Cases from the Community: Investigators Discuss Available Research Guiding the Care of Patients with Non-Hodgkin Lymphoma

Saturday, May 31, 2025
7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Joshua Brody, MD
Christopher Flowers, MD, MS
Ann LaCasce, MD, MMSc
Tycel Phillips, MD, FASCO

Moderator

Jeremy S Abramson, MD, MMSc

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Dr Brody — Disclosures
Faculty

No relevant conflicts of interest to disclose.

Dr Flowers — Disclosures
Faculty

Consulting Agreements	AbbVie Inc, Bayer HealthCare Pharmaceuticals, BeiGene Ltd, Celgene Corporation, Denovo Biopharma, Genentech, a member of the Roche Group, Genmab US Inc, Gilead Sciences Inc, Karyopharm Therapeutics
Contracted Research	D Pharma PLC, AbbVie Inc, Acerta Pharma — A member of the AstraZeneca Group, Alaunos Therapeutics, Allogene Therapeutics, Amgen Inc, Bayer HealthCare Pharmaceuticals, Celgene Corporation, Cellectis, EMD Serono Inc, Genentech, a member of the Roche Group, Gilead Sciences Inc, Guardant Health, Iovance Biotherapeutics, Janssen Biotech Inc, Kite, A Gilead Company, MorphoSys, Nektar Therapeutics, Novartis, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Sanofi, Takeda Pharmaceuticals USA Inc, TG Therapeutics Inc, Xencor
Nonrelevant Financial Relationships	Burroughs Wellcome Fund, Cancer Prevention and Research Institute of Texas (CPRIT Scholar in Cancer Research), Eastern Cooperative Oncology Group, Foresight Diagnostics, National Cancer Institute, N-Power Medicine Inc, V Foundation

Dr LaCasce — Disclosures
Faculty

Advisory Committees	Genmab US Inc, Kite, A Gilead Company
Consulting Agreements	Pierre Fabre

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Dr Phillips — Disclosures
Faculty

Advisory Committees	AbbVie Inc, Genentech, a member of the Roche Group, Genmab US Inc, Merck
Consulting Agreements	AbbVie Inc, ADC Therapeutics, AstraZeneca Pharmaceuticals LP, BeiGene Ltd, Bristol Myers Squibb, Caribou Biosciences Inc, Genentech, a member of the Roche Group, Genmab US Inc, Gilead Sciences Inc, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, Kite, A Gilead Company, Lilly, Merck, Pfizer Inc, Regeneron Pharmaceuticals Inc, Xencor
Contracted Research	AbbVie Inc, Genentech, a member of the Roche Group, Sobi
Nonrelevant Financial Relationships	Leukemia & Lymphoma Society (LLS) Scholar in Clinical Research

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Dr Abramson — Disclosures
Moderator

Consulting Agreements	AbbVie Inc, ADC Therapeutics, AstraZeneca Pharmaceuticals LP, BeiGene Ltd, Bristol Myers Squibb, Celgene Corporation, Genentech, a member of the Roche Group, Gilead Sciences Inc, Interius BioTherapeutics, Novartis, Roche Laboratories Inc, Seagen Inc
Contracted Research	Allogene Therapeutics, Bristol Myers Squibb, Celgene Corporation, Cellectis, Genentech, a member of the Roche Group, Merck, Mustang Bio, Regeneron Pharmaceuticals Inc, Seagen Inc, Takeda Pharmaceuticals USA Inc
Nonrelevant Financial Relationships	Foresight Diagnostics

Dr Love — Disclosures

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Commercial Support

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This educational activity contains discussion of non-FDA-approved uses of agents and regimens. Please refer to official prescribing information for each product for approved indications.

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Friday May 30	**Immunotherapy and Antibody–Drug Conjugates in Lung Cancer** 11:15 AM – 12:45 PM CT (12:15 PM – 1:45 PM ET)
	Colorectal Cancer 6:30 PM – 8:30 PM CT (7:30 PM – 9:30 PM ET)
	EGFR Mutation–Positive Non–Small Cell Lung Cancer 6:30 PM – 8:30 PM CT (7:30 PM – 9:30 PM ET)
Saturday May 31	**Urothelial Bladder Cancer** 6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)
	Non–Hodgkin Lymphoma 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
	Prostate Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Sunday June 1	**Chronic Lymphocytic Leukemia (Webinar)** 7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)
	HER2–Positive Gastrointestinal Cancers 7:00 PM – 8:30 PM CT (8:00 PM – 9:30 PM ET)
	Ovarian and Endometrial Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Monday June 2	**Renal Cell Carcinoma (Webinar)** 7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)
	Multiple Myeloma (Webinar) 6:00 PM – 7:00 PM CT (7:00 PM – 8:00 PM ET)
	Metastatic Breast Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Tuesday June 3	**Soft Tissue Sarcoma and Other Connective Tissue Neoplasms (Webinar)** 7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)

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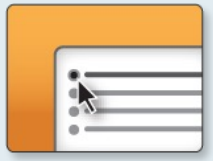
Clinicians in the Meeting Room

Networked iPads are available.

Review Program Slides: Tap the Program Slides button to review speaker presentations and other program content.



Answer Survey Questions: Complete the pre- and postmeeting surveys.

Ask a Question: Tap Ask a Question to submit a challenging case or question for discussion. We will aim to address as many questions as possible during the program.

For assistance, please raise your hand. Devices will be collected at the conclusion of the activity.

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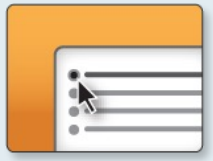
Clinicians Attending via Zoom

Review Program Slides: A link to the program slides will be posted in the chat room at the start of the program.



Answer Survey Questions: Complete the pre- and postmeeting surveys.

Ask a Question: Submit a challenging case or question for discussion using the Zoom chat room.

Get CME Credit: A CME credit link will be provided in the chat room at the conclusion of the program.

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About the Enduring Program

- The live meeting is being video and audio recorded.
- The proceedings from today will be edited and developed into an enduring web-based program. An email will be sent to all attendees when the activity is available.
- To learn more about our education programs, visit our website, **www.ResearchToPractice.com**

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Florida Cancer Specialists
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Fort Myers, Florida

Neil Love, MD
Research To Practice
Miami, Florida

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Agenda

MODULE 1: Selection and Sequencing of Available Therapies for Diffuse Large B-Cell Lymphoma — Dr Flowers

MODULE 2: Evolving Management Paradigm for Mantle Cell Lymphoma — Dr Phillips

MODULE 3: Integration of Novel Therapies into the Management of Follicular Lymphoma — Dr LaCasce

MODULE 4: Integrating Bispecific Antibodies into the Management of NHL — Dr Brody

MODULE 5: Current Role of CAR T-Cell Therapy in Various Non-Hodgkin Lymphoma (NHL) Subtypes — Dr Abramson

Agenda

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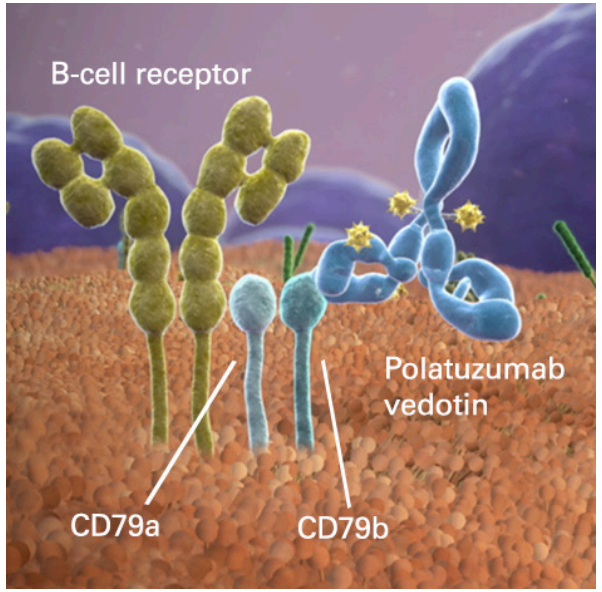
Advances in Treatment of Diffuse Large B-Cell Lymphoma

Christopher Flowers, MD, MS, FASCO

Division Head
Chair, Professor

Division of Cancer Medicine
Department of Lymphoma/Myeloma

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



POLARIX: 1L DLBCL Phase 3

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Polatuzumab Vedotin in Previously Untreated Diffuse Large B-Cell Lymphoma

H. Tilly, F. Morschhauser, L.H. Sehn, J.W. Friedberg, M. Trněný, J.P. Sharman, C. Herbaux, J.M. Burke, M. Matasar, S. Rai, K. Izutsu, N. Mehta-Shah, L. Oberic, A. Chauchet, W. Jurczak, Y. Song, R. Greil, L. Mykhalska, J.M. Bergua-Burgués, M.C. Cheung, A. Pinto, H.-J. Shin, G. Hapgood, E. Munhoz, P. Abrisqueta, J.-P. Gau, J. Hirata, Y. Jiang, M. Yan, C. Lee, C.R. Flowers, and G. Salles

Patients

- Previously untreated DLBCL
- Age 18–80 years
- IPI 2–5
- ECOG PS 0–2

Stratification factors

- IPI score (2 vs 3–5)
- Bulky disease (<7.5 vs ≥7.5cm)
- Geographic region (Western Europe, US, Canada, & Australia vs Asia vs rest of world)

R 1:1

Pola-R-CHP

Polatuzumab vedotin (1.8mg/kg)* + **R-CHP + vincristine placebo**

R-CHOP

R-CHOP† + **polatuzumab vedotin placebo**

Cycles 1–6
(1 cycle=21 days)

Rituximab
375mg/m²

Cycles 7 & 8

Primary endpoint

Progression-free survival (Investigator-assessed)

Secondary endpoints

- Event-free survival
- Complete response rate at end of treatment (PET/CT, IRC-assessed)
- Disease-free survival
- Overall survival

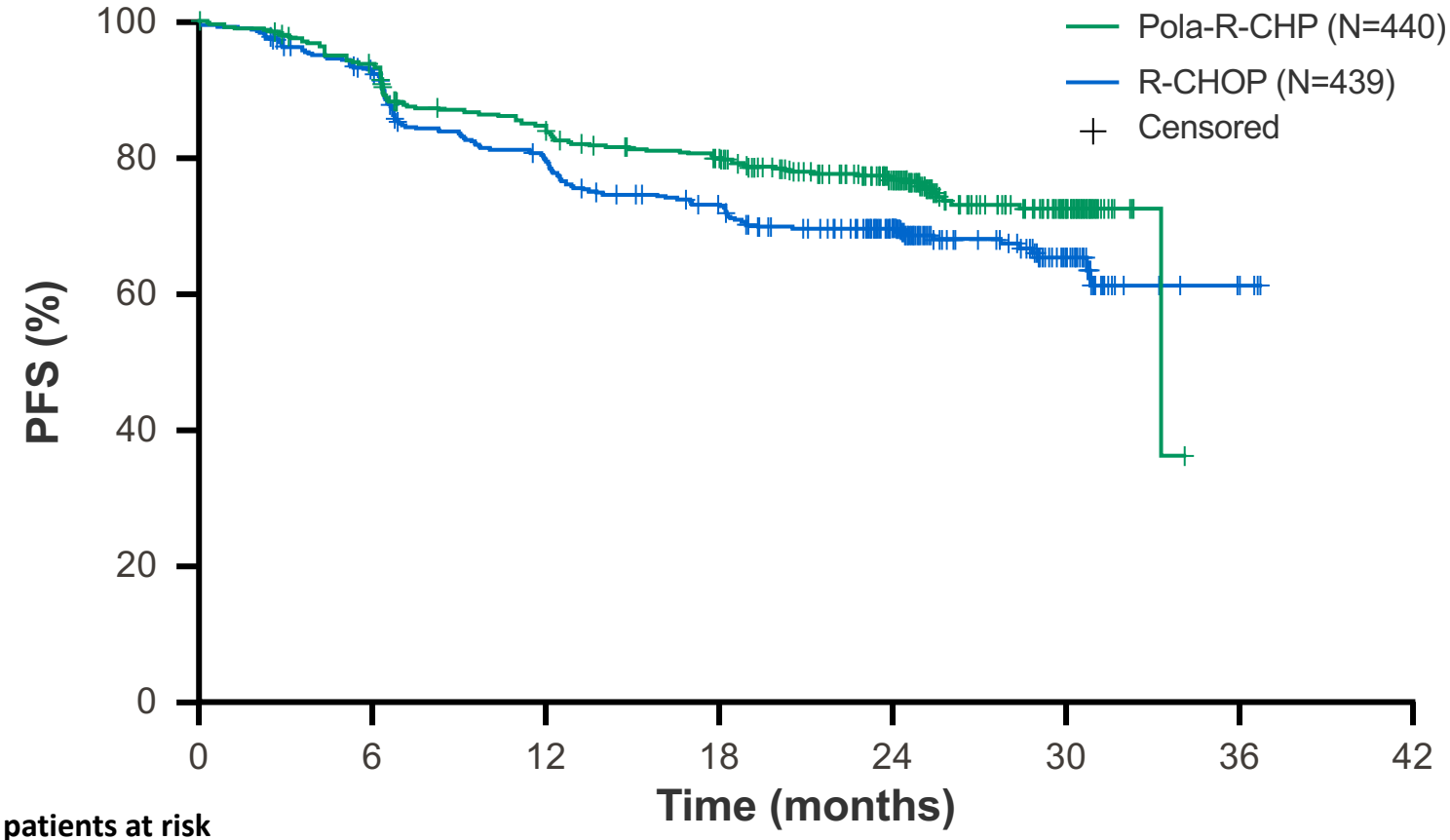
Safety endpoints

Incidence, nature, and severity of adverse events

Tilly et al. *NEJM* 2022

Primary endpoint: Progression-free survival

Pola-R-CHP significantly improved PFS vs R-CHOP



No. of patients at risk

Pola-R-CHP	440	404	353	327	246	78	NE	NE
R-CHOP	439	389	330	296	220	78	3	NE

HR 0.73 **(P=0.02)**

95% CI: 0.57, 0.95

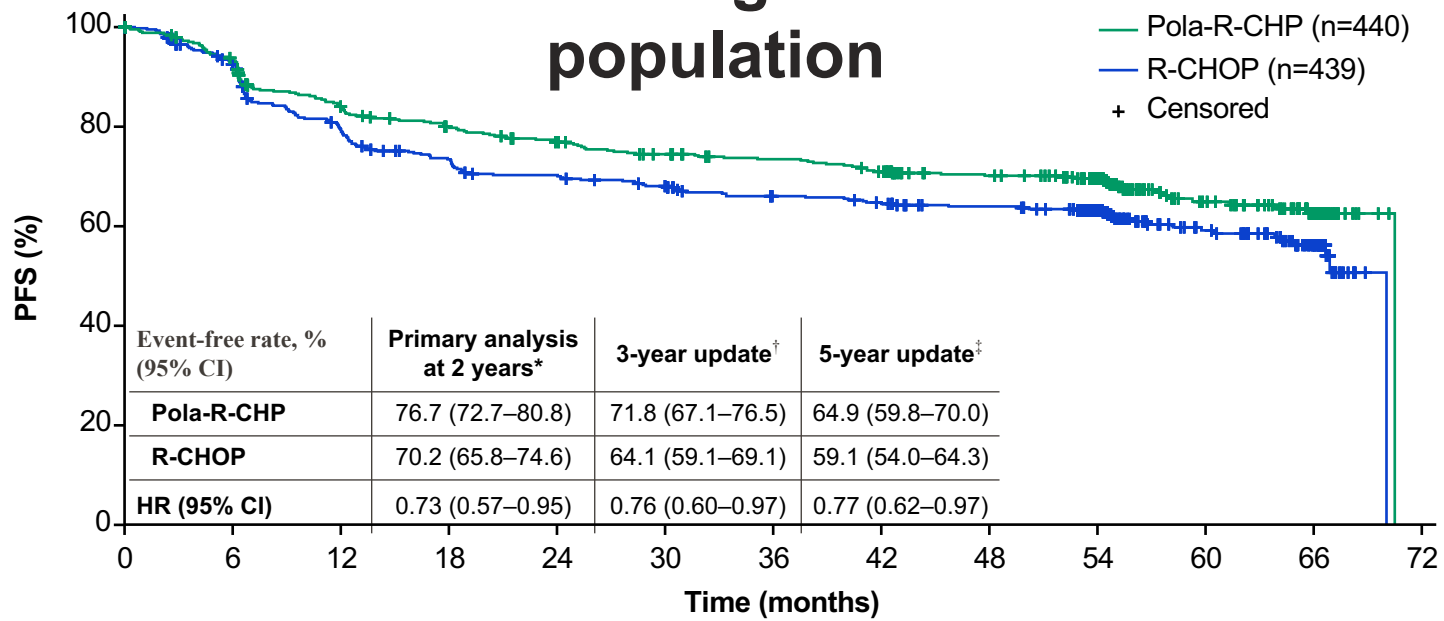
- Pola-R-CHP demonstrated a **27% reduction in the relative risk of disease progression, relapse, or death** vs R-CHOP
- **24-month PFS:** 76.7% with Pola-R-CHP vs 70.2% with R-CHOP (Δ**=6.5%**)

Tilly et al. *NEJM* 2022

Five-year analysis of the POLARIX study

Gilles Salles, Franck Morschhauser, Laurie H. Sehn, Alex F. Herrera, Jonathan W. Friedberg, Marek Trněný, Georg Lenz, Jeff P. Sharman, Charles Herbaux, John M. Burke, Matthew Matasar, Graham P. Collins, Yuqin Song, Antonio Pinto, Shinya Rai, Koji Izutsu, Calvin Lee, Saibah Chohan, Matthew Sugidono, Yanwen Jiang, Connie Lee Batlevi, Mark Yan, Jamie Hirata, Hervé Tilly, Christopher R. Flowers

PFS in the global ITT population



Event-free rate, % (95% CI)	Primary analysis at 2 years*	3-year update†	5-year update‡
Pola-R-CHP	76.7 (72.7–80.8)	71.8 (67.1–76.5)	64.9 (59.8–70.0)
R-CHOP	70.2 (65.8–74.6)	64.1 (59.1–69.1)	59.1 (54.0–64.3)
HR (95% CI)	0.73 (0.57–0.95)	0.76 (0.60–0.97)	0.77 (0.62–0.97)

Patients remaining at risk

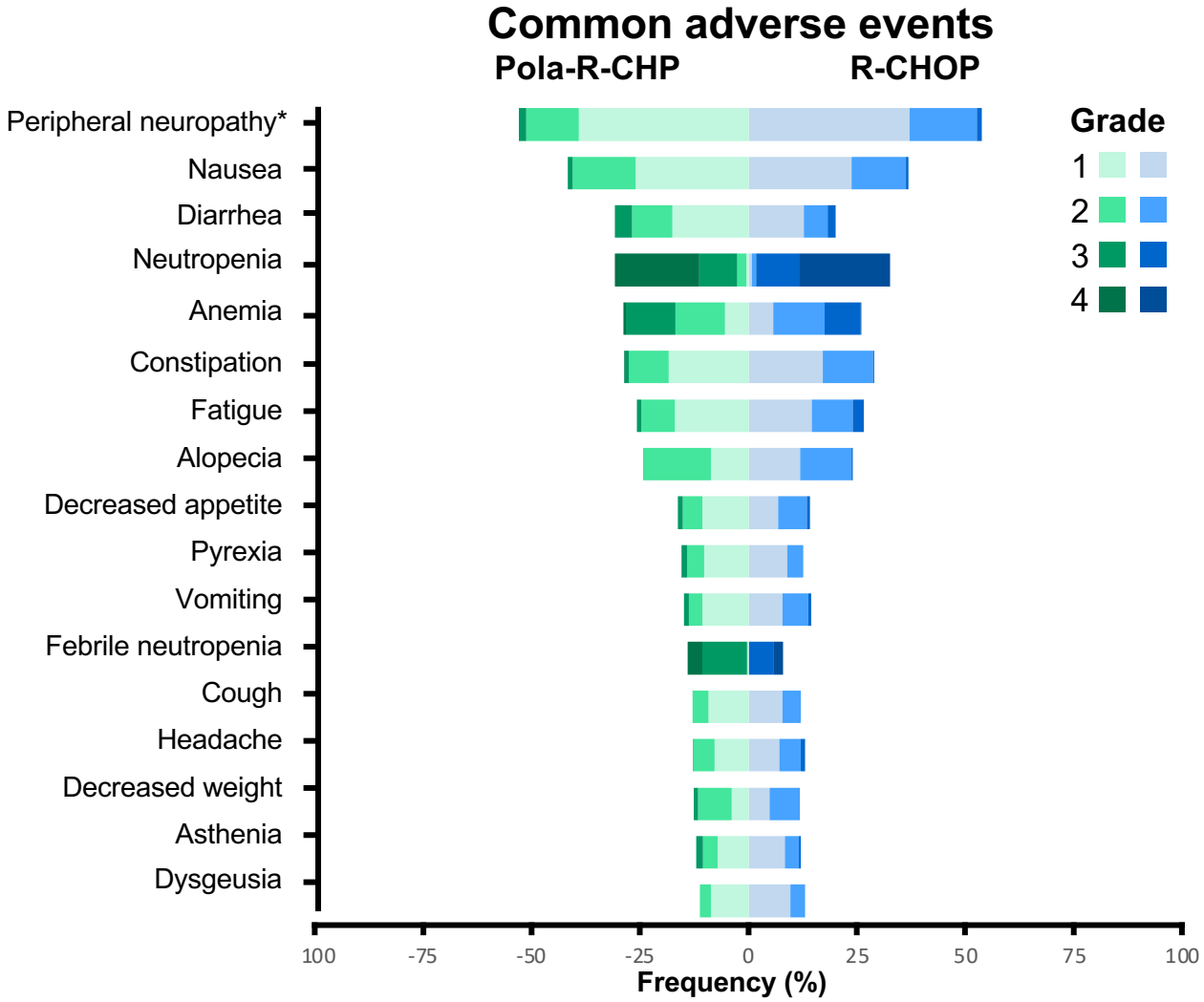
Pola-R-CHP	440	407	357	335	318	303	292	280	258	213	100	56	NE
R-CHOP	439	391	332	302	287	274	258	251	240	192	95	54	NE

At the 5-year follow up, Pola-R-CHP had a **sustained and significant PFS benefit**, confirming results from the primary analysis of PFS at 2 years of follow up (HR 0.73).[1]

Safety summary

Safety profiles were similar with Pola-R-CHP and R-CHOP

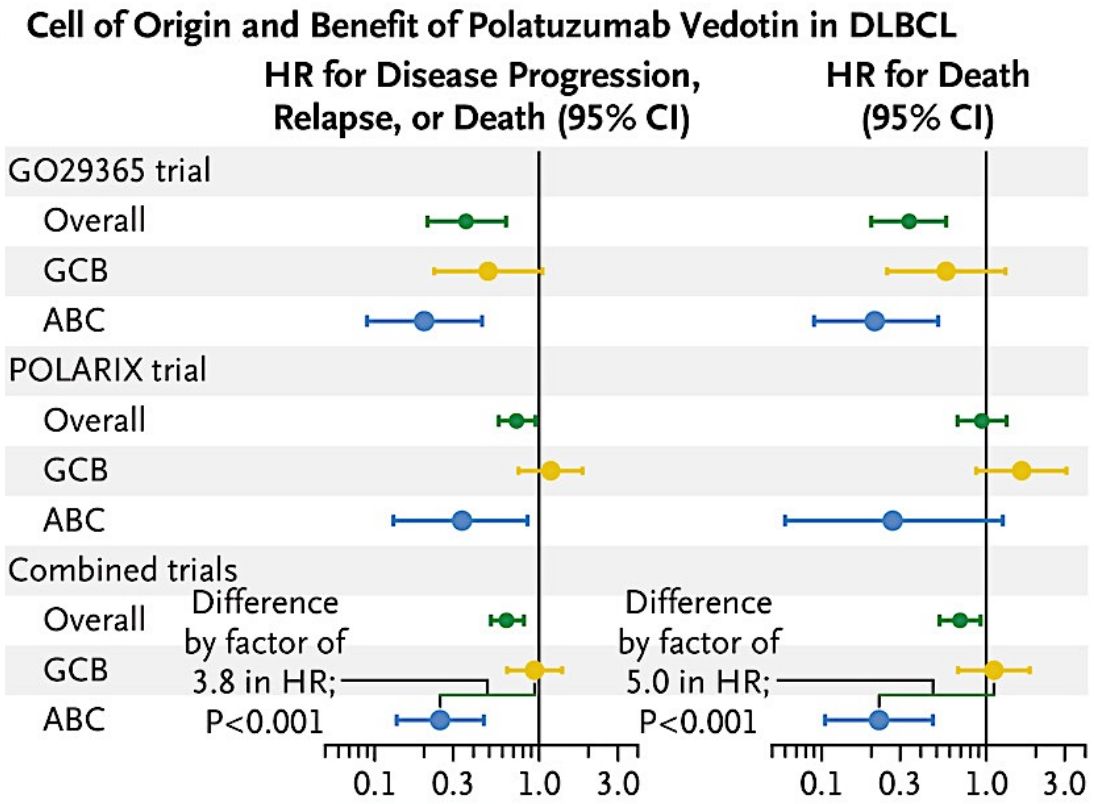
n (%)	Pola-R-CHP (N=435)	R-CHOP (N=438)
Any-grade adverse events	426 (97.9)	431 (98.4)
Grade 3–4	251 (57.7)	252 (57.5)
Grade 5	13 (3.0)	10 (2.3)
Serious adverse events	148 (34.0)	134 (30.6)
Adverse events leading to:		
Discontinuation of any study drug	27 (6.2)	29 (6.6)
Polatuzumab vedotin / vincristine	19 (4.4)	22 (5.0)
Dose reduction of any study drug	40 (9.2)	57 (13.0)



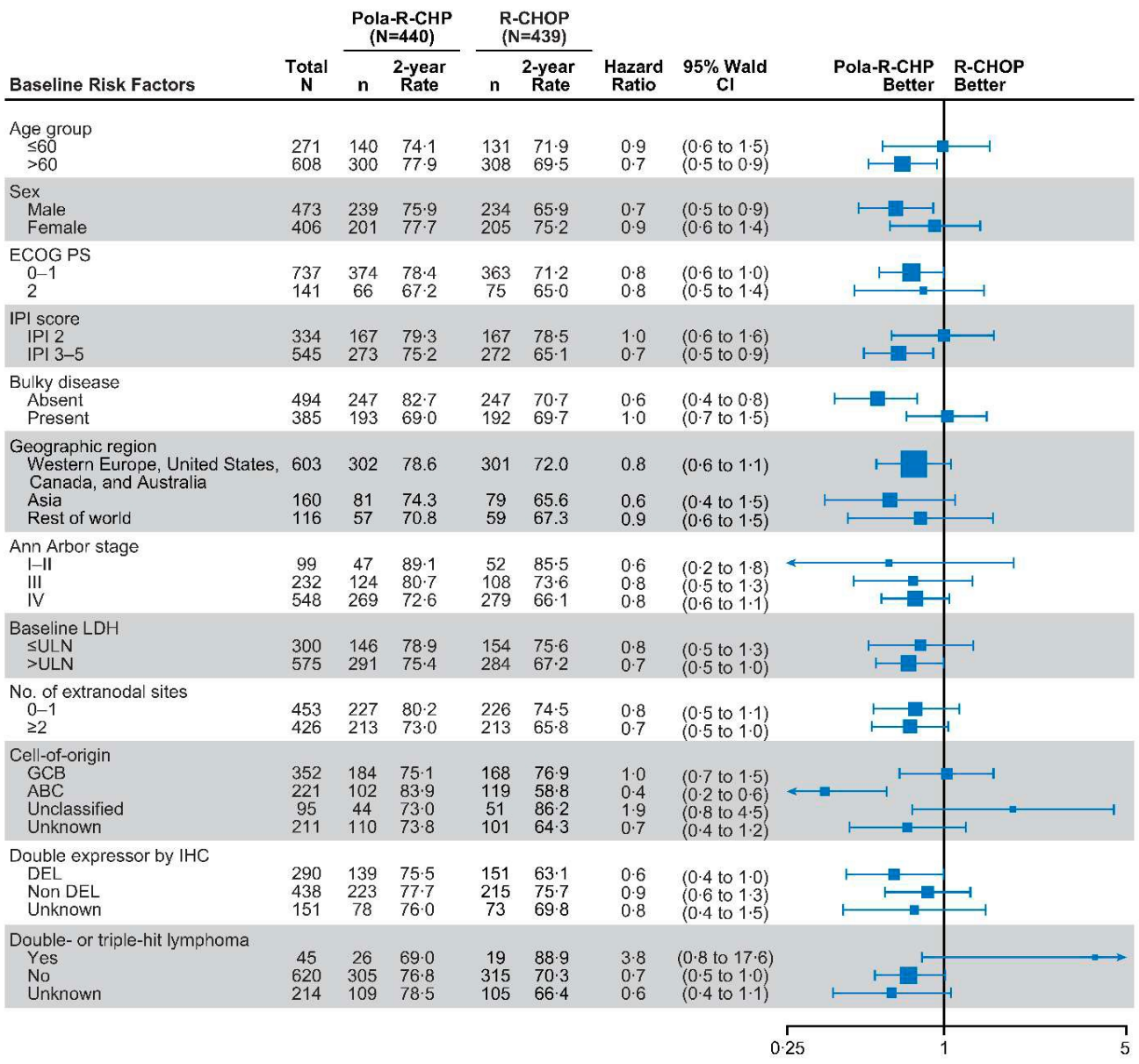
- ITT population. Data cut-off: June 28, 2021; median 28.2 months' follow-up.
  CI, confidence interval; HR, hazard ratio; NE, not evaluable; PFS, progression-free survival.

Tilly et al. *NEJM* 2022

Polatuzumab Vedotin Efficacy in DLBCL Subtypes by COO



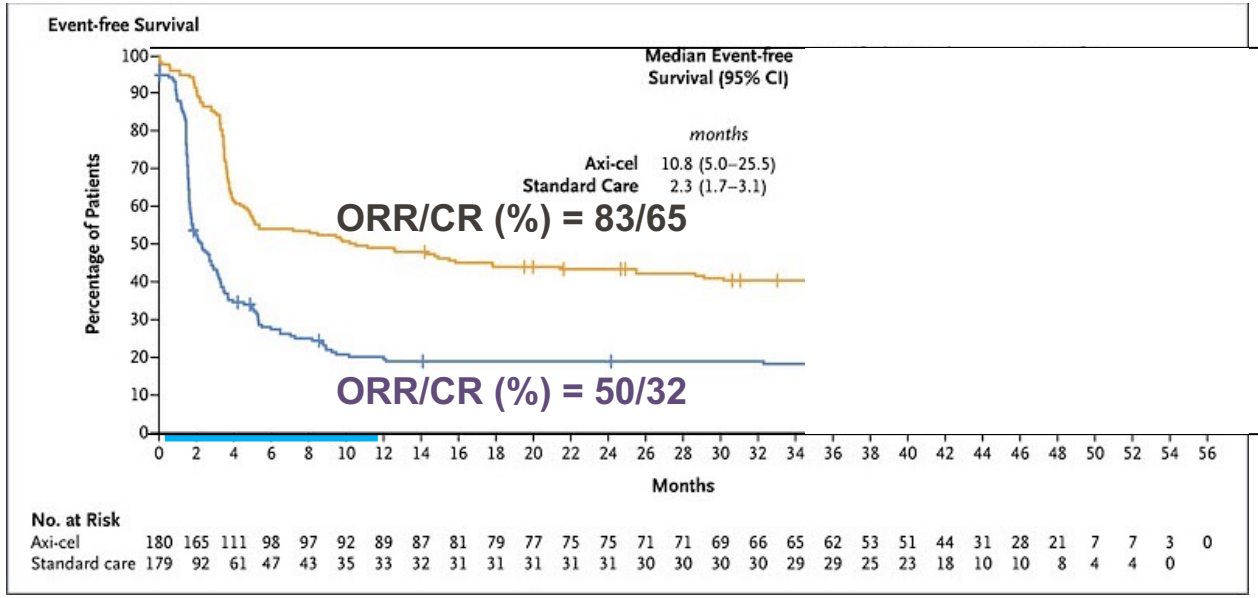
Palmer et al. *NEJM* 2023



Tilly et al. *NEJM* 2022

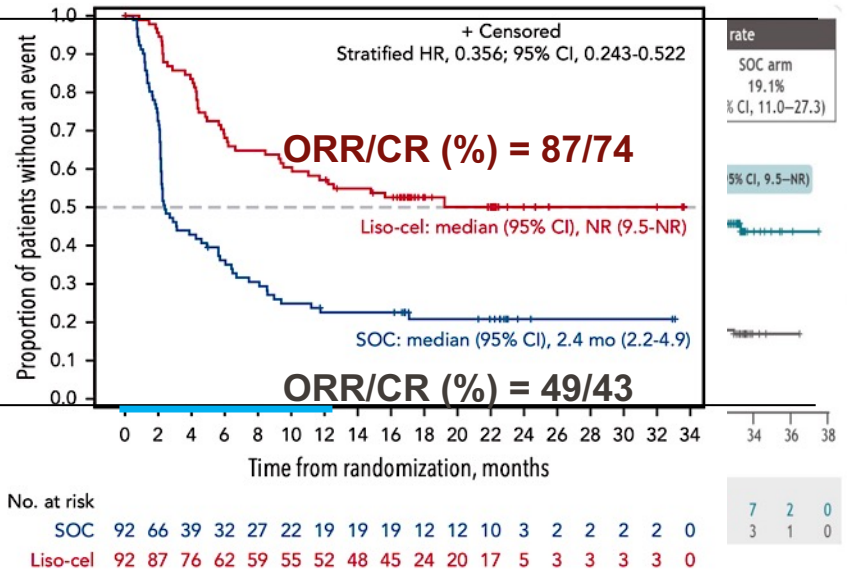
CAR T-cell vs. SOC in 2L for LBCL: EFS

ZUMA 7 / Axi-cel



HR 0.42
Median f/u 47.2 mo

TRANSFORM / Liso-cel

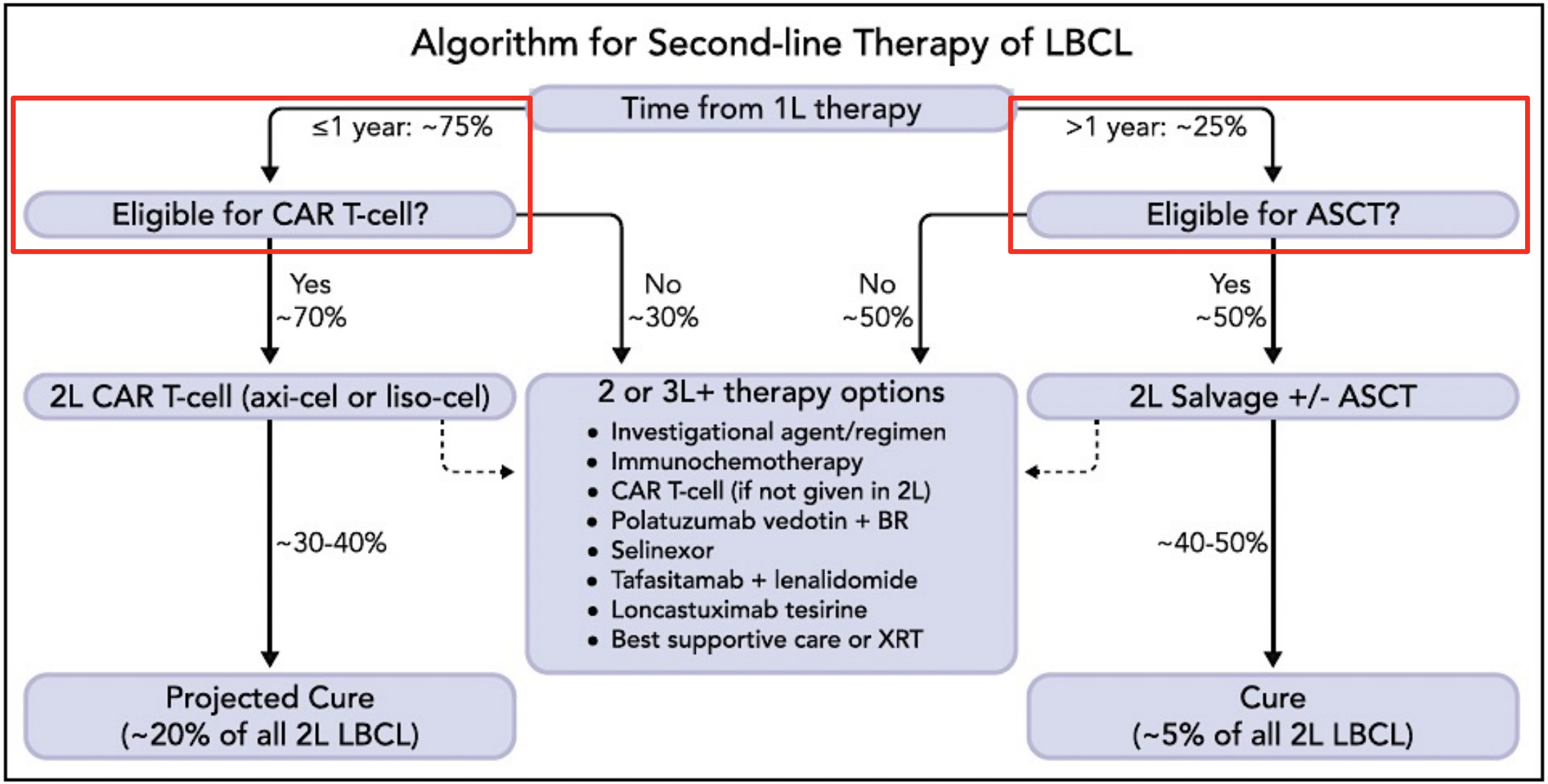


HR 0.375
Median f/u 37.9 mo

3 year EFS estimates:

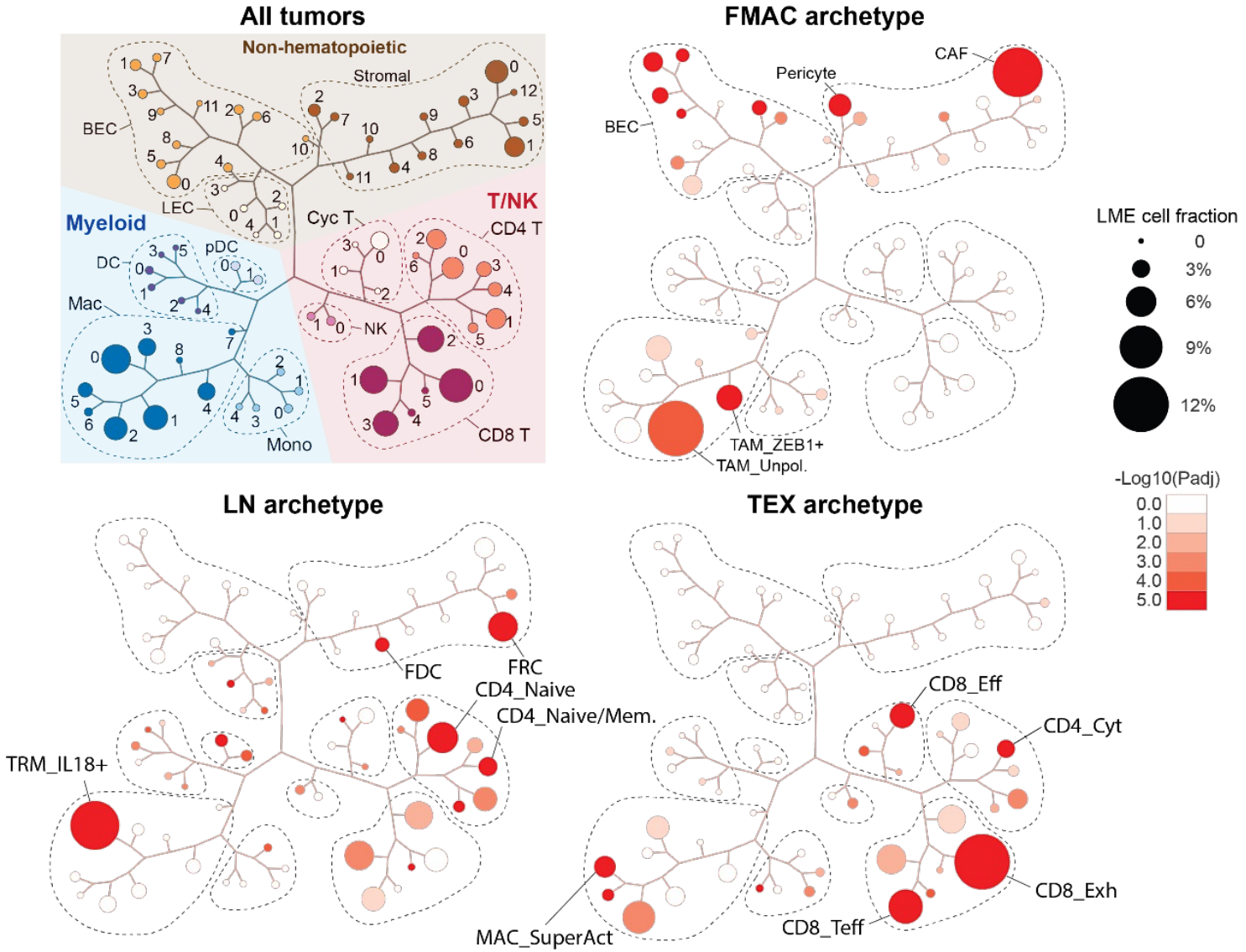
Zuma 7:	Transform:
Axi-cel: 41%	Liso-cel 45%
SOC: 19%	SOC: 19%

Westin J et al, NEJM 2023
Kamdar et al, ASCO 2024, Abramson et al. Blood 2023



Westin and Sehn, Blood 2022

Lymphoma Microenvironment Archetype Profiles (LymphoMAPs)



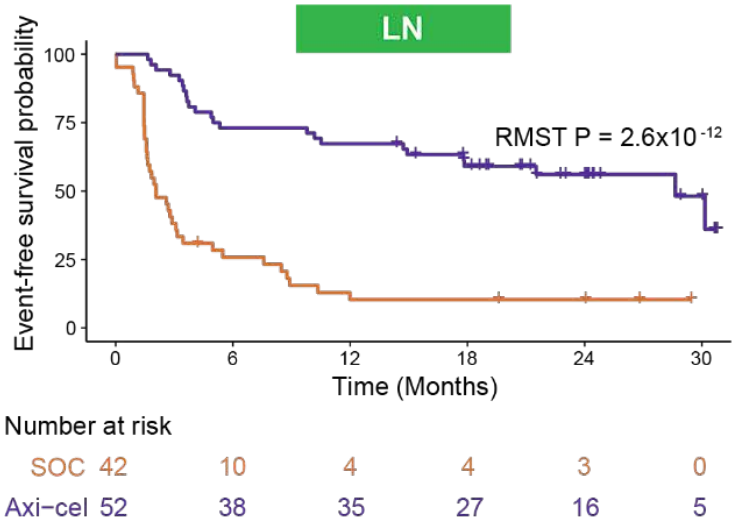
FMAC enriched for CAFs and TAMs

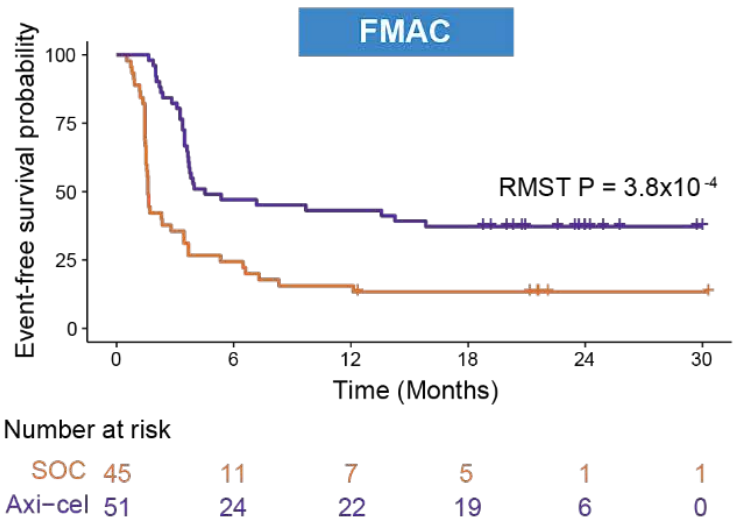
LN enriched for supportive LN stroma (FRC/FDC) and healthy T-cells

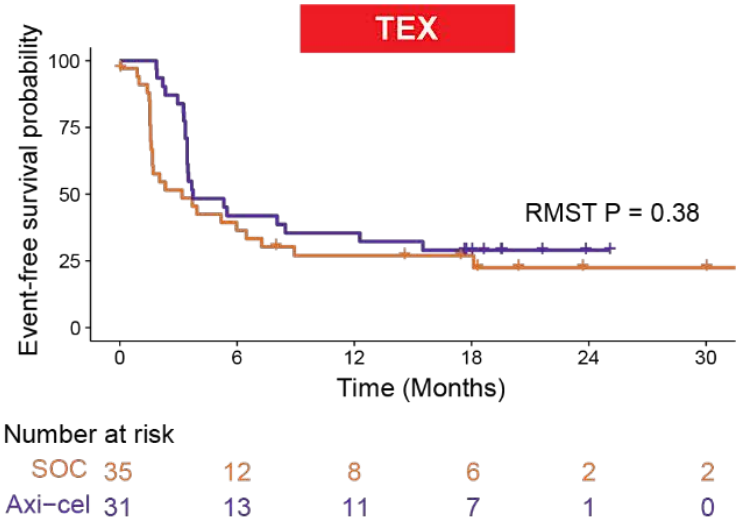
TEX enriched for effector & exhausted T-cells and super-activated macrophages

Li et al, ASH 2024

Projection of LymphoMAPs onto ZUMA7

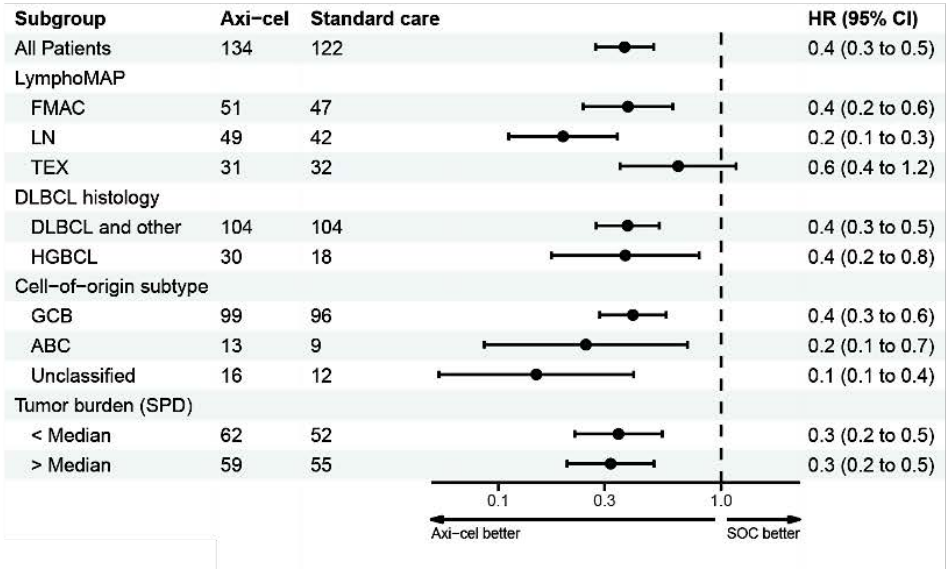






Phase 3 clinical trial comparing axi-cel to SOC in 2L rrLBCL

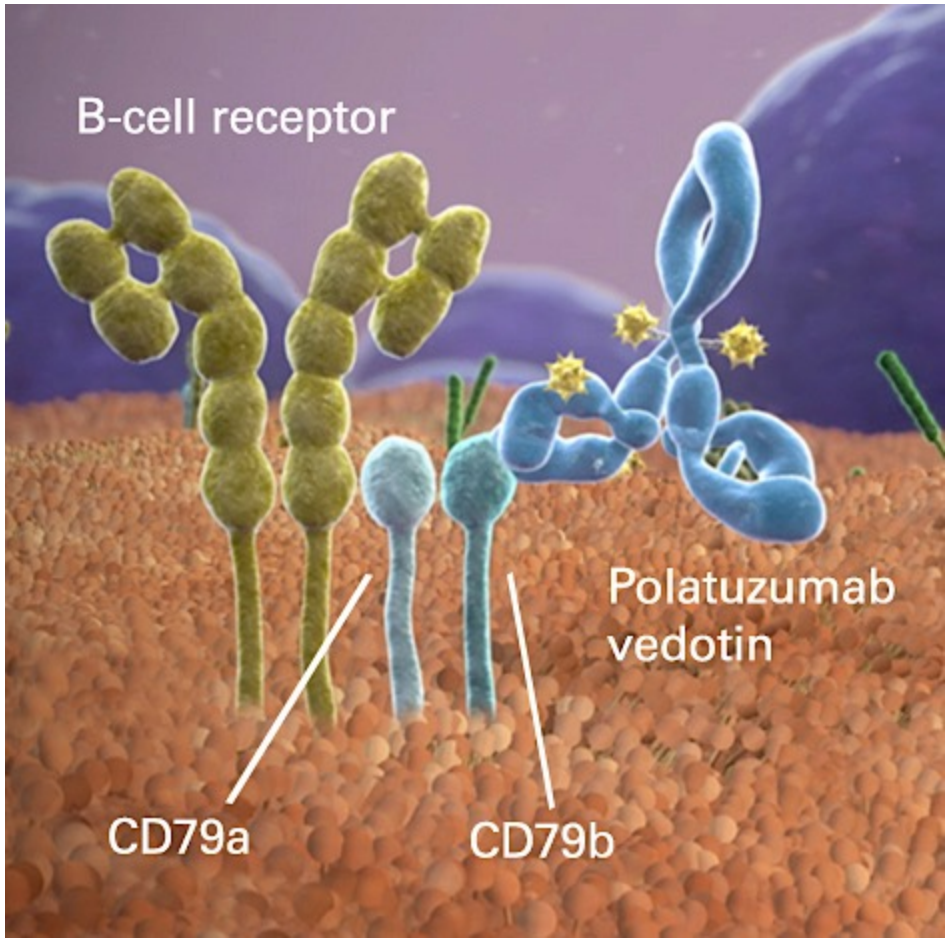
- Defines strategy for future CAR T development



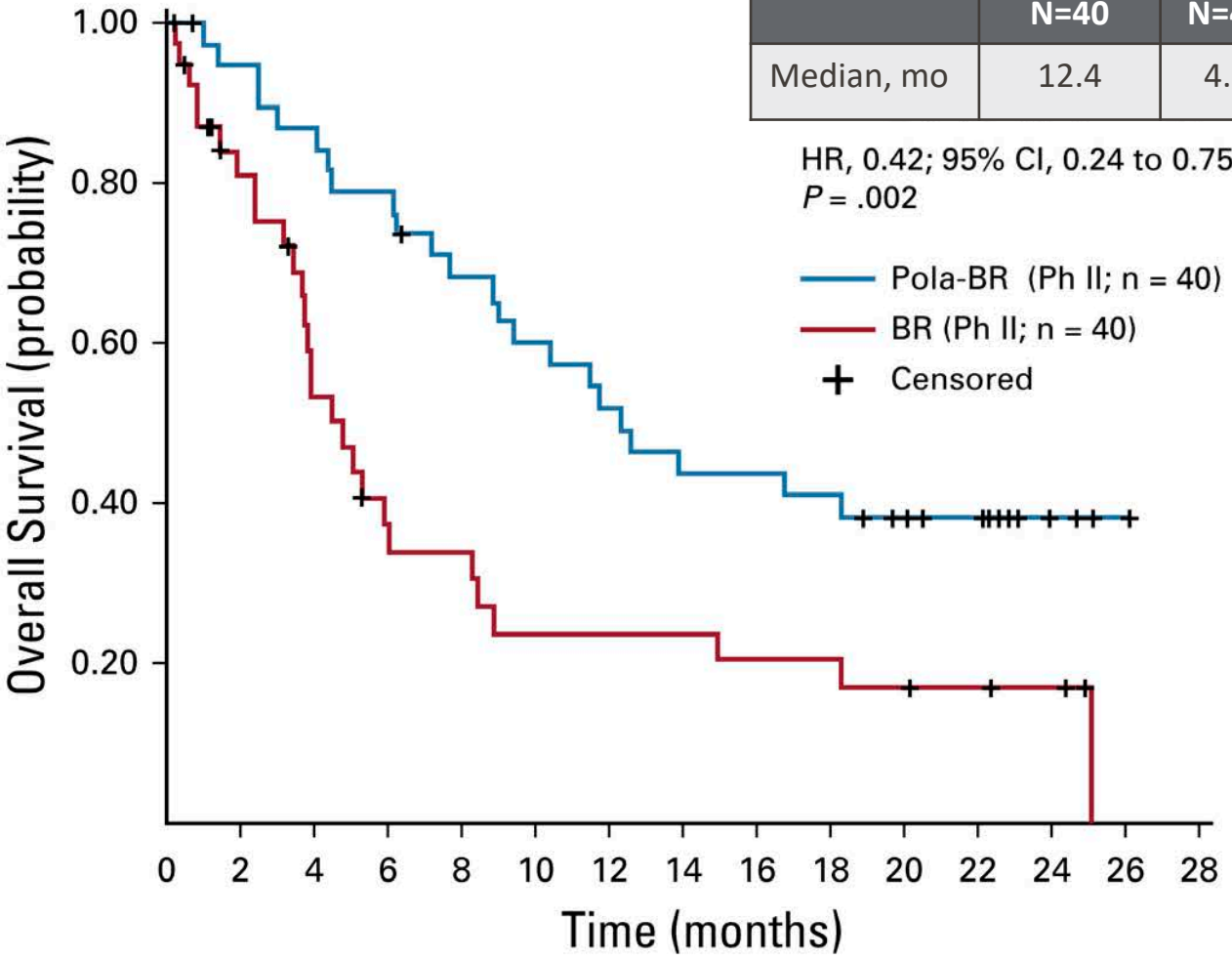
Li et al, ASH 2024

Polatuzumab Vedotin in Relapsed or Refractory Diffuse Large B-Cell Lymphoma *J Clin Oncol.* 2020

Laurie H Sehn, Alex F Herrera, Christopher R Flowers, Manali Kamdar, Andrew McMillan, Mark Hertzberg, Sarit Assouline, Tae Min Kim, Won Seog Kim, Muhit Ozcan, Jamie Hirata, Elicia Penuel, Elicia Penuel, Ji Cheng, Joseph N. Paulson, Grace Ku, Matthew Matasar

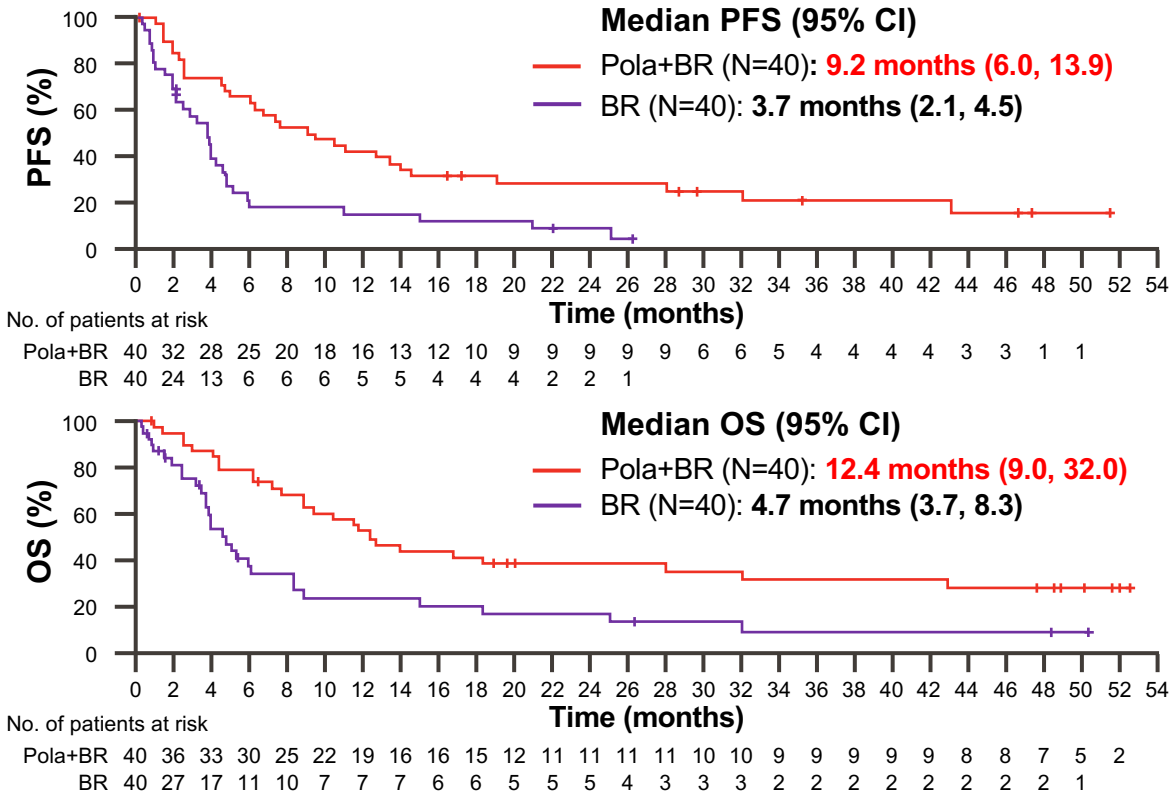


	Pola + BR N=40	BR N=40
Median, mo	12.4	4.7

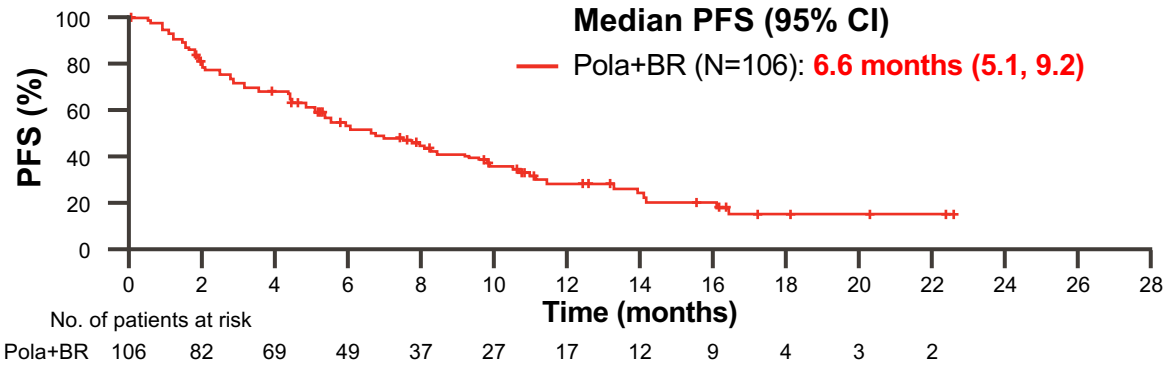


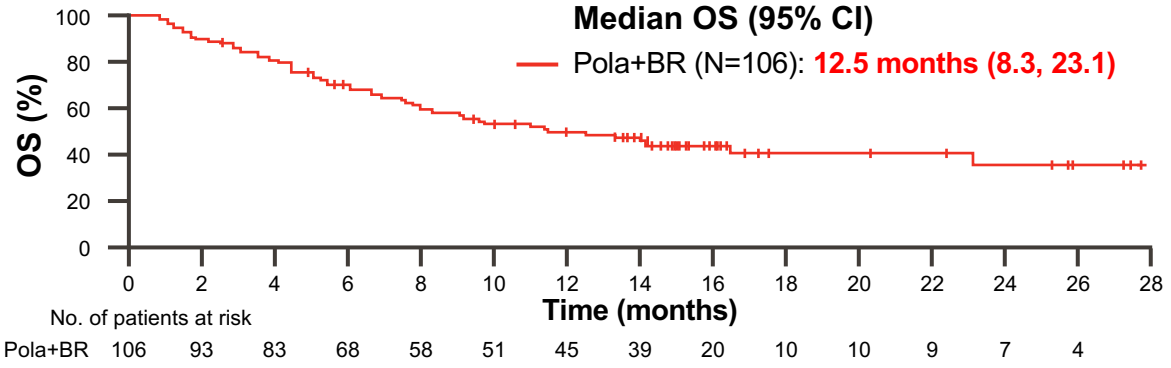
Pola-BR PFS and OS

Randomized



Extension cohort





- The significant survival benefit with Pola+BR persists with longer follow-up
- Response rates in the extension cohort consistent with the randomized Pola+BR arm
- The 2-year PFS 28.4% and the 2-year OS 38.2% for patients in the randomized Pola+BR cohort

Sehn LH et al. Blood Adv. 2022.

Pola BR Safety Summary

AE summary, n (%)	Randomized		Extension Cohort Pola+BR (N=106)	Pooled Pola+BR (N=151)
	BR (N=39)	Pola+BR (N=39)		
Any Grade AEs	38 (97.4)	39 (100)	105 (99.1)	150 (99.3)
Grade 3–4 AEs	28 (71.8)	34 (87.2)	83 (78.3)	122 (80.8)
SAEs	24 (61.5)	26 (66.7)	56 (52.8)	86 (57.0)
Grade 5 AEs	10 (25.6)	11 (28.2)	6 (5.7)	17 (11.3)

No new safety signals identified with longer follow-up in randomized arms + patients in the extension cohort

Common AEs, n (%)	Pooled Pola+BR (N=151)	
	Any grade	Grade 3–4
Hematological AEs		
Neutropenia	**56 (37.1)**	**49 (32.5)**
Thrombocytopenia	49 (32.5)	31 (20.5)
Anemia	49 (32.5)	19 (12.6)
Non-hematological AEs		
Infections and infestations	**74 (49.0)**	**33 (21.9)**
Diarrhea	54 (35.8)	6 (4.0)
Nausea	50 (33.1)	1 (0.7)
Pyrexia	44 (29.1)	2 (1.3)
Fatigue	40 (26.5)	3 (2.0)
Decreased appetite	39 (25.8)	4 (2.6)
AEs of special interest		
Peripheral neuropathy	**47 (31.1)**	**3 (2.0)**

Sehn LH et al. Blood Adv. 2022.

Selected Therapies Approved in R/R DLBCL

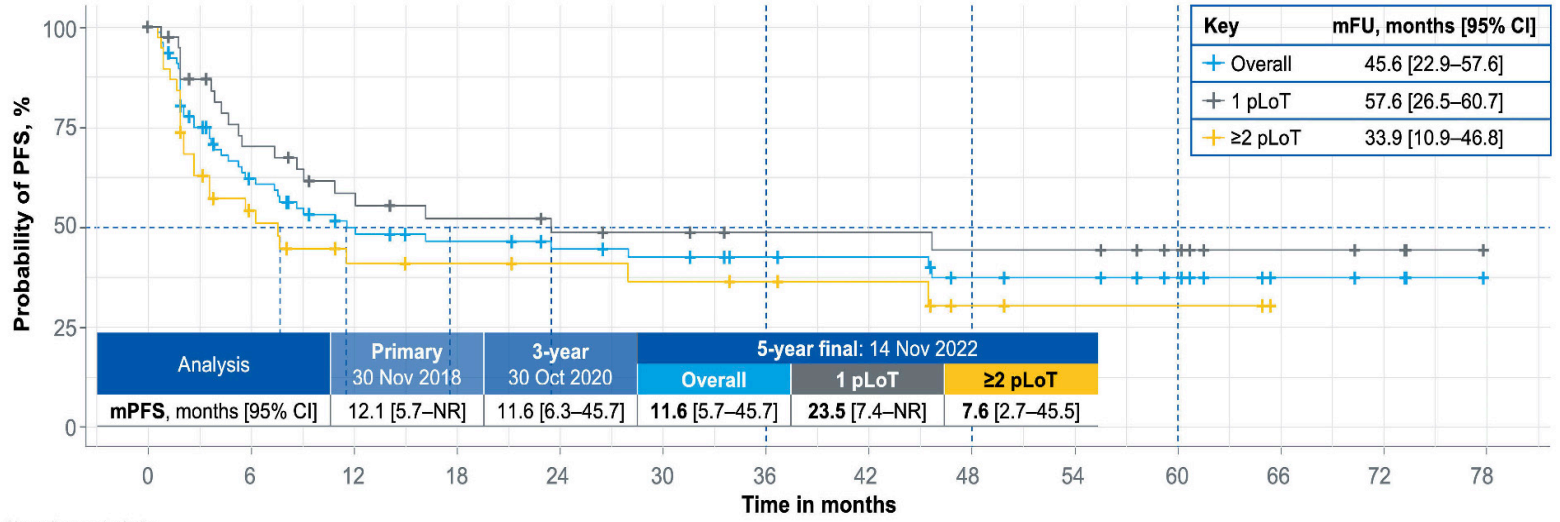
	Pola-BR	Selinexor	Tafasitamab/Lenalidomide	Loncastuximab Tesirine
MOA	Anti-CD79b ADC	XPO-1 inhibitor	Anti-CD19 mAb/Immunomodulator	Anti-CD19 ADC
ORR	45%	28%	58%	48%
CR rate	40%	12%	40%	24%
PFS	9.2 m	2.6 m	11.6 m	4.9 m
DOR	12.6 m	9.3 m	43.9 m	10.3 m
OS	12.4 m	9.1 m	33.5 m	9.9 m

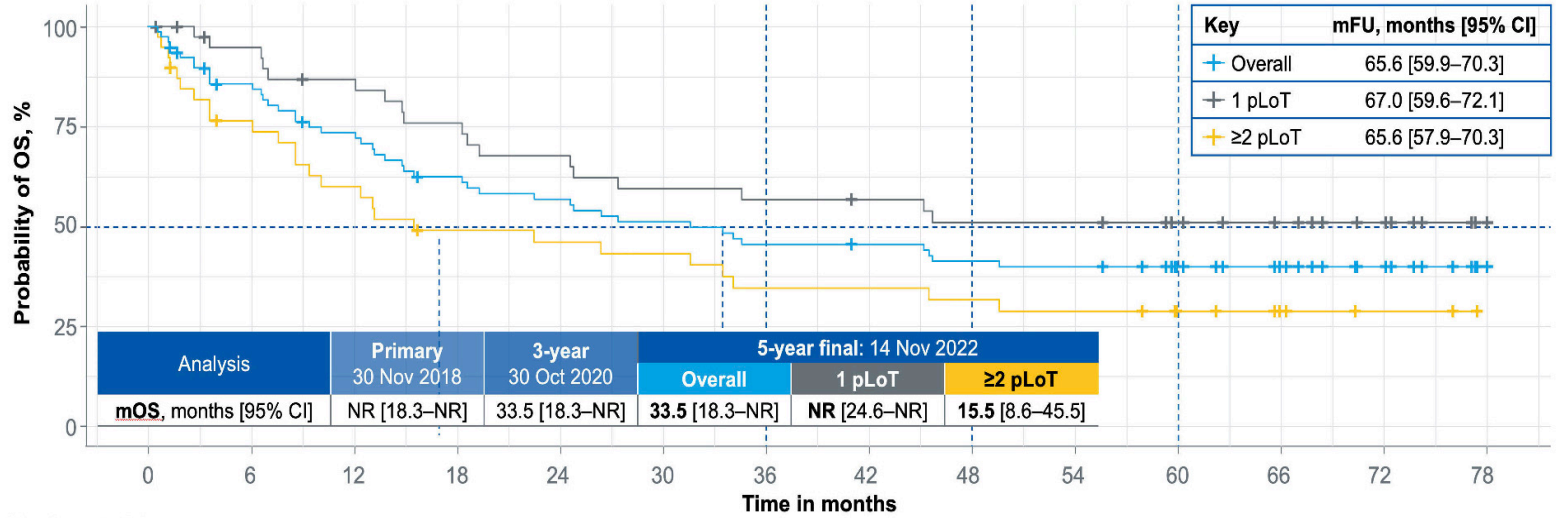
Novel salvage regimens may improve outcomes with ASCT

Sehn LH et al. *Blood Adv*. 2022;6(2):533-543.
Kalakonda N et al. *Lancet Haematol.* 2020;7(7):e511-e522.
Duell J et al. *Haematologica*. 2021;106(9):2417-2426.
Caimi PF et al. *Lancet Oncol.* 2021;22(6):790-800.

Tafasitamab + Lenalidomide: 5-year Outcomes

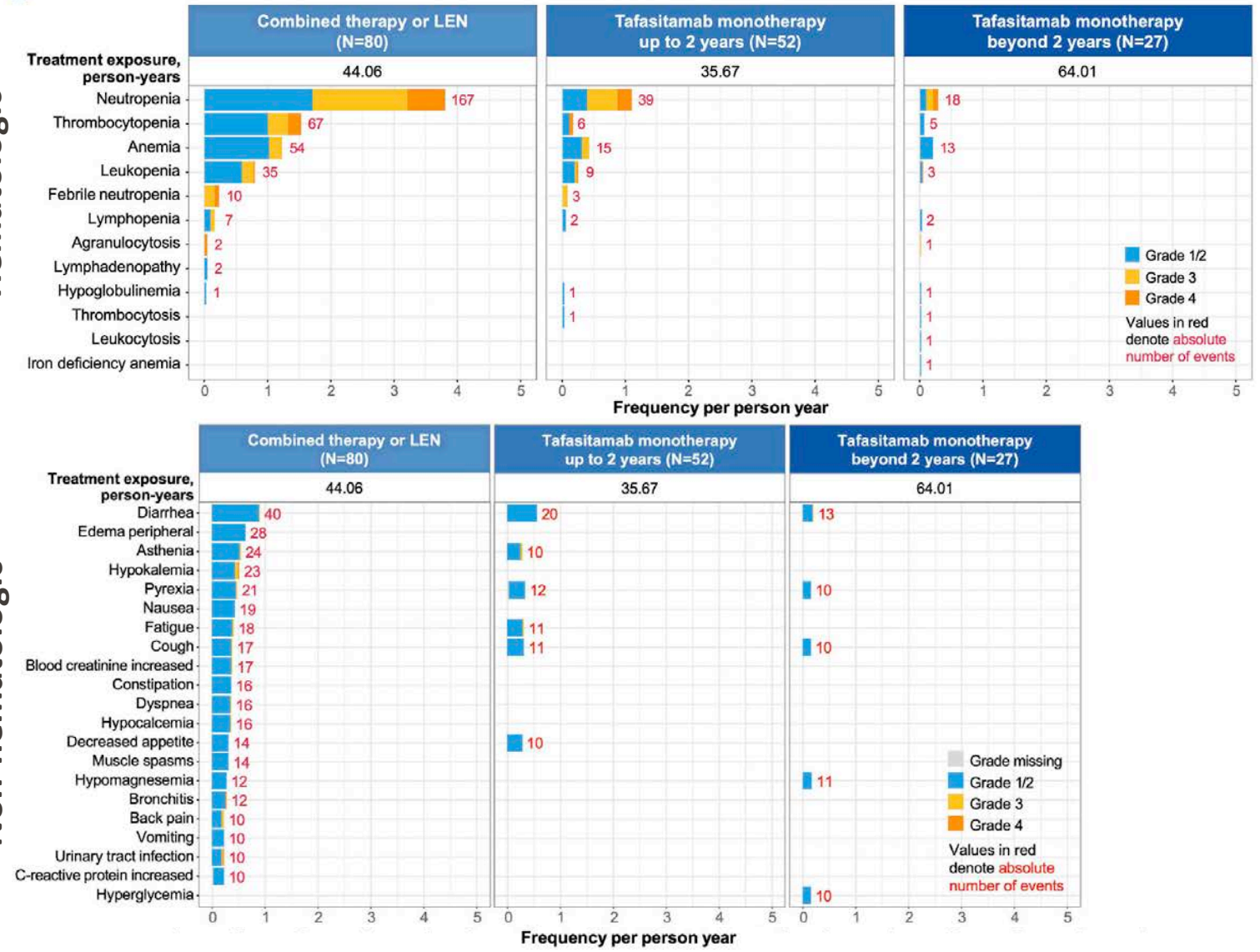
Final 5-year data	N = 80 (%)
Objective Response Rate	46 (57.5)
Complete Response	33 (41.3)
Partial Response	13 (16.3)





Duell J et al. *Haematologica.* 2024

Tafasitamab + Lenalidomide: 5-year Safety Summary



	All grades, N (%)	Grade ≥3, N (%)
Any TEAE	74 (91.4)	52 (64.2)
Hematologic		
Neutropenia	40 (49.4)	39 (48.1)
Anemia	30 (37.0)	6 (7.4)
Thrombocytopenia	23 (28.4)	13 (16.0)
Febrile neutropenia	10 (12.3)	10 (12.3)
Leukopenia	10 (12.3)	8 (9.9)
Non-hematologic		
Asthenia	21 (25.9)	2 (2.5)
Peripheral edema	20 (24.7)	0
Pyrexia	19 (23.5)	1 (1.2)
Fatigue	14 (17.3)	2 (2.5)
Diarrhea	30 (37.0)	1 (1.2)
Constipation	15 (18.5)	0
Nausea	12 (14.8)	0
Vomiting	12 (14.8)	0
Bronchitis	13 (16.0)	1 (1.2)
Urinary tract infection	11 (13.6)	2 (2.4)
Pneumonia	10 (12.3)	8 (9.9)
Respiratory tract infection	9 (11.1)	0
Decreased appetite	18 (22.2)	0
Hypokalemia	15 (18.5)	5 (6.2)
Cough	24 (29.6)	1 (1.2)
Dyspnea	11 (13.6)	2 (2.5)
Back pain	16 (19.8)	3 (3.7)
Muscle spasms	12 (14.8)	0
C-reactive protein increased	9 (11.1)	0

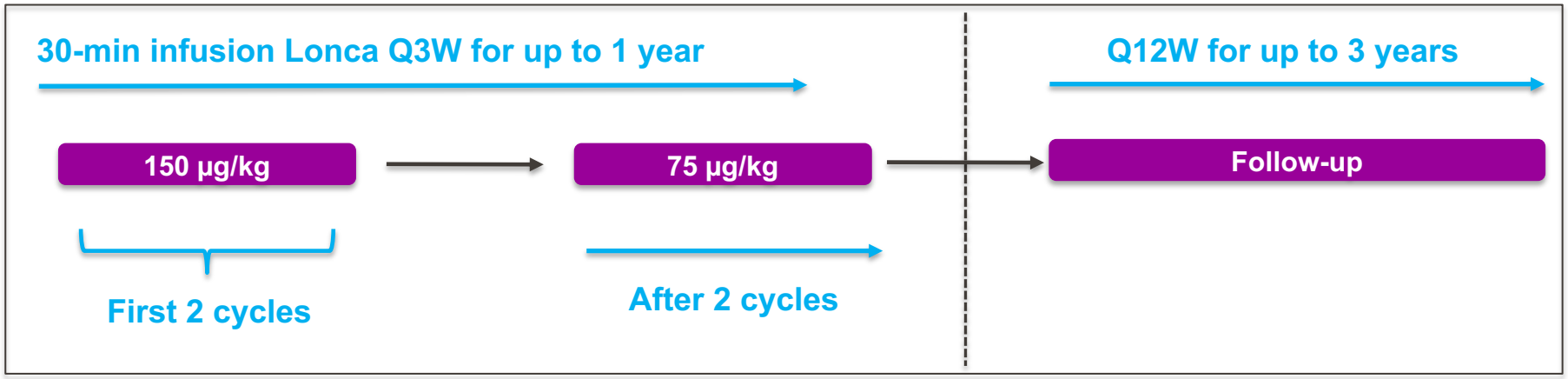
TEAE: treatment-emergent adverse event.

Duell J et al. *Haematologica.* 2024

Loncastuximab Tesirine: LOTIS-2 Trial
Single Arm Open Label Phase 2 Study in DLBCL

Patient population:
Patients with R/R DLBCL following ≥2 lines of prior systemic therapy

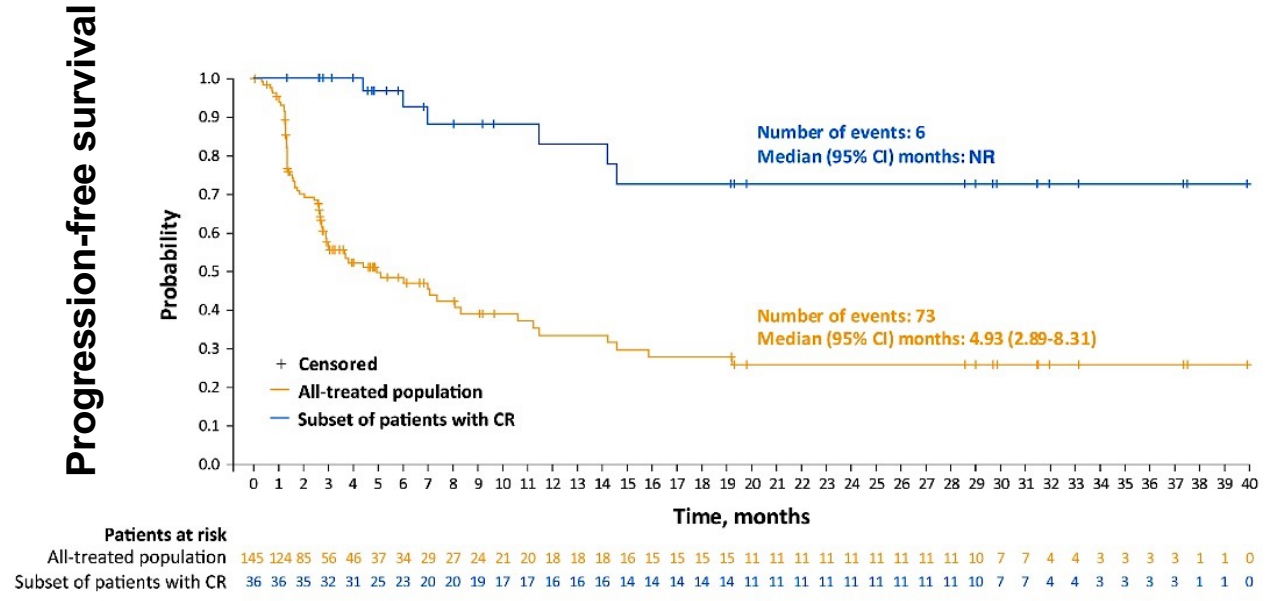
Primary objective:
Evaluate efficacy, **using ORR** (central review), and **safety** of the full Phase 2 study population

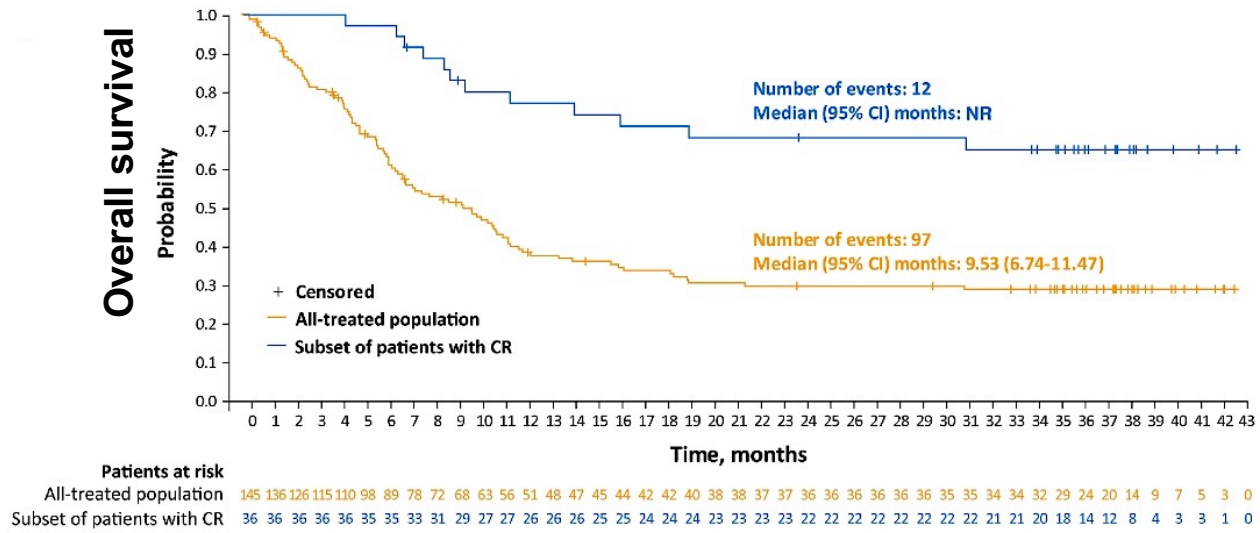


Lonca, loncastuximab tesirine; ORR, overall response rate; Q3W, every 3 weeks; Q12W, every 12 weeks; R/R, relapsed/refractory.

Caimi PF et al. *Lancet Oncol.* 2021

Loncastuximab Tesirine: Results





Caimi PF et al. Haematologica. 2024.

Loncastuximab Tesirine: Adverse Events

Adverse Event (AE)	Patients n (%)
Any Treatment Emergent AE	143 (98.6)
GGT increased	61 (42.1)
Neutropenia	58 (40.0)
Thrombocytopenia	48 (33.1)
Fatigue	40 (27.6)
Anemia	38 (26.2)
Nausea	34 (23.4)
Cough	33 (22.8)
Alkaline phosphatase increased	29 (20.0)
Peripheral Edema	29 (20.0)

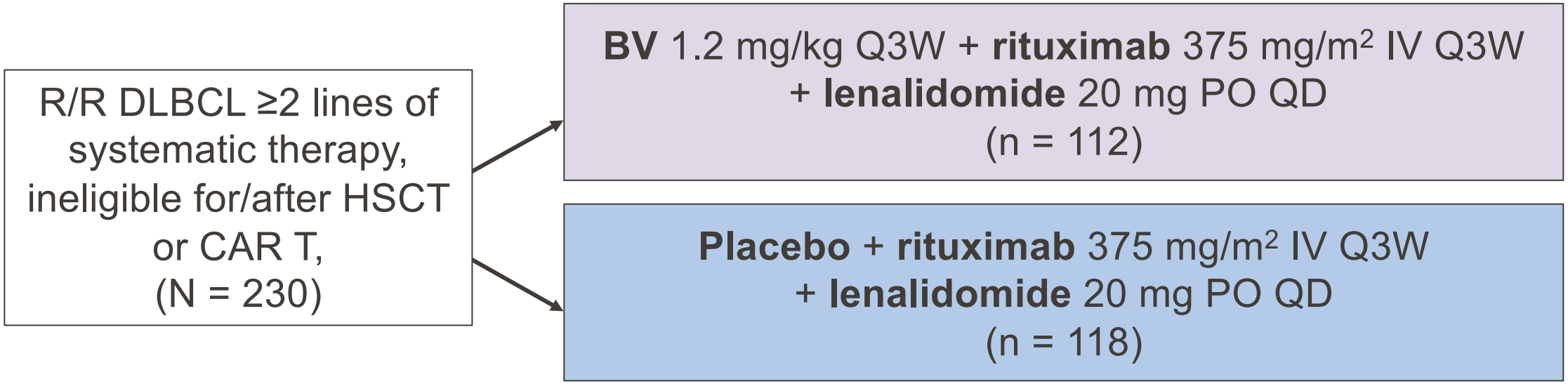
GGT, gamma glutamyltransferase ; SAEs, serious adverse events; TEAE, treatment-emergent adverse event..

TEAE leading to treatment discontinuation: 24.8%

Caimi PF et al. Haematologica. 2024.

ECHELON-3: Study Design

- Multicenter, double-blind, placebo-controlled, randomized phase 3 trial
- **Primary endpoint**: OS in ITT population

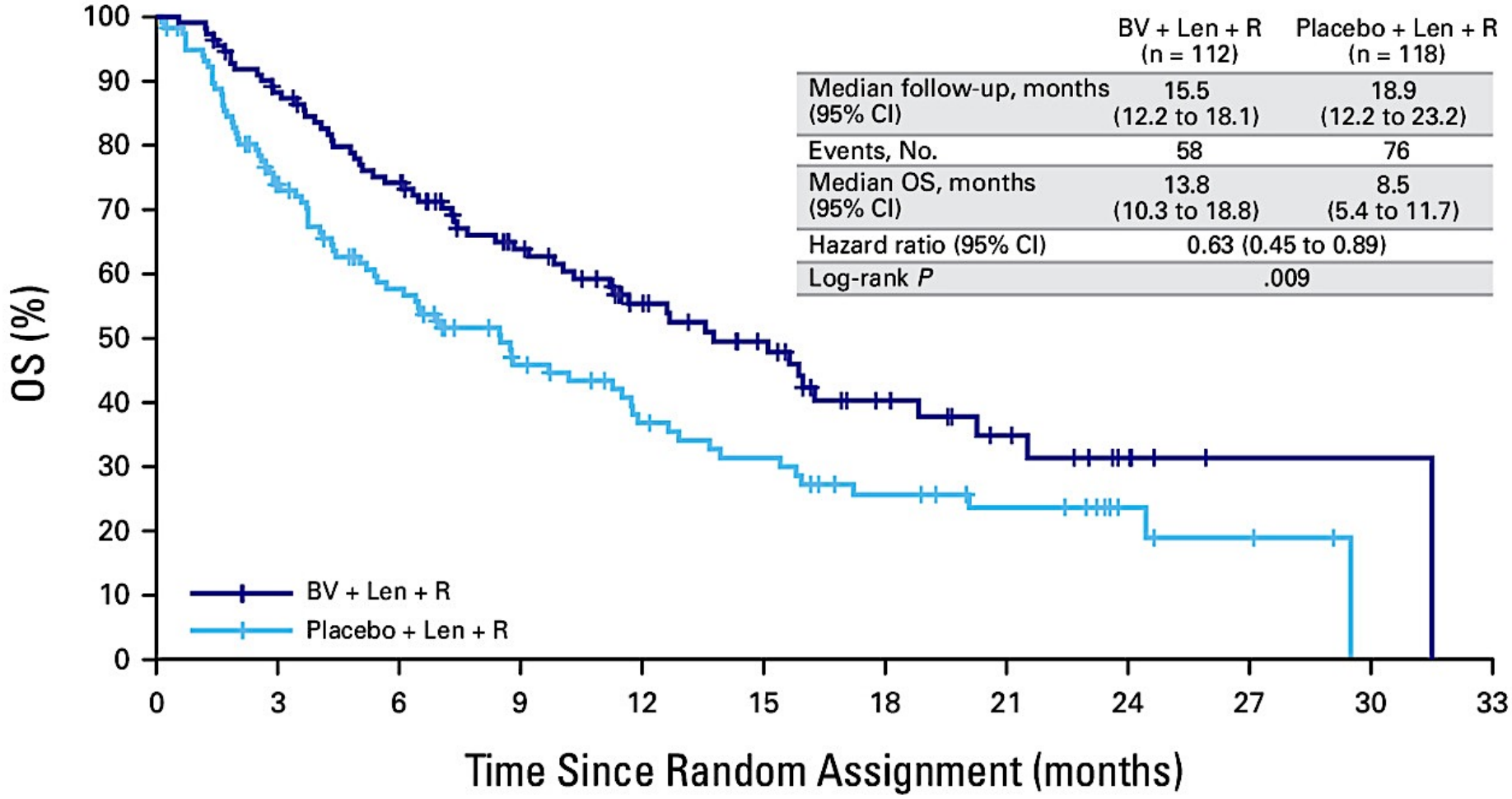


Stratification:

- CD30 status (≥1% vs <1%)
- Cell of origin (GCB vs non-GCB)
- Prior CAR T-cell therapy (yes vs no)
- Prior SCT (yes vs no)

Bartlett et al. J Clin Oncol 2025

ECHELON-3: Outcomes



	BV + Len + R (n = 112)	Placebo + Len + R (n = 118)
Median follow-up, months (95% CI)	15.5 (12.2 to 18.1)	18.9 (12.2 to 23.2)
Events, No.	58	76
Median OS, months (95% CI)	13.8 (10.3 to 18.8)	8.5 (5.4 to 11.7)
Hazard ratio (95% CI)	0.63 (0.45 to 0.89)	
Log-rank *P*	.009	

No. at risk:

BV + Len + R	112	96	79	57	40	30	17	11	5	1	1	0
Placebo + Len + R	118	81	58	39	28	23	16	12	5	3	0	0

Bartlett et al. J Clin Oncol 2025

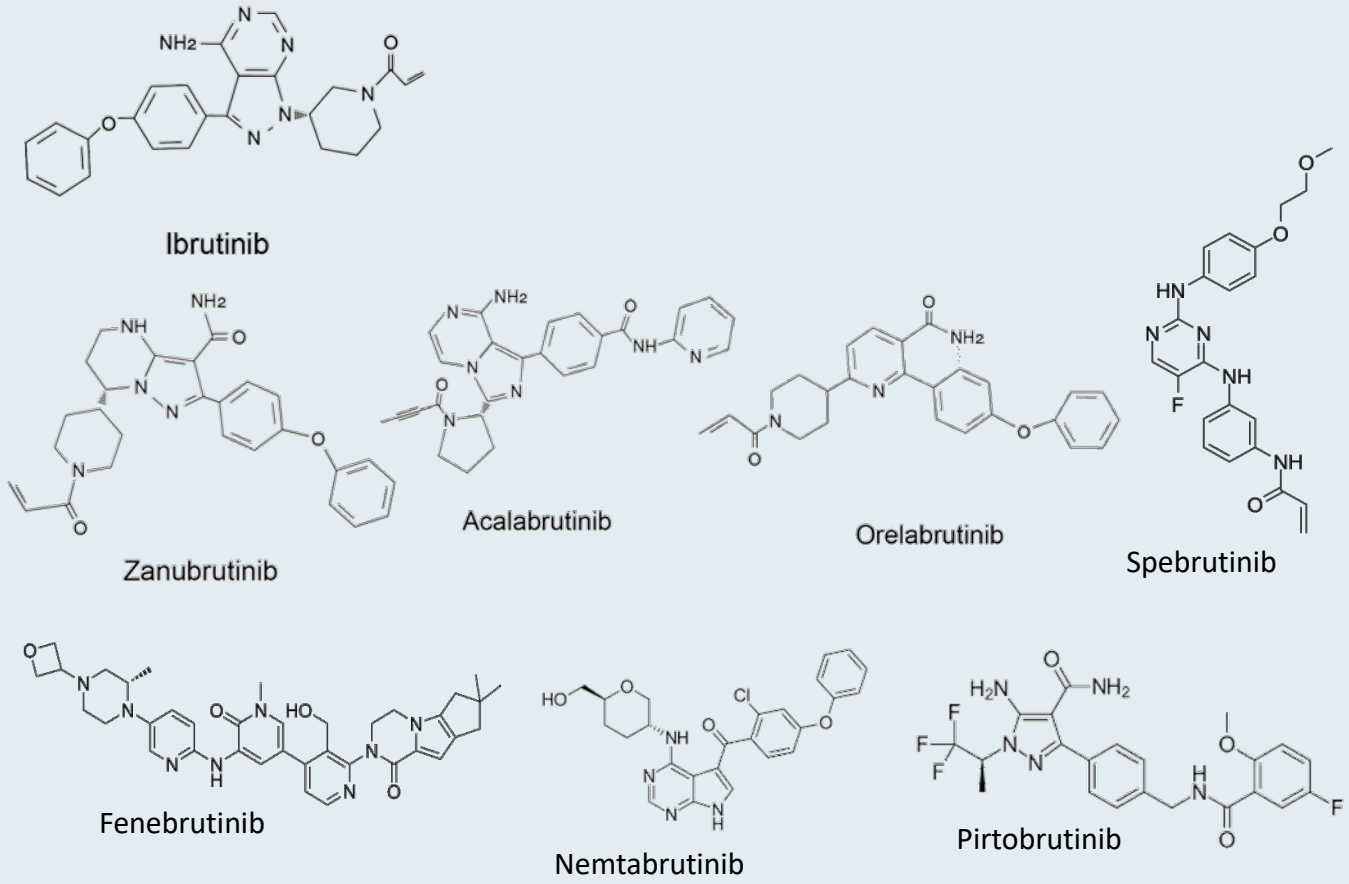
ECHELON-3: AEs

	BV + Len + R (n = 112), No. (%)		Placebo + Len + R (n = 116), No. (%)	
AE	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Any AE	109 (97)	99 (88)	113 (97)	89 (77)
Neutropenia	52 (46)	48 (43)	37 (32)	32 (28)
Thrombocytopenia	36 (32)	28 (25)	25 (22)	22 (19)
Diarrhea	35 (31)	5 (4)	27 (23)	2 (2)
Anemia	32 (29)	25 (22)	31 (27)	24 (21)
Fatigue	27 (24)	7 (6)	20 (17)	3 (3)
COVID-19	26 (23)	8 (7)	18 (16)	6 (5)
Asthenia	24 (21)	4 (4)	14 (12)	3 (3)
Peripheral sensory neuropathy	22 (20)	5 (4)	9 (8)	0
Pneumonia	19 (17)	12 (11)	8 (7)	6 (5)
Constipation	19 (17)	2 (2)	21 (18)	0
Decreased appetite	19 (17)	1 (1)	11 (9)	0
Nausea	17 (15)	1 (1)	19 (16)	1 (1)
Pyrexia	17 (15)	2 (2)	17 (15)	1 (1)
Hypokalemia	15 (13)	6 (5)	9 (8)	3 (3)
Febrile neutropenia	10 (9)	10 (9)	11 (9)	11 (9)
Neutropenia	9 (8)	9 (8)	7 (6)	7 (6)
COVID-19 pneumonia	8 (7)	8 (7)	4 (3)	4 (3)

Bartlett et al. J Clin Oncol 2025

BTK Inhibitors Under Investigation for DLBCL

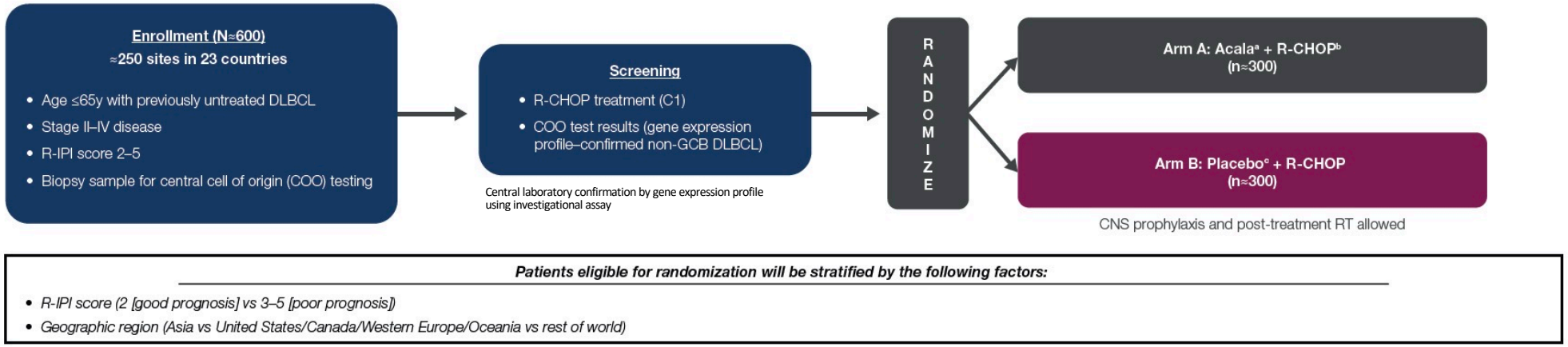
Inhibitor	Binding Mechanism	Clinical Trial Status (in DLBCL)
Ibrutinib	**First-generation, irreversible, covalent** binding to Cys481	Phase II
Acalabrutinib	**Second-generation, irreversible, covalent** binding to Cys481	Phase III
Zanubrutinib		Phase III
Orelabrutinib		Phase III
Spebrutinib		Phase I
Fenebrutinib	**Third-generation, reversible, non-covalent**, binding to both WT BTK and $BTK^{Cys481S}$mutant	Phase I
Pirtobrutinib		Phase I Phase II
Nemtabrutinib		Phase I/II



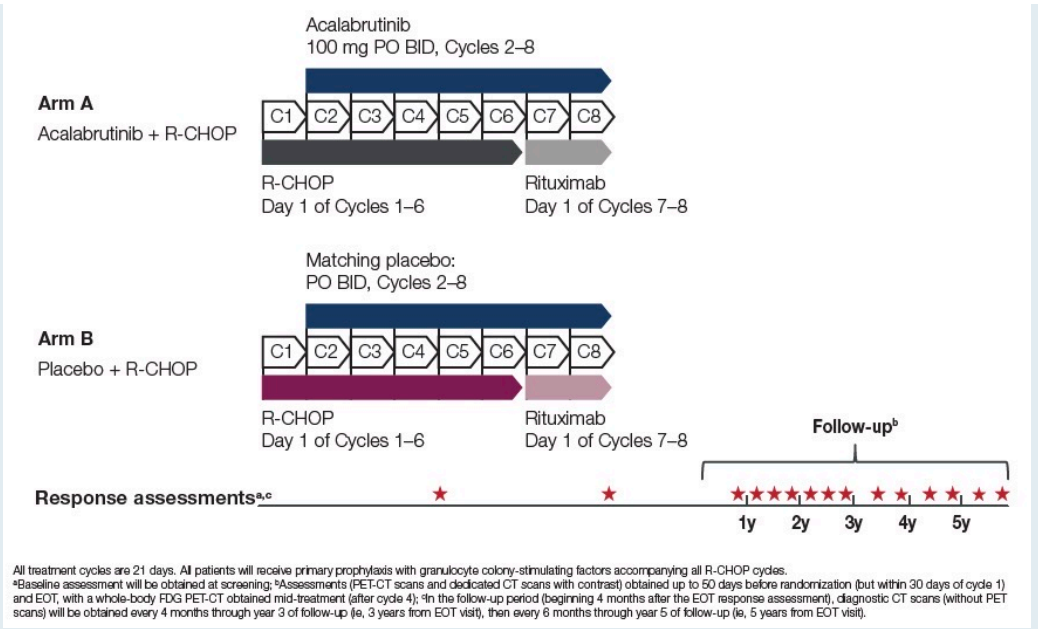
Alu A et al. J Hematol Oncol. 2022 Oct 1;15(1):138.
Mouhssine S et al. Int J Mol Sci. 2024 Mar 12;25(6):3234.

RTP RESEARCH TO PRACTICE

Phase III ESCALADE Study Design and Treatment Schedule



[a]Acalabrutinib 100 mg PO BID (C2 to C8); [b]R-CHOP (C2 to C8) then rituximab (C7 to C8); [c]Placebo PO BID (C2 to C8).



All treatment cycles are 21 days. All patients will receive primary prophylaxis with granulocyte colony-stimulating factors accompanying all R-CHOP cycles.
[a]Baseline assessment will be obtained at screening; [b]Assessments (PET-CT scans and dedicated CT scans with contrast) obtained up to 50 days before randomization (but within 30 days of cycle 1) and EOT, with a whole-body FDG PET-CT obtained mid-treatment (after cycle 4); [c]In the follow-up period (beginning 4 months after the EOT response assessment), diagnostic CT scans (without PET scans) will be obtained every 4 months through year 3 of follow-up (ie, 3 years from EOT visit), then every 6 months through year 5 of follow-up (ie, 5 years from EOT visit).

Sehn LH et al. ASCO 2021;Abstract TPS7572

Case Presentation: 51-year-old man with newly diagnosed GCB-type DLBCL (Stage IV) receives polatuzumab vedotin-R-CHP

Dr Victoria Giffi (Hagerstown, Maryland)

RTP
RESEARCH
TO PRACTICE

QUESTIONS FOR THE FACULTY

For which patients with newly diagnosed DLBCL are you prioritizing the use of polatuzumab vedotin/R-CHP?

Do you actively assess cell of origin for all of your patients with newly diagnosed DLBCL? Do you use cell of origin as a basis for selecting patients for treatment with polatuzumab vedotin/R-CHP? In your opinion, is the Hans algorithm that is used for molecular classification of DLBCL accurate enough to justify this practice?

Have you observed renal insufficiency in patients who have received polatuzumab vedotin/R-CHP as initial therapy? Are there any strategies to prevent its development?

QUESTIONS FOR THE FACULTY

What is your approach to the use of CNS prophylaxis for patients with DLBCL?

What other novel first-line strategies for DLBCL seem promising to you? In your opinion, is there a firm biologic rationale for the evaluation of BTK inhibitors as a component of first-line therapy for DLBCL, particularly for patients with non-GCB disease? When can we anticipate seeing results from the ESCALADE study, and do you have any predictions as to what they will show?

Case Presentation: 83-year-old woman with cardiac comorbidities and recurrent non-GCB DLBCL receives tafasitamab/lenalidomide

Dr Shachar Peles (Lake Worth, Florida)

RTP
RESEARCH
TO PRACTICE

QUESTIONS FOR THE FACULTY

How do you approach sequencing of polatuzumab vedotin/BR, tafasitamab/lenalidomide and loncastuximab tesirine relative to each other and to CAR T-cell therapy and bispecific antibodies in patients with R/R DLBCL? What factors do you consider when selecting among these regimens?

What has been your experience in terms of duration of response with tafasitamab/lenalidomide? How typical is this patient's experience? Are there any types of patients who might benefit more or less from treatment with tafasitamab/lenalidomide?

QUESTIONS FOR THE FACULTY

How do you approach patients who are having difficulty tolerating the lenalidomide component of tafasitamab/lenalidomide? Would you consider discontinuing therapy completely for this patient at some point, given her ongoing complete remission?

Case Presentation: 87-year-old woman with multiregimen-relapsed/refractory DLBCL receives loncastuximab tesirine with near CR but experiences fatigue and cutaneous toxicities

Dr Spencer Bachow (Boca Raton, Florida)

RTP
RESEARCH
TO PRACTICE

QUESTIONS FOR THE FACULTY

For which patients with R/R DLBCL would you prioritize the use of loncastuximab tesirine? Have you observed deep and durable responses with this agent in your own patients?

What are the most concerning tolerability issues you have encountered with loncastuximab tesirine? Have you encountered cutaneous toxicities as in this patient's case? Are there any prophylactic measures that can be taken to reduce the incidence of skin-related adverse events?

Would you consider discontinuing therapy with loncastuximab tesirine in patients who achieve a complete remission?

QUESTIONS FOR THE FACULTY

Do you believe it is reasonable to try multiple CD19-directed approaches for the same patient? Is there a minimum time you would wait after disease progression on one of these strategies before rechallenging with another CD19-targeted approach? Would you asses CD19 expression before doing so?

Agenda

MODULE 1: Selection and Sequencing of Available Therapies for Diffuse Large B-Cell Lymphoma — Dr Flowers

MODULE 2: Evolving Management Paradigm for Mantle Cell Lymphoma — Dr Phillips

MODULE 3: Integration of Novel Therapies into the Management of Follicular Lymphoma — Dr LaCasce

MODULE 4: Integrating Bispecific Antibodies into the Management of NHL — Dr Brody

MODULE 5: Current Role of CAR T-Cell Therapy in Various Non-Hodgkin Lymphoma (NHL) Subtypes — Dr Abramson

RTP RESEARCH TO PRACTICE

Evolving Landscape of Mantle Cell Lymphoma

Tycel Phillips, MD

Associate Professor

City of Hope

Outline

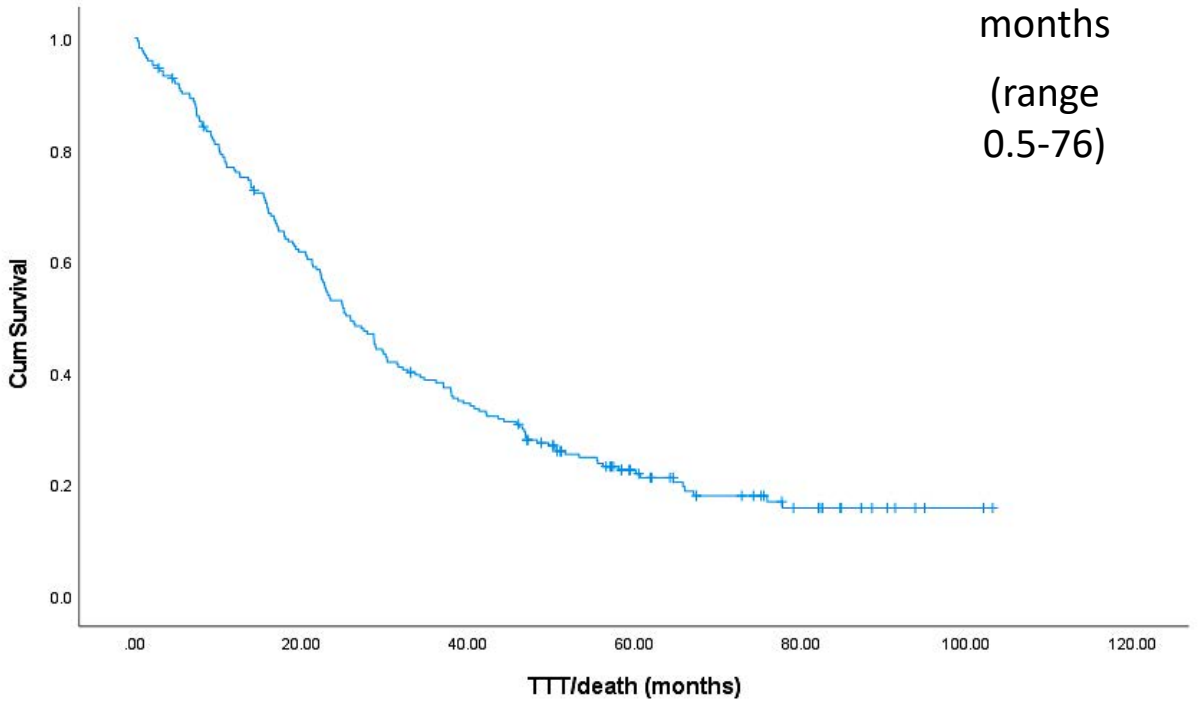
- Historical Treatment
- cBTKi in 1L MCL

Time to treatment amongst patients assigned to W&W

- 141 of 222 (64%) proceeded to treatment
- Only 13 (6%) received treatment within 6 months of diagnosis
- 49 (22%) remain under observation
- 32 (14%) did not proceed to treatment prior to death
- 116 (52%) were observed for over 2 years

Observation is Okay if patient asymptomatic…

Median TTT 21.3 months (range 0.5-76)



Mant et. al EHA 2024

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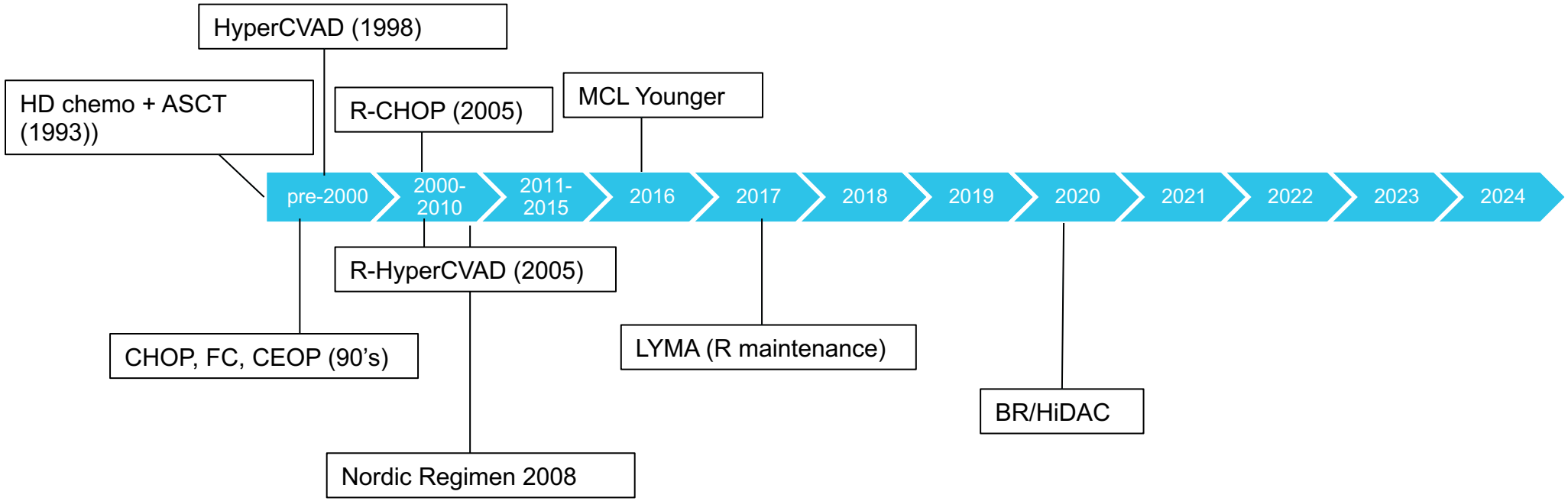
Young/Fit……Then

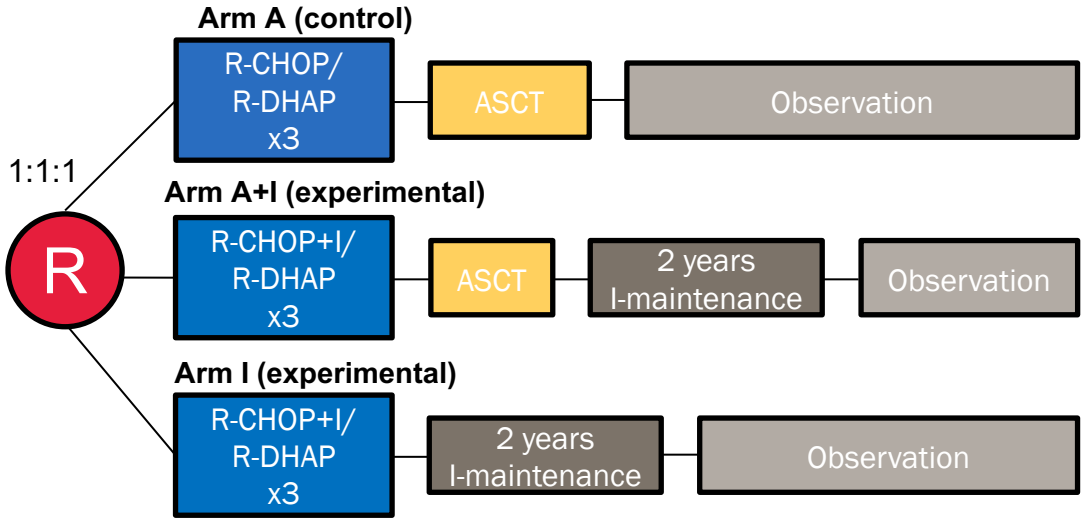


Age of Transplant

City of Hope

TRIANGLE Phase 3 Study of Ibrutinib + SOC as a Substitute for ASCT in Younger Patients With MCL: Study Design and Patients

Key Eligibility Criteria
- Previously untreated stage II-IV MCL
- Age <66 years
- Suitable for HA and ASCT
- ECOG PS 0-2



Primary endpoint: FFS
Secondary endpoints: Response rates, PFS, RD, OS, safety

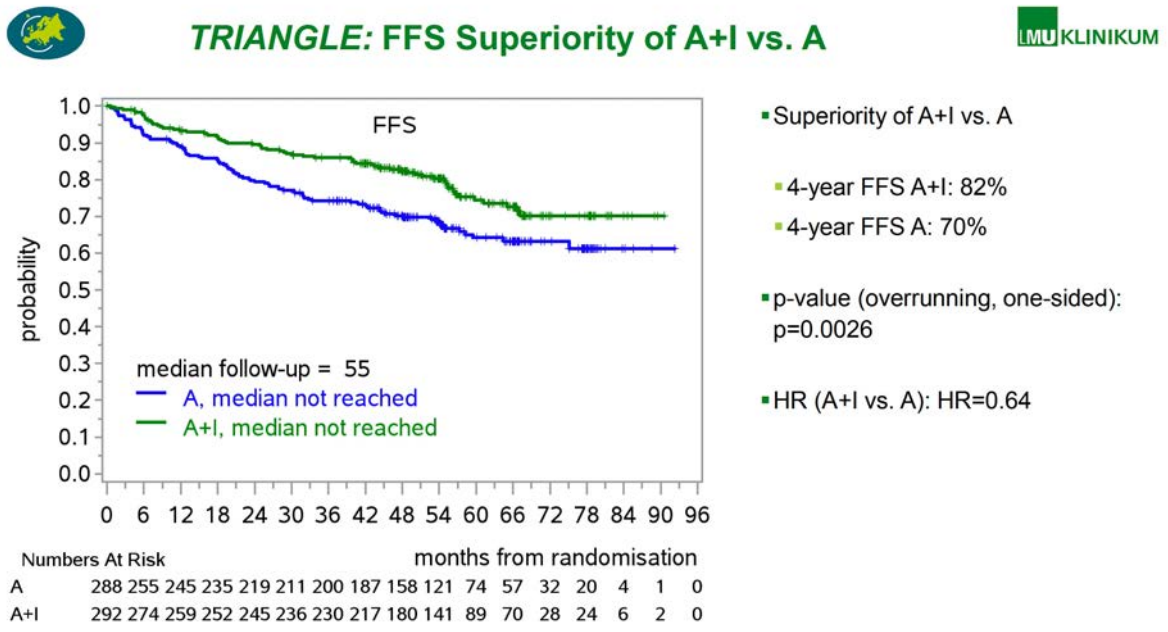
- R maintenance (± I) was added in all 3 trial arms, following national guidelines. It was initiated in 168 (58%) patients in Arm A; 165 (57%) patients in Arm A+I; and 158 (54%) patients in Arm I

[a]2 patients aged 66 & 68 years were randomized. [b]1 CLL, 1 FL. [c]1 NHL NOS, 1 HD, 2 MZL. [d]1 HCL, 1 DLBCL.
Dreyling M, et al. ASH 2022. Abstract 1.

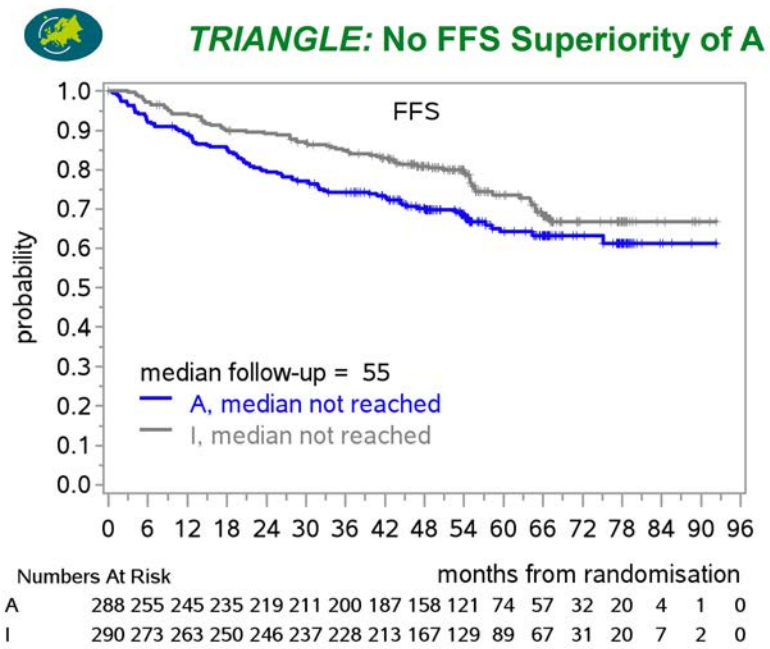
Dreyling M et al. *Lancet* 2024;403(10441):2293-2306.

City of Hope™

Failure Free Survival



- Superiority of A+I vs. A
  - 4-year FFS A+I: 82%
  - 4-year FFS A: 70%
- p-value (overrunning, one-sided): p=0.0026
- HR (A+I vs. A): HR=0.64



- Superiority of A vs. I rejected
  - 4-year FFS A: 70% (MCL Younger: 70%)
  - 4-year FFS I: 81%
- p-value (overrunning, one-sided): p=0.9890
- HR (A vs. I): HR=1.29
- Superiority of I (two-sided, retrospective) p=0.0208

Dreyling M et al. *Lancet* 2024;403(10441):2293-2306.

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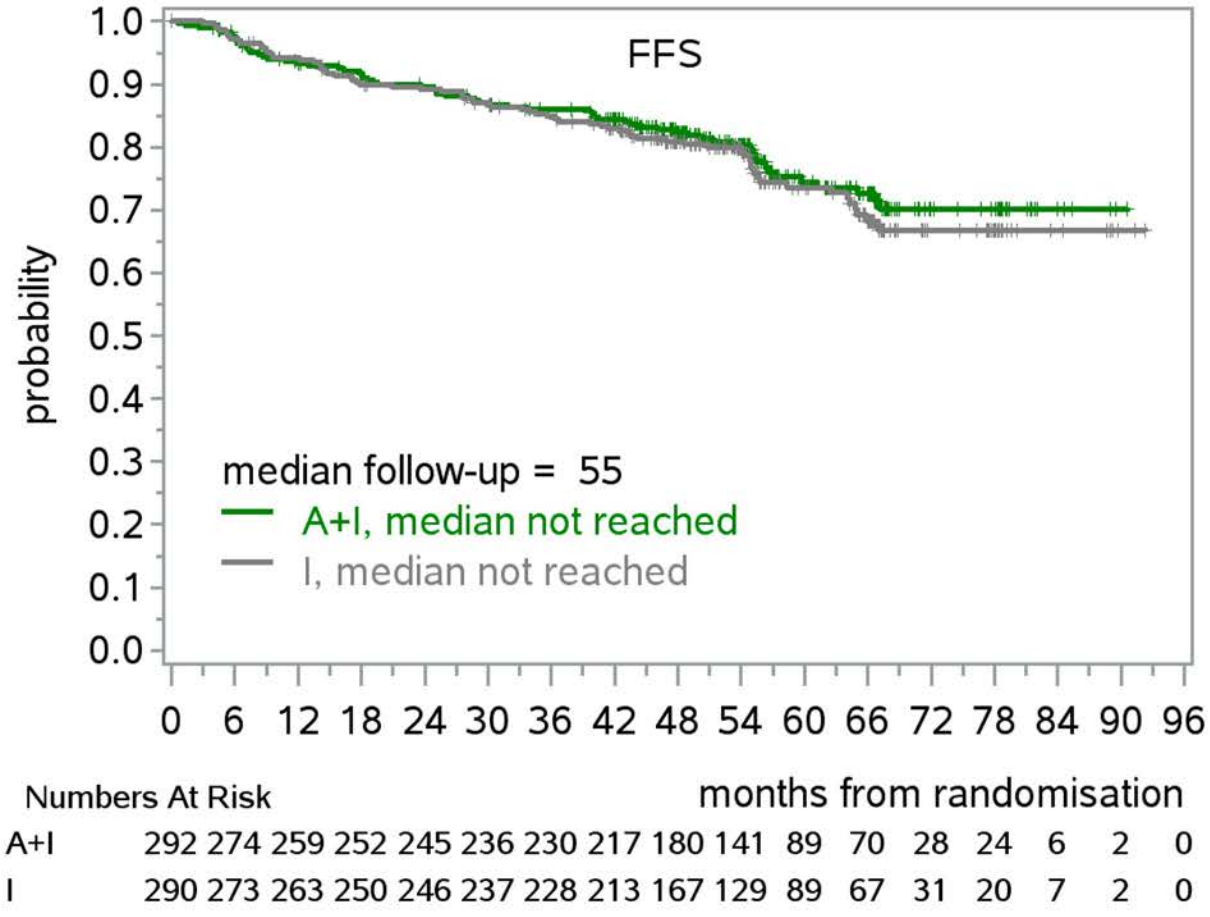
Is Transplant needed when using a BTKi in 1L?

TRIANGLE: FFS Superiority of A+I vs. I ?

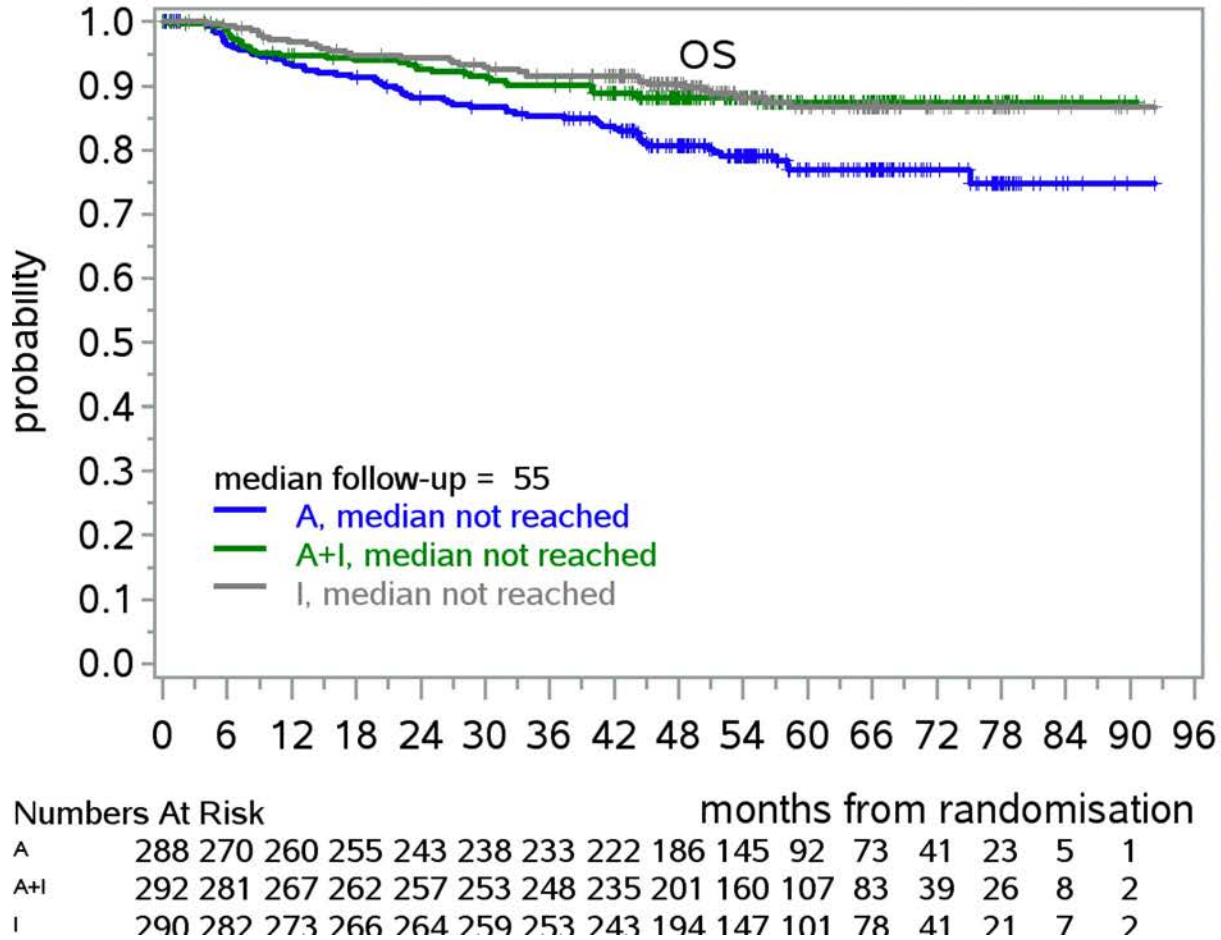


- Superiority of A+I vs. I rejected
  - 4-year FFS A+I: 82%
  - 4-year FFS I: 81%
- p-value (overrunning, one-sided): p=0.21
- HR (A+I vs. I): HR=0.83

Dreyling M et al. *Lancet* 2024;403(10441):2293-2306.

Survival

TRIANGLE: Overall survival



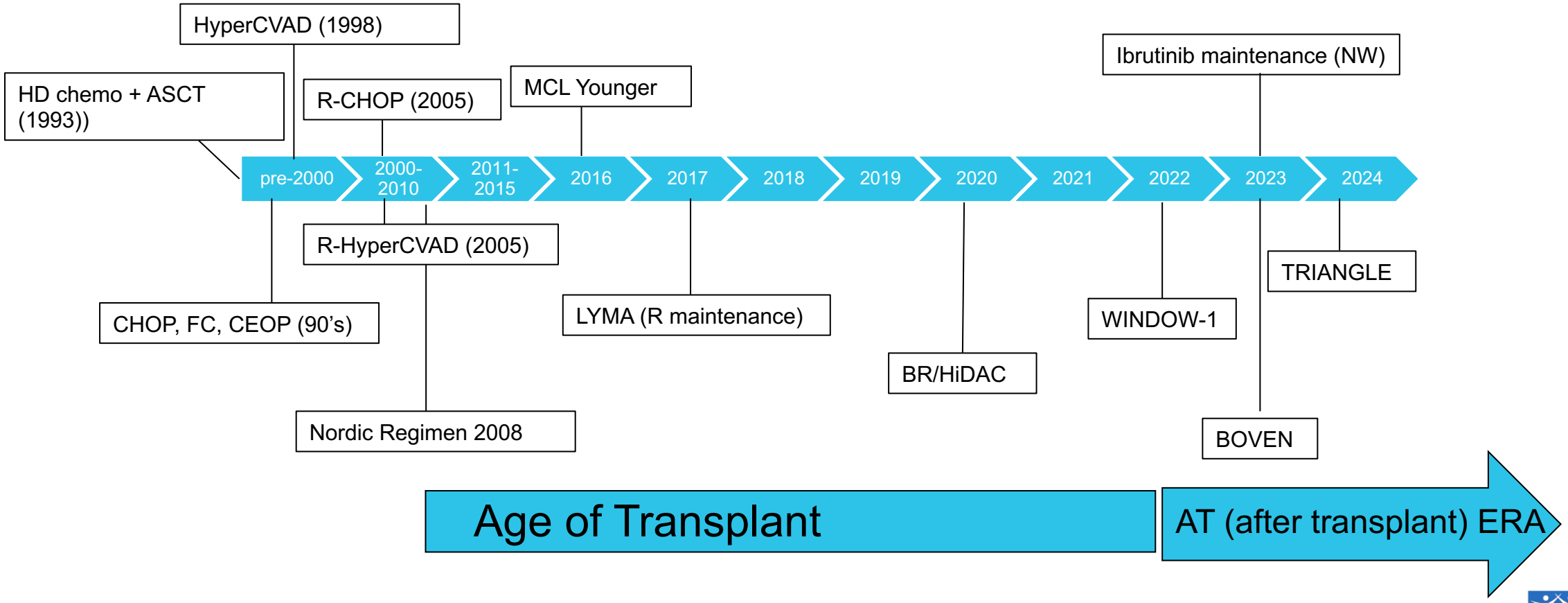
- 4-year OS:
  - A: 81%
    (MCL Younger exp.: 80%)
  - A+I: 88%
  - I: 90%

- two-sided test, (α = 5%):
  - A vs. I: p=0.0019, HR: 0.565
  - A vs. A+I: p=0.0036, HR I: 0.587
  - A+I vs. I: ongoing

Dreyling M et al. *Lancet* 2024;403(10441):2293-2306.

End of an ERA

Young/Fit……Now



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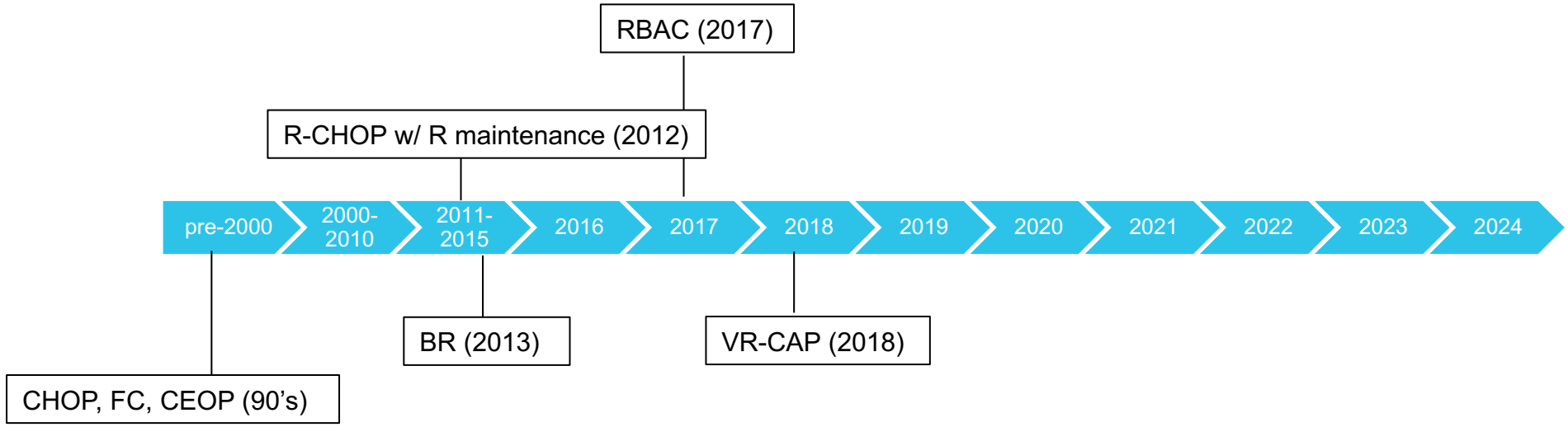
Older/Unfit……Then



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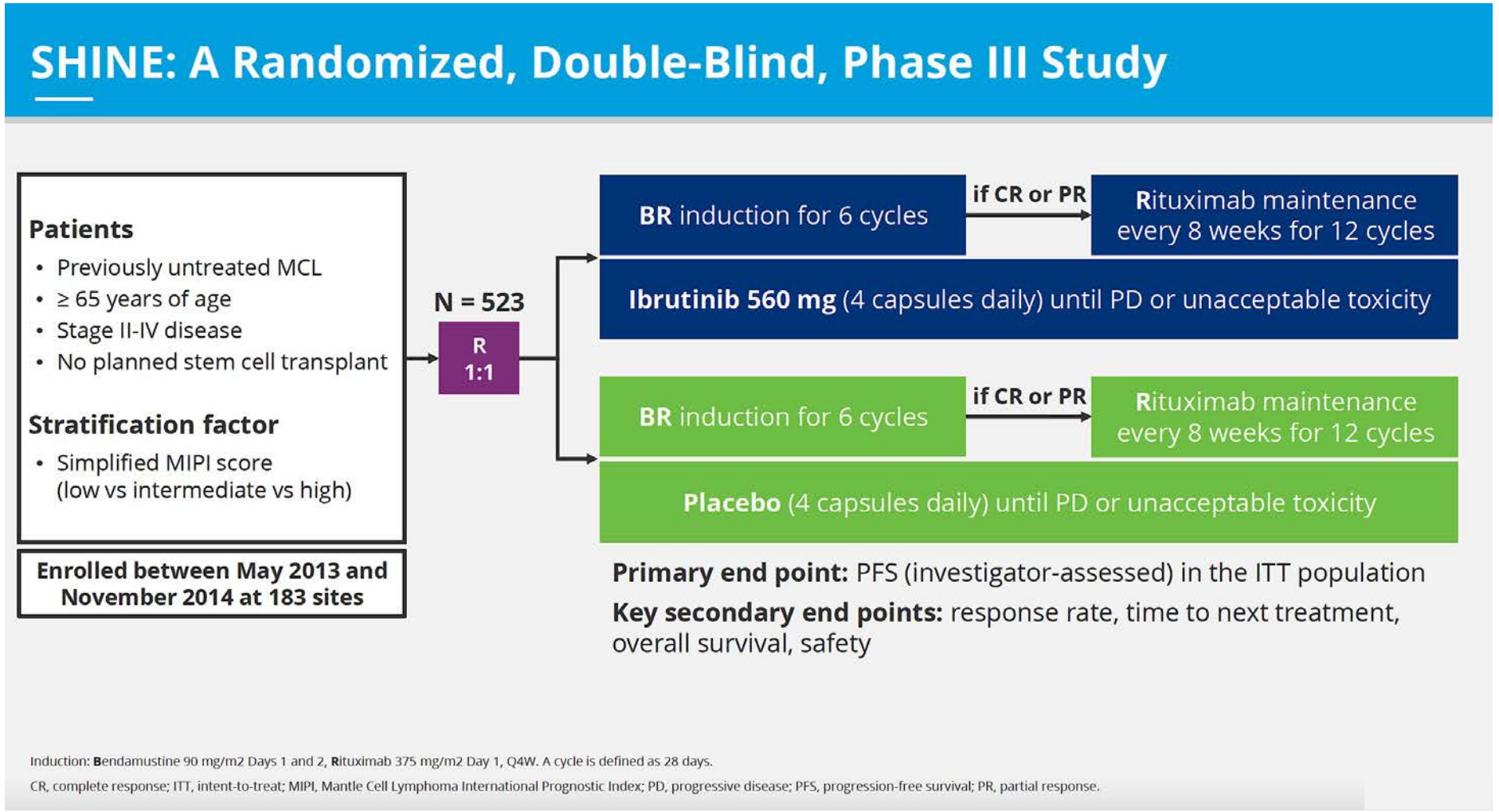
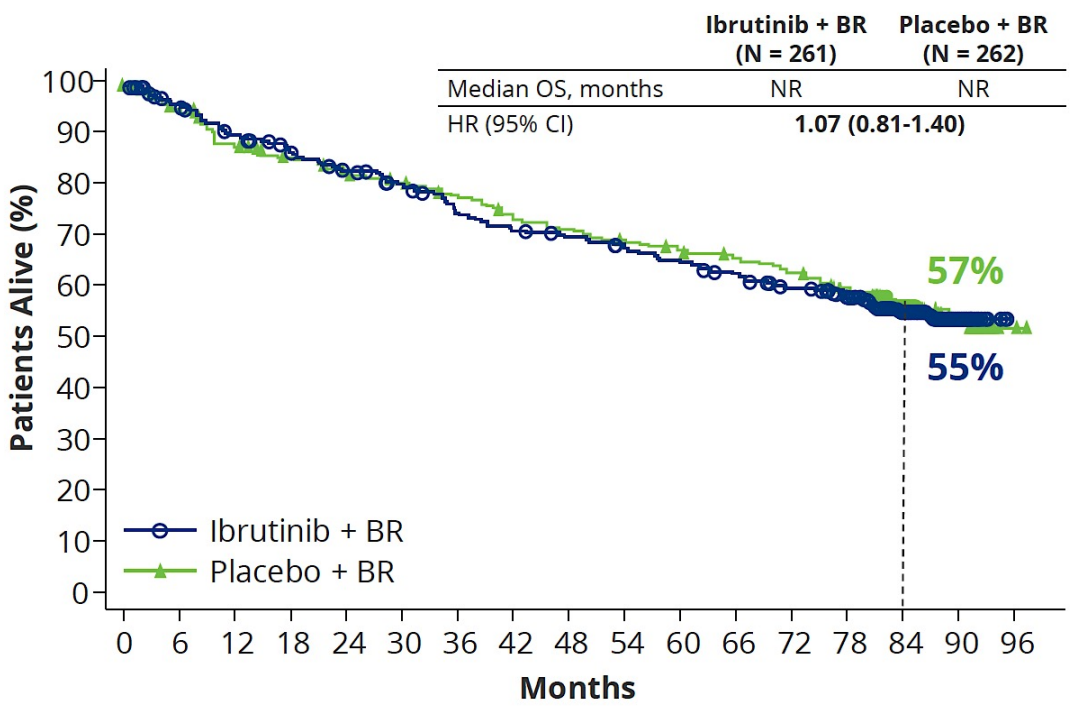
SHINE



Wang et al. ASCO 2022

City of Hope

SHINE OS = Diminished SHINE….



Patients at Risk

Ibrutinib + BR	261	239	221	208	197	187	171	163	158	152	145	138	128	118	70	25	0
Placebo + BR	262	244	223	212	203	197	188	177	171	165	159	154	147	137	90	31	2

Cause of death	Ibrutinib + BR (N = 261)	Placebo + BR (N = 262)
Death due to PD and TEAE	**58 (22.2%)**	**70 (26.7%)**
Death due to PD	**30 (11.5%)**	**54 (20.6%)**
Death due to TEAEs*	**28 (10.7%)**	**16 (6.1%)**
Death during post-treatment follow-up excluding PD and TEAEs	**46 (17.6%)**	**37 (14.1%)**
Total deaths	**104 (39.8%)**	**107 (40.8%)**

- Death due to Covid-19: 3 patients in the ibrutinib arm during the TEAE period and 2 patients in the placebo arm after the TEAE period
- Exploratory analysis of cause-specific survival including only deaths due to PD or TEAEs showed an HR of 0.88

*The most common grade 5 TEAE was infections in the ibrutinib and placebo arms: 9 versus 5 patients. Grade 5 TEAE of cardiac disorders occurred in 3 versus 5 patients, respectively.
CI, confidence interval; HR, hazard ratio; NR, not reached; PD, progressive disease; TEAE, treatment-emergent adverse event.

Wang et al. ASCO 2022

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ENRICH

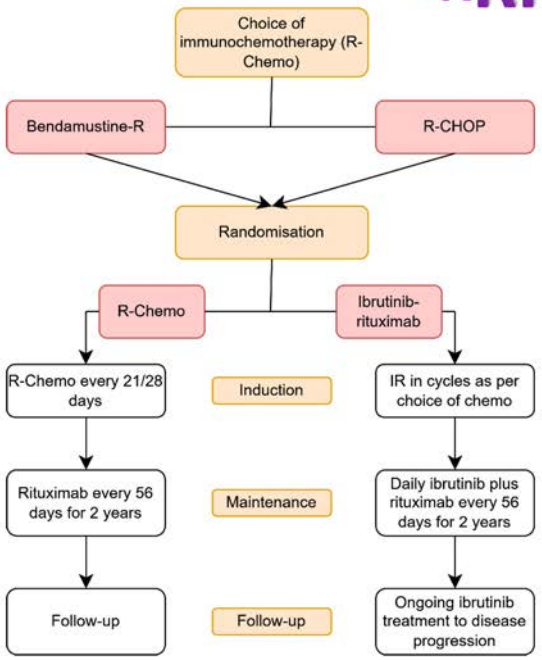
Trial design

Inclusion criteria
- 60 years or older
- Pathologically confirmed MCL, including either cyclin D1 overexpression or t(11;14)(q13;q32)
- Previously untreated, measurable (>1.5cm), stage II-IV MCL in need of treatment
- ECOG 0-2

Exclusion criteria
- Considered fit for stem cell transplantation
- CNS involvement
- Known serological positivity for HBC/HCV/HIV

Rituximab 375mg/m^2
Ibrutinib - 560mg od
Bendamustine 90mg/m^2 D1+D2 of 28 day cycle
CHOP - (Cyclophosphamide 750mg/m^2, Doxorubicin 50mg/m^2, Vincristine 1.4mg/m^2, Prednisolone 100mg *5 days) 21 day cycle
Maintenance rituximab - 1400mg sc every 56 days

ENRICH



ENRICH

Study design and statistical assumptions

Primary endpoint:

Progression-free survival

Primary analysis:

Test for superiority at the one-sided 2.5% level for progression-free survival, adjusting for the pre-randomisation investigator-choice of chemotherapy

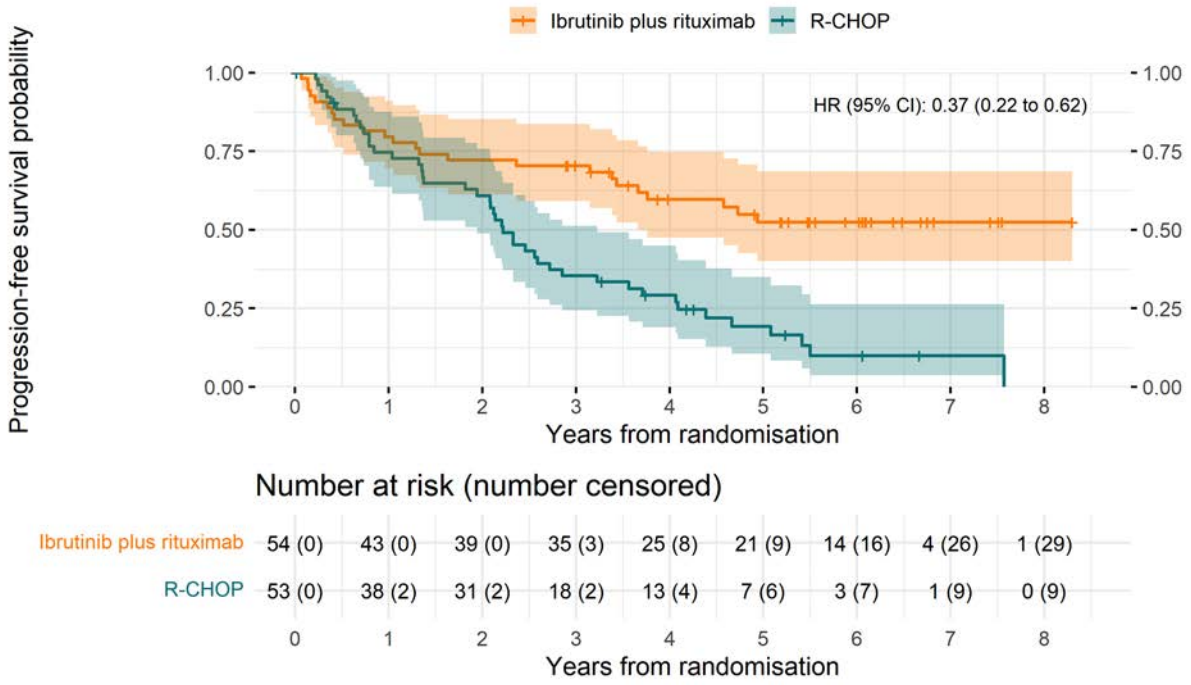
Planned sample size of 400 participants

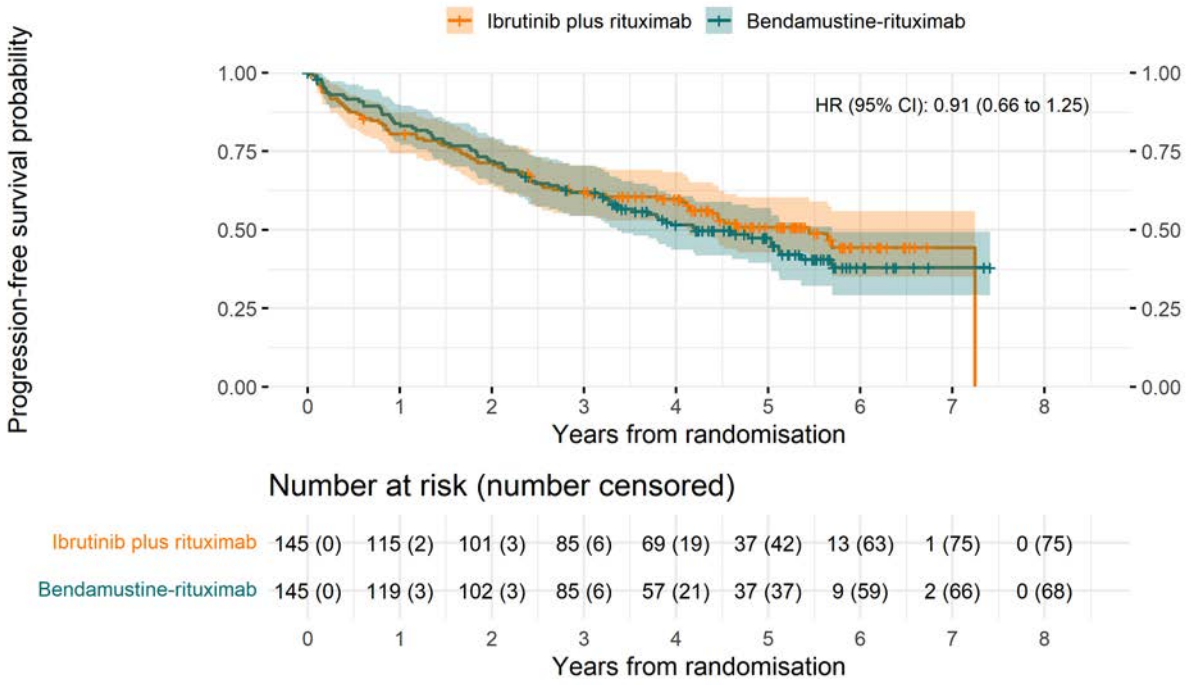
The sample size was determined to have 90% power for a hazard ratio of 0.67, assuming a recruitment rate of 100 patients per year, follow-up after recruitment phase for three years, and losses to follow-up at a rate of 0.05 a year

Lewis et al. ASH 2024

Progression-free survival

ENRICH





5-year PFS (95% CI)
IR: 52.4% (40.0% to 68.6%)
R-CHOP: 19.2% (10.6% to 35.1%)

5-year PFS (95% CI)
IR: 50.8% (42.8% to 60.4%)
BR: 47.4% (39.5% to 56.9%)

the MIRACLE of SCIENCE with SOUL City of Hope

Lewis et al. ASH 2024

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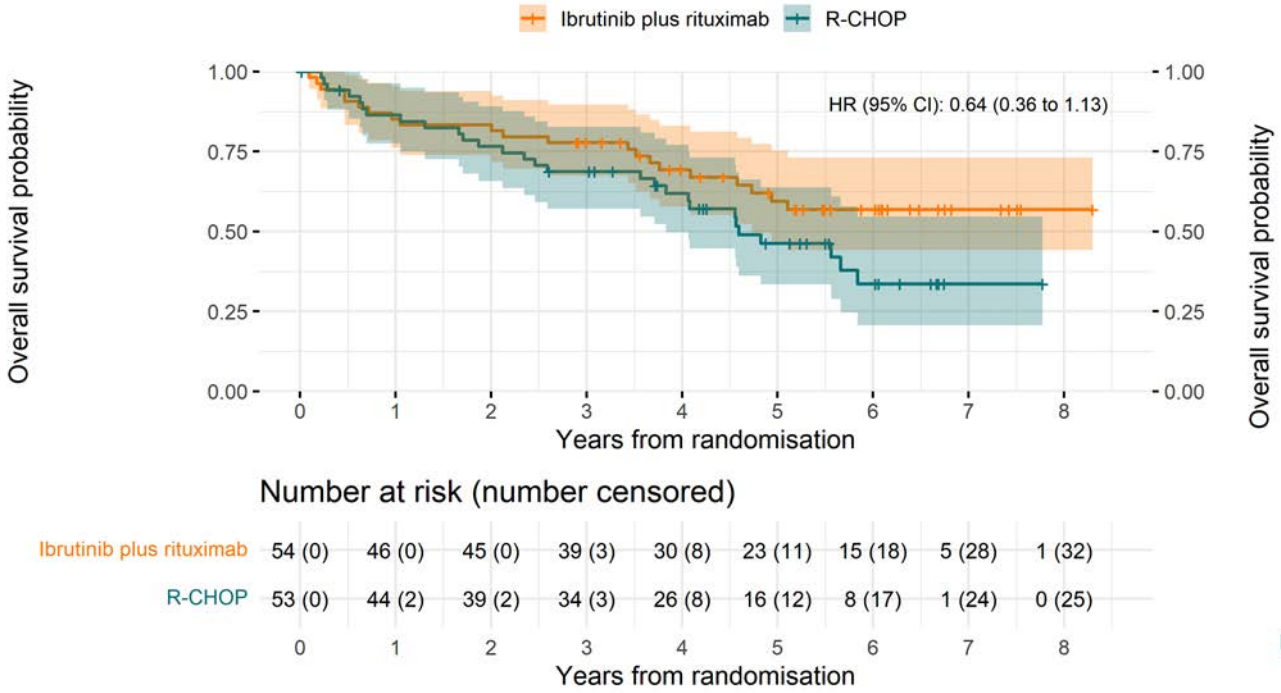
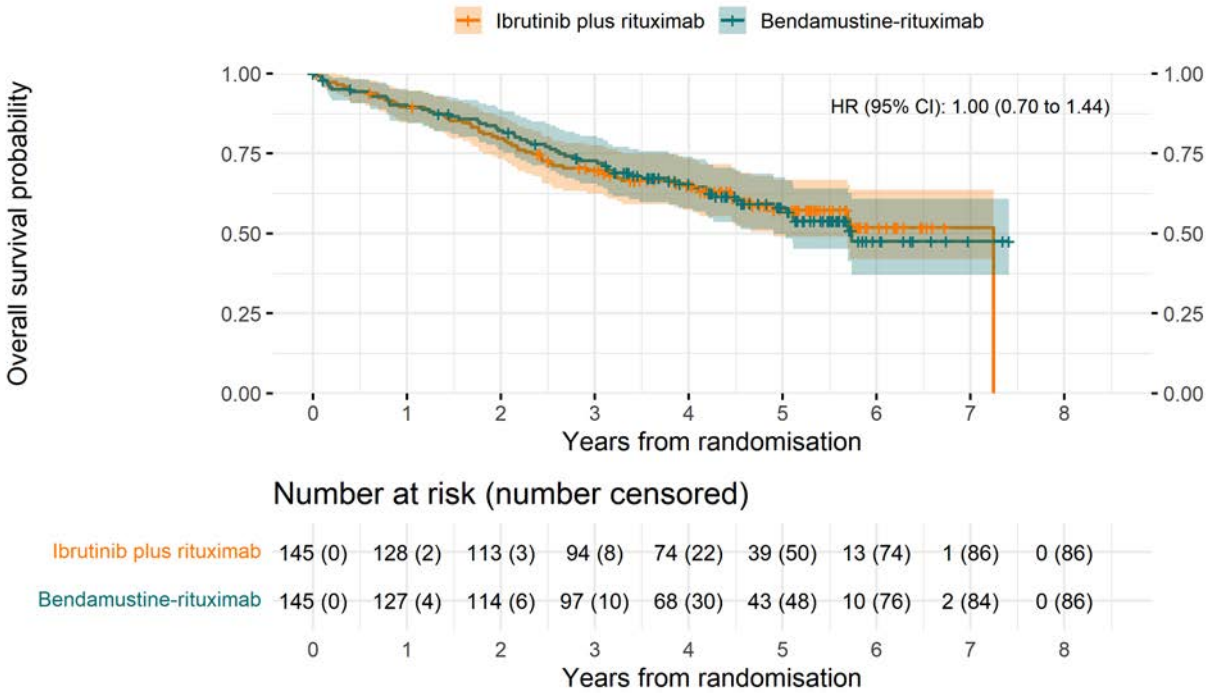
Overall survival



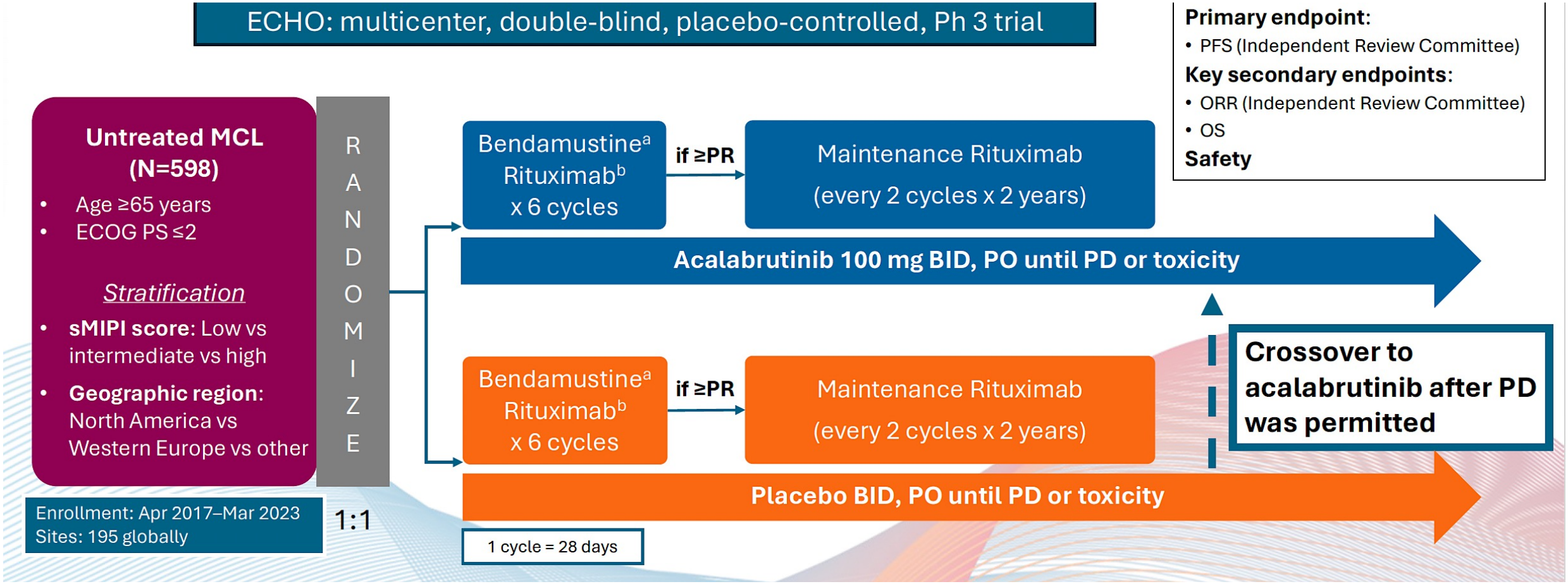
5-year OS (95% CI)
IR: 59.4% (46.9% to 75.3%)
R-CHOP: 46.3% (33.5% to 63.8%)



5-year OS (95% CI)
IR: 57.2% (49.0% to 66.8%)
BR: 58.1% (49.9% to 67.6%)

Lewis et al. ASH 2024

Acalabrutinib plus bendamustine and rituximab in untreated mantle cell lymphoma (MCL): Results from the phase 3, double-blind, placebo-controlled ECHO trial

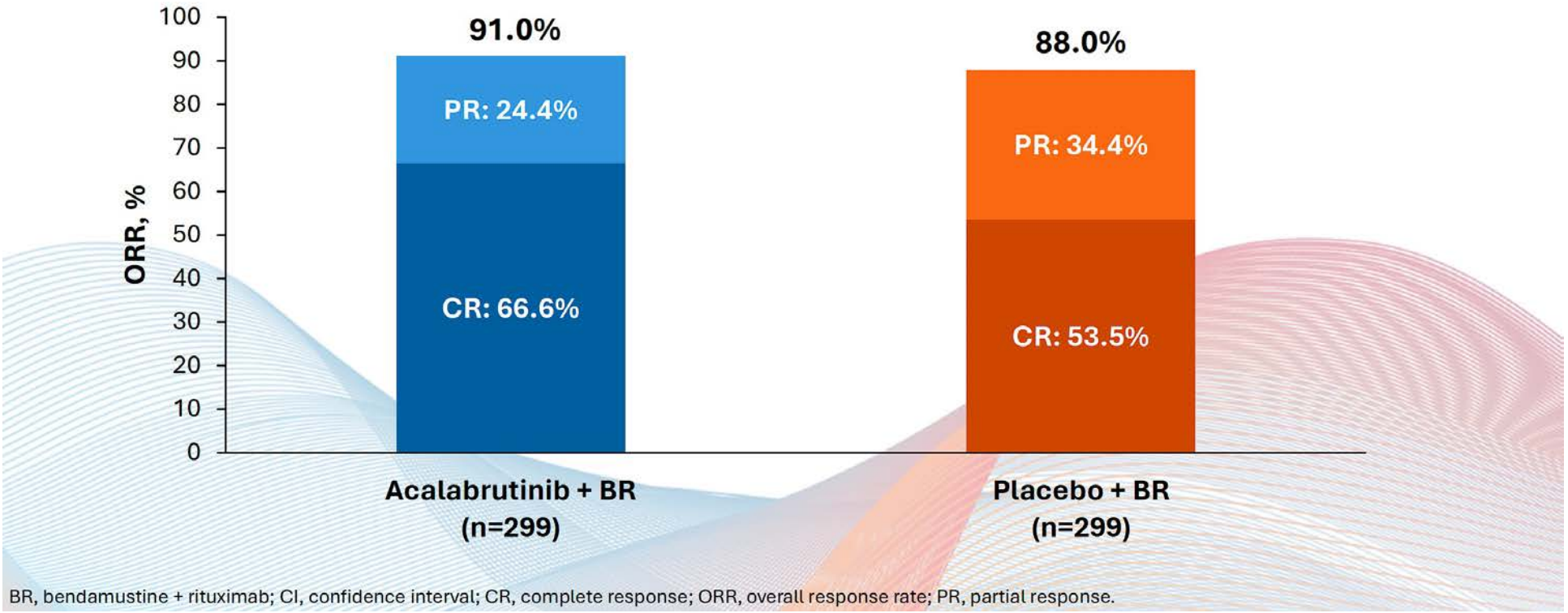


➢ WANG et al. EHA 2024

Response

Best Overall Response and Complete Response Rates

- An additional 13% of patients achieved CR with acalabrutinib + BR



BR, bendamustine + rituximab; CI, confidence interval; CR, complete response; ORR, overall response rate; PR, partial response.

➢ WANG et al. EHA 2024

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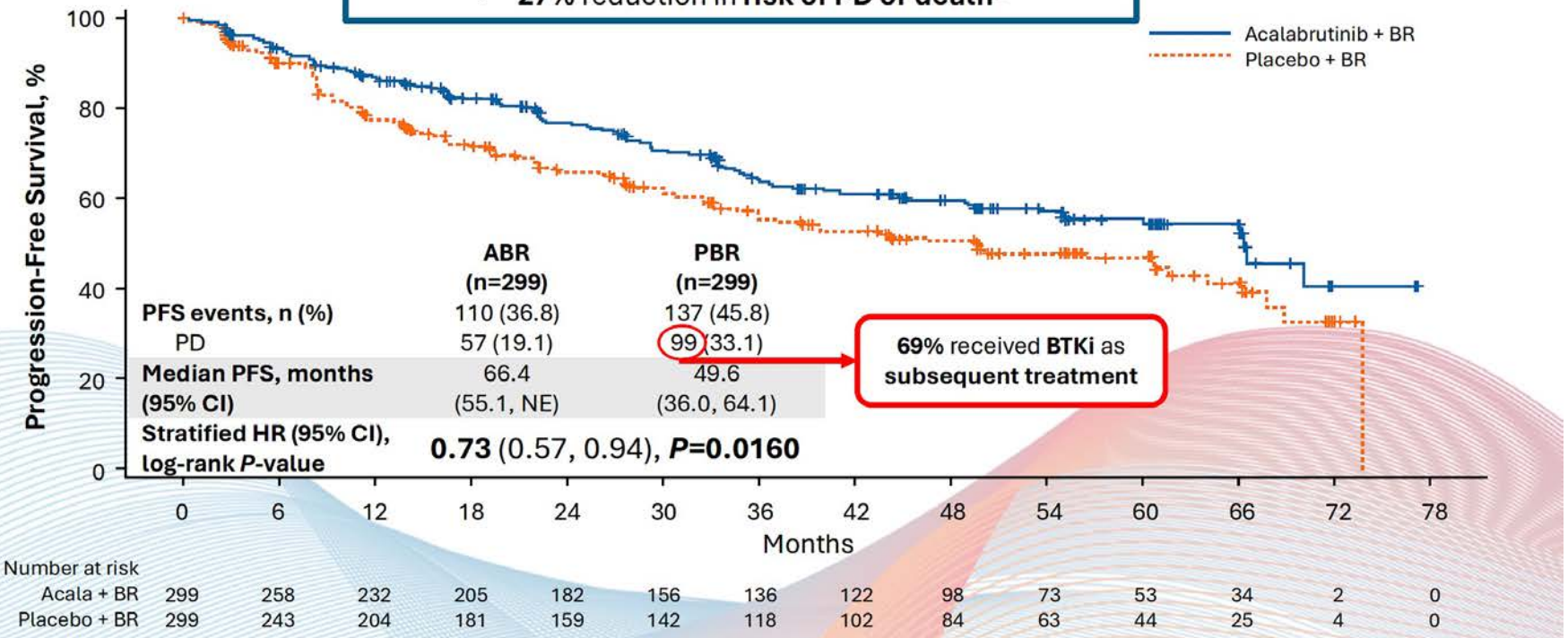
PFS

PFS (primary endpoint) Was Significantly Improved With Acalabrutinib + BR

- **Significant improvement in median PFS by ~17 mo**
- **27%** reduction in **risk of PD or death**[a]



	ABR (n=299)	PBR (n=299)
PFS events, n (%)	110 (36.8)	137 (45.8)
PD	57 (19.1)	99 (33.1)
Median PFS, months (95% CI)	66.4 (55.1, NE)	49.6 (36.0, 64.1)
Stratified HR (95% CI), log-rank *P*-value	**0.73** (0.57, 0.94), ***P*=0.0160**	

Number at risk

Acala + BR	299	258	232	205	182	156	136	122	98	73	53	34	2	0
Placebo + BR	299	243	204	181	159	142	118	102	84	63	44	25	4	0

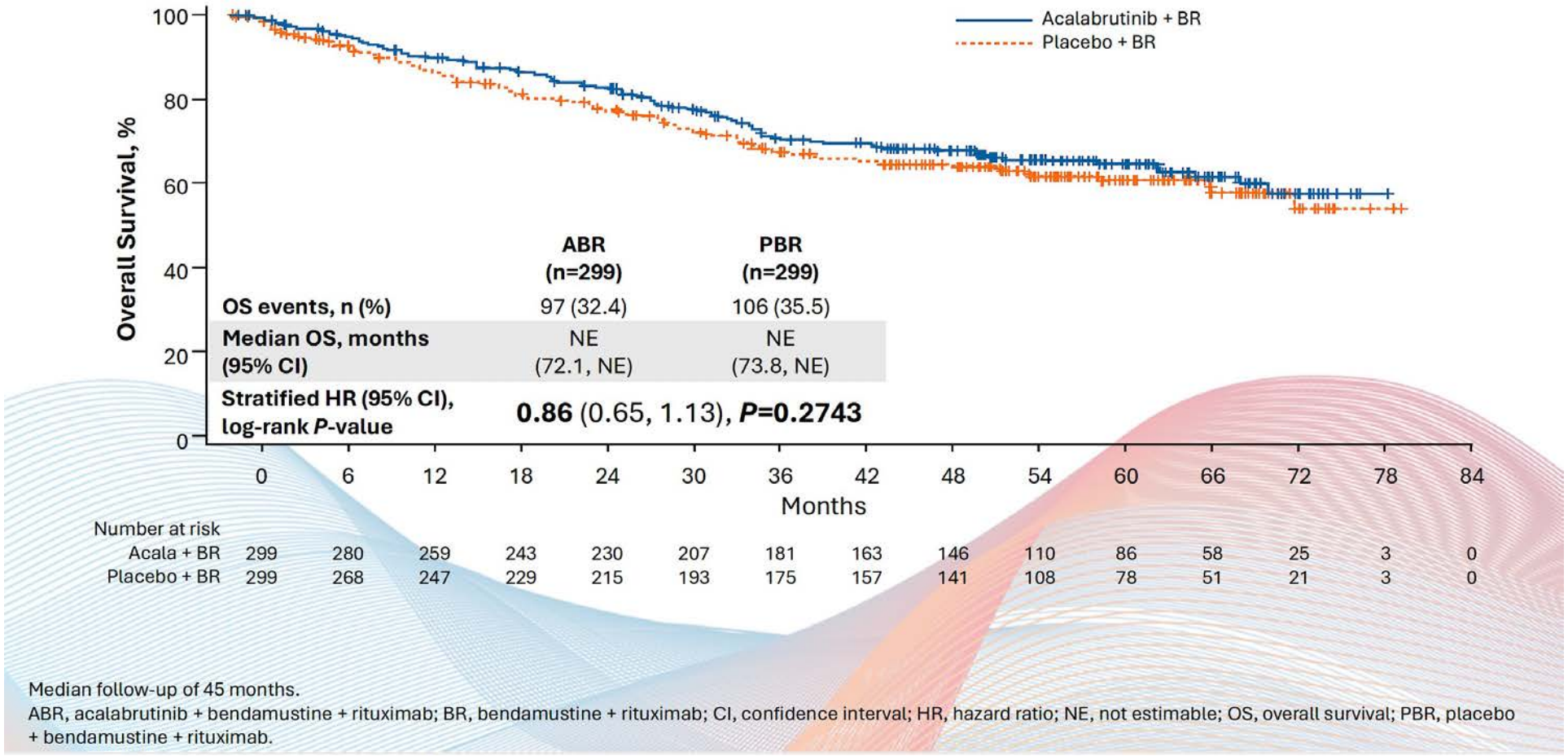
[a]At a median follow-up of 45 months.

ABR, acalabrutinib + bendamustine + rituximab; BR, bendamustine + rituximab; BTKi, Bruton tyrosine kinase inhibitor; CI, confidence interval; HR, hazard ratio; NE, not estimable; PBR, placebo + bendamustine + rituximab; PD, progressive disease; PFS, progression-free survival.

➢ WANG et al. EHA 2024

OS

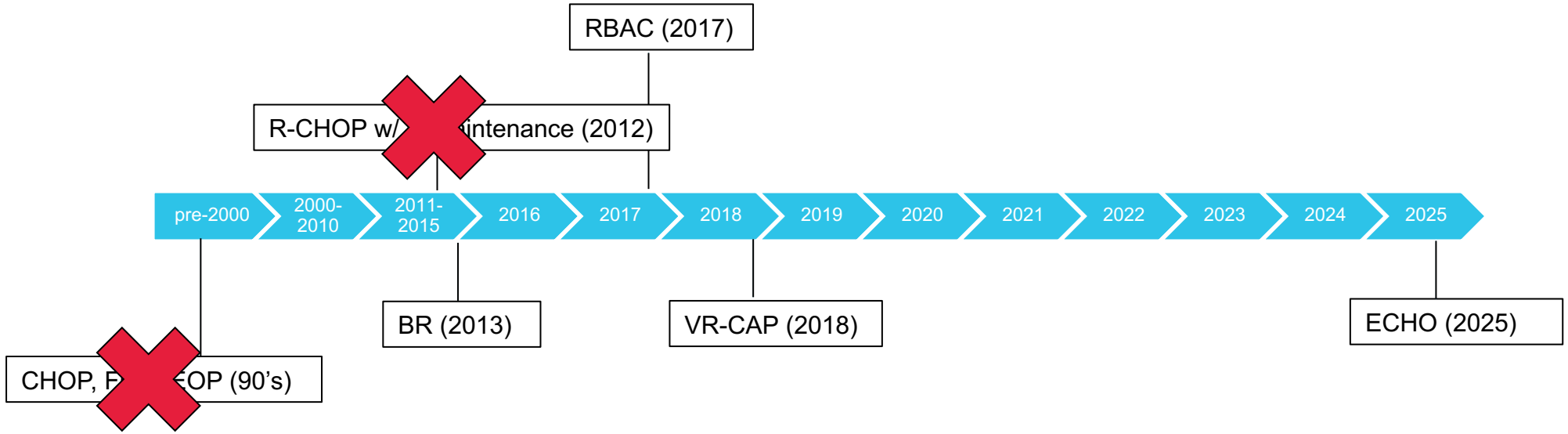
Overall Survival Including Crossover



Median follow-up of 45 months.
ABR, acalabrutinib + bendamustine + rituximab; BR, bendamustine + rituximab; CI, confidence interval; HR, hazard ratio; NE, not estimable; OS, overall survival; PBR, placebo + bendamustine + rituximab.

- WANG et al. EHA 2024

Older/Unfit……Now



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What to make of this

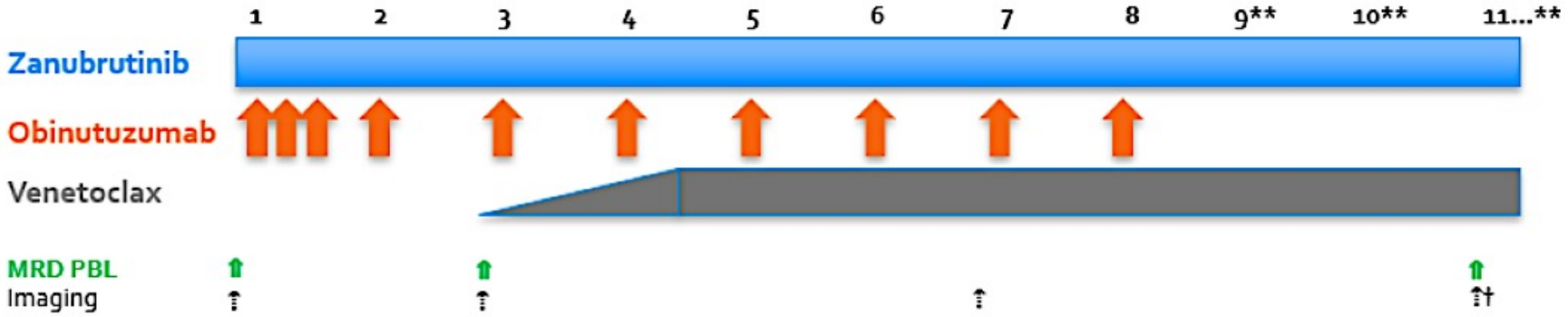
- Easy Answer
  - R-CHOP is a bad 1L regimen for most patients….has been demonstrated in several trials to be inferior to most regimens and needs a lot (ASCT or indefinite maintenance) to have equivalent efficacy to BR and in this case BTKi + R
- Harder Answer
  - Is 1L BTKi the right approach in older patients?
    - ECHO w/ improved PFS vs. BR while ENRICH was equivalent
      - Positive: not chemotherapy, better in p53 mutated patients
      - Negative: indefinite therapy vs. finite, likely not better than sequential therapy in non-p53 mutated patients (again indefinite vs finite).
  - Likely need a better but fixed non-chemo based regimen

Novel Combinations

Phase II Multicenter Study of BOVen

Key Eligibility Criteria:

- Previously untreated MCL (except localized RT prior)
- *TP53* mutation (any variant allele frequency allowed)
- ECOG PS ≤2
- ANC >1, PLT >75, HGB ≥9 (unless if due to MCL)



Dosing:

Zanubrutinib 160 mg oral twice daily
Until EOT or intolerance**

Obinutuzumab 1000 mg IVPB
Cycle 1: day 1, 8, 15
Cycle 2-8: day 1

Venetoclax 400mg oral daily
5-week ramp-up: 1 week each of 20mg; 50mg; 100mg; 200mg; 400 mg oral daily
Until EOT or intolerance**

Total # of cycles: 24 (2 years)

After 24 cycles, if CR and MRD undetectable (uMRD), then no further tx. If <CR and/or MRD positive, then continue zanubrutinib and venetoclax.

Pts with CR/uMRD will be monitored for MRD positivity or recurrence and can restart zanubrutinib and venetoclax.

Aim to enroll 25 pts, if 11 or more alive and progression free at the end of the 2nd year, BOVen will be declared effective in this high-risk population.

Kumar et al. Blood 2023

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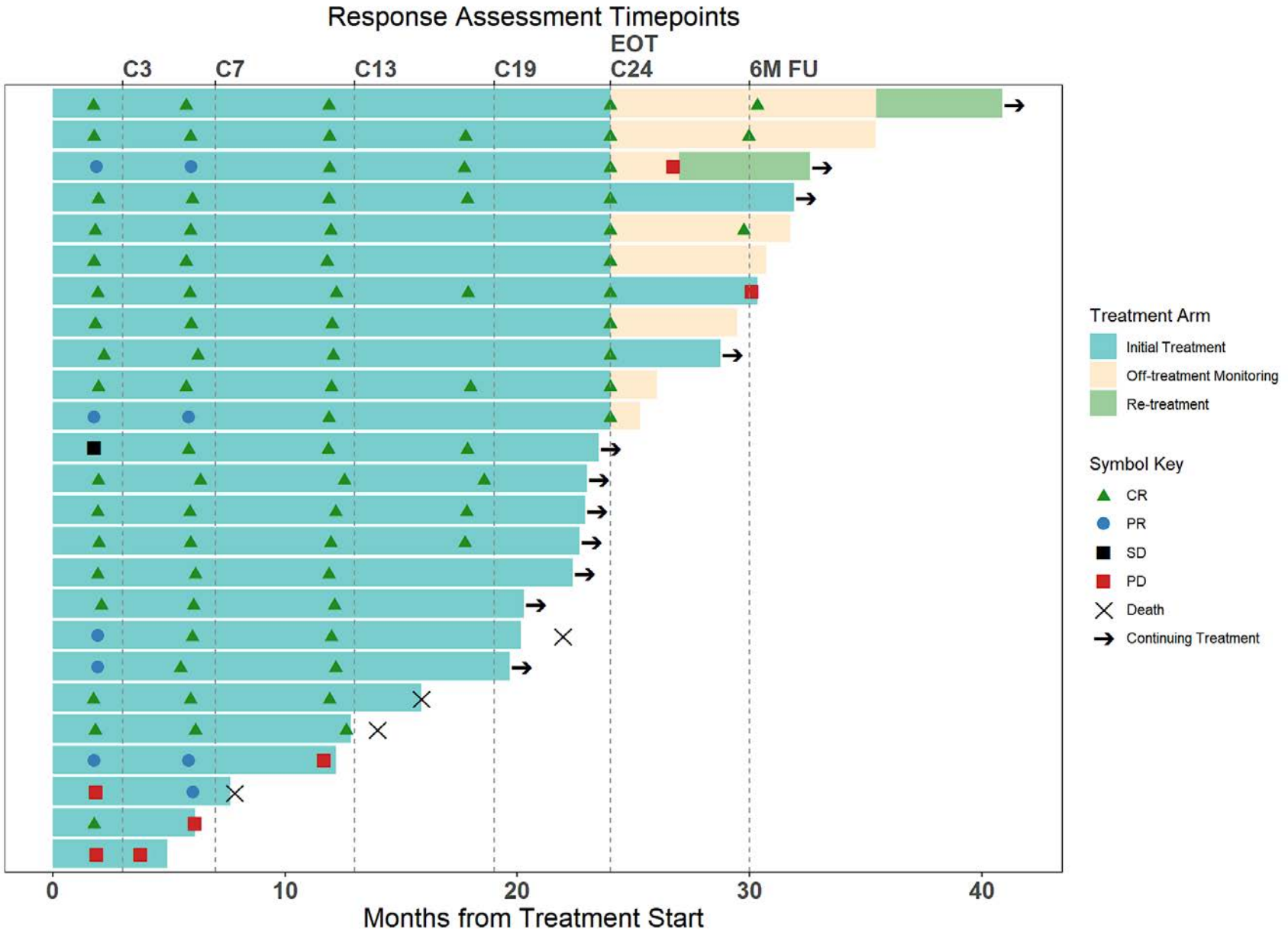
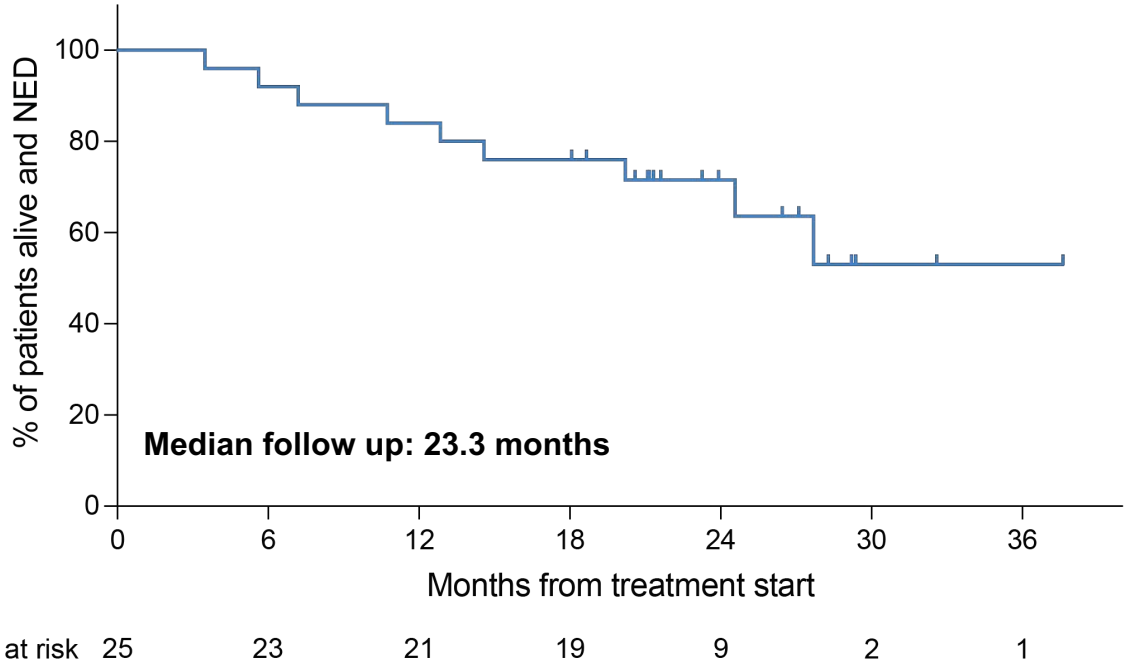
Response timing and duration



- Median follow up:
  - 23.3 months
- There were 9 events:
  - 5 progressions
  - 4 deaths
    - 2 COVID-related
    - 1 unknown
    - 1 PNA / respiratory failure
- The 4 deaths occurred in patients in ongoing response at time of death

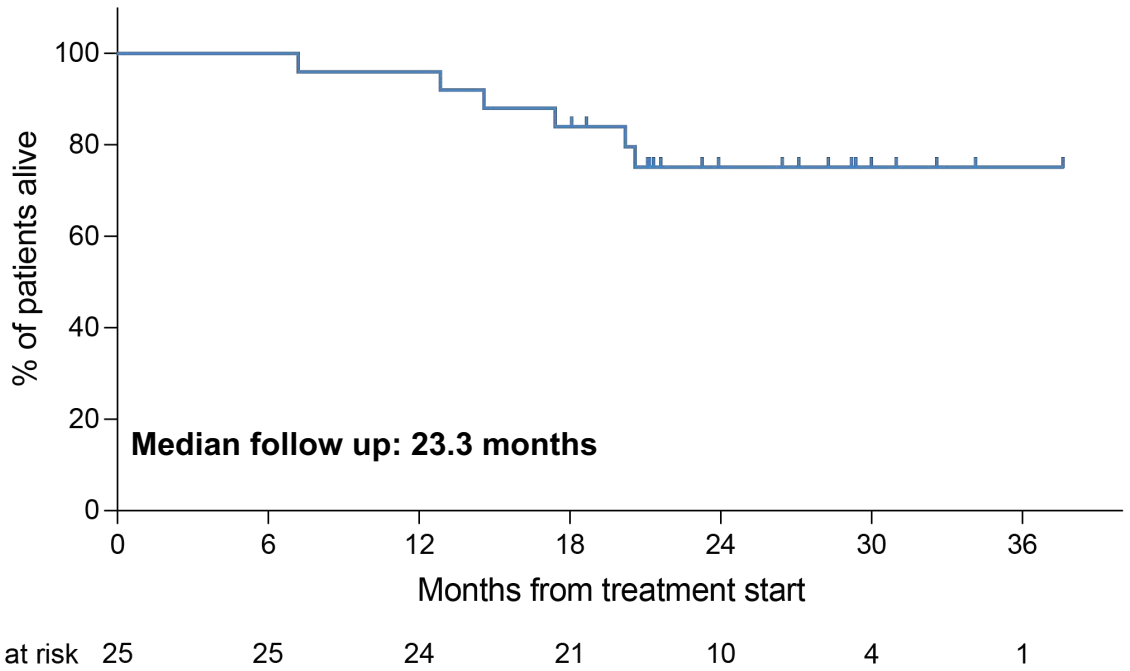
Progression-Free and Overall Survival Outcomes

Progression-Free Survival



2-year PFS: 72% [95% CI: 56, 92]
Median PFS: not reached

Overall Survival



2-year OS: 75% [95% CI: 58, 93]
Median OS: not reached

Primary PFS Endpoint is Met:
11 patients progression-free at 2 years

Acalabrutinib Venetoclax and Rituximab

Acalabrutinib plus venetoclax and rituximab in patients with treatment-naive mantle cell lymphoma: 2-year safety and efficacy analysis

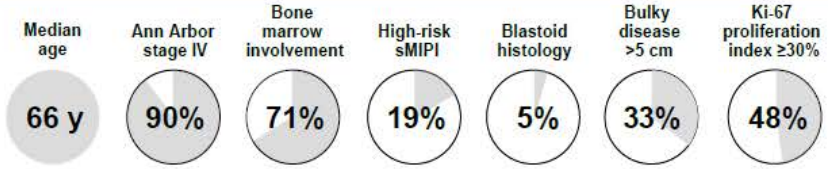
Wang M, et al. ASH 2022 Poster #2884

Patients
Treatment-naive MCL (N=21)

Acalabrutinib: From cycle 1, day 1: 100 mg BID until PD or treatment discontinuation
Venetoclax: From cycle 2, day 1 after ramp-up: 400 mg daily, through cycle 25
Rituximab: 375 mg/m² (day 1, 6 cycles); maintenance every other cycle for pts with CR or PR through cycle 24

- Primary endpoint: Safety
- Secondary endpoints per Lugano criteria: ORR, DOR, PFS
- Exploratory endpoint: MRD

Results



Median follow-up = 25.8 mo
71% remained on study at DCO (March 29, 2022)

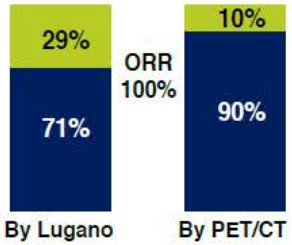
Safety – ECI grade ≥3

- 8 (38%) pts had infections – 5 were from COVID-19
- 7 (33%) pts had neutropenia
- 1 (5%) pts had hypertension
- There were NO CASES of grade ≥3 hemorrhage, cardiac events, or atrial fibrillation
- 5 pts died, all due to COVID-19

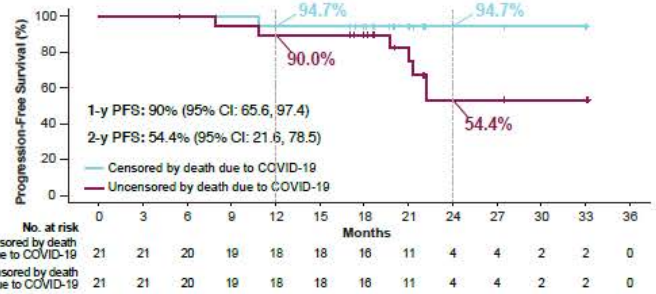
Efficacy

- ✓Median TTIR was 2.8 mo
- ✓Median DOR: not reached
- ✓1-y OS rate: 95%
- ✓2-y OS rate: 74%
- ✓After censoring for 5 COVID-19 deaths, 1-y and 2-y OS rates were 100%

Best ORR



Progression-Free Survival



MRD

- 16 pts had available MRD data
- 14 (87.5%) pts achieved MRD negativity (10^{-6}) at least once during treatment

AVR, acalabrutinib plus venetoclax plus rituximab; BID, twice daily; CI, confidence interval; CR, complete response; CT, computed tomography; DCO, data cutoff; DOR, duration of response; ECI, events of clinical interest; MCL, mantle cell lymphoma; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PD, progressive disease; PET, positron emission tomography; PFS, progression-free survival; PR, partial response; pt, patient; sMIPI, simplified MCL International Prognostic Index; TN, treatment-naive; TTIR, time to initial response

Conclusions

- Treatment with AVR is well tolerated and safe for pts with TN MCL
- 100% of pts responded to AVR; 90% achieved CR by PET/CT and 71% by Lugano
- Treatment with AVR resulted in a high rate of complete molecular responses

Wang et al. *Blood Adv* 2024;8(17):4539-4548.

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Treatment and Outcome Summary

- Observation acceptable for most patients at diagnosis
- Several treatment options available for younger patients but intensive regimen followed by autologous stem cell transplant is practically dead at this time…...(Blastoid??)
  - TRIANGLE, ECHO (lite) – preferred by most
- BR most utilized regimen for older patients deemed not ideal for intensive therapy but will this change w/ ECHO……better question should it change??

Case Presentation: 80-year-old very symptomatic woman with newly diagnosed widespread MCL receives inpatient treatment with R-mini-CHOP

Dr Syed Zafar (Fort Myers, Florida)

RTP
RESEARCH
TO PRACTICE

QUESTIONS FOR THE FACULTY

Would you consider a BTK inhibitor-based regimen for this patient? Do you have a preference for a particular BTK inhibitor for your older patients with newly diagnosed MCL, and if so, which one? What would you partner it with? Given its recently FDA approval, are you preferentially using acalabrutinib/BR for your older patients?

Would you consider a BTK inhibitor in combination with venetoclax and obinutuzumab as initial therapy for a patient with MCL outside of a clinical trial? How are these triplet regimens tolerated?

QUESTIONS FOR THE FACULTY

What is your usual front-line treatment for younger patients with MCL with and without TP53 mutations? Are you generally prioritizing BTK inhibitor-containing regimens for your younger patients, and if so, which ones?

Is there still a role for transplant for younger patients with newly diagnosed MCL? If so, in what situations do you use it?

Case Presentation: 83-year-old man with R/R MCL and complicating psychosocial issues initiates treatment with acalabrutinib

Dr Neil Morganstein (Summit, New Jersey)

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QUESTIONS FOR THE FACULTY

For a patient with R/R MCL to whom you're going to administer a covalent BTK inhibitor, how do you choose between acalabrutinib and zanubrutinib?

How, if at all, does your preference for a BTK inhibitor in the relapsed setting change based on age and comorbidities? How do the individual side-effect profiles weigh into this decision?

Do you still use ibrutinib for your patients with MCL under any circumstances? Is the risk of sudden cardiac death with ibrutinib real? Does this occur with other BTK inhibitors?

Agenda

MODULE 1: Selection and Sequencing of Available Therapies for Diffuse Large B-Cell Lymphoma — Dr Flowers

MODULE 2: Evolving Management Paradigm for Mantle Cell Lymphoma — Dr Phillips

MODULE 3: Integration of Novel Therapies into the Management of Follicular Lymphoma — Dr LaCasce

MODULE 4: Integrating Bispecific Antibodies into the Management of NHL — Dr Brody

MODULE 5: Current Role of CAR T-Cell Therapy in Various Non-Hodgkin Lymphoma (NHL) Subtypes — Dr Abramson

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TO PRACTICE

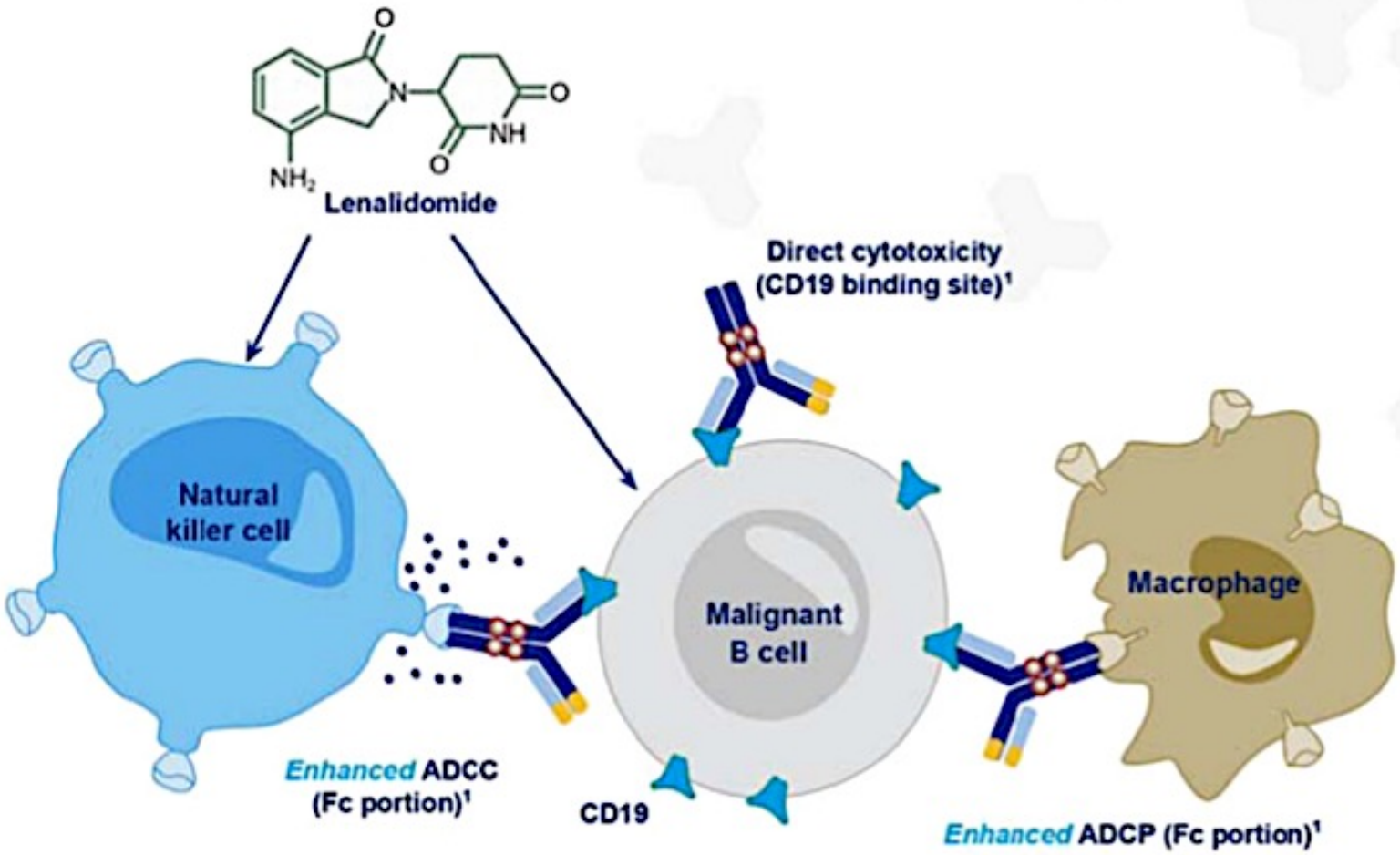
Integration of Novel Therapies into the Management of Follicular Lymphoma

Ann S. LaCasce, MD, MMSc

May 31, 2025

Dana-Farber
Cancer Institute

Rationale for the combination of tafasitamab and lenalidomide in B-cell lymphoma



Tafasitamab (Fc-enhanced, anti-CD19 mAb)[1-3]

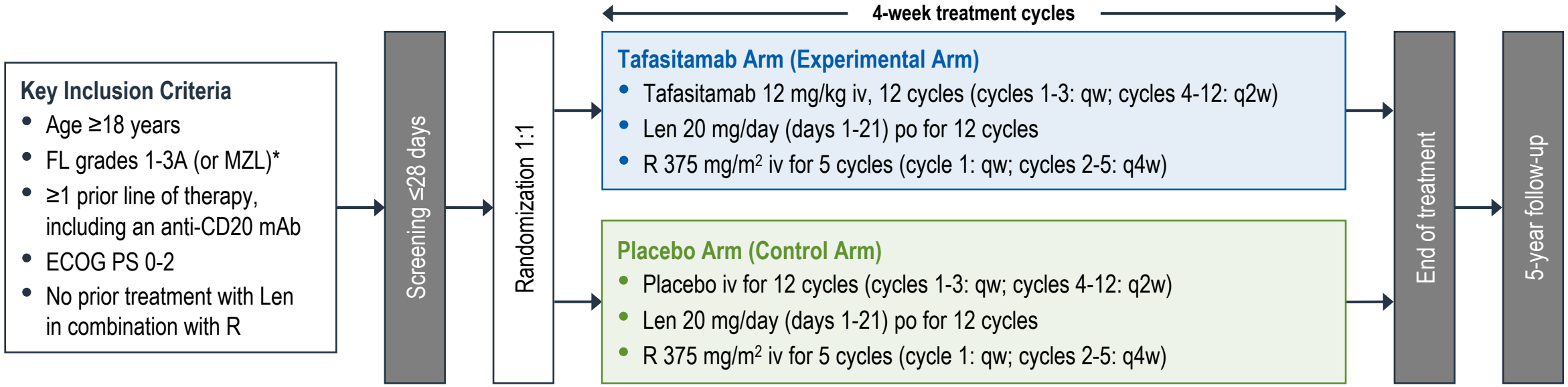
- ADCC ↑
- ADCP ↑
- Direct cell death
- Encouraging single-agent activity in patients with R/R DLBCL and iNHL

Lenalidomide[4,5]

- T-cell and NK-cell activation/expansion
- Direct cell death
- Well-studied as an anti-lymphoma agent, alone or in combination

Cheson et al. Blood Cancer Journal 2021

inMIND: Phase 3, Double-Blind, Placebo-Controlled, International, Multicenter Randomized Study



Stratification Factors (Patients With FL)

- POD24
- Refractoriness to prior anti-CD20 mAb therapy
- Number of prior lines of therapy (1 or ≥2)

Study Endpoints in FL Population (Investigator Assessed Unless Specified)

- **Primary study endpoint:** PFS
- **Key secondary:** PET-CR rate in the FDG-avid population, OS
- **Select other secondary:** PFS by IRC, ORR, DOR, safety, QoL, MRD
- **Exploratory:** TTNT, B-cell recovery, Ig levels, CD19 expression

- Powered to assess PFS in the FL population, triggered when 174 investigator-assessed events occurred
- OS analysis planned after 5 years of follow-up

Sehn et al. ASH 2024

Baseline Characteristics

Variable	Tafasitamab + Len + R (n=273)	Placebo + Len + R (n=275)	Total (N=548)
Median age, years (range)	64.0 (36, 88)	64.0 (31, 85)	64.0 (31, 88)
≥75, n (%)	54 (19.8)	54 (19.6)	108 (19.7)
Male sex, n (%)	150 (54.9)	149 (54.2)	299 (54.6)
Median time since initial diagnosis of FL, years (range)	5.2 (0, 34)	5.5 (1, 33)	5.3 (0, 34)
ECOG PS at screening, n (%)			
0	181 (66.3)	192 (69.8)	373 (68.1)
1-2	92 (33.7)	83 (30.2)	175 (31.9)
Ann Arbor stage, n (%)			
I or II	52 (19.0)	50 (18.2)	102 (18.6)
III or IV	221 (81.0)	225 (81.8)	446 (81.4)
FL grade, n (%)			
1 or 2	203 (74.4)	203 (73.8)	406 (74.1)
3A	67 (24.5)	71 (25.8)	138 (25.2)
B symptoms, n (%)	63 (23.1)	67 (24.4)	130 (23.7)
FLIPI score, n (%)			
0-1	57 (20.9)	57 (20.7)	114 (20.8)
2	79 (28.9)	67 (24.4)	146 (26.6)
3-5	137 (50.2)	150 (54.5)	287 (52.4)
GELF criteria, n (%)	222 (81.3)	232 (84.4)	454 (82.8)
FL diagnosis confirmed by central pathology, n (%)	256 (93.8)	259 (90.5)	505 (92.2)

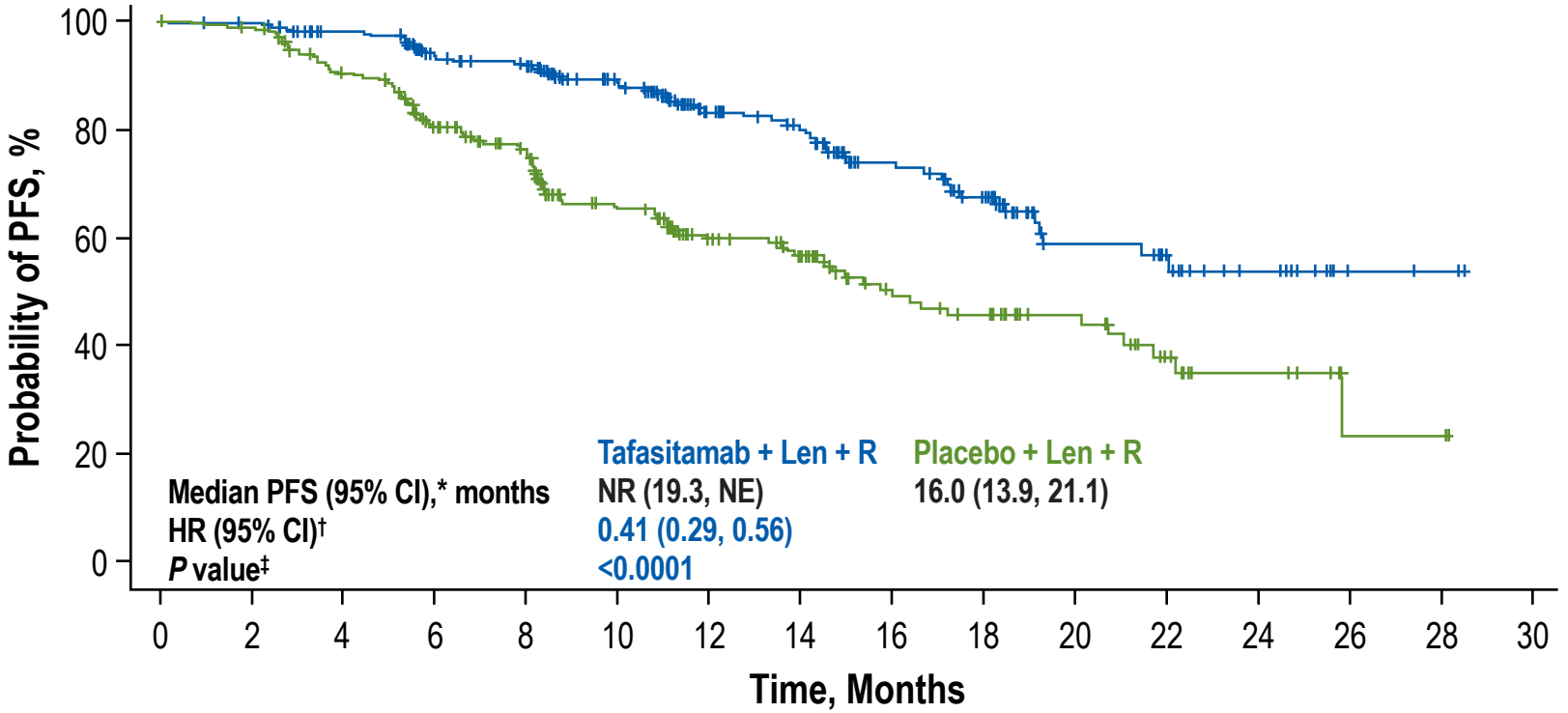
ITT population. ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; FLIPI, Follicular Lymphoma International Prognostic Index; GELF, Groupe d'Etude des Lymphomes Folliculaires; ITT, intent-to-treat; Len, lenalidomide; R, rituximab.

Treatment History

Variable	Tafasitamab + Len + R (n=273)	Placebo + Len + R (n=275)	Total (N=548)
Median number of prior lines of therapy (range)	1.0 (1, 7)	1.0 (1, 10)	1.0 (1, 10)
Number of prior lines of therapy, n (%)			
1	147 (53.8)	153 (55.6)	300 (54.7)
2	66 (24.2)	71 (25.8)	137 (25.0)
3	39 (14.3)	30 (10.9)	69 (12.6)
≥4	21 (7.7)	21 (7.6)	42 (7.7)
Time since last anti-lymphoma therapy, n (%)			
≤2 years	147 (53.8)	157 (57.1)	304 (55.5)
>2 years	126 (46.2)	118 (42.9)	244 (44.5)
POD24, n (%)	85 (31.1)	88 (32.0)	173 (31.6)
Relapsed/refractory status to last therapy, n (%)			
Relapsed	148 (54.2)	164 (59.6)	312 (56.9)
Refractory	112 (41.0)	97 (35.2)	209 (38.1)
Undetermined	13 (4.8)	14 (5.1)	27 (4.9)
Refractory to prior anti-CD20 therapy, n (%)	118 (43.2)	115 (41.8)	233 (42.5)

ITT population. ITT, intent-to-treat; Len, lenalidomide; POD24, disease progression within 24 months of initial diagnosis; R, rituximab.

PFS by Independent Review Committee



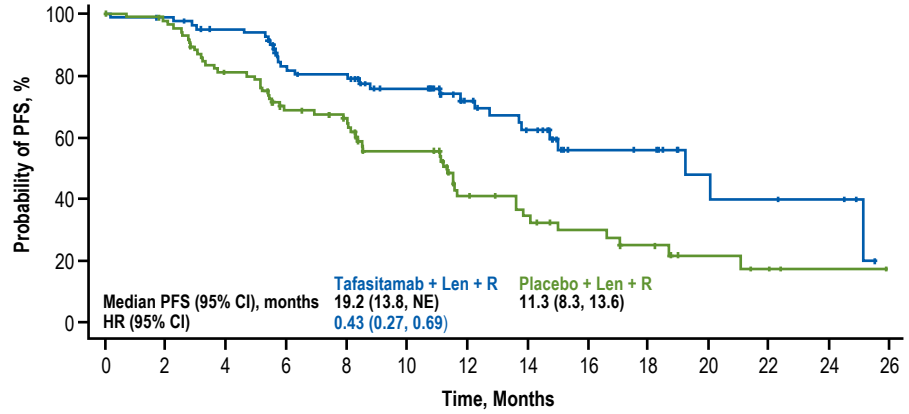
No. at Risk																
Tafasitamab + Len + R	273	260	246	210	200	162	113	98	72	58	28	20	12	3	2	0
Placebo + Len + R	275	260	230	193	170	120	79	67	44	38	26	15	8	2	2	0

Significant PFS benefit was confirmed by independent review committee

ITT population. *Estimated using Kaplan-Meier method. †Estimated using a stratified Cox proportional hazard model. ‡Nominal *P* value; stratified log-rank test with a 2-sided significance level of 5%.
CI, confidence interval; HR, hazard ratio; ITT, intent-to-treat; Len, lenalidomide; NE, not evaluable; NR, not reached; PFS, progression-free survival; R, rituximab.

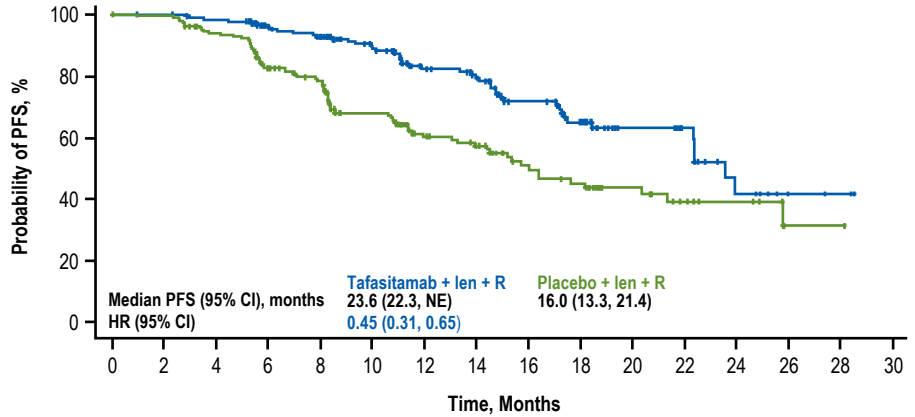
PFS by POD24 Status and Refractoriness to Anti-CD20

POD24: Yes



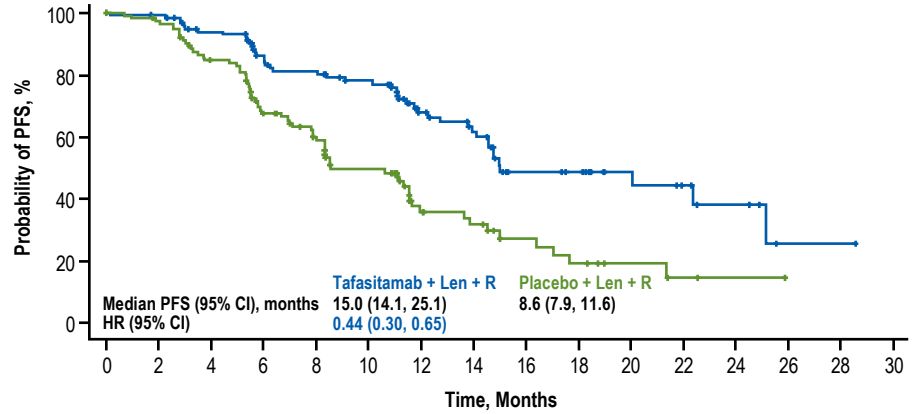
No. at Risk														
Tafasitamab + Len + R	85	81	75	60	57	46	32	25	13	12	6	5	4	0
Placebo + Len + R	88	83	67	52	46	35	21	16	12	9	5	2	1	0

POD24: No



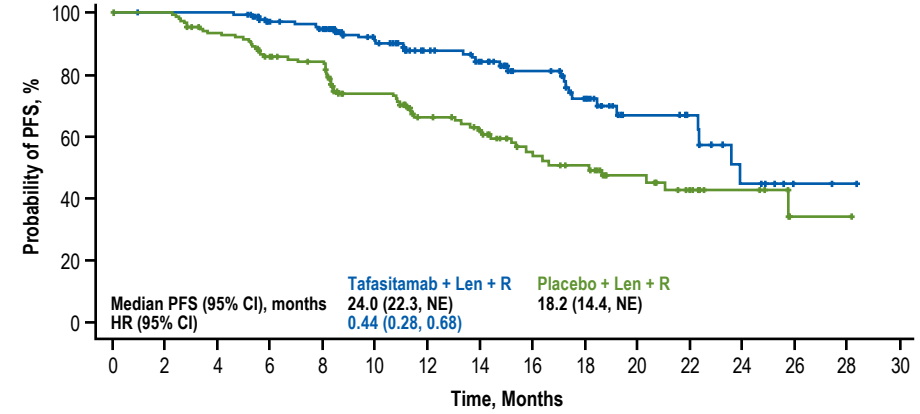
No. at Risk																
Tafasitamab + Len + R	188	180	175	152	143	118	87	78	58	45	24	17	8	3	2	0
Placebo + Len + R	187	182	168	140	127	91	61	54	36	31	21	14	9	2	2	0

Anti-CD20 Refractory: Yes



No. at Risk																
Tafasitamab + Len + R	118	113	102	86	80	71	46	38	21	19	11	8	5	1	1	0
Placebo + Len + R	115	108	91	66	54	41	20	16	10	7	4	2	1	0	0	0

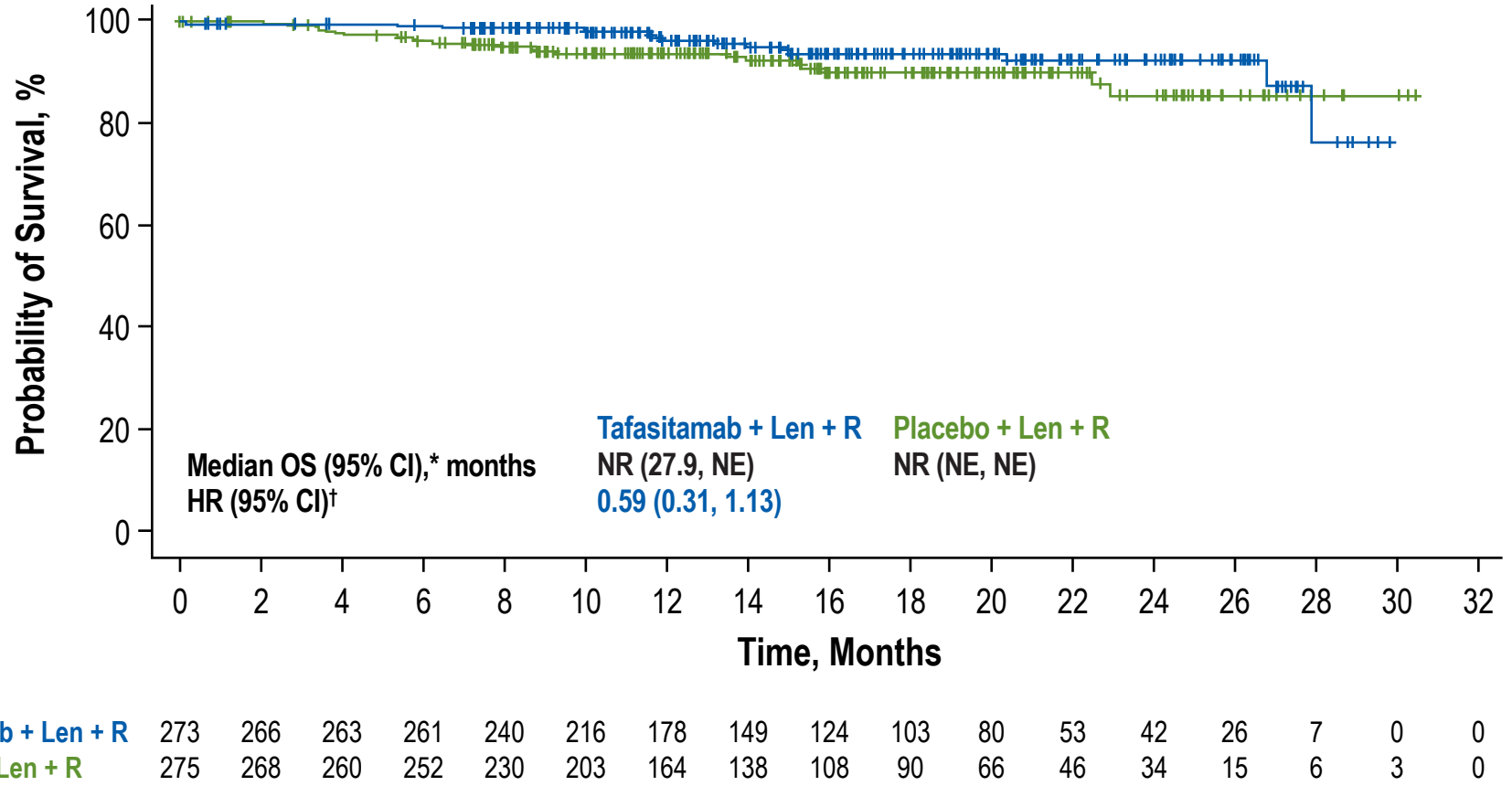
Anti-CD20 Refractory: No



No. at Risk																
Tafasitamab + Len + R	155	148	148	126	120	93	73	65	50	38	19	14	7	2	1	0
Placebo + Len + R	160	157	144	126	119	85	62	54	38	33	22	14	9	2	2	0

ITT population. Subgroup analyses are based on stratification factor. Analysis by investigator assessment. CI, confidence interval; HR, hazard ratio; ITT, intent-to-treat; Len, lenalidomide; NE, not evaluable; PFS, progression-free survival; POD24, progression of disease within 24 months of initial diagnosis; R, rituximab.

Overall Survival



- OS was tested only for futility at the time of the primary analysis
- After a median follow-up of 15.3 months, the futility threshold was not crossed and a positive trend was observed

ITT population. Analysis by investigator assessment. *Estimated using Kaplan-Meier method. †Estimated using a stratified Cox proportional hazard model. CI, confidence interval; HR, hazard ratio; ITT, intent-to-treat; Len, lenalidomide; NE, not evaluable; NR, not reached; OS, overall survival; R, rituximab.

Grade 3 or 4 TEAEs and Dose Modifications

Most Common Grade 3 or 4 TEAEs (≥5% in Any Group)

Preferred Term, n (%)	Tafasitamab + Len + R (n=274)*	Placebo + Len + R (n=272)†	Total (n=546)
Neutropenia	109 (39.8)	102 (37.5)	211 (38.6)
Pneumonia	23 (8.4)	14 (5.1)	37 (6.8)
Thrombocytopenia	17 (6.2)	20 (7.4)	37 (6.8)
Neutrophil count decreased	16 (5.8)	18 (6.6)	34 (6.2)
Anemia	12 (4.4)	16 (5.9)	28 (5.1)
COVID-19	16 (5.8)	6 (2.2)	22 (4.0)
COVID-19 pneumonia	13 (4.7)	3 (1.1)	16 (2.9)

- Tafasitamab and placebo dose interruptions or discontinuations due to TEAEs were similar between treatment arms, n (%):
  - Dose delay or interruption due to TEAEs: 203 (74%) vs 190 (70%)
  - Discontinued study treatment due to TEAEs: 30 (11%) vs 18 (7%)
- Len discontinuations due to TEAEs were similar between tafasitamab and placebo arms, n (%):
  - 39 (14%) vs 31 (11%)
- Len dose reductions were similar between tafasitamab and placebo arms
  - Median relative dose intensity: 86% vs 87%

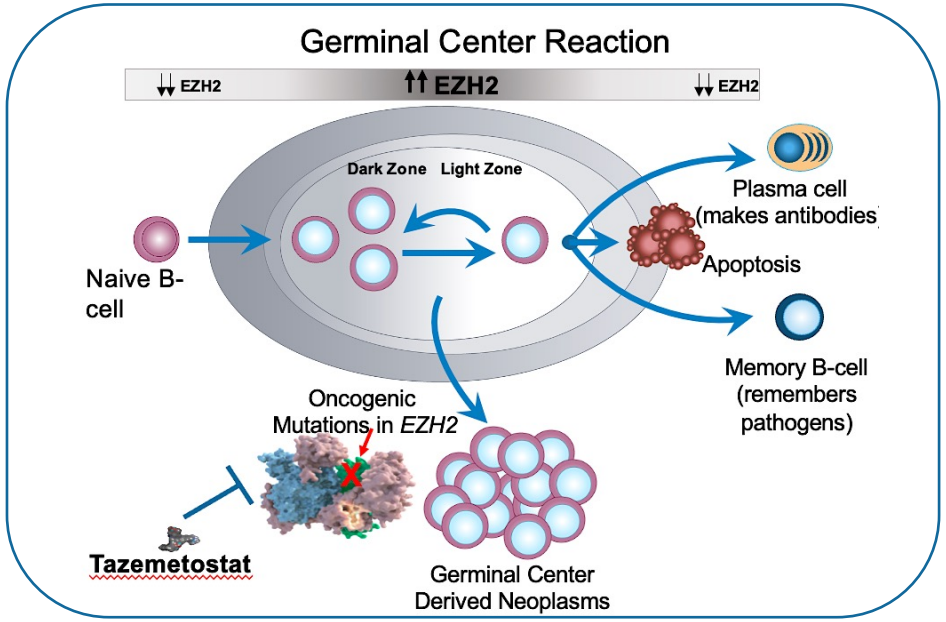
Safety population. *One patient randomized to the placebo + len + R group is included in the tafasitamab + len + R safety population because the patient erroneously received tafasitamab. †Three patients randomized to the placebo + len + R group are not included in the safety population because they erroneously received tafasitamab (n=1), or did not receive any study treatment due to confirmation of R hypersensitivity (n=1), or the patient withdrew from the study (n=1). COVID-19, coronavirus disease 2019; Len, lenalidomide; R, rituximab; TEAE, treatment-emergent adverse event.

FL Patient Population Comparison

Variable	inMIND Tafasitamab + Len + R (n=273)	inMIND Placebo + Len + R (n=275)	AUGMENT[1] R + Len (n=147)
Median age, years	64	64	62
Male, %	55	54	42
Ann Arbor stage IV at enrollment, %	55	59	30
FL grade 3A, %	25	26	12
FLIPI high risk (score 3-5) , %	50	55	37
ECOG PS 0, %	66	70	67
ECOG PS 1-2, %	34	30	33
B symptoms present, %	23	24	8
High tumor burden per GELF (yes), %	81	84	52
Refractory to last prior regimen, %	41	35	18
Refractory to anti-CD20, %	43	42	–

1, Leonard JP, et al. *J Clin Oncol.* 2019;37:1188-1899.
ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; FLIPI, Follicular Lymphoma International Prognostic Index; GELF, Groupe d'Etude des Lymphomes Folliculaires; len, lenalidomide; R, rituximab.

Tazemetostat in relapsed/refractory FL (EZH2 mutant and wild type)



EZH2 an epigenetic regulator, required for normal B-cell biology

Oncogenic mutations in EZH2 "lock" B cells in the germinal center

~20% of patients with FL also have EZH2 gain of function mutations

Morchhauser et al. Lancet Onc 2019

	EZH2^{mut} (n=45)	*EZH2*^{WT} (n=54)
Age, years	62 (57–68)	61 (53–67)
Sex		
Male	19 (42%)	34 (63%)
Female	26 (58%)	20 (37%)
ECOG performance status		
0	21 (47%)	26 (48%)
1	24 (53%)	23 (43%)
2	0	4 (7%)
Missing	0	1 (2%)
Satisfied GELF criteria*		
Yes	31 (69%)	40 (74%)
No	14 (31%)	14 (26%)
Time from initial diagnosis, years	4·7 (1·7–6·4)	6·3 (3·4–9·0)
Histology		
Grade 1, 2, or 3a	42 (93%)	51 (94%)†
Grade 3b or transformed follicular lymphoma‡	3 (7%)	6 (11%)†
Previous lines of anticancer therapy§		
One	2 (4%)	1 (2%)
Two	22 (49%)	16 (30%)
Three	10 (22%)	11 (20%)
Four	4 (9%)	10 (19%)
Five or more	7 (16%)	16 (30%)
Median	2 (2–43)	3 (2–5)
Refractory to last regimen¶	22 (49%)	22 (41%)
Poor risk features		
Refractory to a rituximab-containing regimen‖	22 (49%)	32 (59%)
Double refractory**	9 (20%)	15 (28%)
Previous haematopoietic stem-cell transplant	4 (9%)	21 (39%)
Disease progression within 24 months of disease diagnosis in patients treated with first-line immunochemotherapy (POD24)	19 (42%)	32 (59%)

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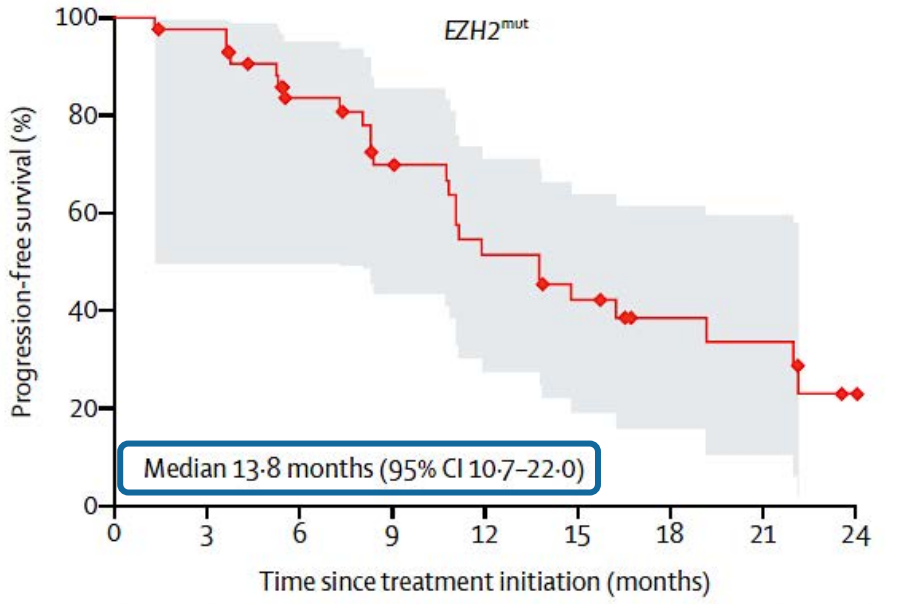
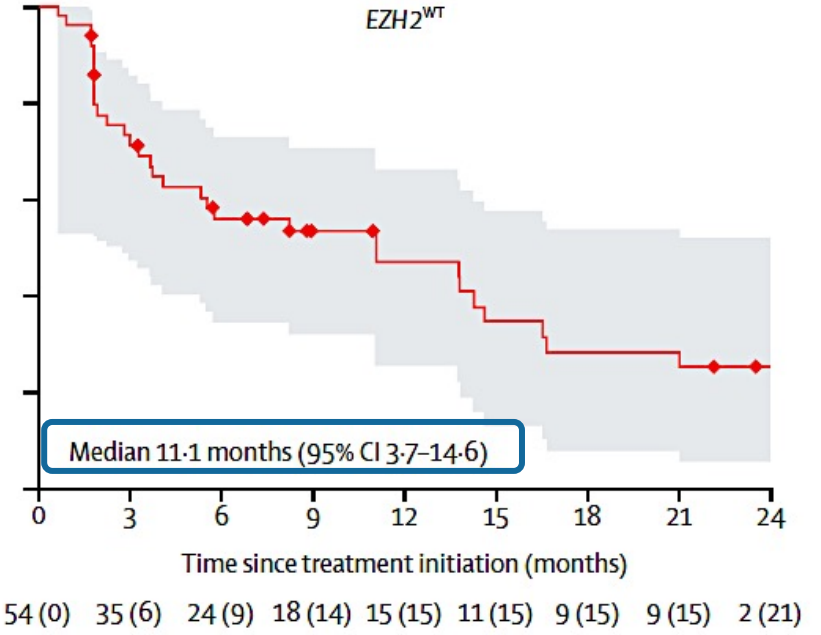
Despite higher response rates in EZH2 mutant patients, PFS similar in both groups

	EZH2^{mut} (n=45)		*EZH2*^{WT} (n=54)	
	IRC-assessed	Investigator-assessed	IRC-assessed	Investigator-assessed
Objective response rate*	31 (69%; 53–82)	35 (78%; 63–89)	19 (35%; 23–49)	18 (33%; 21–48)
Overall disease control rate†	44 (98%)	45 (100%)	37 (69%)	34 (63%)
Best overall response				
Complete response	6 (13%)	4 (9%)	2 (4%)	3 (6%)
Partial response	25 (56%)	31 (69%)	17 (31%)	15 (28%)
Stable disease	13 (29%)	10 (22%)	18 (33%)	16 (30%)
Progressive disease	1 (2%)	0	12 (22%)	16 (30%)
Not estimable or unknown	0	0	5 (9%)	4 (7%)

Data are n (%; 95% CI) or n (%). IRC=independent radiology committee. *Objective response rate includes patients with a complete or partial response. †Overall disease control rate includes patients with a complete response, partial response, or stable disease.

Table 2: **Tumour response by *EZH2* mutation status in the modified intention-to-treat population as assessed by the IRC and investigators**





Morchhauser et al. Lancet Onc 2019

Dana-Farber Cancer Institute

Differences in outcome likely driven by patient selection

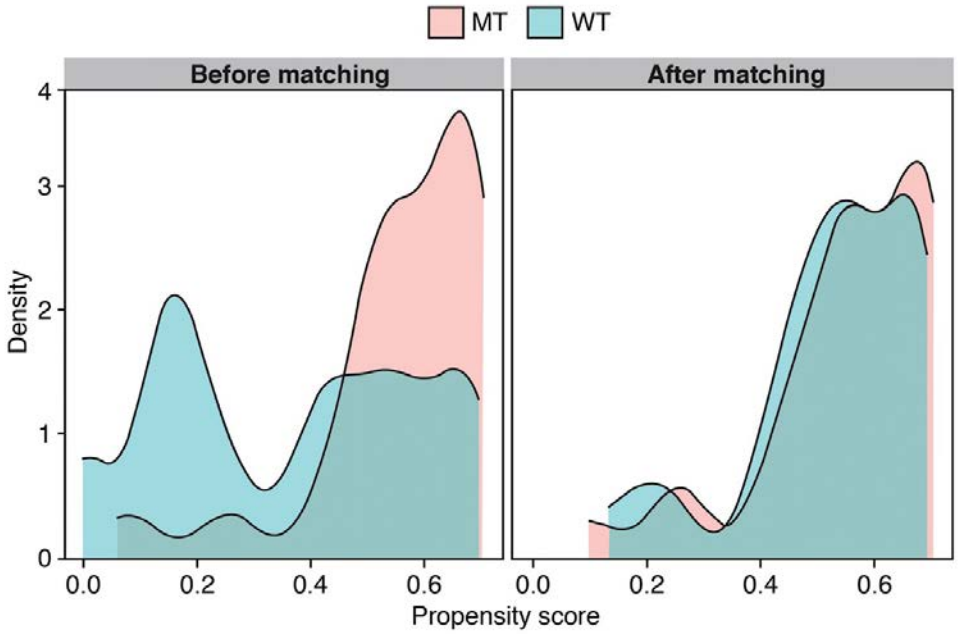


Table 1: Variables before and after matching

Variable	Before matching					After matching				
	Cohort group[a]		Mean difference (MT−WT)	Standardized mean difference	*P* value	Cohort group[a]		Mean difference (MT−WT)	Standardized mean difference	*P* value
	WT (*n* = 54)	MT (*n* = 45)				WT (*n* = 28)	MT (*n* = 28)			
Matched										
ECOG PS										
0	26 (48.2)	21 (46.7)	−1.5			16 (57.1)	15 (53.6)	−3.6		
1	23 (42.6)	24 (53.3)	10.7			12 (42.9)	13 (46.4)	3.6		
2	4 (7.4)	0 (0)	−7.4			0 (0)	0 (0)	0		
Unknown	1 (1.9)	0 (0)	−1.9	0.47	0.18	0 (0)	0 (0)	0	0.07	1.00
POD24	32 (59.3)	19 (42.2)	−17.0	0.35	0.14	14 (50.0)	12 (42.9)	−7.1	0.14	0.79
Prior ASCT	20 (37.0)	4 (8.9)	−28.2	0.71	<0.01	3 (10.7)	3 (10.7)	0	0	1.00
Line of anticancer therapy, *n*	3.7 ± 1.7	3.0 ± 1.7	−0.7 ± 0.3	0.40	0.05	3.1 ± 1.2	2.8 ± 1.4	−0.3 ± 0.4	0.25	0.36
Double refractory	15 (27.8)	9 (20.0)	−7.8	0.18	0.51	6 (21.4)	8 (28.6)	7.1	0.17	0.76
Nonmatched										
Age, mean ± SD, y	61.1 ± 11.4	61.8 ± 9.0	0.8 ± 2.1	0.08	0.71	64.9 ± 9.8	61.0 ± 9.2	−4.0 ± 2.5	0.42	0.13
Female sex	20 (37.0)	26 (57.8)	20.7	0.43	0.06	10 (35.7)	17 (60.7)	25.0	0.52	0.11
Grade 3b and transformed FL	6 (11.1)	3 (6.7)	−4.4	0.16	0.51	4 (14.3)	2 (7.1)	−7.1	0.23	0.67
Refractory to rituximab	32 (59.3)	22 (48.9)	−10.4	0.21	0.41	16 (57.1)	14 (50.0)	−7.1	0.14	0.79
Refractory to last therapy	22 (40.7)	22 (48.9)	8.2	0.16	0.54	11 (39.3)	12 (42.9)	3.6	0.07	1.00

Table 2: Objective response rates before matching

Population	Before matching (*n* = 99) (95% CI), %	After matching (*n* = 56) (95% CI), %
WT *EZH2*	35 (22–48)	50 (31–69)
MT *EZH2*	69 (55–83)	71 (54–88)

Abbreviations: CI: confidence interval; MT: mutant type, WT: wild type.

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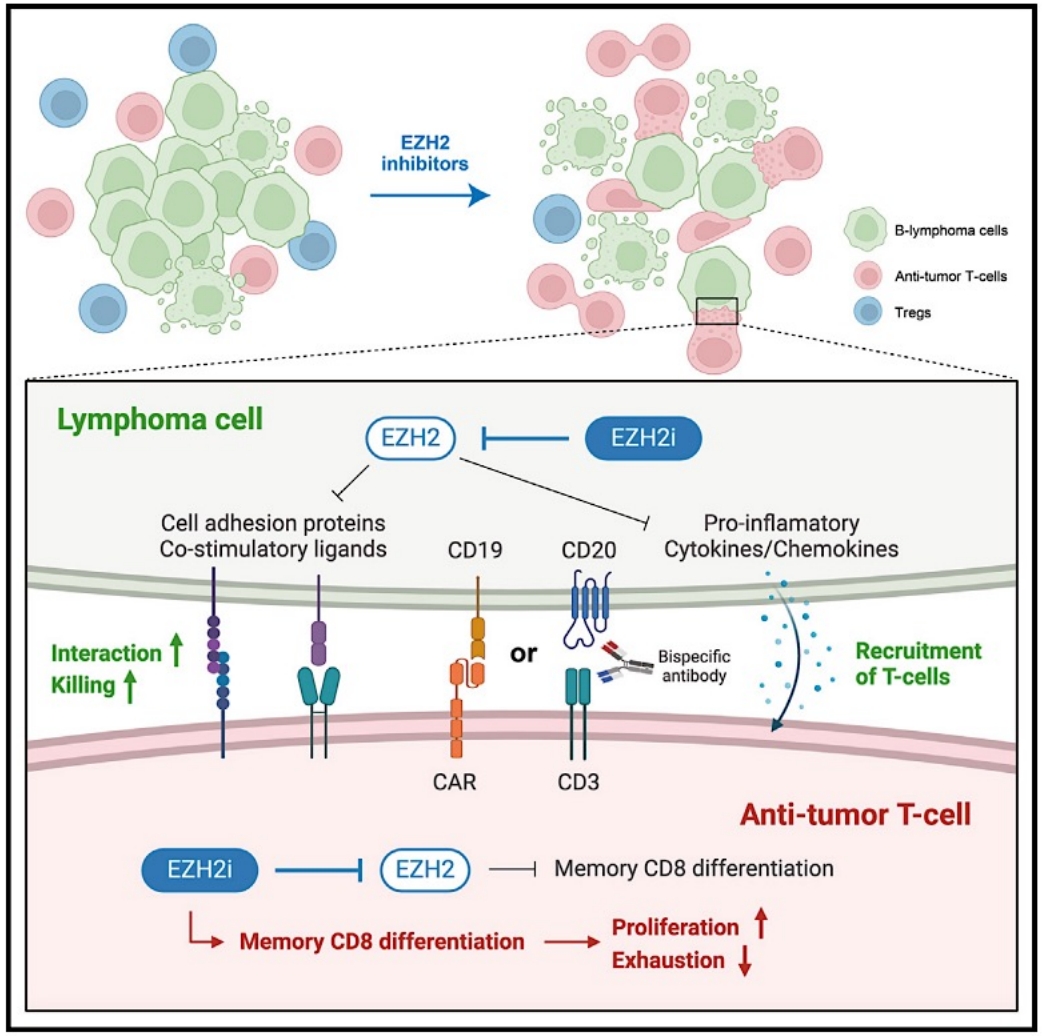
Proudman et al. Oncotarget 2022

Preclinical data suggest EZH2 inhibitors improve T-cell function and may improve efficacy of bi-specifics/CAR-T



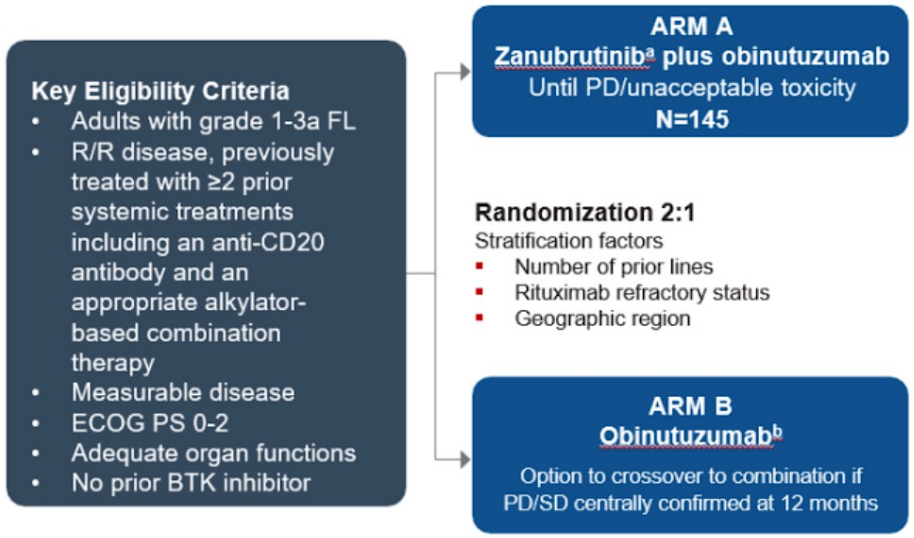
Highlights

- Development of syngeneic models recapitulating human follicular lymphoma and DLBCL
- EZH2 inhibition increases immunogenicity of lymphoma cells and T cell interaction
- EZH2 inhibition sensitizes lymphoma to T cell immunotherapies
- EZH2 inhibition prevents T cell exhaustion by promoting a memory phenotype

Dana-Farber Cancer Institute

Isshiki et al. Cancer Cell 2025

Rosewood study of obinutuzumab +/- zanubrutinib in relapsed/refractory follicular lymphoma



Primary Endpoint
- ORR assessed by ICR according to Lugano classification[1]

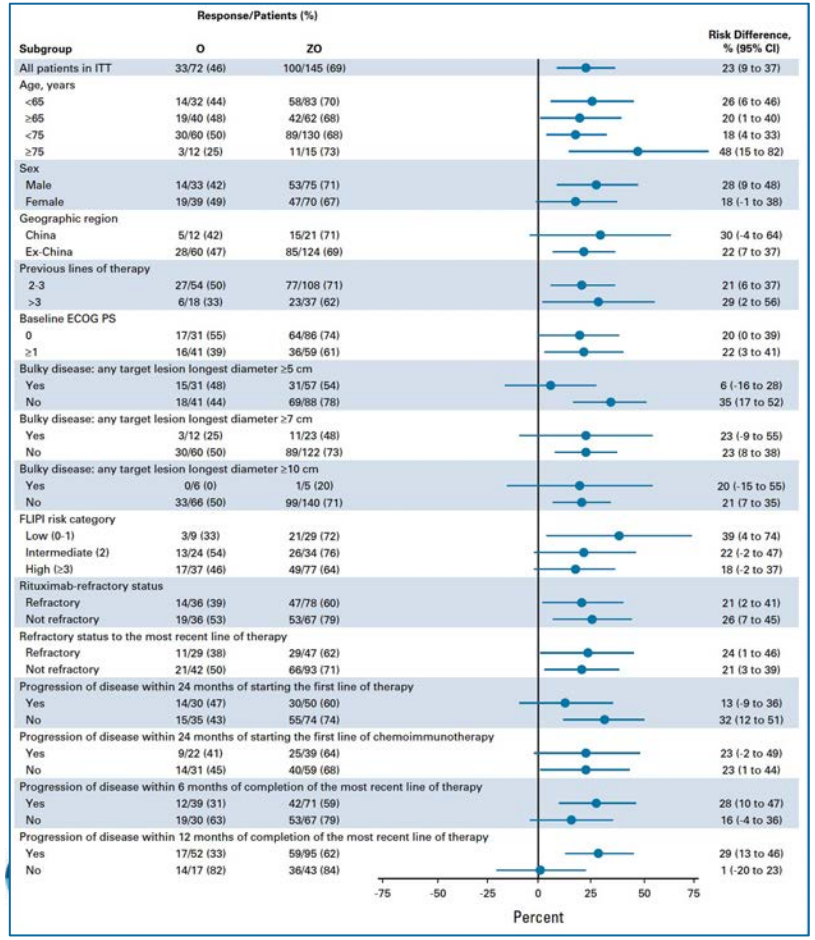
Select Secondary Endpoints
- ORR assessed by investigator
- DOR and PFS determined by ICR review and investigator assessment
- Overall survival
- CR and CMR rate assessed by ICR and investigator assessment

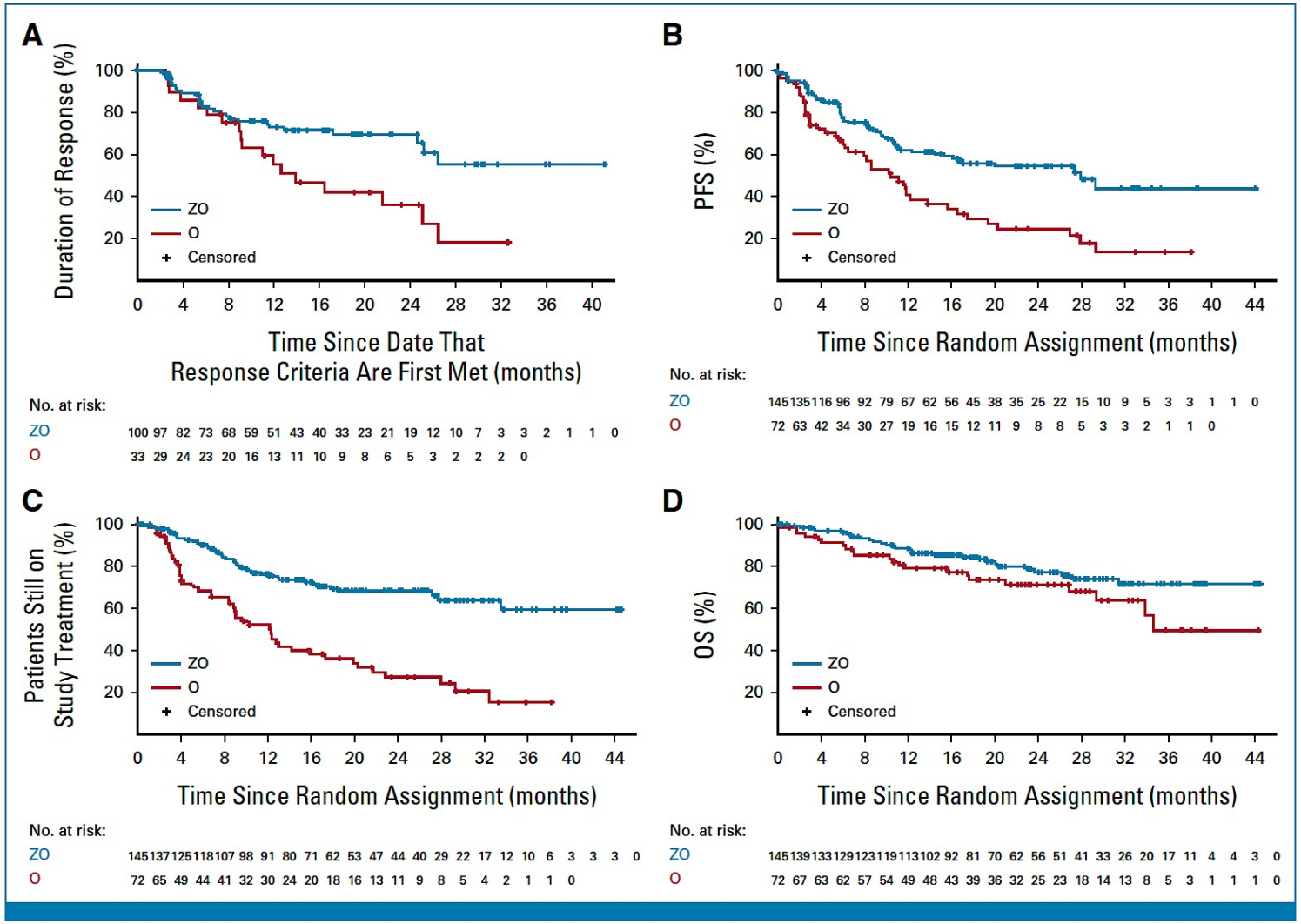
Patient Characteristic	ZO (n = 145)	O (n = 72)	Total (N = 217)
Age, years, median (range)	63.0 (31-84)	65.5 (32-88)	64.0 (31-88)
Geographic region, No. (%)			
Mainland China	21 (14)	12 (17)	33 (15)
Rest of the world	124 (86)	60 (83)	184 (85)
Previous lines of therapy			
Median (range)	3 (2-11)	3 (2-9)	3 (2-11)
2-3, No. (%)	104 (72)	54 (75)	158 (73)
>3, No. (%)	41 (28)	18 (25)	59 (27)
ECOG PS 0-1, No. (%)	140 (97)	71 (99)	211 (97)
High FLIPI score, No. (%)	77 (53)	37 (51)	114 (53)
Ann Arbor stage III-IV, No. (%)	119 (82)	60 (83)	179 (82)
Target lesion SPD by ICR, mm^2, median (Q1, Q3)	1,614.0 (783.0, 3,344.0)	1,727.0 (732.0, 3,504.0)	1,655.0 (756.0, 3,351.5)
Bulky disease (≥7 cm), No. (%)	23 (16)	12 (17)	35 (16)
High LDH level (>ULN), No. (%)	49 (34)	29 (40)	78 (36)
High tumor burden per GELF criteria, No. (%)	83 (57)	40 (56)	123 (57)
Refractory to rituximab, No. (%)	78 (54)	36 (50)	114 (53)
Refractory to most recent line of therapy, No. (%)	47 (32)	29 (40)	76 (35)
PD ≤24 months of starting first line of therapy, No. (%)	50 (34)	30 (42)	80 (37)

Zinzani et al. JCO 2023

Addition of Zanubrutinib associated with improved ORR/CR and PFS

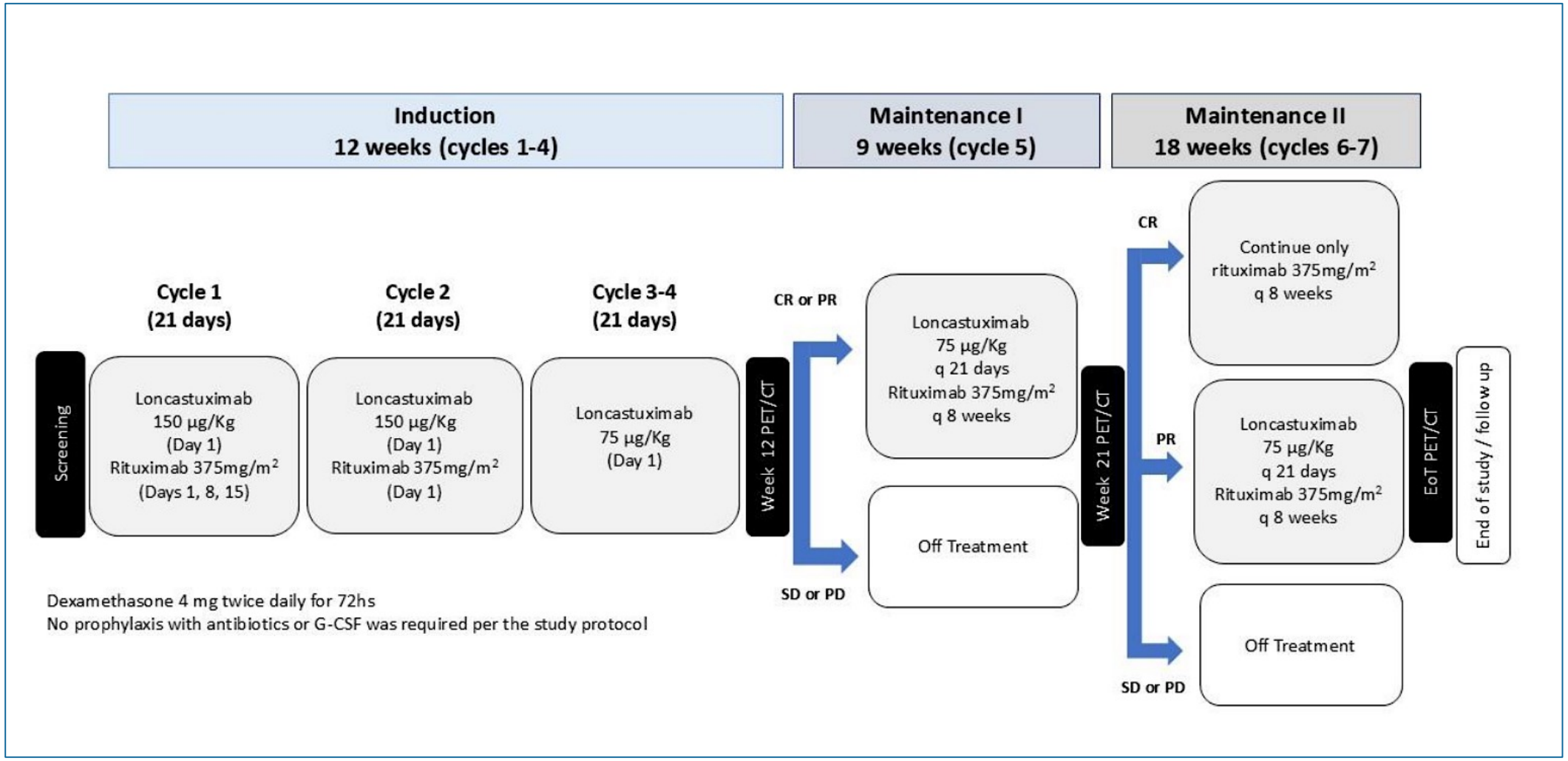
End Point	ZO (n = 145)	O (n = 72)
ORR by ICR, % (95% CI)	69 (61 to 76)	46 (34 to 58)
CR, No. (%)	57 (39)	14 (19)
PR, No. (%)	43 (30)	19 (26)
DOR by ICR, months, median (95% CI)	NE (25.3 to NE)	14.0 (9.2 to 25.1)
18-month rate, %	69 (58 to 78)	42 (23 to 60)
Duration of CR by ICR, months, median (95% CI)	NE (26.5 to NE)	26.5 (2.7 to NE)
18-month rate, % (95% CI)	87 (74 to 94)	51 (21 to 75)
PFS by ICR, months, median (95% CI)	28.0 (16.1 to NE)	10.4 (6.5 to 13.8)





Zinzani et al. JCO 2023

Phase 2, single center study of loncastuximab tesirine with rituximab in relapsed/refractory follicular lymphoma



Alderuccio et al. Lancet Hematology 2025

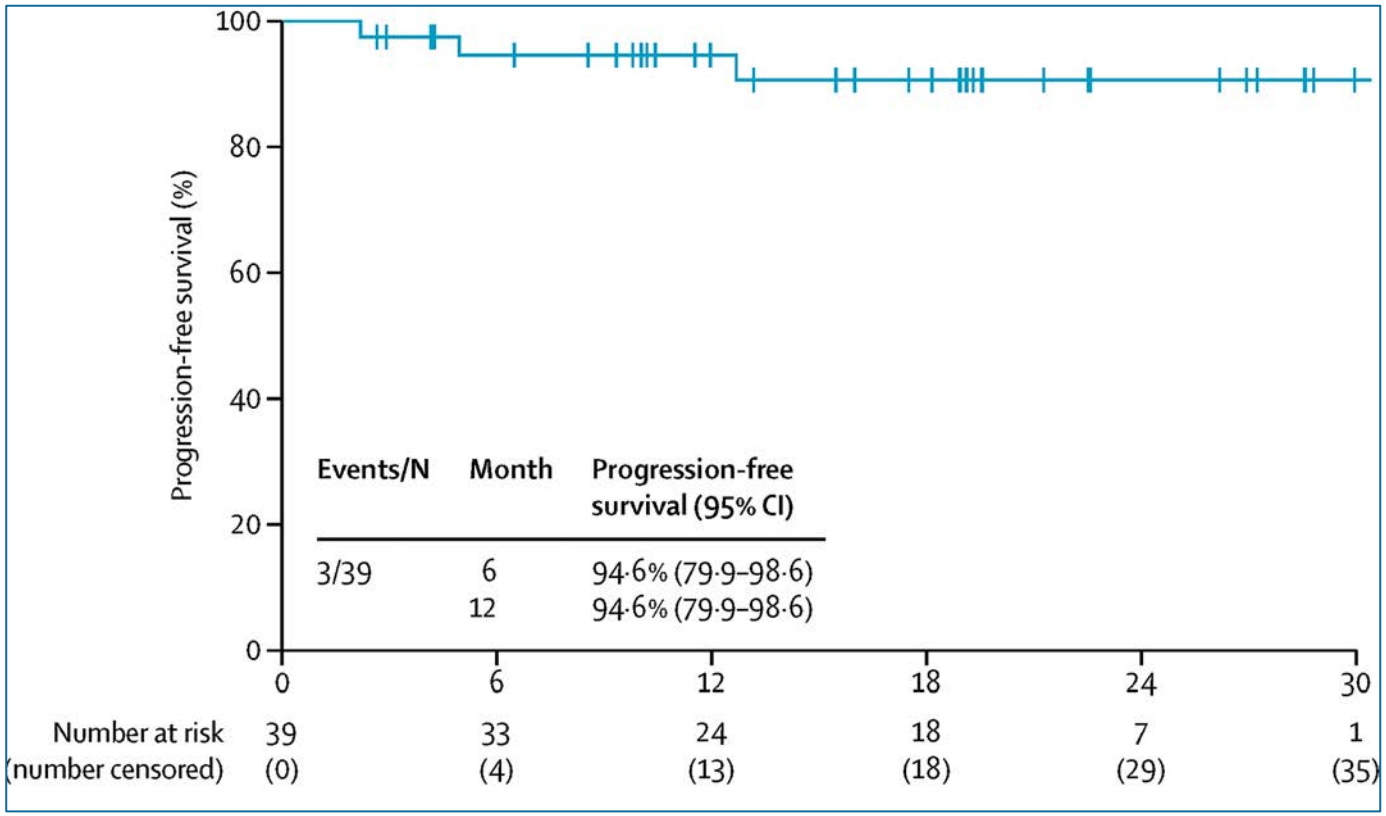
Majority of patients treated in 2nd line, though half were refractory and half were POD24

	Enrolled patients (n=39)
Age, years	68 (58–77)
Sex	
Male	21 (54%)
Female	18 (46%)
Race	
White	37 (95%)
Black or African American	2 (5%)
Ethnicity	
Hispanic	22 (56%)
Non-Hispanic	17 (44%)
ECOG performance status	
0	29 (74%)
1	10 (26%)
Follicular lymphoma grade *	
Grade 1–2	28 (72%)
Grade 3A	11 (28%)
Previous transformed or previous grade 3B * follicular lymphoma	11 (28%)
Ann Arbor stage	
II	7 (18%)
III	11 (28%)
IV	21 (54%)
Bone marrow involvement	13 (33%)
Bulky disease (>7cm)	9 (23%)
Relapsed or refractory disease	
Refractory	20 (51%)
Relapsed	19 (49%)

	Enrolled patients (n=39)
FLIPI risk factors †	
0 or 1	9 (23%)
2	6 (15%)
3	15 (38%)
4	9 (23%)
5	0
β2 microglobulin	
High (>2·3 mg/L)	27 (69%)
Normal (≤2·3 mg/L)	12 (31%)
≥1 GELF criteria	36 (92%)
POD24 after the first line of treatment ‡	20 (51%)
Number of previous lines of therapy	
One	26 (67%)
Two	2 (5%)
Three to six	11 (28%)
First-line lymphoma therapy	
R-CHOP	22 (56%)
Bendamustine with rituximab	10 (26%)
Single-agent rituximab	6 (15%)
Rituximab, fludarabine, mitoxantrone, and dexamethasone	1 (3%)

Alderuccio et al. Lancet Hematology 2025

12-month PFS 95% with favorable toxicity profile



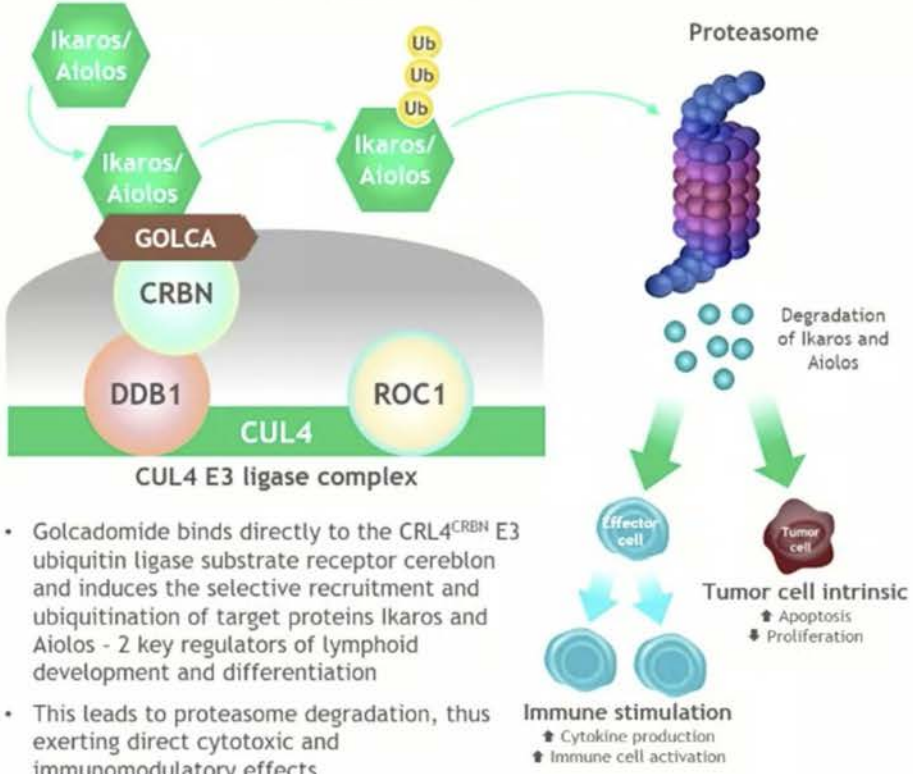
	Grade 1–2	Grade 3	Grade 4
Patients with any TEAEs	37 (95%)	18 (46%)	5 (13%)
Haematological TEAEs			
Neutropenia	10 (26%)	4 (10%)	1 (3%)
Anaemia	14 (36%)	0	0
Lymphopenia	5 (13%)	5 (13%)	3 (8%)
Platelet count decreased	9 (23%)	0	0
Leukopenia	2 (5%)	1 (3%)	0
Febrile neutropenia	0	1 (3%)	0
Non-haematological TEAEs			
Hyperglycaemia	16 (41%)	1 (3%)	0
Alkaline phosphatase increased	16 (41%)	0	0
Alanine aminotransferase increased	14 (36%)	1 (3%)	0
Aspartate aminotransferase increased	15 (38%)	0	0
Fatigue	15 (38%)	0	0
Rash maculopapular	14 (36%)	0	0
Creatinine increased	8 (21%)	0	0
Hyponatraemia	7 (18%)	0	0
Cough	7 (18%)	0	0
Diarrhoea	6 (15%)	0	0
Generalised oedema	5 (13%)	1 (3%)	0
Peripheral oedema	5 (13%)	1 (3%)	0
Photosensitivity	6 (15%)	0	0

Alderuccio et al. Lancet Hematology 2025

CC-220-DLBCL-001

Golcadomide as a potential first-in-class oral CELMoD agent for NHL

Mechanism of action[1]



- Golcadomide binds directly to the CRL4^{CRBN} E3 ubiquitin ligase substrate receptor cereblon and induces the selective recruitment and ubiquitination of target proteins Ikaros and Aiolos - 2 key regulators of lymphoid development and differentiation
- This leads to proteasome degradation, thus exerting direct cytotoxic and immunomodulatory effects

Allosteric regulation of cereblon[1]

- Recent cryo-EM data indicate that the cereblon complex has both an ***open, inactive state*** and a ***closed, active state***[1]
- Due to the unique binding modes of golcadomide, it is significantly more efficient than lenalidomide at driving the closed conformation,[1] leading to deeper and more rapid degradation of Ikaros/Aiolos

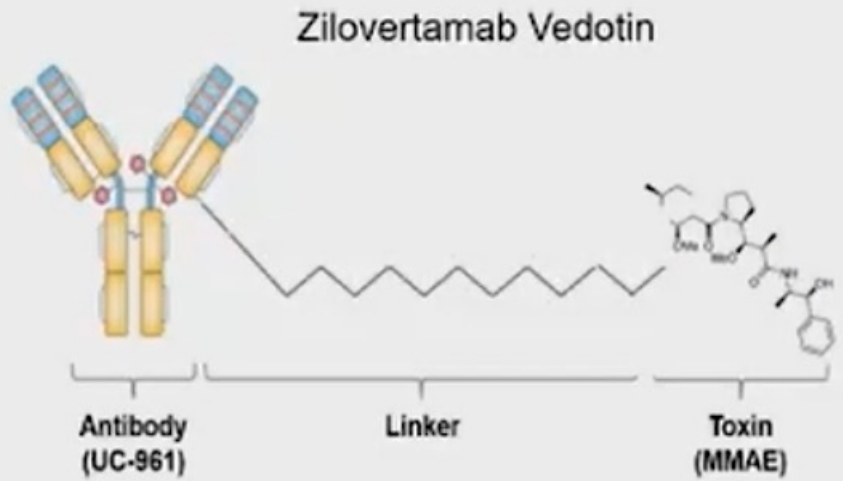
A Study to Compare the Efficacy and Safety of Golcadomide in Combination With Rituximab (Golca + R) vs Investigator's Choice in Relapsed/Refractory Follicular Lymphoma (GOLSEEK-4)

A Study to Evaluate the Efficacy and Safety of Golcadomide in Combination With Rituximab in Newly Diagnosed Advanced Stage Follicular Lymphoma (GOLSEEK-2)

Dana-Farber Cancer Institute

ROR1 and Zilovertamab Vedotin

- ROR1 is an oncofetal protein important for embryonic development
  - Physiologic expression disappears before birth[1]
  - Pathologic expression of ROR1 often reappears in aggressive hematologic and solid tumor cancers[2]
- ROR1 is present on the tumor cell surface and amenable to targeting with antibody-based therapeutics[1]
- Zilovertamab vedotin (MK-2140) is an ADC of:
  - The humanized monoclonal antibody, UC-961, with no normal tissue cross-reactivity
  - A cleavable linker and the anti-microtubule toxin, MMAE[3]
- Binding to tumor cell ROR1 causes rapid internalization and lysosomal trafficking to deliver MMAE



Borcherding N et al. *Protein Cell*. 2014;5:498-502; 2. Daneshmanesh AH et al. *Leuk Lymphoma*. 2013;54:843-850.3. Vaisitti T et al. *Blood*. 2021;137:3365-3377.

A Study of Zilovertamab Vedotin (MK-2140) as Monotherapy and in Combination in Aggressive and Indolent B-cell Malignancies (MK-2140-006)

Dana-Farber Cancer Institute

Case Presentation: 68-year-old man with recurrent FL and bulky disease receives mosunetuzumab

Dr Syed Zafar (Fort Myers, Florida)

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TO PRACTICE

QUESTIONS FOR THE FACULTY

How long do you continue mosunetuzumab in patients with R/R FL? If this patient achieves a complete response, would you discontinue mosunetuzumab in his case?

What other novel strategies are you excited about in R/R FL? Do you believe tafasitamab in combination with lenalidomide/ rituximab (R^2) will receive FDA approval for R/R FL in the near future? If you were able to access tafasitamab/R^2, for which patients with R/R FL would you want to administer it? How would the availability of this regimen affect your sequencing of bispecific antibodies and CAR T-cell therapy?

Agenda

MODULE 1: Selection and Sequencing of Available Therapies for Diffuse Large B-Cell Lymphoma — Dr Flowers

MODULE 2: Evolving Management Paradigm for Mantle Cell Lymphoma — Dr Phillips

MODULE 3: Integration of Novel Therapies into the Management of Follicular Lymphoma — Dr LaCasce

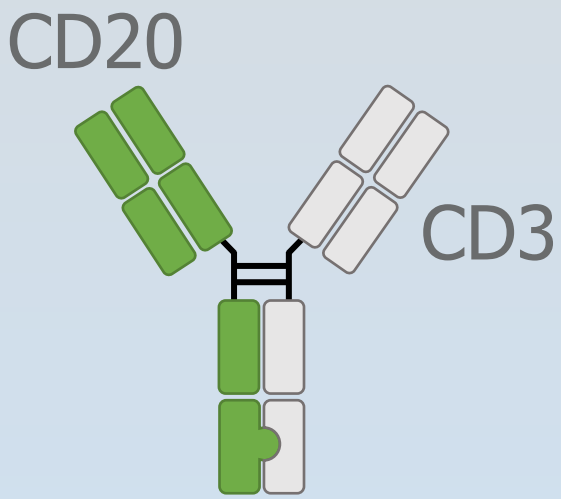
MODULE 4: Integrating Bispecific Antibodies into the Management of NHL — Dr Brody

MODULE 5: Current Role of CAR T-Cell Therapy in Various Non-Hodgkin Lymphoma (NHL) Subtypes — Dr Abramson

RTP RESEARCH TO PRACTICE

Integrating Bispecific Antibodies into the management of NHL

Joshua Brody, MD



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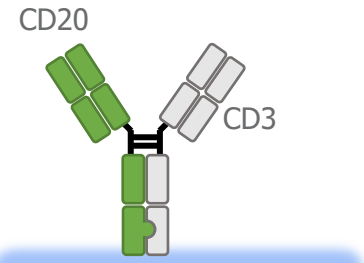
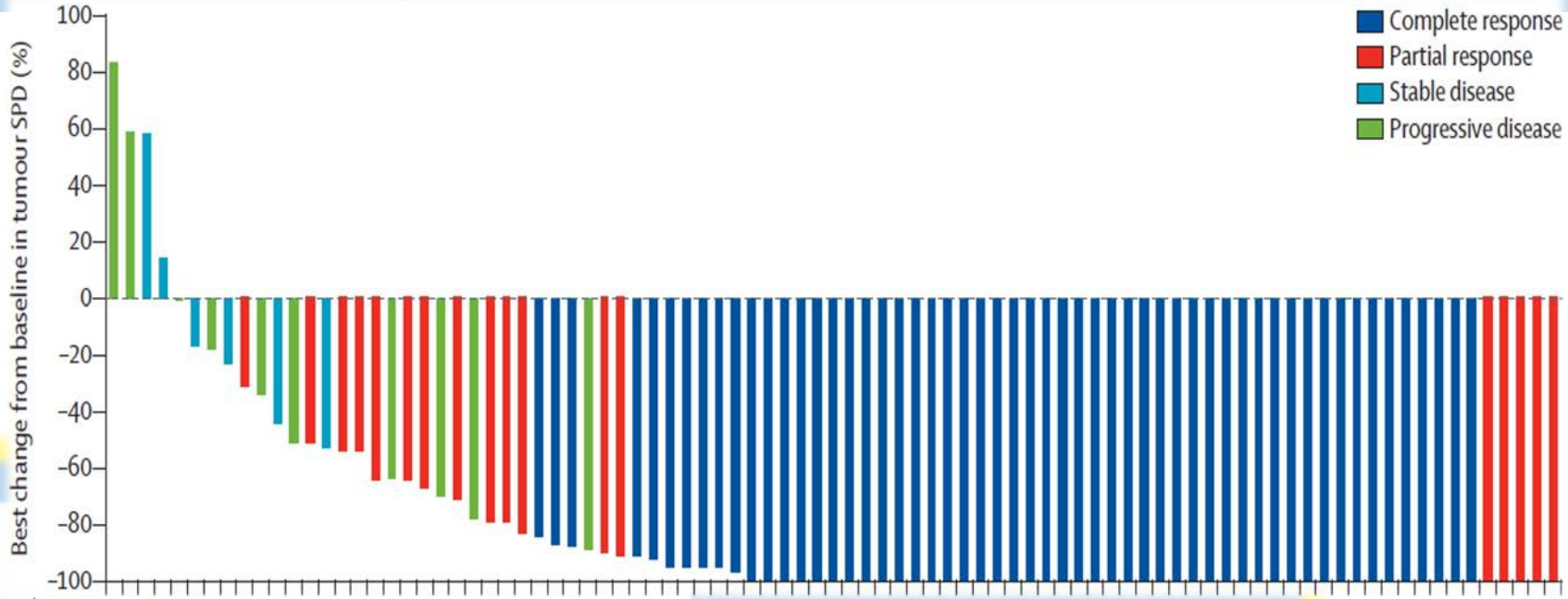
RESEARCH TO PRACTICE

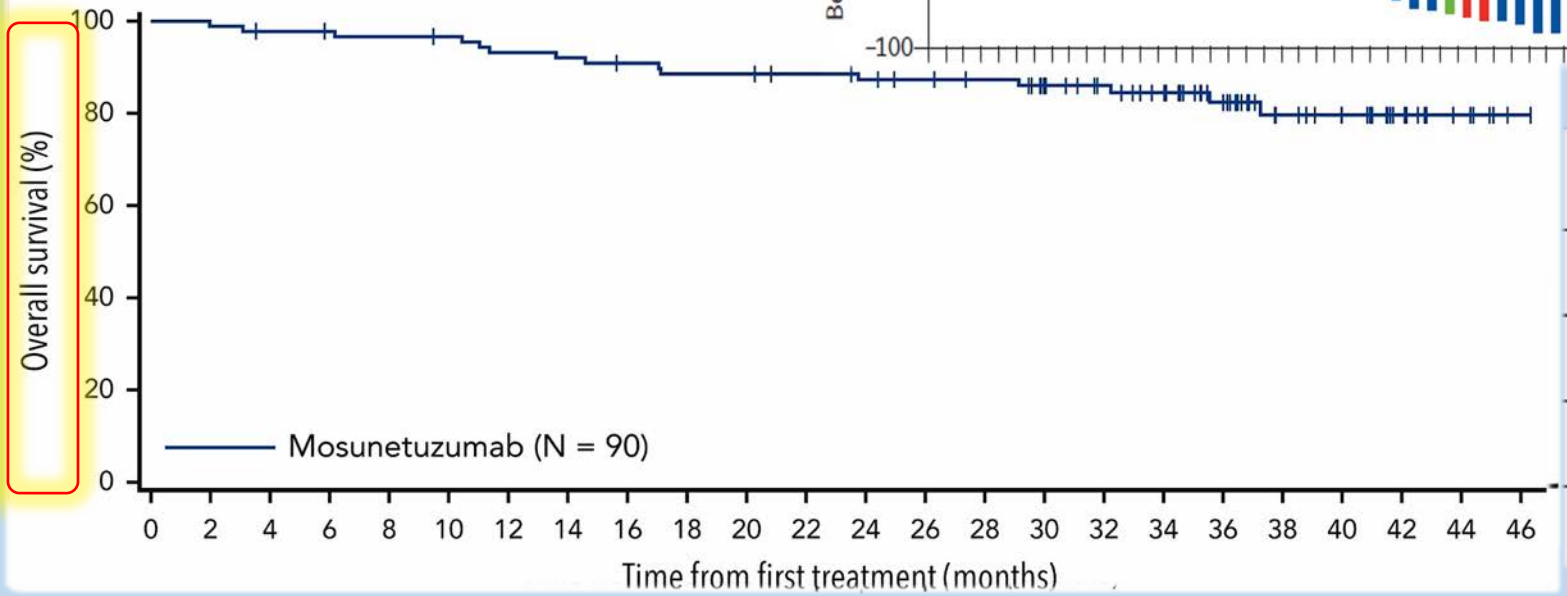
2025 ASCO®
ANNUAL MEETING

Efficacy/Safety: bsAbs for r/r Follicular Lymphoma – mosunetuzumab NCT02500407



Mosunetuzumab



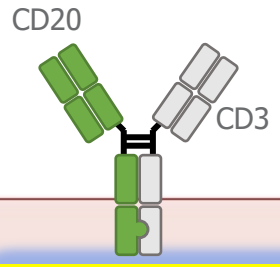


	median, months
DOR	35.9
DOCR	NR
PFS	24
OS	NR

Sehn LH, et al. Blood. 2025;145:708-719.

Budde LE, et al. Lancet Oncol. 2022 Aug;23(8):1055-1065.

Efficacy/Safety: bsAbs for r/r Follicular Lymphoma – mosunetuzumab NCT02500407



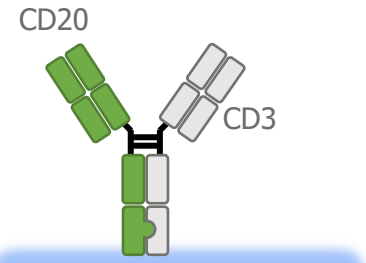
Mosunetuzumab

	Grade 1–2	Grade 3	Grade 4
Cytokine release syndrome	38 (42%)	1 (1%)	1 (1%)
Fatigue	33 (37%)	0	0
Headache	27 (30%)	1 (1%)	0
Neutropenia or decreased neutrophil count	2 (2%)	12 (13%)	12 (13%)
Pyrexia	25 (28%)	1 (1%)	0
Hypophosphataemia	9 (10%)	15 (17%)	0
Pruritus	19 (21%)	0	0
Hypokalaemia	15 (17%)	2 (2%)	0
Cough	16 (18%)	0	0
Constipation	16 (18%)	0	0
Diarrhoea	15 (17%)	0	0
Nausea	15 (17%)	0	0
Rash	13 (14%)	1 (1%)	0

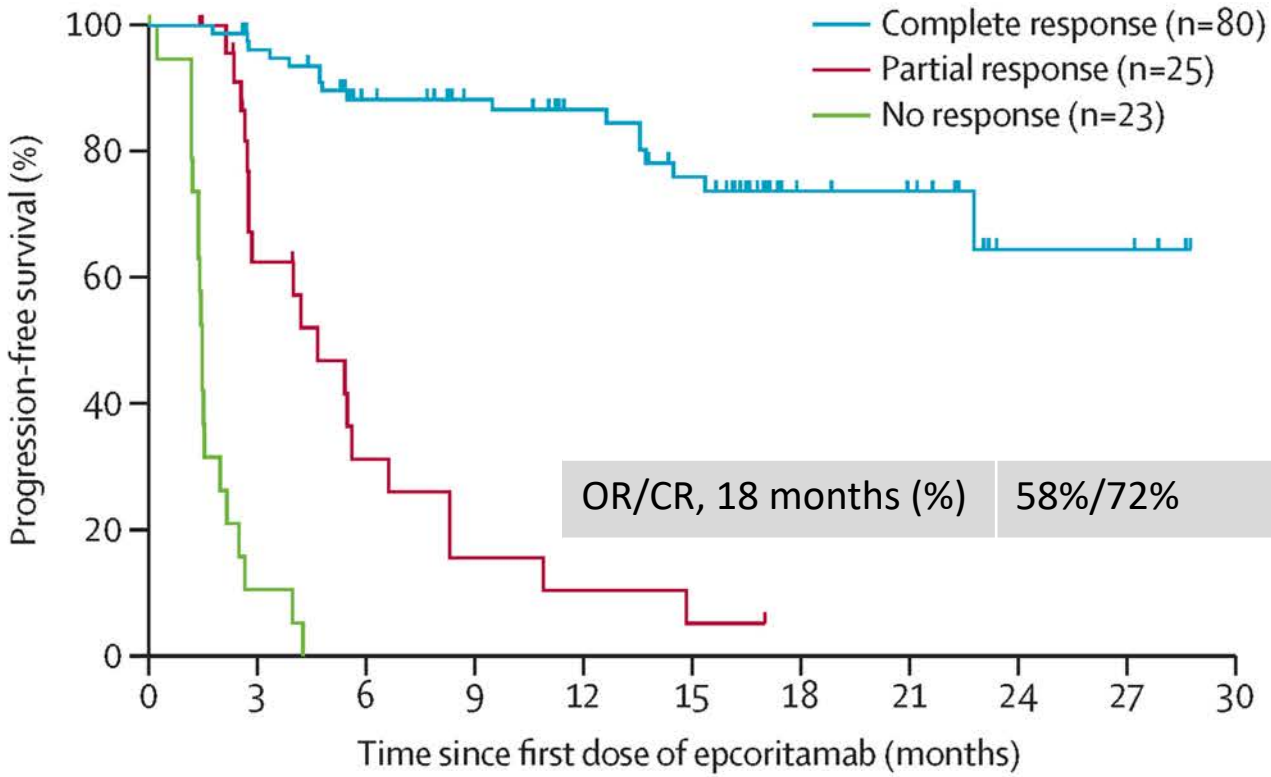
	Grade 1–2	Grade 3	Grade 4
Dry skin	14 (16%)	0	0
Anaemia	5 (6%)	7 (8%)	0
Chills	11 (12%)	1 (1%)	0
Hypomagnesaemia	11 (12%)	0	0
Increased alanine aminotransferase	6 (7%)	4 (4%)	1 (1%)
Insomnia	11 (12%)	0	0
Arthralgia	10 (11%)	0	0
Peripheral oedema	10 (11%)	0	0
Abdominal pain	8 (9%)	1 (1%)	0
Back pain	8 (9%)	1 (1%)	0
Dizziness	9 (10%)	0	0
Urinary tract infection	8 (9%)	1 (1%)	0
Skin exfoliation	9 (10%)	0	0
Thrombocytopenia	5 (6%)	0	4 (4%)

Sehn LH, et al. Blood. 2025;145:708-719. Budde LE, et al. Lancet Oncol. 2022 Aug;23(8):1055-1065.

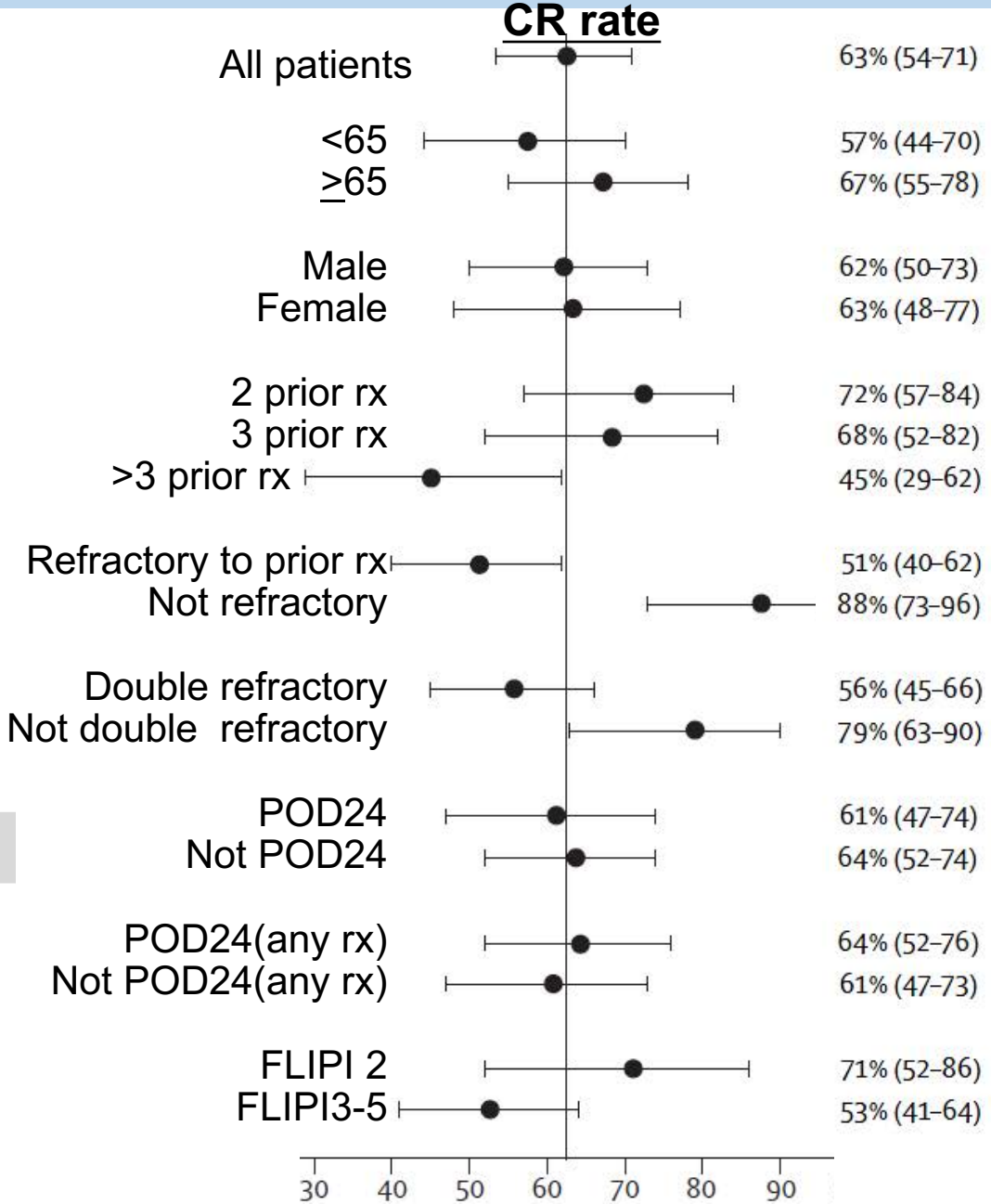
Efficacy/Safety: bsAbs for r/r Follicular Lymphoma – epcoritamab EPCORE NHL-1



Epcoritamab

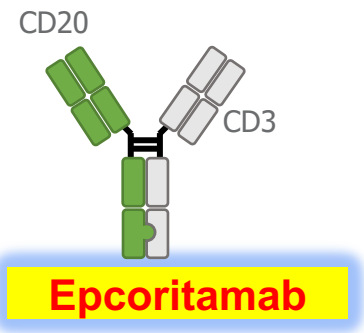


OR/CR, 18 months (%)	58%/72%

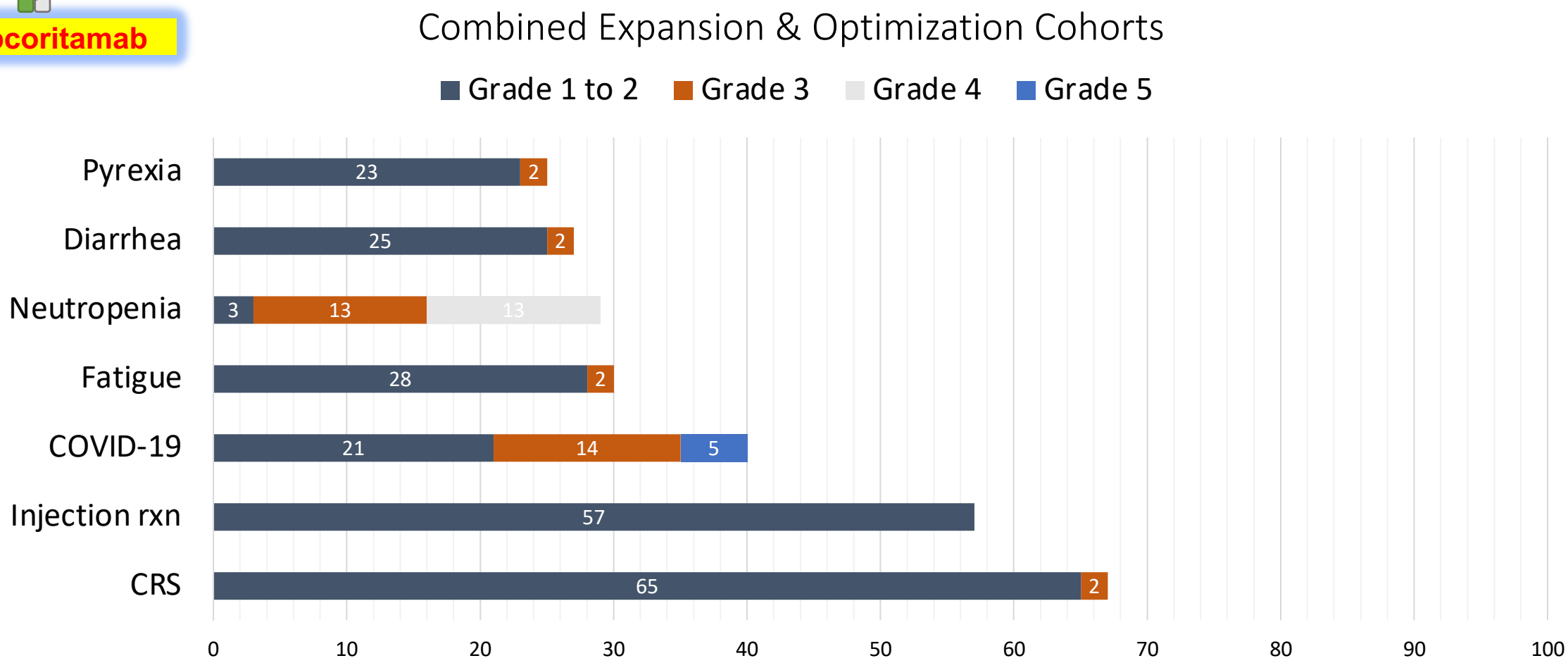


Linton KM, et al. Lancet Haematol. 2024; 11:e593-e605.

Efficacy/Safety: bsAbs for r/r Follicular Lymphoma – epcoritamab EPCORE NHL-1



EPCORE NHL-1: FL Cohort Safety



Linton KM, et al. Lancet Haematol. 2024; 11:e593-e605.

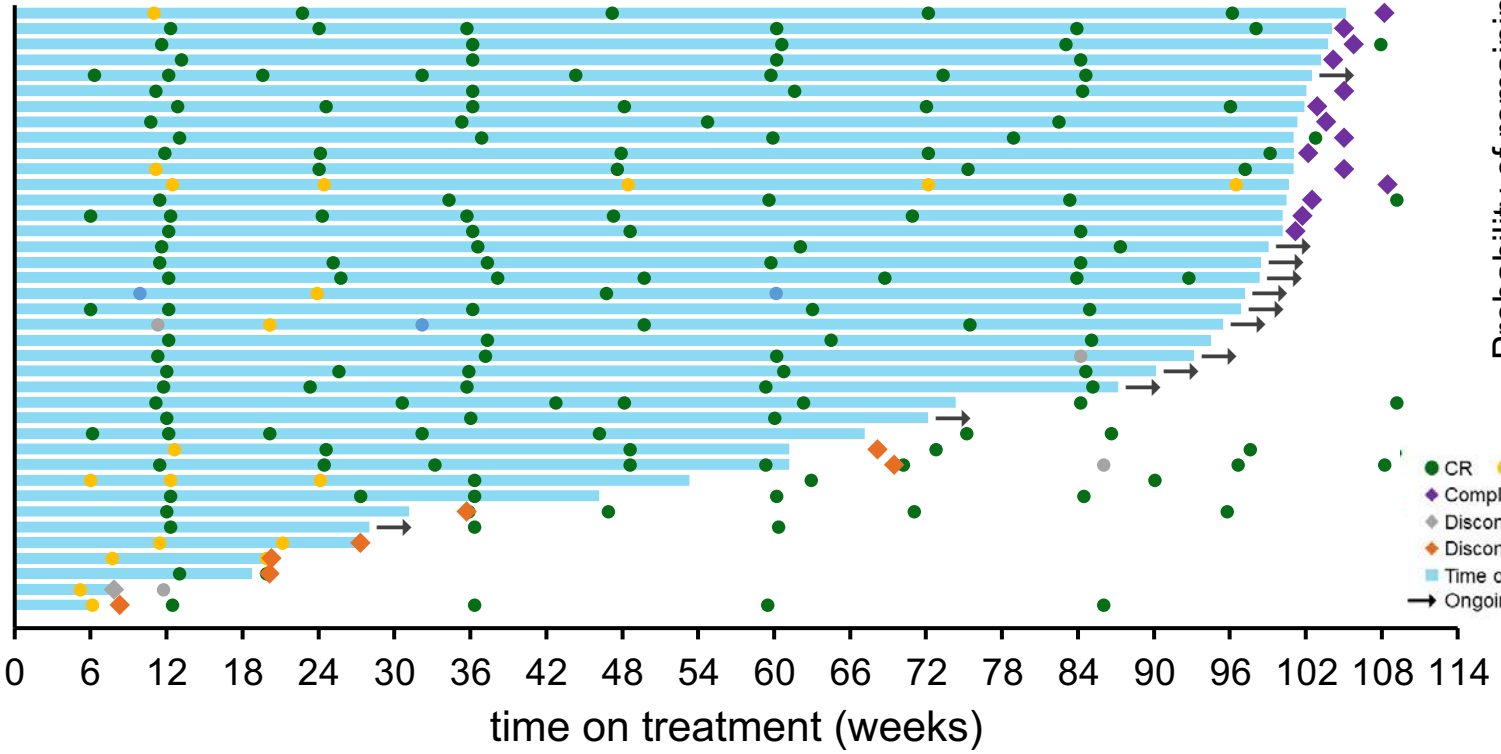
BsAbs in earlier settings and in combination therapies for FL: epcoritamab

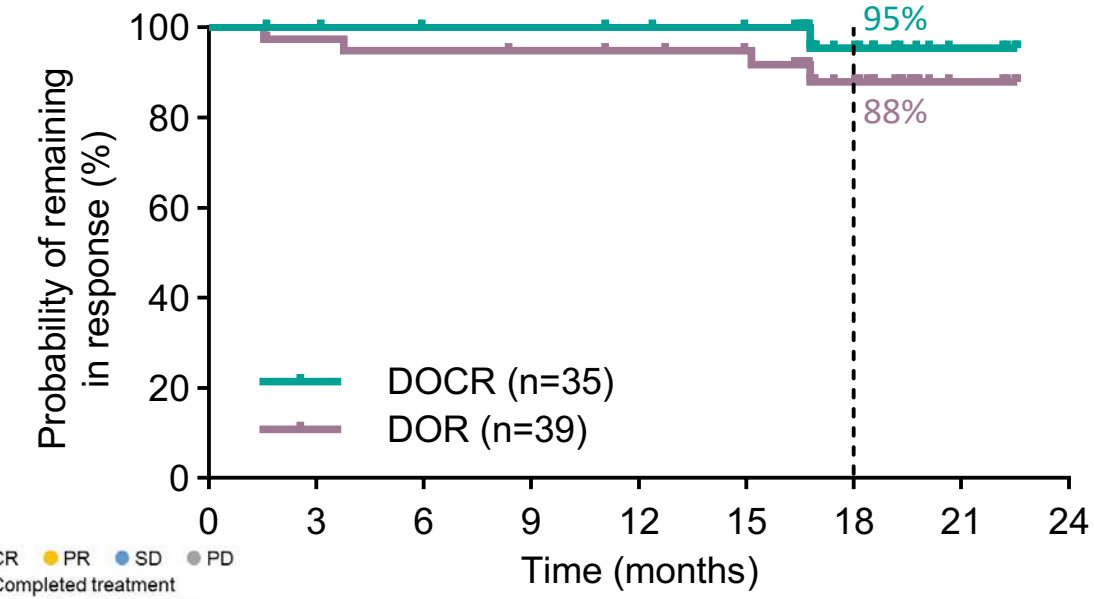
Epcoritamab + R² in First-Line Therapy FL: EPCORE NHL-2 arm 6

N=41

Epcoritamab (SC)	Rituximab (IV)	Lenalidomide (oral)
48 mg	**375 mg/m²**	**20 mg**
QW C1–2, Q4W C3+ (28 d/C)	QW C1, Q4W C2–6	QD for 21 d in C1–12
Treatment up to 2 y		

Overall response, n (%)	39 (95)
Complete response, **n (%)**	35 (85)
Partial response, **n (%)**	4 (10)

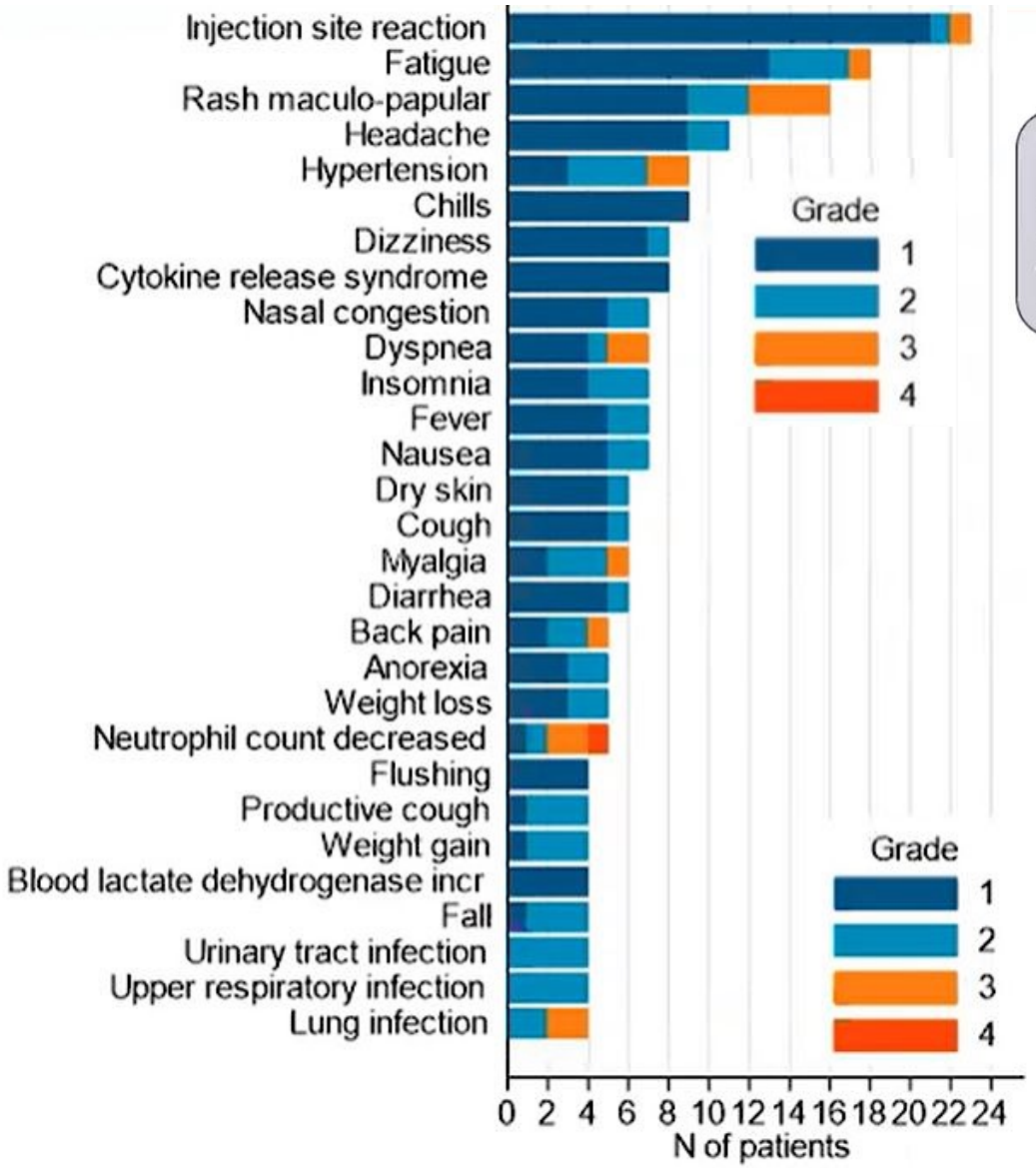


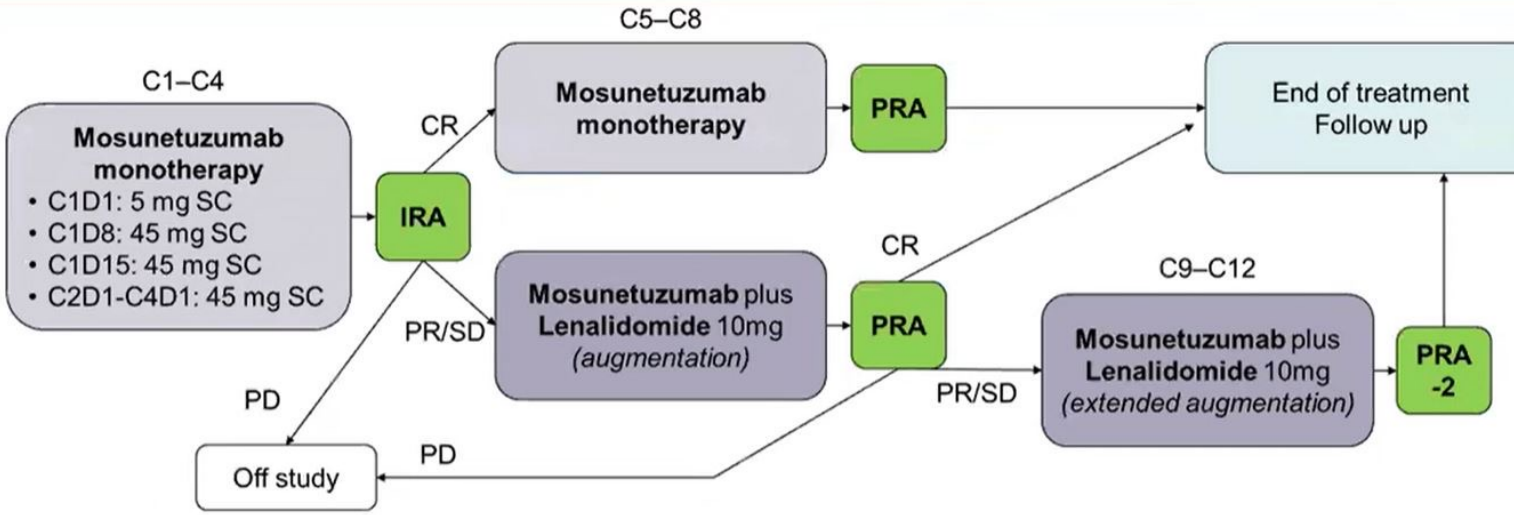


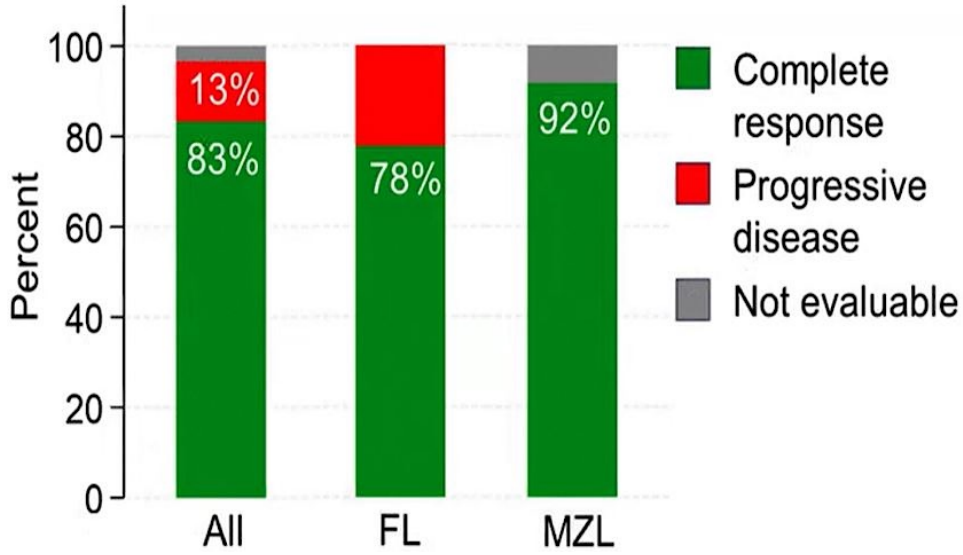
Leslie, L et al., ASCO 2024

BsAbs in earlier settings and in combination therapies for FL: mosunetuzumab

Mosunetuzumab w Response-Driven Lenalidomide Augmentation As 1st-Line Therapy for FL/MZL: (NCT04792502)

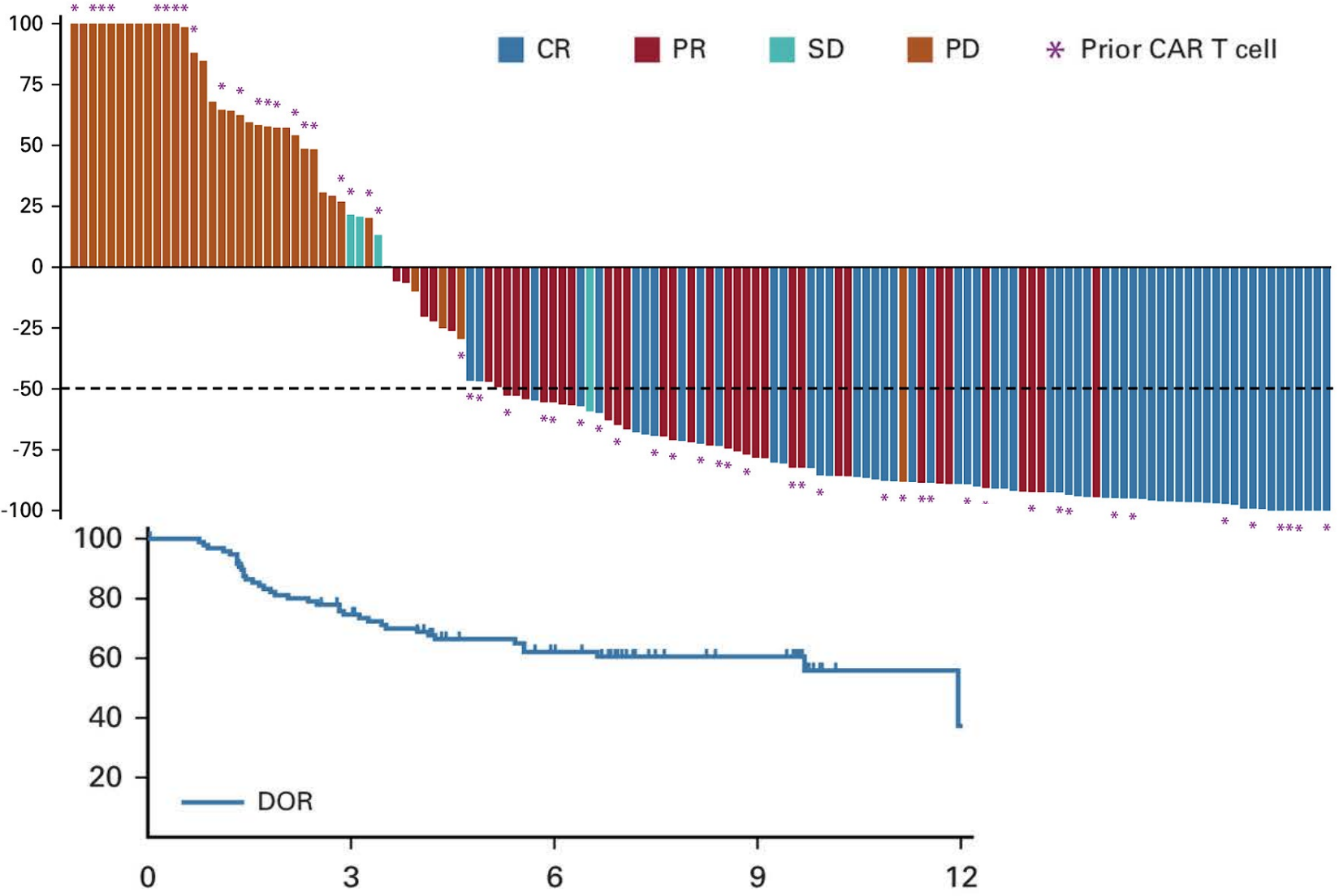






Olszewski AJ et al., ASH 2024

Efficacy/Safety: bsAbs for r/r DLBCL – epcoritamab EPCORE NHL-1

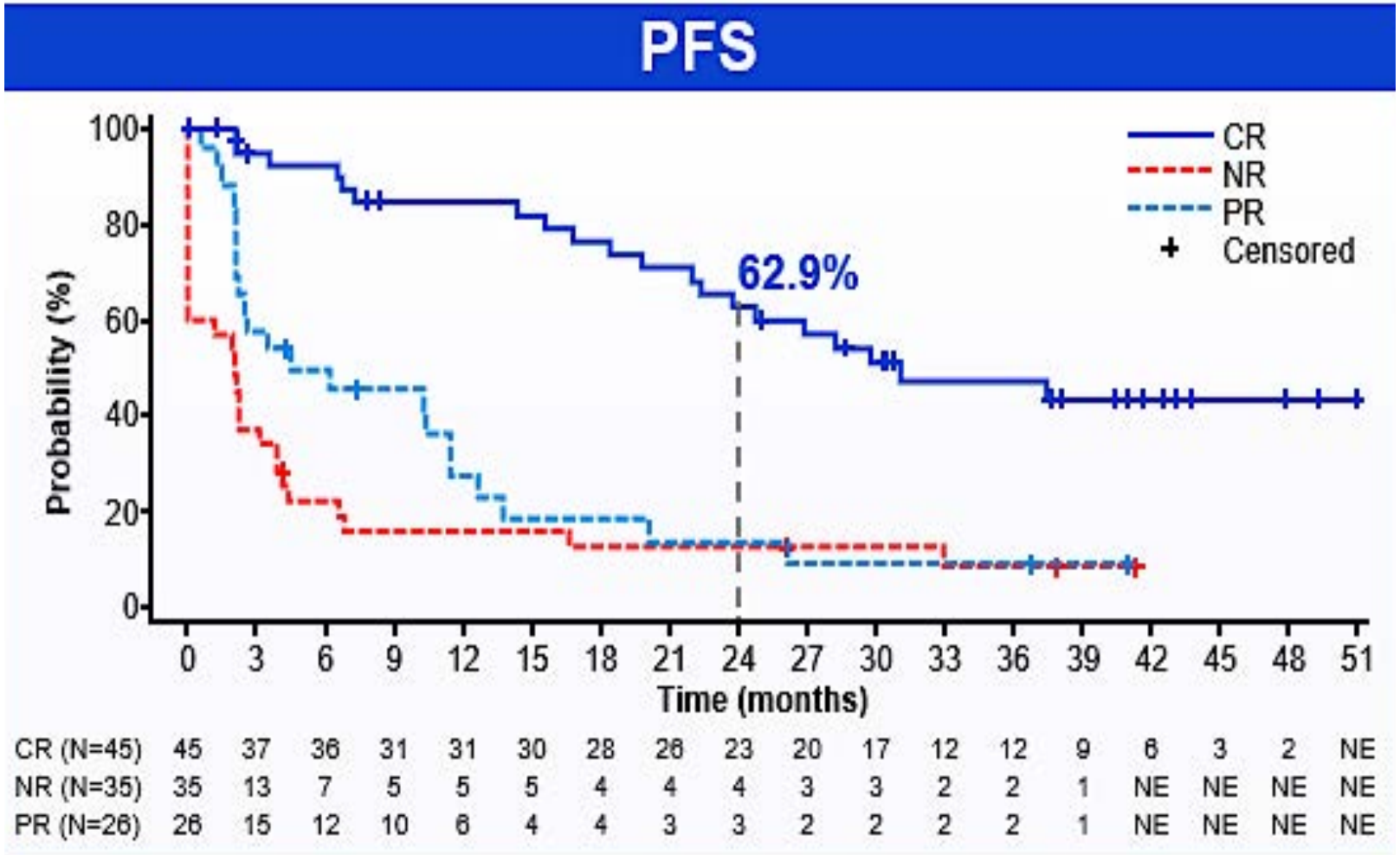


End Point	Patients (N = 157)
ORR, (%) [95% CI]	99 (**63.1**) [55.0, 70.6]
CR	61 (**38.9**) [31.2, 46.9]
PR	38 (24.2)
SD	5 (3.2)
PD	37 (23.6)

Thieblemont C, et al. J Clin Oncol. 2023;41:2238-2247.

Efficacy/Safety: bsAbs for r/r DLBCL – glofitamab NCT02500407

At 3 years	n = 155
ORR	80 (52%)
CRR	61 (39%)
Median PFS	4.9 months
Median DoR	18.4 months
Median DoCR	29.8 months

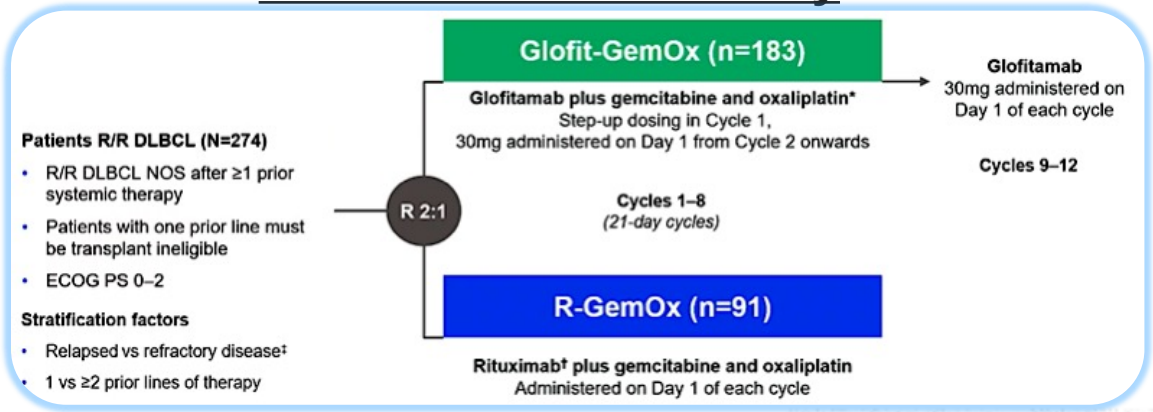


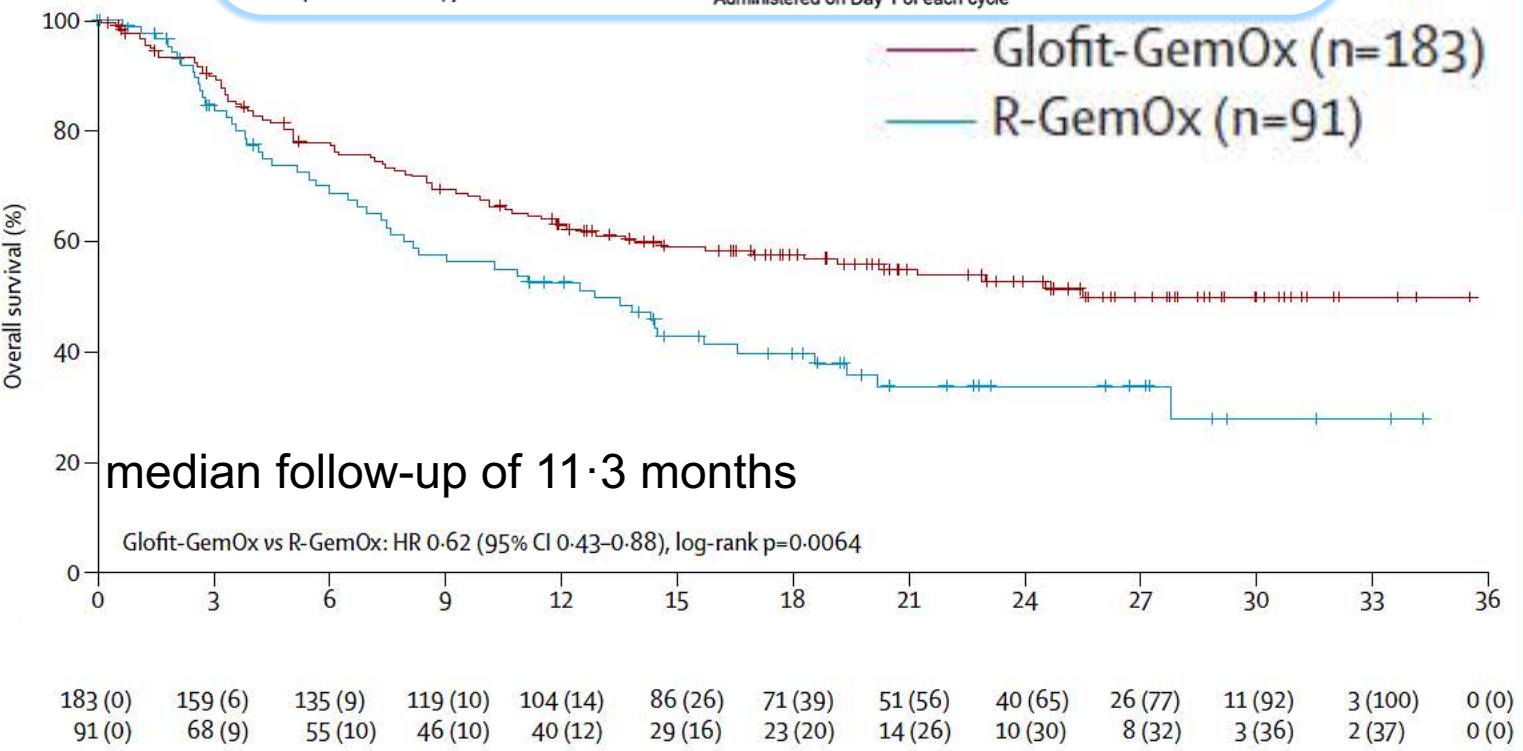
Dickinson M, et al. N Engl J Med. 2022;387:2220-2231.

Dickinson MJ et al. Blood (2024) 144 (Supplement 1): 865

BsAbs with chemo: Gem-Ox + CD20 x CD3 bsAbs for r/r DLBCL

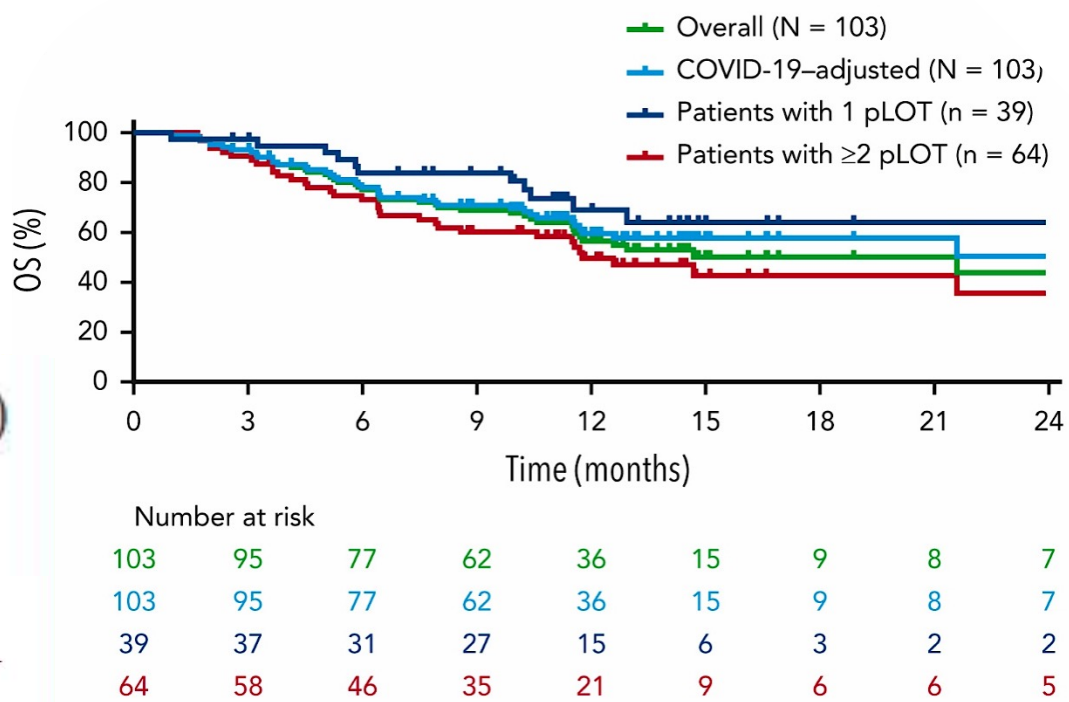
Phase III STARGLO study





Abramson JS et al., Lancet 2024 Nov 16;404(10466):1940-1954.

Phase II Epcor-GemOx (n=103)

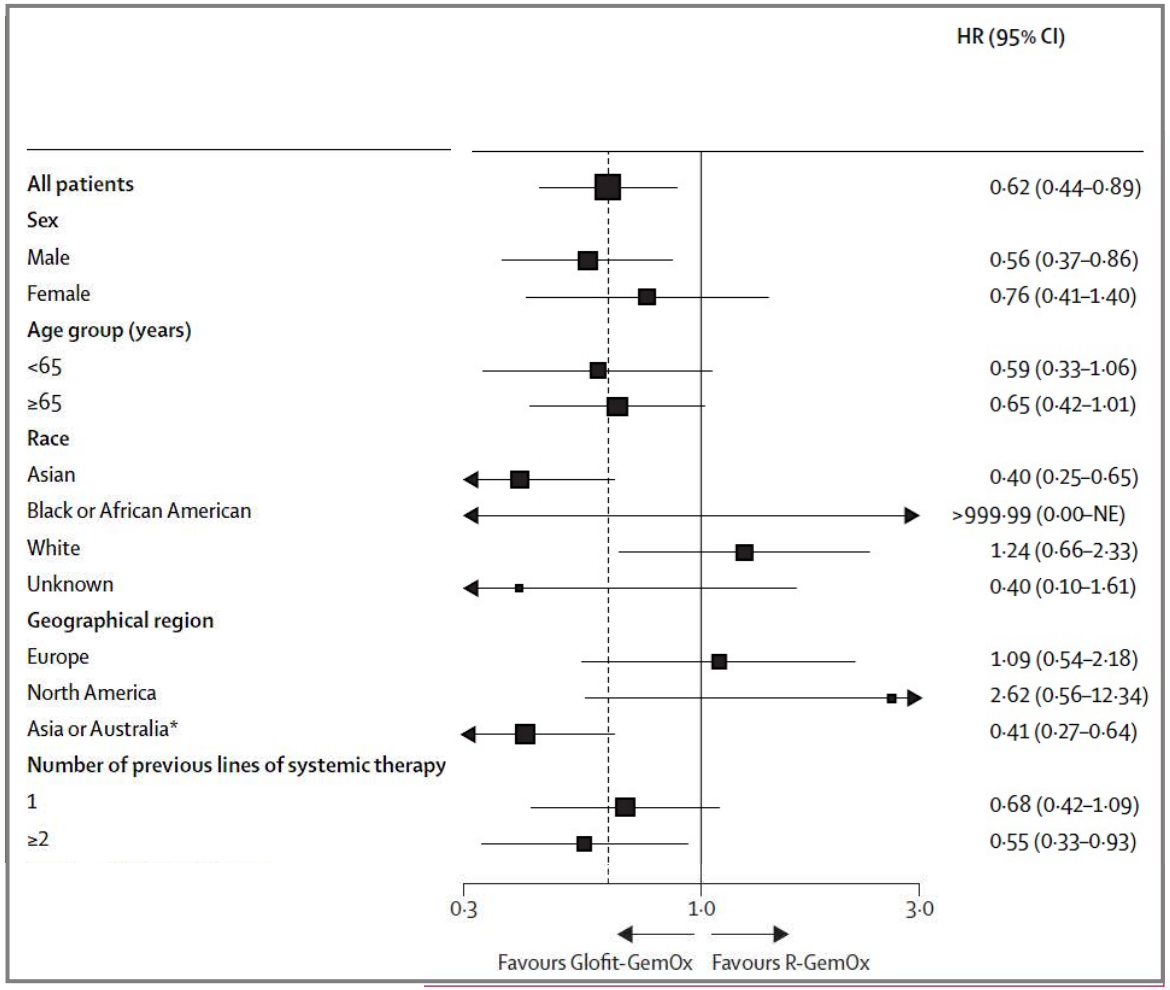


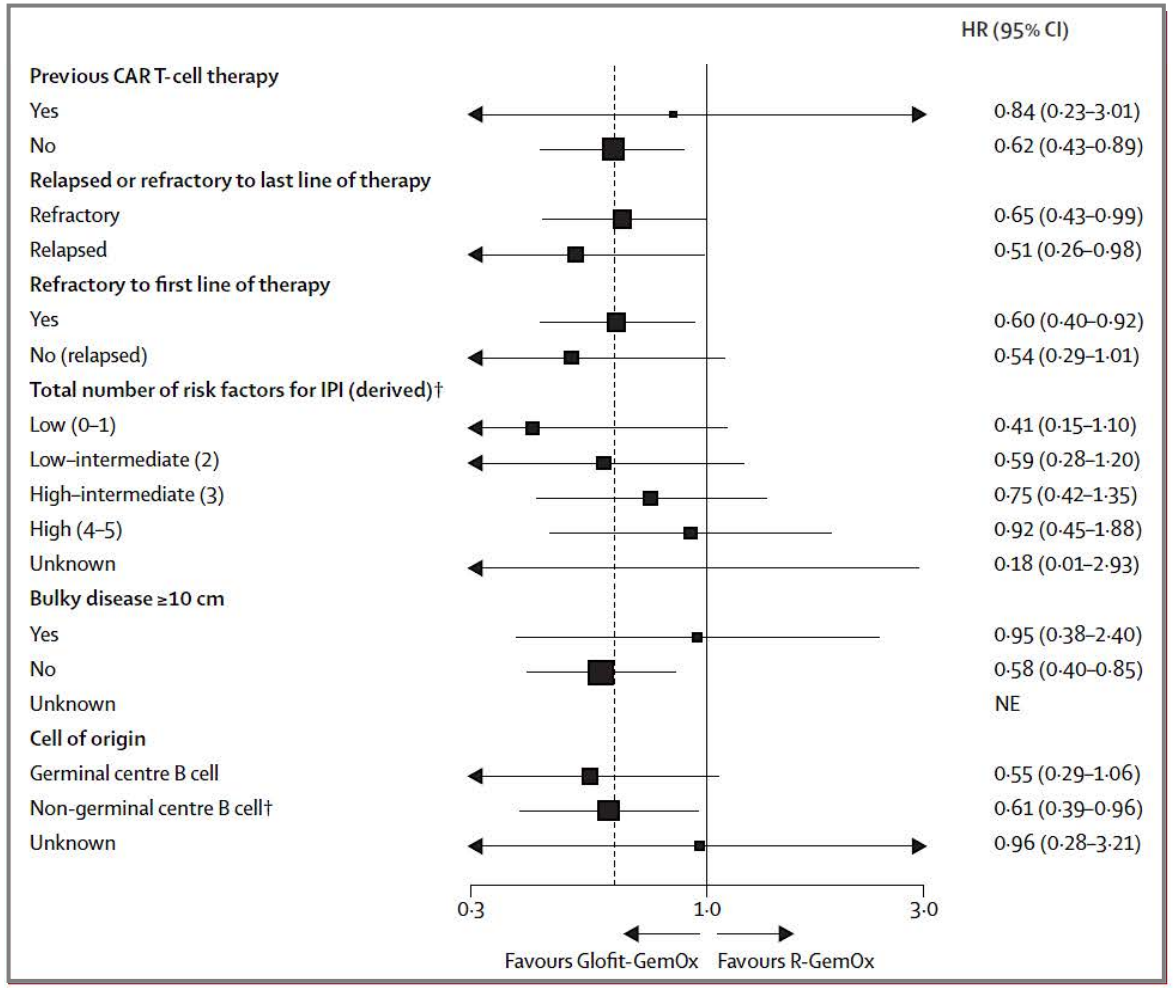
Number at risk

103	95	77	62	36	15	9	8	7
103	95	77	62	36	15	9	8	7
39	37	31	27	15	6	3	2	2
64	58	46	35	21	9	6	6	5

Brody JD et al., Blood 2025 Apr 10;145(15):1621-1631.

BsAbs with chemo: Gem-Ox + CD20 x CD3 bsAbs for r/r DLBCL



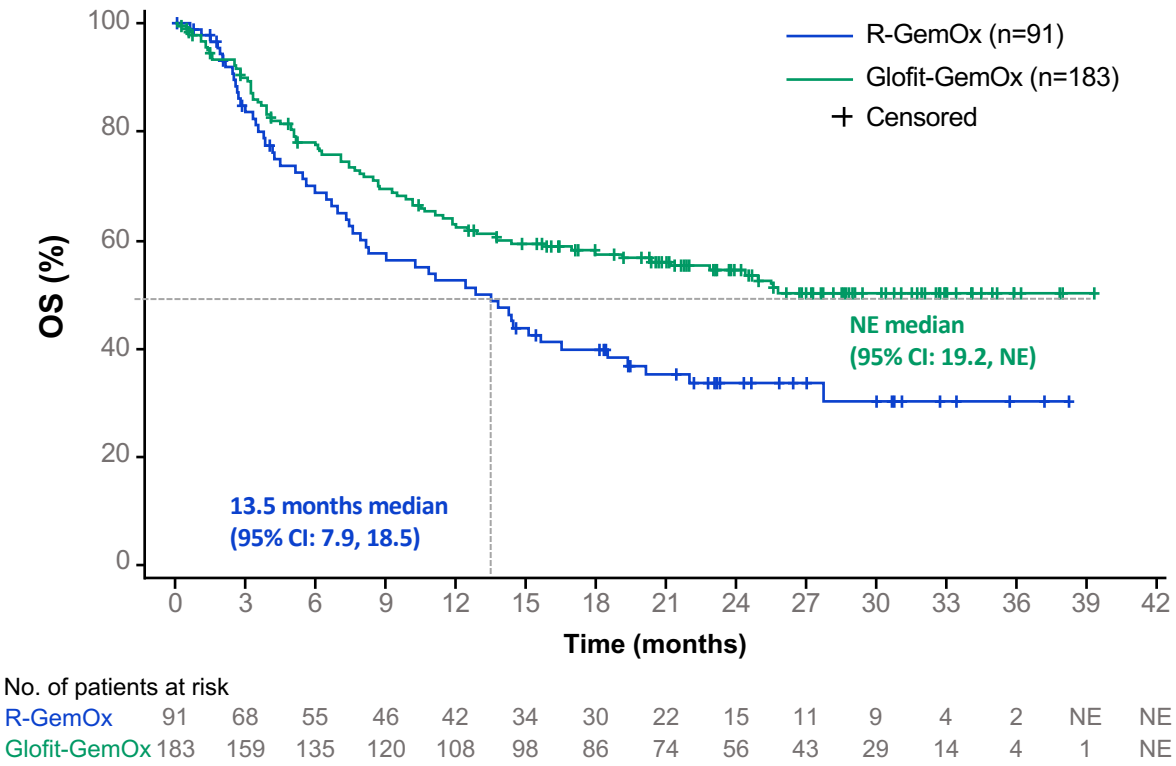


Abramson JS et al., Lancet 2024 Nov 16;404(10466):1940-1954.

BsAbs + chemo: Gem-Ox + CD20 x CD3 bsAbs for r/r DLBCL

Phase III STARGLO - Two-year follow-up

Overall survival with ~2 years of follow up



Outcome	R-GemOx (n=91)	Glofit-GemOx (n=183)
2-year follow up analysis (median follow up: 24.7 months)		
OS, median (95% CI); months	13.5 (7.9, 18.5)	NE (19.2, NE)
HR (95% CI)	**0.60** (0.42, 0.85)	
p-value*	0.003	
24-month OS, % (95% CI)	**33.6** (22.9, 44.2)	**54.4** (46.8, 62.0)

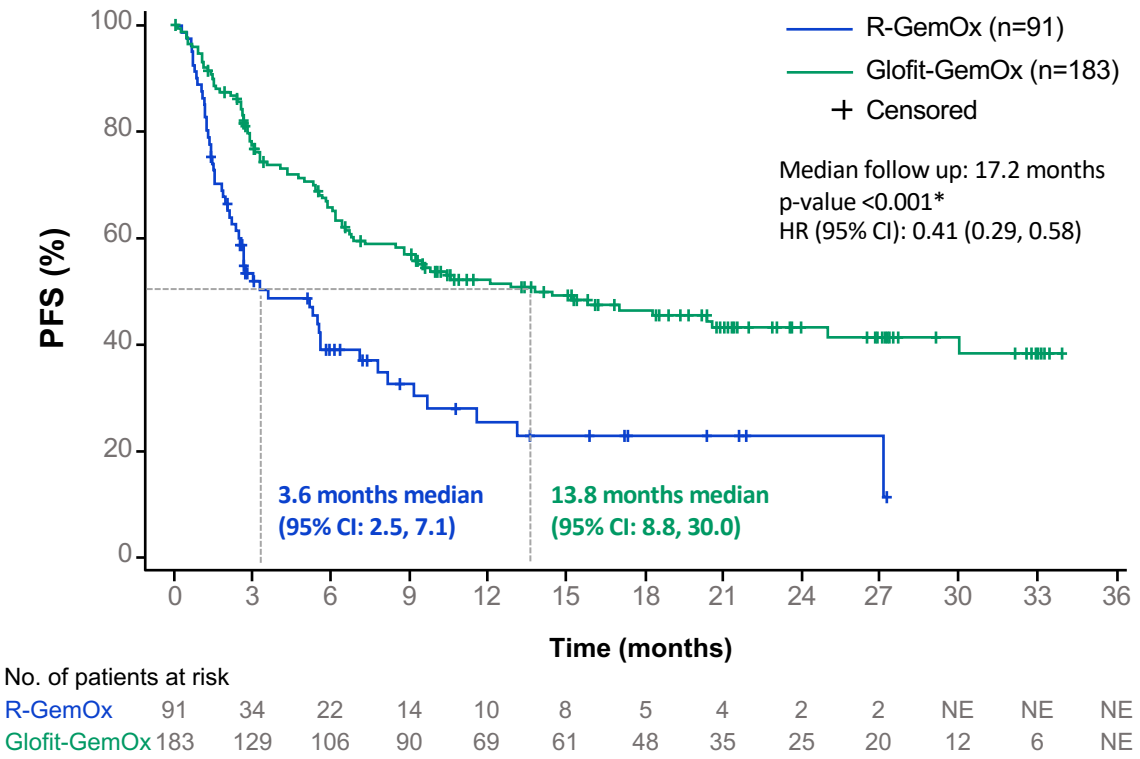
At data cut-off, 26.9% of Glofit-GemOx-treated patients and 57.1% of R-GemOx-treated patients had received ≥1 NALT

Abramson JS et al., Lancet 2024 Nov 16;404(10466):1940-1954.

BsAbs + chemo: Gem-Ox + CD20 x CD3 bsAbs for r/r DLBCL

Phase III STARGLO - Two-year follow-up

Progression-free survival with extended follow up

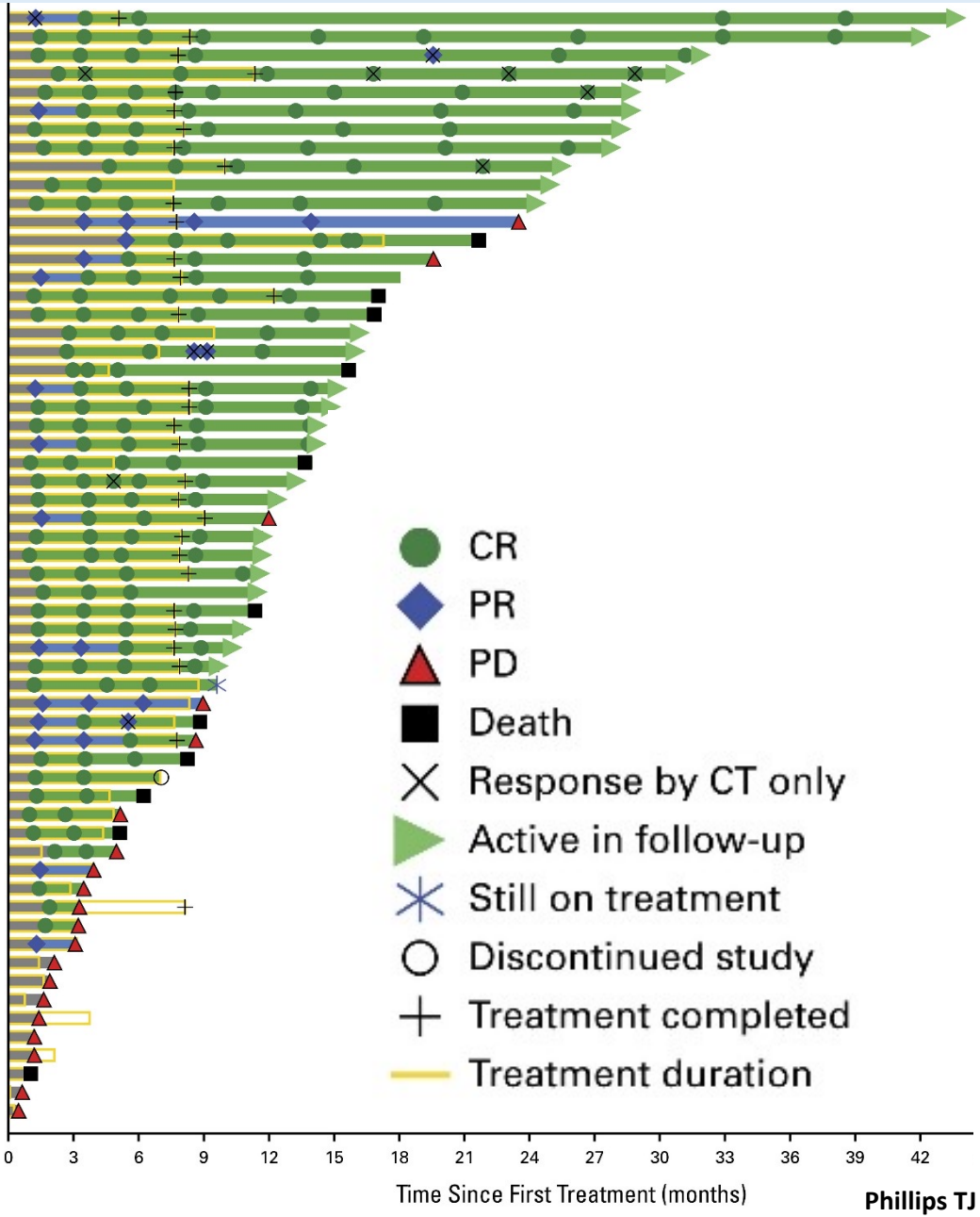


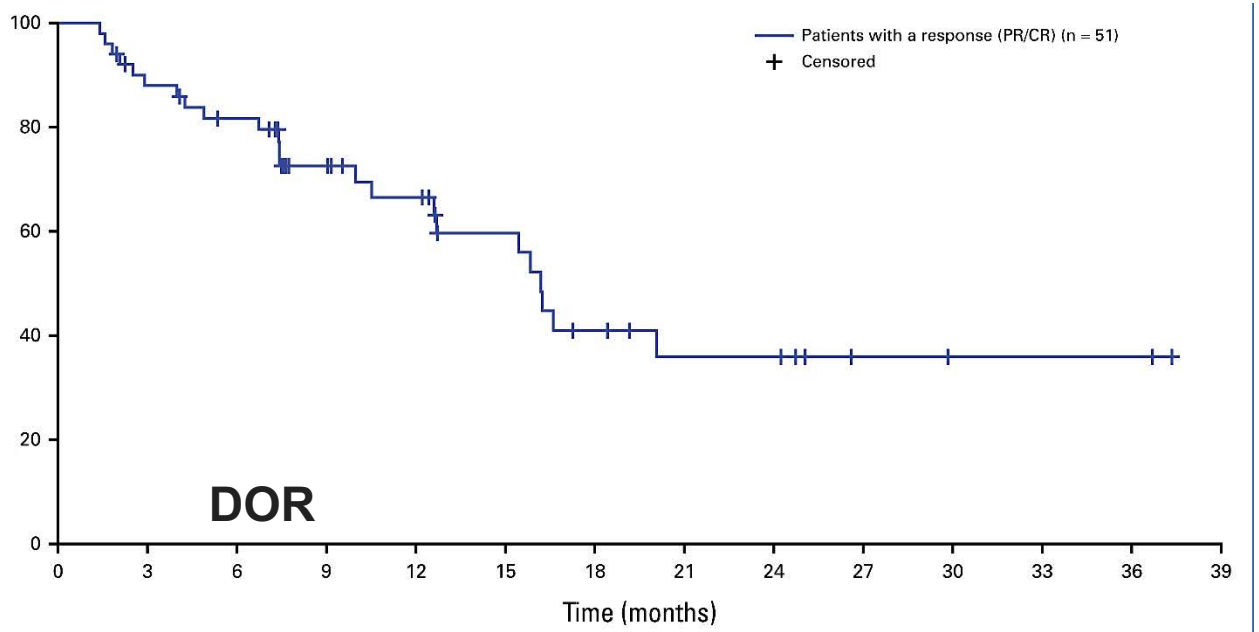
Outcome	R-GemOx (n=91)	Glofit-GemOx (n=183)
PFS, median (95% CI); months	**3.6** (2.5, 7.1)	**13.8** (8.8, 30.0)
ORR, % (95% CI)	**40.7** (30.5, 51.5)	**68.3** (61.0, 75.0)
CR rate, % (95% CI)	**25.3** (16.8, 35.5)	**58.5** (51.0, 65.7)
DoCR, median (95% CI); months	24.2 (6.9, NE)	NE (27.2, NE)
Ongoing CR, % (n)	**17.6** (16)	**42.1** (77)

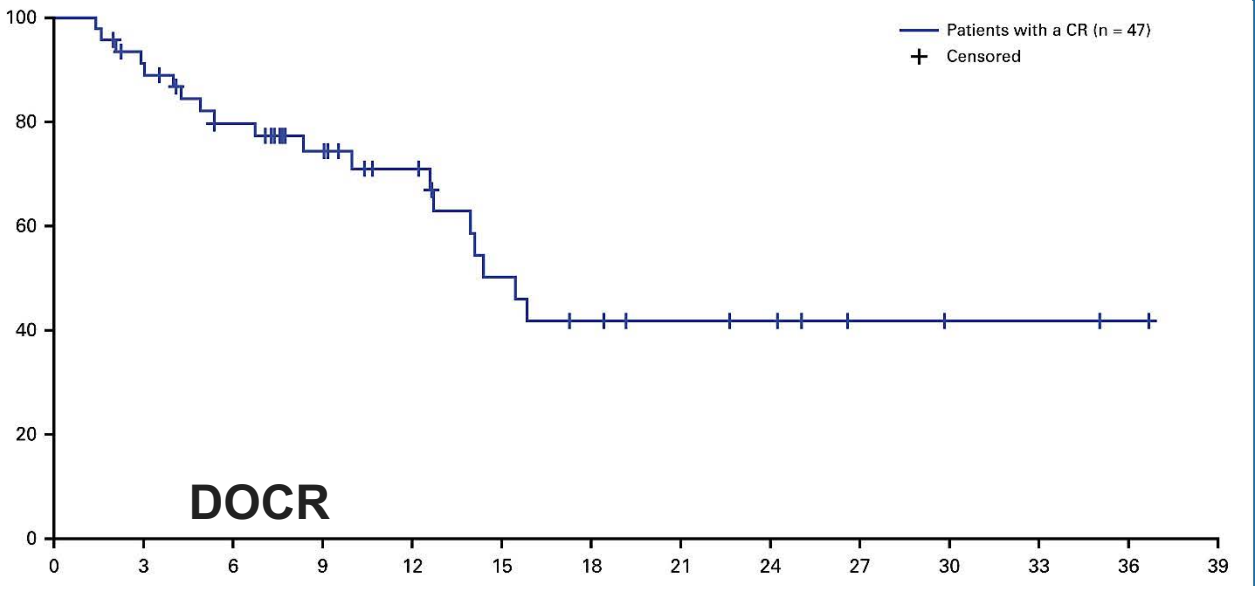
Abramson JS et al., Lancet 2024 Nov 16;404(10466):1940-1954.

Abramson JS et al., ASCO 2025 *do not distribute*

Efficacy/Safety: bsAbs for other lymphomas - glofitamab in mantle cell lymphoma







Phillips TJ et al., J Clin Oncol. 2025 Jan 20;43(3):318-328.

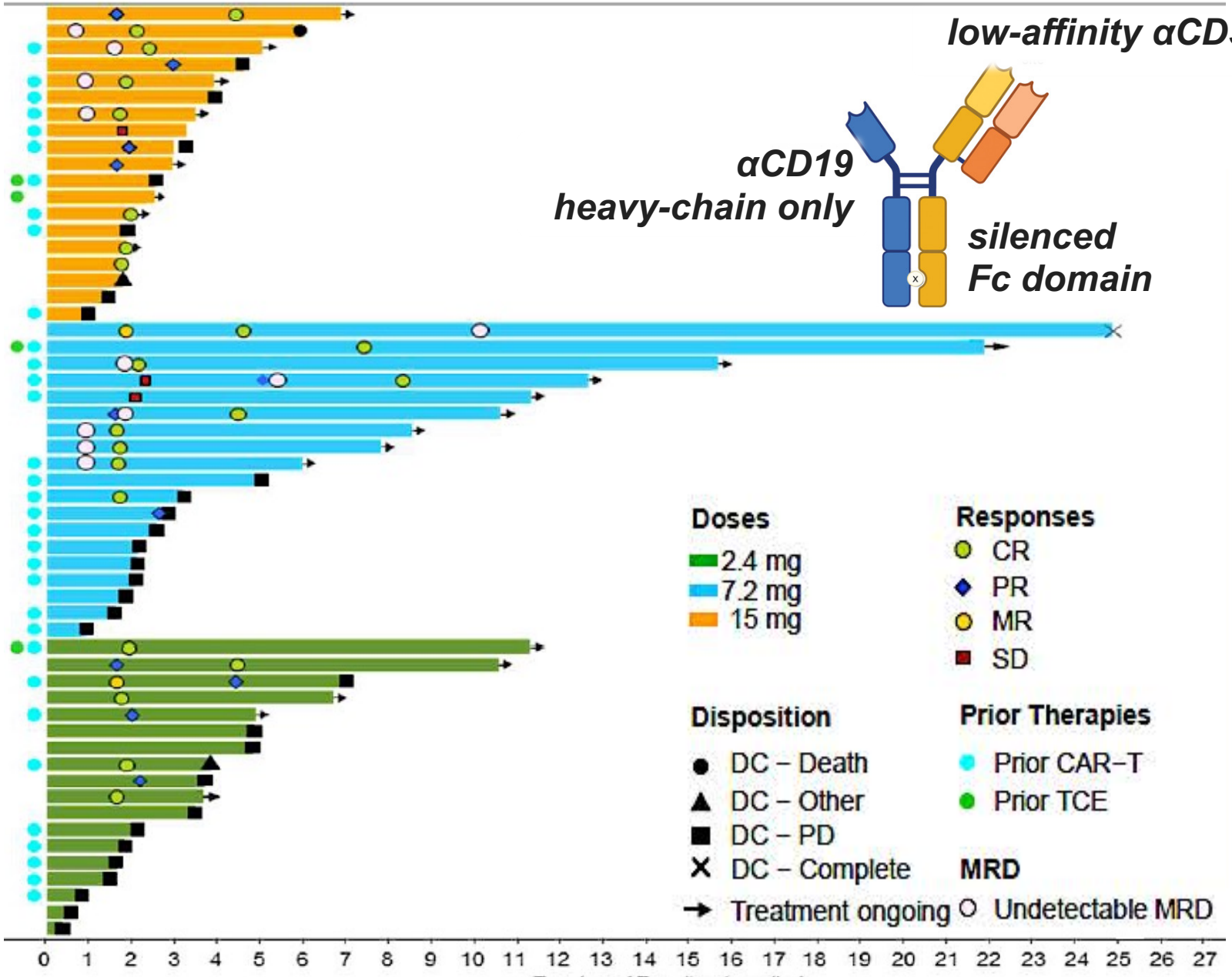
Efficacy/Safety: bsAbs for other lymphomas - glofitamab in mantle cell lymphoma

CRS Event/Management	Glofitamab SUD, No. (%)		
	1,000 mg Gpt Cohort (n = 16)	2,000 mg Gpt Cohort (n = 44)	All Patients (N = 60)
Any CRS	14 (87.5)	28 (63.6)	42 (70.0)
Grade 1	4 (25.0)	18 (40.9)	22 (36.7)
Grade 2	6 (37.5)	7 (15.9)	13 (21.7)
Grade 3	2 (12.5)	3 (6.8)	5 (8.3)
Grade 4	2 (12.5)	0	2 (3.3)
Serious AE of CRS	11 (68.8)	12 (27.3)	23 (38.3)
Fatal CRS event	0	0	0

CRS Event/Management	Glofitamab SUD, No. (%)		
	1,000 mg Gpt Cohort (n = 16)	2,000 mg Gpt Cohort (n = 44)	All Patients (N = 60)
CRS management			
Tocilizumab	11 (68.8)	11 (25.0)	22 (36.7)
Corticosteroid	8 (50.0)	10 (22.7)	18 (30.0)
Tocilizumab and corticosteroids	6 (37.5)	7 (15.9)	13 (21.7)
Low flow oxygen	6 (37.5)	4 (9.1)	10 (16.7)
ICU stay	5 (31.3)	4 (9.1)	9 (15.0)
Fluid support	4 (25.0)	5 (11.4)	9 (15.0)
Single-pressor therapy	4 (25.0)	3 (6.8)	7 (11.7)
Multiple-pressor therapy	2 (12.5)	0	2 (3.3)
High-flow oxygen	1 (6.3)	0	1 (1.7)
Mechanical ventilation	1 (6.3)	0	1 (1.7)

Phillips TJ et al., J Clin Oncol. 2025 Jan 20;43(3):318-328.

Efficacy/Safety: bsAbs *beyond* CD20 – AZD0486 CD19 x CD3



- N=114 (FL: n=56/DLBCL: n=58) 0.3-15 mg target dose
- No related AE leading to discontinuation
- No treatment-related deaths
- **CRS** Grade ≥ 3: **0%** (n=0/90) in 2SUD
- **ICANS** Grade ≥ 3: **2%** (n=2/90) in 2SUD
  - Only in DLBCL patients; transient and reversible
- Majority of ICANS/CRS onset in Cycle 1 during SUD
- **Grade ≥3 TEAEs affecting ≥15% of patients**
  - Neutropenia (18%), lymphopenia (16%)

Gaballah et al., ASH 2024

Case Presentation: 73-year-old man with history of cardiac issues and seizures and primary refractory DLBCL is considered for bispecific antibody therapy

Dr Shams Bufalino (Park Ridge, Illinois)

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QUESTIONS FOR THE FACULTY

In general, for which patients with R/R DLBCL do you administer bispecific antibodies? How do you choose between glofitamab and epcoritamab?

For a patient with R/R DLBCL who has experienced disease progression on a bispecific antibody, would you offer another bispecific antibody as a later line of treatment? If so, at what point?

QUESTIONS FOR THE FACULTY

How long do you continue bispecific antibodies in patients with R/R DLBCL? Do you strictly adhere to the package insert recommendations regarding duration of therapy for glofitamab and epcoritamab?

Beyond CD20, what other targets for bispecific antibodies seem promising in NHL? Based on preliminary data, how does the CD19 x CD3 bispecific antibody AZD0486 seem to stack up against currently available agents?

Case Presentation: 86-year-old man with high-risk recurrent FL with EZH2 mutation and PD after tazemetostat receives mosunetuzumab

Dr Gigi Chen (Pleasant Hill, California)

RTP
RESEARCH
TO PRACTICE

QUESTIONS FOR THE FACULTY

How do you think through sequencing of bispecific antibodies and CAR T-cell therapy for patients with R/R FL? How do patient age/fitness and the pace of their disease affect your thinking?

What would you recommend for this man if he were to experience disease progression? Would you consider restarting mosunetuzumab, or would you move on to something else?

In your experience, are most patients receiving this therapy locally, or are they being referred to tertiary care centers? Do you anticipate that this dynamic may change as clinicians gain greater experience with bispecific antibodies?

QUESTIONS FOR THE FACULTY

What are the most important pearls you would offer a community-based oncologist about monitoring for and mitigating CRS and neurotoxicity with bispecific antibodies?

Do you instruct patients to monitor their temperatures during step-up dosing of bispecific antibodies? Do you recommend that they obtain blood pressure cuffs and pulse oximeters for home testing? Do you provide some or all patients with a prescription for dexamethasone before starting bispecific antibody therapy?

Agenda

MODULE 1: Selection and Sequencing of Available Therapies for Diffuse Large B-Cell Lymphoma — Dr Flowers

MODULE 2: Evolving Management Paradigm for Mantle Cell Lymphoma — Dr Phillips

MODULE 3: Integration of Novel Therapies into the Management of Follicular Lymphoma — Dr LaCasce

MODULE 4: Integrating Bispecific Antibodies into the Management of NHL — Dr Brody

MODULE 5: Current Role of CAR T-Cell Therapy in Various Non-Hodgkin Lymphoma (NHL) Subtypes — Dr Abramson

Mass General Brigham
Mass General Cancer Center

Chimeric Antigen Receptor (CAR) T-Cell Therapy for Diffuse Large B-Cell Lymphoma (DLBCL)

Jeremy S. Abramson, MD, MMSc
Massachusetts General Hospital
Harvard Medical School

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Major findings from phase III trials for 2nd line CAR in DLBCL

Three randomized trials of Chimeric Antigen Receptor (CAR) T-cell therapy versus SOC in transplant-eligible DLBCL with early relapse or primary refractory disease

Clinical trials of CD19 CAR T-cell therapies in 2L ≤ 12 months LBCL

ZUMA-7
(N = 359)
Phase 3; axi-cel vs SOC

Primary Analysis of ZUMA-7: a Phase 3 Randomized Trial of Axicabtagene Ciloleucel versus Standard-of-Care Therapy in Patients with Relapsed/Refractory Large B-Cell Lymphoma

Frederick L. Locke, MD[1]; David B. Miklos, MD, PhD[2]; Caron A. Jacobson, MD, MMSc[3]; Miguel-Angel Perales, MD[4];

POSITIVE!

TRANSFORM
(N = 184)
Phase 3; liso-cel vs SOC

TRANSFORM Study: Lisocabtagene Maraleucel, a CD19-Directed Chimeric Antigen Receptor T Cell Therapy, Versus Standard of Care with Salvage Chemotherapy Followed by Autologous Stem Cell Transplantation as Second-Line Treatment in Patients with Relapsed or Refractory Large B-Cell Lymphoma: Results from the Randomized Phase 3 TRANSFORM Study

Manali Kamdar,[1] Scott R. Solomon,[2] Jon Arnason,[3] Patrick B. Johnston,[4] Bertram Glass,[5] Veronika Bachanova,[6] Sami

POSITIVE!

BELINDA
(N = 322)
Phase 3; tisa-cel vs SOC

Tisagenlecleucel vs Standard of Care as Second-Line Therapy of Primary Refractory or Relapsed Aggressive B-Cell Non-Hodgkin Lymphoma: Analysis of the Phase III BELINDA Study

Michael R. Bishop,[1] Michael Dickinson,[2] Duncan Purtill,[3] Pere Barba,[4] Armando Santoro,[5] Nada Hamad,[6] Koji Kato,[7] Anna Sureda,[8] Richard Greil,[9]

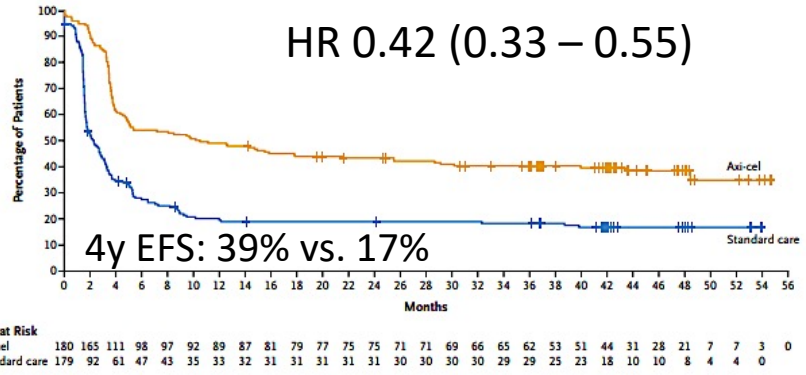
NEGATIVE!

Axi-cel vs. SOC as 2nd line therapy in primary refractory or early relapsed large B-cell lymphomas

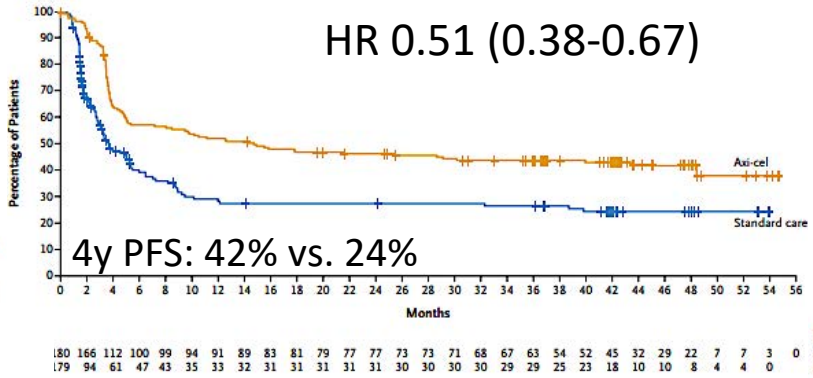
N=359
Refractory 75%
DHL 16%

ORR: 83% vs. 50%
CRR: 65% vs. 32%

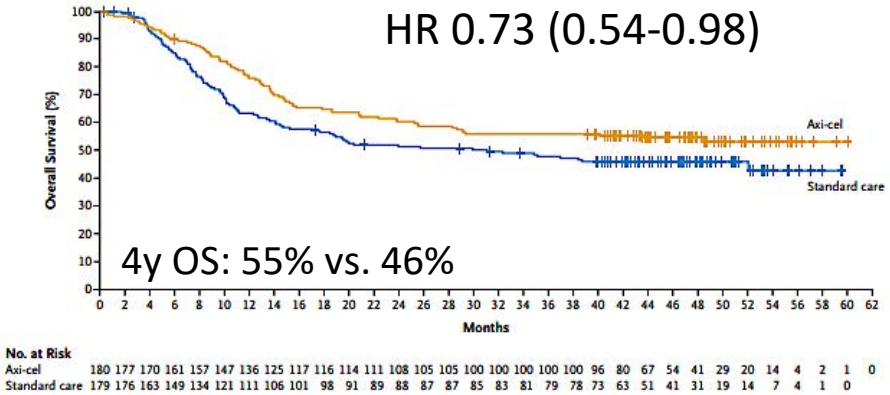
EFS
Median 10.8 vs. 2.3 mos
HR 0.42 (0.33 – 0.55)



PFS
Median 14.7 vs. 3.7 mos
HR 0.51 (0.38-0.67)



OS
Median NR vs. 31.1 mos
HR 0.73 (0.54-0.98)



Median Follow-up: 47.2 mo

Toxicity	Grade	%
CRS	Any grade	92
	Grade ≥3	6
Neurotox	Any grade	60
	Grade ≥3	21

Axi-cel associated with improved QOL by PRO

Locke, et al. NEJM 2021; Westin, et al. NEJM 2023

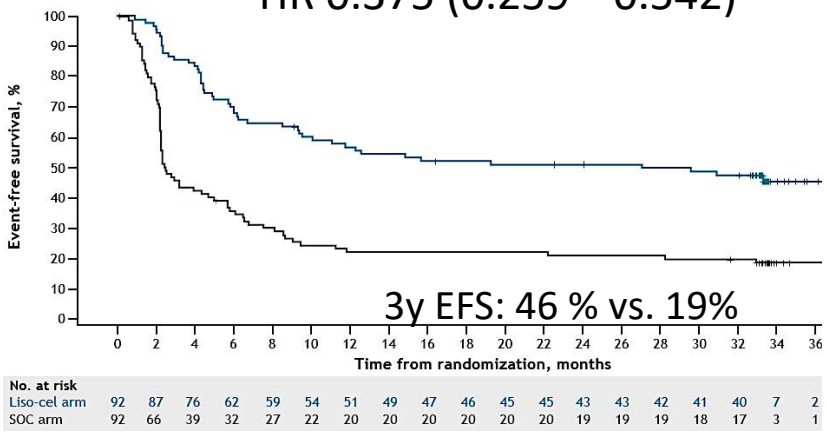
Liso-cel vs. SOC as 2nd line therapy in primary refractory or early relapsed large B-cell lymphomas

N=184
Refractory 73%
DHL 24%

ORR: 87% vs. 49%
CRR: 74% vs. 43%

EFS

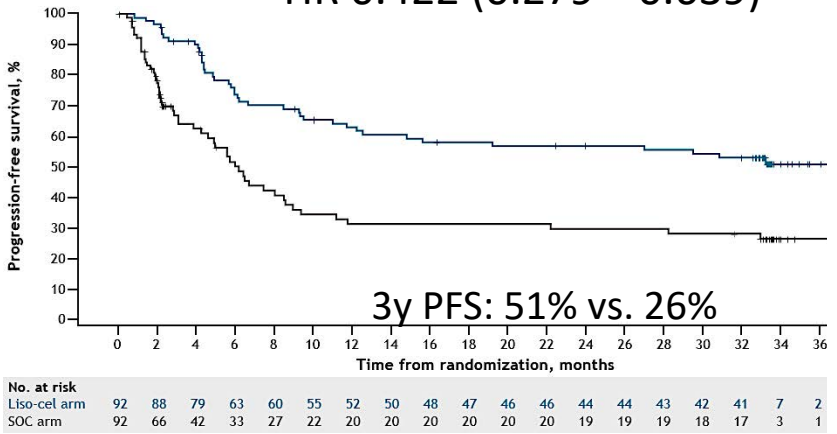
Median 29.5 vs. 2.4 mos
HR 0.375 (0.259—0.542)



3y EFS: 46 % vs. 19%

PFS

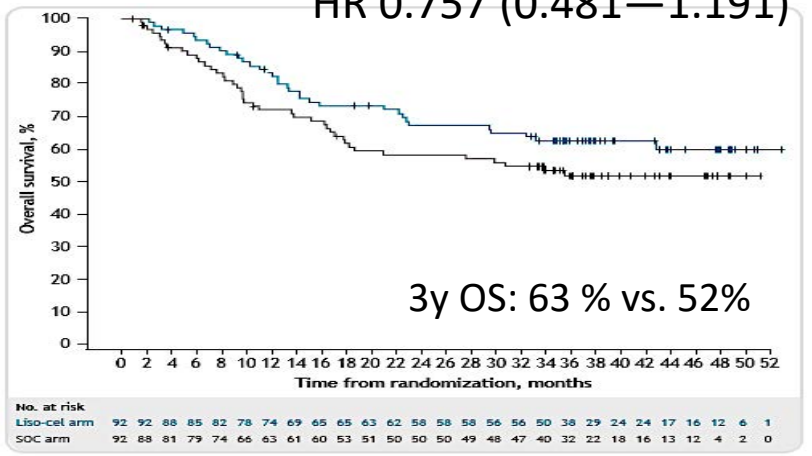
Median NR vs. 6.2 mos
HR 0.422 (0.279—0.639)



3y PFS: 51% vs. 26%

OS

Median NR vs. NR
HR 0.757 (0.481—1.191)



3y OS: 63 % vs. 52%

Median Follow-up: 34 mo

Toxicity	Grade	%
CRS	Any grade Grade 3	49 1
Neurotox	Any grade Grade 3	11 4

Liso-cel associated with improved QOL by PRO

Abramson, et al. Proc. EHA 2024; Abstract S272

Tisa-cel vs. SOC as 2nd line therapy in primary refractory or early relapsed large B-cell lymphomas

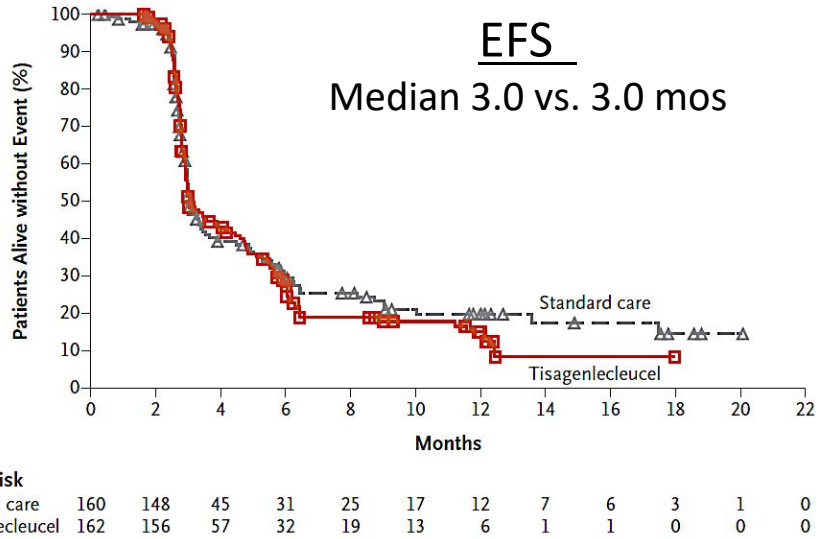
N=322
Refractory 75%
DHL 15%

ORR: 46% vs. 43%
CRR: 28% vs. 28%

51% of SOC crossed over to receive tisa-cel

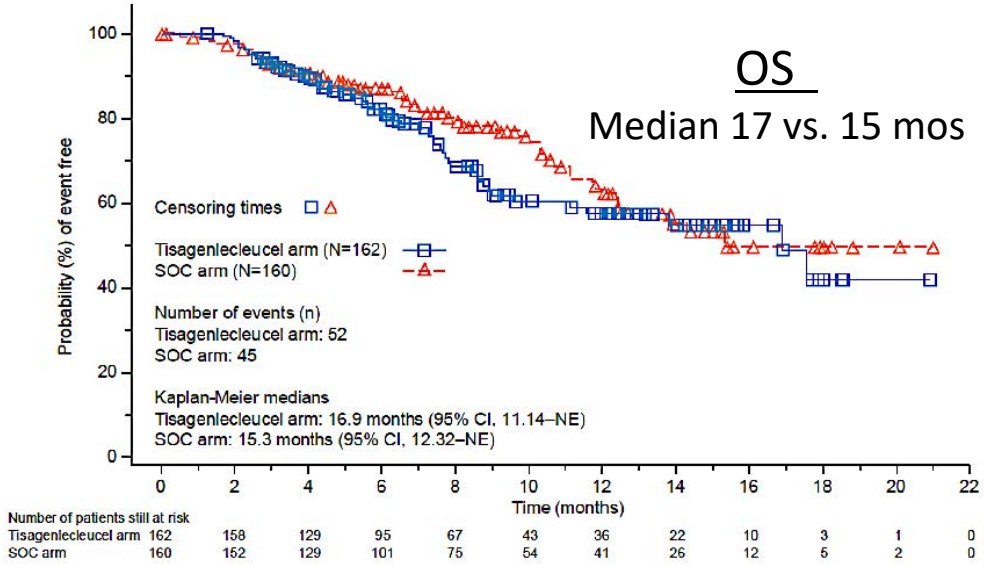
EFS

Median 3.0 vs. 3.0 mos



OS

Median 17 vs. 15 mos



Toxicity	%
CRS	
Any grade	61
Grade ≥3	5
Neurotoxicity	
Any grade	10
Grade ≥3	2

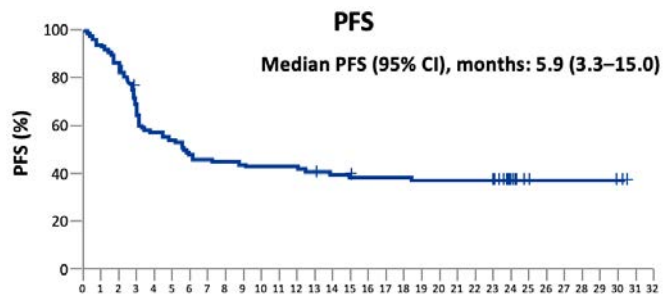
Median Follow-up: 10 mo

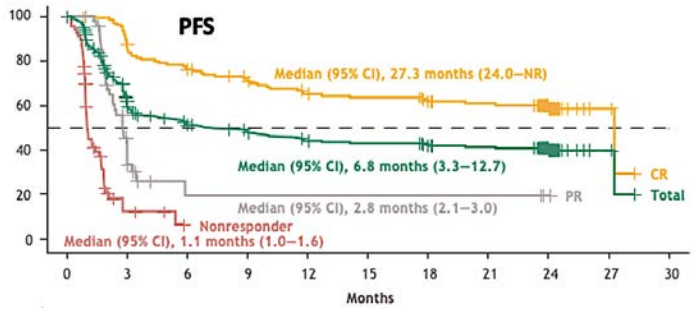
Bishop, et al. NEJM 2021

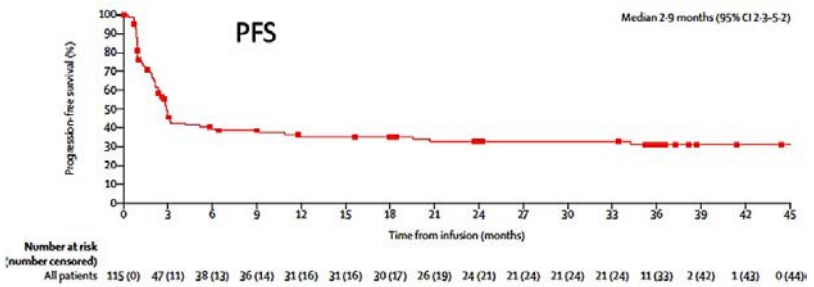
Long term efficacy and safety for 3rd line+ CAR in DLBCL

CAR T-cells can CURE chemotherapy-refractory LBCL in the 3rd line or later setting

	Axicabtagene Ciloleucel ZUMA-1	Lisocabtagene Maraleucel TRANSCEND	Tisagenlecleucel JULIET
Construct	antiCD19-CD28tm-**CD28**-CD3z	antiCD19-CD28tm-**41BB**-CD3z	antiCD19-CD8αtm-**41BB**-CD3z
Med Age, y (range)	58 (23–76)	63 (18–86)	56 (22–76)
ORR/CRR % (IRC)	74/54	73/53	52/40
Median PFS, mos	5.9	6.8	2.9
PFS (2y) %	42	41	30
Median OS, mos	25.8	27.3	11.1
CRS (Any/severe) %	93/13	42/2	58/22 *different grading scale
NT (Any/severe) %	64/28	30/10	21/12
References	Neelapu, et al. NEJM 2017 Locke, et al. Lancet Onc 2019	Abramson, et al. Lancet 2020 Abramson, et al. Blood 2024	Schuster, et al. NEJM 2019 Schuster, et al. Lancet Onc. 2021



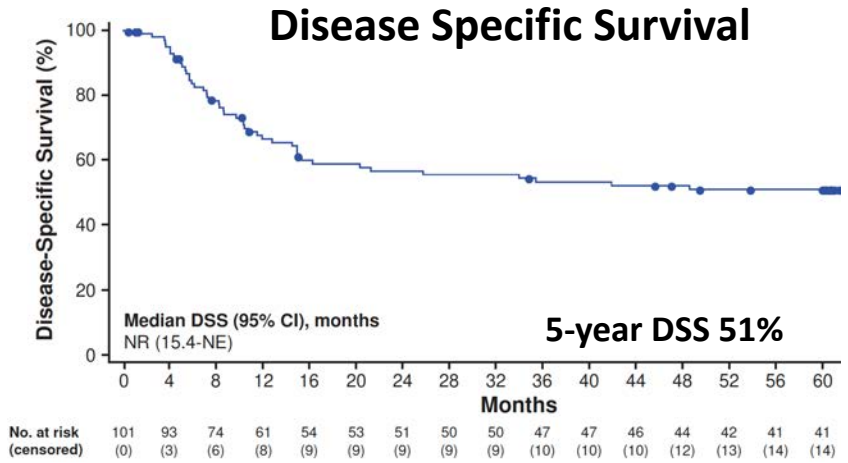


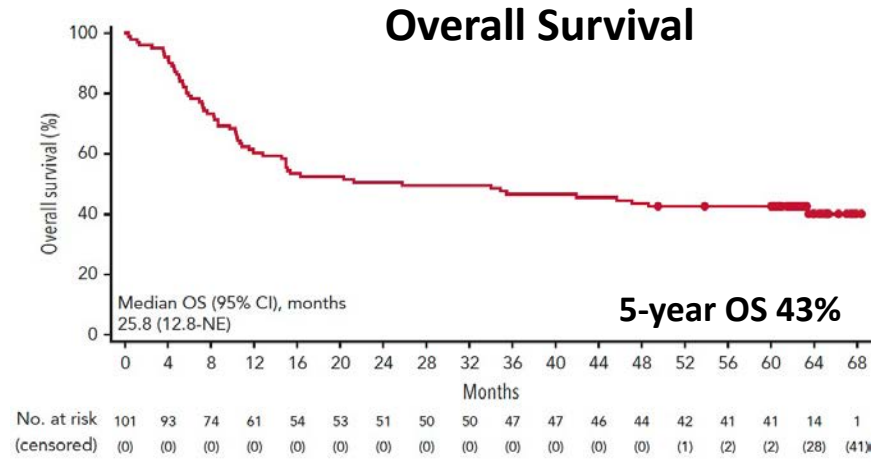


CAR T-cells can CURE Large B-cell Lymphomas as 3rd line or later therapy: 5-year Follow up From ZUMA-1 and TRANSCEND

ZUMA-1

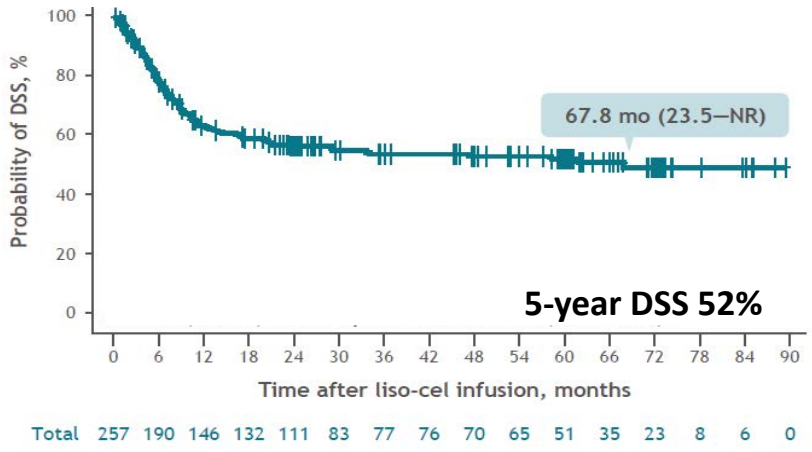
Neelapu, et al. Blood 2023

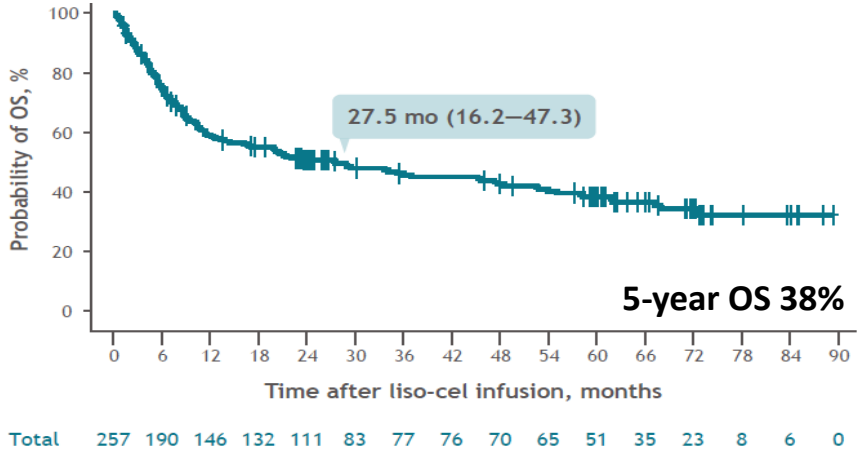




TRANSCEND

Abramson, et al. Proc ASH 2024





- After day 91, 14 (6%) pts had grade ≥ 3 infections (grade 5, n = 3, 2 of whom had additional anti-cancer therapies)
- Nineteen (8%) pts had second primary malignancies (non-melanoma skin cancers [n = 7], MDS [n = 9]).

Long term safety from JULIET

Prolonged cytopenias	Anemia	Thrombocytopenia	Neutropenia
Grade ≥3 cytopenia after day 90	3%	8%	8%

Infections	Any grade	Grade 3	Grade 4
<2 months	33%	14%	0
2-12 months	65%	23%	2%
>12 months	40%	13%	35

Malignancies	Incidence, n (%)	Prior ASCT, n	# prior lines
Any	9 (8%)	4	1-5
Prostate	3 (3%)	1	2-5
Basal cell	2 (2%)	1	1-2
AML	1 (1%)	1	3
Breast	1 (1%)	1	4
MDS	1 (1%)	O	3
Neuroendocrine	1 (1%)	0	2

Jaeger, et al. Blood Advances 2022

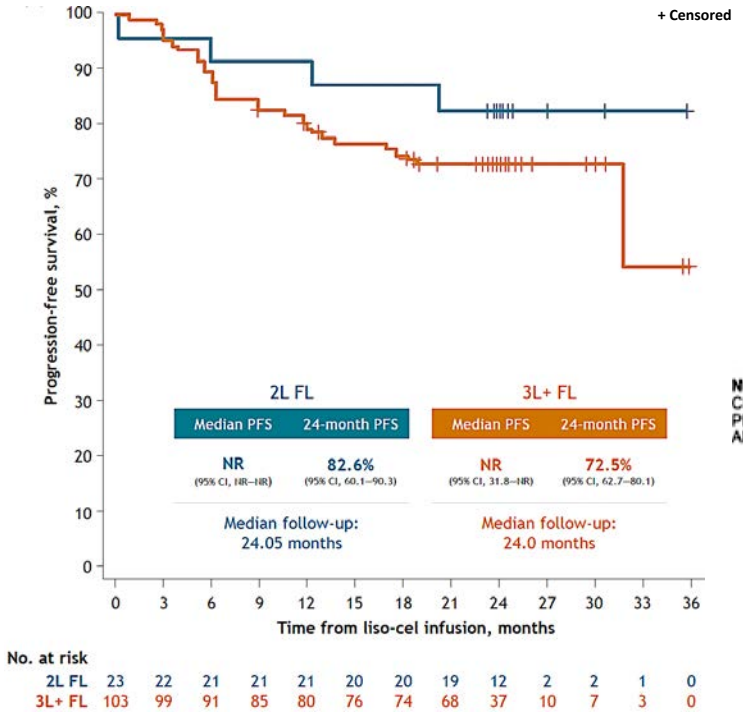
Follicular lymphoma

Three CAR T-cell products for 3rd line + follicular lymphoma

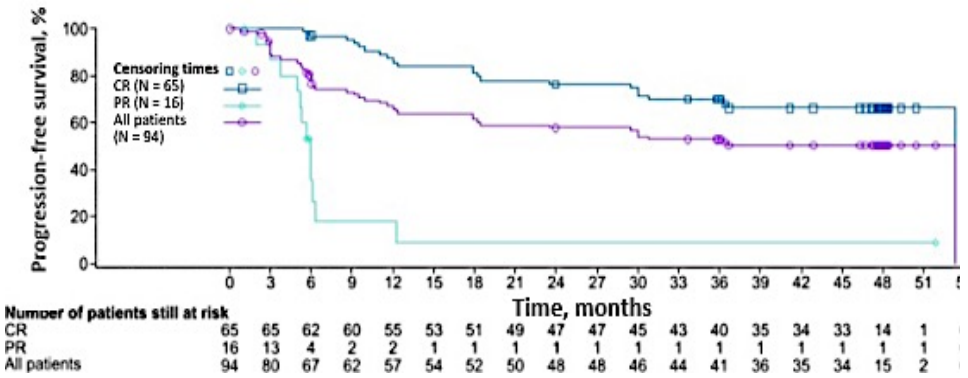
	Lisocabtagene Maraleucel TRANSCEND-FL	Tisagenlecleucel ELARA	Axicabtagene Ciloleucel ZUMA-5
n	107	94	124
Median # prior lines	3	4	3
Chemorefractory	67%	78%	68%
POD24	54%	60%	55%
CR rate	94%	69%	79%
Median PFS, m	NR	53 mo	57 mo
PFS	73% at 24m	50% at 60m	50% at 60m
CRS (Any/severe) %	58/1	49/0	82/7
NT (Any/severe) %	15/2	4/1	59/19
References	Morschhauser, et al. Nature Med 2024 Nastoupil, et al. Proc ASH 2024	Fowler, et al. Nat Med 2022. Thieblemont, et al.Proc ASH 2024	Jacobson, et al. Lancet Onc 2022 Neelapu, et al. Proc ASH 2024

PFS for CAR T-cells in 3rd line or later FL

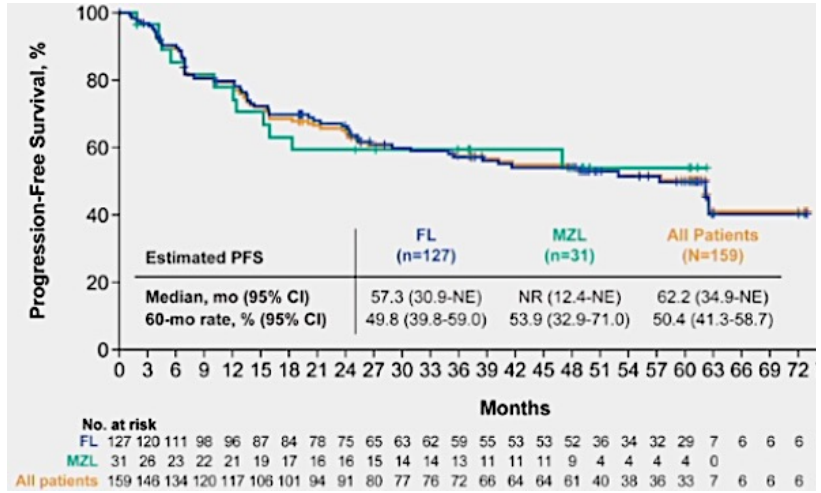
Liso-cel



Tisa-cel



Axi-cel



Liso-cel	Tisa-cel	Axi-cel
73% at 24m	50% at 60m	50% at 60m

Nastoupil, et al. Proc ASH 2024; Neelapu, et al. Proc ASH 2024; Thieblemont, et al.Proc ASH 2024.

Mantle cell lymphoma

CAR T-cell for MCL post covalent BTK inhibition

Brexu-cel

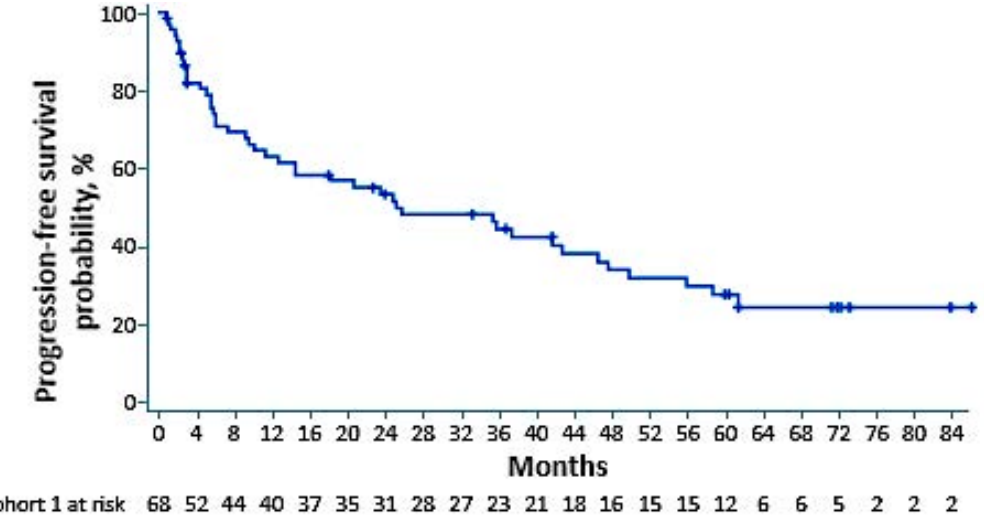
Anti-CD19 CAR T-cell

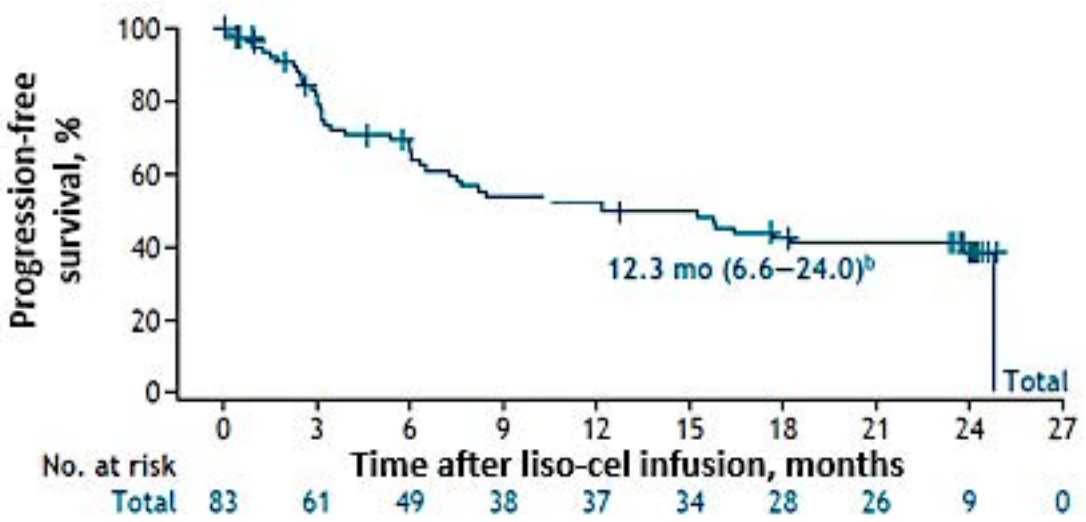
Endpoint	n=68
ORR	93%
CRR	67%
Med PFS	25 mo
Severe CRS/NT	15%/43%

Liso-cel

Anti-CD19 CAR T-cell

Endpoint	n=83
ORR	83%
CRR	72%
Med PFS	12 mo
Severe CRS/NT	1%/9%





Wang M, et al. ASH 2024 Poster 4388; Wang, et al. ASTCT 2025

Marginal zone lymphoma

Liso-cel in Marginal Zone Lymphoma
Press release: February 10, 2025

- The Phase 2 TRANSCEND FL trial evaluating liso-cel in adults with relapsed or refractory indolent B-cell non-Hodgkin lymphoma met its primary endpoint in the marginal zone lymphoma (MZL) cohort
- Results showed a statistically significant overall response rate (ORR) in these patients
- The study also met the key secondary endpoint of complete response rate (CRR).
- Liso-cel demonstrated durable responses and a consistent safety profile with no new safety signals observed
- Await data presentation at ICML 2025

Take home points

- CAR T-cells induce deep and durable remissions in DLBCL, follicular lymphoma, mantle cell lymphoma and marginal zone lymphoma (new data coming soon)
- Liso-cel and axi-cel are preferred 2nd line treatment for DLBCL which is primary refractory or relapsed within 12 months. Liso-cel also approved for 2nd line non-transplant eligible patients
- Liso-cel, axi-cel and tisa-cel also available in 3rd line and later DLBCL
- Liso-cel, tisa-cel or axi-cel available for 3rd line and later treatment of FL, but will likely be used after bispecific antibodies in most patients
- Liso-cel and brexu-cel are preferred for MCL after failure of covalent BTK inhibitors. Pirtobrutinib can serve as a valuable bridging therapy

Case Presentation: 81-year-old man with recurrent non-GCB type DLBCL and significant pulmonary involvement

Dr Warren Brenner (Boca Raton, Florida)

RTP RESEARCH TO PRACTICE

QUESTIONS FOR THE FACULTY

How do you choose between CAR T-cell therapy, bispecific antibodies and other available therapies for patients such as this who are older and have borderline performance status but are symptomatic from their disease?

What bridging strategy would you recommend prior to CAR T-cell therapy for a patient such as this?

Which patients with other NHL subtypes — FL and MCL — represent ideal candidates for CAR T-cell therapy? Where in the treatment sequence do you typically recommend CAR T-cell therapy for these patients? Do you anticipate that CAR T-cell therapy may soon have a role in marginal zone lymphoma as well?

Case Presentation: 76-year-old man with transformed DLBCL and PD after R-CHOP receives bridging therapy with polatuzumab vedotin/rituximab followed by lisocabtagene maraleucel

Dr Spencer Bachow (Boca Raton, Florida)

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TO PRACTICE

QUESTIONS FOR THE FACULTY

If you saw this patient with primary refractory DLBCL today, is there anything you would have done differently? Would you recommend CAR T-cell therapy or another strategy? Would you bring up the idea of transplant?

How should oncologists in the community follow their patients who have received CAR T-cell therapy? How often should CBCs be assessed, and when should growth factors be administered?

Should these patients routinely be assessed for hypogammaglobulinemia and be infused with IVIG if they develop recurrent infections or low immunoglobulin levels?

How do you approach vaccination for patients who have received CAR T-cell therapy?

Contributing General Medical Oncologists

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Neil Love, MD
Research To Practice
Miami, Florida

Thank you

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Consensus or Controversy? Clinical Investigators Provide Perspectives on the Current and Future Care of Patients with Chronic Lymphocytic Leukemia

A CME-Accredited Virtual Event Held in Conjunction with the 2025 ASCO® Annual Meeting

Sunday, June 1, 2025

7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)

Faculty

Catherine C Coombs, MD

William G Wierda, MD, PhD

Moderator

Neil Love, MD

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Thank you for joining us!
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Please complete the survey currently up on the iPads for attendees in the room and on Zoom for those attending virtually. The survey will remain open up to 5 minutes after the meeting ends.

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In-person attendees: Please refer to the program syllabus for the CME credit link or QR code.
Online/Zoom attendees: The CME credit link is posted in the chat room.

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