FALL NEWSLETTER

1ST EDITION NOVEMBER 2023

ACCESS TO IMMUNE EFFECTOR THERAPIES

Written by Nicola Donelan

Bispecific antibodies, CAR-T therapies and other immunotherapies directed towards T-cells or malignant cells are the therapies that the CONCERT Network will focus on bringing to a more diverse and greater number of patients. According to Beth Price, CEO of Accellapy, a very small percentage of patients currently have access to these therapies. "Less than 15 % of the patients eligible for cellular therapy are receiving this therapy," said Beth. She went on to explain that most patients diagnosed and living with cancer are treated in community oncology programs across the country. However, these therapies are predominantly being offered at academic medical centers. Consequently, access to potentially curative cancer treatment is limited. "All providers must

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CONCERT NETWORK

Community ONcology CEllulaR Therapy Network

INSIGHTS FROM THE 2ND MEETING OF THE CONCERT NETWORK

Written by Nicola Donelan

September 30th, 2023, the Indy Hematology Education, Inc. held the second meeting of the CONCERT (Community ONcology CEllulaR Therapy) Network at the Westin, Indianapolis. Several KOLs in the field of hematology oncology attended either physically or remotely and discussed both the advancement of the CONCERT Network and the development of a positioning paper. The paper will serve to guide community oncology practices on the implementation of immune effector therapies for hematologic malignancies, with an aim to alleviate existing disparities in cancer care and make assessable modern therapies to patients in the community. The meeting participants highlighted the need for this type of network and discussed many pertinent issues relating to the delivery of cellular therapy on a community level.

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equip themselves to offer this therapy and open the aperture for access to those who want the treatment and need it. The time is now," emphasized Beth.

CAR-T therapy involves genetically modifying the patient's own T cells, and then reinfusion of the modified cells back into the patient. This therapy can lead to potentially severe side effects, including cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS). Bispecific antibodies are typically manufactured as off-the-shelf products, making them more readily available for a wider patient population. While bispecific can result in adverse effects, they tend to be less severe and more manageable than those associated with CAR-T therapy.

Dr. Saad Usmani, Chief of the Myeloma Service at Memorial Sloan Kettering Cancer Center explained that sometimes physicians must choose between different types of therapies due to logistical reasons. "The availability of manufacturing slots will get in the way of using CAR-Ts, and if that's the case, then bispecific in that scenario is totally fine," said Dr. Usmani in reference to treating multiple myeloma with B-cell maturation antigen (BCMA)-targeted therapy.

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Dr. Ruemu Birhiray, President/CEO of Indy Hematology Education, Inc., is fully committed to this mission, and had these closing remarks: "Cellular therapies including CAR-T and bispecific antibodies provide us with a new therapeutic frontier and extend our armamentarium for the treatment of hematologic malignancies. We must master and offer these therapies to our patients, particularly closer to home and in their communities. The CONCERT network aims to provide the tools and framework to enhance the early adoption and deployment of these novel therapies in the community oncology setting," said Dr. Birhiray.

COST AND REIMBURSEMENT FOR CELLULAR THERAPIES

Written by Nicola Donelan

Cellular therapies can be time-consuming and expensive to manufacture. Then once treatment begins the inpatient costs need to be taken into account. "The team has to be as equipped on the inpatient side as they are in the office," and "organizations need to know what costs are associated with treating these patients and many organizations don't;" explained Beth Price.

When asked if there are significant investments involved in setting up a community oncology practice that offers these therapies, Beth explained that the amount of capital investment to implement cellular therapy primarily depends on whether a site intends to offer apheresis.

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"If a site chooses to offer apheresis, then people, training, equipment, and space will all be necessary. Generally, implementation cost will be driven by delivery of training for the clinical team and in designing effective clinical workflows needed to support the patient journey and positive outcomes," she explained.

Dr. Murthu Veeraputhiran, Associate Professor at the University of Arkansas for Medical Sciences (UAMS) outlined what is required for a community practice set up that can support outpatient therapies. His list included a robust outpatient infusion unit that can support daily monitoring up to 14 days, then 3 times per week monitoring until the 30-day follow-up period is over. Patients require a caregiver during the first month of therapy, and they need to stay within 30 minutes of the infusion unit, or an emergency room should grade 3 or 4 CRS and ICANS occur.

Brooke Peters, Clinical Pharmacist at American Oncology Network (AON) spoke on the topic of reimbursement, and she stated that permanent J codes are the most useful, but not all these new therapies have designated codes. Reimbursement policies for CART and bispecific needs to be closely monitored for any major gaps. Peters explained that a new technology add-on payment (NTAP) designation can enable additional payment to hospitals above the standard Medicare Severity Diagnosis-Related Group (MS-DRG) payment amount. She emphasized that these designations are constantly in flux therefore staying up to date with all the current designations for immune effector therapies is critical.

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RISK MITIGATION AND LEVEL OF COMFORT

Written by Nicola Donelan

Robust risk evaluation and mitigation strategies (REMS) programs will be necessary for the success of immune effector therapies delivered at community oncology practices. This is a pivotal component of the CONCERT Network positioning paper which emphasizes that key clinical personnel should be designated as immune effector therapy champions. These champion clinical personnel should be adequately trained on the treatment indications and be able to recognize and manage adverse reactions associated with immune effector therapies, as well as educate and inform ER physicians and nursing teams.

Community oncology practices that offer these therapies need to be prepared for patients needing extra care if or when adverse reactions occur. Advances in the field may bring less toxic CAR-T products to the market. Dr. Edwards mentioned this possibility, as he shared some results from a recent trial on the safety and efficacy of obecabtagene autoleucel (obe-cel, AUTO1), a new CD-19 CAR -T product. "I think that cellular therapies with a lower toxicity profile are on the horizon for us very soon, which might be more amenable to the community setting in particular," said Edwards, referring here to the treatment of relapsed/refractory adult B-cell acute lymphoblastic leukemia.

Managing CRS and ICANS is going to be a key step for allowing patients to become comfortable with cellular therapies. As Dr. Tycel Phillips, from City of Hope in Duarte, California, highlighted that patient acceptance of cellular therapies will be dictated by how comfortable they are with receiving these treatments. "Whether these drugs sink or swim won't be dictated by academic centers, it will be the community that determines this," said Dr. Phillips.

OVERCOMING THE CHALLENGES TO DELIVER THERAPY WILL REQUIRE A TEAM EFFORT

Written by Nicola Donelan

Dr. Ralph Boccia, the founder of The Center for Cancer and Blood Disorders in Maryland, has significant experience with conducting clinical trials for CAR-T and bispecific in an outpatient community center setting. He is acutely aware of the many stumbling blocks that community oncologist face in setting up outpatient delivery of these therapies.

"Currently, the FDA-approved labels suggest that patients given bispecific "should" be admitted to the hospital to receive and be monitored for CRS and ICANS for some period depending on the agent. Hospitals are traditionally unwilling to admit patients for observation and treatments. The cost of the therapeutic agents, cost of toxicity managing drugs such as tocilizumab, and the cost of possible ICU stays has previously prohibited these treatments from being offered outside of tertiary care centers," described Dr. Boccia.

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He also provided the following words of advice to a community oncology practice that is interested in setting up their first outpatient immune effector therapy program. "Learning about and administering cell therapies requires learning a very new process not only around the acquisition and administration of these treatments, but extremely importantly, understanding a new set of toxicities that can be life threatening, and being absolutely sure to be prepared how to safely manage these significant and distinct adverse events. This is not a therapy that one can simply read about and implement. Having a coach or mentor or experienced partner is critical. Joining an organization like CONCERT, whose mission is to help develop cell therapy capability in appropriate community practices, can be such an opportunity or start," explained Dr. Boccia.

Dr. Evan Chen, from the Dana-Faber Cancer Institute at Harvard, expressed with confidence and enthusiasm his opinion on the CONCERT Network. "This is an immensely important and novel initiative to bring cutting-edge life-saving treatments to more patients in the community who may not live close to a tertiary care medical center. Success in this initiative will require significant multidisciplinary effort and capital investment, but I am confident in the benefits of this important mission and am honored to be able to contribute," he said.

CONCLUSION

After a very collaborative and informative meeting the participants left eager to continue their efforts on developing the CONCERT POSITION PAPER titled "**How we set-up and manage immune effector therapies in community oncology practices**". The aim will be to have this document serve as an overarching blueprint for oncologists to leverage for delivering these life-saving therapies at a community level. The time is now to collaborate, mobilize efforts, and expert capabilities, and work towards providing these cutting-edge treatments to diverse populations.

Extended Follow-up and Landmark Analyses from Pivotal Phase II Trial of Glofitamab in R/R LBCL

Data from a phase 2 trial of glofitamab for relapsed/refractory large B-cell lymphoma (R/R LBCL) shows durable responses and supports the potential for favorable long-term outcomes in heavily pretreated subjects. vSource: Falchi. ASCO 2023. Abstr 7550. For more information see: https://meetings.asco.org/abstracts-presentations/218270

COMMANDS: Luspatercept vs Epoetin alfa for ESA-Naive Transfusion-Dependent Lower-Risk MDS

Phase III trial data for treatment of ESA-naive transfusion-dependent lower-risk MDS demonstrated that luspatercept has a greater efficacy over epoetin and also has the potential to be groundbreaking for treatment of anemia associated with MDS. Source: Garcia-Manero. ASCO 2023. Abstr 7003. For more information see: https://meetings.asco.org/abstracts-presentations/227085/video

IMerge: Phase III Trial of Imetelstat vs Placebo for Transfusion-Dependent Lower-Risk MDS Relapsed/Refractory to ESAs

A phase III trial of imetelstat vs placebo for transfusion-dependent lower-risk MDS relapsed/refractory to ESAs showed that imetelstat had higher RBC-TI rates compared to the placebo which supports the use of imetelstat for treatment. Source: Zeidan. ASCO 2023. Abstr 7004. For more information see: https://meetings.asco.org/abstracts-presentations/219862

Elranatamab Monotherapy for R/R MM After Previous BCMA-Directed Therapy: Pooled Analysis of MagnetisMM Studies

Pooled analysis of four different phase I/II trails (MagnetisMM-1,2,3 and 9) evaluating elranatamab monotherapy for relapsed/refractory multiple myeloma (R/R MM) after previous BCMA-directed therapy demonstrated a 46% ORR and was deemed a reasonable treatment option for patients. Source: 1. Nooka. ASCO 2023. Abstr 8008. 2 Mohty. ASCO 2023. Abstr 8039. For more information see: https://meetings.asco.org/abstracts-presentations/219989 and https://meetings.asco.org/abstracts-presentations/224423

JACKPOT8 Part B: Pivotal Phase II Study of Golidocitinib, a JAK1-Selective Inhibitor, in Relapsed/Refractory PTCL

A phase II study of golidocitinib demonstrated antitumor efficacy and an acceptable safety profile in patients with relapsed/refractory PTCL in all subtypes examined. Source: 1. Kim. ASCO 2022. Abstr 7563. 2. Cai. ASCO 2023. Abstr 7503. For more information see: https://meetings.asco.org/abstracts-presentations/218269

EPCORE NHL-1 Update: Pivotal Phase I/II Trial of Epcoritamab in Patients With R/R B-Cell NHL

In a phase I/II trial epcoritamab showed durable responses and favorable long-term outcomes in patients with R/R B-Cell NHL. This data supports ongoing phase III trials. Source: 1. Karimi. ASCO 2023. Abstr 7525. 2. Thieblemont. JCO. 2023; 41:2238. For more information see: https://dailynews.ascopubs.org/do/long-term-data-support-newly-approved-epcoritamab-relapsed-refractory-large-b-cell

KEYNOTE-667 High-Risk Group Update: Pembrolizumab + COPDAC-28 Consolidation in Children and AYA cHL

Pembrolizumab + COPDAC-28 augmented treatment responses in children and AYA patients with high-risk cHL in a phase II trial. Source: Vinti. ASCO 2023. Abstr 10027. For more information see: https://meetings.asco.org/abstracts-presentations/227173

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BRUIN 2-Yr Update: Phase I/II Trial Evaluating Pirtobrutinib in Covalent BTKi–Treated MCL

Updates from a phase I/II trial demonstrated promising efficacy of pirtobrutinib in patients with previously treated MCL1 and was well tolerated. Source: 1. Shah. ASCO 2023. Abstr 7514. 2. Mato. Lancet. 2021;397:892. For more information see: https://meetings.asco.org/abstracts-presentations/218281

Phase I: BCMA-Targeted PHE885 CAR T-Cell Therapy with Rapid Manufacturing Time for R/R Multiple Myeloma

BCMA-Targeted PHE885 CAR T-Cell Therapy was found to be safe and effective for patients with R/R MM after ≥2 lines of therapy in a phase I trial. Source: Sperling. ASCO 2023. Abstr 8004. For more information see: https://meetings.asco.org/abstracts-presentations/218470

MajesTEC-1 Update: Phase I/II Study of Teclistamab in Patients With R/R MM

A follow up to the Phase I/II study of teclistamab in patients with R/R MM after a two-year period showed continued durable responses in the patients, including those that switched to a reduced dosing schedule. Source: 1. van de Donk. ASCO 2023. Abstr 8011. 2. Moreau. NEJM. 2022;387:495. For more information see: https://meetings.asco.org/abstracts-presentations/227285

Cardiotoxicity of CPX-351 vs 7+3 in Previously Untreated High-Risk or Secondary AML: Post Hoc Analysis of a Pivotal Phase III Trial

A post hoc analysis demonstrated that CPX-351 had a lower cardiotoxicity than 7+3, in patients with previously untreated high-risk or secondary AML. Source: Mitchell. ASCO 2023. Abstr 7029. For more information see: https://meetings.asco.org/abstracts-presentations/220547

CARTITUDE-1 Update: Phase I/II Trial of Ciltacabtagene Autoleucel for Heavily Pretreated Relapsed/Refractory Multiple Myeloma.

An end of study analysis after 2.7 years of a phase I/II trial of ciltacabtagene autoleucel showed durable treatment responses for heavily pretreated patients with R/R MM, however new cases of second primary malignancies were reported. Source: Lin. ASCO 2023. Abstr 8009. For more information see: https://meetings.asco.org/abstracts-presentations/221911

Alliance A041703: Phase II Trial of Inotuzumab Ozogamicin Induction Followed by Blinatumomab Consolidation for Older Adults with Newly Diagnosed Ph-Negative, CD22-Positive B-ALL

Data from this phase II trial demonstrated a 1-year EFS rate of 75% in older adults with newly diagnosed Ph-Negative, CD22-Positive B-ALL. This data supports the use of this regimen as the standard treatment for this population. Source: Wieduwilt. ASCO 2023. Abstr 7006 For more information see: https://meetings.asco.org/abstracts-presentations/219865

TRANSCEND CLL 004: Phase I/II Trial of Lisocabtagene Maraleucel for Relapsed/Refractory CLL/SLL

A single administration of lisocabtagene maraleucel was associated with manageable safety and clinical activity in patients with R/R CLL/SLL and is considered to be a potential novel treatment for this population. Source: Siddiqi. ASCO 2023. Abstr 7501. Siddiqi. Lancet. 2023; [Epub]. For more information see: https://meetings.asco.org/abstracts-presentations/218268

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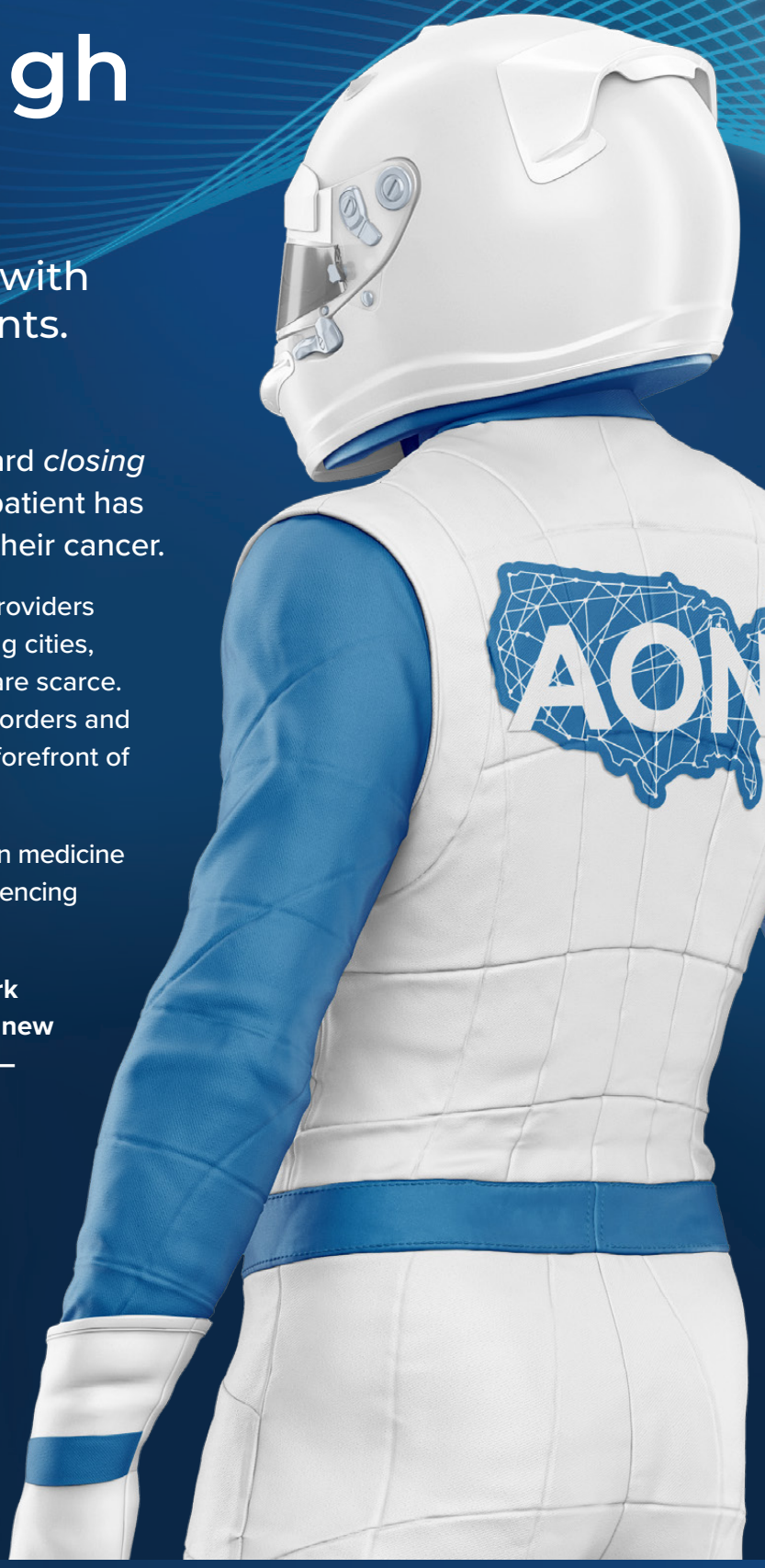

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SWOG S1826: Phase III Trial of Nivolumab + AVD vs Brentuximab Vedotin + AVD for Newly Diagnosed Advanced cHL

Results from a phase III trial showed that Nivo/AVD significantly improved PFS and EFS when compared to BV/AVD and could potentially be the new standard of care for newly diagnosed advanced stage cHL patients. This is the largest study to date by the NCTN and is a critical step towards harmonizing care in adults and pediatric patients with AS HL. Source: Herrera. ASCO 2023. Abstr LBA4. For more information see: https://meetings.asco.org/abstracts-presentations/219808

CARTITUDE-4: Phase III Trial of Ciltacabtagene Autoleucel vs SoC for Lenalidomide-Refractory Multiple Myeloma

Data from this phase III trial demonstrated that ciltacabtagene autoleucel treatment resulted in a greater PFS when compared with the SoC (PVd or DPd) in patients with lenalidomide-refractory MM after 1-3 prior lines of therapy and has the potential to be the new standard of care. Source: Dhakal. ASCO 2023. Abstr LBA106. San-Miguel. NEJM. 2023;[Epub]. For more information see: https://meetings.asco.org/abstracts-presentations/220015

First results from the RedirecTT-1 study with teclistamab (tec) + talquetamab (tal) simultaneously targeting BCMA and GPRC5D in patients (pts) with relapsed/ refractory multiple myeloma (RRMM).

Results from a phase 1b trial show that combination therapy using BCMA- and GPRC5D-targeted bispecific antibodies had clinical efficacy and a manageable safety profile in RRMM patients. These first results support further evaluation of the tec/tal combination therapy, especially in the EMD high-risk, underserved population. Source: DOI: 10.1200/JCO.2023.41.16_suppl.8002 Journal of Clinical Oncology 41, no. 16_suppl (June 01, 2023) 8002-8002. For more information see: https://ascopubs.org/doi/pdf/10.1200/JCO.2023.41.16_suppl.8002?role=tab

Is There a Correlation Between Progression-Free and Overall Survival in Classical Hodgkin Lymphoma?

Data from Phase III randomized GHSG trials shows there is a high correlation between PFS and OS following first-line treatment for patients with classical Hodgkin lymphoma (HL) and PFS can be used to predict treatment effects on OS before OS evaluation. Source: Bröckelmann et al., 2023. For more information see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10428466/

Factors Associated with Long-Term Survival in a Patient Cohort with Acute Promyelocytic Leukemia

A harmony alliance study found that there is a significant survival benefit of the ATRA-ATO chemotherapy-free regimen for patients with APL compared to the AIDA regimen, irrespective of their risk profile. Source: Guarnera et al., 2023. For more information see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10428328/

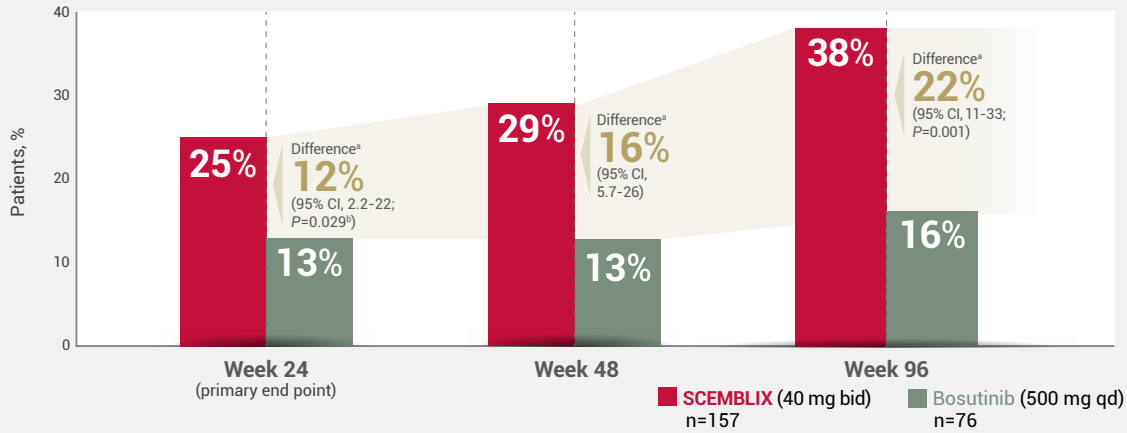
Chimeric Antigen Receptor T Cell Therapy for Post-Transplant Relapse

In a retrospective study assessing the outcomes following chimeric antigen receptor (CAR) T cell therapy, tisagenlecleucel (Tisa-cel), for post-haematopoietic stem cell transplant (HSCT) relapse in young patients (≤25 years) with CD19 positive acute lymphoblastic leukemia (ALL), it was found that late relapsed patients treated with a single Tisa-cel infusion had a positive prognosis, while T cell effector function may be sub-potent in patients that suffered early relapse. Source: Bader et al., 2023 For more information see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10428254/

SCEMBLIX is the first treatment to demonstrate superior response rates vs bosutinib in a Phase 3 trial[1-9]

The MMR benefit with SCEMBLIX vs bosutinib increased over time[1]

MMR rate[1,10]

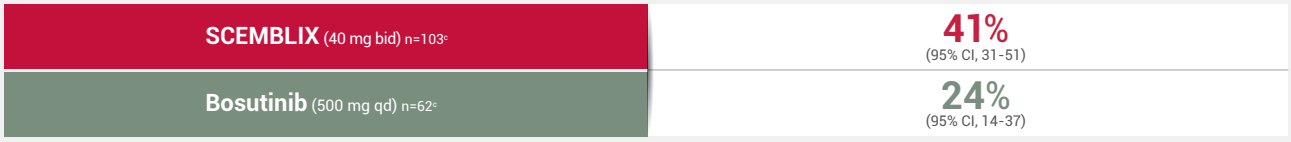


• Median follow-up was 28 months[1]

The median duration of treatment was 24 months (range: 0 to 46 months) for patients receiving SCEMBLIX and 7 months (range: 0 to 43 months) for patients receiving bosutinib.[1]

More patients achieved CCyR at Week 24 with SCEMBLIX vs bosutinib[1]

CCyR rate[1]



The CCyR rate at Week 96 was 40% (95% CI, 30-50) in patients receiving SCEMBLIX and 16% (95% CI, 8-28) for bosutinib. Note that any patients who achieved CCyR and later achieved MMR would not have been assessed for CCyR at Week 96. Of patients achieving CCyR during the study, 1 patient in the SCEMBLIX arm and 2 patients in the bosutinib arm lost response.[1,10]

Results from a multicenter, 2:1 randomized (stratified by MCyR status), active-controlled, and open-label study for the treatment of 233 adult patients with Ph+ CML-CP previously treated with ≥2 TKIs: 157 patients received SCEMBLIX at 40 mg bid and 76 patients received bosutinib at 500 mg qd until unacceptable toxicity or treatment failure occurred.[1]

bid, twice daily; CCyR, complete cytogenetic response; IS, International Scale; MCyR, major cytogenetic response; MMR, major molecular response; qd, once daily.

MMR was defined as *BCR::ABL1*[IS] ≤0.1%.[1]
CCyR was defined as 0% of Philadelphia chromosome–positive metaphases in bone marrow aspirate with at least 20 examined.[1]
MCyR was defined as 0% to 35% Ph+ metaphases.[10]

[a]Estimated using a common risk difference stratified by baseline MCyR status.
[b]Estimated using a Cochran-Mantel-Haenszel 2-sided test stratified by baseline MCyR status.
[c]CCyR analysis based on patients who were not in CCyR at baseline.

INDICATIONS

SCEMBLIX is indicated for the treatment of adult patients with:

- Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with 2 or more tyrosine kinase inhibitors (TKIs)
- Ph+ CML in CP with the T315I mutation

IMPORTANT SAFETY INFORMATION for SCEMBLIX

Myelosuppression

- Thrombocytopenia, neutropenia, and anemia, including grade 3/4 reactions, have occurred in patients receiving SCEMBLIX

Please see Important Safety Information on pages 2-3 and full Prescribing Information.

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets

Global: Links to: https://www.novartis.com/us-en/sites/novartis_us/files/scemblix.pdf

GLOBAL: Links to:https://www.hcp.novartis.com/products/scemblix/ph-cml/#important-safety-info

Myelosuppression

- Thrombocytopenia, neutropenia, and anemia, including grade 3/4 reactions, have occurred in patients receiving SCEMBLIX
- Perform complete blood counts every 2 weeks for the first 3 months of treatment and monthly thereafter or as clinically indicated. Monitor patients for signs and symptoms of myelosuppression
- Based on the severity of thrombocytopenia and/or neutropenia, reduce dose, temporarily withhold, or permanently discontinue SCEMBLIX as described in the prescribing information

Pancreatic Toxicity

- Pancreatitis (including grade 3 reactions) and asymptomatic elevation in serum lipase and amylase (including grade 3/4 elevations), have occurred in patients receiving SCEMBLIX
- Assess serum lipase and amylase levels monthly during treatment with SCEMBLIX, or as clinically indicated. Monitor patients for signs and symptoms of pancreatic toxicity. Perform more frequent monitoring in patients with a history of pancreatitis
- If lipase and amylase elevation are accompanied by abdominal symptoms, temporarily withhold SCEMBLIX and consider appropriate diagnostic tests to exclude pancreatitis
- Based on the severity of lipase and amylase elevation, reduce dose, temporarily withhold, or permanently discontinue SCEMBLIX as described in the prescribing information

Hypertension

- Hypertension, including grade 3/4 reactions, have occurred in patients receiving SCEMBLIX
- Monitor and manage hypertension using standard antihypertensive therapy during treatment with SCEMBLIX as clinically indicated
- For grade 3 or higher reactions, temporarily withhold, reduce dose, or permanently discontinue SCEMBLIX as described in the prescribing information depending on persistence of hypertension

Hypersensitivity

- Hypersensitivity, including grade 3/4 reactions, have occurred in patients receiving SCEMBLIX. Reactions included rash, edema, and bronchospasm
- Monitor patients for signs and symptoms and initiate appropriate treatment as clinically indicated
- For grade 3 or higher reactions, temporarily withhold, reduce dose, or permanently discontinue SCEMBLIX as described in the prescribing information depending on persistence of hypersensitivity

Cardiovascular Toxicity

- Cardiovascular toxicity (including ischemic cardiac and central nervous system conditions; and arterial thrombotic and embolic conditions) and cardiac failure have occurred in patients receiving SCEMBLIX. Some toxicities were grade 3/4 and 3 fatalities were reported
- Arrhythmia, including QTc prolongation, have occurred in patients receiving SCEMBLIX. Some of these arrhythmias were grade 3
- Monitor patients with a history of cardiovascular risk factors for cardiovascular signs and symptoms. Initiate appropriate treatment as clinically indicated
- For grade 3 or higher cardiovascular toxicity, temporarily withhold, reduce dose, or permanently discontinue SCEMBLIX as described in the prescribing information depending on persistence of cardiovascular toxicity

Embryo-Fetal Toxicity

- SCEMBLIX can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus if SCEMBLIX is used during pregnancy or if the patient becomes pregnant while taking SCEMBLIX
- Verify the pregnancy status of females of reproductive potential prior to starting treatment with SCEMBLIX. Advise females to use effective contraception during treatment and for at least 1 week after the last SCEMBLIX dose

ADVERSE REACTIONS

- Most common adverse reactions (≥20%) were upper respiratory tract infections, musculoskeletal pain, headache, fatigue, nausea, rash, and diarrhea
- Most common laboratory abnormalities (≥20%) were platelet count decreased, triglycerides increased, neutrophil count decreased, hemoglobin decreased, creatine kinase increased, alanine aminotransferase increased, lipase increased, amylase increased, aspartate aminotransferase increased, uric acid increased, and lymphocyte count decreased

DRUG INTERACTIONS

- Asciminib is an inhibitor of CYP3A4, CYP2C9, and P-gp. Asciminib is a CYP3A4 substrate
- Closely monitor for adverse reactions during concomitant use of strong CYP3A4 inhibitors and SCEMBLIX at 200 mg twice daily
- Avoid concomitant use of itraconazole oral solution containing hydroxypropyl-β-cyclodextrin and SCEMBLIX at all recommended doses
- Closely monitor for adverse reactions during concomitant use of certain CYP3A4 substrates and SCEMBLIX at 80 mg total daily dose. Avoid use of SCEMBLIX at 200 mg twice daily
- Avoid concomitant use of CYP2C9 substrates and SCEMBLIX at all recommended doses. If coadministration with 80 mg total daily dose is unavoidable, reduce the CYP2C9 substrate dosage as recommended in its prescribing information. If coadministration with 200 mg twice daily is unavoidable, consider alternative therapy with a non-CYP2C9 substrate
- Closely monitor for adverse reactions during concomitant use of certain P-gp substrates and SCEMBLIX at all recommended doses

Please see full Prescribing Information.

References: 1. Scemblix [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corp. **2.** Soverini S, Gnani A, Colarossi S, et al. *Blood.* 2009;114(10):2168-2171. **3.** O'Brien SG, Guilhot F, Larson RA, et al. *N Engl J Med.* 2003;348(11):994-1004. **4.** Saglio G, Kim D-W, Issaragrisil S, et al. *N Engl J Med.* 2010;362(24):2251-2259. **5.** Kantarjian H, Shah NP, Hochhaus A, et al. *N Engl J Med.* 2010;362(24):2260-2270. **6.** Cortes JE, Gambacorti-Passerini C, Deininger MW, et al. *J Clin Oncol.* 2018;36(3):231-237. **7.** Kantarjian HM, Giles FJ, Bhalla KN, et al. *Blood.* 2011;117(4):1141-1145. **8.** Cortes JE, Kantarjian HM, Brümmendorf TH, et al. *Blood.* 2011;118(17):4567-4576. **9.** Shah NP, Kantarjian HM, Kim D-W, et al. *J Clin Oncol.* 2008;26(19):3204-3212. **10.** Data on file. CABL001A2301 clinical study report. Novartis Pharmaceuticals Corp; 2022.

For adults with Ph+ CML-CP after 2 or more TKIs

A FORCE AGAINST CML. FINE-TUNED.[1]

As the first and only inhibitor that binds to the ABL myristoyl pocket, SCEMBLIX offers a different approach for treating Ph+ CML-CP.[1]

SCEMBLIX tolerability profile in a population with suboptimal responses and/or intolerance to 2 or more prior TKIs

- The most common (≥20%) adverse reactions in patients who received SCEMBLIX were upper respiratory tract infections, musculoskeletal pain, headache, and fatigue[1]
- The most common select laboratory abnormalities that worsened from baseline in ≥20% of patients who received SCEMBLIX were platelet count decreased, triglycerides increased, neutrophil count decreased, hemoglobin decreased, creatine kinase increased, alanine aminotransferase (ALT) increased, aspartate aminotransferase (AST) increased, uric acid increased, and lymphocyte count decreased[1]
- Serious adverse reactions occurred in 18% of patients who received SCEMBLIX. Serious adverse reactions in ≥1% included cardiac failure congestive (1.9%), pyrexia (1.9%), urinary tract infection (1.9%), headache (1.3%), and thrombocytopenia (1.3%). Two patients (1.3%) had a fatal adverse reaction, one each for mesenteric artery thrombosis and ischemic stroke[1]

Warnings and Precautions associated with SCEMBLIX include myelosuppression, pancreatic toxicity, hypertension, hypersensitivity, cardiovascular toxicity, and embryo-fetal toxicity.

Discover SCEMBLIX at HCPSCEMBLIX.COM

Links to:https://www.hcp.novartis.com/products/scemblix/ph-cml/

Please see Important Safety Information throughout and full Prescribing Information.

NOVARTIS

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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HIGHLIGHTS OF ASCO AND EHA 2023 MEETINGS (CONTINUED):

Sex Differences in Patients with Sickle Cell Disease

Data from the King's College Hospital (London, UK) patient record system was analyzed to review the effects of sex on SCD outcomes. Using data from over 1000 patients it was found that males with HbSS had worse disease outcomes in the majority of SCD aspects compared to females. However, males had higher haemoglobin levels which was associated with a milder phenotype, and no sex difference in survival was identified. Source: DI Mauro et al., 2023 For more information see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10428274/

Has a Definition for Massive Transfusion Been Found?

A review of MT-related RCTs was conducted to evaluate currently used definitions, it was found that there was no uniformity in the definitions. It was recommended that a standardized definition be created that balances the strengths and weaknesses of previous definitions, and that can be used consistently in future RCTs. Source: Lin et al., 2023. For more information see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10428315/

Luspatercept in Patients with Non-Transfusion-Dependent -Thalassaemia

Data from patients in the BEYOND trial receiving luspatercept was evaluated to determine the long-term efficacy of this drug. Results demonstrated that luspatercept significantly improved and sustained Hb levels in patients, as well as improved the erythroid response duration. Source: Taher et al., 2023. For more information see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10428292/

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