

Where We Are, Where We're Headed: Bispecific Antibodies in the Management of Follicular Lymphoma

A CME/MOC-Accredited Live Webinar

Thursday, October 22, 2026

5:00 PM – 6:00 PM ET

Faculty

Professor Chan Cheah, MBBS (Hons), DMSc
Matthew Matasar, MD

Moderator

Neil Love, MD

Faculty



Professor Chan Cheah, MBBS (Hons), DMSc
Clinical Professor of Medicine
Consultant Haematologist
Sir Charles Gairdner Hospital
Perth, Australia



MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida



Matthew Matasar, MD
Chief, Division of Blood Disorders
Rutgers Cancer Institute
Hematologist/Oncologist
Professor
Rutgers Robert Wood Johnson Medical School
New Brunswick, New Jersey

Commercial Support

This activity is supported by an educational grant from AstraZeneca Pharmaceuticals LP.

Dr Love — Disclosures

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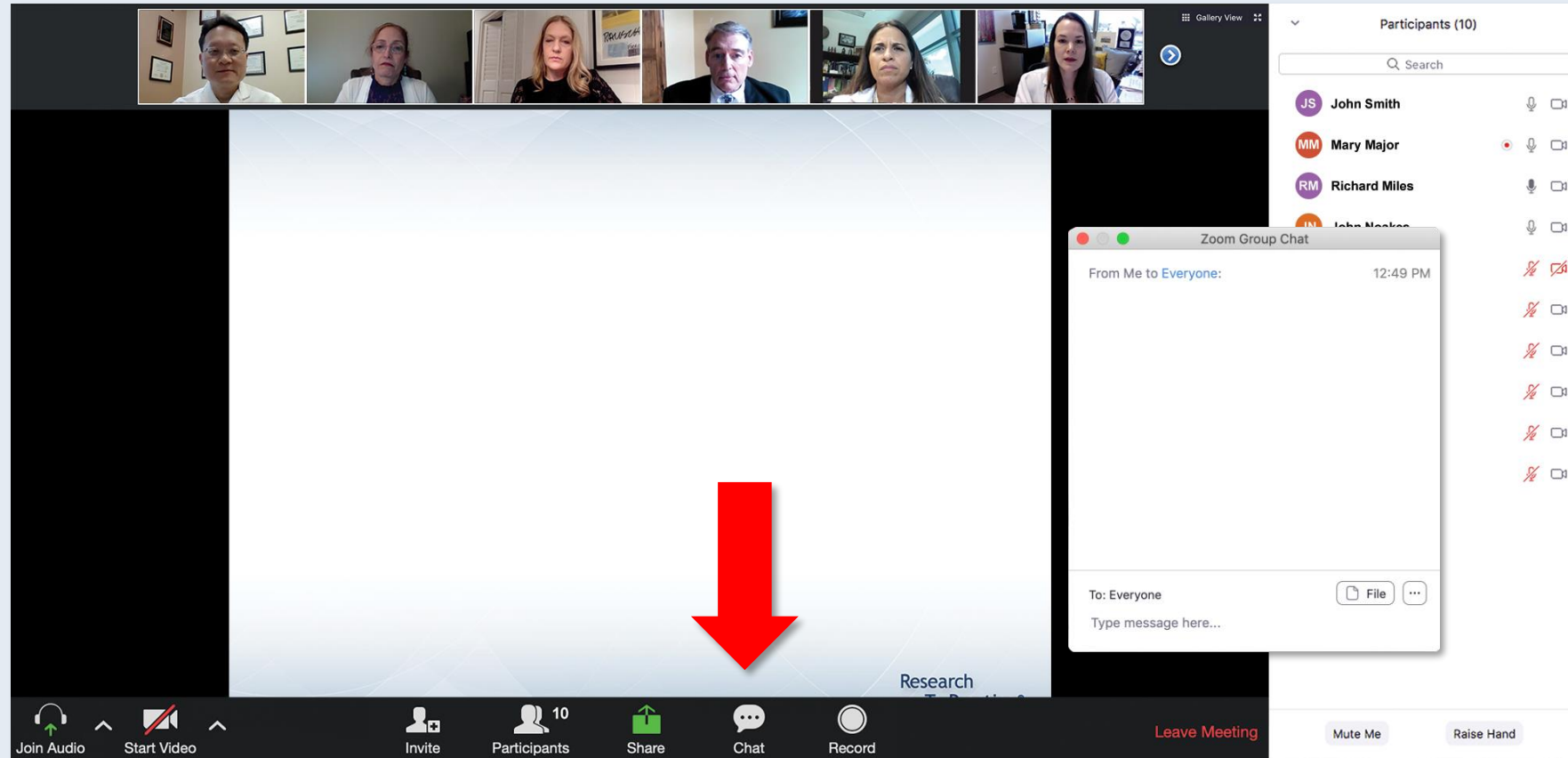
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Dr Matasar — Disclosures

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Expert Testimony	Recursion
Stock Options/Stock — Public Companies	Merck
Nonrelevant Financial Relationships	Arnold & Porter Kaye Scholer LLP

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

We Encourage Clinicians in Practice to Submit Questions



Feel free to submit questions now before the program begins and throughout the program.

Familiarizing Yourself with the Zoom Interface

Expand chat submission box

The screenshot shows a Zoom meeting interface. At the top, there are video thumbnails for participants: RTP Coordinat..., Kirsten Miller, RTP Mike Rivera, and Lisa Suarez. Below the thumbnails is a slide titled "Meet The Professor Program Participating Faculty". The slide lists six faculty members with their photos and titles:

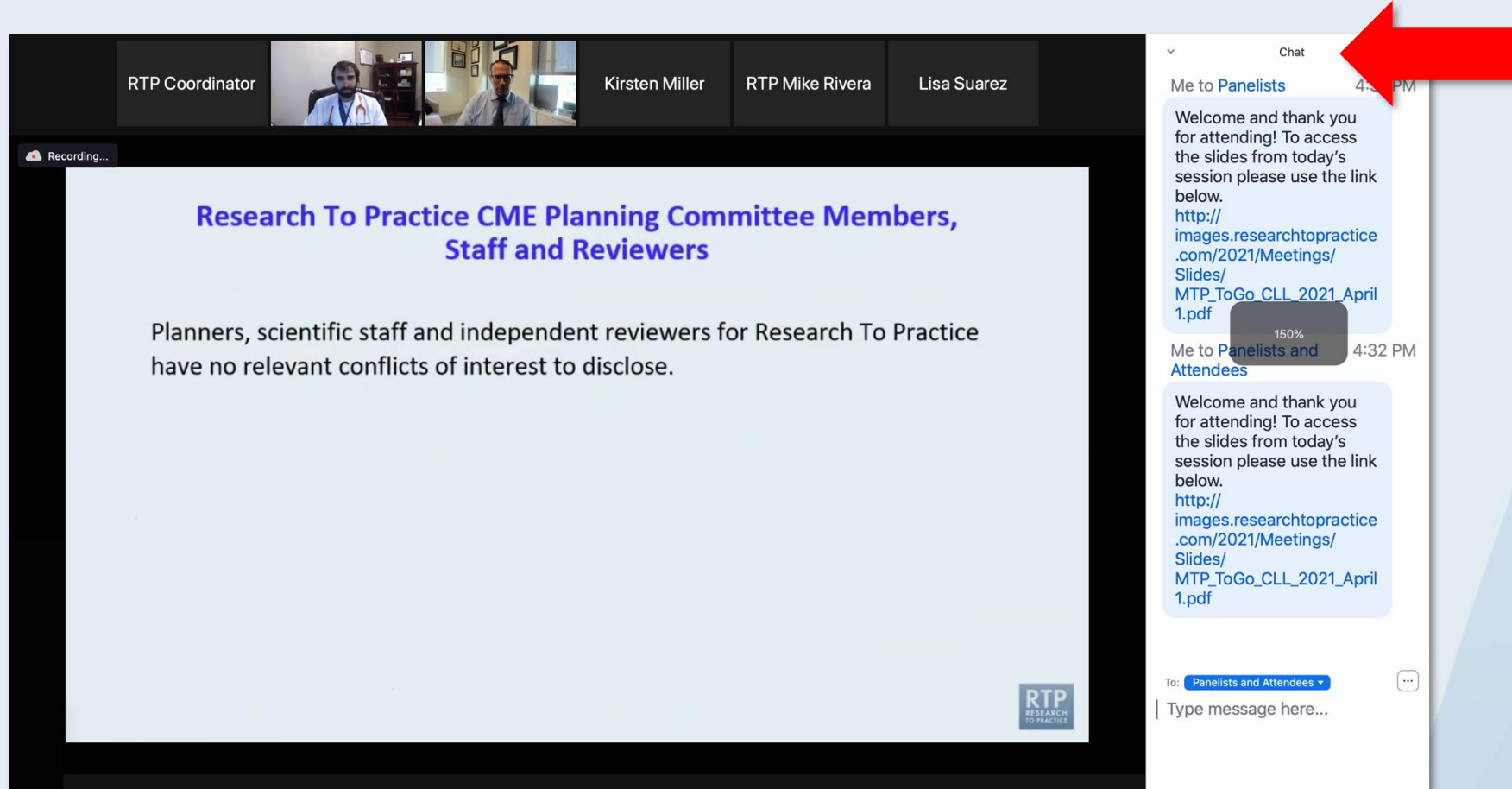
- Nancy L Bartlett, MD**
Professor of Medicine
Koman Chair in Medical Oncology
Washington University School of Medicine
St Louis, Missouri
- Jonathan W Friedberg, MD, MMSc**
Samuel E Durand Professor of Medicine
Director, James P Wilmot Cancer Institute
University of Rochester
Rochester, New York
- Carla Casulo, MD**
Associate Professor of Medicine
Division of Hematology/Oncology
Director, Hematology/Oncology Fellowship Program
University of Rochester
Wilmot Cancer Institute
Rochester, New York
- Brian T Hill, MD, PhD**
Director, Lymphoid Malignancy Program
Cleveland Clinic Taussig Cancer Institute
Cleveland, Ohio
- Christopher R Flowers, MD, MS**
Chair, Professor
Department of Lymphoma/Myeloma
The University of Texas MD Anderson Cancer Center
Houston, Texas
- Brad S Kahl, MD**
Professor of Medicine
Washington University School of Medicine
Director, Lymphoma Program
Siteman Cancer Center
St Louis, Missouri

At the bottom right of the slide is the RTP Research to Practice logo. To the right of the slide is a chat window. The chat window has a title bar "Chat" and a dropdown menu "Me to Panelists" with a timestamp "4:31 PM". The chat content includes a welcome message and a link to the slides: http://images.researchtopractice.com/2021/Meetings/Slides/MTP_ToGo_CLL_2021_April1.pdf. Below this is another message from "Me to Panelists and Attendees" with a timestamp "4:32 PM" and the same link. At the bottom of the chat window is a "To:" dropdown menu set to "Panelists and Attendees" and a text input field "Type message here...". A red arrow points to the white line above the text input field, indicating where to drag to expand the box.

Drag the white line above the submission box up to create more space for your message.

Familiarizing Yourself with the Zoom Interface

Increase chat font size



**Press Command (for Mac) or Control (for PC) and the + symbol.
You may do this as many times as you need for readability.**

Clinicians in the Audience, Please Complete the Pre- and Postmeeting Surveys

The screenshot shows a Zoom meeting with a presentation slide on the left and a 'Quick Survey' pop-up on the right. The slide title is 'Meet The Professor' and the topic is 'Optimizing the Selection and Sequencing of Therapy for Patients with Metastatic Gastrointestinal Cancer'. The date and time are 'Wednesday, August 25, 5:00 PM – 6:00 PM EST'. The faculty member is 'Wells A Messersmith, MD' and the moderator is 'Neil Love, MD'. The survey pop-up lists several treatment options with radio buttons for selection.

Meet The Professor
Optimizing the Selection and Sequencing of Therapy for Patients with Metastatic Gastrointestinal Cancer
Wednesday, August 25, 5:00 PM – 6:00 PM EST
Faculty: Wells A Messersmith, MD
Moderator: Neil Love, MD

Quick Survey

- ☐ Ceritinib +/- dexamethasone
- ☐ Pomalidomide +/- dexamethasone
- ☐ Ceritinib + pomalidomide +/- dexamethasone
- ☐ Elotuzumab + lenalidomide +/- dexamethasone
- ☐ Elotuzumab + pomalidomide +/- dexamethasone
- ☐ Daratumumab + lenalidomide +/- dexamethasone
- ☐ Daratumumab + pomalidomide +/- dexamethasone
- ☐ Daratumumab + bortezomib +/- dexamethasone
- ☐ Ixazomib + Rd
- ☐ Other

Submit

Participants (10)

- JS John Smith
- MM Mary Major
- RM Richard Miles
- JN John Noakes
- AS Alice Suarez
- JP Jane Perez
- RS Robert Stiles
- JF Juan Fernandez
- AK Ashok Kumar
- JS Jeremy Smith

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Regulatory and reimbursement issues aside, what would you recommend for a 65-year-old patient with clear cell renal cell carcinoma (ccRCC) who has a follow-up 3 years later is found to have asymptomatic (PS 0)?

1. Nivolumab/ipilimumab
2. Avelumab/axitinib
3. Pembrolizumab/axitinib
4. Pembrolizumab/lenvatinib
5. Nivolumab/cabozantinib
6. Tyrosine kinase inhibitor (TKI) monotherapy
7. Anti-PD-1/PD-L1 monotherapy
8. Other

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ONCOLOGY TODAY

WITH DR NEIL LOVE

Sharing Best Practices: Investigators and Community Clinicians Discuss CD20 x CD3 Bispecific Antibodies and the Optimal Management of Cytokine Release Syndrome



JENNIFER CROMBIE, MD
DANA-FARBER CANCER INSTITUTE



MANALI KAMDAR,
MD, MBBS
UNIVERSITY OF COLORADO
CANCER CENTER



ALEXANDRA LYNCH, PA-C
DANA-FARBER CANCER INSTITUTE

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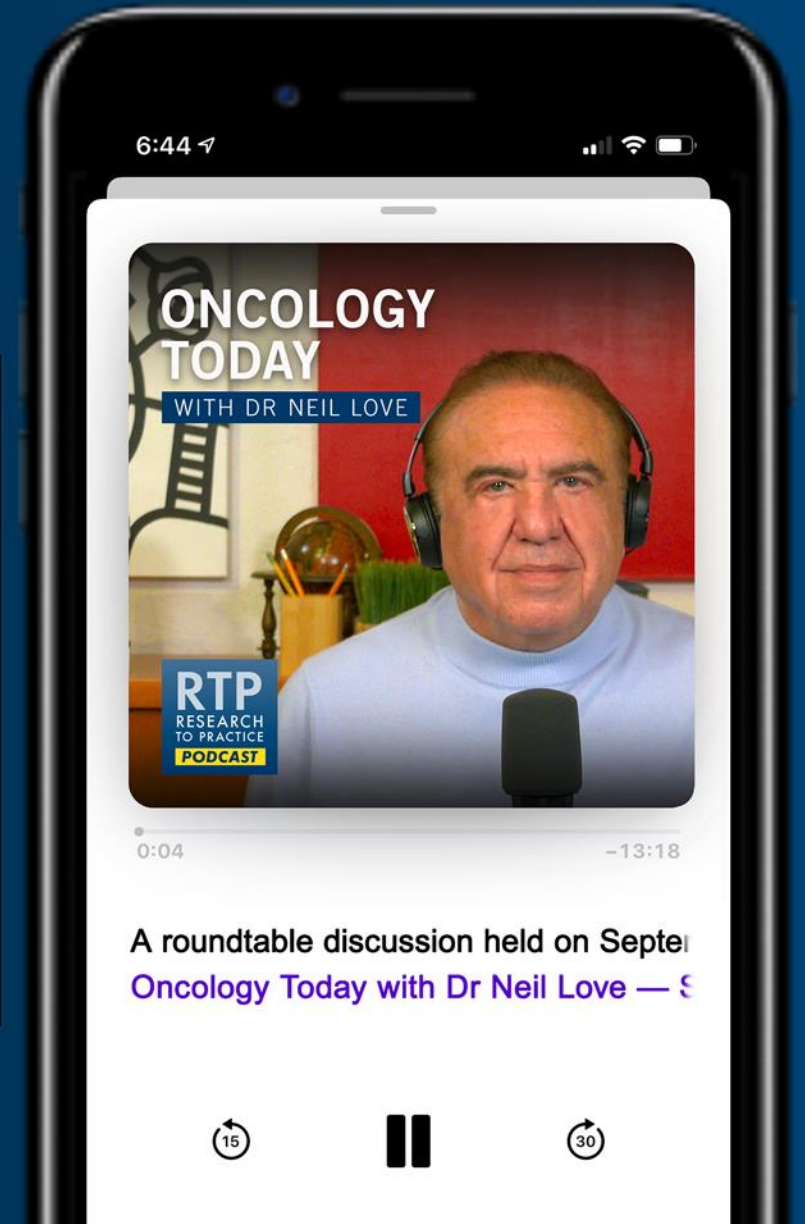
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Cancer Conference Update: ESMO Congress 2026 Review — Breast Cancer

A CME/MOC-Accredited Live Webinar

**Thursday, November 12, 2026
5:00 PM – 6:30 PM ET**

Faculty

Professor Giuseppe Curigliano, MD, PhD

Rebecca A Dent, MD, MSc

Komal Jhaveri, MD, FACP, FASCO

Moderator

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Tuesday, December 8, 2026

7:00 PM – 9:00 PM CT

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Email Meetings@ResearchToPractice.com
or call (800) 233-6153**

Save The Date

Sixth Annual National General Medical Oncology Summit

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

Friday to Sunday, April 23 to 25, 2027

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

Moderated by Neil Love, MD

Thank you for joining us! Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us.

Information on how to obtain CME and ABIM MOC credit will be provided at the conclusion of the activity in the Zoom chat room. Attendees will also receive an email in 1 to 3 business days with these instructions.

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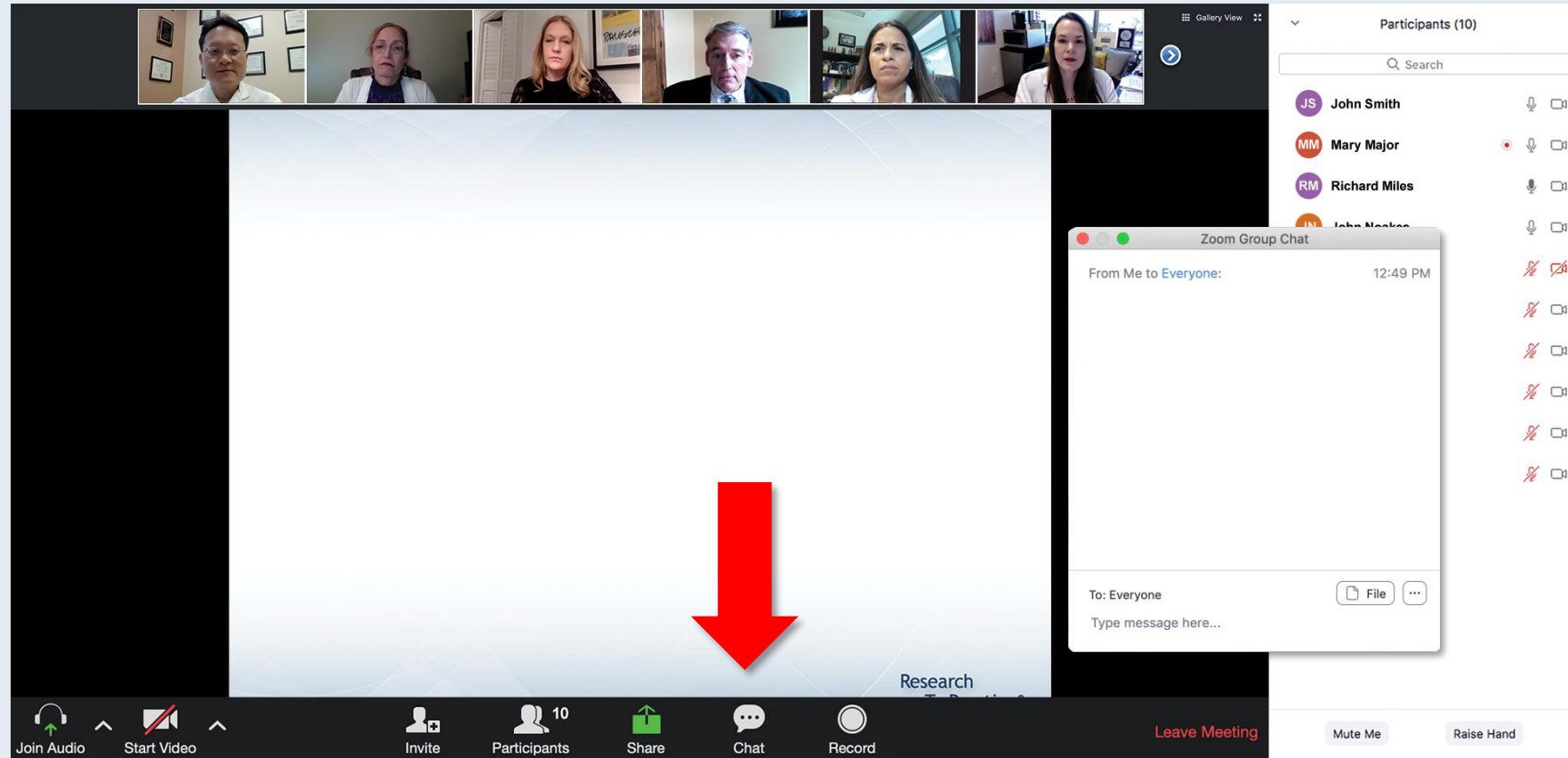


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WITH DR NEIL LOVE

Sharing Best Practices: Investigators and Community Clinicians Discuss CD20 x CD3 Bispecific Antibodies and the Optimal Management of Cytokine Release Syndrome



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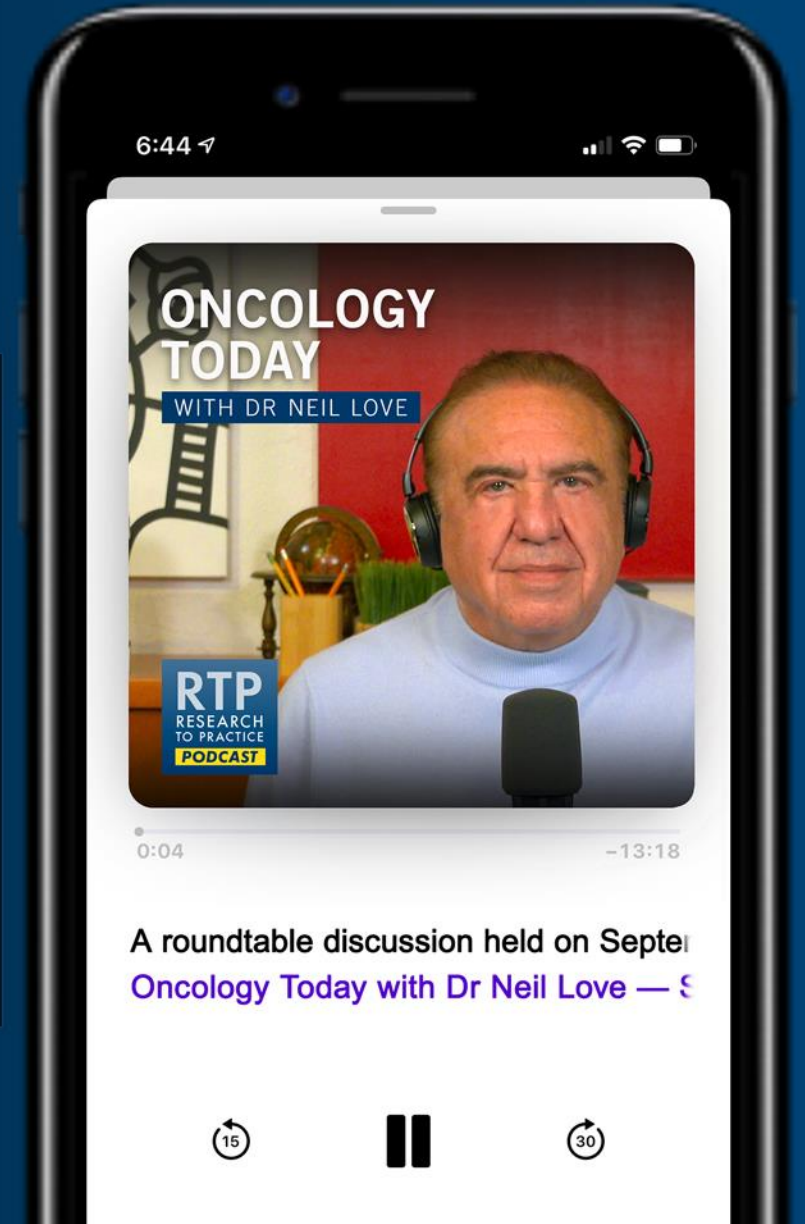
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Agenda

Prologue: Saturday Night Fever

Module 1: Baby Boomers' Guide to Mechanisms of Action

Module 2: Second-Line Treatment

Module 3: Complications Associated with Bispecific Antibodies

Module 4: Case Presentations

Module 5: New Bispecific T-Cell Engagers – Surovatamig

Module 6: Other Novel Agents

Agenda

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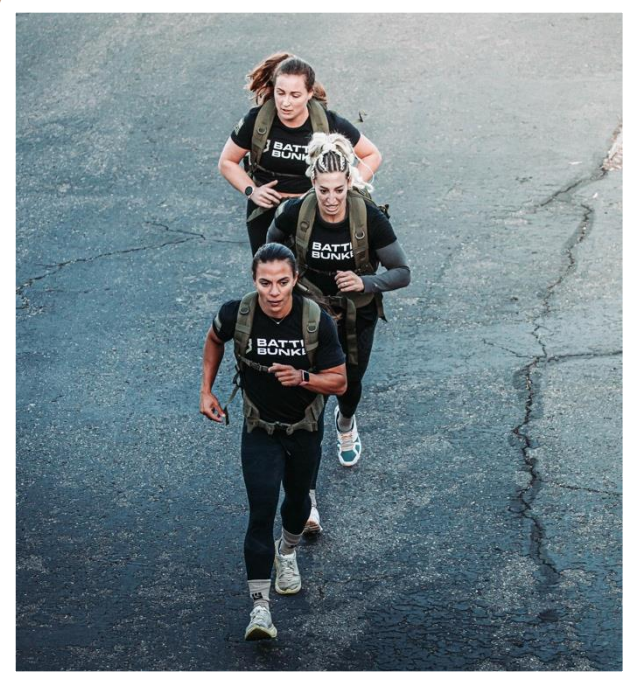
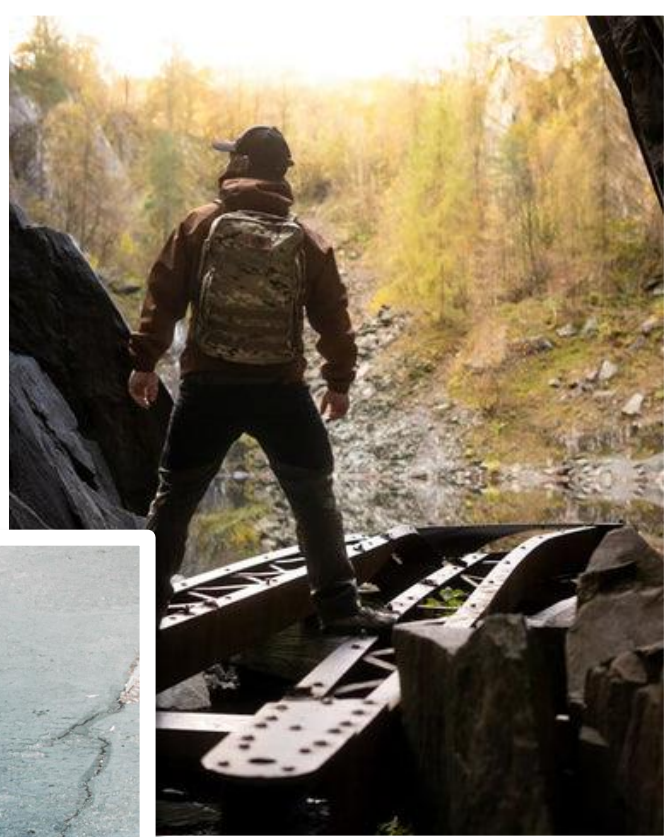
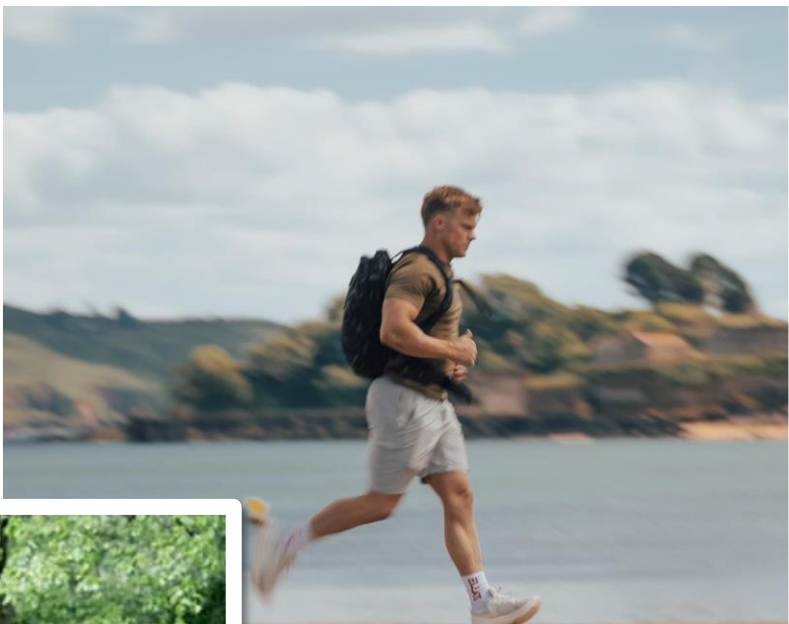
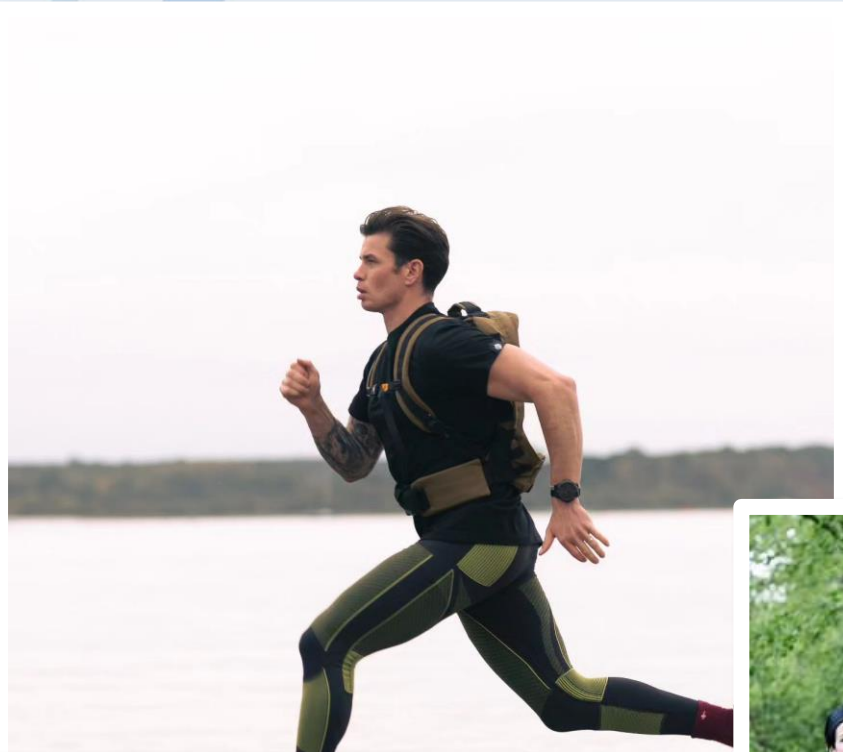
14A



Defensive back Bryce Fitzgerald intercepts the pass for a touchback during the second overtime Saturday against Florida State at Hard Rock Stadium to seal the win against the archrival Seminoles.

CANES 'FIND A WAY' TO NO. 1

After two overtimes — and multiple upsets elsewhere — UM vaults to the top of AP's poll



Agenda

Prologue: Saturday Night Fever

Module 1: Baby Boomers' Guide to Mechanisms of Action

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Module 4: Case Presentations

Module 5: New Bispecific T-Cell Engagers – Surovatamig

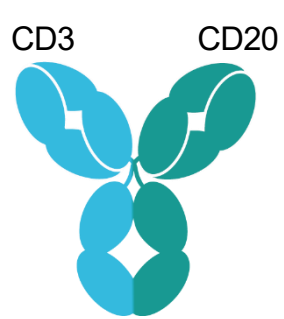
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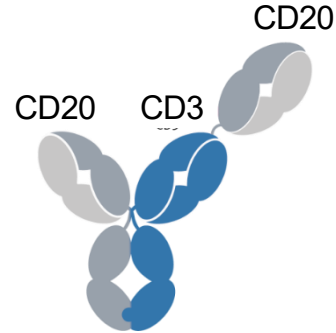
Module 1: Baby Boomers' Guide to MOA

- Anti-CD20 antibodies
- Bispecific antibodies (BsAbs)
- CAR T-cell therapy (Signal 1/Signal 2 phenomenon)

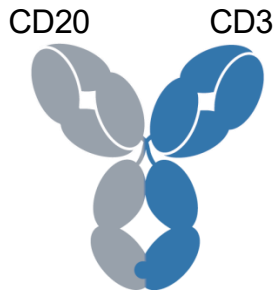
CD20 x CD3 bispecific antibodies



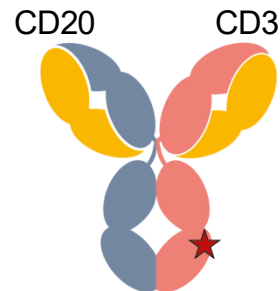
Epcoritamab
DuoBody-CD3 x CD20
IgG1



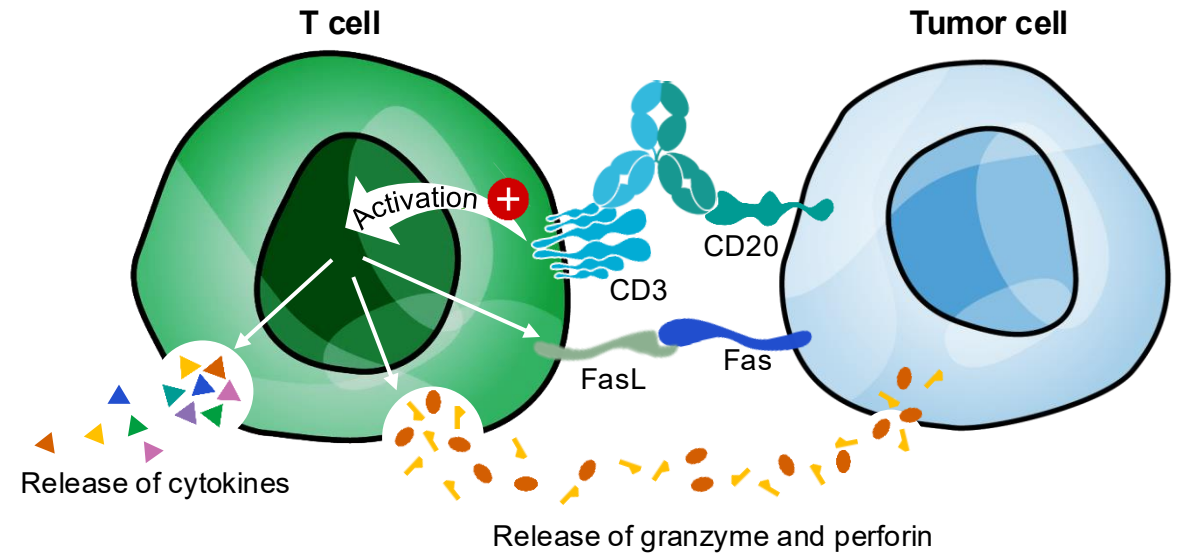
Glofitamab
2+1 CrossMab
IgG1



Mosunetuzumab
Knob-in-hole
IgG1

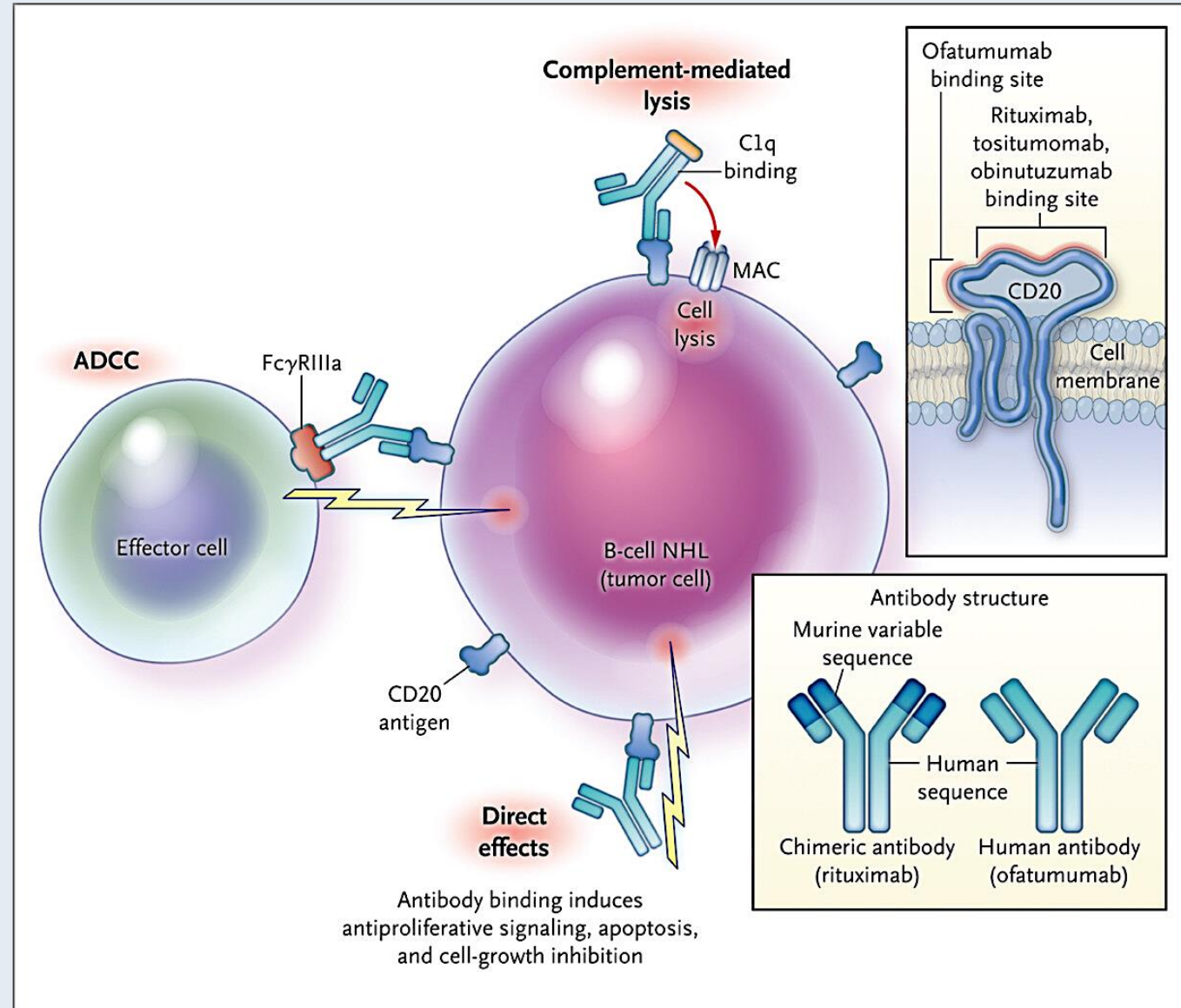


Odronextamab
VELOCI-Bi
IgG4

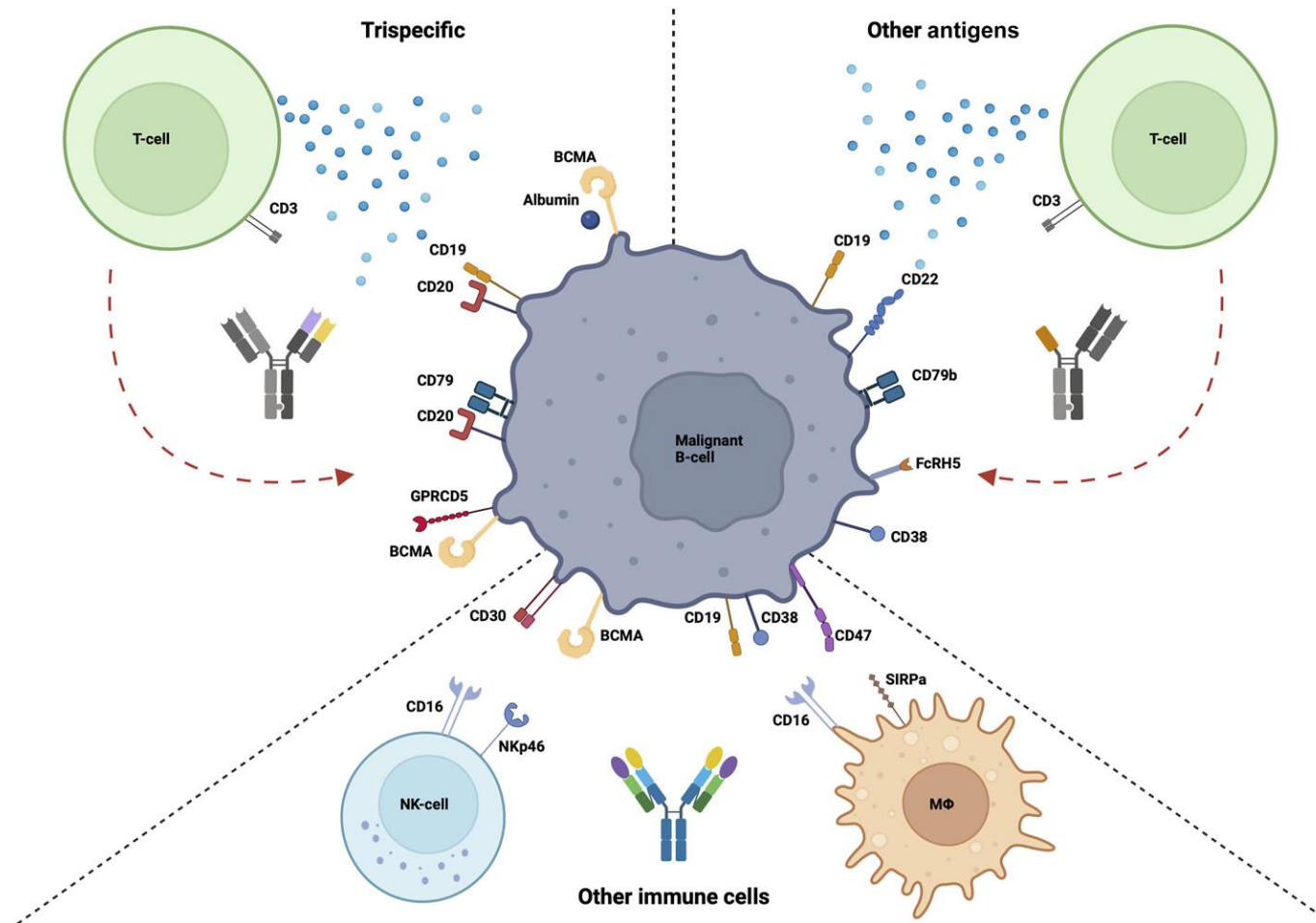


- CD3 x CD20 bsAbs bring together T cells and CD20+ tumor cells to induce T cell-mediated killing of the tumor cell²
- Able to induce effector T cell binding without requiring MHC-mediated antigen presentation²

Antitumor Activity of CD20-Directed Antibodies

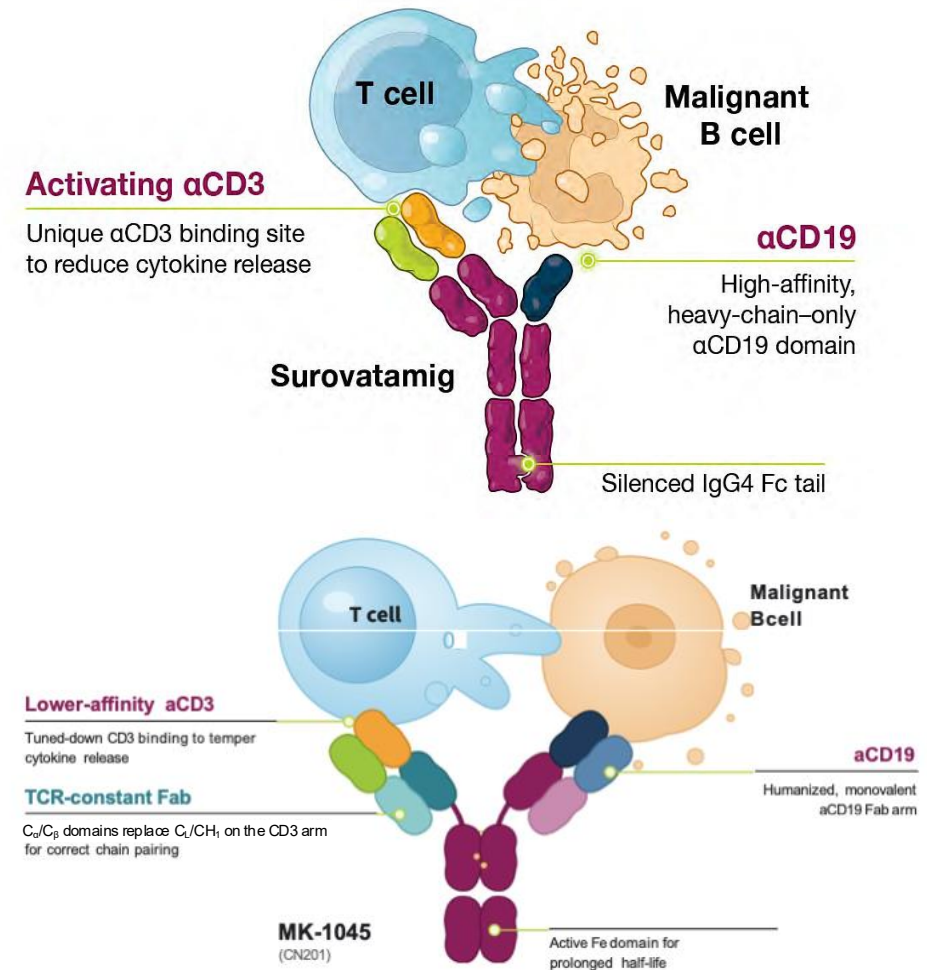


Bispecifics: New agents for new targets

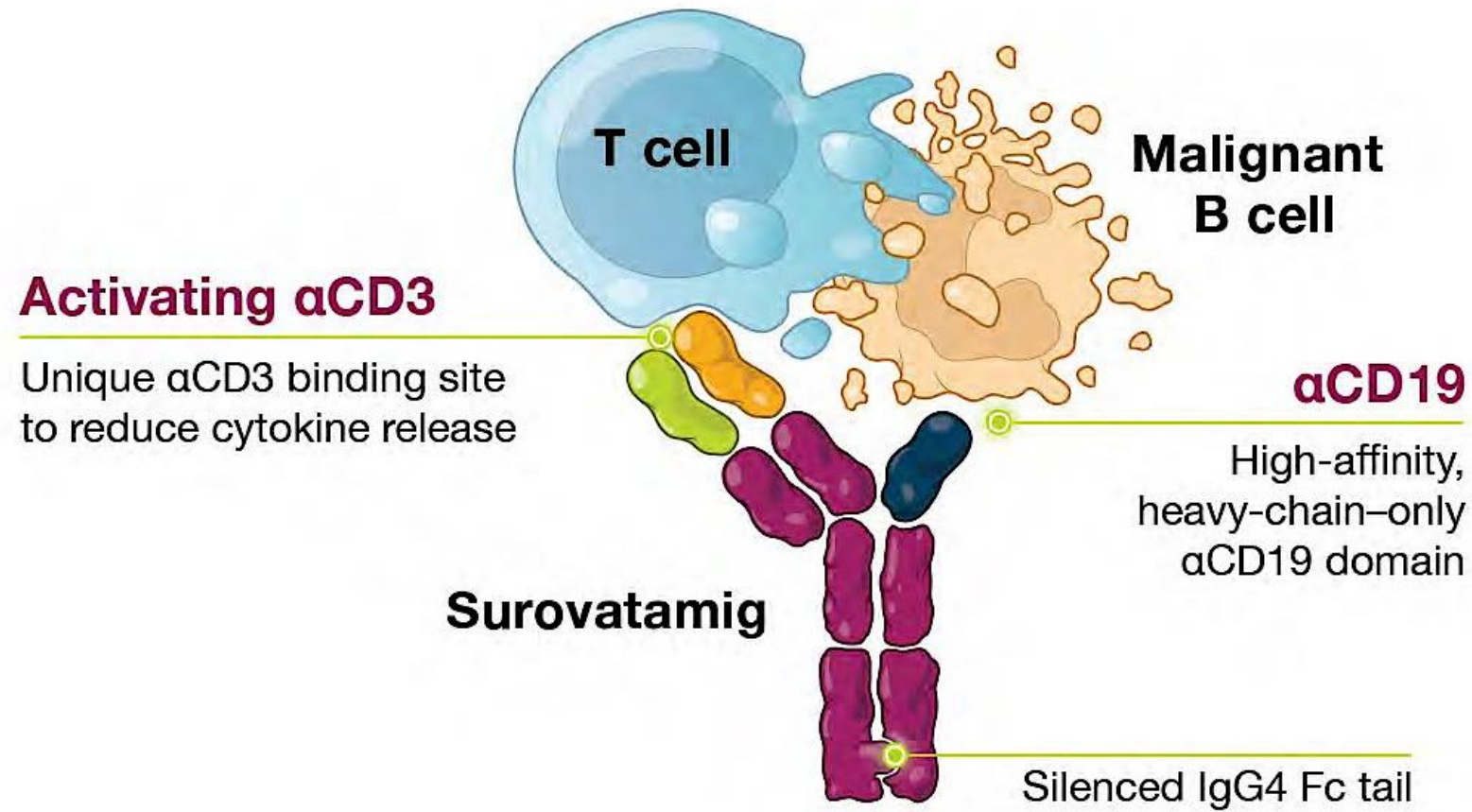


CD19 Bispecific antibodies

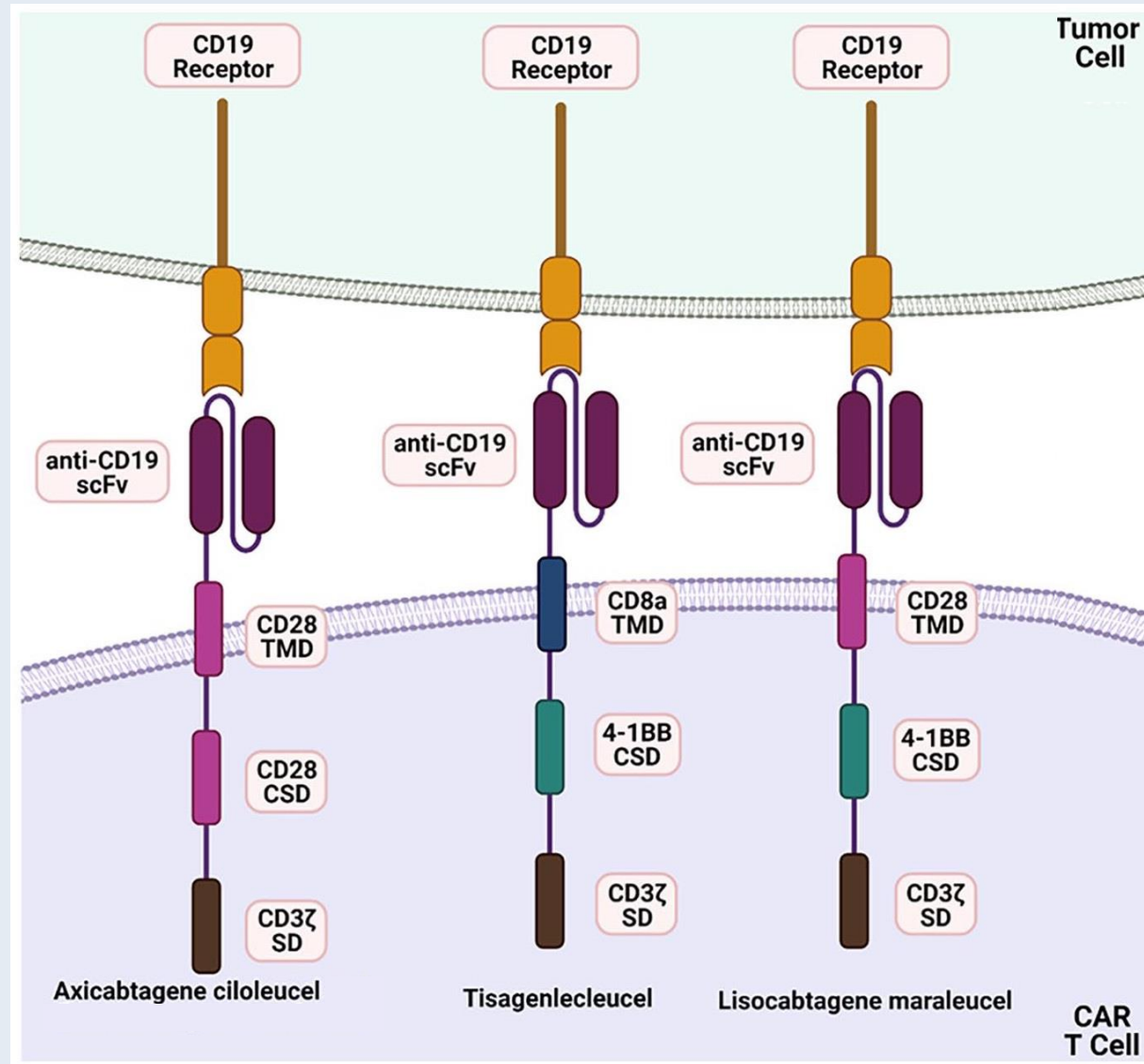
- Loss of CD20 expression is a common mechanism of resistance, with estimates ranging from 34% to 90%
- CD19 is expressed across the spectrum of B-cell lymphomas, and is an established target for T-cell engaging therapy



Surovatamig in follicular lymphoma



CAR T-Cell Therapies for Follicular Lymphoma



Agenda

Module 1: Baby Boomers' Guide to MOA

- Anti-CD20 antibodies
- BsAbs
- CAR T (Signal 1/Signal 2 phenomenon)

Agenda

Prologue: Saturday Night Fever

Module 1: Baby Boomers' Guide to Mechanisms of Action

Module 2: Second-Line Treatment

Module 3: Complications Associated with Bispecific Antibodies

Module 4: Case Presentations

Module 5: New Bispecific T-Cell Engagers – Surovatamig

Module 6: Other Novel Agents

Current use of bispecific antibodies in FL

Professor Chan Cheah

Lymphoma lead and Fellowship program director

Sir Charles Gairdner Hospital

Perth, Western Australia

Key Datasets – Prof Cheah

- Qualls D, Salles G. Prospects in the management of patients with follicular lymphoma beyond first-line therapy. *Haematologica* 2022;107(1):19-34.
- Engelberts PJ et al. DuoBody-CD3xCD20 induces potent T-cell-mediated killing of malignant B cells in preclinical models and provides opportunities for subcutaneous dosing. *EBioMedicine* 2020;52:102625.
- Schuster SJ. Bispecific antibodies for the treatment of lymphomas: Promises and challenges. *Hematol Oncol* 2021;39(Suppl 1):113-6.
- You G et al. Bispecific antibodies: A smart arsenal for cancer immunotherapies. *Vaccines (Basel)* 2021;9(7):724.
- Budde E et al. Fixed treatment duration mosunetuzumab continues to demonstrate clinically meaningful outcomes in patients with relapsed/refractory (R/R) follicular lymphoma (FL) after ≥ 2 prior therapies: 5-year follow-up of a pivotal Phase II study. ASH 2025;Abstract 5352.
- Linton KM et al. Epcoritamab monotherapy in patients with relapsed or refractory follicular lymphoma (EPCORE NHL-1): A phase 2 cohort of a single-arm, multicentre study. *Lancet Haematol* 2024;11(8):e593-605.
- Falchi L et al. Primary phase 3 results from the epcore FL-1 trial of epcoritamab with rituximab and lenalidomide (R2) versus R2 for relapsed or refractory follicular lymphoma. ASH 2025;Abstract 466.
- Crombie JL et al. Consensus recommendations on the management of toxicity associated with CD3 $\times$ CD20 bispecific antibody therapy. *Blood* 2024;143:1565-75.
- Reynolds GK et al. Infections in patients with lymphoma treated with bispecific antibodies: A systematic review and meta-analysis. *Blood Adv* 2024;8:3555-9.

Agenda

Module 2: Second-Line Treatment

- Indications to treat relapsed FL: PFS vs TTNT
- Mosunetuzumab monotherapy at 5 years: PFS 36%, TTNT 64 months, OS 78%
- EPCORE FL-1 – Epcoritamab with R²: PFS HR 0.21, OS HR 0.38
- CELESTIMO – Mosunetuzumab/lenalidomide (press release)
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- Sequencing of BsAbs and CAR T for FL vs DLBCL

TTNT = time to next treatment; R² = lenalidomide/rituximab

Phase II Trial Evaluating Mosunetuzumab in Patients with Relapsed/Refractory FL: Study design

Pivotal, single-arm, multicenter, Phase II expansion in patients with R/R FL and ≥ 2 prior therapies

Key inclusion criteria

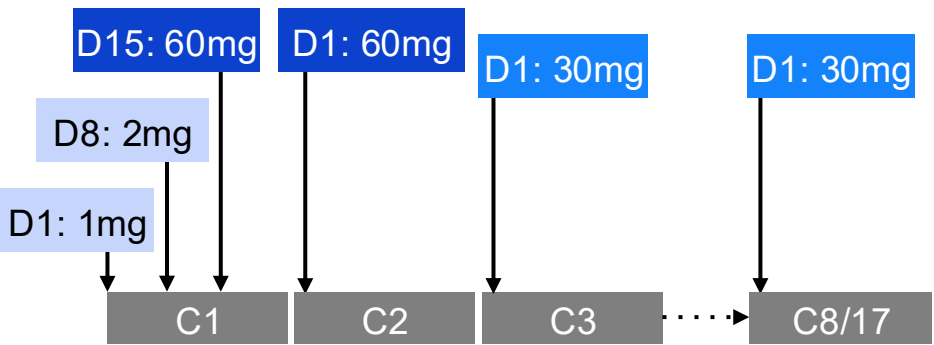
- FL Grade 1–3a
- ECOG PS 0–1
- ≥ 2 prior therapies including an anti-CD20 antibody and an alkylator

Data analysis

- Study met its primary endpoint: 60% CR rate versus 14% historic control ($p < 0.0001$)^{1,2}
- Updated efficacy and safety analysis with median 37.4 months of follow-up

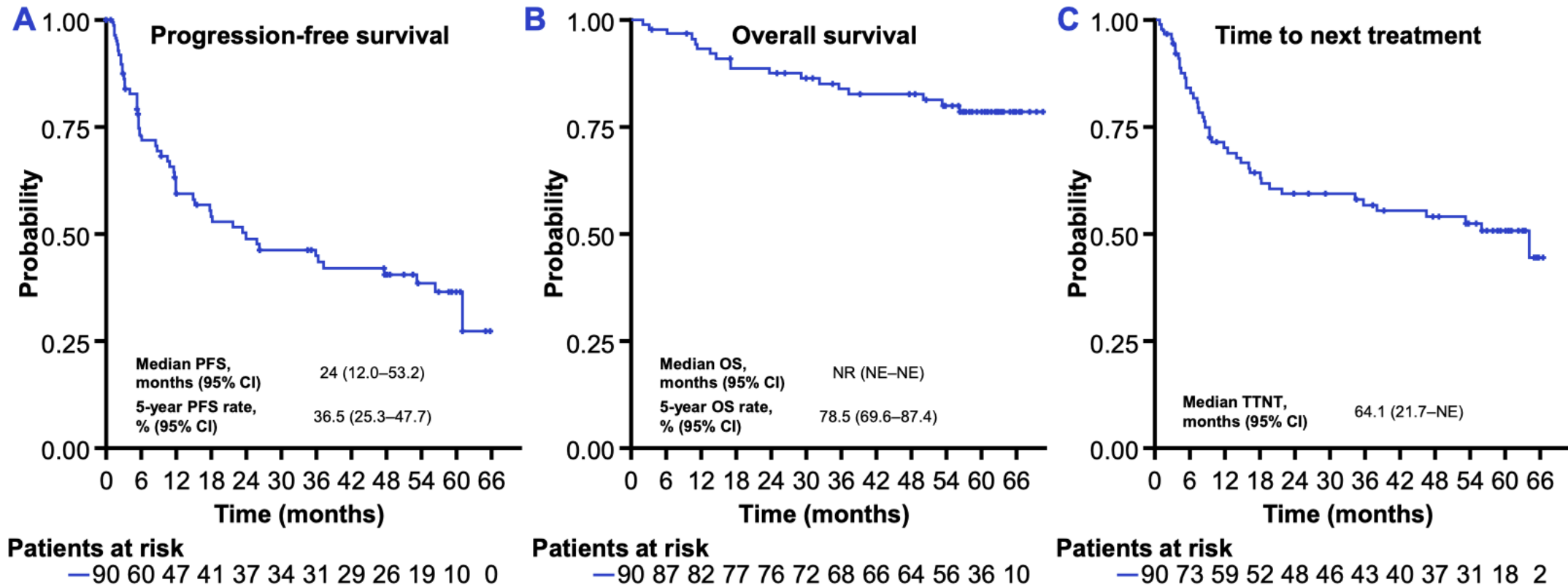
Mosunetuzumab administration

- IV mosunetuzumab administered in 21-day cycles with step-up dosing in C1
- Fixed-duration treatment: Eight cycles if CR after C8; 17 cycles if PR/SD after C8
- Retreatment with mosunetuzumab permitted at relapse for patients who achieved CR
- No mandatory hospitalization



D, day; ECOG PS, Eastern Cooperative Oncology Group performance status; IV, intravenous; PR, partial response; SD, stable disease.

Mosunetuzumab: 5-year FU data



EPCORE FL-1: Phase 3, Global, Randomized, Open-Label Study

Fixed-Duration: 12 Cycles (28-Day Cycles)

Key eligibility criteria

- Histologically confirmed CD20+ FL
- Grade 1-3a, Stage II-IV
- ≥ 1 prior treatment including anti-CD20 mAb plus an alkylating agent
- Met ≥ 1 GELF criterion

Randomization 1:1

Epcoritamab (48 mg) plus R²

- **Epcoritamab** (3-SUD cycle 1: QW;^{a,b} cycles 2–3, QW; cycles 4–12, Q4W)
- **Rituximab** (375 mg/m²), 5 cycles (cycle 1, QW; cycles 2–5, Q4W)
- **Lenalidomide** (20 mg), 12 cycles (cycle 1–12, QD, D1-21)

R²

- **Rituximab** (375 mg/m²), 5 cycles (cycle 1, QW; cycles 2–5, Q4W)
- **Lenalidomide** (20 mg), 12 cycles (cycle 1–12, QD, D1-21)

Stratification factors

- Disease status:
 - 2L: > or ≤ 2 years since last therapy
 - 3L+: > or < 6 months since last therapy
- Region: US/EU vs Rest of World

- **Dual primary endpoints: ORR per IRC and PFS per IRC**

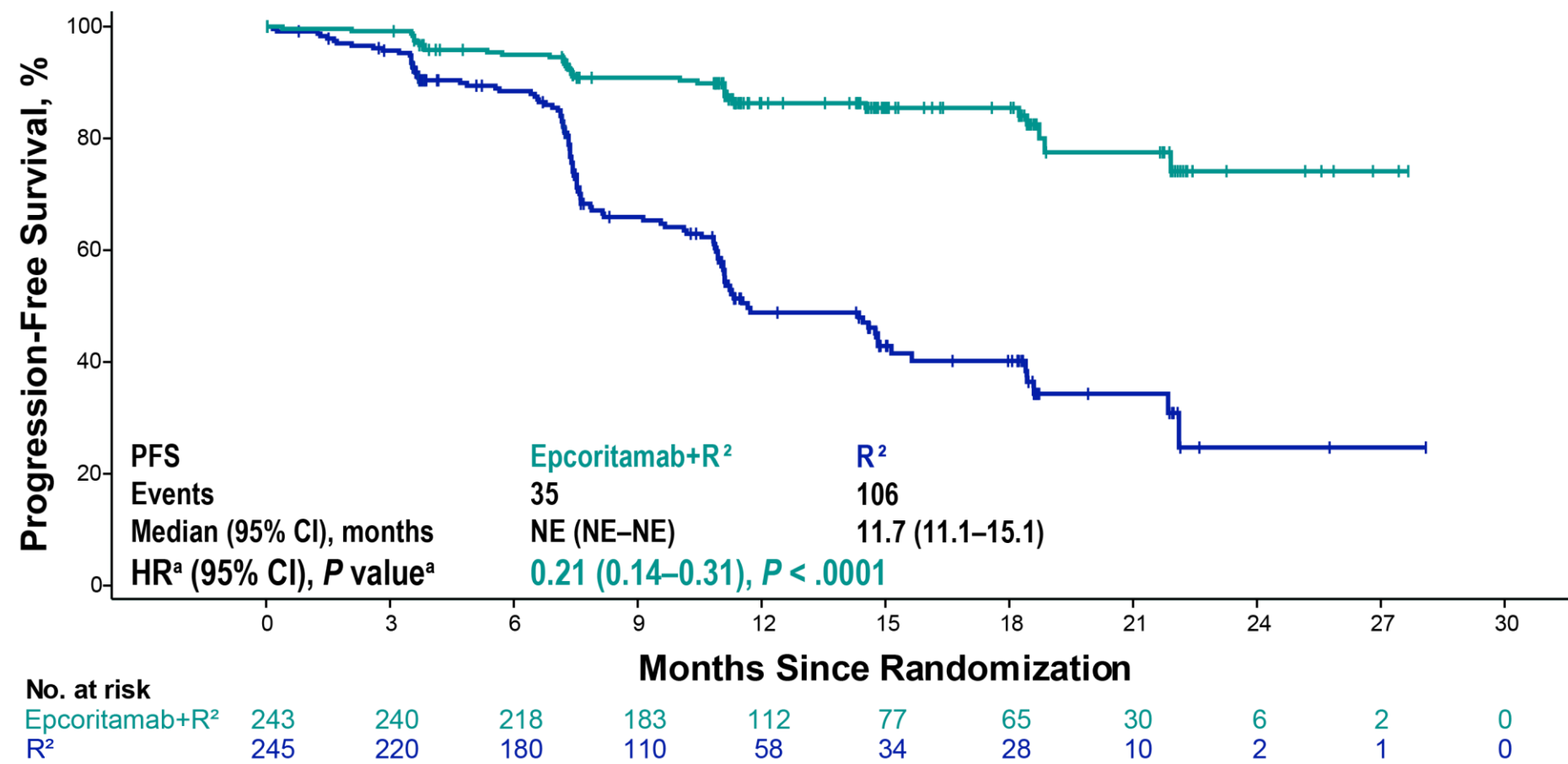
- Key secondary endpoints: CR rate per IRC, OS, and MRD^c
- Additional secondary endpoints: DOR, DOCR, TTNLT, safety, and PRO assessments

Data cutoff: May 24, 2025; median follow-up: 14.8 months^d

Enrollment period: October 2022 - January 2025

^aTwo step-up dosing (SUD) regimens during cycle 1 to mitigate the risk of cytokine release syndrome: either a 2-SUD (0.16 mg on cycle 1 day 1, 0.8 mg on cycle 1 day 8), or 3-SUD (0.16 mg on cycle 1 day 1, 0.8 mg on cycle 1 day 8, 3 mg on cycle 1 day 15) regimen, followed by full dose 48 mg. The 3-SUD regimen was implemented after reduced CRS severity and incidence had been observed in the EPCORE NHL-1 FL trial (NCT03625037).¹ ^bThe 24 mg epcoritamab plus R² arm was closed to enrollment based on the superior efficacy for the 48 mg dose from EPCORE NHL-2.² Only the data for the optimal dose explored (48 mg) are presented here. ^cMinimal residual disease data are forthcoming in a future analysis. ^dThe data presented here are from the second planned interim analysis (May 24, 2025) after 78% Information Fraction for PFS had occurred. 1. Vose J, et al. *J Clin Oncol*. 2024;42(16_suppl):7015–7015. 2. Falchi L, et al. *Blood*. 2024;144(Supplement 1):342–342.

EPCORE FL-1: PFS

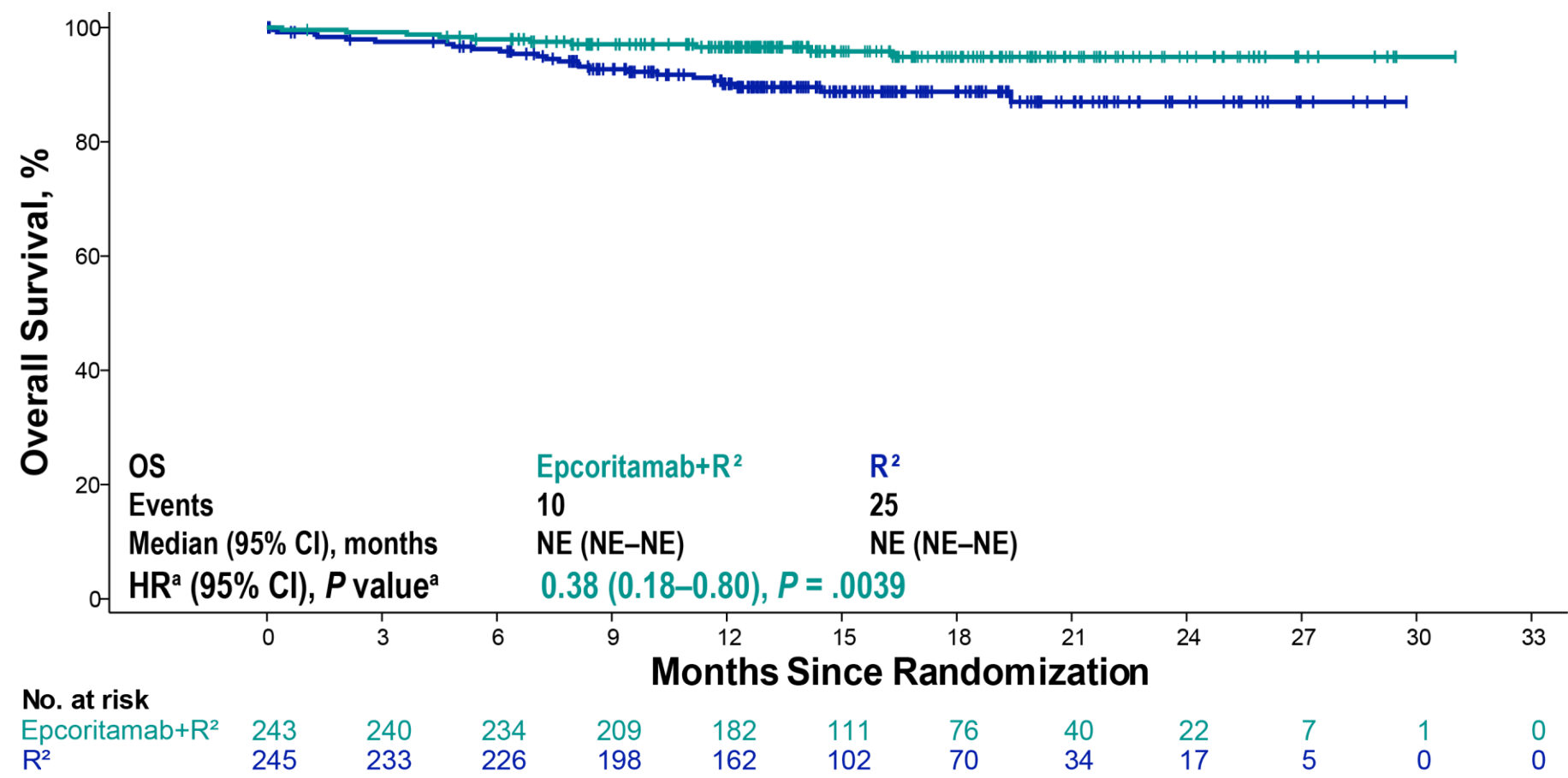


- Concordance rate was 94% for PFS between IRC and investigator assessment
- The estimated 16-month PFS was 85.5% (95% CI: 79.7, 89.7) for epcoritamab+R² and 40.2% (95% CI: 31.8, 48.4) for R²

Median follow-up for PFS: epcoritamab+R² (14.4m), R² (11.5m). The first planned interim analysis (January 10, 2025) achieved statistical significance on PFS, HR 0.21 (95% CI 0.13, 0.33) *P* < 0.0001, with a 1-sided significance level of 0.0023.

^aNominal *P* value is based on stratified log-rank test. Hazard ratio is estimated using stratified Cox proportional hazards model. This analysis was performed on the 78% information fraction.

EPCORE FL-1: Overall Survival



- The 16-month estimate for OS was 95.8% with epcoritamab+R² and 88.8% with R²

Median follow-up for OS: epcoritamab+R² (14.8m), R² (14.6m). The OS data is based on the 24% (35/146 events) information fraction and has not yet reached statistical significance; additional analyses are forthcoming.
^a*P* value is based on stratified log-rank test with 1-sided significance level of 0.000005. Hazard ratio is estimated using stratified Cox proportional hazards model.

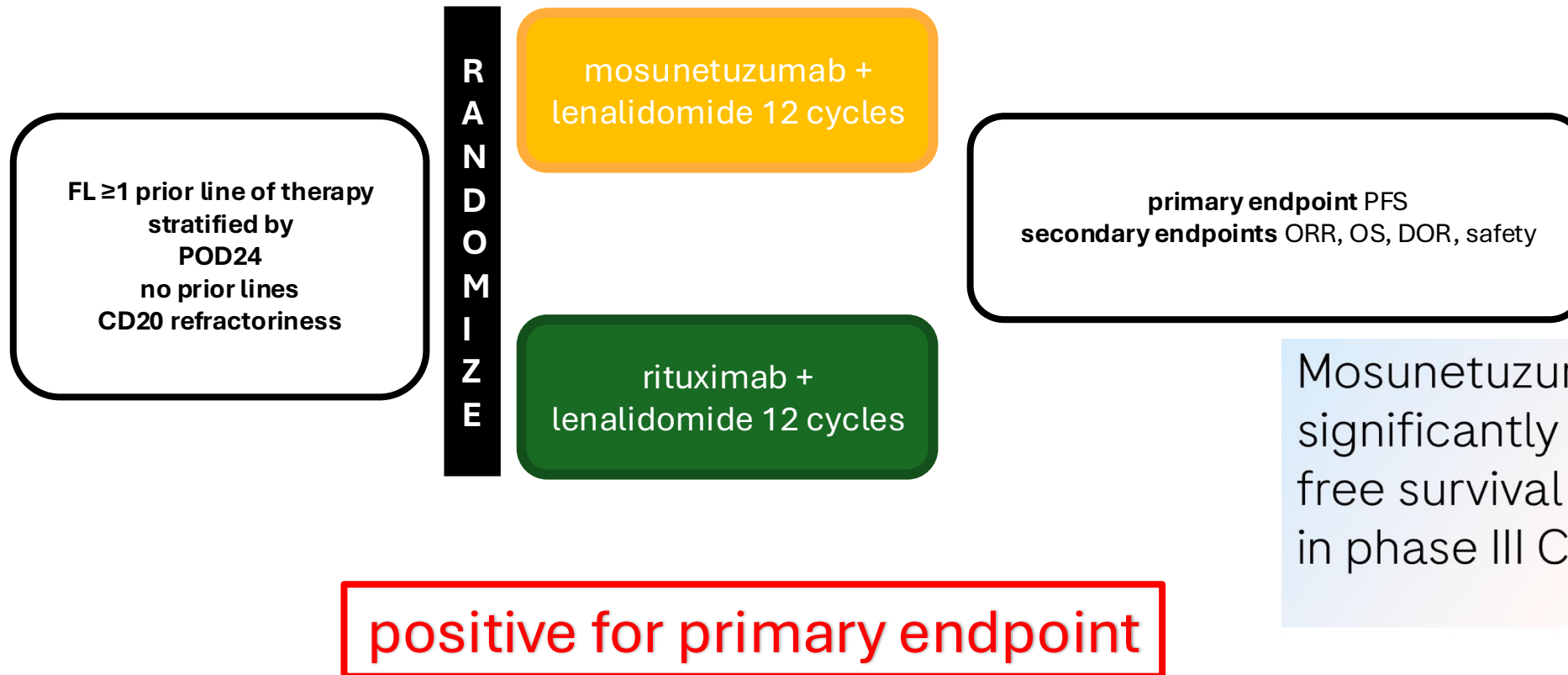
EPCORE FL-1 Manageable AEs With No New Safety Signals

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

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

^aNeutropenia, anemia, pyrexia, rash and COVID-19 are grouped terms comprising multiple clinically related Preferred Terms. ^bThis includes the AESI of CRS. ^cEvents were in the MedDRA system organ class "Infections and Infestations." No grade 5 infections were reported.

CELESTIMO phase III study design



Mosunetuzumab-based regimen significantly improves progression-free survival in follicular lymphoma in phase III CELESTIMO study

September 16, 2026

- Phase III CELESTIMO study met its primary endpoint at the interim analysis demonstrating a statistically significant and clinically meaningful reduction in the risk of disease progression in people with follicular lymphoma who have received at least one prior line of treatment

Agenda

Module 2: Second-Line Treatment

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- Mosunetuzumab monotherapy at 5 years: PFS 36%, TTNT 64 months, OS 78%
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- Sequencing of BsAbs and CAR T for FL vs DLBCL

TTNT = time to next treatment; R² = lenalidomide/rituximab

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Module 4: Case Presentations

Module 5: New Bispecific T-Cell Engagers – Surovatamig

Module 6: Other Novel Agents

Agenda

Module 3: Complications Associated with Bispecific Antibodies

- Cytokine release syndrome (CRS): Cycle 1, median duration 2 to 3 days
- ICANS: Dysgraphia, altered conscious state; ICE score
- Infection: Hypogammaglobulinemia, lymphopenia
- Vaccination; antimicrobial prophylaxis; hepatitis B reactivation

CRS summary

Agent / regimen	Trial	Setting	n	any grade CRS	Grade 1	Grade 2	Grade ≥3
Mosunetuzumab IV	GO29781, pivotal phase II ^{1,2}	≥3L	90	44.4%	25.6%	16.7%	2.2%: G3 1.1%; G4 1.1%
Mosunetuzumab SC	GO29781, pivotal phase II SC cohort ²	≥3L	94	29.8%	20.2%	7.4%	2.1%, all G3
Epcoritamab 2SUD	EPCORE NHL-1, phase II pivotal cohort ³	≥3L	128	66.4%	39.8%	25.0%	1.6%, all G3
Epcoritamab 3SUD	EPCORE NHL-1, phase II optimisation cohort ³	≥3L	86	48.8%	39.5%	9.3%	0%
Epcoritamab + R ² overall	EPCORE FL-1, phase III ⁴	≥2L	243	35%	28%	7%	0%
Epcoritamab + R ² 3SUD	EPCORE FL-1, phase III ⁴	≥2L	133	26%	21%	5%	0%
Mosunetuzumab IV + lenalidomide	CELESTIMO, phase III non- randomised US extension, arm C ⁵	≥2L	54	27.8%	22.2%	3.7%	1.9%, all G3

1. Budde LE, et al. *Lancet Oncol.* 2022;23:1055–1065.
2. Bartlett NL, et al. *Am J Hematol.* 2026;101:986–997.
3. Linton KM, et al. *Lancet Haematol.* 2024;11:e593–e605.
4. Falchi L, et al. *Lancet.* 2026;407:161–173.
5. Sano D, et al. *Blood.* 2025;146(suppl 1):1800 (ASH abstract)

CRS timing and tocilizumab use

Monotherapy cohort	CRS timing	Median duration	Tocilizumab use (%)
Mosunetuzumab IV — GO29781 ^{1, 2}	Predominantly cycle 1	3 days	7.8%
Mosunetuzumab SC — GO29781 ²	All events in cycle 1	2 days	8.5%
Epcoritamab, 2SUD EPCORE NHL-1 ³	Most commonly after first full dose; median onset 15.3 hours after that dose	2 days	24.2%
Epcoritamab, optimised 3SUD EPCORE NHL-1 ³	Most commonly after first full dose; median onset 60.7 hours after that dose	2 days	11.6%

1. Budde LE, et al. *Lancet Oncol.* 2022;23:1055–1065.
2. Bartlett NL, et al. *Am J Hematol.* 2026;101:986–997.
3. Linton KM, et al. *Lancet Haematol.* 2024;11:e593–e605.

ICANS summary in FL bispecific trials

Agent / regimen	Trial / cohort	N	Any-grade ICANS	Severity	Clinical details
Mosunetuzumab IV	GO29781, pivotal phase II ¹	90	4.4% (4/90)	All G1–2; no G≥3	Investigator-assessed neurological events consistent with ICANS: confusion, impaired attention and cognitive disorder; all resolved
Mosunetuzumab SC	GO29781, phase II SC cohort ²	94	3.1%, as reported in US label	All G1; no G≥3	Includes ICANS or suspected ICANS
Epcoritamab SC — 2SUD	EPCORE NHL-1, phase II pivotal cohort ³	128	6.3% (8/128)	G1: 3.9%; G2: 2.3%; no G≥3	Median onset 3.5 days after most recent dose; median resolution 2 days; all resolved; no discontinuations
Epcoritamab SC — 3SUD	EPCORE NHL-1, phase II optimisation cohort ³	86	0%	None	No ICANS reported
Epcoritamab + R ² — both schedules	EPCORE FL-1, phase III overall population ⁴	243	0.4% (1/243)	G1; no G≥2	Single event resolved
Epcoritamab + R ² — 3SUD	EPCORE FL-1, phase III subgroup ⁴	133	0.8% (1/133)	G1; no G≥2	Same event as the overall population
Mosunetuzumab IV + lenalidomide	CELESTIMO, non-randomised US extension, arm C ⁵	54	Not reported	Not reported	ICANS incidence not specified in the published abstract; should not be recorded as 0%

1. Budde LE, et al. *Lancet Oncol.* 2022;23:1055–1065.
2. Bartlett NL, et al. *Am J Hematol.* 2026;101:986–997.
3. Linton KM, et al. *Lancet Haematol.* 2024;11:e593–e605.
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Module 3: Complications Associated with Bispecific Antibodies

Module 4: Case Presentations

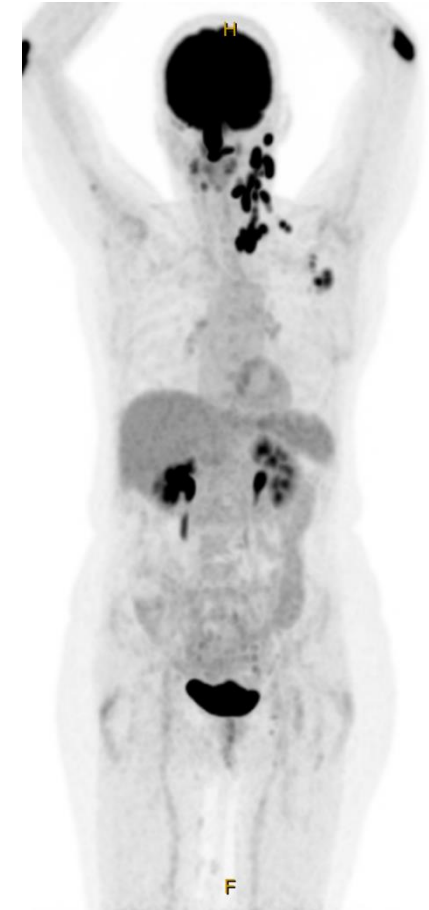
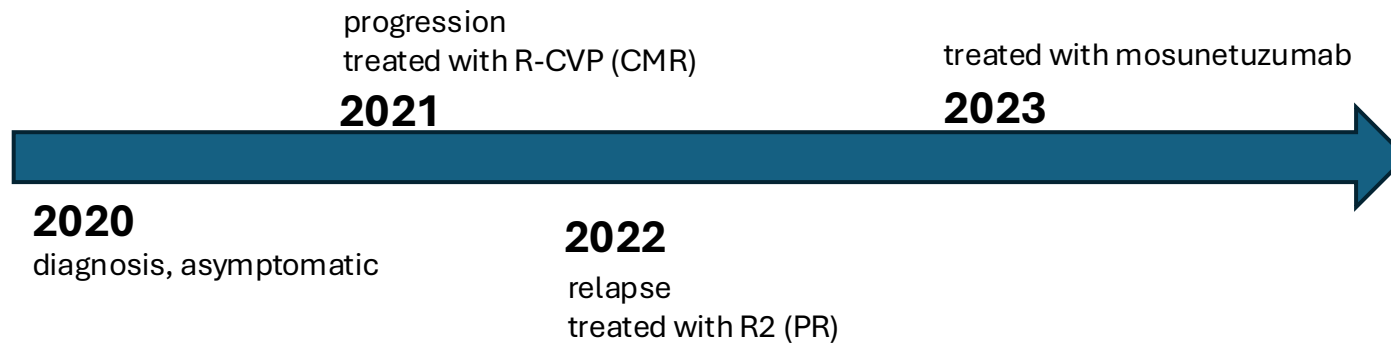
Module 5: New Bispecific T-Cell Engagers – Surovatamig

Module 6: Other Novel Agents

Prof Cheah Case Presentation: 80-year-old woman

PMH

rheumatoid arthritis, T2DM



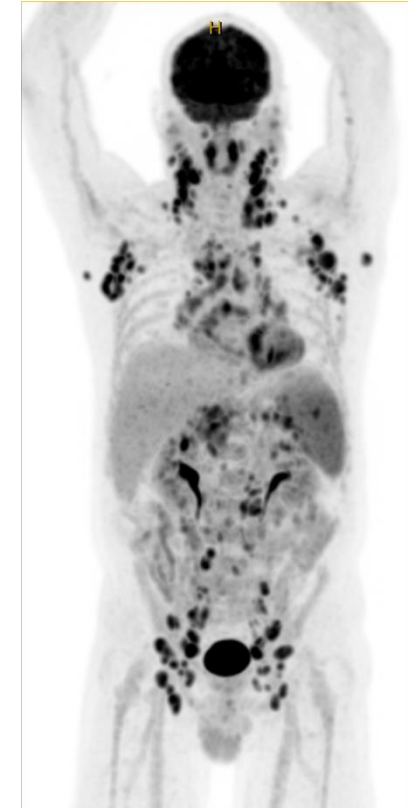
Clinical Progress

- Grade 1 CRS after C1D1
- CMR after cycle 3
- Develops pneumonia in the setting of hypogammaglobulinemia
- Commences IVIg
- Completes 8 cycles
- Ongoing remission 3 years later

Prof Cheah Case Presentation: 56-year-old man

PMH

hypertension, hypercholesterolemia,
smoker, obesity



2014

diagnosis, asymptomatic
W&W

2021

relapse with mediastinal nodes and pleural effusions
offered bispecific study, declines
R-CVP (CMR)

2017

progression with fevers, widespread lymphadenopathy
BR (CMR)

2024 (age 66)

relapse with mediastinal nodes, pleural effusions
treated with epcoritamab + R2

Clinical Progress

- Develops grade 2 CRS requiring steroids, tocilizumab after first full dose of epcoritamab
- Recurrent G2 injection site reactions requiring topical steroids
- Episode of COVID-19 despite vaccination
 - prolonged hospitalisation despite early prescription antiviral therapy
 - 4 days of oxygen requirement
- Completes 12 cycles of therapy
- Remains in CR 1 year later

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Emerging Bispecific Antibody Strategies in FL

Matt Matasar, MD

Chief of Blood Disorders, Rutgers Cancer Institute

Professor of Medicine, Rutgers RWJ Medical School

Key Datasets – Dr Matasar

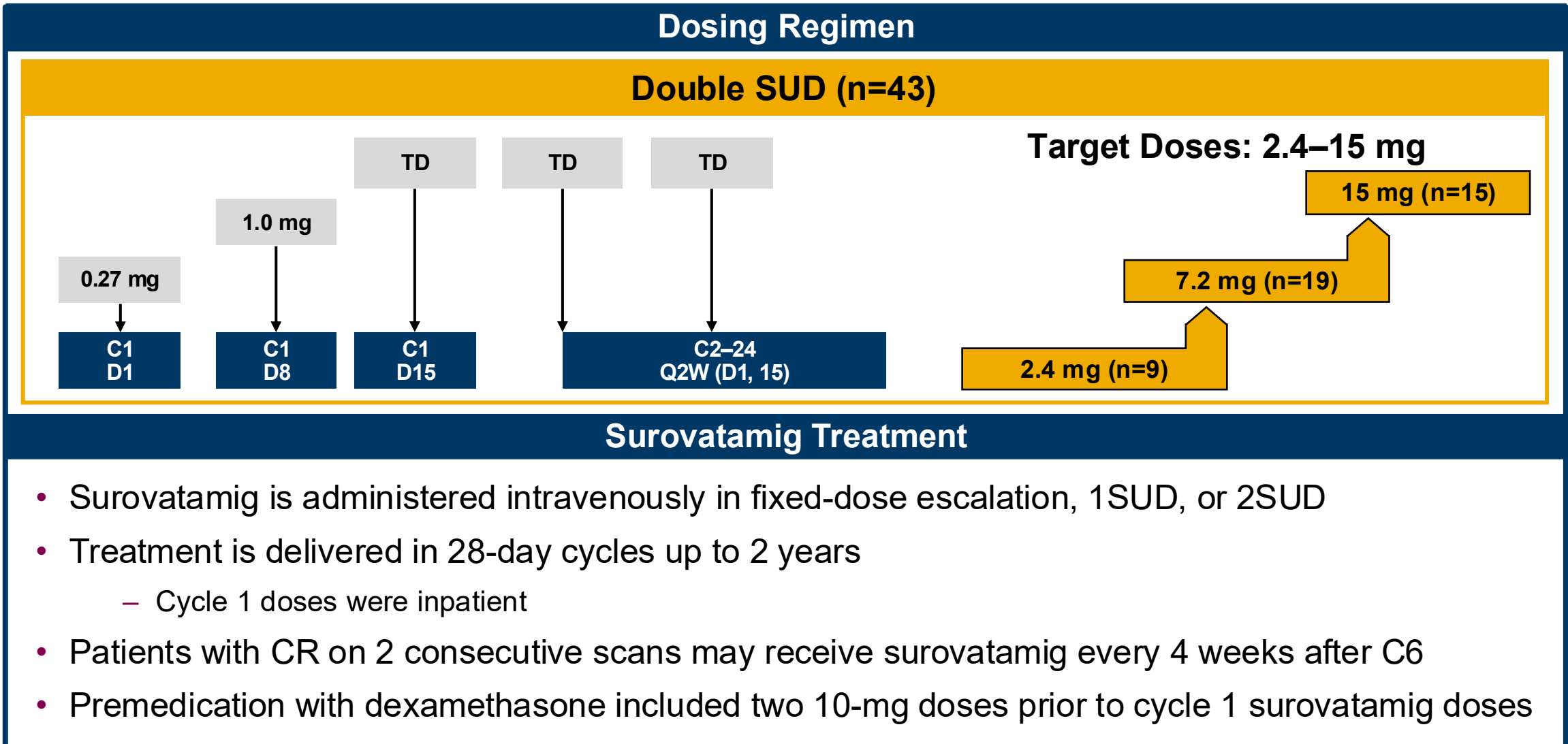
- Braun A et al. Bispecific antibody use in patients with lymphoma and multiple myeloma. *Am Soc Clin Oncol Educ Book* 2024;44(3):e433516.
- Hou JZ et al. Three-year follow-up of the Phase 1 first-in-human study investigating surovatamig, a novel CD19xCD3 T-cell engager, in patients with relapsed/refractory (R/R) follicular lymphoma (FL). ASH 2025;Abstract 1005.
- Cheah CY et al. Surovatamig (AZD0486) plus rituximab in previously untreated follicular lymphoma (FL): Initial safety data from the phase 3 SOUNDTRACK-F1 trial. EHA 2026;Abstract S228.
- Cheah CY et al. SOUNDTRACK-B: A phase 2 single-arm study to evaluate the efficacy and safety of surovatamig (AZD0486) in relapsed or refractory B-cell non-Hodgkin lymphoma. ASH 2025;Abstract 3747.
- Song Y et al. Phase 1 study of MK-1045, a novel CD19xCD3 T-cell engager, in participants with relapsed or refractory follicular lymphoma. ASH 2025;Abstract 5372.
- Wei J et al. CD22-targeted CD28 bispecific antibody enhances antitumor efficacy of odronextamab in refractory diffuse large B cell lymphoma models. *Sci Transl Med* 2022;14(670):eabn1082.

Agenda

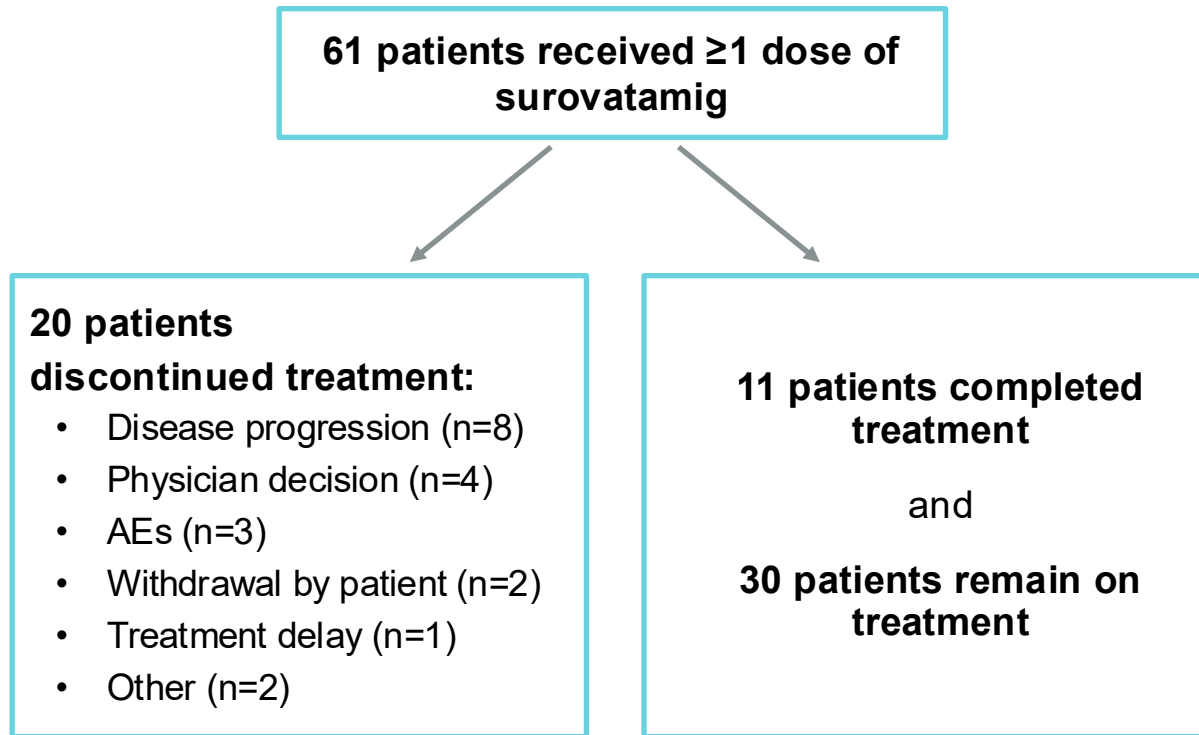
Module 5: New Bispecific T-Cell Engagers – Surovatamig

- Efficacy: Quick MRD-negative durable responses
- Toxicity:
 - CRS
 - ICANS: FL vs large cell lymphoma
 - Infections
- Case presentation: 57-year-old man
- Key ongoing trials
 - SOUNDTRACK-F1: Surovatamig/rituximab $\pm$ surovatamig maintenance vs chemoimmunotherapy + rituximab maintenance
 - SOUNDTRACK-B: Surovatamig monotherapy for R/R FL and R/R DLBCL
 - Multinational investigator-initiated study Stage I/II FL: Surovatamig vs involved-site radiation therapy (ISRT) $\pm$ rituximab

Surovatamig Phase 1 Study Design



Patients Were Heavily Pretreated



- Median study follow-up for TDs ≥ 2.4 mg: 16 mo (range 1–40)

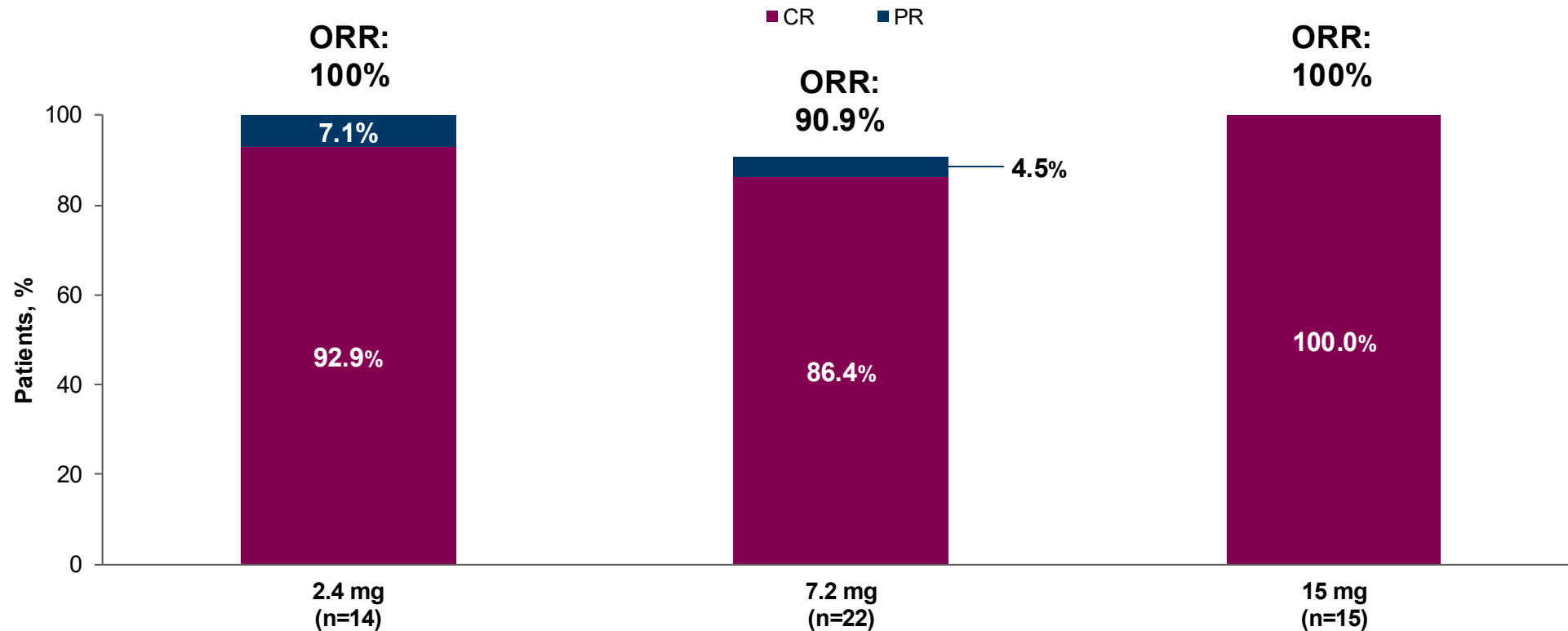
Characteristic	N=61 ^a
Age, median (range), y	63 (33–86)
ECOG PS 2, n (%)	2 (3)
Ann Arbor stage III–IV, n (%)	49 (80)
CD20-negative disease at study entry, n (%)	10 (16)
Bulky disease, ^b n (%)	13 (21)
POD24, n (%)	22 (36)
Median prior lines of therapy (range)	3 (2–11)
3–4 lines, n (%)	27 (44)
≥ 5 lines, n (%)	9 (15)
Refractory to last line of therapy, ^c n (%)	32 (52)
Prior types of treatment, n (%)	
R-CHOP	37 (61)
Lenalidomide	26 (43)
CD19-directed CAR T	7 (11)
CD20 TCE	5 (8)
Allogeneic or autologous SCT	3 (5)

^aRacial demographics included White (56%), Asian (38%), Black or African American (2%), and not reported (5%); 59% of study participants were male, 41% were female

^bDefined as having the longest diameter ≥ 7 cm at baseline target lesion assessment or having 3 or more lesions that are ≥ 3 cm each

^cDefined as SD/PD as best response from last prior line of therapy or if disease progression occurred within 6 months of the last prior cancer therapy end date

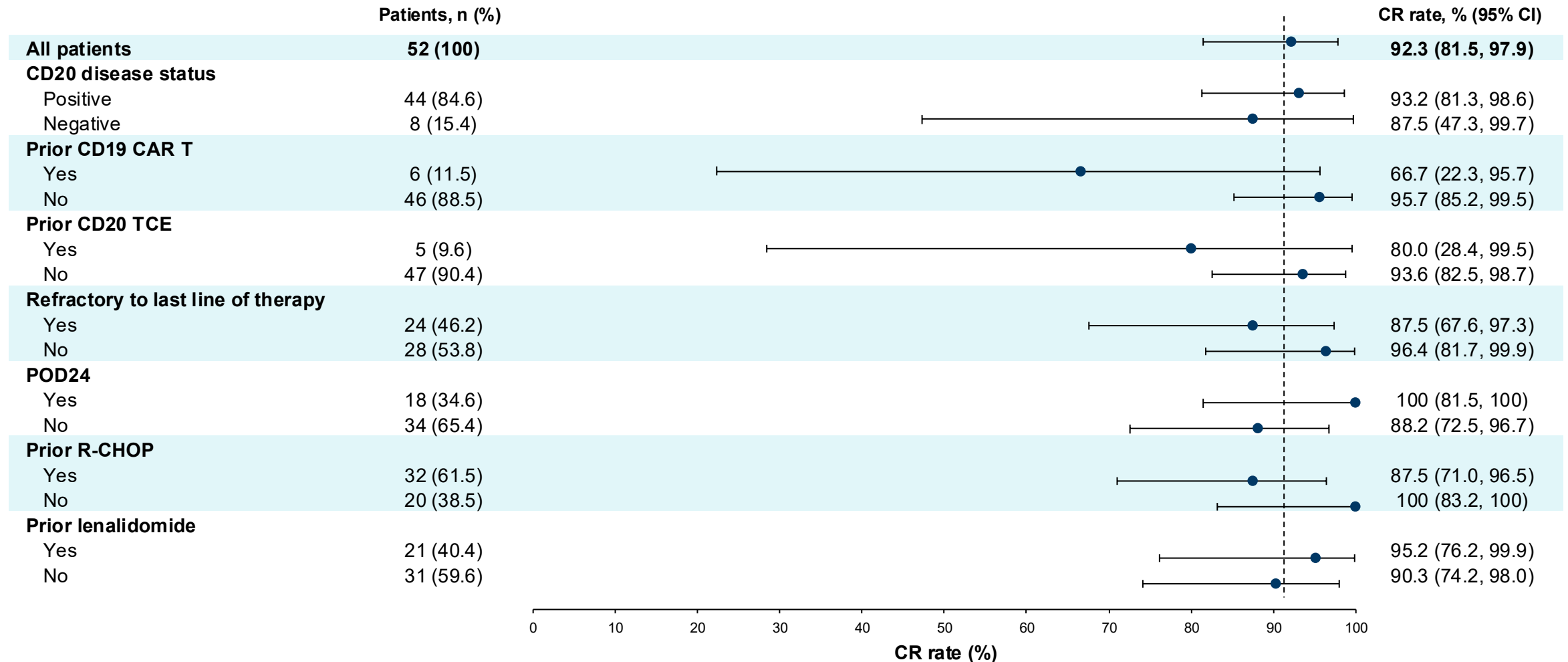
High Response Rates Observed at All Target Doses



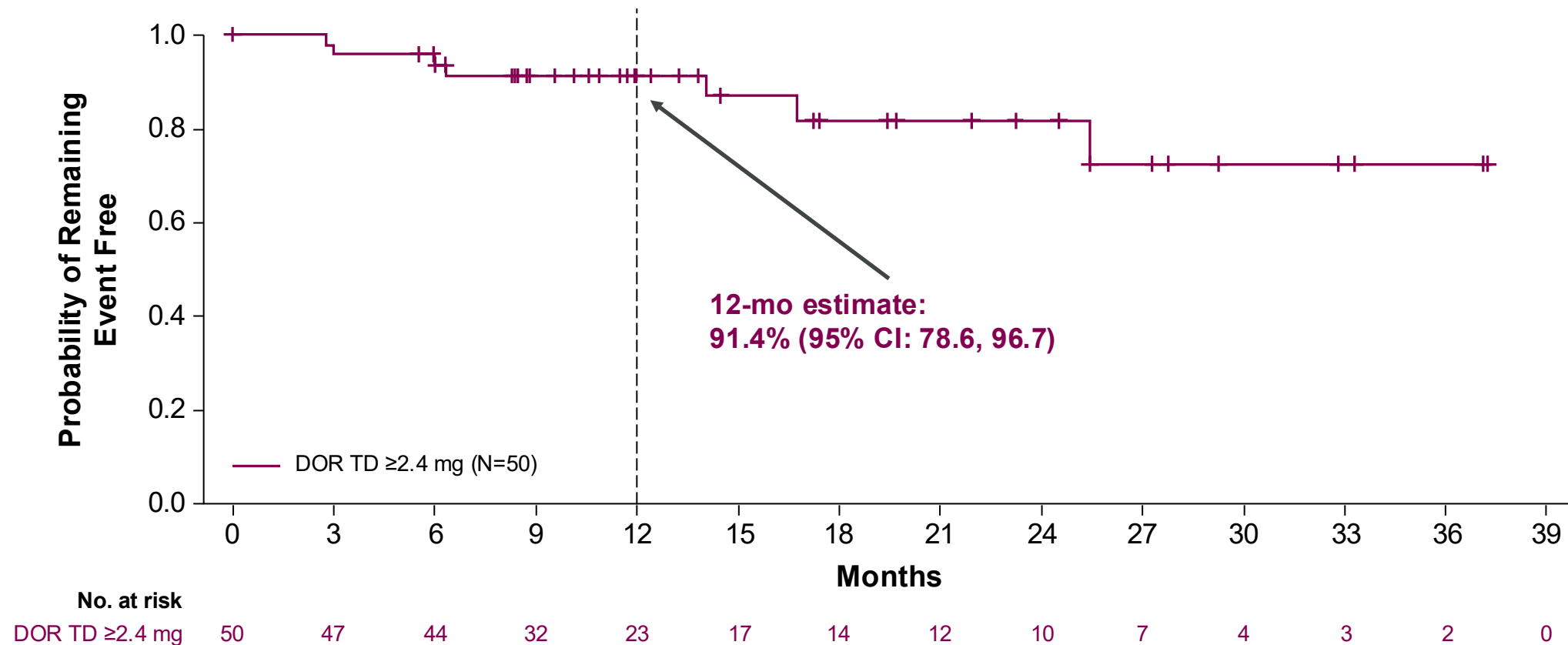
- ORR/CR rate for patients who received ≥ 2.4 mg was 96%/92%
- In the ITT population, ORR/CR rates were 100%/93%, 87%/83% and 100%/100% in the 2.4-mg, 7.2-mg and 15-mg cohorts, respectively^a

^aITT population includes 1 additional patient who discontinued prior to response assessment due to AE at 7.2 mg TD

High CR Rates Overall and in High-Risk Populations for TD ≥ 2.4 mg

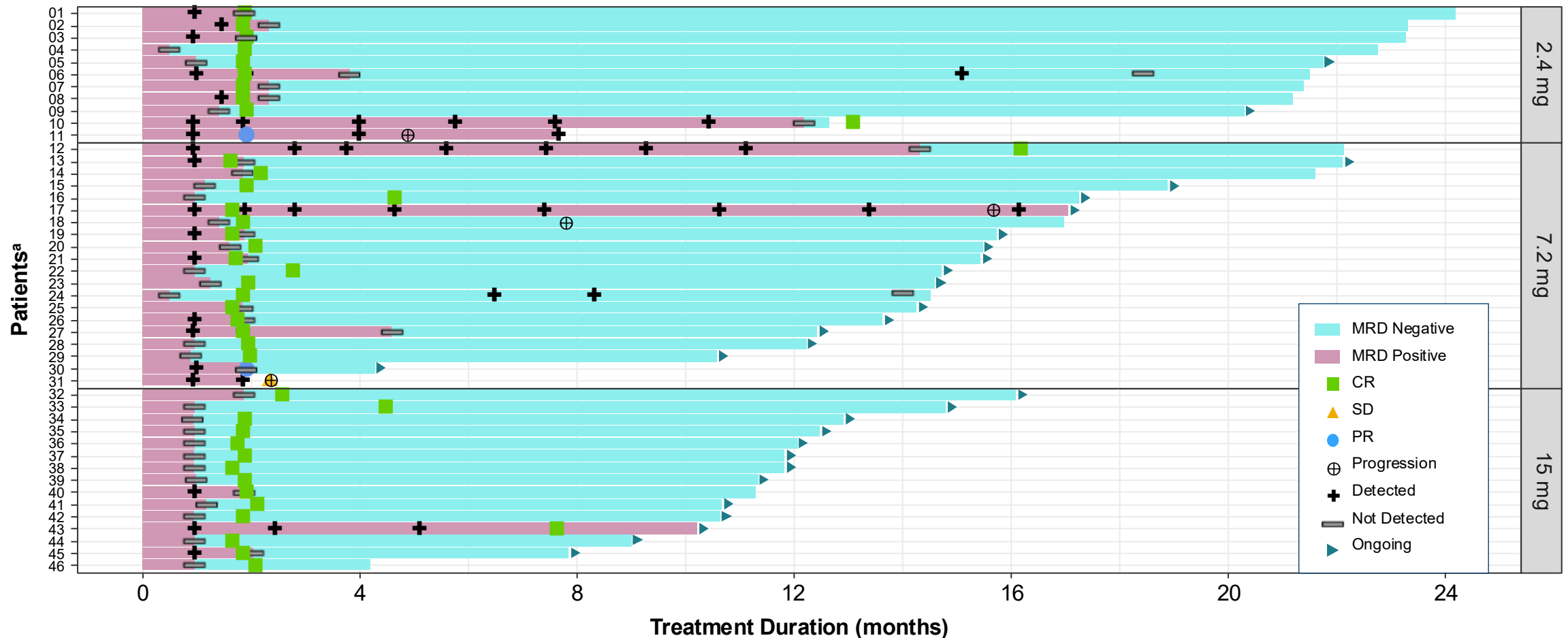


Durable Responses Observed, Including in Patients With Prior CD20 TCE and/or CD19 CAR T



- All 8 patients with prior CD20 TCE therapy and/or CD19 CAR T who achieved CR with surovatamig remain in CR
- All 11 patients who completed surovatamig treatment remain in CR off treatment

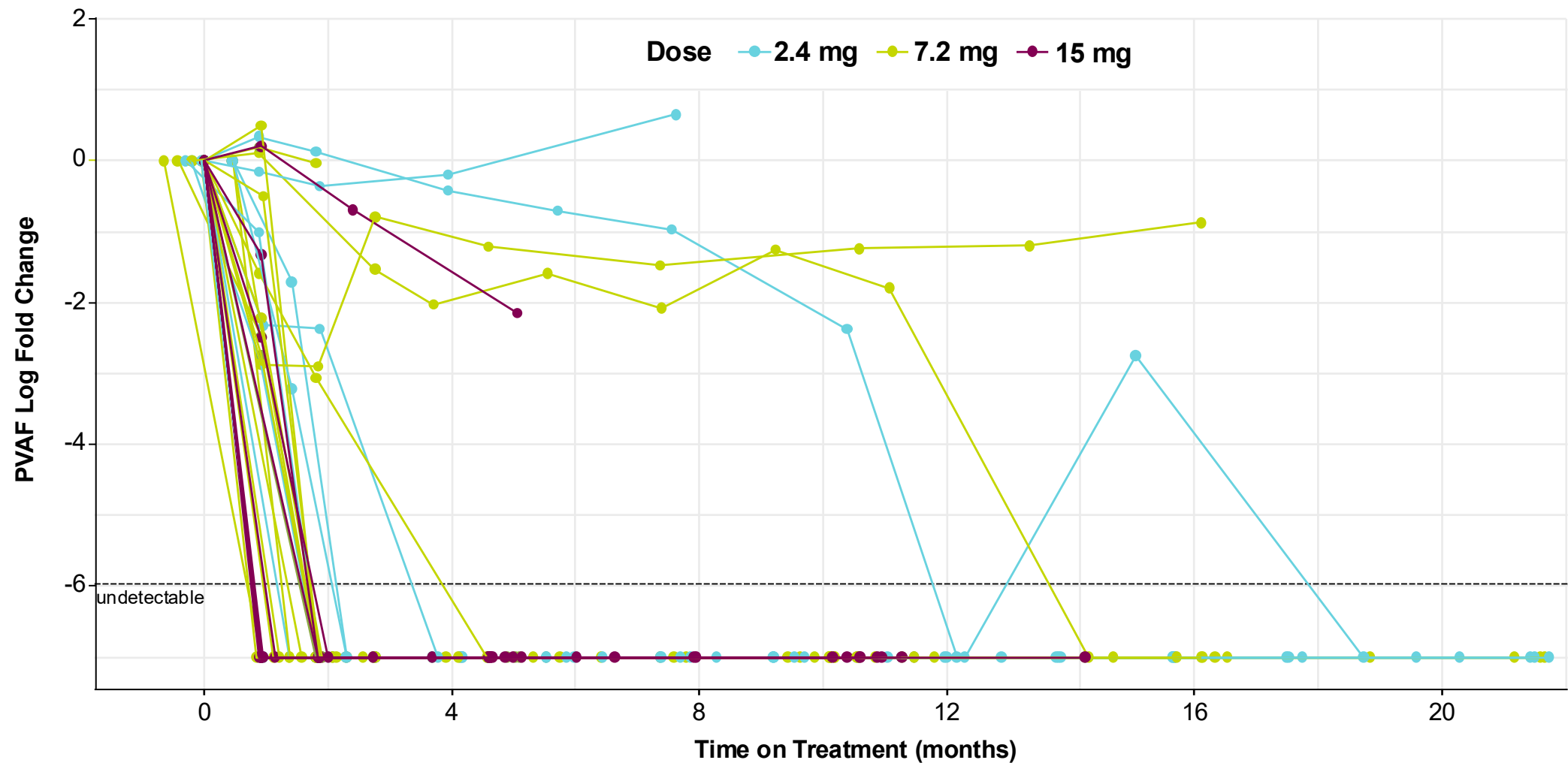
MRD Negativity Correlated With Durable Responses



- 95% (41/43) of MRD-evaluable patients with CR had undetectable MRD
- 12-month PFS estimates were 97% for patients with undetectable MRD and 50% for patients with detectable MRD

^aOnly patients with BOR $\geq$ SD

Rapid Clearance of ctDNA in MRD Responders



ctDNA assessed by PhasED-Seq

Adverse Events in All Patients

Most common AEs (≥20%), n (%)	Any grade	Grade 3	Grade 4
CRS	35 (57)	0	0
COVID-19	20 (33)	2 (3)	0
Headache	20 (33)	0	0
Nausea	19 (31)	0	0
Diarrhea	18 (30)	0	0
Cough	17 (28)	1 (2)	0
Fatigue	15 (25)	1 (2)	0
Neutropenia	14 (23)	9 (15)	3 (5)
Hypogammaglobulinemia	14 (23)	0	0
Hypertension	13 (21)	5 (8)	0

- Infections occurred in 43 (70%) patients (grade 3/4: n=8 [13%]; grade 5: n=2 [3%])
 - The most common infections (≥5%) were COVID-19, upper respiratory tract infection, pneumonia, sinusitis, nasopharyngitis, rhinitis, and UTI

Two grade 5 events were reported (COVID-19 and sepsis)

Summary of CRS With 2SUD

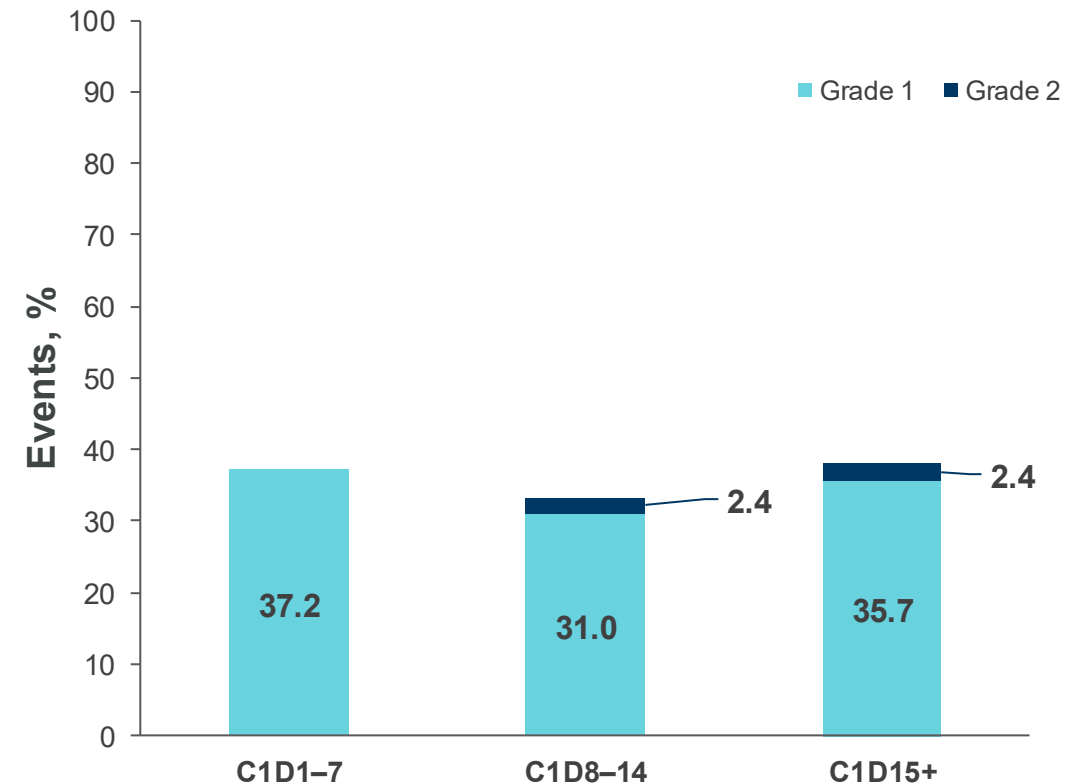
n (%) unless stated	n=43
Any grade CRS^a	22 (51)
Grade 1	21 (49)
Grade 2	1 (2)
Median time to CRS onset,^{b,c} h (range)	16 (5–42)
Median CRS duration,^c h (range)	21 (1–47)
CRS management	
Tocilizumab	5 (12)
Corticosteroids	3 (7)
CRS resolution	22 (100)

^aFor each patient, CRS events are counted once at the maximum grade reported

^bFrom time of infusion to CRS

^cData include doses administered per protocol dose and schedule

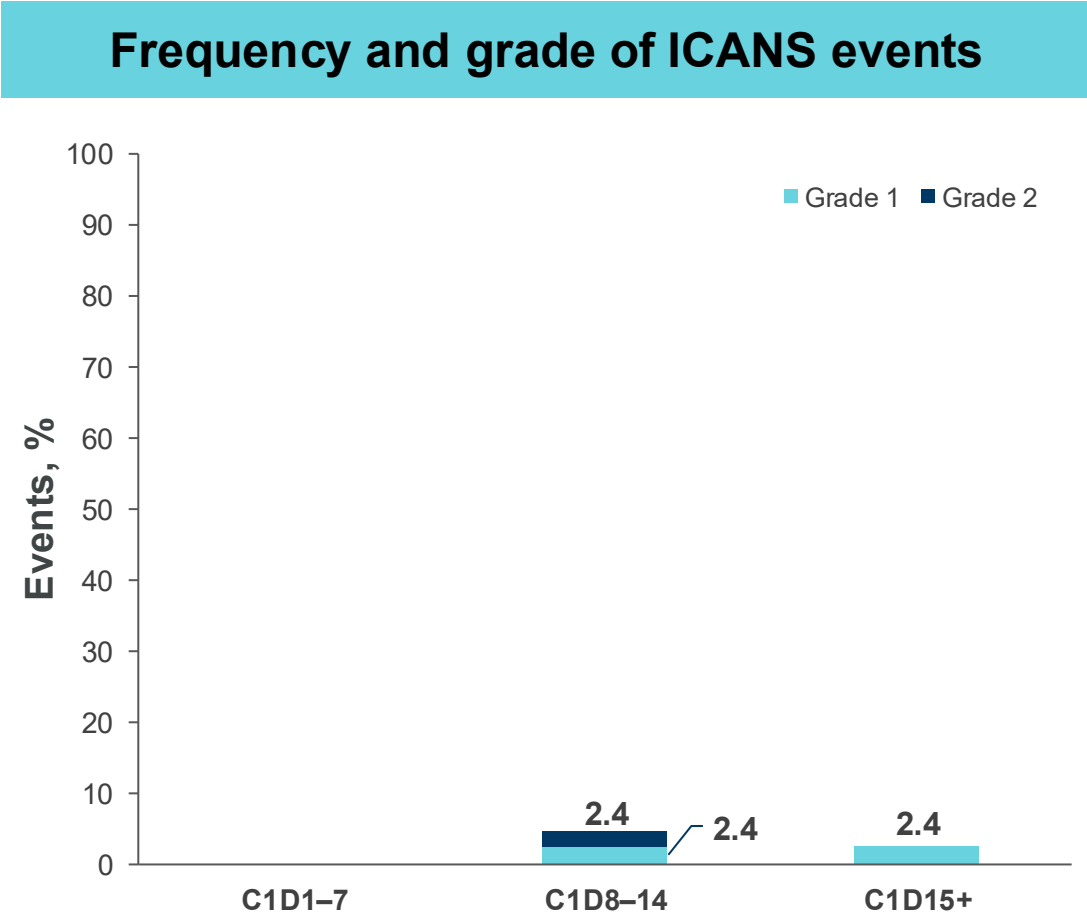
Frequency and grade of CRS events



Summary of ICANS With 2SUD

n (%) unless stated	n=43
Any grade ICANS ^a	2 (5)
Grade 1	1 (2)
Grade 2	1 (2)
Median time to ICANS onset, ^{b,c} h (range)	34 (20–50)
Median ICANS duration, ^c h (range)	21 (9–25)
ICANS management	
Dexamethasone	0
ICANS resolution	2 (100)

^aFor each patient, ICANS events are counted once at the maximum grade reported
^bFrom time of infusion to ICANS
^cData include doses administered per protocol dose and schedule



Conclusions

- Surovatamig treatment is well tolerated and leads to durable responses in patients with heavily pretreated R/R FL, including those with prior exposure to CD19 CAR T or CD20 TCEs
- CR rate of 92% in R/R FL at target doses ≥ 2.4 mg
- 95% of MRD-evaluable patients with CR achieved undetectable MRD
- All CRS and ICANS events were low grade with 2SUD
- Phase 2 and 3 trials of surovatamig in R/R FL and treatment-naive FL are underway (NCT06526793 and NCT06549595, respectively)

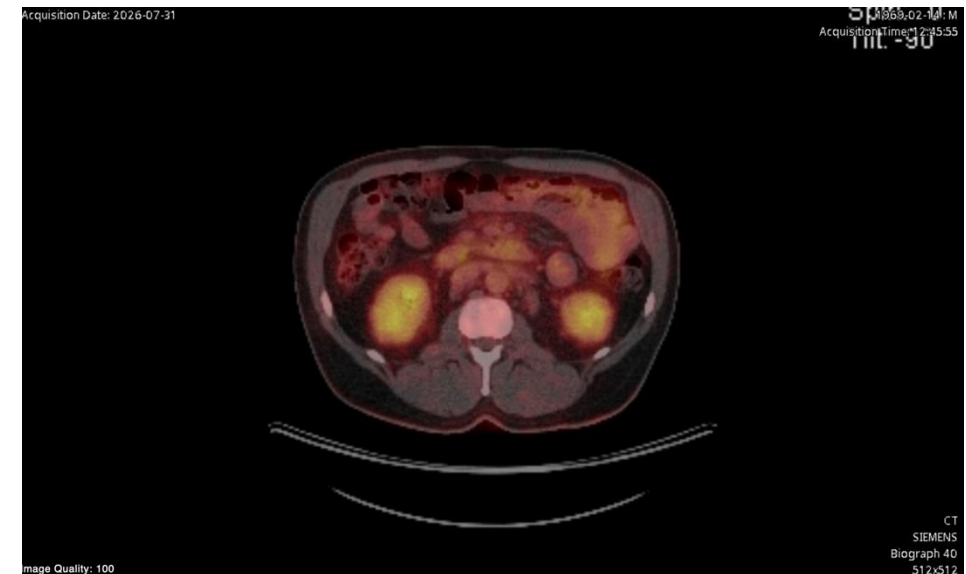
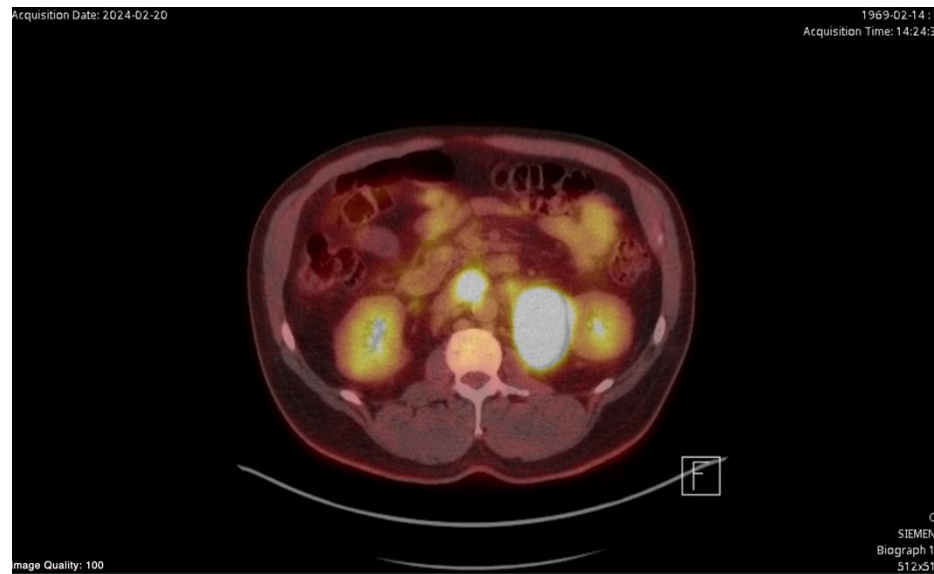
Dr Matasar Case Presentation: 57-year-old man

57-year-old man without major medical history, competitive rucker, diagnosed with Gr3BFL in 2022, treated with RCHOPx6, achieving a PR, bx confirmed 3BFL. Treated with 2L lisocel without bridging 10/2022, achieving a CR. Relapsed 11/2023 with low-grade FL, CD19+CD20+. PET imaging revealed diffuse lymphadenopathy without variable/high grade FDG avidity. Labwork with normal CBC and LDH, patient reported fatigue that did not limit activities other than competitive sport.

Presented options including lenalidomide-based treatment, CD20 bispecifics, clinical trial with surovatamig, which he opted for

Dr Matasar Case Presentation: 57-year-old man (continued)

Pt selected clinical trial participation with surovatamig, started February 2024. Tolerated SUD without CRS/ICANS, achieved CR at first restaging. Completed 24 cycles January of 2026, ongoing CR off treatment

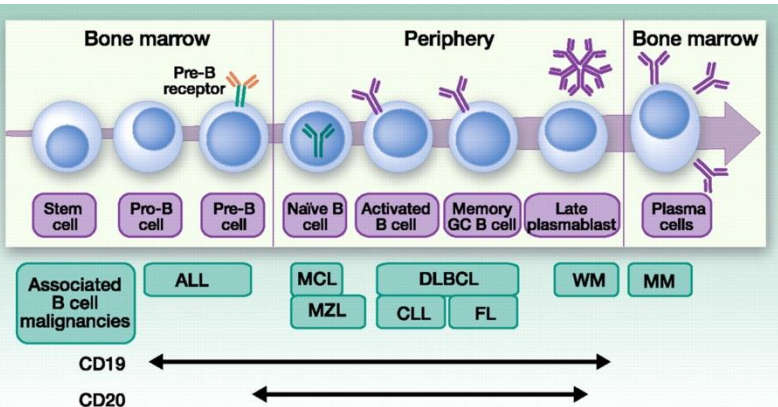


Surovatamig in FL – Next steps

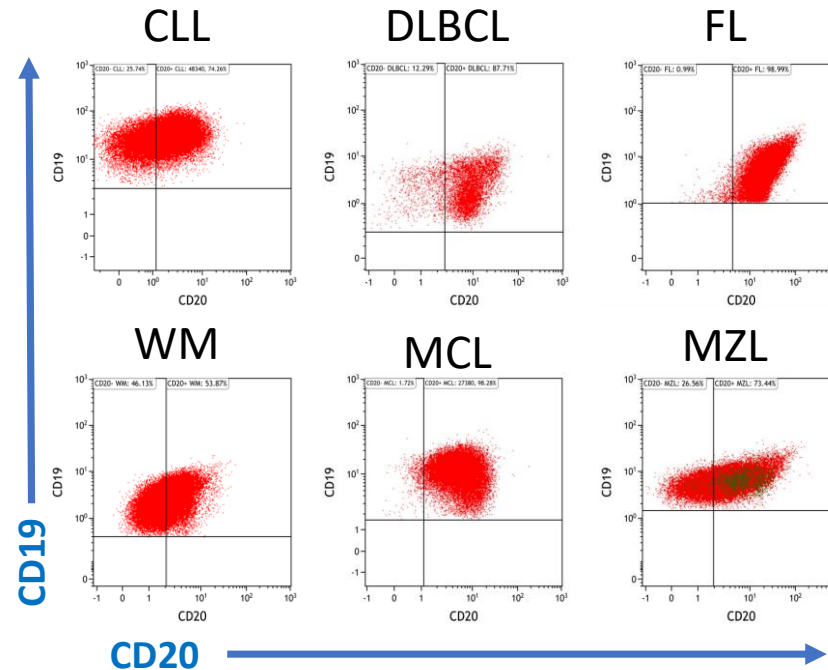
Combination of Surovatamig + Rituximab: Rationale

Dual CD19 + CD20 targeting overcome limitations of CD20

- CD19 is a surface receptor present on neoplastic B cells that has a broader expression than CD20 making it an attractive target for B-cell malignancies.
✓ Effectiveness of targeting CD19 has been validated by CD19 CAR T-cells therapy

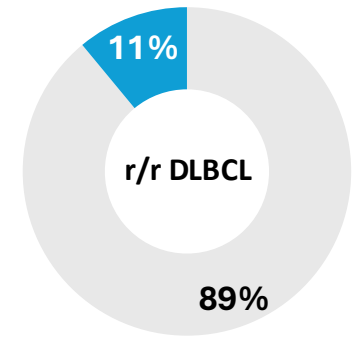


- CD20 antigen expression variable due to tumor heterogeneity



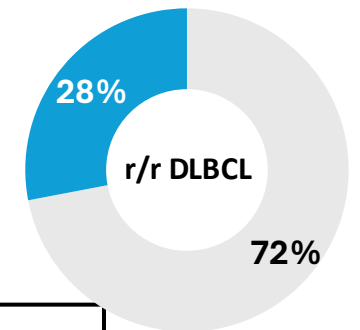
- CD20 antigen frequently lost after CD20-targeted therapy

11% (7/62)
CD20 LOW
at baseline



Treatment with
CD20xCD3

28% (8/29)
CD20 LOST
at progression

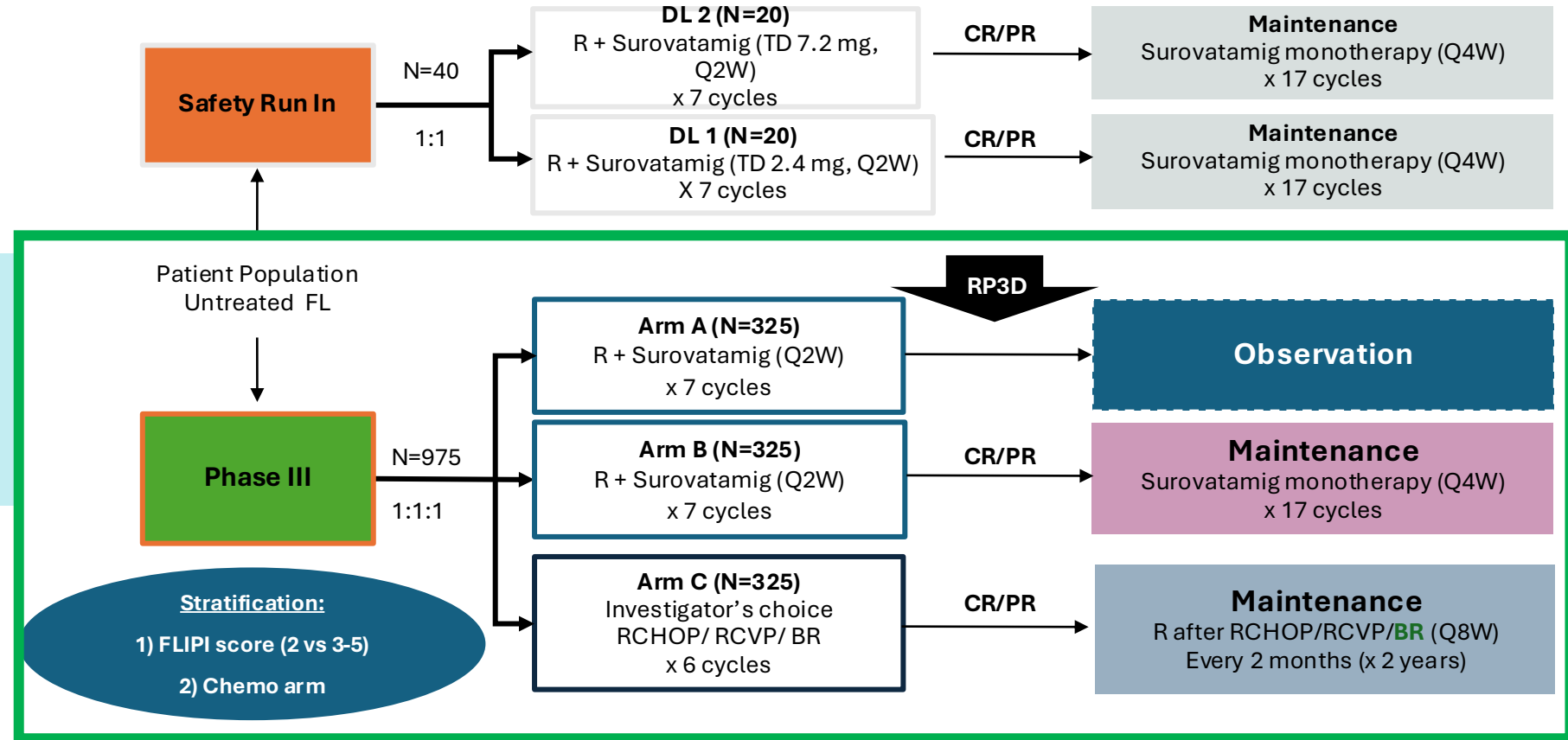


Dual targeting: has potential to lead to **deeper and longer remissions** in B-cell malignancies

SOUNDTRACK-F1: Trial Design

Target population:

- Treatment naïve FL
- Meet GELF criteria
- **[Ph3]: Excluding**
 - **Stage I**
 - **FLIPI 0/1**

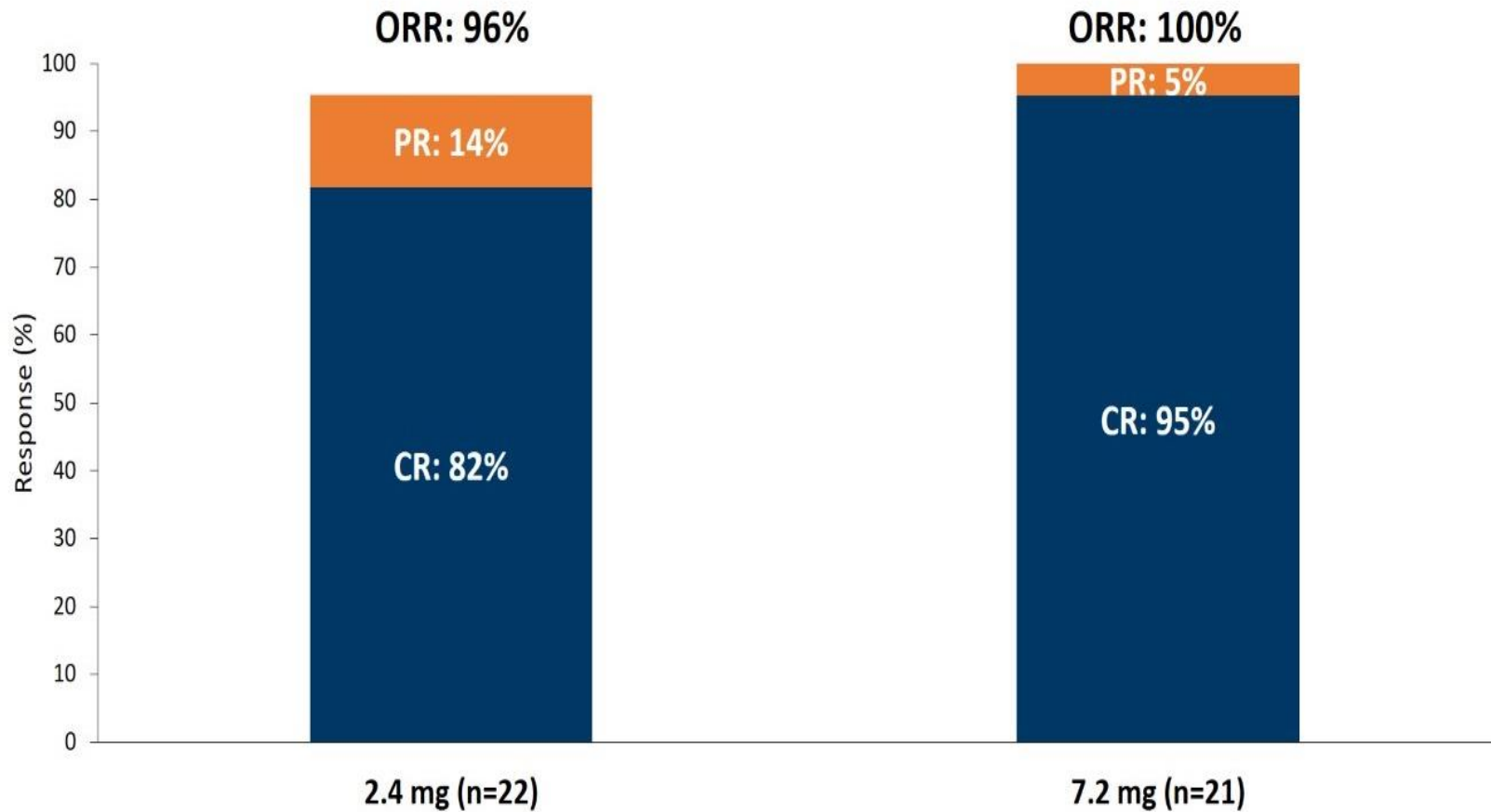


Endpoints:

- **Primary:**
 - Safety Run-in: Safety and tolerability of Surovatamig + R and RP3D determination
 - Phase III: **Dual primary with PFS & EoI ORR** assessed by IRC based on Lugano Response Criteria
- **Secondary:**
 - Safety Run-in: Efficacy (ORR, CRR, CR@EOI, CR30, DoR, PFS, OS), PK/PD/Immunogenicity
 - Phase III: Efficacy (**OS: Key Secondary**), ORR, CRR, ER EoI, CR30, DoR, PFS, TTNT), safety, PK/Immunogenicity, PRO, MRD-ve CR rate

B: Bendamustine; CNS: Central nervous system; CR: complete response; CR30: complete response at 30 months; DL: Dose level; DoR: Duration of Response; EOI: end of induction; FL: Follicular Lymphoma; MRD: Minimal residual disease; ORR: Overall response rate; PB: peripheral blood; OS: Overall survival; PFS: progression free survival; PR: partial response; PRO: Patient reported outcome; QxW: every x weeks; R: rituximab; RP3D: recommended Ph3 dose; SOC= standard of care; TD= target dose; TTNT: Time to next treatment

SOUNDTRACK-F1: High Response Rates Across Both Doses

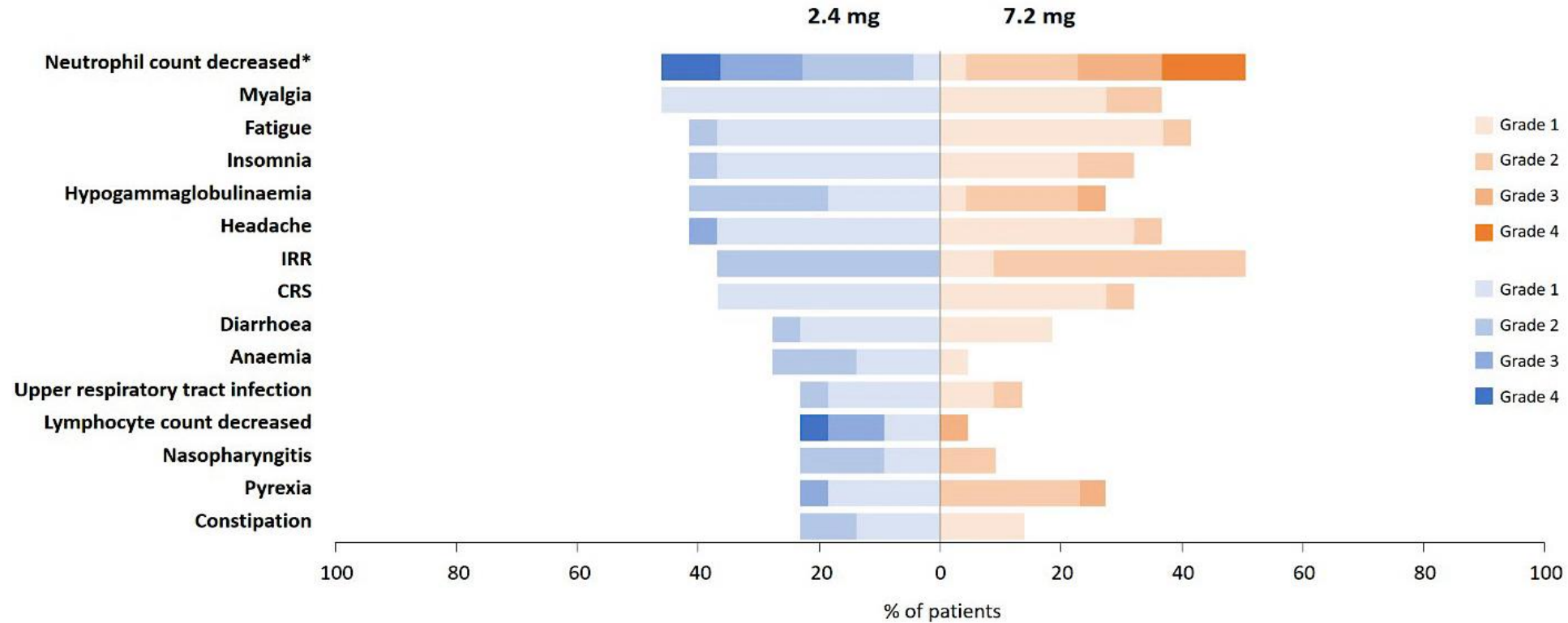


Data cutoff: 19 January 2026.

CR, complete response; ORR, overall response rate; PR, partial response.

SOUNDTRACK-F1: Safety Summary by Dose Level

Most common AEs (≥20% of patients in either arm) by grade



Data cutoff: 19 January 2026.

*Includes both 'neutrophil count decreased' and 'neutropenia'. AE, adverse event; CRS, cytokine release syndrome; IRR, infusion-related reaction.

Agenda

Module 5: New Bispecific T-Cell Engagers – Surovatamig

- Efficacy: Quick MRD-negative durable responses
- Toxicity:
 - CRS
 - ICANS: FL vs large cell lymphoma
 - Infections
- Case presentation: 57-year-old man
- Key ongoing trials
 - SOUNDTRACK-F1: Up-front surovatamig/rituximab $\pm$ surovatamig maintenance vs chemoimmunotherapy + rituximab maintenance
 - SOUNDTRACK-B: Surovatamig monotherapy for R/R FL and R/R DLBCL
 - Multinational investigator-initiated study Stage I/II FL: Surovatamig vs involved-site radiation therapy (ISRT) $\pm$ rituximab

Agenda

Prologue: Saturday Night Fever

Module 1: Baby Boomers' Guide to Mechanisms of Action

Module 2: Second-Line Treatment

Module 3: Complications Associated with Bispecific Antibodies

Module 4: Case Presentations

Module 5: New Bispecific T-Cell Engagers – Surovatamig

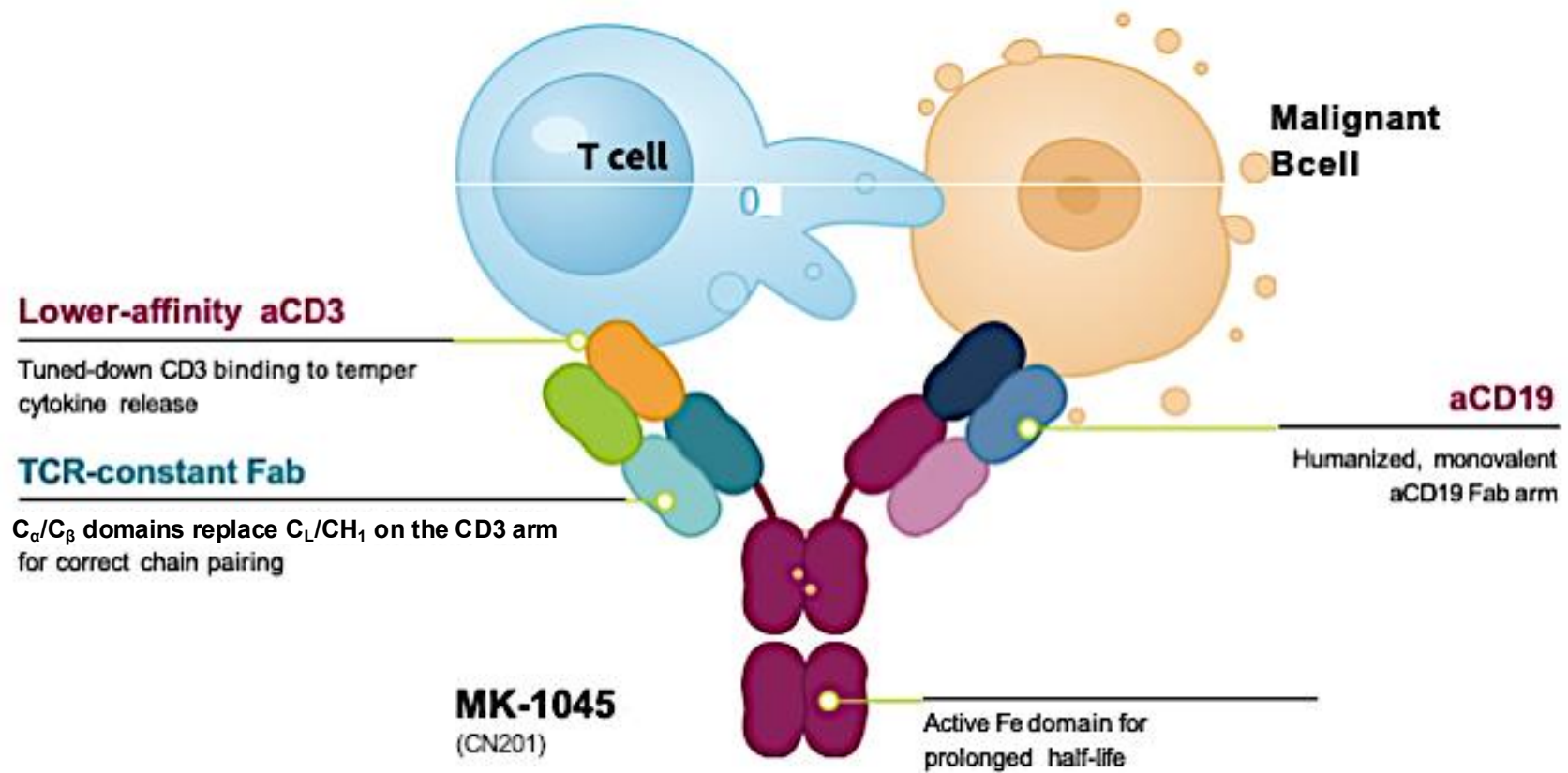
Module 6: Other Novel Agents

Agenda

Module 6: Other Novel Agents

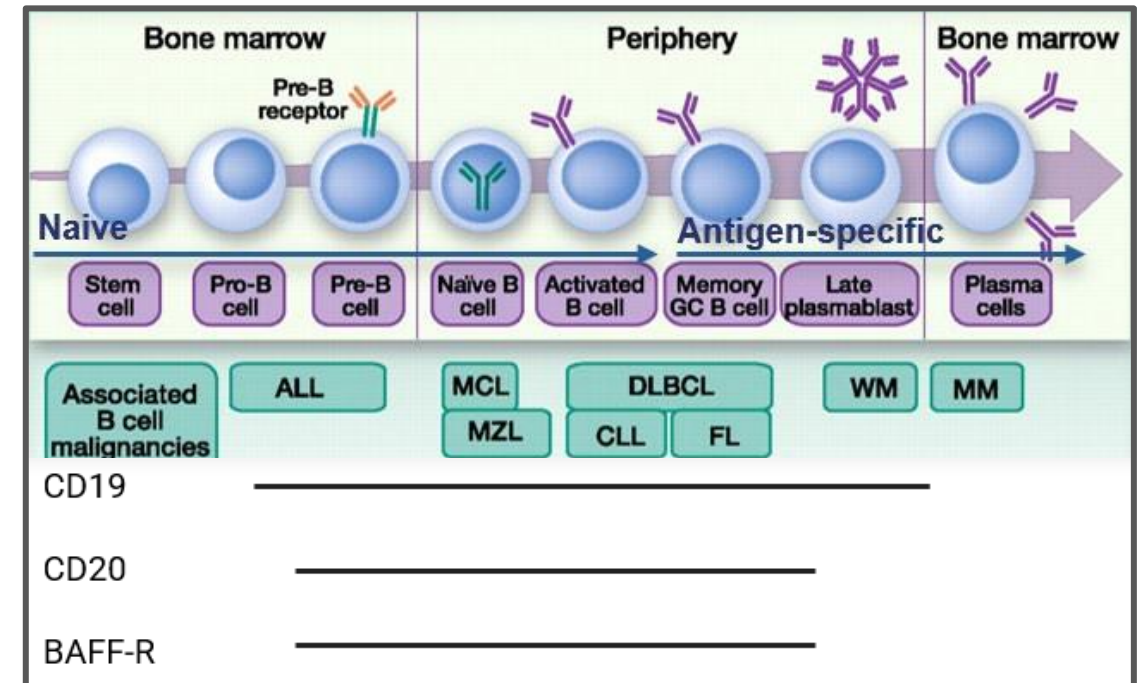
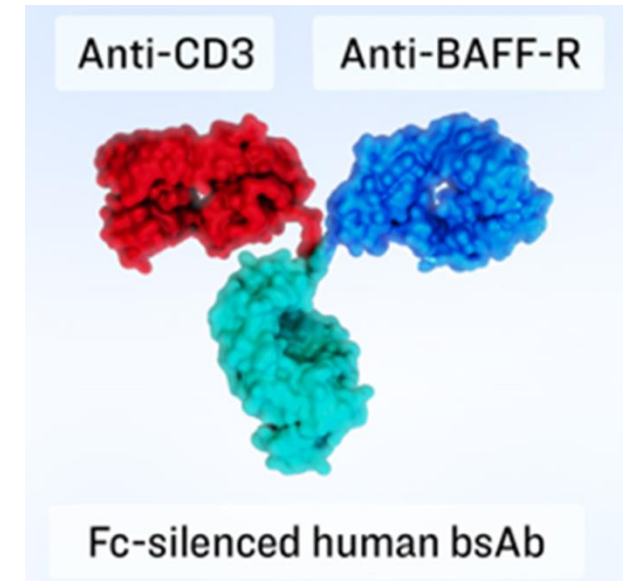
- MK-1045: CD19 x CD3 bispecific antibody
- **BAFF-R: B-cell activating factor receptor**
- Case presentation: 88-year-old man – Phase I ATHENA-1 trial of odronextamab + REGN5837 for R/R B-cell lymphoma (Signal 1/Signal 2)

MK-1045: Another CD19xCD3 Candidate



LY4152199: BAFF-R x CD3

- BAFF-R (B cell activating factor of the TNF-family receptor) is a surface-expressed B cell marker
- BAFF-R is expressed by the majority of B cells and is essential to B-cell development and survival
- CD20/CD19 antigen loss may deleteriously affect long-term responses to CD20 and CD19 targeted therapies
- BAFF-R expression is unaffected by CD20/CD19 antigen loss
- Novel BAFF-RxCD3 bispecific antibody to treat B-cell malignancies, including rescue of relapsed or refractory cancers previously treated with CD20 and/or CD19 therapies



Novel strategy: Dual BsAb to recapitulate signal 1 + signal 2: Odronextamab + REGN5837

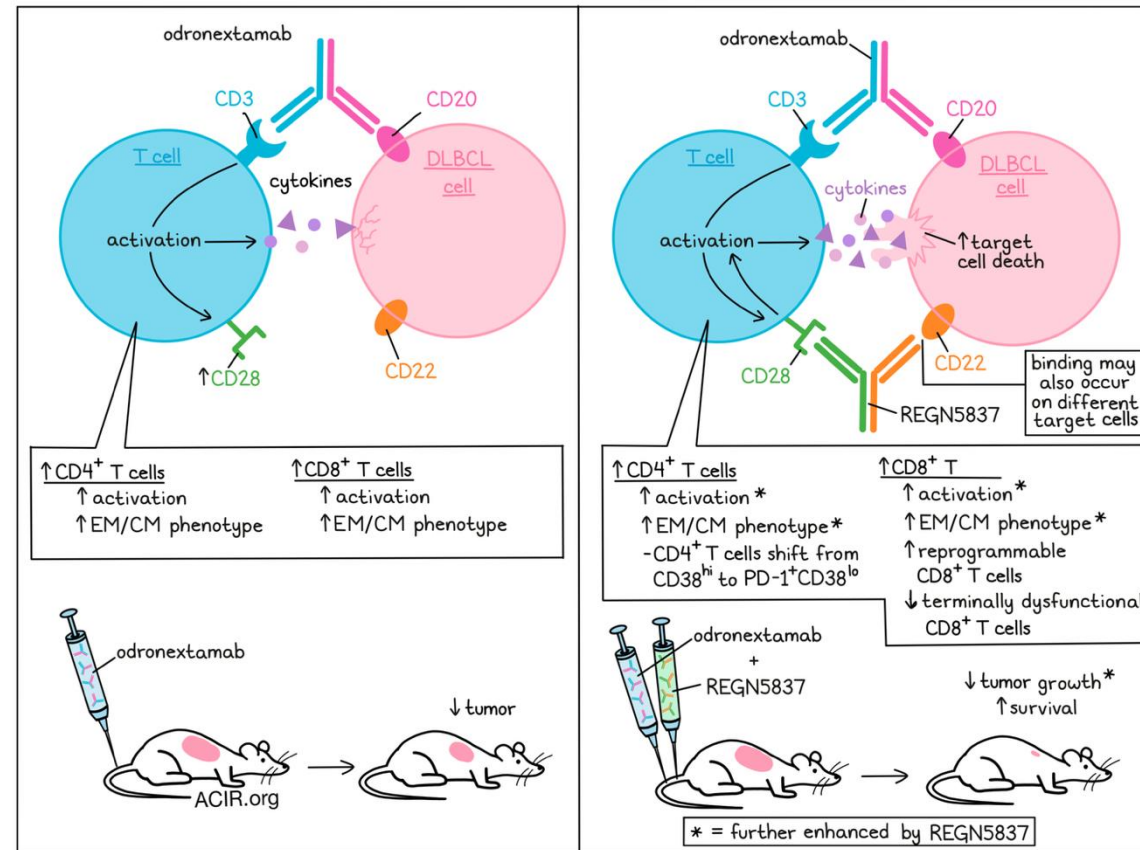


Image taken from Acir.org
Wei J et al. Sci Transl Med. 2022

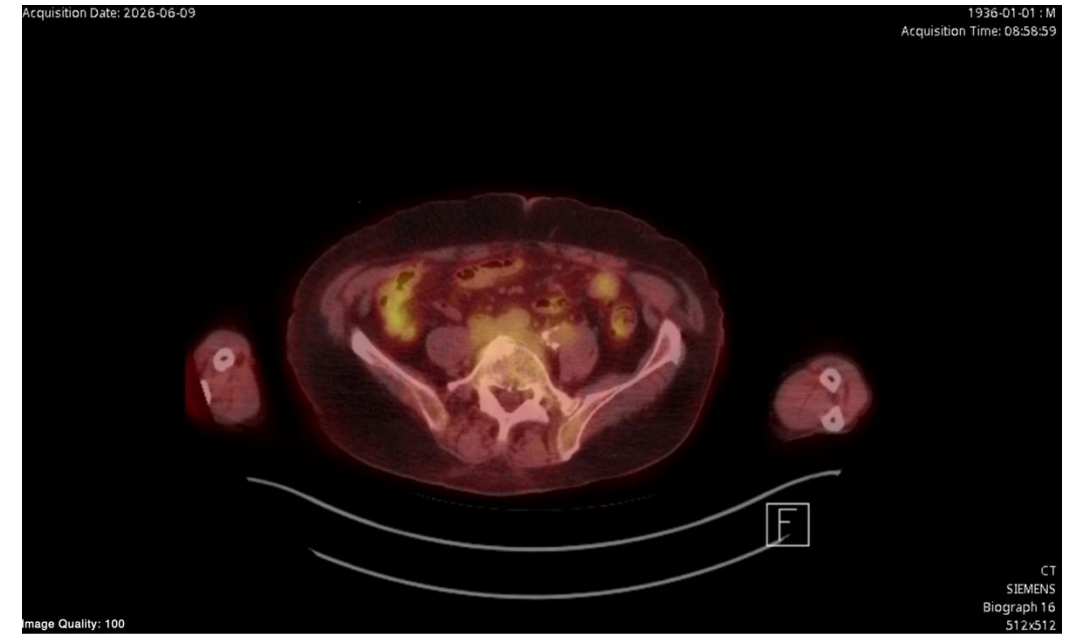
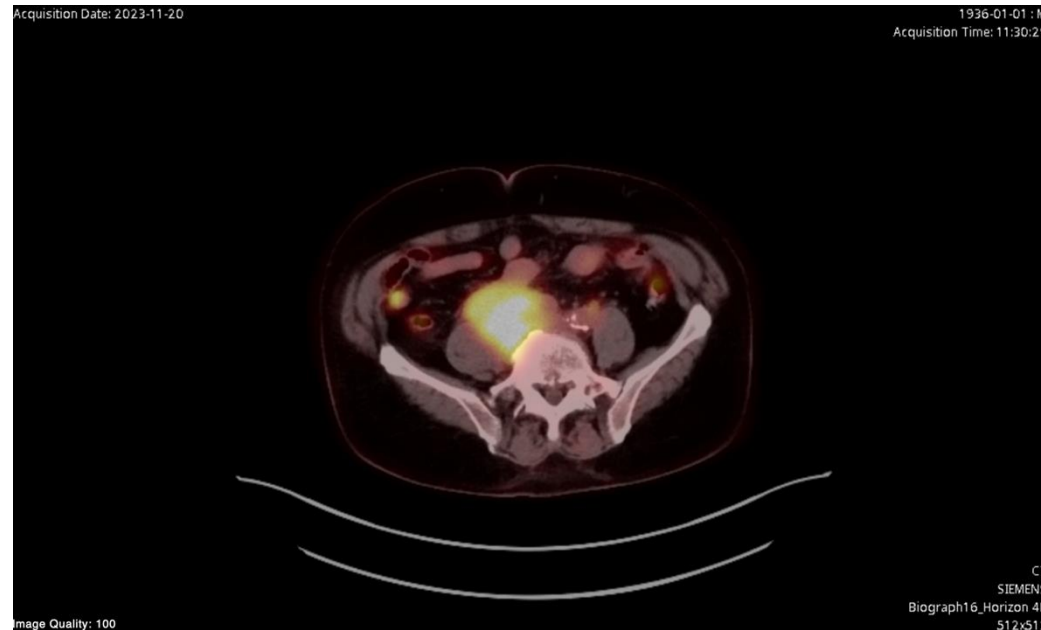
Case Presentation – 88-year-old man

88-year-old man with a history of low-grade FL diagnosed in 2010 at age 76, treated with BR for four cycles, then a brief course of rituximab maintenance. He experienced systemic relapse in 2013, biopsy revealing transformation, and he was treated with RCHOP x6 achieving a CR. He relapsed 5 years later in 2018 with low-grade FL, treated with rituximab and lenalidomide for 9 months achieving a CR and was monitored. Four years later, he received rituximab monotherapy for a systemic relapse, and consolidative RT to the right inguinal region for localized persistent avidity. He presented in April of 2024 with progressive FL causing progressive fatigue, biopsy showed FL, grade 3A.

Reviewed options including clinical trials, and pt preferred ATHENA-1 (odronextamab + REGN5837) over standard of care mosunetuzumab.

Case Presentation – 88-year-old man (continued)

Tolerated SUD of odronextamab with only Gr1 CRS, tolerated addition of REGN5837 uneventfully, achieved CR at first response evaluation, continued and completed therapy 4/2026, in ongoing CR subsequently



Agenda

Module 6: Other Novel Agents

- MK-1045: CD19 x CD3 bispecific antibody
- BAFF-R: B-cell activating factor receptor
- Case presentation: 88-year-old man – Phase I ATHENA-1 trial of odronextamab + REGN5837 for R/R B-cell lymphoma (Signal 1/Signal 2)

Cancer Conference Update: ESMO Congress 2026 Review — Breast Cancer

A CME/MOC-Accredited Live Webinar

**Thursday, November 12, 2026
5:00 PM – 6:30 PM ET**

Faculty

Professor Giuseppe Curigliano, MD, PhD

Rebecca A Dent, MD, MSc

Komal Jhaveri, MD, FACP, FASCO

Moderator

Neil Love, MD

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Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us.

The survey will remain open for 5 minutes after the meeting ends.

Information on how to obtain CME and ABIM MOC credit is provided in the Zoom chat room.

Attendees will also receive an email in 1 to 3 business days with these instructions.