Fifth Annual
National General Medical Oncology Summit

A Multitumor CME/MOC-, NCPD- and ACPE-Accredited Educational Conference Developed in Partnership with

Florida Cancer Specialists & Research Institute

Friday, April 24, 2026

Moderator

Neil Love, MD

Faculty

Manali Kamdar, MD, MBBS

Krish Patel, MD

Gilles Salles, MD, PhD

Fifth Annual National General Medical Oncology Summit

Disclosures for Moderator Neil Love, MD

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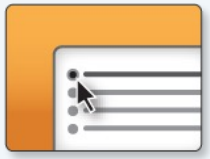

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- The live meeting is being video and audio recorded.
- The proceedings from this weekend will be edited and developed into an enduring web-based program. An email will be sent to all attendees when the activity is available.

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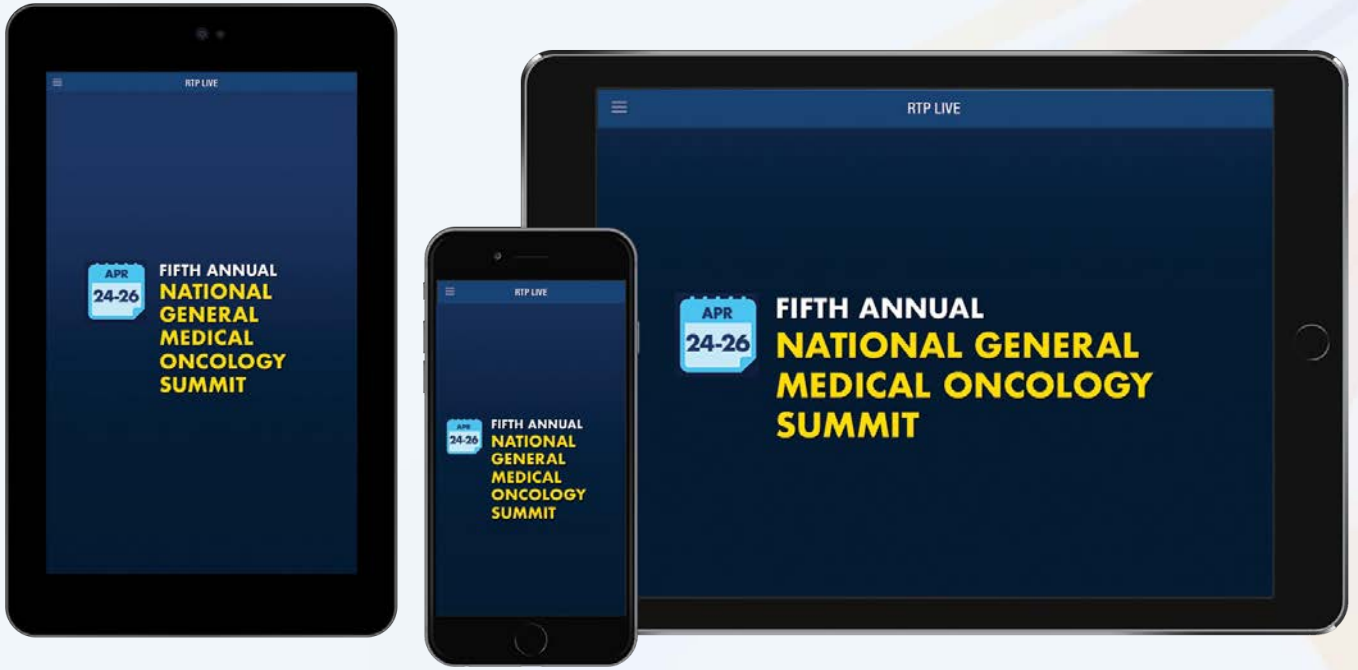

Fifth Annual
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Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

Friday, April 24, 2026

Moderator
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Nashville, Tennessee

Moderator
Neil Love, MD
Research To Practice
Miami, Florida

Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

Part 1 - Diffuse Large B-Cell Lymphoma:

Antibody-Drug Conjugates and Other Novel Strategies in the Management of DLBCL — Prof Salles

Current and Future Role of Monoclonal and Bispecific Antibodies in the Management of DLBCL — Dr Patel

Chimeric Antigen Receptor (CAR) T-Cell Therapy for DLBCL — Dr Kamdar

Part 2 – Follicular Lymphoma:

CAR T-Cell Therapy for FL — Prof Salles

Other Approved and Emerging Novel Therapies for FL — Dr Patel

Integrating Bispecific Antibodies into the Management of FL — Dr Kamdar

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QUESTIONS?

Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

We would like to do a “best paper or presentation of the year” activity. Please suggest one “paper of the year” and 2 other worthy papers based on the value in treatment of current and future patients.

Evidence-Based Incorporation of Antibody-Drug Conjugates and Other Novel Strategies into the Management of DLBCL

Gilles SALLES
Lymphoma Service, Steven Greenberg Chair, Memorial Sloan Kettering Cancer Center
Weill Cornell Medical College, New York, US

Memorial Sloan Kettering Cancer Center

Disclosures

Advisory Committees	AbbVie Inc, BeOne, Bristol Myers Squibb, Foresight Diagnostics, Genentech, a member of the Roche Group, Genmab US Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, Kite, A Gilead Company, Lilly, Merck, Novartis, Nurix Therapeutics Inc, Pfizer Inc, SERB Pharmaceuticals
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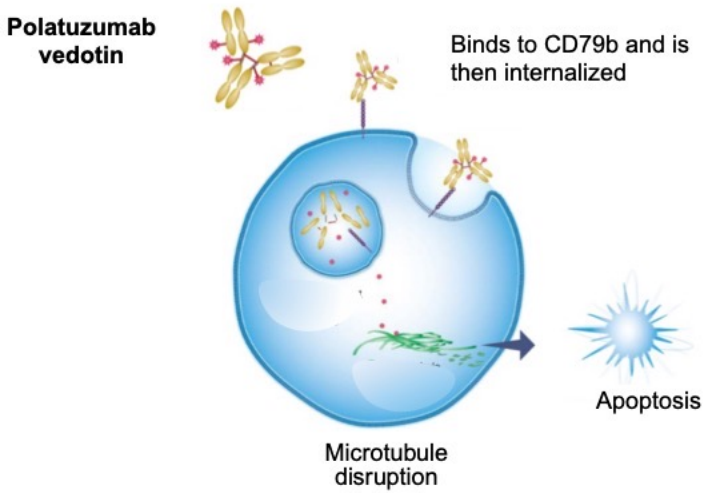
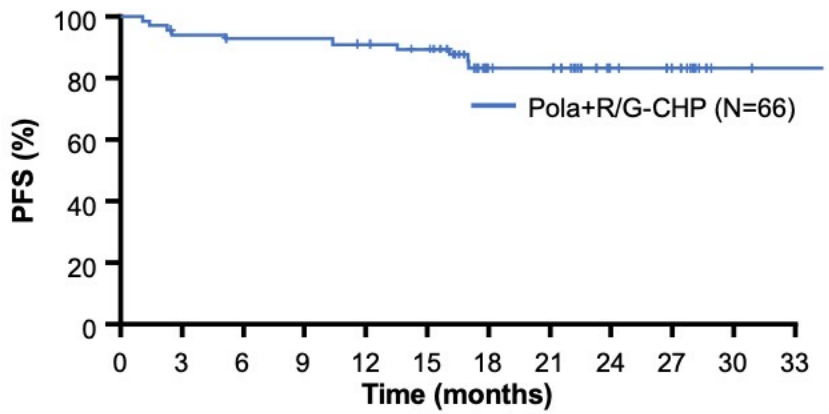
CD79b is ubiquitously expressed on DLBCL cells[1–3]



Pola+R/G-CHP demonstrated activity in first-line DLBCL[4]



POLARIX study design

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

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

Randomize 1:1

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

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

Cycles 1–6
(1 cycle=21 days)

Rituximab
375mg/m²
Cycles 7 & 8

Primary endpoint: PFS by INV

Key secondary endpoints:
EFS_{eff} by INV, PET CR at EOT by BICR, OS

		Pola-R-CHP	R-CHOP	Total	Median PFS follow-up	Median OS follow-up
Global population	ITT‡	440	439	879	54.9 months	64.1 months
	Safety evaluable§	435¶	438#	873		

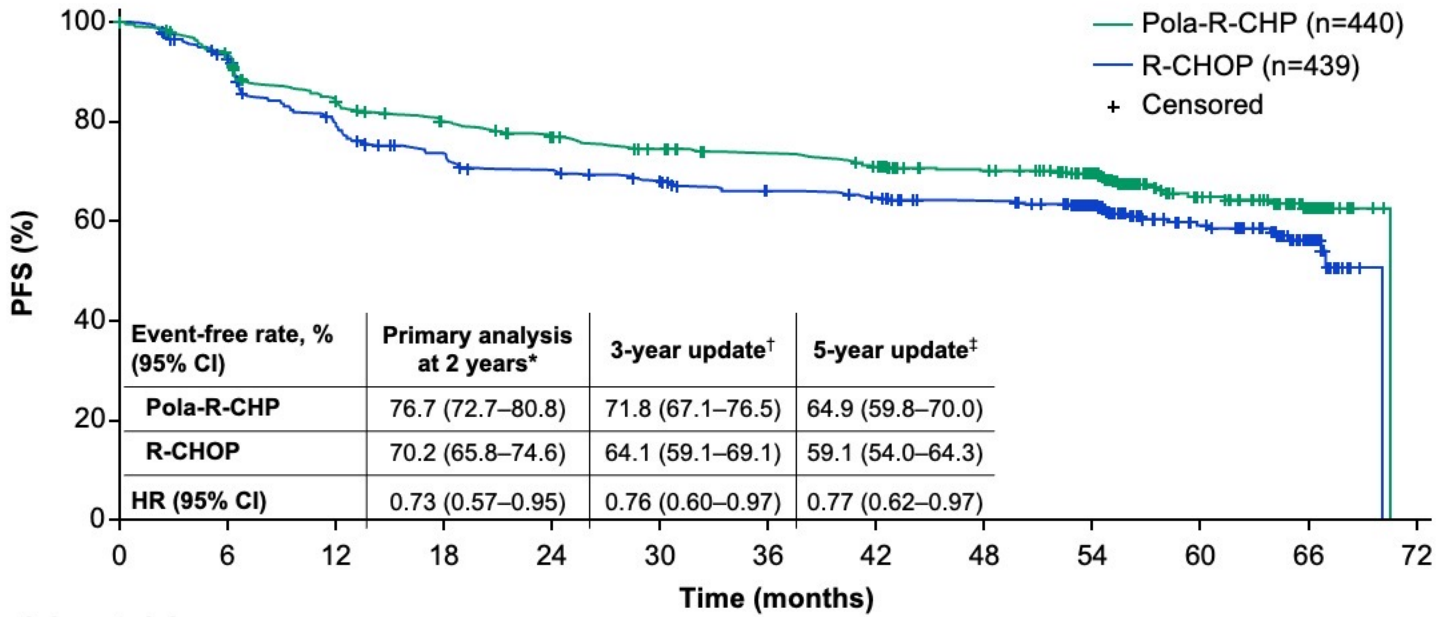
*IV on Day 1; †R-CHOP: IV rituximab 375mg/m², cyclophosphamide 750mg/m², doxorubicin 50mg/m², and vincristine 1.4mg/m² (max. 2mg) on Day 1, plus oral prednisone 100mg once daily on Days 1–5; ‡As randomized population; §As treated population; ¶One patient was randomized to Pola-R-CHP but did not receive polatuzumab vedotin; #One patient was randomized to R-CHOP but did not receive vincristine.
BICR, blinded independent central review; CR, complete response; DLBCL, diffuse large B-cell lymphoma; ECOG PS, Eastern Cooperative Oncology Group performance status; EFS_{eff}, event-free survival (efficacy); EOT, end of treatment; INV, investigator; IPI, International Prognostic Index; OS, overall survival; PET, positron emission tomography; PFS, progression-free survival; R, randomized; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine and prednisone. Tilly H, *et al. N Eng J Med* 2022;386:351–63.

1. Dornan D, et al. Blood 2009;114:2721–9; 2. Polson AG, et al. Expert Opin Invest Drugs 2011;20:75–85;
3. Doronina SO, et al. Nat Biotechnol 2003;21:778–84; 4. Tilly H, et al. Lancet Oncol 2019;20:998–1010
5. Tilly H et al. N Engl J Med. 2022;386(4):351-363.

Initial PFS benefit of Pola-R-CHP over R-CHOP is maintained at 5 years

UPDATED ANALYSIS

PFS in the global ITT population



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

Patients remaining at risk

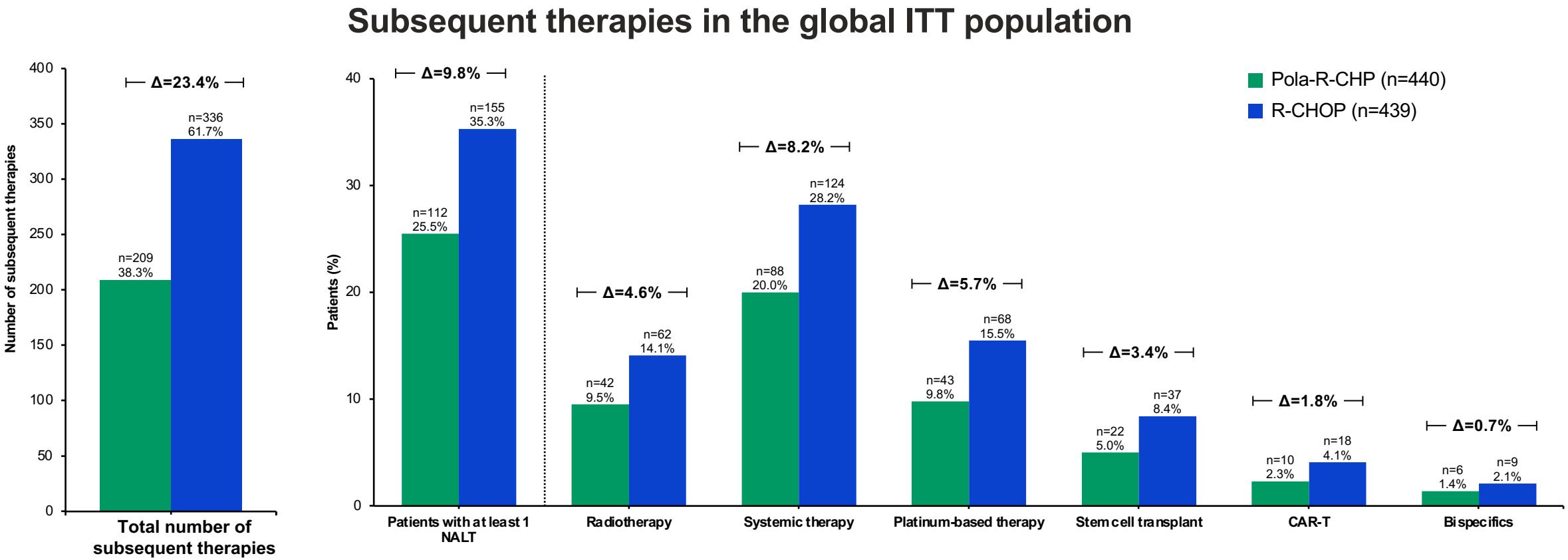
Pola-R-CHP	440	407	357	335	318	303	292	280	258	213	100	56	NE
R-CHOP	439	391	332	302	287	274	258	251	240	192	95	54	NE

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

*Data cut-off: June 28, 2021; †Data cut-off: June 15, 2022; ‡Data cut-off: July 5, 2024.
CI, confidence interval; HR, hazard ratio; NE, not evaluable.

Morschhauser F. et al. JCO 2025.

Patients treated with Pola-R-CHP required 23% fewer subsequent therapies versus patients treated with R-CHOP



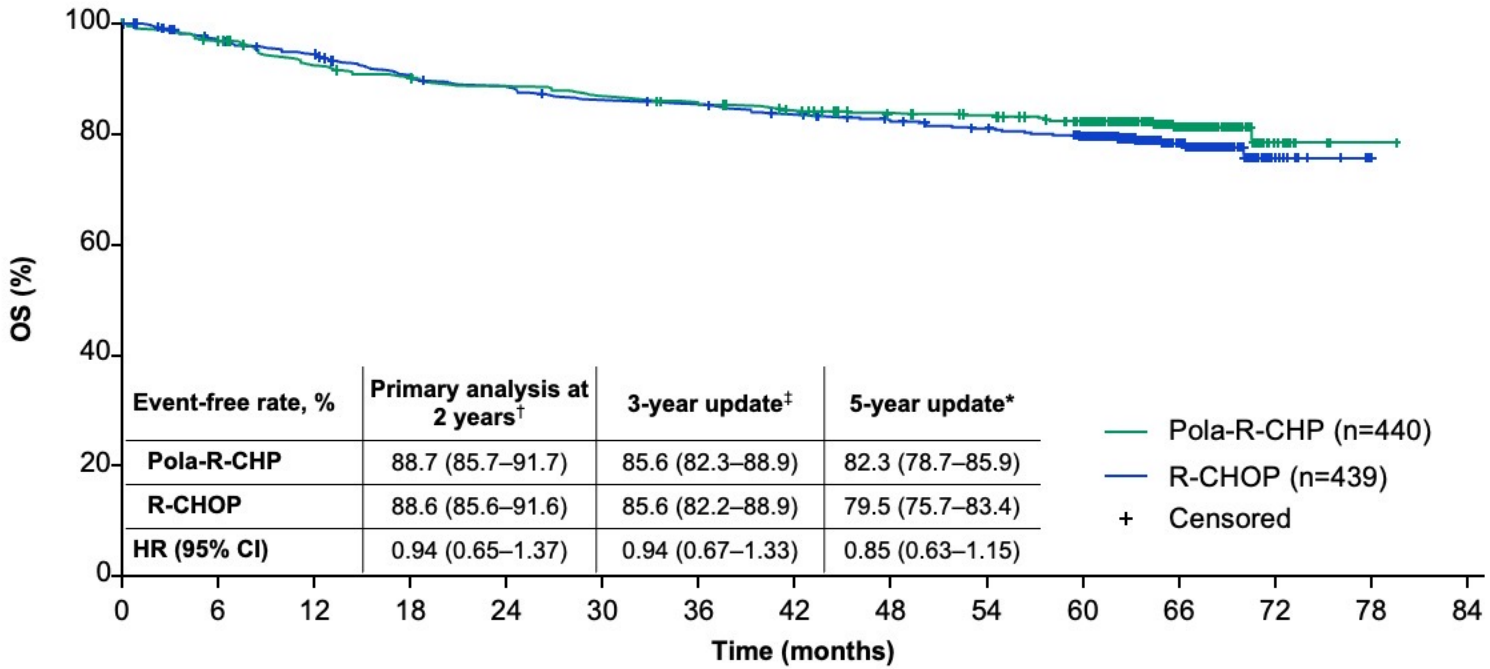
Patterns of subsequent therapies received on study mirror routine clinical care at the time of study conduct.

Data cut-off: July 5, 2024.
CAR-T, chimeric antigen receptor T-cell therapy; NALT, new anti-lymphoma treatment.

Morschhauser F. et al. JCO 2025.

Polarix: 5-year overall survival

OS in the global population*



Event-free rate, %	Primary analysis at 2 years†	3-year update‡	5-year update*
Pola-R-CHP	88.7 (85.7–91.7)	85.6 (82.3–88.9)	82.3 (78.7–85.9)
R-CHOP	88.6 (85.6–91.6)	85.6 (82.2–88.9)	79.5 (75.7–83.4)
HR (95% CI)	0.94 (0.65–1.37)	0.94 (0.67–1.33)	0.85 (0.63–1.15)

Patients remaining at risk

Pola-R-CHP	440	424	399	389	381	373	366	355	343	338	319	124	12	1	NE
R-CHOP	439	415	403	382	372	361	357	347	338	329	311	128	13	1	NE

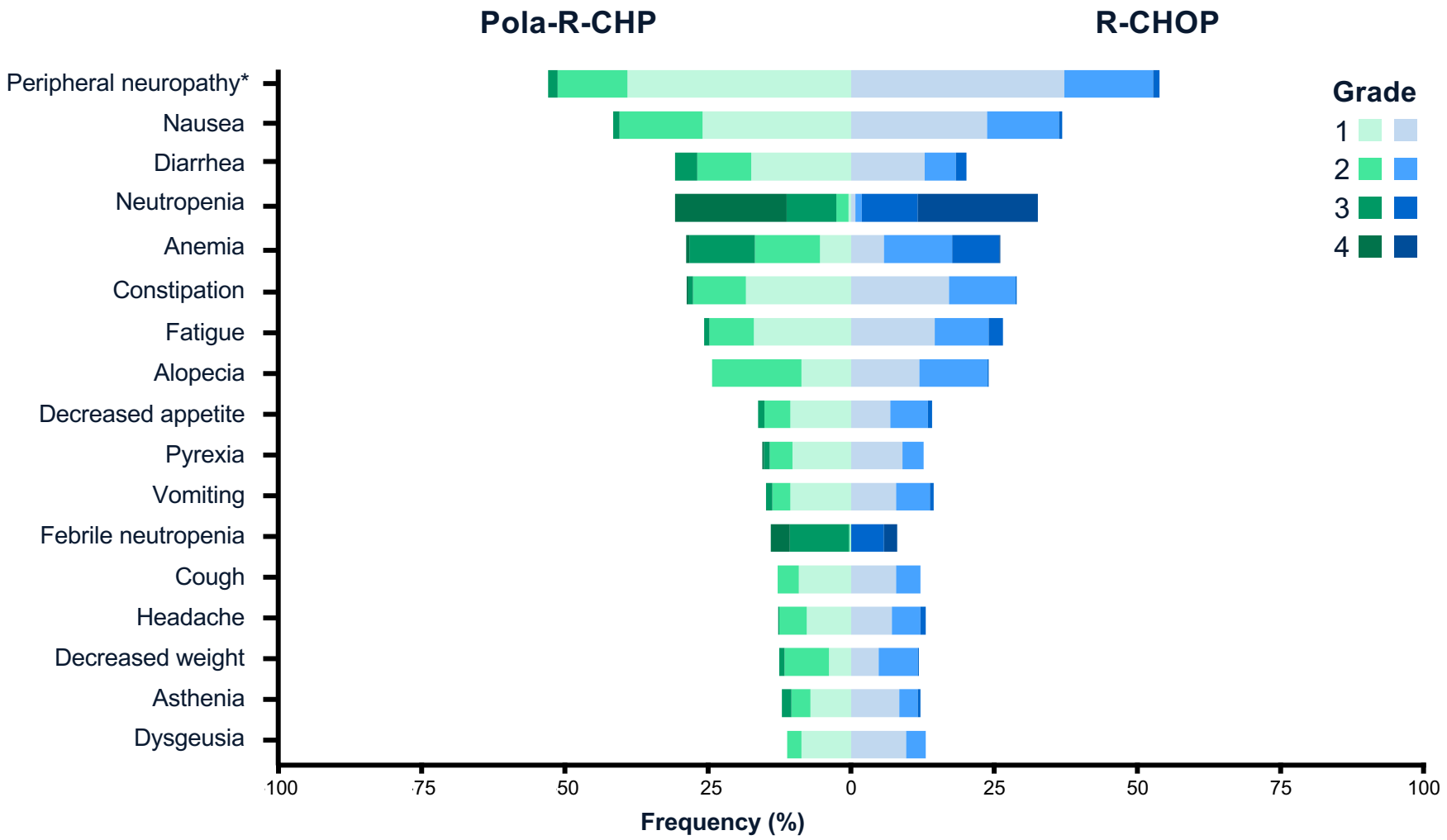
Deaths, n§	Pola-R-CHP (n=440)	R-CHOP (n=439)
Primary analysis at 2 years†	53	57
5-year update*	79	91

After 5 years of follow-up, numerically fewer deaths were observed in the Pola-R-CHP versus R-CHOP arm, with an associated HR of 0.85 (0.63–1.15).

*Data cut-off: July 5, 2024; †Data cut-off: June 28, 2021; ‡Data cut-off: June 15, 2022; §In addition to the known deaths, there were two patients (one in the Pola-R-CHP arm and one in the R-CHOP arm) who died due to an unknown cause and an unknown death date and were not counted as death events in the OS analysis.

Morschhauser F. et al. JCO 2025.

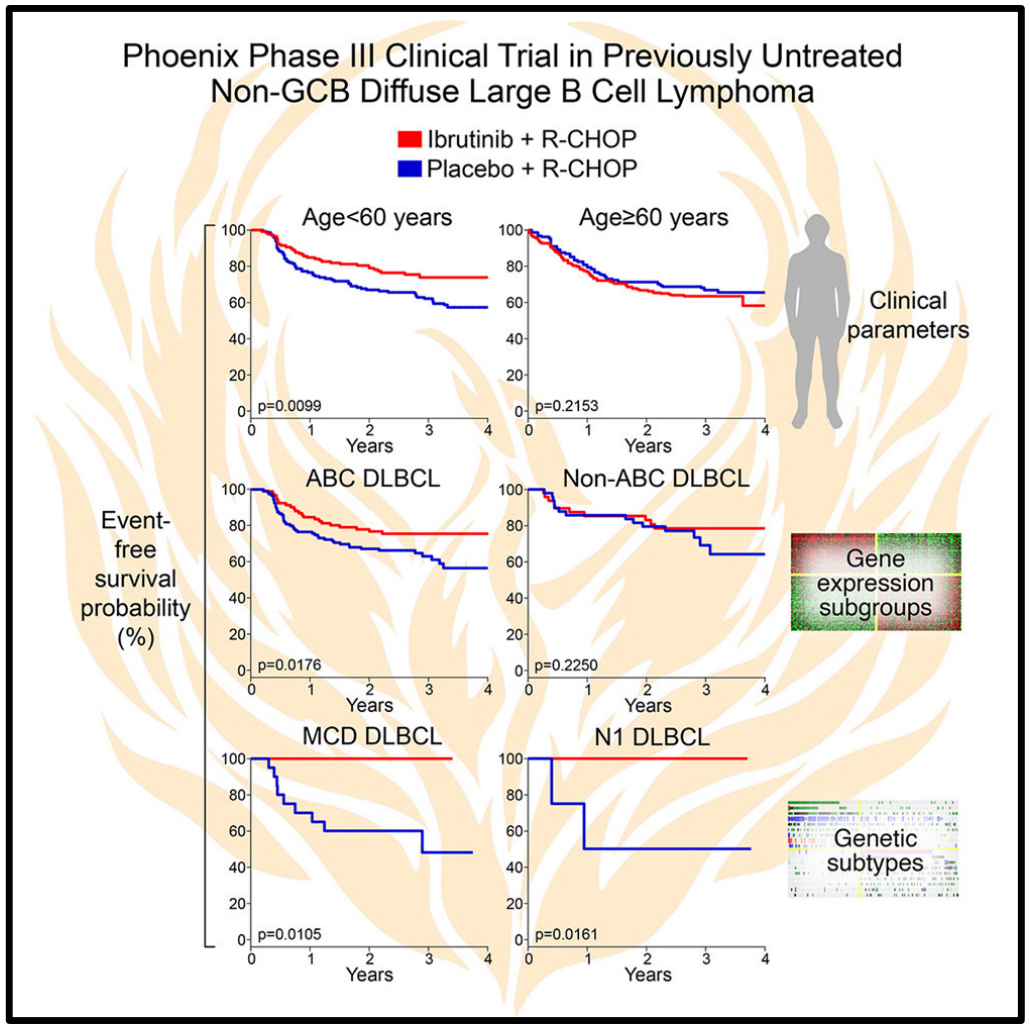
POLARIX: Common Adverse Events



Data cut-off: June 28, 2021. Adverse events are Medical Dictionary for Regulatory Activities version 24.0 preferred terms; shown are all-grade adverse events occurring in ≥12% of patients in any treatment arm. *Peripheral neuropathy is defined by standard organ class group of preferred terms.

Tilly H et al. *N Engl J Med*. 2022;386(4):351-363.

Despite Phoenix (R-CHOP +/- Ibrutinib) being a negative study, further analyses support evaluating BTK inhibition for DLBCL subsets



- BTK inhibitor ibrutinib plus R-CHOP is effective in younger patients with ABC DLBCL
- Genetic subtypes of DLBCL differ in genotype, phenotype, and oncogenic mechanisms
- MCD and N1 subtypes acquire mutations that promote chronic active BCR signaling
- Patients with the MCD and N1 subtypes have 100% survival with ibrutinib plus R-CHOP

Wilson et al Ca Cell 2021

Preliminary Results from a Phase II Trial of Frontline Acalabrutinib + DA-EPOCH-R or R-CHOP in DLBCL

Previously Untreated

Patients ≥18 yr and ECOG PS 0-2 DLBCL or HGBL, including ABC DLBCL, GCB DLBCL, unclassified DLBCL, and double-hit or triple-hit HGBL (n = 34)

Tx Window

Acalabrutinib 100 mg BID for 14 d

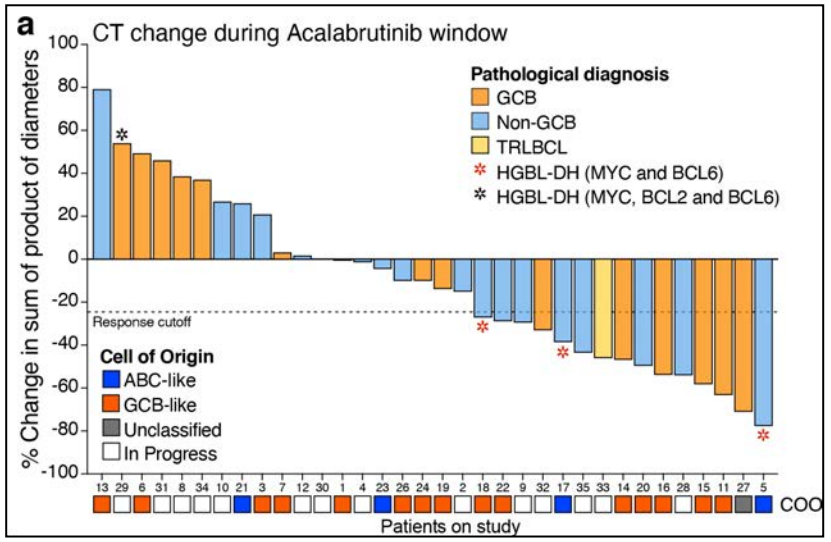
Tumor Size Reduction

<25% → DA-EPOCH-R or R-CHOP for 4-6 cycles

≥25% → DA-EPOCH-R or R-CHOP for 4-6 cycles + Acalabrutinib for 10 days/cycle

Combination Tx

- **Patients who completed tx: n = 27**
  - **Achieved a CR: 100%**
  - **Relapsed: n = 1**
  - **Deaths: n = 1**
- **After median follow-up of 9.2 mo, 1-yr PFS: 84.9%**



AEs Across 156 Cycles in 34 Patients, %	Acala + R-Chemo	
	Gr 3	Gr 4
Neutropenia	50	38
Thrombocytopenia	22	12
No increase in infections, atrial fibrillation, or bleeding with acalabrutinib		

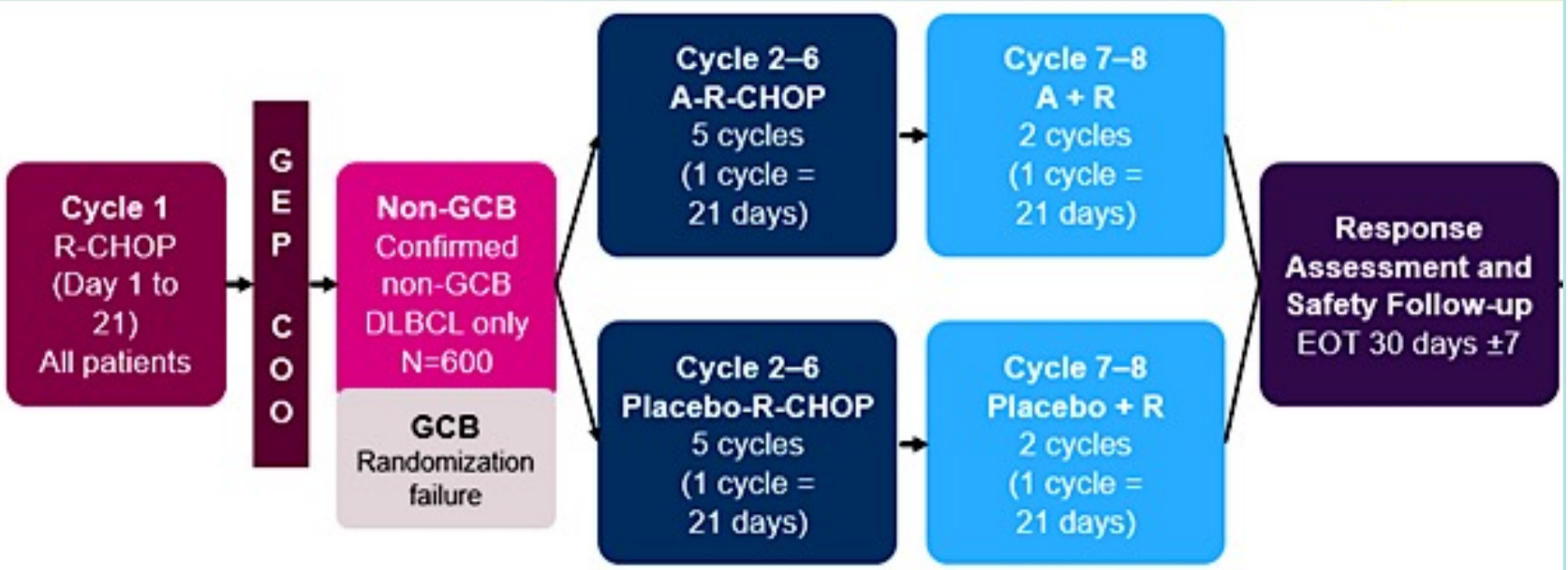
Roschewski. ASH 2021. Abstr 524.

Learnings from PHOENIX informed the ESCALADE design

- **Age ≤ 65 yo - instead of age-all comers**
- **COO by GEP – instead of IHC**
- **G-CSF – mandatory**
- **1st R-CHOP cycle prior to randomization**

Key Inclusion Criteria

- **18 - 65 years**
- **Histologically documented DLBCL**
  - **FFPE tumor tissue sample sent to the central laboratory prior to C1D1**
  - **Central laboratory confirmation by GEP of non-GCB subtype of DLBCL**
- **No prior treatment for DLBCL**
- **ECOG 0-2**
- **IPI 2-5**
- **Stage II-IV**
- **Measurable lesion by CT with contrast (or MRI)**



Primary objective:

A+R-CHOP vs P+R-CHOP efficacy: INV assessed PFS

Key secondary objectives:

A+R-CHOP vs P+R-CHOP efficacy:

- INV assessed EFS
- BICR assessed CR rate at end of study treatment
- OS

Treatment and Duration:

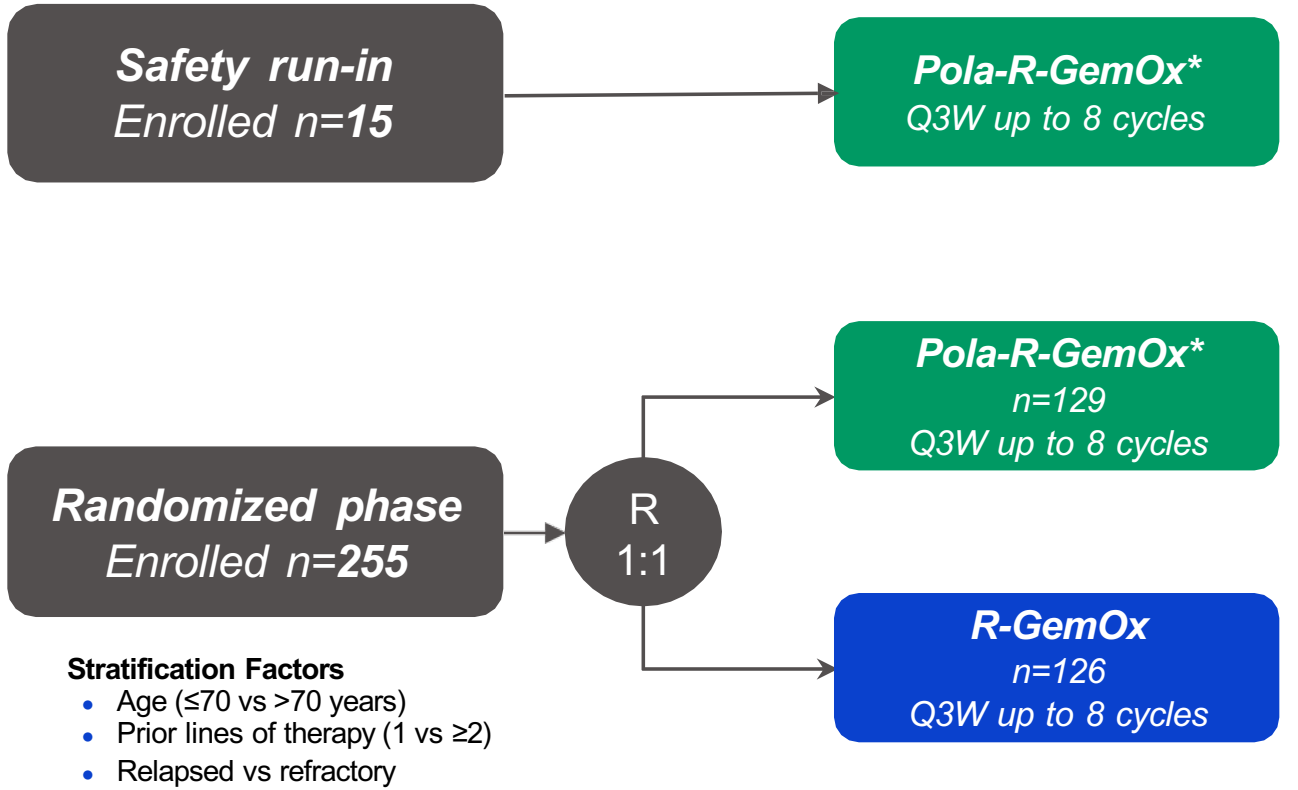
- R-CHOP given every 21 days for 6 cycles starting on C1D1
- From Cycle 2 (randomized on Cycle 2 (C2D1)) to Cycle 6, pts with non-GCB DLBCL will receive either Acalabrutinib 100 mg twice daily plus R-CHOP or placebo plus R-CHOP
- Followed by 2 additional cycles of Rituximab + Acalabrutinib or placebo in Cycle 7 and Cycle 8, as 8 cycles of rituximab is recognized as a common standard per ESMO guidelines with 6 cycles of CHOP

Interim and Final Analysis: One interim analysis for futility only and the final analysis will occur when **102** (45% of final) and **227,** respectively, INV-assessed PFS events combined in Arms A and B have been observed. IA is projected to occur 40 months after first subject randomized (FSR).

POLARGO: randomized Phase III trial in patients with transplant-ineligible R/R DLBCL

Key eligibility criteria

- DLBCL, NOS or history of transformation of indolent disease to DLBCL
- R/R disease after ≥1 prior line of treatment
- Ineligible for transplant



Primary endpoint
Safety and tolerability

Primary endpoint
OS

Key secondary endpoints
PFS (by INV)
CR† (by IRC)
ORR† (by IRC)

*Polatuzumab vedotin (1.8 mg/kg) plus R-GemOx (R, 375 mg/m²; Gem, 1000 mg/m²; Ox, 100 mg/m²). †PET-CT at EOT.
EOT, end of treatment; INV, investigator; IRC, independent review committee; NOS, not otherwise specified; ORR, overall response rate; PET-CT, positron emission tomography and computed tomography; Q3W, every 3 weeks.

POLARGO Baseline characteristics

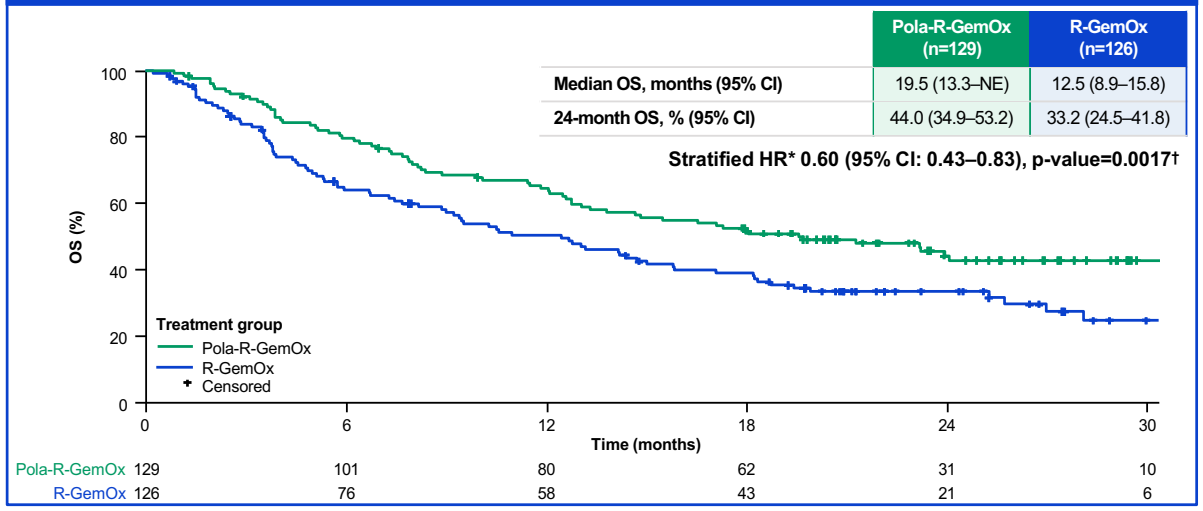
n (%), unless otherwise stated		Pola-R-GemOx (n=129)	R-GemOx (n=126)
Age, years	Median (range)	67 (20–85)	64 (24–89)
	>70 years	45 (34.9)	44 (34.9)
Geographical region	Western Europe, United States, Canada	32 (24.8)	37 (29.4)
	China, South Korea	42 (32.6)	34 (27.0)
	Brazil, Mexico, India, Turkey	55 (42.6)	55 (43.7)
ECOG PS	0–1	115 (89.1)	110 (87.3)
	2	14 (10.9)	16 (12.7)
Ann Arbor stage	I–II	32 (24.8)	28 (22.2)
	III–IV	97 (75.2)	98 (77.8)
IPI risk factor	0–2	66 (51.2)	63 (50.0)
	3–5	63 (48.8)	63 (50.0)
Histopathologic diagnosis	DLBCL, NOS	116 (89.9)	116 (92.1)
	Transformation from indolent disease	13 (10.1)	10 (7.9)
Bulky disease (≥7.5cm)	Present	23 (17.8)	25 (19.8)
Prior lines of therapy for lymphoma	1	81 (62.8)	81 (64.3)
	≥2	48 (37.2)	45 (35.7)
Primary refractory (DLBCL, NOS)	Yes	65/116 (56.0)	71/116 (61.2)
R/R to last prior therapy	Refractory	85 (65.9)	83 (65.9)
Cell of origin (central, GEP)	ABC	41 (31.8)	45 (35.7)
	GCB	48 (37.2)	50 (39.7)
	Unclassified	11 (8.5)	9 (7.1)
	Unknown	29 (22.5)	22 (17.5)

All baseline characteristics are determined at study entry.
ABC, activated B-cells; ECOG PS, Eastern Cooperative Oncology Group performance status; GEP, gene expression profiling; GCB, germinal center derived B-cells; IPI, international prognostic index.

POLARGO Primary and secondary endpoints:
Adding Polatuzumab to R-GemOx improved OS and PFS

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

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



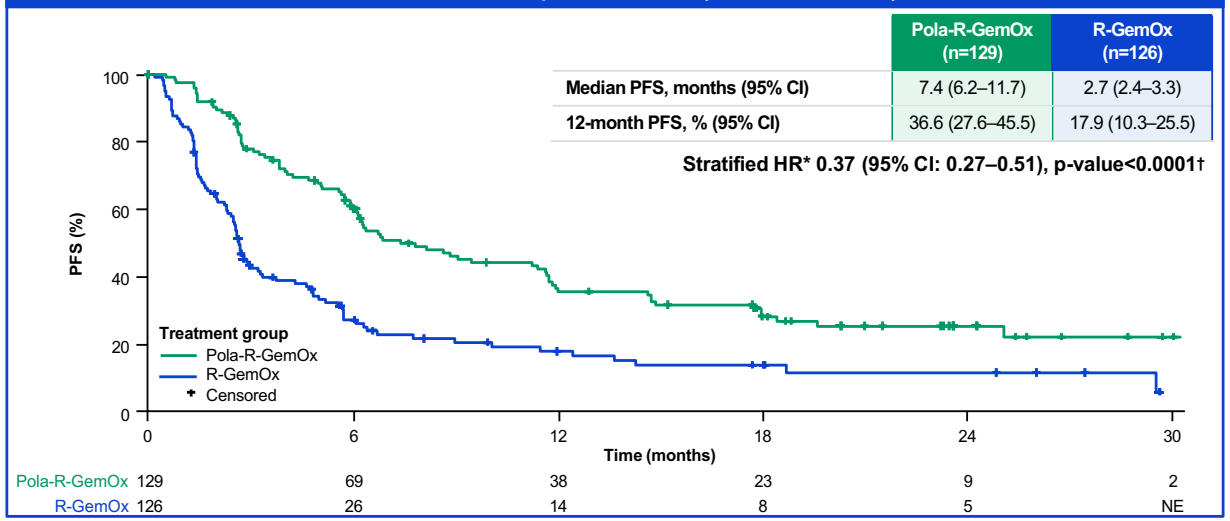
	Pola-R-GemOx (n=129)	R-GemOx (n=126)
Median OS, months (95% CI)	19.5 (13.3–NE)	12.5 (8.9–15.8)
24-month OS, % (95% CI)	44.0 (34.9–53.2)	33.2 (24.5–41.8)

Stratified HR* 0.60 (95% CI: 0.43–0.83), p-value=0.0017†

*Stratified for age (≤70 vs >70 years), prior lines of systemic therapy (1 vs ≥2), outcome of last systemic therapy (relapsed vs refractory). †Log rank.
CI, confidence interval; HR, hazard ratio; NE, not estimable.

Pola-R-GemOx achieved significant improvement in PFS vs R-GemOx

Median PFS follow-up: 18.7 months (95% CI: 17.8–23.3)



	Pola-R-GemOx (n=129)	R-GemOx (n=126)
Median PFS, months (95% CI)	7.4 (6.2–11.7)	2.7 (2.4–3.3)
12-month PFS, % (95% CI)	36.6 (27.6–45.5)	17.9 (10.3–25.5)

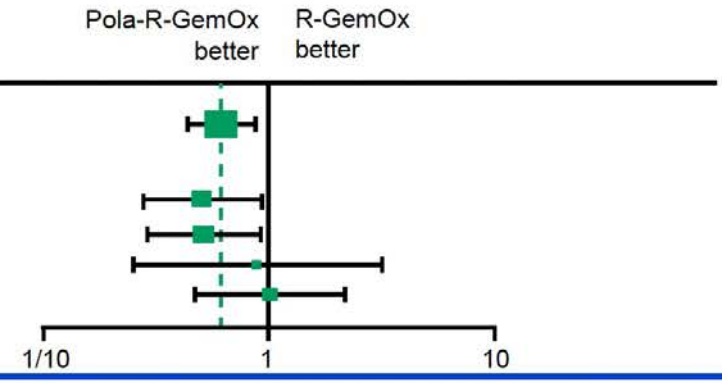
Stratified HR* 0.37 (95% CI: 0.27–0.51), p-value<0.0001†

PFS is censored at earliest subsequent therapy or two or more missing tumor assessments.
*Stratified for age (≤70 vs >70 years), prior lines of systemic therapy (1 vs ≥2), outcome of last systemic therapy (relapsed vs refractory). †Log rank.

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

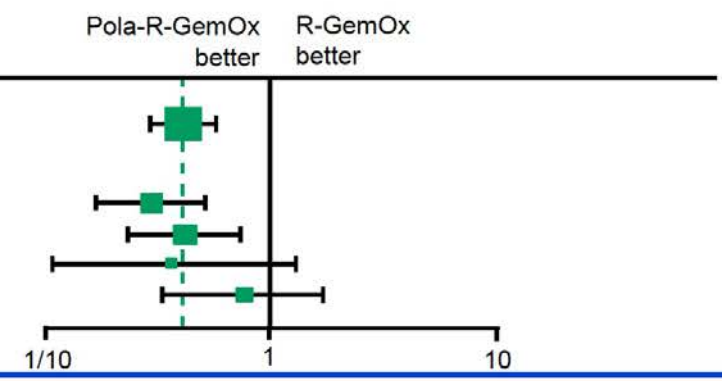
Overall survival

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



Progression-free survival

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



Cell of origin based on GEP.

POLARGO: Safety data

Selected AEs

n (%)	Pola-R-GemOx (n=128)	R-GemOx (n=125)
Thrombocytopenia*	68 (53.1)	51 (40.8)
Grade ≥3	44 (34.4)	33 (26.4)
Neutropenia*	53 (41.4)	52 (41.6)
Grade ≥3	43 (33.6)	38 (30.4)
Febrile neutropenia†	3 (2.3)	3 (2.4)
Grade ≥3	3 (2.3)	3 (2.4)
Anemia*	48 (37.5)	35 (28.0)
Grade ≥3	17 (13.3)	19 (15.2)
Infections*	53 (41.4)	39 (31.2)
Grade ≥3	28 (21.9)	12 (9.6)
Hepatic toxicity*	41 (32.0)	25 (20.0)
Grade ≥ 3	11 (8.6)	2 (1.6)

*Custom grouped terms. †Based on preferred term.

Peripheral neuropathy

n (%), unless otherwise specified	Pola-R-GemOx (n=128)	R-GemOx (n=125)
Any Grade PN*	73 (57.0)	36 (28.8)
Grade 1	48 (37.5)	29 (23.2)
Grade 2	20 (15.6)	7 (5.6)
Grade 3	5 (3.9)	0
Median time to onset, months (range)	1.6 (0–8.0)	0.9 (0–4.4)
PN AEs leading to any study drug discontinuation	4 (3.1)	0
Polatuzumab vedotin discontinuation	3 (2.3)	N/A
Number of PN AEs leading to any dose reduction	13 (10.2)	4 (3.2)
Polatuzumab vedotin reduction	13 (10.2)	N/A
Patients with all PN AEs resolved or improved	37 (50.7)	21 (58.3)
Patients with all PN AEs resolved	28 (38.4)	21 (58.3)

*Custom grouped terms.
N/A, not applicable; PN, peripheral neuropathy.

Updated Results From LOTIS-2, Loncastuximab Tesirine Pivotal Phase 2 Study in Patients With Relapsed/Refractory DLBCL

LOTIS-2 (NCT03589469): a multicenter, open-label, single-arm, phase 2 study

Patient population

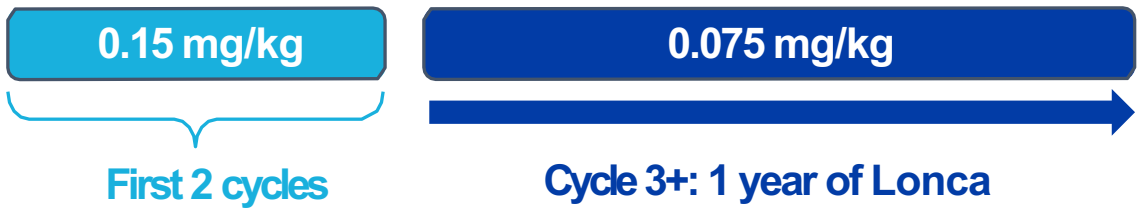
R/R DLBCL[a] after ≥2 prior lines of systemic therapy, including the following:

- DLBCL NOS
- Primary mediastinal large B-cell lymphoma
- HGBCL with *MYC* and *BCL2* and/or *BCL-6* rearrangements

Primary end point

ORR by IRC of PET-CT (Lugano 2014 criteria)

Lonca (IV) was administered as a single, 30-minute outpatient infusion Q3W



Key inclusion/exclusion criteria

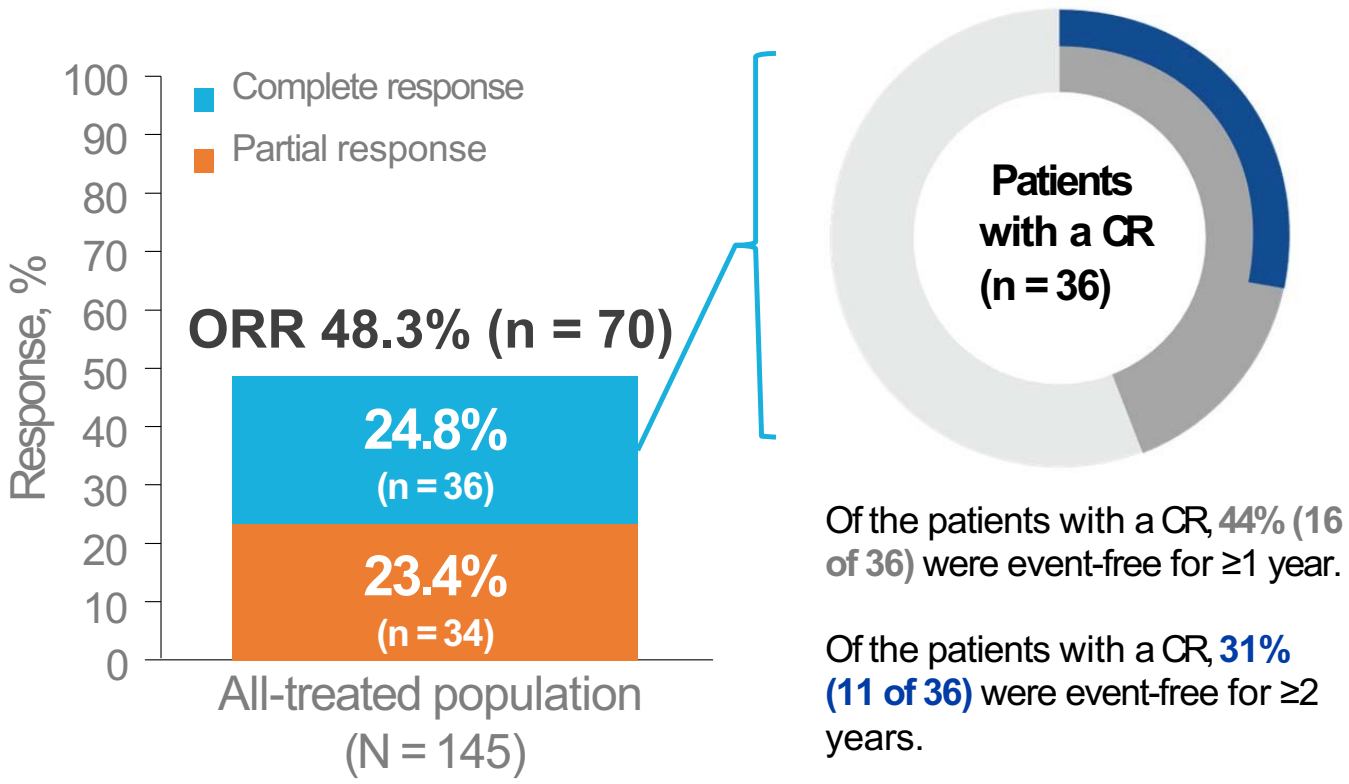
- Male or female patients ≥18 years of age
- Pathologic diagnosis of R/R DLBCL following ≥2 multiagent systemic treatment regimens
- ECOG performance status of 0-2
- No bulky disease (≥10 cm in longest dimension, per protocol amendment 2)

[a]Defined by the 2016 WHO classification.

CT, computed tomography; DLBCL, diffuse large B-cell lymphoma; ECOG, Eastern Cooperative Oncology Group; HGBCL, high-grade B-cell lymphoma; IRC, independent review committee; IV, intravenous; Lonca, loncastuximab tesirine-lpyl; NOS, not otherwise specified; ORR, overall response rate; PET, positron emission tomography; Q3W, every 3 weeks; R/R, relapsed/refractory.

Caimi PF, et al. Haematologica. 2024 Apr 1;109(4):1184-1193.

Overall Response Rate and Long-term Responses Observed in the All-Treated Population



Of the patients with a CR, **44% (16 of 36)** were event-free for ≥1 year.

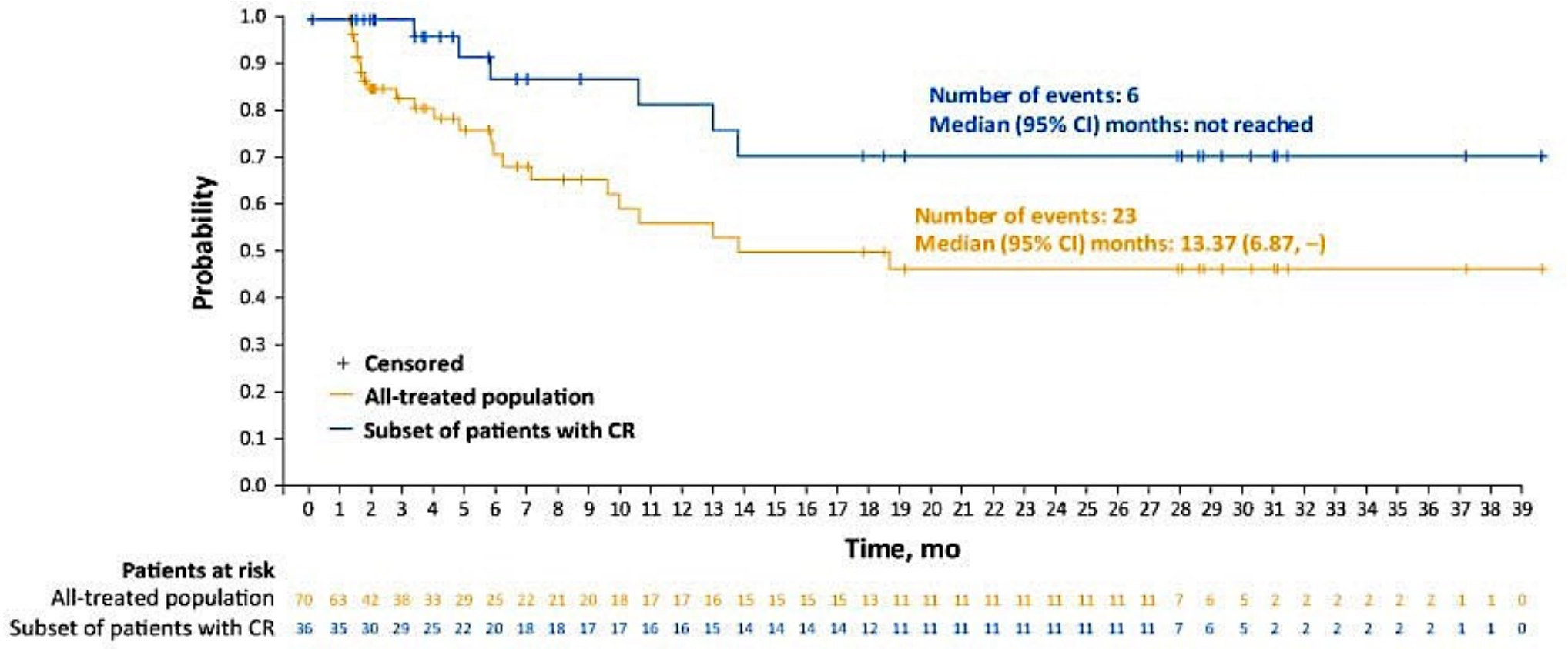
Of the patients with a CR, **31% (11 of 36)** were event-free for ≥2 years.

Median (range) number of treatment cycles	
All-treated population	3.0 (1-26)
Pts with a CR	8.0 (1-26)
Pts with a CR, event-free ≥1 year[a]	12.5 (1-26)
Pts with a CR, event-free ≥2 years[a]	13.0 (1-22)

Data cutoff: September 15, 2022.
The median duration of follow-up was 7.8 months (range, 0.3-42.6 months) in the all-treated population and 35.0 months (range, 4.4-42.6 months) in patients with a CR.
[a]Event-free is defined as no progressive disease or death starting from day 1, cycle 1 of Lonca treatment.
CR, complete response; Lonca, loncastuximab tesirine-lpyl; ORR, overall response rate; pts, patients.

Caimi PF, et al. Haematologica. 2024 Apr 1;109(4):1184-1193.

LOTIS-2: Duration of Response
All-Treated Population and Patients With a CR



The median (range) time to response was 41 (35-247) days in the all-treated population and 42 (36-247) days for patients with a CR.

Data cutoff: September 15, 2022.
CR, complete response; DOR, duration of response.

Caimi PF, et al. Haematologica. 2024 Apr 1;109(4):1184-1193.

LOTIS-2: All-Grade and Grade ≥3 Adverse Events

TEAEs, any grade in ≥30% of patients	All-treated population, N = 145	Patients with a CR, n = 36
Patients with any TEAE	98.6%	100%
Increased GGT	42%	50%
Neutropenia	40%	42%
Thrombocytopenia	33%	36%
Anemia	26%	36%
Peripheral edema	20%	33%
Nausea	23%	31%

TEAEs, grade ≥3 in ≥10% of patients	All-treated population, N = 145	Patients with a CR, n = 36
Patients with any TEAE	73.8%	75%
Neutropenia	26%	28%
Thrombocytopenia	18%	19%
Increased GGT	17%	19%
Anemia	10%	8.3%
Leukopenia	9%	14%
Hypophosphatemia	6%	11%

No new safety signals were identified during the long-term follow-up.

Data cutoff: September 15, 2022.
CR, complete response; GGT, gamma-glutamyltransferase; TEAE, treatment emergent adverse events.

Caimi PF, et al. Haematologica. 2024 Apr 1;109(4):1184-1193.

LOTIS-5: Randomized Trial of Lonca-T versus IC in Patients With R/R DLBCL/HGBL

PHASE 3 LOTIS-5 TRIAL

Eligibility criteria

- ✓ R/R DLBCL/HGBL
- ✓ ≥1 prior systemic therapy
- ✓ Not a candidate for SCT

Part 1: Safety run-in (N=20)

Lonca-R

Part 2: Lonca-R vs R-GemOx (N≈420)

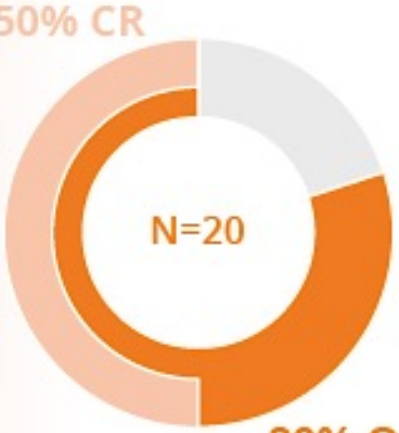
Lonca-R | R-GemOx

Up to 8 cycles of treatment

UPDATED SAFETY RUN-IN RESULTS

Median duration of follow-up:
37.2 (range, 34.1-41.5) months

EFFICACY



Median DOR: 8.0 months
Median PFS: 8.3 months

SAFETY

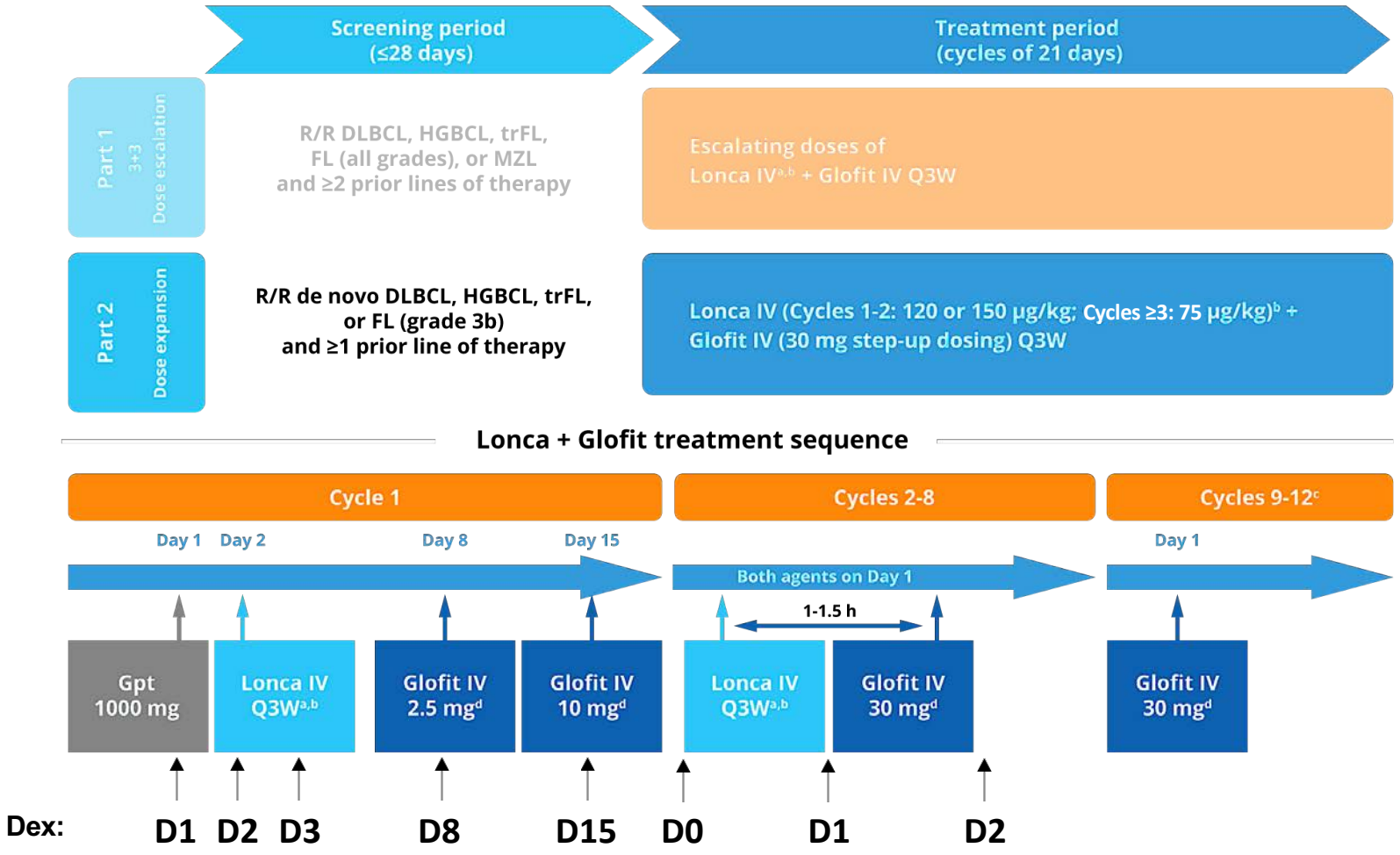
- There were no new safety signals
- The most common grade ≥3 TEAEs were increased GGT (n=5) and neutropenia (n=4)

BIOMARKERS

- CD19 IHC staining was not predictive of efficacy
- Response to therapy was associated with early ctDNA decrease
- All 3 CR patients with ctDNA results were MRD negative at C3D1

Carlo-Stella C et al, presented at EHA 2025, poster 1957

LOTIS-7: Lonca-T plus Glofitamab: Study Design & Patient Population



Study population

- Patients with 3L+ R/R B-NHL (part 1) and 2L+ R/R LBCL (part 2)
- ECOG PS score of 0-2
- Prior autologous SCT (>100 days) or CAR-T therapy (>100 days) is allowed
- Measurable disease (per 2014 Lugano Classification)
- Excludes patients with clinically significant third-space fluid accumulation

Endpoints

- **Primary**: safety and tolerability; MTD and/or RDE
- **Secondary**: ORR, DOR, CR rate, PFS, RFS, and OS; PK and immunogenicity
- **Exploratory**: Glofit concentration in circulation; biomarker and PK correlations with clinical outcomes

Alderuccio JP et al. Oral presentation presented at 18-ICML (17–21 June 2025)

LOTIS-7: PATIENT BASELINE CHARACTERISTICS

TREATED POPULATION (N=41)

	Glofit + Lonca, 120 µg/kg[a] (n=20)	Glofit + Lonca, 150 µg/kg[a] (n=21)	All dose levels (N=41)
Age, median (range), y	70 (50-82)	74 (26-85)	71 (26-85)
Male sex, n (%)	11 (55.0)	12 (57.1)	23 (56.1)
ECOG PS score, n (%)			
0	9 (45.0)	14 (66.7)	23 (56.1)
1	10 (50.0)	7 (33.3)	17 (41.5)
2	1 (5.0)	0	1 (2.4)
Ann Arbor disease stage, n (%)			
Stage I/II	3 (15.0)	3 (14.3)	6 (14.6)
Stage III/IV	17 (85.0)	18 (85.7)	35 (85.4)
IPI score, n (%)			
0-2	9 (45.0)	10 (46.7)	19 (46.3)
3-5	11 (55.0)	11 (52.4)	22 (53.7)
Bulky disease, n (%)	2 (10.0)	2 (9.5)	4 (9.8)
LDH levels high, n (%)	11 (55.0)	10 (47.6)	21 (51.2)
LBCL histology, n (%)			
de novo DLBCL	13 (65.0)	17 (81.0)	30 (73.2)
HGBCL	4 (20.0)	2 (9.5)	6 (14.6)
trFL	2 (10.0)	2 (9.5)	4 (9.8)
FL grade 3b	1 (5.0)	0	1 (2.4)

	Glofit + Lonca, 120 µg/kg[a] (n=20)	Glofit + Lonca, 150 µg/kg[a] (n=21)	All dose levels (N=41)
DLBCL subtype, n (%)			
GCB	10 (50.0)	11 (52.4)	21 (51.2)
non-GCB	5 (25.0)	8 (38.1)	13 (31.7)
Double or triple hit, n (%)	3 (15.0)	5 (23.8)	8 (19.5)
Number of prior LOT			
Median (range)	2 (1-4)	2 (1-5)	2 (1-5)
1, n (%)	10 (50.0)	10 (47.6)	20 (48.8)
≥2, n (%)	10 (50.0)	11 (52.4)	21 (51.2)
Refractory status, n (%)			
Refractory to primary therapy	8 (40.0)	13 (61.9)	21 (51.2)
Refractory to last prior therapy	7 (35.0)	13 (61.9)	20 (48.8)
Prior stem cell transplant, n (%)	3 (15.0)	1 (4.8)	4 (9.8)
Prior CAR-T therapy, n (%)	4 (20.0)	4 (19.0)	8 (19.5)

Data cutoff: April 14, 2025.

CAR-T, chimeric antigen receptor T cell; DLBCL, diffuse large B-cell lymphoma; ECOG PS, Eastern Cooperative Oncology Group Performance Status; FL, follicular lymphoma; HGBCL, high-grade B-cell lymphoma; IPI, International Prognostic Index; LBCL, large B-cell lymphoma; LDH, lactate dehydrogenase; Lonca, loncastuximab tesirine; LOT, lines of therapy; trFL, transformed follicular lymphoma.

[a]When the starting dose of Lonca is 120 µg/kg or 150 µg/kg, the dose will be reduced to 75 µg/kg for Cycles ≥3.

Alderuccio JP et al. Oral presentation presented at 18-ICML (17–21 June 2025)

LOTIS-7 SAFETY SUMMARY: CRS/ICANS PROFILE & MANAGEMENT

TREATED POPULATION (N=41)

	120 µg/kg[b] n=20	150 µg/kg[b] n=21	All n = 41
Cytokine Release Syndrome[a]			
Any grade	11 (55%)	5 (23.8%)	16 (39.0%)
Grade 1	7 (35%)	5 (23.8%)	12 (29.3%)
Grade 2	3 (15%)	0	3 (7.3%)
Grade 3	1 (5%)	0	1 (2.4%)
Grade 4/5	0	0	0
ICANS[a]			
Any grade	2 (10%)	1 (4.8%)	3 (7.3%)
Grade 1	1 (5%)	0	1 (2.4%)
Grade 2	1 (5%)	1 (4.8%)	2 (4.9%)
Grade ≥ 3	0	0	0

Any-grade CRS was less frequent at the Lonca 150 µg/kg starting dose[b] (23.8%) than at 120 µg/kg starting dose[b] (55.0%)

- Grade 1 and 2 CRS cases managed with tocilizumab, corticosteroids, acetaminophen, and/or fluid bolus, without ICU admittance or pressor support
- Grade 3 CRS case managed with tocilizumab, acetaminophen, dexamethasone, norepinephrine. ICU admittance

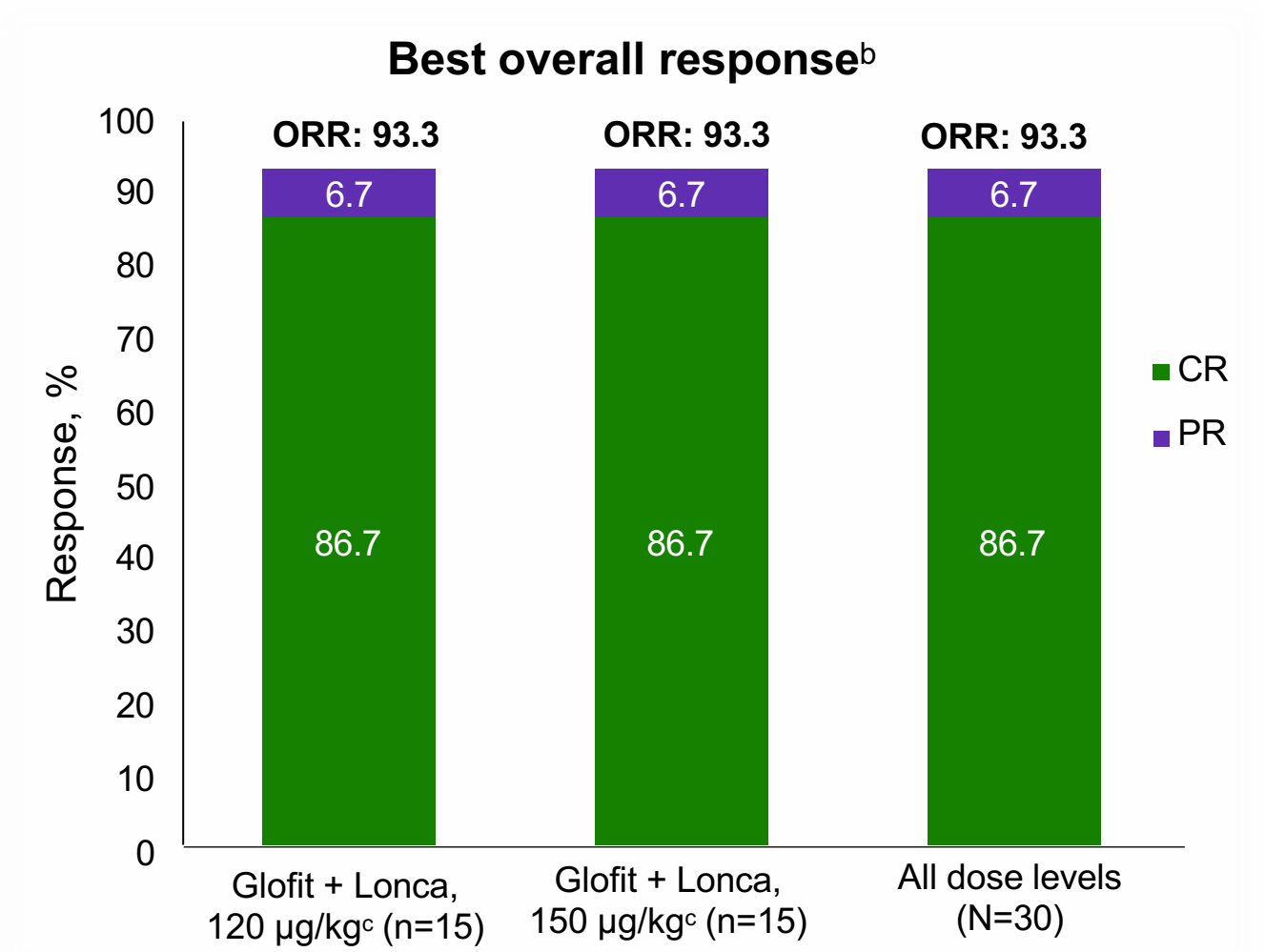
- All patients with ICANS had complete resolution of symptoms
  - Two patients resumed treatment and ultimately achieved a CR
  - One patient elected to discontinue treatment
- ICANS managed primarily with corticosteroids

[a]Number of patients who experienced at least 1 event per ASTCT Consensus Grading for Cytokine Release Syndrome and Neurologic Toxicity Associated with Immune Effector Cells; worst grade reported if applicable
[b]When the starting dose of Lonca is 120 µg/kg or 150 µg/kg, the dose will be reduced to 75 µg/kg for Cycles ≥3.
Data Cutoff 14 Apr 2025. Data extracted from live clinical database. Data is subject to change.

Alderuccio JP et al. Oral presentation presented at 18-ICML (17–21 June 2025)

LOTIS-7: BEST OVERALL RESPONSE & DURATION OF RESPONSE

EFFICACY EVALUABLE POPULATION (N=30)[a]



Duration of response

Characteristic, n (%)	Glofit + Longa, 120 µg/kg[c] (n=15)	Glofit + Longa, 150 µg/kg[c] (n=15)	All dose levels (N=30)
DOR[d] Median	(n=14) NE	(n=14) NE	(n=28) NE
Time to first response (CR or PR) Median, days	(n=14) 42.0	(n=14) 42.0	(n=28) 42.0
Time to first CR Median, days	(n=13) 80.0	(n=13) 42.0	(n=26) 70.5

Data cutoff: April 14, 2025.

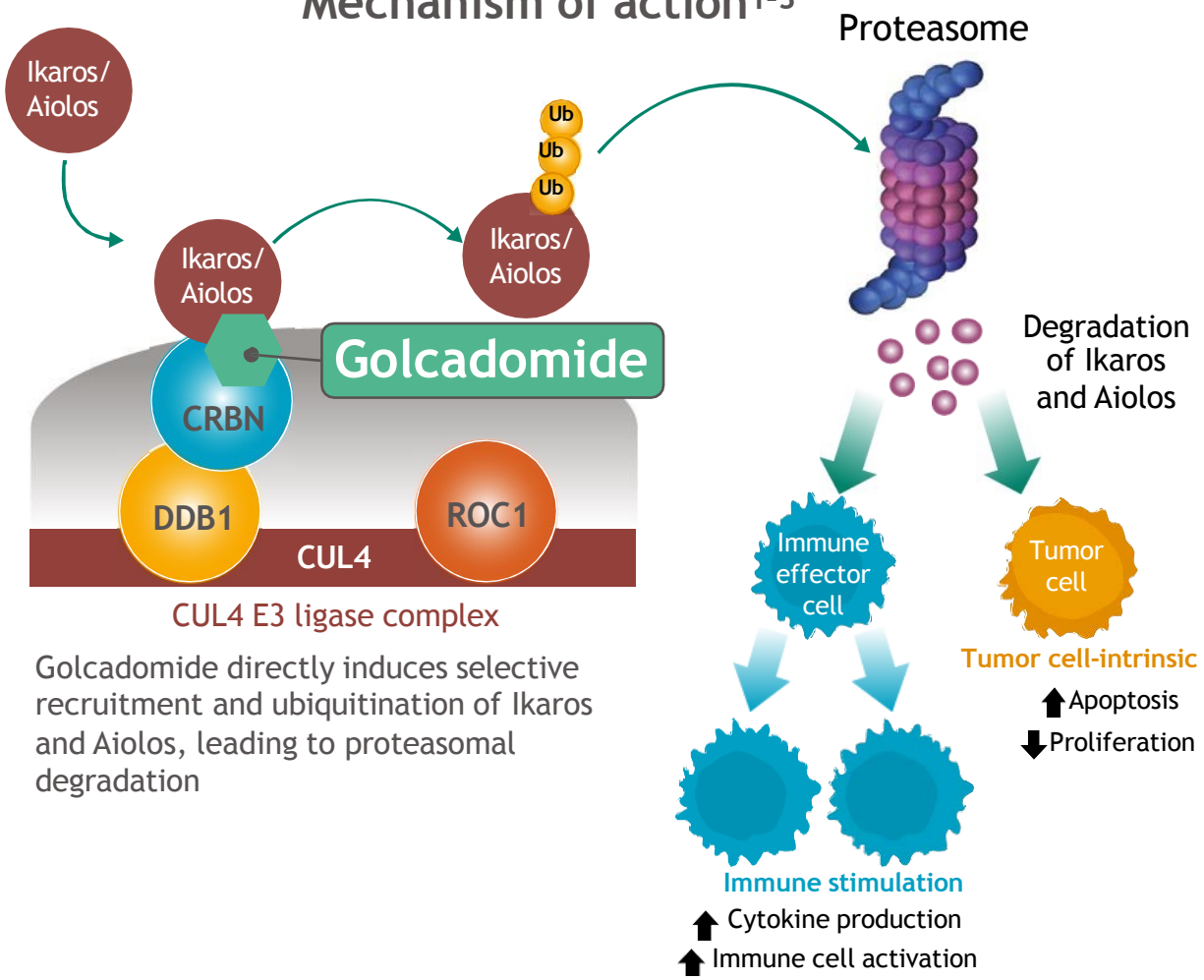
CR, complete response; DOR, duration of response; Glofit, glofitamab; Longa, loncastuximab tesirine; NE, not estimable; ORR, overall response rate; PR, partial response.

[a]The efficacy evaluable population (N=30) included all patients who received ≥1 dose of the study drug with a valid baseline and ≥1 valid postbaseline disease assessment. Patients who did not have a postbaseline assessment owing to early clinical progression or death were also included. [b]Percentages do not add up to total due to rounding. [c]When the starting dose of Longa is 120 µg/kg or 150 µg/kg, the dose will be reduced to 75 µg/kg for Cycles ≥3. [d]In the efficacy evaluable population, the DOR and probability of maintaining an event-free response were evaluated in responders (n=28), including all patients who had a best response of CR or PR.

Alderuccio JP et al. Oral presentation presented at 18-ICML (17–21 June 2025)

Golcadomide is a potential, first-in-class, oral CELMoD™ agent for NHL

Mechanism of action[1-3]



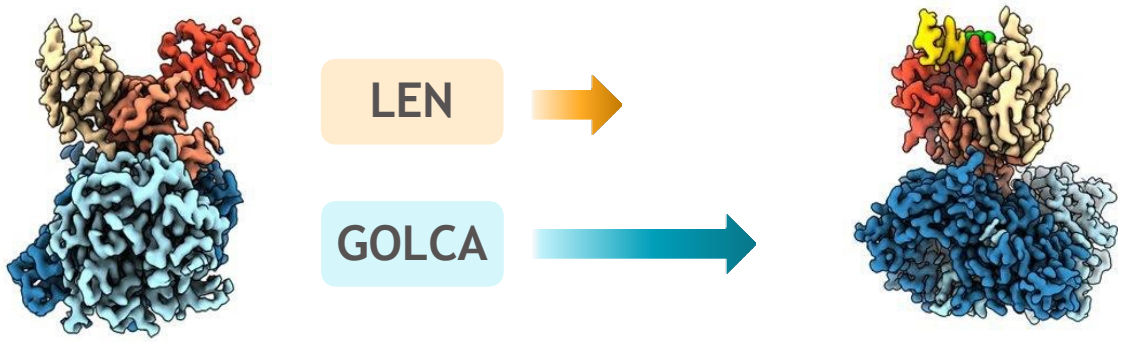
CUL4 E3 ligase complex

Golcadomide directly induces selective recruitment and ubiquitination of Ikaros and Aiolos, leading to proteasomal degradation

Allosteric regulation of cereblon (CRBN)[3,4]

Inactive/open CRBN
No Ikaros/Aiolos bound

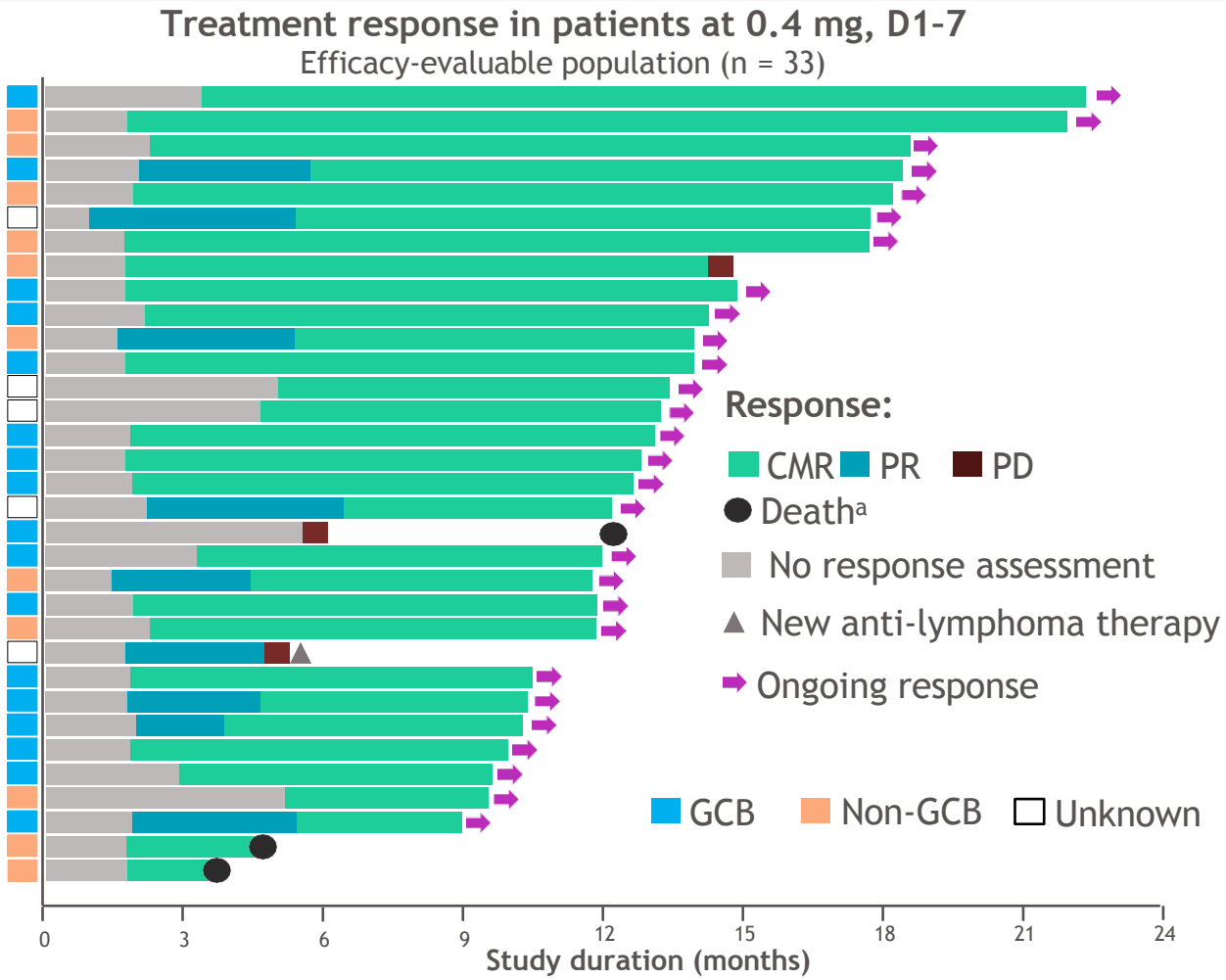
Active/closed CRBN
Ikaros/Aiolos bound



- CRBN has both an ***open, inactive state*** and a ***closed, active state***; IMiD and CELMoD agents drive the closed conformation, however only CELMoD agents bind CRBN outside of the tri-tryptophan pocket[4,5]
- This distinct binding by golcadomide induces the complete conversion to the active, 'closed' conformation of CRBN, leading to deeper and more rapid degradation of Ikaros/Aiolos compared with LEN[5]
- Golcadomide deeply penetrates lymphoid tissue, an optimal feature for the treatment of lymphoma[1,2,6]

CELMoD, cereblon E3 ligase modulatory drug; CRBN, cereblon; CUL4, cullin-4A; DDB1, DNA damage-binding protein 1; IMiD, immunomodulatory imide drug; LEN, lenalidomide; NHL, Non-Hodgkin lymphoma; ROC1, regulator of cullins 1; Ub, ubiquitin. 1. Hoffman MS, et al. Oral presentation at the European Hematology Association (EHA) 2024 Congress; June 13-16, 2024; Madrid, Spain; Abstract S235. 2. Lopez-Girona A, et al. *Hematol Oncol* 2021;39(suppl 1):315-316. 3. Chavez JC, et al. Poster presentation at the American Society of Hematology (ASH) Annual Meeting; December 9-12, 2023; San Diego, CA. Poster 4496. 4. Hartley-Brown MA, et al. *Cancers (Basel)* 2024;16:1166. 5. Watson ER, et al. *Science* 2022;378(6619):549-553. 6. Michot JM, et al. *Blood* 2021;138(suppl. 1):3574.

Phase 1b study (NCT04884035): Golcadomide + R-CHOP resulted in durable CMRs with encouraging 1-year PFS rates, including in patients with high-risk disease[1]



Safety population (DOR, PFS, and OS rates were assessed at 12 months)	0.4 mg (n = 37)	0.4 mg high-risk[b] patients (n = 31)
Median DOR, months	NR	NR
DOR rate, % (n/N)	97 (32/33)	96 (27/28)
PFS rate, %	85	86
OS rate, %	91	93

At data cutoff (June, 2024), median (range) follow-up was 14.3 (0.7–24.2) months in the overall population

In patients treated with golcadomide + R-CHOP, response occurred early in treatment and independently of COO

[a]Two patients achieved CMR but did not have an EOT efficacy assessment due to treatment unrelated death (COVID-19 and cardiac arrest). [b]Defined as IPI 3-5 or IPI 1-2 with ≥ 1 lesion with a maximum diameter ≥ 7 cm and/or screening LDH ≥ 1.3 x ULN. COO, cell of origin; CMR, complete metabolic response; DOR, duration of response; GCB, germinal center B-cell; NR, not reached; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PR, partial response; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone.

1. Amzallag A, et al. Oral presentation at the American Society of Hematology (ASH) Annual Meeting; December 6-9, 2024; Orlando, FL. Abstract 579.

Nowakowski GS, et al. ICML 2025 [Abstract #OT04]

GOLSEEK-1 (NCT06356129) is a global, multicenter, randomized, Phase 3 study of Golcadomide + R-CHOP vs R-CHOP in previously untreated high-risk LBCL

Patients
N ≈ 850

Key eligibility criteria

- Age 18–80 years
- Previously untreated LBCL by WHO 2022 classification[a]
- Ann Arbor stage II–IV disease
- IPI score
  - ≥ 3
  - 1 or 2 with LDH > 1.3 × ULN and/or bulky disease[b]
- Measurable disease by Lugano classification[c]
- No other lymphoma subtypes
- No lymphoma involvement in CNS

Stratified by:
- **IPI score**
  - IPI 1-2 (with risk factors) + IPI 3 vs IPI 4-5
- **Bulky disease**
  - ≥ 7 vs < 7 cm

Screening: ≤ 4 weeks

R 1:1

Golcadomide + R-CHOP
× 6 cycles
(golcadomide 0.4 mg day 1-7 of each 21-day cycle)

Placebo + R-CHOP
× 6 cycles
(placebo day 1-7 of each 21-day cycle)

Primary endpoint

- PFS by investigator based on Lugano Response Criteria[1]

Key secondary endpoints

- PFS (non-high-grade BCL)
- OS
- EFS by investigator
- CMR by IRAC
- MRD-negativity rate (PhaseED-Seq)

Other (select) secondary endpoints

- PFS by IRAC
- OR by investigator
- CMR by investigator
- DOR
- HRQoL
- Safety

Planned: 39 countries
319 sites

Study duration: ~67 months

[a]Includes DLBCL (including GCB and ABC types, or not specified); high-grade BCL (including *MYC* and *BCL2* rearrangements, or not specified); T-cell/histiocyte/rich LBCL; Epstein-Barr virus-positive DLBCL; [b]Single lesion of ≥ 7 cm; [c]≥1 FDG-avid lesion for FDG-avid subtype and 1 bi-dimensionally measurable (> 1.5 cm in longest diameter) disease, by CT or MRI.[10] ABC, activated B-cell; BCL, B-cell lymphoma; CMR, complete metabolic rate; CNS, central nervous system; CT, computed tomography; DLBCL, diffuse large B-cell lymphoma; DOR, duration of response; EFS, event-free survival; FDG, fluorodeoxyglucose; GCB, germinal center B-cell; HRQoL, health-related quality of life; IPI, International Prognostic Index; IRAC, Independent Radiology Adjudication Committee; LBCL, large B-cell lymphoma; LDH, lactate dehydrogenase; MRD, minimal residual disease; MRI, magnetic resonance imaging; OR, overall response; OS, overall survival; PFS, progression-free survival; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone; Tx, treatment; ULN, upper limit of normal; WHO, World Health Organization. 1. Cheson BD, et al. *J Clin Oncol* 2014;32:3059–3068.

Nowakowski GS, et al. ICML 2025 [Abstract #OT04]

Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

Part 1 - Diffuse Large B-Cell Lymphoma:

Antibody-Drug Conjugates and Other Novel Strategies in the Management of DLBCL — Prof Salles

Current and Future Role of Monoclonal and Bispecific Antibodies in the Management of DLBCL — Dr Patel

Chimeric Antigen Receptor (CAR) T-Cell Therapy for DLBCL — Dr Kamdar

Part 2 – Follicular Lymphoma:

CAR T-Cell Therapy for FL — Prof Salles

Other Approved and Emerging Novel Therapies for FL — Dr Patel

Integrating Bispecific Antibodies into the Management of FL — Dr Kamdar

Current and Future Role of Bispecific and Monoclonal Antibodies in DLBCL

Krish Patel, MD

Director, Lymphoma Research

April 24, 2026

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Disclosures

Advisory Committees (All Paid to Institution)	AbbVie Inc, AstraZeneca Pharmaceuticals LP, Bristol Myers Squibb, Genentech, a member of the Roche Group, Janssen Biotech Inc, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Lyell, Merck
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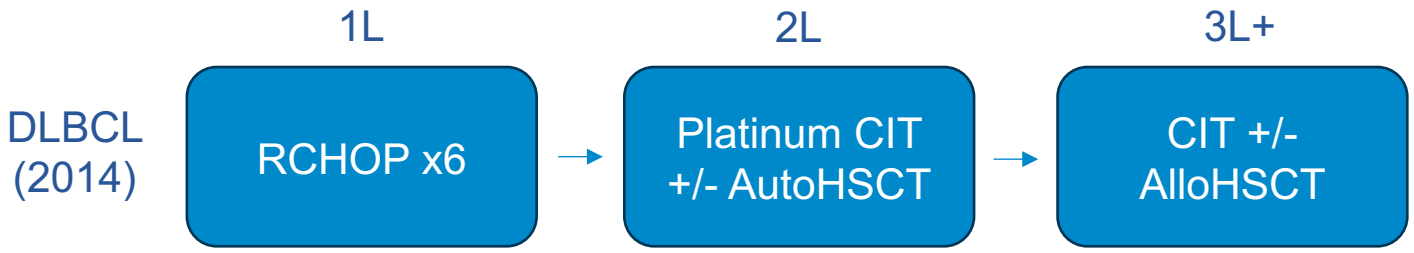
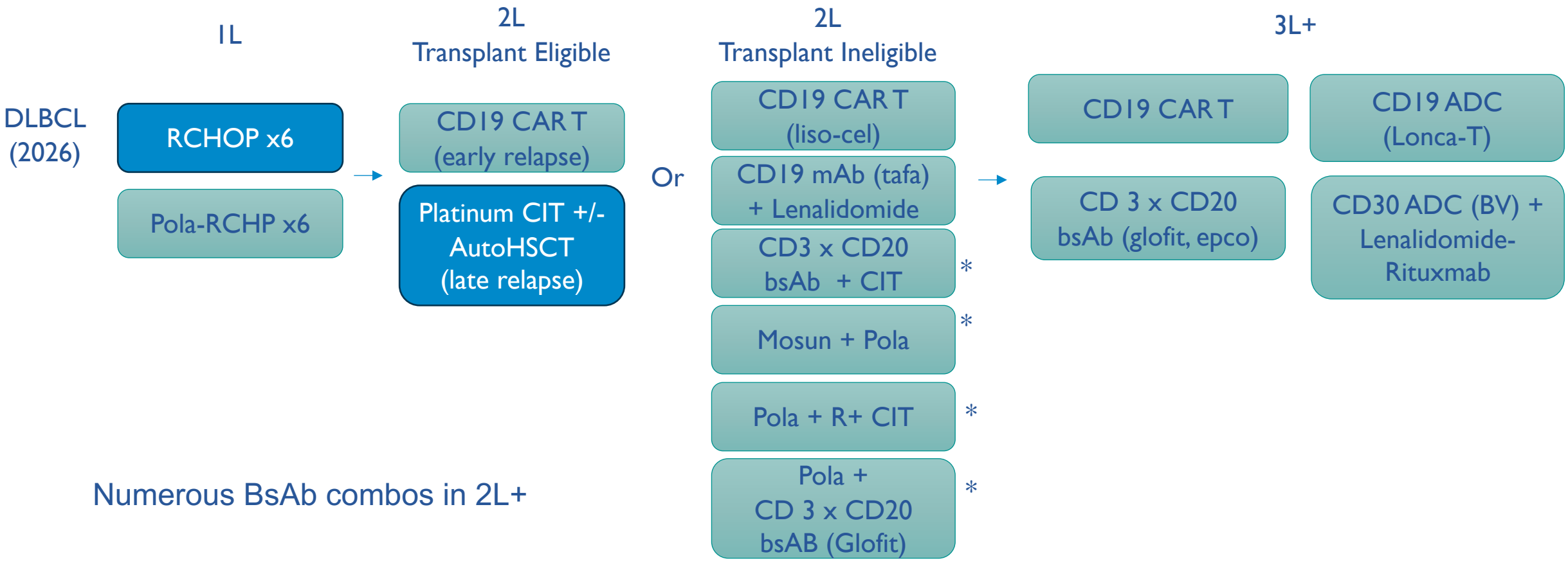
A decade of change: DLBCL circa 2016



Limited tools of the trade (R- chemo)

Adapted from NCCN Guidelines V1.2016

Lymphoma Circa 2026



Numerous BsAb combos in 2L+

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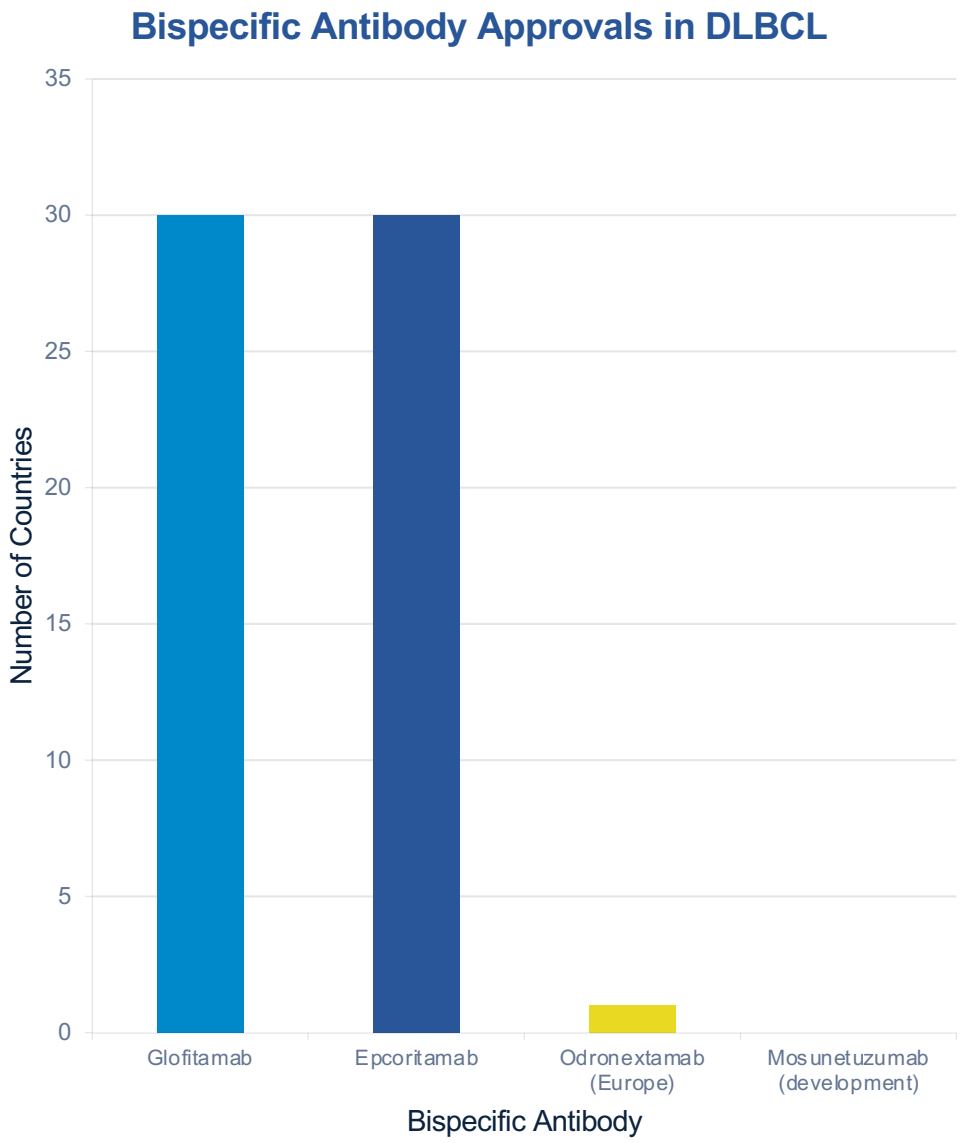
Adapted from NCCN Guidelines v 3.2026. *Not FDA approved

DLBCL Treatment Landscape Transformed by Bispecifics



- Epcoritamab and glofitamab approved globally for DLBCL in 3L+
- Odronextamab received European approval in 3L+
- Mosunetuzumab developed as combination partner with antibody-drug conjugates
- BsAb offer off-the-shelf immunotherapies that can be administered in community settings
- Potentially help to offset accessibility challenges of CAR-T, where CAR-T access is not feasible

Minson A & Dickinson M, Haematologica 2025

Mechanism of Action - CD20×CD3 Bispecific Antibodies

Binding
CD20×CD3 bispecific antibody binds both tumor and T-cell

Activation
T-cell activation occurs independent of MHC-HLA interaction

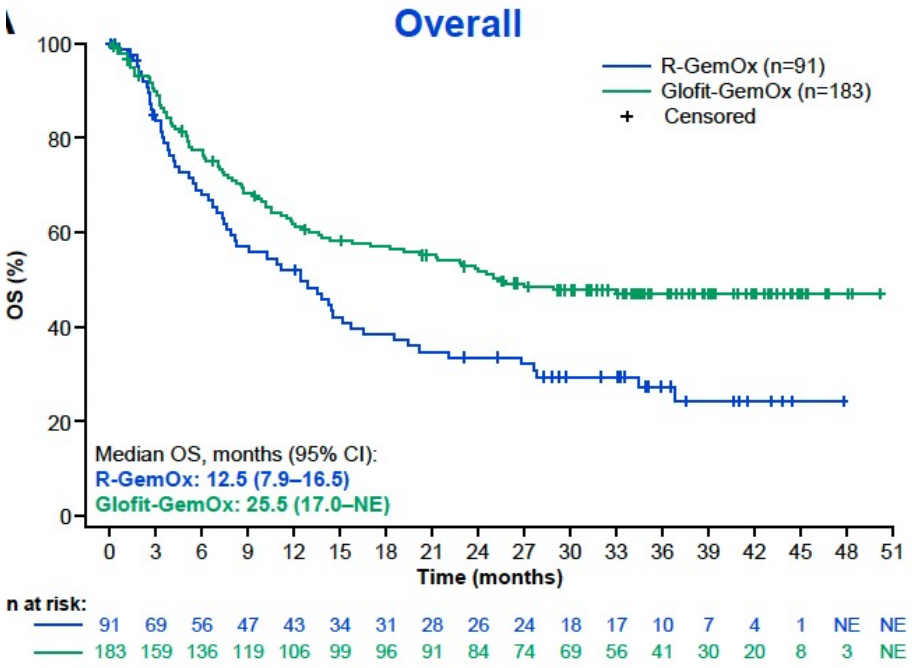
Expansion
Redirected T-cells expand and proliferate at tumor site

Cytotoxicity
T-cell-mediated killing of CD20+ malignant B-cells

- Bispecific antibodies form trimeric complex with CD20+ B-cells and CD3+ T-cells for targeted cytotoxicity
- HLA-independent mechanism allows T-cell activation without antigen presentation, overcoming immune evasion in DLBCL
- Different configurations exist: glofitamab uses 2:1 CD20:CD3 ratio, while epcoritamab uses 1:1 configuration
- Step-up dosing protocols mitigate cytokine release syndrome risk with manageable low-grade events

STARGLO Trial - Glofitamab Doubles Overall Survival

- Phase III STARGLO trial in R/R DLBCL
  - N=274 patients
  - at least one prior therapy, all transplant-ineligible
- Median follow-up 35.1 months
- Hazard ratio 0.60 for OS
- Median PFS was 14.4 months vs 3.3 months with hazard ratio 0.41, showing 59% reduction in progression risk
- CR 58.5% for glofitamab-GemOx versus 25.3% for rituximab-GemOx
- CRS 45% (~13% Gr 2/3) for Glofit GemOx
- Gr 3-4 Infections ~20% Glofit-GemOx vs 13% R-GemOx



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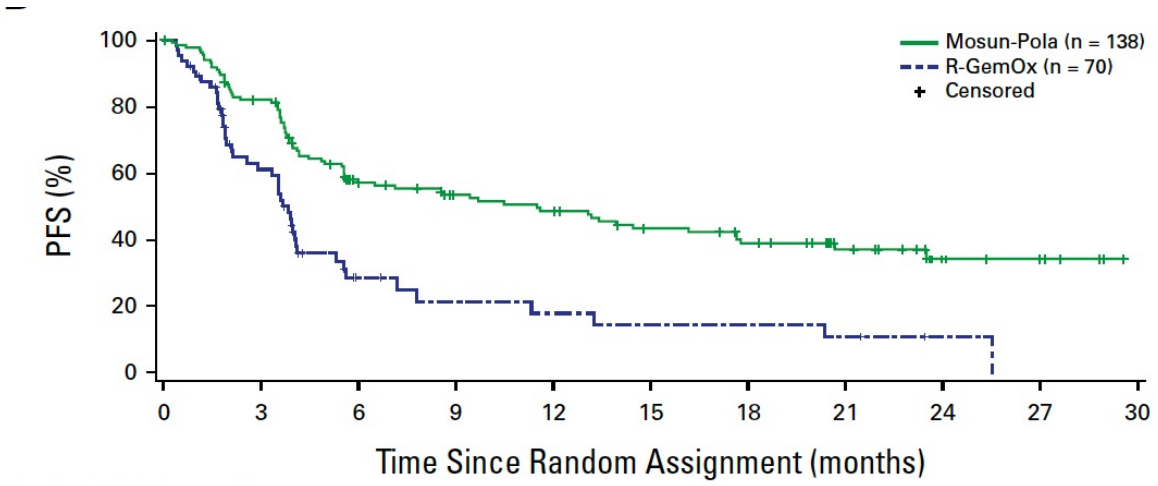
Abramson J et al ASH 2025

SUNMO Trial - Mosunetuzumab Plus Polatuzumab Vedotin



Number at risk (censored)

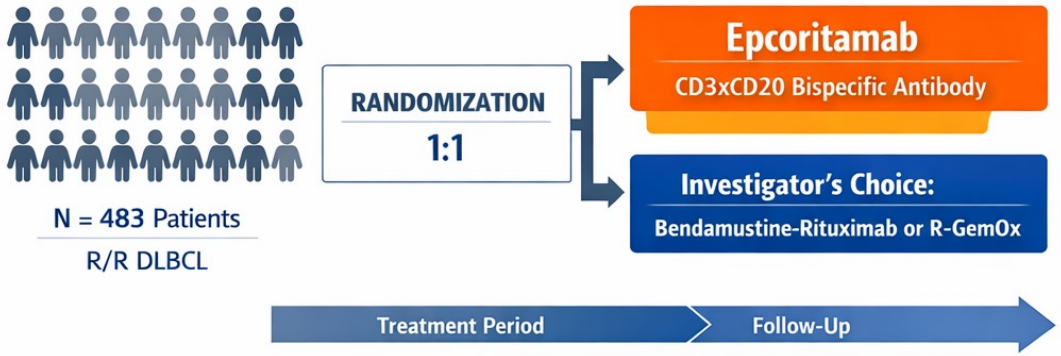
Mosun-Pola	138 (0)	108 (6)	65 (17)	54 (24)	49 (24)	40 (28)	34 (30)	20 (43)	8 (54)	5 (57)	NE
R-GemOx	70 (0)	33 (14)	9 (22)	6 (23)	5 (23)	4 (23)	4 (23)	3 (23)	1 (25)	NE	NE

- Phase III SUNMO study
  - N=208 patients
  - Transplant-ineligible R/R LBCL, 2L+
  - randomized 2:1 to MosunPola vs R-GemOx
  - Fixed duration (8 cycles Mosun, 6 Pola; 8 cycles R-GemOx)
- ORR 70% MosunPola vs. 40% R-GemOx
- CR 51% and 24% respectively
- HR for PFS 0.41; median PFS 11.5 months vs 3.8 mths
- Grade ≥2 cytokine release syndrome occurred in less than 5% of patients, with favorable safety profile suitable for outpatient community care

Budde L et al JCO 2025

EPCORE DLBCL-1 - Epcoritamab Monotherapy 2L+

- Relapsed/Refractory DLBCL (R/R DLBCL)
- ≥ 1 Prior Line of Therapy
- Ineligible for HDT-ASCT



PRIMARY ENDPOINT:

Progression-Free Survival (PFS)

KEY SECONDARY ENDPOINTS:

- Overall Survival (OS)
- Overall Response Rate (ORR)

0.74

Hazard Ratio for PFS

73%

Received ≥2 Prior Lines

First bispecific monotherapy in RCT to demonstrate PFS improvement in relapsed/refractory DLBCL patients ineligible for transplant

Manufacturer Press Release Jan 16, 2026

Safety Profile - Managing Cytokine Release Syndrome

Trial	Therapy	All-Grade CRS (%)	Grade ≥2 CRS (%)	Peak CRS incidence
EPCORE NHL-1	Epcoritamab (SC) monotherapy	49.7%	17.8% (G2: 15.3%; G3: 2.5%)	C1D15
NP30179	Glofitamab (IV) monotherapy	63%	16% (G2: 12%; Grade 3/4: 4%)	C1D8
STARGLO	Glofitamab + GemOx	44%	12% (G2: 10%; G3: 2%)	C1D8
SUNMO	Mosunetuzumab (SC) + polatuzumab vedotin (IV)	26%	<5% (G2 3.7%, G3: 0.7%)	C1D1

Predominantly Grade 1-2

Step-up Dosing Mitigates Risk

Tocilizumab <5% Usage

- CRS reported in 22-83% of patients across bispecific trials, with Grade ≥3 events in ≤9.3% of cases
- Step-up dosing during first cycle reduces severe CRS incidence through weekly dose escalation
- ICANS rare with bispecific antibodies, distinguishing them from CAR-T cell therapy toxicity profiles
- Real-world evidence confirms manageable safety allowing community administration beyond specialized centers

Frontline Integration - Moving Earlier in Treatment

- EPCORE NHL-2 trial with epcoritamab plus R-CHOP in 47 untreated high-risk LBCL
  - 100% ORR, 87% CR
  - 24-month OS and PFS were 87% and 74% respectively

- COALITION trial evaluated glofit with R-CHOP and polatuzumab-R-CHP regimens for high-risk large cell lymphomas
  - 100% ORR, 98% CR
  - 24-month OS 92% and 86% respectively
- OLYMPIA-3 Phase III trial evaluating odronextamab plus CHOP showed 100% CR at 160mg dose

Resistance Mechanisms and CD20 Expression

High CD20 Loss Rate Post-Relapse

Alternative Targets Needed

- CD20 loss is a major challenge post CD3 x CD20 BsAb-refractory disease. 25-60% observed in relapsed patients potentially requiring non-CD20 targeting approaches
- T-cell exhaustion and dysfunction may contribute to resistance
- Baseline T-cell quantity and function critical for bispecific antibody success, more so than CAR-T therapy which provides ex vivo expansion
- Combination with immunomodulatory agents being investigated to overcome resistance and enhance durability

Primary Resistance

Intrinsic tumor biology, T-cell dysfunction, microenvironment factors

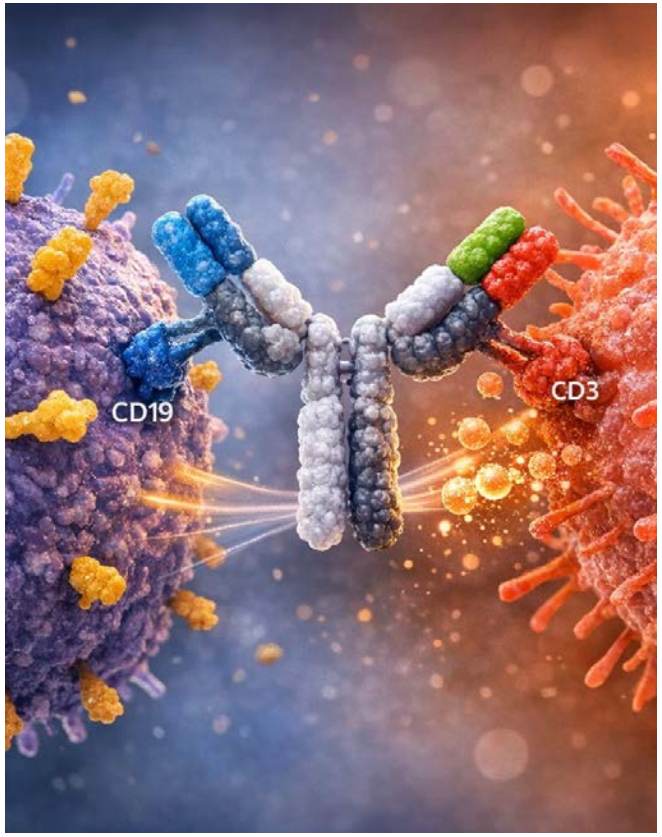
Acquired Resistance

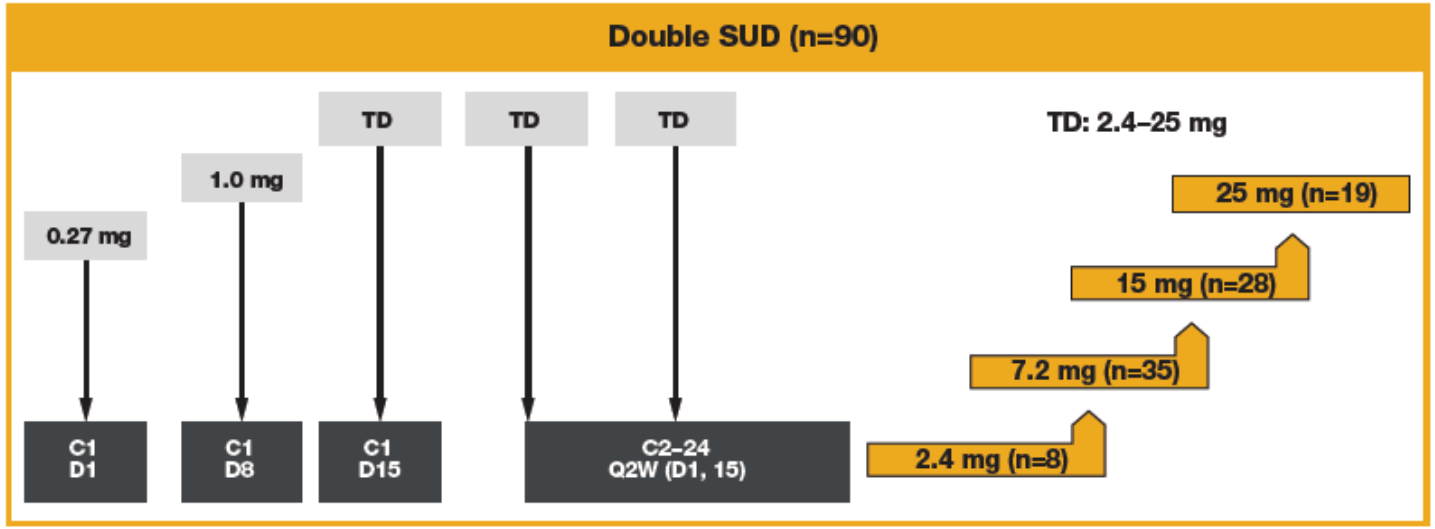
CD20 antigen loss, immune exhaustion, regulatory pathways

Clinical Implications

Sequencing considerations, combination strategies, alternative targets

Surovatamig





N=106

- Median prior lines 3
- 42% prior CD19 CART
- 15% prior CD20 BsAb

- ORR~60%+ , CR~45% in doses 15mg higher
- In pts with CR, ~90% MRD undetectable (CLARITY)
- CRS 49%, no Gr3/4
- ICANS 26%, Gr3 8%

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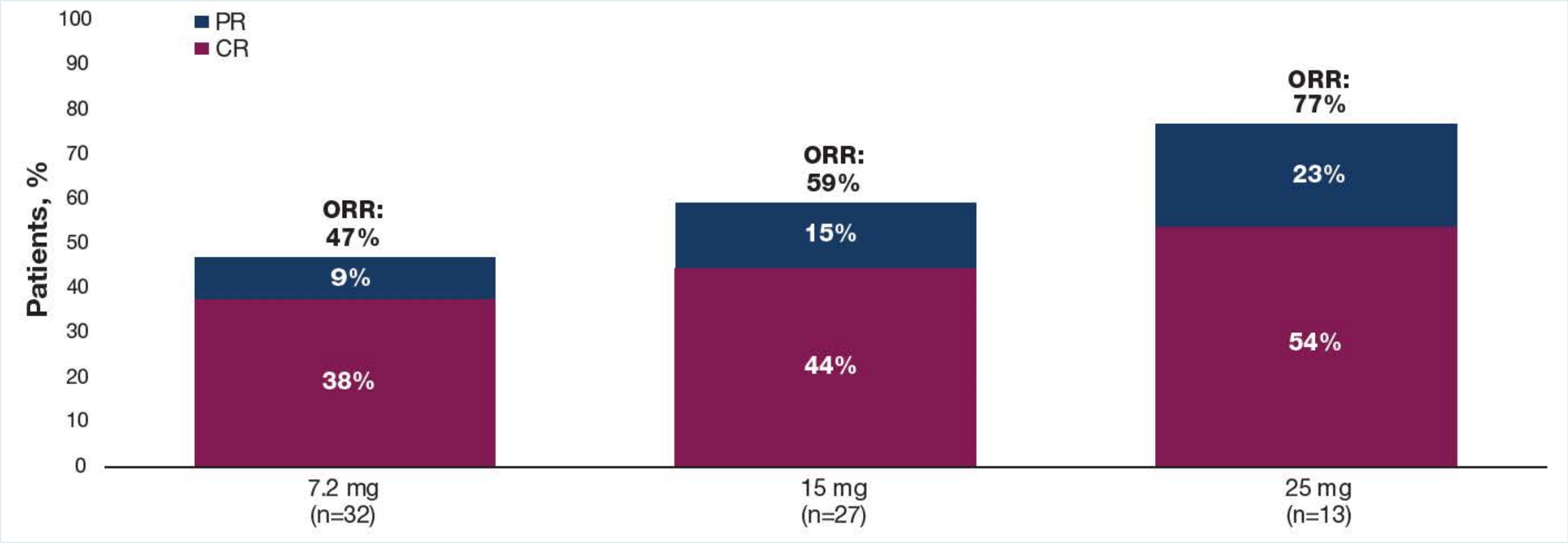
Kim TM et al. ASH 2025;Abstract 5514

Phase I Surovatamig Data: Response Rates by TD



Kim TM et al. ASH 2025;Abstract 5514

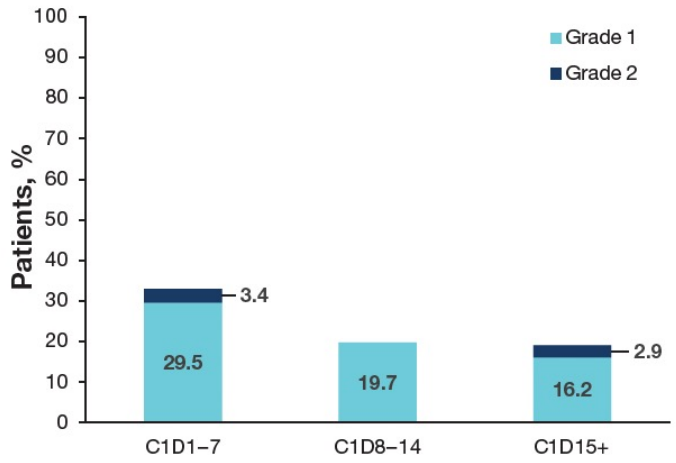
RTP RESEARCH TO PRACTICE

Phase I Surovatamig Data: CRS and ICANS Summary (2SUD Cohort)

	n=90
Any-grade CRS, n (%)	44 (49)
Grade 1	38 (42)
Grade 2	6 (7)
Median time to CRS onset,[a,b] h (range)	23 (6–151)
Median CRS duration,[b] h (range)	3 (1–113)
Management of CRS, n (%)	
Tocilizumab	26 (29)
Corticosteroids	3 (3)
CRS resolution, n (%)	44 (100)

[a]From time of infusion to CRS
[b]Data include doses administered per protocol dose and schedule
[c]Two patients experienced recurrent CRS at C2D1 (1 G1 event each)

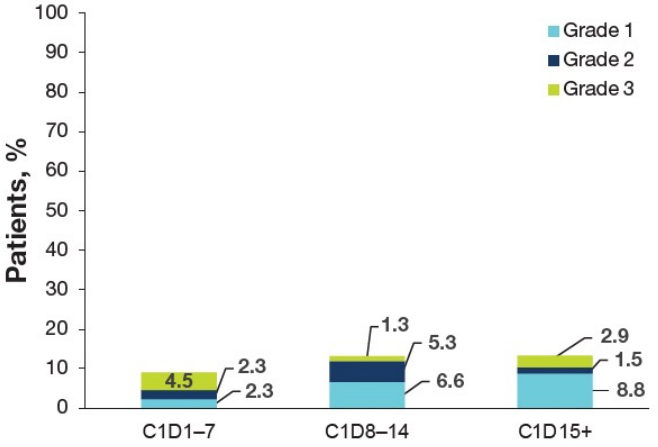
Frequency and Grade of CRS[c]



	n=90
Any-grade ICANS, n (%)	24 (27)
Grade 1	8 (9)
Grade 2	9 (10)
Grade 3	7 (8)
Median time to ICANS onset,[a,b] h (range)	32 (15–132)
Median ICANS duration,[b] h (range)	20 (1–173)
ICANS management, n (%)	
Corticosteroids	20 (22)
ICANS resolution, n (%)	24 (100)

[a]From time of infusion to ICANS
[b]Data include doses administered per protocol dose and schedule
[c]Two patients experienced recurrent ICANS at C2D1 (1 G1 event each)

Frequency and Grade of ICANS[c]



Kim TM et al. ASH 2025;Abstract 5514

RTP RESEARCH TO PRACTICE

Phase III SOUNDTRACK-D2 Trial: First-Line Surovatamig for Older, Unfit Patients

Newly diagnosed LBCL

Age >80
Or
Age 65-79, classified as "unfit" and not considered candidates for full-dose R-CHOP

Estimated enrollment: 420 patients

Arm A: R-mini-CHOP and surovatamig
2 cycles of R-mini-CHOP followed by multiple cycles of surovatamig at RP3D

Arm B: R-mini-CHOP *(active comparator)*
6 cycles of R-mini-CHOP per SoC regimen

Safety Run-In: R-mini-CHOP and surovatamig
2 cycles of R-mini-CHOP followed by multiple cycles of surovatamig at RP2D

Primary endpoint: Progression-free survival

Key secondary endpoint: Overall survival

Data anticipated >2027

RP3D = recommended Phase III dose; SoC = standard of care

www.clinicaltrials.gov. NCT07215585. Accessed April 2026.

RTP RESEARCH TO PRACTICE

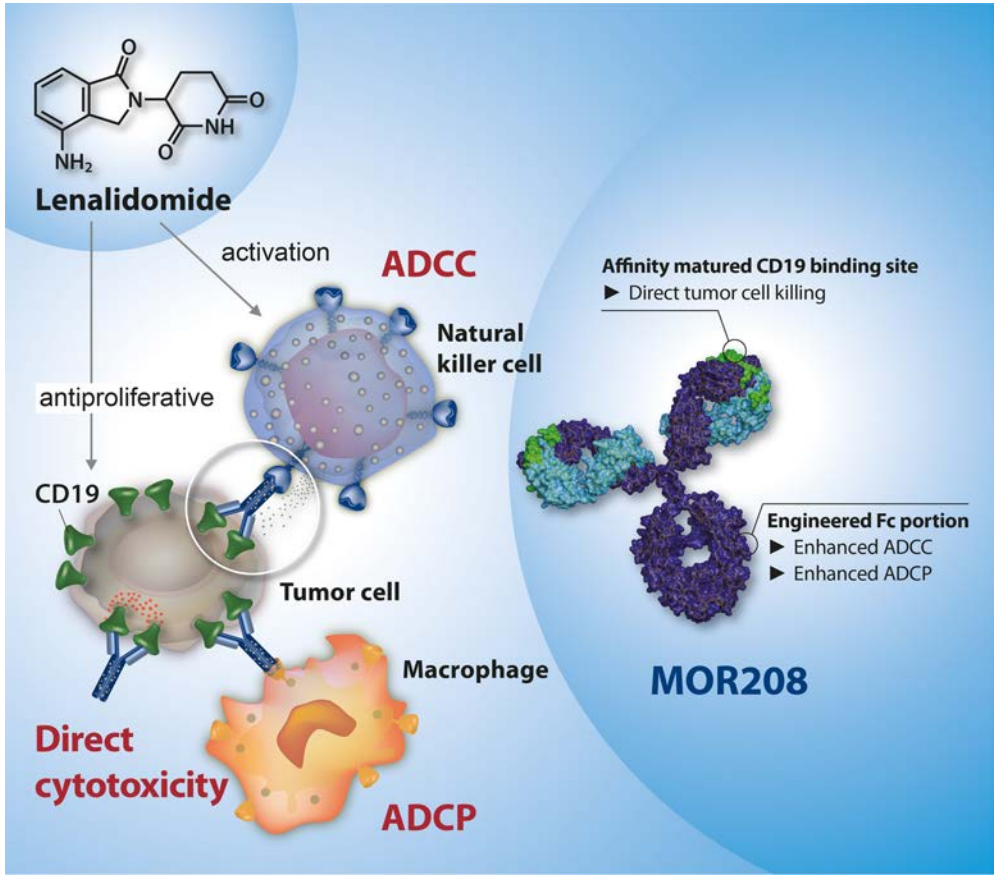
Tafasitamab and Lenalidomide

Tafasitamab (Fc-engineered, anti-CD19 mAb)

- Enhanced to induce cancer cell death via other immune cells
- Direct Cell Death

Lenalidomide

- T and NK Cell Activation/Expansion
- Direct Cell Death
- Well studied as an anti-lymphoma agent, alone or in combination



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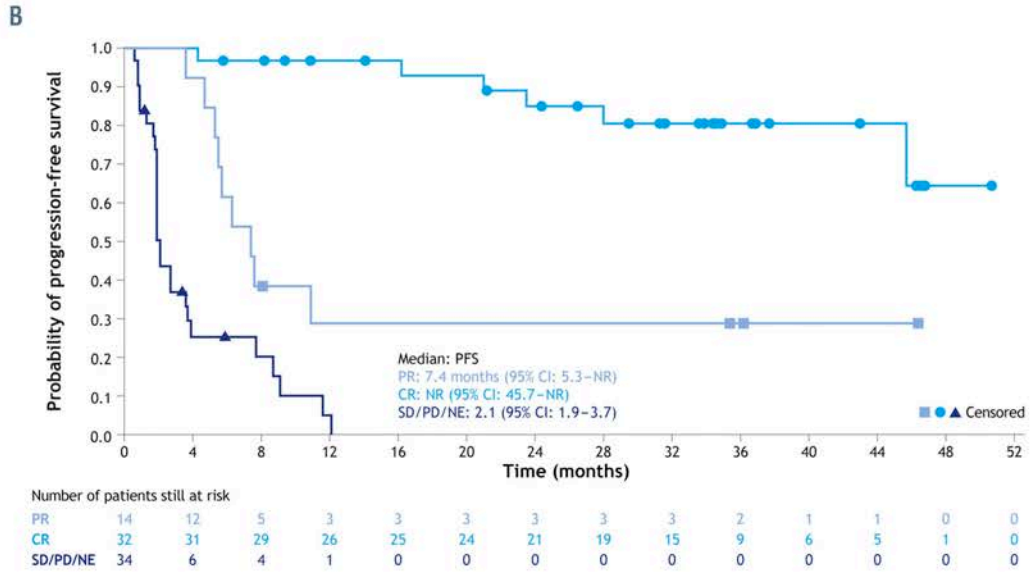
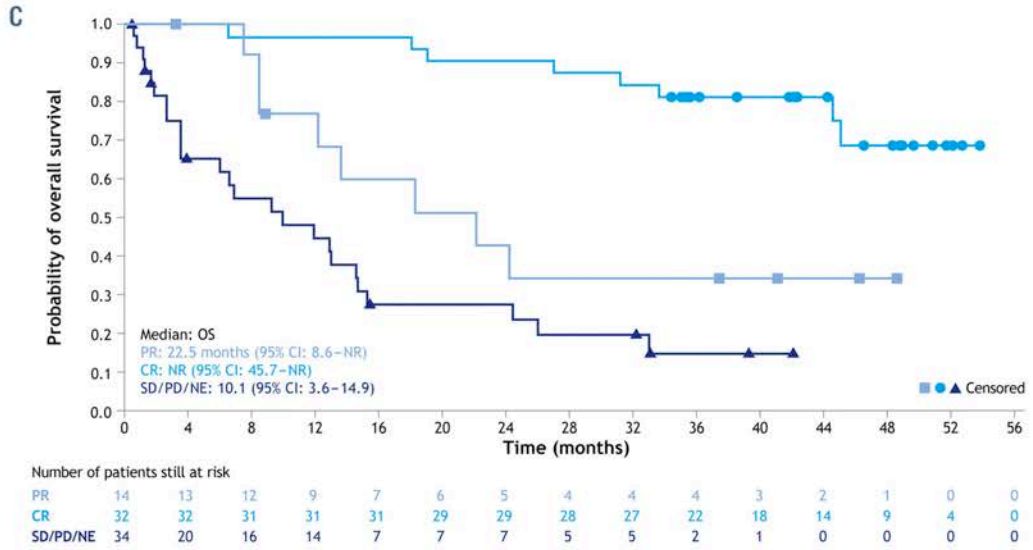
Salles et al. ASH 2019

L-MIND Trial - Tafasitamab in 2L+ DLBCL

Long term f/u indicates those achieving CR (~40%) can have very durable remission

- Median PFS - 11.6mths, CR - NR
- Median OS – 33.5mths, CR – NR





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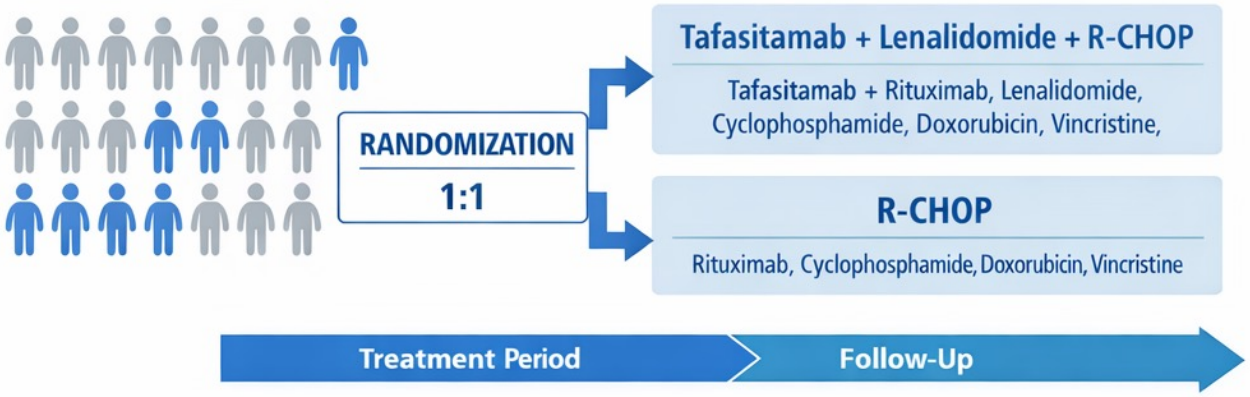
Duell J et al Haematologica. 2021

frontMIND Trial - Tafasitamab in First-Line DLBCL

- Newly Diagnosed High-Risk DLBCL
- IPI 3-5 if > 60 years or aaIPI 2-3 if ≤ 60 years



880
Patients

IPI 3-5
Risk Score

0.75
Hazard Ratio

- Global Ph3 RCT, enrolled 880 treatment-naive patients with high-risk DLBCL (IPI 3-5)
- Primary endpoint met with HR 0.75, p=0.019, representing 25% reduction in progression or death
- Event-free survival achieved with no new safety signals beyond known profiles

Manufacturer Press Release Jan 5, 2026

Clinical Positioning and Treatment Sequencing

1. **2L Transplant-Ineligible**
   Glofitamab-GemOx or Mosun-Pola as preferred regimens

2. **3L+**
   Epcoritamab or glofitamab monotherapy approved options

3. **Post-CAR-T Relapse**
   Bispecific antibodies show activity in CAR-T-refractory patients

4. **1L High-Risk**
   Investigational combinations with R-CHOP/Pola-RCHP under evaluation

Second-line for transplant-ineligible

Post-CAR-T progression option

Frontline high-risk combinations

- FDA and EMA approvals for R/R DLBCL
- STARGLO supports second-line use in transplant-ineligible patients unable to access CAR-T
- Post-CAR-T relapse shows ~50% response rates in heavily pretreated population, higher ORR/CR with combos
- Frontline integration under evaluation in Phase III trials for high-risk DLBCL

BsAb and novel Mabs: Key Takeaways

Phase III Proven

- STARGLO and SUNMO establish new standard of care for transplant-ineligible R/R DLBCL patients
- Off-the-shelf availability and subcutaneous/outpatient administration expand access beyond specialized transplant centers
- Resistance mechanisms including CD20 loss require therapy sequencing and consideration of alternative targets for relapsed disease
- Frontline trial with tafasitamab plus R-CHOP and bispecific combinations may shift treatment paradigm for high-risk newly diagnosed DLBCL within next two years

Community Administration Possible

- Safety profiles manageable with step-up, CRS predominantly low-grade requiring standard supportive care measures
- NCCN guidelines now include mosunetuzumab plus polatuzumab as category 2A recommendation for second-line DLBCL not proceeding to transplant
- General oncologists should familiarize with CRS management, patient selection criteria, and sequencing considerations for optimal outcomes in community practice

Multiple Frontline Trials Ongoing

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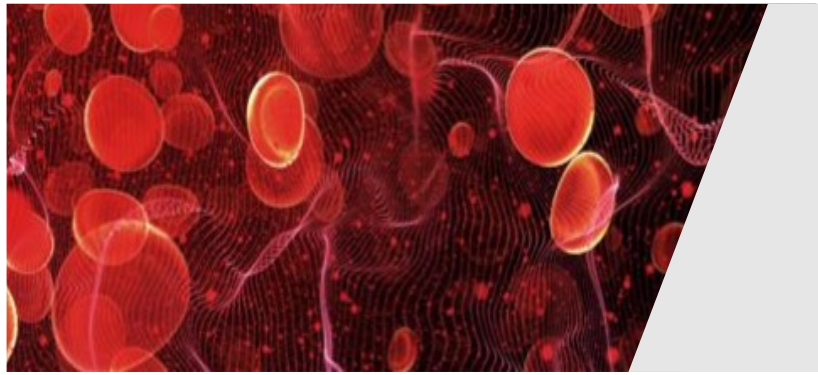


Chimeric Antigen Receptor (CAR) T-Cell Therapy for DLBCL

Manali Kamdar, MD, MBBS

Associate Professor of Medicine, Clinical Director of Lymphoma Services,

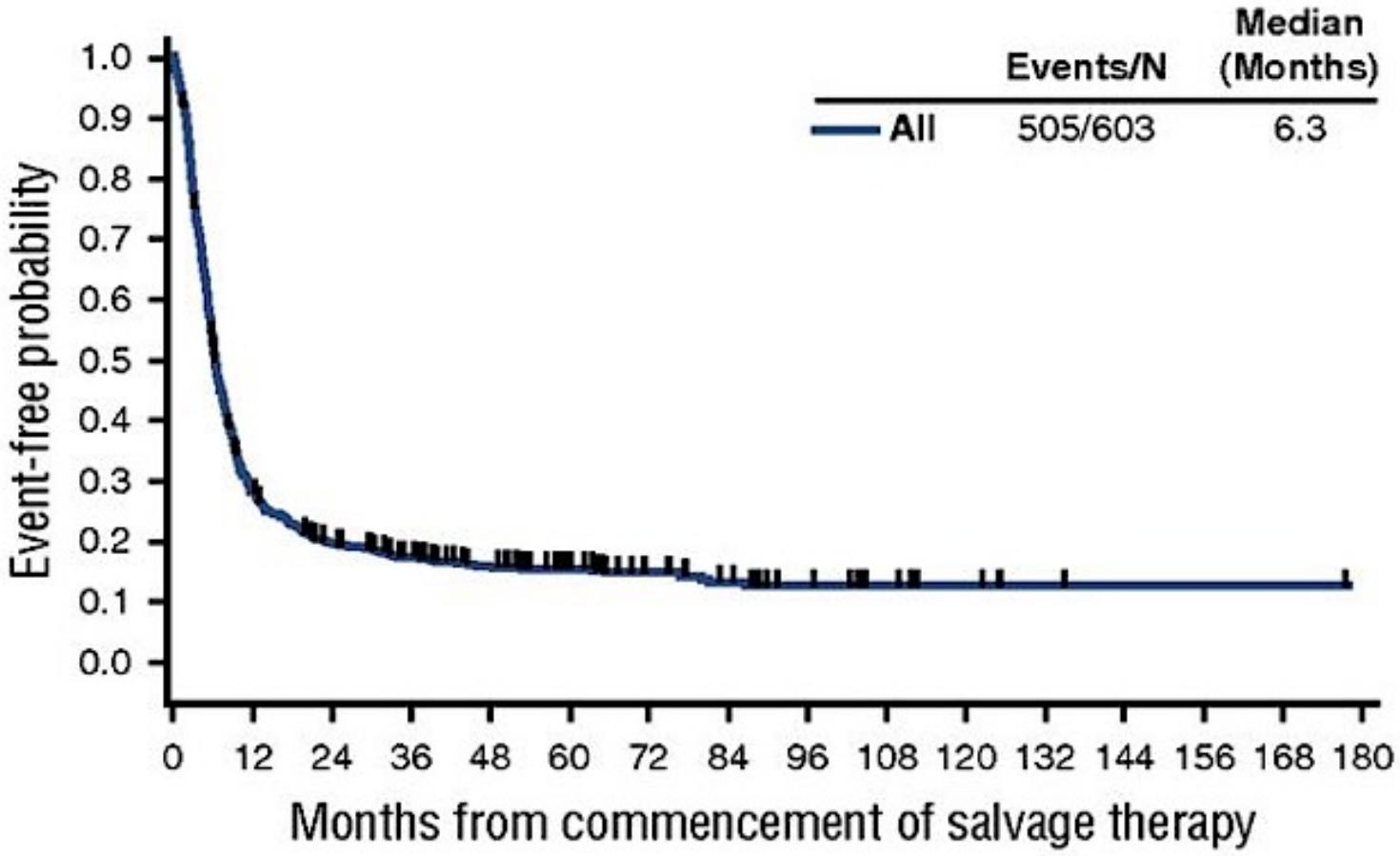
Morton and Sandra Saffer Endowed Chair in Hematology Research, Division of Hematology,

University of Colorado

Disclosures

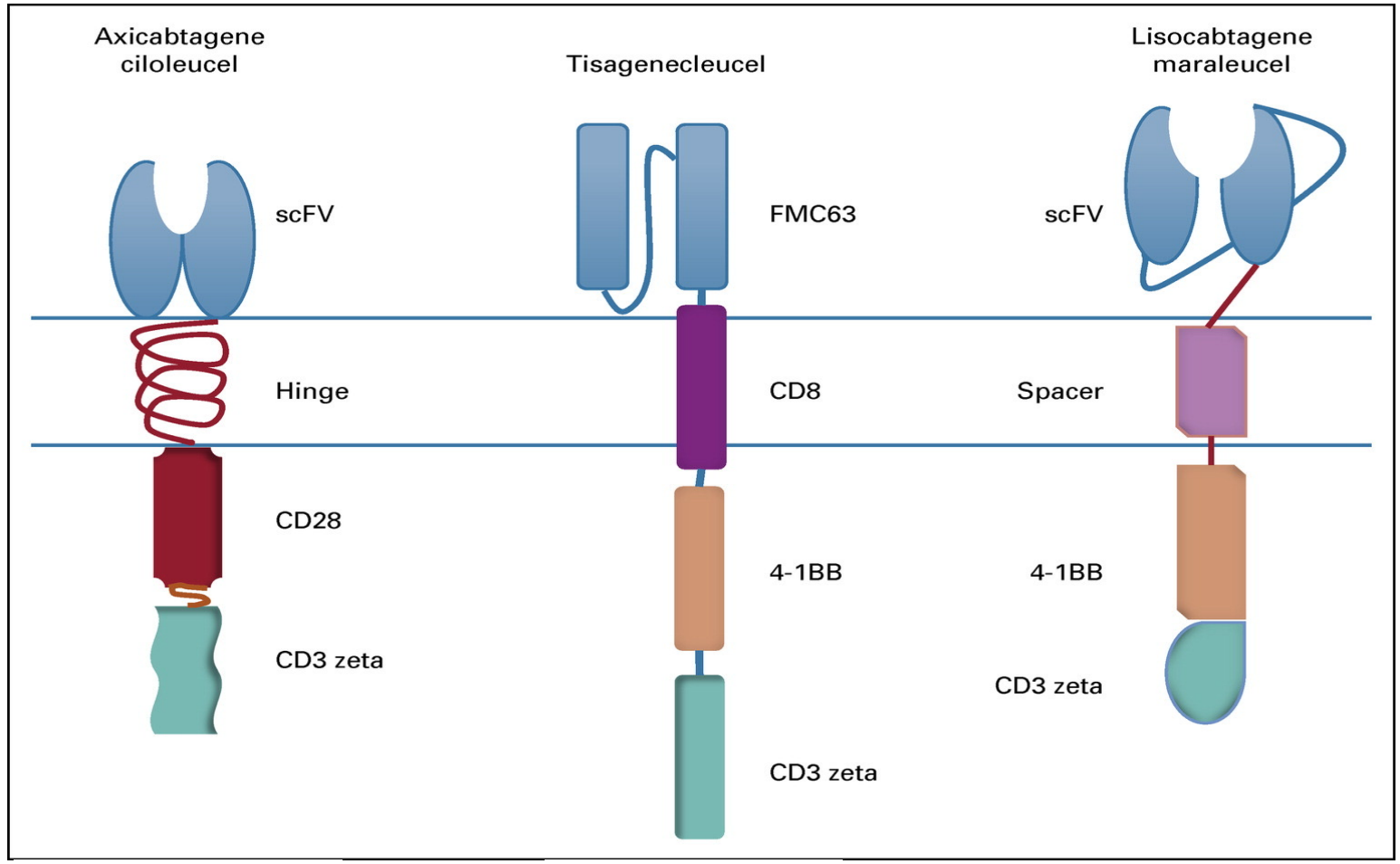
Advisory Committees	AbbVie Inc, AstraZeneca Pharmaceuticals LP, BeOne, Bristol Myers Squibb, Genentech, a member of the Roche Group
Data and Safety Monitoring Boards/Committees	Bristol Myers Squibb, Celgene Corporation, Genentech, a member of the Roche Group.

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



Crump et al Scholar-1 study Blood 2017

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



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

Baseline Characteristics

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

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

Efficacy and Safety

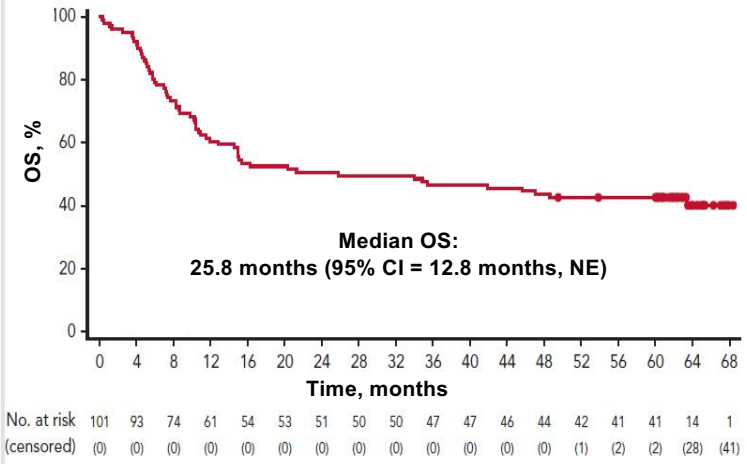
	ZUMA-1 Axicabtagene Ciloleucel	TRANSCEND Lisocabtagene Maraleucel	JULIET Tisagenlecleucel
# Treated / Enrolled	101/111	269/344	111/165
ORR/CR (%) by IRC	74/54	73/53	52/40
Construct	antiCD19-CD28-CD3z	antiCD19-41BB-CD3z	antiCD19-41BB-CD3z
Toxicity grading scale	Lee Criteria	Lee Criteria	Penn Criteria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

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

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

ZUMA-1 (axi-cel)[1]

Overall survival

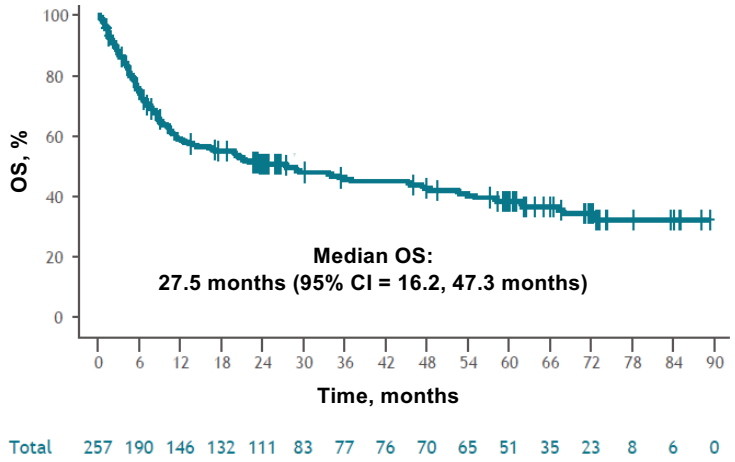


Median OS:
25.8 months (95% CI = 12.8 months, NE)

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

TRANSCEND (liso-cel)[2]

Overall survival

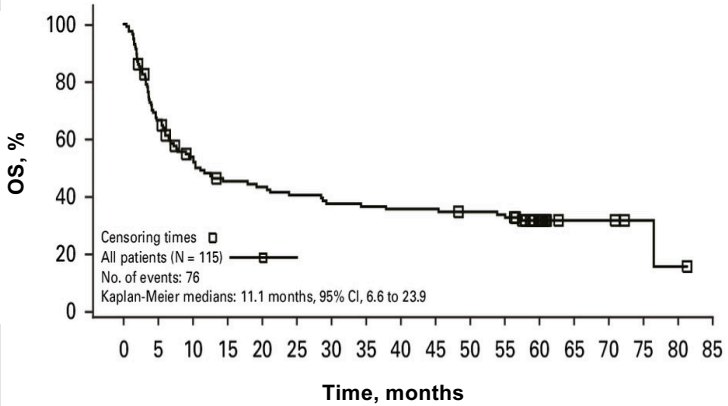


Median OS:
27.5 months (95% CI = 16.2, 47.3 months)

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

JULIET (tisa-cel)[3]

Overall survival



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

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

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

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

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

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

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

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

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

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

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

Locke, F et al, N Engl J Med. 2022 Feb 17;386(7):640-654. doi: 10.1056/NEJMoa2116133
Kamdar, M et al Lancet. 2022 Jun 18;399(10343):2294-2308. doi: 10.1016/S0140-6736(22)00662-6.
Bishop,M et al N Engl J Med. 2022 Feb 17;386(7):629-639. doi: 10.1056/NEJMoa2116596c

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

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

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

ZUMA-7[1,2]

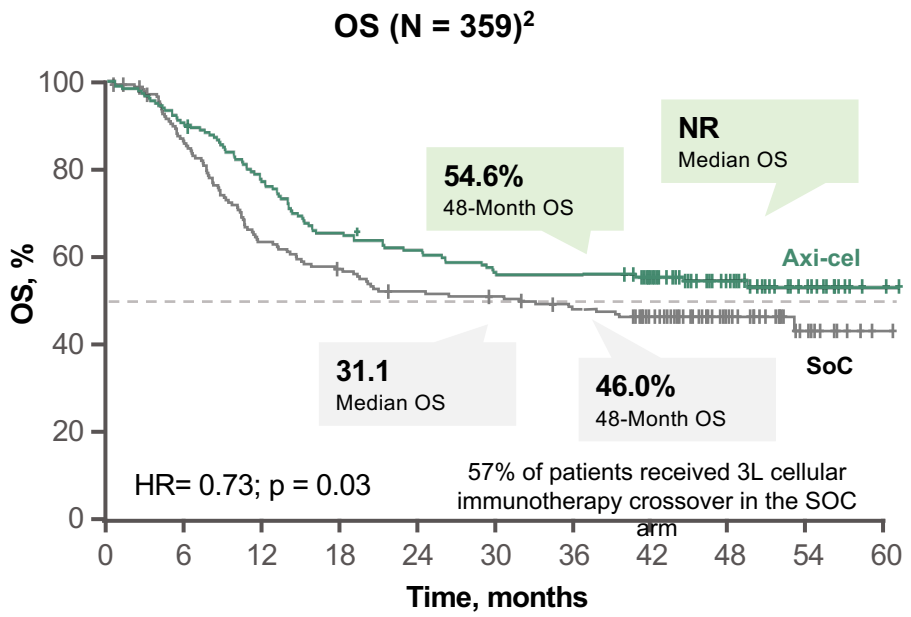
mFU: 47.2 months

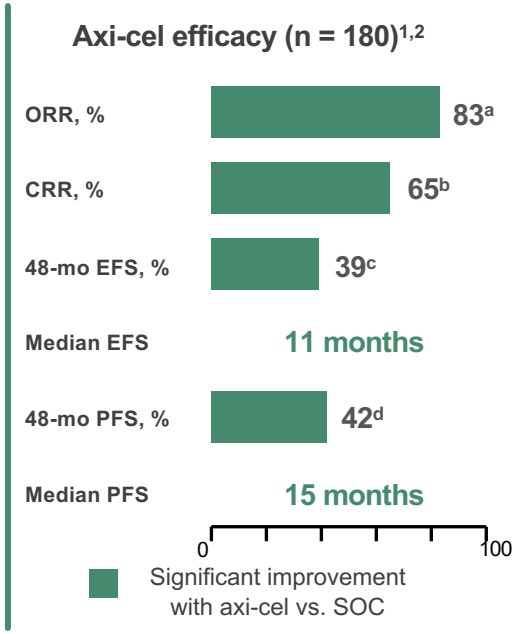
Phase 3, randomized trial of **axi-cel** (n = 180) vs. **SOC** (ASCT, n = 179) as 2L treatment in patients with R/R LBCL (N = 359)

Axi-cel

Primary refractory: 74%

DHL/THL: 17%





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

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

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

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

TRANSFORM

mFU: 33.9 months

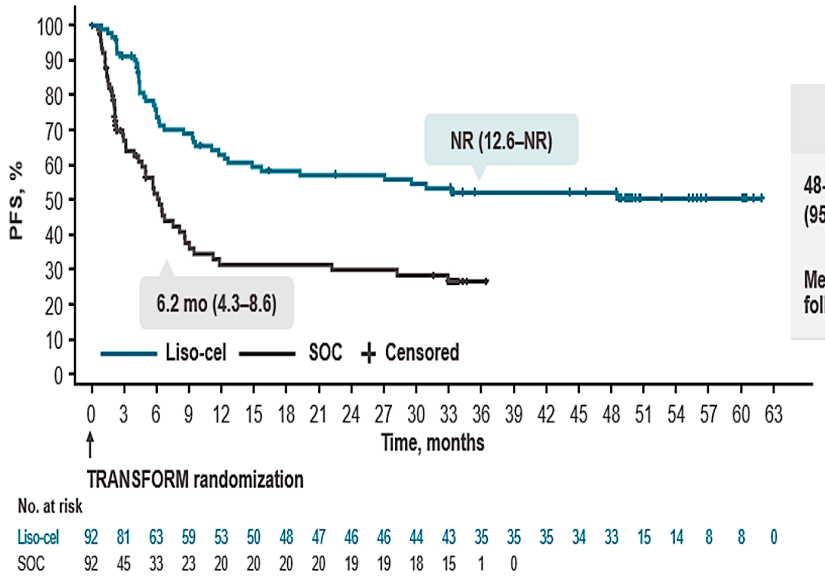
Phase 3, randomized trial of **liso-cel** (n = 92) vs. **SOC** (ASCT, n = 92) as 2L treatment in patients with R/R LBCL (N = 184)

Liso-cel

Primary refractory: 73%

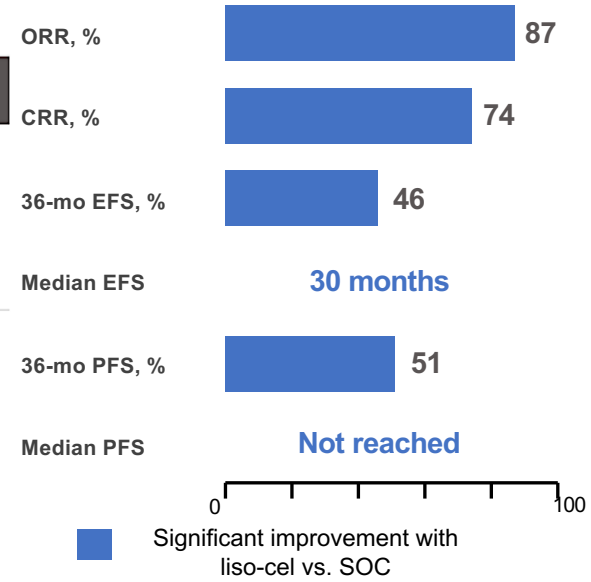
DHL/THL: 24%

Combined TRANSFORM + LTFU



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

Liso-cel efficacy (n = 92)



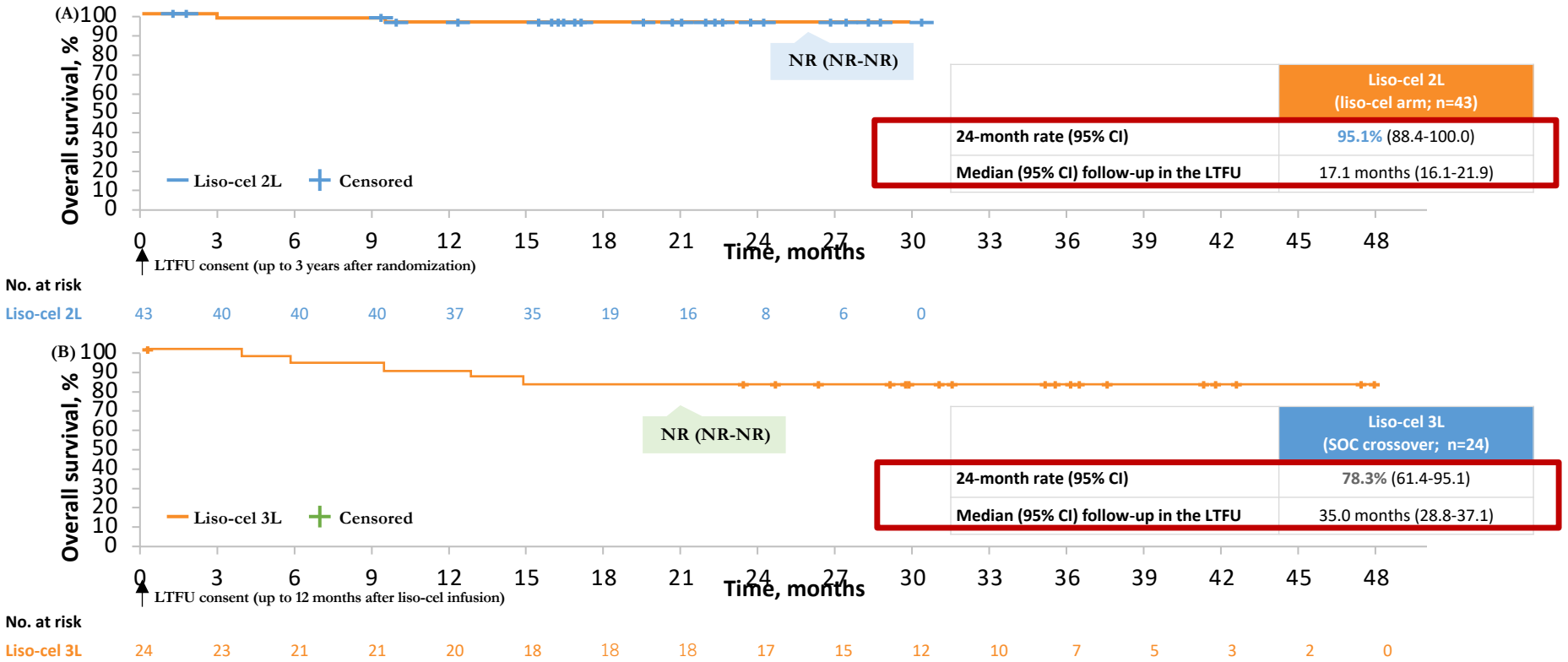
62% of patients crossed over from the SOC arm to receive liso-cel

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

Kamdar M et al. ASH 2025;Abstract 3710

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

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

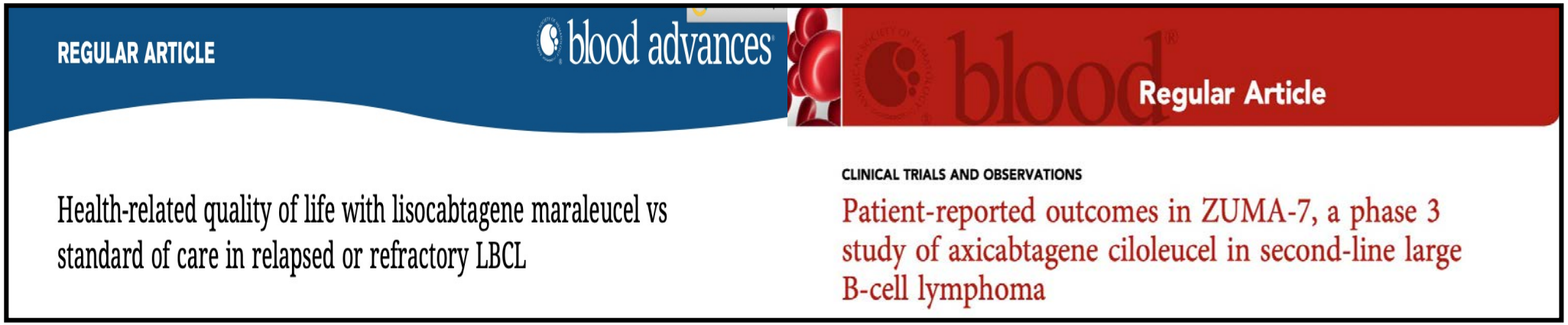


	Liso-cel 2L (liso-cel arm; n=43)
24-month rate (95% CI)	95.1% (88.4-100.0)
Median (95% CI) follow-up in the LTFU	17.1 months (16.1-21.9)

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

Kamdar et. al. ASCO 2024. Oral Presentation

Patient-reported outcomes



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

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

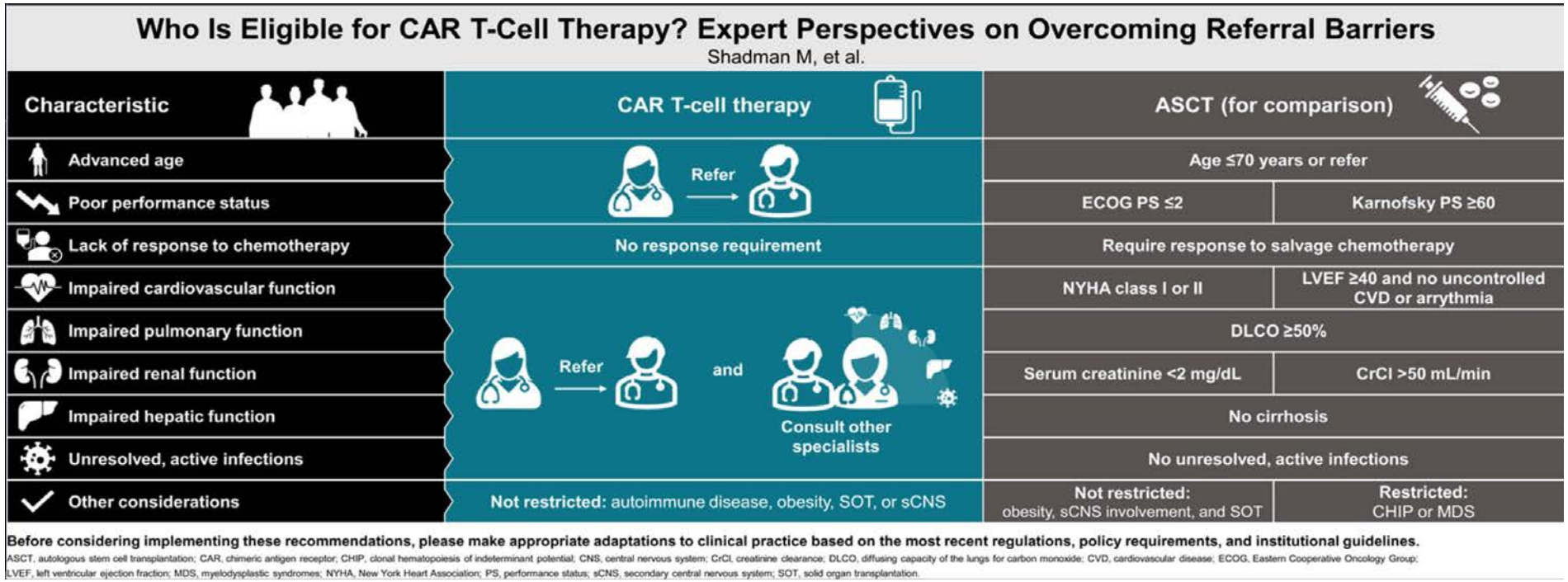
Next question: What about transplant ineligible YET CAR-eligible patients with R/R LBCL?

ASCT, autologous stem cell transplant; axi-cel, axicabtagene ciloleucel; CAR, chimeric antigen receptor; DLBCL, diffuse large B-cell lymphoma; LBCL, large B-cell lymphoma; R/R, relapsed or refractory.

1. Abramson J, et al. Blood Adv 2022;6:23:5969—5979. 2. Elsawy M, et al. Blood 2022;140:2248—2260. 3. Breyanzi (lisocabtagene maraleucel). Summary of product characteristics. Bristol Myers Squibb; 2024.
4. Yescarta (axicabtagene ciloleucel). Summary of product characteristics. Giliead Sciences; 2024.

Determination of CAR-T eligibility

- Several real-world studies[1] have shown that chronological age, comorbidities, or cognitive and/or functional impairments do not consistently affect post - CAR-T outcomes.
- Automatic exclusion of patients based on age/comorbidities is not advised
- Transplant eligibility ≠ CAR-T eligibility
- Recommend referral for at-risk patients to a multidisciplinary clinic for functional optimization prior to CART



Major, Kamdar et al ASH Edu Program book 2023; Shadman M et al. Transplant Cell Ther. 2026 Mar;32(3):277-287.

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

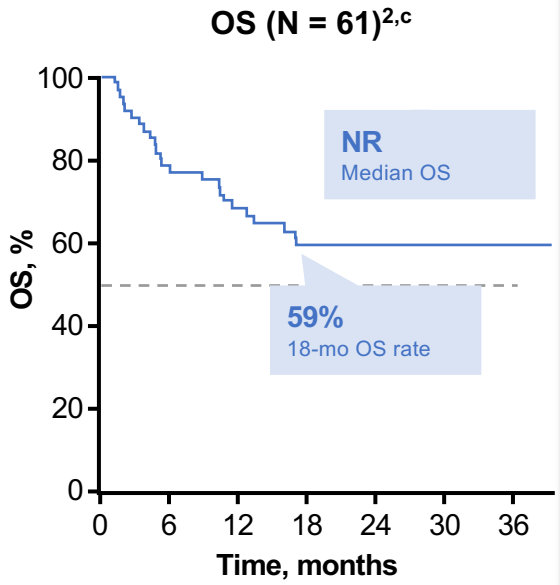
PILOT

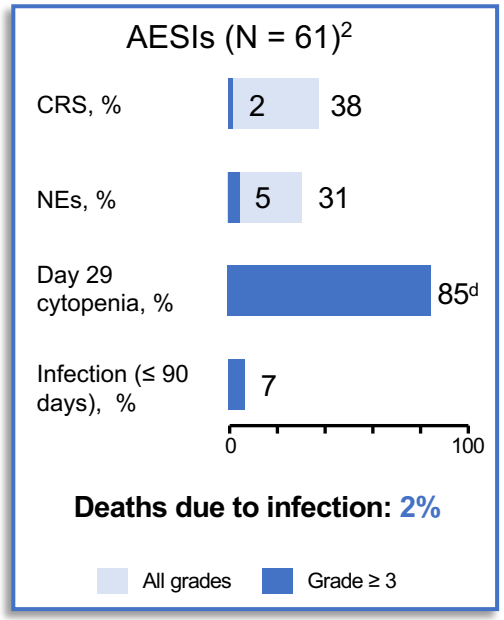
mFU: 24.3 months

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

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

ORR: 80%[2,b]





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

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

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

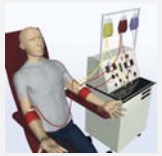
Logistics: CAR T cell therapy process

Manufacturing

Apheresis[1-3]

Washout of prior medications

Patients undergo apheresis (collection of WBCs)



Bridging[1-3]

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

Depends upon extent of disease (chemotherapy vs. RT)

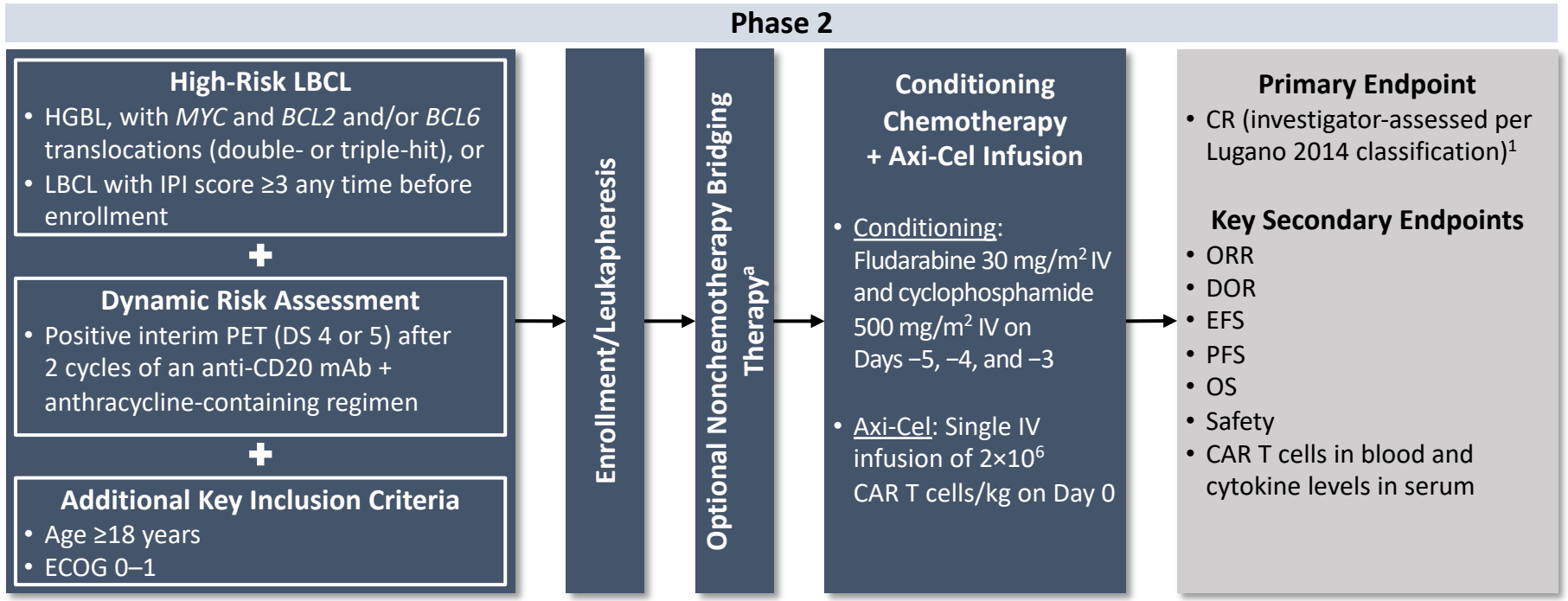
CAR T infusion and management[1,2]

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

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

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

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

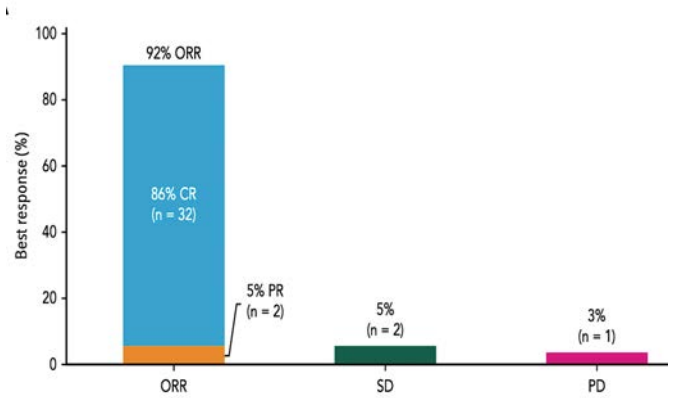


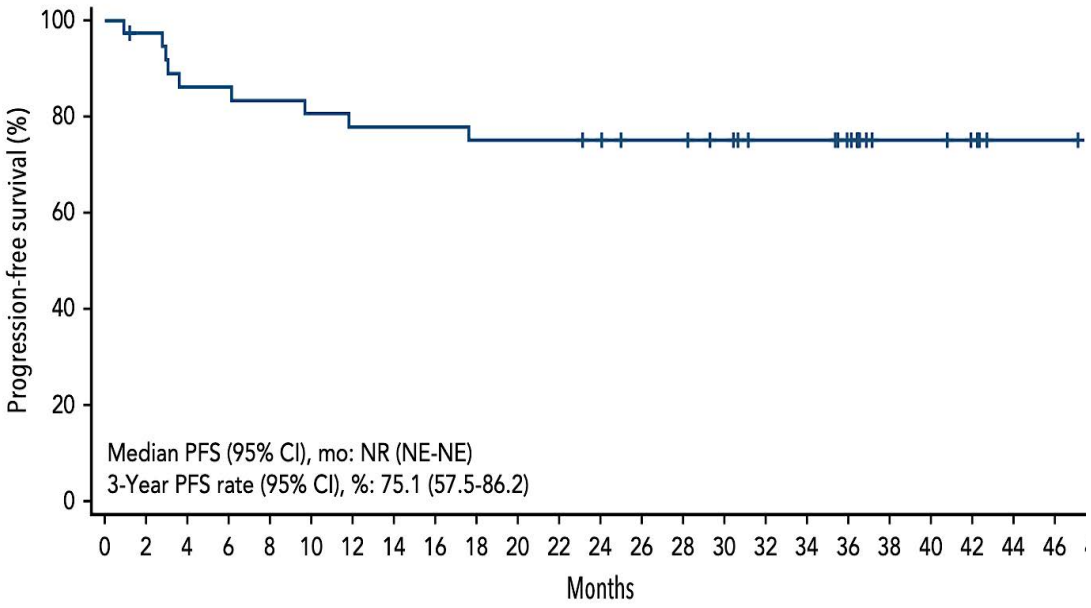
N= 40, Median age 61 (23-86); DHL/THL: 25%, IPI score of >/=3 78%, DS 4: 48%, DS 5 53%

Chavez et al Blood 2025

ZUMA-12: Efficacy/Safety

ORR 89% and
CR Rate 78%





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

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

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

3 yr PFS 75%; 3 yr OS 81%

Chavez et al Blood 2025

Early results with other CAR T-cell platforms in DLBCL

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

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

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

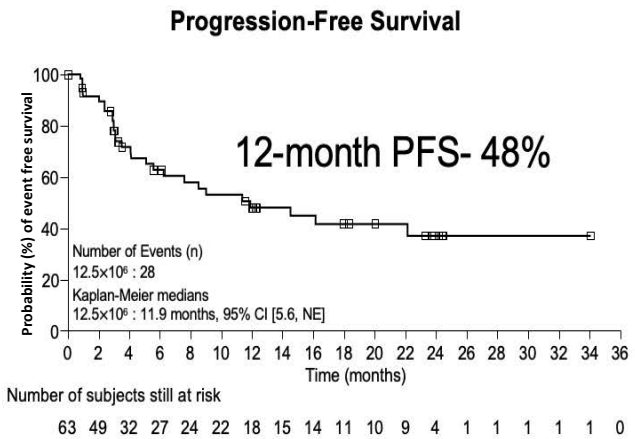
Primary Endpoint: Complete response rate (CR)

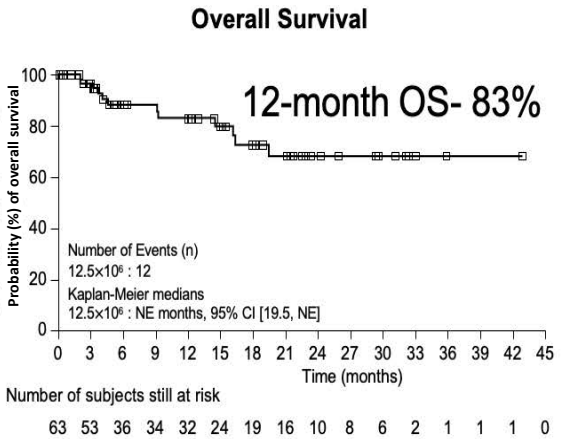
N=63, Median age 64, HGBCL -2 5% Refractory – 58%; mLOT- 2, BT- 60%

RESULTS

Median follow up 16 months

Primary Endpoint met- ORR 88% CR 62%





SAFETY

Most common cytopenias

CRS (44%)

Grade ≥3 CRS (6%) and ICANS (5%)

1 Grade 3 HLH,

Grade ≥3 infection 27%

Grade 5 – 6 patients (2 with PD)

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

Lower dose n=28 Fly/Cy 25/250

Higher dose n=33 Flu/Cy 30/500

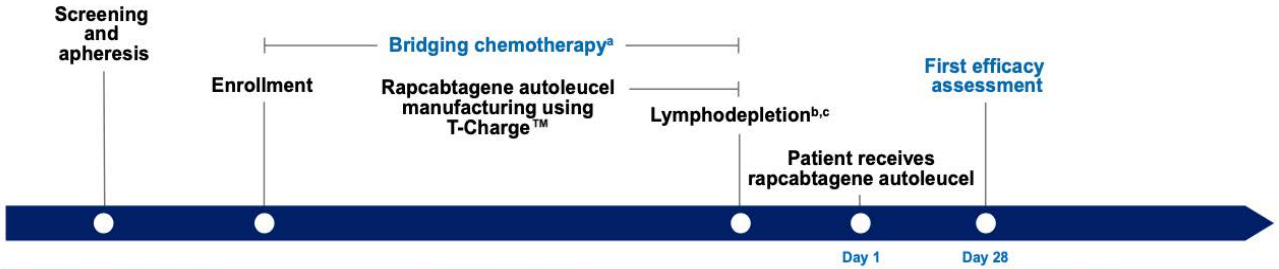
Risk-benefit analyses support lower-dose

Reidel et al ASH 2024 Abstract # 67

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

Phase 2 Study Design

N=53



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

SAFETY

Most common cytopenias
49% low grade CRS
No grade ≥3 CRS events
Median time to onset of CRS 11 days
8% ICANS, 2% Grade 3
Median time to onset 15 days

Response Rate

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

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

Westin et al ASH 2025

CD19×CD20 Dual-Target CAR-T: Early Signals Across Constructs

Trial (NCT)	Phase	N	Method (regimen/duration)	Primary Endpoint	Median Follow-Up	ORR	CR	Median PFS	Median OS	Key ≥G3 toxicities / safety notes
LYL314 / IMPT-314 (NCT05826535)[67]	1/2	45, 31 eval	Dual CD19×CD20 CAR-T;CD62L$^+$-enriched product; single infusion	Safety/tolerability	9 mos.	94%	74%	NR	NR	CRS 62% (mostly low grade), ICANS ≥G3 13%, infections 13%
KITE-363 (NCT04989803)[68]	1	34	Bicistronic CD19/CD20 CAR-T; single infusion	Toxicities and ORR	7.3 mos.	87%	78%	NR	NR	CRS ≥G3 3%, ICANS ≥G3 8%; no grade 4/5 CRS/ICANS
JNJ90014496 / CCAR039 (NCT05421663)[69]	1b	42	Bispecific antiCD19/CD20 CAR-T; RP2D 75M CAR$^+$ cells	Safety/tolerability	12 mos.	90%	76%	NR	NR	No ≥G3 CRS/ICANS; ≥G3 neutropenia 68%

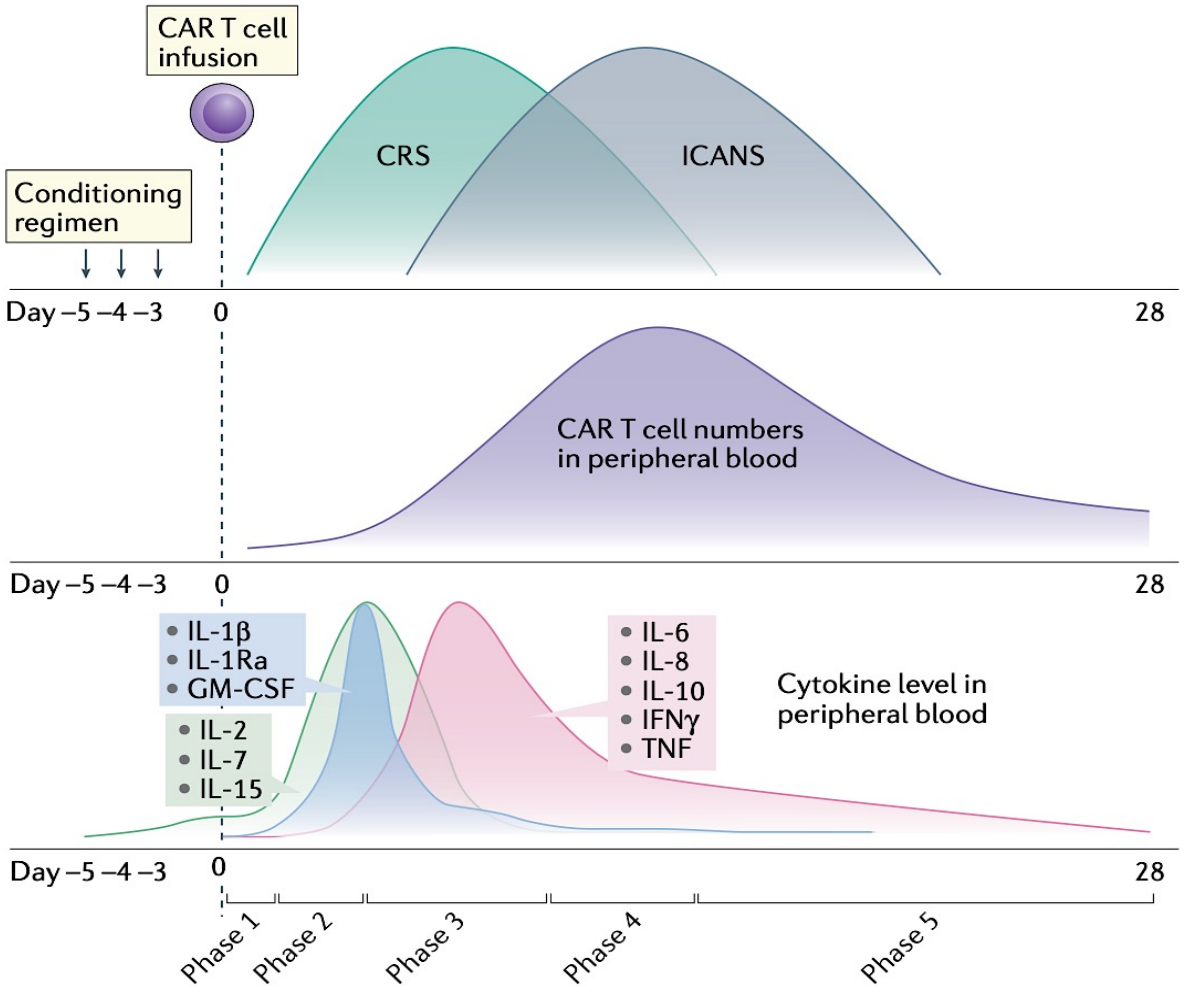
Next Wave of Trials
Phase III RCTs comparing CD19 CARs VERSUS CD19/20 CARs 2L DBCL

Kamdar M, Bartlett NL. Blood 2026

CAR T-cell Therapy Toxicities

- CAR-T-cell therapy related unique adverse events
  - **Cytokine release syndrome (CRS)**
  - **Neurotoxicity (ICANS)**
- On-target/Off tumor toxicity - B cell depletion and Hypogammaglobulinemia
- Delayed hematopoietic recovery
- Risk of infection
- Rarely seen toxicities
  - Insertion mutagenesis, Second Primary malignancies

Management of CRS and ICANS



Morris EC, Nat. Rev Immunol, 2022

CRS management

- **Tocilizumab** is first-line therapy (IL-6R antagonist)
- **Corticosteroids** used for higher grade or 2nd line CRS
- Supportive & infectious disease care for all grades

ICANS management

- **Corticosteroids** are first-line therapy
  - Dosing and frequency based on severity
- Rule out other causes
- Supportive care including seizure prophylaxis

Management of Refractory CRS/ICANS

- Anakinra (IL-1R antagonist) is favored as an alternate
  - Effective in refractory CRS, ICANs and IEC-HLH
- Siltuximab (IL-6 antagonist)
  - Data in tocilizumab failure[1]
- JAK/STAT inhibitors
  - Ruxolitinib
- Lenzilumab (neutralizes GM-CSF)
  - GM-CSF is elevated in severe CRS & neurotoxicity[2]
  - Preclinical studies - prevented CRS and reduced neurotoxicity[3]
  - Clinical trial underway in CD19-CART therapy

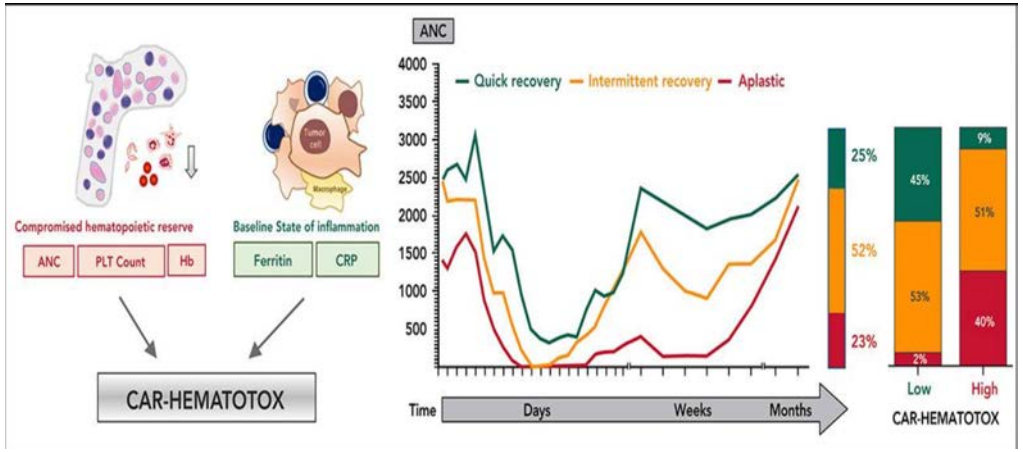
1 Giavridis, Nat Med 2018 2 Neelapu, NEJM 2017 3 Sterner, Blood 2019

CAR-T cell therapy-related toxicities (other) and management

Immune Effector Cell-Associated Hematotoxicity (ICAHT)

- Pre-existing cytopenias
  - Marrow involvement of disease /heavily pre-treated
- General patterns of cytopenias
  - Early (< 30 days) is expected /most common
  - Short-term (30-90 days) can occur in some
  - Prolonged (> 90 days) is uncommon/requires evaluation

CAR-HEMATOTOX Score



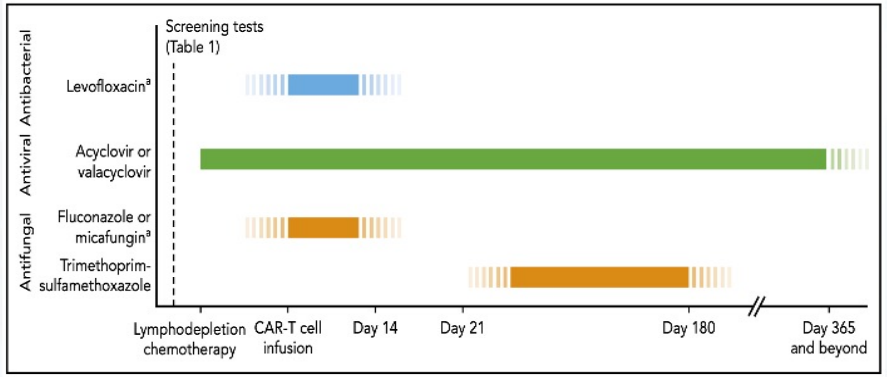
Rejeski et al Blood 2021

B cell Aplasia and Hypogammaglobulinemia

- Expected (On target – off tumor toxicity)
- B-cell aplasia can be profound and severe
- Hypogammaglobulinemia (17-32%)
  - Rates vary across studies
- Management recommendations
  - No consensus
  - Screen monthly during first 3-6 m post CAR T
  - Give IVIG for IgG <400 mg/dL +/- serious infections

Infection Prophylaxis

- Incidence 17-33%
- Work-up neutropenic fevers or infectious symptoms/ Empirically treat until the work-up is negative
- Use growth factor to counter prolonged neutropenia



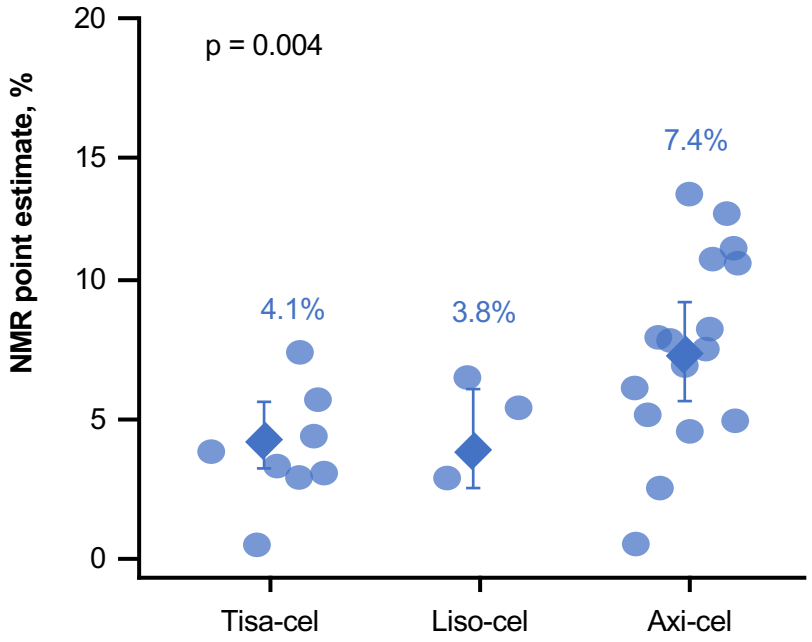
Hill & Seo, Blood Advances, 2020

Infections are the main driver of non-relapse mortality after CAR T

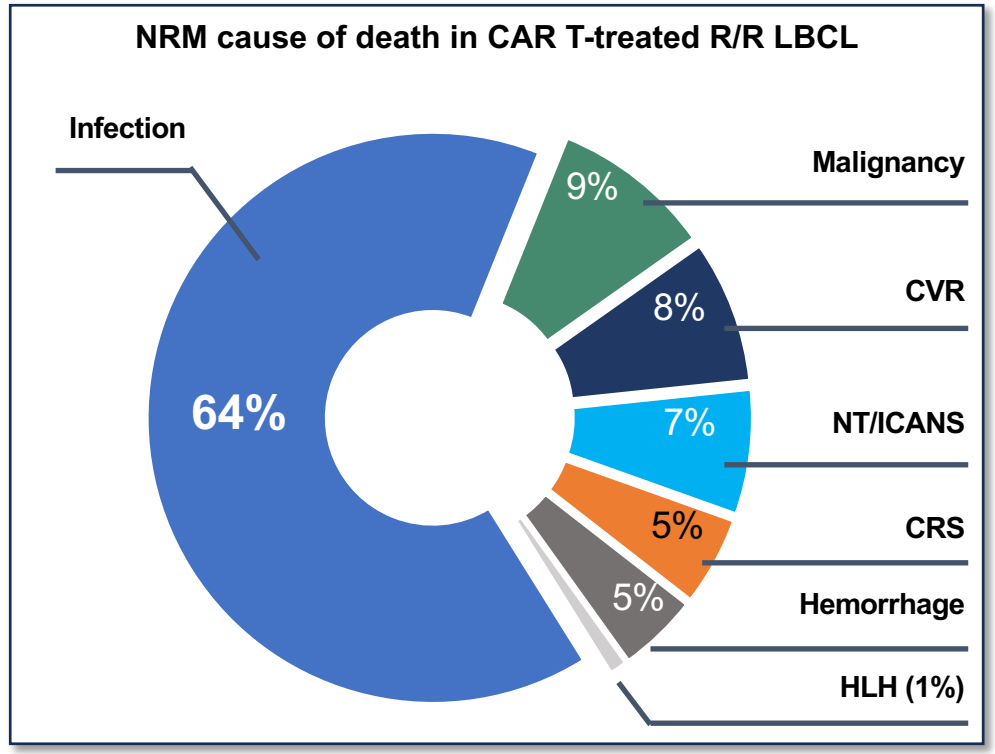
NRM review

Systematic review and meta-analysis assessing non-relapse mortality following CAR T in R/R LBCL for patients treated prior to March 2024 (N = 5,806)

NRM point estimates for CAR T[a] in R/R LBCL



NRM cause of death in CAR T-treated R/R LBCL

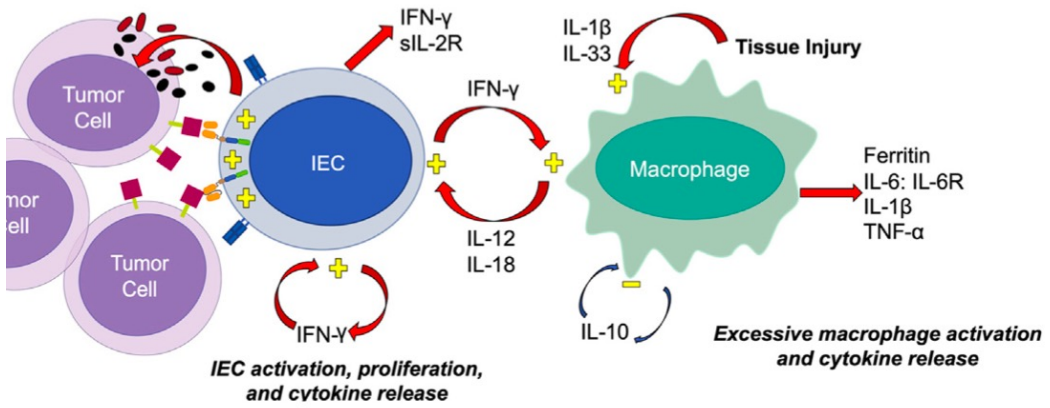


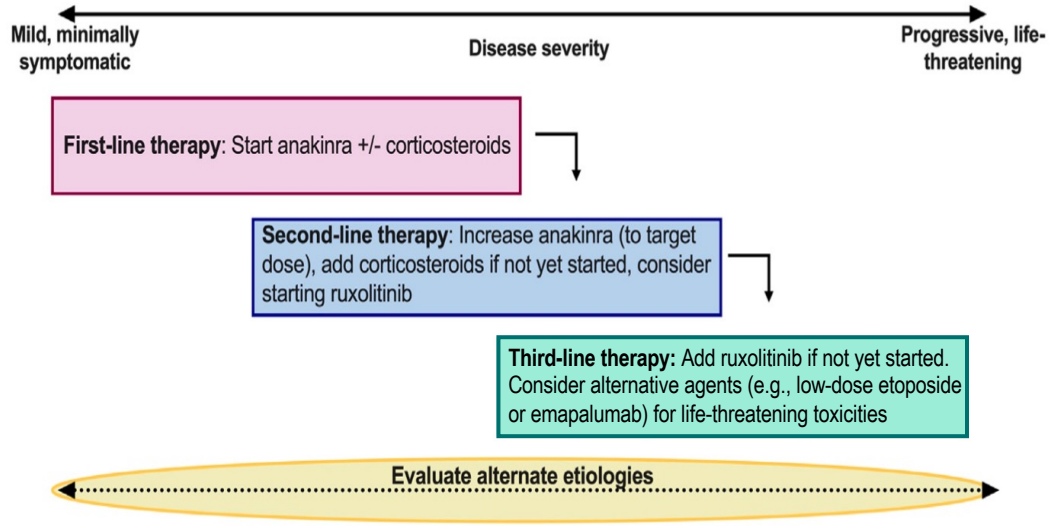
[a] Follow-up times were similar across CAR T-cell products. axi-cel, axicabtagene ciloleucel; CAR, chimeric antigen receptor; CRS, cytokine release syndrome; CVR, cardiovascular or respiratory; HLH, hemophagocytic lymphohistiocytosis; ICANS, immune effector cell-associated neurotoxicity syndrome; LBCL, large B-cell lymphoma; liso-cel, lisocabtagene maraleucel; NRM, non-relapse mortality; NT, neurotoxicity; R/R, relapsed or refractory; tisa-cel, tisagenlecleucel.

Cordas dos Santos DM, et al. Nat Med 2024; 30:2667—2678.

CAR-T cell therapy-related toxicities (Rare) and management

Immune Effector Cell-Associated Hemophagocytic Lymphohistiocytosis-Like Syndrome (IEC-HS)
(usually occurs after CRS – can be delayed)(1-3.5%)





Hines et al. Transplantation & Cell Ther, 2023

Secondary Malignancies[1]

Rates similar to expected incidence following traditional chemotherapy or HSCT

T-cell lymphoma risk- very low

. *1 Cordeiro, BBMT, 2020.*

Transplantation and Cellular Therapy

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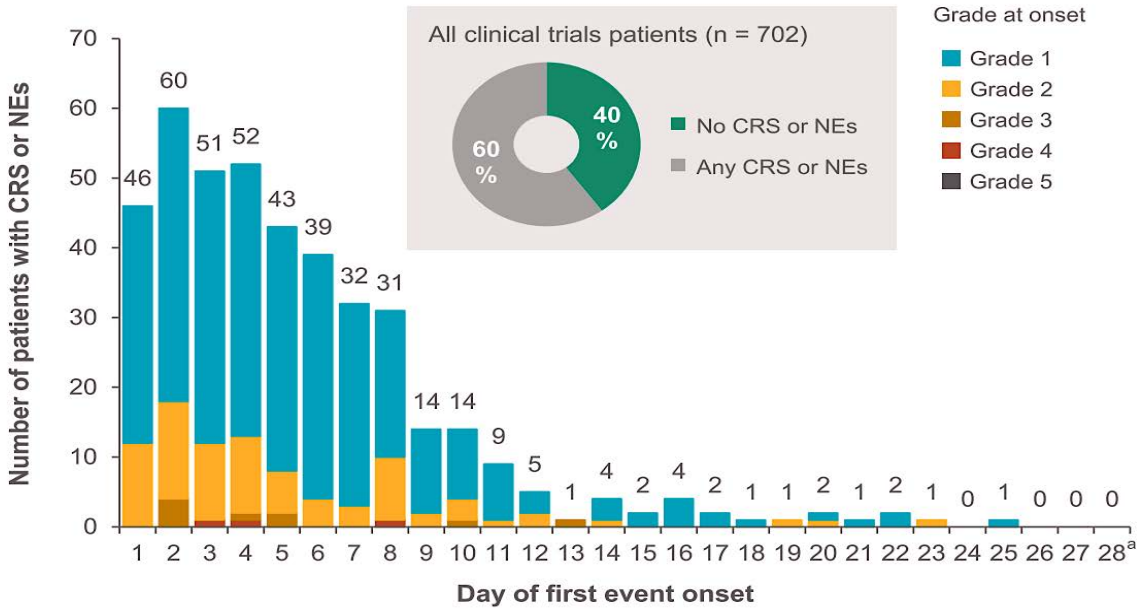
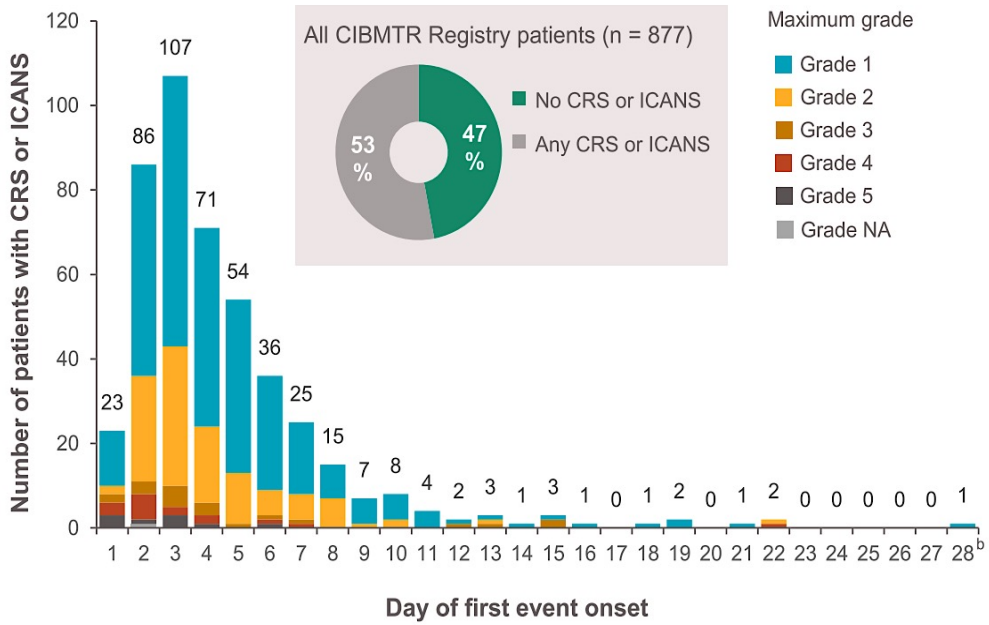
Cellular Therapy

CRS or ICANS Are Rare Beyond 2 Weeks After Lisocabtagene Maraleucel Infusion: Data From Clinical Trials and the Real-World Setting

Bradley D. Hunter[1,*,#], Matthew Lunning[2,#], Mazyar Shadman[3], Sairah Ahmed[4], Jeremy S. Abramson[5], Miguel-Angel Perales[6], Nausheen Ahmed[7], Abu-Sayeef Mirza[8], Iris Isufi[9], Matthew J. Frigault[10], Jennifer L. Crombie[11], David B. Miklos[12], Alberto Vasconcelos[13], Alessandro Crotta[13], David Bernasconi[13], Debasmita Roy[14], Eric Bleickardt[14], Marcelo C. Pasquini[15], Manali Kamdar[16]





Regulatory Updates That Expand Access to CAR T Therapy

Previous Requirement[1-4]	Updated Requirement[5-8]
The Risk Evaluation and Mitigation Strategy (REMS) requirement has been **fully removed**. Breyanzi and Abecma will no longer be administered through a REMS program	
Providers required to ensure 2 doses of tocilizumab are available before infusion	**No change:** Providers are still required to ensure 2 doses of tocilizumab are available
If CRS or neurotoxicity is suspected, physicians are advised to manage the AE according to accompanying recommendations in the label	If CRS or neurotoxicity is suspected, physicians are advised to manage the AE according to the accompanying label recommendations and **may also consider** management per **current practice guidelines**
Daily monitoring for CRS and neurologic toxicities during the first week (10 days for Carvykti) had to occur at the certified healthcare facility	Daily monitoring for CRS and neurologic toxicities during the first week (**without requirement for specific setting**)
Patients had to stay within 2 hours of the certified healthcare facility for 4 weeks	Patients instructed to remain within proximity of a healthcare facility for **2 weeks**
Patients instructed to avoid driving or operating machinery for 8 weeks after treatment	Patients advised to avoid driving for **2 weeks** after treatment

Courtesy: BMS

Expanding Access to Community Centers

- **Risk-adapted delivery models**: Outpatient CAR-T, standardized toxicity algorithms, and early intervention pathways
- **Hub-and-spoke partnerships**: Seamless referral, shared care models, and bidirectional communication between academic and community sites
- **Education & infrastructure**: Targeted training, nursing support, and protocolized monitoring to ensure safety and confidence
- **Operational simplification**: Streamlined referral criteria, predictable timelines, and payer-aligned pathways

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

Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

Part 1 - Diffuse Large B-Cell Lymphoma:

Antibody-Drug Conjugates and Other Novel Strategies in the Management of DLBCL — Prof Salles

Current and Future Role of Monoclonal and Bispecific Antibodies in the Management of DLBCL — Dr Patel

Chimeric Antigen Receptor (CAR) T-Cell Therapy for DLBCL — Dr Kamdar

Part 2 – Follicular Lymphoma:

CAR T-Cell Therapy for FL — Prof Salles

Other Approved and Emerging Novel Therapies for FL — Dr Patel

Integrating Bispecific Antibodies into the Management of FL — Dr Kamdar

CAR T-Cell Therapy in Follicular Lymphoma

Gilles SALLES
Lymphoma Service, Steven Greenberg Chair, Memorial Sloan Kettering Cancer Center
Weill Cornell Medical College, New York, US

Memorial Sloan Kettering Cancer Center

April 2026

Disclosures

Advisory Committees	AbbVie Inc, BeOne, Bristol Myers Squibb, Foresight Diagnostics, Genentech, a member of the Roche Group, Genmab US Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, Kite, A Gilead Company, Lilly, Merck, Novartis, Nurix Therapeutics Inc, Pfizer Inc, SERB Pharmaceuticals
Consulting Agreements	AbbVie Inc, Canopy Life Sciences, Daiichi Sankyo Inc, Ellipses Pharma, Genentech, a member of the Roche Group, Genmab US Inc, Incyte Corporation, Kite, A Gilead Company, ModeX Therapeutics, Treeline Biosciences
Contracted Research	AbbVie Inc, Genentech, a member of the Roche Group, Genmab US Inc, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc

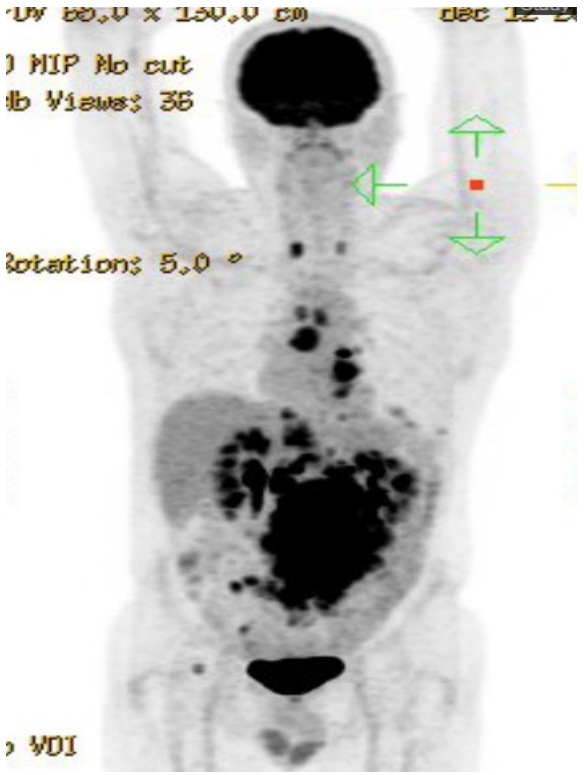
Patient with Refractory FL treated with CAR T-cell

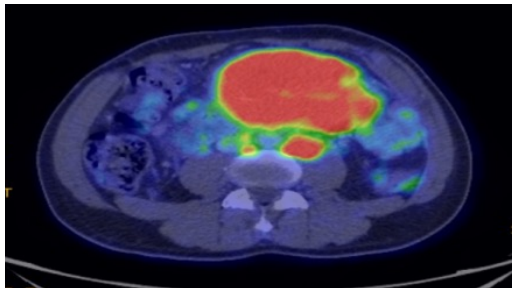
53 year old patient

Resistant to 4 lines of subsequent Tx:

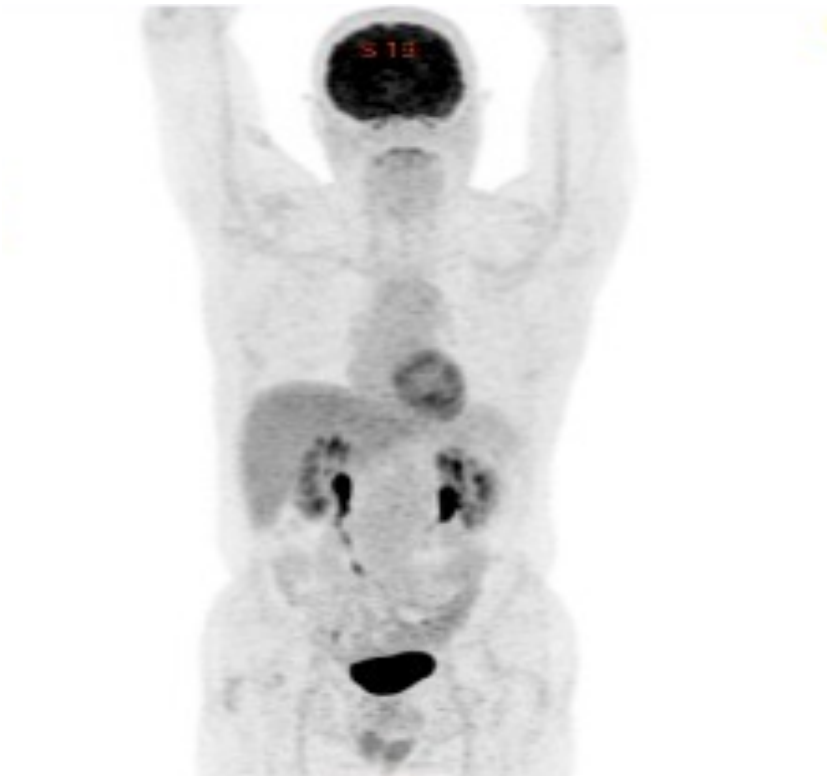
- R-CHOP x 6
- R-DHAOx + Ibru
- Obinu + LEN
- Benda + Obinu

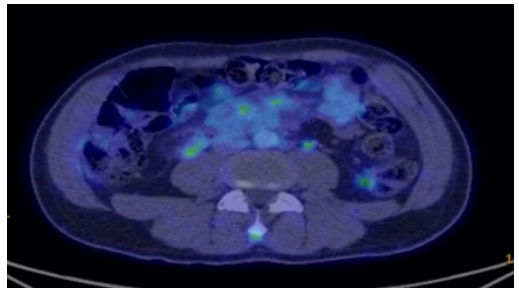
Before CAR-T





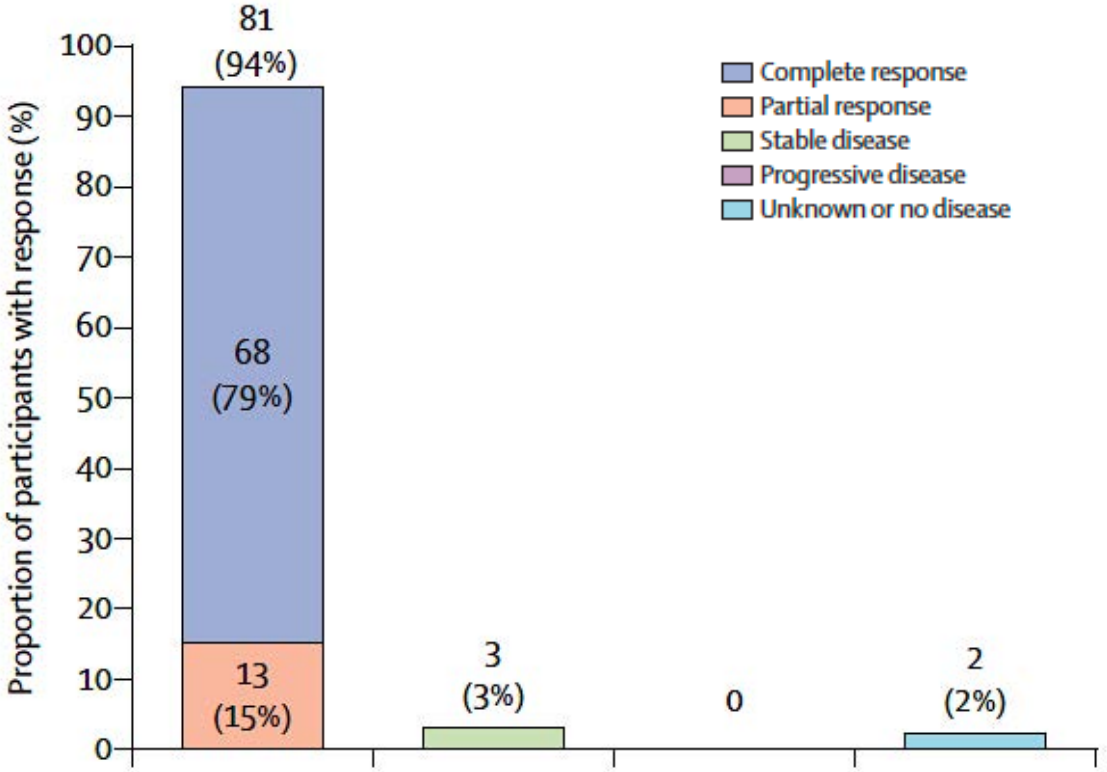
3 months post CAR-T



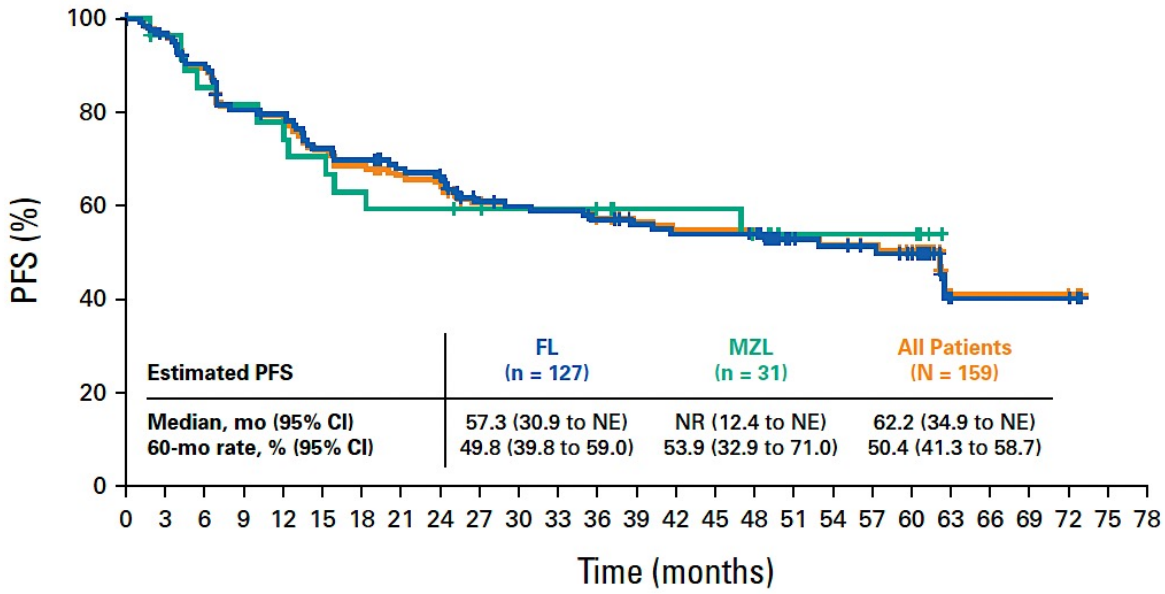


ZUMA-5: Axicabtagene-Ciloleucel (axi-cel)

High response rates



Progression Free Survival



Estimated PFS	FL (n = 127)	MZL (n = 31)	All Patients (N = 159)
Median, mo (95% CI)	57.3 (30.9 to NE)	NR (12.4 to NE)	62.2 (34.9 to NE)
60-mo rate, % (95% CI)	49.8 (39.8 to 59.0)	53.9 (32.9 to 71.0)	50.4 (41.3 to 58.7)

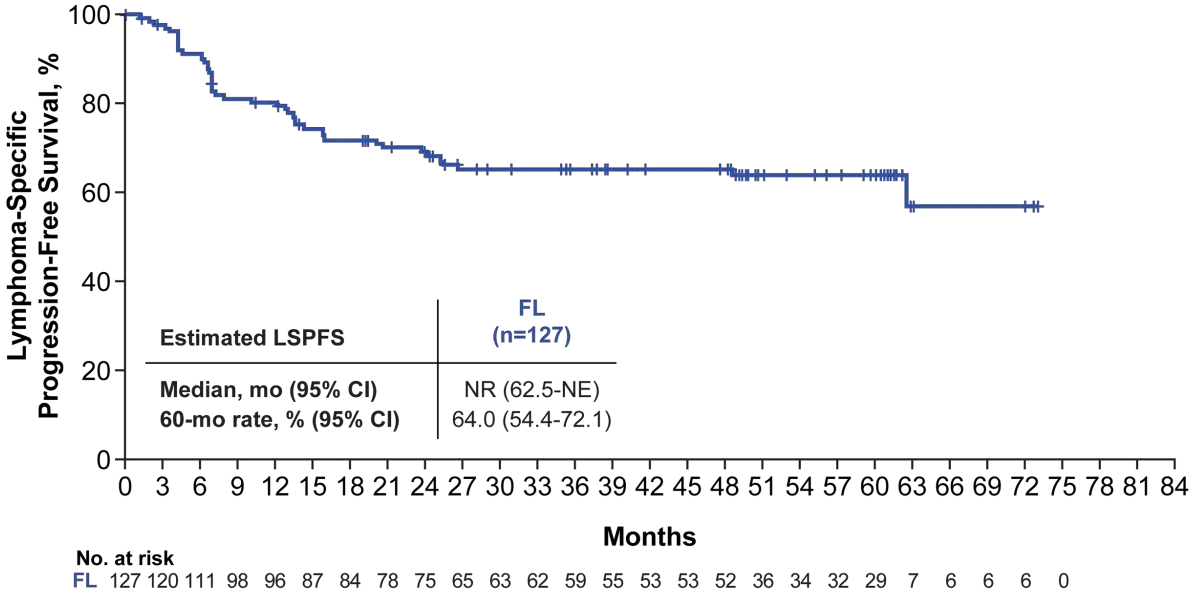
Number at risk:

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

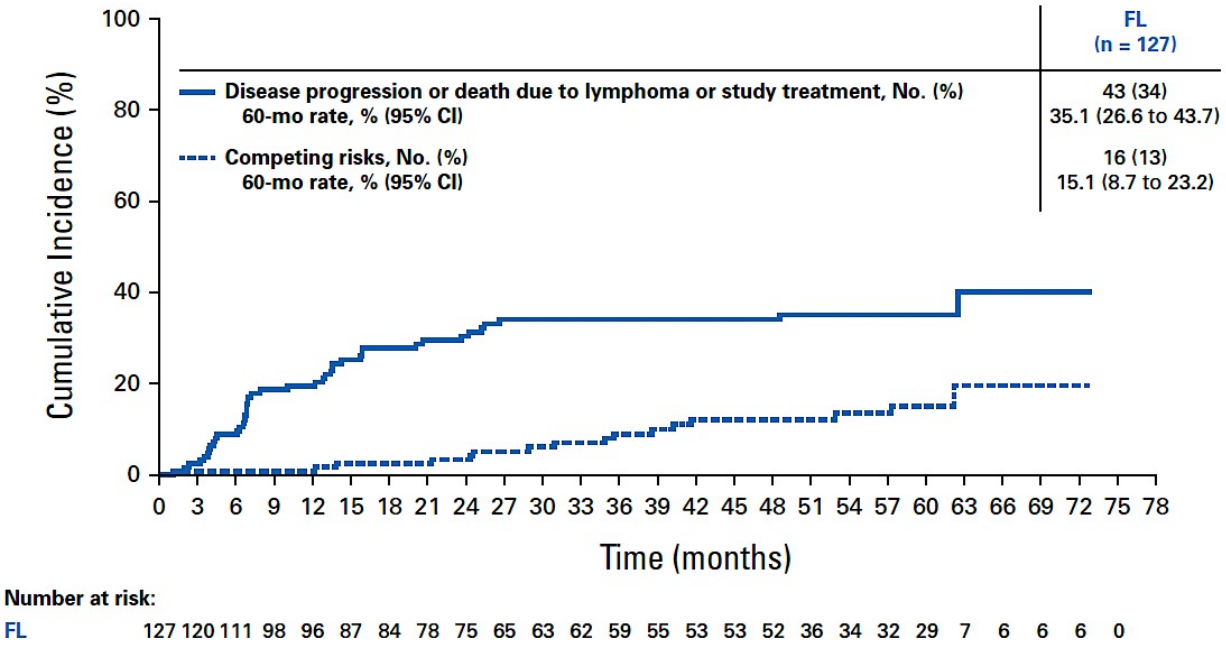
Jacobson C et al, Lancet Onc 2022; Neelapu et al. JCO 2025

ZUMA-5 (axi-cel): 5-year follow-up indicates possible cure in FL

Prolonged duration of response



Cumulative Incidence of Relapse



Neelapu et al. JCO 2025

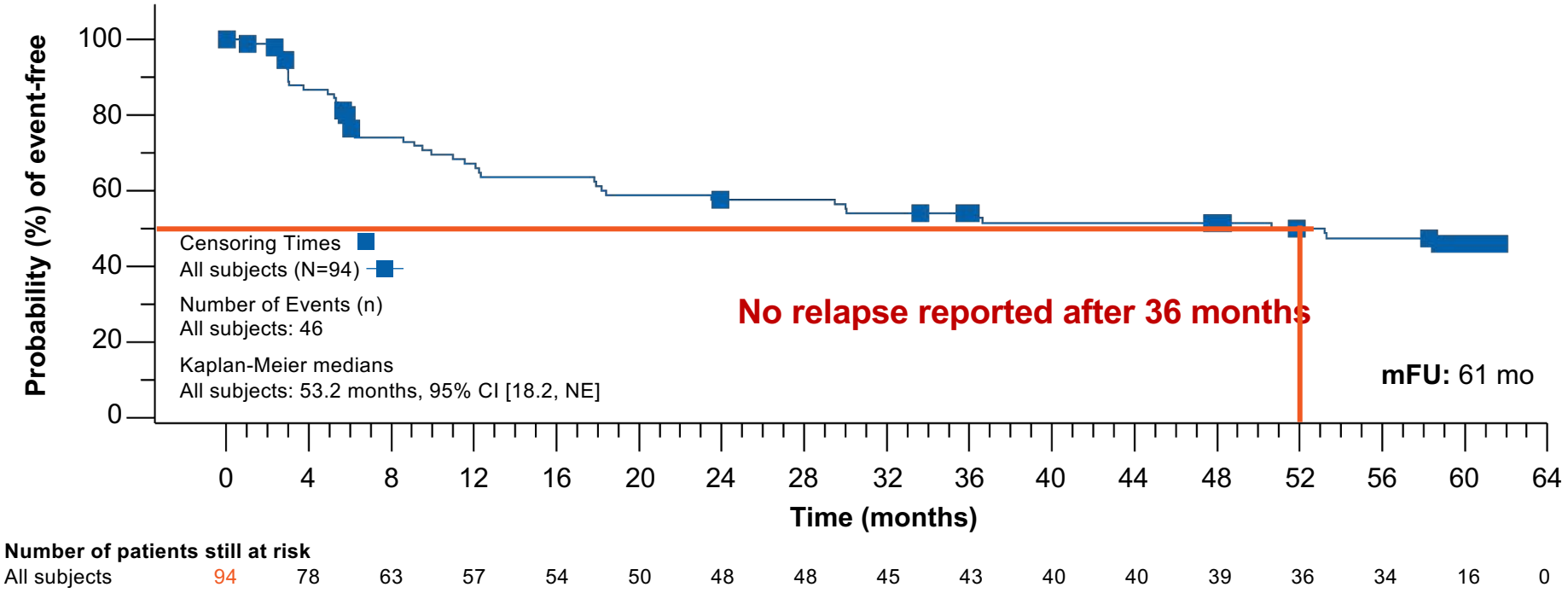
ELARA (tisa-cel): Consistent Response Rate Was Reported in All Patients and High-risk Subgroups

Response rate, all patients and high-risk subgroups	ORR, % (n/N)	CRR, % (n/N)
All patients (efficacy analysis set[a])	86.2 (81/94)	68.1 (64/94)
Patients with high-risk characteristics		
High FLIPI (3-5 risk factors)	80.7 (46/57)	61.4 (35/57)
POD24[b]	82.0 (50/61)	59.0 (36/61)
Bulky disease[c]	85.5 (53/62)	64.5 (40/62)
Double refractory	84.6 (55/65)	66.2 (43/65)

CRR, complete response rate; FLIPI, Follicular Lymphoma International Prognostic Index; ORR, objective response rate; POD24, progression of disease within 2 years of frontline systemic therapy.
[a]Efficacy analysis set includes all patients who have received tisagenlecleucel and had measurable disease at baseline per IRC. [b]POD24 from first anti-CD20 mAb-containing therapy or rituximab monotherapy.
[c]Bulky disease defined as 1 lesion >7 cm or at least 3 lesions >3 cm.

Schuster SJ. et al, ASH2025

ELARA (tisa-cel): Median PFS Was 53.2 Months



- **The 60-month PFS rate was 46% in all patients, and 59.8% in patients who experienced CR[1]**

CI, confidence interval; CR, complete response; mFU, median follow-up; mo, month; NE, not estimable; PFS, progression-free survival.

Reference: 1. Thieblemont C et al. Blood. 2024;144(suppl 1):3034

Schuster SJ. et al, ASH2025

ELARA (tisa-cel): Exploratory Analyses of MRD (clonoSeq assay)

MRD[a]-Negative Rate by Timing After Tisagenlecleucel Infusion

	N = 31[b], % (n/N)
Day 28	82.0 (22/27)
Month 3	75.0 (12/16)
Month 6	69.0 (11/16)
Month 12	76.0 (13/17)
Any time	90.0 (28/31)

- MRD data were available for 31 of 94 patients (33.0%)
  - 90.3% of evaluable patients (28/31) achieved MRD negativity at any time point
  - **63.6% of patients with MRD-negative status at month 6 (7/11) are ongoing without relapse**
  - All 5 patients with MRD-positive status at month 6 relapsed
- CAR transgene persistence was observed for up to 1680 days; median T_{last} was 210 days (range: 13-1680)

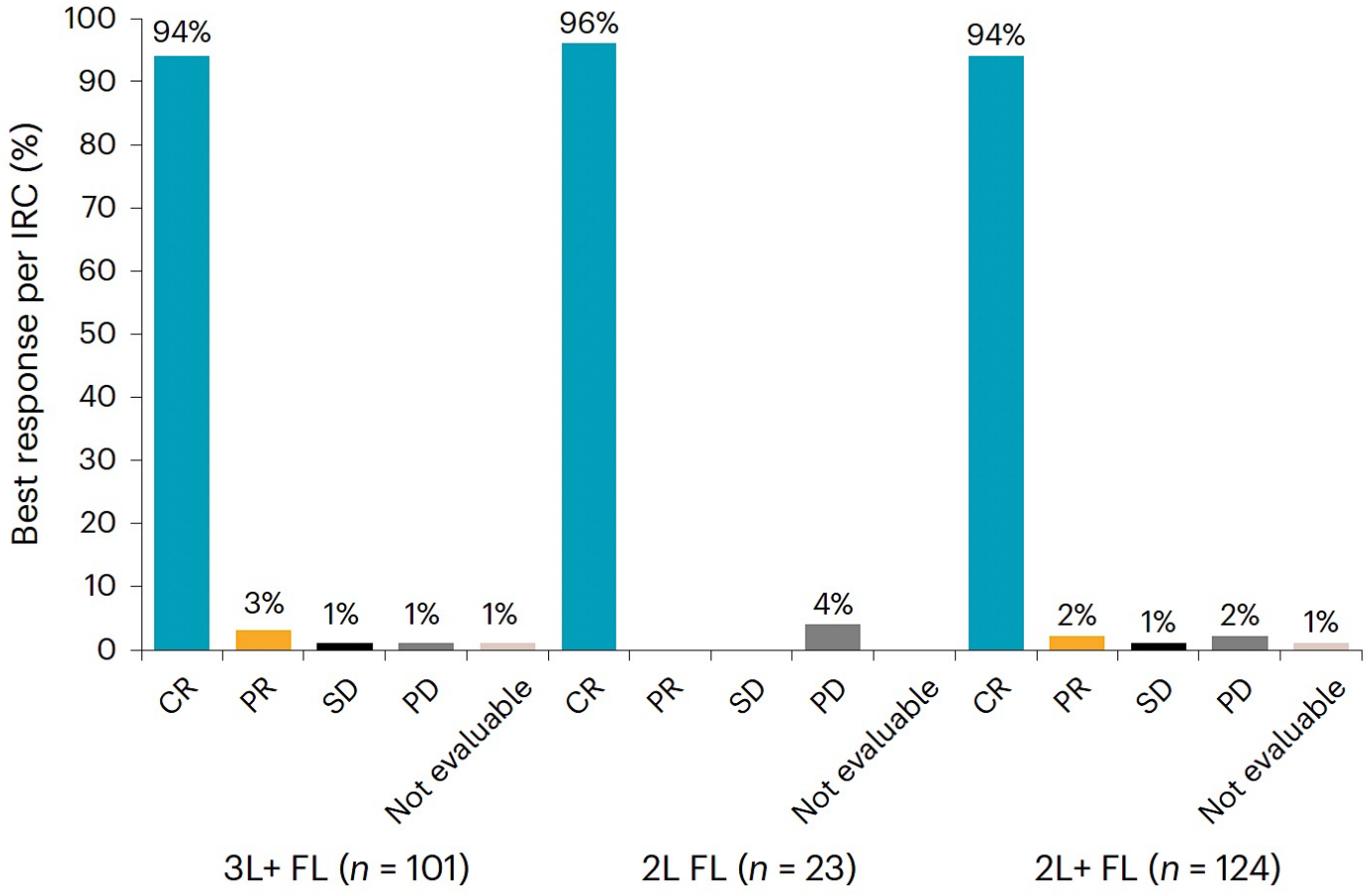
[a]Next Generation Sequencing (clonoSEQ assay - Adaptive Biotechnologies, Seattle, WA) was used for MRD analysis. [b]Patients evaluated for MRD response.
MRD, minimal residual disease; T_{last}, time to last measurable concentration.

Thieblemont C et al, ICML18, 2025

TRANSCEND (liso-cel) FL: Baseline Characteristics

	2L FL (n = 23)	3L+ FL (n = 107)
Median (range) age, y	53 (34–69)	62 (23–80)
Male, n (%)	17 (74)	66 (62)
FL grade 1 or 2 / 3a at screening,[a] n (%)	17 (74) / 6 (26)	81 (76) / 25 (23)
Ann Arbor stage at screening, n (%)		
Stage I/II	6 (26)	12 (11)
Stage III/IV	17 (74)	95 (89)
FL International Prognostic Index at screening, n (%)		
Low risk (0–1) / intermediate risk (2)	11 (48) / 4 (17)	12 (11) / 34 (32)
High risk (3–5)	8 (35)	61 (57)
LDH > ULN before lymphodepletion, n (%)	6 (26)	47 (44)
Met mGELF criteria at most recent relapse, n (%)	16 (70)	57 (53)
Symptoms attributable to FL	6 (26)	13 (12)
Threatened end-organ function/cytopenia secondary to lymphoma/bulky disease	7 (30)	24 (22)
Splenomegaly	0	4 (4)
Steady progression over at least 6 months	3 (13)	16 (15)
Median (range) prior lines of systemic therapy	1 (1–1)	3 (2–10)
Prior HSCT, n (%)	0	33 (31)
Received prior rituximab and lenalidomide, n (%)	0	23 (21)
Refractory to last systemic therapy,[b] n (%)	15 (65)	72 (67)
Double refractory (anti-CD20 and alkylator),[c] n (%)	11 (48)	69 (64)
POD24 from initial immunochemotherapy, n (%)	15 (65)	58 (54)
POD24 from diagnosis, n (%)	12 (52)	46 (43)
Received bridging therapy, n (%)	5 (22)	44 (41)

Liso-cel induces very high response rates in follicular lymphoma

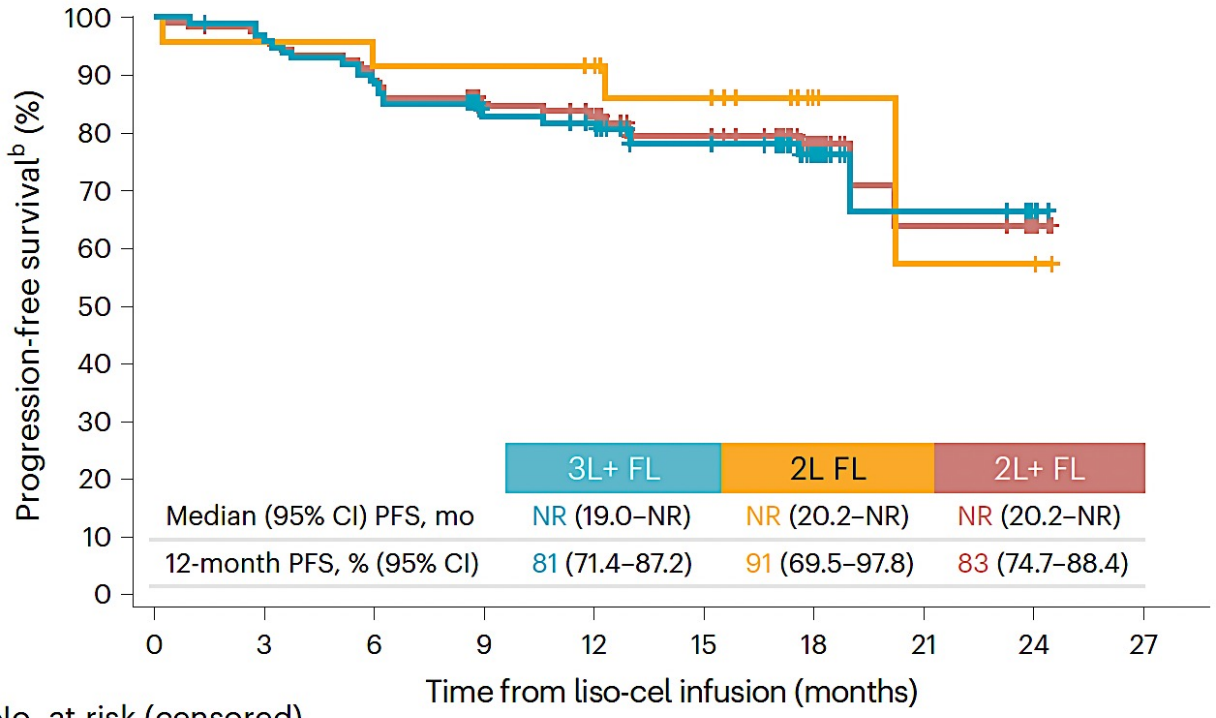


	ORR	CR rate
3L+ FL (n = 101)	97% (95% CI: 91.6–99.4) $P < 0.0001$[a]	94% (95% CI: 87.5–97.8) $P < 0.0001$[a]
2L FL (n = 23)	96% (95% CI: 78.1–99.9) $P < 0.0001$[b]	96% (95% CI: 78.1–99.9) $P < 0.0001$[b]
2L+ FL (n = 124)	97% (95% CI: 91.9–99.1)[c]	94% (95% CI: 88.7–97.7)[c]

Morschhauser et al Nature Medicine 2024.

Liso-cel induces durable remissions in follicular lymphoma

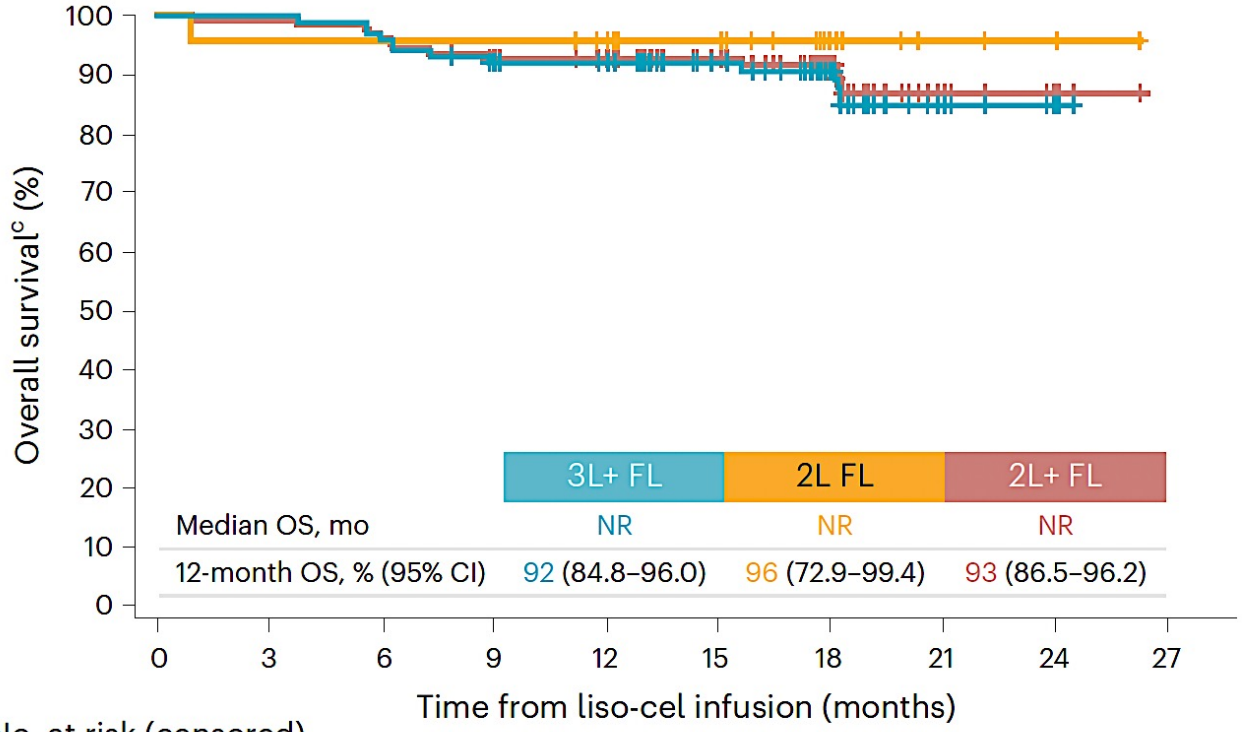
PFS



No. at risk (censored)

3L+ FL	101 (0)	96 (1)	89 (0)	78 (6)	72 (3)	50 (20)	19 (30)	7 (11)	2 (5)	0 (2)
2L FL	23 (0)	22 (0)	21 (0)	21 (0)	20 (1)	16 (3)	5 (11)	2 (2)	2 (0)	0 (2)
2L+ FL	124 (0)	118 (1)	110 (0)	99 (6)	92 (4)	66 (23)	24 (41)	9 (13)	4 (5)	0 (4)

OS



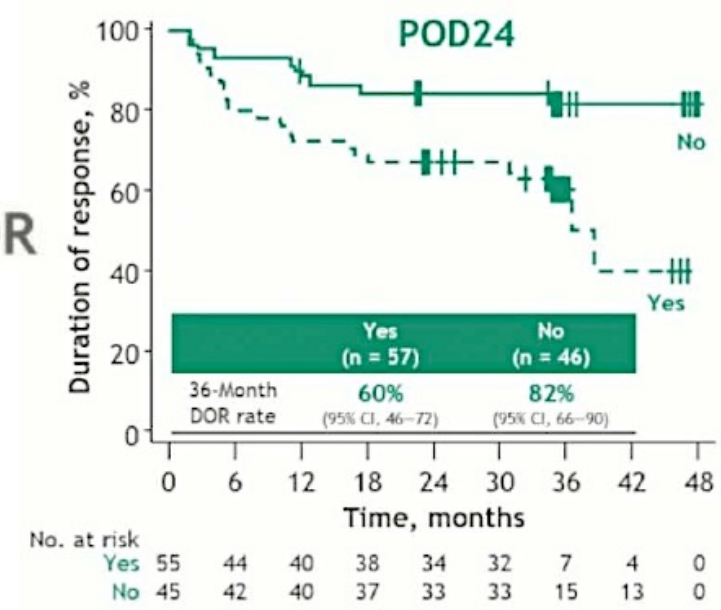
No. at risk (censored)

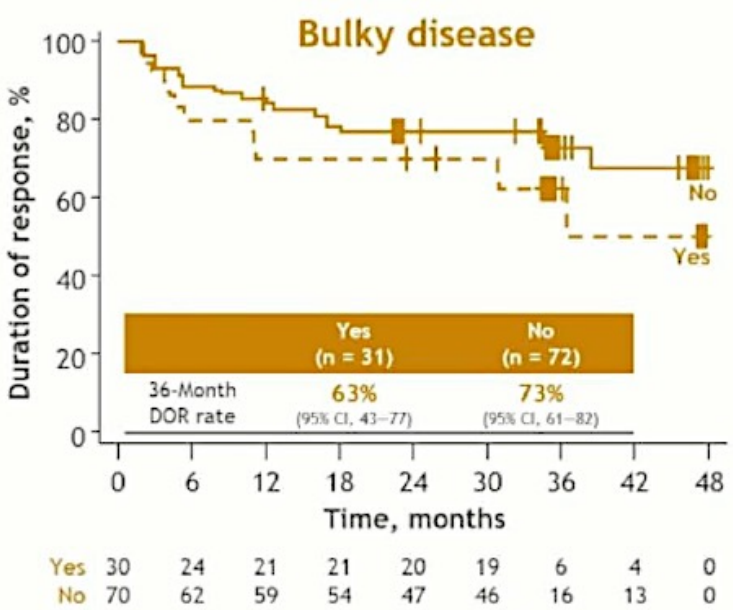
3L+ FL	101 (0)	101 (0)	97 (0)	90 (3)	86 (4)	63 (23)	38 (24)	11 (25)	3 (8)	0 (3)
2L FL	23 (0)	22 (0)	22 (0)	22 (0)	20 (2)	17 (3)	8 (9)	3 (5)	2 (1)	0 (2)
2L+ FL	124 (0)	123 (0)	119 (0)	112 (3)	106 (6)	80 (26)	46 (33)	14 (30)	5 (9)	0 (5)

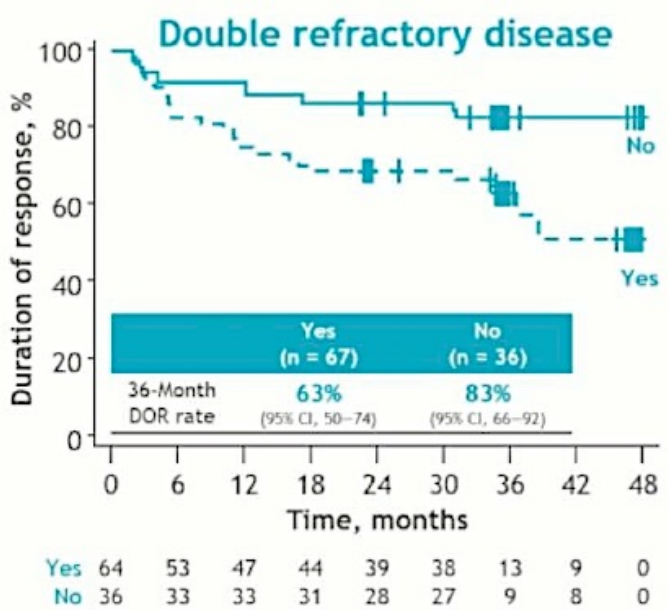
Morschhauser et al Nature Medicine 2024.

3-Year Results From the TRANSCEND FL Study of Lisocabtagene Maraleucel in Patients With 3L+ FL: DOR and PFS Across Subgroups

DOR







36-Month PFS rate

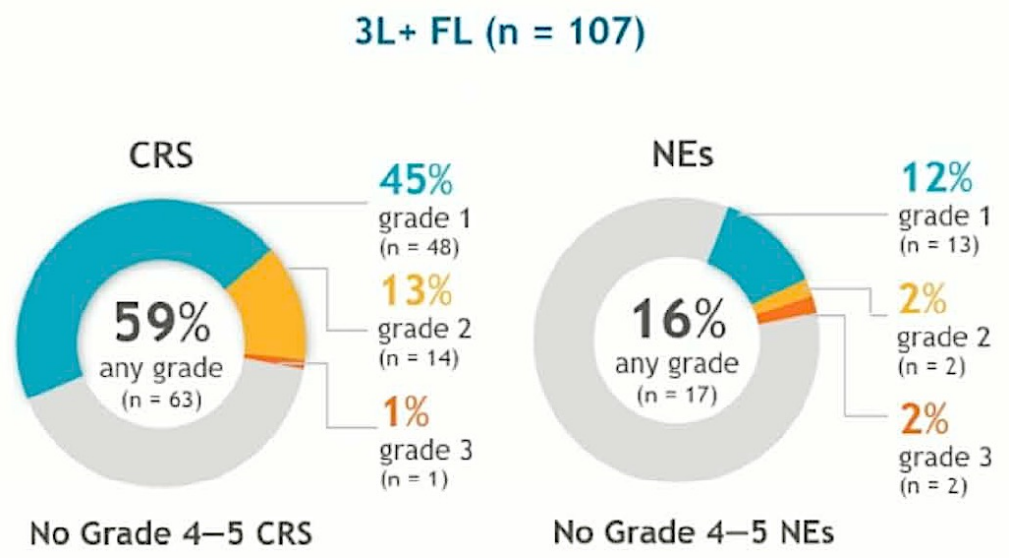
POD24 (n = 57)	No POD24 (n = 46)	Bulky disease (n = 31)	No bulky disease (n = 72)	Double refractory (n = 67)	Not double refractory (n = 36)
58% (95% CI, 43–70)	80% (95% CI, 65–89)	61% (95% CI, 41–75)	71% (95% CI, 58–80)	60% (95% CI, 47–71)	83% (95% CI, 66–92)

- Responses were durable with high PFS rates among patients with high-risk disease
- Of the evaluated subgroups, median DOR was only reached among those with POD24

POD24, progressive disease ≤24 mo from initial immunochemotherapy.

Ahmed S, et al. ASH 2025. Abstract 467.

3-Year Results From the TRANSCEND FL Study of Lisocabtagene Maraleucel in Patients With 3L+ FL: Safety and Summary



	3L+ FL (n=107)
Grade ≥3 infection, n (%)	13 (12)
TE period	7 (7)
Post-TE period	8 (7)
Second primary malignancy, n (%)	11 (10)
Non-hematologic	7 (7)
Hematologic	4 (4)
Secondary T-cell malignancy, n (%)	0 (0)
Grade ≥3 cytopenia at Day 90 visit, n (%)	23 (21)
Recovered to Grade ≤2 by Day 365, n/N (%)	18/19 (95)

- No new safety signals observed with longer follow-up
- Most cases of CRS and NEs were Grades 1-2
- Incidence of Grade ≥3 neutropenia and use of growth factors was consistently low after Month 4
- >50% of patients had persistent B-cell aplasia or hypogammaglobulinemia at 1-y after infusion; despite this, incidence of infections was consistently low in long-term follow-up

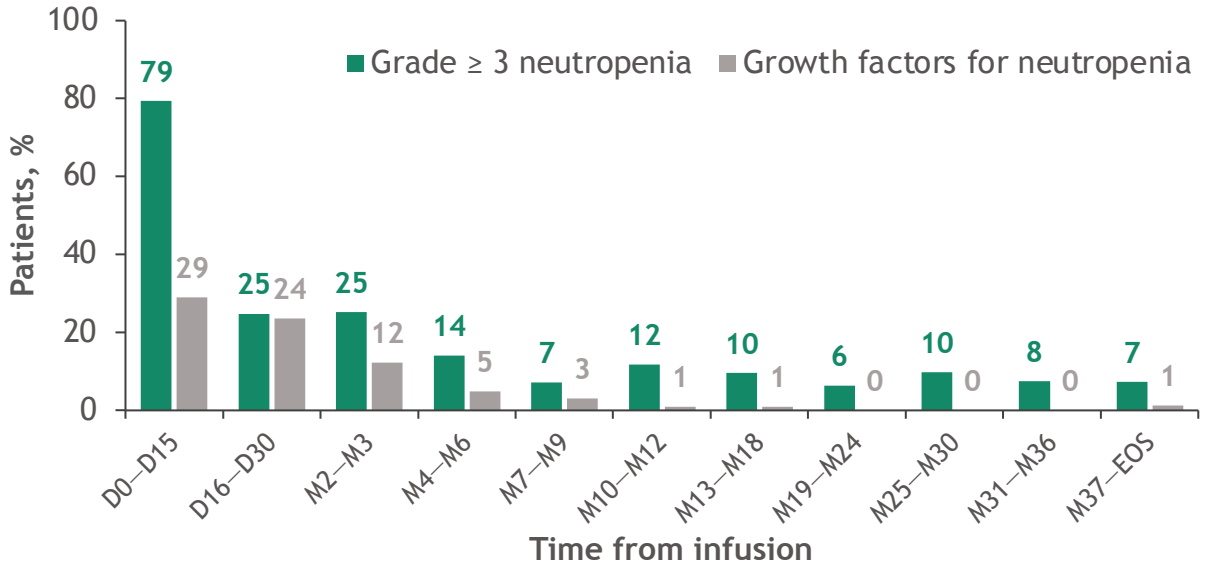
Authors' Conclusions

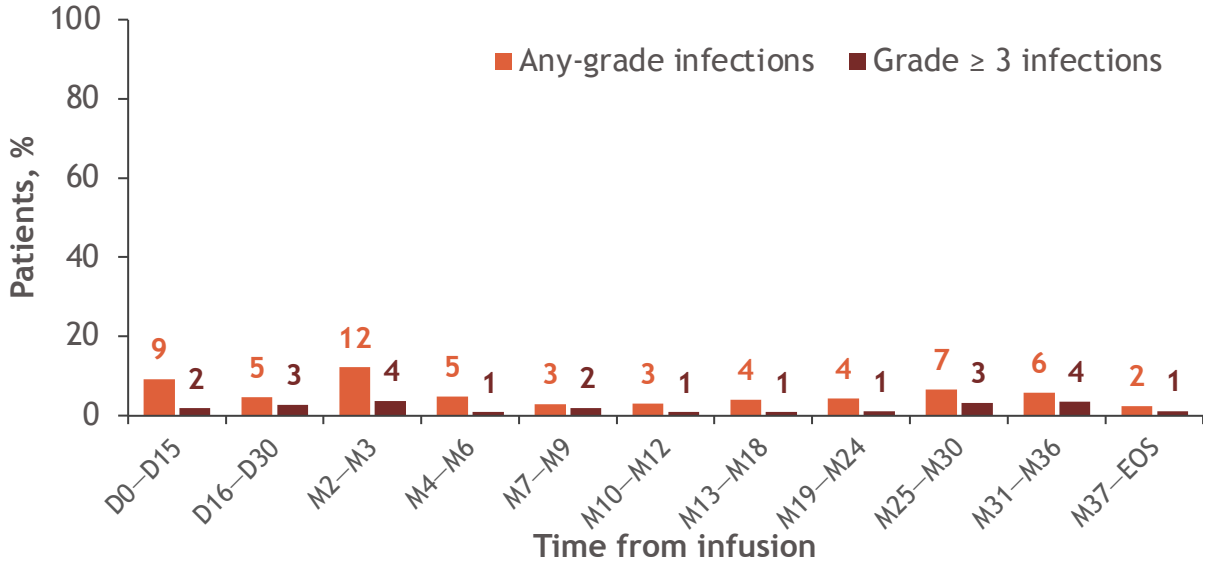
- Liso-cel showed high rates of deep (CR rate, 94%) and durable responses (36-mo DOR, 70%) with sustained survival (36-mo OS, 86%) in 3L+ R/R FL
- Consistently high efficacy was seen across subgroups, even among patients with high-risk characteristics (POD24, bulky disease, double-refractory disease)
- Longitudinal analyses demonstrated favorable long-term safety

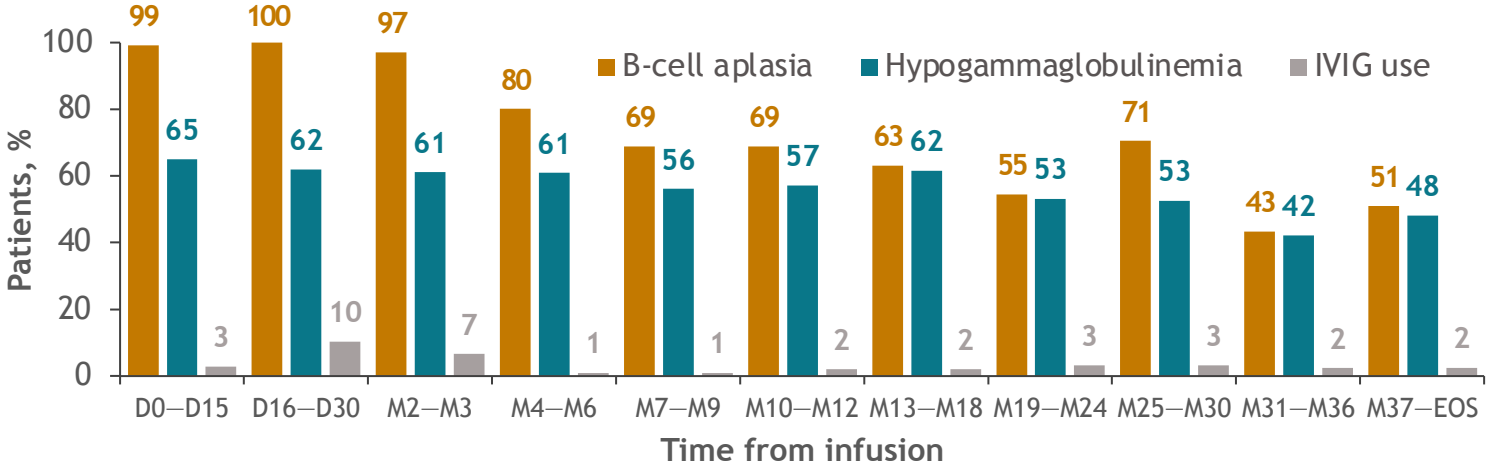
POD24, progressive disease ≤24 mo from initial immunochemotherapy; TE, treatment emergent.

Ahmed S, et al. ASH 2025. Abstract 467.

Liso-cel showed favorable long-term safety







- Incidences of grade ≥ 3 neutropenia and use of growth factors remained consistently low from Month 4 onward
- Incidences of infections were consistently low across all time periods despite persistent B-cell aplasia or hypogammaglobulinemia in > 50% of patients at 1 year after infusion

Proportions for grade ≥ 3 neutropenia, B-cell aplasia, and hypogammaglobulinemia were calculated using the number of patients evaluated for each laboratory parameter in each time period as the denominator. From M25—M36, > 50% of patients on study had missing values for laboratory parameters. Proportions for infections and growth factor use were calculated using the number of patients on study in each time period: D0—D15, n = 107; D16—D30, n = 106; M2—M3, n = 106; M4—M6, n = 105; M7—M9, n = 100; M10—M12, n = 97; M13—M18, n = 97; M19—M24, n = 94; M25—M30, n = 90; M31—M36, n = 85; M37—EOS, n = 81. Monthly ranges start on the first day of the first month and end on the last day of the last month. Each patient is counted once in each time period but is counted again if having an event in another time period. Results are consistent when patients who started subsequent antilymphoma therapy were excluded at the initiation of subsequent therapy. D, Day; M, Month; IVIG, intravenous immunoglobulin G.

Ahmed S, et al. ASH 2025 [Abstract #467]

3L+ CAR T-cell therapy comparison in R/R FL

	Axicabtagene- ciloleucel (ZUMA-5) [1,2]	Tisagenlecleucel (ELARA) [3,4]	Lisocabtagene- maraleucel (TRANSCEND FL) [5,6]
Patients	n = 127	n = 97	n = 107
POD24	55%	63%	43%
Refractory to prior tx	69%	78%	38%
Any grade CRS/NE	78% / 56%	49% / 37%	58% / 15%
Grade ≥3 CRS/NE	6% / 15%	1% /3%	1% / 2%
ORR rate	94%	86%	97%
CR rate	79%	68%	94%
CR duration	36-mo DOCR, 62%	24-mo DOCR, 78%	24-mo DOCR, 75%
PFS	Median 40.2 mos 36-mo rate, 54%	Median, NR 24-mo rate, 57%	Median, NR 24-mo rate, 73%

1. Jacobson CA, et al. *Lancet Oncol*. 2022; 23: 91–103. 2. Neelapu SS, et al. *Blood*. 2024;143(6):496–506. 3. Morschhauser F, et al. *Nat Med*. 2024;30:2199–2207. 4. Nastoupil L, et al. Presented at the 66th American Society of Hematology (ASH) Annual Meeting. 7–10 December, 2024. San Diego, CA, USA. Poster 4387. 5. Fowler NH, et al. *Nat Med*. 2022;28:325–332. 6. Dreyling M, et al. *Blood*. 2024;143(17):1713–1725.

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CAR T-Cell Eligibility in FL

Regulatory

- Country-Specific HA approval
- Reimbursement
- 3rd line
- ASCT eligible?

Patient

- Information/Knowledge
- Referral to a new (distant) team
- Caregiver Presence (30/15 days) / Costs
- Comorbidities
- Organ Dysfunction

Disease

- Disease Pace
- Disease Burden
- Performance Status
- Infection
- CNS Disease?

Logistics

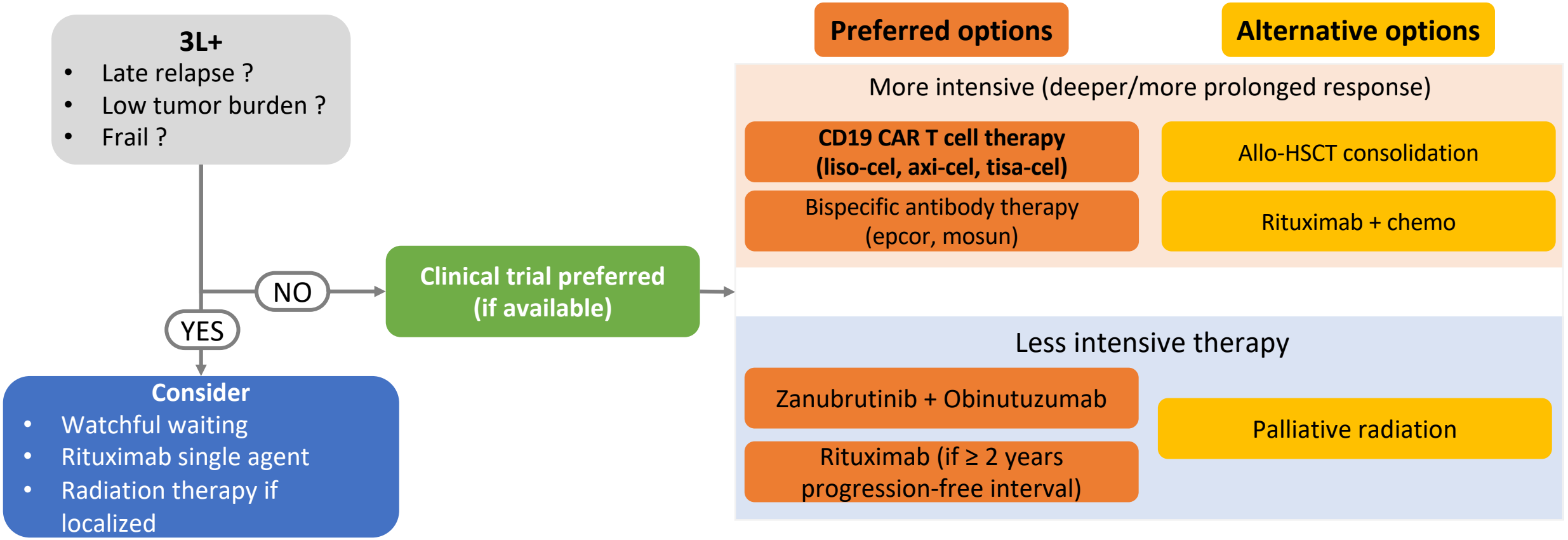
- Patient Referral
- Insurance Approval
- Apheresis Slot
- Bridging
- Manufacturing Failure

Product

- Axi-cel vs Tisa-cel vs Liso-cel

Expert opinion Gilles Salles, MD, PhD.

CAR T cell therapy in Follicular Lymphoma



Always rule out histological transformation – new biopsy recommended

3L, third line; allo-HSCT, allogeneic hematopoietic stem cell transplant, axi-cel, axicabtagene ciloleucel; epcor, epcoritamab; liso-cel, lisocabtagene maraleucel; mosun, mosunetuzumab; tisa-cel, tisagenlecleucel.

Adapted from Qualls D & Salles G. Haematologica 2022; 107:19–34.

BsAb

❖ ***PROs***

- Off the shelf
- Outpatient
- Easy Schedule
- Minimal Constraints

❖ ***CONs***

- CRS 1st cycle
- Infections
- Treatment duration
- Lower efficacy (single agent)
- Long-term data are still missing

CAR T

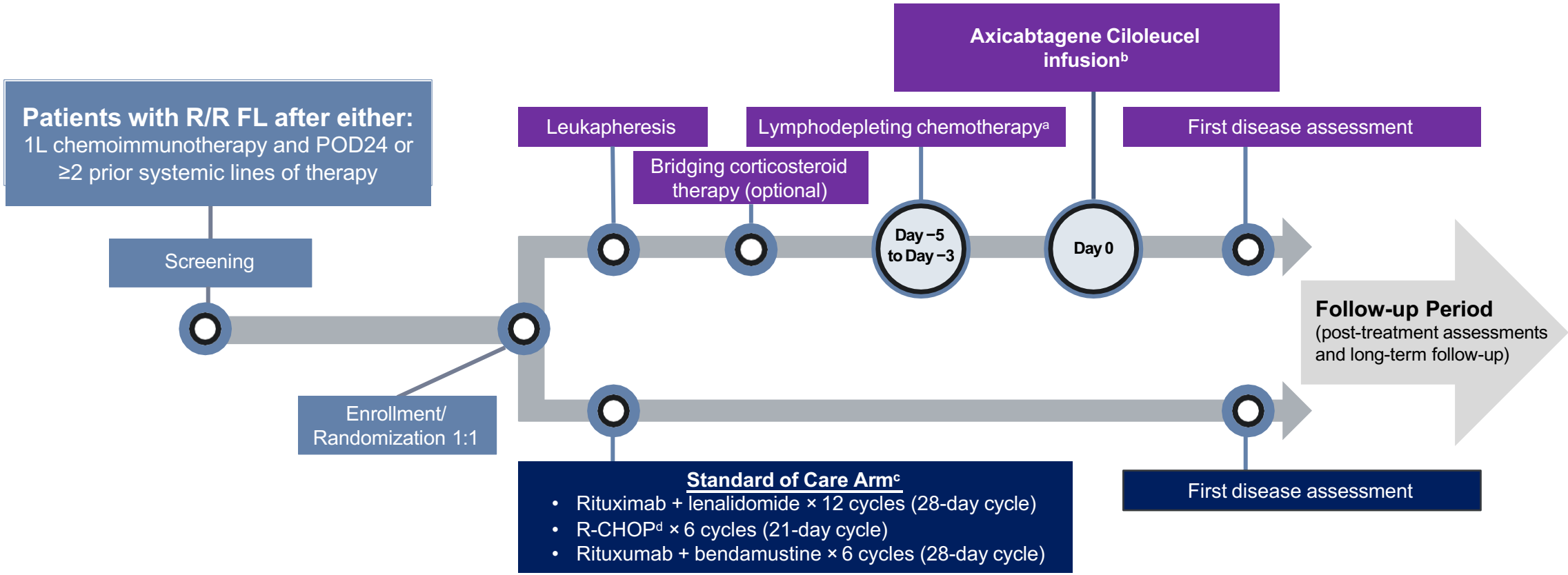
❖ ***PROs***

- High CR rate
- One and done
- Prolonged DoCR
- Possibility of Cure?

❖ ***CONs***

- Logistics (leukapheresis)
- Hospitalisation/proximity
- CRS/ICANS/Cytopenia
- Long-term Ig supplementation
- Long-term risks (MDS)?

ZUMA-22 Study Design and Treatment Schema



Primary Endpoint
- Progression-free survival

Key Secondary Endpoint
- Complete response rate

Secondary Endpoints
- Overall response rate
- Duration of response
- Duration of complete response
- Overall survival
- Event-free survival
- Time to next treatment
- Patient-reported outcomes/Quality of life
- Safety

a: Fludarabine 30 mg/m2 IV & cyclophosphamide 500 mg/m2 IV on Days –5, –4, and –3. b: Single IV infusion of 2×106 CAR T-cells/kg on Day 0. c: SOC therapy should start between 2 and 9 days after randomization. d: The R-CHOP regimen may include a prednisone-equivalent dose of any corticosteroids per institutional guidelines.

NCT05371093

ZUMA-22: Patient Eligibility

Key Inclusion Criteria[1,2]

- Histologically-confirmed FL (Grade 1, 2, or 3a)
- R/R disease after
  - First-line chemoimmunotherapy and high-risk disease with relapse or progression within 24 months of the initial course of chemoimmunotherapy (ie, POD24)
  - ≥2 prior systemic lines of therapy
- Clinical indication for treatment
- At least 1 measurable lesion per the Lugano Classification
- Adequate renal, hepatic, pulmonary, and cardiac function
- ECOG PS of 0 or 1
- 18 years and older

Key Exclusion Criteria

- Transformed FL[1]
- FL Grade 3b[1]
- Prior treatment with:[1]
  - CD19-targeted therapy
  - CAR T-cell therapy
  - Other genetically modified T-cell therapy
- Uncontrolled fungal, bacterial, viral, or other infection[1]
- Active infection with HIV, HBV or HCV[1,2]
  - Note: Patients who are HIV-positive are eligible if taking appropriate anti-HIV medications, having an undetectable viral load by quantitative PCR, and a CD4 count >200 cell/μL
  - Note: Patients with a positive history of HBV or HCV are eligible to enroll with an undetectable viral load
  - If seropositive for HBV,[a] patients are eligible if HBsAg negative
- History or presence of a CNS disorder; known history or presence of CNS lymphoma involvement[1]
- History of :[1,2]
  - Clinically significant cardiac disease ≤6 months of randomization
  - Autoimmune disease resulting in or requiring systemic immunosuppression and/or systemic disease-modifying agents within the last 2 years

[a]Hepatitis B surface antibody and/or hepatitis B core antibody positive.

clinicaltrials.gov/ct2/show/NCT05371093. Accessed 3 April 2023 2. Data on file. Kite Pharma Inc., 2022

A Phase III Trial Comparing Tisagenlecleucel to Standard of Care (SoC) in Adult Patients with Relapsed/Refractory Follicular Lymphoma (LEDA)

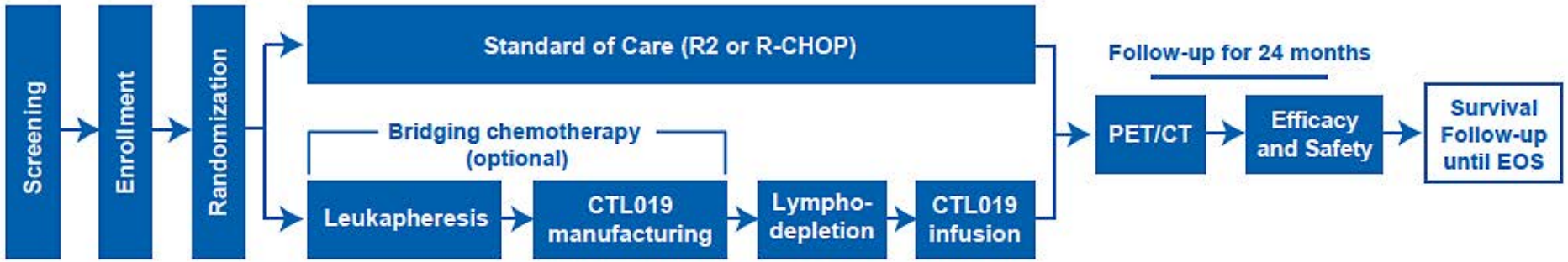
NCT05888493[1]

A Phase III, open-label, multicenter, randomized study comparing tisagenlecleucel to standard of care in adult patients with relapsed/refractory follicular lymphoma[1]

Key Inclusion Criteria[1]:

- Aged ≥18 years
- Confirmed grade 1, 2, or 3A FL per histological assessment
- Relapsed or refractory FL having received ≥2 lines of systemic therapy, including anti-CD20 antibody and an alkylating agent
- Disease activity per PET (Deauville score 4-5) and CT scan
- Must meet institutional criteria to undergo leukapheresis or have historical leukapheresis
- Must be eligible for treatment with SoC regimen
- No prior treatment with anti-CD19 therapy, gene therapy, or adoptive T-cell therapy
- No investigational medicinal product used within the last 30 days or 5 half-lives (whichever is longer) prior to randomization

Study Design[2]: N = 108



[a]CTL019 is a CD19-specific CAR-T cell that is modified via lentiviral transduction.

Primary Endpoints[1]

- PFS as assessed by Blinded Independent Review Committee

Secondary Endpoints[1]

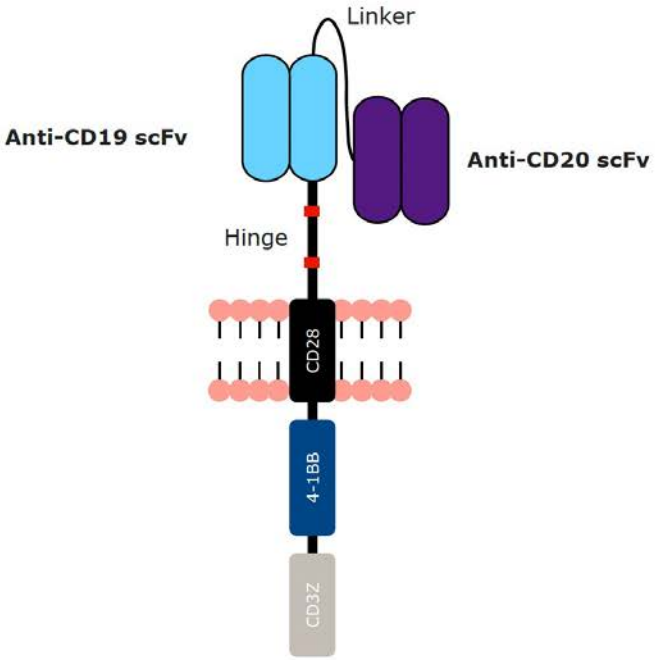
- CRR/ORR as assessed by Blinded Independent Review Committee
- Time to next anti-lymphoma treatment
- OS
- DOR
- Humoral immunogenicity
- Cellular immunogenicity
- CAR transgene levels
- Replication competent lentivirus (tisagenlecleucel)

NCT05888493

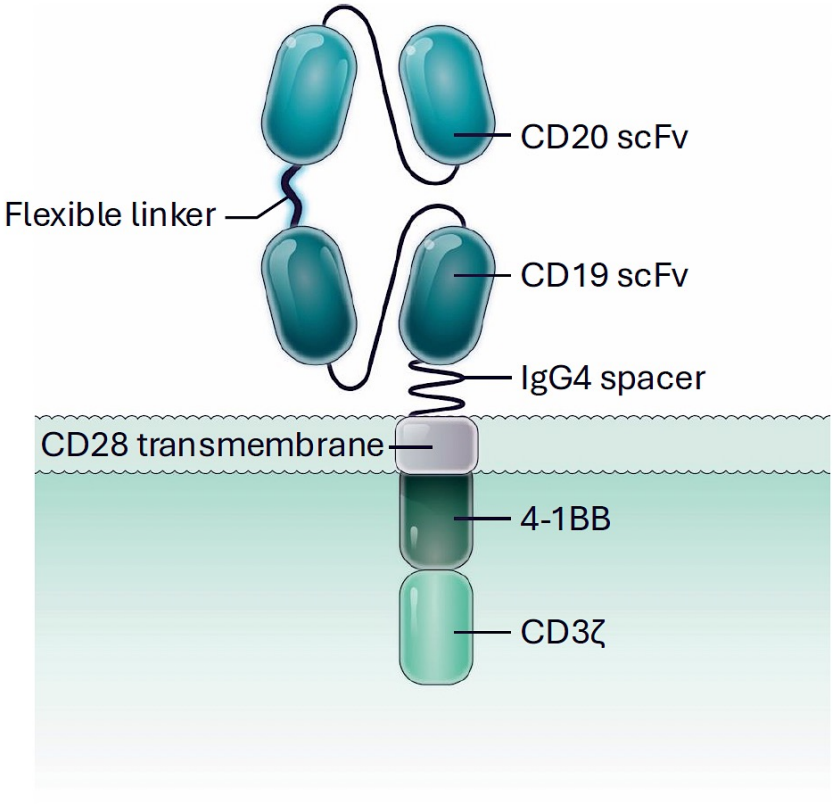
Are dual CD19/CD20 CAR T-cells better than CD19 CAR T?

JNJ-90014496
(prizloncabtagene autoleucel; prizlon-cel)

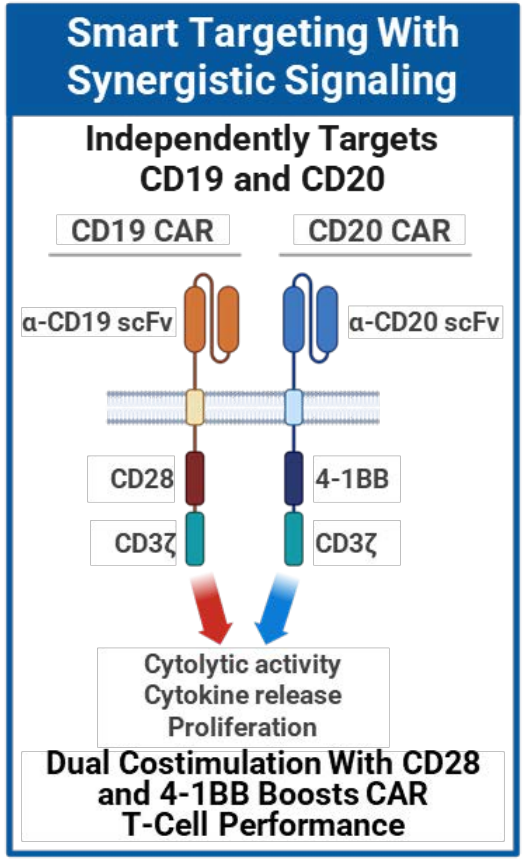
- Bispecific CD19/CD20 antigen target with 4-1BB costimulatory domain
- CD28 transmembrane domain



Ronde-cel



KITE-363



Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

Part 1 - Diffuse Large B-Cell Lymphoma:

Antibody-Drug Conjugates and Other Novel Strategies in the Management of DLBCL — Prof Salles

Current and Future Role of Monoclonal and Bispecific Antibodies in the Management of DLBCL — Dr Patel

Chimeric Antigen Receptor (CAR) T-Cell Therapy for DLBCL — Dr Kamdar

Part 2 – Follicular Lymphoma:

CAR T-Cell Therapy for FL — Prof Salles

Other Approved and Emerging Novel Therapies for FL — Dr Patel

Integrating Bispecific Antibodies into the Management of FL — Dr Kamdar

Other Approved and Emerging Novel Therapies for FL

Krish Patel, MD

Director, Lymphoma Research

April 24th, 2026

SCRI Sarah Cannon Research Institute

Disclosures

Advisory Committees (All Paid to Institution)	AbbVie Inc, AstraZeneca Pharmaceuticals LP, Bristol Myers Squibb, Genentech, a member of the Roche Group, Janssen Biotech Inc, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Lyell, Merck
Consulting Agreements (All Paid to Institution)	AbbVie Inc, Adaptive Biotechnologies Corporation, AstraZeneca Pharmaceuticals LP, Bristol Myers Squibb, Genentech, a member of the Roche Group, Janssen Biotech Inc, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Lyell, Merck, Pfizer Inc, Sanofi
Contracted Research (All Paid to Institution)	AbbVie Inc, AstraZeneca Pharmaceuticals LP, Bristol Myers Squibb, Genentech, a member of the Roche Group, Immunome, Janssen Biotech Inc, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Lyell, Merck

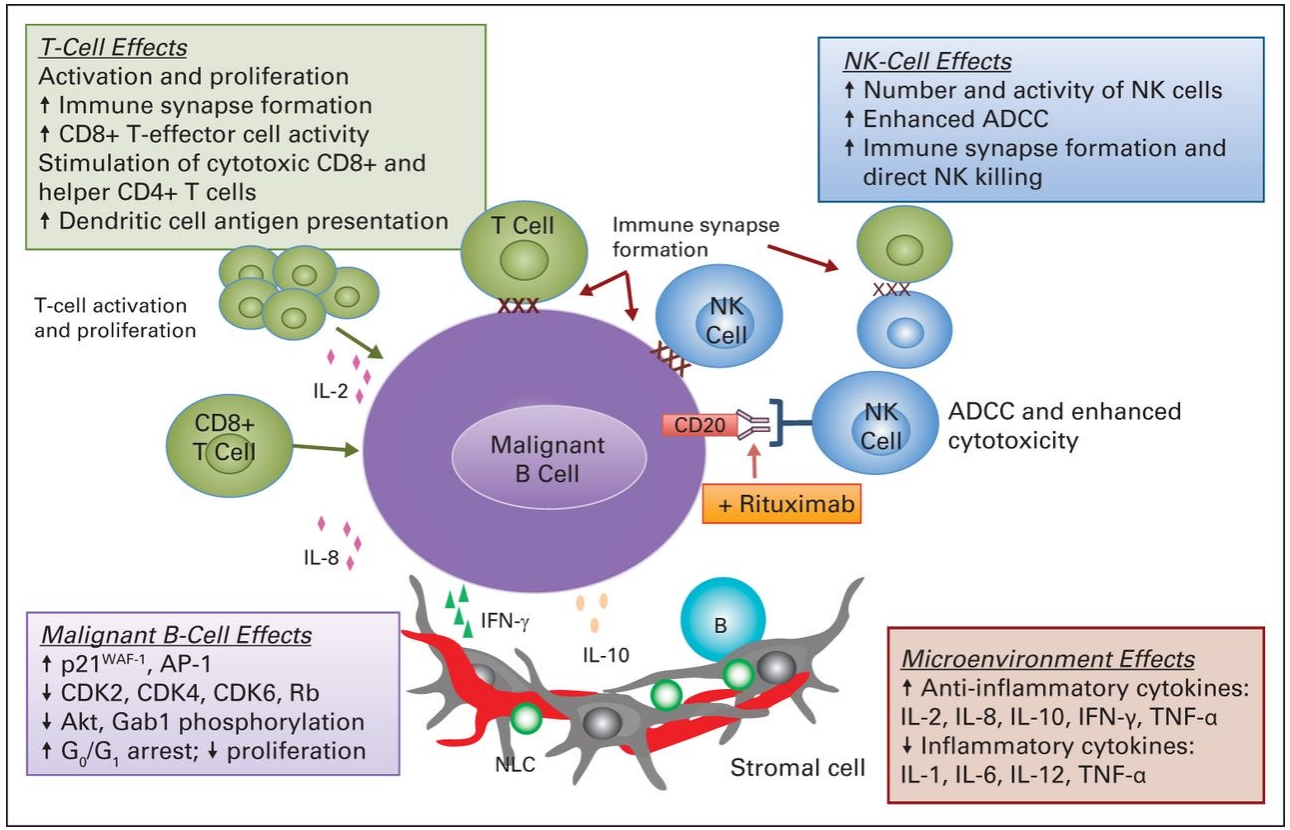
Lenalidomide in R/R Follicular lymphoma

5 yr AUGMENT OS 83%

Median PFS 27.6 mths

Len may

- ↑ T-cell # and activity
- ↑ NK cell # and activity
- Directly kill B-cells



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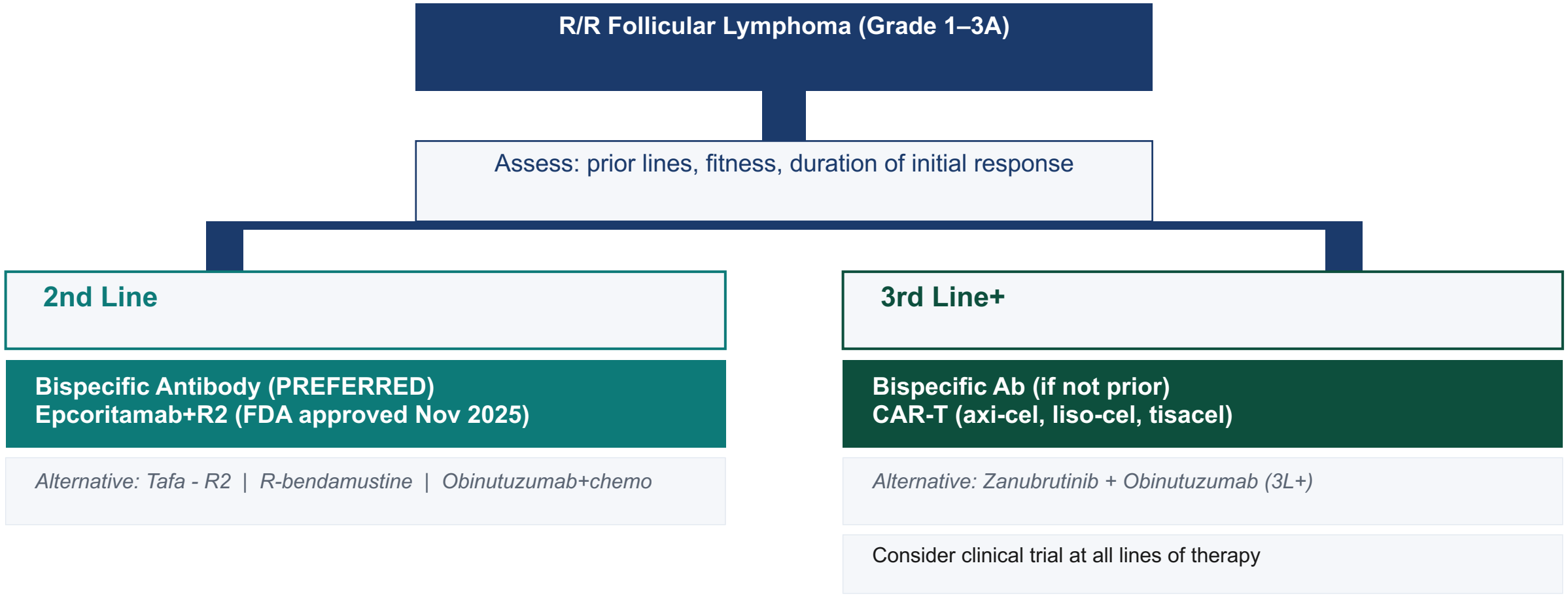
Gribben J et al JCO 2015, Leonard J et al Blood 2022, Leonard J et al J Clin Oncol 2026

R/R Follicular Lymphoma: My approach 2026



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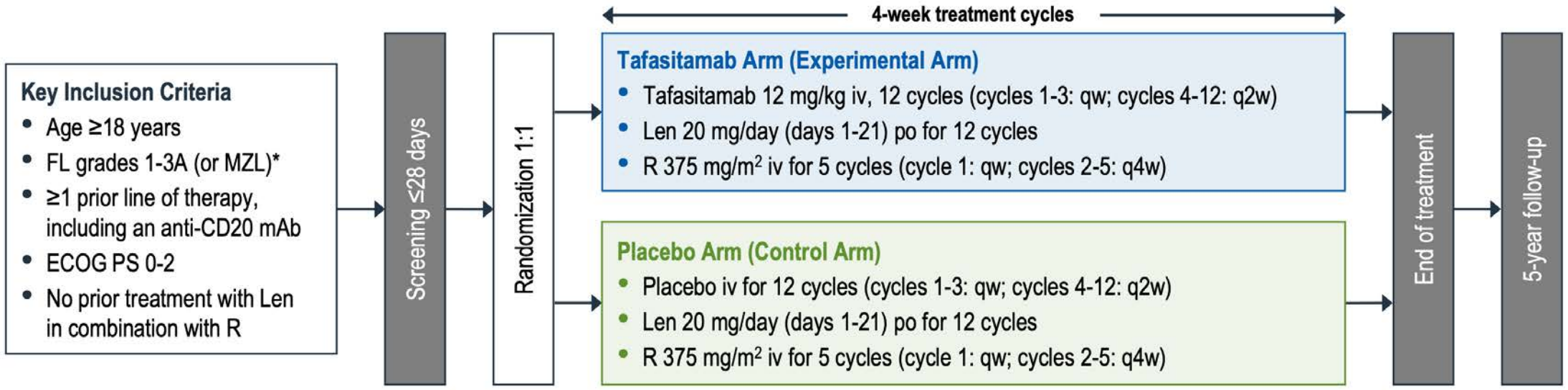
NCCN Guidelines NHL v2.2025; Bartlett NL et al. Lancet Oncol. 2025; FDA Approvals 2023–2025

Follicular Lymphoma: INMIND Ph 3 RCT



Stratification Factors (Patients With FL)

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

Study Endpoints in FL Population (Investigator Assessed Unless Specified)

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

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

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Sehn L et al ASH 2024

INMIND: Patient Characteristics

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

~30% POD24 in both arms. ~40% Rituximab refractory

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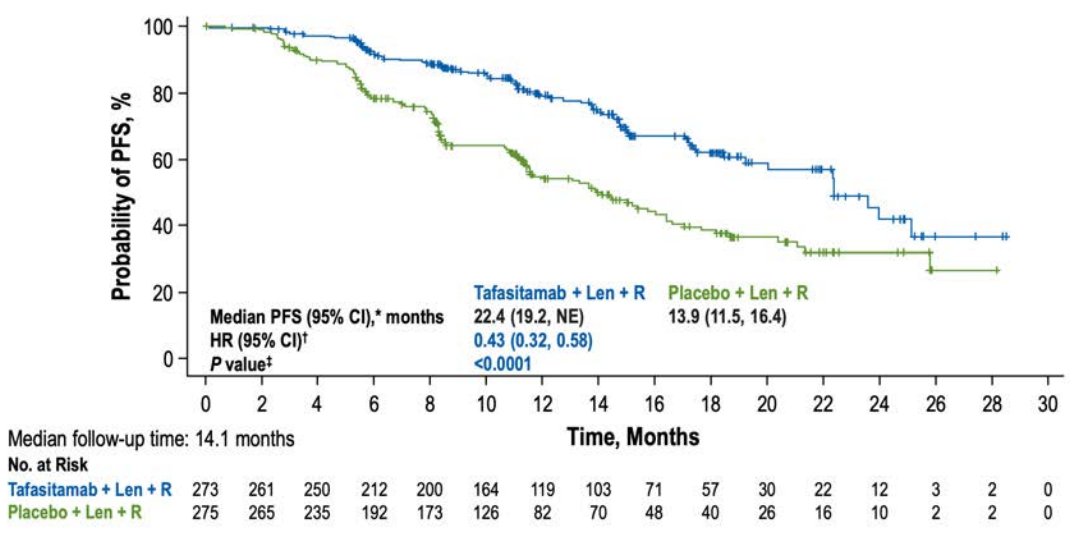
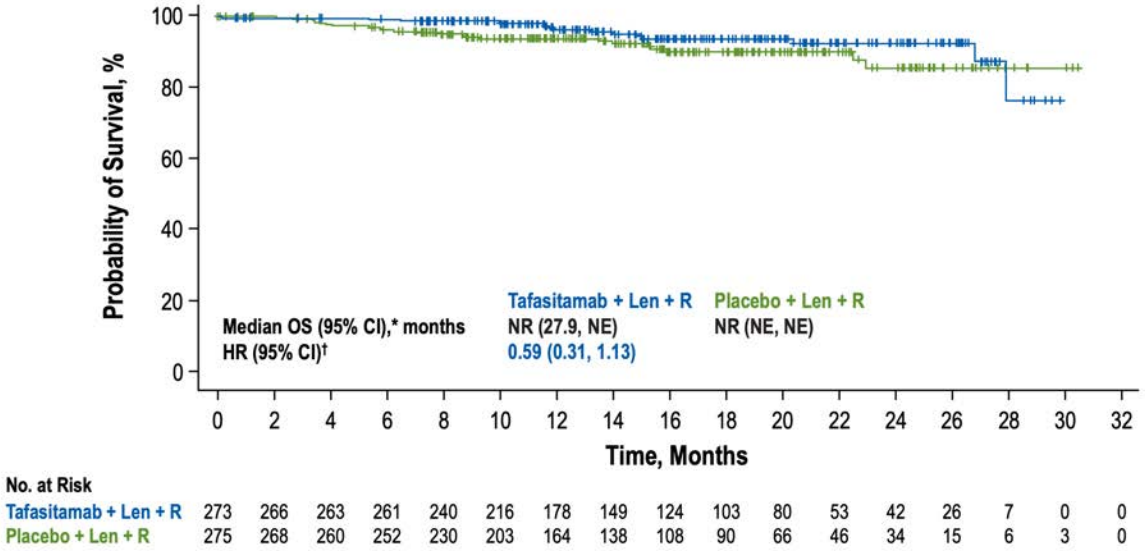
INMIND: PFS & OS





Median PFS 22.4 mths Tafa-R^2 vs 13.9 mths Placebo-R^2

Median OS NR Tafa-R^2 vs NR Placebo-R^2

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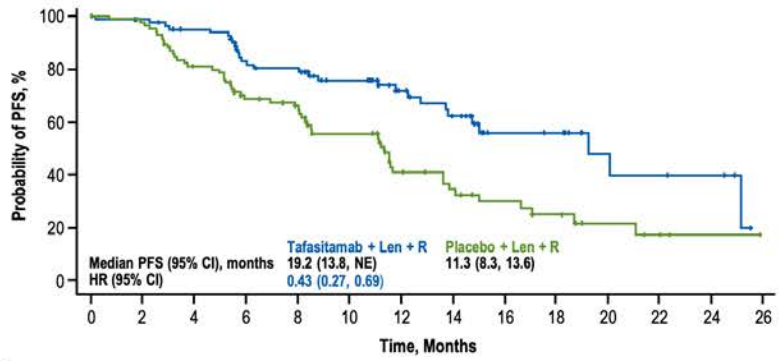
INMIND: PFS in POD24 and CD20 refractory

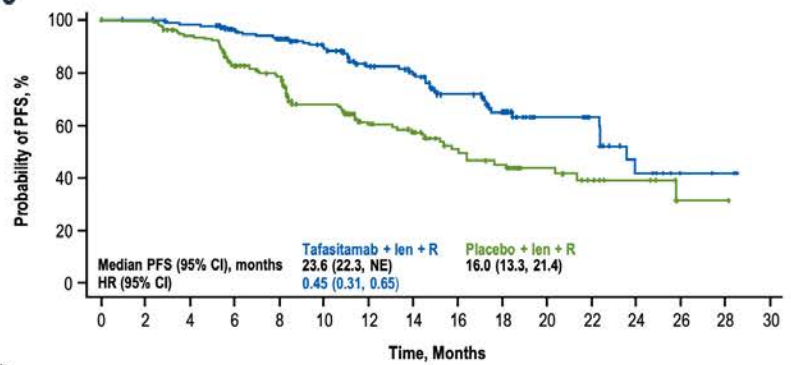
POD24: Yes



No. at Risk

Tafasitamab + Len + R	85	81	75	60	57	46	32	25	13	12	6	5	4	0
Placebo + Len + R	88	83	67	52	46	35	21	16	12	9	5	2	1	0

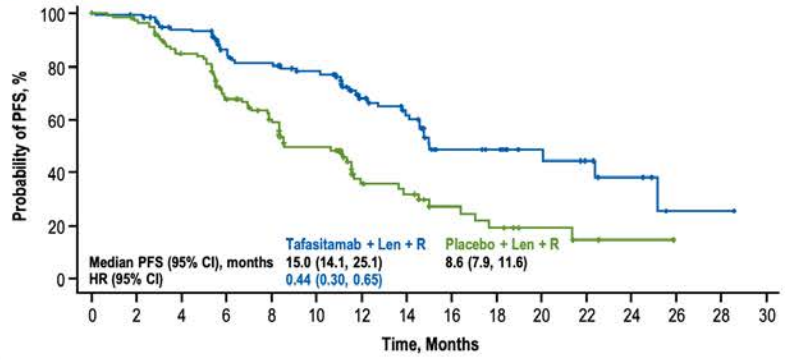
POD24: No



No. at Risk

Tafasitamab + Len + R	188	180	175	152	143	118	87	78	58	45	24	17	8	3	2	0
Placebo + Len + R	187	182	168	140	127	91	61	54	36	31	21	14	9	2	2	0

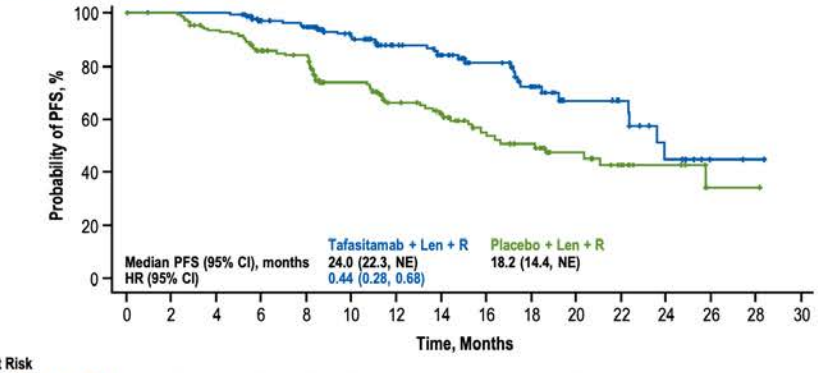
Anti-CD20 Refractory: Yes



No. at Risk

Tafasitamab + Len + R	118	113	102	86	80	71	46	38	21	19	11	8	5	1	1	0
Placebo + Len + R	115	108	91	66	54	41	20	16	10	7	4	2	1	0	0	0

Anti-CD20 Refractory: No



No. at Risk

Tafasitamab + Len + R	155	148	148	126	120	93	73	65	50	38	19	14	7	2	1	0
Placebo + Len + R	160	157	144	126	119	85	62	54	38	33	22	14	9	2	2	0

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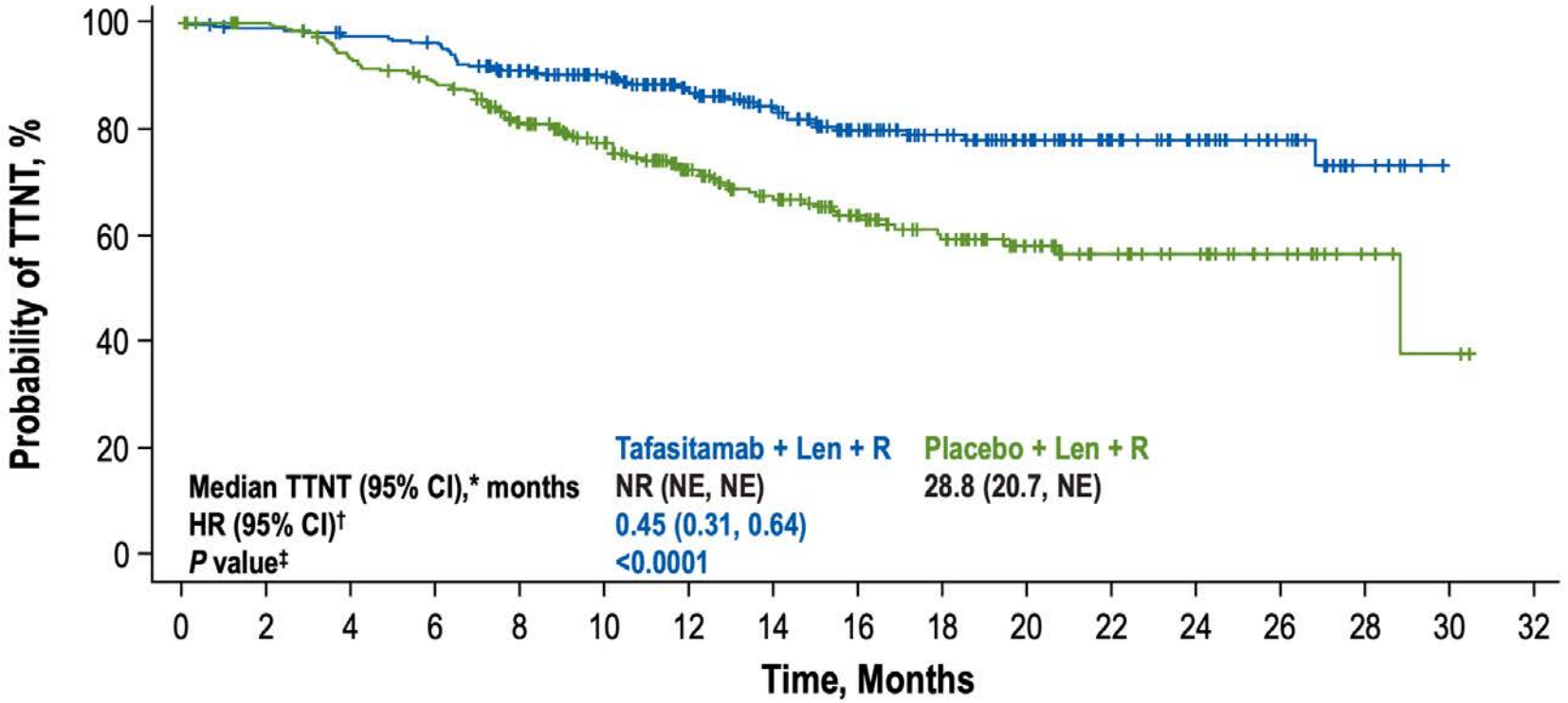
INMIND: Time to Next Treatment



No. at Risk																	
Tafasitamab + Len + R	273	268	261	257	224	199	162	132	105	88	67	43	34	22	7	0	0
Placebo + Len + R	275	268	248	233	199	166	124	101	78	62	43	30	23	13	5	2	0

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INMIND: Adverse Events

Preferred Term, n (%)	Tafasitamab + Len + R (n=274)*	Placebo + Len + R (n=272)†	Total (n=546)
Any adverse event	272 (99.3)	270 (99.3)	542 (99.3)
Neutropenia	133 (48.5)	123 (45.2)	256 (46.9)
Diarrhea	103 (37.6)	77 (28.3)	180 (33.0)
COVID-19	86 (31.4)	64 (23.5)	150 (27.5)
Constipation	80 (29.2)	67 (24.6)	147 (26.9)
Rash	60 (21.9)	58 (21.3)	118 (21.6)
Fatigue	58 (21.2)	43 (15.8)	101 (18.5)
Cough	52 (19.0)	47 (17.3)	99 (18.1)
Pyrexia	52 (19.0)	44 (16.2)	96 (17.6)
Muscle spasms	49 (17.9)	49 (18.0)	98 (17.9)
Nausea	49 (17.9)	38 (14.0)	87 (15.9)
Infusion-related reaction	43 (15.7)	41 (15.1)	84 (15.4)
Thrombocytopenia	37 (13.5)	42 (15.4)	79 (14.5)
Pruritus	44 (16.1)	28 (10.3)	72 (13.2)

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What about Bispecific Antibodies?

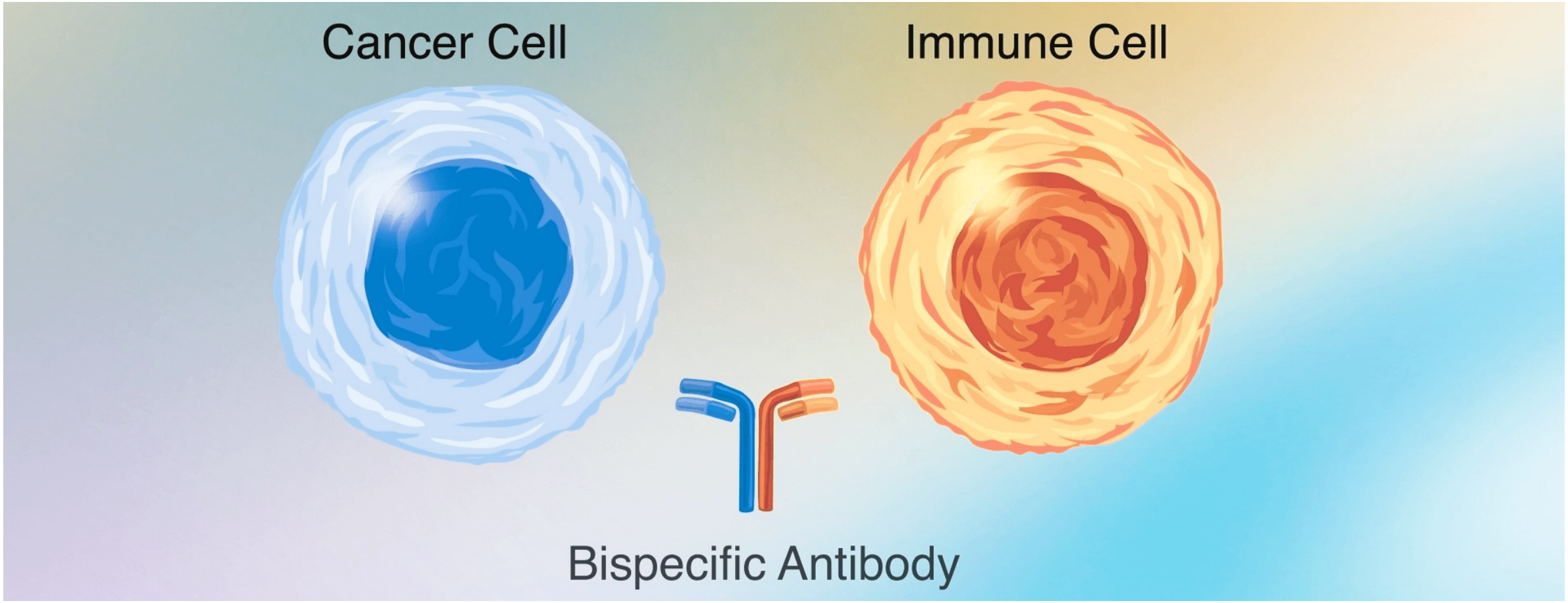

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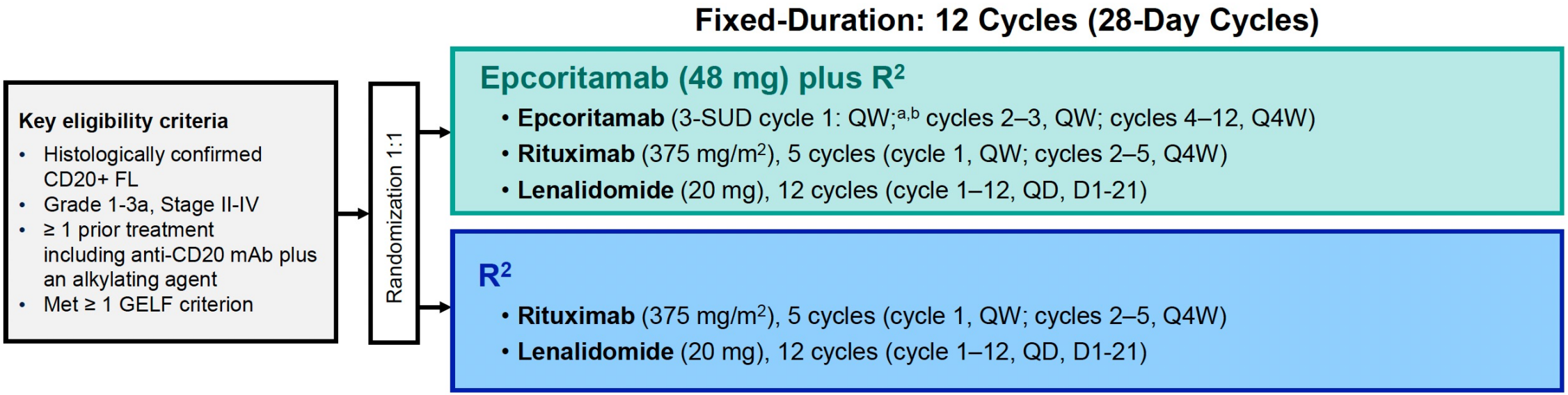
Image from DFCI.org

EPCORE FL-1 Ph3: Epco-R2 vs R2 in 2L+ FL



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

3 dose SUD (0.16mg, 0.8mg, 3mg)

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Falchi, L et al ASH 2025

EPCORE FL-1: Patient Characteristics

Characteristic	Epcoritamab+R^2 (N = 243)	R^2 (N = 245)	Overall (N = 488)
Median age, y (range)	60 (30, 84)	63 (24, 89)	61 (24, 89)
≥ 65, n (%)	88 (36)	106 (43)	194 (40)
Male, n (%)	139 (57)	138 (56)	277 (57)
Race, n (%)			
Asian	63 (26)	54 (22)	117 (24)
Black	6 (2)	2 (< 1)	8 (2)
White	168 (69)	184 (75)	352 (72)
Ethnicity, n (%)			
Hispanic	29 (12)	28 (11)	57 (12)
ECOG, n (%)			
0	166 (68)	170 (69)	336 (69)
1-2	77 (32)	75 (31)	152 (31)
Ann Arbor stage, n (%)			
II	37 (15)	44 (18)	81 (17)
III-IV	206 (85)	201 (82)	407 (83)
FLIPI score, n (%)			
0–1	63 (26)	56 (23)	119 (24)
2	79 (33)	76 (31)	155 (32)
3–5	100 (41)	113 (46)	213 (44)
Bulky disease (≥ 7 cm), n (%)	47 (19)	61 (25)	108 (22)

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Falchi, L et al ASH 2025

EPCORE FL-1: Prior Treatments

	Epcoritamab+R² (N = 243)	R² (N = 245)	Overall (N = 488)
Median time from initial diagnosis to randomization, years (range)	4.5 (0.2, 30.3)	5.3 (0.1, 43.0)	5.0 (0.1, 43.0)
Number of prior lines of therapy, median (range)	1 (1, 7)	1 (1, 6)	1 (1, 7)
1, n (%)	145 (60)	141 (58)	286 (59)
2, n (%)	58 (24)	61 (25)	119 (24)
≥ 3, n (%)	40 (16)	43 (18)	83 (17)
Prior anti-CD20 antibody, n (%)	243 (100)	245 (100)	488 (100)
Prior anti-CD20 antibody containing chemotherapy, n (%)	239 (98)	240 (98)	479 (98)
Prior bendamustine in last line, n (%)	53 (22)	47 (19)	100 (20)
Prior R², n (%)	8 (3)	9 (4)	17 (3)
POD24,[a] n (%)	106 (44)	93 (38)	199 (41)
Refractory to 1L therapy, n (%)	86 (35)	81 (33)	167 (34)
Refractory to anti-CD20 antibody, n (%)	104 (43)	103 (42)	207 (42)
Refractory to last line of therapy, n (%)	84 (35)	82 (33)	166 (34)
Double refractory[b]	91 (37)	91 (37)	182 (37)

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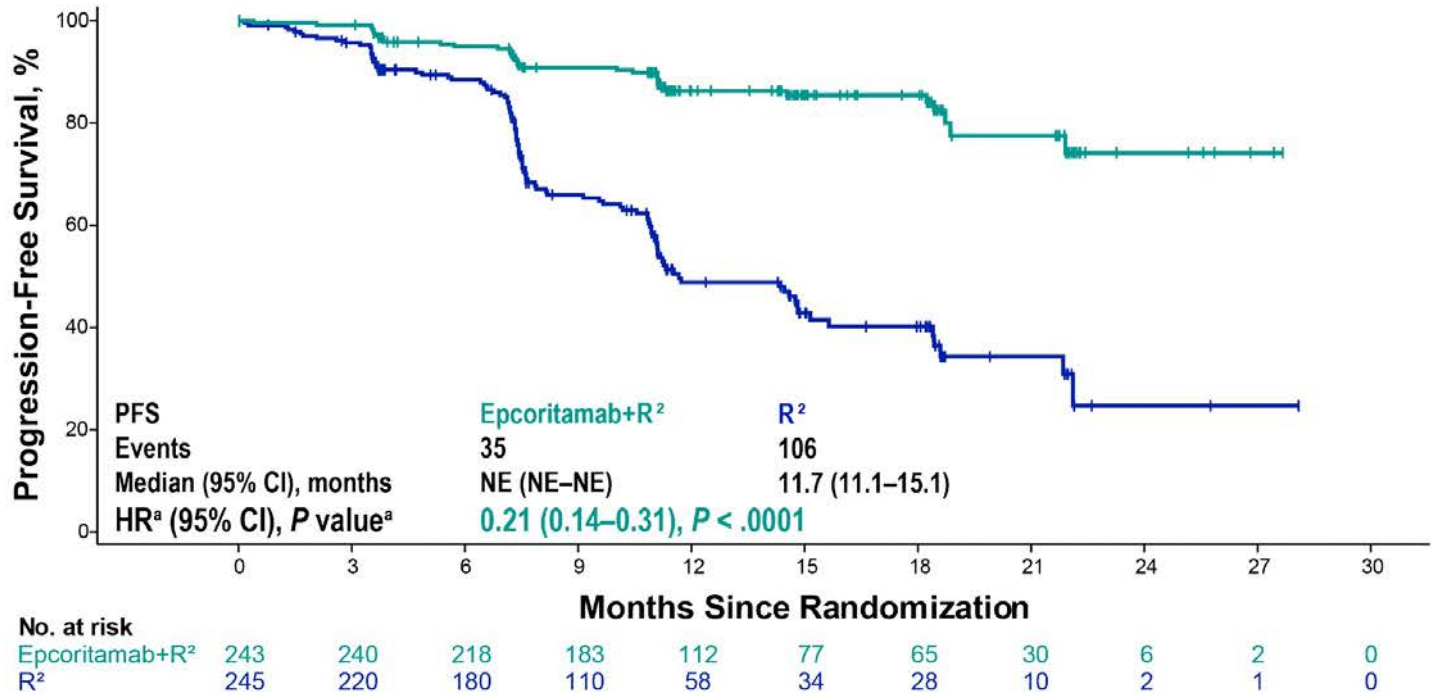
EPCORE FL-1: PFS (IRC)



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

CR rate 33% higher for Epco-R2

- 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

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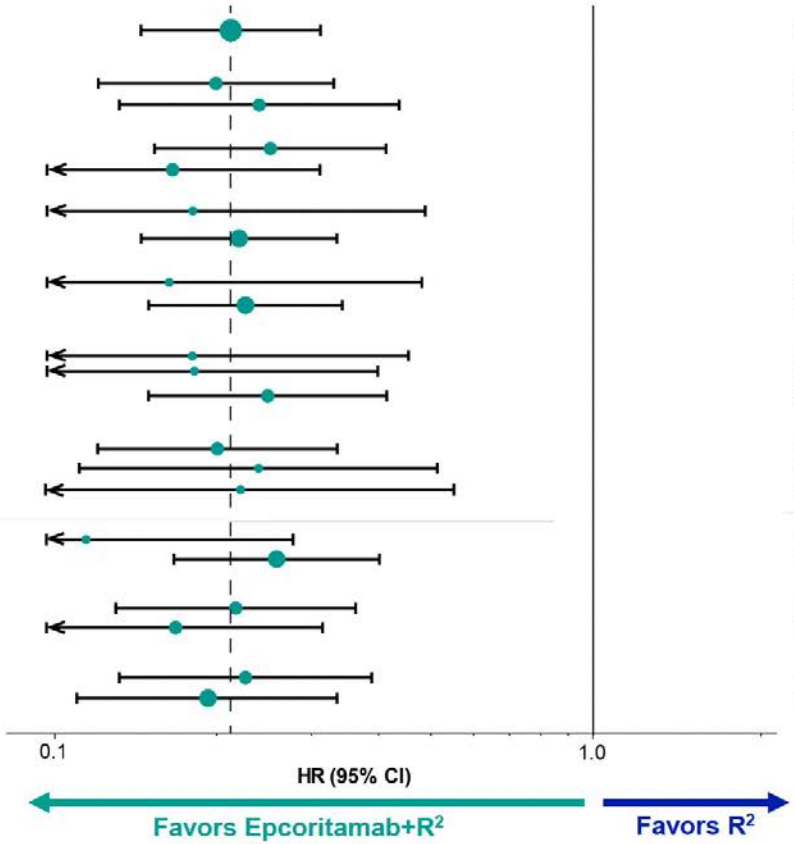
EPCORE FL-1: Prespecified Subgroups (PFS)

Prespecified Subgroups	Epcoritamab+R² Event/N (%)	R² Event/N (%)	HR (95% CI)
All patients	35/243 (14)	106/245 (43)	0.22 (0.15, 0.32)
Age (years)			
< 65	21/155 (13)	58/139 (42)	0.20 (0.12, 0.33)
≥ 65	14/88 (16)	48/106 (45)	0.24 (0.13, 0.44)
Sex			
Male	23/139 (17)	54/138 (39)	0.25 (0.15, 0.42)
Female	12/104 (12)	52/107 (49)	0.17 (0.09, 0.31)
Region			
US/Western Europe	5/58 (9)	18/60 (30)	0.18 (0.07, 0.49)
Rest of World	30/185 (16)	88/185 (48)	0.22 (0.15, 0.34)
Ann Arbor stage			
II	4/37 (11)	21/44 (48)	0.16 (0.06, 0.49)
III+IV	31/206 (15)	85/201 (42)	0.23 (0.15, 0.35)
FLIPI score at baseline			
0-1	6/63 (10)	19/56 (34)	0.18 (0.07, 0.46)
2	8/79 (10)	30/76 (39)	0.18 (0.08, 0.40)
3-5	21/100 (21)	57/113 (50)	0.25 (0.15, 0.42)
Number of prior lines			
1	20/145 (14)	58/141 (41)	0.20 (0.12, 0.34)
2	9/58 (16)	26/61 (43)	0.24 (0.11, 0.52)
≥ 3	6/40 (15)	22/43 (51)	0.23 (0.09, 0.56)
Bulky disease (≥ 7 cm)			
Yes	6/47 (13)	31/61 (51)	0.12 (0.05, 0.28)
No	28/191 (15)	71/176 (40)	0.26 (0.17, 0.41)
POD24			
Yes	22/106 (21)	47/93 (51)	0.22 (0.13, 0.37)
No	12/131 (9)	54/144 (38)	0.17 (0.09, 0.32)
Double refractory			
Yes	19/91 (21)	47/91 (52)	0.23 (0.13, 0.39)
No	16/152 (11)	59/154 (38)	0.19 (0.11, 0.34)



Consistent HR in favor of Epco-R2

Similar consistent HR for CR and DOR

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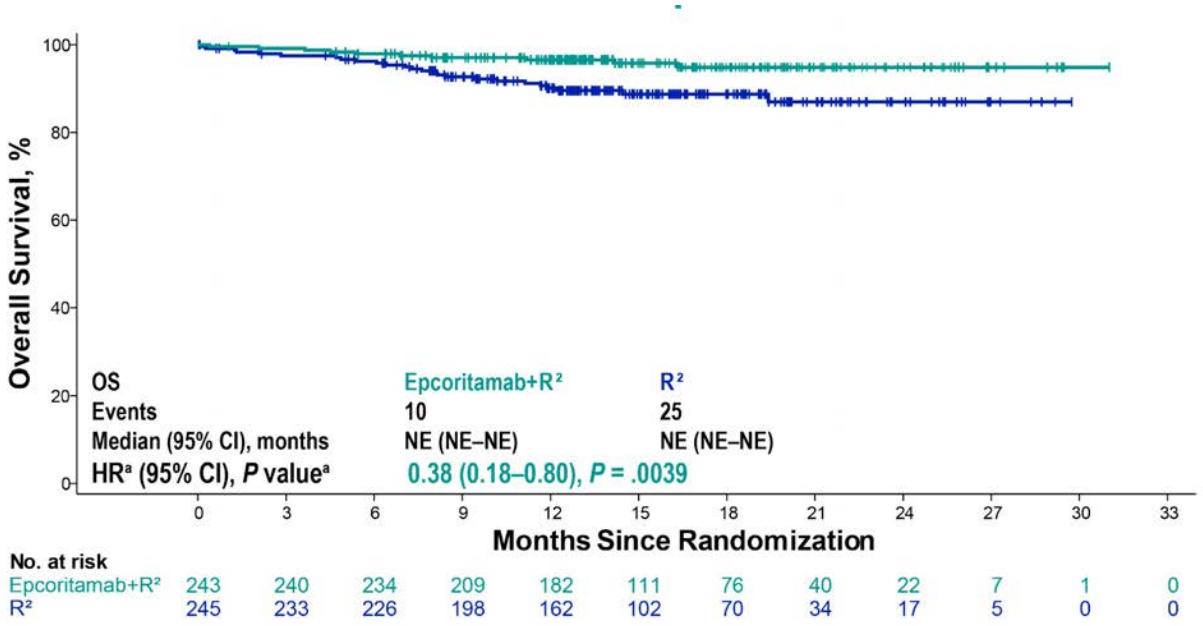
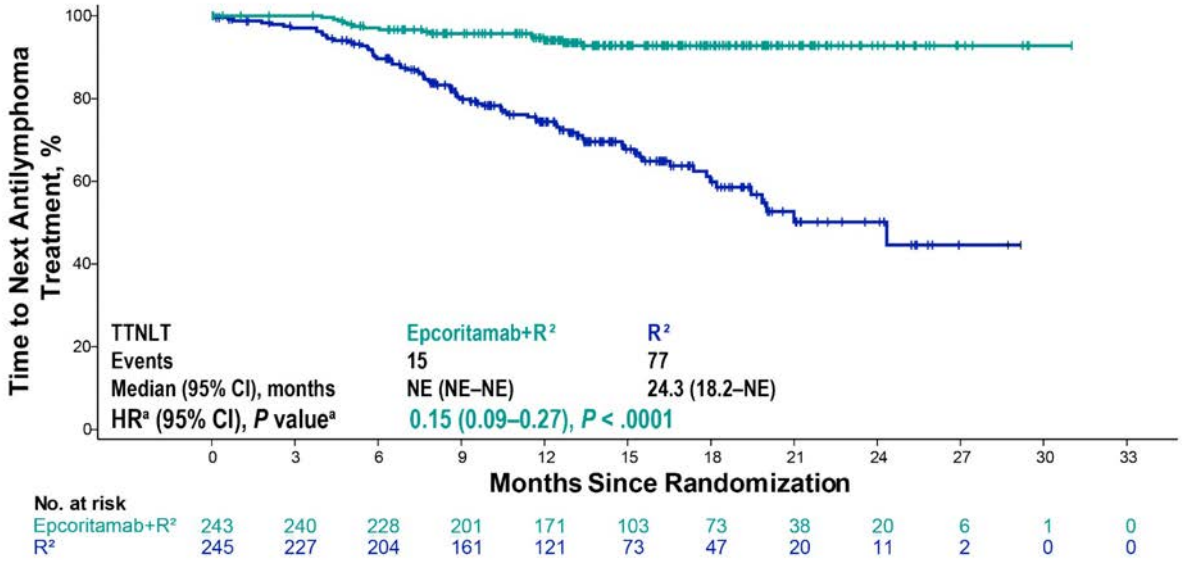
Falchi, L et al ASH 2025

EPCORE FL-1: Overall Survival & TTNT





Improvement in OS and TTNT
At 16 mths 93% free from next treatment vs 64%

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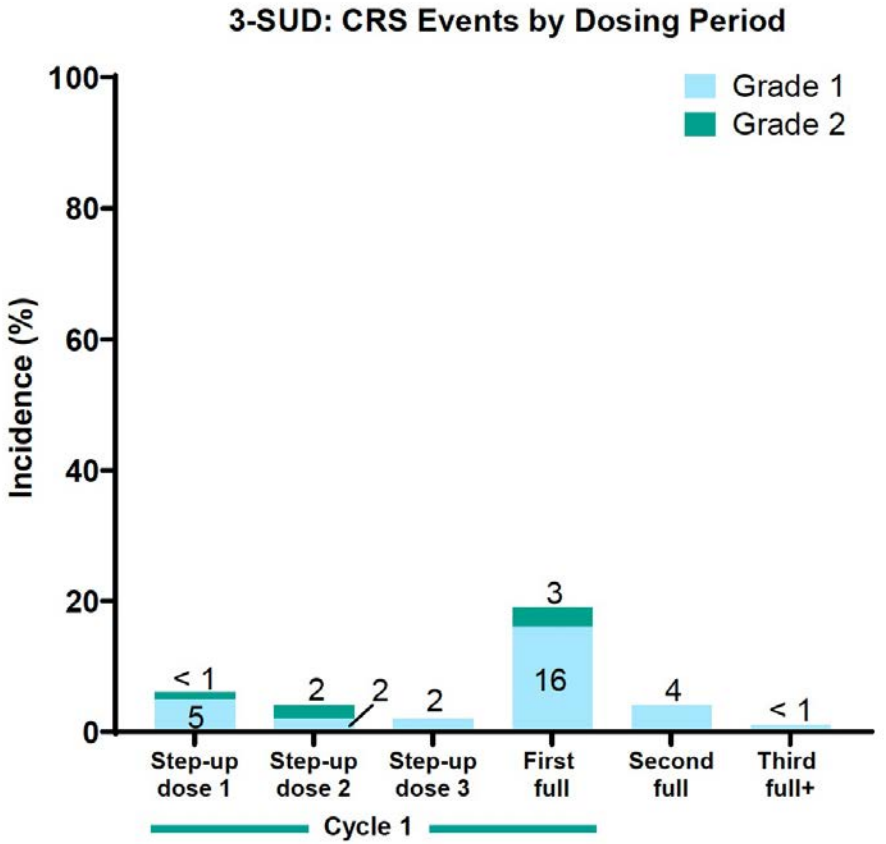
Falchi, L et al ASH 2025

EPCORE FL-1: Adverse Events

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



Febrile Neutropenia Epco-R² 6% vs R² 2%

CRS 26% (21% Gr1, 5% Gr2)

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Falchi, L et al ASH 2025

Mosunetuzumab + Lenalidomide: CELESTIMO ARM C (ASH 2025)

Overall Response Rate

96.3%

52/54 patients

Complete Response

87.0%

US cohort (N=54)

Setting

2L+ R/R FL

CELESTIMO Phase 3

Efficacy

- Mosunetuzumab+lenalidomide (fixed-duration)
- US extension cohort: ORR 96.3%, CR 87.0%
- Deep responses: 52/54 patients responded
- Full primary analysis anticipated 2026
- IV mosunetuzumab × 8 cycles (fixed-duration)

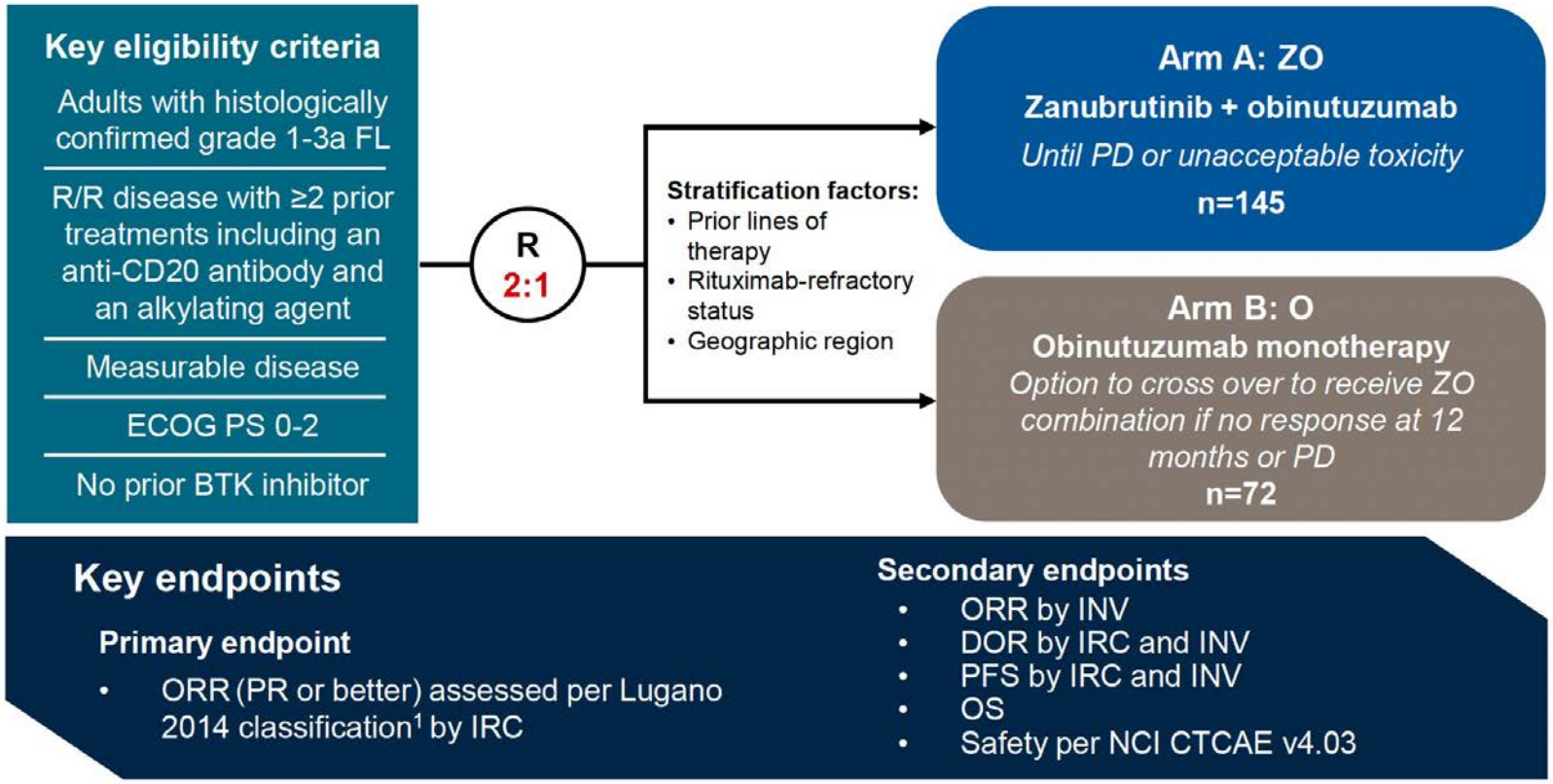
Safety Profile

- CRS: 27.8% (Gr1: 22.2% | Gr2: 3.7% | Gr3: 1.9%)
- No grade 3–4 CRS in US cohort
- Neutropenia grade ≥3: 35.2%
- Infections: 57.4% (grade ≥3: 11.1%)
- No treatment-related deaths

SCRI Sarah Cannon Research Institute

Sano et al. Blood. 2025 (ASH 2025)

Obinutuzumab + Zanubrutinib: Rosewood Ph2 Trial



- ~55% Bulky by GELF
- ~35-40% POD24
- ~50% Rituximab refractory

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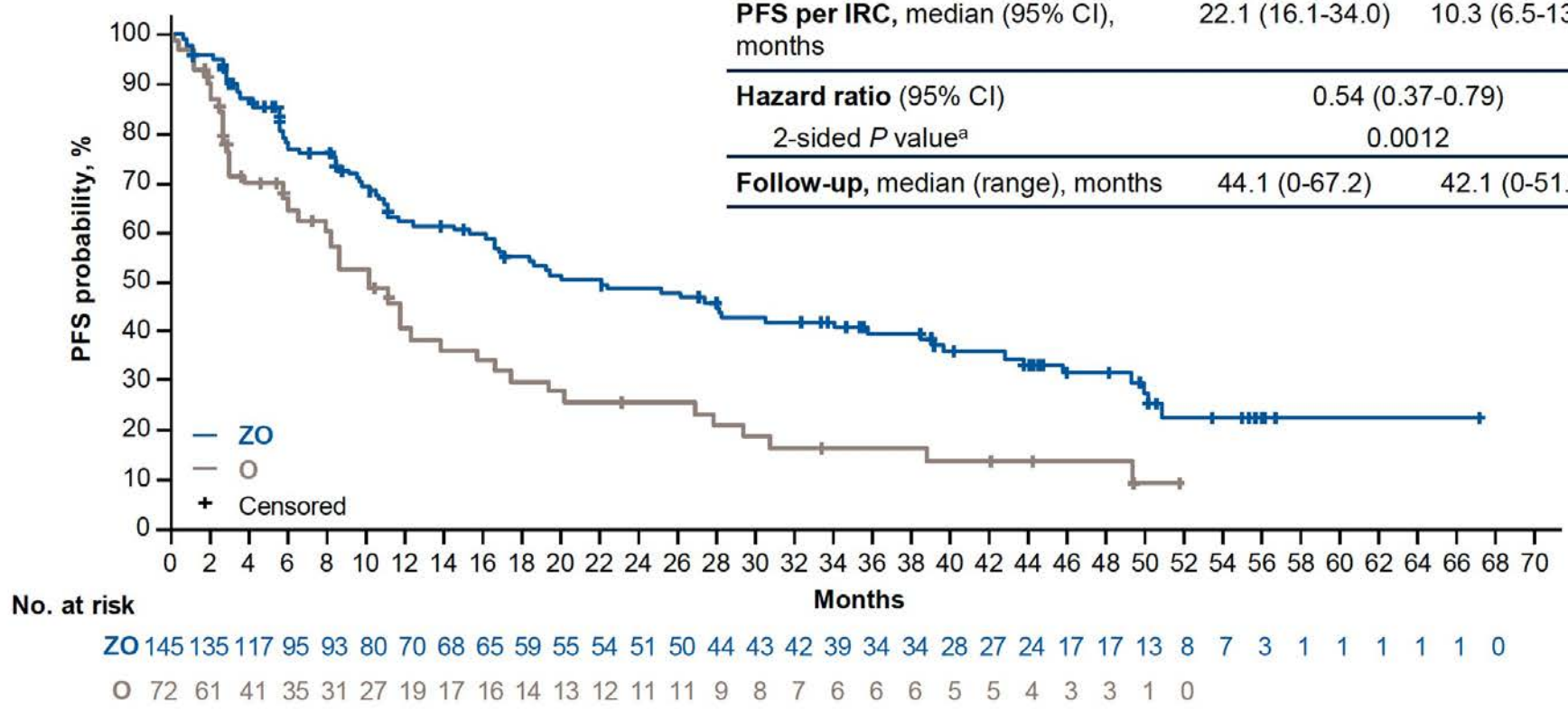
Zinzani P et al ASH 2025

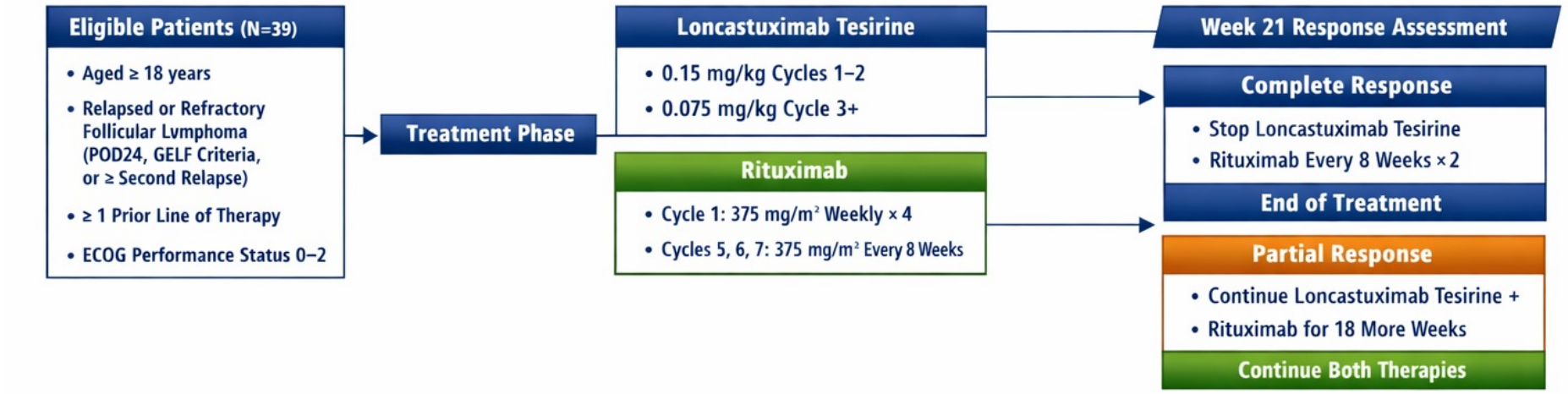
Obinutuzumab + Zanubrutinib: PFS

	ZO	O
PFS per IRC, median (95% CI), months	22.1 (16.1-34.0)	10.3 (6.5-13.8)
Hazard ratio (95% CI)	0.54 (0.37-0.79)	
2-sided *P* value[a]	0.0012	
Follow-up, median (range), months	44.1 (0-67.2)	42.1 (0-51.8)



Toxicity consistent with known tox of Zanu

Loncastuximab Tesirine + Rituximab



Median f/u 18.2 mths
1º Endpoint Week 12 CR (4 cycles)

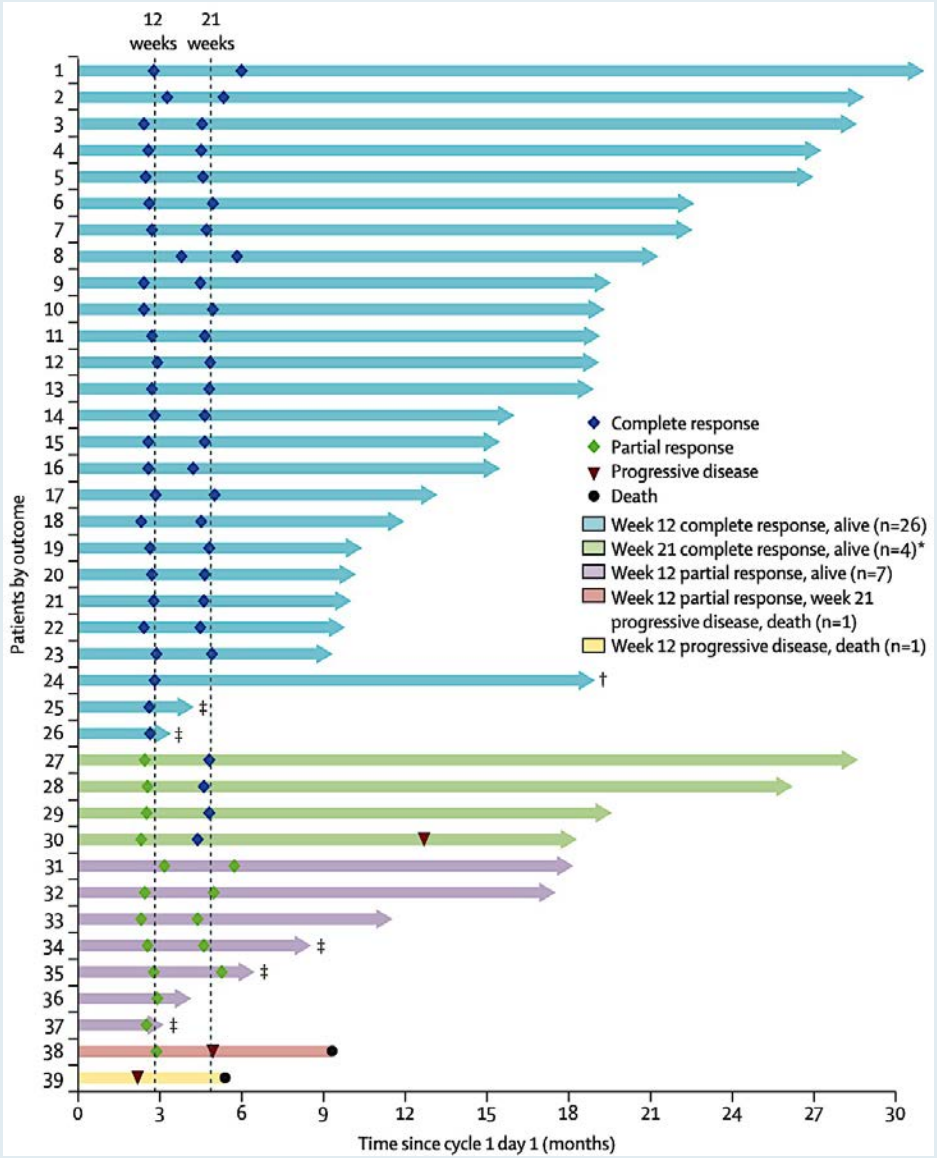
Week 12 CR 67% (ORR 97%)
12 mth PFS 94.6%

Adverse Events consistent with component therapies

NCCN Category 2B listed for 3L+ FL

Alduruccio J et al Lancet Haem 2025

Phase II Trial of Loncastuximab Tesirine with Rituximab: Responses

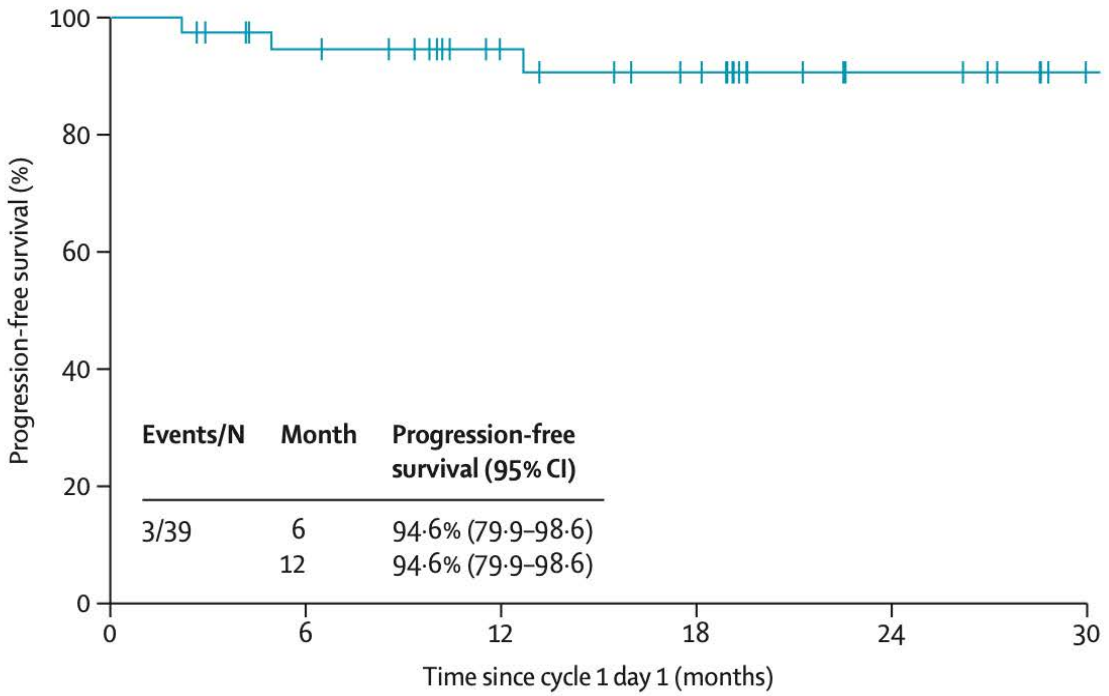


Week 12 complete response 67%
(Overall response rate 97%)

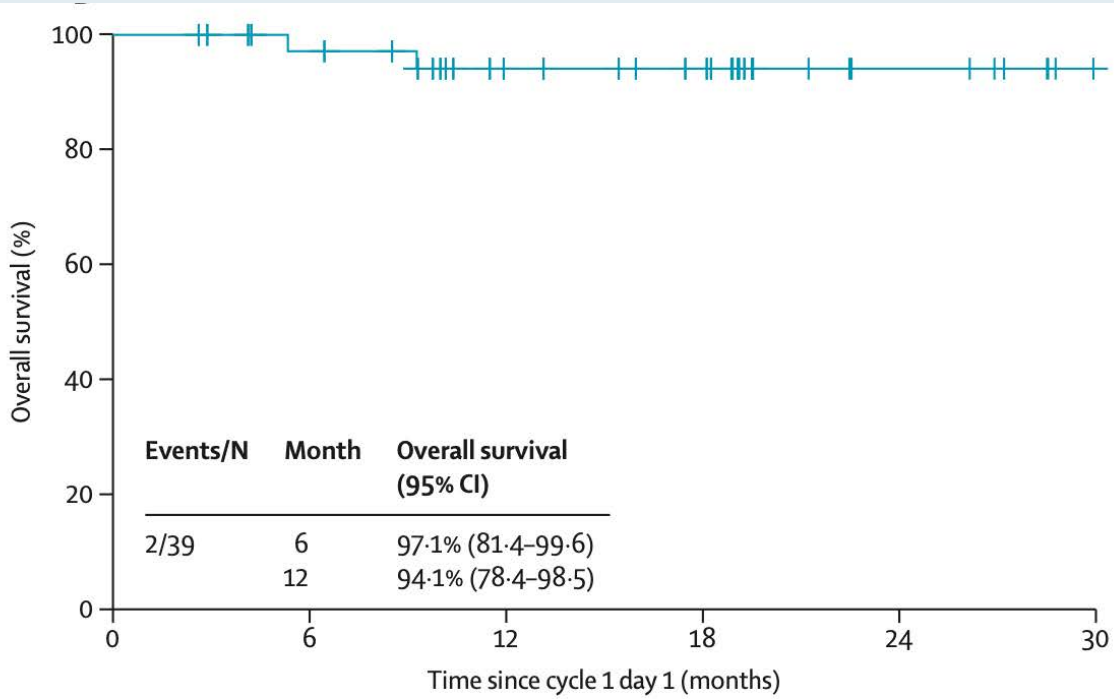
Alderuccio JP et al. *Lancet Haematol* 2025 January;12(1):e23-34.

Phase II Trial of Loncastuximab Tesirine with Rituximab: Survival

Progression-free survival



Overall survival



Alderuccio JP et al. *Lancet Haematol* 2025 January;12(1):e23-34.

Phase II Trial of Loncastuximab Tesirine with Rituximab: Common Treatment-Emergent Adverse Events (TEAEs) (Safety Population, n = 39)

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

Alderuccio JP et al. *Lancet Haematol* 2025 January;12(1):e23-34.

Golcadomide + Rituximab in R/R Follicular Lymphoma

Efficacy Data

97% ORR
0.4 mg dose day 1-14 every 28 days

78% CRR
0.4 mg dose

Median 3 prior lines

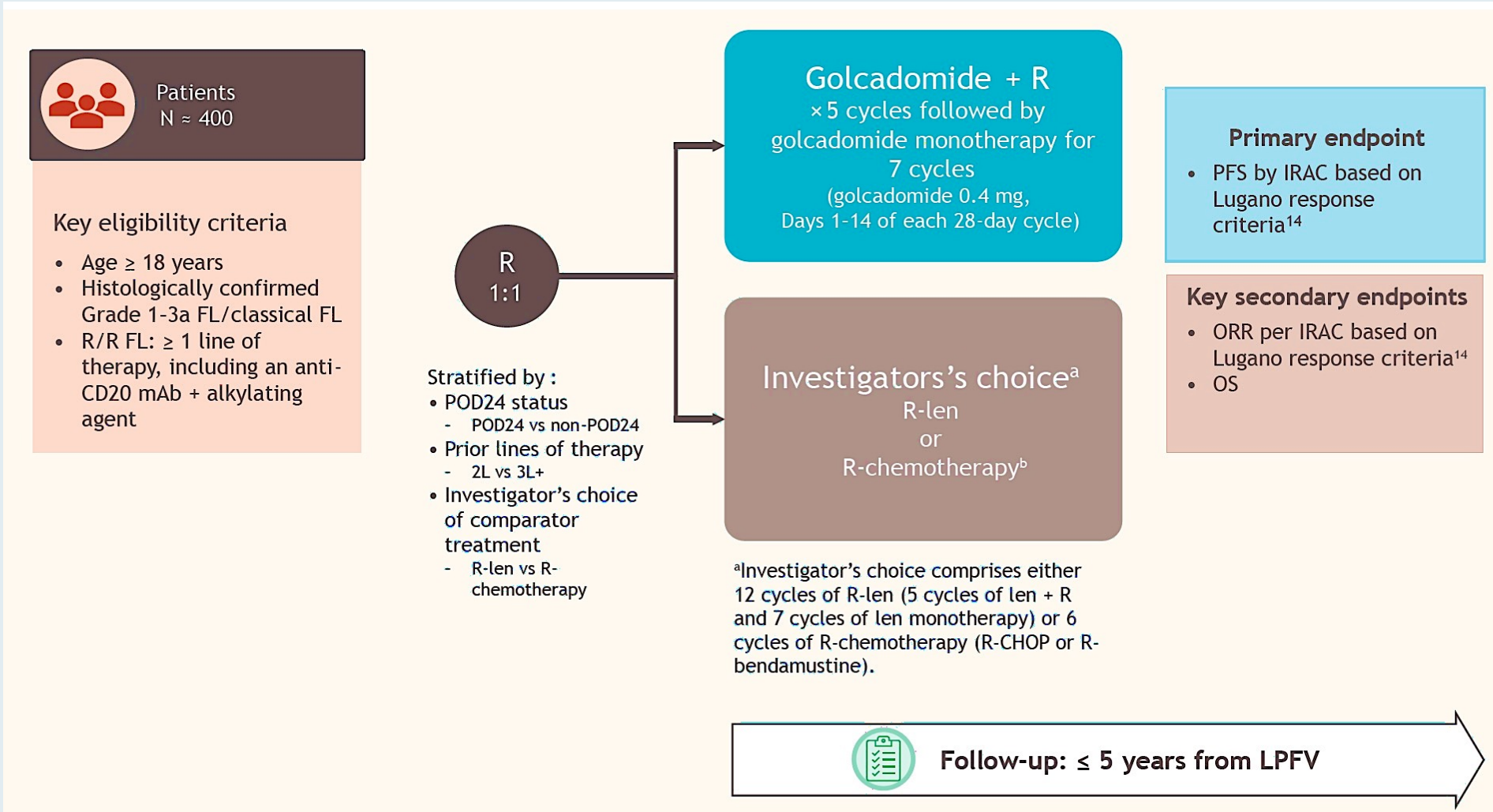
Safety Data

- Most common Grade 3/4 AEs: neutropenia in >50% of patients, managed with G-CSF
- Non-heme AEs: fatigue, diarrhea, and rash, generally mild to moderate severity, no treatment discontinuation

Golseek-4: Ph3 RCT Golca-R vs IC (Len-R/CIT) in 2L+ FL now enrolling

Chavez J et al ASH 2025

Phase III GOLSEEK-4 Study Design



[b]For patients receiving R-chemotherapy, maintenance therapy with an anti-CD20 antibody is not allowed.
2L, second line; 3L+, third line and beyond; CD, cluster of differentiation; FL, follicular lymphoma; IRAC, Independent Radiology Adjudication Committee; len, lenalidomide; LPFV, last patient first visit; mAb, monoclonal antibody; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; POD24, progression of disease within 24 months; R, rituximab; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone; R/R, relapsed/refractory.

Hawkes E et al. ASH 2025;Abstract 3615.

Key Takeaways

- **Epco +R2 or Tafa + R2 preferred 2L regimens for FL**

- **3L+ options include**
  - Epco or Mosun mono (if no prior)
  - Zanu-Obin
  - Lonca-T + Rituximab
  - CAR –T-cell therapy (Axi-cel, Liso-cel, Tisacel)

- **Additional agents under investigation**
  - *Golcadomide + Rituximab*
  - *Surovatamig (CD19 BsAb), MK-1045 (CD19 BsAb)*
  - *BCL6 degraders*

Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

Part 1 - Diffuse Large B-Cell Lymphoma:

Antibody-Drug Conjugates and Other Novel Strategies in the Management of DLBCL — Prof Salles

Current and Future Role of Monoclonal and Bispecific Antibodies in the Management of DLBCL — Dr Patel

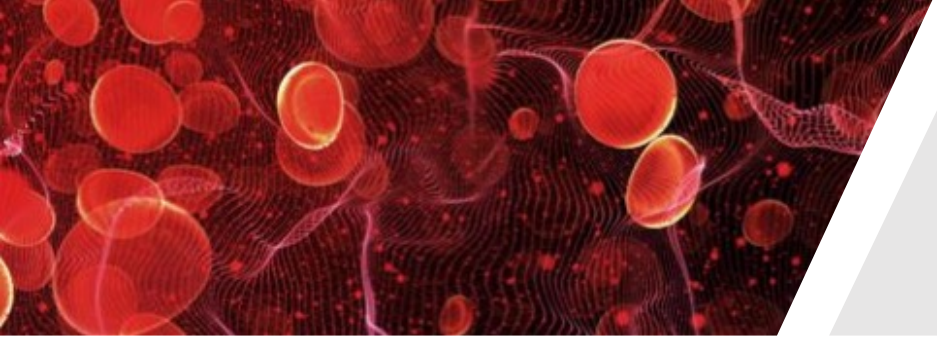
Chimeric Antigen Receptor (CAR) T-Cell Therapy for DLBCL — Dr Kamdar

Part 2 – Follicular Lymphoma:

CAR T-Cell Therapy for FL — Prof Salles

Other Approved and Emerging Novel Therapies for FL — Dr Patel

Integrating Bispecific Antibodies into the Management of FL — Dr Kamdar



Integrating Bispecific Antibodies into the Management of Follicular Lymphoma

Manali Kamdar, MD, MBBS

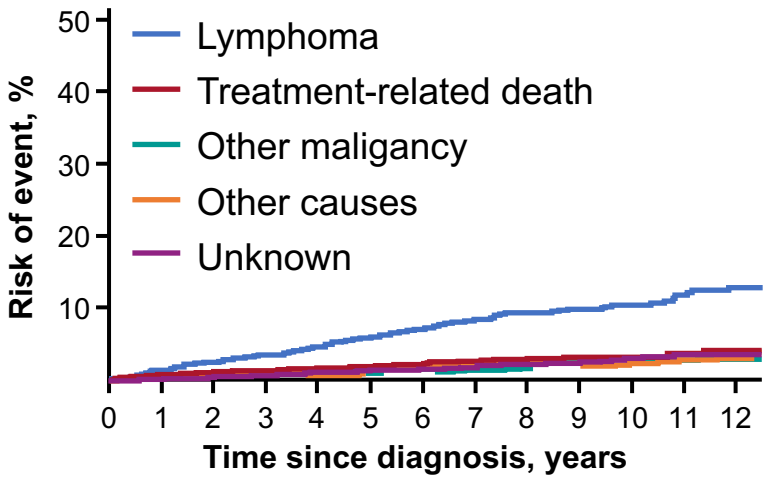
Associate Professor of Medicine, Clinical Director of Lymphoma Services,

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

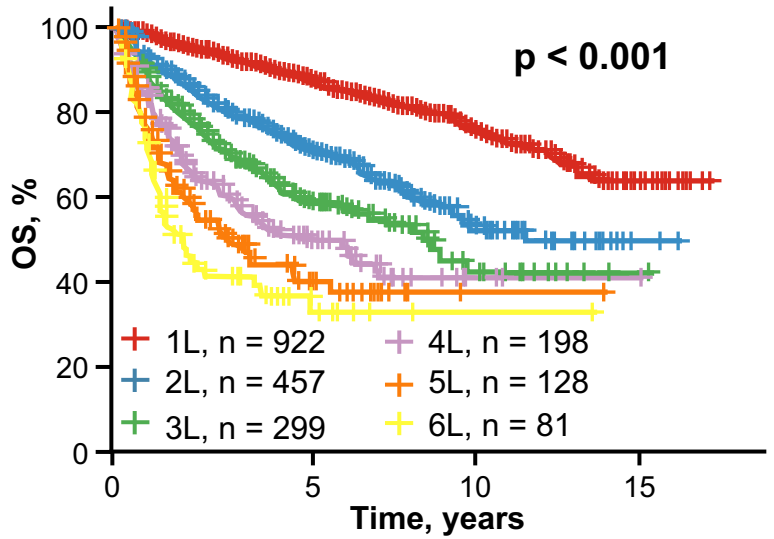
University of Colorado

Relapsed/refractory follicular lymphoma unmet needs

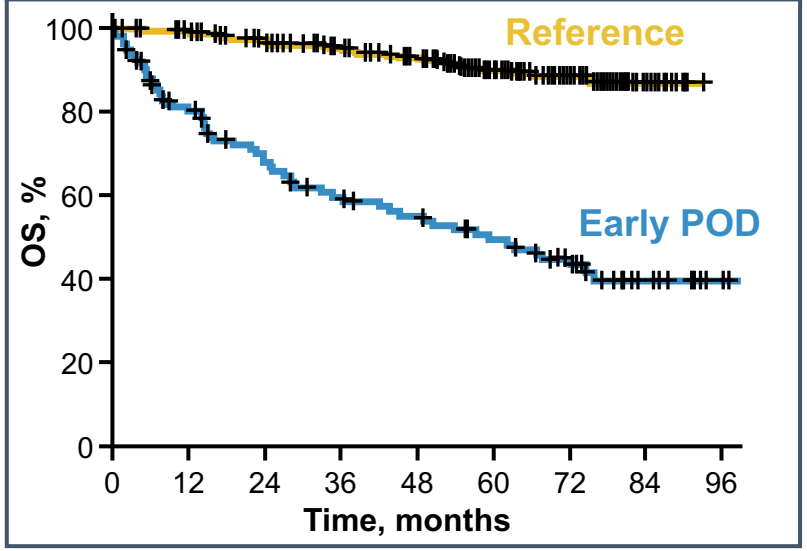
Lymphoma-related death: 10.3% at 10 years[1]



OS by line of therapy[2]



OS based on POD24[3]



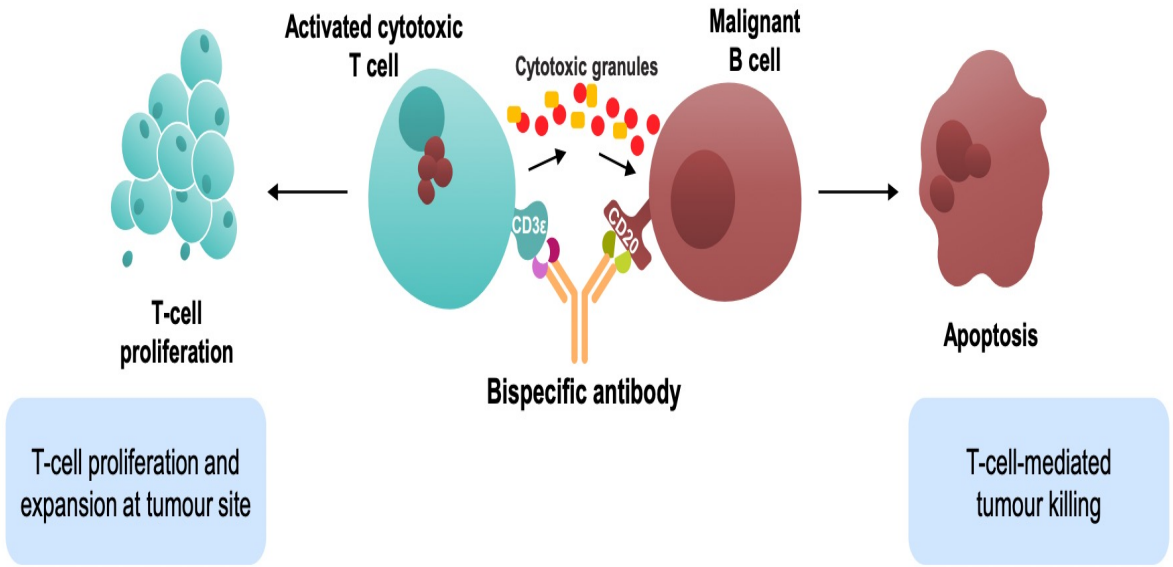
Treatment goals for R/R FL

Efficacious and durable	Time-limited	Potential cure	Improves QoL	Manageable short- and long-term toxicity

FL, follicular lymphoma; OS, overall survival; POD24, progression of disease within 24 months; R/R, relapsed/refractory.

1. Sarkozy C, et al. J Clin Oncol. 2019;37:144–152; 2. Batlevi CL, et al. Blood Cancer J. 2020;10:74; 3. Casulo C, et al. J Clin Oncol. 2015;33:2516–2522.

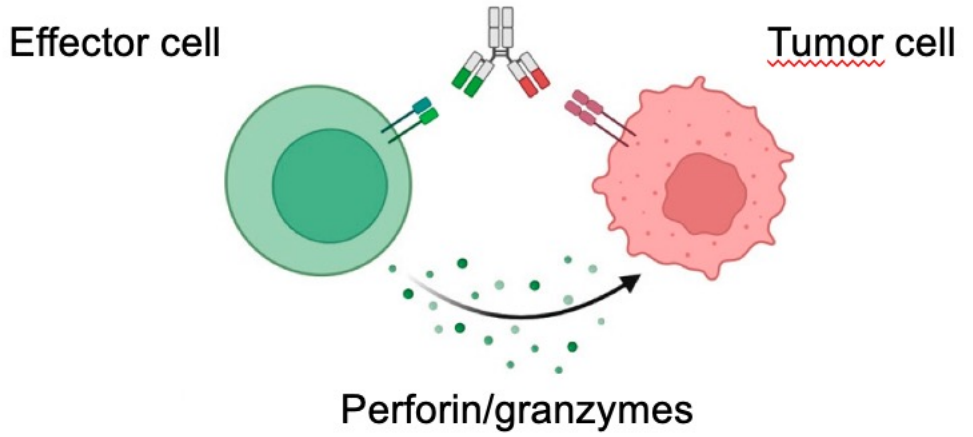
CD20xCD3 bispecific antibodies engage and redirect T cells to eliminate malignant B cells



CD20 bispecific antibodies[2,3]

Redirected tumour lysis[2]

IgG-like bispecific antibody



Mosunetuzumab[3]

IV infusion/
SC
Time-limited

Epcoritamab[3]

SC
Indefinite therapy

Odronextamab

IV
Indefinite Therapy

University of Colorado
Anschutz Medical Campus

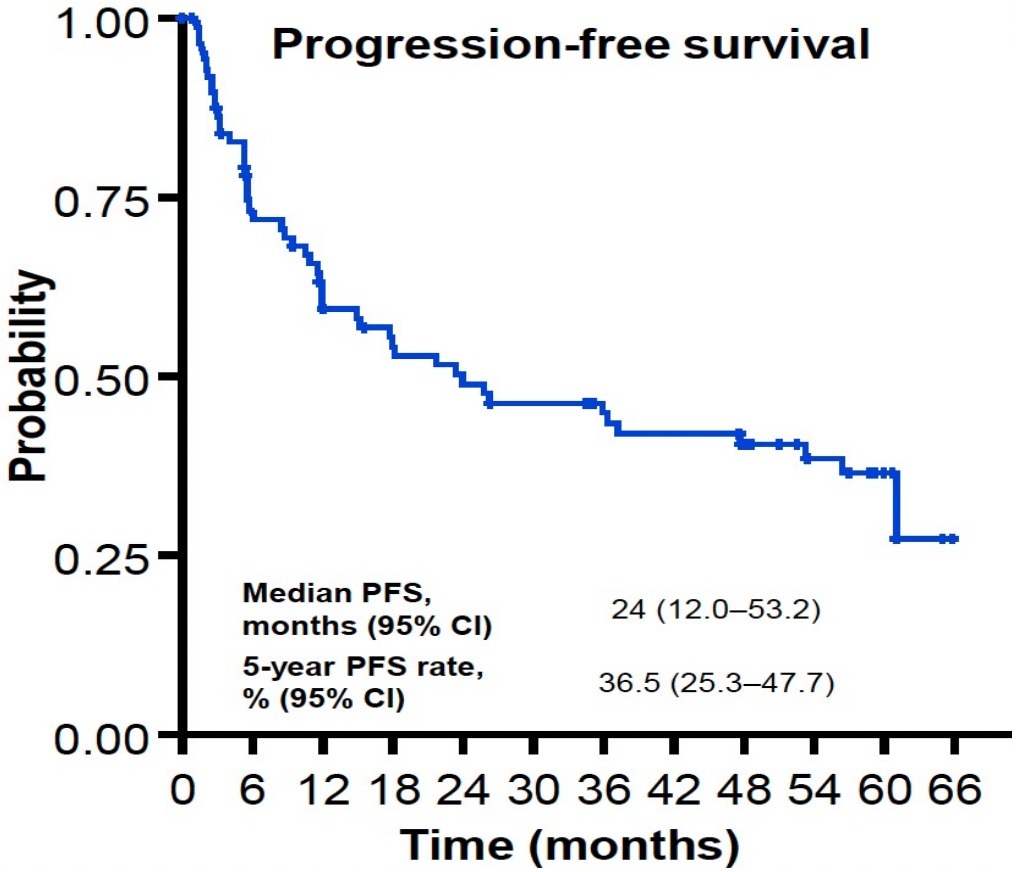
Aldoss I, et al. Leukemia 2017;31:777–87. 2. Khosla AA, et al. Pharmaceuticals 2023;16:1461; 3. Cassanello G, et al. Oncoimmunology 2024;13:2321648

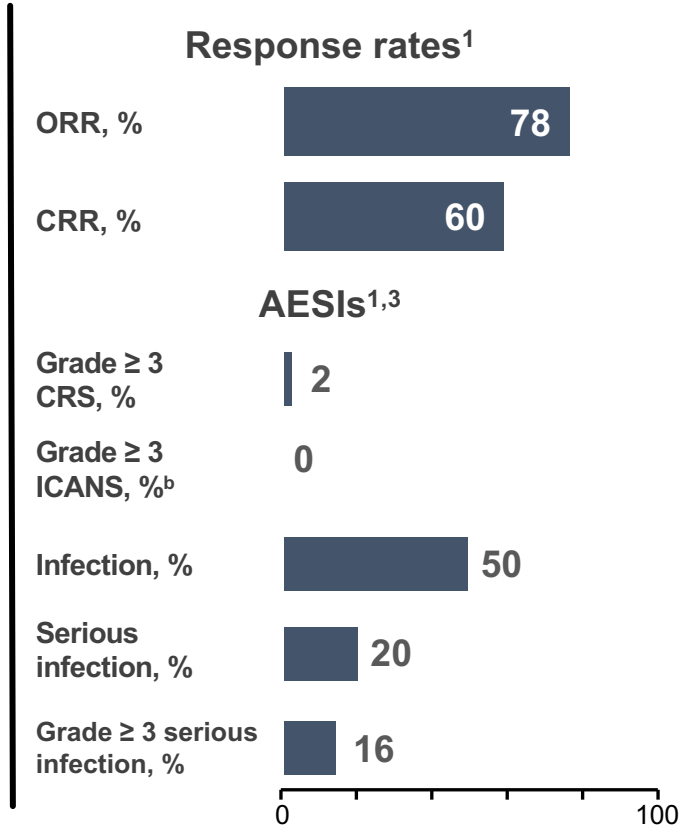
Mosunetuzumab: Median PFS of 24 months at 5-year follow-up

GO29781

mFU: 60.2 months

Phase 2, single-arm, multicenter trial of **mosunetuzumab (n = 90)** in patients with 3L+ R/R FL[1,2]





Serious infections as reported by investigators: 20%; Median TTNT 64 mnths; Similar mPFS in POD24 vs Non-POD24

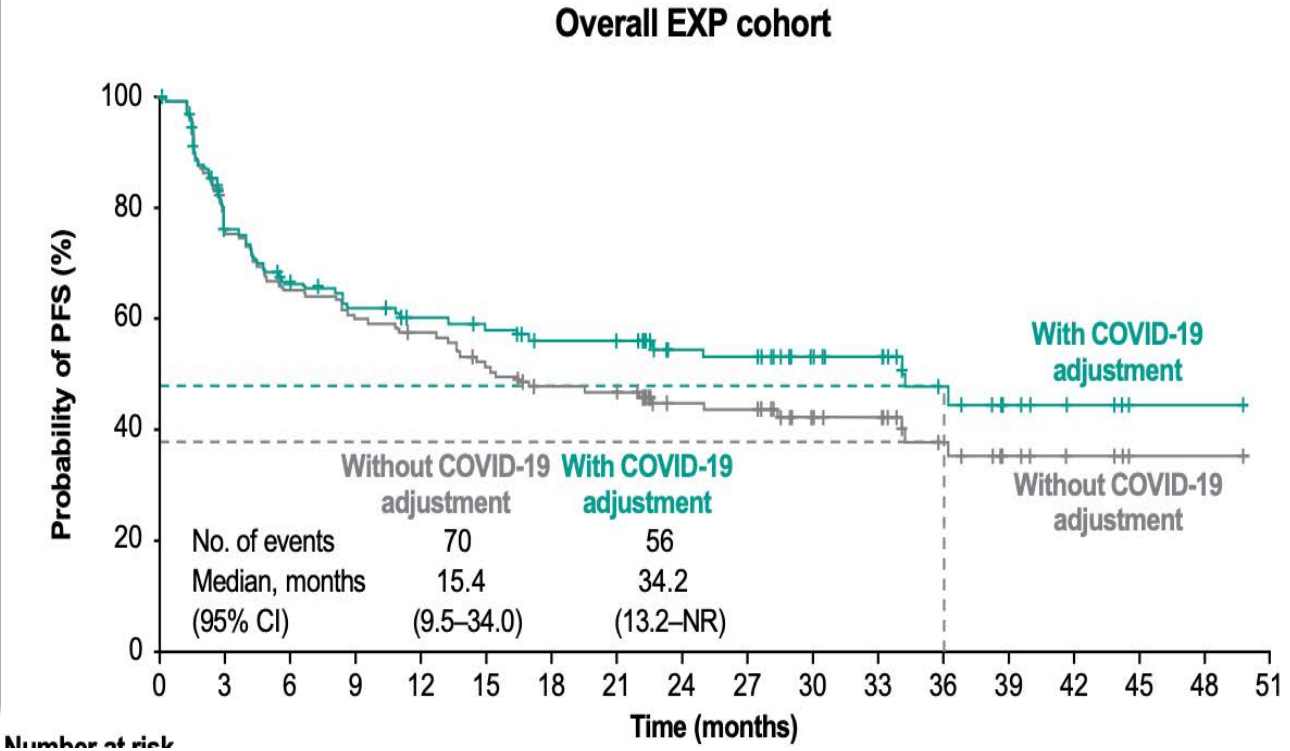
[a] Median follow-up of 28.3 months; [b] Median follow-up 18.3 months in the primary analysis.
3L, third line; AE, adverse event; CRR, complete response rate; CRS, cytokine release syndrome; FL, follicular lymphoma; ICANS, immune effector cell-associated neurotoxicity syndrome; mFU, median follow-up; NE, not estimable; NR, not reached; ORR, overall response rate; PFS, progression-free survival; R/R, relapsed/refractory.
1. Shadman S, et al. ASH 2024. Oral presentation 864; 2. Bartlett NL, et al. Blood. 2022. Oral presentation 610; 3. Budde LE, et al ASH 2025

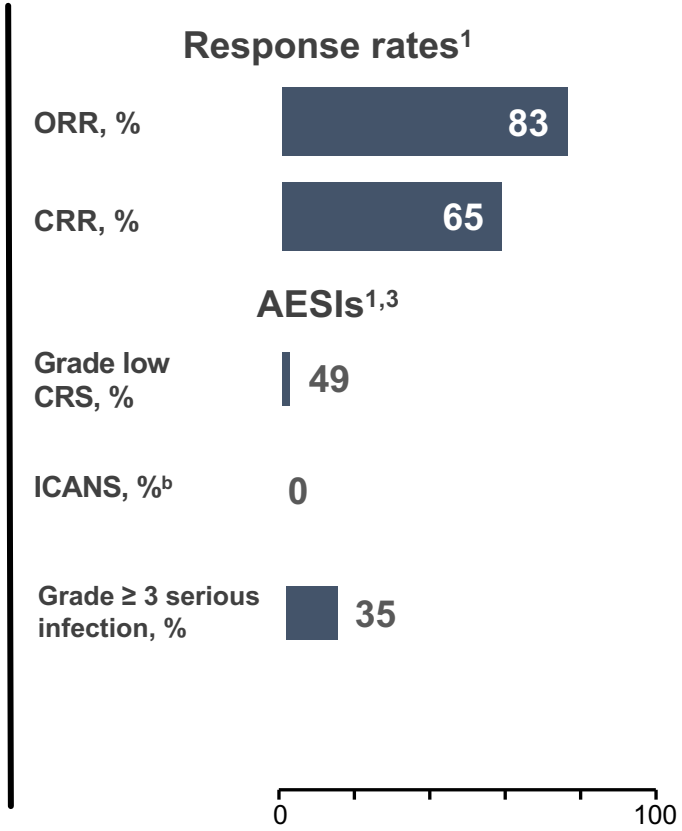
Epcoritamab: Median PFS of 15 months at 3-year follow-up

EPCORE NHL-1 / NHL-3 (pooled EXP cohort)

mFU: 35 months

Phase 1/2, single-arm, multicenter trial of **Epcoritamab (n = 149)** in patients with 3L+ R/R FL[1,2]





30 month OS 79%
Serious infections as reported by investigators: 35%; Median TTNT 45 months; MRD 70%

Vitolo U et al. EHA 2025;Abstract PF881

Primary Phase 3 Results From the EPCORE FL-1 Trial of Epcoritamab With Rituximab and Lenalidomide (R^2) Versus R^2 for Relapsed or Refractory Follicular Lymphoma

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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

[a]Two 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] [b]The 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. [c]Minimal residual disease data are forthcoming in a future analysis. [d]The data presented here are from the second planned interim analysis (May 24, 2025) after 78% Information Fraction for PFS had occurred.

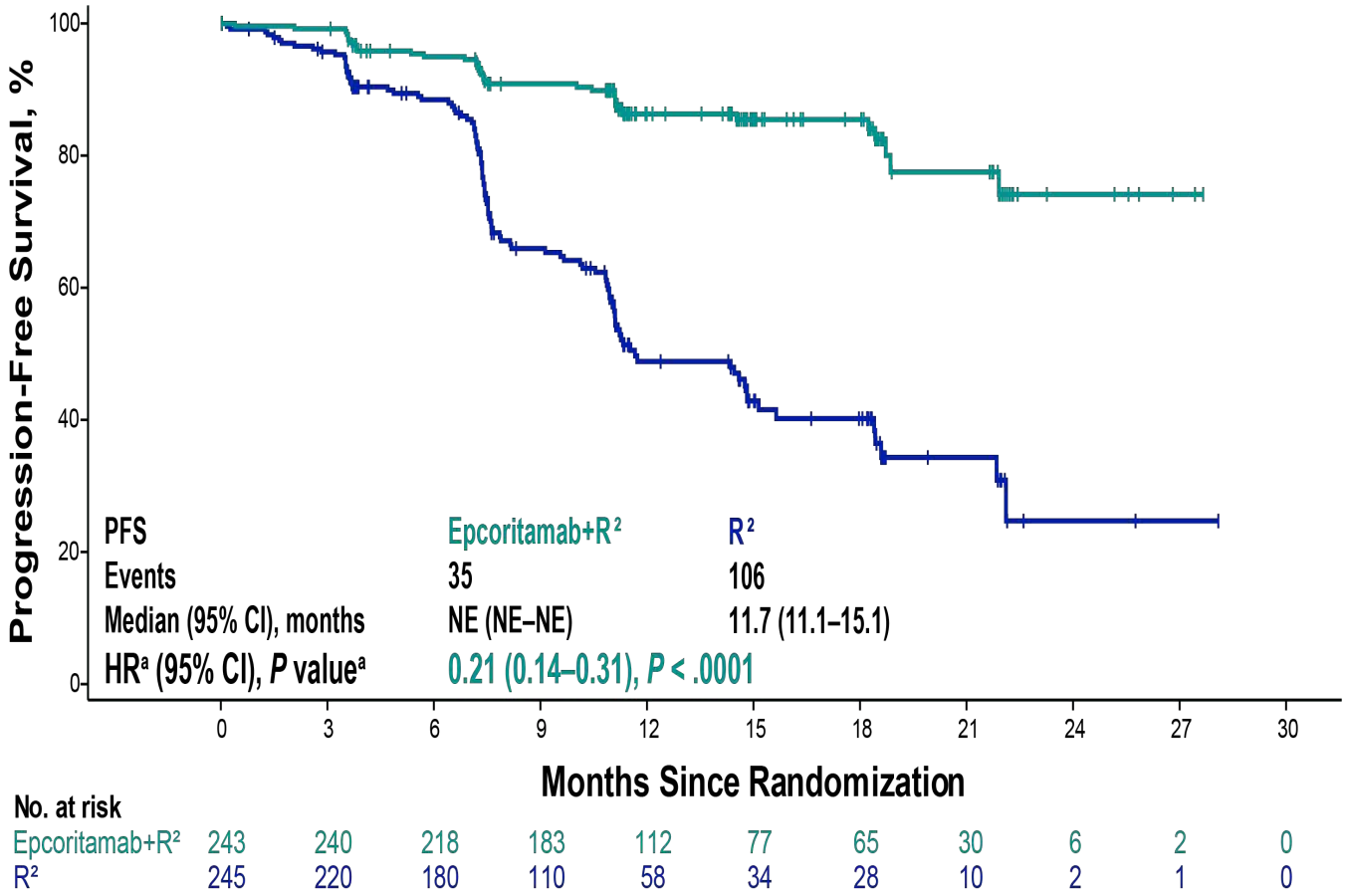
1. Vose J, et al. *J Clin Oncol.* 2024;42(16_suppl):7015–7015. 2. Falchi L, et al. *Blood*. 2024;144(Supplement 1):342–342.

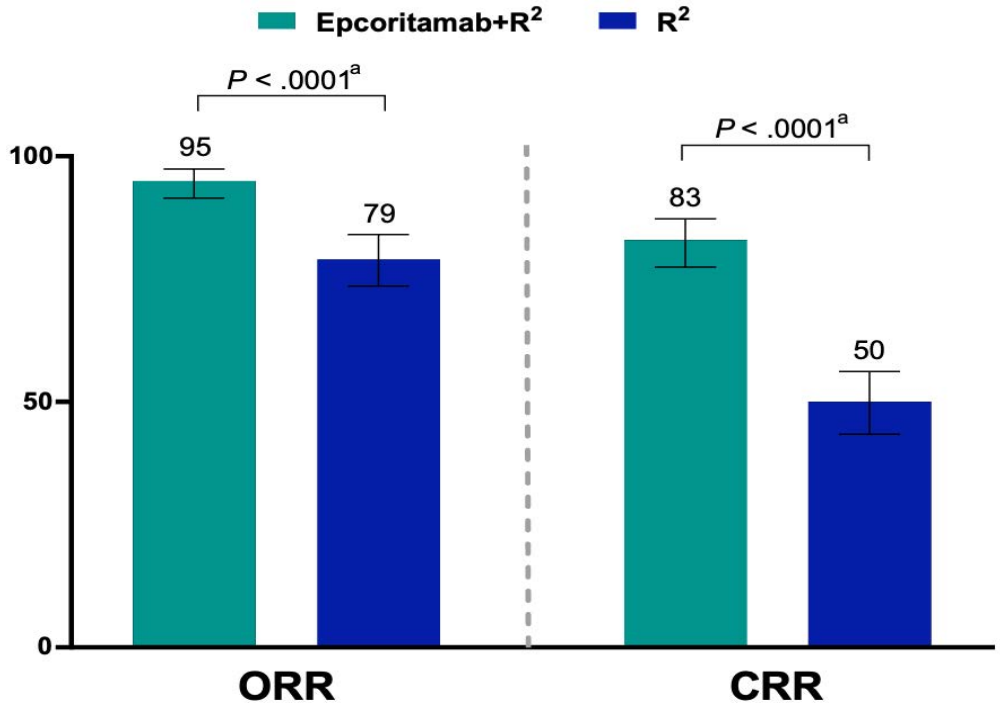
Treatment History Was Generally Balanced Across Epcoritamab+R² and R²

	Epcoritamab+R² (N = 243)	R² (N = 245)	Overall (N = 488)
Median time from initial diagnosis to randomization, years (range)	4.5 (0.2, 30.3)	5.3 (0.1, 43.0)	5.0 (0.1, 43.0)
Number of prior lines of therapy, median (range)	1 (1, 7)	1 (1, 6)	1 (1, 7)
1, n (%)	145 (60)	141 (58)	286 (59)
2, n (%)	58 (24)	61 (25)	119 (24)
≥ 3, n (%)	40 (16)	43 (18)	83 (17)
Prior anti-CD20 antibody, n (%)	243 (100)	245 (100)	488 (100)
Prior anti-CD20 antibody containing chemotherapy, n (%)	239 (98)	240 (98)	479 (98)
Prior bendamustine in last line, n (%)	53 (22)	47 (19)	100 (20)
Prior R², n (%)	8 (3)	9 (4)	17 (3)
POD24,[a] n (%)	106 (44)	93 (38)	199 (41)
Refractory to 1L therapy, n (%)	86 (35)	81 (33)	167 (34)
Refractory to anti-CD20 antibody, n (%)	104 (43)	103 (42)	207 (42)
Refractory to last line of therapy, n (%)	84 (35)	82 (33)	166 (34)
Double refractory[b]	91 (37)	91 (37)	182 (37)

[a]POD24 is defined as progression of disease ≤ 2 years from the date of initiation of frontline therapy. [b]Double refractory is refractory to prior anti-CD20 therapy and prior alkylator therapy.

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



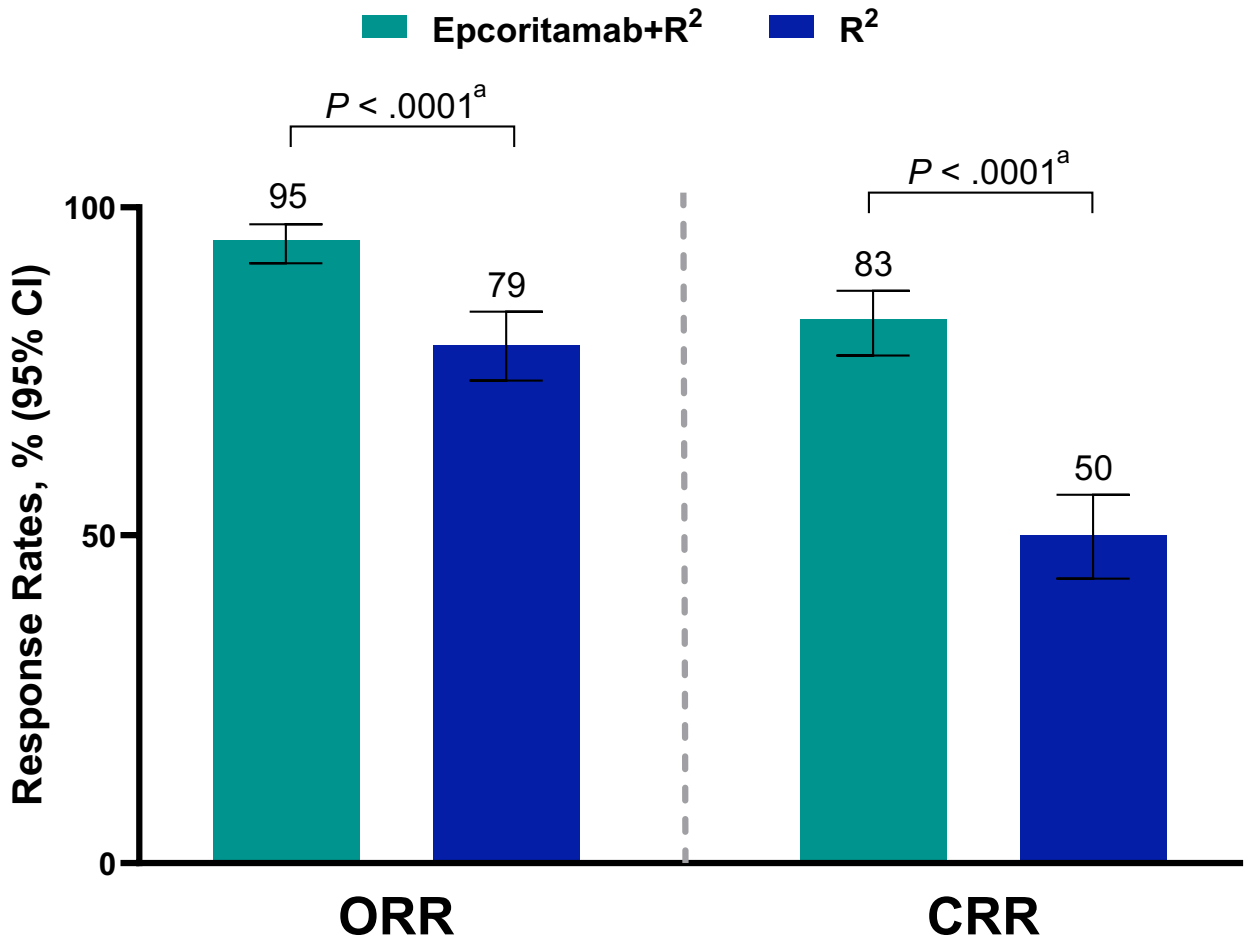


- Concordance rate was 94% for PFS between IRC and investigator assessment
- The estimated 16-month PFS was 85.5% (95% CI: 79.7, 89.7) for epcoritamab+R² and 40.2% (95% CI: 31.8, 48.4) for R²

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

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

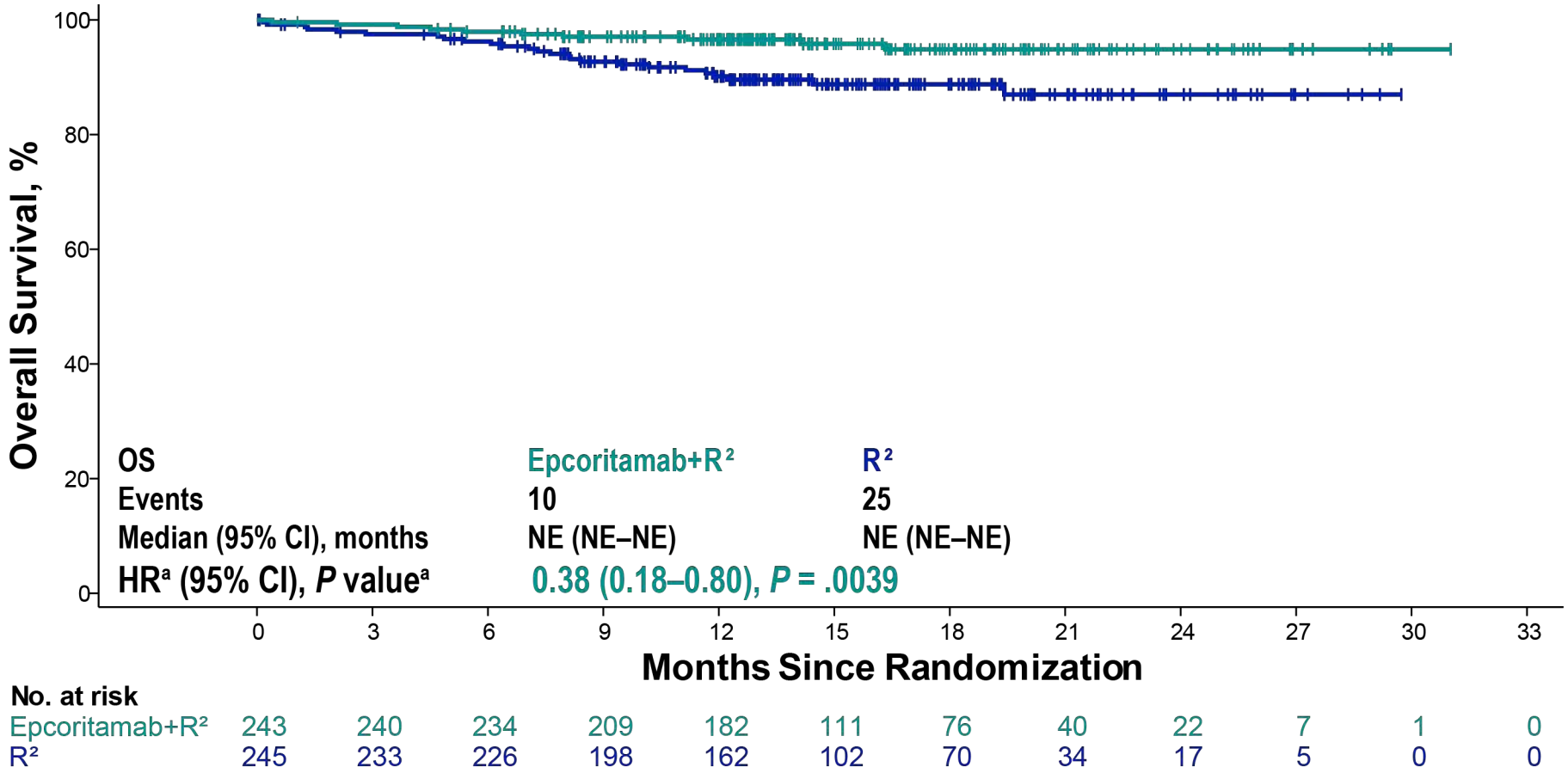
Epcoritamab+R² Resulted in Higher Response Rates Versus R²



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

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

Positive Trend for Overall Survival With Epcoritamab+R²

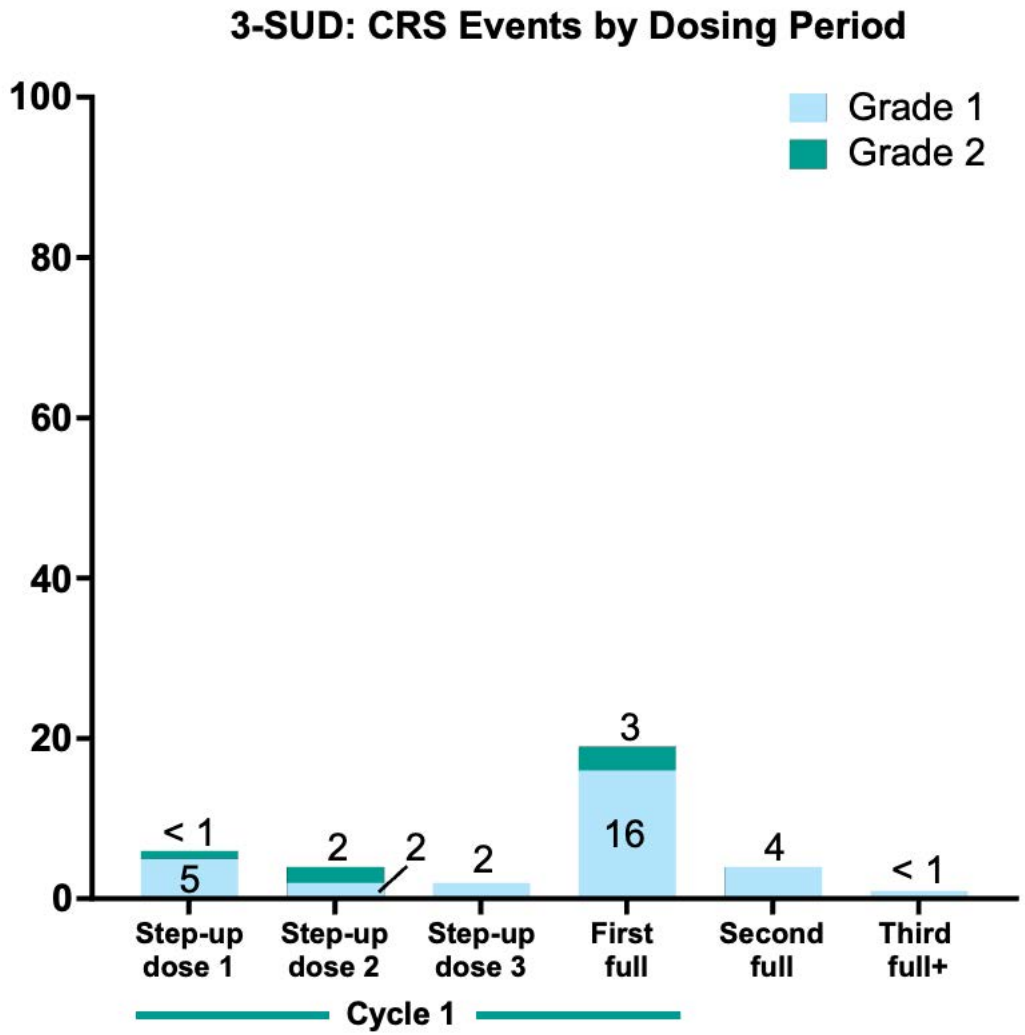


- The 16-month estimate for OS was 95.8% with epcoritamab+R² and 88.8% with R²

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: Safety

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



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

P-1800

Promising response rates and manageable safety with mosunetuzumab plus lenalidomide (Mosun-Len) in patients with relapsed/refractory (R/R) follicular lymphoma (FL): US extension cohort from the Phase III CELESTIMO study

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Study design

- Patients were treated with intravenous (IV) mosunetuzumab and oral lenalidomide for 12 and 11 cycles, respectively (**Figure 1**).

Figure 1. Non-randomized single arm US extension of CELESTIMO.

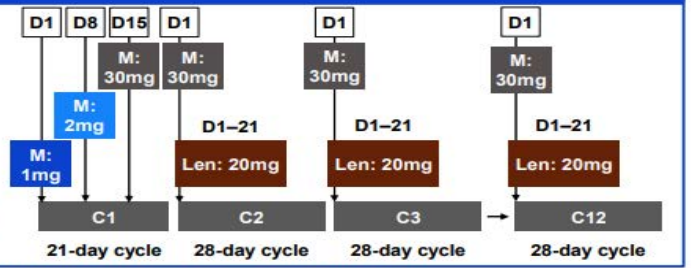
Key inclusion criteria
- CD20+ FL Grade 1–3a
- ≥1 prior systemic therapy for FL
- ECOG PS 0–2

Endpoints
- Preliminary efficacy of Mosun-Len: INV-assessed ORR and CR (Lugano criteria[6])
- Safety: incidence and severity of AEs and CRS according to CTCAE v5.0 and ASTCT[7] criteria, respectively

Mosun-Len administration

Mosunetuzumab
- IV administration for 12 cycles (C1: QW; C2–12: D1 of each cycle)
- C1 step-up dosing (CRS mitigation)
- No mandatory hospitalization

Lenalidomide
- Oral administration for 11 cycles (C2–12)



AE, adverse event; ASTCT, American Society for Transplantation and Cellular Therapy; C, Cycle; CR, complete response; CRS, cytokine release syndrome; CTCAE, Common Terminology Criteria for Adverse Events; D, Day; ECOG PS, Eastern Oncology Group performance status; INV, investigator; M, mosunetuzumab; ORR, objective response rate; QW, weekly.

Table 2. Baseline characteristics.

n (%), unless otherwise stated		2L+ FL US cohort (n=54)
Age, years	Median (range)	62.0 (37–82)
Sex	Male	32 (59.3)
Race	Asian Black or African American White Multiple* Unknown	3 (5.6) 2 (3.7) 47 (87.0) 1 (1.9) 1 (1.9)
Ethnicity	Hispanic or Latino Not Hispanic or Latino	12 (22.2) 42 (77.8)
ECOG PS	0 1 2	40 (74.1) 13 (24.1) 1 (1.9)
Ann Arbor stage	I/II III/IV	9 (16.7) 45 (83.3)
FLIPI score	 0/1 2 3 4 5	n=52† 13 (25.0) 18 (34.6) 17 (32.7) 3 (5.8) 1 (1.9)
FL grade	 1/2 3a	n=47† 28 (59.6) 19 (40.4)
POD24	Yes	16 (29.6)
Number of prior lines of therapy	1 ≥2	30 (55.6) 24 (44.4)
Refractory to prior CD20 therapy	Yes	n=48† 19 (39.6)
Relapsed after prior CD20 therapy	Yes	n=48† 17 (35.4)
Double refractory	Yes	n=53† 9 (17.0)

*American Indian or Alaska Native, White. †Missing or partial data. 2L+, at least one prior therapy.

Efficacy and Safety

- Median duration of follow-up was 12.7 months (range: 5–20).
- At data cut-off, the ORR was 96.3% (95% confidence interval [CI]: 90.3–100), and 87.0% (95% CI: 75.1–94.6) of patients had achieved a CR (**Table 3**).

Table 3. Efficacy overview.

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

- The most common AEs (any grade, by preferred term) were fatigue (57.4%), maculo-papular rash (42.6%), and constipation (42.6%).
- One fatal (Grade 5) AE of pneumonia was reported and was considered to be related to mosunetuzumab.

Table 4. Safety overview.

n (%)	2L+ FL US cohort (n=54)
Any grade AE	54 (100)
Mosunetuzumab related	48 (88.9)
Lenalidomide related	50 (92.6)
AE leading to discontinuation of mosunetuzumab	6 (11.1)
AE leading to discontinuation of lenalidomide	10 (18.5)
Grade 3–4 AE	31 (57.4)
Fatal AE*	1 (1.9)
Serious AE	15 (27.8)
Mosunetuzumab related	9 (16.7)
Lenalidomide related	4 (7.4)
CRS by ASTCT grading	15 (27.8)
Grade 1	12 (22.2)
Grade 2	2 (3.7)
Grade 3	1 (1.9)
Infections	31 (57.4)
Grade 1	2 (3.7)
Grade 2	24 (44.4)
Grade 3	3 (5.6)
Grade 4	1 (1.9)
Grade 5	1 (1.9)
Neutropenia/neutrophil count decreased	22 (40.7)
Grade 3/4	18 (33.3)
Febrile neutropenia (Grade 3)	2 (3.7)

Sano D et al. ASH 2025;Abstract 2295.

Fixed-duration subcutaneous (SC) mosunetuzumab, with maintenance therapy, in patients with previously untreated high-tumor burden follicular lymphoma (HTB FL): Longer follow-up and exploratory circulating tumor (ct)DNA analysis of the Phase II MorningSun study

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Presented at the 67th ASH Annual Meeting | December 6–9, 2025

MorningSun Phase II Study: SC Mosun in 1L High Tumour Burden FL Cohort

Key inclusion criteria

- Previously untreated FL
- HTB by GELF criteria
- ECOG performance status 0–2

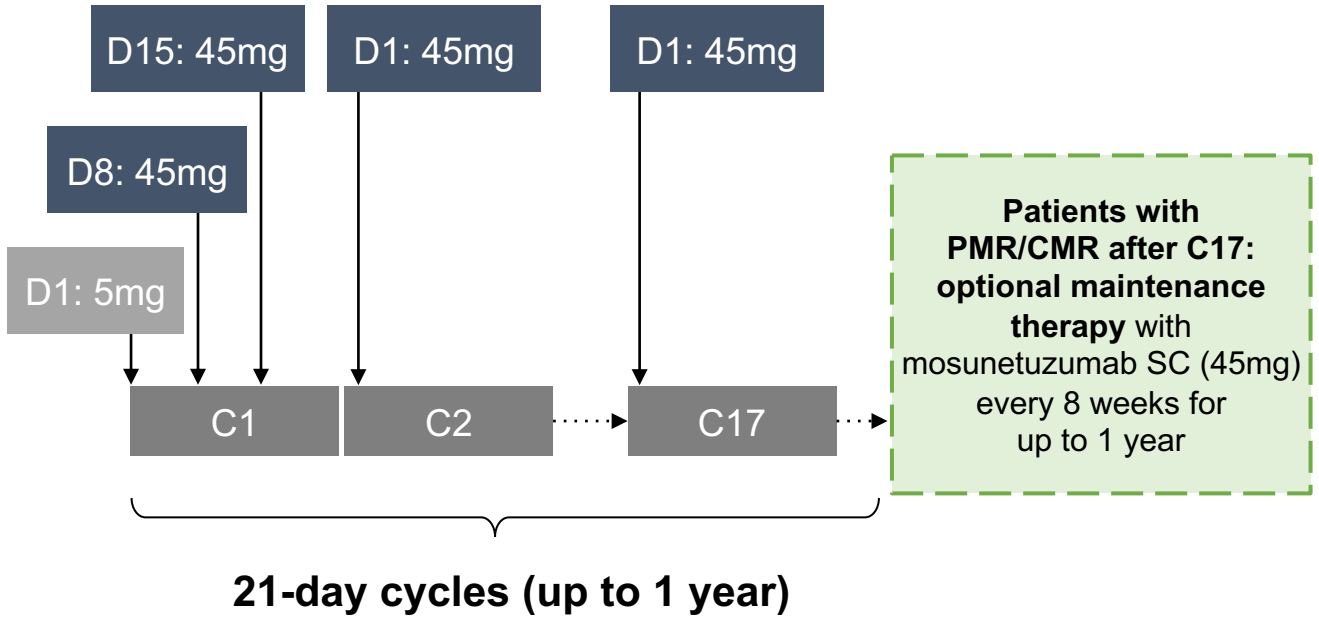
CRS mitigation

- Mosunetuzumab SC step-up dosing in C1
- Corticosteroid prophylaxis* was mandatory in C1–2 and optional thereafter
- Hospitalization was not mandatory

Endpoints

- Primary: PFS rate at 24 months
- Key secondary: ORR, DOR, DOCR, safety
- Exploratory analysis of ctDNA levels†

Mosunetuzumab SC administration

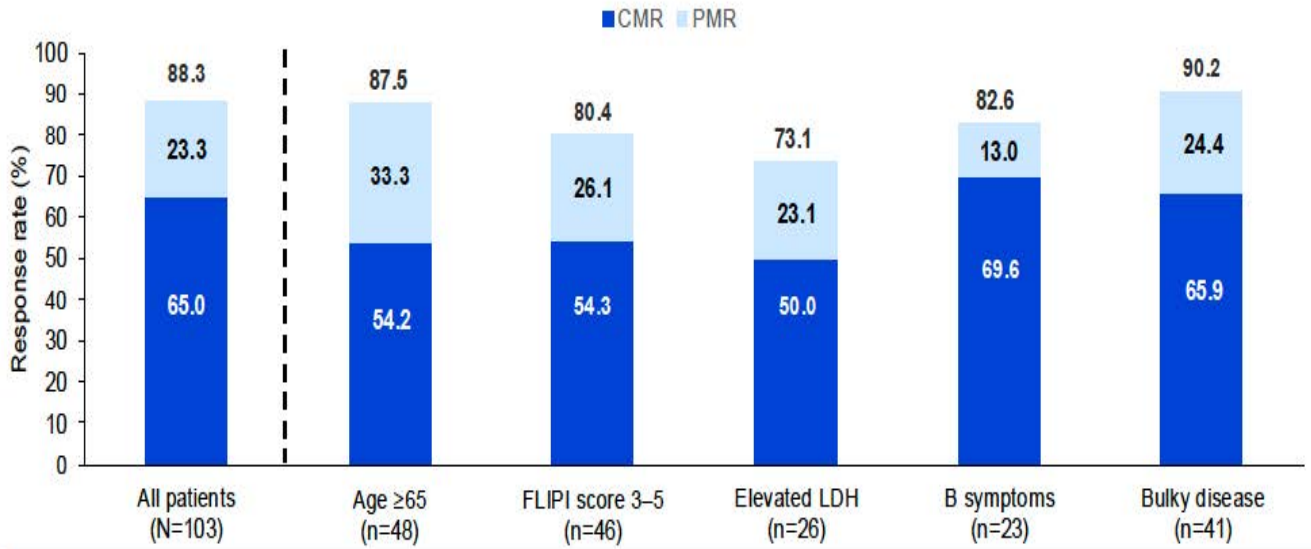


The HTB cohort was enrolled between March 3, 2022, and June 21, 2024 CCOD: February 10, 2025. *Dexamethasone (20mg) or methylprednisolone (80mg); premedication with oral acetaminophen or paracetamol and/or diphenhydramine could also be administered prior to administration of mosunetuzumab. †ctDNA analysis was performed using the AVENIO Oncology Assay Non-Hodgkin Lymphoma (AOA-NHL) assay.

Burke JM, et al, ASH 2025

MorningSun Phase II: Study Characteristics and Response

n (%), unless stated	All patients N=103	Patient receiving maintenance treatment n=46
Median age, years (range)	64.6 (24–86)	64.6 (32–79)
ECOG performance status		
0/1	101 (98.1)	46 (100)
2	2 (1.9)	0
Follicular lymphoma grade		
Grade 1–2	82 (79.6)	37 (80.4)
Grade 3A	20 (19.4)	8 (17.4)
Missing	1 (1.0)	1 (2.2)
Ann Arbor stage		
II	9 (8.7)	3 (6.5)
III	38 (36.9)	18 (39.1)
IV	56 (54.4)	25 (54.3)
Extranodal involvement	40 (38.8)	18 (39.1)
Bulky disease		
Yes	41 (39.8)	19 (41.3)
No	54 (52.4)	22 (47.8)
Unknown	8 (7.8)	5 (10.9)
FLIPI score		
0–1	22 (21.4)	10 (21.7)
2	35 (34.0)	15 (32.6)
3–5	46 (44.7)	21 (45.7)



- Among patients with a response (n=91), median time to response was 2.7 months (range: 1.2–6.0)

Exploratory ctDNA analysis in a subset of patients with a CMR showed that 84.2% were MRD-negative at C4

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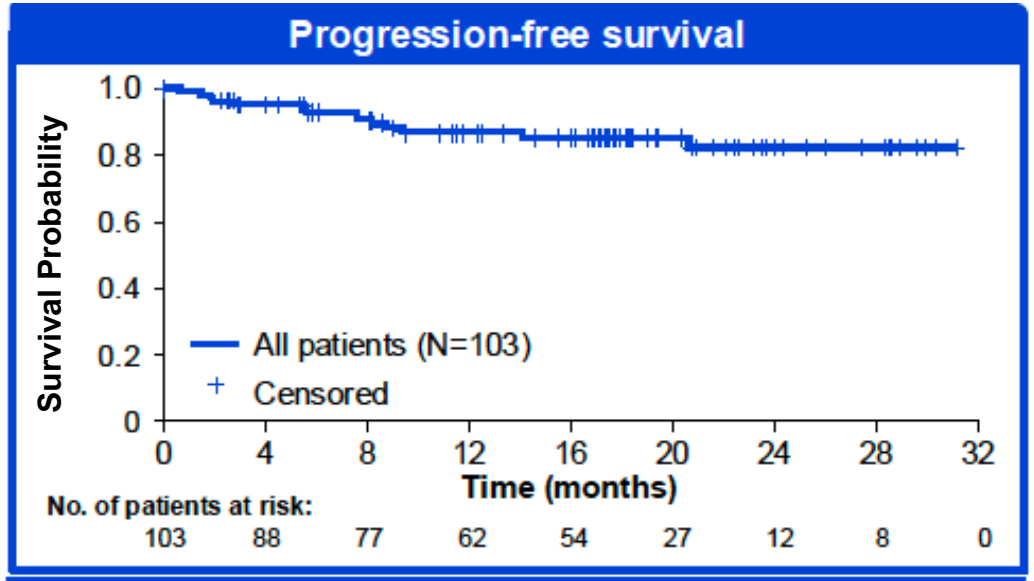
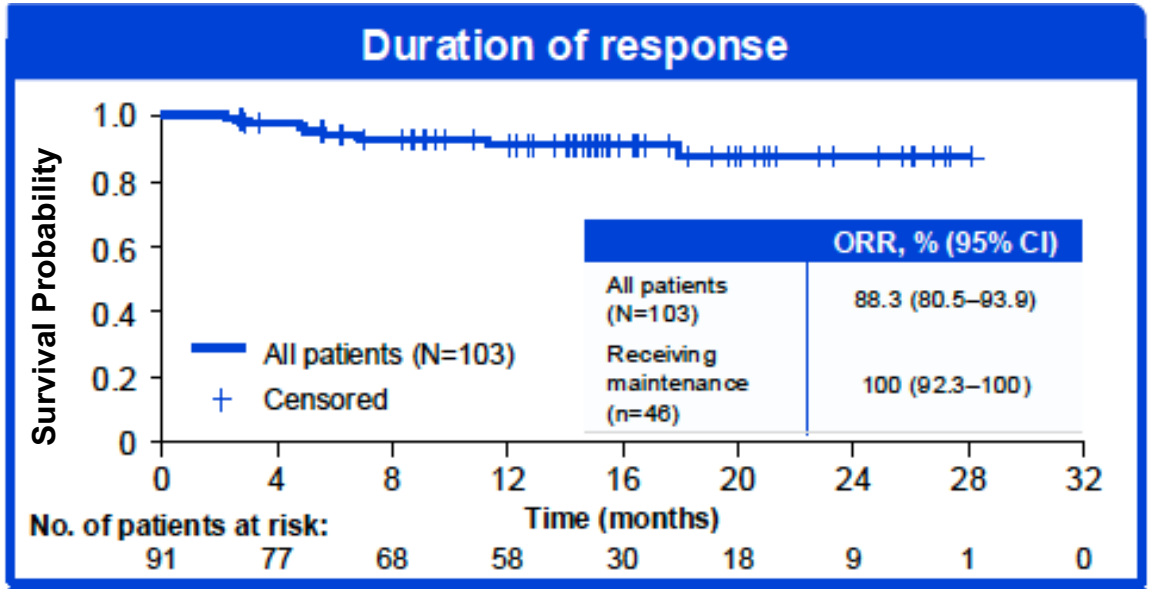
MorningSun Phase II Efficacy: PFS and DOR



Survival rates, (95% CI)	All patients N=103	Patients receiving maintenance treatment n=46
Median PFS, months	NR (NE–NE)	NR (NE–NE)
12-month event-free rate, %	86.7 (77.7–92.3)	100 (100–100)
18-month event-free rate, %	85.3 (75.8–91.2)	100 (100–100)



Response rate, % (95% CI)	All patients N=103	Patients receiving maintenance treatment n=46
Median DOR, months	NR (NE–NE)	NR (NE–NE)
12-month event-free rate, %	90.9 (81.7–95.6)	100 (100–100)
18-month event-free rate, %	87.2 (74.1–94.0)	94.7 (68.1–99.2)

Median follow-up was 22.3 months

Burke JM, et al, ASH 2025

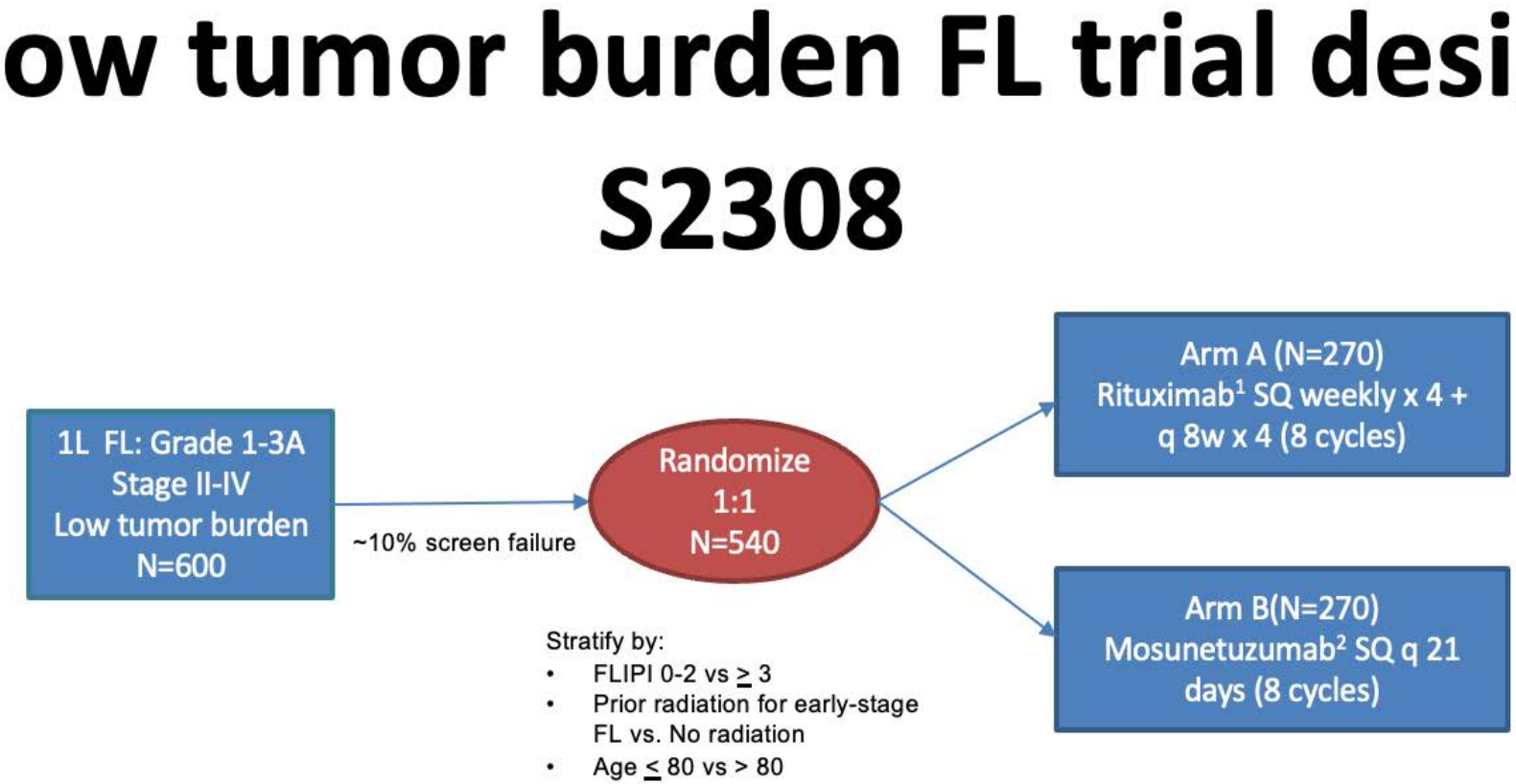
- 66.7% were eligible for maintenance, 44.7% received maintenance
- No CRS occurred during maintenance
- Infections were common (Gr 3-5 19.4%), no increase over time

Front Line Trials in High Tumour Burden FL

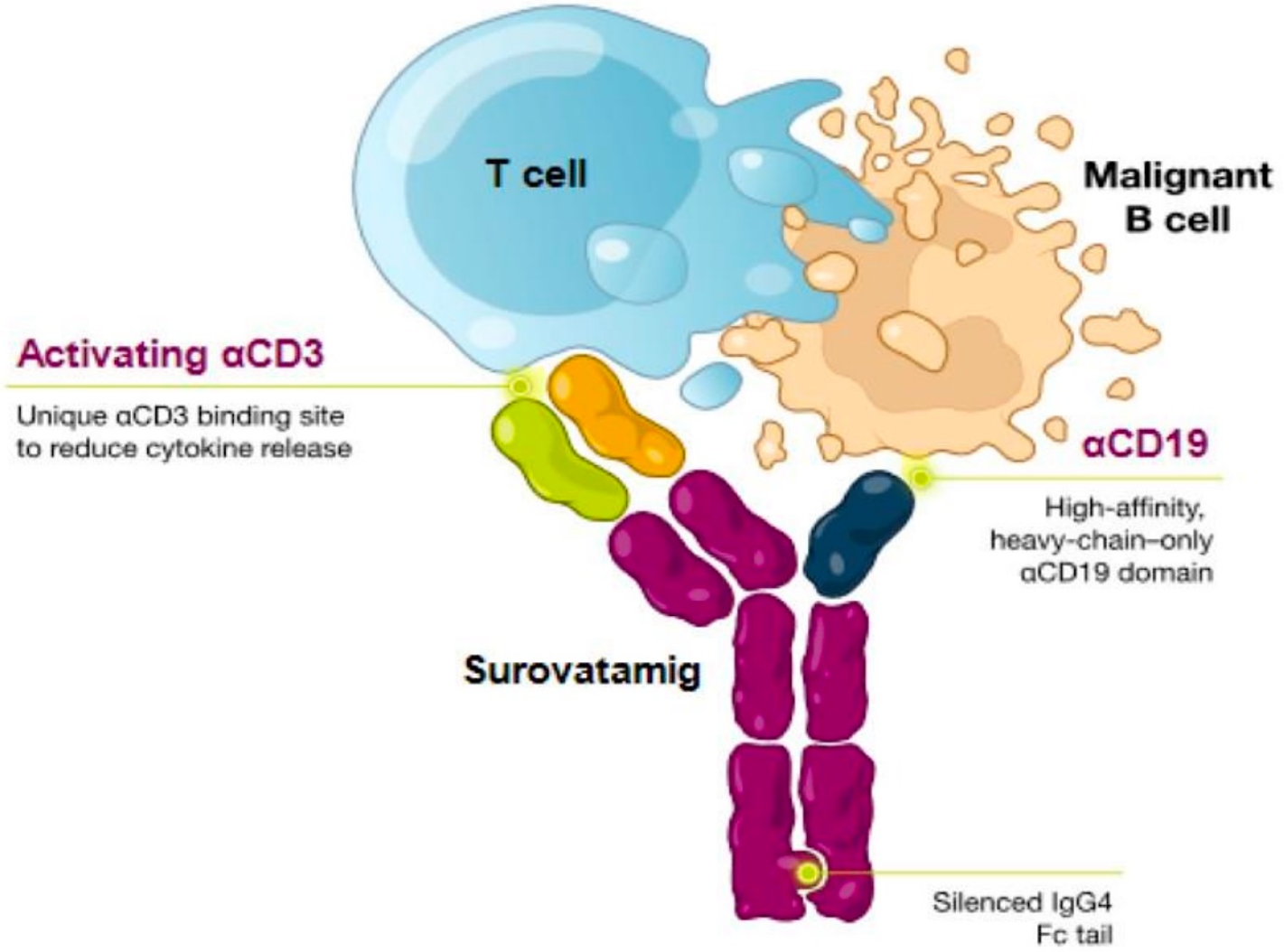
	EPCORE FL-2 (NCT06191744)	MorningLyte (NCT06284122)	OLYMPIA-1 (NCT06091254)	OLYMPIA-2 (NCT06097364)
Experimental agent	Epcoritamab	Mosunetuzumab	Odronextamab	Odronextamab
Route of admnistration	SC	SC	IV	IV
Experimental arm(s)	Epcoritamab + R^2 followed by epcoritamab maintenance (ratio 1:1 with control arm)	Mosunetuzumab + lenalidomide followed by mosunetuzumab maintenance (ratio 1:1 with control arm)	Odronextamab induction and maintenance (ratio 1:1 with control arm)	Odronextamab + CHOP/CVP followed by odronextamab maintenance or odronextamab + CHOP/CVP without maintenance (ratio 1:1:1 with control arm)
Control arm	R/O + CHOP/bendamustine followed by anti-CD20 maintenance	R/O + CHOP/bendamustine followed by anti-CD20 maintenance	R + CHOP/CVP/bendamustine followed by anti-CD20 maintenance	R + CHOP/CVP followed by R maintenance
Primary end point	CR30 (PET-CT Lugano 2014) and PFS (dual end point)	PFS	CR30	PFS
Supplementary arm(s)*	R^2 only and epcoritamab + R^2 without maintenance	None	None	None
Patient population	Stage II to IV disease with at least one GELF high tumor burden criterion (any FLIPI)	Stage I to IV disease with at least 1 GELF high tumor burden criterion FLIPI 2-5	Stage II bulky or stage III/IV (any FLIPI)	Stage II bulky or stage III/IV (any FLIPI)
Planned enrollment	~1080 patients	~790 patients	~446 patients	~669 patients

Bachy et al Blood 2025

Phase III Front Line SWOG Trial in LOW Tumour Burden FL



Surovatamig (formerly AZD0486)
Fully human CD19xCD3 bispecific T- cell engager



Presentation P1005

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)

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Phase 1 Study of Surovatamig: FL Cohort

Phase 1 Study of Surovatamig

Key Eligibility Criteria

- Adults with R/R B-NHL
- CD19+ by flow cytometry or IHC
- ≥2 prior lines of therapy
- ≥1 measurable lesion
- No active CNS disease
- No leukemic presentation
- ECOG PS ≤2
- Prior anti-CD19 therapies, CAR T-cells, and anti-CD20 TCE allowed

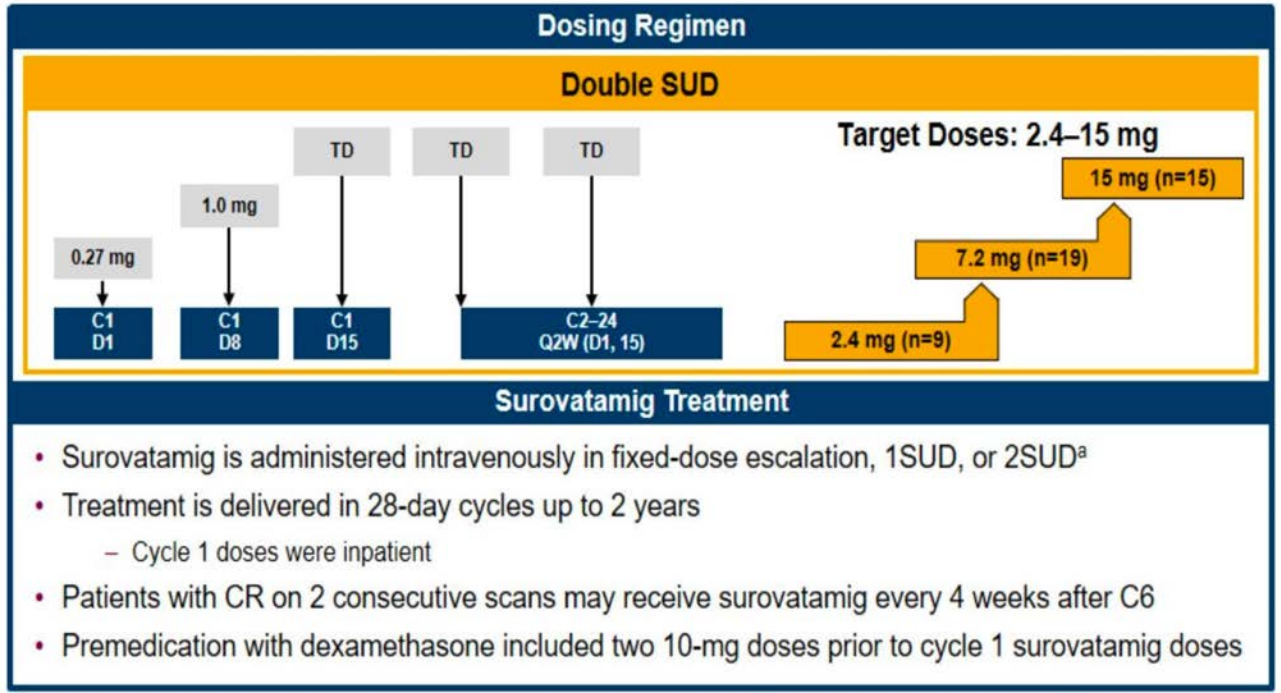
Assessments

- Disease response: RECIL using PET-CT by ICR[1]
- CRS and ICANS: ASTCT criteria[2]
- AEs: CTCAE v5.0
- MRD: PhasED-Seq CLARITY assay in plasma ctDNA (approximately <1 part/million detection limit)

Endpoints

Primary	Secondary
Safety/tolerability	Antitumor activity
MTD/RP2D	
PK	

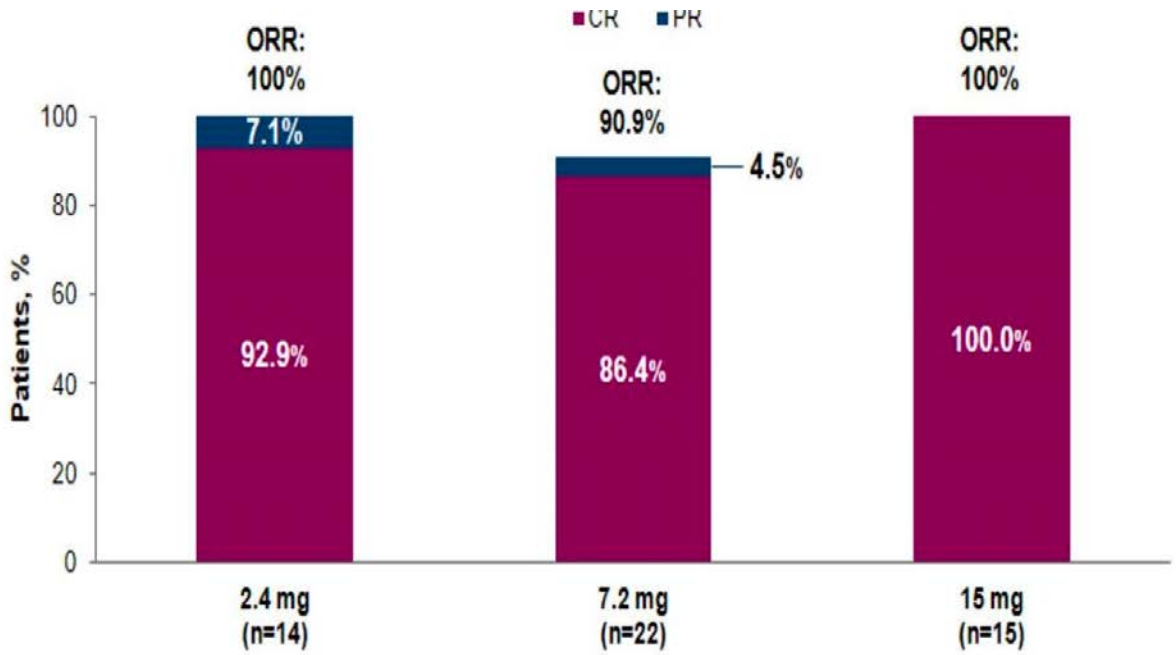
Surovatamig Phase 1 Study Design



Three-year Follow-up of the Phase 1 Surovatamig in R/R FL

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)

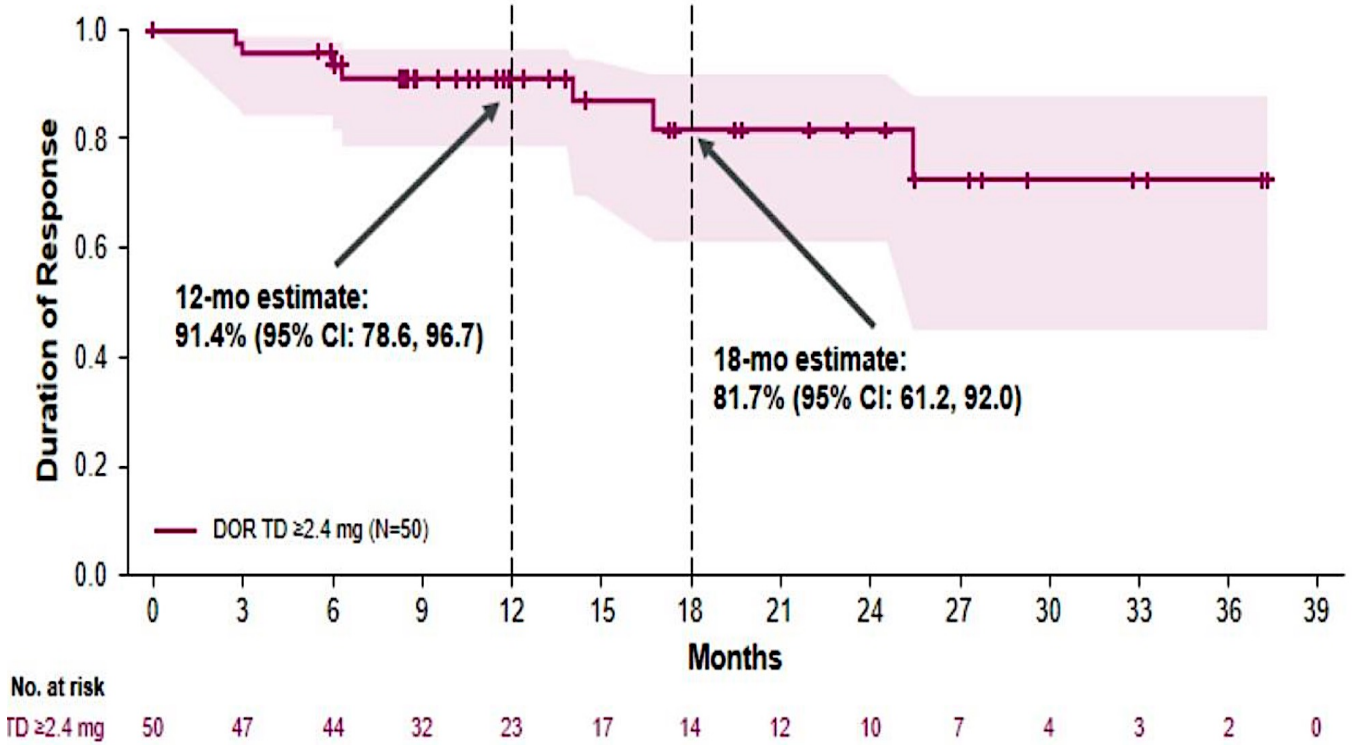
Median study follow-up for TDs >/=2.4 mg – 16 months (1-40)



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

Hou JZ et al. ASH 2025;Abstract 1005

Three-year Follow-up of the Phase 1 Surovatamig in R/R FL



Safety

Infections occurred in 43 (70%) patients- URIs/Covid-19
grade 3/4: n=8 [13%]; grade 5: n=2

All CRS (51%) and ICANS (5%) events were low grade with 2SUD
Resolution of CRS/ICANS in all.

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
Median PFS Not Reached

Hou JZ et al. ASH 2025;Abstract 1005

Phase III SOUNDTRACK-F1 study

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

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

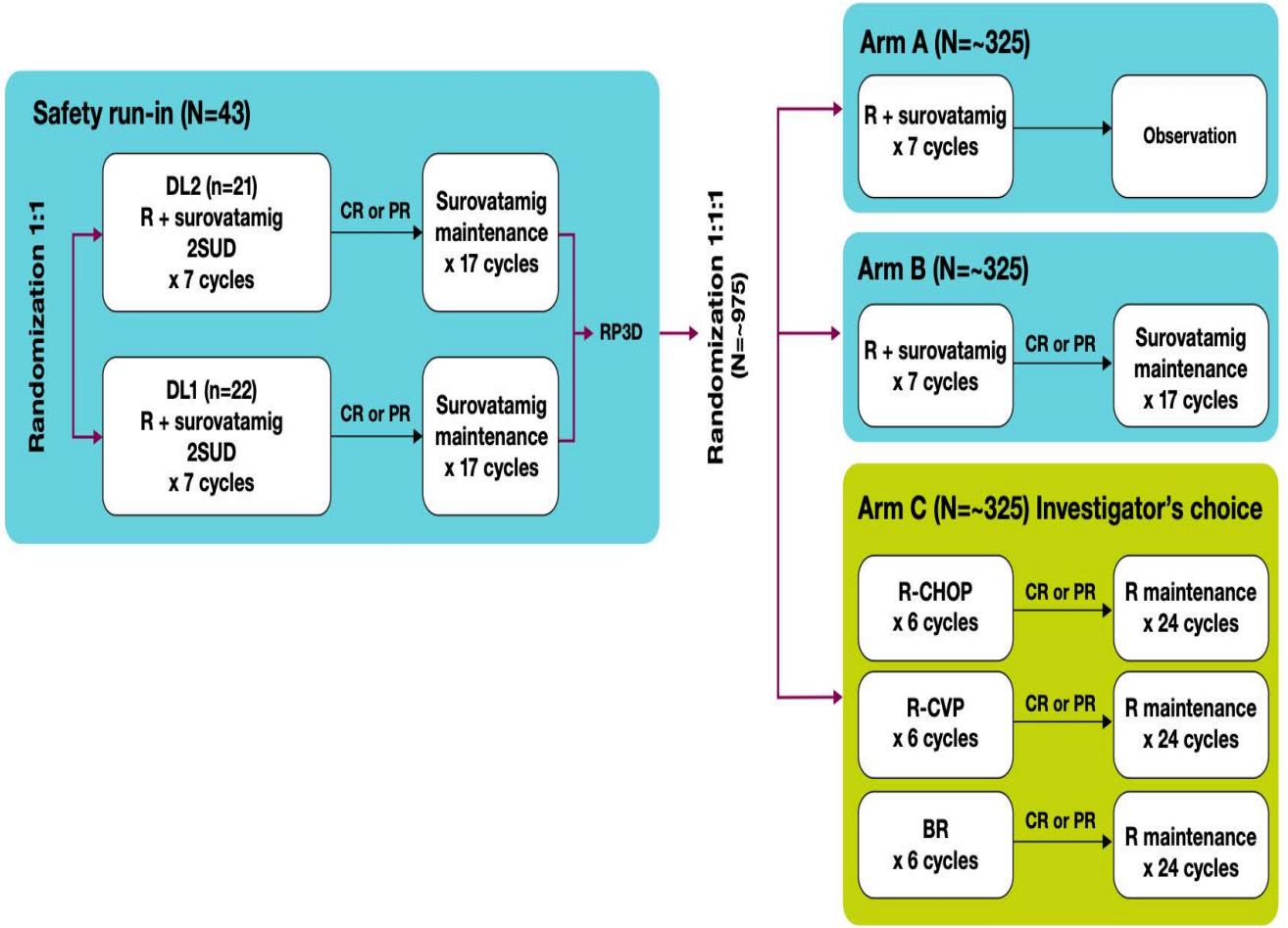
SRI	Phase 3
IV surovatamig + rituximab N=43	IV surovatamig + rituximab OR Rituximab-based CIT[a] Target N=~975

Study Design

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

Phase 3 Study Endpoints

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



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Fifth Annual
National General Medical Oncology Summit

Keynote Session:
Diffuse Large B-Cell Lymphoma and Follicular Lymphoma

Friday, April 24, 2026

Moderator
Neil Love, MD

Faculty
Manali Kamdar, MD, MBBS
Krish Patel, MD
Gilles Salles, MD, PhD

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