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An Industry Supported Symposium at the WAGO 2025 Annual Meeting

Beyond ADCs: Exploring Novel Therapeutic Opportunities in Platinum Resistant Ovarian Cancer

Colorado Springs, Colorado

Friday, June 20, 2025

11:55 am – 1:25 pm MT

This session is not included in main conference CME/CPD credit

To participate for this in-person, CME Symposium, attendees must be registered to attend the 2025 WAGO Annual Meeting

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Welcome & Introductions

All Faculty

Moderator | Faculty

Katherine Fuh, MD, PhD
University of California
San Francisco (UCSF)
San Francisco, CA

Dana Chase, MD
David Geffen School of Medicine at UCLA
Jonsson Comprehensive Cancer Center
Los Angeles, CA

Debra Richardson, MD
Stephenson Cancer Center
University of Oklahoma
Oklahoma City, OK

Faculty Disclosures

All of the relevant financial relationships listed for these individuals have been mitigated. However, if you perceive a bias during a session, please report the circumstances on the session evaluation form

Name	Role in Activity	Disclosures
Katherine Fuh, MD, PhD	Moderator	• **Consultant:** Aravive; AstraZeneca; GlaxoSmithKline; Immunogen, Incyclix • **Intellectual Property:** Patent (Share 3% of the 33% of the investigators)
Dana Chase, MD	Speaker	• **Consultant:** AstraZeneca; ImmunoGen; GSK; Clovis • **Speaker:** AbbVie, Eisai
Debra Richardson, MD	Speaker	• **Consultant:** Mersana • **Advisor:** Araris; AstraZeneca; Genmab;Incyclix GlaxoSmithKline; Immunogen; Daiichi Sankyo, Repare Tx • **Speaker:** GlaxoSmithKline, Zentalis • **Research Grant:** GlaxoSmithKline

Learning Objectives

1. **Identify Emerging Therapies:**
   Review new and recently approved therapies for platinum-resistant ovarian cancer beyond antibody-drug conjugates.

2. **Interpret Safety & Efficacy Data Critically:**
   Analyze and interpret clinical trial endpoints, including PFS/OS, focusing on underlying statistical measures and their real-world implications for patients.

3. **Examine the Competitive Landscape:**
   Understand where novel therapies fit into the current and future treatment paradigms for ovarian cancer.

4. **Foster Clinical Dialogue:**
   Promote thoughtful discussion among oncologists and researchers on implementing these new strategies in clinical practice and research.

Agenda

Welcome and Introductions
Dr. Katherine Fuh

The Evolving Landscape of Platinum-Resistant Ovarian Cancer
Dr. Dana Chase

Beyond ADCs: Novel Agents and Mechanisms on the Horizon
Dr. Katherine Fuh

Digging into the Data: Making Sense of PFS/OS Curves
Dr. Debra Richardson

Panel Discussion: Real-World Implications and What's Next
All Faculty

Audience Q&A
All Faculty

Open Discussion and Closing Remarks
Dr. Katherine Fuh

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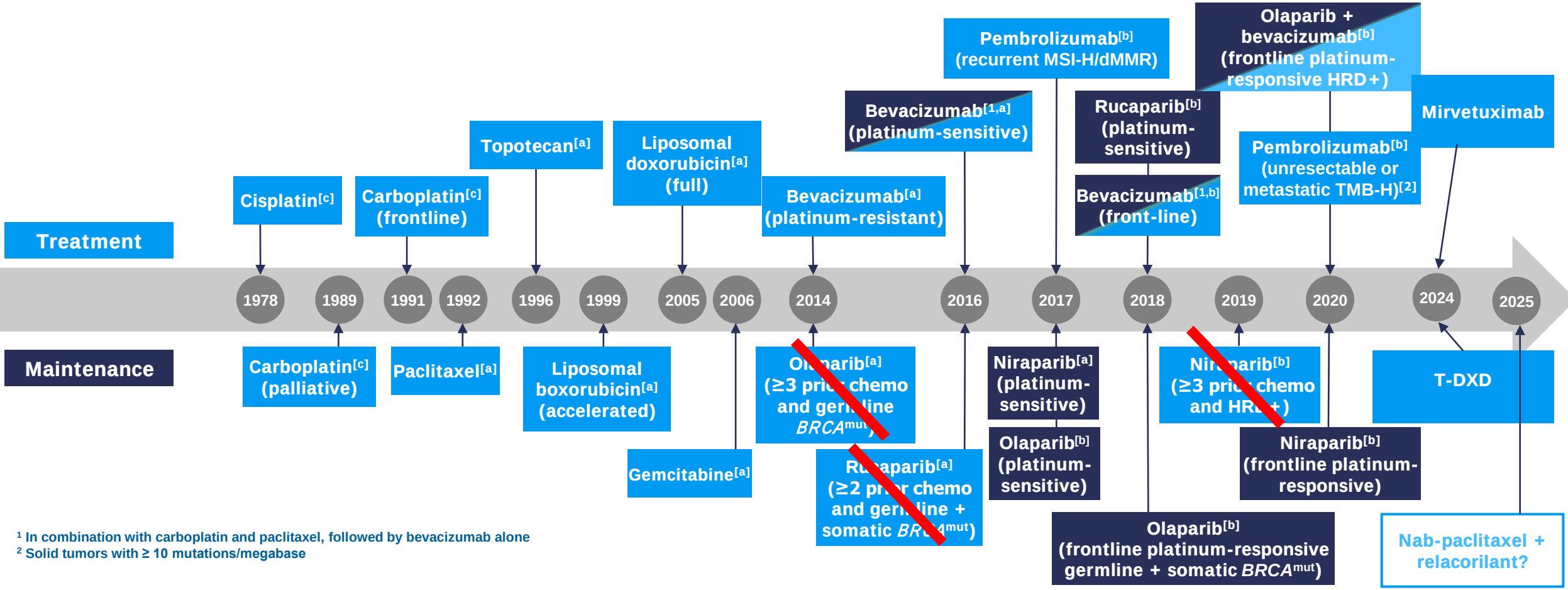
The Evolving Landscape of Platinum-Resistant Ovarian Cancer

Dana Chase, MD

Landmark FDA Approvals in Ovarian Cancer Therapy

Treatments Options and Approaches Have Increased Substantially in the Last Decade[a,b]

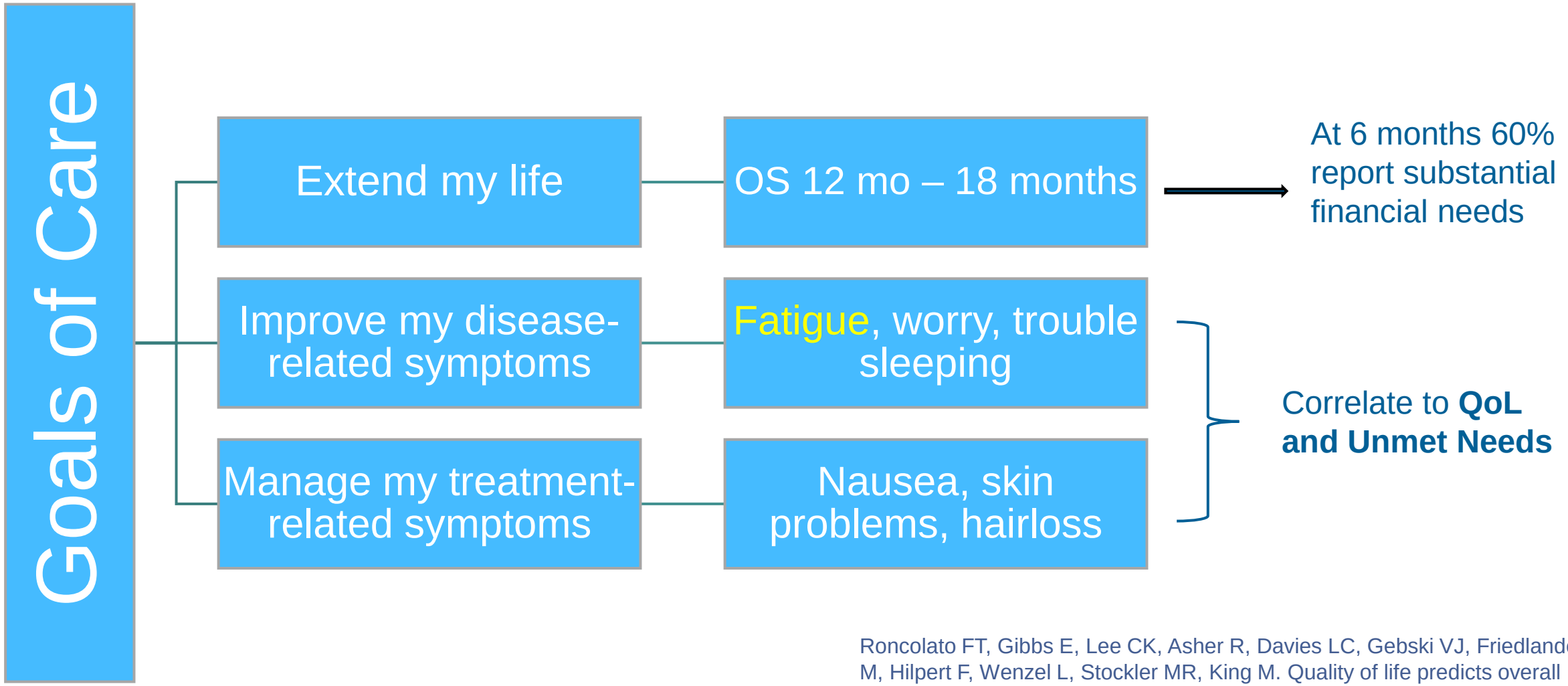


[1] In combination with carboplatin and paclitaxel, followed by bevacizumab alone
[2] Solid tumors with ≥ 10 mutations/megabase

BRCA, breast cancer susceptibility gene; chemo, chemotherapy; dMMR, deficient mismatch repair; FDA, US Food and Drug Administration; HRD+, homologous recombination deficiency positive; MSI-H, high microsatellite instability; mut, mutation; TMB-H, tumor mutational burden-high.

a. Drugs@FDA: FDA-approved drugs. https://www.accessdata.fda.gov/scripts/cder/daf/; b. FDA. Hematology/oncology (cancer) approvals & safety notifications. https://www.fda.gov/drugs/resources-information-approved-drugs/hematologyoncology-cancer-approvals-safety-notifications;
c. Kelland L. *Nat Rev Cancer.* 2007;7:573-584.

Statement about PROC (von Gruenigen et al 2018)



Roncolato FT, Gibbs E, Lee CK, Asher R, Davies LC, Gebski VJ, Friedlander M, Hilpert F, Wenzel L, Stockler MR, King M. Quality of life predicts overall survival in women with platinum-resistant ovarian cancer: an AURELIA substudy. Annals of Oncology. 2017 Aug 1;28(8):1849-55.

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If you had 1.5 years to live, what would you want?

Second-line Platinum Therapy in Patients with Ovarian Cancer Previously Treated with Cisplatin

- Cisplatin-free interval (PFI) of **> 4** months between the completion of their first regimen and the institution of a second cisplatin/carboplatin program

- **31/72 (43% response rate {RR})**
  - PFI = 5 to 12 months, RR= 27%
  - PFI = 13 to 24 months, RR = 33%
  - PFI > 24 months, RR= 59%

"In conclusion, secondary responses to cisplatin/carboplatin-based treatment are common in patients with ovarian cancer who have previously responded to the agents and increase in frequency with greater distance from the initial therapy"

Markman M, et al. *J Clin Oncol.* 1991;Mar;9(3):389-93.

Responses to Salvage Chemotherapy in OC:
A Critical Need for Precise Definitions of the Treated Population

Secondary Platinum-resistant: Patients who responded to a platinum as primary therapy and did not respond to a second organoplatinum

Potentially platinum-sensitive: All *patients whose most recent response to an organoplatinum resulted in at least a partial response. This group can be further subdivided into patients with PFI of:*

- *< 6 months*
- *6-12 months*
- *More 12 months*

Markman M, et al. *J Clin Oncol.* 1992;Apr;10(4):513-4.

Platinum Until "Platinum Not an Option:" *Platinum Combinations in PROC*

Trial	Regimen	ORR	PFS/TTP
Nagourney RA[1] (P)	D1 cisplatin (30 mg/m^2) and D1/8 gem (600-750 mg/m^2) on 21-day cycle	8/14 (57%)	7.0
Penson RT[2] (P)	D1 carbo and D1/8 gem, and iniparib on 21-day cycle	11/45 (26%)	6.8
Nasu H[3] (P)	D1 carbo (AUC4) & D1/8 gem (1000 mg/m^2) & bev on 21-day cycle D1 carbo (AUC4) & D1/8 gem (1000 mg/m^2) on 21-day cycle	12/20 (60%) 2/7 (28%)	8.8 5.6
GOG 126L (P) Brewer CA[4]	D1/8 gem (750 mg/m^2) & D1/8 cis (30 mg/m^2) on 28-day cycle* *Limited to primary platinum resistant	9/57 (16%)	5.4
Walsh CS[5] (P)	D1/8 cis (30 mg/m^2) & D1/8 gem (750 mg/m^2) & D1 pembro on 21-day cycle	11/18 (61%)	6.2/5.2
Rose PG[6] (R)	D1/8 cis (30 mg/m^2) & D1/8 gem (750 mg/m^2) on 21-day cycle	15/35 (43%)	6.0
Richardson DL[7] (R)	D1/15 platinum/gem/bev on a 28-day cycle	7/12 (58%)	NR
Havrilesky LJ[8] (P)	D1, 8, 15, paclitaxel (80 mg/m^2) & carbo (AUC 2) on 28-day cycle	3/8 (38%)	3.2
Sharma R[9] (R)	D1, 8, 15, paclitaxel (70 mg/m^2) & carbo (AUC 3) on 28-day cycle	12/20 (60%)	7.9
Tatsuki S[10] (R)	platinum "rechallenge" (paclitaxel; docetaxel; Gem; PLD; CPT-11)	26/47 (55%)	8.5

AUC, area under the curve; bev, bevacizumab; cis, cisplatin; carbo, carboplatin; gem, gemcitabine; NR, not reported; ORR, objective response rate; P, prospective; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; PROC, platinum-resistant ovarian cancer; R, retrospective; TTP, time to progression.

1. Nagourney RA, et al. *Gynecol Oncol*. 2003;88(1):35–39. 2. Penson RT, et al. *Oncologist*. 2023;oyac275. 3. Nasu H, et al. *J Clin Oncol*. 2022;27(4):790–801. 4.. *Br J Cancer*. 2009;100(5):707–712. 10. Tatsuki S, et Brewer CA, et al. *Gynecol Oncol*. 2006;103(2):446–450. 5. Walsh CS, et al. *PLoS One*. 2021;16(6):e0252665. 6. Rose PG, et al. *Gynecol Oncol*. 2003;88(1):17–21. 7. Richardson DL, et al. *Gynecol Oncol* 2008; 111(3):461–466. 8. Havrilesky LJ, et al. *Gynecol Oncol*. 2003;88(1):51–57. 9. Sharma R, et alal. *Anticancer Res*. 2022;42(9):4603–4610.

Platinum Resistant Ovarian Cancer is Now:

"in patients when platinum-based therapy is not an option"

PROC Re-defined[4]

- **Historically *(regulatory standard)***
  - **Platinum-free interval (PFI)**
    - **Refractory:** Progression (persistence) on primary therapy
    - **Primary Resistance:** Progressed within 6 months of completing primary platinum-based therapy
    - **Acquired (Secondary) Resistance:** Progressed on or within 6 months of completing platinum-based therapy after 2nd line or more of therapy
    - Regulatory agencies do NOT differentiate primary vs acquired resistance
- **Contemporary *(clinical standard)***
  - **Platinum-based therapy is no longer an option**
    - Patients who have progressed while receiving platinum-based chemotherapy
    - Experienced a symptomatic relapse soon after the end of the last platinum-based chemotherapy
    - Contraindication to use further platinum-based treatment, such as allergy

Representative graphic (not to scale) showing mPFS ranges after treatment with various chemotherapy regimens.
mPFS estimates predate the routine use of maintenance therapy in clinical practice.[2]
L, line of therapy; mo, month;

1. Hanker LC, et al. *Ann Oncol*. 2012;23(10):2605–2612. 2. Pignata S, et al. *Ann Oncol*. 2017;28(suppl 8):viii51–viii56. 3. Griffiths RW, et al. *Int J Gynecol Cancer*. 2011;21(1):58–65. 4. Colombo N et al. *Ann Oncol*. 2019;30(5):672–705.

Patients for Which Platinum Is Not an Option Bevacizumab in Combination With Chemotherapy: AURELIA Trial

Platinum-resistant OC

- ≤2 prior anticancer regimens
- No history of bowel obstruction/abdominal fistula, or clinical/radiological evidence of rectosigmoid involvement

R

Chemotherapy → **Treat to PD/toxicity** → **Optional BEV monotherapy[c]**

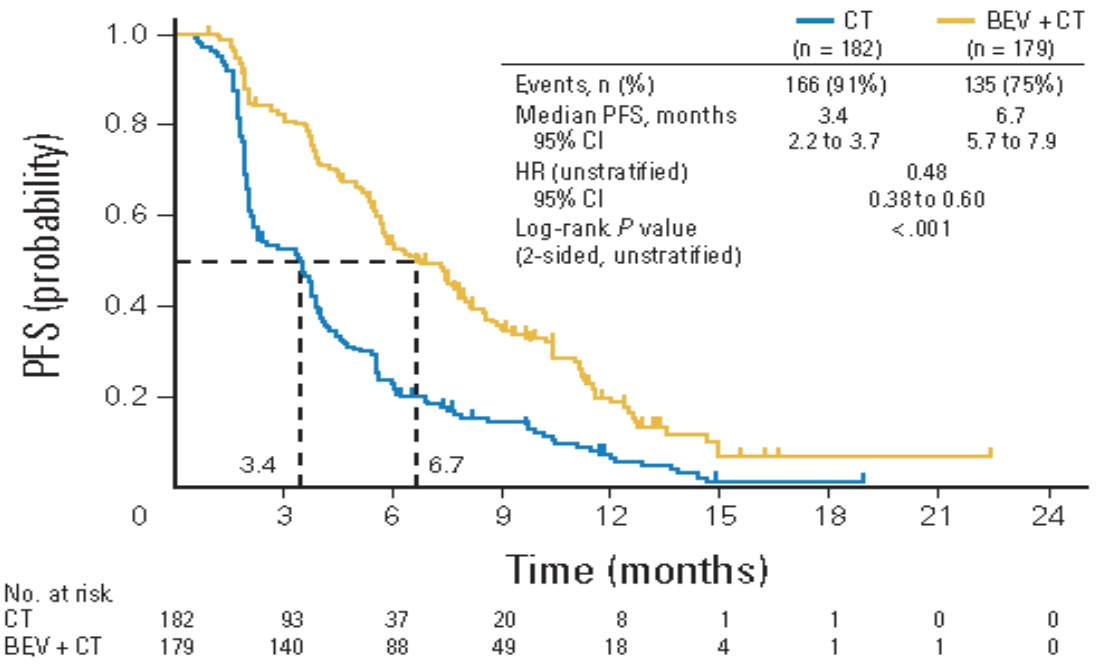
BEV 15 mg/kg q 3 w[b] + chemotherapy → **Treat to PD/toxicity** → **Investigator's choice* (without BEV)**

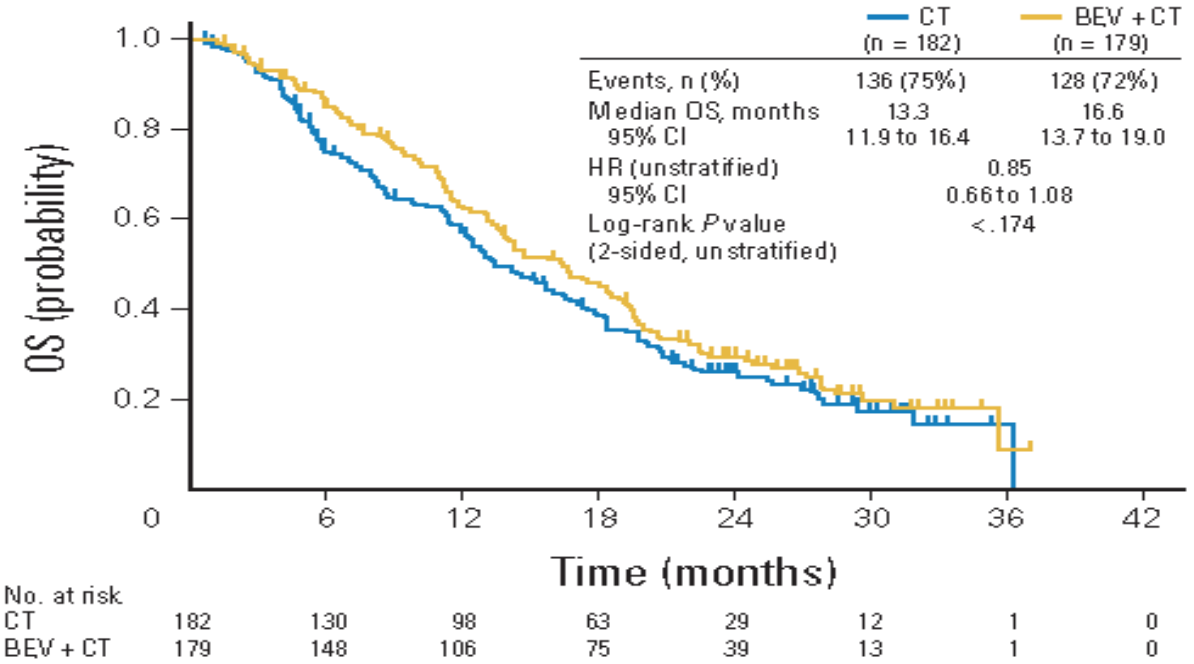
***Chemotherapy options (investigator's choice):**

Paclitaxel 80 mg/m^2 D1,8,15,22 – q4w

Topotecan 4 mg/m^2 D1,8,15 – q4w
(or 1.25 mg/m^2 D1 to 5 – q3w)

PLD 40 mg/m^2 D1 – q4w

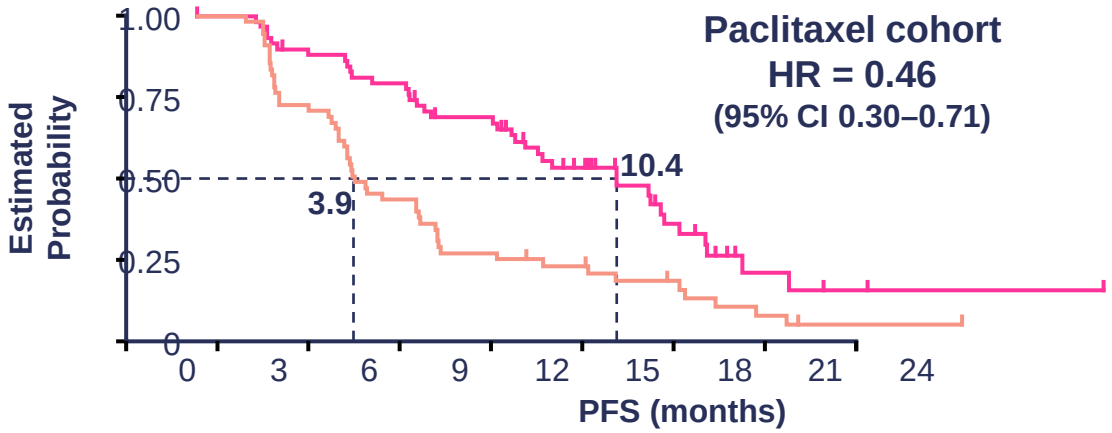


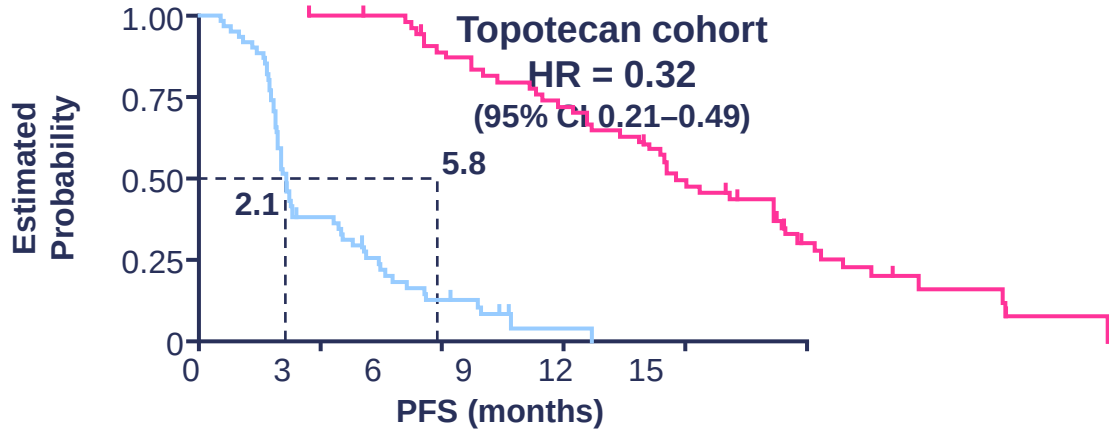


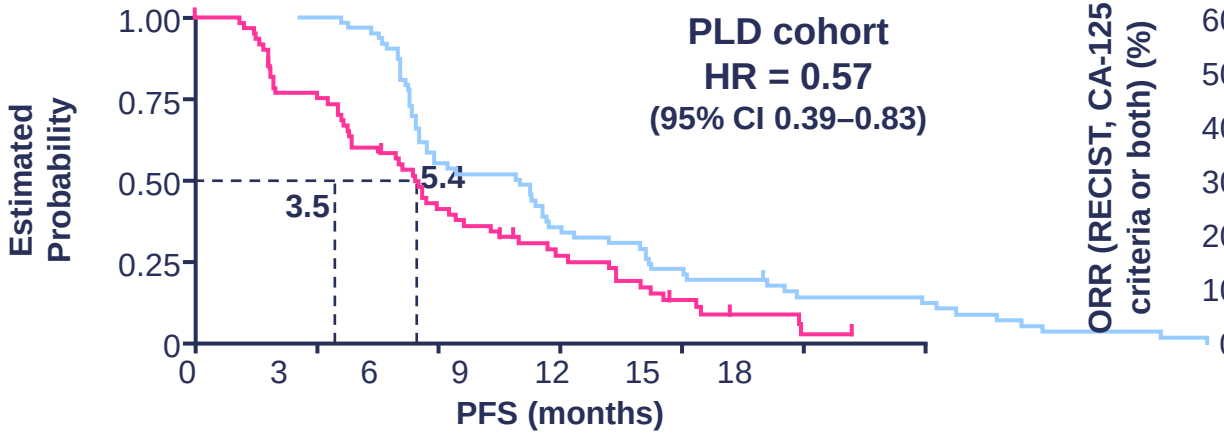
Pujade-Lauraine E, et al. *J Clin Oncol*. 2014;32(13):1302-1308.

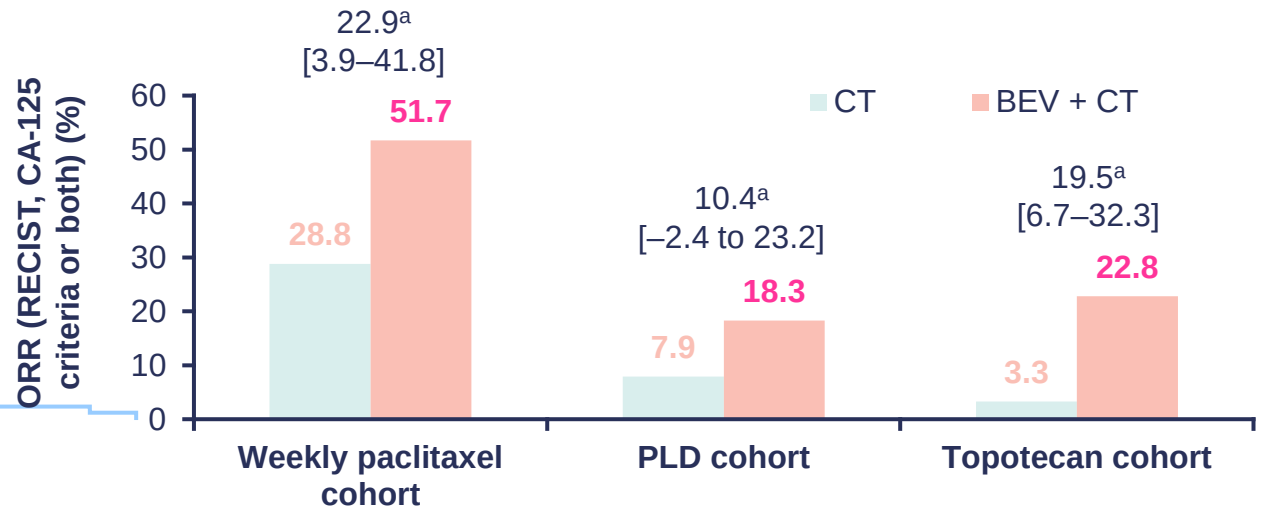
Patients for Which Platinum Is Not an Option

AURELIA trial: Results According to Chemotherapy Cohort









[a]Difference in ORR; 95% CI with Hauck–Anderson continuity correction

Pujade-Lauraine E, et al. *J Clin Oncol*. 2014;32(13):1302-1308.

AURELIA QOL/PRO

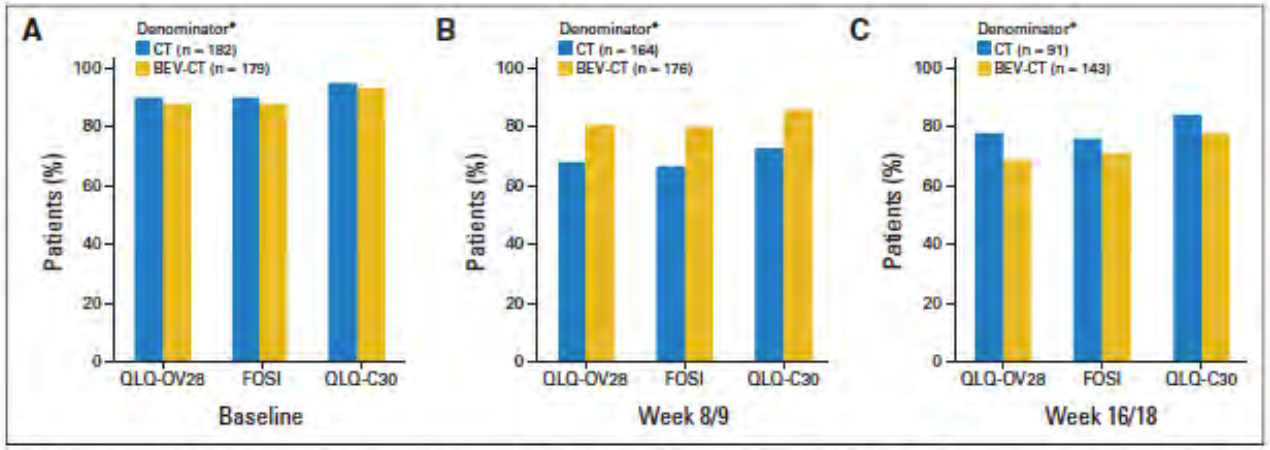


Fig 2. Compliance for the European Organisation for Research and Treatment of Cancer (EORTC) Quality of Life Questionnaire–Ovarian Cancer Module 28 (QLQ-OV28), Functional Assessment of Cancer Therapy–Ovarian Cancer Symptom Index (FOSI), and EORTC QLQ Cancer Module 30 (C30) questionnaires. (A) Baseline; (B) week 8/9; (C) week 16/18. (*) Denominator (patients known to be progression free) excludes patients whose disease progressed or who died or were lost to follow-up at least 14 days before the scheduled assessment date. BEV, bevacizumab; CT, chemotherapy.

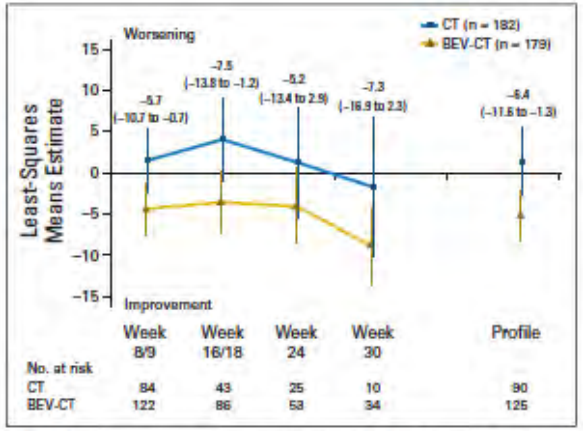


Fig 4. Mixed-model repeated-measures analyses for the abdominal/GI subscale of the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire–Ovarian Cancer Module. Estimates for the between-treatment group comparisons for each time point and for the entire profile were obtained. The estimates are presented with the corresponding 95% CIs in parentheses. BEV, bevacizumab; CT, chemotherapy.

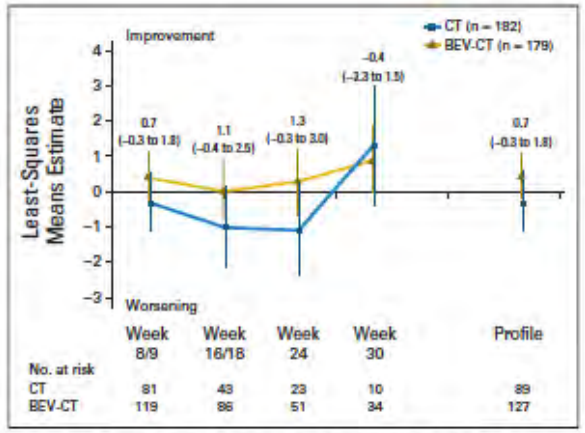
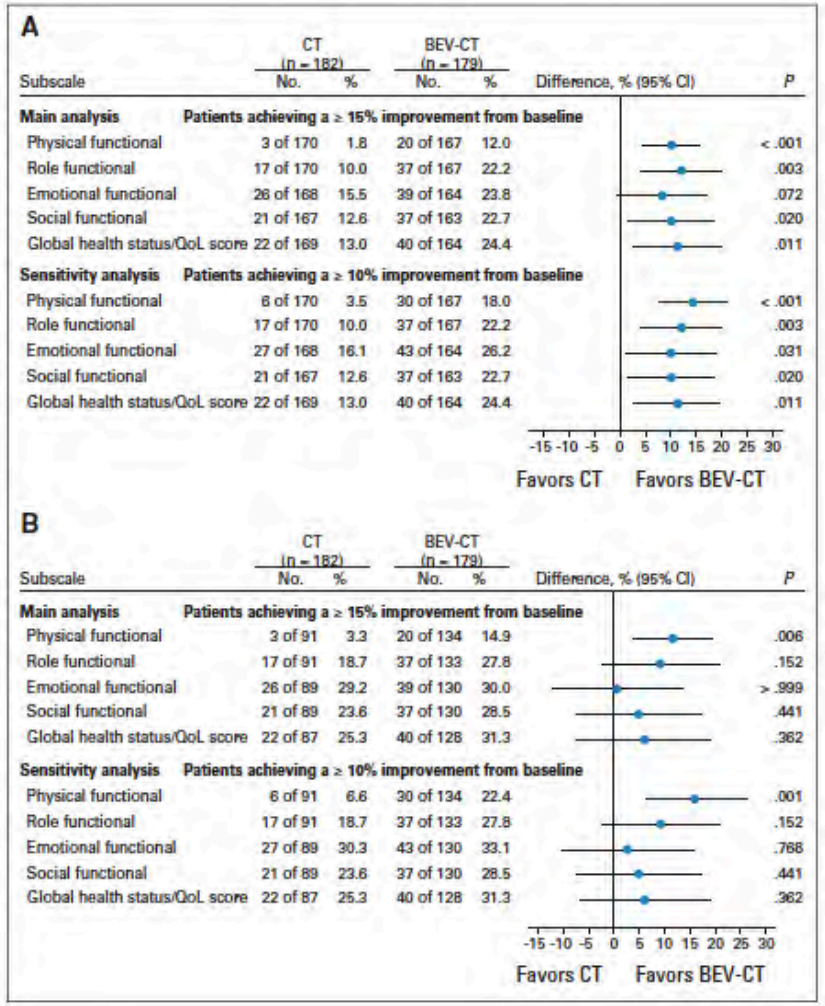


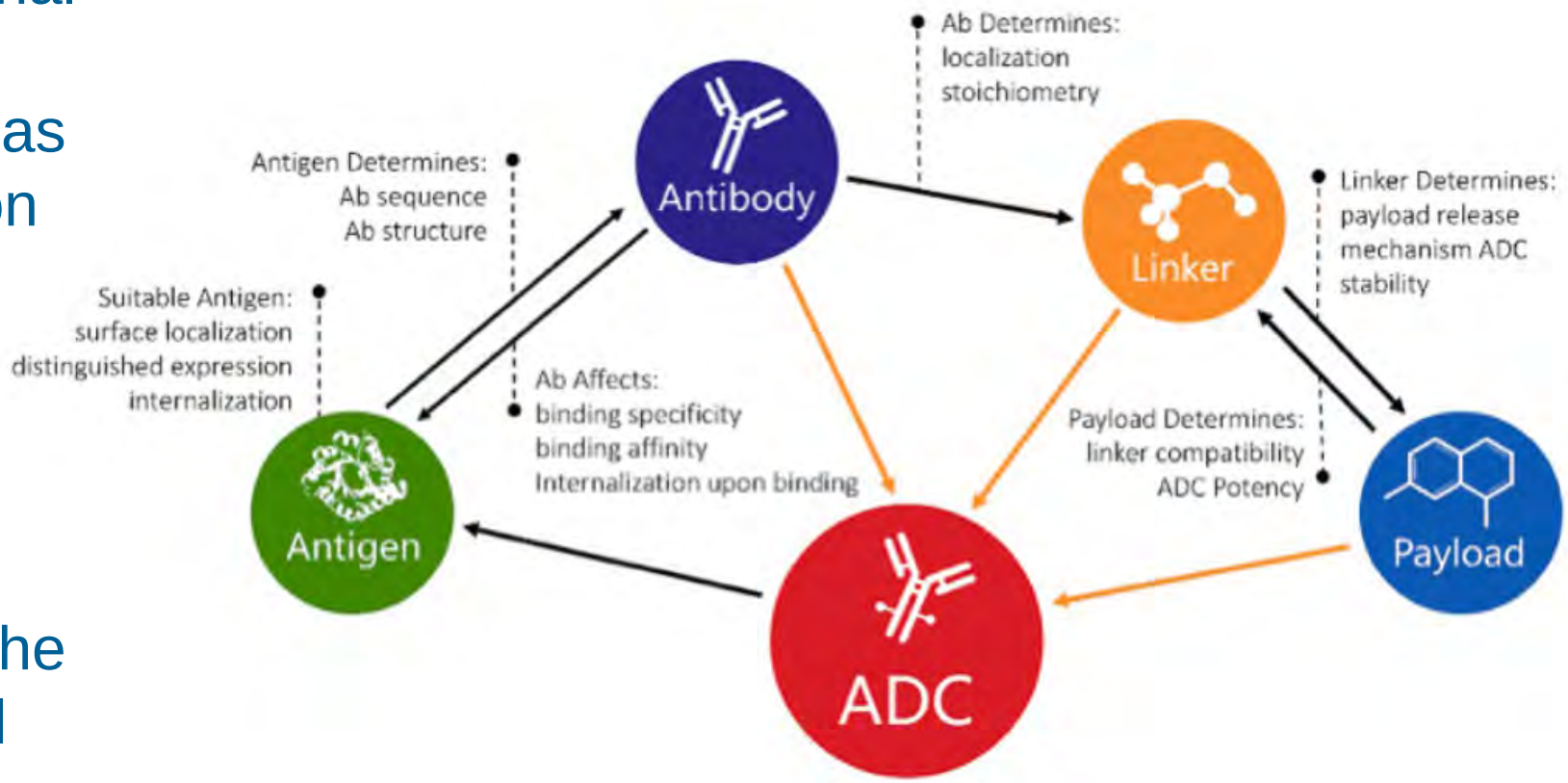
Fig 5. Mixed-model repeated-measures analysis for the Functional Assessment of Cancer Therapy–Ovarian Cancer Symptom Index. Estimates for the between-treatment group comparison for each time point and for the entire profile were obtained. The estimates are presented with the corresponding 95% CIs in parentheses. BEV, bevacizumab; CT, chemotherapy.



https://pmc.ncbi.nlm.nih.gov/articles/PMC4876313/
Martin R Stockler, et al. J Clin Oncol. 2014 Mar 31;32(13):1309–1316.

Antibody Drug Conjugates: A Paradigm Shift

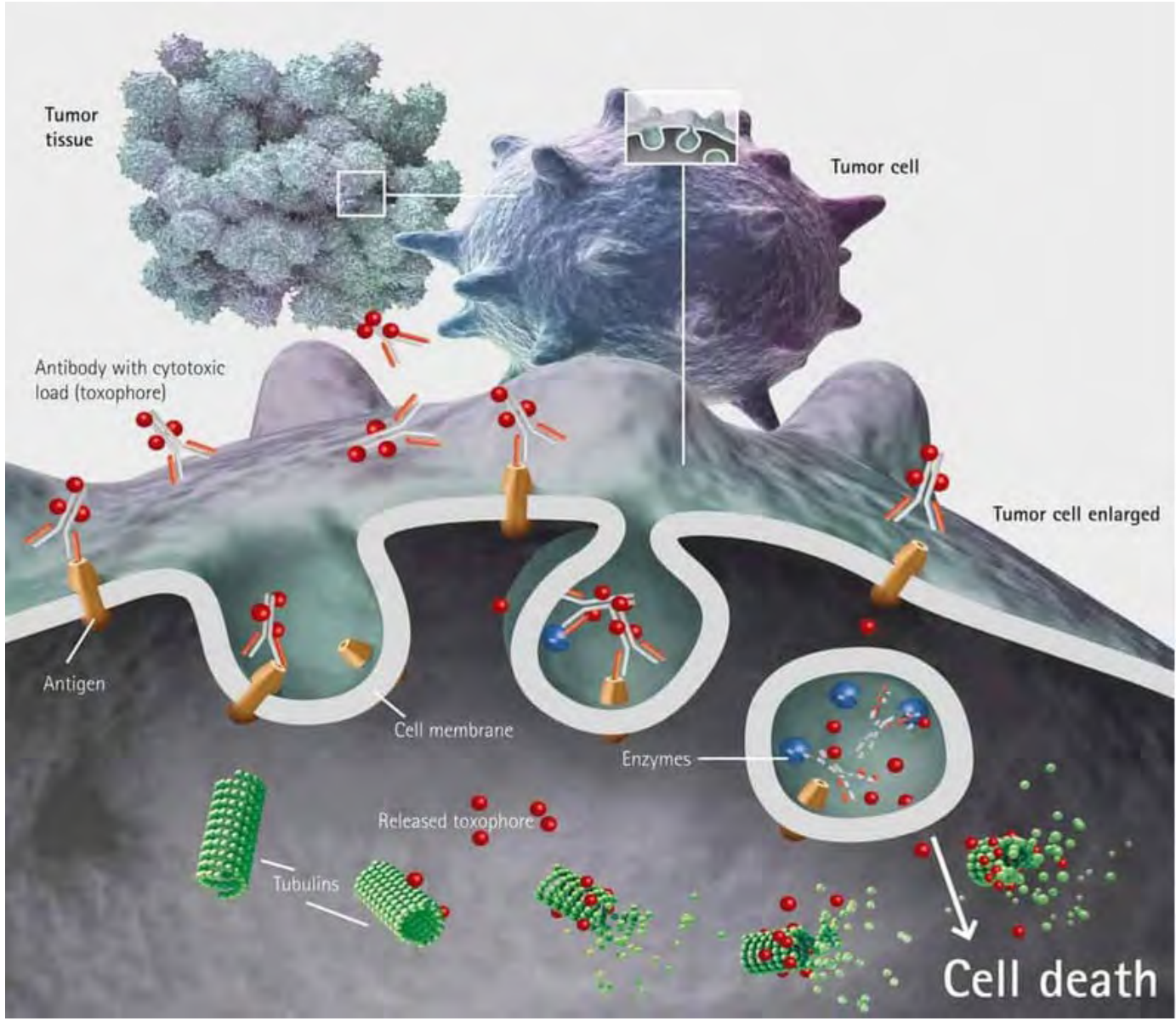
- Highly selective monoclonal antibodies (mAb) tumor associated antigen that has limited, to no exposure, on normal cells
- A potent cytotoxic
- A linker that is stable in circulation, but releases the cytotoxic in the target cell



https://www.adcreview.com/the-review/antibody-drug-conjugate-development/

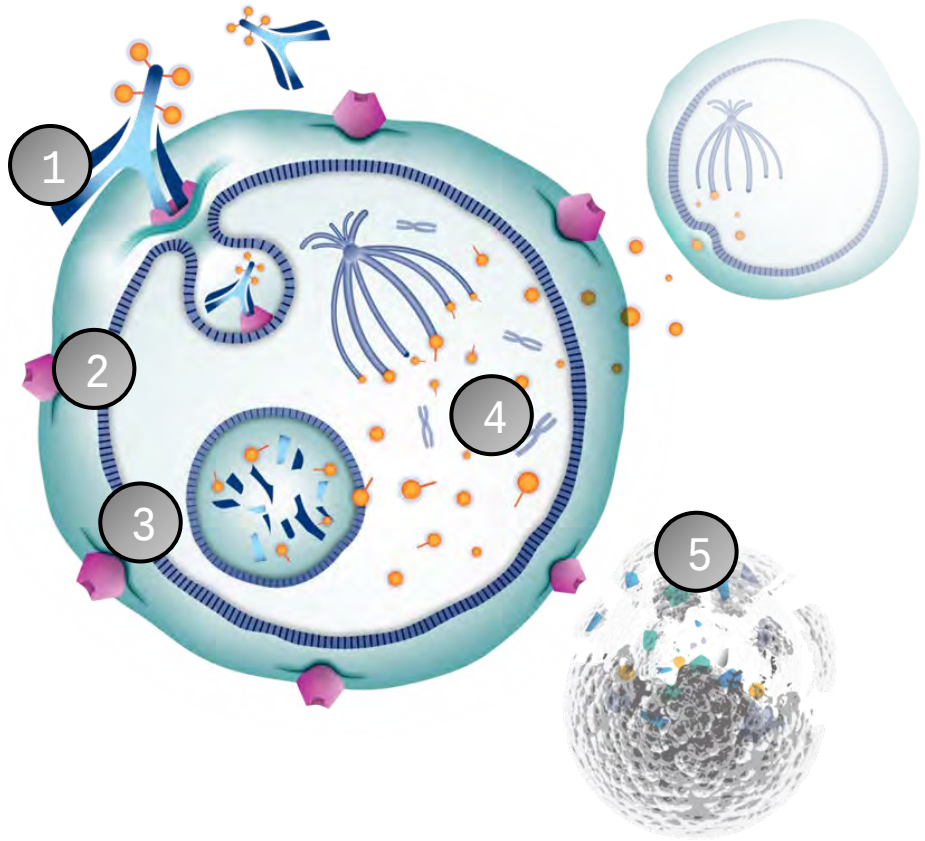
Mechanism of Action:

- ADC localizes to tumor and binds to target antigen
- ADC is internalized
- Internalized vesicles fuse with other vesicles and enter the endosome-lysosome pathway
- Proteases digest the antibody to release the toxins which → apoptosis



https://www.adcreview.com/the-review/antibody-drug-conjugate-development/

Mirvetuximab Soravtansine (MIRV)



- Antibody portion of MIRV binds to FRα found on the surface of epithelial ovarian cancer cells
- MIRV is internalized via endocytosis
- MIRV is degraded within the lysosome to release its cytotoxic payload (DM4)
- DM4 disrupts tubulin resulting in mitotic arrest and apoptosis
- DM4 also diffuses through the lipophilic cell membrane allowing bystander killing on adjacent tumor cells

O'Malley DM & Calo CA. *Curr Oncol Rep.* 2021;23(89). doi: 10.1007/s11912-021-01080-4.

Phase III SORAYA Study of Mirvetuximab Soravtansine: Efficacy Summary

Outcome	Investigator Assessed N=105 (%)	BICR-Assessed N=96 (%)
ORR, n (%) (95% CI)	34 (32.4) (23.6-42.2)	29 (31.6) (22.4-41.9)
Best overall response, n%		
• CR	5 (4.8)	5 (5.3)
• PR	29 (27.6)	25(26.3)
• SD	48 (45.7)	53 (55.8)
• PD	20 (19.0)	8 (8.4)
• Not evaluable	3 (2.9)	4 (4.2)
Median DoR, mo (95% CI)	6.9 (5.6-8.1)	NR (5.0-NR)
Median PFS, mo (95% CI)	4.3 (3.7-5.2)	5.5 (3.8-6.9)

- Clinically meaningful activity seen in patients with FRα-high platinum-resistant OC
- Consistent antitumor activity regardless of prior number of therapies, or prior PARPi
  - **ORR if 1-2 lines of therapy:** 35.3% (range: 22.4-49.9)
  - **ORR if 3 lines of therapy:** 30.2% (range: 18.3%-44.3%)
  - **ORR if prior exposure to PARPi (yes vs no):** 38.0% (range: 24.7%-52.8%) vs 27.5% (range: 15.9%-41.7%)
- Overall median DoR and by prior PARPi were comparable between those with 1-2 prior lines vs. 3 prior lines

https://ascopubs.org/doi/10.1200/JCO.22.01900

Phase III SORAYA Study | MIRV | Safety Summary

TRAE, n (%)	Any Grade	Grade 3	Grade 4
Pts with any event	91 (86)	29 (27)	1 (1)
Blurred vision	43 (41)	6 (6)	0 (0)
Keratopathy	38 (36)	8 (8)	1 (1)
Nausea	31 (29)	0 (0)	0 (0)
Dry eye	24 (23)	2 (2)	0 (0)
Fatigue	24 (23)	1 (1)	0 (0)
Diarrhea	23 (22)	2 (2)	0 (0)
Asthenia	16 (15)	1 (1)	0 (0)
Photophobia	15 (14)	0 (0)	0 (0)
Peripheral neuropathy	13 (12)	0 (0)	0 (0)
Decreased appetite	13 (12)	1 (1)	0 (0)
Vomiting	12 (11)	0 (0)	0 (0)
Neutropenia	11 (10)	1 (1)	0 (0)

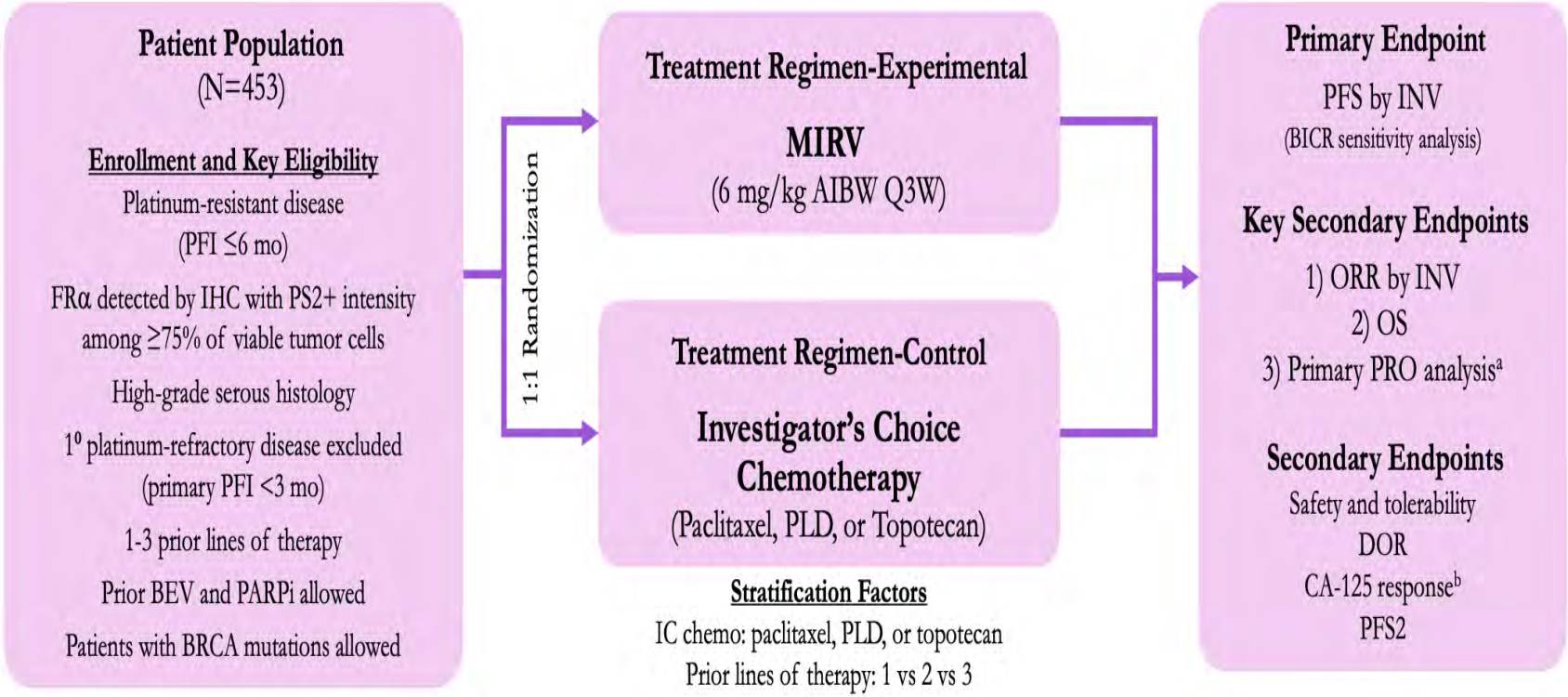
- Most ocular and GI AEs low-grade and reversible
- Grade ≥3 TRAEs: 8%
  - Dose delay: 32%
  - Dose reduction: 19%
  - Discontinuation: 7%
- One death possibly related to study drug
  - Respiratory failure
  - Autopsy: no evidence of drug reaction; lung mets
- No appreciable myelosuppression and limited low-grade neuropathy

https://ascopubs.org/doi/10.1200/JCO.22.01900

Matulonis. SGO 2022. Abstr 242.

MIRASOL Phase III Trial: Platinum Resistant Ovarian Cancer

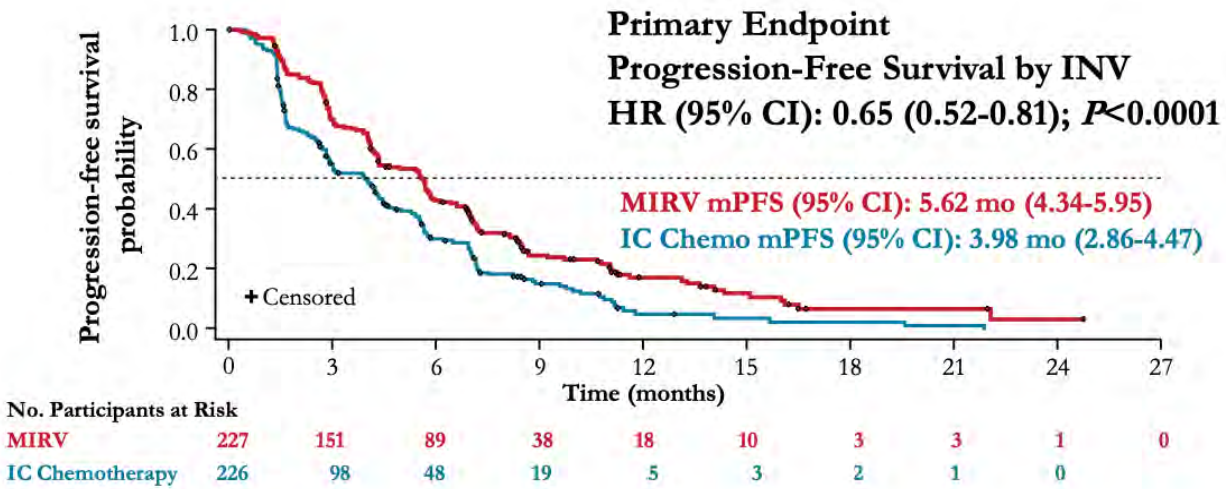
An open-label, phase 3 randomized trial of MIRV vs investigator's choice chemotherapy in patients with FRα-high platinum-resistant ovarian cancer

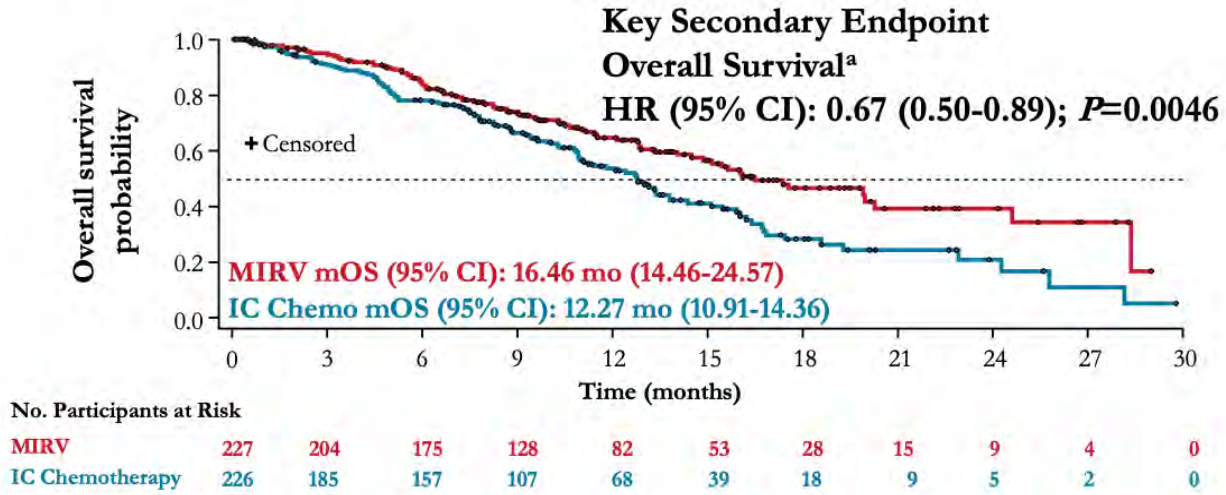


- The primary PRO assessment in MIRASOL (a prespecified key secondary endpoint) evaluated improvements in OV28 Abdominal/GI subscale score from baseline at Week 8/9, with a **conservative improvement threshold** of 15-point[a] decrease
- Anchor-based analyses were performed to further evaluate meaningful change thresholds in abdominal/GI symptoms
- All PROs were assessed at screening and on day 1 of every treatment cycle
  - Upon discontinuation and end of treatment, PRO assessment visit took place within 7 days

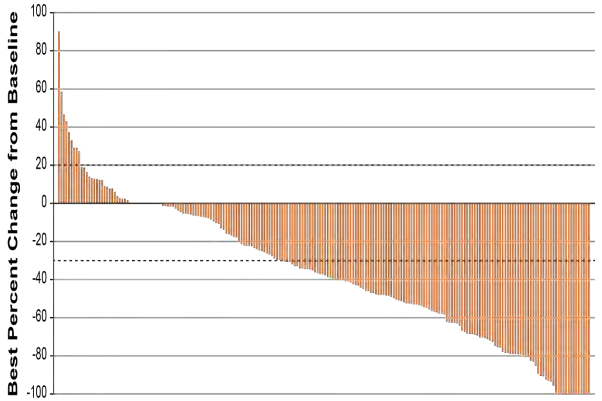
Moore KN, et al. *New Engl J Med.* 2023;389:2162-2174. doi:10.1056/NEJMoa2309169.;
Konecny GE, et al. Presented at: Society of Gynecologic Oncology's (SGO) Annual Meeting on Women's Cancer; 18-21 March 2022; Phoenix, AZ USA.

MIRASOL Phase III Trial: PROC *cont.*

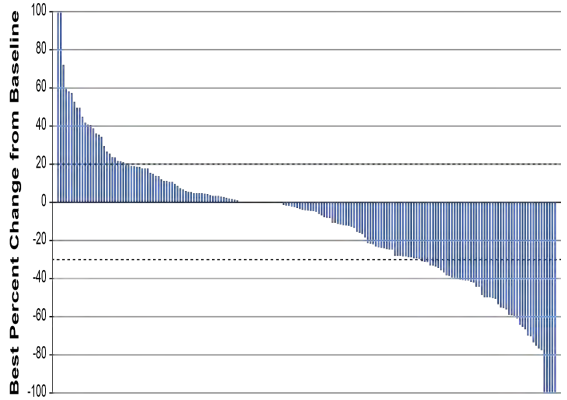




MIRV



IC Chemo



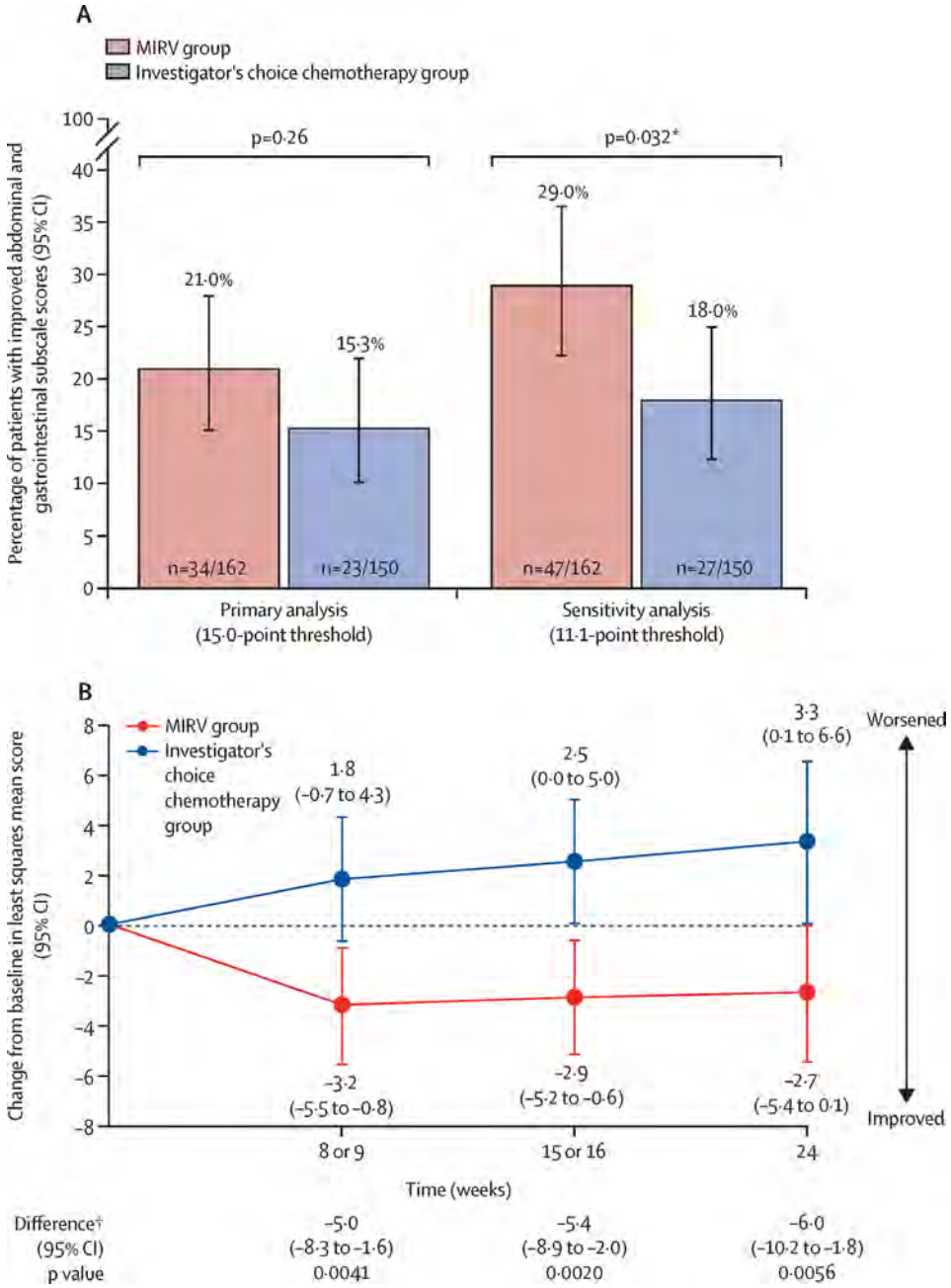
Key Secondary Endpoint: Objective Response Rate by INV

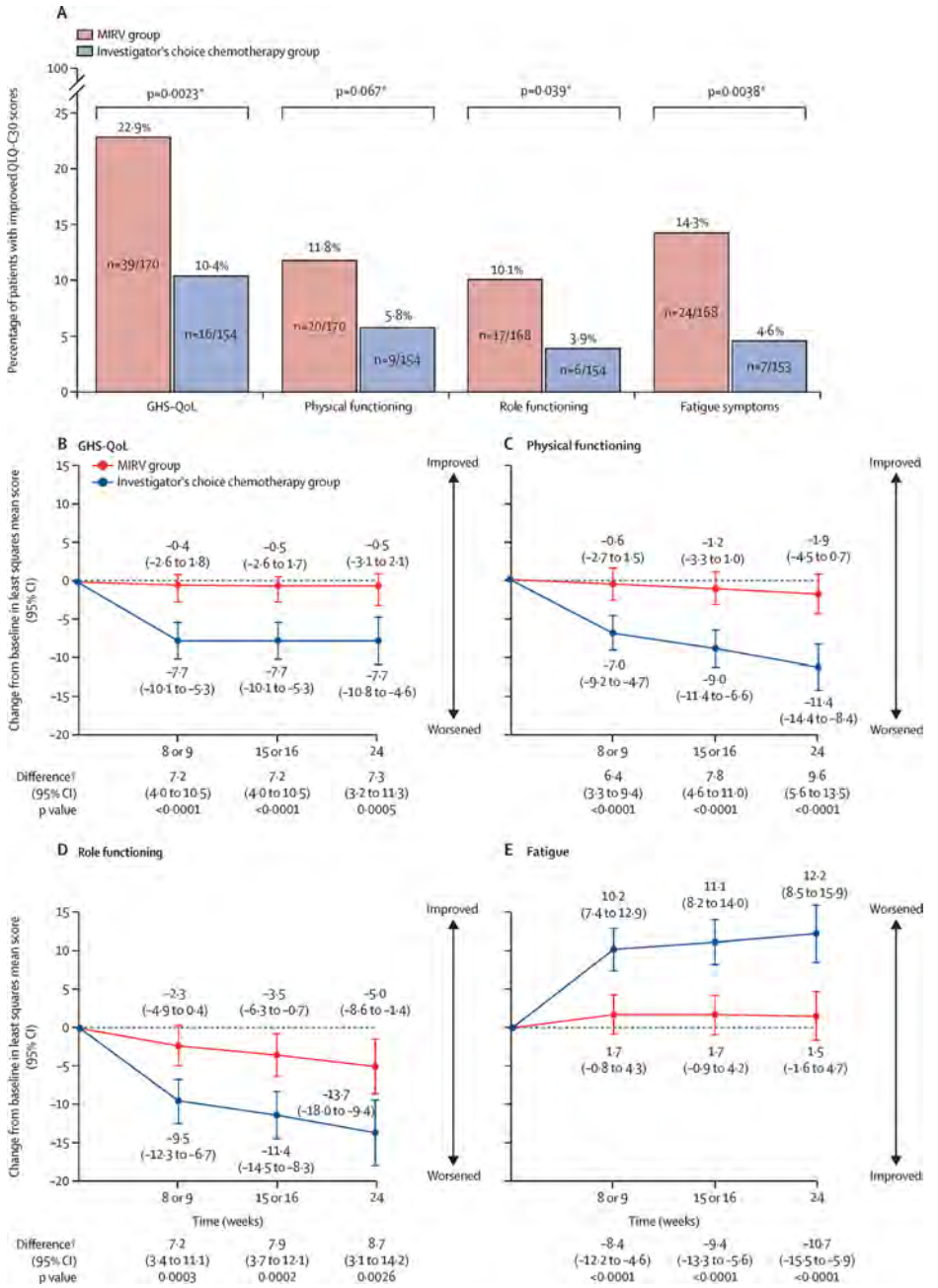
	MIRV (n=227)	IC Chemotherapy (n=226)
ORR by INV, (%)[b] n (95% CI)	42.3% 96 (35.8-49.0)	15.9% 36 (11.4-21.4)
ORR Difference (95% CI), 26.4% (18.4-34.4)		
Odds Ratio (95% CI), 3.81 (2.44-5.94)		
P<0.0001		

Moore KN, et al. *New Engl J Med.* 2023;389:2162-2174. doi:10.1056/NEJMoa2309169.;
Konecny GE, et al. Presented at: Society of Gynecologic Oncology's (SGO) Annual Meeting on Women's Cancer; 18-21 March 2022; Phoenix, AZ USA.

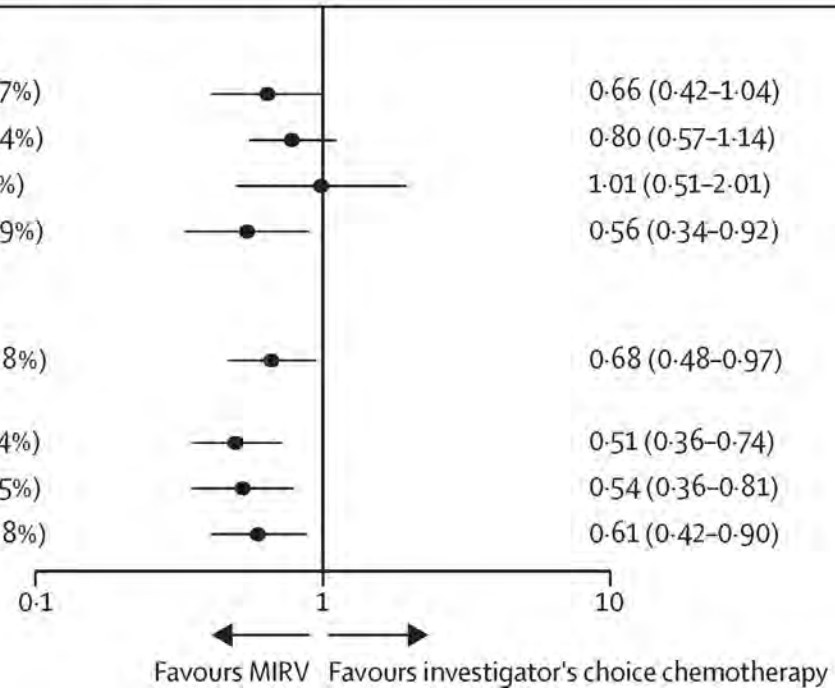
MIRASOL QOL/ PRO

- Trend towards Improved GI Scores
- Improved mean QOL
- Less Fatigue, Less worsening physical and role functioning





	MIRV (n=227)		Investigator's choice of chemotherapy (n=226)		Hazard ratio (95% CI)	p value
	Median, months (95% CI)	Number of events (%)	Median, months (95% CI)	Number of events (%)		
EORTC QLQ-OV28						
Abdominal and gastrointestinal	NR (NR–NR)	37 (16·3%)	10·32 (7·85–NR)	40 (17·7%)	0·66 (0·42–1·04)	0·074
Peripheral neuropathy	9·30 (5·13–NR)	69 (30·4%)	5·62 (3·91–9·07)	62 (27·4%)	0·80 (0·57–1·14)	0·22
Sexual function	5·65 (2·23–6·18)	18 (7·9%)	4·96 (3·71–NR)	17 (7·5%)	1·01 (0·51–2·01)	0·97
Attitude to disease and treatment	11·33 (NR–NR)	30 (13·2%)	9·07 (8·44–NR)	36 (15·9%)	0·56 (0·34–0·92)	0·021
EORTC QLQ-C30						
Global health status and quality of life	9·07 (8·48–NR)	63 (27·8%)	7·16 (6·21–10·6)	65 (28·8%)	0·68 (0·48–0·97)	0·032
Physical functioning	11·17 (9·43–NR)	53 (23·3%)	5·65 (3·88–8·94)	71 (31·4%)	0·51 (0·36–0·74)	0·0003
Role functioning	NR (NR–NR)	42 (18·5%)	8·94 (6·57–NR)	53 (23·5%)	0·54 (0·36–0·81)	0·0028
Fatigue	NR (8·54–NR)	49 (21·6%)	8·44 (6·60–NR)	56 (24·8%)	0·61 (0·42–0·90)	0·013



Time to deterioration of QOL favored MIRV

Plenty of Payloads: Multiple ADCs Are Approved, and Others Are Being Actively Evaluated

ADC	Target	Antibody	Linker	Payload	Regulatory Status
Tisotumab vedotin[1] (TV)	Tissue factor	IgG1-κ	Cleavable	MAME	**Cervical:** Accelerated FDA approval; FDA full approval Apr 29, 2024
Mirvetuximab soravtansine[2] (MIRV)	FRα	IgG1-κ	Cleavable	DM4	**Ovarian:** Accelerated FDA approval; FDA prior full approval Mar 22, 2024
Trastuzumab deruxtecan[3] (T-DXd)	HER2	IgG1	Cleavable	Topoisomerase I inhibitor	**HER2 IHC3+ tumor agnostic:** Accelerated FDA approval Apr 5, 2024

Other transmembrane glycoproteins are highly expressed in gynecologic tumors, often associated with poor prognosis, and under study as ADC targets

TROP2 **B7-H4** **CDH6** **Mesothelin**

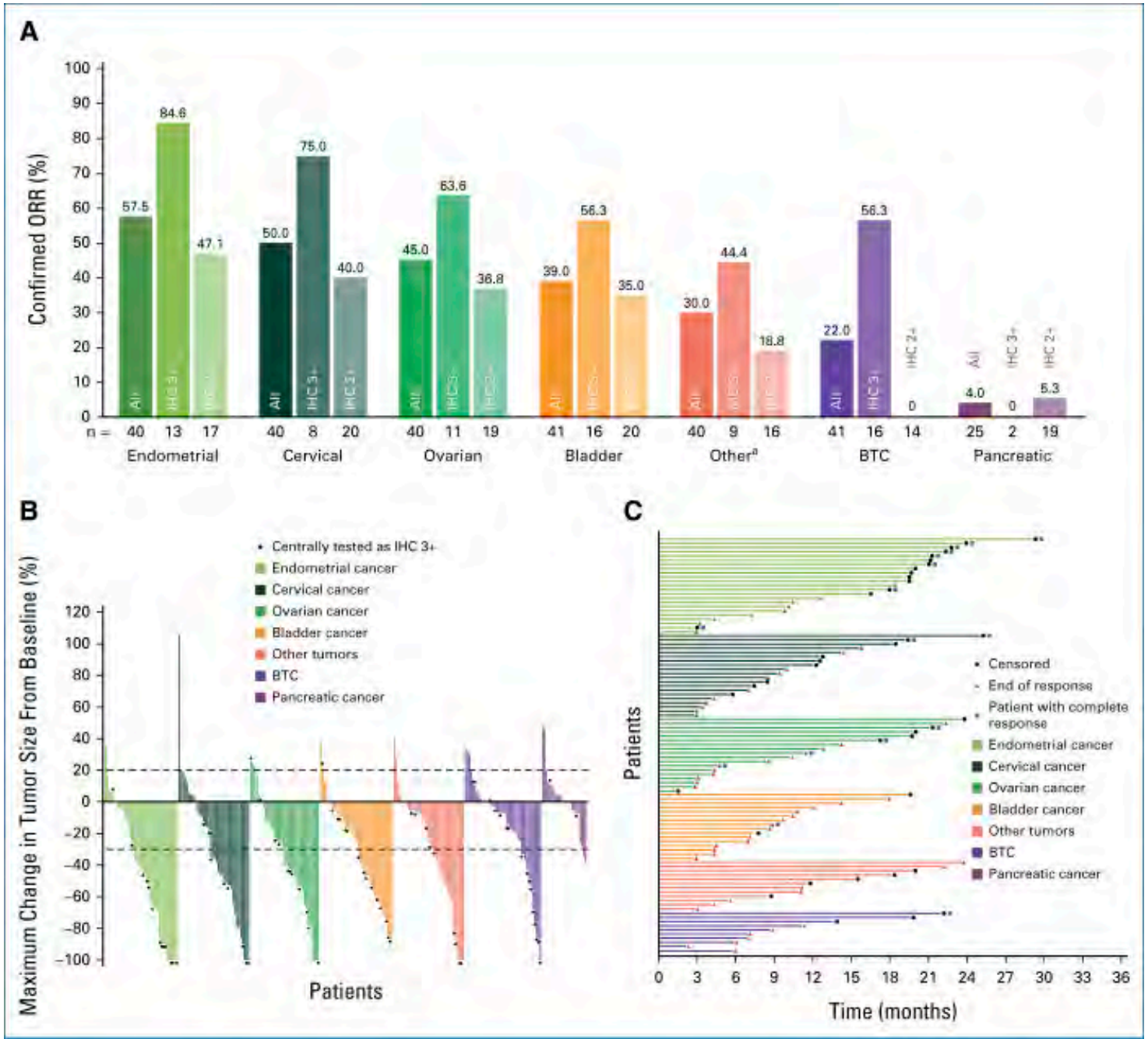
1. https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-tisotumab-vedotin-tftv-recurrent-or-metastatic-cervical-cancer. 2. https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-mirvetuximab-soravtansine-gynx-fra-positive-platinum-resistant-epithelial-ovarian. 3. https://www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-accelerated-approval-fam-trastuzumab-deruxtecan-nxki-unresectable-or-metastatic-her2. 4. Drago JZ, et al. *Nat Rev Clin Oncol.* 2021;18(6):327-344; doi:10.1038/s41571-021-00470-8.

Efficacy and Safety of Trastuzumab Deruxtecan (T-DXd) in Patients With HER2-Expressing Solid Tumors: Primary Results From the DESTINY-PanTumor02 Phase II Trial

ECOG performance status,[a] No. (%)	
0	26 (65.0)
1	13 (32.5)
2	1 (2.5)
HER2 testing for eligibility,[b] No. (%)	
Local	37 (92.5)
Central	3 (7.5)
HER2 IHC status (eligibility),[c] No. (%)	
IHC 3+	15 (37.5)
IHC 2+	25 (62.5)
IHC 1+[c]	0
Centrally confirmed HER2 IHC status, No. (%)	
IHC 3+	11 (27.5)
IHC 2+	19 (47.5)
IHC 1+	5 (12.5)
IHC 0	5 (12.5)
Unknown[d]	0
Prior therapy lines	
Median (range)	3 (1-12)
0, No. (%)	0
1, No. (%)	8 (20.0)
2, No. (%)	8 (20.0)
3, No. (%)	5 (12.5)
4, No. (%)	5 (12.5)
≥5, No. (%)	14 (35.0)
Prior HER2 therapy, No. (%)	2 (5.0)
Trastuzumab	2 (5.0)

Meric-Bernstam et al., Journal of Clinical Oncology, 42(1), 47-58.
https://ascopubs.org/doi/10.1200/JCO.23.02005

T-DXd



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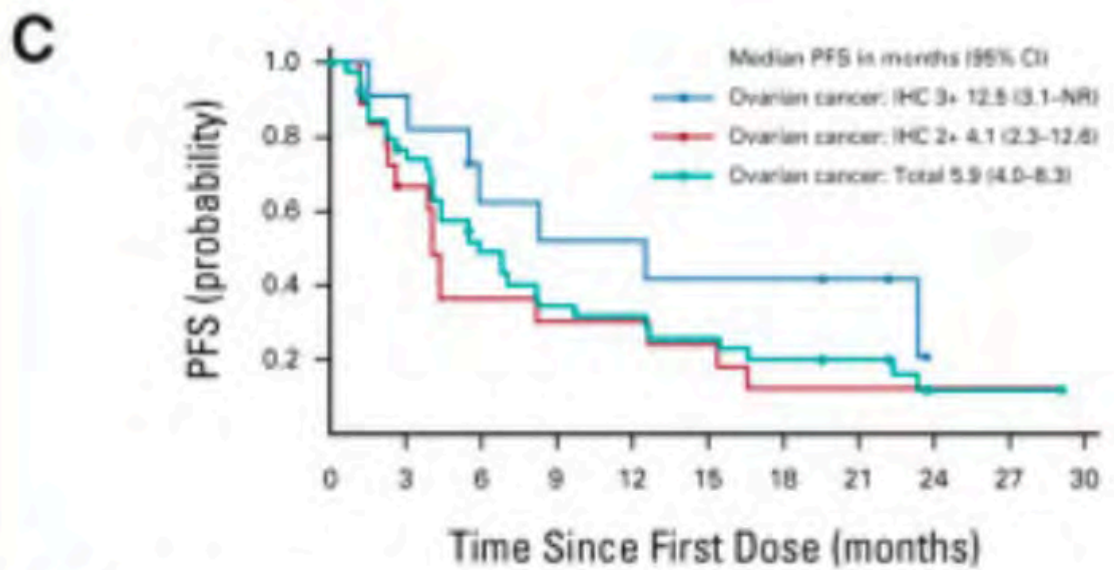
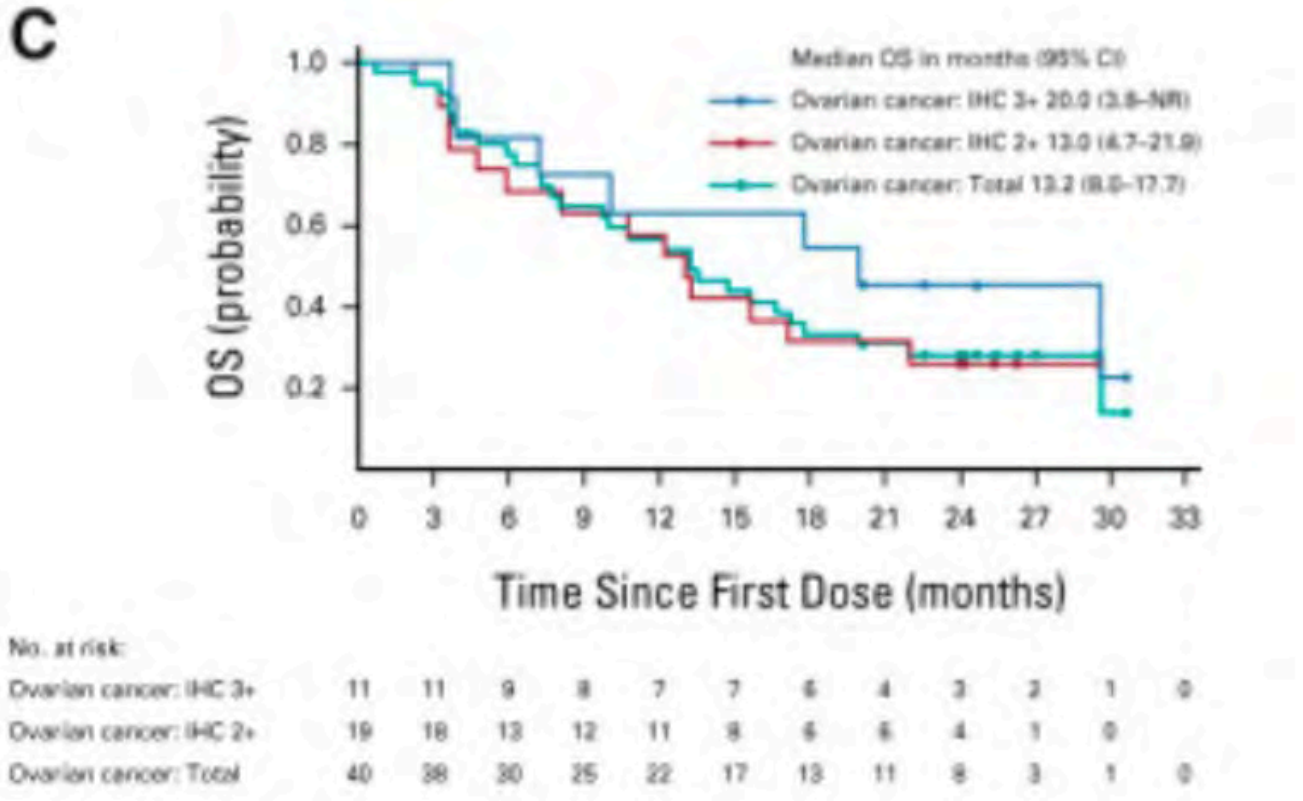
Efficacy and Safety of Trastuzumab Deruxtecan (T-DXd) in Patients With HER2-Expressing Solid Tumors: Primary Results From the DESTINY-PanTumor02 Phase II Trial





Target	Name	Payload	Payload	DAR	Linker	Development stage
HER2	Trastuzumab deruxtecan	Topo1i	deruxtecan	8	Cleavable	Phase II – FDA acc appr
	DB-1303 (BNT323)	Topo1i	P1003	8	Cleavable	Phase I/IIA – FDA BTD
	Trastuzumab duocarmazine	DNA alkylating	duocarmazine	2.8	Cleavable	Phase II
	Disitamab vedotin (RC48)	Anti-microtubule	MMAE	4	Cleavable	Phase II
FRα	Mirvetuximab soravtansine	Anti-microtubule	DM4	3.5	Cleavable	Phase II
	Luveltamab tazevibulin (STRO-002)	Anti-microtubule	SC209	4	Cleavable	Phase I/IIA
	Rinatabart sesutecan (Rina-S, PRO1184)	Topo1i	exatecan	8	Cleavable	Phase I/II
	IMGN151	Anti-microtubule	DM21	3.5	Cleavable	Phase I
TROP2	Sacituzumab govitecan (IMMU-132)	Topo1i	SN38	7.6	Cleavable	Phase II
	Sacituzumab tirumotecan (MK-2870)	Topo1i	tirumotecan	7.4	Cleavable	Phase III
	Datopotamab deruxtecan (DS-1062)	Topo1i	deruxtecan	4	Cleavable	Phase II
	LCB84	Anti-microtubule	MMAE	4	Cleavable	Phase I/II
B7-H4	SGN-B7H4V	Anti-microtubule	MMAE	4	Cleavable	Phase I
	HS-20089	Topo1i	undisclosed	6	Cleavable	Phase II
	XMT-1660	Anti-microtubule	MMAF	6	Cleavable	Phase I
	AZD8205	Topo1i	AZ14170133	8	Cleavable	Phase I/IIA
B7-H3	Ifinatamab veruxtecan (DS-7300a)	Topo1i	deruxtecan	4	Cleavable	Phase I
TF	Tisotumab vedotin	Anti-microtubule	MMAE	4	Cleavable	Phase II
	XB002	Anti-microtubule	MMAE	3.3	Cleavable	Phase I
AXL	Enapotamab vedotin	Anti-microtubule	MMAE	4	Cleavable	Phase I/II
Claudin6	TORL-1–23	Anti-microtubule	MMAE	?	Cleavable	Phase I

Slide courtesy of Toon van Gorp, MD

DAR stands for Drug-to-Antibody Ratio.

GOG Partners Phase 2/3 Portfolio: PROC

	Trial	Phase	Regimen	Prior total lines	Prior total lines for PROC	Tumor Testing/ Prevalence
Taxanes	GOG-3073 (ROSELLA)	3	Nab Paclitaxel+/- relacorliant	3	<3	No
ADCs	GOG-3086 (REFRaME-01)	2/3	Luveltamab tazevibulin (luvelta) vers Completed	1-3	ND	Frα
	GOG-3096 (REJOICE)	2/3	Raludotatug Deruxtecan (R-DXd) ver Discontinued	1-3	ND	Yes
	GOG-3107 (RAINFOL)	3	(Rina-S) versus SOC	1-5	ND	Yes
IO therapy	GOG-3063 (ARTISTRY 7)	3	Nemvaleukin + pembrolizumab vs Pembrolizumab vs Nemvaleukin vs Investigator Choice c Completed	Unlimited (prior bev requ)	<6	No
	GOG-3076 (OnPrime)	3	Olvi-Vec followed by platinum doublet + bev vs. IC chemo	≥3	ND	No
	GOG-3081 (PRESERVE-004)	2	ONC-392 (CTL A4) + Pembro in PROC Completed	1-3	ND	No
	GOG-3084 (SURPASS-3)	2	RPh2 of MAGE directed SPEAR T cell Closed	1-4	ND	Yes
Targeting DDR/PARPi resistance	GOG-3066 (DENALI)	2	A Phase 2 Open-Label, Multicenter Study to Evaluate Efficacy and Safety of ZN c3 in Subjects with High-Grade Serous Ovarian, Fallopian Tube, or Primary Peritoneal Cancer	5 (prior bev req)		No
	GOG-3067 (MAMMOTH)	2	Phase 1/2 Dose-Escalation and Dose Expansion Study of ZN-c3 in Combination with Nirapari Completed Platinum-Resistant Ovarian Cancer	Unlimited (prior bev req)	≤2	No
	GOG-3072 (ZN-c3-002)	2	ZN-c3 (wee-1) as monotx and in combo			+/-
	GOG-3082 (ACR-368-201)	1b/2	ACR-368 (CHK1/2) + gemcitabine in PI Cohort Closed	1-4	ND	Yes

Goals for Future PROC Trials

Let's show that PRO/QOL improves

- Target Fatigue, Work, Sleep, Nausea
- Let's address financial hardship

Let's extend PFS beyond 6 months and OS beyond 18 months

- Novel therapies and combinations
- Improve the patient experience

Table 2. Prognostic value of physical function and abdominal/gastrointestinal symptoms for survival in the AURELIA dataset

	Univariable analysis					Multivariable analysis[a]			
Overall survival	***n***	**Median overall survival (months)**	**HR**	**95% CI**	***P***	***n*[b]**	**HR**	**95% CI**	***P***
Physical function score	322				<0.001	300			0.02
<67	76	11.0	1				1		
67–92	147	14.7	0.62	(0.45–0.85)			0.75	(0.52–1.08)	
>92	99	19.3	0.44	(0.31–0.63)			0.56	(0.37–0.85)	
Abdominal/gastrointestinal symptom score	302				<0.001	300			0.03
<13	76	19.7	1				1		
13–44	159	14.3	1.51	(1.08–2.12)			1.13	(0.80–1.61)	
>44	67	11.9	2.56	(1.74–3.76)			1.67	(1.10–2.54)	

[a]Multivariable analysis adjusted for performance status, ascites, CA125 level, platinum-free interval, primary platinum resistance, and size of measurable lesions.
[b]*n* refers to patients with data available for both quality of life and clinicopathological factors.
HR, hazard ratio; CI, confidence interval.

https://pubmed.ncbi.nlm.nih.gov/28595285/

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Beyond ADCs: Novel Agents and Mechanisms on the Horizon

Katherine Fuh, MD, PhD

Platinum Resistant Ovarian Cancer: Current Strategies

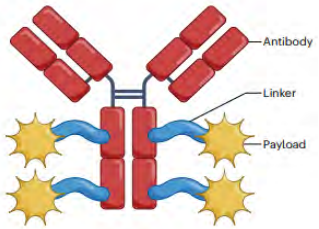
ADCs

MIRVETUXIMAB-SORAVTANSINE [2]

FARLETUZUMAB-ECTERIBULIN [3]

TRASTUZUMAB-DERUXTECAN [4]

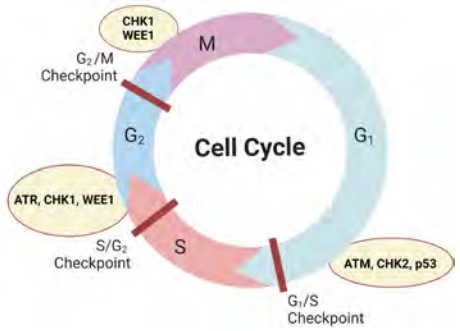
RALUDOTATUG-DERUXTECAN [5]



CELL CYCLE REGULATION AND DNA REPAIR

ADAVOSERTIB [6]

AZENOSERTIB[7]

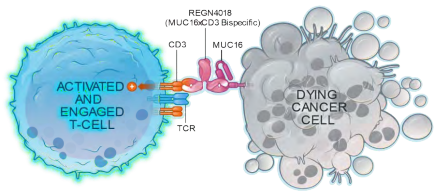


IMMUNOTHERAPY WITH NOVEL AGENTS

NEMVALEUKIN [9]

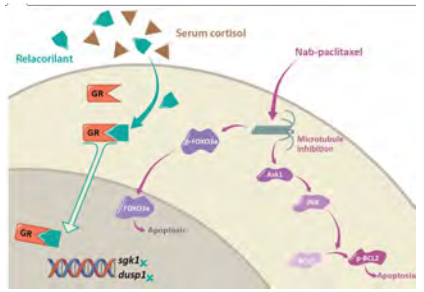
UBAMATAMAB [10]

ADOPTIVE CELL THERAPY



GLUCOCORTICOID RECEPTOR MODULATOR

RELACORILANT [1]



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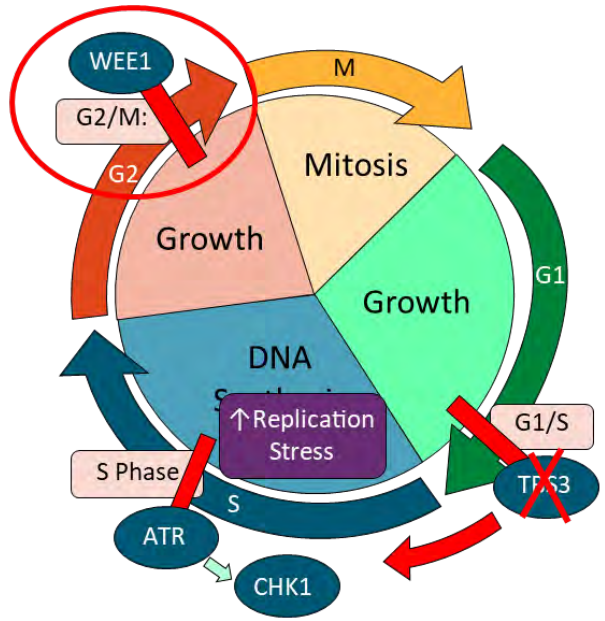
[1] [NCT05257408 – Rosella]; [NCT03776812 – phase II]; [2] [NCT04296890 – Soraya] [NCT04209855 – Mirasol]; [3] [NCT05613088]; [4] [NCT04482309]; [5] [NCT04707248]; [6] [NCT03579316]; [7] [NCT02595892]; [8] [NCT04729387]; [9] [NCT05092360]; [10] [NCT03564340]

Wee1 inhibitors can activate CDKs leading to replication stress and cell death

- Wee1 is a key regulator of G2/M and G1/S cell cycle checkpoint and inhibits Cyclin-Dependent Kinases (CDKs) - molecular clocks/inactive on their own --> allows cell cycle arrest during DNA repair to allow for DNA replication and prevent premature progression to mitosis
- CCNE1 encodes Cyclin E1 and regulates G1/S by forming a complex with CDK2 for necessary DNA replication. CCNE1 amp leads to uncontrolled cell proliferation
- High grade serous cancers have **loss of p53** which controls the **G1/S cell cycle** and increases dependence on the G2/M checkpoint
  - ✓Wee1 inhibition leads to dysregulation of G2M
- Azenosertib is a WEE1 inhibitor --> activates CDK1 --> premature entry into mitosis --> increase in replication stress--> cause DNA damage --> cell death



WEE1 inhibition leads to dysregulation of G2M checkpoint and to mitotic catastrophe

GOG-3072/ZN-c3-002: Phase 1 of Azenosertib (ZN-c3) Plus Chemo in PROC

Dose Finding guided by a CRM

Azenosertib + Paclitaxel

Paclitaxel: 80 mg/m² on D1, D8, D15 (28-day cycles)

200 mg QD 5:2 → 2 dose levels → 300 mg QD 5:2

Azenosertib + Carboplatin

Carboplatin: AUC 5 mg/mL*min on D1 (21-day cycles)

300 mg QD → 4 dose levels → 200 mg QD 5:2

Azenosertib + Gemcitabine

Gemcitabine : D1, D8 (21-day cycles)

G: 1000 mg/m² A: 200 mg QD → 3 dose levels → G: 600 mg/m² A: 200 mg QD 5:2

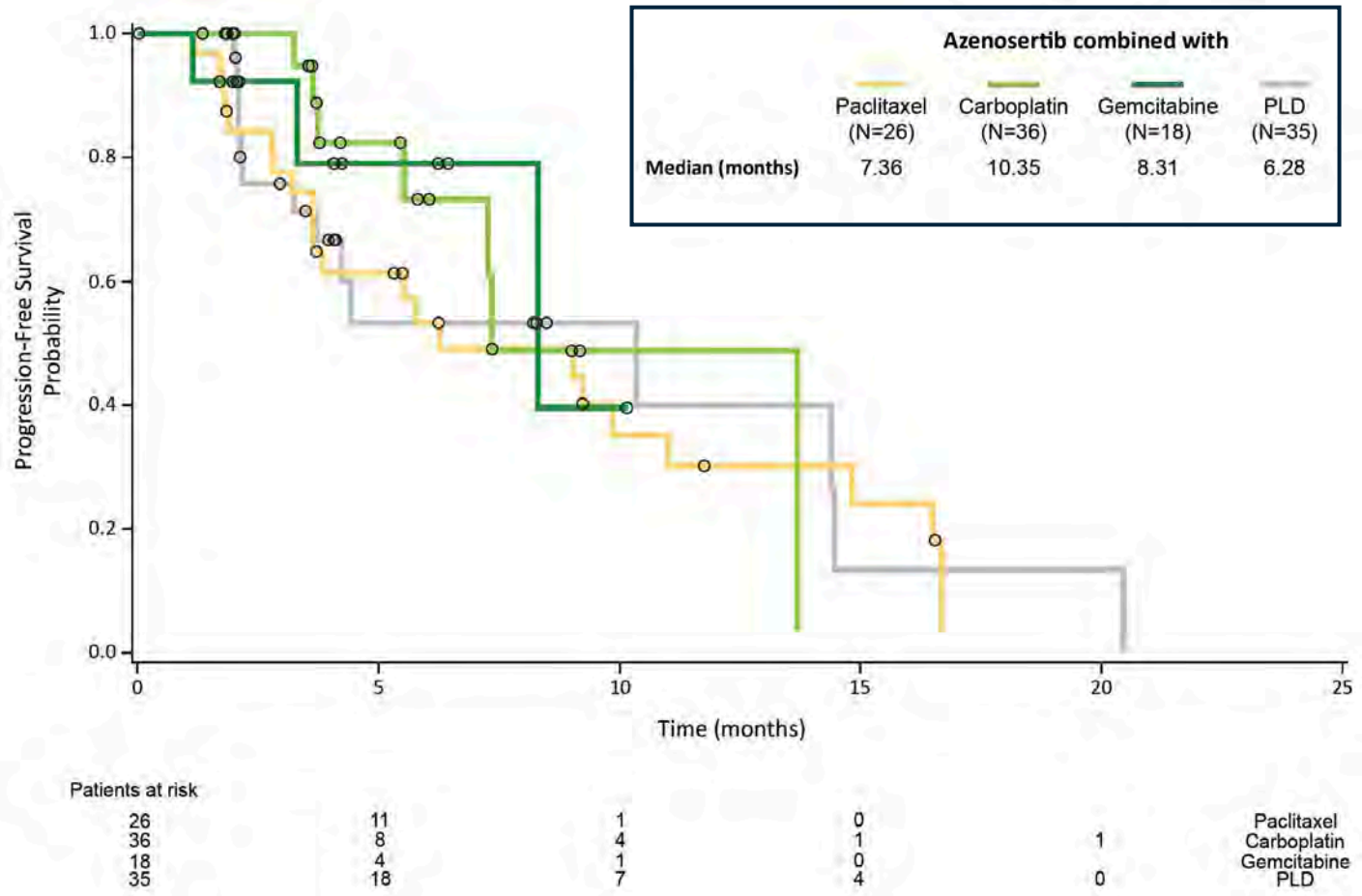
Azenosertib + PLD

PLD: 40 mg/m² D1 (28-day cycles)

200 mg QD → 3 dose levels → 400 mg QD 5:2

Primary: Safety and Tolerability
MTD and/or RP2D

Key Secondary: Clinical Activity
(Endpoints: ORR, DOR, PFS, CA125)



NCT number- NCT04516447

PI: Joyce Liu, MD and Premal Thaker, MD
Joyce Liu, MD Poster Presentation ASCO 2023

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GOG-3066 DENALI: Azenosertib – Wee1 inhibitor

DENALI (G
of Azenose

Key eligibi

- ✓ PROC
- ✓ 1-5 prior therapy
- ✓ Prior bev
- ✓ **All com** (irrespec E1 statu

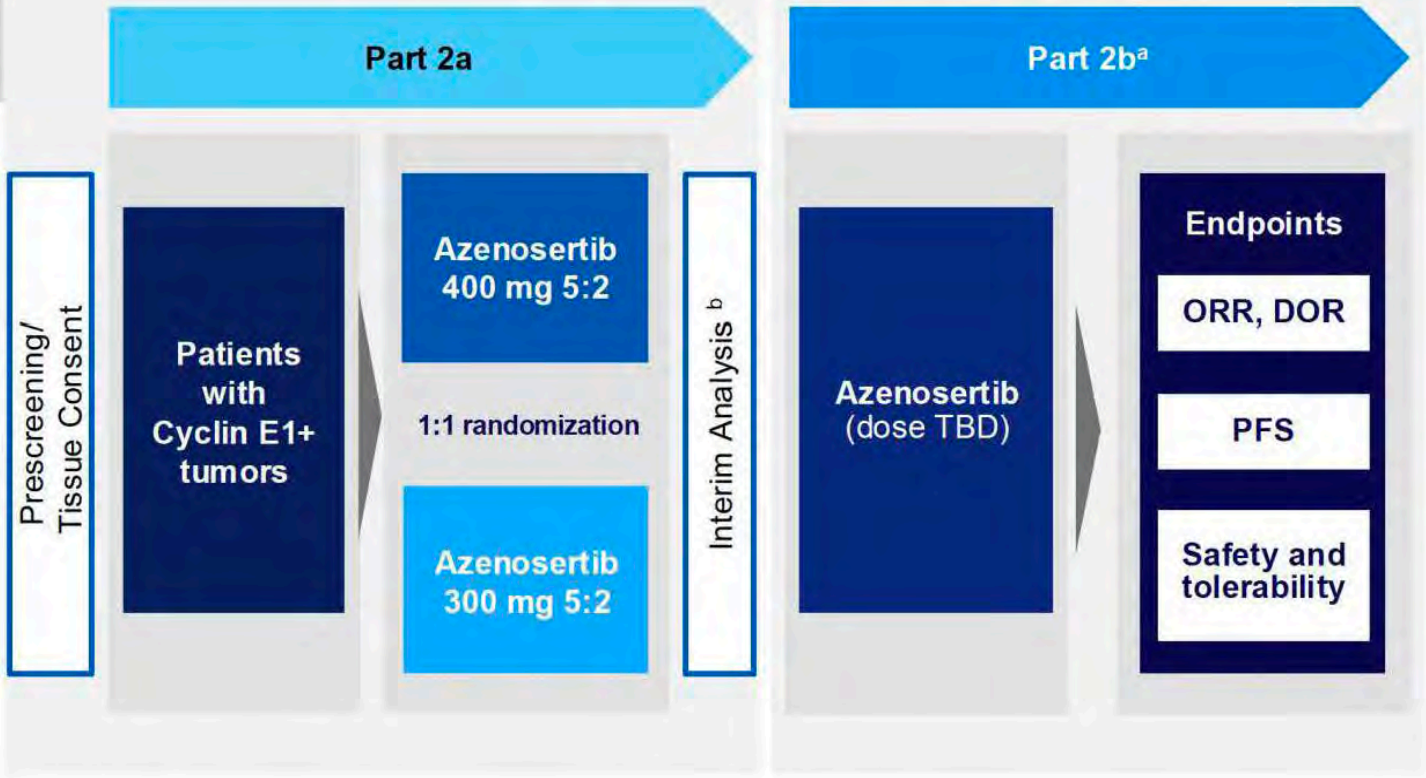
NCT051288

DENALI (GOG-3066): Phase 2, Open-Label, Multicenter Study Investigating Azenosertib in Cyclin E1+ PROC

ANNUAL MEETING ON WOMEN'S CANCER SEATTLE, WA • 2025

Part 2
Key eligibility criteria

- ✓ PROC
- ✓ **Cyclin E1+ IHC**
- ✓ 1-3 prior lines of therapy
- ✓ 4 if prior mirvetuximab



NCT05128825

[a]Subject to FDA feedback. [b]Enrollment will continue through the interim analysis
5:2, 5 days on, 2 days off; DOR, duration of response; FRa, folate receptor alpha; ORR, objective response rate; PFS, progression-free survival; PROC, platinum-resistant ovarian cancer; TBD, to be determined.
ClinicalTrials.gov: https://clinicaltrials.gov/study/NCT05128825.

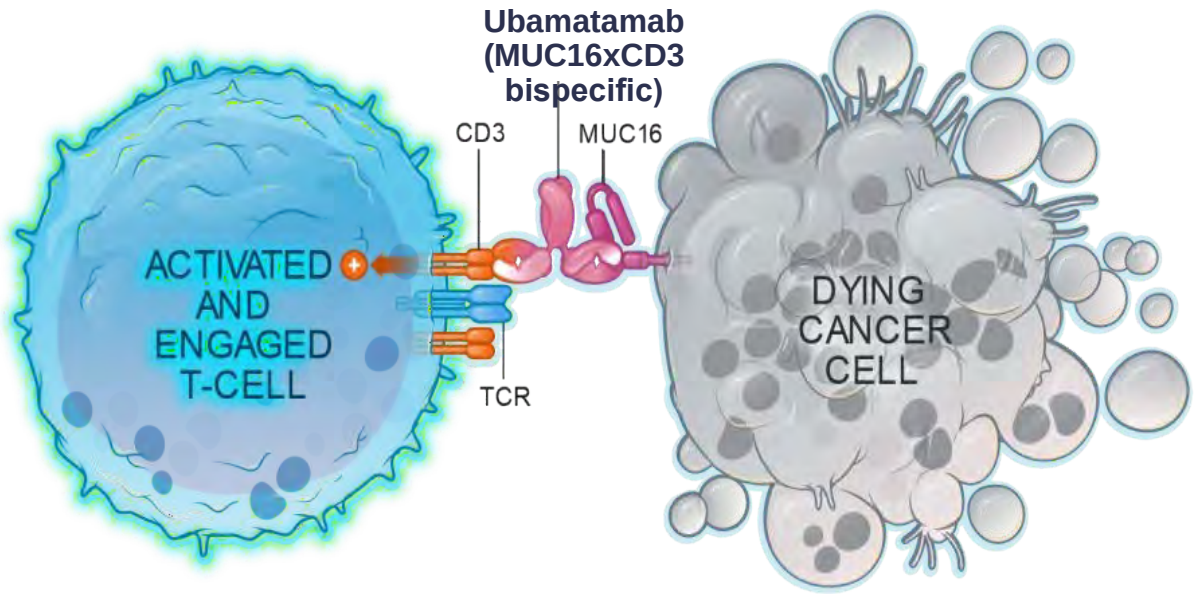
PI: Simpkins
SGO 2025

Immune Checkpoint Inhibitors in Ovarian Cancer: Phase 3 Evidence

1st Line			
Trial	**Agent**	**Combination**	**Met Endpoint**
JAVELIN-100	Avelumab	Chemo+IO	X
IMAgyn050	Atezolizumab	Chemo+IO+Bev	X
DUO-O	Durvalumab	Chemo+IO+Bev+olaparib	X
ATHENA Combo	Nivolumab	Chemo +IO + rucaparib	X
FIRST	Dostarlimab	Chemo + IO + niraparib	✓
KEYLINK 001	Pembrolizumab	Chemo +IO +/- Bev + olaparib	✓
Platinum-sensitive			
ATALANTE	Atezolizumab	Chemo +IO+ Bev	X
ANITA	Atezolizumab	Chemo + IO + niraparib	X
Platinum-resistant			
JAVELIN-200	Avelumab	Chemo + IO	X
NRG GY009	Atezolizumab	Chemo + IO + Bev	X
AGO OVAR 2.29	Atezolizumab	Chemo + IO + Bev	X
KEYNOTE-B96	Pembrolizumab	Chemo + IO +/- Bev	✓

No Clinically Meaningful Activity of Immune Checkpoint Inhibitors of Presented Trials thus far... KEYNOTE-B96 data pending

Phase I trial of Ubamatamab (REGN4018) in PROC with durable response of 12 months



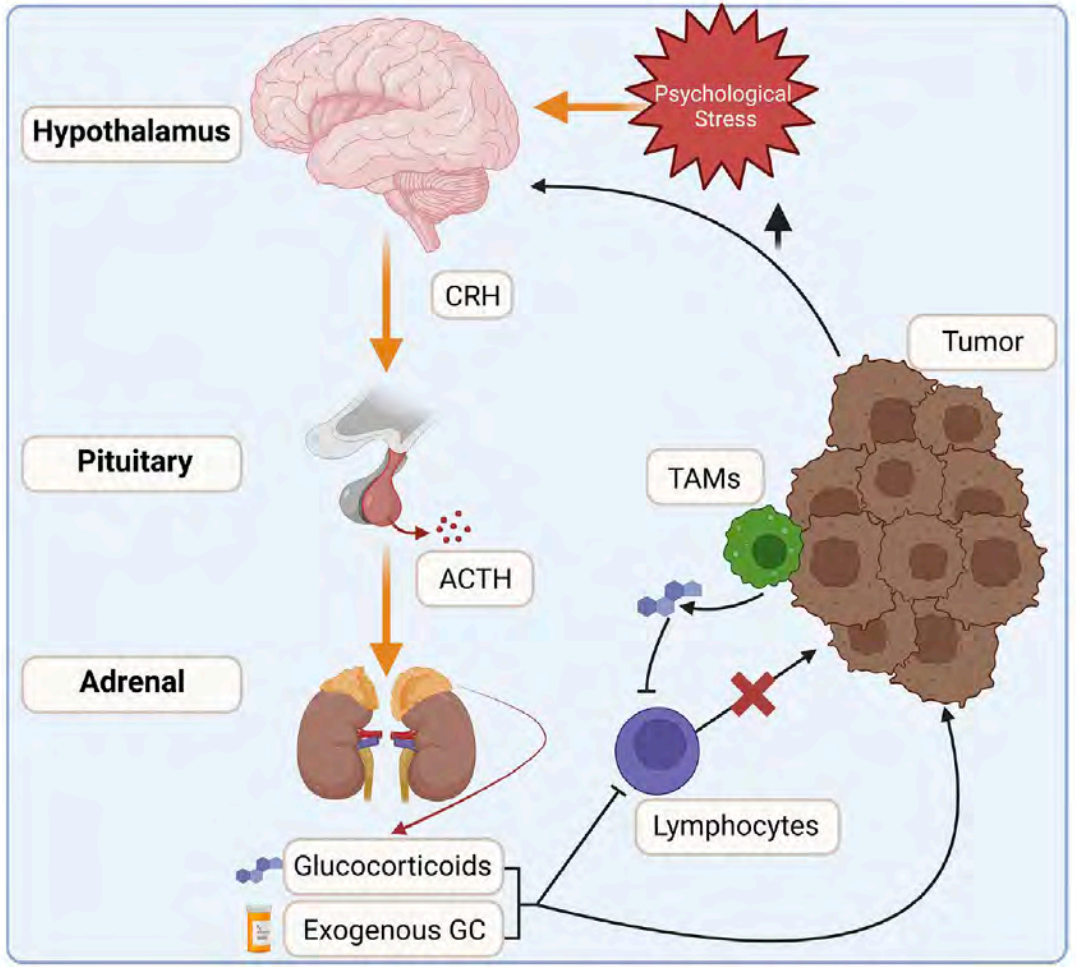
- Ubamatamab is a human bispecific antibody, developed using VelocImmune technology
- Ubamatamab is designed to bridge MUC16 on cancer cells with CD3-expressing T cells to facilitate T-cell activation and cytotoxicity[4]
- In immune-deficient mice, ubamatamab combined with human immune cells led to dose-dependent antitumor activity against intraperitoneal MUC16-expressing ovarian tumour cells and malignant ascites[5,6]

O'Malley ESMO 2022

1. National Cancer Institute. Available at: https://seer.cancer.gov/statfacts/html/ovary.html. Accessed January 20, 2022; 2. Siddiqui MK et al. Gynecol Oncol. 2017;146:44–51; 3. Pujade-Lauraine et al. J Clin Oncol. 2014; 13:1302-8; 4. Crawford A et al. Sci Transl Med. 2019;11:1–13; 5. Crawford A et al. Abstract presented at AACR 2018, Chicago, USA; 6. Crawford A et al. Oral presentation at PEGS Boston Summit 2020, Virtual.

Targeting glucocorticoid receptor signaling: Tumors produce glucocorticoids to evade immunity

- Increased glucocorticoid signaling is commonly associated with cancers
- Glucocorticoids exert immunosuppressive effects --> suppresses cytotoxic T cells & increases M2 suppressive macrophages
- Tumors and TAMs can induce de novo steroid biosynthesis and increase glucocorticoid conc to affect T cells to evade immunity (Mahata et al Nat Comm 2020)
- **GR** is abundantly expressed in ovarian tumors, and high GR expression is associated poor outcomes[2]



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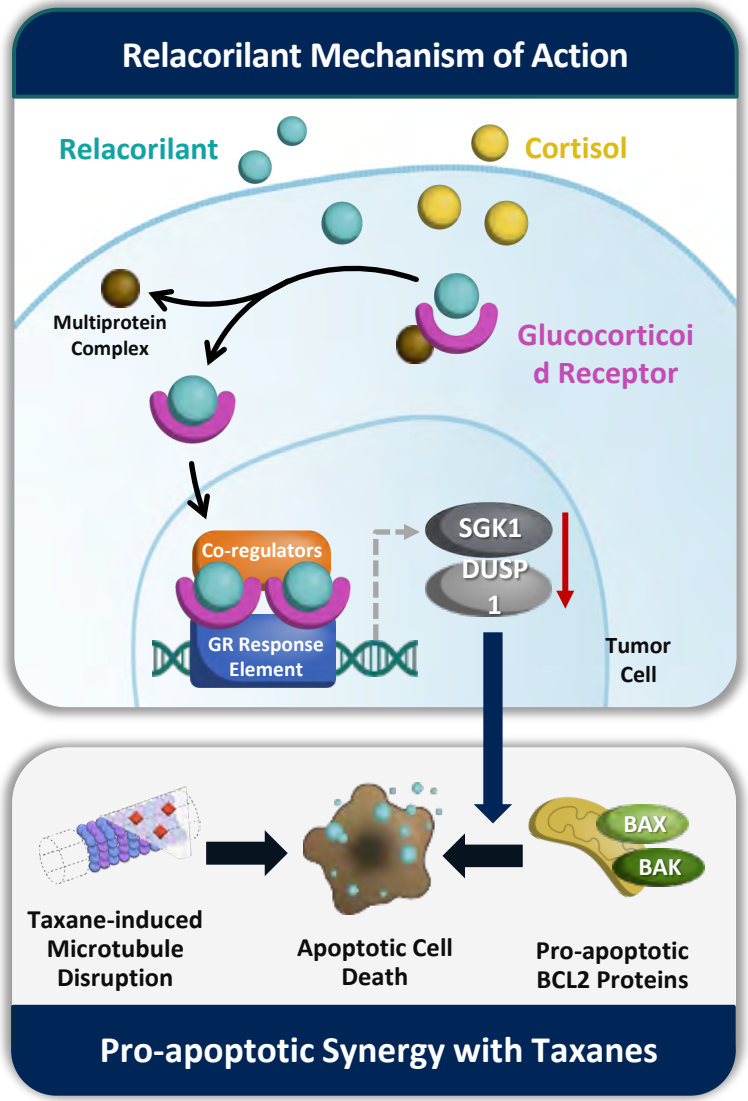
[1] Luvero et al. 2014; [2] Veneris et al. 2017; Munster et al. 2019

Relacorilant binds to the Glucocorticoid Receptor and prevents cortisol from binding and activating

- Relacorilant is a novel, selective GR antagonist (SGRA) that restores the sensitivity of cancers to cytotoxic chemotherapy[3,5,6]
- Relacorilant binds to glucocorticoid receptor with high affinity and prevents cortisol from exerting its effects
- Acts like an antagonist since it prevents cortisol from binding and activating the glucocorticoid receptor
- Combined with nab-paclitaxel since it does not require steroid premedication and thus does not risk impairing the efficacy of relacorilant



1. Martorana, et al. Int J Gynecol Cancer. 2025;35(1):100009. 2. Veneris, et al. Gynecol Oncol. 2017;146(1):153-60. 3. Greenstein, et al. Oncotarget. 2021;12(13):1243-55. 4. Melhelm, et al. Clin Cancer Res. 2009;15(9):3196-3204. 5. Stringer-Reasor, et al. Gynecol Oncol. 2015;138(3):656-62. 6. Munster, et al. Clin Cancer Res. 2022;28(15):3214-24. 7. Colombo, et al. J Clin Oncol. 2023;41(30):4779-89.

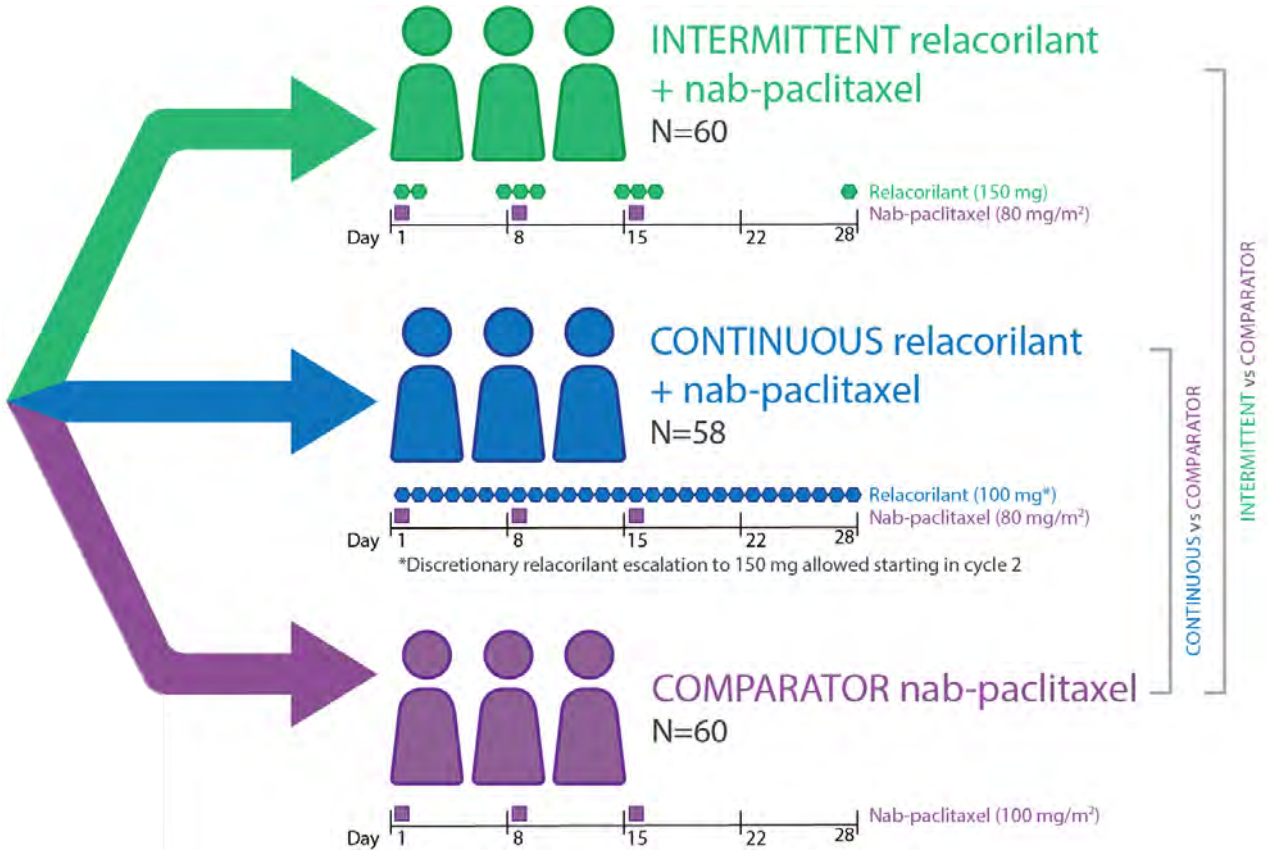
Relacorilant + Nab-Paclitaxel Phase 2 Study Design

Randomized 1:1:1

- Measurable or non-measurable disease by RECIST v1.1
- Up to 4 prior chemotherapeutic regimens

Stratification factors:

- Relapse within 6 months of most recent taxane
- Presence of ascites



Primary endpoint:

- **PFS** by investigator and RECIST v1.1

Secondary endpoints:

- Objective response rate (ORR)
- Duration of response (DoR)
- Overall survival (OS)
- Safety of the relacorilant + nap-paclitaxel combination

Statistical assumptions:

- **CONTINUOUS vs COMPARATOR**: 91 PFS events to detect a HR=0.56 (median PFS increase from 3.8 to 6.8 mo)
- **INTERMITTENT vs COMPARATOR**: 92 PFS events to detect a HR=0.7 (median PFS increase from 3.8 to 5.4 mo)

- **Higher intermittent dosing was found to be more effective than lower continuous dosing**
  - **Possibly due to:**
    - **Improved safety profile**
    - **Restoring taxane chemosensitivity – reverses effects of cortisol on GR**
    - **Preclinical data suggests that a higher dose in intermittent may enhance its effectiveness**

NCT03776812

Nicoletta Colombo, J Clin Oncol. 2023.

2025 ASCO® ANNUAL MEETING

ROSELLA: A Phase 3 Study of Relacorilant in Combination with Nab-Paclitaxel versus Nab-Paclitaxel Monotherapy in Patients with Platinum-Resistant Ovarian Cancer

(GOG-3073, ENGOT-ov72, APGOT-Ov10, LACOG-0223, and ANZGOG-2221/2023)

Alexander Olawaiye,[1] Laurence Gladieff, Lucy Gilbert, Jae-Weon Kim, Mariana Scaranti, Vanda Salutari, Elizabeth Hopp, Linda Mileshkin, Alix Devaux, Michael McCollum, Ana Oaknin, Aliza L. Leiser, Nicoletta Colombo, Andrew Clamp, Boglárka Balázs, Giuseppa Scandurra, Emilie Kaczmarek, Hristina I. Pashova, Sachin G. Pai, and Domenica Lorusso

[1]*University of Pittsburgh School of Medicine and UPMC Magee-Women's Hospital, Gynecologic Oncology Group, Pittsburgh, PA, USA.*

In collaboration with:

GOG FOUNDATION® Transforming the standard of care™

ENGOT European Network of Gynaecological Oncological Trial groups

APGOT Asia-Pacific Gynecologic Oncology Trials Group

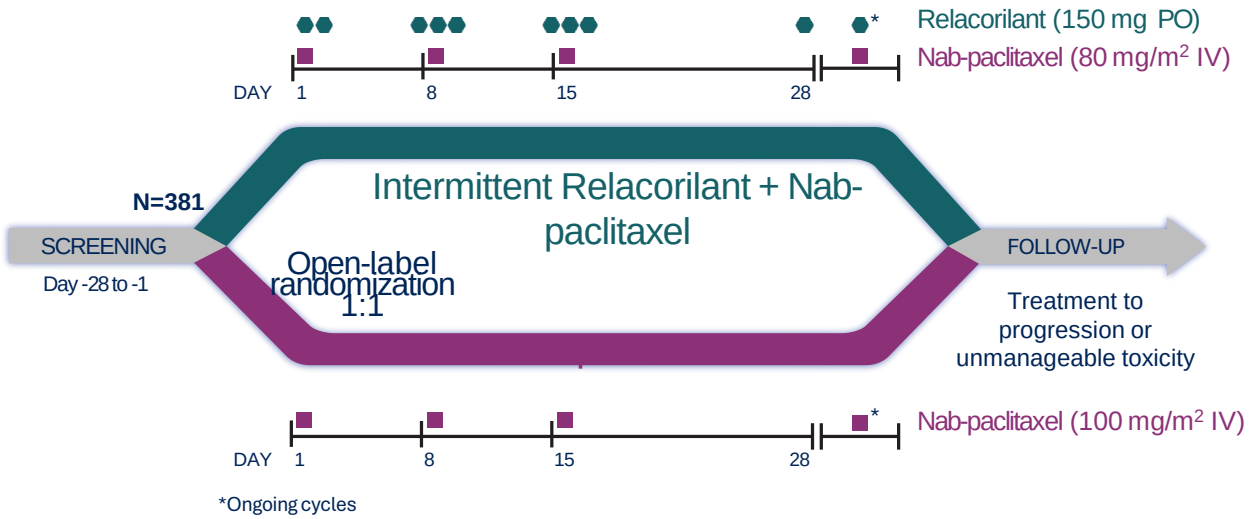
LACOG LATIN AMERICAN COOPERATIVE ONCOLOGY GROUP

ANZGOG

ROSELLA: Phase 3 RCT of Relacorilant + Nab-paclitaxel vs Nab-paclitaxel

Population

- Epithelial ovarian, primary peritoneal or fallopian tube cancer
- ECOG performance status 0 or 1
- **Progression <6 months** after the last dose of platinum therapy (excluding no response to, or progression in <1 month of primary platinum)
- **1–3 prior lines of therapy**
- Prior bevacizumab required



Stratification Factors

- Prior lines of therapy (1 vs >1)
- Region (North America vs Europe vs Korea, Australia, & Latin America)

NCT05257408

Dual Primary Endpoints

- Progression-free survival (PFS) by RECIST v1.1 per blinded independent central review
- Overall survival

Secondary Endpoints

- PFS by RECIST v1.1 per Investigator
- ORR, DoR, CBR (RECIST v1.1)
- Response by CA-125 GCIG criteria
- Combined response (RECIST v1.1 and CA-125 GCIG criteria)
- Safety

First patient enrolled: 5th January 2023
Last patient enrolled: 8th April 2024
Data cutoff: 24th February 2025
Conducted at 117 sites in 14 countries.

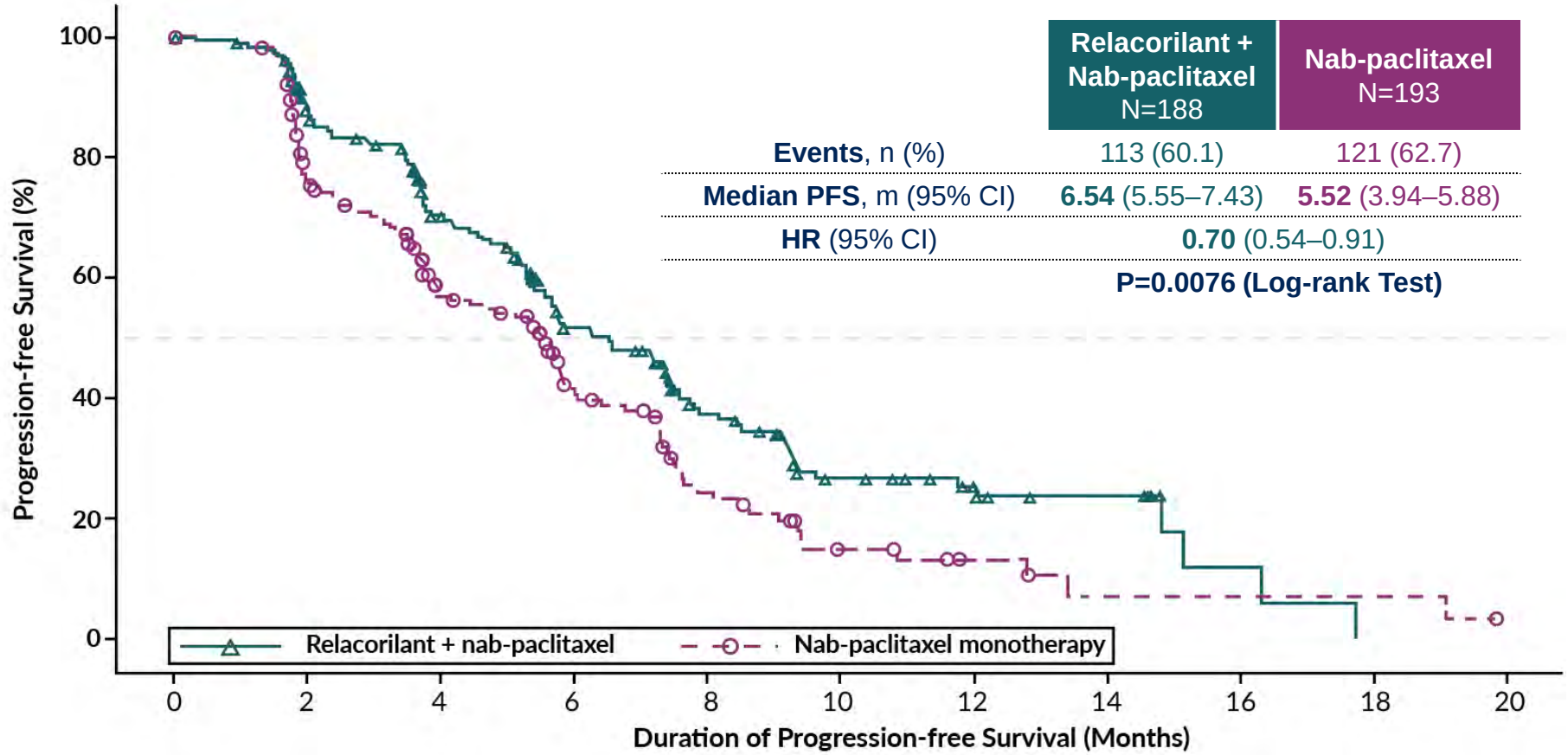
CA, cancer antigen; CBR, clinical benefit rate; DoR, duration of response; ECOG, Eastern Cooperative Oncology Group; GCIG, Gynecologic Cancer Intergroup; IV, intravenous; ORR, objective response rate; PFS, progression-free survival; PO, by mouth; RECIST, Response Evaluation Criteria in Solid Tumors.

ROSELLA | Baseline Characteristics Were Well Balanced

		Relacorilant + Nab-paclitaxel (N=188)	Nab-paclitaxel (N=193)
Age, median (range), years		**61** (26–85)	**62** (33–86)
Race, n (%)	White Black or African-American Asian (92% Korean) Other / Not Reported	136 **(72.3)** 3 **(1.6)** 22 **(11.7)** 27 **(14.4)**	135 **(69.9)** 2 **(1.0)** 26 **(13.5)** 30 **(15.5)**
Ethnicity, n (%)	Hispanic	16 **(8.5)**	17 **(8.8)**
Region	North America Europe Korea, Australia, and Latin America	45 **(23.9)** 107 **(56.9)** 36 **(19.1)**	45 **(23.3)** 109 **(56.5)** 39 **(20.2)**
ECOG Performance Status, n (%)*	1 or 2	53 **(28.2)**	63 **(32.6)**
BRCA1/2 Mutation, n (%)	Yes	23 **(12.2)**	24 **(12.4)**
Prior Lines of Therapy, n (%)	1 2 3	15 **(8.0)** 92 **(48.9)** 81 **(43.1)**	18 **(9.3)** 89 **(46.1)** 86 **(44.6)**
Primary Platinum Refractory, n (%)†	Yes	13 **(6.9)**	13 **(6.7)**
Prior Lines of Therapy in the Platinum-resistant Setting, n (%)	≥1	67 **(35.6)**	82 **(42.5)**
Prior Taxane in the Platinum-resistant Setting, n (%)	Yes	8 **(4.3)**	7 **(3.6)**
Prior Therapies, n (%)	Bevacizumab Taxanes Pegylated Liposomal Doxorubicin PARP Inhibitor	188 **(100)** 187 **(99.5)** 121 **(64.4)** 114 **(60.6)**	193 **(100)** 192 **(99.5)** 125 **(64.8)** 120 **(62.2)**

*In the nab-paclitaxel monotherapy arm, 1 patient had an ECOG performance status of 2. †Progressed within 3 months of the last dose of platinum from their first line platinum regimen. 97% of patients had high-grade serous carcinoma; 8 patients had high-grade endometrioid carcinoma and 2 patients had carcinosarcoma. BRCA, Breast Cancer Gene; ECOG, Eastern Cooperative Oncology Group.

ROSELLA | Relacorilant Significantly Improved Progression-Free Survival Assessed by Blinded Review



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	113 (60.1)	121 (62.7)
Median PFS, m (95% CI)	**6.54** (5.55–7.43)	**5.52** (3.94–5.88)
HR (95% CI)	**0.70** (0.54–0.91)	
	P=0.0076 (Log-rank Test)	

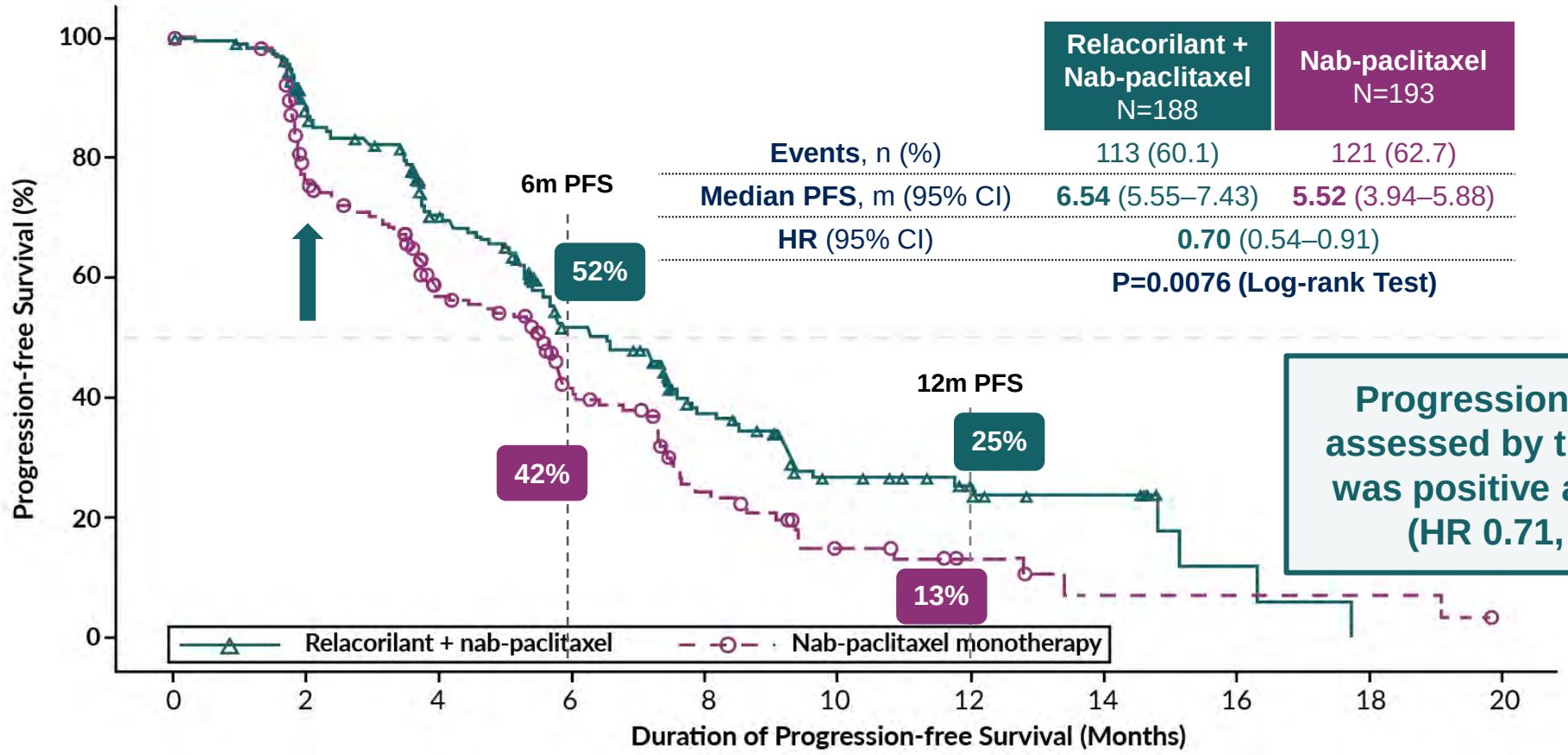
No. at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	151 (22/22)	109 (29/51)	70 (27/78)	43 (18/96)	24 (11/107)	16 (1/108)	11 (1/109)	2 (2/111)	0 (2/113)	
Nab-paclitaxel monotherapy	193 (0/0)	129 (42/42)	85 (31/73)	47 (20/93)	21 (17/110)	9 (7/117)	5 (1/118)	2 (2/120)	2 (0/120)	2 (0/120)	0 (1/121)

Median follow-up time: 9.0 months; statistical significance threshold: P≤0.04. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for progression-free survival in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.
BICR, blinded-independent central review; CI, confidence interval; HR, hazard ratio; m, months; PFS, progression-free survival.

Data cutoff: Feb 24, 2025

ROSELLA | Relacorilant Significantly Improved Progression-Free Survival Assessed by Blinded Review



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HR (95% CI)	**0.70** (0.54–0.91)	
	P=0.0076 (Log-rank Test)	

Progression-free survival assessed by the investigator was positive and consistent (HR 0.71, P=0.0030)

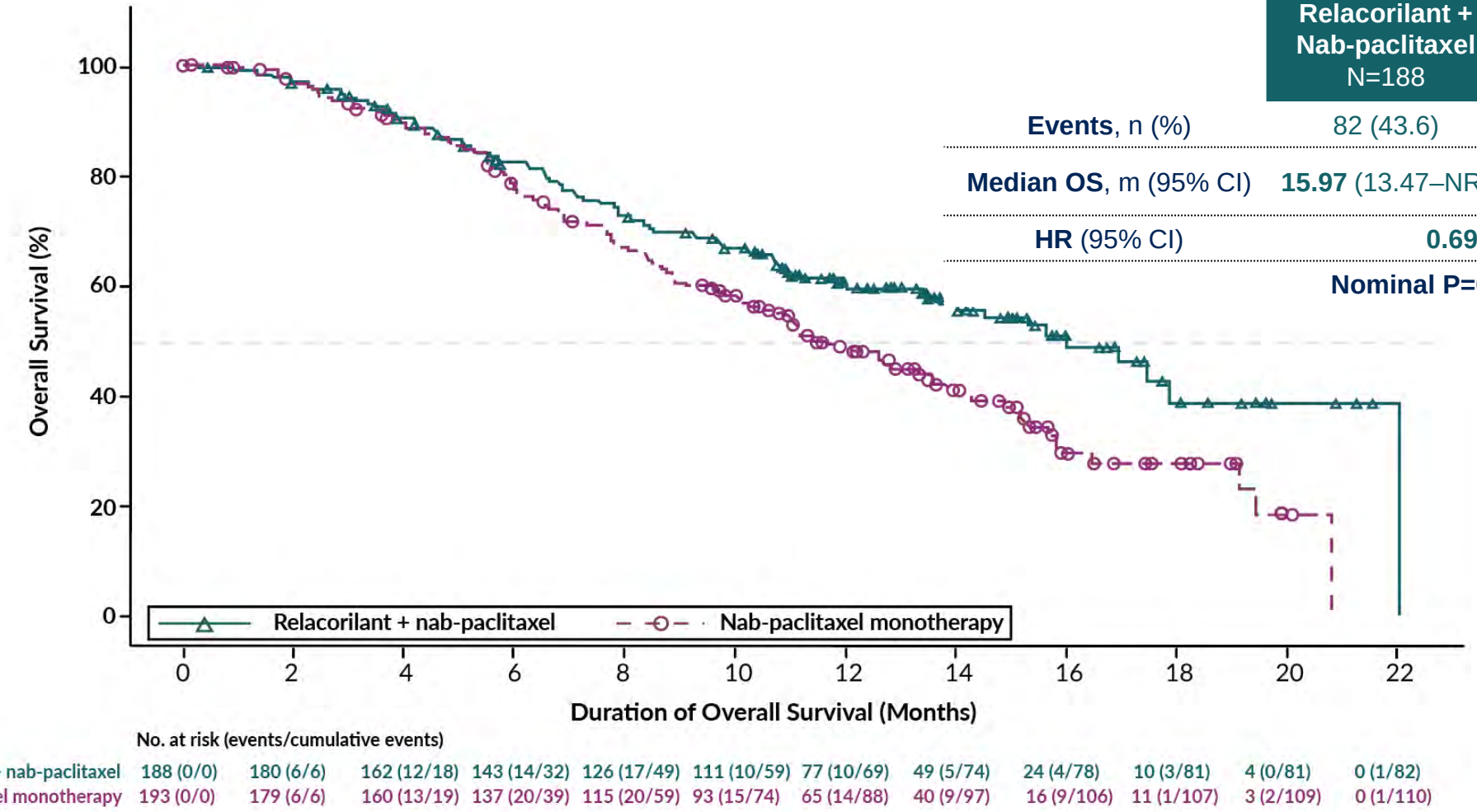
No. at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	151 (22/22)	109 (29/51)	70 (27/78)	43 (18/96)	24 (11/107)	16 (1/108)	11 (1/109)	2 (2/111)	0 (2/113)	
Nab-paclitaxel monotherapy	193 (0/0)	129 (42/42)	85 (31/73)	47 (20/93)	21 (17/110)	9 (7/117)	5 (1/118)	2 (2/120)	2 (0/120)	2 (0/120)	0 (1/121)

Median follow-up time: 9.0 months; statistical significance threshold: P≤0.04. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for progression-free survival in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.
BICR, blinded-independent central review; CI, confidence interval; HR, hazard ratio; m, months; PFS, progression-free survival.

Data cutoff: Feb 24, 2025

ROSELLA | Relacorilant Improved Overall Survival at this Interim Analysis



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	82 (43.6)	110 (57.0)
Median OS, m (95% CI)	**15.97** (13.47–NR)	**11.50** (10.02–13.57)
HR (95% CI)	**0.69** (0.52–0.92)	

Nominal P=0.0121 (Log-rank Test)

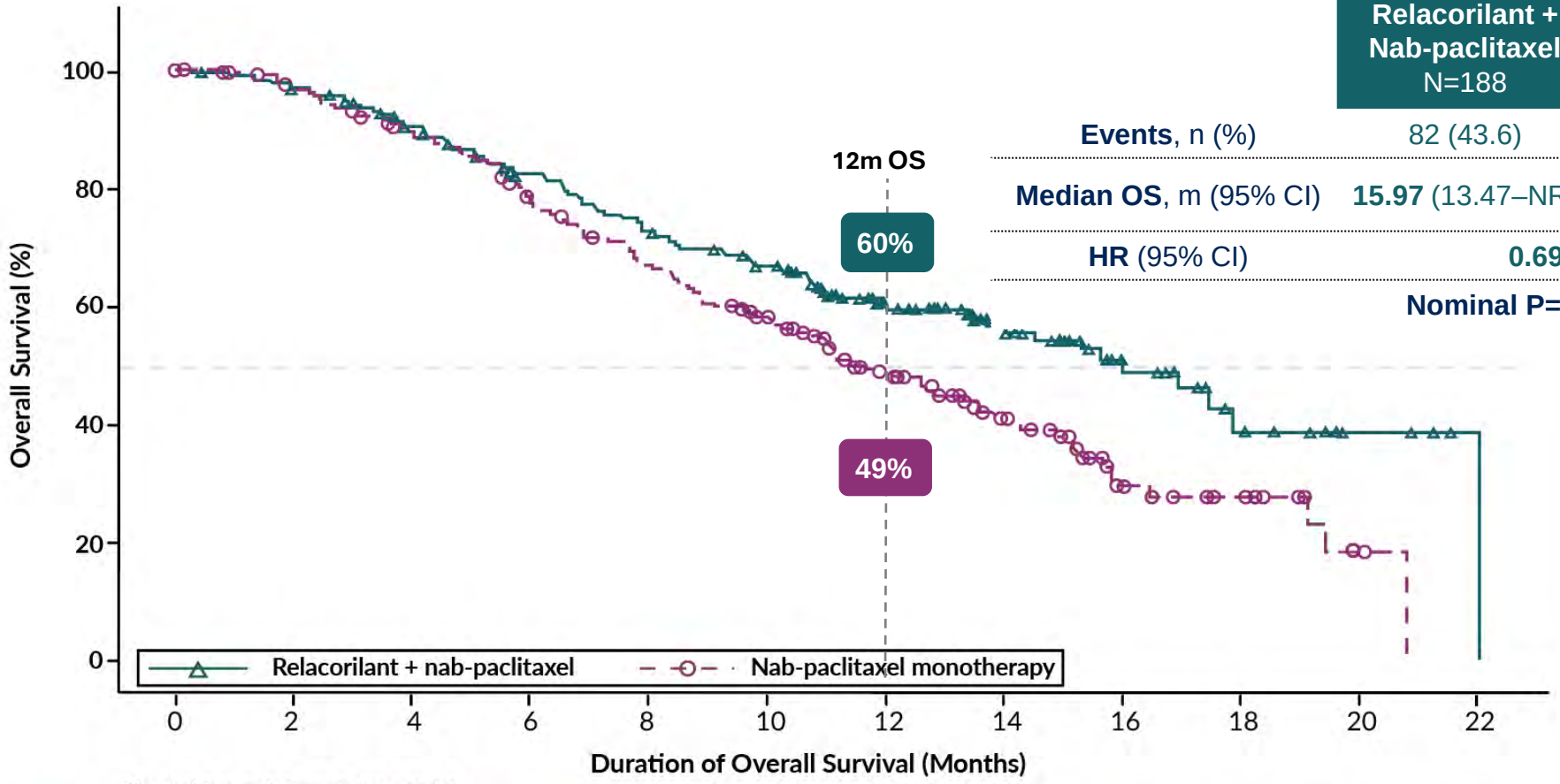
Maturity: 50%

Median follow-up time: 13.9 months; statistical significance threshold at the interim analysis: P≤0.0001; statistical significance threshold at the final analysis: P≤0.0499. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for overall survival in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates. CI, confidence interval; HR, hazard ratio; m, months; NR, not reached; OS, overall survival.

Data cutoff: Feb 24, 2025

Alexander B. Olawaiye, MD

ROSELLA | Relacorilant Improved Overall Survival at this Interim Analysis



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	82 (43.6)	110 (57.0)
Median OS, m (95% CI)	**15.97** (13.47–NR)	**11.50** (10.02–13.57)
HR (95% CI)	**0.69** (0.52–0.92)	

Nominal P=0.0121 (Log-rank Test)

Maturity: 50%

No. at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	180 (6/6)	162 (12/18)	143 (14/32)	126 (17/49)	111 (10/59)	77 (10/69)	49 (5/74)	24 (4/78)	10 (3/81)	4 (0/81)	0 (1/82)
Nab-paclitaxel monotherapy	193 (0/0)	179 (6/6)	160 (13/19)	137 (20/39)	115 (20/59)	93 (15/74)	65 (14/88)	40 (9/97)	16 (9/106)	11 (1/107)	3 (2/109)	0 (1/110)

Median follow-up time: 13.9 months; statistical significance threshold at the interim analysis: P≤0.0001; statistical significance threshold at the final analysis: P≤0.0499. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for overall survival in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates. CI, confidence interval; HR, hazard ratio; m, months; NR, not reached; OS, overall survival.

Data cutoff: Feb 24, 2025

Alexander B. Olawaiye, MD

ROSELLA | Relacorilant Improved PFS & OS Across Key Subgroups

Subgroup		Patients, n	Events, n	Hazard Ratio for PFS (BICR), (95% CI)	Events, n	Hazard Ratio for OS, (95% CI)
All Patients		381	234	0.70 (0.54–0.91)	192	0.69 (0.52–0.92)
Age	<65 years	229	140	0.76 (0.54–1.08)	119	0.83 (0.57–1.20)
	≥65 years	152	94	0.61 (0.40–0.94)	73	0.55 (0.34–0.89)
Region	North America	90	56	0.62 (0.36–1.07)	45	0.69 (0.38–1.27)
	Europe	216	130	0.73 (0.52–1.04)	111	0.67 (0.46–0.98)
	Korea, Australia, Latin America	75	48	0.70 (0.39–1.26)	36	0.76 (0.39–1.48)
ECOG Performance Status	0	262	154	0.72 (0.52–1.00)	118	0.72 (0.50–1.05)
	1	115	80	0.62 (0.39–0.98)	74	0.59 (0.36–0.97)
Prior Lines of Therapy	1	33	21	0.88 (0.35–2.22)	21	0.80 (0.32–1.97)
	2	181	119	0.63 (0.43–0.91)	91	0.74 (0.49–1.12)
	3	167	94	0.71 (0.47–1.08)	80	0.66 (0.42–1.04)
Prior PARP Inhibitor	Yes	234	138	0.60 (0.42–0.85)	116	0.77 (0.53–1.13)
	No	147	96	0.84 (0.55–1.28)	76	0.66 (0.42–1.05)
Primary Platinum-free Interval	≤6 months	112	73	0.50 (0.30–0.84)	62	0.52 (0.31–0.89)
	>6 months	269	161	0.78 (0.57–1.06)	130	0.82 (0.58–1.16)
BRCA1/2 Mutation	Positive	47	32	1.08 (0.49–2.37)	23	0.82 (0.33–2.07)
	Negative / Unknown	334	202	0.65 (0.49–0.87)	169	0.70 (0.52–0.96)
Largest Target Lesion	<5 cm	299	181	0.68 (0.51–0.92)	141	0.65 (0.46–0.91)
	≥5 cm	45	30	0.50 (0.23–1.09)	25	0.58 (0.25–1.34)

BICR, blinded independent central review; BRCA, Breast Cancer Gene; CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; OS, overall survival; PFS, progression-free survival.

Data cutoff: Feb 24, 2025

Alexander B. Olawaiye, MD

ROSELLA | Relacorilant + Nab-Paclitaxel Was Associated with High Objective Response and Clinical Benefit Rates (by Investigator)

Endpoint	Relacorilant + Nab-paclitaxel	Nab-paclitaxel
Objective Response Rate, n (%)	69 **(36.9)**	58 **(30.1)**
	6.8% improvement P=0.17 (Stratified Cochran-Mantel-Haenszel Test)	
Complete Response, n (%)	6 **(3.2)**	4 **(2.1)**
Partial Response, n (%)	63 **(33.7)**	54 **(28.0)**
Stable Disease, n (%)	77 **(41.2)**	68 **(35.2)**
Progressive Disease, n (%)	32 **(17.1)**	52 **(26.9)**
Not Evaluable, n (%)	9 **(4.8)**	15 **(7.8)**
Clinical Benefit Rate, n (%) (Response or stable disease maintained for 24 weeks)	96 **(51.1)**	75 **(38.9)**
	12.2% improvement P=0.016 (Stratified Cochran-Mantel-Haenszel Test)	

Objective response rate was assessed in the subset of intent-to-treat population with measurable disease at baseline, per investigator assessment (n=380 patients). Clinical Benefit Rate was assessed in the intent-to-treat population (n=381 patients). Per RECIST v1.1 guidelines confirmatory scans were not required for this randomized controlled trial.

RECIST, Response Evaluation Criteria in Solid Tumors.

ROSELLA | Safety Summary

Relacorilant + Nab-Paclitaxel was Well-Tolerated, with a Favorable Safety Profile

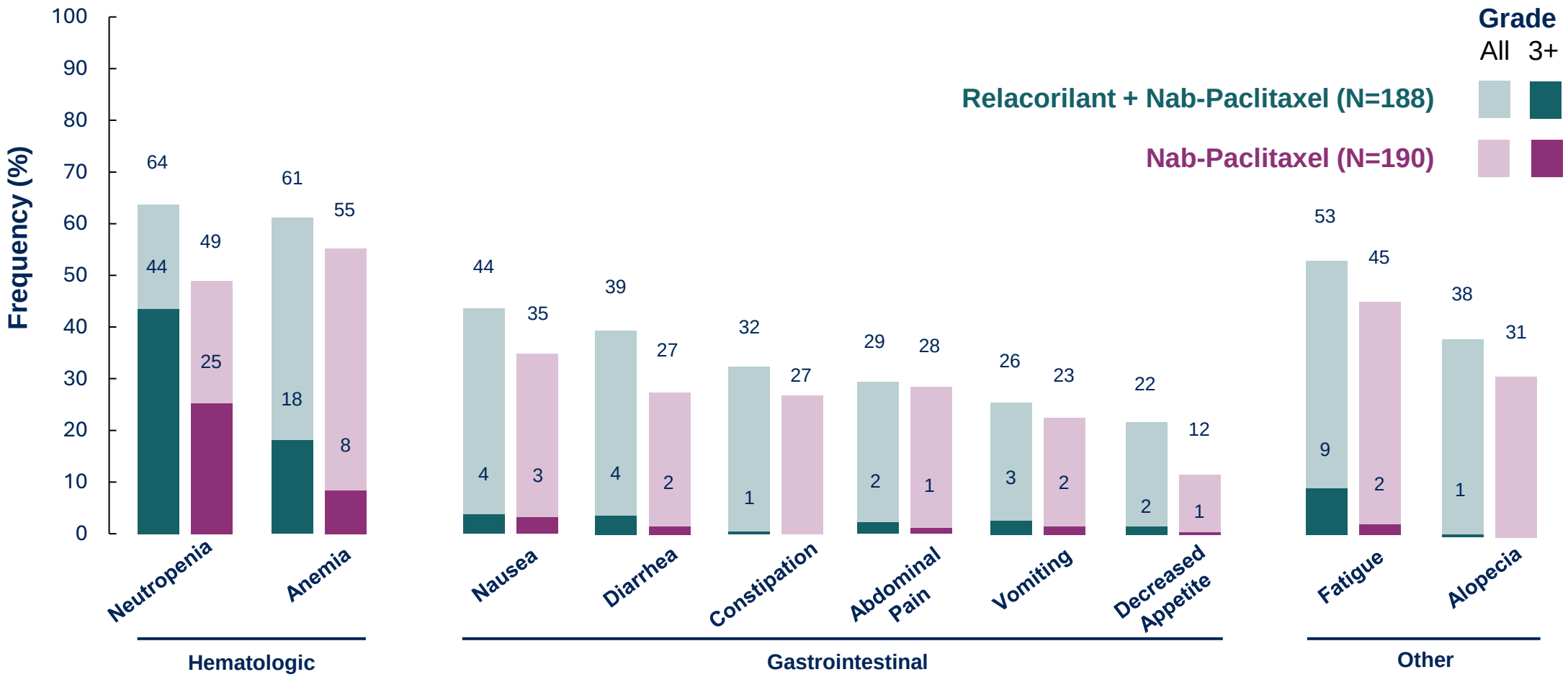
Safety Population Who Received at Least One Dose of Study Drug (N=378)	Relacorilant + Nab-paclitaxel (N=188)	Nab-paclitaxel (N=190)
Weeks of Nab-paclitaxel Therapy, mean (range)	**23.2** (0.1–90.3)	**18.6** (0.1–68.1)
Any TEAEs, n (%)	188 **(100)**	189 **(99.5)**
Grade ≥3 TEAEs, n (%)	140 **(74.5)**	113 **(59.5)**
Serious AEs, n (%)	66 **(35.1)**	45 **(23.7)**
All Deaths on Treatment or Within 30 Days of the Last Dose, n (%)	10 **(5.3)**	8 **(4.2)**
Dose Reductions of Relacorilant Due to TEAEs, n (%)	13 **(6.9)**	—
Dose Reductions of Nab-paclitaxel Due to TEAEs, n (%)	91 **(48.4)**	60 **(31.6)**
Interruptions of Nab-paclitaxel (+ Relacorilant) Due to TEAEs, n (%)*	137 **(72.9)**	104 **(54.7)**
Discontinuations of Nab-paclitaxel (+ Relacorilant) Due to TEAEs, n (%)*	17 **(9.0)**	15 **(7.9)**

*Relacorilant was always interrupted or discontinued when nab-paclitaxel was interrupted or discontinued. AEs, adverse events; TEAEs, treatment-emergent adverse events.

AEs leading to treatment discontinuation in >2 patients included intestinal obstruction and paresthesia. There were no relacorilant-related fatal AEs.

Data cutoff: Feb 24, 2025

ROSELLA | Common (>20%) Adverse Events



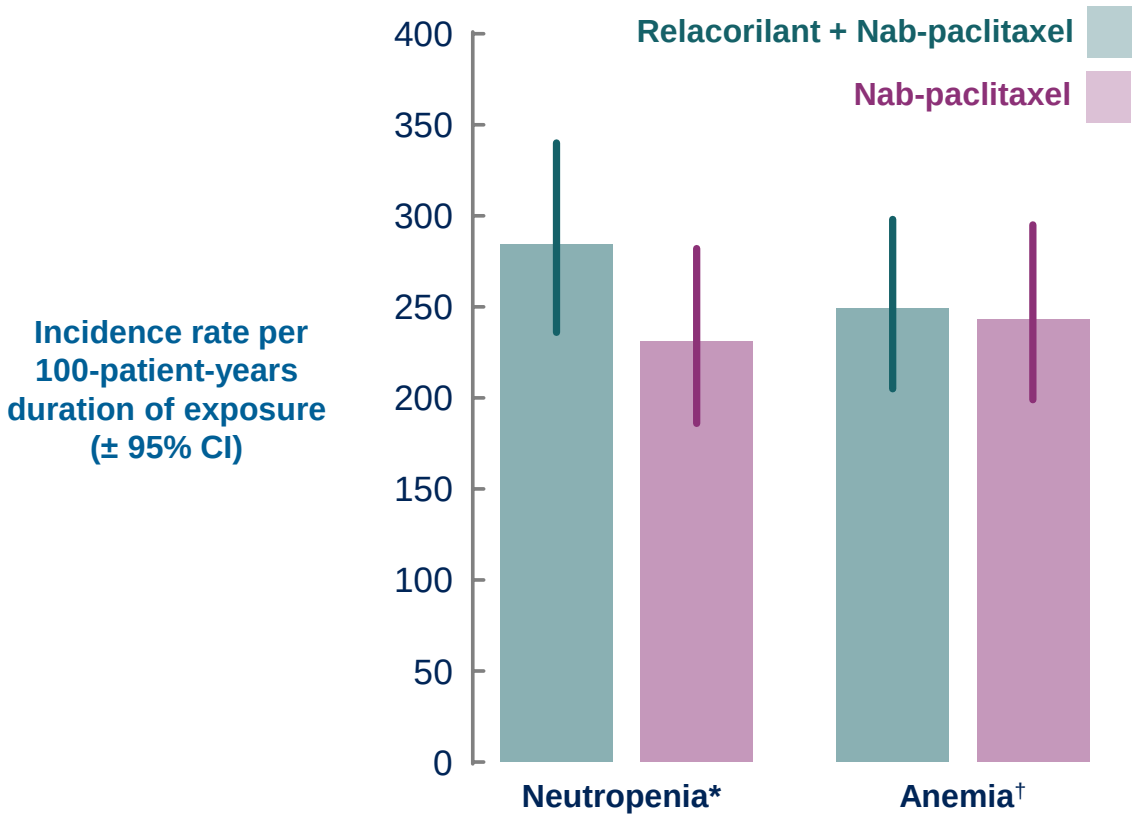
Peripheral neuropathy occurred with similar frequency in both arms (19.1% and 17.4%).
5 SAEs of febrile neutropenia were reported, 4 (2.1%) with relacorilant + nab-paclitaxel and 1 (0.5%) with nab-paclitaxel monotherapy.
5 SAEs of sepsis were reported, 3 (1.6%) with relacorilant + nab-paclitaxel and 2 (1.1%) with nab-paclitaxel monotherapy.

TEAEs that occurred in >20% of patients. Assessed in the safety population of patients who received at least one dose of study drug, N=378. Combined terms are presented for neutropenia (neutropenia, reduced neutrophil count, and febrile neutropenia), anemia (anemia, reduced hemoglobin, and reduced red blood cell count) and fatigue (fatigue and asthenia). SAEs, serious adverse events; TEAEs, treatment-emergent adverse events.

Data cutoff: Feb 24, 2025

ROSELLA | Selected Exposure-Adjusted Adverse Events

Exposure-Adjusted Incidence Rate
(AE incidence normalized to the duration of exposure)



When adjusted for duration of exposure, the incidence rates of neutropenia and anemia were comparable between study arms.

*Combined term including anemia, decreased red blood cell count, and decreased hemoglobin. †Combined term including neutropenia, decreased neutrophil count, and febrile neutropenia. Assessed in the safety population of patients who received at least one dose of study drug, N=378. AE, adverse event; CI, confidence interval. Exposure-Adjusted Incidence Rate (EAIR) is defined as Event Incidence rate per 100 patient-years-exposure (PYE): (Total number of patients with an event/Total PYE)*100. Exact 95% confidence interval based on Poisson distribution for EAIR. The total PYE to a treatment is the sum of individual patient's PYE within the treatment exposure period and is defined as: (i) For patients with an event within the exposure period: (First event start date-first dose date+1)/365.25; (ii) For patients with no event within the exposure period: (Study participation end date- first dose date +1)/365.25.
EAIR difference: [(Relacorilant + Nab-paclitaxel) - Nab-paclitaxel Monotherapy]. The exact confidence interval for difference of EAIR between two treatment arms is based on two independent Poisson distributions.

Data cutoff: Feb 24, 2025

ROSELLA | Conclusions

1 ROSELLA met its primary endpoint of improving PFS	Relacorilant, **a first-in-class, oral, SGRA, extended progression-free survival** by BICR (log-rank test P=0.0076, HR 0.70) compared to nab-paclitaxel monotherapy in patients with platinum-resistant ovarian cancer, in a population including patients who progressed within 1–3 months after their primary platinum regimen
2 Median survival prolonged by 4.5 months	**At this interim overall survival analysis, the addition of relacorilant to nab-paclitaxel showed a clinically meaningful improvement in overall survival** (nominal log-rank test P=0.0121, HR 0.69, median 16.0 vs 11.5 months)
3 Well-tolerated, favorable safety profile	Relacorilant plus nab-paclitaxel was well-tolerated, with a favorable safety profile that was comparable between treatment arms when adjusted for duration of exposure. The safety profile was consistent with previously reported data; no new signals were identified
4 A new standard for PROC	Intermittently dosed relacorilant plus nab-paclitaxel offers an efficacious treatment regimen for women with platinum-resistant ovarian cancer, without the need for a biomarker

BICR, blinded independent central review; PFS, progression-free survival; PROC, platinum-resistant ovarian cancer; SGRA, selective glucocorticoid receptor antagonist.

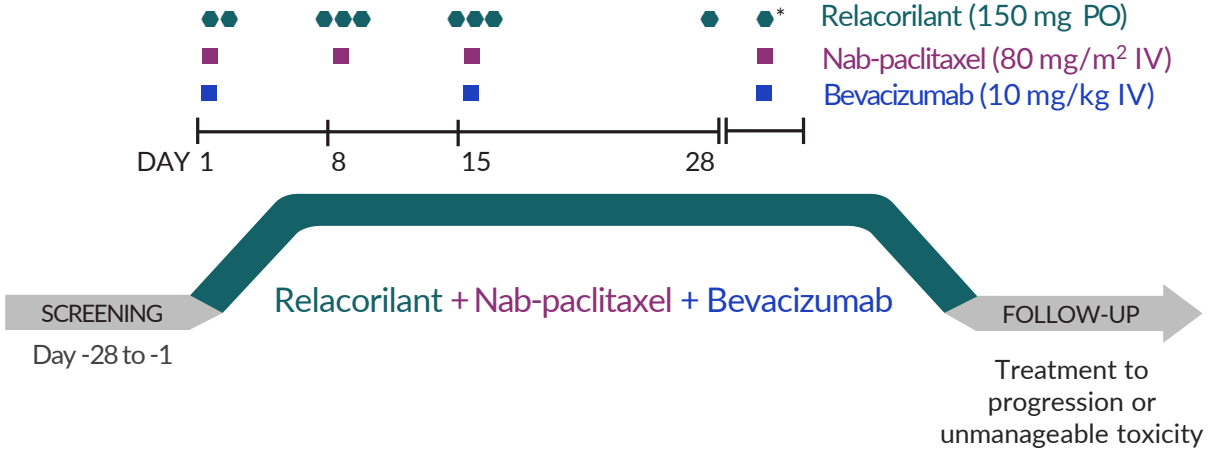
A Phase 2 Study of Relacorilant plus Nab-paclitaxel and Bevacizumab in Platinum-Resistant Ovarian Cancer

BELLA
Relacorilant with Nab-paclitaxel & Bevacizumab in Ovarian Cancer

Population

90 patients

- Epithelial ovarian, primary peritoneal or fallopian tube cancer
- ECOG performance status 0 or 1
- Progression <6 months after the last dose of platinum therapy
- 1 to 3 prior lines of therapy
- Suitable for bevacizumab
- Eligible irrespective of prior bevacizumab



Primary Endpoint

- Progression-free survival

Secondary Endpoints

- Overall survival
- ORR, DoR, CBR
- Safety

NCT06906341

Conducted at 42 sites in the US, EU and Korea

Please note that relacorilant is investigational for the use being studied that is described. The safety and efficacy of such investigational use has not been established by the FDA or any regulatory authority.

CBR, clinical benefit rate; DoR, duration of response; ECOG, Eastern Cooperative Oncology Group; IV, intravenous; ORR, objective response rate; PO, by mouth.

Platinum Resistant Ovarian Cancer: Current Strategies

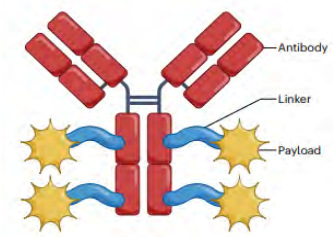
ADCs

MIRVETUXIMAB-SORAVTANSINE [2]

FARLETUZUMAB-ECTERIBULIN [3]

TRASTUZUMAB-DERUXTECAN [4]

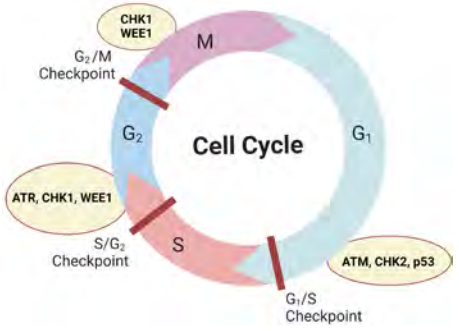
RALUDOTATUG-DERUXTECAN [5]



CELL CYCLE REGULATION AND DNA REPAIR

ADAVOSERTIB [6]

AZENOSERTIB[7]

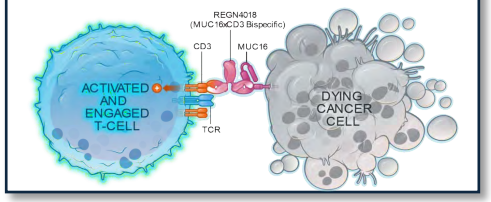


IMMUNOTHERAPY WITH NOVEL AGENTS

NEMVALEUKIN [9]

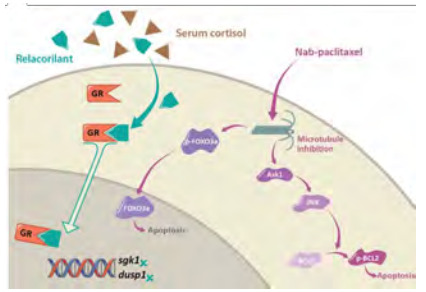
UBAMATAMAB [10]

ADOPTIVE CELL THERAPY



GLUCOCORTICOID RECEPTOR

RELACORILANT [1]



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[1] [NCT05257408 – Rosella]; [NCT03776812 – phase II]; [2] [NCT04296890 – Soraya] [NCT04209855 – Mirasol]; [3] [NCT05613088]; [4] [NCT04482309]; [5] [NCT04707248]; [6] [NCT03579316]; [7] [NCT02595892]; [8] [NCT04729387]; [9] [NCT05092360]; [10] [NCT03564340]

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Digging into the Data: Making Sense of PFS/OS Curves

Debra Richardson, MD

Measures of Treatment Effects

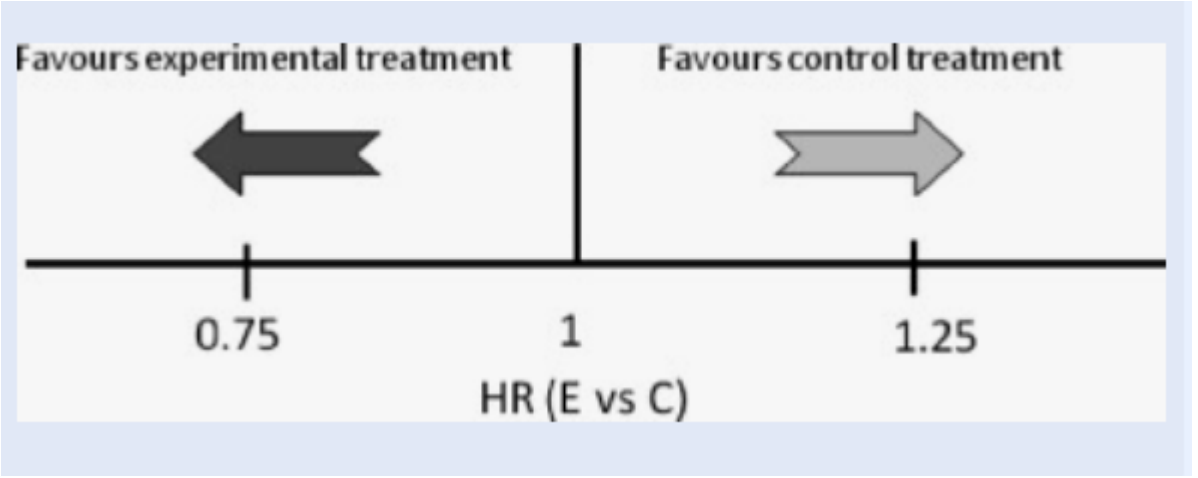
Measure	Strengths	Limitations
Median survival time	- Widely used and familiar to clinicians, researchers, and patients - Clinically interpretable - Insensitive to outliers	- Represents a single datapoint, which may be misleadmg - Insensitive to short- and long-term survivors - Wider confidence intervals - May be unreached (if the follow-up time is not long enough)
Hazard ratio	- Widely used and familiar to clinicians and researchers - A relative measure - Incorporates survival data from all patients - Can be used in multivariable regression analysis	- Depends on the proportional hazards (PH) assumption. For multivariable analysis, the PH assumption needs to hold for each of the variables - Does not provide an evaluation of the absolute difference in survival - Interpretation may not be intuitive
Restricted mean survival time	- Intuitive and clinically interpretable - Has no specific model assumptions (eg, the PH assumption) - Always calculable - Incorporates survival data from all patients - Can be represented as an absolute (RMST, RMST-D) or a relative (RMST-R/RMTL-R) measure - Allows evaluation of treatment benefits across various periods - Can be used in multivariable regression analysis	- Not widely used - Requires determination of a cutoff timepoint - Results vary based on the cutoff timepoint

Abbreviations: RMST = restricted mean survival time; RMST-D = RMST difference; RMST-R = RMST ratio; RMTL-R = restricted mean time lost ratio.

Averbuch Int J Rad Onc 2025

Interpreting Hazard Ratio

- Instantaneous probability of experiencing the event of interest in the next time interval among individuals who have not yet experienced the event
- Assumes HR remains constant over time
- OS HR =0.7
  - 30% reduction in the rate (not risk) of mortality
  - The rate to mortality is slower



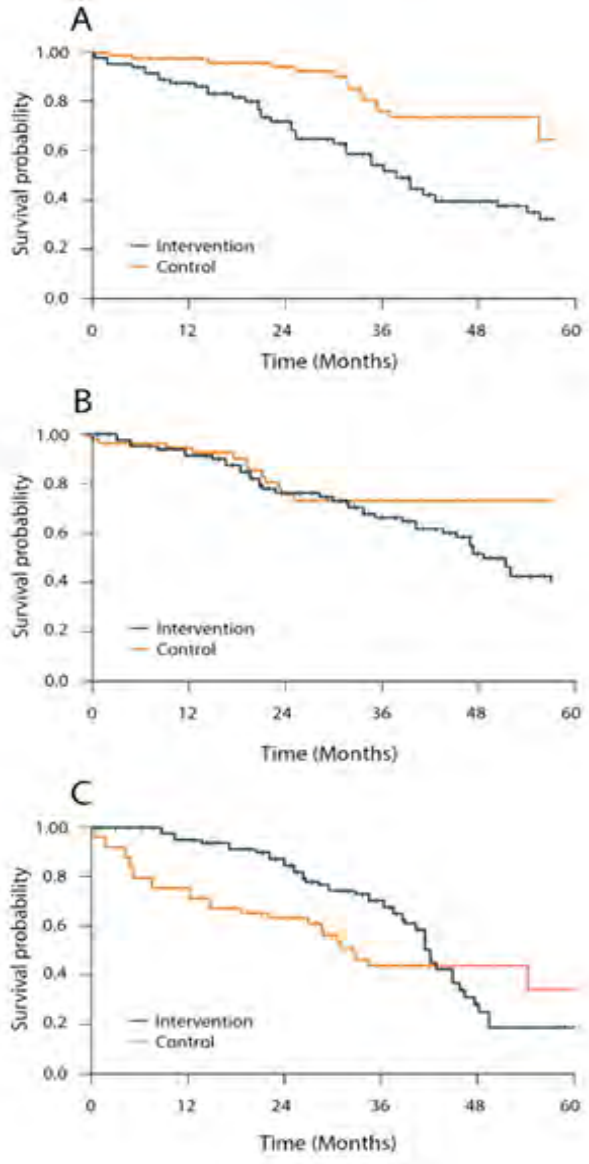
Han NEJM Evid 2023

Censored

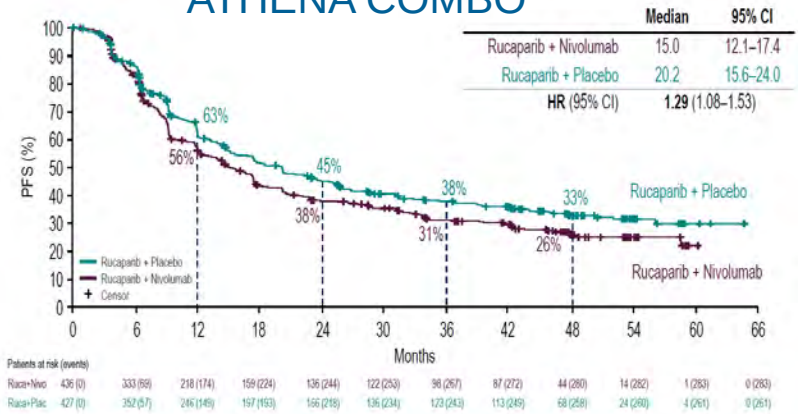
- Patients lost to follow up
- Have not had event of interest at study conclusion
- Some will have event of interest after end of study
- Some will never have the event of interest

Proportional Hazards

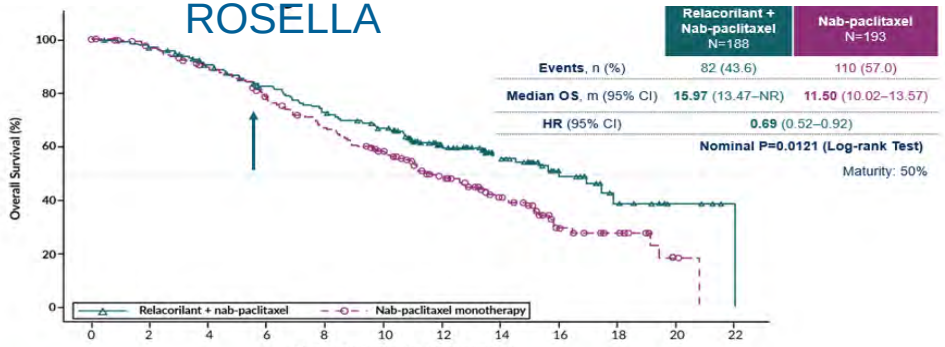
Non Proportional Hazards



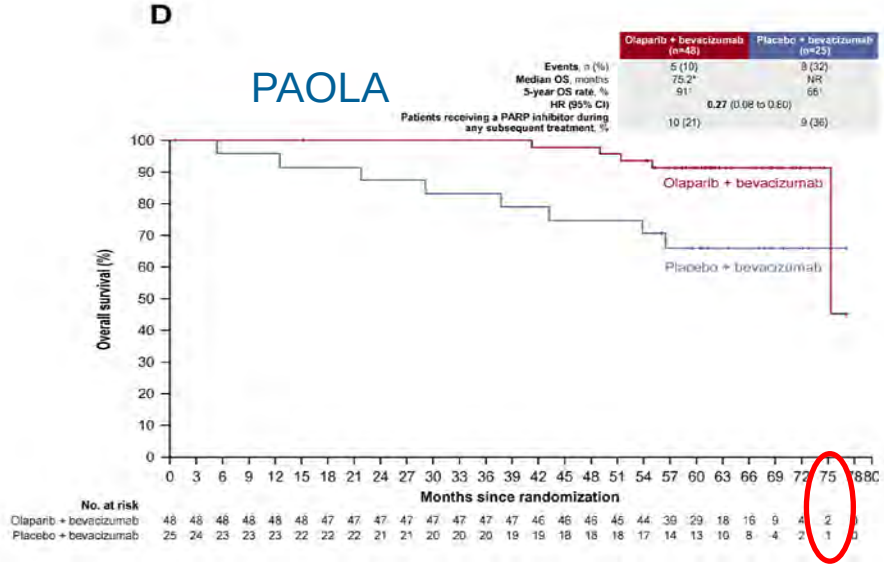
ATHENA COMBO



ROSELLA



PAOLA

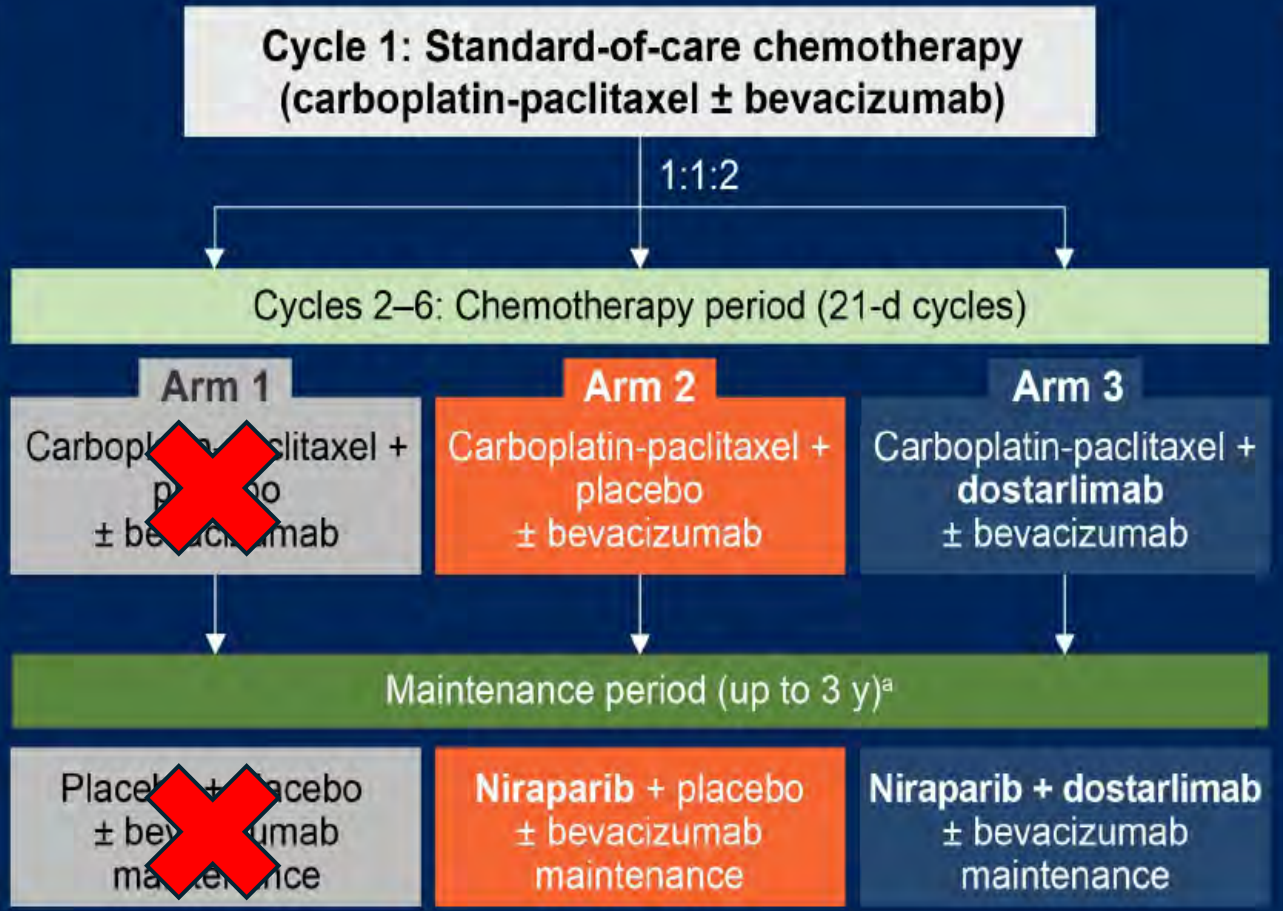


Averbuch Int J Rad Onc 2025, Monk ESMO 2024, Olawaiye ASCO 2025, Lorusso Int J Gynecol Cancer 2024

FIRST Trial Design

Key inclusion criteria

- Aged ≥18 y
  - High-grade nonmucinous epithelial OC
  - Stage IV disease
  - Stage III disease if
    - Stage IIIC with CC0 resection during PDS if aggregate ≥5-cm extrapelvic disease
    - Inoperable disease
    - Macroscopic residual tumor after PDS
    - Planned neoadjuvant chemotherapy
  - PDS, IDS, and inoperable were all included



Stratification factors

- Intended bevacizumab use
- HRR mutation status (*BRCA*m, *BRCA*wt/HRRpos, and *BRCA*wt/HRRneg/ not determined)
- Disease burden: Stage III with residual burden <1 cm (yes or no)

Hardy Bessard ASCO 2025

[a]May continue treatment beyond 3 years in consultation with the medical monitor. *BRCA*m, *BRCA*-mutated; *BRCA*wt, *BRCA* wild-type; CC0, complete resection; HRR, homologous recombination repair; IDS, interval debulking surgery; neg, negative; OC, ovarian cancer; PDS, primary debulking surgery; pos, positive.

	DUO-O	KEYLINK	ATHENA COMBO	FIRST
Control arm	Bevacizumab x 15 months	Placebo +/- bevacizumab x 15 mo	Rucaparib x 25 mo	Niraparib x 36 mo +/- bevacizumab x 15 mo
Experimental arm maintenance	Olaparib x 24 months Durvalumab x 24 months Bevacizumab x 15 months	Olaparib x 24 mo Pembrolizumab x 29 cycles (21 mo) +/- Bevacizumab x 15 mo	Rucaparib x 25 mo Nivolumab x 24 mo	Niraparib x 36 mo Dostarlimab x 36 mo +/- Bevacizumab x 15 mo
PDS vs IDS	60% vs 40%	63% vs 37%	49% vs 51%	35% vs 55%, 10% inoperable
BRCAm	Independent, single arm	Not eligible	21%	19%
Intended bev use	100%	45% vs 55%	None	52% v 48%
PD-L1 positive	TAP ≥ 5% 37%	CPS ≥10 50%	≥1% 46%	TAP ≥ 5% 28%
Primary outcome	PFS- investigator assessed, Arm 3 v Arm 1, both nontBRCAm HRD and ITT	PFS- investigator assessed, both ITT and CPS ≥ 10	PFS- investigator assessed	PFS- investigator assessed
Stage III vs IV	66% vs 34%	60% vs 40%	75% vs 25%	63% vs 37%
Median PFS (ITT)	25.1 vs 20.6 vs 19.3 mo, HR 0.61 (0.51-0.73)	22.2 vs 15.2 vs 14.6, HR 0.71 (0.61-0.84)	15 vs 20.2 mo, HR 1.29 (1.08-1.53)	20.6 vs 19.2 mo, HR 0.85 (0.73-0.99)
Median OS (ITT)	47.7 vs 47.1 mo, HR 1.04 (0.87-1.25)	48.5 vs NR vs 48 mo, HR 0.95 (0.76-1.2)	49.4 vs 58 mo, HR 1.13 (0.93-1.38)	44.4 vs 45.4 mo HR 1.01 (0.86-1.19)

Harter ASCO 2023, Powell SGO 2025, Monk ESMO 2024, Hardy-Bessard ASCO 2025, Richardson ASCO 2025

Endpoints and Statistical Testing Strategy

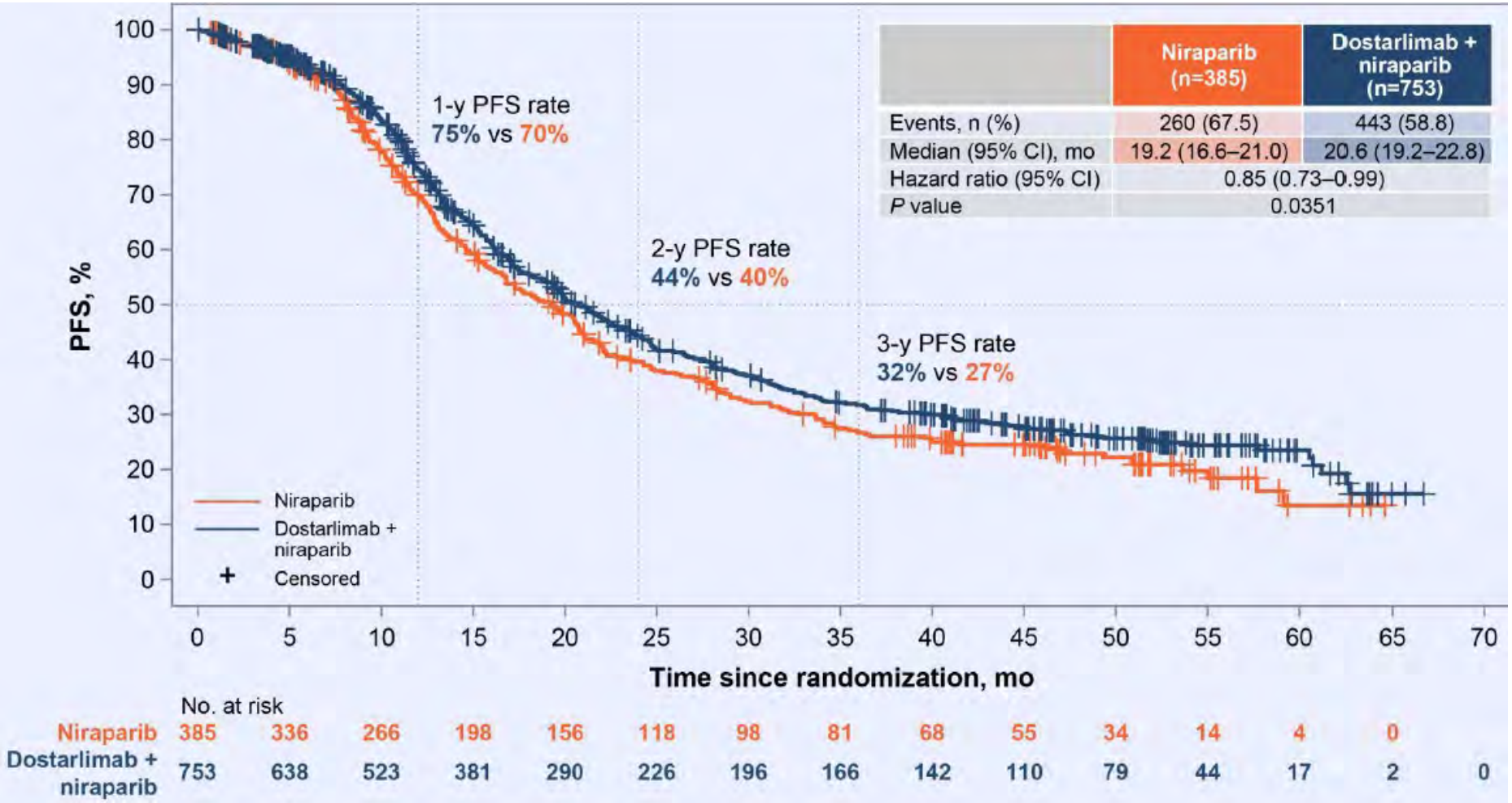
- The primary endpoint was PFS per RECIST v1.1 by investigator assessment in the ITT population (arms 2 and 3)
  - A hierarchical testing strategy was used to control the type I error at 2-sided 0.05 level
  - If PFS results were statistically significant, testing would continue to OS
- Patients with PD-L1–positive or HRd tumors and those with concurrent bevacizumab were specified *a priori* as clinically plausible groups to have differentiated results

Hardy-Bessard ASCO 2025

This slide presents the endpoints and statistical testing strategy for the final protocol. HRd, homologous recombination-deficient; ITT, intention-to-treat; OS, overall survival; PD-L1, programmed cell death-ligand 1; PFS, progression-free survival; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1.

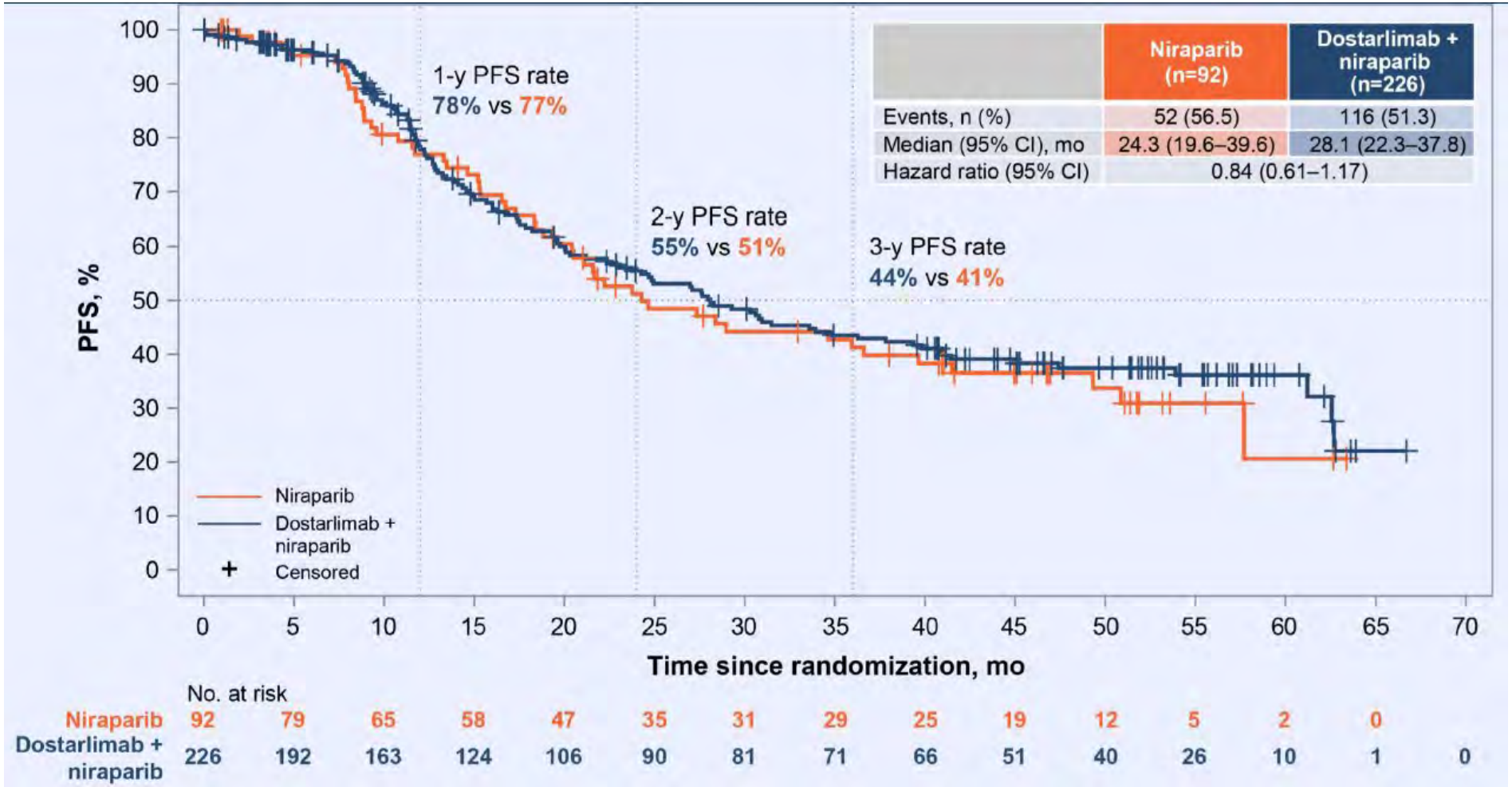
Statistically Significant ≠ Clinically Meaningful Primary Outcome FIRST Trial

Median Follow Up 53.1 Months



	Niraparib (n=385)	Dostarlimab + niraparib (n=753)
Events, n (%)	260 (67.5)	443 (58.8)
Median (95% CI), mo	19.2 (16.6–21.0)	20.6 (19.2–22.8)
Hazard ratio (95% CI)	0.85 (0.73–0.99)	
P value	0.0351	

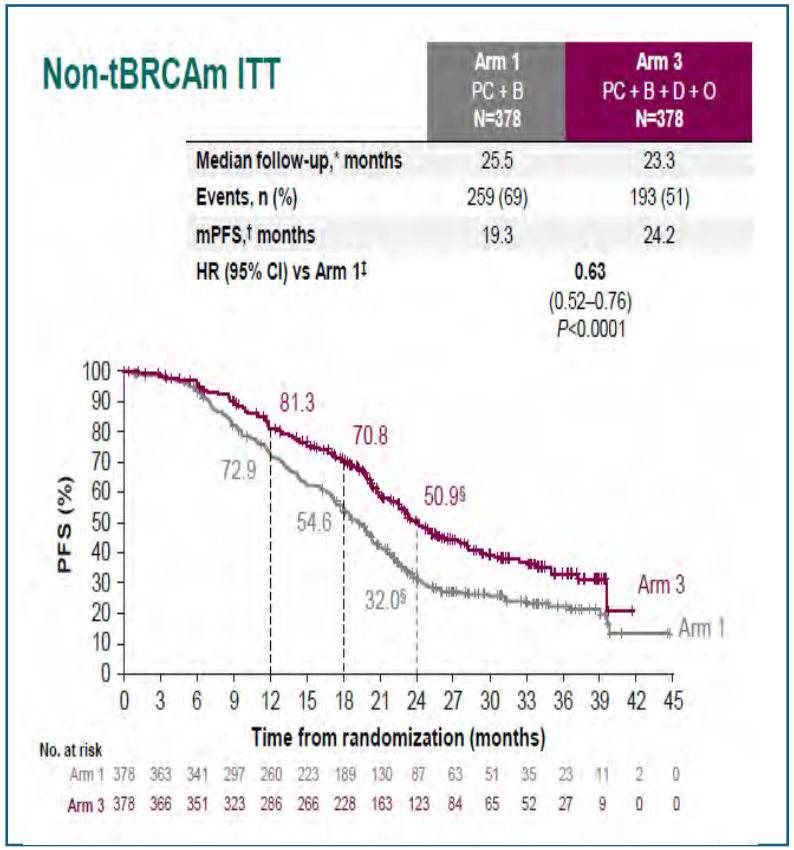
PFS in the PD-L1+ Population



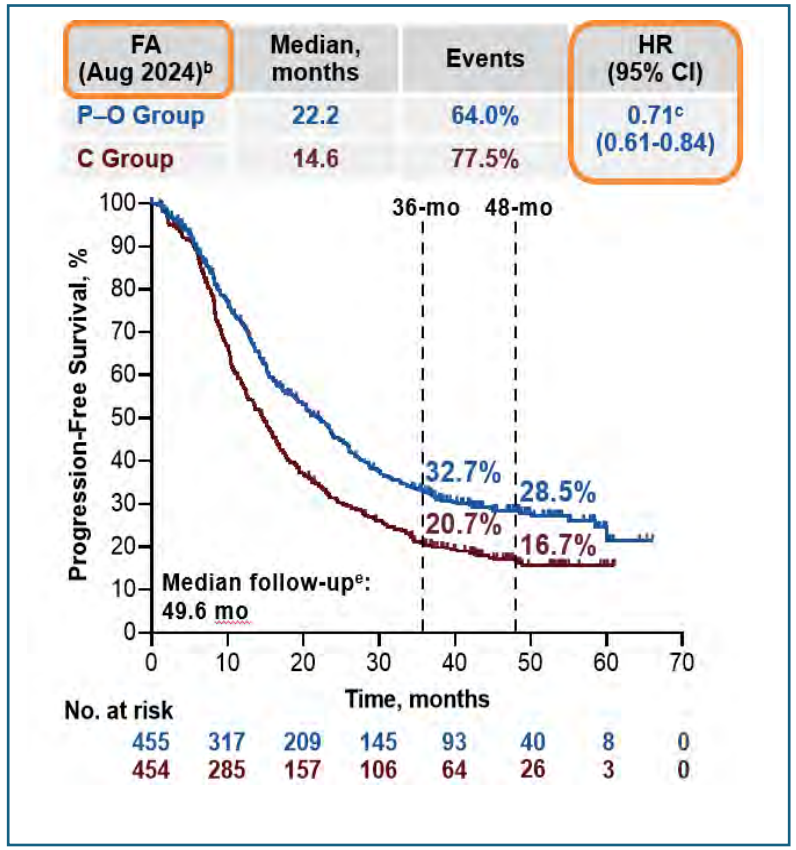
	Niraparib (n=92)	Dostarlimab + niraparib (n=226)
Events, n (%)	52 (56.5)	116 (51.3)
Median (95% CI), mo	24.3 (19.6–39.6)	28.1 (22.3–37.8)
Hazard ratio (95% CI)	0.84 (0.61–1.17)	

One of these trials is not like the others

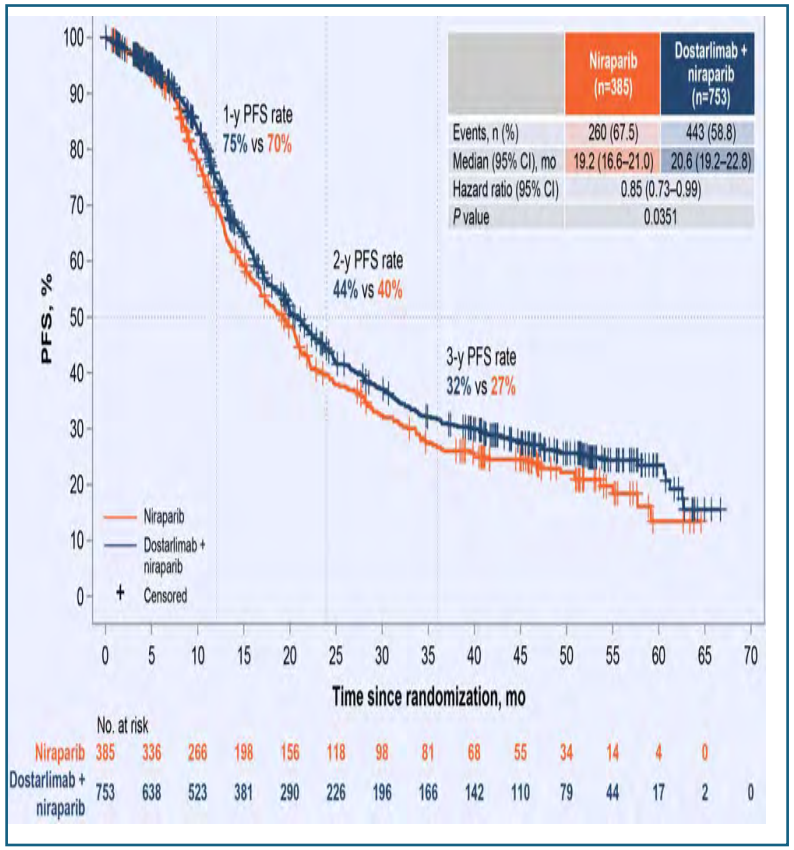
DUO-O: Control arm is bevacizumab maintenance



KEYLINK: Control is +/- bevacizumab maintenance



FIRST: Control is niraparib +/- bevacizumab maintenance



Harter SGO 2024, Powell SGO 2025, Hadry-Bessard ASCO 2025

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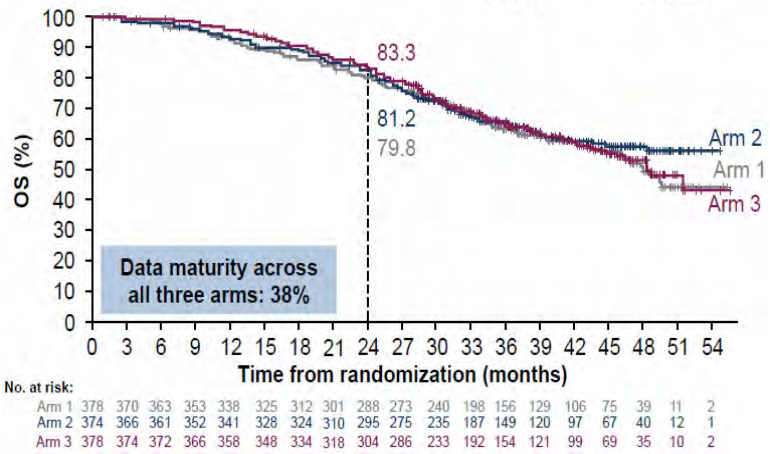
No Overall Survival Benefit from addition of IO to Standard Carboplatin + Paclitaxel +/- Bevacizumab +/- PARPi

DUO-O: Control arm is bevacizumab maintenance

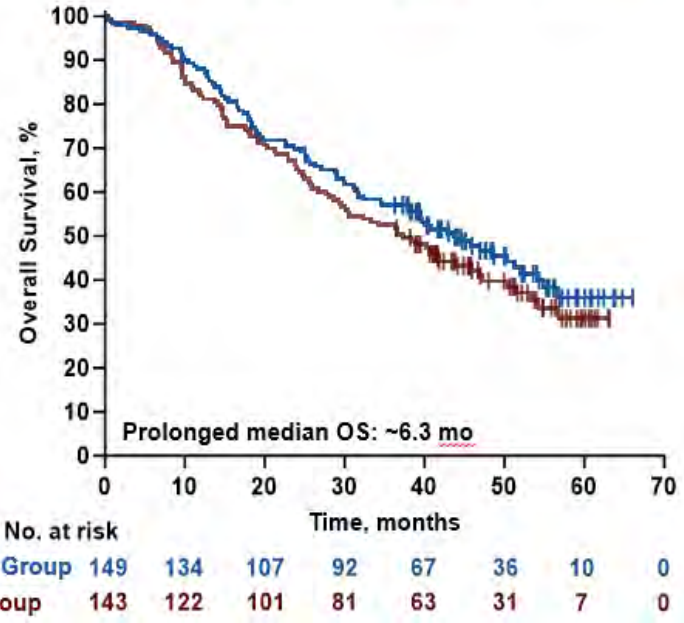
Non-tBRCAm ITT

	Arm 1 PC + B N=378	Arm 2 PC + B + D N=374	Arm 3 PC + B + D + O N=378
Median follow-up,* months	38.7	37.8	37.6
Events, n (%)	150 (40)	137 (37)	145 (38)
mOS,† months	48.0	NR	48.5
HR (95% CI) vs Arm 1‡		0.92 (0.73–1.16) *P*=0.48§	0.95 (0.76–1.20) *P*=0.68§

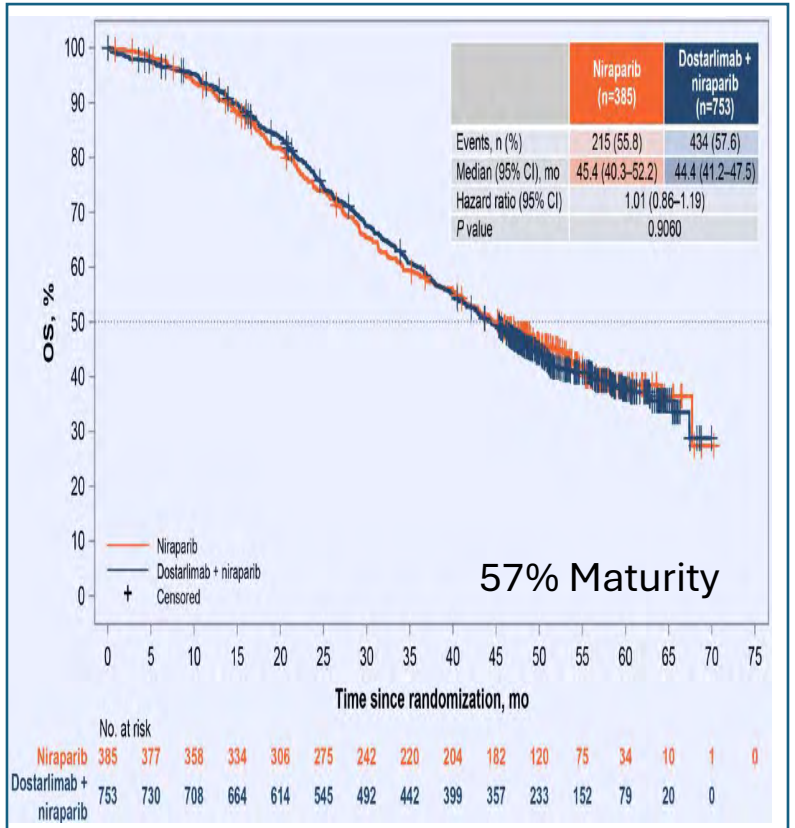


KEYLINK: Control is placebo. FMI LOH-Low, No Bev Subgroup

ITT Population	Median, months	Events	HR (95% CI)
P–O Group	43.6	56.4%	0.85 (0.63–1.15)
C Group	37.3	61.5%	



FIRST: Control is niraparib +/- bevacizumab maintenance



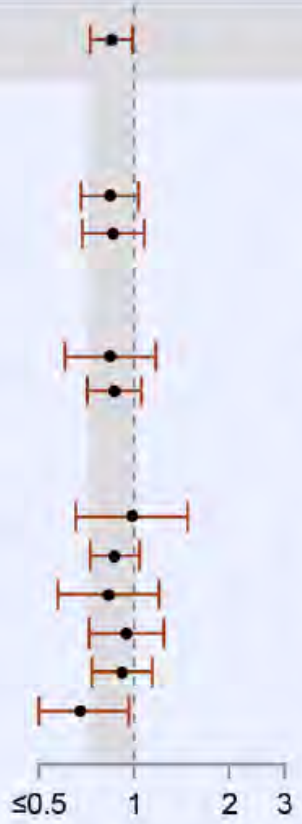
Harter SGO 2024, Powell SGO 2025, Hardy-Bessard ASCO 2025

PFS Subgroup Analyses: Clinical Characteristics

Subgroup	Niraparib *n* / *N* (%)	Dostarlimab + niraparib *n* / *N* (%)	Hazard ratio (95% CI)
All patients	260/385 (68)	443/753 (59)	0.85 (0.73–0.99)
Age categories			
<65 y	129/199 (65)	232/413 (56)	0.84 (0.68–1.05)
≥65 y	131/186 (70)	211/340 (62)	0.85 (0.69–1.06)
ECOG PS score at screening			
0	124/201 (62)	229/399 (57)	0.95 (0.76–1.18)
1	136/184 (74)	214/353 (61)	0.76 (0.61–0.94)
Primary tumor site[a]			
Ovarian	217/310 (70)	353/602 (59)	0.81 (0.69–0.96)
Primary peritoneal	23/34 (68)	52/79 (66)	1.02 (0.62–1.66)
Fallopian tube	20/40 (50)	38/72 (53)	1.17 (0.68–2.01)
Disease stage at initial diagnosis			
III	160/247 (65)	257/466 (55)	0.85 (0.70–1.04)
IV	100/138 (72)	186/287 (65)	0.80 (0.63–1.03)
Surgical status at screening[a]			
PDS	80/132 (61)	144/273 (53)	0.91 (0.69–1.19)
Planned IDS	153/217 (71)	240/404 (59)	0.80 (0.66–0.99)
Nonsurgical (inoperable)	27/36 (75)	59/76 (78)	1.17 (0.74–1.84)

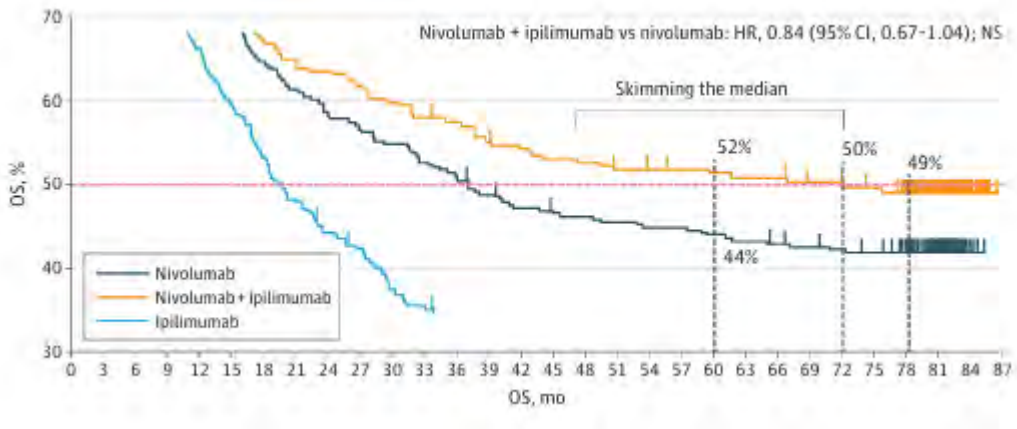
PFS Subgroup Analyses: Treatment and Biomarker Subgroups

Subgroup	Niraparib *n* / *N* (%)	Dostarlimab + niraparib *n* / *N* (%)	Hazard ratio (95% CI)
All patients	260/385 (68)	443/753 (59)	0.85 (0.73–0.99)
Concurrent bevacizumab use, as per exposure			
Yes	137/199 (69)	244/398 (61)	0.84 (0.68–1.03)
No	123/186 (66)	199/355 (56)	0.86 (0.69–1.08)
PD-L1 status			
TAP ≥5% (positive)	52/92 (57)	116/226 (51)	0.84 (0.61–1.17)
TAP <5% (negative)	166/230 (72)	248/403 (62)	0.87 (0.71–1.06)
Myriad MyChoice status			
*BRCA*m	37/81 (46)	63/151 (42)	0.98 (0.65–1.48)
*BRCA*wt	184/253 (73)	336/513 (65)	0.87 (0.73–1.04)
*BRCA*wt HRd	43/65 (66)	86/147 (59)	0.83 (0.58–1.20)
HRd	80/146 (55)	149/298 (50)	0.95 (0.72–1.24)
HRp	126/164 (77)	219/312 (70)	0.92 (0.74–1.14)
HRD unknown	54/75 (72)	75/143 (52)	0.68 (0.48–0.96)

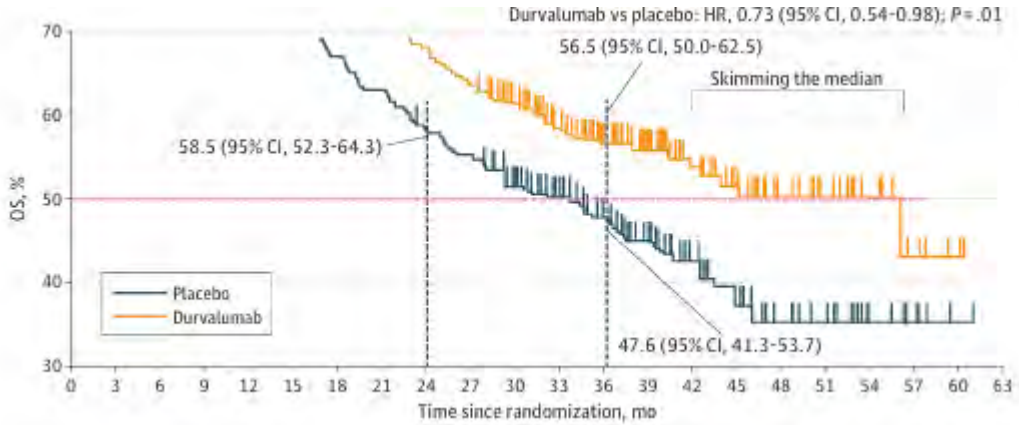


Skimming the Median

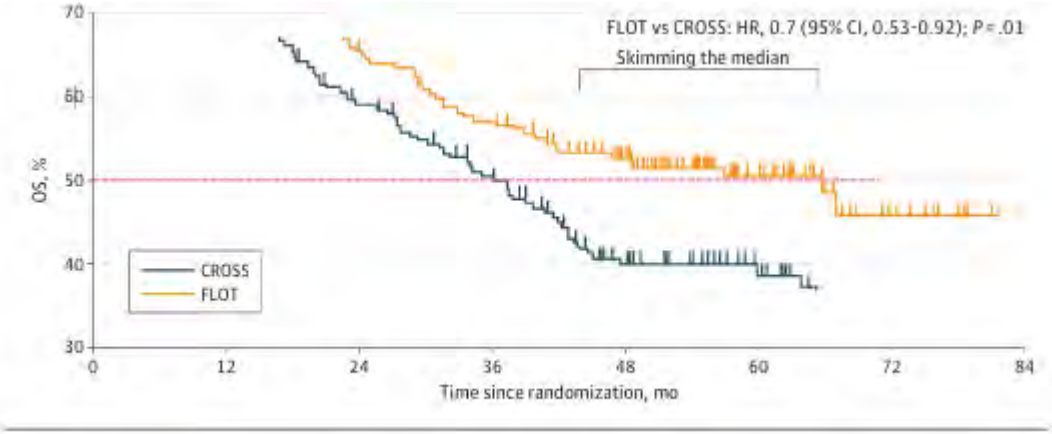
Example 1: CheckMate 067



Example 2: ADRIATIC



Example 3: ESO-PEC



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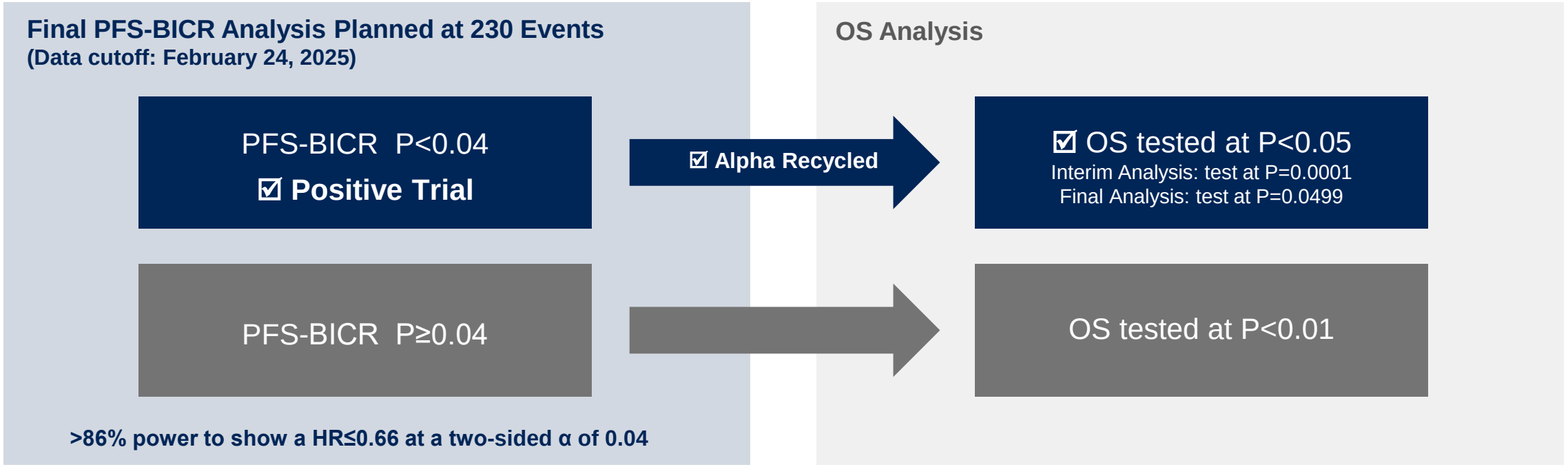
Fojo JAMA Oncol 2025

ROSELLA | Statistical Plan for Dual Primary Endpoints

If the P-value (stratified log-rank test) for either PFS-BICR (α=0.04) or OS (α=0.01) is less than the respective, pre-specified alpha boundary, the trial is positive.

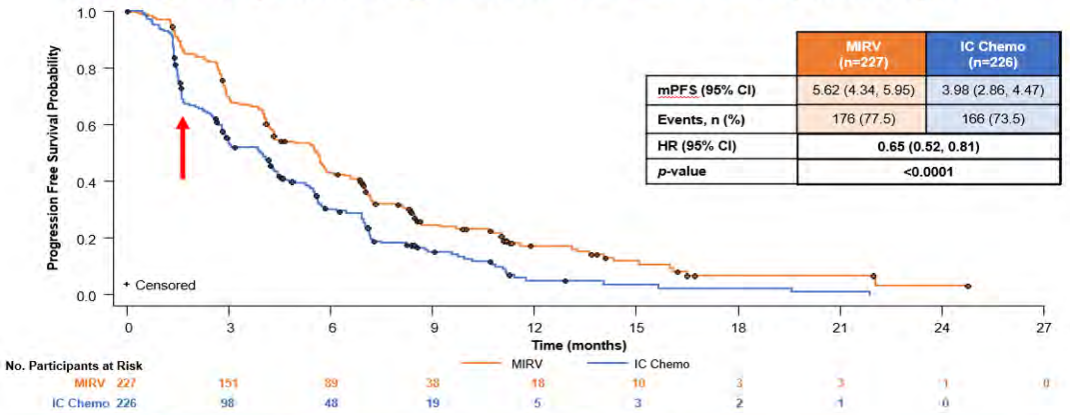


Efficacy endpoints were assessed in the intent-to-treat population (all randomized patients). A group-sequential weighted Holm procedure was used for the dual primary endpoints PFS and OS.
BICR, blinded independent central review; HR, hazard ratio; OS, overall survival; PFS, progression-free survival.

Biomarker versus no Biomarker: that is the question

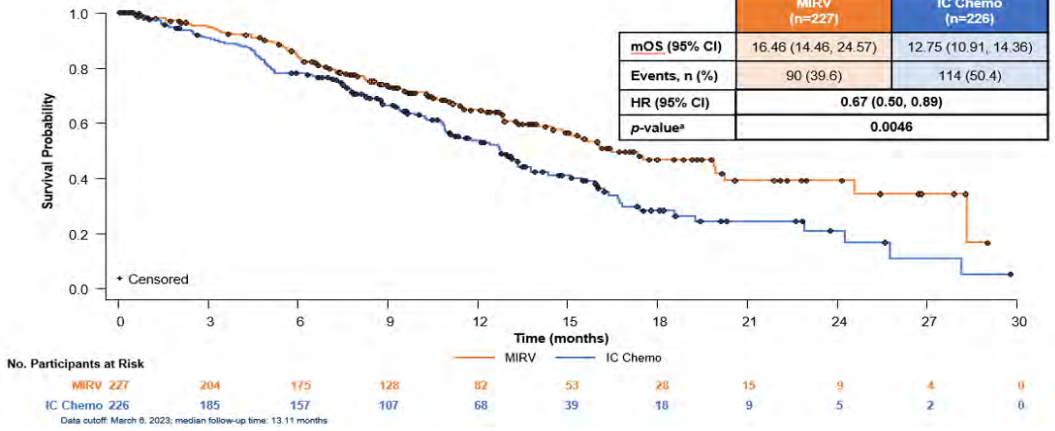
MIRASOL

Primary Endpoint: Progression-Free Survival by Investigator



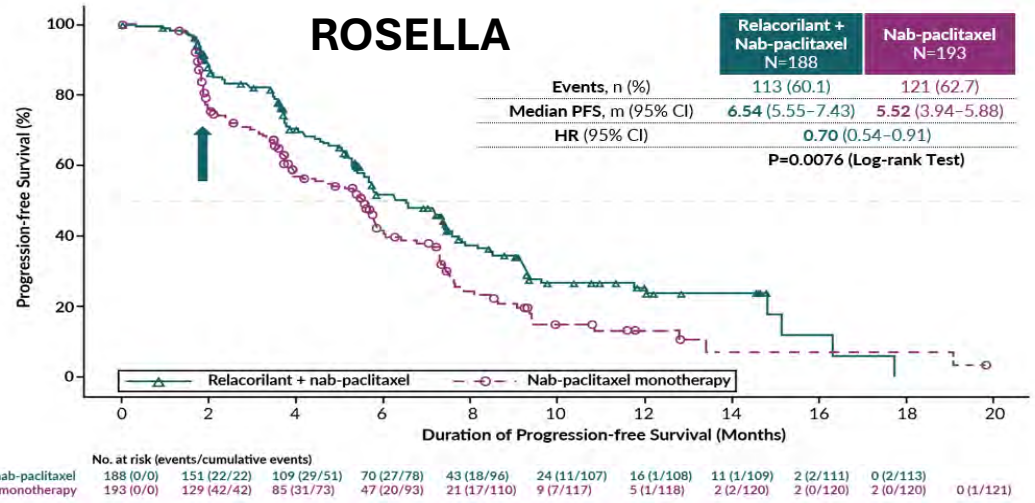
	MIRV (n=227)	IC Chemo (n=226)
mPFS (95% CI)	5.62 (4.34, 5.95)	3.98 (2.86, 4.47)
Events, n (%)	176 (77.5)	166 (73.5)
HR (95% CI)	0.65 (0.52, 0.81)	
p-value	<0.0001	

Overall Survival

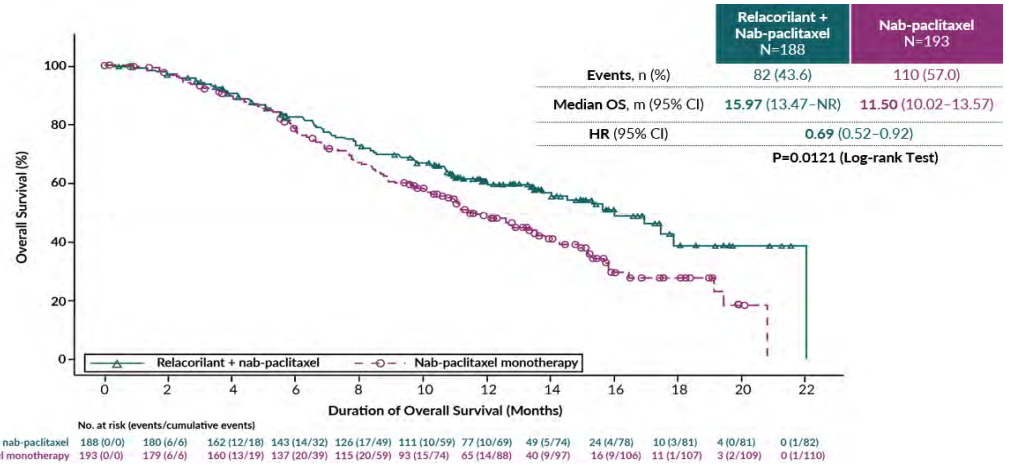


	MIRV (n=227)	IC Chemo (n=226)
mOS (95% CI)	16.46 (14.46, 24.57)	12.75 (10.91, 14.36)
Events, n (%)	90 (39.6)	114 (50.4)
HR (95% CI)	0.67 (0.50, 0.89)	
p-value[a]	0.0046	

ROSELLA



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	113 (60.1)	121 (62.7)
Median PFS, m (95% CI)	6.54 (5.55–7.43)	5.52 (3.94–5.88)
HR (95% CI)	0.70 (0.54–0.91)	
	P=0.0076 (Log-rank Test)	



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	82 (43.6)	110 (57.0)
Median OS, m (95% CI)	15.97 (13.47–NR)	11.50 (10.02–13.57)
HR (95% CI)	0.69 (0.52–0.92)	
	P=0.0121 (Log-rank Test)	

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Audience Q&A

All Faculty

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Panel Discussion: Real-World Implications and What's Next

All Faculty

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Closing Remarks

Katherine Fuh, MD, PhD

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Thank You

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