18th Annual INDY HEMATOLOGY REVIEW® State of the Art 2021: Emerging Therapies in Hematologic Malignancies and Disorders

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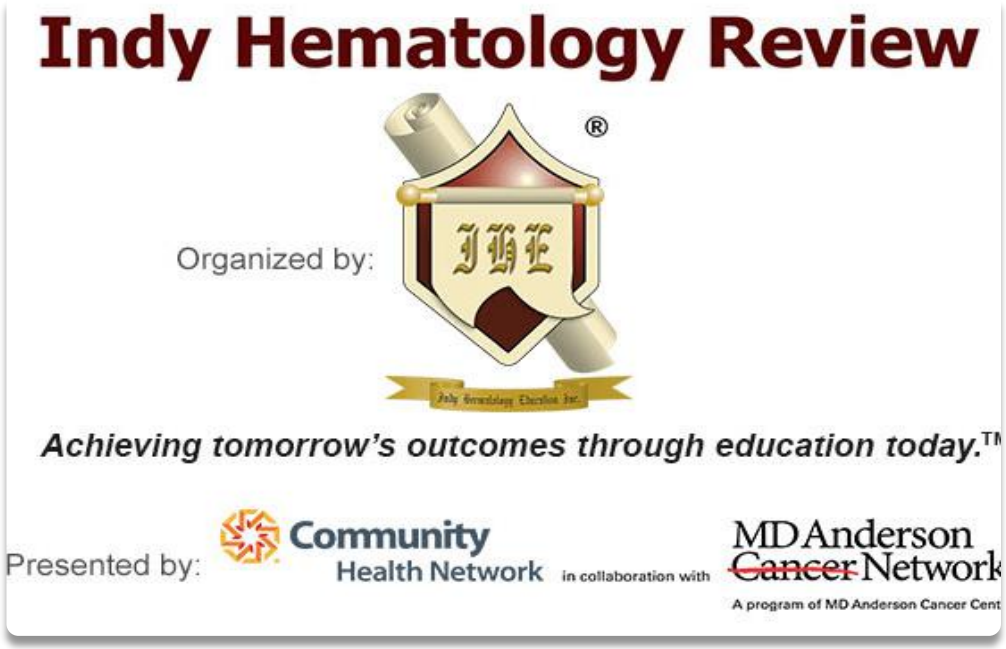

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ACHIEVING TOMMORROW'S OUTCOMES TODAY THROUGH EDUCATION™

ACUTE MYELOGENOUS LEUKEMIA

- **QUAZAR AML-001: Phase III, N=472: CC-486, Maintenance in AML After CR/Cri vs Placebo**
- Ad-Hoc analysis: Escalated CC-486 dosing in early first relapse with 5-15% blasts, reduces blasts to < 5% in 1 in 4 pts (10/43 vs 4/35), improved OS, RFS, irrespective of screening MRD
- MRD positivity associated with significantly reduced OS and RFS in either arms.
- MRD-negative response in BL MRD-positive patients: 37% with oral AZA vs 19% with PBO
- **Gilteritinib Plus Induction/Consolidation in ND FLT3 mutant AML:** Phase I, N=79
- 82% CRc @120 mg (MTD) mutational clearance (FLT3-ITD:total FLT3 signal ratio ≤ 10-4)
- **Magrolimab + Azacitidine in Untreated AML: Phase I, N=64 (AML/MDS)**
- First-in-class macrophage immune checkpoint inhibitor targeting CD47
- CR/Cri 554%, 68% transfusion independence, ORR, CR rates similar in TP53 mutation/WT
- **Flotetuzumab in PIF/ER6 AML: Phase I/II, N=44**
- BiTE targeting CD3 x CD123: CR/Cri: 26%, Grade 3: CRS 1/44

Acute Lymphoblastic Leukemia

- **Hyper-CVAD + Blinatumomab in B-Cell ALL, N=38, Phase II, Ph chromosome negative B-cell ALL:**
- CR: 100%; MRD negativity: 97%, 2-yr OS: 80%
- **Monitoring Measurable Residual Disease Using Peripheral Blood in Acute Lymphoblastic Leukemia: Results of a Prospective, Observational Study**
- NGS performed with proprietary CLONOSEQ assay
- PB MRD was highly correlated with BM MRD ($r=0.87$; $p<0.000$)
- Non-invasive monitoring of PB-based MRD in ALL patients undergoing curative intent cellular therapies represents a viable alternative to serial BM examinations

CHRONIC MYELOID LEUKEMIA

- **ASCEMBL: Asciminib vs Bosutinib for CML-CP Previously Treated With ≥ 2 TKIs, Phase III, N=233**
- Asciminib: first-in-class STAMP inhibitor, which targets the myristoyl pocket of ABL1, improved MMR rate at Wk 24: 25.5% vs 13.2%, (95% CI: 2.19-22.3); P = .029
- 5 AOEs with asciminib vs 1 in bosutinib, but numerically lower rates of AEs leading to d/c, dose adjustment, or requirement for additional therapy with asciminib

- **Ponatinib After Second-Generation TKI in Chronic-Phase Chronic Myeloid Leukemia, Phase II, Combined Analysis (n=35) of OPTIC (n=93)and PACE, (= 257) of Efficacy/Safety in CML:**
- Deep, durable responses and robust survival outcomes, regardless of baseline BCR-ABL1 mutation status (including T315I)

Outcome, %	PACE			OPTIC		
	All Patients (n = 257)	1 TKI (n = 100)	≥ 2 TKI (n = 157)	All Patients (n = 93)	1 TKI (n = 37)	≥ 2 TKI (n = 56)
≤ 1% *BCR-ABL1*^{IS}						
▪ 12 mos	42	47	39	47	43	50
▪ 24 mos	46	53	41	52	51	52
▪ 60 mos	47	56	41	NA	NA	NA
PFS						
▪ 2 yrs	67	72	64	81	86	77
▪ 5 yrs	52	66	43	NA	NA	NA
OS						
▪ 2 yrs	85	82	88	93	95	91
▪ 5 yrs	73	77	69	NA	NA	NA

LYMPHOMA

BISPECIC ANTIBODY

- **Mosunetuzumab in R/R FL, Phase I, N=42, humanized anti-CD3 x CD20 bispecific antibody**

  ORR: 67.7%; CR: 51.6%, mDoR: 20.4 mos, CRS: G2 and no grade ≥3 CRS.
- **Odronextamab, Human. Bispecific anti-CD3 and CD20 antibody, Phase I, N=136, R/R NHL**
- OP Regimen, **R/R FL**: Durable, CR rate, 70%, **R/R DLBCL**: CR (no prior CAR-T), 55% (prior CAR-T)21%

CAR-T THERAPY

- **TRANSCEND NHL 001, Lisocabtagene Maraleucel (R/R Mantle Cell Lymphoma Cohort):**
- **N=44: Phase 1:** ORR: 84%; CR : 66%, CRS 50%, PGr3 ≥ 3 cytopenias, 34%; Gr3 ≥ 3 infs, 16%

ANTI-CD19 ANTIBODY:

- **L-MIND:** ASCT-ineligible **R/R DLBCL**, N=81, **Tafasitamab + Len**: RR; 55%, mDOR 43.9mo
- **LOTIS-2:** R/R **DLCBCL**, ≥2 Prior Regimens: ADC, **Loncastuximab tesirine,** RR: 48.3% mDoR 13.4 mo

LYMPHOMA

- **NHL TKI THERAPY**
- **UNITY-NHL: Umbralisib, PI3Kδ inhibitor, R/R Indolent NHL, Phase II, N=208**
- 47.1% ORR, 16% CR rate in **MZL**, acceptable safety profile and low rate of discontinuations for AEs.
- **CITADEL-204, Parsaclisib, PI3Kδ Inhibitor, in R/R Marginal Zone Lymphoma, Phase II, N=100**
- ORR in daily group: 57%; median time to first response: 8.1 wks, DI: 57%, D/C: 35% due to TEAEs
- **BRUIN: Pirtobrutinib, Waldenström macroglobulinemia, Phase1/2:** N = 19, the ORR 68% , 47%, PR, 21% MRD, 16 SD. 13 patients BTK pretreated, the ORR was 69%
- **CHRONOS-3, Phase III, N=458: Copanlisib plus rituximab vs rituximab in R/R iNHL:** mPFS: 21·5 mos vs 13·8 mos (HR 0·52; p<0·0001), PFS improvement in all histology subtypes (HR): FL 0.580, MZL 0.475, SLL 0.243 **LPL/Waldenström macroglobulinemia:** N= 38, mPFS 33.4 vs 16.6mo, HR 0.443
- **HODGKINS LYMPHOMA**
- **SGN35-015: Brentuximab Vedotin ± Second Agent for Older Patients With cHL Ineligible for CT, Phase II,** Frontline therapy, N=87,ORR: 92% (95% CI: 74% to 99%), mOS: 82 mos (95% CI: 40.1-NR)BV + Nivolumab or DTIC: ORRs: 95% and 100%; Severe TEAEs 45% with Bendamustine

CHRONIC LYMPHOCYTIC LEUKEMIA

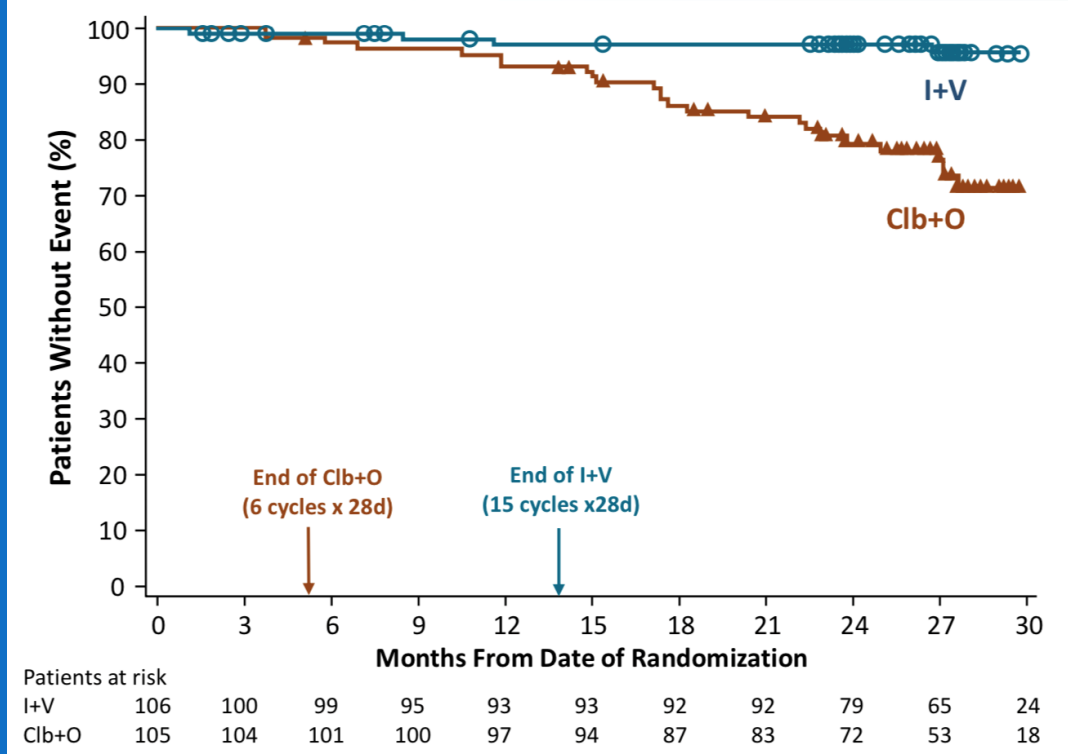
- **RELAPSED/REFRACTORY CLL**
- **PIRTOBRUTINIB (LOXO-305), next-generation, Wild-type and C481S mutant BTKi, Phase I/II, N=323**
- ORR 63% (N=139), increased over time to 86% with ≥ 10 months F/U, (N = 29), independent of prior therapy
- **TRANSCEND CLL 004: Lisocabtagene Maraleucel + Ibrutinib, Phase I**,
- N=19,ORR: 95%, uMRD: PB: 89%, BM: 79%.
- **UNITY-CLL: Umbralisib + Ublituximab vs Obinutuzumab + Chlorambucil, Phase III, N=421, TN and R/R CLL/SLL:** ORR: 83.3% vs. 68.7% (TN: R/R: Prior BTKi: 84, 82, 57 vs 78, 57, 25%), U2 DCR: 93%
- **ACE-CL-003: Acalabrutinib plus Venetoclax and Obinutuzumab or Rituximab in TN/RR CLL/SLL,N=**
- ORR: 92% in R/R and 100 in TN; CR/CRi rate: 50%; uMRD: 71% (67% in R/R patients and 75% in TN patients)
- **BTKi versus BTKi in Relapsed/Refractory Chronic Lymphocytic Leukemia**
- **ELEVATE-RR: OPEN LABEL, Phase III, Acalabrutinib vs Ibrutinib in R/R CLL/SLL, N=533**

  Efficacy: HR 1.00, AEs: Afib/flutter (9.4% vs 16.0% similar grade 3/4), HTN (9.4% vs 23.2%;), diarrhea (34.6% vs 46.0%, arthralgia (15.8% vs 22.8%;), bleeding (38.0% vs 51.3%;)
- **ALPINE STUDY: ZANUBRUTINIB VS IBRUTINIB in R/R CLL/SLL:** Interim analysis, N=415/652 planned Phase III, ORR; Zanubrutinib vs ibrutinib (78.3% vs 62.5%) 2-sided *P*=0.0006, neutropenia (28.4% vs 21.7%)

CHONIC LYMPHOCYTIC LEUKEMIA
FRONTLINE THERAPY

- **CAPTIVATE , Phase II, RCT, FD, Ibrutinib + Venetoclax in TN CLL/SLL, N= 164,**
- 1-yr DFS rate 95.3% in patients with uMRD randomized to placebo after 12 cycles of I+V and 30-mo PFS rates > 95% across all treatment arms
- 24 mos PFS: 96%, unmutated IGHV: 93% vs 97% mutated IGHV, del(17p)/TP53 84% (ASCO 2021)
- **GLOW: Fixed-Duration Ibrutinib + Venetoclax vs Chlorambucil + Obinutuzumab in TN CLL**
- Median PFS: NR vs 21.0 mo (HR: 0.216; 95% CI: 0.131-0.357; *P* <.0001, ORR/CR+CRi: 86.8/38.7 vs 84.8/11.4%
- UMRD rates at EOT +3 by NGS (ITT): BM 51.9 vs 17.1 (p = <0.0001), PB 54.7 vs 39 (P = .0259)
- Substained PB uMRD: 84.5% vs 29.3%

GLOW PFS – EHA 2021, Kater AP, et al.



MYELODYSPLASTIC SYNDROME

- **Enasidenib in High-Risk IDH2-Mutated MDS: N=48**
- ORR of 84% plus AZA (HMA-naive), Single agent: ORR 43% (R/R after HMA), differentiation syndrome 17%.
- **Ivosidenib + Venetoclax ± Azacitidine in IDH1-Mutated Myeloid Malignancies, Phase Ib/II, N=29,** ND or R/R AML or advanced MDS or MPN (≥10% blasts) with IDH1R132 mutation, mFU 27.6mo
- CRc/mOS: I+V400 = 67%, 9mos, I+v800 = 100%, NR, I+V400+A = 85%, NR, uMRD OS:100% vs 33%
- **Roxadustat in Low-Risk MDS: Phase III:, N= 24**, Effective regardless of RS and baseline EPO levels
- Oral hypoxia-inducible factor prolyl hydroxylase inhibitor that increases RBC production
- TI at 8 weeks: Overall 38%, 78% (7/9) received roxadustat 2.5 mg/kg
- **DACOTA Phase III Study of Decitabine vs Hydroxyurea for Advanced Proliferative CMML, N=170**
- ORR: decitabine 63% vs hydroxyurea 34% ; P = .0002, No differences in OS, EFS, TTF to AML
- **GTB-3550 TriKE, Tri-specific killer engager that targets CD16, IL-15, and CD33** stimulates robust natural killer cell activity, with clinical activity. 1 pt @ 50mcg/kg, with R/R MDS responding with transfusion independence.

MYELOPROLIFERATIVE NEOPLASMS

- **MANIFEST: Novel BET Inhibitor, CPI-0610, Plus Ruxolitinib in JAK Inhibitor–Naive Myelofibrosis, N=**
- 42 of 63 (67%) JAK inhibitor–naive MF patients treated with CPI-0610 + ruxolitinib achieved SVR35 at Wk 24
- Compares favorably with 29% to 42% SVR35 at Wk 24 with ruxolitinib alone in JAKi – naive patients
- Symptom improvement: 57% TSS50 at Wk 24
- **Imbark, Imetelstat: Telomerase inhibitor, Phase II, in R/R intermediate-2/high-risk MF, N=107**
- Comparing 2 doses of imetelstat: 9.4 mg/kg vs 4.7 mg/kg IV Q3W
- Dose-related OS improvement: mOS 19.9 vs 28.1mo;
- **Luspatercept in RBC Transfusion-Dependent Patients With Myelofibrosis-Associated Anemia, Phase II, N=100, Transfusion Dependent Groups: Cohort 1: (No RUX) vs Cohort 3b (+ RUX):**
- RBC-TI responses lasting ≥ 12 wk10% and 27%
- 25% of patients achieved more than one RBC-TI responses lasting ≥ 12 wks

Multiple Myeloma: Targeting BCMA

- **BCMA-Directed CAR T-Cell Therapy in R/R MM**
- **Ciltacabtagene Autoleucel:** Phase Ib/II, N = 97: ORR: 96.9%, ≥ 67% sCR, 12-mo PFS: 76.6%; OS: 88.5%
- **CRB-402**: **bb21217:** CART cells engineered for memory T-cells, Phase I, N=69, mDoR; 17mos across all doses.
- **PRIME: P-BCMA-101:** Phase I/II, Manufactured with transposons to preferentially transpose T_{SCM} cells, N=55, ORR: 67%, 1 CRS.
- **BCMA-Directed BiSpecific Antibody in R/R MM**
- **Teclistamab (JNJ-64007957):** Phase I, N=149, ORR: 73% (≥ CR rate: 23% and ≥ VGPR rate: 55%)
- **AMG 701 (Parvuratamab):** Phase I, N= 85, Phase I, Extended half-life for weekly dosing: Responses: 5 sCR, 3 CR, 6 VGPR, 7 PR
- **REGN5458:** Phase I, N=49, 19 responders, 95% with ≥VGPR, 37% with response ≥ 8 mos, mDoR: 6.0 mos
- **BCMA-Directed ADC in R/R MM**
- **MEDI2228:** Humanized anti-BCMA ADC conjugated to tesirine, Phase I, N=82, ORR: 66% at 0.14 mg/kg, mDoR: 5.9 mos, DLT: Thrombocytopenia, Early onset photophobia with discontinuations
- **Belantamab Mafodotin (DREAMM-6: + Bortezomib/Dexamethasone):** Phase II/Preliminary: N=18, ORR: 78%; ≥ VGPR: 67%, 100% keratopathy [61% (11/18) grade 3] **(ALGONQUIN: +Pomalidomide/Dexamethasone):** Phase II, N=24, ORR: 88% ≥ VGPR: 68% with dose dependent keratopathy (Grade 3/4: 25-70%)

Multiple Myeloma: Non-BCMA Targeted Therapy

NON-BCMA-Directed BiSpecific Antibody in R/R MM

Talquetamab: GPCR5D (G protein-coupled receptor class C group 5 member D) x CD3 Antibody, Phase I, N=157, 66% ORR with active doses.

Cevostamab: FcRH5 (Fc Receptor Homolog 5) x CD3 Antibody, Phase I, N=53, ORR: 53% with active doses.

Novel Cereblon E3 ligase modulator CelMOD in R/R MM

Iberdomide Plus Daratumumab/Dex or Bortezomib/Dex: Phase I/II, N=27/23, ORR 42.3%(IDd) and 60.9% (IVd)

Exportin 1 (XPO1) Inhibitor in R/R MM

STOMP Selinexor/Pomalidomide/Dex: Phase I/II, N=64, ORR: 60% (≥ VGPR 30%), CBR: 75%, mPFS: NR

CD 38 Targeted Therapy in R/R MM

APOLLO: Daratumumab SC + Pom/Dex vs Pom/Dex: Phase III, N=304, 37% improved PFS with DPd vs Pd (mPFS: 12.4 vs 6.9 mos; *P* = .0018, HR 0.63)

IKEMA: Isatuximab Plus Carfilzomib/Dex vs Carfilzomib/Dex: Phase III, subgroup analysis: N=302, improved PFS in older ≥ 70 (HR: 0.364), refractoriness status, high risk cytogenetics

Multiple Myeloma: Newly Diagnosed (NDMM)

MAIA in Non-eligible ND MM: (N=737): Phase III, **Daratumumab-Rd** (n=368) or **Rd** (n=369) 5 year Follow-up.

Improved OS: 66% vs. 53% [HR: 0.68; *p*=0.0013], PFS: 53% vs. 29% [HR: 0.53; *p*<0.0001]

GRIFFIN in ASCT-eligible ND MM: Daratumumab + VRd followed by D-R maintenance vs VRd followed by R maintenance; Phase II: N=207,

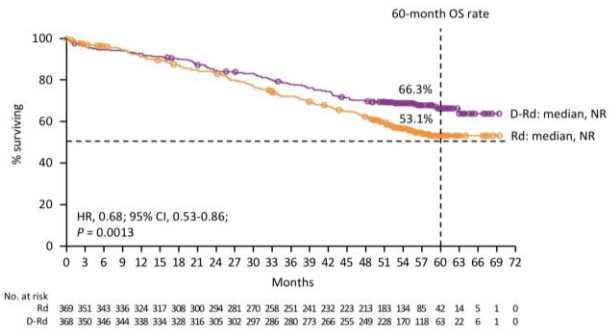
D-VRd + D-R maintenance; 24-mo PFS: 94.5%; 24-mo OS: 94.7%, sCR at 12 mos of maintenance cutoff: 63.6% vs 47.4% (*P* = .0253)

FORTE: KRd with or without ASCT followed by KR or R maintenance in NDMM; Phase II, N=474

KRd-ASCT significantly prolonged 4-yr PFS vs KRd12 across cytogenetic risk groups: standard-risk MM (82% vs 67%), high-risk MM (62% vs 45%), double-hit MM (55% vs 33%)

Maintenance therapy with KR significantly prolonged 3-yr PFS vs R alone: Standard-risk MM (90% vs 73%), high-risk MM (69% vs 59%), double-hit MM (67% vs 42%), except for amp(1q)

OS **MAIA in Non-eligible ND MM: Facon T et al. EHA, 2021; LB190**



D-Rd demonstrated a significant benefit in OS, with a 32% reduction in the risk of death, in patients with NDMM who are transplant ineligible

Hematology: Benign and Not So Benign Disorders

BTK Inhibitor Rilzabrutinib in R/R ITP (including prior splenectomy): Phase I/II, N=53, ORR 42% (400 mg BID)

FLIGHT: First-line Mycophenolate + Steroids vs Standard Steroid Treatment ND ITP: Phase III, N=120,

Similar RR @ 2 wks, fewer TFR with MMF + steroids (22% vs 44%; HR: 0.41; *P* = .0064), SF36 and FACIT-F worse with MMF.

Mitapivat (AG-348)Antisickling, oral, small-molecule inhibitor of pyruvate kinase R, in Sickle Cell Disease: Phase I, N=12, Hb increase by ≥ 1 g/dL in 6 of 11 (55%) and lowered markers of hemolysis.

HOPE-B: Etranacogene Dezaparvovec Gene Therapy in Adults with Severe/Moderately Severe Hemophilia B: Phase III, N=54, total bleeds decreased by 83% and treated bleeds decreased by 91% at 6 mos; 98% d/c of FIX prophylaxis.

PATHFINDER: AVAPRITINIB IN ADVANCED SYSTEMIC MASTOCYTOSIS: Phase II, N=62: (55% with prior midostaurin). ORR: 75% CR: 9%, 12-month OS: 87%

PEGASUS: Pegcetacoplan versus Eculizumab in Paroxysmal Nocturnal Hemoglobinuria; N=80, Phase III, Pegcetacoplan superior; improved hgb from baseline to wk 16,transfusion independence: 85% versus 15%.

PAZOPANIB FOR SEVERE BLEEDING AND TRANSFUSION-DEPENDENT ANEMIA IN HEREDITARY HEMORRHAGIC TELANGIECTASIA: N= 13 (62% prior Bevacizumab), Phase I/II, @ mean dose 100mg, 100% RBC transfusion independence, increased hgb, decreased epistaxis, @12 mo: freedom from anemia 92%, median ferritin increased 91 ng/mL and hemostatic procedures decreased 90%

Hematopoeitic Stem Cell Cell/Cellular Therapy

- **BMT CTN 1102: RIC Allogeneic HSCT vs Non-HSCT Therapy in Patients 50-75 Yrs With Higher-risk MDS: Phase II, N= 384;** 3yr OS: Subgroup analysis of the overall population revealed no difference in OS benefit for donor vs no donor arm based on age
- **UNIVERSAL, Phase I, trial of allogeneic anti-BCMA CAR T-cell therapy in R/R MM, N=35;** ~ 90% received CAR T-cells within 5 days of enrollment, No GVHD or ICANS; 43% grade 1/2 CRS, 5/6 patients assessed with ≥ VGPR had negative MRD status

  CLIMB THAL-111/SCD-121: CTX001(CRISPR/Cas9 modified CD34+ ASCs for TDT β-Thalassemia/Sickle Cell Disease, Phase I/II, first 10 patients with ≥ 3 mos of f/u, achieved TI and no VOC events for SCD
- **GRAFT VERSUS HOST DISEASE:**
- **Gravitas-119: Phase I: N65= Itactinib (JAK-1 inhibitor) plus calcineurin-based regimens** as prophylaxis for aGVHD, 98.3% engraftment, lower rates of aGVHD compared to historical controls.
- **Baricitinib JAK1/2 inhibitor in R/R cGVHD, Phase II, n=20:** ORR at 6 mos (primary endpoint; ITT): 65%
- **ROCKstar: Belumosudil (KD025) oral selective inhibitor of ROCK2 in R/R cGHVD, Phase II, N=132, ORR**: > 70%; QD, 73%; BID, 77% , 44% mean steroid use decline.

What does it all mean?

My thoughts

- **PRACTICE changing:**
- *FIXED DURATION THERAPY IN CLL: Ibrutinib and Venetoclax*
- *Initial therapy with HYPERCVAD/Blinatumumab in ALL*
- *Pirtobrutinib, Umbralisib and Umbratuzumab (U2) in R/R CLL*
- *ASCIMINIB in R/R CML*
- **Practice Confirming**
- *Alternative TKIs; Acalabrutinib and Zanabrutinib for Aes*
- *Anti CD19 therapy in Relapsed DLBCL: Tafasitamab/Lenalidomide and Loncastuximab tesirine, CART-T therapy.*
- **Potentially Practice changing:**
- Copnasilib with Rituximab in R/R iNHL including WM/LPL
- Margolizumab in TP53 mutant AML
- *Enasidenib in IDH2 mutant NDAML,*
- *Frontline Brentuximab vedotin plus Nivolumab in HL*
- *Updated CAR-T Therapy in Myeloma and RR MCL*
- *Pozapanib in Hereditary Hemorrhagic Telangiectasia*
- *Beyond Lenalidomide maiantenance in MM: GRIFFIN/FORTE*
- **Stay tuned**
- *Bispecific antibodies in R/R lymphoma and RRMM*
- *Off the shelf allogeneic CAR-T therapy*
- *Gene Therapy in SCD and Thalassemia*

MULTIPLE MYELOMA: THE CURE AROUND THE CORNER

Kenneth Anderson, MD

PAST PRESIDENT AMERICAN SOCIETY OF HEMATOLOGY 2017

Kraft Family Professor,

Harvard Medical School, Myeloma

Program Director and Chief, Division of Hematologic Neoplasia,

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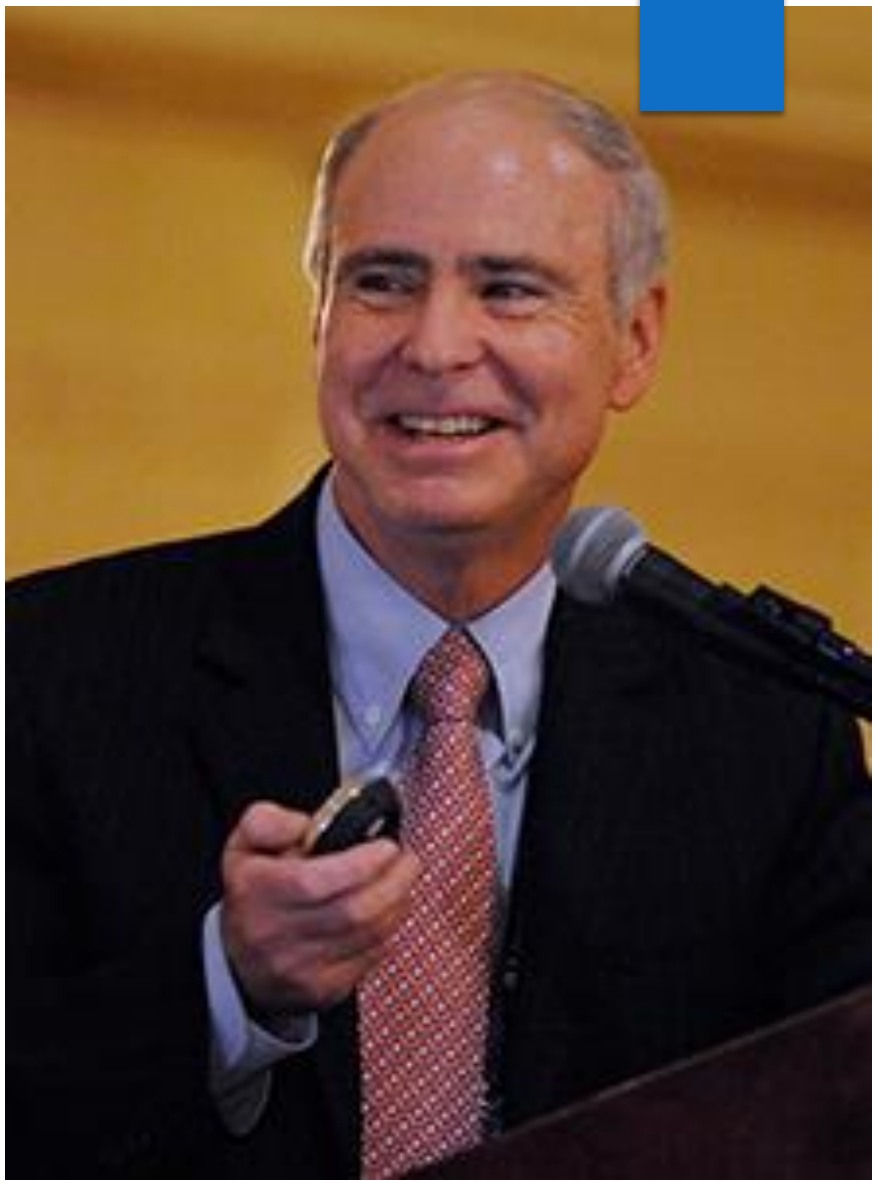

WALDENSTRÖM'S MACROGLOBULINEMIA: TARGETING FOR THE BIG KILL

Steven P. Treon, MD, MA, PhD, FACP, FRCP

Director,

Bing Center for Waldenström's Macroglobulinemia
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CHRONIC MYELOID LEUKEMIA: THERAPY UPDATED AND MODIFIED FOR 2021

Richard A. Larson, MD

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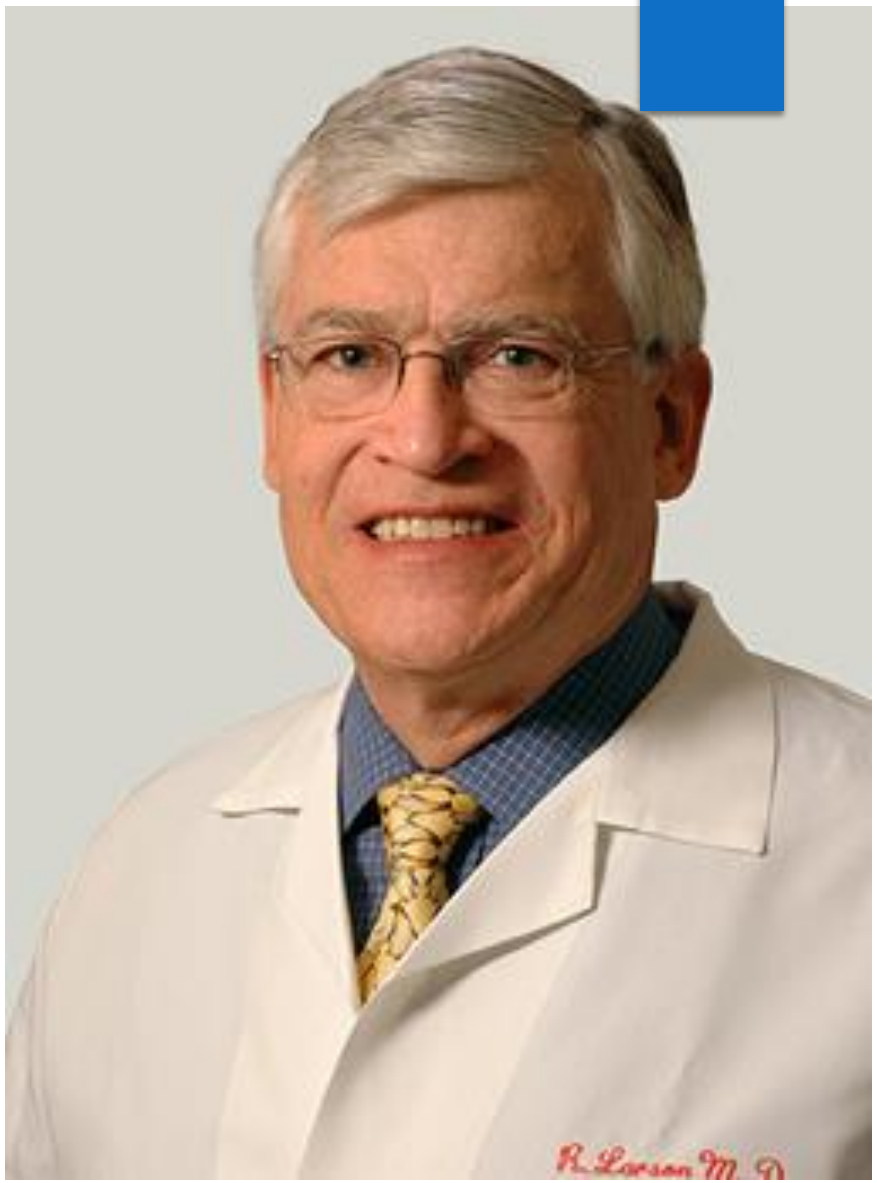


INDOLENT AND MANTLE CELL LYMPHOMA: UPDATING THE TOOLBOX, INCLUDING AND BEYOND ANTI-CD20 ANTIBODIES

Sonali M. Smith, MD

Elwood V. Jensen Professor of Medicine, Interim Section Chief of Hematology/Oncology, and Director of the Lymphoma Program at the University of Chicago's Department of Medicine Chicago, IL

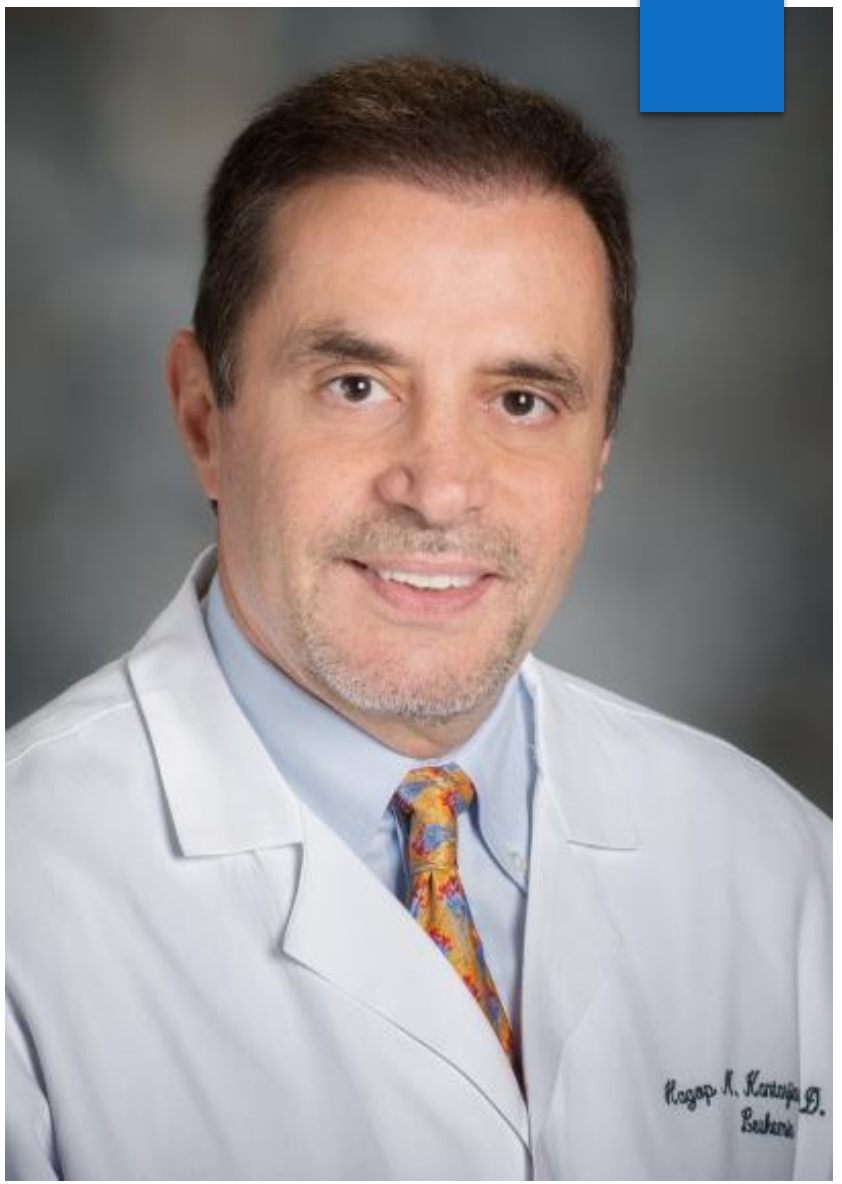
Acute Lymphoblastic Leukemia

Hagop Kantarjian, M.D.

Professor and Samsung Distinguished Leukemia Chair, Department of Leukemia

The University of Texas MD Anderson Cancer Center,

Houston, TX



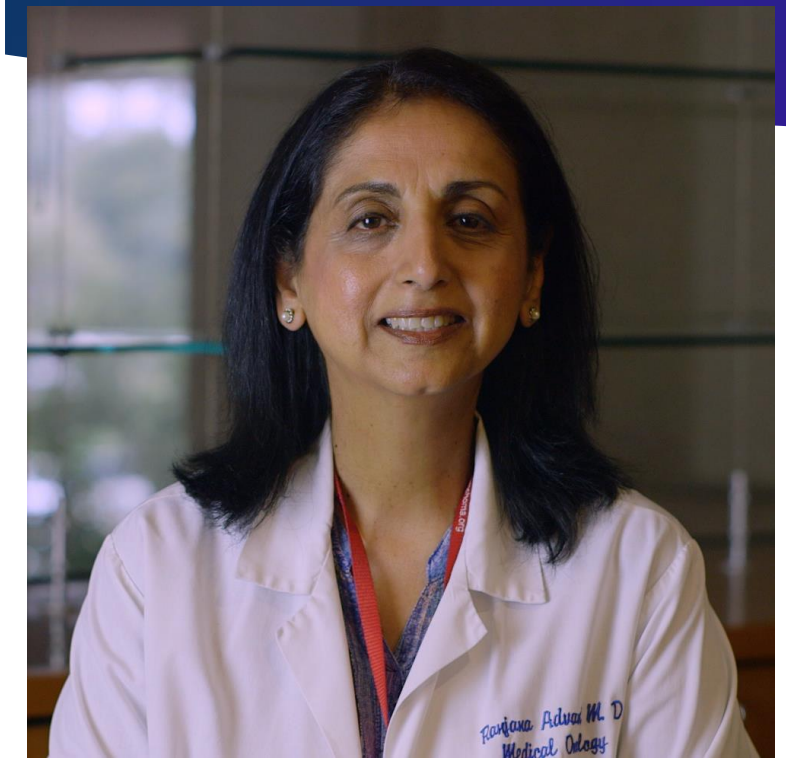
BENIGN HEMATOLOGY: CLOTTING, BLEEDING AND MORE

Craig Kessler, MD

Professor of Medicine and Pathology,

Attending Physician, Division of Hematology-Oncology, Georgetown University Medical Center, Director, Division of Coagulation, Department of Laboratory Medicine and Director of the Therapeutic and Cellular Apheresis Unit. Washington, DC

T. Howard Lee Keynote Lecture



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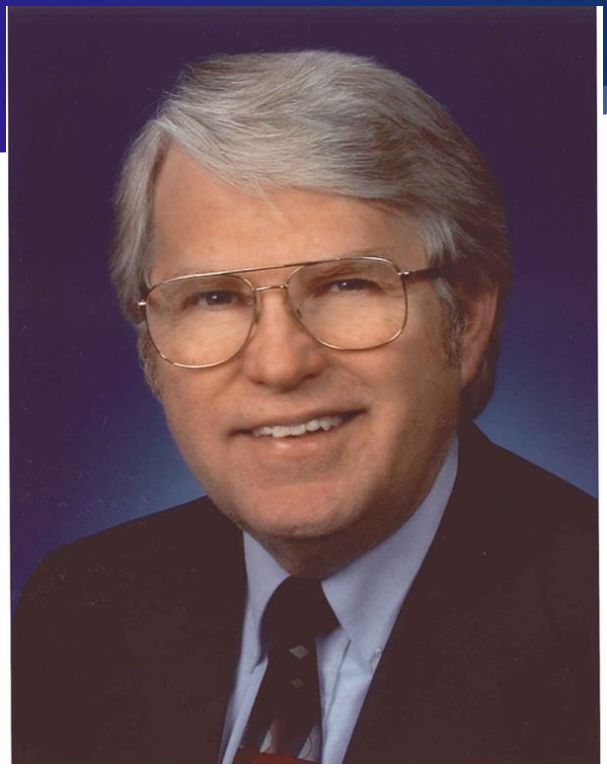
Saul A. Rosenberg Professor of Lymphoma at Stanford University School of Medicine.
Stanford, CA



T. HOWARD LEE, MD
Founder and President Emeritus,
Hematology Oncology of Indiana, PC
Indianapolis, IN

Co-Chair Indy Hematology Review Challenging Cases

MICHAEL C. WIEMANN, MD, FACP

PRESIDENT, CLINICAL
ST. JOHN PROVIDENCE PHYSICIAN NETWORK

DETROIT, MICHIGAN

CLINICAL PROFESSOR OF MEDICINE, MCHIGAN STATE SCOOL OF MEDICINE, EAST LANSING, MI

CHRONIC LYMPHOCYTIC LEUKEMIA: CURABILITY AND DURATION OF THERAPY

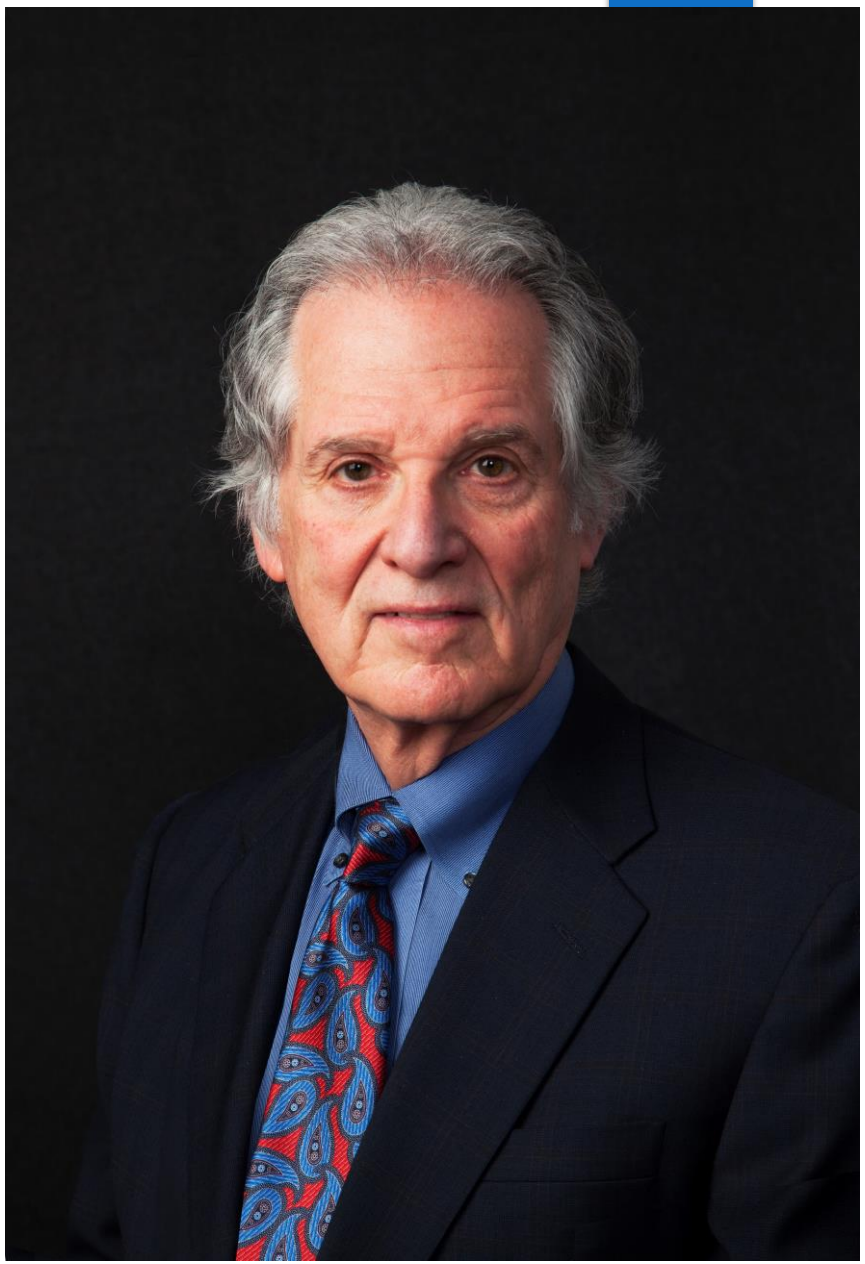
Jennifer Woyach, MD

Professor in the Division of Hematology, Section Chair of Chronic Lymphocytic Leukemia (CLL), and Physician Scientist Focused on Translational Research in CLL, Ohio State University (Columbus, OH)

Relapsed and Refractory CLL "The Cheson Way"

Bruce D. Cheson, MD

Fomerly Professor of Medicine, Georgetown University, Washington DC



MYELOPROLIFERATIVE NEOPLASMS: RISK STRATIFICATION AND THERAPY; A 2021 GLOBAL PERSPECPTIVE

Ruben Mesa, MD, FACP

Executive Director of the Mays Cancer Center,

UT Health San Antonio MD Anderson Cancer Center (Boerne, TX))

MASTOCYTOSIS AND EOSINOPHILIA: THE VEXING DISORDERS OF THE BLOOD

Ayalew Tefferi, MD

Barbara Woodward Lips II Professor of Medicine at the Mayo Clinic (Rochester, MN)

AGGRESSIVE B AND T CELL LYMPHOMAS: EMERGING THERAPIES

John P. Leonard, M.D.
Richard T. Silver Distinguished Professor of Hematology and Medical Oncology and Senior Associate Dean for Innovation and Initiatives at Weill Cornell Medicine.
Executive Vice Chairman of the Weill Department of Medicine at Weill Cornell Medicine and NewYork-Presbyterian Hospital, New York, NY

ACUTE MYELOID LEUKEMIA: FINALLY, A TRIP BEYOND 7+3

Harry Erba, MD

Professor of Medicine, Division of Hematologic Malignancies and Cellular Therapy Director, Duke Leukemia Program, Chair, SWOG Leukemia Committee, Duke University (Durham, NC)

MYELODYSPLASTIC SYNDROME: EMERGING AND TARGETED THERAPIES

Richard Stone, MD

Professor of Medicine

Chair Leukemia Committee ALLIANCE

Chief of Staff and Director of Translational Research for the Adult Leukemia Program at Dana-Farber, and Harvard Medical School, Boston, MA

HEMATOPOIETIC STEM CELL TRANSPLANTATION: UPDATING THE OLD CLOSET

Rear Admiral (RADM) Richard Childs, MD
Clinical Director of the National Heart, Lung, and Blood Institute (NHLBI) at the National Institutes of Health (NIH)

Nursing and Allied Health Symposium

Moderators

Thalia Hammond

Donna M. Birhiray, OTR, MBA

David Reeves, PharmD, BCOP

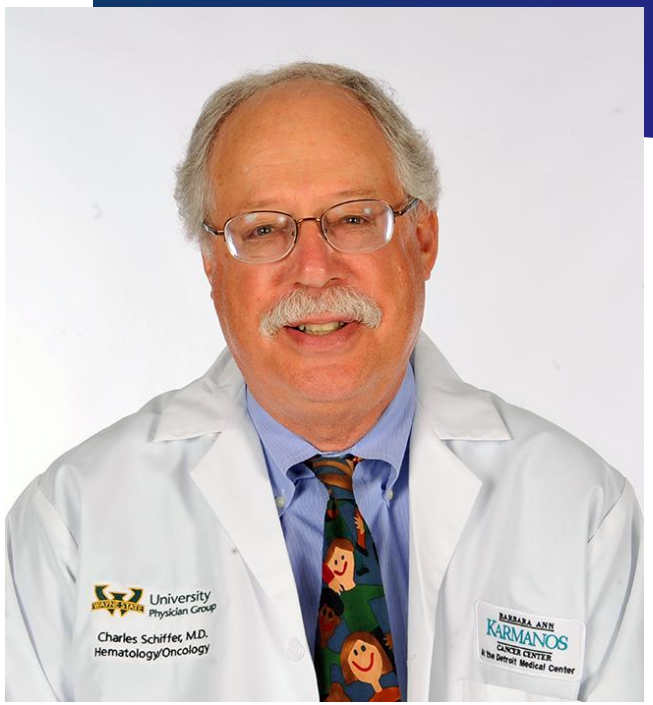
Associate Professor, Butler University and Clinical Pharmacist at Franciscan Hospital,

Kristi Orbaugh, RN, MSN, RNP, AOCN Community Hospital Oncology Physicians Indianapolis,

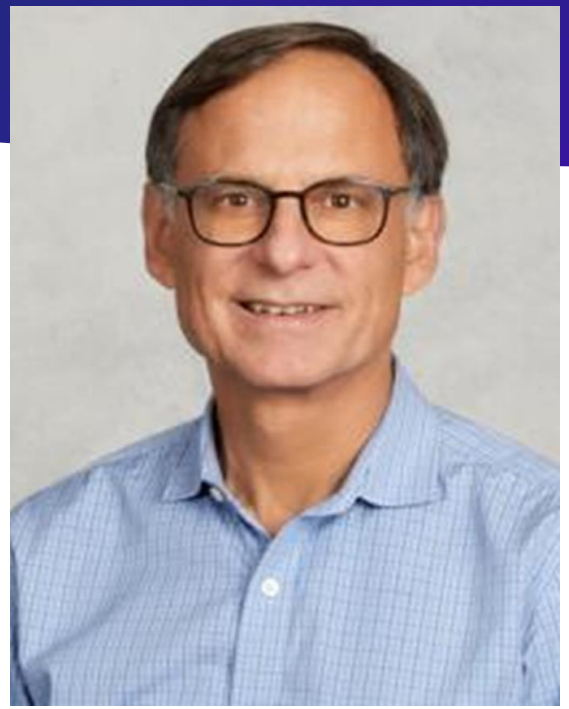
Evening with Experts: Surviving Cancer With Art Therapy

- Meaghan E. Wiggins, MA
- Art Therapist
- Clinical Hospital Coordinator,
- Cancer Support Community,
- Indianapolis, IN

Hematologic Malignancies Town Hall



Charles Schiffer, MD
Emeritus Professor of Oncology and previously the Joseph Dresner Chair for Hematologic Malignancies Wayne State University School of Medicine Detroit, MI



Steven Coutré, MD,
Professor of Medicine in the Division of Hematology at the Stanford University School of Medicine in Stanford, USA

Jessica K. Altman, MD, Professor of Medicine, Northwestern University Feinberg School of Medicine. Director of the Acute Leukemia Program at Robert H. Lurie Cancer Center of Northwestern University.

Morie Gertz, MD
Professor of the Art of Medicine and Chair Emeritus Department of Medicine, Mayo Clinic, Rochester, MN.

PLUS: Michael Weimann,MD, Sonali Smith MD, Jennifer Woyach, MD, MD, Bruce D. Cheson, M.D., FACP, FAAAS, FASCO

SAVE THIS DATE !

19th Annual Indy Hematology Review 2022

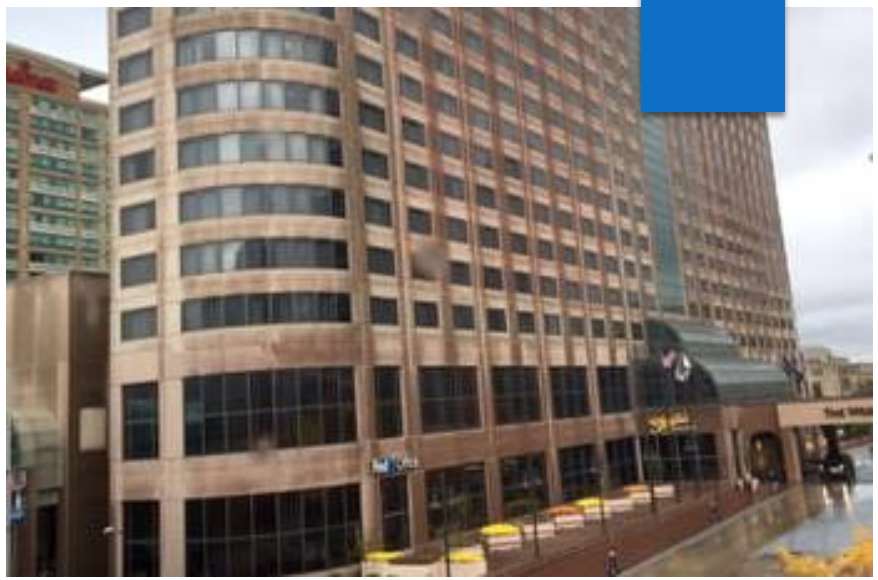
(http://www.indyhematologyreview.com)

March 26th, 2022

Westin Indianapolis,

Indianapolis,

Indiana, 46204



And The Winners are ….

Announcements and Acknowledgments

Support clinical research diversity and inclusion in blood cancers and blood diseases at #DRIVE WITH IHE

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Indy Hematology Review

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60. Mailankody. ASH 2020. Abstr 129
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63. Holtzman. ASH 2020. Abstr 357.
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