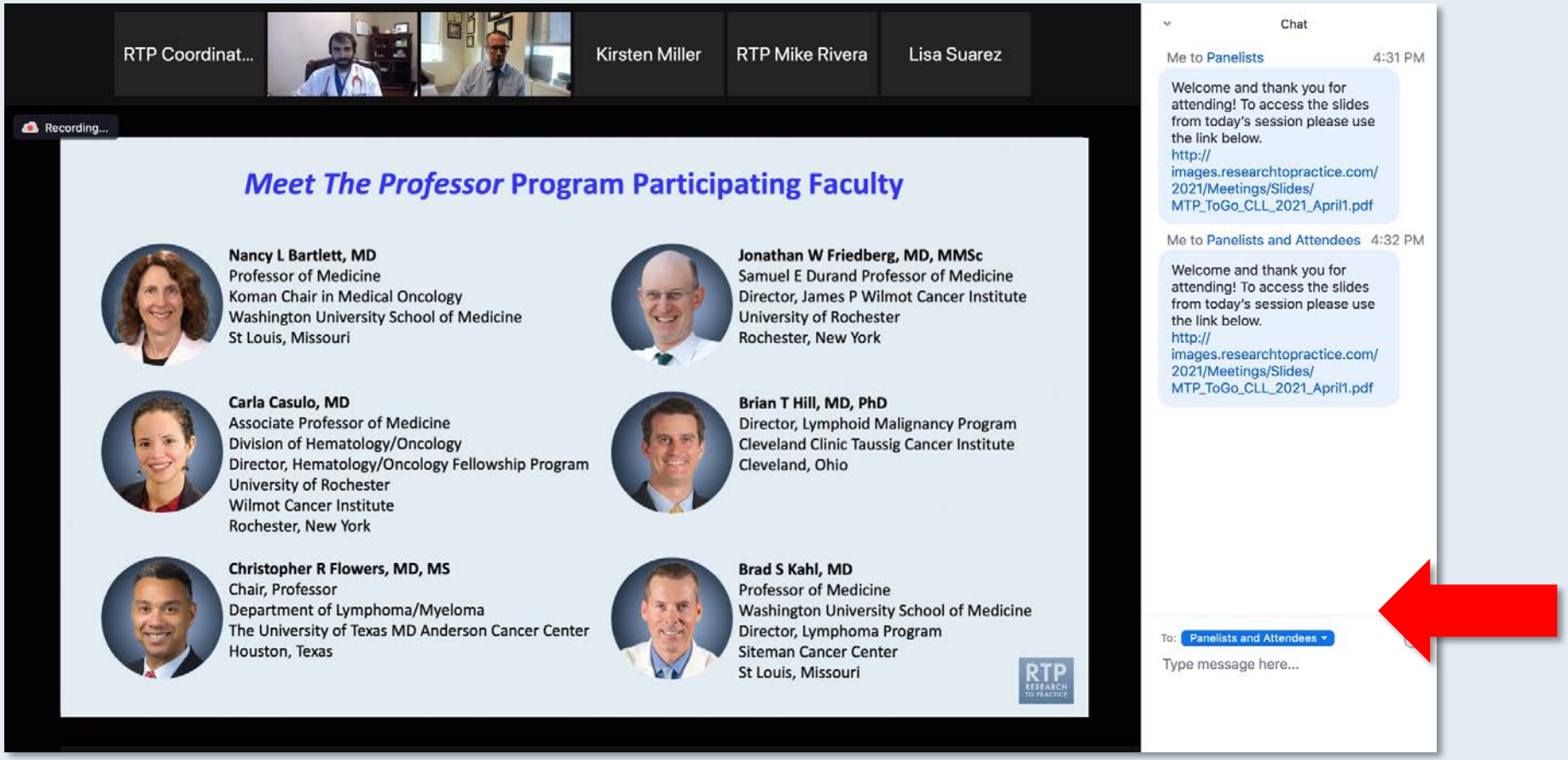

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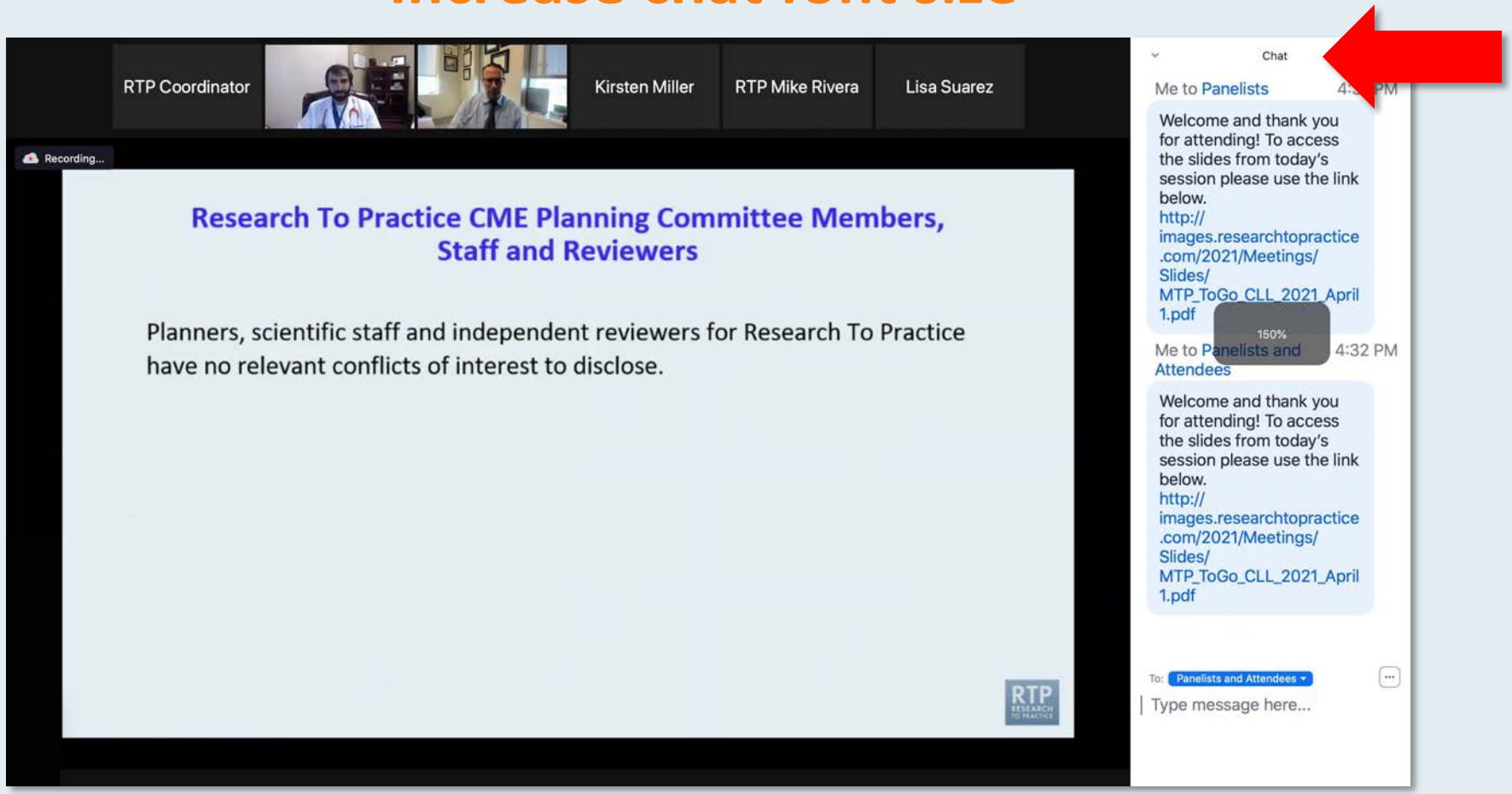

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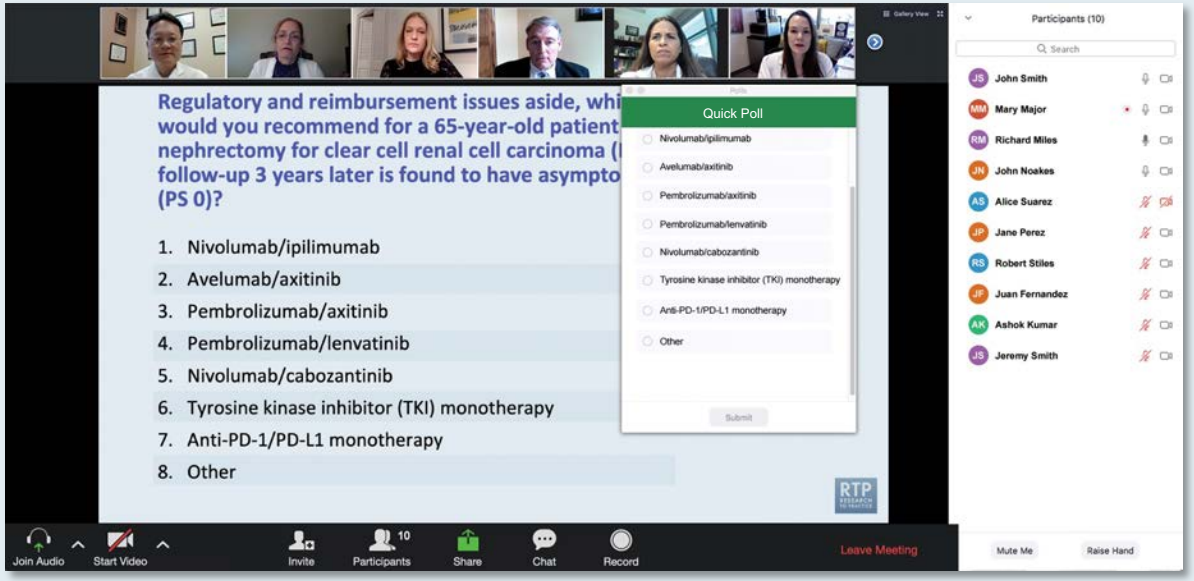

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WITH DR NEIL LOVE

Key Presentations in Acute Myeloid Leukemia and Myelodysplastic Syndromes from the 2022 ASH Annual Meeting

DR RICHARD STONE

DANA-FARBER CANCER INSTITUTE

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Year in Review: Clinical Investigator Perspectives on the Most Relevant New Data Sets and Advances in Oncology

A Multitumor CME/MOC-Accredited Live Webinar Series

Melanoma and Nonmelanoma Skin Cancers

Thursday, July 13, 2023
5:00 PM – 6:00 PM ET

Faculty

Omid Hamid, MD

Evan J Lipson, MD

Moderator

Neil Love, MD

RTP Year in Review 2023

Inside the Issue: Integrating Bispecific Antibodies into the Management of Multiple Myeloma — Patient Selection and Toxicity Management

A CME/MOC-Accredited Live Webinar

Tuesday, July 18, 2023
5:00 PM – 6:00 PM ET

Faculty

Hans Lee, MD
Saad Zafar Usmani, MD, MBA

Moderator

Neil Love, MD

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Inside the Issue: Current and Future Management of ER-Positive Metastatic Breast Cancer After Disease Progression on a CDK4/6 Inhibitor

A CME/MOC-Accredited Live Webinar

Thursday, July 20, 2023
5:00 PM – 6:00 PM ET

Faculty

Aditya Bardia, MD, MPH
Erika Hamilton, MD

Moderator

Neil Love, MD

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Meet The Professor

Optimizing the Management of Soft Tissue Sarcoma and Related Connective Tissue Disorders

Tuesday, July 25, 2023
5:00 PM – 6:00 PM ET

Faculty

Richard F Riedel, MD

Moderator

Neil Love, MD

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Inside the Issue: Exploring the Current and Future Management of High-Risk, Hormone-Sensitive Nonmetastatic Prostate Cancer

A CME/MOC-Accredited Live Webinar

Monday, July 31, 2023
5:00 PM – 6:00 PM ET

Faculty

Neal D Shore, MD
Mary-Ellen Taplin, MD

Moderator

Neil Love, MD

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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

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Associate Professor of Internal Medicine
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The James Cancer Center
Columbus, Ohio

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Leukemia and Bone Marrow Transplant Program
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The Johns Hopkins University School of Medicine
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Dana-Farber Cancer Institute
Professor of Medicine
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Professor of Oncology
Roswell Park Comprehensive Cancer Center
Buffalo, New York

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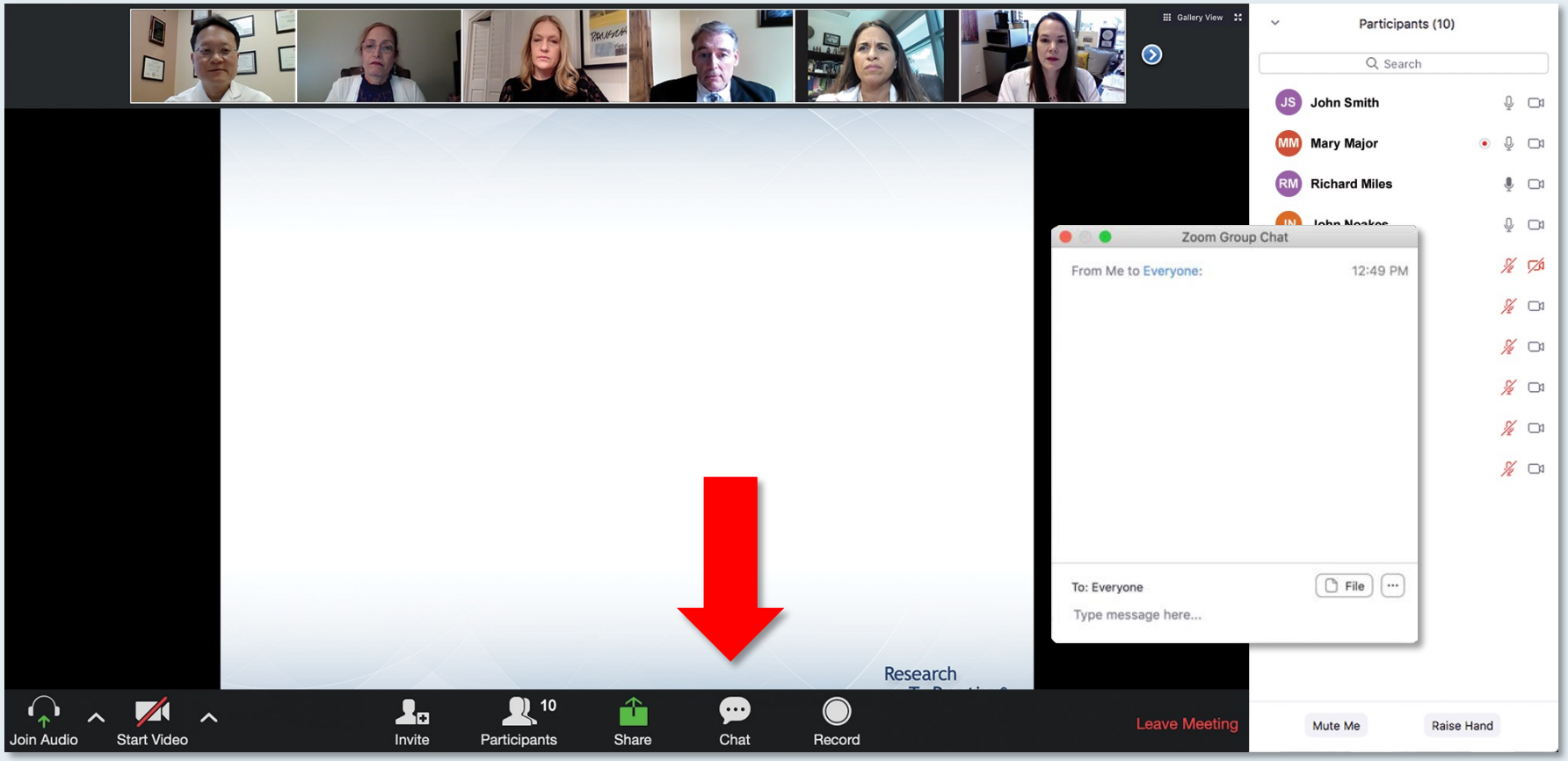

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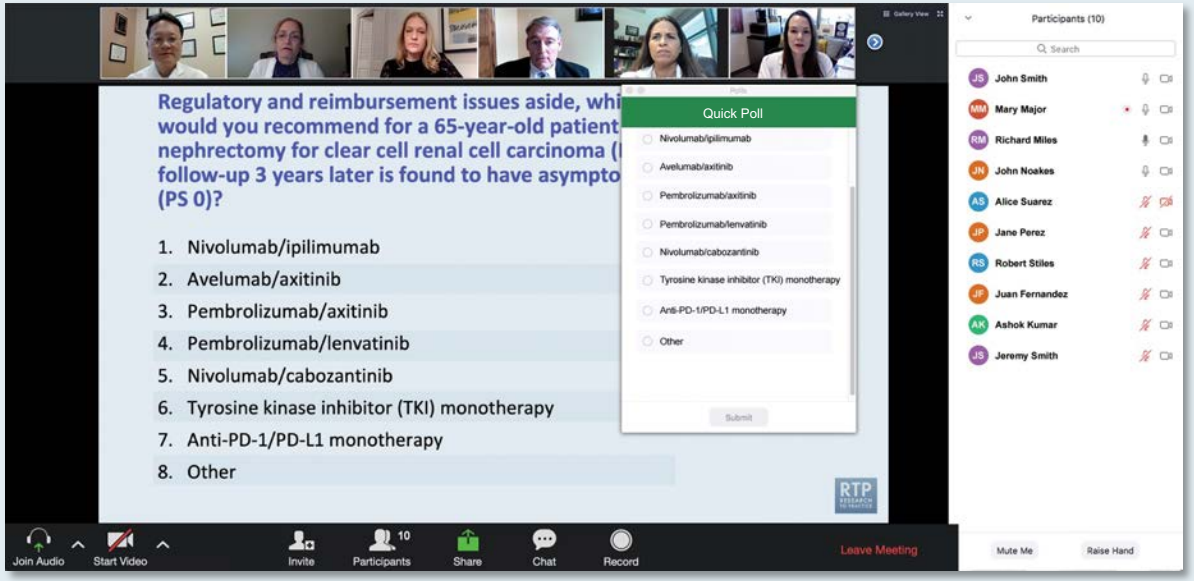

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Dr Garcia-Manero — Disclosures

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Contracted Research	Aprea Therapeutics, Jazz Pharmaceuticals Inc
Nonrelevant Financial Relationship	Intellisphere Oncology Specialty Group

Current Management of Higher Risk MDS

Guillermo Garcia-Manero MD
McCredie Professor
Chief, Section of MDS
Department of Leukemia
MD Anderson Cancer Center
Houston, TX
6/30/23

Future Directions in the Management of Higher Risk MDS

David A. Sallman, MD
Associate Member
Myeloid Section Head
david.sallman@moffitt.org

H. Lee Moffitt Cancer Center
& Research Institute
Tampa, FL

MOFFITT CANCER CENTER

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Key Data Sets

Guillermo Garcia-Manero, MD

- Garcia-Manero G. Myelodysplastic syndromes: 2023 update on diagnosis, risk-stratification, and management. *Am J Hematol* 2023 June 8;[Online ahead of print].
- Bernard E et al. Molecular international prognostic scoring system for myelodysplastic syndromes. *NEJM Evid* 2022;1(7).
- Savona MR et al. An oral fixed-dose combination of decitabine and cedazuridine in myelodysplastic syndromes: A multicentre, open-label, dose-escalation, phase 1 study. *Lancet Haematol* 2019 April;6(4):e194-203.
- Savona MR et al. Prolonged survival observed in 133 MDS patients treated with oral decitabine/cedazuridine. International Congress on Myelodysplastic Syndromes 2021;Abstract P48.
- Savona MR et al. Prolonged survival in bi-allelic TP53-mutated (TP53mut) MDS subjects treated with oral decitabine/cedazuridine in the ASCERTAIN trial (ASTX727-02). ASH 2022;Abstract 854.

Key Data Sets

Guillermo Garcia-Manero, MD (Continued)

- Sekeres MA et al. Pevonedistat (PEV) + azacitidine (AZA) versus AZA alone as first-line treatment for patients with higher-risk myelodysplastic syndromes (MDS)/chronic myelomonocytic leukemia (CMML) or acute myeloid leukemia (AML) with 20-30% marrow blasts: The randomized Phase 3 PANTHER trial. *Blood* 2021;138(Suppl 1):242.
- Bazinet A et al. Azacitidine plus venetoclax in patients with high-risk myelodysplastic syndromes or chronic myelomonocytic leukaemia: Phase 1 results of a single-centre, dose-escalation, dose-expansion, phase 1-2 study. *Lancet Haematol* 2022 Oct;9(10):e756-65.
- Bataller A et al. Phase 1/2 study of oral decitabine/cedazuridine in combination with venetoclax in treatment-naïve higher-risk myelodysplastic syndromes or chronic myelomonocytic leukemia. EHA 2023;Abstract S172.
- Sallman DA et al. Long term follow-up and combined Phase 2 results of eprenetapopt (APR-246) and azacitidine (AZA) in patients with TP53 mutant myelodysplastic syndromes (MDS) and oligoblastic acute myeloid leukemia (AML). ASH 2021;Abstract 246.
- DiNardo CD et al. Targeted therapy with the mutant IDH2 inhibitor enasidenib for high-risk IDH2-mutant myelodysplastic syndrome. *Blood Adv* 2023 June 13;7(11):2378-87.

Key Data Sets

David Sallman, MD

- Grob T et al. Molecular characterization of mutant TP53 acute myeloid leukemia and high-risk myelodysplastic syndrome. *Blood* 2022 April 14;139(15):2347-54.
- Tashakori M et al. TP53 copy number and protein expression inform mutation status across risk categories in acute myeloid leukemia. *Blood* 2022 July 7;140(1):58-72.
- Swoboda DM et al. Marrow ring sideroblasts are highly predictive for TP53 mutation in MDS with excess blasts. *Leukemia* 2022 April;36(4):1189-92.
- Sallman DA et al. Tolerability and efficacy of the first-in-class anti-CD47 antibody magrolimab combined with azacitidine in MDS and AML patients: Phase Ib results. ASCO 2020;Abstract 7507.
- Sallman DA et al. Magrolimab in combination with azacitidine in patients with higher-risk myelodysplastic syndromes: Final results of a phase Ib study. *J Clin Oncol* 2023 May 20;41(15):2815-26.
- Sallman DA et al. Magrolimab in combination with azacitidine for patients with untreated higher-risk myelodysplastic syndromes (HR MDS): 5F9005 phase 1b study results. EHA 2022;Abstract S166.

Key Data Sets

David Sallman, MD (Continued)

- Zeidan AM et al. Primary results of stimulus-MDS1: A randomized, double-blind, placebo-controlled phase II study of TIM-3 inhibition with sabatolimab added to hypomethylating agents (HMAs) in adult patients with higher-risk myelodysplastic syndromes (MDS). ASH 2022;Abstract 853.
- Zeidan AM et al. STIMULUS-MDS2 design and rationale: A phase III trial with the anti-TIM-3 sabatolimab (MBG453) + azacitidine in higher risk MDS and CMML-2. *Future Oncol* 2023 March;19(9):631-42.
- DiNardo CD et al. Targeted therapy with the mutant IDH2 inhibitor enasidenib for high-risk IDH2-mutant myelodysplastic syndrome. *Blood Adv* 2023 June 13;7(11):2378-87.

Agenda

MODULE 1: Biology of Acute Myeloid Leukemia/Myelodysplastic Syndromes

MODULE 2: Assessment of Risk Status

MODULE 3: Oral Hypomethylating Agents (HMAs)

MODULE 4: HMA/Venetoclax; Other Combinations

MODULE 5: Magrolimab/TP53

MODULE 6: Targeted Treatment

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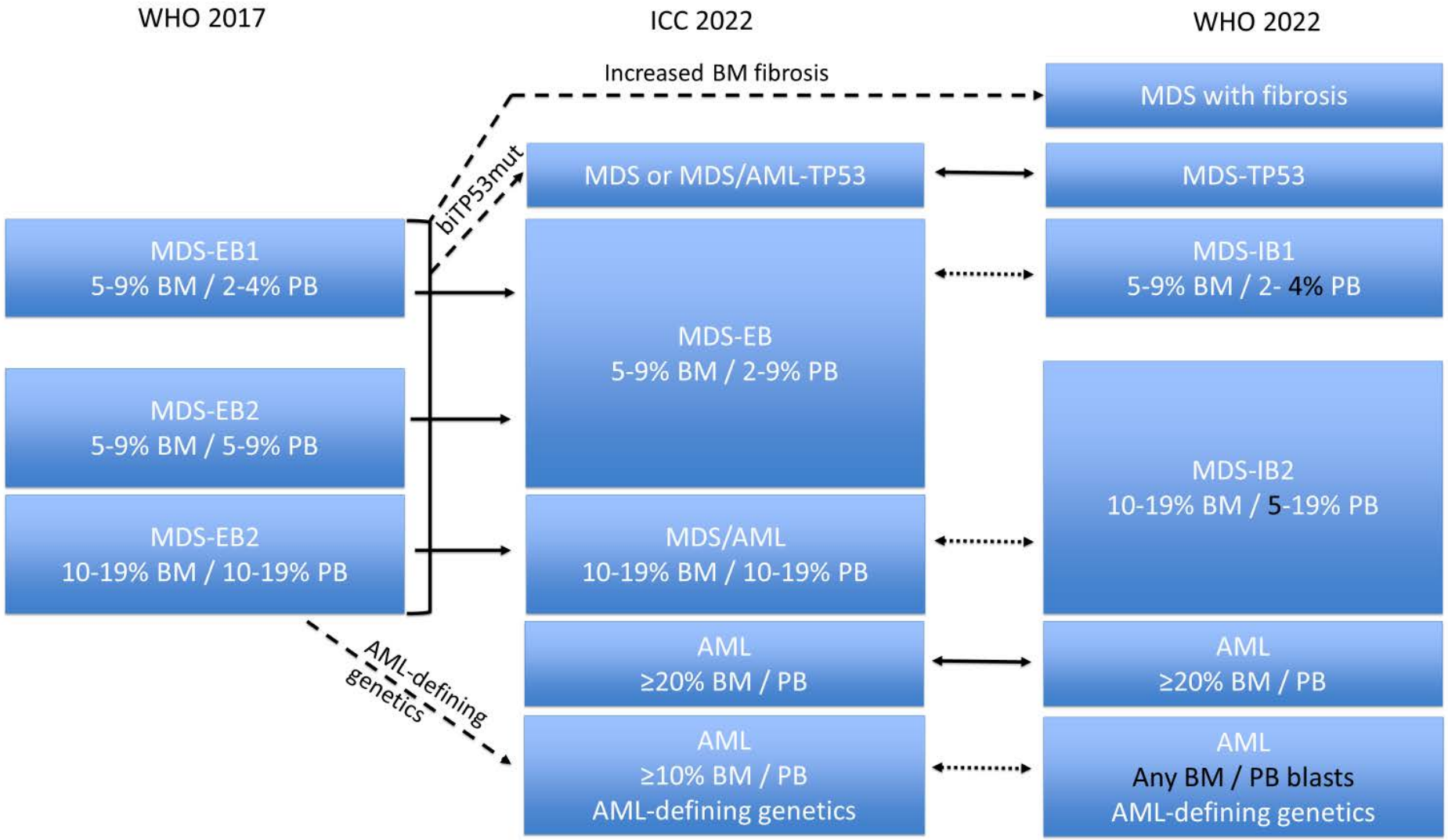
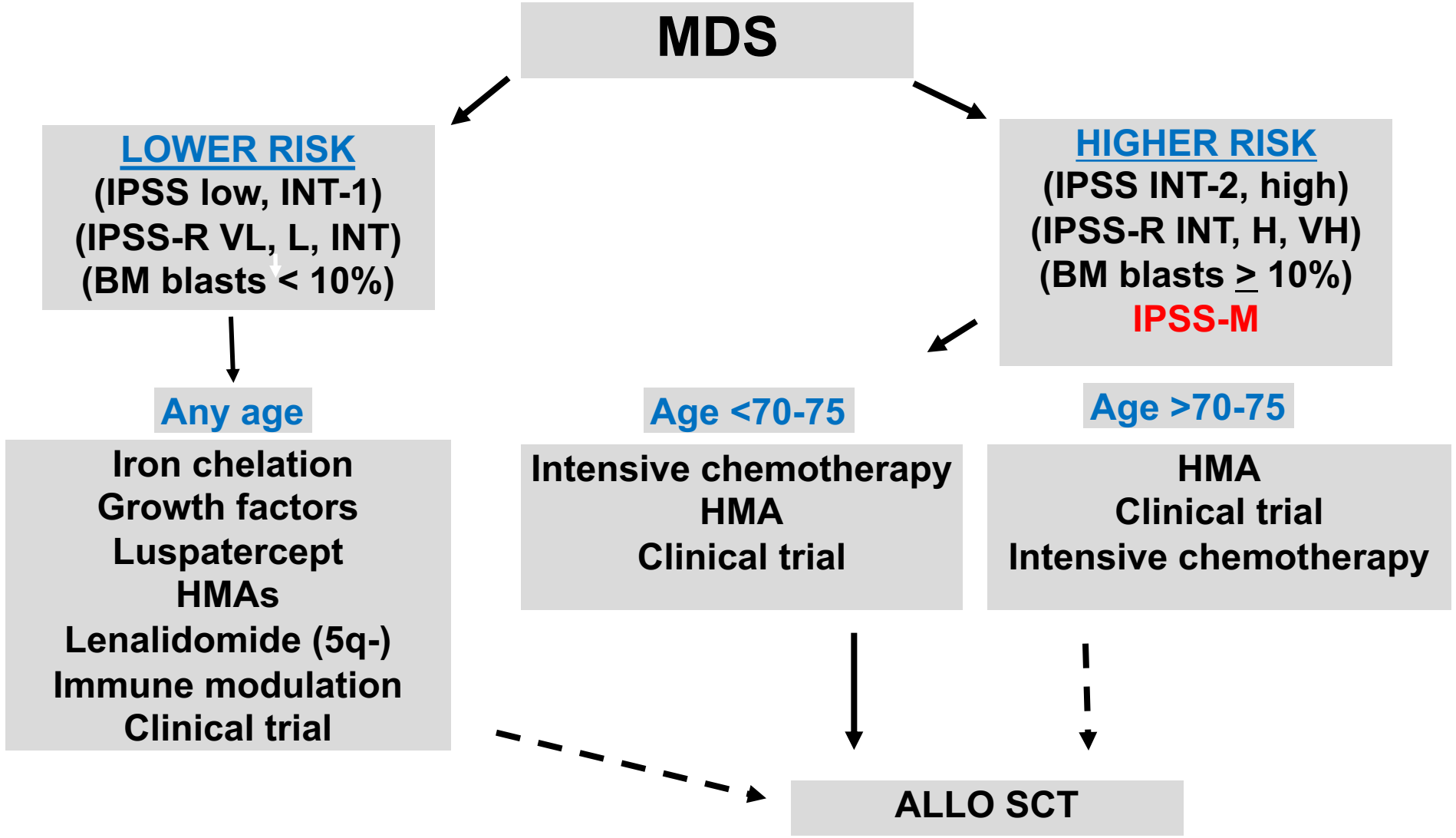
Overlap of MDS and AML



Courtesy of Hasserjian R

Courtesy of David A Sallman, MD

Proposed treatment algorithm for patients with MDS 2023



Garcia-Manero et al AJH 2023

Courtesy of Guillermo Garcia-Manero, MD

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Molecular International Prognostic Scoring System for myelodysplastic syndromes

Elsa Bernard, PhD
Research Associate
Computational Oncology | Papaemmanuil Lab | Memorial Sloan Kettering Cancer Center

@Elsa2Bernard

ASH 21, NEJM Evidence 2022

Courtesy of Guillermo Garcia-Manero, MD

Impact of number of mutations in survival in MDS

Adverse Factor		HR	P value	Assigned Score
IPSS-R	Intermediate	1.45	0.45	0.5
	High/Very high	4.66	<0.001	1.5
TP53 mutation		3.12	0.011	1
≥ 3 mutations		2.51	0.005	1

Montalban-Bravo et al. Oncotarget 2018

Courtesy of Guillermo Garcia-Manero, MD

Which of the following genes do you consider essential to evaluate for alteration in a patient with newly diagnosed myelodysplastic syndromes (MDS)?

 Dr Garcia-Manero	TP53, FLT3, NPM1, IDH2, ASXL1
 Dr Sallman	IPSS-M main effect genes*
 Dr Borate	IPSS-M main effect genes*
 Dr Brunner	IPSS-M main effect genes*
 Dr DeZern	IPSS-M main effect genes*
 Dr Stone	IPSS-M main effect genes*
 Dr Wang	IPSS-M main effect genes*

* TP53, MLL/KMT2A, FLT3, SF3B1, NPM1, RUNX1, NRAS, ETV6, IDH2, CBL, EZH2, U2AF1, SRSF2, DNMT3A, ASXL1, KRAS

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In general, do you wait for next-generation sequencing (NGS) results before initiating treatment for your patients with MDS?

 Dr Garcia-Manero	Yes
 Dr Sallman	Yes
 Dr Borate	Yes
 Dr Brunner	Yes
 Dr DeZern	Yes
 Dr Stone	Yes
 Dr Wang	Yes

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A patient's MDS is designated as lower risk under the IPSS-R system but higher risk under the IPSS-M system. Would you generally treat this patient as having higher-risk MDS?

 Dr Garcia-Manero	It depends
 Dr Sallman	It depends
 Dr Borate	It depends
 Dr Brunner	It depends
 Dr DeZern	Yes
 Dr Stone	It depends
 Dr Wang	Yes

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Oral HMAs in MDS: current status

- ASTX727 (oral decitabine): approved US FDA
- CC-486: improves survival post-consolidation in AML
  - Being re-studied in LR MDS
- ASTX030 (oral azacitidine): ongoing phase 1 trials

Garcia-Manero: Blood 2020; Garcia-Manero EHA 2020

Courtesy of Guillermo Garcia-Manero, MD

Ongoing studies oral decitabine cedazuridine

- Lower risk MDS
- Multiple combinations
  - (IDH, venetoclax, Flt-3, Menin inhibitors, pediatrics)
- Post SCT: total therapy
- Oral azacitidine + cedazuridine (ASTX030)

Courtesy of Guillermo Garcia-Manero, MD

Doublets in Higher Risk MDS

- PANTHER (P-3001): azacitidine +/- pevonedistat
- Azacitidine + APR-246 for p53 mutated MDS
- HMA + venetoclax
- HMA + sabatolimab
- HMA + anti CD47

Courtesy of Guillermo Garcia-Manero, MD

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

Phase 1/2 study of oral decitabine/cedazuridine in combination with venetoclax in treatment-naïve higher-risk myelodysplastic syndromes or chronic myelomonocytic leukemia

Alex Bataller, Guillermo Montalban-Bravo, Alexandre Bazinet, Yesid Alvarado, Kelly Chien, Sangeetha Venugopal, Jo Ishizawa, Danielle Hammond, Mahesh Swaminathan, Koji Sasaki, Ghayas C. Issa, Nicholas J. Short, Lucia Masarova, Naval G. Daver, Tapan M. Kadia, Simona Colla, Wei Qiao, Xuelin Huang, Rashmi Kanagal-Shamanna, Stephany Hendrickson, Farhad Ravandi, Elias Jabbour, Hagop Kantarjian, Guillermo Garcia-Manero

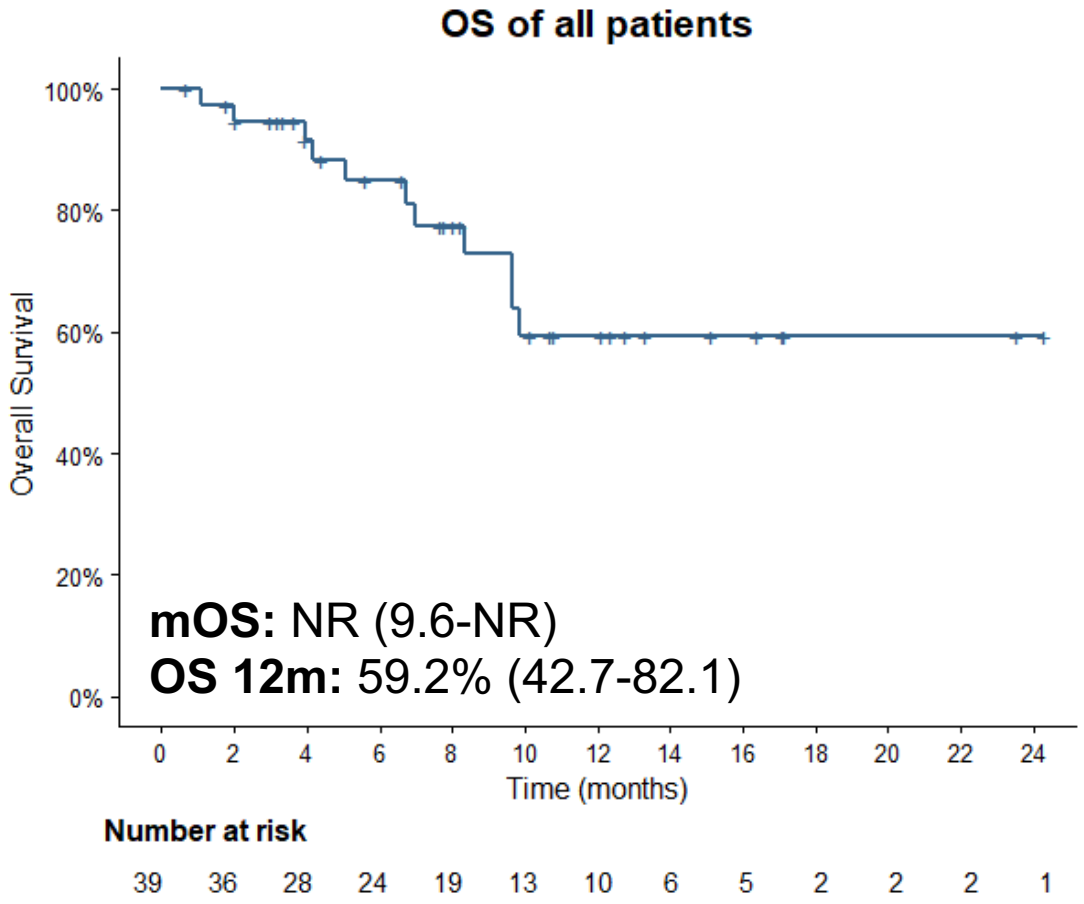
Leukemia Department, The University of Texas MD Anderson Cancer Center, Houston (TX, USA)

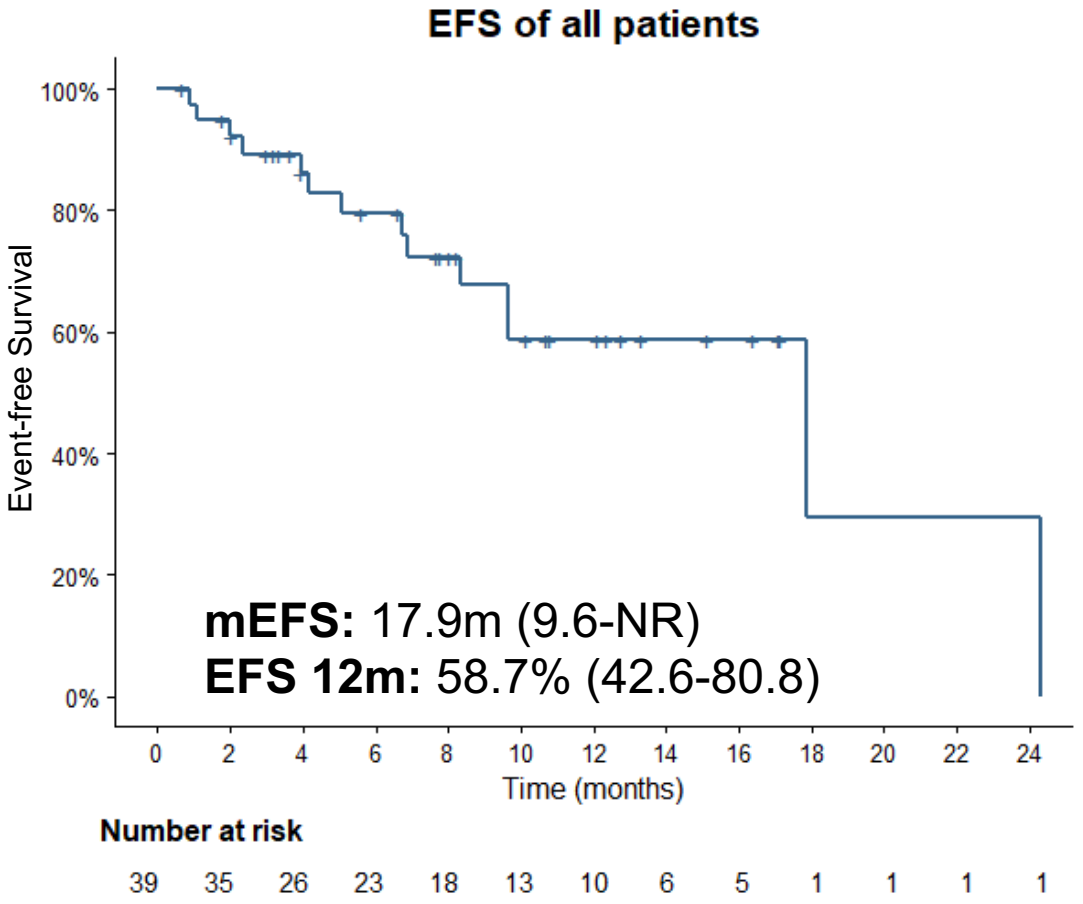
June 10th 2023
s424 Clinical updates in MDS

Efficacy

	Full cohort (n=39)	Phase 1 (n=9)	Phase 2 (n=30))
ORR, n (%, 95% CI) CR mCR mCR mCR + HI	37 (94.9, 82-99) 14 (35.9, 21-53) 23 (59, 42-74) 11 (28.2, 15-45) 12 (30.8, 17-48)	9 (100, 66-100) 6 (66.7, 30-93) 3 (33.3, 7-70) 2 (22.2, 3-60) 1 (11.1, 0-48)	28 (93.3, 78-99) 8 (26.7, 12-46) 20 (66.7, 47-83) 9 (30, 15-49) 11 (36.7, 20-56)
Cytogenetic response, n (%, 95% CI)	14/26 (53.8, 33-73)	4/5 (80, 28-99)	10/21 (47.6, 26-70)
Cycles to first response, n (range)	1 (1-2)	1 (1-1)	1 (1-2)
Cycles to best response, n (range)	1 (1-6)	1 (1-6)	1 (1-4)
Cycles received, n (range)	2 (1-13)	6 (2-13)	2 (1-8)
HSCT, n (%)	19 (48.7)	5 (55.6)	14 (46.7)

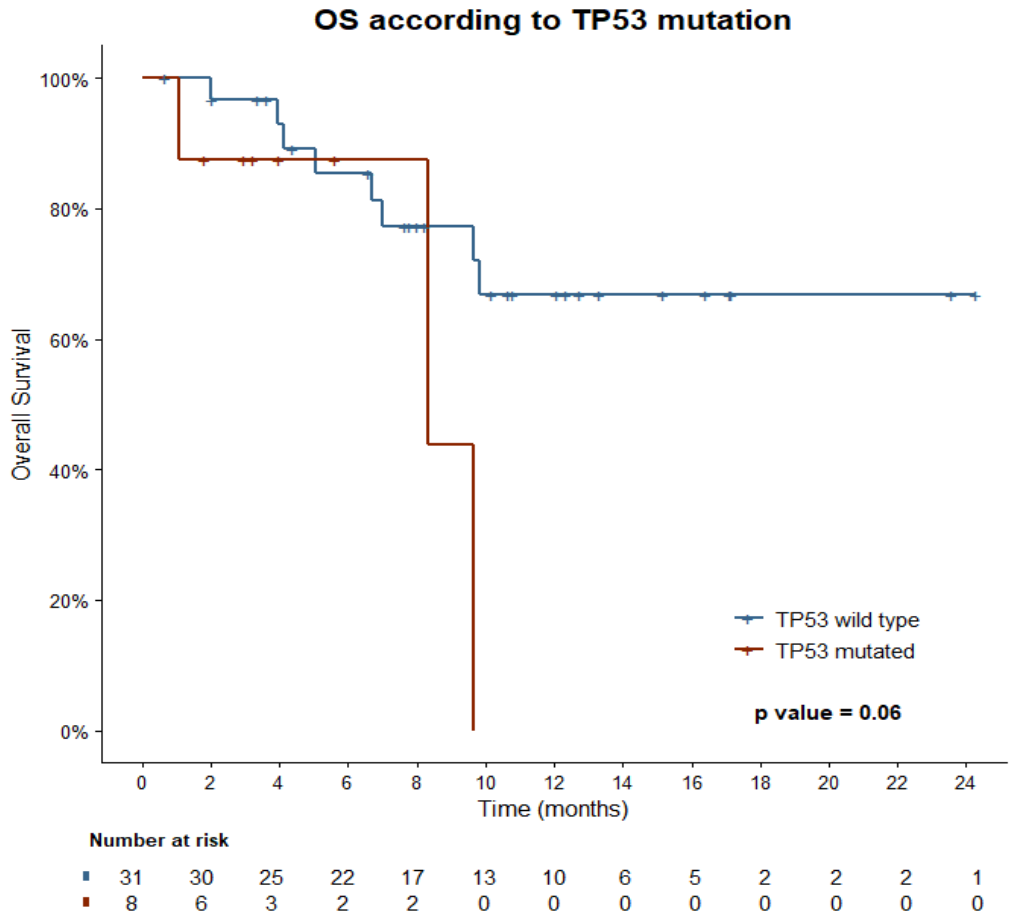
Survival



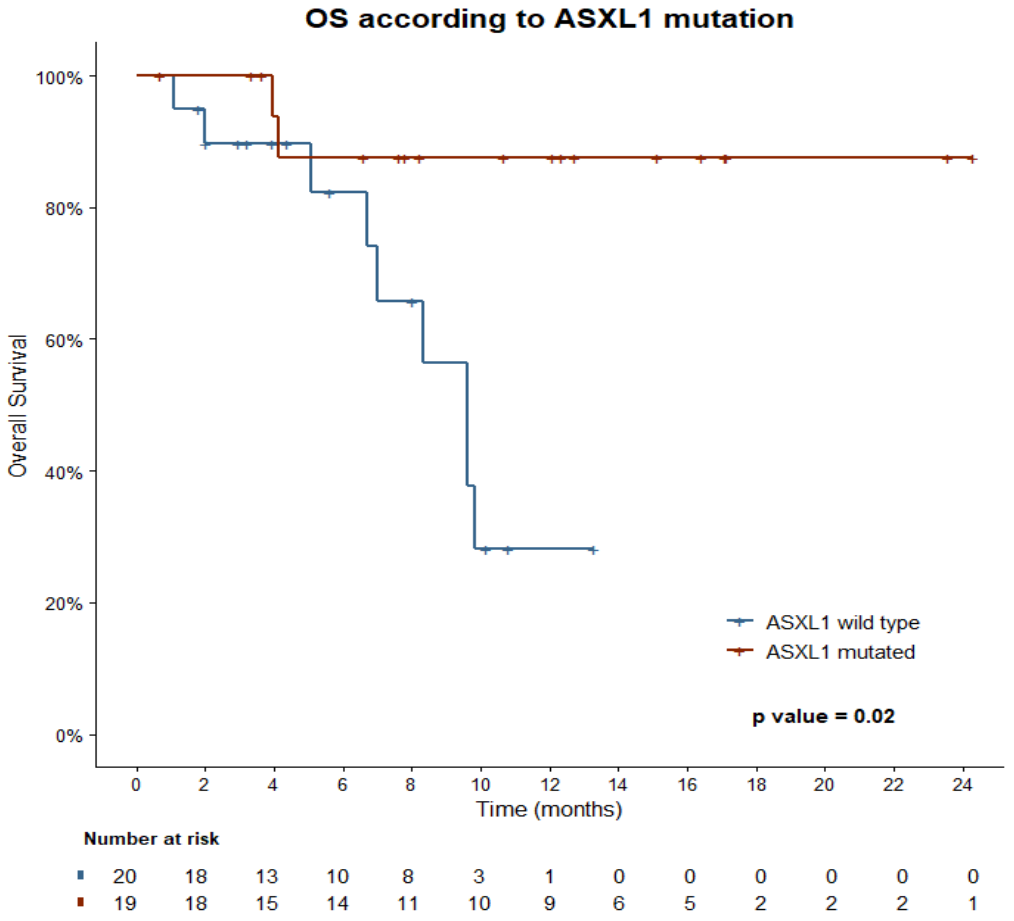


Median follow-up: 10.8m (6-16)

Survival

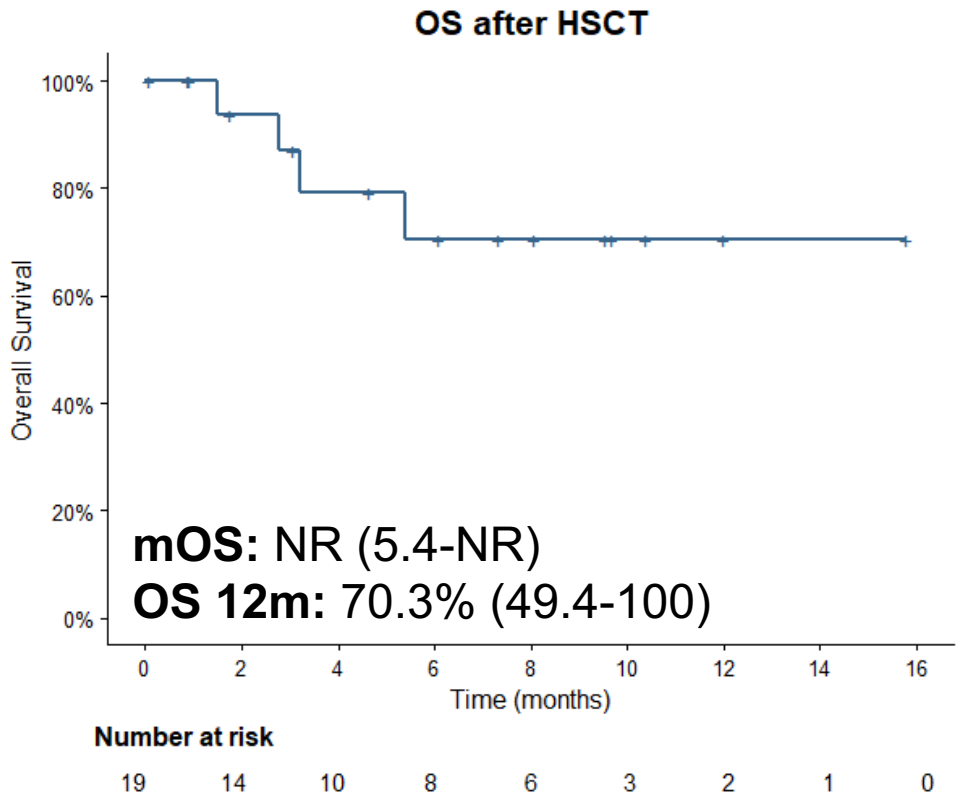


mOS: NR vs 8.3m (8.3-NR)

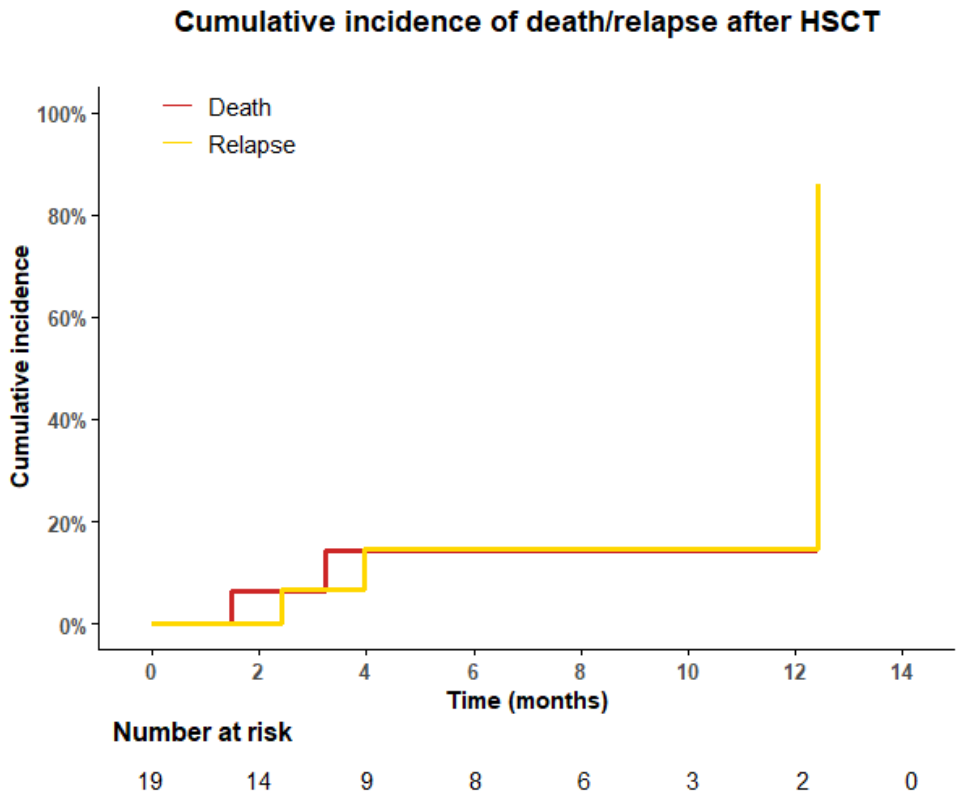


mOS: NR vs 9.6m (7-NR)

Survival after HSCT



mOS: NR (5.4-NR)
OS 12m: 70.3% (49.4-100)



- Median n of cycles: 2 (2-11)
- Median time to HSCT: 3.7m (2.3-15)

- 4 patients died (2 TRM, 2 disease progression)
- 3 patients relapsed after HSCT

Case Presentation – Dr Garcia-Manero

A 78-year-old man presents to your clinic with a history of cytopenia. Bone marrow exam reveals 15% blasts, cytogenetic analysis trisomy 8 and results of NGS reveal TET2 and DNMT3A mutations. Patient is not a candidate for alloSCT. You offer an HMA: azacitidine, decitabine or oral decitabine/cedazuridine.

A 78-year-old man presents with a history of cytopenia. Bone marrow exam reveals 15% blasts, cytogenetic analysis shows trisomy 8 and NGS indicates TET2 and DNMT3A mutations. The patient is not a candidate for allogeneic HSCT. Which front-line treatment would you recommend?

 Dr Garcia-Manero	Oral decitabine and cedazuridine +/- venetoclax
 Dr Sallman	Azacitidine/venetoclax
 Dr Borate	HMA
 Dr Brunner	Oral decitabine and cedazuridine
 Dr DeZern	Azacitidine/venetoclax
 Dr Stone	Azacitidine
 Dr Wang	Oral decitabine and cedazuridine

NGS = next-generation sequencing; HSCT = hematopoietic stem cell transplant; HMA = hypomethylating agent

Agenda

MODULE 1: Biology of Acute Myeloid Leukemia/Myelodysplastic Syndromes

MODULE 2: Assessment of Risk Status

MODULE 3: Oral Hypomethylating Agents (HMAs)

MODULE 4: HMA/Venetoclax; Other Combinations

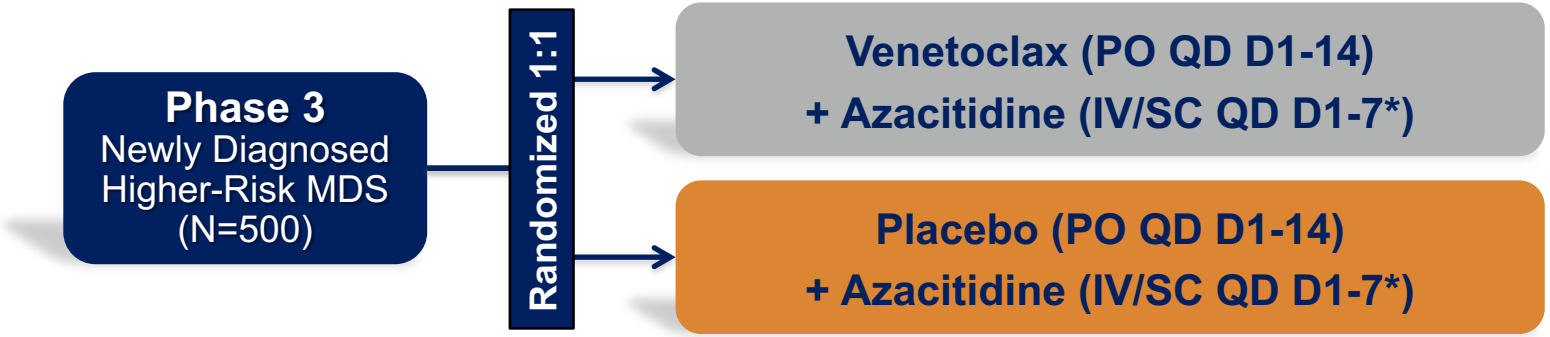
MODULE 5: Magrolimab/TP53

MODULE 6: Targeted Treatment

Phase 3 VERONA (NCT04401748)

Study Design and Endpoints

VERONA Study Design



*7 days within the first 9 calendar days/28 day cycle

Select Inclusion Criteria

+ ≥18 years old with newly diagnosed MDS according to 2016 WHO classification
+ <20% BM blasts
+ ECOG PS 0-2
+ IPSS-R score of >3 (Intermediate, High, Very High)
+ No planned HSCT at the time of C1D1

Select Exclusion Criteria

– Prior therapy for MDS with HMA, chemotherapy, or allo-HSCT
– Prior diagnosis of therapy-related MDS, MDS evolved from MPN, MDS/MPN including CMML, aCML, JMML, and unclassifiable MDS/MPN

End Points

Primary: *CR, OS*

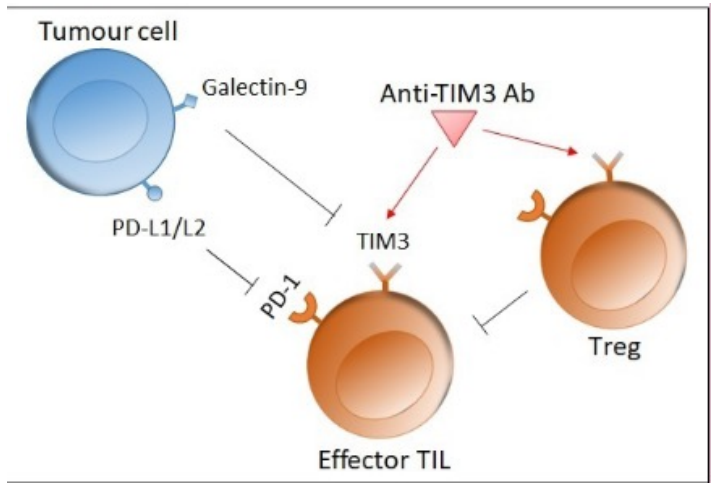
Secondary: *mOR, TI, ORR, fatigue score, physical functioning score, time to deterioration in physical functioning*

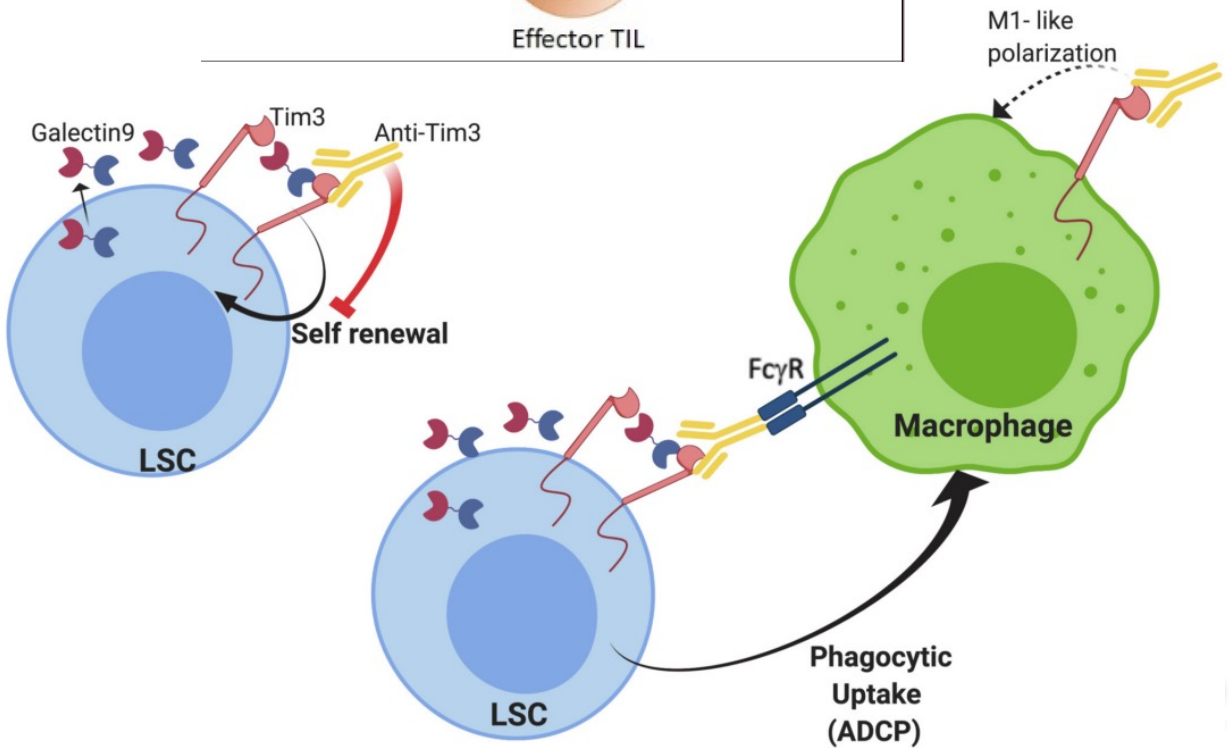
aCML=Atypical Chronic Myeloid Leukemia. allo-HSCT=Allogeneic Hematopoietic Stem Cell Transplant. AML=Acute Myeloid Leukemia. BM=Bone Marrow. C=Cycle. CMML=Chronic Myelomonocytic Leukemia. CR=Complete Remission. D=Day. ECOG PS=Eastern Cooperative Oncology Group Performance Status. HMA=Hypomethylating Agent. HSCT=Hematopoietic Stem Cell Transplantation. IPSS-R=Revised International Prognostic Scoring System. IV=Intravenous. JMML=Juvenile Myelomonocytic Leukemia. MDS=Myelodysplastic Syndrome. mOR=Modified Overall Response. MPN=Myeloproliferative Neoplasm. ORR=Overall Response Rate. OS=Overall Survival. PO=Oral. QD=Daily. SC=Subcutaneous. TI=Transfusion Independence. WHO=World Health Organization. 1. ClinicalTrials.gov. NCT04401748. https://clinicaltrials.gov/ct2/show/NCT04401748. Accessed July 2021

Courtesy of Guillermo Garcia-Manero, MD

Targeting TIM-3 and Sabatolimab

- TIM-3 promotes autocrine LSC self-renewal
- Blocking TIM-3 inhibits downstream signaling that promotes self-renewal
- TIM-3 ligation on T-Cells leads to apoptosis of the effector cell
- May also promote phagocytosis by myeloid cells, macrophages

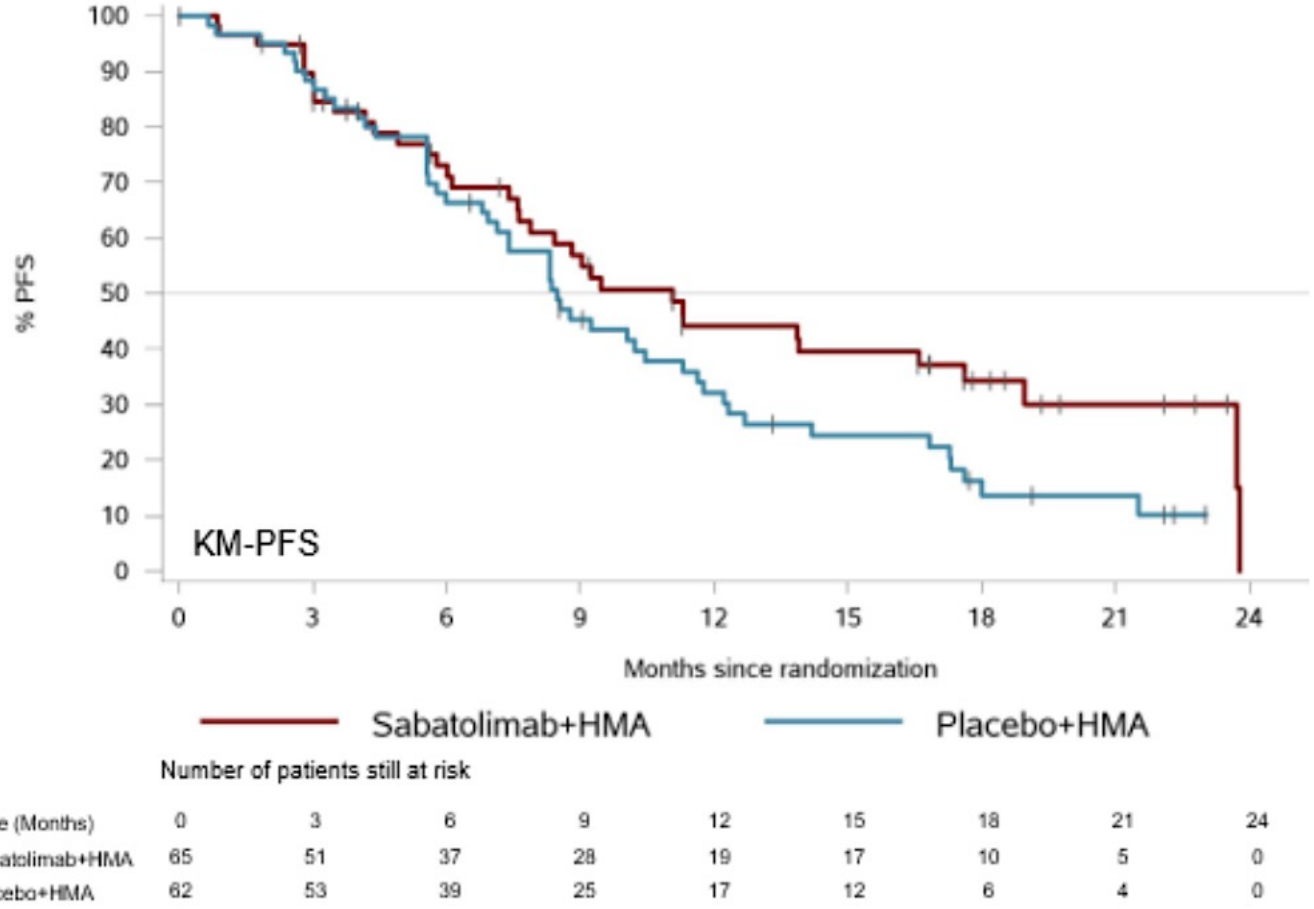




Acharya N, et al. *J Immunother Cancer*. 2020;8:e000911. Kikushige et al., *Cell Stem Cell* 2015

Courtesy of David A Sallman, MD

Sabatolimab + HMA did not result in a statistically significant improvement in CR or PFS



	Sabatolimab + HMA n=65	Placebo + HMA n=62
Primary CR rate (95% CI), %	**21.5 (12.3-33.5)**	**17.7 (9.2-29.5)**
P value[a]	0.769, ns	
PFS, median[b] (95% CI), mo	**11.1 (7.6-17.6)**	**8.5 (6.9-11.3)**
P value[c]	0.102, ns	
Hazard ratio[d]	0.749 (0.479, 1.173)	

- CR was evaluated earlier (March 10, 2021) by an independent data monitoring committee based on data up to 7 months after the last patient was randomized
- **Sabatolimab + HMA may have a delayed-onset benefit in terms of PFS**

Lower Burden of Disease (<10% blasts, IPSS-R and IPSS-M int/high risks) with improved outcomes

Zeidan A et al., ASH2022

Courtesy of David A Sallman, MD

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STIMULUS-MDS2 Phase 3 Study

Primary objective:
Evaluate overall survival of patients with intermediate-, high-, or very high-risk MDS or CMML-2 treated with sabatolimab + azacitidine or placebo + azacitidine alone as a first-line therapy

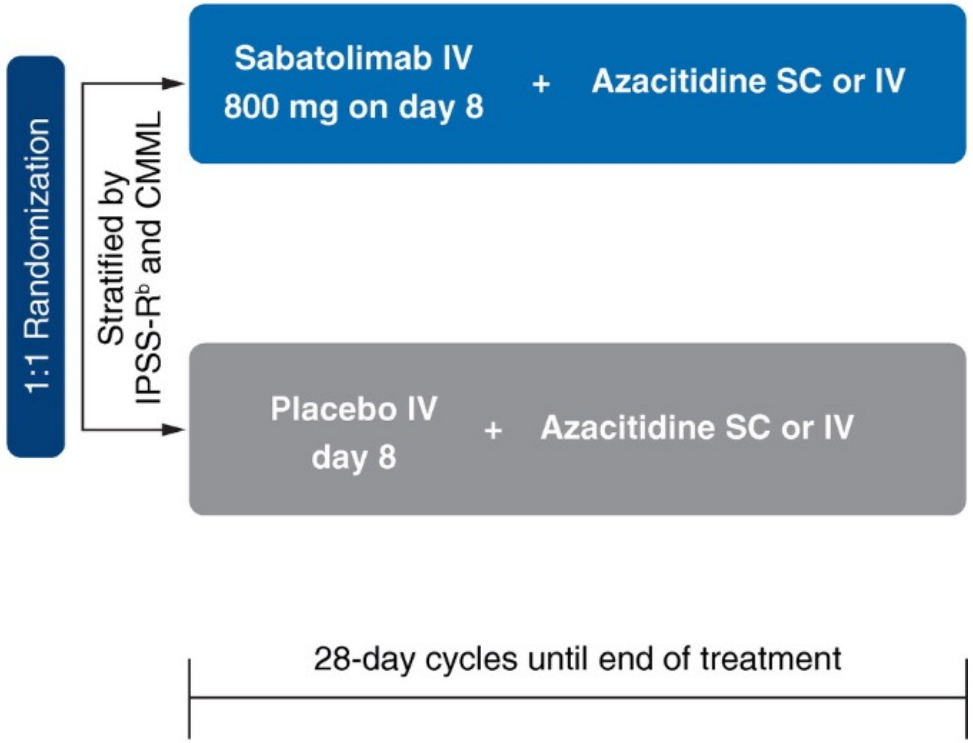
I/H/vHR-MDS or CMML-2
n ~ 500

Key inclusion criteria

- IPSS-R I/H/vHR-MDS or CMML-2[a]
- Ineligibility for intensive chemotherapy or HSCT
- Indication for treatment with azacitidine

Key exclusion criteria

- Prior TIM-3–directed therapy
- Prior immune checkpoint therapy or cancer vaccine within 4 months
- Prior antineoplastic agent for first-line treatment of I/H/vHR-MDS or CMML
- Systemic steroids or immunosuppressive therapy within 2 weeks
- Investigational treatment within 4 weeks



Secondary endpoints:
FACIT-fatigue and EORTC QLQ-C30 (emotional and physical functioning), RBC transfusion-free intervals, RBC/platelet transfusion independence, CR/mCR/PR/HI, PFS, LFS, safety, PK, immunogenicity, EQ-5D-5L

Zeidan A et al., Future Medicine, 2023

Courtesy of David A Sallman, MD

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What would you predict to be the outcome of a Phase III randomized trial evaluating sabatolimab/HMA versus HMA alone as first-line treatment for higher-risk MDS?

 Dr Garcia-Manero	Efficacy is about the same with both regimens
 Dr Sallman	Efficacy is about the same with both regimens
 Dr Borate	Efficacy is about the same with both regimens
 Dr Brunner	Efficacy is about the same with both regimens
 Dr DeZern	Efficacy is about the same with both regimens
 Dr Stone	Efficacy is about the same with both regimens
 Dr Wang	Efficacy is about the same with both regimens

HMA = hypomethylating agent

RTP RESEARCH TO PRACTICE

Case Presentation – Dr Garcia-Manero

A 70-year-old man presents to your clinic with a history of cytopenia. Bone marrow exam reveals 15% blasts, cytogenetic analysis trisomy 8 and results of NGS reveal an ASXL1 mutation. Patient is a candidate for alloSCT. You offer an HMA: azacitidine, decitabine or oral decitabine/cedazuridine and discuss potential clinical trial in combination with venetoclax.

A 70-year-old man presents with a history of cytopenia. Bone marrow exam reveals 15% blasts, cytogenetic analysis shows trisomy 8 and NGS indicates an ASXL1 mutation. Which front-line treatment would you recommend? Would you recommend allogeneic HSCT? If you were able to access magrolimab, would you recommend it?

	Preferred treatment	Allogeneic HSCT	Magrolimab
 Dr Garcia-Manero	Oral decitabine/ cedazuridine and venetoclax	Yes	No
 Dr Sallman	Azacitidine/venetoclax	Yes	Yes
 Dr Borate	HMA +/- venetoclax	Yes	Yes
 Dr Brunner	Oral decitabine/ cedazuridine	Yes	Yes
 Dr DeZern	Azacitidine/venetoclax	Yes	No
 Dr Stone	Azacitidine	Yes	Yes
 Dr Wang	Azacitidine	Yes	Yes

NGS = next-generation sequencing; HSCT = hematopoietic stem cell transplant; HMA = hypomethylating agent

Please describe the last patient with MDS to whom you administered a hypomethylating agent with venetoclax either on or off protocol.

	Clinical characteristics	Treatment	Outcome
 Dr Garcia-Manero	67 y/o M; 15% blasts, diploid cytogenetics, ASXL1	Oral decitabine/ cedazuridine and venetoclax	CR
 Dr Sallman	80 y/o M; 15% blasts, RUNX1, ASXL1	Azacitidine/venetoclax	mCR
 Dr Borate	67 y/o F; 15% blasts, complex cytogenetics, RUNX1, DNMT3A	Decitabine/venetoclax	MLFS
 Dr Brunner	74 y/o M; 15% blasts, t(3;21), PPM1D, TET2, DNMT3A, prior MM	Decitabine/venetoclax	mCR
 Dr DeZern	73 y/o F; 14% blasts, RUNX1, SRSF2, ASXL1fs, TET2, DNMT3A	Azacitidine/venetoclax	CRi
 Dr Stone	68 y/o M; 10% blasts, NK, ASXL1; RUNX1	Azacitidine/venetoclax	CR
 Dr Wang	78 y/o M; PD after multiple cycles of azacitidine	Azacitidine/venetoclax	Brief response

mCR = morphologic complete remission; CRi = complete remission with incomplete count recovery; MLFS = morphological leukemia-free state; PD = progressive disease

In general, when administering HMA/venetoclax to a patient with MDS, for how many days do you administer the venetoclax during the first cycle?

For how many days do you typically administer the venetoclax during subsequent cycles?

	Venetoclax cycle 1	Venetoclax subsequent cycles
 Dr Garcia-Manero	14 days	7 days
 Dr Sallman	14 days	7 days
 Dr Borate	14 days	7-10 days
 Dr Brunner	14 days	7-14 days
 Dr DeZern	14-21 days	7-14 days
 Dr Stone	14 days	7 days
 Dr Wang	14 days	7 days

HMA = hypomethylating agent

In general, when administering HMA/venetoclax to a patient with MDS, when do you order the first bone marrow biopsy?

 Dr Garcia-Manero	After 21-28 days
 Dr Sallman	After 21 days
 Dr Borate	After 21-28 days
 Dr Brunner	After 21 days
 Dr DeZern	After 21 days
 Dr Stone	After 24 days
 Dr Wang	After 21 days

HMA = hypomethylating agent

RTP RESEARCH TO PRACTICE

Agenda

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MODULE 2: Assessment of Risk Status

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MODULE 4: HMA/Venetoclax; Other Combinations

MODULE 5: Magrolimab/TP53

MODULE 6: Targeted Treatment

Case Presentation – Dr Sallman

- 67 yo male presents with severe pancytopenia, 12% myeloblasts, trilineage dysplasia and molecular results show a *TP53* mutation with a VAF of 55% and complex karyotype. The patient has minimal co-moribidities and is still able to walk 1 mile/day. Based on the poor standard of care in *TP53* mutant patients, the patient was enrolled in a clinical trial of azacitidine + magrolimab. The patient had a 2gm/dl drop in hemoglobin on day 1 after infusion of magrolimab without other magrolimab related adverse events. The patient achieved mCR + HI after 2 cycles of therapy and subsequently full CR after 4 cycles and was bridged to allogeneic stem cell transplant.

A 67-year-old man with minimal comorbidities presents with severe pancytopenia and 12% myeloblasts. Molecular testing reveals a TP53 mutation with a variant allele frequency (VAF) of 55% and complex karyotype. What is your usual front-line systemic treatment? Would you recommend allogeneic HSCT? If you were able to access magrolimab, would you recommend it?

	Preferred treatment	Allogeneic HSCT	Magrolimab
 Dr Garcia-Manero	Oral decitabine/ cedazuridine	Yes	Yes
 Dr Sallman	Decitabine	Yes	Yes
 Dr Borate	HMA +/- venetoclax	Yes	Yes
 Dr Brunner	Oral decitabine/ cedazuridine	Yes	Yes
 Dr DeZern	Decitabine	Yes	Yes
 Dr Stone	Azacitidine	Yes	Yes
 Dr Wang	Azacitidine	Yes	Yes

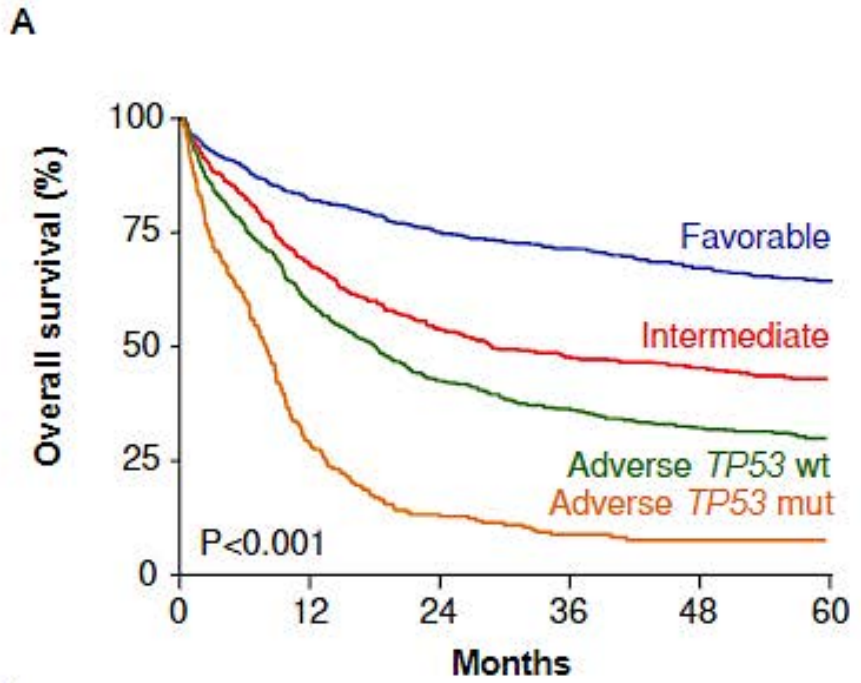
HSCT = hematopoietic stem cell transplant; HMA = hypomethylating agent

A 67-year-old man with minimal comorbidities presents with severe pancytopenia and 12% myeloblasts. Molecular testing reveals a TP53 mutation with a VAF of 10% and no complex karyotype. What is your usual front-line systemic treatment? Would you recommend allogeneic HSCT? If you were able to access magrolimab, would you recommend it?

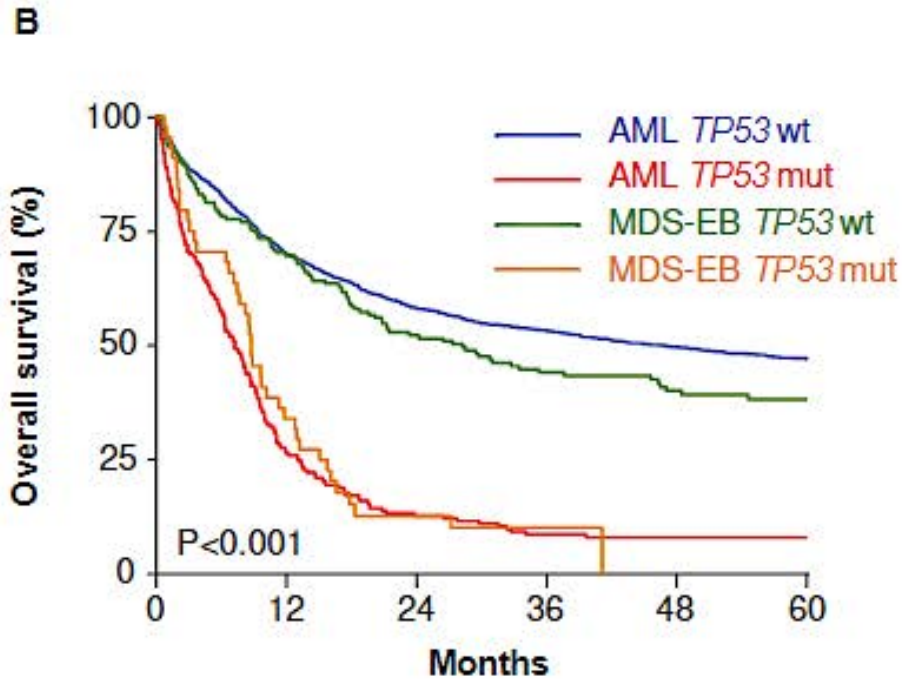
	Preferred treatment	Allogeneic HSCT	Magrolimab
 Dr Garcia-Manero	Cladribine/low-dose ara-C/venetoclax	Yes	Yes
 Dr Sallman	Azacitidine/venetoclax	Yes	Yes
 Dr Borate	HMA/venetoclax	Yes	Yes
 Dr Brunner	Oral decitabine/ cedazuridine	Yes	Yes
 Dr DeZern	Azacitidine/venetoclax	Yes	Yes
 Dr Stone	Azacitidine	Yes	Yes
 Dr Wang	Azacitidine	Yes	Yes

VAF = variant allele frequency; HSCT = hematopoietic stem cell transplant

TP53 Mutant MDS and AML, One Disease?



No. at risk:						
Favorable	713	581	520	432	313	228
Intermediate	602	402	308	236	162	115
Adverse *TP53* wt	655	386	267	201	142	89
Adverse *TP53* mut	230	65	28	15	9	5



No. at risk:						
AML *TP53 wt*	1805	1255	1014	807	572	397
AML *TP53* mut	186	50	23	14	9	5
MDS-EB *TP53* wt	165	114	81	62	45	35
MDS-EB *TP53* mut	44	15	5	1	0	0

Grob T et al., Blood 2022

Courtesy of David A Sallman, MD

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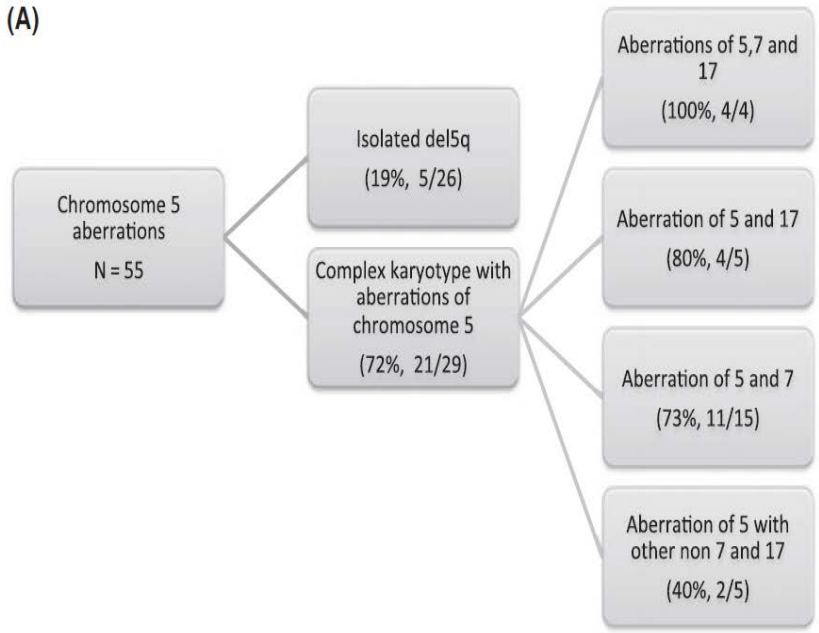
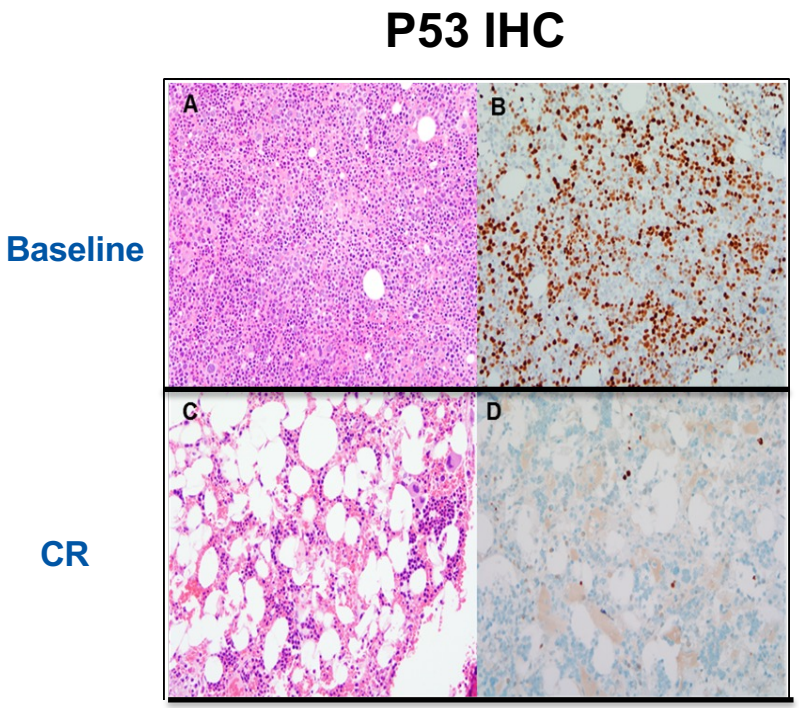
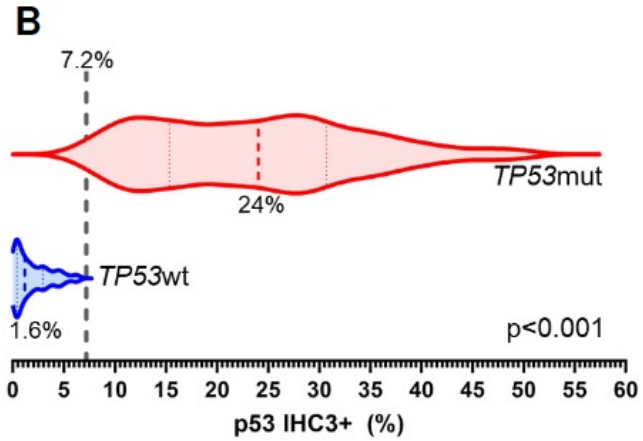
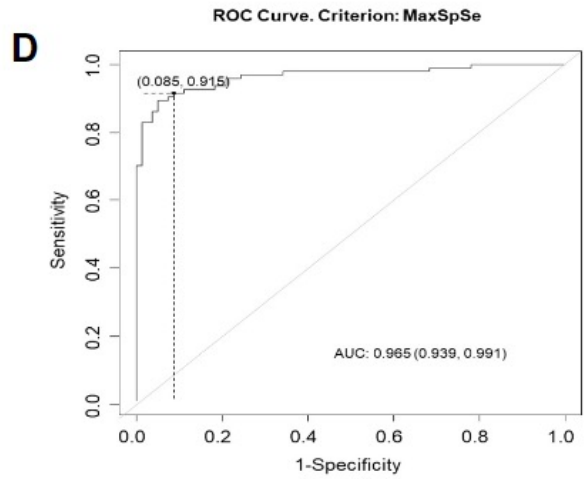
Can We Predict Patients for *TP53* Mutation?









Kulasekararaj A et al. BJH 2013; 160, 660–672; McGraw K et al., Haematologica 2016; Sallman D et al., JCO 2021; Tashakori et al., Blood 2022

Courtesy of David A Sallman, MD

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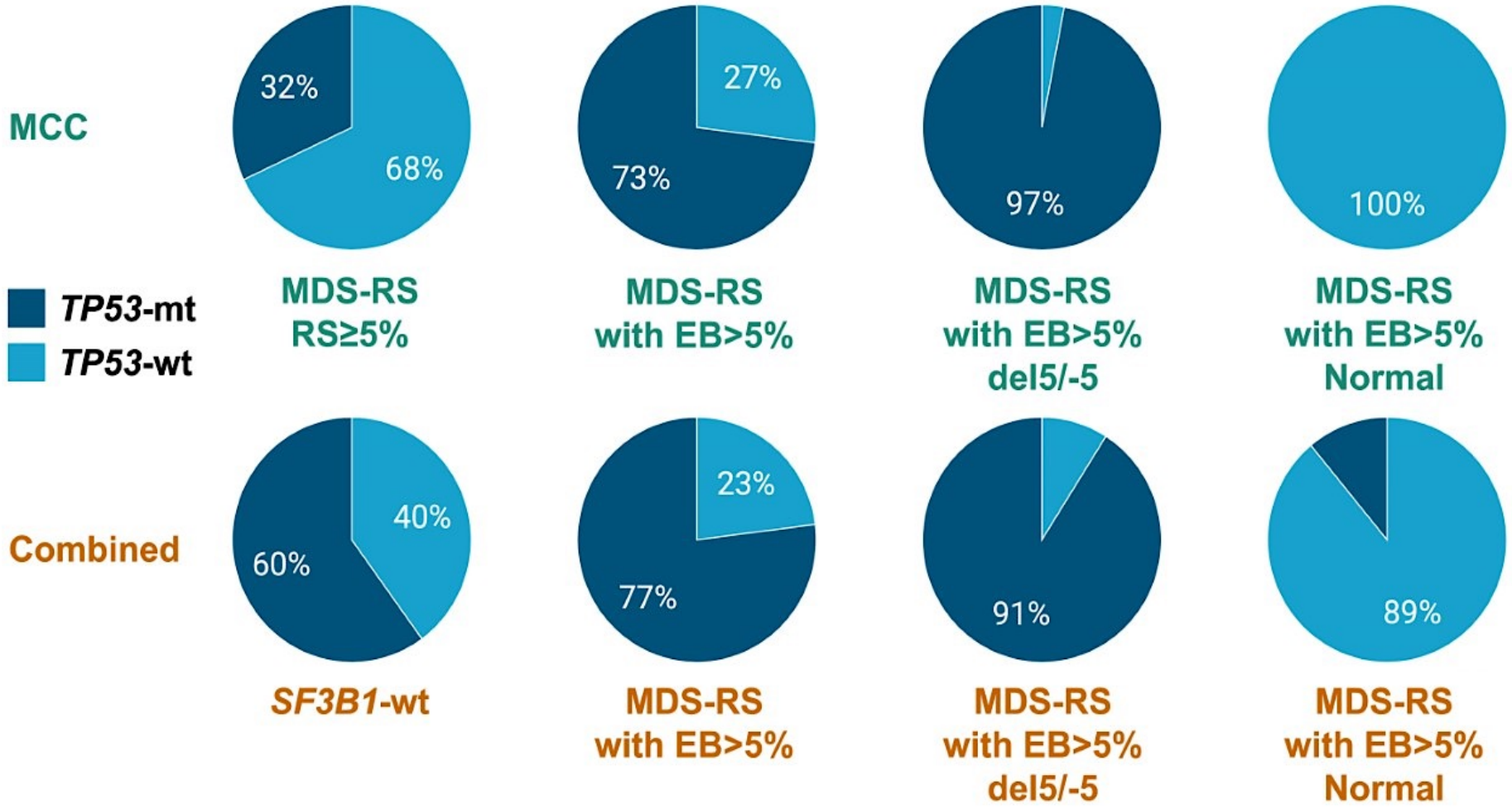
TP53-mt MDS with Ring Sideroblasts



Swoboda D… Sallman D et al. Leukemia 2021

Courtesy of David A Sallman, MD

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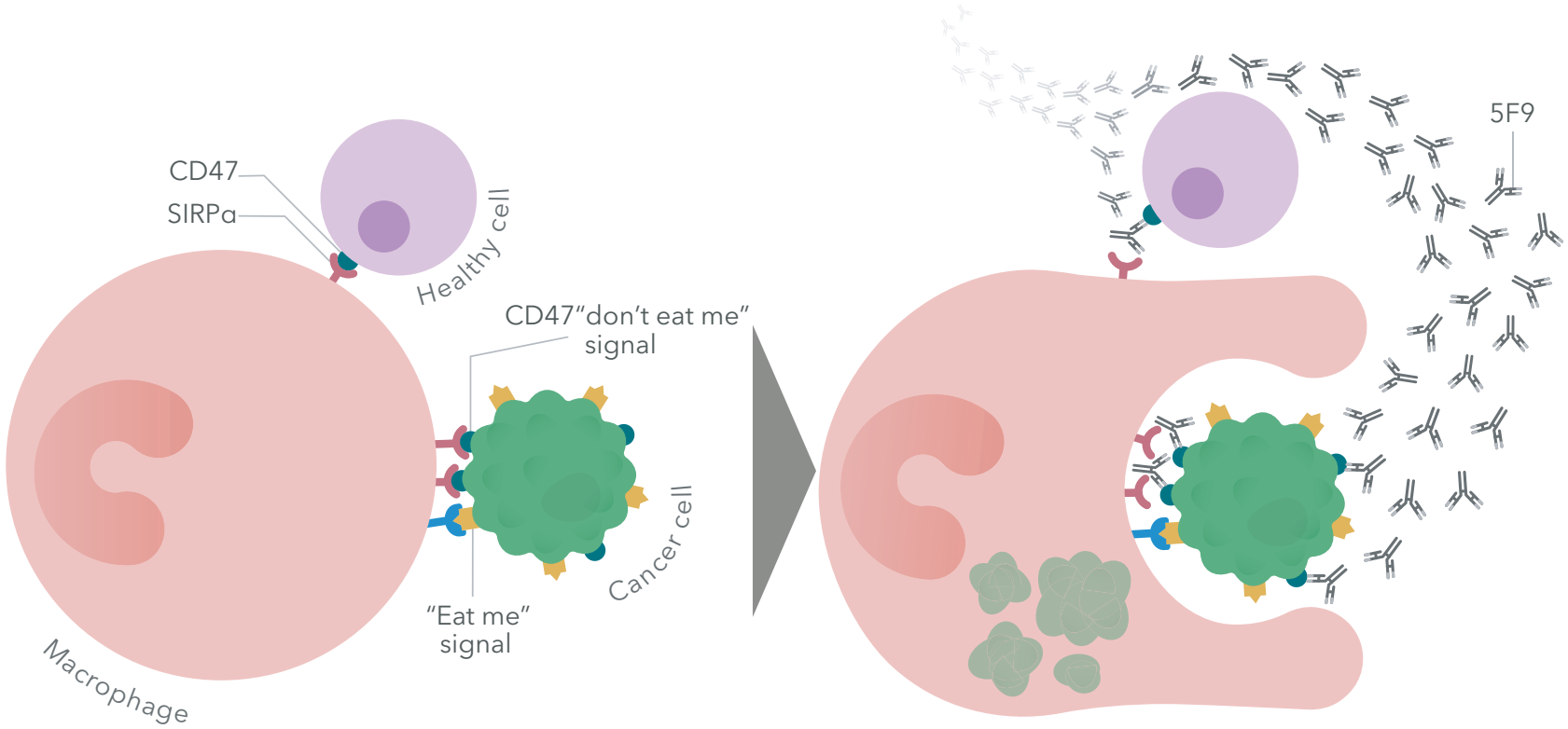
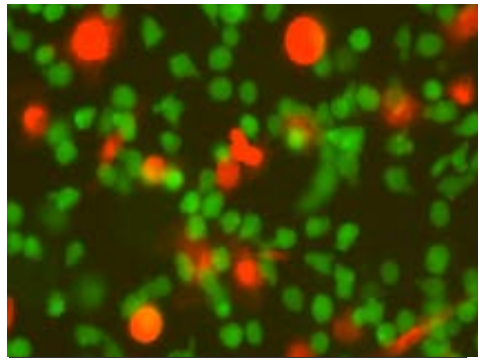
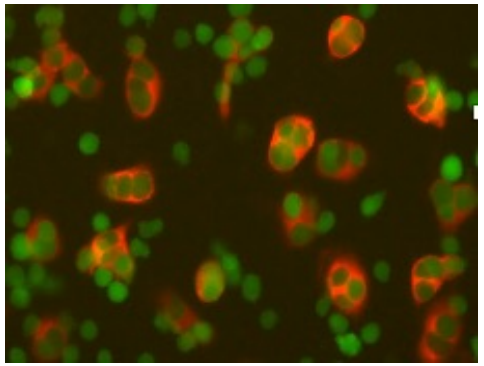
Magrolimab (Formerly 5F9) is a First-in-class Macrophage Immune Checkpoint Inhibitor Targeting CD47



Control mAb: No Phagocytosis



Anti-CD47 mAb: Phagocytosis



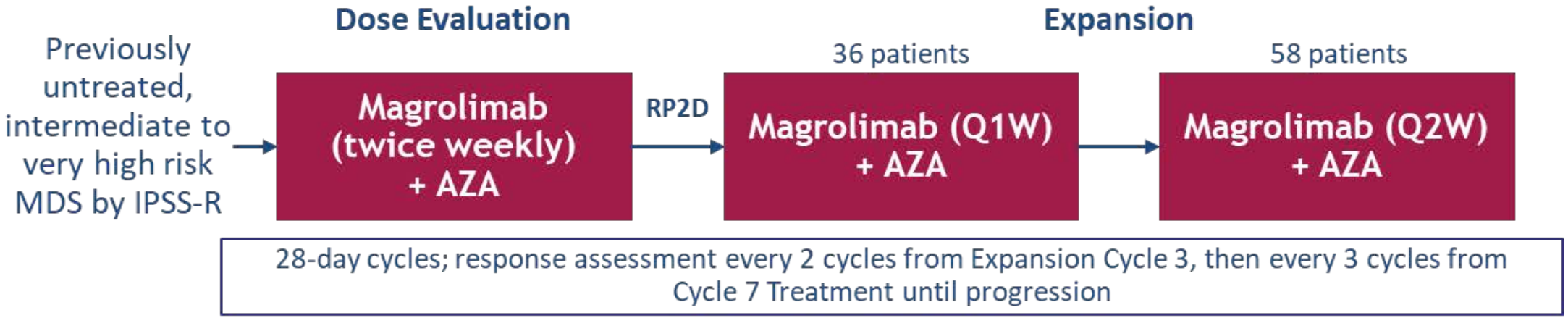
Macrophages Cancer cells

- Magrolimab is an IgG4 anti-CD47 monoclonal antibody being investigated in multiple cancers

Sallman D et al., 2020 ASCO

Courtesy of David A Sallman, MD

5F9005 Study Design: Magrolimab in Combination with AZA in HR-MDS



- Patients received magrolimab IV as a 1 mg/kg priming dose on Days 1 and 4, then ramp-up to 30 mg/kg QW or Q2W maintenance; AZA dose was SC or IV 75 mg/m^2 on Days 1-7 of each cycle.

Primary objectives

Safety, tolerability and efficacy (CR rate) of magrolimab + azacitidine in HR-MDS

Secondary objectives

Efficacy of magrolimab + azacitidine; PK profile; Immunogenicity; MRD negativity

Exploratory objectives

CD47 RO, Biomarkers, Efficacy in molecular subtypes of MDS

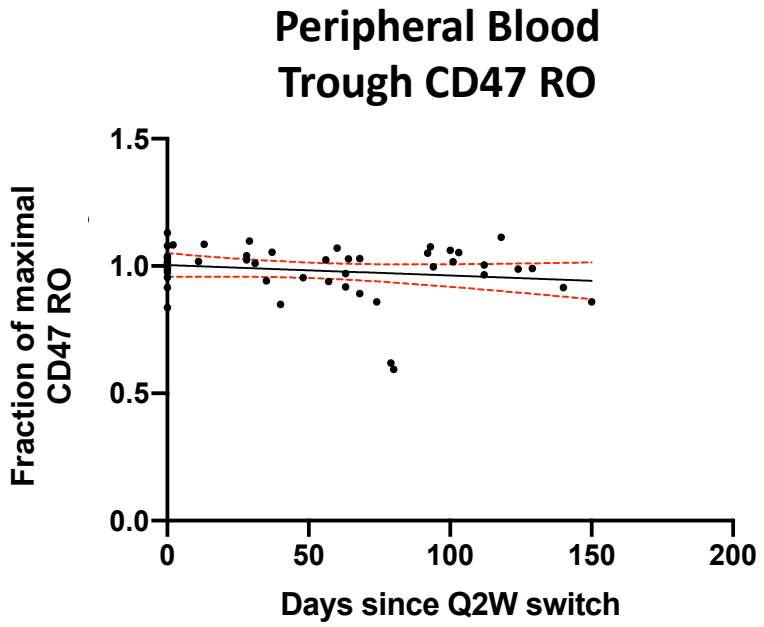
CR = complete remission; IPSS-R = Revised International Prognostic Scoring System; IV = intravenous; MRD = minimal residual disease; RO = receptor occupancy; RP2D = recommended Phase 2 dose; SC = subcutaneous; Q1W = weekly; Q2W = every two weeks.

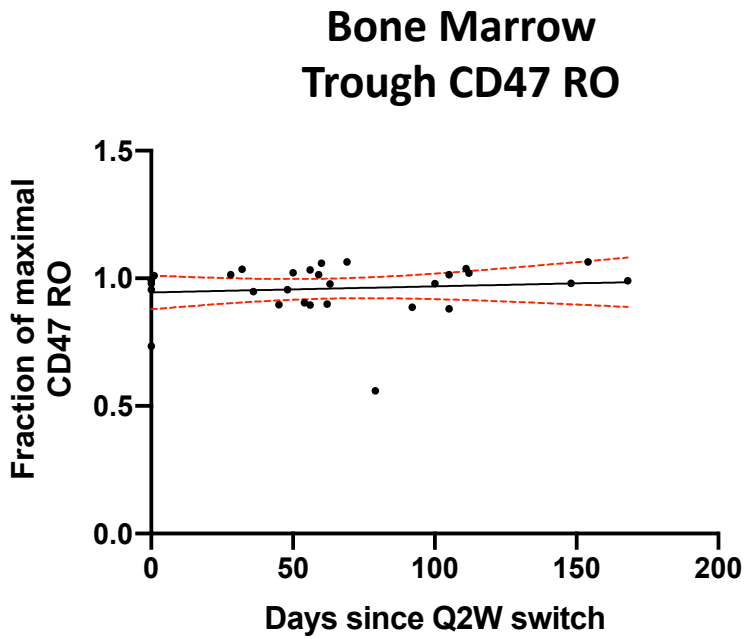
Sallman D et al., EHA 2022; Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

MOFFITT CANCER CENTER

Magrolimab Q2W Dosing Results in Similar CD47 Receptor Occupancy as Q1W Dosing





RO: receptor occupancy.
Black line: linear regression best fit.
Red lines: 95% confidence intervals.

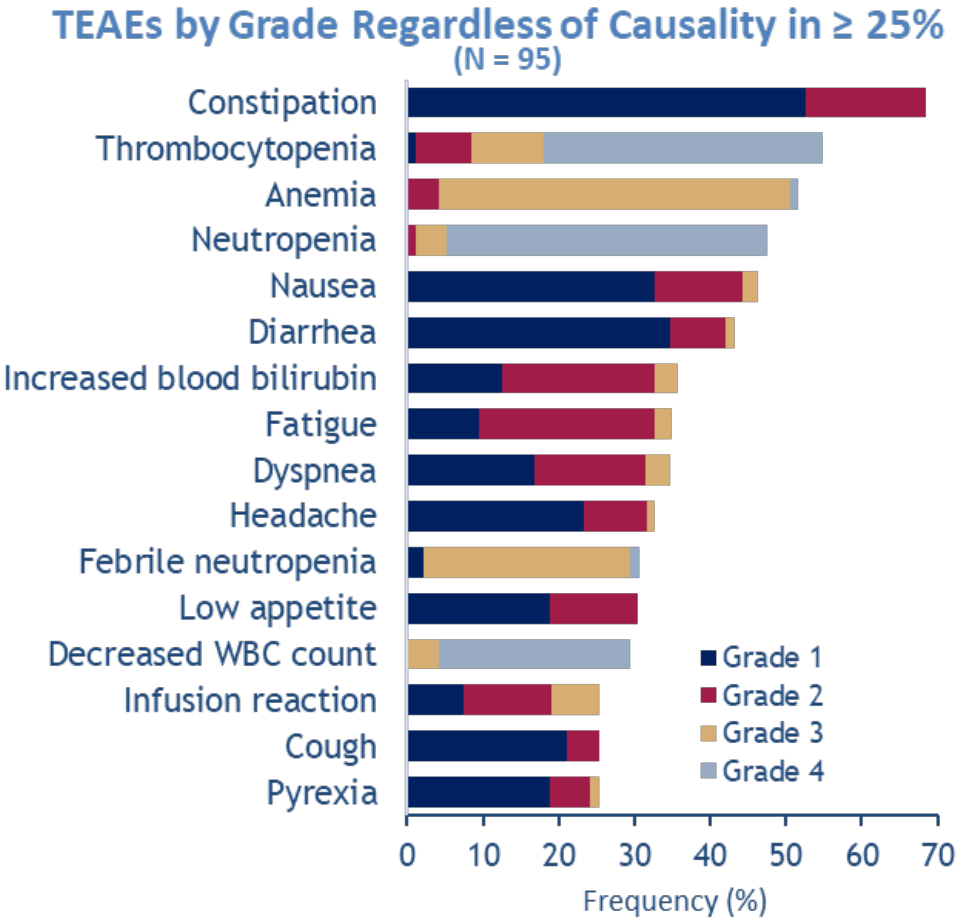
- Patients were dosed with magrolimab Q1W throughout or Q2W dosing starting Cycle 3 and beyond
- Similar CD47 RO was observed in the peripheral blood and bone marrow after Q2W dosing change in Cycle 3+
- **A magrolimab Q2W dose regimen has been selected based on PK/PD results and patient convenience**

Sallman D…… Daver N et al., 2020 ASCO

*Dose ramp-up from 1 mg/kg to 30 mg/kg by week 2, then 30 mg/kg maintenance dosing or 30 mg/kg Q2W starting Cycle 3+.
IPSS-R: Revised International Prognostic Scoring System.

Courtesy of David A Sallman, MD

Magrolimab in Combination with AZA Is Well Tolerated in HR-MDS



AE = adverse event; TEAE = treatment-emergent adverse event; WBC = white blood cell.

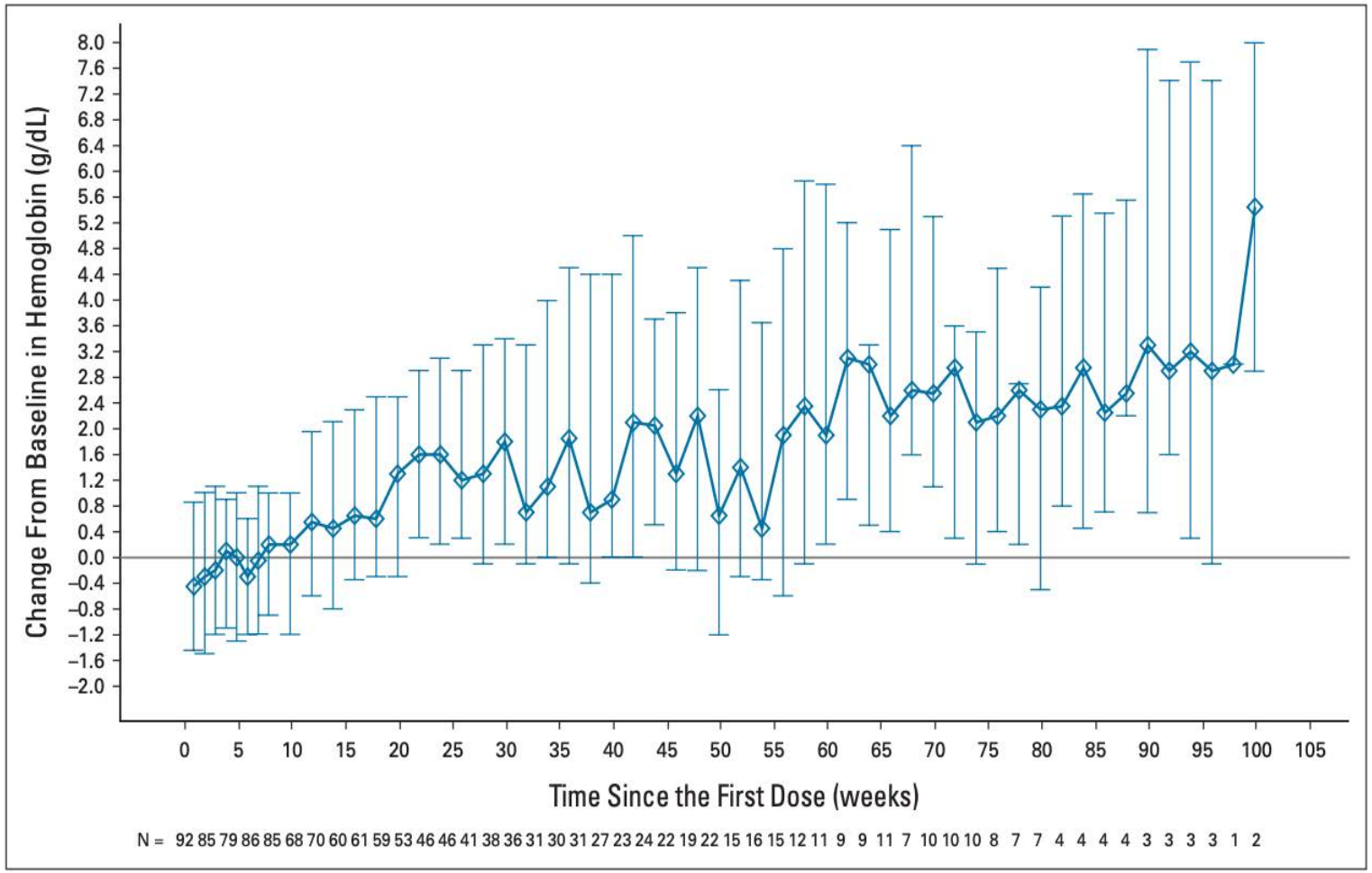
- 30-day mortality was 2.1%, no additional deaths at 60 days.
- TEAEs led to magrolimab dose delays in 52.6% (no dose reductions), and to AZA dose delays in 49.5% (17.9% had dose reductions).
- One Grade 4 anemia occurred in Cycle 4.
- Infusion-related reaction in 25.3%, Grade 3 in 6.3%.
- Magrolimab discontinuation due to AEs in 6.3% and AZA discontinuation due to AEs in 7.4% of patients.

Sallman D et al., EHA 2022; Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

MOFFITT CANCER CENTER

On-Target Anemia Is a Pharmacodynamic Effect and Mitigated with a Magrolimab Priming and Maintenance Dosing Regimen



- An initial priming dose mitigated on-target anemia by CD47 blockade, resulting in a transient hemoglobin drop.
- Median hemoglobin change from baseline was –0.7 g/dL (range –3.1 to +2.4) at first post-treatment visit.
- 37 (38.9%) patients were transfusion dependent at baseline; 13 (35.1%) of these converted to RBC transfusion independence.

Sallman D et al., EHA 2022; Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

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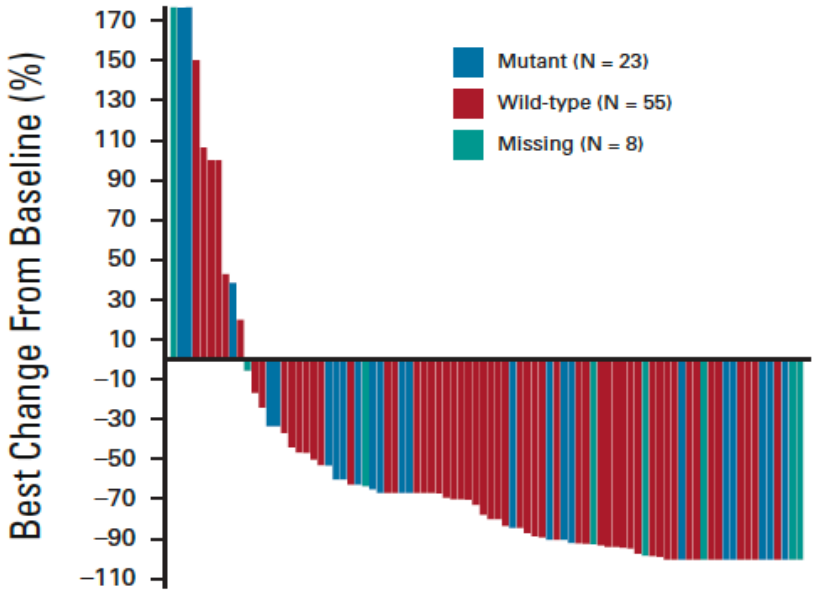
Magrolimab + AZA Induces High Response Rates in HR-MDS

TABLE 3. Efficacy Outcomes

Outcome	All (N = 95[a])	*TP53*-wt MDS (N = 61)	*TP53*-mut MDS (N = 25)
OR rate, %[b]	74.7	78.7	68.0
CR, % (95% CI)	32.6 (23.4 to 43.0)	31.1 (19.9 to 44.3)	40.0 (21.1 to 61.3)
mCR, %	31.6	37.7	20.0
PR, %	0	0	0
SD with HI, %	10.5	9.8	8.0
Duration of CR, months, median (95% CI)	11.1 (7.6 to 13.4)	12.9 (8.0 to NR)	7.6 (3.1 to 13.4)
Time to CR, months, median (range)	3.7 (1.7-7.2)	4.6 (1.7-7.2)	3.1 (1.9-4.0)
Duration of OR, months, median (95% CI)	9.8 (8.8 to 12.9)	9.8 (8.5 to 18.5)	9.2 (5.0 to 12.2)
Time to OR, months, median (range)	1.9 (0.7-10.9)	1.9 (0.7-5.5)	1.9 (1.8-10.3)
mCR with HI/Any HI, %	16.8/58.9	19.7/60.7	12.0/56.0
Converted to RBC transfusion independence, %[c]	35.1	26.1	46.2
PFS, months, median (95% CI)	11.6 (9.0 to 14.0)	11.8 (8.8 to 16.6)	11.0 (6.3 to 12.8)
OS, months, median (95% CI)	NR (16.3 to NR)	NR (21.3 to NR)	16.3 (10.8 to NR)



Sallman D et al., EHA 2022; Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

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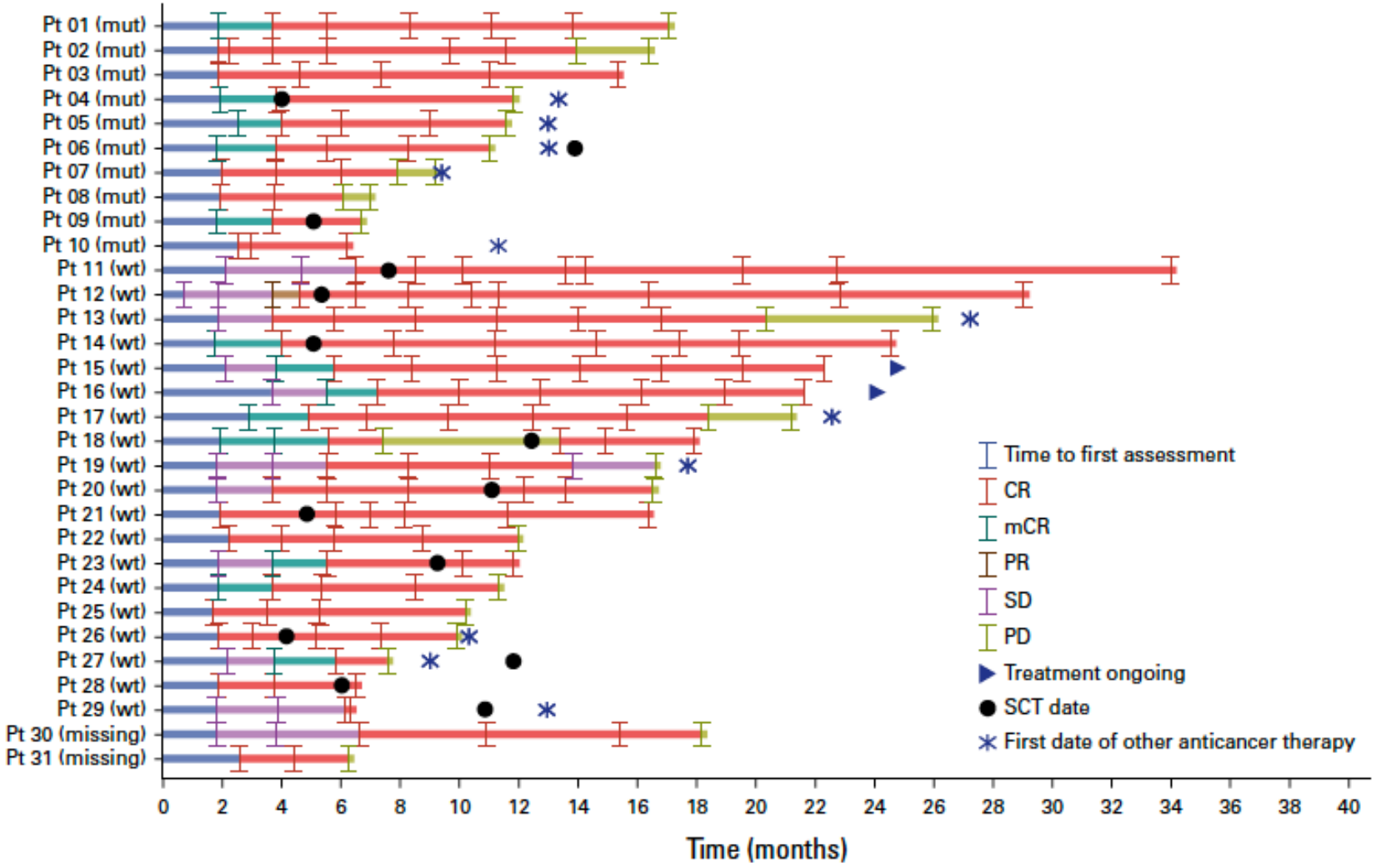
Durable Responses Are Seen in Patients Treated with Magrolimab + AZA and Deepen over Time



Sallman D et al., EHA 2022; Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

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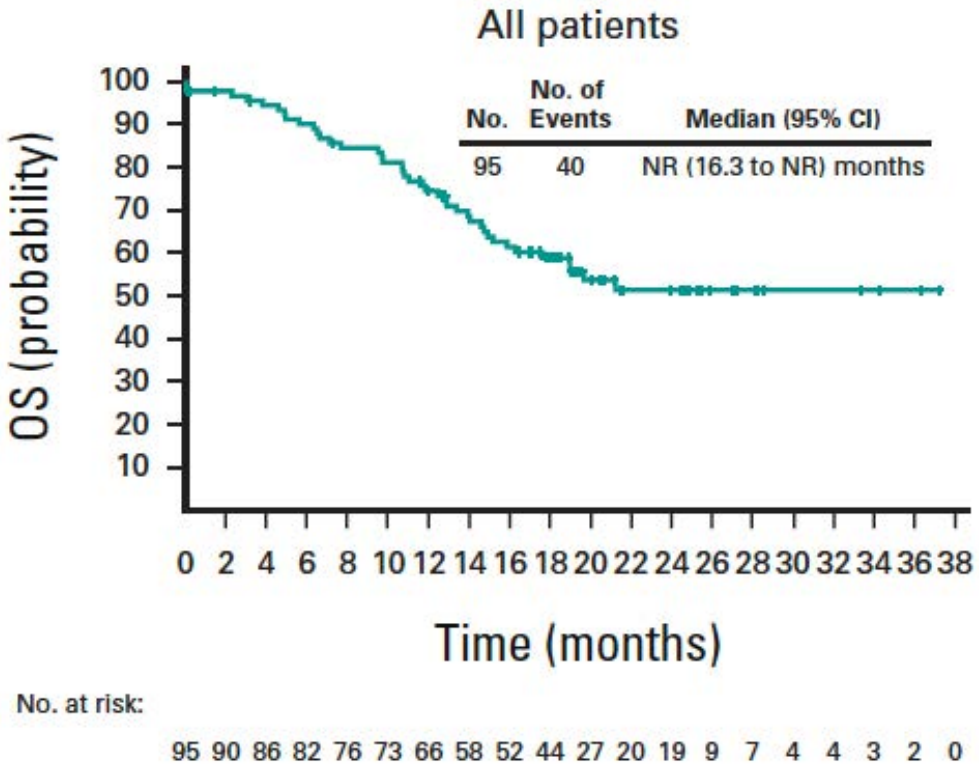
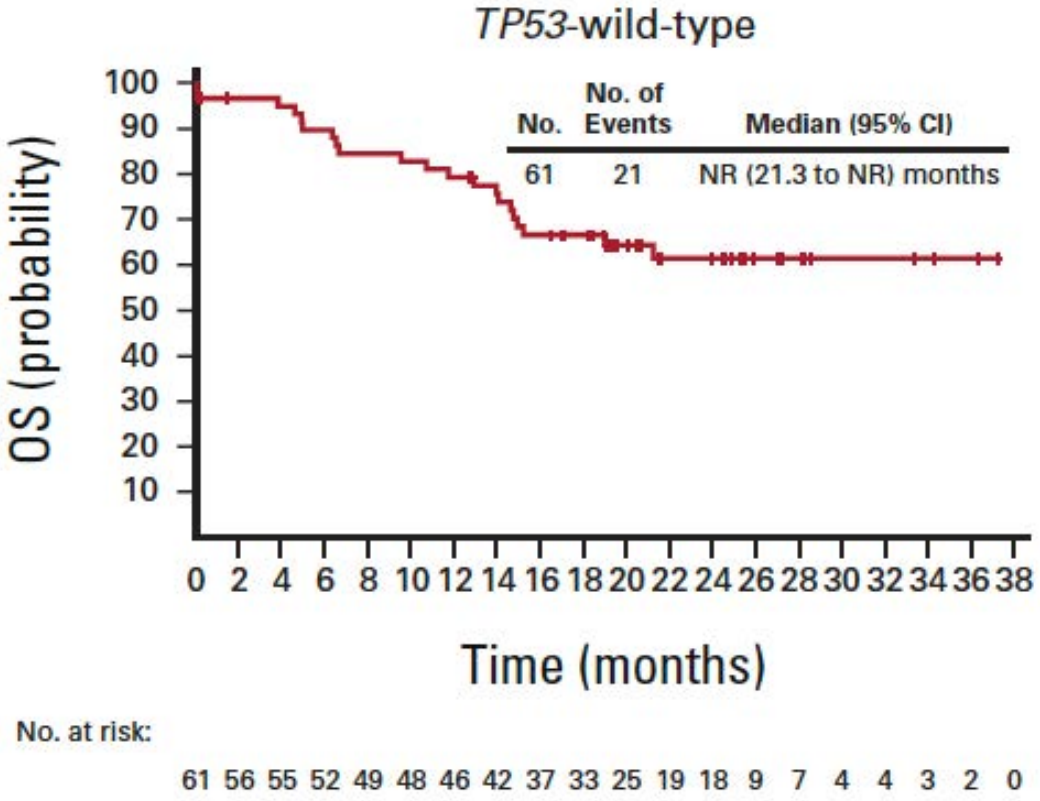
Median OS Is Encouraging in Both *TP53*-Wild Type and Mutant HR-MDS Patients

- With a median follow-up of 17.1 months, median OS was not reached and was 16.3 months in *TP53*-mut MDS.





Sallman D et al., EHA 2022; Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

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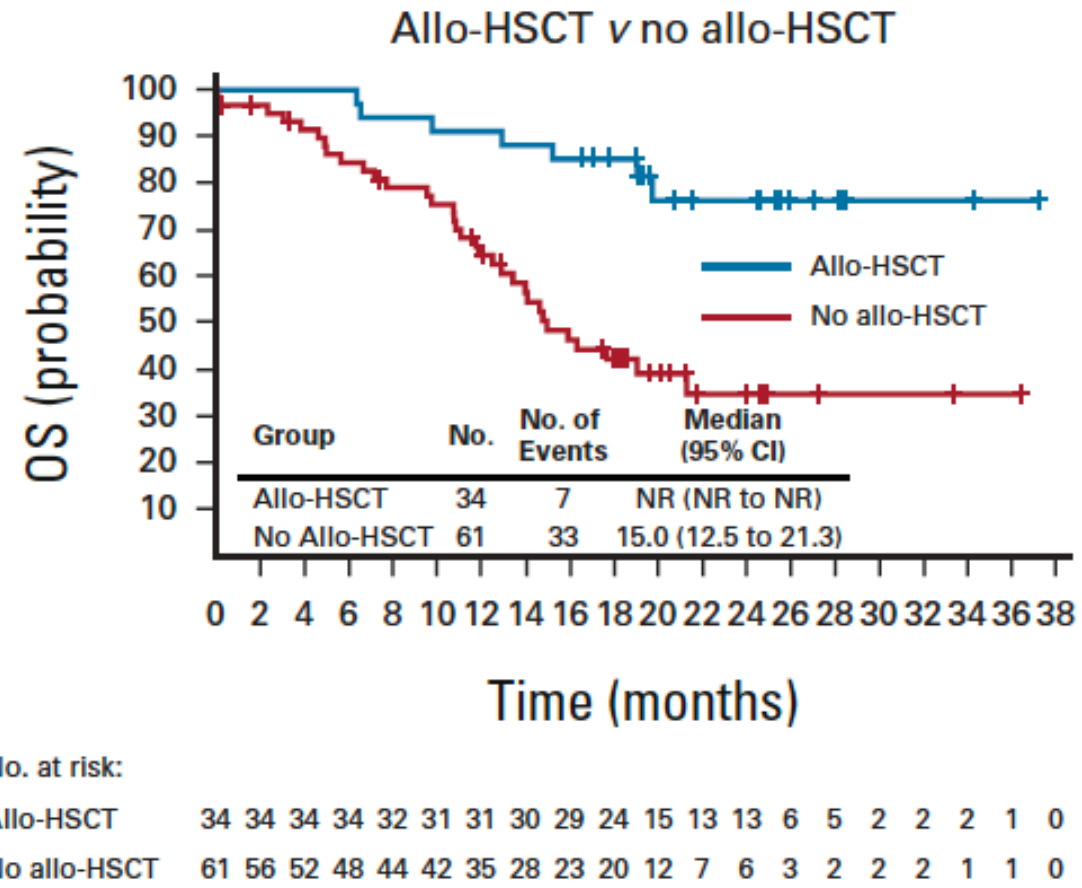
Stem Cell Transplant Outcomes Are Encouraging in HR-MDS Patients Treated with Magrolimab + AZA



Kaplan–Meier Survival Estimates

All Patients	SCT (N = 35)	No SCT (N = 60)
Median follow-up, months	19.6	12.9
Median OS (95% CI)	NR (NR, NR)	14.8 (11.9, 21.3)
1-year OS, % (95% CI)	91.4 (75.7, 97.2)	64.0 (49.9, 75.1)
2-year OS, % (95% CI)	77.3 (57.3, 88.8)	33.9 (20.0, 48.3)

Sallman D et al., EHA 2022; Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

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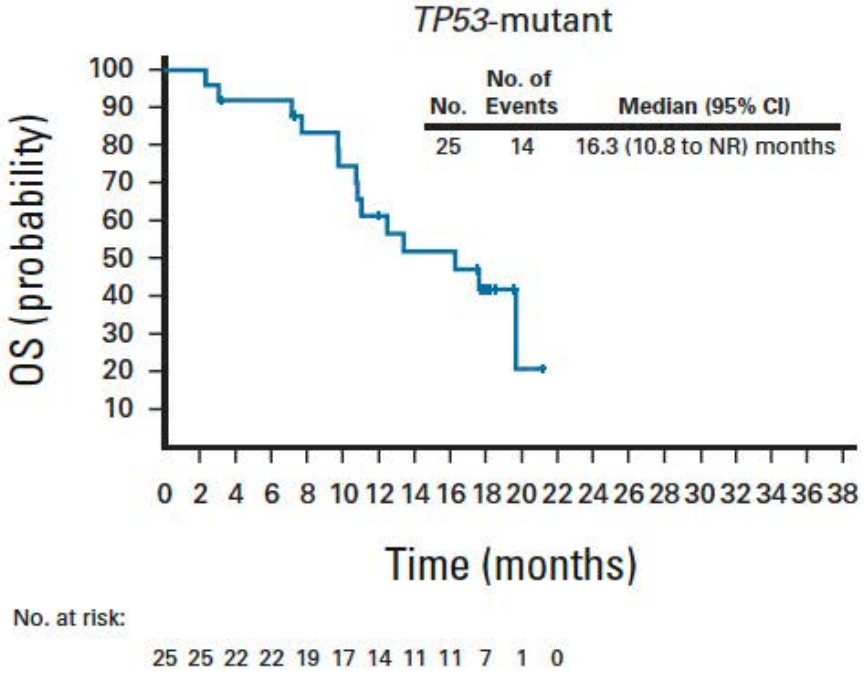
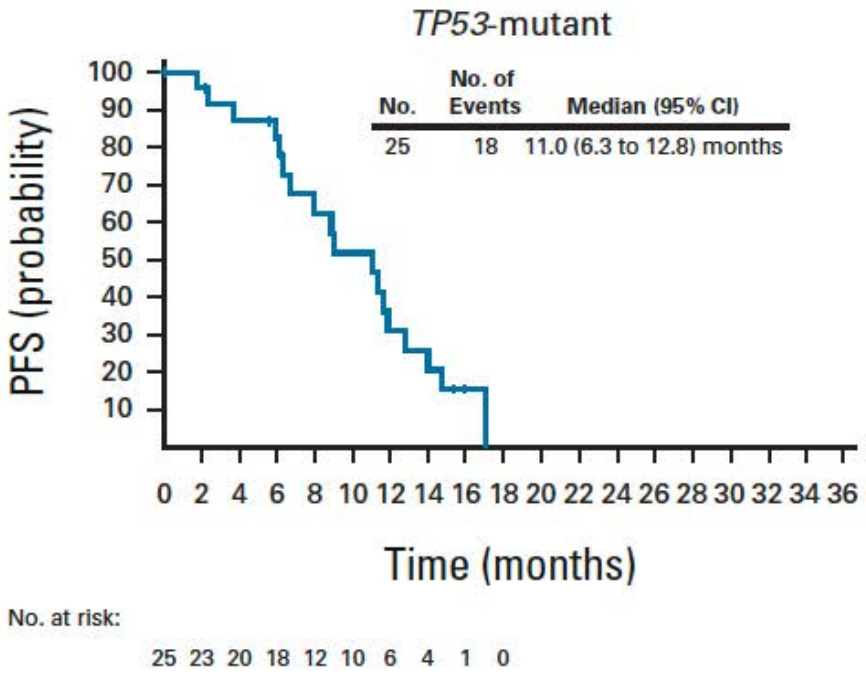
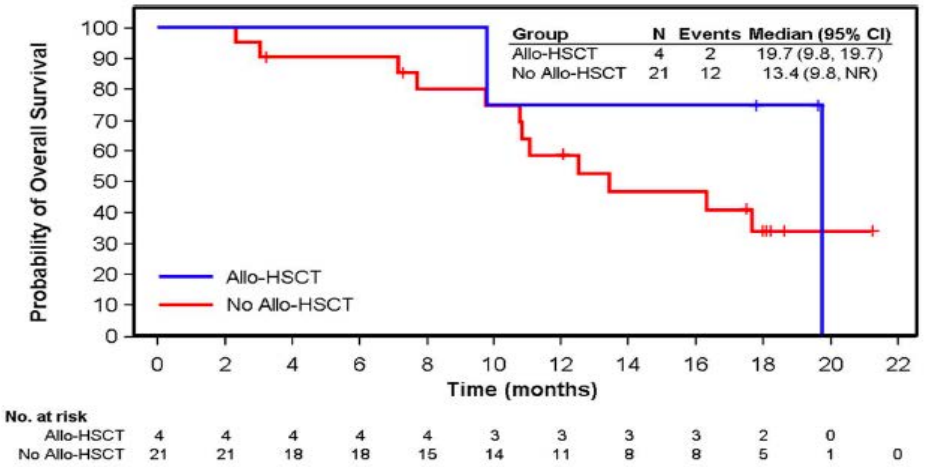
OS and PFS in *TP53* mutant MDS pts with Aza+Magro







Sallman D et al., *JCO* 2023

Courtesy of David A Sallman, MD

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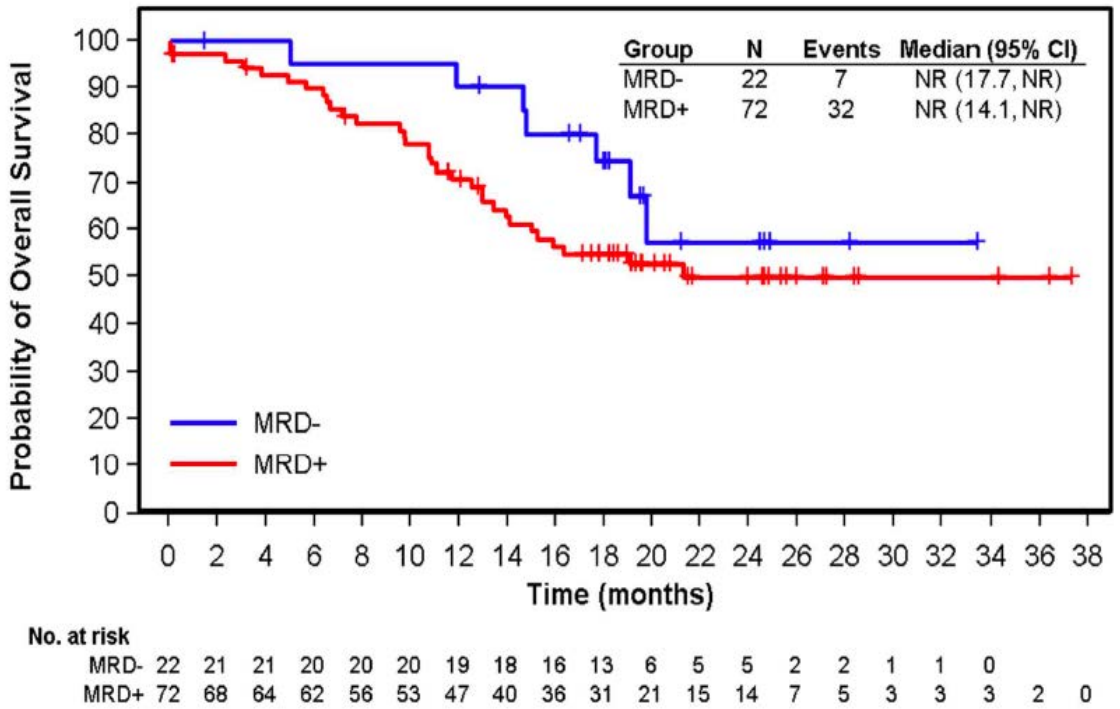
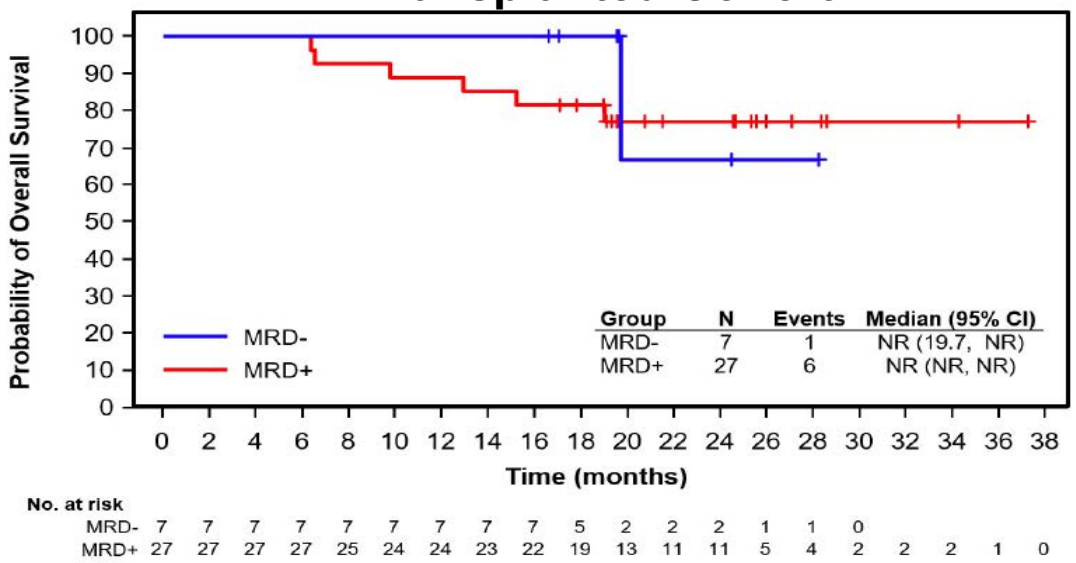
Prognostic Value of MRD in MDS

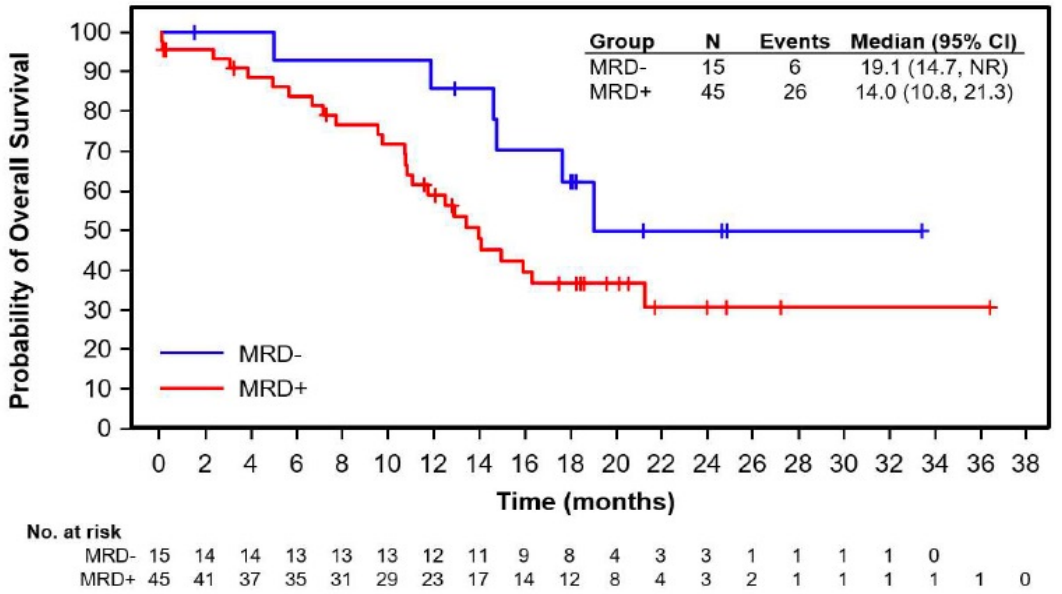
Total Cohort



Transplanted Cohort



Non-Transplanted Cohort



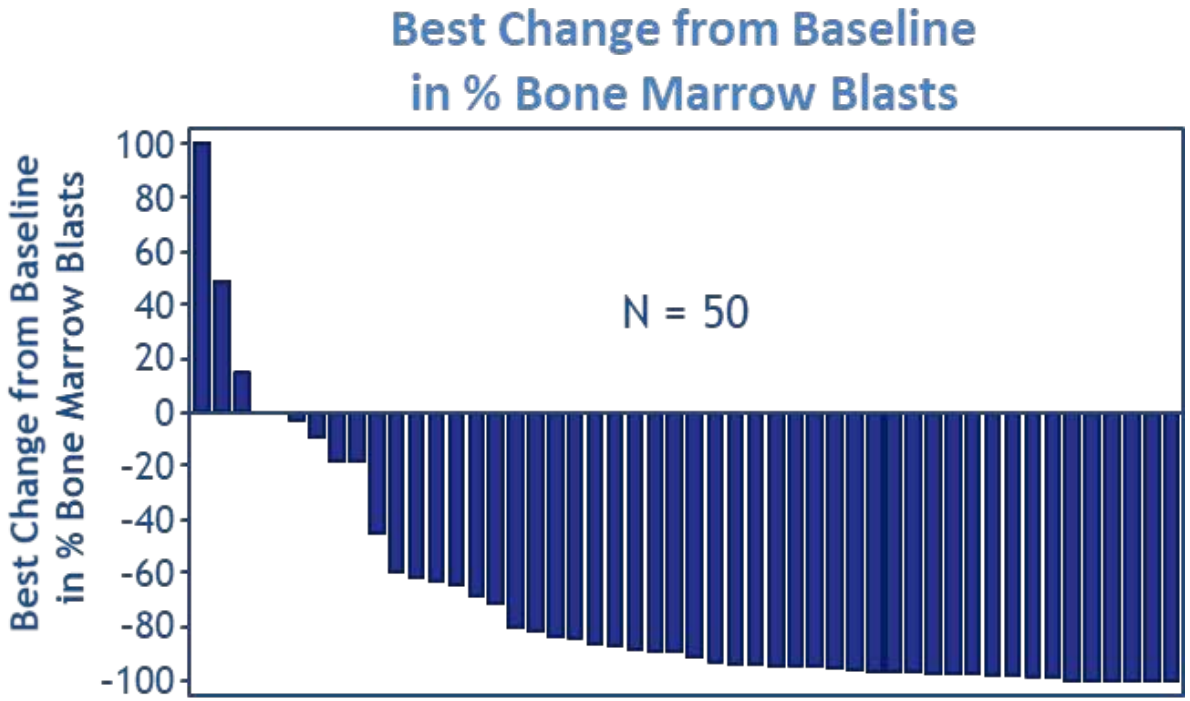
Sallman D et al., JCO. 2023

Courtesy of David A Sallman, MD

Magrolimab in Combination with AZA Demonstrated Encouraging Response Rates in *TP53*-mut AML

Efficacy Endpoints (Intent-to-Treat Analysis)

Outcome	N = 72
ORR, % (95% CI)	**48.6 (36.7, 60.7)**
CR, % (95% CI)	**33.3 (22.7, 45.4)** (n = 24/72)
MRD— CR*, % (95% CI)	50.0 (29.1, 70.9) (n = 12/24)
CRi/CRh, n (%)	6 (8.3)
PR, n (%)	4 (5.6)
MLFS, n (%)	1 (1.4)
DOR, median (95% CI), mo	**8.7 (6.5, 10.4)**
DCR, median (95% CI), mo	7.7 (4.7, 10.9)
CCyR, n/N† (%)	10/31 (32.3)
PFS, median (95% CI), mo	7.3 (3.7, 9.7)

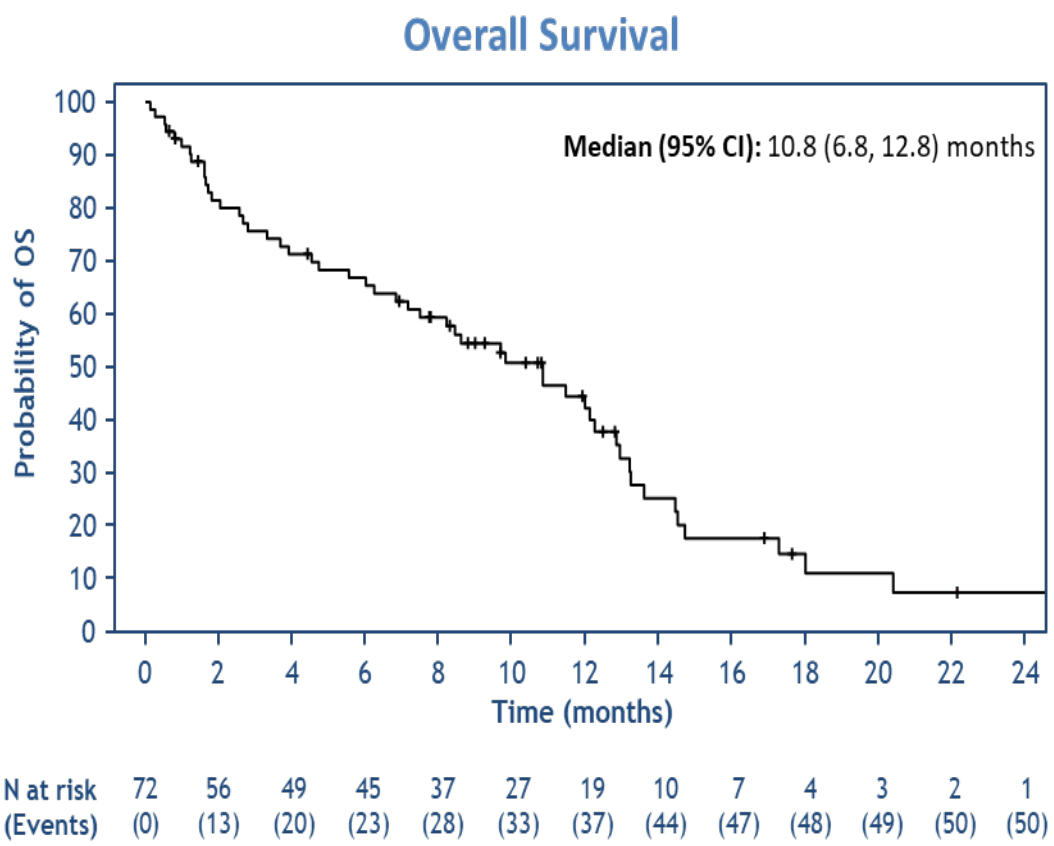


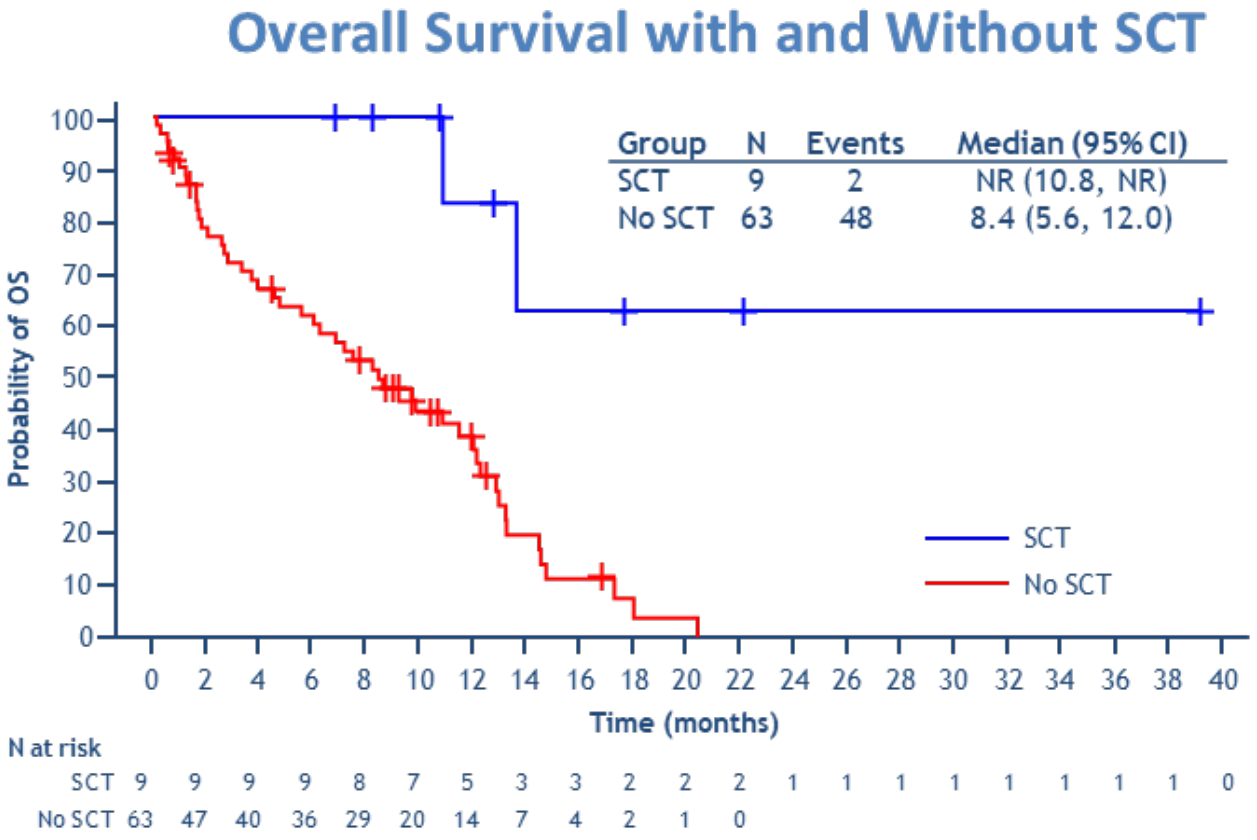
- CR was achieved by 33.3% of patients with half of CR patients being MRD–.
- 30 (41.7%) patients achieved CR/CRi.
- 29.7% and 45.8% of baseline transfusion-dependent patients converted to RBC and platelet transfusion independence,‡ respectively.

Daver N …. Sallman D et al., EHA 2022; manuscript under review

Courtesy of David A Sallman, MD

Overall Survival Is Encouraging in *TP53*-mut AML





1-year OS 83% (27-98) vs 36% 23-49%

Daver N ….. Sallman D et al., EHA 2022; manuscript under review

Courtesy of David A Sallman, MD

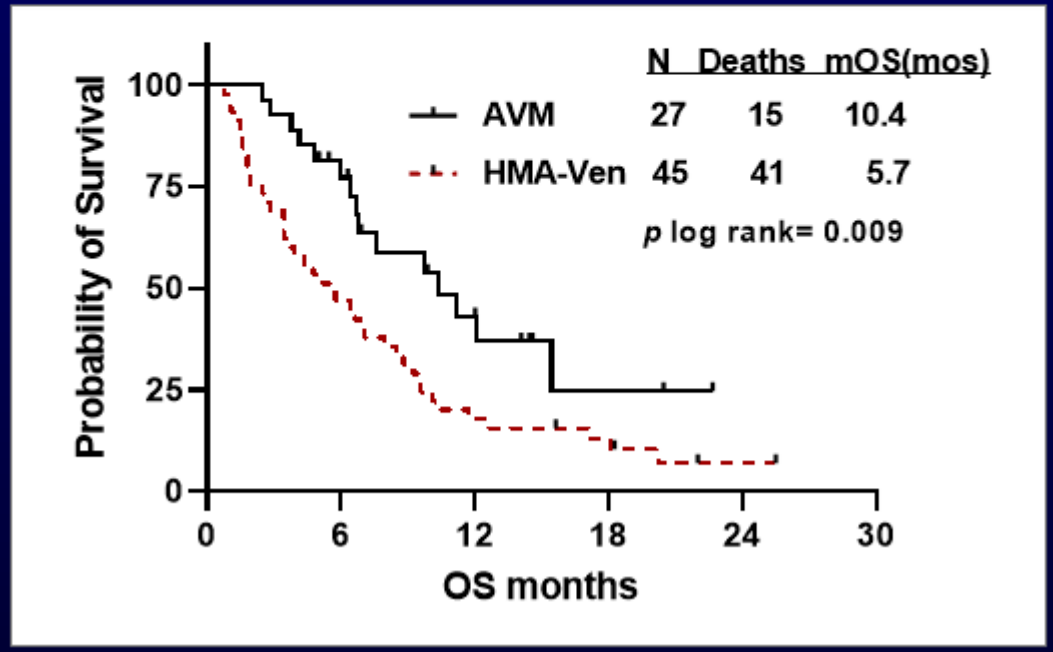
Triplet Azacitidine + Venetoclax + Magrolimab

Parameters		Full Frontline
		N=43
Overall response	CR CRi CR + CRi	21 (49) 10 (23) 31 (72)
	MLFS	4 (9)
MRD-ve best responses#	FCM-CR/CRi	16/28 (67)#
Cytogenetic responses*	CCyR	11/21 (52)*
Time to response (days)	First response Best response	23 [19-105] 51 [20-130]
Counts recovery (days)	ANC ≥ 500/cu mm Platelet ≥ 100 x 10^9/L	36 [16-88] 32 [0-74]
Cycles on therapy		3 [1-17]
Mortality: - 4 week - 8 week		0 (0) 0 (0)

Amongst CR/CRi patients with longitudinally MRD evaluable samples * Amo

Adjusted HR for AVM arm for death= 0.41, 95% CI=0.18-0.88

Comparison of overall survival (unmatched groups)



Daver N et al., ASH 2022

Courtesy of David A Sallman, MD

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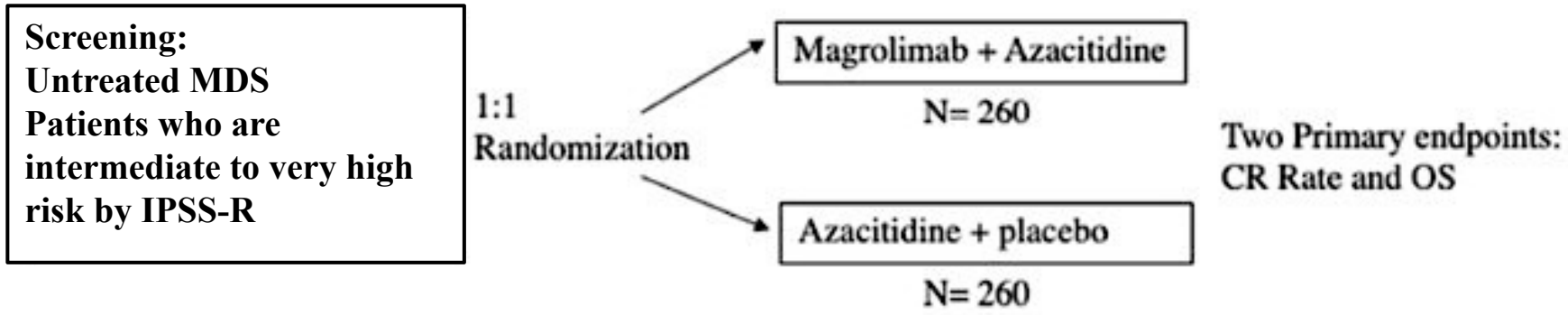
ENHANCE Randomized Phase 3 MDS Study

Figure 4. Study 5F9009 Schematic



Magrolimab (or saline placebo) dosing:
Cycle 1:
- Priming (1 mg/kg) on Days 1 and 4
- 15 mg/kg on Day 8
- 30 mg/kg Days 11, 15, 22

Cycle 2: 30 mg/kg Days 1, 8, 15, 22
Cycle 3 and onward: 30 mg/kg Q2W

Azacitidine dosing:
75 mg/m^2 IV or SC Days 1-7 (or Days 1-5 and 8-9) every cycle

Cycles are 28 days long

Courtesy of David A Sallman, MD

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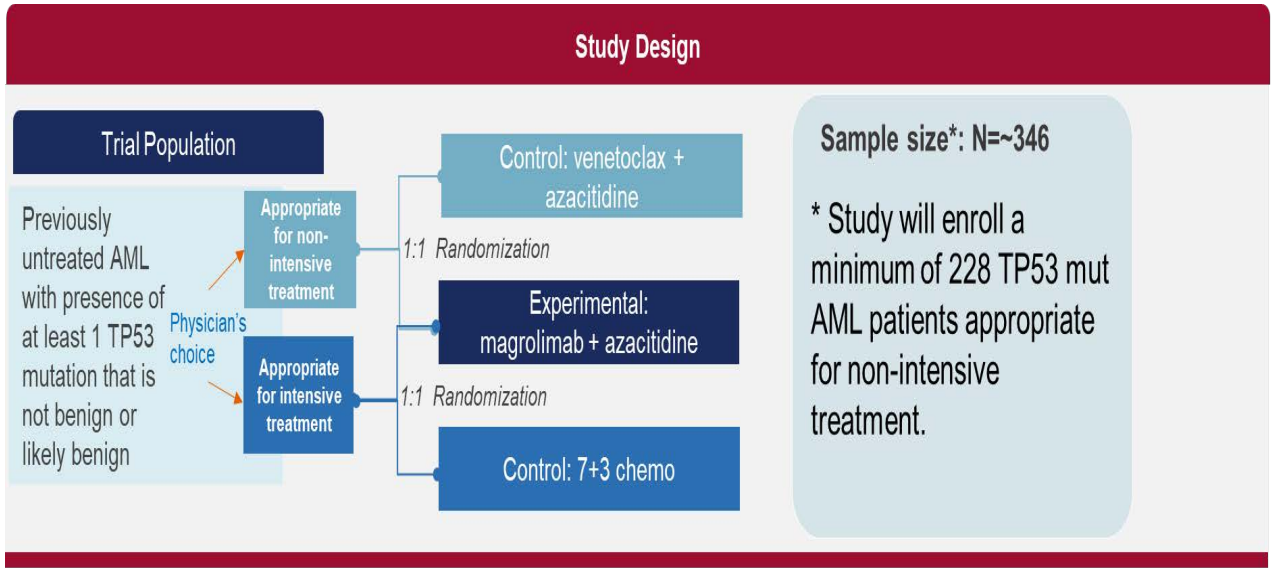
Ongoing Phase 3 Studies with Magro in FL AML

Phase III AZA+Magro vs Investigator Choice in TP53 AML (ENHANCE-2)



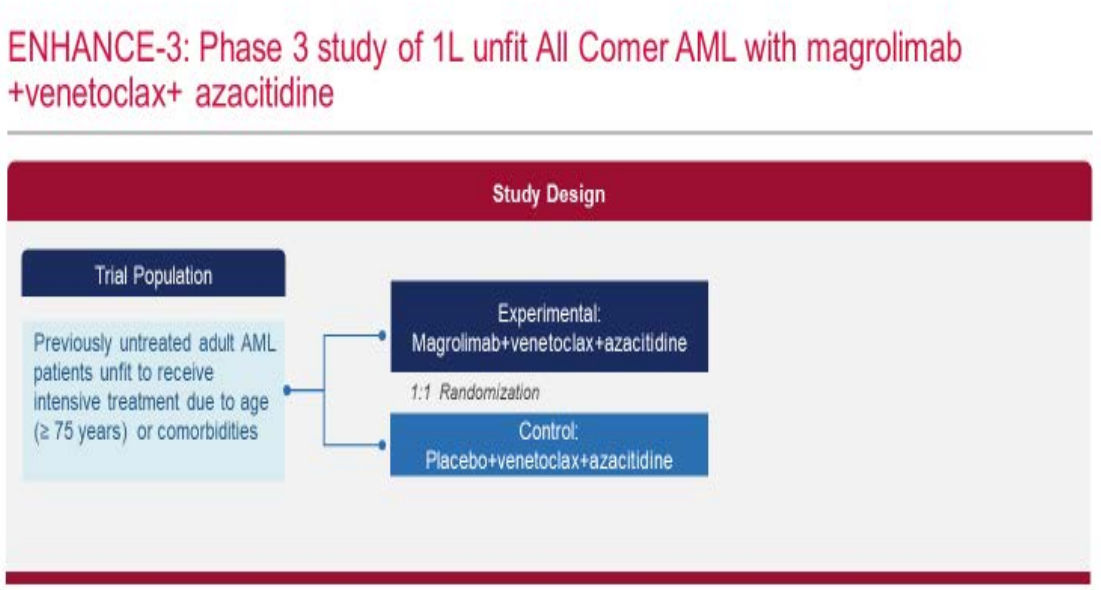
Stratification:

1) Appropriateness for non-intensive therapy vs. intensive therapy
2) Age <75 vs. ≥75
3) Geographic region: US vs. outside the US

Endpoints:

- **Primary endpoint:** OS in TP53 mut AML population appropriate for non-intensive treatment
- **First secondary endpoint (alpha controlled):** OS in all TP53 mut AML population
- **Other key secondary endpoints (alpha controlled):** EFS, Transfusion independence, CR/CR_{MRD-}, PRO in all TP53 mut AML population

Phase III AZA+VEN+Magro vs AZA+VEN in older/unfit AML (ENHANCE-3)



Endpoints:

Primary endpoints: CR, Overall survival

Secondary endpoints: 1. MRD-ve CR 2.CR+CRh, 3. Duration of CR, 4. Duration of CR+CRh 5. Transfusion independence 6. EFS 6. QOL/PRO

Courtesy of David A Sallman, MD

A 67-year-old man presents with 4% myeloblasts, mild pancytopenia and normal cytogenetics. NGS reveals ASXL1 and RUNX1 mutations. What is your usual front-line systemic treatment? Would you recommend allogeneic HSCT? If you were able to access magrolimab, would you recommend it?

	Preferred treatment	Allogeneic HSCT	Magrolimab
 Dr Garcia-Manero	Observation	No	No
 Dr Sallman	Azacitidine or observation	Yes	Yes
 Dr Borate	HMA	Yes	Yes
 Dr Brunner	Observation or ESA	Yes	No
 Dr DeZern	Azacitidine	Yes	No
 Dr Stone	Observation or ESA	No	No
 Dr Wang	Azacitidine	Yes	Yes

NGS = next-generation sequencing; HSCT = hematopoietic stem cell transplant; HMA = hypomethylating agent;
ESA = erythropoiesis-stimulating agent

If magrolimab receives FDA approval, do you expect that it will be administered by general medical oncologists in an outpatient setting?

 Dr Garcia-Manero	No
 Dr Sallman	I'm not sure
 Dr Borate	I'm not sure
 Dr Brunner	I'm not sure
 Dr DeZern	No
 Dr Stone	Yes
 Dr Wang	Yes

RTP RESEARCH TO PRACTICE

Based on available data and your clinical experience, how frequently should hemoglobin level be measured during the first week of treatment with magrolimab/azacitidine?

 Dr Garcia-Manero	At least 3 times if not daily
 Dr Sallman	2 times day 1 and 4 and day 2 check, minimum 5 times/first week
 Dr Borate	Every other day
 Dr Brunner	At least once daily
 Dr DeZern	Daily
 Dr Stone	Daily
 Dr Wang	Immediately prior to first and second doses and then immediately following each dose to transfuse to baseline Hgb 9

Based on available data and your clinical experience, how problematic is the acute drop in hemoglobin associated with the administration of magrolimab/azacitidine?

 Dr Garcia-Manero	Somewhat problematic
 Dr Sallman	Somewhat problematic
 Dr Borate	Very problematic
 Dr Brunner	Somewhat problematic
 Dr DeZern	Somewhat problematic
 Dr Stone	Somewhat problematic
 Dr Wang	Somewhat problematic

RTP RESEARCH TO PRACTICE

To approximately how many patients have you administered magrolimab on a clinical trial?

	MDS	Other cancers
 Dr Garcia-Manero	Multiple	Multiple
 Dr Sallman	Multiple	Multiple
 Dr Borate	5-7	0
 Dr Brunner	8	0
 Dr DeZern	6	0
 Dr Stone	3	3-4
 Dr Wang	7	5

What has been your global experience with anemia and the need for transfusions in your patients who have received magrolimab?

 Dr Garcia-Manero	If one follows mitigating approaches, the drug is safe
 Dr Sallman	No issues with transfusion, just more aggressive monitoring/transfusion in first week, subsequent management similar to aza monotherapy
 Dr Borate	Patients need frequent transfusions for prolonged periods of time especially if they don't respond
 Dr Brunner	It can be a pretty significant issue for some patients, but only in the first week of treatment
 Dr DeZern	Need is high after initial dosing, but wanes as older cells are cleared
 Dr Stone	Most patients do okay
 Dr Wang	Initially first 2 doses there is risk of acute hemolysis but otherwise there is overall much less anemia than venetoclax/azacitidine

aza = azacitidine

RTP RESEARCH TO PRACTICE

What has been your global experience with neutropenia and thrombocytopenia in your patients who have received magrolimab?

 Dr Garcia-Manero	No different than with other HMA-based doublets
 Dr Sallman	Overall mild increase in neutropenia, some patients with recurrent cytopenias on chronic therapy will need dose adjustment
 Dr Borate	Some patients appear to have persistent thrombocytopenia
 Dr Brunner	It does not seem to be an issue compared to HMA alone
 Dr DeZern	No different than with other HMA-based doublets
 Dr Stone	No different than with other HMA-based doublets
 Dr Wang	No different than with other HMA-based doublets

HMA = hypomethylating agent

RTP RESEARCH TO PRACTICE

What other toxicities or tolerability issues have you observed in your patients who have received magrolimab?

 Dr Garcia-Manero	None
 Dr Sallman	Infusion reactions
 Dr Borate	Infusion reactions; LFT abnormalities
 Dr Brunner	Infusion reactions
 Dr DeZern	Fevers, feeling fluish
 Dr Stone	Infusion reactions
 Dr Wang	None

LFT = liver function test

What would you predict to be the outcome of a Phase III randomized trial evaluating magrolimab/azacitidine versus azacitidine alone as first-line treatment for higher-risk MDS?

Would your response change if the trial participants all had TP53 mutations?

	Trial outcome	TP53
 Dr Garcia-Manero	Magrolimab/azacitidine is more efficacious	No
 Dr Sallman	Magrolimab/azacitidine is more efficacious	No
 Dr Borate	Efficacy is about the same with both regimens	Yes
 Dr Brunner	Magrolimab/azacitidine is more efficacious	No
 Dr DeZern	Efficacy is about the same with both regimens	No
 Dr Stone	Magrolimab/azacitidine is more efficacious	Yes
 Dr Wang	Magrolimab/azacitidine is more efficacious	Yes

Agenda

MODULE 1: Biology of Acute Myeloid Leukemia/Myelodysplastic Syndromes

MODULE 2: Assessment of Risk Status

MODULE 3: Oral Hypomethylating Agents (HMAs)

MODULE 4: HMA/Venetoclax; Other Combinations

MODULE 5: Magrolimab/TP53

MODULE 6: Targeted Treatment

Targeted options in MDS

- IDH-2 (5-10%): enasidenib, venetoclax
- IDH-1 (5%): ivosidenib, venetoclax
- Flt-3 (15%): multiple agents
- TP53 (10%): anti-CD47 ?
- NPM1 (1%): ara-C based
- Splicing: IRAK4, H3BIO, Clk

Courtesy of Guillermo Garcia-Manero, MD

Case Presentation – Dr Garcia-Manero

A 78-year-old man presents with a history of cytopenia. Bone marrow exam reveals 15% blasts, cytogenetic analysis shows trisomy 8 and NGS indicates TET2 and DNMT3A mutations.

The patient receives 16 cycles of oral decitabine/cedazuridine and becomes cytopenic after achieving CR. Repeat marrow exam still shows 15% blasts, trisomy 8 but NGS results now reveal a new IDH2 mutation. You discuss treatment with IDH2 inhibitor in a clinical trial for HMA failure.

Case Presentation – Dr Sallman

- 84 yo male with PMH of RAEB-2 MDS presents for relapsed disease after 12 cycles of single agent azacitidine for which he obtained a CR. The patient is currently RBC transfusion dependent with ANC of 300 and platelets of 35,000 and a blast count of 12%. Although NGS was not obtained at baseline, NGS was performed at time of relapse and showed an *IDH2* mutation. The patient was treated with off-label enasidenib.

Practice Changing Potential

Multiple HMA-based doublets currently in phase 3 clinical trials

- VERONA: AZA +/- VEN in ND HR-MDS (excludes therapy related)
- ENHANCE: AZA +/- Magrolimab in HR-MDS
- STIMULUS-MDS1: HMA +/- sabatolimab in HR-MDS
- **SELECT MDS-1: AZA +/- tamibarotene in RARA-positive MDS**

- Targeted Interventions for molecular subsets
  - IDH1/IDH2inh similar (if not more) activity than AML; TP53? Splicing?
- Improving Outcomes with HSCT: total therapy
- Further evaluation of mechanisms of synergy and resistance with combination therapies and other novel strategies
- Evaluation of MRD by serial high sensitivity NGS or duplex sequencing
- What to do for HMA failure and how will frontline landscape impact the R/R setting?

Courtesy of David A Sallman, MD

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Data Sets and Advances in Oncology

A Multitumor CME/MOC-Accredited Live Webinar Series

Melanoma and Nonmelanoma Skin Cancers

Thursday, July 13, 2023
5:00 PM – 6:00 PM ET

Faculty

Omid Hamid, MD

Evan J Lipson, MD

Moderator

Neil Love, MD

RTP Year in Review 2023

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 up to 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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