Consensus or Controversy? Documenting and Discussing Investigators' Approaches to the Management of Ovarian Cancer

Saturday, May 30, 2026
7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Ramez N Eskander, MD
Ursula Matulonis, MD
Alexander B Olawaiye, MD
David M O'Malley, MD

Moderator

Kathleen N Moore, MD, MS

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Division of Gynecologic Oncology in Obstetrics and Gynecology
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Moderator
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Contributing Clinical Investigator

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Milan, Italy

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Prof Eskander — Disclosures
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Dr Matulonis — Disclosures
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Dr Olawaiye — Disclosures
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Prof Colombo — Disclosures
Contributing Clinical Investigators

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Research To Practice President Neil Love, MD — Disclosures

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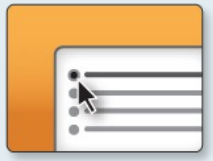
Networked iPads are available.

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

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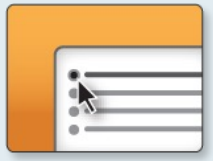

Answer Survey Questions: Complete the pre- and postmeeting surveys.

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

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

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About the Enduring Program

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

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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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Agenda

Module 1: Current Role of PARP Inhibitors in the Management of Advanced Ovarian Cancer (OC) — Prof Eskander

Module 2: Strategies Targeting Folate Receptor Alpha in Advanced OC — Dr Matulonis

Module 3: Other Approved and Promising Investigational Antibody-Drug Conjugates for Advanced OC — Dr Moore

Module 4: Other Novel Agents and Strategies for Advanced OC — Dr O'Malley

Module 5: Diagnosis and Management of Adverse Events Associated with Common Therapies for Advanced OC — Dr Olawaiye

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Current Role of PARP Inhibitors in Advanced Ovarian Cancer

Biomarkers · long-term survival · regimen selection · ongoing trials · the relapsed setting

Ramez N. Eskander, MD
Julie St. John Endowed Chair in Gynecologic Oncology
Professor of Obstetrics, Gynecology and Reproductive Sciences
Medical Director, Clinical Trials Office
Fellowship Program Director, Gynecologic Oncology
UC San Diego Health | Moores Cancer Center | La Jolla, CA

Roadmap

01 **Biomarker testing**
Germline & somatic BRCA, HRD/genomic instability — and why they drive decisions

02 **Long-term & OS data**
SOLO-1, PAOLA-1, PRIMA, ATHENA-MONO maintenance outcomes

03 **Choosing therapy**
Clinical, biologic & practical factors for olaparib, olaparib/bev, niraparib

04 **Ongoing phase III**
MONO-OLA1 and NRG-GY036 — refining who and how long

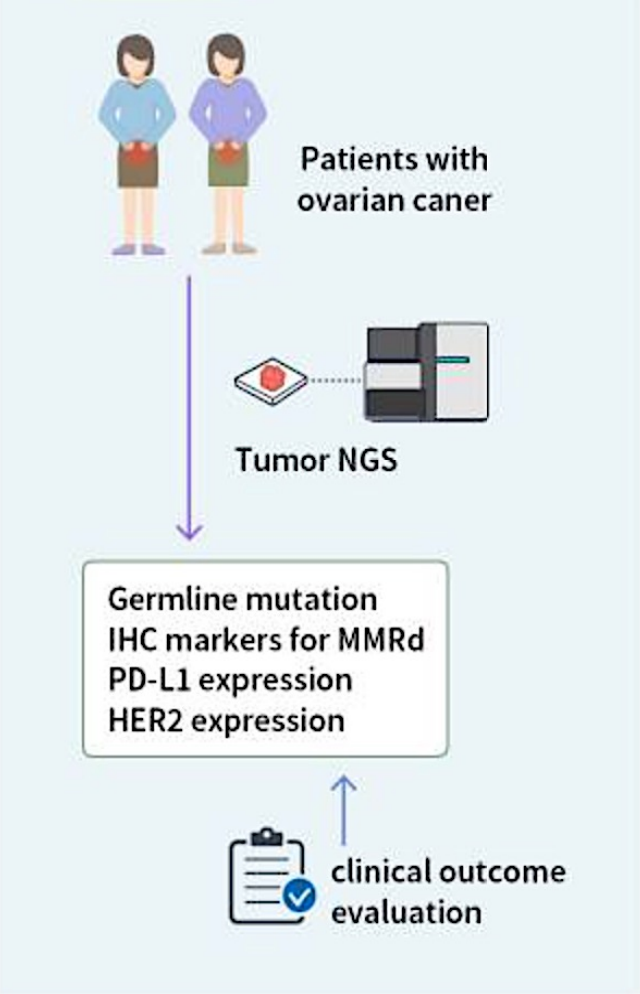
05 **Relapsed / post-PARP**
Utility after progression, including prior PARP exposure

SECTION 01

Biomarker testing in newly diagnosed advanced ovarian cancer

Germline & somatic BRCA and HRD status are prerequisites — not afterthoughts — for first-line decisions.

Biomarker Testing: When, What and Where?



1. Ascites Fluid
2. CT guided biopsy
3. Surgical Procedure
4. ctDNA
5. At time of recurrence?

1. Commercial Assay
   e.g. Foundation Medicine, CARIS, Tempus
2. In house Assay

ACTIONABLE BIOMARKERS (?)

1. **HRD (GIS, LOH, etc.)**
2. **Germline/Somatic BRCA**
3. **FOLR alpha**
4. **HER2 IHC**
5. **MMR/TMB/MSI**
6. **KRAS (LGSOC)**

Others…

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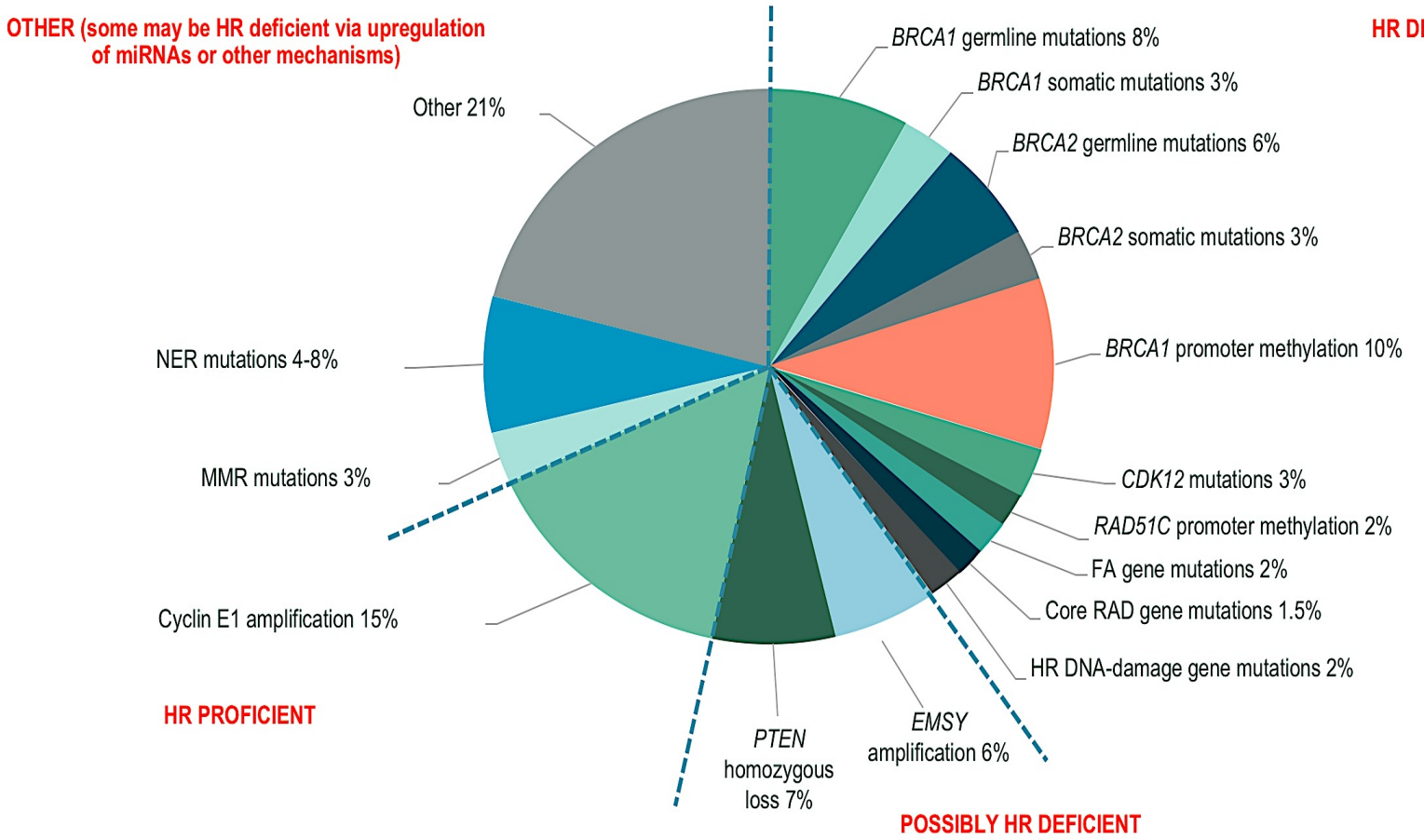
Kim YN, et al. J Gynecol Oncol. 2023 Nov;34:e70.

Homologous Recombination Deficiency



~50% of high-grade serous OC is HRD

- **BRCA1/2 mutation** — ~22% (≈15% germline, ≈7% somatic);
- **BRCA-wildtype / HRD-positive** — ~28%; genomic instability without a BRCA mutation
- **HR-proficient** — ~50%

*Somatic and germline BRCA mutations confer similar PARP sensitivity — but **germline status additionally drives cascade testing** and risk-reduction.*

Kostantinopoulos PA, et al. Cancer Discov 2015;5:1137-54.

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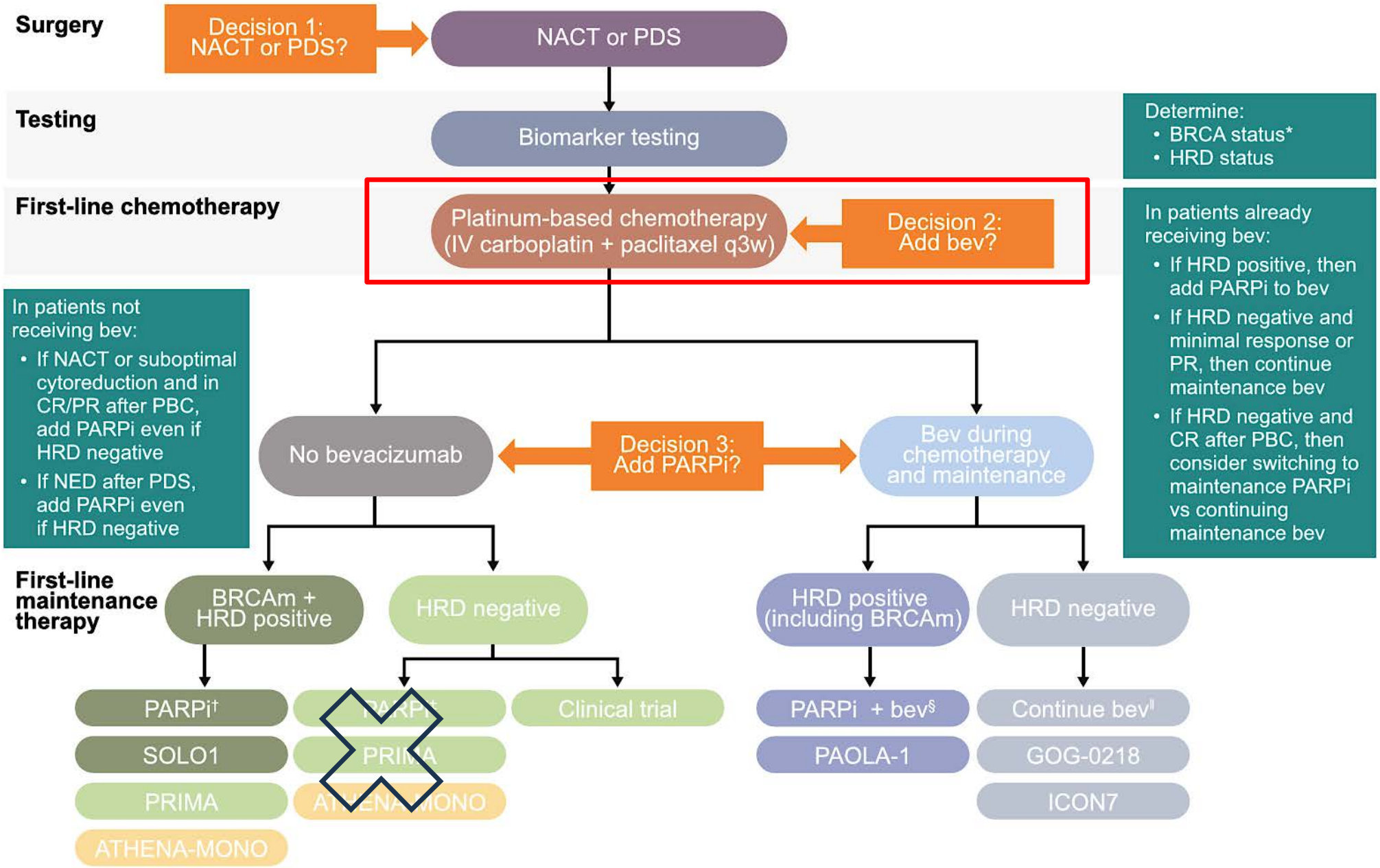
SECTION 02

Front-line maintenance: long-term and overall-survival outcomes

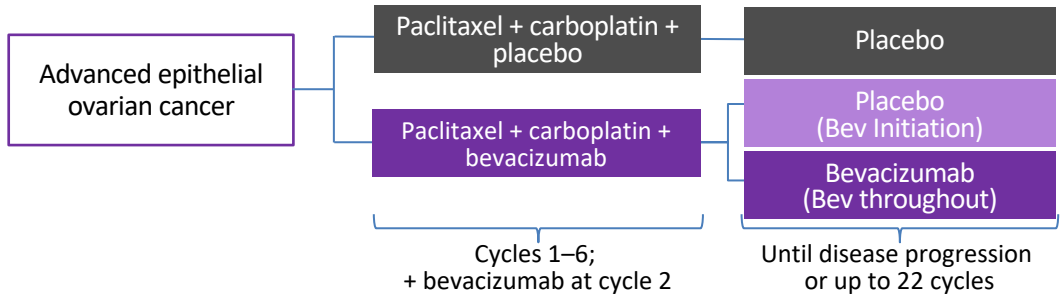
What the mature data — including OS — now show for each regimen.

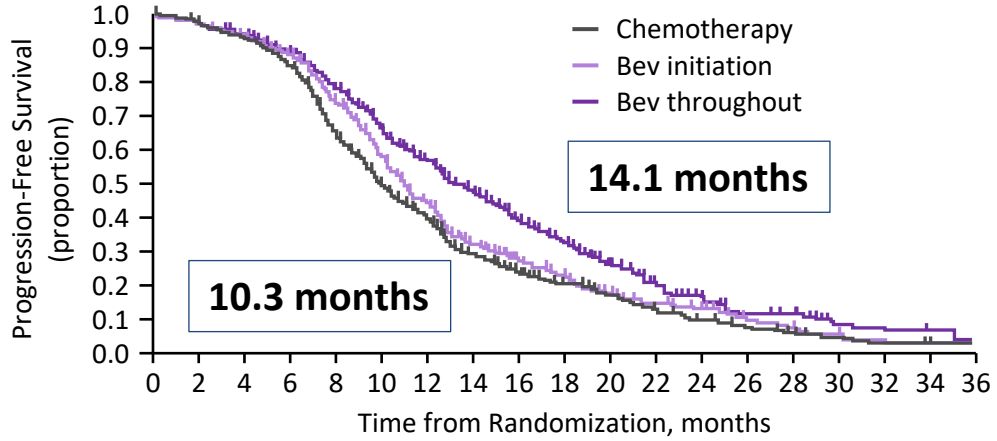


O'Malley DM, Krivak TC, Kabil N, Munley J, Moore KN. PARP Inhibitors in Ovarian Cancer: A Review. Target Oncol

First-Line Chemotherapy: Carboplatin, Paclitaxel & Bevacizumab + Maintenance

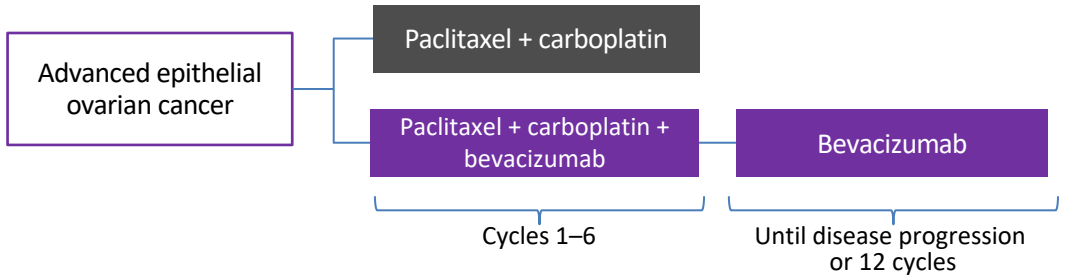
GOG 218[1]

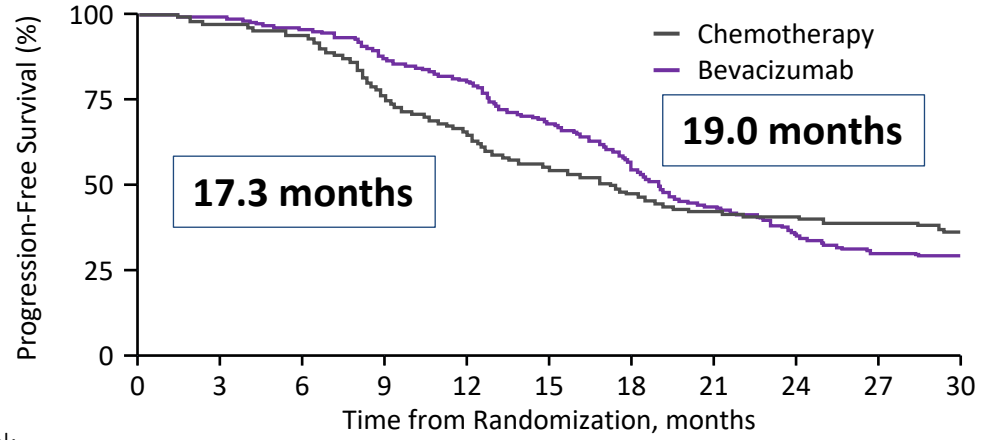




No. at risk				
Chemotherapy	625	199	33	8
Bev initiation	625	219	29	6
Bev throughout	623	254	38	8

ICON7[2]

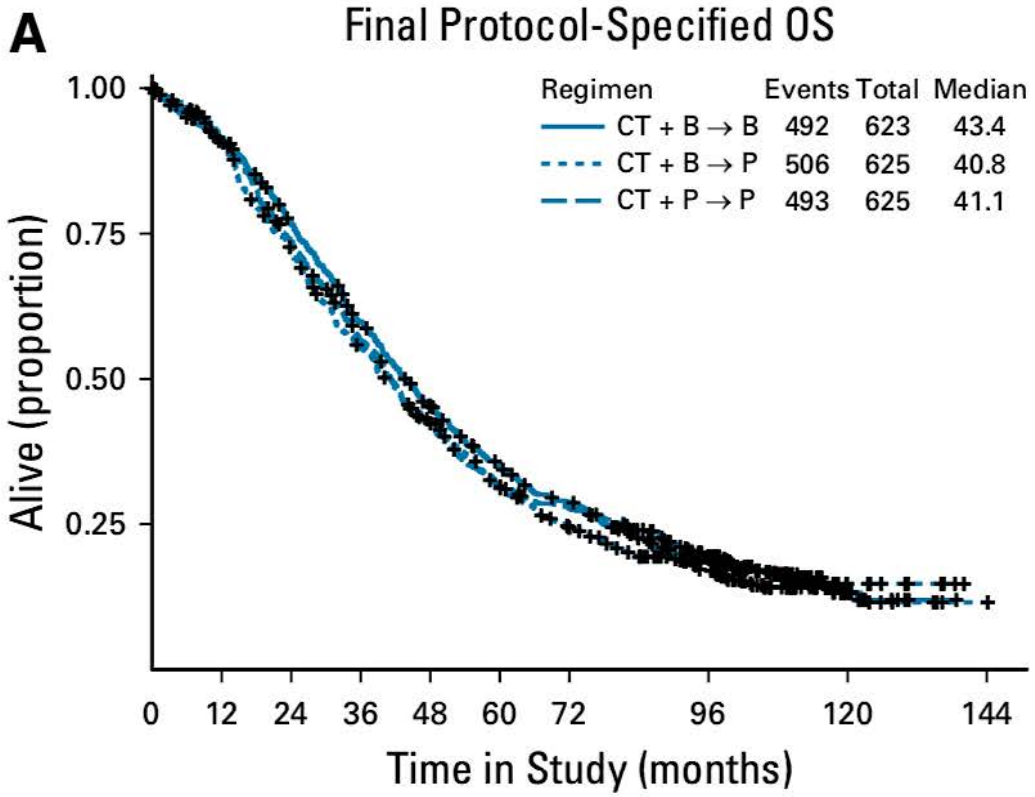




No. at risk						
Chemotherapy	764	693	464	216	91	25
Bevacizumab	764	715	585	263	73	19

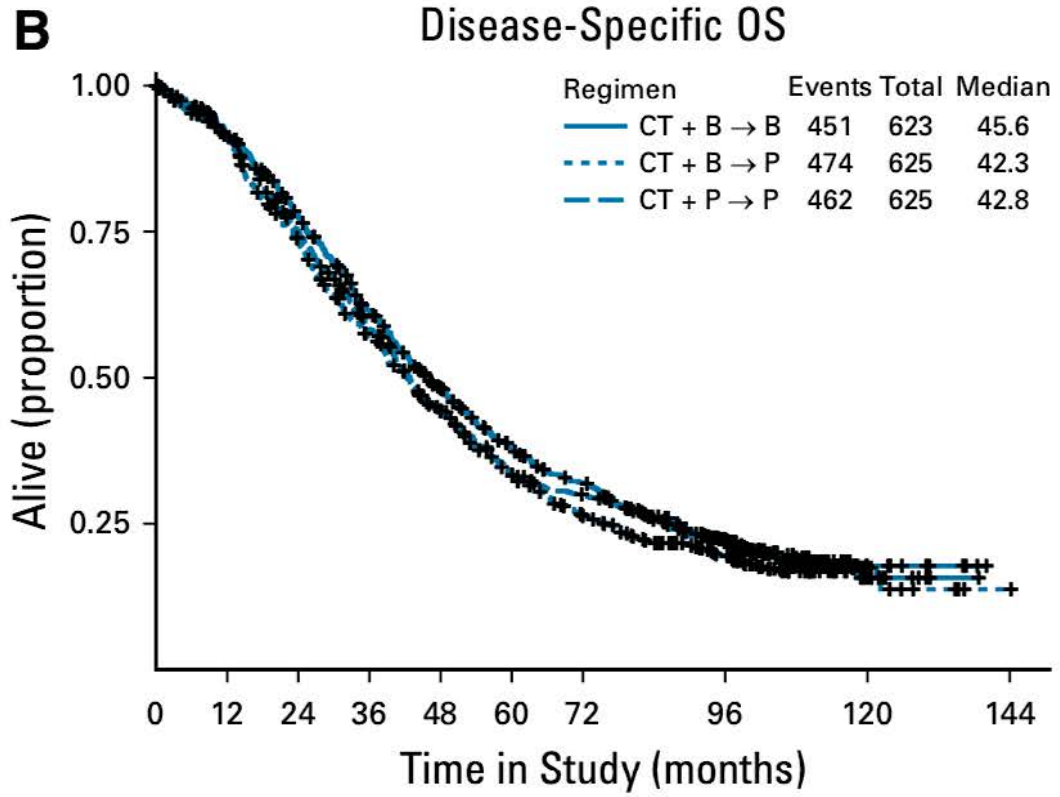
1. Burger RA et al. *N Engl J Med.* 2011;365(26):2473-2483. 2. Perren TJ et al. *N Engl J Med.* 2011;365(26):2484-2496

GOG 218: Final OS



No. at risk

CT + B → B	623	561	464	358	267	201	161	85	11	0
CT + B → P	625	558	443	334	252	185	136	74	11	1
CT + P → P	625	558	448	340	252	183	158	90	9	0



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CT + P → P	625	558	448	340	252	183	158	90	9	0

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Tewari KS, et al. J Clin Oncol 2019;37:2317-28.

To Bev or Not to Bev…That is the Question?

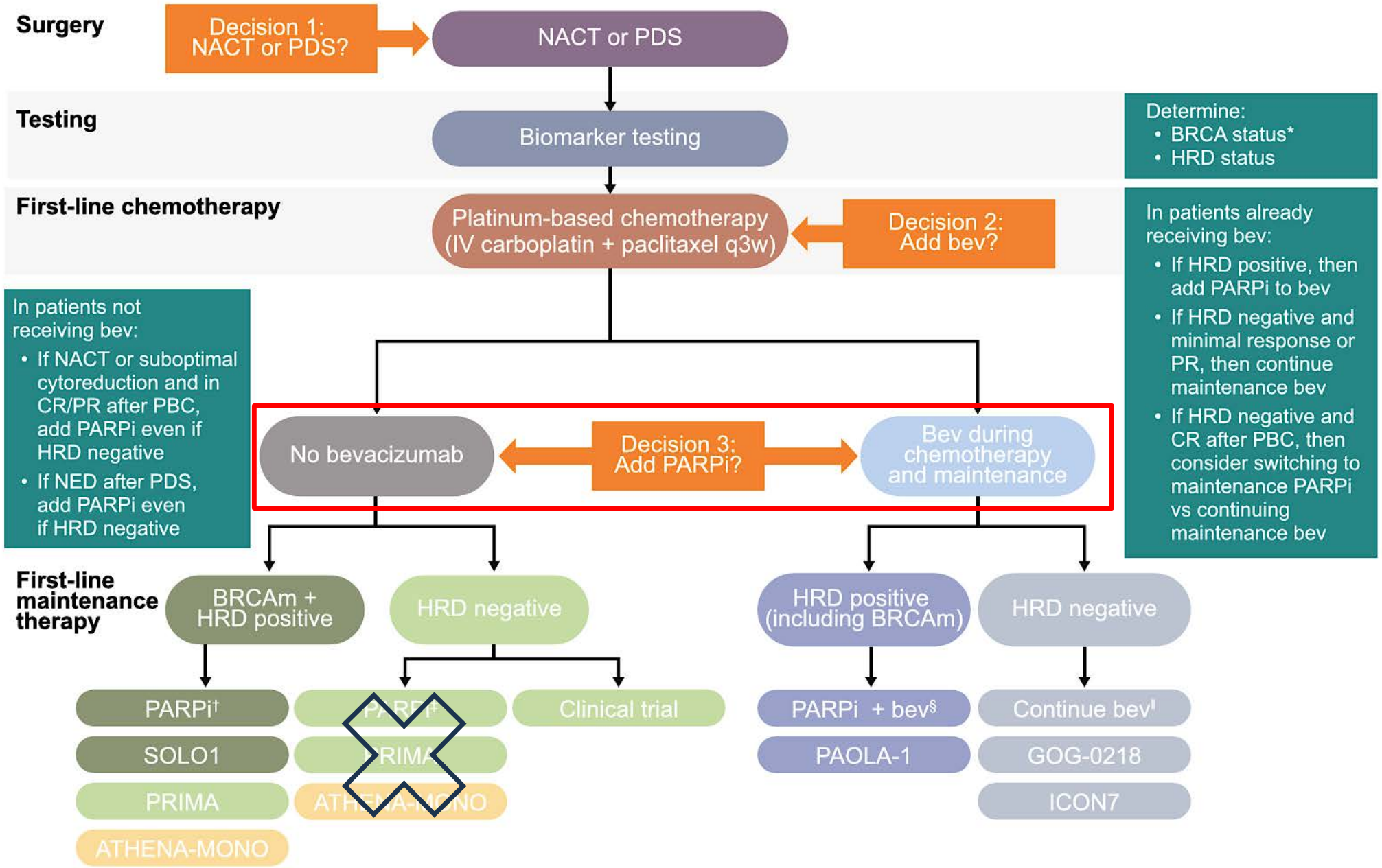
Study	Arms	Sample size	Median PFS (months)	Hazard ratio	*P*-value	Survival advantage
GOG 218 [7]	Arm 1: carboplatin + paclitaxel + placebo	625	10.3 (12.0 π)			
	Arm 2: carboplatin + paclitaxel + bevacizumab + placebo	623	11.2	0.91	0.16	No
	Arm 3: carboplatin + paclitaxel + bevacizumab with maintenance (total 15 months)	625	14.1 (18.0 π)	0.72 0.65 π	<0.0001 <0.0001 π	Stage IV
ICON7 [8]	Arm 1: carboplatin + paclitaxel	764	17.3 α			
	Arm 2: carboplatin + paclitaxel + bevacizumab with maintenance (total 12 months)	764	19.0 α	0.81	0.004	'Patients at high risk for progression'
AURELIA [9]	Arm 1: chemotherapy*	182	3.4 α			
	Arm 2: chemotherapy* + bevacizumab	179	6.7 α	0.48	0.001	No
OCEANS [10]	Arm 1: carboplatin + gemcitabine + placebo	242	8.4 α			
	Arm 2: carboplatin + gemcitabine + bevacizumab until progression	242	12. 4 α	0.48	<0.0001	No

Progression by Ca125 censored

? Standard of Care

? For "high-risk" patients only

Monk BJ, Pujade-Lauraine E, Burger RA. Integrating bevacizumab into the management of epithelial ovarian cancer: the controversy of front-line versus recurrent disease. Ann Oncol. 2013



O'Malley DM, Krivak TC, Kabil N, Munley J, Moore KN. PARP Inhibitors in Ovarian Cancer: A Review. Target Oncol

Frontline Maintenance – The PARPi story

PAOLA-1

ORIGINAL ARTICLE

Olaparib plus Bevacizumab as First-Line Maintenance in Ovarian Cancer

I. Ray-Coquard, P. Pautier, S. Pignata, D. Pérol, A. González-Martín, R. Berger, K. Fujiwara, I. Vergote, N. Colombo, J. Mäenpää, F. Selle, J. Sehouli, D. Lorusso, E.M. Guerra Alía, A. Reinthaller, S. Nagao, C. Lefeuvre-Plesse, U. Canzler, G. Scambia, A. Lortholary, F. Marmé, P. Combe, N. de Gregorio, M. Rodrigues, P. Buderath, C. Dubot, A. Burges, B. You, E. Pujade-Lauraine, and P. Harter, for the PAOLA-1 Investigators*

PRIMA

ORIGINAL ARTICLE

Niraparib in Patients with Newly Diagnosed Advanced Ovarian Cancer

A. González-Martín, B. Pothuri, I. Vergote, R. DePont Christensen, W. Graybill, M.R. Mirza, C. McCormick, D. Lorusso, P. Hoskins, G. Freyer, K. Baumann, K. Jardon, A. Redondo, R.G. Moore, C. Vulsteke, R.E. O'Cearbhaill, B. Lund, F. Backes, P. Barretina-Ginesta, A.F. Haggerty, M.J. Rubio-Pérez, M.S. Shahin, G. Mangili, W.H. Bradley, I. Bruchim, K. Sun, I.A. Malinowska, Y. Li, D. Gupta, and B.J. Monk, for the PRIMA/ENGOT-OV26/GOG-3012 Investigators*

SOLO-1

ORIGINAL ARTICLE

Maintenance Olaparib in Patients with Newly Diagnosed Advanced Ovarian Cancer

K. Moore, N. Colombo, G. Scambia, B.-G. Kim, A. Oaknin, M. Friedlander, A. Lisyanskaya, A. Floquet, A. Leary, G.S. Sonke, C. Gourley, S. Banerjee, A. Oza, A. González-Martín, C. Aghajanian, W. Bradley, C. Mathews, J. Liu, E.S. Lowe, R. Bloomfield, and P. DiSilvestro

N Engl J Med. 2018;379(26):2495-2505.

VELIA

ORIGINAL ARTICLE

Veliparib with First-Line Chemotherapy and as Maintenance Therapy in Ovarian Cancer

R.L. Coleman, G.F. Fleming, M.F. Brady, E.M. Swisher, K.D. Steffensen, M. Friedlander, A. Okamoto, K.N. Moore, N. Efrat Ben-Baruch, T.L. Werner, N.G. Cloven, A. Oaknin, P.A. DiSilvestro, M.A. Morgan, J.-H. Nam, C.A. Leath III, S. Nicum, A.R. Hagemann, R.D. Littell, D. Cella, S. Baron-Hay, J. Garcia-Donas, M. Mizuno, K. Bell-McGuinn, D.M. Sullivan, B.A. Bach, S. Bhattacharya, C.K. Rataiczak, P.I. Ansell, M.H. Dinh, C. Aghajanian, and M.A. Bookman

First Line Treatment Options in Newly Diagnosed Advanced Ovarian Cancer

2003	2011	1L maintenance BRCAm 2018	1L maintenance beyond BRCAm 2019+
Chemotherapy	Bevacizumab: GOG-0218[1], ICON7[2]	Olaparib: SOLO-1[3]	Olaparib + bev: PAOLA-1[4]
			Niraparib: PRIMA[5]
			Veliparib: VELIA[6]
			Rucaparib: ATHENA[7]

Options have expanded in recent years ….

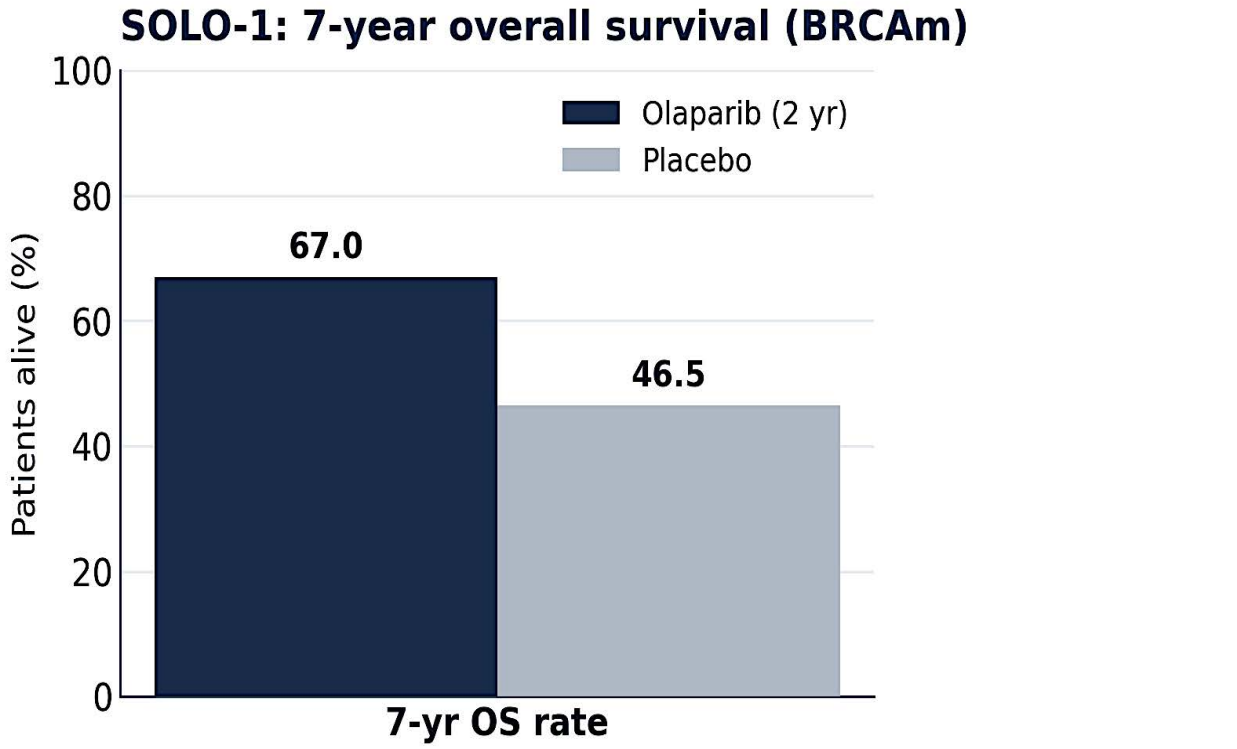
… inflection point

In 2018, we witnessed a paradigm shift in the First Line Treatment

1. Burger R, et al. N Engl J Med. 2011;365:2473-2483; 2. Perren TJ, et al. N Engl J Med. 2011;365:2484-2496; 3. Moore K, et al. N Engl J Med. 2018;379:2495-2505; 4. Ray-Coquard I, et al. N Engl J Med. 2019;381:2416-2428; 5. Gonzalez-Martin A, et al. N Engl J Med. 2019;381:2391-2402; 6. Coleman RL, et al. N Engl J Med. 2019;381:2403-2415; 7. Monk BJ, et al. J Clin Oncol. 2022;40:3952-3964.

SOLO-1: Olaparib in BRCA-mutated disease

SECTION 02 · LONG-TERM OUTCOMES



Median OS: not reached vs 75.2 mo · HR 0.55 (95% CI 0.40–0.76), 38% maturity

- **Population:** BRCA1/2-mutated newly diagnosed; olaparib ×2 years (n=260) vs placebo (n=131)
- **Practice-defining PFS:** median 56.0 vs 13.8 months (HR 0.33) at 5 years
- **Longest PARP follow-up:** 7-yr OS 67.0% vs 46.5%; median OS not reached vs 75.2 mo
- **OS HR 0.55** (95% CI 0.40–0.76) — clinically meaningful; not formally significant (38% maturity)

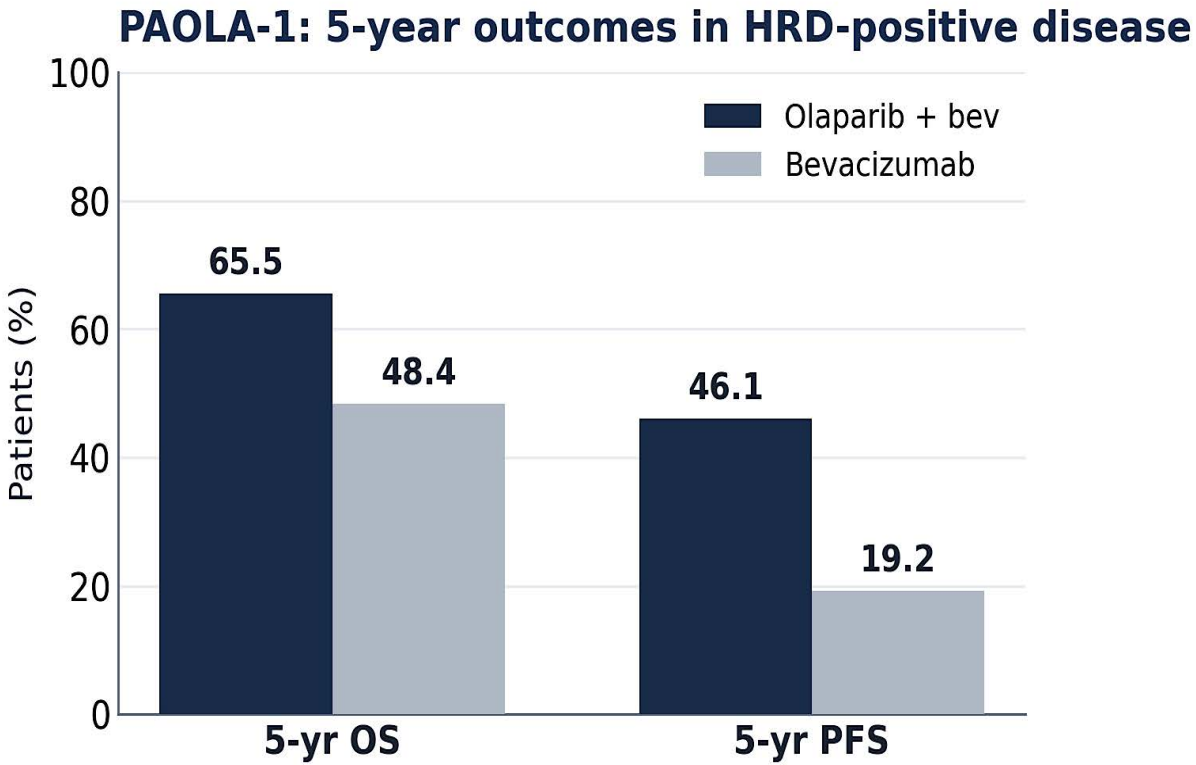
44.3% of patients in the placebo arm receiving subsequent PARPi therapy compared with 14.6% in the Olaparib arm

- **Takeaway:** a finite 2-year course yields durable, plateau-like benefit in BRCAm disease

Banerjee et al. Lancet Oncol 2021 (5-yr PFS); DiSilvestro et al. J Clin Oncol 2023 (7-yr OS). SOLO-1/GOG-3004.

PAOLA-1: olaparib + bevacizumab (HRD-positive)

SECTION 02 · LONG-TERM OUTCOMES



OS HR 0.62 (0.45–0.85) · PFS HR 0.41 (0.32–0.54) · no OS benefit in HRD-negative

- **Design:** olaparib + bev vs bev alone, on a bevacizumab backbone; benefit confined to HRD-positive
- **5-yr PFS:** 46.1% vs 19.2% (HR 0.41, 95% CI 0.32–0.54)
- **5-yr OS:** 65.5% vs 48.4% (HR 0.62, 95% CI 0.45–0.85) in HRD-positive
- **By clinical risk group (5-yr OS):**

  Higher-risk HRD+ 55% vs 42%

  Lower-risk HRD+ 88% vs 61%

Ray-Coquard et al. NEJM 2019; final OS Ann Oncol 2023; risk-stratified IJGC 2024. PAOLA-1/ENGOT-ov25.

PRIMA: niraparib — the PFS / OS disconnect

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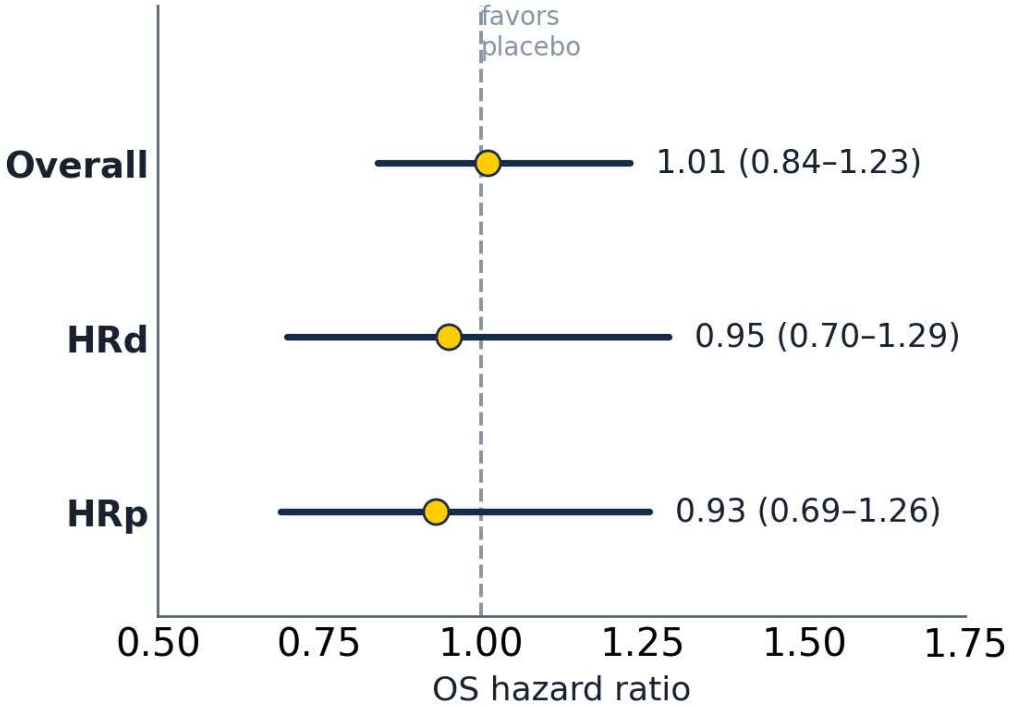
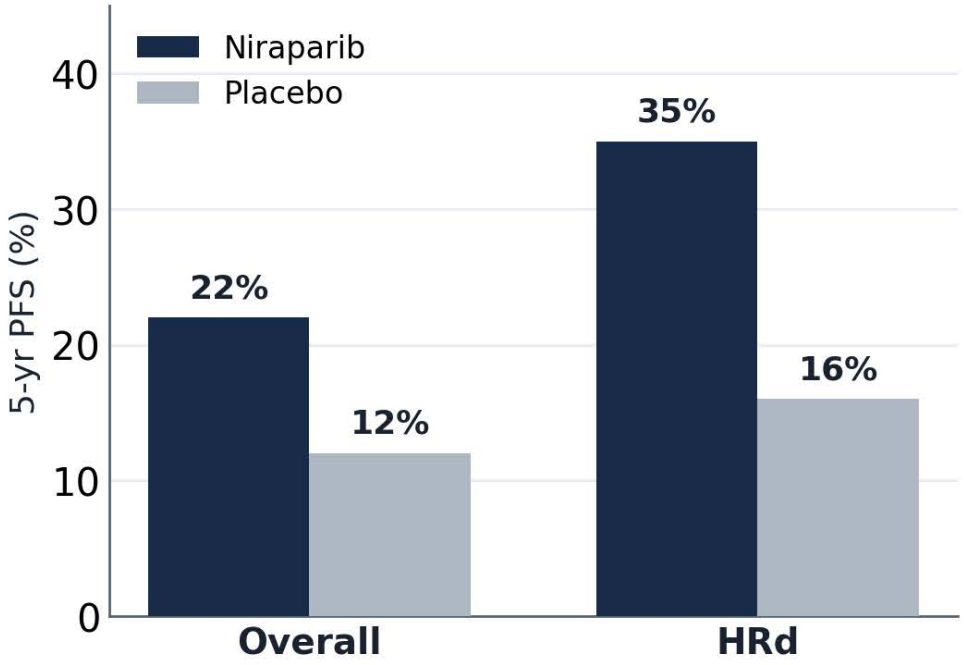
SECTION 02 · LONG-TERM OUTCOMES

Overall survival: no benefit



5-year PFS: benefit sustained

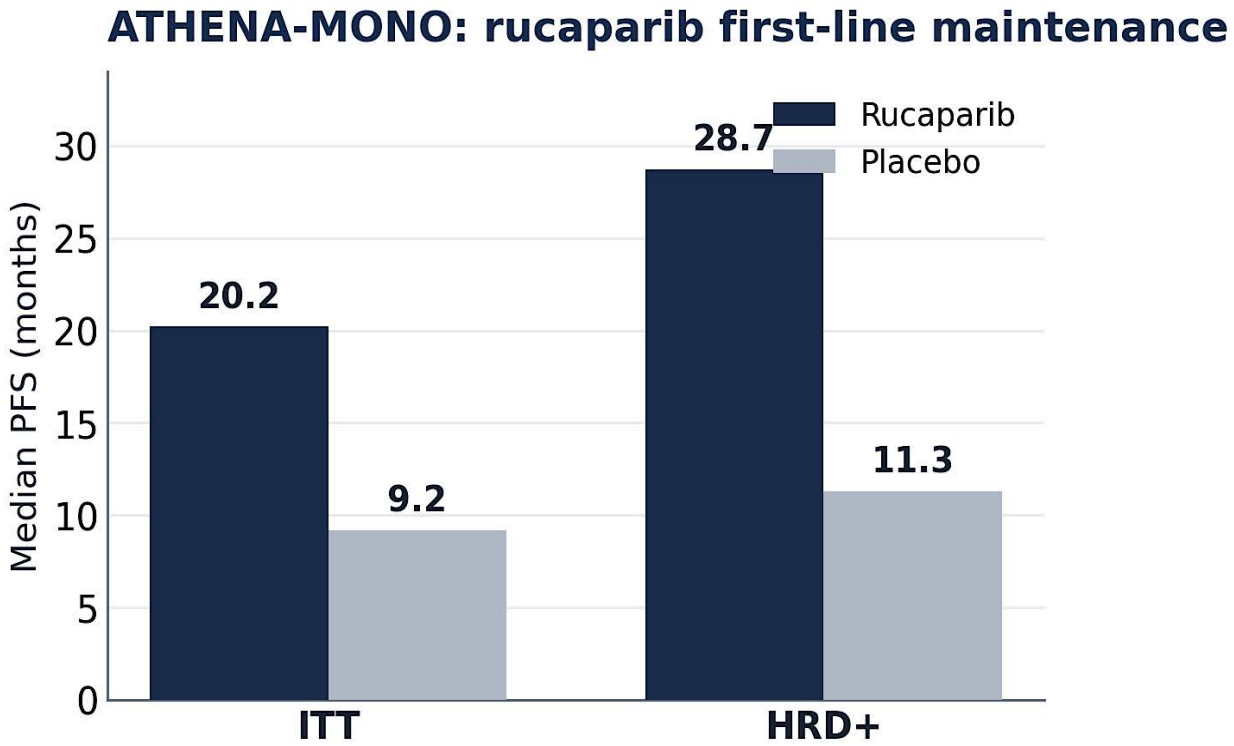


Summary: Durable PFS benefit (sustained at 5 years) that did not translate into a significant OS benefit in any subgroup — tension behind biomarker-unselected use

González-Martín et al. NEJM 2019; final OS Ann Oncol 2024. PRIMA/ENGOT-OV26/GOG-3012.

ATHENA-MONO: rucaparib first-line maintenance

SECTION 02 · LONG-TERM OUTCOMES



ITT HR 0.52 · HRD+ HR 0.47 (0.31–0.72)

- **All-comers:** rucaparib ×2 years vs placebo after response to platinum
- **ITT PFS:** 20.2 vs 9.2 months (HR 0.52)
- **HRD-positive PFS:** 28.7 vs 11.3 months (HR 0.47, 95% CI 0.31–0.72)
- **HRD-negative:** more modest benefit, consistent with the HR gradient
- **Regulatory note:** Not FDA-approved for 1L maintenance in the US

Monk et al. J Clin Oncol 2022; 5-yr interim update Ann Oncol 2025. ATHENA-MONO/GOG-3020/ENGOT-ov45.

No randomized clinical trial data available to directly demonstrate efficacy contribution of bevacizumab to 1L PARPi maintenance

No olaparib monotherapy arm in

- PAOLA-1[1]

No bevacizumab combination arm in

- SOLO1[2]
- PRIMA[3]
- ATHENA-MONO[4]

Ongoing trials will allow a direct comparison of 1L PARPi with and without bevacizumab

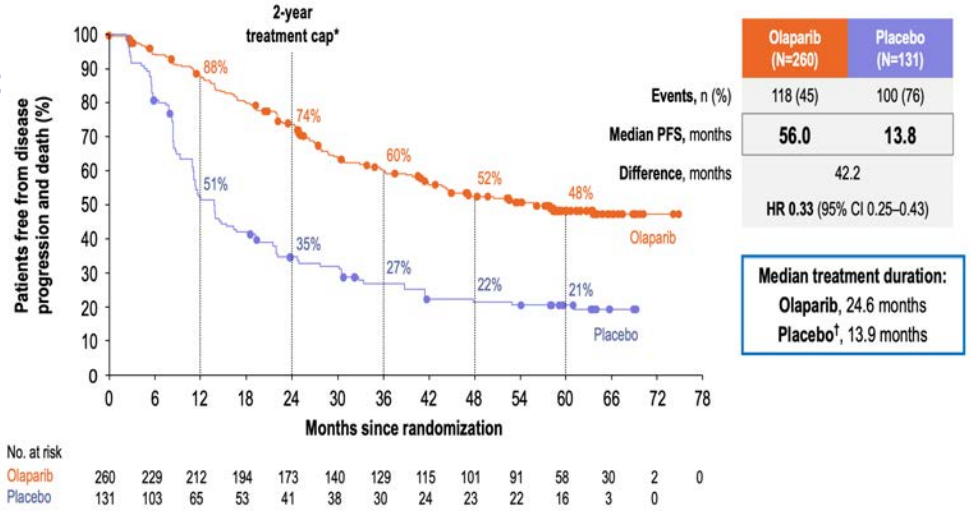
NIRVANA-1[5]	AGO-OVAR 28[6]	MITO25[7]
Niraparib ± bevacizumab as maintenance after complete cytoreduction	Niraparib vs niraparib + bevacizumab as maintenance after platinum + bevacizumab	Chemotherapy ± bevacizumab followed by rucaparib maintenance ± bevacizumab or bevacizumab alone

But what evidence is available to guide clinical practice for today?

1. Ray-Coquard I, et al. *N Engl J Med* 2019;381:2416–242; 2. Moore K, et al. *N Engl J Med* 2018;379:2495–2505. 3. Gonzalez-Martin A, et al. *N Engl J Med* 2019;381:2391–2402; 4. Monk BJ, et al. *Int J Gynecol Cancer* 2021;31:1589–1594; 5. ClinicalTrials.gov. Available at: https://clinicaltrials.gov/ct2/show/NCT05183984 (Accessed November 2022); 6. ClinicalTrials.gov. Available at: https://clinicaltrials.gov/ct2/show/NCT05009082 (Accessed November 2022); 7. ClinicalTrials.gov. Available at: https://clinicaltrials.gov/ct2/show/NCT03462212 (Accessed November 2022)

The Improvement of PFS By PARP Inhibitors in HRD Population Is Clinically Meaningful.

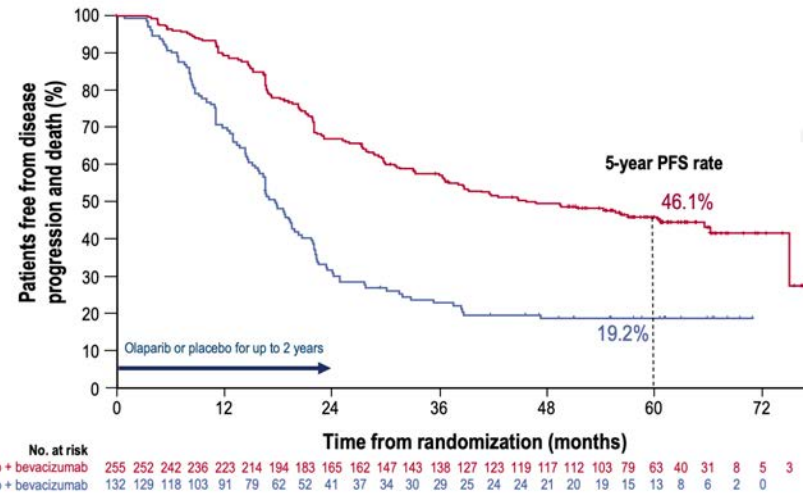
SOLO-1[1,2]



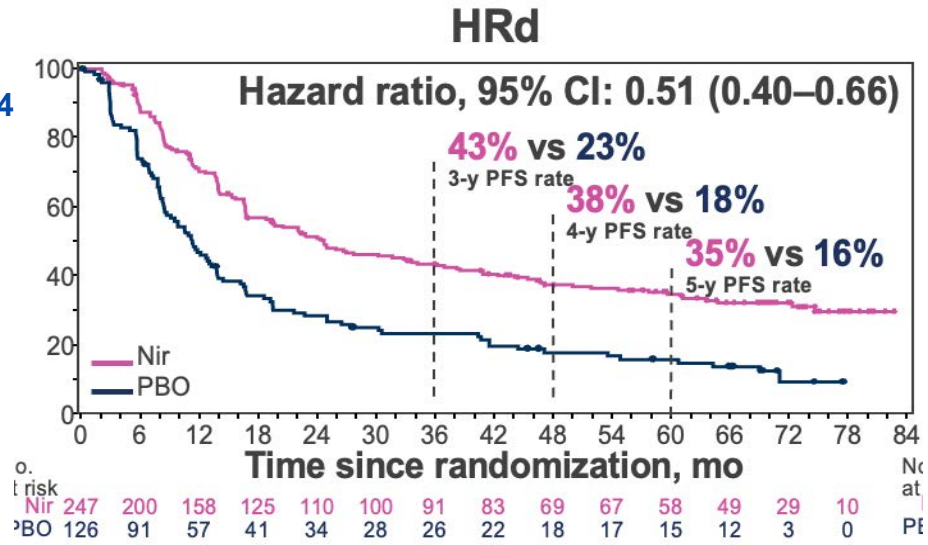
	Olaparib (N=260)	Placebo (N=131)
Events, n (%)	118 (45)	100 (76)
Median PFS, months	56.0	13.8
Difference, months	42.2	
	HR 0.33 (95% CI 0.25–0.43)	

Median treatment duration:
Olaparib, 24.6 months
Placebo†, 13.9 months

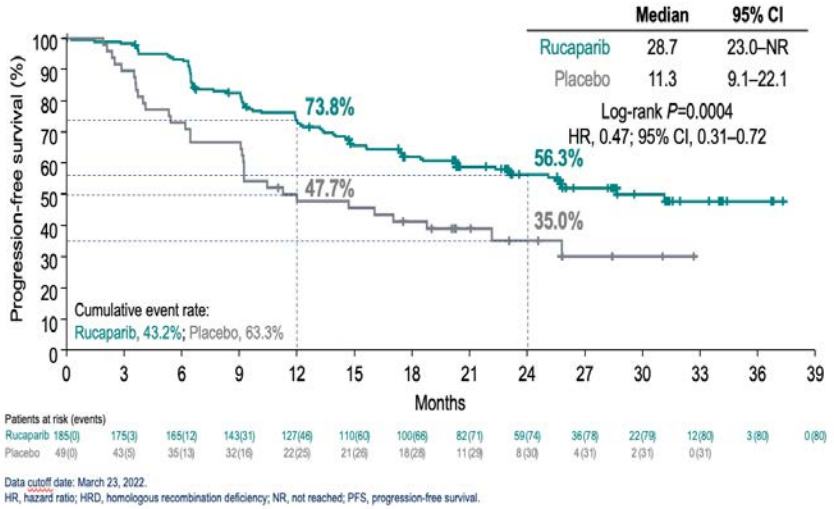
PAOLA-1[3]



PRIMA[4]



ATHENA[5]



1. Banerjee S, et al. Lancet Oncol. 2021;12:1721-1731; 2. Moore K, et al. N Engl J Med. 2018;379:2495-2505; 3. Ray-Coquard I, et al. Ann Oncol. 2023;34:681-692;
4. Monk B, et al. Ann Oncol. 2024;35:981-992; 5. Monk BJ, et al. J Clin Oncol. 2022;40:3952-3964.

SECTION 03

Selecting up-front maintenance therapy

Matching regimen to biology, the chemotherapy backbone, and the patient.

Biomarker-directed regimen selection

SECTION 03 · CHOOSING THERAPY

BRCA-mutated

- **Olaparib ×2 y (SOLO-1)**
- **Olaparib + bev if bev used (PAOLA-1)**
- **Niraparib is an option**

- **Largest, most durable benefit — including provocative directional OS benefit**

BRCAwt / HRD+

- **Olaparib + bev (PAOLA-1) — Suggested OS benefit**
- **Niraparib (PRIMA) — PFS benefit**
- **Clear PFS gain**

- **Contribution of Bevacizumab use at the start of treatment?**

HR-proficient

- **NO current US FDA approved indication for maintenance PARPi** (prior niraparib indication retracted)
- Bevacizumab alone is reasonable

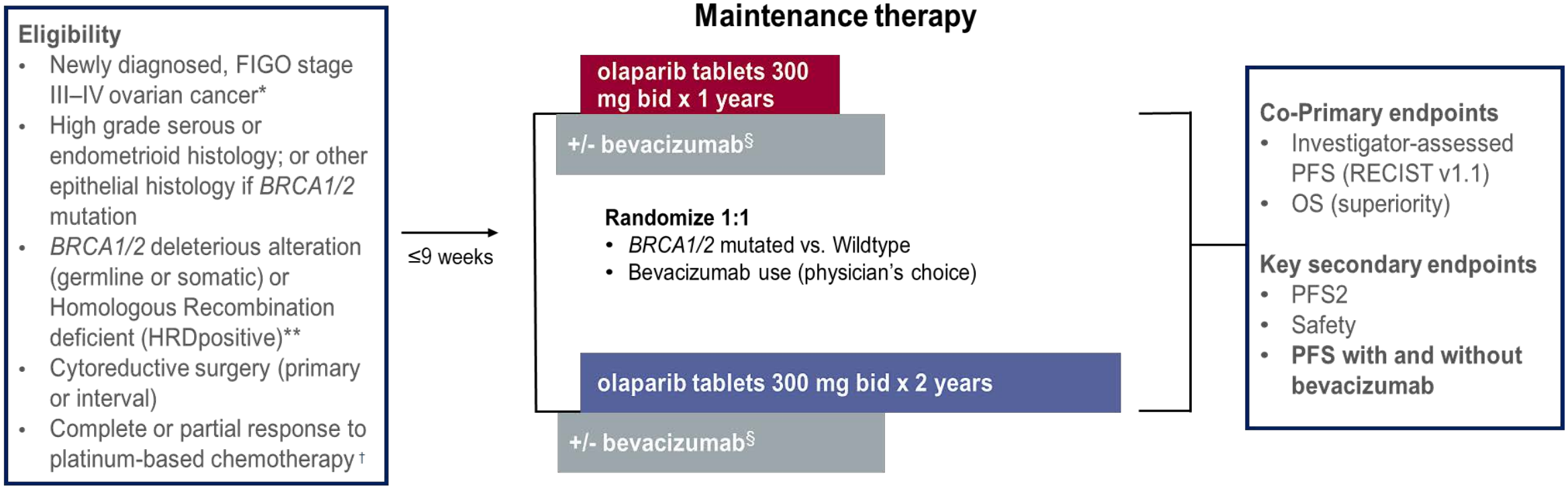
- **Is observation an option for some?**

SECTION 04

Ongoing phase III trials

Refining the unanswered questions: who benefits, and for how long.

Is there an opportunity to de-escalate therapy in the HRD+ population? NRG GY036



*Ovarian cancer = fallopian tube cancer, ovarian cancer, or primary peritoneal cancer. **Using any commercially available test for *BRCA1/2* and HRD (ex. Myriad MyChoice).
†Patients must have received ≥3 and ≤9 cycles of platinum-based chemotherapy
§Bevacizumab 15 mg/kg every 3 weeks for a total of 15 months, including when administered with chemotherapy. Patients must have received ≥3 cycles of bevacizumab with the last 3 cycles of chemotherapy, apart from patients undergoing interval surgery who were permitted to receive only 2 cycles of bevacizumab with the last 3 cycles of chemotherapy;
PFS, times from randomization to first progression or death; PFS2, time from randomization to second progression or death;
Abbreviations: bid, twice daily; FIGO, International Federation of Gynecology and Obstetrics; RECIST, Response Evaluation Criteria in Solid Tumours.

Do we need two years of PARPi in HRD tumors? Opportunity to de-escalate?

MONO-OLA1 and NRG-GY036

SECTION 04 · ONGOING TRIALS

MONO-OLA1

NCT04884360

Question: Does olaparib monotherapy help BRCA-wildtype patients (without bevacizumab)?

Design: Phase III, olaparib vs placebo maintenance after 1L platinum response

Population: BRCA-wildtype stage III–IV high-grade serous/endometrioid OC

Primary: PFS in BRCAwt/HRD+ and in the overall BRCAwt population

NRG-GY036

NCT06580314

Question: Is 1 year of maintenance olaparib as good as 2 years?

Design: Phase III, 1 vs 2 y olaparib ± bev; NRG's first pragmatic/streamlined trial

Population: BRCA-mutated or HRD-positive OC after 1L platinum response

Primary: Non-inferiority of shorter duration (de-escalation)

SECTION 05

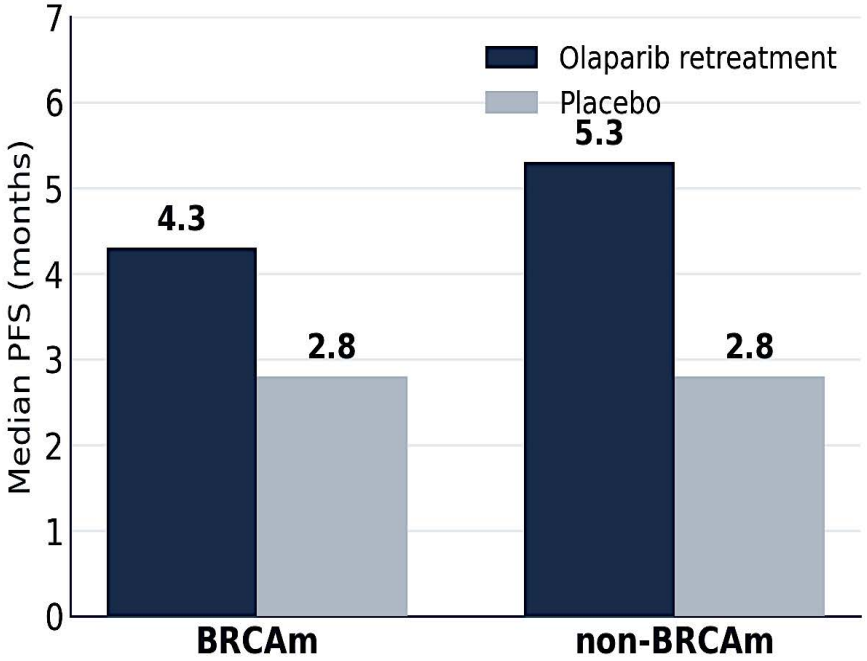
PARP inhibitors in the relapsed / refractory setting

Including patients who progress after prior PARP-inhibitor therapy.

Relapsed disease and PARP rechallenge

SECTION 05 · RELAPSED / POST-PARP

OReO/ENGOT-ov38: PARP-inhibitor rechallenge



BRCAm HR 0.57 (p=0.022) · non-BRCAm HR 0.43 (p=0.0023) · 1-yr PFS 14–19% vs 0%

- **2L+ maintenance has narrowed**

Most patients now receive PARP in 1L; later-line treatment indications were withdrawn in the US

- **OReO: rechallenge is feasible**

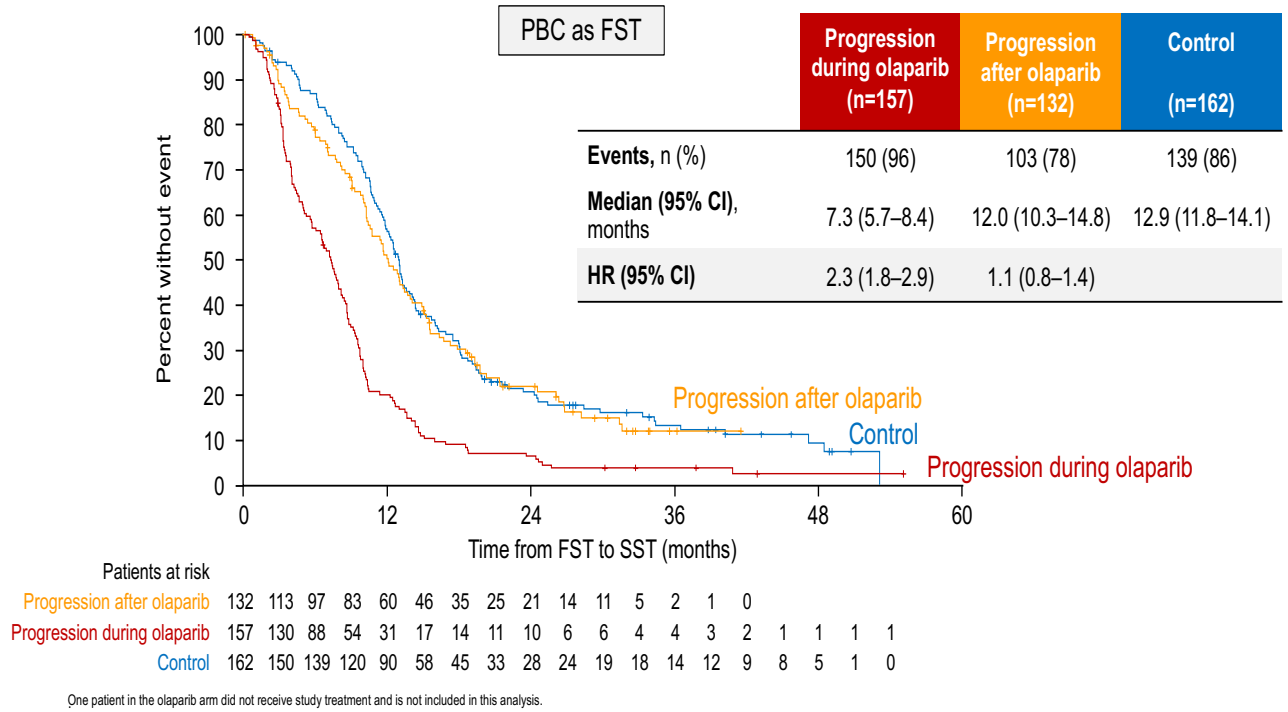
Modest PFS gain after prior PARP — BRCAm HR 0.57, non-BRCAm HR 0.43; 1-yr PFS 14–19% vs 0%

- **Post-PARP progression = ? cross-resistance**

Reversion mutations / restored HR
Response to subsequent platinum rechallenge may be compromised

Pujade-Lauraine et al. (OReO/ENGOT-ov38) Ann Oncol 2023. ARIEL4; FDA label revisions 2022.

Efficacy of Platinum-based Chemotherapy Appears To Be Reduced After Progression On PARPi In The Retrospective Post Hoc Exploratory Analysis Of PAOLA-1



	Progression during olaparib (n=157)	Progression after olaparib (n=132)	Control (n=162)
Events, n (%)	150 (96)	103 (78)	139 (86)
Median (95% CI), months	7.3 (5.7–8.4)	12.0 (10.3–14.8)	12.9 (11.8–14.1)
HR (95% CI)	2.3 (1.8–2.9)	1.1 (0.8–1.4)	

One patient in the olaparib arm did not receive study treatment and is not included in this analysis.

Best response to combination therapy with PBC as FST[1]

Best overall response, *n* (%)	Progression during first-line olaparib maintenance therapy	Progression after first-line olaparib maintenance therapy	Placebo plus bevacizumab arm
Any chemotherapy as FST	*n* = 192	*n* = 145	*n* = 206
Complete response	11 (5.7)	33 (22.8)	38 (18.4)
Partial response	37 (19.3)	39 (26.9)	75 (36.4)
Progressive disease	88 (45.8)	26 (17.9)	38 (18.4)
Stable disease	43 (22.4)	30 (20.7)	43 (20.9)
Not evaluable	13 (6.8)	17 (11.7)	12 (5.8)
Combination PBC as FST	*n* = 157	*n* = 132	*n* = 162
Complete response	11 (7.0)	32 (24.4)	35 (21.6)
Partial response	36 (22.9)	37 (28.0)	68 (42.0)
Progressive disease	64 (40.8)	22 (16.7)	18 (11.1)
Stable disease	39 (24.8)	29 (22.0)	32 (19.8)
Not evaluable	7 (4.5)	12 (9.1)	9 (5.6)

~30% ~52% ~64%

Harter P, et al. Ann Oncol. 2025;36:185-196.

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Regulatory and reimbursement issues aside, what would you most likely recommend as maintenance therapy for a woman with Stage IIIC ovarian cancer (OC) after optimal debulking surgery and chemotherapy with the following biomarker status?

	Germline BRCA	BRCA-negative, HRD-positive	BRCA-negative, HRD-negative
 Prof Eskander	Olaparib	Olaparib/bevacizumab	Bevacizumab
 Dr Matulonis	Olaparib	Niraparib	Bevacizumab
 Dr Moore	Olaparib	Olaparib/bevacizumab	Bevacizumab
 Dr Olawaiye	Olaparib	Olaparib/bevacizumab	Observation
 Dr O'Malley	Olaparib/bevacizumab	Olaparib/bevacizumab	Bevacizumab
 Prof Colombo	Olaparib	Olaparib/bevacizumab	Bevacizumab

HRD = homologous recombination deficiency

Regulatory and reimbursement issues aside, what would you most likely recommend as maintenance therapy for a woman with BRCA-negative Stage IIIC ovarian cancer (OC) after optimal debulking surgery and chemotherapy with the following biomarker status?

	HRD-indeterminate on 3 attempts	HRD-indeterminate on 3 attempts, rapid response to neoadjuvant chemo
 Prof Eskander	Depends on reason for HRD-indeterminant results	Olaparib/bevacizumab
 Dr Matulonis	Bevacizumab	Bevacizumab
 Dr Moore	Bevacizumab	Niraparib
 Dr Olawaiye	Observation	Olaparib/bevacizumab
 Dr O'Malley	Olaparib/bevacizumab	Olaparib/bevacizumab
 Prof Colombo	Bevacizumab	Niraparib or rucaparib

Regulatory and reimbursement issues aside, what would you most likely recommend as maintenance therapy for a woman with Stage IIIC OC after optimal debulking surgery and chemotherapy/bevacizumab with the following biomarker status?

	Germline BRCA	BRCA-negative, HRD-positive	BRCA-negative, HRD-negative
 Prof Eskander	Olaparib/bevacizumab	Olaparib/bevacizumab	Bevacizumab
 Dr Matulonis	Olaparib/bevacizumab	Olaparib/bevacizumab	Bevacizumab
 Dr Moore	Olaparib/bevacizumab	Olaparib/bevacizumab	Bevacizumab
 Dr Olawaiye	Olaparib/bevacizumab	Olaparib/bevacizumab	Observation
 Dr O'Malley	Olaparib/bevacizumab	Olaparib/bevacizumab	Bevacizumab
 Prof Colombo	Olaparib/bevacizumab	Olaparib/bevacizumab	Bevacizumab

How would you indirectly compare the global efficacy of olaparib, olaparib/bevacizumab and niraparib when administered as up-front maintenance therapy for patients with advanced OC and the following biomarker status?

	BRCA mutation	BRCA wild type, HRD-positive
 Prof Eskander	Efficacy is about the same	Olaparib/bevacizumab is the most efficacious
 Dr Matulonis	Either olaparib alone or olaparib/bevacizumab in this setting	Efficacy is about the same
 Dr Moore	Olaparib/bevacizumab is the most efficacious	Olaparib/bevacizumab is the most efficacious
 Dr Olawaiye	Olaparib is most efficacious	Olaparib/bevacizumab is the most efficacious
 Dr O'Malley	Efficacy is about the same	Olaparib/bevacizumab is the most efficacious
 Prof Colombo	Olaparib/bevacizumab is the most efficacious	Olaparib/bevacizumab is the most efficacious

In which situations, if any, are you currently offering up-front PARP inhibitor maintenance to patients with BRCA wild-type, HRD-negative disease?

 Prof Eskander	None
 Dr Matulonis	None
 Dr Moore	None
 Dr Olawaiye	None
 Dr O'Malley	None
 Prof Colombo	Only in case of an optimal response to chemotherapy, with favorable KELIM score and CRS3

In which situations, if any, will you rechallenge with a PARP inhibitor for a patient who has received one in the up-front maintenance setting and subsequently experienced disease progression?

 Prof Eskander	Patients with a BRCA mutation who completed their PARPi maintenance therapy and then developed a recurrence
 Dr Matulonis	After at least 3-5 years since completion of upfront PARPi and recurrence
 Dr Moore	Would consider if no reversion mutation in a patient with a BRCA mutation who experiences good response to 2L platinum
 Dr Olawaiye	Still platinum sensitive with >12 months platinum-free/PARP inhibitor-free/progression-free interval/survival
 Dr O'Malley	If they did not experience progression on PARPi and had a long (2+ years) disease-free interval
 Prof Colombo	None, no data to support this option

RTP RESEARCH TO PRACTICE

Agenda

Module 1: Current Role of PARP Inhibitors in the Management of Advanced Ovarian Cancer (OC) — Prof Eskander

Module 2: Strategies Targeting Folate Receptor Alpha in Advanced OC — Dr Matulonis

Module 3: Other Approved and Promising Investigational Antibody-Drug Conjugates for Advanced OC — Dr Moore

Module 4: Other Novel Agents and Strategies for Advanced OC — Dr O'Malley

Module 5: Diagnosis and Management of Adverse Events Associated with Common Therapies for Advanced OC — Dr Olawaiye

RTP RESEARCH TO PRACTICE

Strategies Targeting Folate Receptor Alpha (FRα) in Advanced Ovarian Cancer

Ursula Matulonis, MD
Chief, Division of Gynecologic Oncology
Dana-Farber Cancer Institute
Professor of Medicine
Harvard Medical School
Boston MA

Folate receptor alpha expression in ovarian cancer histologies and testing

Ventana assay for FOLR1 expression: FDA approved to select patients who are eligible to receive mirvetuximab soravtansine

Positive test: ≥75% of viable tumor cells exhibiting at least 2+ level (moderate and/or strong intensity levels) of membrane staining by IHC

Ovarian cancer histology	Level of high FOLR1 expression:
High Grade Serous	~35%
Low Grade Serous	30-40%
Clear Cell	8%
Endometrioid	6%
Mucinous	0%

Matulonis et al, JCO 2023
Manning Geist, Gyn Onc 2024
Leung et al, J Gyn Oncology 2025

Early clinical trial testing of Mirvetuximab soravtansine

Phase 1: 44 patients enrolled

Doses started at 0.15 up through 7.0 mg/kg

Ocular toxicities found to correlate with dose and exposure, so Adjusted Ideal Body weight was used

Dose escalation went to 7 mg/kg (low phos and eye tox)

Both 5 and 6 mg/kg were then tested (n=7 per group) and no DLTs were observed

6 mg/kg via AIBW was selected as the RP2D

<u>Phase I expansion cohort (46 pts):</u>
ORR for pts who received 1 to 3 prior lines: 39%
ORR for pts who had received ≥ 4 lines was 13%

Good concordance of FRα expression in archival and pre-treatment biopsy tissues, ranging from 71%-86%

Moore et al, JCO 2016, Cancer 2017 and Martin et al, Gyn Onc 2017, Swisher et al, ASCO 2025

65 yo F

Diagnosed with advanced high grade serous ovarian cancer via an omental biopsy that showed HGSC

Received 3 cycles of neoadjuvant carbo/paclitaxel and underwent cytoreductive surgery

Completed 3 additional cycles of carboplatin, paclitaxel, bevacizumab

Continued bevacizumab maintenance

3 month CT following completion of platinum showed PD

initial scan

Date of specimen	Location	Result of FOLR1	HER2 IHC
Initial Biopsy	Omentum	85%	1+
Interval surgery	Omentum	15%	1+

Went on to receive mirvetuximab: After 2 cycles, CA125 went down transiently but just after cycle #2, started to rise

CT scan showed PD

Mirvetuximab and SORAYA

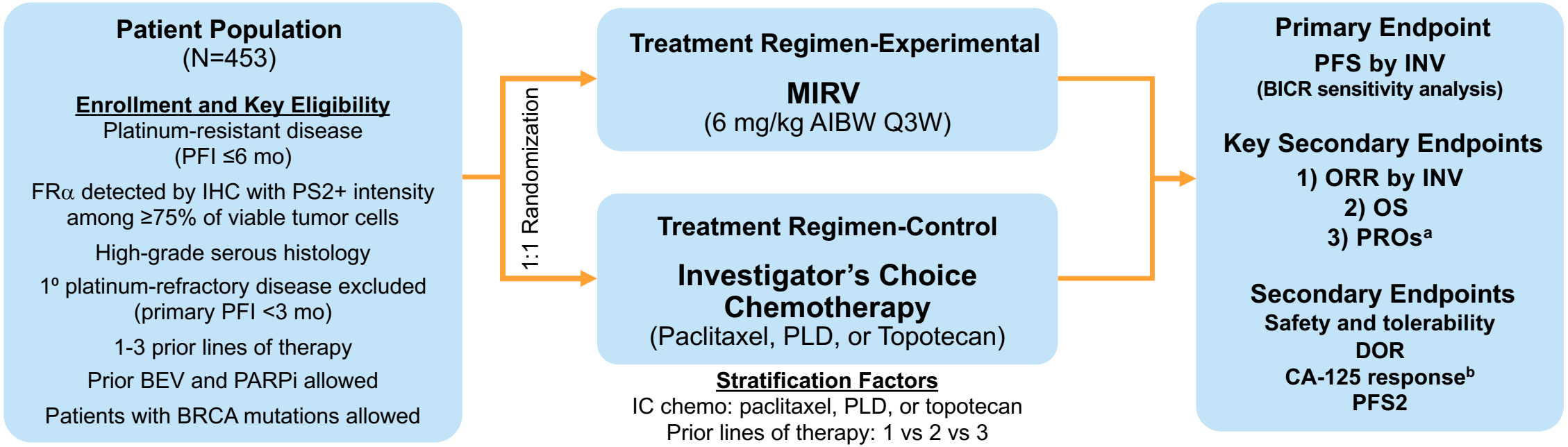
- **SORAYA:** evaluated Mirvetuximab soravtansine for PROC, HGSC with high FRα expression
- 106 pts enrolled
- Primary endpoint: Investigator assessed cORR; Key secondary endpoint: DOR
- Additional eligibility:
  up to 3 prior therapies, including requirement of prior bevacizumab
  Tumor demonstrated FRα-high membrane staining with IHC PS (Proportion Score) 2+ scoring:
  ≥75% of cells staining positive with **≥2+** staining intensity
- Results:
  ORR 32.4%
  mDOR 6.9 m

  N.B.: ORR of 34.8% for pts whose 1st treatment was mirve versus 28.2% for pts receiving mirve as 2nd line + for PROC
- November 2022: accelerated FDA approval

Mirvetuximab FDA PI, Matulonis et al, JCO 2023, Coleman et al, IJGC 2024

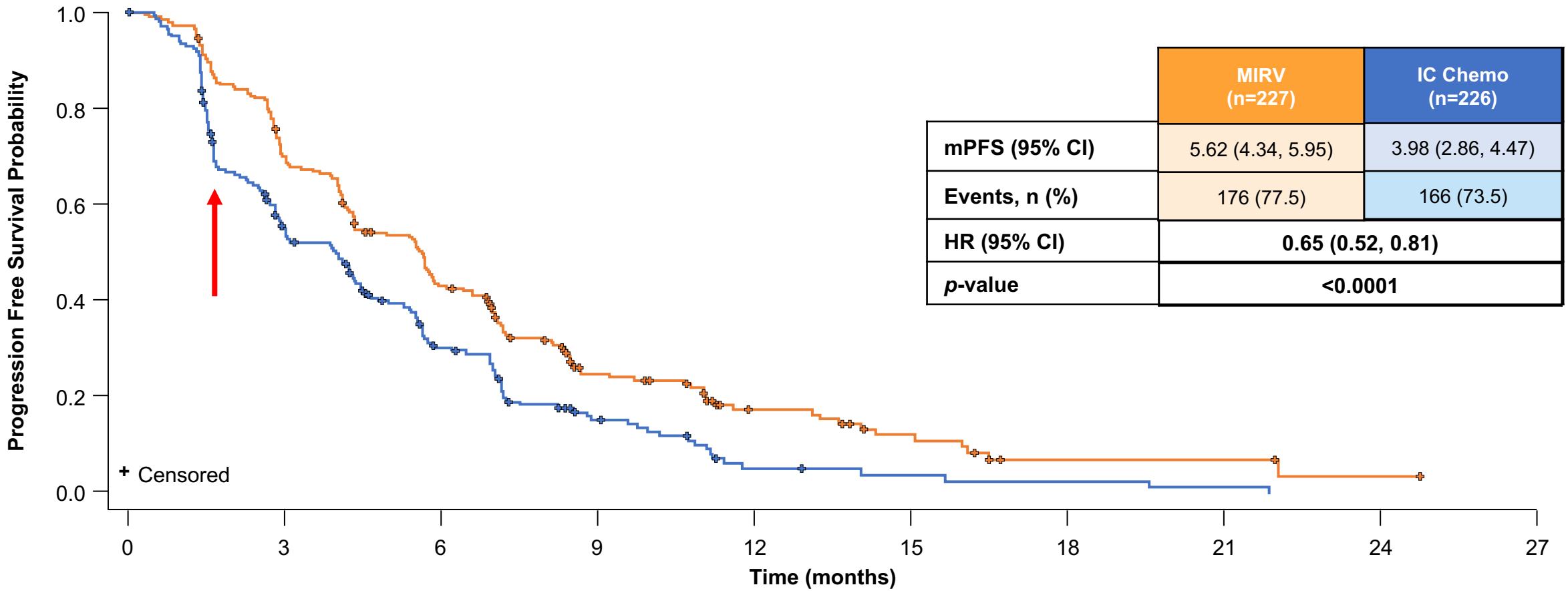
MIRASOL – Study Design[1,2]

An open-label, phase 3 randomized trial of MIRV vs investigator's choice chemotherapy in patients with FRα-high platinum-resistant ovarian cancer



1. ClinicalTrials.gov identifier: NCT04209855. Updated June 16, 2022. Accessed October 5, 2022. https://clinicaltrials.gov/ct2/show/NCT04209855
2. Moore K, et al. Presented at: 2020 American Society of Clinical Oncology Annual Meeting; May 29-31, 2020; Virtual. Abstract TPS6103, NEJM 2023

Primary Endpoint: Progression-Free Survival by Investigator



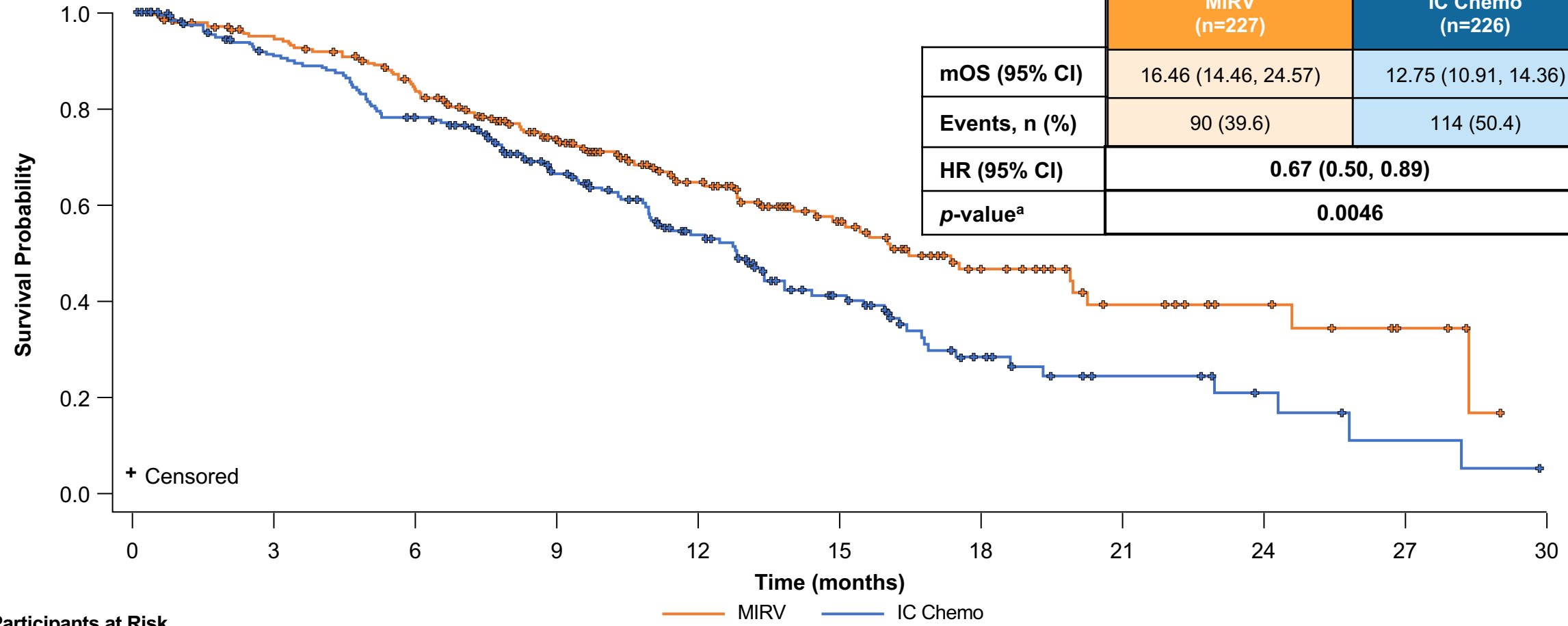
	MIRV (n=227)	IC Chemo (n=226)
mPFS (95% CI)	5.62 (4.34, 5.95)	3.98 (2.86, 4.47)
Events, n (%)	176 (77.5)	166 (73.5)
HR (95% CI)	**0.65 (0.52, 0.81)**	
***p*-value**	**<0.0001**	

No. Participants at Risk

MIRV	227	151	89	38	18	10	3	3	1	0
IC Chemo	226	98	48	19	5	3	2	1	0	

Overall Survival

	MIRV (n=227)	IC Chemo (n=226)
mOS (95% CI)	16.46 (14.46, 24.57)	12.75 (10.91, 14.36)
Events, n (%)	90 (39.6)	114 (50.4)
HR (95% CI)	0.67 (0.50, 0.89)	
p-value[a]	0.0046	



No. Participants at Risk

MIRV	227	204	175	128	82	53	28	15	9	4	0
IC Chemo	226	185	157	107	68	39	18	9	5	2	0

Overall Response Rate by Investigator (N=453)

	MIRV (n=227)	IC Chemo (n=226)
ORR **n, 95% CI**	**42%** 96, (35.8, 49.0)	**16%** 36, (11.4, 21.4)
Best overall response, n (%)		
CR	12 (5%)	0
PR	84 (37%)	36 (16%)
SD	86 (38%)	91 (40%)
PD	31 (14%)	62 (27%)
Not evaluable	14 (6%)	37 (16%)

ORR Difference 26.4% (18.4, 34.4)
OR 3.81 (2.44, 5.94)
***p*<0.0001**

Received full FDA approval on March 22, 2024 for patients with FRα positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have received up to 3 prior systemic treatment regimens.

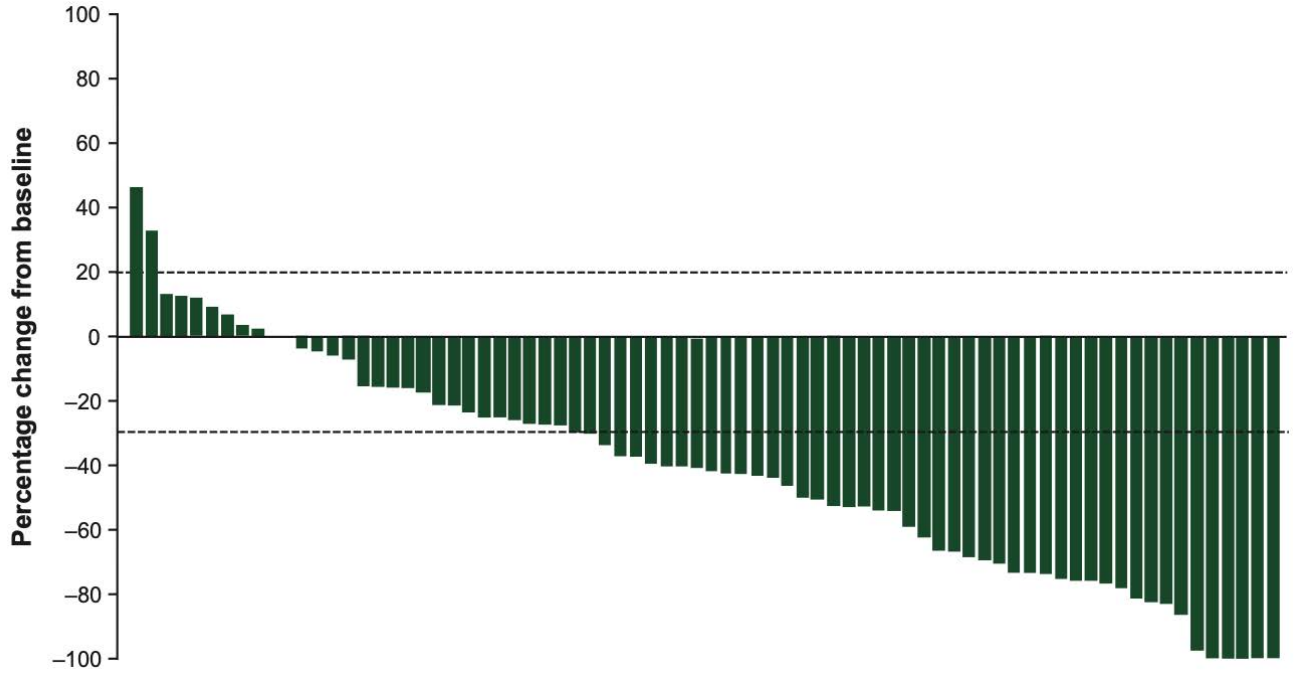
PICCOLO study: Phase 2 of MIRV as ≥ 3L treatment in patients with recurrent platinum sensitive ovarian cancer

Other eligibility: FRa-positive (≥75% of cells with 2+ staining intensity)

Primary endpoint: ORR
Treatment: MIRV 6 mg/kg via AIBW q3 wks IV until PD, tox, withdrawal of consent

79 pts enrolled

Results:
ORR: 51.9% (95% CI 40.4% to 63.3%)
mDOR: 8.25 months
mPFS 6.93 months
OS was not mature



Alvarez Secord, Ann Onc 2025

PICCOLO study: Phase 2 of MIRV as ≥ 3L treatment in patients with recurrent platinum sensitive ovarian cancer

Subgroup	ORR subgroup, *n*	ORR, *n* (%) [95% CI]	DOR subgroup, *n*	Median DOR, months [95% CI]
Prior lines of therapy				
1 or 2	49	27 (55.1) [40.2-69.3]	27	7.44 [4.63-9.66]
3	24	12 (50.0) [29.1-70.9]	12	8.41 [4.63-NR]
≥4	6	2 (33.3) [4.3-77.7]	2	NR [2.69-NR]

4.2026 For plat
NCCN: sensitive

- Mirvetuximab soravtansine-gynx[W] (for FRα-expressing tumors [≥75% positive tumor cells])[35]
- Mirvetuximab soravtansine-gynx + Bevacizumab[r] (for FRα-expressing tumors [≥50% positive tumor cells]) (category 2B)[36]

Alvarez Secord, Ann Onc 2025

Ph 2 of Mirvetuximab/Bevacizumab for recurrent platinum resistant ovarian cancer

Eligibility:
Recurrent platinum resistant high grade serous ovarian cancer
No more than 3 prior lines of treatment
FOLR1 requirements: FOLR1 ≥25% of tumor staining at ≥2+ intensity
Prior Bev and/or PARPi allowed

Primary endpoint: confirmed ORR
Secondary endpoints: DOR, PFS and safety

Treatment:
mirvetuximab soravtansine 6 mg/kg AIBW q3 wks
Bevacizumab 15 mg/kg q3 wks

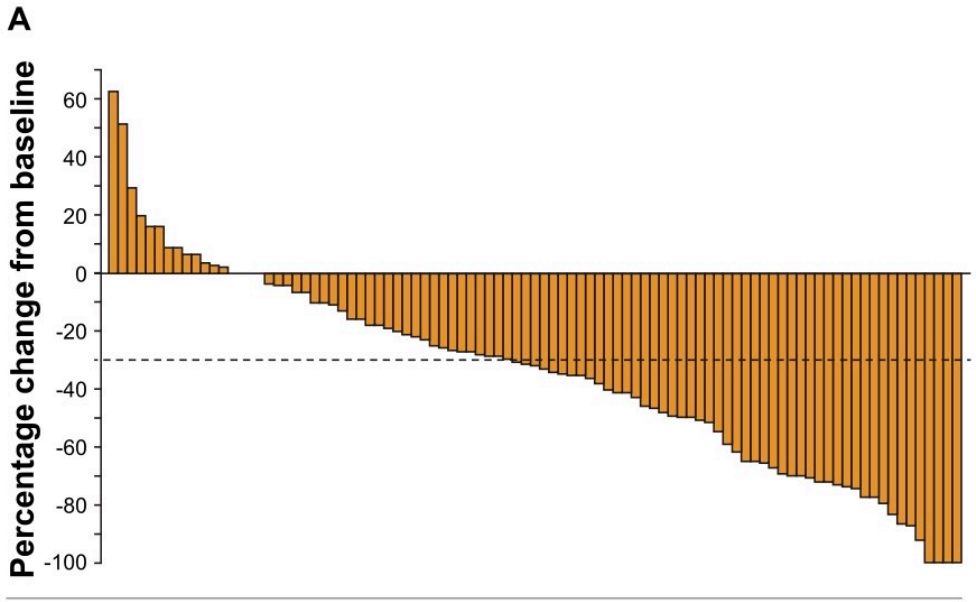
Gilbert et al, Gyn Onc 2023

Phase 2 of Mirve/Bev in platinum resistant ovarian cancer

44% confirmed ORR
Median DOR 9.7 months

Median PFS 8.2 months

Efficacy was demonstrated at all levels FR alpha expression
(25% and higher)



These results led to inclusion of this regimen for PROC in Ovarian cancer NCCN guidelines:

2A recommendation for ≥25% FOLR1

Table 3
Summary of efficacy in patients by subgroups.

Endpoint	FRα ≥ 75% (*n* = 44)	FRα 50–74% (*n* = 39)	FRα 25–49% (*n* = 11)	BEV-naïve (*n* = 39)	BEV-pretreated (*n* = 55)
Confirmed objective response rate, n (%)	21 (48)	16 (41)	4 (36)	22 (56)	19 (35)
95% CI	(33, 63)	(26, 58)	(11, 69)	(40, 72)	(22, 49)
Median duration of response, (months)	9.7	9.7	18.5	10.4	9.7
95% CI	(6.0, 12.0)	(3.0, NR)	(NE)	(6.9, 14.5)	(4.2, NR)
Median progression-free survival, (months)	9.7	6.9	8.6	10.6	6.8
95% CI	(6.8, 11.0)	(5.1, 9.9)	(1.3, NR)	(8.2, 14.5)	(5.3, 8.2)

BEV, bevacizumab; FRα, folate receptor alpha; NE, not evaluable; NR, not reached.

Gilbert et al, Gyn Onc 2023

IMGN853-0420 Mirvetuximab Soravtansine Plus Carboplatin in Folate Receptor Alpha-Expressing Recurrent Platinum-Sensitive Ovarian Cancer

Eligibility

- Platinum-sensitive, high-grade serous EOC[a]
- 1 prior line of platinum-based chemotherapy
- FRα positivity detected by IHC (≥25% tumor cells with ≥2+ membrane intensity)[b]
- Prior PARPi required for patients with somatic and/or germline *BRCA* mutations
- Measurable disease by RECIST v1.1

Overall Study Period

Combination Phase

MIRV (6 mg/kg AIBW) + **Carbo** (AUC 5)

Q3W for 6–8 cycles

N=125

Patients without PD

Continuation Phase

MIRV monotherapy (6 mg/kg AIBW) Q3W

Patients received single-agent MIRV until PD, death, the start of new anticancer therapy, or withdrawal of consent

Primary Endpoint

ORR by INV[c] by the end of 6 combination cycles in a subset of patients from the overall population (ie, patients with ≥25% FRα expression) who had ≥50% FRα expression

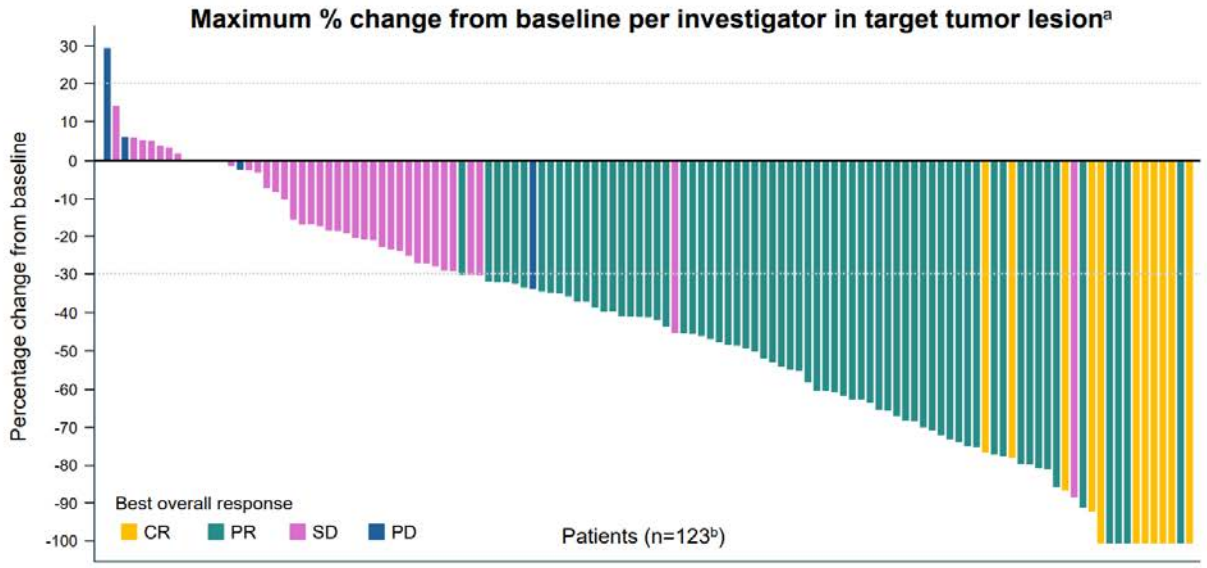
Key Secondary Endpoint

ORR by INV[c] by the end of 6 combination cycles in the overall population (ie, patients with ≥25% FRα expression)

Additional Secondary Endpoints

In the overall study period:

- DOR[c]
- PFS[c]
- CA-125 response
- OS
- TEAEs



Overall population (≥25% FRα expression)	Total (N=125)	≥50% FRα subset (n=102)
By the end of 6 combination cycles		
ORR, % (95% CI)	**62.4 (53.3–70.9)**	**62.7 (52.6–72.1)**

Adjudicated treatment-related pneumonitis occurred in 19 patients (15.2%)

- 14 (11.2%) had grade 1-2 events
- 3 (2.4%) had grade 3–4 events
- 2 (1.6%) deaths occurred (grade 5); both with underlying cardiopulmonary disorders

- **16/19 patients had a final grade of 1 or better**, including 10 with complete resolution
- 11/19 patients were **retreated with MIRV**
- **Median (range) time to onset was 32.1 (8.6–72.0) weeks**

MIROVA/AGO-OVAR 2.34: RP2 of mirvetuximab soravtansine/carboplatin vs SOC plat doublet

- Recurrent epithelial cancer of the ovary, fallopian tube or peritoneum
- TFIp > 3 months
- All histologic subtypes
- FRα high status by PS2+ scoring (≥ 75% of tumor cells with FRα membrane staining and ≥ 2+ intensity*)
- ≥ 1 prior lines of chemotherapy
- Measurable disease or evaluable disease in combination with GCIG CA-125 criteria
- Not a candidate for bevacizumab
- Prior PARPi mandatory for *BRCA*mut tumors

* using Ventana FOLR1 (FOLR1 2.1) CDx assay

N=145

Carboplatin AUC 5 and Mirvetuximab 6 mg/kg x 6 cycles → Mirvetuximab

Carboplatin Doublet (paclitaxel, PLD or gemcitabine) x 6 cycles → PARPi maintenance if applicable

<u>Primary endpoint</u>
PFS

<u>Stratification factors:</u>
BRCA-status
Platinum-free interval
Number of prior lines of chemotherapy

Harter et al, ASCO Annual Meeting. May 29 - June 2, 2026. Chicago, Illinois. Abstract 5506.

Patient characteristics II

	Standard (N=70)	Carbo+Mirv (N=75)
Initial FIGO stage		
I	1 (1.4%)	3 (4%)
II	5 (7.1%)	4 (5.3%)
III	48 (68.6%)	45 (60%)
IV	15 (21.4%)	22 (29.3%)
Not available/unknown	1 (1.4%)	1 (1.3%)
BRCA-Status		
*BRCA*wt	61 (87.1%)	63 (84%)
g*BRCA*mut	5 (7.1%)	9 (12%)
s*BRCA*mut	4 (5.7%)	3 (4%)
No. of prior treatment lines		
1	38 (54.3%)	36 (48%)
2	22 (31.4%)	26 (34.7%)
3	9 (12.9%)	8 (10.7%)
4	1 (1.4%)	3 (4%)
5	0	2 (2.7%)

Patient characteristics III

	Standard (N=70)	Carbo+Mirv (N=75)
Prior treatments (at any line)		
Carboplatin	70 (100%)	75 (100%)
Taxane	70 (100%)	75 (100%)
Bevacizumab	53 (75.7%)	59 (78.7%)
PARPi	49 (70%)	48 (64%)
Platinum free interval [months]		
3-6	5 (7.1%)	6 (8%)
6-12	18 (25.7%)	19 (25.3%)
> 12	47 (67.1%)	50 (66.7%)

Reasons for discontinuation (ITT population)

	Standard (N=70)	Carbo+Mirv (N=75)
Did not receive any study therapy	7[1] (10%)	1[2] (1.3%)
Tumor related	41 (58.6%)	52 (69.3%)
Progressive disease by RECIST v1.1	34 (48.6%)	46 (61.3%)
CA-125 progression	1 (1.4%)	2 (2.7%)
Symptomatic deterioration	4 (5.7%)	3 (4.0%)
Death - cancer related without RECIST assessment	2 (2.9%)	1 (1.3%)
Potentially toxicity related	13 (18.6%)	17 (22.7%)
Termination by investigator	8 (11.4%)	13 (17.3%)
Patient wishes to stop treatment	5 (7.1%)	2 (2.7%)
Withdrawal of patients consent	0	2 (2.7%)
Death	1[3] (1.4%)	1[4] (1.3%)
Other	7[5] (10%)	1[6] (1.3%)

[1]withdrawal of consent (n=6), other/patient wish (n=1); [2]withdrawal of consent (n=1); [3]Brain hemorrhage; [4]unknown; [5]maintenance not indicated (n=6), patient wish (n=1); [6]secondary malignancy,

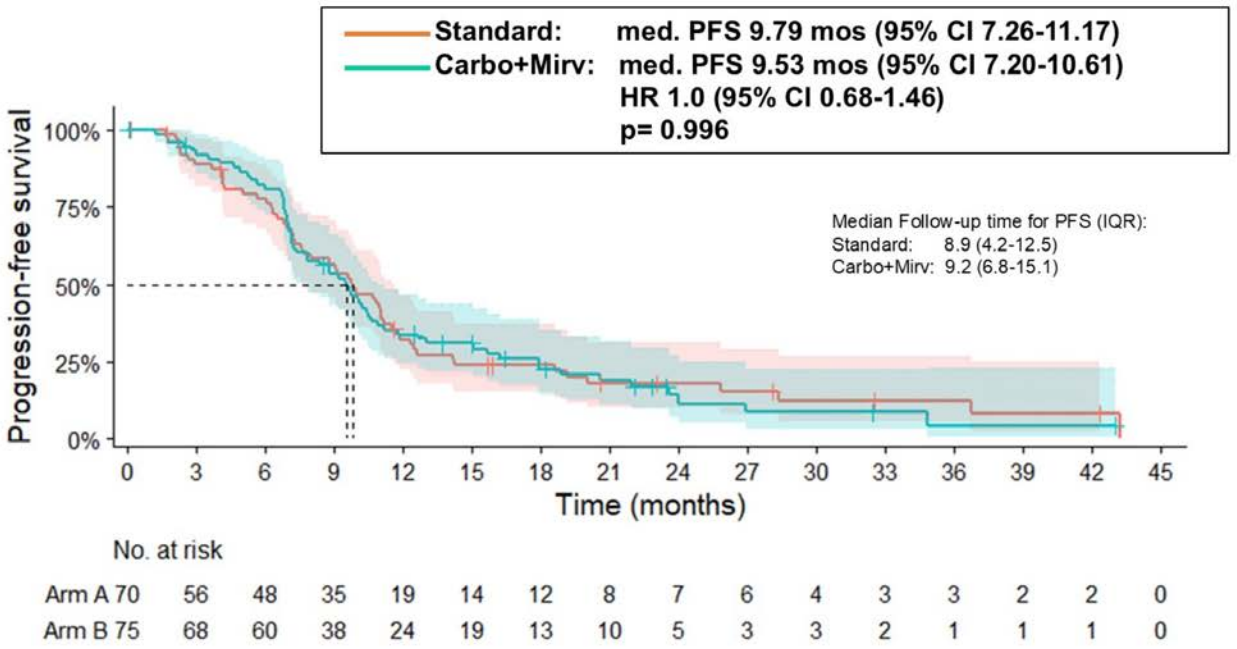
Patient disposition (safety population = at least one dose of study treatment)

		Standard (N=63)		Carbo+Mirv (N=74)
CHEMOTHERAPY PHASE (Cycle 1-6)				
Carboplatin		63 (100%)		74 (100%)
PLD		40 (63.5%)		0
Gemcitabine		18 (28.6%)		0
Paclitaxel		5 (7.9%)		0
Mirvetuximab soravtansine		0		74 (100%)
At least 6 cycles platinum-based therapy		45 (71.4%)		64 (86.5%)
Median no. of cycles		6		6
Discontinuations for other reasons than PD[1]		19 (30.2%)		8 (10.8%)
„MAINTENANCE PHASE“ (Cycle 7+)				
Active therapy after cycle 6 („maintenance-phase“)		29 (46%)[2]		59 (79.7%)
Mirvetuximab soravtansine		0 (0)		59 (79.7%)
PARPi		27 (42.9%)		0 (0)
Discontinuations for other reasons than PD[1]		2 (3.2%)		11 (14.9%)
Still on study treatment		1 (1.6%)		3 (4.1%)
TOTAL STUDY DURATION				
Patients with at least one dose reduction		27 (42.9%)		43 (58.1%)
	Carboplatin	16 (25.4%)	Carboplatin	26 (35.1%)
	Chemo/PARPi	20 (31.7%)	Mirvetuximab	27 (36.5%)
Median duration of treatment [months][3]		11.1		7.82
No. of SAEs		42		78

[1] Includes also cancer related death for patients starting a maintenance therapy; [2] 2 patients with 7 respectively 12 cycles of chemotherapy; [3] calculated from randomization. Only patients with active therapy after cycle 6 in standard arm

Results

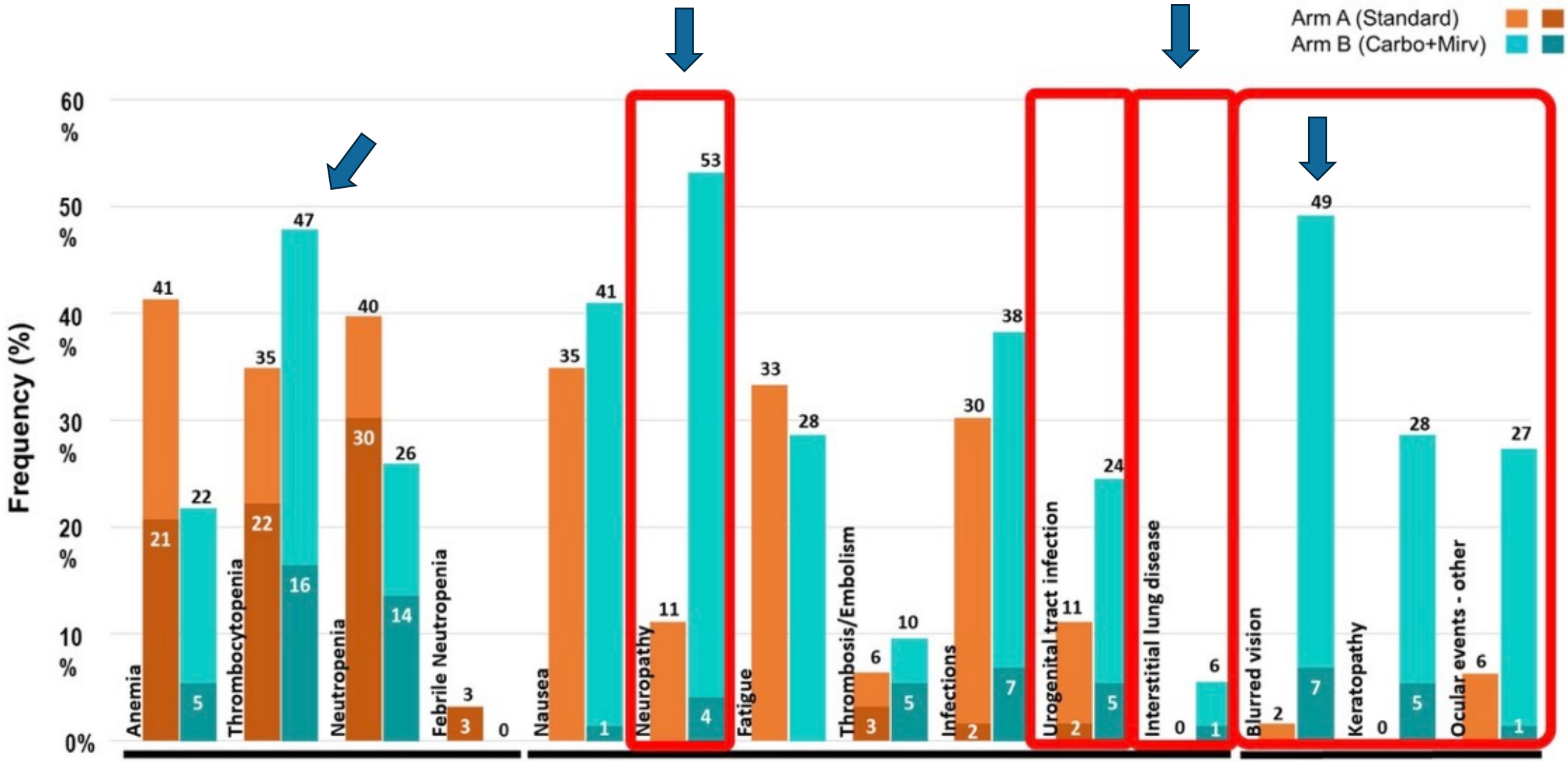
PFS Primary analysis (ITT)



Response rates

ITT population	Standard (n=70)	Carbo+Mirv (n=75)
Response rate		
CR	3 (4.3%)	3 (4%)
PR	17 (24.3%)	44 (58.7%)
SD	38 (54.3%)	20 (26.7%)
PD	3 (4.3%)	4 (5.3%)
not evaluable	9 (12.9%)	4 (5.3%)
Overall response rate (CR/PR)*	32.8%	66.2%
Clinical benefit rate (CR/PR/SD)*	95.1%	94.4%
First timepoint of response	n=20	n=47
Cycle 1-6	18 (90.0%)	40 (85.1%)
During maintenance-phase	2 (10.0%)	7 (14.9%)

Adverse events



*Any ocular toxicity in Arm B was observed in 60 pts (81.1%)

PRESENTED BY: Philipp Harter

Other anti-FOLR1 ADCs: Ovarian cancer results

Drug	Payload	ORR (Ph2)	Phase 3 trial
Rinatabart Sesutecan (NCT05579366)	topo 1 exatecan DAR 8	55.6% Responses occurred regardless of FOLR1 levels	Platinum resistant RAINFOL-02: NCT06619236 Platinum sensitive maintenance: RAINFOL-04: NCT07225270
Torvutatug samrotecan (AZD5335) (NCT05797168)	topo 1 exatecan DAR 8	60.7% high FRα (≥75%) 47.5% low FRα (≥25%)	Platinum resistant TREVI-OC-01: NCT07218809
sofetabart mipitecan (NCT06400472)	topo 1 exatecan DAR 8	40% FRα 0-24% 50% FRα 25-49% and 50-74% 54% FRα ≥75%	Platinum resistant and Platinum sensitive: (PD on PARPi <6 months and PARP naive) FRAmework-01: NCT07213804

Lee et al, SGO 2025, Oaknin et al, ESMO 2025, Pothuri et al, SGO 2026

Comparison amongst the Topo1 payload FOLR1 ADCs

	Rinatabart sesutecan	Torvutatug samrotecan	Sofetabart mipitecan
Antibody	Human monoclonal antibody targeting FRα	Human monoclonal antibody targeting FRα	Fc-silent humanized monoclonal antibody targeting FRα
Linker Type	Hydrophilic, protease-cleavable	Cleavable linker system	Proprietary cleavable polysarcosine (PSARlink™)
Payload (all exatecans)	Sesutecan	samrotecan	Mipitecan

Lee et al, SGO 2025, Oaknin et al, ESMO 2025, Pothuri et al, SGO 2026

GLORIOSA Study: Mirve Maintenance

Eligibility:
Platinum sensitive recurrence after 1st line therapy

FOLR1 ≥ 75%

Must be appropriate for, currently on, or have completed 2L platinum-based chemotherapy doublet plus bevacizumab

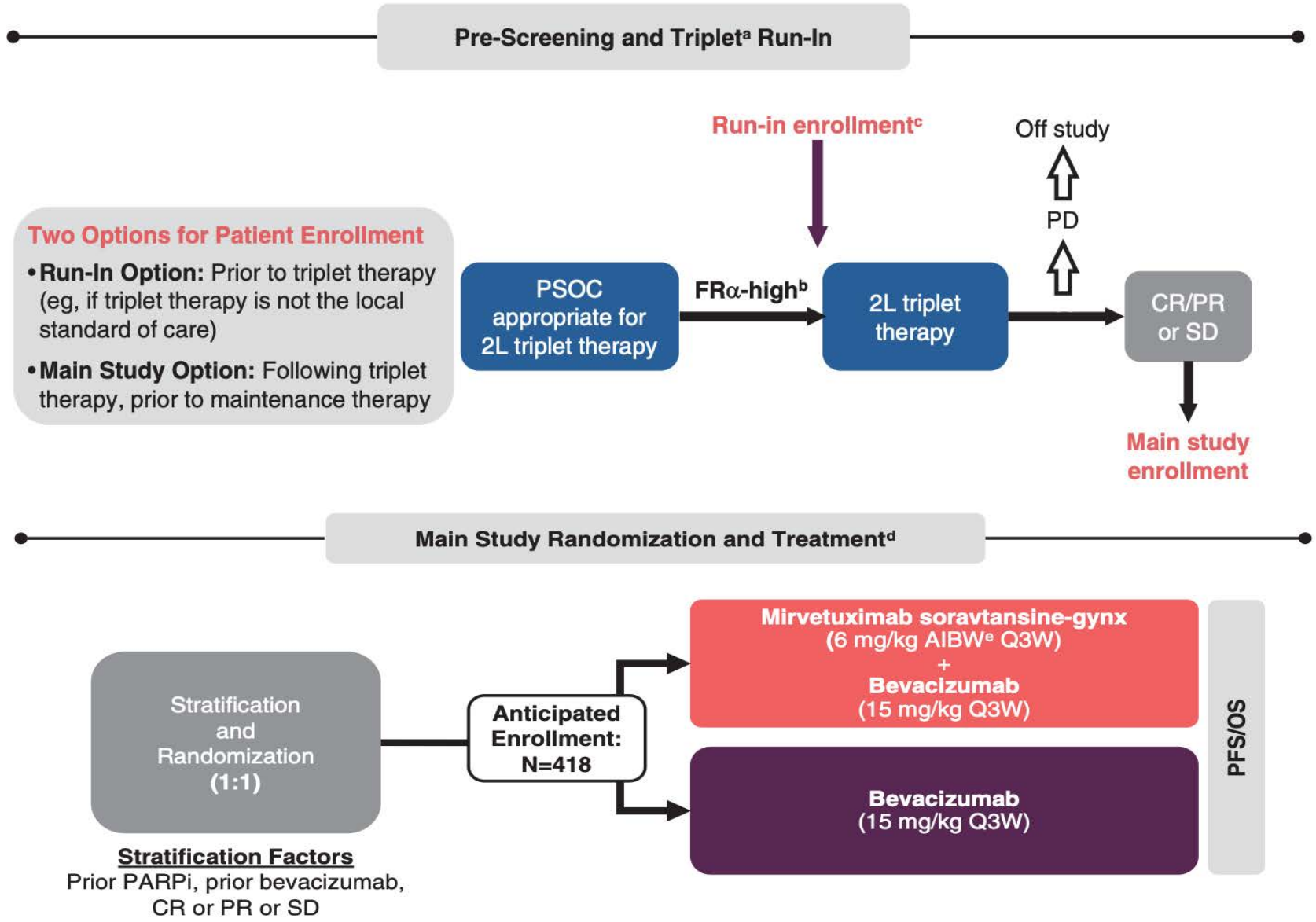


Figure 2. GLORIOSA enrollment and trial design.

O'Malley et al, Future Oncology 2024

NCT05445778

When in the treatment course do you test for folate receptor alpha (FRα) expression in your patients with advanced OC?

 Prof Eskander	At initial diagnosis
 Dr Matulonis	At initial diagnosis
 Dr Moore	At initial diagnosis
 Dr Olawaiye	At the time of first platinum-resistant relapse
 Dr O'Malley	At initial diagnosis
 Prof Colombo	At the time of first platinum-resistant relapse

RTP RESEARCH TO PRACTICE

What testing methodology do you generally use to test for FRα expression in your patients with advanced OC? What threshold for FRα expression do you require to employ mirvetuximab soravtansine for your patients with platinum-resistant advanced OC?

	Testing methodology	FRα expression threshold
 Prof Eskander	In-house testing and outside NGS	75% or greater
 Dr Matulonis	VENTANA FOLR1-2.1 RxDx assay	75% or greater
 Dr Moore	IHC	Will consider for anyone >25% but really look at >50% with bev
 Dr Olawaiye	IHC	75%
 Dr O'Malley	IHC	Greate than 25% for mirv/bev; 75% mirv alone
 Prof Colombo	IHC	75% or greater

NGS = next-generation sequencing; IHC = immunohistochemistry; bev = bevacizumab; mirv = mirvetuximab soravtansine

In the absence of other actionable biomarkers, in which line of therapy are you typically employing mirvetuximab soravtansine for your patients with FRα-positive, platinum-resistant OC?

 Prof Eskander	First line after platinum resistance
 Dr Matulonis	First line after platinum resistance
 Dr Moore	First line after platinum resistance
 Dr Olawaiye	Second line after platinum resistance
 Dr O'Malley	First line after platinum resistance
 Prof Colombo	First line after platinum resistance

RTP RESEARCH TO PRACTICE

Would you employ mirvetuximab soravtansine in combination with another systemic therapy under any circumstances?

 Prof Eskander	Yes, with carboplatin on clinical trial
 Dr Matulonis	Yes, with bevacizumab if FRα expression is 25% or greater
 Dr Moore	Yes, with bevacizumab
 Dr Olawaiye	Yes, if less than 75% FRα expression and no other good therapy options
 Dr O'Malley	Yes, with bevacizumab
 Prof Colombo	No

In your opinion, do the mechanistic differences between the FRα-targeted antibody-drug conjugates (ADCs) in development (eg, rinatabart sesutecan, torvutatug samrotecan, sofetabart mipitecan) and mirvetuximab soravtansine offer any potential advantages for the former from either an efficacy or a tolerability perspective?

 Prof Eskander	Yes, there is potential for greater use as it is not biomarker restricted; there is also no need for ocular assessments
 Dr Matulonis	I'm not sure
 Dr Moore	Yes, I think some will have less hematolgic toxicity than others and that may be important
 Dr Olawaiye	Yes, these agents are initially showing good efficacy signals in tumors with low FRα expression
 Dr O'Malley	Yes, likely improved efficacy and less eye toxicity than mirvetuximab soravtansine
 Prof Colombo	Yes, different payload, potentially more effective with a different spectrum of toxicity

RTP RESEARCH TO PRACTICE

Agenda

Module 1: Current Role of PARP Inhibitors in the Management of Advanced Ovarian Cancer (OC) — Prof Eskander

Module 2: Strategies Targeting Folate Receptor Alpha in Advanced OC — Dr Matulonis

Module 3: Other Approved and Promising Investigational Antibody-Drug Conjugates for Advanced OC — Dr Moore

Module 4: Other Novel Agents and Strategies for Advanced OC — Dr O'Malley

Module 5: Diagnosis and Management of Adverse Events Associated with Common Therapies for Advanced OC — Dr Olawaiye

RTP RESEARCH TO PRACTICE

Other Approved and Promising Investigational Antibody-Drug Conjugates for Advanced OC

Kathleen N. Moore, MD, MS, FASCO

Deputy Director & Director of Phase 1

Fred & Pamela Buffett Cancer Center

Omaha, NE

GOG F BOD

ASCO BOD

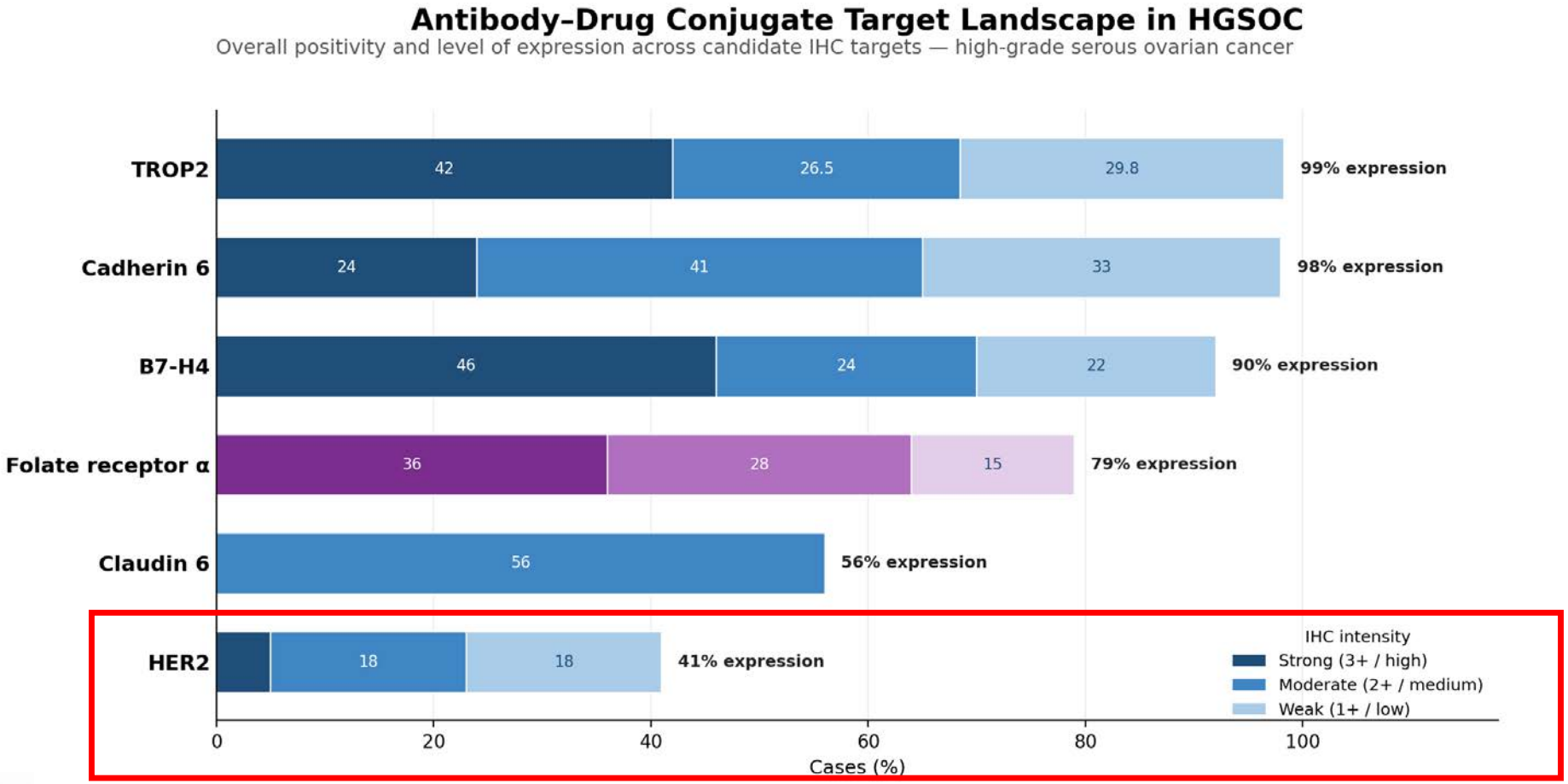
UNMC

FRED & PAMELA BUFFETT CANCER CENTER

@DrKatyMoore

The Growing Complexity of Biomarkers in Ovarian Cancer

Overlapping targets by any expression and by levels of expression (many not yet validated), with prevalence differing across histotypes



Bars stacked by IHC intensity; total expression labeled at right. FRα four-tier intensity (high 36% / medium 28% / low 15% / negative 21%) — 21% negative, so 79% express. Claudin 6 reported as total expression without a full intensity split.

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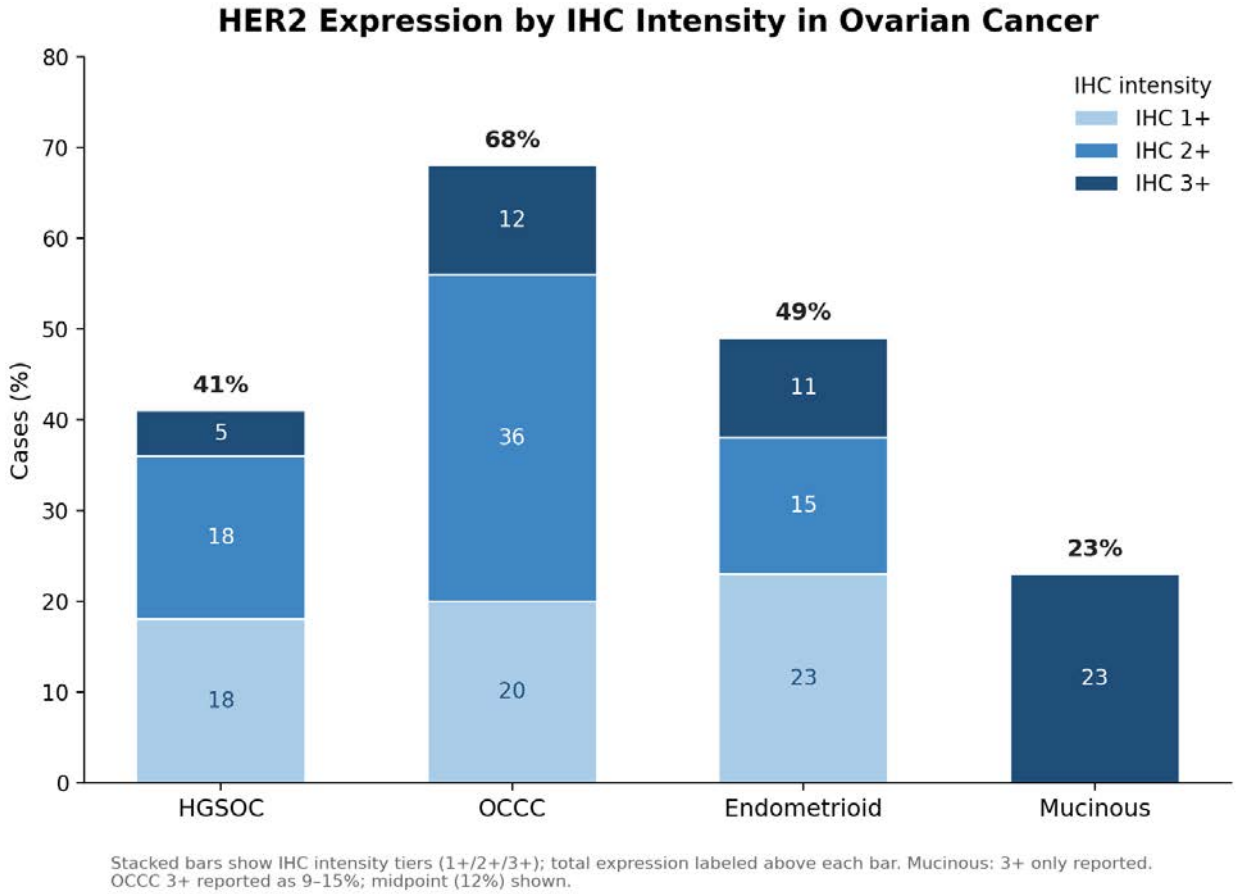
Leung et al. J Gynecol Oncl 2025; Deutschman E, et al. *Arch Pathol Lab Med*. 2025;149:930-937; Hamagawa K et al. ESM Gyne 2025; Ettorre VM et al. Int J Gynecol Cancer 2025; Dum D et al. Pathobiology 2022; Liang L et al. Hum Pathol. 2017

@DrKatyMoore

The Growing Complexity of Biomarkers in Ovarian Cancer

HER2: Estimates vary widely based on sample size



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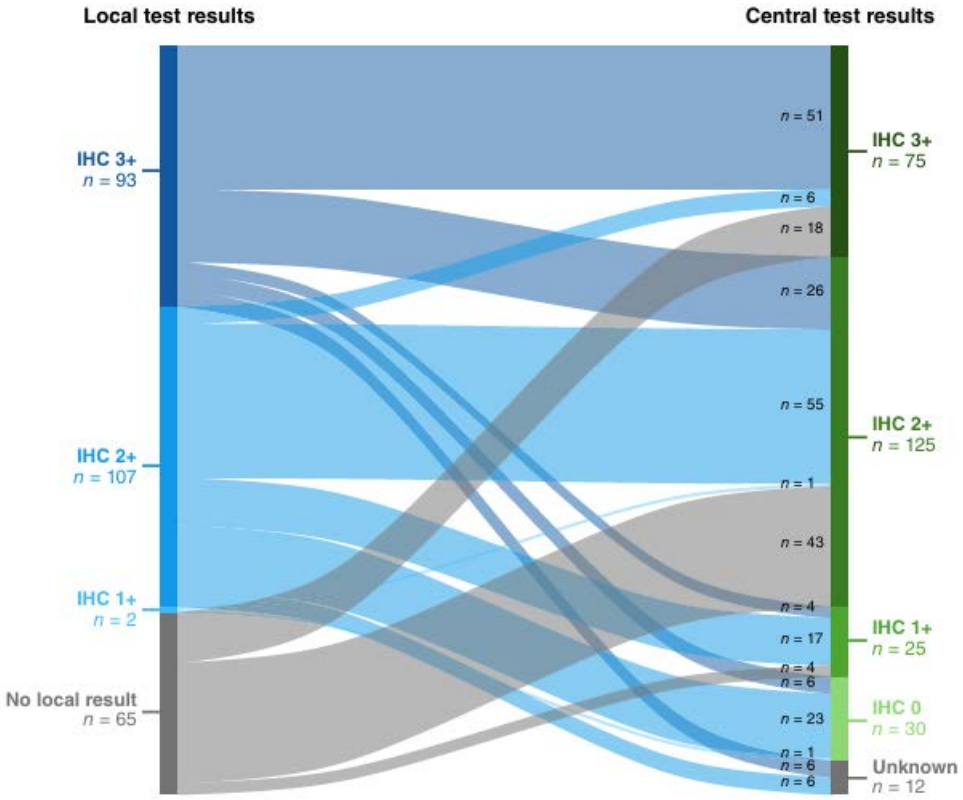
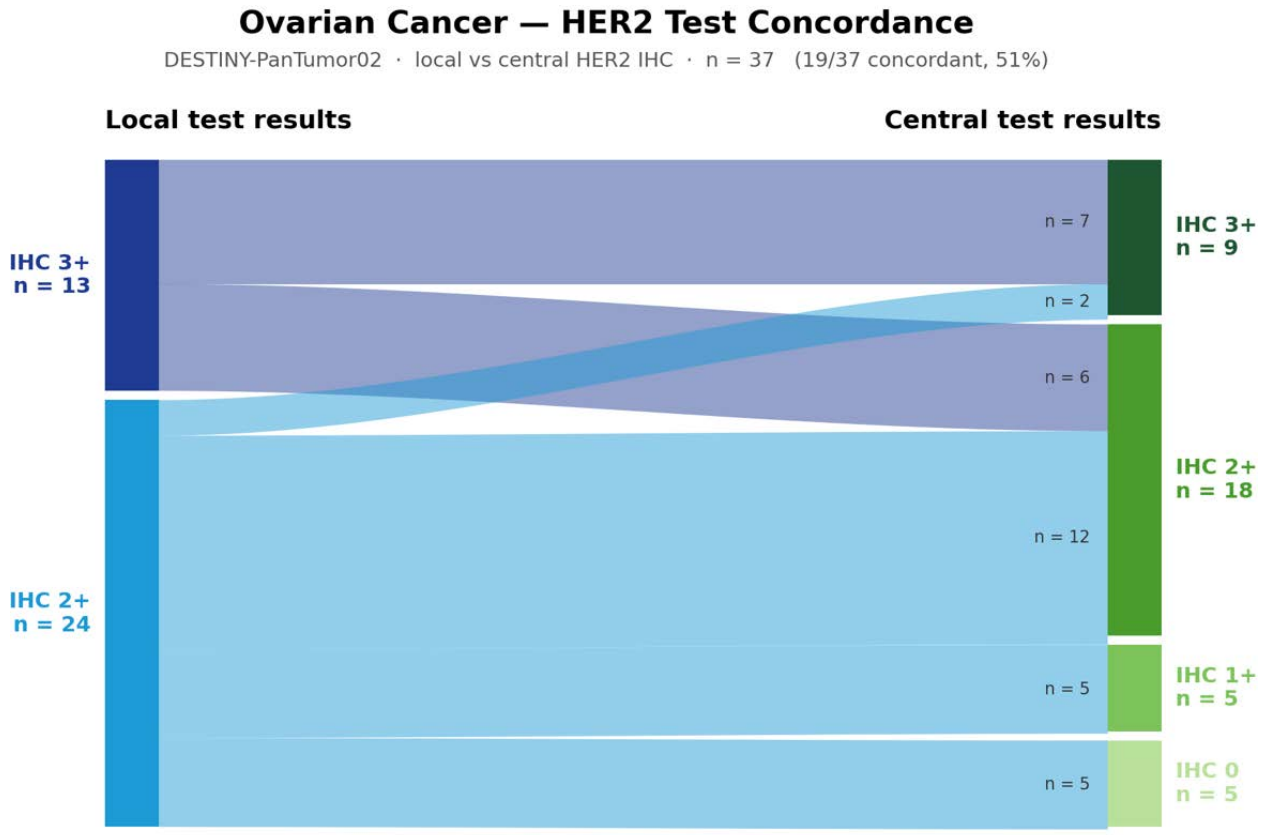
Leung et al. J Gynecol Oncl 2025; Deutschman E, et al. *Arch Pathol Lab Med*. 2025;149:930-937; Hamagawa K et al. ESMO Gyne 2025; Ettorre VM et al. Int J Gynecol Cancer 2025; Dum D et al. Pathobiology 2022; Liang L et al. Hum Pathol. 2017

@DrKatyMoore

HER2 IHC expression by local vs central review: Ovarian Highlight - DESTINY-PanTumor02



Overall concordance of local and central testing
(Makker et al. Clin Cancer Research 2026)



Concordance of local and central testing for ovarian cancer
(Figure derived from Makker et al. Clin Cancer Research 2026)

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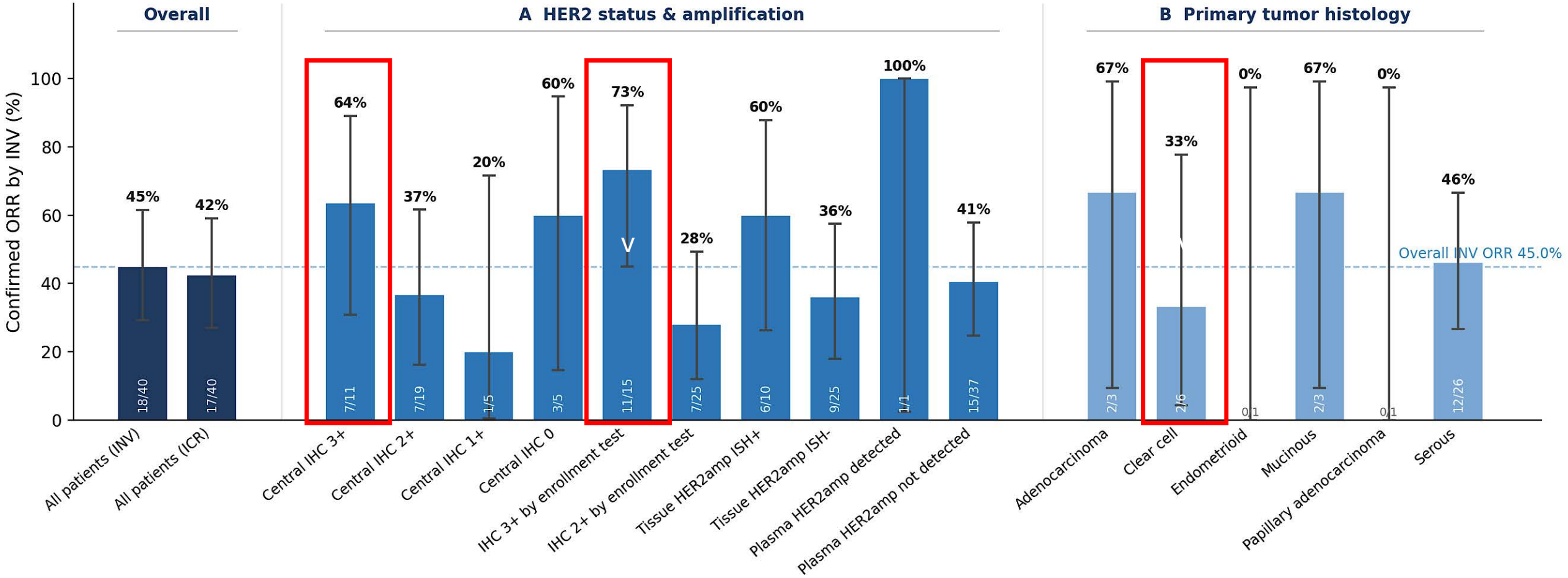
DESTINY-PanTumor02: Efficacy of T-DXd by local vs central IHC & Histology

Ovarian cancer (n=40) — HER2 status & histology



Confirmed ORR by INV; error bars are 95% Clopper-Pearson exact CIs; n/N shown below each bar. Dashed line = overall INV ORR (45.0%). HER2amp evaluated centrally (tissue dual ISH; plasma ctDNA GuardantOMNI).

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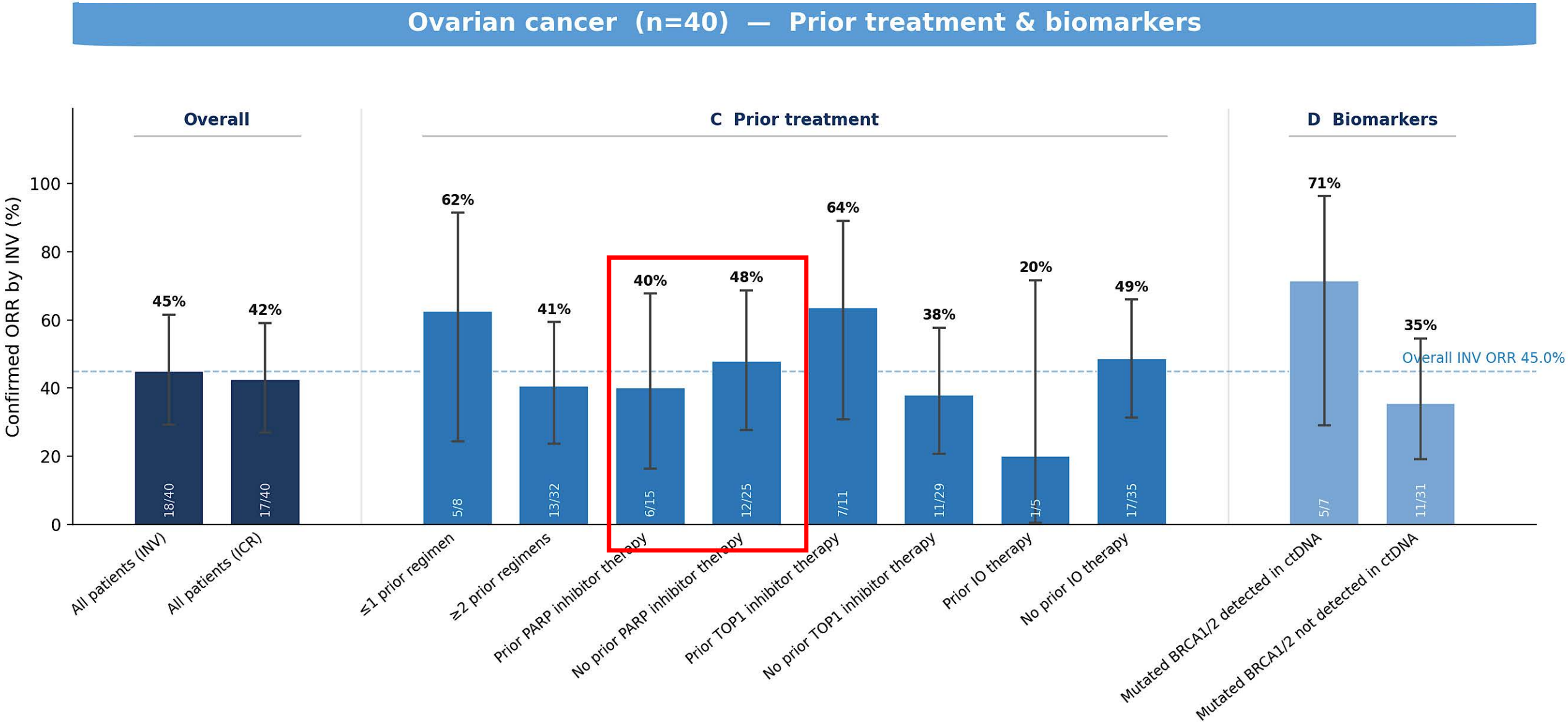
Figure developed from Lee Jung-Yun et al. J Gynecol Oncol 2026

@DrKatyMoore

Efficacy by Number of LOT and Prior Lines: What Drives Benefit?



Confirmed ORR by INV; error bars are 95% Clopper-Pearson exact CIs; n/N shown below each bar. Dashed line = overall INV ORR (45.0%). ctDNA BRCA1/2 status measured via GuardantOMNI as a proxy measure.

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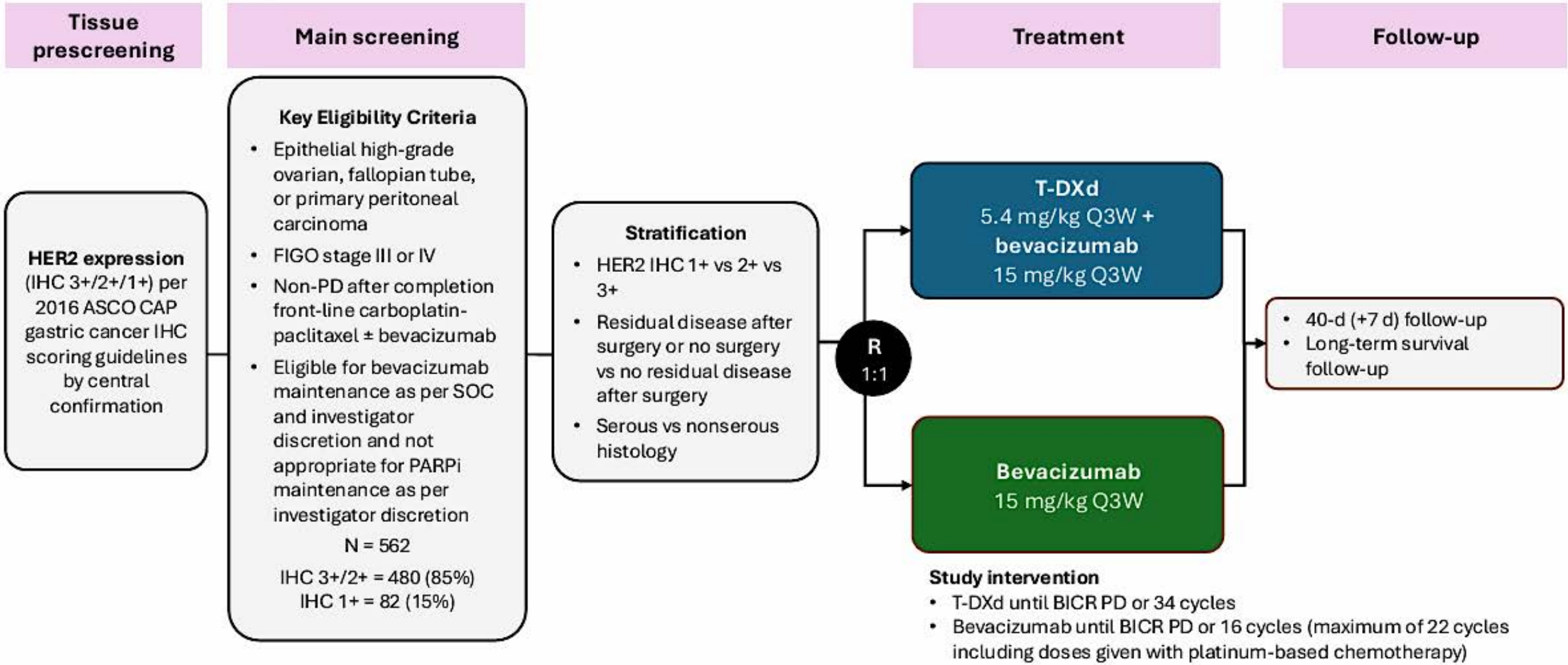
Figure developed from Lee Jung-Yun et al. J Gynecol Oncol 2026

@DrKatyMoore

Phase 3 DESTINY-Ovarian01: T-DXd + Bevacizumab as 1L maintenance therapy in HER2-Expressing Ovarian Cancer[1]



NCT06819007

DESTINY-Ovarian01 Safety Run-in (SRI)

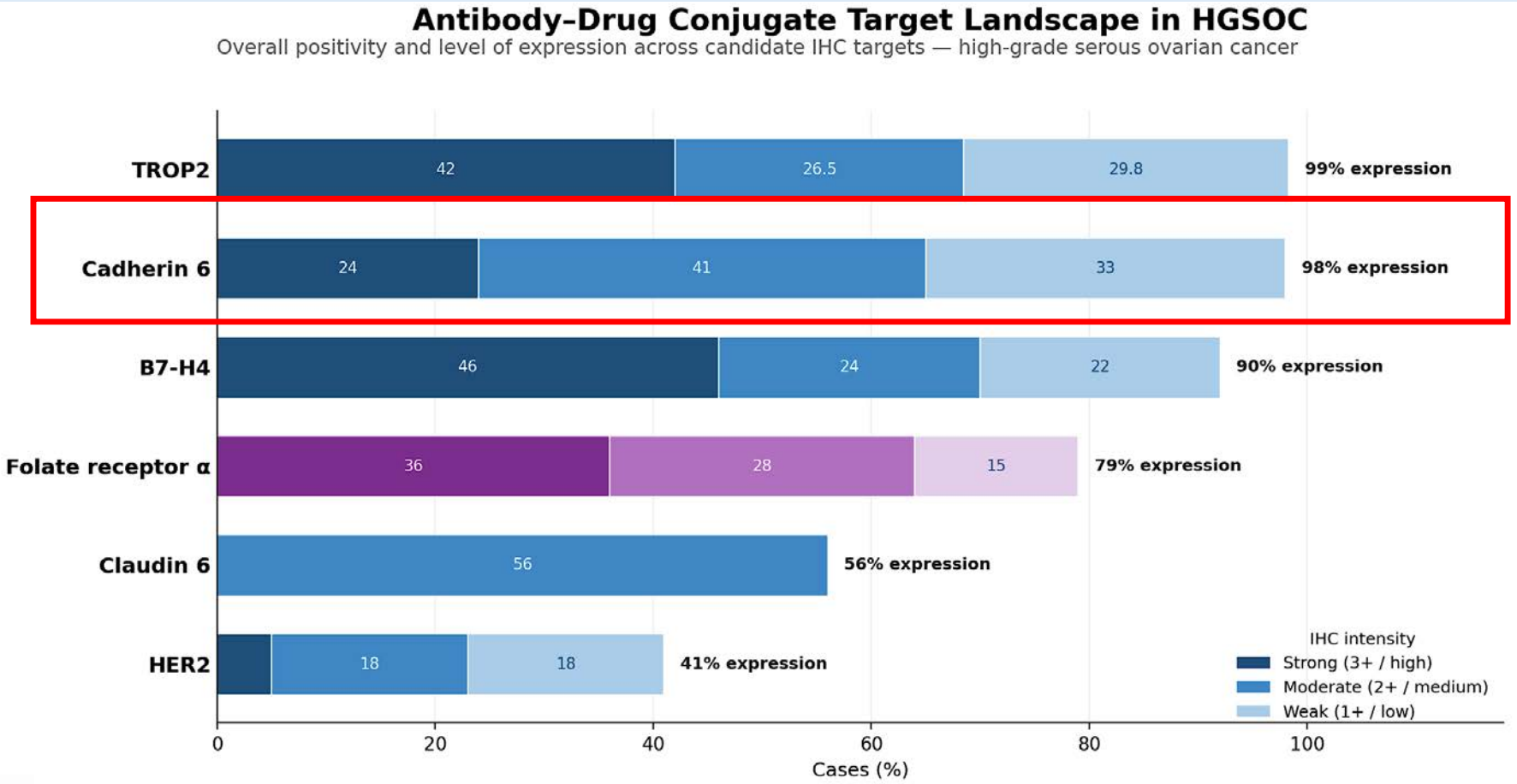
- 21 pts received a median of 4 cycles (range, 2-8) of T-DXd + BEV; no pt withdrew before cycle 2.
- At data cut-off, 20 pts (95.2%) completed DLT evaluation and remained on treatment; DLTs occurred in 2 pts (10.0%)
- Most common drug-related TEAEs (>50%) were nausea (76.2%), leukopenia (52.4%), and neutropenia (52.4%). No cases of adjudicated drug-related interstitial lung disease or left ventricular dysfunction were reported.

Pts with events, n (%)	T-DXd + BEV N = 21
Drug-related TEAEs	21 (100)
Drug-related grade ≥3 TEAEs	9 (42.9)
Drug-related TEAEs leading to discontinuation	0
Drug-related TEAEs leading to dose reduction	5 (23.8)
Drug-related TEAEs leading to dose delay	6 (28.6)
TEAEs with outcome of death	0

Gonzalez Martin A et al. ASCO 2026;Abstract 5554.

The Growing Complexity of Biomarkers in Ovarian Cancer

Overlapping targets by any expression and by levels of expression (many not yet validated), with prevalence differing across histotypes



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Leung et al. J Gynecol Oncl 2025; Deutschman E, et al. *Arch Pathol Lab Med*. 2025;149:930-937; Hamagawa K et al. ESMO Gyne 2025; Ettorre VM et al. Int J Gynecol Cancer 2025; Dum D et al. Pathobiology 2022; Liang L et al. Hum Pathol. 2017

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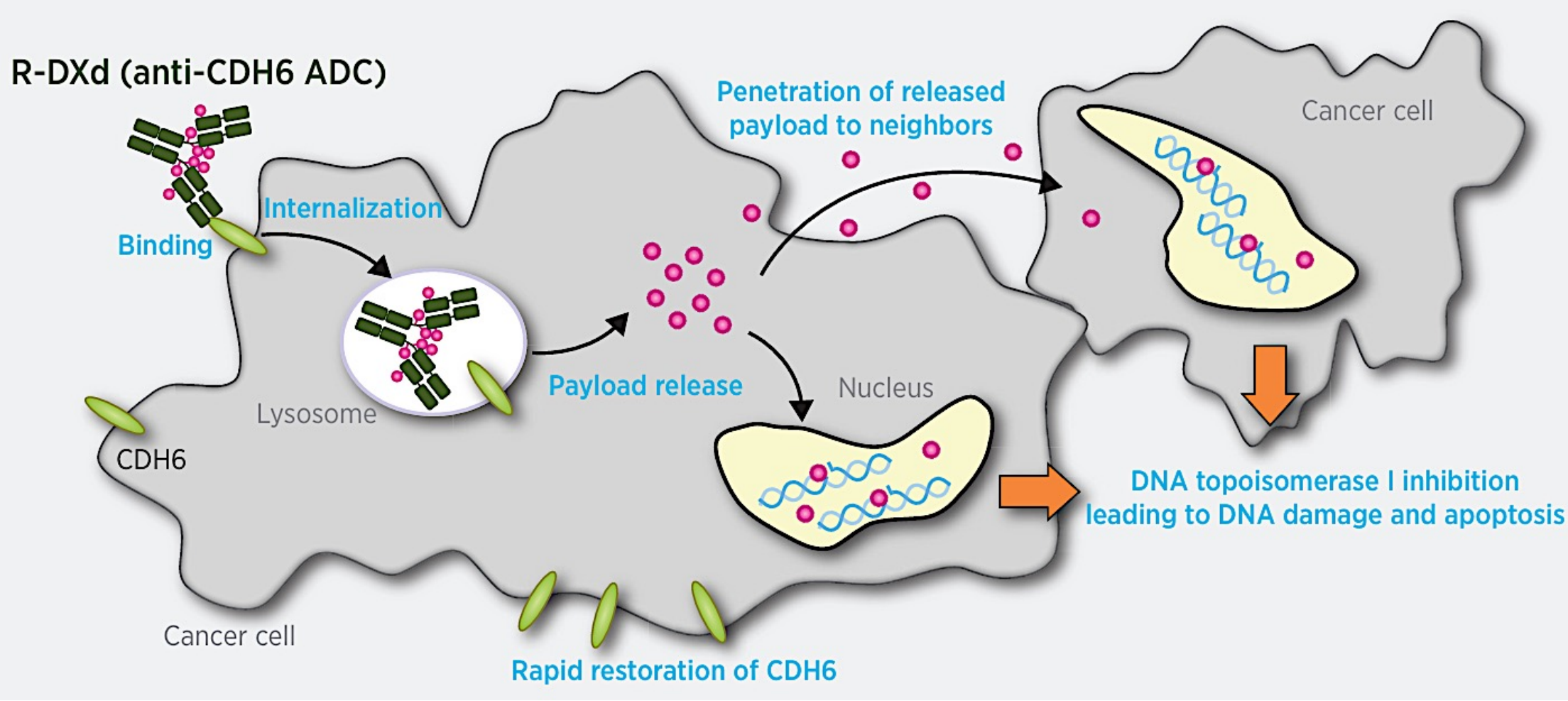
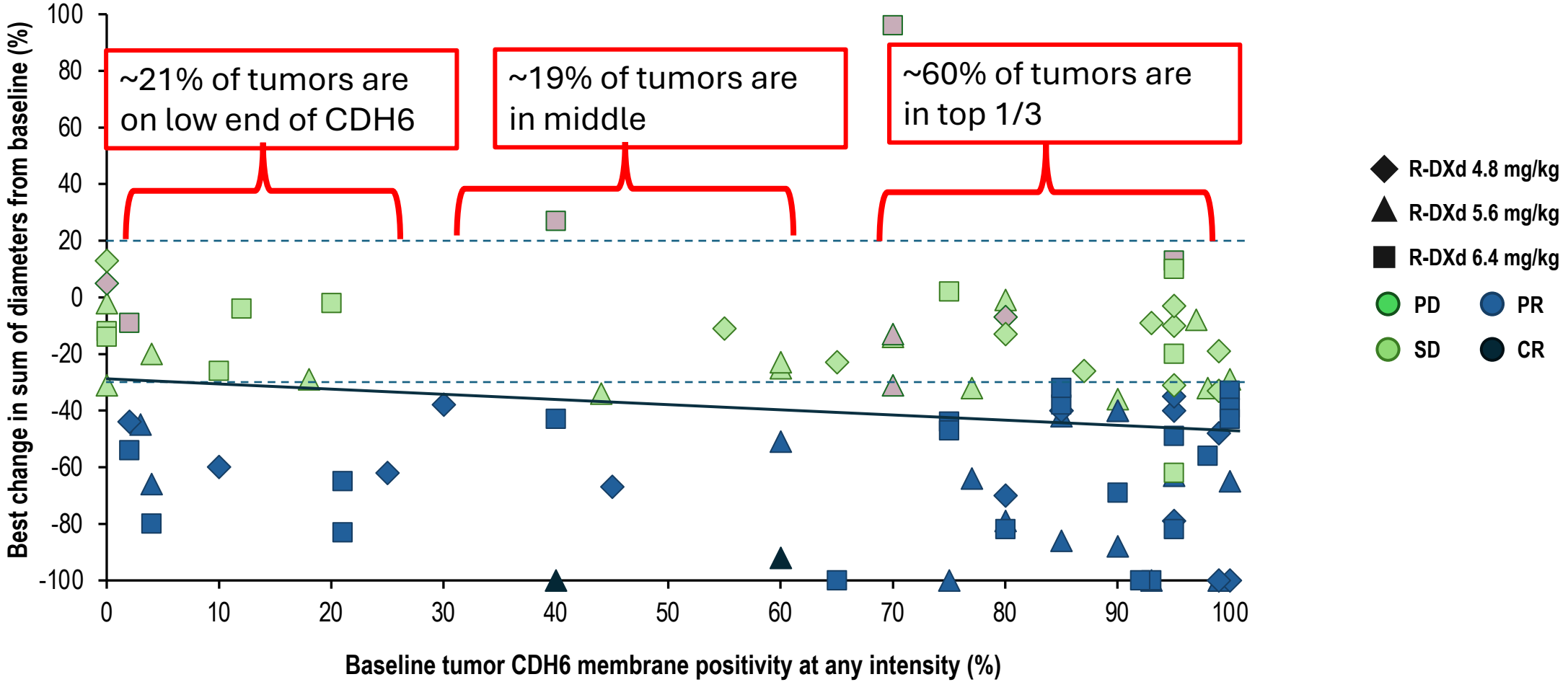
Raludotatug Deruxtecan (R-DXd) Mechanism of Action



ADC = antibody-drug conjugate

Suzuki H et al. *Mol Cancer Ther* 2024;23(3):257-71.

Clinically meaningful tumor responses were observed across a range of CDH6 expression levels with raludotatug-deruxtecan (R-DXd)

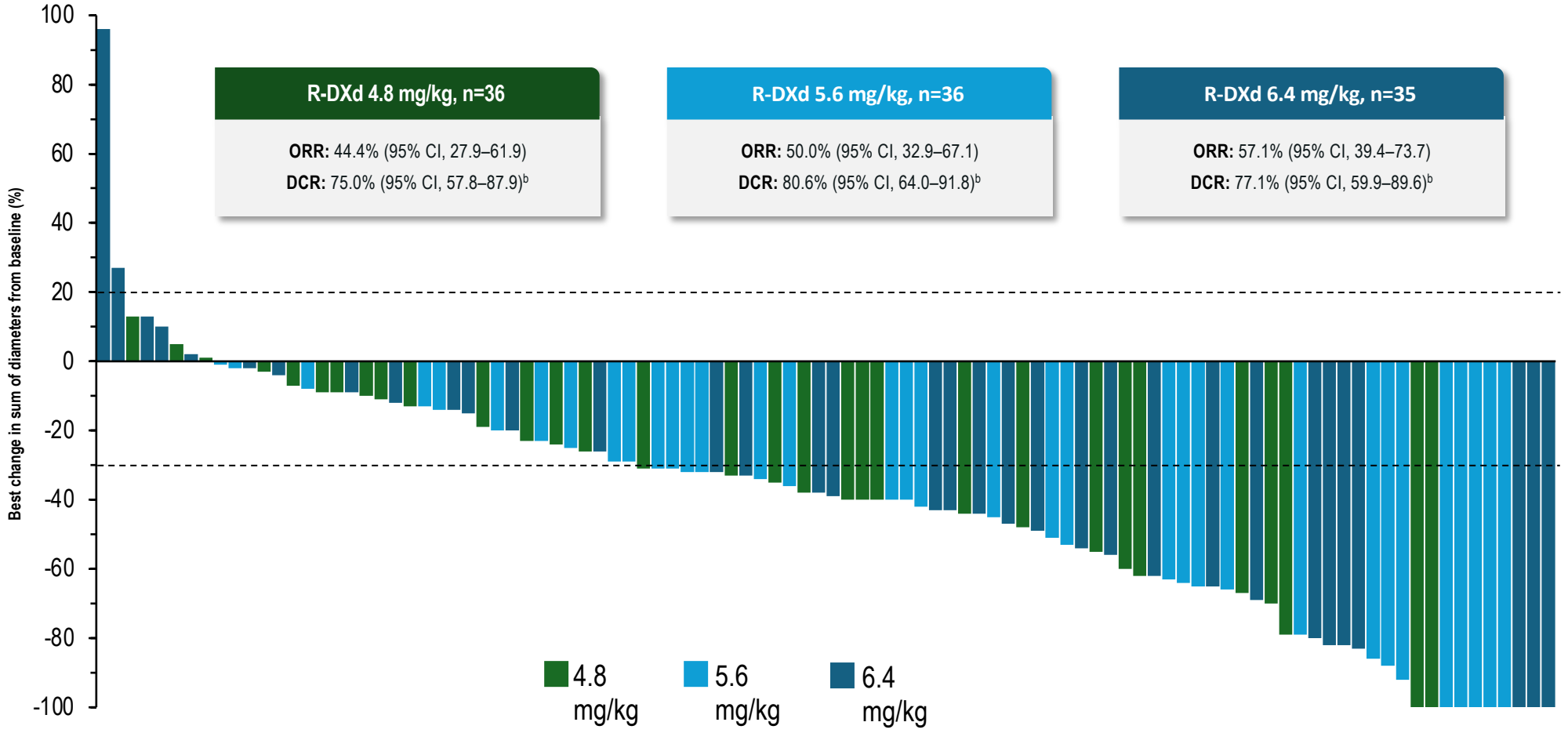


Data cutoff: February 26, 2025. The median follow-up for 4.8-mg/kg, 5.6-mg/kg, and 6.4-mg/kg cohorts was 5.6 months (95% CI, 4.7–6.3), 5.6 months (95% CI, 4.6–5.8), and 5.2 months (95% CI, 4.9–5.8), respectively.

Patients with available baseline tumor CDH6 expression data, who had measurable disease at baseline and ≥1 post-baseline tumor scan (assessed by BICR), were included in the scatter plot (n=94).

REJOICE 01: Phase 2

Raludotatug deruxtecan

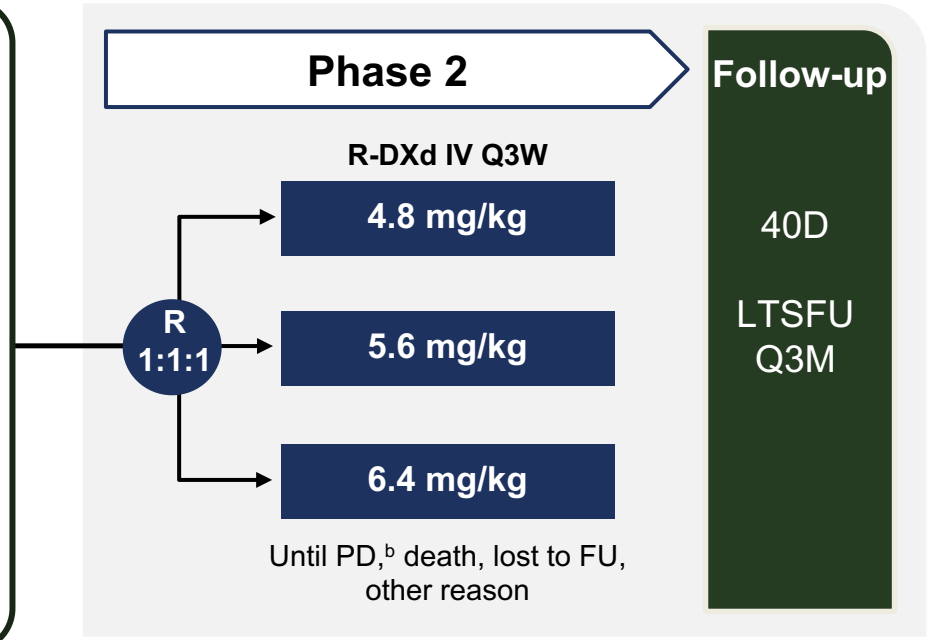


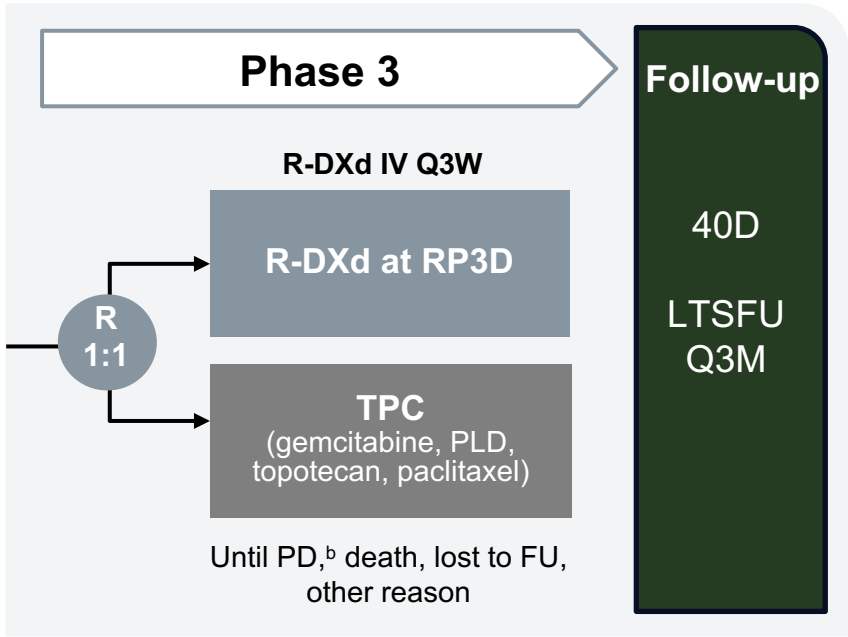
Ray Coquard et al. ESMO 2025.

REJOICE-Ovarian01/GOG-3096: Phase 2/3 Randomized Study of R-DXd in Platinum-Resistant EOC

Key eligibility criteria:

- High-grade serous or endometrioid ovarian, primary peritoneal, or fallopian tube cancer
- 1−3 prior LOT (inc. bevacizumab)
- Platinum-resistant disease
- Prior MIRV if high FRα[a]
- ECOG PS 0−1
- No prior CDH6-targeting agents or ADCs with linked TOPO I inhibitor
- Patients with primary platinum-refractory disease are not eligible





Stratification:

- Number of prior LOT (1 vs 2/3)
- CDH6 expression (high vs low)
- TPC (paclitaxel vs others; *Ph 3 only*)

Primary endpoints:

- ORR per BICR[b]

Key secondary endpoints:

- ORR per inv[b]
- DOR

Primary endpoints:

- ORR per BICR[b]
- PFS per BICR[b]

Key secondary endpoints:

- OS
- QOL

NCT06161025

NCT06161025. Accessed from: https://clinicaltrials.gov/study/NCT06161025?term=NCT06161025&rank=1. Ray-Coquard IL, et al. ESMO 2025. Abstract LBA42.

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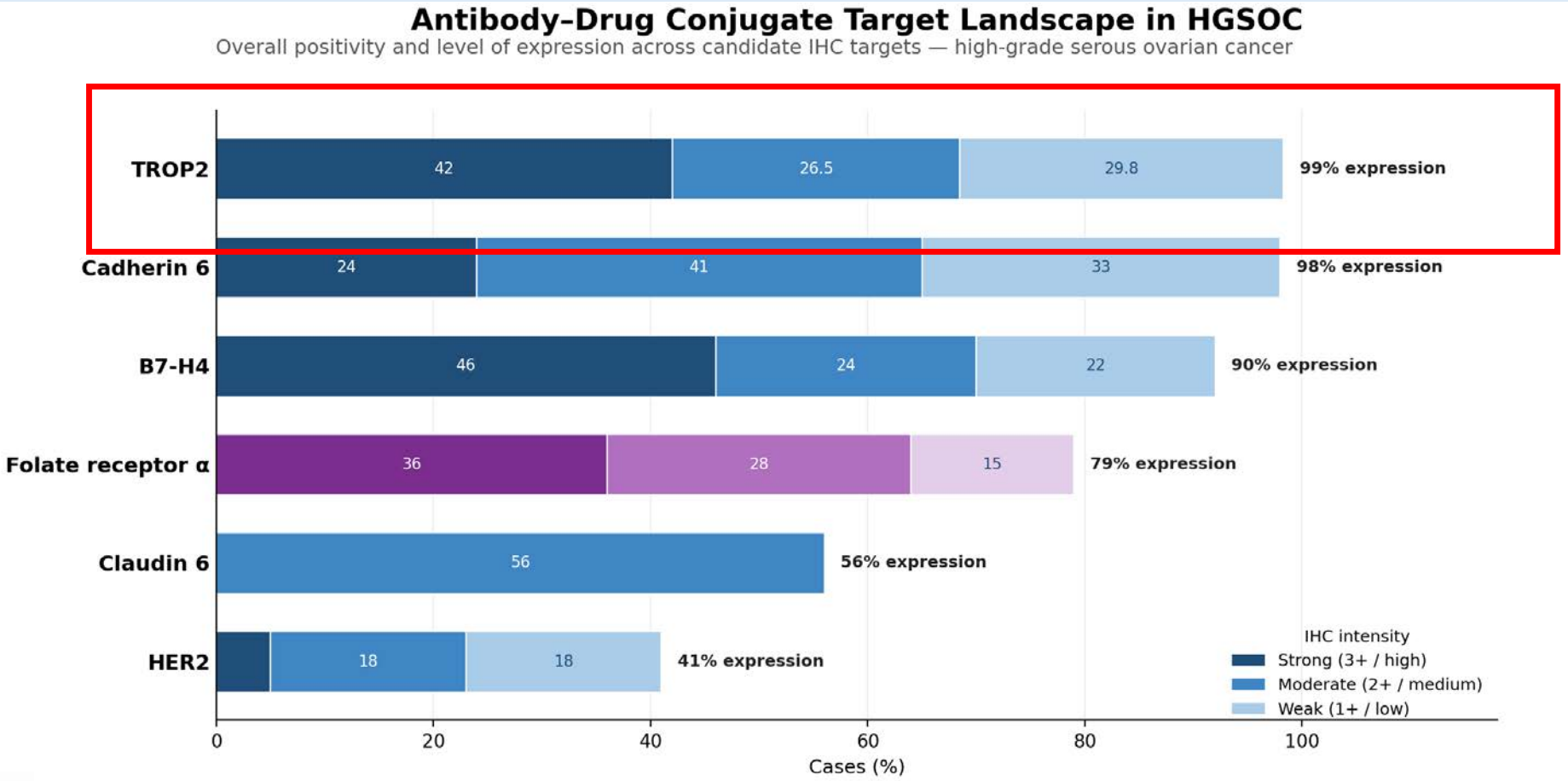

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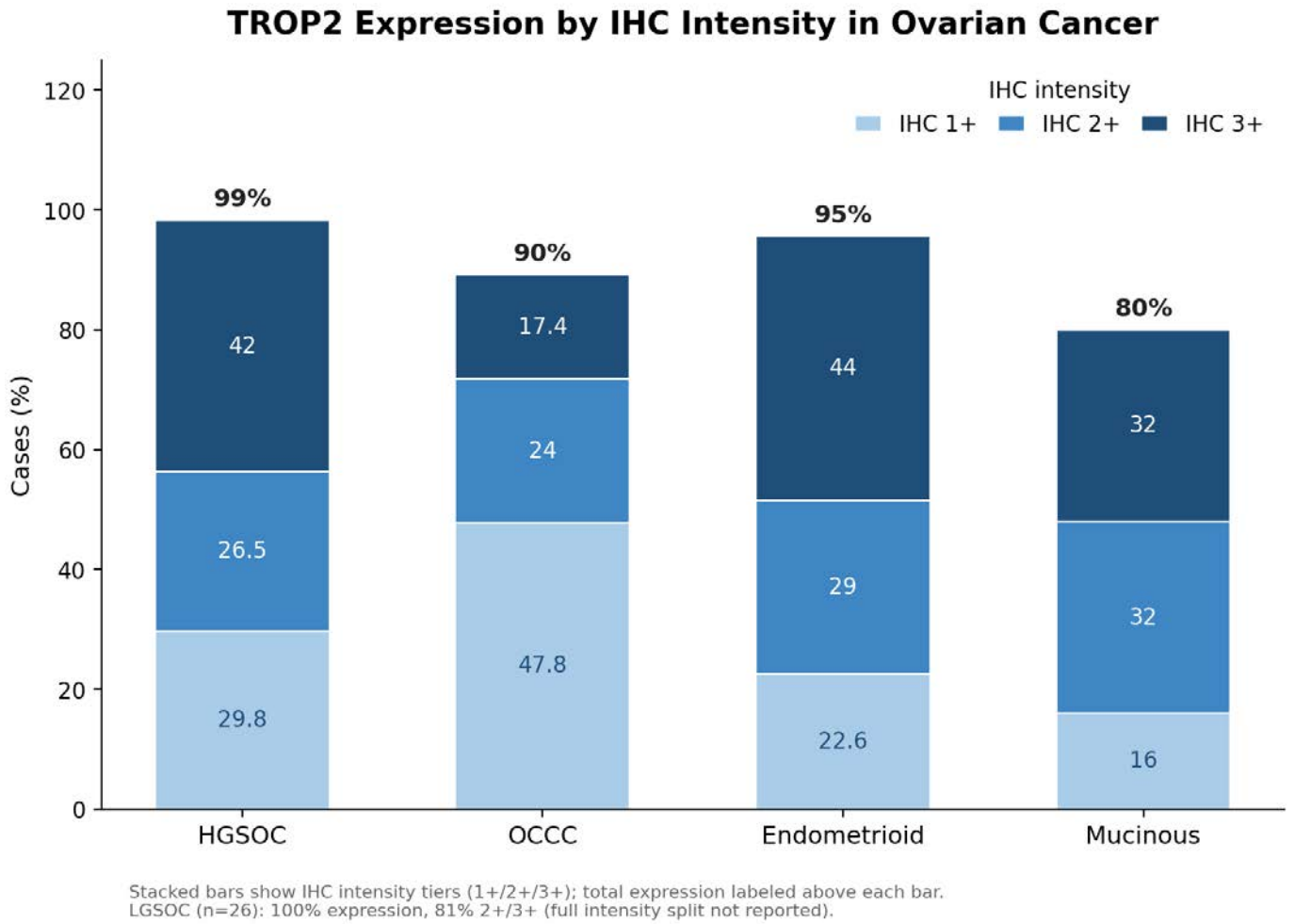
TROP2: Levels of positivity not yet validated/public



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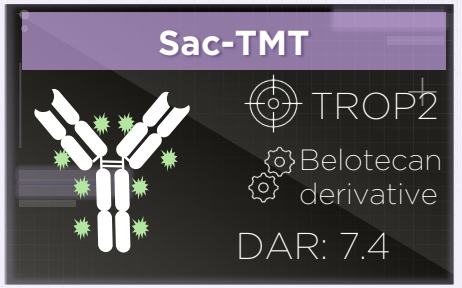
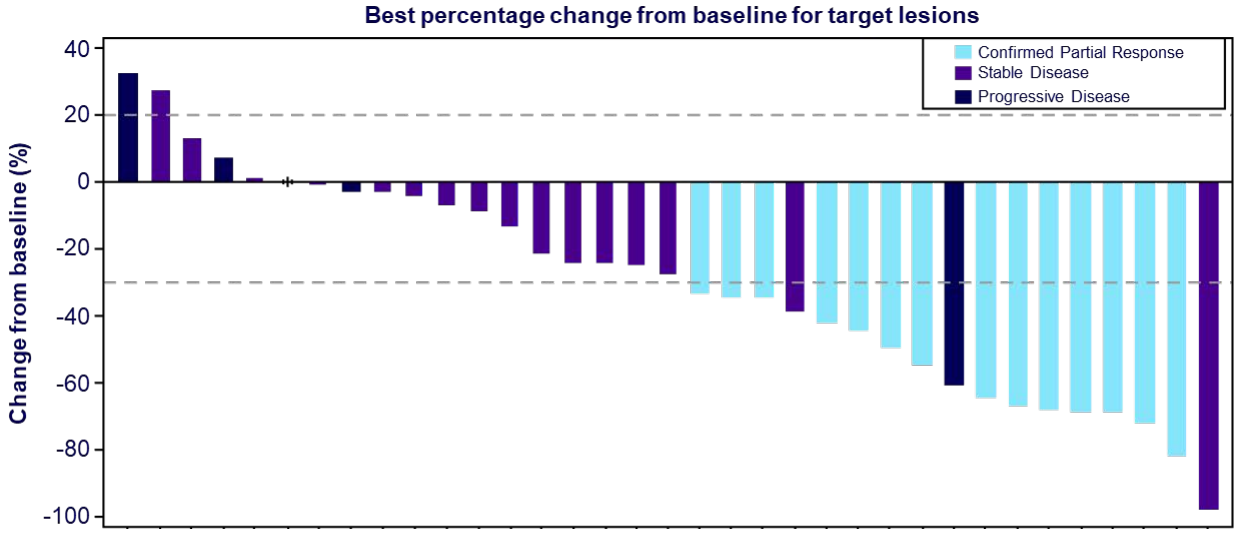
Sacituzumab tirumotecan (Sac-TMT): Antitumour activity and safety profile in OC



	OC (N=40)*
ORR, % (n/N)	**40.0** (16/40)
Confirmed ORR	**35.0** (14/40)
TROP2 H-score >200	**61.5** (8/13)
Platinum-resistant	**37.1** (13/35)
DCR, % (n/N)	**75.0** (30/40)
PR	**40.0** (16/40)
SD	**35.0** (14/40)
DOR, % (n/N)	
Median (range), months	**5.3** (2.1, 24.4+)
PFS	
Median (95% CI), months	**6.0** (3.9, 7.3)

*Responses assessed per RECIST v1.1 by investigator



The most common TRAEs were anaemia (**85.0%**), WBC decreased (**60.0%**), and neutrophil count decrease (**57.5%**)

Grade ≥3 TEAEs were reported by **67.5%** of participants and led to discontinuation in **12.5%** of participants

CI, confidence interval; DAR, antibody-to-drug ratio; DCR, disease control rate; DOR, duration of response; H-score, histoscore; OC, ovarian cancer; ORR, objective response rate; PFS, progression-free survival; PR, partial response; RECIST 1.1, Response evaluation criteria in solid tumours, version 1.1; Sac-TMT, sacituzumab tirumotecan; SD, stable disease; TEAE, treatment-emergent adverse event; TRAE, treatment-related adverse effect; TROP2, trophoblast cell surface antigen 2; WBC, white blood cell.

Wang D, et al. Presented at ESMO Congress, 2024.

Sac-TMT plus Pembrolizumab 4mg/kg q 2W vs 5 mg/kg q 2 w in PSOC

Key Eligibility Criteria for Ovarian Cohort (Cohort C)

- Aged ≥18 y
- Histologically or cytologically confirmed platinum-sensitive, *BRCA* wild-type ovarian cancer, primary peritoneal cancer, or fallopian tube cancer
- 2 prior courses of platinum-containing therapy
- Objective response of CR or PR to the last platinum-based regimen[a]; response must be ongoing at time of enrollment
- ECOG PS 0 or 1

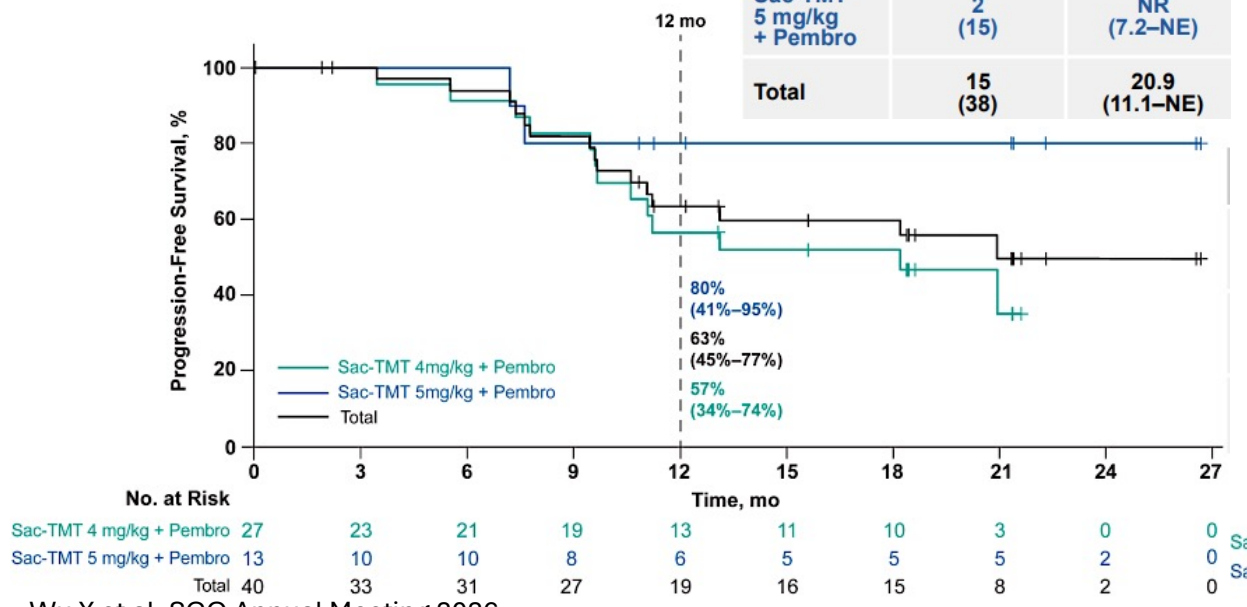
Nonrandomized allocation[b]

N = 40

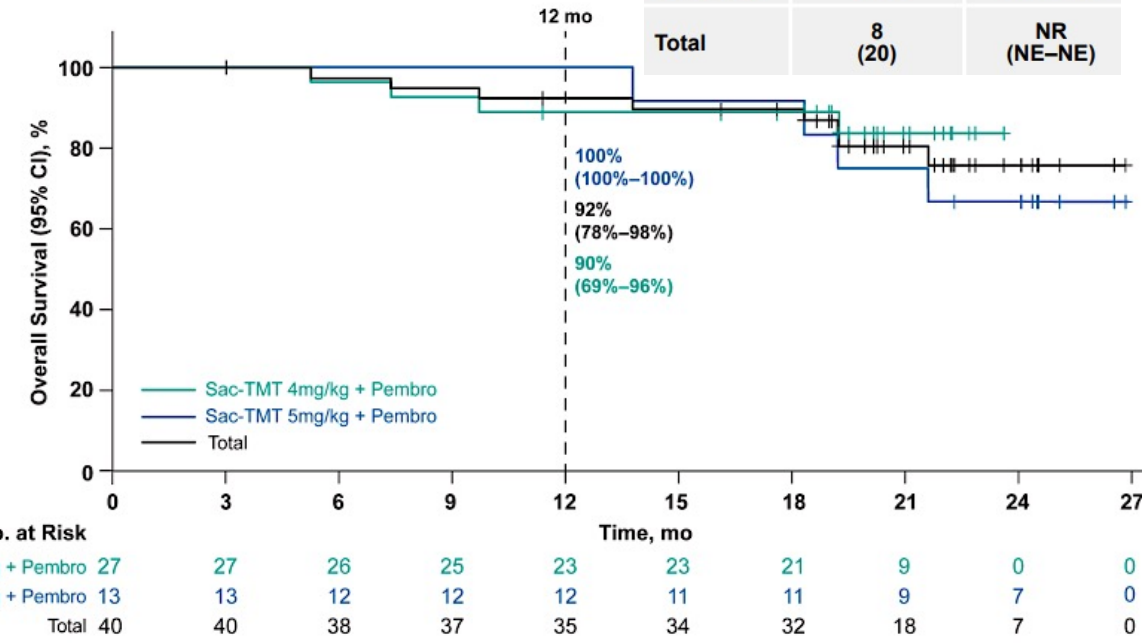
- **Sac-TMT 4 mg/kg IV Q2W[b,c] + Pembrolizumab 400 mg IV Q6W**
- **Sac-TMT 5 mg/kg IV Q2W[b,c] + Pembrolizumab 400 mg IV Q6W**

- **Primary endpoints:** include safety (incidence of AEs and AEs that led to discontinuation)
- **Secondary endpoints:** include DCR, DOR, and PFS per RECIST v1.1 and OS

	Events, n (%)	Median (95% CI), mo
Sac-TMT 4 mg/kg + Pembro	13 (48)	18.2 (9.7–NE)
Sac-TMT 5 mg/kg + Pembro	2 (15)	NR (7.2–NE)
Total	15 (38)	20.9 (11.1–NE)

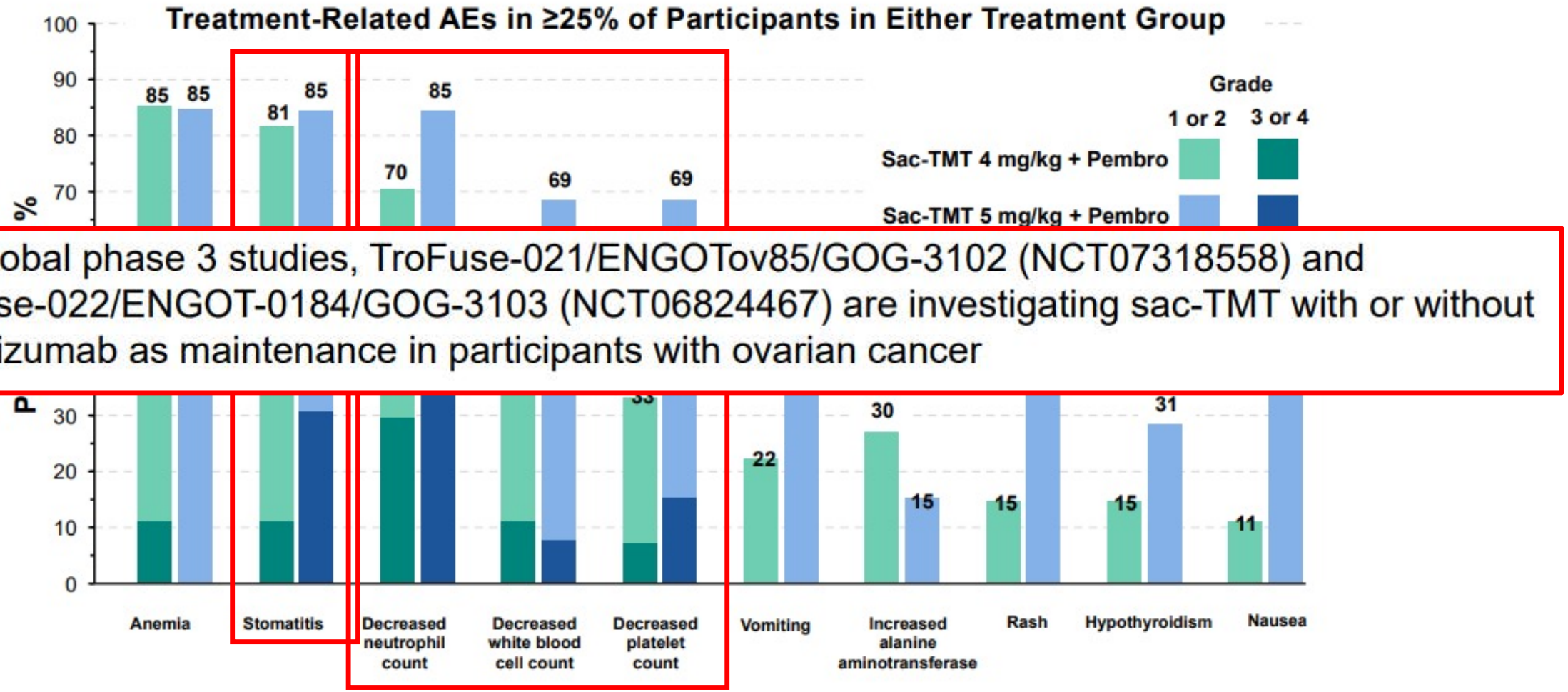


	Events, n (%)	Median (95% CI), mo
Sac-TMT 4 mg/kg + Pembro	4 (15)	NR (NE–NE)
Sac-TMT 5 mg/kg + Pembro	4 (31)	NR (18.3–NE)
Total	8 (20)	NR (NE–NE)



Wu X et al. SGO Annual Meeting 2026

Sac-TMT plus Pembrolizumab 4mg/kg q 2W vs 5 mg/kg q 2 w in PSOC



The global phase 3 studies, TroFuse-021/ENGOTov85/GOG-3102 (NCT07318558) and TroFuse-022/ENGOT-0184/GOG-3103 (NCT06824467) are investigating sac-TMT with or without bevacizumab as maintenance in participants with ovarian cancer

Wu X et al. SGO Annual Meeting 2026

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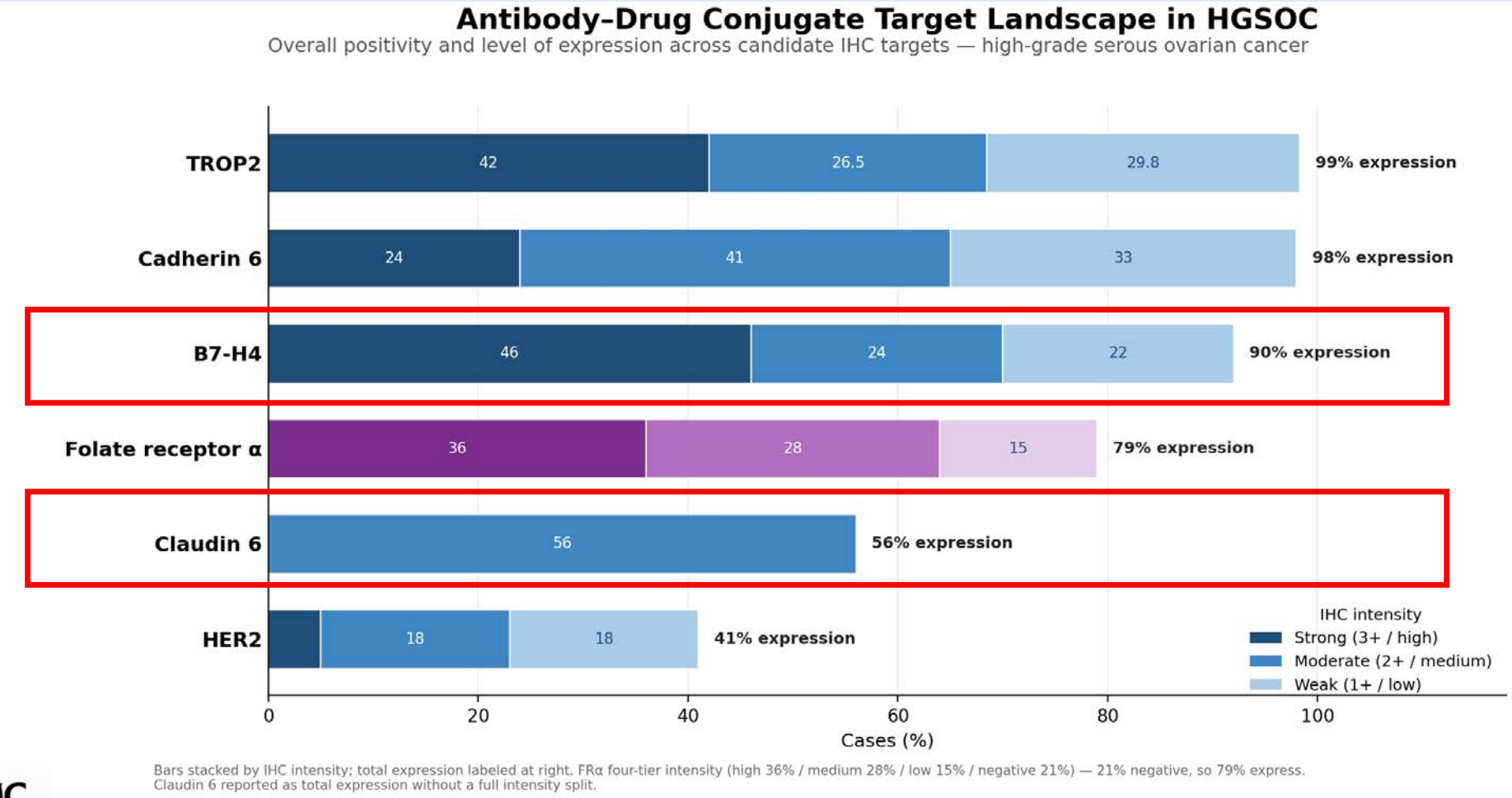

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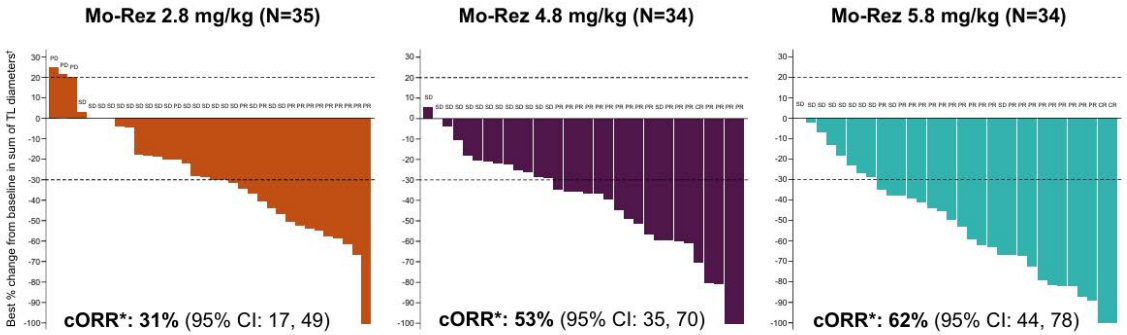
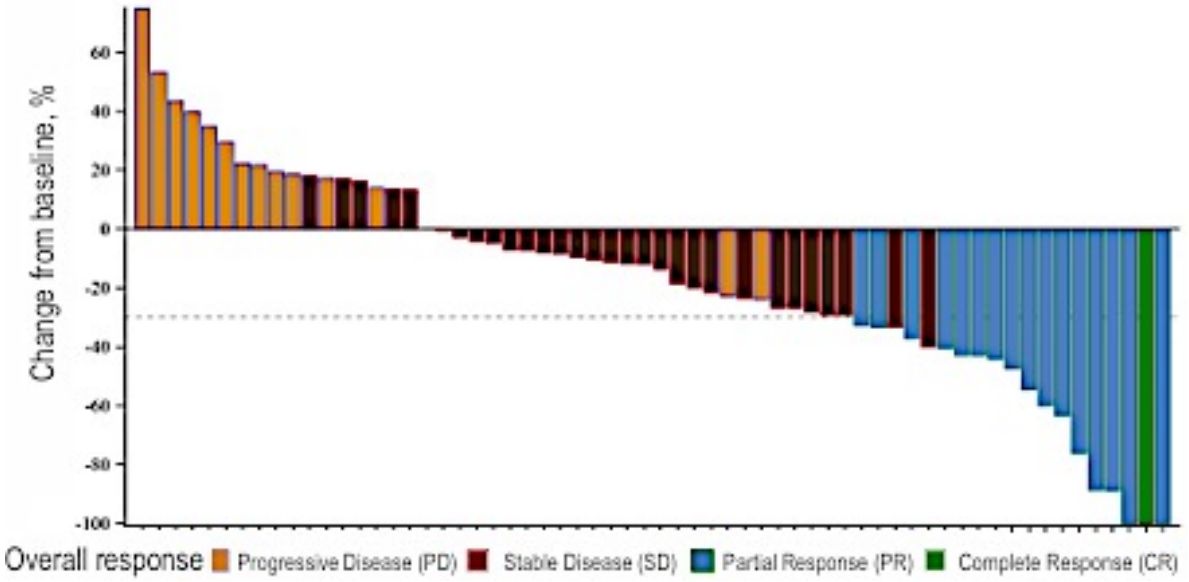
New Agents targeting B7H4 and CLDN6 entering late phase trials

Mocertatug Rezetecan (GSK5733584) in PROC



Responses were observed across a range of B7-H4 expression levels

Ixotatug vedotin (TORL-1-23)



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Oaknin A et al. SGO 2026; Konecny GE et al. ESMO 2024

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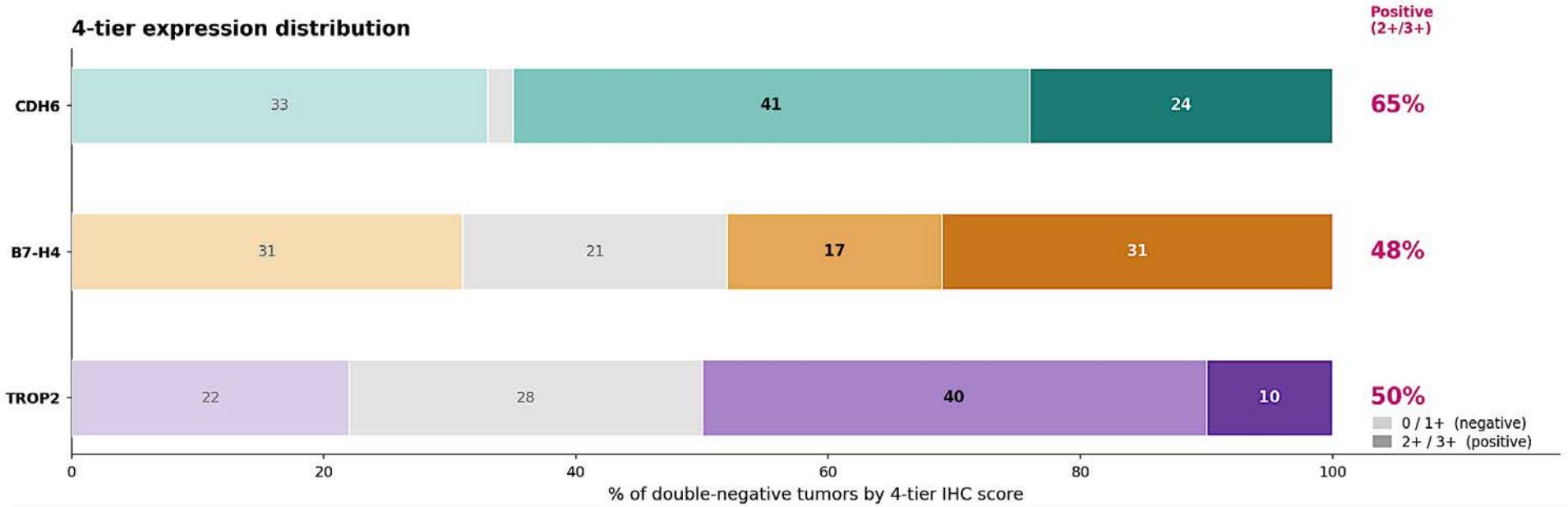
CDH6, B7-H4 and TROP2 are frequently expressed — and co-expressed — in FRα-negative / HER2 non-3+ (“double-negative”) ovarian tumors



Pairwise co-expression (high = 2+/3+)

CDH6 × B7-H4

31%

both positive

	B7-H4 high (n=18/58)	B7-H4 low
CDH6 high	18	20
CDH6 low	10	10

χ^2 $p = 0.8488$

B7-H4 × TROP2

22%

both positive

	TROP2 high (n=13/58)	TROP2 low
B7-H4 high	13	15
B7-H4 low	16	14

χ^2 $p = 0.5992$

TROP2 × CDH6

36%

both positive

	CDH6 high (n=21/58)	CDH6 low
TROP2 high	21	8
TROP2 low	17	12

χ^2 $p = 0.2692$

Why it matters

Most double-negative tumors express at least one of these targets, and pairwise co-expression is common.

No pair was mutually exclusive (all p = NS): a tumor positive for one marker is not less likely to express the others — supporting a multi-target strategy.

Adapted from Hamagawa K et al. ESMO Gynaecological Cancers 2025

Conclusions

The efficacy data for ADCs in EOC are compelling.

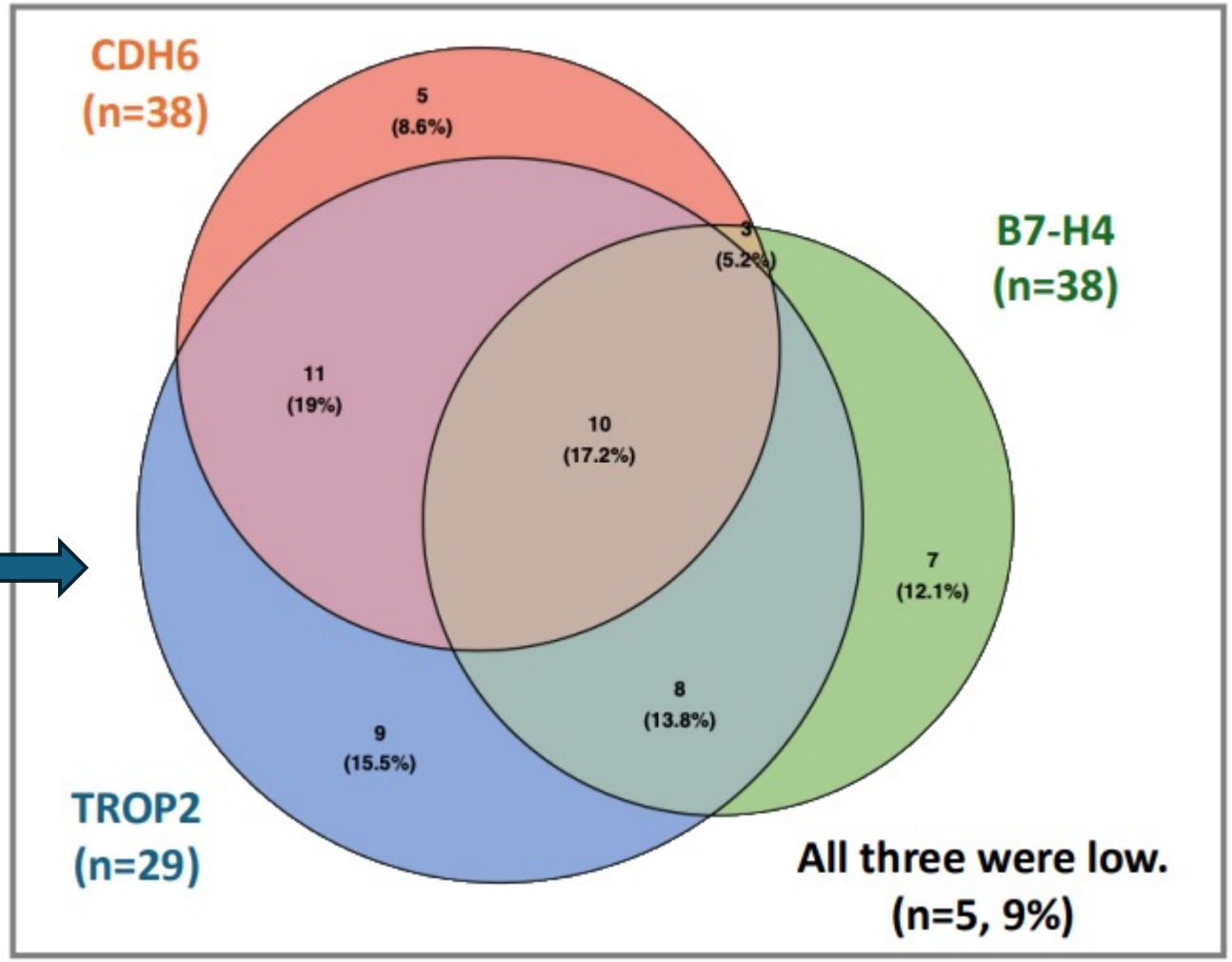
Mirvetuximab soravtansine has already established FRα-targeted ADCs as standard of care in FRα-positive PROC, and a new wave of Phase 3 trials is poised to extend ADC benefit further in PROC

RAINFOL-02: rinatabart sesutecan FRα/topo-1 A
REJOICE-Ovarian01: raludotatug deruxtecan, CDH6/topo-1

Choosing among the topo-1 ADCs will ultimately come down to efficacy, safety, schedule, and tolerability; not target alone.

And because these tumors frequently co-express multiple targets, understanding the *predictive* value of each biomarker becomes critical,

especially if topo-1 ADCs prove to be "one and done," where sequencing one after another offers diminishing returns.



Hamagawa et al. ESMO Gynaecological Cancers 2025

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When in the treatment course do you test for HER2 expression in your patients with advanced OC? What testing methodology do you generally use to test for HER2 expression in your patients with advanced OC?

	When do you test?	Testing methodology?
 Prof Eskander	At initial diagnosis	IHC
 Dr Matulonis	At initial diagnosis	IHC
 Dr Moore	At initial diagnosis	IHC
 Dr Olawaiye	At the time of first platinum-resistant relapse	IHC
 Dr O'Malley	At initial diagnosis	IHC
 Prof Colombo	At initial diagnosis	IHC

What threshold for HER2 expression (eg, IHC 3+, IHC 2+, IHC 1+, ISH-amplified) do you require to employ T-DXd for your patients with platinum-resistant advanced OC?

 Prof Eskander	IHC 2+ or 3+
 Dr Matulonis	IHC 2+ or 3+
 Dr Moore	IHC 1+ and higher
 Dr Olawaiye	IHC 2+ or 3+
 Dr O'Malley	IHC 3+
 Prof Colombo	IHC 2+ or 3+

RTP RESEARCH TO PRACTICE

For a patient with advanced OC who is eligible to receive both strategies, how would you generally sequence T-DXd and mirvetuximab soravtansine?

 Prof Eskander	Mirvetuximab soravtansine → T-DXd
 Dr Matulonis	Mirvetuximab soravtansine → T-DXd
 Dr Moore	Mirvetuximab soravtansine → T-DXd
 Dr Olawaiye	Mirvetuximab soravtansine → T-DXd
 Dr O'Malley	Mirvetuximab soravtansine → T-DXd
 Prof Colombo	T-DXd → mirvetuximab soravtansine

RTP RESEARCH TO PRACTICE

If R-DXd were available today, would you be comfortable using it in sequence with other antibody-drug conjugates currently employed in advanced OC?

 Prof Eskander	Yes, both mirvetuximab soravtansine and T-DXd
 Dr Matulonis	Yes, only mirvetuximab soravtansine
 Dr Moore	Yes, only mirvetuximab soravtansine
 Dr Olawaiye	Yes, only mirvetuximab soravtansine
 Dr O'Malley	Yes, only mirvetuximab soravtansine
 Prof Colombo	Yes, only mirvetuximab soravtansine

RTP RESEARCH TO PRACTICE

How would you indirectly compare the rates and severity of interstitial lung disease (ILD) with R-DXd to those with T-DXd for patients with advanced OC?

 Prof Eskander	ILD is about the same
 Dr Matulonis	ILD is worse with T-DXd
 Dr Moore	ILD is worse with T-DXd
 Dr Olawaiye	ILD is worse with T-DXd
 Dr O'Malley	ILD is about the same
 Prof Colombo	ILD is worse with T-DXd

RTP RESEARCH TO PRACTICE

Agenda

Module 1: Current Role of PARP Inhibitors in the Management of Advanced Ovarian Cancer (OC) — Prof Eskander

Module 2: Strategies Targeting Folate Receptor Alpha in Advanced OC — Dr Matulonis

Module 3: Other Approved and Promising Investigational Antibody-Drug Conjugates for Advanced OC — Dr Moore

Module 4: Other Novel Agents and Strategies for Advanced OC — Dr O'Malley

Module 5: Diagnosis and Management of Adverse Events Associated with Common Therapies for Advanced OC — Dr Olawaiye

RTP RESEARCH TO PRACTICE

Other Novel Agents and Strategies for Advanced Ovarian Cancer

David O'Malley, MD
Director for Translational and Clinical Research Partnerships at OSUCCC
Leader of Clinical Trial Innovation in the Center for Cancer Innovation
Professor, Division of Gyn Oncology in OB/Gyn
John G. Boutselis Chair in Gynecologic Oncology
Co-Director, Gyn Oncology Phase I Program

Ovarian Cancer Portfolio Lead, GOG-P
BOD, GOG Foundation

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Creating a cancer-free world. One person, one discovery at a time.

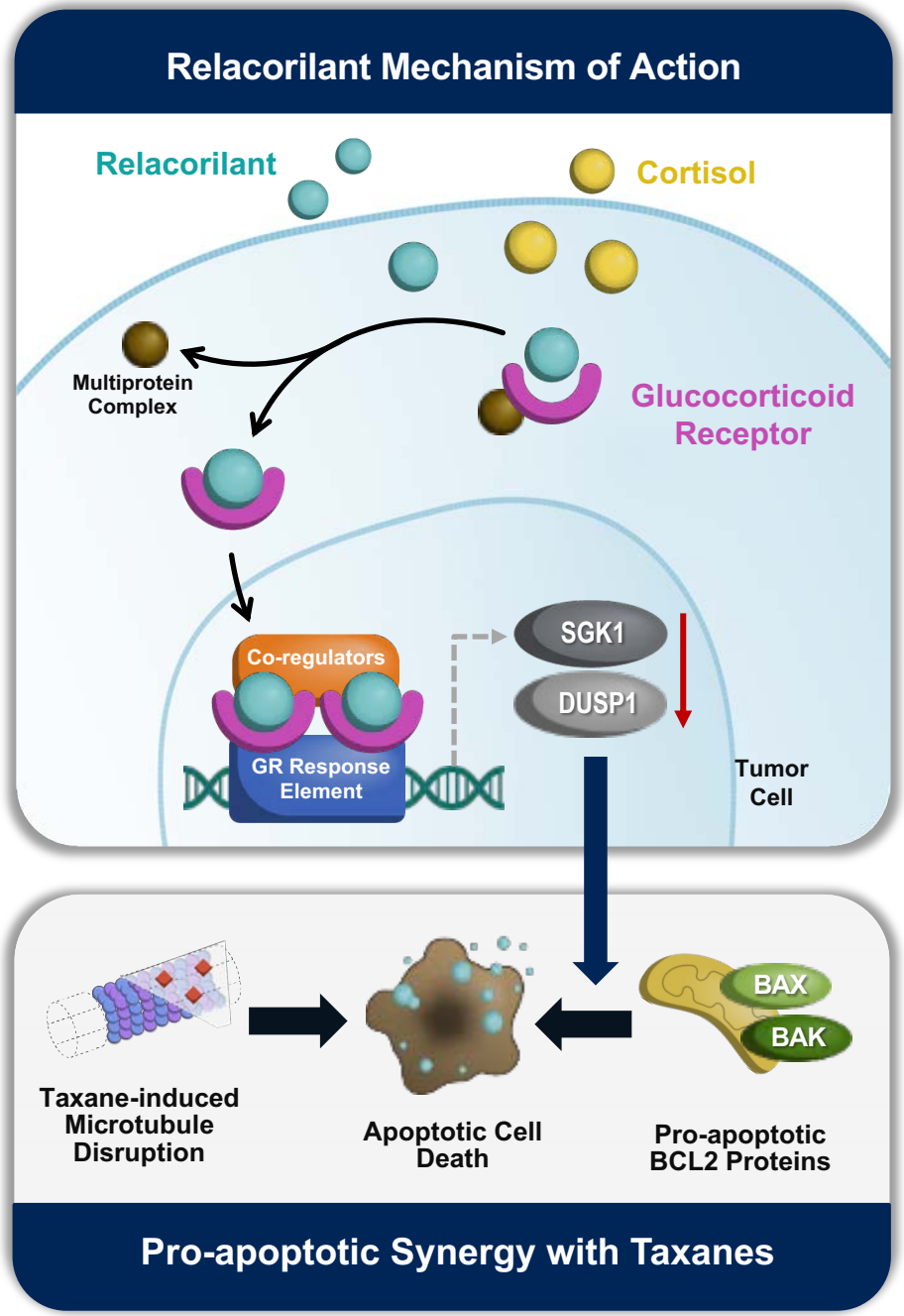



Strategies for Advanced OC Treatment

- ROSELLA (nab-paclitaxel +/- relacorilant)
- KEYNOTE-B96 (paclitaxel +/- Bev +/- pembro)
- Other promising novel agents (Other Than ADCs)

Background

- Patients with platinum-resistant ovarian cancer have an overall survival of ~1 year and need new treatments[1]
- Ovarian cancers express the glucocorticoid receptor (GR), a marker of poor prognosis[2]
- GR signaling reduces sensitivity to chemotherapy[3,4]
- Relacorilant is a novel, selective GR antagonist (SGRA) that restores the sensitivity of cancers to cytotoxic chemotherapy[3,5,6]



1. Martorana, et al. *Int J Gynecol Cancer*. 2025;35(1):100009. 2. Veneris, et al. *Gynecol Oncol*. 2017;146(1):153-60.
3. Greenstein, et al. *Oncotarget*. 2021;12(13):1243-55. 4. Melhelm, et al. *Clin Cancer Res*. 2009;15(9):3196-3204.
5. Stringer-Reasor, et al. *Gynecol Oncol*. 2015;138(3):656-62.6. Munster, et al. *Clin Cancer Res*. 2022;28(15):3214-24.

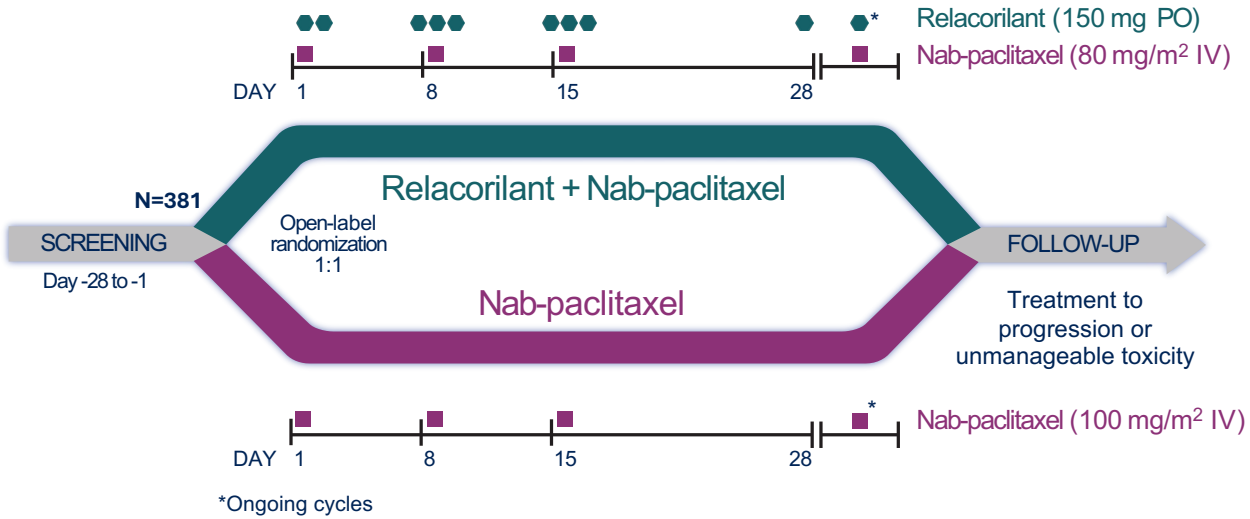
Presented By: Alexander B. Olawaiye, MD

ROSELLA | Study Schema

Population

- Epithelial ovarian, primary peritoneal, or fallopian tube cancer
- ECOG performance status 0 or 1
- Progression <6 months after the last dose of platinum therapy (excluding no response to, or progression in <1 month of primary platinum)
- 1–3 prior lines of therapy
- Prior bevacizumab required

NCT05257408



Stratification Factors

- Prior lines of therapy (1 vs >1)
- Region (North America vs Europe vs Korea, Australia, & Latin America)

Dual Primary Endpoints

- Progression-free survival (PFS) by RECIST v1.1 per blinded independent central review
- Overall survival (OS)

Secondary Endpoints

- PFS by RECIST v1.1 per Investigator
- ORR, DoR, CBR (RECIST v1.1)
- Response by CA-125 GCIG criteria
- Combined response (RECIST v1.1 and CA-125 GCIG criteria)
- Safety

First patient enrolled: Jan 5, 2023
Last patient enrolled: Apr 8, 2024
Primary results data cutoff: Feb 24, 2025
Final OS data cutoff: Jan 8, 2026
Conducted at 117 sites in 14 countries.

CA, cancer antigen; CBR, clinical benefit rate; DoR, duration of response; ECOG, Eastern Cooperative Oncology Group; GCIG, Gynecologic Cancer Intergroup; IV, intravenous; ORR, objective response rate; PO, by mouth; RECIST, Response Evaluation Criteria in Solid Tumors.

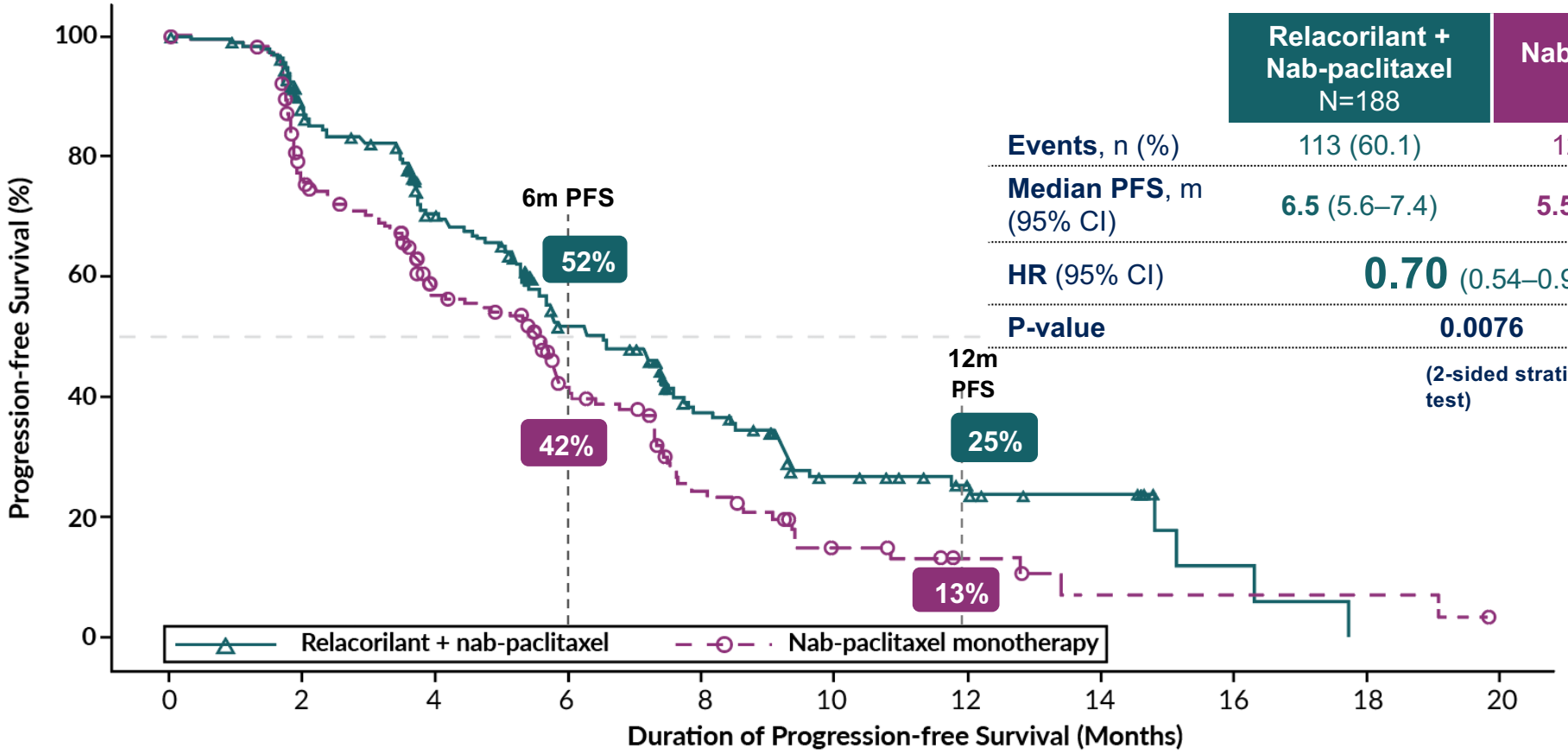
ROSELLA - Demographics

		Relacorilant + Nab-paclitaxel (N=188)	Nab-paclitaxel (N=193)
Age, median (range), years		**61** (26–85)	**62** (33–86)
Race, n (%)	White Black or African-American Asian (92% Korean) Other / Not Reported	136 **(72.3)** 3 **(1.6)** 22 **(11.7)** 27 **(14.4)**	135 **(69.9)** 2 **(1.0)** 26 **(13.5)** 30 **(15.5)**
Ethnicity, n (%)	Hispanic	16 **(8.5)**	17 **(8.8)**
Region	North America Europe Korea, Australia, and Latin America	45 **(23.9)** 107 **(56.9)** 36 **(19.1)**	45 **(23.3)** 109 **(56.5)** 39 **(20.2)**
ECOG Performance Status, n (%)*	1 or 2	53 **(28.2)**	63 **(32.6)**
BRCA1/2 Mutation, n (%)	Yes	23 **(12.2)**	24 **(12.4)**
Prior Lines of Therapy, n (%)	1 2 3	15 **(8.0)** 92 **(48.9)** 81 **(43.1)**	18 **(9.3)** 89 **(46.1)** 86 **(44.6)**
Primary Platinum Refractory, n (%)†	Yes	13 **(6.9)**	13 **(6.7)**
Prior Lines of Therapy in the Platinum-resistant Setting, n (%)	≥1	67 **(35.6)**	82 **(42.5)**
Prior Taxane in the Platinum-resistant Setting, n (%)	Yes	8 **(4.3)**	7 **(3.6)**
Prior Therapies, n (%)	Bevacizumab Taxanes Pegylated Liposomal Doxorubicin PARP Inhibitor	188 **(100)** 187 **(99.5)** 121 **(64.4)** 114 **(60.6)**	193 **(100)** 192 **(99.5)** 125 **(64.8)** 120 **(62.2)**

*In the nab-paclitaxel monotherapy arm, 1 patient had an ECOG performance status of 2. †Progressed within 3 months of the last dose of platinum from their first line platinum regimen. 97% of patients had high-grade serous carcinoma; 8 patients had high-grade endometrioid carcinoma and 2 patients had carcinosarcoma. BRCA, Breast Cancer Gene; ECOG, Eastern Cooperative Oncology Group; PARP, poly(ADP-ribose) polymerase.

Data cutoff: Feb 24, 2025

ROSELLA | Progression-Free Survival – BICR (Primary Analysis)



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	113 (60.1)	121 (62.7)
Median PFS, m (95% CI)	**6.5** (5.6–7.4)	**5.5** (3.9–5.9)
HR (95% CI)	**0.70** (0.54–0.91)	
P-value	**0.0076**	

(2-sided stratified log-rank test)

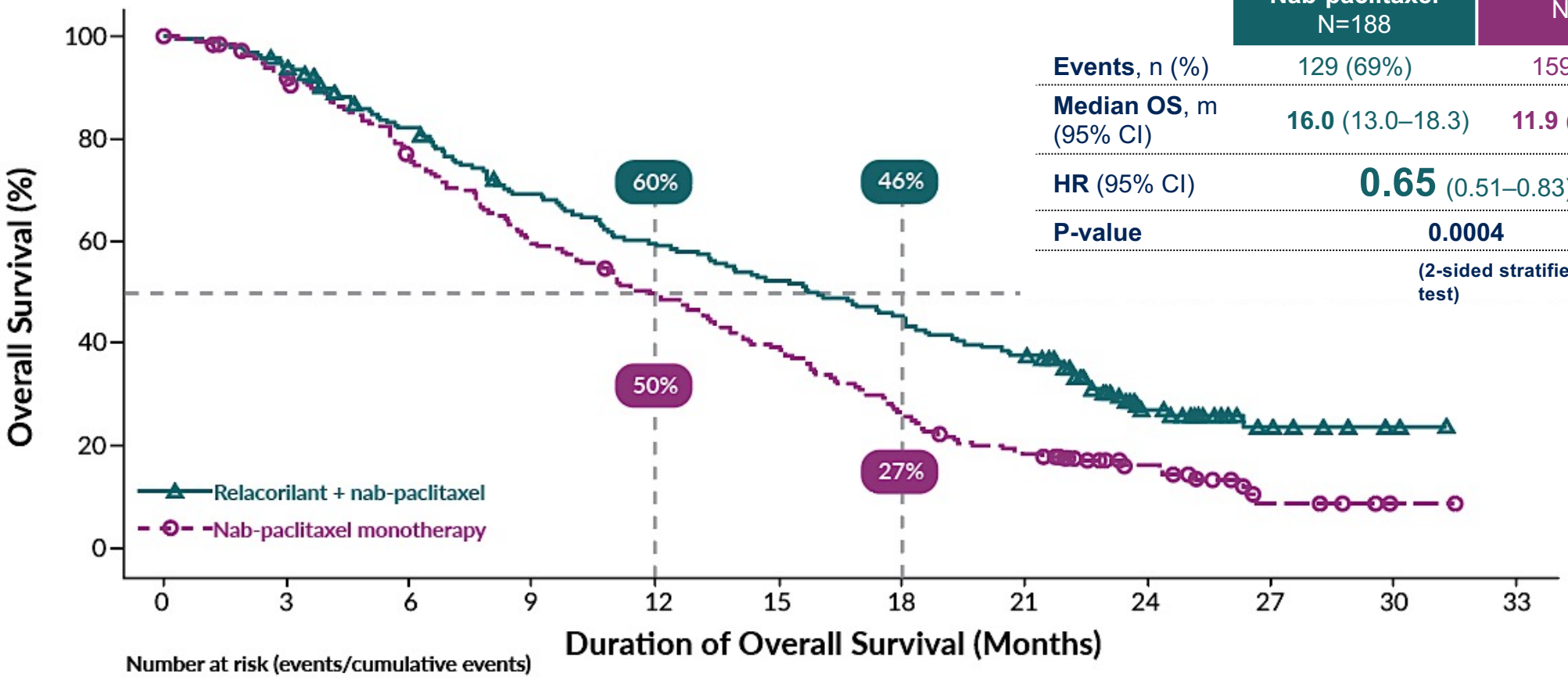
No. at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	151 (22/22)	109 (29/51)	70 (27/78)	43 (18/96)	24 (11/107)	16 (1/108)	11 (1/109)	2 (2/111)	0 (2/113)	
Nab-paclitaxel monotherapy	193 (0/0)	129 (42/42)	85 (31/73)	47 (20/93)	21 (17/110)	9 (7/117)	5 (1/118)	2 (2/120)	2 (0/120)	2 (0/120)	0 (1/121)

Median follow-up time: 9.0 months; statistical significance threshold: P≤0.04. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for progression-free survival in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.
CI, confidence interval; HR, hazard ratio; m, months; PFS, progression-free survival.

Data cutoff: Feb 24, 2025

ROSELLA | Overall Survival - Final Analysis



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	129 (69%)	159 (82%)
Median OS, m (95% CI)	**16.0** (13.0–18.3)	**11.9** (10.0–13.8)
HR (95% CI)	**0.65** (0.51–0.83)	
P-value	**0.0004**	

(2-sided stratified log-rank test)

76% maturity

Number at risk (events/cumulative events)

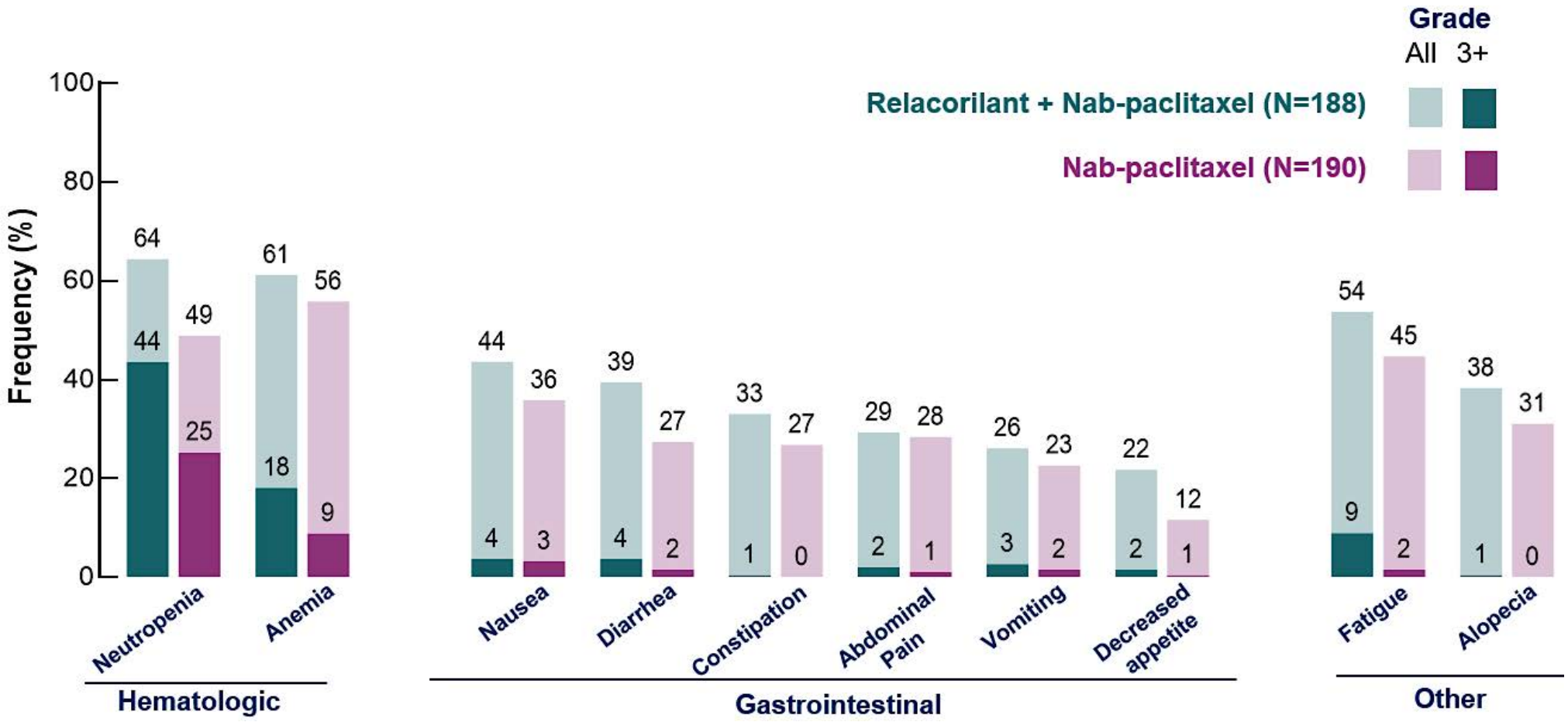
Relacorilant + nab-paclitaxel	188 (0/0)	176 (11/11)	148 (22/33)	123 (23/56)	106 (17/73)	93 (13/86)	81 (12/98)	67 (14/112)	28 (15/127)	10 (2/129)	3 (0/129)	0 (0/129)
Nab-paclitaxel monotherapy	193 (0/0)	173 (15/15)	142 (28/43)	110 (32/75)	91 (18/93)	72 (19/112)	49 (23/135)	33 (15/150)	18 (3/153)	5 (6/159)	1 (0/159)	0 (0/159)

Median follow-up time: 24.8 months; statistical significance threshold at the final analysis: P≤0.0499. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for OS in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.
CI, confidence interval; HR, hazard ratio; m, months; OS, overall survival.

Data cutoff: Jan 8, 2026

Presented By: Alexander B. Olawaiye, MD, SGO 2026

ROSELLA | Common (>20%) Adverse Events



When adjusted for duration of exposure, the incidence rates of neutropenia and anemia were similar between study arms.
Peripheral neuropathy occurred with similar frequency in both arms (19.1% and 17.4%).
5 SAEs of febrile neutropenia: 4 (2.1%) vs 1 (0.5%).* 5 SAEs of sepsis: 3 (1.6%) vs 2 (1.1%).*

Treatment-emergent adverse events that occurred in >20% of patients. Assessed in the safety population of patients who received at least one dose of study drug, N=378. Combined terms are presented for neutropenia (neutropenia, reduced neutrophil count, and febrile neutropenia), anemia (anemia, reduced hemoglobin, and reduced red blood cell count) and fatigue (fatigue and asthenia). SAEs, serious adverse events. *Comparing the relacorilant combination arm to the nab-paclitaxel monotherapy arm, respectively.

Data cutoff: Jan 8, 2026

FDA Approves relacorilant with *nab* paclitaxel for platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer

Press Release: March 25, 2026

"On March 25, 2026, the Food and Drug Administration approved relacorilant, a glucocorticoid receptor antagonist, in combination with *nab*-paclitaxel for the treatment of adults with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received one to three prior systemic treatment regimens, at least one of which included bevacizumab.

Efficacy was evaluated in ROSELLA (NCT05257408), a multicenter, open-label, trial in 381 patients with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer. Patients were permitted to receive up to three prior lines of systemic therapy and prior bevacizumab was required. The trial excluded patients who required chronic or frequent use of glucocorticoids. Patients were randomized (1:1) to receive relacorilant in combination with *nab*-paclitaxel or *nab*-paclitaxel alone."

https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-relacorilant-nab-paclitaxel-platinum-resistant-epithelial-ovarian-fallopian-tube-or

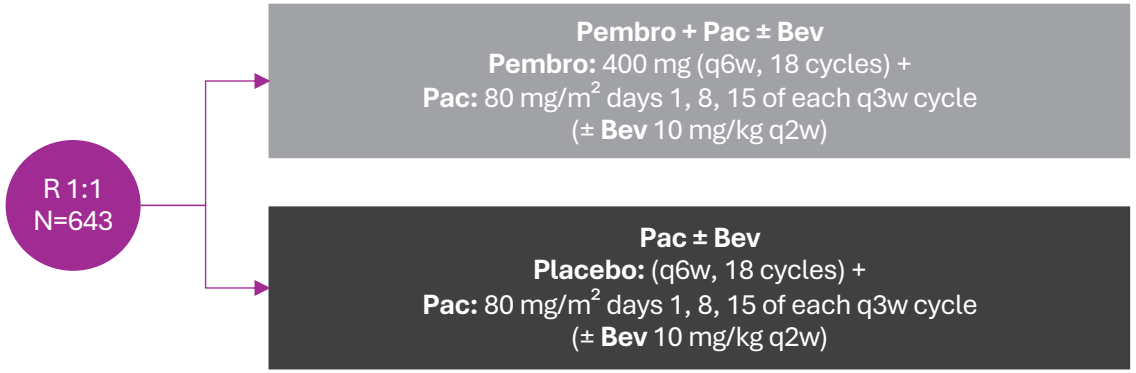
RTP RESEARCH TO PRACTICE

KEYNOTE-B96: Phase 3 Trial of Pembro in PROC

Study Design and Patient Characteristics

Key Eligibility Criteria

- Histologically confirmed epithelial ovarian, fallopian tube, or primary peritoneal carcinoma
- 1 or 2 prior lines of therapy; at least 1 platinum-based Chemo
- Prior anti–PD-1 or anti–PD-L1, PARPi and Bev permitted
- Radiographic progression within 6 months after the last dose of platinum-based Chemo
- ECOG PS 0 or 1



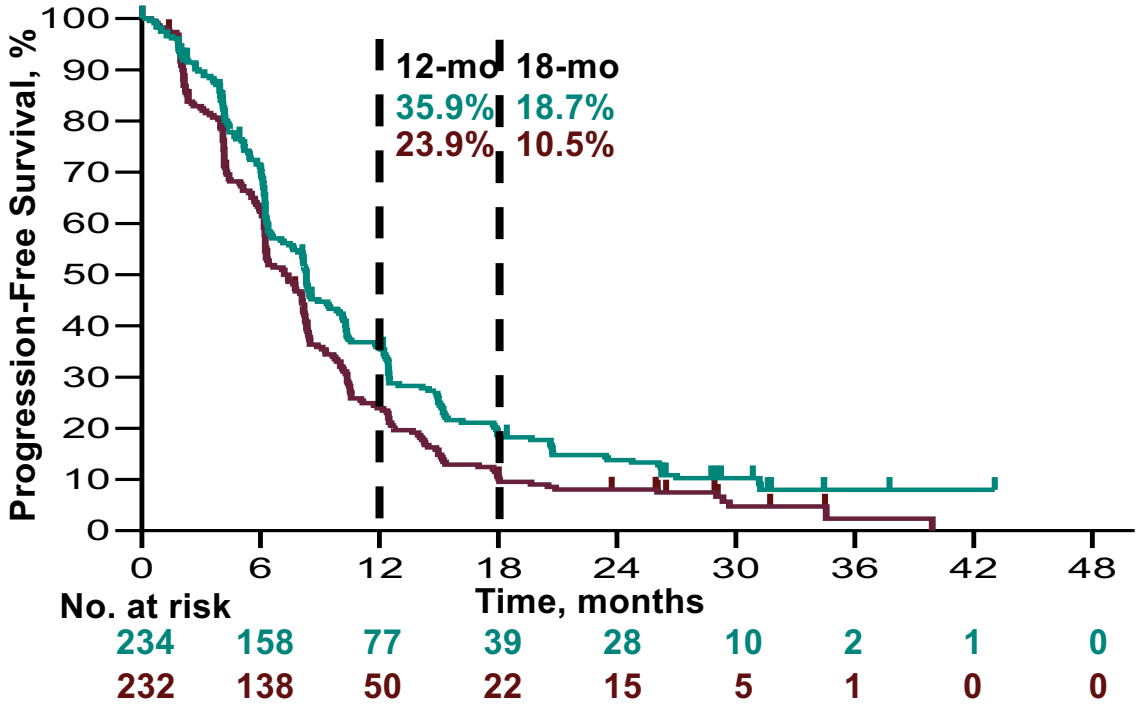
Primary endpoint: PFS per RECIST v1.1 by INV
Secondary endpoint: OS

Patient Characteristics	Pembro + Pac ± Bev (n=322)	Pac ± Bev (n=321)
Median age (range), years	62 (37-85)	61 (37-82)
Prior LOT, n (%)		
1	121 (38)	113 (35)
2	200 (62)	207 (65)
PD-L1 CPS, n (%)		
<1	88 (27)	89 (28)
1 to <10	133 (41)	132 (41)
≥10	101 (31)	100 (31)
Bev use, n (%)	235 (73)	236 (74)
Prior anticancer therapy, n (%)		
Anti–PD-1 or PD-L1	7 (2)	7 (2)
Bev	149 (46)	146 (46)
PARPi	112 (35)	123 (38)
ECOG PS 1, n (%)	142 (44)	144 (45)
Platinum-free interval, n (%)		
<3 months	137 (43)	162 (51)
≥3 to ≤6 months	183 (57)	154 (48)
>6 months	2 (1)	4 (1)

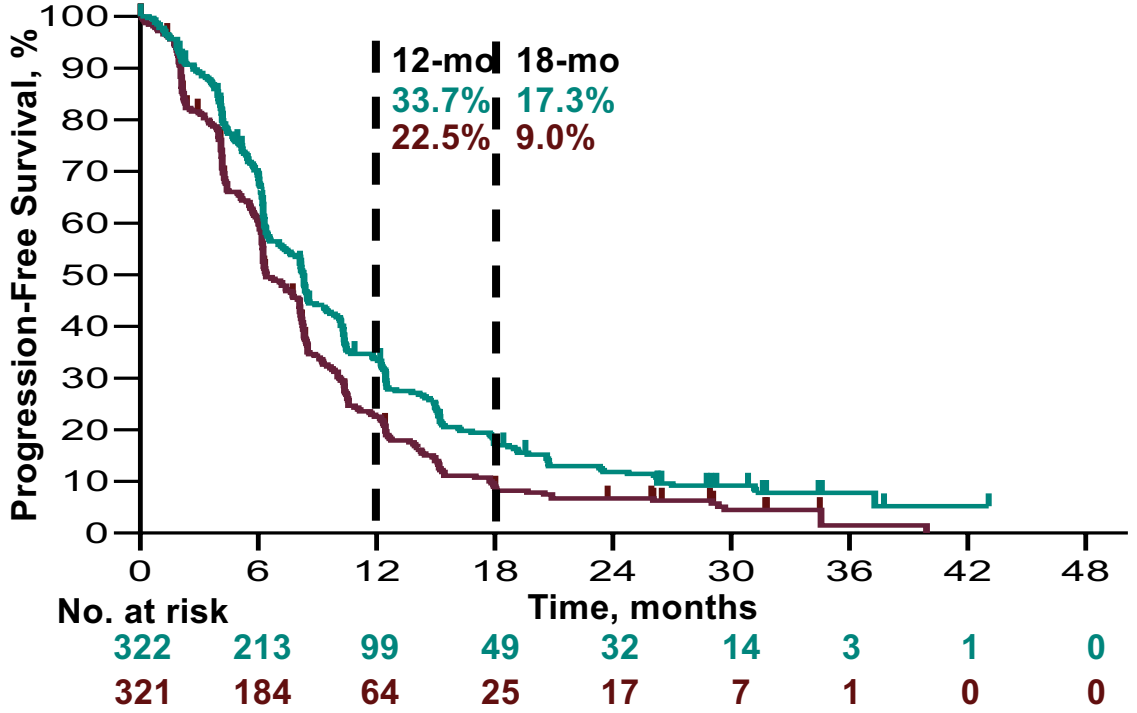
Colombo N, et al. ESMO 2025. Abstract LBA3.

PFS in CPS ≥1 and ITT Populations at Final Analysis

CPS ≥1 Population	Events	Median, mo (95% CI)	HR[a] (95% CI)
Pembro Arm	84.6%	8.3 (7.0–9.5)	0.76 (0.62–0.93)
Placebo Arm	88.8%	7.2 (6.2–8.1)	



ITT Population	Events	Median, mo (95% CI)	HR[a] (95% CI)
Pembro Arm	85.7%	8.3 (7.2–8.6)	0.73 (0.62–0.87)
Placebo Arm	89.1%	6.4 (6.2–8.1)	

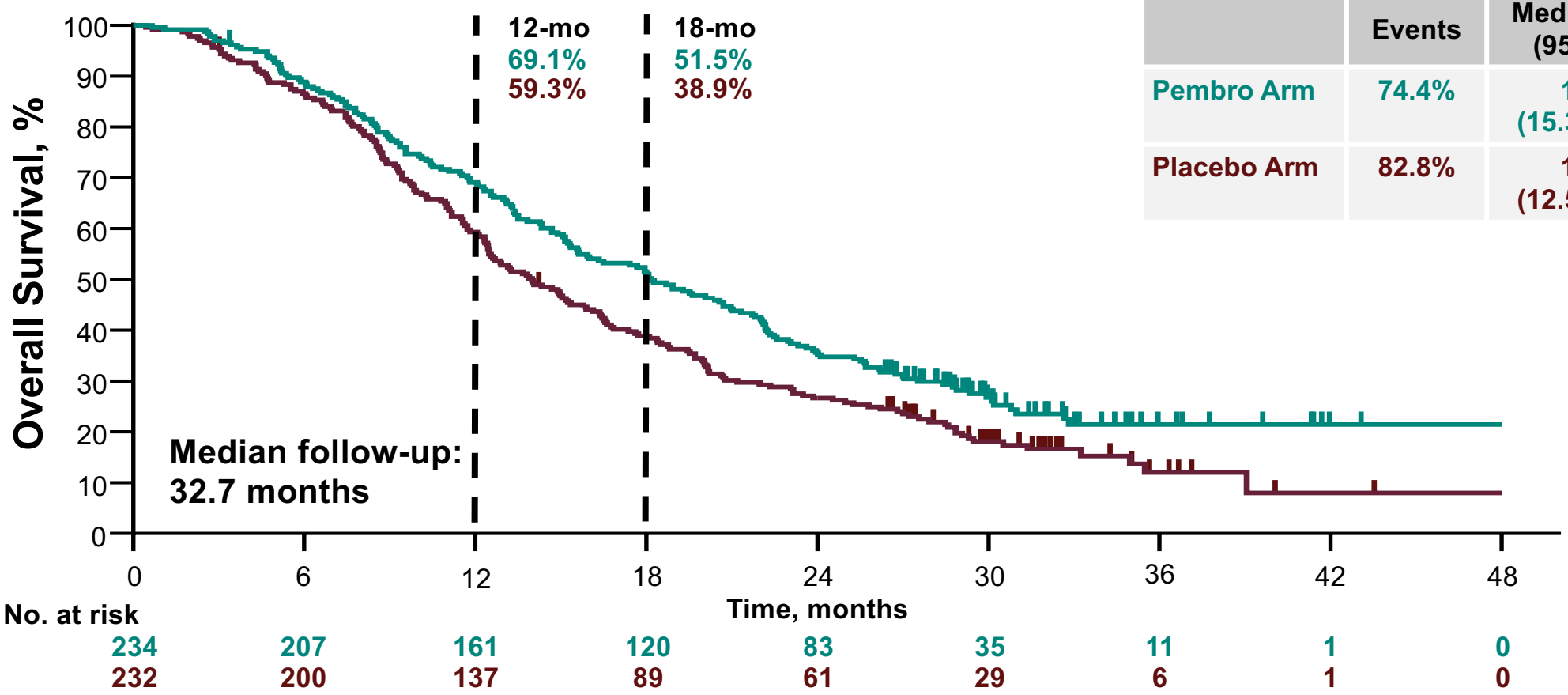


Median follow-up: 32.7 months

Monk SGO 2026

Response assessed per RECIST v1.1 by investigator review. [a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors.
Data cutoff date: September 5, 2025.

OS in CPS ≥1 Population at Final Analysis

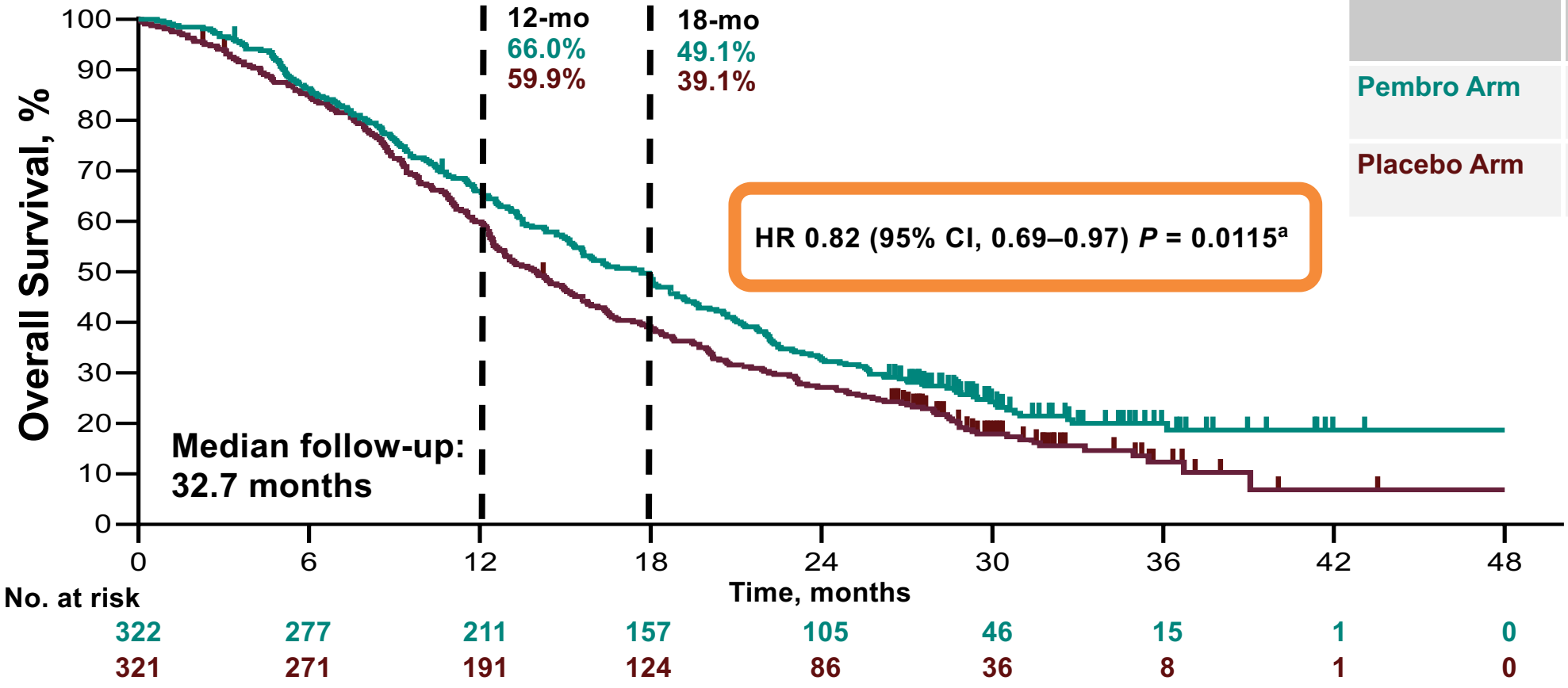


	Events	Median, mo (95% CI)	HR (95% CI)
Pembro Arm	74.4%	18.2 (15.3–21.3)	0.76 (0.62–0.93)
Placebo Arm	82.8%	14.0 (12.5–16.1)	

[a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

Monk SGO 2026

OS in ITT Population at Final Analysis

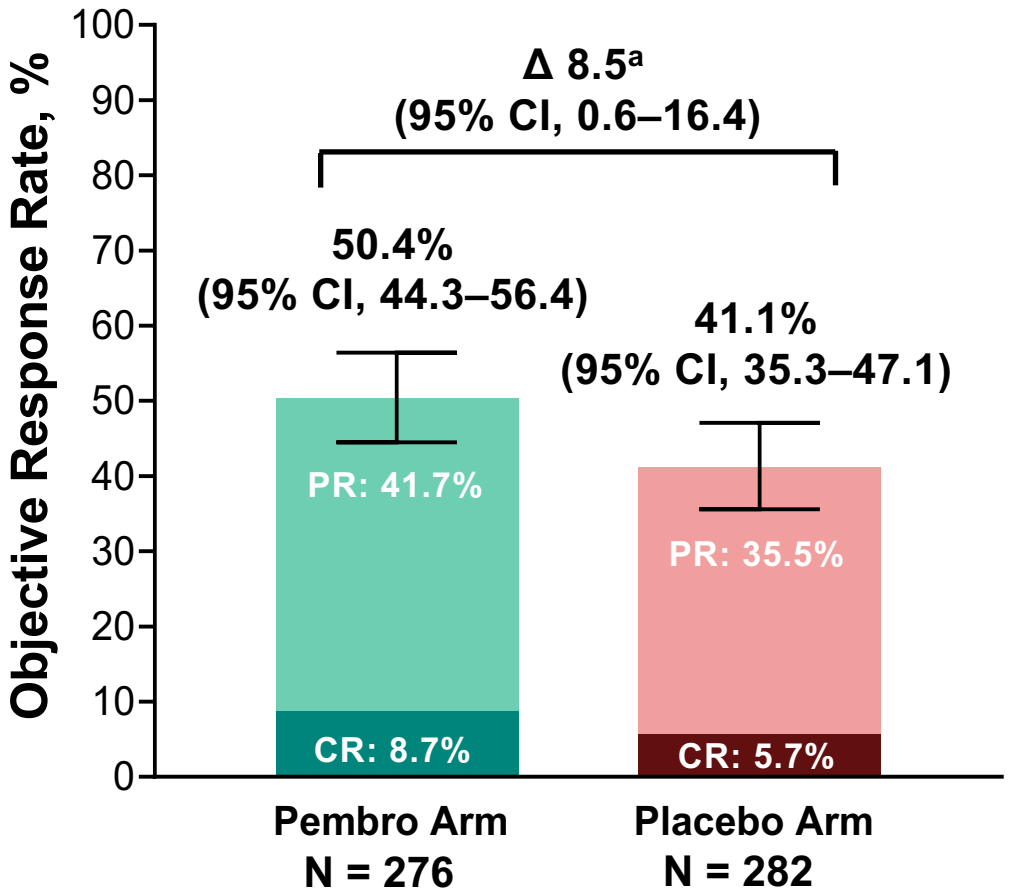


	Pts w/ Event	Median, mo (95% CI)
Pembro Arm	76.7%	17.7 (15.2–19.2)
Placebo Arm	82.9%	14.0 (12.5–15.6)

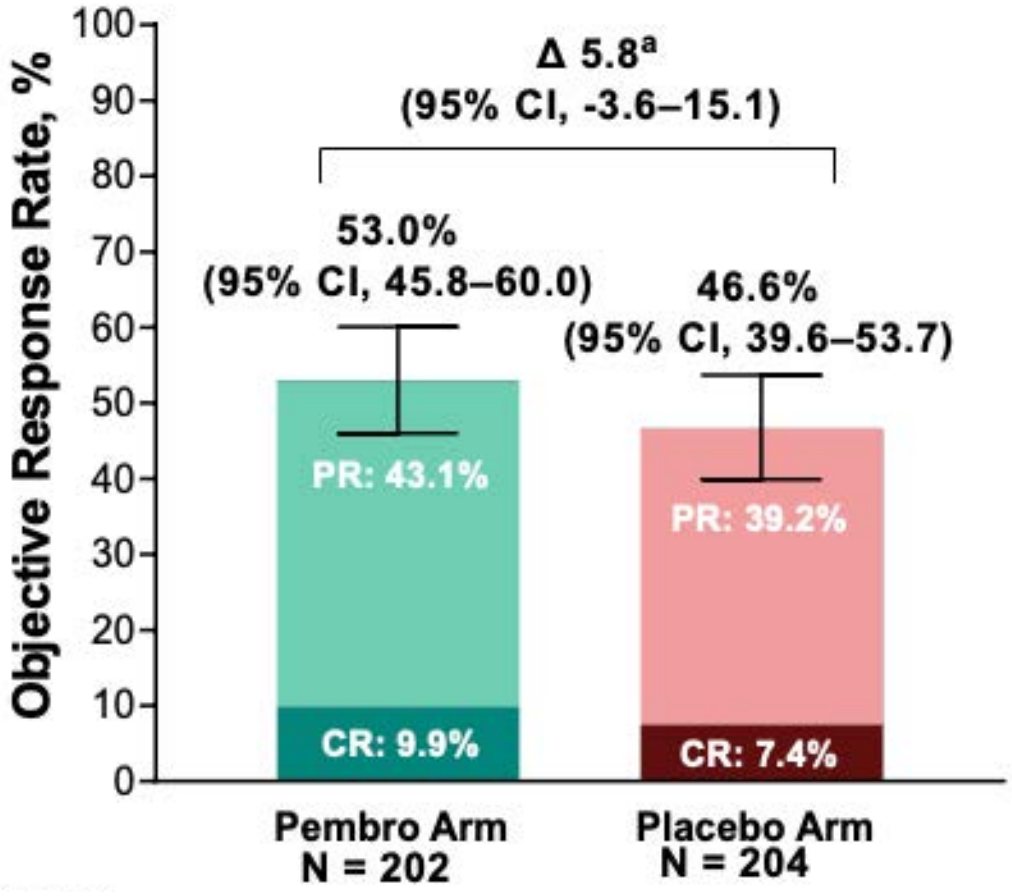
[a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors. The observed p-value crossed the prespecified nominal boundary of 0.0242 at this planned final analysis. Data cutoff date: September 5, 2025.

Monk SGO 2026

FINAL ANALYSIS
ORR ITT Population



ORR CPS ≥1

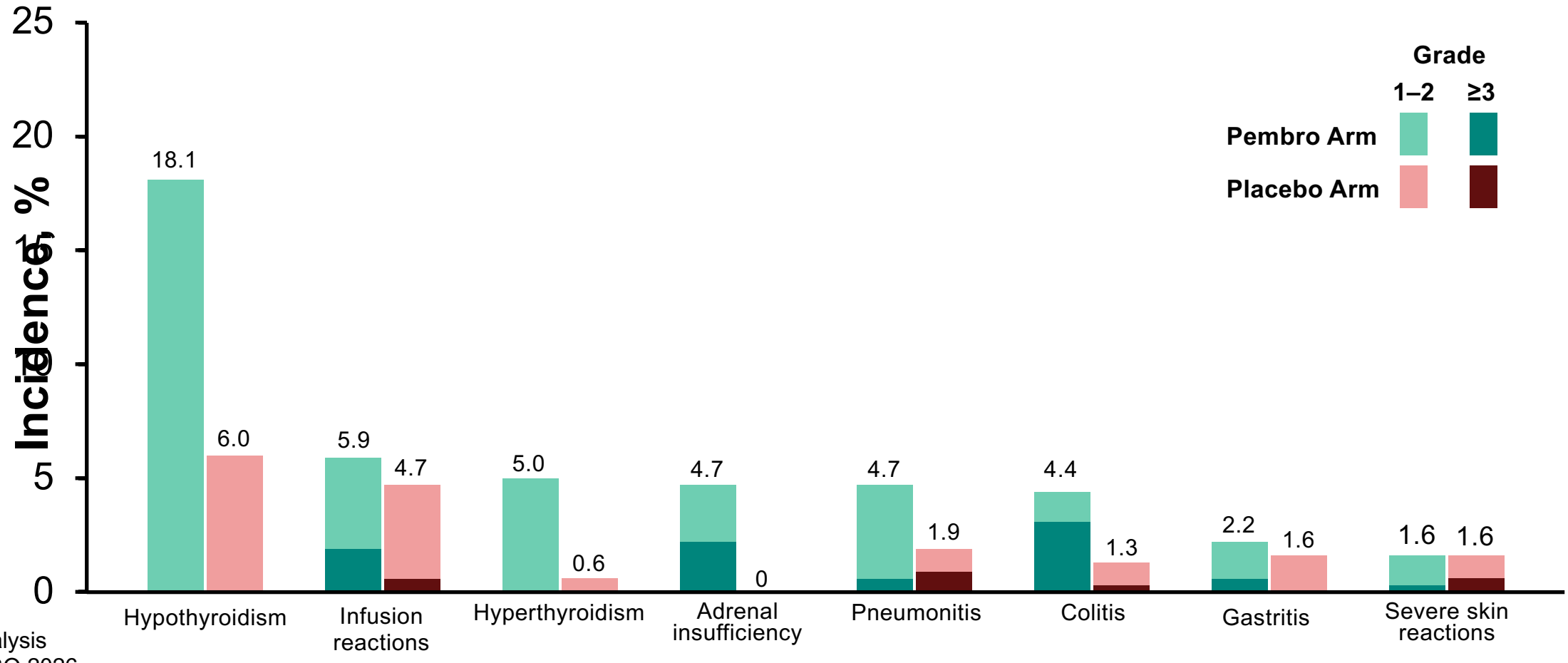


- Final Analysis
- Monk SGO 2026

Monk SGO 2026

Response assessed per RECIST v1.1 by investigator review. [a]Delta estimated using Miettinen & Nurminen method stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

Immune-Mediated AEs and Infusion Reactions, Incidence ≥5 Participants in Either Arm*



- Final Analysis
- Monk SGO 2026

Monk SGO 2026

Events were based on a list of preferred terms intended to capture the known risks of pembrolizumab and considered regardless of attribution to treatment by the investigator.
Data cutoff date: September 5, 2025.

FDA approves pembrolizumab with paclitaxel for platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal carcinoma

Press Release: February 10, 2026

"On February 10, 2026, the Food and Drug Administration approved pembrolizumab as well as pembrolizumab and berahyaluronidase alfa-pmph in combination with paclitaxel, with or without bevacizumab, for adult patients with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal carcinoma whose tumors express PD-L1 (CPS≥1) as determined by an FDA-authorized test, and who have received one or two prior systemic treatment regimens.

Efficacy was evaluated in KEYNOTE-B96 (NCT05116189), a multicenter, randomized, double-blind, placebo-controlled trial that enrolled 643 patients with platinum-resistant, epithelial ovarian, fallopian tube, or primary peritoneal carcinoma who received one or two prior lines of systemic therapy for ovarian carcinoma. Patients must have received at least one line of platinum-based chemotherapy for ovarian cancer with radiographic evidence of disease progression within six months after the last dose. Patients were randomized (1:1) to either pembrolizumab plus paclitaxel with or without bevacizumab or placebo plus paclitaxel with or without bevacizumab."

https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-pembrolizumab-paclitaxel-platinum-resistant-epithelial-ovarian-fallopian-tube-or

RTP RESEARCH TO PRACTICE

Other Agents – non ADCs

Evolving Landscape: Non-ADC Options in the PROC space

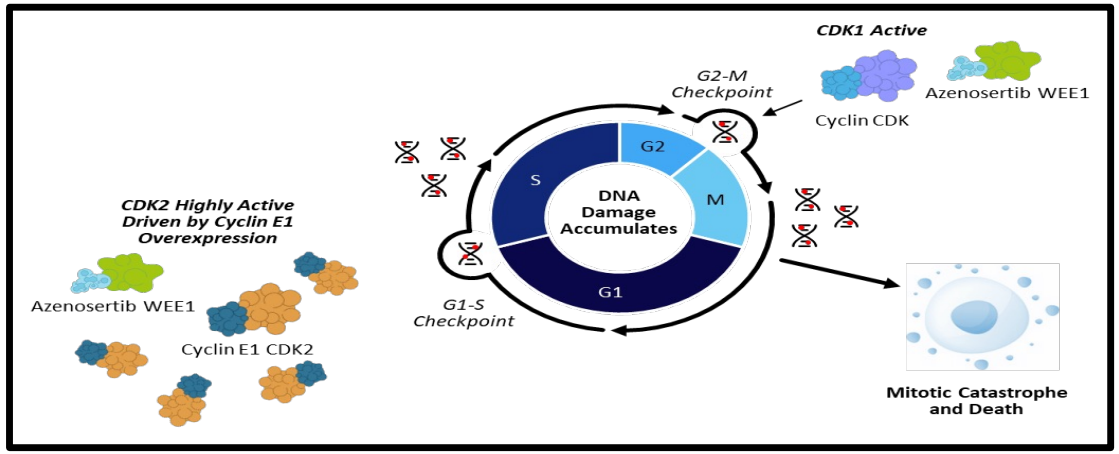
	GOG-3129/MAESTRA 1 (NCT07023627)[1]	GOG-3066/DENALI[2] (NCT05128825)	GOG-3076/OnPrime[3] (NCT05281471)
MOA	CDK2 inhibitor	Wee-1 inhibitor	Oncolytic vaccinia virus-based immunotherapy
Prior lines	2-4 prior lines of treatment	Up to 3 prior lines (4 prior lines permitted, if prior mirvetuximab)	Unlimited prior lines
Biomarker	Cyclin E1 overexpression	Cyclin E1 + overexpression	All comers

	PYNNACLE (NCT04585750)[4]	MUC16xCD3 Bispecific (NCT06787612)
MOA	P53 reactivator	MUC16xCD3 Bispecific
Prior lines	Unlimited prior lines	Not Reported
Biomarker	TP53 Y220C mutation	Elevated CA125

1. *Thaker PH, et al.ESMO 2025;Abstract 1220TiP; 2. Leary A, et al. AACR-NCI-EORTC 2025;Abstract B013; 3. Holloway RW, et al. International Journal of Gynecological Cancer. 2023 Sep 1;33(9):1458-63; 4. Schram AM et al. ASCO 2025;Abstract TPS11581.*

DENALI (GOG-3066): Phase 2, Open-Label, Multicenter Study of Azenosertib in PROC

- Cyclin E1 protein overexpression results in cells moving prematurely from G1 to S, there by increasing reliance on the G2-M checkpoint to allow DNA repair[1,2]
- WEE1 is a master regulator of the cell cycle acting as a brake at G1-S and G2-M to allow DNA repair[3]
- Targeting WEE1 with azenosertib ultimately leads to mitotic catastrophe[4]



Part 1b: Study design

Key eligibility criteria

- ✓ PROC
- ✓ 1-5 prior lines of therapy
- ✓ Prior bevacizumab
- ✓ **All comers** (irrespective Cyclin E1 status)

Enrollment
(N=102)

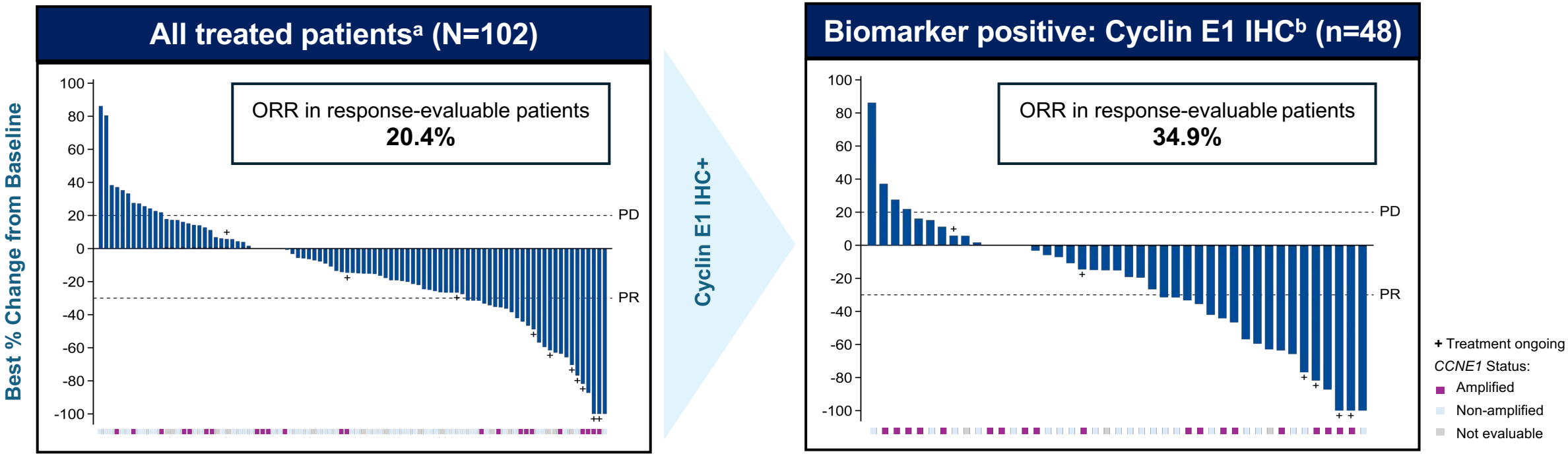
Azenosertib
400 mg QD 5:2

Endpoints

- **Safety and tolerability**
- **ORR, DOR[a]**
- **PFS[b]**

Simpkins SGO 2025

DENALI (GOG-3066) Part 1b: Cyclin E1+ by IHC is a Biomarker Predicting Response to Azenosertib



	All treated patients (N=102)
ORR in response-evaluable[c] patients, % (n/N; 95% CI)	**20.4** (19/93; 12.8-30.1)
ORR, ITT % (n/N; 95% CI)	**18.6** (19/102; 11.6-27.6)

	Cyclin E1 IHC+ (n=48)
ORR in response-evaluable[c] patients, % (n/N; 95% CI)	**34.9** (15/43; 21.0-50.9)
ORR, ITT % (n/N; 95% CI)	**31.3** (15/48; 18.7-46.3)

Data cutoff date: January 13, 2025. [a]Full analysis set: all treated patients. [b]Biomarker dataset: all treated patients with evaluable tissue and Cyclin E1 IHC status. [c]Includes patients who received at least one post-treatment scan. Amp, amplified; IHC, immunohistochemistry; ORR, objective response rate; PD, progressive disease; PR, partial response.

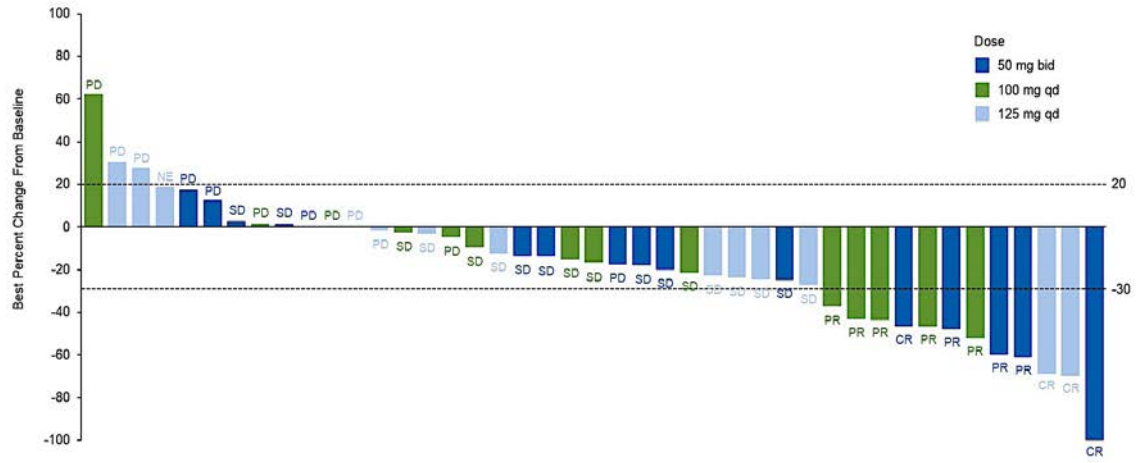
Simpkins SGO 2025

GOG-3129 / MAESTRA 1 (NCT07023627)

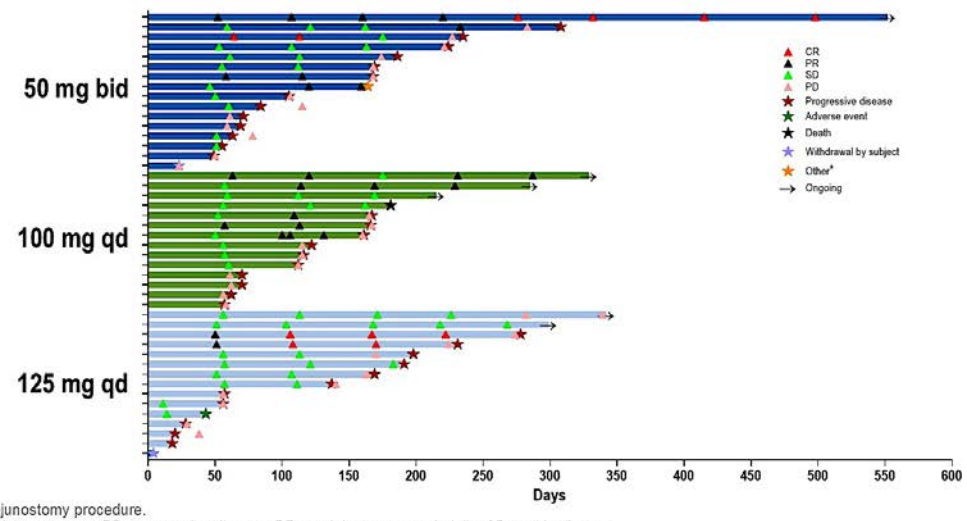
- CDK2 normally pairs with Cyclin E1 (CCNE1) to phosphorylate Rb and drive S-phase entry
- CCNE1 amplification (15–20% of HGSOC) leads to unchecked CDK2 activity, driving rapid replication and chemoresistance
- CDK2 inhibitors arrest the cell cycle at G1/S, inducing senescence or apoptosis preferentially in CCNE1-overexpressing cells
- Rationale: CCNE1-amplified tumors are distinctly resistant to platinum and PARP inhibitors — CDK2 is a compelling synthetic lethal target

Variable	50 mg bid (n=16)	100 mg qd (n=14)	125 mg qd (n=15)
Overall response rate, n (%) [95% CI]	5 (31.3) [11.0, 58.7]	5 (35.7) [12.8, 64.9]	2 (13.3) [1.7, 40.5]
Complete response	2 (12.5)	0 (0)	2 (13.3)
Partial response	3 (18.8)	5 (35.7)	0 (0)
Stable disease	7 (43.8)	5 (35.7)	6 (40.0)
Progressive disease	4 (25.0)	4 (28.6)	4 (26.7)
Not evaluable/missing, n (%)	0 (0)	0 (0)	3 (20.0)
Disease control rate, n (%) [95% CI]	12 (75.0) [47.6, 92.7]	10 (71.4) [41.9, 91.6]	8 (53.3) [26.6, 78.7]
Duration of response, median (95% CI), months	4.5 (1.7, NE)	3.6 (1.9, NE)	-
Progression-free survival, median (95% CI), months	5.5 (2.0, 7.3)	4.5 (2.0, 6.2)	5.4 (1.8, 9.0)

Median follow-up of 9.4 months.
bid; twice daily; CCNE1, cyclin E1; CI, confidence interval; DOR, duration of response; NE, not evaluable; ORR, overall response rate; PFS, progression-free survival; qd, daily.



bid, twice daily; CR, complete response; PD, progressive disease; PR, partial response; qd, daily; SD, stable disease.



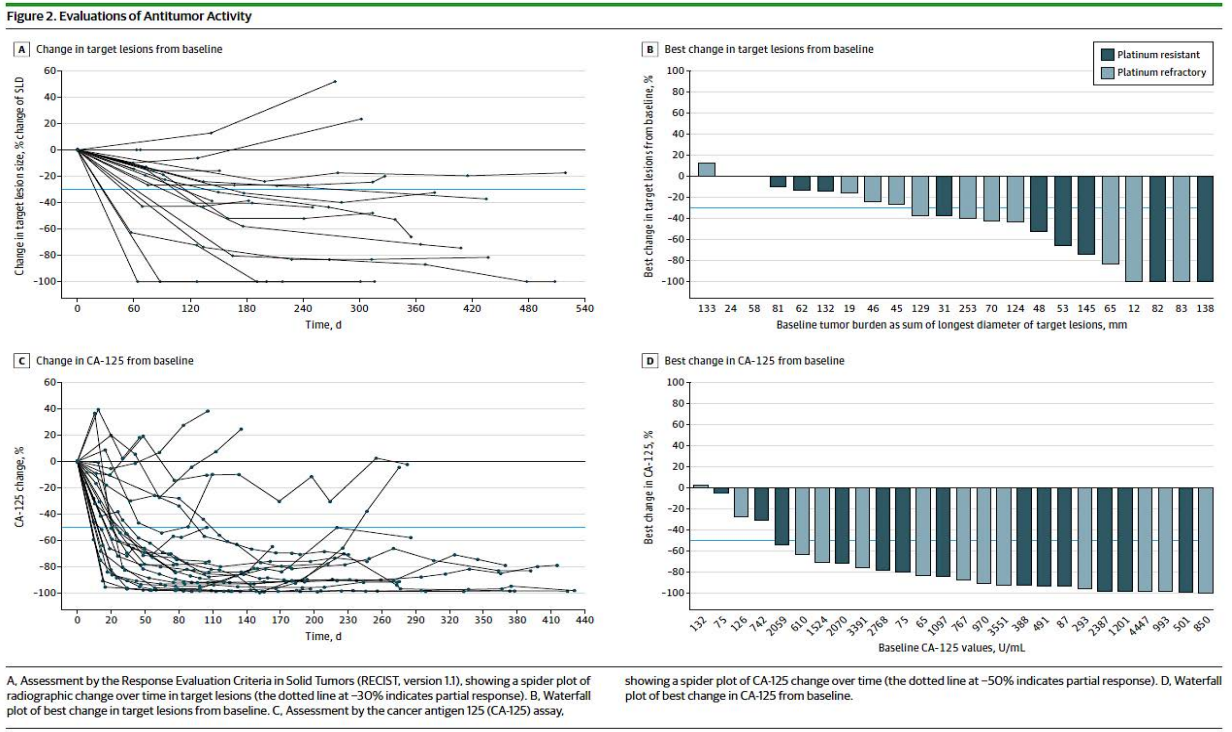
*Sponsor decision after jejunostomy procedure.
bid, twice daily; CR, complete response; PD, progressive disease; PR, partial response; qd, daily; SD, stable disease.

Damian S et al. ASCO 2025; Abstract 5514

GOG-3076/Olvi-Vec-022/OnPrime

A Randomized Phase 3 Study Assessing the Efficacy and Safety of Olvi-Vec followed by Platinum-doublet Chemotherapy and Bevacizumab Compared with Physician's Choice of Chemotherapy and Bevacizumab in Women with Platinum-Resistant/Refractory Ovarian Cancer (

- **Engineered Vaccinia Virus**
  - Genetic modifications to attenuate the virus and enhance tumor targeting & replication in malignant cells
  - Vaccinia is not a natural human pathogen.
- **Tumor immune modulation and immunogenic cell death**
  - Increased tumor vasodilation and permeability
  - Innate Immune Response
    - Increase Type 1 IFN
    - Increase DAMPs/PAMPs
  - Adaptive Immune Response
    - APCs present (neo)antigens
    - T-cell activation and cytotoxicity
    - Anti-tumor immune memory
- Blocks immune-suppression



Platinum-resistant/refractory ovarian cancer (PRROC)
- Number of prior lines: ≥3
- Had prior bevacizumab or biosimilar
- Platinum-free interval (PFI): <1 month or 1-6 months

Stratification at Enrollment Prior to Randomization
- PFI after most recent platinum-based therapy: <1 month vs. 1-6 months
- Baseline germline BRCA1/2 mutation status: positive vs. negative

Progressive Disease

RANDOMIZE 2:1

Experimental Arm
With successful catheter implantation
Olvi-Vec IP Qdx2 Week 0
→ **Platinum-doublet + bevacizumab** (starting Week 4); → non-platinum single-agent chemotherapy + bevacizumab

Active Comparator Arm
Physician's Choice of Chemotherapy + bevacizumab (starting Week 0; platinum optional); → non-platinum single-agent chemotherapy + bevacizumab

Primary Endpoints:
- PFS by RECIST 1.1 (ITT)

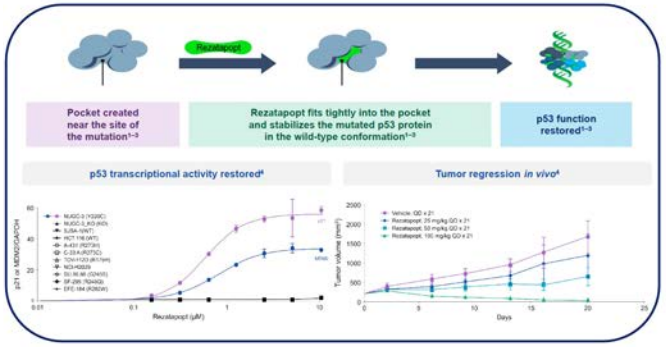
Secondary Endpoints:
- ORR by RECIST 1.1
- DOR by RECIST 1.1
- PFS by RECIST 1.1 (mITT)
- PFS by iRECIST
- OS
- Safety

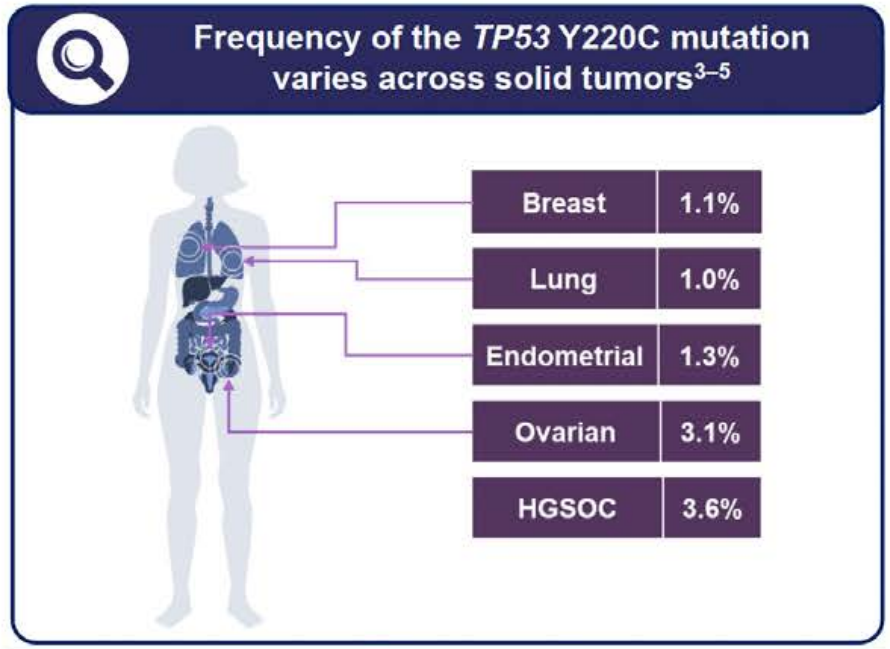
NCT05281471

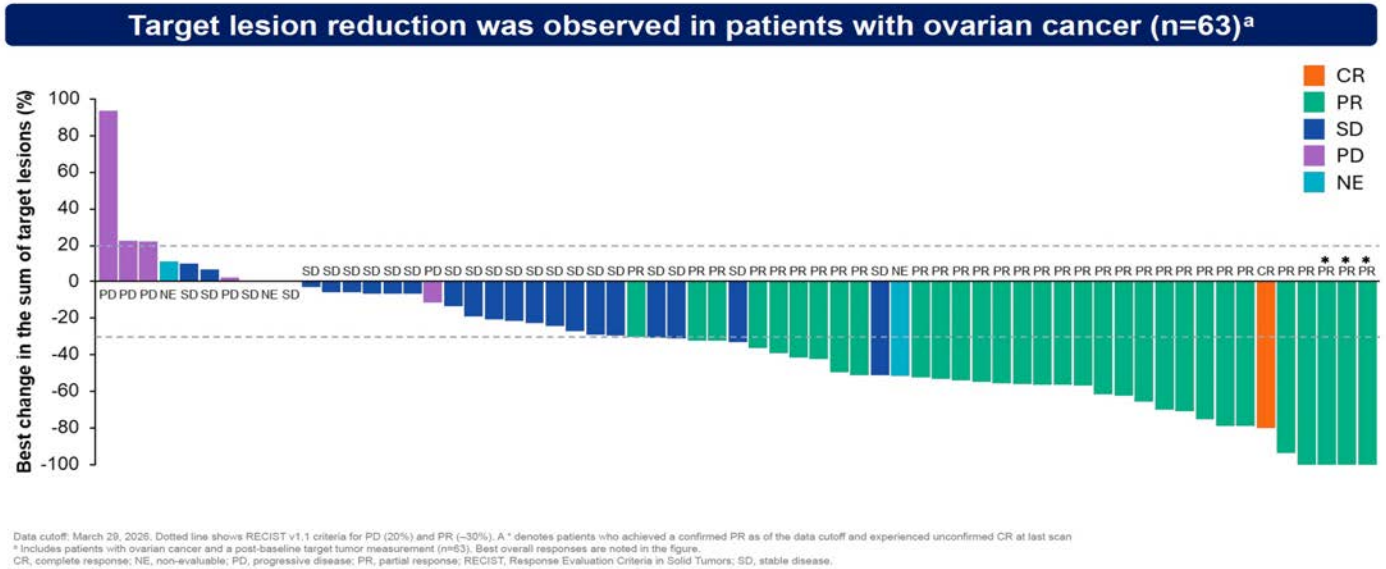
Holloway RW et al. JAMA Oncol. 2023;9(7):903-908.

PYNNACLE

- TP53 Y220C is a key hotspot TP53 missense mutation present in about 1% of all solid tumors
    - Up to 3.6% of HGSOC[3]
- Rezatapopt – selective p53 reactivator specific to the TP53 Y220C mutation [1-3]
- Rezatapopt stabilizes the mutated protein in the wtp53 conformation by binding to a pocket created by the tyrosine-to-cysteine substitution-restoring the p53 function







Data cutoff: March 29, 2026. Dotted line shows RECIST v1.1 criteria for PD (20%) and PR (–30%). A * denotes patients who achieved a confirmed PR as of the data cutoff and experienced unconfirmed CR at last scan
[a] Includes patients with ovarian cancer and a post-baseline target tumor measurement (n=63). Best overall responses are noted in the figure.
CR, complete response; NE, non-evaluable; PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease.

Schram A et al. SGO 2026
(NCT04585750)

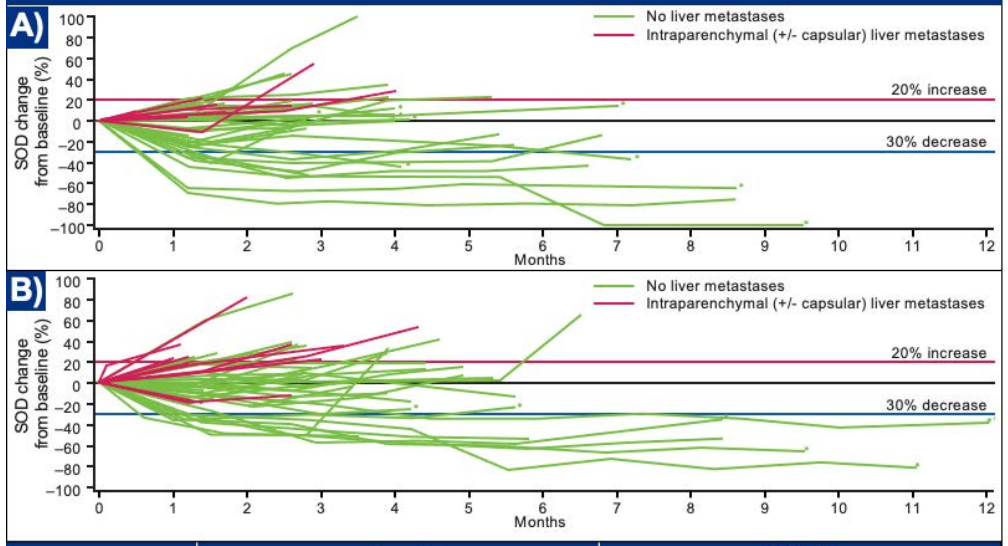
HGSOC, high-grade serous ovarian cancer.

1. Baugh EH, et al. *Cell Death Differ*. 2018;25:154–160; 2. Hassin O, et al. *Nat Rev Drug Discov*. 2023;22:127–144; 3. FoundationInsights™. A proprietary database used under license with review and approval from Foundation Medicine®. Available at: https://www.foundationmedicine.com/service/genomic-data-solutions. Accessed March 2026; 4. de Andrade KC, et al. *Cell Death Differ*. 2022;29:1071–1073; 5. Dumbrava EE, et al. ASCO Annual Meeting. 2022; Oral presentation: abstract 3003.

Ubamatamab (REGN4018) - MUC16xCD3 Bispecific (NCT06787612)

- Ubamatamab (REGN4018) is a MUC16 × CD3 bispecific antibody that bridges MUC16 on tumour cells and CD3 on T cells to promote T-cell–mediated cytotoxicity
- Cemiplimab is a PD-1i

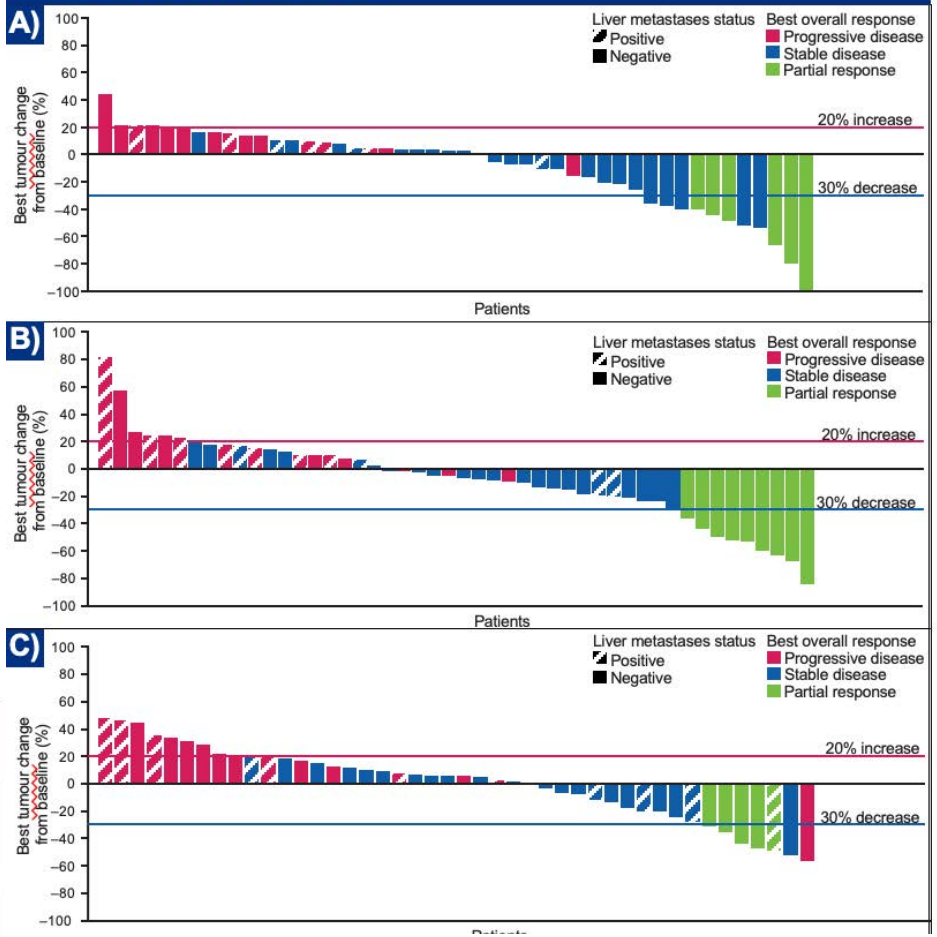
Figure 3. Comparison of duration of response spider plots for treatment Arms A and B*



	Arm A Ubamatamab 250 mg IV Q3W	Arm B Ubamatamab 800 mg IV Q3W
Median DOR, months (range)	5.7 (2.8–NE)	10.5 (2.5–NE)

	Arm A Ubamatamab 250 mg			Arm B Ubamatamab 800 mg			Arm C Ubamatamab 250 mg + cemiplimab 350 mg		
Liver metastases	All	Yes	No	All	Yes	No	All	Yes	No
present, n	50	9	41	50	11	39	50	11	39
ORR, n (%)	8† (16.0)	0	8† (19.5)	9 (18.0)	0	9 (23.1)	6‡ (12.0)	1 (9.1)	5‡ (12.8)
mPFS (95% CI), months	2.9 (2.6–4.0)	1.6 (0.5–2.9)	2.9 (2.6–4.2)	2.9 (2.6–3.9)	1.5 (1.1–2.6)	3.5 (2.8–4.4)	2.8 (1.6–3.0)	1.7 (1.2–2.9)	2.9 (1.6–4.2)

Figure 2. Comparison of best overall tumour response across treatment Arms A, B, and C*



Lee JY, ESMO 2025; Abstract 1078P

1. Burova E, et al. *Mol Cancer Ther* 2017;16(5):861–70.
2. Liu J, et al. International Journal of Gynecologic Cancer PO011LBA/#1512 2023;33:A9-A10

For a patient with advanced OC who is eligible to receive all 3 strategies, how would you generally sequence mirvetuximab soravtansine, relacorilant/*nab* paclitaxel and pembrolizumab/weekly paclitaxel?

 Prof Eskander	Mirvetuximab soravtansine → pembrolizumab/ weekly paclitaxel → relacorilant/*nab* paclitaxel
 Dr Matulonis	Mirvetuximab soravtansine → pembrolizumab/ weekly paclitaxel → relacorilant/*nab* paclitaxel
 Dr Moore	I would not sequence these agents
 Dr Olawaiye	Relacorilant/*nab* paclitaxel → mirvetuximab soravtansine → pembrolizumab/weekly paclitaxel
 Dr O'Malley	Mirvetuximab soravtansine → relacorilant/nab paclitaxel → pembrolizumab/weekly paclitaxel*
 Prof Colombo	Mirvetuximab soravtansine → pembrolizumab/ weekly paclitaxel → relacorilant/*nab* paclitaxel

* Would only use either *nab*/paclitaxel or paclitaxel – not both

RTP RESEARCH TO PRACTICE

Would you employ pembrolizumab/weekly paclitaxel with or without bevacizumab for a patient with PD-L1-negative advanced OC under any circumstances?

 Prof Eskander	Yes, I do not view this to be effective only in the PD-L1+ population based on the trial, although I understand the FDA label
 Dr Matulonis	No
 Dr Moore	No
 Dr Olawaiye	No
 Dr O'Malley	Yes, no marked difference in outcomes between biomarker-positive and -negative
 Prof Colombo	No

RTP RESEARCH TO PRACTICE

In which situations are you currently adding bevacizumab when employing pembrolizumab/weekly paclitaxel for your patients with advanced OC?

 Prof Eskander	In all situations, unless contraindicated
 Dr Matulonis	If the patient hasn't received bevacizumab or received with evidence of benefit, unless contraindicated
 Dr Moore	In all situations, unless contraindicated
 Dr Olawaiye	I have not used this regimen
 Dr O'Malley	If the patient is a candidate for bevacizumab
 Prof Colombo	In all situations, unless contraindicated

RTP RESEARCH TO PRACTICE

Would you employ relacorilant in combination with any other chemotherapeutic agent beyond *nab* paclitaxel under any circumstances? Would you employ relacorilant/*nab* paclitaxel in combination with bevacizumab under any circumstances?

	In combination with other chemotherapy	In combination with bevacizumab
 Prof Eskander	No	No
 Dr Matulonis	No	No
 Dr Moore	No	Only on protocol
 Dr Olawaiye	Only on protocol	Only on protocol
 Dr O'Malley	No	Only on protocol
 Prof Colombo	No	No

Do you currently use glutocorticoid expression levels to inform how you sequence relacorilant/*nab* paclitaxel for your patients with advanced OC?

 Prof Eskander	No
 Dr Matulonis	No
 Dr Moore	No
 Dr Olawaiye	No
 Dr O'Malley	No
 Prof Colombo	No

RTP RESEARCH TO PRACTICE

Agenda

Module 1: Current Role of PARP Inhibitors in the Management of Advanced Ovarian Cancer (OC) — Prof Eskander

Module 2: Strategies Targeting Folate Receptor Alpha in Advanced OC — Dr Matulonis

Module 3: Other Approved and Promising Investigational Antibody-Drug Conjugates for Advanced OC — Dr Moore

Module 4: Other Novel Agents and Strategies for Advanced OC — Dr O'Malley

Module 5: Diagnosis and Management of Adverse Events Associated with Common Therapies for Advanced OC — Dr Olawaiye

RTP RESEARCH TO PRACTICE

Diagnosis and Management of Adverse Events Associated with Commonly Employed Therapies for Advanced Ovarian Cancer

Alexander B. Olawaiye, MD
Professor
University of Pittsburgh School of Medicine
Pittsburgh
Pennsylvania, USA

University of Pittsburgh

Outline

- PARP Inhibitors
- ADCs (Mirvetuximab, T-DXd)
- Relacorilant

University of Pittsburgh

Phase III PAOLA-1/ENGOT-ov25: maintenance olaparib with bevacizumab in patients with newly diagnosed, advanced ovarian cancer treated with platinum-based chemotherapy and bevacizumab as standard of care

Isabelle Ray-Coquard, Patricia Pautier, Sandro Pignata, David Pérol, Antonio González-Martin, Paul Sevelda, Keiichi Fujiwara, Ignace Vergote, Nicoletta Colombo, Johanna Mäenpää, Frédéric Selle, Jalid Sehouli, Domenica Lorusso, Eva Maria
Frederik Marmé, Eric Pujade-L

Niraparib Therapy in Patients With Newly Diagnosed Advanced Ovarian Cancer (PRIMA/ENGOT-OV26/GOG-3012)

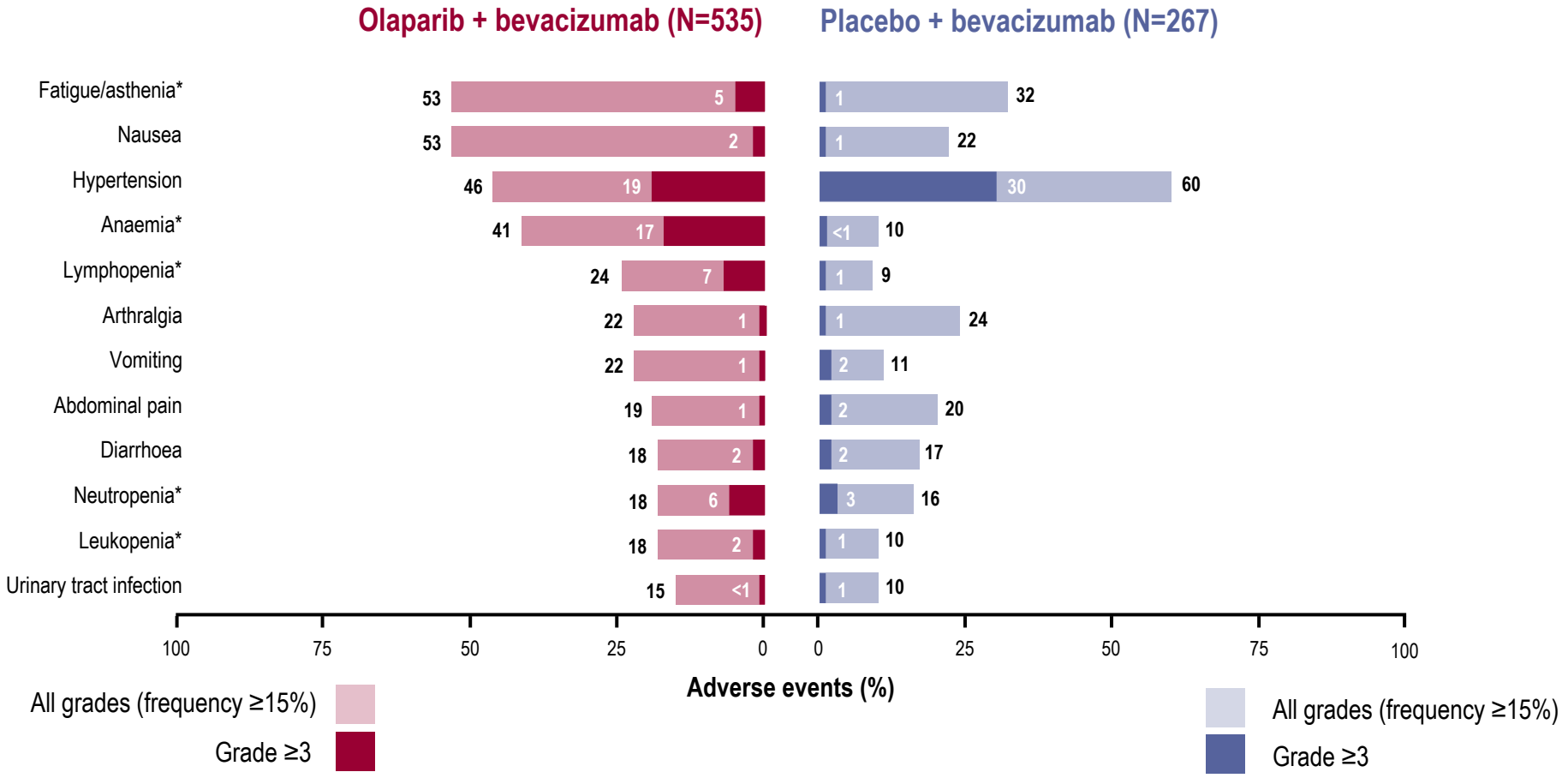
A. González-Martín,[1] B. Pothuri,[2] I. Vergote,[3] R.D. Christensen,[4] W. Graybill,[5] M.R. Mirza,[6] C. McCormick,[7] D. Lorusso,[8] P. Hoskins,[9] G. Freyer,[10] F. Backes,[11] K. Baumann,[12] A. Redondo,[13] R. Moore,[14] C. Vulsteke,[15] R.E. O'Cearbhaill,[16] R. Lund,[17] Y. Li,[18] D. Gupta,[18] R. L. Monk[19]

SOLO1: Phase III trial of maintenance olaparib following platinum-based chemotherapy in newly diagnosed patients with advanced ovarian cancer and a *BRCA1/2* mutation

Kathleen Moore,[1] Nicoletta Colombo,[2] Giovanni Scambia,[3] Byoung-Gie Kim,[4] Ana Oaknin,[5] Michael Friedlander,[6] Alla Lisyanskaya,[7] Anne Floquet,[8] Alexandra Leary,[9] Gabe S. Sonke,[10] Charlie Gourley,[11] Susana Banerjee,[12] Amit Oza,[13] Antonio González-Martín,[14] Carol Aghajanian,[15] William Bradley,[16] Elizabeth S. Lowe,[17] Ralph Bloomfield,[18] Paul DiSilvestro[19]

University of Pittsburgh

PAOLA-1: Most common AEs

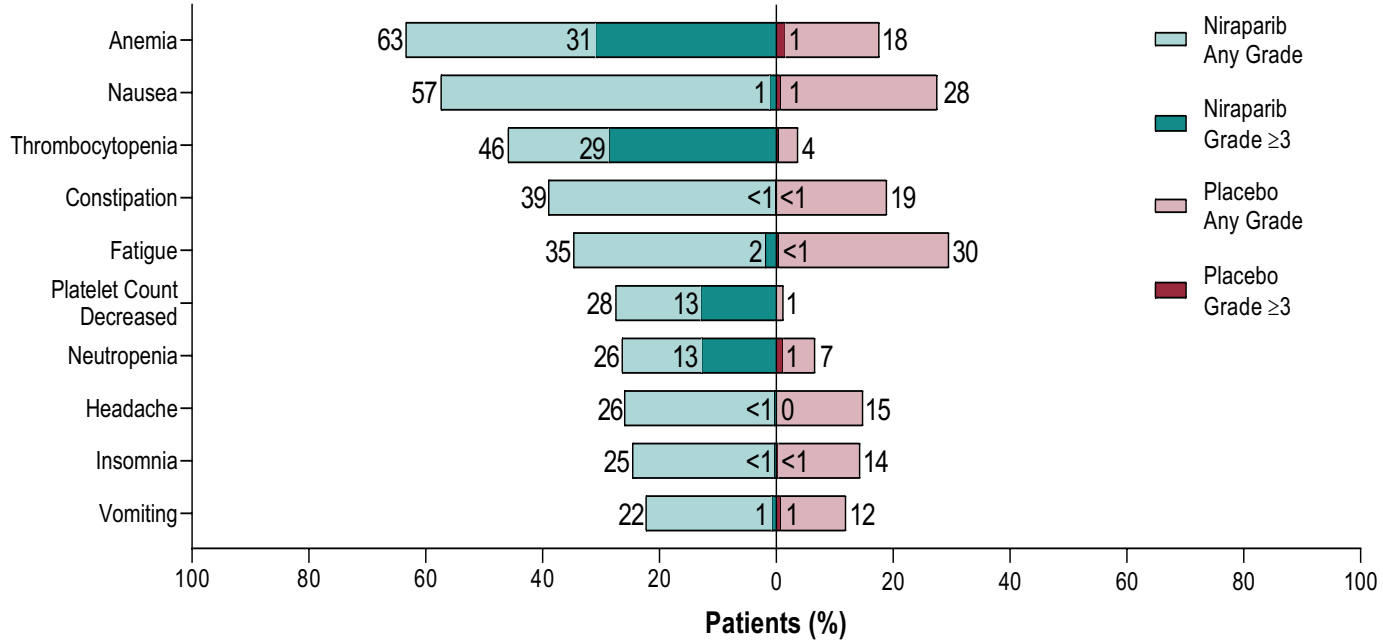


*Grouped terms. All-grade thrombocytopenia (grouped term) occurred in 8% of patients in the olaparib group and 3% of patients in the placebo group, grade ≥3 thrombocytopenia occurred in 2% of patients in the olaparib group and <1% of patients in the placebo group

BARCELONA 2019 ESMO congress

Ray-Coquard I et al. ESMO 2019;Abstract LBA2_PR

PRIMA Safety

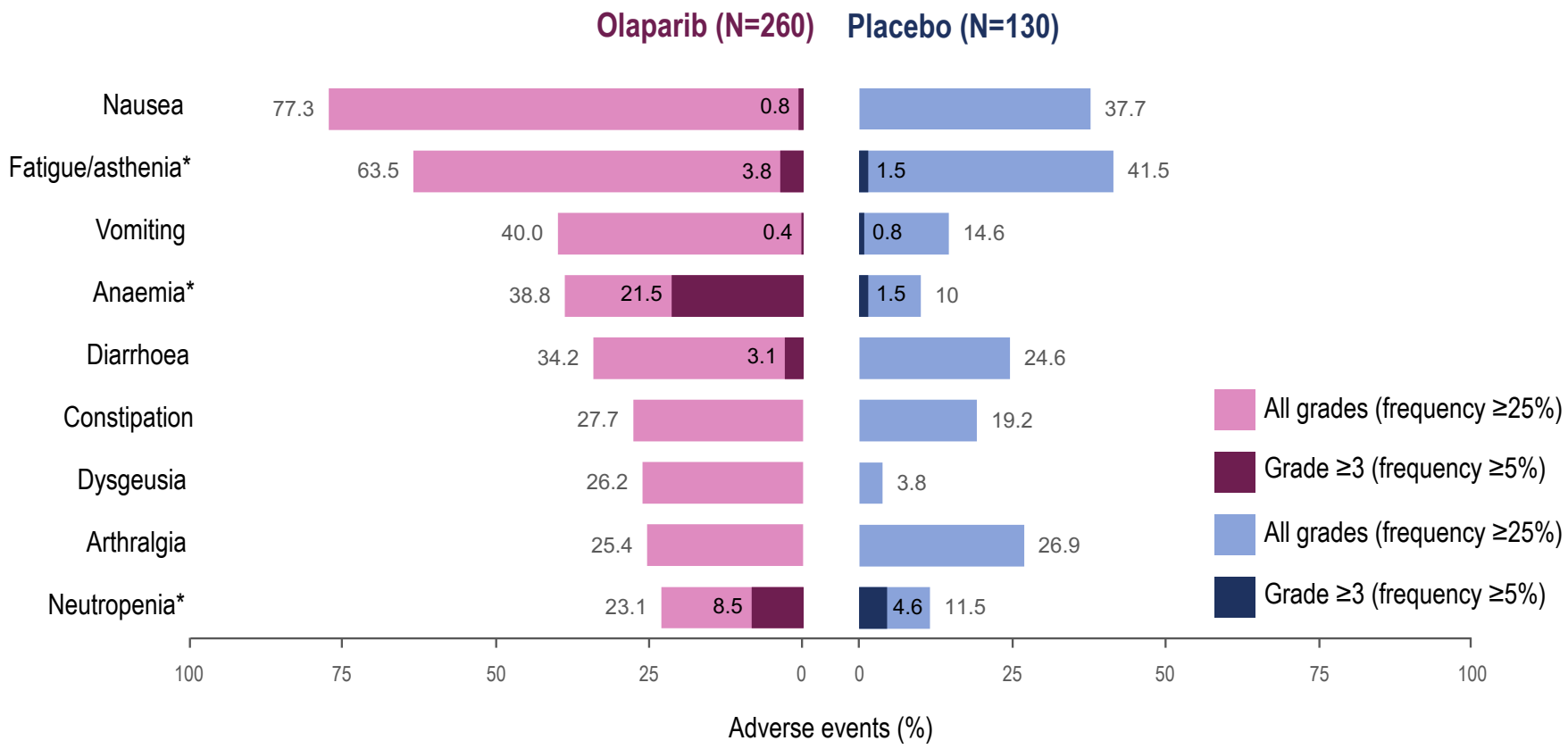


- No new safety signals were identified for niraparib
- Most common TEAE was reversible myelosuppression
- One patient was diagnosed with MDS after 9 months of niraparib treatment

TEAEs ≥20% incidence in niraparib arm. Note: Hematologic TEAEs are not combined with laboratory results
MDS, myelodysplastic syndrome; TEAE, treatment-emergent adverse event.

Gonzalez-Martin A et al. ESMO 2019;Abstract LBA1

SOLO1: Most common treatment-emergent adverse events



*Grouped terms. All-grade thrombocytopenia (grouped term) occurred in 11.2% of patients in the olaparib group and 3.8% of patients in the placebo group and grade ≥3 thrombocytopenia (grouped term) occurred in 0.8% and 1.5%, respectively.

MUNICH 2018 ESMO congress

Moore K et al. ESMO 2018;Abstract LBA7_PR

Most Common Grade 3/4 Adverse Events

STUDY	1	2	3	4
PAOLA 1	Hypertension (19%)	Anemia (17%)	Lymphopenia (7%)	Fatigue/asthenia (5%)
PRIMA	Anemia (31%)	Thrombocytopenia (29%)	Neutropenia (13%)	Fatigue (2%)
SOLO 1	Anemia (21.5%)	Neutropenia (8.5%)	Fatigue/asthenia (3.8%)	Diarrhea (3.1%)

Managing Fatigue

Prior to treatment	Inform patients that fatigue is common - generally improves over time although can persist
Exclude other causes	Anaemia Depression Insomnia Hypothyroid Menopausal symptoms – hot flashes -which impact on sleep
Management	➢ Non-pharmacologic: e.g. afternoon nap ➢ Massage therapy ➢ Psychosocial interventions -CBT ➢ Exercise: referral to an exercise physiologist ➢ Ginseng / methylphenidate ➢ Dose interrupt and restart at a reduced dose

(< 2% stop a PARP inhibitor in trials due to fatigue)

Lafarge et al Lancet Oncol 20:e15-e28, 2019 ;Moore et al, Oncologist 21:954-63, 2016; Lorusso et al Support Care Cancer 28:2435-2442, 2020;Tookman et al, Ther Adv Med Oncol 12:1758835920921980, 2020; Friedlander et al ASCO Educational Book 2023

Monitoring for Haematological toxicity

Prior to treatment	• Baseline testing of complete blood count (CBC) • Ensure recovery (grade ≤1) from any existing haematological toxicity caused by previous chemotherapy
Monitoring	• Monthly CBC for the first 12 months (8-12 weekly thereafter) – Olaparib and Rucaparib • **Weekly** CBC **for the first month** – Niraparib. Then monthly as above if CBC stable

Ringley et al P T. 2018 Sep;43(9):549-556 Madriaga et al Int J Gynecol Cancer 30:903-915, 2020

Haematological toxicity –Anemia

GRADE 1 10-12g/dl	Continue and monitor
GRADE 2 8-10g/dl	Interrupt and monitor Restart when G1 and Dose Reduce
GRADE 3 / 4 6.5-8g/dl/ < 6.5 g/dl	Interrupt and Transfuse Restart when G1 with dose reduction

Exclude other causes of anaemia where relevant
Check B12; Folate ; Iron

1.4- 3% cease for anaemia – depends on agent and setting

Tookman et al Ther Adv Med Oncol. 2020 May 27;12:1758835920921980.; LaFargue et al Lancet Oncol20:e15-e28 2019 Madriaga et al Int J Gynecol Cancer 30:903-915, 2020

Haematological Toxicity –Thrombocytopenia

Platelets <100,000 u/l

G1 75-100,000 u/l
G2 50-75,000 u/l
G3 25-50,000 u/l
G4 < 25,000 u/l

- Interrupt treatment and monitor CBC weekly/ bi weekly until recovery
- Resume at the same/ reduced dose (G1)
- Reduced dose if < 75,000u/l (G2)
- Reduced dose if < 50,000 u/l (G3 /4)
- If not recovered to CTCAE ≤ grade 1 after 4 weeks, refer to a hematologist

MONITOR CBC WEEKLY X 4 AFTER RESTARTING

(Platelet transfusion if < 10,000u/l)

0.5 -4% cease due to thrombocytopenia varies by trial

Tookman et al Ther Adv Med Oncol. 2020 May 27;12:1758835920921980.; LaFargue et al Lancet Oncol20:e15-e28 2019 Madriaga et al Int J Gynecol Cancer 30:903-915, 2020

Haematological Toxicity –Thrombocytopenia

Interrupt treatment if platelet count < 100,000 on Niraparib

Platelets <100,000 u/l

G1 75-100,000 u/l
G2 50-75,000 u/l
G3 25-50,000 u/l
G4 < 25,000 u/l

- Interrupt treatment and monitor blood counts weekly/ bi weekly until recovery
- Resume at the same/ reduced dose (G1)
- Reduced dose if < 75,000u/l (G2)
- Reduced dose if < 50,000 u/l (G3 /4)
- If not recovered to CTCAE ≤ grade 1 after 4 weeks, refer to a hematologist

Less stringent for olaparib or rucaparib – interrupt if platelets < Grade 3 or 4 (In practice – consider interrupt if grade 2 or monitor closely)

(Platelet transfusion if < 10,000u/l)

0.5 -4% cease due to thrombocytopenia varies by trial

https://ec.europa.eu/health/documents/community-register/2017/20171116139116/anx_139116_en.pdf Tookman et al Ther Adv Med Oncol. 2020 May 27;12:1758835920921980; Colombo et al Gynecol Oncol. 2021 Oct;163(1):41-49.

Haematological toxicity –Neutropenia

GRADE 1 1.5-2 x10^9 /l	Continue and monitor
GRADE 2 1.0-1.5 x10^9 /l	Interrupt and monitor Restart when G1 and Dose Reduce
GRADE 3 / 4 0.5-1 x10^9 /l / <0.5 x10^9 /l	Interrupt Restart when G1 with dose reduction

If not recovered to ≤ grade 1 after 4 weeks
refer to hematologist

0.8-1.9% cease due to neutropenia

Tookman et al Ther Adv Med Oncol. 2020 May 27;12:1758835920921980.; LaFargue et al Lancet Oncol20:e15-e28 2019; Madriaga et al Int J Gynecol Cancer 30:903-915, 2020

MDS/AML

- Incidence of myeloid neoplasms has increased with introduction of PARP inhibitors
- Low risk (to date) in 1st line trials of maintenance therapy
- Higher risk **(3.8-8%)** in recurrent setting after multiple lines of chemotherapy
- **Risk factors include**

➢ Older Age

➢ Multiple lines of platinum based chemotherapy prior to PARPi

➢ BRCA mutation

➢ TP53 clonal hematopoesis of indeterminate potential variants

Marmouset et al Clin Cancer Res 28:5211-5220, 2022;Kwan et al JAMA Oncol 7:1772-1781, 202;Morice et al Lancet Haematol 8:e122-e134, 2021

2023 ASCO ANNUAL MEETING

Phase III MIRASOL (GOG 3045/ENGOT-ov55) Study: Mirvetuximab Soravtansine vs. Investigator's Choice of Chemotherapy in Platinum-Resistant, Advanced High-Grade Epithelial Ovarian, Primary Peritoneal or Fallopian Tube Cancers with High Folate Receptor-Alpha (FRα) Expression

Kathleen N. Moore[1], Antoine Angelergues[2], Gottfried E. Konecny[3], Susana Banerjee[4], Sandro Pignata[5], Nicoletta Colombo[6], John Moroney[7], Casey Cosgrove[8], Jung-Yun Lee[9], Andrzej Roszak[10], Shani Breuer[11], Jacqueline Tromp[12], Diana Bello Roufai[13], Lucy Gilbert[14], Rowan Miller[15], Tashanna Myers[16], Yuemei Wang[17], Anna Berkenblit[17], Domenica Lorusso[18], Toon Van Gorp[19]

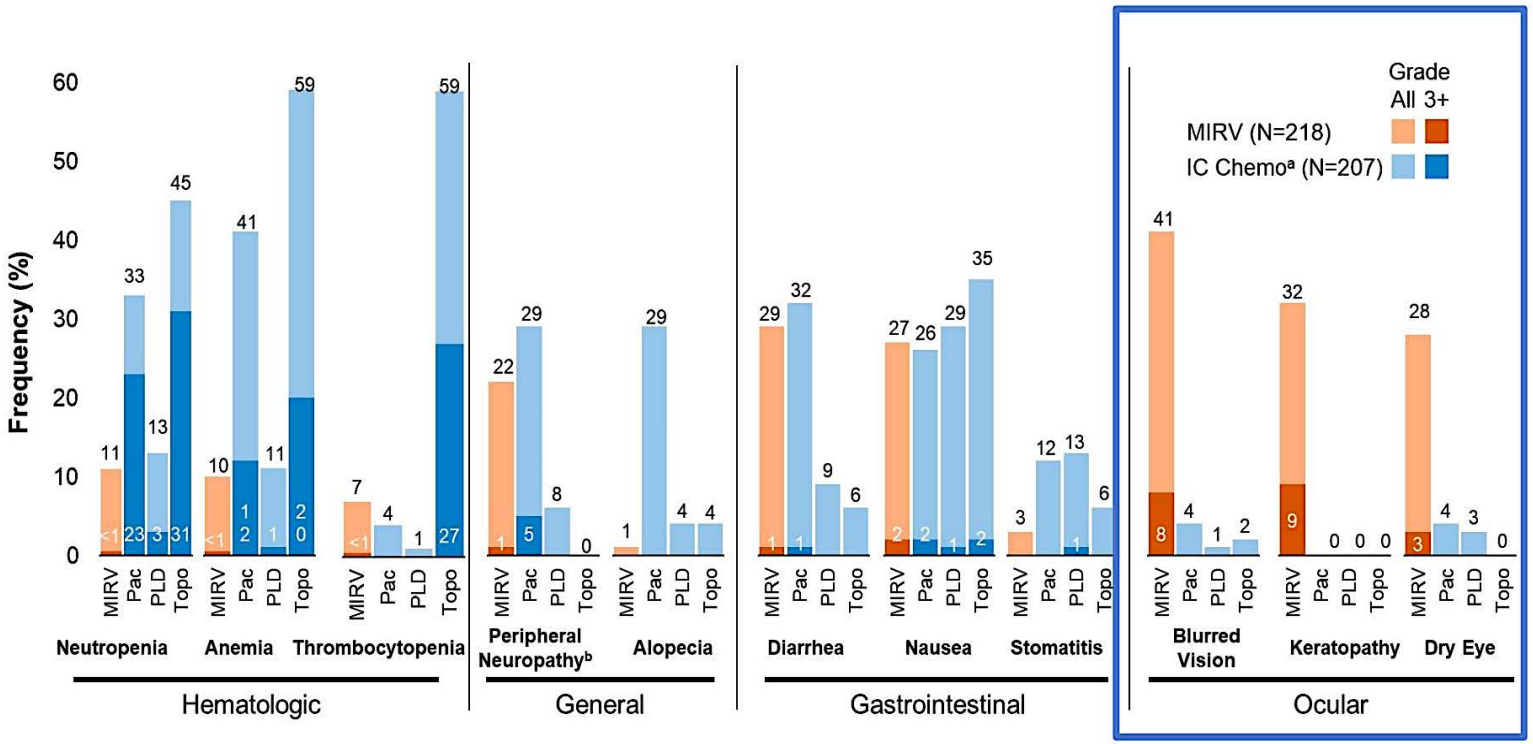
[1]Stephenson Cancer Center University of Oklahoma College of Medicine, Oklahoma City, OK, USA; [2]Groupe Hospitalier Diaconesses Croix Saint Simon, Paris, France; [3]UCLA Jonsson Comprehensive Cancer Center, Los Angeles, CA, USA; [4]The Royal Marsden NHS Foundation Trust - Royal Marsden Hospital, London, UK; [5]Istituto Nazionale Tumori- G. Pascale, Naples, Italy; [6]European Institute of Oncology IRCCS, Milan, Italy and University of Milan-Bicocca, Milan, Italy; [7]The University of Chicago, Chicago, IL, USA; [8]The Ohio State University, Columbus, OH, USA; [9]Severance Hospital, Seoul, South Korea; [10]Wielkopolskie Centrum Onkologii, Poznan, Poland; [11]Hadassah Ein Kerem – Sharett, Jerusalem, Israel; [12]Amsterdam UMC, Amsterdam, The Netherlands; [13]Hopital Rene Huguenin, Institut Curie, Saint-Cloud, France; [14]McGill University Health Centre, Montreal, Canada; [15]University College London Hospital, London, UK; [16]Baystate Medical Center, Springfield, MA, USA; [17] ImmunoGen, Inc., Waltham, MA, USA; [18]Fondazione Policlinico Universitario A. Gemelli, IRCCS and Catholic University of Sacred Heart, Rome, Italy; [19]University Hospital Leuven Leuven Cancer Institute, Leuven, Belgium

ENGOT European Network of Gynaecological Oncological Trial groups

GOG FOUNDATION® Transforming the standard of care™

Mirvetuximab Soravtansine

Safety MIRASOL trial



- 56% **ocular AE**
- Majority **resolved to G≤1**
- **No G4**
- **Median time onset**: 5.4 weeks
- 4 pts (1.8%) **discontinue** due to ocular AE
- No corneal ulceration or perforations and no permanent alterations

BARCELONA 2024 ESMO congress

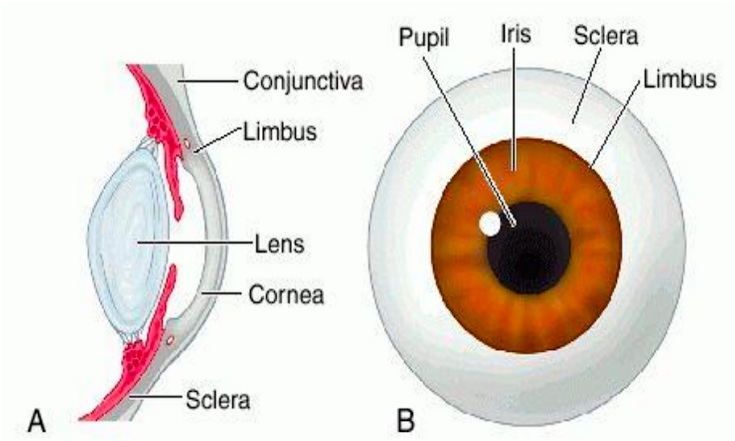
Moore, ASCO 2023 and NEJM 2023

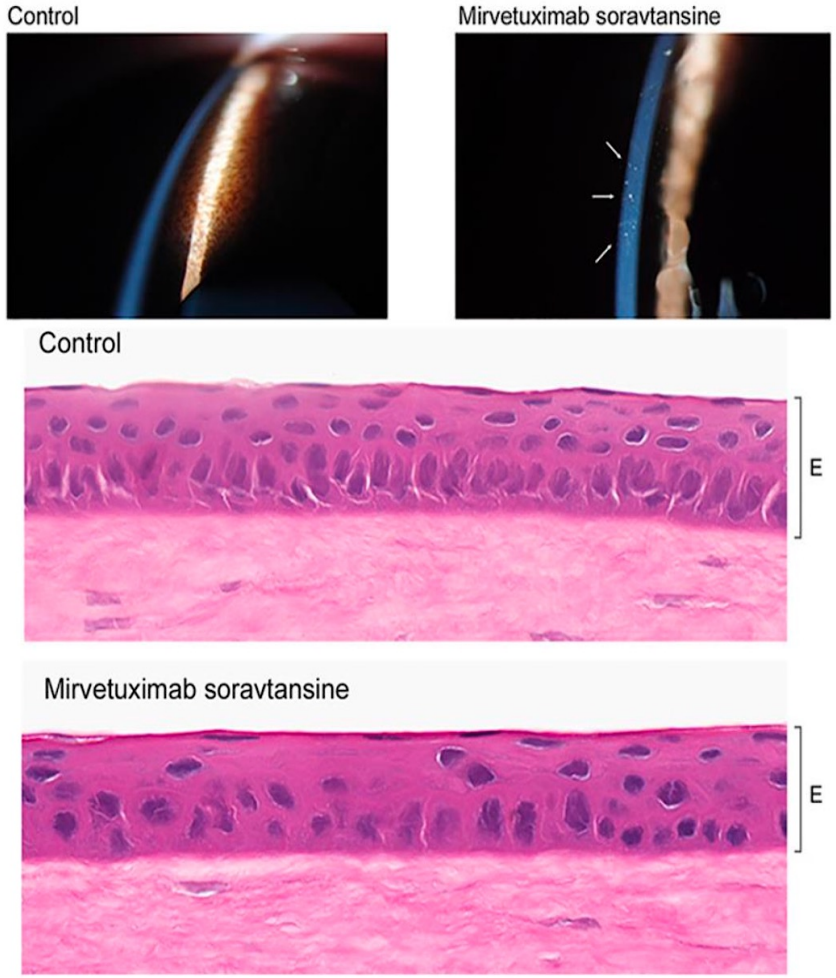
University of Pittsburgh

Manifestation of ocular toxicity

Mirvetuximab Soravtansine

- **FRα is expressed** in the retina but NOT in the non-retinal structures (cornea, conjunctiva, limbal region)
- **Off-target effect** of DM4 payload (endocytosis or passive diffusion)
- Transient corneal alterations, called "**microcystic-like epithelial changes**" due to anti-mitotic effect in the **limbal region of the cornea** (reservoir of stem cells)
- **Dose dependent and reversible**





Matulonis, CCR 2019

University of Pittsburgh

Mitigation strategies

	Mirvetuximab Soravtansine
Eye exam	Baseline, every other cycle up to 8th
Medical history	Baseline
Lubricating eye drops	At least QID
Corticosteroid eye drops	1 drop 6 times/ day, D-1 to D4, 1 drop qid D5-8
Vasoconstrictor eye drops	Not recommended
Cold packs	Not recommended
Contact lens	Avoid use

2022 ASCO® ANNUAL MEETING

DESTINY-PanTumor02

Efficacy and safety of trastuzumab deruxtecan in patients with HER2-expressing solid tumors: DESTINY-PanTumor02 interim results

Funda Meric-Bernstam

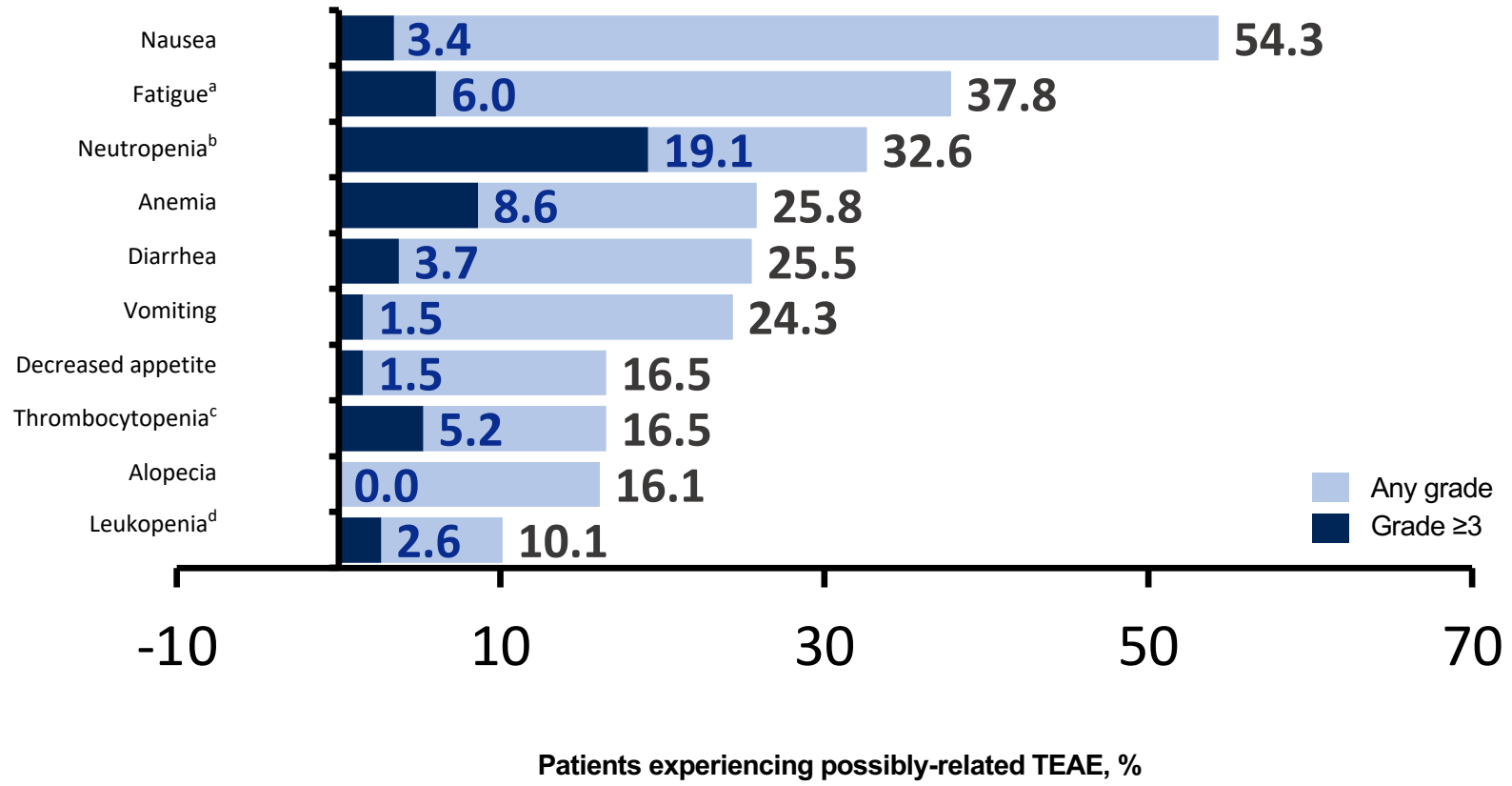
The University of Texas MD Anderson Cancer Center, Houston, TX, USA

June 5, 2023

Additional authors: Vicky Makker, Ana Oaknin, Do-Youn Oh, Susana Banerjee, Antonio González-Martín, Kyung Hae Jung, Iwona Ługowska, Luis Manso, Aránzazu Manzano, Bohuslav Melichar, Salvatore Siena, Daniil Stroyakovskiy, Chiedozie Anoka, Yan Ma, Soham Puvvada, Jung-Yun Lee

On behalf of the DESTINY-PanTumor02 investigators

Drug-Related TEAEs in ≥10% of Patients



Analyses were performed in patients who received ≥1 dose of T-DXd (n=267). [a]This category includes the preferred terms fatigue, asthenia, and malaise. [b]This category includes the preferred terms neutrophil count decreased and neutropenia. [c]This category includes the preferred terms platelet count decreased and thrombocytopenia. [d]This category includes the preferred terms white blood cell count decreased and leukopenia.
TEAE, treatment-emergent adverse event; T-DXd, trastuzumab deruxtecan.

Adverse Events of Special Interest

ILD/pneumonitis adjudicated as T-DXd–related

n (%)	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Any grade
All patients (N=267)	6 (2.2)	12 (4.5)	1 (0.4)	0	1 (0.4)	20 (7.5)

Left ventricular dysfunction[a]

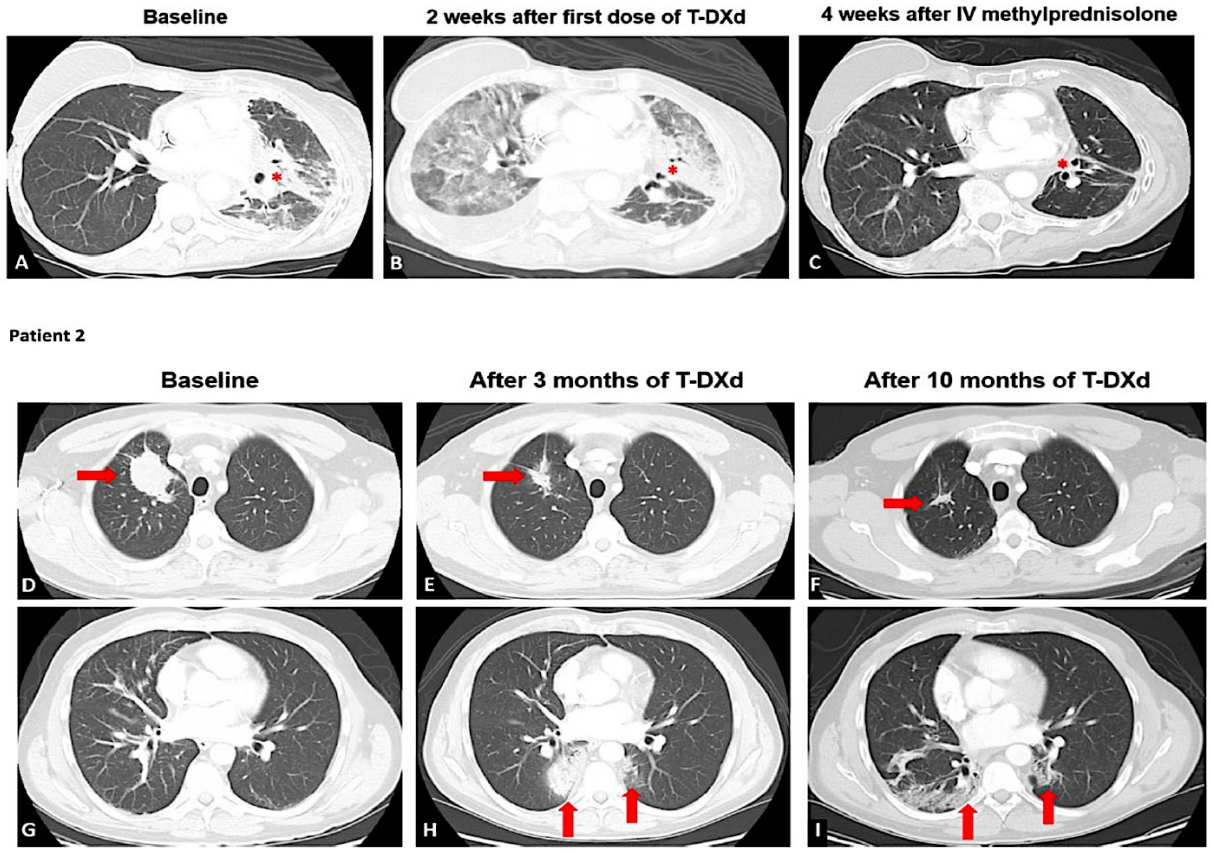
n (%)	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Any grade
Ejection fraction decreased						
All patients (N=267)	1 (0.4)	**4 (1.5)**	**1 (0.4)**	0	0	7 (2.6)[b]
Cardiac failure						
All patients (N=267)	0	0	1 (0.4)	0	0	1 (0.4)

Analyses were performed in patients who received ≥1 dose of T-DXd (n=267).
[a]Left ventricular dysfunction was reported in a total of 12 (4.5%) patients, of which 8 (3.0%) were considered possibly T-DXd–related. [b]One patient had unknown grade of ejection fraction decrease.
ILD, interstitial lung disease; T-DXd, trastuzumab deruxtecan.

Interstitial Lung Disease (ILD)

Trastuzumab Deruxtecan

- **Inflammation and/or fibrosis** in the lungs
- T-DXd accumulation in **alveolar macrophages → off-target toxicity**
- Presentation with variable pulmonary **symptomatology or asymptomatically** (radiographic opacities)
- **Symptoms**: dyspnea (most common), cough, malaise, chest pain, hypoxemia, and low-grade fever
- Can be **fulminant** and life-threatening



Swain, CTR 2022

Management of ILD

The 5 "S" rule

Pre–T-DXd treatment

Complete history and physical
HRCT
Baseline SpO_2
Consider pulmonary consult for patients with significant lung comorbidities
Provide patient education on risk and symptom identification

On T-DXd treatment

HRCT at least every 12 weeks, or every 6-9 weeks with baseline respiratory symptoms
Vitals signs including SpO_2 and symptom assessment with treatment visits

If ILD suspected

T-DXd–related ILD/pneumonitis should be suspected when
Radiographic changes potentially consistent with ILD/pneumonitis are seen
Patient experiences acute onset of new or worsening pulmonary signs/symptoms, such as dyspnea, cough, or fever

Immediately hold T-DXd therapy and proceed with diagnostic workup

Vitals and SpO_2 | **HRCT** | **Blood tests**

If clinically indicated, consider
PFTs
ABG
Bronchoscopy/BAL

Consider early
Consultation of a pulmonologist
Treatment with corticosteroids as clinically indicated

Differential diagnostic workup and subsequent management should involve MDT including specialists as appropriate
Follow standard clinical practice as indicated for infectious, inflammatory, etc etiologies
For confirmed T-DXd–associated ILD, Tables 1 and 2 and T-DXd prescribing information

BARCELONA 2024 ESMO congress

Hugo, Oncol Pract 2023; Tarantino P, JCO Oncol Pract 2023;

University of Pittsburgh

SGO ANNUAL MEETING ON WOMEN'S CANCER
SAN JUAN, PR
APRIL 10-13, 2026

Final Overall Survival Results From the Phase 3 ROSELLA Trial: Relacorilant Plus Nab-Paclitaxel vs Nab-Paclitaxel Monotherapy in Patients With Platinum-Resistant Ovarian Cancer

(GOG-3073, ENGOT-ov72, APGOT-Ov10, LACOG-0223, and ANZGOG-2221/2023)

Alexander B Olawaiye,[1] Stanislas Quesada, Lucy Gilbert, Jae-Weon Kim, Mariana Scaranti, Elena Giudice, Elizabeth Hopp, Linda Mileshkin, Toon Van Gorp, Michael E McCollum, Ana Oaknin, Aliza L Leiser, Philippe Follana, Chiara Cassani, Boglárka Balázs, Andrew Clamp, Hristina I. Pashova, Sachin G Pai, Nicoletta Colombo and Domenica Lorusso

[1]University of Pittsburgh School of Medicine and UPMC Magee-Women's Hospital, Gynecologic Oncology Group, Pittsburgh, PA, USA.

Scan to access:

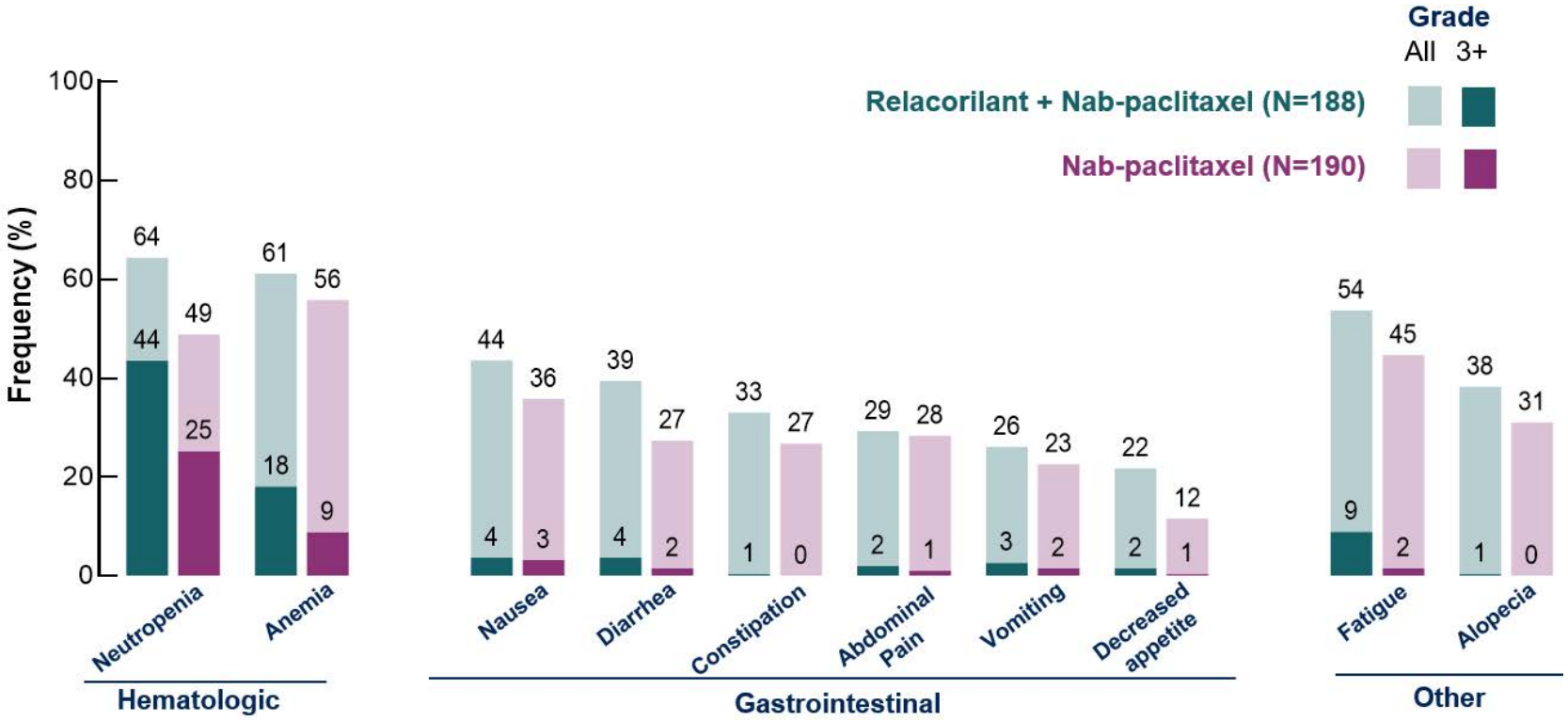
Presentation

Plain Language Summary

In collaboration with:

GOG FOUNDATION · ENGOT European Network of Gynaecological Oncological Trialgroups · APGOT Asia-Pacific Gynecologic Oncology Trials Group · LACOG Latin American Cooperative Oncology Group · ANZGOG

ROSELLA | Common (>20%) Adverse Events



When adjusted for duration of exposure, the incidence rates of neutropenia and anemia were similar between study arms.
Peripheral neuropathy occurred with similar frequency in both arms (19.1% and 17.4%).
5 SAEs of febrile neutropenia: 4 (2.1%) vs 1 (0.5%).* 5 SAEs of sepsis: 3 (1.6%) vs 2 (1.1%).*

Treatment-emergent adverse events that occurred in >20% of patients. Assessed in the safety population of patients who received at least one dose of study drug, N=378. Combined terms are presented for neutropenia (neutropenia, reduced neutrophil count, and febrile neutropenia), anemia (anemia, reduced hemoglobin, and reduced red blood cell count) and fatigue (fatigue and asthenia). SAEs, serious adverse events. *Comparing the relacorilant combination arm to the nab-paclitaxel monotherapy arm, respectively.

Data cutoff: Jan 8, 2026

Mitigations

- Vigilance
- Monitor aggressively
- Prophylactic use of G-CSF in at-risk patients
- Reactive use of G-CSF in other patients

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Relacorilant USPI: Dose Modifications for Neutropenia

		Nab-paclitaxel	Relacorilant
ANC		**Dosage Modification**	
Day 1	1,000 to < 1,500/mm^3	Withhold until ≥ 1,500/mm^3; resume at same dose	Withhold; Resume at the same dose once nab-paclitaxel resumes
	< 1,000/mm^3	Withhold until ≥ 1,500/mm^3; resume at reduced dose	Withhold; Resume at the same dose once nab-paclitaxel resumes
Day 8 or 15	< 1,000/mm^3	Omit dose; resume at reduced dose or continue at the same dose with short acting G-CSF* If the delay in nab-paclitaxel dosing exceeds 7 days, omit the nab-paclitaxel dose.	Withhold; Resume at the same dose once nab-paclitaxel resumes
Febrile neutropenia	Grade 3 or 4	Withhold until fever resolves and ANC ≥ 1,500/mm^3; resume at reduced dose	Withhold; Resume at the same dose once nab-paclitaxel resumes

** Supportive short acting G-CSF administered 24 hours after nab-paclitaxel for 2 days in accordance with clinical practice*

Unless otherwise specified, Grade per National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE) version 5.0.

Reference: Relacorilant Prescribing Information. 2026.

Conclusions

- Adverse events are integral to cancer therapy
- Counseling and education of patients are important in mitigation
- Cancer care providers are duty-bound to familiarize themselves with therapy toxicities
- Vigilance can significantly reduce the impact of adverse events

University of Pittsburgh

In general, do you initiate prophylactic steroid eye drops for your patients who are about to begin mirvetuximab soravtansine, or do you wait for ocular side effects to occur?

 Prof Eskander	Wait for ocular side effects to occur
 Dr Matulonis	Initiate prophylactic steroid eye drops
 Dr Moore	Initiate prophylactic steroid eye drops
 Dr Olawaiye	Initiate prophylactic steroid eye drops
 Dr O'Malley	Initiate prophylactic steroid eye drops
 Prof Colombo	Wait for ocular side effects to occur

RTP RESEARCH TO PRACTICE

Approximately what proportion of patients with advanced OC receiving mirvetuximab soravtansine develop new or worsening peripheral neuropathy?

 Prof Eskander	40%-50% in clinical practice
 Dr Matulonis	50%
 Dr Moore	22%
 Dr Olawaiye	20%
 Dr O'Malley	20%-30%
 Prof Colombo	20%

RTP RESEARCH TO PRACTICE

In your experience, what are the most commonly encountered treatment-related adverse events with relacorilant/*nab* paclitaxel?

 Prof Eskander	Hematologic, nausea/emesis
 Dr Matulonis	Myelosuppression, rash, fatigue, neuropathy, some hair loss
 Dr Moore	Hematologic and gastrointestinal
 Dr Olawaiye	Mostly side effects of *nab* paclitaxel, eg, anemia, neutropenia, nausea, vomiting
 Dr O'Malley	Hematologic toxicity
 Prof Colombo	Myelosuppression, nausea, fatigue

RTP
RESEARCH
TO PRACTICE

How would you indirectly compare the global tolerability of relacorilant/*nab* paclitaxel to that of pembrolizumab/weekly paclitaxel for patients with advanced OC?

 Prof Eskander	Tolerability is about the same
 Dr Matulonis	Pembrolizumab/weekly paclitaxel is more tolerable
 Dr Moore	Relacorilant/*nab* paclitaxel is more tolerable
 Dr Olawaiye	Relacorilant/*nab* paclitaxel is more tolerable
 Dr O'Malley	Relacorilant/*nab* paclitaxel is more tolerable
 Prof Colombo	Pembrolizumab/weekly paclitaxel is more tolerable

RTP RESEARCH TO PRACTICE

How would you indirectly compare the rates and severity of peripheral neuropathy with relacorilant/*nab* paclitaxel to those with mirvetuximab soravtansine for patients with advanced OC?

 Prof Eskander	Peripheral neuropathy is worse with mirvetuximab soravtansine
 Dr Matulonis	Peripheral neuropathy is worse with relacorilant/*nab* paclitaxel
 Dr Moore	Peripheral neuropathy is worse with mirvetuximab soravtansine
 Dr Olawaiye	Peripheral neuropathy is worse with mirvetuximab soravtansine
 Dr O'Malley	Peripheral neuropathy is worse with relacorilant/*nab* paclitaxel
 Prof Colombo	Peripheral neuropathy is worse with mirvetuximab soravtansine

RTP RESEARCH TO PRACTICE

Consensus or Controversy? Documenting and Discussing Investigators' Approaches to the Use of Oral SERDs and Agents Targeting the PI3K/AKT/mTOR Pathway in Breast Cancer

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

Sunday, May 31, 2026

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

Faculty

Sara A Hurvitz, MD, FACP
Erica Mayer, MD, MPH, FASCO
Joyce O'Shaughnessy, MD
Nicholas Turner, MD, PhD

Moderator

Sara M Tolaney, MD, MPH

RTP RESEARCH TO PRACTICE

What Clinicians Want to Know: Addressing Community Oncologists' Questions About the Current and Future Management of Endometrial Cancer

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

Sunday, May 31, 2026

7:00 PM – 8:30 PM CT (8:00 PM – 9:30 PM ET)

Faculty

Floor J Backes, MD

Brian M Slomovitz, MD

Moderator

Shannon N Westin, MD, MPH, FASCO, FACOG

RTP RESEARCH TO PRACTICE

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

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

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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