Year in Review:
Acute Myeloid Leukemia

A Multitumor CME/MOC-Accredited Live Webinar

Wednesday, April 17, 2024
5:00 PM – 6:00 PM ET

Faculty

Naval Daver, MD
Courtney D DiNardo, MD, MSCE

Moderator

Neil Love, MD

RTP Year in Review 2024

Faculty

Naval Daver, MD
Director, Leukemia Research Alliance Program
Professor
Department of Leukemia
The University of Texas
MD Anderson Cancer Center
Houston, Texas

Courtney D DiNardo, MD, MSCE
Professor, Department of Leukemia
Division of Cancer Medicine
The University of Texas
MD Anderson Cancer Center
Houston, Texas

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

Commercial Support

This activity is supported by educational grants from AbbVie Inc, Astellas, Daiichi Sankyo Inc, Syndax Pharmaceuticals, and Taiho Oncology Inc.

Dr Love — Disclosures

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Dr DiNardo — Disclosures

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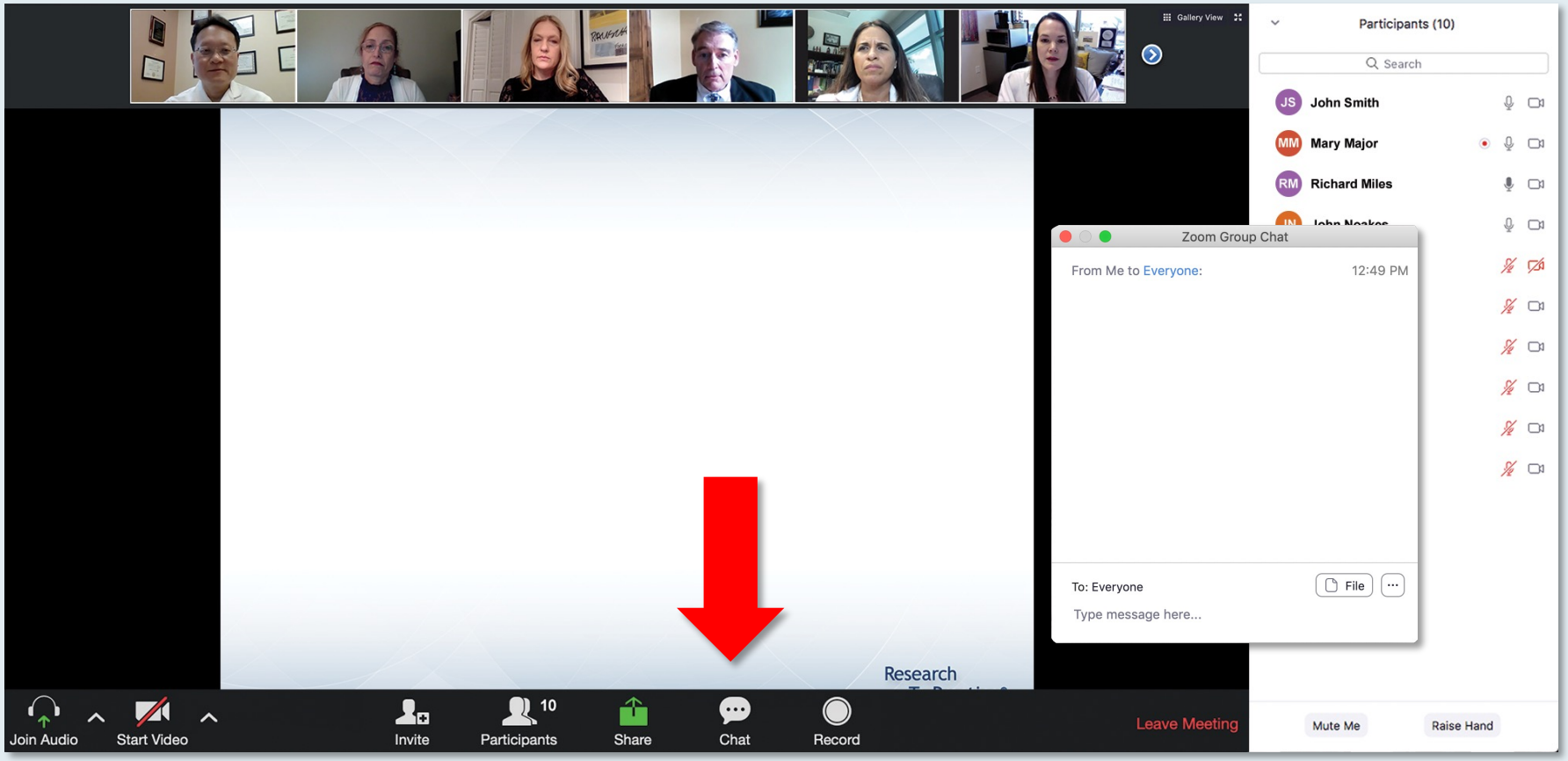
Data and Safety Monitoring Board/ Committee	Genmab US Inc

We Encourage Clinicians in Practice to Submit Questions



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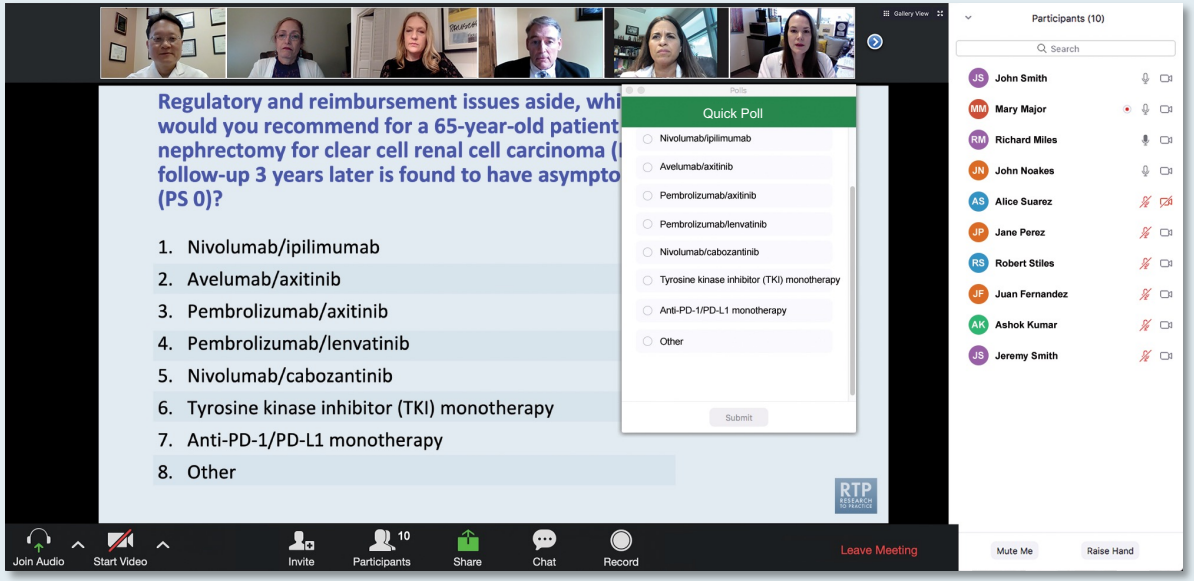

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Meet The Professor: Optimizing the Management of Acute Myeloid Leukemia and Myelodysplastic Syndromes — Part 3 of a 3-Part Series

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Hormone Receptor-Positive Breast Cancer

Wednesday, April 24, 2024
6:00 PM – 8:00 PM ET

Faculty
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Kelly Fischer, MSN, FNP-BC
Komal Jhaveri, MD, FACP
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MODULE 2: Current and Emerging Role of Biomarker-Directed Therapeutic Approaches for Patients with AML — Dr DiNardo

Thank you for joining us!

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

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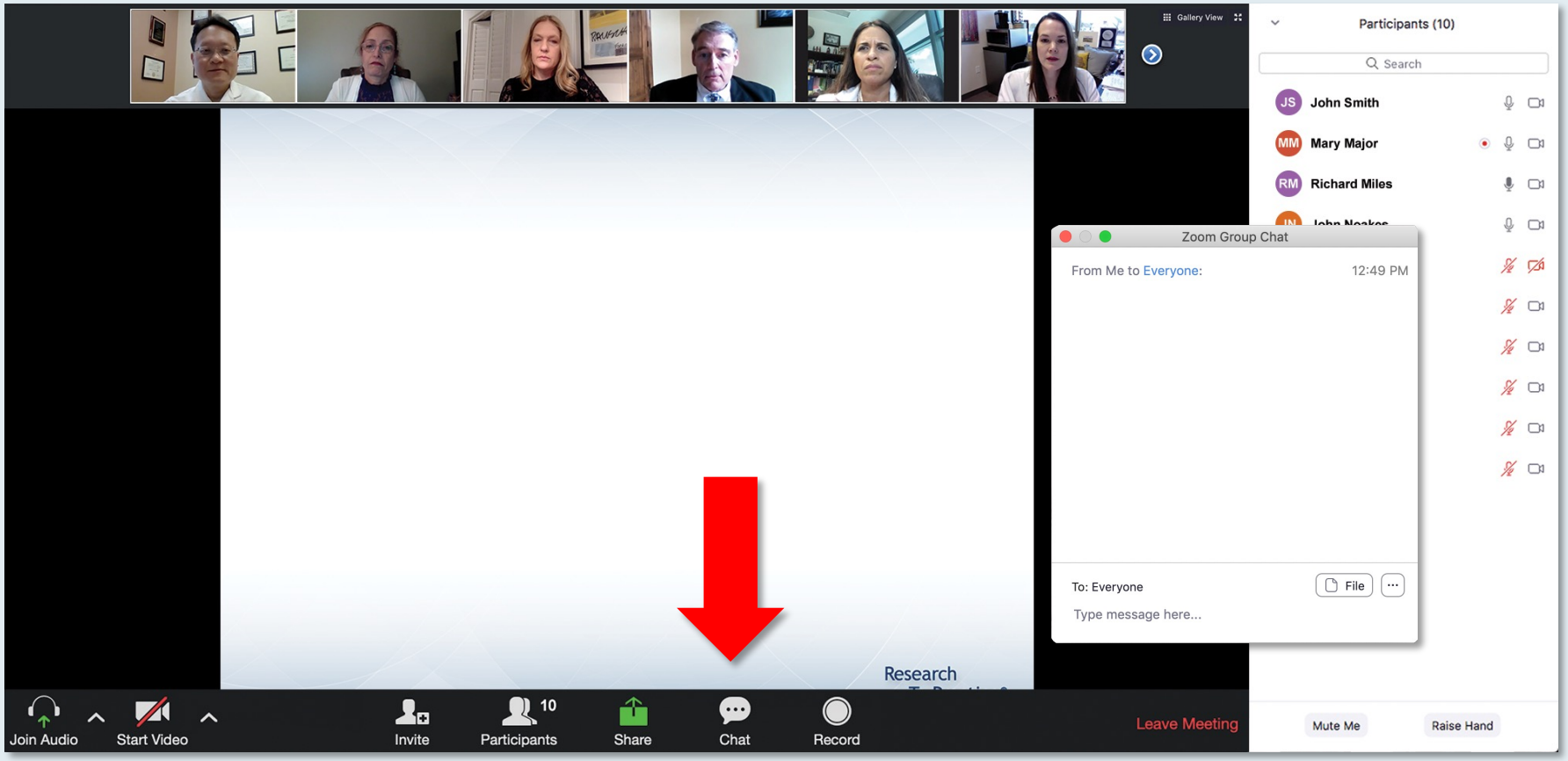

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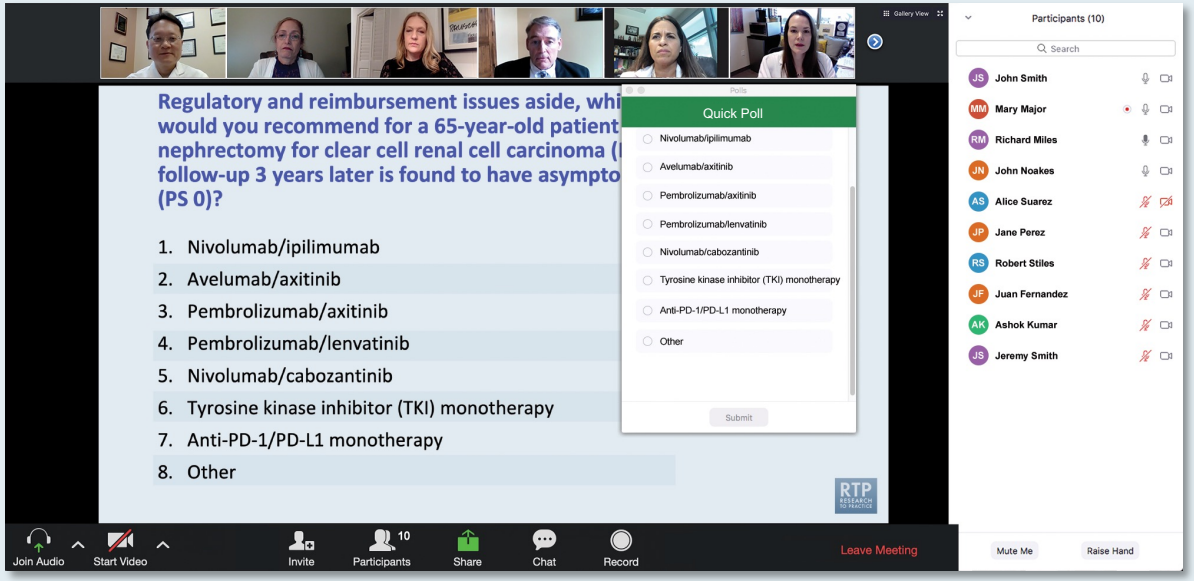

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RTP: Year in Review

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RTP: Current and Emerging Role of Biomarker-Directed Therapeutic Approaches for Patients with AML

Courtney DiNardo

Key Data Sets

Naval Daver, MD

- Pratz KW et al. **Long-term follow-up of VIALE-A**: **Venetoclax** and **azacitidine** in **chemotherapy-ineligible untreated** acute myeloid leukemia. *Am J Hematol* 2024;99(4):615-24.
- Garciaz S et al. Acute myeloid leukemia patients who **stopped venetoclax** or/and **azacytidine** for other reasons than progression have a prolonged treatment free remission and overall survival. A **Filo study**. ASH 2023;Abstract 161.
- Kadia T et al. A phase 2 study of the **fully oral combination of ASTX727 (decitabine/cedazuridine)** plus **venetoclax** for **older and/or unfit** patients with acute myeloid leukemia. ASH 2023;Abstract 833.
- Ruhnke L et al. **Venetoclax** plus **high-dose cytarabine** and **mitoxantrone (HAM-ven)** as **salvage** treatment for **relapsed/refractory** AML: Updated results of the phase-I/II **SAL relax** trial. ASH 2023;Abstract 160.
- Suo X et al. **Venetoclax** combined with **daunorubicin and cytarabine (2 + 6)** in acute myeloid leukemia: Updated results of a phase II trial. ASH 2023;Abstract 969.

Key Data Sets

Naval Daver, MD (continued)

- Wei AH et al. Long-term survival with **oral azacitidine** for patients with acute myeloid leukemia in first remission after chemotherapy: Updated results from the randomized, placebo-controlled, **phase 3 QUAZAR AML-001** trial. *Am J Hematol* 2023 April;98(4):E84-7.
- Guolo F et al**. Optimal duration** of **CPX-351** treatment and best timing for consolidation with allogeneic stem cell transplantation: Evidence from a large real-world Italian study. ASH 2023;Abstract 731.
- Yang Li et al. **Selinexor** in combination with **venetoclax** and **azacitidine** for **newly diagnosed** (ND) **unfit** acute myeloid leukemia (AML): A multicenter, open-label prospective study. ASH 2023;Abstract 55.
- Garcia-Manero G et al. **Eprenetapopt** combined with **venetoclax** and **azacitidine** in **TP53-mutated** acute myeloid leukaemia: A phase 1, dose-finding and expansion study. *Lancet Haematol* 2023;10(4):e272-83.

Key Data Sets

Naval Daver, MD (continued)

- Pabst T et al. **Cusatuzumab** plus **azacitidine** in **newly diagnosed** acute myeloid leukaemia **ineligible** for **intensive chemotherapy (CULMINATE):** Part one of a randomised, phase 2, dose optimisation study. *Lancet Haematol* 2023;10(11):e902-12.
- Daver NG et al. **Pivekimab sunirine (IMGN632),** a **novel CD123-targeting antibody-drug conjugate**, in **relapsed or refractory** acute myeloid leukaemia: A phase 1/2 study. *Lancet Oncol* 2024;25(3):388-99.
- Stein AS et al. A first-in-human study of **CD123 NK cell engager SAR443579** in **relapsed or refractory** acute myeloid leukemia, B-cell acute lymphoblastic leukemia, or high-risk myelodysplasia. ASCO 2023;Abstract 7005.

Key Data Sets

Courtney D DiNardo, MD, MSCE

- Erba HP et al. **Quizartinib** plus **chemotherapy** in **newly diagnosed** patients **with FLT3-internal-tandem-duplication-positive** acute myeloid leukaemia **(QuANTUM-First)**: A randomised, double-blind, placebo-controlled, **phase 3** trial. *Lancet* 2023;401(10388):1571-83.
- Perl A et al. **Quantum-first trial:** FMS-like tyrosine kinase 3-internal tandem duplication **(FLT3-ITD)–specific measurable residual disease (MRD)** clearance assessed through induction (IND) and consolidation (CONS) is associated with improved overall survival (OS) in **newly diagnosed** (nd) FLT3-ITD+ AML patients (pts). ASH 2023;Abstract 832.
- Montesinos P et al. Preliminary results of **QUIWI**: A double blinded, randomized clinical trial comparing standard **chemotherapy plus quizartinib** versus **placebo** in adult patients with **newly diagnosed FLT3-ITD wild-type** AML. EHA 2023;Abstract S130.
- Pratz KW et al. **Gilteritinib** in combination **with induction and consolidation chemotherapy** and as **maintenance** therapy: A phase IB study in patients with **newly diagnosed** AML. *J Clin Oncol* 2023;41(26):4236-46.

Key Data Sets

Courtney D DiNardo, MD, MSCE (continued)

- Perl AE et al. Outcomes in patients with **FLT3-mutated relapsed/refractory** acute myelogenous leukemia who underwent transplantation in the **phase 3 ADMIRAL** trial of **gilteritinib** versus **salvage chemotherapy**. *Transplant Cell Ther* 2023;29(4):265.e1-10.
- Levis MJ et al. **BMT-CTN 1506 (MORPHO)**: A randomized trial of the **FLT3 inhibitor gilteritinib** as **post-transplant maintenance** for FLT3-ITD AML. EHA 2023;Abstract LB2711.
- Atluri H et al. Phase Ib/2 study of **oral decitabine/cedazuridine (ASTX727)** and **venetoclax** in **combination** with the targeted mutant **IDH1 inhibitor ivosidenib** or the targeted mutant **IDH2 inhibitor enasidenib**: 2023 Update. ASH 2023;Abstract 968.
- de Botton S et al. **Olutasidenib (FT-2102)** induces durable complete remissions in patients with **relapsed or refractory IDH1-mutated** AML. *Blood Adv* 2023;7(13):3117-27.

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Courtney D DiNardo, MD, MSCE (continued)

- Aldoss I et al. **Revumenib** monotherapy in patients with **relapsed/refractory KMT2Ar** acute leukemias: Efficacy and safety results from the **augment-101** phase 1/2 study. ASH 2023;Abstract LBA-5.
- Issa GC et al. Early results of the phase I/II study investigating the **all-oral combination** of the **menin inhibitor revumenib (SNDX-5613)** with **decitabine/cedazuridine (ASTX727)** and **venetoclax** in acute myeloid leukemia (**SAVE**). ASH 2023;Abstract 58.
- Fathi A et al. Activity, tolerability, and resistance profile of the **menin inhibitor ziftomenib** in adults with **R/R NPM1-mutated** AML. EHA 2023;Abstract LB2713.
- Jabbour E et al. A first-in-human phase 1 study of the **menin-KMT2A (MLL1) inhibitor JNJ-75276617** in adult patients with **relapsed/refractory** acute leukemia harboring **KMT2A or NPM1 alterations**. ASH 2023;Abstract 57.

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MODULE 2: Current and Emerging Role of Biomarker-Directed Therapeutic Approaches for Patients with AML — Dr DiNardo

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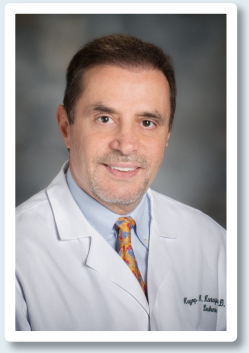
Department of Leukemia, MD Anderson Department Leadership



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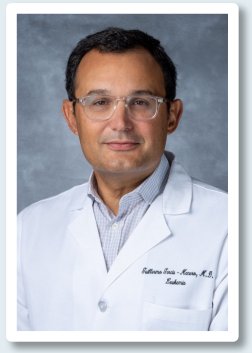

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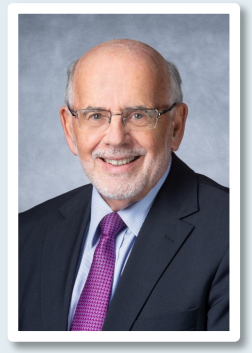
William Wierda, MD, PhD

Alessandra Ferrajoli, MD



Michael Andreeff, MD, PhD

Gautam Borthakur, MD

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Courtney D DiNardo, MD, MSCE

Ghayas C Issa, MD

Elias Jabbour, MD

Nitin Jain, MD

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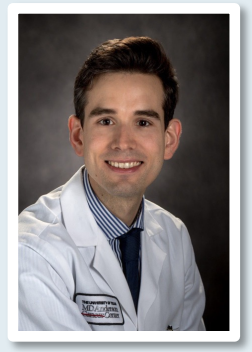


Guillermo Montalban Bravo, MD

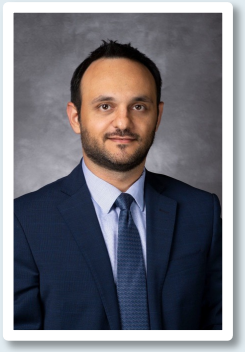
Naveen Pemmaraju, MD

Farhad Ravandi, MD

Koji Sasaki, MD

RTP Year in Review 2024

Department of Leukemia, MD Anderson Clinical Faculty

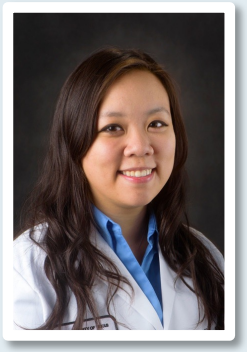


Hussein A Abbas, MD, PhD

Yesid Alvarado-Valero, MD

Prithviraj Bose, MD

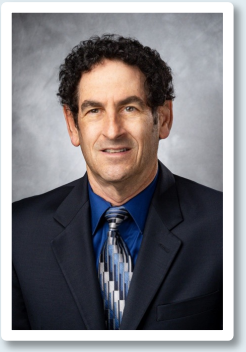
Jan A Burger, MD, PhD



Kelly Chien, MD

Fadi Haddad, MD

Danielle Hammond, MD



Steven M Kornblau, MD

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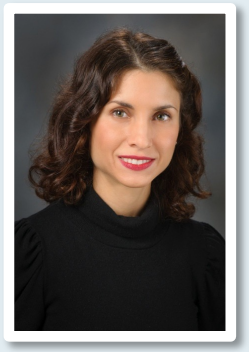

Maro Ohanian, DO

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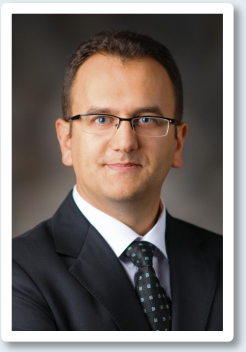
Mahesh Swaminathan, MB, BS

Koichi Takahashi, MD, PhD



Musa Yilmaz, MD

RTP Year in Review 2024

Agenda

INTRODUCTION

MODULE 1: Available and Emerging Nontargeted Therapies for Acute Myeloid Leukemia (AML) — Dr Daver

MODULE 2: Current and Emerging Role of Biomarker-Directed Therapeutic Approaches for Patients with AML — Dr DiNardo

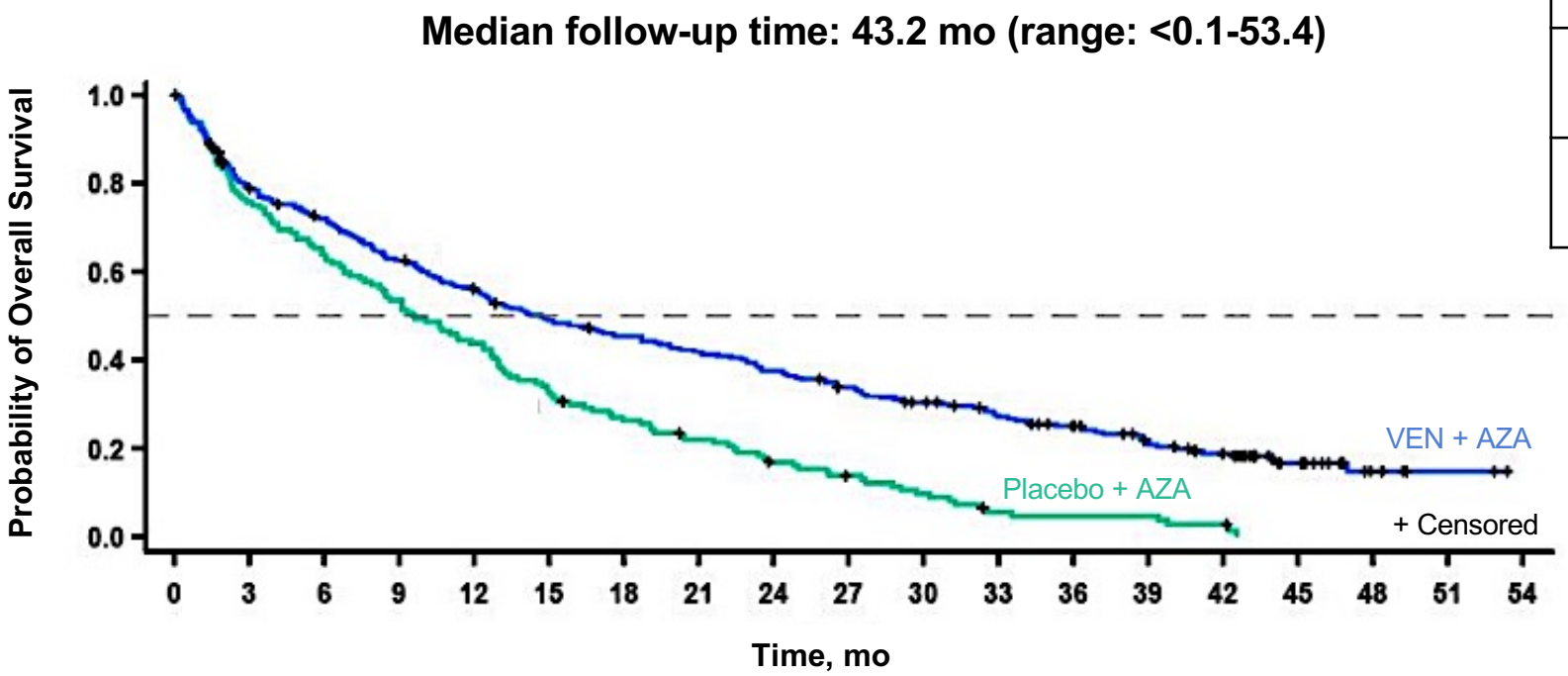
In general, do you provide direct care for your patients with AML?

1. No
2. Yes, but only older patients not eligible for intensive chemotherapy
3. Yes, both older and younger patients

Novel Venetoclax-Based Approaches

- Pratz KW et al. **Long-term follow-up of VIALE-A**: **Venetoclax** and **azacitidine** in **chemotherapy-ineligible untreated** acute myeloid leukemia. *Am J Hematol* 2024;99(4):615-24.
- Garciaz S et al. Acute myeloid leukemia patients who **stopped venetoclax** or/and **azacytidine** for other reasons than progression have a prolonged treatment free remission and overall survival. A **Filo study**. ASH 2023;Abstract 161.
- Kadia T et al. A phase 2 study of the **fully oral combination of ASTX727 (decitabine/cedazuridine)** plus **venetoclax** for **older and/or unfit** patients with acute myeloid leukemia. ASH 2023;Abstract 833.
- Ruhnke L et al. **Venetoclax** plus **high-dose cytarabine** and **mitoxantrone (HAM-ven)** as **salvage** treatment for **relapsed/refractory** AML: Updated results of the phase-I/II **SAL relax** trial. ASH 2023;Abstract 160.
- Suo X et al. **Venetoclax** combined with **daunorubicin and cytarabine (2 + 6)** in acute myeloid leukemia: Updated results of a phase II trial. ASH 2023;Abstract 969.

Long term OS with AZA+VEN needs further improvement (3 year follow-up)



No. at Risk																			
VEN + AZA	286	220	199	173	153	133	122	113	101	89	78	67	57	45	34	18	6	2	0
Placebo + AZA	145	109	92	77	63	47	37	30	22	17	12	6	5	5	3	0	0	0	0

	Events/Patients n (%)	OS median, mo (95% CI)
VEN + AZA	222/286 (77.6)	14.7 (12.1-18.7)
Placebo + AZA	138/145 (95.2)	9.6 (7.4-12.7)

HR = 0.58 (95% CI, 0.465-0.723)
***P* < .001**

HR reduction from 0.66 (95% CI, 0.52-0.85) at 75% OS analysis

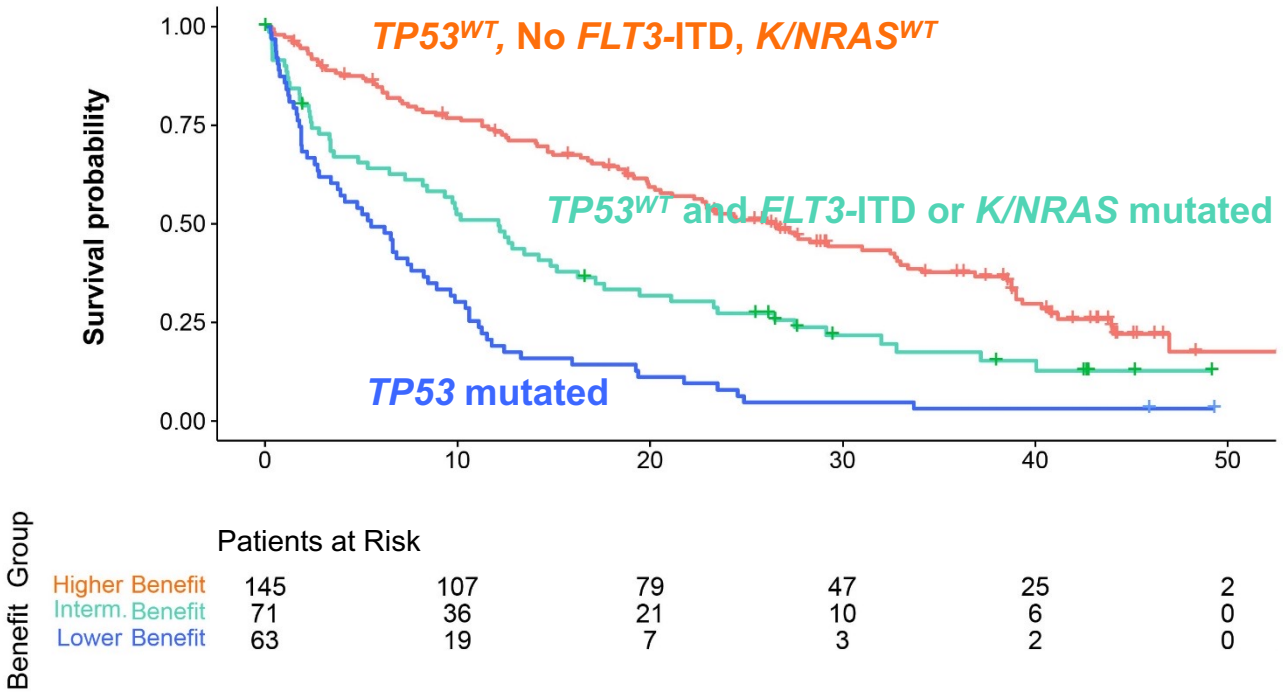
Courtesy of Naval Daver, MD

Pratz K et al. ASH 2022. Abstract 219. **Pratz KW et al. Am J Hematol 2024;99(4):615-24.**

What are the most urgent populations in need of improvement?

Patients receiving Ven+Aza distinguishable into 3 subgroups by OS benefit

- First a higher benefit group was identified, with a median OS > 24 months
- Subsequently a lower benefit group was determined, with a median OS < 6 months
- Patients fitting neither criteria were categorized as the intermediate benefit group, with a median OS of 12 months



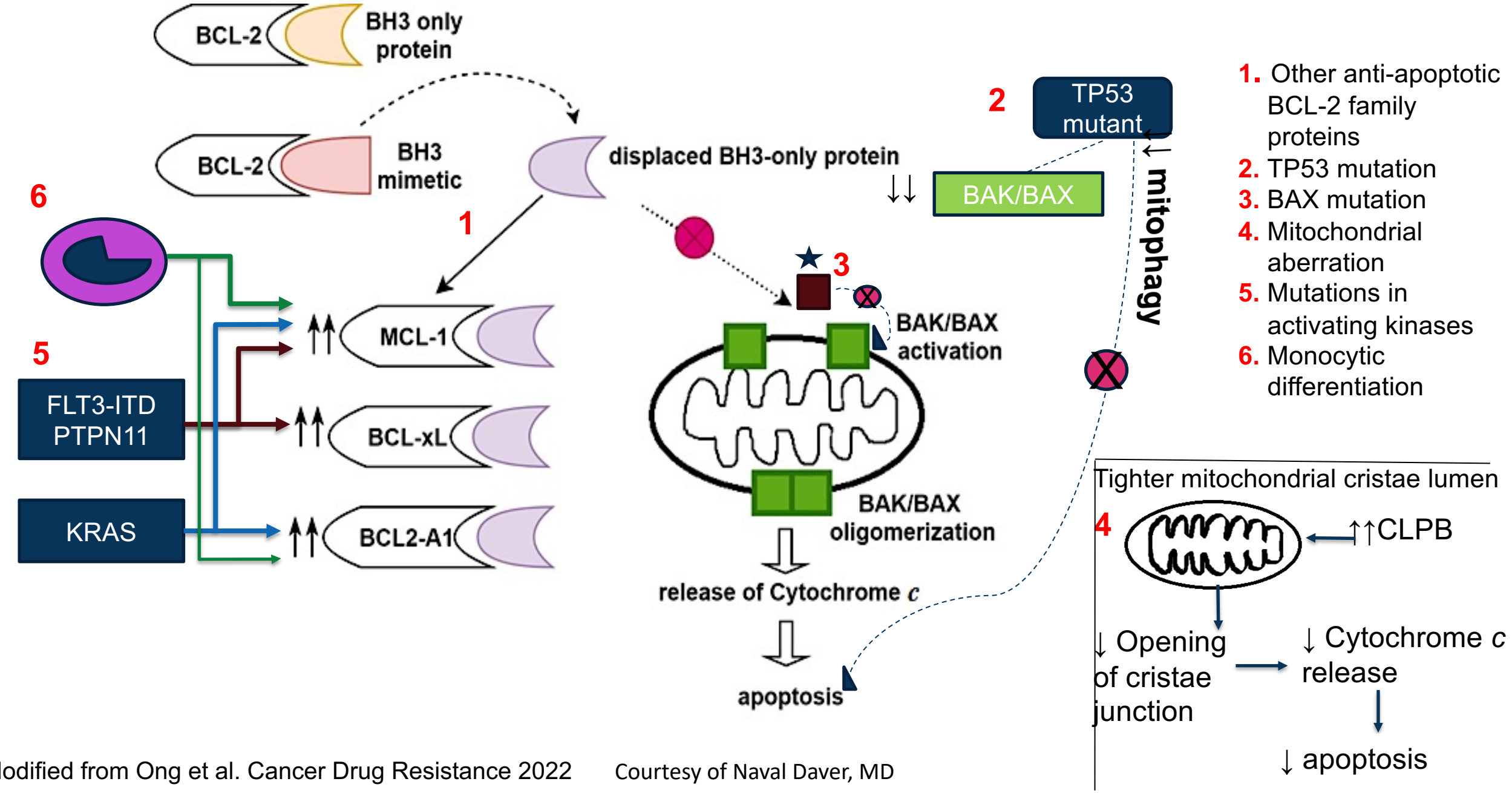
Ven + Aza (N = 279)	n	Events	Median OS, months (95% CI)
Higher Benefit	145	96	**26.51** (20.24, 32.69)
Intermediate Benefit	71	57	**12.12** (7.26 – 15.15)
Lower Benefit	63	61	**5.52** (2.79 – 7.59)

- **Majority of patients in the Ven+Aza arm are in the higher benefit group: 52% (145/279)**
- The remainder of the patients are distributed equally between the intermediate and lower benefit groups: 25.4% (71/279) and 22.6% (63/279), respectively

Courtesy of Naval Daver, MD

Dohner H et al, ASH 2022

Venetoclax Resistance: Road to "Triplets"



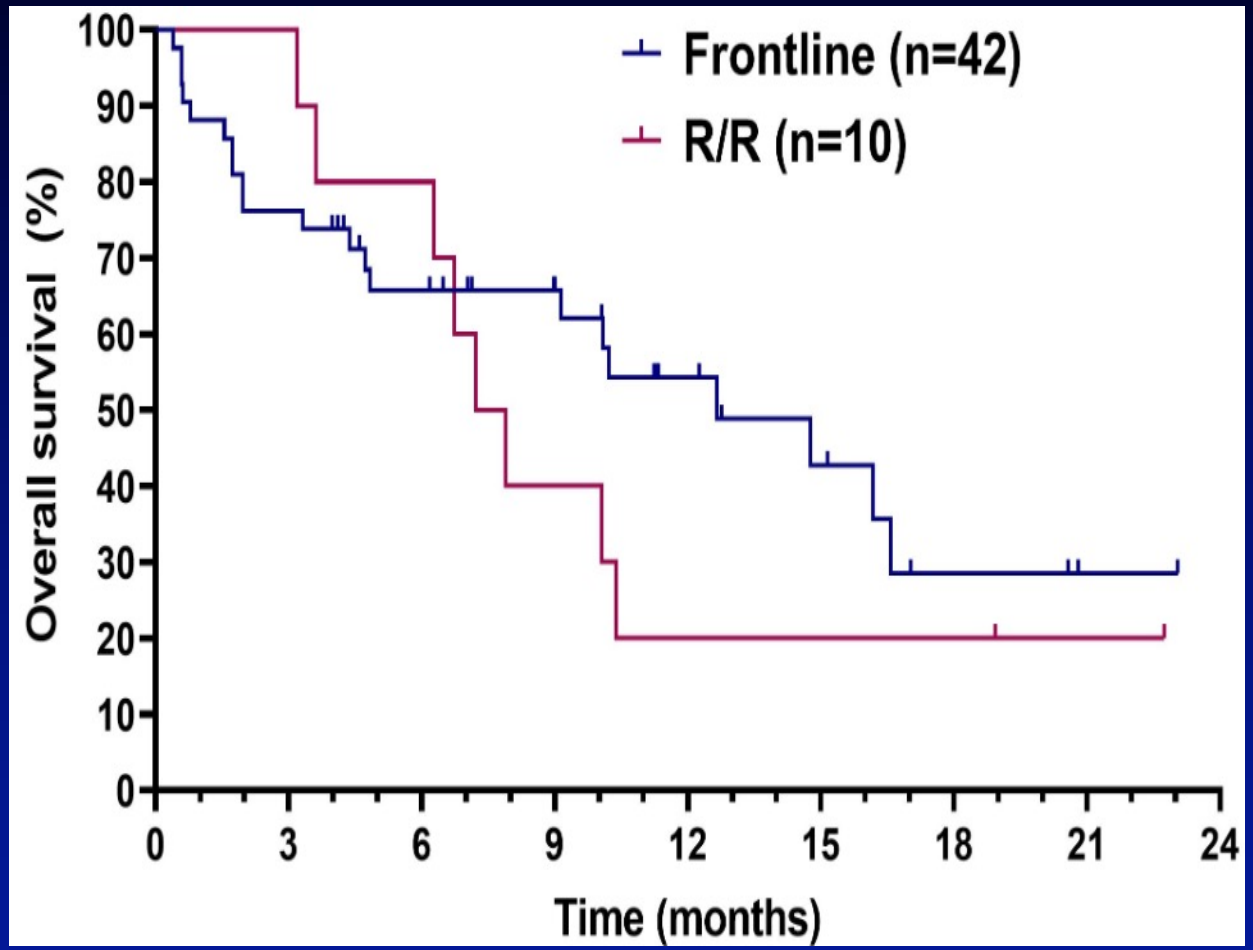
1. Other anti-apoptotic BCL-2 family proteins
2. TP53 mutation
3. BAX mutation
4. Mitochondrial aberration
5. Mutations in activating kinases
6. Monocytic differentiation

Modified from Ong et al. Cancer Drug Resistance 2022

Courtesy of Naval Daver, MD

Oral DAC + Venetoclax in Older /Unfit AML

- 52 pts: 42 frontline (median age 79 yrs [50-92]); 10 R-R. 17/42 Rx secondary AML
- Oral DAC 35mg/Dx5, VEN 40mg/Dx21-28
- ORR 281/42=67%: CR 36%, CRi 26%. MLFS 5%. FCM-MRD 7/22=32%
- Median OS 12.7 mos
- R-R ORR 5/10=50%. Median OS 7.6 mos

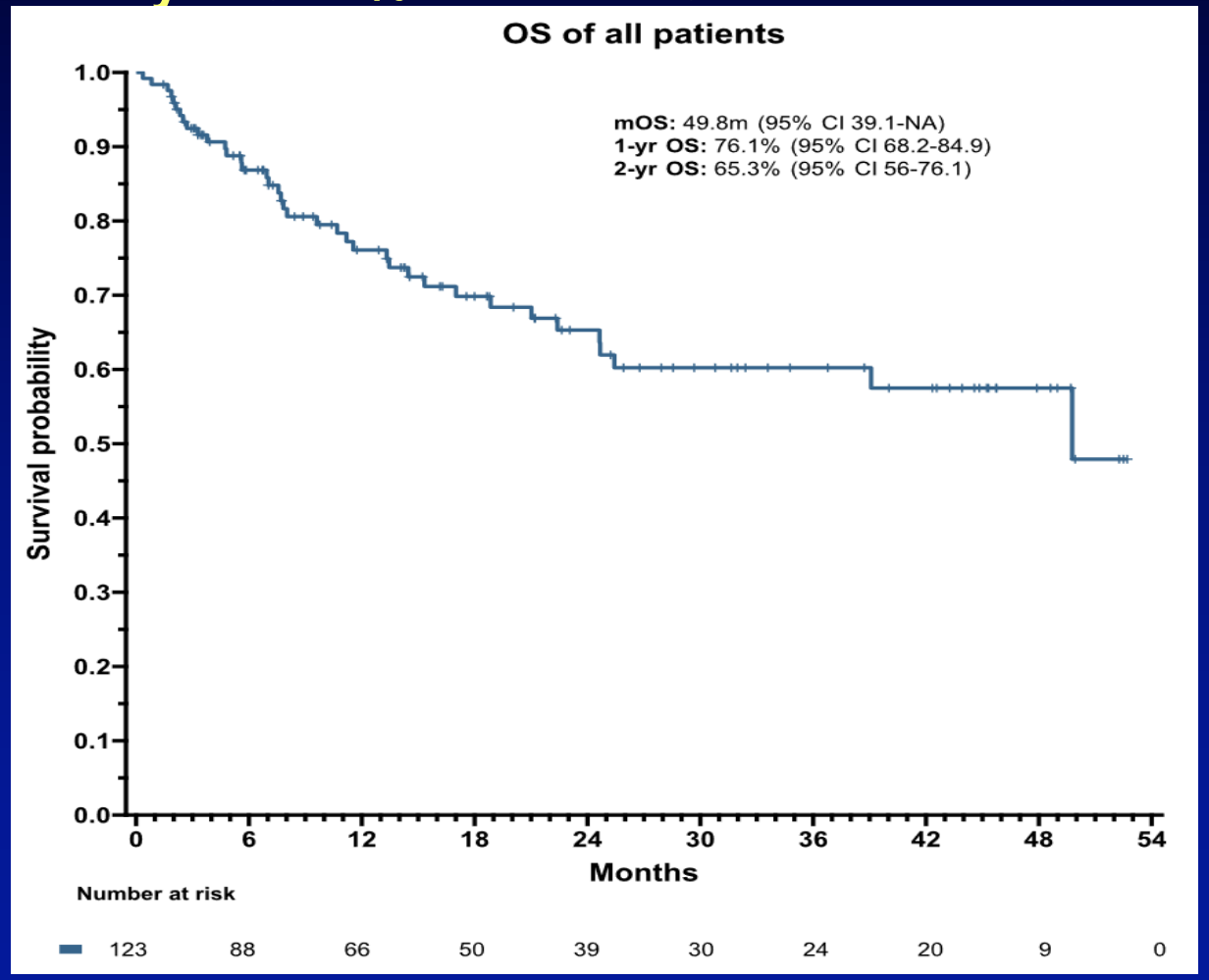


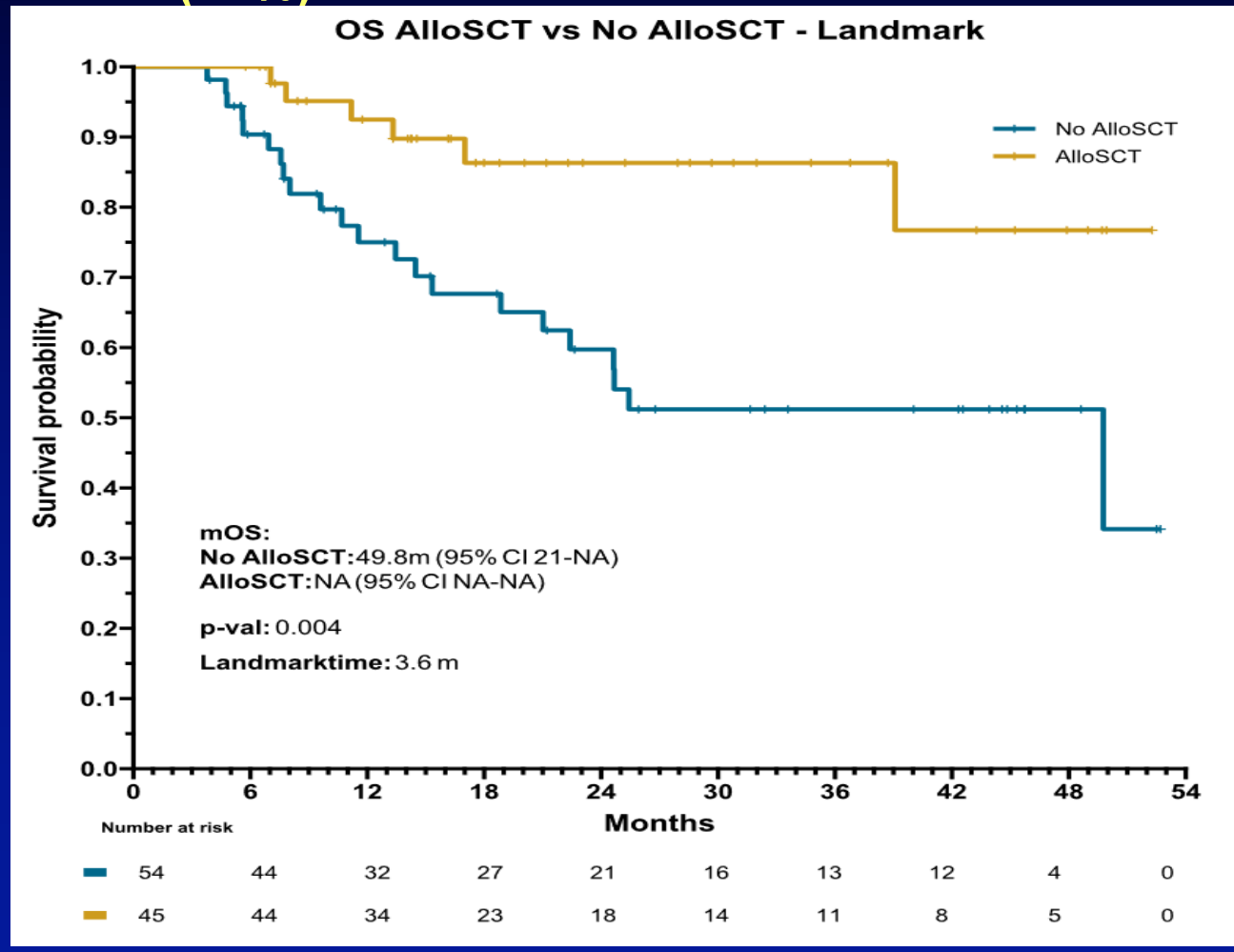
Bazinet. Blood 142: abst 833; 2023

Courtesy of Naval Daver, MD

Triple-Nucleoside Regimen (CDA- LDaraC-AZA) + Venetoclax in Newly Dx older AML

- 123 pts; median age 68 yrs (57-84)
- CDA-LD araC VEN x 2 alternating with AZA VEN x2. Total 2 years
- CR 92/123 = 75%. CR+CRi 105/123 = 92%. MRD-negative 81%. Early (4-wk) death 3/123 (2%)
- 2-yr OS 65%. Median OS 50 mos. Allo SCT = 51/123 (41%)



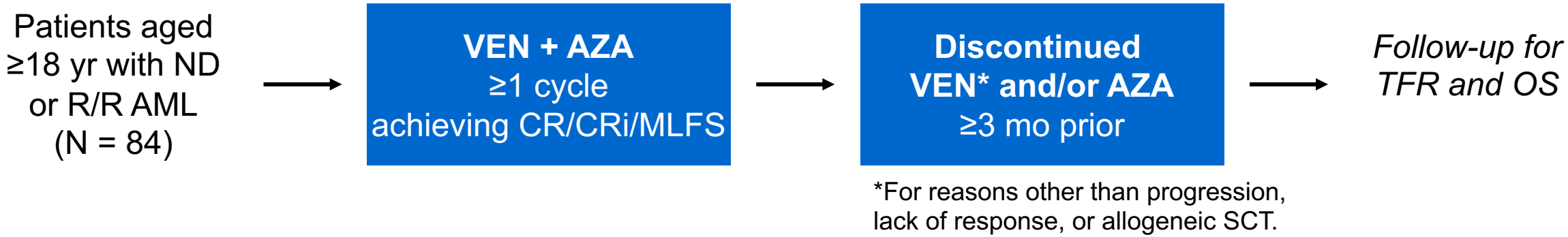


Kadia. JCO 21: June 16,2022. Bataller. Blood 142: abstr 4256; 2023

Courtesy of Naval Daver, MD

STOP-VEN: Study Design

- Retrospective study of patients treated at French FILO centers and US Moffit Cancer Center between Nov. 2018 and July 2023



- **Primary Endpoints**: OS, TFR (from last day of VEN)
- **Secondary Endpoints**: Multivariate analysis of OS and TFR by Cox regression based on disease and mutation status

Garciaz. ASH 2023. Abstr 161.

Courtesy of Naval Daver, MD

STOP-VEN: Investigator Conclusions

- In this retrospective analysis, discontinuation of VEN + AZA treatment in responding patients with ND or R/R AML was associated with sustained responses and survival
  - Median TFR: 60 mo and 10 mo, respectively
  - Median OS: 44 mo and 19 mo, respectively
- MRD negativity was associated with sustained remission
  - Median OS in ND AML: NR
  - Median OS in R/R AML: 31 mo
- Investigators concluded that it is feasible to discontinue VEN + AZA in patients with ND AML in remission and will explore this strategy in a prospective clinical trial

Garciaz. ASH 2023. Abstr 161.

Courtesy of Naval Daver, MD

MD Anderson

Improving Cytotoxic therapy, non-FLT3, non-CBF approaches with the Addition of Venetoclax to frontline IC

Induction:

- **Cladribine 5 mg/m²** IV daily for 5 days on D1-5
- **Idarubicin 10 mg/m²** IV daily for 3 days on D1-3
- **Cytarabine 1500 mg/m²** (1000 mg/m² for patients ≥ 60) IV daily for 5 days on D1-5

Consolidation:

- Cladribine **5 mg/m²** IV daily for 3 days on D1-3
- Idarubicin **8 mg/m²** IV daily for 2 days on D1-2
- Cytarabine **1000 mg/m²** (750 mg/m² for patients ≥ 60) IV daily for 3 days on D1-3

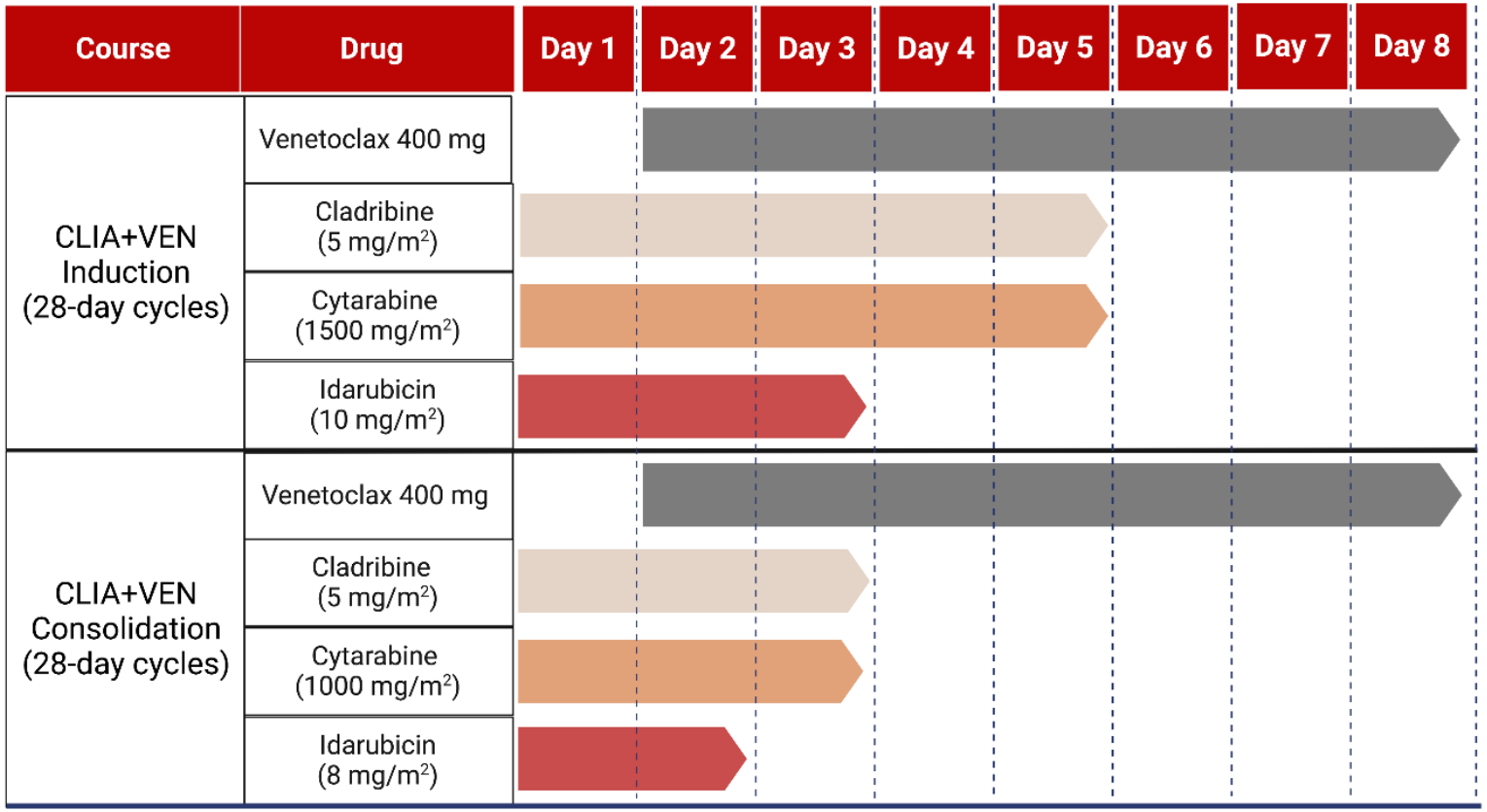
Venetoclax dosing:

- 400 mg daily (modifications made for CYP3A4i)
- Given on days 2-8 of each cycle

Cytoreduce to WBC < 20,000 prior to venetoclax

TLS monitoring per institutional standard

Antimicrobial Prophylaxis in all patients: antibacterial, antiviral, antifungal



Courtesy of Naval Daver, MD

Emerging Nontargeted Therapies for AML

- Wei AH et al. Long-term survival with **oral azacitidine** for patients with acute myeloid leukemia in first remission after chemotherapy: Updated results from the randomized, placebo-controlled, **phase 3 QUAZAR AML-001** trial. *Am J Hematol* 2023 April;98(4):E84-7.
- Guolo F et al**. Optimal duration** of **CPX-351** treatment and best timing for consolidation with allogeneic stem cell transplantation: Evidence from a large real-world Italian study. ASH 2023;Abstract 731.
- Yang Li et al. **Selinexor** in combination with **venetoclax** and **azacitidine** for **newly diagnosed** (ND) **unfit** acute myeloid leukemia (AML): A multicenter, open-label prospective study. ASH 2023;Abstract 55.
- Garcia-Manero G et al. **Eprenetapopt** combined with **venetoclax** and **azacitidine** in **TP53-mutated** acute myeloid leukaemia: A phase 1, dose-finding and expansion study. *Lancet Haematol* 2023;10(4):e272-83.

Emerging Nontargeted Therapies for AML (Continued)

- Pabst T et al. **Cusatuzumab** plus **azacitidine** in **newly diagnosed** acute myeloid leukaemia **ineligible** for **intensive chemotherapy (CULMINATE):** Part one of a randomised, phase 2, dose optimisation study. *Lancet Haematol* 2023;10(11):e902-12.
- Daver NG et al. **Pivekimab sunirine (IMGN632),** a **novel CD123-targeting antibody-drug conjugate**, in **relapsed or refractory** acute myeloid leukaemia: A phase 1/2 study. *Lancet Oncol* 2024;25(3):388-99.
- Stein AS et al. A first-in-human study of **CD123 NK cell engager SAR443579** in **relapsed or refractory** acute myeloid leukemia, B-cell acute lymphoblastic leukemia, or high-risk myelodysplasia. ASCO 2023;Abstract 7005.

Pivekimab (IMGN632) With AZA+VEN in Newly Diagnosed AML

- PVEK with AZA + VEN (14-21 days) in newly diagnosed CD123+ AML (NCT04086264)
- Peripheral Edema All grades (44%), Grade 3/4 (4%)
- IRRs: 16% (all Grade 1/2)
- No capillary leak syndrome, CRS, or VOD events
- Study discontinuation: 2/50 (1 generalized edema, 1 prolonged myelosuppression)
- 30-day mortality: 0; 60-day mortality 2/50 (4%) (1 PNA, 1 disease progression)
- EOC1 r: ANC>500 34 days, PLT>50 22 days
- Post-remission cycles : ANC>500 28 days, PLT>50 22 days
- Among 29 responders with evaluable central MRD (</=0.02%): MRDneg 22/29 (76%)

Responses (N=50)			
	CR rate	CCR rate	CCR_{mrd-} rate
Overall Population (N=50)	54% (27/50)	68% (34/50)	76% (22/29)
Strictly meet unfit FDA criteria (n=23)	61% (14/23)	78% (18/23)	79% (11/14)

Molecular Stratification in Subsets		PVEK Triplet
Higher benefit (*TP53*^{wt}, no *FLT3*-ITD, *K/NRAS*^{wt})	CCR CR MRD-	94% (17/18) 89% (16/18) 73% (11/15)
Intermediate benefit (*TP53*^{wt} and *FLT3*-ITD or *K/NRAS*^{mut})	CCR CR MRD-	71% (5/7) 71% (5/7) 100% (5/5)
Lower benefit (*TP53*^{mut})	CCR CR MRD-	50% (7/14) 21% (3/14) 50% (3/6)

Courtesy of Naval Daver, MD

Daver N et al, ASH 2023

First-in-Human Study of the CD123 NK Cell Engager SAR443579 in Relapsed or Refractory Acute Myeloid Leukemia, B-Cell Acute Lymphoblastic Leukemia or High Risk-Myelodysplasia: Updated Safety, Efficacy, Pharmacokinetics and Pharmacodynamics

Ashish Bajel,[1] Sylvain Garciaz,[2] Pinkal Desai,[3] Gerwin A. Huls,[4] Abhishek Maiti,[5] Mojca Jongen-Lavrencic,[6] Nicolas Boissel,[7] Stephane De Botton,[8] David C. deLeeuw,[9] Shaun A. Fleming,[10] C. Michel Zwaan,[11] Martha L. Arellano,[12] David Avigan,[13] Jennifer N. Saultz,[14] loannis Mantzaris,[15] Kyle Jensen,[16] Timothy Wagenaar,[16] Gu Mi,[16] Samira Ziti-Ljajic,[17] Dobrin Draganov,[16] Giovanni Abbadessa,[16] Anthony Selwyn Stein,[18]

[1]Peter MacCallum Cancer Centre and Royal Melbourne Hospital, Melbourne, Australia; [2]Institut Paoli-Calmettes, Aix-Marseille University, Marseille, France; [3]Weill Cornell Medicine, New York, NY; [4]University Medical Center Groningen, Groningen, Netherlands; [5]MD Anderson Cancer Center, Houston, TX; [6]Erasmus University Medical Center, Rotterdam, Netherlands; [7]Hôpital Saint-Louis, Paris, France; [8]Institut Gustave Roussy, Paris, France; [9]Amsterdam University Medical Center, Amsterdam, Netherlands; [10]The Alfred Hospital, Melbourne, Australia; [11]Prinses Máxima Center for Pediatric Oncology Research, Utrecht, Netherlands; [12]Emory University, Atlanta, GA; [13]Beth Israel Deaconess Medical Center, Boston, MA; [14]Oregon Health & Science University, Portland, OR; [15]Montefiore Medical Center, Bronx, NY; [16]Sanofi, Cambridge, MA; [17]Sanofi, Chilly-Mazarin, France; [18]City of Hope National Medical Center, Duarte, CA

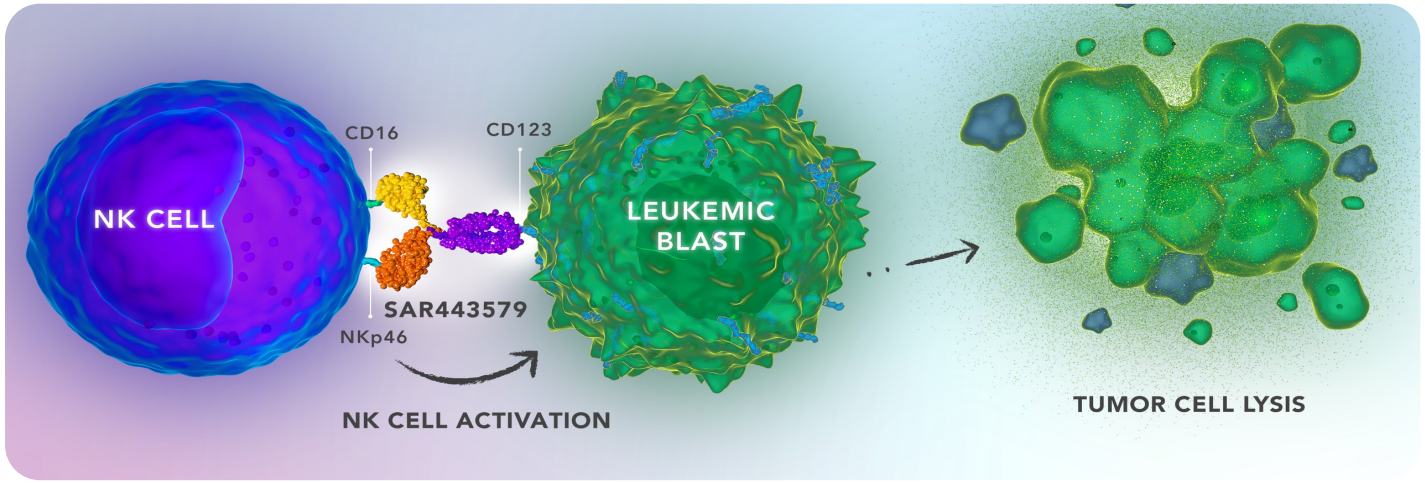
Poster presented at the 65th Annual Meeting of the American Society of Hematology (ASH), San Diego, CA.
December 9–12, 2023 #3474

Courtesy of Naval Daver, MD

Background

- CD123 is widely expressed in hematological malignancies[1-4]
- T cell engagers targeting CD123 have displayed some preliminary clinical efficacy; however, they have been associated with safety concerns including cytokine release syndrome and neurotoxicity[5]

Mechanism of Action



- SAR443579 (SAR'579) is a trifunctional anti-CD123 NKp46xCD16 NKCE targeting the CD123 antigen and co-engaging NKp46 and CD16a on NK cells triggering tumor cell death
- TCD17197 (NCT05086315) is an ongoing first-in-human phase 1/2 open-label, multicenter trial evaluating SAR'579 in patients with R/R AML, B-ALL, or HR-MDS
- In early clinical results, SAR'579 was well tolerated up to 3000 µg/kg QW with no dose-limiting toxicities and clinical remissions were identified at a maximal target dose of 1000 µg/kg/infusion[6]
- Here we present updated results from TCD17197 on SAR'579 doses ranging from 10 µg/kg through 6000 µg/kg at a data cutoff of October 23, 2023

B-ALL, B-cell acute lymphoblastic leukemia; CD, cluster of differentiation; HR-MDS, high risk-myelodysplasia; NK, natural killer; NKCE, NK cell engager; QW, once weekly; R/R AML, relapsed or refractory acute myeloid leukemia.

1. Lyapichev KA, et al. *Clin Lymph Myel Leuk*. 2021;21(4):e317-e320. 2. Patnaik MM, et al. *Leuk Lymphoma*. 2021;62(11):2568-86. 3. Uckun FM, et al. *Front Aging*. 2021;2:757276. 4. El Achi H, et al. *Cancers (Basel)*. 2020;12(11):3087. 5. Uy GL, et al. *Blood*. 2021;137(6):751-62; 6. Stein AS, et al. *J Clin Oncol*. 2023;41(suppl 16):7005.

Courtesy of Naval Daver, MD

Agenda

INTRODUCTION

MODULE 1: Available and Emerging Nontargeted Therapies for Acute Myeloid Leukemia (AML) — Dr Daver

MODULE 2: Current and Emerging Role of Biomarker-Directed Therapeutic Approaches for Patients with AML — Dr DiNardo

FLT3 Inhibition for AML

- Erba HP et al. **Quizartinib** plus **chemotherapy** in **newly diagnosed** patients **with FLT3-internal-tandem-duplication-positive** acute myeloid leukaemia **(QuANTUM-First)**: A randomised, double-blind, placebo-controlled, **phase 3** trial. *Lancet* 2023;401(10388):1571-83.
- Perl A et al. **Quantum-first trial**: FMS-like tyrosine kinase 3-internal tandem duplication **(FLT3-ITD)–specific measurable residual disease (MRD)** clearance assessed through induction (IND) and consolidation (CONS) is associated with improved overall survival (OS) in **newly diagnosed** (nd) FLT3-ITD+ AML patients (pts). ASH 2023;Abstract 832.
- Montesinos P et al. Preliminary results of **QUIWI**: A double blinded, randomized clinical trial comparing standard **chemotherapy plus quizartinib** versus **placebo** in adult patients with **newly diagnosed FLT3-ITD wild-type** AML. EHA 2023;Abstract S130.
- Pratz KW et al. **Gilteritinib** in combination **with induction and consolidation chemotherapy** and as **maintenance** therapy: A phase IB study in patients with **newly diagnosed** AML. *J Clin Oncol* 2023;41(26):4236-46.

FLT3 Inhibition for AML (Continued)

- Perl AE et al. Outcomes in patients with **FLT3-mutated relapsed/refractory** acute myelogenous leukemia who underwent transplantation in the **phase 3 ADMIRAL** trial of **gilteritinib** versus **salvage chemotherapy**. *Transplant Cell Ther* 2023;29(4):265.e1-10.
- Levis MJ et al. **BMT-CTN 1506 (MORPHO)**: A randomized trial of the **FLT3 inhibitor gilteritinib** as **post-transplant maintenance** for FLT3-ITD AML. EHA 2023;Abstract LB2711.

Newly Dx IC-eligible FLT3-ITD Mutated: QuANTUM-First Updates

Background: The addition of QUIZ to IC induction, Consolidation and Maintenance Improves OS

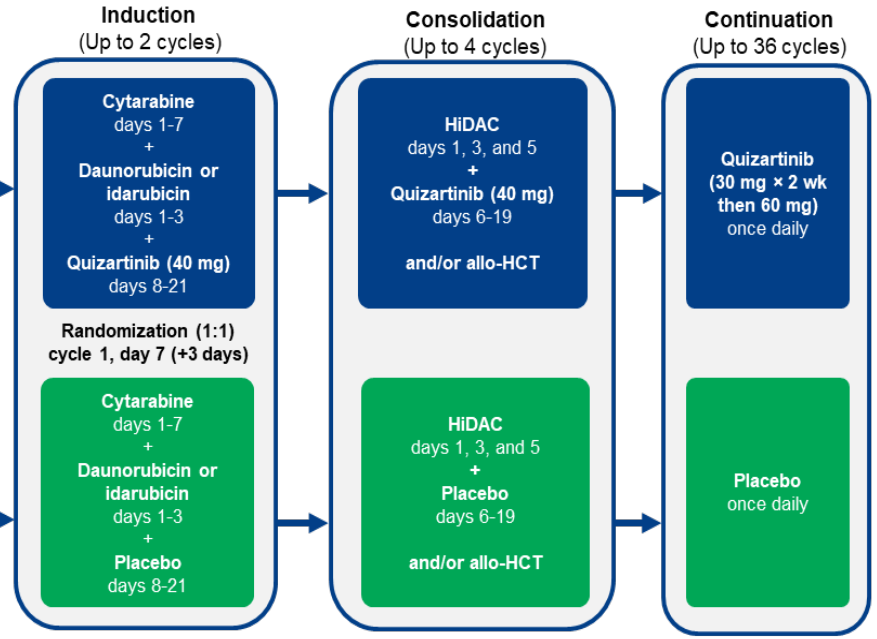
QuANTUM-First Trial Protocol (NCT02668653)[1]

Enrollment dates: Sep 2016 to Aug 2019
Data cutoff: Aug 13, 2021; Sep 30, 2022 (MRD data)

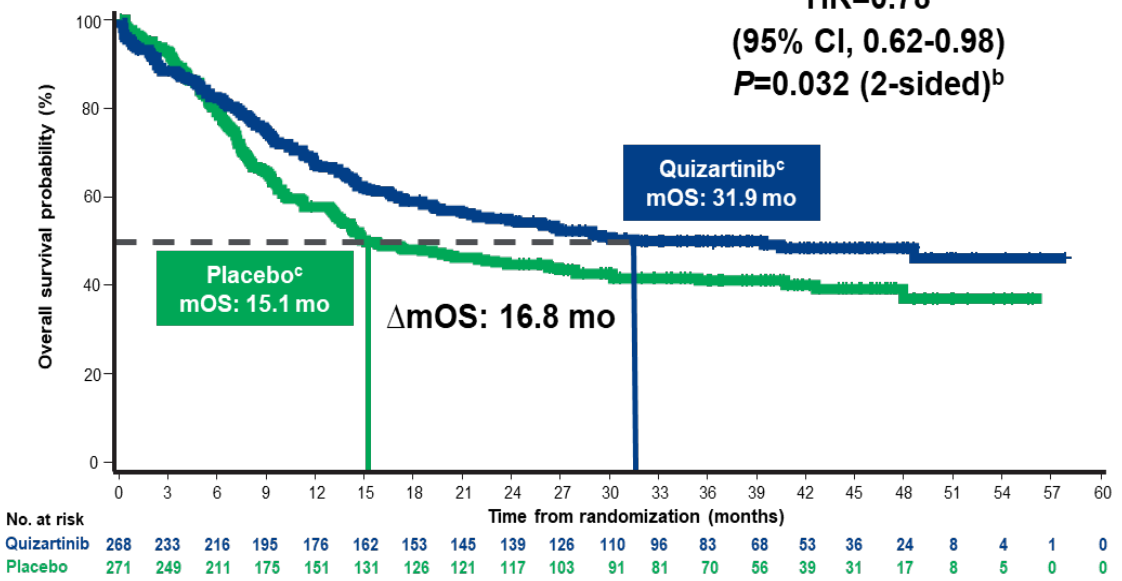
Stratification factors
- **Region**: NA, EU, and Asia/other regions
- **Patient age**: <60 years, ≥60 years
- **WBC**[a]: <40×10^9/L, ≥40×10^9/L

- Newly diagnosed *FLT3*-ITD+ AML
- 18-75 years of age
- ≥3% *FLT3*-ITD allele frequency
- Patients begin 7+3 chemotherapy during screening

Key endpoints[a]
- **Primary endpoint**: OS
- **Secondary endpoints**: EFS, CR, CRc, CR/CRc with MRD− end of induction, safety
- **Exploratory endpoints**: RFS, DoCR



Primary Endpoint: Overall Survival[1]



Rates of CR/CRi per IRC After 1-2 Courses of Induction

	CR (%)	CR/CRi (%)
Quizartinib	54.9	71.6
Placebo	55.4	64.9

Erba H et al, Lancet 2023

Courtesy of Courtney D DiNardo, MD, MSCE

QuANTUM-First: Conclusions

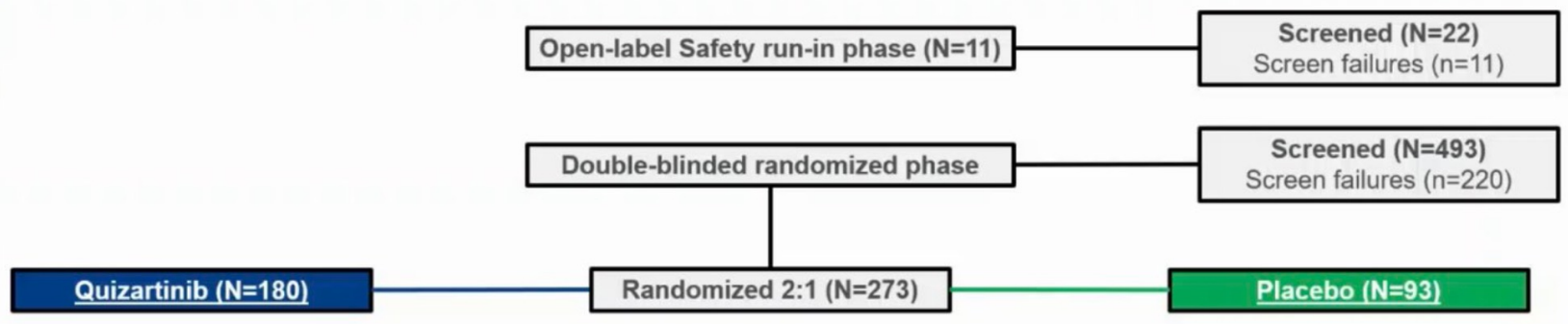
There is a clear prognostic utility of FLT3-ITD specific MRD measurements in management of patients with FLT3-ITD AML

Elimination of detectable FLT3-ITD MRD is associated with longer OS (in patients both w/wo QUIZ)

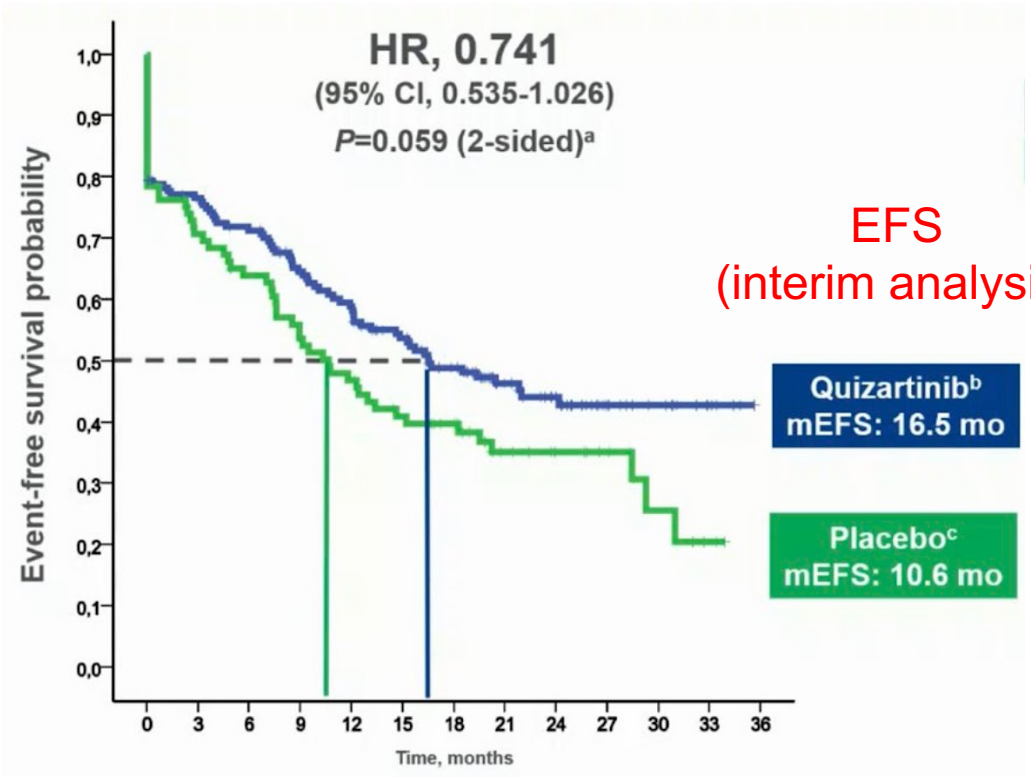
QUIZ is associated with deeper responses and more frequent MRD clearance

Courtesy of Courtney D DiNardo, MD, MSCE

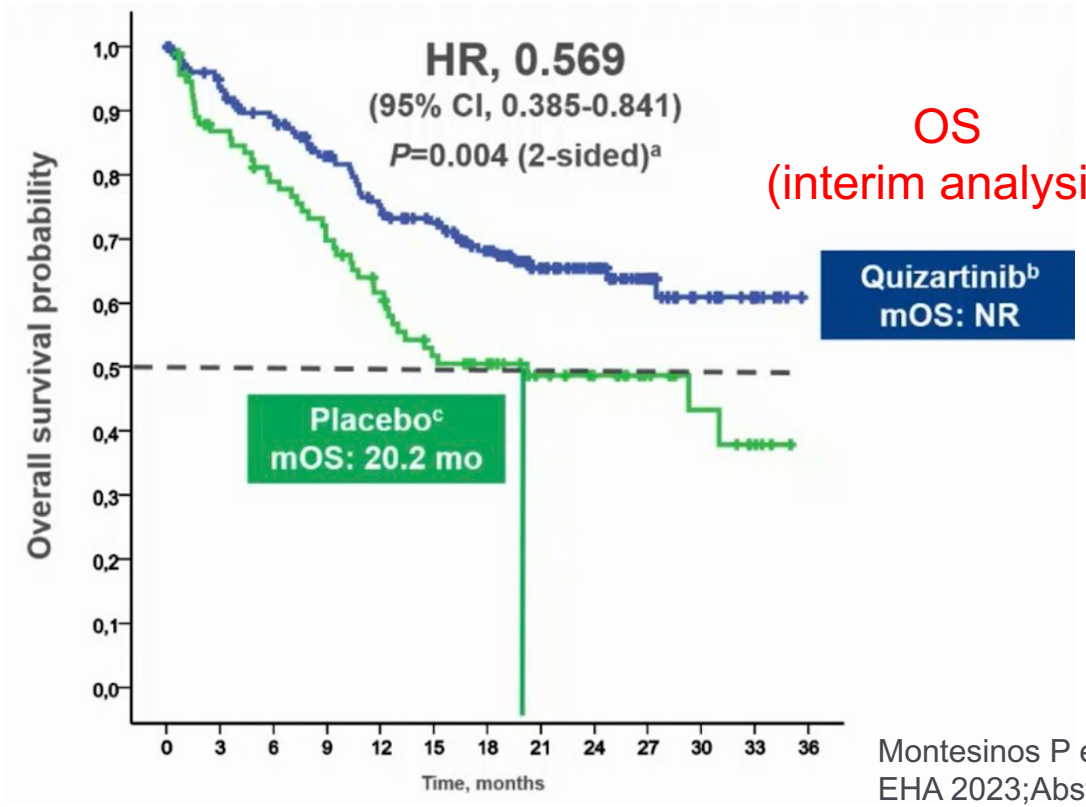
QUIWI: A Double-Blinded, Randomized Phase 2 Study Comparing Standard Chemotherapy Plus Quizartinib Versus Placebo Newly Diagnosed FLT3-ITD Wildtype AML



EFS
(interim analysis)



OS
(interim analysis)



Courtesy of Courtney D DiNardo, MD, MSCE

Montesinos P et al.
EHA 2023;Abstract S130.

QUIZ for patients with FLT3-"like" gene expression signature

Mosquera Orgueira A, ASH #974

Background: A FLT3-like transcriptomic signature is present in 28-53% of FLT3-ITD neg patients[1]

The QUIWI Trial compared QUIZ vs PBO + standard chemo in FLT3-ITD wild-type AML (n=284)

***2-yr OS was 63.5% (QUIZ) vs 47% (PBO)**

***49.7% of QUIWI cases had "FLT3-LIKE" expression**

The FLT3-like signature[1]

Differential Expression: 649 distinct genes were significantly differentially expressed in FLT3 mutants vs. WT samples.

FLT3 Clustering: FLT3-ITD mutants consistently clustered together in multiple datasets. 28-53% of all FLT3-ITD negative patients were FLT3-like.

Mutation Landscape: *NPM1* and *DNMT3A* mutations were highly enriched in FLT3-like AMLs.

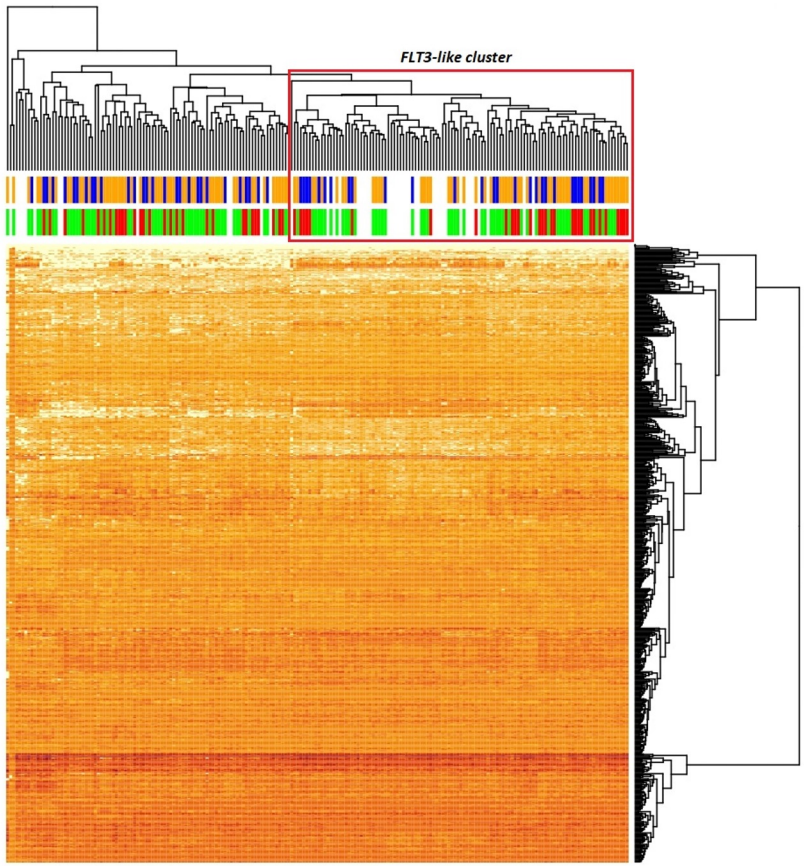
Implications: Findings suggest that FLT3-like AMLs have unique gene expression profiles.

Overview of the Non-FLT3-Like Transcriptomic Cluster

FLT3-Like Patients: 50% of FLT3-ITD negative patients (N=81)

ELN-17 Classification:

- **Low Risk: 18.2%**
- **Intermediate Risk: 39.5%**
- **High Risk: 42.0%**



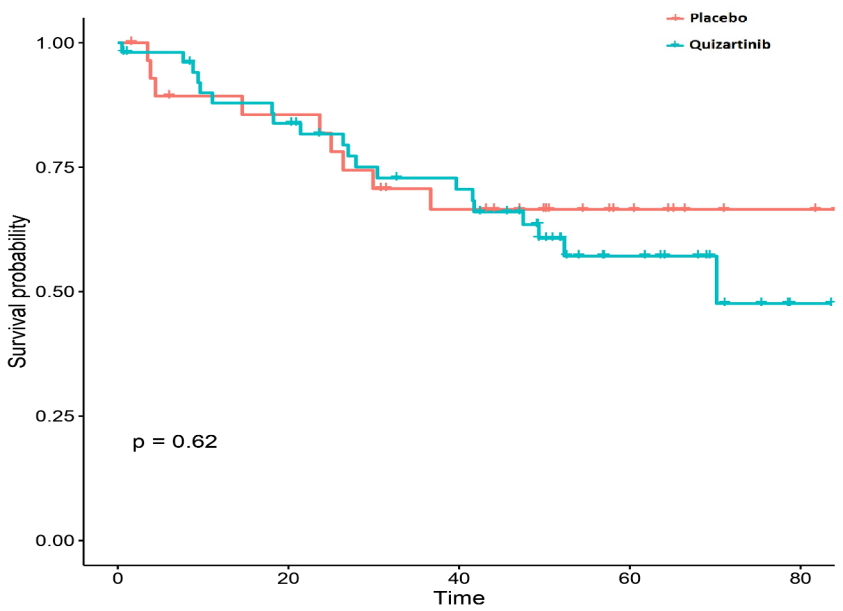
Courtesy of Courtney D DiNardo, MD, MSCE

[1]Mosquera et al, Plos One 2021

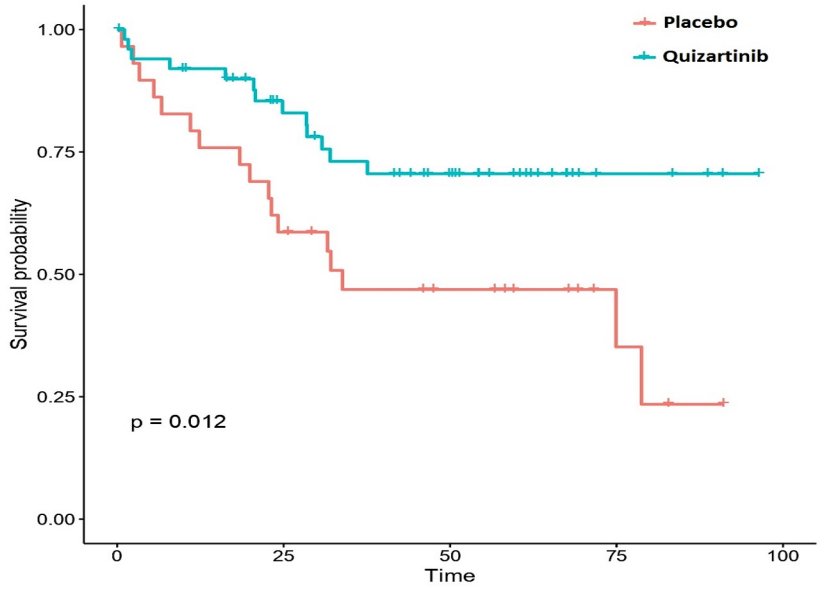
QUIZ for patients with FLT3-"like" gene expression signature

QUIWI trial of QUIZ in wild-type FLT3 patients (PETHEMA group)

NON-FLT3-LIKE AML (n=81)



FLT3-LIKE AML (n=80)



$NMP1^{mut}$ & $DNMT3A^{mut}$ enrichment

FLT3-like AMLs: 42.5% $NMP1^{mut}$, 38.7% $DNMT3A^{mut}$, 23.7% double mutants

Non-FLT3-like AMLs: 6.2% *NMP1*mut, 14.8% $DNMT3A^{mut}$, 2.5% double mutants

FLT3-Like with *NPM1* or *DNMT3A* mut
26% were FLT3-TKD

Characteristics of Non-FLT3-Like Cluster

50.33% of FLT3-ITD negative patients (N=81)

ELN-17 Classification:

- Low Risk: 18.2%
- Intermediate Risk: 39.5%
- High Risk: 42.0%

Characteristics of FLT3-Like Patients

49.67% of FLT3-ITD negative patients (N=80)

ELN-17 Classification:

- Low Risk: 30.4%
- Intermediate Risk: 40.5%
- High Risk: 29.1%

Mosquera A, ASH #974

Courtesy of Courtney D DiNardo, MD, MSCE

QUIWI results of QUIZ for FLT3-ITD wild-type AML

- The QUIWI trial provides initial evidence of efficacy of quizartinib with standard chemotherapy for FLT3-WT patients with “FLT3-like” disease based on expression patterns
- Expression patterns are hard to obtain in real time in the clinical setting, but this contributes to the growing body of evidence suggesting a more personalized and targeted approach for AML therapy is possible

Courtesy of Courtney D DiNardo, MD, MSCE

FLT3-like "Gene Expression" Predicts Outcome on Quizartinib (QIWI)

- FLT3-like gene expression signature that clustered a proportion of FLT3 WT with FLT3 mutated
- 206 pts—112 (54%) cluster enriched in FLT3-mutant cases (71%).
- 80 cases (50%) of FLT3 WT were "FLT3-like"
- FLT3-like pts benefited from addition of QUIZ

HR/p Value	Not FLT3-like QUIZ vs NO	FLT3-like QUIZ vs NO
EFS	1.07/.8	0.45/.009
RFS	0.88/.76	0.37/.01
OS	1.22/.62	0.41/.01

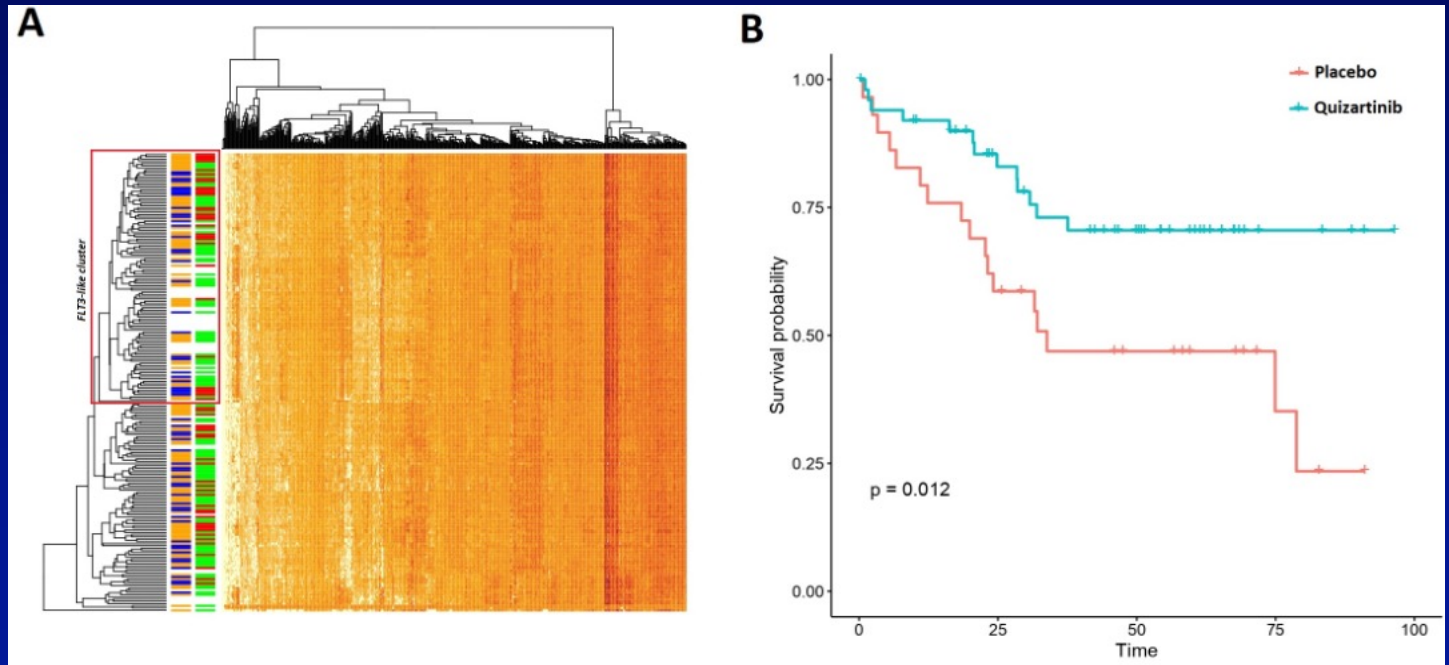


Figure 1. A) Heatmap representing the 595-signature in the 206 patients available for analysis. The top dendogram represents the hierarchical clustering of genes in the signature. The left side dendrogram represents the hierarchical clustering of samples according to the gene expression signature. Two colored row bars are represented. The left one represents the treatment arm in the clinical trial: quizartinib (orange), placebo (blue) and screening failure due to FLT3-mutation (white). The right one represents the status of patients at last follow-up: alive (green), death (red) and screening failure due to FLT3 mutation (white). The FLT3-like cluster is highlighted in the red box, an it is characterized by an enrichment in FLT3 mutant AML cases (71.1% of all FLT3-mutated cases). B) Kaplan-Meier plot representing the overall survival of patients in the FLT3-like cluster, indicating a superiority of quizartinib over placebo in this group.

Mosquera-Orgueira. Blood 142: abst 974; 2023

Courtesy of Naval Daver, MD

MORPHO Study Design: GILT post HSCT maintenance

- **PCR-NGS MRD Assay (MRD6)**
  - ***First 2cc aspirate sent for MRD***
- **46% + 4.5% = 50.5% FLT3-ITD MRD+**

AML with a FLT3-ITD mutation
Morphologic first remission with only 1 or 2 inductions

46% detectable:
21.1% ≥ 10^{-4} (MRD4)
15.4% ≥ 10^{-5} (MRD5)
9.6% ≥ 10^{-6} (MRD6)

Registration → Marrow aspirate sample for MRD analysis

Allogeneic transplant within 1 year of CR1
Any conditioning, donor, or GVHD prophylaxis allowed

19.9% detectable ≥ MRD6
Including 4.5% who were undetectable pre-HCT

Day +30 to +90 after transplant:
Engraftment (ANC ≥500, platelets ≥20K, transfusion independent)
Able to take oral medication
No active grades II-IV acute GVHD requiring > 0.5 mg/kg prednisone daily → Sample for MRD analysis

Randomization

Gilteritinib 120 mg po daily → 24 months maintenance treatment

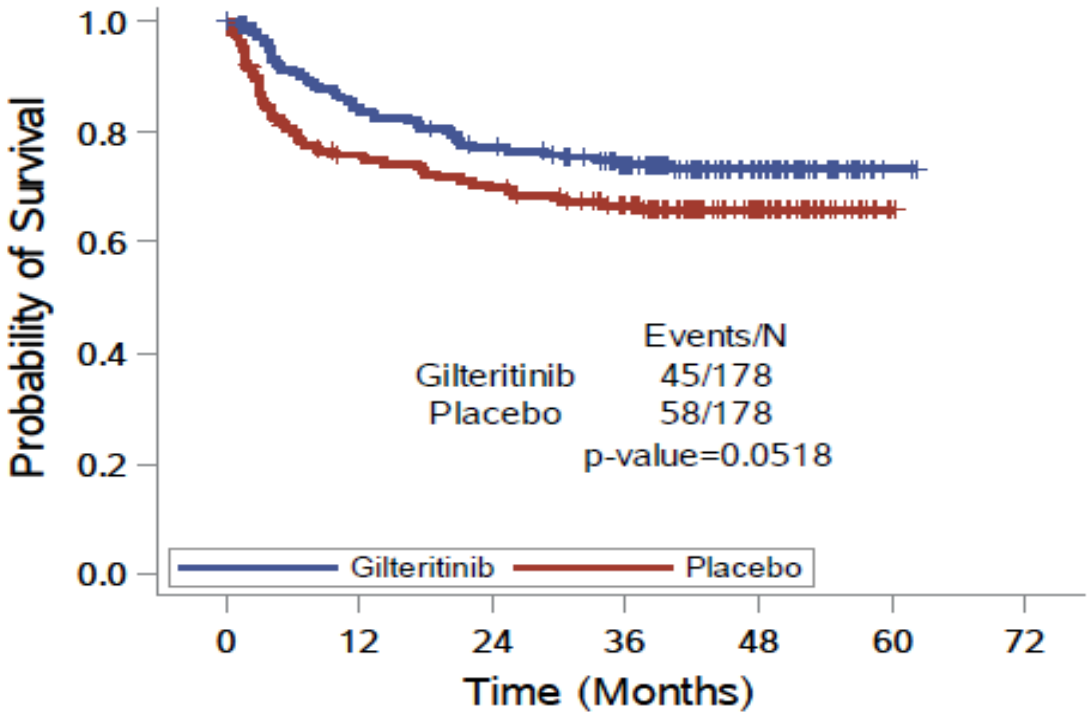
Placebo → 24 months maintenance treatment

Stratification:
Conditioning regimen intensity (myeloablative vs. reduced intensity)
Time from transplant to randomization (30-60 days vs. 61-90 days)
Measurable residual disease ≥ 10^{-4} (presence vs absence from registration sample)

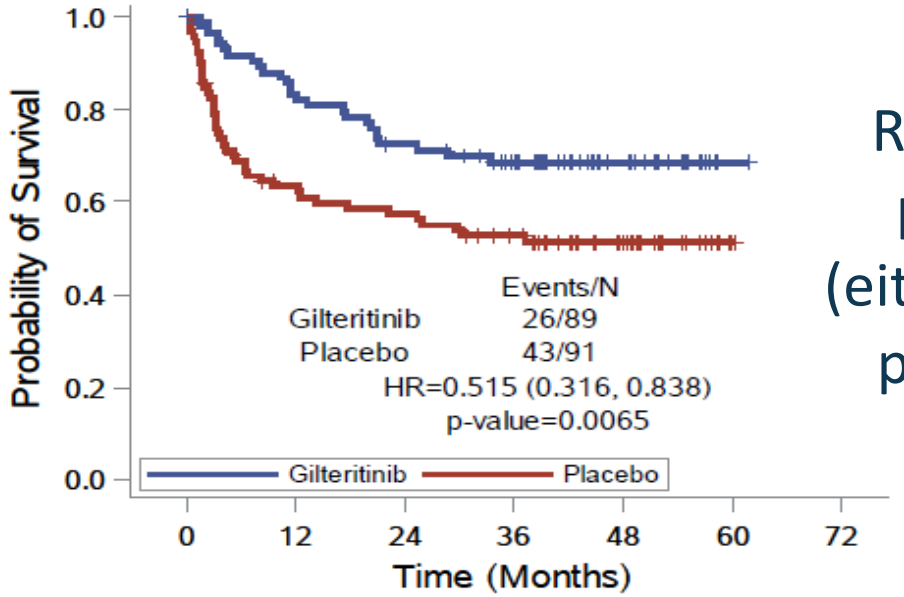
Courtesy of Courtney D DiNardo, MD, MSCE

Post-Hoc MRD Analysis of MORPHO Study: FLT3i post SCT improves RFS in MRD+ patients

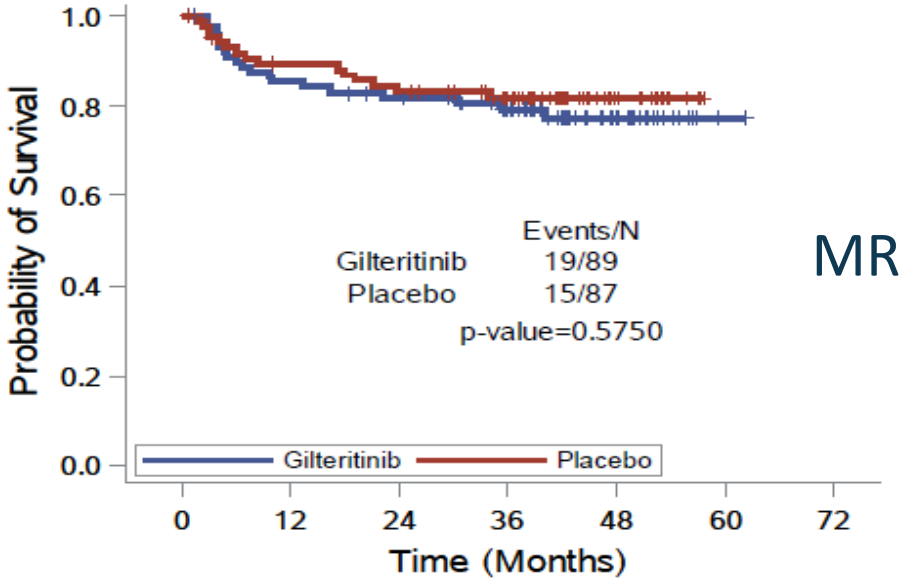
Primary objective:
Relapse-free survival (RFS)
HR = 0.679 (0.459-1.005)
P = 0.0518



Levis M ASH #973



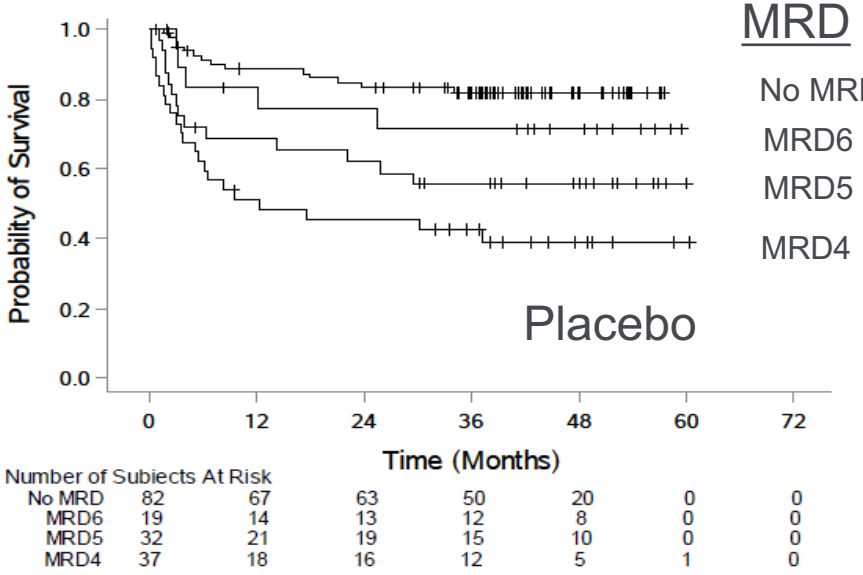
RFS: MRD positive (either pre or post SCT)



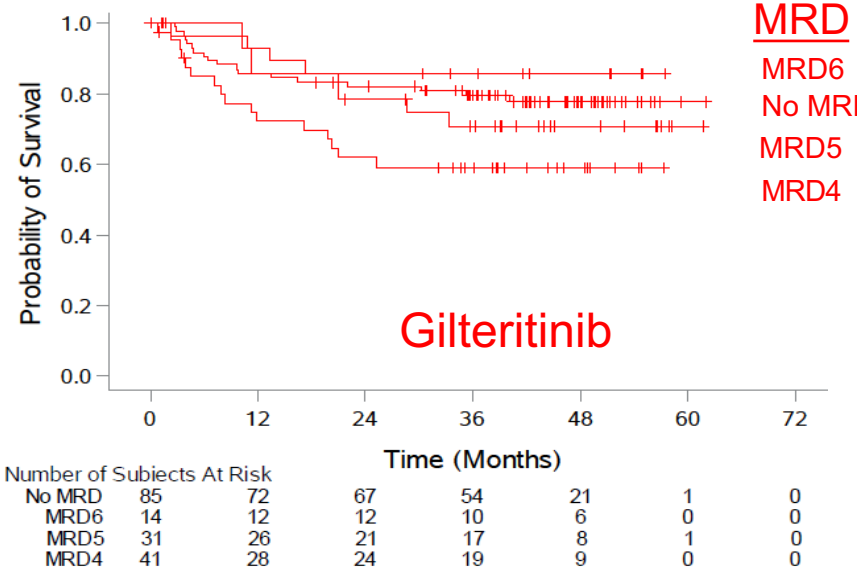
RFS:
MRD negative

Courtesy of Courtney D DiNardo, MD, MSCE

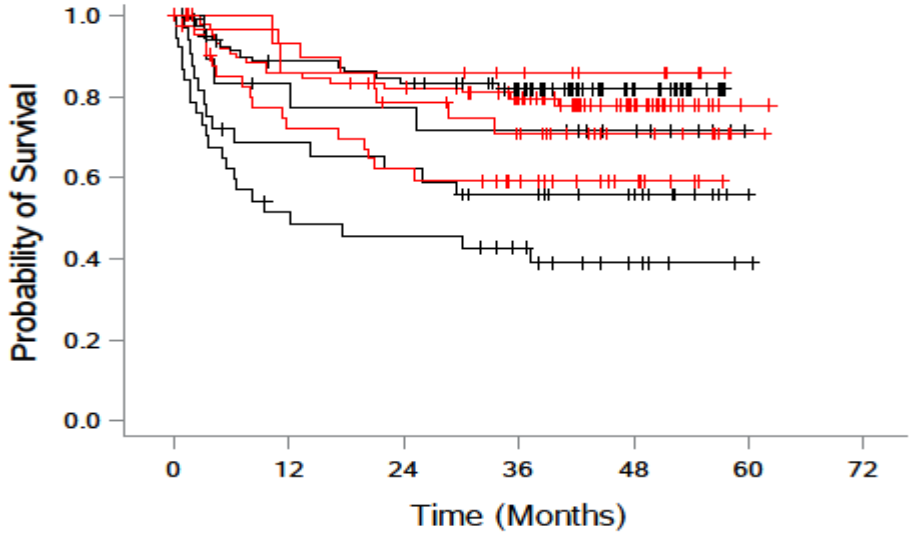
FLT3 MRD at any level impacts RFS, and is improved with GILT



MRD	Events/N
No MRD	14/82
MRD6	5/19
MRD5	14/32
MRD4	22/37



MRD	Events/N
MRD6	2/14
No MRD	18/85
MRD5	8/31
MRD4	16/41



$10^{-6} \leq$ MRD6 $< 10^{-5}$

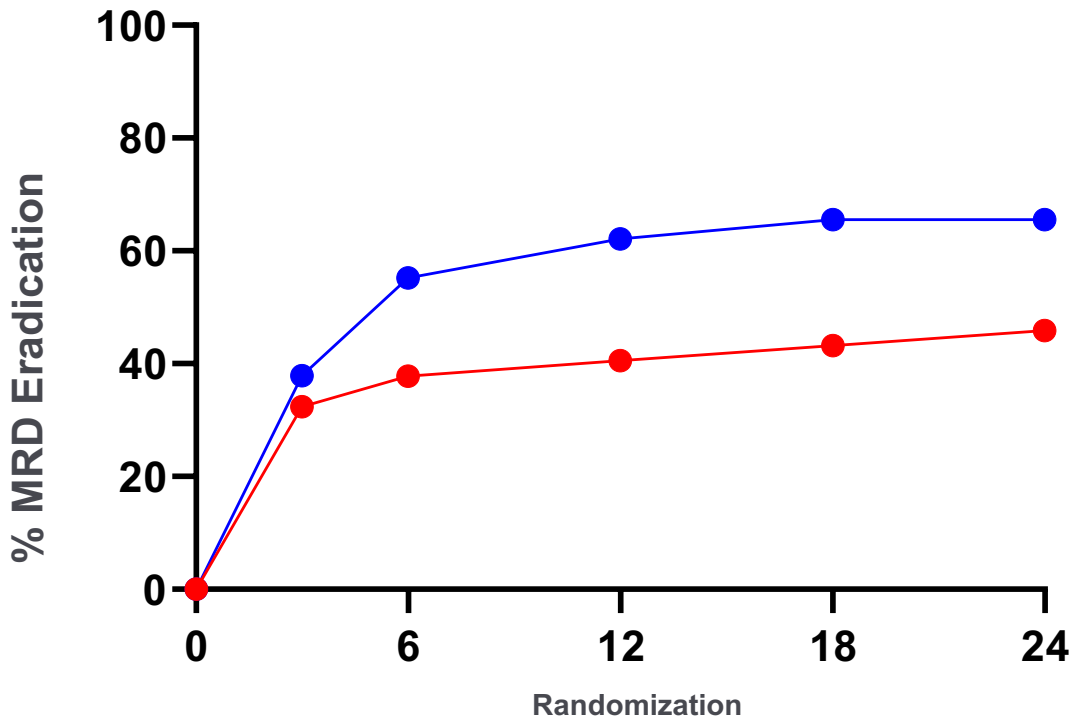
$10^{-5} \leq$ MRD5 $< 10^{-4}$

$10^{-4} \leq$ MRD4

Levis M ASH #973

Courtesy of Courtney D DiNardo, MD, MSCE

FLT3-ITD MRD eradication post-SCT is improved with GILT



- **FLT3-ITD clones post-SCT are more often eradicated with GILT compared to placebo**
  - **MRD was eradicated in 69% of pts on GILT** vs 44% with placebo
- **Relapse or eradication predominantly occurs during the first 6 months post-SCT**
- **Any level of FLT3-ITD MRD impacts RFS (the higher the MRD the worse the RFS)**

Courtesy of Courtney D DiNardo, MD, MSCE

GILT as post-HSCT maintenance

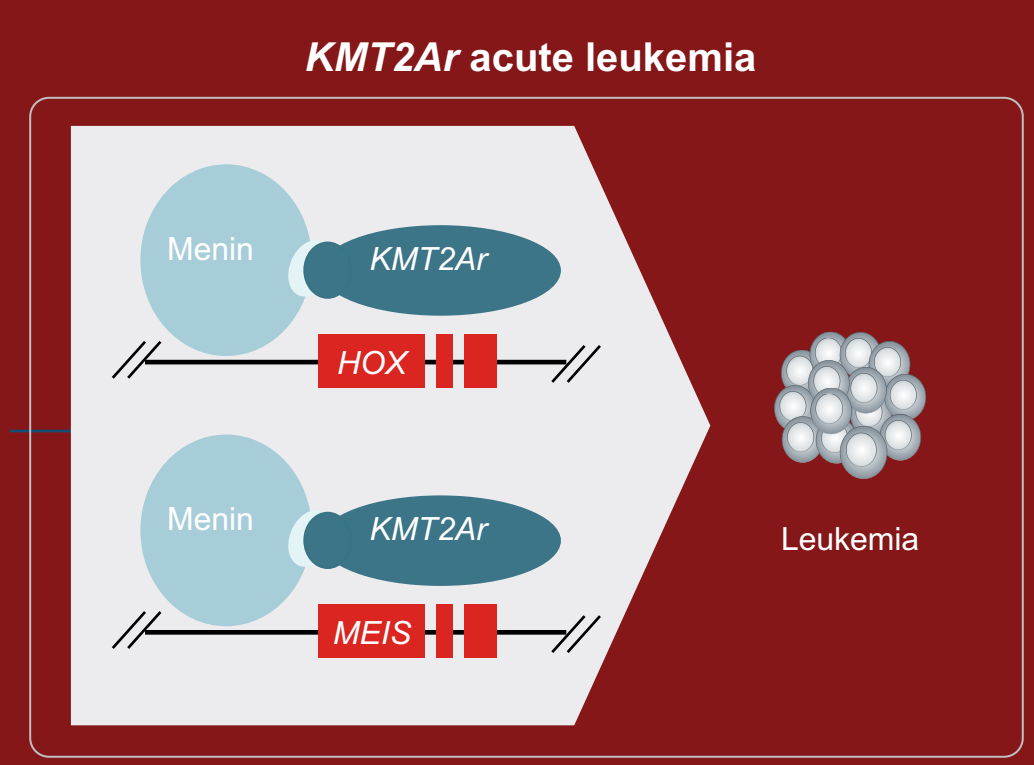
- Identification of FLT3 MTD **at any level** peri-transplant impacts RFS, and is improved with gilteritinib post-HSCT maintenance (the higher the MRD level, the worse the RFS)
- FLT3-ITD MRD eradication post-SCT is improved with GILT
- **Relapse or eradication predominantly occurs during the first 6 months post-SCT**

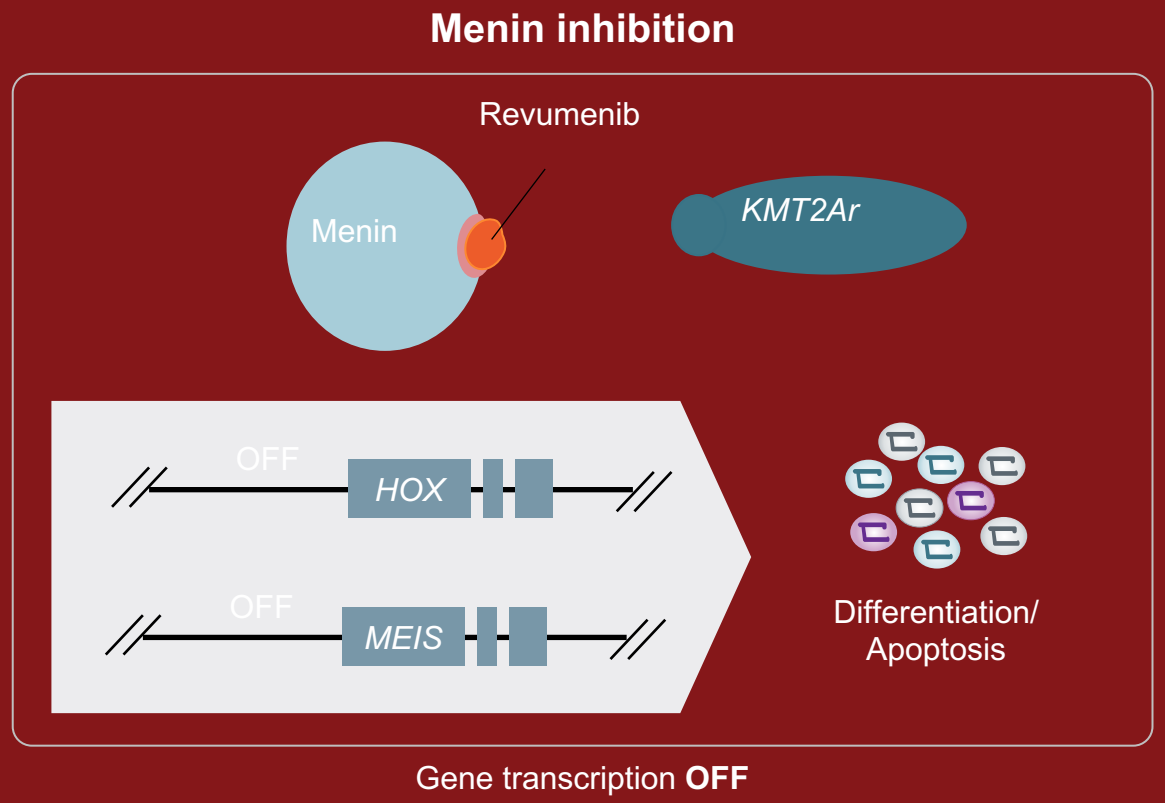
Courtesy of Courtney D DiNardo, MD, MSCE

Menin Inhibition for NPM1-Mutated and KMT2Ar Acute Leukemias

- Aldoss I et al. **Revumenib** monotherapy in patients with **relapsed/refractory KMT2Ar** acute leukemias: Efficacy and safety results from the **augment-101** phase 1/2 study. ASH 2023;Abstract LBA-5.
- Issa GC et al. Early results of the phase I/II study investigating the **all-oral combination** of the **menin inhibitor revumenib (SNDX-5613)** with **decitabine/cedazuridine (ASTX727)** and **venetoclax** in acute myeloid leukemia (**SAVE**). ASH 2023;Abstract 58.
- Fathi A et al. Activity, tolerability, and resistance profile of the **menin inhibitor ziftomenib** in adults with **R/R NPM1-mutated** AML. EHA 2023;Abstract LB2713.
- Jabbour E et al. A first-in-human phase 1 study of the **menin-KMT2A (MLL1) inhibitor JNJ-75276617** in adult patients with **relapsed/refractory** acute leukemia harboring **KMT2A or NPM1 alterations**. ASH 2023;Abstract 57.

Menin Inhibitors for R/R AML





Courtesy of Courtney D DiNardo, MD, MSCE

Overview of Menin Inhibitors in Development for AML

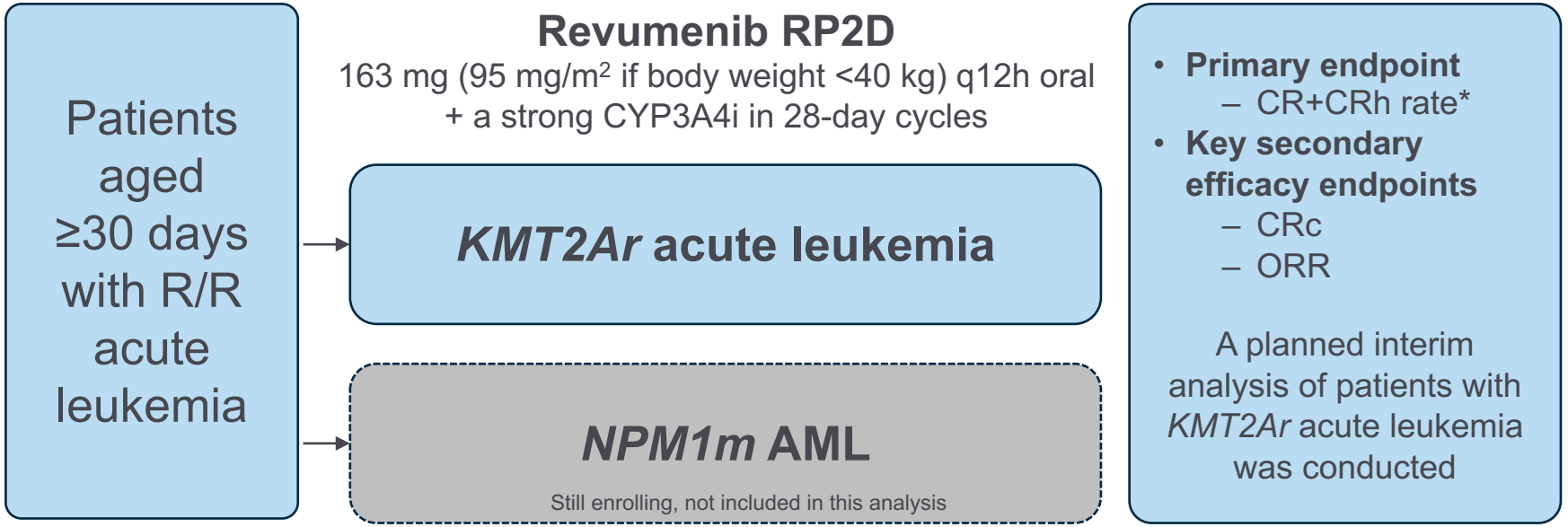
Agent (Former Name) Route of Administration	NCT Identifier (Trial Name)	Study Phase (n)	Phase 1/ 2 Expansion Cohorts for R/R Disease	Current Status
Revumenib (SNDX-5613)[1] PO BID	NCT04065399 (AUGMENT-101)	Phase 1 (n = 186)	• ALL or MPAL with *KMT2A*r • AML with *KMT2A*r • AML with *NPM1*mut	In expansion (10 sites) **FDA breakthrough**
Ziftomenib (KO-539)[2] PO QD	NCT04067336 (KOMET-001)	Phase 1/2 (n = 199)	• AML with *KMT2A*r • AML with *NPM1*mut	Recruiting (25 sites)
BMF-219[3] PO	NCT05153330	Phase 1 (n = 177)	• AML/ALL/MPAL, DLBCL, and MM/PCD	Recruiting (6 sites)
D1594b[4] PO BID	NCT04752163	Phase 1/2 (n = 20)	• AML/ALL with *KMT2A*r • AML with *NPM1*mut	Active (1 site)
DSP-5336[5] PO QD	NCT04988555	Phase 1/2 (n = 70)	• R/R AML, R/R ALL • Phase 2: *NPM1*mut/*KMT2A*r	Recruiting (6 sites)
JNJ-75276617[6] PO QD	NCT04811560	Phase 1 (n = 110)	• AML/ALL with *KMT2A*r • AML with *NPM1*mut	Recruiting (27 sites)

.

1. Issa GC, et al. Blood. 2022;140: Abstract 63; 2. Erba HP, et al. Blood. 2022;140: Abstract 64; 3. Clinicaltrials.gov. Accessed August 31, 2023. https://clinicaltrials.gov/ct2/show/NCT05153330; 4. Clinicaltrials.gov. Accessed August 31, 2023. https://clinicaltrials.gov/ct2/show/ NCT04752163; 5. Daver N, et al. Blood. 2022;140: Poster 1460; 6. Kwon MC, et al. Blood. 2022;140: Poster 2637.

Courtesy of Courtney D DiNardo, MD, MSCE

AUGMENT-101: Revumenib Monotherapy for R/R KMT2Ar



*CR+CRh rate >10% in adult evaluable population considered lower efficacy bound

Parameter	Efficacy population (n=57)	Safety population (n=94)[a]
Median age, y (range)	34.0 (1.3–75)	37.0 (1.3–75)
Age <18 y, n (%)	13 (23)	23 (25)
Age ≥18 y, n (%)	44 (77)	71 (76)
Sex, n (%)		
Female	33 (58)	56 (60)

Courtesy of Courtney D DiNardo, MD, MSCE

Aldoss I ASH LBA#5

AUGMENT-101: Revumenib Monotherapy for R/R KMT2Ar

Revumenib is effective and safe in pediatric and adult patients with R/R *KMT2Ar* acute leukemia

Durable MRD-negative remissions were observed in responders

High rates of transplants among responders

Discontinuations and dose reductions due to adverse events were low

Study was stopped early after meeting the primary efficacy endpoint at the predefined interim analysis. A New Drug Application for *KMT2Ar* leukemia has been initiated under the FDA Real-Time Oncology Review program based on these data

The independent NPM1m cohort continues to enroll at all sites

Courtesy of Courtney D DiNardo, MD, MSCE

SAVE: SNDX + ASTX727 + VEnetoclax triplet

Early results **of all-oral SAVE** [**revumenib (SNDX-5613)**, **oral decitabine (ASTX727)** and **VEnetoclax**] → acceptable safety and high efficacy in **children and adults** with R/R AML susceptible to menin inhibition

High rates of response in heavily pretreated population

- **ORR 100%** (9/9), **CR/CRh 44%** (4/9), **MRD-neg 67%** (6/9)
- 5/9 patients to alloHSCT, 2 resumed revumenib maintenance with ongoing remission > 11 months

No severe differentiation syndrome or ≥Grade 3 QT prolongation

Myelosuppression, confounded by expected risk with HMA + Ven in R/R AML

- Future mitigation measures to include intermittent revumenib dosing, without compromising efficacy given clearance of leukemia by day 14

This study continues to accrue patients

Courtesy of Courtney D DiNardo, MD, MSCE

Generalized Conclusions

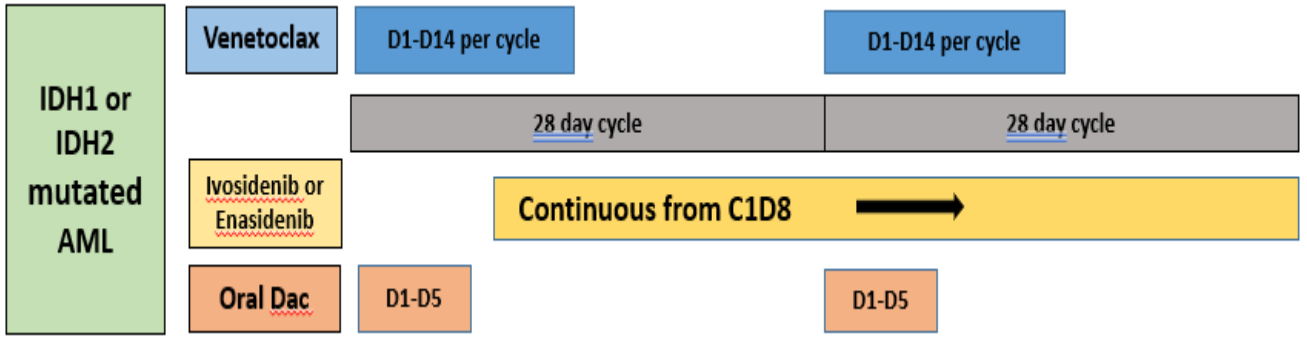
- AML therapeutic options continue to improve with increasingly individualized treatments
- Monitoring MRD is essential for ongoing risk assessment, and we now have studies showing that acting on MRD can improve patient outcome
- Menin inhibitors are a new effective class of therapy in AML, with initial studies evaluating patients with R/R *NPM1* and *KMT2A-rearranged* leukemias

Courtesy of Courtney D DiNardo, MD, MSCE

IDH Inhibitors in AML

- Atluri H et al. Phase Ib/2 study of **oral decitabine/cedazuridine (ASTX727)** and **venetoclax** in **combination** with the targeted mutant **IDH1 inhibitor ivosidenib** or the targeted mutant **IDH2 inhibitor enasidenib**: 2023 Update. ASH 2023;Abstract 968.
- de Botton S et al. **Olutasidenib (FT-2102)** induces durable complete remissions in patients with **relapsed or refractory IDH1-mutated** AML. *Blood Adv* 2023;7(13):3117-27.

Update of HMA+VEN+IDHi for IDHm AML



Selected RP2D Combination Doses

Arm A:
ASTX727 (D1-5) + VEN 600 mg (D1-14) + Ivosidenib 500 mg daily (D8 onwards)

Arm B:
ASTX727 (D1-5) + VEN 400 mg (D1-14) + Enasidenib 100 mg daily (D8 onwards)

Prior Treatments (R/R Only)		
	IDH1 (n=11)	IDH2 (n=19)
Prior HMA + VEN	6 (55)	13 (68)
No Prior VEN	3 (27)	6 (32)
Prior IDHi	4 (36)	3 (16)
HMA/VEN/IDHi naïve	1 (9)	4 (21)

Baseline Characteristics

Variable	All (n=57)	Newly Diagnosed (n=27)		Relapsed Refractory (n=30)	
		IDH1 (n=11)	IDH2 (n=16)	IDH1 (n=11)	IDH2 (n=19)
Age (years)	72 (41-86)	74 (70-80)	71 (62-83)	73 (41-86)	70 (56-84)
Male	35 (61)	4 (36)	12 (75)	8 (72)	11 (58)
ECOG	1 (1-2)	2 (1-2)	2 (1-2)	1 (1-2)	1(1-2)
ELN Risk (2022)					
ELN Favorable	7 (12)	3 (27)	2 (13)	1 (9)	1 (5)
ELN Intermediate	2 (4)	-	1 (6)	-	2 (10)
ELN Adverse	47 (82)	8 (72)	13 (81)	10 (91)	16 (85)
Cytogenetic Risk					
Intermediate Risk	37 (65)	8 (73)	14 (88)	4 (36)	11 (58)
Adverse Risk	20 (35)	3 (27)	2 (12)	7 (64)	8 (42)
Co-Occurring Mutations					
NPM1	9 (16)	3 (27)	3 (19)	2 (18)	1 (5)
KRAS/NRAS	6 (14)	1 (9)	3 (19)	1 (9)	1 (5)
FLT3	1 (2)	-	-	1 (9)	-
TP53	12 (21)	-	2 (12)	6 (55)	4 (21)

Atluri H ASH #968

Courtesy of Courtney D DiNardo, MD, MSCE

Conclusions

Safety profile and tolerability of triplet combination of ASTX727 + VEN + IDHi in both ND and R/R AML appears reassuring and may prove to be the optimal method of incorporating all effective therapies (HMA+VEN vs HMA+IVO vs HMA+VEN+IVO)

Triplet outcomes to date:

CRc rates of 96.2% (ND-AML) and 56.6% (RR-AML)

Median OS NR (ND-AML); mOS 17.7 and 10.4 months for *IDH1* and *IDH2* RR-AML

Courtesy of Courtney D DiNardo, MD, MSCE

Phase 1/2 Study of Novel IDH1 Inhibitor Olutasidenib

Multiple Cohorts of Monotherapy and Combination With Aza[1]

Monotherapy

Olutasidenib 150 mg BID

Cohort 1: R/R AML (N = 153)

Cohort 2: MRD-positive AML in CR/CRi

Cohort 3: R/R AML/MDS treated with prior IDH1 inhibitors; standard treatments contraindicated

Cohort 7: ND AML; standard treatments contraindicated

Combination Therapy

Olutasidenib 150 mg BID + Aza

Cohort 4: R/R AML/MDS with no prior HMA or IDH1 inhibitor

Cohort 5: R/R AML/MDS with progression on HMA

Cohort 6: R/R AML most recently treated with IDH1 inhibitor monotherapy

Cohort 8: ND AML eligible for frontline Aza

Primary endpoint

CR + CRh

Key secondary endpoints

- ORR
- DoR
- transfusion independence
- OS
- Safety

Results of Cohort 1 led to FDA approval of olutasidenib in December 2022 for *IDH1*-mutated R/R AML[2]

1. ClinicalTrials.gov. Accessed August 31, 2023. https://www.clinicaltrials.gov/study/NCT02719574; 2. Olutasidenib [PI]. Approved 2022.

Courtesy of Courtney D DiNardo, MD, MSCE

Olutasidenib and Ivosidenib Data in R/R AML

***NOTE:** This is a summary of data from independent trials, not a head-to-head comparison within a single study.

PARAMETERS	OLUTASIDENIB[1]	IVOSIDENIB[2,3]
Composite complete remission *(CR + CRh)*	**35%**	**33%**
Median duration of CR/CRh (95% CI)	**25.9 months (13.5, NR)**	**8.2 months (5.6, 12)**
Complete remission rate (CR)	**32%**	**25%**
Median duration of CR	**28.1 months**	**10.1 months**
Overall response rate *(CR + CRh + CRi + PR + MLFS)*	**48%**	**42%**
Median duration of overall response	**11.7 months**	**6.5 months**

Courtesy of Courtney D DiNardo, MD, MSCE

1. de Botton S, et al. *Blood Adv.* 2023;bloodadvances.2022009411. 2. Tibsovo®. Prescribing information. Servier Pharmaceuticals LLC. 3. DiNardo CD, et al. *N Engl J Med.* 2018;378:2386-2398.

What I Tell My Patients:
Integrating New Research Information into Current Clinical Care

A Complimentary NCPD Hybrid Symposium Series Held During the 49th Annual ONS Congress April 24-27

Hormone Receptor-Positive Breast Cancer

Wednesday, April 24, 2024
6:00 PM – 8:00 PM ET

Faculty
Harold J Burstein, MD, PhD
Kelly Fischer, MSN, FNP-BC
Komal Jhaveri, MD, FACP
Melissa Rikal, FNP-BC, AOCNP

Antibody-Drug Conjugates

Thursday, April 25, 2024
12:15 PM – 1:45 PM ET

Faculty
Jamie Carroll, APRN, MSN, CNP
Kelly EH Goodwin, MSN, RN, ANP-BC
Erika Hamilton, MD
Hope S Rugo, MD

Endometrial Cancer

Thursday, April 25, 2024
6:00 AM – 7:30 AM ET

Faculty
Jennifer Filipi, MSN, NP
Kathryn M Lyle, MSN, WHNP-BC, AGNP-C
David M O'Malley, MD
Shannon N Westin, MD, MPH, FASCO, FACOG

Chronic Lymphocytic Leukemia and Bispecific Antibodies in Lymphoma

Thursday, April 25, 2024
6:00 PM – 8:00 PM ET

Faculty
John N Allan, MD
Brad S Kahl, MD
Robin Klebig, MSN, APRN, CNP, AOCNP
Mollie Moran, APRN-CNP, AOCNP

What I Tell My Patients:
Integrating New Research Information into Current Clinical Care

A Complimentary NCPD Hybrid Symposium Series Held During the 49th Annual ONS Congress April 24-27

Head and Neck Cancer

Friday, April 26, 2024
6:00 AM – 7:30 AM ET

Faculty
Meetal Dharia, NP-C, AOCNP
Robert L Ferris, MD, PhD
Robert Haddad, MD
Lynsey P Teulings, APRN

Ovarian Cancer

Friday, April 26, 2024
6:00 PM – 7:30 PM ET

Faculty
Courtney Arn, CNP
Floor J Backes, MD
Kathleen N Moore, MD, MS
Jaclyn Shaver, MS, APRN, CNP, WHNP

Non-Small Cell Lung Cancer with an EGFR Mutation

Friday, April 26, 2024
12:15 PM – 1:45 PM ET

Faculty
Marianne J Davies, DNP, ACNP, AOCNP, FAAN
Alexander I Spira, MD, PhD
Jillian Thompson, MSN, ANP-BC, AOCNP
Helena Yu, MD

Hepatobiliary Cancers

Saturday, April 27, 2024
6:00 AM – 7:30 AM ET

Faculty
Blanca Ledezma, MSN, NP, AOCNP
Stacey Stein, MD
Amanda K Wagner, APRN-CNP, AOCNP
Mark Yarchoan, MD

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Myelofibrosis
Saturday, April 27, 2024
12:15 PM – 1:45 PM ET

Faculty
Ilene Galinsky, NP
Andrew T Kuykendall, MD
Sara M Tinsley-Vance, PhD, APRN, AOCN
Abdulraheem Yacoub, MD

Gastroesophageal and Colorectal Cancers
Saturday, April 27, 2024
6:00 PM – 8:00 PM ET

Faculty
Deanna A Griffie, MSN, AGNP-C
Caroline Kuhlman, MSN, APRN-BC
Manish A Shah, MD
John Strickler, MD

LIVE WEBINAR

Prostate Cancer
Wednesday, May 1, 2024
7:00 PM – 8:00 PM ET

Faculty
Andrew J Armstrong, MD, ScM
Brenda Martone, MSN, NP-BC, AOCNP

Thank you for joining us!

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

RTP Year in Review 2024