The Implications of Recent Datasets for the Current and Future Management of Non-Hodgkin Lymphoma and Chronic Lymphocytic Leukemia — An ASCO/EHA 2026 Review

A CME/MOC-Accredited Live Webinar

Wednesday, September 2, 2026

5:00 PM – 6:30 PM ET

Faculty

Brad S Kahl, MD

Jeff Sharman, MD

Tanya Siddiqi, MD

Moderator

Neil Love, MD

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Faculty

Brad S Kahl, MD
Professor of Medicine
Washington University School of Medicine
Director, Lymphoma Program
Siteman Cancer Center
St Louis, Missouri

Tanya Siddiqi, MD
Medical Director of Lymphoma and IEC Programs
City of Hope OC
Director, CLL Program
Professor, Department of Hematology/HCT
City of Hope
Duarte, California

Jeff Sharman, MD
Medical Director of Hematology Research
Sarah Cannon Research Institute at
Willamette Valley Cancer Center
Eugene, Oregon

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

Commercial Support

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Dr Love — Disclosures

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Data and Safety Monitoring Boards/Committees	Acrotech Biopharma, Bristol Myers Squibb, Foresight Diagnostics, a wholly-owned subsidiary of Natera Inc, Nurix Therapeutics Inc, PeproMene Bio Inc

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Data and Safety Monitoring Boards/Committees	BeOne

Dr Siddiqi — Disclosures

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Contracted Research	Bristol Myers Squibb

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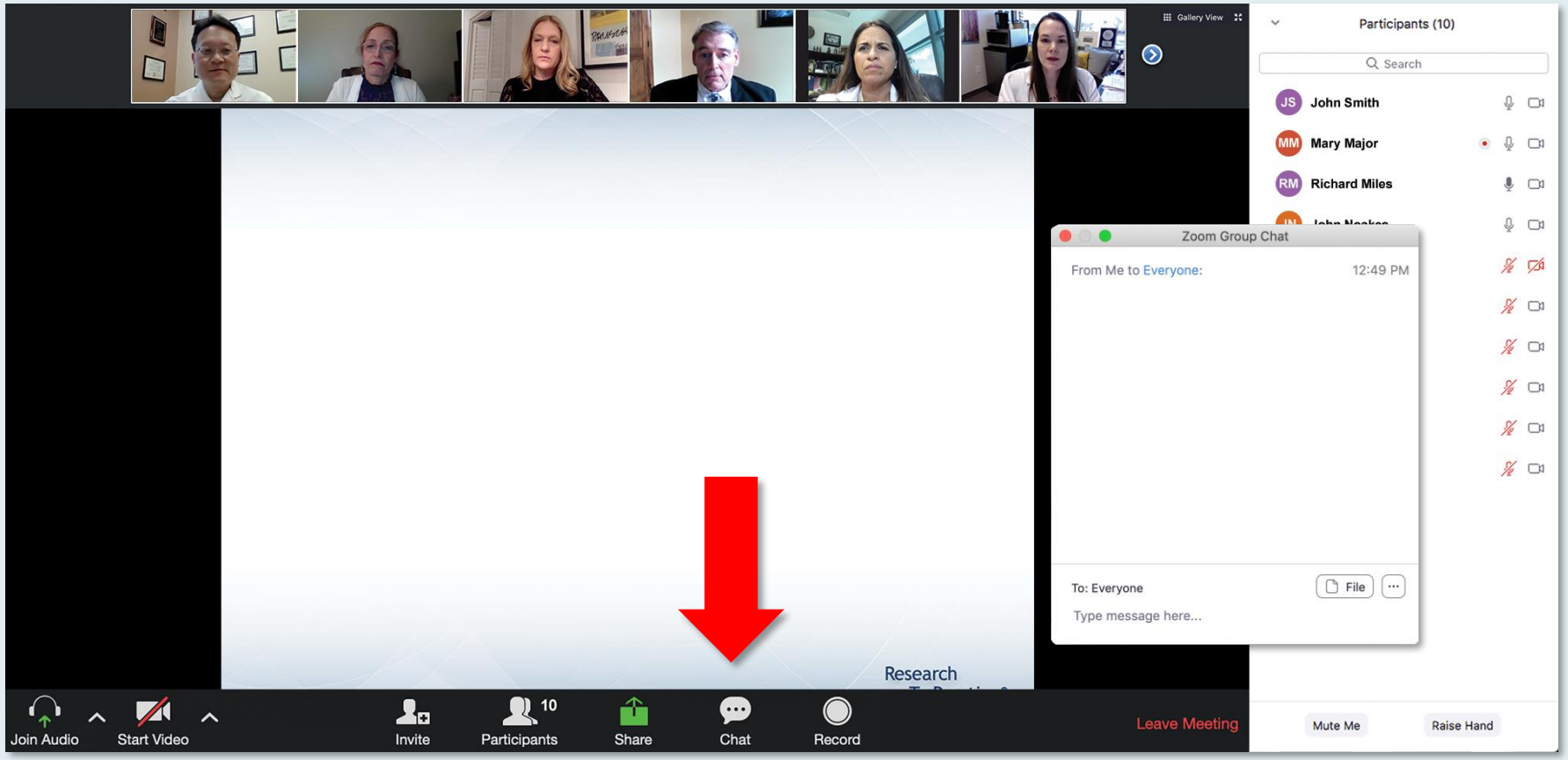

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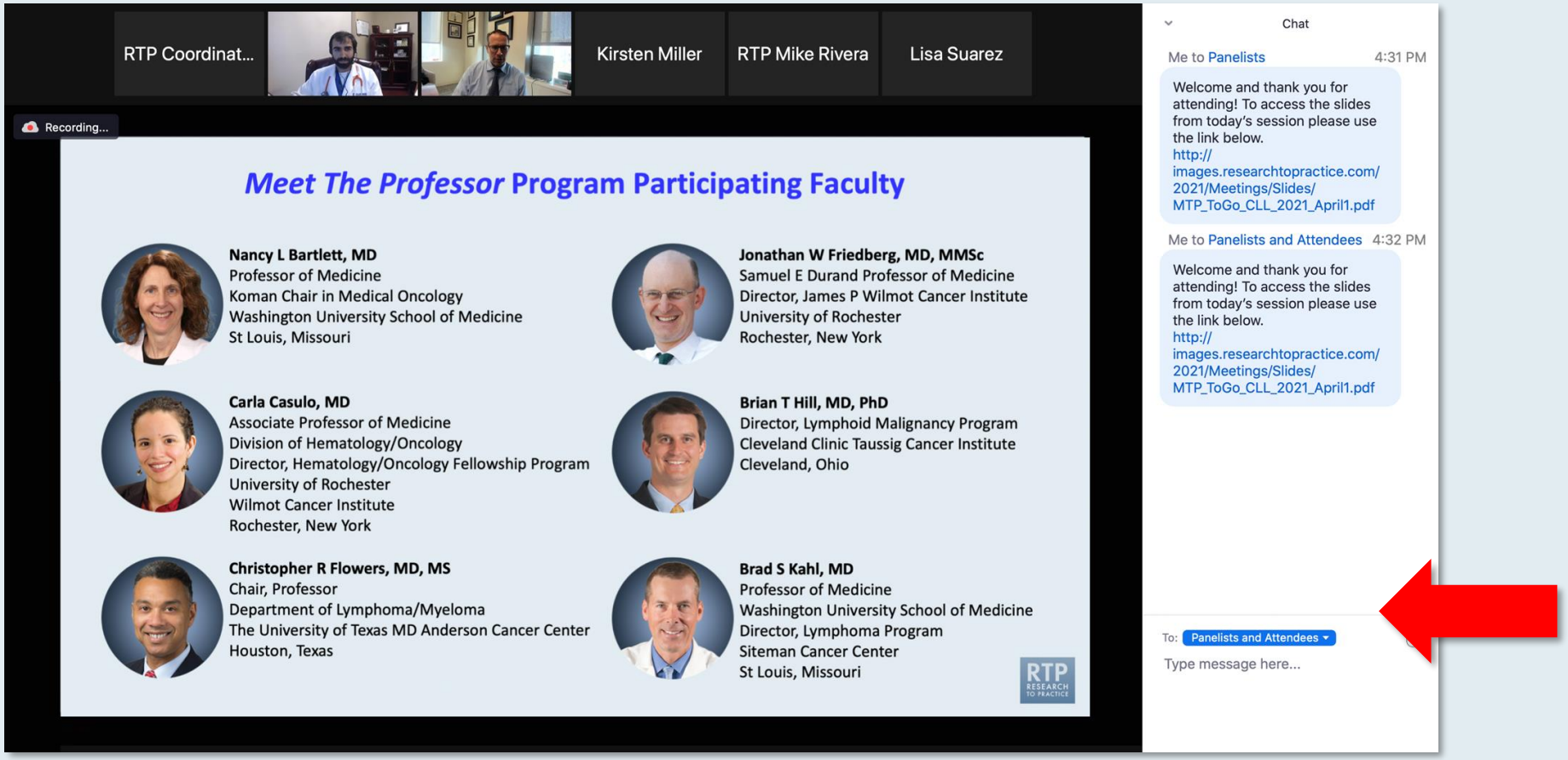

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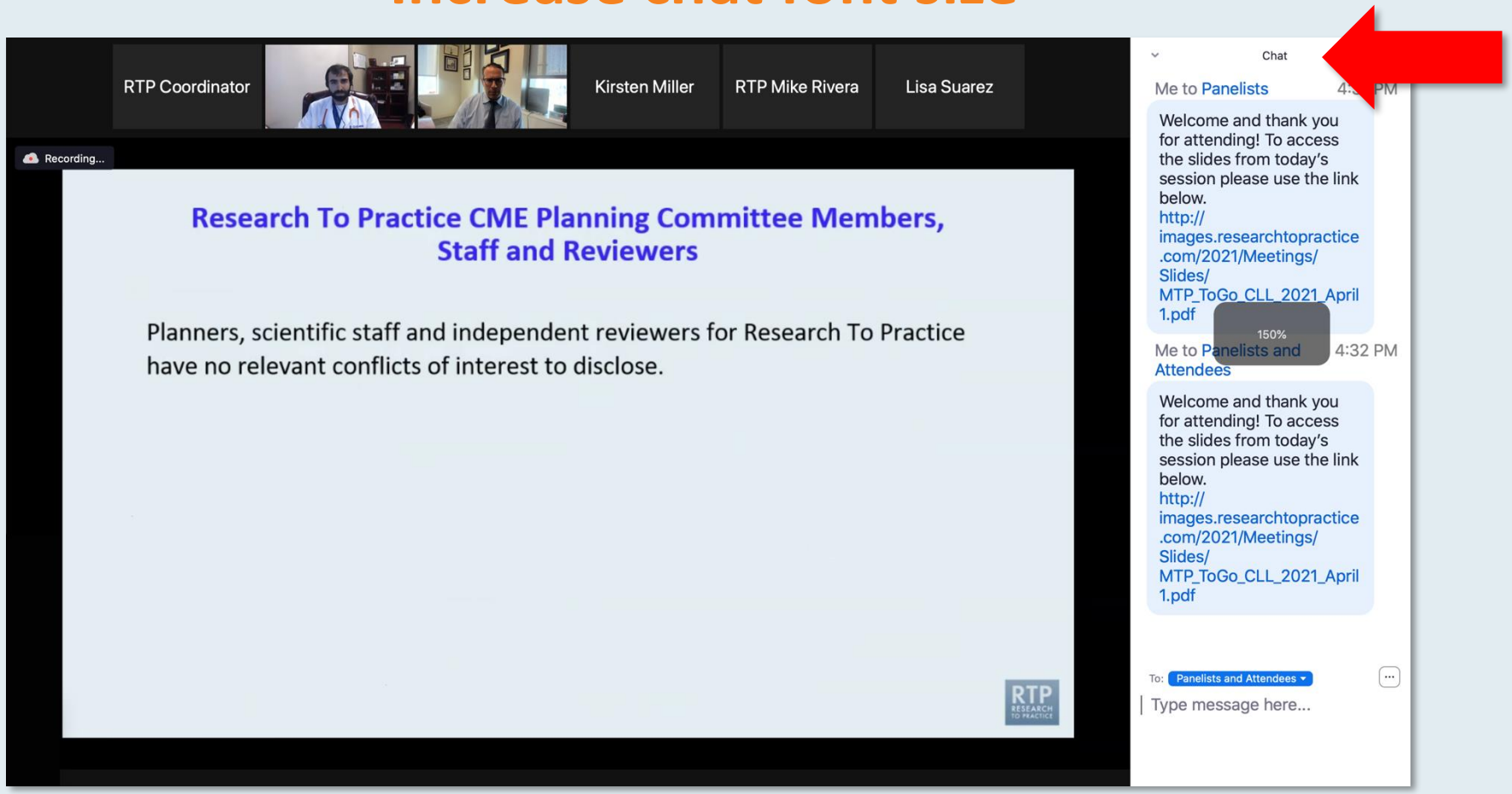

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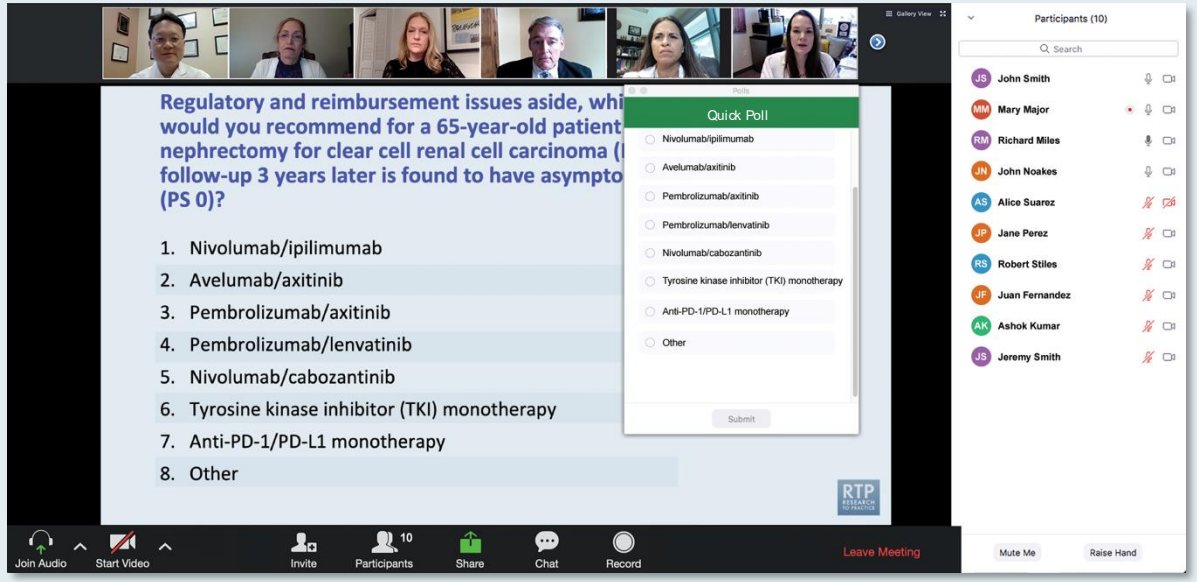

ONCOLOGY TODAY

WITH DR NEIL LOVE

Non-Hodgkin Lymphoma — Proceedings from a Session Held in Conjunction with the 2026 ASCO Annual Meeting on the Roles of CAR T-Cell Therapy and Bispecific Antibodies

JEREMY S ABRAMSON, MD, MMSC
MASSACHUSETTS GENERAL HOSPITAL

TYCEL PHILLIPS, MD, FASCO
CITY OF HOPE COMPREHENSIVE CANCER CENTER

JOSHUA BRODY, MD
THE TISCH CANCER INSTITUTE

JASON WESTIN, MD, MS
THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER

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Data + Perspectives: Investigators Discuss the Optimal Management of Relapsed/Refractory Multiple Myeloma

A CME-Accredited Satellite Symposium During the Society of Hematologic Oncology 2026 Annual Meeting

Wednesday, September 9, 2026
11:56 AM – 12:56 PM CT

Faculty

Meletios-Athanasios (Thanos) C Dimopoulos, MD
Noopur Raje, MD

Moderator

Robert Z Orlowski, MD, PhD

RTP RESEARCH TO PRACTICE

Data + Perspectives: Investigators Discuss the Optimal Management of Chronic Lymphocytic Leukemia

A CME/MOC-Accredited Live Webinar

Thursday, September 17, 2026
5:00 PM – 6:00 PM ET

Faculty

Catherine C Coombs, MD
Matthew S Davids, MD, MMSc

Moderator

Neil Love, MD

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RESEARCH TO PRACTICE

Integrating New Advances into Community Oncology Practice

A Multitumor Symposium in Partnership with Florida Cancer Specialists & Research Institute

Saturday, October 17, 2026
7:15 AM – 12:00 PM ET

The Ritz-Carlton Orlando Grande Lakes | Orlando, Florida

Faculty

Faculty to be announced.

Moderator

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RESEARCH TO PRACTICE

Second Opinion: A Case-Based Exploration of Clinical Investigator Best Practices Related to the Management of Breast Cancer

A CME Satellite Symposium Series

HER2-Positive Breast Cancer

Tuesday, December 8, 2026

7:00 PM – 9:00 PM CT

PI3K/AKT/mTOR Inhibitors for HR-Positive Breast Cancer

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A Friday Satellite Symposium Series Preceding the 68th ASH Annual Meeting

Friday, December 11, 2026

Acute Myeloid Leukemia
7:30 AM – 9:30 AM CT

Chronic Lymphocytic Leukemia
7:30 AM – 9:30 AM CT

Non-Hodgkin Lymphoma
11:30 AM – 1:30 PM CT

Multiple Myeloma
11:30 AM – 1:30 PM CT

Myelofibrosis
3:15 PM – 5:15 PM CT

BCMA ADCs and Bispecific Antibodies for Multiple Myeloma
7:00 PM – 9:00 PM CT

Novel Therapies for Non-Hodgkin Lymphoma
7:00 PM – 9:00 PM CT

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Grand Rounds

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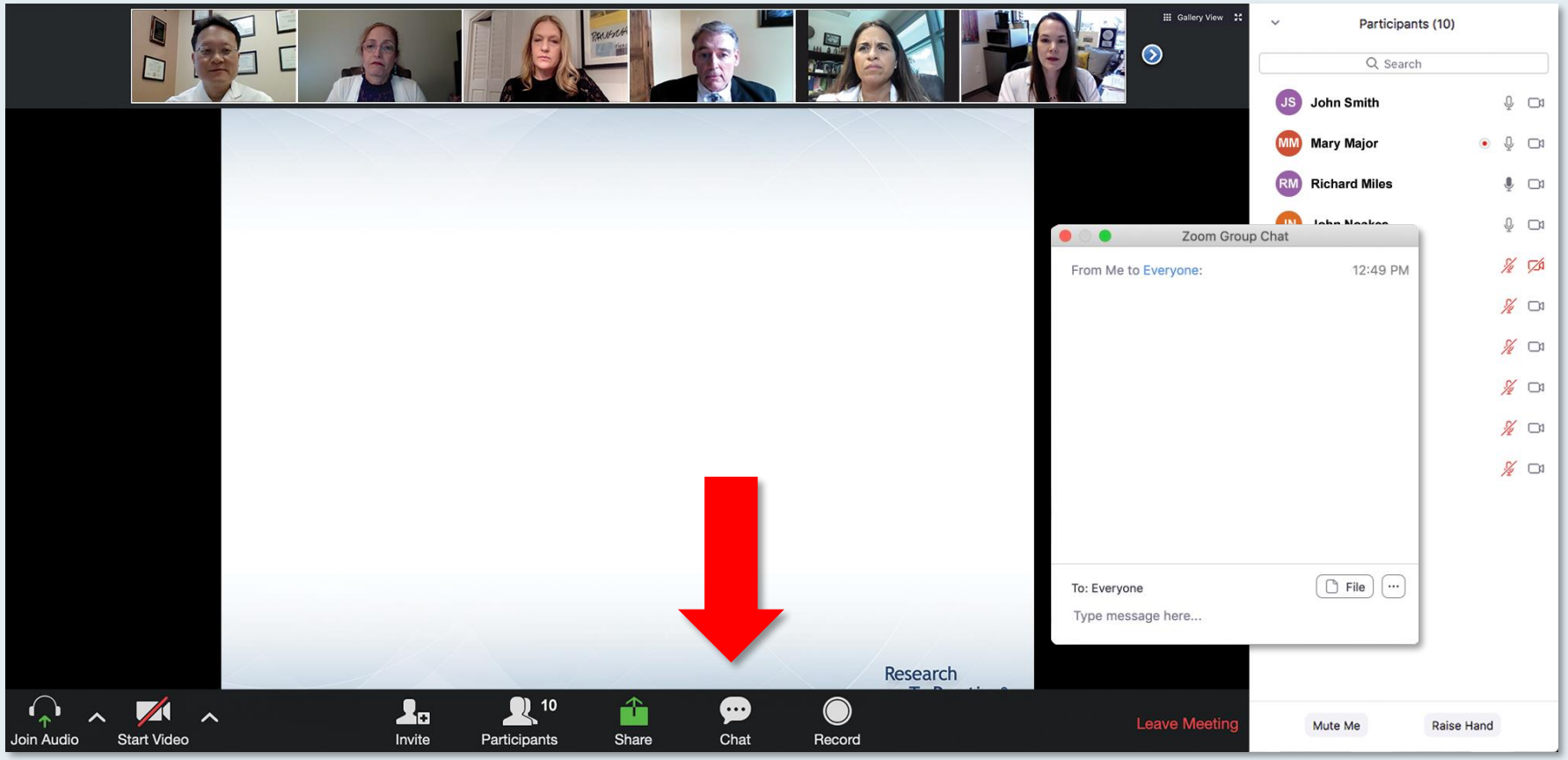

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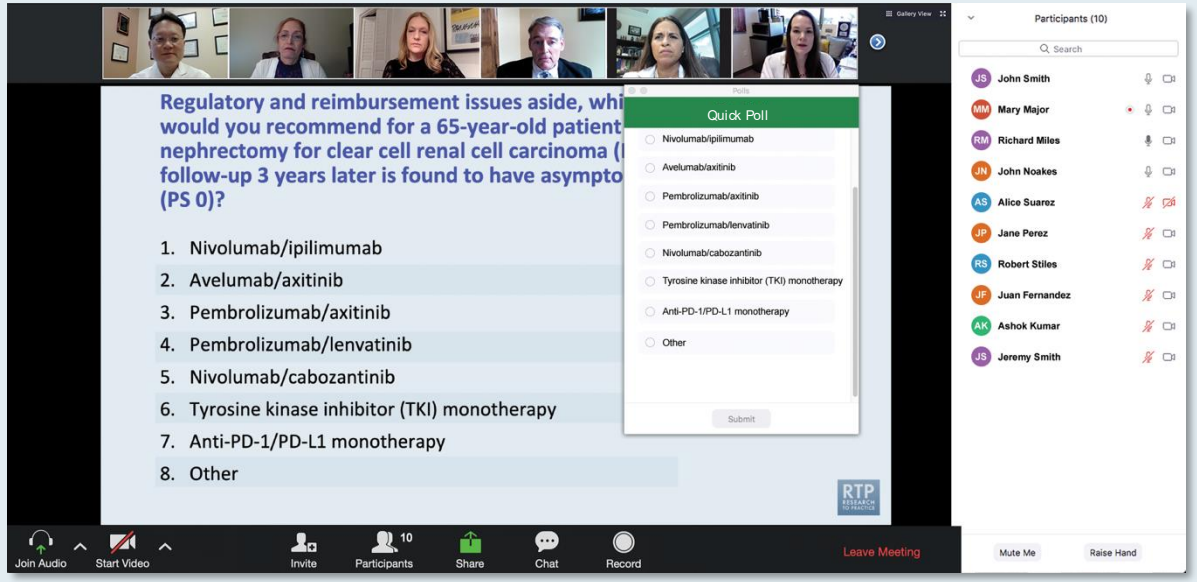

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Agenda

Introduction: Trials in Progress

Module 1: Chronic Lymphocytic Leukemia

Module 2: Diffuse Large B-Cell Lymphoma

Module 3: Mantle Cell Lymphoma

Module 4: Follicular Lymphoma

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Agenda

Introduction: Trials in Progress

Module 1: Chronic Lymphocytic Leukemia

- First-Line Therapy
- BRUIN CLL-322 (Pirtobrutinib/Venetoclax/Rituximab for Relapsed Disease)
- Bispecific Antibodies (Epcoritamab)
- BTK Degraders

Module 2: Diffuse Large B-Cell Lymphoma

Module 3: Mantle Cell Lymphoma

Module 4: Follicular Lymphoma

Key Datasets

- Fischer K et al. **Venetoclax-obinutuzumab** for **previously untreated chronic lymphocytic leukemia**: **Final results** of the randomized **CLL14 study**. EHA 2026;Abstract S146.
- Seymour JF et al. **Safety** of **fixed-duration** (FD) **acalabrutinib-venetoclax combinations** in patients (pts) with **chronic lymphocytic leukemia** (CLL) stratified by age: **Post hoc analysis** of the **phase 3 AMPLIFY trial**. EHA 2026;Abstract PF614.
- Cheah CY et al. **First-line treatment** of CLL/SLL with the **all-oral combination of sonrotoclax and zanubrutinib** achieves **undetectable minimal residual disease** rates of >90%, including in patients with **del(17p)/TP53**. EHA 2026;Abstract S145.
- Ahn I et al. A **phase 2 study** of **fixed-duration pirtobrutinib** and obinutuzumab in **previously untreated CLL**. EHA 2026;Abstract S148.
- Wierda W et al. **Pirtobrutinib** in **treatment-naïve** patients with CLL/SLL: **Pooled results from BRUIN CLL-313 and BRUIN CLL-314**. ASCO 2026;Abstract 7044.

Key Datasets (Continued)

- Davids MS et al. **Fixed duration pirtobrutinib** plus venetoclax–rituximab versus venetoclax–rituximab for patients with **previously treated CLL/SLL**: A **phase 3**, randomized trial (BRUIN CLL-322). EHA 2026;Abstract LB5001.
- Kater AP et al. **Fixed duration venetoclax plus epcoritamab** shows favorable tolerability and high response rates with early molecular responses in R/R CLL/SLL: **Interim analysis** of the randomized **HOVON 165/AETHER trial**. EHA 2026;Abstract S153.
- Stilgenbauer S et al. **BGB-16673,** a Bruton tyrosine kinase (BTK) degrader, in patients with **relapsed/refractory** (R/R) **chronic lymphocytic leukemia/small lymphocytic lymphoma** (CLL/SLL): A **phase 1 CADANCE-101 study update**. EHA 2026;Abstract S152.
- Munir T et al. **Updated efficacy and safety data** from an ongoing **phase 1a/b trial** of the BTK degrader **bexobrutideg (NX-5948)** in patients with **CLL** across lines of therapy. EHA 2026;Abstract S150.

Updates in CLL

Jeff Sharman M.D.

Medical Director of Hematology Research SCRI

Key Datasets — First-Line Therapy

- Fischer K et al. **Venetoclax-obinutuzumab** for **previously untreated chronic lymphocytic leukemia**: **Final results** of the randomized **CLL14 study**. EHA 2026;Abstract S146.
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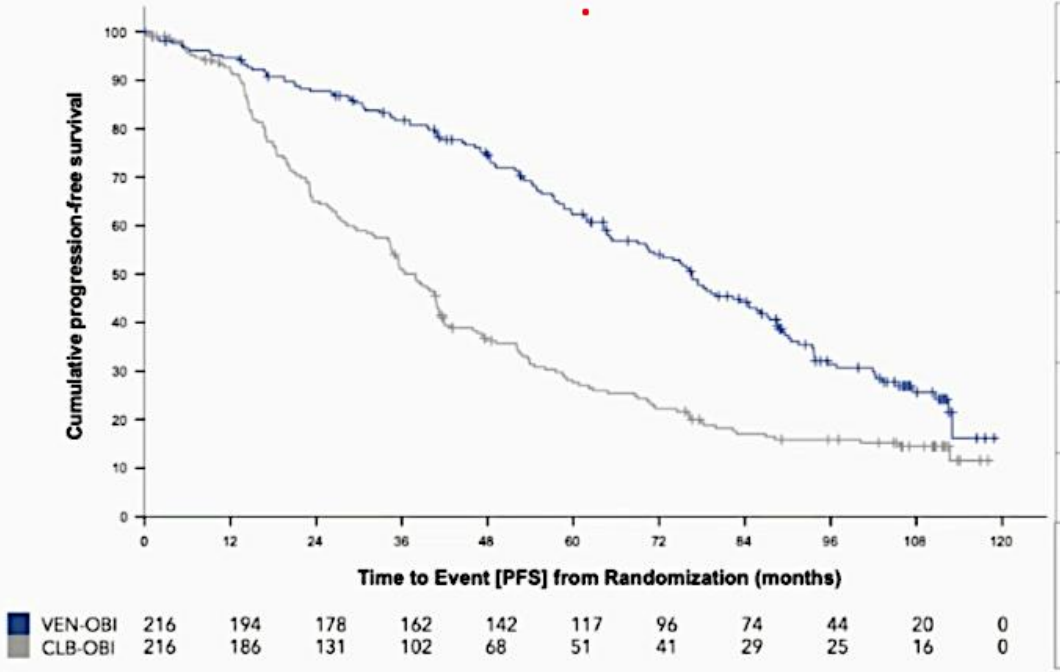
S146 I VENETOCLAX-OBINUTUZUMAB FOR PREVIOUSLY UNTREATED CHRONIC LYMPHOCYTIC LEUKEMIA: FINAL ANALYSIS OF THE RANDOMIZED PHASE 3 CLL14 STUDY

Kirsten Fischer, Othman Al-Sawaf, Sandra Robrecht, Adam Giza, Can Zhang, Anna-Maria Fink, Christof Schneider, Karl-Anton Kreuzer, Tatiana Chagorova, Liliya Sivcheva, Olga Samoylova, Stephen Opat, Carsten Utoft Niemann, Igor Aurer, Lachezar Bogdanov, Anthony Schwarer, Christian Bjørn Poulsen, Andrew Butler, Javier Loscertales Pueyo, Carolyn Owen, Emil Spasov, Anja Wrisch, Madlaina Breuleux, Yanwen Jiang, Hyun Yong Jin, Eugen Tausch, Anke Schilhabel, Matthias Ritgen, Stephan Stilgenbauer, Barbara Eichhorst, Michael Hallek

Progression-Free Survival



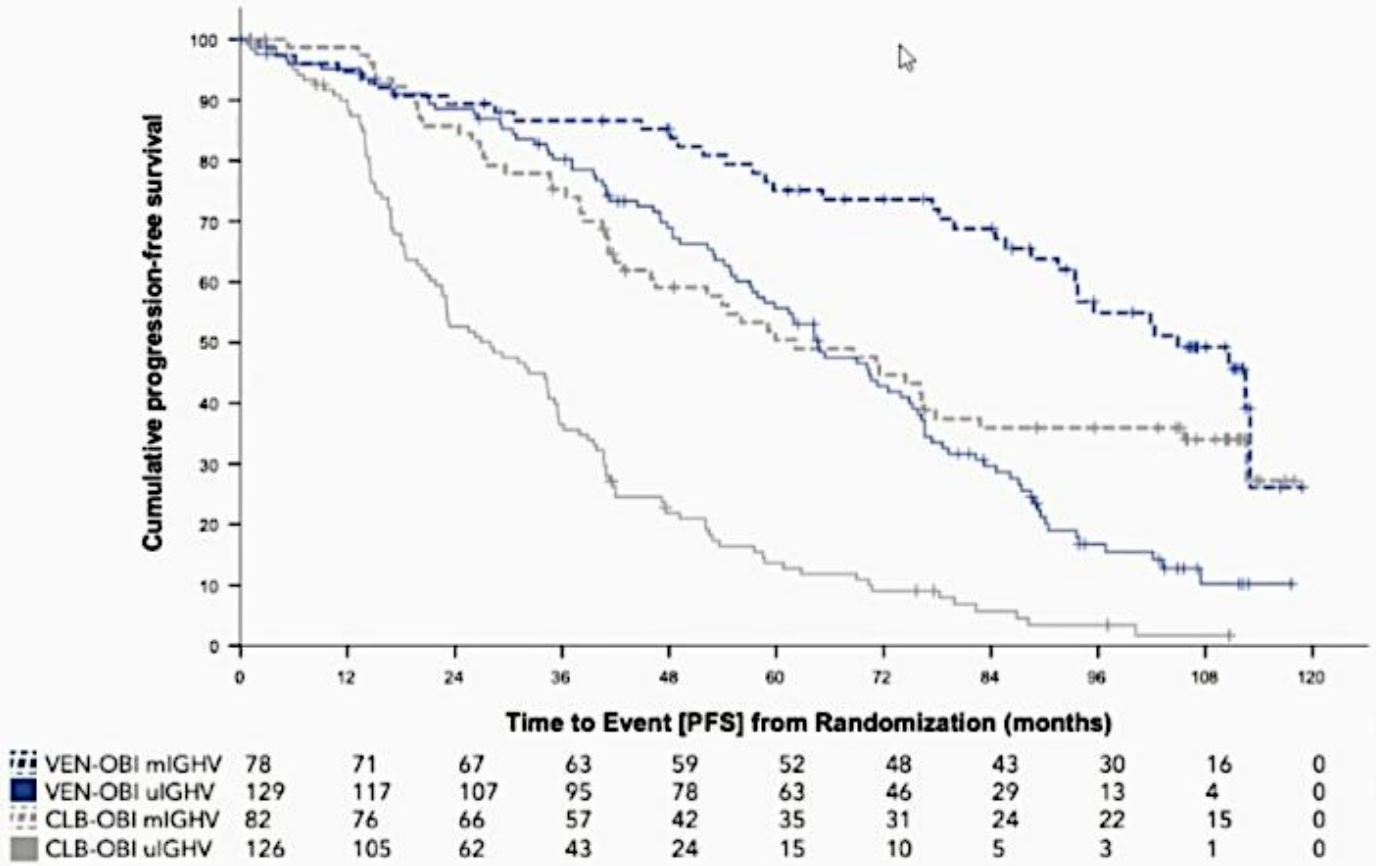
MEDIAN OBSERVATION TIME	110.1 months
MEDIAN PFS VEN-OBI	76.6 months
9-YEAR PFS VEN-OBI	25.6%
MEDIAN PFS CLB-OBI	37.9 months
9-YEAR PFS CLB-OBI	14.4%
HAZARD RATIO	0.50, 95% CI 0.39-0.63
P VALUE	<0.001

MEDIAN PFS FOR VEN-OBI
6.4 YEARS

Fischer K et al. EHA 2026;Abstract S146

/05 KAPLAN-MEIER ESTIMATES

Progression-Free Survival By IGHV Mutational Status



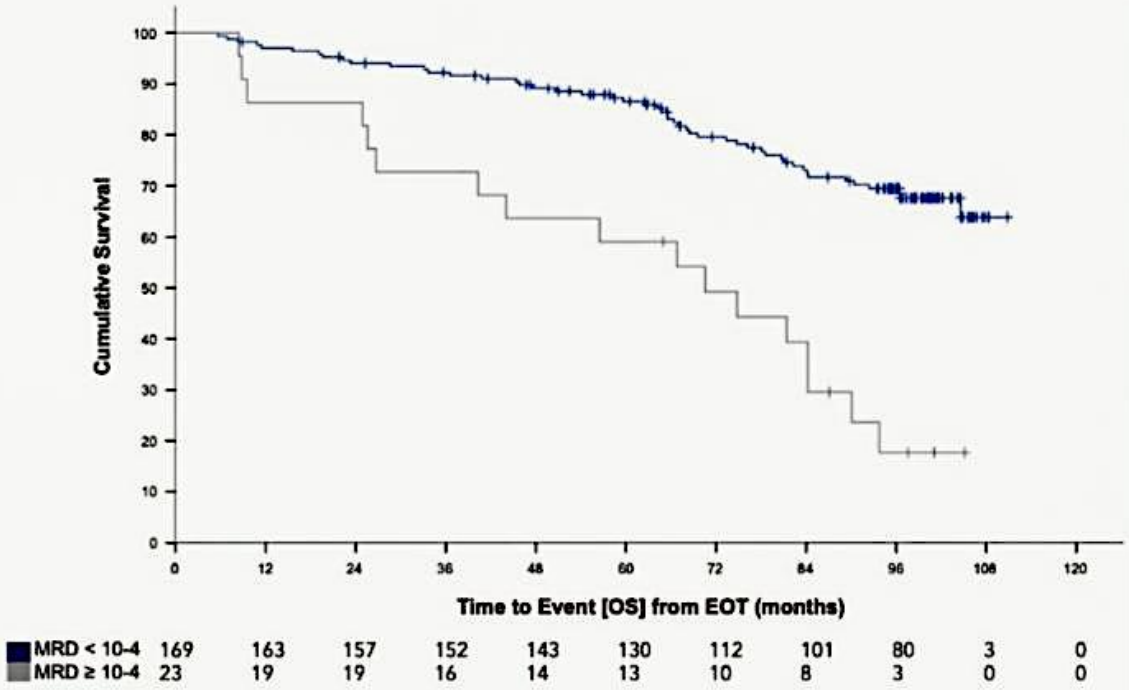
MEDIAN OBSERVATION TIME	110.1 months
MEDIAN PFS VEN-OBI & mIGHV	104.9 months
MEDIAN PFS VEN-OBI & uIGHV	64.7 months
HAZARD RATIO	2.74, 95% CI 1.85-4.06
P VALUE	<0.001
MEDIAN PFS CLB-OBI & mIGHV	62.2 months
MEDIAN PFS CLB-OBI & uIGHV	28.0 months
HAZARD RATIO	3.13, 95% CI 2.21-4.45
P VALUE	<0.001

MEDIAN PFS VEN-OBI mIGHV 8.7 YEARS
MEDIAN PFS VEN-OBI uIGHV 5.4 YEARS

Fischer K et al. EHA 2026;Abstract S146

/06 LANDMARK ANALYSIS

Overall Survival & MRD Status For Ven-Obi



MEDIAN OBSERVATION TIME	110.1 months
MRD < 10-4	Not reached
MRD ≥ 10-4	70.5 months
HAZARD RATIO	3.73, 95% CI 2.14-6.50

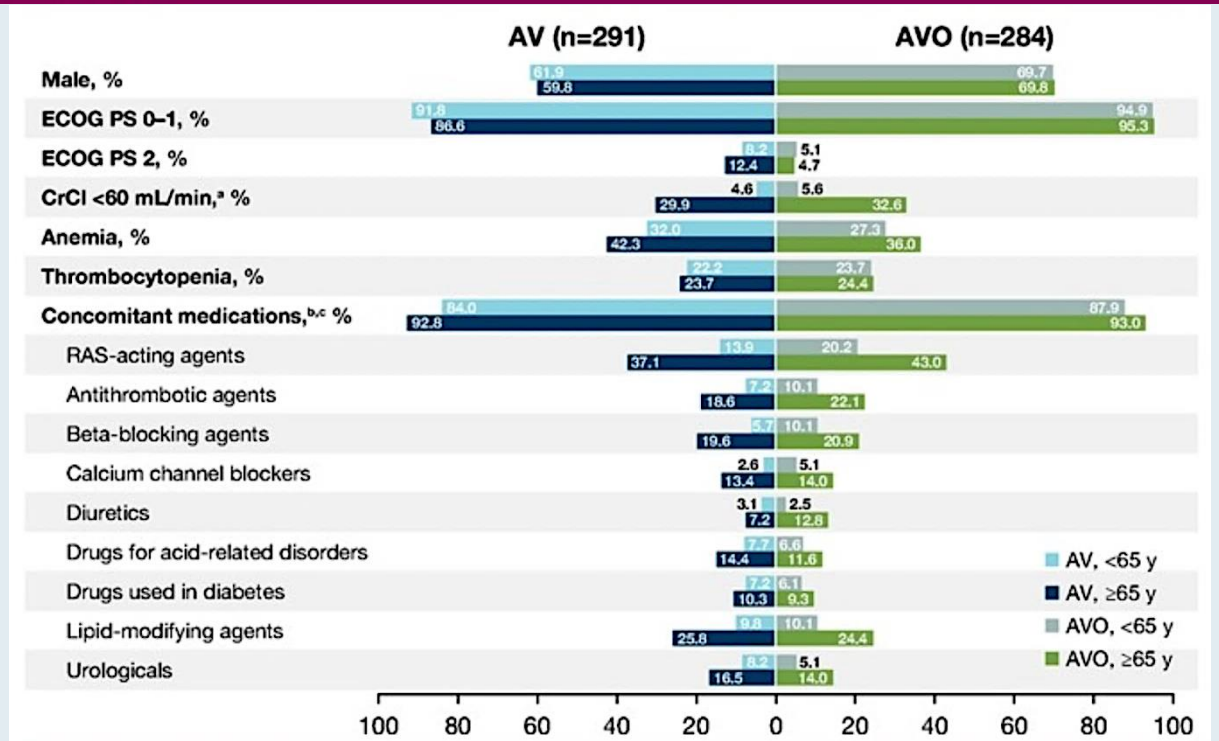
MRD STATUS AFTER VEN-OBI REMAINS PROGNOSTIC FOR OS

Fischer K et al. EHA 2026;Abstract S146

PF614

Safety of Fixed-Duration Acalabrutinib-Venetoclax Combinations in Patients With Chronic Lymphocytic Leukemia Stratified by Age: Post Hoc Analysis of the Phase 3 AMPLIFY Trial

John F. Seymour, MBBS, PhD,[1] Andrew Aw, MD,[2] Vincent Ribrag, MD, PhD,[3] Guillaume Cartron, MD, PhD,[4] Arnon P. Kater, MD, PhD,[5] Ki-Seong Eom, MD,[6] Alan Skarbnik, MD,[7] Alessandra Tedeschi, MD,[8] Malgorzata Wach, MD,[9] Jing-Zhou Hou, MD,[10] Arpad Illes, MD,[11] Batul Suterwala, MD,[12] Jiefen Munley, MD,[13] Ellie John, PhD,[14] Toshifumi Fujimori, PhD,[14] Jennifer R. Brown, MD, PhD[15]



Seymour JF et al. EHA 2026;Abstract PF614.

RTP RESEARCH TO PRACTICE

Phase III AMPLIFY: Post-Hoc Safety Analysis

N (%)	AV (n=291) <65 y (n=194)	AV (n=291) ≥65 y (n=97)	AVO (n=284) <65 y (n=198)	AVO (n=284) ≥65 y (n=86)
Any grade	182 (93.8)	88 (90.7)	189 (95.5)	80 (93.0)
Grade ≥3	99 (51.0)	57 (58.8)	133 (67.2)	64 (74.4)
SAE,[a]	46 (23.7)	26 (26.8)	72 (36.4)	37 (43.0)
COVID-19 pneumonia	11 (5.7)	6 (6.2)	25 (12.6)	7 (8.1)
COVID-19	5 (2.6)	4 (4.1)	11 (5.6)	6 (7.0)
Febrile neutropenia	3 (1.5)	2 (2.1)	3 (1.5)	2 (2.3)
Acute kidney injury	1 (0.5)	0	1 (0.5)	2 (2.3)
Anemia	1 (0.5)	2 (2.1)	2 (1.0)	0
Pneumonia	1 (0.5)	3 (3.1)	5 (2.5)	5 (5.8)
Pyrexia	1 (0.5)	1 (1.0)	5 (2.5)	1 (1.2)
Acute myocardial infarction	0	0	0	2 (2.3)
Infusion-related reaction	NA	NA	1 (0.5)	2 (2.3)
Nausea	0	0	0	2 (2.3)
SAE with fatal outcome,[a]	5 (2.6)	5 (5.2)	7 (3.5)	10 (11.6)
COVID-19 pneumonia	2 (1.0)	4 (4.1)	5 (2.5)	5 (5.8)
COVID-19	2 (1.0)	0	2 (1.0)	3 (3.5)
Cardiac events	17 (8.8)	10 (10.3)	19 (9.6)	15 (17.4)
Atrial fibrillation	0	2 (2.1)	3 (1.5)	3 (3.5)
Ventricular arrhythmias (grouped term)	2 (1.0)	0	2 (1.0)	1 (1.2)
Anemia	13 (6.7)	7 (7.2)	10 (5.1)	3 (3.5)
Leukopenia	68 (35.1)	41 (42.3)	101 (51.0)	46 (53.5)
Neutropenia	68 (35.1)	40 (41.2)	98 (49.5)	45 (52.3)
Other leukopenia	4 (2.1)	7 (7.2)	7 (3.5)	5 (5.8)
Thrombocytopenia	12 (6.2)	5 (5.2)	23 (11.6)	12 (14.0)
Hemorrhage	58 (29.9)	36 (37.1)	60 (30.3)	26 (30.2)
Major hemorrhage	1 (0.5)	2 (2.1)	3 (1.5)	5 (5.8)
Hepatotoxicity	12 (6.2)	5 (5.2)	13 (6.6)	6 (7.0)
Hypertension	10 (5.2)	2 (2.1)	10 (5.1)	1 (1.2)
Infections	104 (53.6)	44 (45.4)	112 (56.6)	41 (47.7)
Interstitial lung disease/pneumonitis	0	0	1 (0.5)	4 (4.7)
Second primary malignancies	7 (3.6)	8 (8.2)	6 (3.0)	6 (7.0)
Second primary malignancies, excluding non-melanoma skin	5 (2.6)	3 (3.1)	2 (1.0)	5 (5.8)
Secondary primary malignancies, non-melanoma skin	4 (2.1)	5 (5.2)	4 (2.0)	1 (1.2)
Tumor lysis syndrome[b]	0	1 (1.0)	1 (0.5)	0

[a]Events reported in >2% of patients in any subgroup.

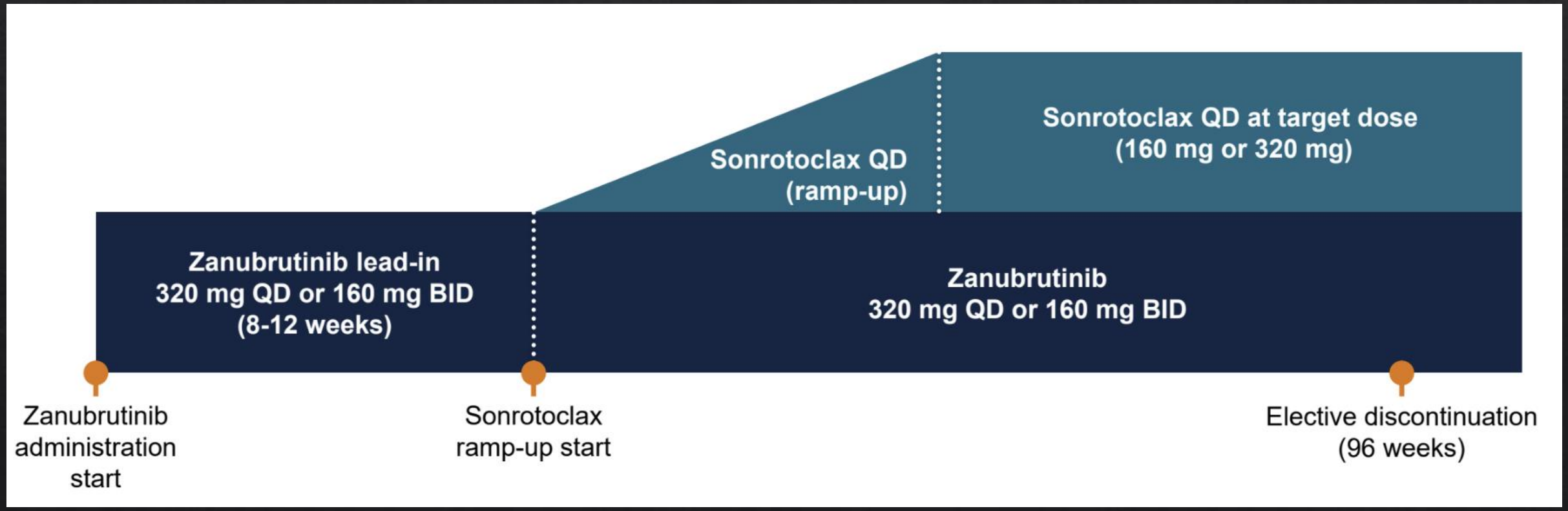
[a]Events of clinical interest categories are by grouped terms.
[b]Tumor lysis syndrome events were limited to laboratory tumor lysis syndrome only; no clinical tumor lysis syndrome was observed.

- Despite modest increases in grade ≥3 AEs, SAEs, and AE-related discontinuations with AVO, both AV and AVO improved PFS vs CIT in patients aged ≥65 years, with similar hazard ratios vs CIT
  - Age <65 years:
    - AV vs CIT: HR: 0.84 (95% CI: 0.58, 1.22)
    - AVO vs CIT: HR: 0.42 (95% CI: 0.27, 0.64)
  - Age ≥65 years:
    - AV vs CIT: HR: 0.47 (95% CI: 0.29, 0.76)
    - AVO vs CIT: HR: 0.47 (95% CI: 0.28, 0.79)

Seymour JF et al. EHA 2026;Abstract PF614.

First-Line Treatment of CLL/SLL With the All-Oral Combination of Sonrotoclax and Zanubrutinib Achieves Undetectable Minimal Residual Disease Rates of >90%, Including in Patients With del(17p)/*TP53*

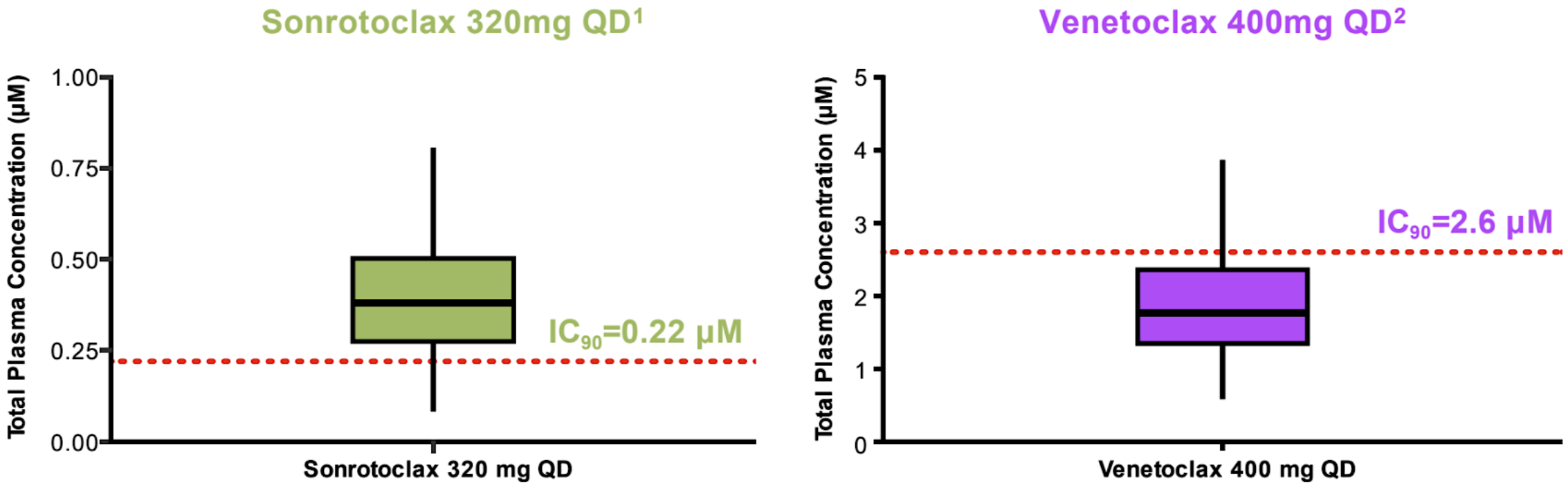
Chan Y. Cheah,[1-3] Stephen S. Opat,[4] Masa Lasica,[5] Peter Browett,[6] Mary Ann Anderson,[7,8] Emma Verner,[9,10] Shuo Ma,[11] Robert Weinkove,[12,13] Marc Hoffmann,[14] Jacob D. Soumerai,[15] Mazyar Shadman,[16,17] Talha Munir,[18] Sophie Leitch,[19] Raul Cordoba,[20] David Westerman,[21,22] Paolo Ghia,[23,24] Binghao Wu,[25] Gabriel Man,[25] Yiqian Fang,[25] Sheel Patel,[25] Remus Vezan,[25] Constantine S. Tam[26]



Cheah CY et al. EHA 2026;Abstract S145

Sonrotoclax Achieves Deep Target Inhibition at Clinical Dose

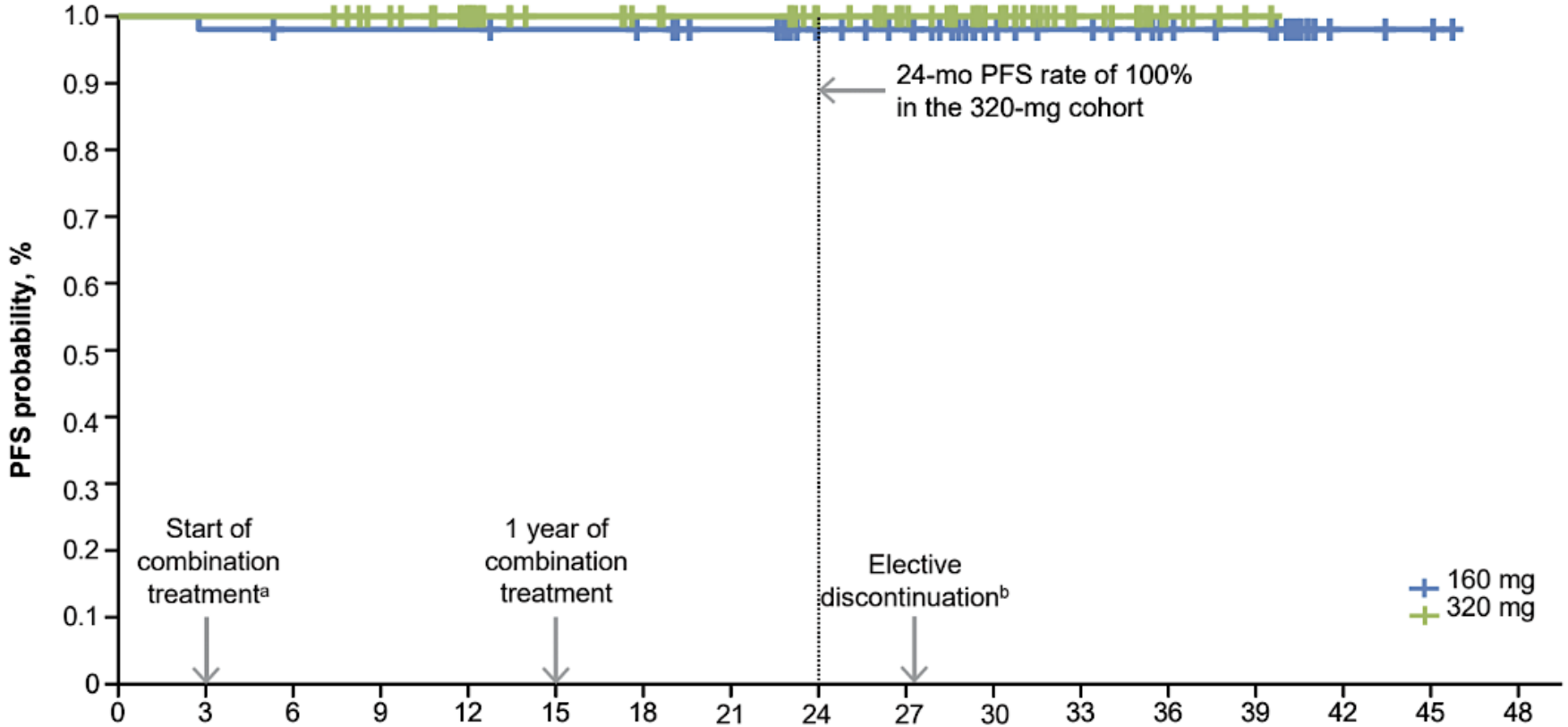
- Achieving nearly complete BCL2 inhibition (ie, IC_{90}) is key to enable deep responses such as uMRD
- Sonrotoclax has peak plasma concentrations above IC_{90} for most patients, supporting its best-in-class potential[1,2]



Cheah CY et al. EHA 2026;Abstract S145

Progression Free Survival: No Events Occurred in the 320-mg Cohort

- 69 patients electively discontinued sonrotoclax, the median time off treatment was 9.2 months (range, 0.6-21.6 months)



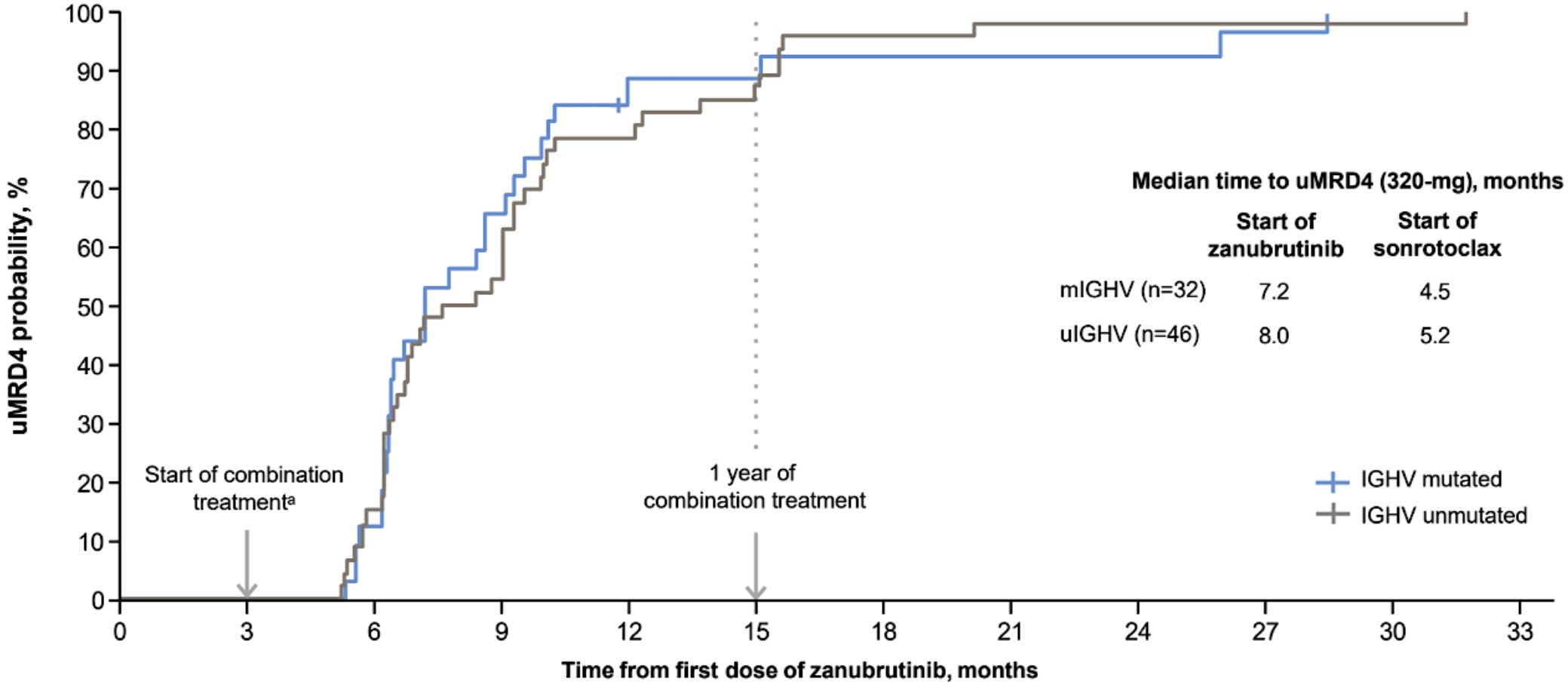
Number At Risk																	
160 mg	51	50	49	49	49	48	47	44	36	33	23	20	15	13	3	2	0
320 mg	86	84	84	80	70	59	56	54	48	40	30	16	5	1	0	0	0

In the 160-mg cohort, progressive disease was observed in one patient with Richter transformation

[a]Zanubrutinib lead-in was 8-12 weeks. [b]Protocol defined elective discontinuation after 96 weeks at target dose. mo, month; PFS, progression-free survival; RP2D, recommended phase 2 dose.

Cheah CY et al. EHA 2026;Abstract S145

uMRD4 Was Achieved Rapidly, Regardless of IGHV Status



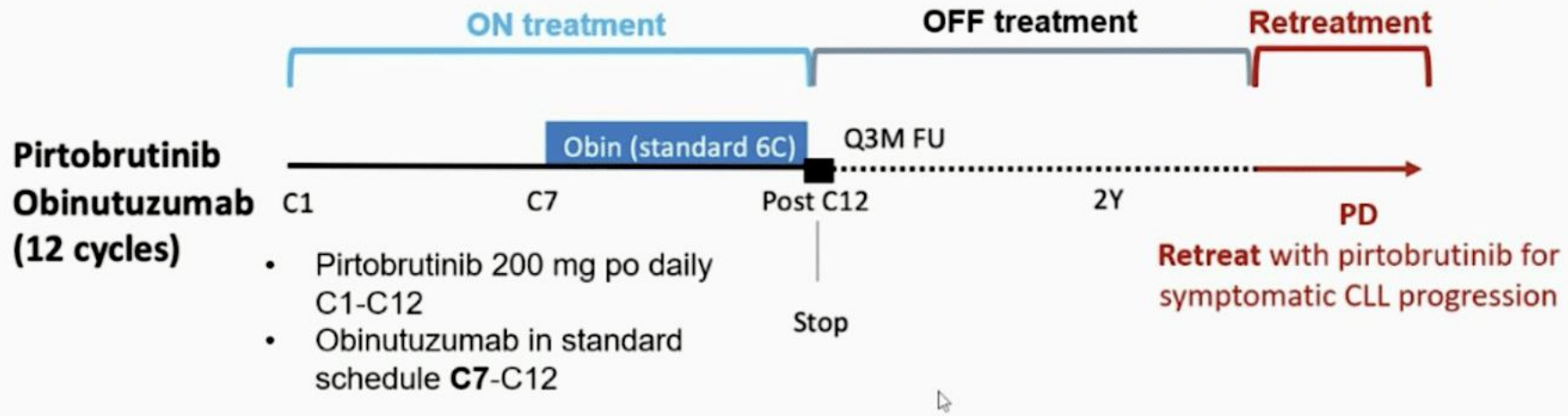
[a]Zanubrutinib lead-in was 8-12 weeks.
IGHV, immunoglobulin heavy chain variable; mIGHV, mutated IGHV; uIGHV, unmutated IGHV; uMRD4, undetectable minimal residual disease at <1 CLL cell per 10,000 leukocytes ($<10^4$).

Cheah CY et al. EHA 2026;Abstract S145

A Phase 2 Study Of Fixed-Duration Pirtobrutinib And Obinutuzumab In Previously Untreated CLL (POP)

Inhye E. Ahn,[1] Svitlana Tyekucheva,[2] Andrew Lipsky,[3] Andres Chang,[4] Jack Suher,[1] Hang Phan,[1] Virginia Cyr,[1] Ijaabo Ali,[1] Philippe Armand,[1] Amy Bessnow,[1] Jennifer Crombie,[1] David Fisher,[1] Cynthia Hahn,[1] Eric D. Jacobsen,[1] Caron Jacobson,[1] Austin I. Kim,[1] Ann Lacasce,[1] Reid Merryman,[1] Oreofe Odejide,[1] Erin Parry,[1] David Qualls,[1] Christine Ryan,[1] Aswin Sekar,[1] Olivier F. Clerc,[5] Sarah Cuddy,[5] Nancy Kaddis,[6] Jon E. Arnason,[7] John Winters,[8] Steven Lo,[9] Nicole Lamanna,[3] Jennifer R. Brown,[1] Matthew S. Davids[1]

Study Design



Ahn I et al. EHA 2026;Abstract S148

Median Time On Study: 14 months

N (%)	After 6 cycles (pirtobrutinib monotherapy)	EOT after 12 cycles (pirto-obin)
N of evaluable patients*	60	33*
Complete response	4 (6.7)	4 (12.1)
Partial response	39 (65.0)	22 (66.7)
Partial response with lymphocytosis	4 (6.7)	-
Stable disease	5 (8.3)	1 (3.0)
Progressive disease	1 (1.7)*	2 (6.1)*
Not evaluable	7 (11.7)	4 (12.1)
Overall response (CR + PR + PR-L)	**47 (78.3)**	**26 (78.8)**

Peripheral blood minimal residual disease (MRD)

N (%)	After 6 cycles (pirtobrutinib monotherapy)		EOT after 12 cycles (pirtobrutinib + obinutuzumab)	
	N, evaluable	N, intent-to-treat	N, evaluable*	N, intent-to-treat
Total N of patients	41	60	39	53
N, not assessed	-	19 (31.7)	-	14 (26.4)
MRD detectable ($\geq 10^{-4}$)	40 (97.6)	40 (70.2)	19 (48.7)	19 (35.8)
MRD undetectable ($<10^{-4}$)	**1 (2.4)**	**1 (1.8)**	**20 (51.2)**	**20 (37.7)**

*PB MRD was assessed within 1-2 months of EOT, earlier than clinical response assessment.

Ahn I et al. EHA 2026;Abstract S148

Pirtobrutinib in Treatment-Naïve Patients with CLL/SLL: Pooled Results from BRUIN CLL-313 and BRUIN CLL-314

William G Wierda,[1] Wojciech Jurczak,[2] Jose Antonio Garcia Vela,[3] Marcelo Capra,[4] Gerardo Musuraca,[5] Michal Kwiatek,[6] Lugui Qiu,[7] Jianyong Li,[8] Hiro Tatetsu,[9] Shinsuke Iida,[10] Kamel Laribi,[11] Lutz Jacobasch,[12] Catherine C Coombs,[13] Katharine L Lewis,[14] Katherine Bao,[15] Alejandro Levy,[15] Yuanyuan Bian,[15] Weiji Su,[15] Marisa Hill,[15] Jennifer A Woyach[16]

STUDY DESIGN

BRUIN CLL-313 (NCT05023980)

Key Inclusion Criteria

- Confirmed CLL/SLL requiring therapy (per iwCLL 2018[8])
- No evidence of 17p deletion
- ≥18 years of age and ECOG PS 0-2

Stratification factors

- IGHV mutation status (mutated vs unmutated)
- Rai stage (low/intermediate vs high)

N=282, R 1:1

- **Arm A**: Pirtobrutinib 200 mg PO, QD, N=141
- **Arm B**: Bendamustine[a] + Rituximab[b], N=141

BRUIN CLL-314 (NCT05254743)

Key Inclusion Criteria

- Confirmed CLL/SLL requiring therapy (per iwCLL 2018[8])
- BTKi naïve (including TN[c] and R/R[d])
- 17p deletion status (by FISH)
- ECOG PS 0 to 2

Stratification factors

- 17p deletion presence: Yes vs No
- Prior lines of therapy: 0 vs 1 vs ≥2

N=662, R 1:1

- **Arm A**: Pirtobrutinib 200 mg PO QD, N=331
- **Arm B**: Ibrutinib 420 mg PO QD, N=331

TN Patients (All) N=141

TN Patients N=112

Pooled analysis of TN patients randomized to pirtobrutinib N=253

- **Efficacy endpoints**: Investigator-assessed ORR, PFS, OS
- PFS and OS estimated using the Kaplan–Meier method
- **Efficacy population**: All TN patients randomized to pirtobrutinib
- **Safety population**: All TN patients who received pirtobrutinib

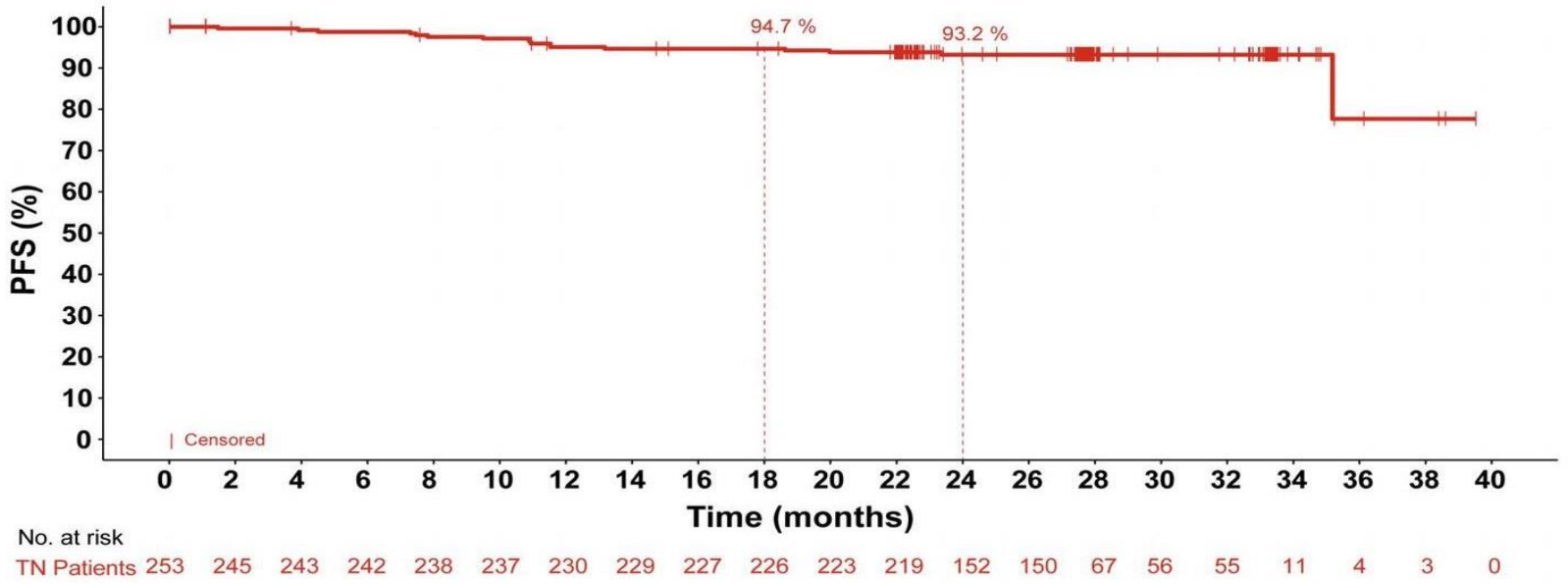
[a] Bendamustine: 90 mg/m² IV, QD on Days 1–2 of Cycles 1–6. [b] rituximab: 375 mg/m² IV, QD, Cycle 1 Day 1; followed by 500 mg/m² IV on Day 1 of Cycles 2–6. [c] Enrolled TN patients 34%. [d] Enrolled R/R patients 66%.

Wierda W et al. ASCO 2026;Abstract 7044

Table 2. Investigator-Assessed Efficacy Outcomes in TN Patients

Parameter		BRUIN CLL-313 N=141	BRUIN CLL-314 N=112	Total N=253
ORR, % (95% CI)		94.3 (89.13, 97.52)	92.0 (85.29, 96.26)	93.3 (89.5, 96.0)
PFS, % (95% CI)	Median, months	NR (35.19, NE)	NR (NE, NE)	NR (35.19, NE)
	18-month rate	94.2 (88.7, 97.1)	95.3 (89.1, 98.0)	94.7 (91.0, 96.9)
	24-month rate	92.7 (86.8, 96.0)	94.3 (87.8, 97.4)	93.2 (89.1, 95.8)
	Median follow-up, months	28.0 (27.8, 31.8)	22.5 (22.3, 22.8)	27.7 (27.6, 27.7)
OS, % (95% CI)	Median, months	NR (NE, NE)	NR (NE, NE)	NR (NE, NE)
	18-month rate	99.3 (95.0, 99.9)	97.2 (91.5, 99.1)	98.4 (95.7, 99.4)
	24-month rate	97.8 (93.3, 99.3)	97.2 (91.5, 99.1)	97.5 (94.6, 98.9)
	Median follow-up, months	32.7 (31.9, 33.3)	27.0 (26.6, 27.4)	29.5 (28.9, 30.7)

Figure 1. Investigator-Assessed PFS in Total TN Population

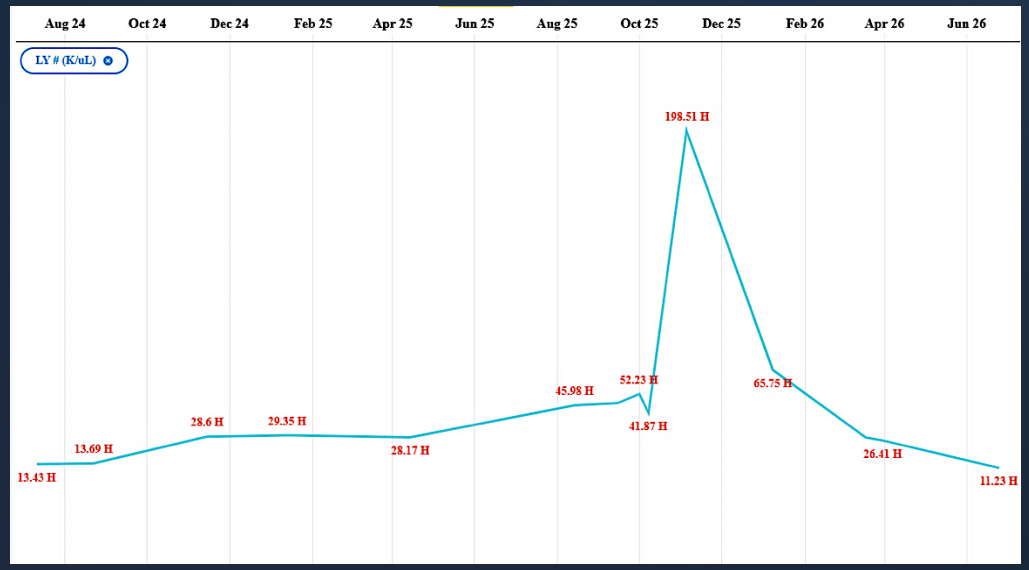


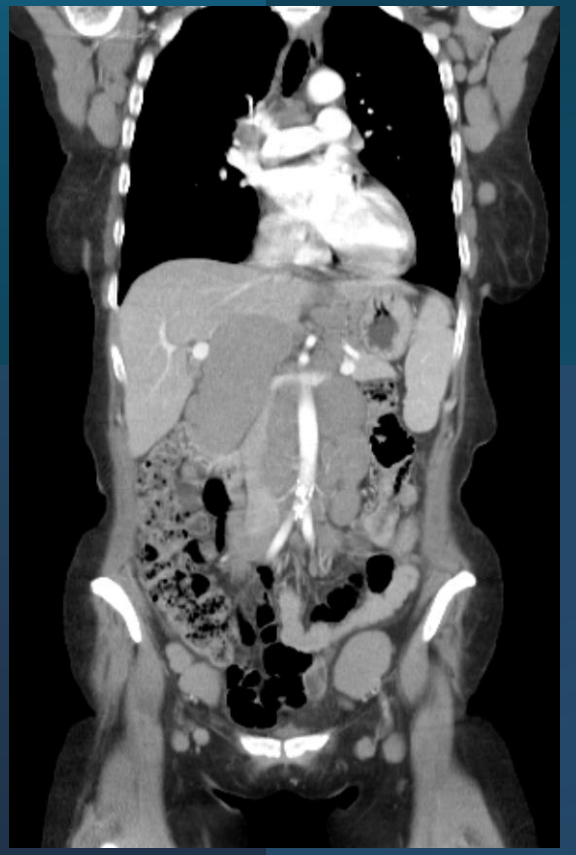
Wierda W et al. ASCO 2026;Abstract 7044

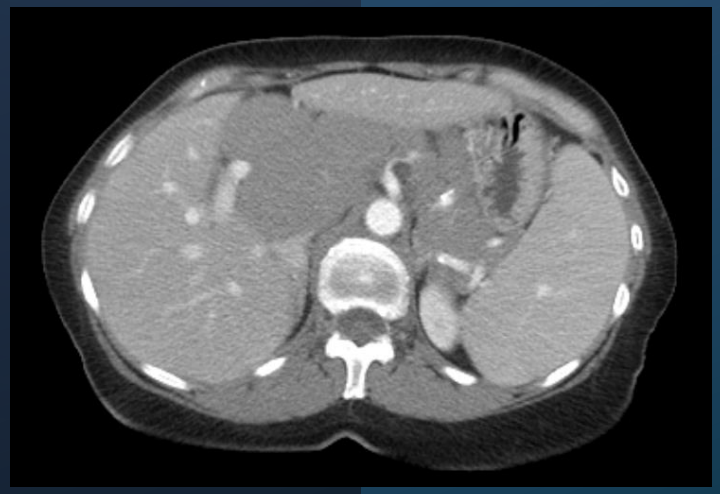
Dr. Sharman Case Presentation

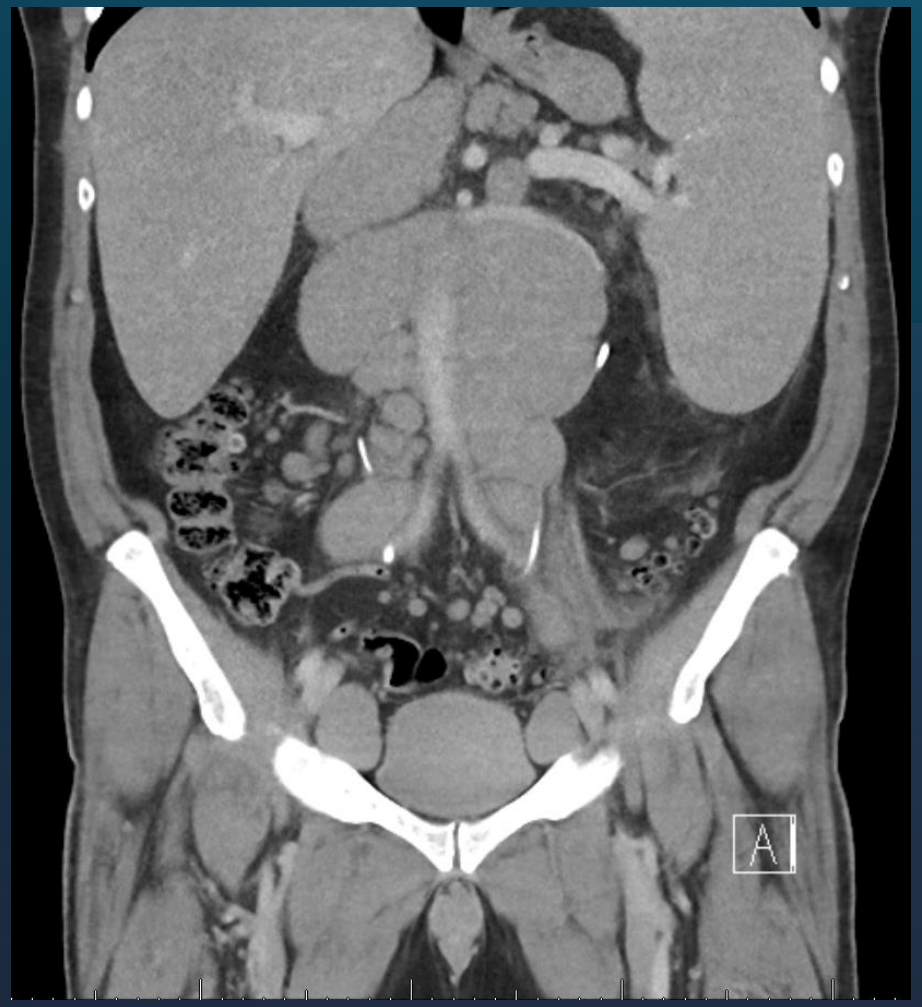
68-year-old woman who presents initially with substantial lymphadenopathy but relatively modest absolute lymphocytosis. Found to have IgHV unmutated disease, with FISH showing deletion of 11Q

Imaging revealed adenopathy considerably larger than appreciated on physical exam. Started initially on BTK monotherapy, with venetoclax to be added.







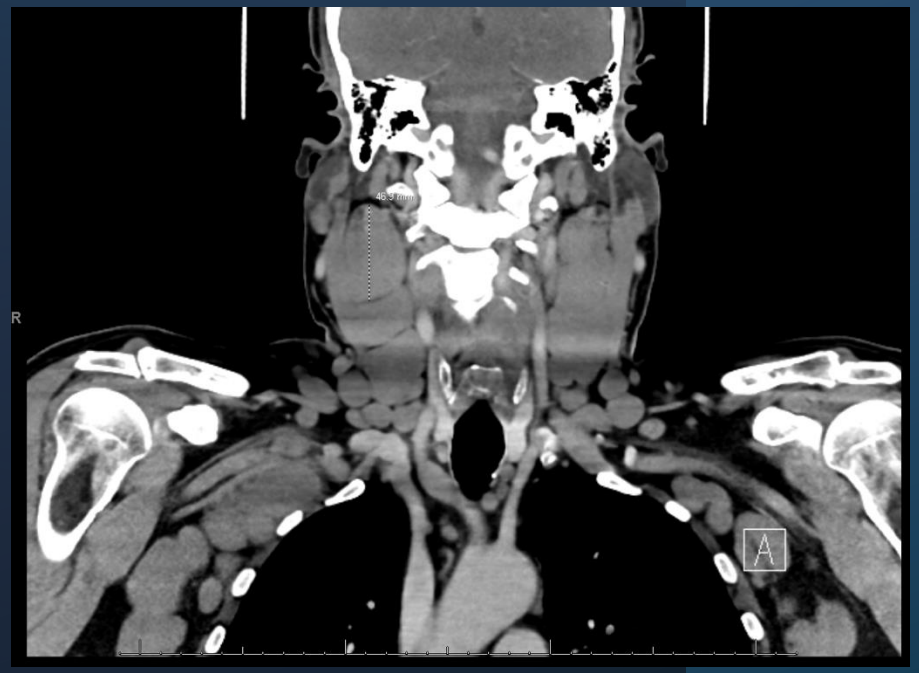


Dr. Sharman Case Presentation

64 year-old otherwise healthy male, rarely goes to doctor. Aware of adenopathy in his neck but does not really recall when it started. Wife suspects longer than he does.

IgHV unmutated, Del 13Q, TP53 wildtype.

Started on AVO regimen – only just began A for one month and now adding Obinutuzumab. Venetoclax to follow.



Questions?

First-Line Therapy

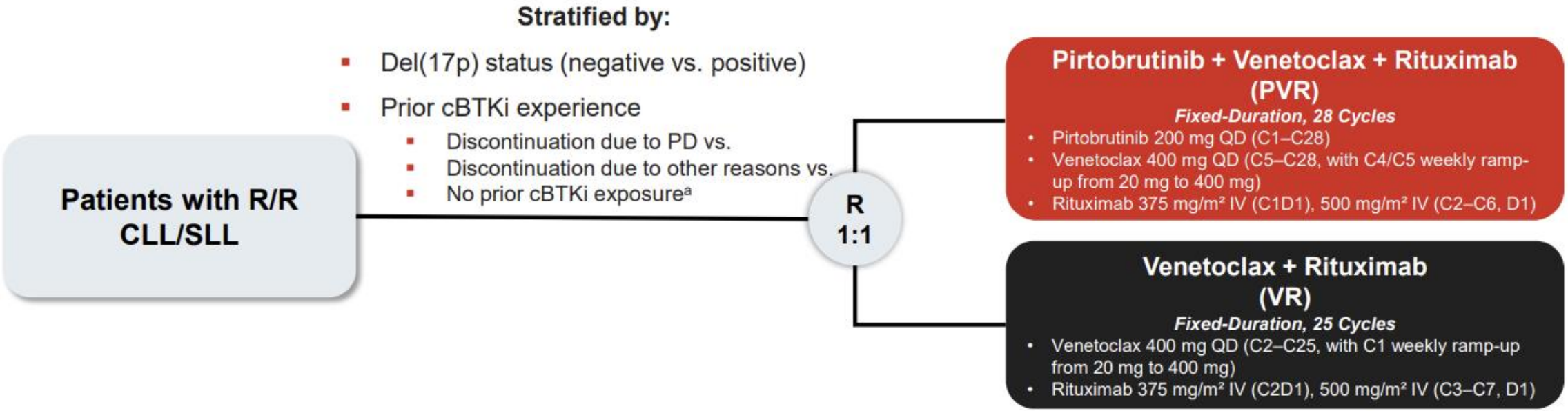
- Fischer K et al. **Venetoclax-obinutuzumab** for **previously untreated chronic lymphocytic leukemia**: **Final results** of the randomized **CLL14 study**. EHA 2026;Abstract S146.
- Seymour JF et al. **Safety** of **fixed-duration** (FD) **acalabrutinib-venetoclax combinations** in patients (pts) with **chronic lymphocytic leukemia** (CLL) stratified by age: **Post hoc analysis** of the **phase 3 AMPLIFY trial**. EHA 2026;Abstract PF614.
- Cheah CY et al. **First-line treatment** of CLL/SLL with the **all-oral combination of sonrotoclax and zanubrutinib** achieves **undetectable minimal residual disease** rates of >90%, including in patients with **del(17p)/TP53**. EHA 2026;Abstract S145.
- Ahn I et al. A **phase 2 study** of **fixed-duration pirtobrutinib** and obinutuzumab in **previously untreated CLL**. EHA 2026;Abstract S148.
- Wierda W et al. **Pirtobrutinib** in **treatment-naïve** patients with CLL/SLL: **Pooled results from BRUIN CLL-313 and BRUIN CLL-314**. ASCO 2026;Abstract 7044.

Key Datasets — BRUIN CLL-322 (Pirtobrutinib/Venetoclax/Rituximab for Relapsed Disease)

- Davids MS et al. **Fixed duration pirtobrutinib** plus venetoclax–rituximab versus venetoclax–rituximab for patients with **previously treated CLL/SLL**: A **phase 3**, randomized trial (BRUIN CLL-322). EHA 2026;Abstract LB5001.

BRUIN CLL-322 Trial Design

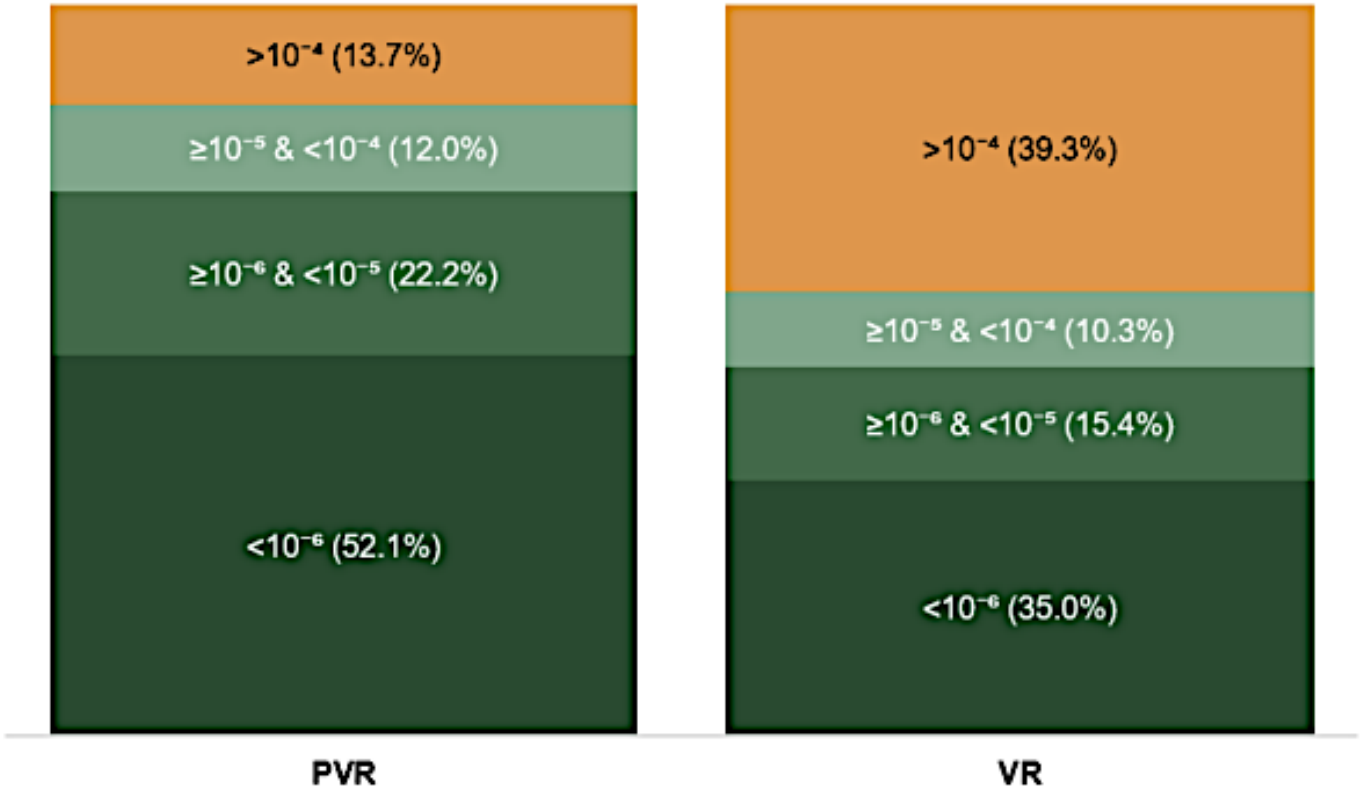
Phase 3, Randomized, Open-Label, Global, Multicenter Trial | 22 Countries | NCT04965493



Davids MS et al. EHA 2026;Abstract LB5001

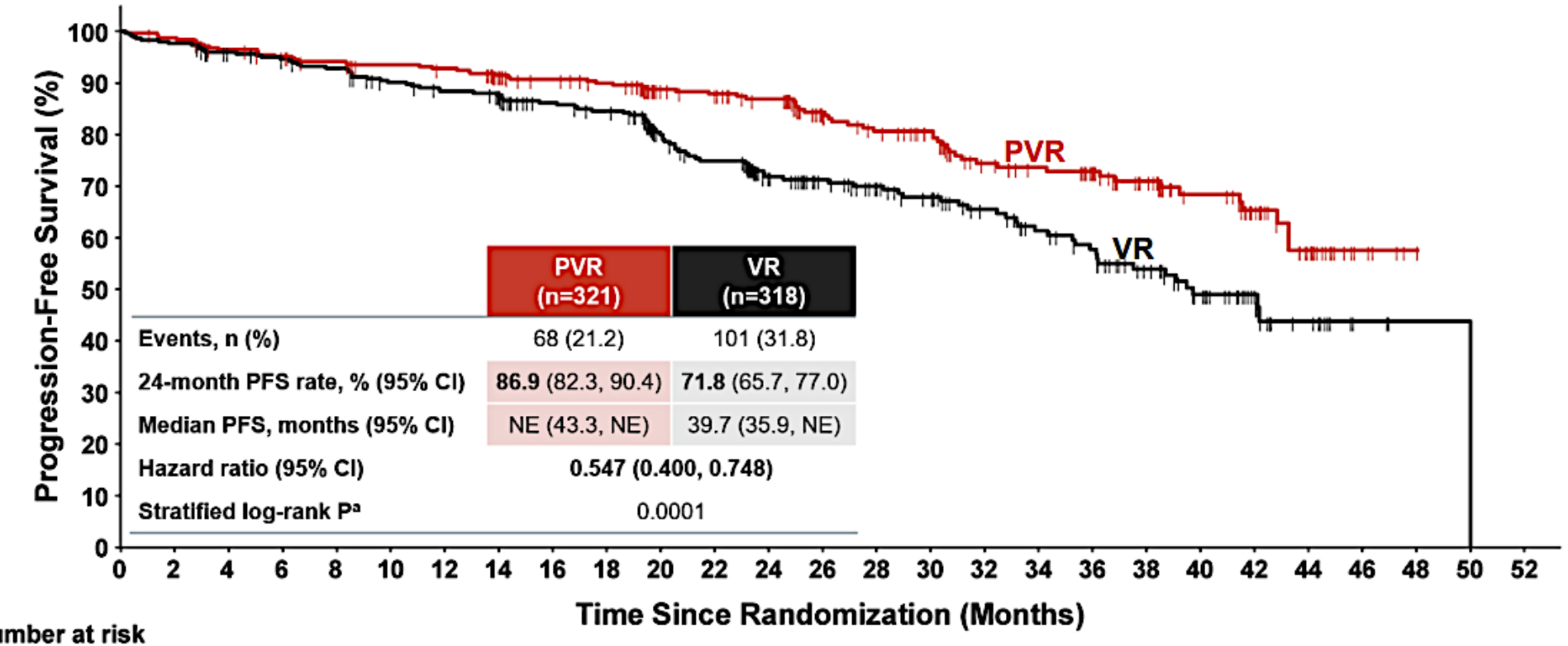
Patients with evaluable samples at EOT[a]

uMRD Threshold, n (%)[b]	PVR N=117	VR N=117	P-value[c]
uMRD4	101 (86.3)	71 (60.7)	<0.0001
uMRD5	87 (74.4)	59 (50.4)	0.0002
uMRD6	61 (52.1)	41 (35.0)	0.0103



Davids MS et al. EHA 2026;Abstract LB5001

Progression-Free Survival by IRC (ITT population)



	PVR (n=321)	VR (n=318)
Events, n (%)	68 (21.2)	101 (31.8)
24-month PFS rate, % (95% CI)	**86.9** (82.3, 90.4)	**71.8** (65.7, 77.0)
Median PFS, months (95% CI)	NE (43.3, NE)	39.7 (35.9, NE)
Hazard ratio (95% CI)	**0.547 (0.400, 0.748)**	
Stratified log-rank P[a]	0.0001	

Number at risk

PVR	321	308	297	291	284	278	275	258	243	237	196	191	182	147	131	123	99	93	86	66	48	32	19	5	1	0	0
VR	318	293	282	276	269	256	249	245	221	215	175	161	127	114	104	94	80	70	63	49	36	21	11	3	1	1	0

16 events of Richter Transformation occurred in the VR arm *vs* 8 events in the PVR arm

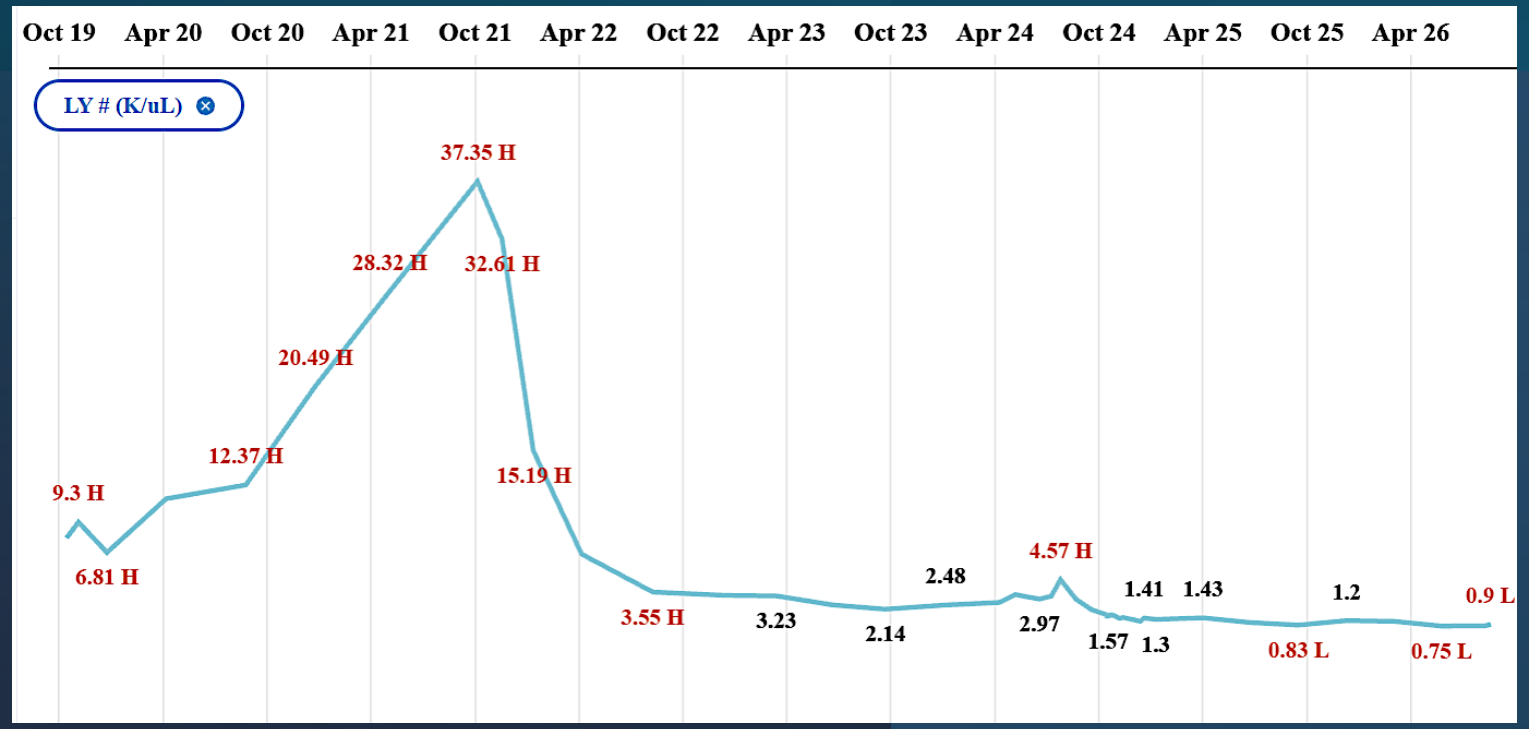
With a median follow-up of 27.3 months, PVR demonstrated superiority in IRC-assessed PFS compared with VR, reducing the risk of progression or death by 45%

Davids MS et al. EHA 2026;Abstract LB5001

Dr. Sharman Case Presentation

Mid 70's woman - recently retired nurse who initially presented with IgHV unmutated CLL. FISH testing had revealed Del17P. Started on BTK monotherapy in 2021.

Did well for 4 years but developed progressive / recurrent adenopathy and slight bump in lymphocyte count. Enrolled on a clinical trial of Ven/R versus pirto/ven/R receiving the triplet



Questions?

BRUIN CLL-322 (Pirtobrutinib/Venetoclax/Rituximab for Relapsed Disease)

- Davids MS et al. **Fixed duration pirtobrutinib** plus venetoclax–rituximab versus venetoclax–rituximab for patients with **previously treated CLL/SLL**: A **phase 3**, randomized trial (BRUIN CLL-322). EHA 2026;Abstract LB5001.

Key Datasets — Bispecific Antibodies (Epcoritamab)

- Kater AP et al. **Fixed duration venetoclax plus epcoritamab** shows favorable tolerability and high response rates with early molecular responses in R/R CLL/SLL: **Interim analysis** of the randomized **HOVON 165/AETHER trial**. EHA 2026;Abstract S153.

AETHER treatment scheme

- R/R CLL/SLL
- At least 1 prior line of treatment
- At least 2 yrs after previous Ven

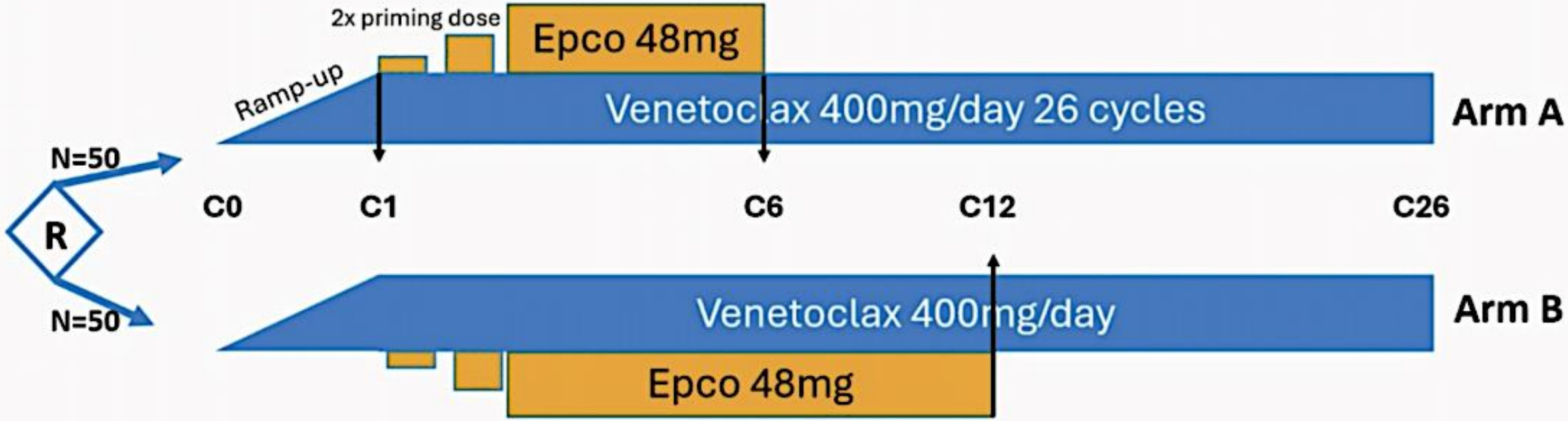
Primary endpoint

Phase I

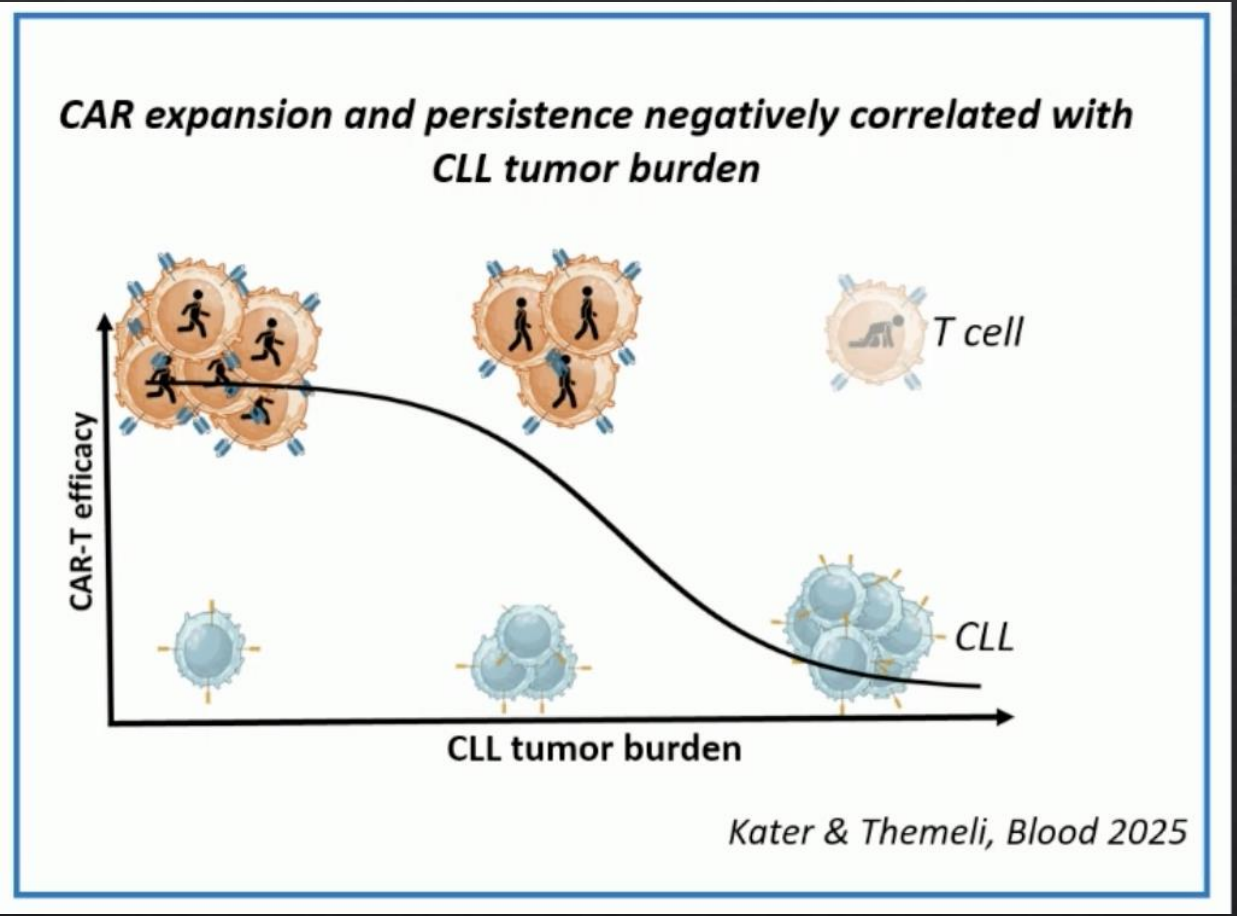
- Safety and recommended Phase 2 epcoritamab dose

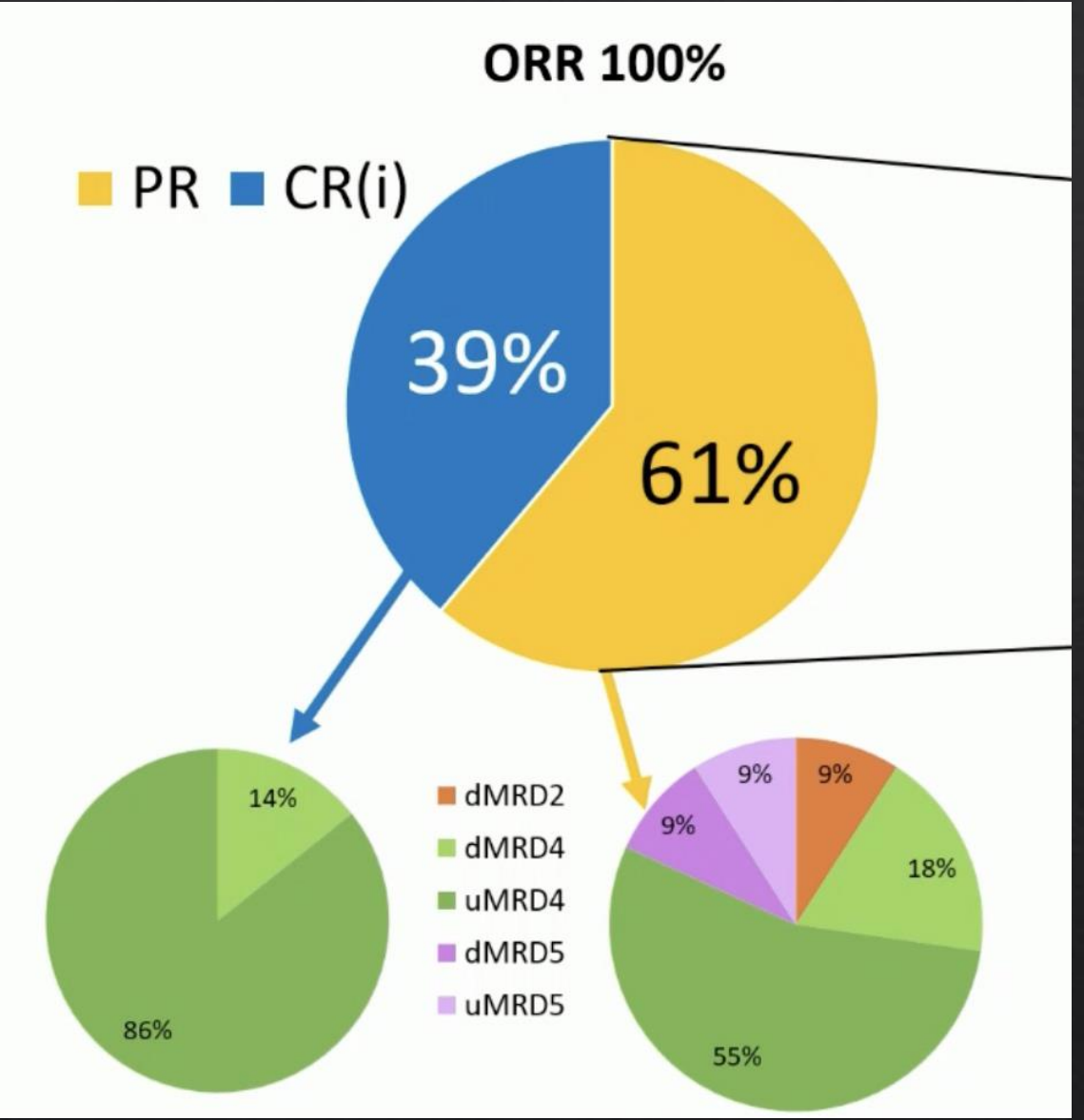
Phase II

- uMRD (NGS) after C26



Kater AP et al. EHA 2026;Abstract S153





Kater AP et al. EHA 2026;Abstract S153

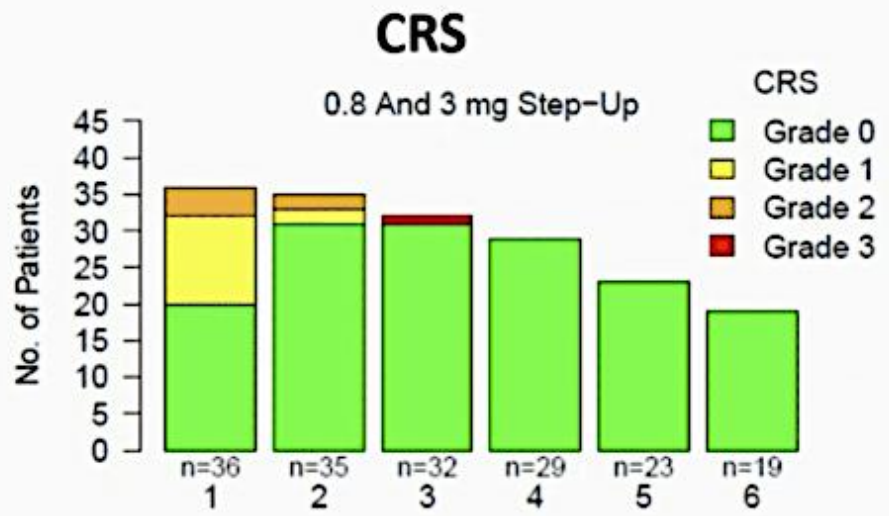
Adverse events of special interest after amendment

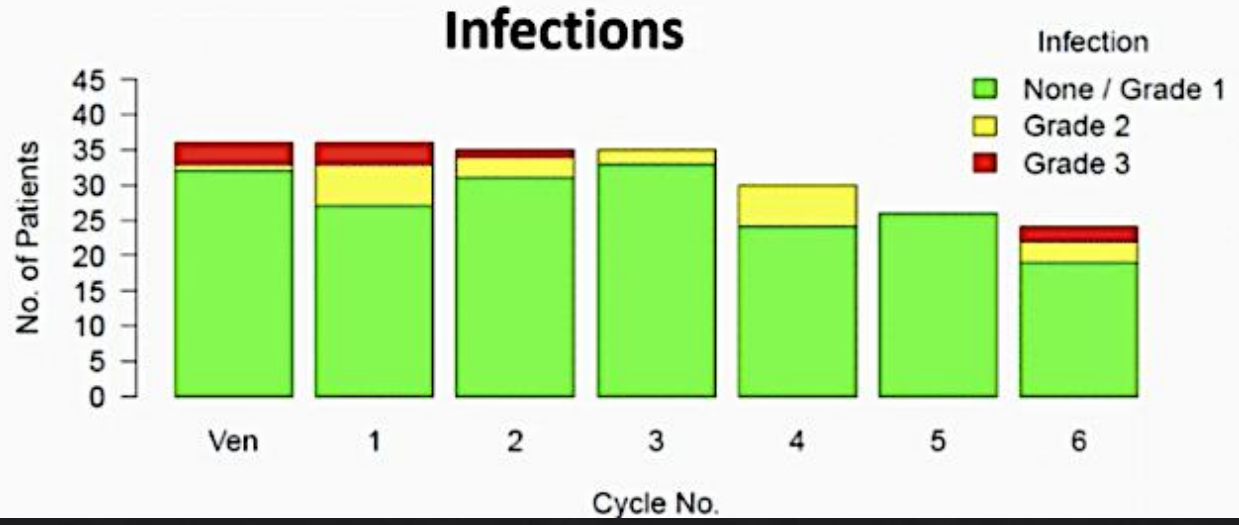
AESI during cycle 1

CRS C1	n (%)
No CRS	20 (56)
Grade 1	12 (33)
Grade 2	4 (11)
Resolution	100%
Median time to resolution, days (range)	2 (1 – 7)

Other toxicity of special interest C1	N (%)
Any ICANS	0
TLS	0
Infections:	
No	28 (78)
Grade 2	3 (8)
Grade 3	5 (14)

AESI cycle 1 - 6





Kater AP et al. EHA 2026;Abstract S153

Questions?

Bispecific Antibodies (Epcoritamab)

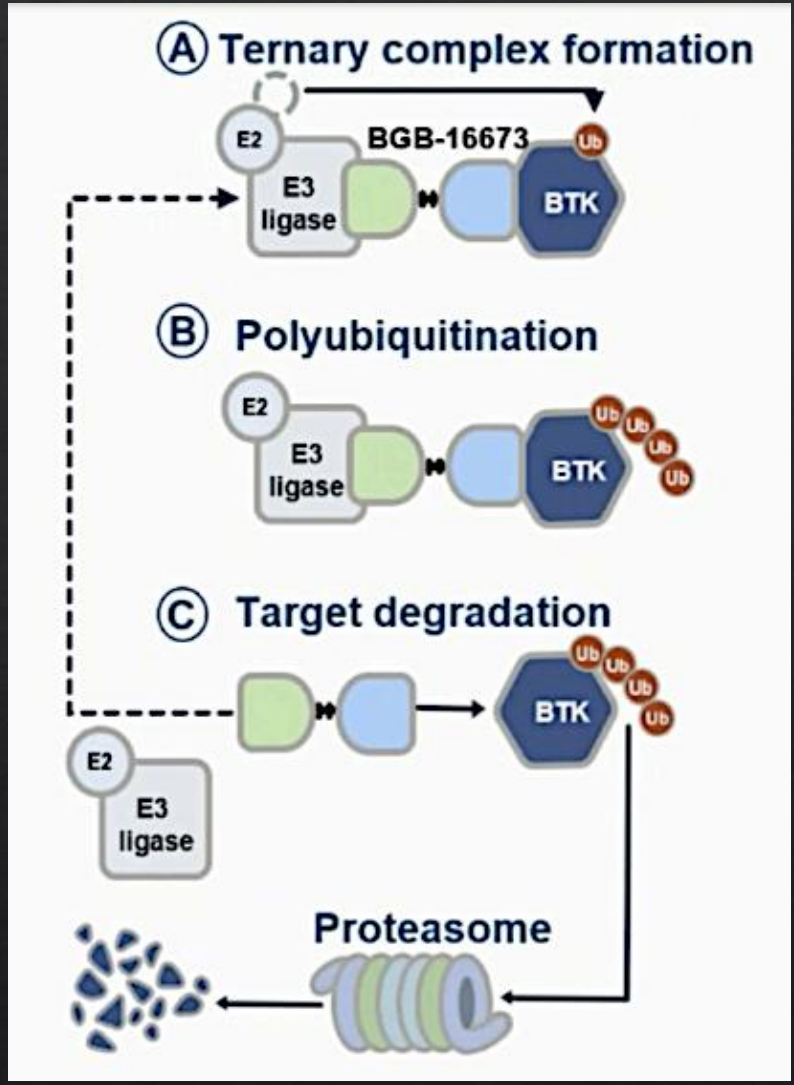
- Kater AP et al. **Fixed duration venetoclax plus epcoritamab** shows favorable tolerability and high response rates with early molecular responses in R/R CLL/SLL: **Interim analysis** of the randomized **HOVON 165/AETHER trial**. EHA 2026;Abstract S153.

Key Datasets — BTK Degraders

- Stilgenbauer S et al. **BGB-16673,** a Bruton tyrosine kinase (BTK) degrader, in patients with **relapsed/refractory** (R/R) **chronic lymphocytic leukemia/small lymphocytic lymphoma** (CLL/SLL): A **phase 1 CADANCE-101 study update**. EHA 2026;Abstract S152.
- Munir T et al. **Updated efficacy and safety data** from an ongoing **phase 1a/b trial** of the BTK degrader **bexobrutideg (NX-5948)** in patients with **CLL** across lines of therapy. EHA 2026;Abstract S150.

Tacabrutideg (BGB-16673), A Bruton Tyrosine Kinase Degrader, in Patients With Relapsed/Refractory Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma: A Phase 1 CaDAnCe-101 Study Update

Stephan Stilgenbauer,[1] Ricardo D. Parrondo,[2] Meghan C. Thompson,[3] Anna Maria Frustaci,[4] John N. Allan,[5] Paolo Ghia,[6,7] Irina Mocanu,[8] Damien Roos-Weil,[9] Constantine S. Tam,[10] Judith Trotman,[11] Inhye E. Ahn,[12] Lydia Scarfò,[6,7] Carlo Visco,[13] Michael Choi,[14] Yanan Zhang,[15] Linlin Xu,[15] Kunthel By,[15] Shannon Fabre,[15] Daniel Persky,[15] Shelonitda Rose,[15] John F. Seymour[16]



Stilgenbauer S et al. EHA 2026;Abstract S152

Baseline Patient Characteristics

Heavily pretreated, with high-risk CLL features

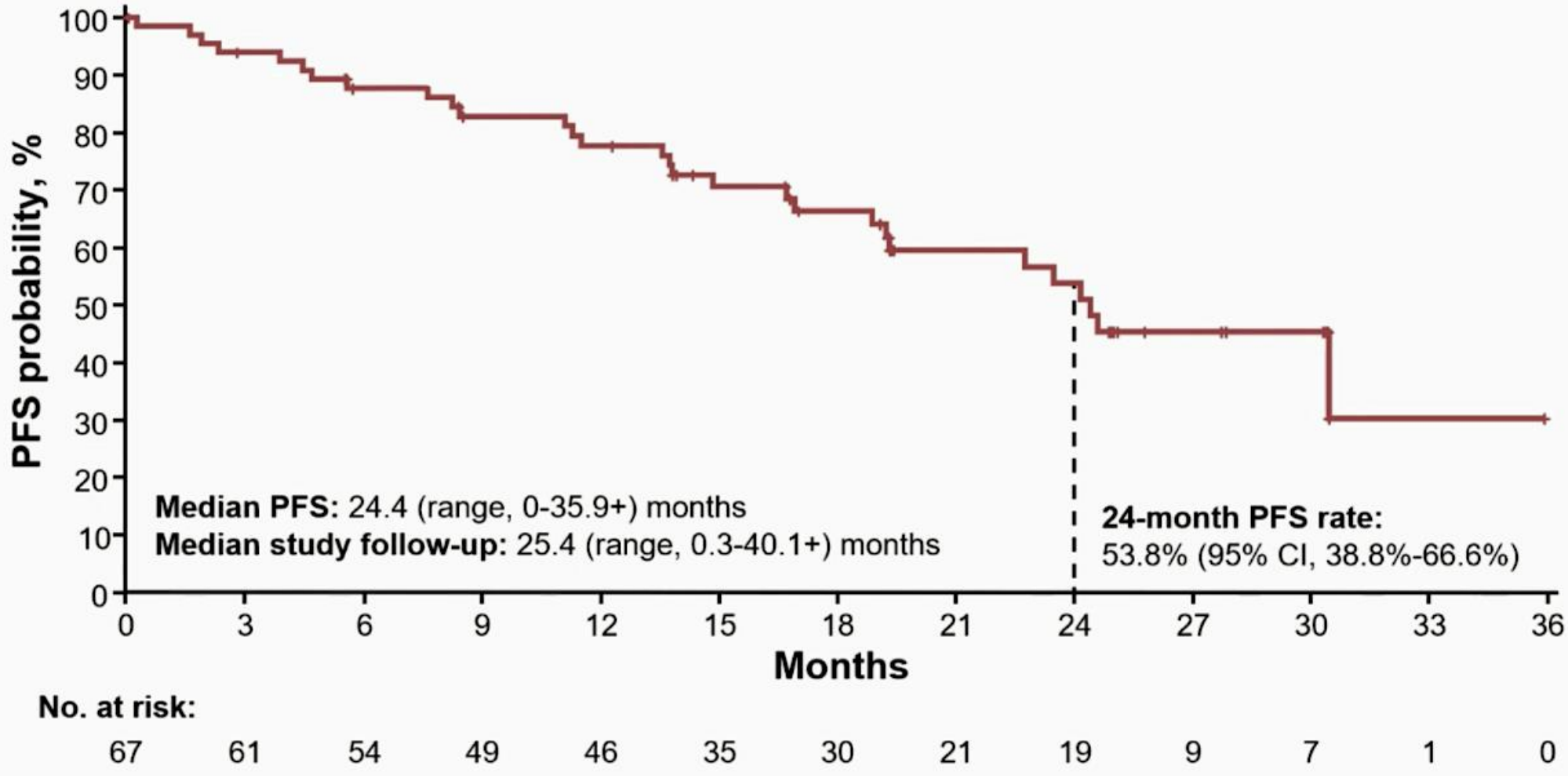
	Total (N=67)
Age, median (range), years	70 (47-91)
Male, n (%)	46 (68.7)
ECOG PS, n (%)	
0	38 (56.7)
1	28 (41.8)
2	1 (1.5)
CLL/SLL risk characteristics, n/N (%)	
Unmutated IGHV	43/56 (76.8)
del(17p) and/or *TP53* mutation	44/67 (65.7)
Complex karyotype (≥3 abnormalities)	23/43 (53.5)
Mutation status, n/N (%)	
BTK mutation present	25/66 (37.9)
PLCG2 mutation present	10/66 (15.2)
BTK and *PLCG2* mutation present	5/66 (7.6)

	Total (N=67)
No. of prior lines of therapy, median (range)	4 (2-10)
Prior therapy, n (%)	
Chemotherapy	48 (71.6)
cBTK inhibitor	63 (94.0)
ncBTK inhibitor	14 (20.9)
BCL2 inhibitor	55 (82.1)
cBTK + BCL2 inhibitors (no ncBTK inhibitor)	43 (64.2)
cBTK + ncBTK + BCL2 inhibitors	12 (17.9)
Refractory to last cBTK inhibitor + last BCL2 inhibitor[a]	37/41 (90.2)
Discontinued prior BTK inhibitor due to PD, n/N (%)[b]	56/63 (88.9)

Stilgenbauer S et al. EHA 2026;Abstract S152

Progression-Free Survival

Durable PFS in heavily-pretreated patients across all dose levels in phase 1



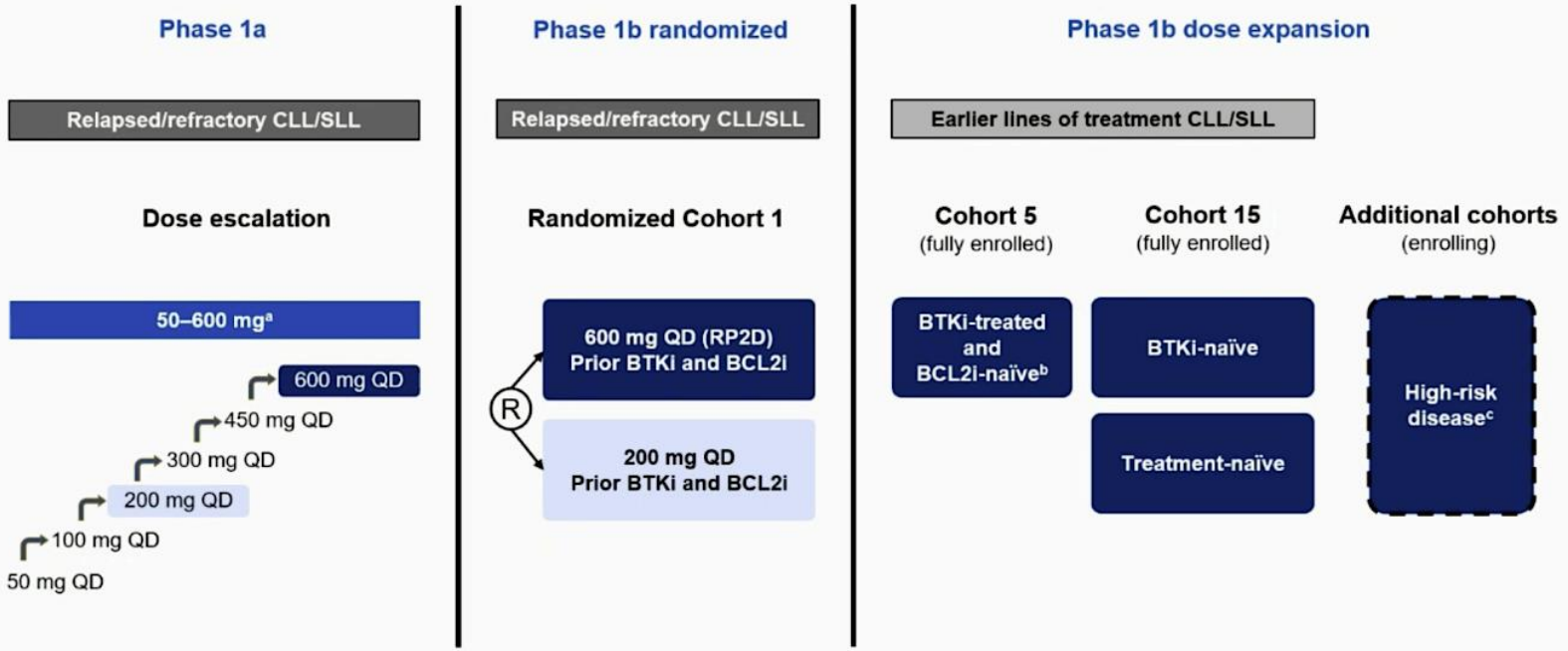
Stilgenbauer S et al. EHA 2026;Abstract S152

Updated efficacy and safety data from an ongoing phase 1a/b trial of the BTK degrader bexobrutideg (NX-5948) in patients with CLL/SLL across lines of therapy

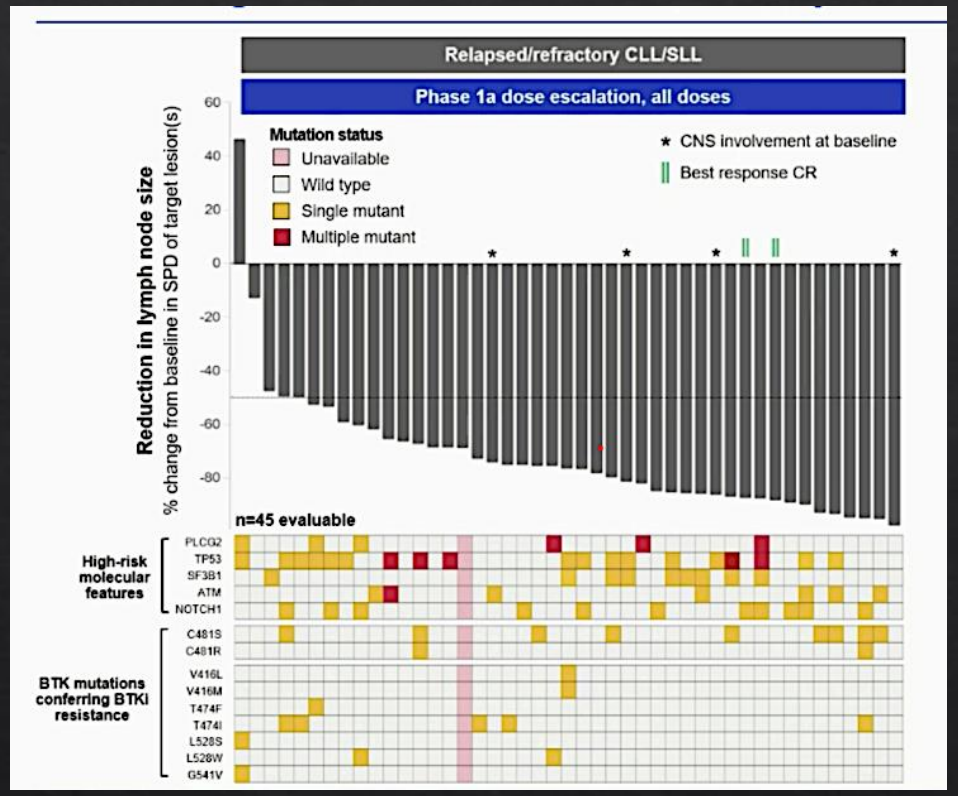
[1]Talha Munir, [2]Zulfa Omer, [3]Sebastian Grosicki, [4]Michal Kwiatek, [5]Alexey Danilov, [6]Nirav N. Shah, [7]Francesco Forconi, [8]Alvaro Alencar, [9,10]Mary Gleeson, [11]Laura Samples, [12]Graham P. Collins, [13]Jane Robertson, [14]Jonathon B. Cohen, [15]William Wierda, [16]Danielle Brander, [17]Shuo Ma, [18]Allison Winter, [19]Krzysztof Giannopoulos, [2]John C. Byrd, [20]Sarah Injac, [21]Wojciech Jurczak

Bexobrutideg Trial Design (NX-5948-301, CLL/SLL Cohorts, Phase 1a/b)

Including Phase 1b cohorts with BTKi-treated and BCL2i-naïve; BTKi-naïve (including treatment-naïve)

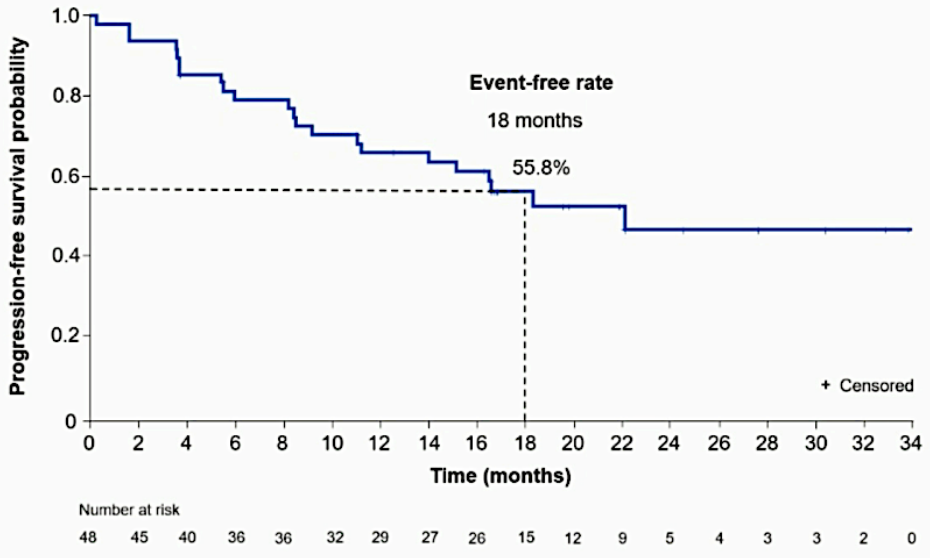


Munir T et al. EHA 2026;Abstract S150



Bexobrutideg PFS and ORR in Relapsed/Refractory Patients (Phase 1a)

PFS remains durable with a median of 22.1 months



Relapsed/refractory CLL/SLL	
PFS summary	
	n=48
Median PFS[a], months (95% CI)	**22.1** (14.0–NR)
ORR summary	
	n=47[b]
ORR, % (95% CI)[c]	**83.0** (69.2–92.4)
CR	2 (4.3)
nPR	1 (2.1)
PR	36 (76.6)
SD	6 (12.8)
PD	2 (4.3)
Median follow-up,[d] months (range)	22.4 (16.9–35.7)

Munir T et al. EHA 2026;Abstract S150

Questions?

BTK Degraders

- Stilgenbauer S et al. **BGB-16673,** a Bruton tyrosine kinase (BTK) degrader, in patients with **relapsed/refractory** (R/R) **chronic lymphocytic leukemia/small lymphocytic lymphoma** (CLL/SLL): A **phase 1 CADANCE-101 study update**. EHA 2026;Abstract S152.
- Munir T et al. **Updated efficacy and safety data** from an ongoing **phase 1a/b trial** of the BTK degrader **bexobrutideg (NX-5948)** in patients with **CLL** across lines of therapy. EHA 2026;Abstract S150.

Agenda

Introduction: Trials in Progress

Module 1: Chronic Lymphocytic Leukemia

Module 2: Diffuse Large B-Cell Lymphoma

- First-Line Therapy
- Bispecific Antibodies (Epcoritamab, Mosunetuzumab)
- Antibody-Drug Conjugates (Polatuzumab Vedotin)
- CELMoDs (Golcadomide)

Module 3: Mantle Cell Lymphoma

Module 4: Follicular Lymphoma

Key Datasets

- Harkins RA et al. **Outcomes** by **LymphoMAP** archetypes in **untreated diffuse large B-cell lymphoma** from the **POLARIX trial**. ASCO 2026;Abstract 7017.
- Jerkeman M et al. **Safety data** and **initial pooled efficacy data** from the Nordic Lymphoma Group **phase 3 POLAR BEAR trial** in elderly or frail patients with **diffuse large cell lymphoma** - R-Pola-mini-CHP vs R-mini-CHOP. EHA 2026;Abstract S238.
- Lenz G et al. **Tafasitamab plus lenalidomide** and R-CHOP for patients with **previously untreated diffuse large B-cell lymphoma** (DLBCL): **Results** from the **phase 3 frontMIND study**. ASCO 2026;Abstract LBA7000.
- Thieblemont C et al. **Sustained remissions** beyond 4 years with **epcoritamab monotherapy**: **Long-term follow-up results** from the pivotal **EPCORE NHL-1 trial** in patients with **relapsed or refractory large B-cell lymphoma**. EHA 2026;Abstract PF977.

Key Datasets (Continued)

- Fox CP et al. **Results from EPCORE DLBCL-1**: Randomized **Phase 3** study of **epcoritamab** (epcor) vs investigator's choice chemoimmunotherapy (CIT) in patients with **relapsed/refractory large B-cell lymphoma** (R/R LBCL). EHA 2026;Abstract S235.
- [Manufacturer] announces **positive phase 3 results** for **epcoritamab plus lenalidomide** in patients with **relapsed/refractory diffuse large B-cell lymphoma**, demonstrating statistically significant improvement in progression-free survival [press release]. June 29, 2026. https://www.us.genmab.com/company/news/press-releases/genmab-announces-positive-phase-3-results-for-epcoritamab-plus-lenalidomide-in-patients-with-relapsed-refractory-diffuse-large-b-cell-lymphoma-demonstrating-statistically-significant-improvement-in-progression-free-survival-2026-06.
- Chihara D et al. **Phase 2 trial** of **epcoritamab** in combination with rituximab-mini CVP for **older unfit/frail** or anthracycline-ineligible adult patients with **newly diagnosed diffuse large B-cell lymphoma: Interim futility analysis**. ASCO 2026;Abstract 7002.

Key Datasets (Continued)

- Flinn I et al. Fixed-duration **subcutaneous (SC) mosunetuzumab** (Mosun) in **elderly/unfit patients with previously untreated diffuse large B-cell lymphoma (DLBCL)**: Interim analysis and patient-reported outcomes (PROs) from the **phase 2 MorningSun** study. ASCO 2026;Abstract 7029.
- Matasar M et al. **Multivariable analyses (MVAs) of overall survival (OS)** in the phase 3 **SUNMO, STARGLO, and POLARGO** trials in **relapsed/refractory large B-cell lymphoma (LBCL).** ASCO 2026;Abstract 7093.
- Glass B et al. **Polatuzumab vedotin** plus rituximab, ifosfamide, carboplatin, etoposide (Pola-R-ICE) vs R-ICE as **second line treatment** in **large B cell lymphoma** (LBCL). **Final analysis** of a randomized **phase 3 study**. EHA 2026;Abstract S237.
- Budde LE et al. **Mosunetuzumab plus polatuzumab vedotin** versus rituximab, gemcitabine and oxaliplatin in **large B-cell lymphoma**: **Updated efficacy and safety** from the **phase 3 SUNMO study** including in patient subgroups. EHA 2026;Abstract PF968.
- Hoffmann M et al. **Golcadomide** (GOLCA), a potential, first-in-class, **oral CELMoD**, + Pola-RCHP in patients (pts) with **newly diagnosed aggressive B-cell lymphoma** (a-BCL): **Safety** and **12-month** (mo) **efficacy** results. ASCO 2026;Abstract 7011.

Post-ASCO/EHA 2026: Diffuse Large B-Cell Lymphoma

Tanya Siddiqi, MD

City of Hope Orange County, CA

Research To Practice webinar

9/2/26

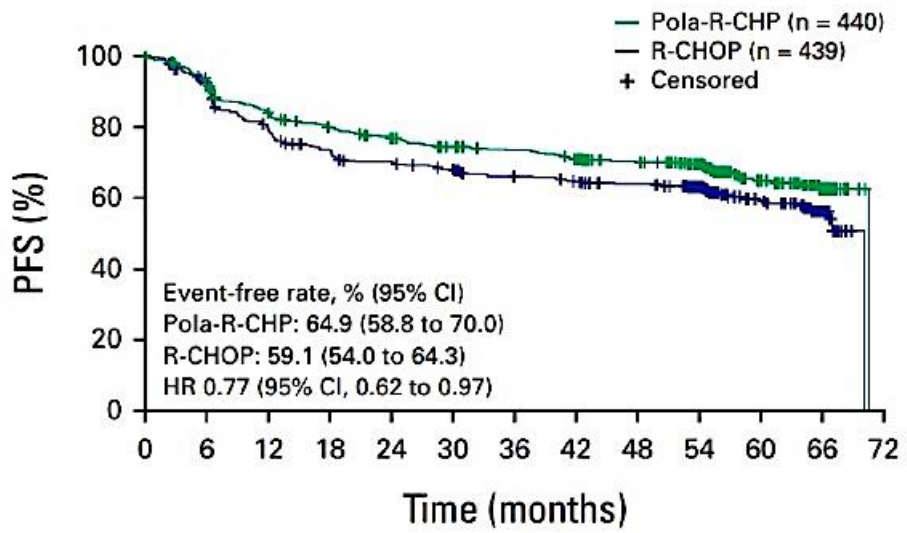
City of Hope

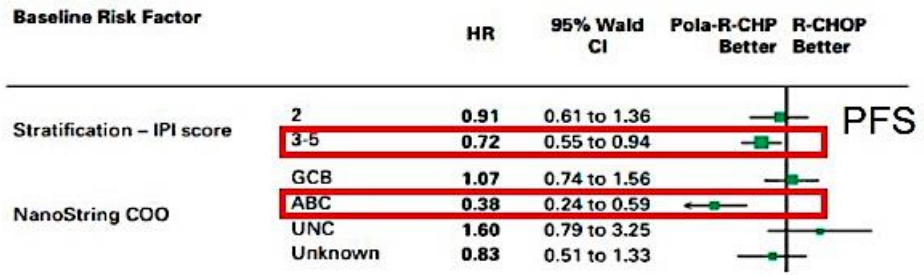
Key Datasets — First-Line Therapy

- Harkins RA et al. **Outcomes** by **LymphoMAP** archetypes in **untreated diffuse large B-cell lymphoma** from the **POLARIX trial**. ASCO 2026;Abstract 7017.
- Jerkeman M et al. **Safety data** and **initial pooled efficacy data** from the Nordic Lymphoma Group **phase 3 POLAR BEAR trial** in elderly or frail patients with **diffuse large cell lymphoma** - R-Pola-mini-CHP vs R-mini-CHOP. EHA 2026;Abstract S238.
- Lenz G et al. **Tafasitamab plus lenalidomide** and R-CHOP for patients with **previously untreated diffuse large B-cell lymphoma** (DLBCL): **Results** from the **phase 3 frontMIND study**. ASCO 2026;Abstract LBA7000.

POLARIX Established Pola-R-CHP as a SOC 1L Therapy for DLBCL

- POLARIX: Phase III study comparing Pola-R-CHP with R-CHOP in 1L intermediate- or high-risk DLBCL
- Pola-R-CHP: PFS benefit and non-significant trend for improved OS
- Exploratory analysis: showed survival benefit in high-risk subgroups
- **Established Pola-R-CHP as a SOC option for 1L DLBCL**
- We investigated clinical outcomes of LymphoMAP subtypes in POLARIX





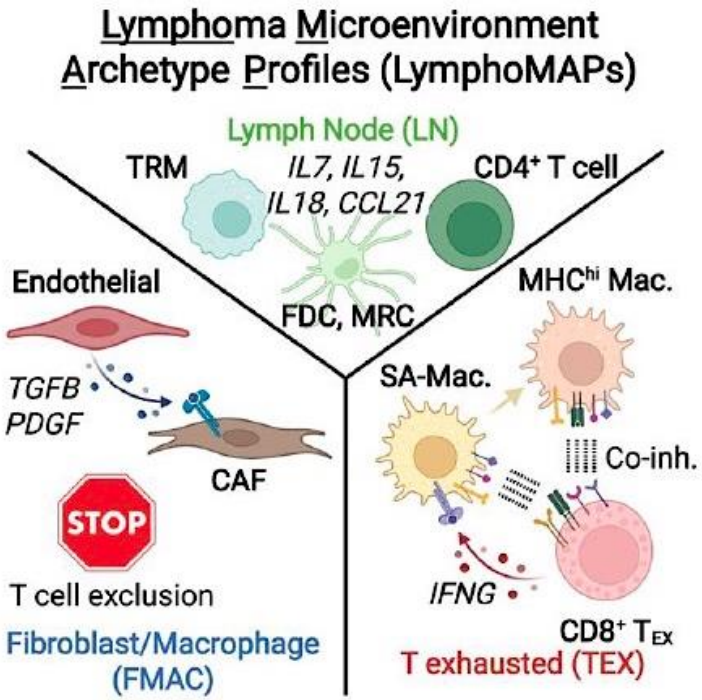
CI, confidence interval; COO, cell of origin; HR, hazard ratio; IPI, International Prognostic Index score; SOC, standard of care.

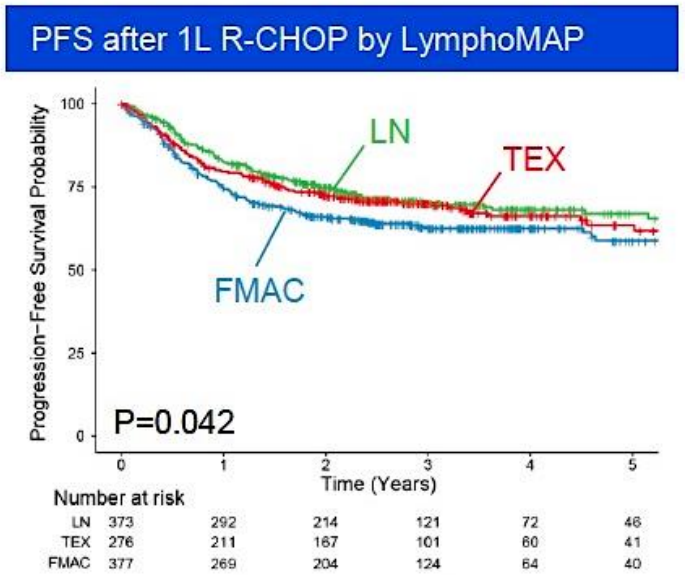
Morschhauser F, et al, J Clin Oncol 2025;43:3698–705.
Tilly H, et al. N Engl J Med 2022; 386:351–63..

Harkins RA et al. ASCO 2026;Abstract 7017

Lymphoma Microenvironment Archetype Profiles (LymphoMAPs)

- **FMAC:** cancer-associated Fibroblasts and tumor-associated MACrophages
- **LN:** Lymph Node stromal cells and healthy T cells
- **TEX:** T cells expressing EXhaustion markers and superactivated macrophages



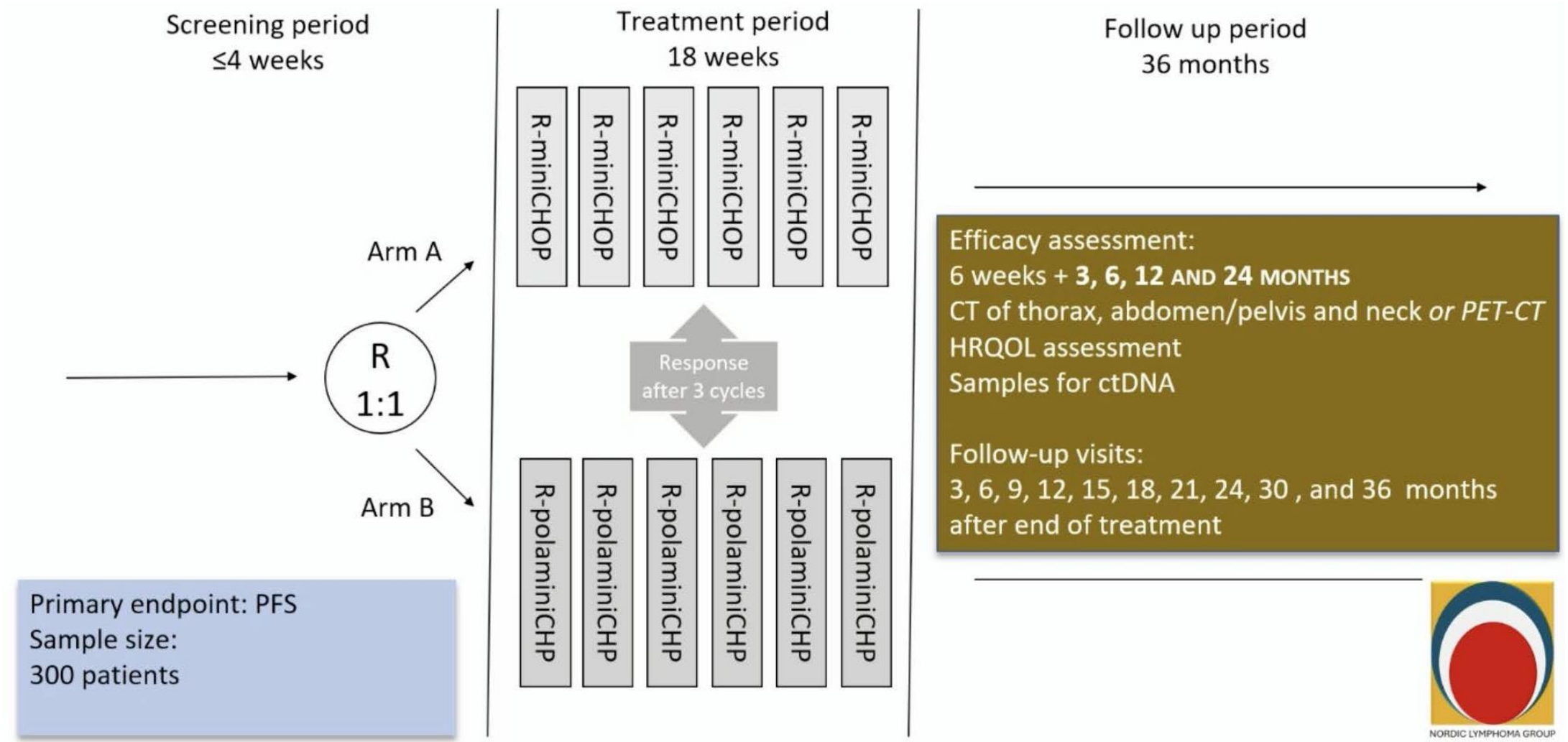


LymphoMAP	2-year PFS	95% CI
LN	74.8%	70.4–79.5%
TEX	72.2%	67.0–77.8%
FMAC	65.8%	61.1–70.9%

Li H, et al, Cancer Cell 2025;43:757–75.

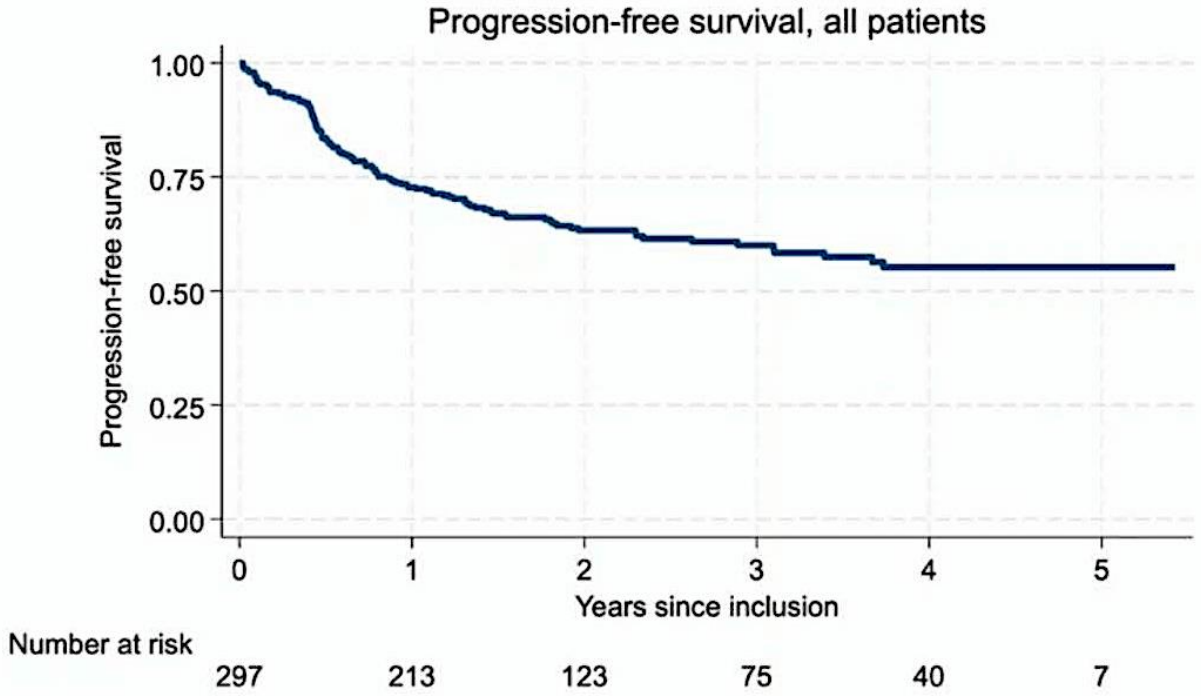
Harkins RA et al. ASCO 2026;Abstract 7017

R-Pola-mini-CHP for Frail/Elderly Patients: Phase III POLAR BEAR Study



Jerkeman M et al. EHA 2026;Abstract S238

Phase III POLAR BEAR: Pooled PFS



2-year PFS (95% CI)	63% (57-69)
Median follow-up (IQR)	2.54 years (1.71-3.91)
Number of events (total)	114
Deaths as first event	46
Progressions	68
Event-rate (events/person-year)	0.19 (0.16-0.23)
Projected time to reach 158 events	Q3 2027 – Q4 2027

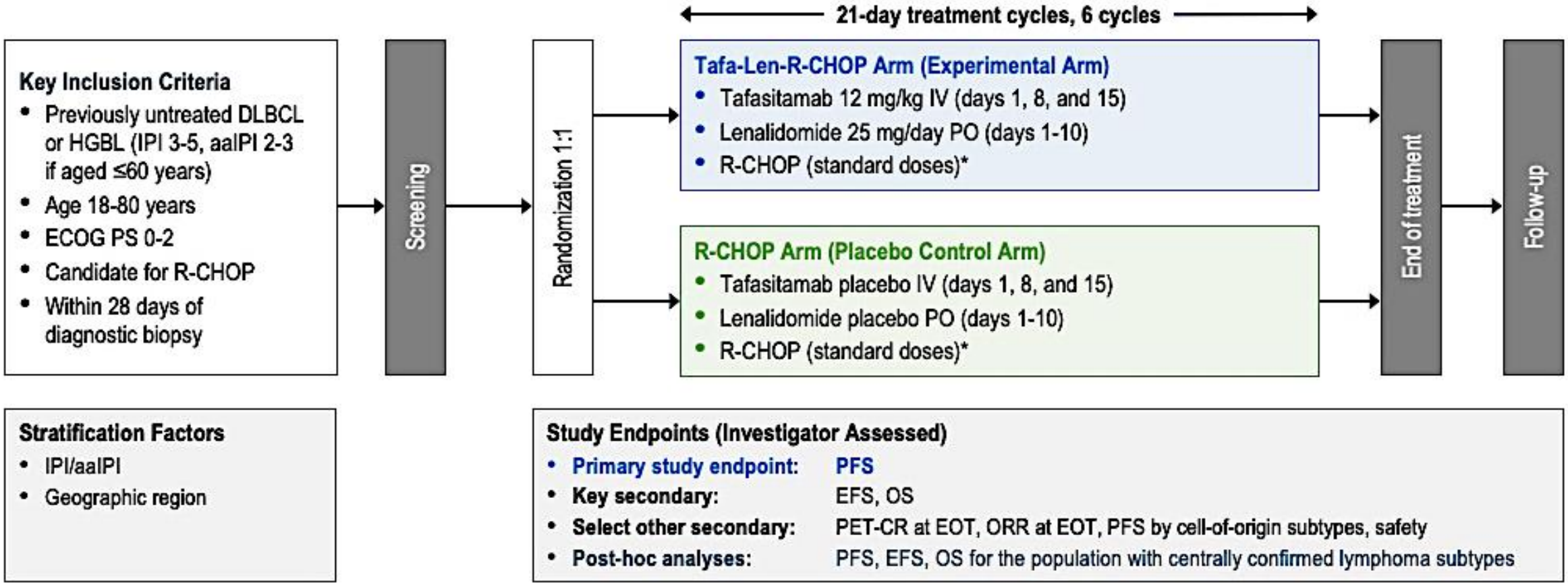
SENIOR trial, *Oberic JCO 2021*

R-miniCHOP: 2-year PFS 56%, R-miniCHOP+Len: 55%

NORDIC LYMPHOMA GROUP

Jerkeman M et al. EHA 2026;Abstract S238

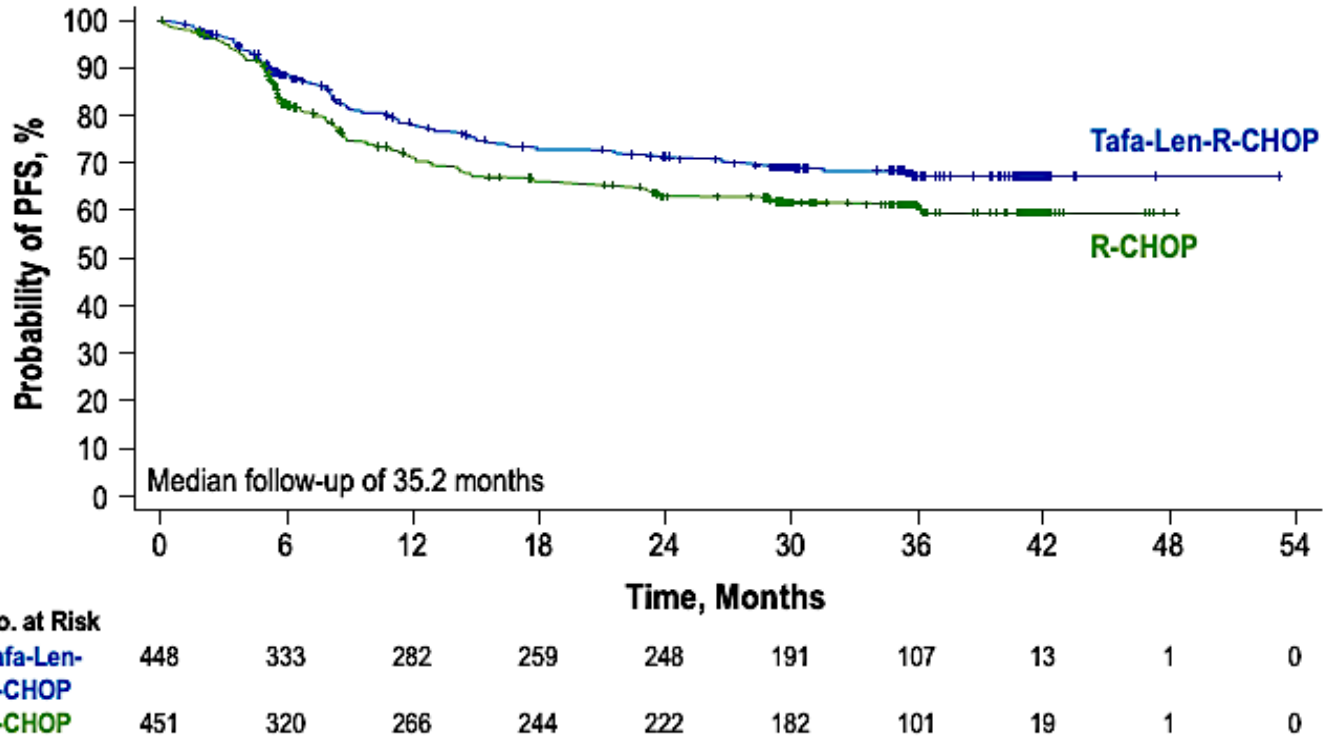
Phase III frontMIND Study Design



*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.

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

Phase III frontMIND Primary Endpoint: Investigator-Assessed Progression-Free Survival



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

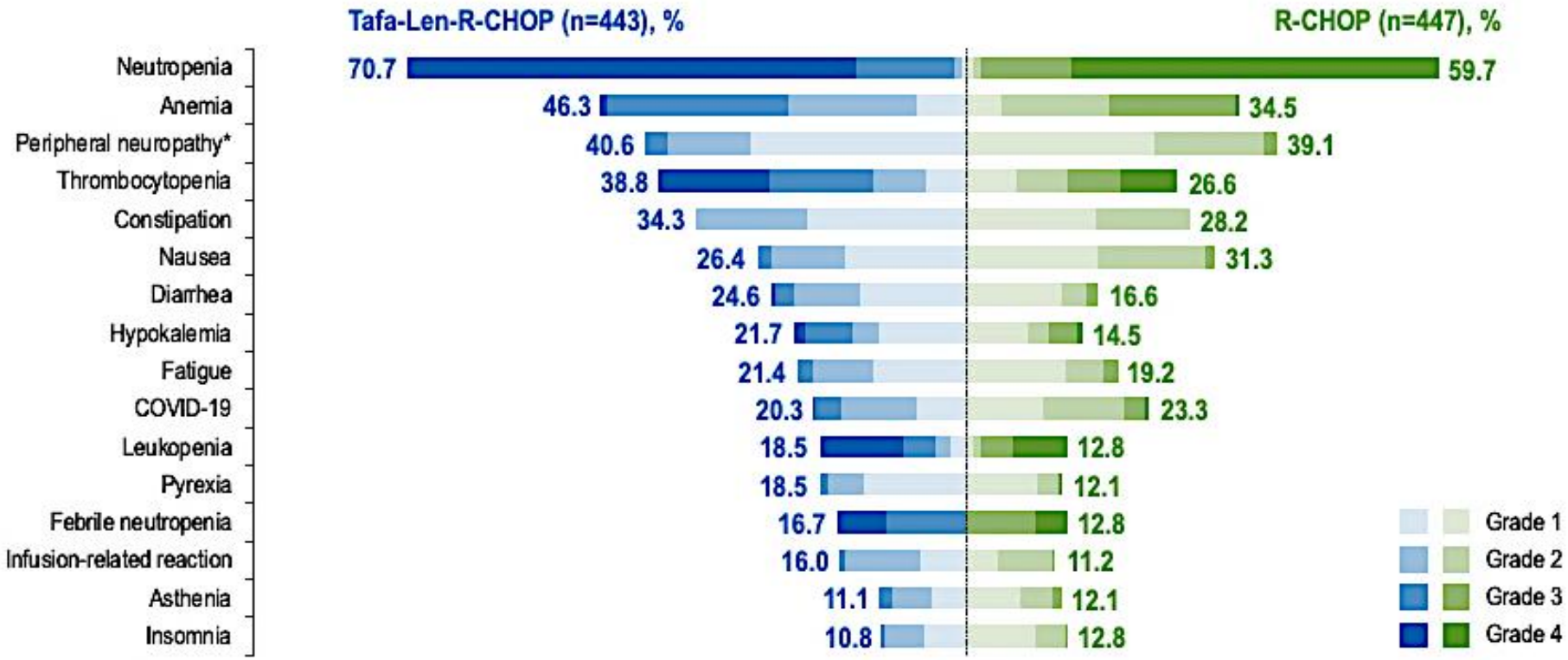
- A **25% reduction in risk of progression or death** demonstrated with Tafa-Len-R-CHOP vs R-CHOP
- **2-year PFS:** 71.1% with Tafa-Len-R-CHOP vs 62.9% with R-CHOP (Δ=**8.2%**)
- **3-year PFS:** 67.3% with Tafa-Len-R-CHOP vs 60.7% with R-CHOP (Δ=**6.6%**)

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, there are trends toward PFS advantage with Tafa-Len-R-CHOP

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

Phase III 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.

Dr. Siddiqi: DLBCL Case 1 – 1L

43 y.o. female hospital worker who initially presented with abdominal pain and distention x 5 days, which prompted an ED visit on 2/5/24. CT Abdomen done in the ER on 2/6/24 showed extensive mesenteric lymphadenopathy with a partially visualized left paracentral mesenteric mass measuring at least 6.7 x 6.3 cm. Diffuse omental infiltration with a small amount of ascites suspicious for peritoneal carcinomatosis and trace right pleural effusion were also seen.

She underwent abdominal peritoneum core needle biopsy on 2/7/24. Pathology reported High grade lymphoma, CD10+ but on our pathology review it was confirmed to be Diffuse large B-cell lymphoma, germinal center subtype, with IHC showing CD20+/CD10+/BCL2+ disease with Ki67 at ~70%. FISH was negative for MYC (Rearrangement and Amplification). Flow cytometry: CD10 positive B-cell lymphoproliferative disorder, kappa restricted, without CD5 or CD11c. Paracentesis was performed on 2/9/24 and showed lymphoma as well. Bone marrow biopsy on 2/20/24 was negative.

Staging PET CT on 2/15/24 showed extensive hypermetabolic peritoneal and omental carcinomatosis with bulky hypermetabolic mesenteric adenopathy. Hypermetabolic cervical and thoracic adenopathy and evidence of right pleural metastases. (IPI 2-3)

Started treatment with Pola-R-CHP on 2/27/24 and achieved CR which is durable thus far.

Questions?

First-Line Therapy

- Harkins RA et al. **Outcomes** by **LymphoMAP** archetypes in **untreated diffuse large B-cell lymphoma** from the **POLARIX trial**. ASCO 2026;Abstract 7017.
- Jerkeman M et al. **Safety data** and **initial pooled efficacy data** from the Nordic Lymphoma Group **phase 3 POLAR BEAR trial** in elderly or frail patients with **diffuse large cell lymphoma** - R-Pola-mini-CHP vs R-mini-CHOP. EHA 2026;Abstract S238.
- Lenz G et al. **Tafasitamab plus lenalidomide** and R-CHOP for patients with **previously untreated diffuse large B-cell lymphoma** (DLBCL): **Results** from the **phase 3 frontMIND study**. ASCO 2026;Abstract LBA7000.

Key Datasets — Bispecific Antibodies (Epcoritamab, Mosunetuzumab)

- Thieblemont C et al. **Sustained remissions** beyond 4 years with **epcoritamab monotherapy**: **Long-term follow-up results** from the pivotal **EPCORE NHL-1 trial** in patients with **relapsed or refractory large B-cell lymphoma**. EHA 2026;Abstract PF977.
- Fox CP et al. **Results from EPCORE DLBCL-1**: Randomized **phase 3** study of **epcoritamab** (epcor) vs investigator's choice chemoimmunotherapy (CIT) in patients with **relapsed/refractory large B-cell lymphoma** (R/R LBCL). EHA 2026;Abstract S235.
- [Manufacturer] announces **positive phase 3 results for epcoritamab plus lenalidomide** in patients with **relapsed/refractory diffuse large B-cell lymphoma**, demonstrating statistically significant improvement in progression-free survival [press release]. June 29, 2026. https://www.us.genmab.com/company/news/press-releases/genmab-announces-positive-phase-3-results-for-epcoritamab-plus-lenalidomide-in-patients-with-relapsed-refractory-diffuse-large-b-cell-lymphoma-demonstrating-statistically-significant-improvement-in-progression-free-survival-2026-06.
- Chihara D et al. **Phase 2 trial** of **epcoritamab** in combination with rituximab-mini CVP for **older unfit/frail** or anthracycline-ineligible adult patients with **newly diagnosed diffuse large B-cell lymphoma: Interim futility analysis**. ASCO 2026;Abstract 7002.
- Flinn I et al. Fixed-duration **subcutaneous (SC) mosunetuzumab** (Mosun) in **elderly/unfit patients with previously untreated diffuse large B-cell lymphoma (DLBCL)**: Interim analysis and patient-reported outcomes (PROs) from the **phase 2 MorningSun** study. ASCO 2026;Abstract 7029.
- Matasar M et al. **Multivariable analyses (MVAs) of overall survival (OS)** in the phase 3 **SUNMO, STARGLO, and POLARGO** trials in **relapsed/refractory large B-cell lymphoma (LBCL).** ASCO 2026;Abstract 7093.

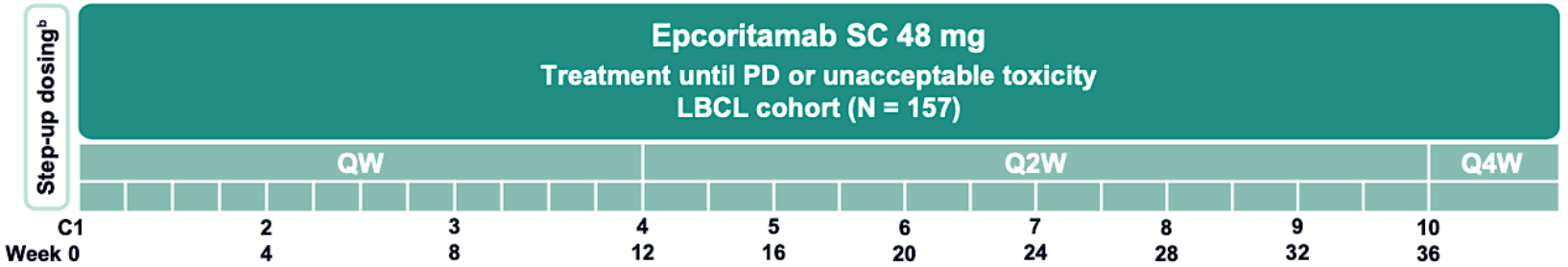
RTP RESEARCH TO PRACTICE

Phase II EPCORE NHL-1 Trial Long-Term Follow-Up

Dose expansion

Key inclusion criteria

- R/R CD20+ mature B-cell neoplasm
  - DLBCL (de novo or transformed)
  - DH or TH DLBCL[a]
  - PMBCL
  - HGBCL, NOS
  - FL grade 3B
- ECOG PS score of 0–2
- ≥ 2 prior lines of systemic antineoplastic therapy, including ≥ 1 regimen with an anti-CD20 mAb
- FDG PET–avid and measurable disease by CT/MRI
- Prior CAR T therapy allowed



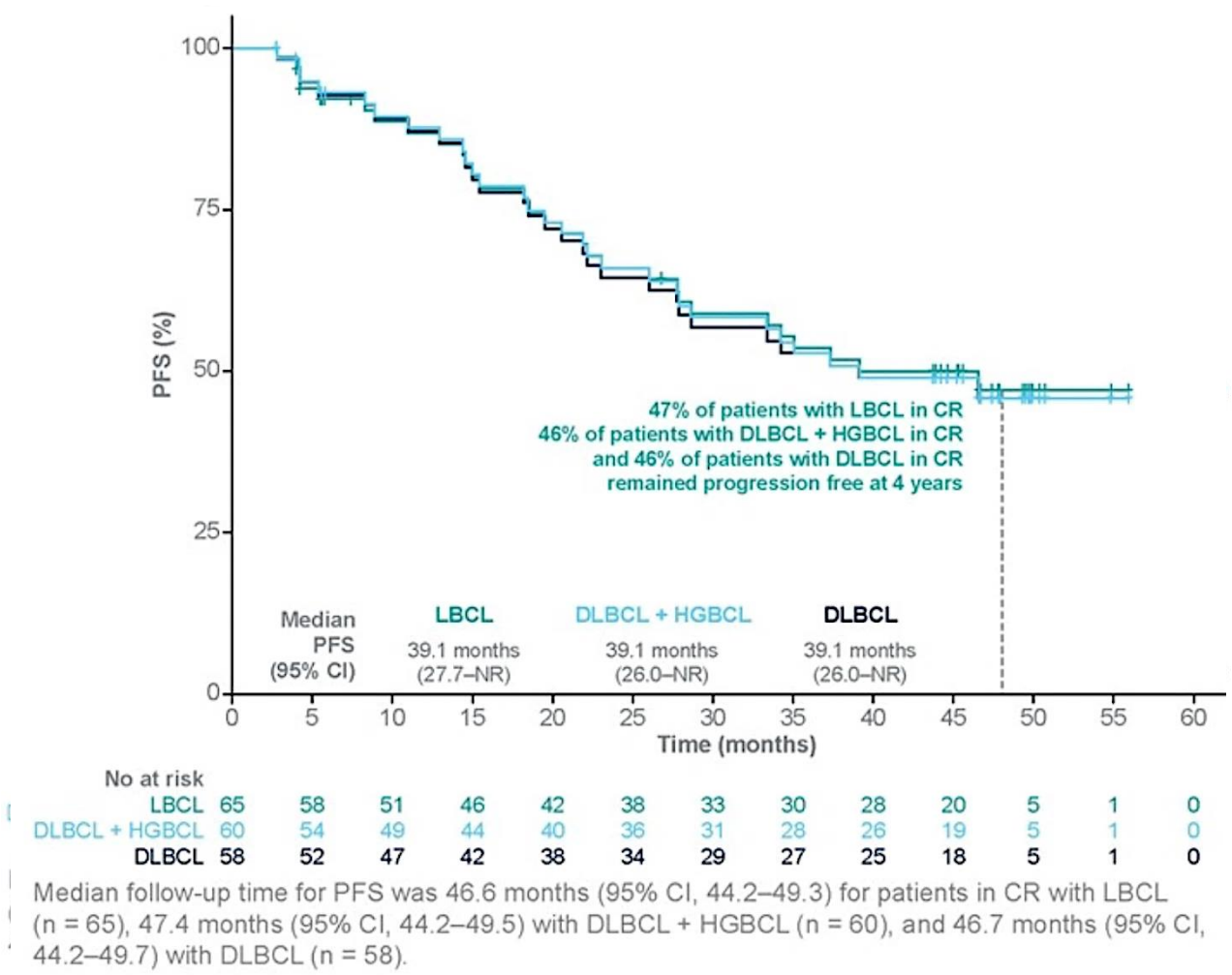
Data cutoff: May 2, 2025
Median follow-up: 49.2 months (range, 0.3–57.0)

Endpoints: ORR by investigator assessment per Lugano criteria[5], DOR, DOCR, PFS, OS, and safety/tolerability

Radiographic disease evaluation was performed Q6W for the first 24 weeks (weeks 6, 12, 18, and 24), then Q12W (weeks 36 and 48), and Q6M thereafter. White vertical lines in the study design indicate visits for epcoritamab administration. [a]Classified as HGBCL, with *MYC* and *BCL2* and/or *BCL6* translocations. [b]Step-up dose 1: priming, 0.16 mg; step-up dose 2: intermediate, 0.8 mg. Corticosteroid prophylaxis was used in C1 to mitigate CRS. To ensure patient safety and better characterize CRS, inpatient monitoring was required at first full dose for 24 hours. ClinicalTrials.gov: NCT03625037. EudraCT: 2017-001748-36.

Thieblemont C et al. EHA 2026;Abstract PF977

Phase II EPCORE NHL-1 Trial Long-Term Follow-Up: Responses



Median follow-up time for PFS was 46.6 months (95% CI, 44.2–49.3) for patients in CR with LBCL (n = 65), 47.4 months (95% CI, 44.2–49.5) with DLBCL + HGBCL (n = 60), and 46.7 months (95% CI, 44.2–49.7) with DLBCL (n = 58).

	LBCL (N = 157)	DLBCL + HGBCL (n = 148)	DLBCL (n = 139)
ORR,[a] n (%)	92 (59)	85 (57)	80 (58)
CR	65 (41)	60 (41)	58 (42)
PR	27 (17)	25 (17)	22 (16)
Median DOR,[b] months (95% CI)	20.8 (13.0–32.0)	20.8 (13.0–32.0)	21.7 (13.4–32.0)
48-month estimate, %	34	33	34

[a]Based on investigator assessment using Lugano criteria.[5] [b]Median follow-up time for DOR was 44.3 months (95% CI, 43.0–47.7) for patients in response with LBCL (n = 92), 46.2 months (95% CI, 43.0–48.1) with DLBCL + HGBCL (n = 85), and 45.3 months (95% CI, 43.0–48.2) with DLBCL (n = 80).

LBCL = large B-cell lymphoma; HGBCL = high-grade B-cell lymphoma;
ORR = overall response rate; PR = partial response; DOR = duration of response

Thieblemont C et al. EHA 2026;Abstract PF977

Phase III EPCORE DLBCL-1: 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

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[2,3]
- OS

Secondary endpoints:
- ORR, CR rate, and DOR per IRC by Lugano criteria[2,3]
- TTNT
- Safety

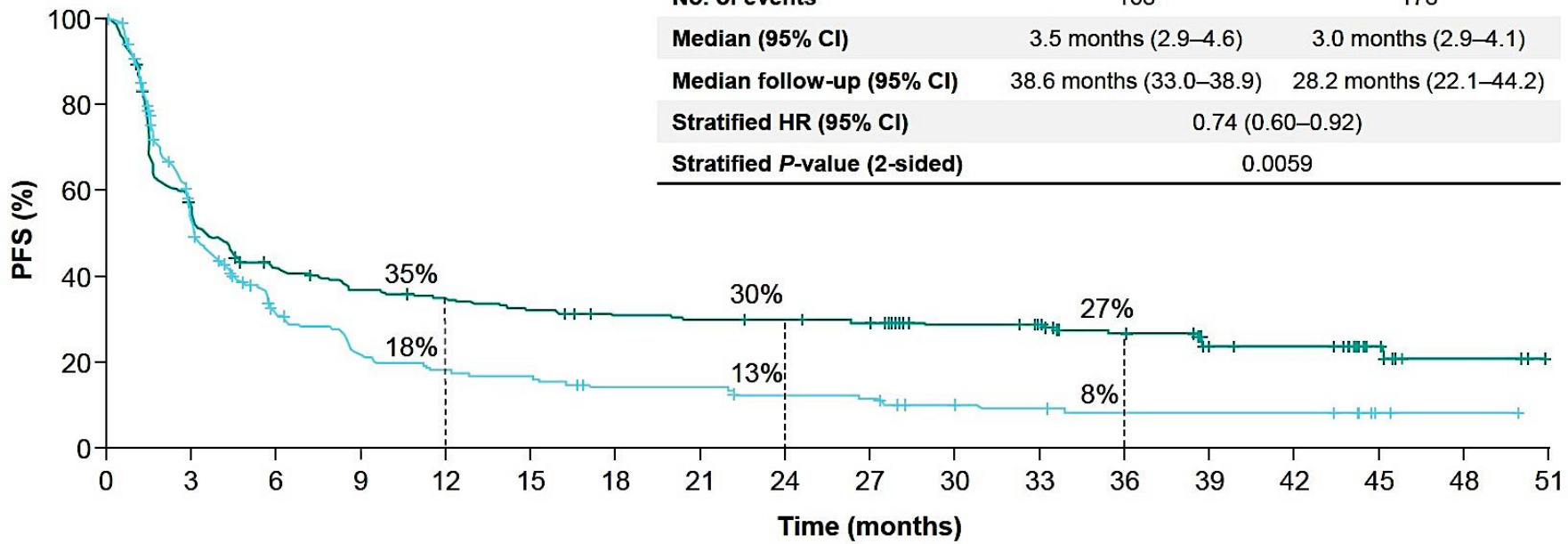
EPCORE DLBCL-1 trial was conducted during the COVID-19 pandemic; 67% of patients were randomized during the peak and subsequent waves of the highly infectious Omicron variant

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 *BCL-2* and/or *BCL-6* 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 United States.
ASCT, autologous stem cell transplantation; *BCL-2/6*, B-cell lymphoma 2/6; BR, bendamustine plus rituximab; C, cycle; CAR T, chimeric antigen receptor T-cell; CIT, chemoimmunotherapy; COVID-19, coronavirus disease 2019; CR, complete response; CRS, cytokine release syndrome; DH, double hit; DLBCL, diffuse large B-cell lymphoma; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; HDT, high-dose therapy; HGBCL, high-grade B-cell lymphoma; IRC, independent review committee; IV, intravenous; LBCL, large B-cell lymphoma; LOT, line of treatment; *MYC*, MYC proto-oncogene, bHLH transcription factor; NOS, not otherwise specified; ORR, overall response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; pLOT, prior line of treatment; Q2W, every 2 weeks; Q3W, every 3 weeks; Q4W, every 4 weeks; QW, once weekly; R/R, relapsed or refractory; R-GemOx, rituximab plus gemcitabine/oxaliplatin; SC, subcutaneous; TH, triple hit; TTNT, time to next treatment; WHO, World Health Organization.
1. Fox CP, et al. Presented at the European Hematology Association Annual Meeting; June 11–14, 2026; Stockholm, Sweden. Abstract S235. 2. Cheson BD, et al. *J Clin Oncol*. 2014;32:3059-68. 3. Cheson BD, et al. *Blood*. 2016;128:2489-26.

Fox CP et al. EHA 2026;Abstract S235

Phase III 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.
CI, confidence interval; CIT, chemoimmunotherapy; HR, hazard ratio; ITT, intent-to-treat; PFS, progression-free survival.
Fox CP, et al. Presented at the European Hematology Association Annual Meeting; June 11–14, 2026; Stockholm, Sweden. Abstract S235.

- Epcoritamab resulted in clinically meaningful improvement in CR, DOR and duration of complete response
- 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

Phase III 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

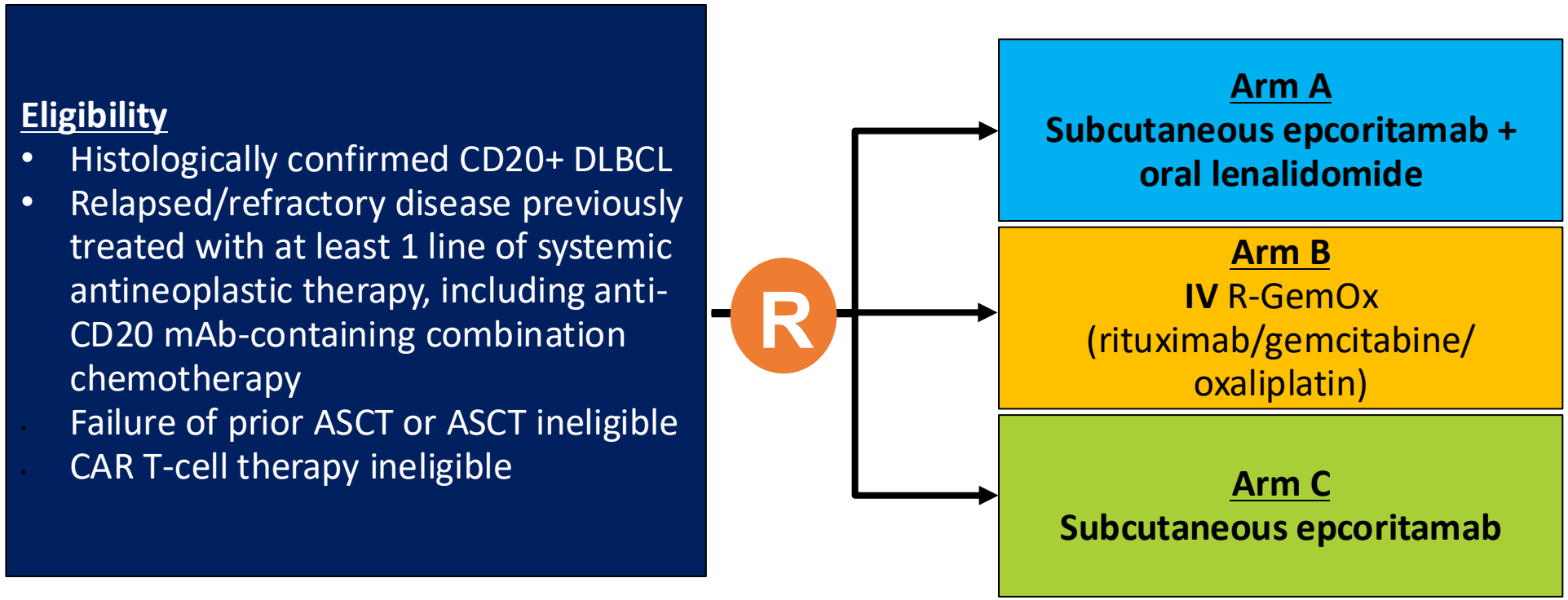
- Higher rates of Grade 3–4 infections (30% vs 12%) were reported in the epcoritamab vs the CIT arm, with Grade 3–4 infection EAERs of 4.3 vs 4.9, respectively
- Febrile neutropenia was reported in 2% of patients in the epcoritamab arm and 5% in the CIT arm; EAERs were 0.2 vs 1.7, respectively
- ICANS 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 erythema, 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.
CIT, chemoimmunotherapy; COVID-19, coronavirus disease 2019; CRS, cytokine release syndrome; EAER, exposure-adjusted event rate; ICANS, immune effector cell-associated neurotoxicity syndrome; NA, not applicable; TEAE, treatment-emergent adverse event.
Fox CP, et al. Presented at the European Hematology Association Annual Meeting; June 11–14, 2026; Stockholm, Sweden. Abstract S235.

Fox CP et al. EHA 2026;Abstract S235

Phase III EPCORE DLBCL-4 Study Design

Trial identifier: NCT06508658 (closed)



Primary endpoint (Arm A vs Arm B): Progression-free survival

Secondary endpoints (Arm A vs Arm B): Complete response, overall survival, minimal residual disease negativity rate

www.clinicaltrials.gov. Accessed August 2026.

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

Press Release: June 29, 2026

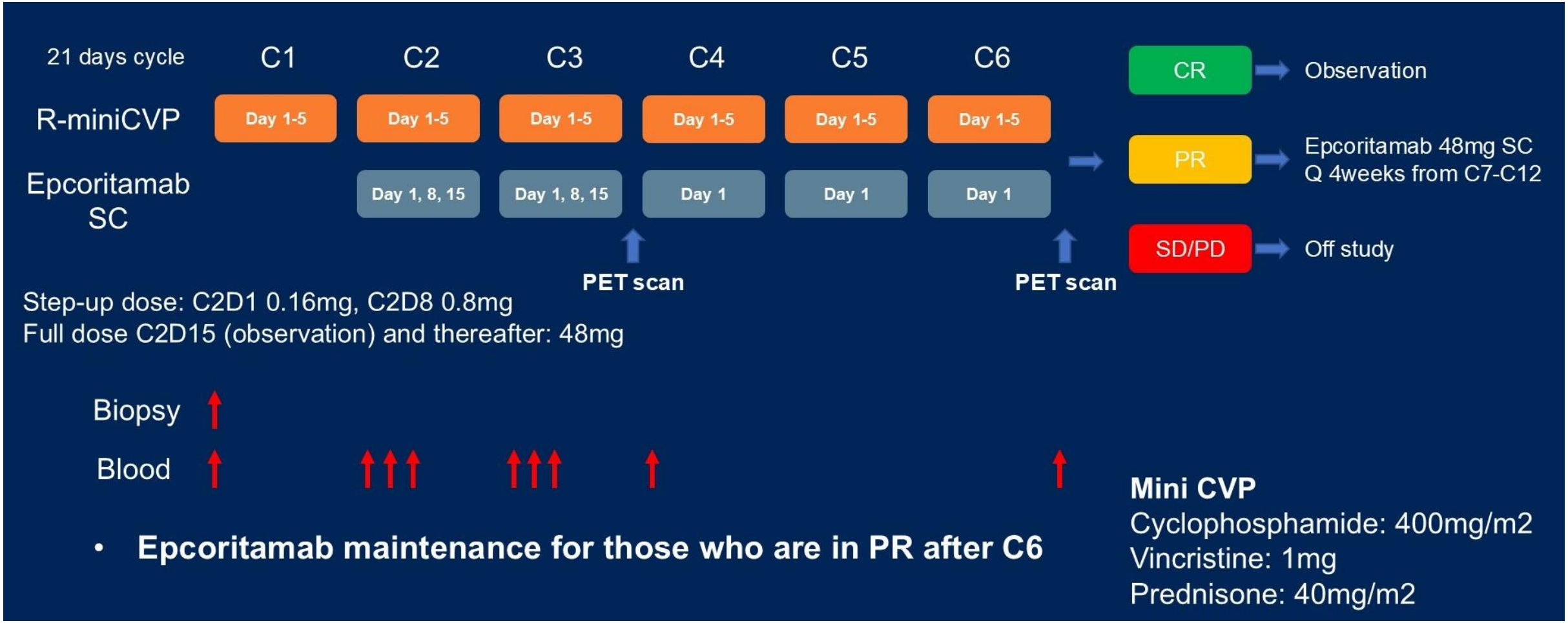
"[The manufacturers] today announced topline results from the Phase 3 EPCORE DLBCL-4 trial evaluating the combination of fixed duration epcoritamab, a T-cell engaging bispecific antibody administered subcutaneously, and lenalidomide, compared to standard-of-care, rituximab plus gemcitabine plus oxaliplatin (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 treatment. Based on topline results, the trial met its primary objective, 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 U.S. and outside the U.S., respectively.

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

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

https://www.us.genmab.com/company/news/press-releases/genmab-announces-positive-phase-3-results-for-epcoritamab-plus-lenalidomide-in-patients-with-relapsed-refractory-diffuse-large-b-cell-lymphoma-demonstrating-statistically-significant-improvement-in-progression-free-survival-2026-06

Phase II Epco-R-mini CVP Study Design: Epcoritamab Combination Therapy for Older Unfit/Frail Patients



Chihara D et al. ASCO 2026;Abstract LBA7002

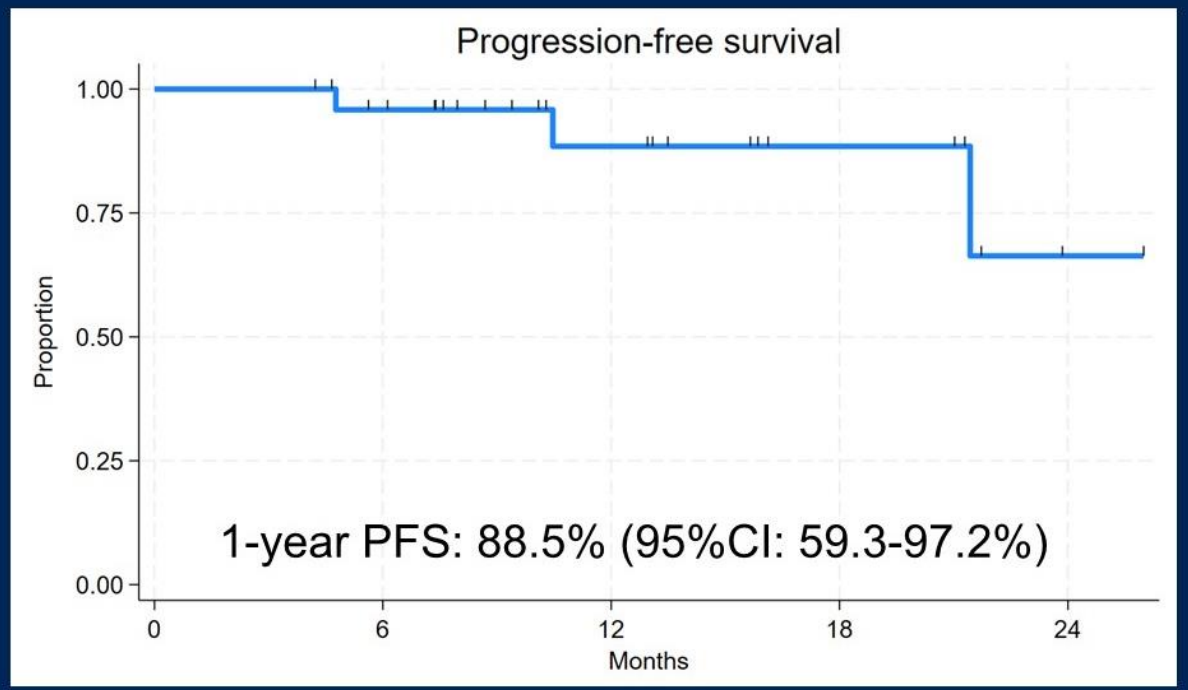
Phase II Epco-R-mini CVP: Overall Safety

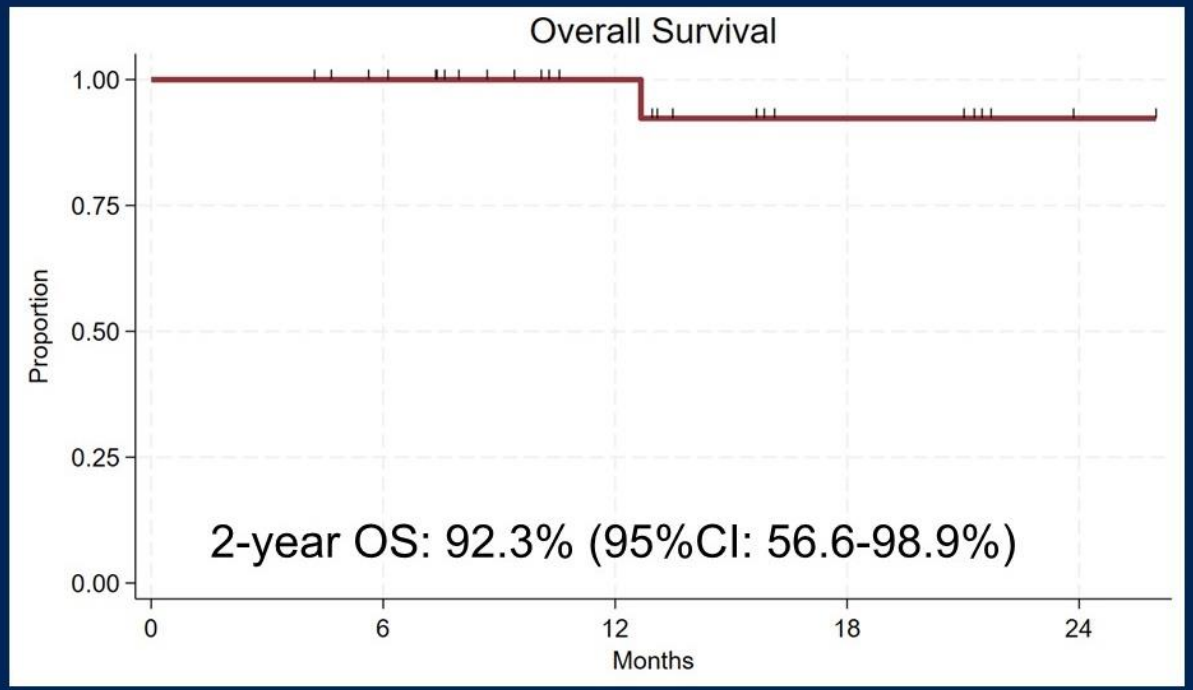
Adverse Event	All Grades	Grade 1&2	Grade 3&4
Neutropenia	13 (50%)	0	13 (50%)
Anemia	12 (46%)	0	12 (46%)
Fatigue	9 (35%)	9 (35%)	0
Diarrhea	8 (31%)	8 (31%)	0
Injection site reaction	8 (31%)	8 (31%)	0
Infections	**7 (27%)**	**4 (15%)**	**3 (12%)**
Hypotension	5 (19%)	5 (19%)	0

- All patients completed planned treatment
  - One patient had significant delay due to compression fracture unrelated to study treatment
- Most non-hematologic adverse events were grade 1-2.
- Grade ≥3 non-hematologic toxicities were uncommon and did not result in treatment discontinuation.

Chihara D et al. ASCO 2026;Abstract LBA7002

Phase II Epco-R-mini CVP: Survival





Median follow-up: 11.6 months (range: 4.2-25.9 months)

Chihara D et al. ASCO 2026;Abstract LBA7002

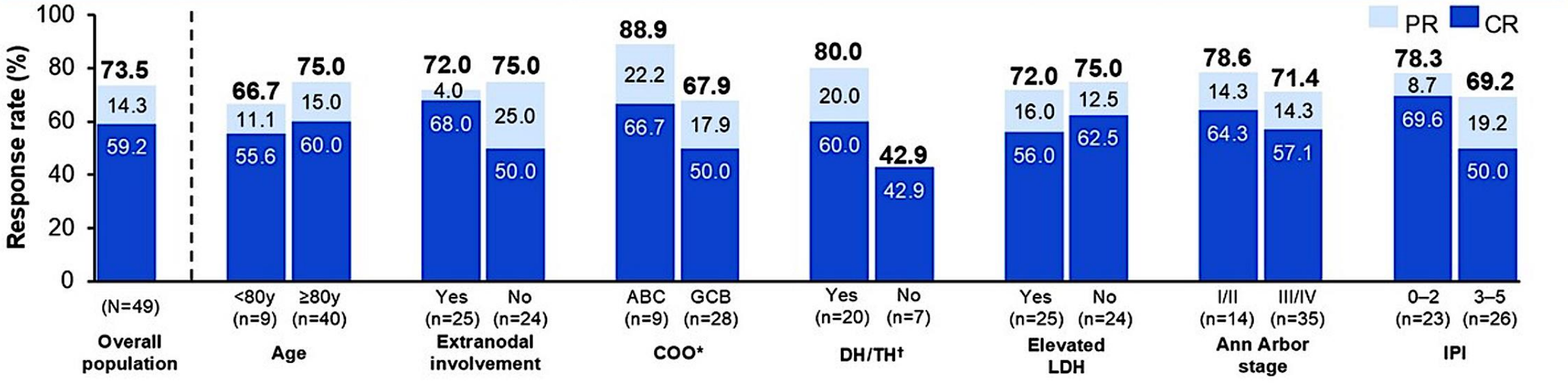
Fixed-duration subcutaneous (SC) mosunetuzumab (Mosun) in elderly/unfit patients with previously untreated diffuse large B-cell lymphoma (DLBCL): interim analysis and patient-reported outcomes (PROs) from the Phase 2 MorningSun study

Ian W. Flinn,[1] John M. Burke,[2] Aung M. Tun,[3] Ayed Ayed,[4] Juliana M.L. Biondo,[5] Mei Wu,[5] Farah Hossain,[5] Yong Mun,[5] Rona Farighi,[5] Avrita Singh,[5] Jamal Misleh,[6] Shachar Peles,[7] Elizabeth L. Budde,[8] Jose C. Villasboas,[9] Jeff P. Sharman[10]

ASCO 2026;Abstract 7029.

Phase II MorningSun: Subcutaneous Mosunetuzumab for Older or Unfit Patients with Previously Untreated DLBCL – Objective Response Rate

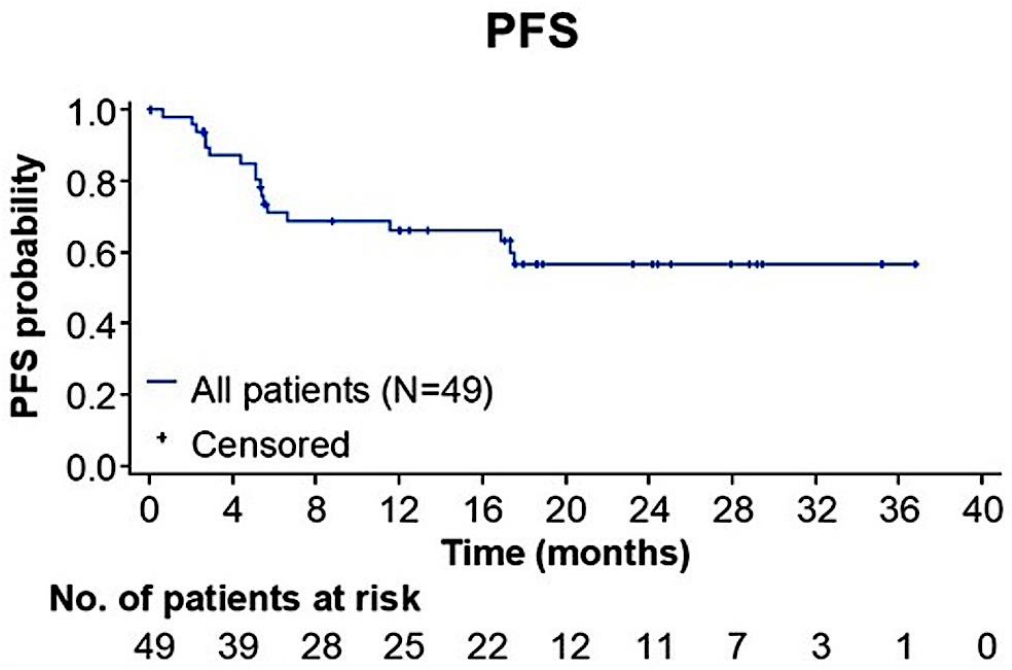
- After a median follow-up of 23.3 months, objective response and CR rates in all patients were 73.5% and 59.2%, respectively
- Median DOR and median DOCR were not reached at data cut-off
- 12- and 24-month rates were 82.6% (95% CI: 65.2–91.8) and 70.5% (95% CI: 50.2–83.7) for DOR and 83.9% (95% CI: 62.3–93.7) and 78.6% (95% CI: 55.5–90.7) for DOCR, respectively

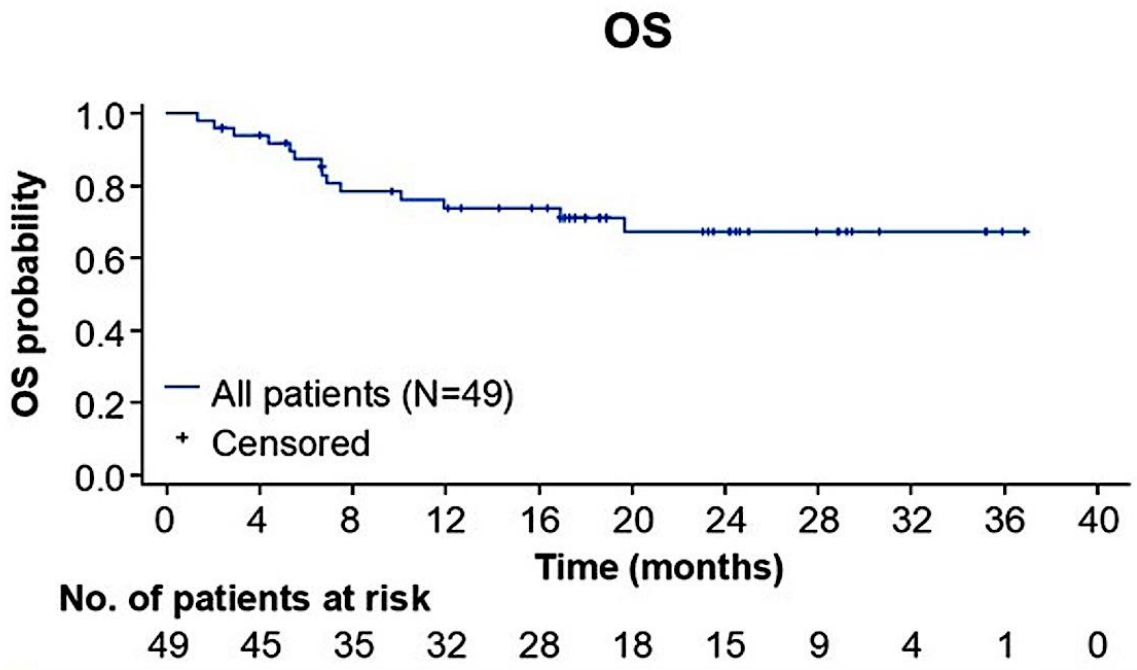


DOCR = duration of complete response; COO = cell of origin; DH/TH = double-hit/triple-hit

Flinn I et al. ASCO 2026;Abstract 7029.

Phase II MorningSun: Subcutaneous Mosunetuzumab for Older or Unfit Patients with Previously Untreated DLBCL – Survival





	N=49
Median PFS, months (95% CI)	NR (11.6–NE)
12-month PFS rate, % (95% CI)	66.0 (49.9–78.0)
24-month PFS rate, % (95% CI)	56.4 (39.4–70.3)

	N=49
Median OS, months (95% CI)	NR (NE–NE)
12-month OS rate, % (95% CI)	73.8 (58.4–84.2)
24-month OS rate, % (95% CI)	67.3 (50.5–79.5)

Flinn I et al. ASCO 2026;Abstract 7029.

Multivariable analyses (MVAs) of overall survival (OS) in the Phase 3 SUNMO, STARGLO and POLARGO trials in relapsed/refractory large B-cell lymphoma (LBCL)

Matthew Matasar,[1*] Jason Westin,[2] Jeremy S. Abramson,[3] Adam J. Olszewski,[4] Song Pham,[5] Jue Wang,[6] Steven Barrett,[6] Iris To,[6] Shen Yin,[6] Connie Batlevi,[6] Lisa Musick,[6] Linda Lundberg,[7] Michael C. Wei,[6] L. Elizabeth Budde[8]

ASCO 2026;Abstract 7093.

Analysis of OS in the Phase III SUNMO, STARGLO, and POLARGO Trials

Table 4. Unadjusted and MVA-adjusted OS HRs for each Phase 3 trial

	SUNMO n=208	STARGLO n=274	POLARGO n=255
Median follow-up, months (range)	23.2 (0–32)	20.7 (0–36)	24.6 (0–34)
MVA factors	Treatment, sex, region, baseline ECOG PS, IPI score (study entry), NHL subtype, Ann Arbor stage (study entry), bulky disease (>7.5cm), COO (local), baseline LDH, prior ASCT, trFL	Treatment, sex, region, baseline BMI, IPI score (study entry), bulky disease (≥10cm), prior lines of systemic therapy, refractory status to last systemic therapy	Treatment, baseline ECOG PS, IPI score (study entry), bulky disease (≥7.5cm), extranodal involvement (study entry), baseline MYC by IHC, China subgroup
Unadjusted OS, HR (95% CI)	0.80 (0.54–1.20)	0.62 (0.43–0.88)	0.60 (0.43–0.83)
MVA-adjusted OS, HR (95% CI)	0.65 (0.41–1.02)	0.63 (0.44–0.90)	0.52 (0.36–0.74)

Table 5. Unadjusted and MVA-adjusted OS HRs for the pooled analysis

Efficacy endpoints	Pooled Mosun-Pola versus R-GemOx n=465*
MVA factors	Treatment, sex, region, baseline BMI, baseline ECOG PS, NHL subtype, bulky disease (≥7.5cm), baseline LDH, prior lines of systemic therapy (1 vs ≥2), relapsed/refractory to first-line therapy, prior ASCT, trFL
Unadjusted OS, HR (95% CI)	0.62 (0.48–0.81)
MVA-adjusted OS, HR (95% CI)	0.59 (0.43–0.80)

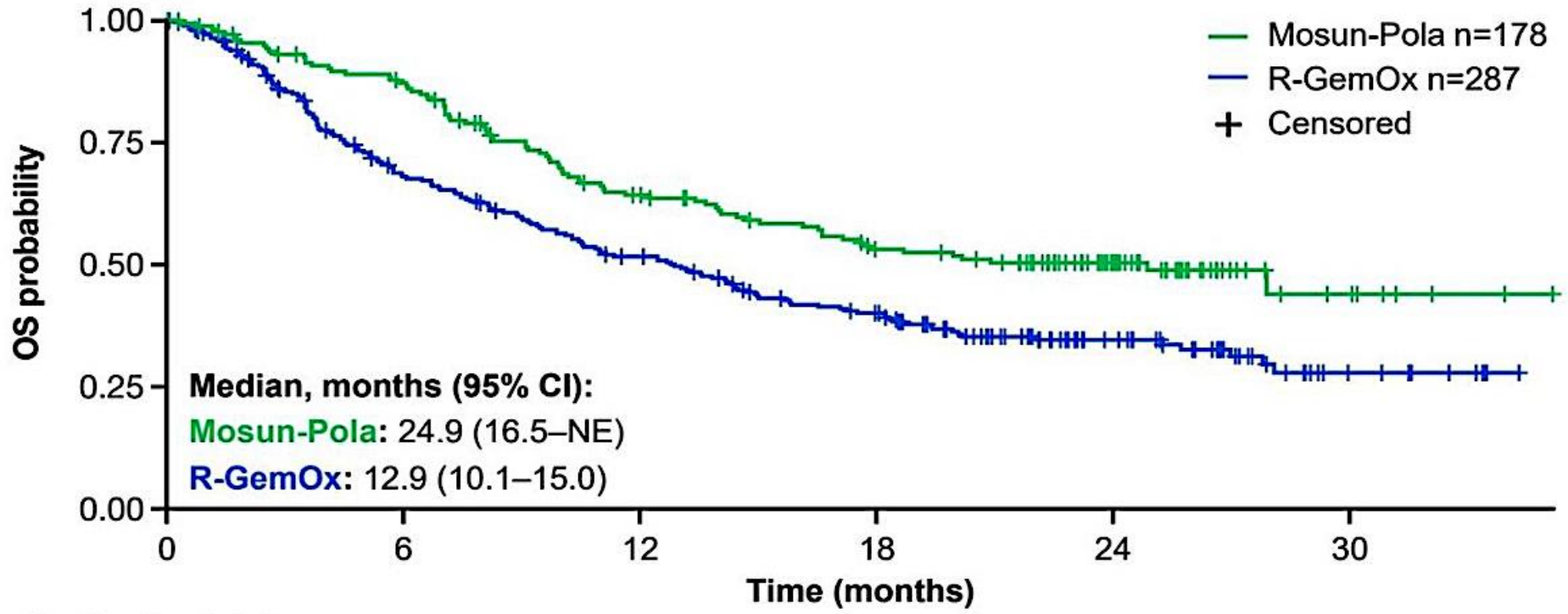
*Mosun-Pola (SUNMO, n=138; GO40516, n=40) versus R-GemOx (SUNMO, n=70; STARGLO, n=91; POLARGO, n=126).

BMI = body mass index; trFL = transformed follicular lymphoma

Matasar M et al. ASCO 2026;Abstract 7093.

Pooled Analysis of OS with Mosunetuzumab/Polatuzumab Vedotin

Figure 1. Unadjusted OS for the pooled analysis



No. of patients at risk

Mosun-Pola	178	148	103	78	44	7
R-GemOx	287	177	130	90	42	9

Matasar M et al. ASCO 2026;Abstract 7093.

Dr. Siddiqi: DLBCL Case 2 – R/R

55 y.o. female who developed abdominal pain around March 2024. Her internist sent her for work-up with endoscopy which was reportedly normal. She started pantoprazole and traveled to Vietnam. There her pain worsened significantly and she had a CT scan done which showed lymphadenopathy. She returned to US and CT AP from 4/4/24 showed matted group of lymph nodes measuring 8.4 x 4.3 cm in axial plane and 4.8 cm in height in the mesenteric area; superior to this group of matted lymph nodes, there was another vertically oriented group of matted lymph nodes measuring 4.9 x 5.4 cm in axial plane and 9.3 cm in height extending to the peripancreatic region. Patient underwent abdominal mass biopsy on 4/9/24 and pathology showed diffuse large b-cell lymphoma, activated B-cell subtype. MYC rearrangement not detected. She also had a BMBx on 4/10/24 which showed no evidence of lymphoma. B symptoms were present.

Patient started RCHOP chemotherapy on 5/1/24. Her mid-treatment scan showed excellent response to chemotherapy, with mesenteric mass SUV down to 2.6 from 17. She completed 6 cycles on 8/21/24. Unfortunately, restaging scan at the end of treatment now showed some disease progression. Due to primary refractory disease, she was started on RICE chemo and referred for ASCT vs. CAR T cell therapy. However, she did not respond to this and was consented for a CD19 CAR T cell trial at our institution. She failed to respond to this as well, with disease progression soon after her day 28 response assessment.

CD20 bispecific antibody was the next treatment option for her to try: epcoritamab was tried.

Questions?

Bispecific Antibodies (Epcoritamab, Mosunetuzumab)

- Thieblemont C et al. **Sustained remissions** beyond 4 years with **epcoritamab monotherapy**: **Long-term follow-up results** from the pivotal **EPCORE NHL-1 trial** in patients with **relapsed or refractory large B-cell lymphoma**. EHA 2026;Abstract PF977.
- Fox CP et al. **Results from EPCORE DLBCL-1**: Randomized **phase 3** study of **epcoritamab** (epcor) vs investigator's choice chemoimmunotherapy (CIT) in patients with **relapsed/refractory large B-cell lymphoma** (R/R LBCL). EHA 2026;Abstract S235.
- [Manufacturer] announces **positive phase 3 results** for **epcoritamab plus lenalidomide** in patients with **relapsed/refractory diffuse large B-cell lymphoma**, demonstrating statistically significant improvement in progression-free survival [press release]. June 29, 2026. https://www.us.genmab.com/company/news/press-releases/genmab-announces-positive-phase-3-results-for-epcoritamab-plus-lenalidomide-in-patients-with-relapsed-refractory-diffuse-large-b-cell-lymphoma-demonstrating-statistically-significant-improvement-in-progression-free-survival-2026-06.
- Chihara D et al. **Phase 2 trial** of **epcoritamab** in combination with rituximab-mini CVP for **older unfit/frail** or anthracycline-ineligible adult patients with **newly diagnosed diffuse large B-cell lymphoma: Interim futility analysis**. ASCO 2026;Abstract 7002.
- Flinn I et al. Fixed-duration **subcutaneous (SC) mosunetuzumab** (Mosun) in **elderly/unfit patients with previously untreated diffuse large B-cell lymphoma (DLBCL)**: Interim analysis and patient-reported outcomes (PROs) from the **phase 2 MorningSun** study. ASCO 2026;Abstract 7029.
- Matasar M et al. **Multivariable analyses (MVAs) of overall survival (OS)** in the phase 3 **SUNMO, STARGLO, and POLARGO** trials in **relapsed/refractory large B-cell lymphoma (LBCL).** ASCO 2026;Abstract 7093.

RTP RESEARCH TO PRACTICE

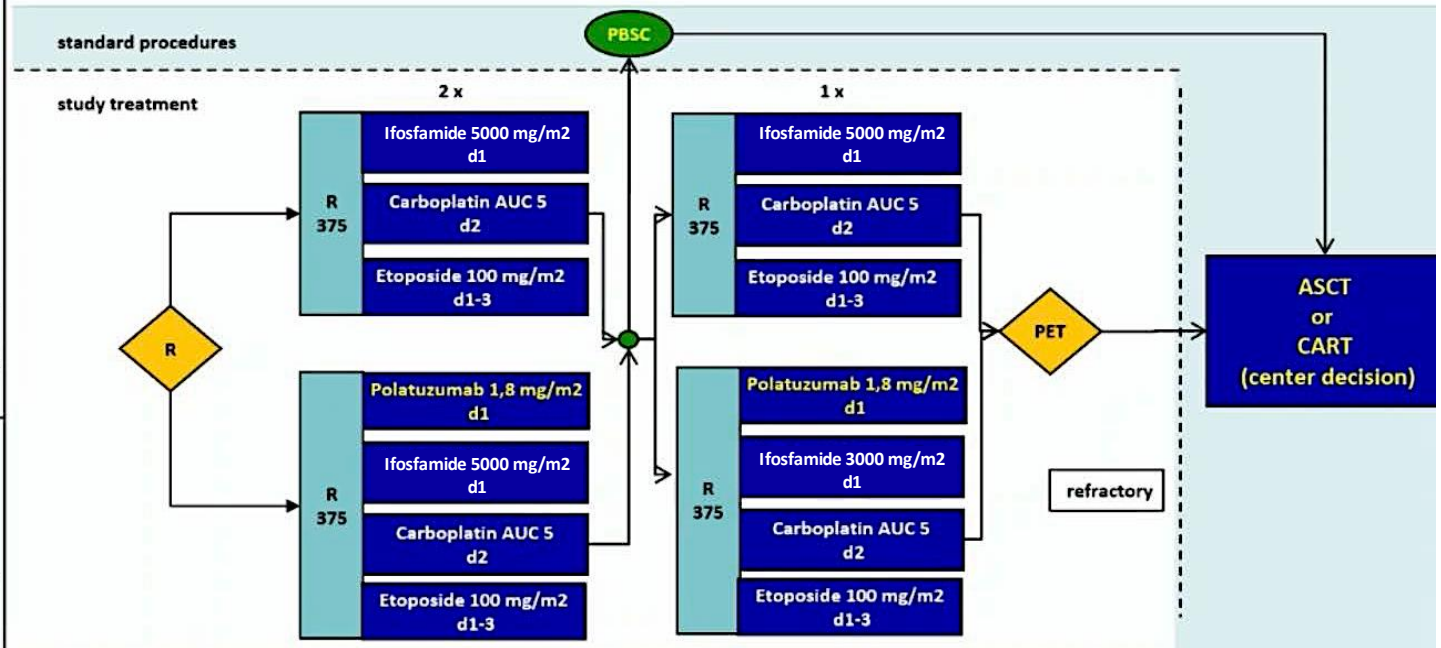
Key Datasets — Antibody-Drug Conjugates (Polatuzumab Vedotin)

- Glass B et al. **Polatuzumab vedotin** plus rituximab, ifosfamide, carboplatin, etoposide (Pola-R-ICE) vs R-ICE as **second line treatment** in **large B cell lymphoma** (LBCL). **Final analysis** of a randomized **phase 3 study**. EHA 2026;Abstract S237.
- Budde LE et al. **Mosunetuzumab plus polatuzumab vedotin** versus rituximab, gemcitabine and oxaliplatin in **large B-cell lymphoma**: **Updated efficacy and safety** from the **phase 3 SUNMO study** including in patient subgroups. EHA 2026;Abstract PF968.

Phase III Study of Pola-R-Ice or R-Ice as 2L Salvage Therapy for LBCL

Key inclusion criteria	Histology* of aggressive B-NHL DLBCL (NOS) TCHRBCL primary cutaneous DLBCL, leg type EBV-positive DLBCL, NOS DLBCL ass. chronic inflammation PMBCL HGBCL, with MYC and BCL2 and/or BCL6 rearrangements HGBCL, NOS First treatment failure after standard primary treatment * acc. WHO definition 4th ed
Key exclusion criteria	ECOG > 3 LVEF < 45% FEV1 < 50% GFR < 50 mL/min (calculated) ALAT, ASAT or bilirubin > 1.5 x upper limit of normal (ULN). If elevation is caused by the disease, threshold of 2.5 x ULN is accepted Peripheral neuropathy > Grade II

Pola-R-Ice = Polatuzumab vedotin plus rituximab, ifosfamide, carboplatin, etoposide



Primary end point:	**Increase EFS at two years from** **30% for R-ICE to** **45% for Pola-R-ICE (HR=0.663)** With Alpha at 5% two-sided and Power at 80 % **324 patients per arm are needed** (154 patients per arm plus 16 5% lost to follow up.

Glass B et al. EHA 2026;Abstract S237

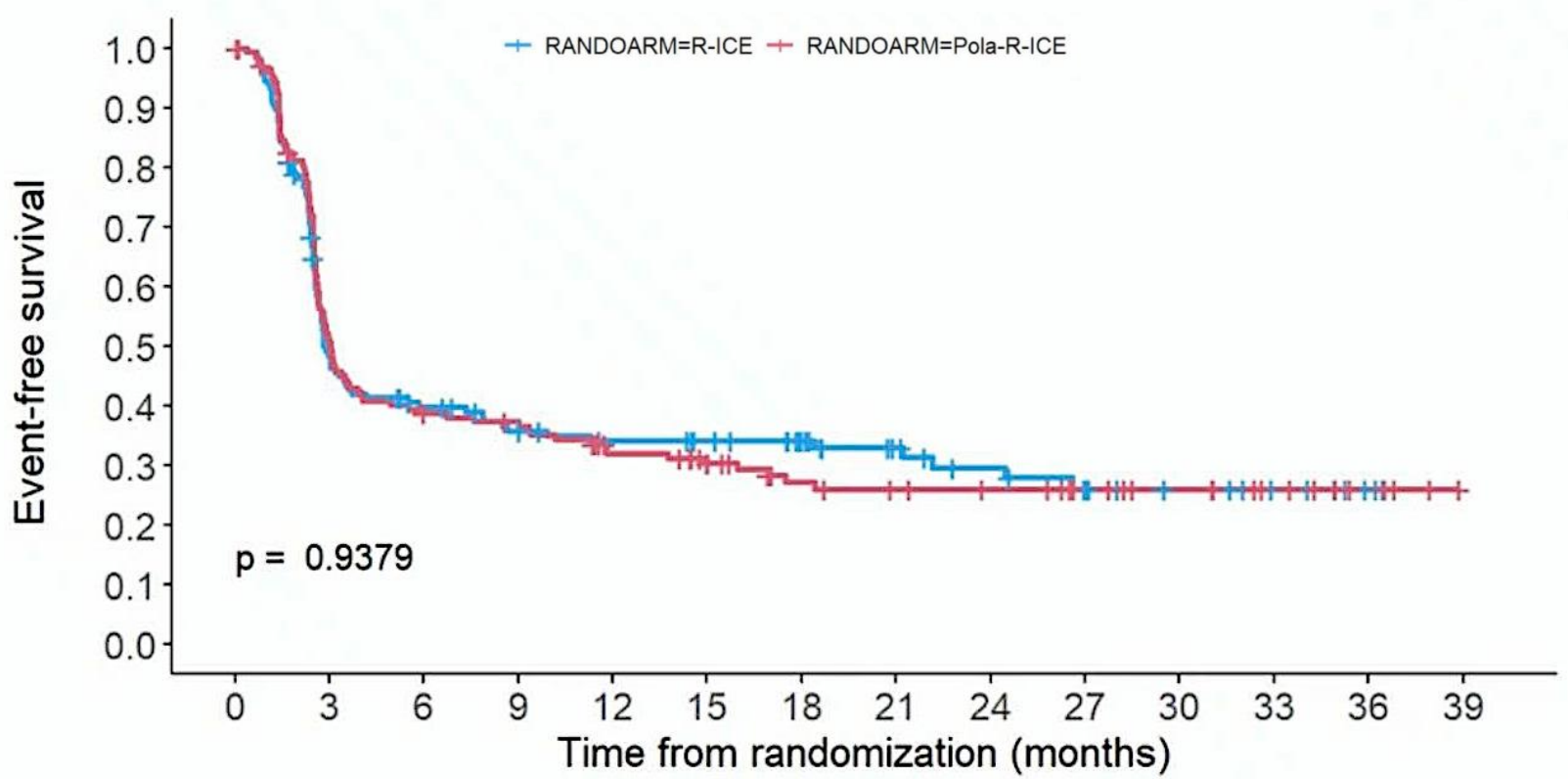
Phase III Study of Pola-R-Ice: Grade ≥3 Adverse Events

All adverse events – number affected patients (%)	R-ICE	Pola-R-ICE
Blood and lymphatic system disorders	78 (53.1)	83 (56.5)
Eye disorders	0 (0.0)	1 (0.7)
Gastrointestinal disorders	10 (6.8)	9 (6.1)
General disorders and administration site conditions	7 (4.8)	3 (2.0)
Hepatobiliary disorders	2 (1.4)	4 (2.7)
Immune system disorders	0 (0.0)	2 (1.4)
Infections and infestations	12 (8.2)*	23 (15.6)*
Injury, poisoning and procedural complications	1 (0.7)	0 (0.0)
Investigations	5 (3.4)	7 (4.8)
Metabolism and nutrition disorders	5 (3.4)	6 (4,1)
Neoplasms benign, malignant and unspecified	0 (0.0)	1 (0.7)
Nervous system disorders	4 (2.7)	8 (5.4)
Psychiatric disorders	1 (0.7)	0 (0.0)
Renal and urinary disorders	4 (2.7)	4 (2.7)
Skin and subcutaneous tissue disorders	1 (0.7)	1 (0.7)
Vascular disorders	1 (0.7)	3 (2.0)

* Pearson's Chi-squared test: p-value = 0.0476 ***) Maximum grade considered**

Glass B et al. EHA 2026;Abstract S237

Phase III Study of Pola-R-Ice: EFS (Primary Endpoint)

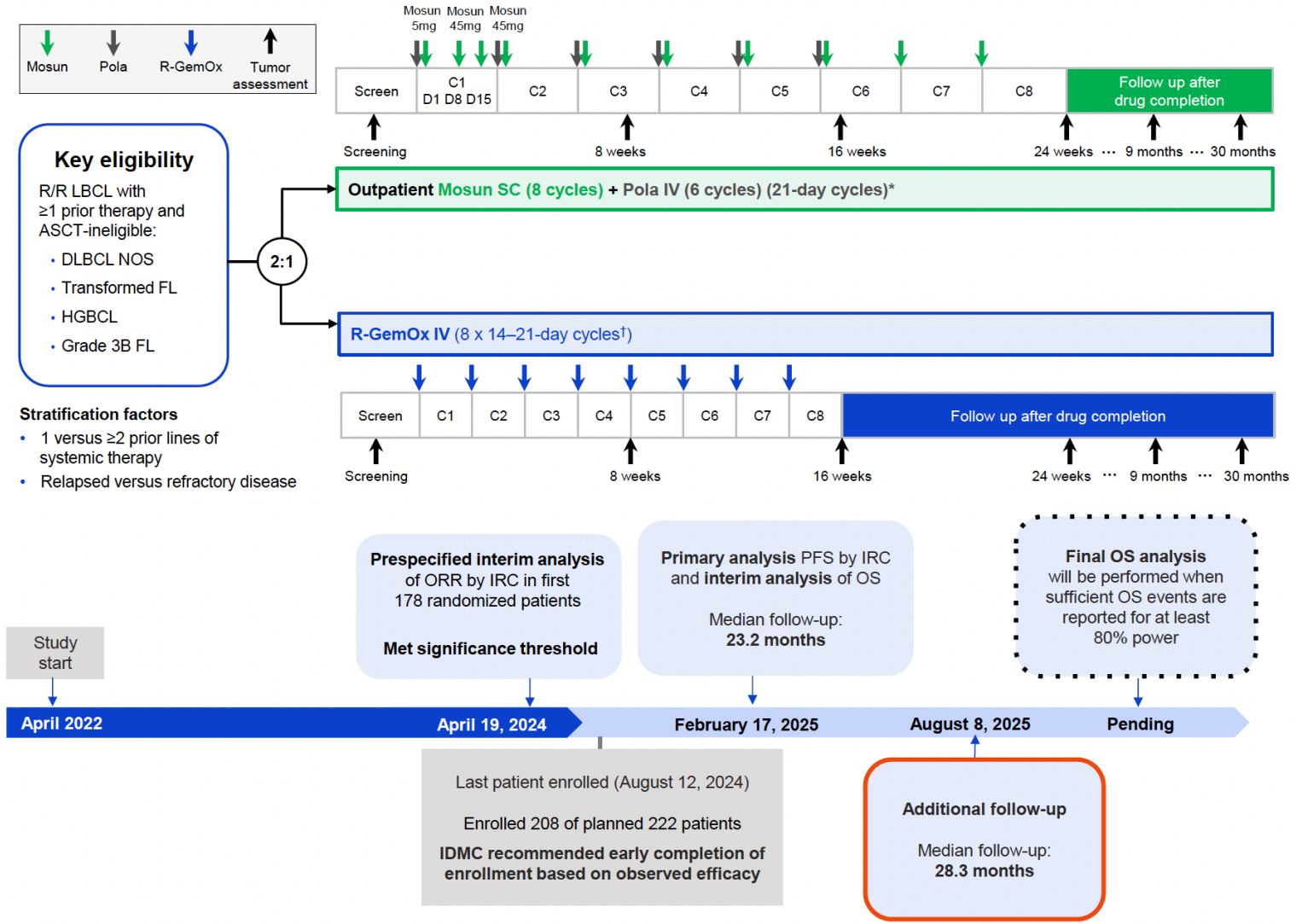


Multivariable analysis EFS

Factor	HR (95%CI)	p-value
Treatment arm: Pola-R-ICE	0.8 (0.6-1.1)	0.2271
Freedom from progression: ≤ 12 months	2.0 (1.4-2.9)	0.0003
Best response primary therapy: SD, PD (refractory)	1.8 (1.2-2.6)	0.0016
IPI score: 3-5	1.1 (0.8-1.5)	0.7268

Glass B et al. EHA 2026;Abstract S237

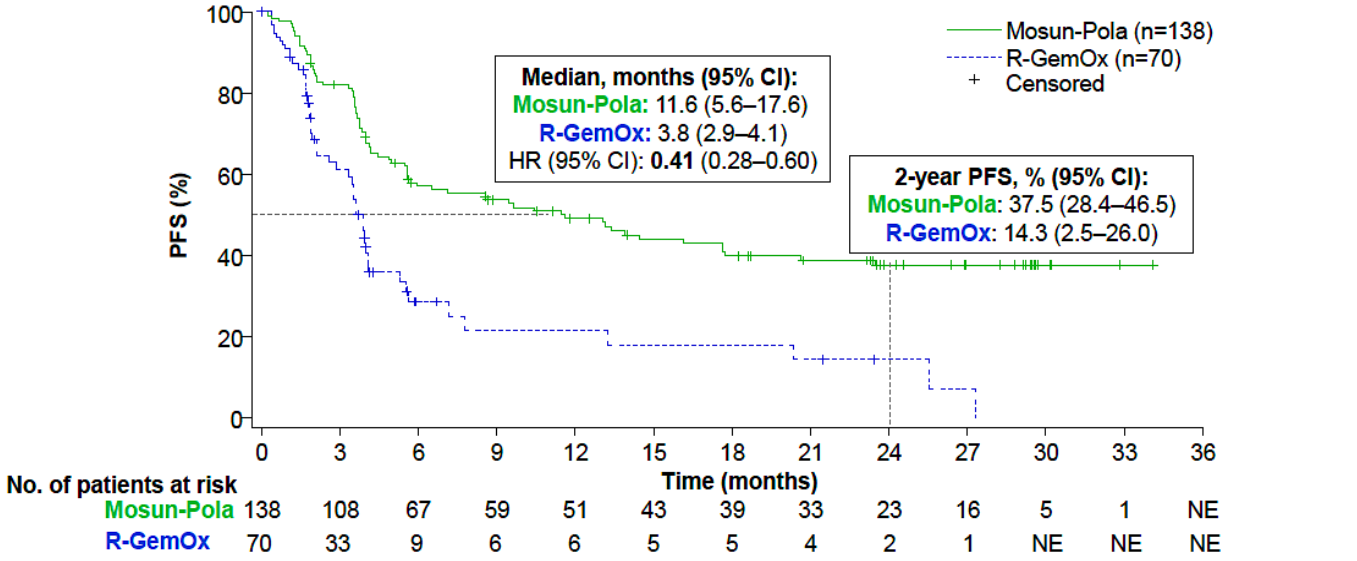
Phase III SUNMO Study Design



*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: PFS, ORR (Dual Primary Endpoints)



% (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)

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.

ORR = objective response rate

Budde LE et al. EHA 2026;Abstract PF968

Dr. Siddiqi: DLBCL Case 3

77 y.o. male with enlarged left inguinal lymph node noted in 1/2024. He brought it to his doctor's attention who order CT for 3/1/2024. CT chest showed some enlarged mediastinal and left inguinal lymph nodes. 3/11/2024 US-guided left inguinal lymph node biopsy was performed and pathology revealed follicular lymphoma, grade 1-2/3 (and focally grade 3A). There was no immediate indication for treatment (no GELF criteria and FLIPI score 1-2) as the nodes remained stable.

However, PET CT from 1/30/25 showed overall progression of disease compared to 9/30/24. He subsequently began treatment with rituximab + lenalidomide on 2/26/25. He had a partial response on the next scan but the left inguinal node worsened in uptake so another biopsy was performed on 6/26/25. Pathology now revealed DLBCL with a high Ki67 (>80%) focally involving the node.

Given his age and frailty, zanubrutinib was added to the regimen first to see if a non-chemo approach would work. However, there was significant disease progression with the subsequent scan showing new and intensely FDG avid retroperitoneal left external iliac lymph nodes along with persistent left inguinal disease.

He was started on Mosun + Pola on 12/16/25, tolerated it well, and achieved a CR which is durable thus far.

Questions?

Antibody-Drug Conjugates (Polatuzumab Vedotin)

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- Budde LE et al. **Mosunetuzumab plus polatuzumab vedotin** versus rituximab, gemcitabine and oxaliplatin in **large B-cell lymphoma**: **Updated efficacy and safety** from the **phase 3 SUNMO study** including in patient subgroups. EHA 2026;Abstract PF968.

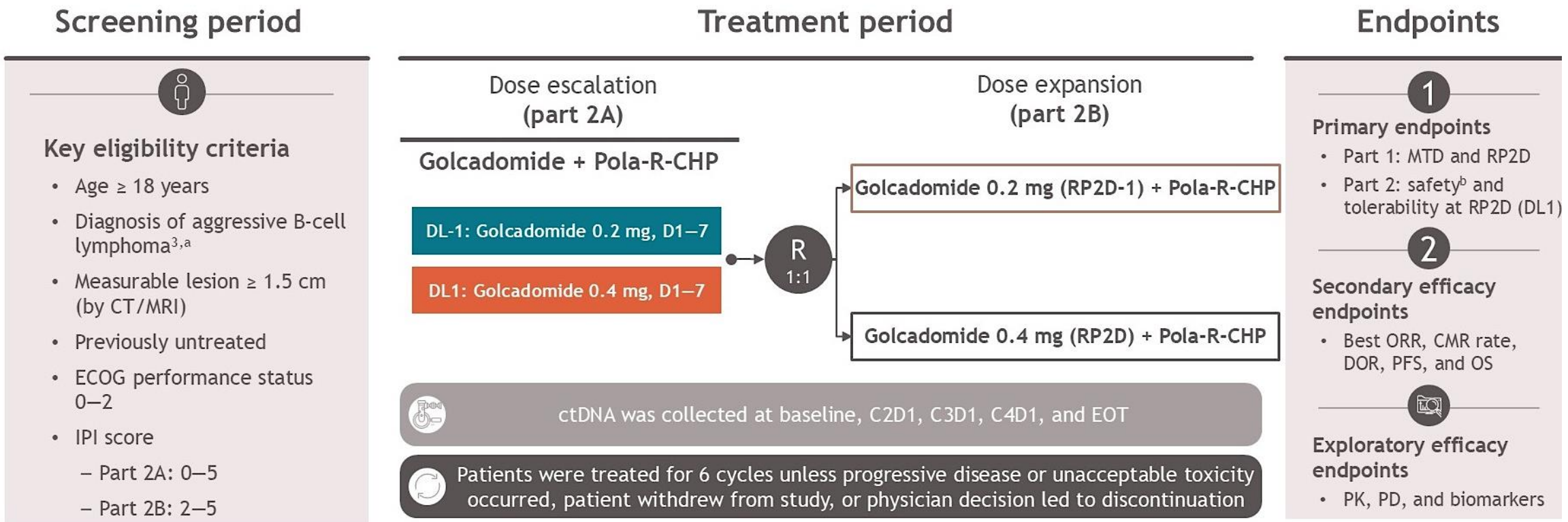
Key Datasets — CELMoDs (Golcadomide)

- Hoffmann M et al. **Golcadomide** (GOLCA), a potential, first-in-class, **oral CELMoD**, + Pola-RCHP in patients (pts) with **newly diagnosed aggressive B-cell lymphoma** (a-BCL): **Safety** and **12-month** (mo) **efficacy** results. ASCO 2026;Abstract 7011.

CELMoD = cereblon E3 ligase modulator

RTP RESEARCH TO PRACTICE

Phase Ib CC-220-DLBCL-001: Study Design

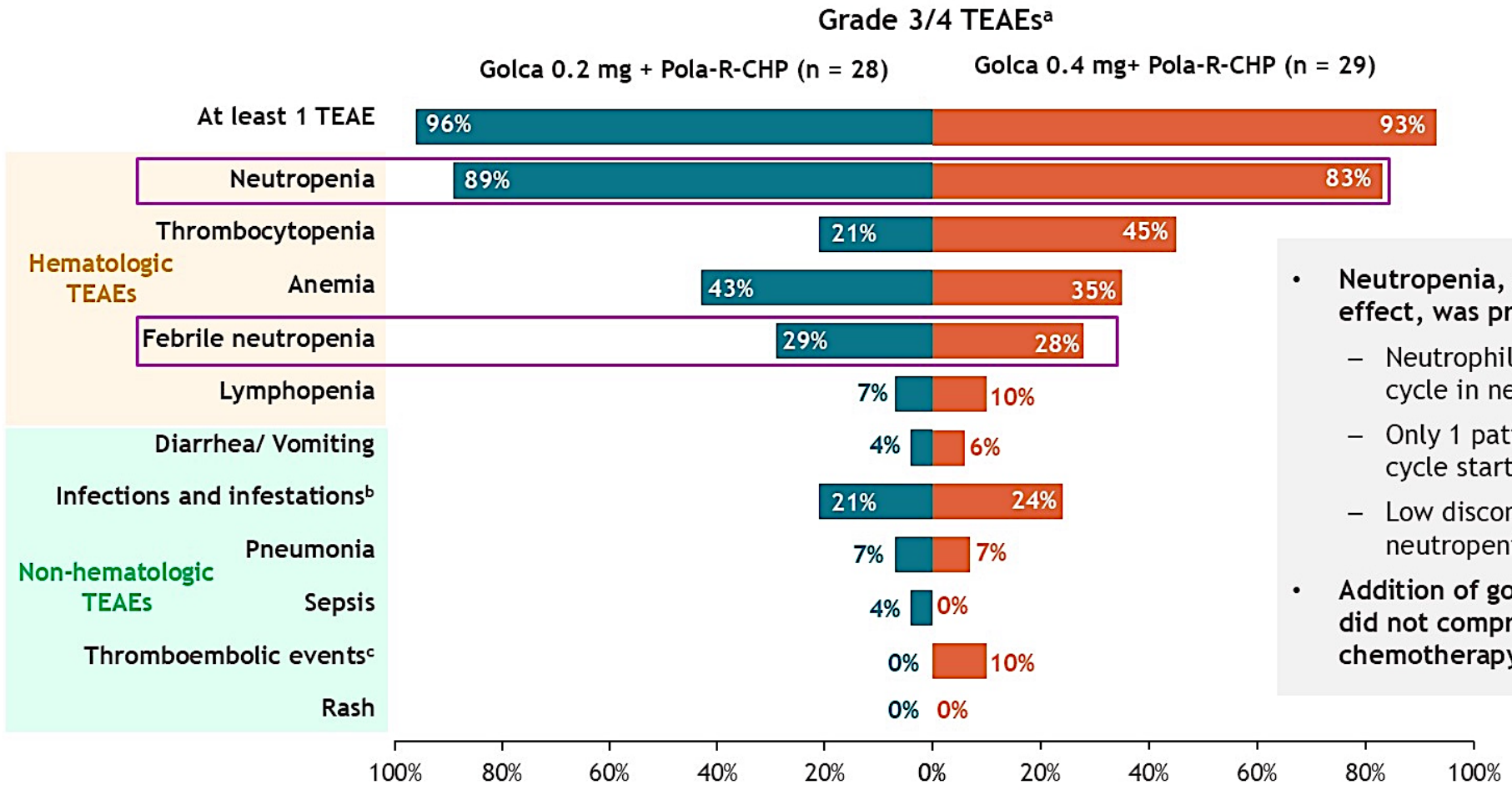


[a] Aggressive B-cell lymphoma defined according to WHO 2016 classification,[3] including DLBCL, high-grade BCL with *MYC* and *BCL2* and/or *BCL6* rearrangements, primary mediastinal BCL, primary cutaneous DLBCL—leg type, ALK-positive large BCL, EBV-positive DLBCL, and grade 3b FL; [b] Safety analysis population included all enrolled patients who received ≥ 1 dose of study drug. ALK, anaplastic lymphoma kinase; C, cycle; CMR, complete metabolic response; CT, computed tomography; ctDNA, circulating tumor DNA; D, day; DL, dose level; DLBCL, diffuse large B-cell lymphoma; DOR, duration of response; EBV, Epstein-Barr virus; ECOG, Eastern Cooperative Oncology Group; EOT, end of treatment; FL, follicular lymphoma; IPI, International Prognostic Index; MRI, magnetic resonance imaging; MTD, maximum tolerated dose; ORR, overall response rate; OS, overall survival; PD, pharmacodynamics; PFS, progression-free survival; PK, pharmacokinetics; Pola-R-CHP, polatuzumab vedotin, rituximab, cyclophosphamide, doxorubicin, and prednisone; R, randomized; RP2D, recommended Phase 2 dose; WHO, World Health Organization.

1. Hoffmann MS, et al. ASH 2023. Abstract 4459; 2. Hoffmann MS, et al. EHA 2024. Abstract S235; 3. Swerdlow SH, et al. Blood 2016;127:2375—2390.

Hoffman M et al. ASCO 2026;Abstract 7011

Phase Ib CC-220-DLBCL-001: High-Grade AEs

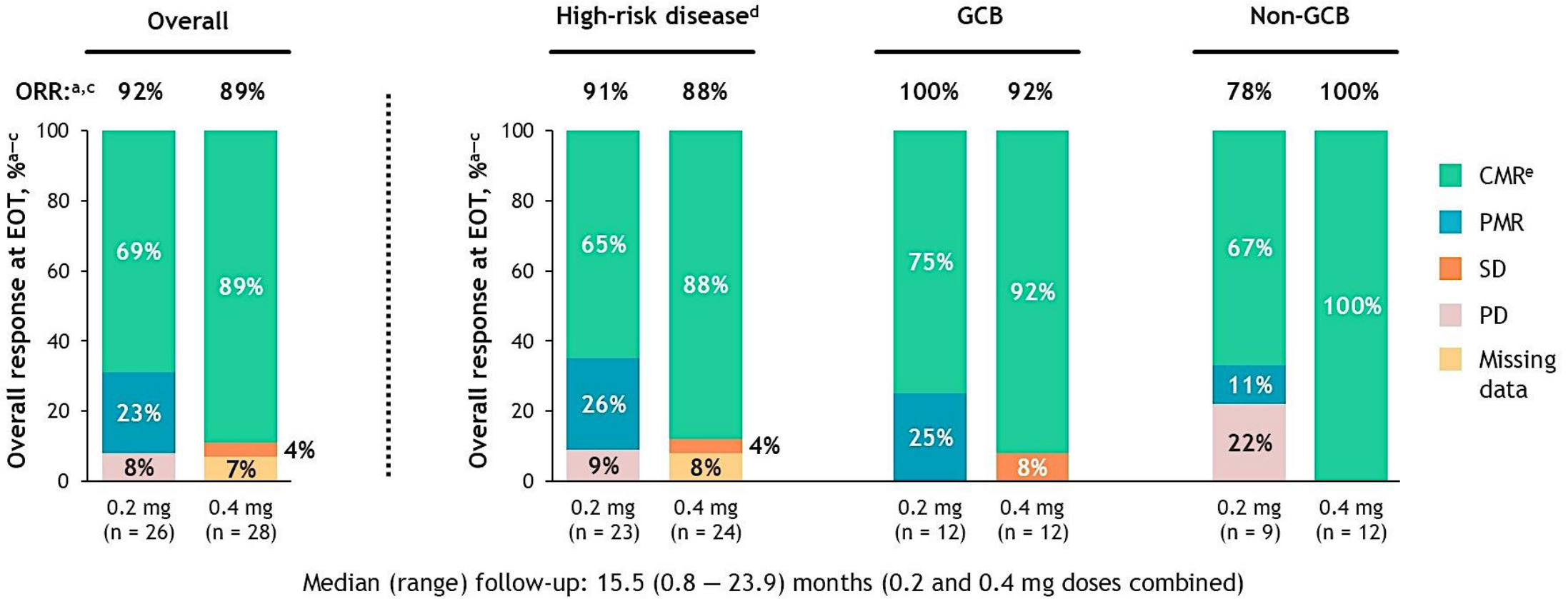


- **Neutropenia, an on-target treatment effect, was predictable and manageable**
  - Neutrophil recovery prior to next cycle in nearly all patients
  - Only 1 patient had ANC <1,000 at cycle start at 0.4 mg
  - Low discontinuation rate due to neutropenia (2%)
- **Addition of golcadomide to Pola-R-CHP did not compromise delivery of chemotherapy (≥ 99% dose intensity)**

Data cutoff: September 15, 2025. [a] System organ classes with events occurring in ≥10% of the overall population are shown. Additional clinically relevant TEAEs have been included. System organ class and preferred terms are coded using the Medical Dictionary for Regulatory Activities version 28.0 or higher. TEAEs were graded according to the National Cancer Institute Common Terminology Criteria for Adverse Events version 5.0; [b] System organ class term; [c] From different system organ classes and includes the terms pulmonary embolism, deep vein thrombosis, superficial vein thrombosis, jugular vein thrombosis, and venous thrombosis limb. ANC, absolute neutrophil count; Pola-R-CHP, polatuzumab vedotin, rituximab, cyclophosphamide, doxorubicin, and prednisone; TEAE, treatment-emergent adverse event.

Hoffman M et al. ASCO 2026;Abstract 7011

Phase Ib CC-220-DLBCL-001: Responses



Median (range) follow-up: 15.5 (0.8 — 23.9) months (0.2 and 0.4 mg doses combined)

High CMRs at EOT were consistent across the overall and high-risk populations and irrespective of cell of origin

Data cutoff: September 15, 2025.
[a] The efficacy-evaluable population included all enrolled patients who received ≥ 1 dose of study drug, had a baseline efficacy assessment, and had ≥ 1 valid post-baseline tumor assessment or discontinued treatment due to PD or study disease–related death; [b] Percentages may not sum to 100% due to rounding; [c] Response assessment based on the 2014 IWG Response Criteria for Lymphoma (Cheson BD, et al. J Clin Oncol 2014;32:3059–3068); [d] Includes patients with IPI 3–5 or high-risk IPI 1–2 disease (defined as IPI 1–2 with screening LDH ≥ 1.3 × ULN or any lesion with maximum diameter ≥ 7 cm); [e] Includes durable CT-based CRs.

Hoffman M et al. ASCO 2026;Abstract 7011

Questions?

CELMoDs (Golcadomide)

- Hoffmann M et al. **Golcadomide** (GOLCA), a potential, first-in-class, **oral CELMoD**, + Pola-RCHP in patients (pts) with **newly diagnosed aggressive B-cell lymphoma** (a-BCL): **Safety** and **12-month** (mo) **efficacy** results. ASCO 2026;Abstract 7011.

Agenda

Introduction: Trials in Progress

Module 1: Chronic Lymphocytic Leukemia

Module 2: Diffuse Large B-Cell Lymphoma

Module 3: Mantle Cell Lymphoma

- BTK Inhibitors
- Bcl-2 Inhibitors
- Bispecific Antibodies

Module 4: Follicular Lymphoma

Key Datasets

- [Manufacturer] announces **positive phase 3 results for [zanubrutinib] in frontline mantle cell** lymphoma [press release]. June 30, 2026. https://ir.beonemedicines.com/news/beone-medicines-announces-positive-phase-3-results-for-brukinsa-in-frontline-mantle-cell-lymphoma/44597eac-a44b-451f-a021-48d345cdb85e.
- Testing continuous versus intermittent treatment with the study drug zanubrutinib for older patients with previously untreated mantle cell lymphoma. NCT05976763
- Wang ML et al. **Pirtobrutinib** in covalent **Bruton tyrosine kinase inhibitor pretreated mantle-cell lymphoma**. *J Clin Oncol* 2023;41(24):3988-97.

Key Datasets (Continued)

- Eyre TA et al. Phase I/II study of sonrotoclax (BGB-11417) monotherapy in patients with mantle cell lymphoma previously treated with anti-CD20 therapy and a Bruton tyrosine kinase inhibitor. *J Clin Oncol* 2026;44(23):2233-43.
- A study to investigate the efficacy and safety of **sonrotoclax plus zanubrutinib** compared with placebo plus zanubrutinib in adults with **relapsed/refractory mantle cell lymphoma (CELESTIAL-RRMCL)**. NCT06742996
- Karimi Y et al. **Fixed-duration glofitamab monotherapy** in **relapsed/refractory** (R/R) **mantle cell lymphoma** (MCL) with/without prior Bruton's tyrosine kinase inhibitor (BTKi) exposure: **Updated data** after a **3.5-year follow-up**. ASCO 2026;Abstract 7006.
- Budde LE et al. **Mosunetuzumab plus polatuzumab vedotin** for relapsed/refractory MCL after BTK inhibitor therapy: A **phase 2** study. *Blood* 2026;148(6):682-692.

SITEMAN CANCER CENTER

WashU Medicine | BJC HealthCare

Post ASCO/EHA NHL Updates

Brad Kahl, MD,

September 2, 2026

SITEMAN Kids
AT ST. LOUIS Children's HOSPITAL
WashU Medicine Physicians

NCCN National Comprehensive Cancer Network®

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Key Datasets — BTK Inhibitors

- [Manufacturer] announces **positive phase 3 results for [zanubrutinib] in frontline mantle cell lymphoma** [press release]. June 30, 2026. https://ir.beonemedicines.com/news/beone-medicines-announces-positive-phase-3-results-for-brukinsa-in-frontline-mantle-cell-lymphoma/44597eac-a44b-451f-a021-48d345cdb85e.
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- Wang ML et al. **Pirtobrutinib** in covalent **Bruton tyrosine kinase inhibitor pretreated mantle-cell lymphoma**. *J Clin Oncol* 2023;41(24):3988-97.

Press Release

The Manufacturer Announces Positive Phase 3 Results for Zanubrutinib in Frontline Mantle Cell Lymphoma

Jun 30, 2026 6:00 AM

Foundational BTKi zanubrutinib plus rituximab reduced the risk of progression or death by 43% versus bendamustine plus rituximab (HR=0.57; p<0.0001), meeting the primary endpoint of PFS

MANGROVE is the first Phase 3 trial to advance a new chemotherapy-free standard in frontline MCL, potentially allowing patients freedom from the burden of years of infusions

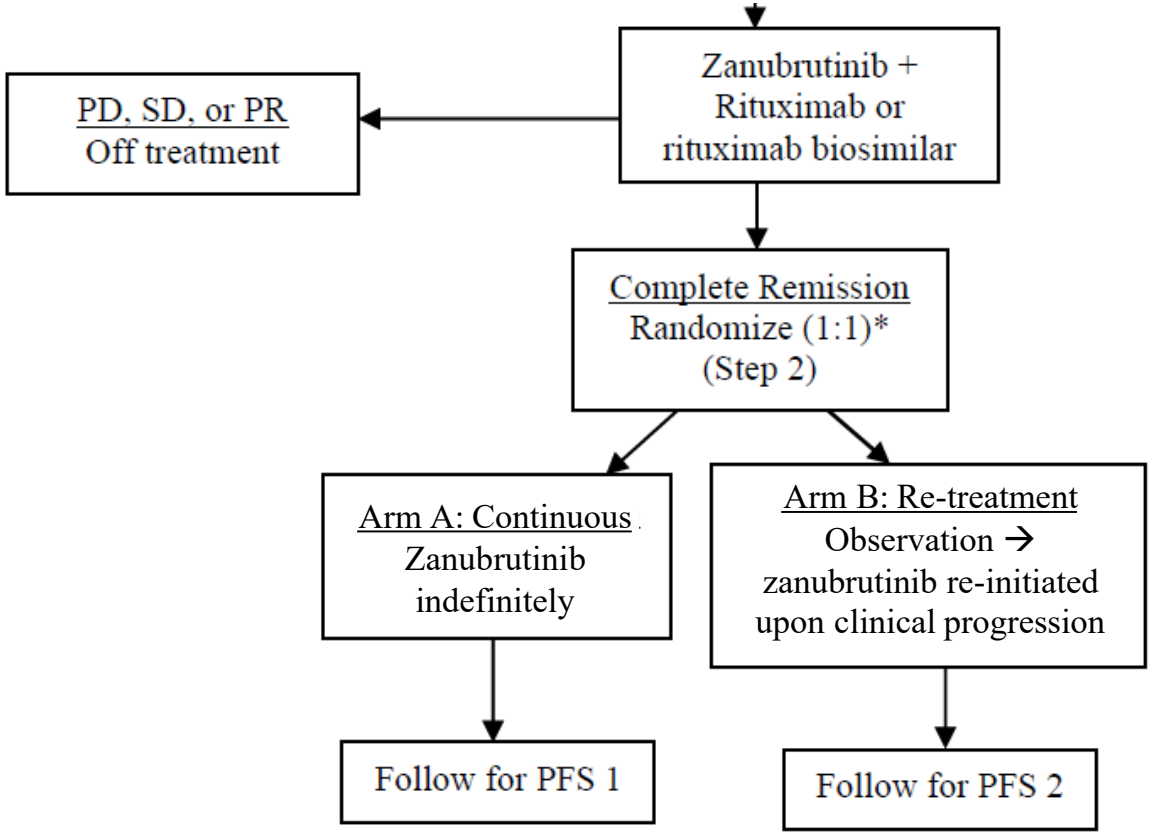
Full results from MANGROVE, including efficacy and safety, will be presented at an upcoming medical meeting; global regulatory submissions are planned for 2H 2026

A case from my practice: MCL receiving chemo-free regimen

- 74 yo female presents with worsening fatigue.
- Labs reveal HgB 8.2 and WBC 22k
- Flow cytometry and FISH confirm MCL.
- Marrow 60% involved. Ki67 30%.
- PET shows widespread involvement of marrow and spleen. Some adenopathy.
- Agrees to participate in AO52101

A052101- A Randomized Phase 3 Trial Of Continuous vs. Intermittent Maintenance Therapy With Zanubrutinib As Upfront Treatment In Older Patients With Mantle Cell Lymphoma

- **Receives 6 months of Zanubrutinib plus Rituximab**
- **Well tolerated except for some HTN and easy bruising**
- **EOT PET shows complete metabolic response**
- **EOT marrow confirms complete response**
- **On 8/26/26 she is randomized to Arm B**



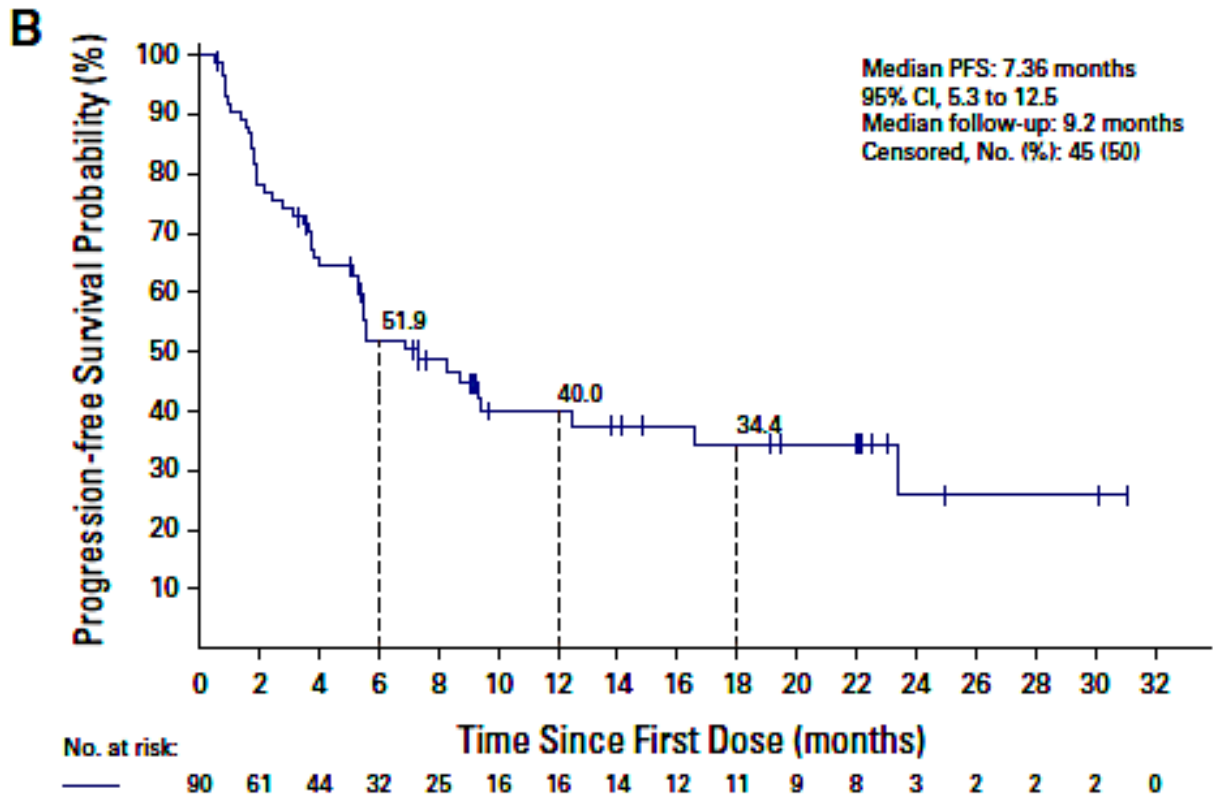
* Patients will be stratified by age (60-69 years vs. ≥70 years) and MCL IPI score (low, intermediate, or high)

Pirtobrutinib in Covalent Bruton Tyrosine Kinase Inhibitor Pretreated Mantle-Cell Lymphoma

Michael L. Wang, MD[1]; Wojciech Jurczak, MD, PhD[2]; Pier Luigi Zinzani, MD, PhD[3,4]; Toby A. Eyre, MD, MBChB, DipMedEd, MRCP, FRCPath[5]; Chan Y. Cheah, MD[6,7]; Chaitra S. Ujjani, MD[8]; Youngil Koh, MD[9]; Koji Izutsu, MD, PhD[10]; James N. Gerson, MD[11]; Ian Flinn, MD, PhD[12]; Benoit Tessoulin, MD[13]; Alvaro J. Alencar, MD[14]; Shuo Ma, MD, PhD[15]; David Lewis, PhD, MBChB[16]; Ewa Lech-Maranda, MD, PhD[17]; Joanna Rhodes, MD[18,19]; Krish Patel, MD[20]; Kami Maddocks, MD[21]; Nicole Lamanna, MD[22]; Yucai Wang, MD, PhD[23]; Constantine S. Tam, MD[24]; Talha Munir, MBBS[25]; Hirokazu Nagai, MD, PhD[26]; Francisco Hernandez-Ilizaliturri, MD[27]; Anita Kumar, MD[28]; Timothy S. Fenske, MD, MS[29]; John F. Seymour, PhD, MBBS, FRACP[24]; Andrew D. Zelenetz, MD, PhD[28]; Binoj Nair, PhD[30]; Donald E. Tsai, MD, PhD[30]; Minna Balbas, PhD[30]; Richard A. Walgren, MD, PhD[30]; Paolo Abada, MD, PhD[30]; Chunxiao Wang, PhD[31]; Junjie Zhao, PhD[30]; Anthony R. Mato, MD, MSCE[28]; and Nirav N. Shah, MD[29]

TABLE 2. Efficacy of Pirtobrutinib in Patients With cBTKi Pre-treated and cBTKi-Naïve MCL

Response	cBTKi Pretreated MCL (n = 90)	cBTKi-Naïve MCL (n = 14)
Overall response rate, % (95% CI)	57.8 (46.9 to 68.1)	85.7 (57.2 to 98.2)
Best overall response, No. (%)		
Complete response	18 (20.0)	5 (35.7)
Partial response	34 (37.8)	7 (50)
Stable disease	14 (15.6)	0
Progressive disease	15 (16.7)	1 (7.1)
Not evaluable[a]	9 (10.0)	1 (7.1)
DOR		
Patients with a response, No.	52	12
Patients with censored data, No. (%)	33 (63.5)	12 (100)
DOR, months, median (95% CI)	21.6 (7.5 to NR)	NR (NR to NR)
Median follow-up, months	11.9	7.1
PFS		
Patients with censored data, No. (%)	45 (50.0)	13 (92.9)
PFS, months, median (95% CI)	7.4 (5.3 to 12.5)	NR (NR to NR)
Median follow-up, months	9.2	8.6
OS		
Patients with censored data, No. (%)	60 (66.7)	13 (92.9)
OS, months, median (95% CI)	NR (14.8 to NR)	NR (NR to NR)
Median follow-up, months	16.6	9.4



Wang ML et al. JCO 2023

A case from my practice: R/R MCL on Pirtobrutinib

- 55 yo man dx with MCL in 2014. presented with painless adenopathy. Stage IV. Ki67 20%.
- Received R-CHOP/R-DHAP plus ASCT. Achieves CR.
- Maintenance Rituximab x 2 years.
- Relapses in January 2021. Receives ibrutinib for 4 months but dc's due to HTN, rash, severe muscle cramping.
- Zanubrutinib started 5/21. Dose reduced to 80 mg BID due to severe muscle cramps in 8/22. Progressive Disease 10/23.
- Pirtobrutinib 200 mg day started 11/23. Achieves CR.
- Now age 67. Remains on Pirto in CR. Well tolerated.

Questions?

BTK Inhibitors

- [Manufacturer] announces **positive phase 3 results for [zanubrutinib] in frontline mantle cell lymphoma** [press release]. June 30, 2026. https://ir.beonemedicines.com/news/beone-medicines-announces-positive-phase-3-results-for-brukinsa-in-frontline-mantle-cell-lymphoma/44597eac-a44b-451f-a021-48d345cdb85e.
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Key Datasets — Bcl-2 Inhibitors

- Eyre TA et al. Phase I/II study of **sonrotoclax (BGB-11417) monotherapy** in patients with **mantle cell lymphoma previously treated with anti-CD20 therapy and a Bruton tyrosine kinase inhibitor**. *J Clin Oncol* 2026;44(23):2233-43.
- A study to investigate the efficacy and safety of **sonrotoclax plus zanubrutinib** compared with placebo plus zanubrutinib in adults with **relapsed/refractory mantle cell lymphoma (CELESTIAL-RRMCL)**. NCT06742996

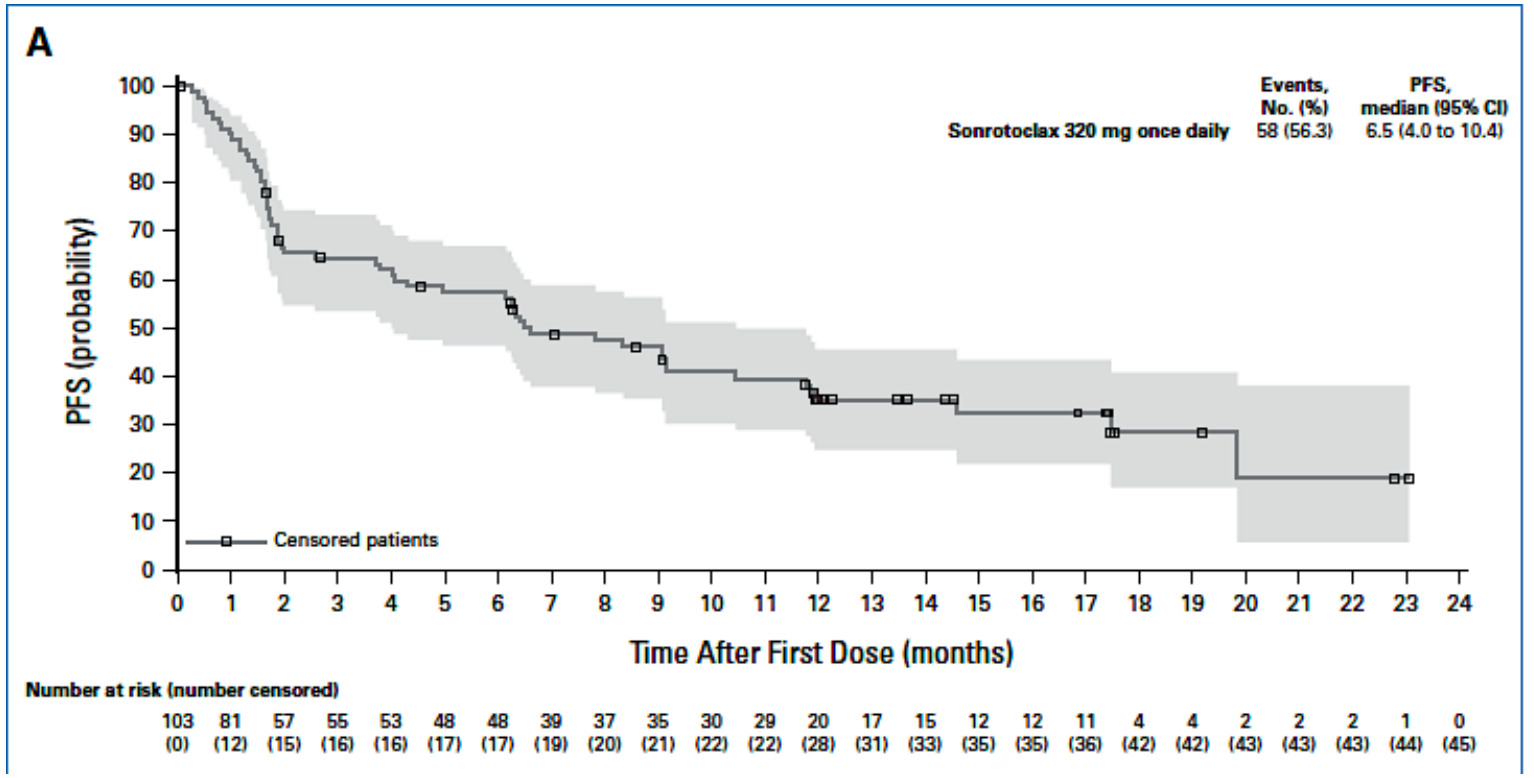
Phase I/II Study of Sonrotoclax (BGB-11417) Monotherapy in Patients With Mantle Cell Lymphoma Previously Treated With Anti-CD20 Therapy and a Bruton Tyrosine Kinase Inhibitor

Toby A. Eyre, MBChB, DipMedEd, MRCP, FRCPath, MD[1]; Yuqin Song, MD, PhD[2]; Olivier Hermine, MD, PhD[3]; Yuerong Shuang, MD[4]; Wojciech Jurczak, MD, PhD[5]; João Samuel Farias, MD[6]; Carolina Mahuad, MD, PhD[7]; Muhit Özcan, MD[8]; Ron D. Jachimowicz, MD[9]; Tianlei Chen, PhD[10]; Elena Ivanova, PhD[11]; Xiaotong Li, MD[12]; Gabriel Man, MD[10]; Priscille Bourquelot, MD[10]; Remus Vezan, MD, PhD[10]; and Michael Wang, MD[13]

DOI https://doi.org/10.1200/JCO-26-00550

TABLE 2. Part 2 Efficacy End Points

Parameter	Part 2: Sonrotoclax 320 mg Once Daily (n = 103)	
	IRC	INV
ORR, No. (%)	54 (52.4)	49 (47.6)
95% CI	42.4 to 62.4	37.6 to 57.6
One-sided *P*	<.0001	NA
CRR, No. (%)	16 (15.5)	23 (22.3)
95% CI	9.1 to 24.0	14.7 to 31.6
TTR-IRC, median (range), months	1.91 (1.6-6.2)	
DOR-IRC, median (95% CI), months	15.8 (7.4 to NE)	
Probability of ongoing response at 9 months (95% CI), %	62.9 (47.6 to 74.8)	
Follow-up, median (95% CI), months	11.9 (10.0 to 15.5)	
PFS-IRC, median (95% CI), months	6.5 (4.0 to 10.4)	
PFS rate at 12 months (95% CI), %	35.1 (24.8 to 45.5)	
Follow-up, median (95% CI), months	12.3 (11.9 to 16.9)	
OS, median (95% CI), months	NR (14.8 to NE)	
OS rate at 12 months (95% CI), %	67.4 (57.1 to 75.7)	
Follow-up, median (95% CI), months	15.2 (14.2 to 16.7)	

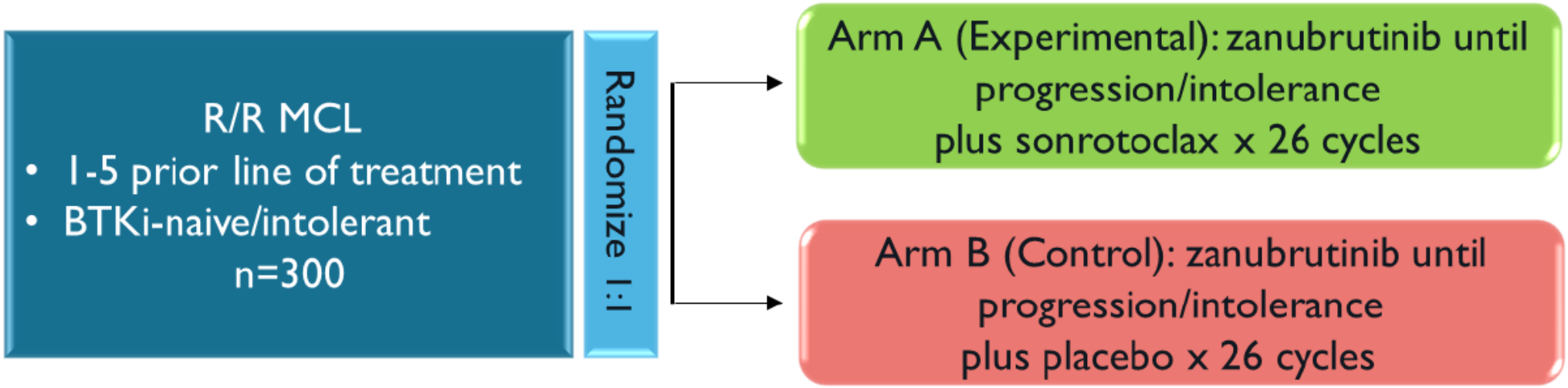


Eyre TA et al. JCO 2026

Important Ongoing Global Study

BGB-11417-302 Stratification Guidelines

Mantle Cell Lymphoma



Questions?

Bcl-2 Inhibitors

- Eyre TA et al. Phase I/II study of **sonrotoclax (BGB-11417) monotherapy** in patients with **mantle cell lymphoma previously treated with anti-CD20 therapy and a Bruton tyrosine kinase inhibitor**. *J Clin Oncol* 2026;44(23):2233-43.
- A study to investigate the efficacy and safety of **sonrotoclax plus zanubrutinib** compared with placebo plus zanubrutinib in adults with **relapsed/refractory mantle cell lymphoma (CELESTIAL-RRMCL)**. NCT06742996

Key Datasets — Bispecific Antibodies

- Karimi Y et al. **Fixed-duration glofitamab monotherapy** in **relapsed/refractory** (R/R) **mantle cell lymphoma** (MCL) with/without prior Bruton's tyrosine kinase inhibitor (BTKi) exposure: **Updated data** after a **3.5-year follow-up**. ASCO 2026;Abstract 7006.
- Budde LE et al. **Mosunetuzumab plus polatuzumab vedotin** for relapsed/refractory MCL after BTK inhibitor therapy: A **phase 2** study. *Blood* 2026;148(6):682-692.

Fixed-duration glofitamab monotherapy in relapsed/refractory (R/R) mantle cell lymphoma (MCL) with/without prior Bruton's tyrosine kinase inhibitor (BTKi) exposure: Updated data after a 3.5-year follow-up

Yasmin H. Karimi,[1] Martin Hutchings,[2] Tycel Phillips,[3] Marek Trněný,[4] Michael Dickinson,[5] Fritz C. Offner,[6] Franck Morschhauser,[7] Emmanuel Bachy,[8] Nancy L. Bartlett,[9] Joshua Brody,[10] Jan Zaucha,[11] Tomasz Wrobel,[12] Lidia Gil,[13] Vanessa Breton,[14] Raluca Negricea,[15] Martine Kallemeijn,[16] Aurelien Berthier,[16] Gila Sellam,[16] Linda Lundberg,[16] Carmelo Carlo-Stella[17]

[1]Division of Hematology/Oncology, University of Michigan, Ann Arbor, MI, USA; [2]Rigshospitalet and University of Copenhagen, Copenhagen, Denmark; [3]City of Hope, Los Angeles, CA, USA; [4]First Faculty of Medicine, Charles University and the General Hospital, Prague, Czech Republic; [5]Peter MacCallum Cancer Centre, Royal Melbourne Hospital and The University of Melbourne, Melbourne, VIC, Australia; [6]Department of Hematology Universitair Ziekenhuis, Gent, Belgium; [7]CHU Lille, Service des Maladies du Sang, Lille, France; [8]Centre Hospitalier Lyon Sud, Lyon, France; [9]Siteman Cancer Center, Washington University School of Medicine, St. Louis, MO, USA; [10]Tisch Cancer Institute, New York, NY, USA; [11]Medical University of Gdańsk, Gdańsk, Poland; [12]Wroclaw Medical University, Wroclaw, Poland; [13]Department of Hematology and Hematopoietic Cell Transplantation, Medical University, Poznan, Poland; [14]Hoffmann-La Roche Ltd, Mississauga, ON, Canada; [15]Roche Products Ltd, Welwyn Garden City, UK; [16]F. Hoffmann-La Roche Ltd, Basel, Switzerland; [17]Humanitas University and IRCCS Humanitas Research Hospital, Milan, Italy.

Presented at the 2026 American Society of Clinical Oncology (ASCO) Annual Meeting | May 29 – June 2, 2026

NP30179 Phase I/II study design

Multicenter, open-label, dose-escalation and dose-expansion study of glofitamab with Gpt in patients with R/R MCL

Key inclusion criteria

- Age ≥18 years
- ≥1 prior systemic therapy
- ECOG PS 0 or 1

Endpoints

- Efficacy: CR rate*, ORR*, DOCR*, DOR*, PFS*, OS
- Safety

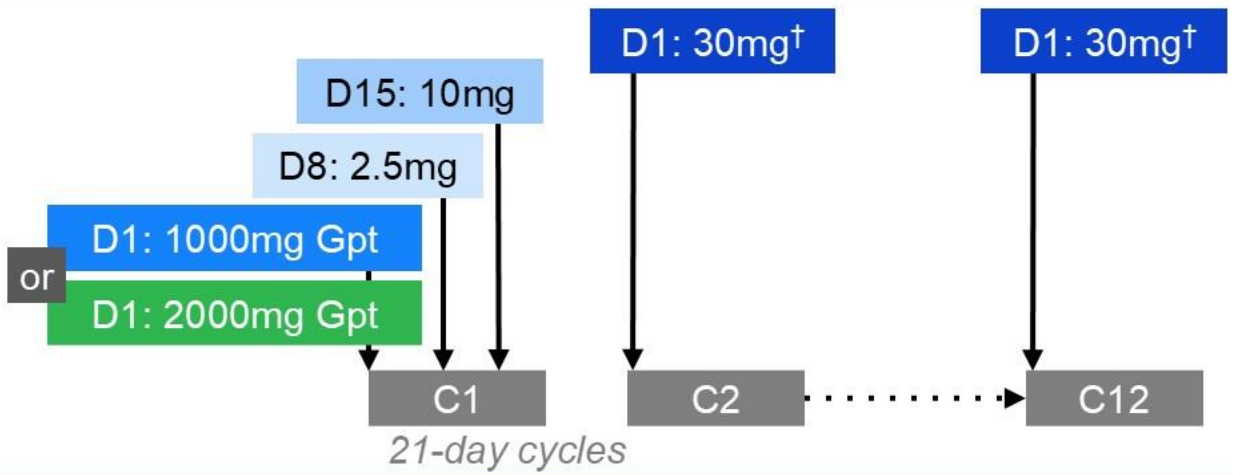
Glofitamab administration

Fixed-duration IV treatment:

- Maximum 12 cycles over approximately 8.5 months

CRS mitigation:

- Gpt pretreatment (1000mg or 2000mg)
- C1 step-up dosing
- Monitoring after first dose (2.5mg)



Clinical cut-off date: September 08, 2025.

*INV-assessed. †In the 1000mg Gpt cohort, two patients had 16mg glofitamab as their target dose in the dose escalation phase.

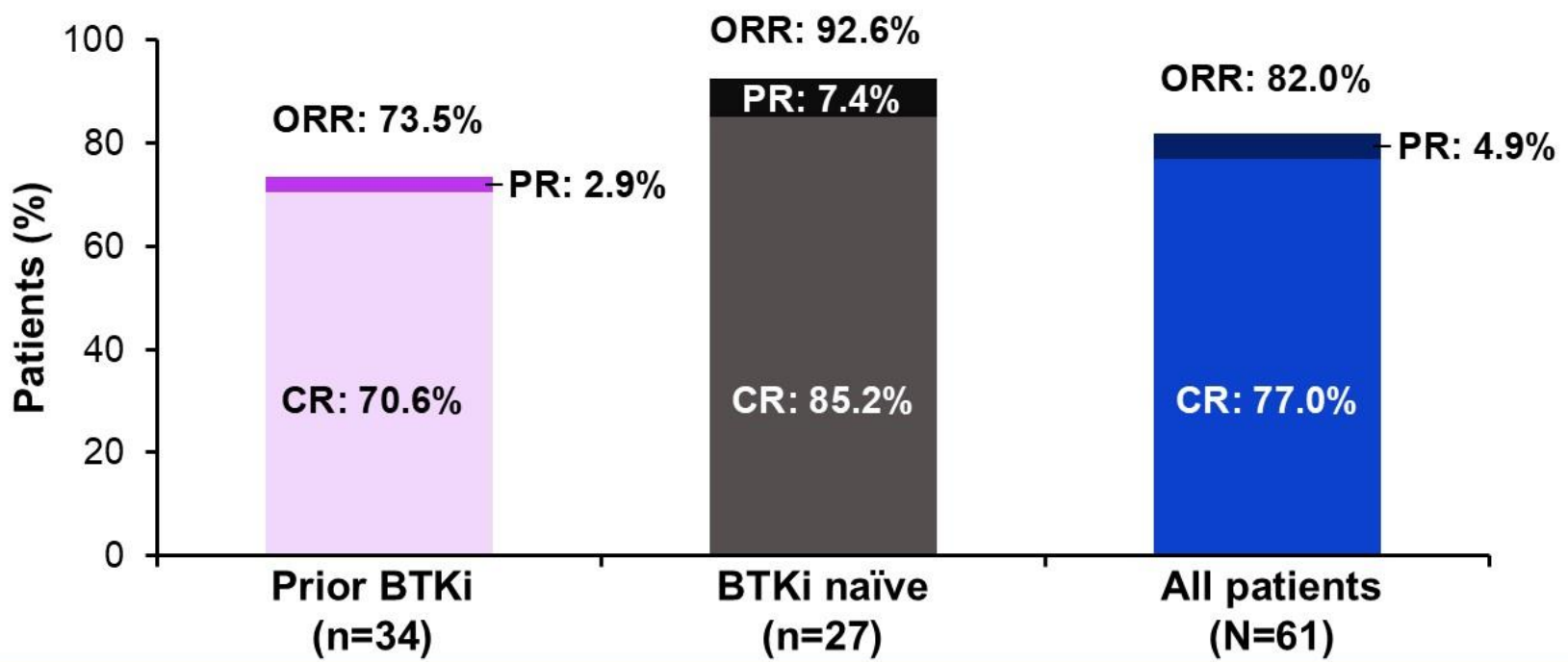
C, cycle; CRS, cytokine release syndrome; D, day; DOCR, duration of complete response; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; Gpt, obinutuzumab pretreatment; INV, investigator; IV, intravenous; ORR, overall response rate; OS, overall survival; PFS, progression-free survival.

NCT03075696. Available at: https://clinicaltrials.gov/.

Karimi Y et al. ASCO 2026;Abstract 7006

Response rates

Response rates* in patients with R/R MCL



Median time to first CR (n=47):
45 days (range: 29–234)

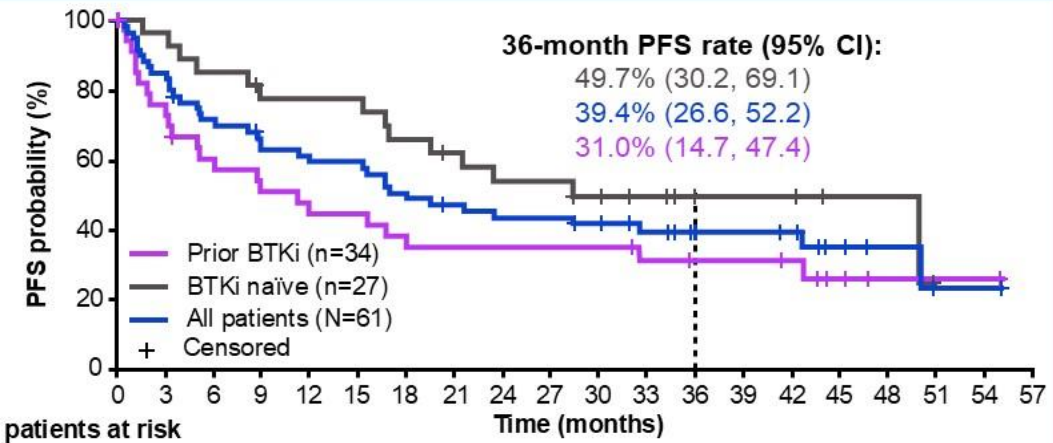
High ORR and CR rates were observed early during glofitamab treatment in both the overall population and patients with prior BTKi and those who were BTKi naïve

*INV-assessed.
PR partial response.

Karimi Y et al. ASCO 2026;Abstract 7006

Progression-free survival

PFS*†

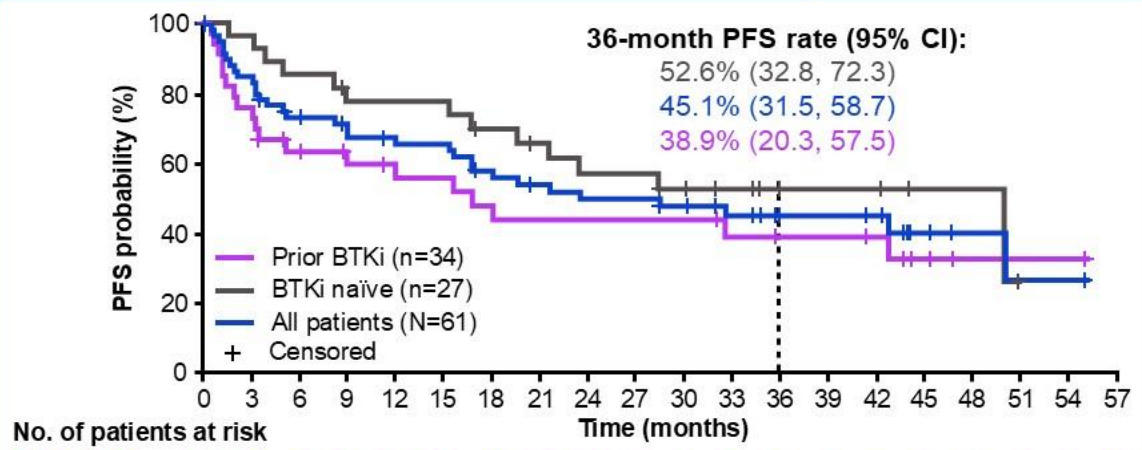


No. of patients at risk

Prior BTKi	34	25	19	16	14	14	12	11	11	11	11	8	7	7	6	3	1	1	1	NE
BTKi naïve	27	26	23	20	20	20	17	15	13	13	11	9	5	4	4	2	2	NE		
All patients	61	51	42	36	34	34	29	26	24	24	22	17	12	11	10	5	3	1	1	NE

PFS	Prior BTKi (n=34)	BTKi naive (n=27)	All patients (N=61)
Median PFS, months (95% CI)	11.3 (5.1, 32.6)	28.5 (17.0, NE)	18.0 (11.3, 42.8)

PFS COVID-19 sensitivity*



No. of patients at risk

Prior BTKi	34	25	19	16	14	14	12	11	11	11	11	8	7	7	6	3	1	1	1	NE
BTKi naïve	27	26	23	20	20	20	17	15	13	13	11	9	5	4	4	2	2	NE		
All patients	61	51	42	36	34	34	29	26	24	24	22	17	12	11	10	5	3	1	1	NE

PFS	Prior BTKi (n=34)	BTKi naive (n=27)	All patients (N=61)
Median PFS, months (95% CI)	16.8 (5.2, NE)	50.0 (19.6, NE)	23.5 (15.6, NE)

Clinically meaningful PFS was achieved with glofitamab monotherapy after 3.5 years of follow-up; COVID-19 censoring further extended the median PFS from 18.0 to 23.5 months

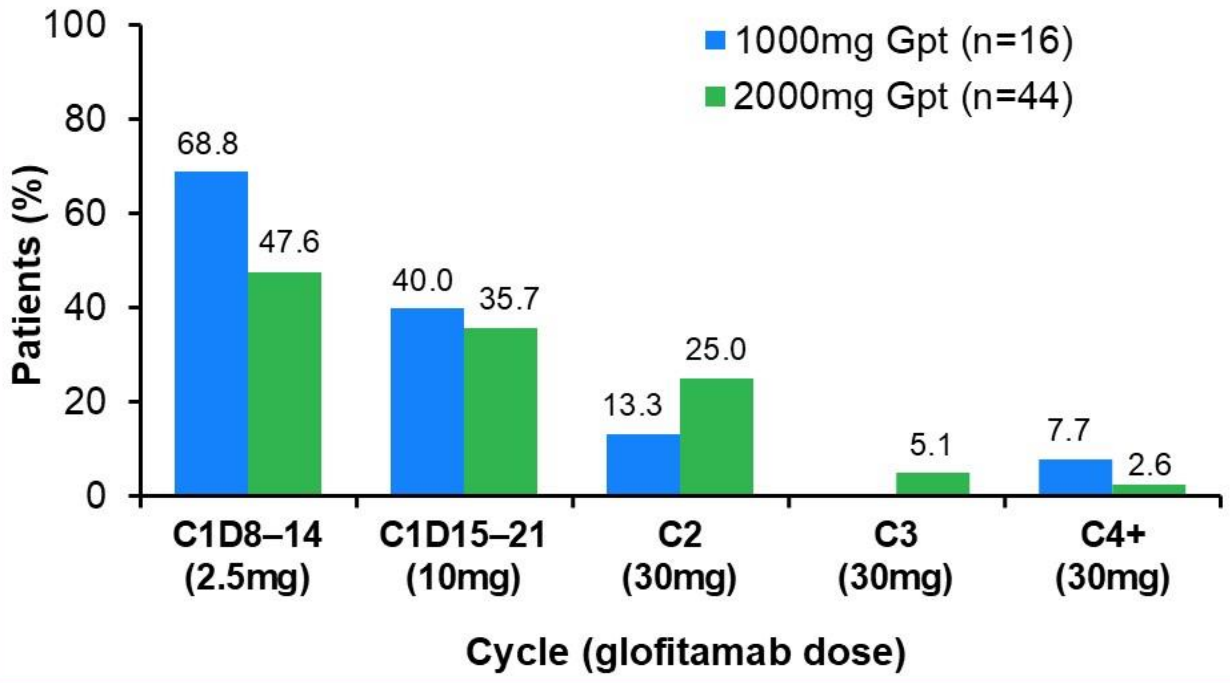
*INV-assessed. †Median PFS follow-up was 36.0 months (range: 0–55) overall, and 43.7 months (range: 0–55) and 35.9 months (range: 2–51) in the prior-BTKi and BTKi-naïve cohorts, respectively.

Karimi Y et al. ASCO 2026;Abstract 7006

CRS summary

n (%)	1000mg Gpt cohort (n=16)	2000mg Gpt cohort (n=44)	All patients (N=60)*
Any grade CRS†	14 (87.5)	28 (63.6)	42 (70.0)
Grade 1	4 (25.0)	18 (40.9)	22 (36.7)
Grade 2	6 (37.5)	7 (15.9)	13 (21.7)
Grade 3	2 (12.5)	3 (6.8)	5 (8.3)
Grade 4	2 (12.5)	0	2 (3.3)
CRS management‡			
Tocilizumab	11 (68.8)	11 (25.0)	22 (36.7)
Corticosteroids	8 (50.0)	10 (22.7)	18 (30.0)
ICU admittance	5 (31.3)	4 (9.1)	9 (15.0)

Any grade CRS† by cycle and Gpt dose

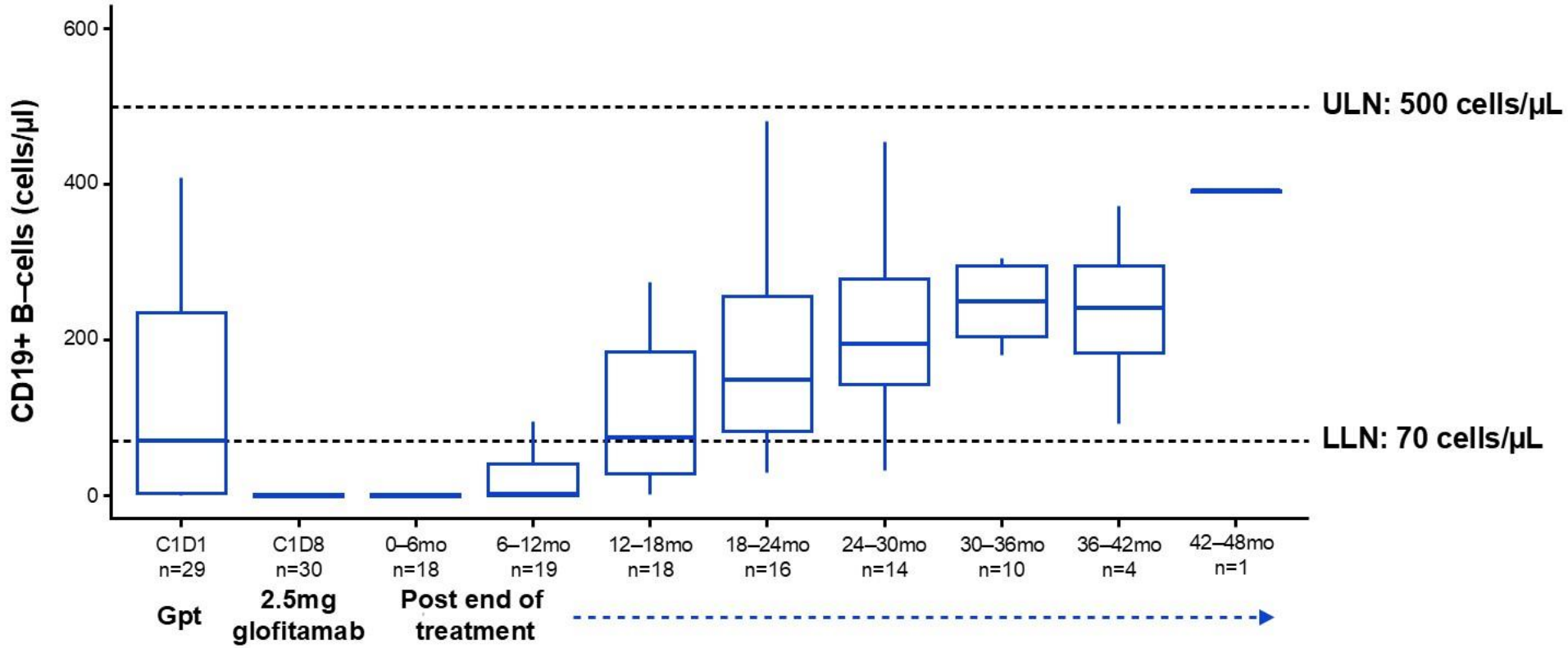


Most CRS events were Grade 1–2, with a lower incidence in the 2000mg cohort and a notable decrease after the C1 step-up dosing period

*Any treatment-exposed. †CRS by ASTCT consensus grading criteria.[1] ‡CRS management was also performed by single pressor (n=7), multiple pressors (n=2), low flow oxygen (n=10) and high flow oxygen (n=1), overall.
ASTCT, American Society for Transplantation and Cellular Therapy; ICU, intensive care unit.

1. Lee DW, et al. Biol Blood Marrow Transplant 2019;25:625–38.

B-cell depletion and recovery



Peripheral B-cell depletion was rapid and sustained after treatment initiation.
Recovery above the lower limit of normal was observed 12–18 months post EOT

Patients who completed 12 cycles of treatment and did not have progressive metabolic disease at EOT were included in this analysis. Samples occurring within 45 days of a progression event were excluded. Only serious infections were systematically collected beyond the 90-day AE reporting period.
LLN, lower limit of normal; mo, months; ULN, upper limit of normal.

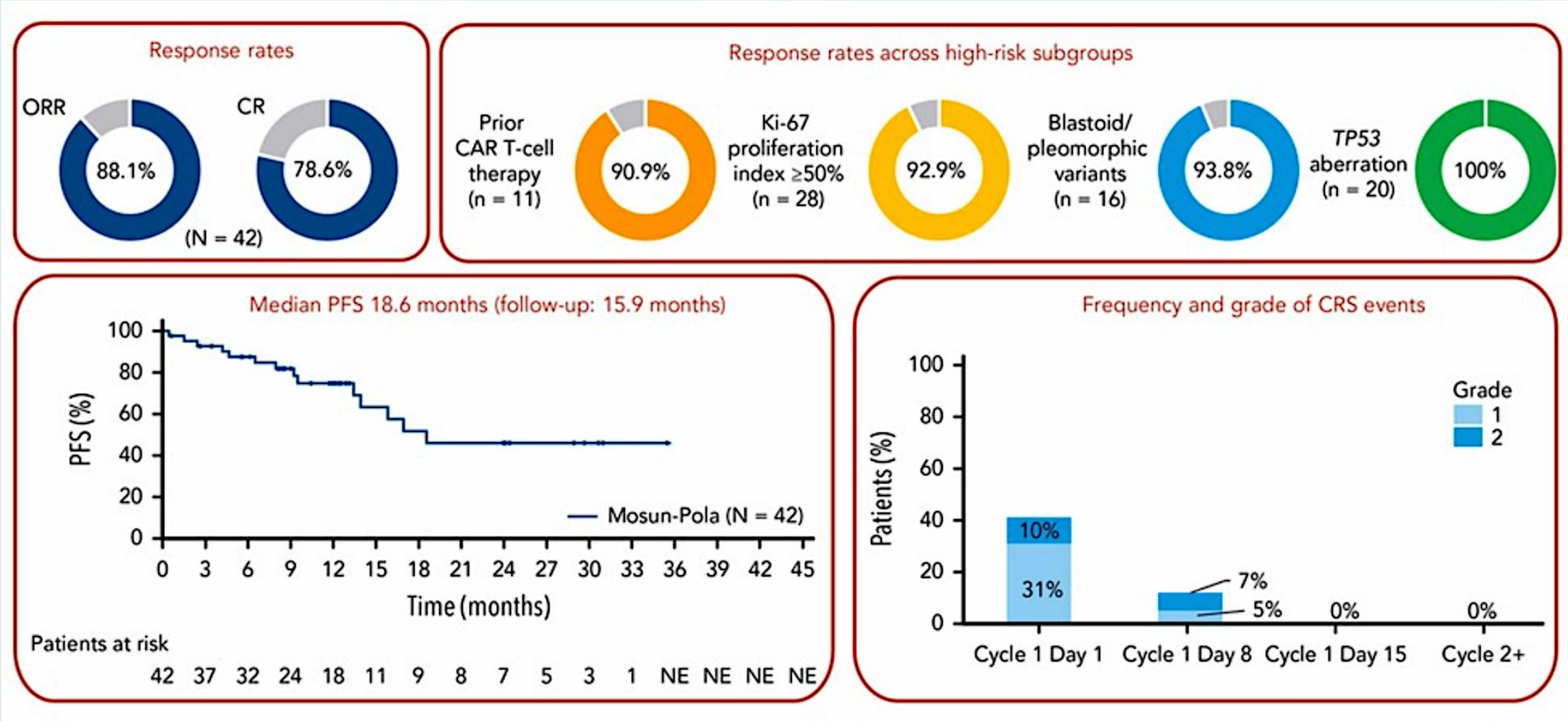
Karimi Y et al. ASCO 2026;Abstract 7006

Mosunetuzumab plus polatuzumab vedotin for relapsed/refractory MCL after BTK inhibitor therapy: a phase 2 study

Lihua E. Budde,[1,*] Manali Kamdar,[2,*] Sarit E. Assouline,[3] Julio C. Chavez,[4] Nilanjan Ghosh,[5] Thomas A. Ollila,[6] Daniel J. Hodson,[7] Dipenkumar Modi,[8] Mariana Bastos-Oreiro,[9] Seema G. Naik,[10] Shazia K. Nakhoda,[11] Connie Lee Batlevi,[12] Jue Wang,[12] Sneha Makadia,[12] Antonia Kwan,[12] Elicia Penuel,[12] Jing Jing,[12] Hao Wu,[12] Wahib Ead,[12] Song Pham,[13] Iris To,[12] Michael C. Wei,[12] and Michael L. Wang[14]

Blood 2026;148(6):682-92.

Mosunetuzumab with Polatuzumab Vedotin for Relapsed/Refractory MCL After Prior BTK Inhibitor



ORR = objective response rate; CRS = cytokine release syndrome

Budde LE et al. *Blood* 2026;148(6):682-92.

Questions?

Bispecific Antibodies

- Karimi Y et al. **Fixed-duration glofitamab monotherapy** in **relapsed/refractory** (R/R) **mantle cell lymphoma** (MCL) with/without prior Bruton's tyrosine kinase inhibitor (BTKi) exposure: **Updated data** after a **3.5-year follow-up**. ASCO 2026;Abstract 7006.
- Budde LE et al. **Mosunetuzumab plus polatuzumab vedotin** for relapsed/refractory MCL after BTK inhibitor therapy: A **phase 2** study. *Blood* 2026;148(6):682-692.

Agenda

Introduction: Trials in Progress

Module 1: Chronic Lymphocytic Leukemia

Module 2: Diffuse Large B-Cell Lymphoma

Module 3: Mantle Cell Lymphoma

Module 4: Follicular Lymphoma

- inMIND
- Epcoritamab
- Mosunetuzumab/Lenalidomide
- Surovatamig
- Golcadomide

RTP RESEARCH TO PRACTICE

Key Datasets

- Scholz CW et al. **Phase 3 inMIND study** of **tafasitamab** (tafa) **plus lenalidomide** (len) and rituximab (R) for **relapsed or refractory follicular lymphoma** (R/R FL): **Outcomes** in patients **with or without high-risk factors**. EHA 2026;Abstract PS2048.
- Tessoulin B et al. **Clinically relevant subgroup analysis** from the randomized **phase 3 EPCORE FL-1 trial**: **Treatment** (tx) **effect** of **epcoritamab** with lenalidomide and rituximab (R^2) in **R/R follicular lymphoma** (FL). EHA 2026;Abstract S229.
- Budde LE at al. **CELESTIMO single arm extension**: **Safety and efficacy** of **mosunetuzumab plus lenalidomide** in patients with **R/R follicular lymphoma**. EHA 2026;Abstract PS2043.
- Cheah CY et al. **Surovatamig (AZD0486)** plus rituximab in **previously untreated follicular lymphoma** (FL): **Initial safety data** from the **phase 3 SOUNDTRACK-F1 trial**. EHA 2026;Abstract S228.
- Morillo D et al. **Golcadomide** (GOLCA), a potential, first-in-class, **oral CELMoD** ± rituximab (R) in patients (pts) with **relapsed/refractory** (R/R) **follicular lymphoma** (FL): **Phase** (Ph) **1/2 study long-term follow-up** (f/u). EHA 2026;Abstract S227.

RTP RESEARCH TO PRACTICE

Key Datasets — inMIND

- Scholz CW et al. **Phase 3 inMIND study** of **tafasitamab** (tafa) **plus lenalidomide** (len) and rituximab (R) for **relapsed or refractory follicular lymphoma** (R/R FL): **Outcomes** in patients **with or without high-risk factors**. EHA 2026;Abstract PS2048.

PS2048

Phase 3 inMIND Study of Tafasitamab Plus Lenalidomide and Rituximab for Relapsed or Refractory Follicular Lymphoma: Outcomes in Patients With or Without High-Risk Factors

Presented at the
European Hematology Association Hybrid Congress 2026
Stockholm, Sweden · June 11-14, 2026

Christian W. Scholz,[1] Paolo Strati,[2] Laurie H. Sehn,[3] Julie Wu,[4] Philomena Colucci,[4] Oscar Bortolami,[5] Kai Hübel[6]

[1]Vivantes Klinikum Am Urban, Berlin, Germany; [2]Department of Lymphoma and Myeloma, Division of Cancer Medicine, The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [3]BC Cancer Centre for Lymphoid Cancer and The University of British Columbia, Vancouver, BC, Canada; [4]Incyte Corporation, Wilmington, DE, USA; [5]Incyte Biosciences International Sàrl, Morges, Switzerland; [6]University of Cologne and Faculty of Medicine and University Hospital of Cologne, Cologne, Germany

Table 1. Distribution of Patients by Risk Categories From inMIND Across Treatment Arms

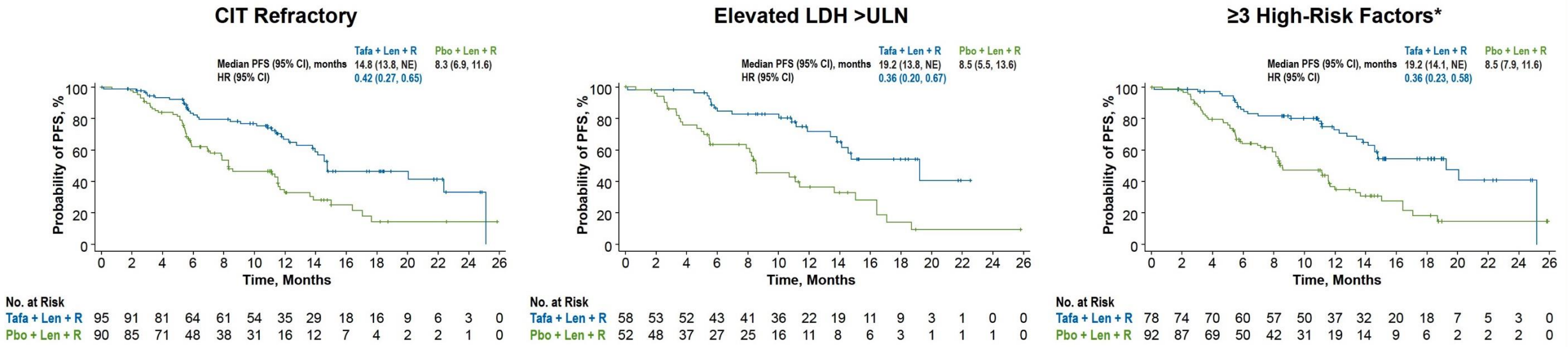
	All Randomized Patients		
Patients, n (%)	Tafa + Len + R (n=273)	Pbo + Len + R (n=275)	Total (N=548)
Ann Arbor stage III or IV	221 (81.0)	225 (81.8)	446 (81.4)
ECOG PS 1-2	92 (33.7)	83 (30.2)	175 (31.9)
≥1 GELF criterion met	222 (81.3)	232 (84.4)	454 (82.8)
FL grade 3A	67 (24.5)	71 (25.8)	138 (25.2)
CIT refractory	95 (34.8)	90 (32.7)	185 (33.8)
Bulky disease	98 (35.9)	109 (39.6)	207 (37.8)
FLIPI score 3-5	137 (50.2)	150 (54.5)	287 (52.4)
POD24 positive	121 (44.3)	128 (46.5)	249 (45.4)
LDH >ULN (250 IU/L)	58 (21.2)	52 (18.9)	110 (20.1)
≥3 high-risk factors at baseline*	78 (28.6)	92 (33.5)	170 (31.0)

*CIT refractory, bulky disease, FLIPI score 3-5, POD24 positive, or LDH >ULN (250 IU/L).
CIT, chemoimmunotherapy; ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; FLIPI, Follicular Lymphoma International Prognostic Index; GELF, Groupe d'Etude des Lymphomes Folliculaires; LDH, lactate dehydrogenase; len, lenalidomide; Pbo, placebo; POD24, progression of disease within 24 months of initial diagnosis; R, rituximab; tafa, tafasitamab; ULN, upper limit of normal.

Scholz CW et al. EHA 2026;Abstract PS2048

Efficacy demonstrated in high-risk subgroups

Figure 1. PFS by Investigator in Select High-Risk Subgroups of Patients From inMIND



ITT population. *CIT refractory, bulky disease, FLIPI score 3-5, POD24 positive, or LDH >ULN (250 IU/L).
CI, confidence interval; CIT, chemoimmunotherapy; FLIPI, Follicular Lymphoma International Prognostic Index; HR, hazard ratio; ITT, intention-to-treat; LDH, lactate dehydrogenase; len, lenalidomide; NE, not evaluable; Pbo, placebo; PFS, progression-free survival; POD24, progression of disease within 24 months of initial diagnosis; R, rituximab; tafa, tafasitamab; ULN, upper limit of normal.

Scholz CW et al. EHA 2026;Abstract PS2048

Questions?

inMIND

- Scholz CW et al. **Phase 3 inMIND study** of **tafasitamab** (tafa) **plus lenalidomide** (len) and rituximab (R) for **relapsed or refractory follicular lymphoma** (R/R FL): **Outcomes** in patients **with or without high-risk factors**. EHA 2026;Abstract PS2048.

Key Datasets — Epcoritamab

- Tessoulin B et al. **Clinically relevant subgroup analysis** from the randomized **phase 3 EPCORE FL-1 trial**: **Treatment** (tx) **effect** of **epcoritamab** with lenalidomide and rituximab (R^2) in **R/R follicular lymphoma** (FL). EHA 2026;Abstract S229.

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

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

Key eligibility criteria

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

Randomization 1:1

Epcoritamab (48 mg) plus R²

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

R²

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

Post Hoc Subgroup Analyses

Clinically relevant subgroups:

- Age (<70 vs ≥70 years)
- NHL-5 comorbidity index (low vs high/intermediate)[2]
- Prior LOTs (1 vs ≥2)
- FLIPI (0–2 vs 3–5)
- POD24 status[b]
- Bulky disease status[b,c]
- Double refractory status[b]

Len RDI subgroups: <50% vs ≤70% vs >70%

- **Dual primary endpoints: ORR per IRC and PFS per IRC**
- Select secondary endpoints: CR rate per IRC, OS, and safety

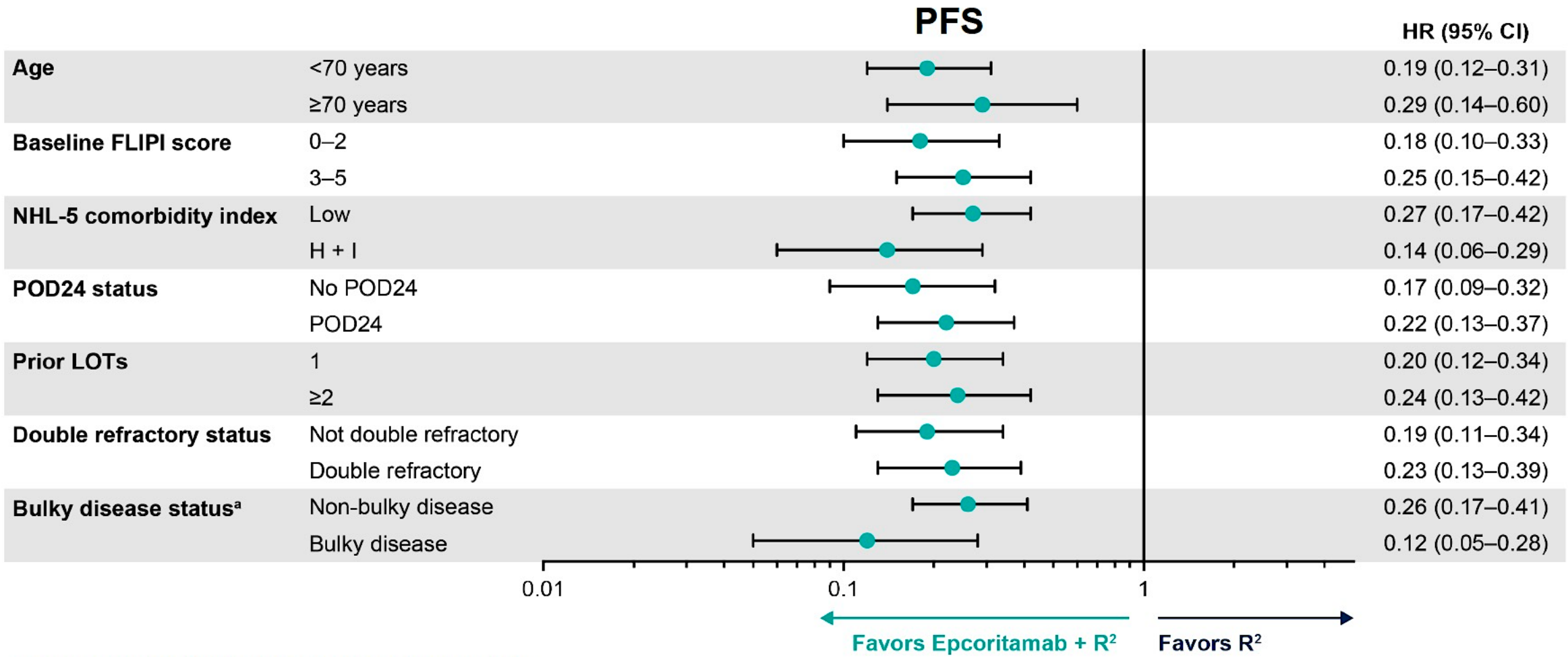
Data cutoff: May 24, 2025
Median follow-up: 14.8 months[d]
Enrollment period: Oct 2022 to Jan 2025

[a]Two SUD regimens were evaluated during cycle 1 to mitigate the risk of CRS: either a 2-SUD (0.16 mg on cycle 1 day 1, 0.8 mg on cycle 1 day 8), or 3-SUD (0.16 mg on cycle 1 day 1, 0.8 mg on cycle 1 day 8, 3 mg on cycle 1 day 15) regimen, followed by full dose 48 mg. The 3-SUD regimen was implemented after reduced CRS severity and incidence had been observed in the EPCORE NHL-1 FL trial (NCT03625037).[3] [b]Pre-specified subgroup per the study statistical analysis plan. [c]Bulky disease was defined by the presence of a lymph node ≥7 cm at baseline/screening. [d]The data presented here are from the second planned interim analysis (May 24, 2025) after 78% information fraction for PFS had occurred.

1. Falchi et al. *Lancet*. 2026;407:161-173. 2. Gordon MJ, et al. *JCO Clin Cancer Inform*. 2024;8:e2300223. 3. Vose J, et al. *J Clin Oncol*. 2024;42(16_suppl):7015.

CR, complete response; CRS, cytokine release syndrome; D, day; FL, follicular lymphoma; FLIPI, Follicular Lymphoma International Prognostic Index; GELF, Groupe d'Etude des Lymphomes Folliculaires; IRC, independent review committee; Len, lenalidomide; LOT, line of therapy; mAb, monoclonal antibody; NHL-5, non-Hodgkin lymphoma comorbidity score; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; POD24, progression of disease ≤2 years from the date of initiation of frontline therapy; Q4W, once every 4 weeks; QD, once daily; QW, once every week; R², lenalidomide and rituximab; RDI, relative dose intensity; R/R, relapsed/refractory; SUD, step-up dosing; TEAE, treatment-emergent adverse event.

Both Low- and High-Risk Clinically Relevant Subgroups Showed Improved PFS With Epcoritamab + R^2 Over R^2



HRs were determined by unstratified Cox proportional hazards model.
[a]Bulky disease was defined by the presence of a lymph node ≥7 cm at baseline/screening.
FLIPI, Follicular Lymphoma International Prognostic Index; HR, hazard ratio; LOT, line of therapy; NHL-5, non-Hodgkin lymphoma comorbidity score; PFS, progression-free survival; POD24, progression of disease ≤2 years from the date of initiation of frontline therapy; R^2, lenalidomide and rituximab.

A case from my practice: Epco plus R2 for R/R FL

- 69 yo man dx'd with FL in 3/24. High tumor burden.
- BR x 6 from 4/24 – 9/24.
- Starts maintenance rituximab but PD in fall of 2025.
- So now POD 24 and R refractory.
- Epco – R2 starts 1/26. Responds initially but PD by 5/26.
- Repeat bx: Grade 1-2 FL
- CAR-T planned for 9/26.

Questions?

Epcoritamab

- Tessoulin B et al. **Clinically relevant subgroup analysis** from the randomized **phase 3 EPCORE FL-1 trial**: **Treatment** (tx) **effect** of **epcoritamab** with lenalidomide and rituximab (R^2) in **R/R follicular lymphoma** (FL). EHA 2026;Abstract S229.

Key Datasets — Mosunetuzumab/Lenalidomide

- Budde LE at al. **CELESTIMO single arm extension**: **Safety and efficacy** of **mosunetuzumab plus lenalidomide** in patients with **R/R follicular lymphoma**. EHA 2026;Abstract PS2043.

Mosunetuzumab plus Lenalidomide

CELESTIMO single arm extension: Safety and efficacy of mosunetuzumab▼ plus lenalidomide in patients with R/R follicular lymphoma

L. Elizabeth Budde,[1]* Dahlia Sano,[2] Nancy Bartlett,[3] Nina Wagner-Johnston,[4] Brett Brinker,[5] Rakhee Vaidya,[6] Sunil Babu,[7] Chijioke Nze,[8] Edward Pearson,[9] Matthew McKinney,[10] Ying Zhuo,[11] Ruemu Birhiray,[12] Noah Kornblum,[13] Elicia Penuel,[14] Connie Y. Ma,[14] Andrea Knapp,[15] Michelle Doral,[14] Vivian Chen,[14] Paloma Hauser,[14] Michael C. Wei,[14] Enkhtsetseg Purev,[14] Catherine Diefenbach[16]

Study design

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

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

Key inclusion criteria

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

Endpoints

- Efficacy: INV-assessed ORR and CR rate (Lugano criteria[7])
- Safety: incidence and severity of AEs and CRS according to CTCAE v5.0 and ASTCT[8] criteria, respectively
- Biomarker: MRD status by NGS in PBMC samples

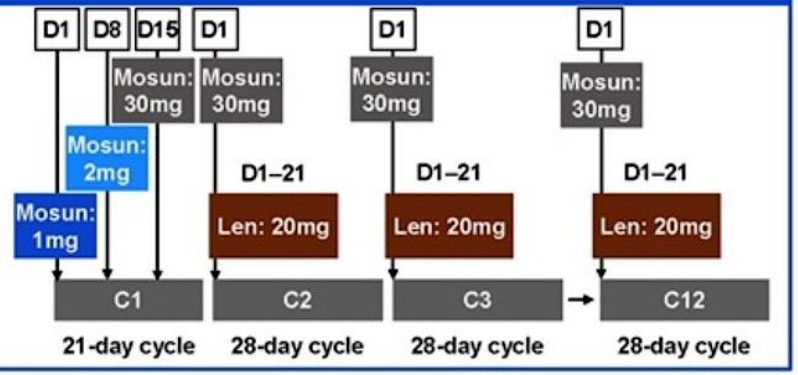
Mosun-Len administration*

Mosunetuzumab

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

Lenalidomide

- Oral administration for 11 cycles (C2–12)



*G-CSF use was optional; antiviral prophylaxis was per investigator choice.

AE, adverse event; ASTCT, American Society for Transplantation and Cellular Therapy; C, Cycle; CR, complete response; CRS, cytokine release syndrome; CTCAE, Common Terminology Criteria for Adverse Events; D, Day; ECOG PS, Eastern Cooperative Oncology Group performance status; G-CSF, granulocyte colony-stimulating factor; INV, investigator; NGS, next-generation sequencing; ORR, objective response rate; PBMC, peripheral blood mononuclear cell; QW, weekly.

Budde LE et al. EHA 2026;Abstract PS2043

Efficacy of Mosun plus Lenalidomide

As of January 12, 2026, 54 patients were enrolled across 15 US sites in the CELESTIMO extension arm

- Enrollment in this cohort took place between September 2023 and December 2024.
- Overall, 40.7% of patients had a Follicular Lymphoma International Prognostic Index (FLIPI) score of ≥3, and 44.4% had progressive disease within 24 months of first systemic therapy (POD24; **Table 1**).

Table 1. Baseline characteristics

n (%), unless otherwise stated		CELESTIMO US extension (n=54)
Age, years	Median (range)	62 (37–82)
Sex	Male	32 (59.3)
Race	Asian	3 (5.6)
	Black or African American	2 (3.7)
	White	47 (87.0)
	Multiple*	1 (1.9)
	Unknown	1 (1.9)
Ethnicity	Hispanic or Latino	12 (22.2)
ECOG PS	0	40 (74.1)
	1	13 (24.1)
	2	1 (1.9)
Ann Arbor stage	III/IV	45 (83.3)
FLIPI score	0–1	13 (24.1)
	2	19 (35.2)
	3–5	22 (40.7)
FL grade	1	11 (20.4)
	1–3a (low grade)	4 (7.4)
	2	25 (46.3)
	3a	14 (25.9)
POD24	Yes	24 (44.4)
Number of prior lines of therapy	1	32 (59.3)
	≥2	22 (40.7)
Refractory to prior CD20 therapy	Yes	23 (42.6)
Relapsed after prior CD20 therapy	Yes	28 (51.9)
Double refractory	Yes	11 (20.4)

Durable and complete responses were observed with Mosun-Len

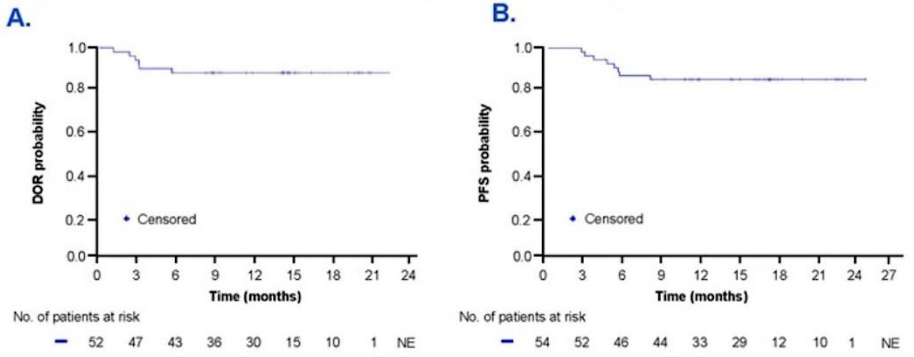
- High response rates and durable efficacy were observed at the CCOD (**Table 2** and **Figure 2**).

Table 2. Efficacy summary (by INV)

Efficacy endpoints	CELESTIMO US extension (n=54)
ORR, % (95% CI)	96.3 (87.3–99.6)
CR rate, % (95% CI)	88.9 (77.4–95.8)
Median DOR, months (95% CI)	NR (NE–NE)
18-month DOR rate, % (95% CI)	88.2 (79.3–97.1)
Median DOCR, months (95% CI)	NR (NE–NE)
18-month DOCR rate, % (95% CI)	93.6 (86.5–100)
Median PFS, months (95% CI)	NR (NE–NE)
18-month PFS rate, % (95% CI)	85.0 (75.4–94.6)
Median OS, months (95% CI)	NR (NE–NE)
18-month OS rate, % (95% CI)	92.3 (85.0–99.6)

CI, confidence interval; DOCR, duration of complete response; DOR, duration of response; NE, not estimable; NR, not reached; OS, overall survival; PFS, progression-free survival.

Figure 2. Kaplan–Meier curves for (A) DOR and (B) PFS



Budde LE et al. EHA 2026;Abstract PS2043

Questions?

Mosunetuzumab/Lenalidomide

- Budde LE at al. **CELESTIMO single arm extension**: **Safety and efficacy** of **mosunetuzumab plus lenalidomide** in patients with **R/R follicular lymphoma**. EHA 2026;Abstract PS2043.

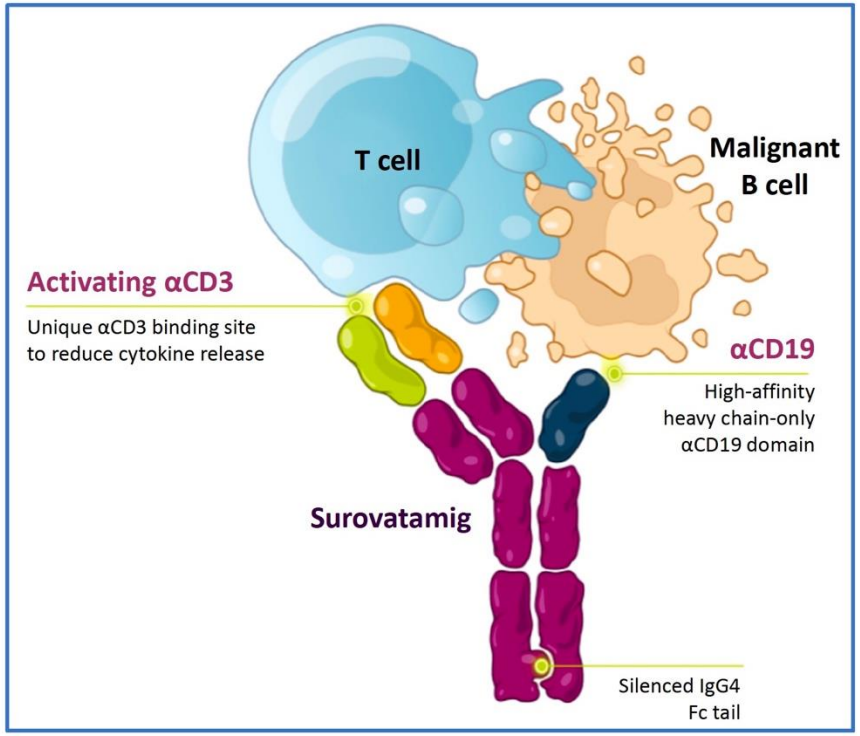
Key Datasets — Surovatamig

- Cheah CY et al. **Surovatamig (AZD0486)** plus rituximab in **previously untreated follicular lymphoma** (FL): **Initial safety data** from the **phase 3 SOUNDTRACK-F1 trial**. EHA 2026;Abstract S228.

Surovatamig

Background

- **Surovatamig**, a novel **CD19xCD3 human IgG4 bispecific T-cell engager**, yielded high and durable response rates in patients with heavily pretreated FL[1]
  - For doses ≥2.4 mg: ORR 96%; CR rate 92%
  - Recommended Phase 2 monotherapy dose: 7.2 mg
- Dual antigen targeting (CD19 and CD20) would potentially cover a wider range of tumour cells and minimise antigen escape
- **SOUNDTRACK-F1 (NCT06549595)** is a global, randomised, Phase 3, open-label study evaluating surovatamig + rituximab vs chemotherapy + rituximab in patients with 1L FL and high tumour burden



We report initial safety run-in data from SOUNDTRACK-F1

Cheah CY et al. EHA 2026;Abstract S228

Surovatamig

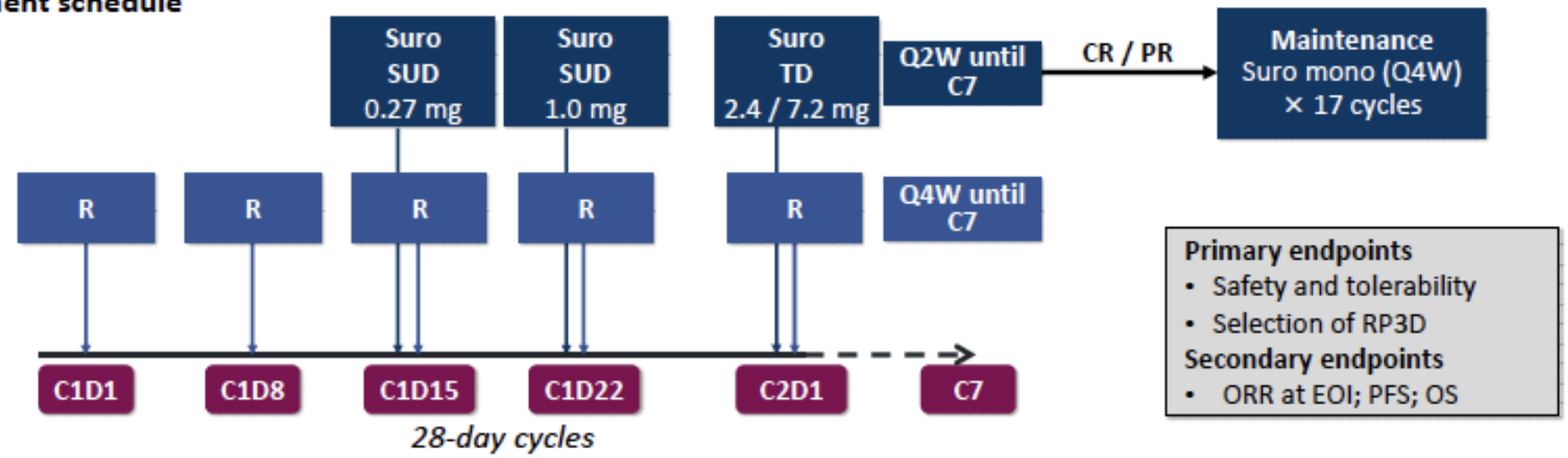
Study design: safety run-in

SOUND TRACK-F1

Key eligibility criteria:
- Aged ≥18 years
- 1L FL
- ECOG PS 0–2
- Need for systemic treatment meeting ≥1 GELF criteria

1:1 → Surovatamig TD
- DL1 (2.4 mg)
- DL2 (7.2 mg)

Treatment schedule



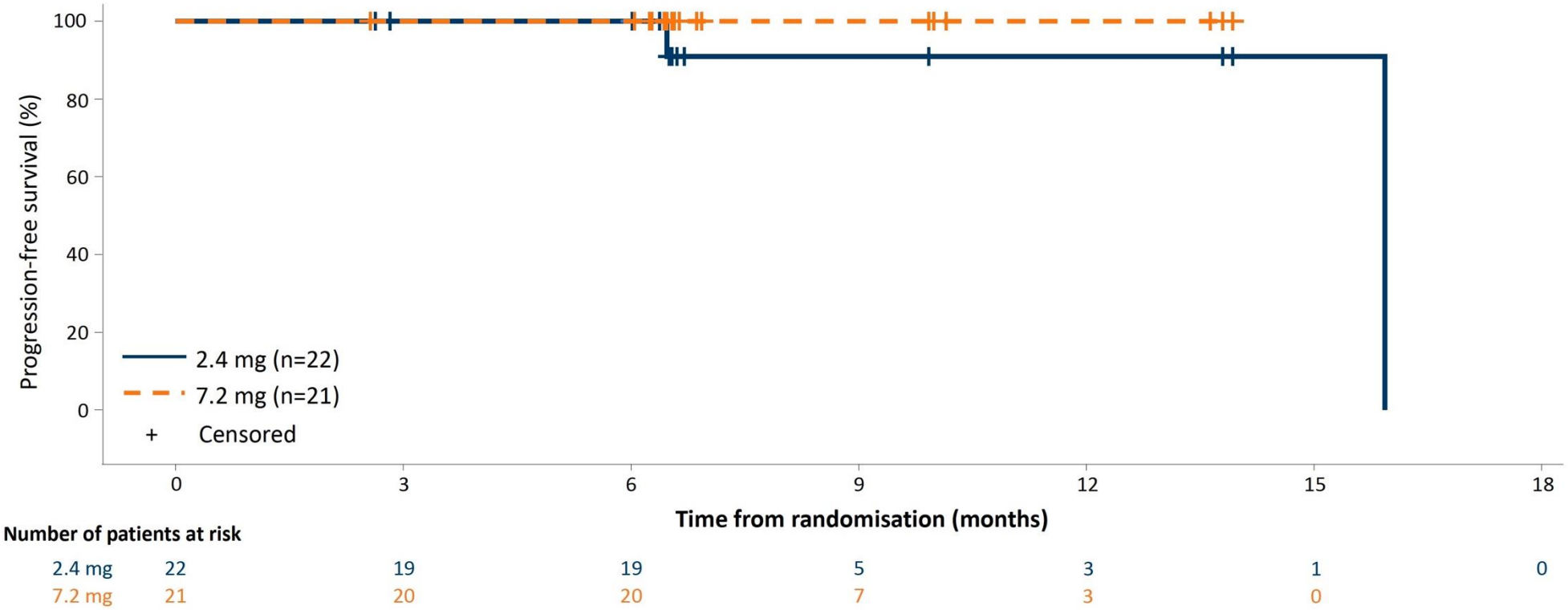
Primary endpoints
- Safety and tolerability
- Selection of RP3D

Secondary endpoints
- ORR at EOI; PFS; OS

Cheah CY et al. EHA 2026;Abstract S228

S228: Surovatamig (AZD0486) + Rituximab in 1L FL

- 2.4 mg DL (n=22) → ORR 96%, CRR 82%
- 7.2 mg DL (n=21) → ORR 100%, CRR 95%



Cheah CY et al. EHA 2026;Abstract S228

Surovatamig Toxicity

	2.4 mg	7.2 mg
Infections (any grade)	68%	71%
CRS (any grade)	36%	38%
ICANs	5% (grade 1)	5% (grade 3)

Cheah CY et al. EHA 2026;Abstract S228

Questions?

Surovatamig

- Cheah CY et al. **Surovatamig (AZD0486)** plus rituximab in **previously untreated follicular lymphoma** (FL): **Initial safety data** from the **phase 3 SOUNDTRACK-F1 trial**. EHA 2026;Abstract S228.

Key Datasets — Golcadomide

- Morillo D et al. **Golcadomide** (GOLCA), a potential, first-in-class, **oral CELMoD** ± rituximab (R) in patients (pts) with **relapsed/refractory** (R/R) **follicular lymphoma** (FL): **Phase** (Ph) **1/2 study long-term follow-up** (f/u). EHA 2026;Abstract S227.

Golcadomide Overview

Golcadomide is a potential, first-in-class, oral CELMoD designed for the treatment of lymphoma[1]

Induces complete conversion of cereblon to the active, closed conformation[1,2]

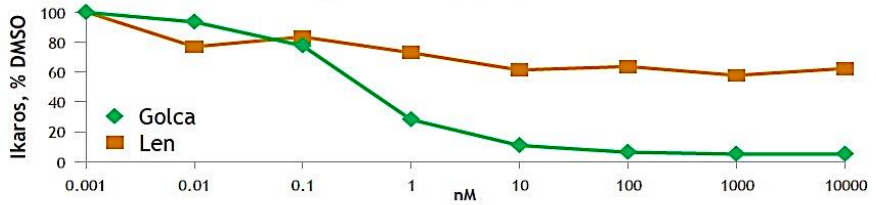
Inactive/open cereblon
No Ikaros/Aiolos bound

Active/closed cereblon
Ikaros/Aiolos bound

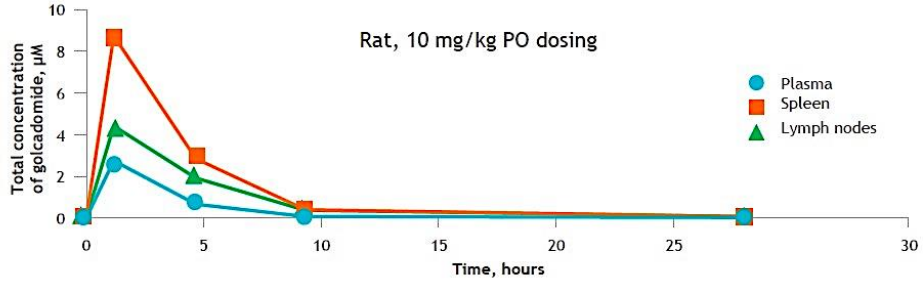
- Golcadomide's unique structure extends distinct binding to outside the tri-TRP pocket of cereblon, inducing complete conversion to the active, closed conformation vs lenalidomide (~100% vs ~20%)[1]
- This leads to rapid and deep degradation of Ikaros/Aiolos, resulting in direct cell killing and immunomodulatory activity (stimulation of NK and T cells)[1,4,5]

Demonstrates enhanced target degradation and lymphoid tissue distribution[1–3]

Golcadomide induces deeper, more rapid Ikaros/Aiolos degradation as compared with lenalidomide[1]



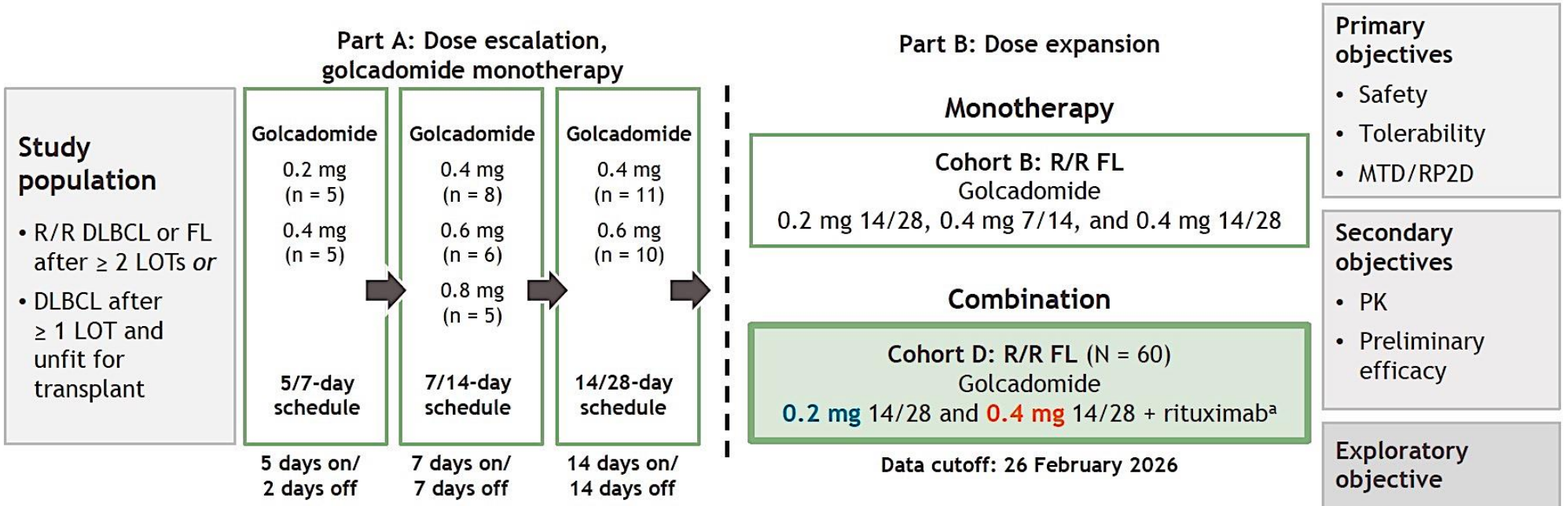
Golcadomide preferentially distributes to lymphoid tissue[1]



Morillo D et al. EHA 2026;Abstract S227

Golcadomide plus Rituximab in R/R FL

CC-99282-NHL-001: A two-part, multicenter, Phase 1/2 study of golcadomide as monotherapy and in combination with rituximab in patients with R/R NHL

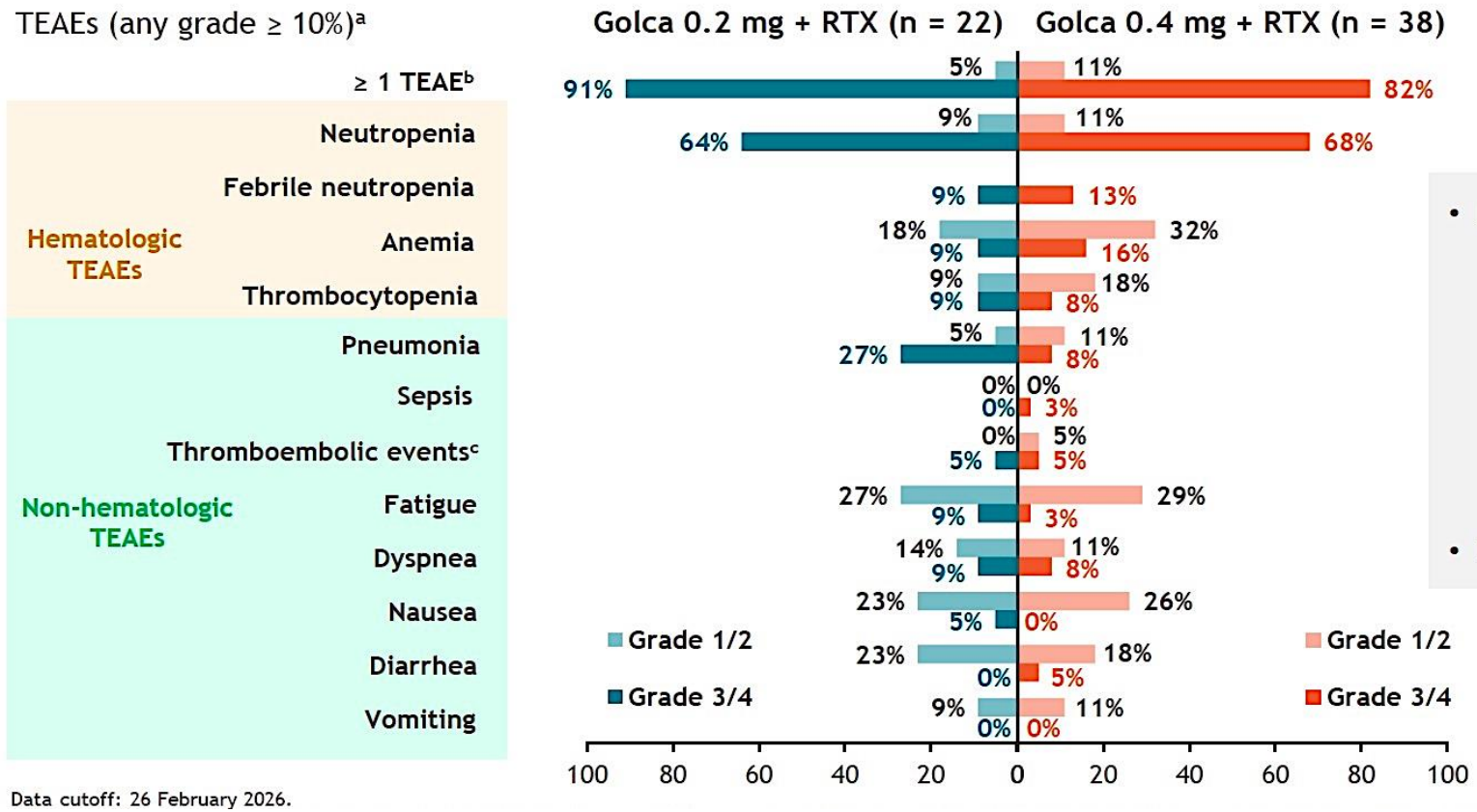


- Total duration of treatment with golcadomide was up to 2 years
- PD changes in immune populations and Ikaros/Aiolos degradation were monitored by flow cytometry
- ctDNA was analyzed by CAPP-Seq, and BL biopsies were profiled by RNA-Seq

Morillo D et al. EHA 2026;Abstract S227

Golcadomide Toxicity

Safety was predictable and TEAEs were mainly hematologic, while non-hematologic TEAEs were infrequent and mostly low grade

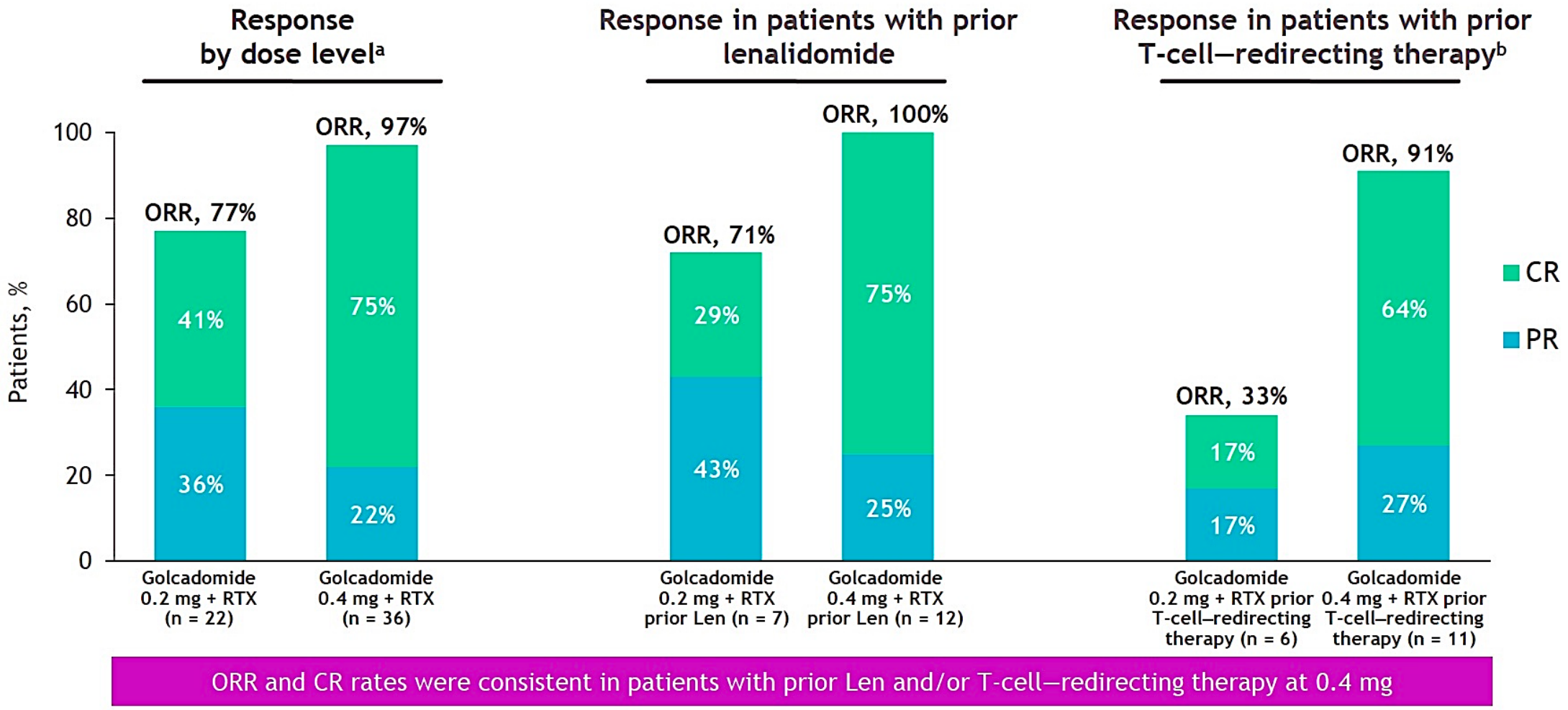


- Neutropenia:
  - Expected, on-target effect due to Ikaros degradation in neutrophil precursors
  - Transient and manageable with G-CSF support
  - Median time to neutrophil recovery was 8 days
  - Rates of febrile neutropenia and pneumonia/sepsis remained low
- No Grade 5 treatment-related AEs

Data cutoff: 26 February 2026.

Morillo D et al. EHA 2026;Abstract S227

Golcadomide Efficacy



Morillo D et al. EHA 2026;Abstract S227

Questions?

Golcadomide

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Data + Perspectives: Investigators Discuss the Optimal Management of Relapsed/Refractory Multiple Myeloma

A CME-Accredited Satellite Symposium During the Society of Hematologic Oncology 2026 Annual Meeting

Wednesday, September 9, 2026
11:56 AM – 12:56 PM CT

Faculty

Noopur Raje, MD
Paul G Richardson, MD

Moderator

Robert Z Orlowski, MD, PhD

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