Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Novel Treatment Approaches for Non-Hodgkin Lymphoma

A CME/MOC-Accredited Live Webinar

Wednesday, June 17, 2026

5:00 PM – 6:00 PM ET

Faculty

Matthew Matasar, MD

Sonali M Smith, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

Faculty

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

Sonali M Smith, MD
Elwood V Jensen Professor of Medicine
Chief, Section of Hematology/Oncology
Co-Leader, Cancer Service Line
The University of Chicago
Chicago, Illinois

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

Commercial Support

This activity is supported by educational grants from AstraZeneca Pharmaceuticals LP and ADC Therapeutics.

Research To Practice CME Planning Committee Members, Staff and Reviewers

Planners, scientific staff and independent reviewers for Research To Practice have no relevant financial relationships to disclose.

Dr Love — Disclosures

Dr Love is president and CEO of Research To Practice. Research To Practice receives funds in the form of educational grants to develop CME activities from the following companies: Aadi Bioscience, AbbVie Inc, ADC Therapeutics, Agendia Inc, Alexion Pharmaceuticals, Amgen Inc, Array BioPharma Inc, a subsidiary of Pfizer Inc, Arvinas, Astellas, AstraZeneca Pharmaceuticals LP, Aveo Pharmaceuticals, Bayer HealthCare Pharmaceuticals, BeOne, Biotheranostics Inc, A Hologic Company, Black Diamond Therapeutics Inc, Blueprint Medicines, Boehringer Ingelheim Pharmaceuticals Inc, Bristol Myers Squibb, Catalyst Pharmaceuticals Inc, Celcuity, Clovis Oncology, Coherus BioSciences, Corcept Therapeutics Inc, CTI BioPharma, a Sobi Company, Daiichi Sankyo Inc, Eisai Inc, Elevation Oncology Inc, Exact Sciences Corporation, Exelixis Inc, Genentech, a member of the Roche Group, Genmab US Inc, Geron Corporation, Gilead Sciences Inc, GSK, Helsinn Therapeutics (US) Inc, ImmunoGen Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Jazz Pharmaceuticals Inc, Johnson & Johnson, Karyopharm Therapeutics, Kite, A Gilead Company, Kura Oncology, Legend Biotech, Lilly, MEI Pharma Inc, Merck, Mersana Therapeutics Inc, Mirati Therapeutics Inc, Mural Oncology Inc, Natera Inc, Novartis, Novartis Pharmaceuticals Corporation on behalf of Advanced Accelerator Applications, Novocure Inc, Nuvalent, Nuvation Bio Inc, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Puma Biotechnology Inc, Regeneron Pharmaceuticals Inc, Revolution Medicines Inc, Rigel Pharmaceuticals Inc, R-Pharm US, Sanofi, Seagen Inc, Servier Pharmaceuticals LLC, SpringWorks Therapeutics Inc, Stemline Therapeutics Inc, Sumitomo Pharma America, Summit Therapeutics, Syndax Pharmaceuticals, Taiho Oncology Inc, Takeda Pharmaceuticals USA Inc, TerSera Therapeutics LLC, Tesaro, A GSK Company, and Verastem Inc.

Dr Matasar — Disclosures

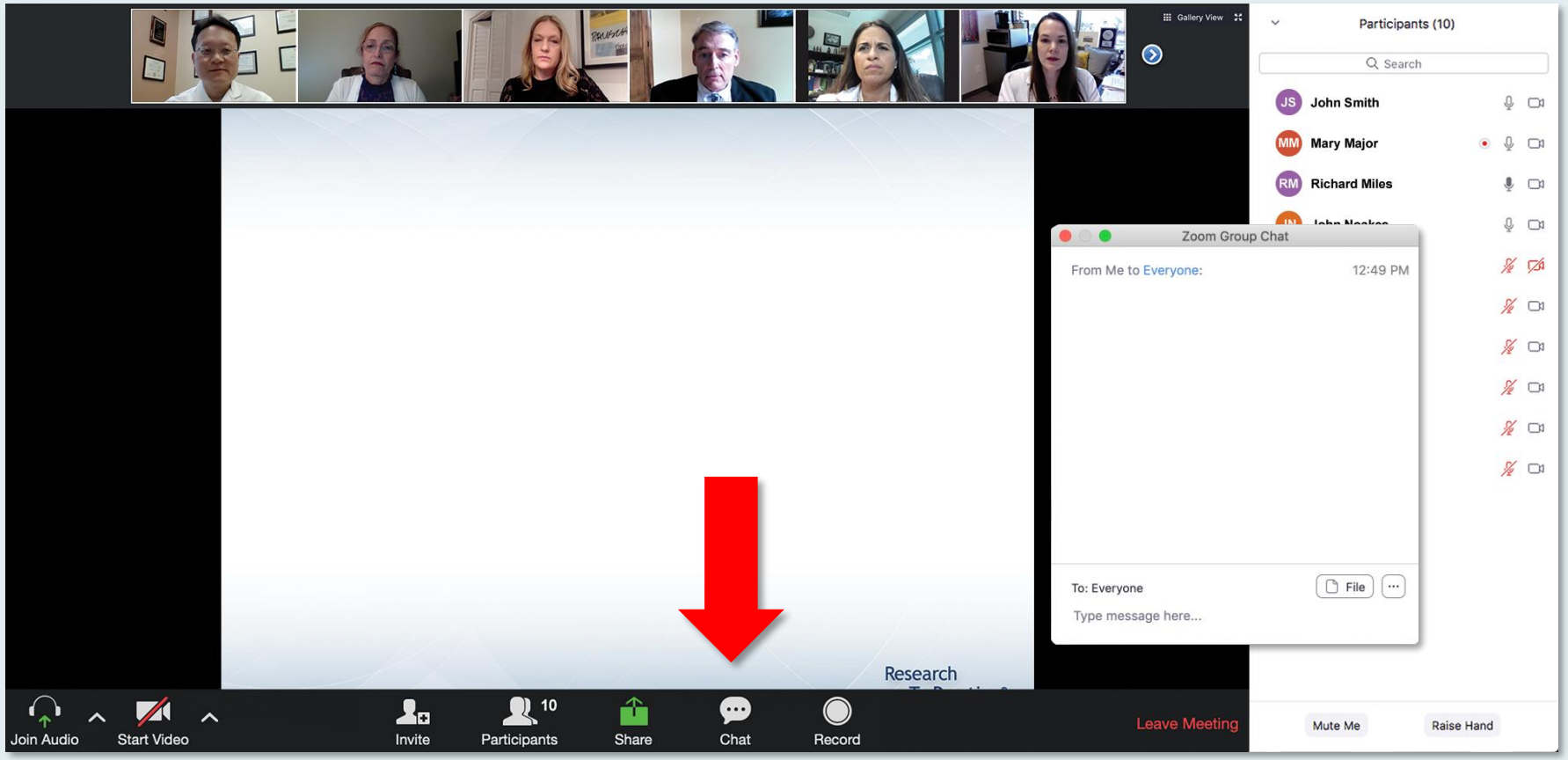
Advisory Committees and Consulting Agreements	AbbVie Inc, Allogene Therapeutics, Arvinas, Genentech, a member of the Roche Group, Genmab US Inc, Incyte Corporation, Merck, Novartis, Pfizer Inc, Roche Laboratories Inc, Visionary Pharmaceuticals
Contracted Research	Bayer HealthCare Pharmaceuticals, Genentech, a member of the Roche Group, Johnson & Johnson, Pharmacyclics LLC, an AbbVie Company, Roche Laboratories Inc, Seagen Inc
Expert Testimony	Recursion
Stock Options/Stock — Public Companies	Merck
Nonrelevant Financial Relationships	Arnold & Porter Kaye Scholer LLP

Dr Smith — Disclosures

Consulting Agreements	Foresight Diagnostics, a wholly-owned subsidiary of Natera Inc, Genmab US Inc, Regeneron Pharmaceuticals Inc
Contracted Research	Celgene Corporation, Genentech, a member of the Roche Group, Incyte Corporation, Ipsen Biopharmaceuticals Inc

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

We Encourage Clinicians in Practice to Submit Questions

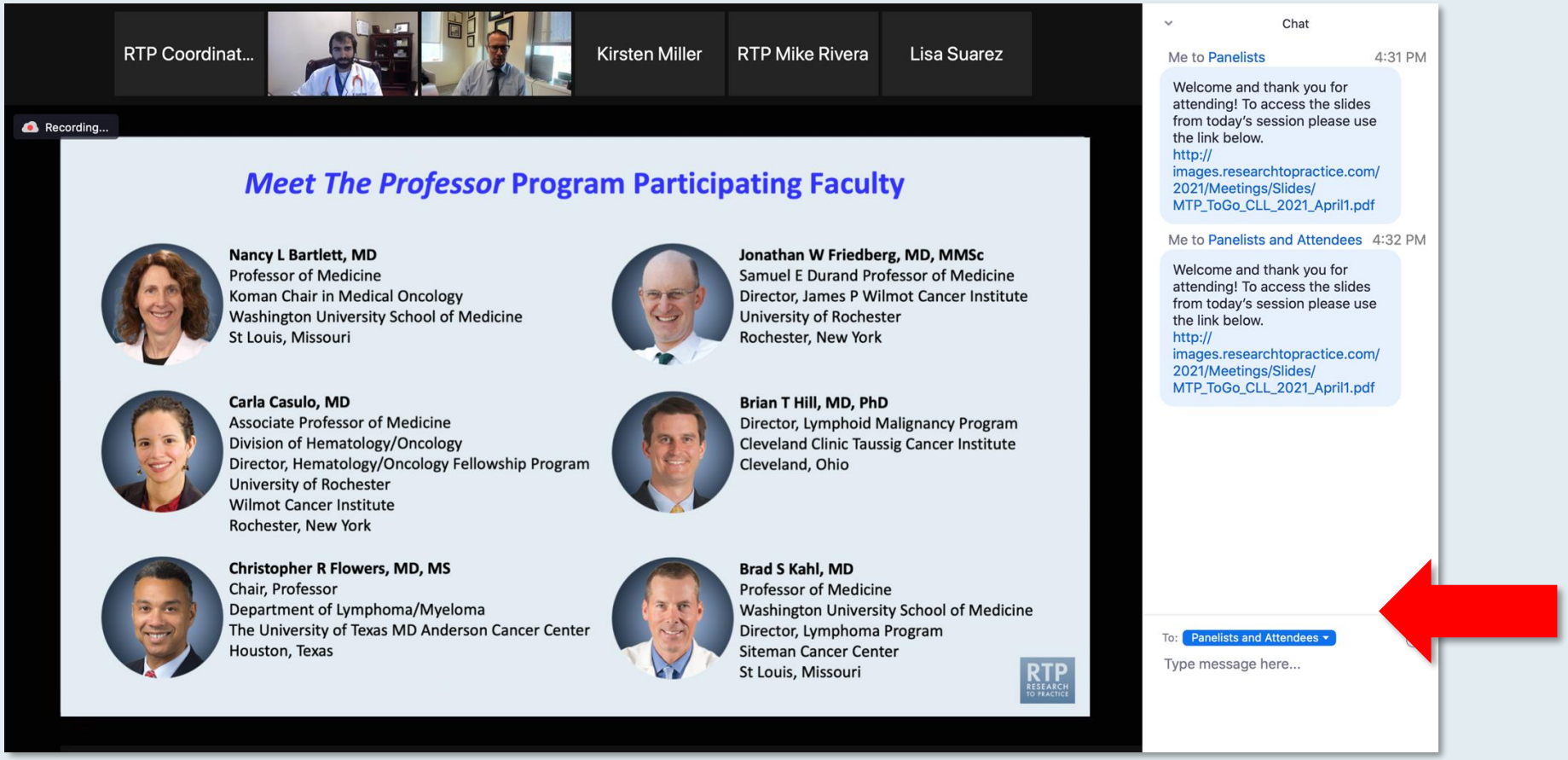


Feel free to submit questions now before the program begins and throughout the program.

RTP Year in Review 2026

Familiarizing Yourself with the Zoom Interface

Expand chat submission box

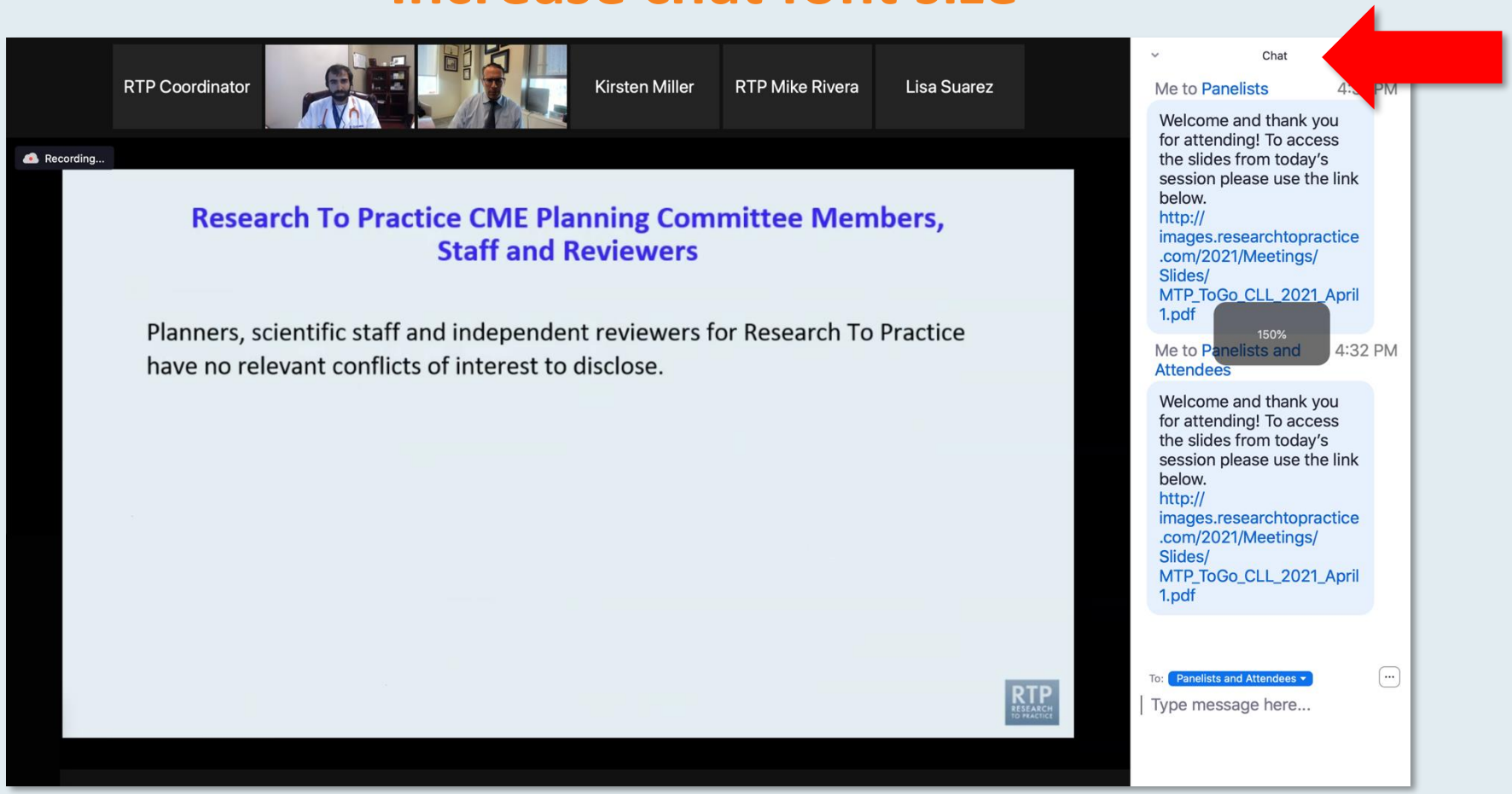


Drag the white line above the submission box up to create more space for your message.

RTP Year in Review 2026

Familiarizing Yourself with the Zoom Interface

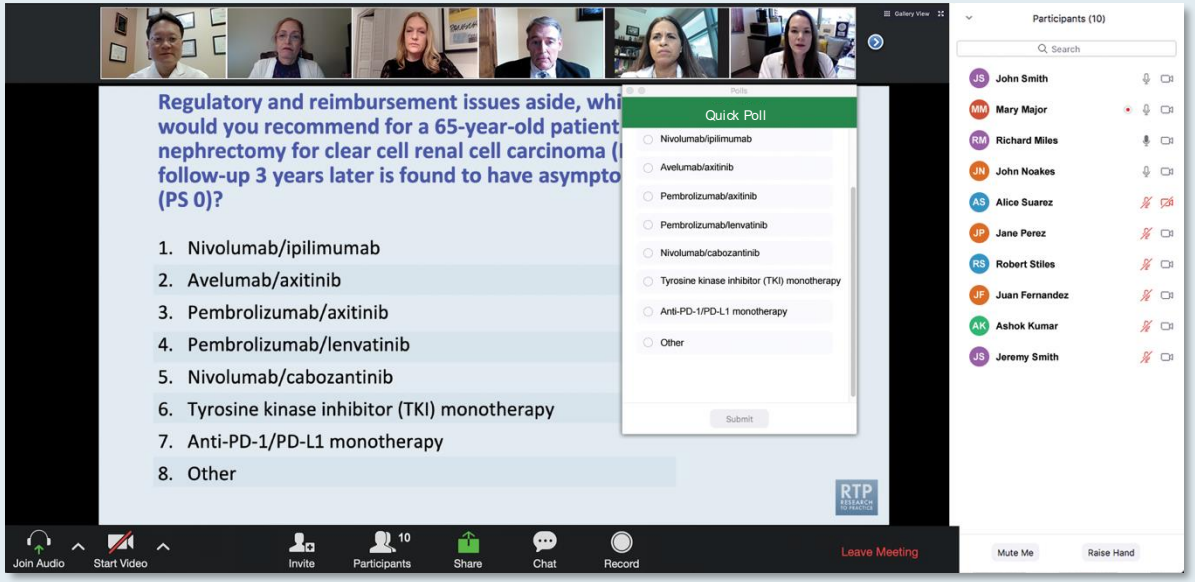
Increase chat font size



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

RTP Year in Review 2026

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



ONCOLOGY TODAY

WITH DR NEIL LOVE

Expert Second Opinion: Investigators Discuss the Role of Novel Treatment Approaches in the Care of Patients with Follicular Lymphoma and Diffuse Large B-Cell Lymphoma

NANCY L BARTLETT, MD
WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

LORETTA J NASTOUPIL, MD
SOUTHWEST ONCOLOGY

JOHN P LEONARD, MD
PERLMUTTER CANCER CENTER

PROFESSOR PIER LUIGI ZINZANI
UNIVERSITY OF BOLOGNA

MATTHEW MATASAR, MD
RUTGERS CANCER INSTITUTE

Listen on Apple Podcasts

Spotify

Listen on Google Podcasts

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Gastroesophageal Cancers

A CME/MOC-Accredited Live Webinar

Tuesday, June 23, 2026

5:00 PM – 6:00 PM ET

Faculty

David H Ilson, MD, PhD

Kohei Shitara, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Multiple Myeloma

A CME/MOC-Accredited Live Webinar

Thursday, June 25, 2026
5:00 PM – 6:00 PM ET

Faculty

Amrita Krishnan, MD
Robert Z Orlowski, MD, PhD

Moderator

Neil Love, MD

RTP Year in Review 2026

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Therapeutic Targets Beyond EGFR for Non-Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, June 30, 2026

5:00 PM – 6:00 PM ET

Faculty

John V Heymach, MD, PhD

Maurice Pérol, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

Patterns of Care: Exploring How Community Oncologists Manage HR-Positive, HER2-Positive Metastatic Breast Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, July 1, 2026

5:00 PM – 6:00 PM ET

Faculty

Lisa A Carey, MD, ScM, FASCO

Reshma L Mahtani, DO

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Grand Rounds

CME/MOC-Accredited Interactive Series

Regional Activities

Two Series

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

Optimizing Therapy for Patients with Hormone Receptor-Positive Localized Breast Cancer

Host a 1-hour session at your institution:
Email Meetings@ResearchToPractice.com
or call (800) 233-6153

RTP RESEARCH TO PRACTICE

Year in Review:
Novel Treatment Approaches for Non-Hodgkin Lymphoma

INTRODUCTION

MODULE 1: Novel Treatment Approaches for Diffuse Large B-Cell Lymphoma (DLBCL) — Dr Matasar

MODULE 2: Novel Treatment Approaches for Follicular Lymphoma (FL) and Mantle Cell Lymphoma (MCL) — Dr Smith

Thank you for joining us!

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

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

RTP Year in Review 2025

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Novel Treatment Approaches for Non-Hodgkin Lymphoma

A CME/MOC-Accredited Live Webinar

Wednesday, June 17, 2026

5:00 PM – 6:00 PM ET

Faculty

Matthew Matasar, MD

Sonali M Smith, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

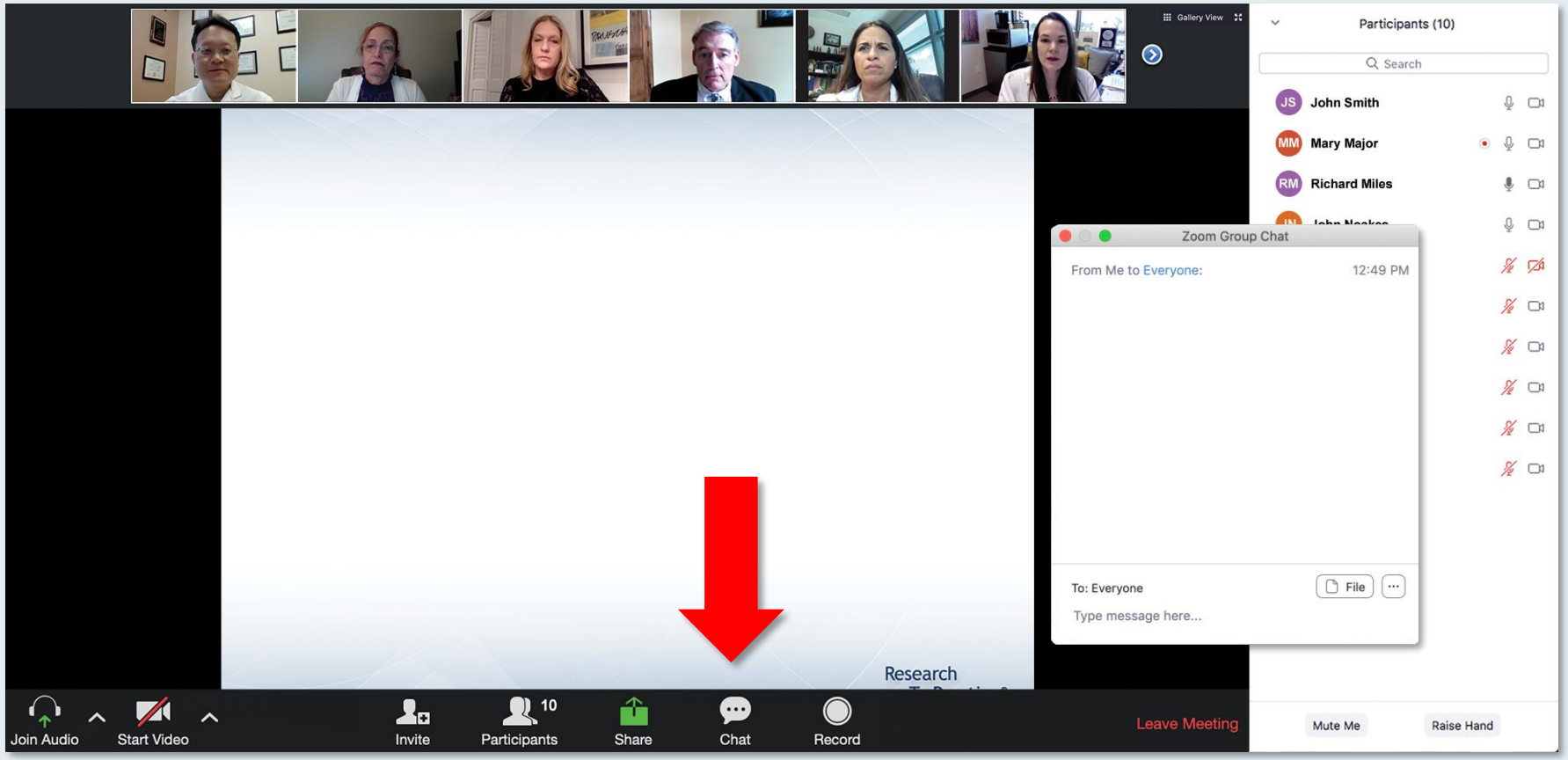
Faculty

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

Sonali M Smith, MD
Elwood V Jensen Professor of Medicine
Chief, Section of Hematology/Oncology
Co-Leader, Cancer Service Line
The University of Chicago
Chicago, Illinois

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

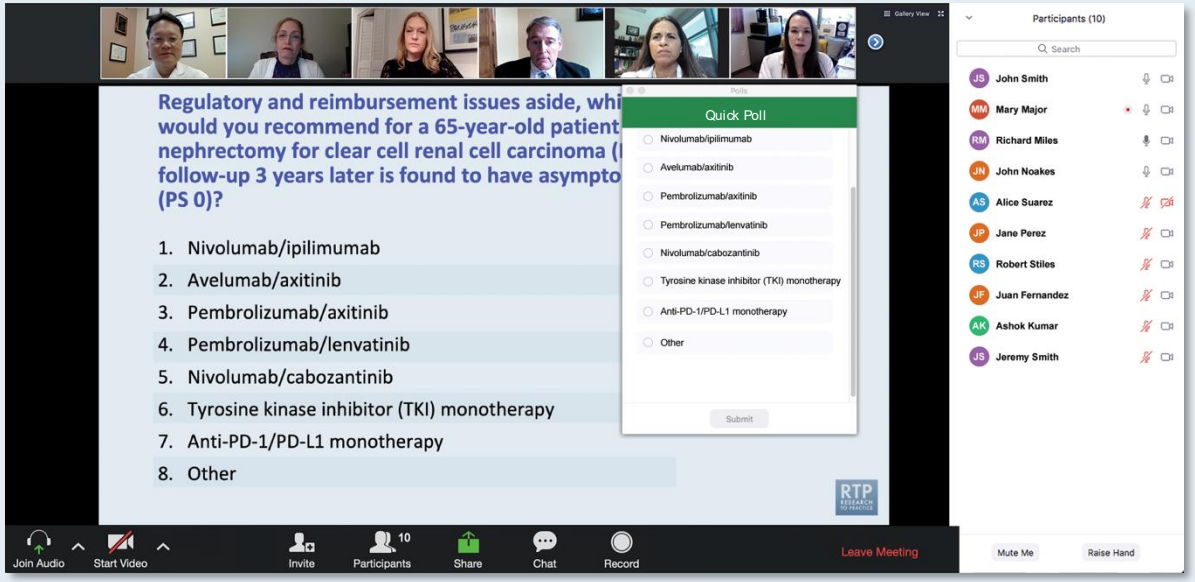
We Encourage Clinicians in Practice to Submit Questions



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

RTP Year in Review 2026

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



ONCOLOGY TODAY

WITH DR NEIL LOVE

Expert Second Opinion: Investigators Discuss the Role of Novel Treatment Approaches in the Care of Patients with Follicular Lymphoma and Diffuse Large B-Cell Lymphoma

NANCY L BARTLETT, MD
WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

LORETTA J NASTOUPIL, MD
SOUTHWEST ONCOLOGY

JOHN P LEONARD, MD
PERLMUTTER CANCER CENTER

PROFESSOR PIER LUIGI ZINZANI
UNIVERSITY OF BOLOGNA

MATTHEW MATASAR, MD
RUTGERS CANCER INSTITUTE

Listen on Apple Podcasts

Spotify

Listen on Google Podcasts

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Gastroesophageal Cancers

A CME/MOC-Accredited Live Webinar

Tuesday, June 23, 2026

5:00 PM – 6:00 PM ET

Faculty

David H Ilson, MD, PhD

Kohei Shitara, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Multiple Myeloma

A CME/MOC-Accredited Live Webinar

Thursday, June 25, 2026
5:00 PM – 6:00 PM ET

Faculty

Amrita Krishnan, MD
Robert Z Orlowski, MD, PhD

Moderator

Neil Love, MD

RTP Year in Review 2026

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Therapeutic Targets Beyond EGFR for Non-Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, June 30, 2026

5:00 PM – 6:00 PM ET

Faculty

John V Heymach, MD, PhD

Maurice Pérol, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

Patterns of Care: Exploring How Community Oncologists Manage HR-Positive, HER2-Positive Metastatic Breast Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, July 1, 2026

5:00 PM – 6:00 PM ET

Faculty

Lisa A Carey, MD, ScM, FASCO

Reshma L Mahtani, DO

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Grand Rounds

CME/MOC-Accredited Interactive Series

Regional Activities

Two Series

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

Optimizing Therapy for Patients with Hormone Receptor-Positive Localized Breast Cancer

Host a 1-hour session at your institution:
Email Meetings@ResearchToPractice.com
or call (800) 233-6153

RTP RESEARCH TO PRACTICE

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Novel Treatment Approaches for Non-Hodgkin Lymphoma

A CME/MOC-Accredited Live Webinar

Wednesday, June 17, 2026

5:00 PM – 6:00 PM ET

Faculty

Matthew Matasar, MD

Sonali M Smith, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

Commercial Support

This activity is supported by educational grants from AstraZeneca Pharmaceuticals LP and ADC Therapeutics.

Research To Practice CME Planning Committee Members, Staff and Reviewers

Planners, scientific staff and independent reviewers for Research To Practice have no relevant financial relationships to disclose.

Dr Matasar — Disclosures

Advisory Committees and Consulting Agreements	AbbVie Inc, Allogene Therapeutics, Arvinas, Genentech, a member of the Roche Group, Genmab US Inc, Incyte Corporation, Merck, Novartis, Pfizer Inc, Roche Laboratories Inc, Visionary Pharmaceuticals
Contracted Research	Bayer HealthCare Pharmaceuticals, Genentech, a member of the Roche Group, Johnson & Johnson, Pharmacyclics LLC, an AbbVie Company, Roche Laboratories Inc, Seagen Inc
Expert Testimony	Recursion
Stock Options/Stock — Public Companies	Merck
Nonrelevant Financial Relationships	Arnold & Porter Kaye Scholer LLP

Dr Smith — Disclosures

Consulting Agreements	Foresight Diagnostics, a wholly-owned subsidiary of Natera Inc, Genmab US Inc, Regeneron Pharmaceuticals Inc
Contracted Research	Celgene Corporation, Genentech, a member of the Roche Group, Incyte Corporation, Ipsen Biopharmaceuticals Inc

Dr Love — Disclosures

Dr Love is president and CEO of Research To Practice. Research To Practice receives funds in the form of educational grants to develop CME activities from the following companies: Aadi Bioscience, AbbVie Inc, ADC Therapeutics, Agendia Inc, Alexion Pharmaceuticals, Amgen Inc, Array BioPharma Inc, a subsidiary of Pfizer Inc, Arvinas, Astellas, AstraZeneca Pharmaceuticals LP, Aveo Pharmaceuticals, Bayer HealthCare Pharmaceuticals, BeOne, Biotheranostics Inc, A Hologic Company, Black Diamond Therapeutics Inc, Blueprint Medicines, Boehringer Ingelheim Pharmaceuticals Inc, Bristol Myers Squibb, Catalyst Pharmaceuticals Inc, Celcuity, Clovis Oncology, Coherus BioSciences, Corcept Therapeutics Inc, CTI BioPharma, a Sobi Company, Daiichi Sankyo Inc, Eisai Inc, Elevation Oncology Inc, Exact Sciences Corporation, Exelixis Inc, Genentech, a member of the Roche Group, Genmab US Inc, Geron Corporation, Gilead Sciences Inc, GSK, Helsinn Therapeutics (US) Inc, ImmunoGen Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Jazz Pharmaceuticals Inc, Johnson & Johnson, Karyopharm Therapeutics, Kite, A Gilead Company, Kura Oncology, Legend Biotech, Lilly, MEI Pharma Inc, Merck, Mersana Therapeutics Inc, Mirati Therapeutics Inc, Mural Oncology Inc, Natera Inc, Novartis, Novartis Pharmaceuticals Corporation on behalf of Advanced Accelerator Applications, Novocure Inc, Nuvalent, Nuvation Bio Inc, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Puma Biotechnology Inc, Regeneron Pharmaceuticals Inc, Revolution Medicines Inc, Rigel Pharmaceuticals Inc, R-Pharm US, Sanofi, Seagen Inc, Servier Pharmaceuticals LLC, SpringWorks Therapeutics Inc, Stemline Therapeutics Inc, Sumitomo Pharma America, Summit Therapeutics, Syndax Pharmaceuticals, Taiho Oncology Inc, Takeda Pharmaceuticals USA Inc, TerSera Therapeutics LLC, Tesaro, A GSK Company, and Verastem Inc.

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

Novel Treatment Approaches for Diffuse Large B-Cell Lymphoma (DLBCL)

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

RTP Lymphoma YIR 2026: FL and MCL

Sonali M Smith, MD
Elwood V Jensen Professor of Medicine
Chief, Section of Hematology/Oncology
Co-Leader, Cancer Service Line
The University of Chicago
Chicago, Illinois

RTP Year in Review 2026

Key Datasets

Matthew Matasar, MD

- Morschhauser F et al. Five-year outcomes of the POLARIX study comparing Pola-R-CHP and R-CHOP in patients with diffuse large B-cell lymphoma. *J Clin Oncol* 2025;43(35):3698-705.
- Lenz G et al. frontMIND: Phase 3 study of tafasitamab (Tafa) plus lenalidomide (Len) and R-CHOP for patients (pts) with newly diagnosed diffuse large B-cell lymphoma (DLBCL). ASCO 2026;Abstract LBA7000.
- Westin J et al. Primary analysis of the Smart Stop trial: Lenalidomide, tafasitamab, rituximab, and acalabrutinib alone and with combination chemotherapy in newly diagnosed diffuse large B-cell lymphoma. ASH 2025;Abstract 477.
- Kim W et al. Mosunetuzumab plus polatuzumab vedotin (Mosun-Pola) versus rituximab, gemcitabine and oxaliplatin (R-GemOx) in patients with relapsed/refractory large B-cell lymphoma (R/R LBCL): Updated efficacy and safety from the phase 3 SUNMO study including in second-line (2L) versus third-line plus (3L+) patient subgroups. ASCO 2026;Abstract 7007.
- Matasar M et al. Polatuzumab vedotin, rituximab, gemcitabine and oxaliplatin for R/R DLBCL: Results from the randomized phase III POLARGO trial. EHA 2025;Abstract S101.
- Carlo-Stella C et al. Updated safety run-in results from LOTIS-5: A phase III, randomized trial of loncastuximab tesirine with rituximab versus immunochemotherapy in patients with R/R DLBCL/HGBL. EHA 2025;Abstract PS1957.

Key Datasets

Matthew Matasar, MD (continued)

- Alderuccio JP et al. Initial results from LOTIS-7: A phase Ib study of loncastuximab tesirine plus glofitamab in patients with R/R DLBCL. EHA 2025;Abstract PS1911.
- Armand P et al. WaveLINE-003: Phase II/III trial of zilovertamab vedotin plus standard of care in R/R DLBCL. ASCO 2025;Abstract 7005.
- Kim TM et al. Surovatamig (AZD0486), a CD19xCD3 T-cell engager (TCE), demonstrates high rate of minimal residual disease (MRD)-negative complete responses in relapsed/refractory (R/R) diffuse large B-cell lymphoma (DLBCL), including in patients who previously progressed on CD20 TCE and CD19 CAR T-cell therapies. ASH 2025; Abstract 5514.
- 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.
- 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.
- Bouzani 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 efficacy from a phase 1b study. EHA 2026;Abstract S239.

Key Datasets

Sonali M Smith, MD

- Sehn LH et al. Tafasitamab, lenalidomide, and rituximab in relapsed or refractory follicular lymphoma (inMIND): A global, phase 3, randomised controlled trial. *Lancet* 2026;407(10524):133-46.
- Zinzani PL et al. Final analysis of the randomized phase 2 ROSEWOOD study of zanubrutinib + obinutuzumab vs obinutuzumab monotherapy in patients with relapsed/refractory follicular lymphoma. ASH 2025;Abstract 227.
- Alderuccio JP et al. Loncastuximab tesirine with rituximab in patients with R/R FL: A single-centre, single-arm, phase II trial. *Lancet Haematol* 2025;12(1):e23-34.
- Hou J-Z et al. Three-year follow-up of the phase 1 first-in-human study investigating surovatamig, a novel CD19xCD3 T-cell engager, in patients with relapsed/refractory (R/R) follicular lymphoma (FL). ASH 2025; Abstract 1005.
- Wang ML et al. Time to third-line treatment after bendamustine-rituximab with or without acalabrutinib in patients with previously untreated mantle cell lymphoma: Updated analysis of the phase 3 ECHO trial after 50 months of follow-up. ASH 2025;Abstract 885.
- Dreyling M et al. Efficacy of rituximab-bendamustine with or without acalabrutinib in patients with untreated, high-risk mantle cell lymphoma: An analysis of the phase 3 ECHO trial. EHA 2025;Abstract S233.

Key Datasets

Sonali M Smith, MD (continued)

- Hawkes E et al. Acalabrutinib plus venetoclax and rituximab in patients with treatment-naive (TN) mantle cell lymphoma (MCL): Results from the phase 2 TrAVeRse study. ASH 2025;Abstract 884.
- Jain P et al. Acalabrutinib in combination with rituximab is highly effective frontline treatment for older patients with MCL. ICML 2025;Abstract 272.
- Wang M et al. Pirtobrutinib in relapsed/refractory (R/R) mantle cell lymphoma (MCL): Final update from the phase 1/2 BRUIN study. ASH 2025;Abstract 665.
- Wang M et al. Sonrotoclax (BGB-11417) monotherapy in patients with relapsed/refractory (R/R) mantle cell lymphoma (MCL) previously treated with a Bruton tyrosine kinase (BTK) inhibitor: Early results from a phase 1/2 study. ASH 2025;Abstract 663.
- 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.

Year in Review:
Novel Treatment Approaches for Non-Hodgkin Lymphoma

INTRODUCTION: Lymphoma Survivorship

MODULE 1: Novel Treatment Approaches for Diffuse Large B-Cell Lymphoma — Dr Matasar

MODULE 2: Novel Treatment Approaches for Follicular Lymphoma and Mantle Cell Lymphoma — Dr Smith

RTP Year in Review 2026

Year in Review:
Novel Treatment Approaches for Non-Hodgkin Lymphoma

INTRODUCTION: Lymphoma Survivorship

MODULE 1: Novel Treatment Approaches for Diffuse Large B-Cell Lymphoma — Dr Matasar

MODULE 2: Novel Treatment Approaches for Follicular Lymphoma and Mantle Cell Lymphoma — Dr Smith

Journal of Cancer Survivorship (2024) 20:483–495
https://doi.org/10.1007/s11764-024-01664-6

Survivorship preparedness and activation among survivors of lymphoma

Sharon L. Manne[1] · Shawna V. Hudson[2] · Dena O'Malley[2] · Katie A. Devine[3] · Matthew Matasar[3] · Jacintha Peram[1] · Justin Solleder[1] · Elizabeth Handorf[4] · Andrew M. Evens[3]

JCO Oncol Pract. 2025 October ; 21(10): 1458–1467. doi:10.1200/OP-24-00742.

Perspectives of Lymphoma Survivors and Oncology Care Providers on Survivorship Care: A Qualitative Study

Jeanne M. Ferrante, MD, MPH[1,2], Myneka Macenat, MPH[2], Jenna Howard, PhD[1,2], Nimi Patel, BS[2,3], Jaanvi Mahesh, BS[2,3], Meghan Bissett, MPH, CHES[2], Jacintha J. Peram, MHA[2], Justin D. Solleder, MA[2], Marissa Grosso, MSW, LCSW[2], Shawna V. Hudson, PhD[1,2], Dena O'Malley, PhD[1,2], Katie A. Devine, PhD[2], Matthew Matasar, MD[2], Andrew M. Evens, DO[2], Sharon L. Manne, PhD[2]

Emergent Themes

Theme 1: A Predominant Unmet Need Was How to Manage the Profound Fear of Recurrence and Anxiety Post-Treatment

Theme 2: There Were Diverse Views Regarding the Importance of Transition From Oncology to Primary Care Providers

Theme 3: Psychosocial Support, Wellness Services, and Assistance With Financial and Employment Programs Are Needed for an Ideal Survivorship Program

Ferrante JM et al. *JCO Oncol Pract* 2025;21(10):1458-67.

Year in Review:
Novel Treatment Approaches for Non-Hodgkin Lymphoma

INTRODUCTION: Lymphoma Survivorship

MODULE 1: Novel Treatment Approaches for Diffuse Large B-Cell Lymphoma — Dr Matasar

MODULE 2: Novel Treatment Approaches for Follicular Lymphoma and Mantle Cell Lymphoma — Dr Smith

RTP Year in Review 2026

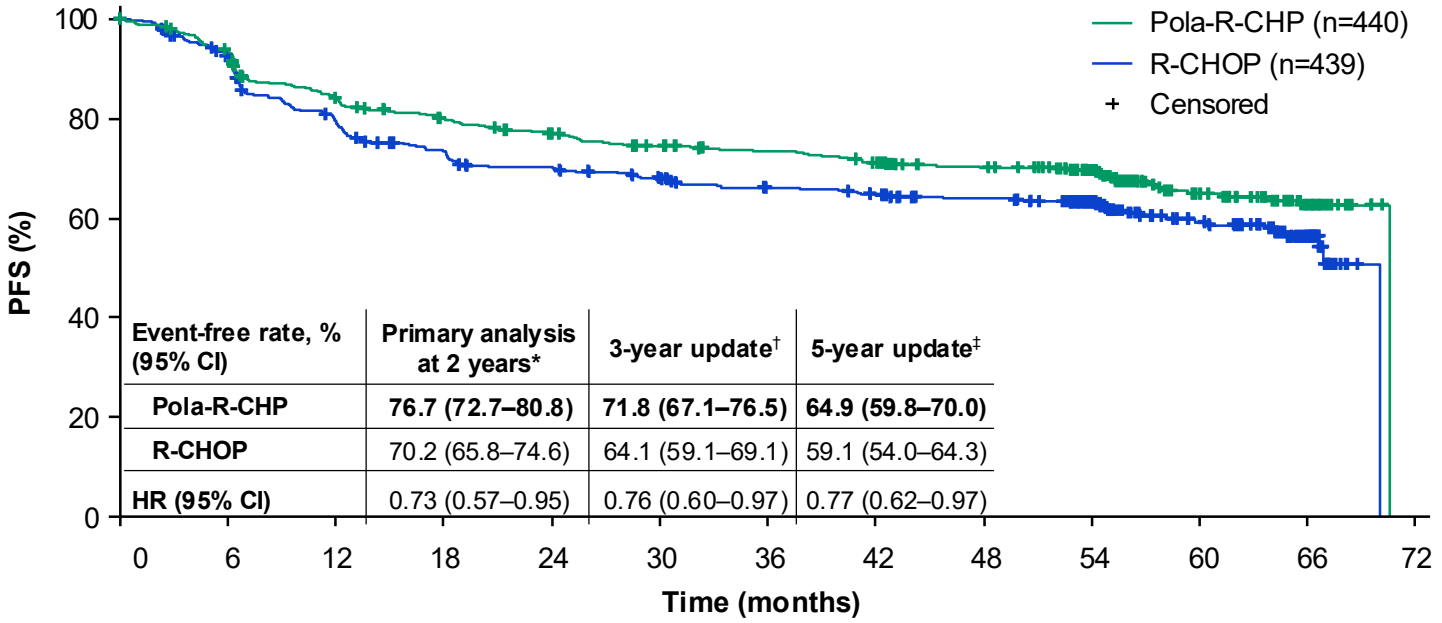
Novel Treatment Approaches for Diffuse Large B-Cell Lymphoma (DLBCL)

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

POLARIX 5Y

POLARIX: PFS benefit with 5y follow-up

PFS in the global ITT population



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

Patients remaining at risk

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

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

RWJBarnabas HEALTH

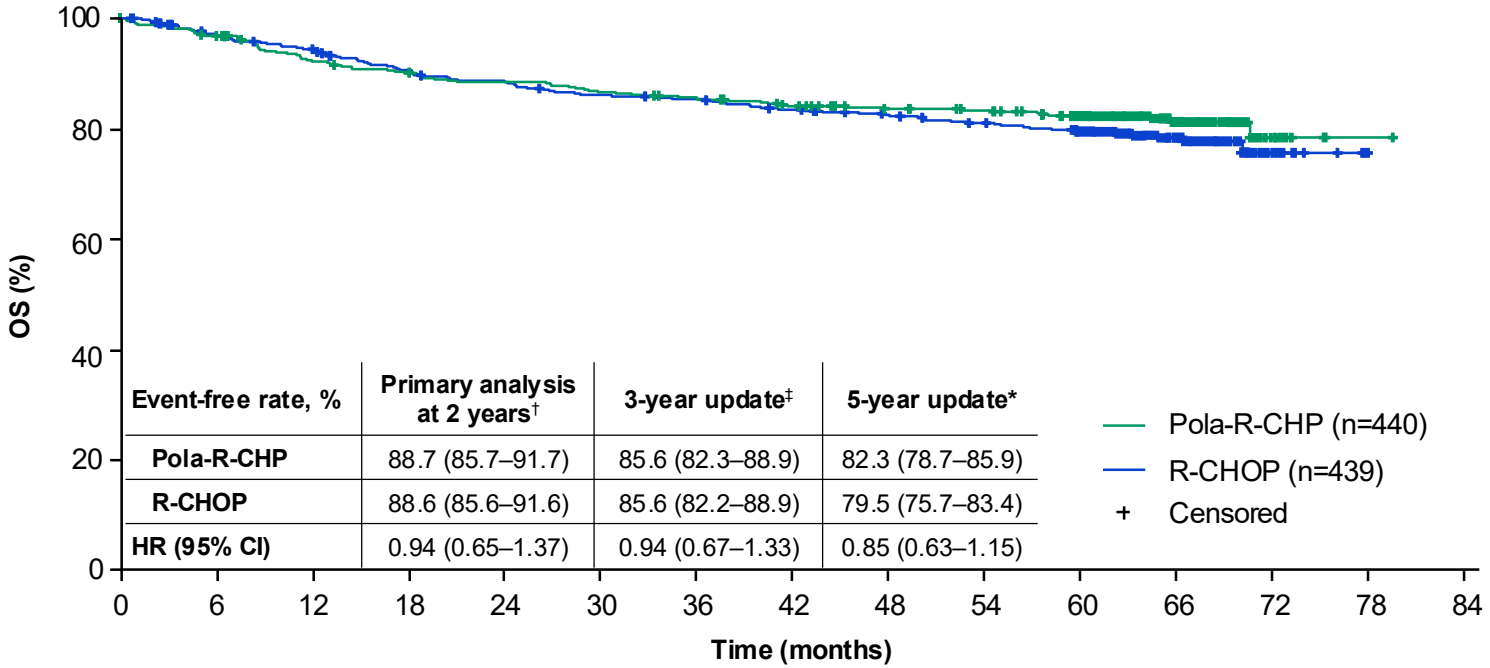
RUTGERS HEALTH Rutgers Cancer Institute

NCI Designated Comprehensive Cancer Center

Salles ASH 2024 469 &
Morschhauser J Clin Oncol 2025

POLARIX: 5-year overall survival

OS in the global population*



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

Patients remaining at risk

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

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

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

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

RWJBarnabas HEALTH

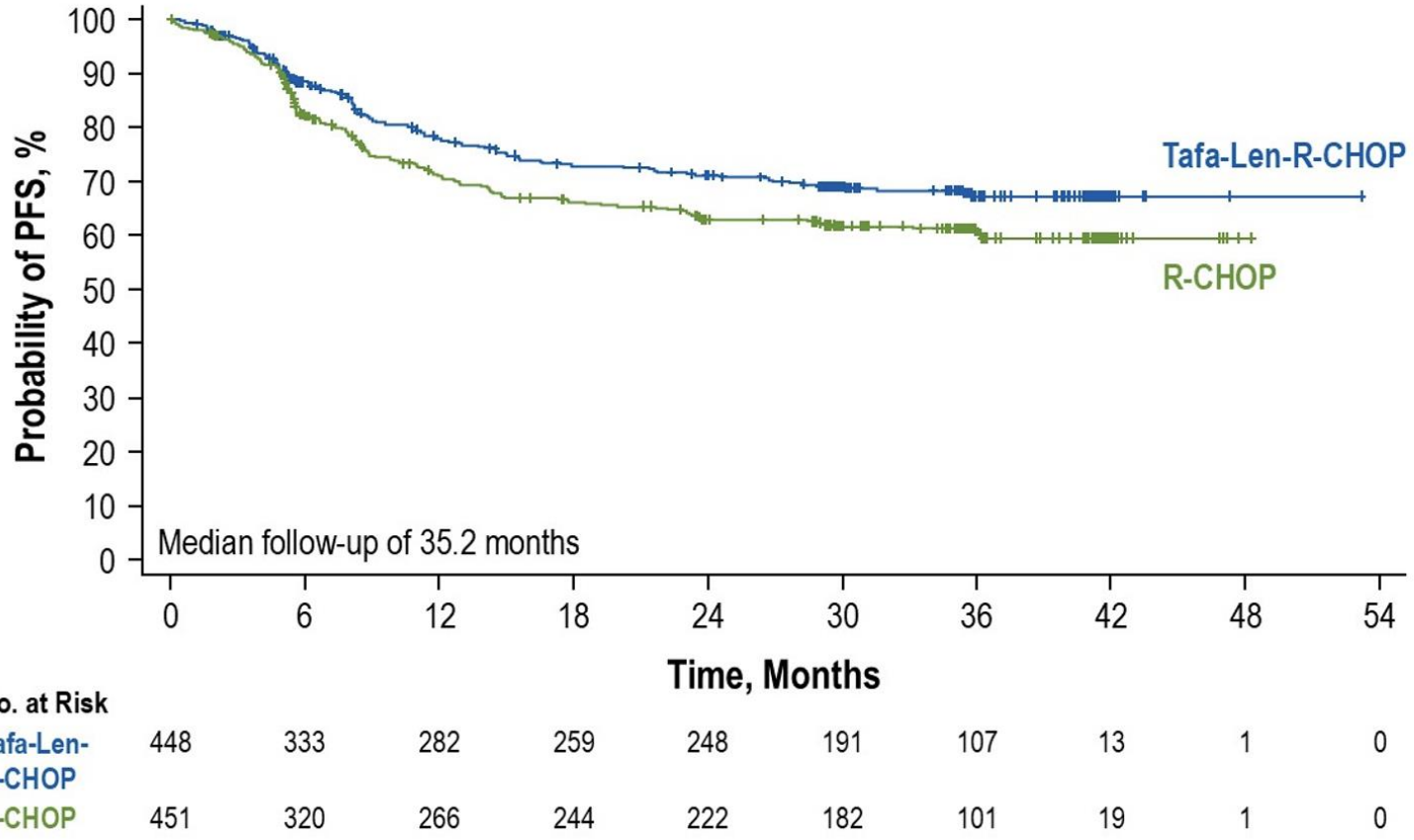
RUTGERS HEALTH Rutgers Cancer Institute

NCI Designated Comprehensive Cancer Center

Salles ASH 2024 469 &
Morschhauser J Clin Oncol 2025

FrontMIND

FrontMIND: Progression-free survival



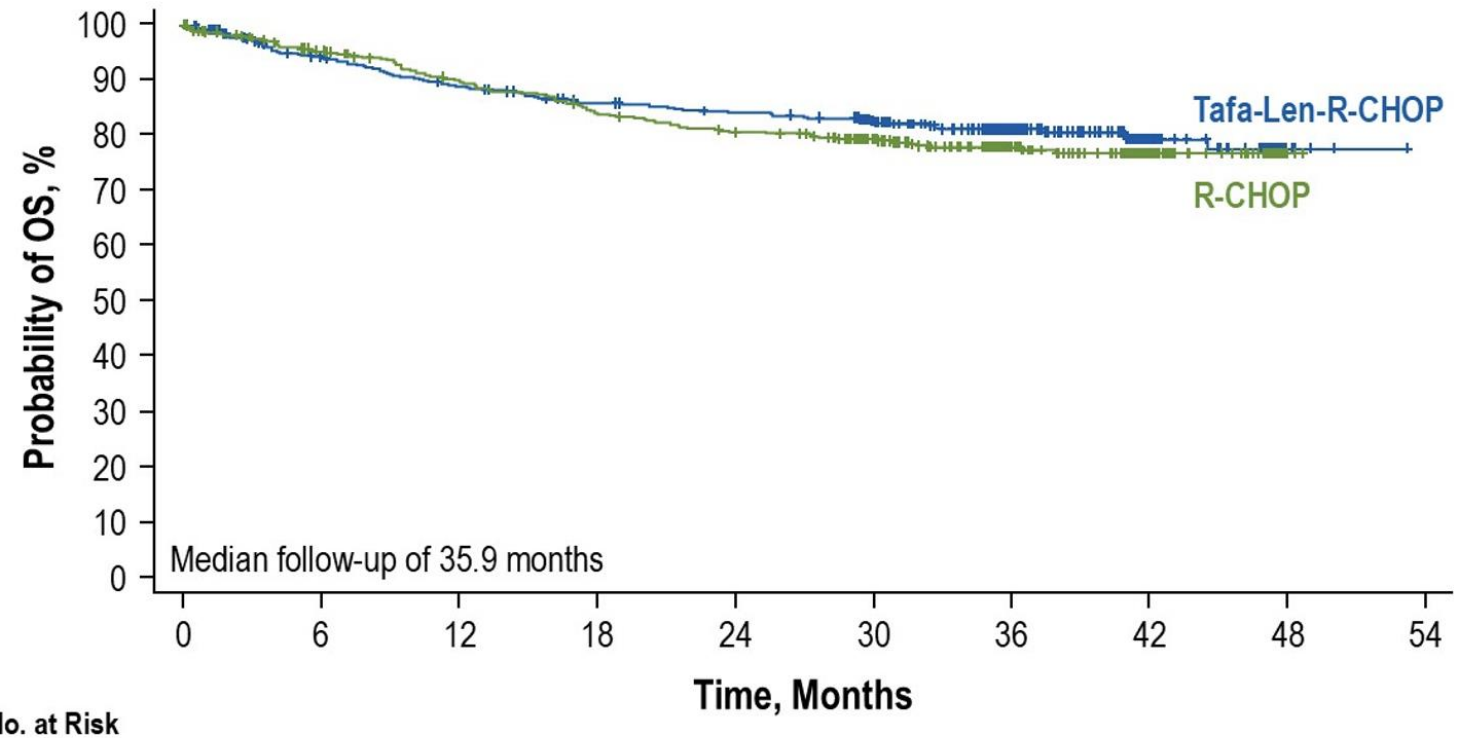
HR 0.75* (*P*=0.0194)
95% CI: 0.59, 0.96

- 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%**)

RWJBarnabas HEALTH
RUTGERS HEALTH Rutgers Cancer Institute
NCI Designated Comprehensive Cancer Center

Lenz ASCO 2026;Abstract LBA7000

FrontMIND: Overall Survival



No. at Risk										
Tafa-Len-R-CHOP	448	398	374	353	343	295	178	63	5	0
R-CHOP	451	409	379	353	336	283	167	71	2	0

HR 0.85* (*P*=0.2703)

95% CI: 0.63, 1.14

- **2-year OS:**
  84.1% with Tafa-Len-R-CHOP vs
  80.5% with R-CHOP
- **3-year OS:**
  81.1% with Tafa-Len-R-CHOP vs
  77.8% with R-CHOP

RWJBarnabas HEALTH

RUTGERS HEALTH Rutgers Cancer Institute

NCI Designated Comprehensive Cancer Center

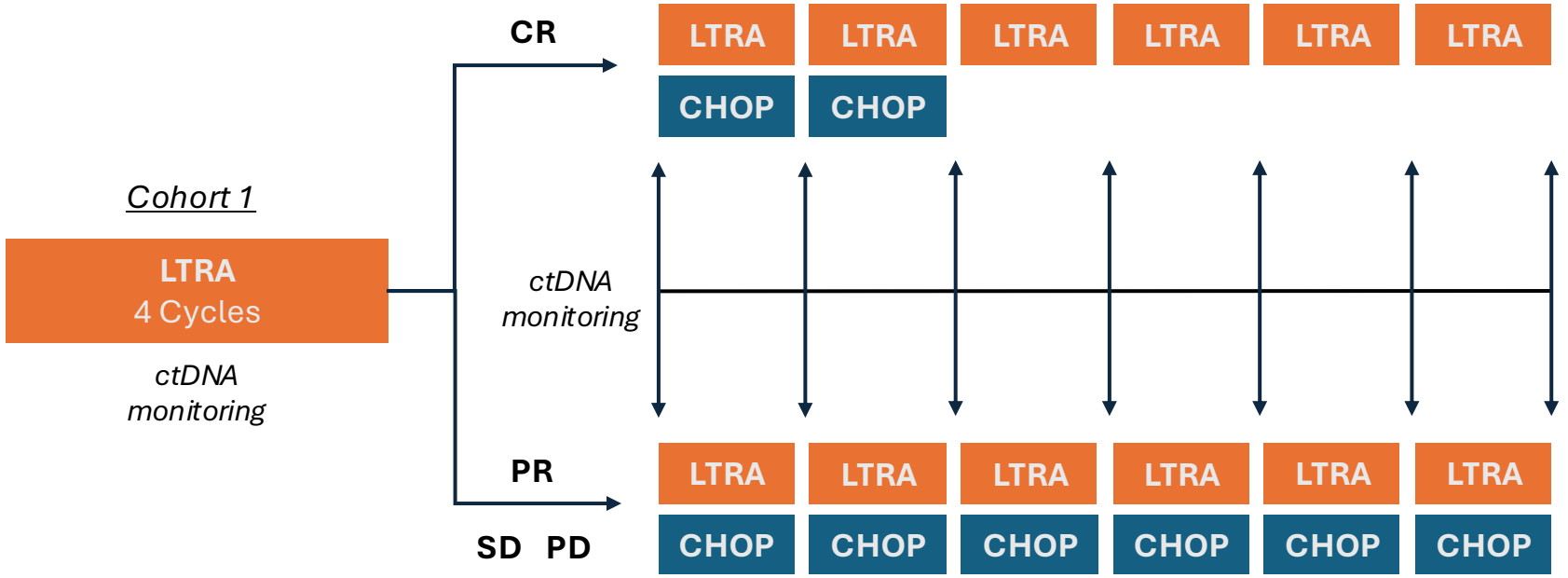
Lenz ASCO 2026;Abstract LBA7000

SMART-STOP

Phase 2 Smart Stop Trial: Acalabrutinib

Key Eligibility Criteria

- Aged 18+ with previously untreated DLBCL
- Adequate organ and bone marrow function, with no known CNS involvement of lymphoma, recent thrombosis, or inability to tolerate prophylactic anticoagulation



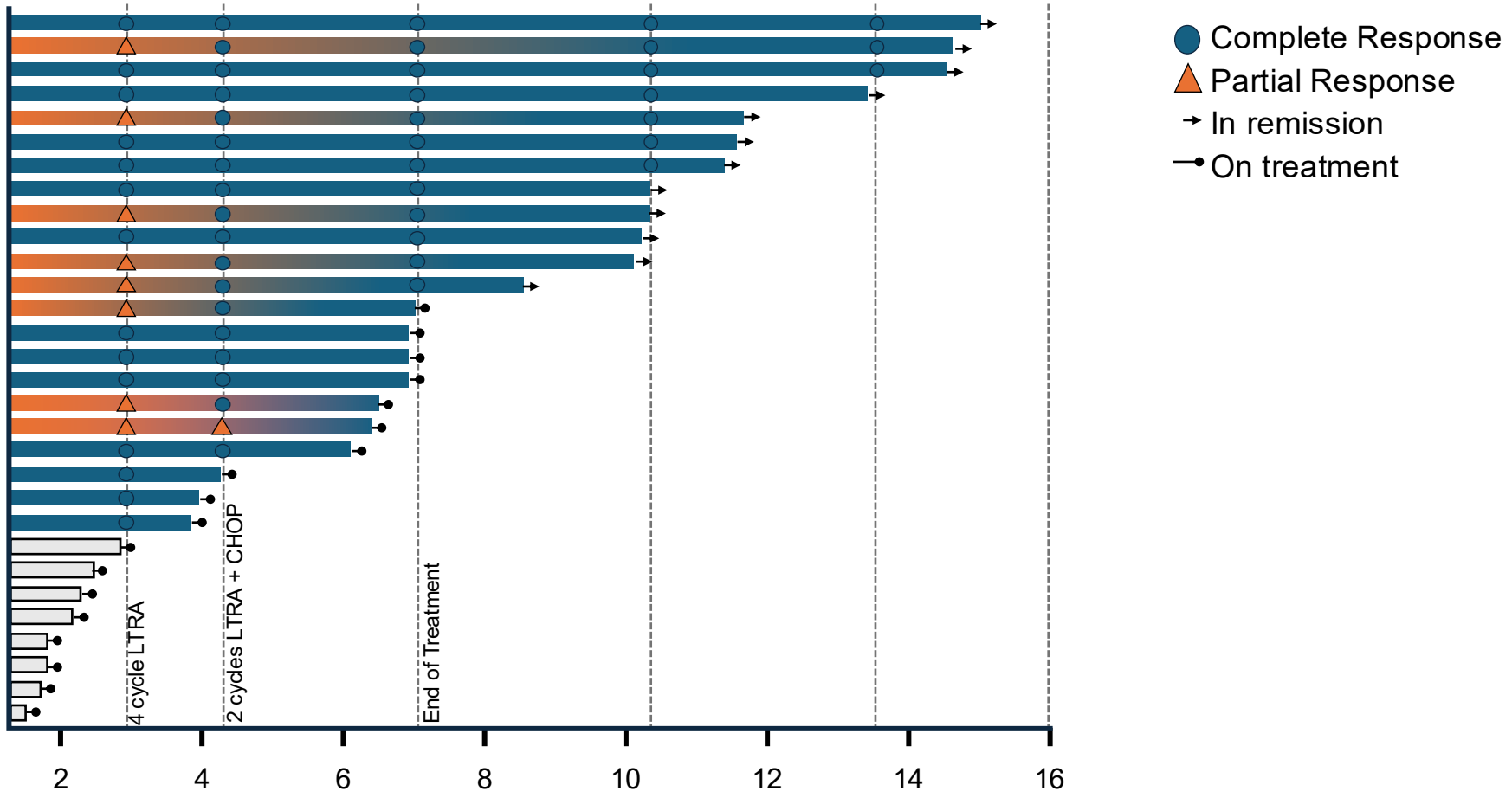
- At the end of all therapy, the CRR was 100%
- 47% of patients experienced rash and 40% of patients required a dose reduction of lenalidomide

LTRA is highly effective as an initial chemotherapy-free combination in patients with newly diagnosed DLBCL and may permit for response-adapted reduction in chemotherapy

A, acalabrutinib; CHOP, cyclophosphamide, doxorubicin, vincristine, prednisone; CNS, central nervous system; CR, complete response; CRR, complete response rate; ctDNA, circulating tumor DNA; DLBCL, diffuse large B-cell lymphoma; L, lenalidomide; PD, progressive disease; PR, partial response; R, rituximab; SD, stable disease; T, tafasitamab.

Westin. *Blood*. 2023;142(Suppl 1):856.

Phase 2 Smart Stop Trial: Acalabrutinib

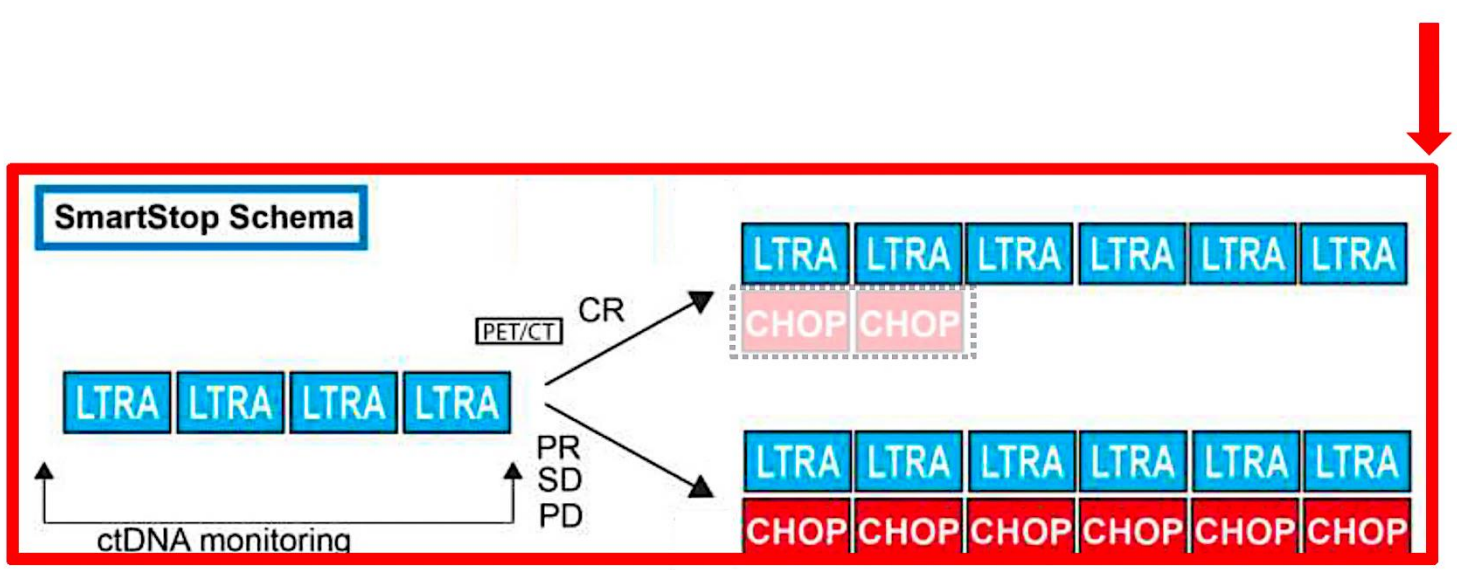


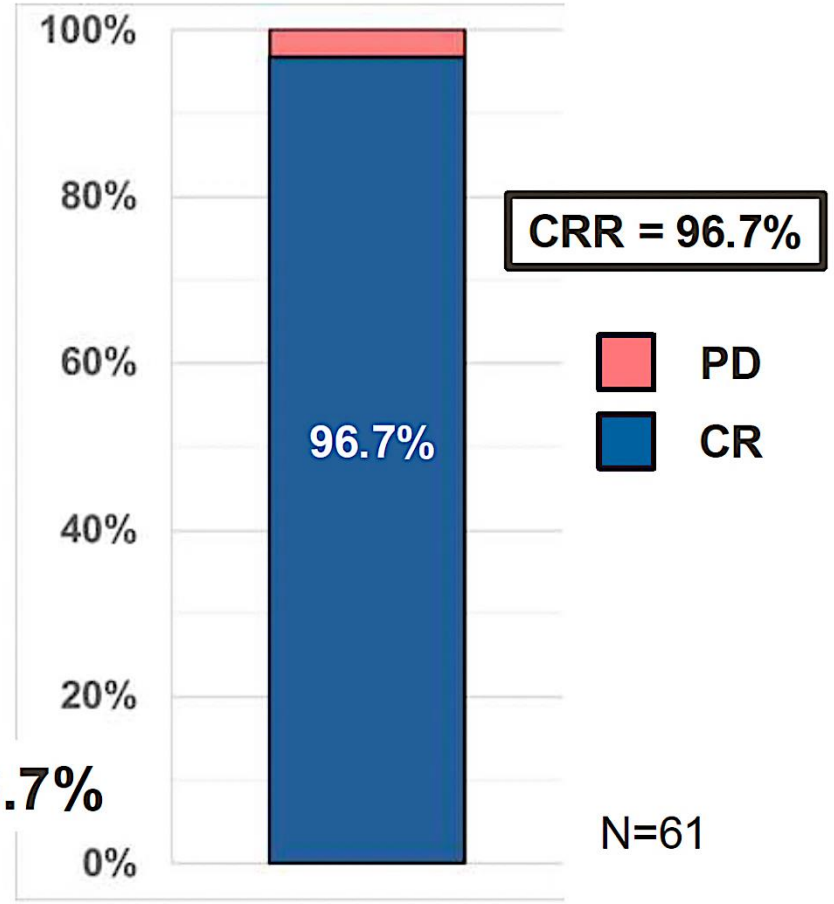
A, acalabrutinib; CHOP, cyclophosphamide, doxorubicin, vincristine, prednisone; CNS, central nervous system; CR, complete response; CRR, complete response rate; ctDNA, circulating tumor DNA; DLBCL, diffuse large B-cell lymphoma; L, lenalidomide; PD, progressive disease; PR, partial response; R, rituximab; SD, stable disease; T, tafasitamab.

Westin. *Blood*. 2023;142(Suppl 1):856.

Phase 2 Smart Stop Trial

Results:
Primary Endpoint 1B: CR at End of Treatment

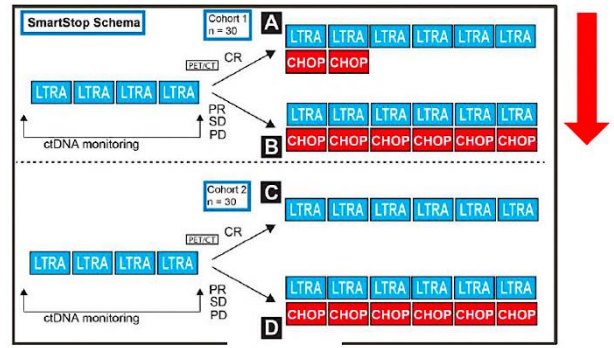




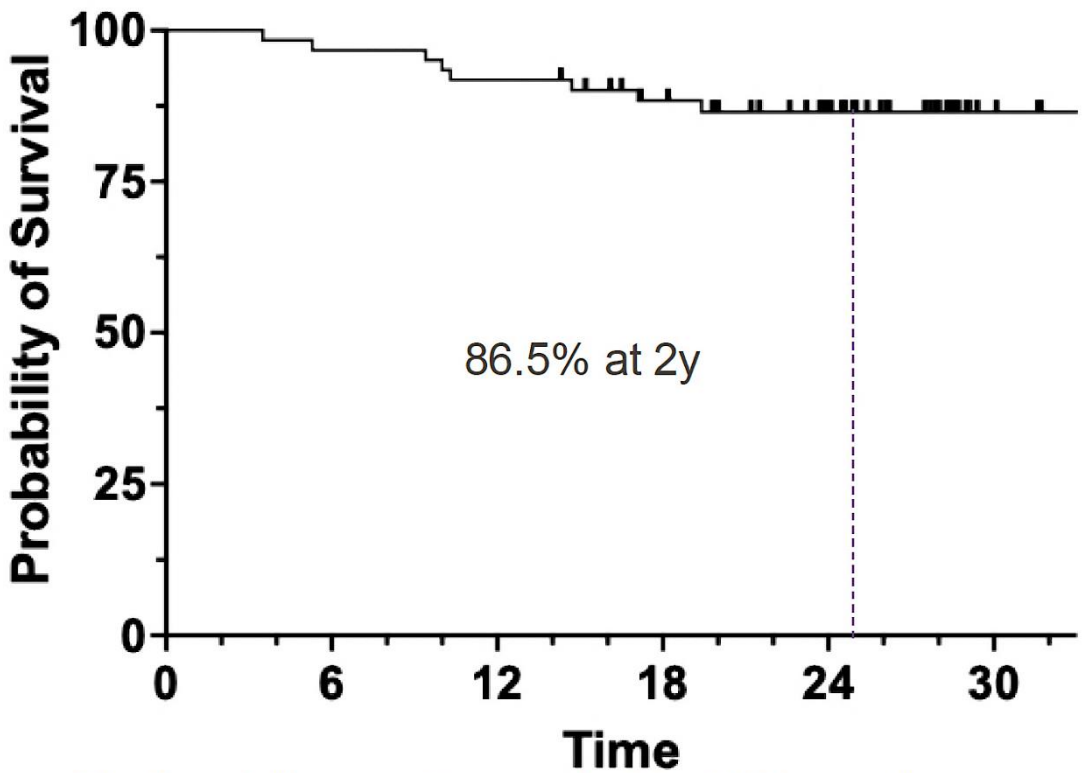
Primary Endpoint 1B: CR at End of Treatment is 96.7%

Westin ASH 2025; Abstract 477.

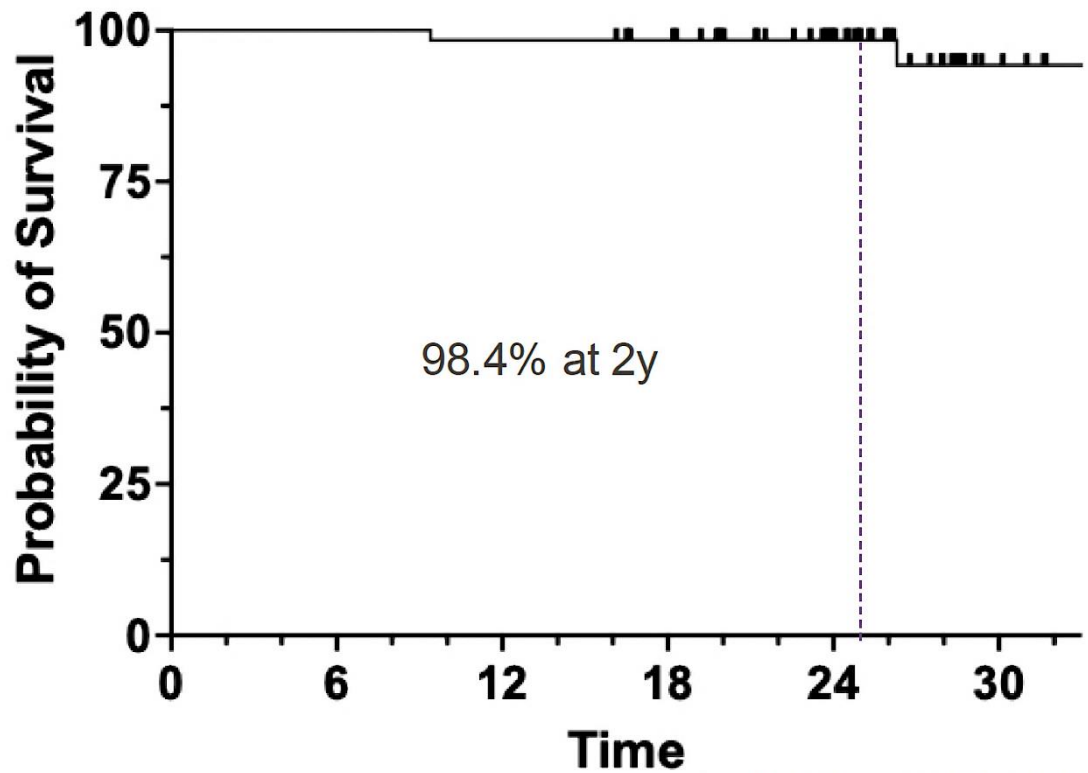
Results:
PFS and OS with Smart Stop (n = 61)



PFS



OS



- Median follow up for survival is 25.3 months

SUNMO

SUNMO: Mosunetuzumab + Polatuzumab in R/R DLBCL

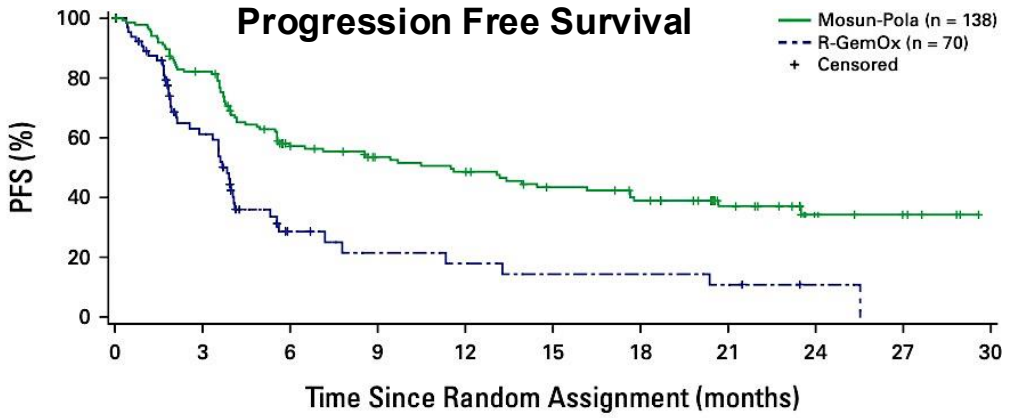
Phase III trial of patients with R/R LBCL who were ineligible for ASCT were randomly assigned (2:1) to receive Mosun-Pola or R-GemOx

Overall response rate was 70% for Mosun-Pola versus 40% with R-GemOx

- 51% of patients receiving Mosun-Pola achieved a CR
- Duration of CR was not reached with Mosun-Pola

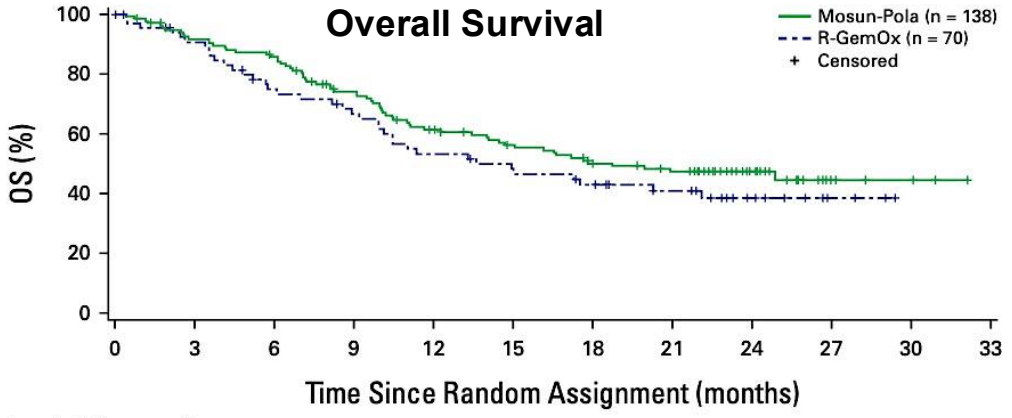
Progression Free Survival: HR 0.41 (0.3 – 0.6)

Overall Survival: 0.80 (0.5 – 1.2)



Number at risk (censored)

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



Number at risk (censored)

Mosun-Pola	138 (0)	122 (5)	113 (6)	93 (11)	75 (13)	65 (17)	55 (20)	50 (22)	24 (48)	5 (66)	3 (68)	NE
R-GemOx	70 (0)	58 (6)	46 (8)	40 (9)	32 (9)	27 (10)	24 (11)	19 (15)	11 (22)	3 (30)	NE	NE

Budde LE et al. *J Clin Oncol*. 2025;00:1-13.

POLARGO

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

Key eligibility criteria

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

Safety run-in
*Enrolled n=**15***

→ ***Pola-R-GemOx**** *Q3W up to 8 cycles*

Primary endpoint
Safety and tolerability

Randomized phase
*Enrolled n=**255***

R 1:1

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

→ ***R-GemOx*** *n=126 Q3W up to 8 cycles*

Primary endpoint
OS

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

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

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

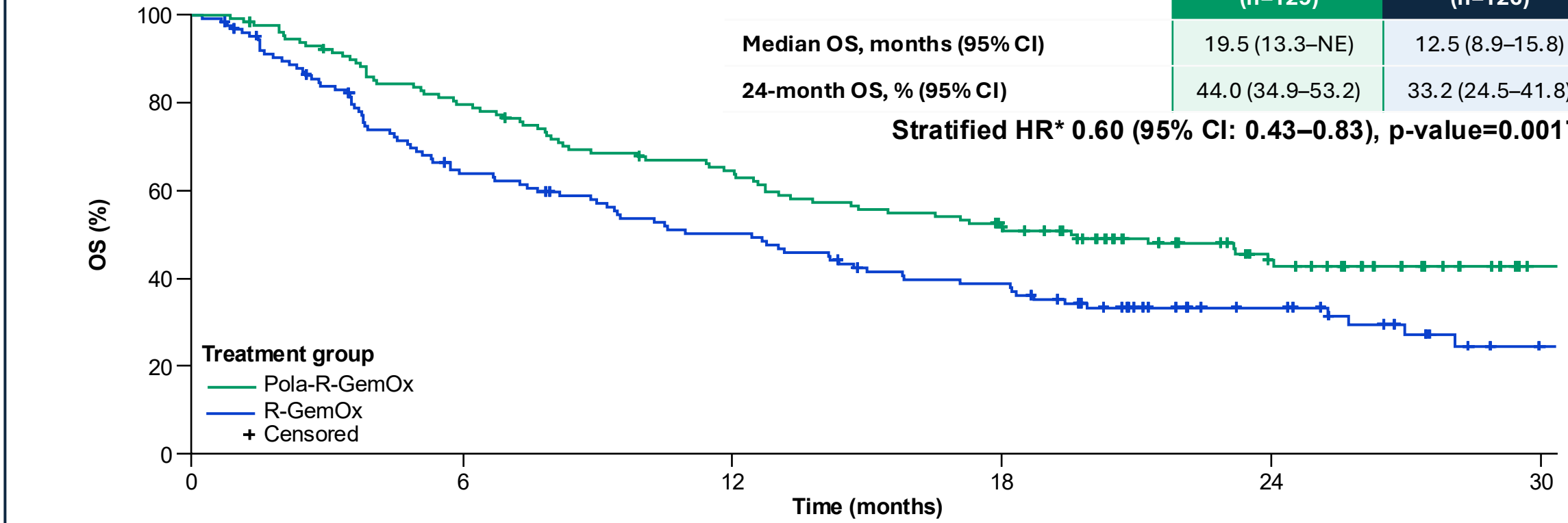
Matasar EHA 2025;Abstract S101

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

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

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

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



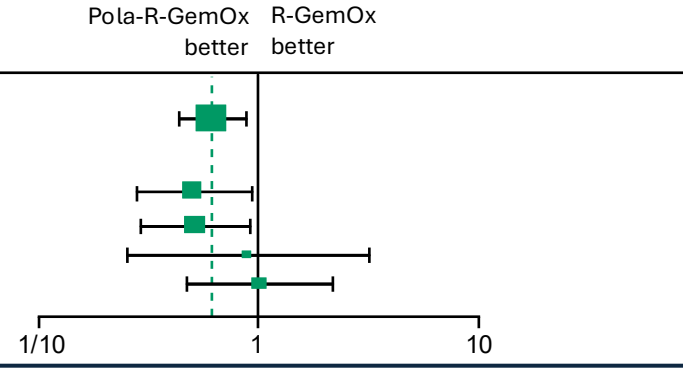
*Stratified for age (≤70 vs >70 years), prior lines of systemic therapy (1 vs ≥2), outcome of last systemic therapy (relapsed vs refractory). †Log rank.
CI, confidence interval; HR, hazard ratio; NE, not estimable.

Matasar EHA 2025;Abstract S101

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

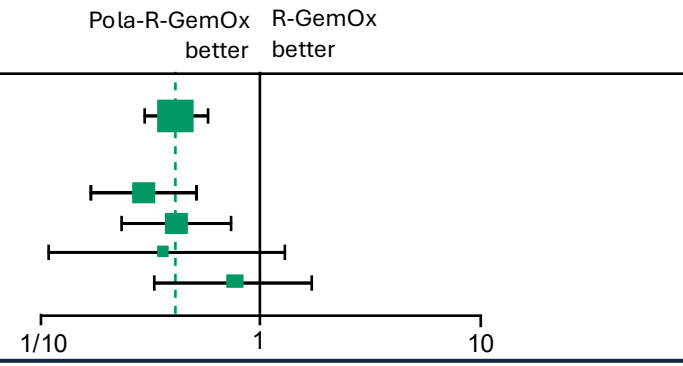
Overall survival

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



Progression-free survival

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

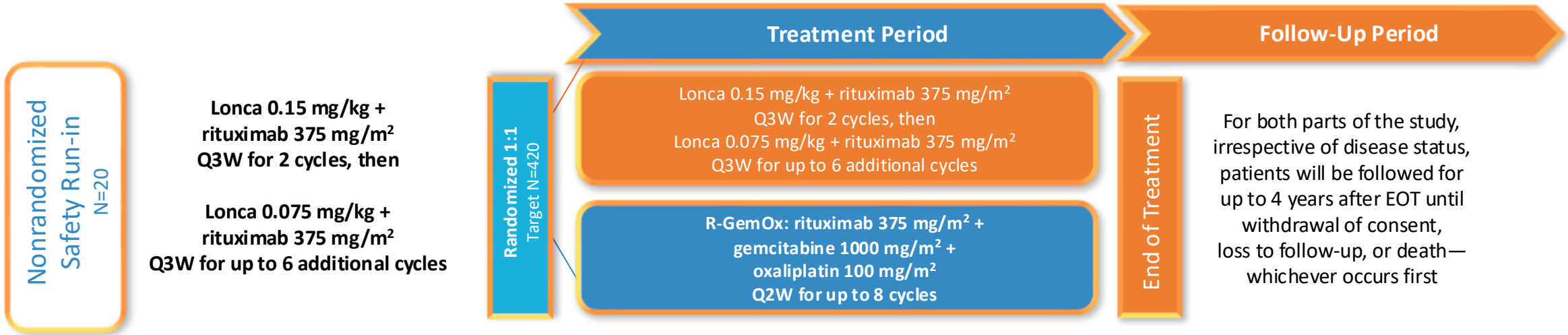


Cell of origin based on GEP.

Matasar EHA 2025;Abstract S101

LOTIS-5

Phase III LOTIS-5



PRIMARY ENDPOINTS

- PFS[a] by independent central review

SECONDARY ENDPOINTS

- OS, ORR, CRR, DOR
- Frequency and severity of AEs and laboratory parameters
- PK parameters, for Lonca total Ab, PBD-conjugated Ab, and free SG3199
- ADA titers to Lonca
- Changes in PROs from baseline

KEY INCLUSION/EXCLUSION CRITERIA

- Adults with a pathologic diagnosis of R/R DLBCL (including DLBCL transformed from indolent lymphoma) or HGBCL, with *MYC* and *BCL2* and/or *BCL6* rearrangements
- R/R disease following ≥1 multi-agent systemic treatment regimen
- Measurable disease (2014 Lugano classification)
- Not a candidate for SCT based on performance status, advanced age, and/or significant medical comorbidities (as considered by the investigator)
- If patient had received previous CD19 directed therapy, biopsy proven CD19 expression required
- ECOG performance status of 0-2
- Excludes previous treatment with Lonca or R-GemOx

Carlo-Stella C. EHA 2025

Safety Run-in: Baseline Characteristics and Safety

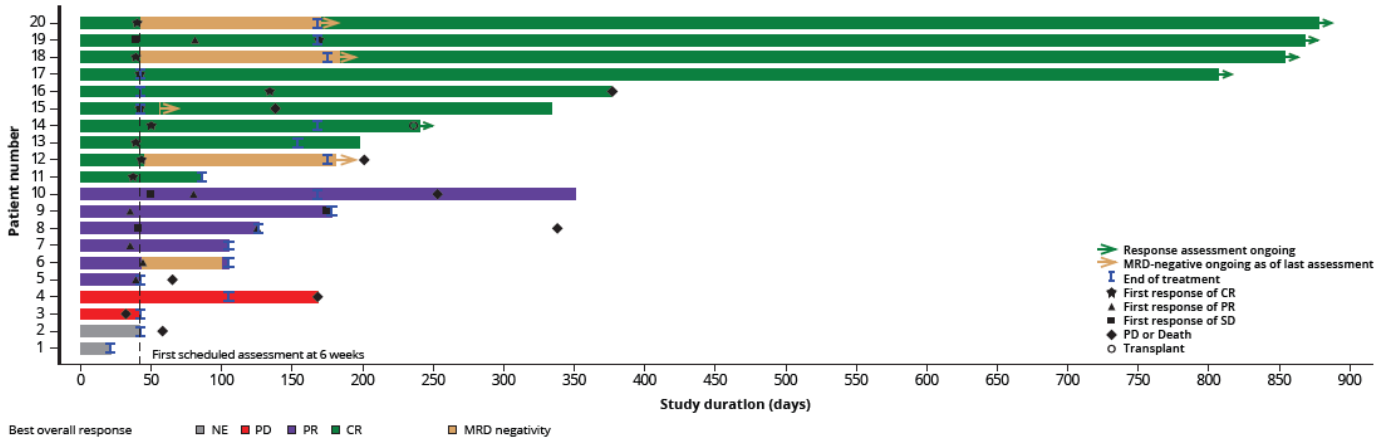
Baseline characteristics	N=20
Sex, female, n (%)	11 (55)
Median (range) age, years	74.5 (35-93)
Race, white, n (%)	20 (100)
ECOG score, n (%)	
Grade 0-1	16 (80)
Disease stage (Lugano criteria), n (%)	
Stage III-IV	12 (60)
Histology, n (%)	
DLBCL, NOS	18 (90)
HGBCL, with MYC and BCL2 and/or BCL6 rearrangements	2 (10)
Median (range) number of prior therapy	1 (1-7)
≥2 prior therapies, n (%)	1 (5)
First line prior systemic response, n (%)	
Relapsed	18 (90)
Refractory	2 (10)
Response to last prior therapy, n (%)	
Relapsed	9 (45)
Refractory	11 (55)

Safety endpoints, n (%)	N=20
All TEAEs	20 (100)
Grade ≥3 TEAEs	11 (55)
Increased GGT	5 (25)
Neutropenia	4 (20)
COVID-19/COVID-19 pneumonia	3 (15)
Serious AEs	9 (45)
Infection	6 (30)
Hyponatremia	1 (5)
Anaphylactic shock	1 (5)
Pleural effusion	1 (5)
Malaise	1 (5)
Neurological decompensation	1 (5)
TEAEs leading to any study drug withdrawal	8 (40)

Carlo Stella C. EHA 2025

Safety Run-in: Efficacy Assessment

Efficacy outcomes in safety run-in population (N=20)	
ORR (95% CI), %	80.0 (56.3, 94.3)
CR rate (95% CI), %	50.0 (27.2-72.8)
Median DOR (95% CI), months	8.0 (3.2-NE)
Median PFS (95% CI), months	8.3 (4.5, NE)
Efficacy outcomes in responders (n=16)	
Median DOR (95% CI), months	8.0 (3.19-NE)
Events (%), n	5 (31.3)
Efficacy outcomes in complete responders (n=10)	
Median DOR (95% CI), months	NE (3.19-NE)
Events (%), n	3 (30.0)
MRD results in patients with ctDNA measurements (n=8)	
CR and MRD negative (%), n	4 (50.0)
MRD negative at end of treatment (%), n	4 (50.0)



Carlo Stella C. EHA 2025

Results from the Phase III LOTIS-5 Confirmatory Clinical Trial of Loncastuximab Tesirine-lpyl in Combination with Rituximab for Relapsed or Refractory Diffuse Large B-Cell Lymphoma

Press Release: June 3, 2026

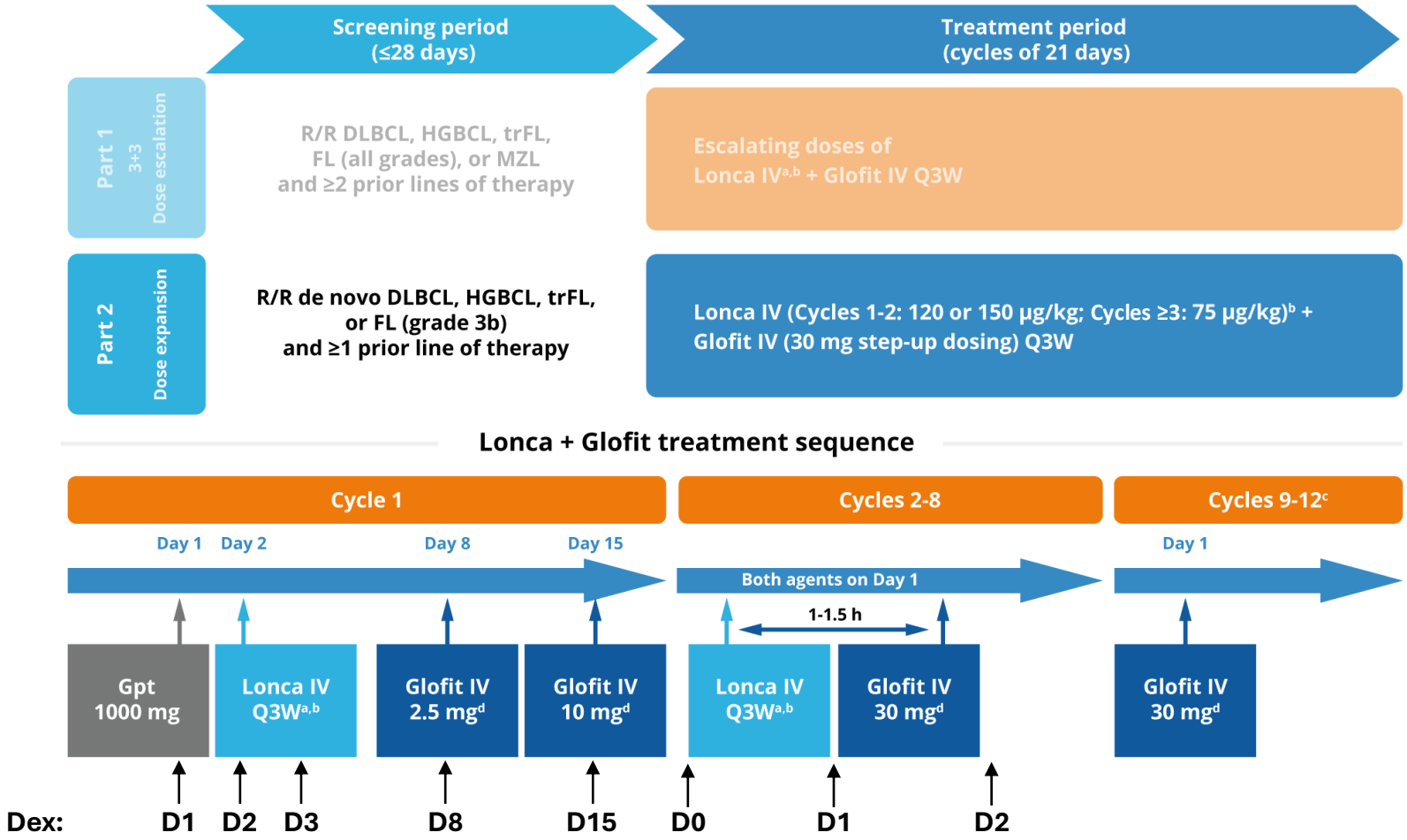
"[The manufacturer] today announced topline data from its Phase 3 LOTIS-5 confirmatory trial evaluating loncastuximab tesirine-lpyl in combination with rituximab in patients with relapsed or refractory diffuse large B-cell lymphoma (r/r DLBCL). Loncastuximab tesirine-lpyl plus rituximab achieved statistical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

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

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

LOTIS-7

Phase Ib LOTIS-7



Study population

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

Endpoints

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

Alderuccio JP. ICML 2025

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

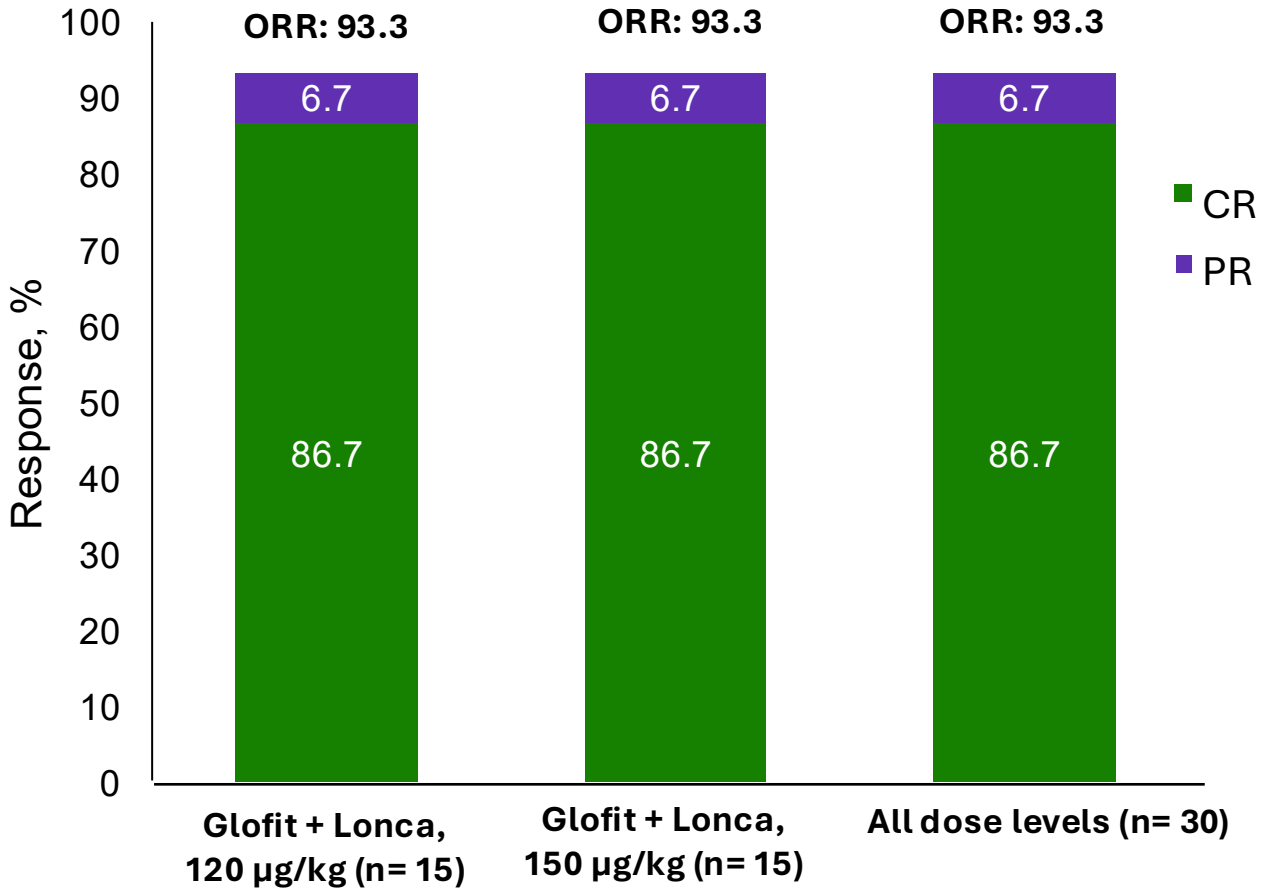
Alderuccio JP. ICML 2025

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

Alderuccio JP. ICML 2025

Efficacy Assessment (n= 30)

Best overall response



Duration of response

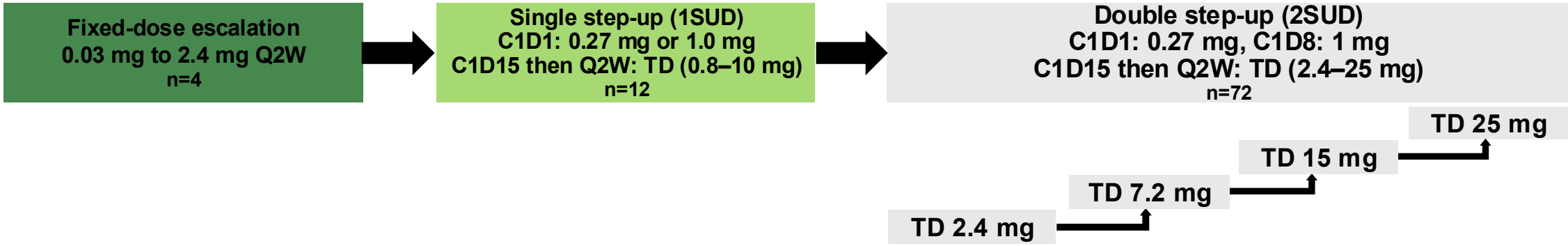
Characteristic, n (%)	Glofit + Lonca, 120 µg/kg (n=15)	Glofit + Lonca, 150 µg/kg (n=15)	All dose levels (N=30)
DOR[d] Median	(n=14) NE	(n=14) NE	(n=28) NE
Time to first response (CR or PR) Median, days	(n=14) 42.0	(n=14) 42.0	(n=28) 42.0
Time to first CR Median, days	(n=13) 80.0	(n=13) 42.0	(n=26) 70.5

Alderuccio JP. ICML 2025

Surovatamig

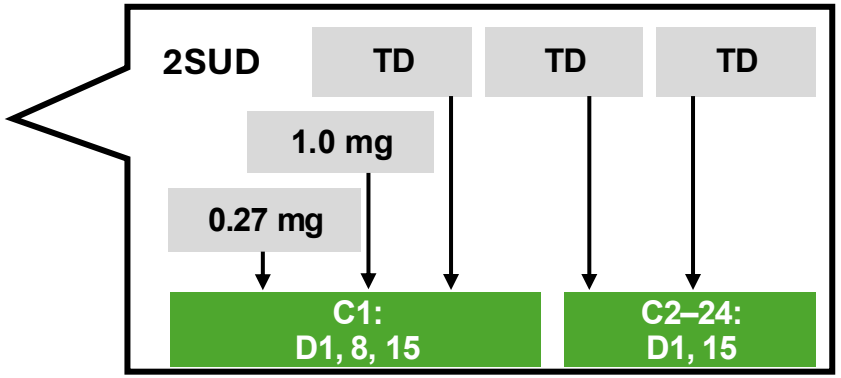
Study Design
Ongoing phase 1 study of surovatamig in R/R DLBCL

Overall Study Design



2SUD Treatment Schedule

- Surovatamig is administered intravenously
- 2SUD on C1D1, C1D8 with TD on C1D15, then on D1, D15 each 28-day cycle up to 2 years
  - Cycle 1 doses were inpatient
- Patients with CR on 2 consecutive scans may receive surovatamig every 4 weeks after C6



NCT04594642; data cutoff: 14 January 2025.
C, cycle; CR, complete response; D/d, day; Q2W, every 2 weeks; SUD, step-up dosing; TD, target dose.

Overall and Complete Response Rates

High response rates with dose-dependent increases in OR and CR rates overall and by prior CAR-T status (surovatamig TD ≥7.2 mg)

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

CAR-T, chimeric antigen receptor T-cell therapy; CR, complete response; ORR, overall response rate.

Hun-Yoon et al. EHA 2025;Abstract PS1927

Summary of Adverse Events in All Schedules

Most common AEs were consistent with other TCEs

Safety Population (N=106)	n (%)		
Most common AEs (≥15%)	**Any Grade**	**Grade 3**	**Grade 4**
CRS	52 (49)	0	0
Neutropenia	36 (34)	11 (10)	20 (19)
ICANS	28 (26)	8 (8)	0
Constipation	24 (23)	0	0
Anemia	23 (22)	16 (15)	0
Fatigue	23 (22)	4 (4)	0
Hypogammaglobulinemia	21 (20)	1 (1)	0
Diarrhea	18 (17)	0	0
Myalgia	17 (16)	1 (1)	0
Pyrexia	16 (15)	0	0
Nausea	16 (15)	1 (1)	0
Insomnia	16 (15)	0	0
Cough	16 (15)	0	0

Four grade 5 events were reported (pneumonia, n=3; COVID-19, n=1)

Kim ASH 2025; Abstract 5514

Zilovertamab

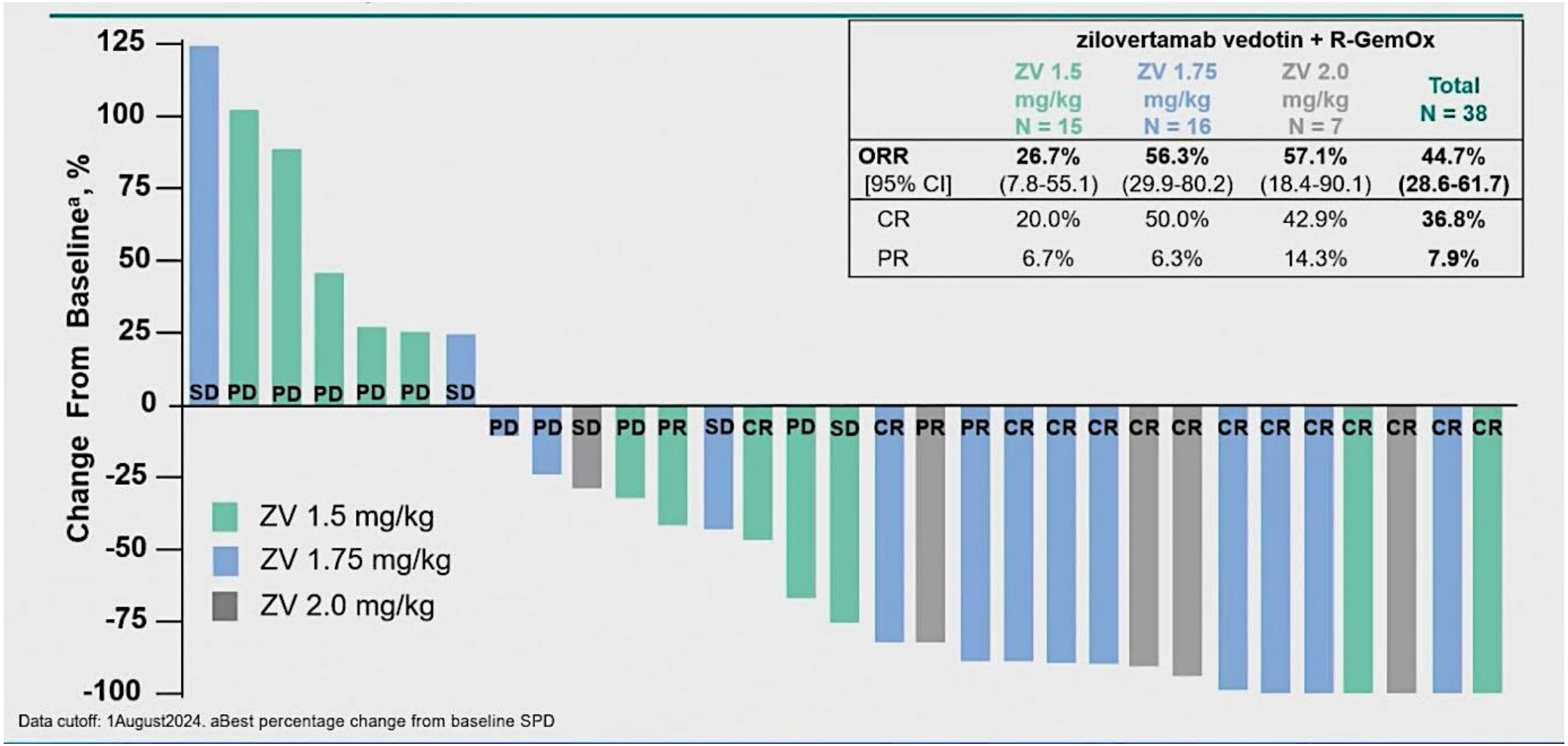
Zilovertamab + R-GemOx in R/R DLBCL

Characteristic, n (%)	zilovertamab vedotin + R-GemOx			
	ZV 1.5 mg/kg N = 17	ZV 1.75 mg/kg N = 16	ZV 2.0 mg/kg N = 7	Total N = 40
Median age (range), years	62.0 (27-78)	68.5 (32-78)	59.0 (42-81)	66.5 (27-81)
≥ 65	7 (41)	13 (81)	2 (29)	22 (55)
ECOG performance status				
0	9 (53)	4 (25)	4 (57)	17 (43)
1	7 (41)	10 (63)	2 (29)	19 (48)
2	1 (6)	2 (13)	1 (14)	4 (10)
Ann Arbor Stage				
I	2 (12)	1 (6)	2 (29)	5 (13)
II	1 (6)	6 (38)	1 (14)	8 (20)
III	1 (6)	4 (25)	1 (14)	6 (15)
IV	13 (77)	5 (31)	3 (43)	21 (53)
Number of Prior Lines of Therapy				
Median	2.0	2.0	3.0	2.0
Range	1-7	1-7	1-7	1-7
Prior polatuzumab vedotin	0	1 (6)	1 (14)	2 (5)
DLBCL cell-of-origin (by Hans)				
GCB	9 (53)	9 (56)	0	18 (45)
Non-GCB	5 (29)	5 (31)	5 (71)	15 (38)
Unknown	3 (18)	2 (13)	2 (29)	7 (18)

Data cutoff: 1August2024; GCB, germinal center B-like; Unknown, not tested.

Armand P. et al. ASCO 2025;Abstract 7005

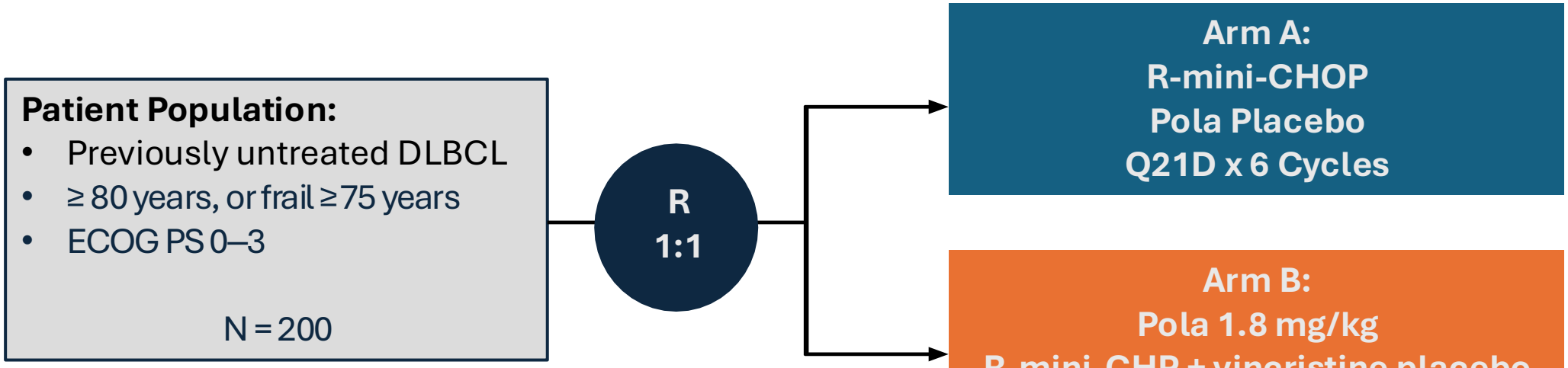
Zilovertamab + R-GemOx in R/R DLBCL: ORR



	zilovertamab vedotin + R-GemOx			
	ZV 1.5 mg/kg N = 15	ZV 1.75 mg/kg N = 16	ZV 2.0 mg/kg N = 7	Total N = 38
ORR [95% CI]	**26.7%** (7.8-55.1)	**56.3%** (29.9-80.2)	**57.1%** (18.4-90.1)	**44.7%** **(28.6-61.7)**
CR	20.0%	50.0%	42.9%	**36.8%**
PR	6.7%	6.3%	14.3%	**7.9%**

POLAR BEAR: Pola+R-Mini-CHOP in Elderly People With DLBCL

Study Design



Primary endpoint: PFS

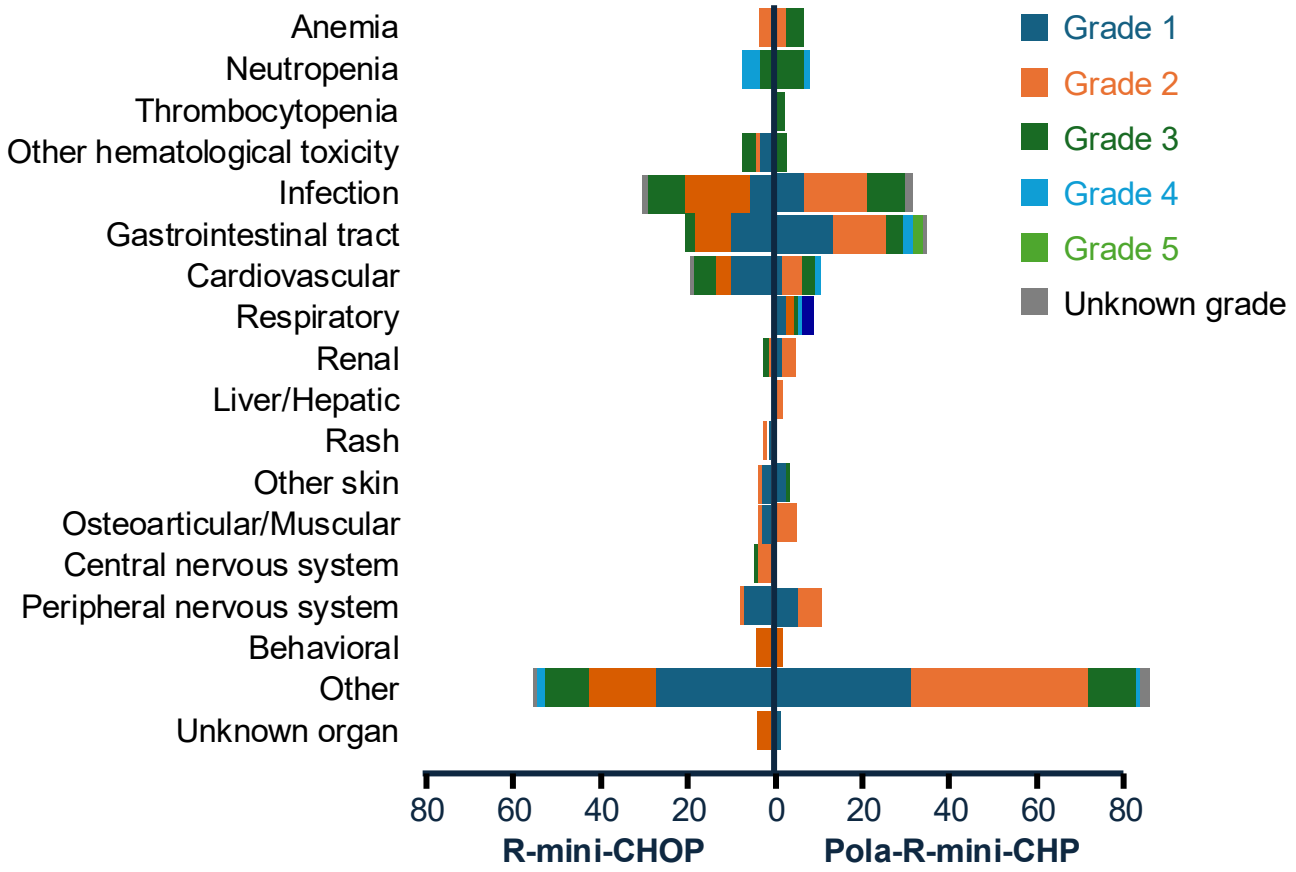
DLBCL, diffuse large B-cell lymphoma; ECOG PS, Eastern Cooperative Oncology Group performance status; PFS, progression-free survival; Pola, polatuzumab vedotin; Q21D, every 21 days; R, randomized; R-mini-CHP, rituximab, cyclophosphamide, doxorubicin, prednisone; R-mini-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone.

Jerkeman. *Hemasphere*. 2023;7(Suppl):e91359ec.

POLAR BEAR: Pola+R-mini-CHOP in Elderly People With DLBCL

No Increased Toxicity Signal

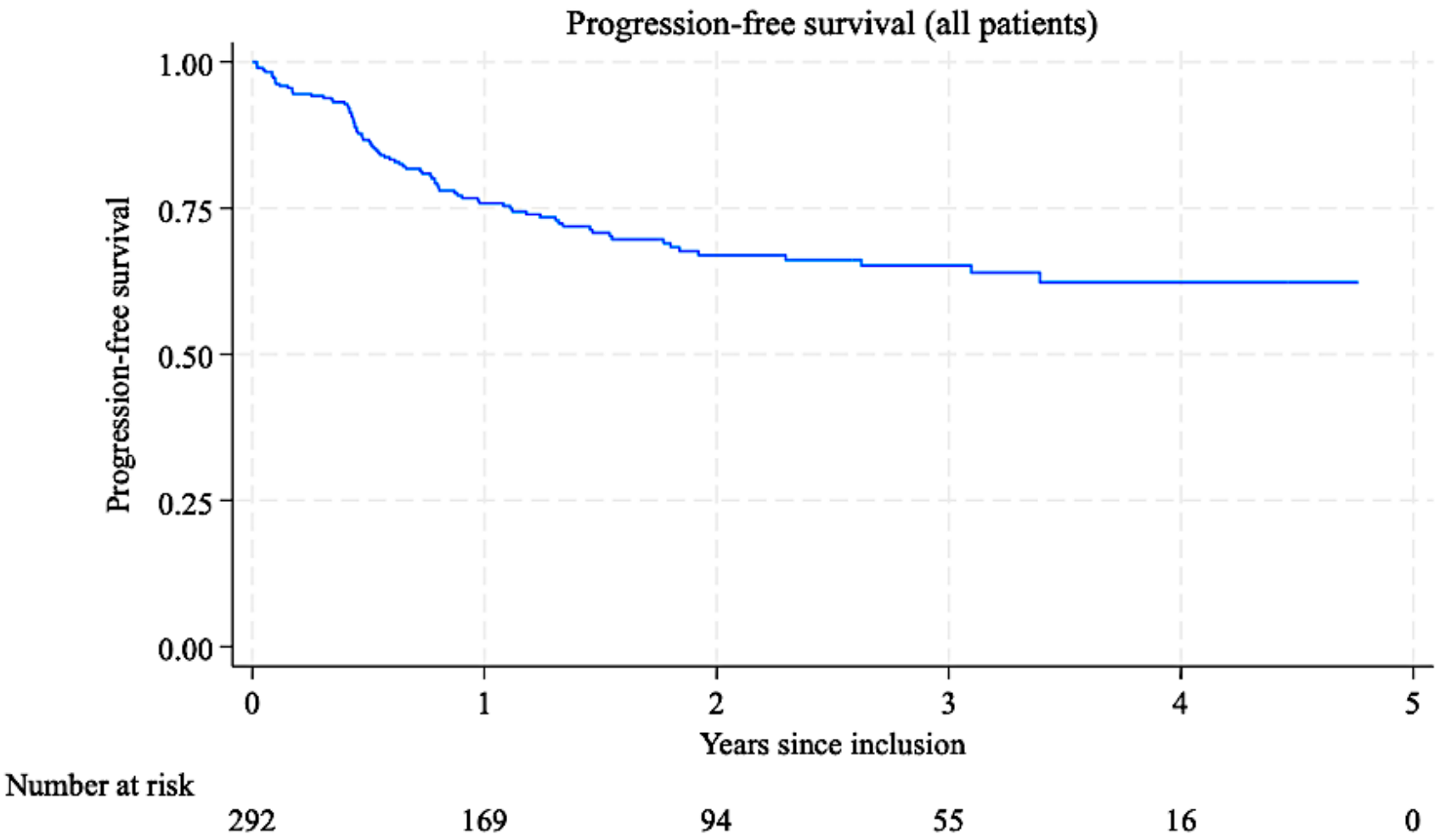
- No difference in terms of grade 3–4 hematological toxicity between treatment groups
- Gastrointestinal toxicity > grade 1 occurred twice as frequently in the R-pola-miniCHP polatuzumab group than in recipients of standard R-miniCHP
- Relevant clinical consideration for select patients



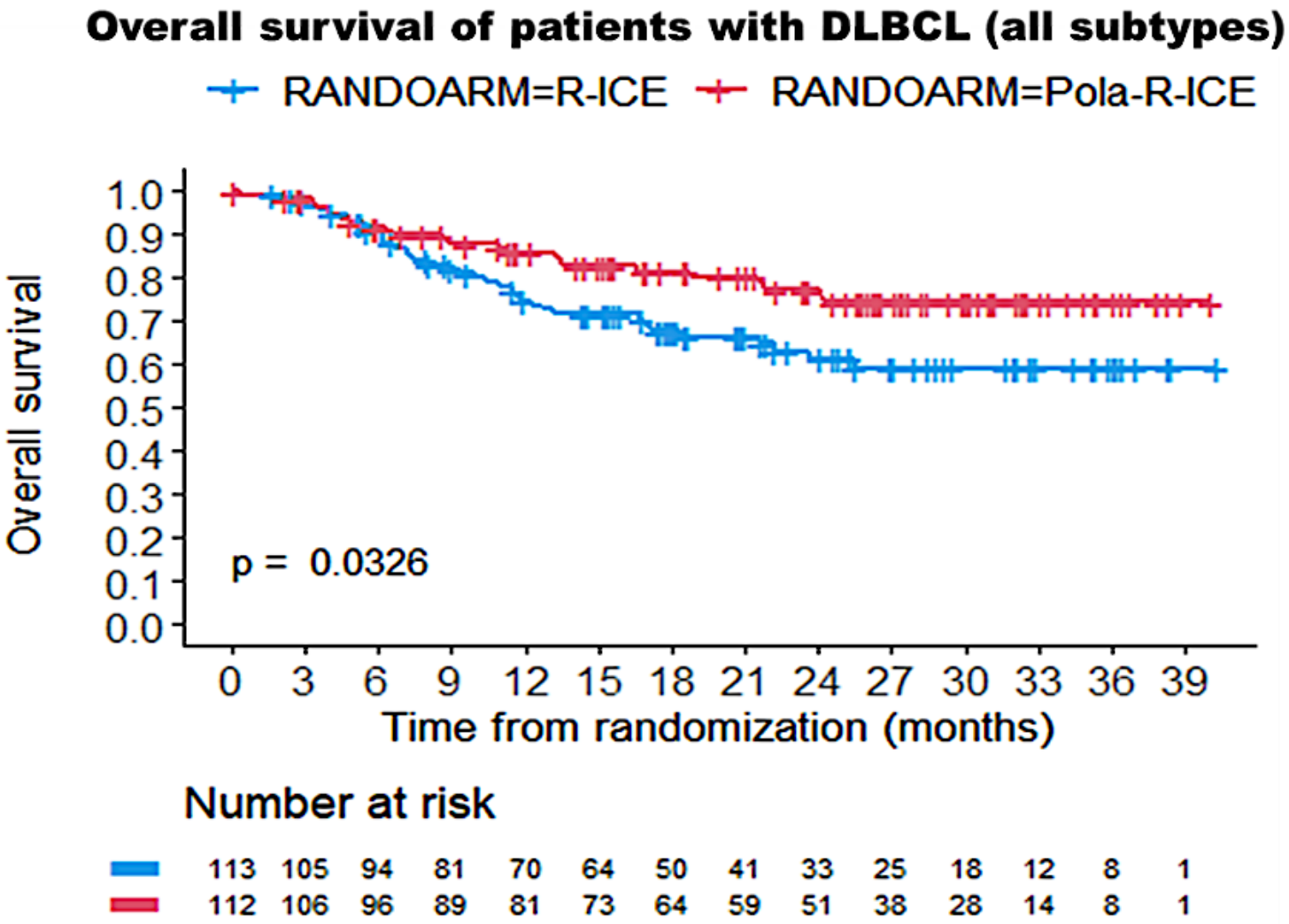
Pola-R-mini-CHP, polatuzumab vedotin, rituximab, cyclophosphamide, doxorubicin, prednisone; R-mini-CHOP, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone.

Jerkeman. *Hemasphere*. 2023;7(Suppl):e91359ec.

POLAR BEAR


Progression-free survival (all patients)
Progression-free survival
1.00
0.75
0.50
0.25
0.00
0
1
2
3
4
5
Years since inclusion
Number at risk
292
169
94
55
16
0

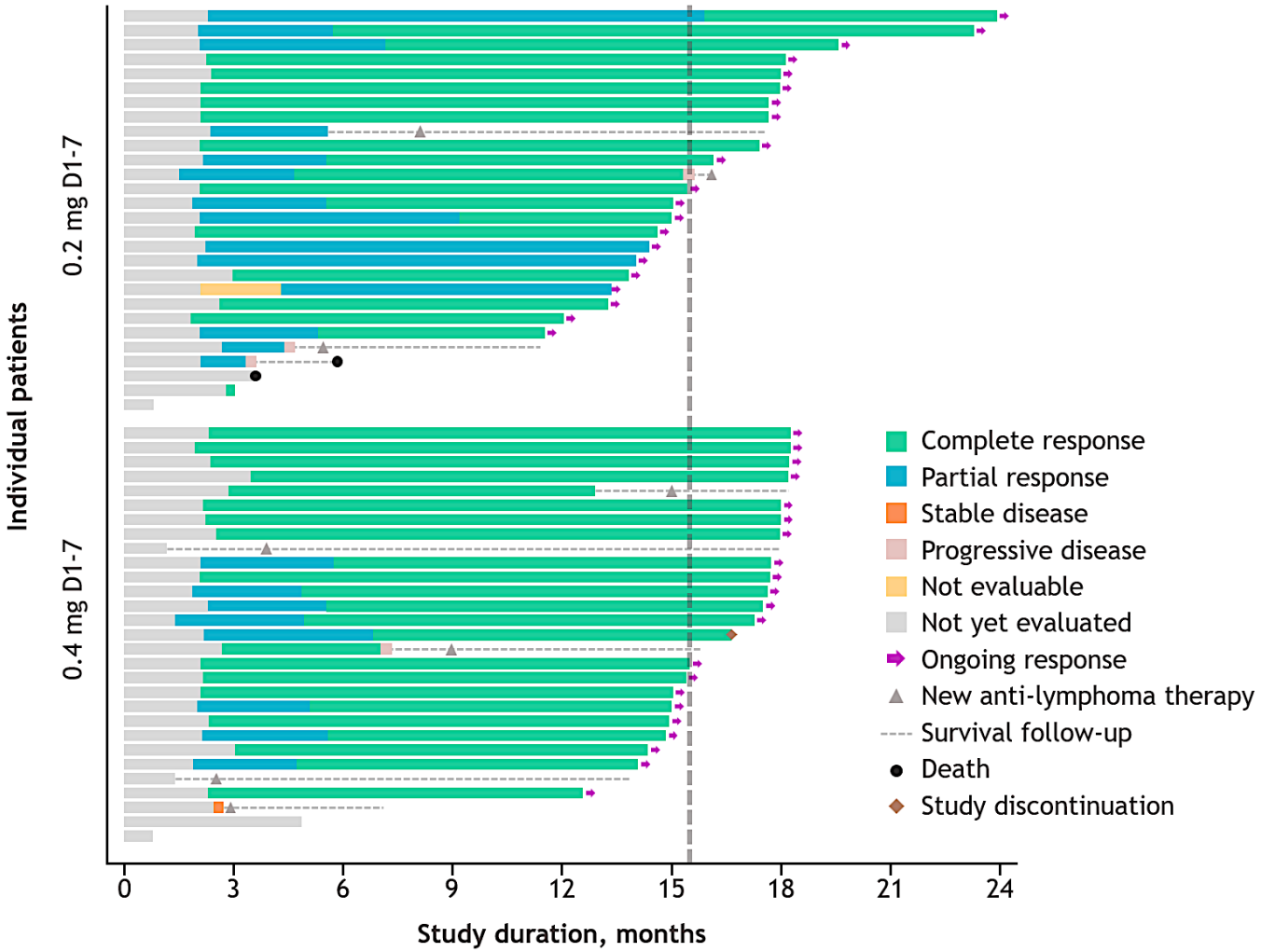
Pola-RICE vs. RICE in R/R DLBCL



Glass B. et al. EHA 2026; Abstract S237

Golca+PolaRCHP in newly diagnosed DLBCL

Figure. Treatment duration and response (safety population)



Bouzani M. et al. EHA 2026;Abstract S239

Year in Review:
Novel Treatment Approaches for Non-Hodgkin Lymphoma

INTRODUCTION: Lymphoma Survivorship

MODULE 1: Novel Treatment Approaches for Diffuse Large B-Cell Lymphoma — Dr Matasar

MODULE 2: Novel Treatment Approaches for Follicular Lymphoma and Mantle Cell Lymphoma — Dr Smith

RTP Year in Review 2026

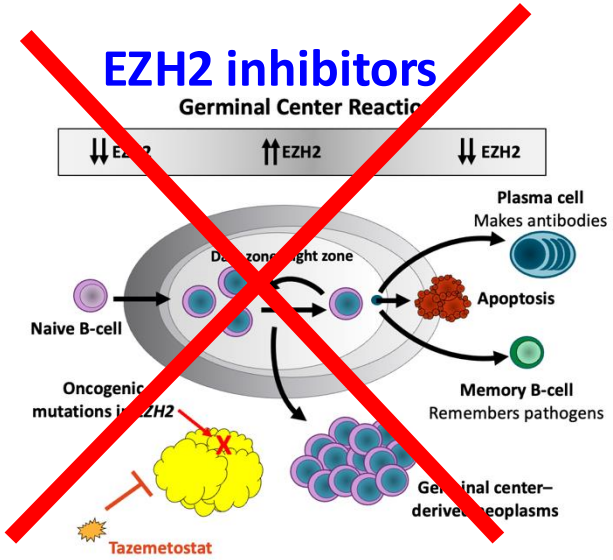
RTP Lymphoma YIR 2026: FL and MCL

Sonali M Smith, MD
Elwood V Jensen Professor of Medicine
Chief, Section of Hematology/Oncology
Co-Leader, Cancer Service Line
The University of Chicago
Chicago, Illinois

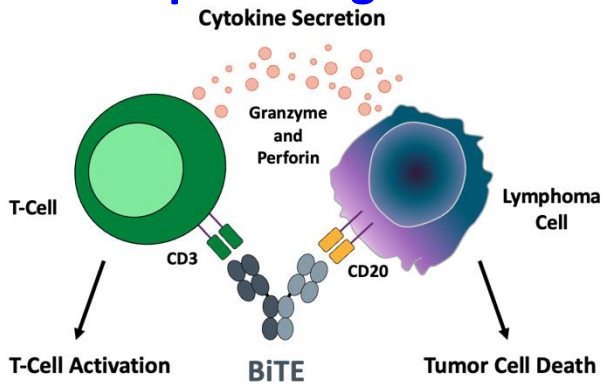
FOLLICULAR LYMPHOMA

NOVEL APPROACHES FOR R/R FL: (approved and unapproved)

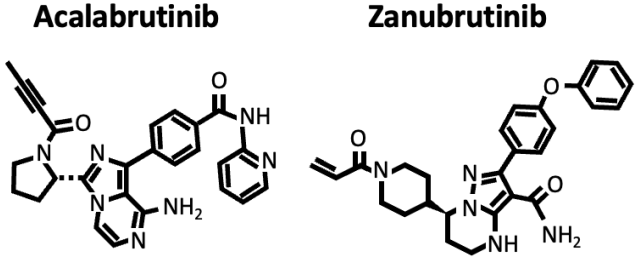
EZH2 inhibitors

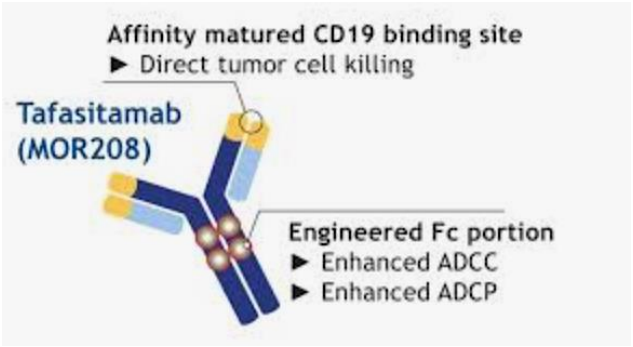


Bispecific agents

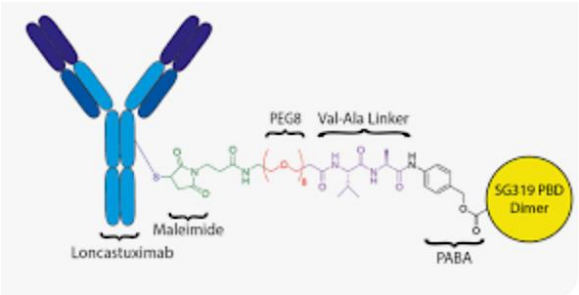


BTK inhibitors

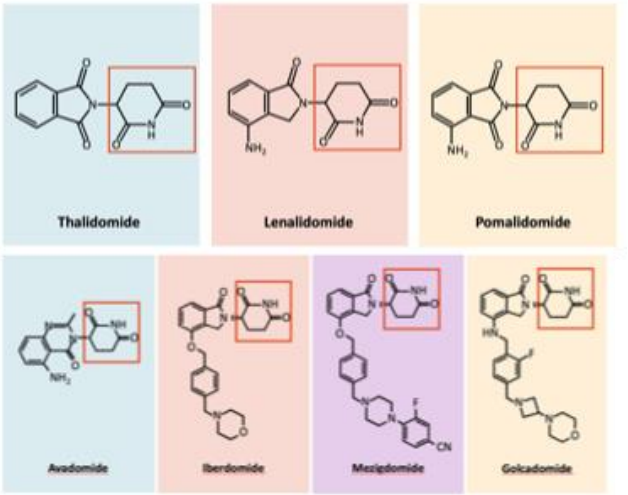




antiCD19 moAb



antiCD19 ADC

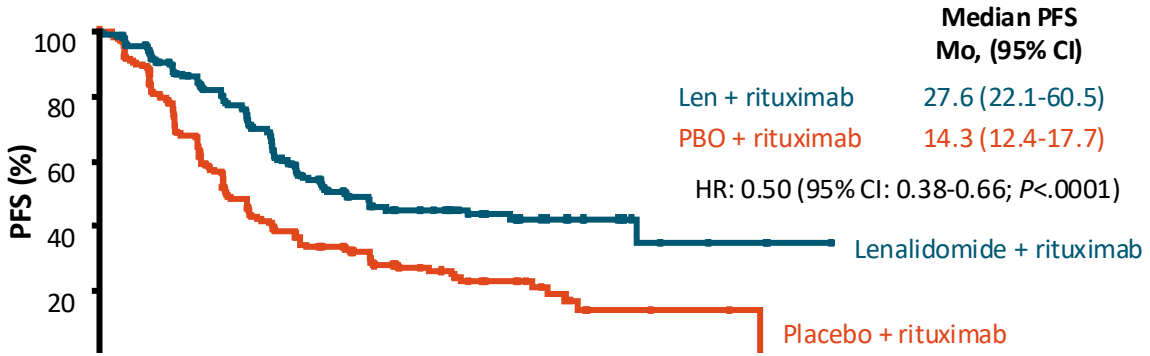


CELMoDs

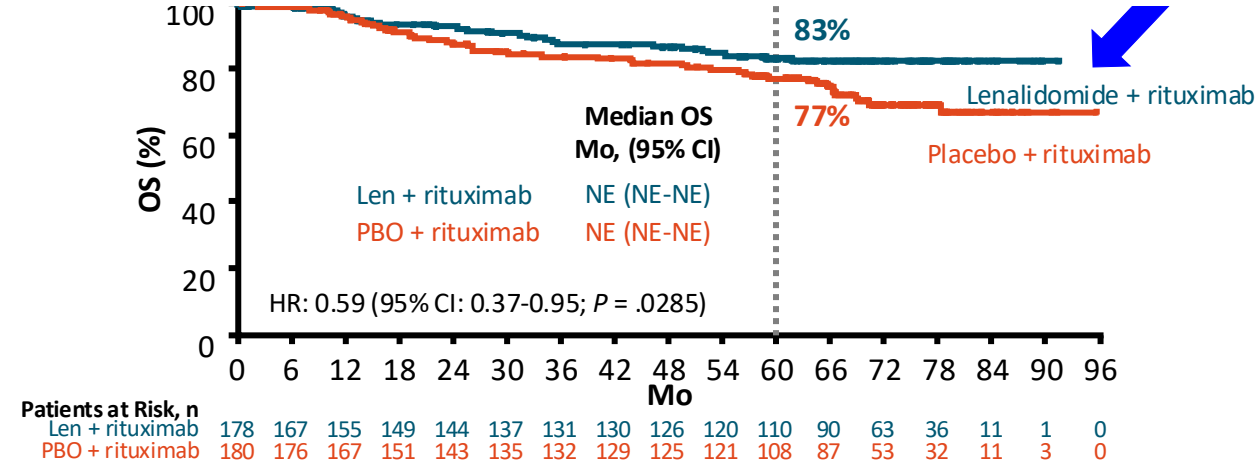
AT THE FOREFRONT
UChicago Medicine

AUGMENT--RP3 of LenR vs PBO-R in relapsed (not refractory) FL: 5-Yr Survival

- Median follow-up: 65.9 mo



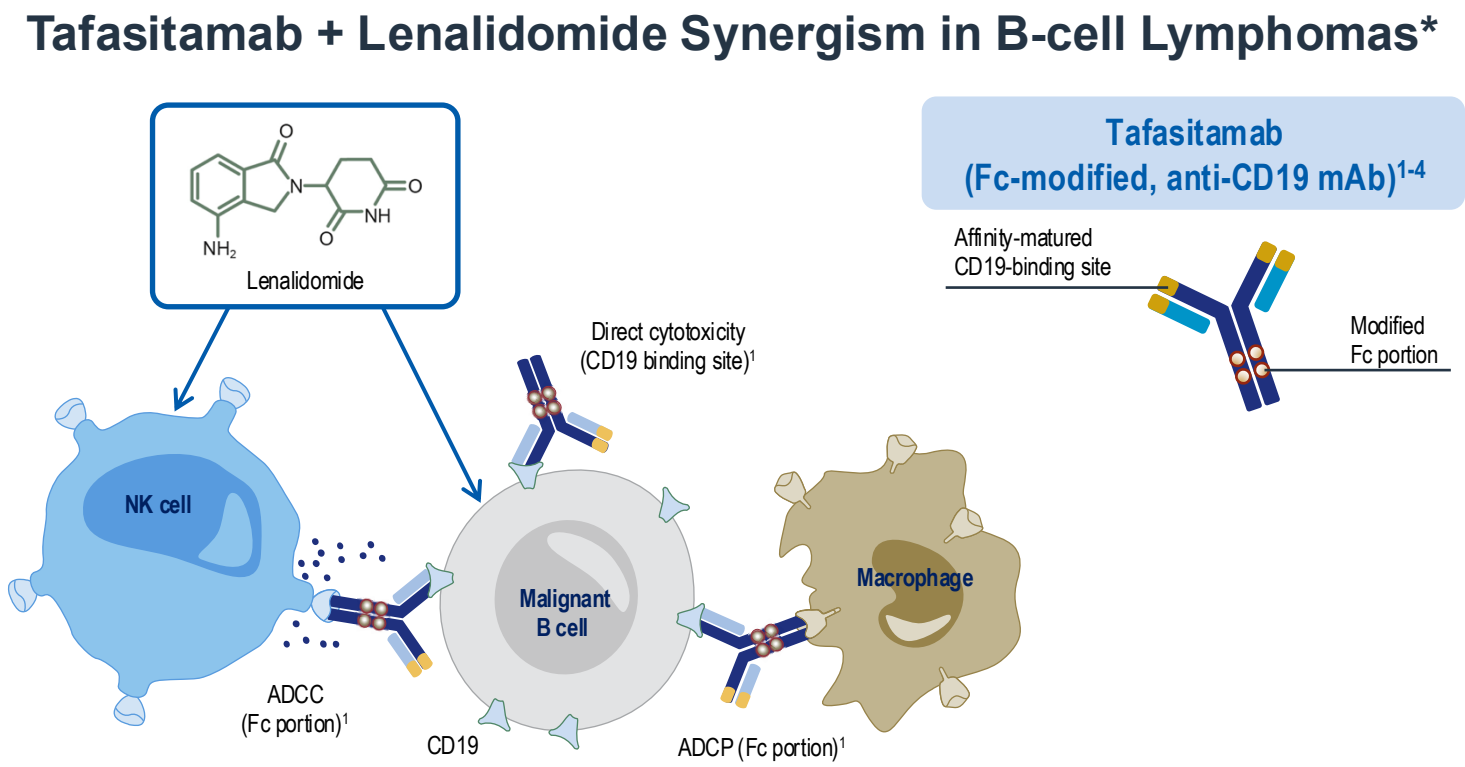
P **Can (and should) LenR be a backbone for future drug development?**



Leonard. ASH 2022. Abstr 230.

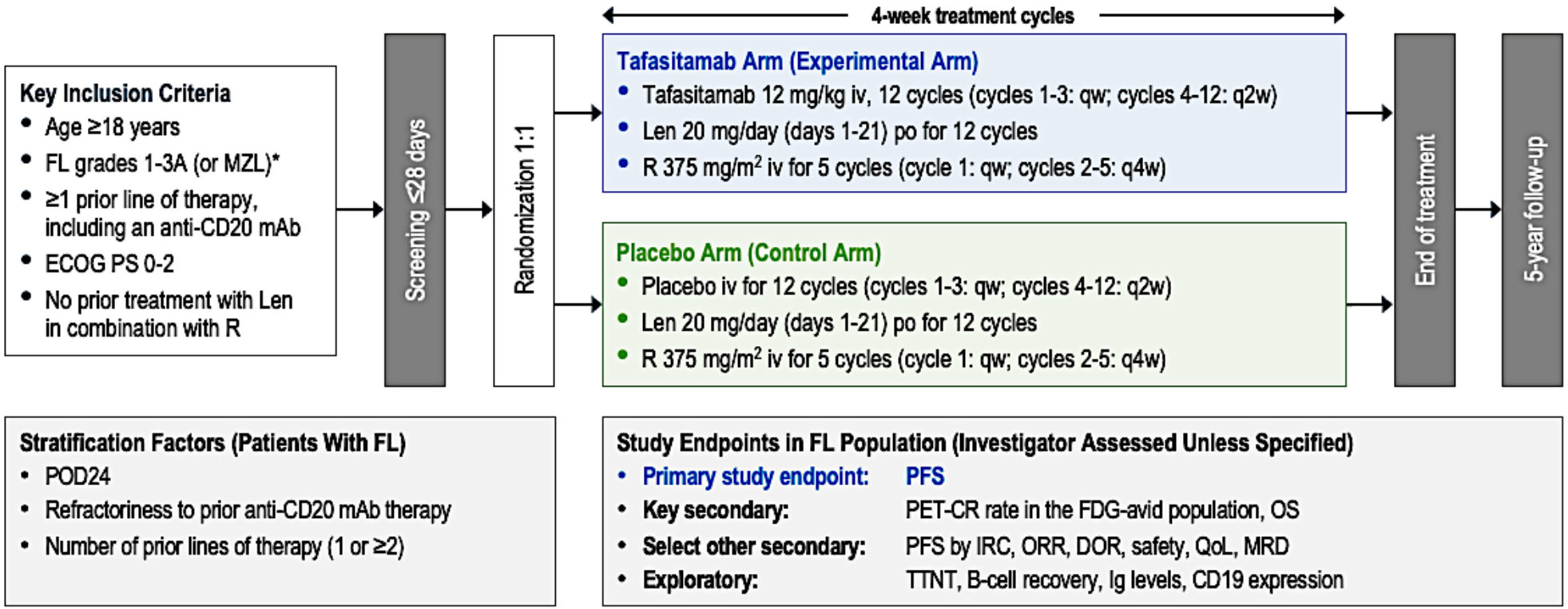
Background: Tafasitamab

- Tafasitamab targets CD19 on malignant B cells
- The engineered Fc region increases affinity to immune effector cells
- Lenalidomide expands and activates effector cell activation and increases ADCC, ACDP, and direct cell death caused by tafasitamab



Sehn LH et al. Tafasitamab, lenalidomide, and rituximab in relapsed or refractory follicular lymphoma (inMIND): A global, phase 3, randomised controlled trial. Lancet 2026;407(10524):133-46.

inMIND: RP3 Double-Blind, Placebo-Controlled, International, Multicenter Study of LenR +/- tafasitamab

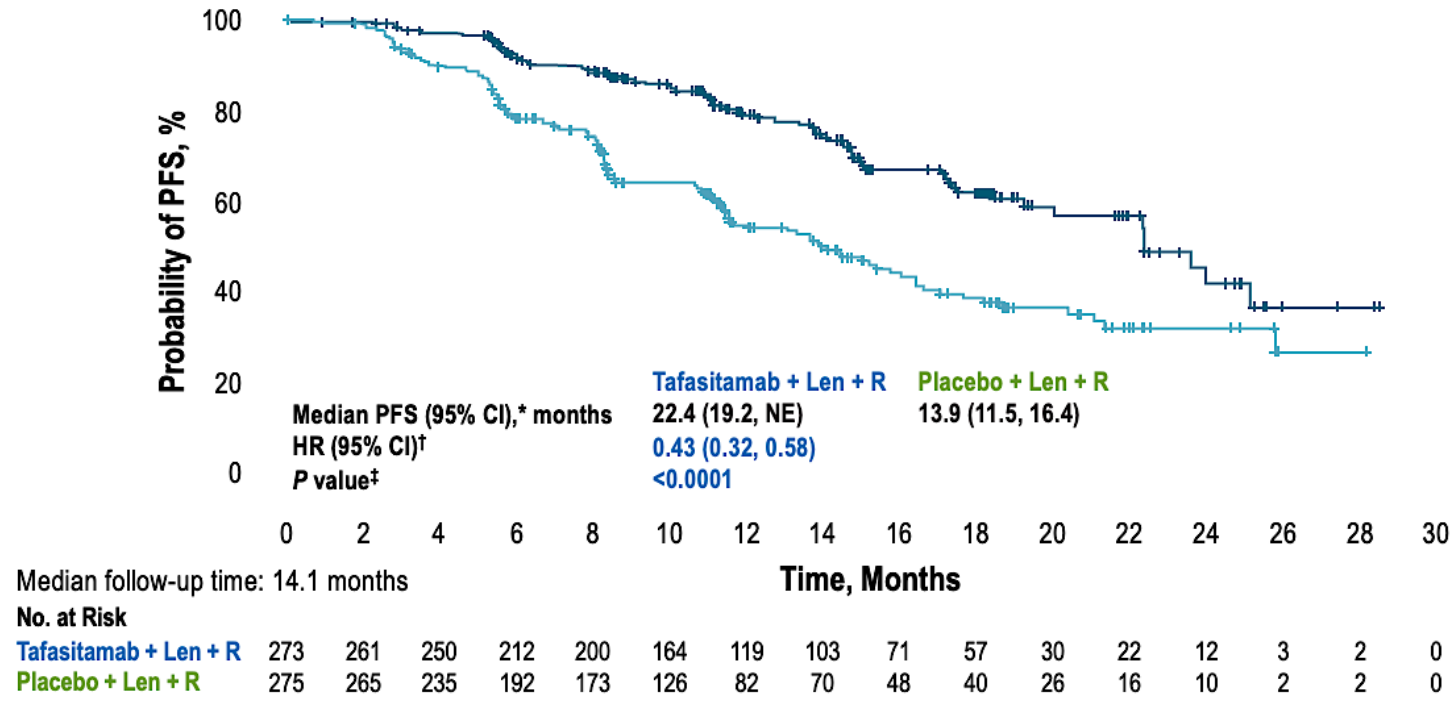


- Powered to assess PFS in the FL population, triggered when 174 investigator-assessed events occurred
- OS analysis planned after 5 years of follow-up

AT THE FOREFRONT
UChicago Medicine

Primary endpoint:
PFS

Primary Endpoint: PFS by Investigator Assessment



Key Results:

Med PFS 22.4m vs 13.9m

2L: 24m v 16m

3L+: 22.4m v 11.5m

Works in all subgroups

Improved PET-CR (49.4% v 39.8%) and ORR rates with tafa

AT THE FOREFRONT
UChicago Medicine

Sehn LH et al. Lancet 2026;407(10524):133-46.

InMIND: Response (ORR, PET response) and Toxicity

	Tafasitamab plus lenalidomide plus rituximab	Placebo plus lenalidomide plus rituximab
Overall response rate (intention-to-treat population)		
Patients	273	275
Best response*		
Complete response	124 (45%)	94 (34%)
Partial response	104 (38%)	105 (38%)
Stable disease	28 (10%)	46 (17%)
Progressive disease	7 (3%)	20 (7%)
Not evaluable	2 (1%)	0
Not done	8 (3%)	10 (4%)
Complete response (radiographic)†	141 (52%)	110 (40%)
Overall response rate‡, % (95% CI)§	84% (78·6–87·7)	72% (66·7–77·6)
Odds ratio¶|| (95% CI)§	2·0 (1·30–3·02)	..
Nominal p value||	0·0014	..

	Tafasitamab plus lenalidomide plus rituximab	Placebo plus lenalidomide plus rituximab
PET-CR (FDG-avid population)		
Patients with FDG-avid positive PET scan at baseline	251	254
Patients with post-baseline PET assessments**	201/251 (80%)	205/254 (81%)
Best metabolic response based on PET		
Complete metabolic response (PET-CR)	124 (49%)	101 (40%)
Partial metabolic response	37 (15%)	39 (15%)
No metabolic response/stable disease	19 (8%)	12 (5%)
Progressive metabolic disease	19 (8%)	51 (20%)
PET after confirmed progressive disease or new anti-lymphoma treatment initiation	2 (1%)	2 (1%)
Not done	50 (20%)	49 (19%)
PET-CR††, % (95% CI)§	49% (43·1–55·8)	40% (33·7–46·1)
Odds ratio¶|| (95% CI)§	1·5 (1·04–2·13)	..
p value||	0·029	..

Most common toxicities: cytopenias, infection
Slight increase in tafa arm but no significant difference between the groups

AT THE FOREFRONT
UChicago Medicine

Sehn LH et al. Lancet 2026;407(10524):133-46.

InMIND: Take home points

- **Improved PFS, DoR, TTNT for Tafa-LenR**
- **Activity in relapsed *and* refractory FL, including high-risk subsets**
- **Fixed-duration therapy**
- **Manageable toxicity profile**
- **NOTE:** 23/24 post-treatment lymphoma samples retained CD19 expression

A new standard of care for relapsed/refractory FL

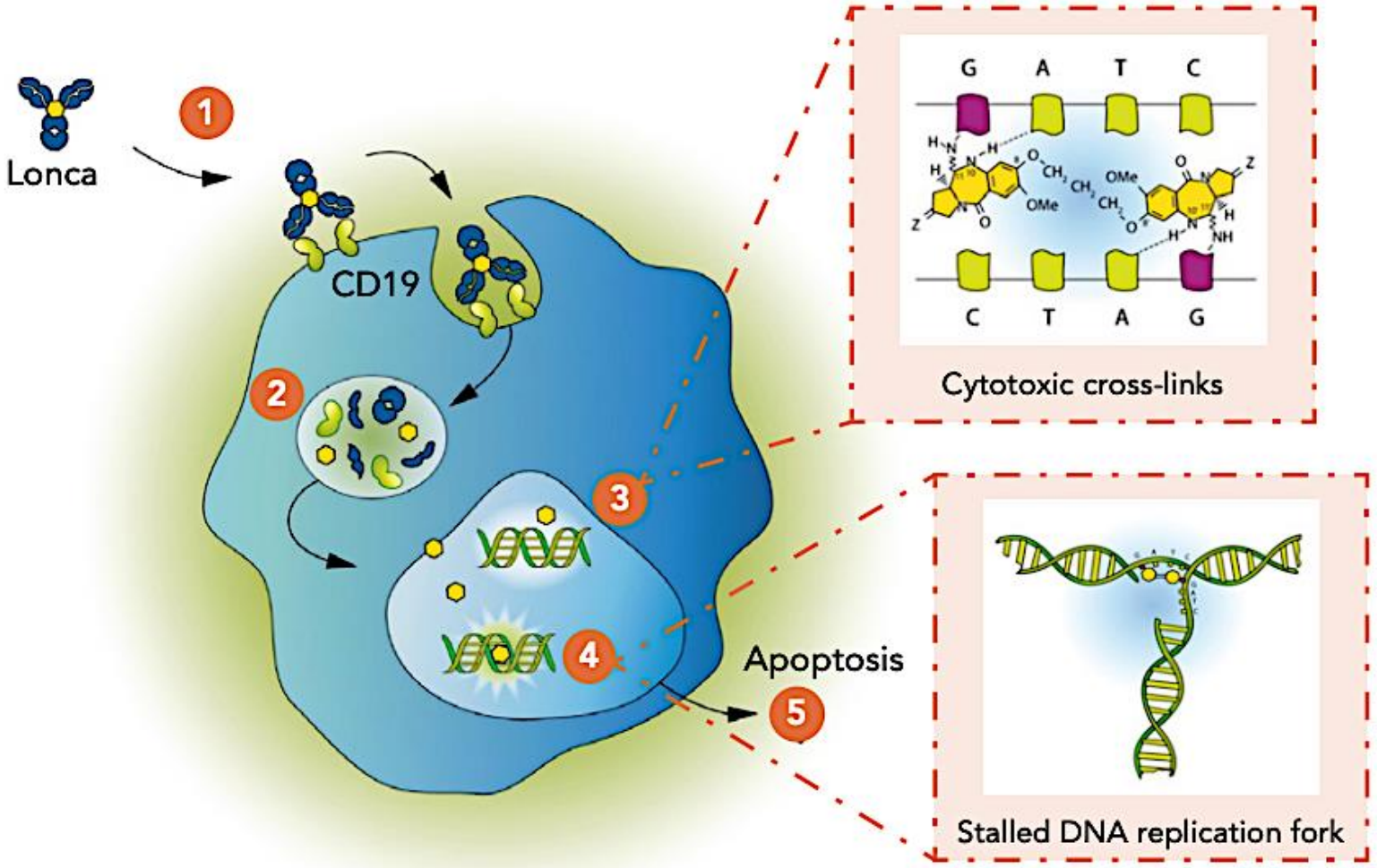
Zinzani PL et al. Final analysis of the randomized phase 2 ROSEWOOD study of zanubrutinib + obinutuzumab vs obinutuzumab monotherapy in patients with relapsed/refractory follicular lymphoma. ASH 2025;Abstract 227.

ROSEWOOD: Take home points

- Another option for RR FL
- Addition of Zanubrutinib to obinutuzumab improved ORR, CR, PFS, DOR
- Similar and manageable safety profile without new signals
- MAHOGANY study: RP3 of ZO vs LenR ongoing

Alderuccio JP et al. Loncastuximab tesirine with rituximab in patients with R/R FL: A single-centre, single-arm, Phase II trial. Lancet Haematol 2025;12(1):e23-e34.

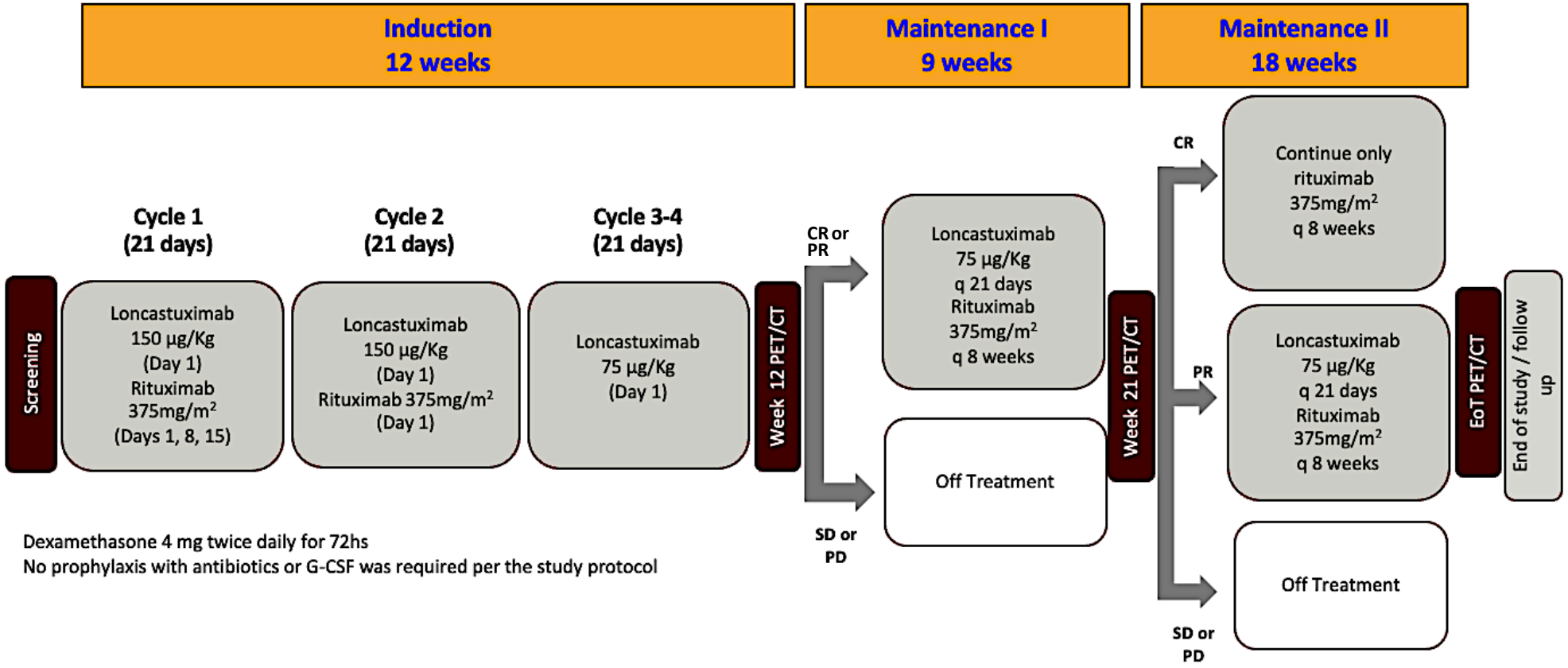
Loncastuximab tesirine is an ADC against CD19 with a PBD dimer payload



AT THE FOREFRONT
UChicago Medicine

Calabretta Blood Volume 140, Issue 4, 28 July 2022, Pages 303-308

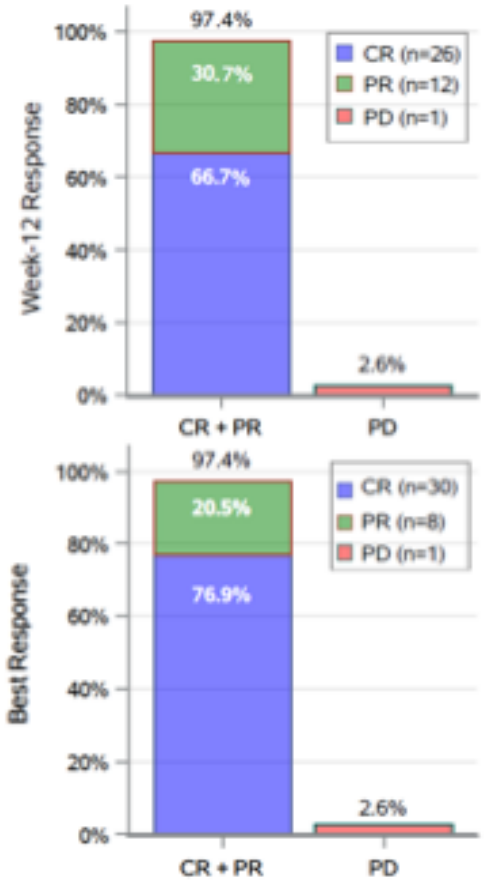
U Miami: Loncastuximab tesirine plus rituximab: single arm, single center phase 2 study in RR FL

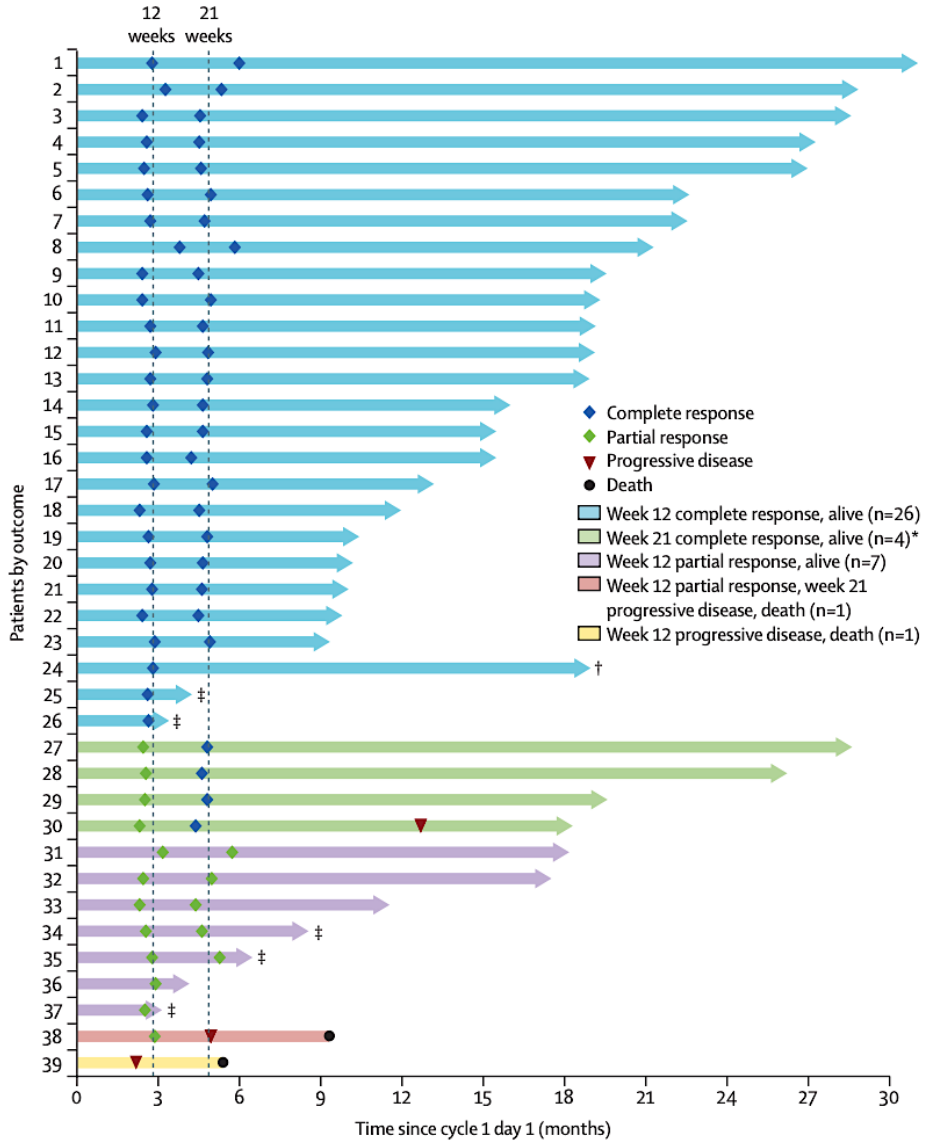


AT THE FOREFRONT
UChicago Medicine

Alderuccio ASH 2024, abstract 337

Loncastuximab plus rituximab in RR FL: Results





Toxicity:
Cytopenias
Generalized edema

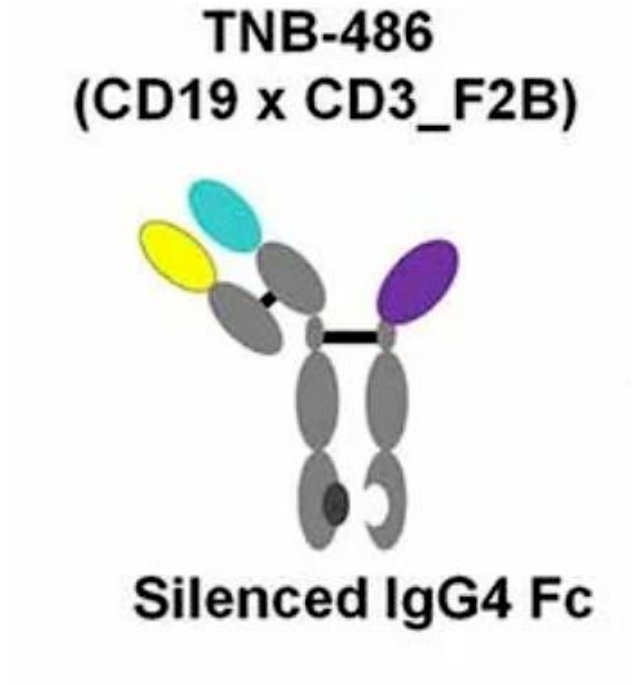
*(***elderly DLBCL data from LOTIS-5***)*

SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HEALTH SYSTEM

Alderuccio ASH 2024, abstract 337; Alderuccio Lancet Haematology 2025 Jan;12(1):e23-e34

Hou J-Z et al. Three-year follow-up of the Phase 1 first-in-human study investigating surovatamig, a novel CD19xCD3 T-cell engager, in patients with relapsed/refractory (R/R) follicular lymphoma (FL). ASH 2025; Abstract 1005.

Surovatamig (TNB-486, AZD0486) CD19xCD3 bispecific antibody



TNB-486 is a fully human bispecific antibody engaging CD19 and CD3 (a) TNB-486 was constructed using knobs-into-holes technology.

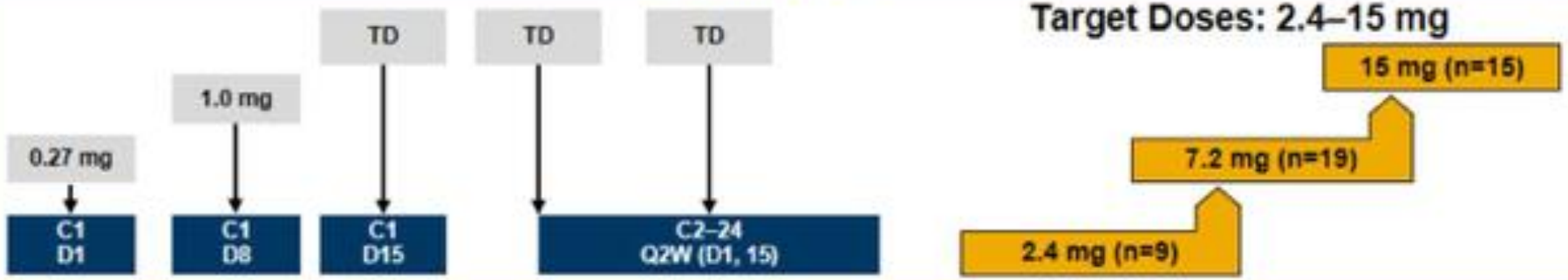
AT THE FOREFRONT
UChicago Medicine

Malik-Chaudhry HK et al. MAbs. 2021 Jan-Dec;13(1):1890411.

Surovatamig Phase 1 Study Design

Dosing Regimen

Double SUD



Surovatamig Treatment

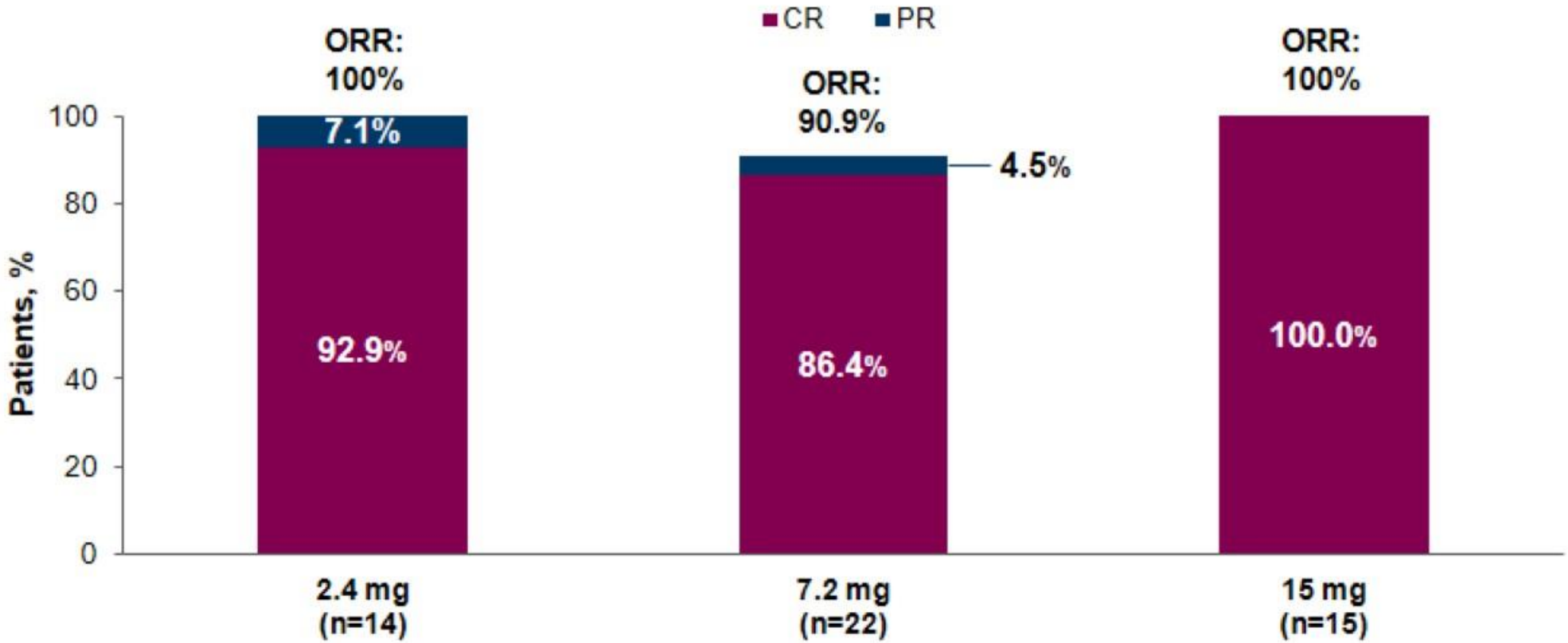
- Surovatamig is administered intravenously in fixed-dose escalation, 1SUD, or 2SUD[a]
- Treatment is delivered in 28-day cycles up to 2 years
  - Cycle 1 doses were inpatient
- Patients with CR on 2 consecutive scans may receive surovatamig every 4 weeks after C6
- Premedication with dexamethasone included two 10-mg doses prior to cycle 1 surovatamig doses

NCT04594642; data cutoff: 19 May 2025

[a] Fixed-dose escalation (n=6), 1SUD (n=12), 2SUD (n=43)

AT THE FOREFRONT
UChicago Medicine

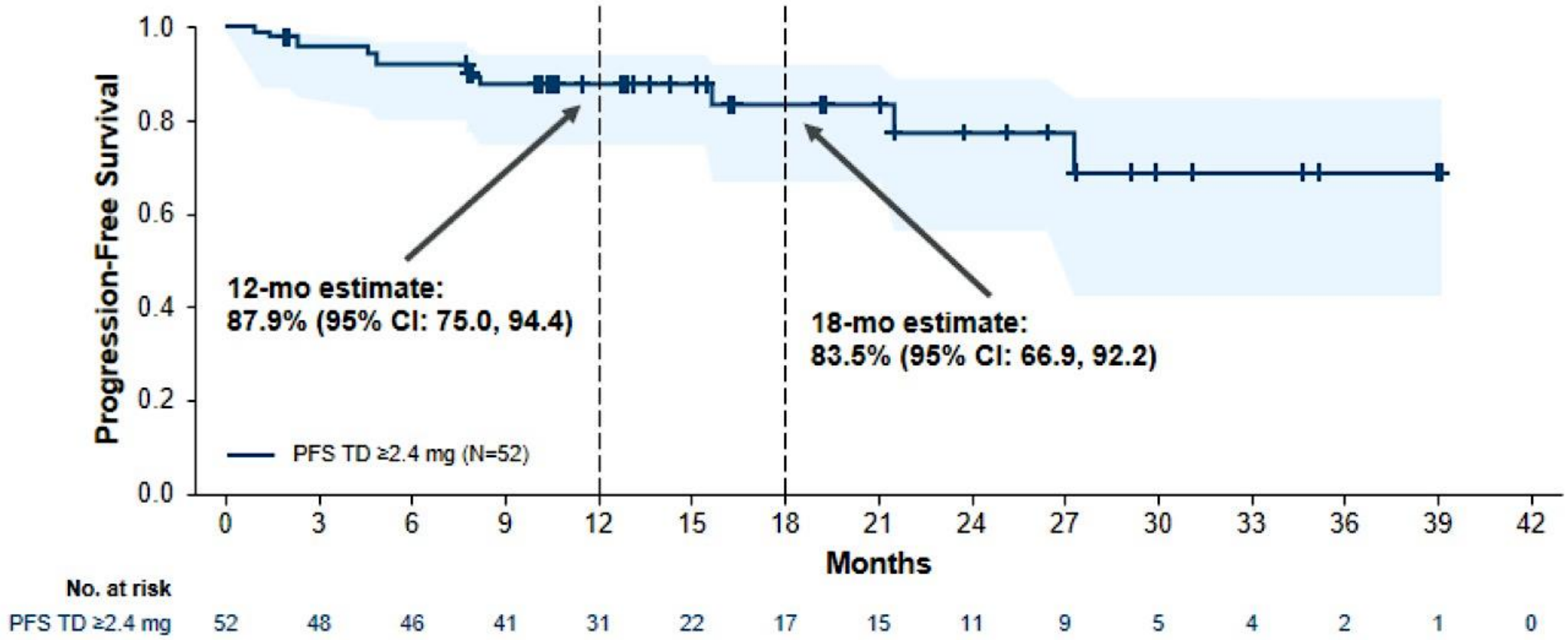
High Response Rates Observed at All TDs ≥2.4 mg



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

Hou J-Z et al. ASH 2025; Abstract 1005.

Median PFS Not Reached for TD ≥2.4 mg

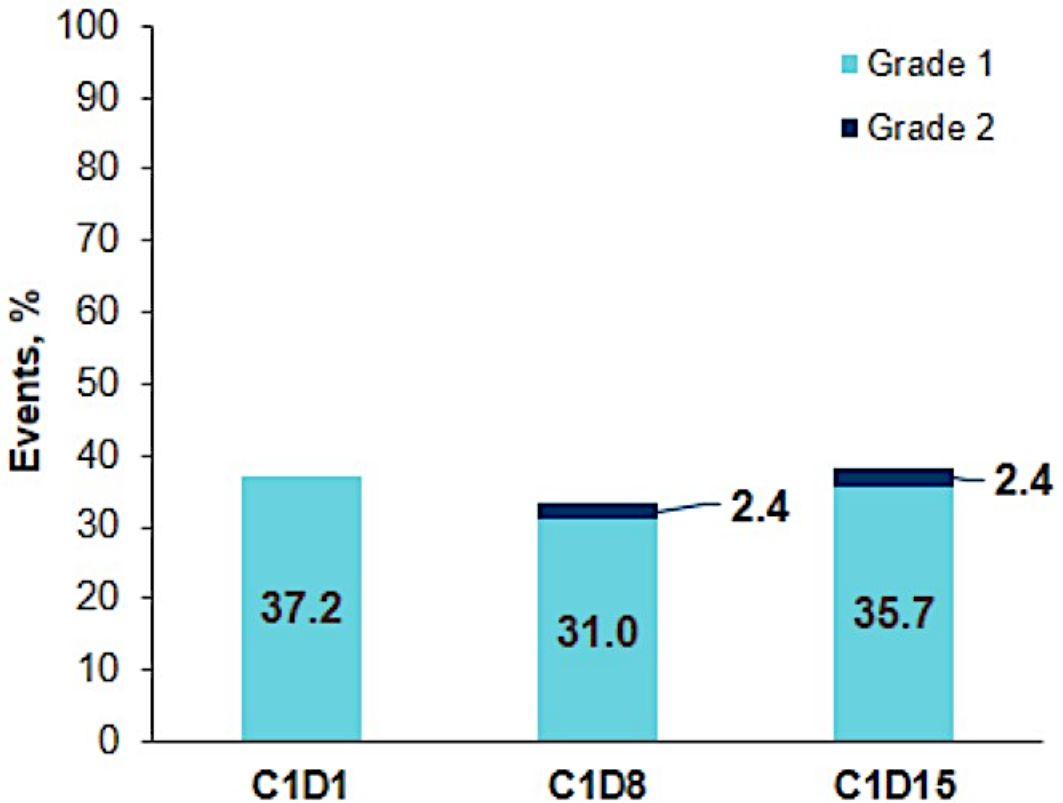


Hou J-Z et al. ASH 2025; Abstract 1005.

Summary of CRS With 2SUD

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

Frequency and grade of CRS events[d]



[a] For each patient, CRS events are counted once at the maximum grade reported
[b] From time of infusion to CRS
[c] Data include doses administered per protocol dose and schedule
[d] No CRS events occurred after cycle 1

EHA 2026: SUROVATAMIG (AZD0486) PLUS RITUXIMAB IN PREVIOUSLY UNTREATED FOLLICULAR LYMPHOMA (FL): INITIAL SAFETY DATA FROM THE PHASE 3 SOUNDTRACK-F1 TRIAL

- 43 pts (DL1=22 and DL2=21)
- Short follow up 6.3m
- ORR 95-100%, CR ~85% and 100% MRD negativity in DL2
- TEAE: grade 1-2 CRS

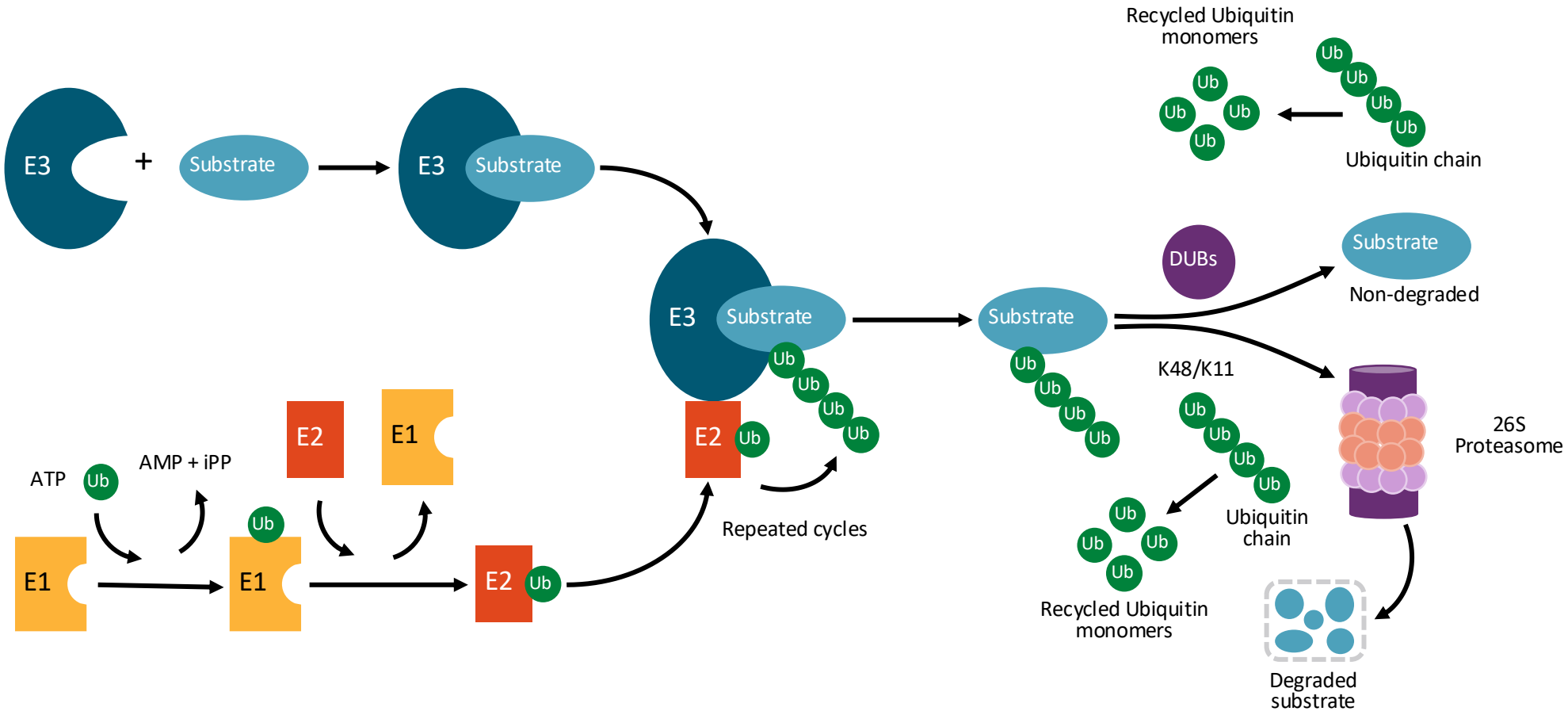
Table:

n (%)	DL1 2.4 mg (n=22)	DL2 7.2 mg (n=21)
Any CRS (any Gr)	8 (36)	8 (38)
CRS at SUD (all Gr 1)	8 (36)	5 (24)
CRS at TD (any Gr)	3 (14)	5 (24)
Gr 1	3 (14)	4 (19)
Gr 2	0	1 (5)
ICANS at SUD (any Gr)	1 (5)	1 (5)
Gr 1	1 (5)	0
Gr 3	0	1 (5)
ICANS at TD (any Gr)	0	0

AT THE FOREFRONT
UChicago Medicine

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.

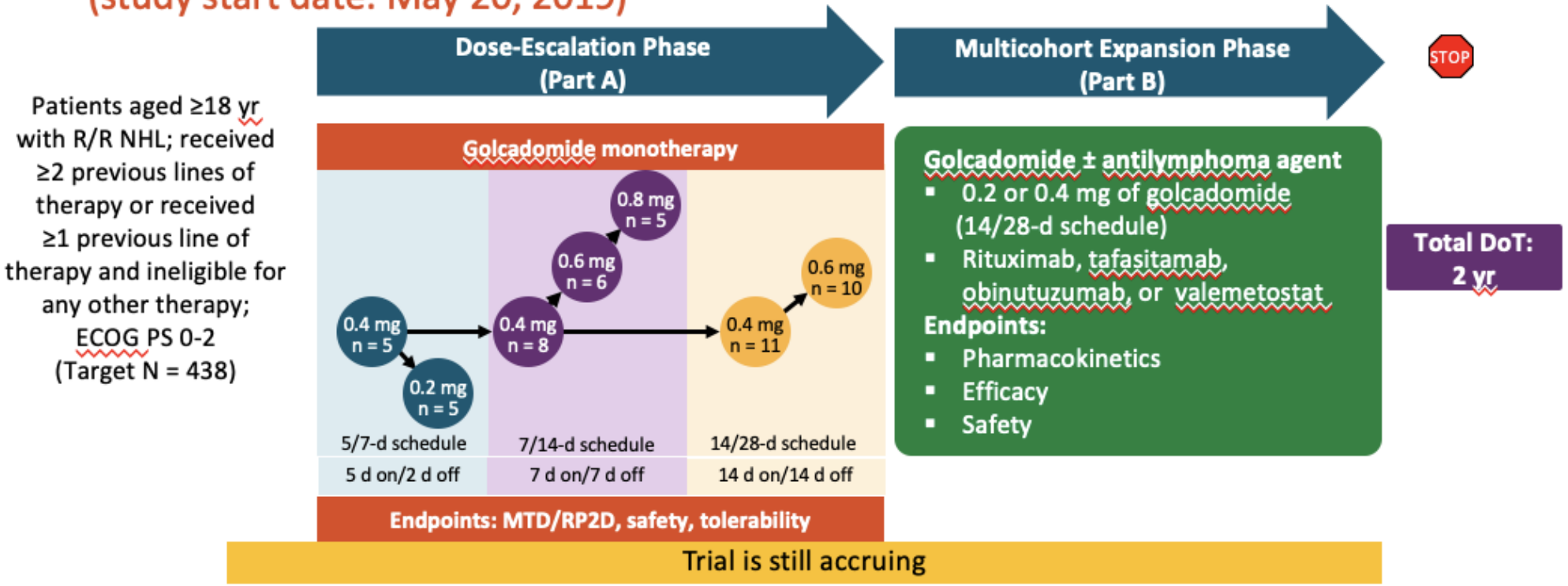
Ubiquitin-Proteasome System (UPS)



Bhat. Curr Opin Pharmacol. 2022;67:102310.

CC-99282-NHL-001: Phase I/II First-in-Human Trial of Golcadomide in R/R NHL

- Nonrandomized multicenter, 2-part, first-in-human, open-label phase I/II trial (study start date: May 20, 2019)

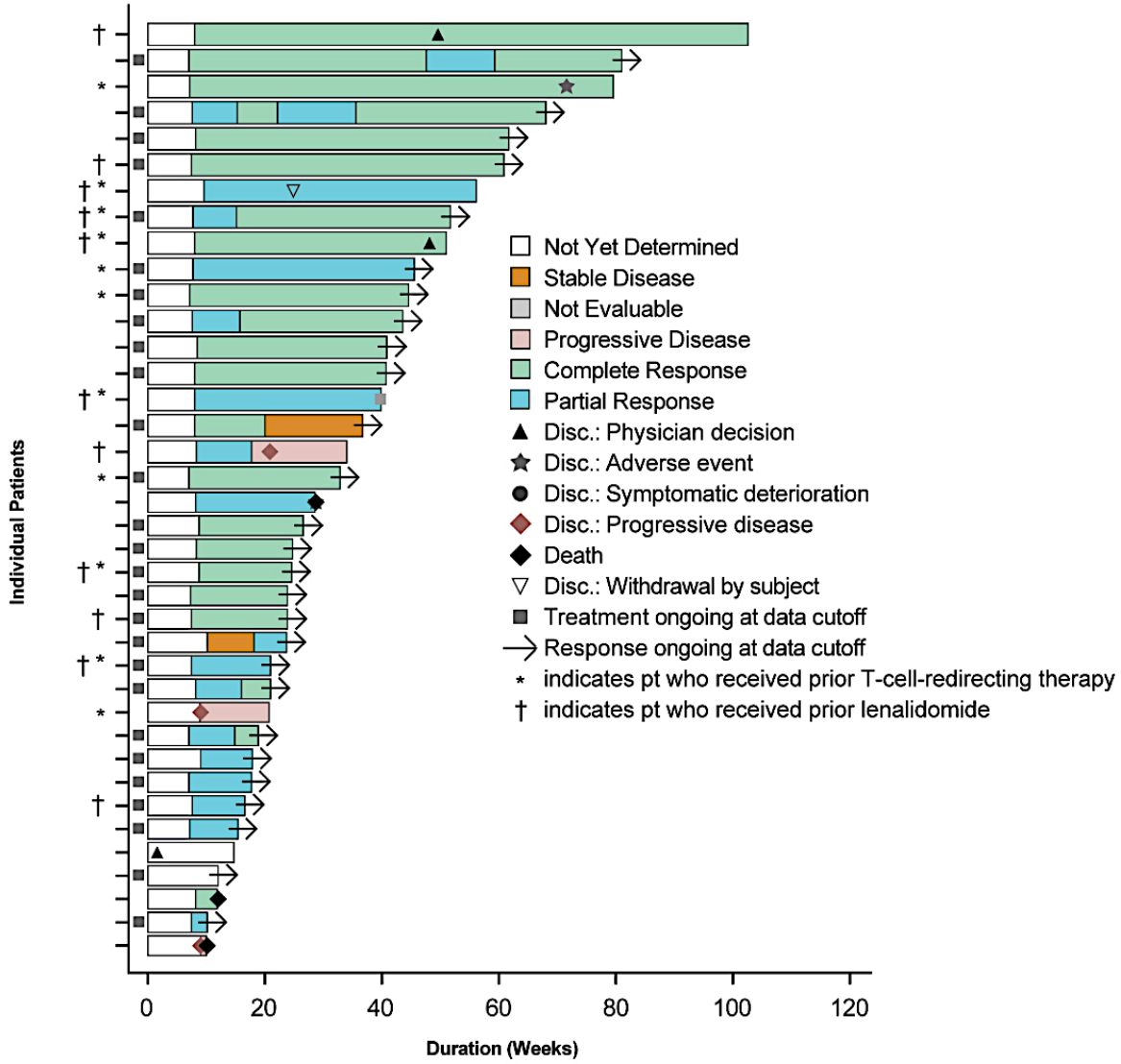


FIXED DURATION (up to 24m)

AT T UChicago Medicine

Golcadomide with or without rituximab R in 2L+ FL: EHA 2025

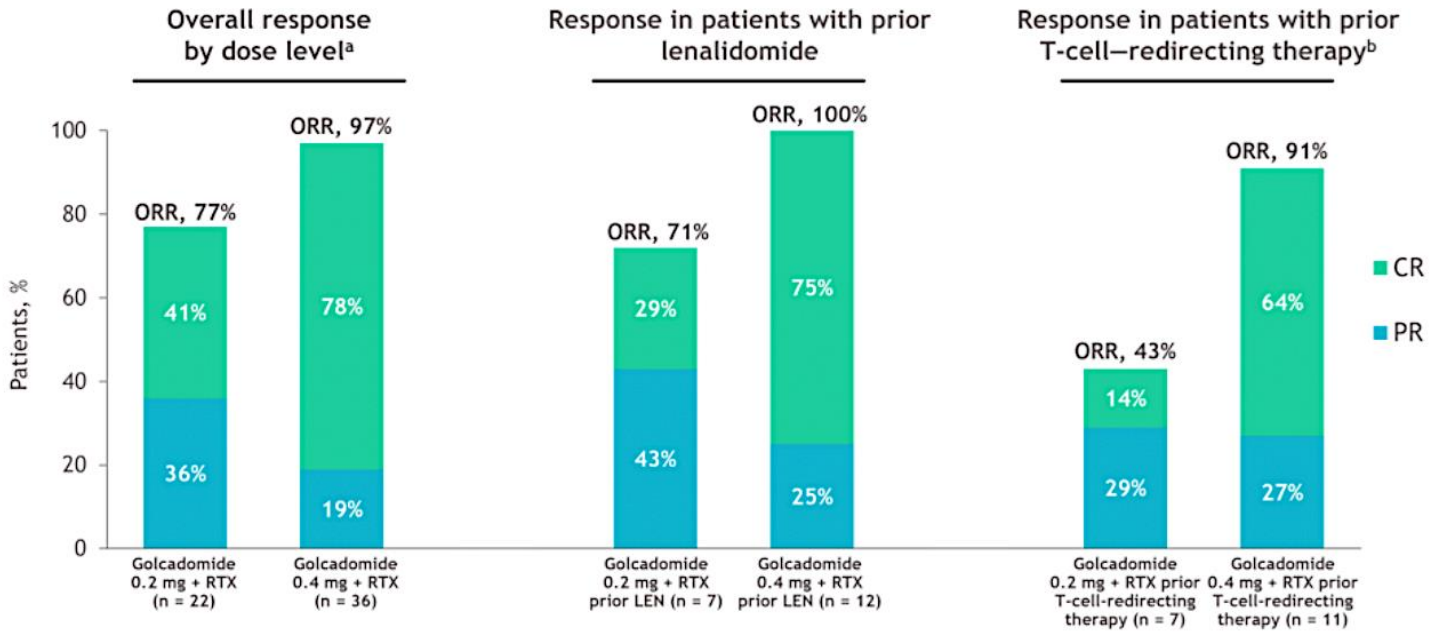
Figure. Duration of response in the GOLCA 0.4mg +R dose group.



Cordoba R et al. EHA 2025;Abstract 441.

Golcadomide EHA 2026 update: RR FL

Fig. Responses (efficacy-evaluable pts)



Data cutoff: 15 September 2025.
[a] Efficacy-evaluable population consisting of patients who completed ≥ 1 cycle of golcadomide (taking ≥ 75% of assigned doses) and having a baseline and ≥ 1 postbaseline tumor assessment.; [b] CAR T and/or bispecific antibody treatment.
CAR, chimeric antigen receptor; CR., complete response; CRR, complete response rate; LEN, lenalidomide; ORR, overall response rate; PR, partial response; RTX, rituximab.

EHA 2026 update: now, n=60

Patient characteristics:

Med prior treatment = 3
~30% prior lenalidomide,
~30% refractory to last regimen

Toxicity: cytopenias

Results:

with med f/u 14m, ORR 77% and CRR 41% in 0.2mg group
ORR 97% and CR 78%

AT THE FOREFRONT
UChicago Medicine

TOXICITY: Neutropenia was most common grade 3/4 TEAE occurring in 59% and 68% of pts at 0.2 and 0.4 mg, followed by anemia (9% and 16%) and febrile neutropenia (9%and 8%).

Golcadomide plus rituximab: author's conclusions

- With longer f/u, GOLCA + R demonstrated promising efficacy with durable responses and no new safety signals.
- 0.4 mg group had higher ORR and CRR than 0.2 mg, including in pts with prior LEN-based and/or T-cell–redirecting Tx, with a manageable safety profile at both doses
- The results support the development of GOLCA + R as a fixed-duration, chemotherapy-free outpatient Tx in the Ph 3 GOLSEEK-4 study in 2L+ FL (NCT06911502)

Overall thoughts about RR FL

- **Increasing number of options**
  - Lenalidomide-rituximab (often used as comparator for new regimens): exciting data with EpcoR2
  - Bispecific agents (CD20xCD3, CD19xCD3)
  - CD19 targeting agents (tafa-len, loncastuximab)
  - BTKi
  - CAR-T
  - CelMods
  - New agents (i.e. degraders) and new means of risk stratification (i.e. MRD)
- **Still no precision or subgroup approaches** –POD24? Transformation risk?
- **Still no data on sequencing**
  - But some regimens have impressive activity in 2L setting—is LenR going to be replaced?

MANTLE CELL LYMPHOMA

Modern Management of Mantle Cell Lymphoma

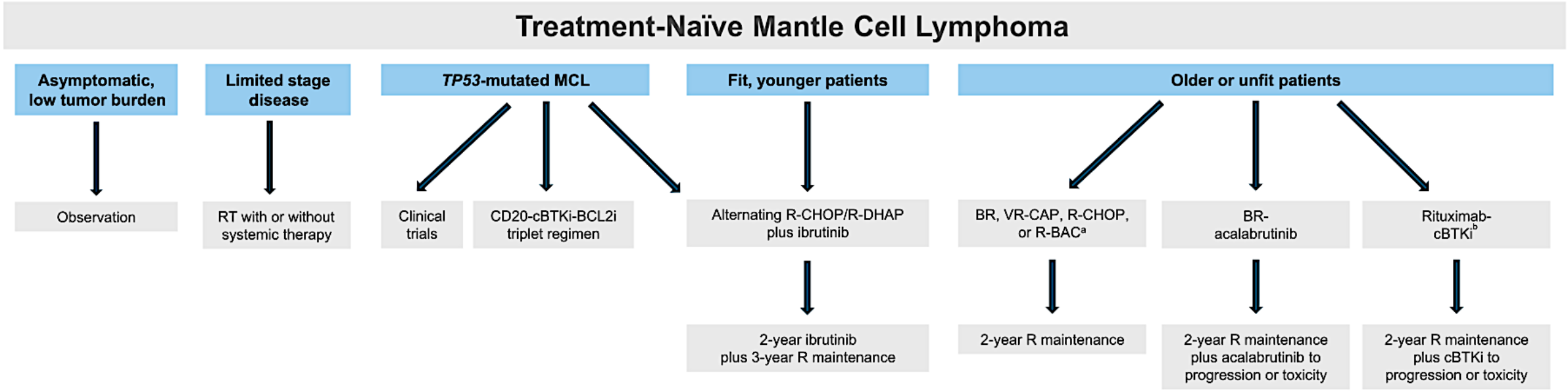


FIG 1. Suggested therapeutic algorithm for treatment-naïve patients with MCL. [a]After R-BAC, no R-maintenance is needed. [b]In low-risk patients, consider MRD-directed time-limited cBTKi therapy. BCL2i, BCL2 inhibitor; BR, bendamustine-rituximab; cBTKi, covalent Bruton tyrosine kinase inhibitor; CHOP, cyclophosphamide, doxorubicin, vincristine, prednisone; DHAP, dexamethasone, high-dose cytarabine, cisplatin; MCL, mantle cell lymphoma; MRD, minimal residual disease; R, rituximab; RT, radiotherapy; VR-CAP, bortezomib, rituximab, cyclophosphamide, doxorubicin, prednisone.

Consideration of age/fitness
Three major RF's for high-risk disease:
Ki67 > 30%, blastoid morphology, p53 mutation

AT THE FOREFRONT
UChicago Medicine

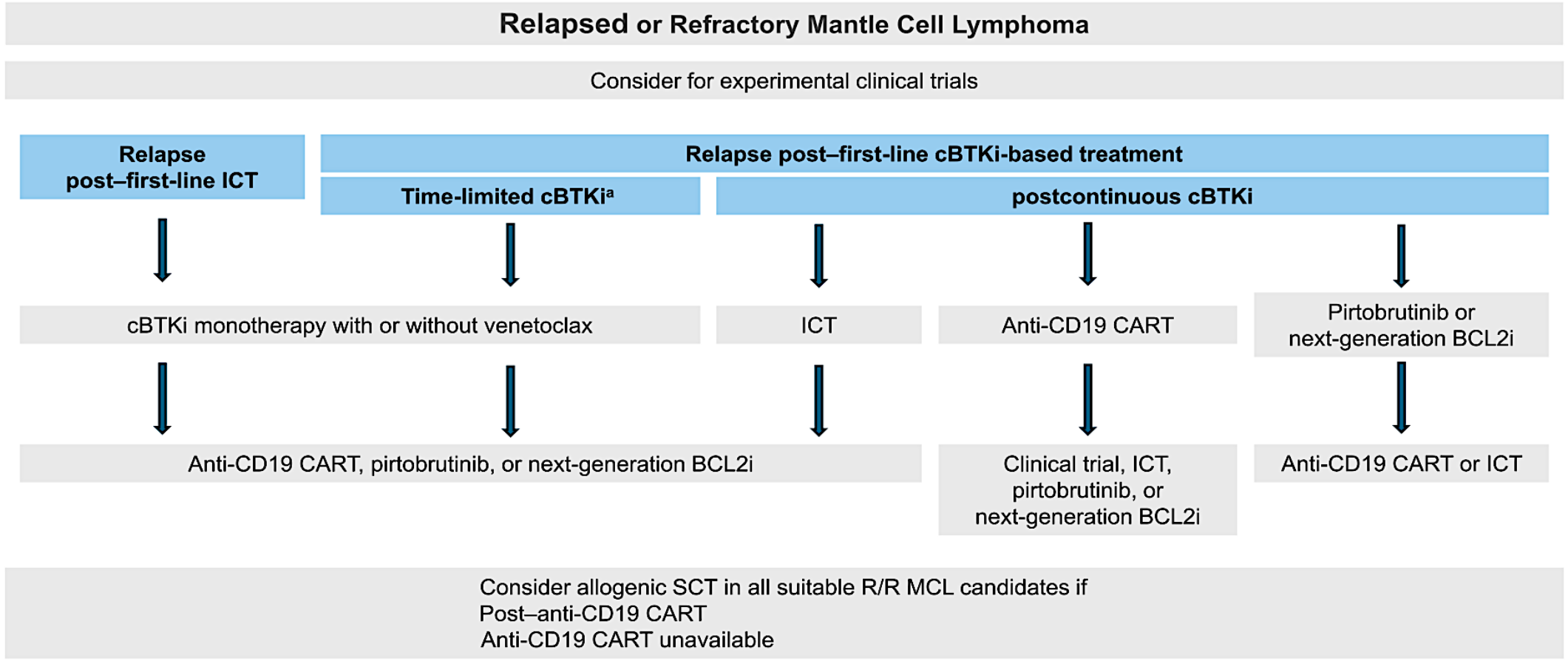
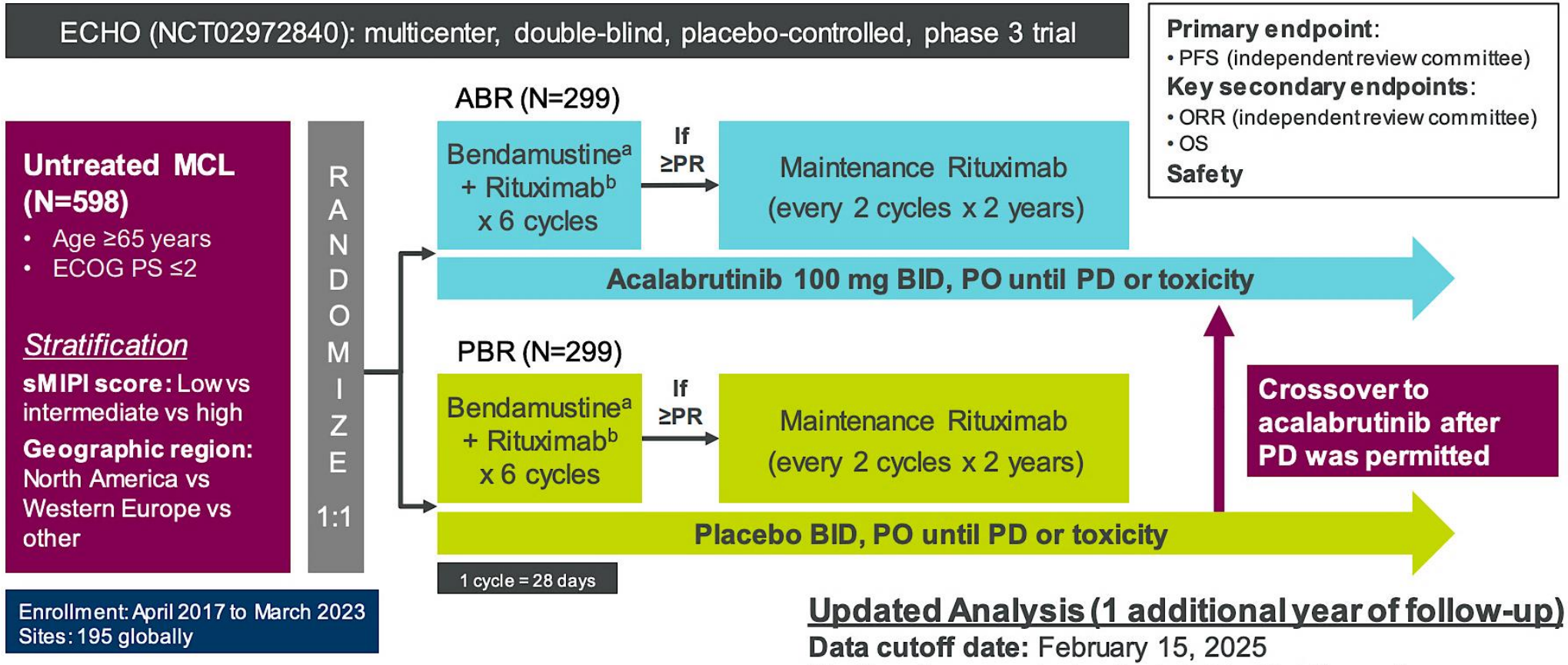


FIG 2. Suggested therapeutic algorithm for patients with relapsed/refractory MCL. [a]Including after toxicity. BCL2i, BCL2 inhibitor; CART, chimeric antigen receptor T-cell therapy; cBTKi, covalent Bruton tyrosine kinase inhibitor; ICT, immunochemotherapy; MCL, mantle cell lymphoma; SCT, stem-cell transplantation.

Wang ML et al. Time to third-line treatment after bendamustine-rituximab with or without acalabrutinib in patients with previously untreated mantle cell lymphoma: Updated analysis of the phase 3 ECHO trial after 50 months of follow-up. ASH 2025;Abstract 885.

Dreyling M et al. Efficacy of rituximab-bendamustine with or without acalabrutinib in patients with untreated, high-risk mantle cell lymphoma: An analysis of the phase 3 ECHO trial. EHA 2025;Abstract S233.

ECHO: RP3 trial of BR +/- acalabrutinib in TN MCL



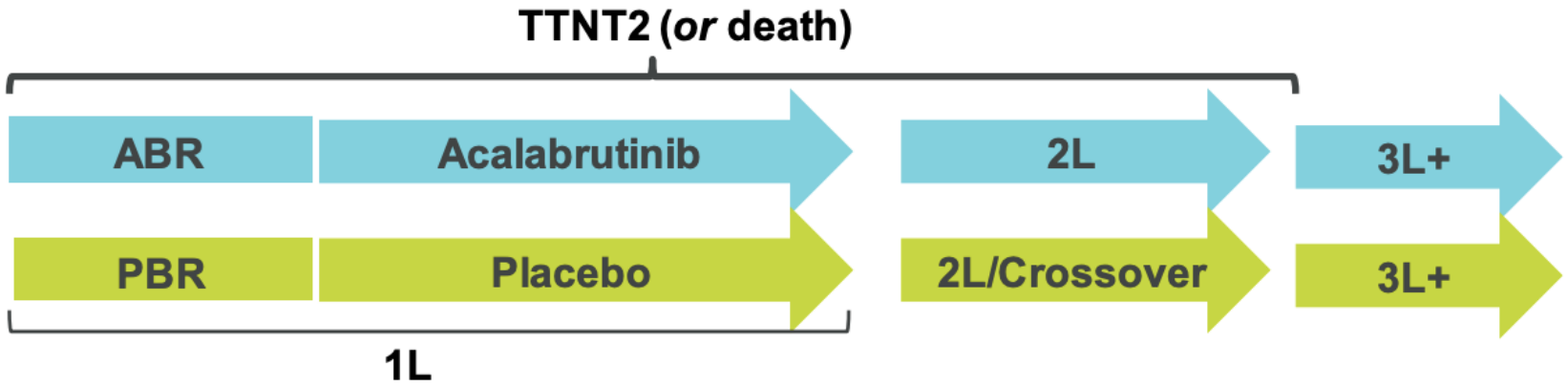
Updated Analysis (1 additional year of follow-up)
Data cutoff date: February 15, 2025
Median time on study: 51.9 (0.03–93.04) months

AT THE FOREFRONT
UChicago Medicine

Wang ASH 2025 Abstract 885

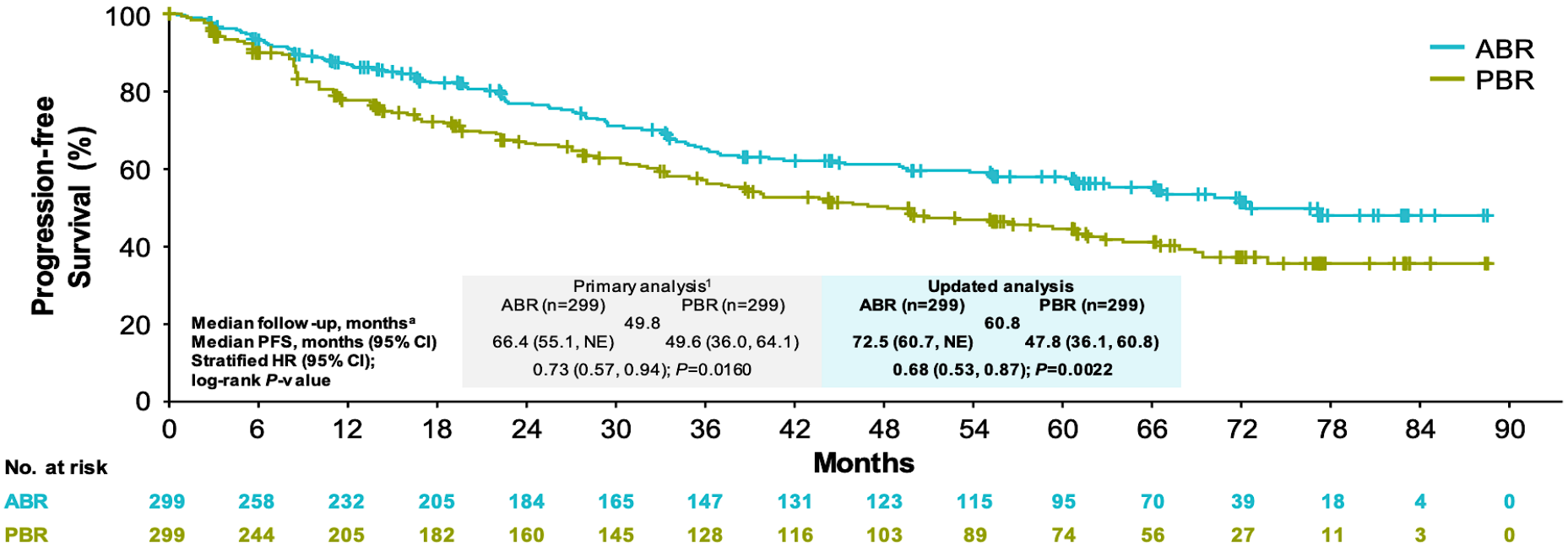
ASH 2025 Update: Wang ML et al. Time to third-line treatment after bendamustine-rituximab with or without acalabrutinib in patients with previously untreated mantle cell lymphoma: Updated analysis of the phase 3 ECHO trial after 50 months of follow-up. ASH 2025;Abstract 885.

- TTNT2 was assessed in a post hoc analysis[b]
  - TTNT2 was defined as the time from randomization to ***either*** the start of 3L antilymphoma treatment after discontinuation of randomized treatment ***or*** death



ECHO ASH 2025 update: outcome with mature follow up

At 60.8 Months of Follow-up, PFS Further Improved With ABR vs PBR



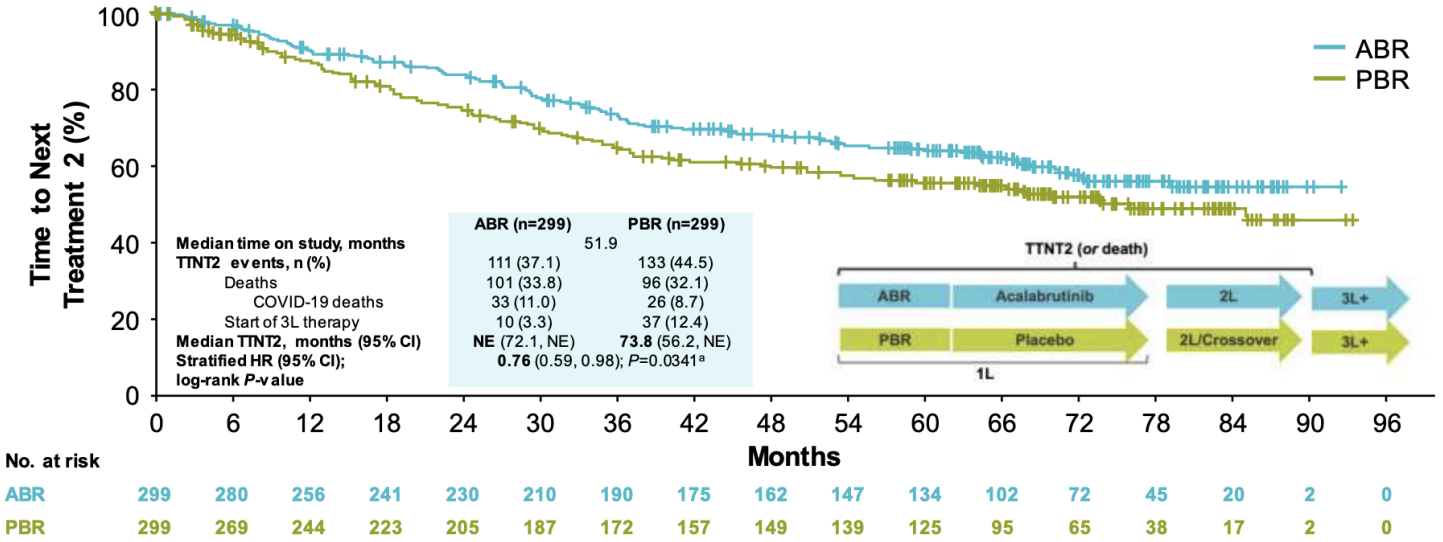
- PFS risk reduction with ABR vs PBR increased from 27% (primary analysis) to 32% (updated analysis)
- Median PFS was longer with ABR vs PBR (6 years vs 4 years)

AT THE FOREFRONT
UChicago Medicine

Wang ASH 2025 Abstract 885

ECHO: TTNT2 results

ABR Lowered the Risk of Needing 3L Therapy (TTNT2) by 24% Compared With PBR



- At 48 months, the rate of patients who had not yet initiated 3L therapy or had not died was 67.6% for ABR vs 59.2% for PBR

- **Need for subsequent anticancer therapy was 3-fold higher with PBR (11% v 33%)**
- **No new safety signals**
- **PFS of ABR v PBR is 72.5m vs 47.8m**
- **Med TTNT2 was NR vs 73.8m**
- **No new safety signals**
- **No OS differences**

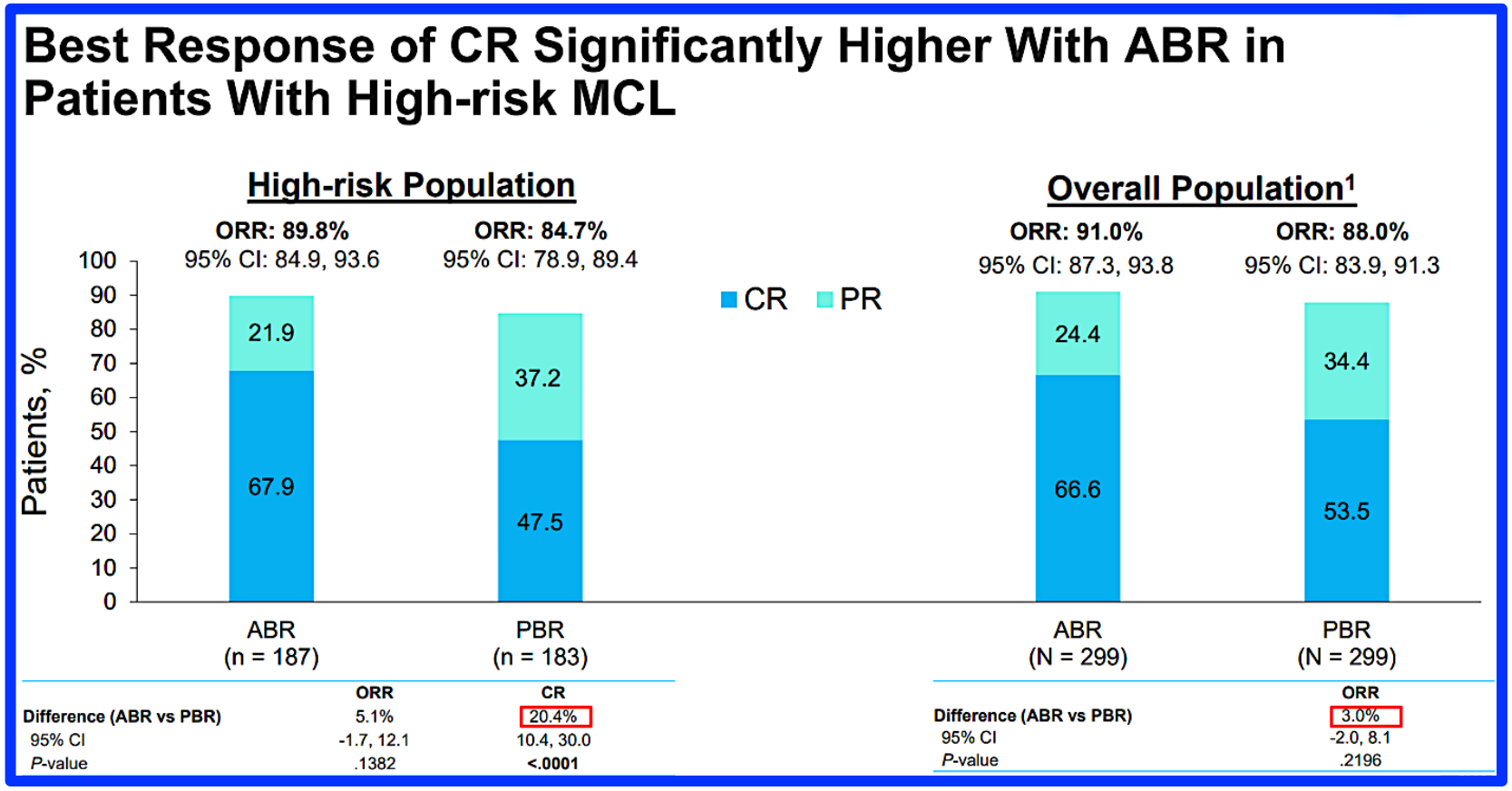
Author's take-home point: no need to "save" BTKi for relapse

AT THE FOREFRONT UChicago Medicine

Wang ASH 2025 Abstract 885

ECHO: RP3 trial of BR +/- acalabrutinib in TN MCL—focus on high-risk MCL

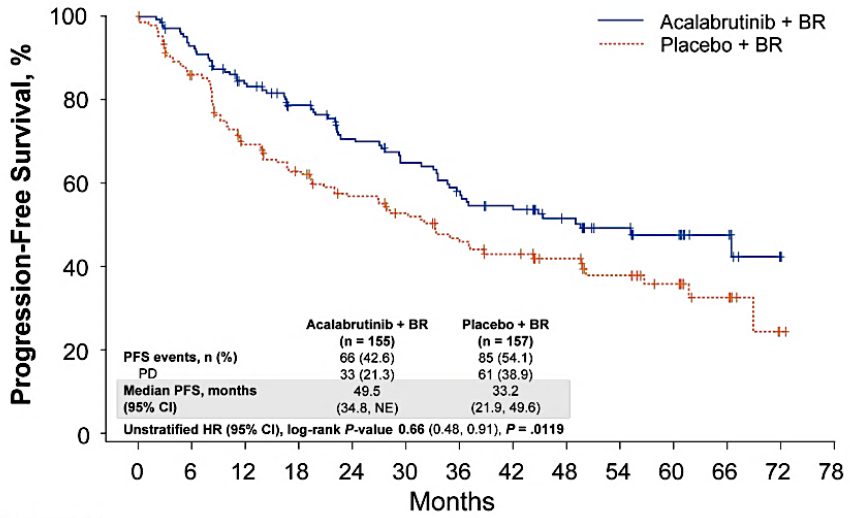
EHA 2025
N=598 pts



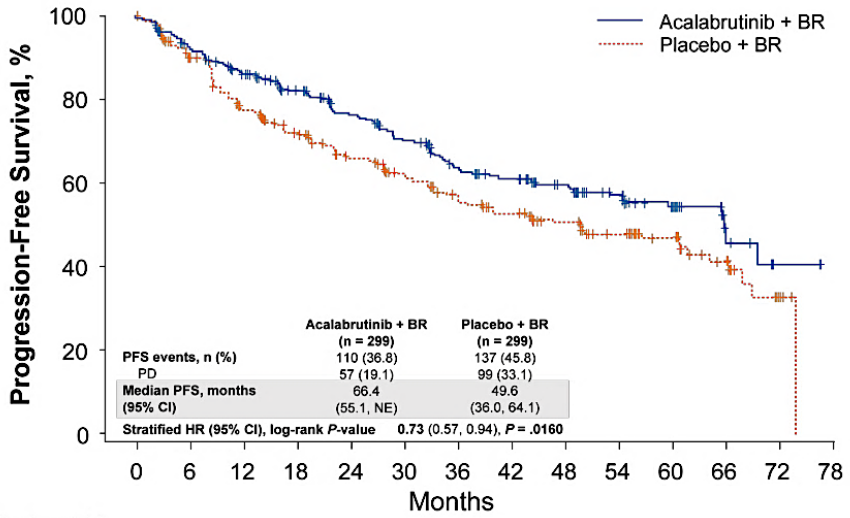
AT THE FOREFRONT
UChicago Medicine

Significantly Longer PFS With ABR in Patients With Biological Risk Factors

PFS in Patients With Ki-67 ≥30%, Blastoid/ Pleomorphic Histology, and/or *TP53* Mutation



PFS in Full Analysis Population[1]



- This grouping removes MIPI, which was considered less important than biological factors in the phase 2 ALTAMIRA trial[2]
- When only patients with Ki-67 index ≥30% and/or blastoid/pleomorphic histology were evaluated, PFS was longer with ABR vs PBR (HR 0.64; 95% CI 0.46, 0.90; *P* = .0092)

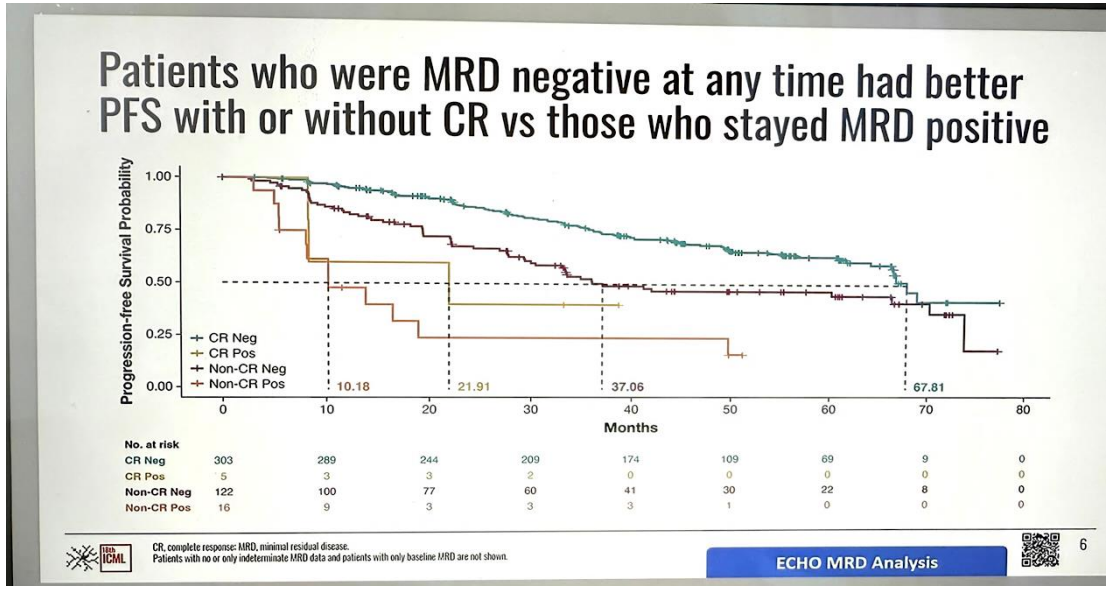
AT THE FOREFRONT
UChicago Medicine

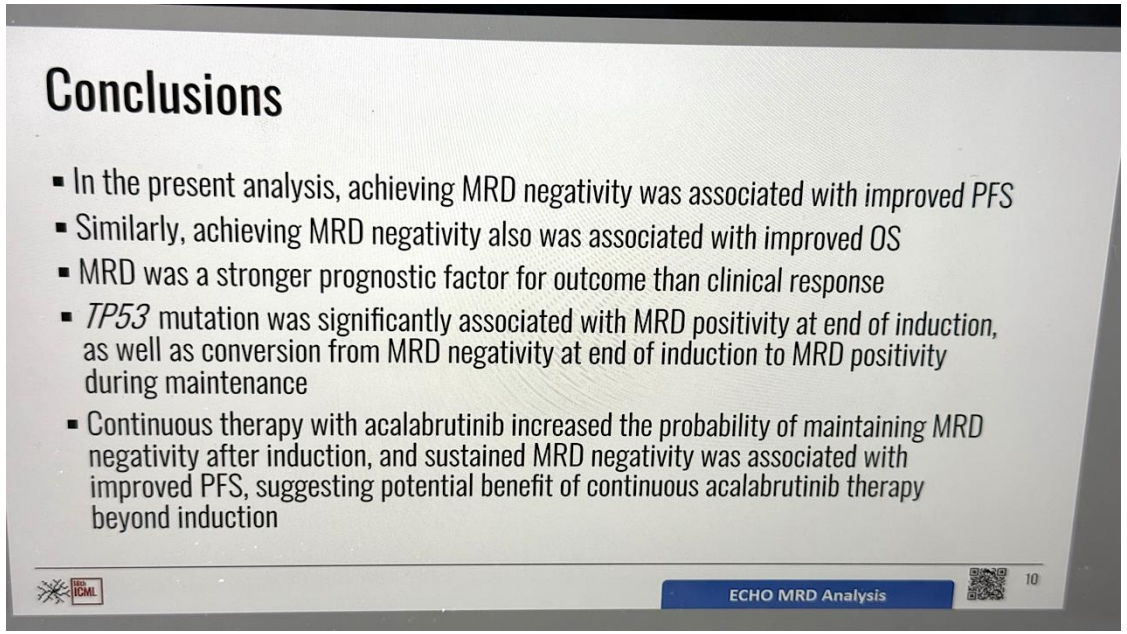
EHA 2025

When to stop acala? "MRD is your friend" (Michael Wang)

MRD Results from ECHO Trial

Zinzani PL EHA 2025 Oral 136





AT THE FOREFRONT
UChicago Medicine

Hawkes E et al. Acalabrutinib plus venetoclax and rituximab in patients with treatment-naive (TN) mantle cell lymphoma (MCL): Results from the phase 2 TrAVeRse study. ASH 2025;Abstract 884.

Triplet therapy for *p53* mutated and high-risk MCL→ now moving to other populations

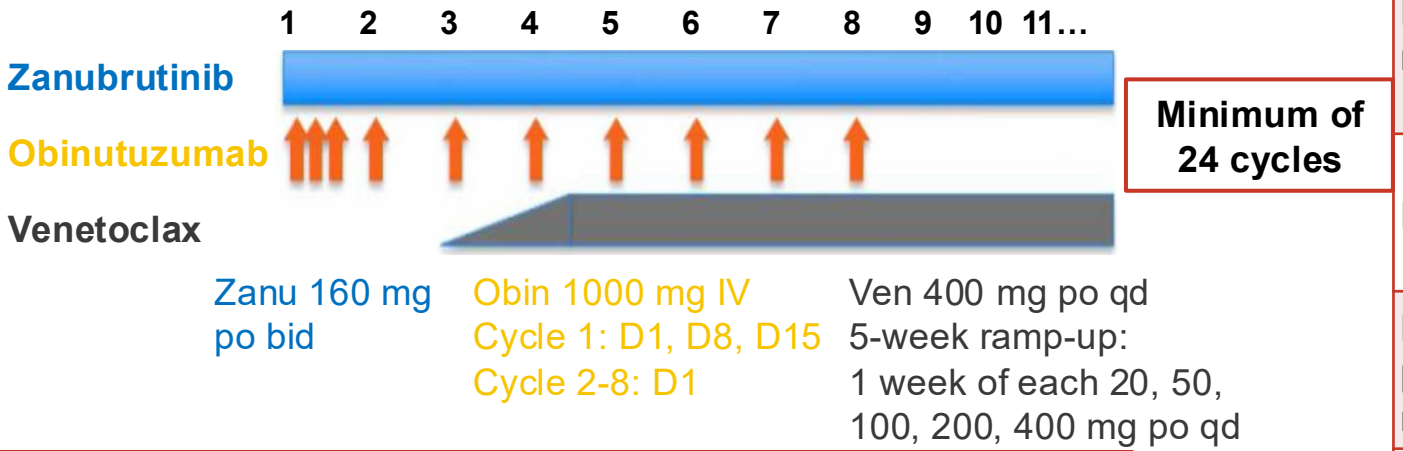
BTKi + Anti-CD20 + BCL2i

BOVen ?↔ AVR

Preliminary Results From a Phase 2 Study of BOVen (Zanubrutinib + Obinutuzumab + Venetoclax) as 1L Therapy for Older Patients With MCL

Key Eligibility Criteria

- Previously untreated MCL
- Aged ≥65 years or with comorbidities precluding ASCT
- ECOG PS ≤2



Minimum of 24 cycles

After 24 cycles, MRD-driven approach to treatment duration

- If CR and uMRD6: Stop treatment
- <CR and/or dMRD6: Continue Zanu and Ven

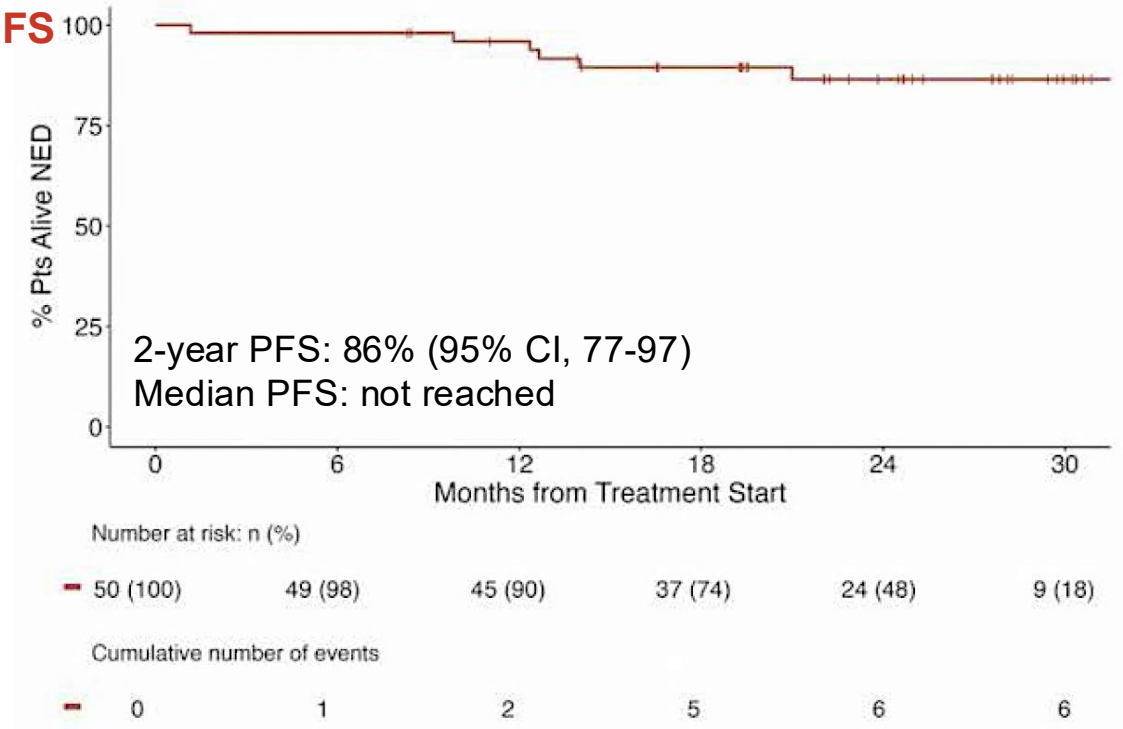
Primary endpoint: 3-year PFS (promising 3-year PFS rate ≥70%; unacceptable rate ≤50% [historical comparison to BR])

Baseline Characteristics		All Patients (N=50)
Age, years	Median (range)	72 (47-89)
	≥75 years, n (%)	17 (34)
MCL histology, n (%)	Classical	35 (73)
	Blastoid/pleomorphic	7 (15)
	Non-nodal leukemic	6 (13)
MIPI, n (%)	Low	4 (8)
	Intermediate	11 (22)
	High	35 (70)
Ki-67 proliferation rate, n (%)	<30%	24 (49)
	≥30% and <50%	11 (22)
	≥50%	14 (29)
Cytogenetics, n (%)	*TP53* mutation	13 (28)
	del(17p)	10 (20)
	del(17p) and *TP53* mutation	7 (14)

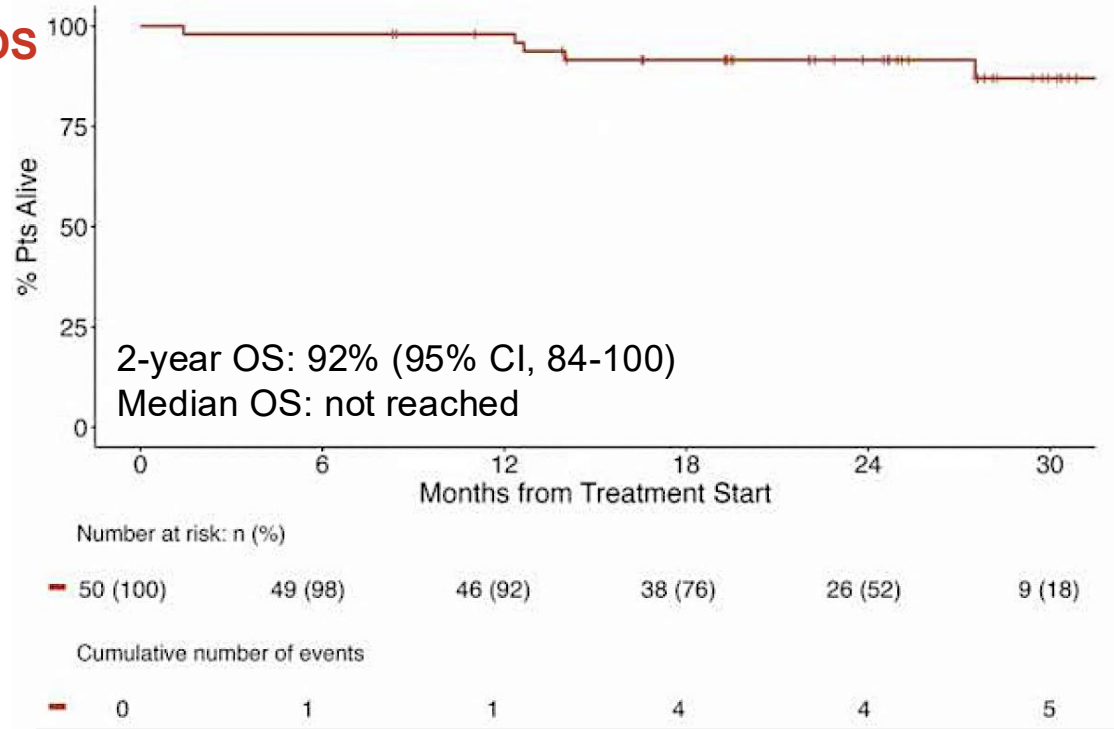
Kumar A, et al. ASH 2025. Abstract 888.

Preliminary Results From a Phase 2 Study of BOVen as 1L Therapy for Older Patients With MCL: PFS, OS, Response, and MRD

PFS



OS



Response

- Metabolic response: 48 patients (96%) achieved CMR; 1 patient (2%) achieved PMR
- 30 patients (60%) completed treatment (C24) and achieved CR, no patient has progressed off treatment (4 PD on therapy)

PB MRD (clonoSEQ)

- uMRD6: 39/45 patients (87%) at C13; 28/30 patients (93%) at C24 (EOT)

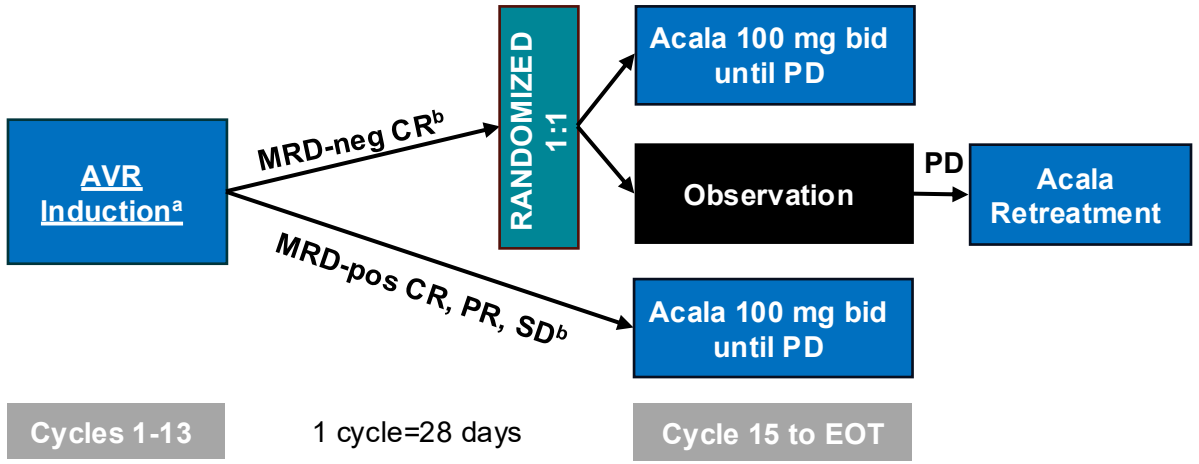
Median follow-up: 25 months.

Kumar A, et al. ASH 2025. Abstract 888.

Results From the Phase 2 TrAVeRse Study of Acalabrutinib + Venetoclax + Rituximab (AVR) in Patients With MCL

Key Eligibility Criteria

- Aged ≥18 years with untreated MCL
- Ann Arbor stage II-IV
- ECOG PS 0-2/3



Primary endpoint: MRD-neg CR rate[b] at end of induction
Other endpoints: ORR/CR rate, MRD-neg rate, DOR, PFS, OS, safety

Baseline Characteristics		AVR (N=108)
Median age (range), years		69 (40-89)
Aged <65 years, n (%)		42 (38.9)
Ann Arbor stage IV, n (%)		99 (91.7)
Extranodal involvement, n (%)		102 (94.4)
BM involvement, n (%)		90 (83.3)
Ki-67 ≥30%, n (%)		41 (38.0)
Blastoid/pleomorphic histology, n (%)		9 (8.3)
Positive p53 expression by IHC, n (%)		34 (31.5)
TP53 mutation by NGS, n (%)		17 (15.7)
Simplified MIPI, n (%)	Low risk (0-3)	30 (27.8)
	Intermediate risk (4-5)	45 (41.7)
	High risk (≥6)	33 (30.6)

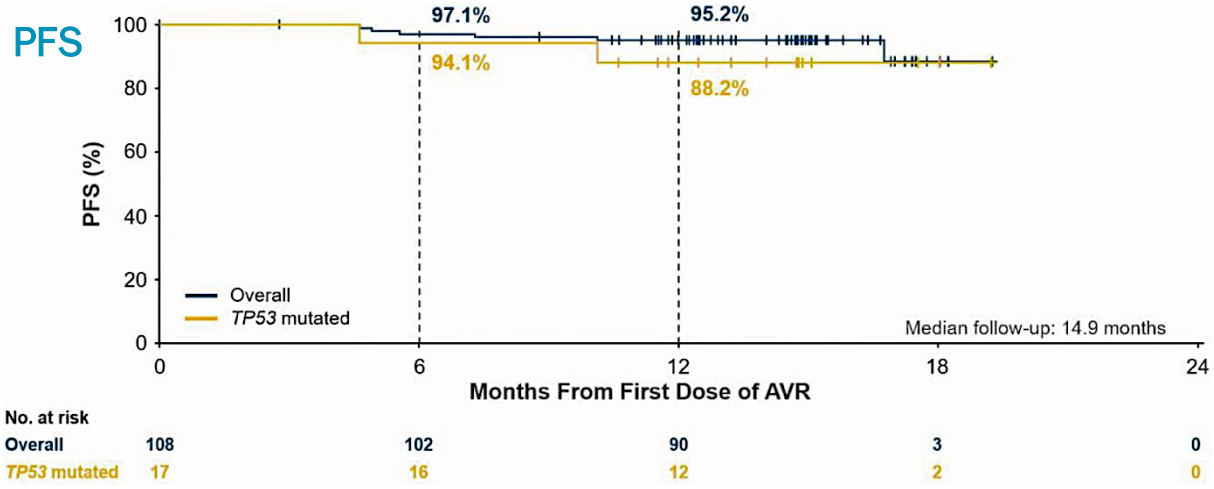
- Median follow-up: 14.9 months (range, 1-19)

[a] Acala 100 mg bid (C1-C13; C14 postinduction); Ven (C2-C13 [5-week ramp-up in C2: 20 mg to ≥400 mg qd]); Ritux 375 mg/m^2 D1 of C1-12). [b] MRD assessed by NGS (10^{-5}) in PB (clonoSEQ).

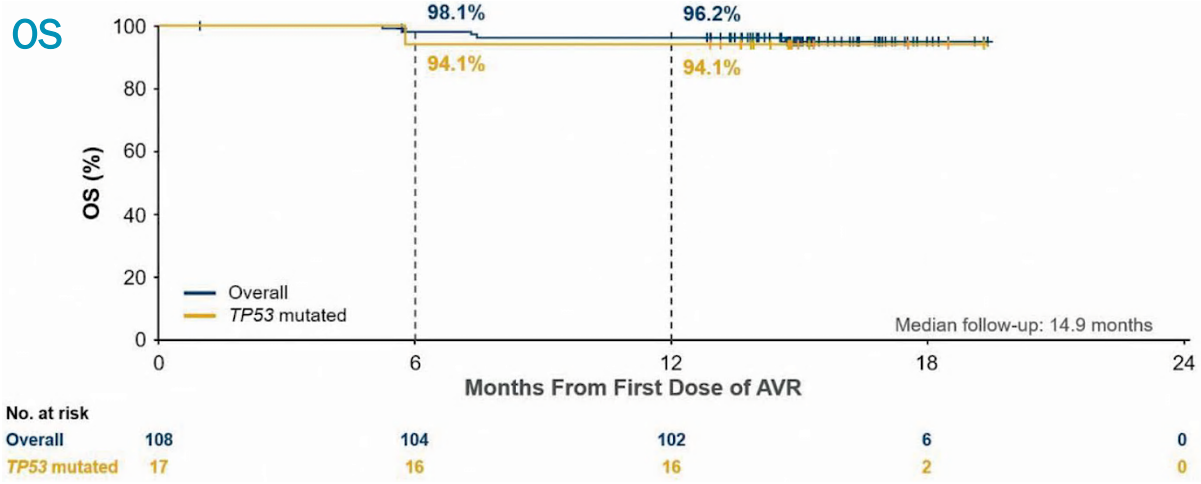
Hawkes EA, et al. ASH 2025. Abstract 884.

Results From the Phase 2 TrAVeRse Study of **AVR** in Patients With MCL: Outcomes in Patients With *TP53* Mutation

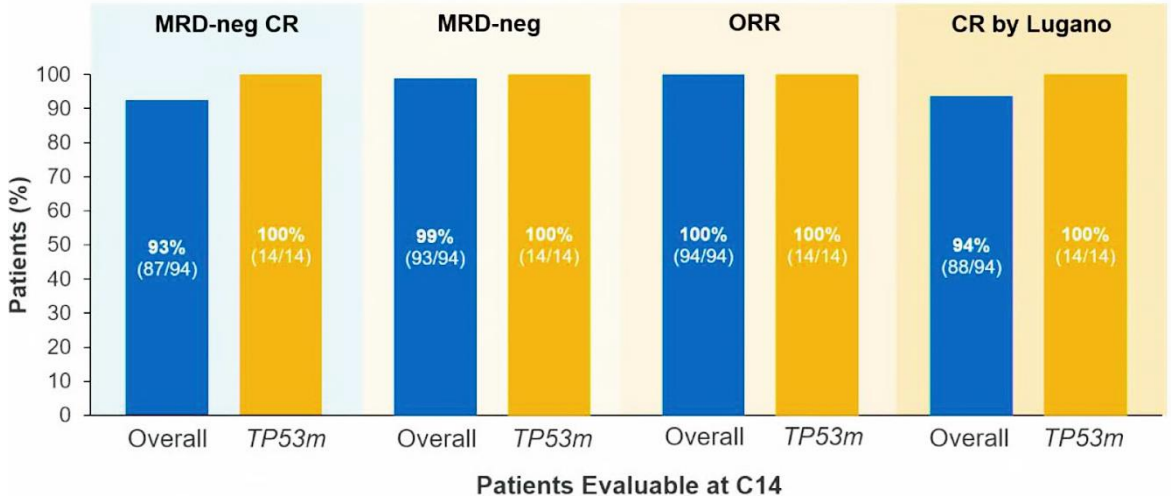
PFS



OS



Outcomes at End of Induction in Patients With *TP53*mut



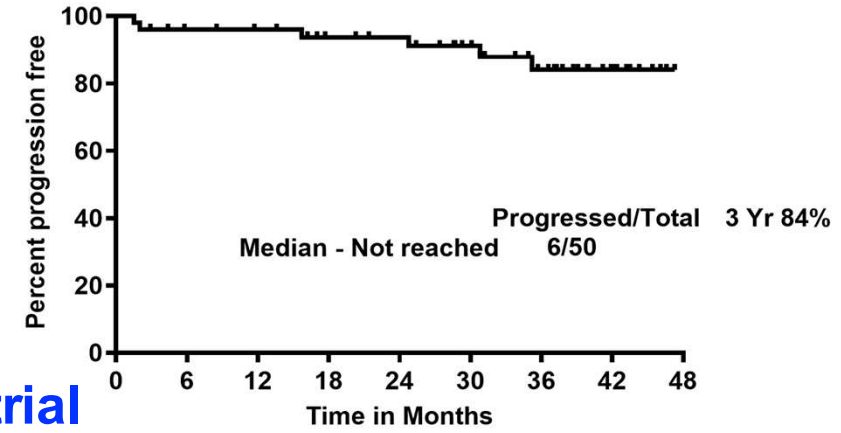
DOR

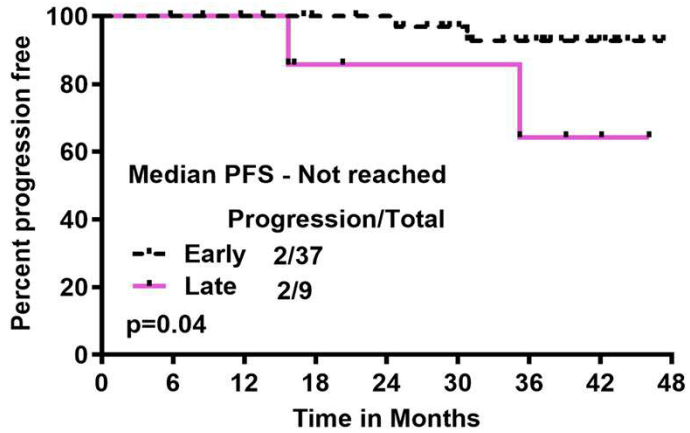
- Responses were durable, regardless of *TP53*mut status
  - DOR rate at 6 months: 98.0% overall and 100% in patients with *TP53*mut
  - DOR rate at 12 months: 97.0% overall and 93.3% in patients with *TP53*mut

Hawkes EA, et al. ASH 2025. Abstract 884.

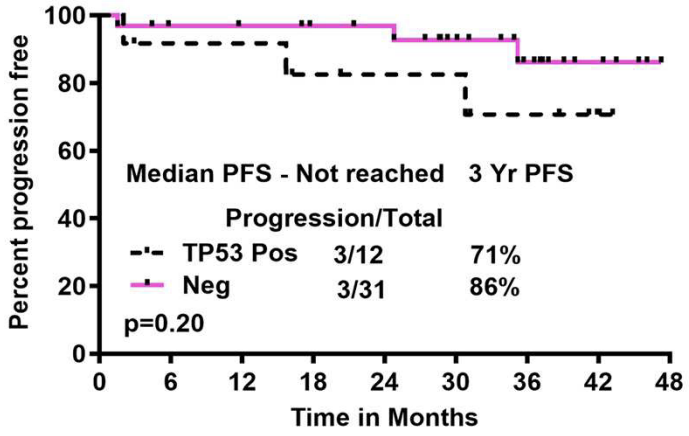
Jain P et al. Acalabrutinib in combination with rituximab is highly effective frontline treatment for older patients with MCL. ICML 2025;Abstract 272.

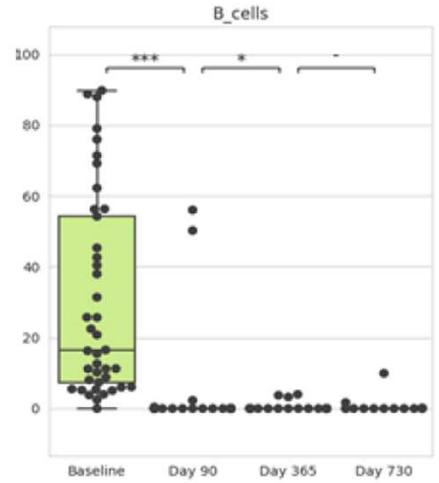
Acalabrutinib plus rituximab in older adults with MCL

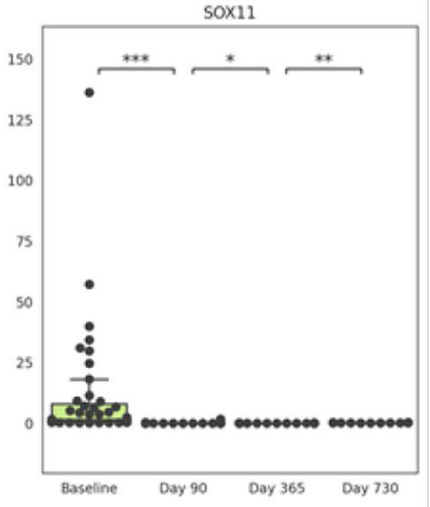




- Single arm, single institution trial
- N=50 pts
- Treatment with R weekly x 4, then monthly x 12, and then every 2m up to 24m
- indefinite acala







AT THE FOREFRONT
UChicago Medicine

Evolving landscape of trials for older adults with MCL

Table 1. Induction regimens for older adults with MCL.

Trial; number of participants with MCL receiving regimen	Regimen	Median PFS (OS), months	Response rate, %	Complete remission rate, %	Proportion of older adults, %
BRIGHT; *N* = 36 [39, 40]	BR	NR	94	50	NR
StiL NHL1; *N* = 46 [41]	BR	35.4 (NR)	NR	NR	NR
E1411; *N* = 180 [42]	BR → maintenance[a]	64 (NR)	90	61	NR
ECHO; *n* = 299 [43]	BR → rituximab	49.6[b] (NR)	88	54	100 ≥ 65 years
ECHO; *n* = 299 [43]	BR + acalabrutinib → rituximab + acalabrutinib	66.4[c] (NR)	91	67	100 ≥ 65 years
SHINE; *n* = 262 [44]	BR → rituximab	52.9 (NR)	89	58	100 ≥ 65 years
SHINE; *n* = 261 [44]	BR + ibrutinib → rituximab + ibrutinib	80.6 (NR)	90	66	100 ≥ 65 years
N = 62 [45]	R-CHOP	NR	94	34	37 ≥ 65 years
MCL Elderly; *N* = 267 [46, 47]	R-CHOP (plus maintenance)	NR (76.8)	84	32	100 ≥ 60 years
LYM-3002; *n* = 244 [48, 49]	R-CHOP	14.4 (55.7)	89	42	73 ≥ 60 years
LYM-3002; *n* = 243 [48, 49]	VR-CAP	24.7 (90.7)	92	53	73 ≥ 60 years
N = 57 [28, 50]	RBAC500	NR	91	91	100 ≥ 60 years
N = 38 [51–53]	R2 (plus maintenance)	9 years (NR)	92	64	63 > 60 years 26 > 70 years 13 > 80 years
N = 50 [54]	IR	NR	96	71	100 ≥ 65 years
N = 50 [55]	AR	NR	94	90	100 ≥ 65 years
N = 18 [56]	ZR	NR	94	94	NR
N = 46 [57]	BOVen	NR	98	79	100 ≥ 65 years

CHEMO-BASED

LenR

BTKi

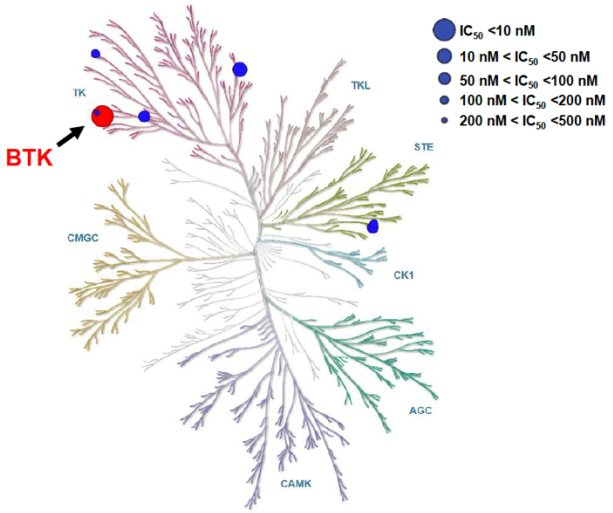
AT THE FOREFRONT
UChicago Medicine

Munoz Leukemia & Lymphoma Volume 66, 2025 - Issue 3

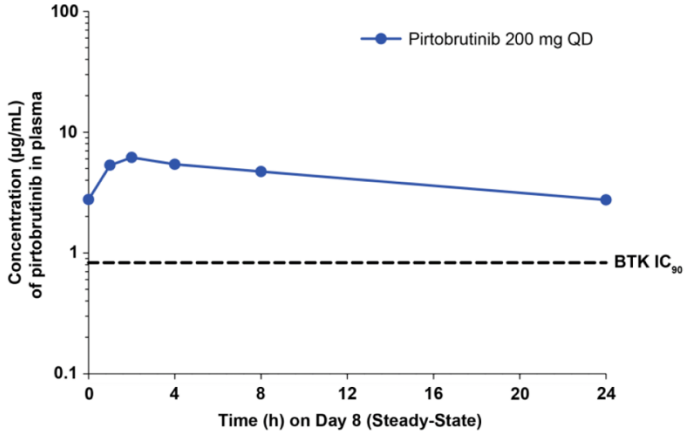
Wang M et al. Pirtobrutinib in relapsed/refractory (R/R) mantle cell lymphoma (MCL): Final update from the Phase 1/2 BRUIN study. ASH 2025;Abstract 665.

Pirtobrutinib is a Highly Selective, Non-covalent (Reversible) BTKi

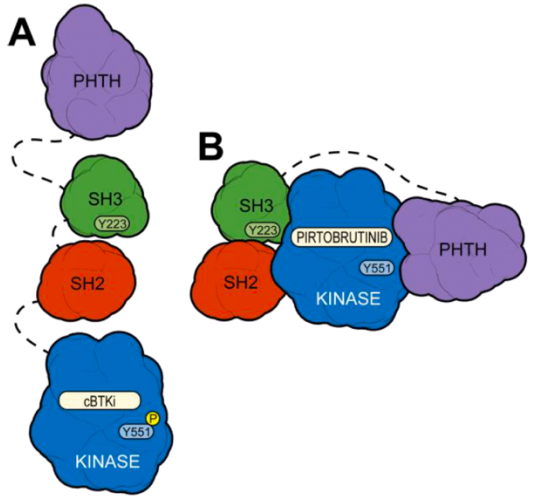
Highly Selective for BTK[1,2]



Plasma Exposures Exceeded BTK IC_{90} Throughout Dosing Interval



Pirtobrutinib May Stabilize/Maintain BTK in a Closed Inactive Conformation[3]



BRUIN phase 1/2 trial of pirtobrutinib monotherapy:

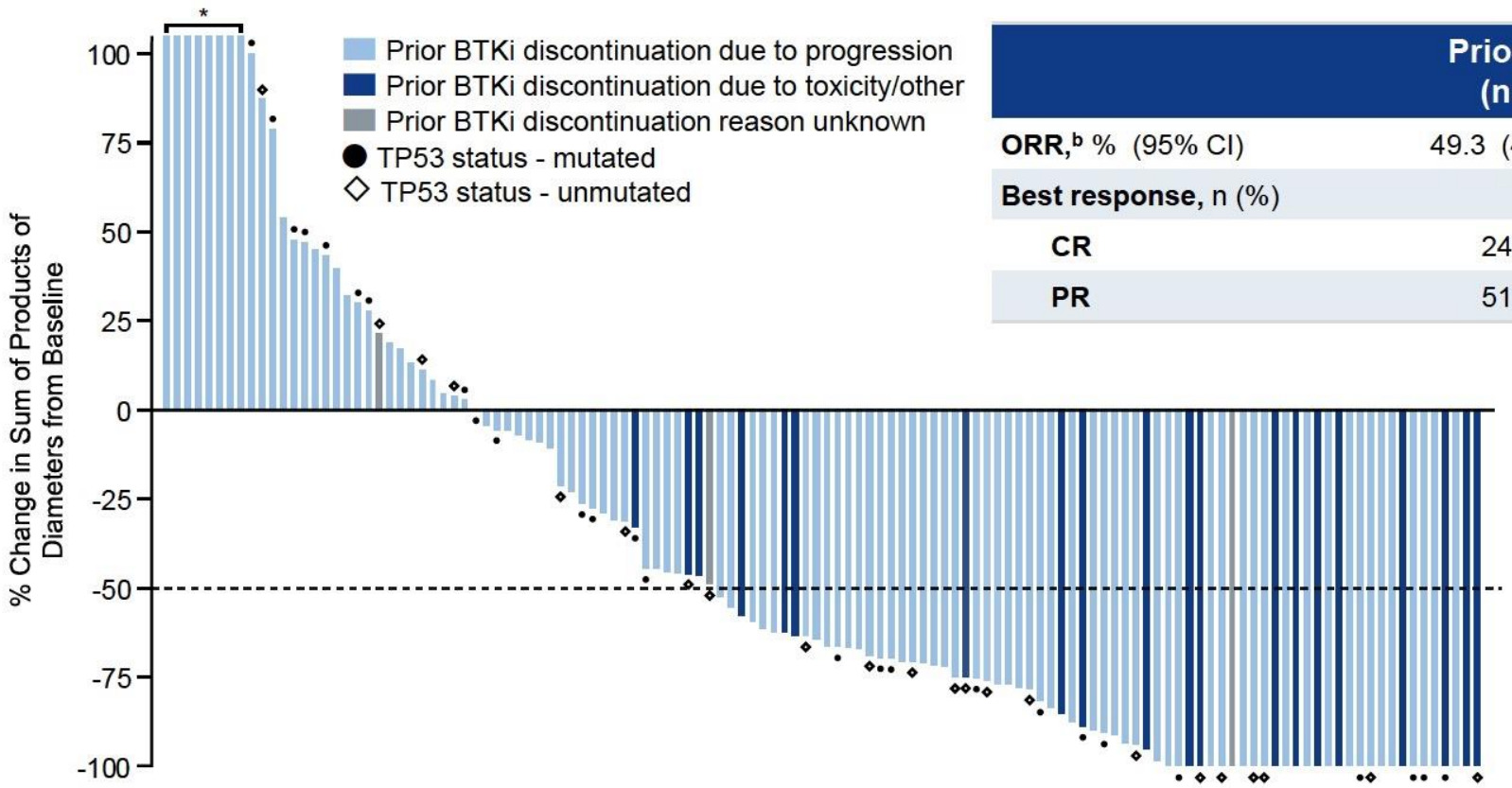
n=166 with RR MCL

92% with prior cBTKi (84% stopping for PD and 10% stopping for toxicity)

Med age 70yo with 3 PLOT

AT THE FOREFRONT
UChicago Medicine

Pirtobrutinib Efficacy in Patients With MCL Who Received Prior cBTKi



	Prior cBTKi (n=152)
ORR,[b] % (95% CI)	49.3 (41.1, 57.6)
Best response, n (%)	
CR	24 (15.8)
PR	51 (33.6)

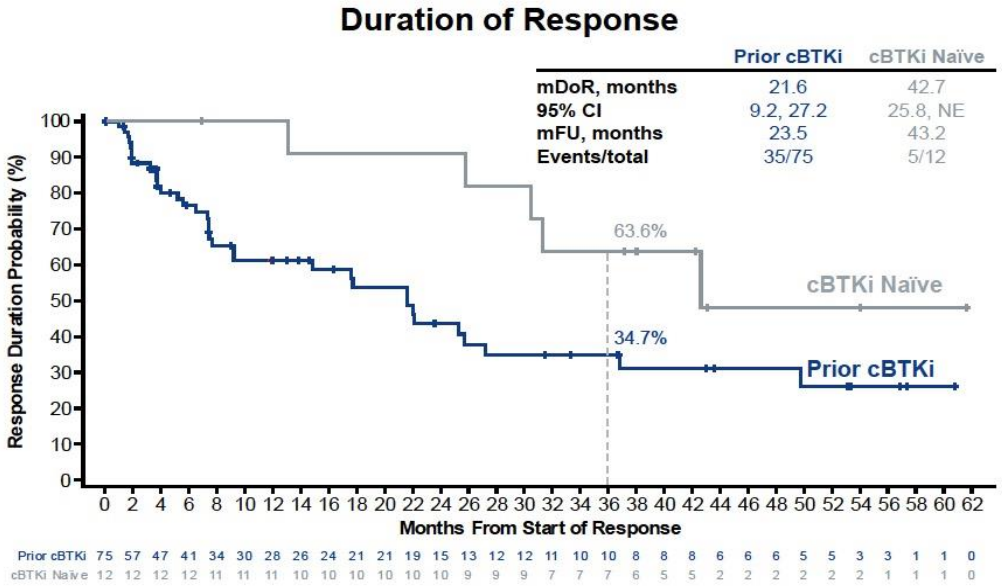
Median time to first response was 1.8 months (range: 0.8-13.8)

- In patients with MCL who were cBTKi naïve (n=14), ORR (95% CI) was 85.7% (57.2, 98.2)

AT THE FOREFRONT
UChicago Medicine

Pirtobrutinib Outcomes in Prior cBTKi and cBTKi-Naïve Patients With MCL

Duration of Response



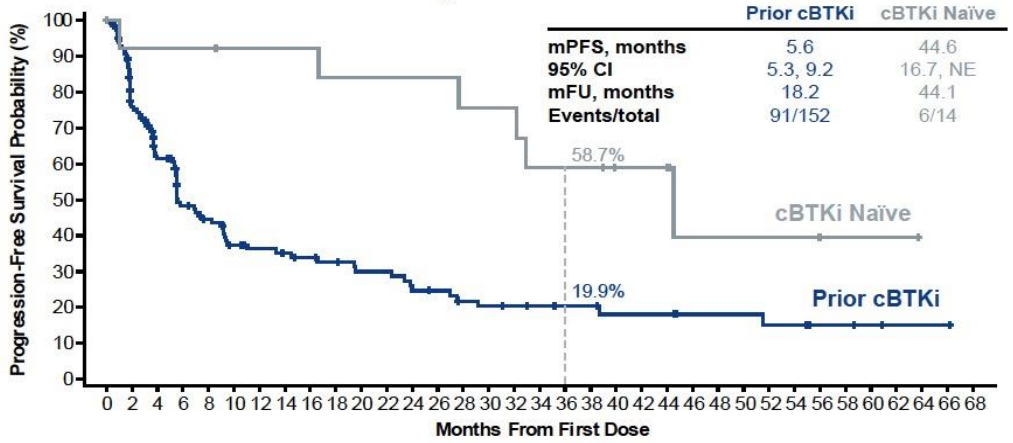
	Prior cBTKi	cBTKi Naïve
mDoR, months	21.6	42.7
95% CI	9.2, 27.2	25.8, NE
mFU, months	23.5	43.2
Events/total	35/75	5/12

Prior cBTKi	75	57	47	41	34	30	28	26	24	21	21	19	15	13	12	12	11	10	10	8	8	8	6	6	6	5	5	3	3	1	1	0
cBTKi Naïve	12	12	12	12	11	11	11	10	10	10	10	10	10	9	9	9	7	7	7	6	5	5	2	2	2	2	2	2	1	1	1	0

Outcome by Reason of Discontinuation From Prior BTKi

	PD	Toxicity/Other
mDoR, months	14.8	25.3
95% CI	4.0, 27.2	7.5, NE
mPFS, months	5.5	27.0
95% CI	3.8, 7.4	9.3, NE
mOS, months	18.5	57.8
95% CI	11.3, 33.5	32.2, NE

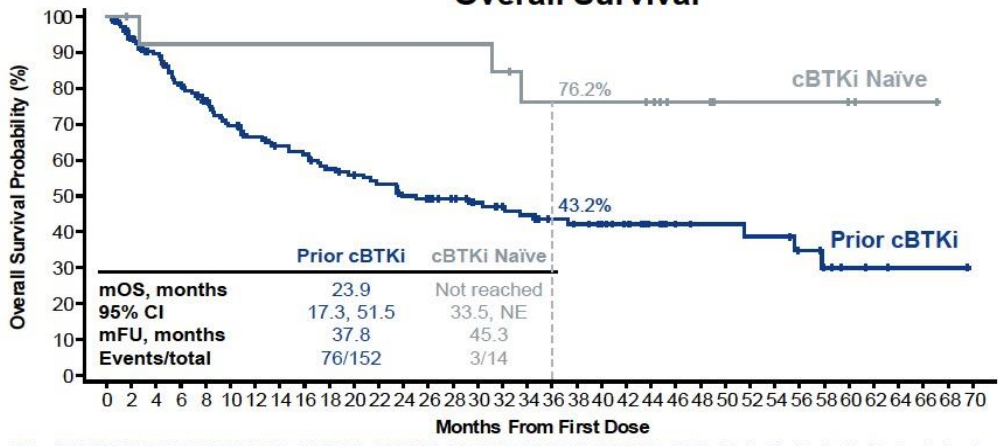
Progression-Free Survival



	Prior cBTKi	cBTKi Naïve
mPFS, months	5.6	44.6
95% CI	5.3, 9.2	16.7, NE
mFU, months	18.2	44.1
Events/total	91/152	6/14

Prior cBTKi	152	99	71	51	44	35	32	29	27	25	22	22	18	17	14	13	12	11	10	10	8	8	6	6	6	5	5	3	3	2	1	1	1	0
cBTKi Naïve	14	12	12	12	12	11	11	11	11	10	10	10	10	10	9	9	9	7	7	7	5	5	5	2	2	2	2	2	1	1	1	0	0	0

Overall Survival



	Prior cBTKi	cBTKi Naïve
mOS, months	23.9	Not reached
95% CI	17.3, 51.5	33.5, NE
mFU, months	37.8	45.3
Events/total	76/152	3/14

Prior cBTKi	152	135	123	109	100	90	84	79	76	70	67	63	58	55	49	44	40	37	33	31	28	25	17	13	12	12	11	11	8	5	3	2	1	1	1	0
cBTKi Naïve	14	13	12	12	12	12	12	12	12	12	12	12	12	12	12	12	11	9	9	9	9	9	8	5	5	3	3	3	3	3	2	1	1	1	0	0

Abbreviations: BTKi, Bruton tyrosine kinase inhibitor; cBTKi, covalent BTKi; CI, confidence interval; MCL, mantle cell lymphoma; mDoR, median duration of response; mFU, median follow-up; mOS, median overall survival; mPFS, median progression-free survival; NE, not estimable; PD, progressive disease.

UChicago Medicine

Wang M et al. Sonrotoclax (BGB-11417) monotherapy in patients with relapsed/refractory (R/R) mantle cell lymphoma (MCL) previously treated with a Bruton tyrosine kinase (BTK) inhibitor: Early results from a phase 1/2 study. ASH 2025;Abstract 663.

Sonrotoclax (BGB-11417): next gen BCL2 inhibitor

	Sonrotoclax	Venetoclax	Clinical implication for sonrotoclax
Potency (IC_{50})	0.014 nM[1]	0.20 nM[1]	14-fold more potent, which may lead to deeper target inhibition
Selectivity (vs BCL-xL)	2000×[1]	325×[1]	Improved (6-fold) selectivity may improve tolerability
Half-life in humans	≈5 hours[2]	26 hours[3]	No accumulation may improve tolerability Short half-life results in simplified TLS monitoring

Sonrotoclax(BGB-11417), a next-generation BCL2 inhibitor, is a more selective and pharmacologically potent inhibitor of BCL2 than venetoclax, with a shorter half-life and no drug accumulation

AT THE FOREFRONT
UChicago Medicine

Sonrotoclax in RR MCL: Outcomes (RP2 dose of 320mg/d)

RESPONSE

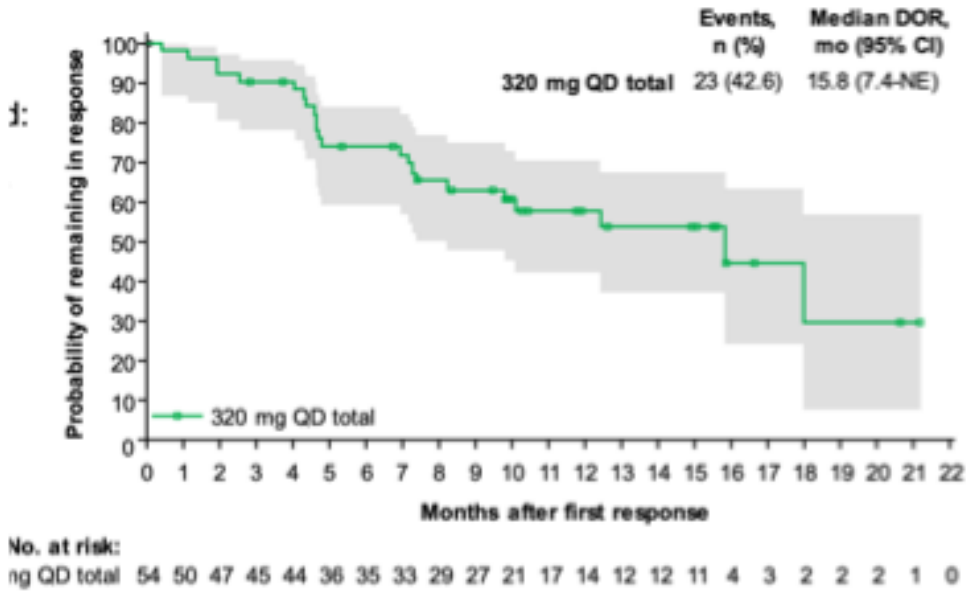
Parameters	Part 2: Sonrotoclax 320 mg (n=103) IRC-assessed	INV-assessed
ORR, n (%)	54 (52.4)	49 (47.6)
95% CI, %	42.4-62.4	37.6-57.6
1-sided *P* value	<.0001	N/A
CR rate, n (%)	16 (15.5)	23 (22.3)
95% CI, %	9.1-24.0	14.7-31.6
TTR, median (range), months	1.9 (1.6-6.2)	1.9 (1.6-4.0)

Primary endpoint was met: relative to the historical control ORR of 30%, IRC-assessed ORR of 52.4% represents a clinically meaningful improvement

ORR by IRC for patients with <3 prior lines of therapy: 61.0% (95% CI, 44.5%-75.8%)

Median study follow-up: 14.2 months (range, 0.3-24.9 months)

DOR



- Median follow up 14.2m
- Med DOR 15.8m
- Med PFS 6.5m
- Med OS NR

AT THE FOREFRONT
UChicago Medicine

FDA Grants Accelerated Approval to Sonrotoclax for Relapsed or Refractory Mantle Cell Lymphoma

Press Release: May 13, 2026

"On May 13, 2026, the Food and Drug Administration granted accelerated approval to sonrotoclax, a BCL-2 inhibitor, for adults with relapsed or refractory mantle cell lymphoma (MCL) after at least two lines of systemic therapy, including a Bruton's tyrosine kinase (BTK) inhibitor.

Efficacy was evaluated in BGB-11417-201 (NCT05471843), a single-arm, multicenter trial in 103 adults with relapsed or refractory MCL who previously received anti-CD20-based therapy and a BTK inhibitor.

Efficacy was established based on overall response rate (ORR) and duration of response (DOR), as assessed by an independent review committee (IRC) using Lugano criteria. ORR was 52% (95% CI: 42, 62), with a median time to response of 1.9 months. The median DOR was 15.8 months (95% CI: 7.4, not estimable), after an estimated median follow-up of 11.9 months.

The prescribing information includes warnings and precautions for tumor lysis syndrome (TLS), serious infections, and neutropenia. Of 115 patients with MCL evaluated for safety, serious adverse reactions occurred in 37%, most frequently from pneumonia (10%)."

https://www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-accelerated-approval-sonrotoclax-relapsed-or-refractory-mantle-cell-lymphoma

RTP RESEARCH TO PRACTICE

Overall thoughts about MCL

- **Moving away from "younger/fit versus older/unfit" dichotomy**
- **More selective (or nonexistent) use of autologous stem cell transplant**
- **Key biologic risk factors will influence treatment decisions**
  (Ki67, p53 status, blastoid morphology)
- **We are evolving in how we think about BTKi**
  "save the best" for the future mentality is going away
  Fixed duration is needed
  MRD will change how we treat this disease
- **New agents and classes of agents are likely to significantly change our treatment paradigm in the next several years**
  Bispecific agents, BTK degraders, safer CAR-T

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Gastroesophageal Cancers

A CME/MOC-Accredited Live Webinar

Tuesday, June 23, 2026

5:00 PM – 6:00 PM ET

Faculty

David H Ilson, MD, PhD

Kohei Shitara, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

Thank you for joining us!

Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us. The survey will remain open for 5 minutes after the meeting ends.

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

RTP Year in Review 2026