INNOVATIONS IN LUNG CANCER TREATMENT

JAMES JETT, MD
EDWARD KIM, MD
DAVID SPIGEL, MD
KEVIN OEFFINGER, MD (FACILITATOR)

JANUARY 17, 2019
9:00 AM ET
**TODAY’S AGENDA**

<table>
<thead>
<tr>
<th>Time</th>
<th>Presentation</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>9:00-9:10</td>
<td>Welcome, roll call, housekeeping</td>
<td>Dr. Oeffinger</td>
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<tr>
<td>9:10-9:45</td>
<td>Didactic Presentation:</td>
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<tr>
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<td>Part 1: 20 minutes &lt;Title&gt;</td>
<td>Dr. Kim</td>
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<td>Part 2: 15 minutes &lt;Title&gt;</td>
<td>Dr. Jett</td>
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<td>9:45-10:00</td>
<td>Q &amp; A/Discussion</td>
<td>Dr. Oeffinger</td>
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<tr>
<td>10:00-10:15</td>
<td>Program/Case Presentation:</td>
<td>Dr. Spigel</td>
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<tr>
<td>10:15-10:25</td>
<td>Q &amp; A/Discussion</td>
<td>Dr. Oeffinger</td>
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<td>10:25-10:30</td>
<td>Conclusion/Next session</td>
<td>Dr. Oeffinger</td>
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<td>Dawn Wiatrek, Ph.D. Octavia Vogel, MPH</td>
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*Sessions will be recorded.*
*Please mute phones when not speaking. Mute cell phones and try to reduce extraneous noise.*
*Remember to e-mail Octavia Vogel by 1/21 if you are requesting CME/CEU credit.*
DISCLOSURE

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- The following planners and faculty disclose that they have no financial relationships with any commercial interest: (next slide)
Lead Facilitator: Kevin Oeffinger  
Director, Duke Center for Onco-Primary Care  
Director, Duke Supportive Care and Survivorship Center  
Duke Cancer Institute

Presenters: James R. Jett, MD  
Professor of Medicine, Emeritus  
National Jewish Health  
Chief Medical Officer, Oncimmune Ltd  
Nottingham, United Kingdom.

Edward S. Kim, MD  
Chair of Solid Tumor Oncology and Investigational Therapeutics  
Donald S. Kim Distinguished Chair for Cancer Research  
Levine Cancer Institute  
Carolinias Health Care System, Charlotte, NC

Case Presenter: David Spigel, MD  
Chief Scientific Officer  
Director, Lung Cancer Research Program  
Sarah Cannon Health System
This session will provide information on innovations in lung cancer treatment including:

1. Molecular assessment and targeted therapies
2. Immune checkpoint inhibitors
3. Long term survival rates
4. Implications for treatment decision making
Molecular Assessment and Targeted Therapy of Lung Cancer Patients in 2019

Edward S. Kim, M.D., FACP
Chair, Solid Tumor Oncology and Investigational Therapeutics
Medical Director, Clinical Trials Office
Levine Cancer Institute, Atrium Health, Charlotte, NC
Disclosures

• Consulting
  – AstraZeneca
  – Boehringer-Ingelheim
  – Pfizer
  – Roche/Genentech
  – Takeda
  – Celltrion
The Era of Precision Medicine

- Genomic Testing
  - Tissue and blood
- Novel Therapeutics
  - Small molecules, Immunotherapy
- Less Chemotherapy
- More choices
- People living longer with cancer
Importance of Clinical Trials

A clinical trial saved my life. It could save yours, too.

Stan Collender, Opinion contributor  Published 8:00 a.m. ET Aug. 8, 2017 | Updated 9:25 a.m. ET Aug. 6, 2017

After being diagnosed with brain cancer, the Arizona Republican said he plans to work through the summer and return to Capitol Hill in the fall. Buzz20

It was the best decision I ever made, yet many doctors don’t recommend trials and most cancer patients aren’t inclined to participate.

Arizona Senator John McCain’s battle with a rare brain cancer has people thinking the worst. I know from very personal experience that the worst isn’t always what’s going to happen.

Two years ago I was about to start a clinical trial to deal with a very rare cancer — Merkel cell carcinoma — because there was no approved treatment for my disease. That decision to be treated with a very promising but-not-yet-approved drug saved my life.
Must Allow More Patients to Participate

Cancer researchers push to relax rules for clinical trials

US government examines whether criteria for participating in drug studies unnecessarily exclude some people.

Heidi Ledford
Modernizing Eligibility Criteria for Molecularly Driven Trials


ABSTRACT

As more clinical trials of molecularly targeted agents evolve, the number of eligibility criteria seems to be increasing. The importance and utility of eligibility criteria must be considered in the context of the fundamental goal of a clinical trial: to understand the risks and benefits of a treatment in the intended-use patient population. Although eligibility criteria are necessary to define the population under study and conduct trials safely, excessive requirements may severely restrict the population available for study, and often, this population is not reflective of the general population for which the drug would be prescribed. The American Society of Clinical Oncology Cancer Research Committee, which comprises academic faculty, industry representatives, and patient advocates, evaluated this issue. Evaluation results were mixed.
NSCLC: A Major Public Health Problem

• Estimated 1.6 million deaths each year worldwide from lung cancer

• In 2015:
  • Estimated 221,200 new cases of lung cancer expected to be diagnosed in US
  • 158,000 Americans expected to die from lung cancer

• Leading cause of cancer-related deaths in US men and women
  • More deaths from lung cancer than breast, prostate, colon, liver, melanoma, and kidney cancers combined

• Need for better thought out, patient-driven studies

Lung Cancer Treatment 2000: ECOG 1594 Comparison of 4 First-Line Doublet Regimens in Advanced NSCLC

- Nonsquamous and squamous histologies
- No differences
- Efficacy not so encouraging
- Easy for providers to “take home a message”
- “Treat with any doublet you would like”

The BATTLE Trial: Personalizing Therapy for Lung Cancer

Edward S. Kim, M.D., Roy S. Herbst, M.D., Ph.D., Ignacio I. Wistuba, M.D., J. Jack Lee, Ph.D., George R. Blumenschein Jr., M.D., Anne Tsao, M.D., David J. Stewart, M.D., Marshall E. Hicks, M.D., Jerome Erasmus Jr., M.D., Sanjay Gupta, M.D., Christina M. Aldon, R.N., Suyu Liu, M.S., Ximing Tang, M.D., Ph.D., Fadlo R. Khuri, M.D., Hai T. Tran, Pharm.D., Bruce E. Johnson, M.D., John V. Heymach, M.D., Ph.D., Li Mao, M.D., Frank Fossella, M.D., Merrill Kies, M.D., Vassiliki Papadimitrakopoulou, M.D., Suzanne E. Davis, M.M.S., M.B.A., Scott M. Lippman, M.D., and Wann K. Hong, M.D.

departments of Thoracic/Head and Neck Medical Oncology (E.S.K., R.S.H., J.J.L.), Department of Radiology, University of Pittsburgh Cancer Institute, Pittsburgh, Pennsylvania; and Department of Internal Medicine, Wake Forest University School of Medicine, Winston-Salem, North Carolina.
Randomization:
Equal → Adaptive

Primary end point: 8 week Disease Control (DC)
ES Kim et al. Cancer Discovery 2011
The Changing Landscape of Lung Cancer: 2005

80 of 100 patients eligible for chemotherapy

Only 15-20% of tumors had a partial response
The Changing Landscape of Lung Cancer: 2019
Molecular subsets: EGFR Mutations
The Changing Landscape of Lung Cancer: 2019

Molecular subsets: ALK
The Changing Landscape of Lung Cancer: 2019

Molecular subsets: ROS1
The Changing Landscape of Lung Cancer: 2019

Molecular subsets: PD-L1

Atrium Health
The Changing Landscape of Lung Cancer: 2019

Molecular subsets: BRAFv600E
The Changing Landscape of Lung Cancer: 2019

Molecular subsets: 50% of patients candidates for targeted therapy
NSCLC Drug Approvals/Indications: 2015 - Present

- Alectinib
- Necitumumab
- Nivolumab
- Osimertinib
- Gefitinib
- Ramucirumab
- Atezolizumab
- Ceritinib
- Brigatinib
- Dacomitinib
- Pembrolizumab
  - PD-L1 + (1st, 2nd line)
  - MSI-H or dMMR solid tumors
  - NSCLC (Carboplatin + Pemetrexed)
- Crizotinib (ROS1)
- Lorlatinib
- Dabrafenib, Trametinib
- Durvalumab
# Targeted Therapy in 2019

<table>
<thead>
<tr>
<th>EGFR (10%)</th>
<th>ALK (4%)</th>
<th>ROS1 (1%)</th>
<th>BRAF (2%)</th>
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<tbody>
<tr>
<td>2013: Afatinib</td>
<td>2014: Ceritinib</td>
<td>2015: Alectinib</td>
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<tr>
<td>2015: Gefitinib</td>
<td>2015: Alectinib</td>
<td>2017: Brigatinib</td>
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<td>2015: Osimertinib</td>
<td>2018: Lorlatinib</td>
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<td>2018: Dacomitinib</td>
<td>2018: Lorlatinib</td>
<td>2018: Lorlatinib</td>
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Activating Mutations in the Epidermal Growth Factor Receptor Underlying Responsiveness of Non–Small-Cell Lung Cancer to Gefitinib

Thomas J. Lynch, M.D., Daphne W. Bell, Ph.D., Raffaella Sordella, Ph.D., Sarada Gurubhagavatula, M.D., Ross A. Okimoto, B.S., Brian W. Brannigan, B.A., Patricia L. Harris, M.S., Sara M. Hascall, B.A., Jeffrey G. Supko, Ph.D., Frank G. Hainska, M.D., Ph.D., David N. Louis, M.D., David C. Christiani, M.D., Jeff Settleman, Ph.D., and Daniel A. Haber, M.D., Ph.D.

EGFR Mutations in Lung Cancer: Correlation with Clinical Response to Gefitinib Therapy

J. Guillermo Paez, 1,2* Pasi A. Jänne, 1,2* Jeffrey C. Lee, 1,3* Sean Tracy, 1 Heidi Greulich, 1,2* Stacey Gabriel, 4 Paula Herman, 1 Frederic J. Kaye, 5 Neal Lindeman, 6 Titus J. Boggon, 1,3 Katsuhiko Naoki, 1 Hidefumi Sasaki, 7 Yoshitaka Fujii, 7 Michael J. Eck, 1,3 William R. Sellers, 1,2,4† Bruce E. Johnson, 1,2† Matthew Meyerson 1,3,4†
Osimertinib vs. Pemetrexed Platinum in T790M Positive EGFR mutant NSCLC

- Non-Squamous NSCLC
- EGFR+ NSCLC with Progression on EGFR-TKI
- Central confirmation of T790M variant
- ECOG 0 or 1

Osimertinib 80 mg Day

Pemetrexed 500 mg/m2
Cis/Carbo q 3 Wks

Mok et al. NEJM 2017; 376:629
**Osimertinib vs. Pemetrexed Platinum in T790M Positive EGFR mutant NSCLC**

**Patients in Intention-to-Treat Population**

**A**

- **No. of Patients:**
  - Osimertinib: 279
  - Platinum-pemetrexed: 140

- **Median Progression-free Survival:**
  - Osimertinib: 10.1 (8.3–12.3) mo (95% CI)
  - Platinum-pemetrexed: 4.4 (4.2–5.6) mo (95% CI)

- **P**<0.001

**No. at Risk**

- Osimertinib: 279 240 162 88 50 13 0
- Platinum-pemetrexed: 140 93 44 17 7 1 0

**Hazard ratio for disease progression or death:**

- 0.30 (95% CI, 0.23–0.41)

Mok et al. *NEJM* 2017; 376:629
First-line Osimertinib vs SoC for EGFR Mutant Advanced NSCLC (FLAURA)

- Primary endpoint: PFS
- Secondary endpoints including: ORR, DoR, OS, safety

**Treatment-naive pts with advanced NSCLC adenocarcinoma with an EGFR exon 19 or 21 mutation, WHO PS 0/1, stable CNS mets permitted (N = 556)**

- **Osimertinib** 80 mg PO daily (n = 279)
- **Erlotinib** 150 mg or **Gefitinib** 250 mg PO daily (n = 277)

Until disease progression or unacceptable toxicity

EGFR mutation (del19 vs L858R) and race (Asian vs non-Asian)
**FLAURA: PFS**


<table>
<thead>
<tr>
<th>Pts at Risk, n</th>
<th>Osimertinib (n = 279)</th>
<th>SoC (n = 277)</th>
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<tbody>
<tr>
<td>Mos</td>
<td>Median PFS, mos</td>
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<tr>
<td>0</td>
<td>18.9</td>
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HR (95% CI): 0.46 (0.37-0.57); \( P < .0001 \)
FLAURA: Overall Survival Interim Analysis

HR 0.63
(95% CI 0.45, 0.88)
p=0.0068†
**PFS in Patients w/ & w/out CNS Metastases**

With CNS metastases (n=116)

- Median PFS, months (95% CI): Osimertinib 15.2 (12.1, 24.4), SoC 9.6 (7.0, 12.4)
- HR 0.47 (95% CI 0.30, 0.74), p=0.0009

Without CNS metastases (n=440)

- Median PFS, months (95% CI): Osimertinib 19.1 (15.2, 23.5), SoC 10.9 (9.6, 12.3)
- HR 0.46 (95% CI 0.36, 0.59), p<0.0001

CNS progression events occurred in 17 (6%) vs 42 (15%) patients receiving osimertinib vs SoC (all patients)
Uncommon Mutations: Afatinib

- 3 patients in group 1 achieved complete response
  - 1 each with G719X, K739_1744dup6, and L858R+Q709G/V

<table>
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<tr>
<th>Group 1 (n=33): point mutations or duplications in exons 18-21</th>
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<th>Group 2 (n=14): de novo T790M mutations</th>
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<th>Group 3 (n=20): exon 20 insertions</th>
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<td>Insertions:</td>
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Alectinib vs crizotinib in treatment-naïve advanced ALK+ NSCLC: primary results of the global phase III ALEX study (LBA9008)

Alice Shaw¹, Solange Peters², Tony Mok³, Shirish M. Gadgeel⁴, Jin Seok Ahn⁵, Sai-Hong Ignatius Ou⁶, Maurice Perol⁷, Rafał Dzialewiczko⁸, Dong-Wan Kim⁹, Rafael Rosell¹⁰, Ali Zeaier¹¹, Ting Liu¹¹, Sophie Golding¹¹, Bogdana Balas¹¹, Johannes Noe¹¹, Peter N. Morcos¹², and D. Ross Camidge¹³ on behalf of the ALEX investigators

1. Massachusetts General Hospital, Boston, MA, USA; 2. Lausanne University Hospital, Switzerland; 3. Chinese University of Hong Kong, Hong Kong; 4. Karmanos Cancer Institute/Wayne State University, Detroit, MI, USA; 5. Sungkyunkwan University School of Medicine, Seoul, South Korea; 6. Chao Family Comprehensive Cancer Center, University of California, Irvine School of Medicine, Orange, CA, USA; 7. Department of Medical Oncology, Léon Bérard Cancer Center, Lyon, France; 8. Department of Oncology and Radiotherapy, Medical University of Gdańsk, Gdańsk, Poland; 9. Seoul National University Hospital, Seoul, South Korea; 10. Catalan Institute of Oncology, Barcelona, Spain; 11. F. Hoffmann-La Roche Ltd, Basel, Switzerland; 12. Roche Innovation Center, New York, USA; 13. University of Colorado, Denver, CO, USA
Primary endpoint: PFS, investigator-assessed

- Crizotinib (N=151)
- Alectinib (N=152)

- Patients with events, n (%): 102 (68) vs. 62 (41)
- Median PFS, months (95% CI): 11.1 (9.1–13.1) vs. NR (17.7–NR)
- HR (95% CI): 0.47 (0.34–0.65) vs. P < 0.0001

Graph showing progression-free survival (PFS) over time for Crizotinib and Alectinib. The median PFS for Crizotinib is 11.1 months compared to NR for Alectinib.
Leptomeningeal carcinomatosis responded to alectinib

Pre-alectinib CSF cytology

Ou, Ser et al., WCLC 2013
ROS1+ NSCLC treated with Crizotinib

- Advanced NSCLC
- ROS1 Rearrangement
- PS 0-2
- Measureable Disease

Shaw et al. *NEJM* 2014 371:1963
BRAF V600E: Dabrafenib and Trametinib

36 of 57 (63%) had a Complete or Partial Response
Median Progression-Free Survival 9.7 Months

June 2017 FDA granted approval to dabrafenib and trametinib for Pts with metastatic NSCLC with BRAF V600E mutation

Larotrectinib (LOXO-101)

Efficacy regardless of tumor type
Biomarker Recommendations: Practical Applications

- EGFR
- BRAF
- ALK
- ROS1
- PD-L1
- EGFR T790M (post EGFR-TKI therapy)
- TRK fusions

Biomarkers performed at baseline
• Pragmatic phase 2 study with FDA-approved, targeted agents
• 60-70% match rates
• Incorporates general and drug-specific eligibility criteria
• Adopted ASCO-Friends Eligibility Criteria
## Drugs Available in TAPUR

<table>
<thead>
<tr>
<th>Pharmaceutical Company (Number of Drugs)</th>
<th>Drug(s) Provided for TAPUR Study</th>
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<tbody>
<tr>
<td>AstraZeneca (1)</td>
<td>Olaparib</td>
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<tr>
<td>Bayer (1)</td>
<td>Regorafenib</td>
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<tr>
<td>Bristol-Meyers Squibb (3)</td>
<td>Dasatinib, Nivolumab + Ipilimumab</td>
</tr>
<tr>
<td>Eli Lilly (1)</td>
<td>Cetuximab</td>
</tr>
<tr>
<td>Genentech (4)</td>
<td>Trastuzumab + Pertuzumab, Vemurafenib + Cobimetinib</td>
</tr>
<tr>
<td>Merck (1)</td>
<td>Pembrolizumab</td>
</tr>
<tr>
<td>Pfizer (6)</td>
<td>Axitinib, Bosutinib, Crizotinib, Palbociclib, Sunitinib, Temsirolimus</td>
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HER2 and Breast Cancer Patients

• Would you _ever_ treat a patient with breast cancer without knowing the HER2 status?
Conclusions: Delivering Precision Medicine

- Must practice Precision Medicine now
- Molecularly-base clinical medicine
  - Genomic testing at appropriate points of care
  - Reflex biomarker testing, Molecular tumor board
- Blood-based marker testing and collection system-wide
- Cutting-Edge Clinical trials
  - ASCO TAPUR, Phase I sites
The Fight Against Lung Cancer:
Thank you for your attention
ECHO-ACS
January 17, 2019

James R. Jett, M.D.
Professor of Medicine, Emeritus
National Jewish Health
Immune Checkpoint Inhibitors

- **Anti PD-1**
  - Nivolumab*
  - Pembrolizumab*

- **Anti PD-L1**
  - Atezolizumab*
  - Durvalumab*
  - Avelumab

- * FDA approved for NSCLC
Durvalumab after Chemoradiotherapy for Stage III NSCLC

- RCT of durvalumab (PD-L1) or placebo after chemoRT: Rx for 1 year duration
- 713 patients randomized 2:1
- Median PFS from randomization
  - 16.8 months vs 5.6 months: HR 0.52
- Median time to death or distant mets
  - 23.2 months vs 14.6 months: p < .001

Antonia SJ et al NEJM 2017; 377:1919-1929
Pembrolizumab in Untreated NSCLC

- Phase III trial of 305 patients with untreated stage IV NSCLC (>50% PD-L1)
  - Fixed dose 200mg IV q 3 weeks
- RCT of pembrol vs platinum doublet CT
  - No EGFR or ALK mutations
- PFS of 10.3 vs 6.0 months (HR=0.50)
  - 6 month survival 80 vs 72% (HR 0.60)

Reck et al. NEJM 2016; 375:1823-33
Hazard ratio for disease progression or death, 0.50 (95% CI, 0.37–0.68)
P<0.001

Progression-free Survival (%)

Month

No. at Risk
Pembrolizumab  154  104  89  44  22  3  1
Chemotherapy  151  99  70  18  9  1  0

Reck et al NEJM 2016; 375:1823-33
Pembrolizumab in Untreated NSCLC

- Response rate: 44.8 vs 27.8%
- Median duration of response
  - Not reached (1.9-14.1) vs 6.3 months
- Grade 3+ toxicity: 26.6% vs 53.3%

FDA approved pembrolizumab for frontline treatment in stage IV NSCLC with 50%+ staining of PD-L1 of tumor cells

Reck et al NEJM 2016; 375:1823-33
Reck et al NEJM 2016; 375:1823-33
Pembrolizumab plus Chemotherapy in Metastatic Non–Small-Cell Lung Cancer


Gandhi L et al  NEJM 2018; 378:2078-2092
Pembro plus Chemotherapy in Nonsquamous NSCLC: KEYNOTE 189

• Phase III trial of pemetrexed and a platinum with or without pembrolizumab

• PFS 8.8 vs 4.9 mos

• Survival at 1-year 69% vs 49%

• Improvement in survival seen in all PD-L1 categories

Gandhi L et al  NEJM 2018; 378:2078-2092
Gandhi L et al. NEJM 2018; 378:2078-2092
Pembro plus Chemotherapy for Squamous Cell Lung: KEYNOTE 407

- Phase III trial of carboplatin and paclitaxel with or without pembro (n=559)
  - Pembro 200mg IV every 3 weeks
- RR of 59% vs 38%; favor pembro arm
- **Overall survival was 15.9 vs 11.3 mos**
- Magnitude of survival benefit was similar in all PD-L1 groups
  - <1%, 1-49%, ≥50%

Paz-Ares L et al NEJM 2018; 379:2040-2051
Squamous Cell: KEYNOTE 407

Paz-Ares L et al NEJM 2018; 379:2040-2051
First-Line Atezolizumab plus Chemotherapy in Extensive-Stage Small-Cell Lung Cancer


Horn L et al  NEJM 2018; 379:2220-2229
Atezo in Frontline ED Small Cell

Horn L et al  NEJM 2018; 379:2220-2229
Long Term Survival with Stage IV Non-Small Cell Lung Cancer
Five Year Survival in EGFR Mutant Lung Adenocarcinoma Treated with TKIs

- 137 patients with metastatic adenocarcinoma
  - PFS was 12.1 months
  - Overall median survival of 30.9 months
- Five year survival of 14.6%
  - 95% CI of 9.7-21.9%

Final Overall Survival Analysis From a Study Comparing First-Line Crizotinib Versus Chemotherapy in ALK-Mutation-Positive Non–Small-Cell Lung Cancer

Benjamin J. Solomon, Dong-Wan Kim, Yi-Long Wu, Kazuhiko Nakagawa, Tarek Mekhail, Enriqueta Felip, Federico Cappuzzo, Jolanda Paolini, Tiziana Usari, Yiyun Tang, Keith D. Wilner, Fiona Blackhall, and Tony S. Mok
HR 0.76

4 yr survival (57 vs 49%)

HR 0.35 (85% crossover)

Solomon B et al  J Clin Oncol pub online May 16, 2018
Pembrolizumab and Long Term Survival in Stage IV NSCLC

- KEYNOTE trials with pembrolizumab in second or greater line therapy
  - Eval with long term survival models
- Estimated survival beyond 5 years at 21% and 25% in two trials
  - With docetaxel long term survival 5%

Hellman MD et al ASCO-SITC Clin Immuno-Oncology symposium abst #77, 2017
Five Year Survival in NSCLC Responders to Immunotherapy

• F/U of a Phase Ib dose ranging study of advanced NSCLC treated with nivolumab
  • Dose escalating study of 129 pts
  • Dose cohorts 1mg, 3mg, 10mg/kg
• At 5 years the overall survival was 16%
  • 5 year survival on docetaxel was 4%

Gettinger S et al J Clin Oncol 2018; 36:1675-1684
In Summary

- Treatment of Stage IV NSCLC has changed dramatically in the last five years.
- Osimertinib has to move to frontline treatment for EGFRm NSCLC.
- Alectinib has moved to frontline treatment of ALK mutated NSCLC.
- Durvalumab is FDA approved for Stage III NSCLC following CT/RT.
- Immunotherapy alone has move into frontline therapy in selected NSCLC (PD-L1 ≥50%).
- 5 year survival with stage IV NSCLC is now being observed with TKIs and Immune Check Point.
CASE PRESENTATION
DAVID SPIGEL, MD
CASE RELATED QUESTIONS FOR GROUP DISCUSSION
JOIN US FOR LUNG CANCER PATIENT SUPPORT ECHO:
MULTIDISCIPLINARY TEAMS AND CARE COORDINATION IN LUNG CANCER PATIENT CARE
JANUARY 31, 2019
9:00 AM ET

Presenters:

Thomas Asfeldt, RN, MAN, MBA
   Director, Outpatient Cancer Services & Radiation Oncology, Sanford Health
   ACCC Advisory Board Member for the Optimal Care Coordination Model for Medicaid Patients with Lung Cancer

Peter Mazzone, M.D., MPH
   Pulmonologist
   Director, Lung Cancer Program
   Respiratory Institute, Cleveland Clinic

Wendi Waugh
   Administrative Director of Cancer Services/Community Health and Wellness
   Southern Ohio Medical Center
   Pilot site director for the ACCC Optimal Care Coordination Model Pilot Study