Data + Perspectives: Clinical Investigators Explore the Application of Recent Datasets in Current Oncology Care

CME/MOC, NCPD and ACPE Accredited

Saturday, October 11, 2025
7:15 AM – 12:30 PM ET

RTP
RESEARCH
TO PRACTICE

Agenda

Module 1 — Breast Cancer: *Drs Burstein, Goetz, McArthur and Nanda*

Module 2 — Prostate Cancer: *Drs Antonarakis and M Smith*

Module 3 — Colorectal Cancer: *Drs Lieu and Strickler*

Module 4 — Diffuse Large B-Cell Lymphoma and Follicular Lymphoma: *Drs Lunning and S Smith*

Diffuse Large B-Cell Lymphoma and Follicular Lymphoma Faculty

Matthew Lunning, DO
Professor
Medical Director
Gene and Cellular Therapy
Associate Vice Chair of Research
Department of Medicine
Assistant Vice Chancellor for Clinical Research
Fred and Pamela Buffett Cancer Center
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Omaha, Nebraska

Sonali M Smith, MD
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Chief, Section of Hematology/Oncology
Co-Leader, Cancer Service Line
The University of Chicago
Chicago, Illinois

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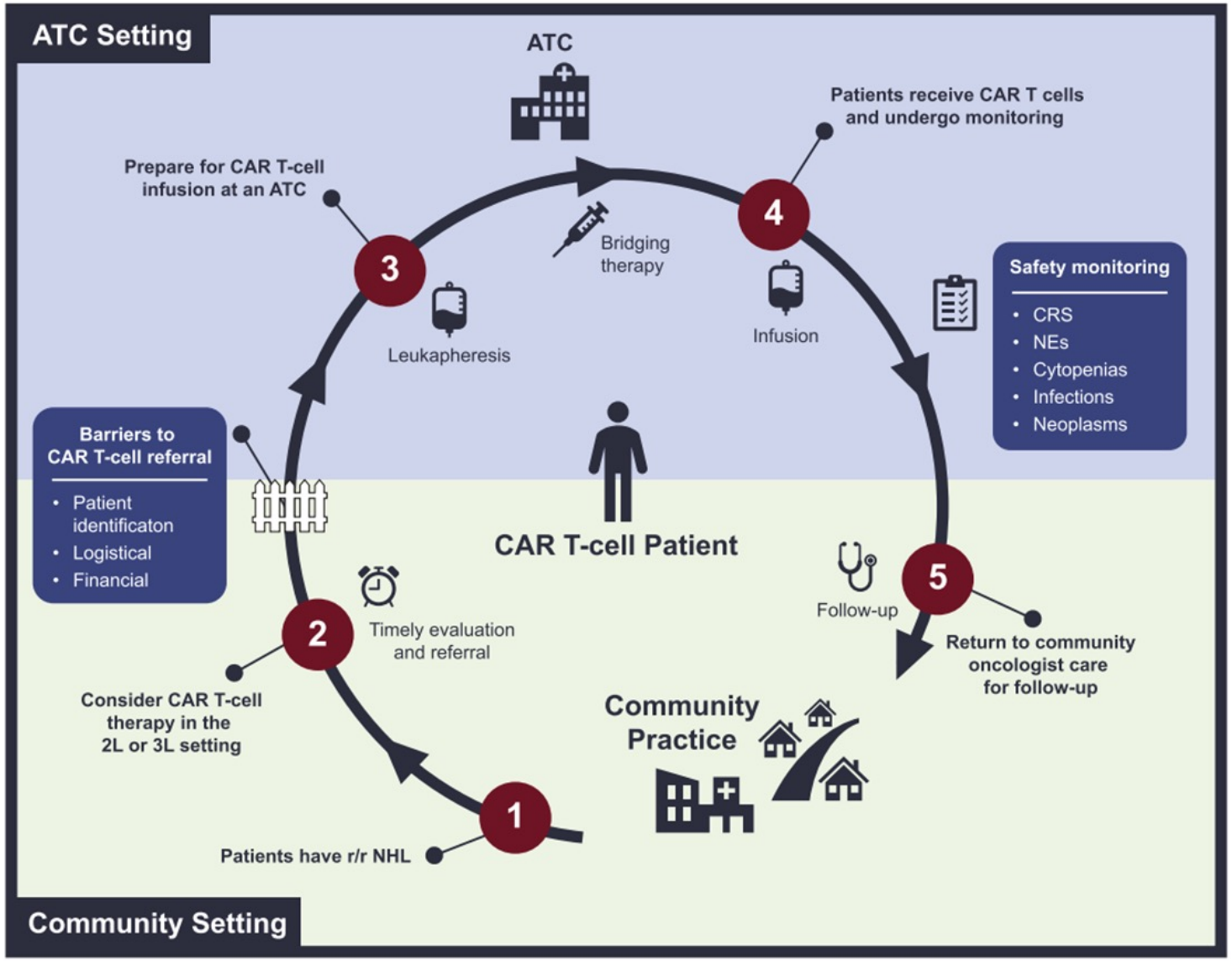
Which Driver & Which Race: CAR-T & BsAb for Relapsed or Refractory DLBCL & Follicular Lymphoma

Matthew Lunning, DO, FACP
Professor, Division of Oncology & Hematology
Medical Director, Gene & Cellular Therapy
Assistant Vice Chancellor for Clinical Research

University of Nebraska Medical Center
Nebraska Medicine

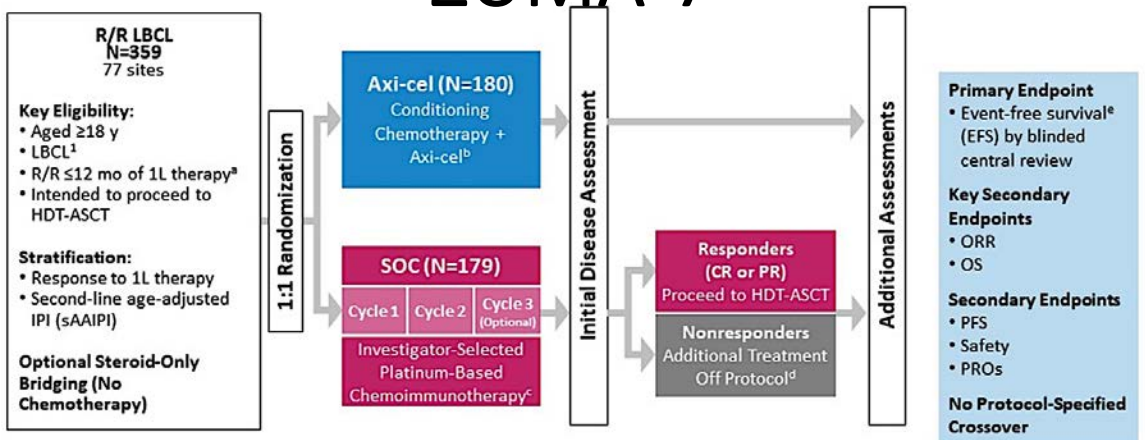
It Takes a Pit Crew



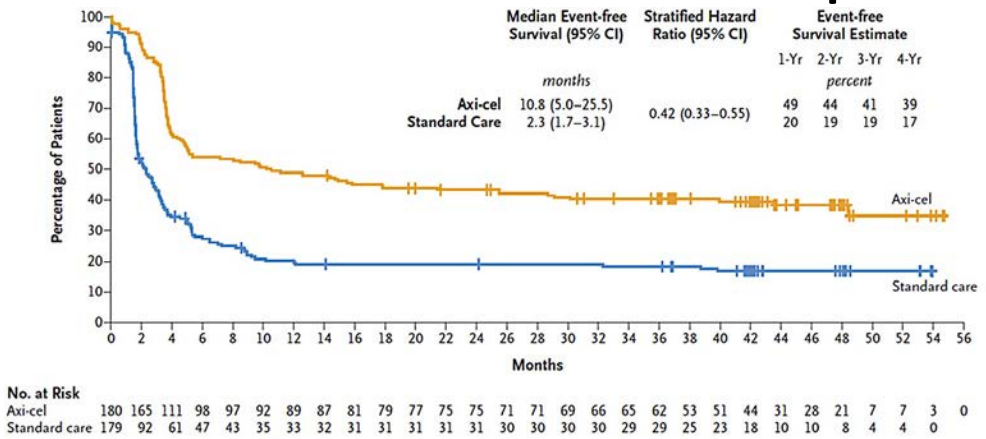
Bishop MR, Kay GE. *Semin Oncol*. 2024

Sprint Cars: ZUMA-7/TRANSFORM

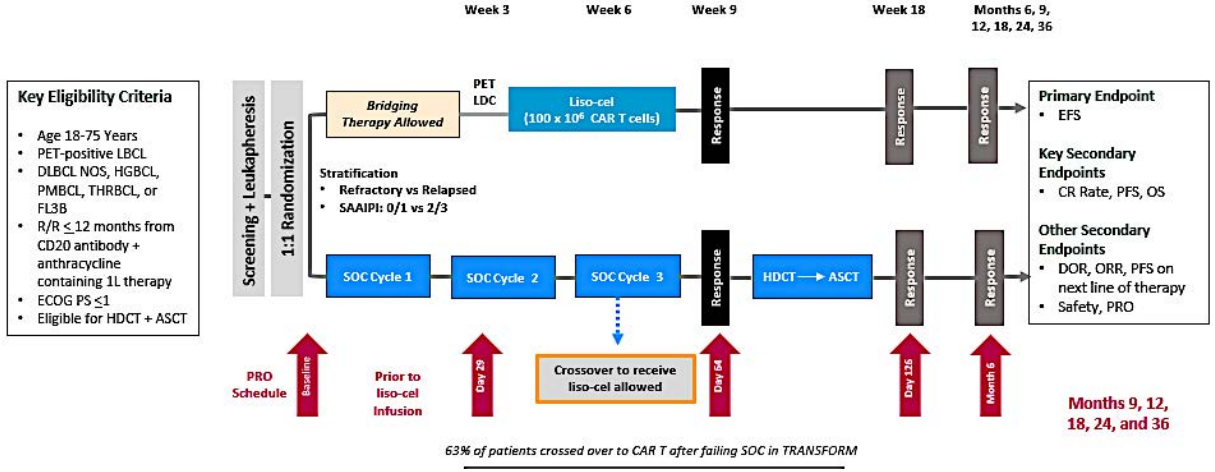
ZUMA-7



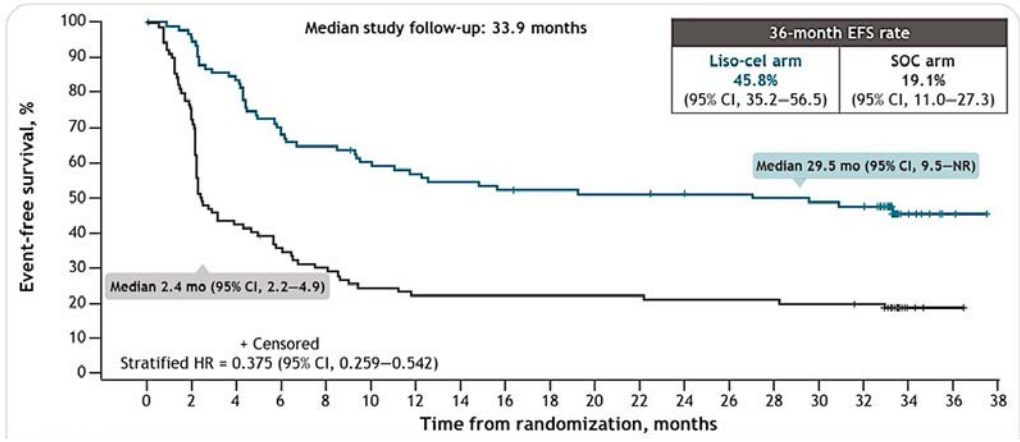
4-Year Follow-Up



TRANSFORM



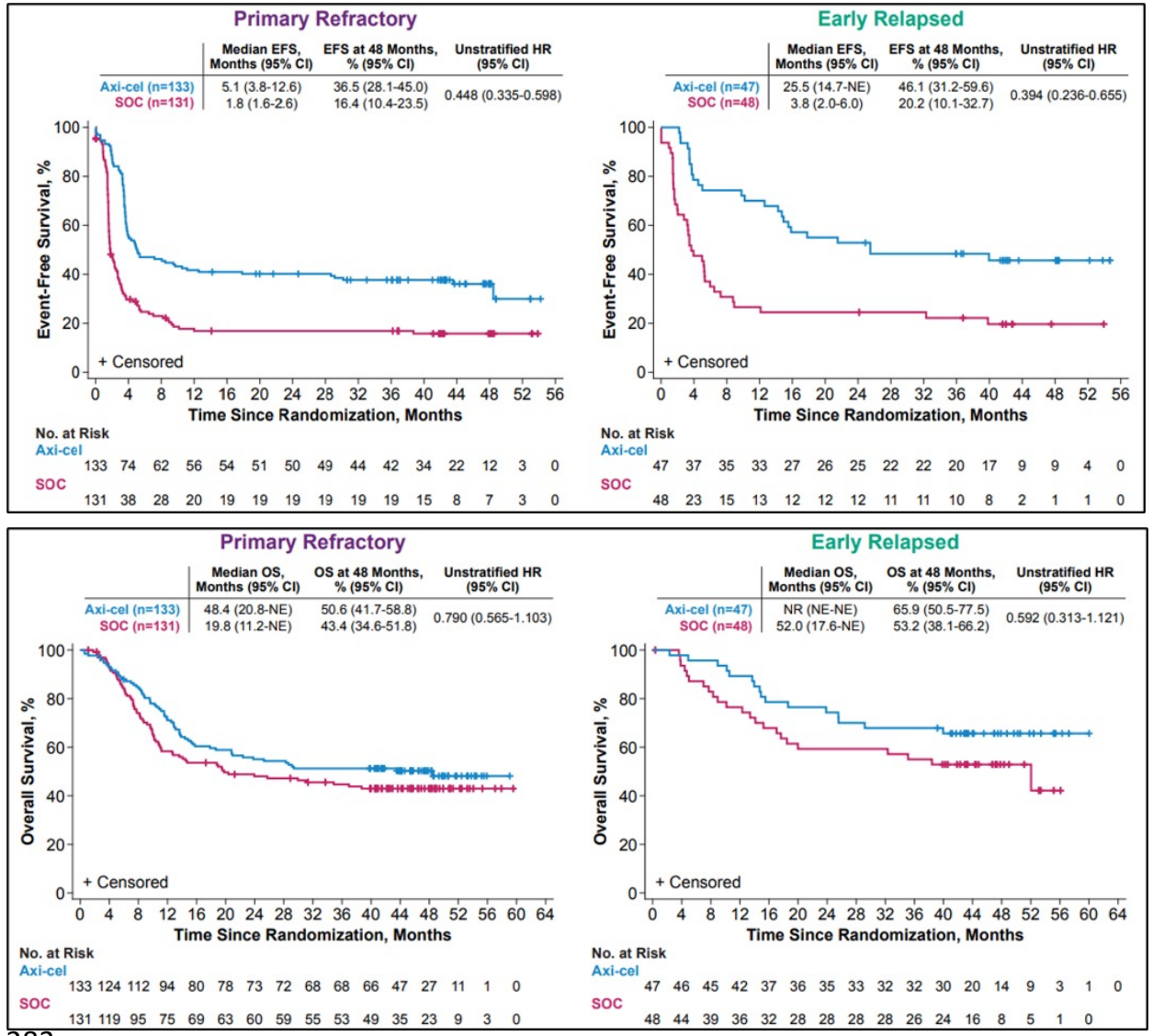
3-Year Follow-Up



Locke et al. NEJM 2022; Westin et al. *New Engl J Med* 2023; Abramson et al. *Blood* 2023; Kamdar et al. *J Clin Oncol* 2025

Use Your Spotter?

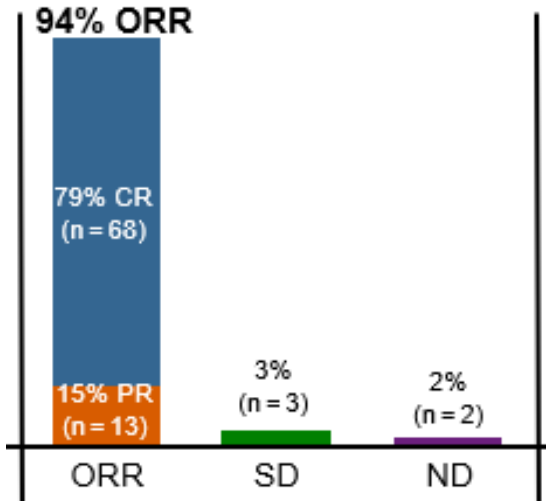
ZUMA-7



Westin JR et al. ASTCT 2025;Abstract 283

LeMonds: CAR-T for 3L FL

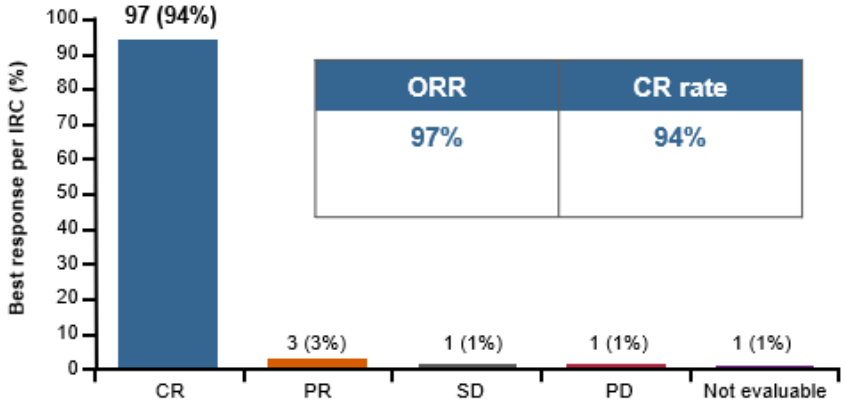
Axi-cel



Tisa-cel

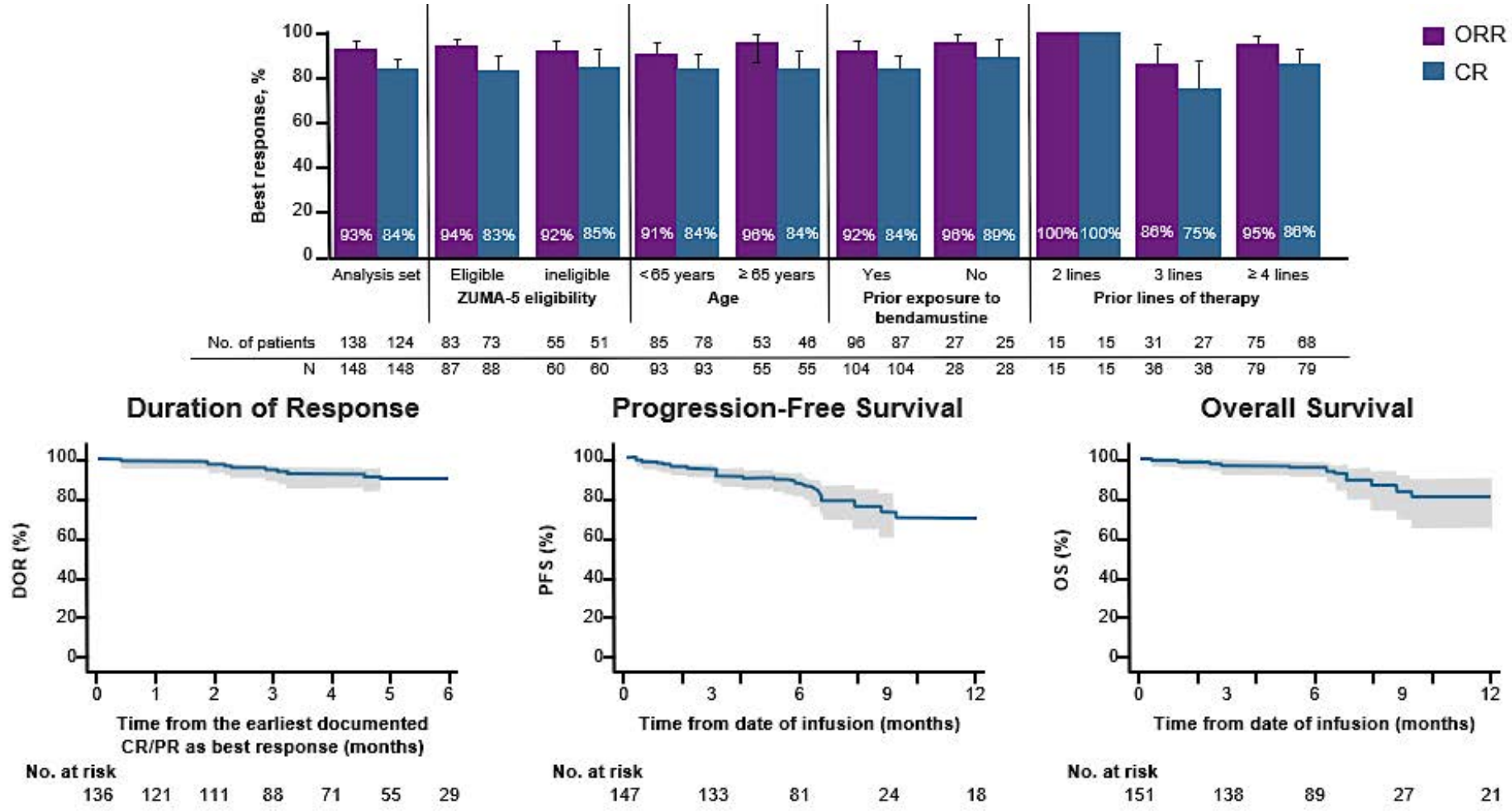
Efficacy Cohort	%
ORR	86
CRR	68

Liso-cel



Jacobson, et al. Lancet Oncol 2022; Schuster ASH 2023;Abstract 601; Neelapu et al. ASH 2024;Abstract 864

LeMonds: CAR-T for 3L FL



Jacobson CA et al. ASCO 2023;Abstract 7509

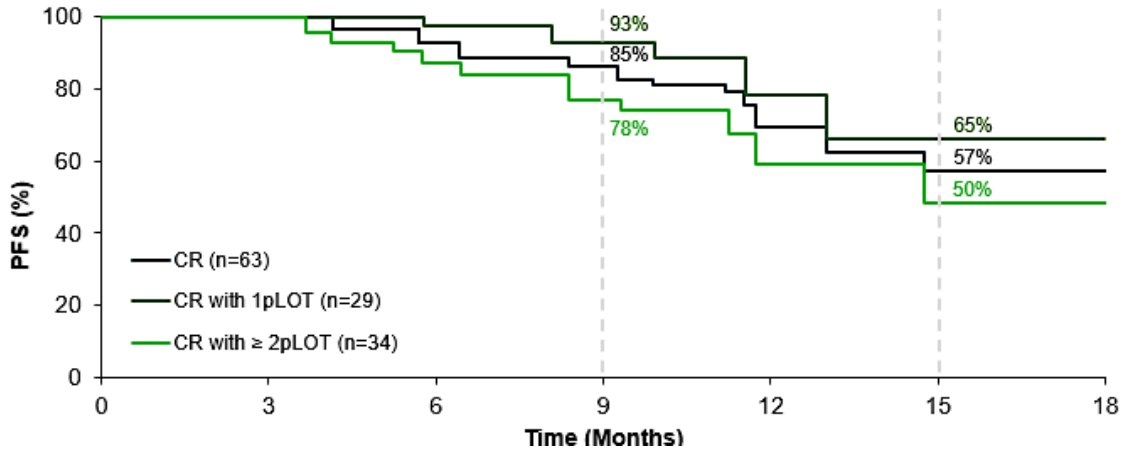
Going Two Wide: Epco & Glofit for Rel/Ref LBCL

	Epcoritamab (N=157)	Glofitamab (N=155)
Population	2+ prior therapies (allowed p CAR-T)	2+ prior therapies (allowed p CAR-T)
Median F/U	37.1 months	41.0 months
ORR	59%	52%
CR	41%	40%
PFS of CR	37.3 months	57%
OS of CR	NR	77%
CRS	All Grades: 51% G1: 32% G2: 16% G3/4 : 3%	All Grades: 63% G1: 43% G2: 16% G3/4: 4%

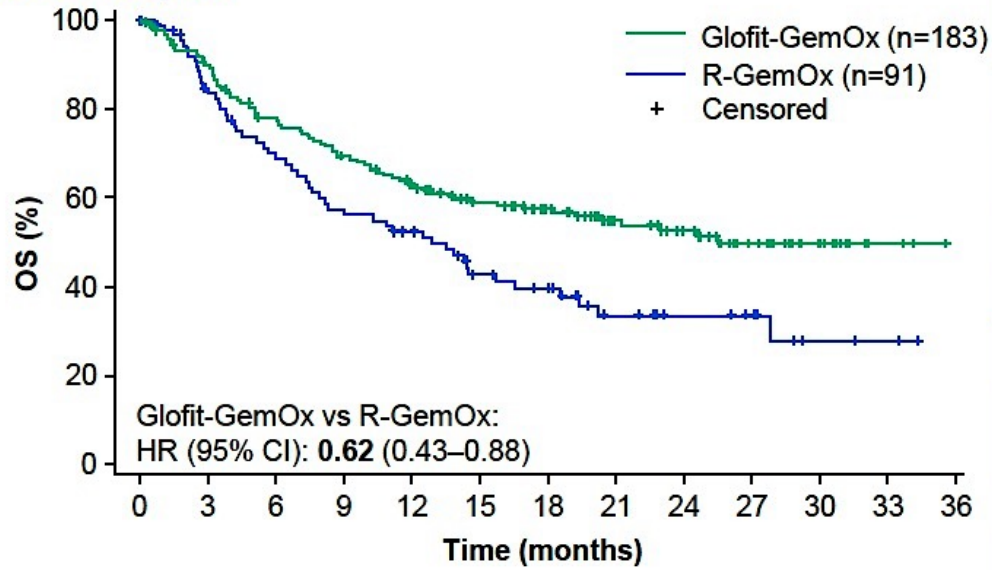
Vose et al. ASH 2024;Abstract 4480; Dickinson et al. ASH 2024;Abstract 865; Dickinson et al. NEJM 2022

Who's Driving the Benefit?

Epco + Gem-Ox



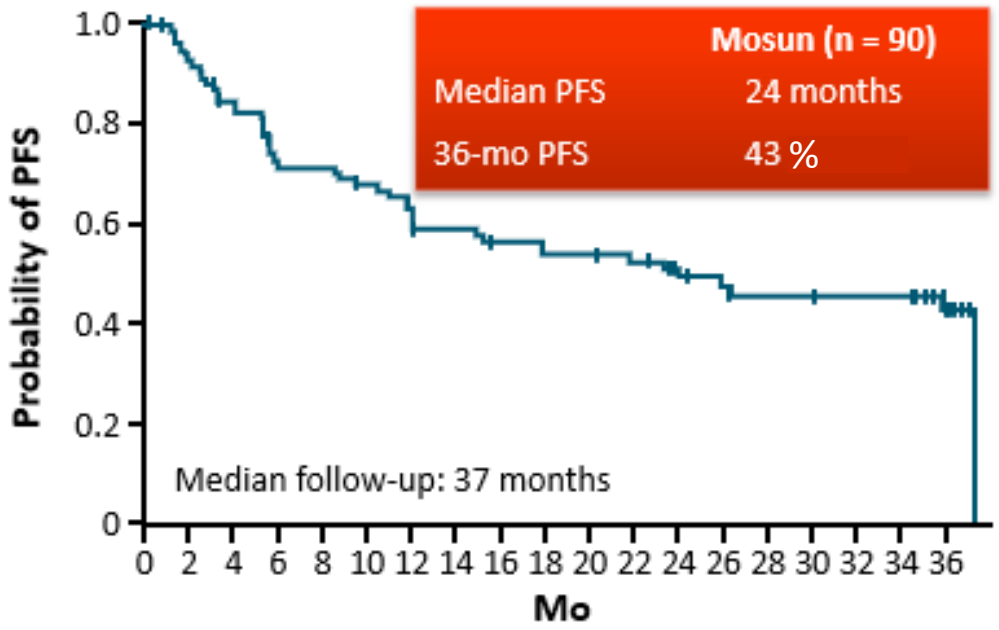
Glofit + Gem-Ox

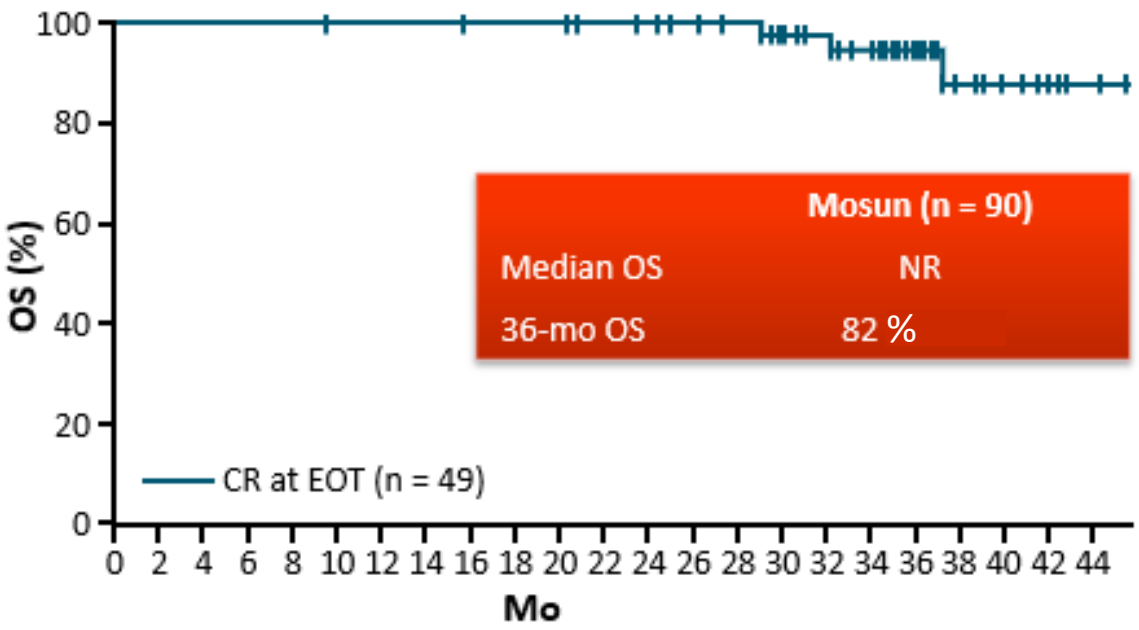


	R-GemOx (n=91)	Glofit-GemOx (n=183)
Updated analysis (median follow-up: 20.7 months)		
OS, median (95% CI); months	12.9 (7.9–18.5)	25.5 (18.3–NE)

Brody J, et al. ASCO 2024;Abstract 7037; Abramson J, et al. EHA 2024;Abstract LB3438

Mosun in Rel/Ref FL

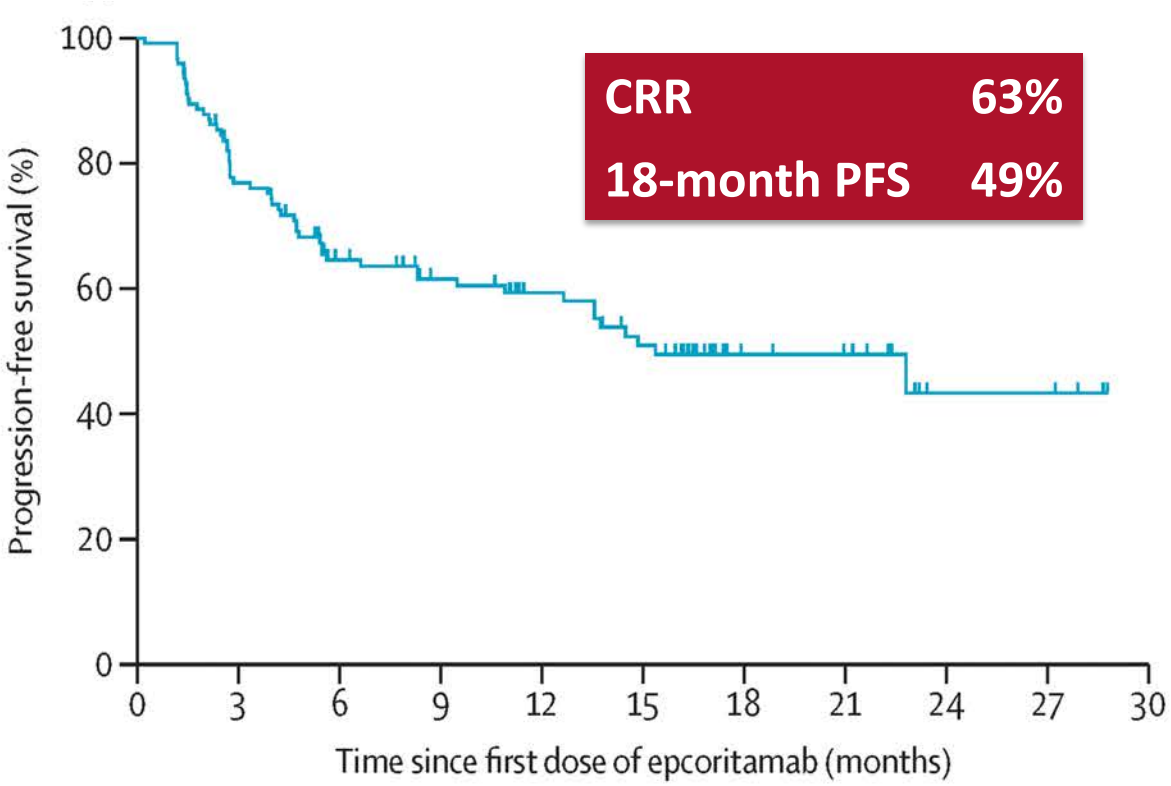


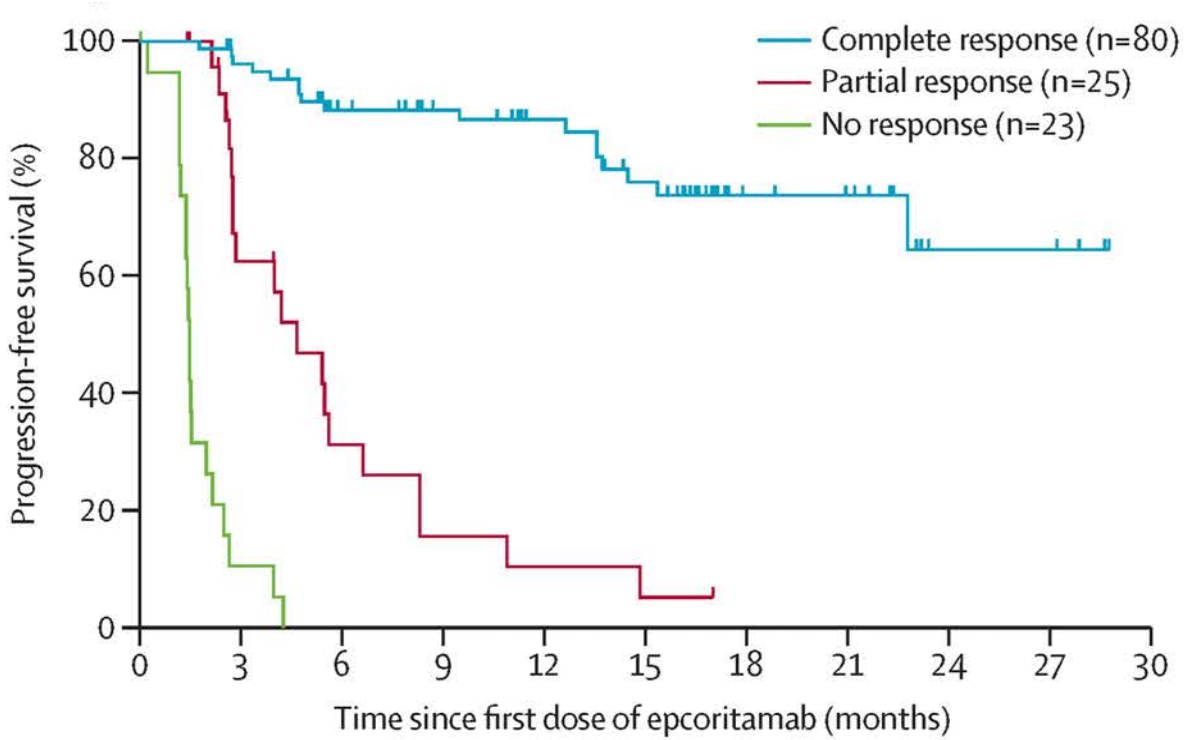


Sehn et al. Blood 2025

Epco in Rel/Ref FL

CRR	**63%**
18-month PFS	**49%**





Linton KM et al. Lancet Haematol 2024

Phase 3 EPCORE FL-1 Clinical Trial Met Dual Primary Endpoints in Patients with Relapsed/Refractory (R/R) Follicular Lymphoma (FL)

Press Release: August 7, 2025

"[The manufacturer] today announced positive results of the Phase 3 EPCORE FL-1 trial evaluating subcutaneous epcoritamab, a bispecific antibody, in combination with rituximab and lenalidomide (R^2) versus R^2 alone for the treatment of adult patients with relapsed or refractory (R/R) follicular lymphoma (FL).

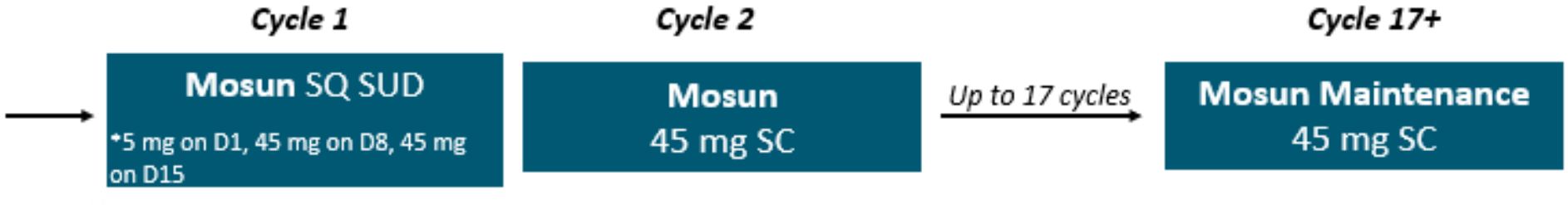
The study met its dual primary endpoints of overall response rate (ORR, p-value < 0.0001) and progression-free survival (PFS, HR 0.21, p-value <0.0001), demonstrating statistically significant and clinically meaningful differences in both endpoints, reducing the risk of disease progression or death by 79%.

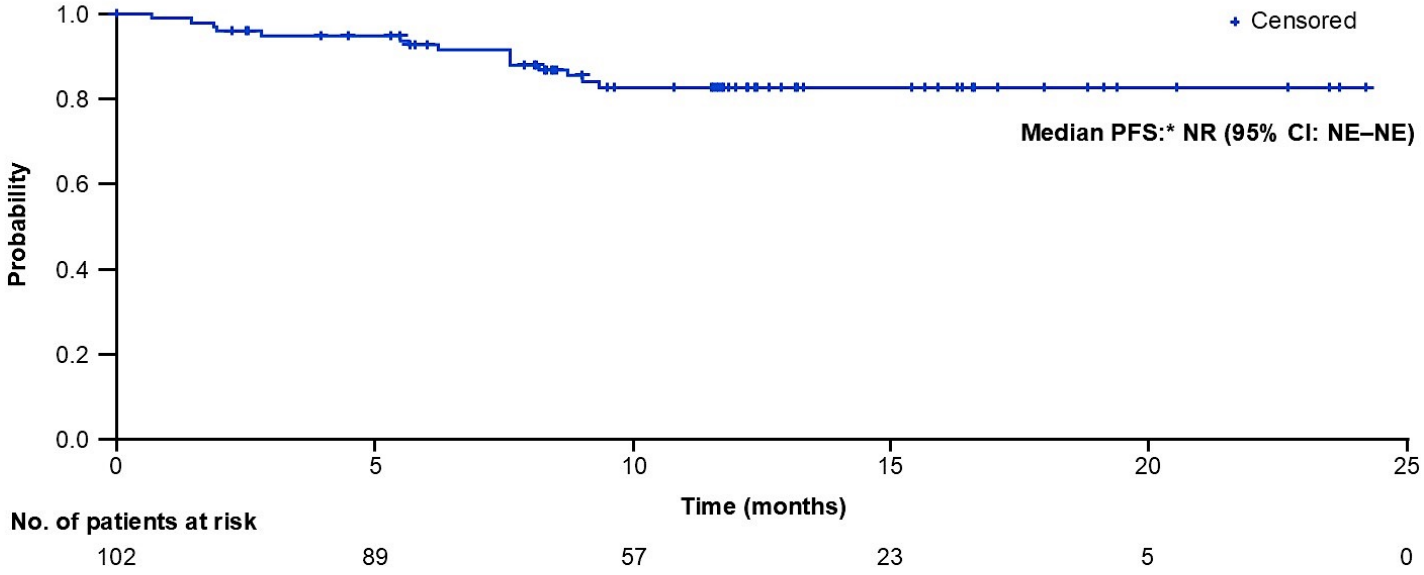
The results, derived from a pre-planned interim analysis, will be submitted for presentation at the 67th Annual Meeting and Exposition of the American Society of Hematology (ASH) and will serve as the basis for global regulatory submissions."

https://ir.genmab.com/news-releases/news-release-details/genmab-announces-phase-3-epcorer-fl-1-clinical-trial-met-dual

BsAb in Front Line FL

- Untreated FL
- Met GELF criteria
- ECOG PS 0-2





	N=102
12-month PFS rate, % (95% CI)	82.8 (73.0–89.3)
Patients with progressive disease/relapse, n (%)	10 (9.8)
Patients who died, n (%)	5 (4.9)

*PFS and other time-to-event endpoints, except for time to response, were immature at the current analysis period.
CI, confidence interval; NE, not estimable; NR, not reached.

Flinn et al. ASCO 2025;Abstract 7014

BsAb in Front Line FL

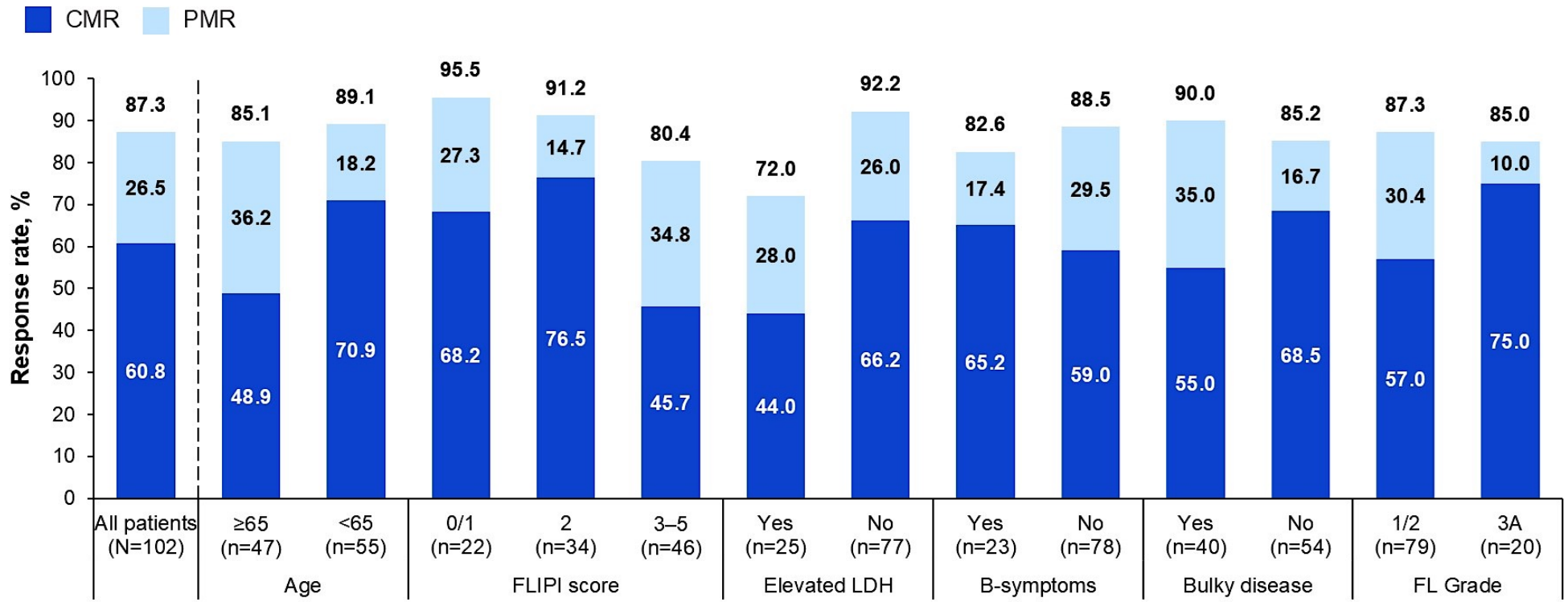
- Untreated FL
- Met GELF criteria
- ECOG PS 0-2

Cycle 1: **Mosun** SQ SUD — *5 mg on D1, 45 mg on D8, 45 mg on D15

Cycle 2: **Mosun** 45 mg SC

Up to 17 cycles

Cycle 17+: **Mosun Maintenance** 45 mg SC



Flinn et al. ASCO 2025;Abstract 7014

Odronextamab: Side CAR-T

ELM-1 DLBCL post-CAR T expansion cohort

Key eligibility criteria (post-CAR T cohort)

- R/R DLBCL with disease progression after CAR T-cell therapy
- ≥1 prior treatment with an anti-CD20 antibody
- ECOG PS 0 or 1
- Adequate organ function
- Recovered from toxicities of CAR T-cell therapy and lymphodepletion*

Dose expansion (N=60)

DLBCL after CAR T
Odronextamab IV

Primary endpoint
- ORR† by ICR

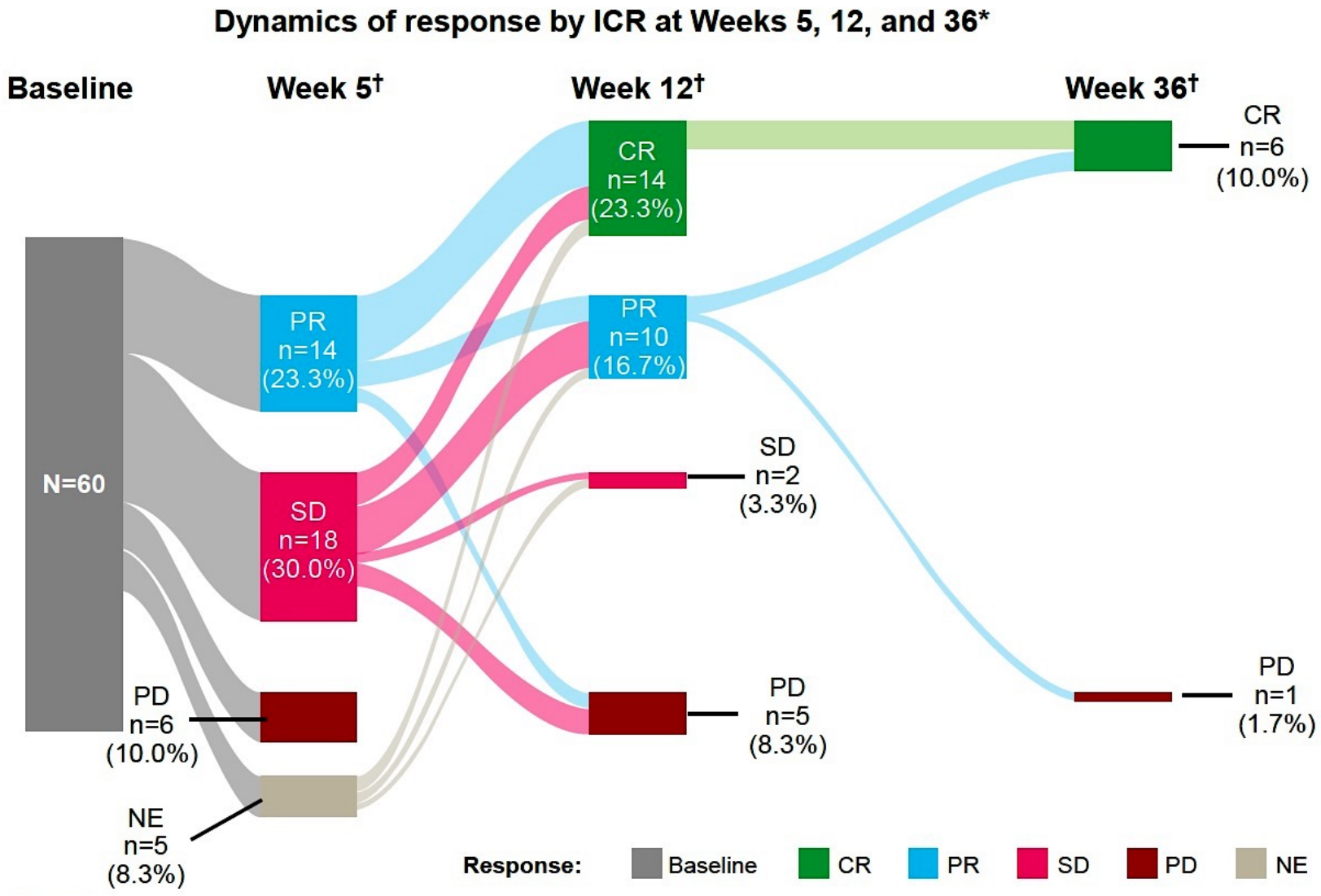
Key secondary endpoints
- DOR, PFS, and OS
- Safety

Exploratory endpoint
- Immune biomarkers

- Odronextamab was administered with premedication and step-up doses of 0.7/4/20 mg‡ during C1 to mitigate the risk of CRS, followed by 160 mg on D1, 8, and 15 of C2–4, then 320 mg Q2W until disease progression or unacceptable toxicity
- Patients who achieved a CR that was durable for ≥9 months transitioned to odronextamab 320 mg Q4W dosing
- Anti-infection prophylaxis was recommended during the study

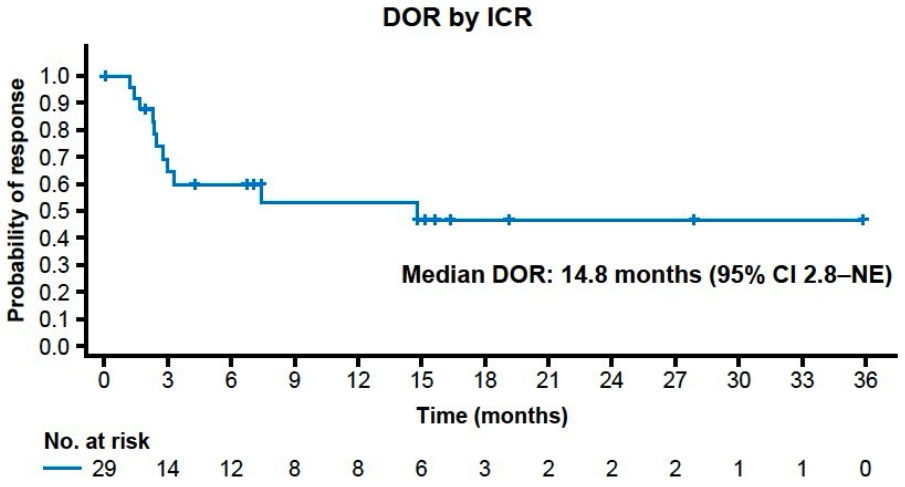
Matasar et al. ASH 2024;Abstract 866

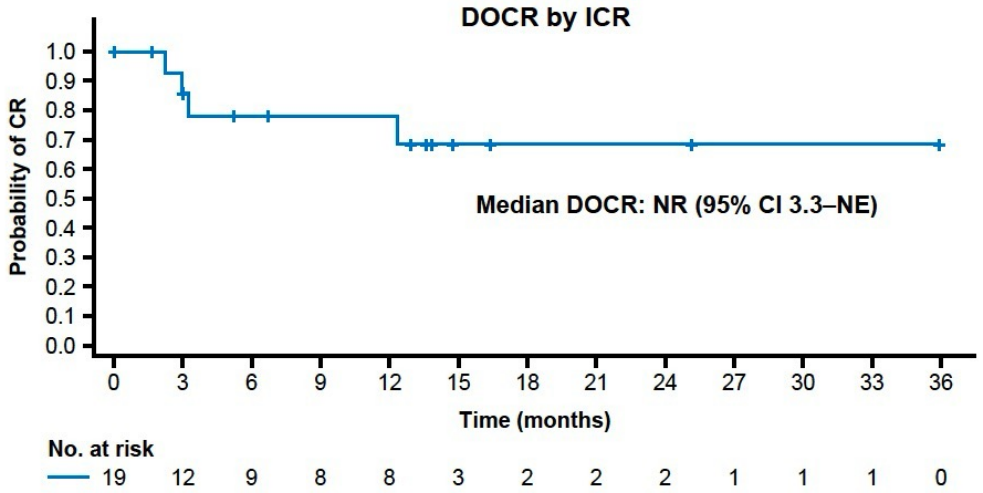
ELM-1 (Odronextamab) post CAR-T

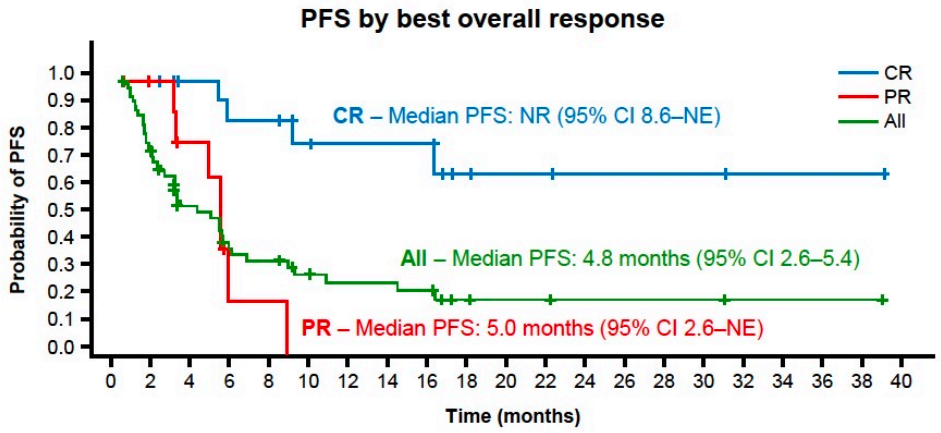


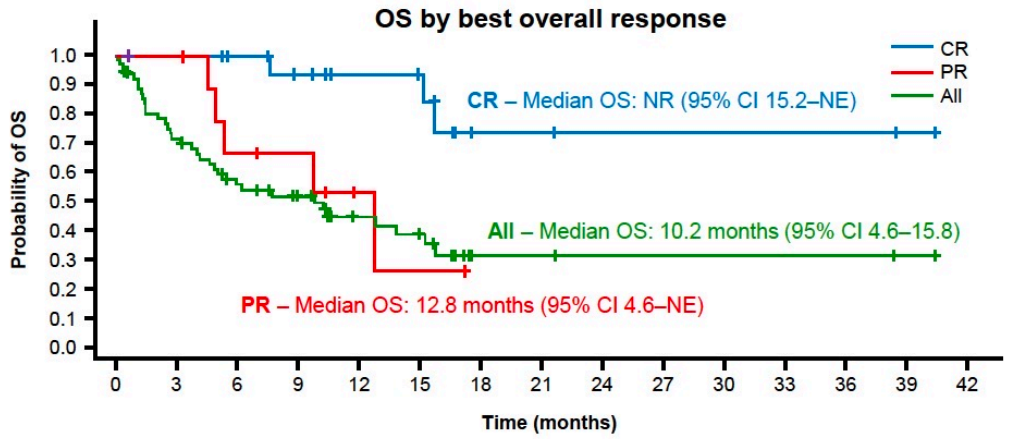
Matasar et al. ASH 2024;Abstract 866

ELM-1 (Odronextamab) post CAR-T



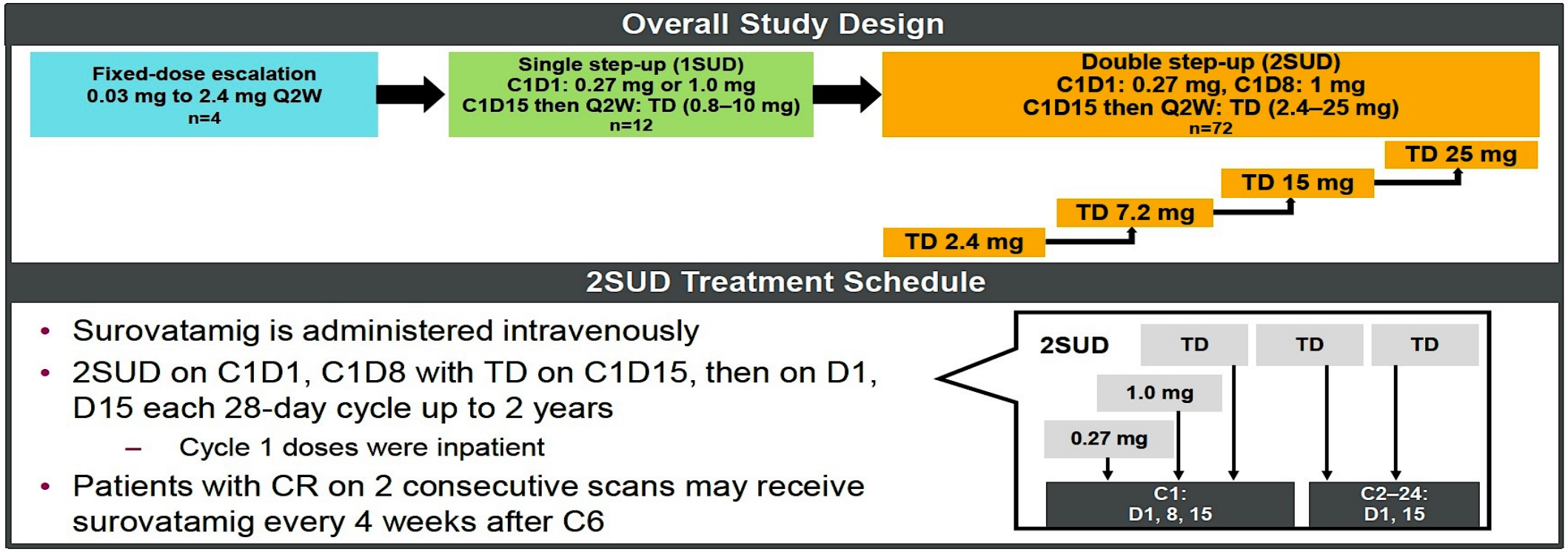






Matasar et al. ASH 2024;Abstract 866

Super Charger: Surovatamig (AZD0486) [CD3 X CD19]

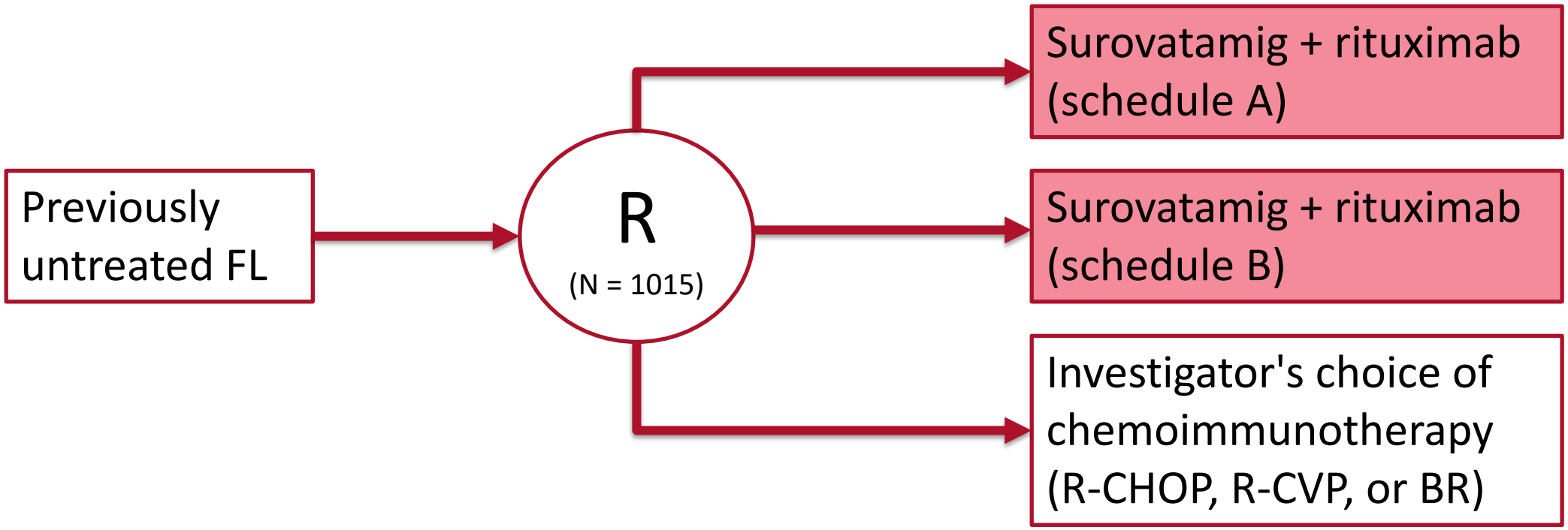


	Overall (N=58)			CAR-T Naive (n=31)			CAR-T Exposed (n=27)		
	n	ORR	CR rate	n	ORR	CR rate	n	ORR	CR rate
7.2 mg	24	46%	33%	9	67%	44%	15	33%	27%
15 mg	26	62%	39%	16	75%	38%	10	40%	40%
25 mg	8	75%	63%	6	83%	67%	2	50%	50%

Surovatamig 2SUD cohort (n=70), n (%)	Grade 1	Grade 2	Grade 3	Grade ≥4
CRS	30 (43)	4 (6)	0	0
ICANS	4 (6)	6 (9)	4 (6)	0

Hun-Yoon et al. EHA 2025;Abstract PS1927

SOUNDTRACK-F1: Phase III Study of Surovatamig (AZD0486) Plus Rituximab in Previously Untreated FL



ClinicalTrials Identifier: NCT06549595. Accessed October 2025.

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Questions from General Medical Oncologists

- **In general, how do you decide between the three available CAR T-cell products, and does it matter if the patient has DLBCL or FL?**

Questions from General Medical Oncologists

- **How do you usually sequence CAR T-cell therapy and bispecific antibodies in DLBCL? What about in FL?**
- **Is there any available data for combining CAR T-cell therapy with a bispecific antibody?**

Questions from General Medical Oncologists

- **CASE: For a 44-year-old woman with multiply relapsed FL who is otherwise fit, at what point would you recommend CAR-T?**
- **CASE: A 76-year-old man with DLBCL relapses within 6 months of R-CHOP but is not a candidate for transplant. Which would you recommend: CAR T, Pola-R-GemOx or a bispecific antibody?**

Questions from General Medical Oncologists

- **What is the spectrum of CRS symptoms seen with CAR-T, and how are they managed?**
- **How would you compare the frequency and severity of CRS associated CAR T versus bispecific antibodies?**
- **Is there a role for prophylactic tocilizumab in patients receiving CAR T-cell therapy? What about for patients getting a bispecific antibody?**

Questions from General Medical Oncologists

- **How long after CAR T-cell therapy administration does ICANS normally present? Does ICANS occur with bispecific antibodies?**

Questions from General Medical Oncologists

- **How do you prevent and manage infections in patients who are receiving bispecific antibodies? How do you approach vaccinations for these patients? What about patients who have undergone CAR T-cell therapy?**

AT THE FOREFRONT
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Available and Emerging Novel Therapies for Diffuse Large B-Cell Lymphoma (DLBCL) and Follicular Lymphoma (FL)

Sonali Smith, MD FASCO
Elwood V. Jensen Professor of Medicine
Chief, Section of Hematology/Oncology
Co-Leader, Cancer Service Line

Overview

TN DLBCL

Pola-RCHP updates

RCHOP-acala (ESCALADE)

RR DLBCL

POLARGLO

Tafasitamab + lenalidomide

Loncastuximab-tesirine

RR FL

Tafasitamab + lenalidomide + rituximab (InMIND)

Zanubrutinib + obinutuzumb (ROSEWOOD)

Loncastuximab-tesirine combos
Golcadomide

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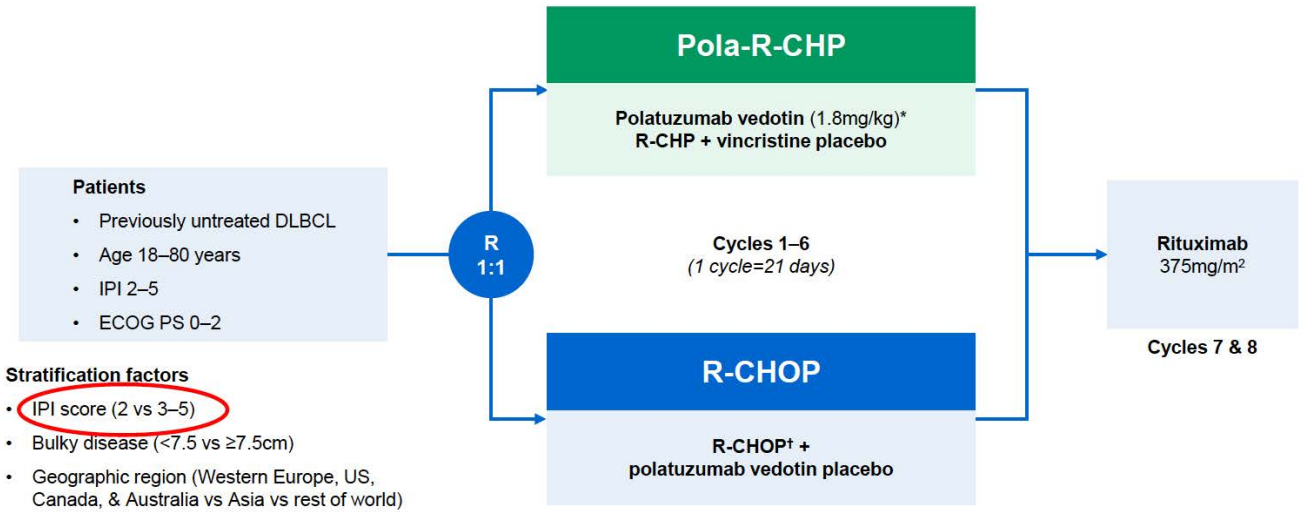
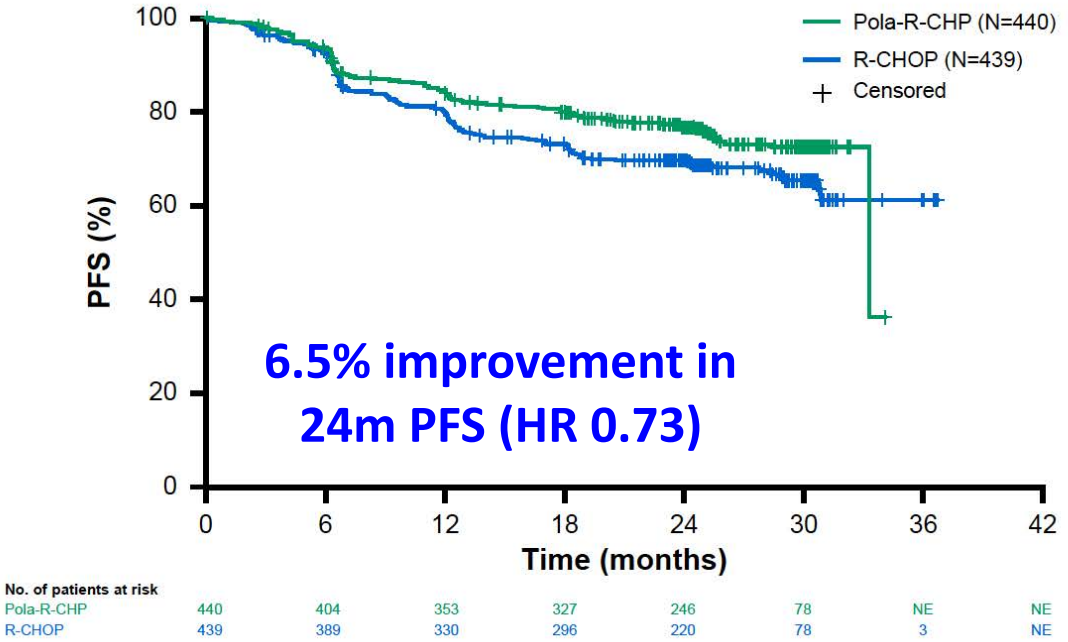
Frontline DLBCL

POLARIX: randomized, double-blind, placebo-controlled phase 3 international trial of Pola-R-CHP vs. R-CHOP in high-risk TN DLBCL





COO was *not* a stratification factor

PRIMARY ENDPT: PFS
Med f/u 28.2m

Med f/u 28m
No difference in OS

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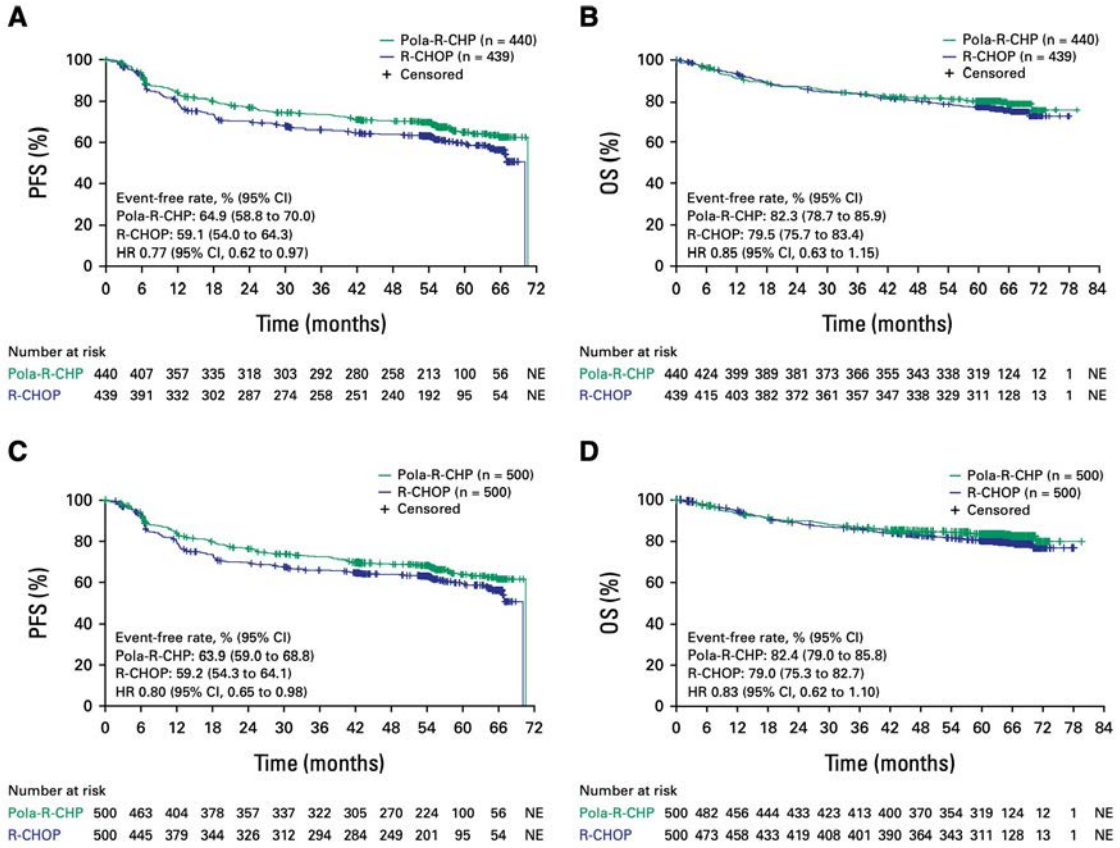
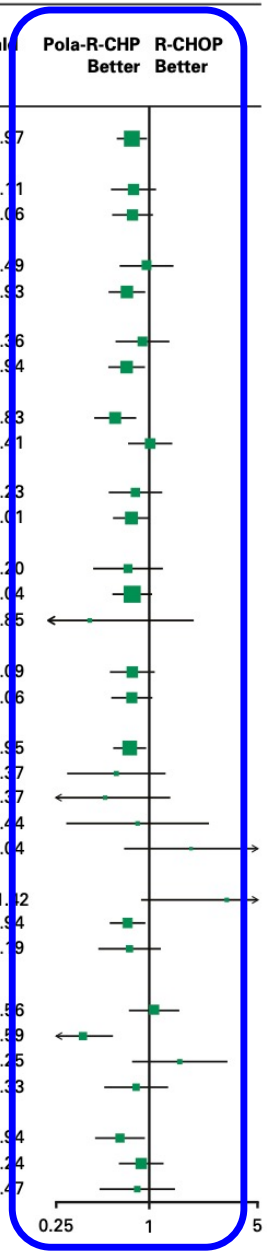
Tilly N Engl J Med. 2022 Jan 27;386(4):351-363

POLARIX: what's new?



5y update: persistent PFS advantage for pola-R-CHP; no OS advantage

Baseline Risk Factors		PFS: Pola-R-CHP (n = 440) No.	Pola-R-CHP 60-Month (%)	R-CHOP (n = 439) No.	R-CHOP 60-Month (%)	HR	95% Wald CI
All patients		440	64.9	439	59.1	**0.78**	0.62 to 0.97
Age group, years	≤65	225	69.6	219	64.3	**0.80**	0.57 to 1.11
	>65	215	60.0	220	54.5	**0.78**	0.58 to 1.06
Age group 2, years	≤60	140	67.6	131	69.2	**0.96**	0.62 to 1.49
	>60	300	63.6	308	55.8	**0.72**	0.55 to 0.93
Stratification – IPI score	2	167	67.2	167	68.3	**0.91**	0.61 to 1.36
	3-5	273	63.2	272	53.5	**0.72**	0.55 to 0.94
Stratification – bulky disease (≥7cm)	Absent	247	69.9	247	60.0	**0.61**	0.44 to 0.83
	Present	193	58.5	192	57.9	**1.02**	0.73 to 1.41
Baseline LDH	≤1×ULN	146	65.3	154	64.8	**0.83**	0.55 to 1.23
	>1×ULN	291	64.3	284	55.7	**0.77**	0.59 to 1.01
Bone marrow involvement	Yes	76	53.3	72	44.2	**0.75**	0.47 to 1.20
	No	342	67.3	349	63.2	**0.80**	0.61 to 1.04
	Indeterminate	11	70.0	11	51.9	**0.44**	0.10 to 1.85
No. of extranodal sites	0-1	227	68.1	226	64.2	**0.78**	0.56 to 1.09
	≥2	213	61.2	213	53.8	**0.78**	0.58 to 1.06
NHL subtype (investigator)	DLBCL, NOS, ABC, GCB	373	65.7	367	58.8	**0.75**	0.59 to 0.95
	HGBCL, NOS, DHL/THL	43	66.0	50	57.6	**0.67**	0.33 to 1.37
	NOS	22	72.7	23	51.7	**0.52**	0.20 to 1.37
	DHL/THL	21	56.7	27	64.2	**0.84**	0.29 to 2.44
	Other LBCL	24	49.7	22	70.3	**1.86**	0.69 to 5.04
Double-/triple-hit lymphoma	DHL/THL+	26	48.8	19	83.0	**3.18**	0.89 to 11.42
	DHL/THL–	305	65.9	315	57.6	**0.72**	0.56 to 0.94
	Unknown	109	65.5	105	62.0	**0.75**	0.47 to 1.19
NanoString COO	GCB	187	65.9	170	65.8	**1.07**	0.74 to 1.56
	ABC	106	72.5	129	45.8	**0.38**	0.24 to 0.59
	UNC	44	55.2	53	70.8	**1.60**	0.79 to 3.25
	Unknown	103	60.2	87	59.7	**0.83**	0.51 to 1.33
Double expressor by IHC	DEL	139	63.1	151	50.0	**0.65**	0.45 to 0.94
	Non-DEL	223	66.6	215	64.7	**0.89**	0.64 to 1.24
	Unknown	78	63.7	73	63.5	**0.84**	0.48 to 1.47



AT THE FOREFRONT
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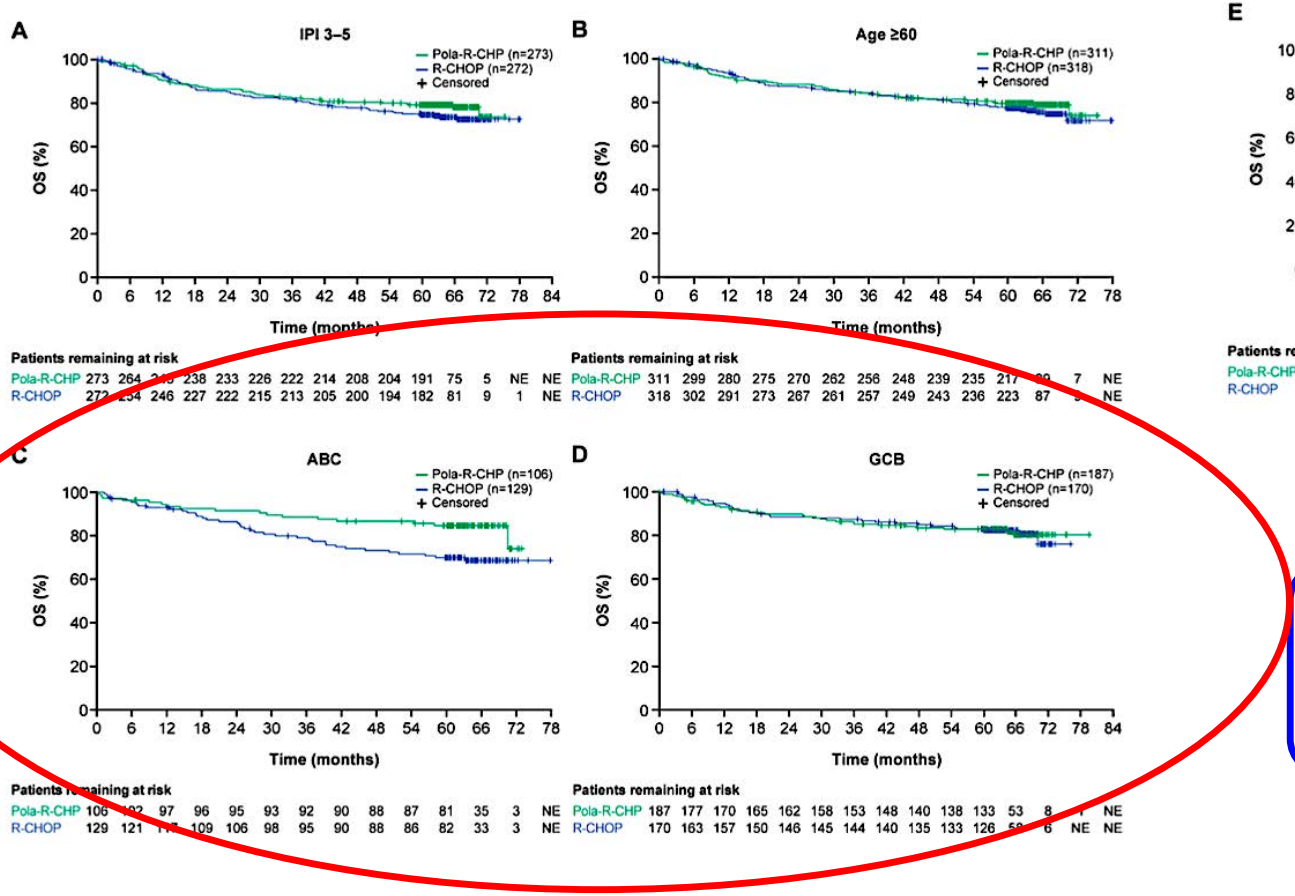
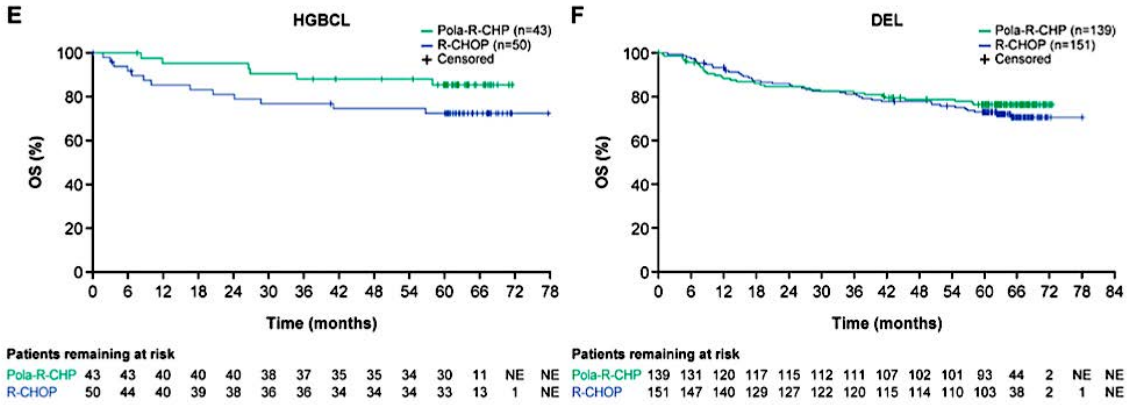
Morschhauser F *J Clin Oncol* 2025; Sep25 [online ahead of print].

POLARIX: what's new? OVERALL SURVIVAL in specific subgroups





Favorable OS advantage in ABC (NanoString) and HGBCL groups

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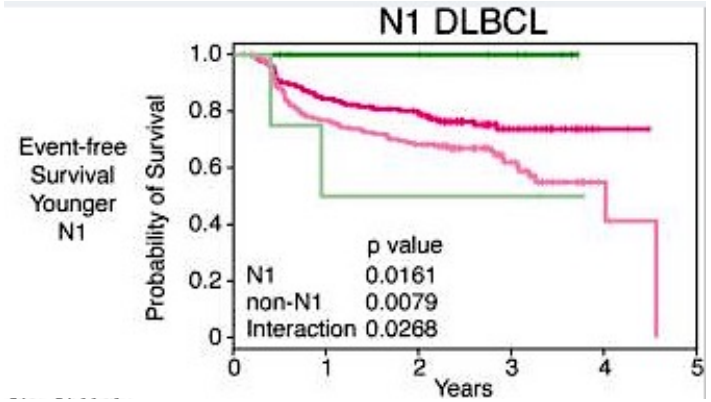
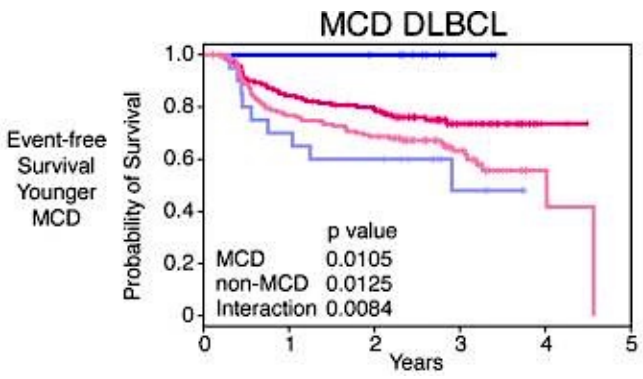
Morschhauser F *J Clin Oncol* 2025; Sep25 [online ahead of print].

From PHOENIX (R-CHOP +/- ibrutinib) to ESCALADE (R-CHOP +/- acalabrutinib) for non-GC DLBCL

PHOENIX was a negative trial

- Increased toxicity in older patients
- Gap from dx to treatment
- Underlying genomic heterogeneity
  - MCD and N1 groups benefit the most





ESCALADE (RCHOP +/- acalabrutinib)

- ≤ 75yo
- Allows 1 cycle of RCHOP prior to protocol treatment
- Gene expression profiling to determine cell of origin
- N=600

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Sehn N Engl J Med. 2021 Mar 4;384(9):842-858; Wilson Cancer Cell. 2021 Dec 13;39(12):1643-1653.e3

On the horizon for frontline DLBCL: targeted vs. precision approaches

RCHOP plus "X"

Golcadomide

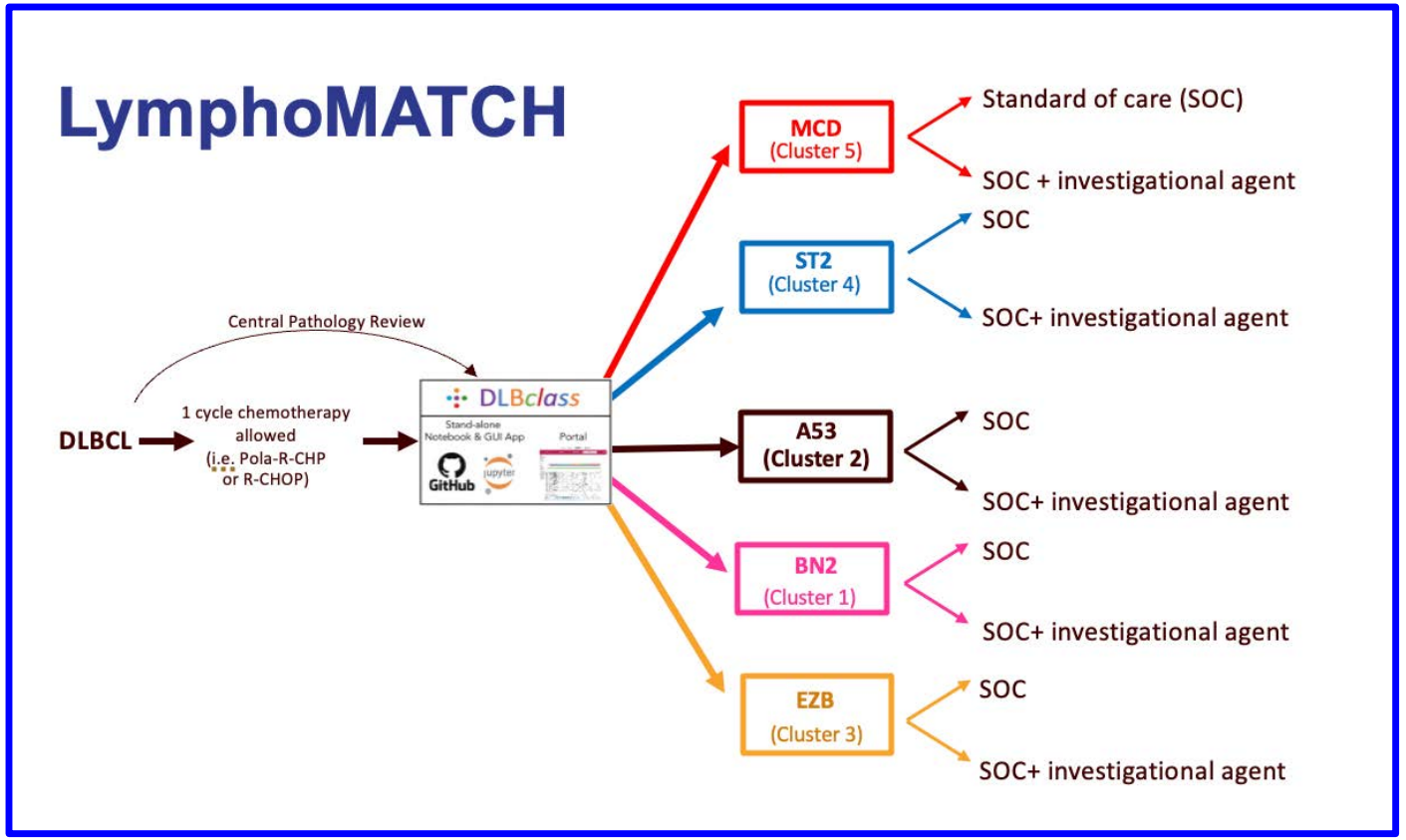
Bispecific agents

- glofitamab
- epcoritamab
- odronextamab

Tafasitamab +/- len

Polatuzumab

VS.



Rel/Ref large B-cell lymphoma

Last year: STARGLO: RP3 Trial of R-GEMOX vs. glofit-GEMOX in rel/ref LBCL

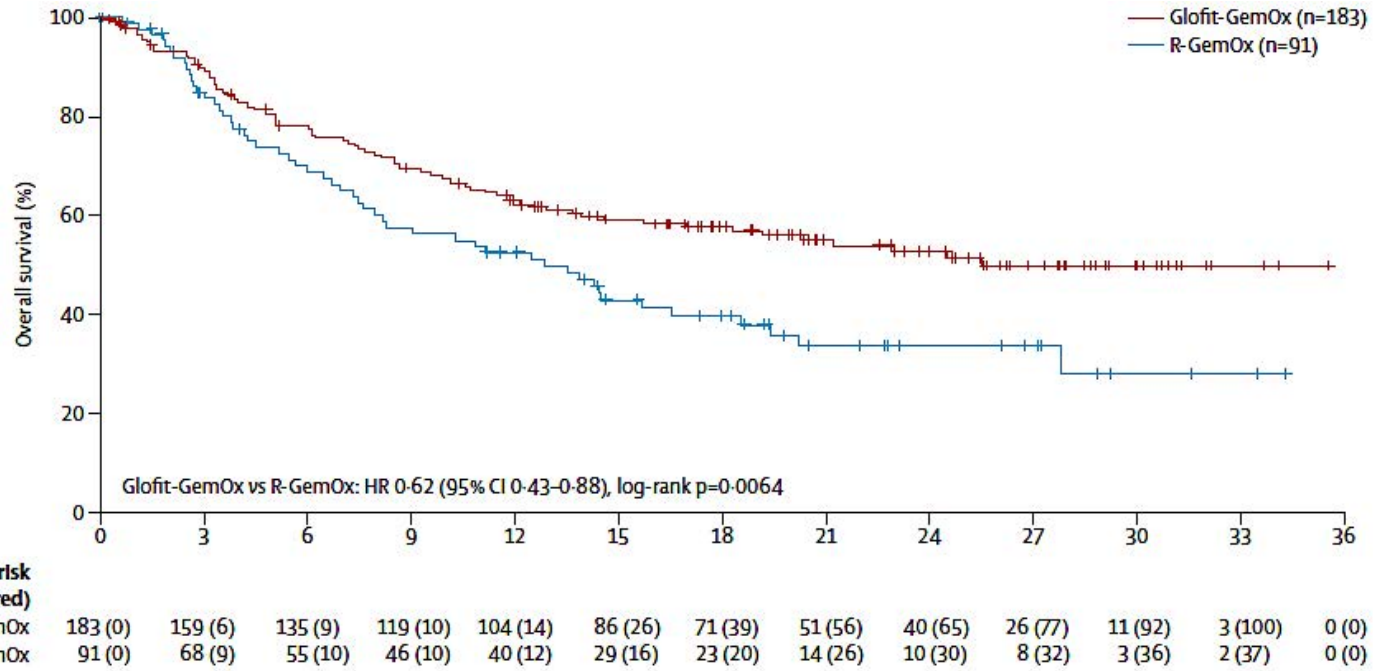
Rel/Ref LBCL
(autoHCT inelig)
1 vs ≥2 Rx
Rel vs ref dz

1 R-GemOx x 8 cycles (n=91)

2 Glofit plus GEMOX x 8 cycles → glofit x 4 (n=183)

Primary endpoint: OS

Med f/u 20.7m
Med OS 25.5m vs 12.9m
(HR 0.62)



Number at risk (number censored)													
Glofit-GemOx	183 (0)	159 (6)	135 (9)	119 (10)	104 (14)	86 (26)	71 (39)	51 (56)	40 (65)	26 (77)	11 (92)	3 (100)	0 (0)
R-GemOx	91 (0)	68 (9)	55 (10)	46 (10)	40 (12)	29 (16)	23 (20)	14 (26)	10 (30)	8 (32)	3 (36)	2 (37)	0 (0)

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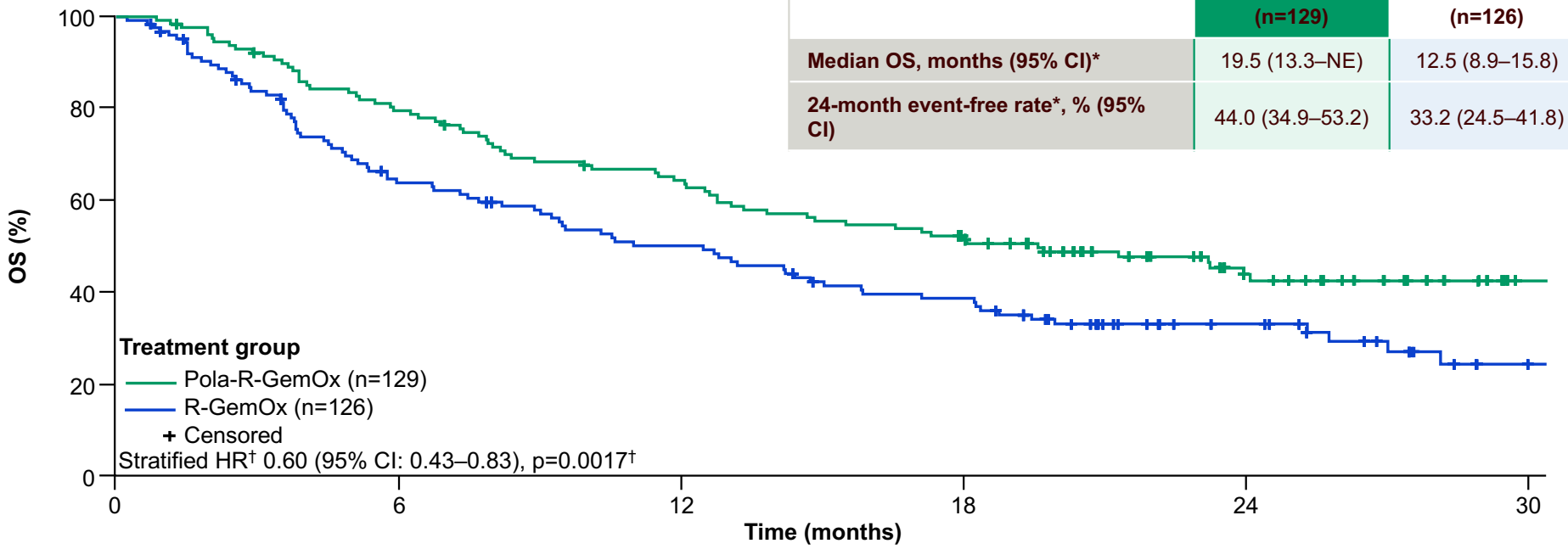
NOW: POLARGLO: Pola-R-GemOx significantly improved OS vs R-GemOx in patients with R/R DLBCL

Median OS follow-up: 24.6 months (95% CI: 23.0–26.0)

	Pola-R-GemOx (n=129)	R-GemOx (n=126)
Median OS, months (95% CI)*	19.5 (13.3–NE)	12.5 (8.9–15.8)
24-month event-free rate*, % (95% CI)	44.0 (34.9–53.2)	33.2 (24.5–41.8)



Pola-R-GemOx	129	101	80	62	31	10
R-GemOx	126	76	58	43	21	6

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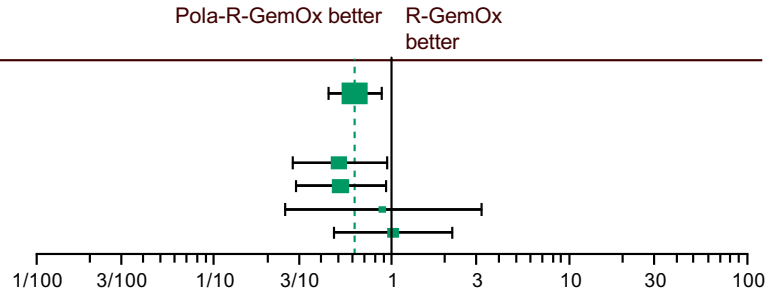
Matasar M et al. EHA 2025; Abstract S101.

POLARGLO: Survival benefit seen in both ABC and GCB cell-of-origin subgroups

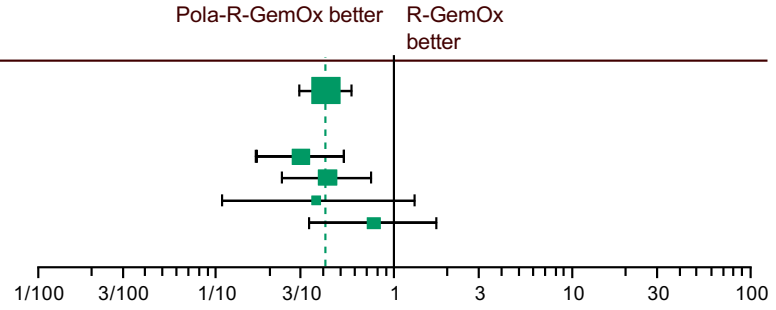
Overall survival

Biomarker risk factors	Total n	Pola-R-GemOx (n=129) n	Events	Median (months)	R-GemOx (n=126) n	Events	Median (months)	HR	95% Wald CI
All patients	255	129	69	19.5	126	83	12.5	0.64	(0.47–0.89)
Cell of origin (central)									
ABC	86	41	22	23.2	45	30	10.5	0.53	(0.31–0.93)
GCB	98	48	23	23.9	50	33	11.0	0.54	(0.32–0.93)
Unclassified	20	11	6	12.7	9	6	14.2	0.89	(0.28–2.84)
Unknown	51	29	18	16.5	22	14	18.2	1.01	(0.50–2.02)



Progression-free survival

Biomarker risk factors	Total n	Pola-R-GemOx (n=129) n	Events	Median (months)	R-GemOx (n=126) n	Events	Median (months)	HR	95% Wald CI
All patients	255	129	84	7.4	126	98	2.7	0.46	(0.34–0.62)
Cell of origin (central)									
ABC	86	41	31	7.4	45	40	2.6	0.35	(0.21–0.57)
GCB	98	48	28	7.9	50	36	2.8	0.47	(0.28–0.77)
Unclassified	20	11	6	10.3	9	9	2.6	0.42	(0.14–1.24)
Unknown	51	29	19	4.3	22	13	4.7	0.79	(0.39–1.61)



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Matasar M et al. EHA 2025; Abstract S101.

Tafasitamab plus lenalidomide in RR DLBCL (phase 2 trial) and RWE

Analysis	5-year final: 14 Nov 2022		
	Overall	1 pLoT	≥2 pLoT
mPFS, months [95% CI]	**11.6** [5.7–45.7]	**23.5** [7.4–NR]	**7.6** [2.7–45.5]

Analysis	5-year final: 14 Nov 2022		
	Overall	1 pLoT	≥2 pLoT
mOS, months [95% CI]	**33.5** [18.3–NR]	**NR** [24.6–NR]	**15.5** [8.6–45.5]

Table 4. Final Cox Model of Factors Associated With rwPFS Among Patients Initiating Tafasitamab for R/R DLBCL*

Characteristic	n	Hazard Ratio (95%CI)	*P* Value
Line of therapy patient received tafasitamab			
3L-5L	51	1.79 (1.20, 2.66)	0.004
2L (reference)	130	–	–
Ann Arbor stage at tafasitamab initiation			
Stage I/II	10	0.30 (0.10, 0.95)	0.041
Stage III/IV (reference)	169	–	–
Charlson Comorbidity Index (NCI version) at tafasitamab initiation (continuous)	181	1.43 (1.03, 1.97)	0.033
Tumor volume at tafasitamab initiation			
Bulky	36	1.96 (1.26, 3.05)	0.003
Nonbulky (reference)	145	–	–

*To overcome violation of proportional hazards assumption caused by the variable ECOG PS, coefficients were adjusted for ECOG PS ≥2 vs <2 through stratifying the model on ECOG PS.

Table 5. Final Cox Model of Factors Associated With rwOS Among Patients Initiating Tafasitamab for R/R DLBCL

Characteristic	n	Hazard Ratio (95% CI)	*P* Value
Median age at tafasitamab initiation, years (continuous)	181	1.06 (1.03, 1.09)	<0.001
Line of therapy patient received tafasitamab			
3L-5L	51	2.39 (1.46, 3.93)	<0.001
2L (reference)	130	–	–
ECOG PS at tafasitamab initiation			
≥2	86	3.57 (2.13, 5.97)	<0.001
<2 (reference)	95	–	–
Tumor volume at tafasitamab initiation			
Bulky	36	2.22 (1.27, 3.87)	0.005
Nonbulky (reference)	145	–	–

Body of evidence suggests:

- **Best for 2L disease**
- **Non-bulky**
- **Good PS**
- **CR**

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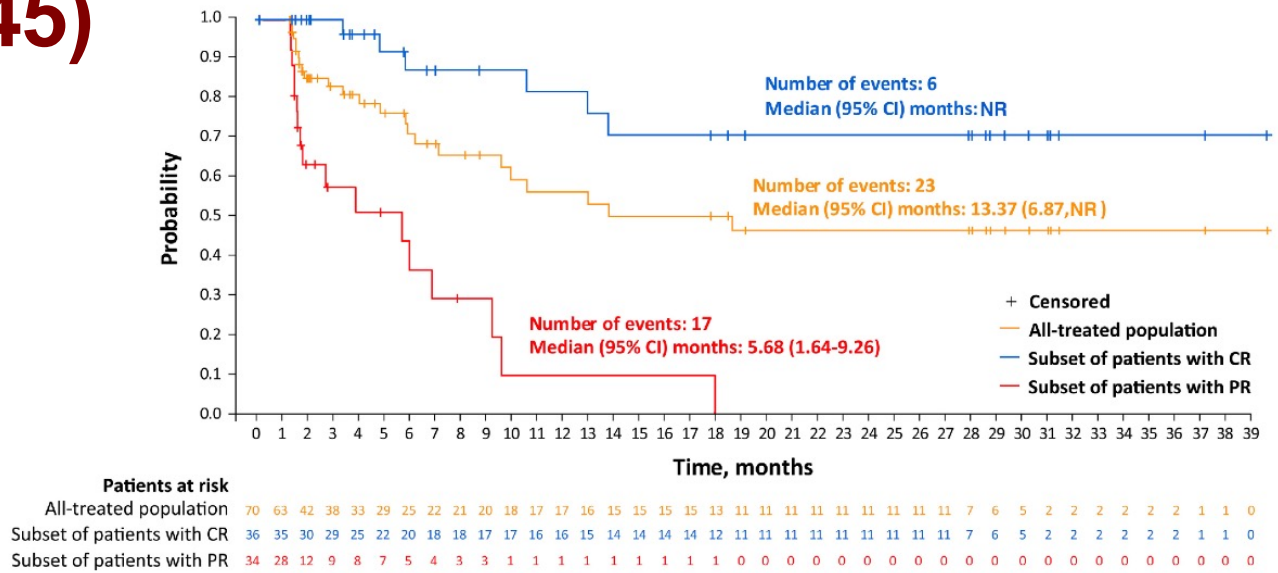
Saverno 2025 Tandem Meetings; Duell Haematologica 2024 Feb 1;109(2):553-566.

Loncastuximab tesirine: Final analysis of LOTIS-2 trial in rel/ref LBCL (n=145)



LOTIS-5 RP3 Confirmatory Trial Lonca-R vs. R-GemOx:

- Regimen: Lonca 150 µg/kg + rituximab 375 mg/m^2 every 3 weeks (Q3W) for 2 cycles, then Lonca 75 µg/kg + rituximab 375 mg/m^2 Q3W for up to 6 additional cycles.
- Loncastuximab plus rituximab in RR DLBCL completed accrual (press release December 2024)
- Safety run-in of 20 pts had ORR 80% (16/20) with CR 50% (10/20) and no new safety signals

LOTIS-7 Lonca plus glofit

ORR 93%, CR 87%, Low CRS (mainly grade 1), Dose-expansion part underway

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Kwiatek ASCO 2024 TIP; Caimi Haematologica. 2024 Apr 1;109(4):1184-1193; Alderuccio ICML 2025

Follicular Lymphoma: treatment other than T-cell engaging approaches

Treatment options for rel/ref FL

2L Options

Chemo+ Ritux or Obinu
Len + rituximab or obinu
Anti-CD20 monotherapy
+/- maintenance
(tazemetostat)
(autoHCT)

3L+ Options

Bispecific antibody
- Mosunetuzumab
- Epcoritamab
- ***Odronextamab (not approved)*

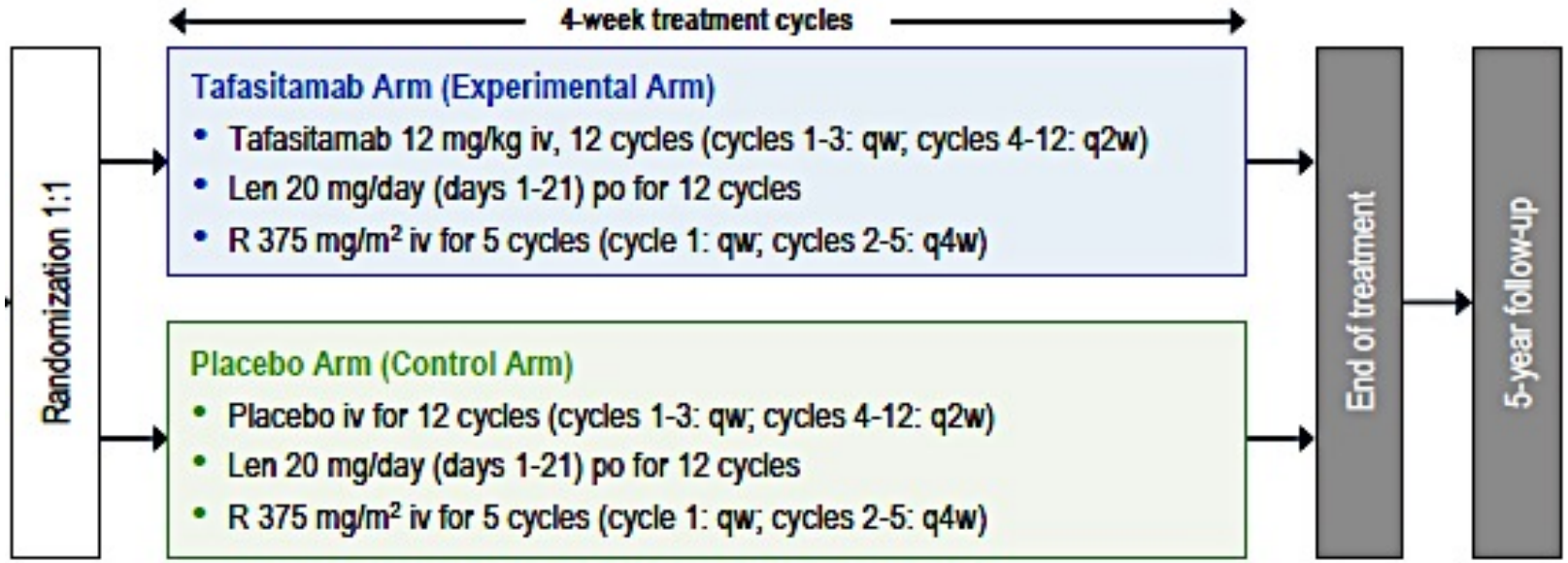
CAR-T
- Axi-cel
- Tisa-cel
- Liso-cel

Tazemetostat
Zanubrutinib + obin
(alloHCT)

***NEW*:**
Tafa-LenR
Lonca-R

inMIND trial: RP3 double-blind len-rituximab +/- tafasitamab in rel/ref FL

Adults with R/R FL (grade 1-3a) or MZL previously treated with ≥1 anti-CD20 mAb; no prior R²; ECOG PS 0-2 (Planned N = 618; FL, 528; MZL, 60-90) (N = 654)



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

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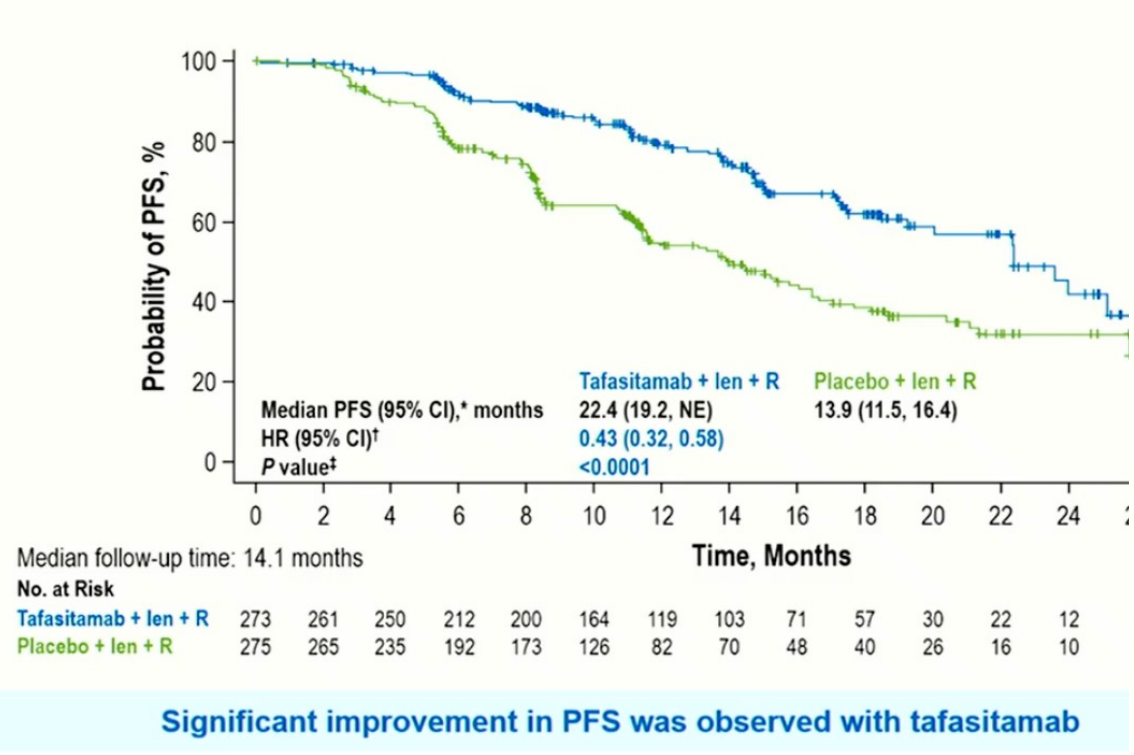
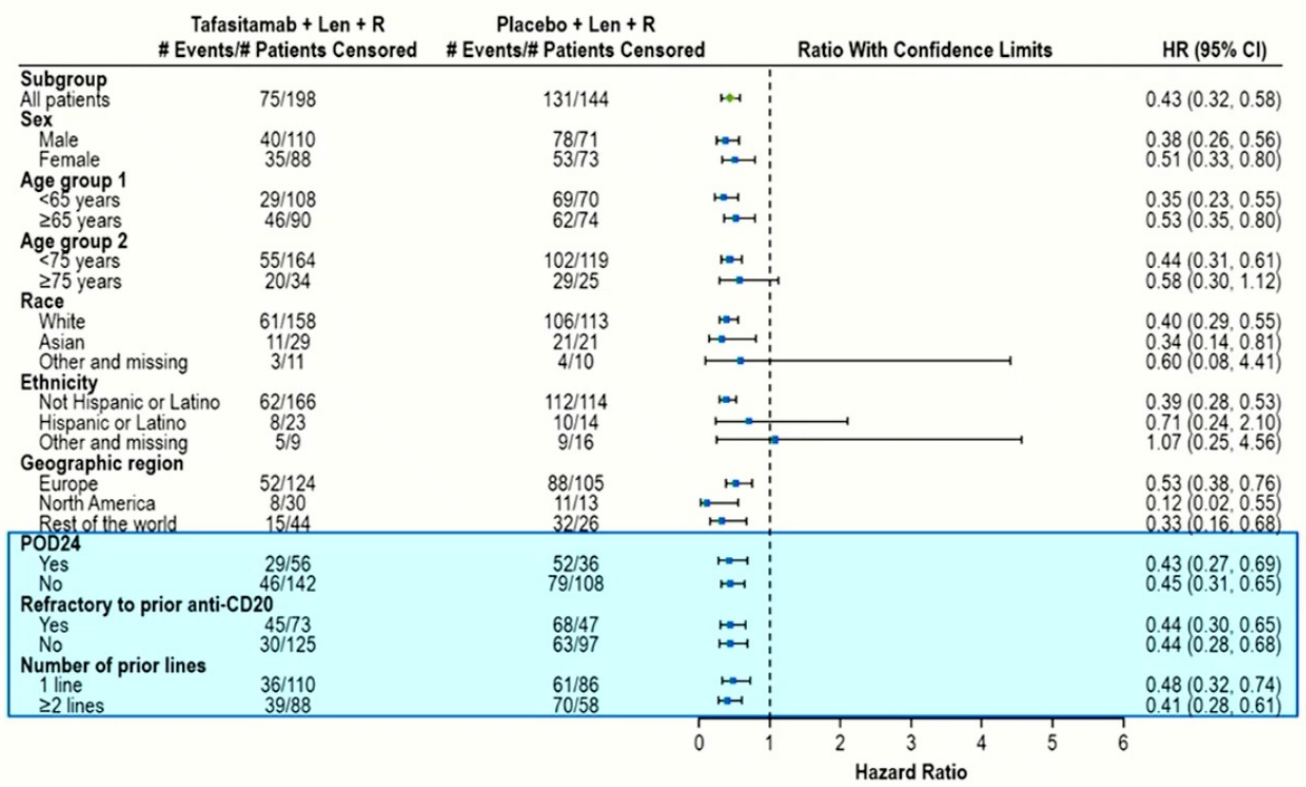
Sehn ICML 2025; Sehn ASH 2024; Abstract LBA-1.

inMIND Results: Tafa-LenR vs. Pbo-LenR



Significant improvement in PFS was observed with tafasitamab



- **Improved PFS, DoR, TTNT for Tafa-LenR**
- **NOTE:** 23/24 post-treatment lymphoma samples retained CD19 expression

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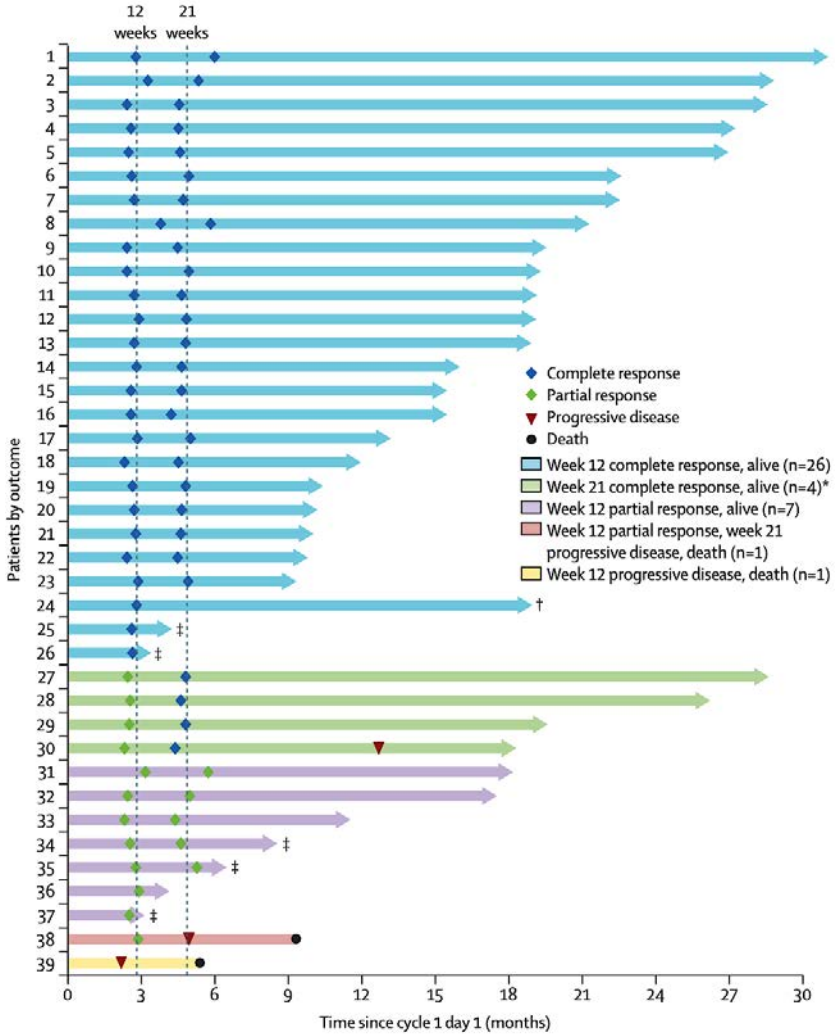
Sehn ICML 2025

Lonca plus rituximab in RR FL (phase 2) n=39



Short follow up
Patients with 51% early POD
CR 67%
TEAEs: lymphopenia, neutropenia, generalized and peripheral edema

Added to NCCN Guidelines as other recommended regimen in third line and beyond for FL (v3.2025, category 2B)

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Alderuccio Lancet Haematol 2025; 12: e23–34

ROSEWOOD: RP2 (2:1) trial of Zanu-obin vs. obin in RR FL

Pt features	ZO (n=145)	O (n=72)	P value
Med age	63y	65.5y	
Prior Tx	3 (2-11)	3 (2-9)	
High FLIPI	53%	51%	
POD24	34%	42%	
Ref to last Tx	32%	40%	
Results			
ORR	69%	46%	0.001
CR	39%	19%	0.004
Med DOR	NE	14m	
Med PFS	28m	10.4m	<0.001
Med OS	NE	34.6m	0.085

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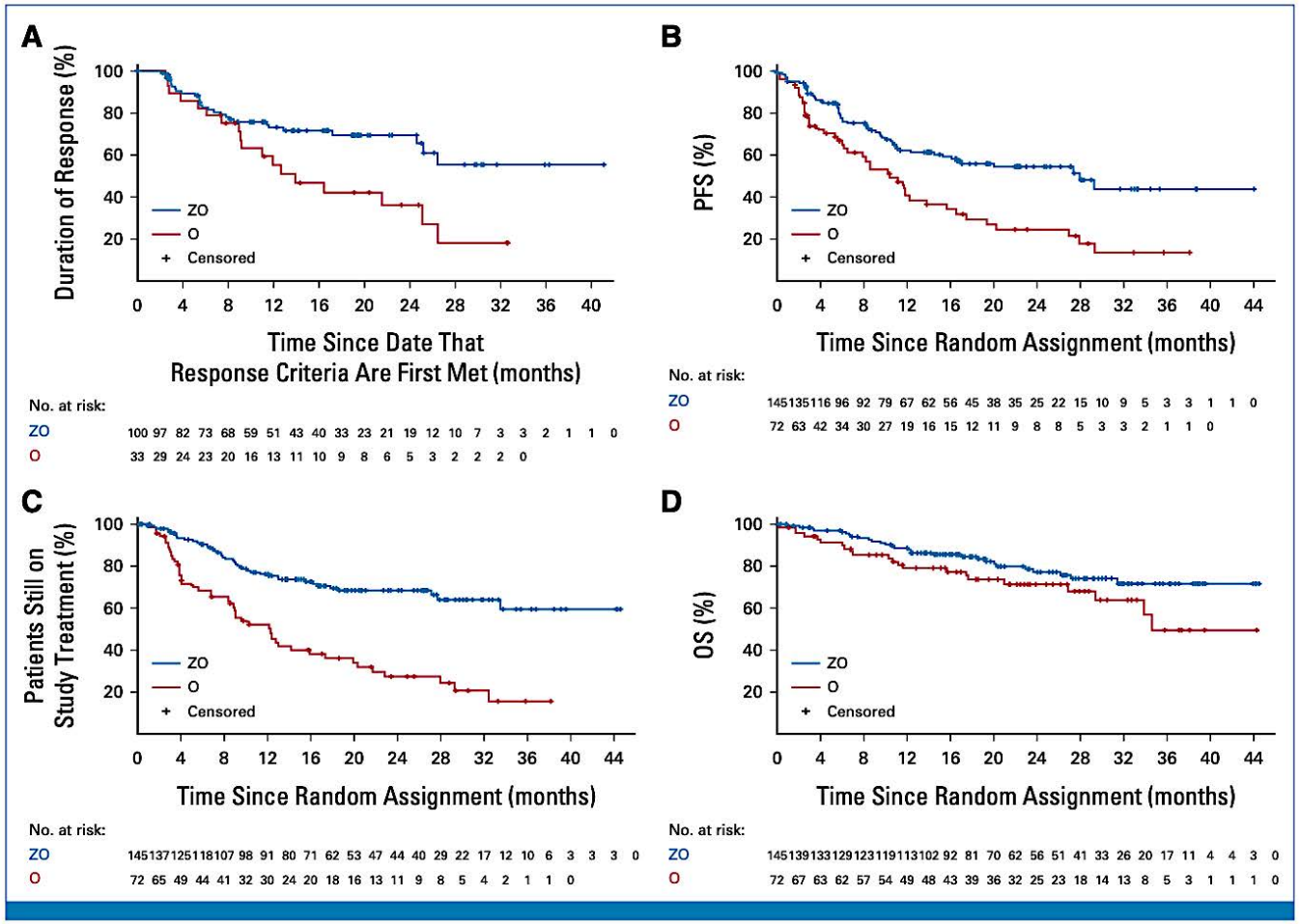
Zinzani JCO 41(33) https://doi.org/10.1200/JCO.23.00775

ROSEWOOD: RP2 (2:1) Zanu-obin versus obin



ASH 2024 Update:

Post-hoc analysis of data from ROSEWOOD showed that the majority (>60%) of patients with R/R FL receiving ZO had a significant improvement in PFS vs their last prior tx, irrespective of the number of prior lines (only 2 or >2) and in all tested subgroups of high clinical interest

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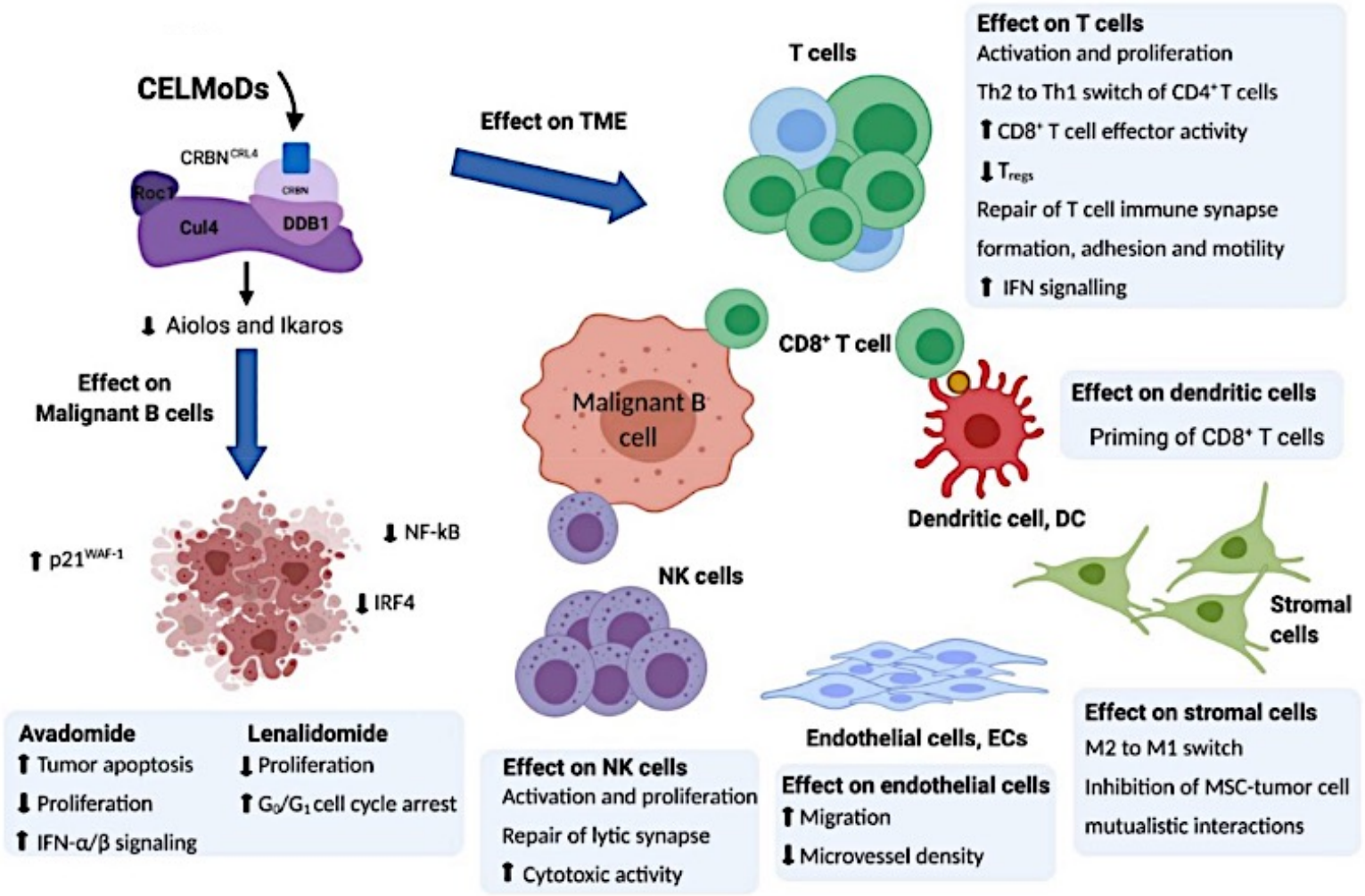
Trotman ASH 2024; Zinzani JCO 41(33) https://doi.org/10.1200/JCO.23.00775

Emerging agents: CELMoDs



CELMoDs:

- Avadomide
- Iberdomide
- Golcadomide
- Mezigdomide

Ongoing trials:

- Golca plus RCHOP/pola-RCHP
- Golca post CAR-T

Side effects:

- Cytopenias, hyperglycemia, electrolyte abnormalities

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Ioannou N et al. Int J Mol Sci 2021 Aug 9;22(16):8572.

Data + Perspectives: Clinical Investigators Explore the Application of Recent Datasets in Current Oncology Care

CME/MOC, NCPD and ACPE Accredited

Saturday, October 11, 2025
7:15 AM – 12:30 PM ET

RTP
RESEARCH
TO PRACTICE

Questions from General Medical Oncologists

- **For which patients with DLBCL do you use polatuzumab vedotin + R-CHP as up-front treatment?**

Questions from General Medical Oncologists

- **How are BTK inhibitors being evaluated in DLBCL? If these agents are proven effective in the first-line in non-GCB subtype, how will you select between them and pola-R-CHP?**
- **Where are you currently considering the use of zanubrutinib/obinutuzumab for R/R FL?**

Questions from General Medical Oncologists

- **How are you using tafasitamab in DLBCL?**
- **Is tafasitamab in combination with R^2 now your usual second-line therapy?**

Questions from General Medical Oncologists

- How are you incorporating loncastuximab tesirine into your current management of DLBCL?
- Given lonca-T has now been added to NCCN for FL, where are you thinking about using it in relation to zanu/obin or tazemetostat?
- What are the common toxicities of loncastuximab tesirine? How are these prevented and mitigated?
- Are you comfortable using all three CD19 directed approaches in the same patient? How will we potentially integrate a 4th?

Questions from General Medical Oncologists

- **In general, how do you sequence agents for patients with FL and POD24 (disease progression within 24 months of initial treatment)?**

Save The Date

Fifth Annual
National General Medical Oncology Summit

A Multitumor CME/MOC-, NCPD- and ACPE-Accredited Educational Conference Developed in Partnership with Florida Cancer Specialists & Research Institute

Friday to Sunday, April 24 to 26, 2026

The Ritz-Carlton Orlando, Grande Lakes | Orlando, Florida

Moderated by Neil Love, MD

Thank you for joining us!
Your feedback is very important to us.

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.

How to Obtain Credit

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

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