What Clinicians Want to Know: Addressing Community Oncologists' Questions About the Roles of CAR T-Cell Therapy and Bispecific Antibodies in the Management of Non-Hodgkin Lymphoma

Sunday, May 31, 2026

7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Joshua Brody, MD

Manali Kamdar, MD, MBBS

Tycel Phillips, MD, FASCO

Jason Westin, MD, MS, FACP, FASCO

Moderator

Jeremy S Abramson, MD, MMSc

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Faculty

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Dr Brody — Disclosures
Faculty

No relevant financial relationships to disclose

Dr Kamdar — Disclosures
Faculty

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Data and Safety Monitoring Boards/Committees	Bristol Myers Squibb, Celgene Corporation, Genentech, a member of the Roche Group

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Dr Phillips — Disclosures
Faculty

Advisory Boards/Consulting	AbbVie Inc, ADC Therapeutics, AstraZeneca Pharmaceuticals LP, BeOne, Bristol Myers Squibb, Caribou Biosciences Inc, Celgene Corporation, Genentech, a member of the Roche Group, Genetics Pharmaceuticals, Genmab US Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, Johnson & Johnson, Kite, A Gilead Company, Lilly, Merck, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Seagen Inc, Xencor
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Data and Safety Monitoring Boards/Committees	Xencor
Nonrelevant Financial Relationships	Blood Cancer United

Dr Westin — Disclosures
Faculty

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Dr Abramson — Disclosures
Moderator

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Research To Practice President Neil Love, MD — Disclosures

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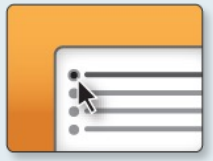
Clinicians in the Meeting Room

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. Survey questions will be discussed throughout the meeting.

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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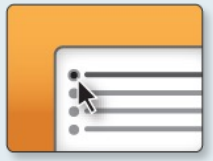
Clinicians Attending via Zoom

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



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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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Friday May 29	**Gastroesophageal Cancers** 11:30 AM – 1:00 PM CT (12:30 PM – 2:00 PM ET)
	Non-Small Cell Lung Cancer 6:30 PM – 8:30 PM CT (7:30 PM – 9:30 PM ET)
	Chronic Lymphocytic Leukemia 6:30 PM – 8:30 PM CT (7:30 PM – 9:30 PM ET)
	Colorectal Cancer 6:30 PM – 8:00 PM CT (7:30 PM – 9:00 PM ET)
Saturday May 30	**Ovarian Cancer** 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)
	Small Cell Lung Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Sunday May 31	**Oral SERDs and Agents Targeting the PI3K/AKT/mTOR Pathway for Breast Cancer** 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
	Endometrial Cancer 7:00 PM – 8:30 PM CT (8:00 PM – 9:30 PM ET)
	CAR T-Cell Therapy and Bispecific Antibodies for Non-Hodgkin Lymphoma 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Monday June 1	**ADCs for Breast Cancer** 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
	Novel Therapies for Non-Hodgkin Lymphoma 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
	Relapsed/Refractory Multiple Myeloma 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Tuesday June 2	**Myelofibrosis (Webinar)**

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Moderator

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What Clinicians Want to Know: Addressing Community Oncologists' Questions About the Roles of CAR T-Cell Therapy and Bispecific Antibodies in the Management of Non-Hodgkin Lymphoma

Survey of US-Based General Medical Oncologists
May 13-26, 2026

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Agenda

Module 1: Chimeric Antigen Receptor (CAR) T-Cell Therapy for Diffuse Large B-Cell Lymphoma (DLBCL) — Dr Kamdar

Module 2: Bispecific Antibody Therapy for DLBCL — Dr Westin

Module 3: CAR T-Cell Therapy for Other Lymphoma Subtypes — Dr Abramson

Module 4: Bispecific Antibody Therapy for Follicular Lymphoma and Other Lymphoma Subtypes — Dr Phillips

Module 5: Tolerability Considerations with CAR T-Cell Therapy and Bispecific Antibodies — Dr Brody

Agenda

Module 1: Chimeric Antigen Receptor (CAR) T-Cell Therapy for Diffuse Large B-Cell Lymphoma (DLBCL) — Dr Kamdar

Module 2: Bispecific Antibody Therapy for DLBCL — Dr Westin

Module 3: CAR T-Cell Therapy for Other Lymphoma Subtypes — Dr Abramson

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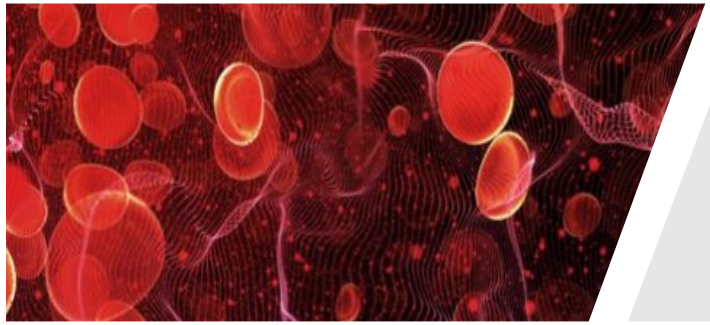
Module 5: Tolerability Considerations with CAR T-Cell Therapy and Bispecific Antibodies — Dr Brody



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

Manali Kamdar, MD, MBBS

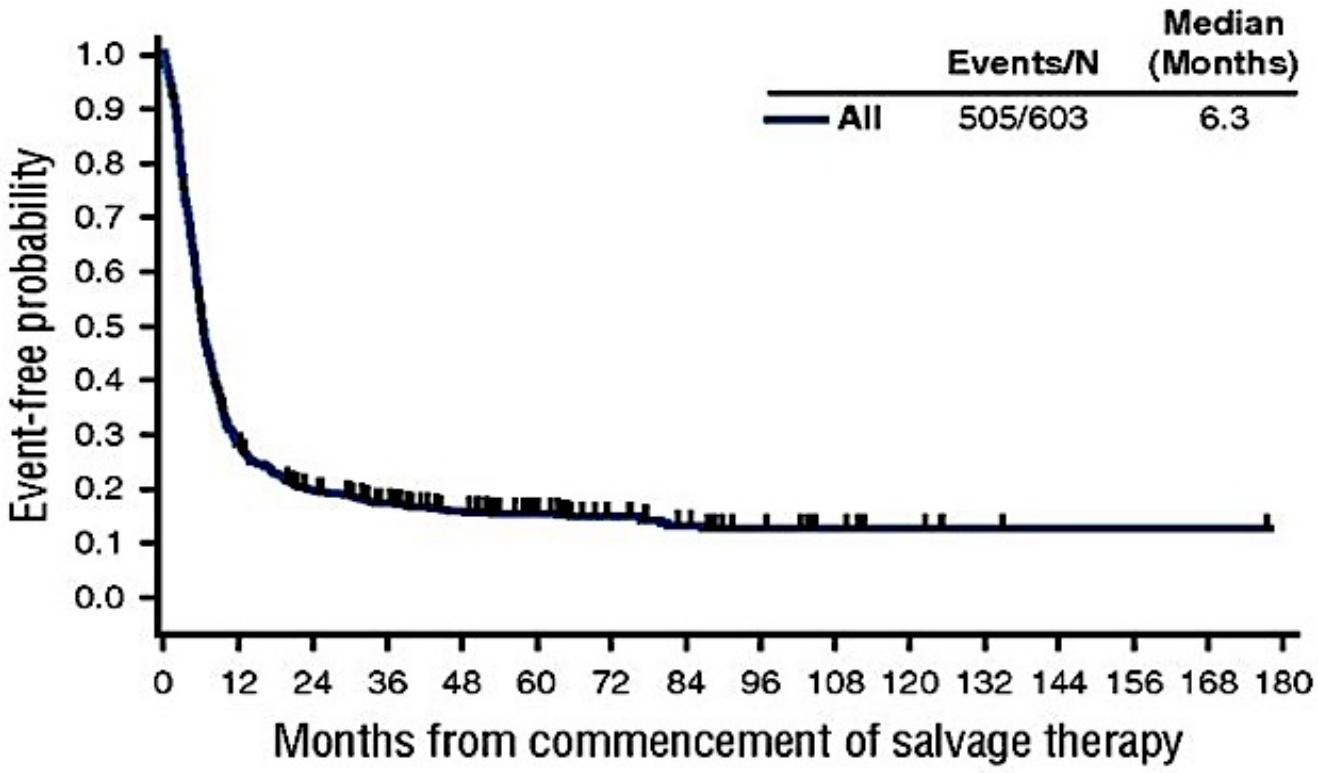
Associate Professor of Medicine, Clinical director of lymphoma services,

Morton and Sandra Saffer Endowed Chair in Hematology Research,
Division of Hematology,

University of Colorado

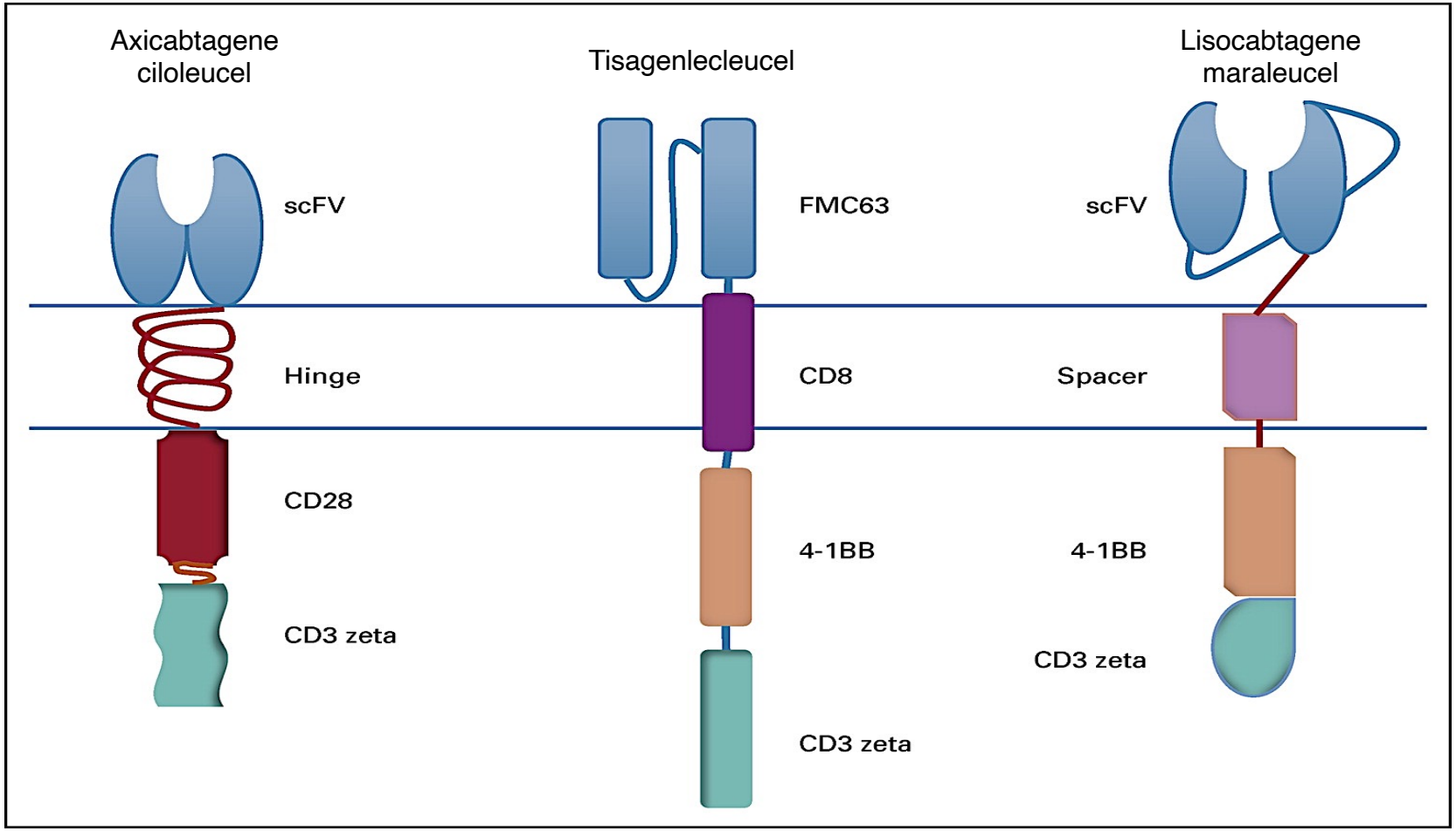
Pre-CAR-T ERA

Relapsed/Refractory Chemotherapy-resistant Large B Cell Lymphoma (R/R LBCL) → dismal prognosis



Crump et al Scholar-1 study Blood 2017

Anti-CD19 CAR-T cell therapies approved in R/R LBCL after failure of ≥2 lines of treatment



Caron A. Jacobson; *Journal of Clinical Oncology* 2019

Baseline Characteristics

	ZUMA-1 Axicabtagene Ciloleucel	TRANSCEND Lisocabtagene Maraleucel	JULIET Tisagenlecleucel
Dose	2 x 10^6/kg	100 x 10^6	0.6 to 6.0 x 10^8
Lymphodepletion x3 days	Flu/Cy 500/30	Flu/Cy 300/30	Flu/Cy 250/25, OR Bendax2
# Treated / Enrolled	101/111	269/344	111/165
Bridging Rx (%)	0	59	92
Lymphoma Subtypes	DLBCL, PMBCL, HGBCL, Transformed FL	DLBCL, PMBCL, HGBCL, Transformed FL, Transformed Non-FL, Sec CNS involvement, Prior Allo	DLBCL, Transformed FL
Median Age	58 (23-76)	63 (18-86)	56 (22-76)
Median prior LOT	3	3	2 (44%), 3 (31%)
Refractory/Prior ASCT (%)	100/23	67/35	55/49

Locke FL, et al. Lancet Oncol. 2019;20:31-42
Schuster, et al. Lancet Onc. 2021
Abramson JS, et al. Lancet 2020

Efficacy and Safety

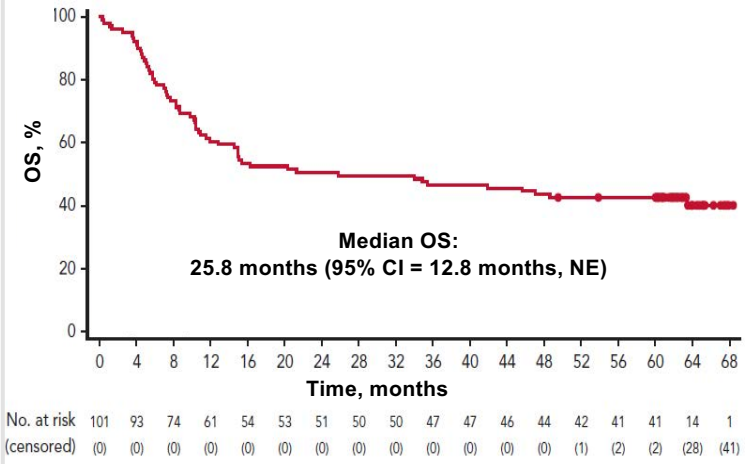
	ZUMA-1 Axicabtagene Ciloleucel	TRANSCEND Lisocabtagene Maraleucel	JULIET Tisagenlecleucel
# Treated / Enrolled	101/111	269/344	111/165
ORR/CR (%) by IRC	74/54	73/53	52/40
Construct	antiCD19-CD28-CD3z	antiCD19-41BB-CD3z	antiCD19-41BB-CD3z
Toxicity grading scale	Lee Criteria	Lee Criteria	Penn Criteria
Median time to CRS onset	2 days	5 days	3 days
Any Grade/Gr ≥3 Cytokine release syndrome (CRS)	93% / 11%	42% / 2%	58% / 23%
Any Gr/Gr ≥3 Neurotoxicity	64% / 32%	30% / 10%	21% / 12%
2yr PFS/OS	42% / 51%	41% / 51%	30%/median 11m

Locke FL, et al. Lancet Oncol. 2019;20:31-42
Schuster, et al. Lancet Onc. 2021
Abramson JS, et al. Lancet 2020

Long-term follow-up supports the curative potential of CD19 CAR T in R/R 3L+ LBCL

ZUMA-1 (axi-cel)[1]

Overall survival

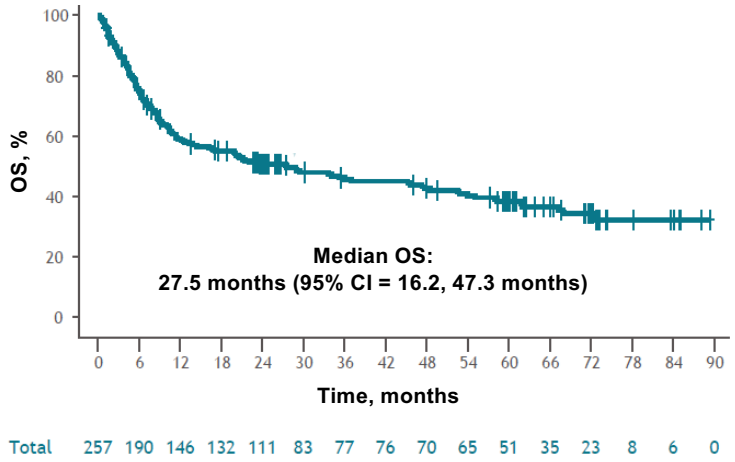


Median OS:
25.8 months (95% CI = 12.8 months, NE)

5-year OS rate: 43%
Median follow-up: 63.1 months

TRANSCEND (liso-cel)[2]

Overall survival

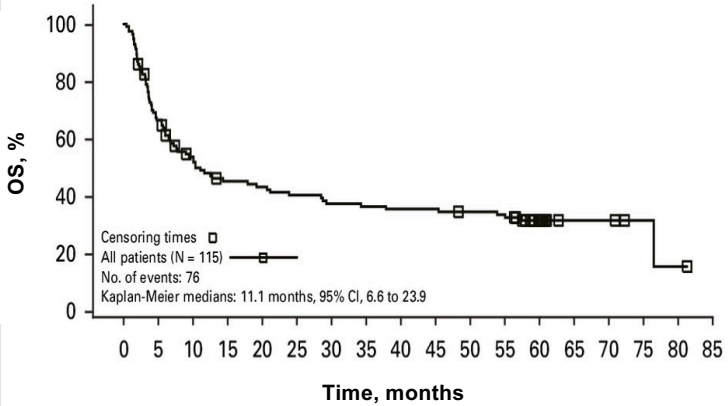


Median OS:
27.5 months (95% CI = 16.2, 47.3 months)

5-year OS rate: 38%
Median follow-up: 60.1 months

JULIET (tisa-cel)[3]

Overall survival



Median OS:
11.1 months (95% CI = 6.6, 23.9 months)

5-year OS rate: 32%
Median follow-up: 74.3 months

Inter-trial comparisons should not be made due to differences in study design, patient populations, treatment interventions, and durations of follow-up, among others. We cannot make direct comparisons or draw conclusions from one trial to another. For descriptive purposes, efficacy and safety results for each of the studies mentioned are listed.

3L, third line; axi-cel; axicabtagene ciloleucel; CAR, chimeric antigen receptor; LBCL, large B-cell lymphoma; liso-cel, lisocabtagene maraleucel; NE, not estimable; OS, overall survival, R/R, relapsed or refractory ; tisa-cel, tisagenlecleucel. 1. Neelapu SS, et al. Blood 2023;141:2307—2315. 2. Abramson JS, et al. ASH 2024. Abstract 3125. 3. Maziarz RT et al. J Clin Oncol. 2026 Jan 10;44(2):86-91.

3 Randomized trials of CAR T-cell therapy vs SOC in transplant-eligible DLBCL with early relapse or primary refractory disease

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

ASH 2021

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

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

ASH 2021

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

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

ASH 2021

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],

Locke, F et al, N Engl J Med. 2022 Feb 17;386(7):640-654. doi: 10.1056/NEJMoa2116133
Kamdar, M et al Lancet. 2022 Jun 18;399(10343):2294-2308. doi: 10.1016/S0140-6736(22)00662-6.
Bishop, M et al N Engl J Med. 2022 Feb 17;386(7):629-639. doi: 10.1056/NEJMoa2116596

	ZUMA 7 (Axi-cel)[1]	TRANSFORM (Liso-cel)[2,4]	BELINDA (Tisa-cel)[3]
N	359	184	322
% pts proceeded in CART vs AutoTx	94% vs 36%	97% vs 46%	96% vs 32%
Primary Refractory Double hit lymphoma	75 %/16%	75%/24%	75%/ 19% Tisacel/11% SOC
Median time from registration to CAR	29 days	34 days	52 days
Bridging therapy	Steroids only	1 cycle of salvage chemo allowed (63%)	>1 cycle of salvage chemo allowed (83%)
Crossover	Not allowed	Allowed (51%)	Allowed (51%)
Median follow up	25 months	17.5 months	10 months
Median EFS	8.3 m vs. 2 m	10.1 m vs 2.4 m	3 m vs 3 m
Hazard ratio	0.39 (p<0.0001)	0.34 (p< 0.0001)	1.07 (p=0.69)
ORR	83% vs 50%	87% vs 49%	47% vs 43%
CR rate	65% vs 32%	74% vs 43%	28% vs 28%
Grade >=3 CRS/NE	6%/21%	1%/4%	5%/3%

1.Locke, F et al, N Engl J Med. 2022 Feb 17;386(7):640-654. doi: 10.1056/NEJMoa2116133
2.Kamdar, M et al Lancet. 2022 Jun 18;399(10343):2294-2308. doi: 10.1016/S0140-6736(22)00662-6.
3.Bishop,M et al N Engl J Med. 2022 Feb 17;386(7):629-639. doi: 10.1056/NEJMoa2116596c
4.Abramson JS et al Blood 2023 6;141(14):1675-1684

Axi-cel continued to demonstrate higher rates of survival vs. SOC at ≈ 4 years of follow-up

ZUMA-7[1,2]

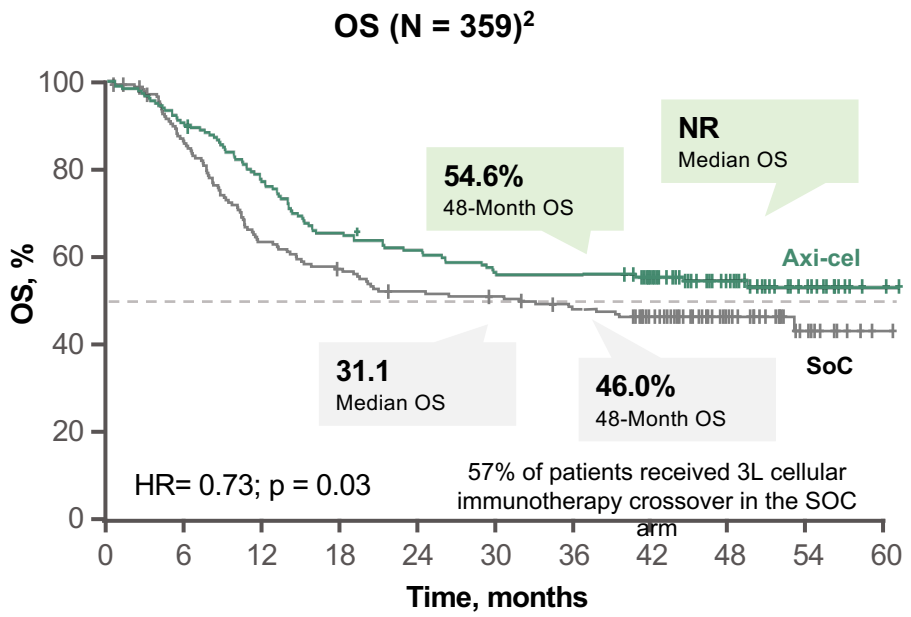
mFU: 47.2 months

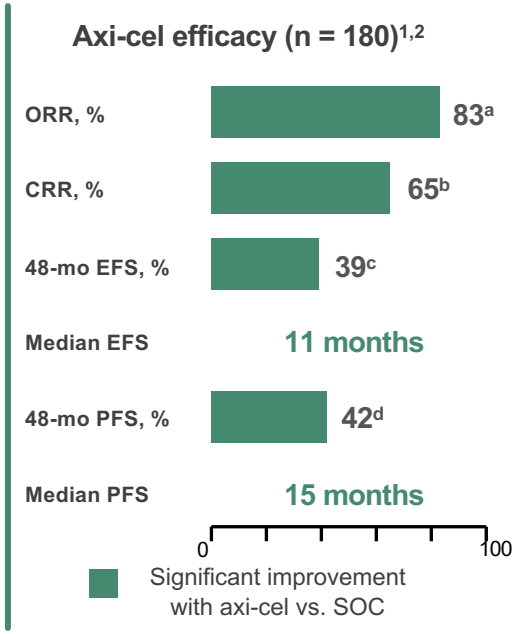
Phase 3, randomized trial of **axi-cel** (n = 180) vs. **SOC** (ASCT, n = 179) as 2L treatment in patients with R/R LBCL (N = 359)

Axi-cel

Primary refractory: 74%

DHL/THL: 17%





Axi-cel provided a 27% reduction in risk of death vs. SOC[2]

[a] ORR with SOC was 50%; [b] CRR with SOC was 32%; [c] 48-month EFS with SOC was 17%; [d] 48-month PFS with SOC was 24%. 2L, second line; ASCT, autologous stem cell transplant; axi-cel, axicabtagene ciloleucel; CRR, complete response rate; DHL, double-hit lymphoma; EFS, event-free survival; HR, hazard ratio; LBCL, large B-cell lymphoma; mFU, median follow-up; mo, month; NR, not reached; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; R/R, relapsed or refractory; SOC, standard of care; THL, triple-hit lymphoma.

1. Locke FL, et al. N Engl J Med 2022;386:640—654. 2. Westin JR, et al. N Engl J Med 2023;389:148—157.

Liso-cel continued to demonstrate higher rates of survival at ≈ 3 and 4 years of follow-up

TRANSFORM[1,2]

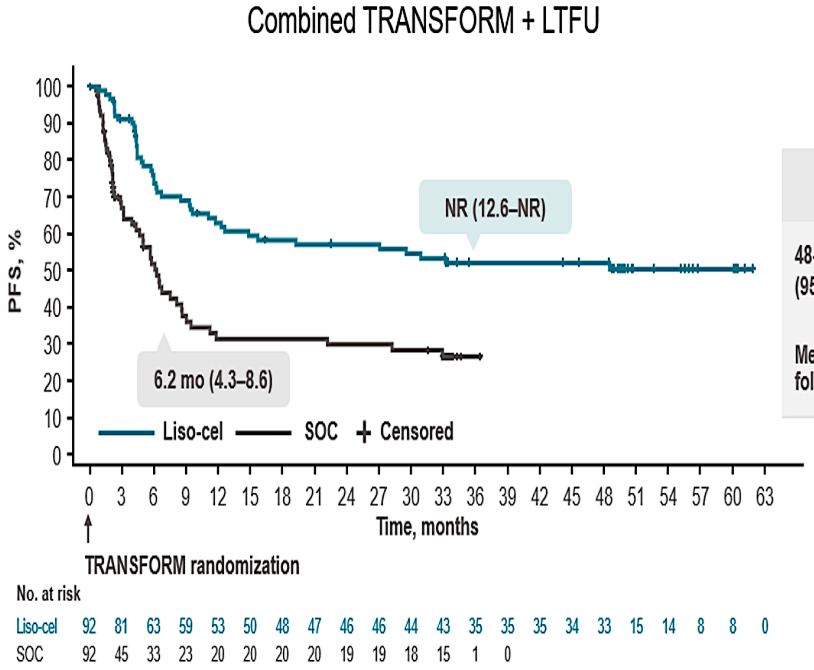
mFU: 33.9 months

Phase 3, randomized trial of **liso-cel** (n = 92) vs. **SOC** (ASCT, n = 92) as 2L treatment in patients with R/R LBCL (N = 184)

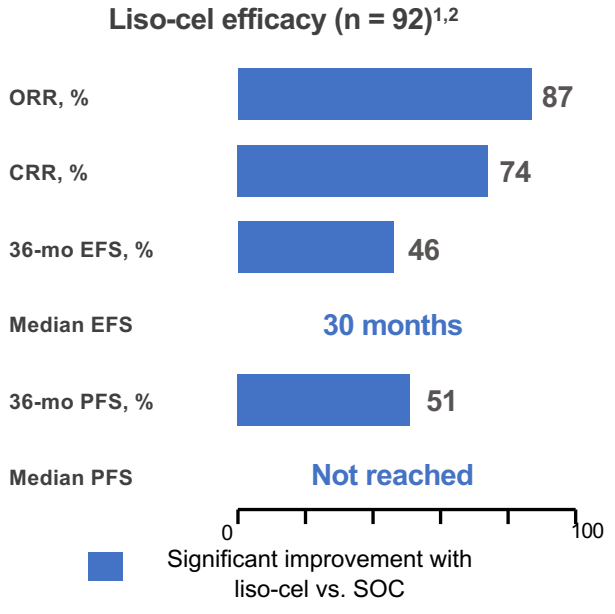
Liso-cel

Primary refractory: 73%

DHL/THL: 24%



	Liso-cel (n = 92)	SOC (n = 92)
48-month rate (95% CI)	52.2% (41.5–62.8)	NA (NA–NA)
Median (95% CI) follow-up	49.4 months (48.7–50.3)	33.2 months (32.9–33.6)



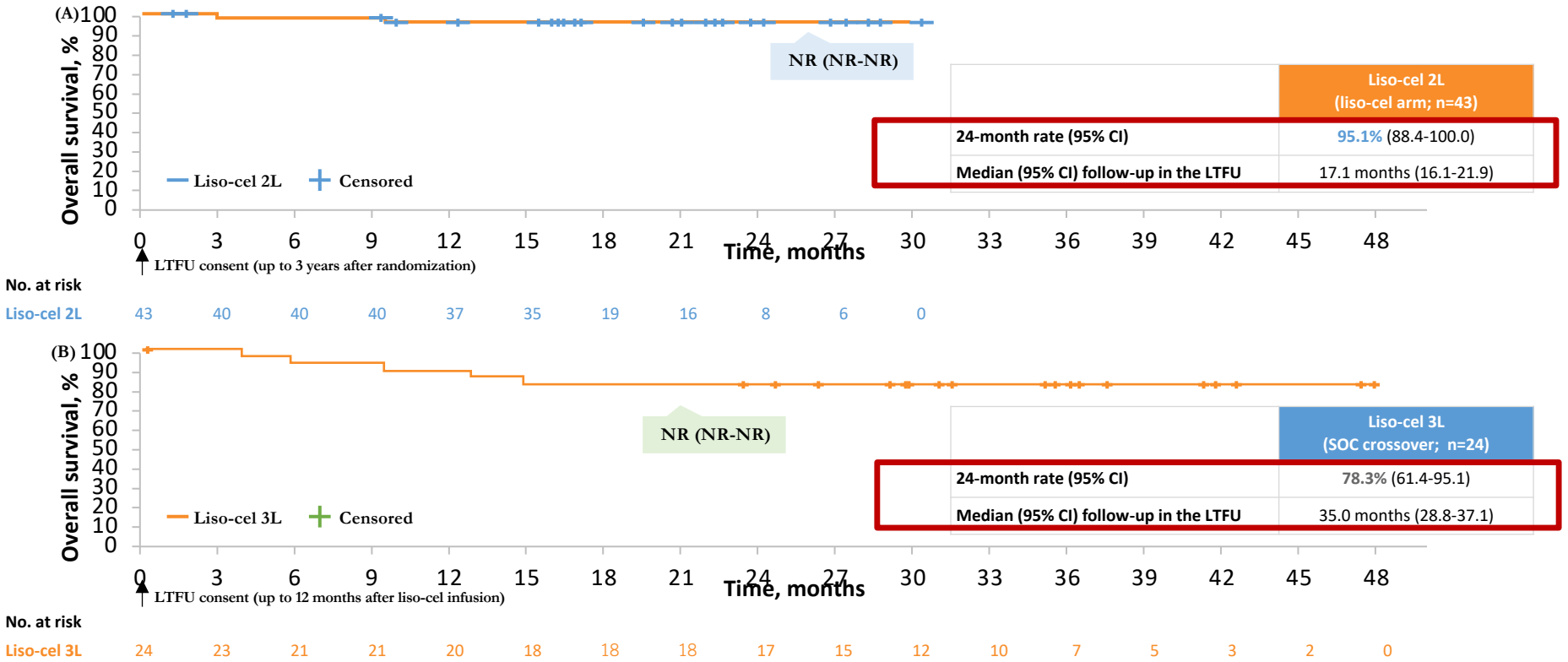
62% of patients crossed over from the SOC arm to receive liso-cel[1,2]

Liso-cel provided a 43% reduction in risk of death vs. SOC in a prespecified analysis adjusted for crossover[1,2,a]

Kamdar et al. ASH 2025; Kamdar et al. J Clin Oncol. 2025;43:2671-2678

Receiving CAR-T in 2L versus 3L impacts outcomes

Figure 5. OS in liso-cel 2L (A) and liso-cel 3L (B) patients in the LTFU

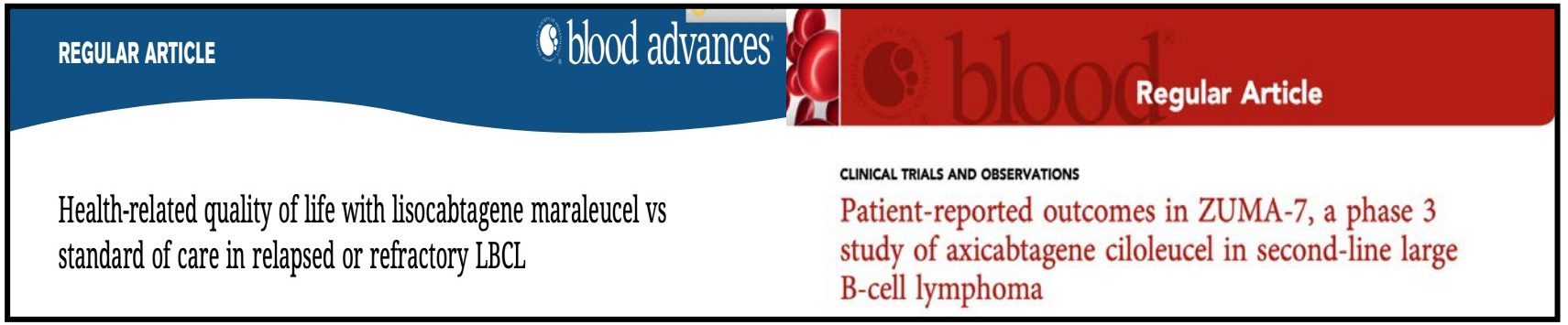


	Liso-cel 2L (liso-cel arm; n=43)
24-month rate (95% CI)	95.1% (88.4-100.0)
Median (95% CI) follow-up in the LTFU	17.1 months (16.1-21.9)

	Liso-cel 3L (SOC crossover; n=24)
24-month rate (95% CI)	78.3% (61.4-95.1)
Median (95% CI) follow-up in the LTFU	35.0 months (28.8-37.1)

Kamdar et. al. ASCO 2024. Oral Presentation

Patient-reported outcomes



The TRANSFORM and ZUMA-7 trials showed clinically meaningful improvement in quality of life for patients randomized to CAR T-cell therapy compared with ASCT[1,2]

Liso-cel and axi-cel were approved for transplant-eligible high-risk DLBCL in first relapse[3,4]

Next question: What about transplant ineligible YET CAR-eligible patients with R/R LBCL?

ASCT, autologous stem cell transplant; axi-cel, axicabtagene ciloleucel; CAR, chimeric antigen receptor; DLBCL, diffuse large B-cell lymphoma; LBCL, large B-cell lymphoma; R/R, relapsed or refractory.
1. Abramson J, et al. Blood Adv 2022;6:23:5969—5979. 2. Elsawy M, et al. Blood 2022;140:2248—2260. 3. Lisocabtagene maraleucel PI 2026. Axicabtagene ciloleucel PI. 2026.
4. Axicabtagene ciloleucel. Summary of product characteristics. Giliead Sciences; 2024.

PILOT study : Liso-cel demonstrated outcomes comparable to those in TRANSFORM in an ASCT-ineligible population

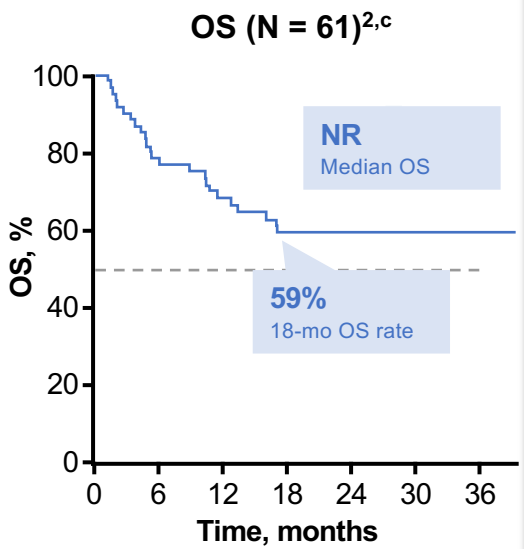
PILOT

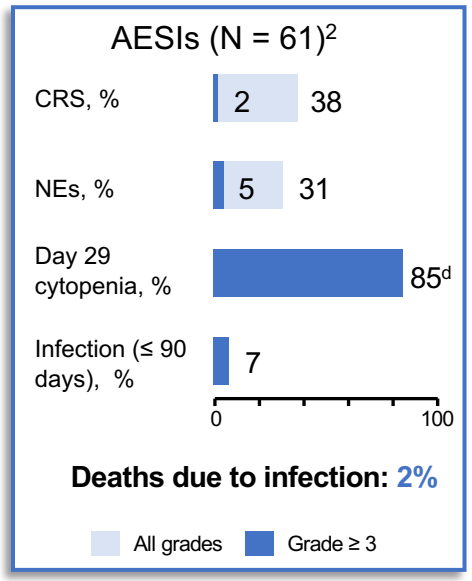
mFU: 24.3 months

Phase 2, single-arm analysis assessing **liso-cel** as 2L treatment in patients with R/R LBCL who were deemed ineligible for ASCT[a] (N = 61)[1,2]

ORR: 80%[2,b]

ASCT ineligibility criteria	Liso-cel, % (N = 61)
Age ≥ 70 years	79
ECOG PS 2	26
CrCl < 60 mL/min	25
DL_{CO} ≤ 60%	7
LVEF < 50%	2





Median OS was not reached with liso-cel at ≈ 2-year median follow-up[2]

Liso-cel is not approved in Europe for the 2L treatment of DLBCL in patients who experienced relapse more than 12 months after completion of 1L therapy.

[a] Patients must have also met at lease one transplant-not-intended criterion as determined by the investigator: age ≥ 70 years, ECOG PS of 2, DLCO ≤ 60%, LVEF < 50%, CrCl < 60 mL/min, ALT/AST > 2 × ULN; [b] Median follow-up of 12.3 months; [c] OS data include data from the LTFU study; [d] Prolonged cytopenia is defined as Grade ≥ 3 decreased hemoglobin level, neutrophil count or platelet count at the Day 29 visit as confirmed by laboratory results. 1L, first line; 2L, second line; AESI, adverse event of special interest; ALT, alanine transaminase; ASCT, autologous stem cell transplant; AST, aspartate aminotransferase; CrCl, creatinine clearance; CRS, cytokine release syndrome; DL_{CO}, diffusing capacity of the lungs for carbon monoxide; ECOG PS, Eastern Cooperative Oncology Group performance status; LBCL, large B-cell lymphoma; liso-cel, lisocabtagene maraleucel; LTFU, long-term follow up; LVEF, left ventricular ejection fraction; mFU, median follow-up; mo, month; NE, neurologic events; NR, not reached; ORR, overall response rate; OS, overall survival; R/R, relapsed or refractory, ULN, upper limit of normal. 1. Sehgal A, et al. Lancet Oncol 2022;23:1066—1077. 2. Sehgal A, et al. ASH 2023 Oral presentation 105.

Logistics: THE PROCESS

Manufacturing

Apheresis[1-3]

Washout of prior medications
Patients undergo apheresis (collection of WBCs)

Bridging[1-3]

Optional bridging therapy to maintain disease control during CAR T-cell manufacturing

Depends upon extent of disease (chemotherapy vs. RT)

CAR T infusion and management[1,2]

LDC administered prior to CAR T-cell infusion followed by infusion at the certified treatment center

CAR, chimeric antigen receptor; LDC, lymphodepleting chemotherapy; RT, radiotherapy; WBC, white blood cell.

1. Beaupierre A, et al. J Adv Pract Oncol 2019; 10:29—40. 2. Beaupierre A, et al. Clin J Oncol Nurs 2019; 23:27—34. 3. McGuirk J, et al. Cytotherapy 2017; 19:1015—1024.

The biggest barrier to CAR-T is often not biology, it is delayed recognition and delayed referral.

Why Early Referral Matters

Referral should occur ASAP
“BRAIN” to “VEIN” time (*courtesy* Dr Lunning)

Real-world analyses show substantial attrition before CAR-T access- Many patients are never referred despite eligibility (2/10 based on claims data)

Early Referral
improves access and planning
allows insurance approval, caregiver planning, and leukapheresis coordination

Telehealth and early specialist input can reduce delays

Bridging Therapy

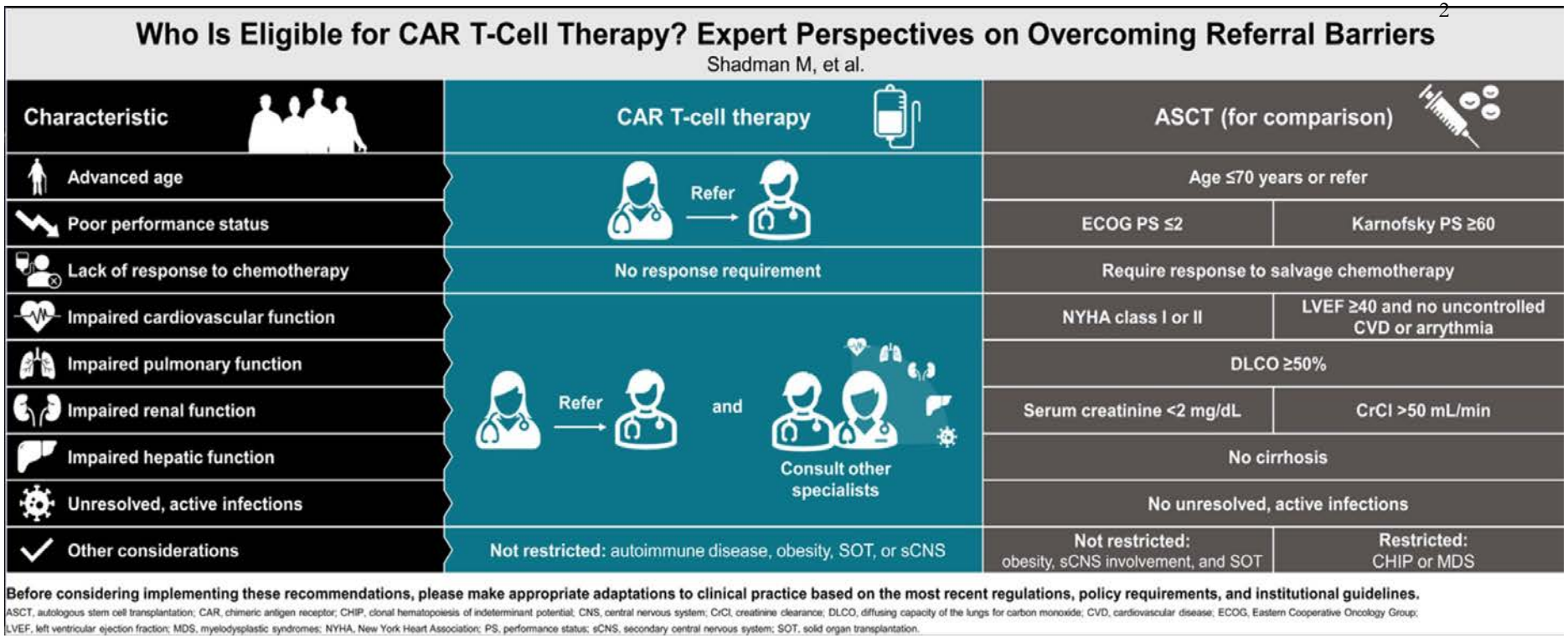
Therapy Considerations

Steroids
Radiation
Bispecific antibodies/T-cell engagers
Selected chemotherapy approaches
AVOID BENDAMUSTINE

Consult CAR-T specialists BEFORE bridging whenever possible

Determination of CAR-T eligibility

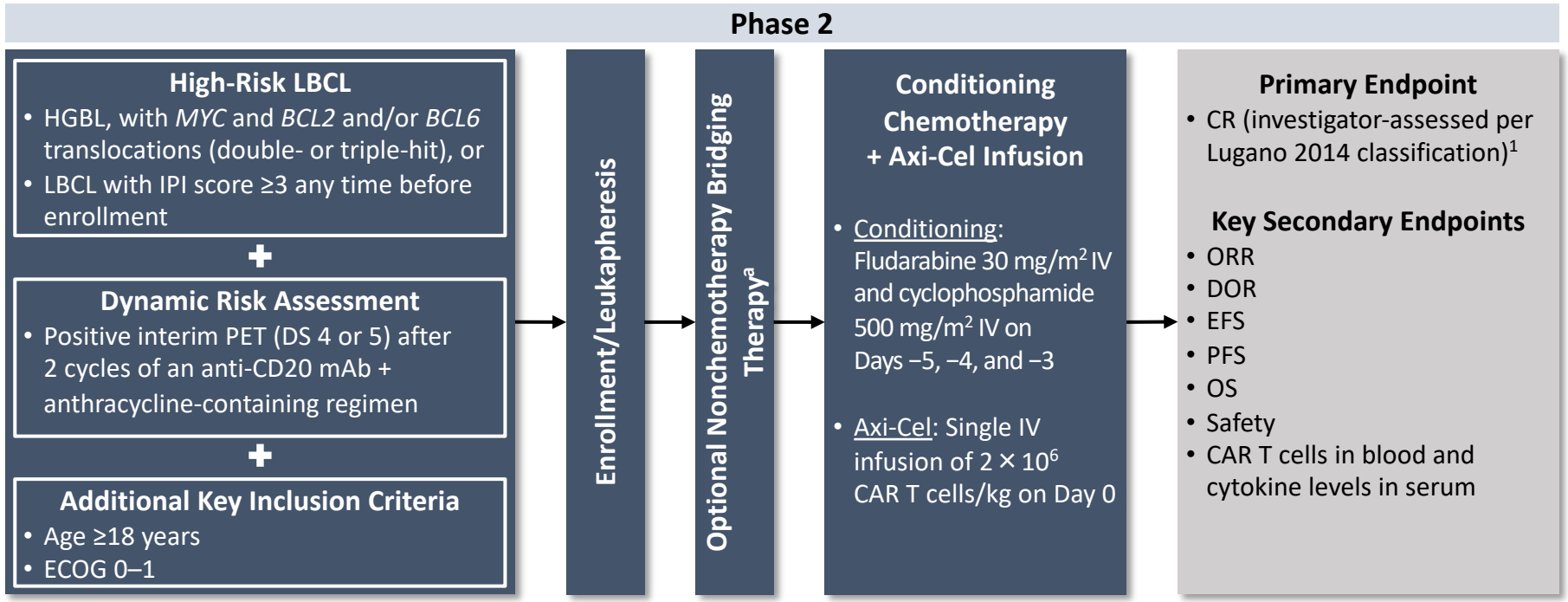
- Several real-world studies[1] have shown that chronological age, comorbidities, or cognitive and/or functional impairments do not affect post-CAR T outcomes.
- Automatic exclusion of patients based on age/comorbidities is not advised
- Transplant eligibility ≠ CAR-T eligibility



"If a patient can tolerate lymphoma-directed therapy, they deserve CAR-T evaluation"

1.Major, Kamdar et al ASH Edu Program book 2023
2.Shadman et al. Cellular Therapy 2026;32:P277-287

CARs in the front-line setting: ZUMA-12 Study Design

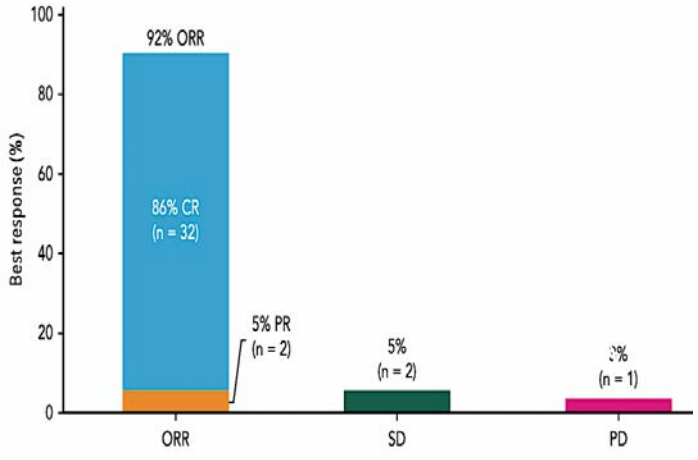


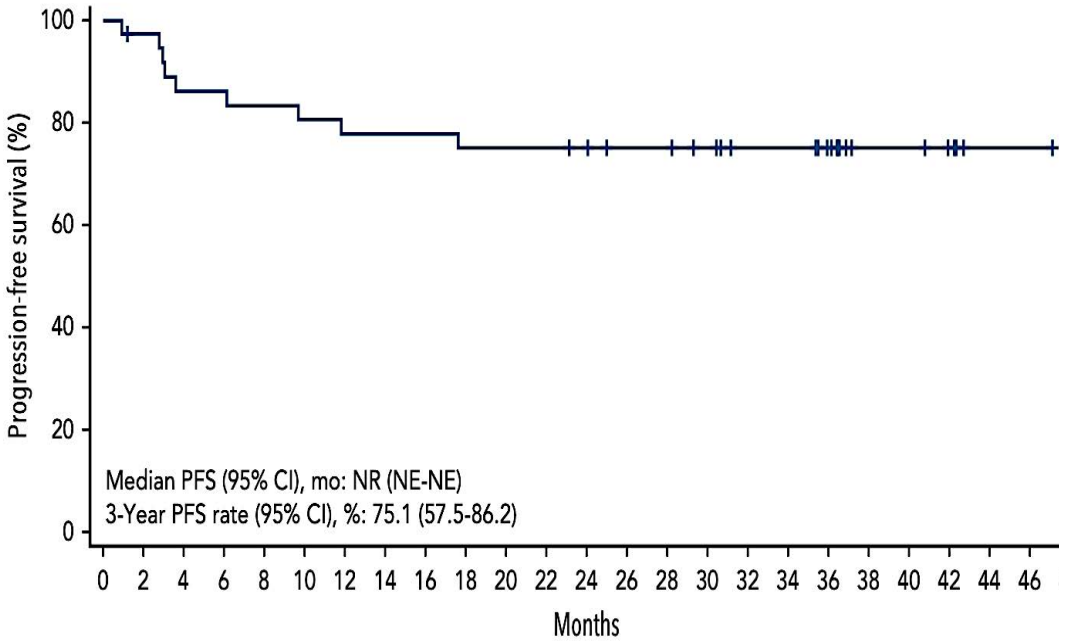
N= 40, Median age 61 (23-86); DHL/THL: 25%, IPI score of >/=3 78%, DS 4: 48%, DS 5 53%

Chavez et al Blood 2025

ZUMA-12 : Efficacy/Safety

ORR 89% and
CR Rate 78%





3 yr PFS 75%; 3 yr OS 81%

The most common axi-cel–related Grade ≥3 AEs were neutropenia (53%), anemia (30%), encephalopathy (15%) and thrombocytopenia (15%)

CRS : Any Grade: 100%, Grade 3/> 8%
No Grade 4 and 5 CRS occurred

NE: Any Grade 73%, Grade 3/>23%, 5% Grade 4
No Grade 5 NE occurred

Chavez et al Blood 2025

Early results with other CAR T-cell platforms in DLBCL

Rapcabtagene Autoleucel (YTB323) in Patients with Relapsed/Refractory Diffuse Large B-cell Lymphoma: Phase II Trial Clinical Update

CD19-directed CAR-T cell therapy utilizes the T-Charge™ platform-preserve T-cell stemness + 2 day manufacturing time followed by release testing.

Phase II study; 12.5×10^6 CAR+ viable T-cell dose;

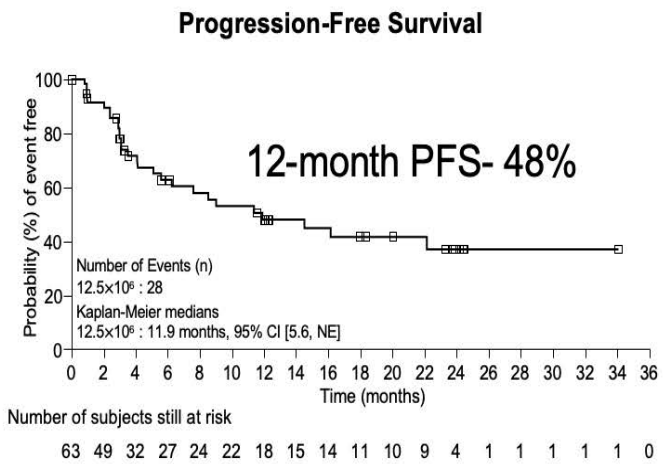
Primary Endpoint: Complete response rate (CR)

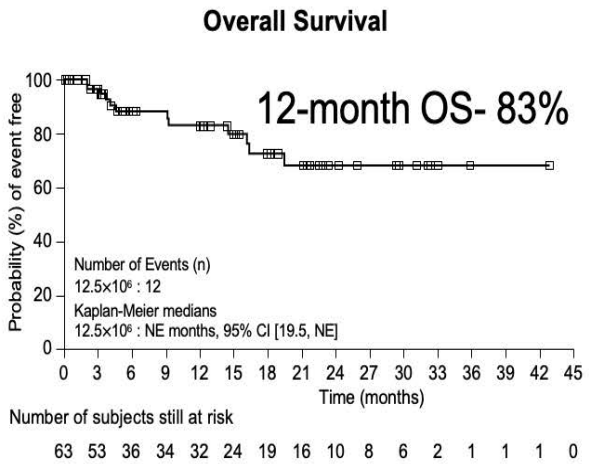
N=63, Median age 64, HGBCL -25% Refractory – 58%; mLOT- 2, BT- 60%

RESULTS

Median follow up 16 months

Primary Endpoint met- ORR 88% CR 62%





SAFETY

Most common cytopenias

CRS (44%)

Grade ≥3 CRS (6%) and ICANS (5%)

1 Grade 3 HLH,

Grade ≥3 infection 27%

Grade 5 – 6 patients (2 with PD)

<u>2 doses of LD chemo tested</u>

Lower dose n=28 Fly/Cy 25/250

Higher dose n=33 Flu/Cy 30/500

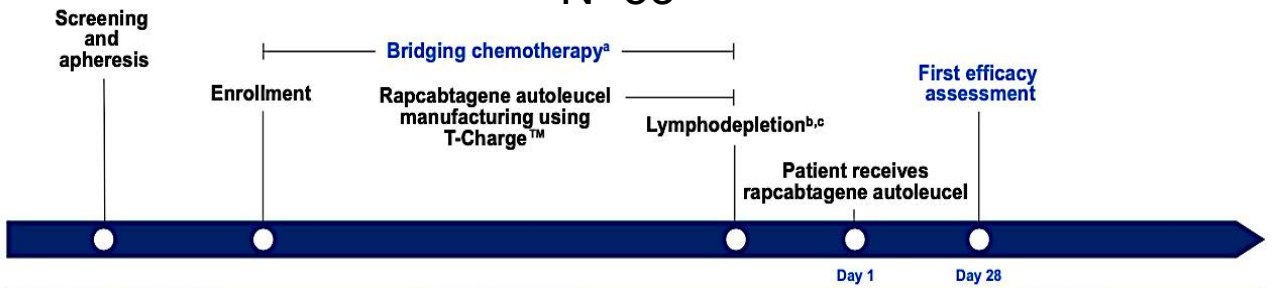
Risk-benefit analyses support lower-dose

Reidel et al ASH 2024 Abstract # 67

Rapcabtagene Autoleucel (YTB323) for Patients With First Line High-Risk Large B-Cell Lymphoma: Phase 2 Interim Results

Phase 2 Study Design

N=53



Key eligibility criteria	Study treatment	End points
• ≥18 years of age • IPI score 3-5 and/or double-hit lymphoma • Deauville PET score of 4-5 and PR/SD after two cycles of 1L chemoimmunotherapy	• Rapcabtagene autoleucel single IV dose at 12.5×10^6 CAR+ cells	**Primary:** CRR (BOR of CR) **Secondary:** ORR, DOR, PFS, EFS, OS, cellular kinetics, and safety **Exploratory:** Immunophenotyping data

SAFETY

Most common cytopenias
38% low grade CRS
No grade ≥3 CRS events
Median time to onset of CRS 10 days
8% ICANS, 2% Grade 3
Median time to onset 17 days

Response Rate

	Full analysis set (N = 53)
Median follow-up, months (range)	8.5 (2-24)
ORR (95% CI)[a]	89% (77-96)
BOR	
CR (95% CI)[a]	74% (60-85)
PR[b]	15%

	All patients (N = 53)	Patients with CR at month 3 (N = 29)
Median PFS,[a] months	NR[b]	NR[b]
6-month PFS,[c] %	76	96

Westin et al ASH 2025

Beyond CD19: Early Clinical Signals with CD19/CD20 CAR-T Constructs

Trial (NCT)	Phase	N	Method (regimen/duration)	Primary Endpoint	Median Follow-Up	ORR	CR	Median PFS	Key ≥G3 toxicities / safety notes
LYL314 / IMPT-314 (NCT05826535)	1/2	45, 31 eval	Dual CD19×CD20 CAR-T; CD62L+ enriched product; single infusion	Safety/ tolerability	9 mos.	**94%**	**74%**	NR	CRS 62% (mostly low grade), ICANS ≥G3 13%, infections 13%
KITE-363 (NCT04989803)	1	34	Bicistronic CD19/CD20 CAR-T; single infusion	Toxicities and ORR	7.3 mos.	**87%**	**78%**	NR	CRS ≥G3 3%, ICANS ≥G3 8%; no grade 4/5 CRS/ICANS
JNJ90014496 / CCAR039 (NCT05421663)	1b	42	Bispecific anti-CD19/CD20 CAR-T; RP2D 75M CAR+ cells	Safety/ tolerability	12 mos.	**90%**	**76%**	NR	No ≥G3 CRS/ICANS; ≥G3 neutropenia 68%

Next Wave of Trials – ENROLLING NOW!
Phase III RCTs comparing SOC CD19 CARs VERSUS CD19/20 CARs in 2L DBCL

Kamdar/Bartlett Blood 2026

Conclusion

The Path Forward

- Move from *center-based excellence → system-wide capability*
- Measure success by **who receives CAR-T**, not just **who can deliver it**
- Align stakeholders—clinicians, payers, industry, and regulators—around **access as a quality metric**

- **The future of CAR-T is not just innovation it is implementation, scalability, and access.**

- **Relapse should trigger referral because access to CAR-T may be access to cure.**

Discussion Questions

80 y/o man with stage IV DLBCL, non-GCB subtype
PMH: coronary artery disease, stage 3 chronic kidney disease, atrial fibrillation on anticoagulation
R-CHOP as initial therapy with CR for 3 years; relapsed with nodal and extranodal disease
Tafasitamab/lenalidomide as second-line treatment with good response for 2 years; now with multifocal progressive disease

Would you recommend CAR T-cell therapy, a bispecific antibody or something else at this point? Which specific platform or agent/regimen would you select?

Discussion Questions (Questions)

80 y/o man with stage IV DLBCL, non-GCB subtype
PMH: coronary artery disease, stage 3 chronic kidney disease, atrial fibrillation on anticoagulation
R-CHOP as initial therapy with CR for 3 years; relapsed with nodal and extranodal disease
Tafasitamab/lenalidomide as second-line treatment with good response for 2 years; now with multifocal progressive disease

How does prior use of a CD19-directed approach influence your sequencing of available therapies, and do you conduct CD19 expression testing to assist in decision-making?

Would you consider palliative radiation or bridging therapy before instituting CAR-T or a bispecific?

Discussion Questions

65 y/o woman with stage 2 DLBCL
R-CHOP as initial therapy; recurrent disease at 13 months

Would you offer CAR-T over SCT in this situation? In general, what factors do you consider when making this decision? Has your enthusiasm for SCT waned at all given the effectiveness of CAR-T?

What are the advantages and disadvantages of the available CAR-T products? Would you have any preference for one platform versus the others for this patient?

53 y/o man with double-hit DLBCL
R-EPOCH as initial therapy; recurrent disease at 18 months

Although this patient is transplant eligible, is CAR-T a consideration?

RTP
RESEARCH
TO PRACTICE

Discussion Questions

67 y/o man with DLBCL
R-CHOP as initial therapy with rapid relapse
Poor performance status and logistics prevented CAR-T
GemOx + epcoritamab as second-line treatment

The patient would now be eligible for CAR-T — would you offer it if/when he progresses? Is the efficacy of CAR-T diminished after progression on a bispecific-based approach?

Agenda

Module 1: Chimeric Antigen Receptor (CAR) T-Cell Therapy for Diffuse Large B-Cell Lymphoma (DLBCL) — Dr Kamdar

Module 2: Bispecific Antibody Therapy for DLBCL — Dr Westin

Module 3: CAR T-Cell Therapy for Other Lymphoma Subtypes — Dr Abramson

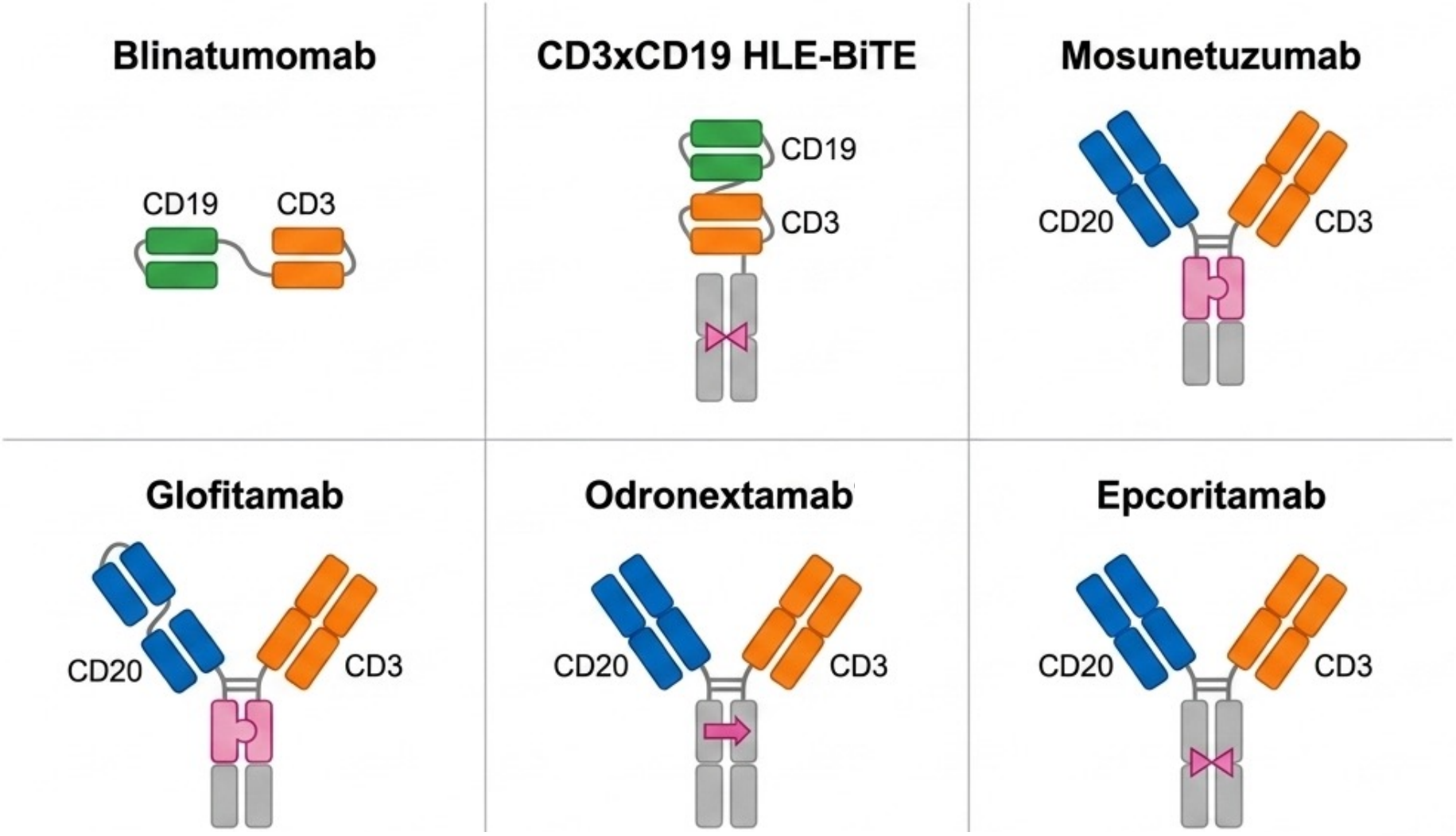
Module 4: Bispecific Antibody Therapy for Follicular Lymphoma and Other Lymphoma Subtypes — Dr Phillips

Module 5: Tolerability Considerations with CAR T-Cell Therapy and Bispecific Antibodies — Dr Brody

Bispecific Antibody Therapy for DLBCL

Jason Westin, MD, MS
Director, Lymphoma Clinical Research
Section Chief, Aggressive Lymphoma
Professor, Department of Lymphoma and Myeloma
The University of Texas MD Anderson Cancer Center
Houston, Texas

Bispecific CD3/CD20 Antibodies in B-NHL



Target Domains

- CD3
- CD19
- CD20

Structural Engineering Markers

- Knob-into-hole
- Dipeptide substitution in Fc portion ablating Protein A affinity
- Single matched point mutations in the CH3 domains

Adapted from Lussana et al, J Clin Oncol. 2021 Feb 10;39(5):444-455

*Design of odronextamab exploits differences in the affinities of the immunoglobulin isotypes for Protein A coupled with the use of common light chain, allowing efficient large-scale purification.

B-NHL, B-cell non-Hodgkin lymphoma; Fc, fragment crystallisable; HLE-BiTE, half-life-extended-bispecific T-cell engager.

Glofitamab Monotherapy: Efficacy and Safety in Relapsed/Refractory Large B-Cell Lymphoma (LBCL)

Data from a pivotal Phase II study (**NCT03075696**) evaluating fixed-duration glofitamab monotherapy in heavily pretreated patients. **Glofitamab** is a CD20xCD3 bispecific antibody that redirects T cells to eliminate malignant B cells.

CLINICAL EFFICACY OUTCOMES

52% Objective Response Rate (ORR)

Over half of the heavily pretreated patients achieved a clinical response.

40% Complete Response Rate (CRR)

Data from a 3-year follow-up confirms high rates of total cancer disappearance.

4.9 Months Median Progression-Free Survival (PFS)

Represents the median time patients remained alive without disease progression.

TOXICITY AND CYTOKINE RELEASE SYNDROME (CRS)

63% Overall CRS Incidence

Cytokine Release Syndrome occurred in nearly two-thirds of patients, primarily during early doses.

4% Grade 3 or Higher CRS

Severe or life-threatening CRS events were uncommon with step-up dosing and pretreatment.

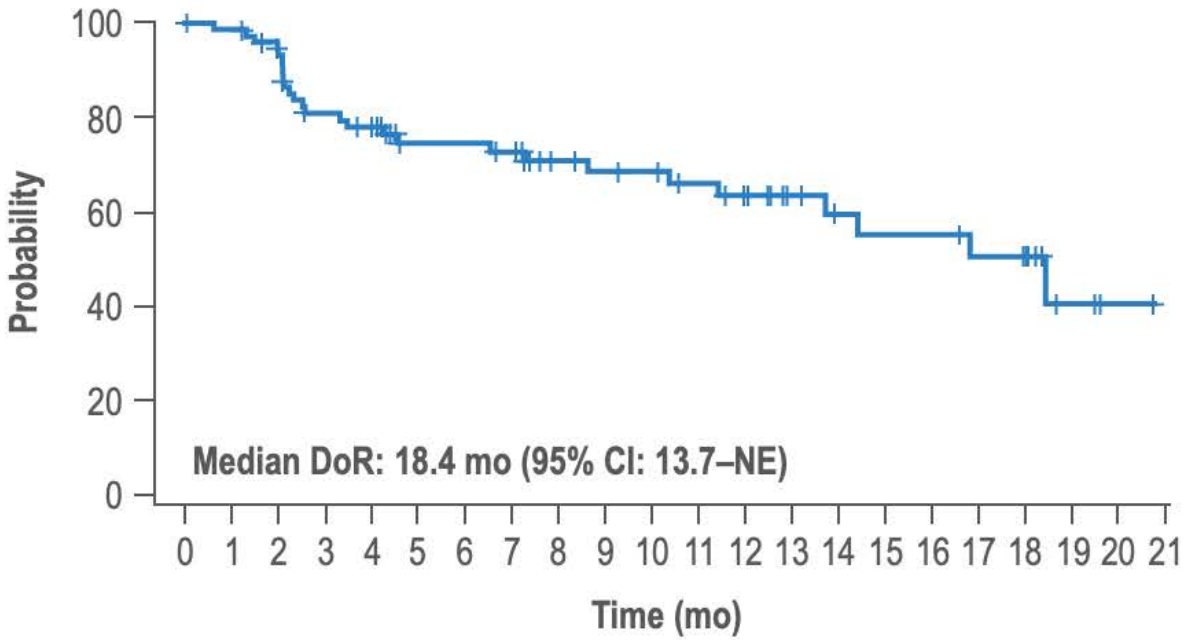
Predictable Safety Profile

Most CRS events were low-grade (Grade 1-2) and manageable with standard protocols.

Dickinson et al NEJM 2022

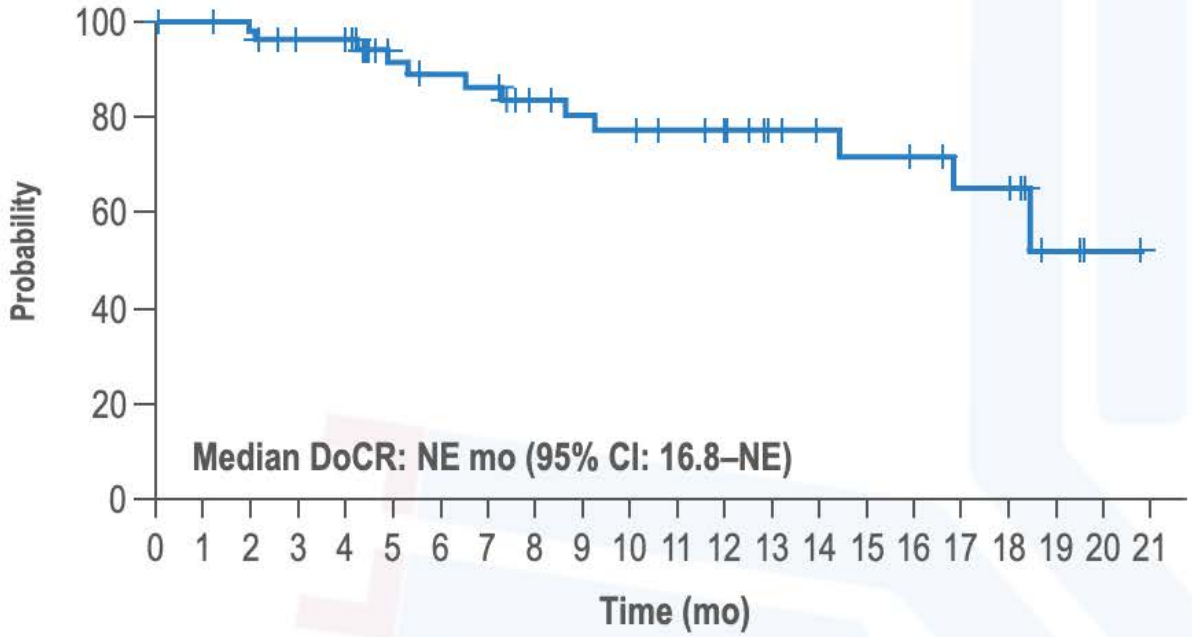
Durable Responses Maintained After Cessation of Therapy

DoR by IRC



	(N=80)
Median DoR follow-up, mo (range)	10.6 (0–21)
12-mo DoR, % (95% CI)	**63.6 (51.1–76.2)**
ORs ongoing at CCOD, n (%)	53 (66.3)

DoCR by IRC



	(N=61)
Median DoCR follow-up, mo (range)	10.6 (0–21)
12-mo DoCR, % (95% CI)	**77.6 (64.3–90.8)**
CRs ongoing at CCOD, n (%)	49 (80.3)

CCOD, clinical cutoff date; CR, complete response; DoCR, duration of complete response; DoR, duration of response; EoT, end of treatment; IRC, independent review committee; NE, not evaluable.

Adapted from: 1. Dickinson M.J. et al. *N Engl J Med.* 2022;387(24):2220-2231. 2. Hutchings M. et al. Presented at: ASH 2022. A441.

Epcoritamab Monotherapy: Efficacy and Safety in Relapsed/Refractory Large B-Cell Lymphoma (LBCL)

Data from the pivotal Phase I/II EPCORE NHL-1 study (NCT03625037) evaluating subcutaneous epcoritamab monotherapy in heavily pretreated patients. Epcoritamab is a CD3×CD20 bispecific antibody that directs T cells to eliminate malignant B cells.

CLINICAL EFFICACY OUTCOMES

63.1% Overall Response Rate (ORR)

Deep and rapid responses achieved in highly refractory, heavily pretreated patients.

38.9% Complete Response Rate (CRR)

Represents the proportion of patients achieving total cancer disappearance.

4.4 Months Median Progression-Free Survival (PFS)

Represents the median time patients remained alive without disease progression.

TOXICITY AND CYTOKINE RELAYSE SYNDROME (CRS)

49.7% Overall CRS Incidence

Cytokine Release Syndrome occurred in roughly half of patients, primarily low-grade and during early cycle step-up dosing.

2.5% Grade 3 or Higher CRS

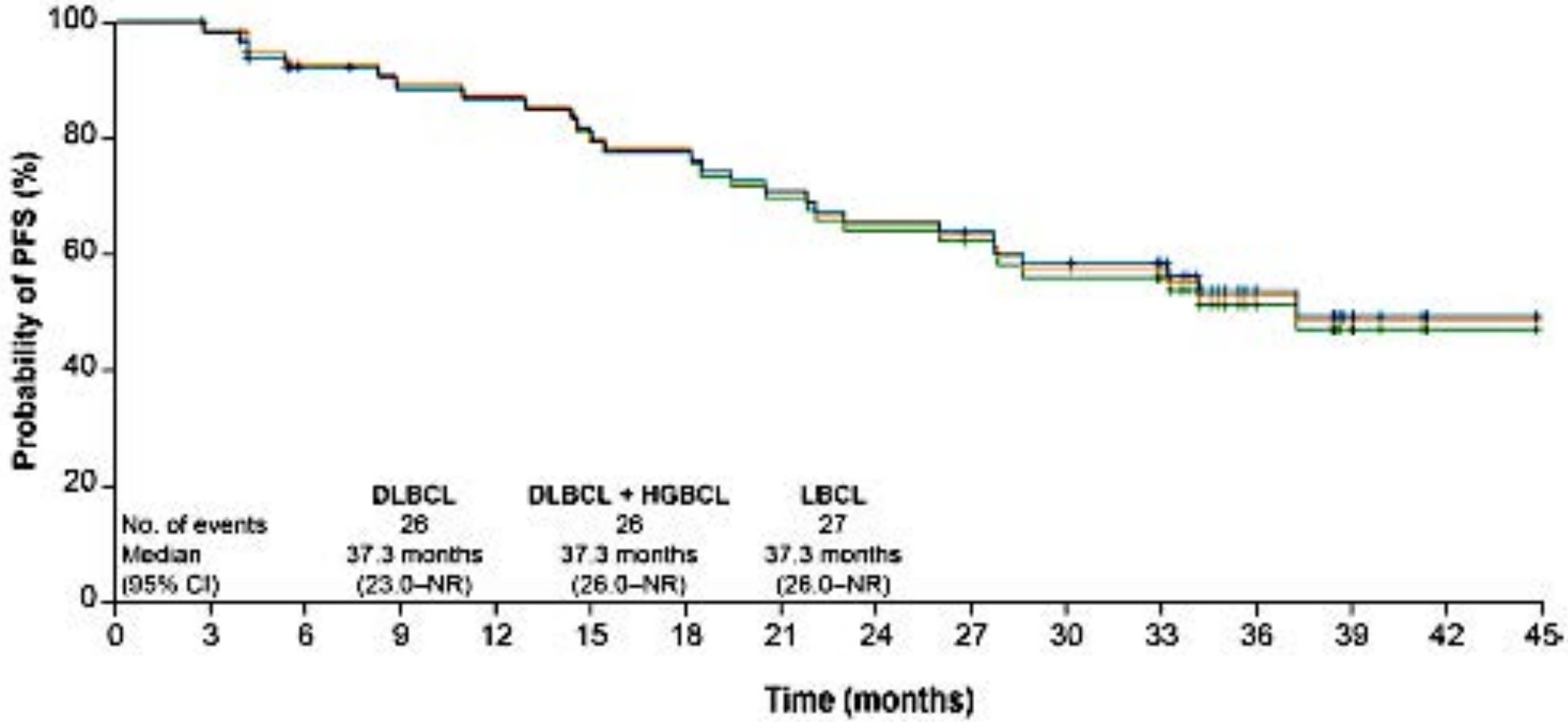
Severe or life-threatening CRS events were uncommon, with no Grade 4 or 5 events reported.

Predictable Safety Profile

Most adverse events were manageable with standard protocols, allowing patients to remain on treatment.

Thieblemont et al, JCO 2022

Durability of response to Epcoritamab



Patients at risk

LBCL	65	62	53	50	49	45	44	40	37	35	32	29	13	7	1	0
DLBCL+HGBCL	60	57	50	48	47	43	42	38	35	33	30	27	13	7	1	0
DLBCL	58	55	48	46	45	41	40	36	33	31	28	26	12	7	1	0

Karimi et al, Annals of Hematology 2026

EPCORE DLBCL-1: Epcoritamab Monotherapy vs. Chemoimmunotherapy (CIT)

R/R DLBCL | ASCT-ineligible | ≥1 prior line of therapy (73% had ≥2 prior lines)
1:1 Randomisation (N=483). Epcoritamab vs. CIT (R-GemOx or BR)

Efficacy Profile (Primary & Secondary Endpoints)

	Epcoritamab	CIT	
Progression-Free Survival (PFS)	30% (24-mo PFS)	13% (24-mo PFS)	**HR: 0.74 (P=0.0059)**
Complete Response Rate (CRR)	38%	26%	**Nominal P=0.0032**
Duration of Response (DOR)	37 months (Median)	6 months (Median)	
Overall Survival (OS)	38% (24-mo OS)	33% (24-mo OS)	HR 0.96

Clinical Context: OS was confounded by COVID-19 mortality and subsequent novel treatments (26% of CIT arm received subsequent CAR-T/bsAb/SCT vs. only 6% in Epcoritamab arm).

Adjusted OS HR: 0.76 (95% CI, 0.59–0.99).

Safety Profile

Immune Effector Toxicities

CRS: **53%** Overall | Grade 3: **3%**

ICANS: **4%** Overall | Grade 3–4: **1%**

Infections & COVID-19 Impact

67% of patients randomised during the Omicron wave (2022 or later).

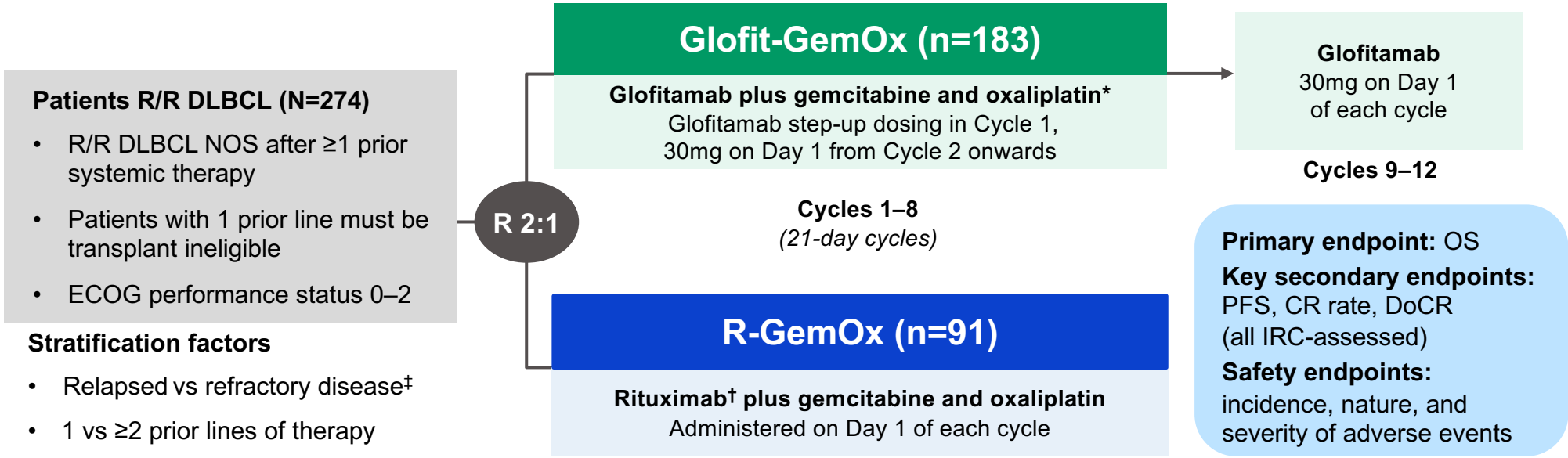
Grade 3–4 Infections: 30% (Epcoritamab) vs. 12% (CIT)

Grade 5 TEAEs: 17% (Epcoritamab) vs. 6% (CIT)

→ Largely attributable to Grade 5 COVID-19 mortality (9% Epcoritamab vs. 2% CIT).

STARGLO (NCT04408638): A randomized, global, Phase III trial

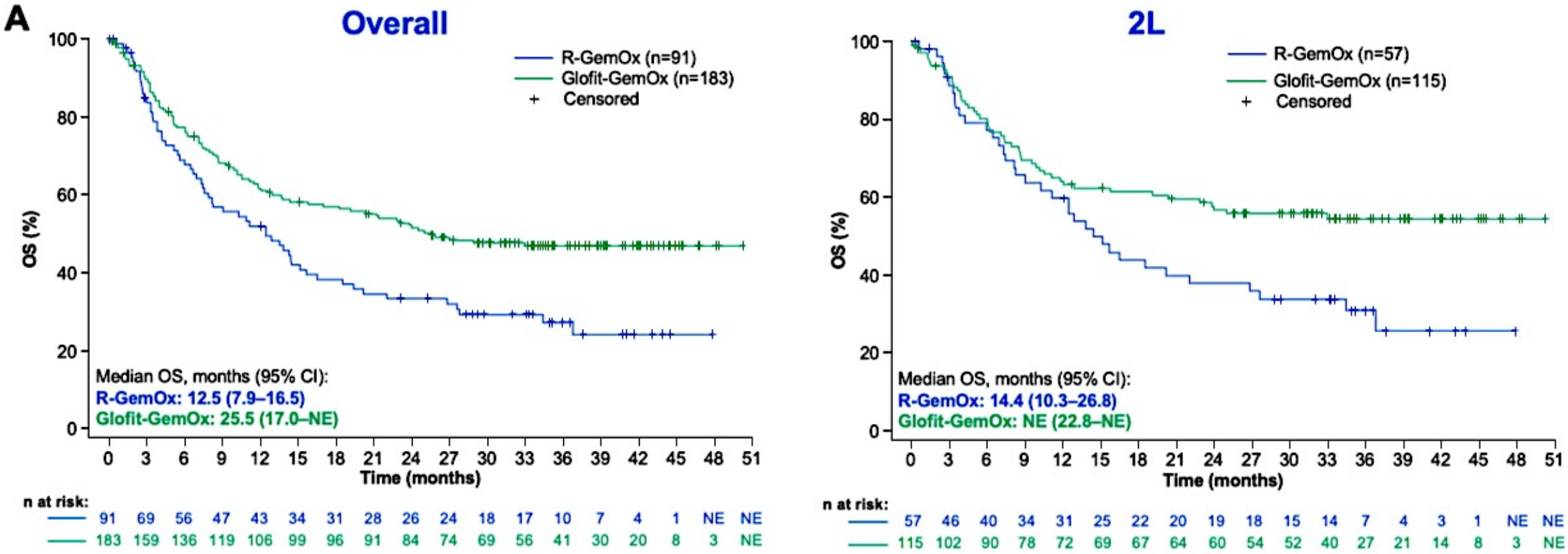
- Glofit-GemOx has shown clinically meaningful and statistically significant benefits in OS, PFS, and CR rate compared with R-GemOx in patients with ASCT-ineligible R/R DLBCL in the STARGLO trial[1]



*Gemcitabine 1000mg/m², oxaliplatin 100mg/m². In Cycle 1, obinutuzumab pretreatment administered on Day 1, GemOx on Day 2, Glofit 2.5mg on Day 8, Glofit 10mg on Day 15; in Cycles 2–8, Glofit 30mg and GemOx administered on Day 1. †Rituximab 375mg/m². ‡Relapsed disease: recurrence after a response that lasted ≥6 months after completion of last line of therapy; refractory disease: disease that did not respond to, or that progressed <6 months after completion of last line of therapy. ASCT, autologous stem cell transplant; CR, complete response; DLBCL, diffuse large B-cell lymphoma; DoCR, duration of complete response; ECOG, Eastern Cooperative Oncology Group; IRC, independent review committee; LOT, line of therapy; OS, overall survival; PFS, progression-free survival; R 2:1, randomized in a 2:1 ratio.

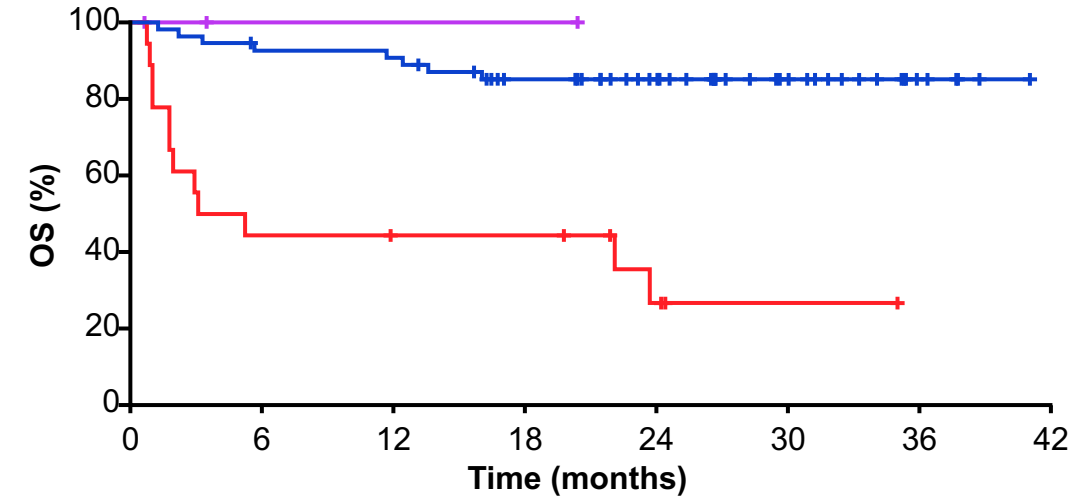
1. Abramson JS, et al. Lancet 2024;404:1940–54.

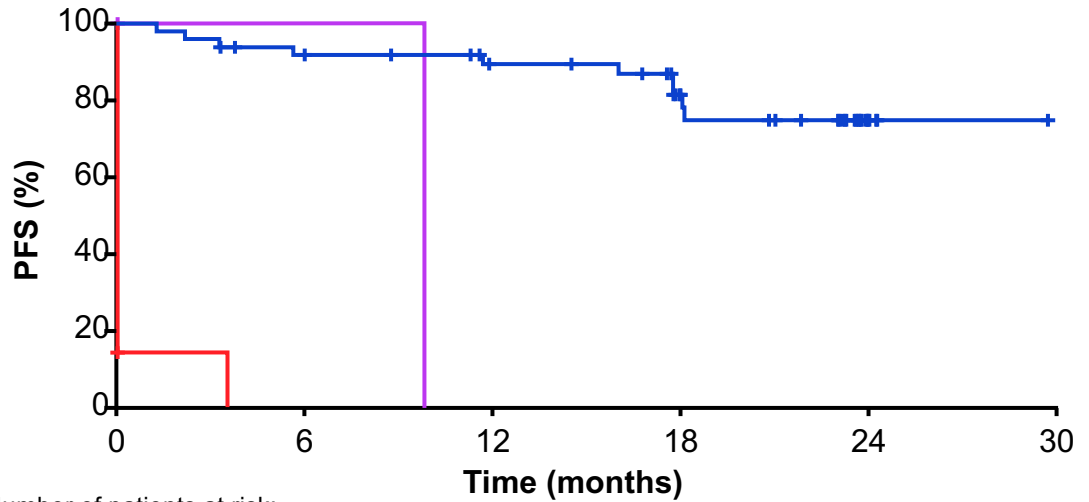
STARGLO OS at 3y



Abramson et al, ASH 2025

Landmark analysis by response at EOT in 2L patients treated with Glofit-GemOx





CR (n=55) No response (n=18) PR (n=3) + Censored

Landmark OS from EOT in 2L patients with CR at EOT	n=55
Median OS, months (95% CI)	NR (NE)
24-month OS, % (95% CI)	85.2 (75.7–94.7)

Landmark PFS from EOT in patients with CR at EOT	n=55
Median PFS, months (95% CI)	NR (NE)
24-month PFS, % (95% CI)	74.8 (60.9–88.7)

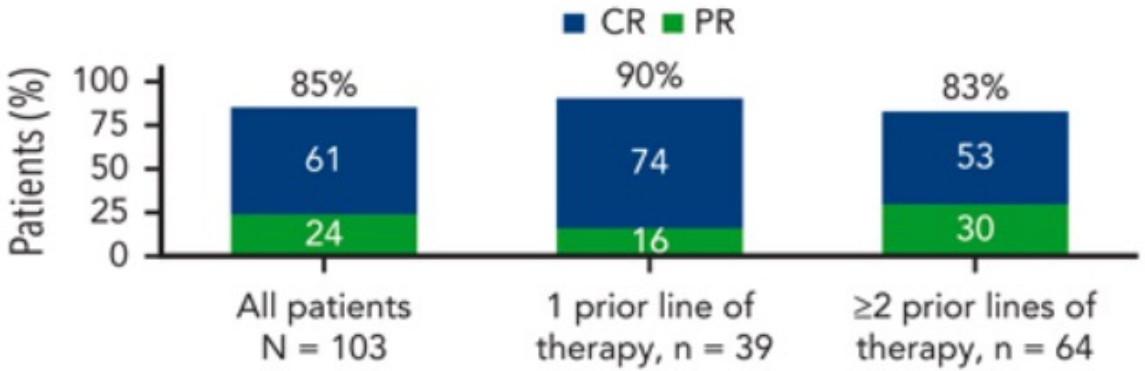
The majority of 2L patients who reached CR at EOT remained alive and progression free 2 years after EOT

Data cut-off: May 1, 2025. EOT, end of treatment; PR, partial response.

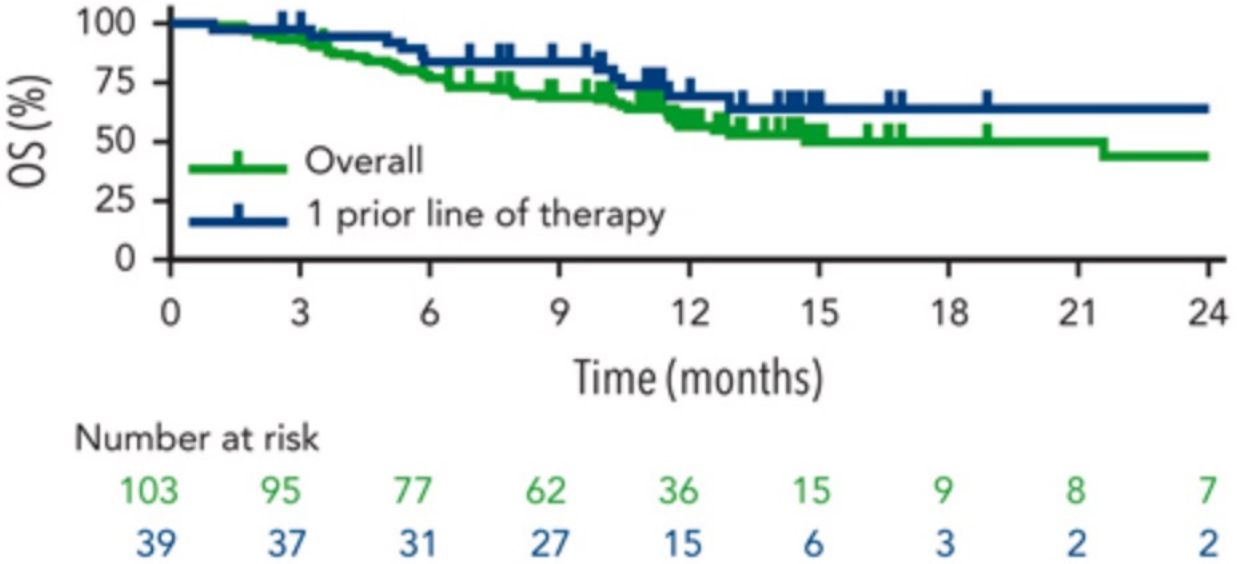
Abdulhaq et al, ASH 2025

Phase Ib/II EPCORE NHL-2 Trial: Epcor-GemOx ≥ 2L R/R DLBCL

Response and Overall Survival



- Median DOCR was 23.6 months

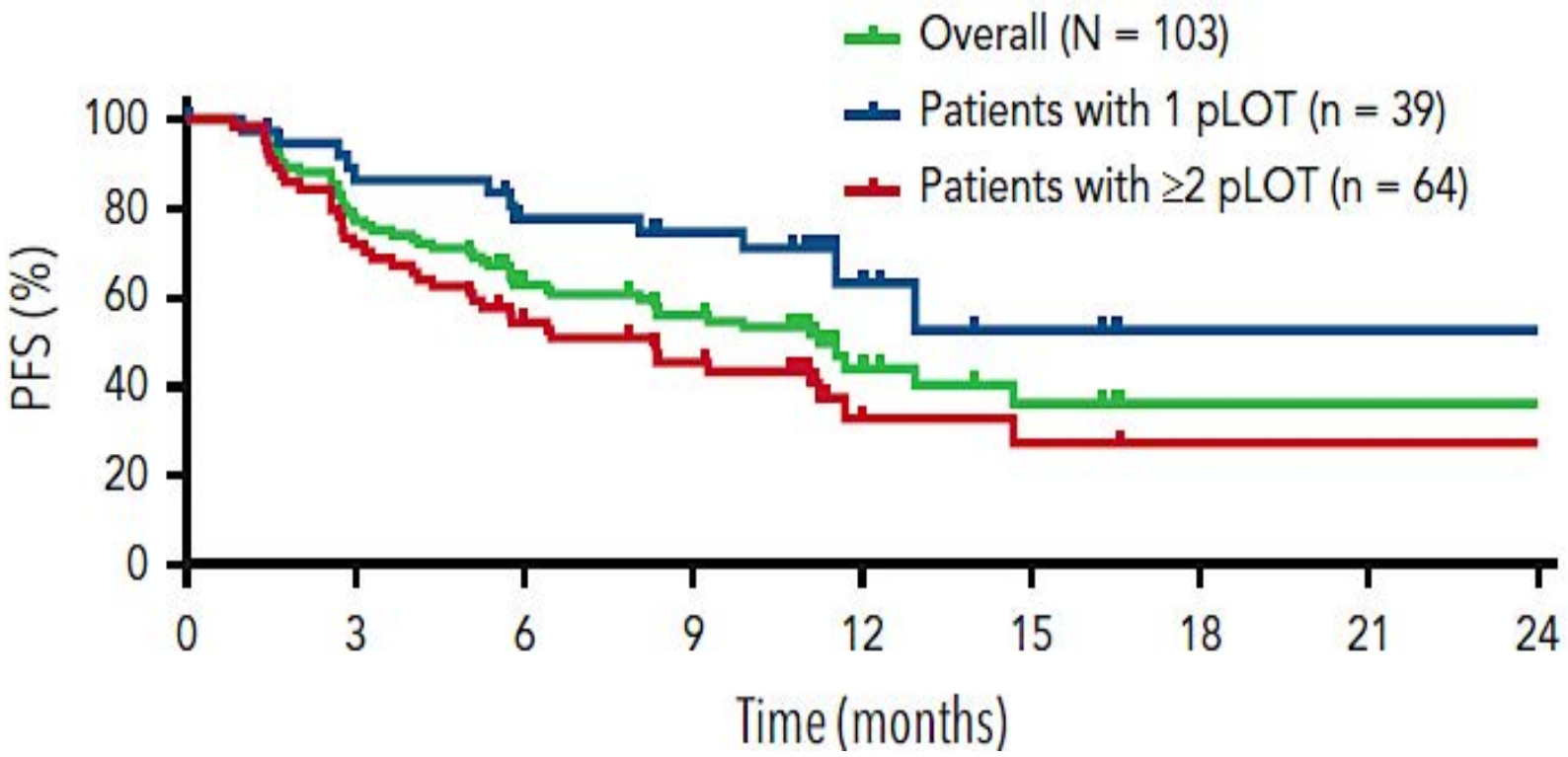


- Median OS was 21.6 months overall and not reached in patients with CR
  - 12-month OS estimate in patients with 1 prior line of therapy was 69%

Brody et al Blood 2025;145:1621–1631

Phase Ib/II EPCORE NHL-2 Trial: Epcor-GemOx ≥ 2L R/R DLBCL

2nd vs later line of therapy significantly affected outcomes



12mo PFS 63%
12mo PFS 44%
12mo PFS 33%

Brody et al Blood 2025;145:1621–1631

SUNMO Study design

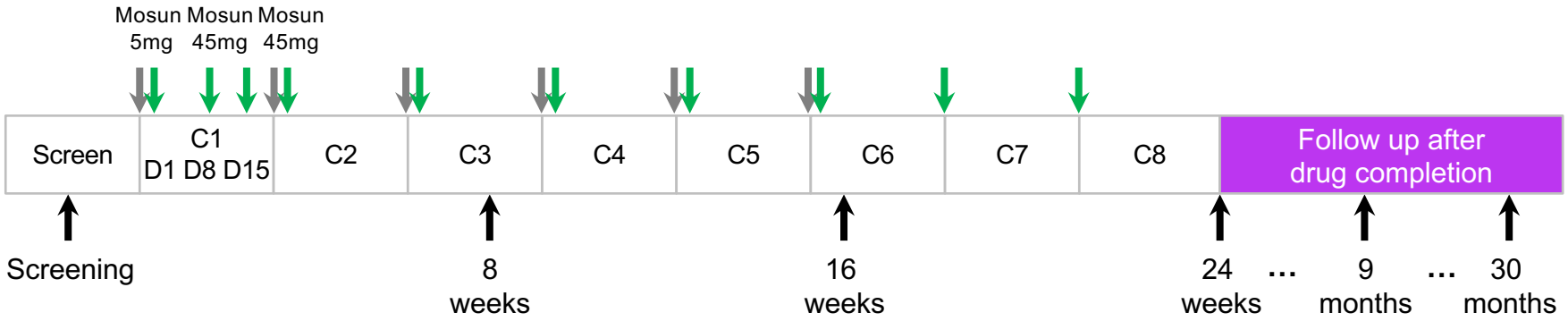
Key eligibility

R/R LBCL with ≥1 prior therapy and ASCT-ineligible:

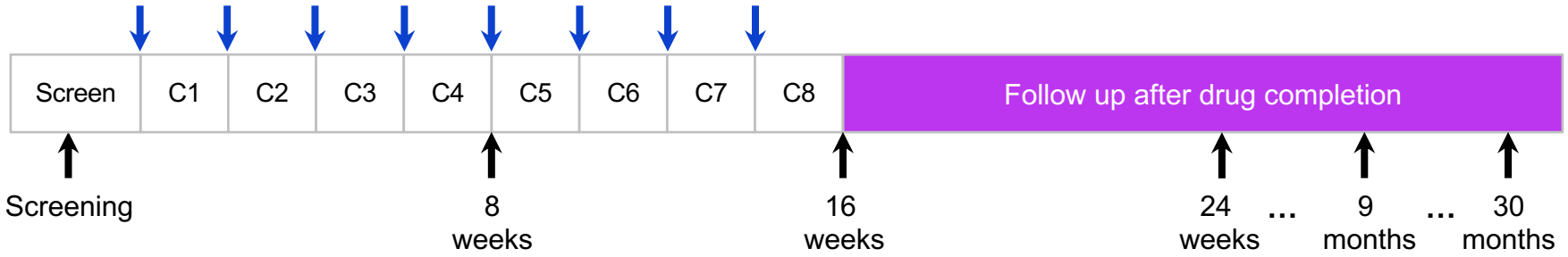
- DLBCL NOS
- Transformed FL
- HGBCL
- Grade 3B FL

2:1

Outpatient Mosun SC (8 cycles) + Pola IV (6 cycles) (21-day cycles)

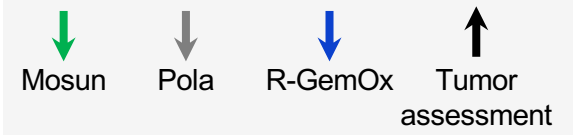


R-GemOx IV (8 x 14–21-day cycles*)



Stratification factors

- 1 vs ≥2 prior lines of systemic therapy
- Relapsed vs refractory disease

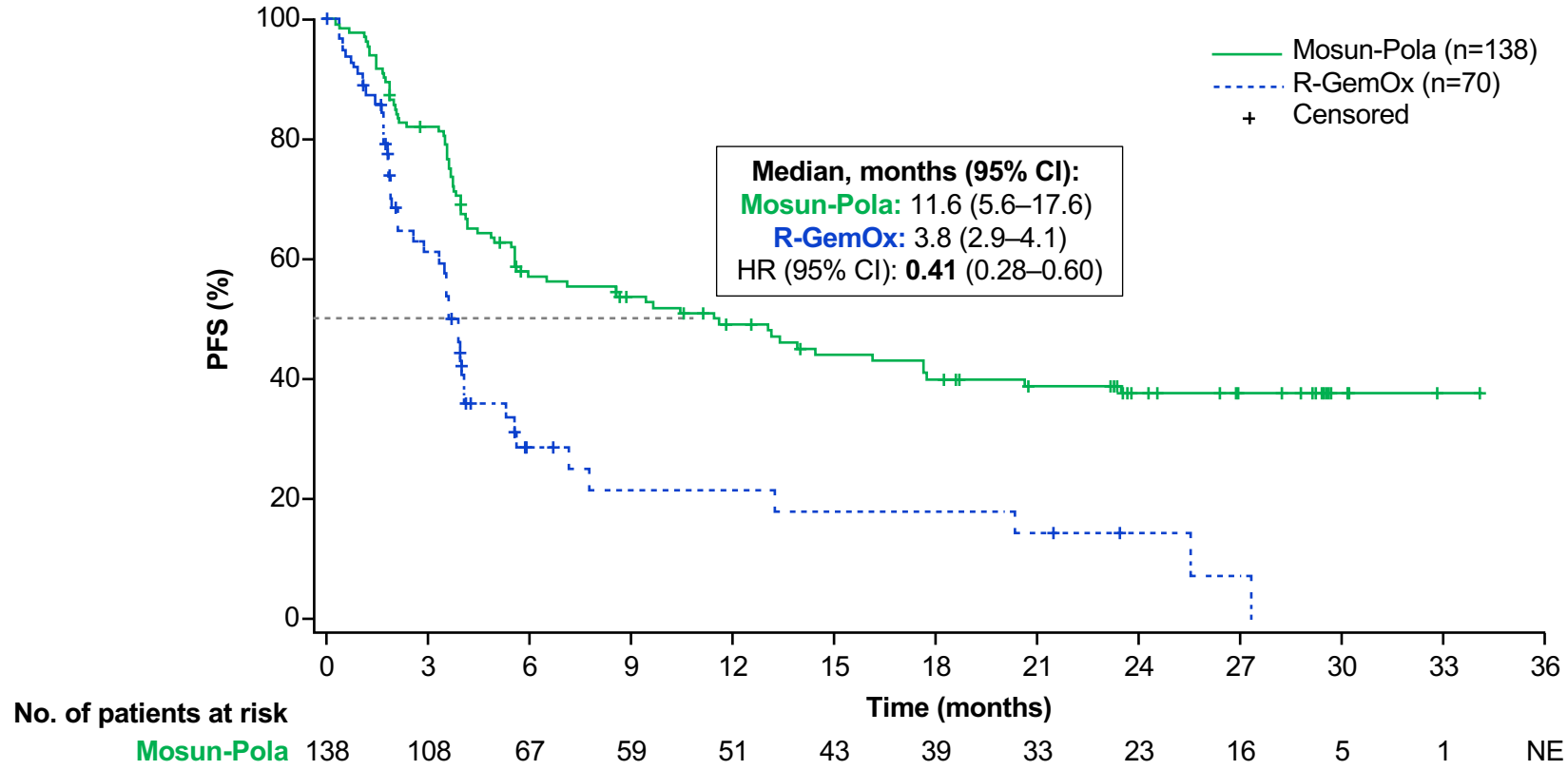


*14-day cycles unless delayed to 21-day cycles if needed in case of hematologic toxicity.
C, cycle; D, day; DLBCL, diffuse large B-cell lymphoma; FL, follicular lymphoma; HGBCL, high-grade B-cell lymphoma; IV, intravenous; NOS, not otherwise specified; SC, subcutaneous.

Presented as LBA3 by Westin et al, ICML 2025

Mosun-Pola continued to demonstrate a durable PFS benefit after a median follow-up of 28.3 months

Primary endpoint: PFS by IRC in ITT



Clinical cut-off date: August 8, 2025.
PFS is censored at earliest of NALT or two or more missing tumor assessments, whichever occurred first.
CI, confidence interval; HR, hazard ratio; NALT, new anti-lymphoma therapy; NE, not evaluable.

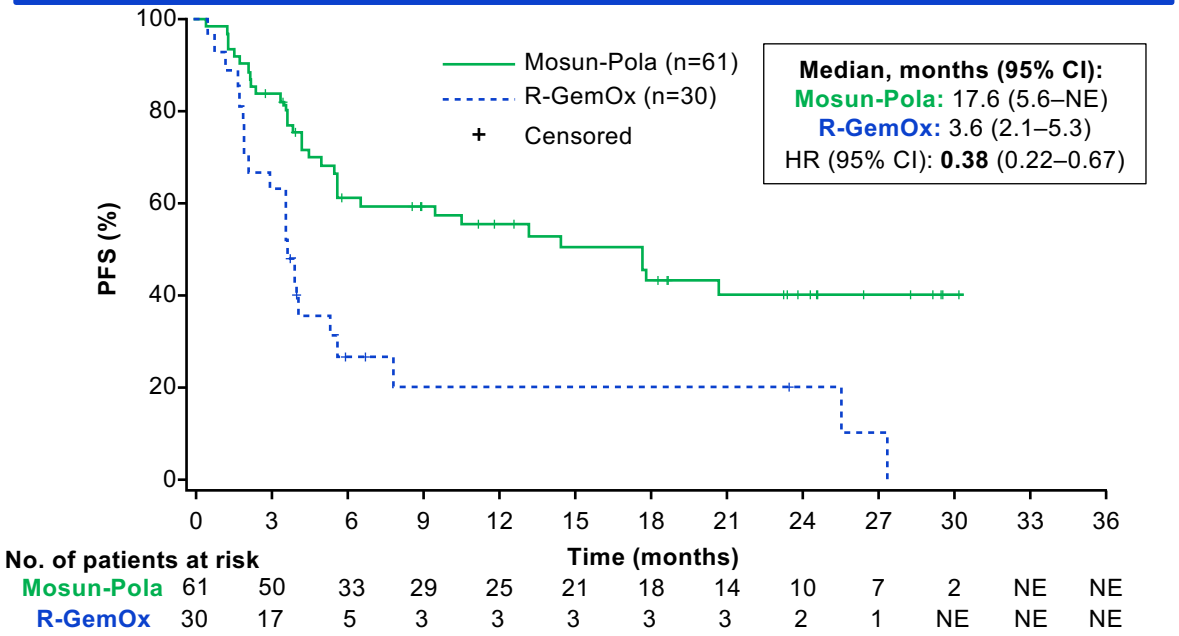
Kim et al, ASCO 2026

Mosun-Pola demonstrated high efficacy in the 2L setting

IRC-assessed efficacy % (95% CI), unless otherwise stated	2L Mosun-Pola (n=61)	2L R-GemOx (n=30)
Median PFS, months (95% CI)	17.6 (5.6–NE)	3.6 (2.1–5.3)
ORR	75.4 (62.7–85.5)	36.7 (19.9–56.1)
CR	60.7 (47.3–72.9)	20.0 (7.7–38.6)
Median DOR, months (95% CI)	18.8 (11.3–NE)	6.0 (3.9–NE)
Median DOCR, months (95% CI)	NR (15.6–NE)	21.4 (3.9–NE)

Clinical cut-off date: August 8, 2025.

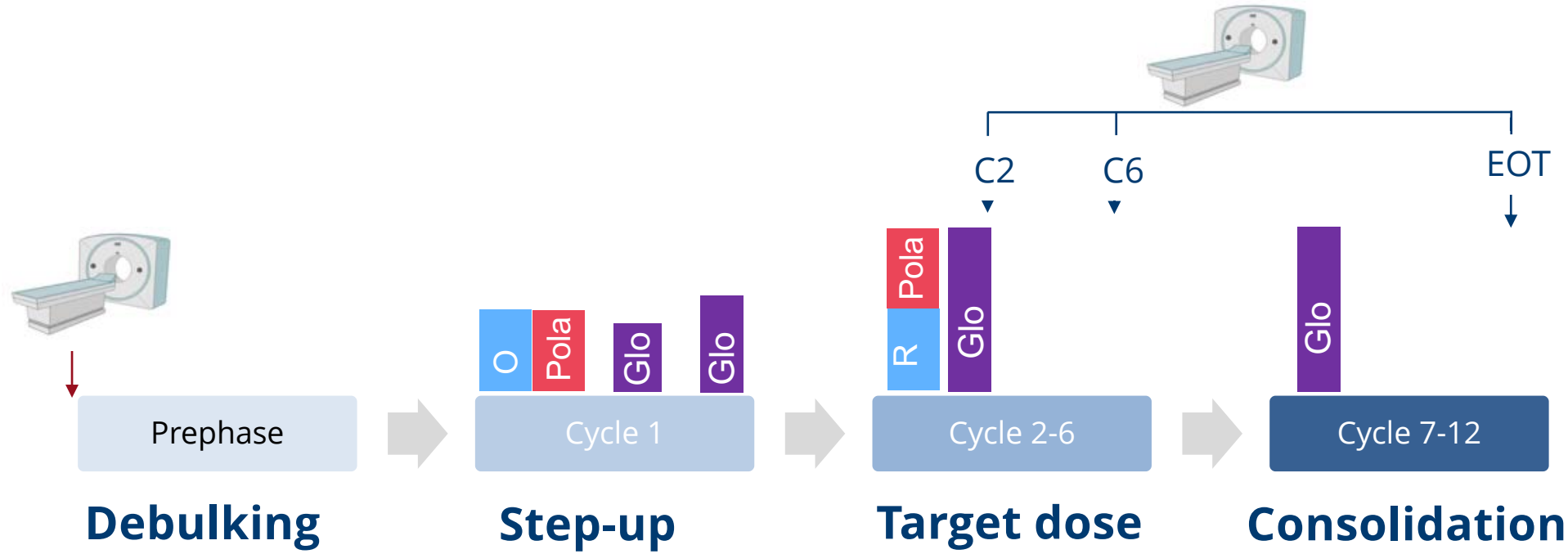
PFS by IRC: 2L



- A PFS HR of 0.38 was demonstrated in the 2L population
  - The 2-year PFS rate was doubled with Mosun-Pola versus R-GemOx: 40.3% vs 20.1%
  - Median DOCR was not reached with Mosun-Pola

Kim et al, ASCO 2026

R-Pola-Glo – Study Design



Indication

- **Untreated** patients >60 yo with LBCL
- Non-eligible for full dose R-CHOP

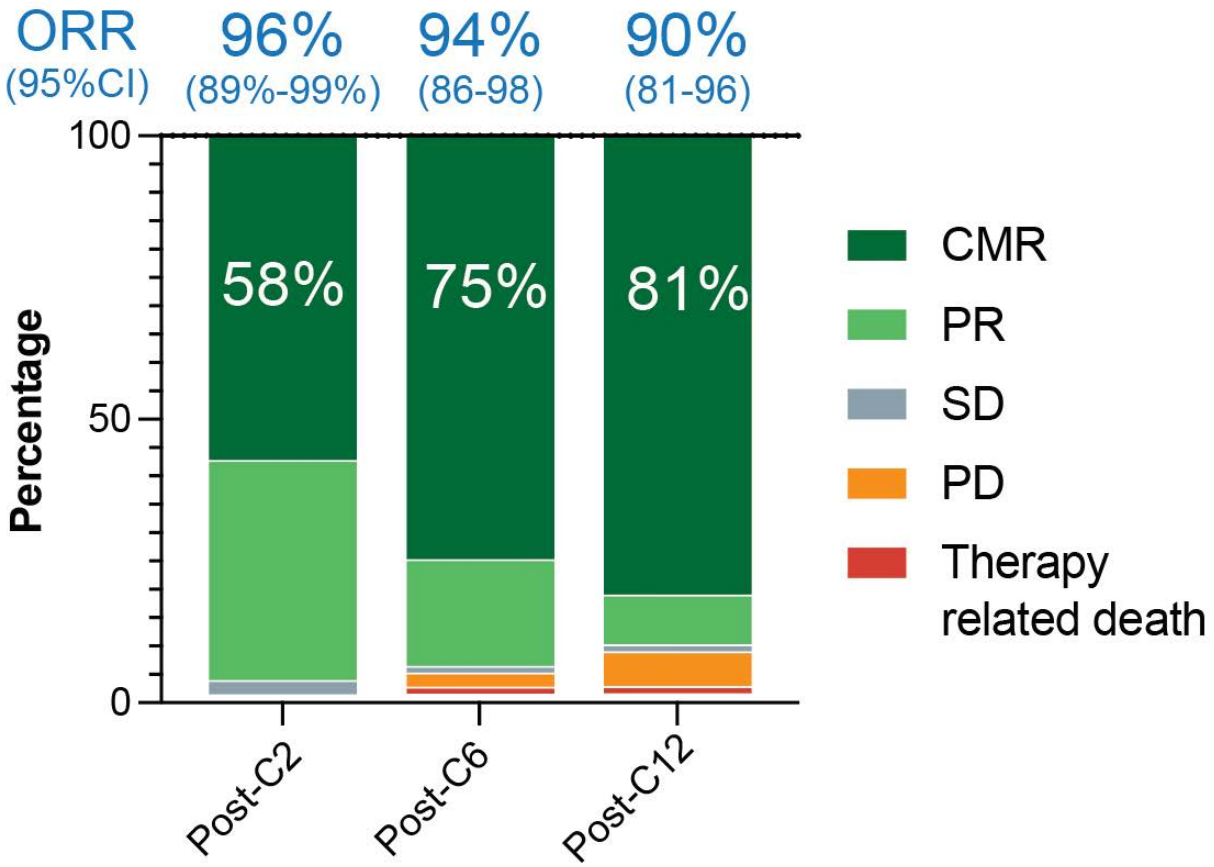
Study Design

- One-arm, multicenter phase II
- 30 centers in Germany and Austria
- **80 pts** (C1-6 mandatory inpatient)
- Mandatory prophylaxis

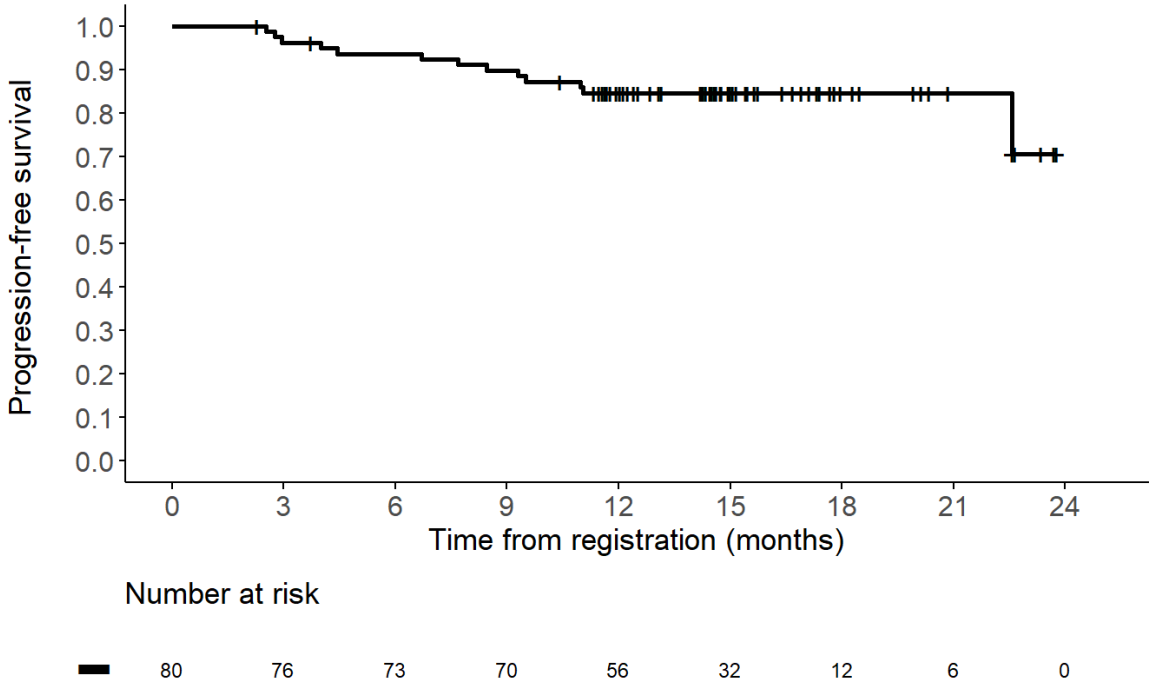
Endpoints

- *Primary:* **1y-PFS rate**
- *Secondary:*
  - Efficacy (OS, EFS)
  - Feasibility/Toxicity

R-Pola-Glo – Outcome



1-year Progression-free Survival (PFS)



Chapuy et al, ASH 2025

NCCN Suggested Treatment Regimens

SECOND-LINE THERAPY[e,j,k] (relapsed disease >12 mo)	
Intention to Proceed to Transplant	**No Intention to Proceed to Transplant**
Preferred (in alphabetical order) • DHA + platinum (Carboplatin, Cisplatin, or Oxaliplatin) ± Rituximab • GDP ± Rituximab • ICE ± Rituximab **Other recommended (in alphabetical order)** • ESHAP ± Rituximab • GEMOX ± Rituximab	**Preferred (in alphabetical order by category)** • CAR T-cell therapy (CD19-directed)[l] (with pre/postpheresis therapy as needed; BCEL-C 2 of 7) (if eligible) ▸ Lisocabtagene maraleucel • GEMOX + Epcoritamab-bysp[n,o] • GEMOX + Glofitamab-gxbm[n,o] • GEMOX[n] + Polatuzumab vedotin-piiq + Rituximab • Lenalidomide + Tafasitamab-cxix[p] • Polatuzumab vedotin-piiq ± Bendamustine[m] ± Rituximab • Mosunetuzumab-axgb (IV or SC)[n,o,q] + Polatuzumab vedotin-piiq • Glofitamab-gxbm[n,o] + Polatuzumab vedotin-piiq (category 2B) **Other recommended (in alphabetical order)** • CEOP ± Rituximab • GDP ± Rituximab • GEMOX ± Rituximab (if unable to receive epcoritamab-bysp, glofitamab-gxbm, or polatuzumab vedotin-piiq) • Rituximab **Useful in certain circumstances** • Brentuximab vedotin • Ibrutinib[n] (non-GCB DLBCL) • Lenalidomide ± Rituximab (non-GCB DLBCL)

NCCN Clinical Practice Guidelines in Oncology. B-Cell Lymphomas. Version 4.2026.

Epco-R-mini CVP: Study Design

Step-up dose: C2D1 0.16mg, C2D8 0.8mg
Full dose C2D15 (observation) and thereafter: 48mg

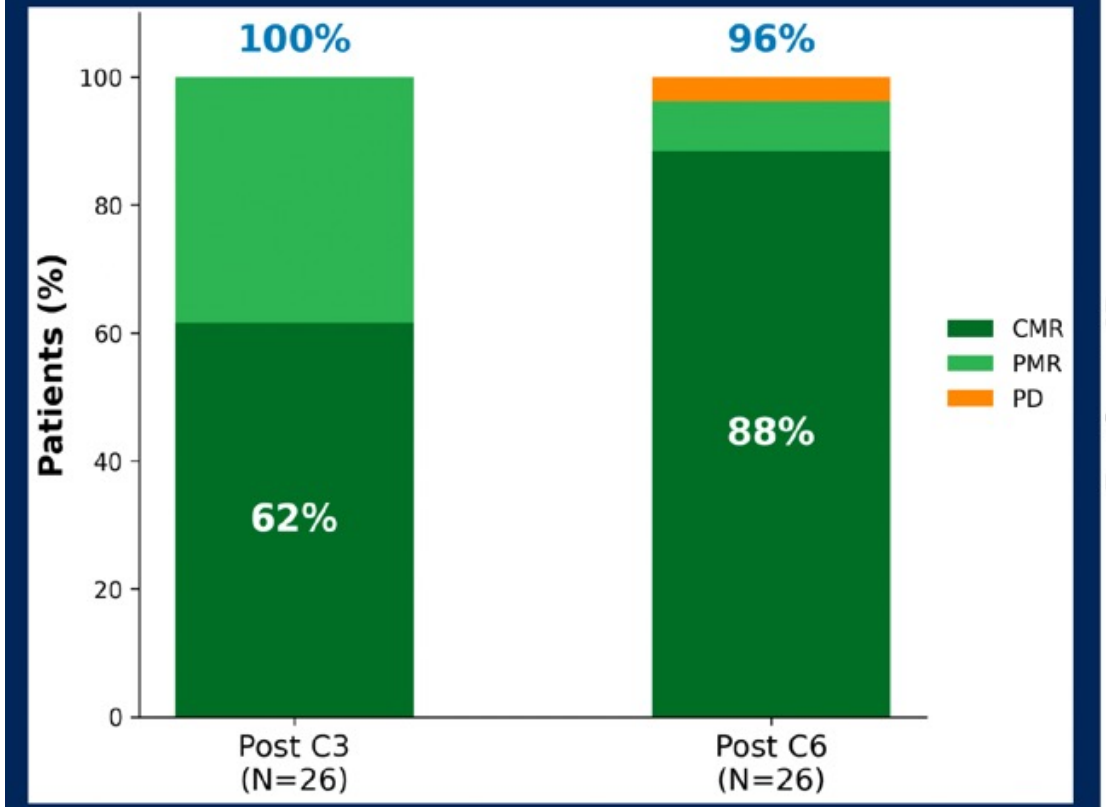
Biopsy ↑

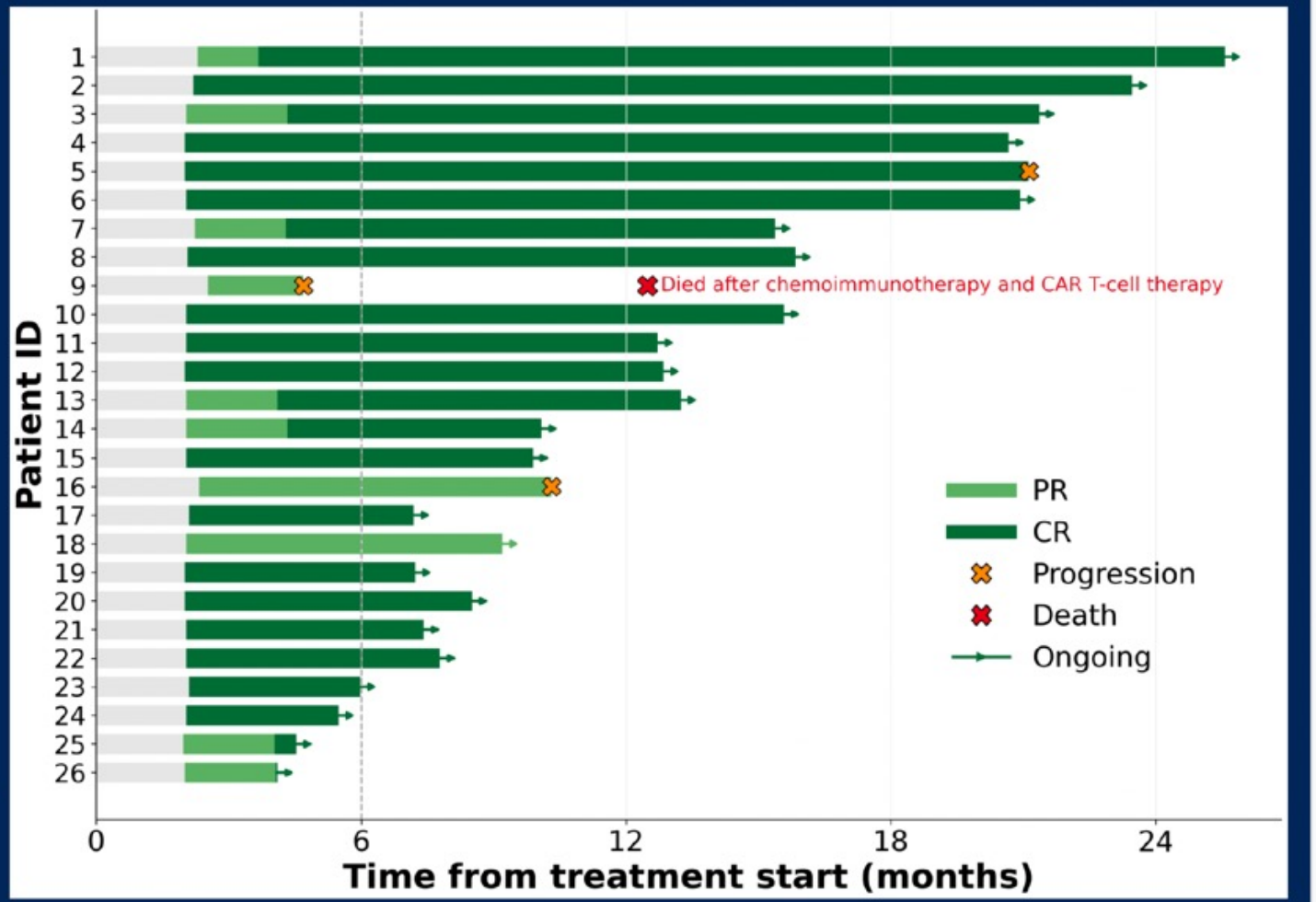
Blood ↑ ↑↑↑ ↑↑↑ ↑ ↑

- **Epcoritamab maintenance for those who are in PR after C6**

Mini CVP
Cyclophosphamide: 400mg/m2
Vincristine: 1mg
Prednisone: 40mg/m2

Epco-R-mini CVP: Response



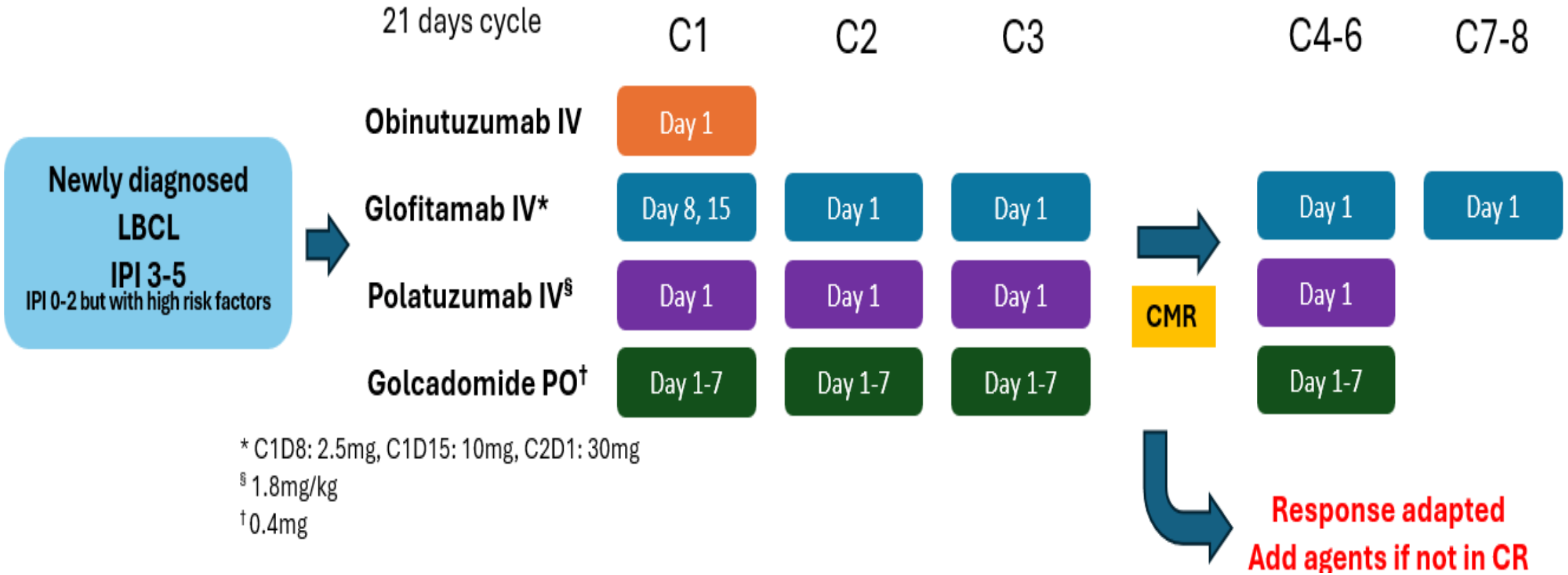


Select Ongoing Phase III Trials of Bispecific Antibody Combination Regimens in LBCL

Trial Identifier	Setting	Treatment Arms	Primary Endpoint
SKYGLO (NCT06047080)	Newly Diagnosed	• Glofitamab + Pola-R-CHP • Pola-R-CHP	PFS
EPCORE-DLBCL-2 (NCT05578976)	Newly Diagnosed	• Epcoritamab + R-CHOP • R-CHOP	PFS with IPI 3-5
Olympia-3 (NCT06091865)	Newly Diagnosed	• Odronextamab + CHOP • R-CHOP	PFS
EPCORE-DLBCL-4 (NCT06508658)	Relapsed/Refractory	• Arm A: Epcoritamab (subcutaneous) + Lenalidomide • Arm B: R-GemOx • Arm C: Epcoritamab (subcutaneous)	PFS

www.clinicaltrials.gov (Accessed May 2026).

Smart 3



* C1D8: 2.5mg, C1D15: 10mg, C2D1: 30mg

§ 1.8mg/kg

† 0.4mg

Chihara D and Westin JR

Conclusion:
Bispecific Antibody Therapy for DLBCL

- Highly effective as single agents in R/R LBCL
  - Glofit CRR: 40%, Epco CRR 39%
- Highly effective compared with GemOx
  - Glofit-GemOx improved OS
  - Epco improved PFS
  - Mosun-Pola improved PFS
- Frontline trials are eagerly anticipated

Discussion Questions

58 y/o man with stage IV DLBCL, non-GCB subtype
R-CHOP as initial therapy with only partial response followed by progression within 6 months
Salvage polatuzumab vedotin/BR with transient response but rapid progression
CD19-directed CAR T-cell therapy with initial metabolic complete response on PET imaging
Recurrent adenopathy and biopsy-confirmed relapse less than 6 months later

How would you treat this patient? How are you thinking about bispecific antibody combinations for DLBCL? Are you prioritizing combinations over monotherapy for most patients?

RTP
RESEARCH
TO PRACTICE

Discussion Questions (Continued)

58 y/o man with stage IV DLBCL, non-GCB subtype
R-CHOP as initial therapy with only partial response followed by progression within 6 months
Salvage polatuzumab vedotin/BR with transient response but rapid progression
CD19-directed CAR T-cell therapy with initial metabolic complete response on PET imaging
Recurrent adenopathy and biopsy-confirmed relapse less than 6 months later

Would you consider allogeneic stem cell transplantation in a younger, fit patient who achieves a response after bispecific antibody therapy?

How do you approach CRS and infection-risk monitoring in heavily pretreated patients receiving sequential immune-engaging therapies?

RTP
RESEARCH
TO PRACTICE

Discussion Questions

81 y/o woman with stage IV DLBCL, non-GCB subtype
The patient is frail with a history of Parkinson's disease
R-mini-CHOP as initial therapy with CR but symptomatic relapse at 13 months

What treatment would you recommend?

Is there an age at which you will no longer consider CAR-T, or is the decision solely based on performance status/patient fitness?

Discussion Questions (Continued)

81 y/o woman with stage IV DLBCL, non-GCB subtype
The patient is frail with a history of Parkinson's disease
R-mini-CHOP as initial therapy with CR but symptomatic relapse at 13 months

For a patient in whom you are going to use bispecific antibody monotherapy, how do you choose between epcoritamab and glofitamab? Do you view them as equivalent options? Are there any advantages or disadvantages to either approach?

Discussion Questions

56 y/o man with DLBCL and bulky right neck LN
Primary refractory to Pola-R-CHP as initial therapy
CAR-T as second-line therapy; recurrence in the right neck 6 months later

What treatment would you offer next? Are there any promising investigational approaches in this space? Do CD19 bispecifics have any potential advantages over those directed at CD20?

If you were going to use a bispecific antibody combination, which one would you use?

Discussion Questions (Continued)

56 y/o man with DLBCL and bulky right neck LN
Primary refractory to Pola-R-CHP as initial therapy
CAR-T as second-line therapy; recurrence in the right neck 6 months later

For patients who receive polatuzumab as part of induction therapy, will you use it in later lines as part of a bispecific-based combination?

Agenda

Module 1: Chimeric Antigen Receptor (CAR) T-Cell Therapy for Diffuse Large B-Cell Lymphoma (DLBCL) — Dr Kamdar

Module 2: Bispecific Antibody Therapy for DLBCL — Dr Westin

Module 3: CAR T-Cell Therapy for Other Lymphoma Subtypes — Dr Abramson

Module 4: Bispecific Antibody Therapy for Follicular Lymphoma and Other Lymphoma Subtypes — Dr Phillips

Module 5: Tolerability Considerations with CAR T-Cell Therapy and Bispecific Antibodies — Dr Brody

Mass General Brigham
Cancer Institute

CAR T-cell Therapy in Other Lymphoma Subtypes (FL, MZL, MCL)

Jeremy S. Abramson, MD, MMSc
Professor of Medicine, Harvard Medical School
Director, Center for Lymphoma, Mass General Brigham Cancer Institute

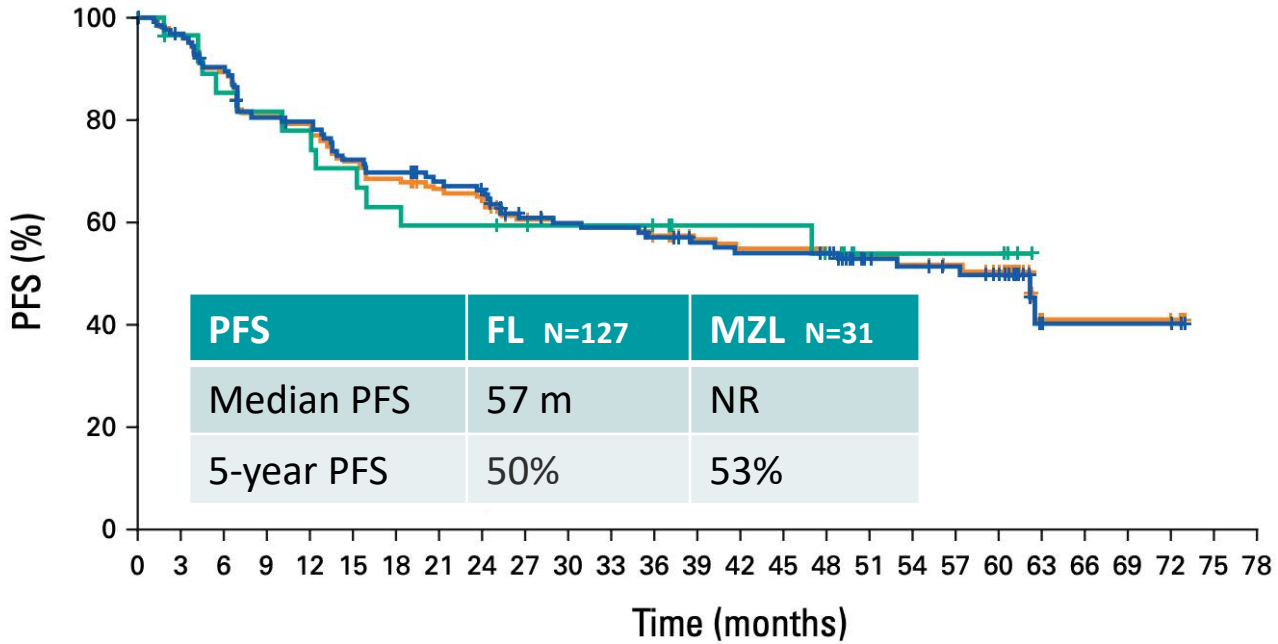
HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Follicular and Marginal Zone lymphomas

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%
OR rate	97%	86%	94%
CR rate	94%	69%	79%
CRS, any grade %	58	49	82
CRS, severe %	1	0	7
Neurotox, any grade %	15	4	59
Neurotox, severe %	2	1	15
References	Morschhauser, et al. Nature Med 2024 Ahmed, et al. Proc ASH 2025	Fowler, et al. Nat Med 2022. Schuster, et al.Proc ASH 2025	Jacobson, et al. Lancet Onc 2022 Neelapu, et al. JCO 2025

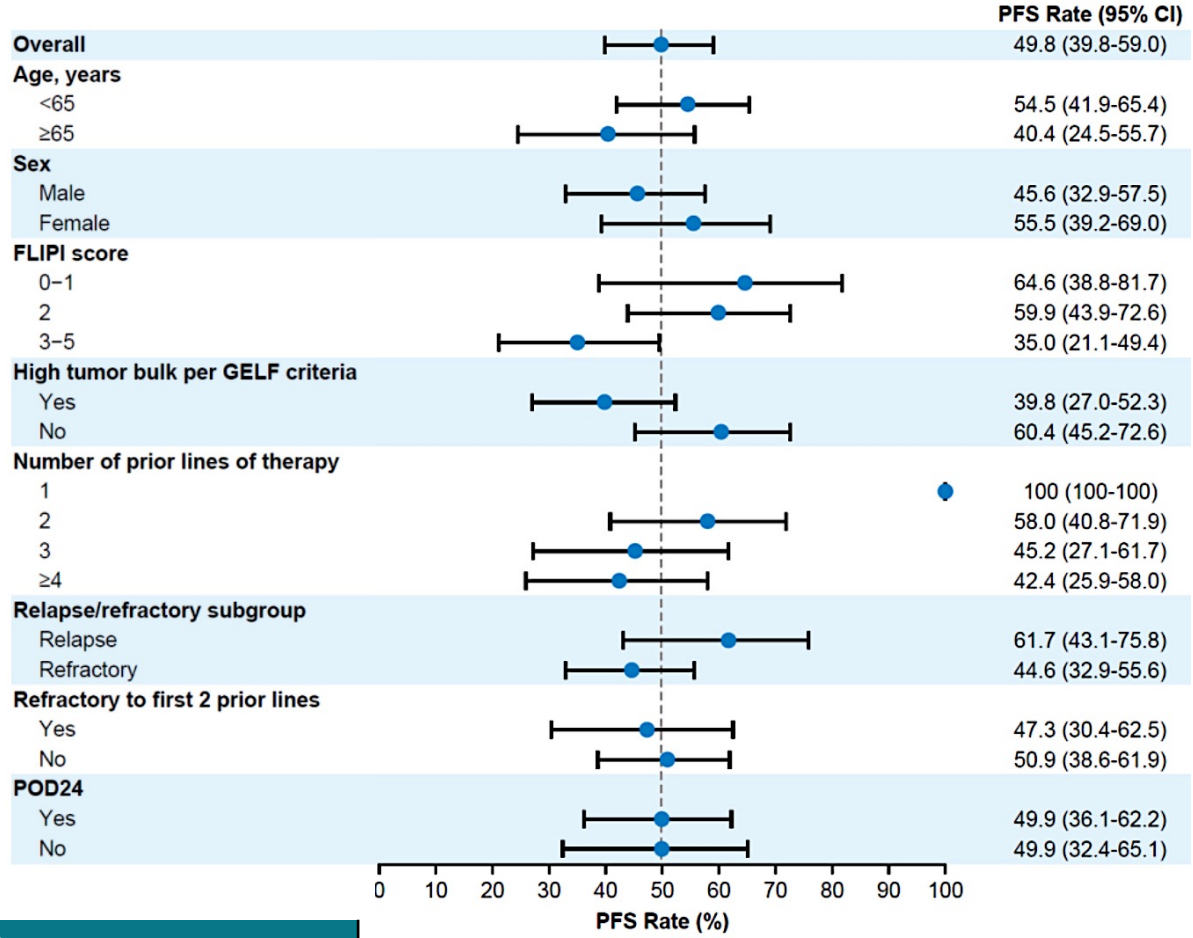
ZUMA-5: Sustained PFS at 5 years in FL and MZL



PFS	FL N=127	MZL N=31
Median PFS	57 m	NR
5-year PFS	50%	53%

Number at risk:

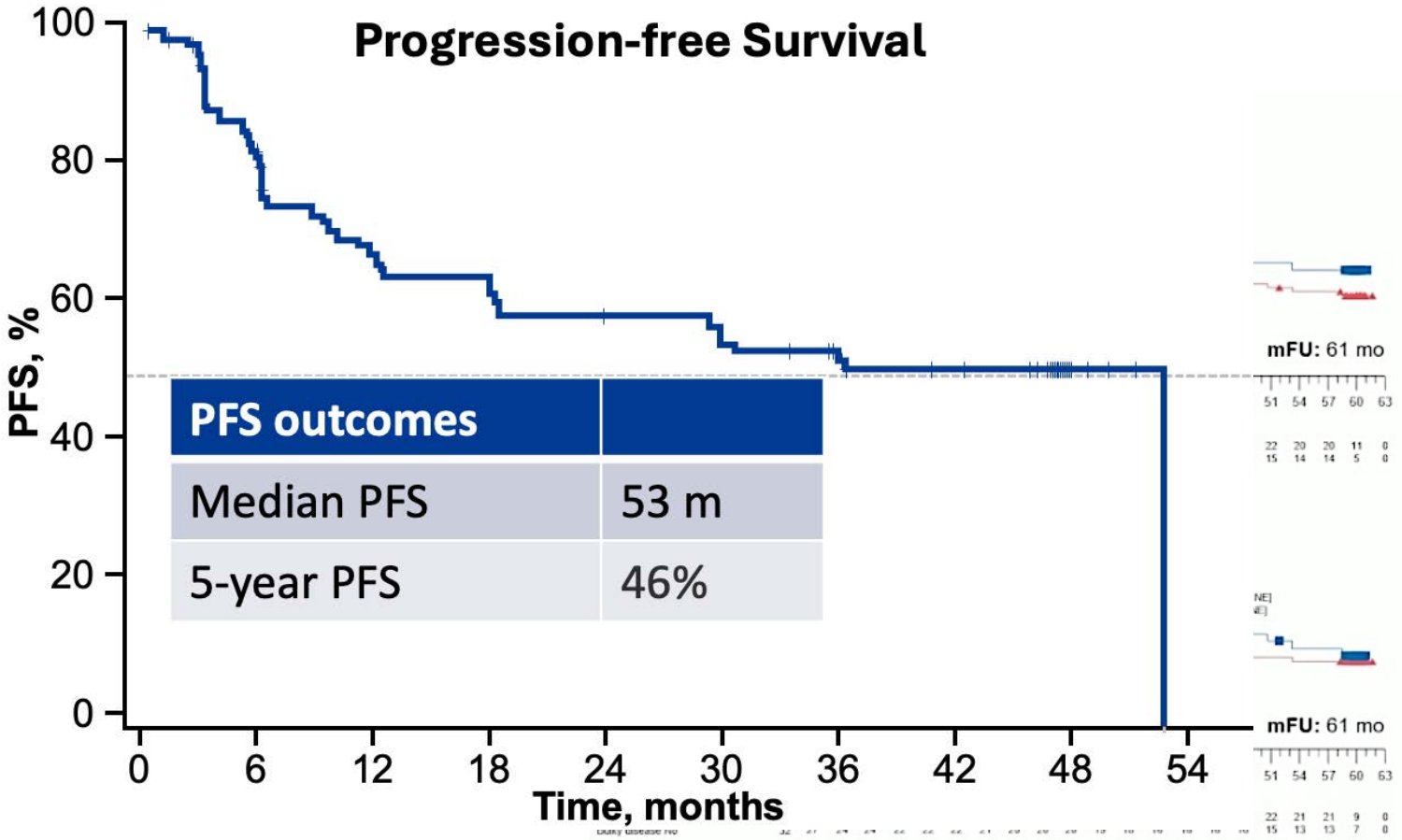
FL	127	120	111	98	96	87	84	78	75	65	63	62	59	55	53	53	52	36	34	32	29	7	6	6	6	0
MZL	31	26	23	22	21	19	17	16	16	15	14	14	13	11	11	11	9	4	4	4	4	0				
All patients	159	146	134	120	117	106	101	94	91	80	77	76	72	66	64	64	61	40	38	36	33	7	6	6	6	0

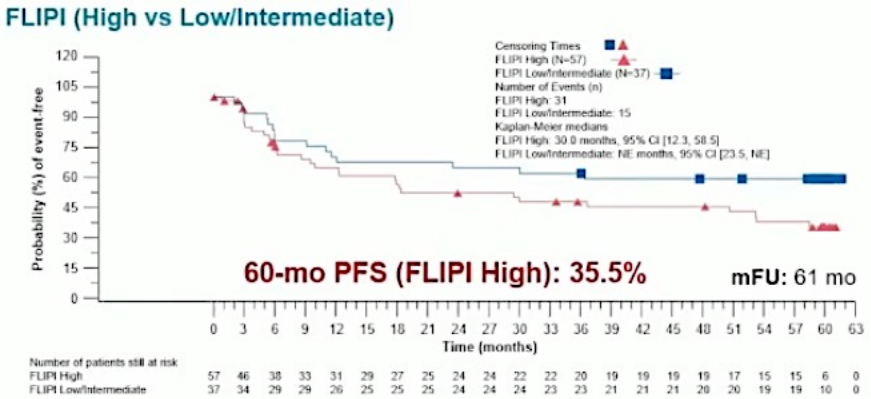


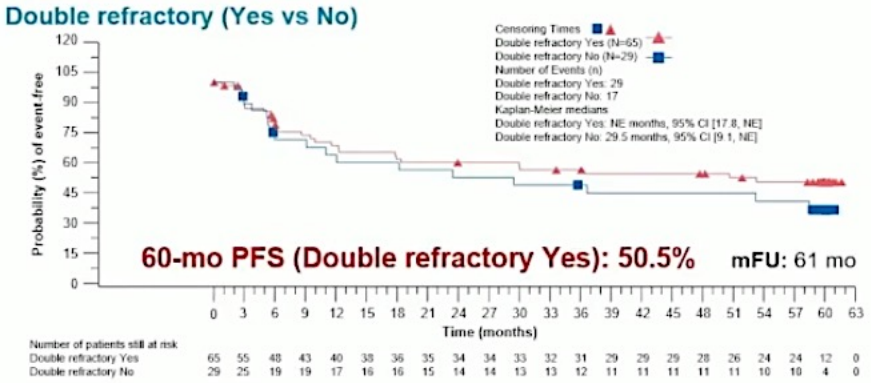
	Prior bendamustine exposure			
	None (n = 39)	≤ 6 mo (n = 8)	6—12 mo (n = 10)	> 12 mo (n = 70)
24-month DOR, %	70	40	56	52
24-month PFS, %	70	25	70	50

Neelapu, et al. JCO 2025; Neelapu, et al. Blood 2024.

Long term follow up of Tisa-cel: 5-year results from ELARA

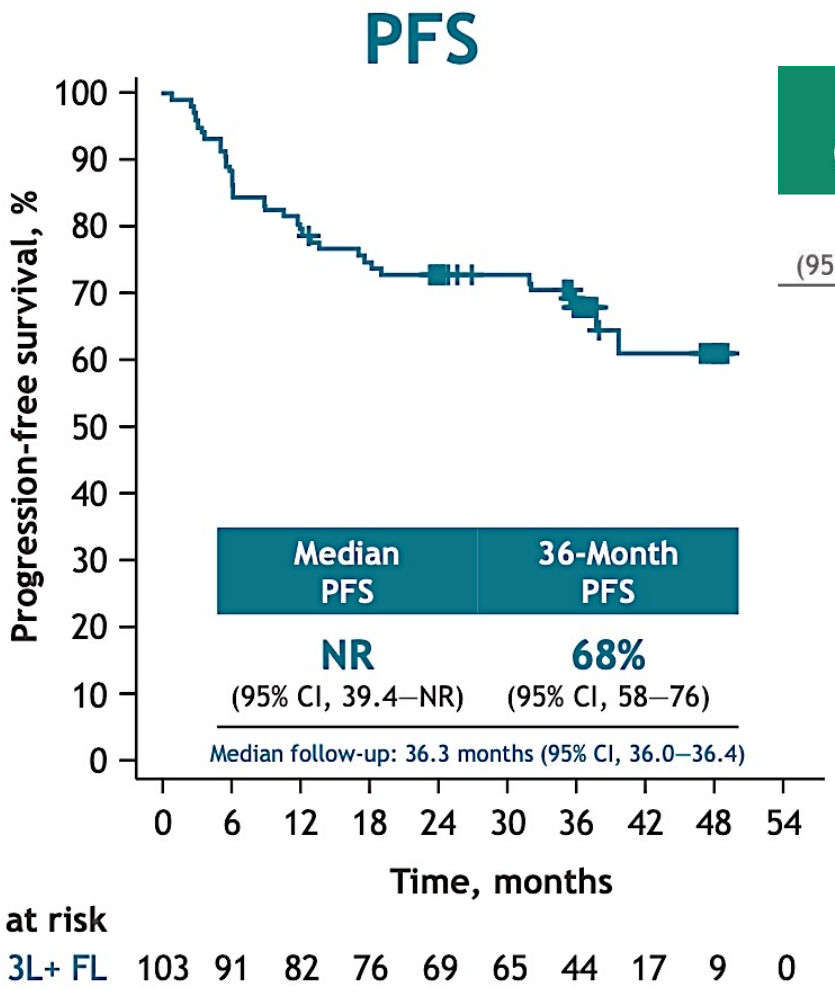






Thieblemont, et al. Proc ASH 2024; Schuster, et al ASTCT 2026.

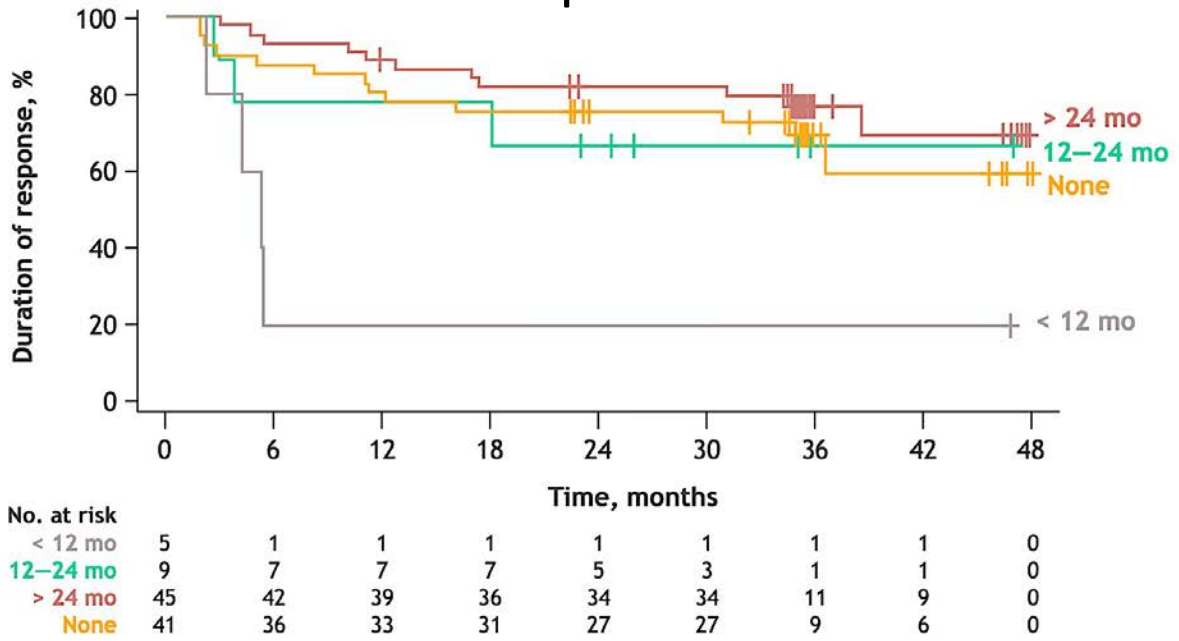
Long term follow up of TRANSCEND FL: Liso-cel at 3 years



3-year PFS in high-risk subsets

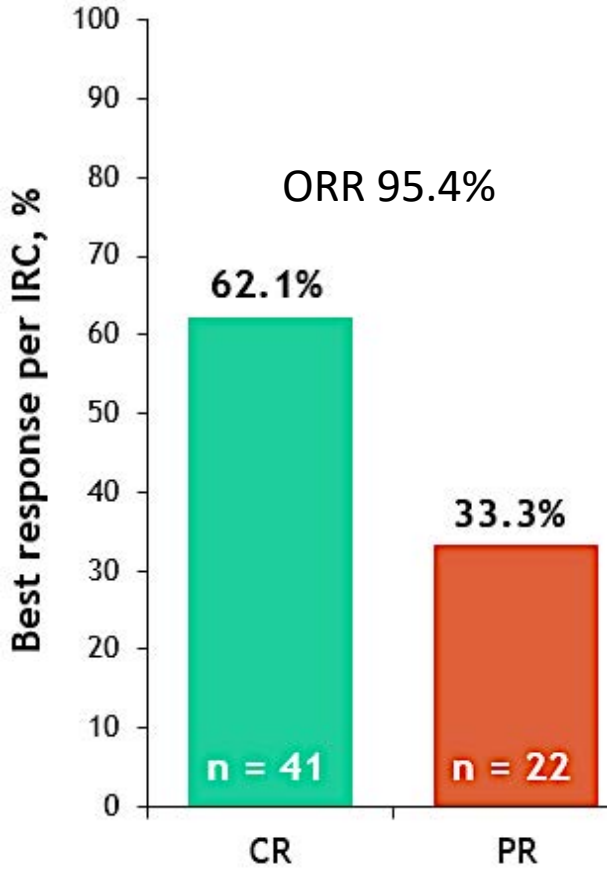
POD24 (n = 57)	No POD24 (n = 46)	Bulky disease (n = 31)	No bulky disease (n = 72)	Double refractory (n = 67)	Not double refractory (n = 36)
58% (95% CI, 43—70)	80% (95% CI, 65—89)	61% (95% CI, 41—75)	71% (95% CI, 58—80)	60% (95% CI, 47—71)	83% (95% CI, 66—92)

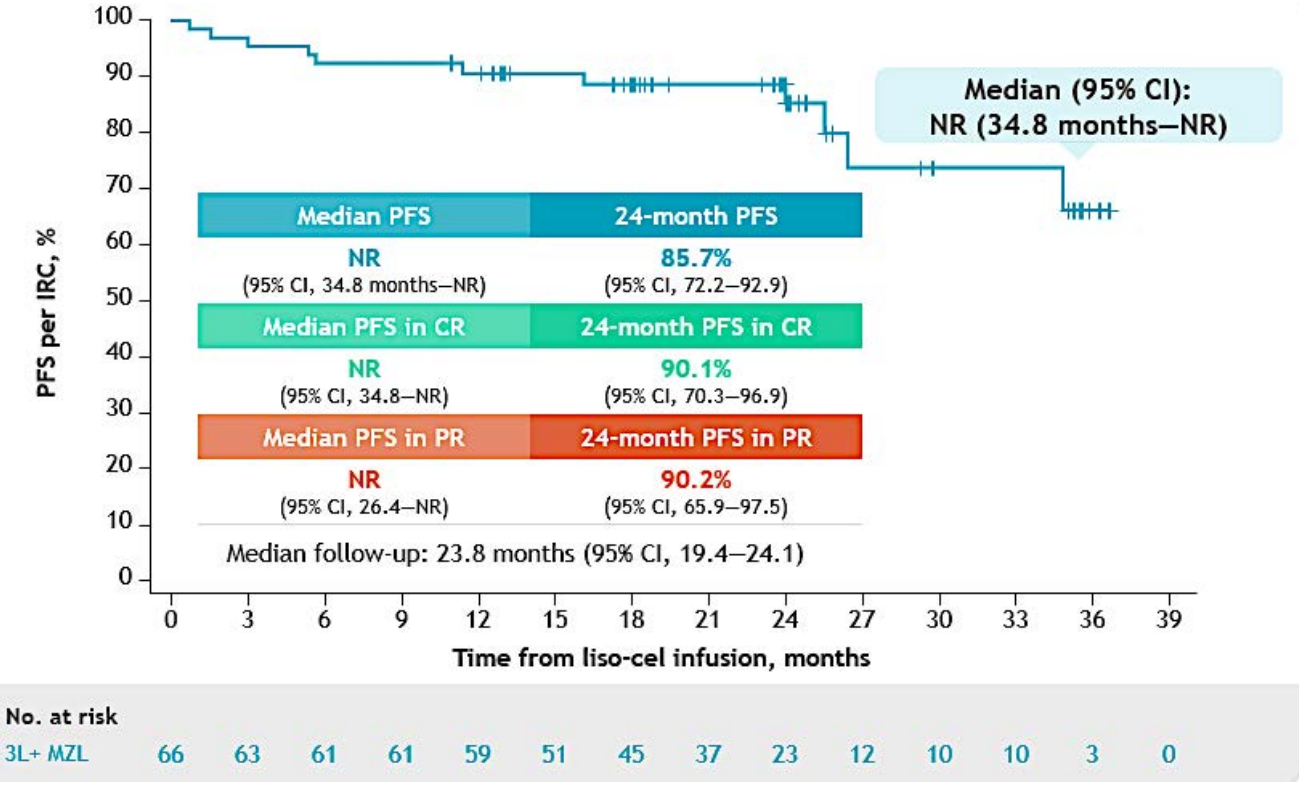
DOR based on prior bendamustine

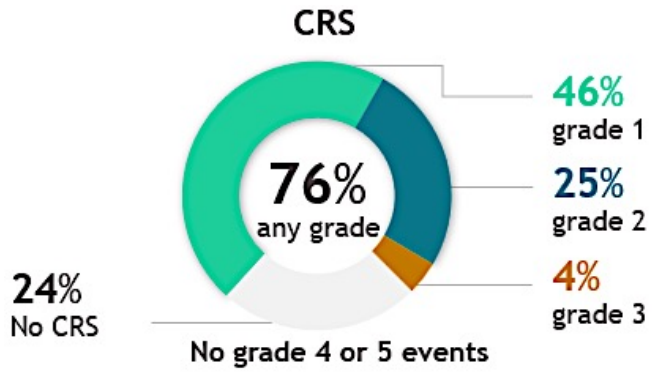


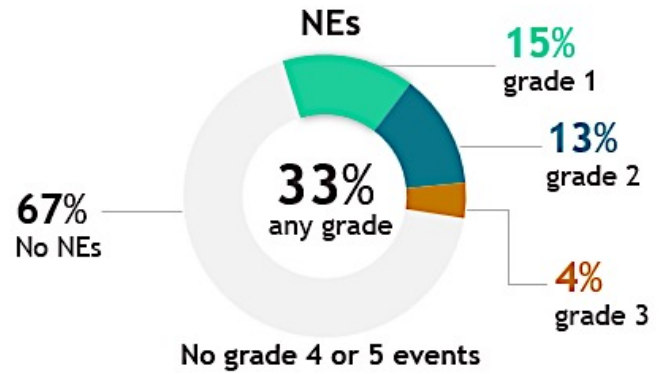
Dreyling M, et al. EBMT 2026 [Presentation #OS02-02]

Sustained efficacy and safety for liso-cel in relapsed/refractory marginal zone lymphomas









Palomba, et al. Proc ICML 2025

Future directions in FL: randomized trials

ZUMA-22

Randomized phase III trial of axi-cel vs. SOC in relapsed/refractory follicular lymphoma

- Grade 1-3A FL
- 1 prior line of tx and POD, *or* ≥2 prior lines
- SOC: investigators choice of R-CHOP, R-Benda, or R-Len
- Primary endpoint PFS

NCT05371093

LEDA

Randomized phase III trial of tisa-cel vs. SOC in relapsed/refractory follicular lymphoma

- Grade 1-3A FL
- ≥2 prior lines of tx
- SOC: investigators choice of R-CHOP or R-Len
- Primary endpoint PFS

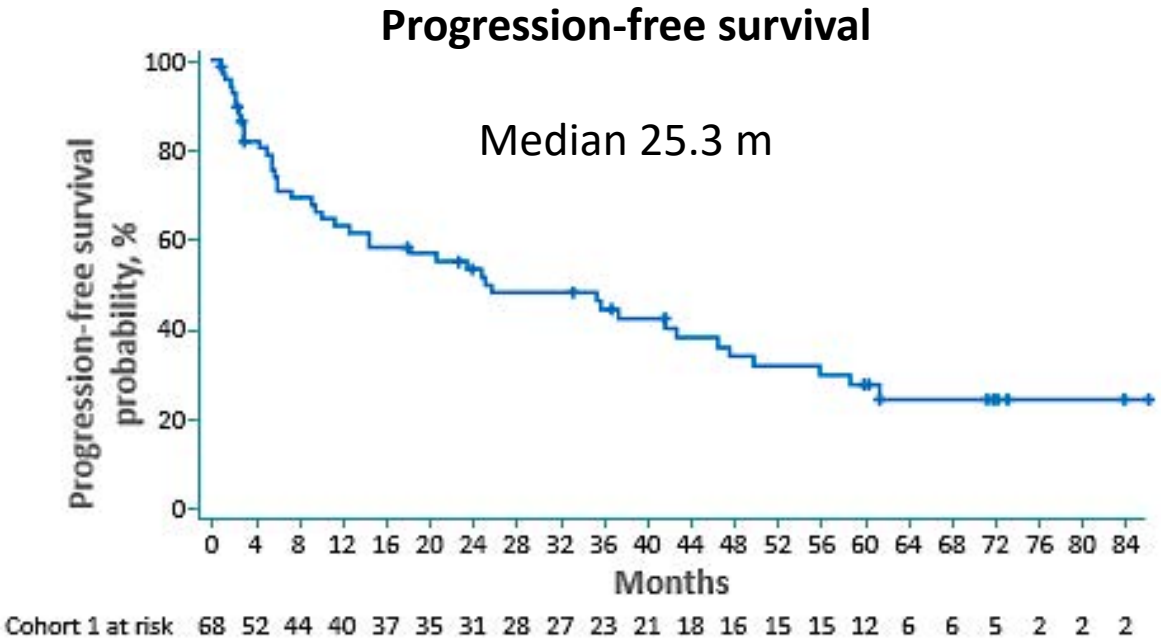
NCT05888493

Mantle cell lymphoma

Brexu-cel for 3L+ MCL post cBTK inhibition: ZUMA-2

Baseline Characteristics	
n	68
Median # prior lines	3 (1-5)
BTKI refractory	62%
TP53 mut	17%
Blastoid	31%
KI67 ≥ 30%	82%

Endpoint	n=68
ORR	93%
CRR	67%
Median DOR	36.5 m
Median DOCR	46.7 m



Toxicity	
Any-grade CRS	91%
Grade ≥ 3 CRS	15%
Any-grade ICANS	63%
Grade ≥ 3 ICANS	31%

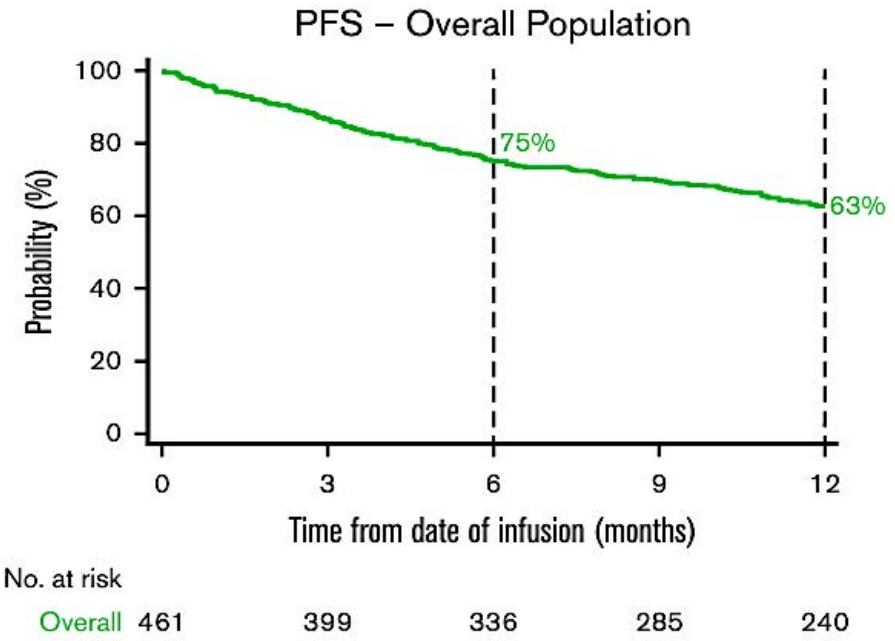
Wang, et al. NEJM 2020; Wang, et al. Proc ASH 2024; Munoz, et al. J Hematology & Oncology 2026

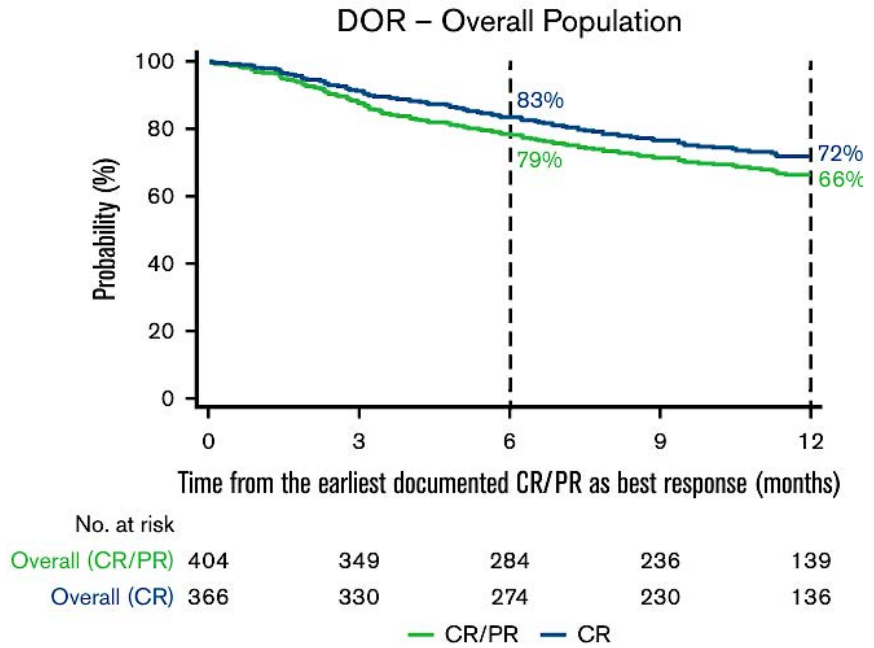
Real world evidence for Brexu-cel in MCL from CIBMTR

Characteristics	n = 476
Median age	67 (34-85)
TP53 mutated	19%
KI67 ≥ 30%	68%
Median no. of prior treatments	4 (1-12)
Prior BTKi	88%
Prior ASCT	30%

Endpoint	
ORR	91%
CRR	82%
12m DOR	79%

Toxicity	
Any-grade CRS	89%
Grade ≥ 3 CRS	11%
Any-grade ICANS	62%
Grade ≥ 3 ICANS	30%
12m NRM	8%



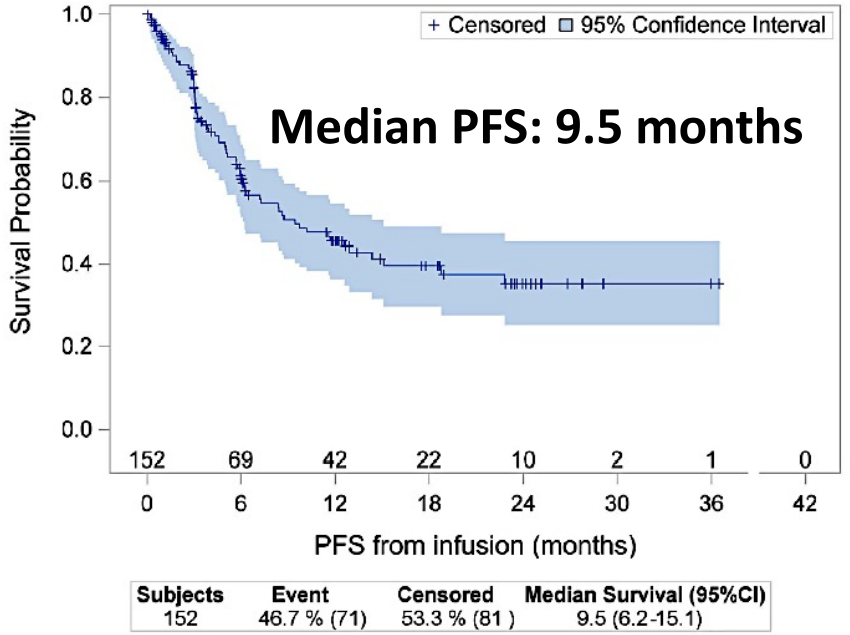


Ahmed, at al. Blood Adv 2024

Real world evidence for Brexu-cel in MCL from DESCAR-T

Characteristics	n = 152 (of 178)
Median age	69 (39-83)
TP53 mutated	30%
KI67 ≥ 30%	79%
Median no. of prior treatments	3 (1-9)
Prior BTKi	100%
Prior ASCT	40%

Endpoint	
ORR	85%
CRR	72%



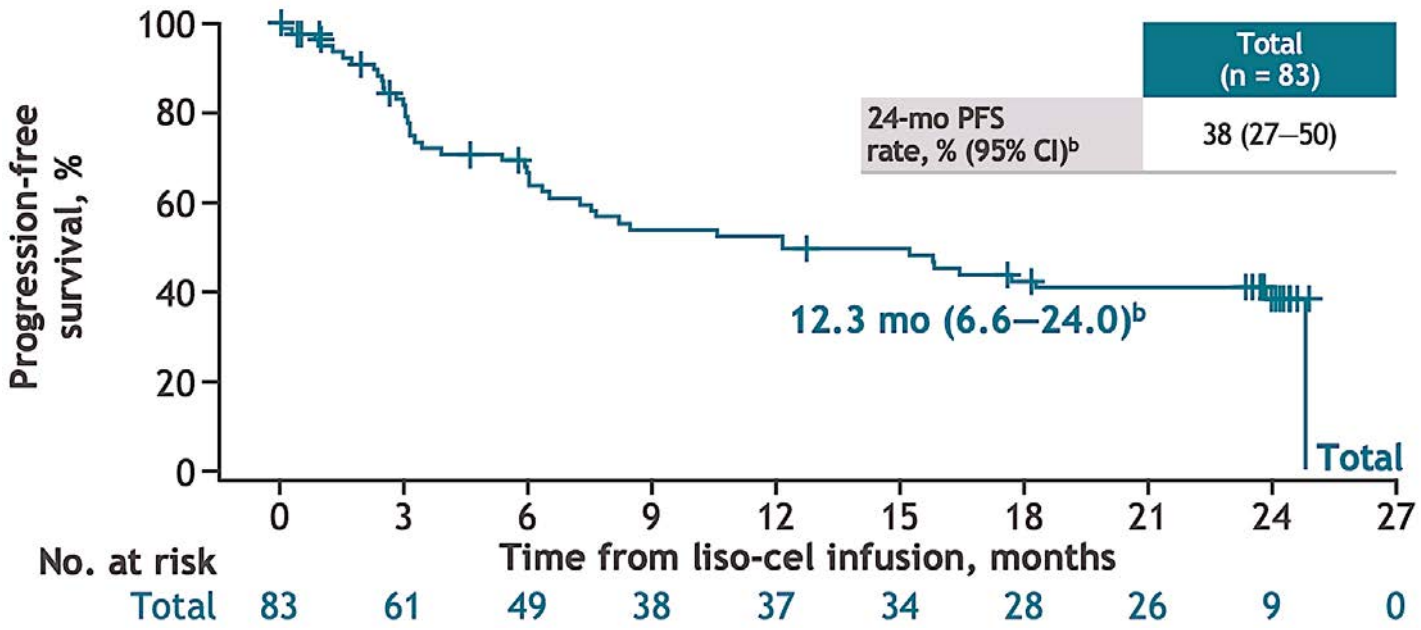
Toxicity	
Any-grade CRS	88%
Grade ≥ 3 CRS	12%
Any-grade ICANS	55%
Grade ≥ 3 ICANS	15%
ICU	34%
NRM	11%

Herbaux, at al. Haematologica 2024

Liso-cel for 3L+ MCL post cBTK inhibition: TRANSCEND

Baseline Characteristics	
n	88
Median # prior lines	3 (1-11)
BTKI refractory	53%
TP53 mut	23%
Blastoid	31%

Endpoint	n=83
ORR	83%
CRR	72%
Median DOR	14.5 m
Median DOCR	15.7 m



Toxicity	
Any-grade CRS	61%
Grade ≥ 3 CRS	1%
Any-grade ICANS	31%
Grade ≥ 3 ICANS	9%
ICU	6%

Wang, et al. JCO 2023.; Wang M, et al. ASTCT 2025. Abstract 240.

Discussion Questions

68 y/o man with Stage IV FL, grade 2, FLIPI 4 with widespread LAN and bone marrow involvement without B symptoms, ECOG 1
PMH: HTN, type 2 diabetes, AMI with preserved EF
BR as initial therapy with partial response; progression at 18 months
R^2 with CR; progression 14 months later with axillary and inguinal LAN and cytopenias
Obinutuzumab + chemo with PR; progression after 9 months

In FL, are you typically using CAR-T or bispecific antibodies first? What would you recommend for this patient?

Given this patient has already received R^2, is there any role for bispecific combinations?

Discussion Questions

59 y/o man with FL
R-CHOP followed by R maintenance as initial therapy
Epcoritamab + R^2 as second-line therapy; currently in remission

At disease progression, what would you offer as third-line therapy? Would the length of remission influence your decision-making in any way?

Discussion Questions

70 y/o man, a retired physician, with extensive, symptomatic MCL
BR as initial therapy with response; progression within 2 years
Ibrutinib with response but now with extensive, symptomatic GI and nodal progression

What therapy would you use next? If CAR-T, would you have a preference for one platform versus the others?

For patients with MCL going to CAR-T, what bridging therapy, if any, do you typically employ?

How, if at all, does the recent approval of sonrotoclax impact your sequencing of therapy for MCL?

Is there any role for bispecifics in MCL at the current time?

RTP
RESEARCH
TO PRACTICE

Agenda

Module 1: Chimeric Antigen Receptor (CAR) T-Cell Therapy for Diffuse Large B-Cell Lymphoma (DLBCL) — Dr Kamdar

Module 2: Bispecific Antibody Therapy for DLBCL — Dr Westin

Module 3: CAR T-Cell Therapy for Other Lymphoma Subtypes — Dr Abramson

Module 4: Bispecific Antibody Therapy for Follicular Lymphoma and Other Lymphoma Subtypes — Dr Phillips

Module 5: Tolerability Considerations with CAR T-Cell Therapy and Bispecific Antibodies — Dr Brody

Tycel Phillips, MD

Associate Professor

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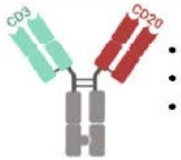
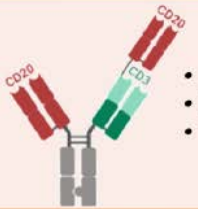
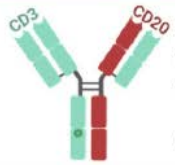
Evolving Role of Bispecific Antibodies in Low and Intermediate Grade Lymphoma

Follicular Lymphoma

- R/R FL has ur… …n the approval of se…
  - CAR-T
    - Approval …
  - Small Molec…
    - Zanubrutin…
      - Rose… (MAH…
    - Tazemeto…
      - RIP

Bispecific Antibodies

Bi-Specific Antibody	Targets	Design	Ig Fragment Formats	Ref.
mosunetuzumab	CD20 x CD3		• humanized mouse heterodimeric IgG1-based antibody • monovalent CD20 and monovalent CD3ε binding • modified Fc devoid of FcγR and complement binding	4
glofitamab	$(CD20)_2$ x CD3		• humanized mouse IgG1-based antibody • bivalent CD20 and monovalent CD3ε binding • modified Fc devoid of FcγR and complement binding	5
odronextamab	CD20 x CD3		• fully human IgG4-based heterodimeric antibody • monovalent CD20 and monovalent CD3ε binding • Fc-dependent effector function-minimized antibody with Fc of the anti-CD3ε heavy chain modified to reduce Protein A binding • common κ light chain from anti-CD3ε mAb	6
epcoritamab	CD20 x CD3		• humanized mouse IgG1-based heterodimeric antibody • monovalent CD20 and monovalent CD3 binding • IgG1 Fc modified to minimize Fc-dependent effector functions and to control Fab-arm exchange of mAb half-molecules, resulting in high bispecific product yield	7

Ig, immunoglobulin; scFv, single-chain variable fragment; mAb, monoclonal antibody; Fc, fragment crystallizable; FcγR, Fc gamma receptor

[1]Dufner V, *et al*. Blood Adv (2019) 3:2491; [2]Goebeler ME, *et al*. J Clin Oncol (2016) 34:1104; [3]Viardot *et al*. Blood (2016) 127(11):1410; [4]Schuster SJ, *et al*. ASH 2019, Plenary Abstract 6; [5]Hutchings M, *et al*. ASH 2020, Abstract 403; [6]Bannerji R, *et al*. ASH 2020, Abstract 400; [7]Hutchings M, *et al*. ASH 2020, Abstract 406

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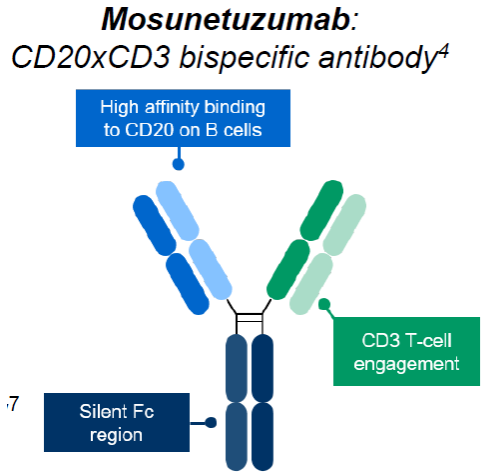
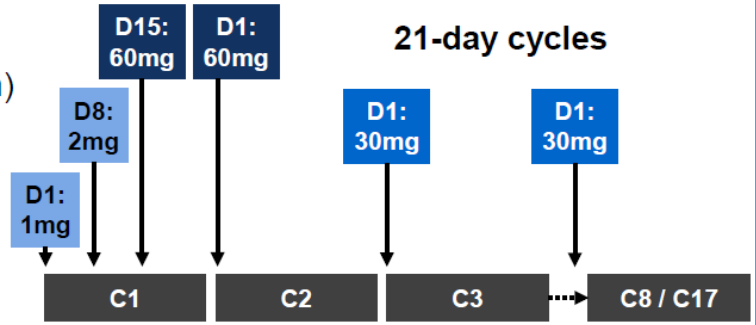
Mosunetuzumab



Mosunetuzumab administration

- Q3W intravenous administration
- C1 step-up dosing (CRS mitigation)
- **Fixed-duration treatment**
  - 8 cycles if CR after C8
  - 17 cycles if PR/SD after C8
- **No mandatory hospitalization**



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

SQ dosing 5 mg (C1D1), 45 mg (C1D8), 45 mg C1D15 until EOT

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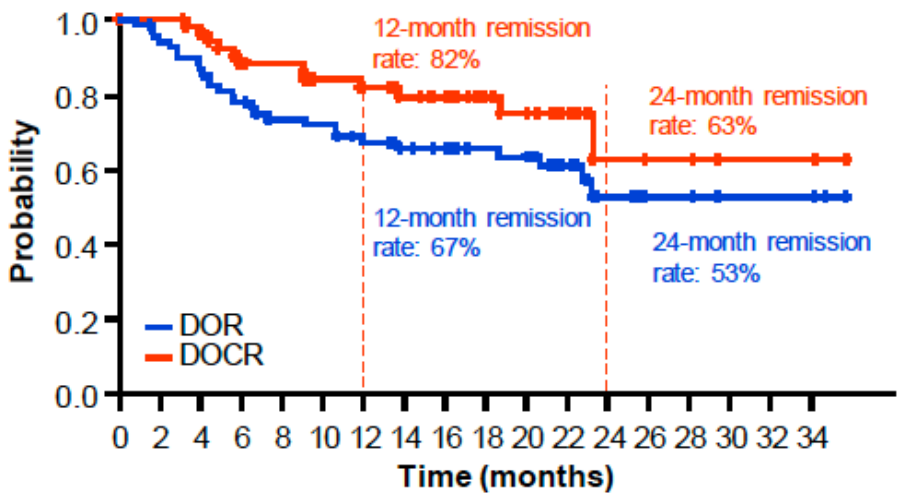
Mosunetuzumab Response (FL)

Durability of responses

Efficacy endpoint by investigator assessment	N=90
Median DOR, months (range), n=70	NR (21–NR)
24-month DOR (95% CI)	53% (38–68)
Median DOCR, months (range), n=54	NR (23–NR)
24-month DOCR (95% CI)	63% (38–88)
Median PFS, months (range)	24 (12–NR)
24-month PFS (95% CI)	48% (36–60)
Median TTNT, months (range)	NR (18–NR)
24-month TTNT (95% CI)	56% (45–67)
Median OS, months (range)	NR (NR–NR)
24-month OS (95% CI)	87% (80–94)

DOR and DOCR



Durable responses: majority of patients in remission after 2 years

DOCR, duration of complete response; TTNT, time-to-next therapy.

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

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Mosunetuzumab Safety (FL)

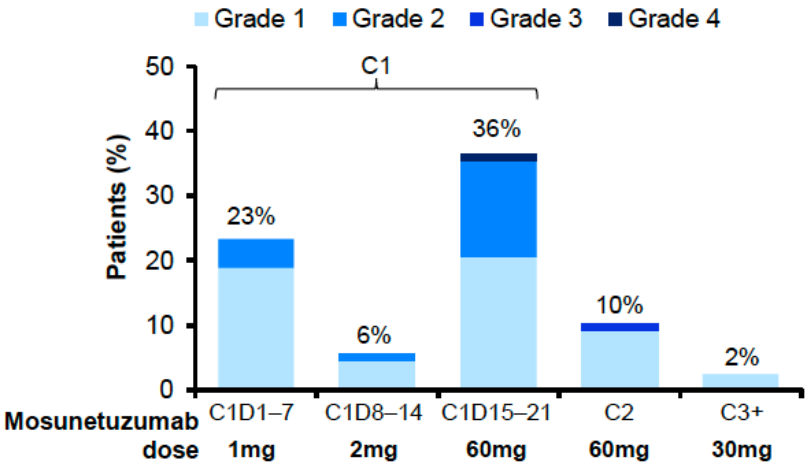
Safety profile

Adverse events (AEs)	N=90
AE	100%
Mosunetuzumab related	92%
Grade 3/4 AE	70%
Mosunetuzumab related	51%
Serious AE	47%
Mosunetuzumab related	33%
Grade 5 (fatal) AE	2%*
Mosunetuzumab related	0
AE leading to treatment discontinuation	4%†
Mosunetuzumab related	2%

CRS summary

CRS by ASTCT criteria[1]	N=90
CRS (any grade)	44%
Grade 1	26%
Grade 2	17%
Grade 3	1%
Grade 4	1%
Median time to CRS onset, hours (range)	
C1D1	5.2 (1.2–24)
C1D15	27 (0.1–391)
Median CRS duration, days (range)	3 (1–29)
Corticosteroids for CRS management	11%
Tocilizumab for CRS management	8%
Events resolved	100%

CRS by cycle and grade



CRS was predominantly low grade and during Cycle 1
All CRS events resolved; no new events were reported with 10 months of additional follow-up

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

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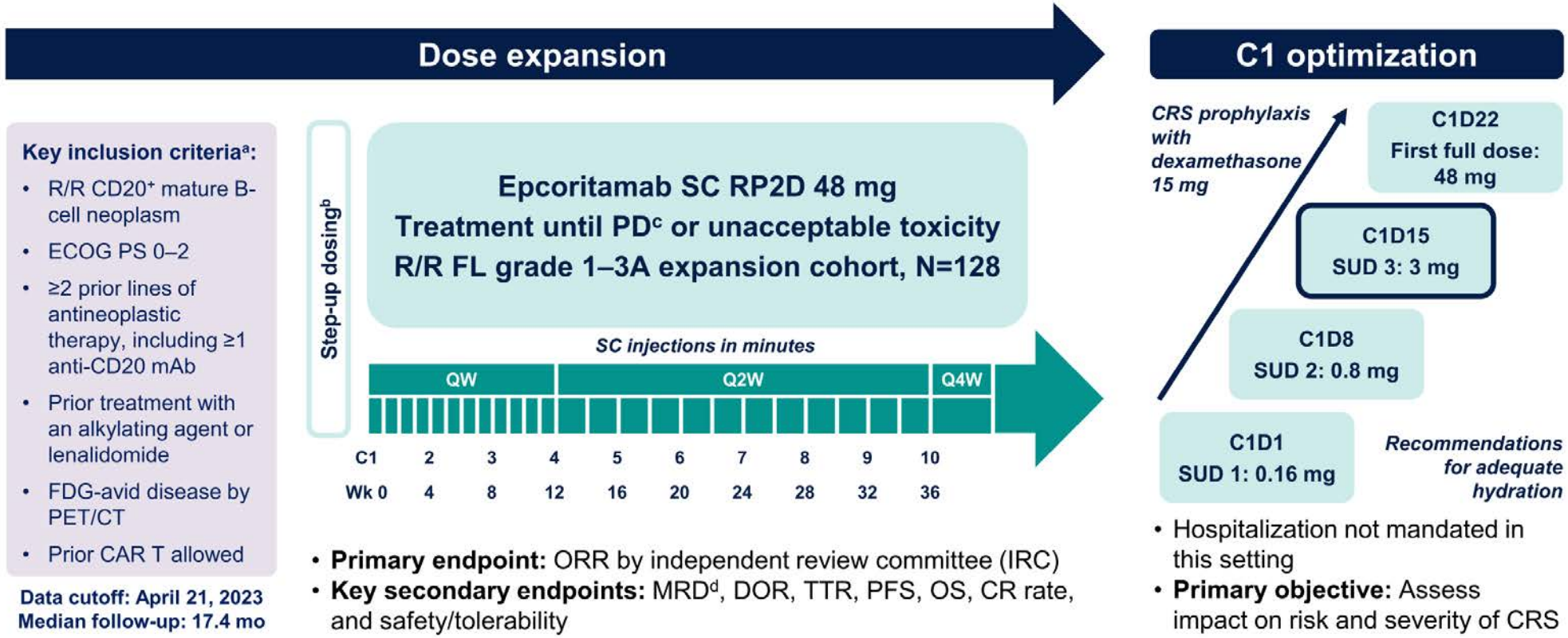
Epcoritamab

Trial Design: Pivotal EPCORE™ NHL-1 Study



Phase 1/2 trial. [a]Patients enrolled in this trial (and excluded from trials of other T-cell–engaging therapies) included those with worse anemia, lymphopenia, and/or renal function. [b]Step-up dosing (SUD; priming [SUD 1] 0.16 mg and intermediate [SUD 2] 0.8 mg dosing before first full dose) and corticosteroid prophylaxis were used to mitigate CRS. [c]≥2 measurable (by CT/MRI) and FDG PET–positive lesions; radiographic disease evaluation was performed every 6 wk for the first 24 wk (6, 12, 18, and 24 wk), then every 12 wk (36 and 48 wk), and every 6 mo thereafter. [d]MRD was assessed in peripheral blood using the clonoSEQ® (Adaptive Biotechnologies, Seattle, WA) next-generation sequencing assay. ClinicalTrials.gov: NCT03625037; EudraCT: 2017-001748-36.

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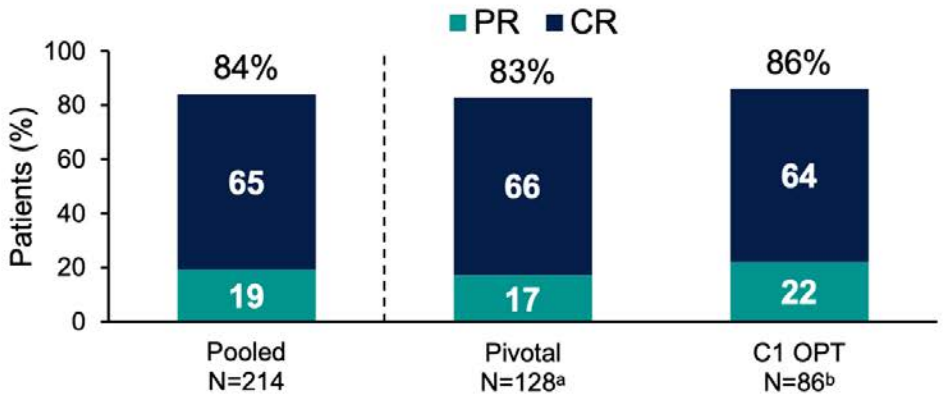
Epcoritamab Response (R/R FL)

Epcoritamab in R/R FL

High Rates of Complete Response and MRD Negativity



MRD-Negativity Rate	n (%)
Pooled (n=135)	89 (66)
Pivotal (n=91)	61 (67)
C1 OPT (n=44)	28 (64)

Based on MRD-evaluable population per clonoSEQ® PBMC assay with 10^{-6} cutoff.

- At 6 mo in C1 OPT, an estimated 86% of patients with CR remained in CR
- No impact on time to response in C1 OPT
  - Median time to response was 1.4 mo in both cohorts[c]
  - Median time to complete response was 1.5 mo in both cohorts[d]

CR was complete metabolic response (ie, PET negativity). CR, complete response; PBMC, peripheral blood mononuclear cell; PR, partial response. [a]Three patients (2%) were not evaluable. [b]Five patients (6%) were not evaluable. [c]Range: 1.2–4.4 in C1 OPT, 1.0–3.0 in pivotal. [d]Range: 1.2–4.7 in C1 OPT, 1.2–11.1 in pivotal.

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Epcoritamab Safety (R/R FL)

C1 Optimization Reduced Risk and Severity of CRS

	Pivotal Cohort N=128	C1 Optimization Cohort[a] N=50
CRS, n (%)[b]	85 (66)	24 (48)
Grade 1	51 (40)	20 (40)
Grade 2	32 (25)	4 (8)
Grade 3	2 (2)	0
Treated with tocilizumab, n/n (%)	31/85 (36)	6/24 (25)
Leading to epcoritamab discontinuation, n (%)	**0**	**0**
CRS resolution, n/n (%)	**85/85 (100)**	**24/24 (100)**
Median time to resolution, d (range)	2 (1–54)	3 (1–14)

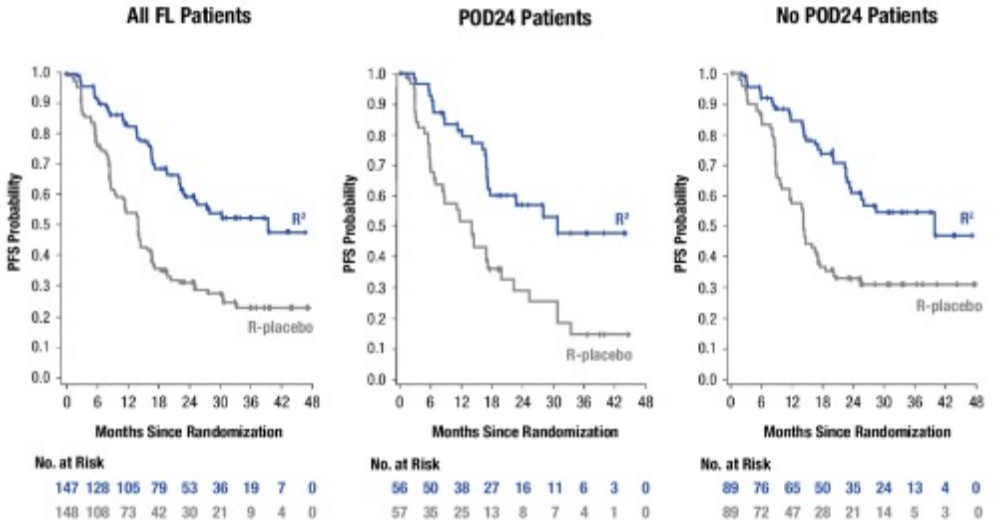
- Patient baseline characteristics were consistent between cohorts
- C1 optimization substantially reduced rate and severity of CRS
- In both cohorts, CRS was mostly confined to C1
- Similar response rates were observed in the C1 optimization cohort
- There were no cases of ICANS in the C1 optimization cohort; 8 cases were observed in the pivotal cohort (all grade 1–2 and resolved; none led to discontinuation)

[a]Data cutoff: September 21, 2023. Median follow-up: 3.8 mo (range, 1.9–8.7). [b]Graded by Lee et al 2019 criteria.[1] **1.** Lee DW, et al. *Biol Blood Marrow Transplant*. 2019;25:625-38.

➢ Linton et al. ASH 2023

2L FL: AUGMENT

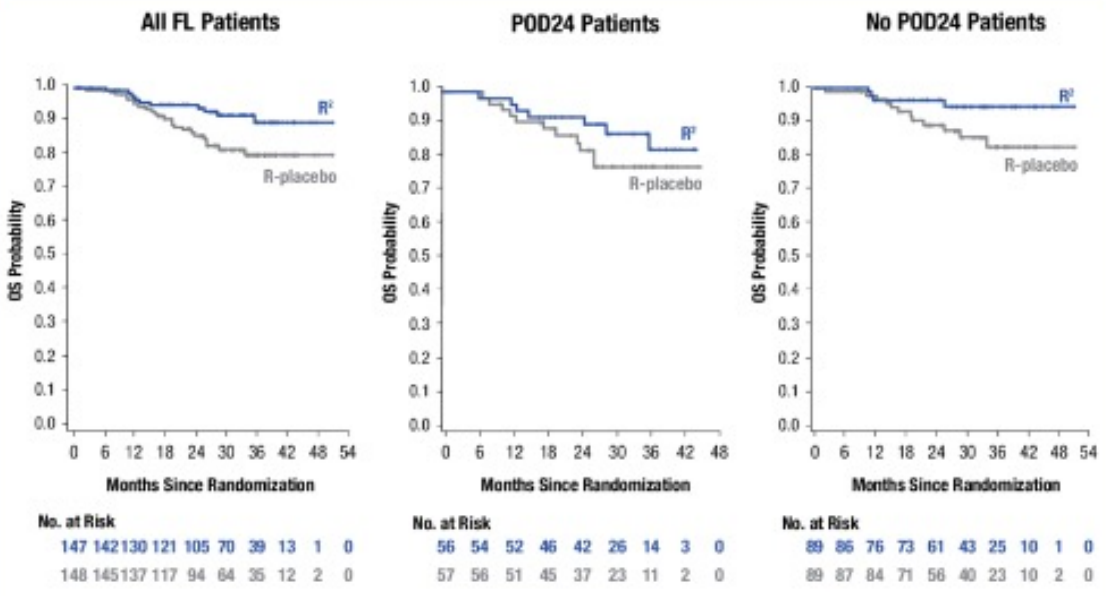
Figure 2. AUGMENT: Progression-Free Survival for All FL Patients and by POD24 Status (ITT)



Median PFS, mo (95% CI) *(n R²/n R-placebo)*	All FL Patients *(n = 147/148)*	POD24 *(n = 56/57)*	No POD24 *(n = 89/89)*
R²	39.4 (23.1-NR)	30.4 (16.8-NR)	39.4 (22.9-NR)
R-placebo	13.9 (11.2-16.0)	13.8 (6.7-16.9)	13.9 (11.2-16.6)
HR (95% CI)	0.40 (0.29-0.56)	0.41 (0.24-0.68)	0.43 (0.28-0.65)
P value	< 0.0001	0.0004	< 0.0001

Data cutoff June 22, 2018. PFS, progression-free survival. Note: Censoring rules were based on FDA guidance.

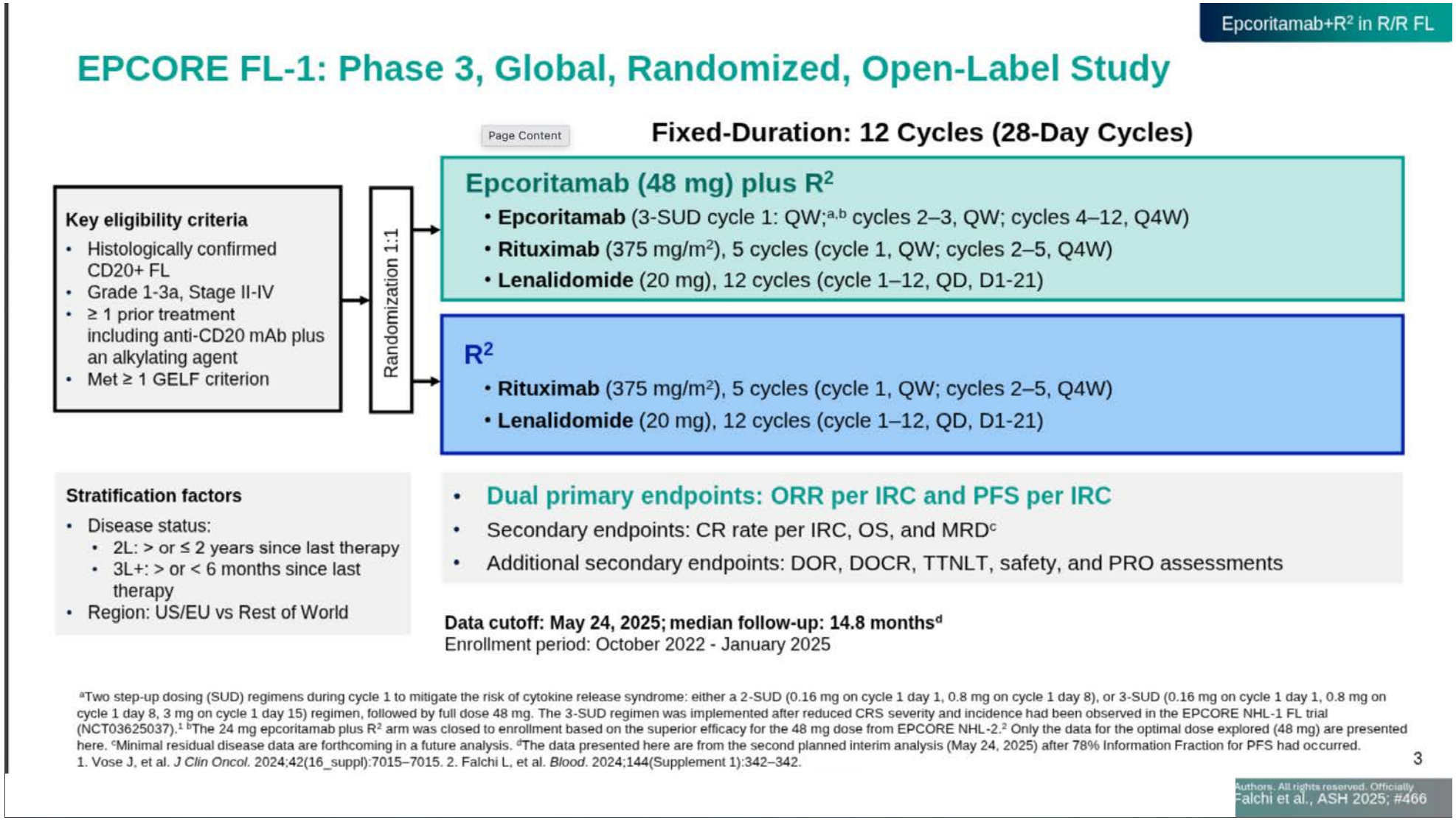
Figure 4. AUGMENT: Overall Survival for All FL Patients and by POD24 Status



Data cutoff June 22, 2018. OS, overall survival.

- At a median follow-up of 28.6 mo (range, 0.5-50.9), OS was not reached in all patients or according to POD24 status (**Figure 4**)

EPCORE FL-1



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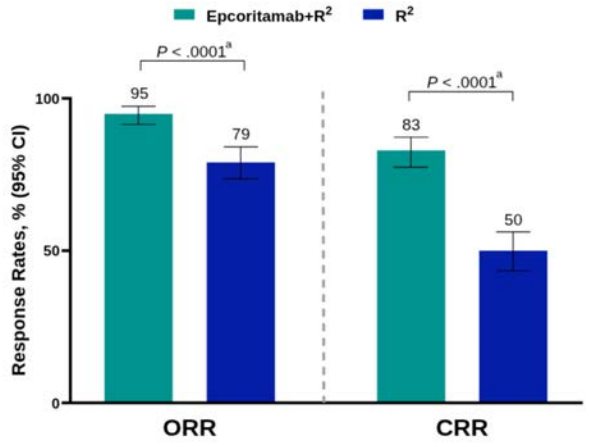
EPCORE FL-1: Response

Epcoritamab+R² in R/R FL

Epcoritamab+R² Resulted in Higher Response Rates Versus R²



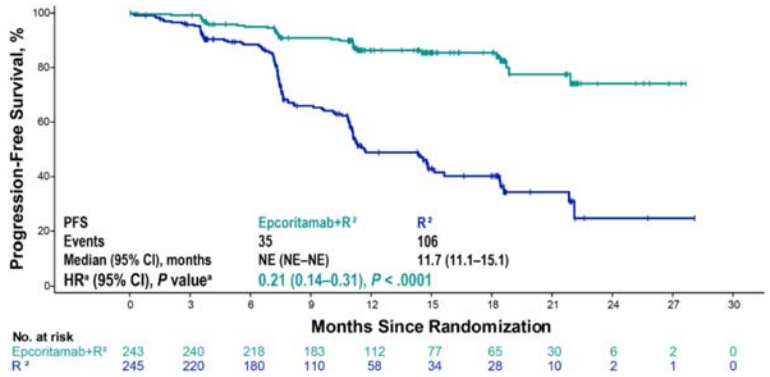
	Epcoritamab+R² (N = 243)	R² (N = 245)
ORR, n (%)	231 (95)	194 (79)
CRR, n (%)	201 (83)	122 (50)
PR, n (%)	30 (12)	72 (29)
SD, n (%)	1 (< 1)	17 (7)
PD, n (%)	7 (3)	16 (7)
NE,[b] n (%)	4 (2)	18 (7)

The first planned interim analysis (January 10, 2025) achieved statistical significance for ORR (N = 232; 95.7% vs 81.0%; $P < 0.0001$, with a 1-sided significance level of 0.005) and CR (74.5% vs 43.3%; $P < 0.0001$, with a 1-sided significance level of 0.025).
[a]Nominal P value by stratified Cochran-Mantel-Haenszel method. [b]Patients with no post-baseline disease assessment were also included.

9

Epcoritamab+R² in R/R FL

Epcoritamab+R² Resulted in Superior PFS per IRC With 79% Risk Reduction



- Concordance rate was 94% for PFS between IRC and investigator assessment
- The estimated 16-month PFS was 85.5% (95% CI: 79.7, 89.7) for epcoritamab+R² and 40.2% (95% CI: 31.8, 48.4) for R²

Median follow-up for PFS: epcoritamab+R² (14.4m), R² (11.5m). The first planned interim analysis (January 10, 2025) achieved statistical significance on PFS, HR 0.21 (95% CI 0.13, 0.33) $P < 0.0001$, with a 1-sided significance level of 0.0023.
[a]Nominal P value is based on stratified log-rank test. Hazard ratio is estimated using stratified Cox proportional hazards model. This analysis was performed on the 78% information fraction.

7

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EPCORE FL-1: Safety

Epcoritamab+R² in R/R FL

Manageable AEs With No New Safety Signals

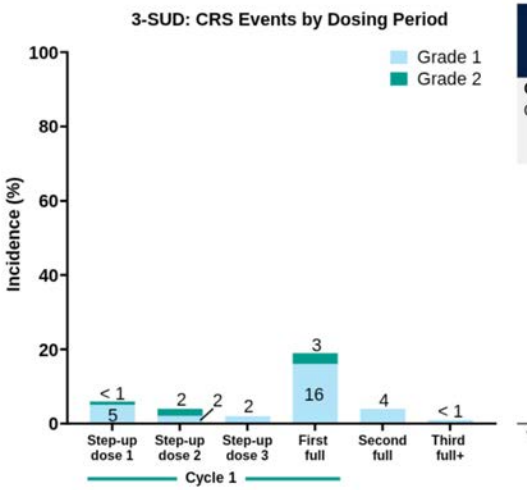
Adverse Event, n (%)	Epcoritamab+R² (N = 243) Any Grade	Epcoritamab+R² (N = 243) Grade ≥ 3	R² (N = 238) Any Grade	R² (N = 238) Grade ≥ 3
Any adverse event	242 (100)	219 (90)	235 (99)	161 (68)
Serious adverse event	135 (56)	-	69 (29)	-
Adverse event leading to treatment discontinuation	46 (19)	-	29 (12)	-
Epcoritamab	21 (9)	-	-	-
Rituximab	7 (3)	-	12 (5)	-
Lenalidomide	45 (19)	-	29 (12)	-
Adverse event of clinical interest > 20%[a,b]				
Infections[c]	188 (77)	81 (33)	125 (53)	37 (16)
Neutropenia	180 (74)	167 (69)	123 (52)	100 (42)
Cytokine release syndrome	85 (35)	-	1 (< 1)	-
Anemia	68 (28)	19 (8)	41 (17)	11 (5)
Thrombocytopenia	67 (28)	23 (9)	44 (18)	15 (6)
Pyrexia	58 (24)	1 (< 1)	33 (14)	3 (1)
Rash	58 (24)	19 (8)	53 (22)	9 (4)
COVID-19	54 (22)	7 (3)	32 (13)	4 (2)

- Neutropenia was manageable and few patients discontinued any study drug (epcoritamab+R², 3%; R², 2%)
  - Incidence of febrile neutropenia: epcoritamab+R², 6%; R², 3%
- Infections were manageable and few patients discontinued any study drug (epcoritamab+R², 6%; R², 1%)
- Fatal adverse events were rare (epcoritamab+R², 2%; R², 4%)
- Despite higher rates of AEs in the epcoritamab+R² arm, most patients completed the prescribed regimen (median relative dose intensity ≥ 90% for epcoritamab+R²)

[a]Neutropenia, anemia, pyrexia, rash and COVID-19 are grouped terms comprising multiple clinically related Preferred Terms. [b]This includes the AESI of CRS. [c]Events were in the MedDRA system organ class "Infections and Infestations." No grade 5 infections were reported.

Epcoritamab+R² in R/R FL

CRS Was Low-Grade and Predictable With Epcoritamab+R²



	Epcoritamab+R² 2-SUD N = 110	Epcoritamab+R² 3-SUD[a] N = 133
CRS, n (%)	50 (45)	35 (26)
CRS grade, n (%)		
1	40 (36)	28 (21)
2	10 (9)	7 (5)
CRS signs and symptoms, n (%)*		
Fever	49 (98)	33 (94)
Hypotension	9 (18)	6 (17)
Hypoxia	1 (2)	2 (6)
Time to first CRS onset from first full dose, days, median (range)	1 (< 1, 6)	1.5 (< 1, 10)
Time to CRS resolution, days, median (range)	1 (< 1, 12)	1 (< 1, 26)
CRS interventions, n (%)*		
Treated with tocilizumab	12 (24)	9 (26)
Treated with corticosteroid	23 (46)	13 (37)

*Of patients who had CRS

- Hydration and dexamethasone were utilized for CRS prophylaxis
- One event of ICANS was observed and was grade 1
- No discontinuations due to CRS and ICANS. All events resolved.
- No events of CTLS were reported

[a]The 3-SUD regimen was implemented based off the EPCORE NHL-1 FL trial (NCT03625037).[1]
[1]Vose J, et al. *J Clin Oncol* 2024; 42 (suppl 16): 7015.

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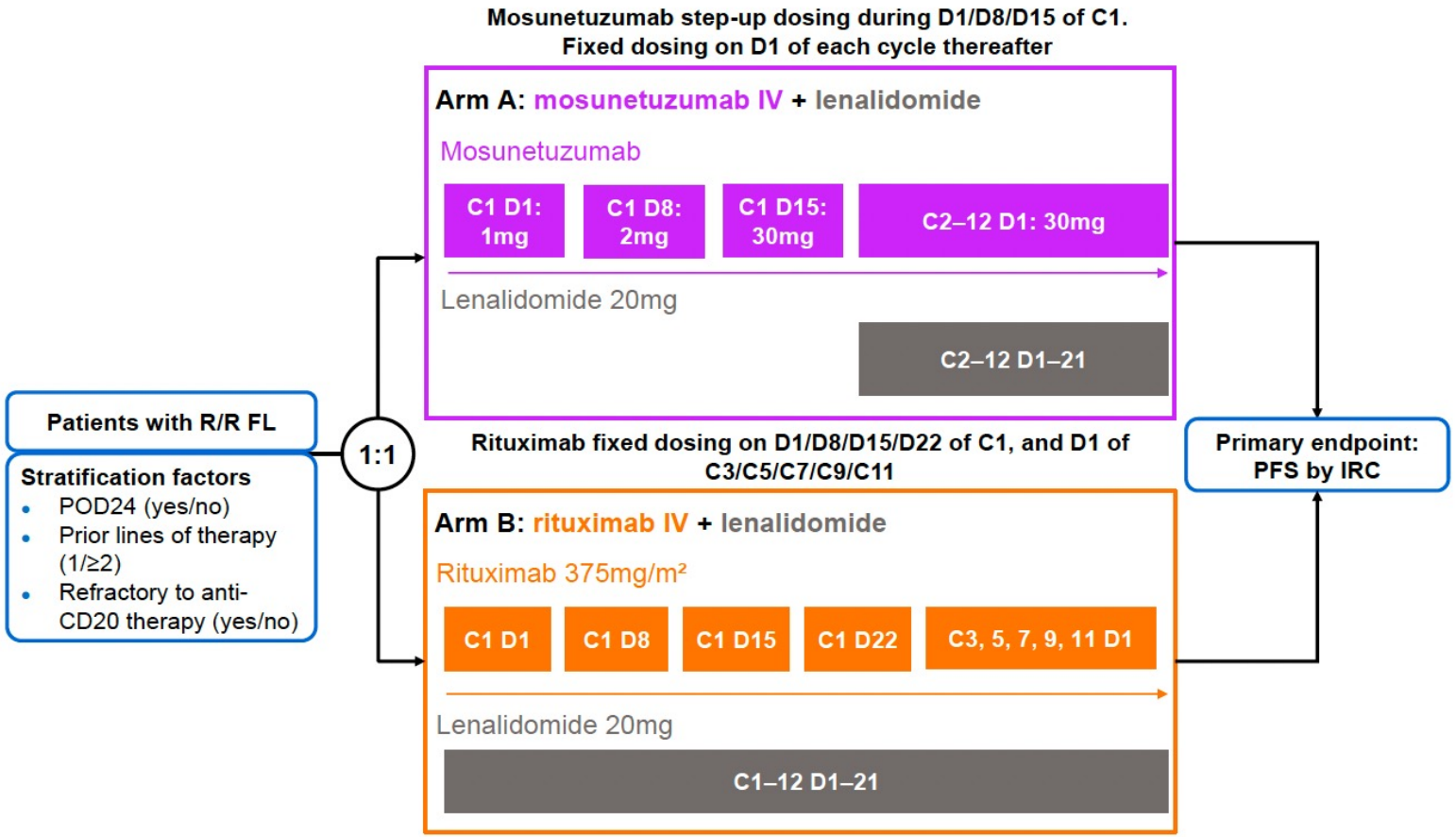
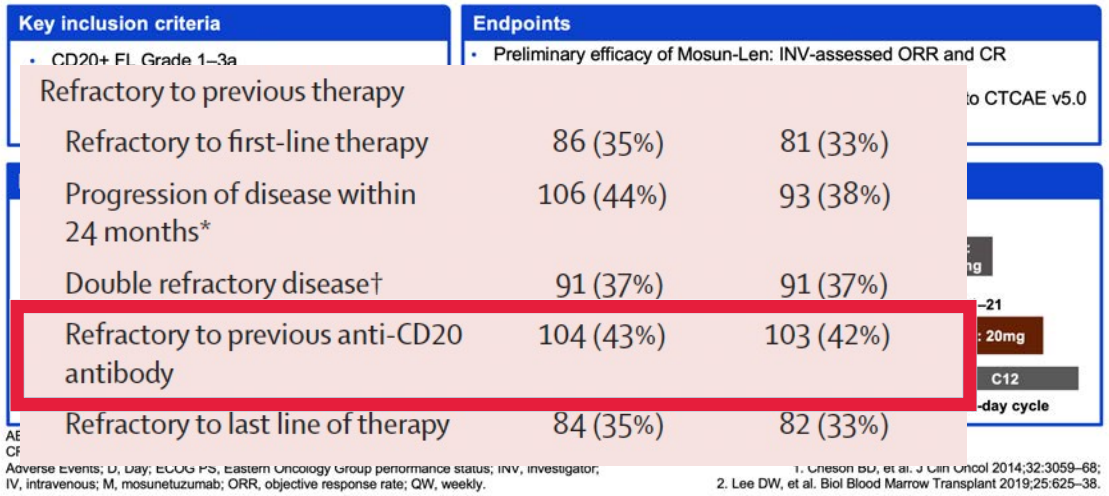
CELESTIMO Trial of Mosunetuzumab-Lenalidomide versus R^2 in R/R FL



C, cycle; D, Day; FL, follicular lymphoma; IRC, independent review committee; IV, intravenous; PFS, progression-free survival; POD24, progression of disease within 24 months of first-line chemoimmunotherapy; R/R, relapsed/refractory.

CELESTIMO US Cohort: Baseline Characteristics

Non-randomized single arm US extension of CELESTIMO



Refractory to previous therapy		
Refractory to first-line therapy	86 (35%)	81 (33%)
Progression of disease within 24 months*	106 (44%)	93 (38%)
Double refractory disease†	91 (37%)	91 (37%)
Refractory to previous anti-CD20 antibody	104 (43%)	103 (42%)
Refractory to last line of therapy	84 (35%)	82 (33%)

n (%)		2L+ FL US cohort (n=54)
FLIPI score	0/1 2 3 4 5	n=52† 13 (25.0) 18 (34.6) 17 (32.7) 3 (5.8) 1 (1.9)
FL grade	1/2 3a	n=47† 28 (59.6) 19 (40.4)
POD24	Yes	16 (29.6)
Number of prior lines of therapy	1 ≥2	30 (55.6) 24 (44.4)
Refractory to prior CD20 therapy	Yes	n=48† 19 (39.6)
Relapsed after prior CD20 therapy	Yes	n=48† 17 (35.4)
Double refractory	Yes	n=53† 9 (17.0)

CELESTIMO US Cohort: Safety/Response

Mosun-Len had manageable safety

n (%)	2L+ FL US cohort (n=54)
Any grade AE	54 (100)
Mosunetuzumab related	48 (88.9)
Lenalidomide related	50 (92.6)
AE leading to discontinuation of mosunetuzumab	6 (11.1)
AE leading to discontinuation of lenalidomide	10 (18.5)
Grade 3/4 AE	31 (57.4)
Grade 5*	1 (1.9)
Serious AE	15 (27.8)
Mosunetuzumab related	9 (16.7)
Lenalidomide related	4 (7.4)

n (%)	2L+ FL US cohort (n=54)
CRS by ASTCT grading	15 (27.8)
Grade 1	12 (22.2)
Grade 2	2 (3.7)
Grade 3	1 (1.9)
Infections†	31 (57.4)
Grade 1	2 (3.7)
Grade 2	24 (44.4)
Grade 3	3 (5.6)
Grade 4	1 (1.9)
Grade 5	1 (1.9)
Neutropenia/neutrophil count decreased	22 (40.7)
Grade 3/4	18 (33.3)
Febrile neutropenia (Grade 3)	2 (3.7)

CRS events were mainly low grade and all resolved
- Median duration of CRS: 4.0 days (range: 1.0–23.0)
- Median time to onset of first CRS event: 2.0 days (range: 1.0–27.0)

The most common AEs (any grade, by preferred term) were fatigue (57.4%), maculo-papular rash (42.6%), and constipation (42.6%)

Data cut-off: June 9, 2025. *Pneumonia, considered to be mosunetuzumab related. †The most common infections were: COVID-19, 20.4%; sinusitis, 18.5%; and upper respiratory tract infection, 16.7%; which were mainly Grade 2 (44.4%) in severity.

Mosun-Len achieved high response rates in patients with R/R FL

n (%)	2L+ FL US cohort (n=54)
ORR	52 (96.3)
CR	47 (87.0)
PR	5 (9.3)
Stable disease	0
Progressive disease	2 (3.7)

The **median duration of follow-up** was **12.7 months** (range: 5–20)

Data cut-off: June 9, 2025.
PR, partial response.

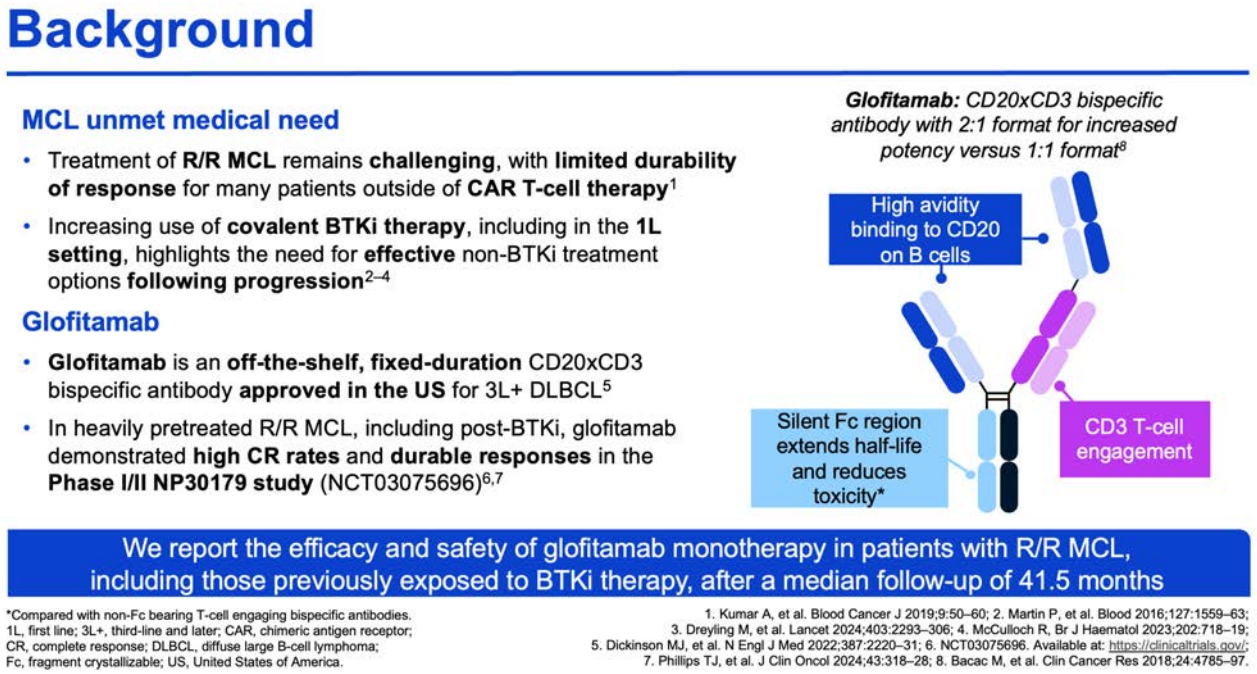
Ongoing Studies

Phase	Line	Drug	Comparator	Study	Primary Endpoint	Global	Sites
3	2L	Mosunetuzumab + lenalidomide	CIT	MorningLyte	PFS	N	France Germany Portugal Spain
3	1L	Mosunetuzumab	Rituximab	S2308	PFS	N	USA
3	1L	Odronextamab	CIT	OLYMPIA-1	CR30	Y	
3	2L	Odronextamab + R^2	R^2	OLYMPIA-5*	PFS	Y	
3	1L	Epcoritamab + R^2	CIT	EPCORE – FL -2	CR30 PFS	Y	
3	2L	Mosunetuzumab + lenalidomide	CIT or R^2	MARSUN	PFS	N	France Germany Portugal Belgium Italy

*includes MZL

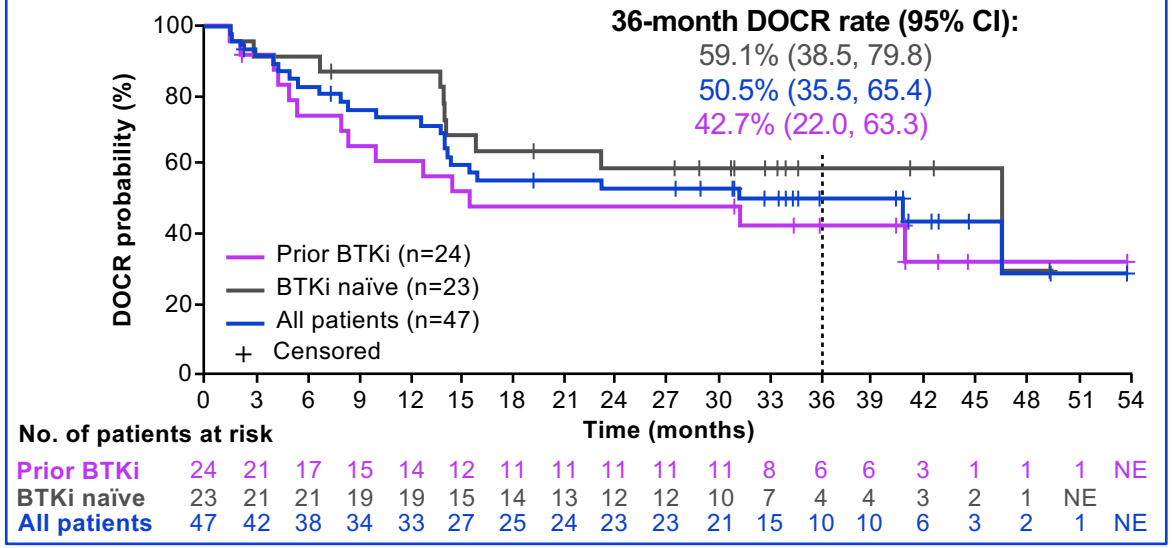
R/R MCL – Glofitamab updated data after a 3.5-year follow-up

- Remains a difficult space despite approval of
  - CAR-T (long term follow up w/ very few patients still in remission (cure unlikely).
  - Pirtobrutinb (likely best served as a bridge for most patients).
  - Sonrotoclax (response rates similar to pirto)
- As such other options are still needed.
  - Mosun/Pola – Impressive early response, and safety but lacks long term data to support durability



Duration of complete response

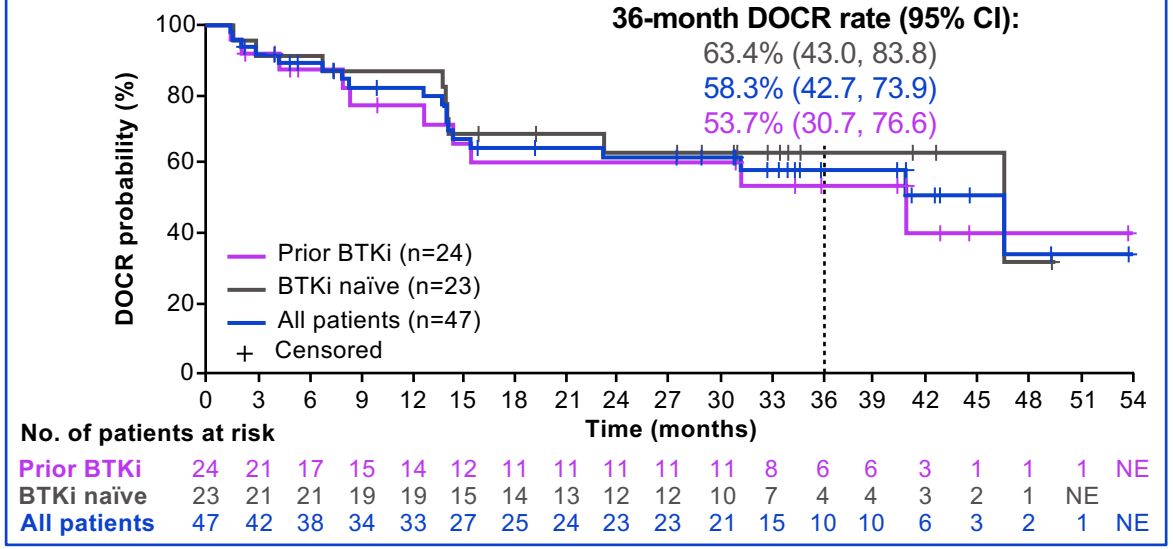
DOCR*†



No. of patients at risk

Prior BTKi	24	21	17	15	14	12	11	11	11	11	11	8	6	6	3	1	1	1	NE
BTKi naïve	23	21	21	19	19	15	14	13	12	12	10	7	4	4	3	2	1	NE	
All patients	47	42	38	34	33	27	25	24	23	23	21	15	10	10	6	3	2	1	NE

DOCR COVID-19 sensitivity*



No. of patients at risk

Prior BTKi	24	21	17	15	14	12	11	11	11	11	11	8	6	6	3	1	1	1	NE
BTKi naïve	23	21	21	19	19	15	14	13	12	12	10	7	4	4	3	2	1	NE	
All patients	47	42	38	34	33	27	25	24	23	23	21	15	10	10	6	3	2	1	NE

DOCR	Prior BTKi (n=24)	BTKi naive (n=23)	All patients (n=47)
Median DOCR, months (95% CI)	15.4 (8.3, NE)	46.5 (14.1, NE)	40.8 (14.1, NE)

DOCR	Prior BTKi (n=24)	BTKi naive (n=23)	All patients (n=47)
Median DOCR, months (95% CI)	40.8 (14.4, NE)	46.5 (14.1, NE)	46.5 (23.1, NE)

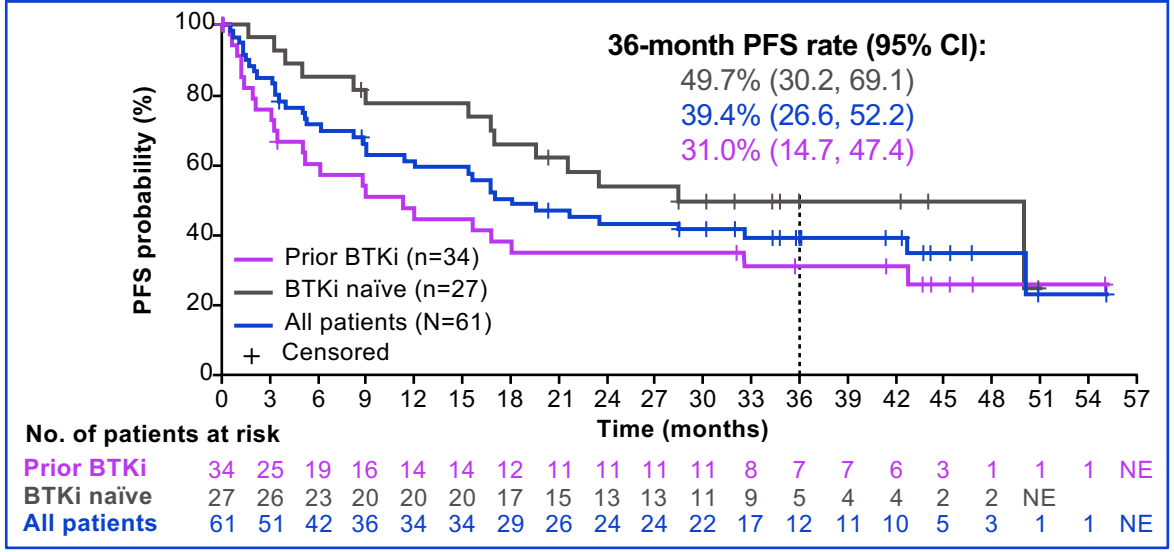
Fixed-duration glofitamab monotherapy achieved durable CRs in patients with prior BTKi and those who were BTKi naïve; COVID-19 censoring further extended the median DOCR

*INV-assessed. †Median DOCR follow-up was 34.6 months (range: 1–54) overall, and 40.3 months (range: 1–54) and 33.4 months (range: 2–49) in the prior-BTKi and BTKi-naïve cohorts, respectively.
CI, confidence interval; NE, not estimable.

Karimi et al. ASCO 2026

Progression-free survival

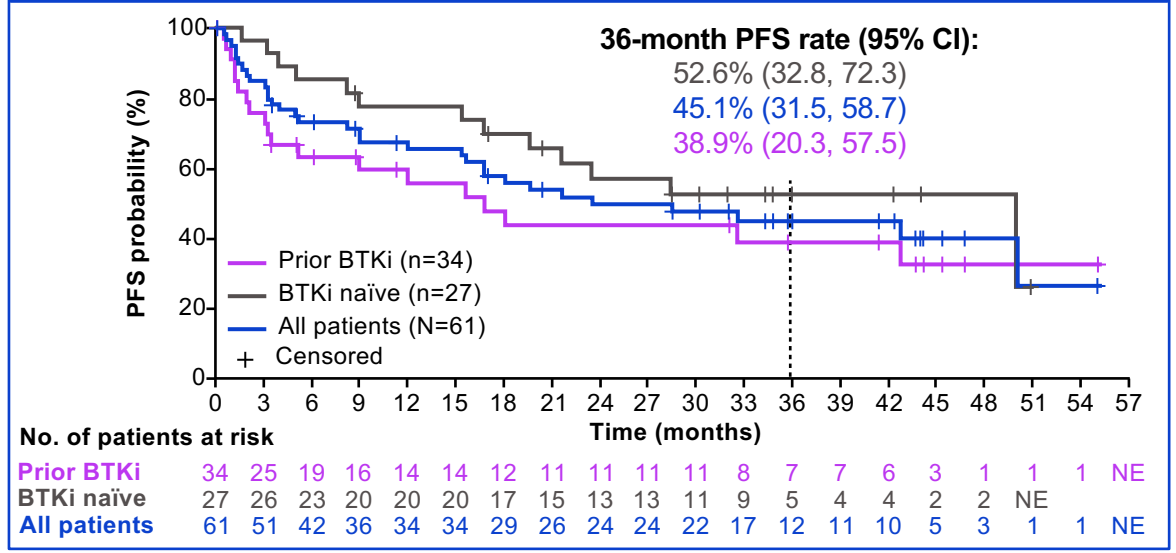
PFS*†



No. of patients at risk

Prior BTKi	34	25	19	16	14	14	12	11	11	11	11	8	7	7	6	3	1	1	1	NE
BTKi naïve	27	26	23	20	20	20	17	15	13	13	11	9	5	4	4	2	2	NE		
All patients	61	51	42	36	34	34	29	26	24	24	22	17	12	11	10	5	3	1	1	NE

PFS COVID-19 sensitivity*



No. of patients at risk

Prior BTKi	34	25	19	16	14	14	12	11	11	11	11	8	7	7	6	3	1	1	1	NE
BTKi naïve	27	26	23	20	20	20	17	15	13	13	11	9	5	4	4	2	2	NE		
All patients	61	51	42	36	34	34	29	26	24	24	22	17	12	11	10	5	3	1	1	NE

PFS	Prior BTKi (n=34)	BTKi naive (n=27)	All patients (N=61)
Median PFS, months (95% CI)	11.3 (5.1, 32.6)	28.5 (17.0, NE)	18.0 (11.3, 42.8)

PFS	Prior BTKi (n=34)	BTKi naive (n=27)	All patients (N=61)
Median PFS, months (95% CI)	16.8 (5.2, NE)	50.0 (19.6, NE)	23.5 (15.6, NE)

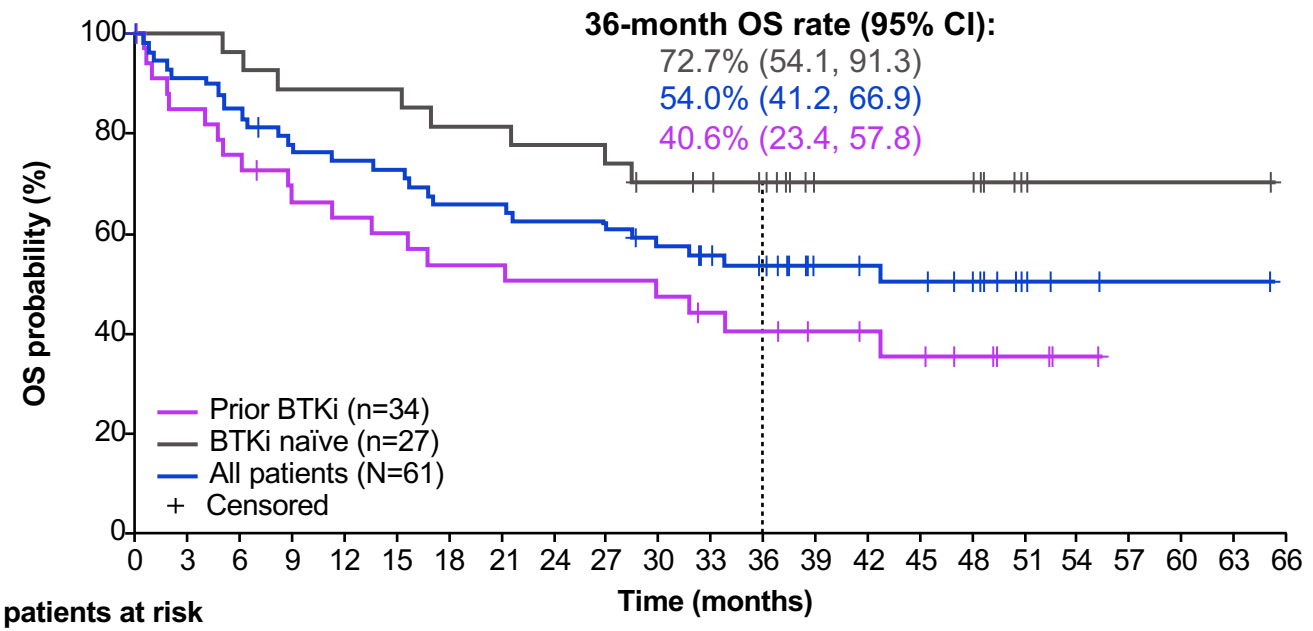
Clinically meaningful PFS was achieved with glofitamab monotherapy after 3.5 years of follow-up; COVID-19 censoring further extended the median PFS from 18.0 to 23.5 months

*INV-assessed. †Median PFS follow-up was 36.0 months (range: 0–55) overall, and 43.7 months (range: 0–55) and 35.9 months (range: 2–51) in the prior-BTKi and BTKi-naïve cohorts, respectively.

Karimi et al. ASCO 2026

Overall survival

OS*



No. of patients at risk

Prior BTKi	34	28	25	21	20	19	17	17	16	16	15	12	11	9	8	7	5	3	1	NE		
BTKi naïve	27	27	26	24	24	24	22	22	21	20	18	17	15	8	8	8	8	2	1	1	1	NE
All patients	61	55	51	45	44	43	39	39	37	36	33	29	26	17	16	15	13	5	2	1	1	NE

OS	Prior BTKi (n=34)	BTKi naive (n=27)	All patients (N=61)
Median OS, months (95% CI)	29.9 (11.3, NE)	NE (NE, NE)	NE (26.9, NE)

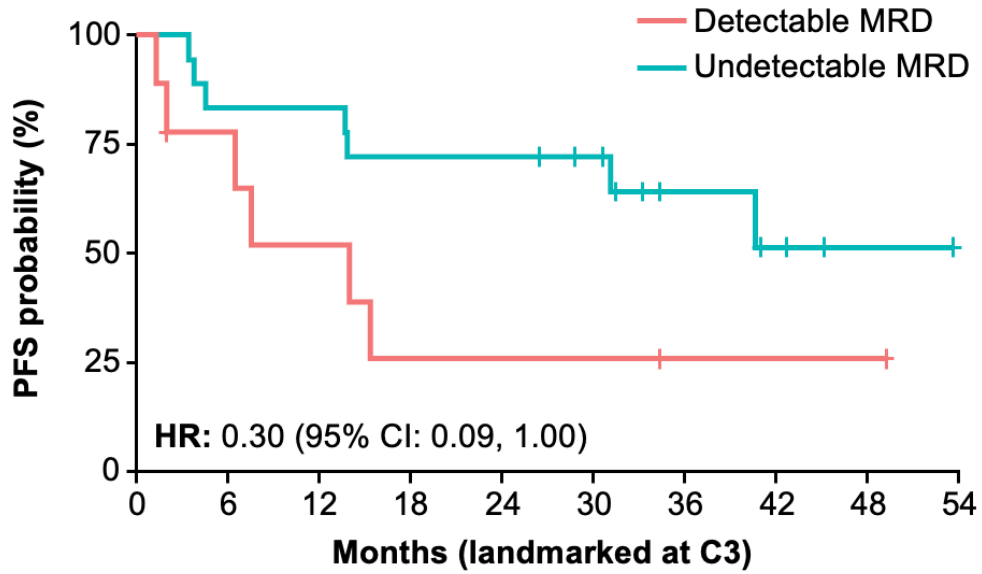
Durable OS was achieved with fixed-duration glofitamab monotherapy in patients with prior BTKi and those who were BTKi naïve

*Median OS follow-up was 41.5 months (range: 0–65) overall, and 45.4 months (range: 0–55) and 38.4 months (range: 5–65) in the prior-BTKi and BTKi-naïve cohorts, respectively; at the time of analysis, 22 patients had died, the majority due to progressive disease (n=7) or COVID-19 (n=7). All patients who died due to COVID-19 had achieved a CR, and six remained in remission at the time of death.

Karimi et al. ASCO 2026

Landmark analysis of PFS by MRD status

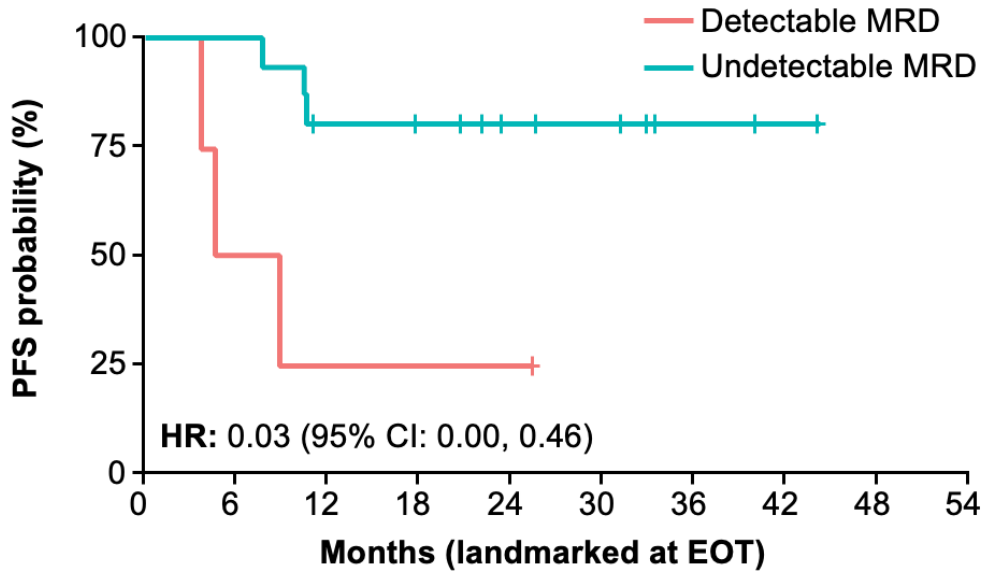
Patients with a CR at C3



No. of patients at risk

Detectable MRD	9	6	4	2	2	2	1	1	1	0
Undetectable MRD	18	15	15	13	13	11	5	3	1	0

Patients with a CR at EOT



No. of patients at risk

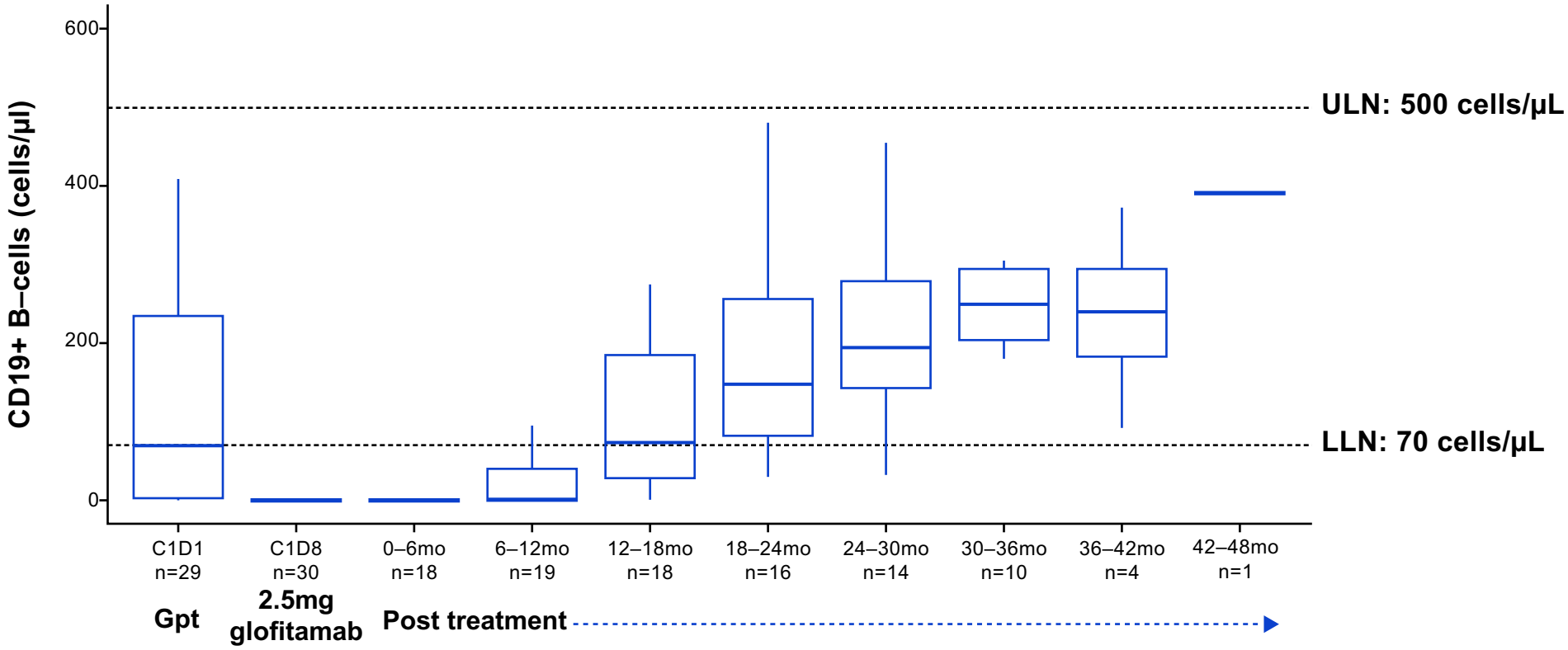
Detectable MRD	4	2	1	1	1	0	0	0	0	0
Undetectable MRD	15	15	11	11	8	6	2	1	0	0

The majority of patients with a CR with undetectable MRD at C3 (66.7%) and EOT (78.9%) achieved durable PFS

MRD performed using Clonoseq assay. HRs were calculated using Cox regression and adjusted for MIPI score (<6, ≥6) and age (≤65 vs >65 years).
HRs are calculated in a biomarker evaluable population and are exploratory in nature.
HR, hazard ratio; MRD, minimal residual disease; PET-CT, positron emission tomography-computed tomography.

Karimi et al. ASCO 2026

B-cell depletion and recovery

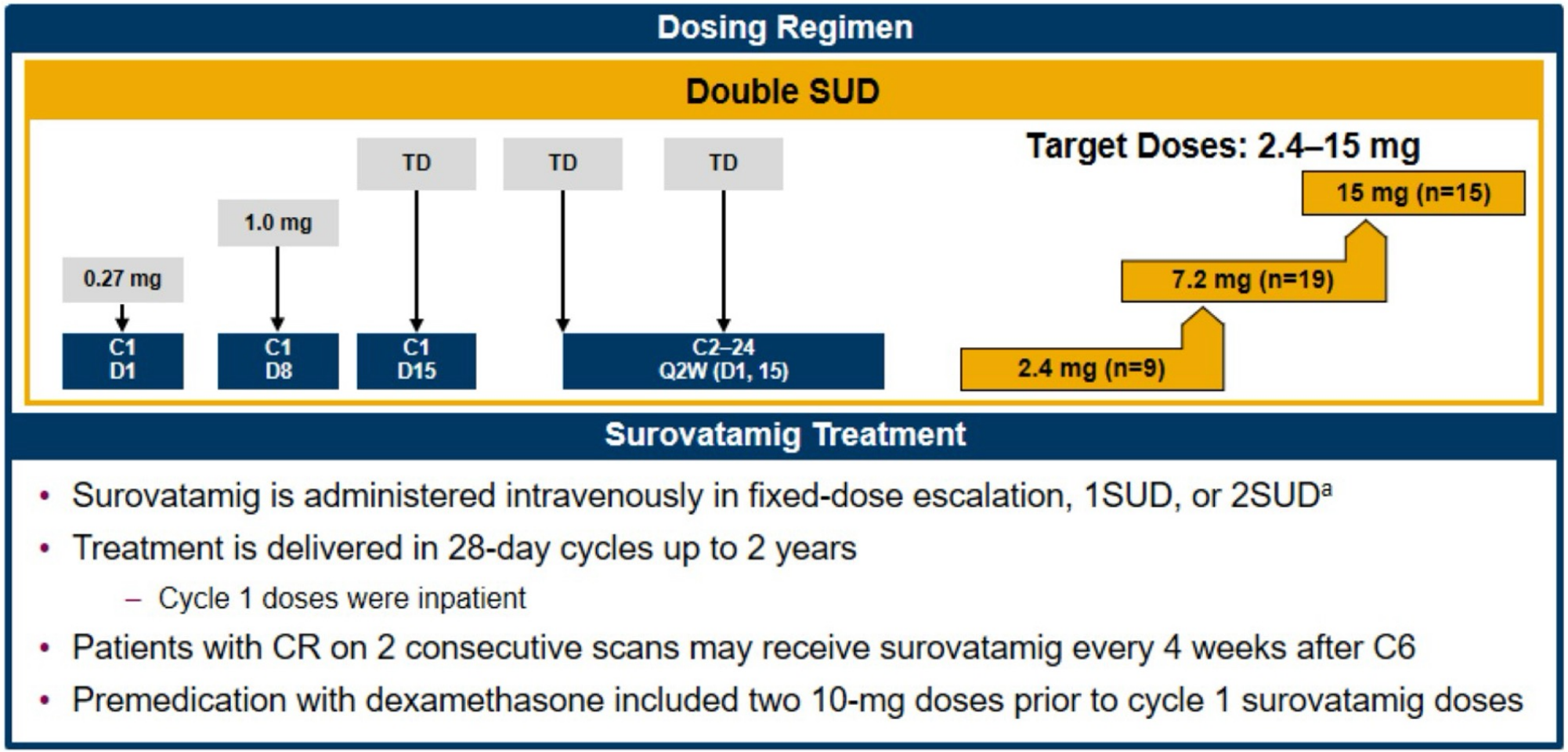


Peripheral B-cell depletion was rapid and sustained after treatment initiation. Recovery above the lower limit of normal was observed 12–18 months post EOT

Patients who completed 12 cycles of treatment and did not have progressive metabolic disease at EOT were included in this analysis. Samples occurring within 45 days of a progression event were excluded. Only serious infections were systematically collected beyond the 90-day AE reporting period.
LLN, lower limit of normal; mo, months; ULN, upper limit of normal.

Karimi et al. ASCO 2026

Surovatamig Phase I Study: FL Cohort



5

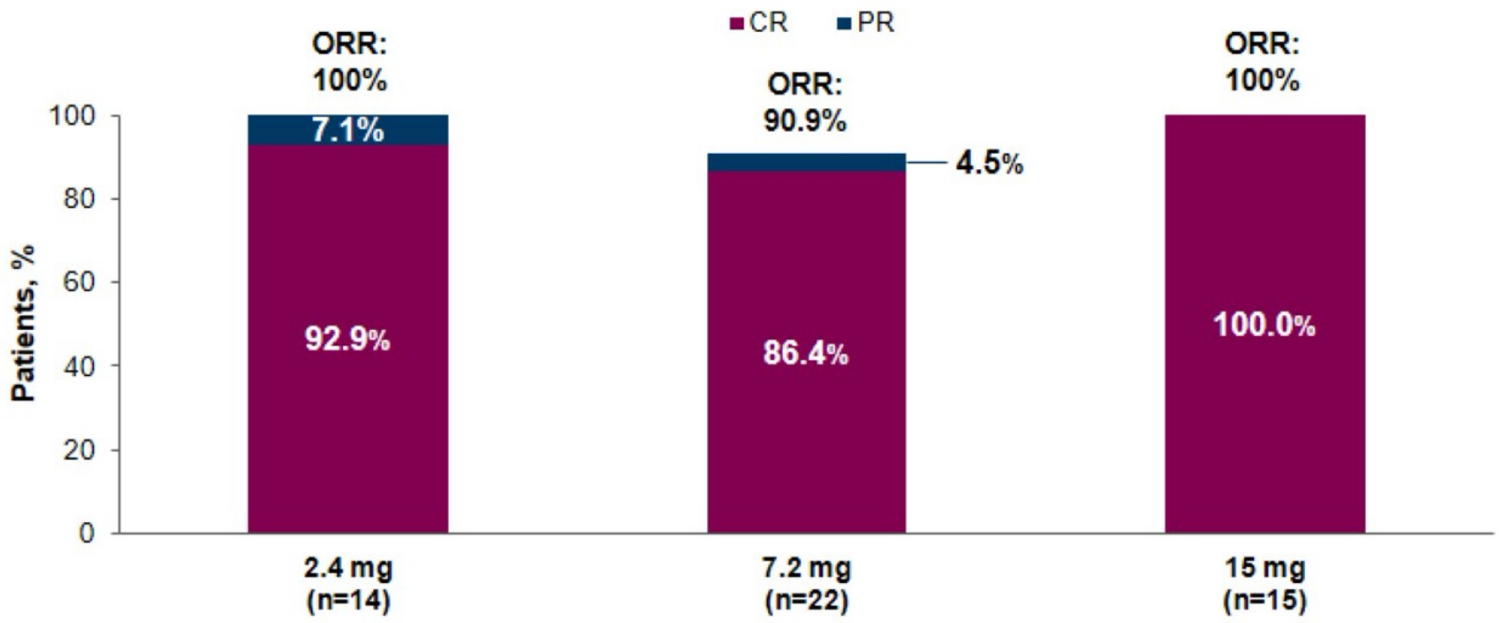
NCT04594642; data cutoff: 19 May 2025

[a] Fixed-dose escalation (n=6), 1SUD (n=12), 2SUD (n=43)

Hou et al. ASH 2025; Abstract 1005.

City of Hope

Surovatamig Phase I Study: Response Rates in FL Cohort



- ORR/CR rate for patients who received ≥2.4 mg was 96%/92%

Responses were noted in various patient subgroups examined, including those with prior exposure to CD19 CAR T and CD20 T-cell engagers

95% of MRD-evaluable patients with CR achieved undetectable MRD

Hou et al. ASH 2025; Abstract 1005.

City of Hope

Phase III SOUNDTRACK-F1 study

Global, Randomized, Phase 3, Multicenter, Open-label Study of Surovatamig Plus Rituximab in Patients With Previously Untreated High Tumor Burden FL

SOUNDTRACK-F1 Consists of a SRI Followed by a Phase 3 Portion

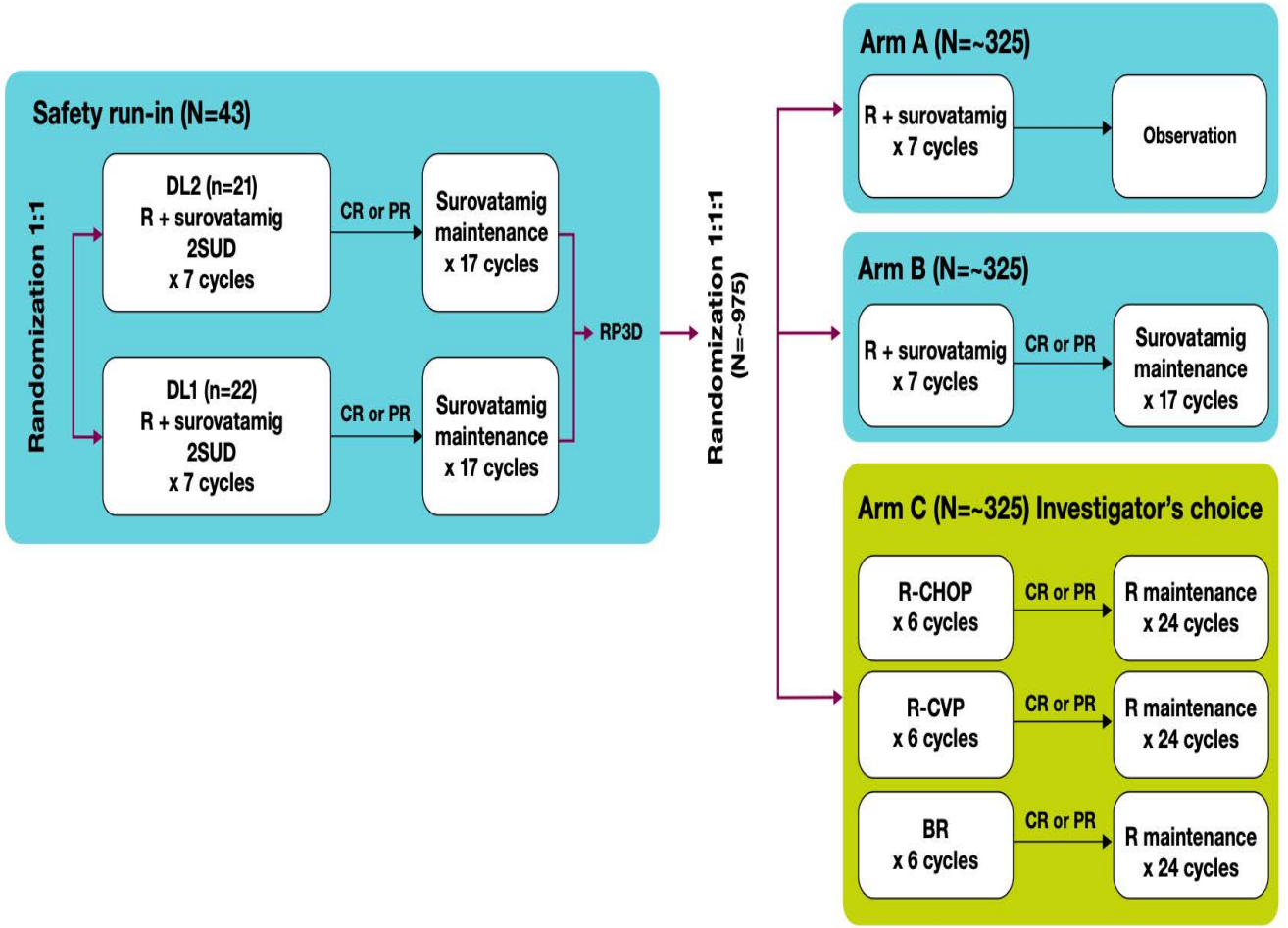
SRI	Phase 3
IV surovatamig + rituximab N=43	IV surovatamig + rituximab OR Rituximab-based CIT[a] Target N=~975

Study Design

- The SRI will identify the RP3D of surovatamig in combination with rituximab (**Figure 3**)
  - **Dose 1:** surovatamig 2.4 mg (monotherapy RP2D minus 1 dose level for R/R FL)
  - **Dose 2:** surovatamig 7.2 mg (monotherapy RP2D for R/R FL)
- The phase 3 portion consists of 3 randomization arms (**Figure 3**); patients will be randomized 1:1:1 to:
  - **Arm A:** surovatamig + rituximab without maintenance therapy
  - **Arm B:** surovatamig + rituximab with maintenance therapy
  - **Arm C:** rituximab-based CIT[a] with rituximab maintenance therapy

Phase 3 Study Endpoints

- **Dual primary:** PFS; ORR at EOI
- **Key secondary:** OS



Cheah et al ASH 2025

Conclusion

- Bispecific antibodies w/ excellent response rate and safety as single agents in FL.
- Combination w/ lenalidomide has helped to improve DOR, ORR, PFS, and TTNT.
  - Impressive data in 2L FL and pending studies in 1L setting vs. rituximab (asymptomatic patients) and CIT (symptomatic by GELF).
- Additional options need in R/R MCL.
  - Time limited glofitamab w/ durable responses in patients who obtain a complete response
    - Especially notable in those who maintain a CR at EOT.
    - Improvement in rates/severity of CRS is needed.

Discussion Questions

60 y/o man with FL

BR as initial therapy; progression 6 month into R maintenance

Switched to temporizing R^2

Rebiopsy shows no transformation to DLBCL

Would you add epcoritamab to R^2 at the current time? In general, how are you using that regimen in your practice? Are you prioritizing it over R^2 alone and tafasitamab/R^2 for most patients with FL?

Discussion Questions

80 y/o woman with FL
BR as initial therapy; progression
Tafasitamab/R^2 as second-line therapy; ECOG 2 and frail

What is the optimal third-line therapy for R/R FL in elderly, frail patients, given the withdrawal of tazemetostat? Is a bispecific a reasonable consideration? If so, would you have a preference for mosunetuzumab or epcoritamab?

RTP RESEARCH TO PRACTICE

Discussion Questions

78 y/o woman with FL and excellent performance status
Past treatments include weekly rituximab, BR and R^2

Would you offer either tafasitamab/R^2 or epcoritamab/R^2 to this patient?
If so, what is the minimum interval for these treatments after prior exposure to R^2?

RTP
RESEARCH
TO PRACTICE

Agenda

Module 1: Chimeric Antigen Receptor (CAR) T-Cell Therapy for Diffuse Large B-Cell Lymphoma (DLBCL) — Dr Kamdar

Module 2: Bispecific Antibody Therapy for DLBCL — Dr Westin

Module 3: CAR T-Cell Therapy for Other Lymphoma Subtypes — Dr Abramson

Module 4: Bispecific Antibody Therapy for Follicular Lymphoma and Other Lymphoma Subtypes — Dr Phillips

Module 5: Tolerability Considerations with CAR T-Cell Therapy and Bispecific Antibodies — Dr Brody

RTP
RESEARCH
TO PRACTICE

Tolerability Considerations with CAR T-Cell Therapy and Bispecific Antibodies

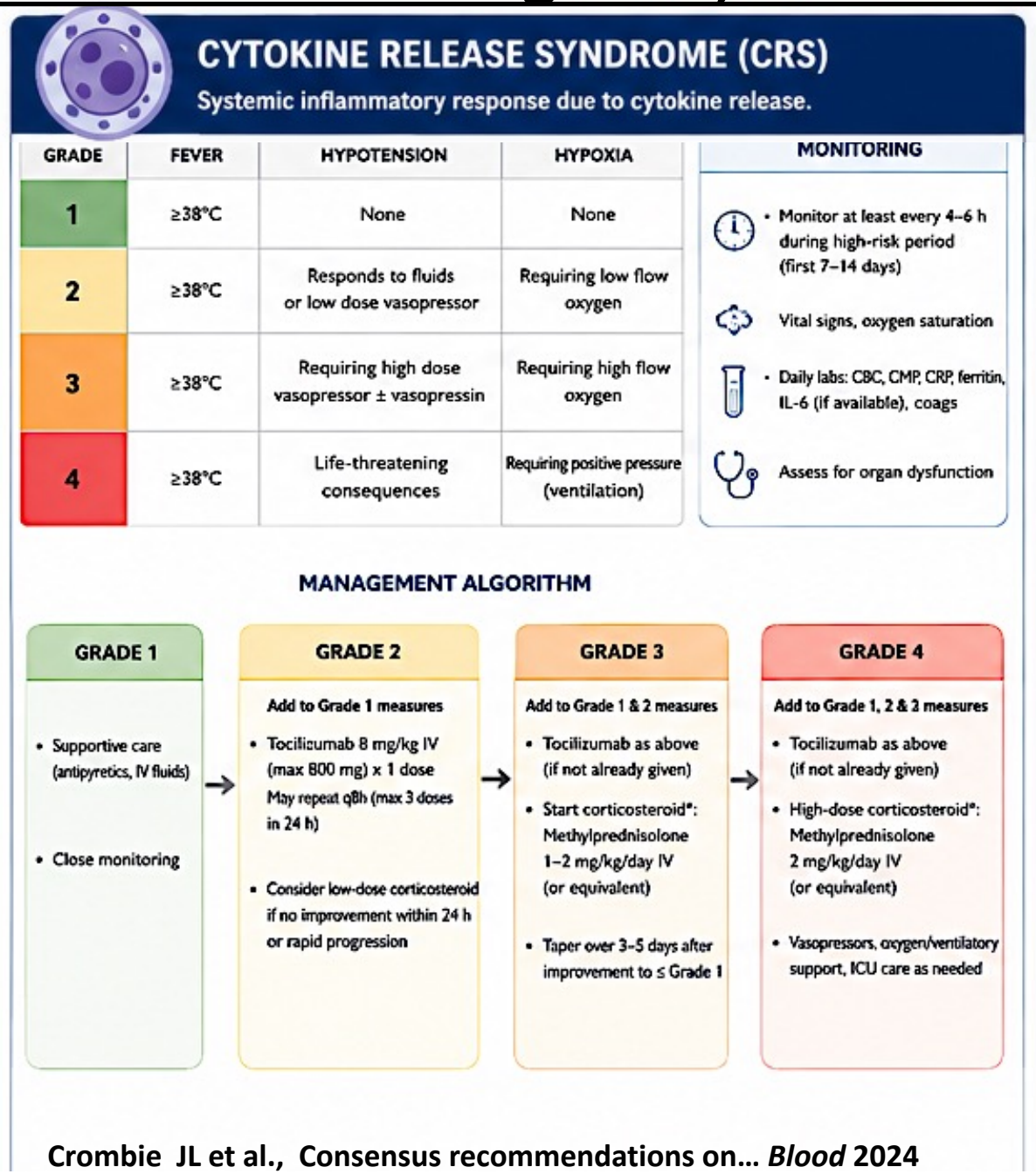
Joshua Brody MD
Professor of Hematology and Medical Oncology
Director, Lymphoma Immunotherapy Program
Mount Sinai School of Medicine, New York, NY

Comparative CRS and ICANS with αCD19 CAR-T in NHL

subtype	construct	trial	pub year	N	CRS any	CRS ≥3	ICANS any	ICANS ≥3
LBCL	axi-cel	ZUMA-1	2017	111	93%	**13%**	64%	**28%**
LBCL	tisa-cel	JULIET	2019	93	58%	**22%**	21%	**12%**
LBCL	liso-cel	TRANSCEND	2020	256	42%	**2%**	30%	**10%**
MCL	brexu-cel	ZUMA-2	2020	60	91%	**15%**	63%	**31%**
FL	axi-cel	ZUMA-5	2021	104	82%	**7%**	59%	**19%**
LBCL (2L)	axi-cel	ZUMA-7	2022	180	92%	**6%**	60%	**21%**
LBCL (2L)	tisa-cel	BELINDA	2022	162	61%	**5%**	10%	**2%**
LBCL (2L)	liso-cel	TRANSFORM	2022	92	49%	**1%**	11%	**4%**
FL	tisa-cel	ELARA	2022	97	49%	**0%**	37%	**3%**

Locke FL et al. Lancet Oncol, 2019; Schuster SJ et al. New Engl J Med, 2019; Abramson JS et al. Lancet, 2020; Wang M et al. New Engl J Med, 2020; Jacobson CA et al. Lancet Oncol, 2022; Locke FL et al. New Engl J Med, 2022; Bishop MR et al. Lancet Oncol, 2023; Kamdar M et al. Lancet, 2022; Fowler NH et al. Nat Med, 2022

Guidelines for mitigation, monitoring, management of CRS and ICANS



Crombie JL et al., Consensus recommendations on… *Blood* 2024

Rationale for and implications: 7/2025 elimination of CAR-T REMS

FDA: "*accumulated physician experience, improved toxicity-recognition algorithms, standardized management pathways for CRS and ICANS, and extensive safety data now make formal REMS programs unnecessary*"

Rationale:

1.Clinical familiarity and standardization

- extensive experience managing CRS and ICANS

- consensus grading systems, standardized steroid/toci algorithms, and earlier intervention reduced high-grade AEs

2. Real-world evidence demonstrating manageable risk

- 100s of centers and 10,000s of patients => large post-marketing datasets showing that toxicities are predictable and treatable. - boxed warnings and product labeling alone are now sufficient to communicate these risks.

Implications:

1. Access barriers created by REMS

-REMS significantly constrained geographic availability of CAR-T

-for small hospitals: certification, staffing requirements, reporting obligations, and pharmacy prep were resource-intensive

2. Operational inefficiency and delays

-CAR-T patients may have rapidly progressive dx =>

-administrative delays with REMS certification and transfer to specialized centers prevents timely treatment.

-eliminating REMS is expected to shorten referral-to-infusion timelines, box warnings remain in place

3. Updated label requirements

-Duration to stay near site **reduced** to 2 weeks

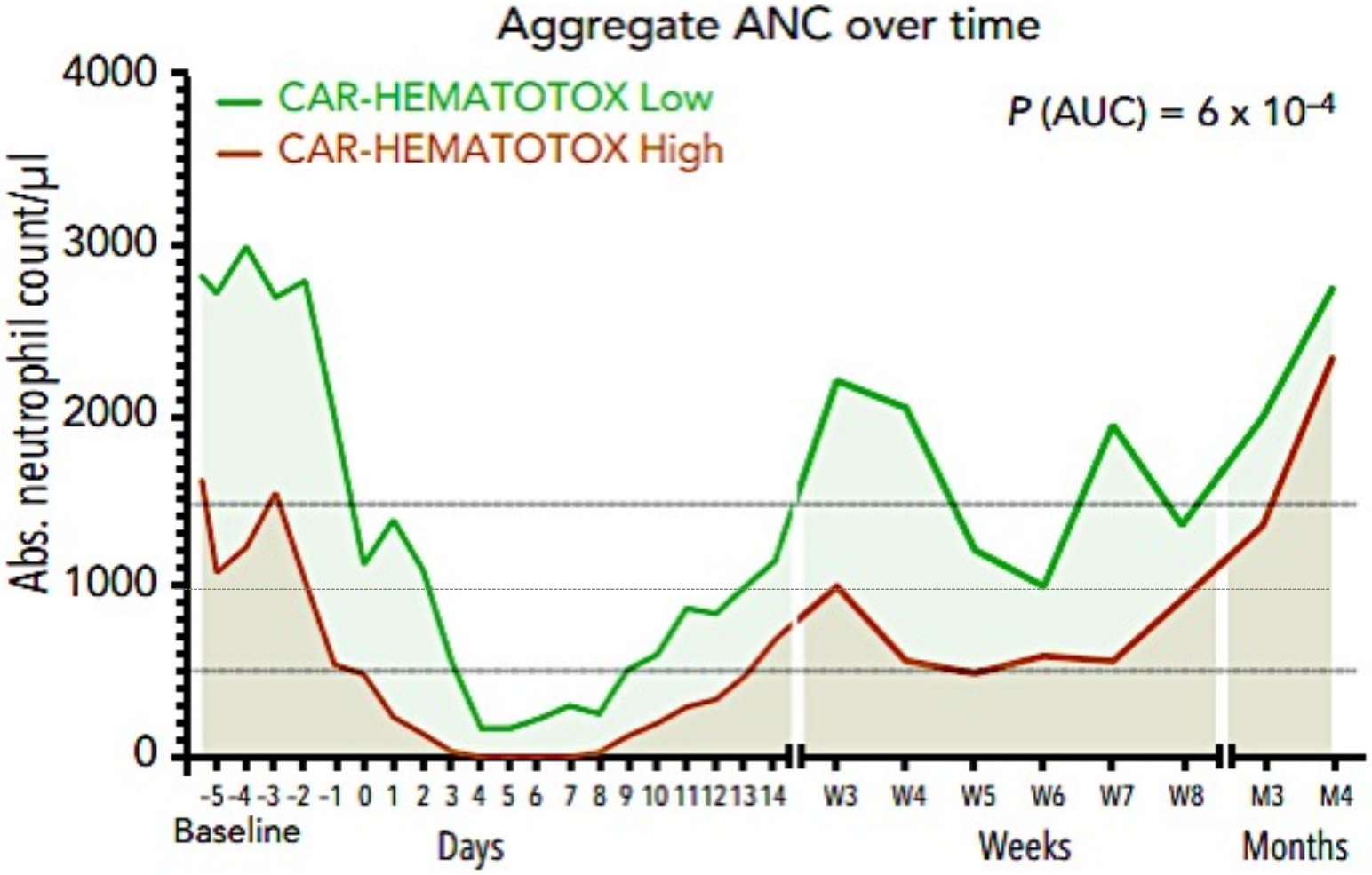
-Driving restrictions **reduced** to 2 weeks

-Boxed warnings remain

CAR T-Cells: Late toxicities - cytopenias

Platelet Count	< 75,000 /µl
Absolute Neutrophil Count (ANC)	< 1,200 /µl
Hemoglobin	< 9.0 g/dl
C-reactive protein (CRP)	< 3.0 mg/dl
Ferritin	> 2,000 ng/ml
CAR-HEMATOTOX score	6

Patient belongs to CAR-HEMATOTOX *high* risk group.

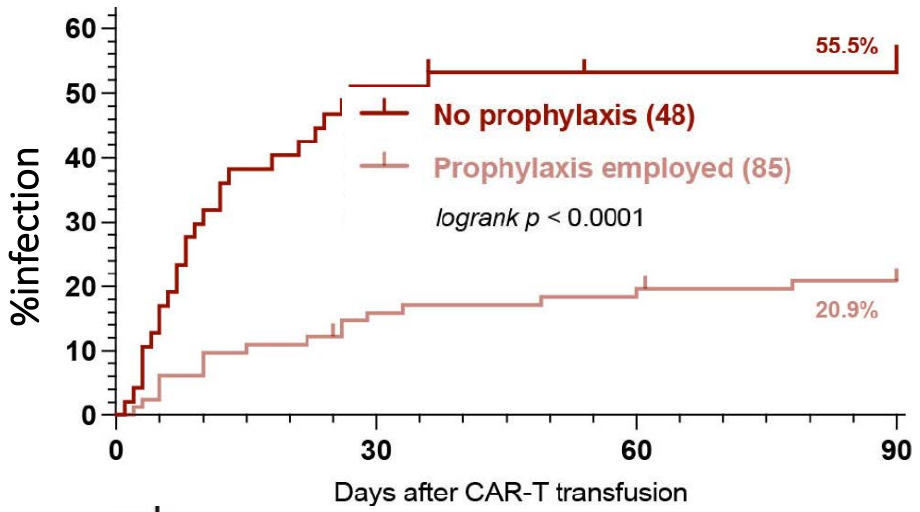


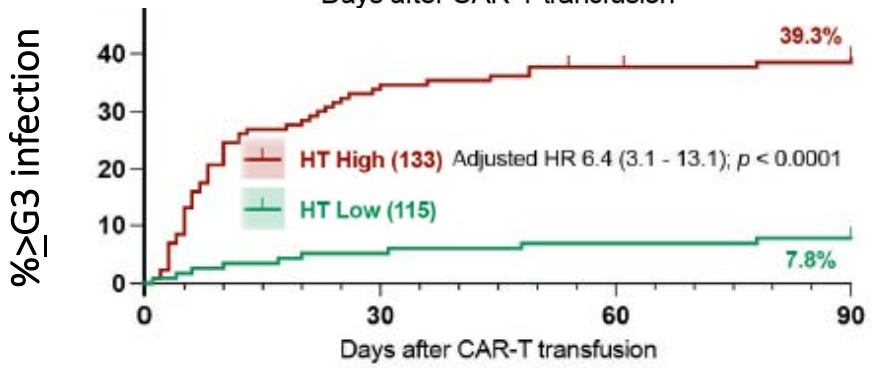
Rejeski K et al., Blood. 2021 www.german-lymphoma-alliance.de/Scores.html

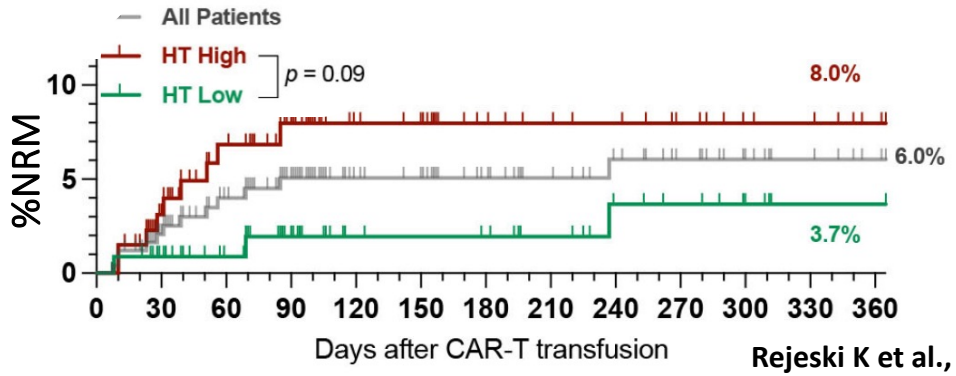
Mount Sinai Tisch Cancer Center

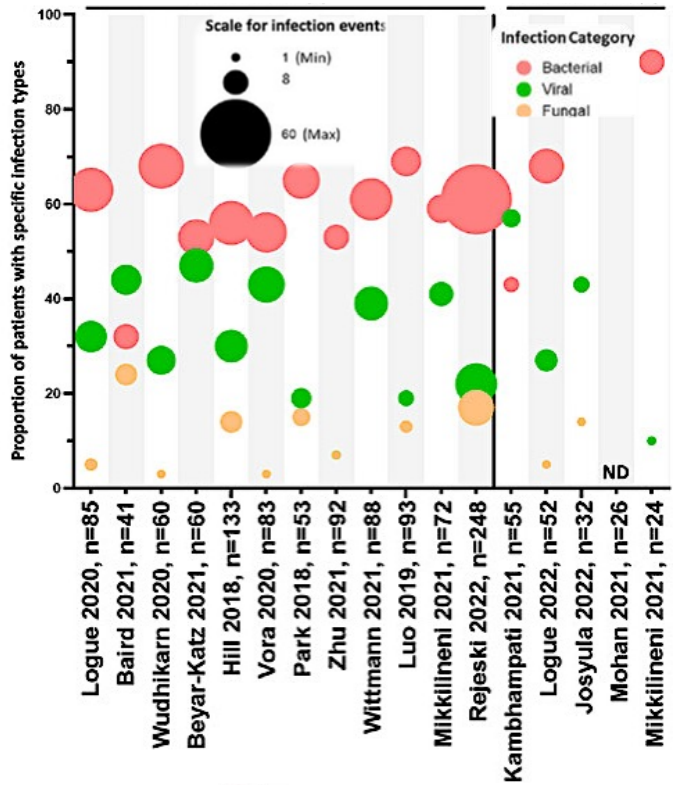
*HT, CAR-HEMATOTOX score

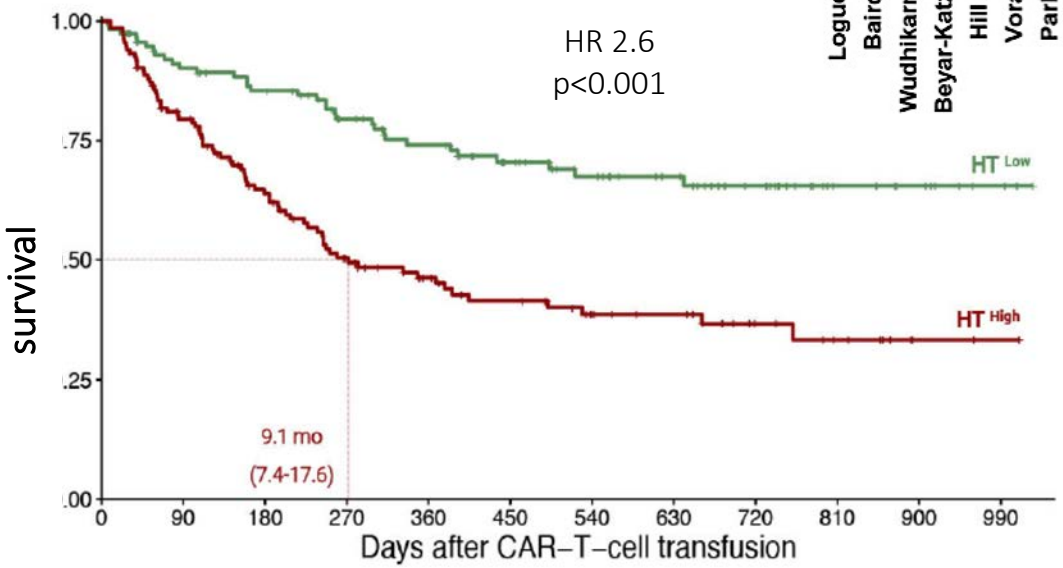
CAR T-Cells: Late toxicities - infections











Rejeski K et al., *J Immunother Cancer*. 2022

Kampouri E et al., *Transpl Infect Dis.* 2023

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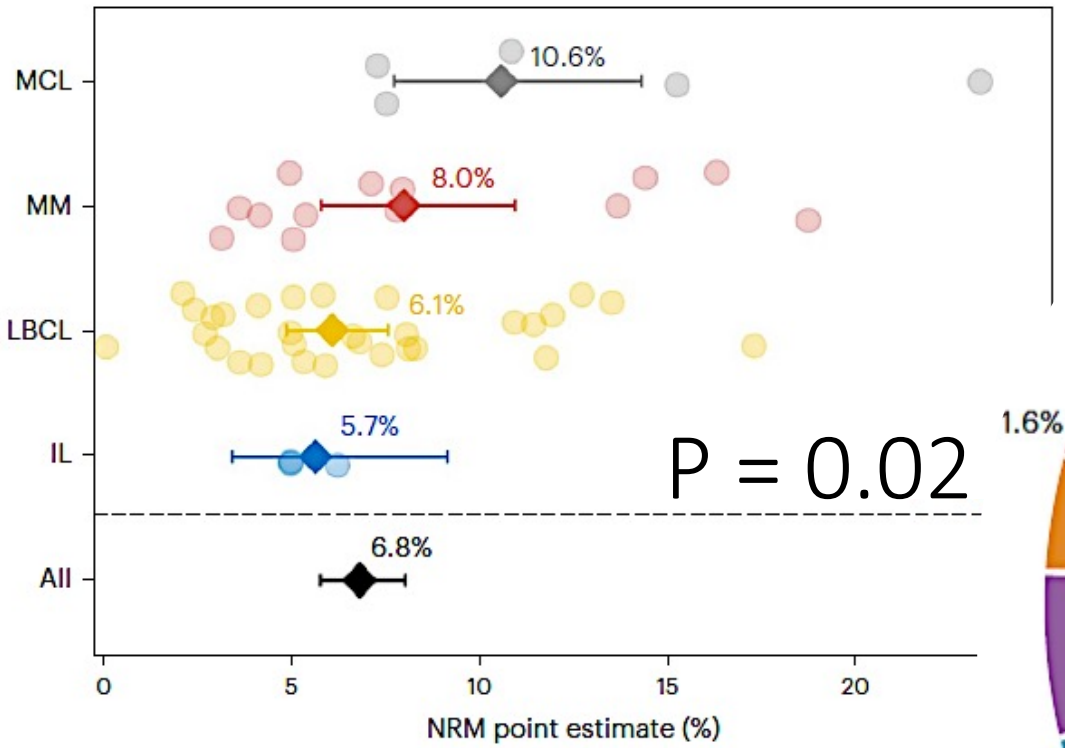
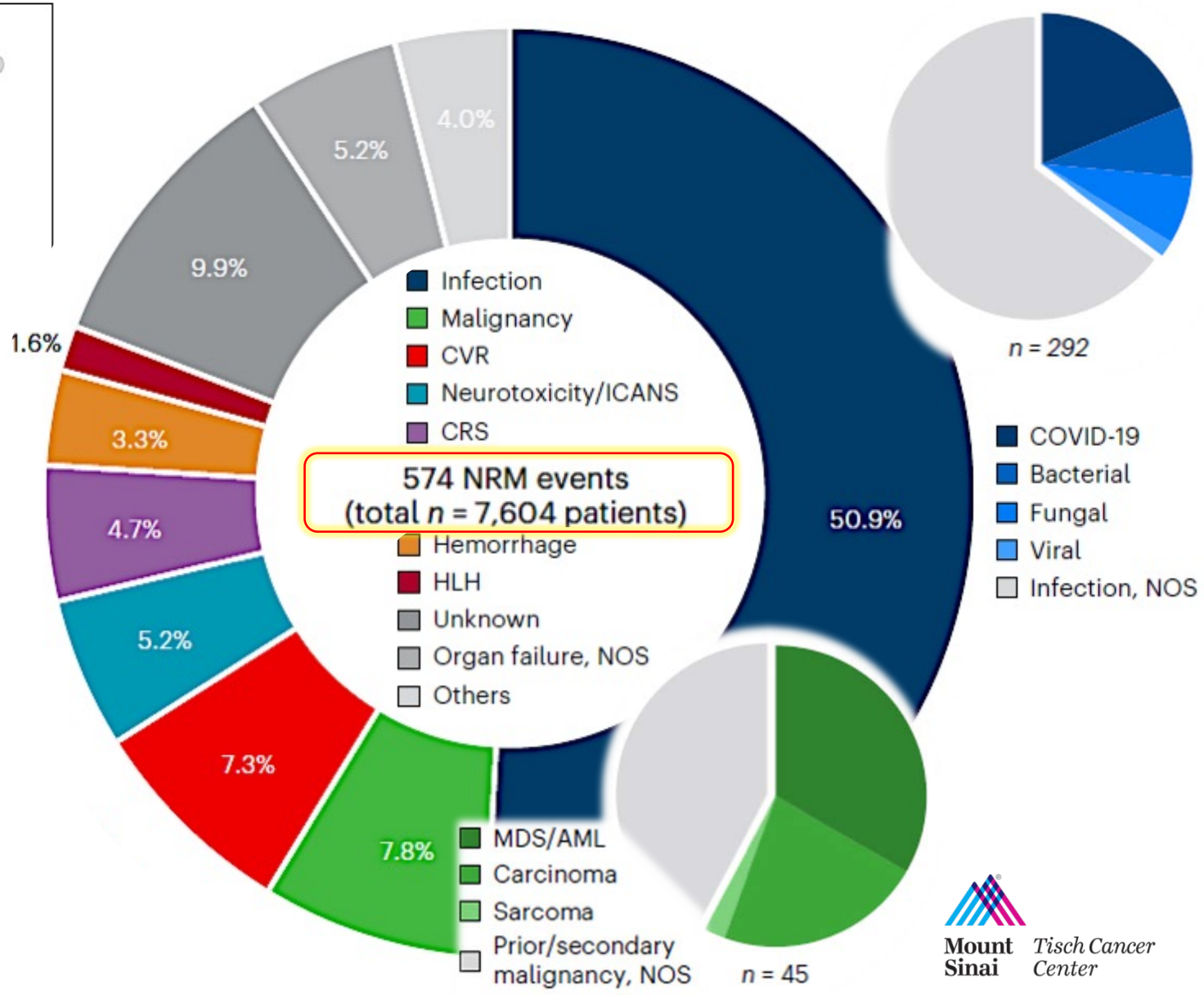
CAR T-Cells: Late toxicities - infections





Cordas Dos Santos, DM et al., *Nat Med* 2024

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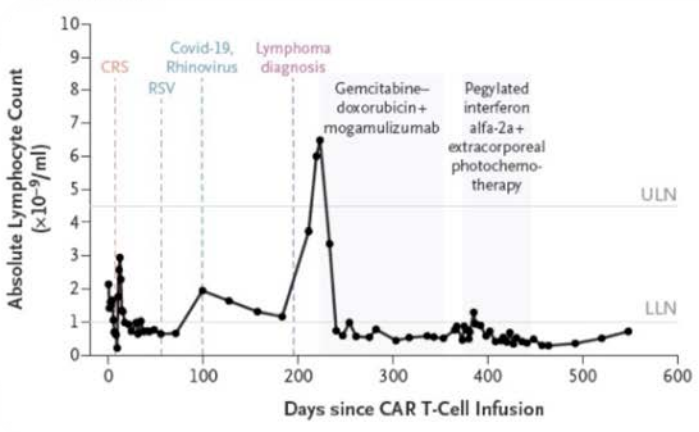
Long-term tolerability/toxicity: secondary malignancy

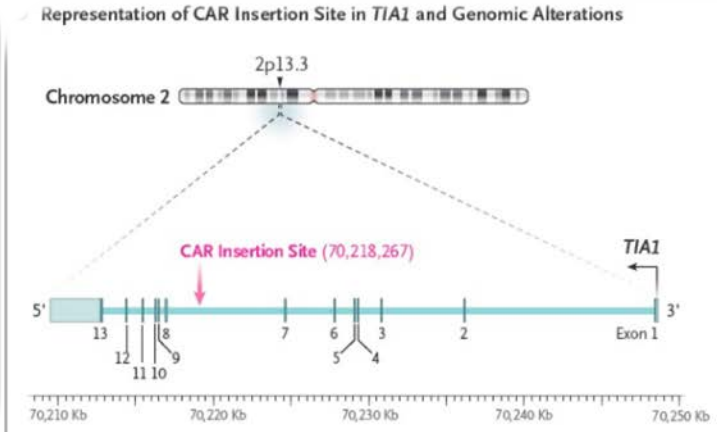
Targeted Therapy of CAR+ T-Cell Lymphoma after Anti-BCMA CAR T-Cell Therapy

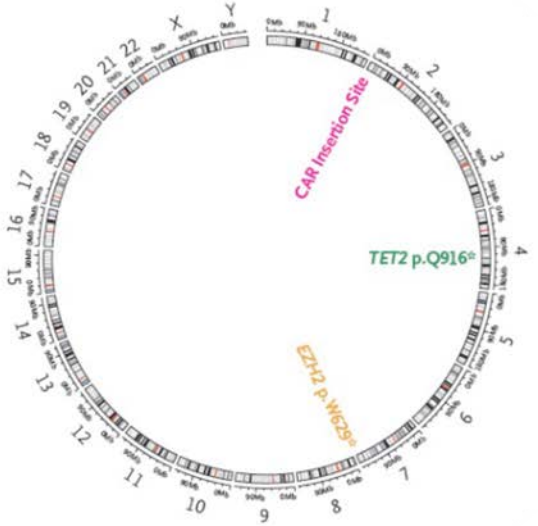
Published August 20, 2025 | N Engl J Med 2025;393:823-825 | DOI: 10.1056/NEJMc2504588 | VOL. 393 NO. 8

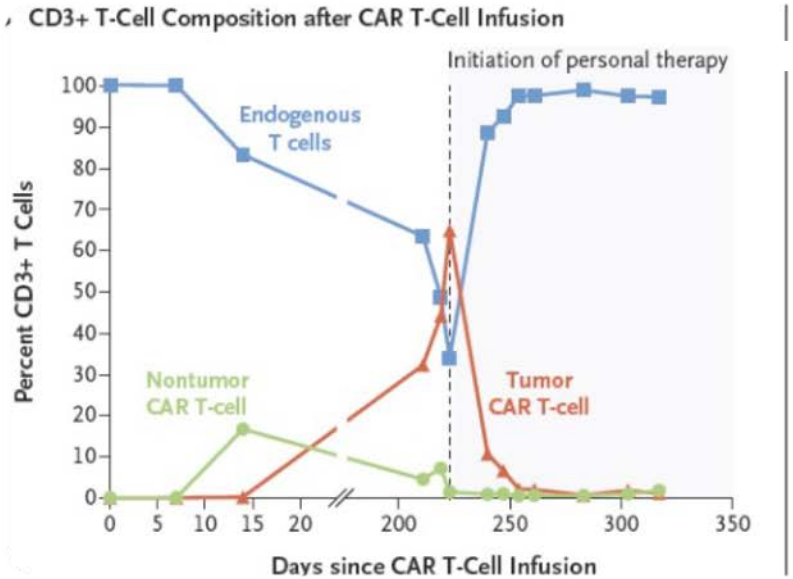


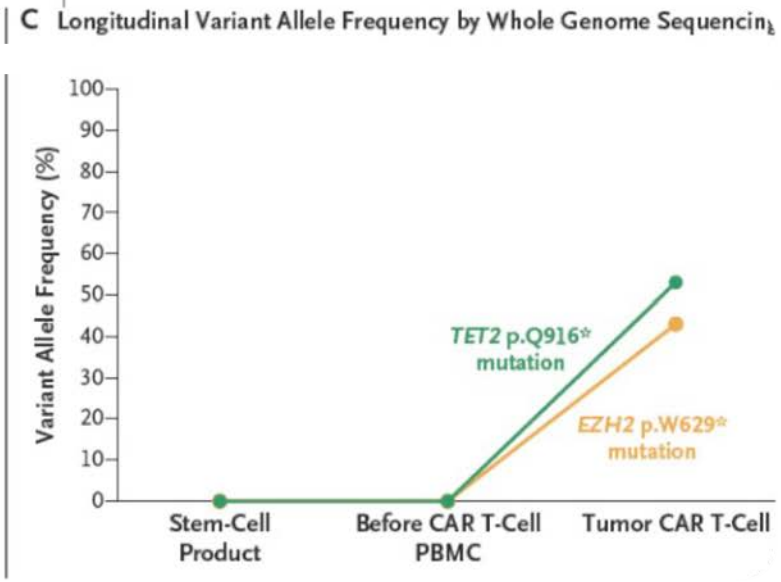
Facial Skin Lesions (day 196 after CAR T-Cell infusion)

Hypermetabolic Cutaneous Lesions (day 190 after CAR T-Cell infusion)





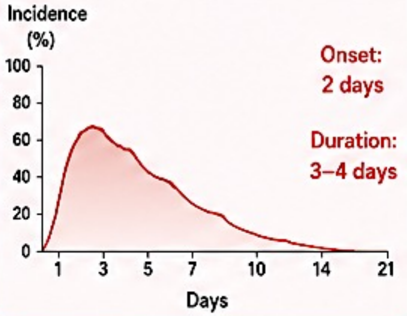


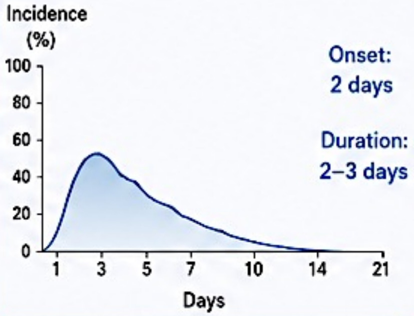


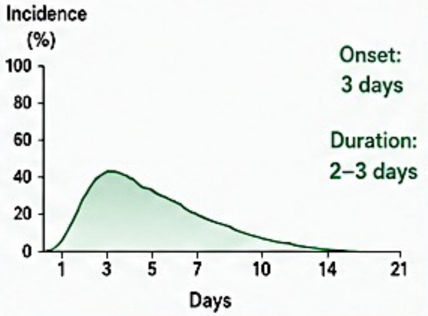
Aleman A, Van Oekelen O, …, Brody JD, Parekh S.N Engl J Med. 2025 Aug 21;393(8):823-825

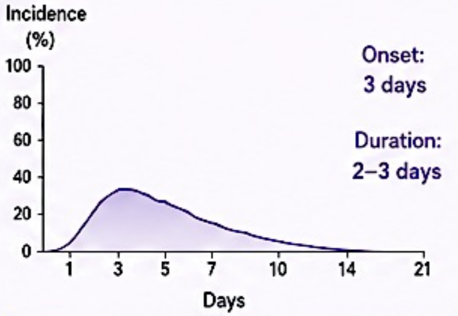
Incidence, severity, timing of CRS and ICANS with bispecifics in B-NHL

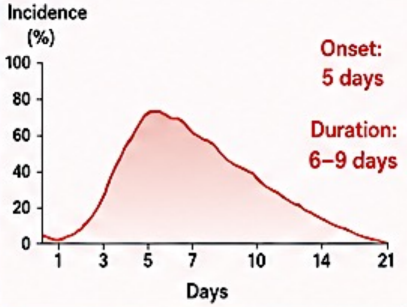
		Glofitamab	Epcoritamab	Mosunetuzemab	Surovatamig
CRS	Incidence (Any Grade / Grade ≥3)	61% / 3%	49% / 1%	45% / 1%	35% / <1%
	Severity (% by Grade)	Grade 1: 49% Grade 2: 9% Grade ≥3: 3%	Grade 1: 36% Grade 2: 12% Grade ≥3: 1%	Grade 1: 33% Grade 2: 11% Grade ≥3: 1%	Grade 1: 26% Grade 2: 8% Grade ≥3: <1%
	Time Course (Median onset, duration)	Onset: 2 days Duration: 3–4 days	Onset: 2 days Duration: 2–3 days	Onset: 3 days Duration: 2–3 days	Onset: 3 days Duration: 2–3 days
ICANS	Incidence (Any Grade / Grade ≥3)	25% / 2%	15% / 1%	10% / 1%	8% / <1%
	Severity (% by Grade)	Grade 1: 20% Grade 2: 4% Grade ≥3: 2%	Grade 1: 12% Grade 2: 2% Grade ≥3: 1%	Grade 1: 8% Grade 2: 1% Grade ≥3: 1%	Grade 1: 6% Grade 2: 1% Grade ≥3: <1%
	Time Course (Median onset, duration)	Onset: 5 days Duration: 6–9 days	Onset: 6 days Duration: 5–8 days	Onset: 6 days Duration: 5–8 days	Onset: 7 days Duration: 5–9 days

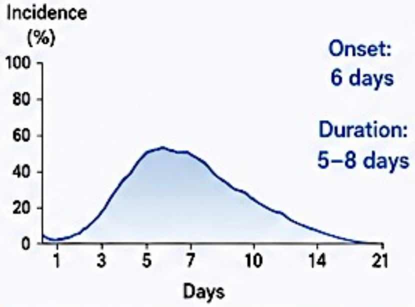


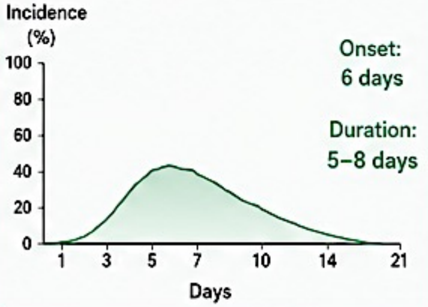


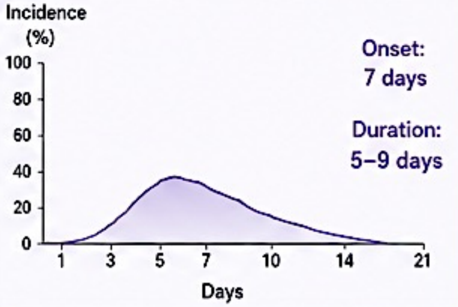












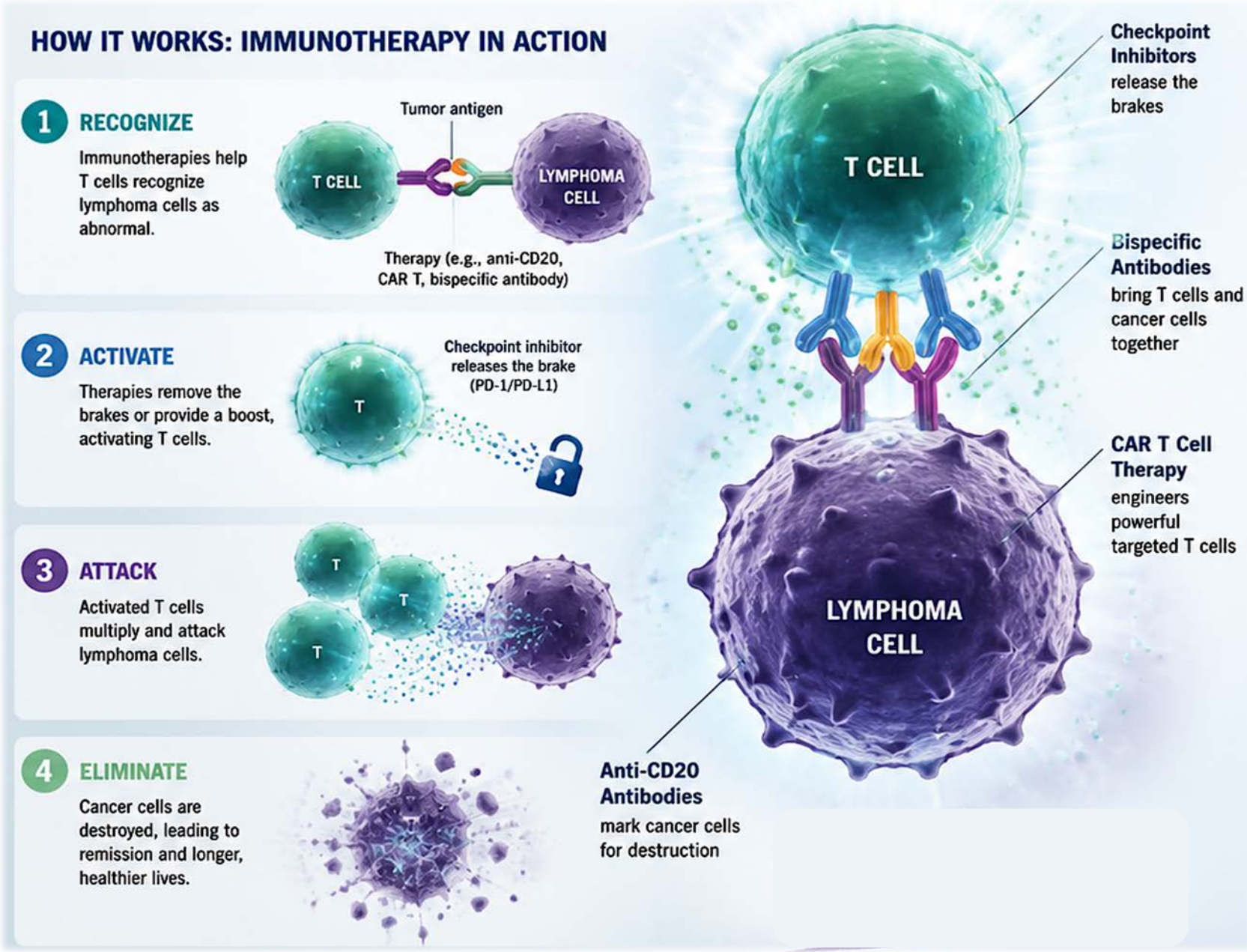
Hutchings et al., JCO 2021, Thieblemont et al., JCO 2023, Budde et al., JCO 2022, Min Kim et al., (Suppl) Blood 2025

Fewer Infections with *Lymphoma* vs Myeloma Bispecifics

Agent		Grade ≥ 3 Infections	Grade 5 Infections	Grade ≥ 3 CRS	Grade ≥ 3 Neutropenia
Multiple Myeloma	BCMA target[1]				
	Linvoseltamab	29%	4%	1%	23%
	Elranatamab	32%	5%	0	48%
	Teclistamab	45%	12%	1%	64%
Multiple Myeloma	Non-BCMA target[1] (talquetamab)	18%	0	3%	37%
Lymphoma	**Mosunetuzumab[2]**	**14%**	**–**	**1%**	**27%**
Lymphoma	**Epcoritamab[3]**	**14%**	**–**	**2.5%**	**14.6%**

1. Gemma Reynolds, et al. Blood Adv. 2023;7:5898-5903; 2. Budde LE, et al. Lancet Oncol. 2022;23:1055-1065; 3. Thieblemont, et al. J Clin Oncol. 2023 20;41:2238-2247.

Lymphoma Immunotherapy 2026: miraculous advances since 2000



Discussion Questions

71 y/o woman with FL with bulky symptomatic nodal disease
PMH: COPD, recurrent respiratory infections
Past treatments include weekly BR and R^2
Currently receiving a bispecific antibody with good clinical response

What are the current best practices regarding infection prophylaxis, IVIG replacement and long-term monitoring for patients receiving bispecifics for FL?

For patients with NHL receiving bispecific antibodies, are you recommending prophylactic tocilizumab as is commonly done in multiple myeloma?

Discussion Questions

72 y/o man with blastoid variant MCL with TP53 mutation
R-CHOP/acalabrutinib as initial therapy with almost no response
Treated with emergent fractionated cyclophosphamide/rituximab/ radiotherapy followed by CAR-T; dramatic CR on PET
Patient had grade 2 CRS and grade 1 ICANS

Is there more CRS and/or ICANS with CAR-T in MCL versus DLBCL or FL? If so, why?

How should we be monitoring patients with ongoing responses to CAR-T? Is there a time point after which toxicities are highly unlikely to occur?

Would the experts recommend any type of maintenance therapy post CAR-T, and if so what?

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Discussion Questions

50 y/o woman with stage 4, grade 2 FL diagnosed in 2012
BR as initial treatment; disease progression at 2 years
R-CHOP followed by 2 years of R maintenance as second-line therapy; long-term remission with symptomatic progression in 2023
Mosunetuzumab as third-line therapy
Recurrent admissions for hematuria; cystoscopy shows hemorrhagic cystitis

Is hemorrhagic cystitis associated with mosunetuzumab?

Are there any uncommon toxicities with bispecific antibodies that community-based clinicians should know about?

What Clinicians Want to Know: Addressing Community Oncologists' Questions About the Current and Future Role of Antibody-Drug Conjugates in the Management of Breast Cancer

A CME Symposium Held Adjunct with the 2026 ASCO® Annual Meeting

Monday, June 1, 2026

7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Professor Giuseppe Curigliano, MD, PhD

Rebecca A Dent, MD, MSc

Erika Hamilton, MD

Nadia Harbeck, MD, PhD

Moderator

Hope S Rugo, MD

RTP RESEARCH TO PRACTICE

Second Opinion: Investigators Provide Perspectives on the Current and Future Use of Novel Therapies for Non-Hodgkin Lymphoma

A CME Symposium Held Adjunct with the 2026 ASCO® Annual Meeting

Monday, June 1, 2026

7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Christopher Flowers, MD, MS, FASCO

Matthew Lunning, DO

Sonali M Smith, MD

Moderator

Brad S Kahl, MD

RTP RESEARCH TO PRACTICE

Consensus or Controversy? Documenting and Discussing Investigators' Approaches to the Management of Relapsed/Refractory Multiple Myeloma

A CME Symposium Held Adjunct with the 2026 ASCO® Annual Meeting

Monday, June 1, 2026

7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Melissa Alsina, MD

Hans Lee, MD

Paul G Richardson, MD

Moderator

Sagar Lonial, MD, FACP, FASCO

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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.

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