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RESEARCH TO PRACTICE

Optimizing the Use of Novel Therapies for Patients with Diffuse Large B-Cell Lymphoma

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Disclosures

Advisory Committees	AstraZeneca Pharmaceuticals LP, Genentech, a member of the Roche Group, Pfizer Inc
Contracted Research	AstraZeneca Pharmaceuticals LP, BeOne, Genentech, a member of the Roche Group, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Merck, Pfizer Inc, Prelude Therapeutics, Seagen Inc

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RTP RESEARCH TO PRACTICE

Optimizing the Use of Novel Therapies for Patients with DLBCL

Module 1: Selection of First-Line Therapy for Patients with Diffuse Large B-Cell Lymphoma (DLBCL)

Module 2: Clinician Survey Results

Module 3: Current and Future Roles of Monoclonal and Bispecific Antibodies in Therapy for Relapsed/Refractory (R/R) DLBCL

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Module 6: Clinician Survey Results

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Key Datasets

- Morschhauser F et al. **Five-year outcomes** of the **POLARIX study** comparing **Pola-R-CHP and RCHOP in patients with diffuse large B-cell lymphoma**. *J Clin Oncol* 2025 December 10;43(35):3698-705.
- Trněný M et al. Analysis of **peripheral neuropathy in the POLARIX** study using **clinician- and patient-reported outcomes**. *Blood Adv* 2025 July 8;9(13):3263-7.
- Lenz G et al. **frontMIND: Phase 3** study of **tafasitamab (Tafa) plus lenalidomide (Len) and R-CHOP** for patients (pts) with **newly diagnosed diffuse large B-cell lymphoma (DLBCL)**. ASCO 2026;Abstract LBA700.
- Sehn LH et al. **ESCALADE:** A **phase 3** study of **acalabrutinib in combination** with rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP) for **patients ≤65y** with **untreated non-germinal center B-cell–like (non-GCB) diffuse large B-cell lymphoma (DLBCL)**. ASCO 2021;Abstract TPS7572.

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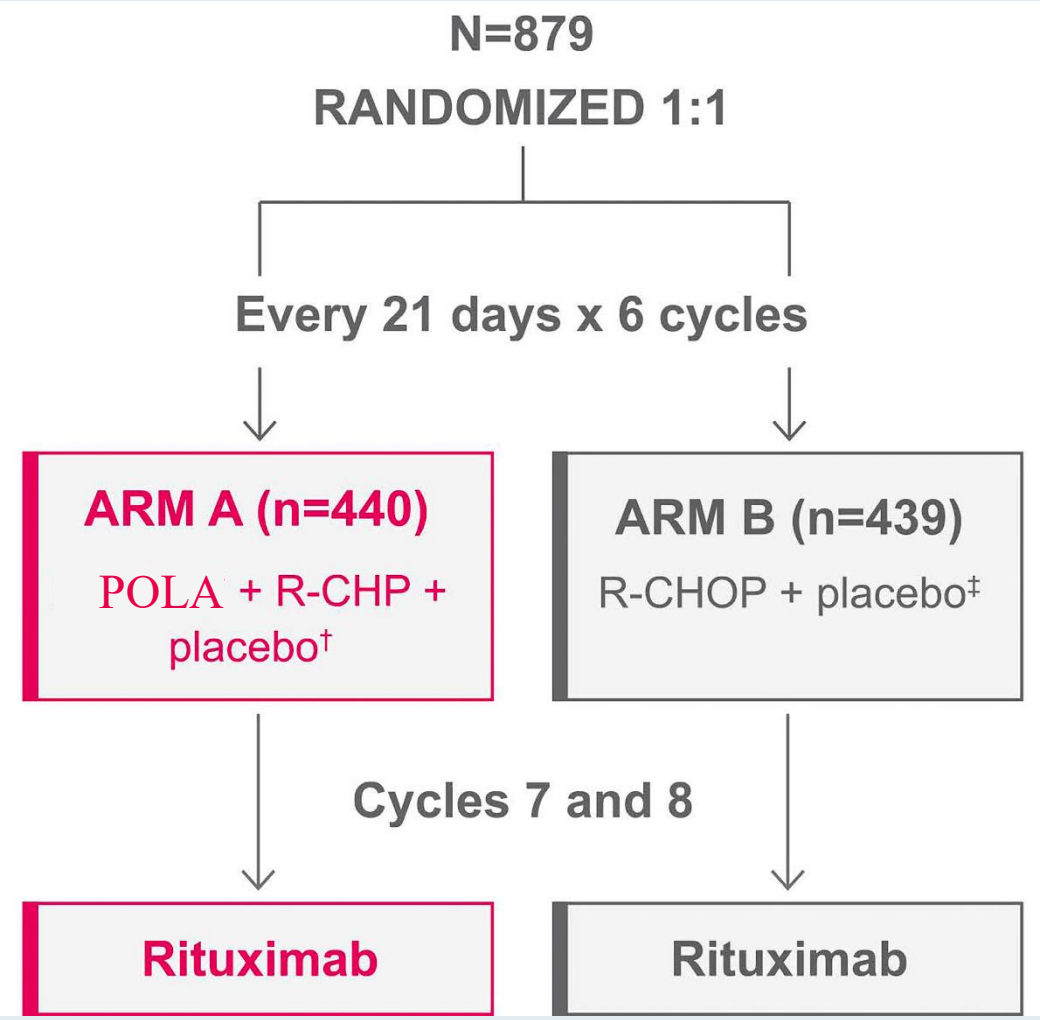
Phase III POLARIX Study Design

Eligibility Criteria:

- Previously untreated LBCL
- Aged 18-80 years
- IPI score 2-5
- ECOG PS 0-2

Primary endpoint:
Investigator-assessed PFS

Secondary endpoints:
Investigator-assessed EFS, ORR, OS



LBCL = large B-cell lymphoma; PFS = progression-free survival; EFS = event-free survival; ORR = overall response rate; OS = overall survival

[from the manufacturer's website]

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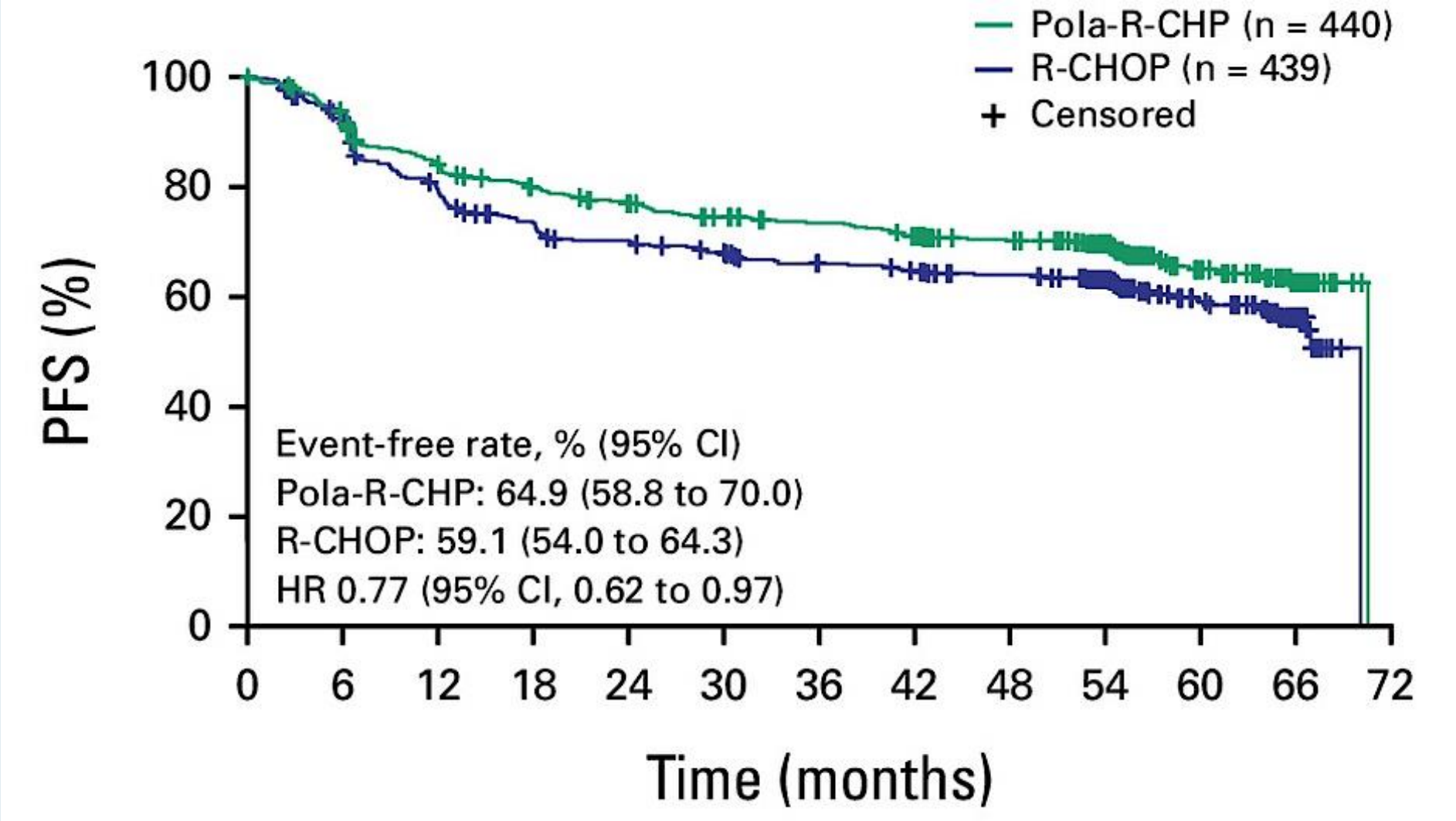
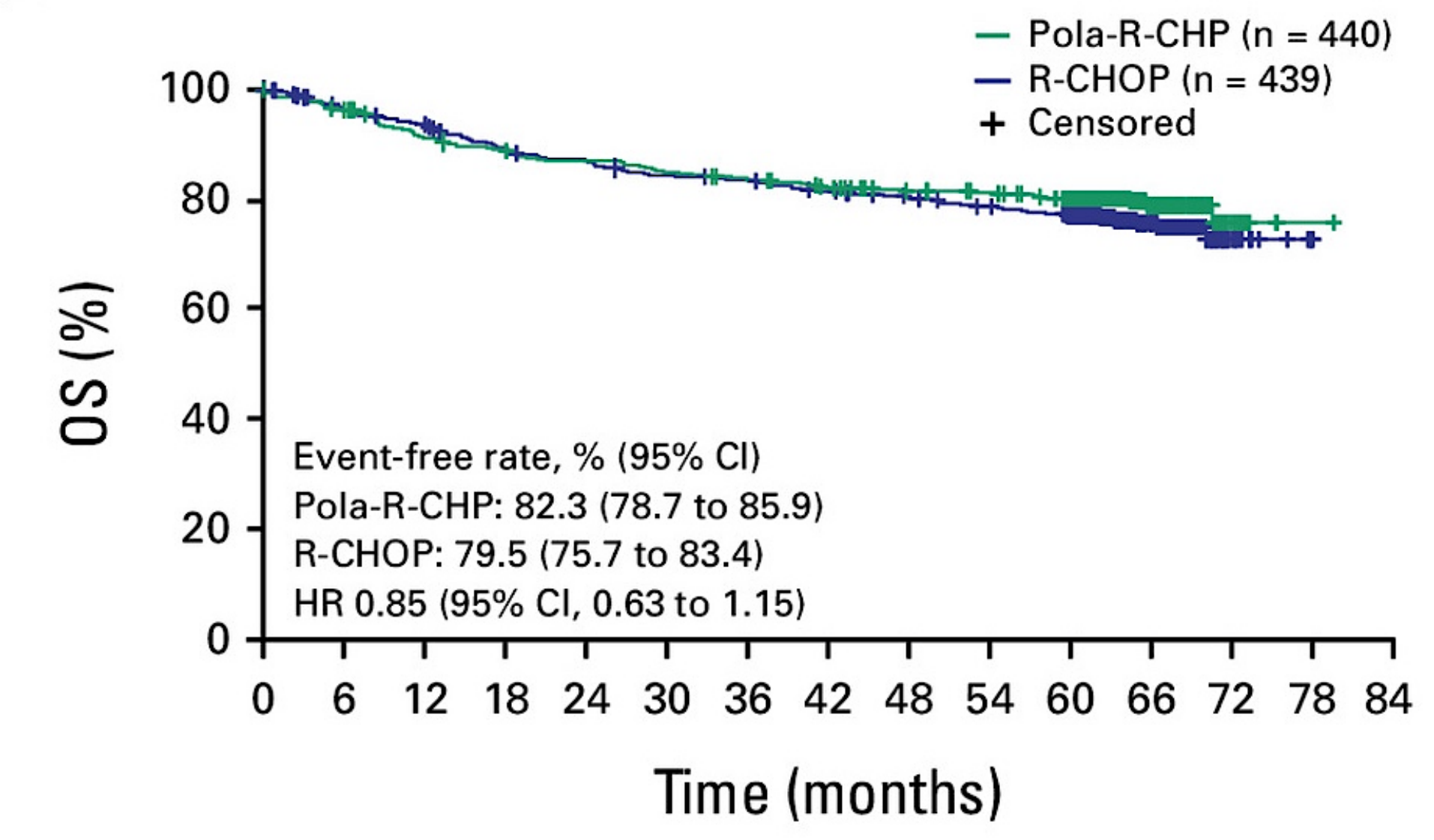
Phase III POLARIX: 5-Year PFS (Global Population)



Morschhauser F et al. *J Clin Oncol* 2025 December 10;43(35):3698-705.

Phase III POLARIX: 5-Year OS (Global Population)



Morschhauser F et al. *J Clin Oncol* 2025 December 10;43(35):3698-705.

Phase III POLARIX: Adverse Events of Interest

Patients, n (%)	Pola-R-CHP (n=495)	R-CHOP (n=498)
Peripheral neuropathy		
All grade	249 (50.3)	261 (52.4)
Grade 3–5	7 (1.4)	5 (1.0)
Resolved[a]	170 (68.3)	195 (74.7)
Ongoing/Unresolved[b]	79 (31.7)	66 (25.3)
Neutropenia		
All grade	240 (48.5)	228 (45.8)
Grade 3–5	216 (43.6)	205 (41.2)
Infections		
All grade	237 (47.9)	219 (44.0)
Grade 3–5	75 (15.2)	66 (13.3)
Anemia		
All grade	165 (33.3)	150 (30.1)
Grade 3–5	56 (11.3)	49 (9.8)
Thrombocytopenia		
All grade	89 (18.0)	86 (17.3)
Grade 3–5	32 (6.5)	31 (6.2)
Cardiac arrhythmias		
All grade	18 (3.6)	26 (5.2)
Grade 3–5	3 (0.6)	5 (1.0)
Secondary malignancies[c]		
All grade	5 (1.0)	12 (2.4)
Grade 3–5	5 (1.0)	9 (1.8)

Morschhauser F et al. *J Clin Oncol* 2025 December 10;43(35):3698-705.

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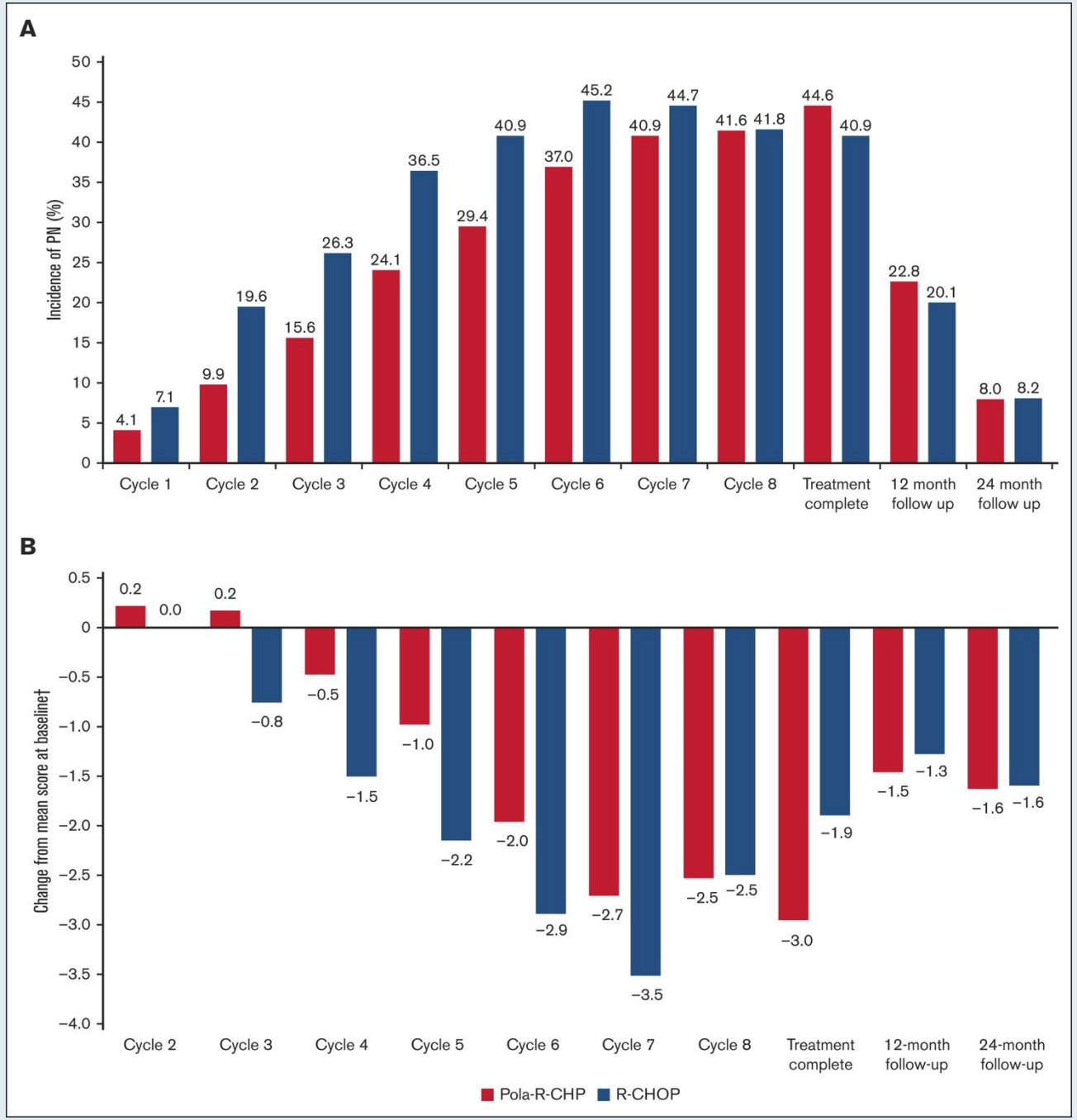
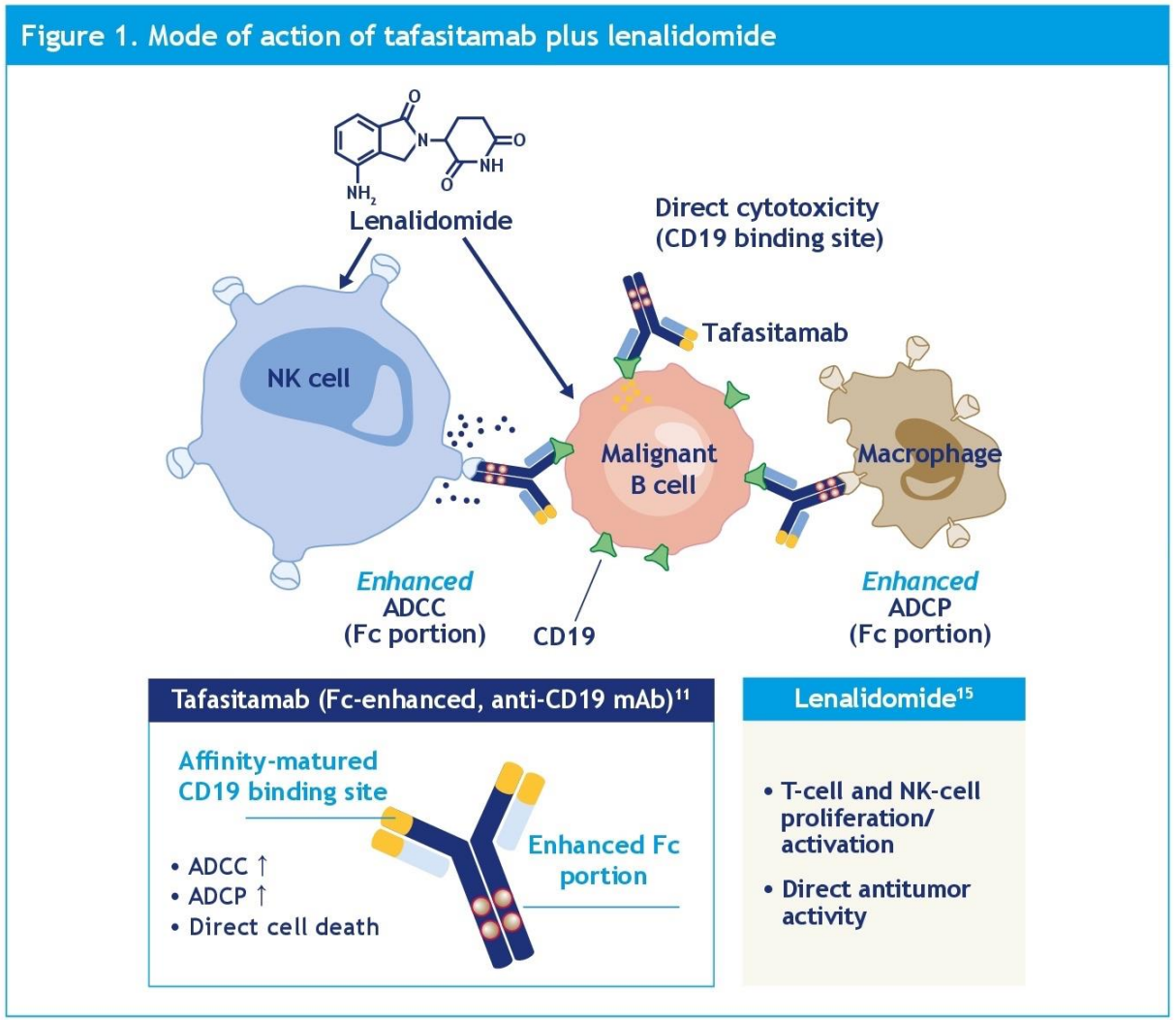
Phase III POLARIX: Peripheral Neuropathy



Trněný M et al. *Blood Adv* 2025 March 17;9(13):3263-7.

Rationale for Tafasitamab and Lenalidomide Combination Therapy



Adapted from Salles et al. Expert Opin Biol Ther 2021.[12]
ADCC, antibody-dependent cell-mediated cytotoxicity; ADCP, antibody-dependent cell-mediated phagocytosis; mAb, monoclonal antibody; NK,

Vitolo U et al. ASCO 2022;Abstract TPS7590.

frontMIND: Phase 3 Study of Tafasitamab Plus Lenalidomide and R-CHOP for Patients With Newly Diagnosed Diffuse Large B-cell Lymphoma

Georg Lenz,[1] Marek Trněný,[2] John M. Burke,[3] Grzegorz S. Nowakowski,[4] Christopher P. Fox,[5] Annalisa Chiappella,[6] Johannes Duell,[7] Young Woo Jeon,[8] Chan Y. Cheah,[9] Jason Westin,[10] Joseph Z. Ye,[11] Priscilla B. Caguioa,[12] David Belada,[13] Ho-Jin Shin,[14] Sung Yong Oh,[15] Sandy Amorim,[16] Andreas Rosenwald,[17] Roberto Chiarle,[18] Philomena Colucci,[19] Sonia Ioannidis,[20] Lulu Cheng,[19] and Umberto Vitolo[21]

[1]University Hospital Münster, Department of Medicine A for Hematology, Oncology and Pneumology, Münster, Germany; [2]First Faculty of Medicine, Charles University, Prague, Czech Republic; [3]Sarah Cannon Research Institute at Rocky Mountain Cancer Centers, Aurora, CO, USA; [4]Division of Hematology, Mayo Clinic, Rochester, MN, USA; [5]School of Medicine, University of Nottingham, and Clinical Haematology, Nottingham University Hospitals NHS Trust, Nottingham, UK; [6]Fondazione IRCCS Istituto Nazionale dei Tumori, Hematology, Milano, Italy; [7]Department of Internal Medicine II, University Hospital Würzburg, Würzburg, Germany; [8]Department of Hematology, Yeouido St. Mary's Hospital, C
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Medical Center, Quezon, Philippines; [13]Department of Internal Medicir
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Presented at the 2026 ASCO Annual Meeting • Chicago, IL, USA & Online • May

Tafasitamab plus lenalidomide and R-CHOP versus R-CHOP for first-line treatment of patients with high-risk diffuse large B-cell lymphoma (frontMIND): a global, phase 3, randomised, double-blind, placebo-controlled trial

*Georg Lenz, Marek Trněný, John M Burke, Grzegorz S Nowakowski, Christopher P Fox, Annalisa Chiappella, Johannes Duell, Young Woo Jeon, Chan Y Cheah, Jason Westin, Joseph Z Ye, Priscilla B Caguioa, David Belada, Ho-Jin Shin, Sung Yong Oh, Sandy Amorim, Matthew Ku, Heidi Mocikova, Javier López Jiménez, Gianluca Gaidano, Andreas Rosenwald, Roberto Chiarle, Philomena Colucci, Sonia Ioannidis, Lulu Cheng, Umberto Vitolo, on behalf of the frontMIND Study investigators**

***Lancet* 2026 May 30;[Online ahead of print].**

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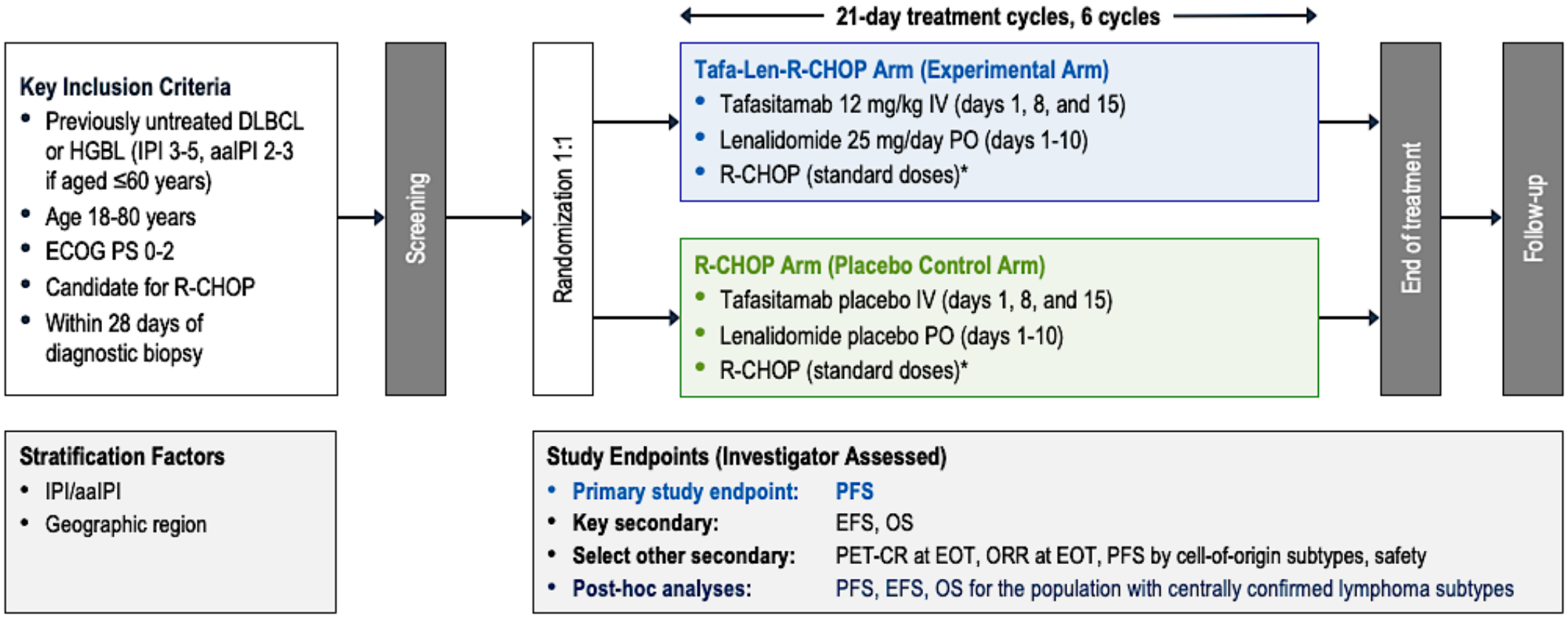
Phase III frontMIND Study Design



*Rituximab administered at 375 mg/m^2 IV (day 1); cyclophosphamide, doxorubicin, and vincristine administered IV (day 1); prednisone/prednisolone administered PO (days 1-5).
aaIPI, age-adjusted IPI; CR, complete response; DLBCL, diffuse large B-cell lymphoma; ECOG PS, Eastern Cooperative Oncology Group performance status; EFS, event-free survival; EOT, end of treatment; HGBL, high-grade B-cell lymphoma; HRQoL, health-related quality of life; IPI, International Prognostic Index; IV, intravenously; Len, lenalidomide; ORR, objective response rate; OS, overall survival; PET, positron emission tomography; PFS, progression-free survival; PO, orally; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone or prednisolone; Tafa, tafasitamab.

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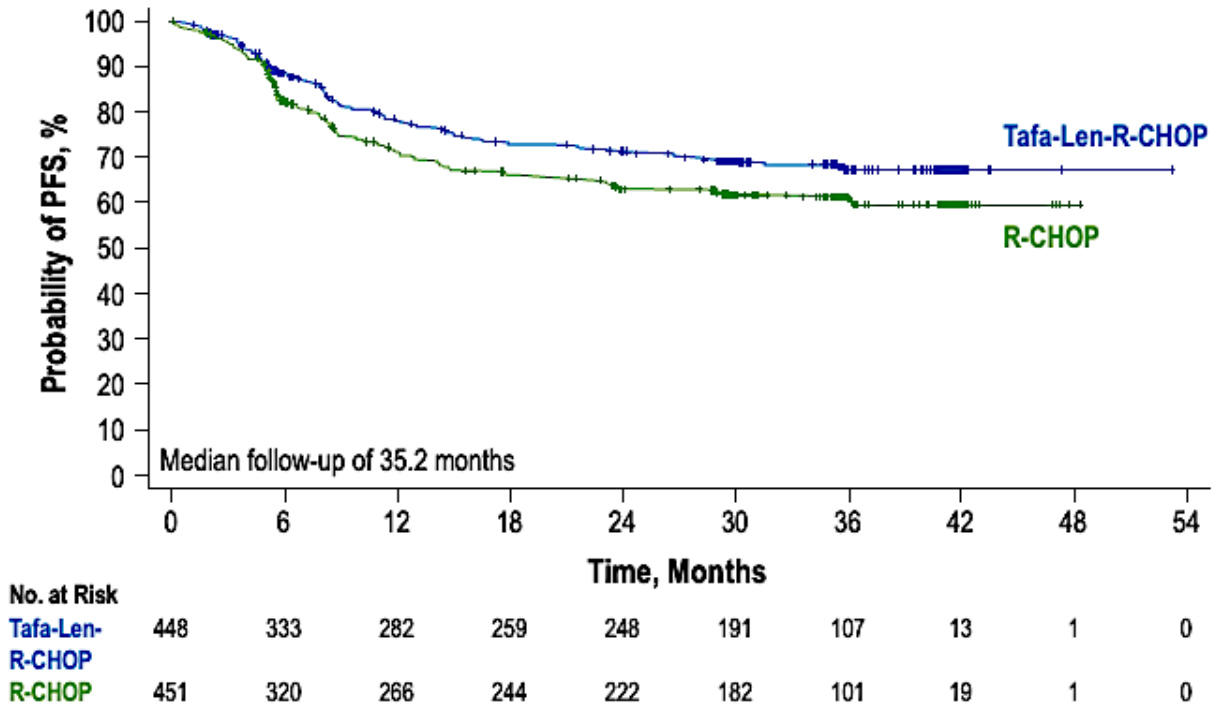
Lenz G et al. ASCO 2026;Abstract LBA7000; Lenz G et al. *Lancet* 2026 June 20;407(10547):2528-41.

frontMIND Primary Endpoint: Investigator-Assessed Progression-Free Survival



HR 0.75* (*P*=0.0194)
95% CI: 0.59, 0.96

- A **25% reduction in risk of progression or death** demonstrated with Tafa-Len-R-CHOP vs R-CHOP
- **2-year PFS:** 71.1% with Tafa-Len-R-CHOP vs 62.9% with R-CHOP (**Δ=8.2%**)
- **3-year PFS:** 67.3% with Tafa-Len-R-CHOP vs 60.7% with R-CHOP (**Δ=6.6%**)

ITT population. *Calculated using a stratified Cox proportional hazards model.
CI, confidence interval; HR, hazard ratio; ITT, intention-to-treat; Len, lenalidomide; PFS, progression-free survival; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone or prednisolone; Tafa, tafasitamab.

In key prespecified subgroup analyses, point estimates suggested trends toward PFS advantage with Tafa-Len-R-CHOP

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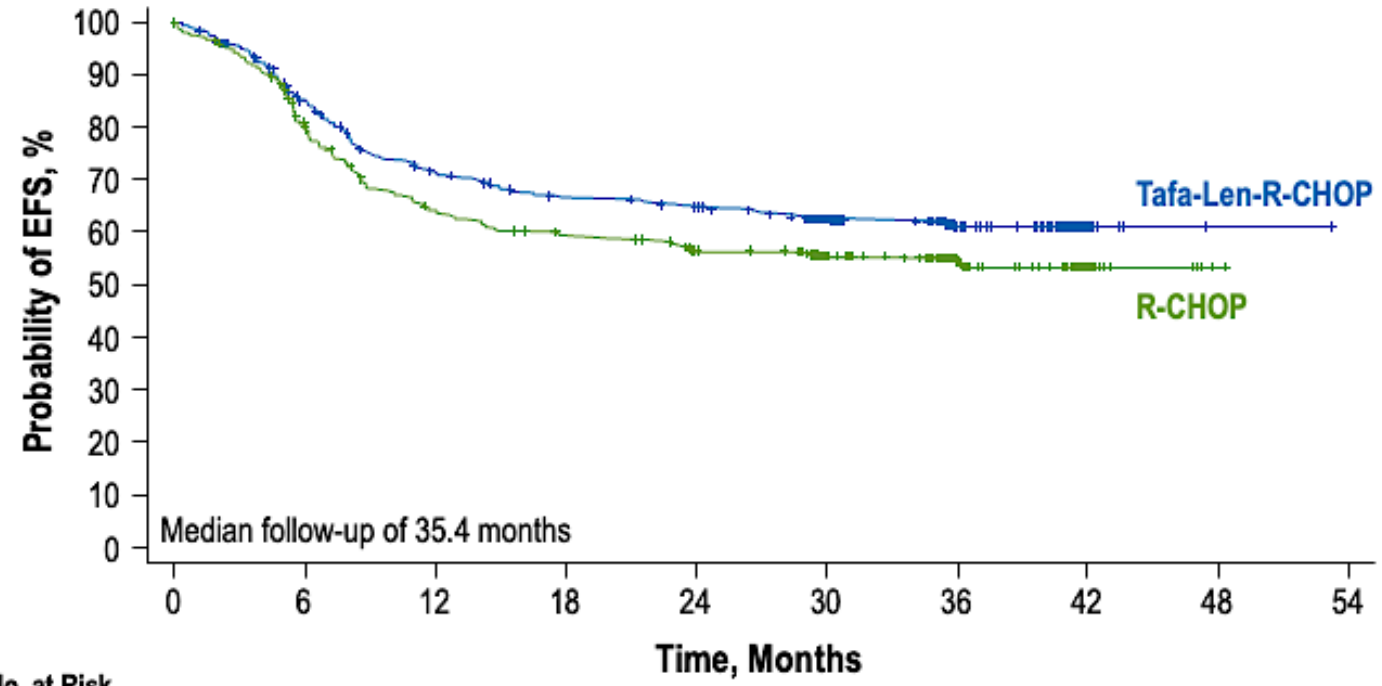
Lenz G et al. ASCO 2026;Abstract LBA7000; Lenz G et al. *Lancet* 2026 June 20;407(10547):2528-41.

frontMIND Key Secondary Endpoint: Investigator-Assessed Event-Free Survival



No. at Risk										
Tafa-Len-R-CHOP	448	346	283	259	249	191	107	13	1	0
R-CHOP	451	339	267	244	222	182	101	19	1	0

HR 0.79* (*P*=0.0260)
95% CI: 0.64, 0.97

- **2-year EFS:**
  65.0% with Tafa-Len-R-CHOP vs 56.7% with R-CHOP
- **3-year EFS:**
  61.2% with Tafa-Len-R-CHOP vs 54.8% with R-CHOP

ITT population. *Calculated using a stratified Cox proportional hazards model.
CI, confidence interval; EFS, event-free survival; HR, hazard ratio; ITT, intention-to-treat; Len, lenalidomide; R-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone or prednisolone; Tafa, tafasitamab.

Lenz G et al. ASCO 2026;Abstract LBA7000; Lenz G et al. *Lancet* 2026 June 20;407(10547):2528-41.

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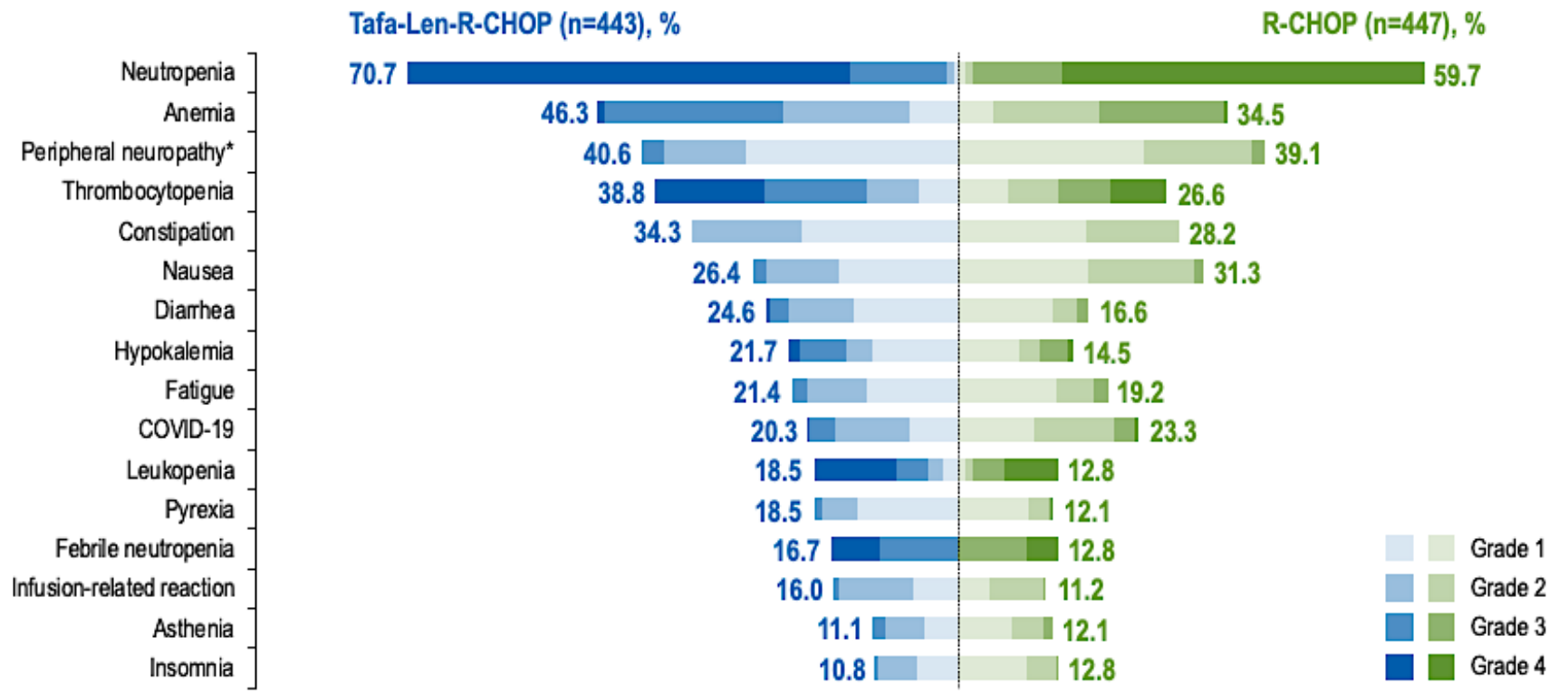
frontMIND: Most Frequent Treatment-Emergent Adverse Events



- **Most common** grade ≥3 adverse events were related to **cytopenias**
  - Rate of **serious febrile neutropenia:** 13.3% with Tafa-Len-R-CHOP and 9.8% with R-CHOP

Safety events with Tafa-Len-R-CHOP were manageable and did not affect the delivery of the R-CHOP backbone

Lenz G et al. ASCO 2026;Abstract LBA7000; Lenz G et al. *Lancet* 2026 June 20;407(10547):2528-41.

Studies Supporting the ESCALADE Study

- **ACCEPT — Davies et al. ASH 2020**
  - "There is a strong rationale for combining A with R-CHOP in pts with untreated DLBCL, and safety of A + R-CHOP has been shown in a phase 1b/2 study"
- **PHOENIX — Younes et al. *J Clin Oncol* 2019;37:1285-9.**
  - "In untreated non-GCB DLBCL pts, [PHOENIX] showed that addition of the BTKi ibrutinib to R-CHOP (R-CHOP-I) did not improve outcomes in the intent-to-treat population. However, pts age <60y treated with R-CHOP-I had significantly improved progression-free survival (PFS) and overall survival (OS) compared with those receiving R-CHOP alone."

Sehn LH et al. ASCO 2021;Abstract TPS7572.

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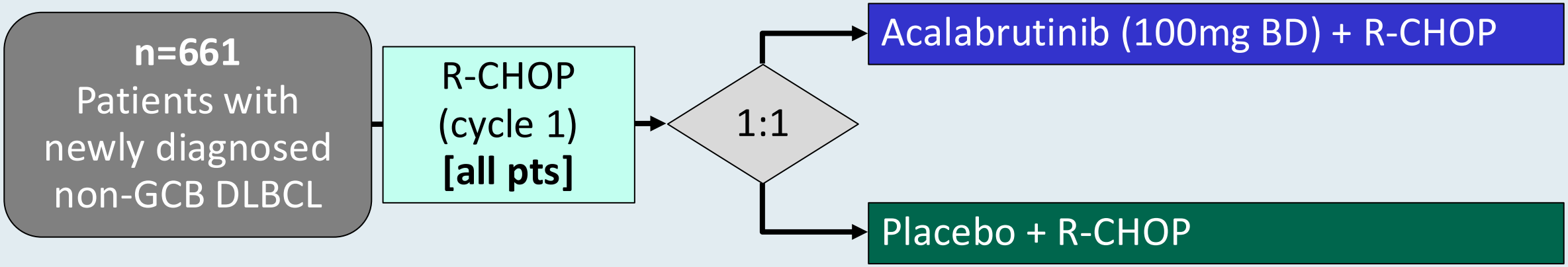
Phase III ESCALADE (ACE-LY-312) Study Design



***All patients will receive primary prophylaxis with G-CSF accompanying all R-CHOP cycles.**

Primary endpoint:
PFS

Secondary endpoints:
EFS, CR rate, OS, pharmacokinetics, safety

GCB = germinal center B-cell-like; CR = complete response; G-CSF = granulocyte-colony stimulating factor

Sehn LH et al. ASCO 2021;Abstract TPS7572.

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Which first-line therapy would you generally recommend for an otherwise healthy patient with Stage IV germinal center B-cell (GCB)-type diffuse large B-cell lymphoma (DLBCL) with an International Prognostic Index (IPI) score of 3?

	65-year-old	80-year-old
Dr Abramson	R-CHP + polatuzumab vedotin	Dose-reduced R-CHP + polatuzumab vedotin
Dr Flowers	R-CHP + polatuzumab vedotin	R-CHP + polatuzumab vedotin
Dr Kamdar	R-CHP + polatuzumab vedotin	R-mini-CHOP
Dr LaCasce	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
Dr Matasar	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
Dr Portell	R-CHOP	R-mini-CHOP
Prof Salles	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
Dr Westin	R-CHOP	R-mini-CHOP

R-CHP = rituximab/cyclophosphamide/doxorubicin/prednisone; R-mini-CHOP = rituximab/cyclophosphamide/doxorubicin/vincristine/prednisone (attenuated)

Which first-line therapy would you generally recommend for an otherwise healthy patient with Stage IV activated B-cell (ABC)-type DLBCL with an IPI score of 3?

	65-year-old	80-year-old
Dr Abramson	R-CHP + polatuzumab vedotin	Dose-reduced R-CHP + polatuzumab vedotin
Dr Flowers	R-CHP + polatuzumab vedotin	R-CHP + polatuzumab vedotin
Dr Kamdar	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
Dr LaCasce	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
Dr Matasar	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
Dr Portell	R-CHP + polatuzumab vedotin	R-mini-CHOP
Prof Salles	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
Dr Westin	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin

A 75-year-old woman with a history of congestive heart failure and a LVEF of 45% presents with Stage IV DLBCL with an IPI of 3. Which initial therapy would you most likely recommend if she had the DLBCL molecular subtype below?

	GCB-type	ABC-type, high-risk
Dr Abramson	R-CHOP + dexrazoxane	Pola-R-CHP + dexrazoxane
Dr Flowers	R-CHP + polatuzumab vedotin (dose adjustments PRN, cardiac monitoring)	R-CHP + polatuzumab vedotin (dose adjustments PRN, cardiac monitoring)
Dr Kamdar	Dose-adjusted R-EPOCH	Pola-R-CHP + dexrazoxane
Dr LaCasce	R-GCVP	Pola-R-CGP
Dr Matasar	R-GCVP	R-GCVP
Dr Portell	R-CHOP or R-CEOP	R-CHP + Pola or R-CEOP
Prof Salles	R-GCVP	R-mini-CGemP-Pola
Dr Westin	R-CEOP	RCEP-Pola

R = rituximab; C = cyclophosphamide; E = etoposide; O = vincristine; P = prednisone; G = gemcitabine; V = vincristine; Pola = polatuzumab vedotin

Optimizing the Use of Novel Therapies for Patients with DLBCL

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Key Datasets

- Duell J et al. **Tafasitamab** for patients with **relapsed or refractory diffuse large B-cell lymphoma: Final 5-year efficacy and safety findings** in the phase II **L-MIND** study. *Haematologica* 2024 February 1;109(2):553-66.
- Arias DA et al. **CD19 expression** persists in **diffuse large B-cell lymphoma** patient biopsies after treatment with **tafasitamab**. EHA 2024;Abstract P1234.
- Kim TM et al. **Safety and efficacy** of **AZD0486**, a **CD19xCD3 T-cell engager**, in **relapsed or refractory diffuse large B-cell lymphoma**. ASCO 2025;Abstract 7046.
- Dickinson MJ et al. **Glofitamab** for **relapsed or refractory diffuse large B-cell lymphoma**. *N Engl J Med* 2022 December 15;387(24):2220-31.
- Karimi YH et al. **3-year update** from the **Epcore NHL-1 trial**: **Epcoritamab** leads to deep and durable responses in **relapsed or refractory large B-cell lymphoma.**. ASH 2024;Abstract 4480.
- Fox CP et al. Results from **EPCORE DLBCL-1**: Randomized **phase 3** study of **epcoritamab vs investigator's choice chemoimmunotherapy** in patients with **relapsed/refractory large B-cell lymphoma**. EHA 2026;Abstract S235.
- Abramson JS et al. **Glofitamab plus gemcitabine and oxaliplatin (GemOx)** versus rituximab-GemOx for **relapsed or refractory diffuse large B-cell lymphoma (STARGLO):** A global **phase 3**, randomised, **open-label** trial. *Lancet* 2024 November 16;404(10466):1940-54.

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Phase II L-MIND Study Design

- Age ≥18 years
- R/R DLBCL
- Not eligible for HDT + ASCT
- 1–3 prior regimens
- Primary refractory patients were excluded[b]
- ECOG 0–2

N=81

Cycles 1–3

Tafasitamab
12 mg/kg IV
d1, 8, 15, 22 q4w[a]

+

Cycles 4–12

Tafasitamab
12 mg/kg IV
d1, 15 q4w

+

Lenalidomide
25 mg/d PO
d1–21 q4w

If ≥SD

Cycles 12+

Tafasitamab
12 mg/kg IV
d1, 15 q4w

Treatment with tafasitamab until progression

Median follow-up: 17.3 months

Primary endpoint:
ORR

Secondary endpoints:
PFS, DoR, OS, safety, exploratory and biomarker-based assays

HDT = high-dose therapy; ASCT = autologous stem cell transplant; SD = stable disease; DoR = duration of response

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Duell J et al. *Haematologica* 2024 February 1;109(2):553-66.

Phase II L-MIND: Efficacy Outcomes (Primary, 3-Year, 5-Year Analyses)

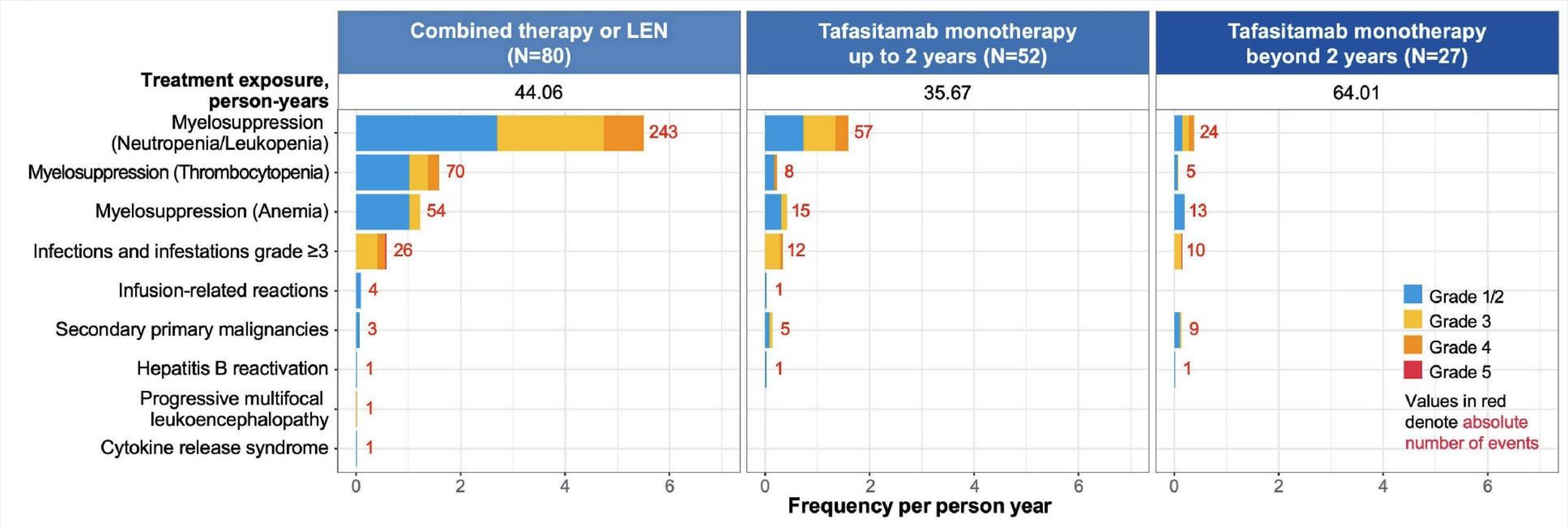
Characteristics	Primary analysis	3-year follow-up	Final 5-year data	5-year data for patients with 1 prior line of therapy, N=40	5-year data for patients with ≥2 prior lines of therapy, N=40
Data cut-off date	Nov 30, 2018	Oct 30, 2020	Nov 14, 2022	Nov 14, 2022	Nov 14, 2022
Best ORR, N (%) [95% CI]	48 (60.0) [48.4-70.9]	46 (57.5) [45.9-68.5]	46 (57.5) [45.9-68.5]	27 (67.5) [50.9-81.4]	19 (47.5) [31.5-63.9]
CR rate, N (%) [95% CI]	34 (42.5) [32.0-54.0]	32 (40.0) [29.2-51.6]	33 (41.3) [30.4-52.8]	21 (52.5) [36.1-68.5]	12 (30.0) [16.6-46.5]
PR rate, N (%) [95% CI]	14 (17.5) [10.0-28.0]	14 (17.5) [9.9-27.6]	13 (16.3) [8.9-26.2]	6 (15.0) [5.7-29.8]	7 (17.5) [7.3-32.8]
Median DoR in months [95% CI]	21.7 [21.7-NR]	43.9 [26.1-NR]	NR [33.8-NR]	NR [9.1-NR]	NR [26.1-NR]
Median PFS in months [95% CI]	12.1 [5.7-NR]	11.6 [6.3-45.7]	11.6 [5.7-45.7]	23.5 [7.4-NR]	7.6 [2.7-45.5]
Median OS in months [95% CI]	NR [18.3-NR]	33.5 [18.3-NR]	33.5 [18.3-NR]	NR [24.6-NR]	15.5 [8.6-45.5]

ORR: objective response rate; 95% CI: 95% confidence interval; CR: complete response; PR: partial response; DoR: duration of response; NR: not reached; PFS: progression-free survival; OS: overall survival.

RTP RESEARCH TO PRACTICE

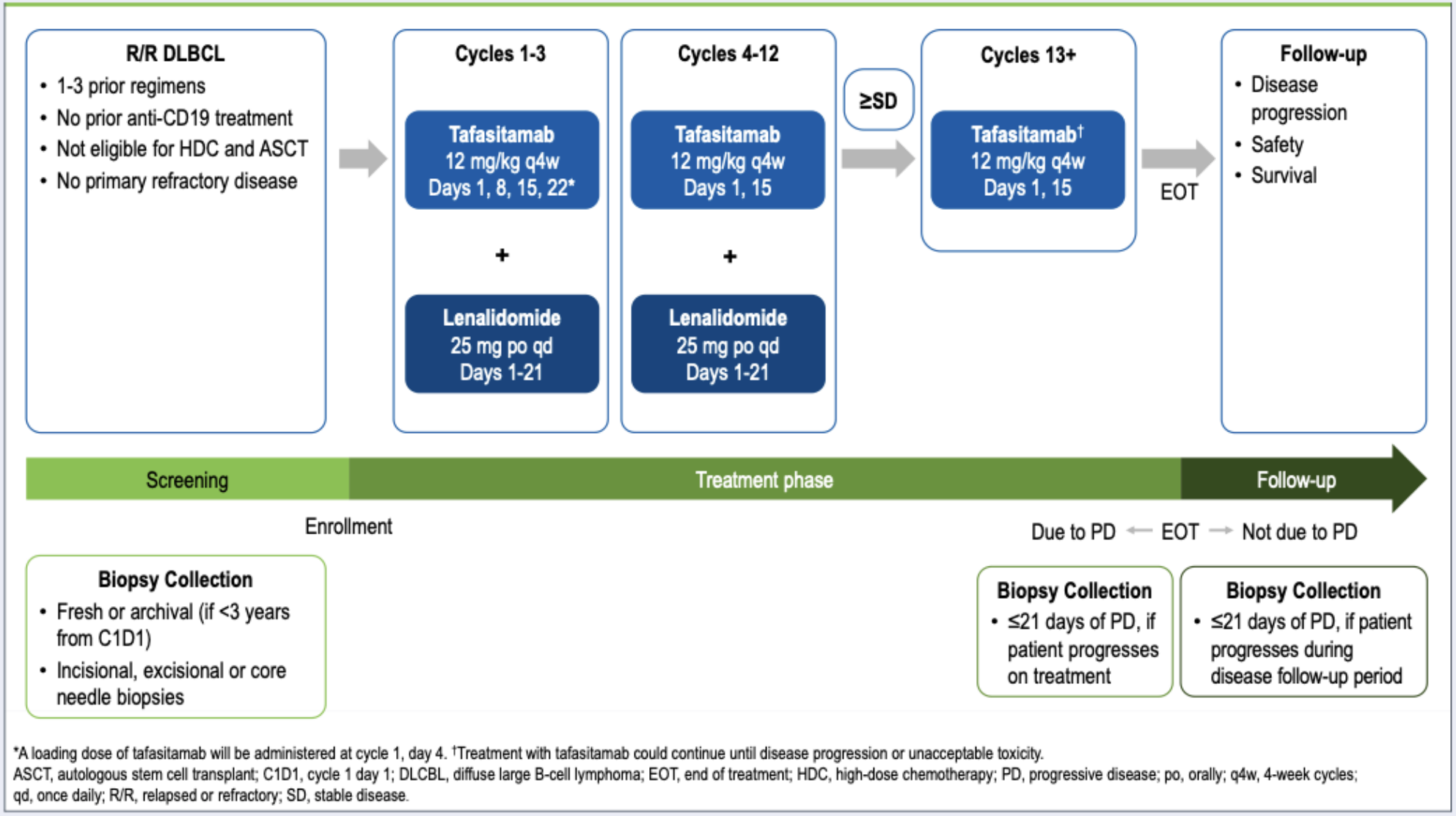
Duell J et al. *Haematologica* 2024 February 1;109(2):553-66.

Phase II L-MIND: Adverse Events of Special Interest



Duell J et al. *Haematologica* 2024 February 1;109(2):553-66.

Phase III firmMIND Study Design

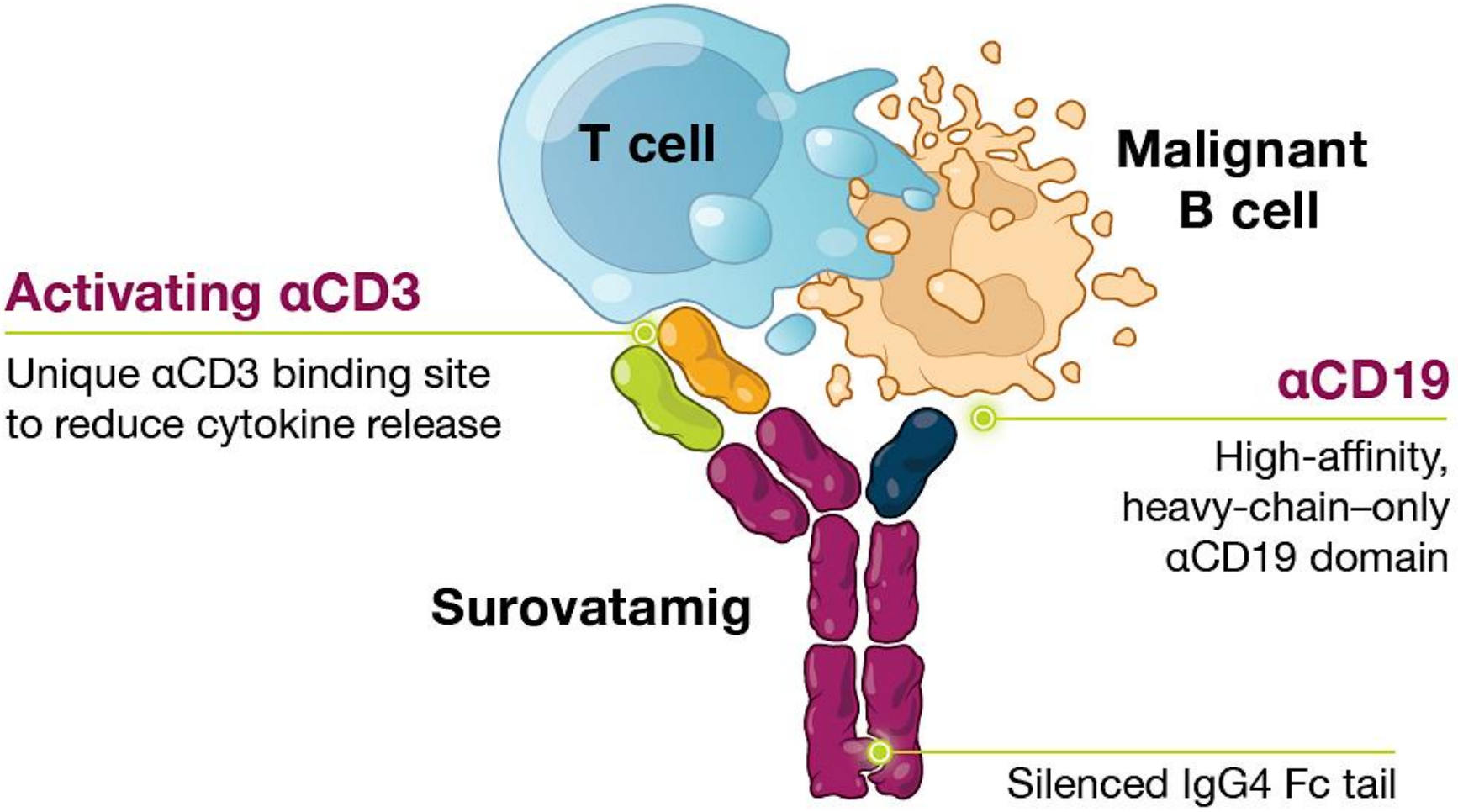


Arias DA et al. EHA 2024;Abstract P1234.

Estimated completion (primary): 2026-04-01

RTP RESEARCH TO PRACTICE

Surovatamig (AZD0486): A CD19 x CD3 Bispecific T-Cell Engager



Cheah C et al. ASH 2025;Abstract 3747.

RTP RESEARCH TO PRACTICE

Phase I Surovatamig Study: Responses by Target Dose (≥7.2 mg)

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

Kim TM et al. ASCO 2025;Abstract 7046.

RTP RESEARCH TO PRACTICE

Phase I Surovatamig Study: Safety

Most common AEs (≥15%)	Any grade	Grade 3	Grade 4
CRS	42 (49)	0	0
Infections and infestations[b]	39 (45)	10 (12)	1 (1)
Neutropenia	29 (34)	9 (10)	15 (17)
Constipation	21 (24)	0	0
Anemia	20 (23)	14 (16)	0
Fatigue	20 (23)	3 (3)	0
ICANS	17 (20)	5 (6)	0
Hypogammaglobulinemia	16 (19)	0	0
Nausea	16 (19)	1 (1)	0
Diarrhea	14 (16)	0	0
Pyrexia	13 (15)	0	0

Values are n (%).
[a]All patients eventually received TD.
[b]Grouped by system organ class. One grade 5 event reported (pneumonia). COVID-19 infections reported in 9 (10%) patients (n=3 grade 1; n=6 grade 2).

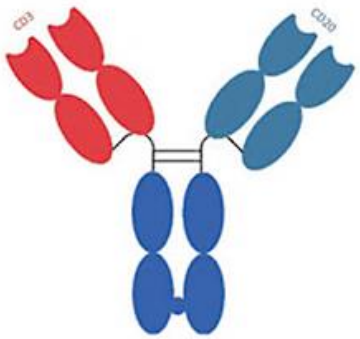
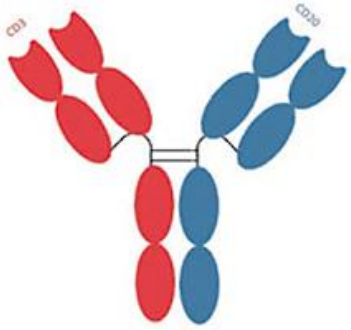
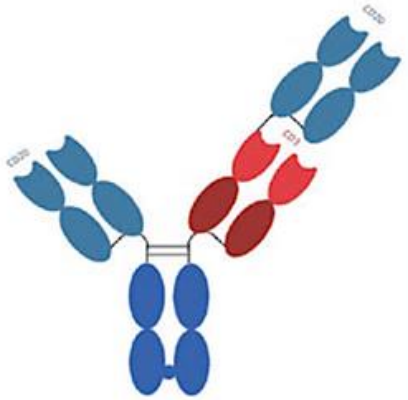
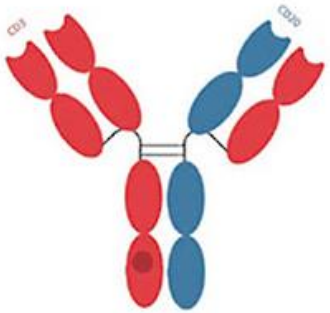
AEs = adverse events; CRS = cytokine release syndrome; ICANS = immune effector cell-associated neurotoxicity syndrome

AZD0486 2SUD cohort (n=70), n (%)	Grade 1	Grade 2	Grade 3	Grade ≥4	Total
CRS	30 (43)	4 (6)	0	0	34 (49)
ICANS	4 (6)	6 (9)	4 (6)	0	14 (20)

Kim TM et al. ASCO 2025;Abstract 7046.

RTP RESEARCH TO PRACTICE

Bispecifics for DLBCL

	BLINATUMOMAB	MOSUNETUZUMAB	EPCORITAMAB	GLOFITAMAB	ODRONEXTAMAB
TARGET	CD3xCD19	CD3xCD20	CD3xCD20	CD3x$(CD20)_2$	CD3xCD20
DESIGN					
	• Monovalent CD3 and monovalent CD19 binding • Two murine scFv-joined by a glycine–serine linker	• Monovalent CD3 and monovalent CD20 binding • Humanized mouse IgG1-based antibody	• Monovalent CD3 and monovalent CD20 binding • Humanized mouse IgG1-based antibody	• Monovalent CD3 and bivalent CD20 binding • Humanized mouse IgG1-based antibody	• Monovalent CD3 and monovalent CD20 binding • Fully human IgG4-based antibody

Brijs J et al. *Belg J Hematol* 2023;14(2):67-72.

RTP RESEARCH TO PRACTICE

Glofitamab for R/R DLBCL Study: Efficacy (IRC- and Investigator-Assessed)

Outcome	Assessment According to Independent Review Committee (N=155)	Assessment According to Investigator (N=155)
Complete response		
No. of patients with response	61	58
Percentage of patients (95% CI)	39 (32–48)	37 (30–46)
Objective response		
No. of patients with response	80	89
Percentage of patients (95% CI)	52 (43–60)	57 (49–65)
Duration of complete response†		
Median (95% CI) — mo	NR (16.8–NR)	19.8 (18.2–NR)
Complete response at 12 mo (95% CI) — %	78 (64–91)	72 (59–86)
Duration of objective response‡		
Median (95% CI) — mo	18.4 (13.7–NR)	10.4 (6.8–NR)
Objective response at 12 mo (95% CI) — %	64 (51–76)	49 (37–61)
Median time to first complete response (range) — days†	42 (31–308)	43 (31–274)
Progression-free survival		
Median (95% CI) — mo	4.9 (3.4–8.1)	3.8 (3.3–5.4)
Alive without progression at 12 mo (95% CI) — %	37 (29–46)	30 (22–38)
Overall survival		
Median (95% CI) — mo	—	11.5 (7.9–15.7)
Alive at 12 mo (95% CI) — %	—	50 (41–58)

Dickinson MJ et al. *N Engl J Med* 2022 December 15;387(24):2220-31.

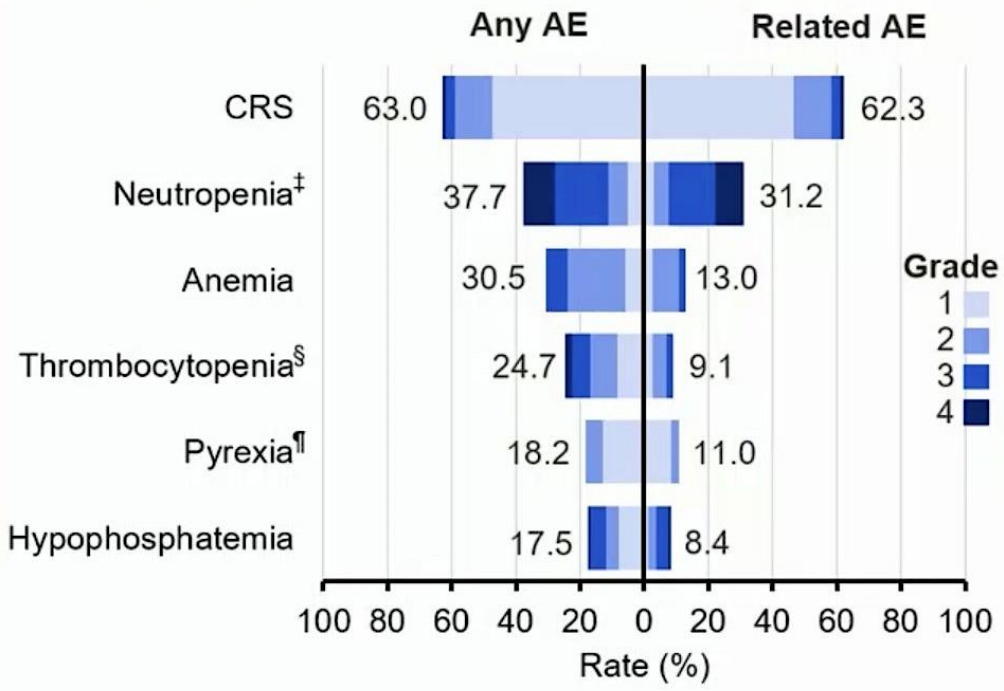
IRC = independent review committee

RTP RESEARCH TO PRACTICE

Glofitamab for R/R DLBCL: Safety

n (%)*	N=154
Median no. of cycles received (range)	5 (1–13)
Median relative dose intensity, % (range)	100 (94–100)
AE	152 (98.7)
Related AE	140 (90.9)
Grade 3–4 AE	87 (56.5)
Related AE	64 (41.6)
Serious AE	73 (47.4)
Related AE	46 (29.9)
Grade 5 (fatal AE)	8 (5.2)†
Related AE	0
AE leading to treatment discontinuation	14 (9.1)
Related AE	5 (3.2)

AEs (≥15%) by grade and relationship with glofitamab



Glofitamab was well tolerated, with a favorable safety profile

*unless otherwise specified; †COVID-19/COVID-19 pneumonia (n=5); sepsis (n=2); delirium (n=1);
‡includes neutrophil count decreased; §includes platelet count decreased; ¶pyrexia events separate from CRS.

Dickinson MJ et al. EHA 2022;Abstract S220.

RTP RESEARCH TO PRACTICE

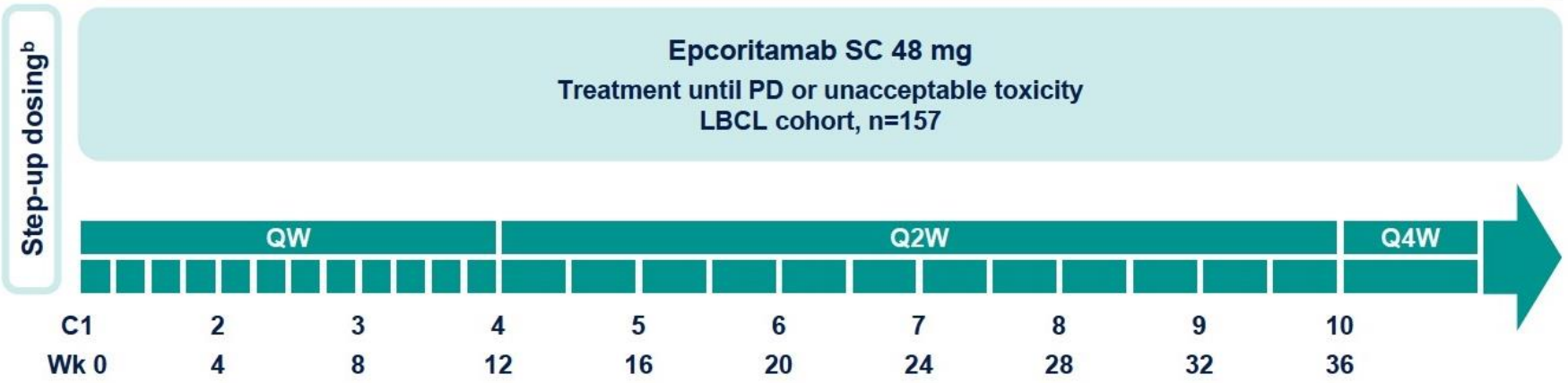
Phase II EPCORE NHL-1 Study Design

Dose expansion

Key inclusion criteria:

- R/R CD20+ LBCL
  - DLBCL (*de novo* or transformed)
  - "Double-" or "triple-hit" DLBCL[a]
  - PMBCL
  - HGBCL
  - FL G3B
- ECOG PS 0–2
- ≥2 prior lines of antineoplastic therapy, incl ≥1 anti-CD20 mAb
- Measurable disease by CT/MRI
- Prior CAR T therapy allowed

Median follow-up: 37.1 mo



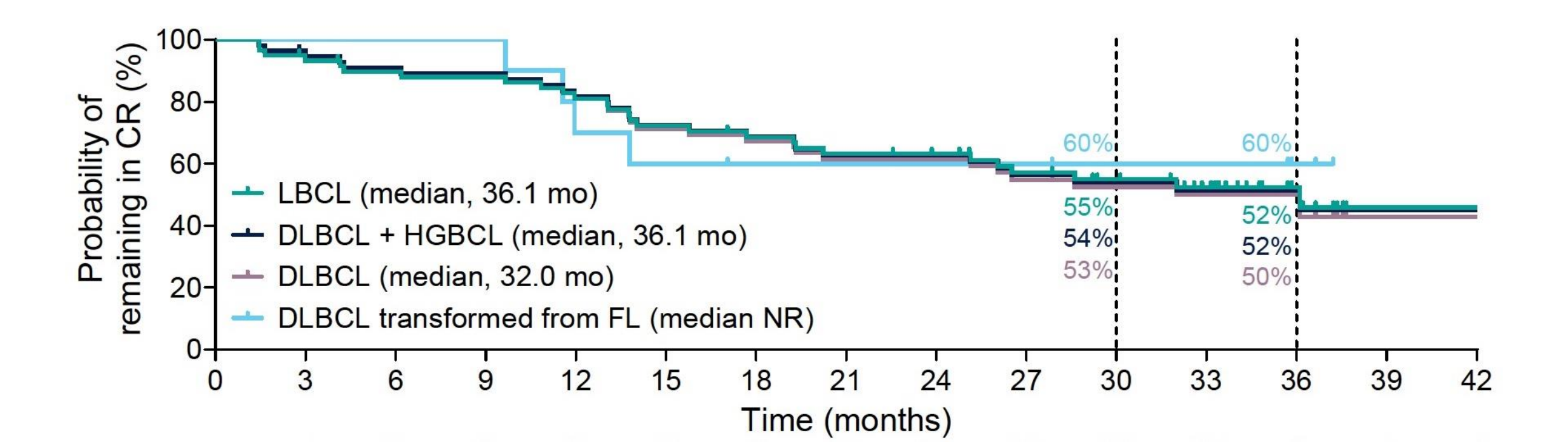
- **Primary endpoint:** ORR per Lugano criteria[1]
- **Key secondary endpoints:** CR, DOR, DOCR, PFS, OS, TTNT, MRD- rate, and safety/tolerability
- Exploratory MRD analyses of ctDNA were performed using the clonoSEQ® NGS assay[c]

PMBCL = primary mediastinal B-cell lymphoma; HGBCL = high-grade B-cell lymphoma; FL = follicular lymphoma; DOCR = duration of complete response; TTNT = time to next treatment; MRD = minimal residual disease; ctDNA = circulating tumor DNA

Karimi YH et al. ASH 2024;Abstract 4480.

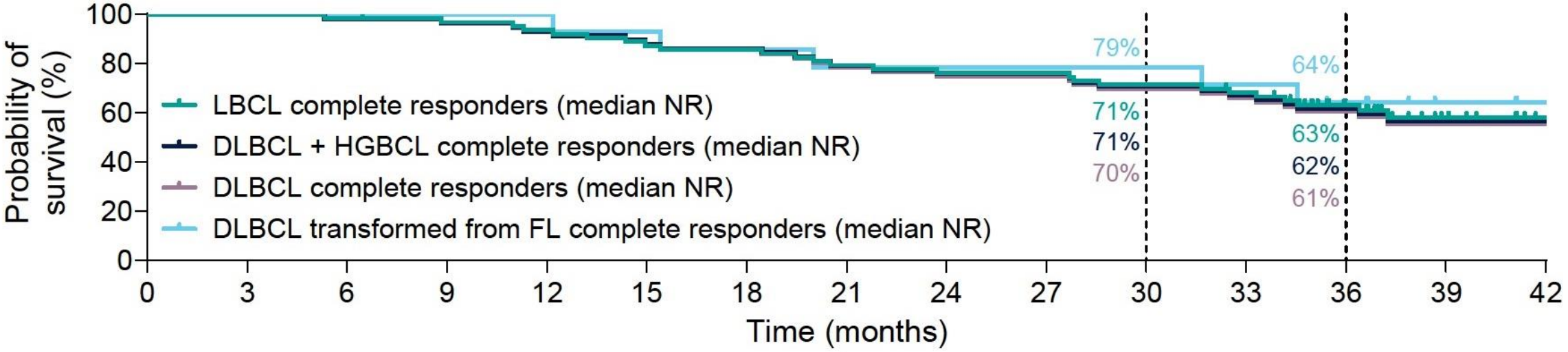
RTP RESEARCH TO PRACTICE

Phase II EPCORE NHL-1: Responses



Karimi YH et al. ASH 2024;Abstract 4480.

Phase II EPCORE NHL-1: Overall Survival



Karimi YH et al. ASH 2024;Abstract 4480.

EPCORE DLBCL-1 Phase III Trial of Epcoritamab versus Investigator's Choice Chemoimmunotherapy (CIT) for R/R LBCL

A phase 3, randomized, open-label trial to evaluate the efficacy of epcoritamab vs investigator's choice CIT in patients with R/R LBCL who are ineligible for, or have relapsed after, HDT-ASCT

Key inclusion criteria:

- CD20+ R/R LBCL (de novo or transformed from FL):
  - DLBCL, NOS
  - DH/TH DLBCL[a]
  - FL Grade 3B
  - T-cell/histiocyte-rich LBCL
- ≥ 1 prior systemic LOT
- ECOG PS 0–2
- Ineligible for, or relapsed after, HDT-ASCT

Stratification factors:

- No. of pLOTs (1 vs > 1)
- ECOG PS (0-1 vs 2)
- Prior ASCT (yes vs no)
- Prior CAR T (yes vs no)

Caps:

- Max 120 patients (25%) with 1 pLOT
- Max 120 (50% CIT) patients to receive BR

Median study follow-up: 43.2 months (epcoritamab arm) and 42.3 months (CIT arm)

Randomization 1:1

N = 241 → Epcoritamab SC 48 mg; 28-day cycles; C1-3: QW[b]; C4-9: Q2W; C10+: Q4W → Until PD or unacceptable toxicity

N = 242 → R-GemOx IV (n = 174); 28-day cycles; C1-4: Q2W → Until completed therapy, PD or unacceptable toxicity

N = 242 → BR IV (n = 68); 21-day cycles; C1-6: Q3W → Until completed therapy, PD or unacceptable toxicity

Dual primary endpoints[c]:

- PFS per IRC by Lugano criteria[1,2]
- OS

Secondary endpoints:

- ORR, CR rate, and DOR per IRC by Lugano criteria[1,2]
- TTNT
- Safety

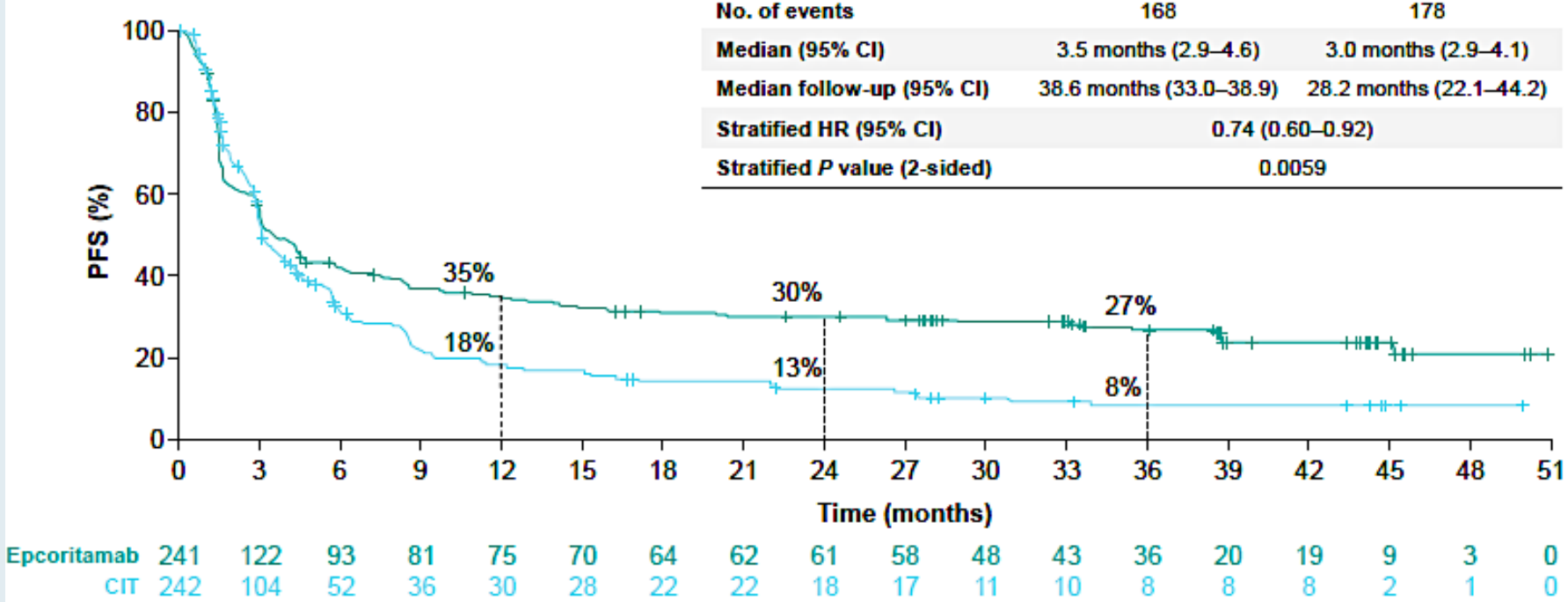
EPCORE DLBCL-1 trial was conducted during the COVID-19 pandemic; 67% of patients were randomized during the peak and subsequent waves of the highly infectious Omicron variant

Data cutoff: Oct 13, 2025. EudraCT: 2020-003016-27. Corticosteroid prophylaxis was used to mitigate CRS, and protocol-mandated hospitalization was required for ≥ 24 hours after the first full epcoritamab dose in C1 and in any repriming cycles. [a]Based on WHO 2016 classification (HGBCL, with *MYC* and *BCL2* and/or *BCL6* translocations). [b]Patients received epcoritamab in weekly dosing of 2 step-up doses (0.16 mg; 0.8 mg) before the first full dose in C1. [c]Primary endpoint is OS in the US. 1. Cheson BD, et al. *J Clin Oncol* 2014;32:3059-3068. 2. Cheson BD, et al. *Blood* 2016;128:2489-2496. DH, double-hit; HDT-ASCT, high-dose therapy with autologous stem cell transplantation; IRC, independent review committee; NOS, not otherwise specified; pLOT, prior line of therapy; TH, triple-hit; TTNT, time to next treatment.

Fox CP et al. EHA 2026;Abstract S235.

RTP RESEARCH TO PRACTICE

EPCORE DLBCL-1: Efficacy Summary



	Epcoritamab	CIT
No. of events	168	178
Median (95% CI)	3.5 months (2.9–4.6)	3.0 months (2.9–4.1)
Median follow-up (95% CI)	38.6 months (33.0–38.9)	28.2 months (22.1–44.2)
Stratified HR (95% CI)	0.74 (0.60–0.92)	
Stratified *P* value (2-sided)	0.0059	

Data cutoff: Oct 13, 2025. PFS in the ITT population without censoring for subsequent anti-cancer therapy. Percentages are Kaplan–Meier estimates. HR (epcoritamab vs CIT) is based on stratified Cox regression model with treatment as the sole explanatory variable.

- Epcoritamab resulted in clinically meaningful improvement in CR, DOR and DOCR
- OS was not significantly different; confounded by COVID-19 mortality and higher use of effective subsequent treatments in the CIT arm

Fox CP et al. EHA 2026;Abstract S235.

RTP RESEARCH TO PRACTICE

EPCORE DLBCL-1: Most Common Treatment-Emergent Adverse Events

	Epcoritamab (N = 236)	CIT (N = 237)	Epcoritamab (N = 236)	CIT (N = 237)
	n (%)	n (%)	EAER[a]	EAER[a]
CRS[b]	124 (53)	NA	NA	NA
COVID-19[c]	88 (37)	28 (12)	4.8	3.9
Neutropenia[d]	84 (36)	109 (46)	6.4	30.1
Pyrexia	62 (26)	30 (13)	3.1	4.4
Anemia	61 (26)	84 (35)	2.6	15.6
Injection site reactions[e]	51 (22)	NA	NA	NA
Diarrhea	47 (20)	30 (13)	2.1	4.3
Thrombocytopenia[f]	42 (18)	125 (53)	1.9	28.3
Nausea	32 (14)	74 (31)	1.4	11.3

- Higher rates of grade 3–4 infections (30% vs 12%) were reported in the epcoritamab vs the CIT arm, with grade 3–4 infection EAERs of 4.3 vs 4.9, respectively
- Febrile neutropenia was reported in 2% of patients in the epcoritamab arm and 5% in the CIT arm; EAERs were 0.2 vs 1.7, respectively
- ICANS events were reported in 9 patients (grade 1–2, in 7; grade 3–4 in 2) in the epcoritamab arm

Data cutoff: Oct 13, 2025. [a]EAER equals the number of events*100/patient-months of exposure. [b]Most CRS events were grade 1–2 (117/124 [94%]) with the remaining 7/124 (6%) grade 3. [c]Includes preferred terms COVID-19, COVID-19 pneumonia, and post-acute COVID-19 syndrome. [d]Includes preferred terms neutropenia and neutrophil count decreased. [e]Includes preferred terms injection site reaction, injection site reaction erythrema, injection site reaction pain, injection site reaction pruritus, injection site reaction rash, injection site reaction inflammation, injection site reaction swelling. [f]Includes preferred terms platelet count decreased and thrombocytopenia. EAER, exposure-adjusted event rate.

Fox CP et al. EHA 2026;Abstract S235.

RTP RESEARCH TO PRACTICE

Positive Phase III Results Announced for Epcoritamab with Lenalidomide for Patients with Relapsed or Refractory DLBCL

Press Release: June 29, 2026

"[The manufacturer] today announced topline results from the **Phase 3 EPCORE DLBCL-4 trial** evaluating the combination of epcoritamab, a T-cell engaging bispecific antibody, and lenalidomide, compared to rituximab plus gemcitabine plus oxaliplatin (R-GemOx) in adult patients with relapsed or refractory (R/R) diffuse large B-cell lymphoma (DLBCL) who received at least one prior line of therapy**. Based on topline results from the prespecified primary analysis, the trial met its primary endpoint, demonstrating statistically significant and clinically meaningful improvement in progression-free survival (PFS).** The risk of disease progression and death was reduced by 60% (HR 0.40 [95% CI 0.30, 0.55]; *p*-value <0.0001) and 56% (HR 0.44 [95% CI 0.33, 0.60]; *p*-value <0.0001), based on different censoring rules in the US and outside the US, respectively.

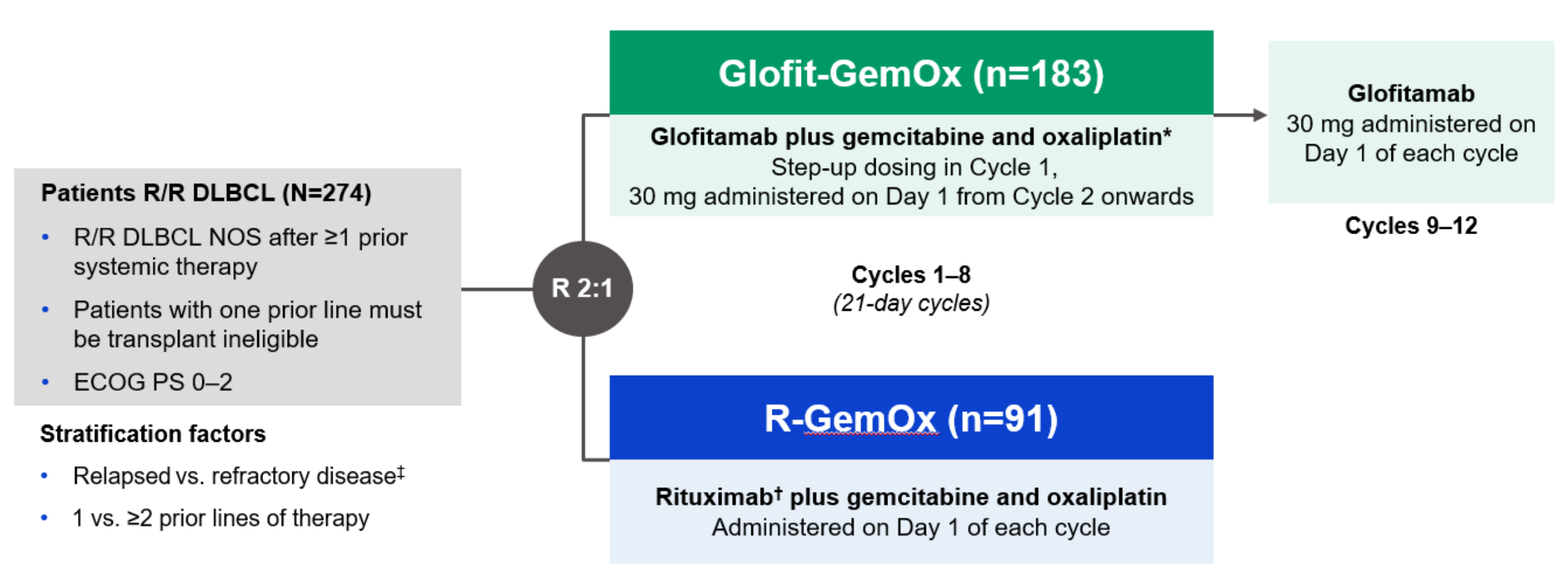
The safety profile of epcoritamab when administered in combination with lenalidomide was consistent with the known safety profiles of the individual agents (epcoritamab and lenalidomide).

Data will be submitted for presentation at a future medical meeting."

https://news.abbvie.com/2026-06-29-AbbVie-Announces-Positive-Phase-3-Results-for-Epcoritamab-Plus-Lenalidomide-in-Patients-with-Relapsed-or-Refractory-Diffuse-Large-B-Cell-Lymphoma

RTP RESEARCH TO PRACTICE

Phase III STARGLO Study Design

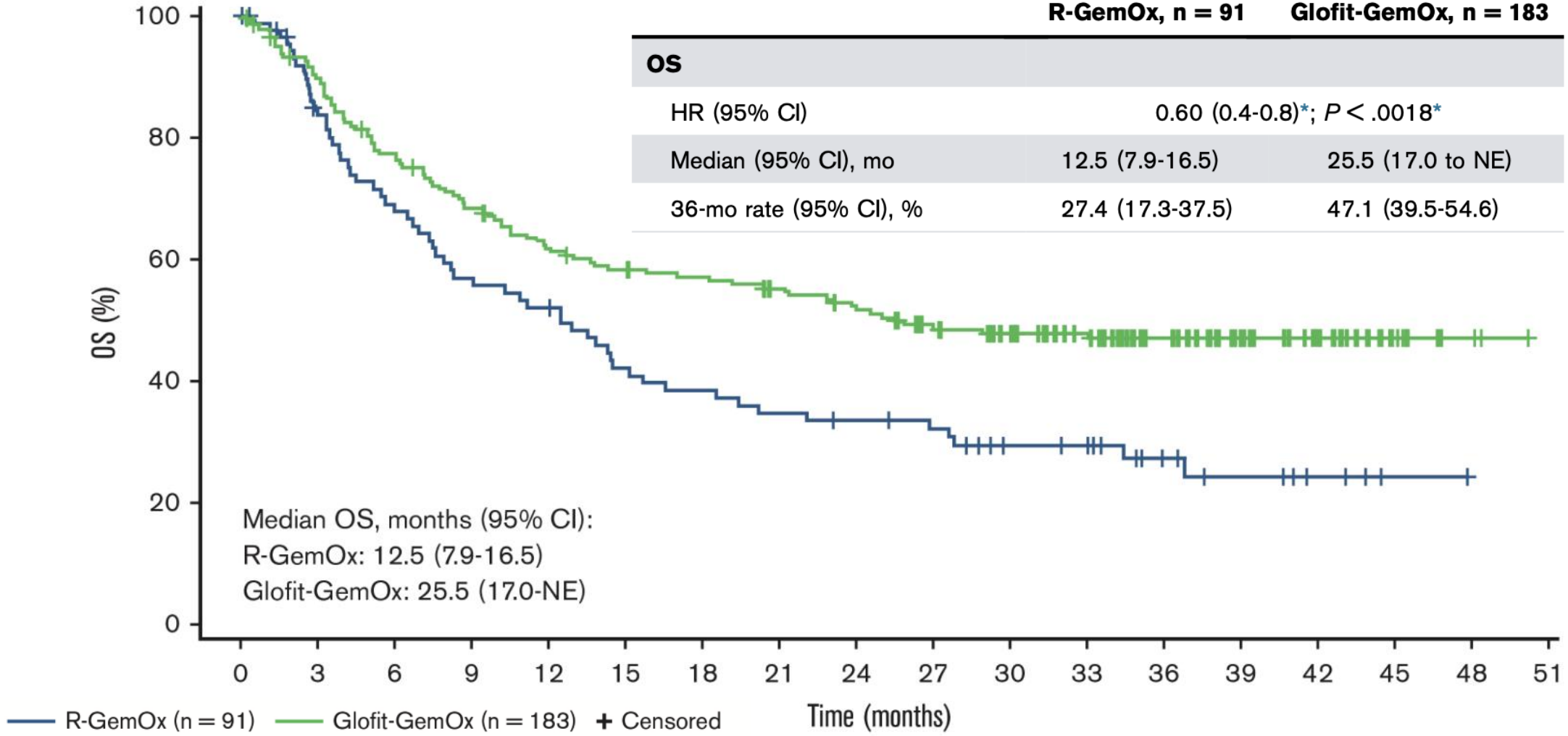


Primary endpoint:
Overall survival

Secondary endpoints:
Progression-free survival, ORR, DoR

Abramson JS et al. *Lancet* 2024 November 16;404(10466):1940-54.

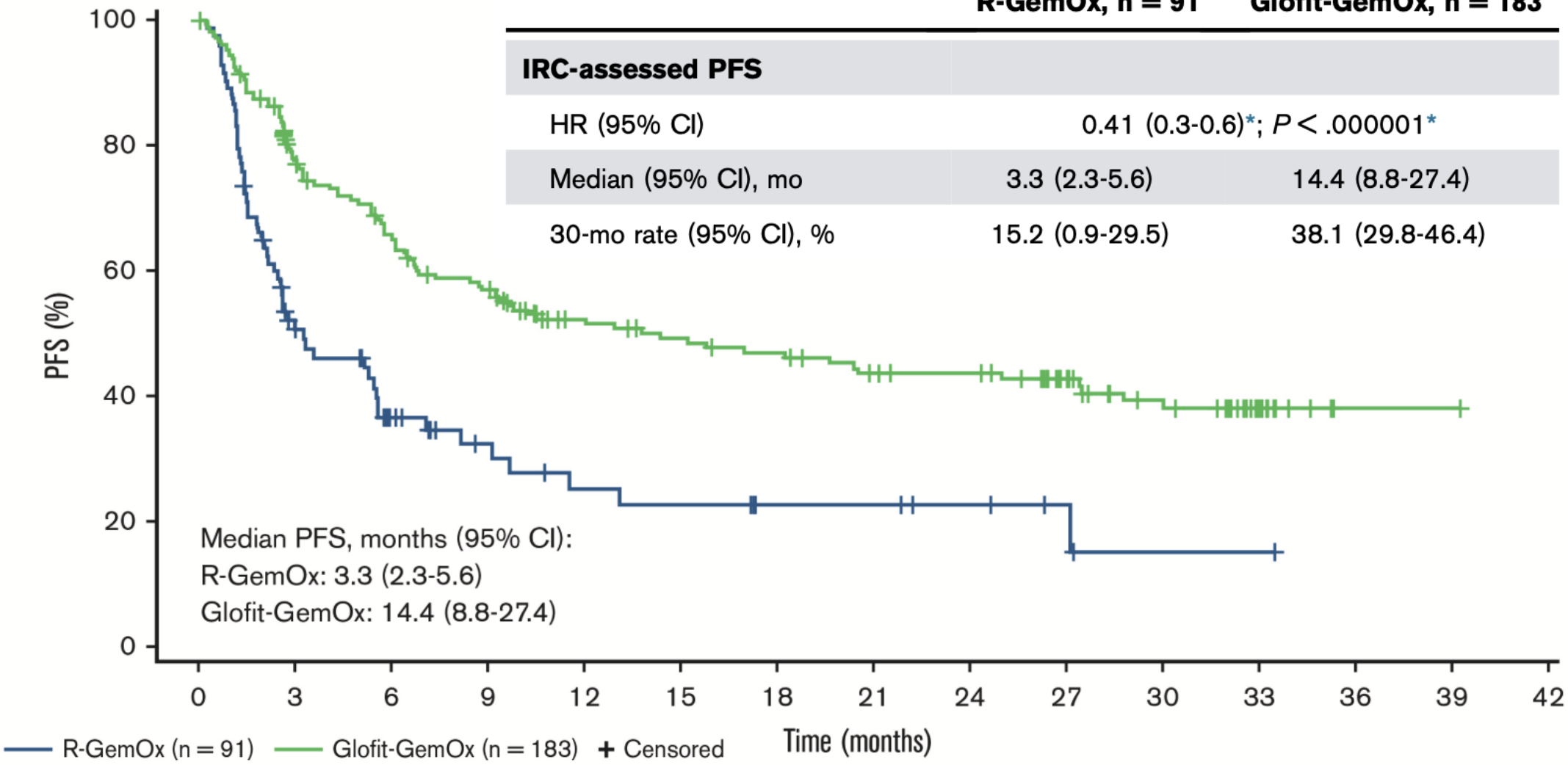
Phase III STARGLO 3-Year Follow-Up: Overall Survival (OS; Primary Endpoint)



	R-GemOx, n = 91	Glofit-GemOx, n = 183
OS		
HR (95% CI)	0.60 (0.4-0.8)*; $P < .0018$*	
Median (95% CI), mo	12.5 (7.9-16.5)	25.5 (17.0 to NE)
36-mo rate (95% CI), %	27.4 (17.3-37.5)	47.1 (39.5-54.6)

Abramson JS et al. *Blood Adv* 2026 August 11;10(15):5367-77.

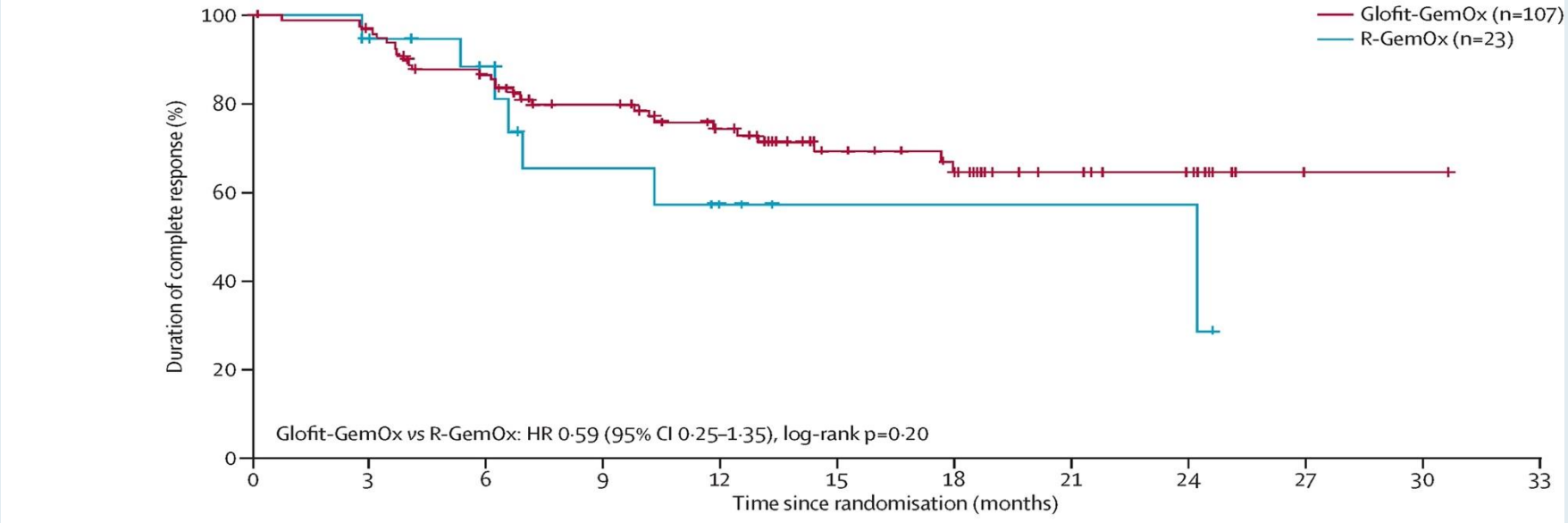
Phase III STARGLO 3-Year Follow-Up: Progression-Free Survival (PFS)



	R-GemOx, n = 91	Glofit-GemOx, n = 183
IRC-assessed PFS		
HR (95% CI)	0.41 (0.3-0.6)*; $P < .000001$*	
Median (95% CI), mo	3.3 (2.3-5.6)	14.4 (8.8-27.4)
30-mo rate (95% CI), %	15.2 (0.9-29.5)	38.1 (29.8-46.4)

Abramson JS et al. *Blood Adv* 2026 August 11;10(15):5367-77.

Phase III STARGLO: Responses



	R-GemOx (n=91)	Glofit-GemOx (n=183)	p value*
Secondary endpoints			
IRC-assessed best overall response‡, %	..	..	..
Objective response	40·7 (30·5–51·5)	68·3 (61·0–75·0)	p<0·0001†
Complete response	25·3 (16·8–35·5)	58·5 (51·0–65·7)	p<0·0001†
Investigator-assessed best overall response‡, %	..	..	..
Objective response	37·4 (27·4–48·1)	69·9 (62·7–76·5)	p<0·0001†
Complete response	23·1 (14·9–33·1)	57·4 (49·9–64·6)	p<0·0001†
IRC-assessed duration of complete response	n=23	n=107	..
HR	..	0·59 (0·25–1·35)§	p=0·20§
Median, months	24·2 (6·9–NE)	NE (NE–NE)	..
IRC-assessed duration of objective response	n=37	n=125	..
HR	..	0·57 (0·30–1·10)§	p=0·089§
Median, months	10·3 (6·5–NE)	NE (17·6–NE)	..

Abramson JS et al. *Lancet* 2024 November 16;404(10466):1940-54.

Phase III STARGLO: Safety

	R-GemOx (n=88)	Glofit-GemOx (n=180)
Any adverse event	84 (96%)	180 (100%)
Most common adverse event (≥30% patients in either group)		
Thrombocytopenia*	42 (48%)	87 (48%)
CRS†	NA	76 (44%)†
Neutropenia‡	27 (31%)	76 (42%)
Anaemia	19 (22%)	73 (41%)
Nausea	35 (40%)	71 (39%)
Peripheral neuropathy§	23 (26%)	64 (36%)
Diarrhoea	24 (27%)	62 (34%)
Aspartate transferase increased	17 (19%)	59 (33%)
Alanine transaminase increased	19 (22%)	57 (32%)
Any glofitamab-related or rituximab-related adverse event	58 (66%)	149 (83%)
Any grade ≥3 adverse event	36 (41%)	140 (78%)
Any glofitamab-related or rituximab-related grade ≥3 adverse event	20 (23%)	85 (47%)
Any serious adverse event	15 (17%)	98 (54%)
Any glofitamab-related or rituximab-related serious adverse event	7 (8%)	62 (34%)
Any adverse event of special interest	69 (78%)	176 (98%)
CRS†	NA	76 (44%)†
Grade 1	NA	54 (31%)†
Grade 2	NA	18 (11%)†
Grade 3	NA	4 (2%)†
Neurological adverse event (grade ≥2)	11 (13%)	55 (31%)
Serious infections	11 (13%)	46 (26%)
Febrile neutropenia	1 (1%)	6 (3%)
Tumour flare (grade ≥2)	1 (1%)	1 (1%)
Any grade 5 adverse event	4 (5%)	15 (8%)

Abramson JS et al. *Lancet* 2024 November 16;404(10466):1940-54.

RTP RESEARCH TO PRACTICE

Optimizing the Use of Novel Therapies for Patients with DLBCL

Module 1: Selection of First-Line Therapy for Patients with Diffuse Large B-Cell Lymphoma (DLBCL)

Module 2: Clinician Survey Results

Module 3: Current and Future Roles of Monoclonal and Bispecific Antibodies in Therapy for Relapsed/Refractory (R/R) DLBCL

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Module 6: Clinician Survey Results

RTP RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, which second-line therapy would you generally recommend for an older (85-year-old) patient with DLBCL who experienced disease relapse 18 months after first-line R-CHOP and who was …

	CAR T eligible but transplant ineligible	Transplant *and* CAR T ineligible
Dr Abramson	CAR T-cell therapy	Mosunetuzumab/polatuzumab vedotin
Dr Flowers	Mosunetuzumab/polatuzumab vedotin	Mosunetuzumab/polatuzumab vedotin
Dr Kamdar	CAR T-cell therapy	Tafasitamab/lenalidomide or glofitamab/GemOx
Dr LaCasce	CAR T-cell therapy	Mosunetuzumab/polatuzumab vedotin
Dr Matasar	CAR T-cell therapy	Glofitamab/GemOx
Dr Portell	Epcoritamab	Epcoritamab
Prof Salles	Glofitamab/GemOx	Glofitamab/GemOx
Dr Westin	CAR T-cell therapy	Tafasitamab/lenalidomide or mosunetuzumab/polatuzumab vedotin

GemOx = gemcitabine/oxaliplatin

Regulatory and reimbursement issues aside, which third-line therapy would you generally recommend for a 65-year-old patient with DLBCL who received first-line R-CHOP and subsequently experienced disease progression on second-line CAR T-cell therapy?

Dr Abramson	Glofitamab/GemOx
Dr Flowers	Glofitamab
Dr Kamdar	Glofitamab
Dr LaCasce	Glofitamab
Dr Matasar	Polatuzumab vedotin/R-GemOx
Dr Portell	Epcoritamab/GemOx
Prof Salles	Glofitamab/GemOx or polatuzumab vedotin/glofitamab
Dr Westin	Glofitamab/GemOx or polatuzumab vedotin/glofitamab

R-GemOx = rituximab/gemcitabine/oxaliplatin

RTP RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, which third-line therapy would you generally recommend for a 65-year-old patient with DLBCL who received first-line polatuzumab vedotin/R-CHP and subsequently experienced disease progression on second-line CAR T-cell therapy?

Dr Abramson	Glofitamab/GemOx
Dr Flowers	Glofitamab
Dr Kamdar	Glofitamab
Dr LaCasce	Glofitamab
Dr Matasar	Loncastuximab tesirine
Dr Portell	Epcoritamab/GemOx
Prof Salles	Glofitamab/GemOx
Dr Westin	Glofitamab/GemOx

RTP
RESEARCH TO PRACTICE

Regulatory and reimbursement issues aside, which third-line therapy would you generally recommend for an 85-year-old patient with DLBCL who received first-line R-mini-CHOP and subsequently experienced disease progression on second-line polatuzumab vedotin with bendamustine/rituximab (BR)?

Dr Abramson	Glofitamab
Dr Flowers	Epcoritamab
Dr Kamdar	Glofitamab
Dr LaCasce	Glofitamab
Dr Matasar	Glofitamab/GemOx
Dr Portell	Epcoritamab
Prof Salles	Glofitamab/GemOx
Dr Westin	Glofitamab or epcoritamab

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RESEARCH TO PRACTICE

Assuming equal access, which bispecific antibody would you prefer to use when administering one of these agents as monotherapy for your patients with R/R DLBCL?

Dr Abramson	Glofitamab
Dr Flowers	No preference
Dr Kamdar	Glofitamab
Dr LaCasce	Glofitamab
Dr Matasar	Glofitamab
Dr Portell	Epcoritamab
Prof Salles	Glofitamab
Dr Westin	Glofitamab

RTP
RESEARCH TO PRACTICE

Based on the published literature and your clinical experience, would you like to have access to surovatamig for your patients with R/R DLBCL today?

Dr Abramson	Yes, for patients with CD20-negative disease
Dr Flowers	Yes, as part of second-line combinations prior to CAR T; third-line+ relapse
Dr Kamdar	Yes, for CAR T-ineligible pts in the second-line setting
Dr LaCasce	Yes, for patients who are ineligible for CD19 CAR T
Dr Matasar	No
Dr Portell	Yes, for patients who remain CD19+ in the relapsed setting who are either ineligible for CD19 CAR T or for whom CD19 CAR T or a CD20 bispecific antibody has failed
Prof Salles	Yes, for patients with PD on CD3 x CD20 combinations or monotherapy, and for those with CD20-negative disease
Dr Westin	Yes, for patients with CD20 loss and non-CAR T eligible

RTP
RESEARCH TO PRACTICE

If surovatamig were granted regulatory approval, would you employ a CD20 x CD3 bispecific antibody and surovatamig in sequence for the same patient with R/R DLBCL?

Dr Abramson	Yes
Dr Flowers	Yes
Dr Kamdar	Yes
Dr LaCasce	Maybe
Dr Matasar	Yes
Dr Portell	Yes
Prof Salles	Yes
Dr Westin	Yes

RTP
RESEARCH TO PRACTICE

Optimizing the Use of Novel Therapies for Patients with DLBCL

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Module 6: Clinician Survey Results

RTP RESEARCH TO PRACTICE

Key Datasets

- Sehn LH et al. **Polatuzumab vedotin plus bendamustine and rituximab in relapsed/refractory diffuse large B-cell lymphoma (R/R DLBCL): Final results of a phase Ib/II randomized study and single-arm extension (ext) study**. ASH 2022;Abstract 4260.
- Matasar M et al. **Polatuzumab vedotin, rituximab, gemcitabine and oxaliplatin (Pola-R-GemOx) for relapsed/refractory (R/R) diffuse large B-cell lymphoma (DLBCL): Results** from the randomized **phase III POLARGO** trial. EHA 2025;Abstract S101.
- Kim W et al. **Mosunetuzumab plus polatuzumab vedotin (Mosun-Pola)** versus rituximab, gemcitabine and oxaliplatin (R-GemOx) in patients with **relapsed/refractory large B-cell lymphoma (R/R LBCL): Updated efficacy and safety from the phase 3 SUNMO study** including in second-line (2L) versus third-line plus (3L+) patient subgroups. ASCO 2026;Abstract 7007.
- Kim JA et al. **Brentuximab vedotin in combination with lenalidomide and rituximab** in patients with **relapsed/refractory diffuse large B-cell lymphoma: Results** from the **phase 3 ECHELON-3** study**.** ASCO 2024;Abstract LBA7005.
- Caimi PF et al. **Loncastuximab tesirine in relapsed/refractory diffuse large B-cell lymphoma: Long-term efficacy and safety from the phase II LOTIS-2 study.** *Haematologica* 2024 April 1;109(4):1184-93.
- Carlo-Stella C et al. **Updated safety run-in results** from **LOTIS-5:** A **phase 3,** randomized trial of **loncastuximab tesirine with rituximab** versus immunochemotherapy in patients with **R/R DLBCL/HGBL**. EHA 2025;Abstract PS1957.
- Alderuccio JP et al. **Initial results from LOTIS-7: A phase 1b** study of **loncastuximab tesirine plus glofitamab** in patients with **relapsed/refractory (R/R) diffuse large B-cell lymphoma (DLBCL)**. ICML 2025;Abstract 078.

RTP RESEARCH TO PRACTICE

Phase Ib/II GO29365 Study Final Results: Efficacy

Outcome*	Randomized		Extension
	Pola+BR (n=40)	BR (n=40)	Pola+BR (n=106)
ORR, % (95% CI)	42.5 (27.0–59.1)	17.5 (7.3–32.8)	43.4 (33.8–53.4)
CR, % (95% CI)	42.5 (27.0–59.1)	17.5 (7.3–32.8)	39.6 (30.3–49.6)
BOR, % (95% CI)	62.5 (45.8–77.3)	25.0 (12.7–41.2)	57.5 (47.6–67.1)
BCR, % (95% CI)	52.5 (36.1–68.5)	22.5 (10.8–38.5)	53.8 (43.8–63.5)
Median DOR, months (95% CI)	10.9 (5.7–40.7)	10.6 (4.0–19.7)	13.4 (8.6–20.0)
Median PFS, months (95% CI)	9.2 (6.0–13.9)	3.7 (2.1–4.5)	7.0 (5.1–9.8)
Median OS, months (95% CI)	12.4 (9.0–32.0)	4.5 (3.7–6.0)	12.3 (8.3–17.0)

*All endpoints were determined by IRC, except OS, which was INV-determined.
BCR, best complete response; BOR, best overall response; BR, bendamustine + rituximab; CI, confidence interval; CR, complete response; DOR, duration of response; INV, investigator; IRC, independent review committee; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; Pola, polatuzumab vedotin.

Sehn LH et al. ASH 2022;Abstract 4260.

RTP RESEARCH TO PRACTICE

Phase Ib/II GO29365 Final Results: Safety

	Randomized		Extension
	Pola+BR (n=39*)	BR (n=39*)	Pola+BR (n=106)
Any-grade AEs, n (%)	39 (100.0)	38 (97.4)	105 (99.1)
Grade 3–4 AEs, n (%)	34 (87.2)	28 (71.8)	83 (78.3)
Neutropenia	18 (46.2)	13 (33.3)	31 (29.2)
Thrombocytopenia	15 (38.5)	9 (23.1)	15 (14.2)
Serious AEs, n (%)	27 (69.2)	24 (61.5)	57 (53.8)
Pyrexia	5 (12.8)	0 (0.0)	7 (6.6)
Pneumonia	4 (10.3)	4 (10.3)	6 (5.7)
Febrile neutropenia	4 (10.3)	4 (10.3)	9 (8.5)
Sepsis	2 (5.1)	2 (5.1)	7 (6.6)
Grade 5 AEs, n (%)	11 (28.2)	10 (25.6)	6 (5.7)
Any-grade PN, n (%)	17 (43.6)	3 (7.7)	29 (27.4)
Grade ≥2 PN	6 (15.4)	2 (5.1)	16 (15.1)
AEs leading to delay of any drug, n (%)	21 (53.8)	14 (35.9)	53 (50.0)
AEs leading to discontinuation of any drug, n (%)	13 (33.3)	5 (12.8)	16 (15.1)

*One patient in each group did not receive study treatment and so was excluded from the safety-evaluable population.

AE, adverse event; BR, bendamustine + rituximab; PN, peripheral neuropathy; Pola, polatuzumab vedotin.

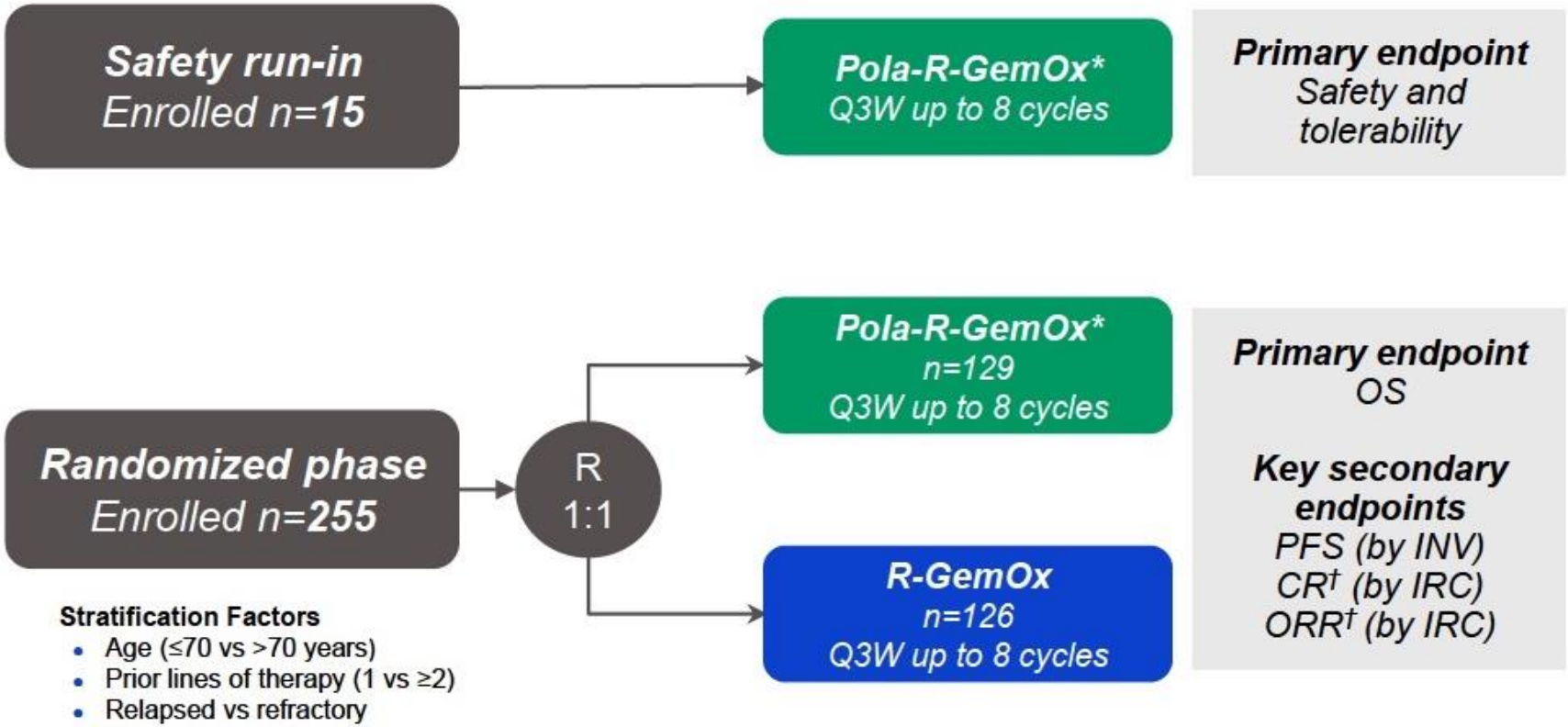
Sehn LH et al. ASH 2022;Abstract 4260.

RTP RESEARCH TO PRACTICE

Phase III POLARGO Study Design

Key eligibility criteria

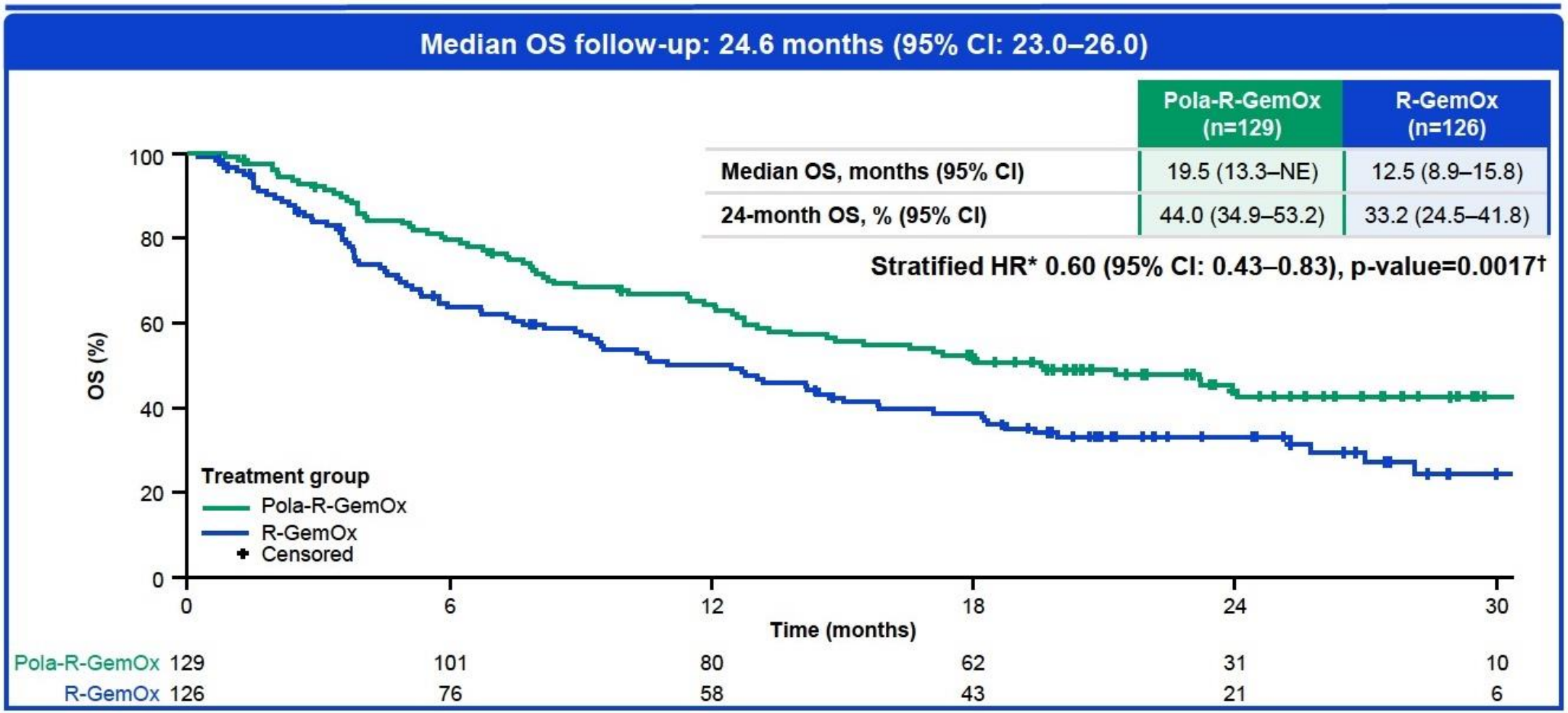
- DLBCL, NOS or history of transformation of indolent disease to DLBCL
- R/R disease after ≥1 prior line of treatment
- Ineligible for transplant



Matasar M et al. EHA 2025;Abstract S101.

RTP RESEARCH TO PRACTICE

Phase III POLARGO Overall Survival



*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.

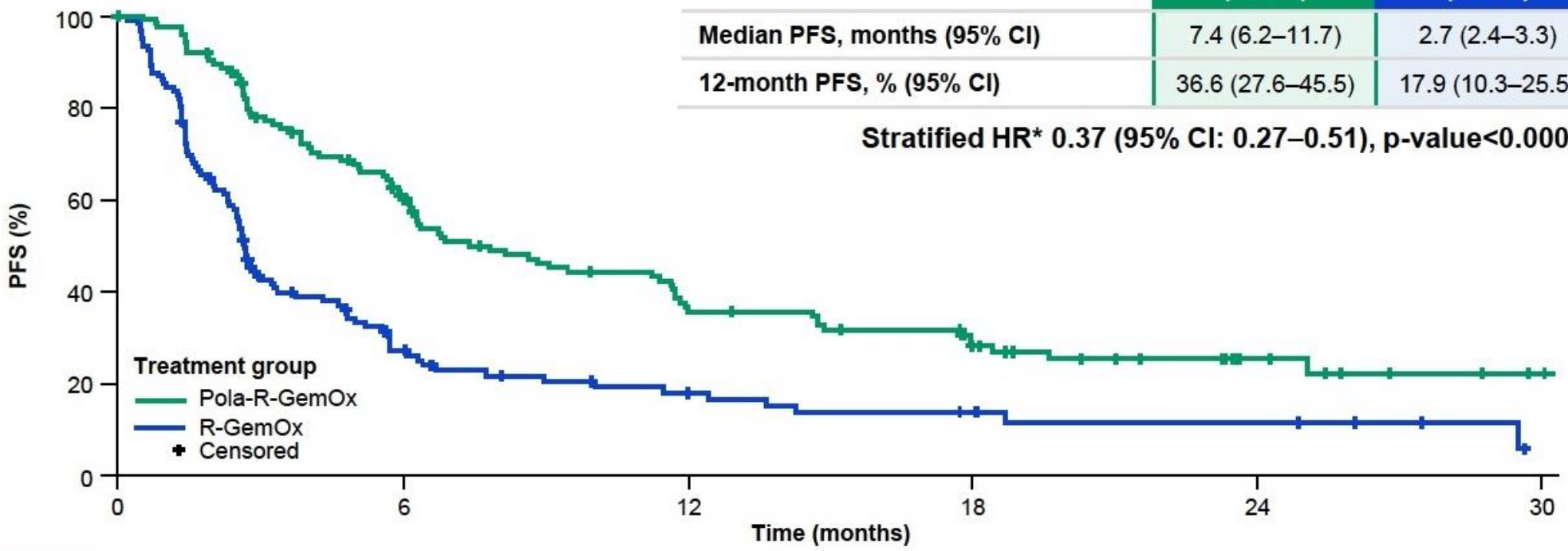
Matasar M et al. EHA 2025;Abstract S101.

Phase III POLARGO: Progression-Free Survival

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†



	0	6	12	18	24	30
Pola-R-GemOx	129	69	38	23	9	2
R-GemOx	126	26	14	8	5	NE

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.

Matasar M et al. EHA 2025;Abstract S101.

RTP RESEARCH TO PRACTICE

Phase III POLARGO: Select 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.

Matasar M et al. EHA 2025;Abstract S101.

RTP RESEARCH TO PRACTICE

Phase III POLARGO: Peripheral Neuropathy

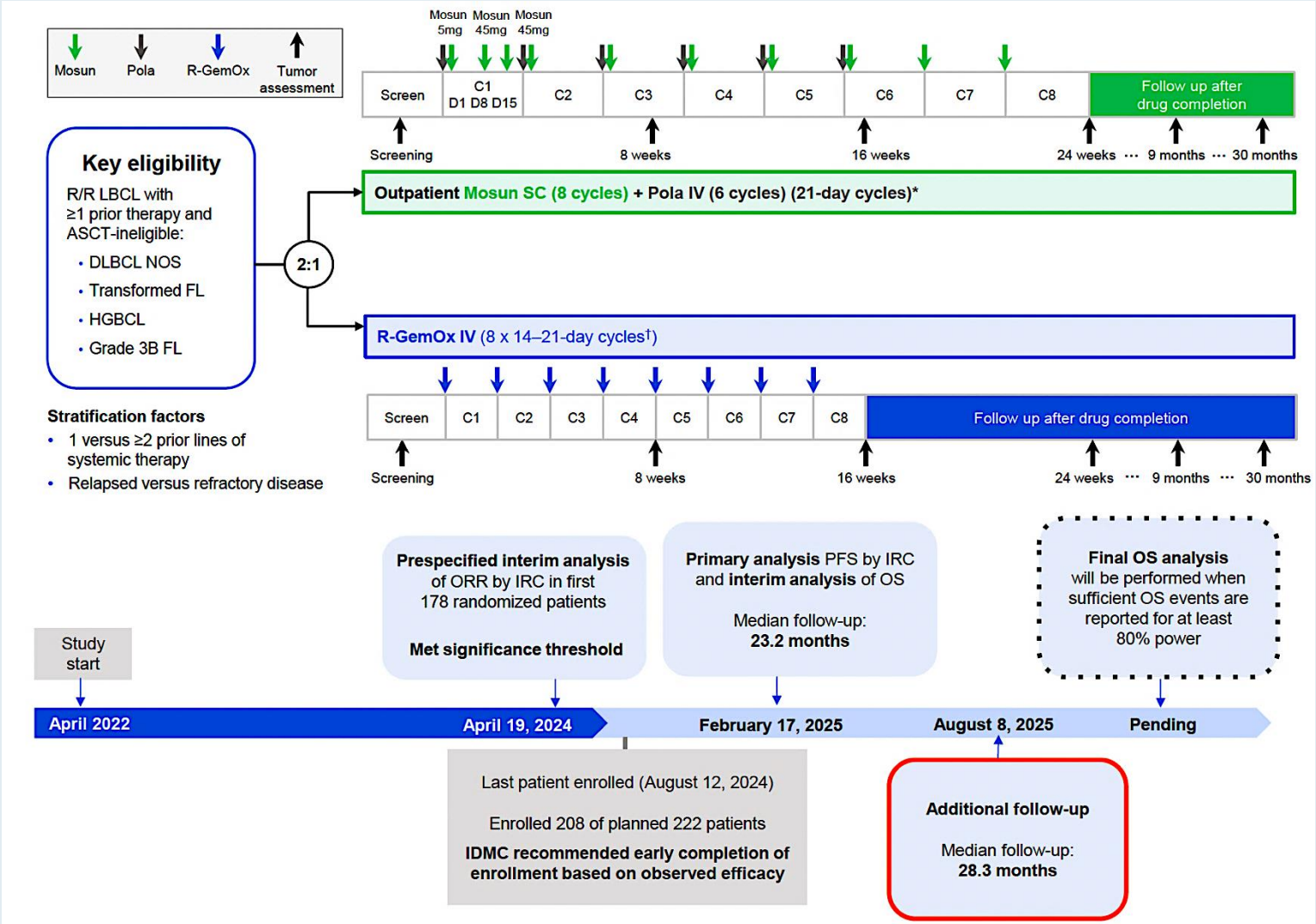
n (%), unless otherwise specified	Pola-R-GemOx (n=128)	R-GemOx (n=125)
Any Grade PN*	73 (57.0)	36 (28.8)
Grade 1	48 (37.5)	29 (23.2)
Grade 2	20 (15.6)	7 (5.6)
Grade 3	5 (3.9)	0
Median time to onset, months (range)	1.6 (0–8.0)	0.9 (0–4.4)
PN AEs leading to any study drug discontinuation	4 (3.1)	0
Polatuzumab 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.

Matasar M et al. EHA 2025;Abstract S101.

RTP RESEARCH TO PRACTICE

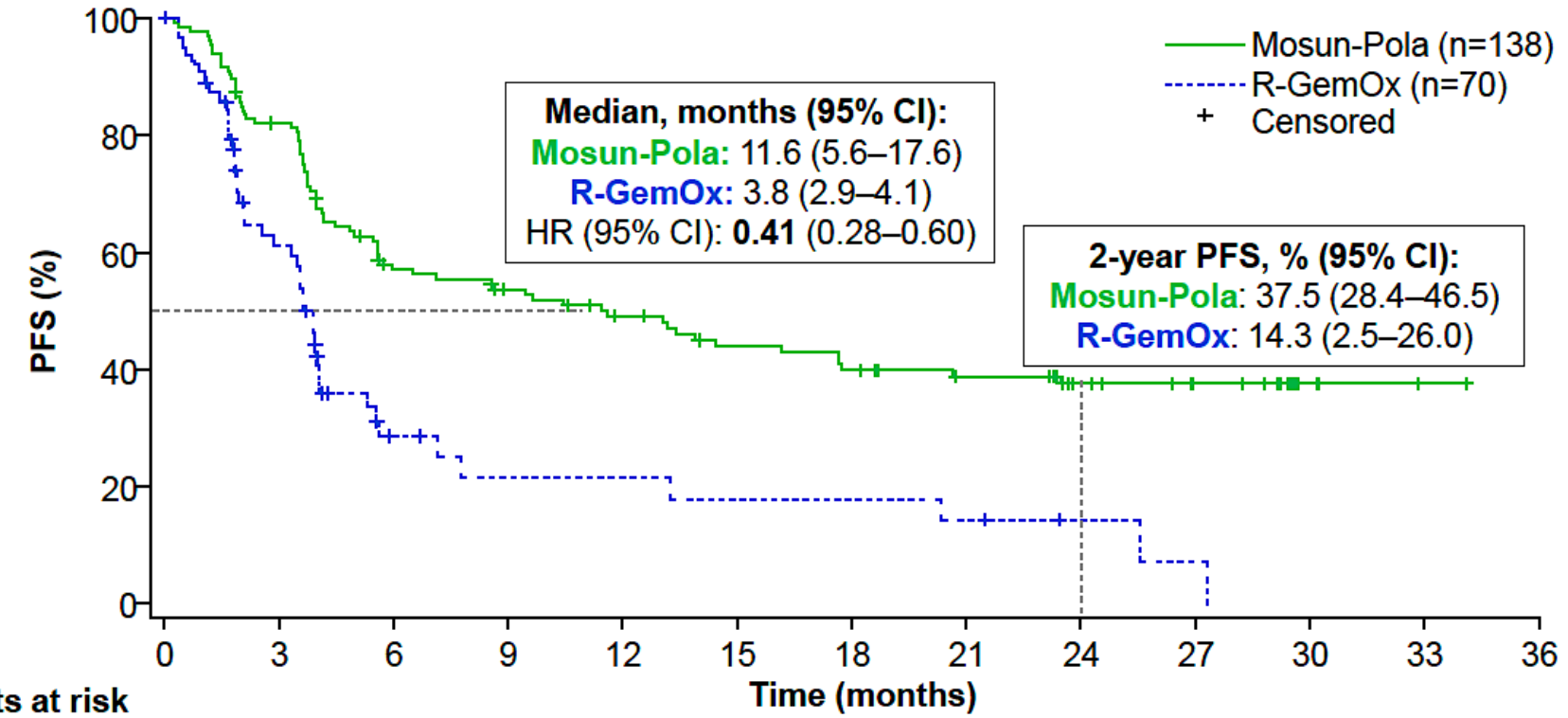
Phase III SUNMO Study Design



*Corticosteroid premedication was administered prior to each dose in C1 and was optional in subsequent cycles; †14-day cycles unless delayed to 21-day cycles if needed in case of hematologic toxicity. C, cycle; D, day; DLBCL NOS, diffuse large B-cell lymphoma, not otherwise specified; FL, follicular lymphoma; HGBCL, high-grade B-cell lymphoma; IDMC, Independent Data Monitoring Committee; IV, intravenous; SC, subcutaneous.

Budde LE et al. EHA 2026;Abstract PF968.

Phase III SUNMO Primary Endpoint: PFS by IRC in the Intention-to-Treat Population (28.3-Month Follow-Up)



No. of patients at risk

Mosun-Pola	138	108	67	59	51	43	39	33	23	16	5	1	NE
R-GemOx	70	33	9	6	6	5	5	4	2	1	NE	NE	NE

PFS is censored at earliest of NALT or two or more missing tumor assessments, whichever occurred first.
NALT, new anti-lymphoma therapy; NE, not evaluable; NR, not reached.

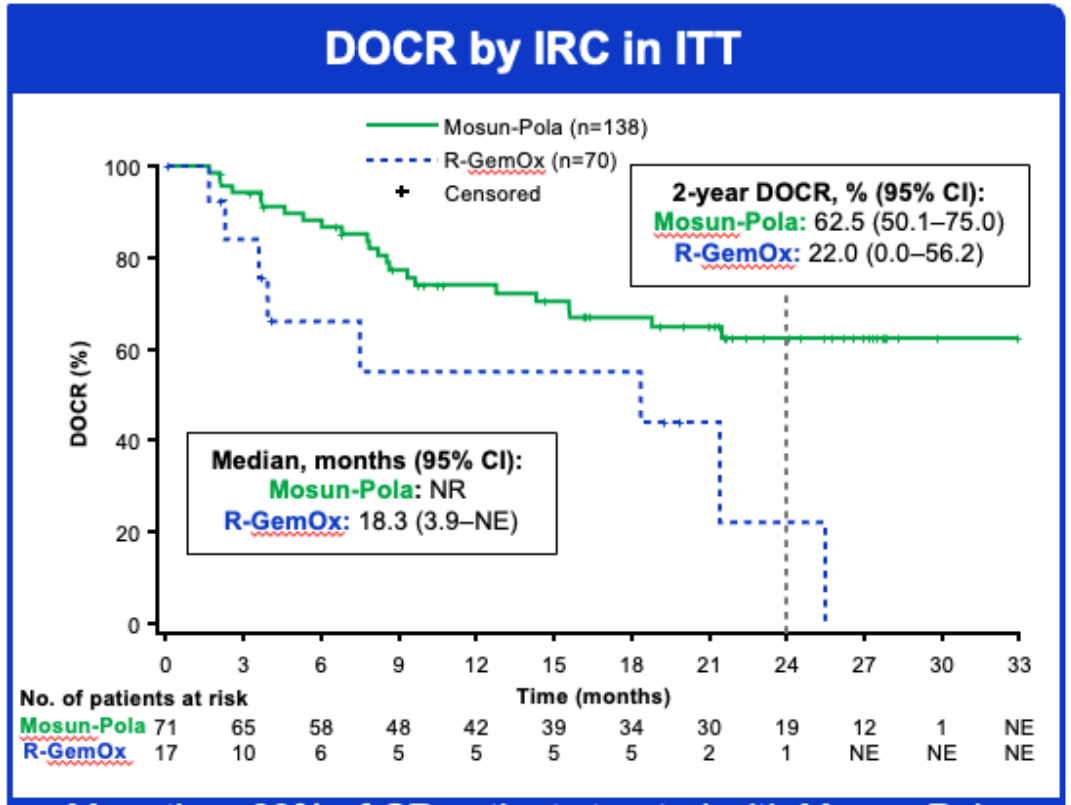
Efficacy and safety of mosun-pola were comparable across age groups

Budde LE et al. EHA 2026;Abstract PF968.

RTP RESEARCH TO PRACTICE

Phase III SUNMO: Overall Response Rate and Duration of Complete Response

IRC-assessed efficacy % (95% CI), unless otherwise stated	Mosun-Pola (n=138)	R-GemOx (n=70)
ORR	70.3% (61.9–77.8)	40.0% (28.5–52.4)
CR	51.4% (42.8–60.0)	24.3% (14.8–36.0)
DOR		
Median, months	18.8 (11.5–NE)	6.0 (3.7–23.9)
2-year rate	47.9% (37.0–58.8)	15.4% (0.0–39.8)
DOCR		
Median, months	NR	18.3 (3.9–NE)
2-year rate	62.5% (50.1–74.9)	22.0% (0.0–56.2)



More than 60% of CR patients treated with Mosun-Pola remained in remission at 2 years after CR

Clinical cut-off date: August 8, 2025.
DOCR, duration of complete response; DOR, duration of response; NR, not reached.

Kim W et al. ASCO 2026;Abstract 7007.

RTP RESEARCH TO PRACTICE

Phase III SUNMO: Efficacy in the Second-Line Setting

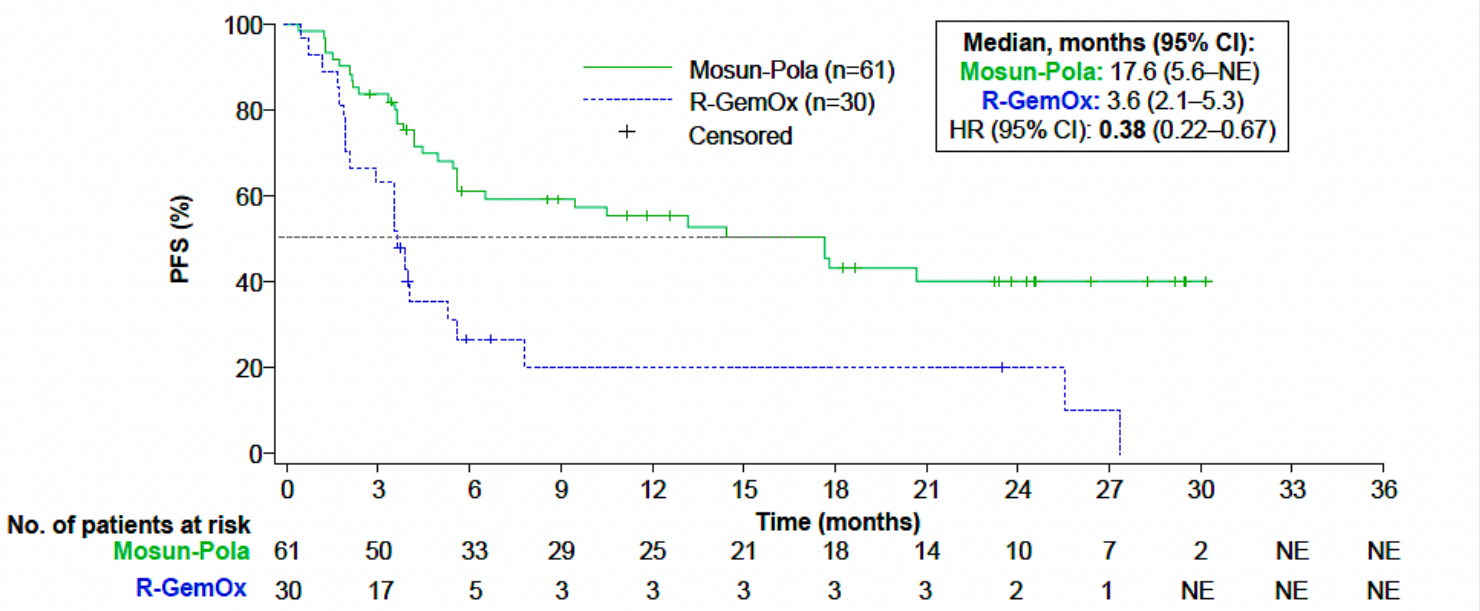


Table 3. Summary of IRC-assessed efficacy endpoints in the 2L setting

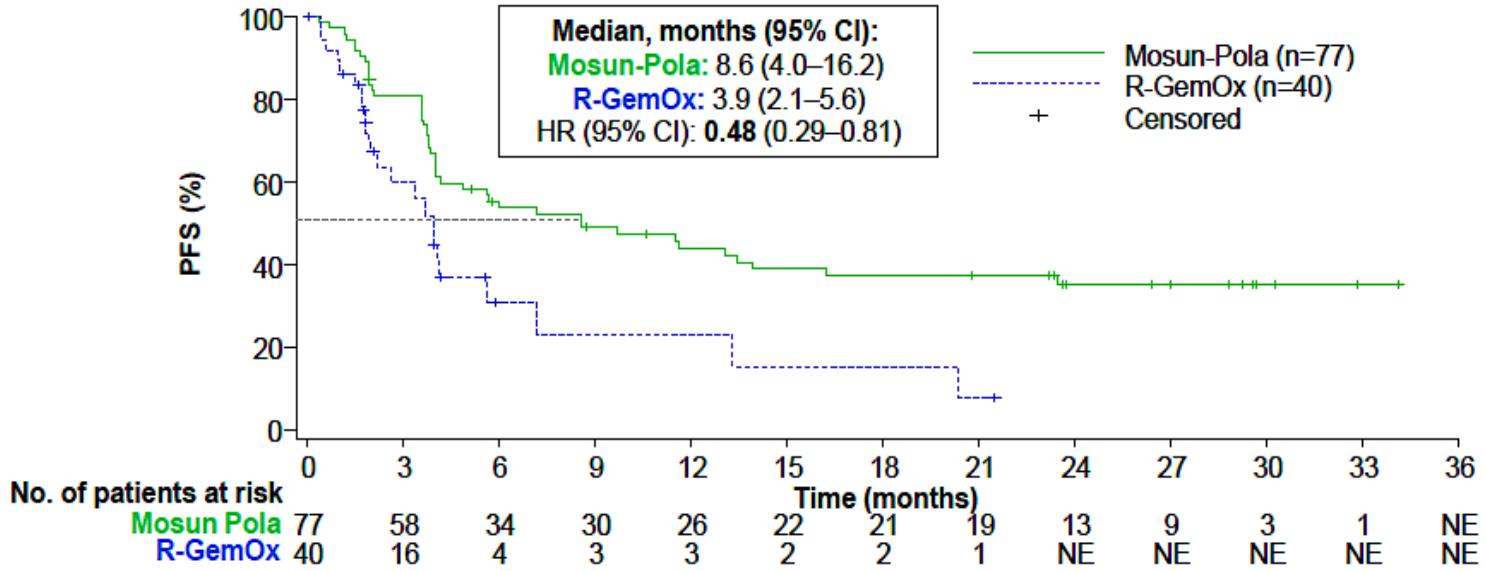
% (95% CI), unless otherwise stated	2L Mosun-Pola (n=61)	2L R-GemOx (n=30)
Median PFS, months (95% CI)	17.6 (5.6–NE)	3.6 (2.1–5.3)
ORR	75.4% (62.7–85.5)	36.7% (19.9–56.1)
CR	60.7% (47.3–72.9)	20.0% (7.7–38.6)
Median DOR, months (95% CI)	18.8 (11.3–NE)	6.0 (3.9–NE)
Median DOCR, months (95% CI)	NR (15.6–NE)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

ORR = objective response rate; CR = complete response;
DOR = duration of response; DOCR = duration of complete response

Budde LE et al. EHA 2026;Abstract PF968.

RTP RESEARCH TO PRACTICE

Phase III SUNMO: Efficacy in the Third-Line and Beyond Setting



% (95% CI), unless otherwise stated	3L+ Mosun-Pola (n=77)	3L+ R-GemOx (n=40)
Median PFS, months (95% CI)	8.6 (4.0–16.2)	3.9 (2.1–5.6)
ORR	66.2% (54.6–76.6)	42.5% (27.0–59.1)
CR	44.2% (32.8–55.9)	27.5% (14.6–43.9)
Median DOR, months (95% CI)	21.5 (9.5–NE)	5.4 (2.3–18.3)
Median DOCR, months (95% CI)	NR (21.5–NE)	7.5 (2.3–NE)

ORR = objective response rate

Budde LE et al. EHA 2026;Abstract PF968.

RTP RESEARCH TO PRACTICE

Phase III ECHELON-3 Study Design

Phase 3 in Relapsed/Refractory Diffuse Large B-Cell Lymphoma

Key inclusion criteria
- R/R DLBCL with eligible subtypes[a]
- Age ≥18 years
- **≥2 prior lines of therapy**
- **Ineligibility for or disease relapse following HSCT or CAR T-cell therapy**
- ECOG PS 0-2
- FDG-avid, measurable disease

Key exclusion criteria
- Prior BV or Len
- Active cerebral/meningeal disease
- Grade ≥2 peripheral neuropathy

Randomization 1:1

BV+Len+R (n=112)
BV 1.2 mg/kg IV Q3W + Len 20 mg PO QD + R 375 mg/m^2 IV Q3W[b]

Treatment groups[c]

Placebo+Len+R (n=118)
Placebo IV Q3W + Len 20 mg PO QD + R 375 mg/m^2 IV Q3W[b]

Stratification
- CD30 status (≥1% vs <1%)
- Cell of origin (GCB or non-GCB)
- Prior treatment with CAR-T therapy (received or not)
- Prior treatment with SCT (received or not)

Primary endpoint
- OS in ITT population

Secondary endpoints
- PFS_{INV} and ORR_{INV} using the response criteria per Lugano 2014 in ITT population
- CR $rate_{INV}$
- DOR_{INV}
- OS in CD30-positive population
- Safety and tolerability

- Per protocol, G-CSF prophylaxis was required

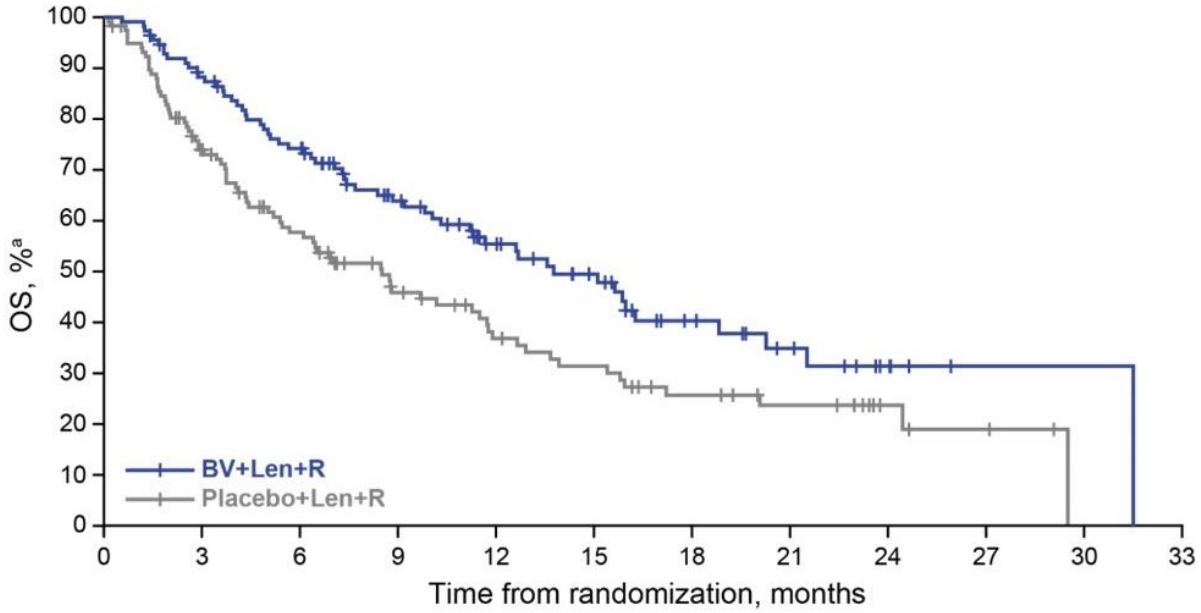
HSCT = hematopoietic stem cell transplantation; FDG = fluorodeoxyglucose; ITT = intent to treat; SCT = stem cell transplant

Kim JA et al. ASCO 2024;Abstract LBA7005.

RTP RESEARCH TO PRACTICE

Phase III ECHELON-3: Overall Survival (Primary Endpoint)

BV+Len+R reduced risk of death by 37% compared with placebo+Len+R



No. at risk												
BV+Len+R	112	96	79	57	40	30	17	11	5	1	1	0
Placebo+Len+R	118	81	58	39	28	23	16	12	5	3	0	0

	BV+Len+R (n=112)	Placebo+Len+R (n=118)
OS, median (95% CI), months	**13.8** (10.3-18.8)	**8.5** (5.4-11.7)
Hazard ratio (95% CI)[b]	0.629 (0.445-0.891)	
Log-rank *P* value[c]	.0085	
Events (deaths)	58	76
Follow-up, median (95% CI), months	15.5 (12.2-18.1)	18.9 (12.2-23.2)

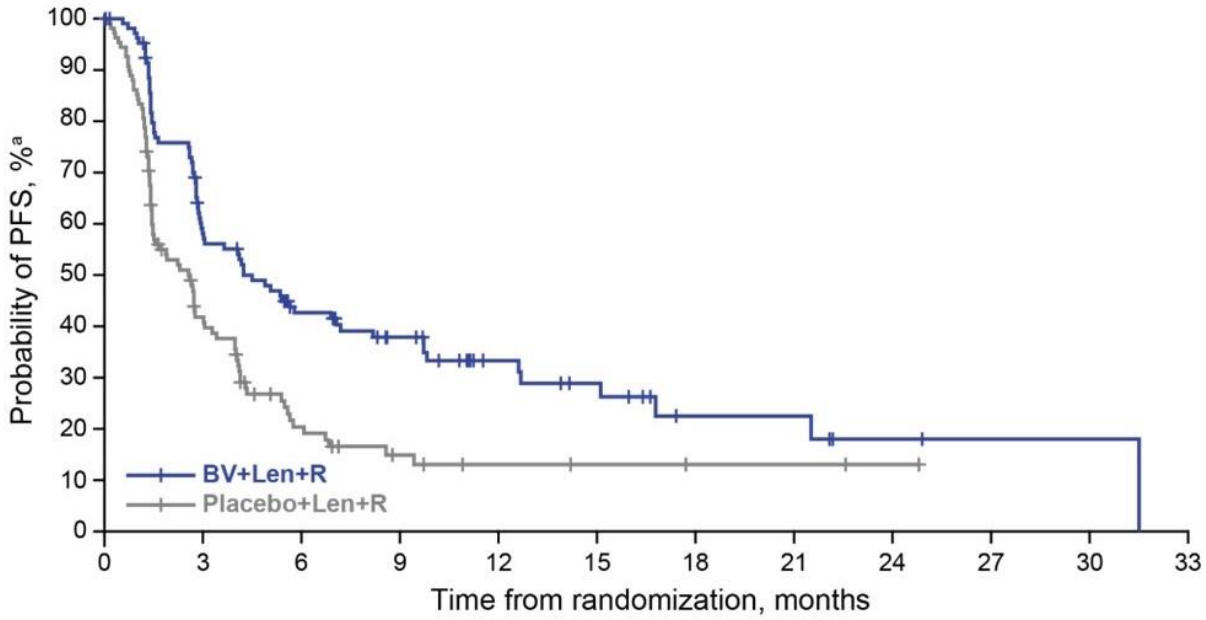
- BV+Len+R prolonged median OS by 5.3 months compared with placebo+Len+R
- Prespecified O'Brien-Fleming efficacy boundary was crossed at this interim analysis

Kim JA et al. ASCO 2024;Abstract LBA7005.

RTP RESEARCH TO PRACTICE

Phase III ECHELON-3: PFS (Key Secondary Endpoint)

BV+Len+R reduced risk of disease progression or death by 47% compared with placebo+Len+R



No. at risk												
BV+Len+R	112	58	38	27	15	11	5	5	2	1	1	0
Placebo+Len+R	118	40	16	8	4	3	2	2	1	0	0	0

	BV+Len+R (n=112)	Placebo+Len+R (n=118)
PFS, median (95% CI), months	**4.2** (2.9-7.1)	**2.6** (1.4-3.1)
Hazard ratio (95% CI)[b]	0.527 (0.380-0.729)	
Log-rank *P* value[c]	<.0001	
Events	71	85
Follow-up, median (95% CI), months	11.1 (8.6-14.2)	8.8 (6.9-10.9)

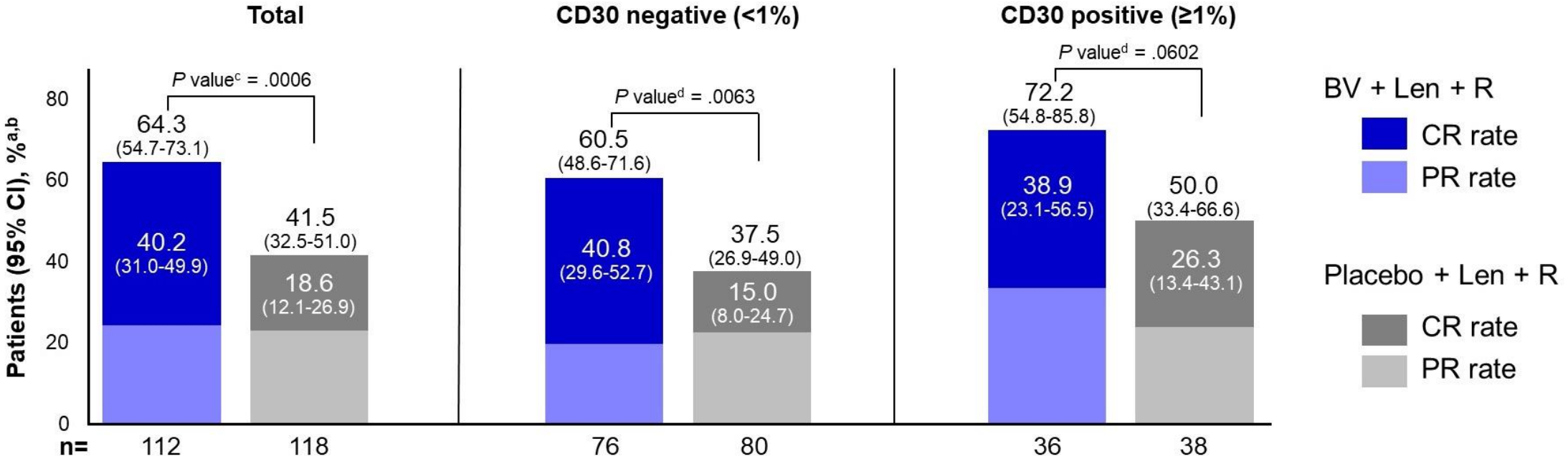
- PFS was an alpha controlled key secondary endpoint

Kim JA et al. ASCO 2024;Abstract LBA7005.

RTP RESEARCH TO PRACTICE

Phase III ECHELON-3: Responses

40% CR rate with BV+Len+R and ORR improvement regardless of CD30 expression

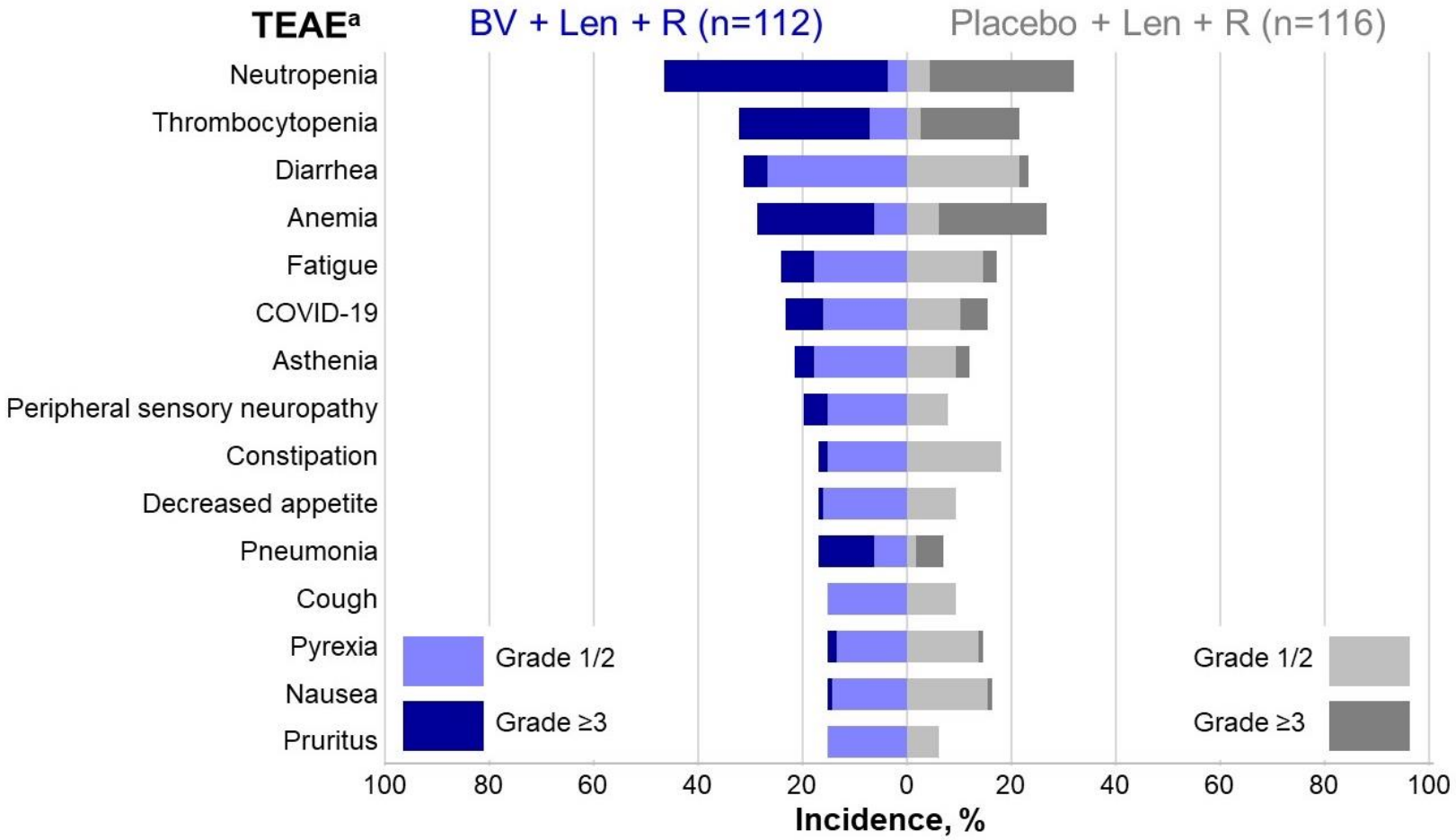


- In the total population, the median DOR (95% CI) was longer with BV+Len+R: 8.3 months (4.2-15.3 months) vs 3.0 months (2.8-5.4 months)
  - In patients who had a CR, the median DOR (95% CI) was 18.9 months (11.1 months-NR) with BV+Len+R and NR (2.8 months-NR) with placebo+Len+R
  - The median time to CR onset (range) was 1.58 months (1.2-7.3 months) with BV+Len+R and 1.61 months (0.7-4.6 months) with placebo+Len+R

Kim JA et al. ASCO 2024;Abstract LBA7005.

RTP RESEARCH TO PRACTICE

Phase III ECHELON-3: Safety

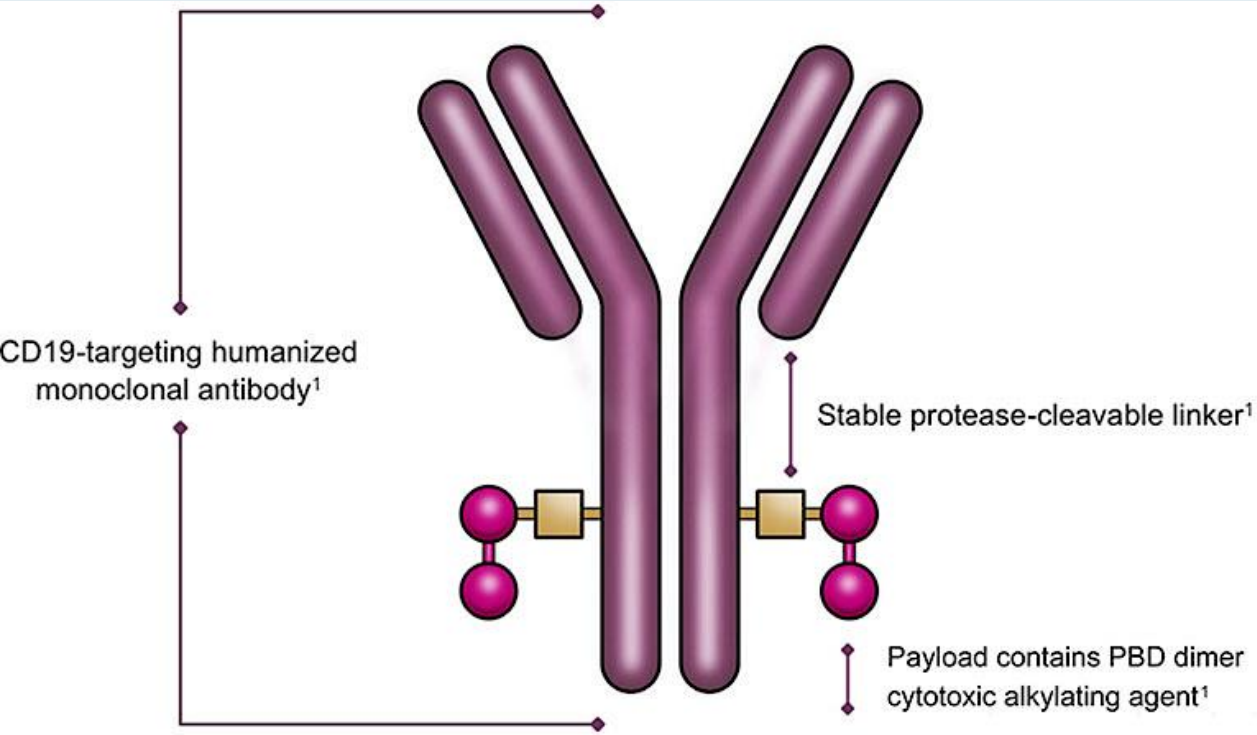


- TEAEs of any grade occurred in 97% of patients with each treatment
- Grade ≥3 TEAEs:
  - 88% with BV+Len+R
  - 77% with placebo+Len+R
  - 9% febrile neutropenia in each group
- Grade 5 TEAEs:
  - 12% with BV+Len+R
  - 8% with placebo+Len+R
- Any grade peripheral neuropathy TEAEs
  - 31% with BV+Len+R
  - 24% with placebo+Len+R
- Relative dose intensity
  - 94.4% for BV
  - 99.7% for placebo

Kim JA et al. ASCO 2024;Abstract LBA7005.

RTP RESEARCH TO PRACTICE

Loncastuximab Tesirine: A CD19-Directed Antibody-Drug Conjugate



Upon binding to CD19, Loncastuximab tesirine is internalized into the tumor cell and the PBD dimer cytotoxin is released into the cell[1]

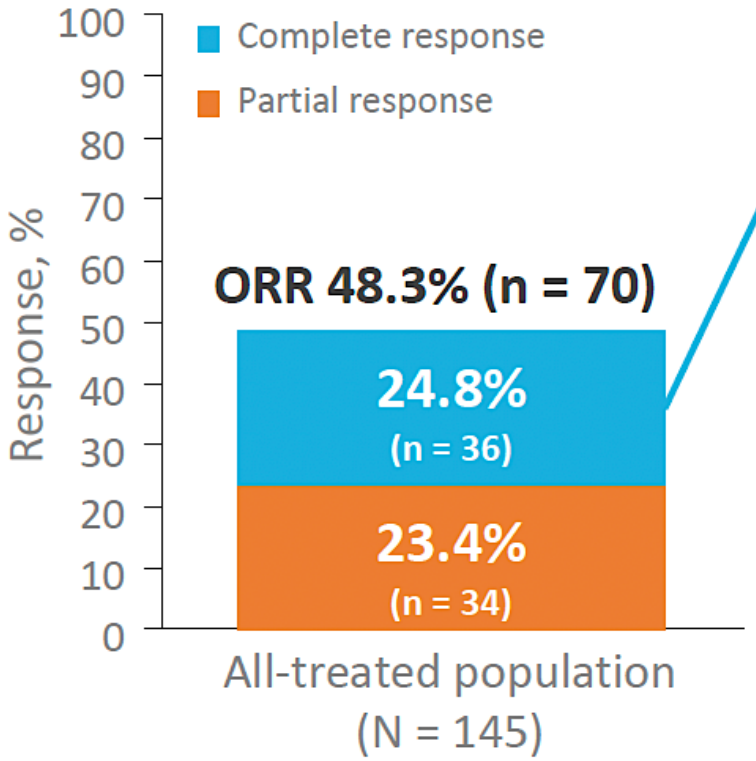
PBD dimer—an alkylating agent—binds to the DNA minor groove and forms highly cytotoxic DNA interstrand crosslinks[1]

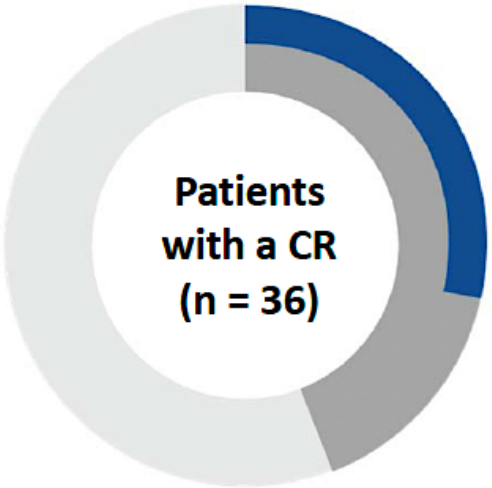
DNA interstrand crosslinks subsequently induce tumor cell death[1]

ADC = antibody-drug conjugate; PBD = pyrrolobenzodiazepine.

[Loncastuximab tesirine manufacturer prescribing information].

Phase II LOTIS-2 Study: Overall Response Rate (ORR) and Long-Term Responses — 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.

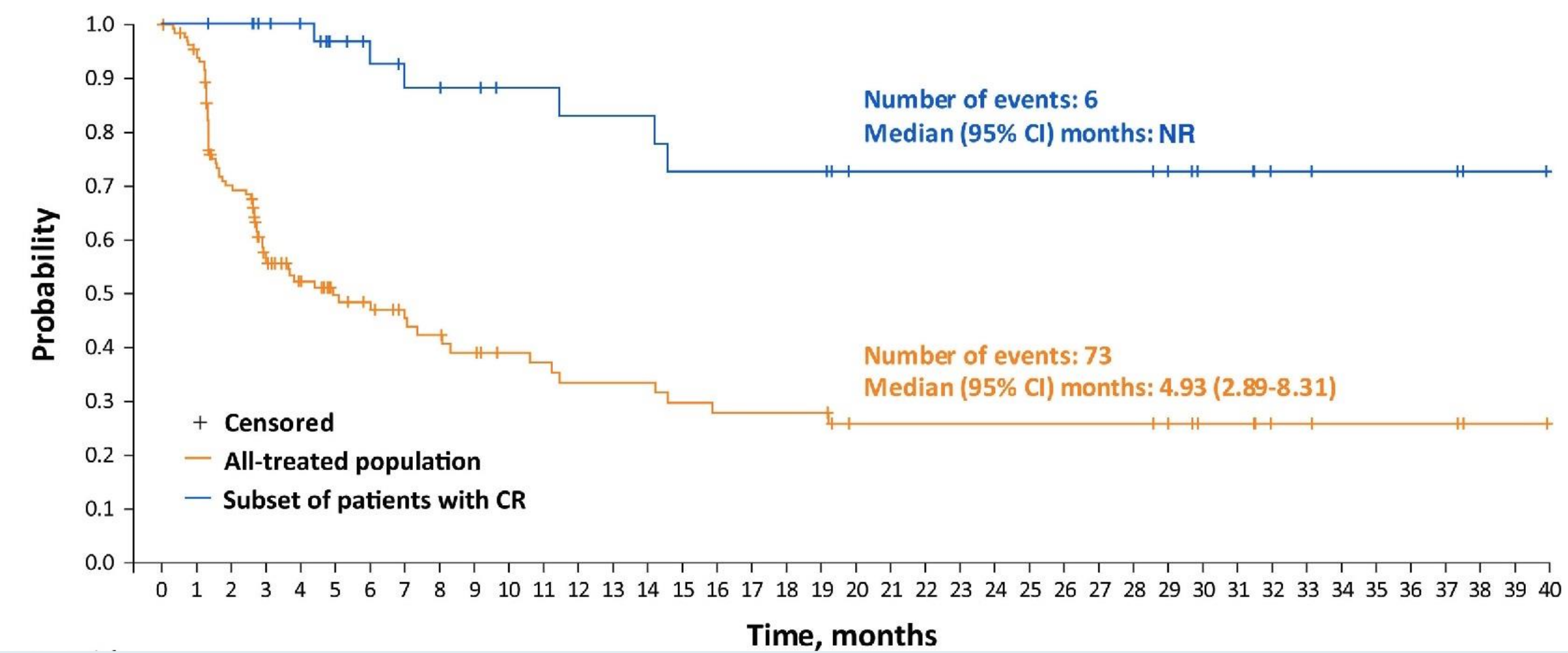
Median (range) number of treatment cycles	
All-treated population	3.0 (1-26)
Pts with a CR	8.0 (1-26)
Pts with a CR, event-free ≥1 year[a]	12.5 (1-26)
Pts with a CR, event-free ≥2 years[a]	13.0 (1-22)

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

Caimi PF et al. EHA 2023;Abstract P1132.

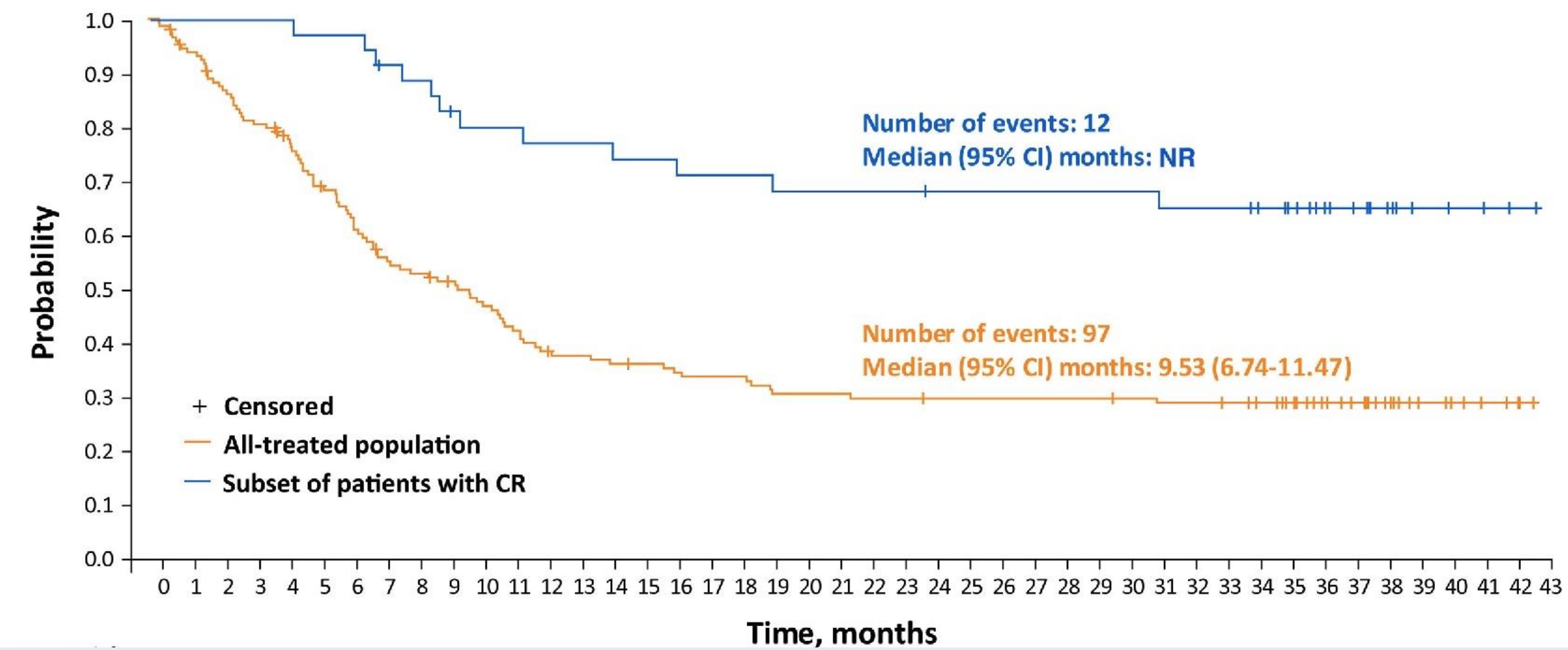
RTP RESEARCH TO PRACTICE

Phase II LOTIS-2: Progression-Free Survival



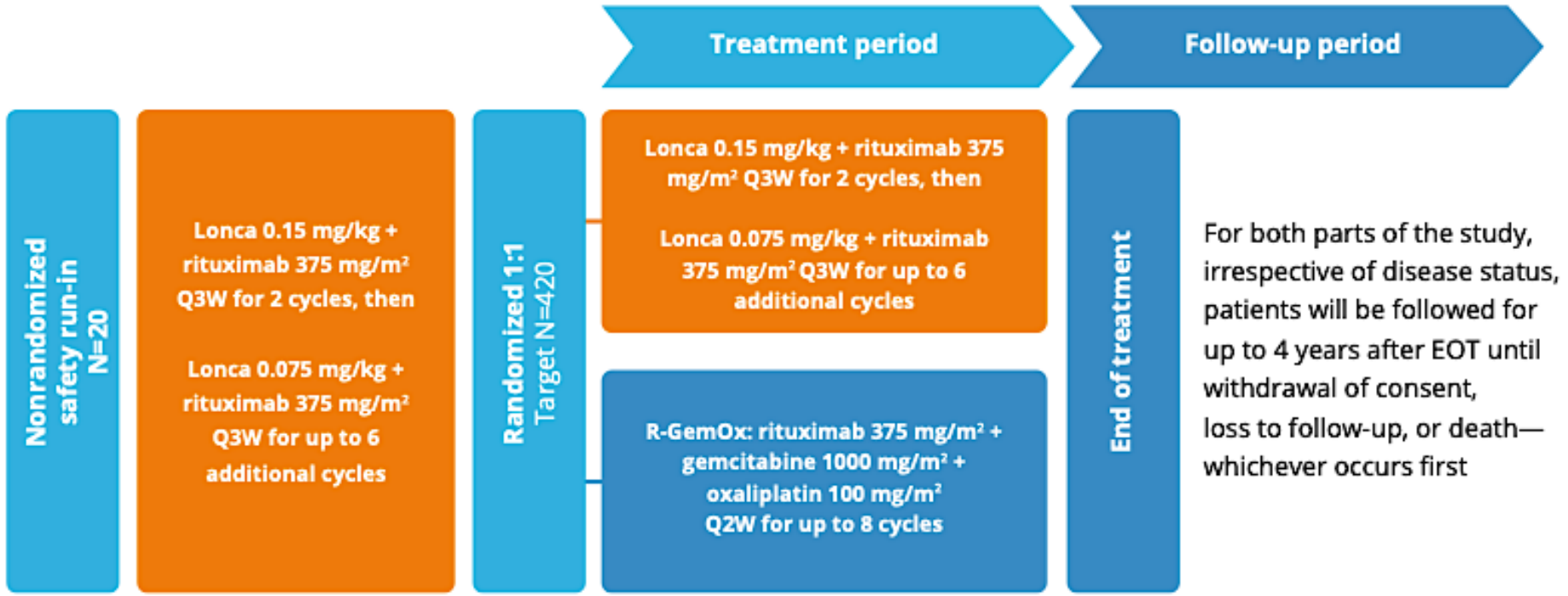
Caimi PF et al. *Haematologica* 2024 April 1;109(4):1184-93.

Phase II LOTIS-2: Overall Survival



Caimi PF et al. *Haematologica* 2024 April 1;109(4):1184-93.

Phase III LOTIS-5 Study Design



EOT, end of treatment; Lonca, loncastuximab tesirine; QXW, every X weeks.

Study Endpoints

- The primary endpoint is progression-free survival (PFS) by independent central review
- Secondary endpoints include OS, overall response rate (ORR), CR rate, duration of response (DOR), safety, PK parameters, Lonca ADAs, and patient-reported outcomes (PROs)
- Exploratory endpoints include correlations between clinical activity and Lonca exposure (ie, Lonca dose and PK metrics) and tumor and/or blood biomarkers

Carlo-Stella C et al. EHA 2025;Abstract PS1957.

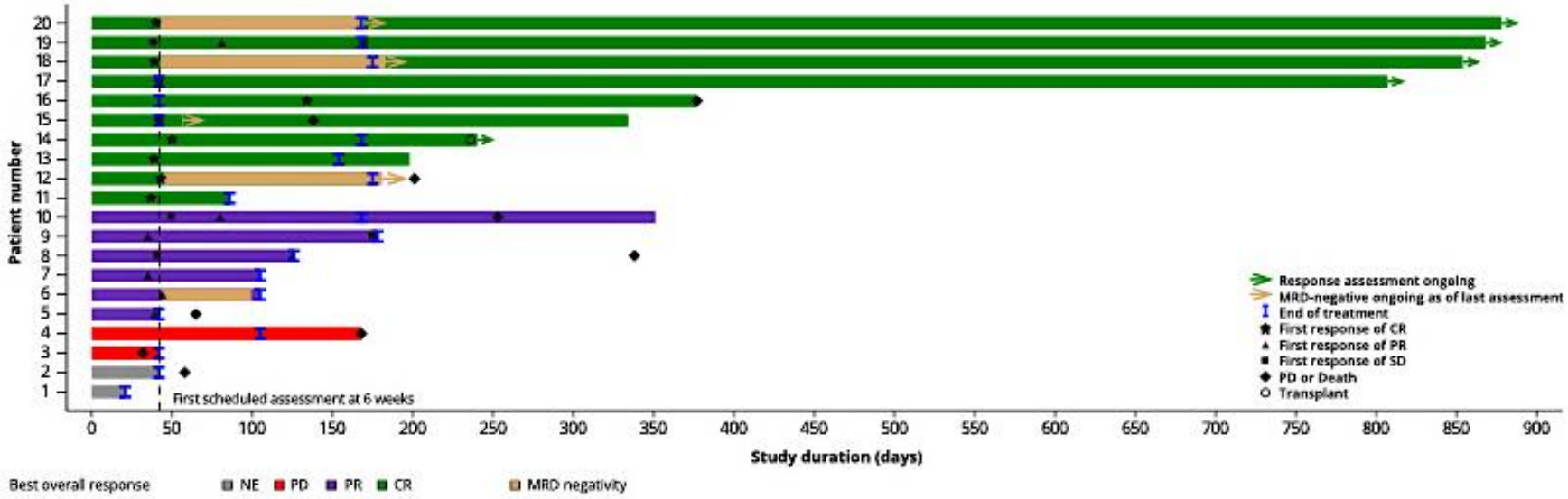
RTP RESEARCH TO PRACTICE

Phase III LOTIS-5: Efficacy

Efficacy outcomes in safety run-in population (N=20)	
ORR (95% CI), %	80.0 (56.3-94.3)
CRR (95% CI), %	50.0 (27.2-72.8)
Median PFS (95% CI), months	8.3 (4.5-NE)
Efficacy outcomes in responders (n=16)	
Median DOR (95% CI), months	8.02 (3.19-NE)
Events, n (%)	5 (31.3)
Efficacy outcomes in complete responders (n=10)	
Median DOR, months (95% CI)	NE (3.19-NE)
Events, n (%)	3 (30.0)
MRD results in patients with ctDNA measurements (n=8)	
CR and MRD negative, n (%)	4 (50.0)
MRD negative at end of treatment, n (%)	4 (50.0)

CRR, complete response rate; ctDNA, circulating tumor DNA; DOR, duration of response; MRD, minimal residual disease; NE, not estimable; ORR, overall response rate; PFS, progression-free survival.

Figure 2. Swimmer plot of safety run-in population (N=20)



Each bar represents one patient in the study. Response is determined by independent reviewer.
CR, complete response; MRD, minimal residual disease; NE, not estimable; PD, progressive disease; PR, partial response.

Carlo-Stella C et al. EHA 2025;Abstract PS1957.

RTP RESEARCH TO PRACTICE

Phase III LOTIS-5: Safety

Safety endpoint, n (%)	N=20
All grade TEAE	20 (100)
Grade ≥3 TEAE	11 (55)
GGT increased	5 (25)
Neutropenia	4 (20)
COVID-19/COVID-19 pneumonia	3 (15)
Alanine aminotransferase increased	1 (5)
Anemia	1 (5)
Aspartate aminotransferase increased	1 (5)
Blood alkaline phosphatase increased	1 (5)
Cataract	1 (5)
Cellulitis gangrenous	1 (5)
Cytomegalovirus infection reactivation	1 (5)
Hyponatremia	1 (5)
Malaise	1 (5)
Neurological decompensation	1 (5)
Photosensitivity reaction	1 (5)
Pleural effusion	1 (5)
Tumor lysis syndrome	1 (5)
Urinary tract infection	1 (5)
Serious adverse events	9 (45)
Infection	6 (30)
Hyponatremia	1 (5)
Anaphylactic reaction	1 (5)
Pleural effusion	1 (5)
Malaise	1 (5)
Neurological decompression	1 (5)
TEAEs leading to any study drug withdrawal	8 (40)

GGT, gamma-glutamyl transferase; TEAE, treatment-emergent adverse event.

Carlo-Stella C et al. EHA 2025;Abstract PS1957.

RTP RESEARCH TO PRACTICE

Results from LOTIS-5 Phase III Confirmatory Clinical Trial of Loncastuximab Tesirine-lpyl in Combination with Rituximab for R/R DLBCL
Press Release: June 3, 2026

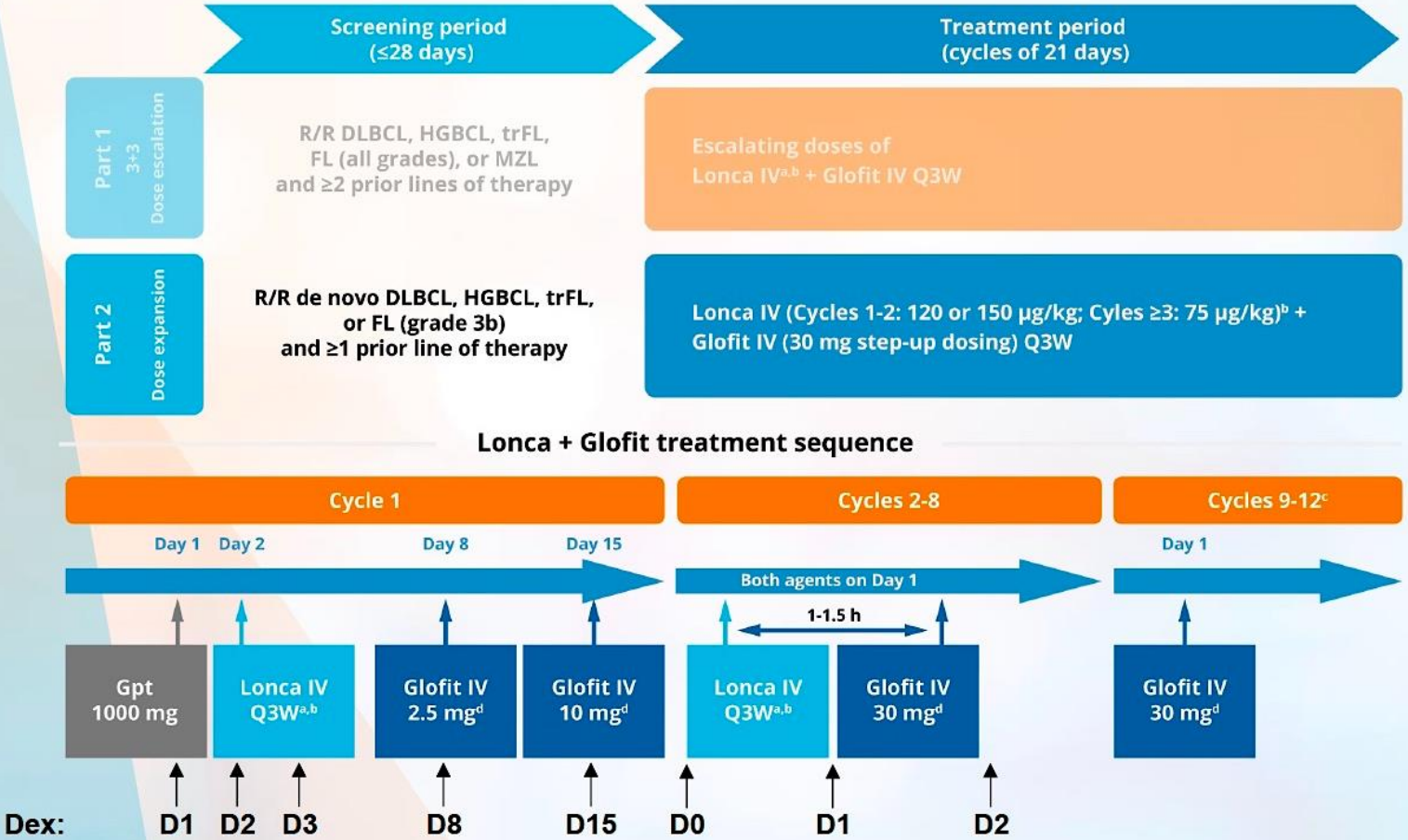
"[The manufacturer] today announced topline data from its **Phase 3 LOTIS-5 confirmatory trial** evaluating loncastuximab tesirine-lpyl in combination with rituximab in patients with relapsed or refractory diffuse large B-cell lymphoma (r/r DLBCL). **Loncastuximab tesirine-lpyl plus rituximab achieved statistical significance on the trial's primary endpoint of progression-free survival (PFS) and demonstrated no detrimental effect on the key secondary efficacy endpoint of overall survival (OS).** In addition, a higher complete response (CR) rate and duration of CRs (DoCR) were observed with loncastuximab tesirine-lpyl plus rituximab.

Overall, treatment emergent adverse event (TEAE) rates were similar between arms. Similar rates of overall Grade ≥3 TEAEs greater than 5% were observed across both arms, with hematologic TEAEs higher in the control arm and infection, hepatotoxicity, and edema/effusion higher in the test arm. Serious adverse events (SAEs), TEAEs leading to study drug withdrawal, and Grade 5 events were higher in the test arm, with the majority of Grade 5 TEAEs in the test arm occurring in patients aged 75 years or older."

https://ir.adctherapeutics.com/2026-06-03-ADC-Therapeutics-Announces-Results-From-LOTIS-5-Phase-3-Confirmatory-Clinical-Trial-of-ZYNLONTA-R-in-Combination-with-Rituximab-in-Relapsed-or-Refractory-Diffuse-Large-B-Cell-Lymphoma

RTP RESEARCH TO PRACTICE

Phase Ib LOTIS-7 Study Design



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. ICML 2025;Abstract 078.

RTP RESEARCH TO PRACTICE

Phase Ib LOTIS-7 Initial Results: Safety Outcomes

TREATED POPULATION (N=41)

	120 µg/kg[b] n=20	150 µg/kg[b] n=21	All n = 41
Grade 3/4 TEAEs (> 5% of patients)[a]	**11 (55%)**	**12 (57.1%)**	**23 (56.1%)**
Neutropenia	4 (20%)	6 (28.6%)	10 (24.4%)
Anemia	1 (5%)	3 (14.3%)	4 (9.8%)
AST increased	2 (10%)	1 (4.8%)	3 (7.3%)
GGT increase	1 (5%)	2 (9.5%)	3 (7.3%)
Thrombocytopenia	2 (10%)	1 (4.8%)	3 (7.3%)
Grade 3/4 AESI (all patients)[a]			
Febrile neutropenia	0	1 (4.8%)	1 (2.4%)
Thrombocytopenia	2 (10%)	1 (4.8%)	3 (7.3%)
GGT increase	1 (5%)	2 (9.5%)	3 (7.3%)
Generalized oedema	1 (5%)	1 (4.8%)	2 (4.9%)
Rash	1 (5%)	0	1 (2.4%)
Photosensitivity reaction	0	1 (4.8%)	1 (2.4%)
Sepsis	1 (5%)	0	1 (2.4%)
Upper respiratory infection	1 (5%)	0	1 (2.4%)
Pneumonia	1 (5%)	0	1 (2.4%)
Serious TEAE	**11 (55%)**	**9 (42.9%)**	**20 (48.8%)**
No Grade 5 TEAEs occurred			

[a]As per Investigator reported adverse events. [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.
TEAE = treatment emergent adverse event; AESI = adverse event of special interest | Data cutoff: 14 Apr 2025. Data extracted from live clinical database. Data is subject to change.

Alderuccio JP et al. ICML 2025;Abstract 078.

Phase Ib LOTIS-7 Initial Results: CRS and ICANS

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.

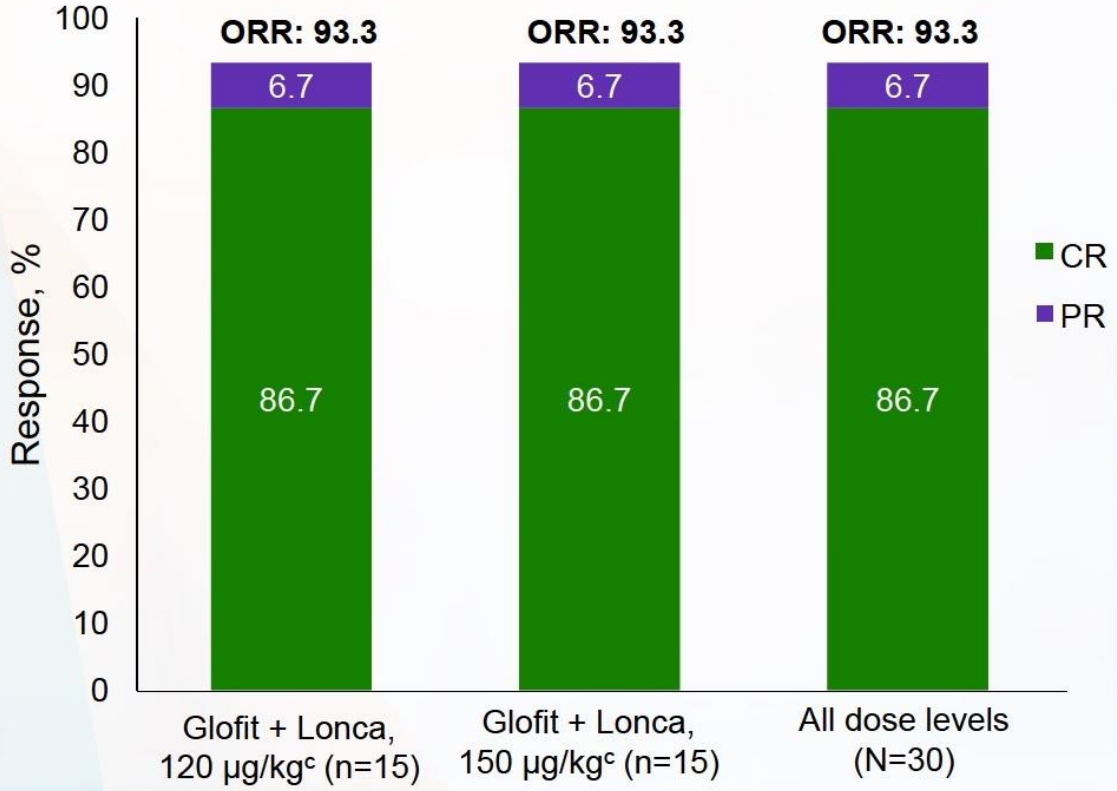
Alderuccio JP et al. ICML 2025;Abstract 078.

RTP RESEARCH TO PRACTICE

Phase Ib LOTIS-7 Initial Results: Best Overall Responses, DoR

EFFICACY EVALUABLE POPULATION (N=30)[a]

Best overall response[b]



Duration of response

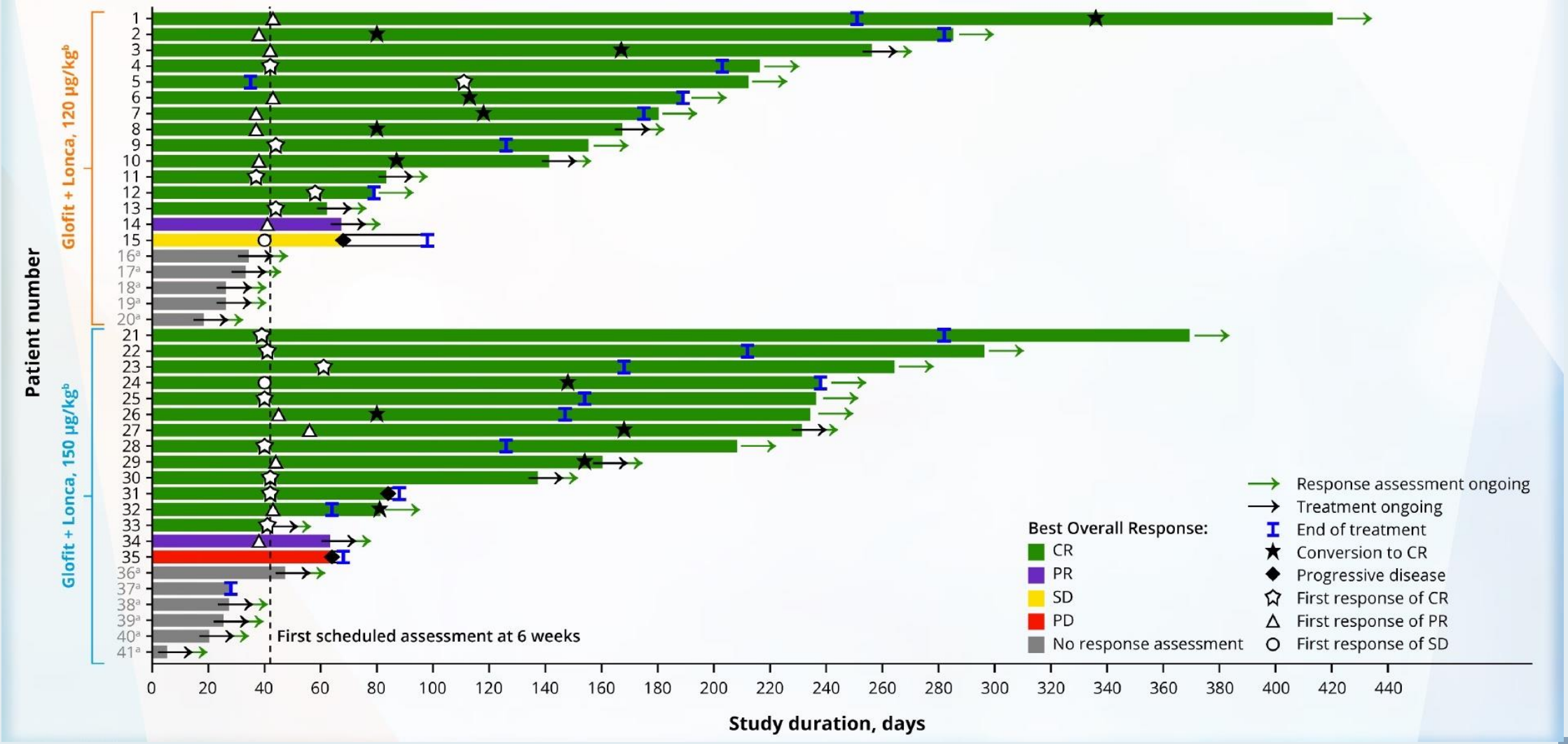
Characteristic, n (%)	Glofit + Lonca, 120 µg/kg[c] (n=15)	Glofit + Lonca, 150 µg/kg[c] (n=15)	All dose levels (N=30)
DOR[d] Median	(n=14) NE	(n=14) NE	(n=28) NE
Time to first response (CR or PR) Median, days	(n=14) 42.0	(n=14) 42.0	(n=28) 42.0
Time to first CR Median, days	(n=13) 80.0	(n=13) 42.0	(n=26)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

Data cutoff: April 14, 2025.
CR, complete response; DOR, duration of response; Glofit, glofitamab; Lonca, 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 Lonca 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. ICML 2025;Abstract 078.

RTP RESEARCH TO PRACTICE

Phase Ib LOTIS-7 Initial Results: Efficacy over Time



Alderuccio JP et al. ICML 2025;Abstract 078.

Optimizing the Use of Novel Therapies for Patients with DLBCL

Module 1: Selection of First-Line Therapy for Patients with Diffuse Large B-Cell Lymphoma (DLBCL)

Module 2: Clinician Survey Results

Module 3: Current and Future Roles of Monoclonal and Bispecific Antibodies in Therapy for Relapsed/Refractory (R/R) DLBCL

Module 4: Clinician Survey Results

Module 5: Evidence-Based Incorporation of Antibody-Drug Conjugates into the Management of R/R DLBCL

Module 6: Clinician Survey Results

RTP RESEARCH TO PRACTICE

Outside of a clinical trial, would you partner polatuzumab vedotin with other systemic therapies beyond BR for patients with R/R DLBCL under any circumstances?

Dr Abramson	Yes, mosunetuzumab and glofitamab
Dr Flowers	Yes, mosunetuzumab
Dr Kamdar	Yes, mosunetuzumab and glofitamab
Dr LaCasce	Yes, mosunetuzumab and glofitamab
Dr Matasar	Yes, R-GemOx, R-ICE, mosunetuzumab and glofitamab
Dr Portell	Yes, mosunetuzumab
Prof Salles	Yes, mainly glofitamab
Dr Westin	Yes, mosunetuzumab

R-ICE = rituximab/ifosfamide/carboplatin/etoposide

RTP RESEARCH TO PRACTICE

Where in the treatment course do you typically employ loncastuximab tesirine for your patients with R/R DLBCL? Would you administer it to a patient who has experienced disease progression on one or more other CD19-directed approaches?

	When	After PD on other CD19-directed tx?
Dr Abramson	After CAR T and BsAb therapies	Yes, but only after assessing CD19 expression
Dr Flowers	Fourth line or later	Yes, but only after assessing CD19 expression
Dr Kamdar	After CAR T and BsAb therapies	Yes, but only after assessing CD19 expression
Dr LaCasce	After CD20 BsAb therapy	Yes, but only after assessing CD19 expression
Dr Matasar	3L+ especially post-CAR T with residual CD19+	Yes, but only after assessing CD19 expression
Dr Portell	Usually after CAR T or BsAbs	Yes, but only after assessing CD19 expression
Prof Salles	When first-line, CAR T and BsAb treatments have failed	Yes, but only after assessing CD19 expression
Dr Westin	If CAR T ineligible and unable/ unwilling/relapsed after BsAb	Yes, but only after assessing CD19 expression

PD = disease progression; BsAb = bispecific antibody

Approximately what proportion of your patients with R/R DLBCL receiving loncastuximab tesirine derive meaningful clinical benefit? What is the longest duration of response that you have observed with loncastuximab tesirine in your own practice?

	Patients with clinical benefit	Longest duration of response
Dr Abramson	30%	>1 year
Dr Flowers	15%	3 months
Dr Kamdar	20%	9 months
Dr LaCasce	10%	3 months
Dr Matasar	50%	4 years+
Dr Portell	30%	4 months
Prof Salles	30%	6 months
Dr Westin	45%	>1 year

Approximately what proportion of your patients with DLBCL receiving loncastuximab tesirine develop clinically significant peripheral edema? In general, how do you manage peripheral edema in patients who are receiving loncastuximab tesirine?

	Patients with significant peripheral edema	Management
Dr Abramson	25%	Dexamethasone prophylaxis, diuretics
Dr Flowers	40%	Add spironolactone; dose reduce
Dr Kamdar	30%	Dexamethasone prophylaxis, diuretics
Dr LaCasce	20%	Peri-drug dexamethasone per label, diuretics
Dr Matasar	25%	Diuretics
Dr Portell	50%	Steroids, spironolactone, compression stockings and holding drug
Prof Salles	20%	Diuretic and prophylactic steroids, then diuretic alone
Dr Westin	33%	Diuretics and steroids

AE = adverse event

Would you administer brentuximab vedotin/R^2 to a patient with CD30-negative R/R DLBCL?

Dr Abramson	Yes
Dr Flowers	No
Dr Kamdar	Yes
Dr LaCasce	No
Dr Matasar	No
Dr Portell	Yes
Prof Salles	No
Dr Westin	No

R^2 = lenalidomide/rituximab

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Questions?

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