

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

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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

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 ≤ 65 y with untreated non-germinal center B-cell–like (non-GCB) diffuse large B-cell lymphoma (DLBCL).** ASCO 2021;Abstract TPS7572.

Phase III POLARIX Study Design

Eligibility Criteria:

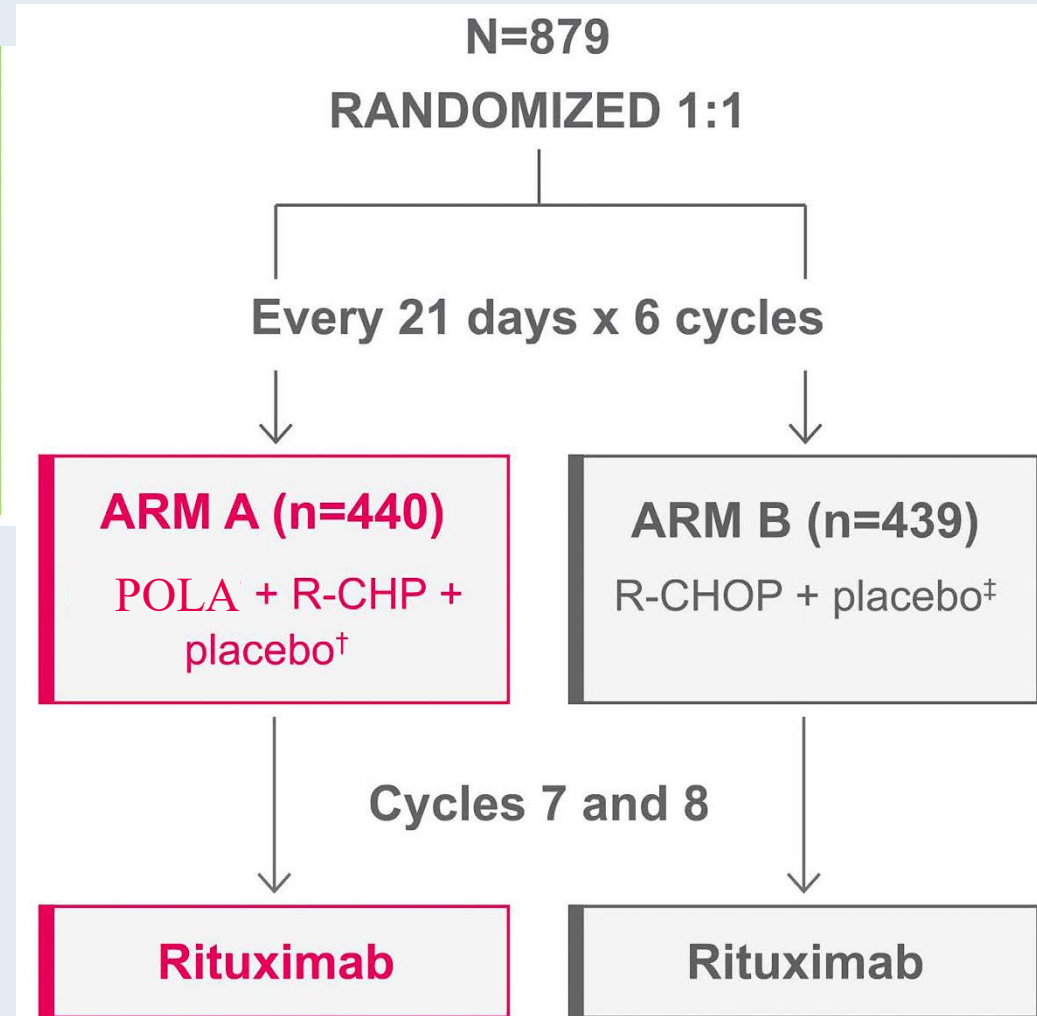
- Previously untreated LBCL
- Aged 18-80 years
- IPI score 2-5
- ECOG PS 0-2

Primary endpoint:

Investigator-assessed PFS

Secondary endpoints:

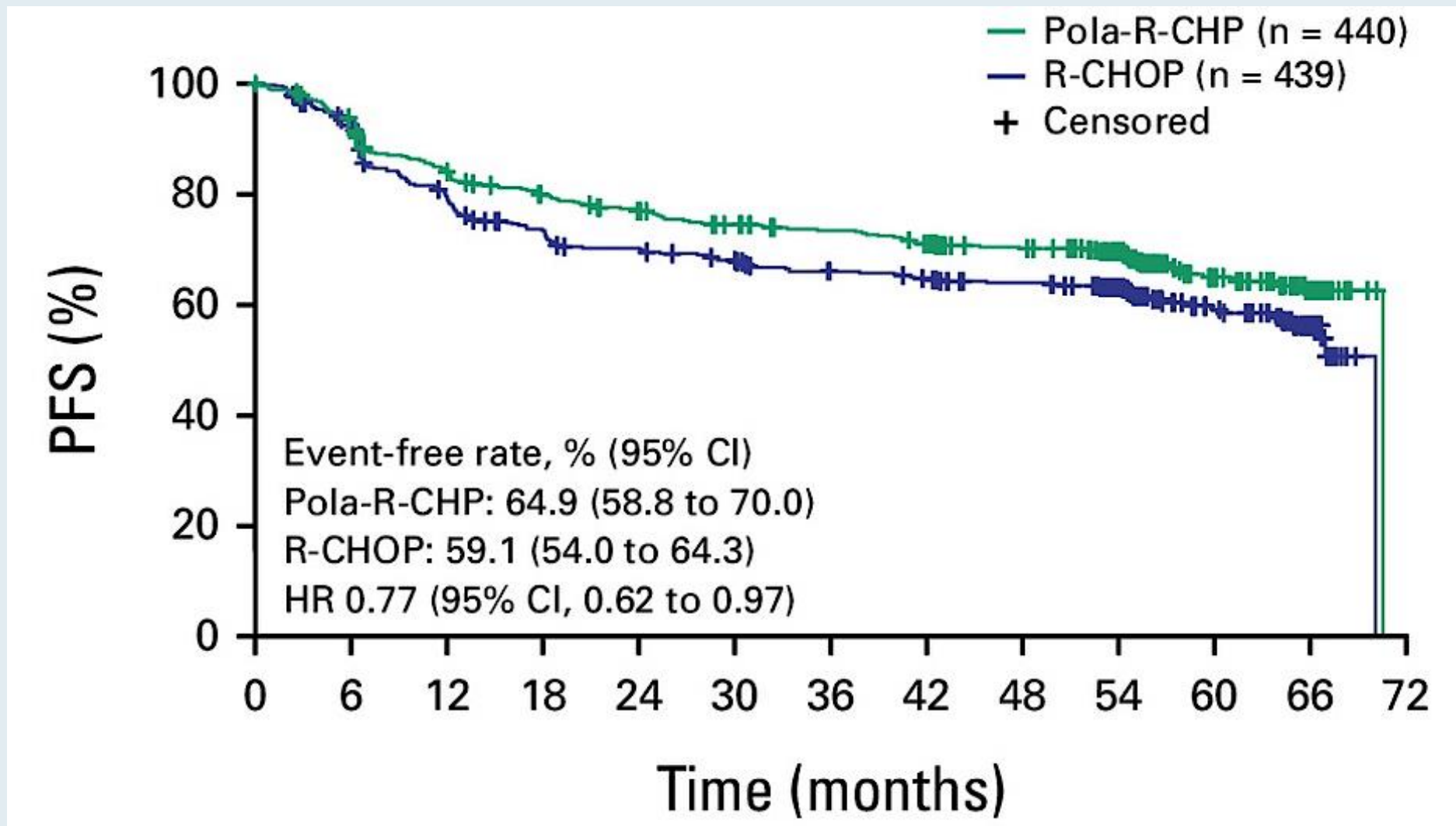
Investigator-assessed EFS, ORR, OS



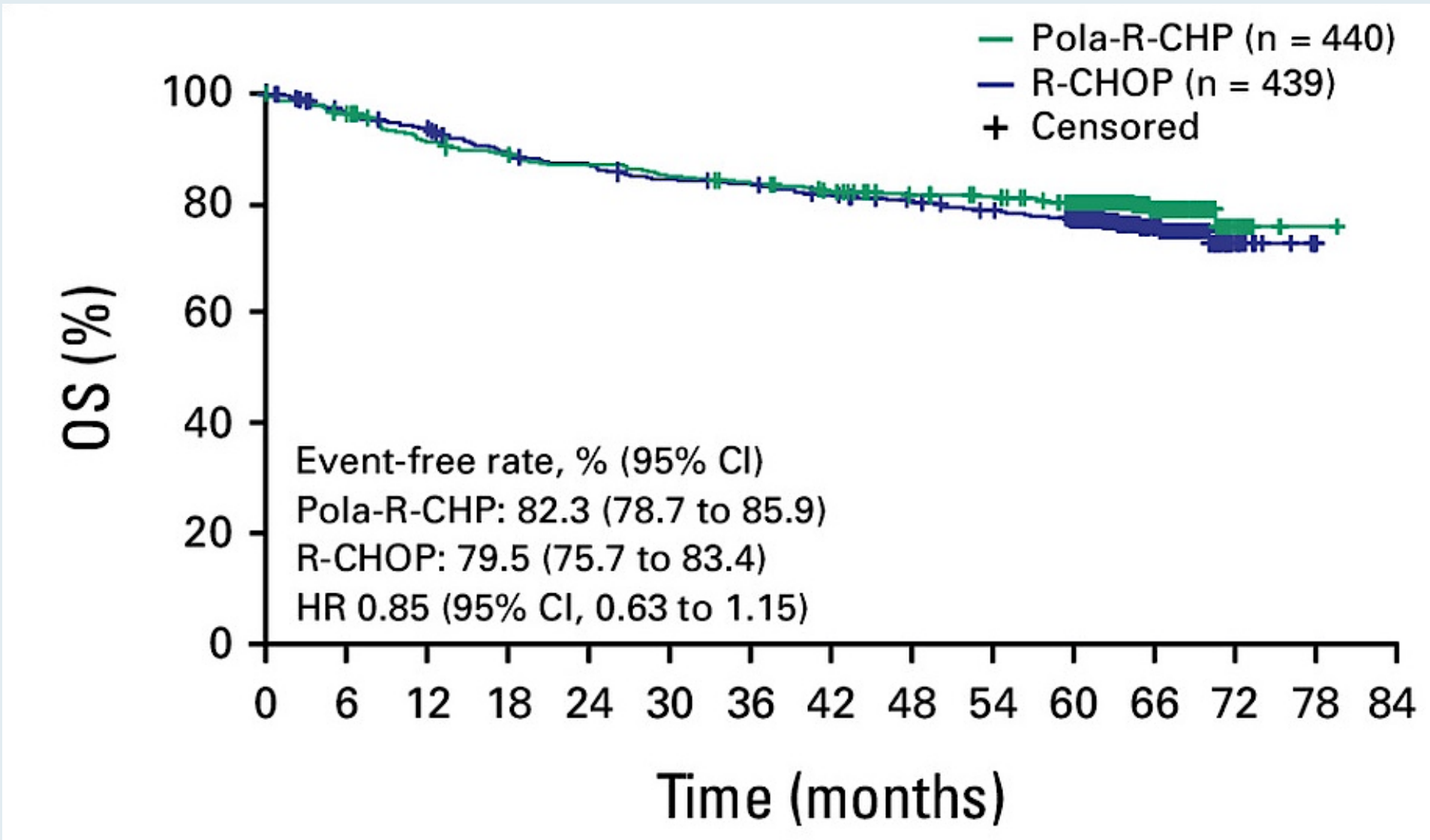
LBCL = large B-cell lymphoma; PFS = progression-free survival; EFS = event-free survival; ORR = overall response rate; OS = overall survival

[from the manufacturer's website]

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

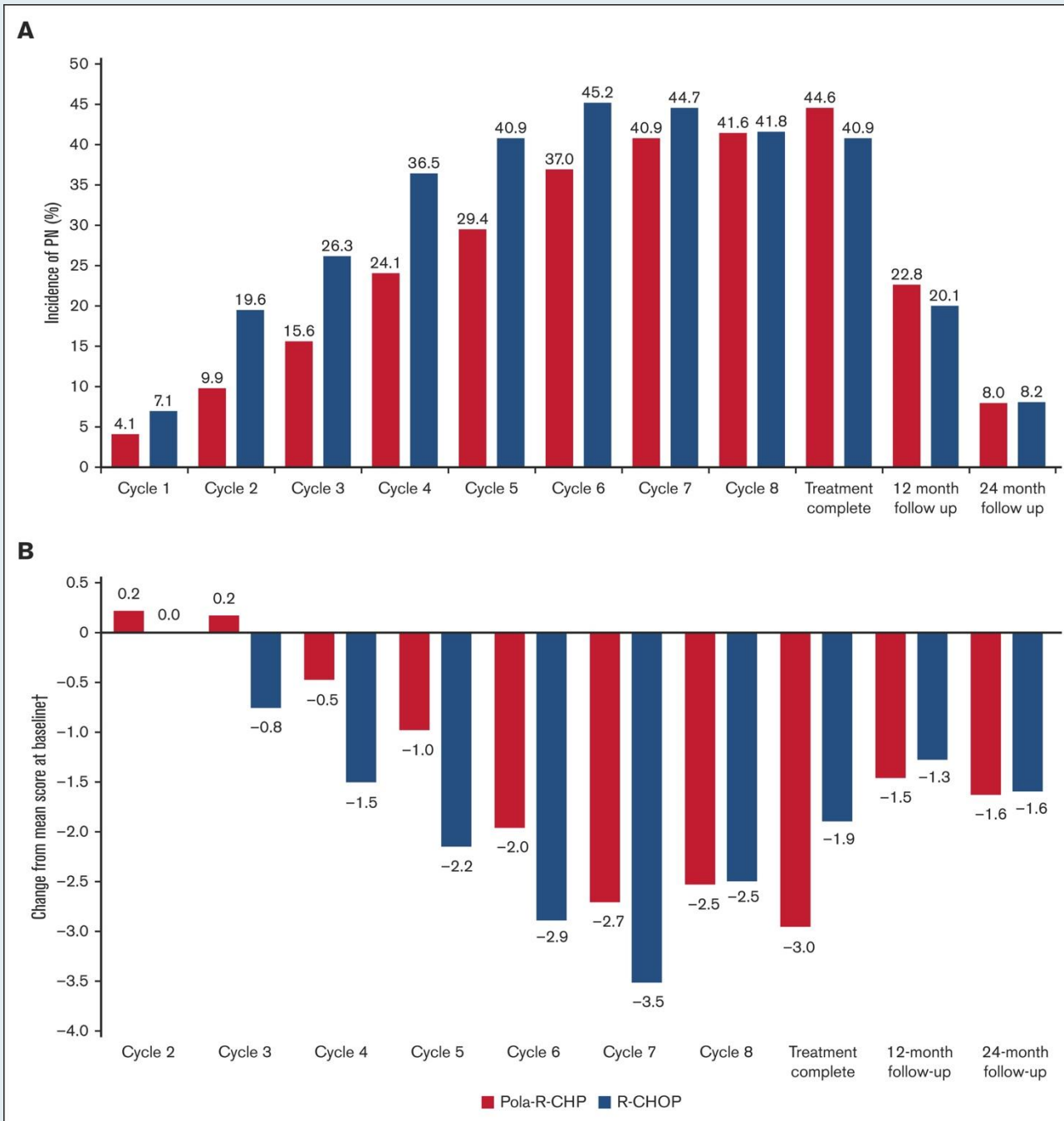


Phase III POLARIX: 5-Year OS (Global Population)



Phase III POLARIX: Adverse Events of Interest

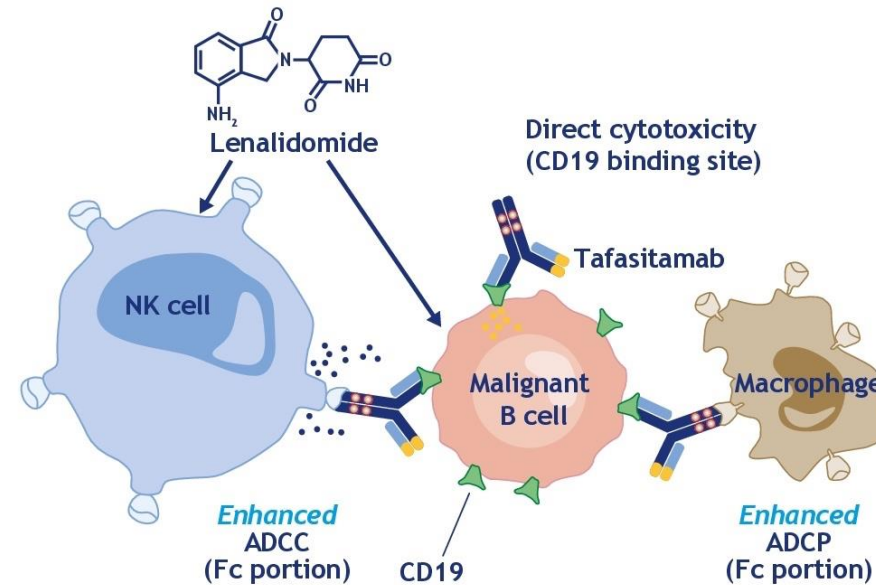
Patients, n (%)	Pola-R-CHP (n=495)	R-CHOP (n=498)
Peripheral neuropathy		
All grade	249 (50.3)	261 (52.4)
Grade 3–5	7 (1.4)	5 (1.0)
Resolved ^a	170 (68.3)	195 (74.7)
Ongoing/Unresolved ^b	79 (31.7)	66 (25.3)
Neutropenia		
All grade	240 (48.5)	228 (45.8)
Grade 3–5	216 (43.6)	205 (41.2)
Infections		
All 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)



Phase III POLARIX: Peripheral Neuropathy

Rationale for Tafasitamab and Lenalidomide Combination Therapy

Figure 1. Mode of action of tafasitamab plus lenalidomide



Tafasitamab (Fc-enhanced, anti-CD19 mAb)¹¹

Affinity-matured CD19 binding site

- ADCC ↑
- ADCP ↑
- Direct cell death



Lenalidomide¹⁵

- T-cell and NK-cell proliferation/activation
- Direct antitumor activity

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,

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 Vitolo²¹

¹University Hospital Münster, Department of Medicine A for Hematology, Oncology and Pneumology, Münster, Germany; ²First Faculty of Medicine, Charles University, Prague, Czech Republic; ³Sarah Cannon Research Institute at Rocky Mountain Cancer Centers, Aurora, CO, USA; ⁴Division of Hematology, Mayo Clinic, Rochester, MN, USA; ⁵School of Medicine, University of Nottingham, and Clinical Haematology, Nottingham University Hospitals NHS Trust, Nottingham, UK; ⁶Fondazione IRCCS Istituto Nazionale dei Tumori, Hematology, Milano, Italy; ⁷Department of Internal Medicine II, University Hospital Würzburg, Würzburg, Germany; ⁸Department of Hematology, Yeouido St. Mary's Hospital, G Private Hospital, Nedlands, Western Australia, Australia; ⁹MD Anders Medical Center, Quezon, Philippines; ¹⁰Department of Internal Medicine, Czech Republic; ¹¹Division of Hematology-Oncology, Department of Internal Medicine, Pusan National University School of Medicine, Busan, Republic of Korea; ¹²College of Medicine, Busan, Republic of Korea; ¹³Department of Hematology, University of Würzburg, Würzburg, Germany; ¹⁴Division of Hematology, University of Würzburg, Würzburg, Germany; ¹⁵Department of Molecular Biotechnology and Health Sciences, University of Turin, Italy; ¹⁶Department of Molecular Biotechnology and Health Sciences, University of Turin, Italy; ¹⁷Department of Molecular Biotechnology and Health Sciences, University of Turin, Italy; ¹⁸Department of Molecular Biotechnology and Health Sciences, University of Turin, Italy; ¹⁹Department of Molecular Biotechnology and Health Sciences, University of Turin, Italy; ²⁰Department of Molecular Biotechnology and Health Sciences, University of Turin, Italy; ²¹Candiolo Cancer Institute, F

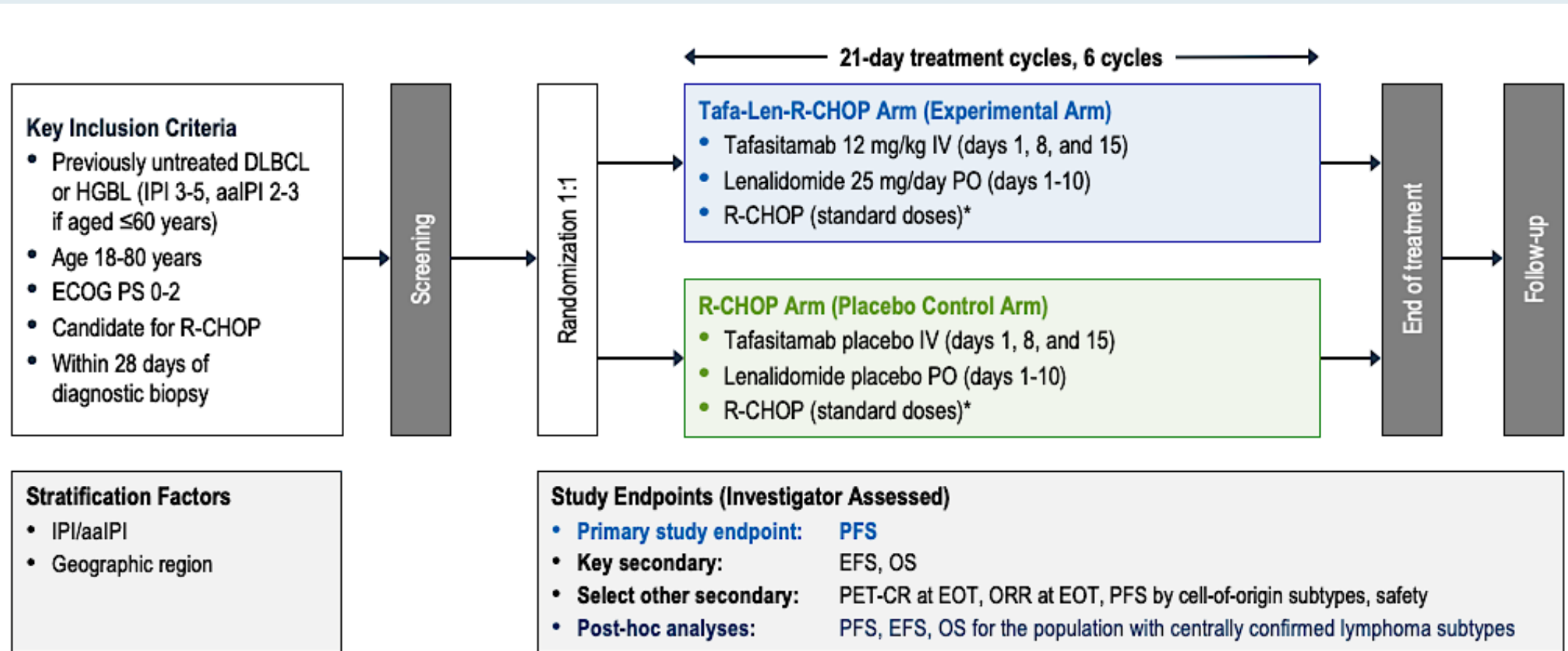
Presented at the 2026 ASCO Annual Meeting • Chicago, IL, USA & Online • May 2026

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*

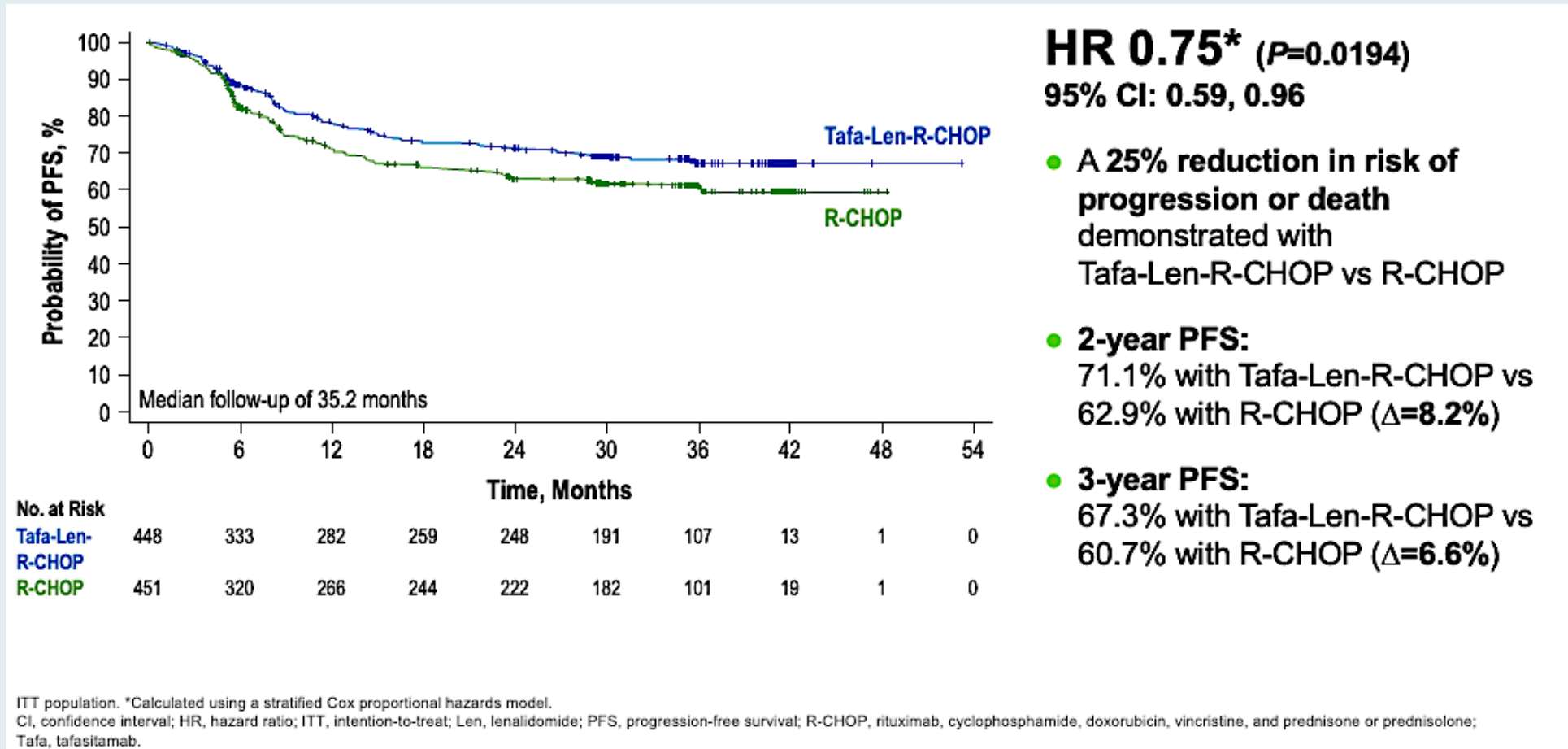
Lancet 2026 May 30;[Online ahead of print].

Phase III frontMIND Study Design



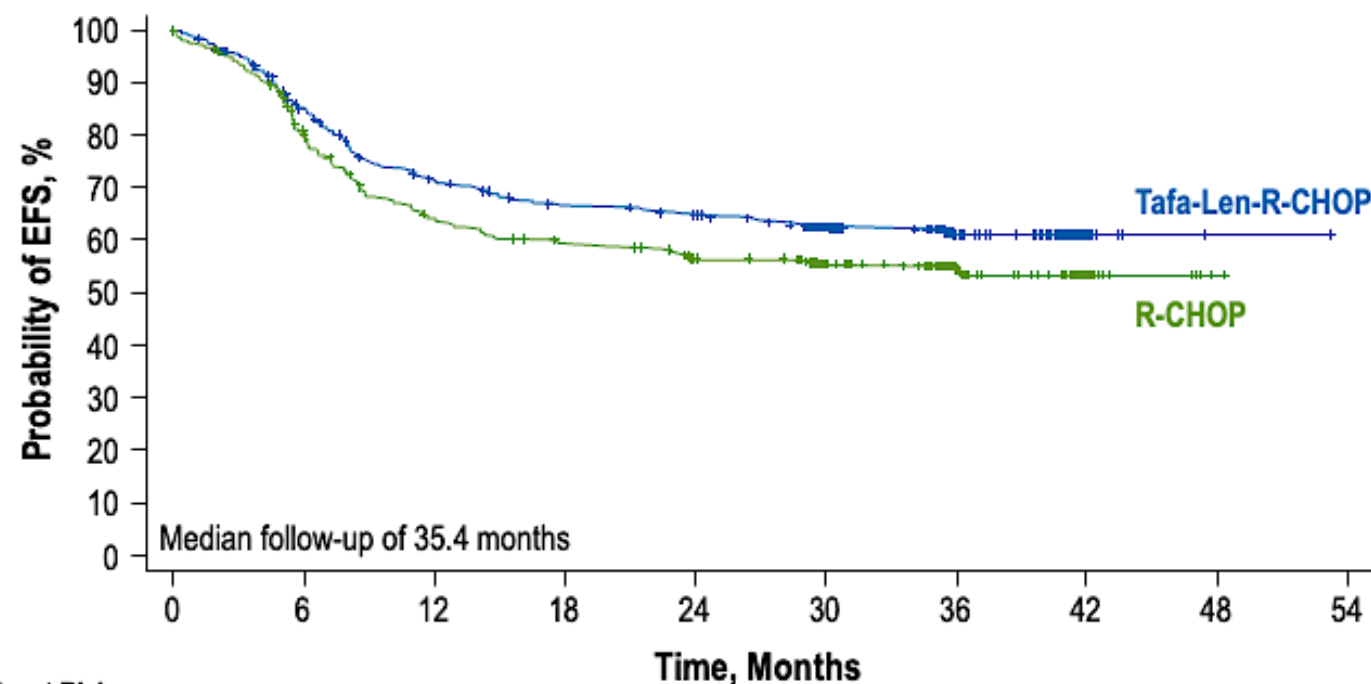
*Rituximab administered at 375 mg/m² IV (day 1); cyclophosphamide, doxorubicin, and vincristine administered IV (day 1); prednisone/prednisolone administered PO (days 1-5).
aalPI, age-adjusted IPI; CR, complete response; DLBCL, diffuse large B-cell lymphoma; ECOG PS, Eastern Cooperative Oncology Group 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.

frontMIND Primary Endpoint: Investigator-Assessed Progression-Free Survival



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

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



No. at Risk

Tafa-Len-R-CHOP

R-CHOP

448	346	283	259	249	191	107	13	1	0
451	339	267	244	222	182	101	19	1	0

HR 0.79* ($P=0.0260$)

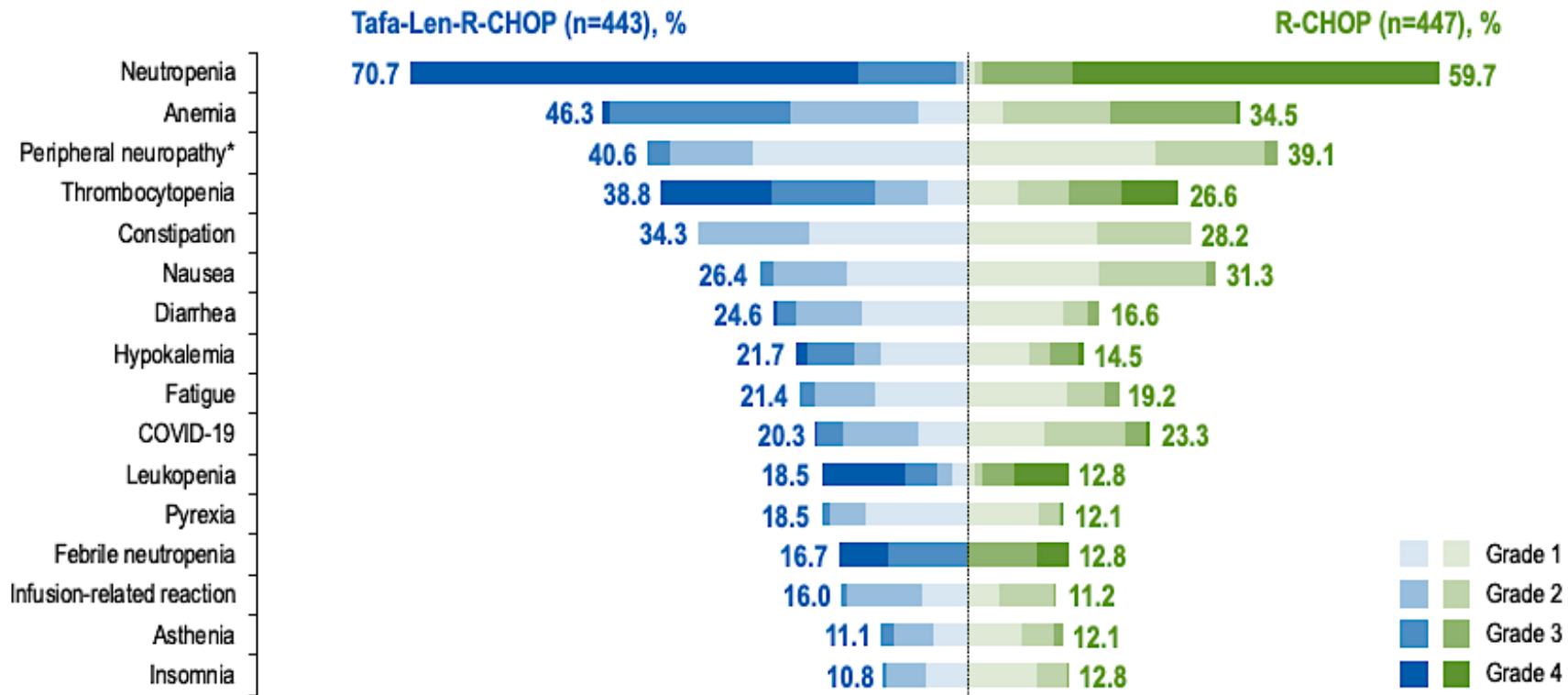
95% CI: 0.64, 0.97

- **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.

frontMIND: Most Frequent Treatment-Emergent Adverse Events



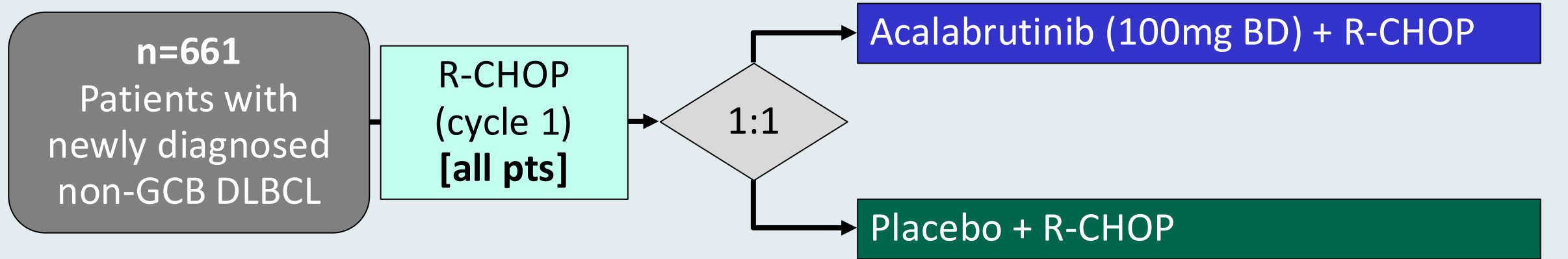
- **Most common** grade ≥ 3 adverse events were related to **cytopenias**
 - Rate of **serious febrile neutropenia**: 13.3% with Tafa-Len-R-CHOP and 9.8% with R-CHOP

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

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.”

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



Primary endpoint:

PFS

Secondary endpoints:

EFS, CR rate, OS, pharmacokinetics, safety

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

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

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Module 6: Clinician Survey Results

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 Phillips	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
 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 Phillips	R-CHP + polatuzumab vedotin	R-mini-CHP + polatuzumab vedotin
	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 Phillips	Dose-adjusted R-EPOCH	R-CP + Pola + infusional doxorubicin
 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

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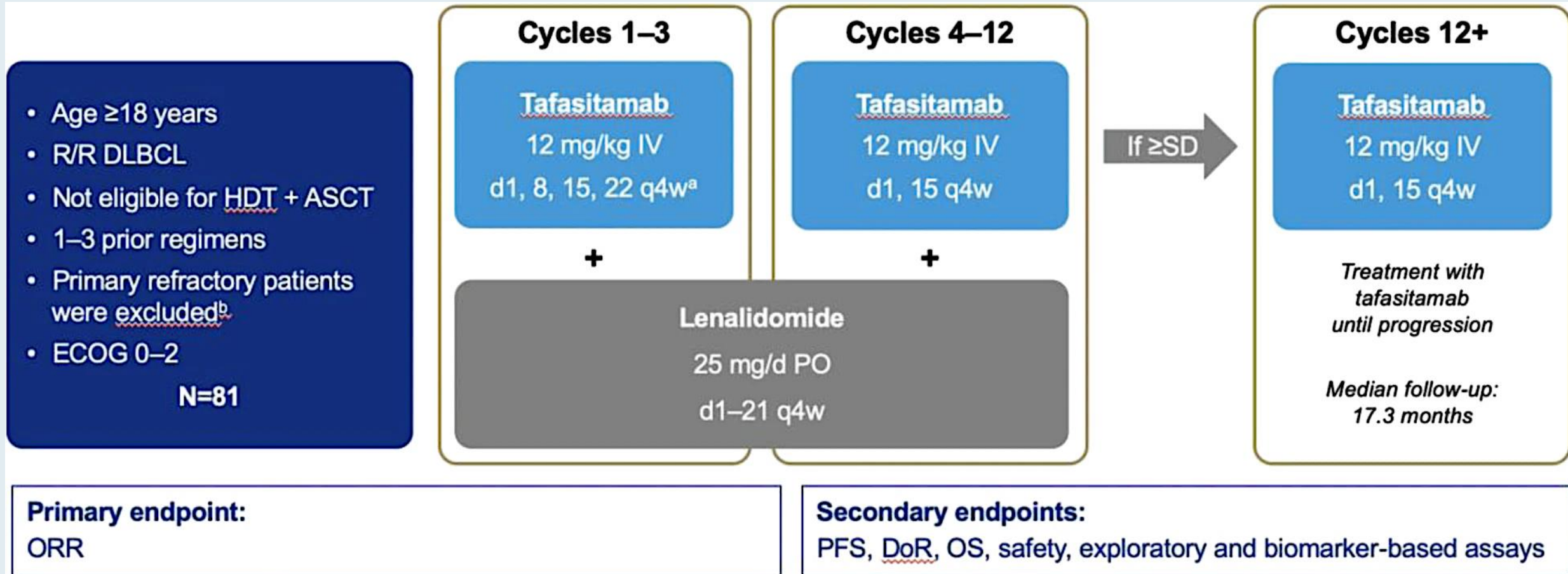
Module 5: Evidence-Based Incorporation of Antibody-Drug Conjugates into the Management of R/R DLBCL

Module 6: Clinician Survey Results

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.

Phase II L-MIND Study Design



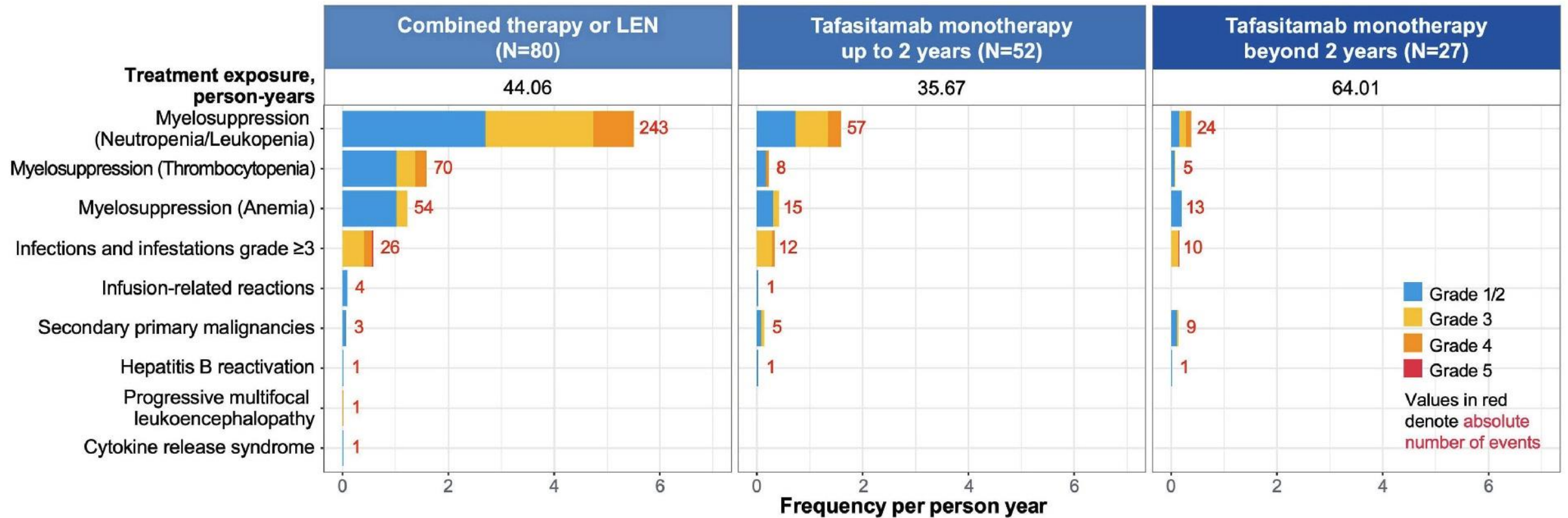
HDT = high-dose therapy; ASCT = autologous stem cell transplant; SD = stable disease; DoR = duration of response

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

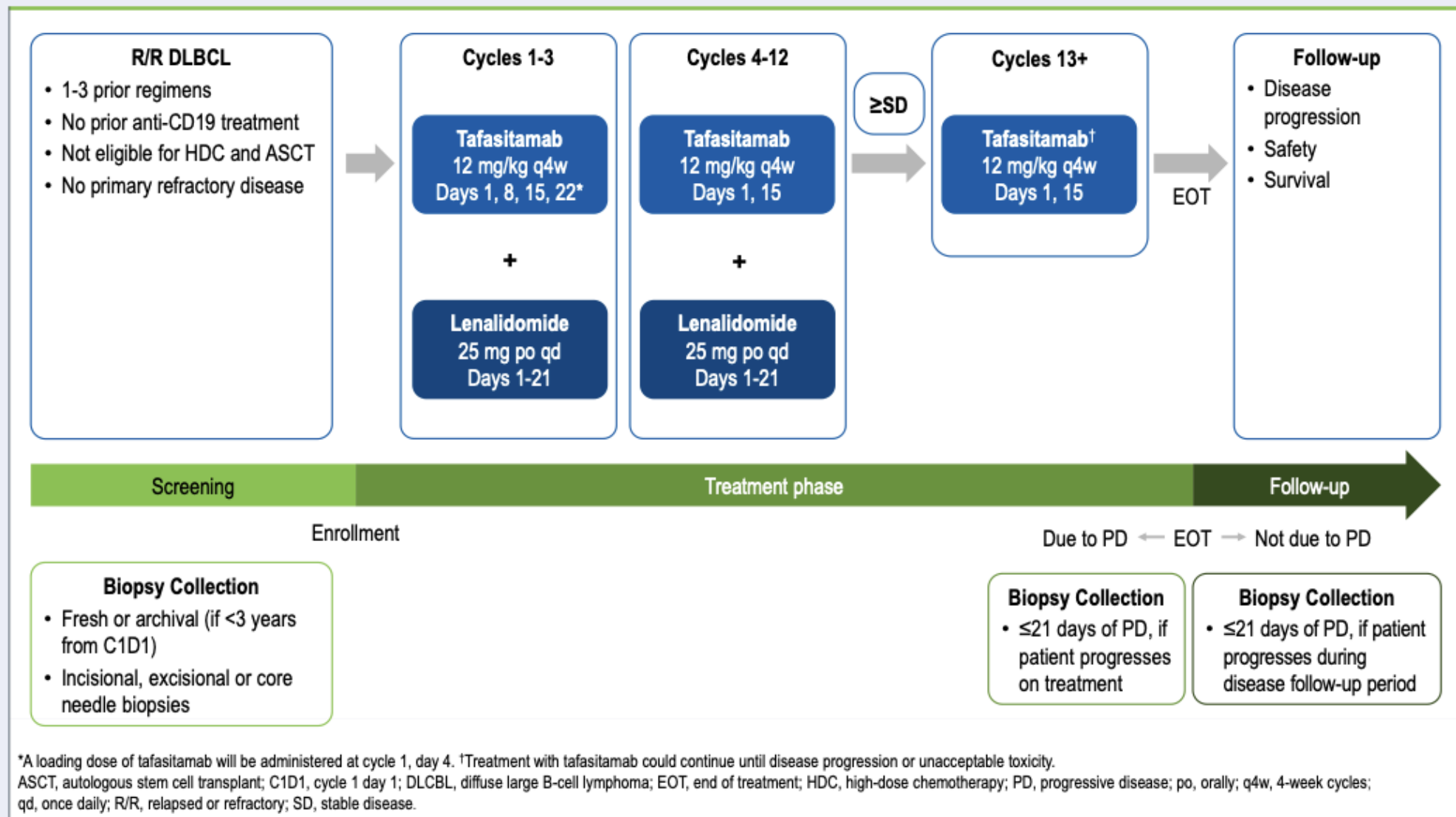
Characteristics	Primary analysis	3-year follow-up	Final 5-year data	5-year data for patients with 1 prior line of therapy, N=40	5-year data for patients with ≥2 prior lines of therapy, N=40
Data cut-off date	Nov 30, 2018	Oct 30, 2020	Nov 14, 2022	Nov 14, 2022	Nov 14, 2022
Best ORR, N (%) [95% CI]	48 (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.

Phase II L-MIND: Adverse Events of Special Interest

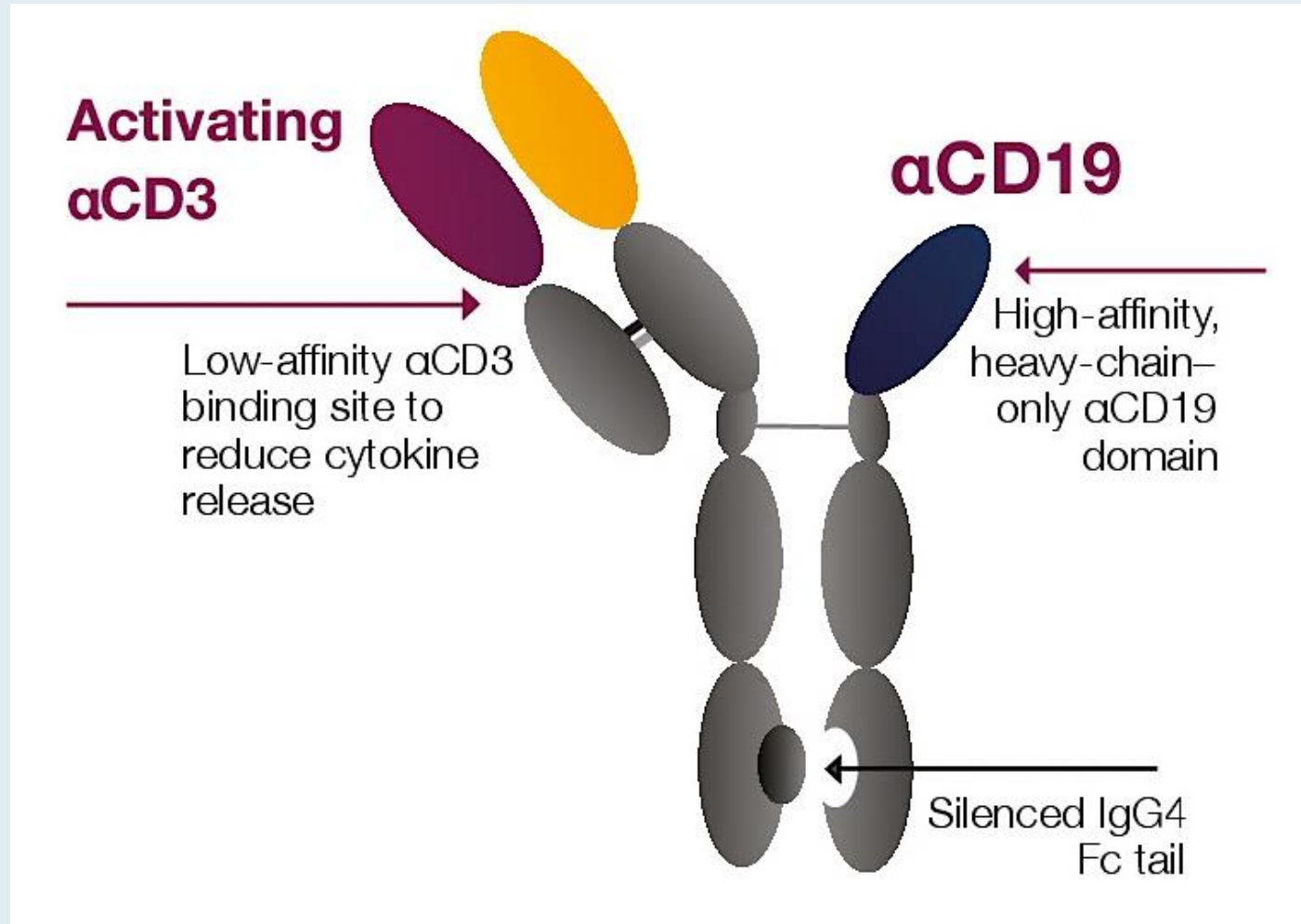


Phase III firmMIND Study Design



Estimated completion (primary): 2026-04-01

AZD0486: A CD19 x CD3 Bispecific T-Cell Engager



Phase I AZD0486 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%

Phase I AZD0486 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 (%).

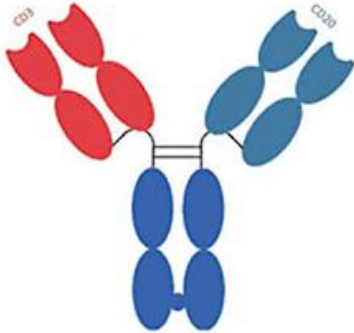
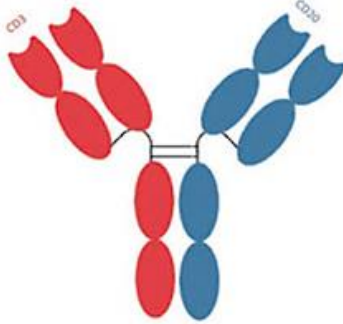
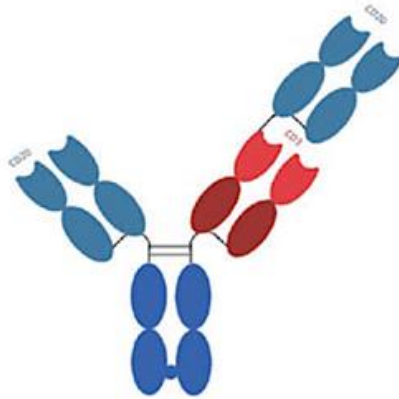
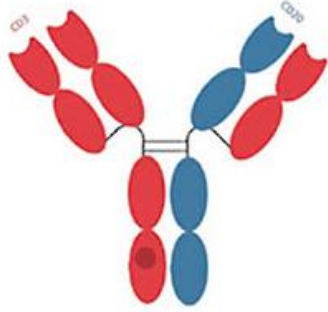
^aAll patients eventually received TD.

^bGrouped 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)

Bispecifics for DLBCL

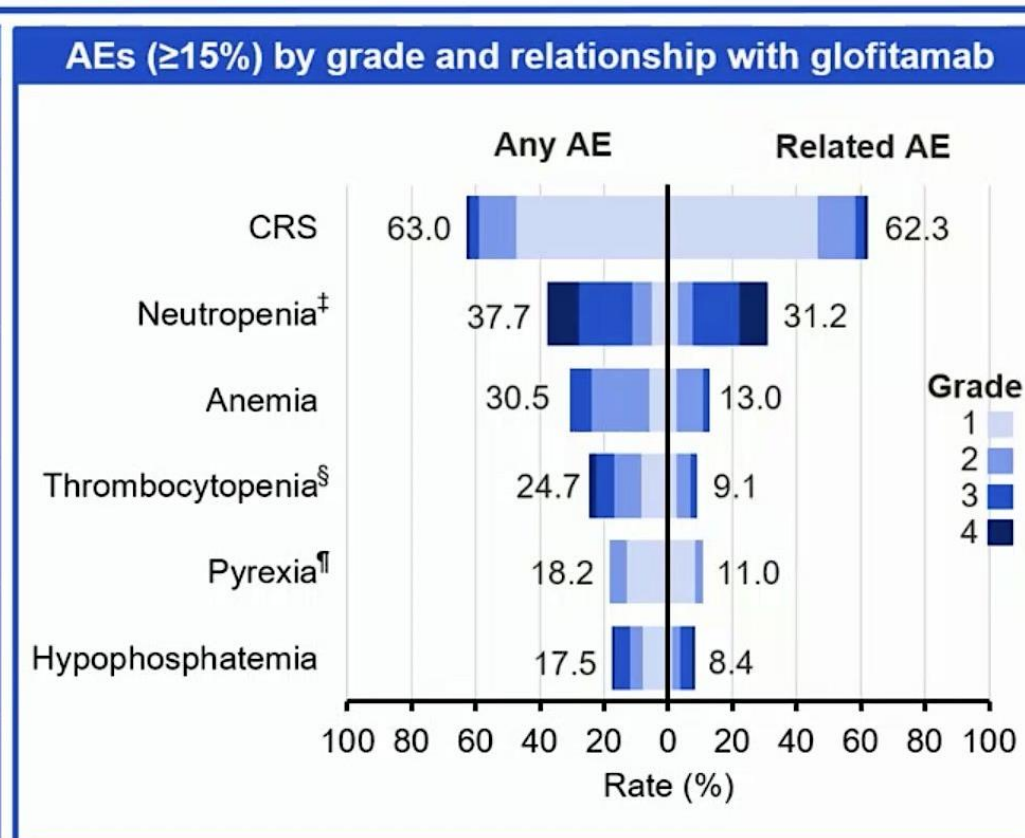
	BLINATUMOMAB	MOSUNETUZUMAB	EPCORITAMAB	GLOFITAMAB	ODRONEXTAMAB
TARGET	CD3xCD19	CD3xCD20	CD3xCD20	CD3x(CD20) ₂	CD3xCD20
DESIGN					
	• Monovalent CD3 and monovalent CD19 binding • Two murine scFv-joined by a glycine-serine linker	• Monovalent CD3 and monovalent CD20 binding • Humanized mouse IgG1-based 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

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)

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)



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.

Phase II EPCORE NHL-1 Study Design

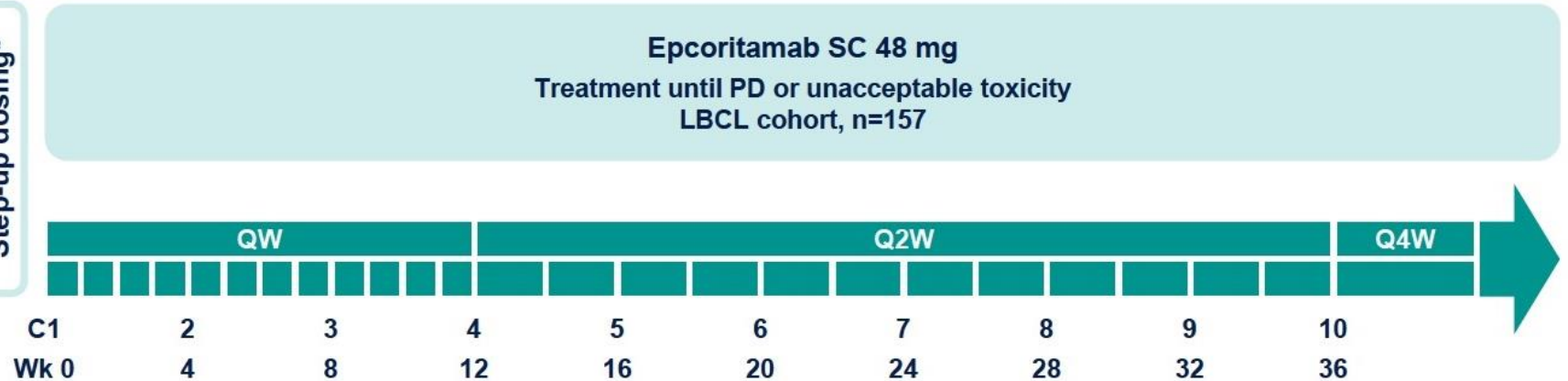
Dose expansion

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

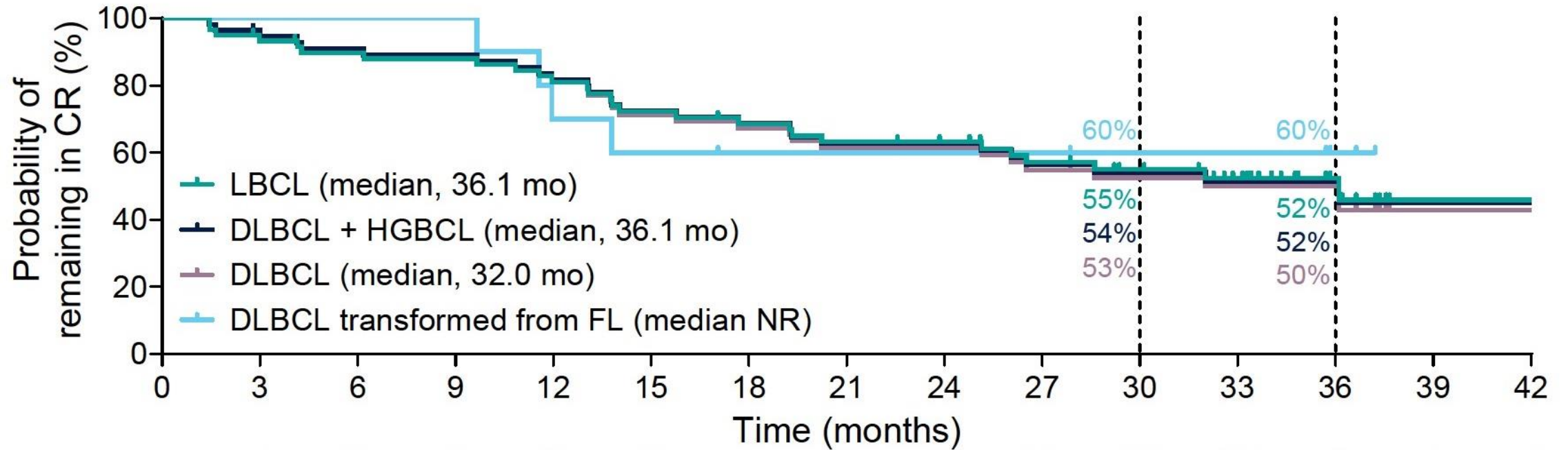
Step-up dosing^b



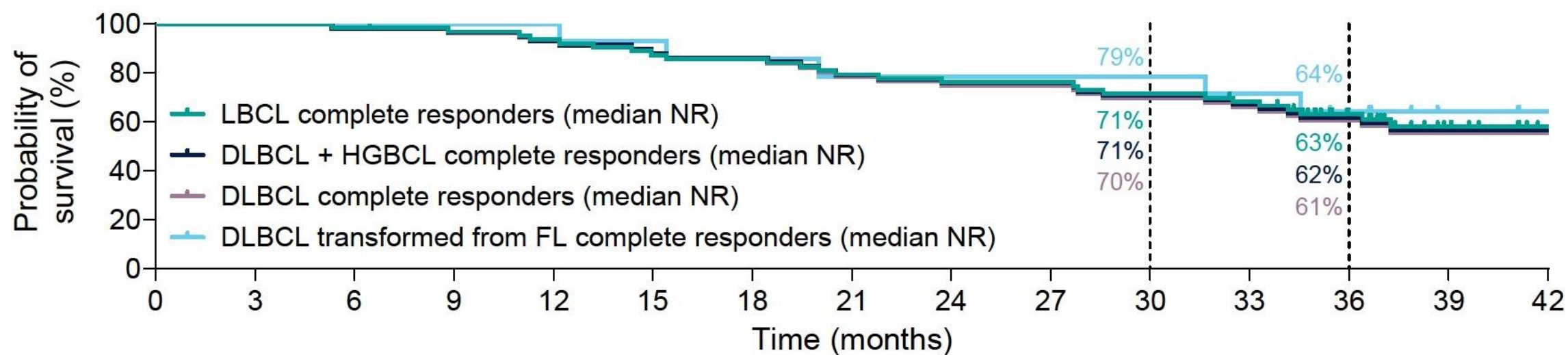
- **Primary endpoint:** ORR per Lugano criteria¹
- **Key secondary endpoints:** CR, DOR, DOCR, PFS, OS, TTNT, MRD- rate, and safety/tolerability
- Exploratory MRD analyses of ctDNA were performed using the clonoSEQ[®] NGS assay^c

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

Phase II EPCORE NHL-1: Responses



Phase II EPCORE NHL-1: Overall Survival



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:

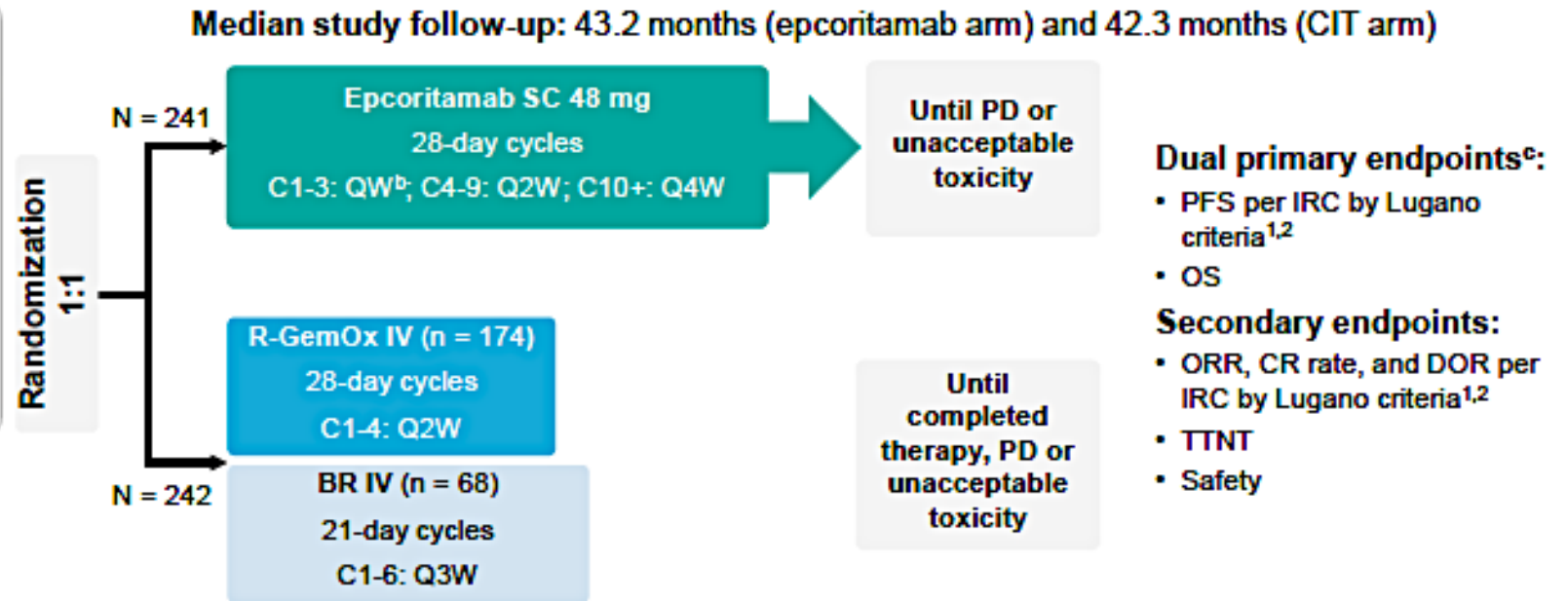
- CD20+ R/R LBCL (de novo or transformed from FL):
 - DLBCL, NOS
 - DH/TH DLBCL^a
 - FL Grade 3B
 - T-cell/histiocyte-rich LBCL
- ≥ 1 prior systemic LOT
- ECOG PS 0–2
- Ineligible for, or relapsed after, HDT-ASCT

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:

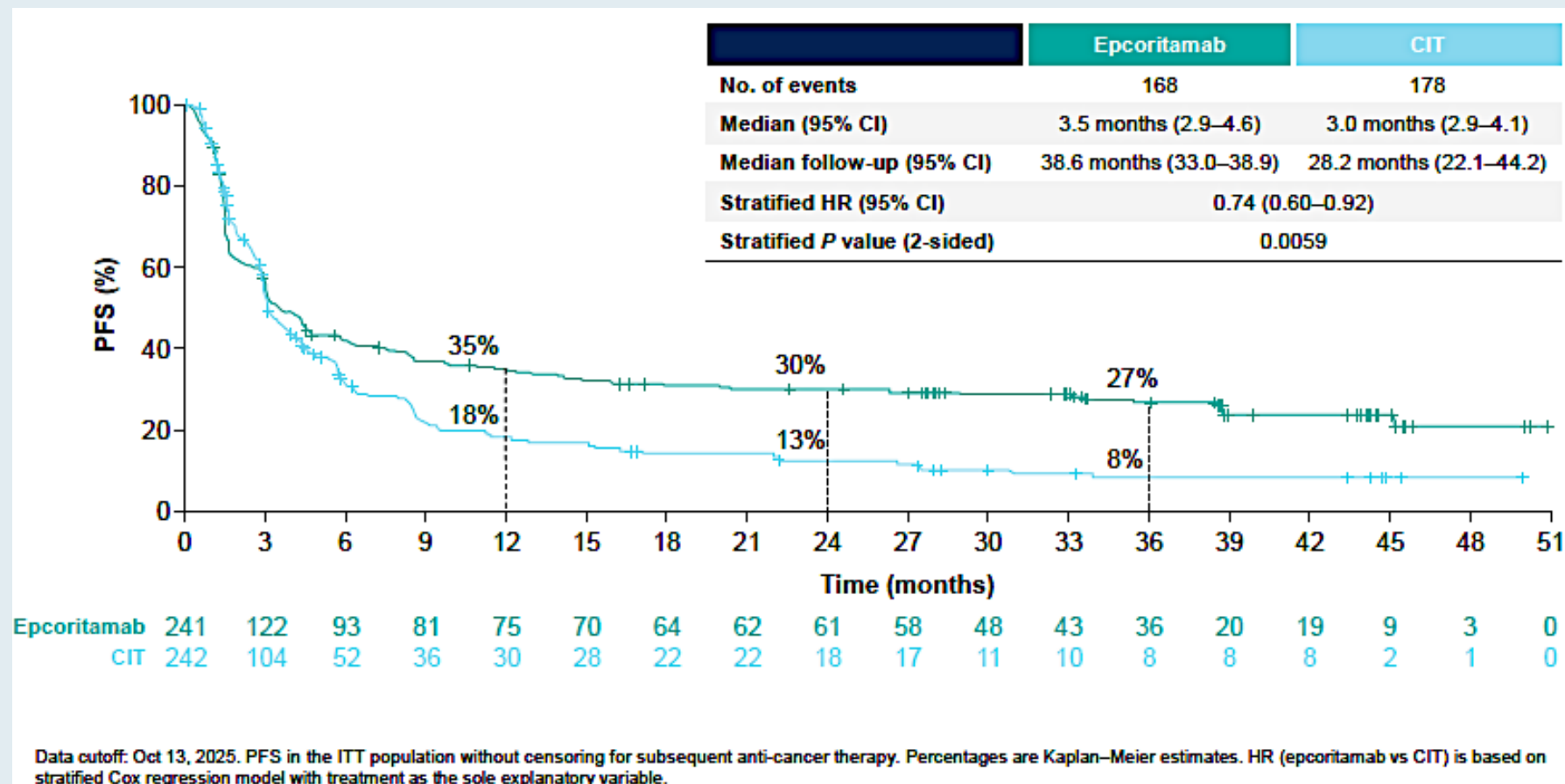
- Max 120 patients (25%) with 1 pLOT
- Max 120 (50% CIT) patients to receive BR



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. ^aBased on WHO 2016 classification (HGBCL, with MYC and BCL2 and/or BCL6 translocations). ^bPatients received epcoritamab in weekly dosing of 2 step-up doses (0.16 mg; 0.8 mg) before the first full dose in C1. ^cPrimary 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.

EPCORE DLBCL-1: Efficacy Summary



- 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

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

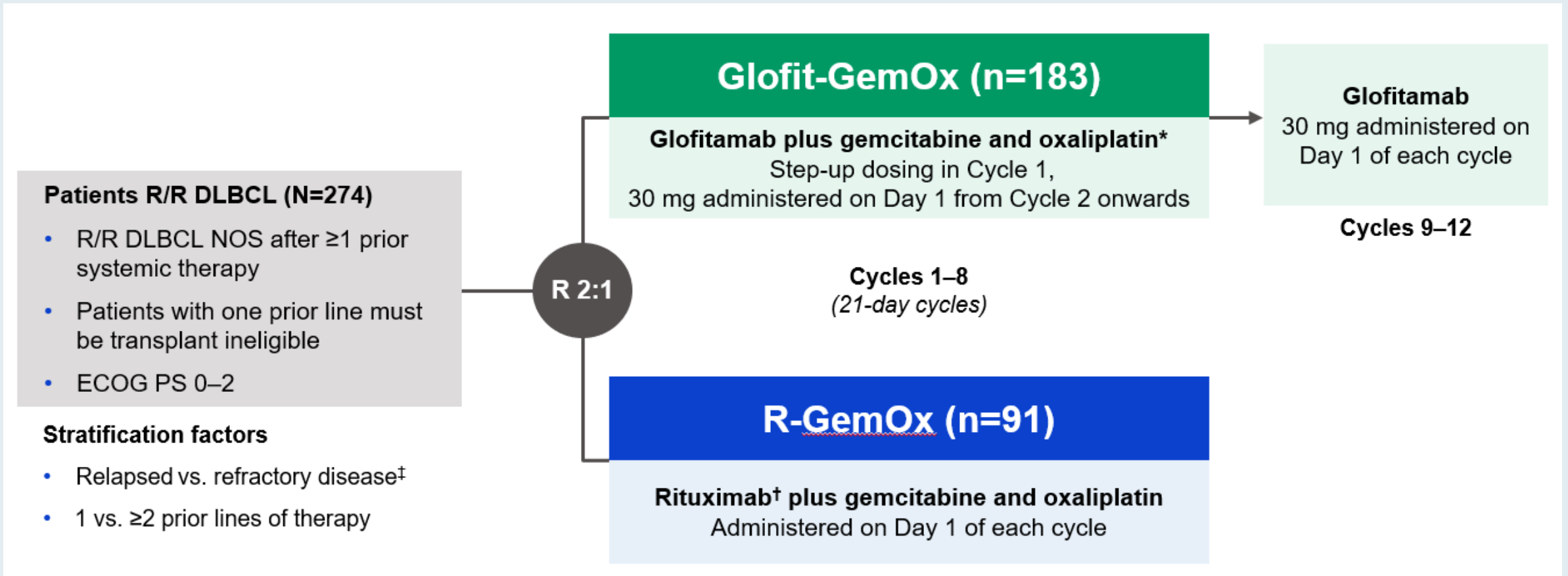
	Epcoritamab (N = 236)	CIT (N = 237)	Epcoritamab (N = 236)	CIT (N = 237)
	n (%)	n (%)	EAER ^a	EAER ^a
CRS ^b	124 (53)	NA	NA	NA
COVID-19 ^c	88 (37)	28 (12)	4.8	3.9
Neutropenia ^d	84 (36)	109 (46)	6.4	30.1
Pyrexia	62 (26)	30 (13)	3.1	4.4
Anemia	61 (26)	84 (35)	2.6	15.6
Injection site reactions ^e	51 (22)	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. ^aEAER equals the number of events*100/patient-months of exposure. ^bMost CRS events were grade 1–2 (117/124 [94%]) with the remaining 7/124 (6%) grade 3.

^cIncludes preferred terms COVID-19, COVID-19 pneumonia, and post-acute COVID-19 syndrome. ^dIncludes preferred terms neutropenia and neutrophil count decreased. ^eIncludes preferred terms injection site reaction, injection site reaction erythema, injection site reaction pain, injection site reaction pruritus, injection site reaction rash, injection site reaction inflammation, injection site reaction swelling. ^fIncludes preferred terms platelet count decreased and thrombocytopenia. EAER, exposure-adjusted event rate.

Phase III STARGLO Study Design



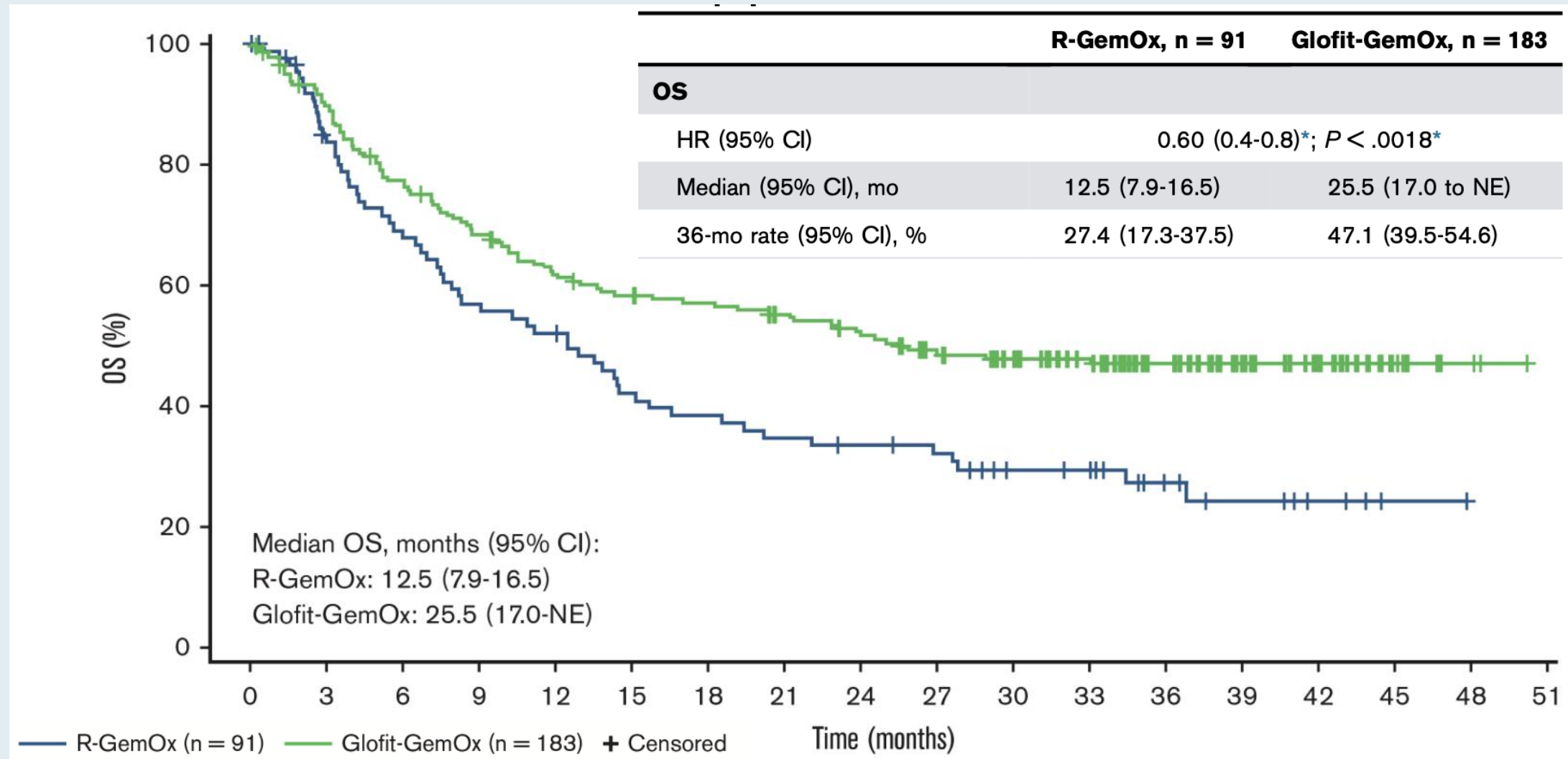
Primary endpoint:

Overall survival

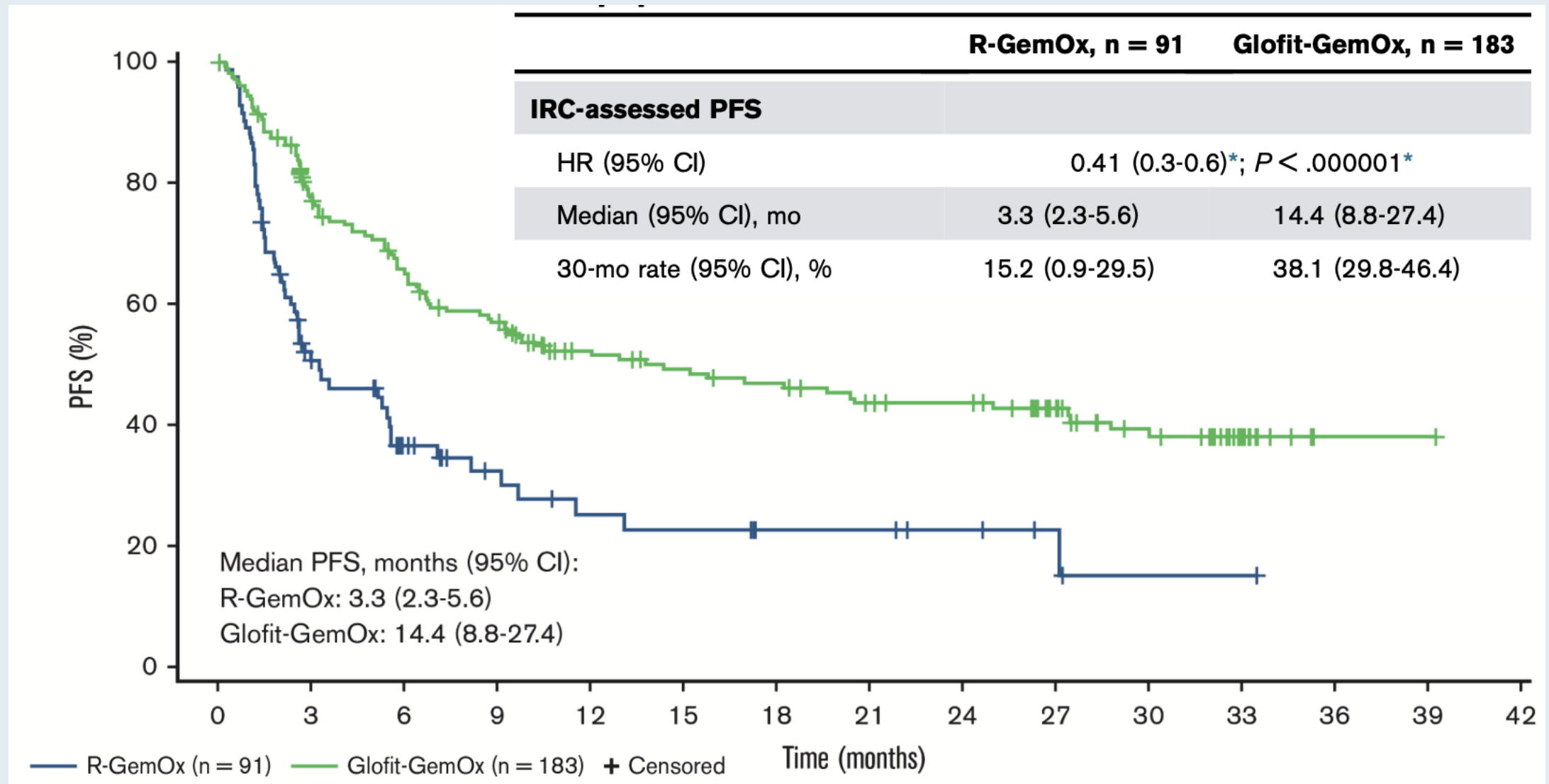
Secondary endpoints:

Progression-free survival, ORR, DoR

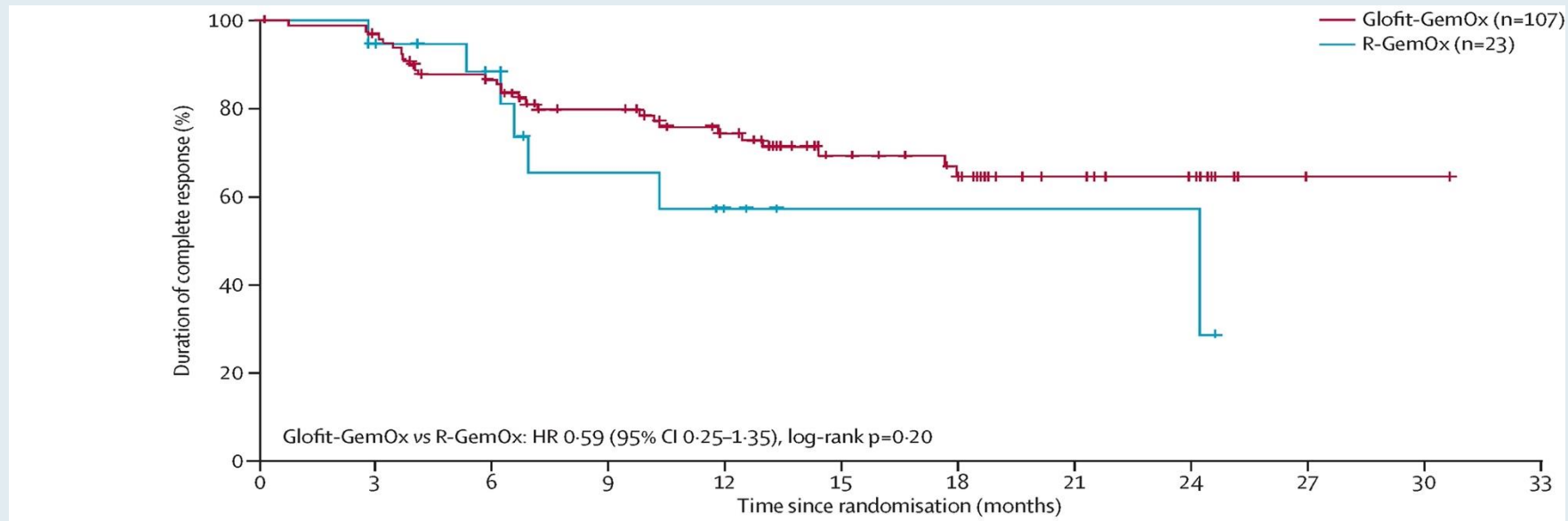
Phase III STARGLO 3-Year Follow-Up: Overall Survival (OS; Primary Endpoint)



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



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)	..

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%)

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

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 <i>and</i> 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 Phillips	Mosunetuzumab/polatuzumab vedotin	Mosunetuzumab/polatuzumab vedotin
 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 Phillips	Glofitamab/polatuzumab vedotin
	Prof Salles	Glofitamab/GemOx or polatuzumab vedotin/glofitamab
	Dr Westin	Glofitamab/GemOx or polatuzumab vedotin/glofitamab

R-GemOx = rituximab/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 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 Phillips

Glofitamab/GemOx



Prof Salles

Glofitamab/GemOx



Dr Westin

Glofitamab/GemOx

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 Phillips

Glofitamab or epcoritamab



Prof Salles

Glofitamab/GemOx



Dr Westin

Glofitamab or epcoritamab

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 Phillips	No preference
	Prof Salles	Glofitamab
	Dr Westin	Glofitamab

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 Phillips

Yes, after CAR T-cell therapy



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

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 Phillips

Yes



Prof Salles

Yes



Dr Westin

Yes

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Module 6: Clinician Survey Results

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.

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.

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.

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

Safety run-in
Enrolled $n=15$

Pola-R-GemOx*
Q3W up to 8 cycles

Primary endpoint
Safety and tolerability

Randomized phase
Enrolled $n=255$

Stratification Factors

- Age (≤ 70 vs > 70 years)
- Prior lines of therapy (1 vs ≥ 2)
- Relapsed vs refractory

R
1:1

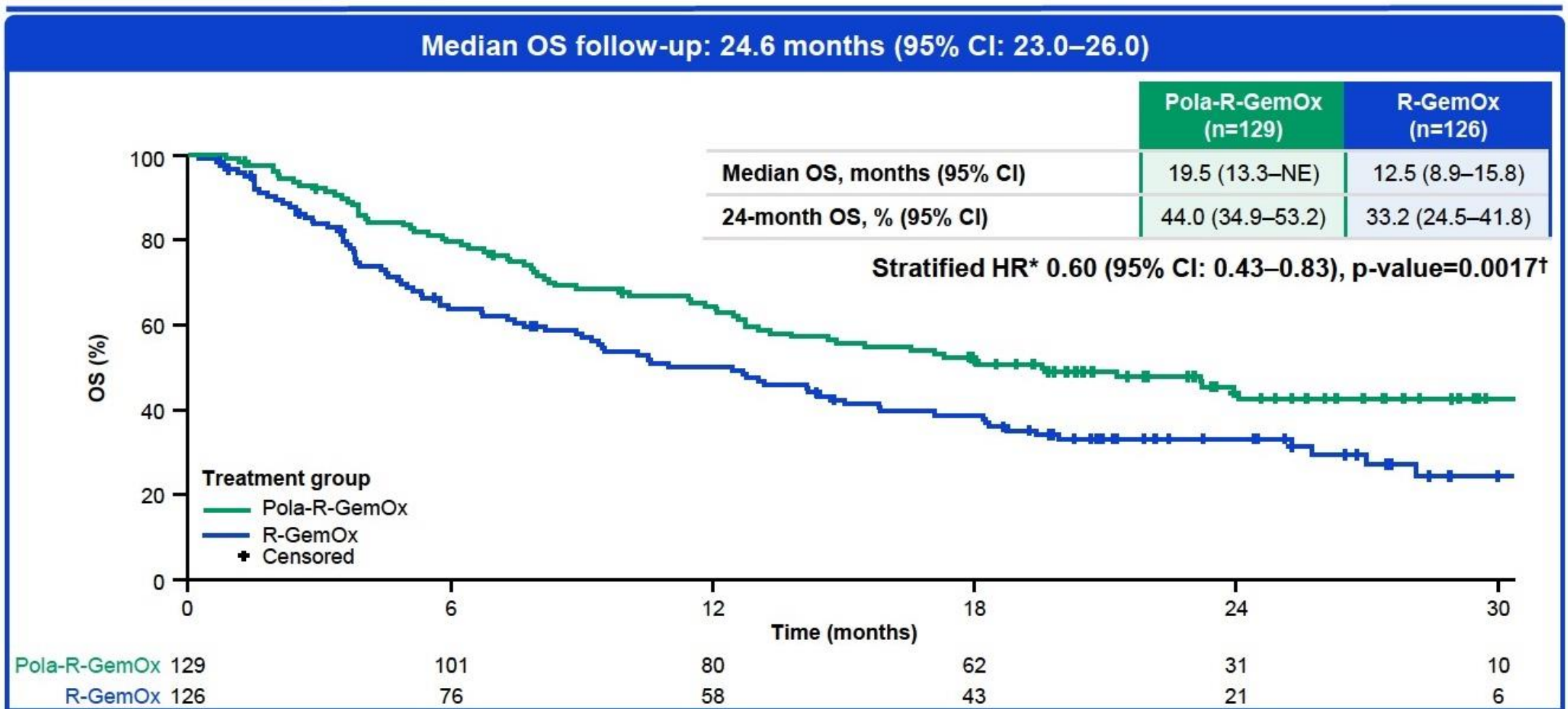
Pola-R-GemOx*
 $n=129$
Q3W up to 8 cycles

Primary endpoint
OS

R-GemOx
 $n=126$
Q3W up to 8 cycles

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

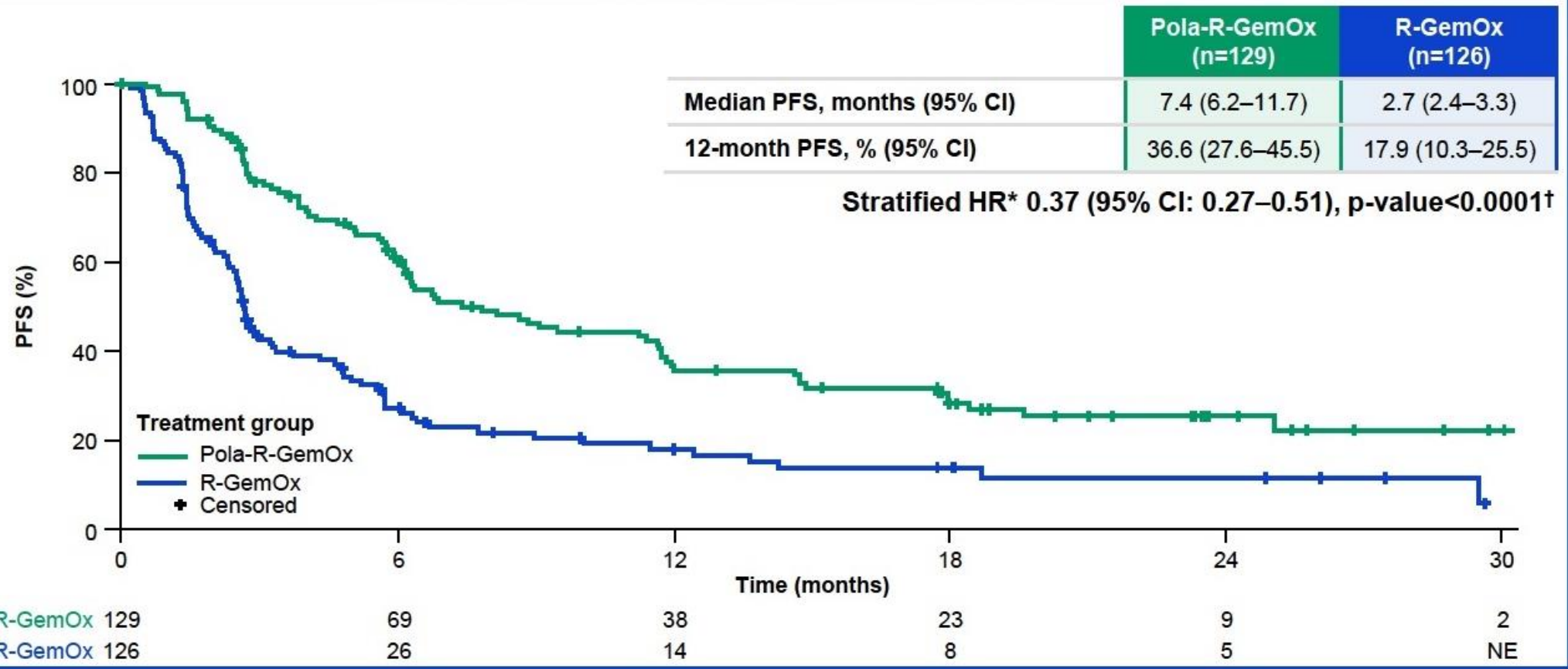
Phase III POLARGO Overall Survival



*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.

Phase III POLARGO: Progression-Free Survival

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



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.

Phase III POLARGO: Select AEs

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

*Custom grouped terms. †Based on preferred term.

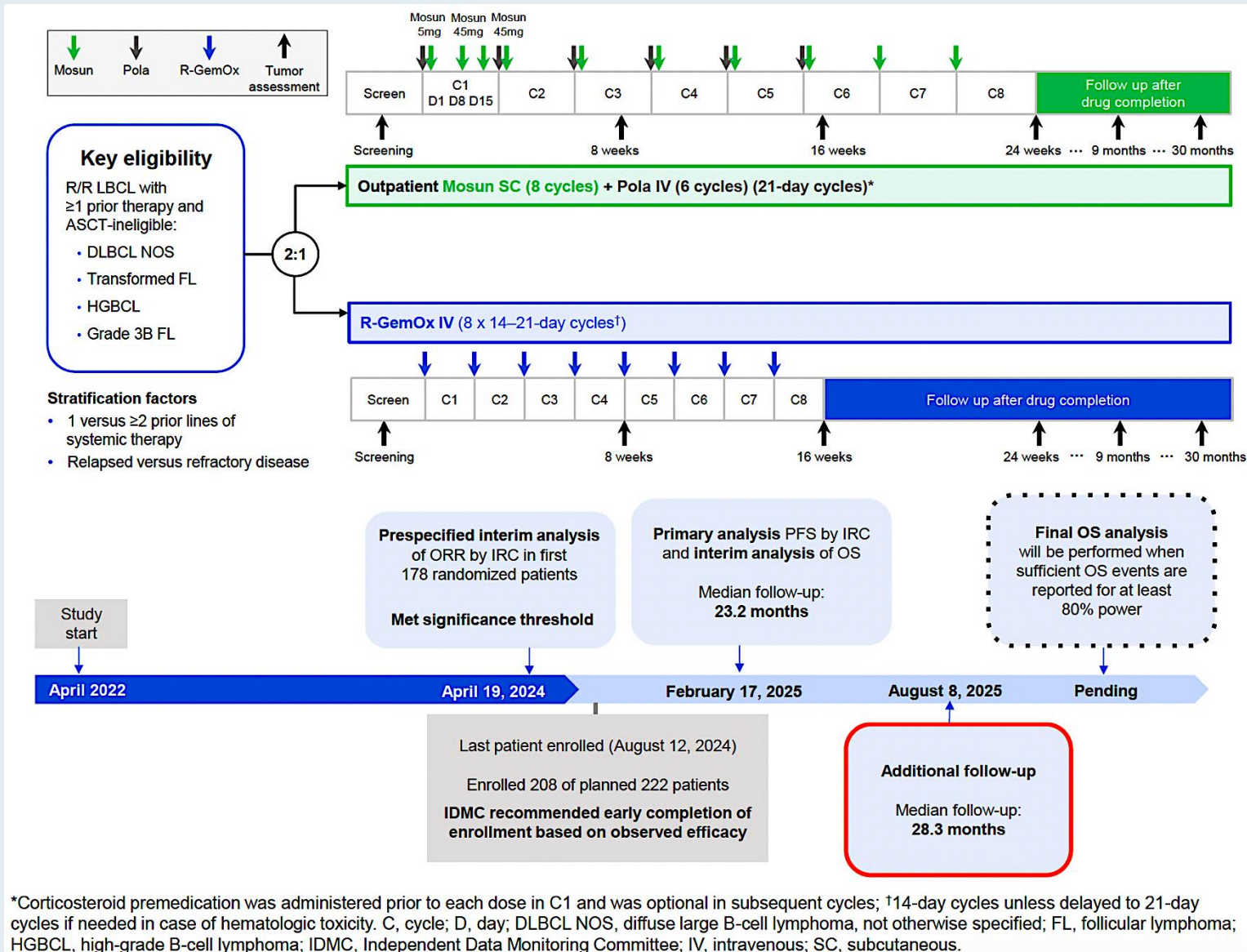
Phase III POLARGO: Peripheral Neuropathy

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)

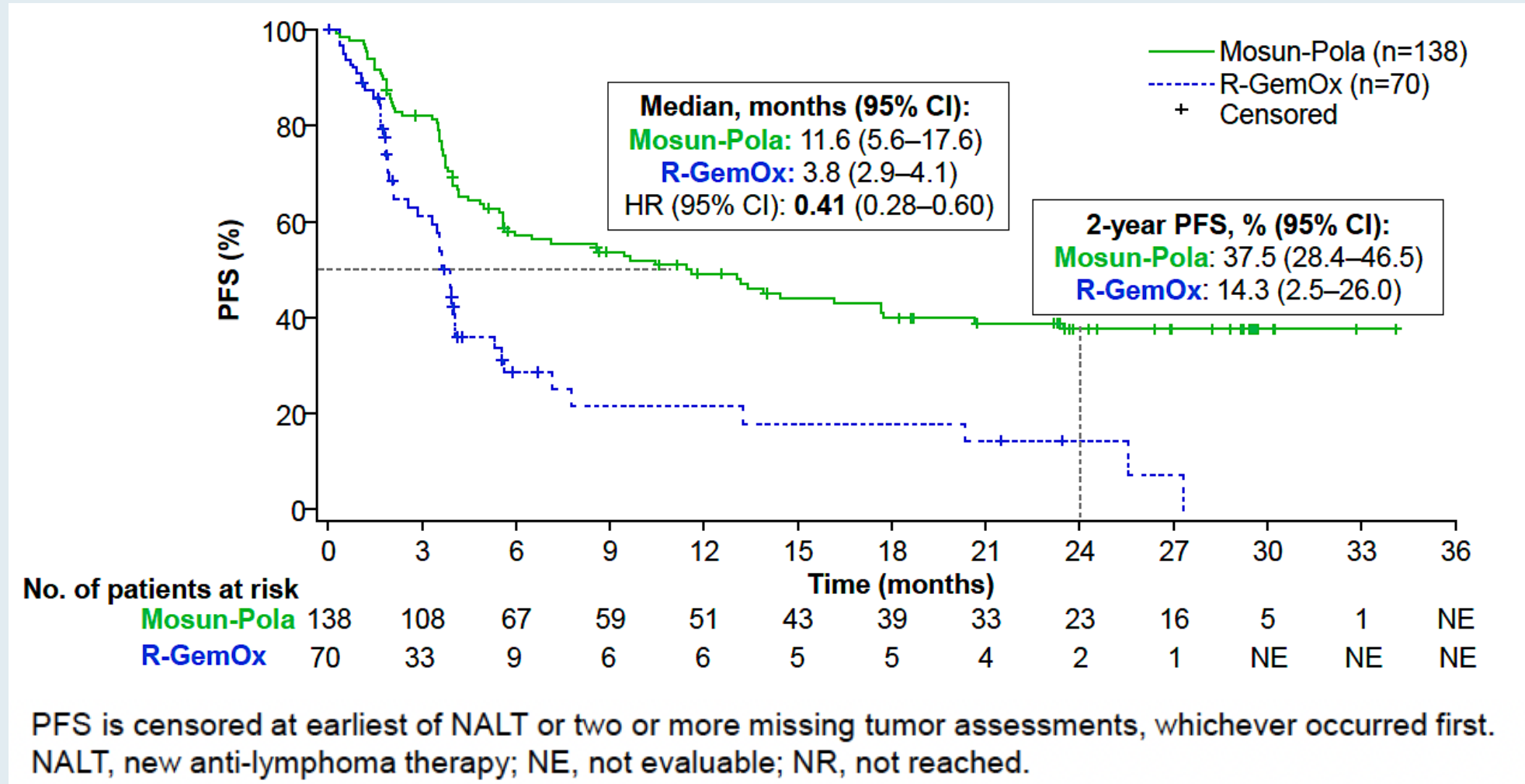
*Custom grouped terms.

N/A, not applicable; PN, peripheral neuropathy.

Phase III SUNMO Study Design



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



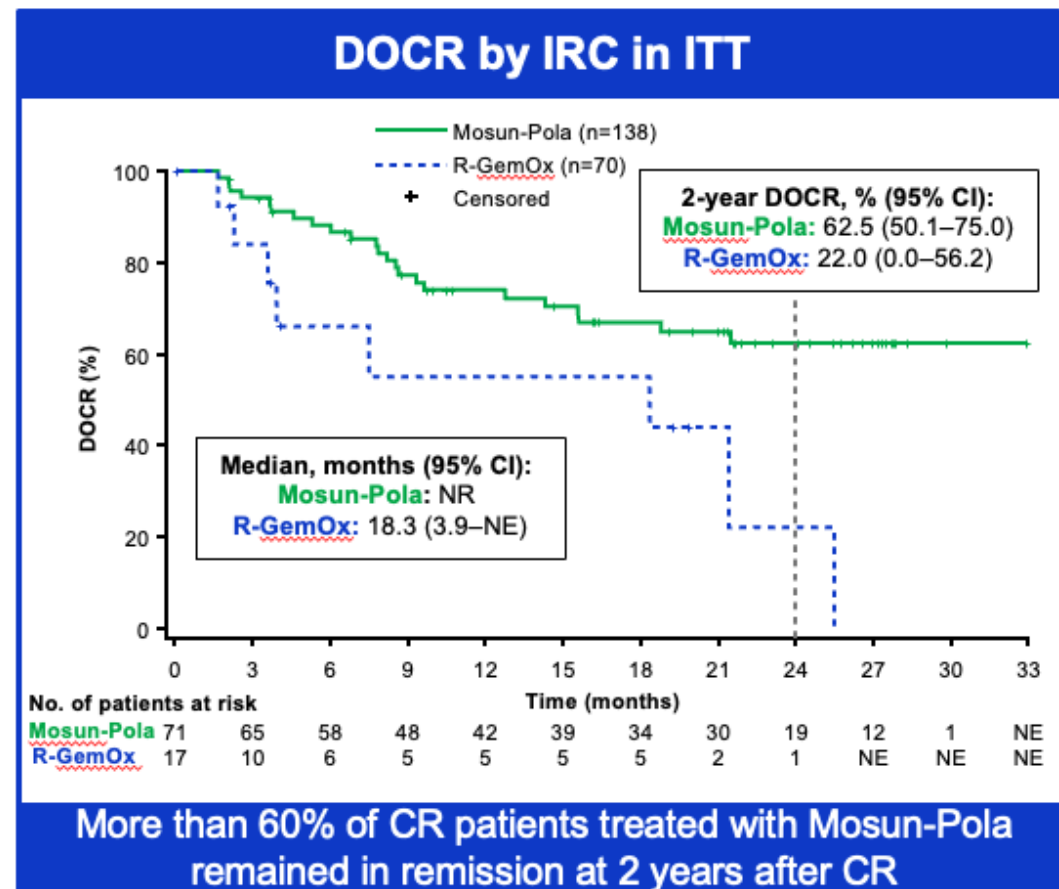
Efficacy and safety of mosun-pola were comparable across age groups

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)

Clinical cut-off date: August 8, 2025.

DOCR, duration of complete response; DOR, duration of response; NR, not reached.



Phase III SUNMO: Efficacy in the Second-Line Setting

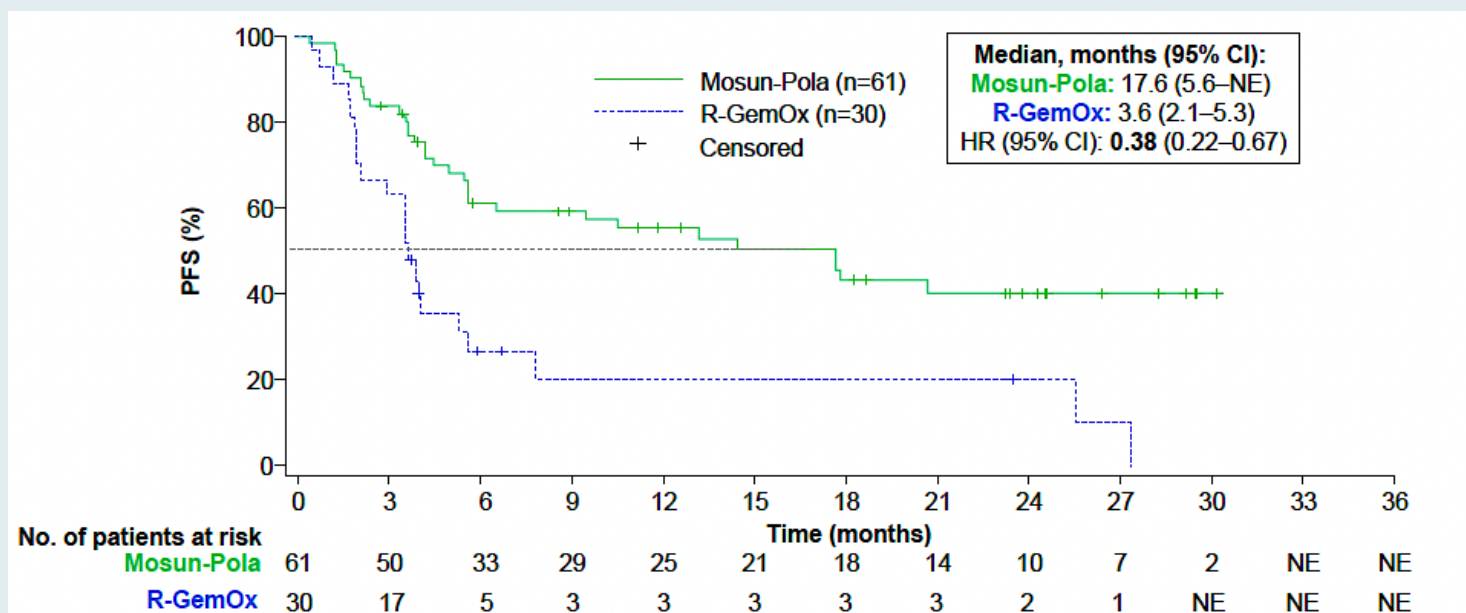


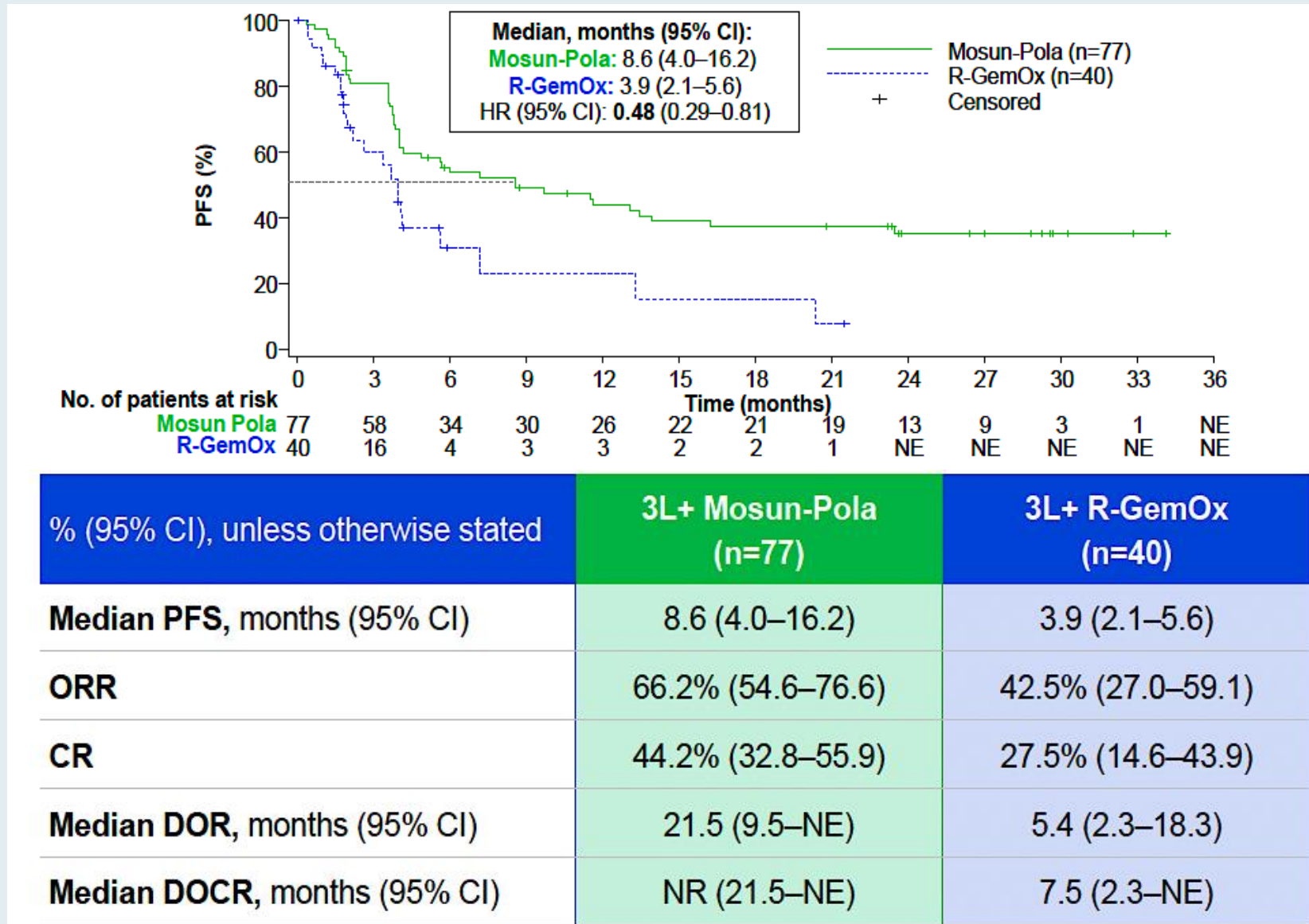
Table 3. Summary of IRC-assessed efficacy endpoints in the 2L setting

% (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

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



ORR = objective response rate

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

- Per protocol, G-CSF prophylaxis was required

Randomization 1:1

BV+Len+R (n=112)

BV 1.2 mg/kg IV Q3W + Len 20 mg PO QD + R 375 mg/m² IV Q3W^b

Treatment groups^c

Placebo+Len+R (n=118)

Placebo IV Q3W + Len 20 mg PO QD + R 375 mg/m² 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

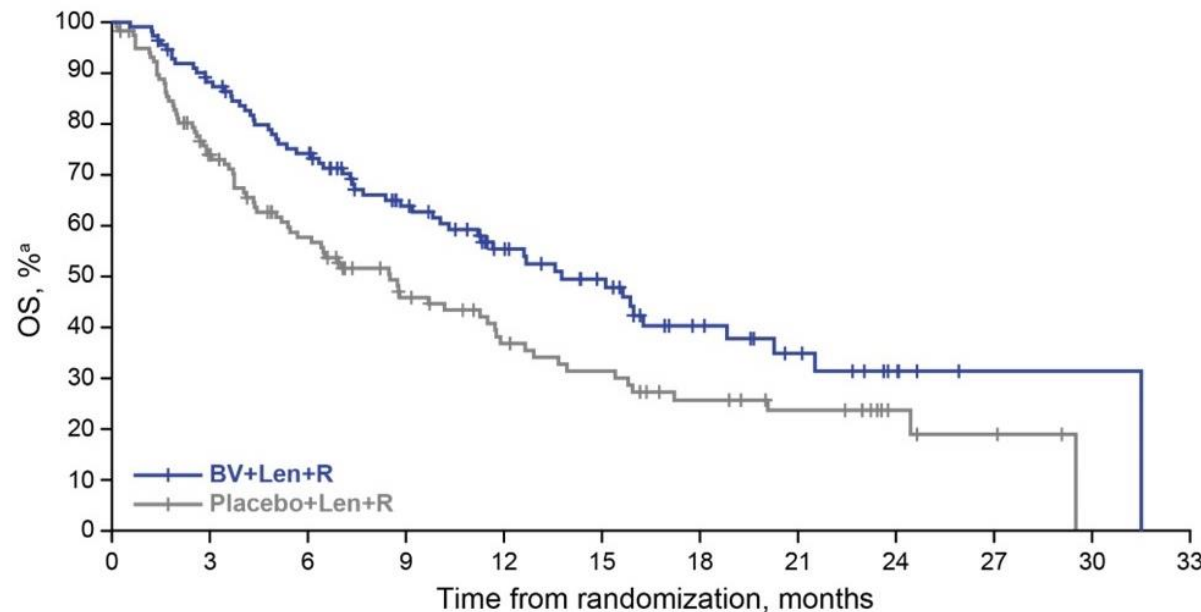
Secondary endpoints

- 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

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

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

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



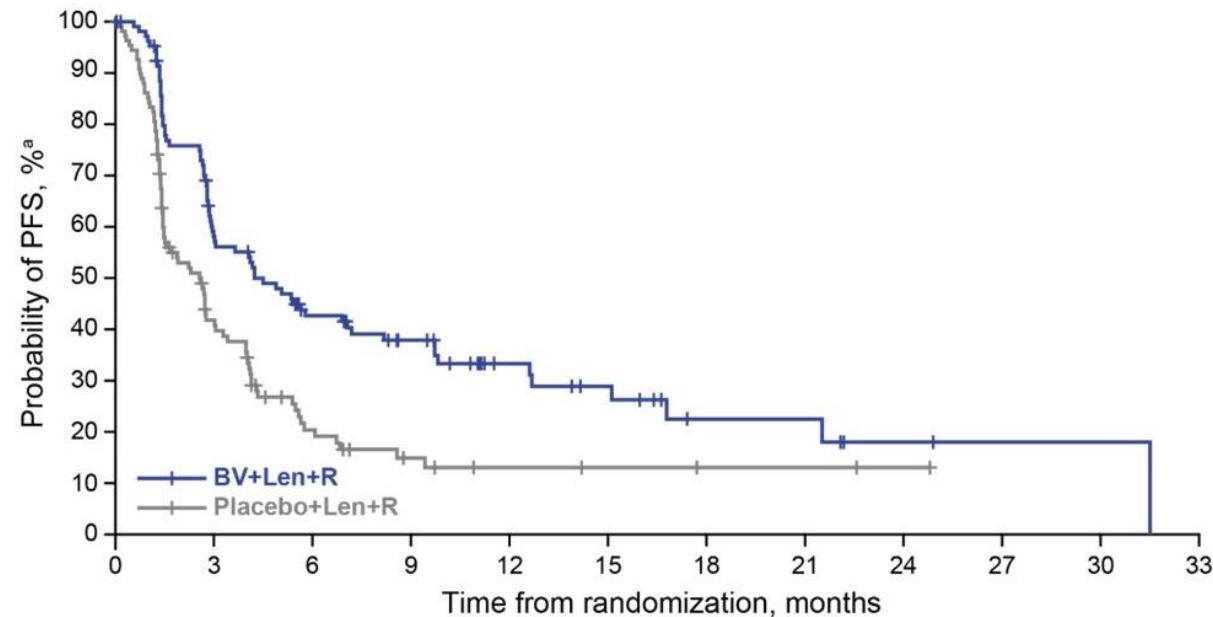
No. at risk												
BV+Len+R	112	96	79	57	40	30	17	11	5	1	1	0
Placebo+Len+R	118	81	58	39	28	23	16	12	5	3	0	0

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

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



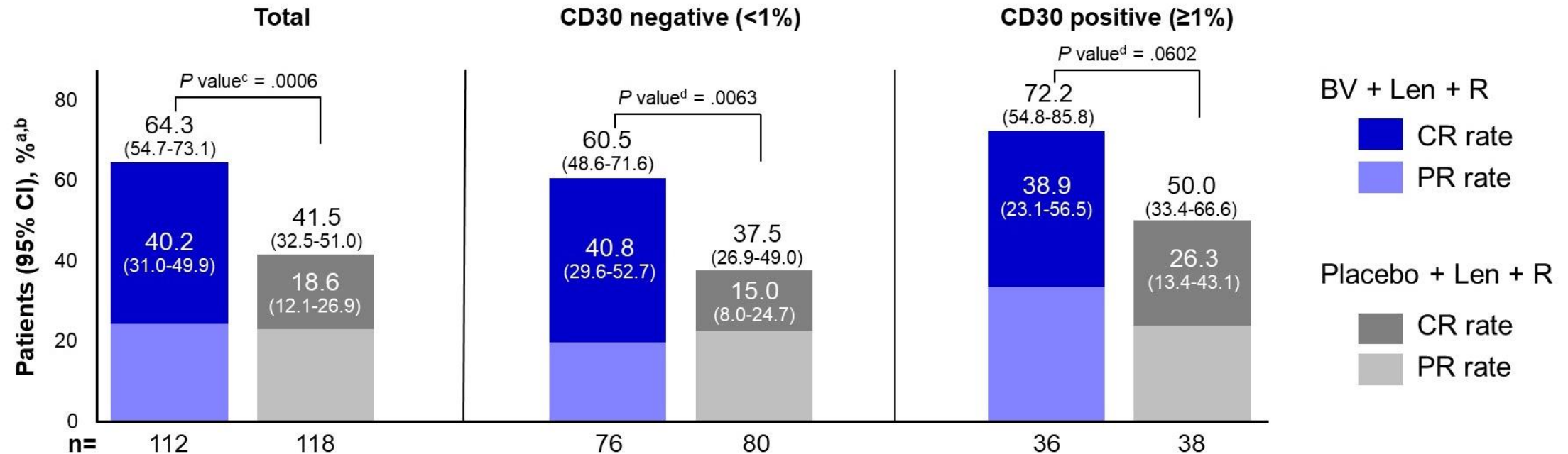
	BV+Len+R (n=112)	Placebo+Len+R (n=118)
PFS, median	4.2	2.6
(95% CI), months	(2.9-7.1)	(1.4-3.1)
Hazard ratio (95% CI) ^b	0.527 (0.380-0.729)	
Log-rank <i>P</i> value ^c	<.0001	
Events	71	85
Follow-up, median	11.1	8.8
(95% CI), months	(8.6-14.2)	(6.9-10.9)

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

- PFS was an alpha controlled key secondary endpoint

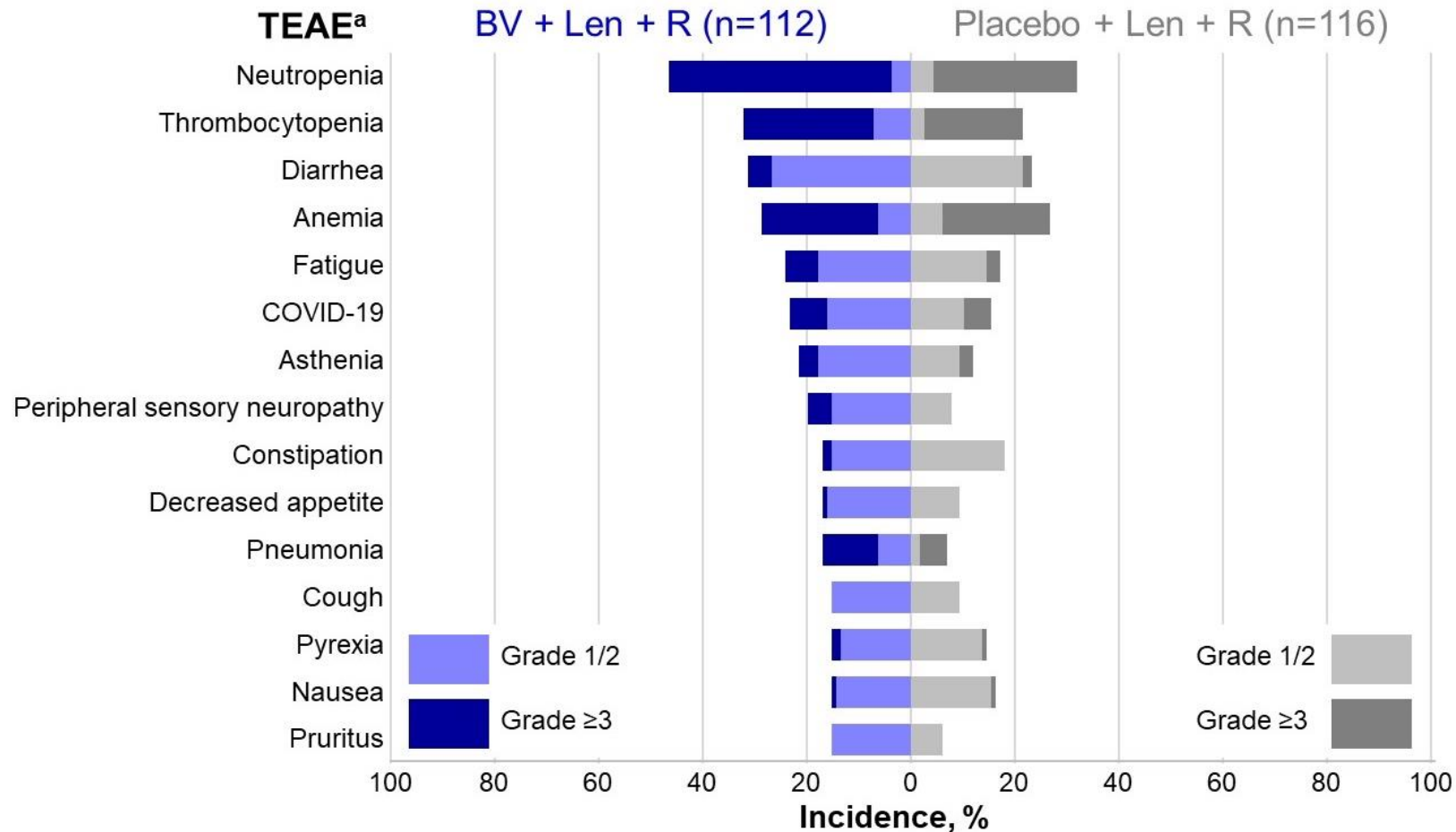
Phase III ECHELON-3: Responses

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



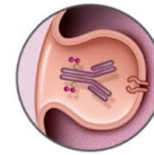
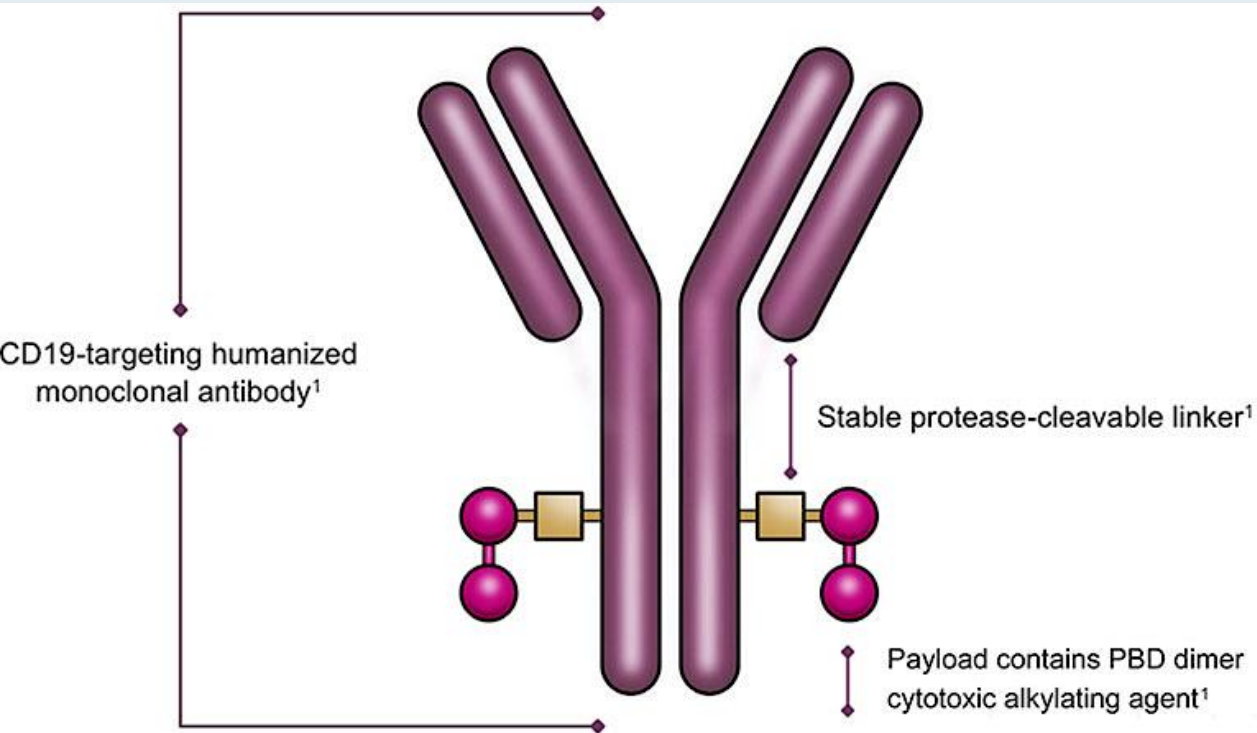
- In the total population, the median DOR (95% CI) was longer with BV+Len+R: 8.3 months (4.2-15.3 months) vs 3.0 months (2.8-5.4 months)
 - In patients who had a CR, the median DOR (95% CI) was 18.9 months (11.1 months-NR) with BV+Len+R and NR (2.8 months-NR) with placebo+Len+R
 - The median time to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

Phase III ECHELON-3: Safety

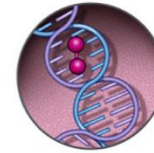


- TEAEs of any grade occurred in 97% of patients with each treatment
- Grade ≥3 TEAEs:
 - 88% with BV+Len+R
 - 77% with placebo+Len+R
 - 9% febrile neutropenia in each group
- Grade 5 TEAEs:
 - 12% with BV+Len+R
 - 8% with placebo+Len+R
- Any grade peripheral neuropathy TEAEs
 - 31% with BV+Len+R
 -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

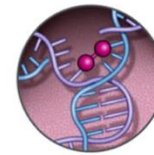
Loncastuximab Tesirine: A CD19-Directed Antibody-Drug Conjugate



Upon binding to CD19, Loncastuximab tesirine is internalized into the tumor cell and the PBD dimer cytotoxin is released into the cell¹



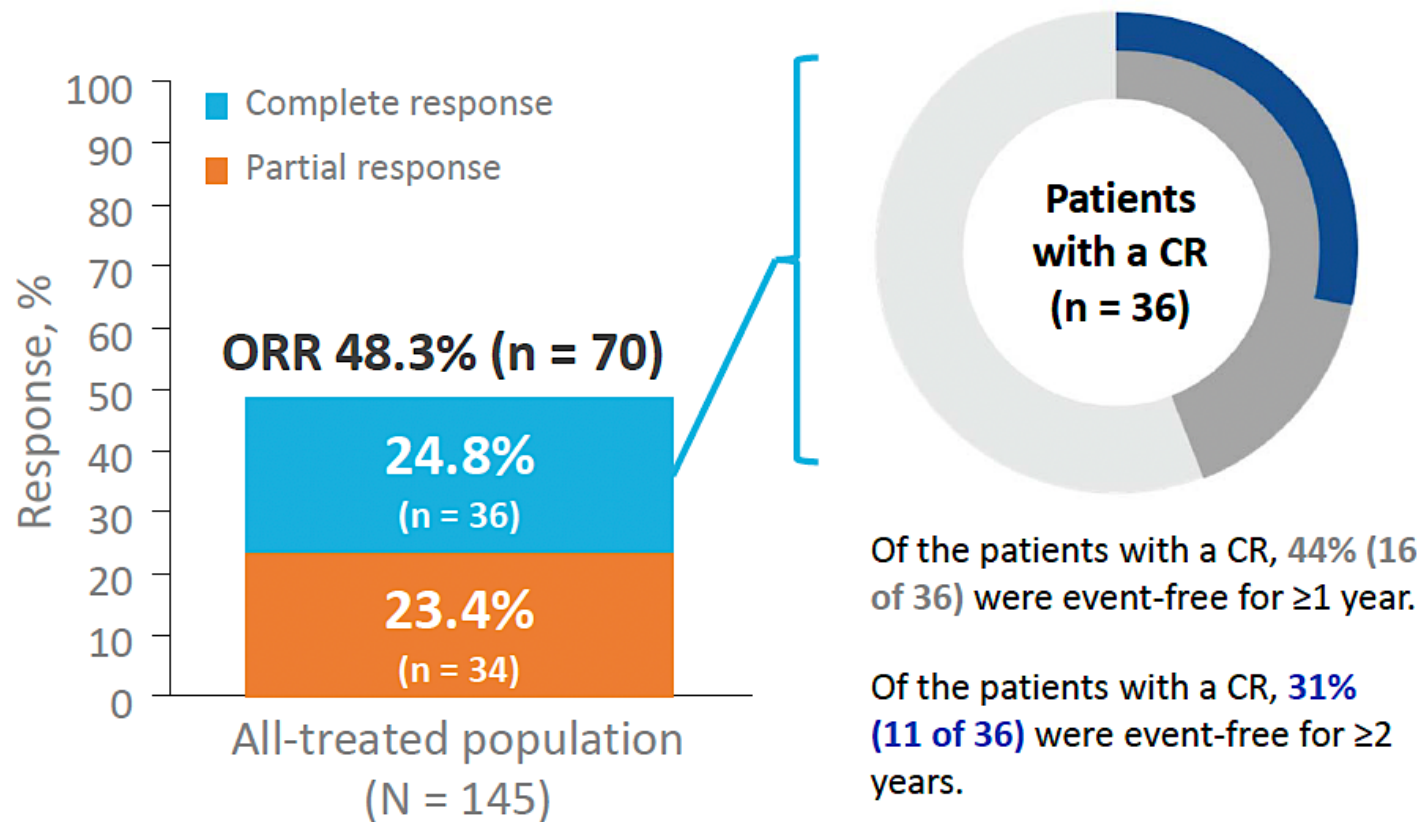
PBD dimer—an alkylating agent—binds to the DNA minor groove and forms highly cytotoxic DNA interstrand crosslinks¹



DNA interstrand crosslinks subsequently induce tumor cell death¹

ADC = antibody-drug conjugate; PBD = pyrrolobenzodiazepine.

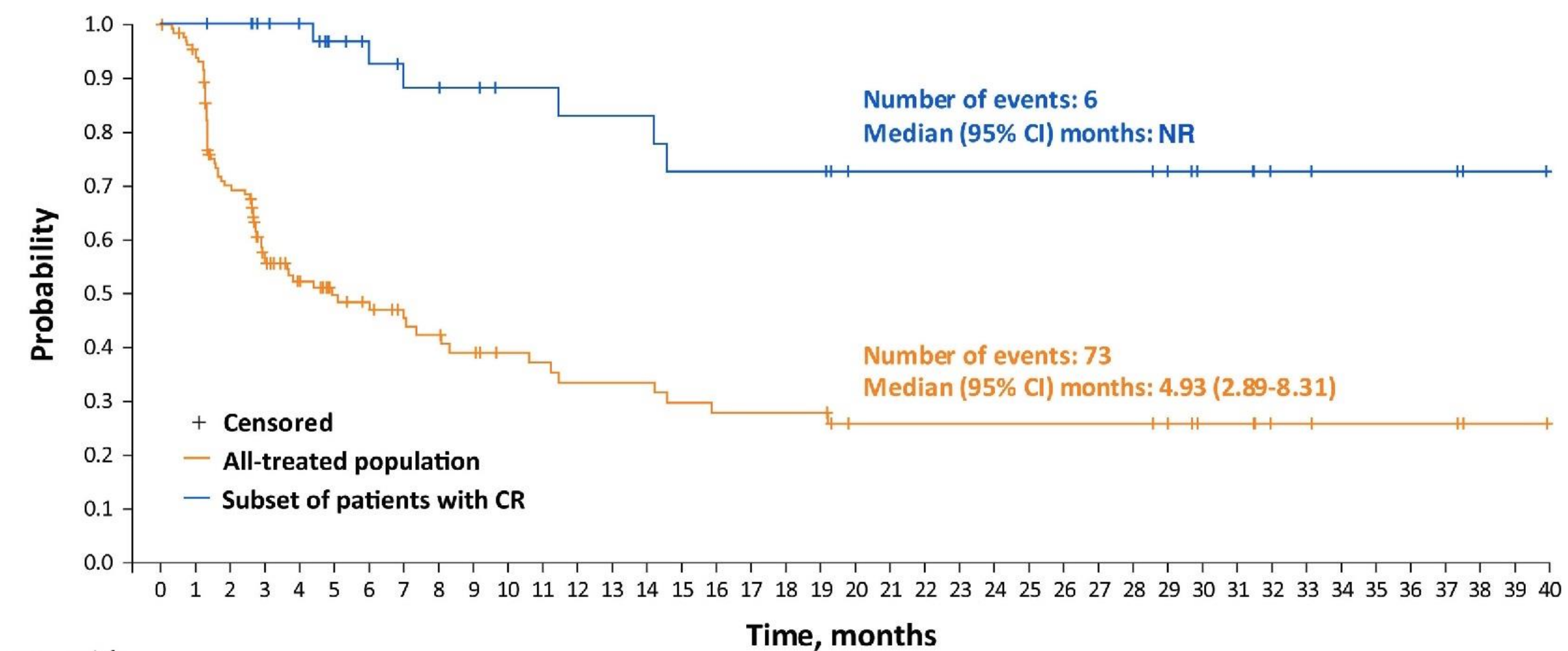
Phase II LOTIS-2 Study: Overall Response Rate (ORR) and Long-Term Responses — All-Treated Population



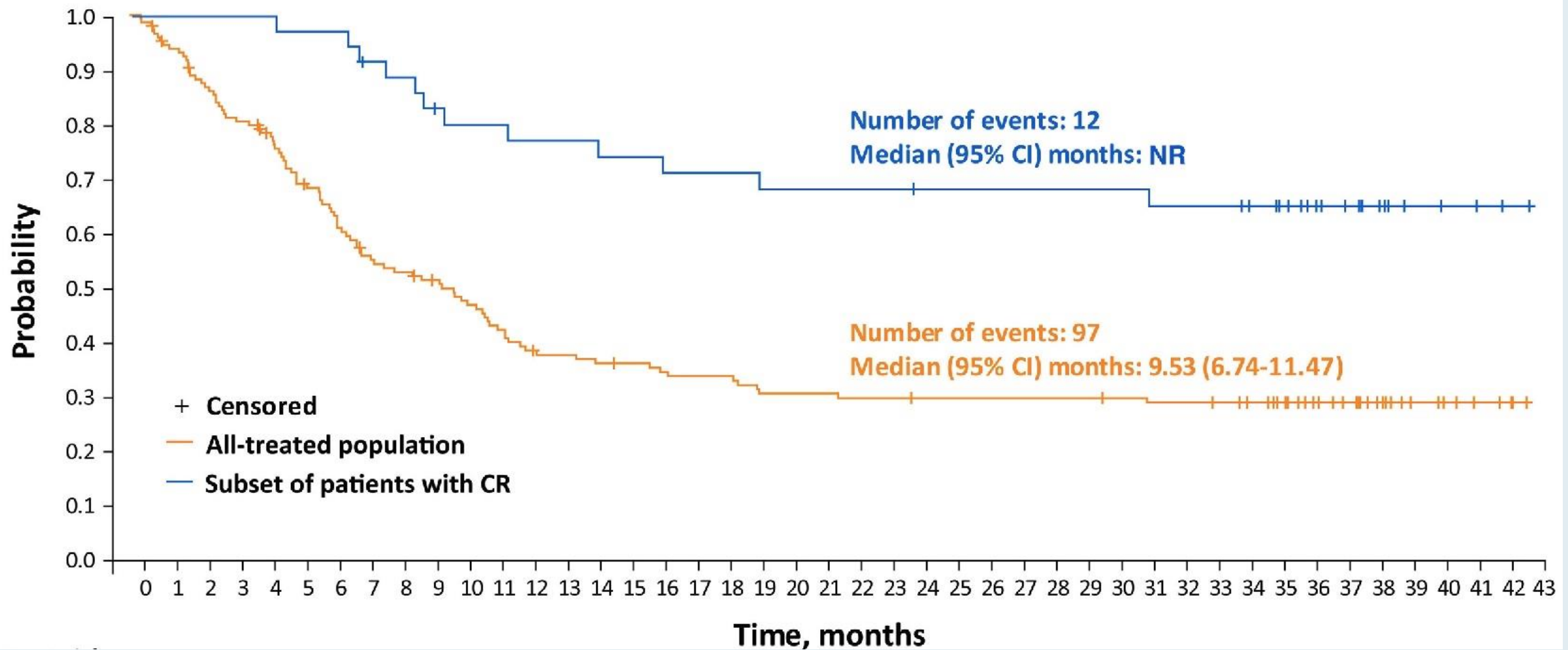
Median (range) number of treatment cycles	
All-treated population	3.0 (1-26)
Pts with a CR	8.0 (1-26)
Pts with a CR, event-free ≥1 year ^a	12.5 (1-26)
Pts with a CR, event-free ≥2 years ^a	13.0 (1-22)

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

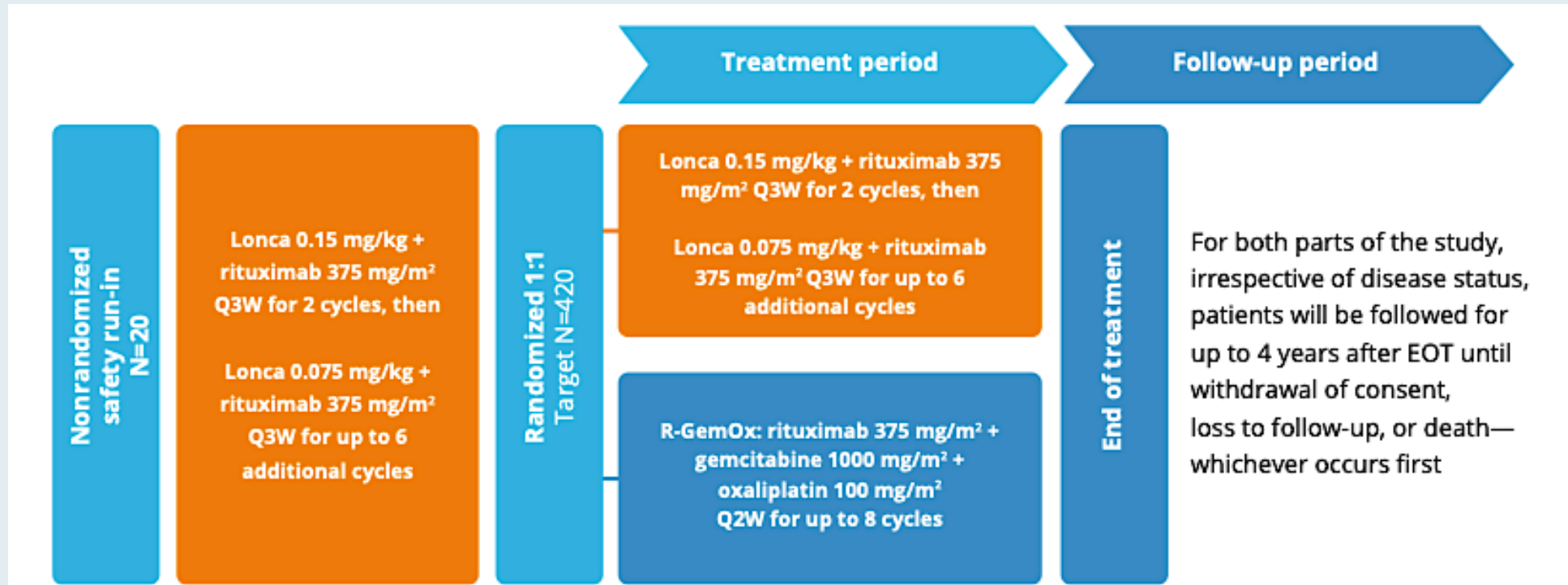
Phase II LOTIS-2: Progression-Free Survival



Phase II LOTIS-2: Overall Survival



Phase III LOTIS-5 Study Design



EOT, end of treatment; Lonca, loncastuximab tesirine; Q3W, every 3 weeks.

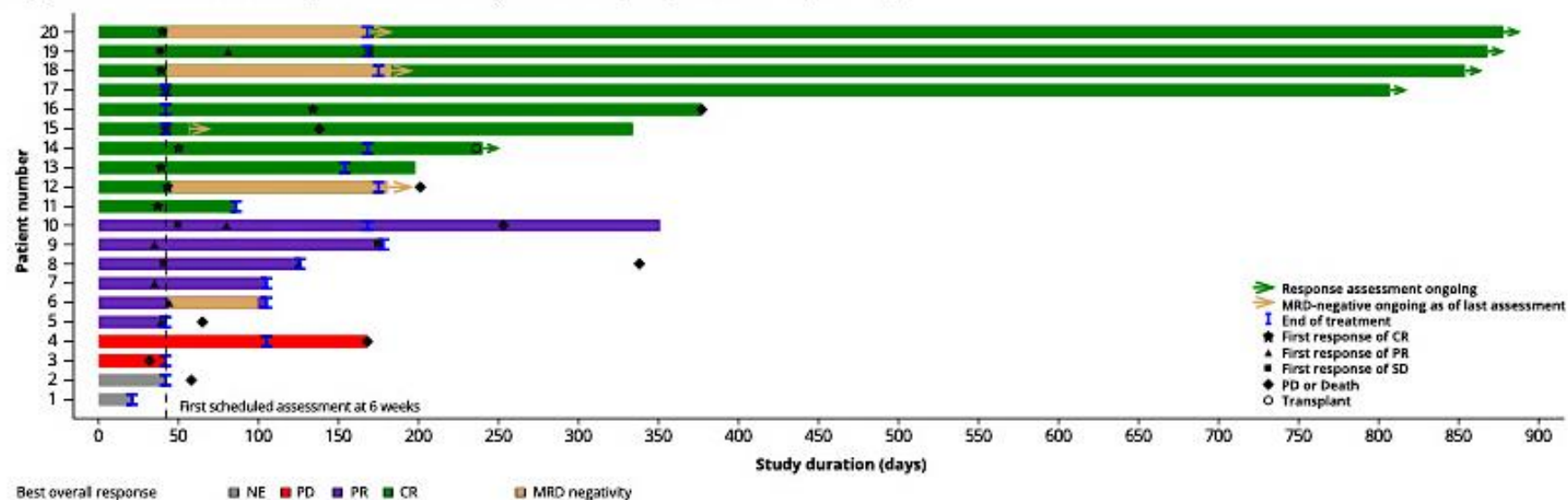
Study Endpoints

- 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

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.

Phase III LOTIS-5: Efficacy

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.

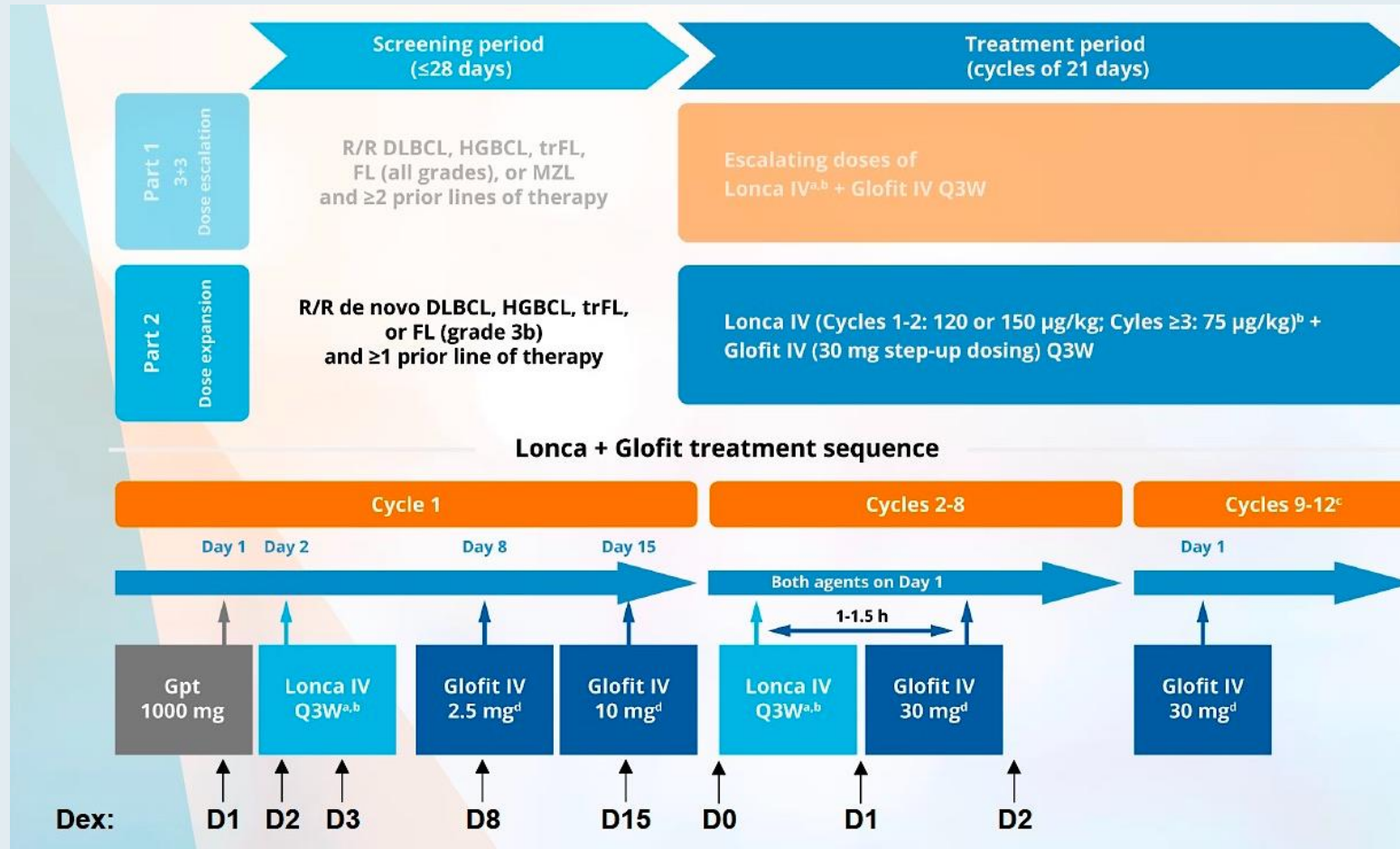
Results from LOTIS-5 Phase III Confirmatory Clinical Trial of Loncastuximab Tesirine-Ipyl in Combination with Rituximab for R/R DLBCL

Press Release: June 3, 2026

“[The manufacturer] today announced topline data from its Phase 3 LOTIS-5 confirmatory trial evaluating loncastuximab tesirine-Ipyl in combination with rituximab in patients with relapsed or refractory diffuse large B-cell lymphoma (r/r DLBCL). Loncastuximab tesirine-Ipyl 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-Ipyl 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.”

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

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			

^aAs per Investigator reported adverse events. ^bWhen 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.

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

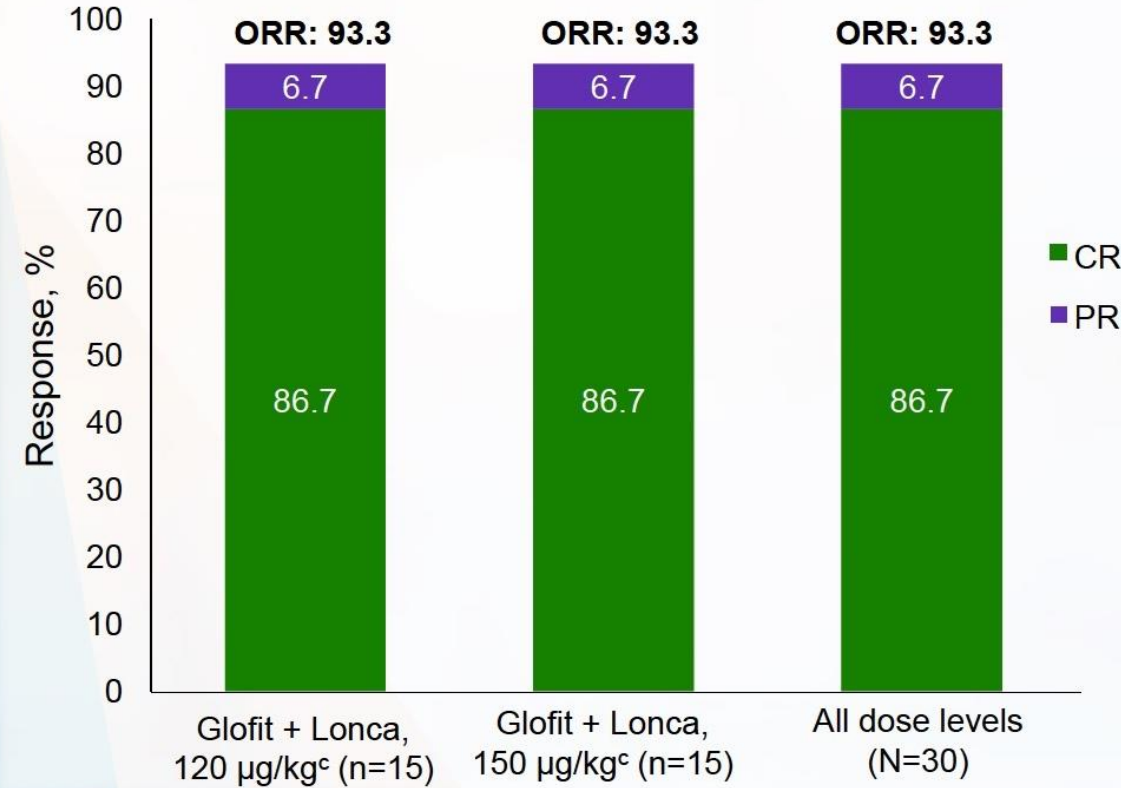
- All patients with ICANS had complete resolution of symptoms
 - Two patients resumed treatment and ultimately achieved a CR
 - One patient elected to discontinue treatment
- ICANS managed primarily with corticosteroids

^aNumber 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
^bWhen 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.

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

EFFICACY EVALUABLE POPULATION (N=30)^a

Best overall response^b



Duration of response

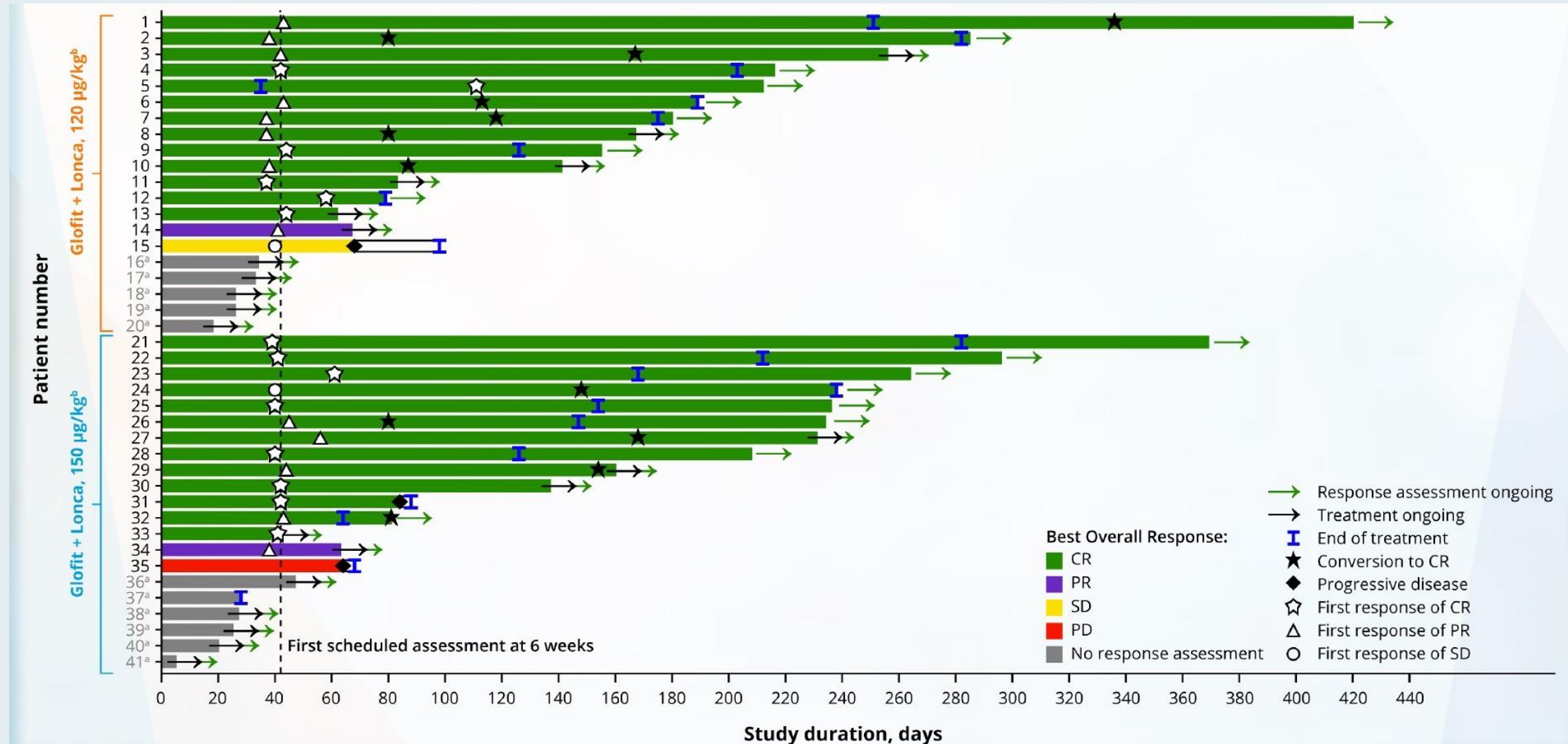
Characteristic, n (%)	Glofit + Lonca, 120 µg/kg ^c (n=15)	Glofit + Lonca, 150 µg/kg ^c (n=15)	All dose levels (N=30)
DOR ^d Median	(n=14) NE	(n=14) NE	(n=28) NE
Time to first response (CR or PR) Median, days	(n=14) 42.0	(n=14) 42.0	(n=28) 42.0
Time to first CR Median, days	(n=13) 80.0	(n=13) 42.0	(n=26)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

^aThe 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. ^bPercentages do not add up to total due to rounding. ^cWhen 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. ^dIn 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.

Phase Ib LOTIS-7 Initial Results: Efficacy over Time



Updated Data Announced from LOTIS-7 Phase 1b Trial of Loncastuximab Tesirine in Combination with Bispecific Antibody Supporting Potential Best-in-Class Regimen for R/R DLBCL

Press Release: December 3, 2025

“On December 3, 2025, [the manufacturer] announced updated data from the LOTIS-7 Phase 1b open-label clinical trial evaluating the safety and efficacy of loncastuximab tesirine in combination with the bispecific antibody glofitamab in patients with relapsed or refractory diffuse large B-cell lymphoma (r/r DLBCL). The updated data is based on investigator assessment and reflects the 49 efficacy-evaluable patients with a minimum of 6 months of follow-up from treatment initiation.

Enrollment in the LOTIS-7 clinical trial is ongoing, with complete enrollment of approximately 100 patients at the selected 150 µg/kg dose expected during the first half of 2026. The Company plans to share full data at a medical meeting and submit for publication by the end of 2026. In addition, the Company plans to assess regulatory and compendia strategies.”

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

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 Phillips	Yes, mosunetuzumab and glofitamab
	Prof Salles	Yes, mainly glofitamab
	Dr Westin	Yes, mosunetuzumab

R-ICE = rituximab/ifosfamide/carboplatin/etoposide

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 Phillips	3L+, after PD on CAR T (early relapse) or BsAb (late relapse after CAR T)	Yes, but only after assessing CD19 expression
 Prof Salles	When first-line, CAR T and bispecific Ab 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 Phillips	30%	>1 year
	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 Phillips	50%	Initiate preventative diuretic in most patients, hold/stop drug if AE
 Prof Salles	20%	Diuretic and prophylactic steroids, then diuretic alone
 Dr Westin	33%	Diuretics and steroids

AE = adverse event

Would you administer brentuximab vedotin/R² 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 Phillips	No
	Prof Salles	No
	Dr Westin	No

R² = lenalidomide/rituximab

Questions?