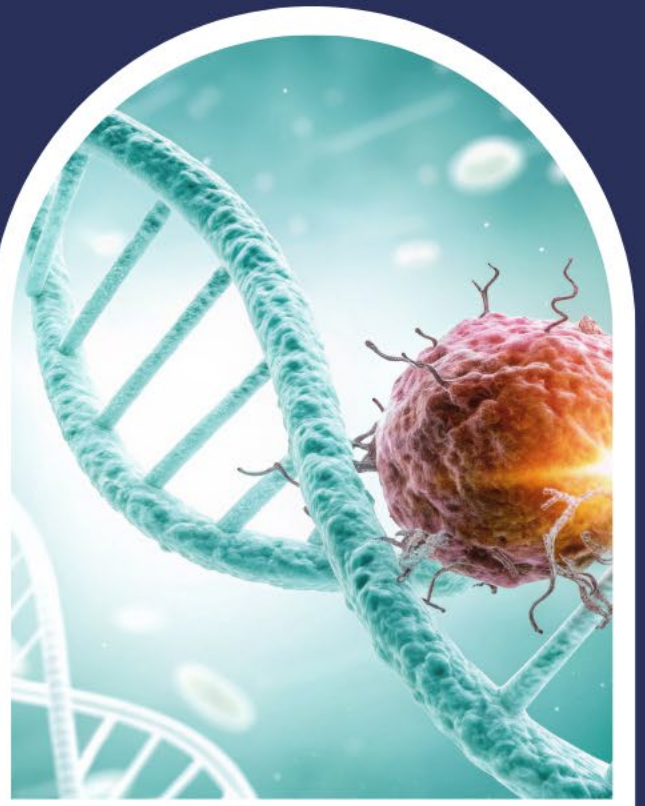
An Educational Symposium at the WAGO 2026 Annual Meeting

Evolving Evidence and Treatment Strategies in Platinum Resistant Ovarian Cancer: From Biology to Bedside



Thursday, June 18, 2026

12:15 pm – 1:45 pm

Meritage Resort Hotel, Napa Valley, CA

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

CME for this Educational Symposium is provided by The GOG Foundation, Inc. Credit is available only for live, in-person attendance and completion of the activity evaluation. CME credit will not be awarded for virtual attendance or viewing of recorded materials.

Moderator

Christine Walsh, MD, MS

UCSF Hellen Diller Family
Comprehensive Cancer Center

Faculty

Christine Walsh, MD, MS

University of Colorado
Anschutz Medical Campus

Shanon Westin, MD, MPH

MD Anderson Cancer Center

GOG Continuing Education

In support of improving patient care, this activity has been planned and implemented by The GOG Foundation, Inc. (GOG).

Accreditation Statement
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Participants who complete the educational activity, pre- and post-test, and evaluation will receive a certificate of credit.

Faculty Disclosure Information

Evolving Evidence and Treatment Strategies in Platinum Resistant Ovarian Cancer: From Biology to Bedside
Industry Supported Symposium
Thursday, June 18, 2026, Napa Valley, California

In accordance with the ACCME Accreditation Criteria, The GOG Foundation, Inc., as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any ineligible company *(formally known as commercial interests). All **Committee/Planning/Faculty members** were required to disclose all financial relationships and speakers were required to disclose any financial **relationship as it pertains to the content of the presentations.**

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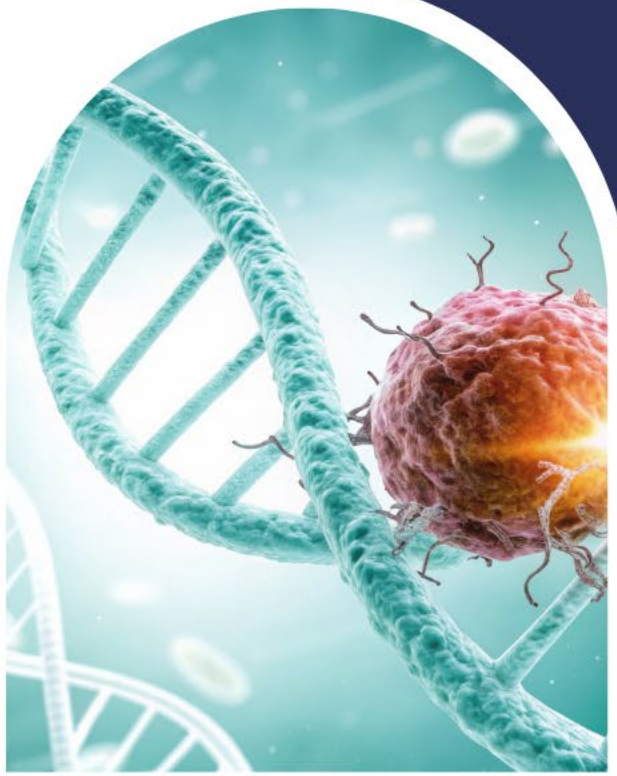
All of the relevant financial relationships listed for these individuals have been mitigated. However, if you perceive a bias during a session, please report the circumstances on the session evaluation form.

NEW TERM *An “**ineligible company**” is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.



Faculty Disclosure Information

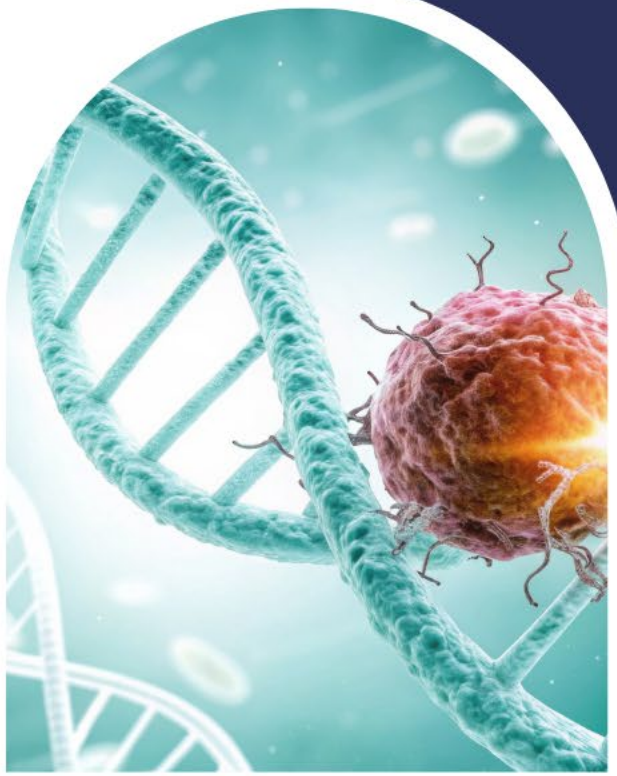
LAST NAME	FIRST NAME	Individual's Role(s) in Activity	Name of Ineligible Company(s)	Nature of Relevant Financial Relationship(s)
Planning Disclosures				
Fuh, MD	Katherine	Moderator	Corcept; Merck; Incyclix; AstraZeneca; GSK	Leadership and Advisory Roles
Speaker Disclosures				
Walsh, MD	Christine	Speaker	Nothing to Disclose	
Westin, MD	Shannon	Speaker	AstraZeneca; AvengeBio; Bayer; Bio-Path; Clovis Oncology; Daiichi Sankyo; GSK; Jazz Pharmaceuticals; Loxo; Mereo; Novartis; Nuvectis; Pfizer; Roche/Genentech; Verastem; Zentails; AbbVie; Caris; Corcept; Eisai; GenMab; Gilead; Immunocore; Immunogen; Incyte; Lilly; Merck; NGM Bio; Nuvectis; Pfizer; SeaGen; ZielBio	Research (AstraZeneca; AvengeBio; Bayer; Bio-Path; Clovis Oncology; Daiichi Sankyo; GSK; Jazz Pharmaceuticals; Loxo; Mereo; Novartis; Nuvectis; Pfizer; Roche/Genentech; Verastem; Zentails) Consulting (AbbVie; AstraZeneca; Bayer; Caris; Clovis Oncology; Corcept; Daiichi Sankyo; Eisai; GenMab; Gilead; GSK; Immunocore; Immunogen; Incyte; Lilly; Loxo; Marck; Mereo; NGM Bio; Nuvectis; Pfizer; Roche/Genentech; Seagen; Verastem; Zentalls; ZielBio)
Engbert	Holley	Staff	Nothing to disclose	
Rush	Heather	Staff	Nothing to disclose	
Shumaker	Kara	Reviewer/Staff	Nothing to disclose	
Small, MPH	Michelle N	Reviewer/Staff	Nothing to disclose	
Alvarez Secord, MD	Angeles	Reviewer/Edu-Chair	AbbVie; Aravive; AstraZeneca; Daiichi Sankyo; Ellipses Pharma; Genmab; GSK; Immunogen; Karyopharm; Merck; Mersana; Myriad; Oncoquest/Canaria Bio; Oncoquest; Roche/Genentech; TORL Biotherapeutics; Zentalis; Foundation Medicine; Gilead; Histosonics; Medtronic; Porject Nana; Up to Date; SGO; FWC; GOG Foundation; Amgen; Johnson & Johnson	Research funds to Institution (AbbVie; Aravive; AstraZeneca; Daiichi Sankyo; Ellipses Pharma; Genmab; GSK; Immunogen; Karyopharm; Merck; Mersana; Myriad; Oncoquest/Canaria Bio; Oncoquest; Roche/Genentech; TORL Biotherapeutics; Zentalis) Honorarium (Merck; GSK) Advisory Board with Honoraria (AbbVie; AstraZeneca; Daiichi Sankyo; Foundation Medicine; GSK; Genmab; Gilead; Histosonics; Medtronic; Merck) Medical Advisory Board (Porject Nana) Steering Committee Uncomp. (Oncoquest; Genmab) Royalties (Up to Date) Board of Directors (SGO; FWC; GOG Foundation) Stock-Divested in June 2024 (Amgen; Johnson & Johnson)
Duska, MD	Linda	Edu-Co-Chair/ Reviewer	Merck; Corcept	Honoraria (Merck) Speakers Bureau (Corcept) Research Funding (Merck)
Blank, MD	Stephanie	Reviewer	American Board of Obstetrics and Gynecology; Merck; AstraZeneca; GlaxoSmithKline; Pfizer; Seattle Genetics/Astellas; Acrivon; Zentalis; NX Development Corp.	Leadership (American Board of Obstetrics and Gynecology) Research Funding (Merck; AstraZeneca; GlaxoSmithKline; Pfizer; Seattle Genetics/Astellas; Acrivon; Zentalis; NX Development Corp.)
Gien, MD	Lilian	Reviewer	Glaxo Smith Kline; Merck; Abbvie; AstraZeneca	Speaker Honoraria (Glaxo Smith Kline; Merck) Advisory Board (Abbvie; AstraZeneca)
Mutch, MD	David	Reviewer	Nothing to disclose	
Zweizig, MD	Susan	Reviewer	Nothing to disclose	

This presentation includes discussion of off-label uses or investigational agents not approved by the FDA for the indications discussed. The opinions expressed are those of the presenters and are not necessarily those of the GOG Foundation, Inc. Please refer to the official prescribing information for each product for approved indications, contraindications, and warnings.

THANK YOU

Corcept Therapeutics

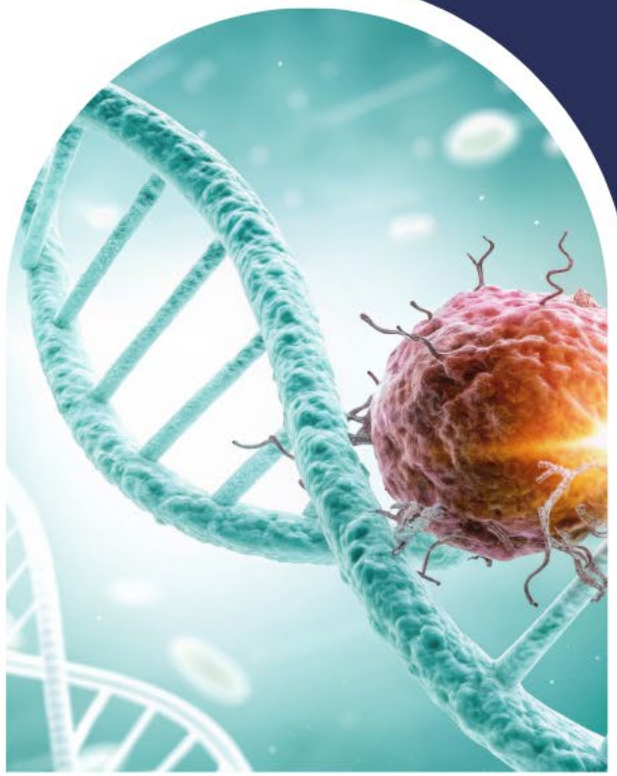
For Supporting This Activity With
An Independent Medical Education Grant



Learning Objectives

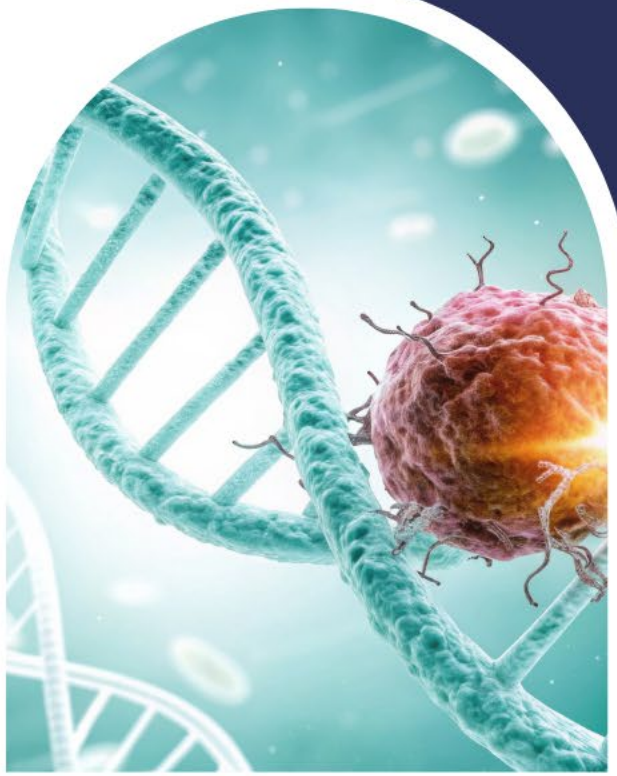
After participating in this activity, learners will be able to:

1. Summarize the current U.S. treatment landscape and unmet needs in platinum resistant ovarian cancer, including survival benchmarks and patterns of progression.
2. Explain key biological drivers of resistance (e.g., DNA damage repair, replication stress, microenvironmental/immune factors) and how they inform therapeutic rationale and trial design.
3. Critically interpret Phase 3 evidence (HRs, PFS/OS hierarchy, censoring, subgroup analyses, external validity) to guide evidence based practice.
4. Apply biomarker information (e.g., FRα, BRCA, HRD) pragmatically—recognizing testing access, turnaround, and interpretation challenges—without referencing specific products.
5. Engage in case based decision making and articulate how pending FDA decisions and guideline updates may shape future patient selection and sequencing.



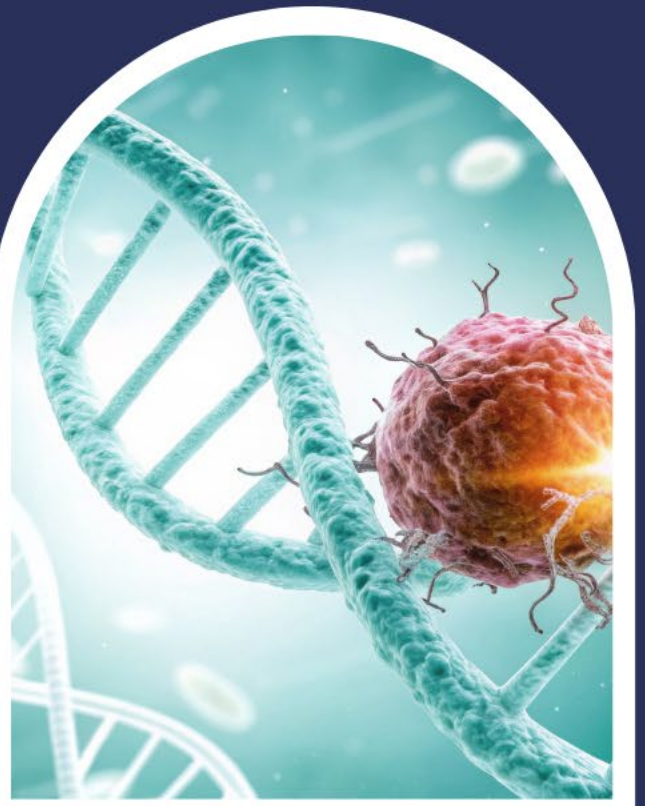
Agenda

10 minutes	**Welcome, Needs, and Pre-Assessment** Katherine Fuh, MD, PhD
20 minutes	**Current U.S. Management & Unmet Needs in PROC** Christine Walsh, MD, MS
20 minutes	**Why Resistance Happens: Clinical Implications of Tumor Biology** Shanon Westin, MD, MPH
20 minutes	**Interpreting New Phase 3 Evidence: A Methodology Masterclass** All Faculty
15 minutes	**Case Based Application** All Faculty
5 minutes	**Panel Q&A, Post Assessment** Katherine Fuh, MD, MPH



Current U.S. Management & Unmet Needs in PROC

Christine Walsh, MD, MS, University of Colorado Hospital, Anschutz Cancer Pavilion

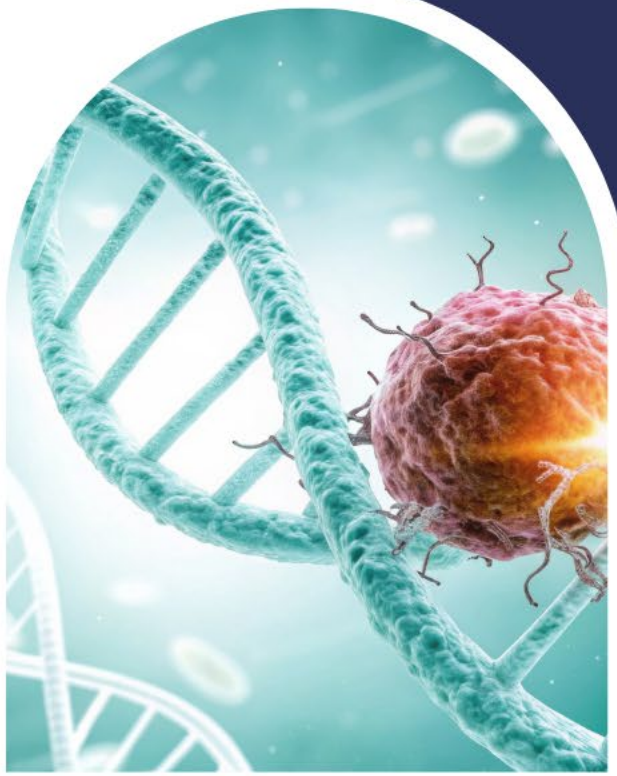


FDA Approved Drugs for Ovarian Cancer - Timeline

1978

- 1978 Cisplatin
- 1990 Altretamine
- 1991 Carboplatin
- 1992 Paclitaxel
- 1996 Topotecan
- 1999 Liposomal Doxorubicin (Accelerated)
- 2005 Liposomal Doxorubicin (Full)
- 2006 Gemcitabine
- 2014 Olaparib (BRCA mutation carriers)
- 2014 Bevacizumab

2015



Source: U.S. FDA Oncology Drug Approvals Database; NCCN Guidelines.

Clinical Trials – Ovarian Cancer Experience

GOG 22

- 3 arm trial
- N=233
- 1° Stage III/IV or recurrent disease
- Working towards the modern backbone

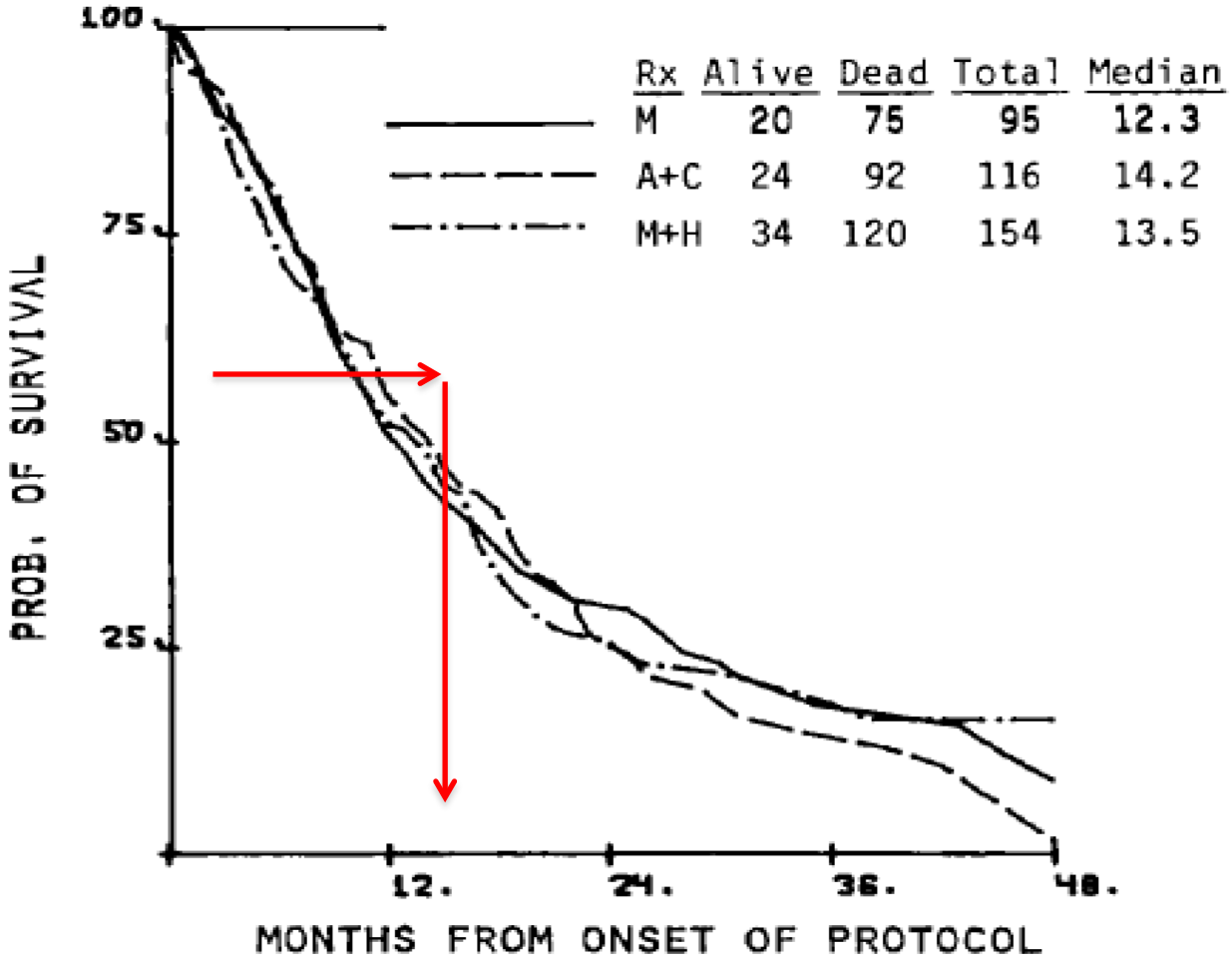


FIG. 3. Survival probability (by Rx).

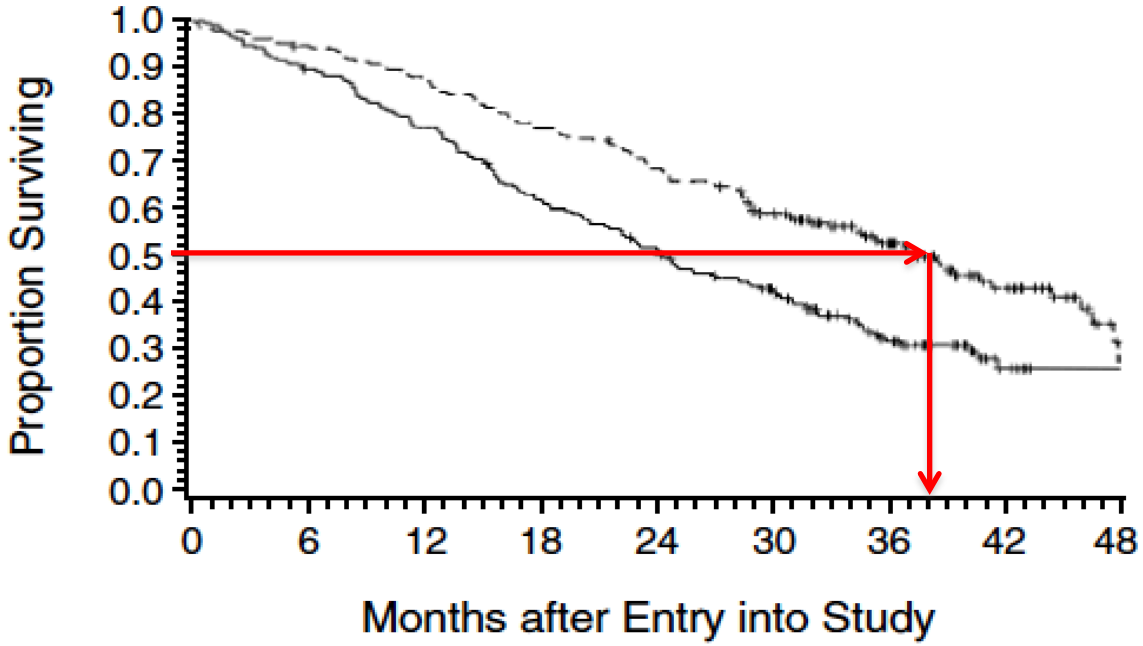
Abbreviations: GOG, Gynecologic Oncology Group; N, number of patients; Rx, treatment; A+C, doxorubicin plus cyclophosphamide; M+H, melphalan plus hexamethylmelamine.

Omura GA, et al. Cancer. 1983;51(5):783-789; Adapted from: Omura G et al. Cancer 1983

Clinical Trials – Ovarian Cancer Experience

GOG 111

- 2 arm trial
- N=410
- 1° Stage III/IV
- Addition of “wonder drug” paclitaxel



Treatment	No. Alive	No. Dead	Total	Median Survival (mo)
—— Cisplatin + cyclophosphamide	65	137	202	24
- - - - Cisplatin + paclitaxel	86	98	184	38

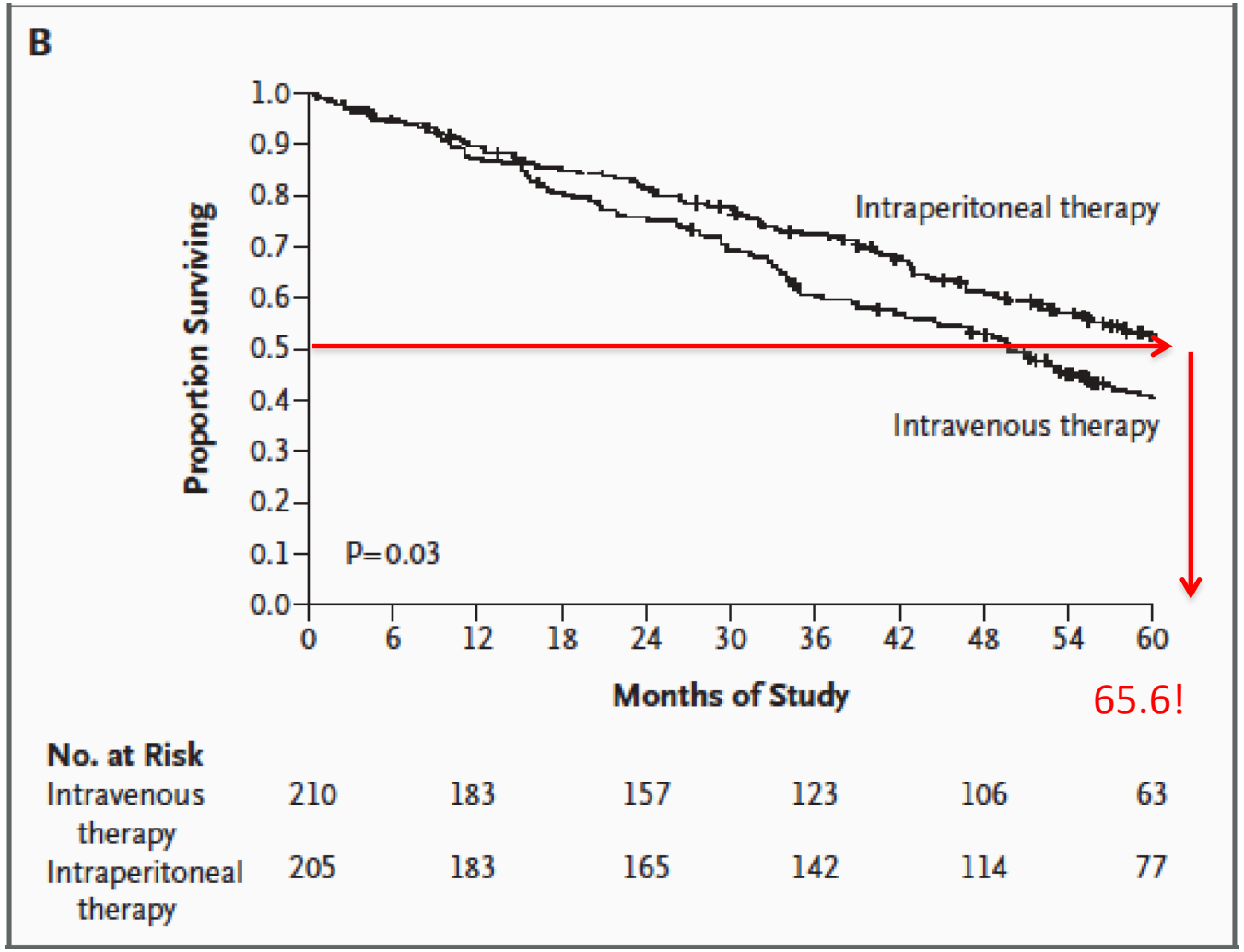
Figure 2. Survival According to Treatment Group.

Adapted from: McGuire WP, et al. N Engl J Med. 1996;334:1-6.

Clinical Trials – Ovarian Cancer Experience

GOG 172

- 2 arm trial
- N=415
- Optimal 1° Stage III
- Different route



Armstrong DK, et al. N Engl J Med. 2006;354:34-43.

Treatment

Stage I/II

- Hysterectomy, BSO, Staging Procedures
- Post-operative chemotherapy for most

Stage III/IV

- Triage to PDS vs. NACT+IDS / Role of HIPEC?
- “Cytoreductive” or “debulking” surgery
- All require post-operative chemotherapy
- Determine maintenance approach

Abbreviations: *BSO, bilateral salpingo-oophorectomy; HIPEC, hyperthermic intraperitoneal chemotherapy; IDS, interval debulking surgery; NACT, neoadjuvant chemotherapy; PDS, primary debulking surgery.*

Armstrong DK et al. J Natl Compr Canc Netw 2025.

Treatment – Maintenance

Regimen	Setting	Dose/Administration	Duration
Olaparib + bevacizumab[1]	Maintenance post primary chemotherapy + bevacizumab	• Olaparib 300 mg PO twice daily • Bevacizumab 15 mg/kg IV every 21 days	• Olaparib: Until disease progression or unacceptable toxicity or up to 2 years • Bevacizumab: Until disease progression or unacceptable toxicity or up to 15 months
Niraparib + bevacizumab[2]	Maintenance post primary chemotherapy + bevacizumab	• Niraparib: 300 mg PO once daily (or 200 mg once daily for patients with a baseline body weight of <77 kg, and/or a platelet count of <150,000/mm^3) • Bevacizumab: 15 mg/kg IV every 21 days	• Niraparib: Until disease progression or unacceptable toxicity or up to 3 years • Bevacizumab: Until disease progression or unacceptable toxicity or up to 15 months
Niraparib monotherapy[3,4]	Maintenance post primary chemotherapy	300 mg PO once daily (or 200 mg once daily for patients with a baseline body weight of <77 kg, and/or a platelet count of <150,000/mm^3)	Until disease progression or unacceptable toxicity or up to 36 months
	Maintenance post recurrence chemotherapy	300 mg PO once daily (or an initial dose of 200 mg once daily for patients with a baseline body weight of <77 kg, and/or a platelet count of <150,000/mm^3; after 2 to 3 months, in the absence of hematologic toxicity, may consider escalation to 300 mg once daily)	Until disease progression or unacceptable toxicity
Olaparib monotherapy[5-7]	Maintenance post primary chemotherapy	300 mg PO twice daily[b]	Until disease progression or CR (no evidence of disease) at 2 years[b] or unacceptable toxicity
	Maintenance post recurrence chemotherapy	300 mg PO twice daily[b]	Until disease progression or unacceptable toxicity
Rucaparib monotherapy[8,9]	Maintenance post primary chemotherapy	600 mg PO twice daily	Until disease progression or unacceptable toxicity or up to 24 months
	Maintenance post recurrence chemotherapy	600 mg PO twice daily	Until disease progression or unacceptable toxicity

Armstrong DK et al. J Natl Compr Canc Netw 2025.

Primary Systemic Therapy

Primary Systemic Therapy Recommended Dosing

Paclitaxel/carboplatin every 3 weeks[g,l]
- Paclitaxel 175 mg/m^2 IV followed by carboplatin[m] AUC 5–6 IV Day 1
- Repeat every 21 days x 3–6 cycles[l]

Paclitaxel/cisplatin every 3 weeks[10,11]
- Paclitaxel 175 mg/m^2 IV followed by cisplatin 75 mg/m^2 IV
- Repeat every 21 days x 3–9 cycles

IV/IP Paclitaxel/cisplatin
- Paclitaxel 135 mg/m^2 IV continuous infusion[n] Day 1; cisplatin 75–100 mg/m^2 IP Day 2 after IV paclitaxel; paclitaxel 60 mg/m^2 IP Day 8
- Repeat every 21 days x 6 cycles

IV/IP Paclitaxel/carboplatin[12]
- Paclitaxel 80 mg/m^2 IV on days 1, 8, and 15; carboplatin AUC 6 IP Day 1 after IV paclitaxel
- Repeat every 21 days x 6–8 cycles

Paclitaxel weekly/carboplatin every 3 weeks[g]
- Dose-dense paclitaxel 80 mg/m^2 IV Days 1, 8, and 15 followed by carboplatin[n] AUC 5–6 IV Day 1
- Repeat every 21 days x 6 cycles

Paclitaxel weekly/carboplatin weekly[g]
- Paclitaxel 60 mg/m^2 IV followed by carboplatin AUC 2 IV
- Days 1, 8, and 15; repeat every 21 days x 6 cycles (18 weeks)[k]

Docetaxel/oxaliplatin/bevacizumab + maintenance bevacizumab
- Docetaxel 75 mg/m^2 IV followed by oxaliplatin 85 mg/m^2 IV, and bevacizumab 15 mg/kg IV
- Repeat every 21 days x 6 cycles
- Continue bevacizumab 15 mg/kg IV every 21 days to complete 1 year of therapy

Individuals >70 Years and/or Those with Comorbidities

Paclitaxel 135/carboplatin[g,13]
- Paclitaxel 135 mg/m^2 IV + carboplatin AUC 5 IV given every 21 days x 3–6 cycles[l]

Paclitaxel weekly/carboplatin weekly[g]
- Paclitaxel 60 mg/m^2 IV over 1 hour followed by carboplatin AUC 2 IV over 30 minutes
- Days 1, 8, and 15; repeat every 21 days x 6 cycles (18 weeks)

Docetaxel/carboplatin[l]
- Docetaxel 60–75 mg/m^2 IV followed by carboplatin[m] AUC 5–6 IV Day 1
- Repeat every 21 days x 3–6 cycles[k]

Carboplatin/liposomal doxorubicin[l]
- Carboplatin AUC 5 IV + pegylated liposomal doxorubicin 30 mg/m^2 IV
- Repeat every 28 days for 3–6 cycles[k]

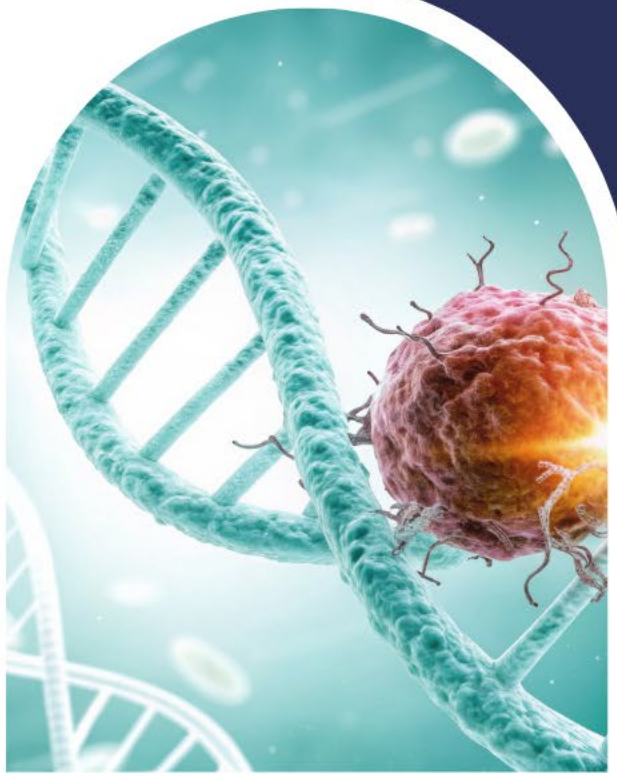
Paclitaxel/carboplatin/bevacizumab + maintenance bevacizumab[g] (ICON-7)
- Paclitaxel 175 mg/m^2 IV followed by carboplatin[m] AUC 5–6 IV, and bevacizumab 7.5 mg/kg IV Day 1
- Repeat every 21 days x 5–6 cycles
- Continue bevacizumab for up to 12 additional cycles

Paclitaxel/carboplatin/bevacizumab + maintenance bevacizumab[g] (GOG-218)
- Paclitaxel 175 mg/m^2 IV followed by carboplatin[m] AUC 6 IV Day 1. Repeat every 21 days x 6 cycles
- Starting Day 1 of cycle 2, give bevacizumab 15 mg/kg IV every 21 days for up to 22 cycles

Docetaxel/carboplatin/bevacizumab + maintenance bevacizumab (GOG-218)
- Docetaxel 75 mg/m^2 IV followed by carboplatin[m] AUC 6 IV Day 1. Repeat every 21 days x 6 cycles
- Starting Day 1 of cycle 2, give bevacizumab 15 mg/kg IV every 21 days for up to 22 cycles

Armstrong DK et al. J Natl Compr Canc Netw 2025.

PROC Management



PROC Treatment Options

- EOC/FTCA/PPC that has progressed/recurred within 6 months of the last line of platinum-based therapy
  - Primary platinum refractory excluded from most clinical trials
- Median PFS 2-6 months most therapies
- Median OS 12-18 months
- Traditionally non-platinum cytotoxic chemotherapies
- Should we use platinum eligible or ineligible instead?
- How do we fully integrate biomarkers?

Abbreviations: EOC, epithelial ovarian cancer; FTCA, fallopian tube cancer; OS, overall survival; PFS, progression-free survival; PPC, primary peritoneal cancer; PROC, platinum-resistant ovarian cancer.
St. Laurent et al. JCO, 2023, 42(2):127-133; *Armstrong DK et al. J Natl Compr Canc Netw 2025; Martorana F, et al.* Int J Gynecol Cancer. 2025 Jan;35(1):100009.

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer

Principles of Systemic Therapy:

Acceptable Recurrence Therapies for Epithelial Ovarian (including LCOC)/Fallopian Tube/Peritoneal Cancer

Recurrence Therapy for Platinum-Resistant Disease (alphabetical order)

Preferred

Cytotoxic Therapy
- Albumin-bound Paclitaxel/Relacorilant
- Docetaxel
- Gemcitabine
- Liposomal Doxorubicin
- Liposomal Doxorubicin + Bevacizumab
- Paclitaxel (Weekly)
- Paclitaxel (Weekly) + Bevacizumab
- Oral Cyclophosphamide + Bevacizumab
- Topotecan
- Topotecan + Bevacizumab

Targeted Therapy (single agents)
- Mirvetuximab soravtansine-gynx (for FRα- expressing tumors [≥75% positive tumor cells]) (category 1)

Other Recommended

Cytotoxic Therapy
- Albumin-bound Paclitaxel
- Capecitabine
- Carboplatin
- Carboplatin/Docetaxel
- Carboplatin/Paclitaxel (Weekly)
- Carboplatin/Gemcitabine ± Bevacizumab
- Carboplatin/Liposomal Doxorubicin ± Bevacizumab
- Carboplatin/Paclitaxel ± Bevacizumab
- Cisplatin/Gemcitabine
- Cyclophosphamide
- Doxorubicin
- Gemcitabine ± Bevacizumab
- Ifosfamide/Mesna
- Irinotecan
- Ixabepilone ± Bevacizumab (category 2B)
- Oral Cyclophosphamide + Pembrolizumab + Bevacizumab
- Oral Etoposide
- Oxaliplatin
- Paclitaxel
- Pemetrexed
- Sorafenib/Topotecan
- Vinorelbine

Targeted Therapy (single agents)
- Bevacizumab
- Pazopanib (category 2B)

Hormone Therapy
- Aromatase inhibitors (Anastrozole, Exemestane, Letrozole)
- Goserelin acetate
- Leuprolide acetate
- Megestrol acetate
- Tamoxifen

Useful in Certain Circumstances

- Albumin-bound Paclitaxel/Carboplatin (for confirmed taxane hypersensitivity)
- Carboplatin/Paclitaxel (for age >70)

Immunotherapy
- Dostarlimab-gxly (for dMMR/MSI-H recurrent or advanced tumors)
- Paclitaxel + Pembrolizumab ± Bevacizumab (for PD-L1- positive tumors [CPS≥1])
- Pembrolizumab (for patients with MSI-H or dMMR solid tumors, or TMB-H tumors ≥10 mutations/megabase)
- For clear cell carcinoma:
  - Ipilimumab + Nivolumab

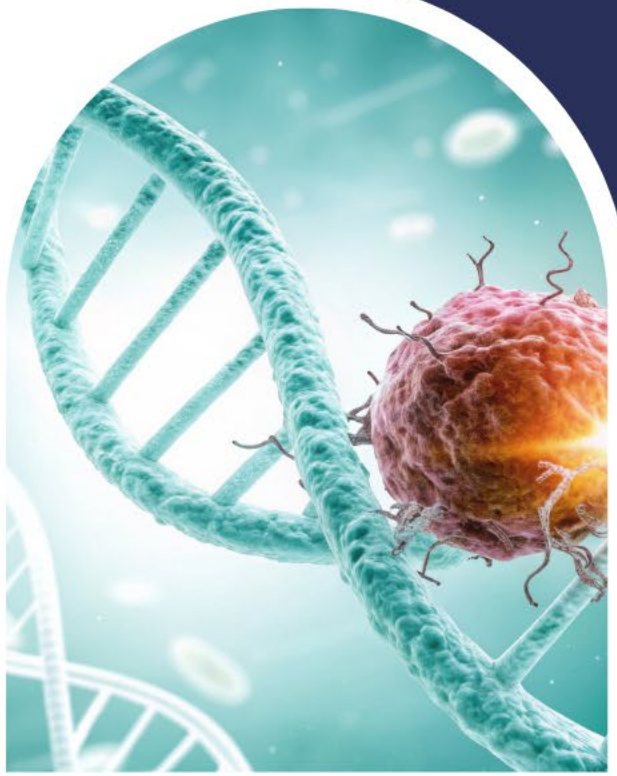
Hormone Therapy
- Fulvestrant (for low-grade serous carcinoma)

Targeted Therapy
- Dabrafenib/Trametinib (for BRAF V600E positive tumors)
- Entrectinib or Larotrectinib or Repotrectinib (for *NTRK1/2/3* gene fusion-positive tumors)
- Fam-trastuzumab deruxtecan-nxki (for HER2-positive tumors [IHC 3+ or 2+])
- Mirvetuximab soravtansine-gynx + Bevacizumab (for FRα- expressing tumors [≥25% positive tumor cells])
- Selpercatinib (for RET gene fusion-positive tumors)
- For low-grade serous carcinoma:
  - Avutometinib/Defactinib (for KRAS-mutated tumors)
  - Trametinib
  - Binimetinib (category 2B)
- For mucinous carcinoma:
  - FOLFIRI ± Bevacizumab (category 2B)

Note: All recommendations are NCCN Category 2A unless otherwise indicated.

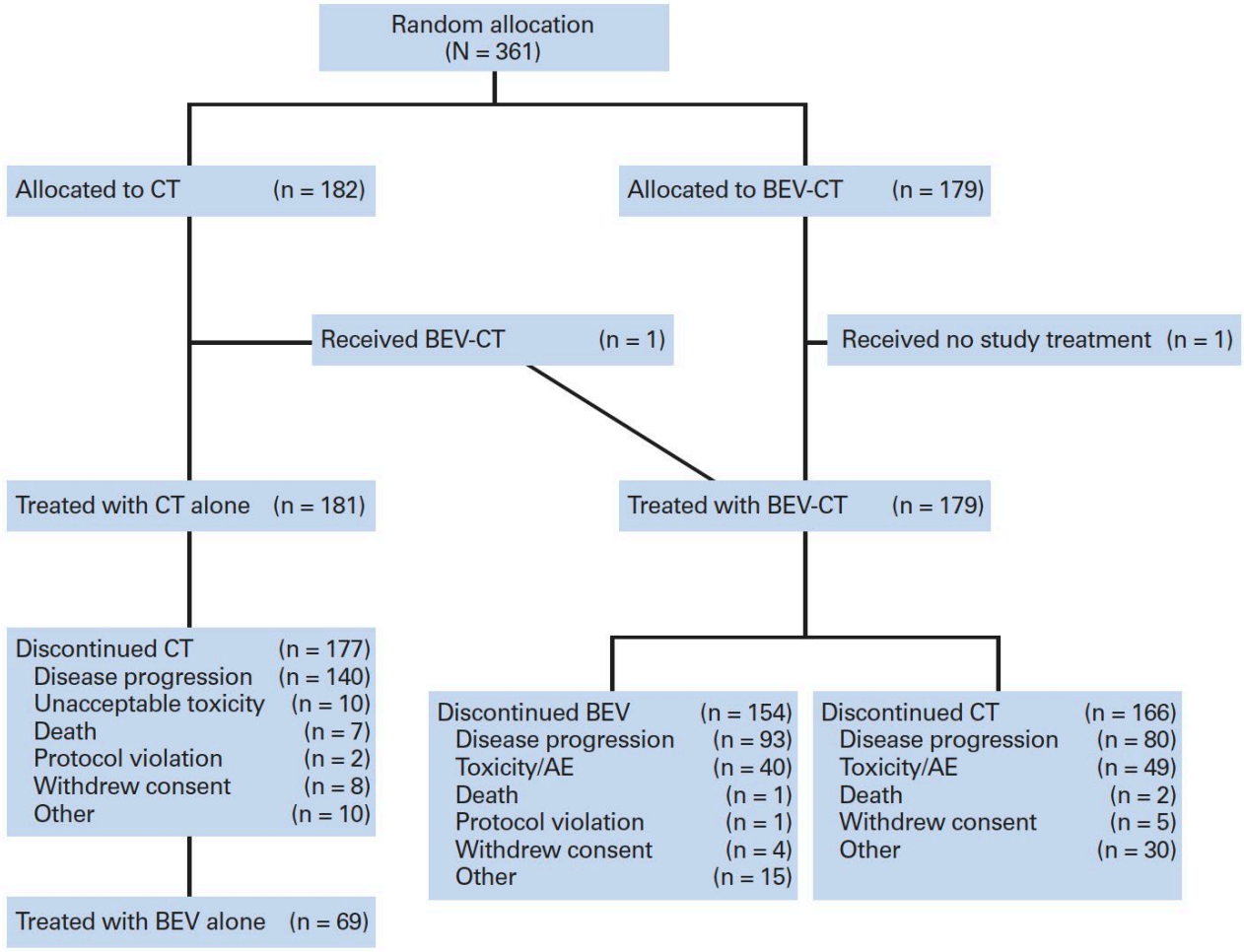
See Pages 56-59 of NCCN Guidelines®

Some Successes, Miss(es), and To Be Determined…



AURELIA – Chemotherapy +/- Bevacizumab

- Phase III, Open-label RCT 1:1 (Weekly paclitaxel/PLD/topotecan +/- bevacizumab)
- EOC/FTCA/PPC by RECIST or GCIG CA-125
- ECOG PS 0-2
- Progression <6 months last platinum
  - Platinum refractory excluded
- 1-2 prior lines of therapy
- Standard bevacizumab exclusions
  - Bowel obstruction, Fistula, perforation, etc.
- Prior anti-angiogenic therapy allowed (7.2%)
- Primary endpoint
  - PFS Investigator per RECIST

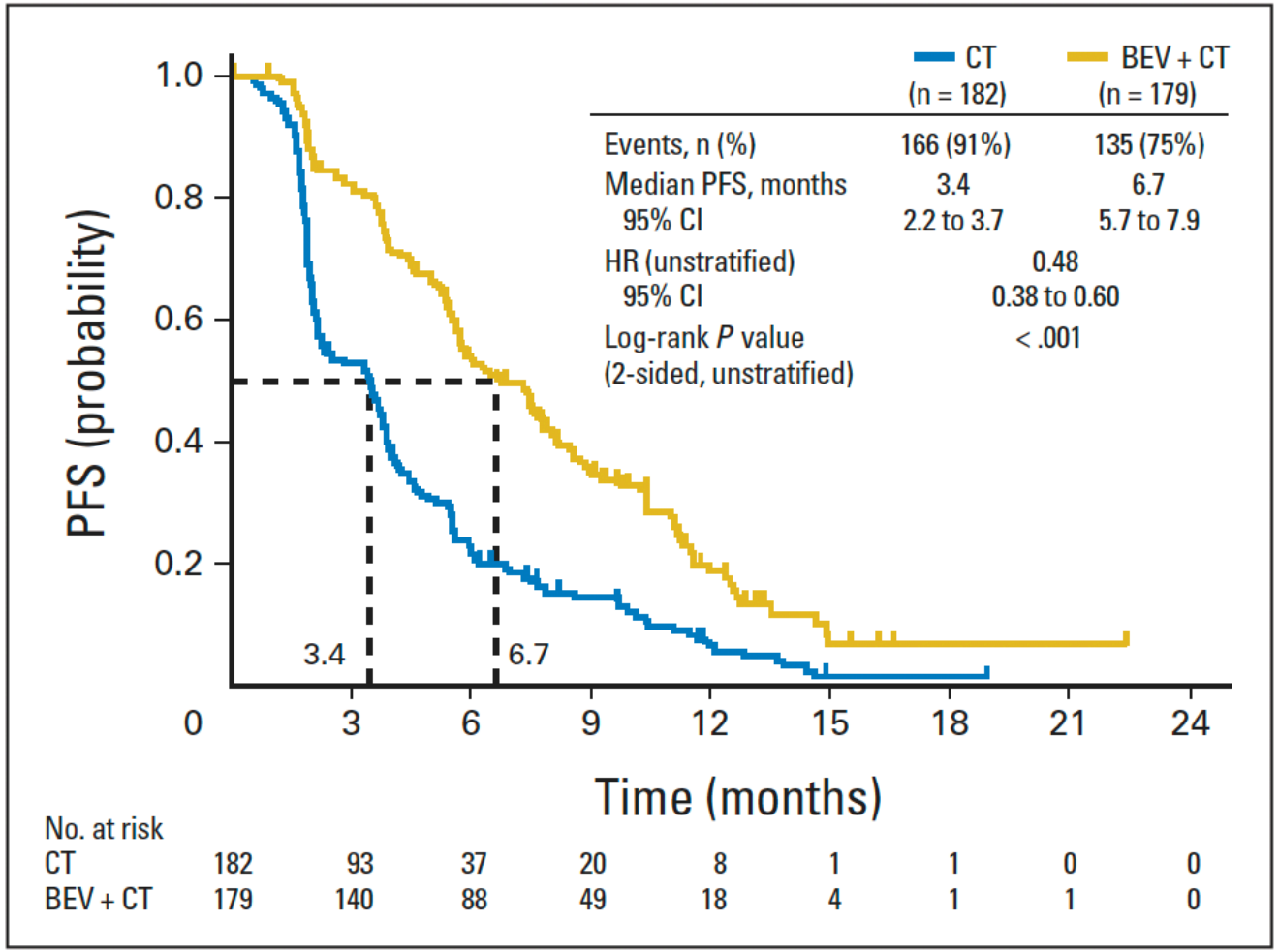


Abbreviations: CT, chemotherapy; BEV, bevacizumab; AE, adverse event; ECOG PS, Eastern Cooperative Oncology Group performance status; EOC, epithelial ovarian cancer; FTCA, fallopian tube cancer; GCIG, Gynecologic Cancer InterGroup; GI, gastrointestinal; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; PPC, primary peritoneal cancer; RECIST, Response Evaluation Criteria in Solid Tumors.

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

AURELIA – PFS

- N=361
- Statistics
  - Predicted to be 5.56 vs. 4 months
- 6.7 vs. 3.4 months
- HR 0.48 (0.38-0.60, P < 0.001)



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

AURELIA – OS

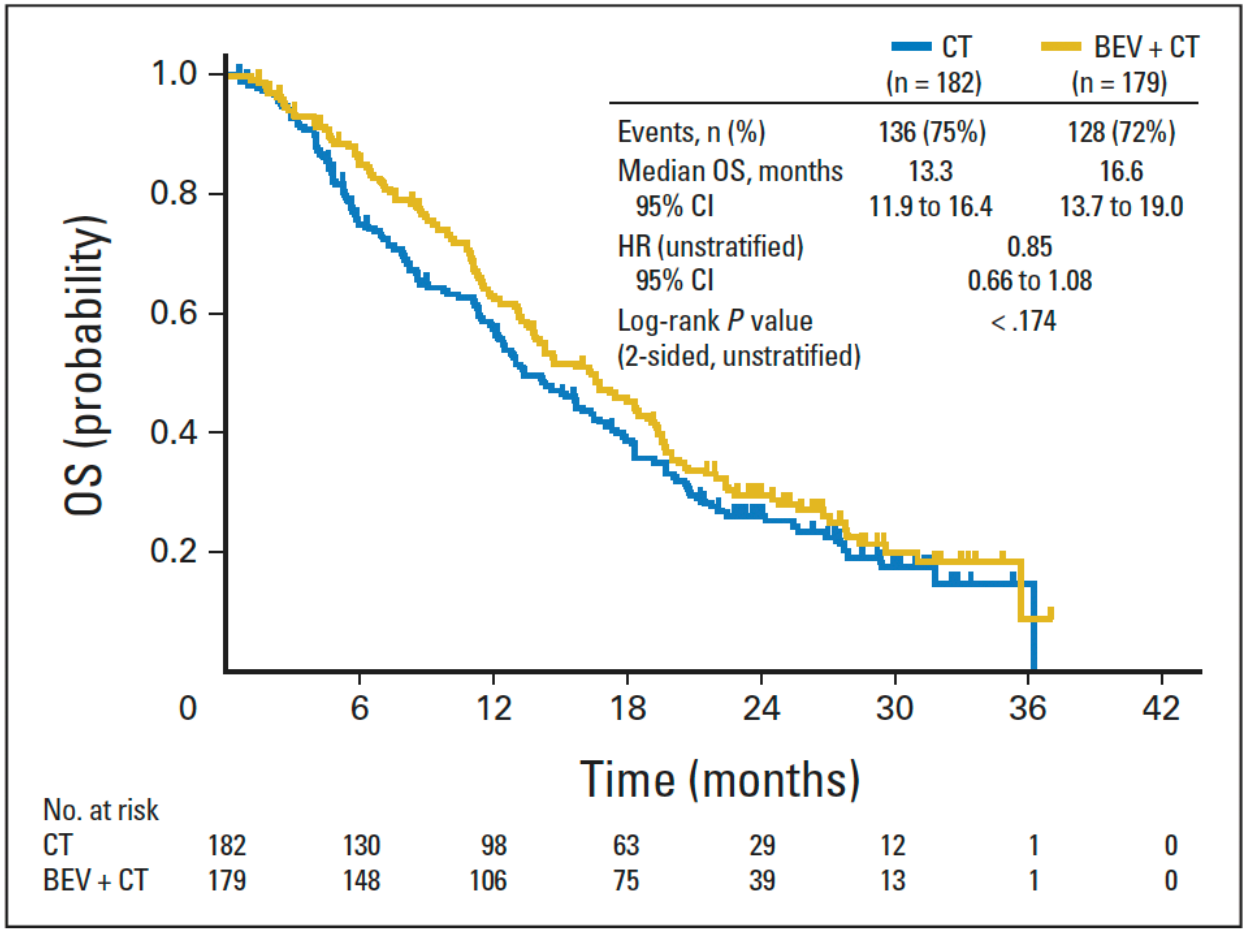
- 16.6 vs. 13.3 months
- HR 0.85 (0.66-1.08, p < 0.174)

Media / News Feature

FDA Approves Genentech Medicine for Women with Platinum-Resistant Recurrent Ovarian Cancer

November 14th, 2014

On November 14, 2014, the FDA approved bevacizumab in combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan chemotherapy for the treatment of women with platinum-resistant, recurrent, epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have received no more than two prior chemotherapy regimens.



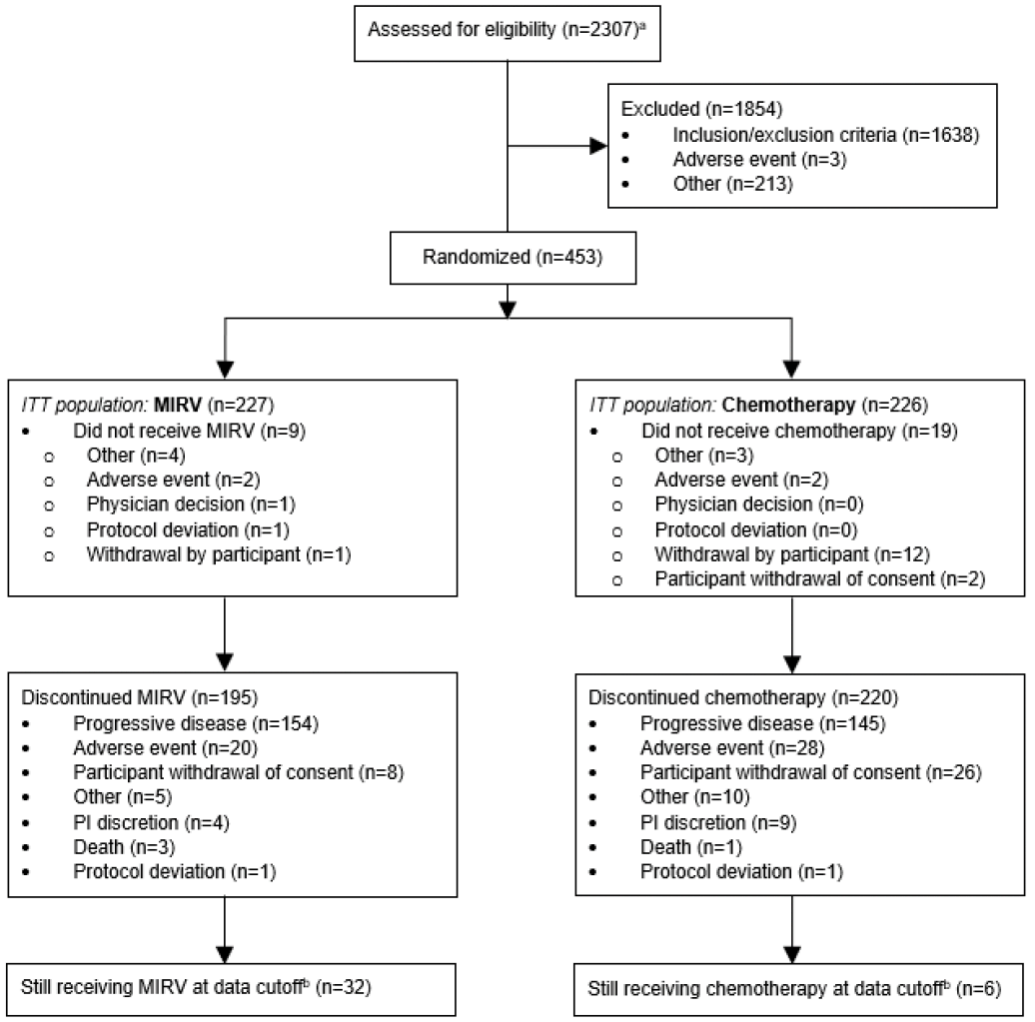
Abbreviations: CT, chemotherapy; BEV, bevacizumab; HR, hazard ratio; OS, overall survival.

Pujade-Lauraine E, et al. J Clin Oncol. 2014;32(13):1302-1308; Genentech. Genentech medicine FDA approved for women with platinum-resistant recurrent ovarian cancer; 2014.

MIRASOL – Mirvetuximab vs. Physician's Choice

- Phase III, Open-label RCT 1:1 (mirvetuximab vs. paclitaxel/PLD/topotecan)
- HGSOC
- FOLR1 75% PS2 Scoring
- ECOG PS 0-1
- Progression 3-6 months if only 1 platinum vs. <6 months
- 1-3 prior lines of therapy
- Neuropathy and ocular exclusions
- Primary endpoint
  - PFS Investigator Assessed

Figure S1. Participant flow diagram

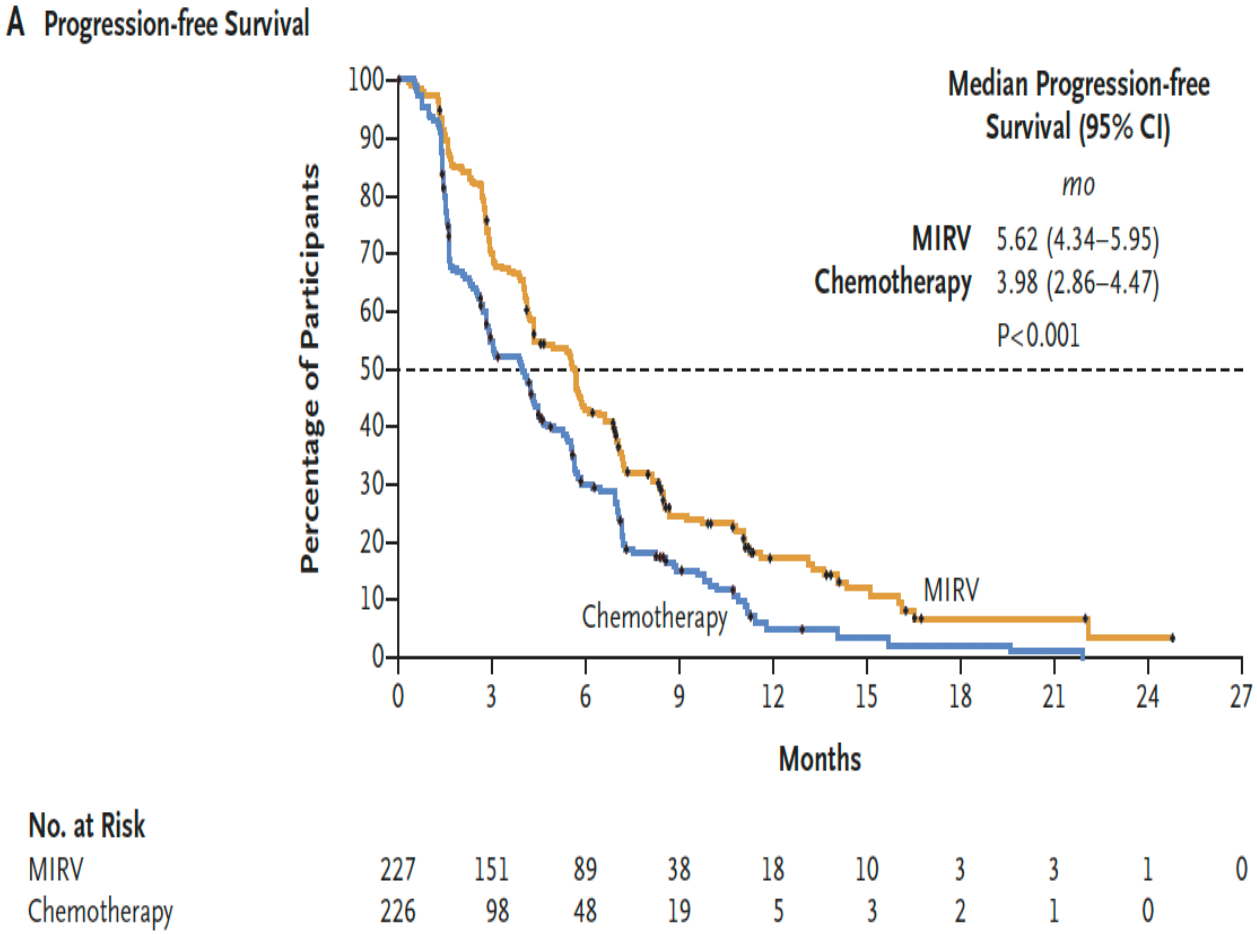


Abbreviations: ECOG PS, Eastern Cooperative Oncology Group performance status; FOLR1, folate receptor alpha 1; HGSOC, high-grade serous ovarian cancer; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; RCT, randomized controlled trial.

Moore KN, et al. N Engl J Med. 2023;389:2165-2177; ClinicalTrials.gov number, NCT04209855

MIRASOL – PFS

- N=453
  - 2-3 prior lines (86.1%)
  - 62% prior bevacizumab
  - 55.4% prior PARPi
- Statistics
  - Predicted to be 5.0 vs. 3.5 month
- 5.62 vs. 3.98 months, p < 0.001
- Restricted mean PFS @ 12 months
  - MIRV 6.13 mo (5.62-6.64 mo)
  - Chemo 4.72 mo (4.21-5.23 mo)



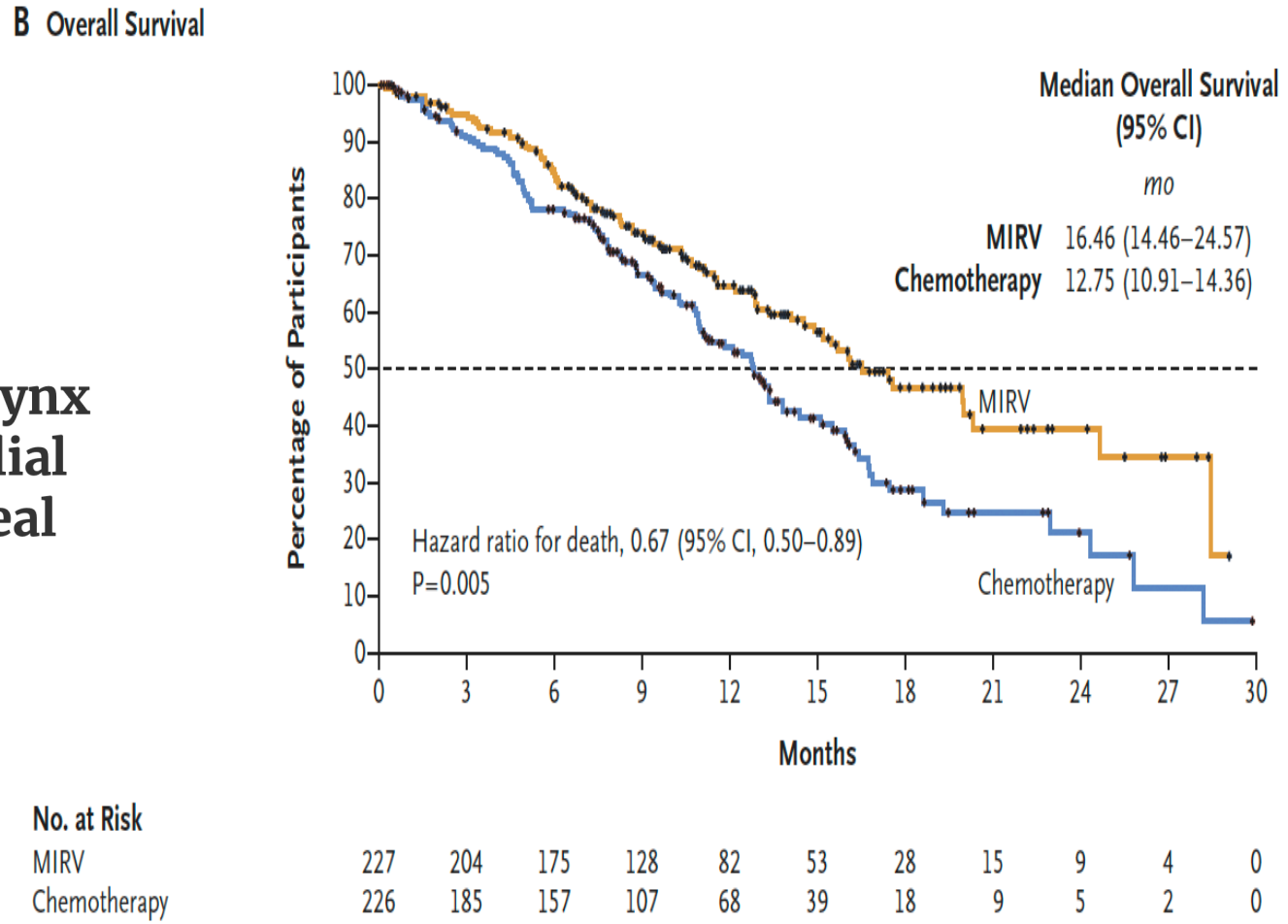
Abbreviations: CI, confidence interval; HR, hazard ratio; PARPi, poly(ADP-ribose) polymerase inhibitor; PFS, progression-free survival, Chemo, chemotherapy; MIRV, mirvetuximab soravtansine.
Moore KN, et al. N Engl J Med. 2023;389:2165-2177; ClinicalTrials.gov number, NCT04209855

MIRASOL – OS

- 16.46 vs. 12.75 months
- HR 0.67 (0.50-0.89, p= 0.005)

FDA approves mirvetuximab soravtansine-gynx for FRα positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer

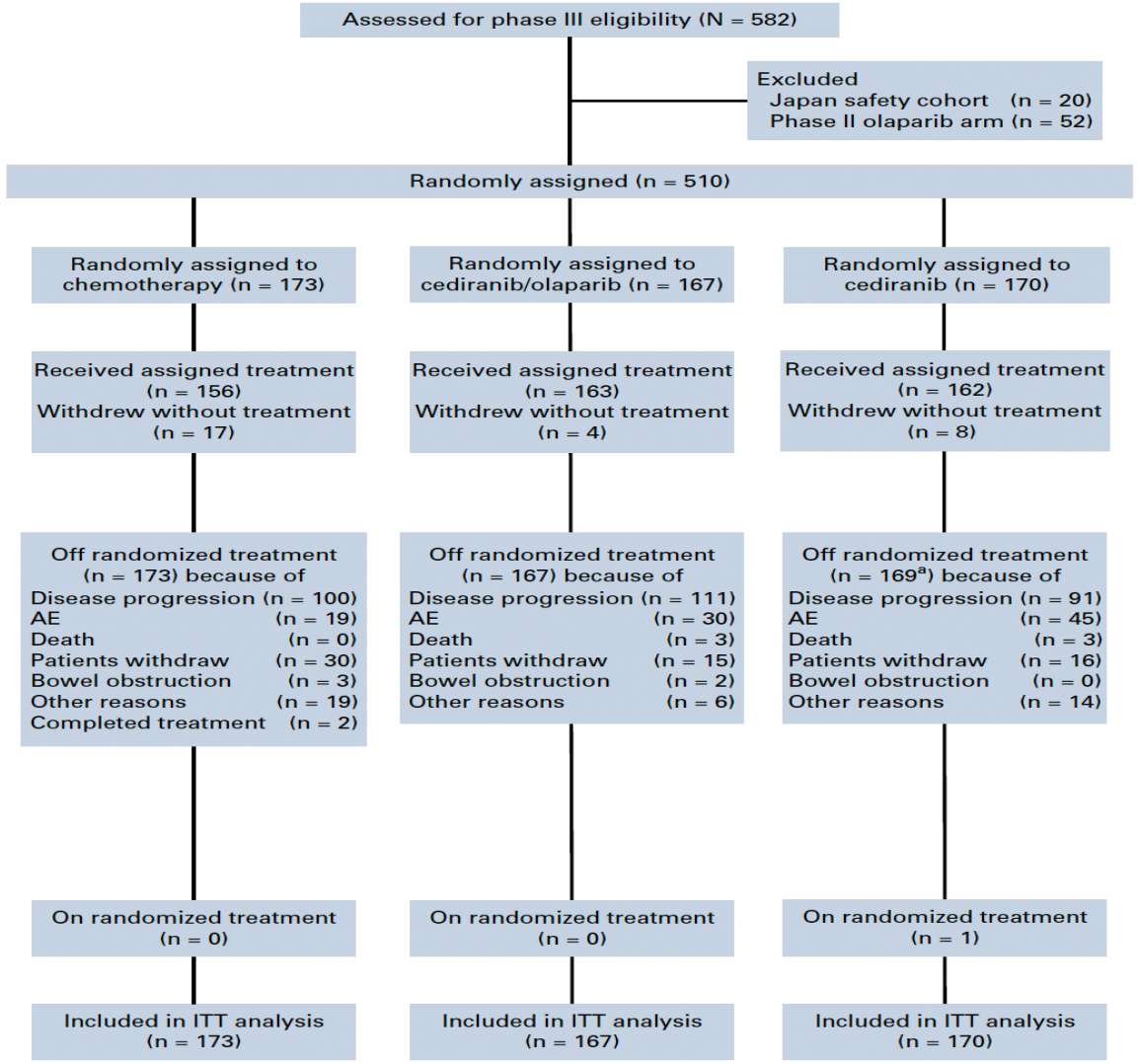
On March 22, 2024, the Food and Drug Administration approved mirvetuximab soravtansine-gynx for adult patients with FRα positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have received one to three prior systemic treatment regimens. Patients are selected based on an FDA-approved test. Mirvetuximab soravtansine-gynx previously received accelerated approval for this indication.



Moore KN, et al. N Engl J Med. 2023;389:2165-2177; ClinicalTrials.gov number, NCT04209855; FDA. FDA approves mirvetuximab soravtansine-gynx for FRα-positive platinum-resistant ovarian cancer; 2024.

GY005 – PHASE II/III – 4 Arms

- Phase II/III, Open-label RCT 1:1:1:1 (Cediranib, Cediranib+Olaparib,Olaparib vs. paclitaxel/PLD/Topotecan)
  - Single agent olaparib excluded from PIII
- HG Serous / Endometrioid OC /FTCA/PPC
- ECOG PS 0-2
- Platinum resistant and refractory patients
- 1-3 prior lines of therapy
- Primary endpoint
  - Phase II – PFS Investigator Assessed
  - Phase III – Co-primary PFS & OS

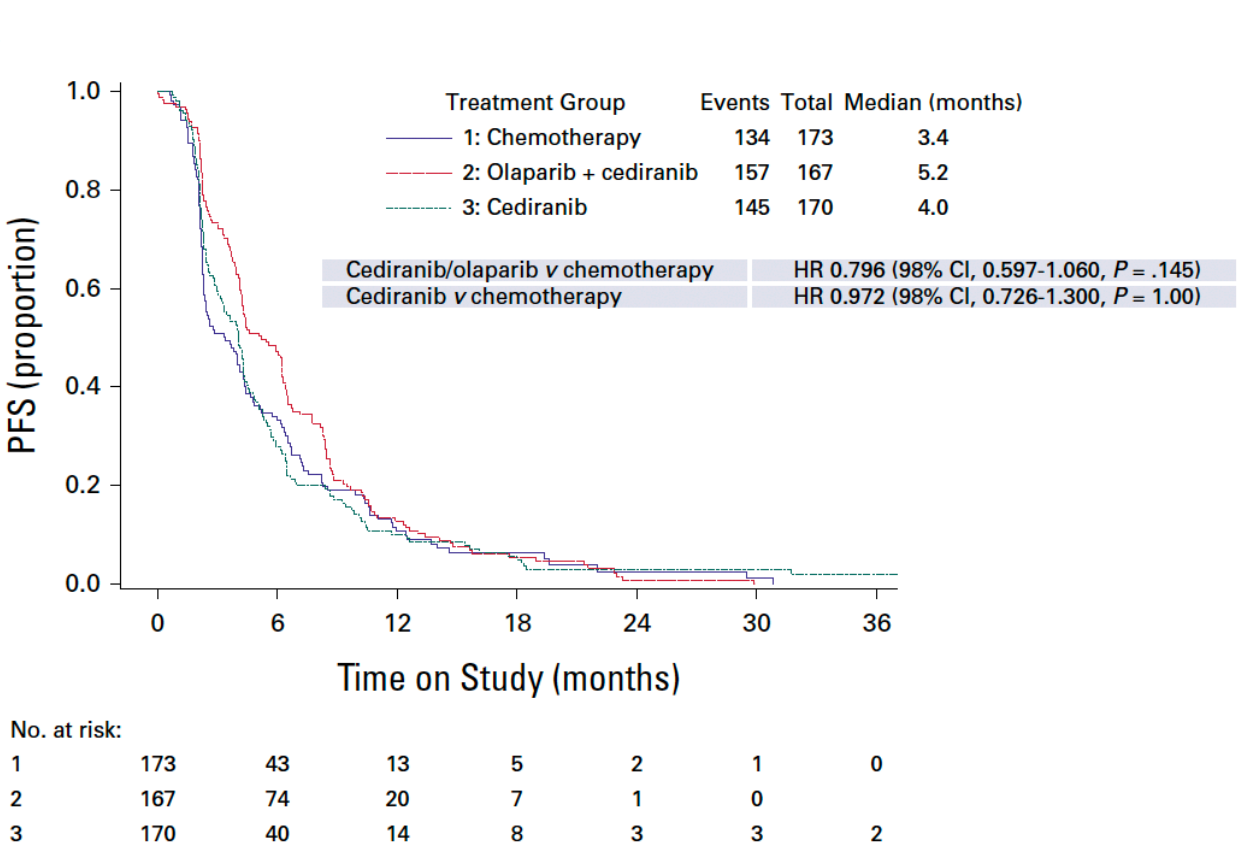


Abbreviations: ECOG PS, Eastern Cooperative Oncology Group performance status; FTCA, fallopian tube cancer; HG, high-grade; OC, ovarian cancer; OS, overall survival; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; PPC, primary peritoneal cancer.

Lee JM et al. J Clin Oncol. 2024 Dec 20;42(36):4305-4316. ClinicalTrials.gov NCT02502266.

GY005 – PFS

- N=562
  - 1 prior line (53.9%)
  - 19.2% prior antiangiogenic therapy
  - 31.6% primary platinum refractory
  - 52 Phase II Olaparib pts excluded
- 3.4 SOC vs. 5.2 Ola+Ced vs. 4.0 Ced months, p=NS

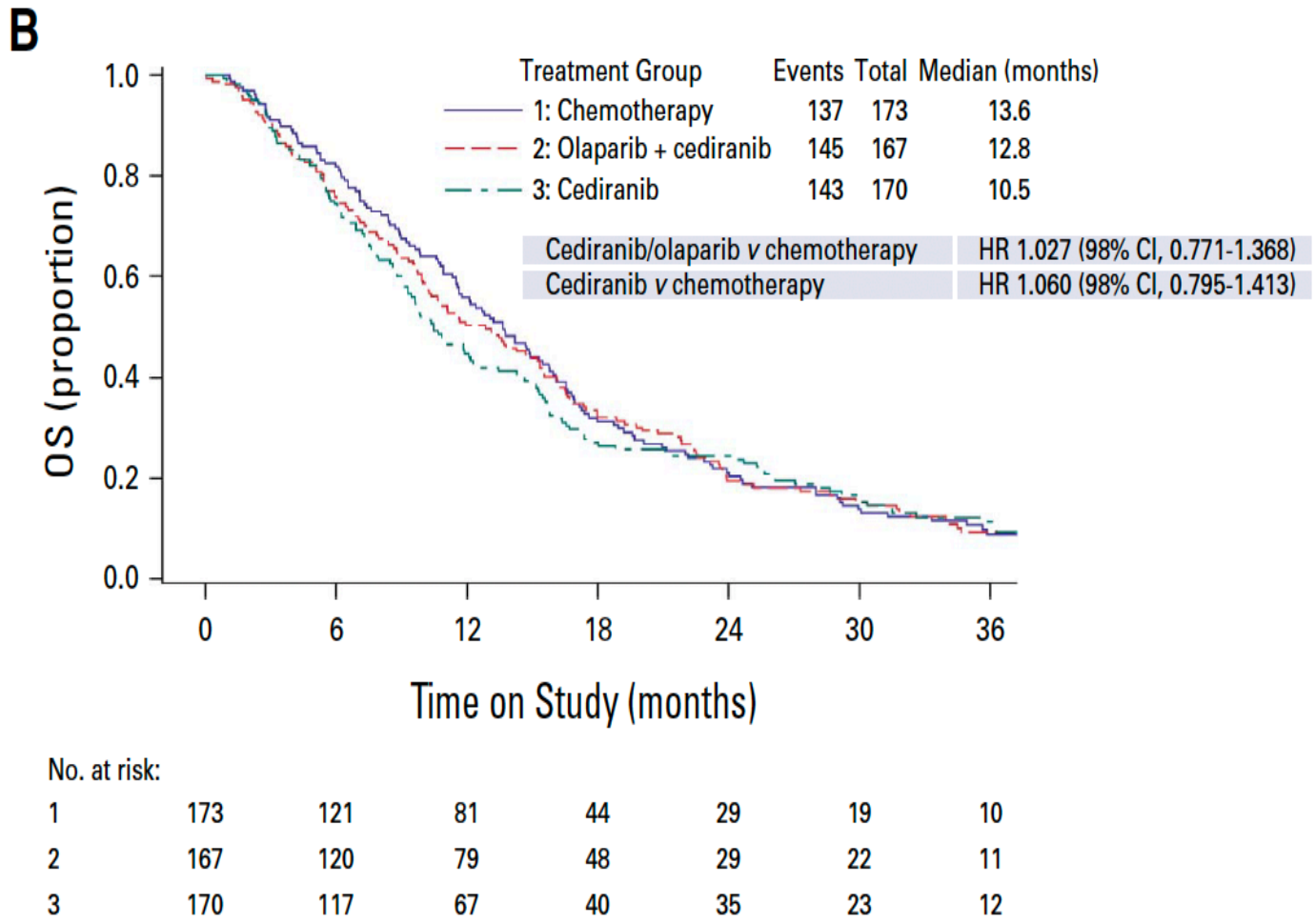


Abbreviations: Ced, cediranib; HR, hazard ratio; Ola, olaparib; SOC, standard of care; NS, not significant; pts, patients.
Lee JM et al. J Clin Oncol. 2024 Dec 20;42(36):4305-4316. ClinicalTrials.gov NCT02502266.

GY005 – OS

- 13.6 SOC vs.12.8 Ola+Ced vs. 10.5 Ced months
- Ola+Ced vs. SOC HR 1.027 (98% CI 0.771-1.368)
- Ced vs. SOC HR 1.060 (98% CI 0.795-1.1413)

- Is phase II/III the best design?
- Role of inclusion of platinum refractory pts?



Lee JM et al. J Clin Oncol. 2024 Dec 20;42(36):4305-4316. ClinicalTrials.gov NCT02502266.

PROC Therapeutic Activity

TABLE 1. Reported Response Rates in Recent PROC Trials

Trial	Population	Control Arm	ORR, %	PFS, Months	OS, Months
AURELIA[10] (2014)	≤2 previous lines 8% previous Bev	PLD, Pac, Topo	13	3.4	13.3
PENELOPE[11] (2016)	HER3 low PROC 30% previous Bev	Gem, Pac, Topo	8.7	2.6	7.9
CORAIL[12] (2021)	≤3 previous lines 46% previous Bev	PLD, Topo	12	3.6	10.9
FORWARD1[13] (2021)	1-3 previous lines (FRα high) 33% previous Bev	Pac, PLD, Topo	12	4.4	14
Javelin Ovarian 200[14] (2021)	≤3 previous lines 28% previous Bev	PLD	4	3.5	17.4
NINJA[15] (2021)	≤1 platinum-resistant line	PLD, Gem	13	3.8	12.1
OVAL (2023)[16]	<2 platinum-resistant 70% previous Bev	Pac	29.6	5.4	13.1
MIRASOL[17] (2023)	1-3 previous lines 62% previous Bev	PLD, Pac, Topo	15.9	4.0	12.8
AXLerate-OC[18] (2023)	50% previous Bev	Pac	—	5.5	—

Abbreviations: Bev, bevacizumab; FRα, folate receptor alpha; Gem, gemcitabine; HER3, human epidermal growth factor receptor 3; ORR, objective response rate; OS, overall survival; Pac, paclitaxel; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; PROC, platinum-resistant ovarian cancer; Topo, topotecan.

Cross-trial comparison must be interpreted with caution

Adapted from: St Laurent J, Liu JF. Treatment Approaches for Platinum-Resistant Ovarian Cancer. J Clin Oncol. 2024;42(2):127-133.

PROC Therapeutic Activity

Table Main characteristics and outcomes of the included trials

Author (y) trial name, trial registration no.	Trial design	Experimental drug type	Max no. of prior lines	Platinum refractory (no. exp/ control)	Patient no. (exp/control)	Biomarker selection	Primary end point	Progression-free survival mo (exp/control) HR (95% CI)	Overall survival mo (exp/control) HR (95% CI)
Colombo and colleagues[14] (2012), EPO906 NCT00262990	Patupilone vs PLD	Chemotherapy	No limit	Yes (83/78)	828 (412/416)	No	Overall survival	3.7/3.2 HR 0.99 (0.84-1.16)	13.2/12.7 HR 0.93 (0.79-1.09)
Gaillard and colleagues[15] (2021), CORAIL NCT02421588	Lurbinectedin vs PLD or topotecan	Chemotherapy	3	No	442 (221/221)	No	Progression-free survival	3.5/3.6 HR 0.99 (0.81-1.21)	11.4/10.9 HR 0.96 (0.77-1.18)
Monk and colleagues[16] (2010), OVA301 NCT00113607	Trabectedin + PLD vs PLD	Chemotherapy	1	No	232 (115/117)	No	Progression-free survival	4.0/3.7 HR 0.95 (0.7-1.3)	14.2/12.4 HR 0.92 (0.70-1.21)
Vergote and colleagues[17] (2010), NA NCT00350948	Canfosfamide + PLD vs PLD	Chemotherapy	2	Yes (13/8)	125 (65/60)	No	Progression-free survival	5.6/3.7 HR 0.92 (95% CI NR)	NR
Monk and colleagues[18,19] (2014, 2016), TRINOVA1 NCT01204749	Trebananib + paclitaxel vs paclitaxel	Anti-angiogenic	3	No[a]	490 (235/245)	No	Progression-free survival	NR HR 0.70 (0.58-0.84)	NR HR 0.97 (0.79-1.19)
Pujade-Lauraine and colleagues[20] (2014), AURELIA NCT04209855	Bevacizumab + Cht vs Cht	Anti-angiogenic	2	No	361 (182/179)	No	Progression-free survival	6.7/3.4 HR 0.48 (0.38-0.60)	16.6/13.3 HR 0.85 (0.66-1.08)
Kristeleit and colleagues[21] (2022), ARIEL4 NCT02855944	Rucaparib vs paclitaxel	Targeted agent	No limit	No	179 (120/59)	Yes *BRCA1/2*	Progression-free survival	6.4/5.7 HR 0.78 (0.54-1.13)	14.2/22.2 HR 1.51 (1.05-2.17)
Kurzeder and colleagues[22] (2016), PENELOPE NCT01684878	Pertuzumab + Cht vs placebo + Cht	Targeted agent	2	Yes (19/21)[b]	156 (78/78)	Yes HER3	Progression-free survival	4.1/2.6 HR 0.86 (0.59-1.25)	10.2/8.4 HR 0.90 (0.61-1.32)
Hamanishi and colleagues[23] (2021), NINJA JapicCTI-153004	Nivolumab vs PLD or gemcitabine	Immune checkpoint inhibitor	No limit	Yes (51/46)	316 (157/159)	No	Overall survival	2.0/3.8 HR 1.5 (1.2-1.9)	10.1/12.1 HR 1.0 (0.8-1.3)

Cross-trial comparison must be interpreted with caution

Adapted from: Martorana F, et al. Can we learn from failures? A systematic review of phase III trials in platinum-resistant ovarian cancer. Int J Gynecol Cancer. 2025;35(1):100009.

PROC Therapeutic Activity

Pujade-Lauraine and colleagues[24] (2021), JAVELINE 200 NCT02580058	Avelumab + PLD vs avelumab vs PLD	Immune checkpoint inhibitor	3	Yes (47/47/48)	568 (190/190/188)	No	Progression-free survival/overall survival	3.7/1.9/3.5 HR A + P vs P 0.78 (1.59-1.24)[c] HR A vs P 1.68 (1.32-2.60)[c]	15.7/11.8/13.1 HR A + P vs P 0.85 (0.74-1.24)[d] HR A vs P 1.14 (0.95-1.58)[d]
Moore and colleagues[25] (2021), FORWARD1 NCT02631876	Mirvetuximab vs Cht	Antibody-drug conjugate	3	No	366 (248/148)	Yes FRα	Progression-free survival	4.1/4.4 HR 0.98 (0.73-1.131)	16.4/14.0 HR 0.85 (0.64-1.13)
Moore and colleagues[26] (2023), MIRASOL NCT04209855	Mirvetuximab vs Cht	Antibody-drug conjugate	3	No	453 (227/226)	Yes FRα	Progression-free survival	5.62/3.98 NR	16.46/12.75 HR 0.67 (0.50-0-89)
Arend and colleagues[27] (2024), OVAL/GOG3018 NCT03398655	Ofra-vec + paclitaxel vs placebo + paclitaxel	Other (gene-based therapy)	5	No	409 (204/205)	No	Progression-free survival/overall survival	5.29/5.36 HR 1.03 (0.83-1.29)	13.37/13.14 HR 0.97 (0.75-1.27)
Fotopoulou and colleagues[28] (2014), OVATURE NCT00382811	Phenoxodiol vs phenoxodiol + CBDCA	Other (apoptosis inducer)	No limit	Yes (NR)	142 (70/72)	No	Progression-free survival	3.6/4.6 HR 1.22 (0.84-1.22)	8.8./10.5 HR 1.20 (0.83-1.73)
Lindemann and colleagues[29] (2017), OVARESIST NCT02728622	Tamoxifen vs PLD or paclitaxel	Other (endocrine therapy)	No limit	Yes (6/10)	238 (82/156)	No	HR-QoL	1.9/2.9 HR 1.54 (1.16-2.05)	NR

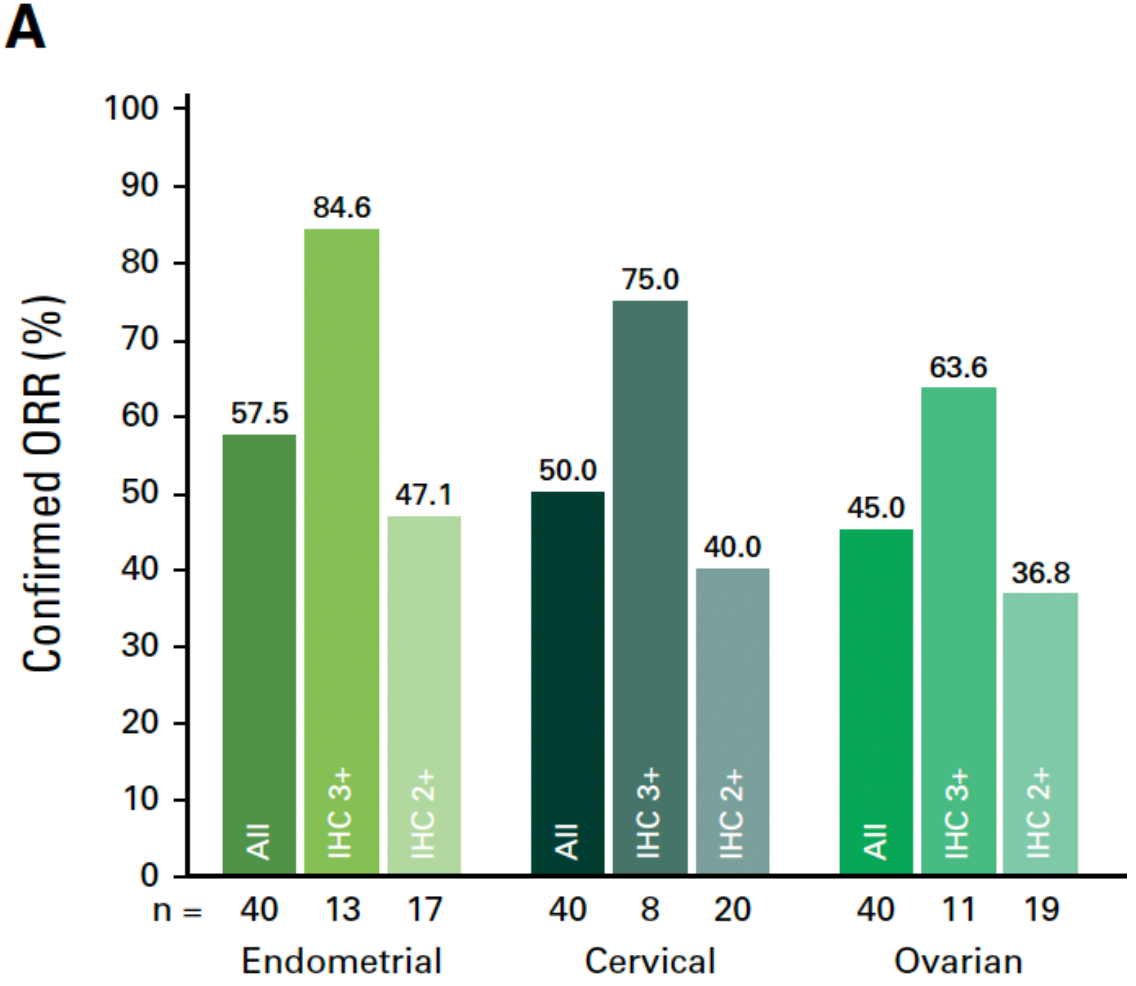
Cross-trial comparison must be interpreted with caution

Abbreviations: Bev, bevacizumab; CBDCA, carboplatin; ChT, chemotherapy; FRα, folate receptor alpha; HR, HR-QoL, health-related quality of life; NR, not reported; Pac, paclitaxel; PLD, pegylated liposomal doxorubicin; PROC, platinum-resistant ovarian cancer; A, avelumab; P, PLD.

Adapted from: Martorana F, et al. Can we learn from failures? A systematic review of phase III trials in platinum-resistant ovarian cancer. Int J Gynecol Cancer. 2025;35(1):100009.

DESTINY-PanTumor02 – Trastuzumab Deruxtecan (T-DXd)

- Phase II, Single arm Open-label trial
  T-DXd 5.4 mg/kg Q 3 weeks
- 40 patients with HER2 2/3+ EOC
- ECOG PS 0-1
- Progression ≥ 1 prior therapy
- 1-3 prior lines of therapy
- ILD/pneumonitis excluded
- Primary endpoint
  - ORR Investigator

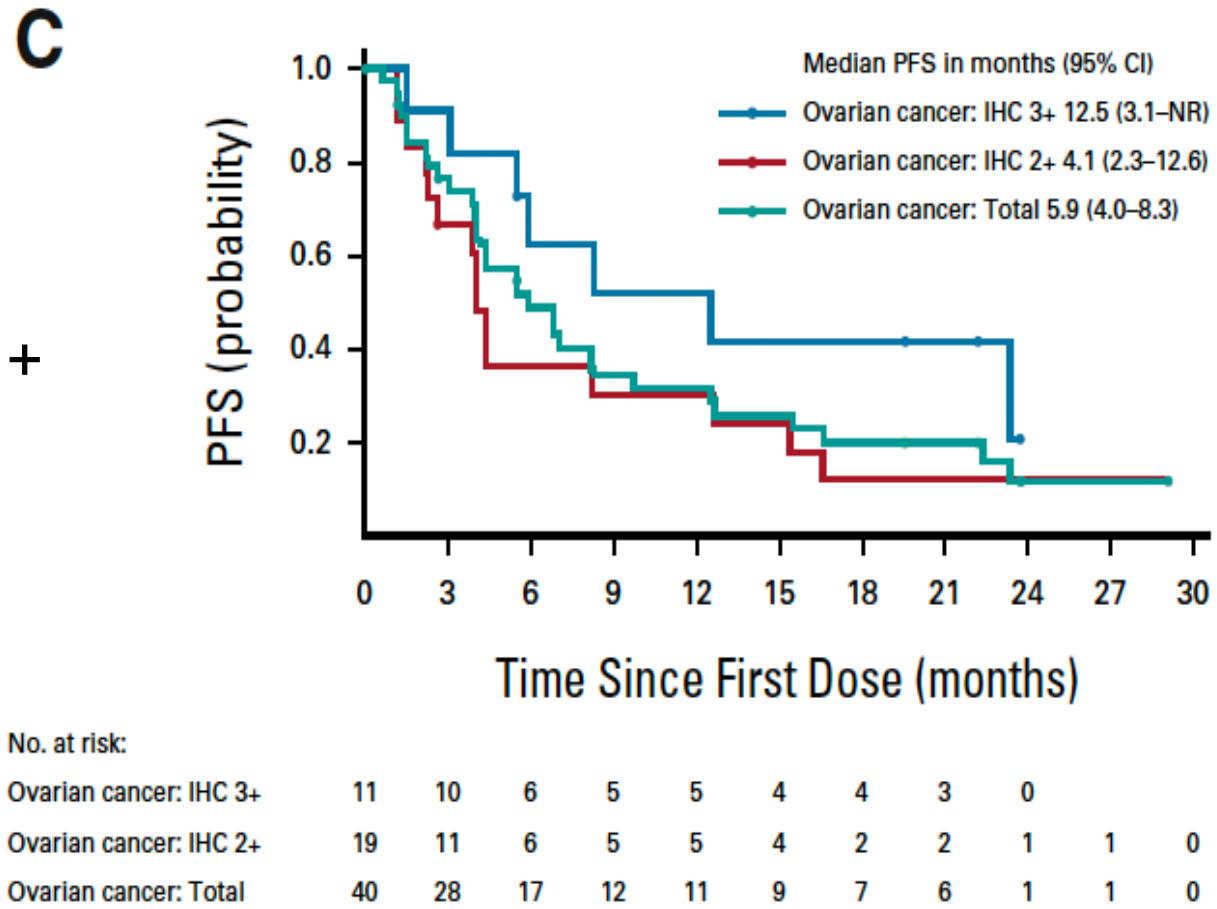


Abbreviations: ECOG PS, Eastern Cooperative Oncology Group performance status; EOC, epithelial ovarian cancer; ILD, interstitial lung disease; HER2, human epidermal growth factor receptor 2; IHC, immunohistochemistry; T-DXd, trastuzumab deruxtecan.

Meric-Bernstam F, et al. J Clin Oncol. 2024;42(1):47-58. ClinicalTrials.gov NCT04482309.

DESTINY-PanTumor02 – PFS

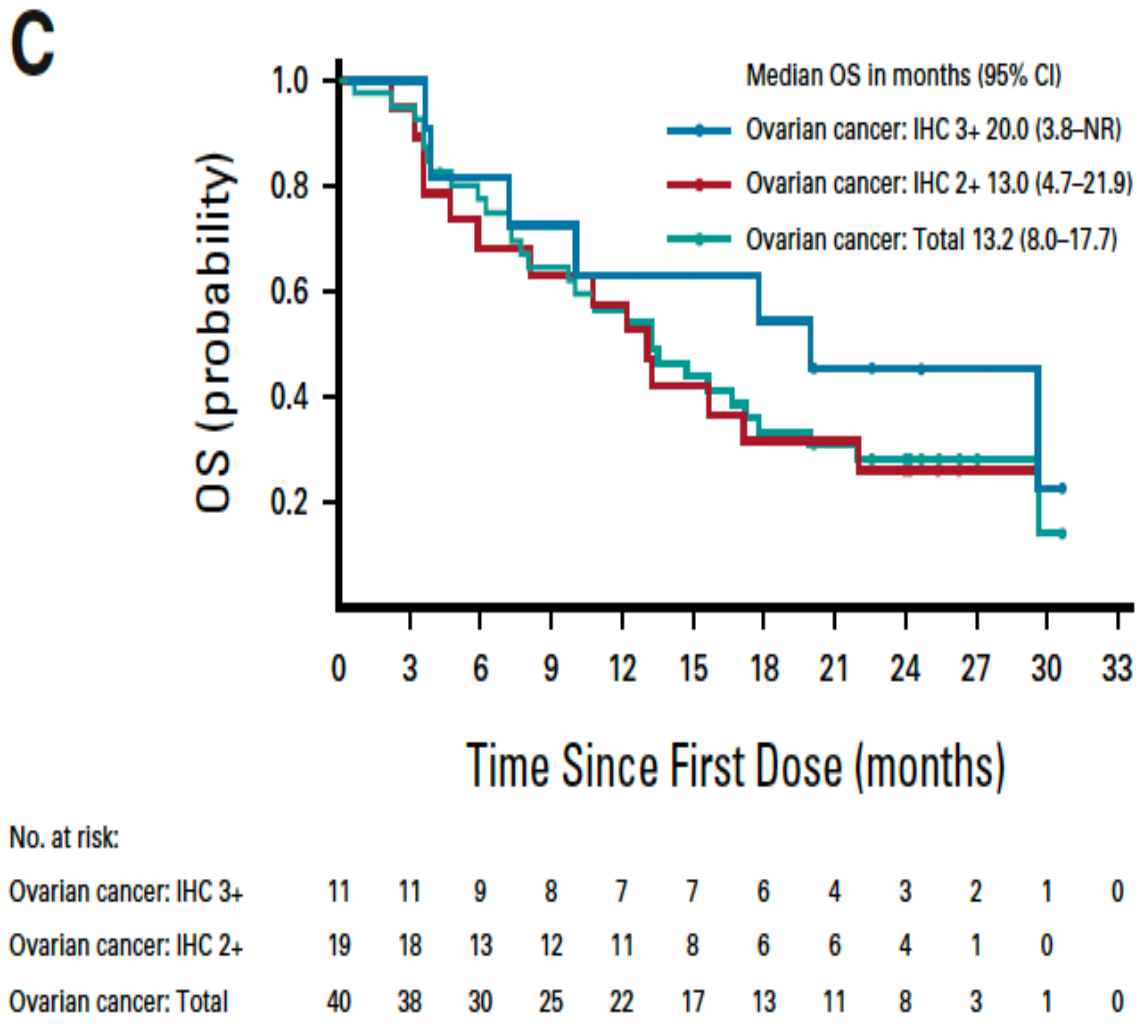
- N=40
  - 2+ prior lines (80%)
  - ECOG PS=0 (65%)
  - Central review with 12.5% HER2 1+ and 12.5% HER2 0
- IHC 3+ 12.5 vs. IHC 2+ 4.1 months



Meric-Bernstam F, et al. J Clin Oncol. 2024;42(1):47-58. ClinicalTrials.gov NCT04482309.

DESTINY-PanTumor02 – OS

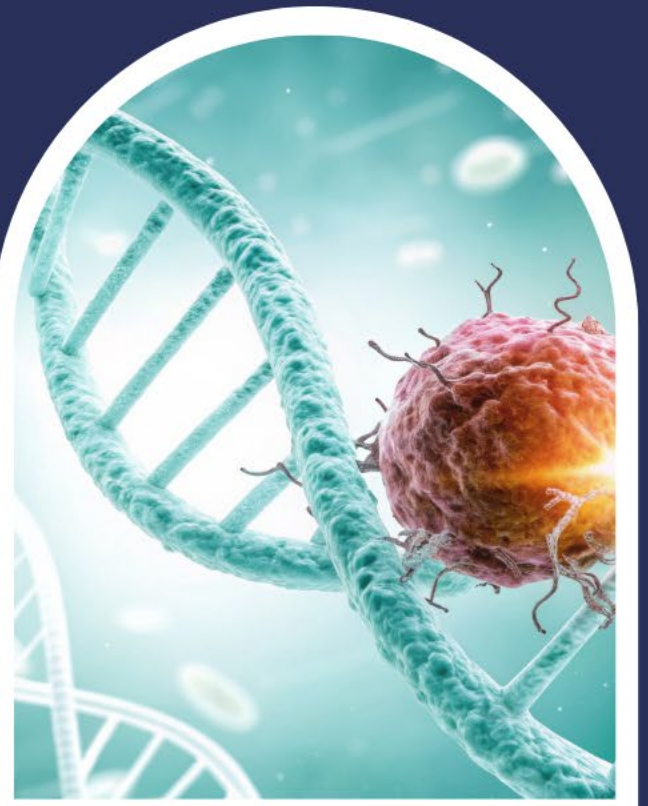
- HER2 3+: 20.0 mo (95 CI 3.8 – NR)
- HER2 2+: 13.0 mo (95% CI 4.7 – 21.9)



Meric-Bernstam F, et al. J Clin Oncol. 2024;42(1):47-58. ClinicalTrials.gov NCT04482309.

Why Resistance Happens: Clinical Implications of Tumor Biology

Shannon Westin, MD, MPH
MD Anderson Cancer Center



NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer

Principles of Systemic Therapy:

Acceptable Recurrence Therapies for Epithelial Ovarian (including LCOC)/Fallopian Tube/Peritoneal Cancer

Recurrence Therapy for Platinum-Resistant Disease (alphabetical order)

Preferred

Cytotoxic Therapy

- Albumin-bound Paclitaxel/Relacorilant
- Docetaxel
- Gemcitabine
- Liposomal Doxorubicin
- Liposomal Doxorubicin + Bevacizumab
- Paclitaxel (Weekly)
- Paclitaxel (Weekly) + Bevacizumab
- Oral Cyclophosphamide + Bevacizumab
- Topotecan
- Topotecan + Bevacizumab

Targeted Therapy (single agents)

- Mirvetuximab soravtansine-gynx (for FRα-expressing tumors [≥75% positive tumor cells]) (category 1)

Other Recommended

Cytotoxic Therapy

- Albumin-bound Paclitaxel
- Capecitabine
- Carboplatin
- Carboplatin/Docetaxel
- Carboplatin/Paclitaxel (Weekly)
- Carboplatin/Gemcitabine ± Bevacizumab
- Carboplatin/Liposomal Doxorubicin ± Bevacizumab
- Carboplatin/Paclitaxel ± Bevacizumab
- Cisplatin/Gemcitabine
- Cyclophosphamide
- Doxorubicin
- Gemcitabine ± Bevacizumab
- Ifosfamide/Mesna
- Irinotecan
- Ixabepilone ± Bevacizumab (category 2B)
- Oral Cyclophosphamide + Pembrolizumab + Bevacizumab
- Oral Etoposide
- Oxaliplatin
- Paclitaxel
- Pemetrexed
- Sorafenib/Topotecan
- Vinorelbine

Targeted Therapy (single agents)

- Bevacizumab
- Pazopanib (category 2B)

Hormone Therapy

- Aromatase inhibitors (Anastrozole, Exemestane, Letrozole)
- Goserelin acetate
- Leuprolide acetate
- Megestrol acetate
- Tamoxifen

Useful in Certain Circumstances

- Albumin-bound Paclitaxel/Carboplatin (for confirmed taxane hypersensitivity)
- Carboplatin/Paclitaxel (for age >70)

Immunotherapy

- Dostarlimab-gxly (for dMMR/MSI-H recurrent or advanced tumors)
- Paclitaxel + Pembrolizumab ± Bevacizumab (for PD-L1- positive tumors [CPS≥1])
- Pembrolizumab (for patients with MSI-H or dMMR solid tumors, or TMB-H tumors ≥10 mutations/megabase)
- For clear cell carcinoma:
  - Ipilimumab + Nivolumab

Hormone Therapy

- Fulvestrant (for low-grade serous carcinoma)

Targeted Therapy

- Dabrafenib/Trametinib (for BRAF V600E positive tumors)
- Entrectinib or Larotrectinib or Repotrectinib (for *NTRK1/2/3* gene fusion-positive tumors)
- Fam-trastuzumab deruxtecan-nxki (for HER2-positive tumors [IHC 3+ or 2+])
- Mirvetuximab soravtansine-gynx + Bevacizumab (for FRα- expressing tumors [≥25% positive tumor cells])
- Selpercatinib (for RET gene fusion-positive tumors)
- For low-grade serous carcinoma:
  - Avutometinib/Defactinib (for KRAS-mutated tumors)
  - Trametinib
  - Binimetinib (category 2B)
- For mucinous carcinoma:
  - FOLFIRI ± Bevacizumab (category 2B)

Note: All recommendations are NCCN Category 2A unless otherwise indicated.

See Pages 56-59 of NCCN Guidelines®

NCCN Guidelines Footnotes

For patients who have been treated with up to three lines of therapy and prior bevacizumab.

Steroid premedication should not be used.

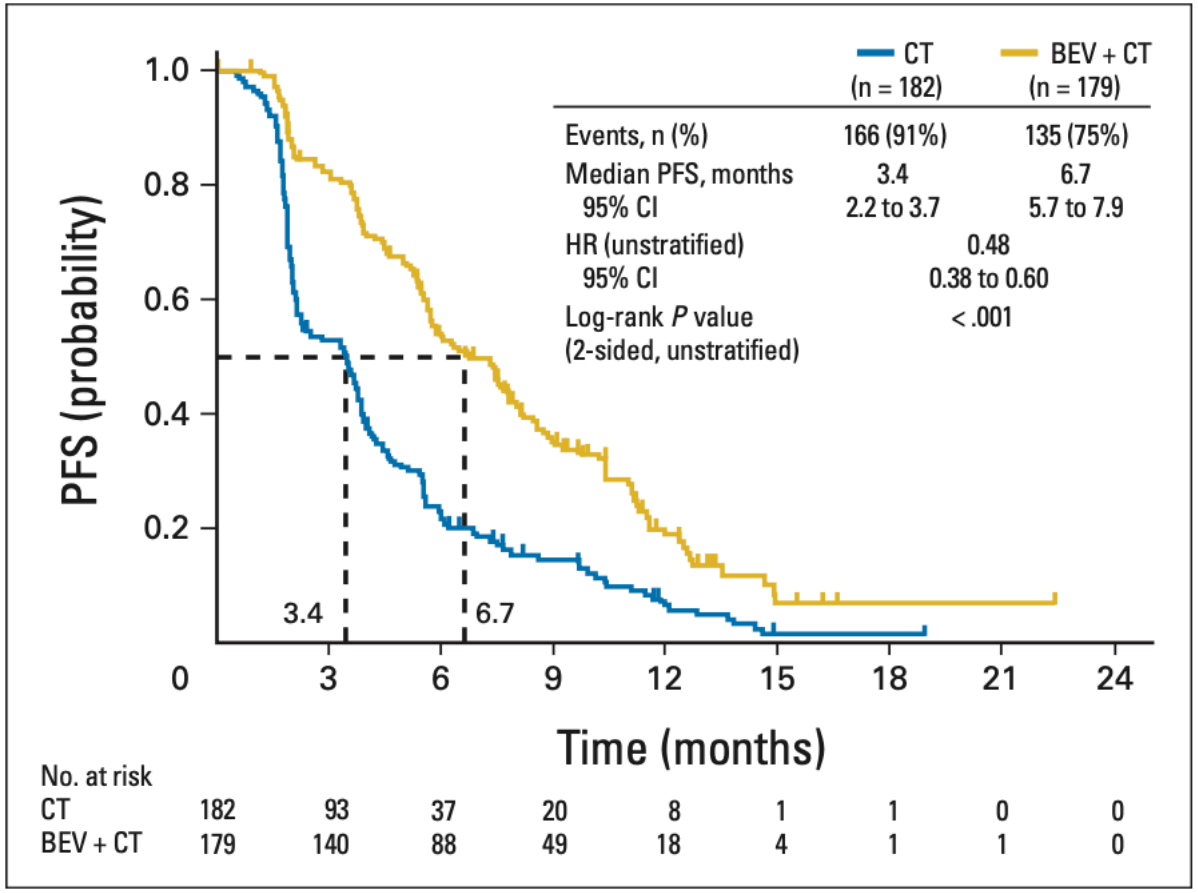
Randomized Studies in PROC

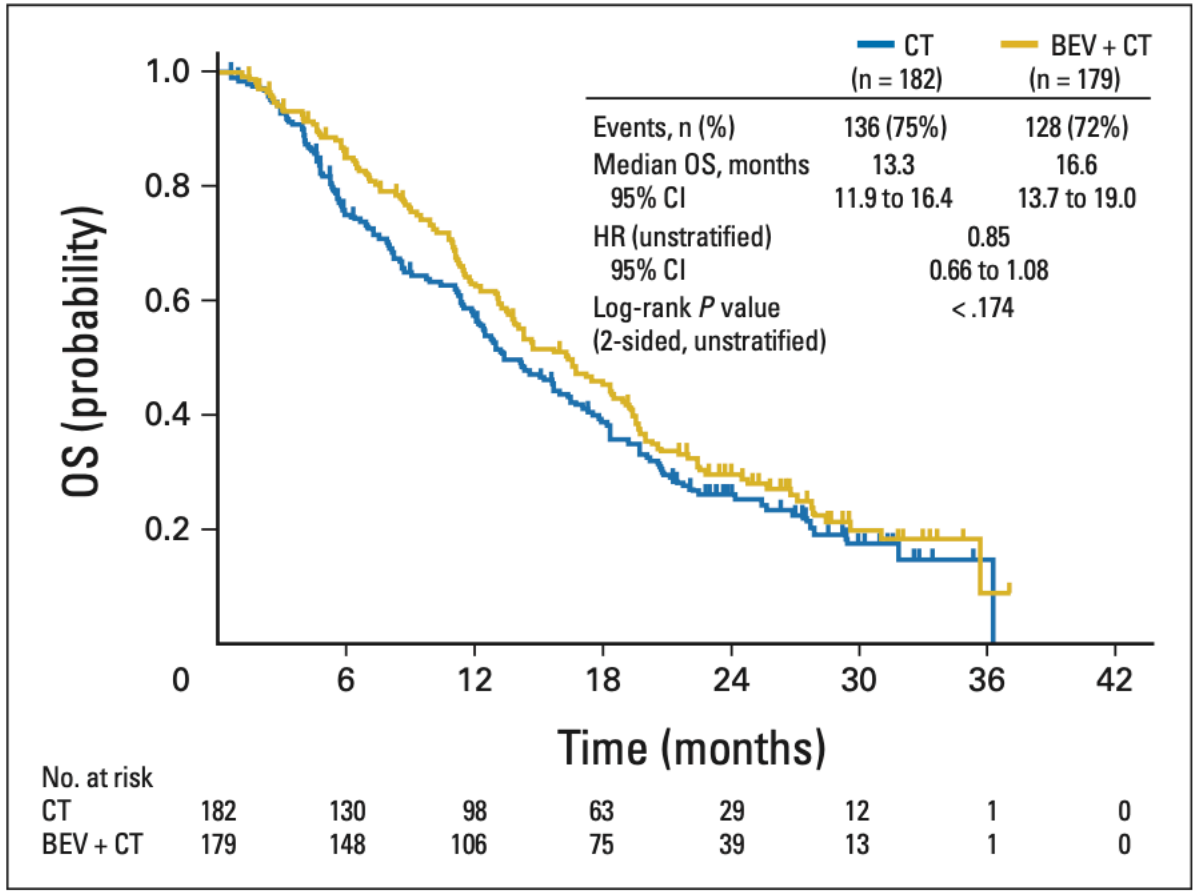
Author	Agents	N	RR (%)	TTP (months)	OS (months)
Ten Bokkel Huinink	Topotecan	112 (60 PR)	13%	5.3	14.2
	Paclitaxel	114 (59 PR)	7%	3.2	10.0
Gordon	Topotecan	235 (124 PR)	8%	3.2	9.5
	PLD	239 (130 PR)	16%	2.1	8.1
O'Byrne	PLD	106 (60% PR)	19%	5.1	10.9
	Paclitaxel	107 (63% PR)	24%	5.1	13.0
Vermorken	Oxaliplatin	79 (51 PR)	4%	–	–
	Topotecan	79 (53 PR)	6%	–	–
Ferrandina	PLD	76 (43 PR)	16%	3.7	13.0
	Gemcitabine	77 (43 PR)	29%	4.6	1.9
Mutch	PLD	96 PR	6%	3.6	12.7
	Gemcitabine	99 PR	8%	3.1	13.5
Sehouli	Topotecan	97 PR	14%	4.4	9.6
	Topotecan weekly	97 PR	7%	3.0	9.3

RR 6%-14%

González-Martín A, Ann Oncol 24(s10):48-52, 2013

AURELIA

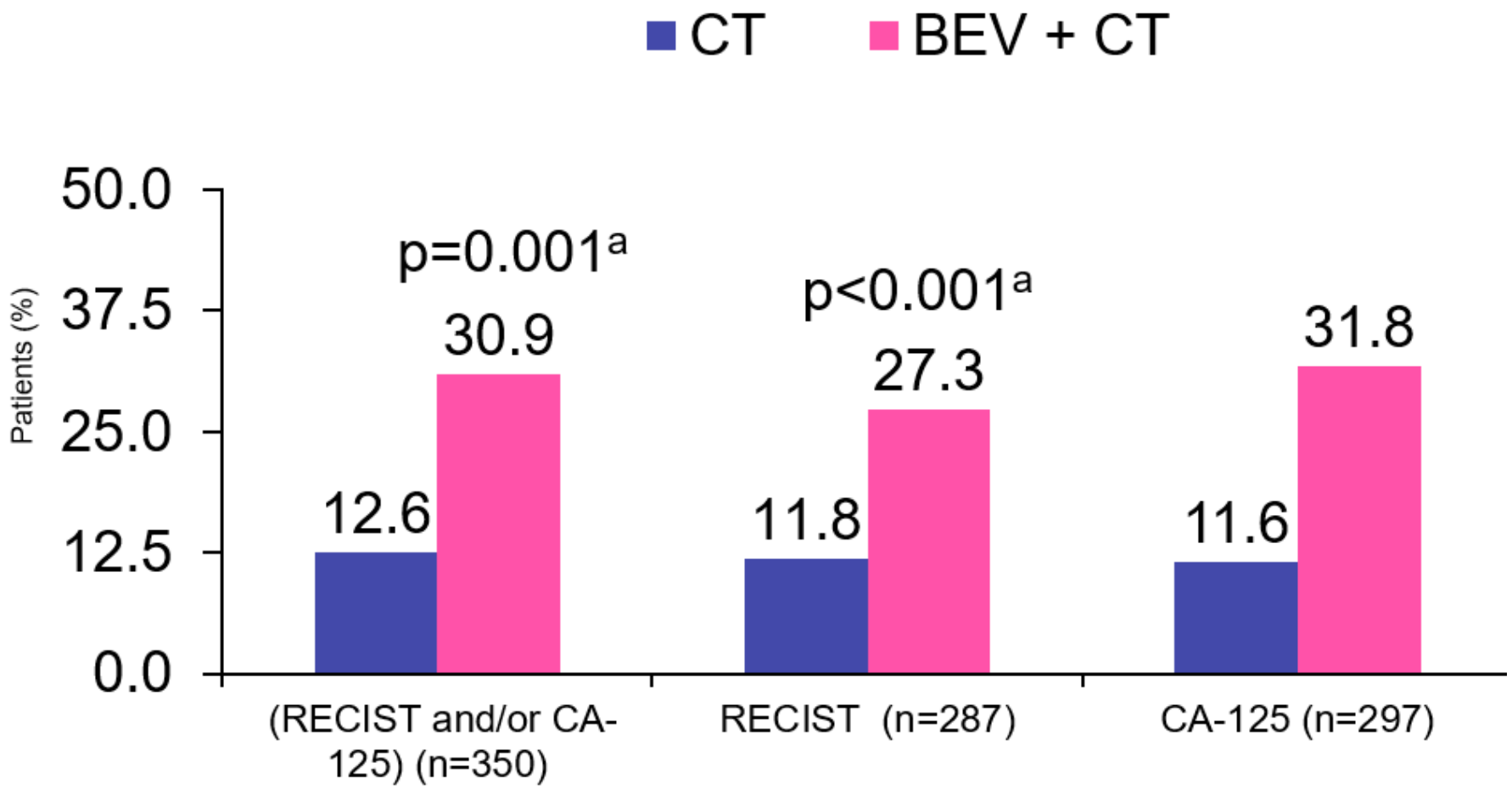




Abbreviations: BEV, bevacizumab; CT, chemotherapy;

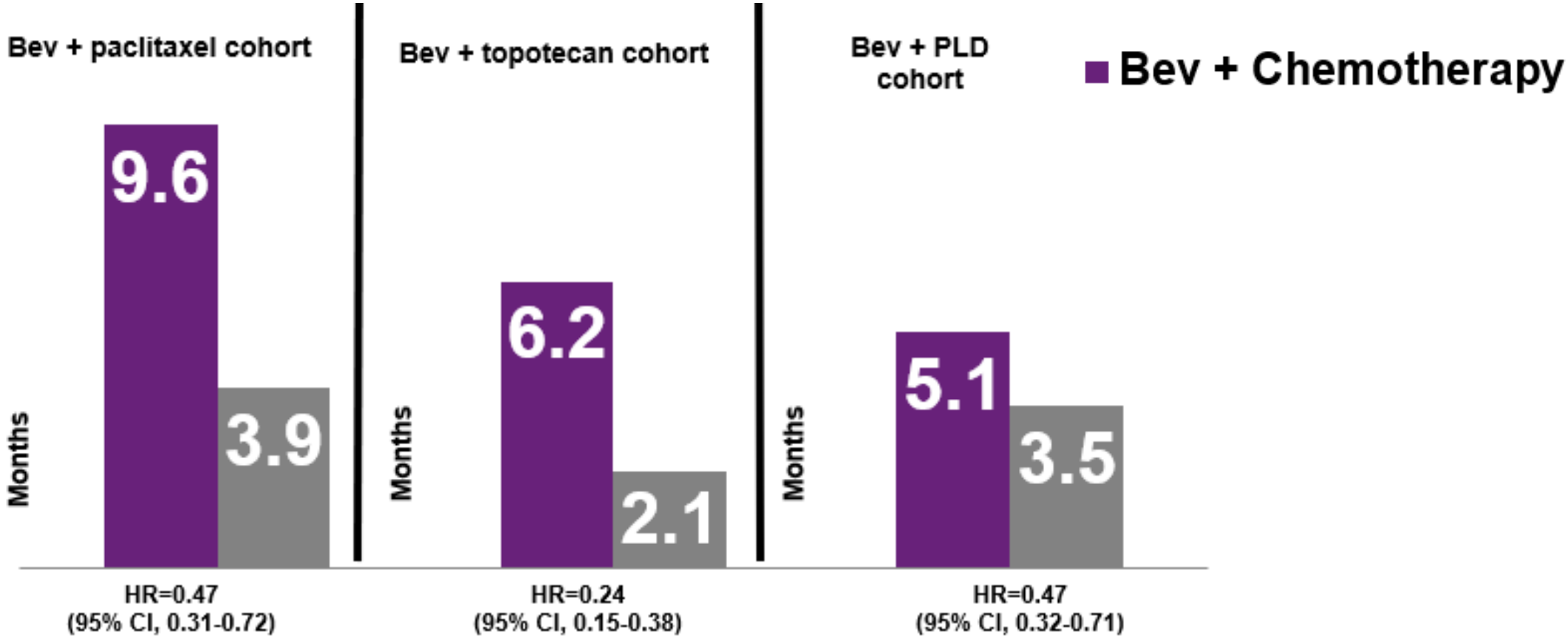
Pujade-Lauraine E, J Clin Oncol 32(13):1302, 2014. ClinicalTrials.gov NCT00976911.

AURELIA:
Summary of best overall response rates



Pujade-Lauraine E, J Clin Oncol 32(13):1302, 2014 ClinicalTrials.gov NCT00976911.

AURELIA: Summary of Median PFS Outcomes in Chemotherapy Cohorts

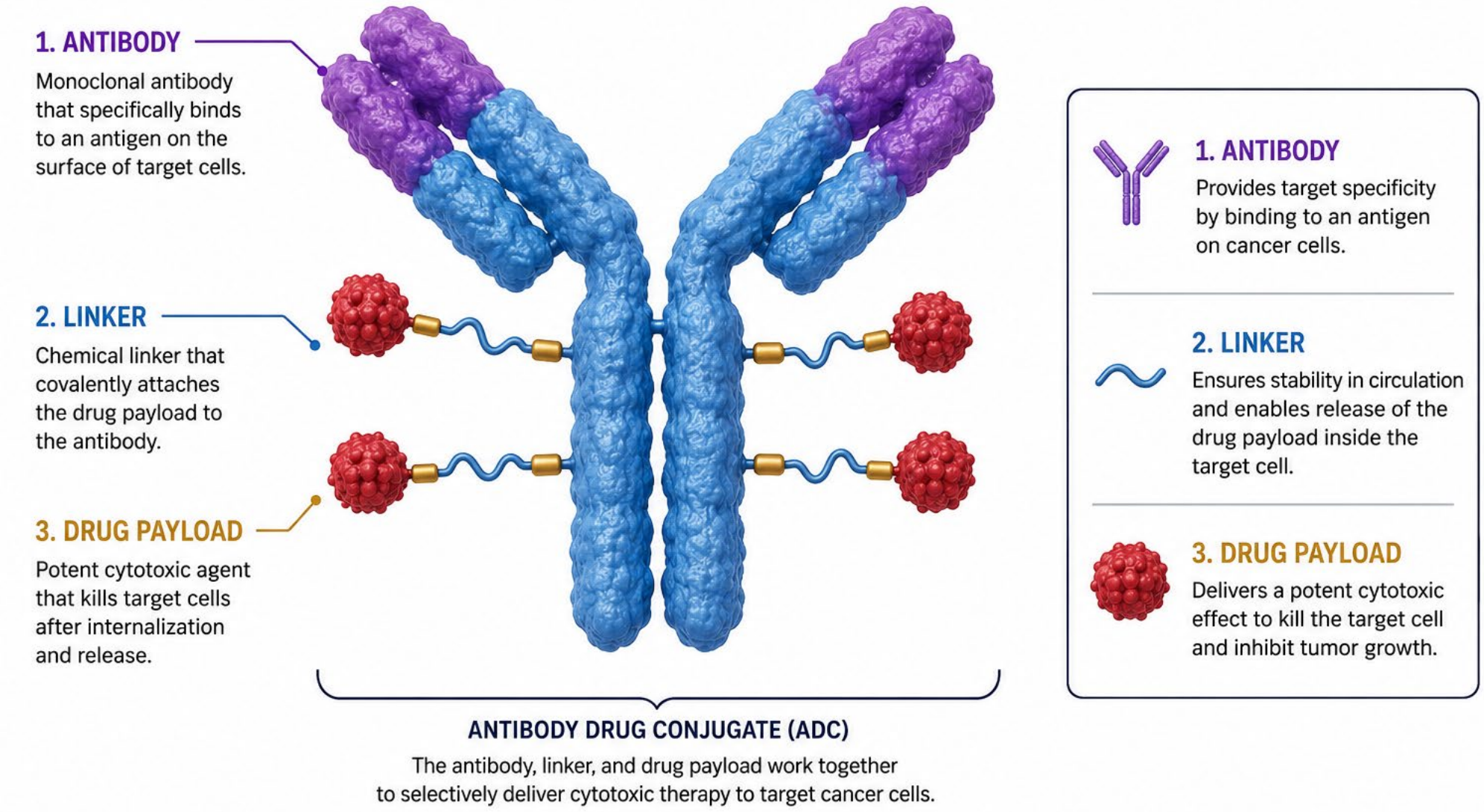


Cohort analysis was exploratory. This analysis was not designed to evaluate statistical significance between treatment arms or compare among the three chemotherapy cohorts

PLD=pegylated liposomal doxorubicin.

Pujade-Lauraine E, J Clin Oncol 32(13):1302, 2014. ClinicalTrials.gov NCT00976911.

Components of Antibody Drug Conjugate (ADC)



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Safety and efficacy of mirvetuximab soravtansine, a folate receptor alpha (FRα)-targeting antibody-drug conjugate (ADC), in combination with bevacizumab in patients with platinum-resistant ovarian cancer

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Mirvetuximab + Bev in PROC with FOLR1 25% - 100%

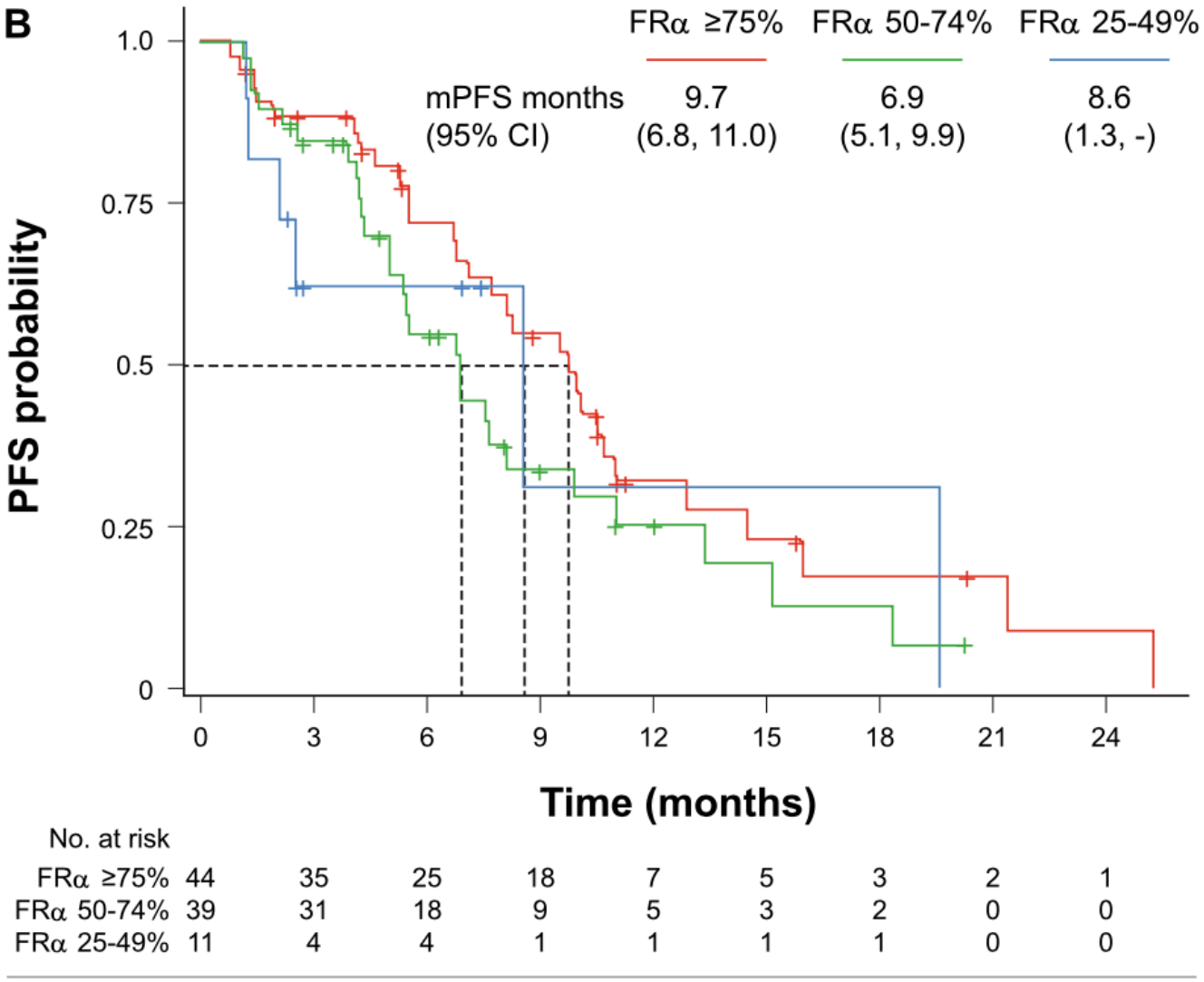
Table 1
Patient demographics and baseline characteristics.

Characteristic	$N = 94$
Age, years	
Median (range)	62 (39–81)
Primary diagnosis, n (%)	
Epithelial ovarian cancer	72 (77)
Fallopian tube cancer	17 (18)
Primary peritoneal cancer	5 (5)
ECOG PS, n (%)	
0	60 (64)
1	34 (36)
No. of prior systemic therapies, n (%)	
1–2	45 (48)
≥3[a]	49 (52)
FRα expression,[b] n (%)	
≥75%	44 (47)
50–74%	39 (42)
25–49%	11 (12)
Prior exposure, n (%)	
Taxane	91 (97)
Bevacizumab	55 (59)
PARP inhibitor	25 (27)

Almost 50% were FOLR1 high

Abbreviations: Bev, bevacizumab; FRα, folate receptor alpha; PARPi, poly(ADP-ribose) polymerase inhibitor; PROC, platinum-resistant ovarian cancer.
Gilbert L, et al. Gynecol Oncol,2023;170:241. Clinicaltrials.gov, NCT0260630

Mirvetuximab: PFS by FOLR1 Expression in PROC



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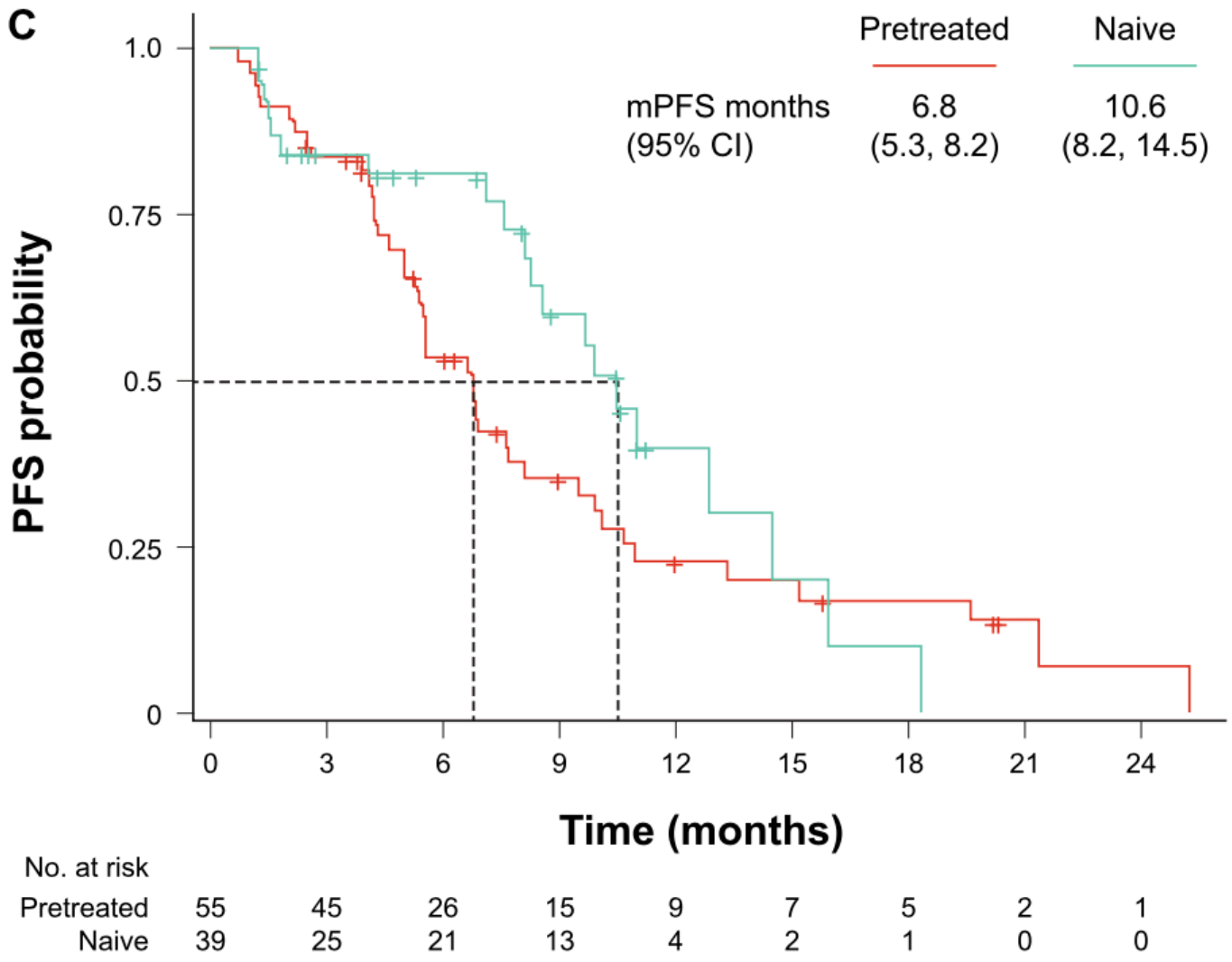
Mirvetuximab: PFS by prior Bev Exposure in PROC



Gilbert L, et al. Gynecol Oncol,2023;170:241. Clinicaltrials.gov, NCT0260630

Mirvetuximab in PROC: RR by Expression

Table 3
Summary of efficacy in patients by subgroups.

Endpoint	FRα ≥ 75% *(n = 44)*	FRα 50–74% *(n = 39)*	FRα 25–49% *(n = 11)*	BEV-naïve *(n = 39)*	BEV-pretreated *(n = 55)*
Confirmed objective response rate, n (%)	21 (48)	16 (41)	4 (36)	22 (56)	19 (35)
95% CI	(33, 63)	(26, 58)	(11, 69)	(40, 72)	(22, 49)
Median duration of response, (months)	9.7	9.7	18.5	10.4	9.7
95% CI	(6.0, 12.0)	(3.0, NR)	(NE)	(6.9, 14.5)	(4.2, NR)
Median progression-free survival, (months)	9.7	6.9	8.6	10.6	6.8
95% CI	(6.8, 11.0)	(5.1, 9.9)	(1.3, NR)	(8.2, 14.5)	(5.3, 8.2)

Abbreviations: RR, response rate.
Gilbert L, et al. Gynecol Oncol,2023;170:241. Clinicaltrials.gov, NCT0260630

MIRASOL (NCT04209855 – Study Design[1,2]

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

Patient Population
(N=453)

Enrollment and Key Eligibility
Platinum-resistant disease
(PFI ≤6 mo)

FRα detected by IHC with PS2+ intensity among ≥75% of viable tumor cells

1º platinum-refractory disease excluded (primary PFI <3 mo)

1-3 prior lines of therapy

Prior BEV and PARPi allowed

Patients with BRCA mutations allowed

1:1 Randomization

Treatment Regimen-Experimental

MIRV
(6 mg/kg AIBW Q3W)

Treatment Regimen-Control

Investigator's Choice Chemotherapy
(Paclitaxel, PLD, or Topotecan)

Stratification Factors
IC chemo: paclitaxel, PLD, or topotecan
Prior lines of therapy: 1 vs 2 vs 3

Primary Endpoint

PFS by INV
(BICR for sensitivity analysis)

Secondary Endpoints

ORR by INV
OS
PROs[a]
Safety and tolerability
DOR
CA-125 response[b]
PFS2

AIBW, adjusted ideal body weight; BEV; bevacizumab; BICR, blinded independent central review; BRCA, BReast CAncer gene; CA-125, cancer antigen 125; chemo, chemotherapy; DOR, duration of response; FRα, folate receptor alpha; IC, investigator's choice; IHC, immunohistochemistry; INV, investigator; MIRV, mirvetuximab soravtansine; ORR, objective response rate; OS, overall survival; PARPi, poly (ADP-ribose) polymerase inhibitors; PFI, platinum-free interval; PFS, progression-free survival; PFS2, time from randomization until second disease progression; PLD, pegylated liposomal doxorubicin; PROs, patient-reported outcomes; PS2+, positive staining intensity ≥2; Q3W, every 3 weeks.
[a]PROs will be measured using the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire, 28-item Ovarian Cancer Module (OV28) study instrument.
[b]Gynecological Cancer InterGroup (GCIG) criteria.

1. ClinicalTrials.gov identifier: NCT04209855. Updated June 16, 2022. Accessed October 5, 2022. https://clinicaltrials.gov/ct2/show/NCT04209855
2. Moore K, et al. Presented at: 2020 American Society of Clinical Oncology Annual Meeting; May 29-31, 2020; Virtual. Abstract TPS6103.

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Baseline Demographics (N=453)

Characteristics		MIRV (n=227)	IC Chemo (n=226)
Age, median (range)	Age in years	63 (32-88)	62 (29-87)
Stage at initial diagnosis, n (%)[a]	I-II III IV	9 (4) 137 (60) 76 (33)	9 (4) 147 (65) 65 (29)
BRCA mutation, n (%)	Yes No/Unknown	29 (13) 198 (87)	36 (16) 190 (84)
No. of prior systemic therapies, n (%)	1 2 3	29 (13) 90 (40) 108 (48)	34 (15) 88 (39) 104 (46)
Prior exposure, n (%)	Bevacizumab PARPi Taxanes	138 (61) 124 (55) 227 (100)	143 (63) 127 (56) 224 (99)
Primary platinum-free interval, n (%)[b]	≤ 12 months > 12 months	146 (64) 80 (35)	142 (63) 84 (37)
Platinum-free interval, n (%)[c]	≤ 3 months > 3 - ≤6 months	88 (39) 138 (61)	99 (44) 124 (55)

Data cutoff: March 6, 2023
BRCA, BReast cancer gene; PARPi, poly (adenosine diphosphate [ADP]-ribose) polymerase inhibitor.
[a]Five patients (2%) in the MIRV arm and five patients in the IC chemo arm (2%) were missing information for stage at initial diagnosis. [b]One patient (<1%) in the MIRV arm was missing information on primary platinum-free interval.
[c]One patient (<1%) in the MIRV arm and 3 patients (1%) in the IC chemo arm enrolled with platinum-free interval of >6 months

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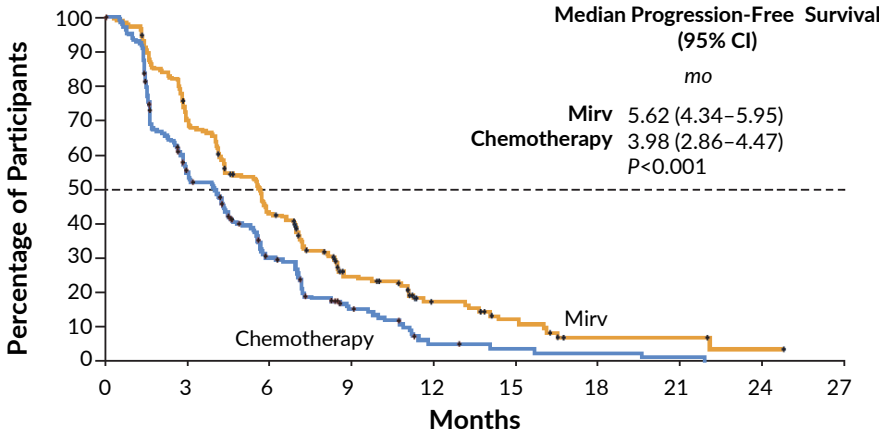
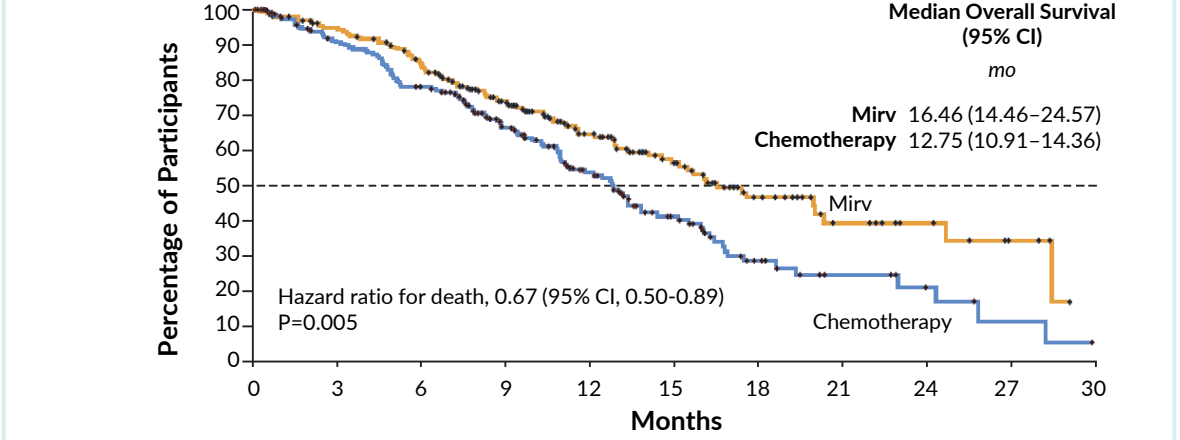
MIRASOL | Efficacy

Progression-Free Survival



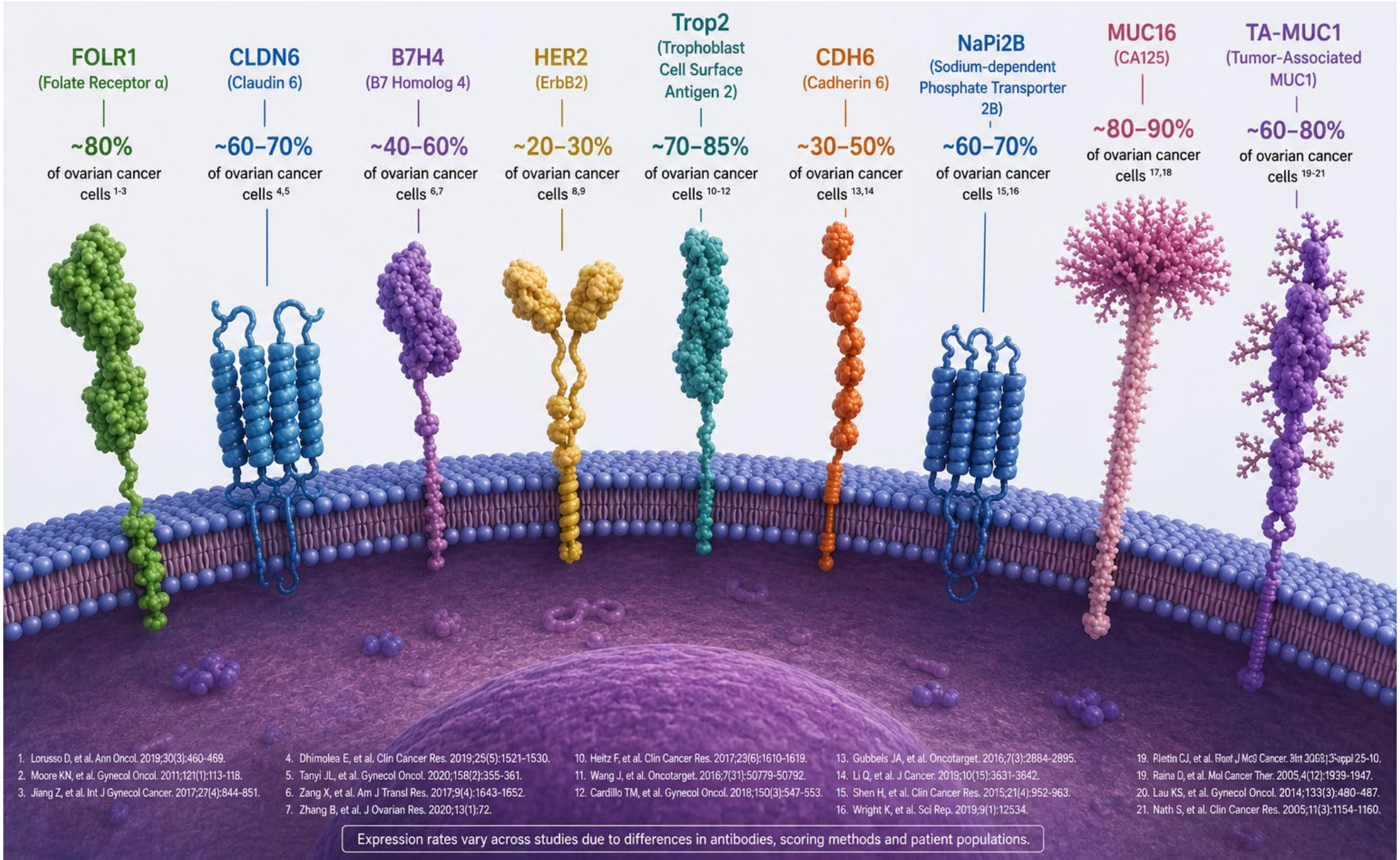
Overall Survival



Best Overall Response, n (%)	Mirv (n=227)	Chemotherapy (n=226)
ORR	96 (42)	36 (16)
CR	12 (5)	0
PR	84 (37)	36 (16)
SD	86 (38)	91 (40)
PD	31 (14)	62 (27)
NE	14 (6)	37 (16)

- CI, confidence interval; CR, complete response; Mirv, mirvetuximab soravtansine; NE, not evaluable; ORR, objective response rate; PD, progressive disease; PR, partial response; SD, stable disease.
- Moore KN, et al. *New Engl J Med.* 2023;389(23):2162–2174.

Ovarian Cancer Cell Surface Targets and Reported Expression



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Expression rates vary across studies due to differences in antibodies, scoring methods and patient populations.


FRα
Mirvetuximab soravtansine-gynx, (FRα DM4 ADC)
MAYTANSINOID (DM4)
FRα
IMGN151 (FRα DM21 ADC)
MAYTANSINOID (DM21)
FRα
ZW191 (FRα Top1i ADC)
TOP1 INHIBITOR (DXd)
HER2
Fam-trastuzumab deruxtecan-nxki, Enhertu, T-DXd (HER2 Top1i ADC)
TOP1 INHIBITOR (DXd)
TROP2
SHRA-1921 (TROP2 Top1i ADC)
TOP1 INHIBITOR (DXd)
CDH6
Raludotatug deruxtecan, R-DXd (CDH6 Top1i ADC)
TOP1 INHIBITOR (DXd)
B7H4
AZD8205, Puxitatug samrotecan (B7H4 Top1i ADC)
TOP1 INHIBITOR (DXd)
B7H3
Ifinatamab deruxtecan (B7H3 Top1i ADC)
TOP1 INHIBITOR (DXd)
FRα
Luvetiamab tazevibulin, Luvelta, STRO-002 (FRα hemiasterlin ADC)
MICROTUBULE DISRUPTOR (HEMIASTERLIN)
FRα
Torvutatug samrotecan, AZD5335 (FRα Top1i ADC)
TOP1 INHIBITOR (DXd)
FRα
CBP1008 (FRα/TRPV6 bi-specific MMAE ADC)
TUBULIN INHIBITOR (MMAE)
HER2
Disitamab vedotin, RC48, Aidexi (HER2 MMAE ADC)
TUBULIN INHIBITOR (MMAE)
TROP2
BNT325/DB-1305 (TROP2 Top1i ADC)
TOP1 INHIBITOR (DXd)
CDH6
CUSP06 (CDH6 Top1i ADC)
TOP1 INHIBITOR (DXd)
B7H4
SGNB-7H4V (B7H4 MMAE ADC)
TUBULIN INHIBITOR (MMAE)
CLDN6
TORL-1-23 (CLDN6 MMAE ADC)
TUBULIN INHIBITOR (MMAE)
FRα
Rinatabart sesutecan, Rina-S™, GEN1184 (FRα Top1i ADC)
TOP1 INHIBITOR (DXd)
FRα
BAT8006 (FRα Top1i ADC)
TOP1 INHIBITOR (DXd)
NaPi2b
TUB-0400 (NaPi2b Exatecan ADC)
TUBULIN INHIBITOR (EXETECAN)
HER2
JSKN003 (HER2 Top1i ADC)
TOP1 INHIBITOR (DXd)
TROP2
Sacituzumab tirumotecan, sac-TMT, SKB264/MK-2870 (TROP2 Top1i ADC)
TOP1 INHIBITOR (TOP1i)
CDH6
SIM-0505 (CDH6 Top1i ADC)
TOP1 INHIBITOR (DXd)
B7H4
LNCB74 (B7H4 MMAE ADC)
TUBULIN INHIBITOR (MMAE)
FRα
Farletuzumab ecteribulin, FZEC (formerly MORAb-202) (FRα eribulin ADC)
MICROTUBULE DISRUPTOR (ERIBULIN)
FRα
LY4170156 Sofetabart mipitecan (FRα Top1i ADC)
TOP1 INHIBITOR (TOP1i)
EGFR x HER3
Izalontamab brengitecan, iza-bren, BL-B01D1 (EGFR x HER3 TOP1i ADC)
TOP1 INHIBITOR (TOP1i)
TROP2
Datopotamab deruxtecan, Datroway, Dato-DXd (TROP2 Top1i ADC)
TOP1 INHIBITOR (DXd)
TROP2
Sacituzumab govitecan, Trodelvy (TROP2 SN38 ADC)
TOP1 INHIBITOR (SN38)
MSLN
RC88 (MSLN MMAE ADC)
TUBULIN INHIBITOR (MMAE)
B7H4
GSK5733584 (B7H4 Top1i ADC)
TOP1 INHIBITOR (TOP1i)
WARHEAD (PAYLOAD) CLASS
TOP1 INHIBITOR (DXd / TOP1i)
TOP1 INHIBITOR (SN38)
TUBULIN INHIBITOR (MMAE)
MICROTUBULE DISRUPTOR (HEMIASTERLIN)
MICROTUBULE DISRUPTOR (ERIBULIN)
MAYTANSNIOID (DM4 / DM21)
TUBULIN INHIBITOR (EXETECAN)
Top1i = Topoisomerase I inhibitor

Mechanisms of Resistance to Chemotherapy

Cancer cells acquire diverse strategies to survive and proliferate despite chemotherapy exposure

1. INCREASED DRUG EFFLUX

- Overexpression of ATP-binding cassette (ABC) transporters (e.g., P-gp, MRP1, BCRP)
- Reduced intracellular drug accumulation

2. ALTERED DRUG TARGETS

- Mutations or alterations in drug targets
- Reduced drug binding and efficacy

3. ENHANCED DNA DAMAGE REPAIR

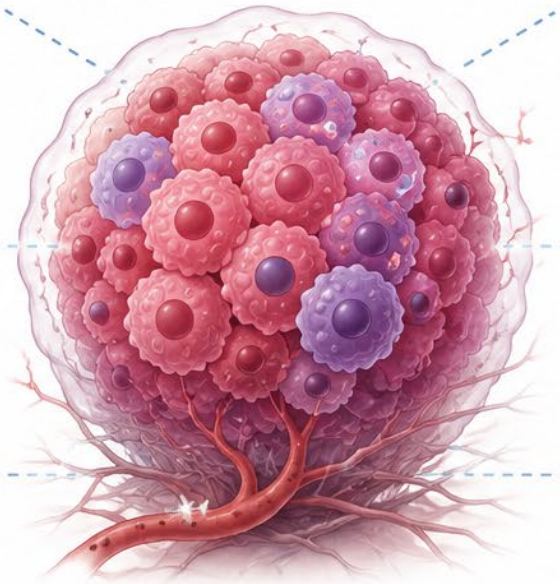
- Upregulation of DNA repair pathways (e.g., NER, HR, NHEJ)
- Restoration of DNA integrity and cell survival

4. EVASION OF APOPTOSIS

- Dysregulation of pro- and anti-apoptotic proteins (e.g., ↑ BCL-2, ↓ BAX)
- Increased cell survival despite damage

HETEROGENEOUS TUMOR

Different clones, different vulnerabilities



RESULT:

Treatment failure, relapse, and disease progression

5. DRUG INACTIVATION

- Increased expression of drug-metabolizing enzymes (e.g., GST, CYPs)
- Direct inactivation of chemotherapeutic agents

6. ALTERED CELL CYCLE CHECKPOINTS

- Loss or adaptation of checkpoint control
- Allowing survival and proliferation with damaged DNA

7. TUMOR MICROENVIRONMENT PROTECTION

- Protective niches (hypoxia, acidosis, stromal cells)
- Reduced drug penetration and activity

8. CANCER STEM CELL SUBPOPULATIONS

- Intrinsic resistance of cancer stem cells
- Self-renewal and tumor regeneration

Resistance is often multifactorial.

Combining therapies and targeting resistance pathways are key to improving patient outcomes.

STRATEGIC APPROACHES

Biomarker-driven therapy • Combination regimens • Targeting resistance pathways
Overcoming microenvironmental barriers • Eliminating cancer stem cells

NON ADC AGENTS IN DEVELOPMENT

Selective glucocorticoid receptor modulator

(relacorilant) + nab-paclitaxel

MOA: Selective glucocorticoid receptor antagonism

PD-L1

(pembrolizumab) + paclitaxel +/- bevacizumab

MOA: PD-L1 inhibitor (Immune checkpoint blockade)

Oncolytic viral immunotherapy

Olvi-Vec, olvimulogene nanivacirepvec

MOA: Oncolytic virus induces tumor cell lysis and anti-tumor immunity

IL-2 + PD-L1i

Nemvaleukin + pembrolizumab

MOA: IL-2 cytokine agonist + PD-L1 checkpoint inhibition

CHK1/2i

ACR-368, prexasertib

MOA: CHK1/2 inhibitor (Disrupts DNA damage response)

CDK2i

INCB123667

MOA: CDK2 inhibitor (Cell cycle arrest in S phase)

ATP-competitive pan-AKTi

Afuresertib + paclitaxel

MOA: Pan-AKT inhibitor (Blocks PI3K/AKT/mTOR signaling)

LIPA

ERX-208

MOA: LIPA enzyme replacement (Restores lipase activity)

IL-12

IMNN-001 + paclitaxel and carboplatin

MOA: IL-12 cytokine agonist (Enhances anti-tumor immunity)

MUC16×CD3

REGN4018

MOA: Bispecific antibody (T cell engager targeting MUC16 and CD3)

PARP1-specific PARPi

NMS-03305293 + topotecan

MOA: PARP1 inhibitor (Inhibits DNA repair in HR-deficient cells)

mRNA bispecific mAb targeting CD3 and CLDN6

BNT142

MOA: Bispecific antibody (Recruit T cells to CLDN6+ tumor cells)

WEE1 inhibitor

AZD1775 (Azenosertib)

MOA: WEE1 kinase inhibitor (Abrogates G2/M checkpoint)

WEE1 inhibitor

SGR-3515

MOA: WEE1 kinase inhibitor (Abrogates G2/M checkpoint)

anti-VEGF mAb

BD00801 (suvemcitug)

MOA: VEGF inhibitor (Blocks angiogenesis)

MSLN × CD47 bispecific antibody

NI-1801

MOA: Bispecific antibody (Blocks CD47 "don't eat me" signal + targets MSLN)

IL-2Rβ/γ-selective IL-2 analogue

TransCon IL-2 β/γ

MOA: IL-2Rβ/γ-selective agonist (Enhances T and NK cell activity)

MECHANISM OF ACTION (MOA) LEGEND: Immune checkpoint modulation · Oncolytic virus · DNA damage response / DNA repair · Cell cycle regulation · PI3K/AKT/mTOR signaling · Enzyme replacement · Angiogenesis inhibition · Cytokine therapy · Bispecific antibody / T cell engager

Immune Checkpoint Inhibitors in Ovarian Cancer: Phase 3 Trials

1st-Line

• JAVELIN-100	(Avelumab)	CHT + IO		✗
• IMAgyn050	(Atezo)	CHT + IO + Bev		✗
• DUO-O	(Durva)	CHT + IO + Bev	+ PARPi	✗
• ATHENA Combo	(Nivo)	CHT + IO	+ PARPi	✗
• FIRST	(Dostar)	CHT + IO	+ PARPi	✗
• KEYLINK 001	(Pembro)	CHT + IO ± Bev	+ PARPi	✗

Platinum-sensitive

• ATALANTE	(Atezo)	CHT + IO + Bev		✗
• ANITA	(Atezo)	CHT + IO	+ PARPi	✗

Platinum-resistant

• JAVELIN-200	(Aveluamb)	CHT + IO		✗
• NRG GY 009	(Atezo)	CHT + IO + Bev		✗
• AGO OVAR 2.29	(Atezo)	CHT + IO + Bev		✗
• KEYNOTE-B96	(Pembro)	CHT + IO ± Bev		✔

Multiple phase 3 trials have shown no clinically meaningful activity of immune checkpoint inhibitors

Irrespective of:

- line of treatment
- Combination (Bev & PARPi)

Except in KEYNOTE B96.....

Immune Checkpoint Inhibitors in Ovarian Cancer: Phase 3 Trials

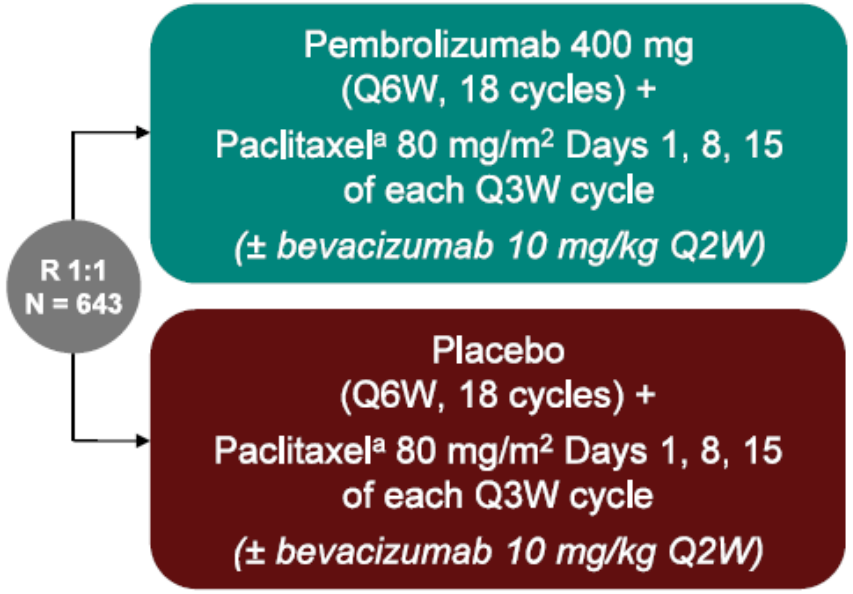
Abbreviations: *Atezo, atezolizumab; Avel, avelumab; Bev, bevacizumab; CHT, chemotherapy; Dosta, dostarlimab; Durva, durvalumab; ICI, immune checkpoint inhibitor; IO, immunotherapy; Nivo, nivolumab; PARPi, poly(ADP-ribose) polymerase inhibitor; Pembro, pembrolizumab; PLD, pegylated liposomal doxorubicin.*

NCT02718417. Monk BJ, et al. Lancet Oncol. 2021 Sep;22(9):1275-1289; NCT03038100. Moore KN, et al. J Clin Oncol. 2021;39:1842-1855; NCT03737643. Harter P, et al. Ann Oncol. 2026;37(4):503-520; NCT03522246. Monk BJ, et al. J Clin Oncol. 2022;40(34):3952-3964; NCT03602859. Hardy-Bessard AC, et al. Ann Oncol. 2025;36(12):1503-1513; NCT03740165. Powell M, et al. Gynecologic Oncology, 200, 348-349. NCT02891824. Kurtz JE, et al. J Clin Oncol. 2023;41(30):4768-4778; NCT03598270. González-Martín A, et al. J Clin Oncol. 2024;42(36):4294-4304; NCT02580058. Pujade-Lauraine E, et al. Lancet Oncol. 202122(7):1034-1046; NCT02839707. O'Cearbhaill R, et al. Int J Gynecol Cancer, 34A10; NCT03353831. Harter P, et al. J Clin Oncol. 2026;44(2):103-116; NCT05116189. Colombo N, et al. The Lancet, 2026; 407, 1525-1537

ENGOT-ov65/KEYNOTE-B96 Study Design

Key Eligibility Criteria

- Histologically confirmed epithelial ovarian, fallopian tube, or primary peritoneal carcinoma
- 1 or 2 prior lines of therapy; at least 1 platinum-based chemotherapy
  - Prior anti-PD-1 or anti-PD-L1, PARPi and bevacizumab permitted
- Radiographic progression within 6 months after the last dose of platinum-based chemotherapy
- ECOG PS 0 or 1



Stratification Factors

- Planned bevacizumab use (yes vs no)
- Region (US vs EU vs ROW)
- PD-L1 CPS (<1 vs 1 to <10 vs ≥10)[b]

Primary Endpoint: PFS per RECIST v1.1 by investigator

Key Secondary: OS

aDocetaxel (75 mg/m2 Q3W) may be considered in participants with severe hypersensitivity reaction to paclitaxel or an adverse event requiring discontinuation of paclitaxel after consultation with the Sponsor.
bThe combined positive score (CPS) was assessed at a central laboratory using PD-L1 IHC 22C3 pharmDx and defined as the number of PD-L1 CPS ≥1 cells (tumor cells, lymphocytes, macrophages) divided by the total number of tumor cells × 100.
Abbreviations: CPS, combined positive score; ECOG, Eastern Cooperative Oncology Group; OS, overall survival; PARPi, poly(ADP-ribose) polymerase inhibitor; PD-1, programmed cell death protein 1; PD-L1, programmed death ligand 1; PFS, progression-free survival; Q2W, every 2 weeks; Q3W, every 3 weeks; Q6W, every 6 weeks; RECIST, Response Evaluation Criteria in Solid Tumors.

Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537

Baseline Characteristics

	Pembro Arm (N = 322)	Placebo Arm (N = 321)
Age, median (range), y	62 (37–85)	61 (37–82)
Race,[a] n (%)		
White	207 (64.3)	217 (67.6)
Asian	72 (22.4)	58 (18.1)
Multiple	12 (3.7)	17 (5.3)
Black or African American	8 (2.5)	6 (1.9)
Hawaiian/Pacific Islander	1 (0.3)	1 (0.3)
PD-L1 CPS, n (%)		
<1	88 (27.3)	89 (27.7)
1 to <10	133 (41.3)	132 (41.1)
≥10	101 (31.4)	100 (31.2)
Stage at diagnosis (FIGO 2014 criteria), n (%)		
IA–IIB	24 (7.4)	26 (8.1)
III–IIIC	183 (56.9)	189 (58.9)
IVA–IVB	115 (35.7)	106 (33.0)

	Pembro Arm (N = 322)	Placebo Arm (N = 321)
ECOG PS 1, n (%)	142 (44.1)	144 (44.9)
High-grade serous histology,[b] n (%)	278 (86.3)	275 (85.7)
Bevacizumab use, n (%)	235 (73.0)	236 (73.5)
Prior lines of therapy,[c] n (%)		
1 line	121 (37.6)	113 (35.2)
2 lines	200 (62.1)	207 (64.5)
Prior anticancer therapy, n (%)		
Anti–PD-1 or PD-L1	7 (2.2)	7 (2.2)
Bevacizumab	149 (46.3)	146 (45.5)
PARP inhibitor	112 (34.8)	123 (38.3)
Platinum-free interval, n (%)		
<3 mo	137 (42.5)	161 (50.2)
≥3 to ≤6 mo	183 (56.8)	155 (48.3)
>6 mo	2 (0.6)	5 (1.6)

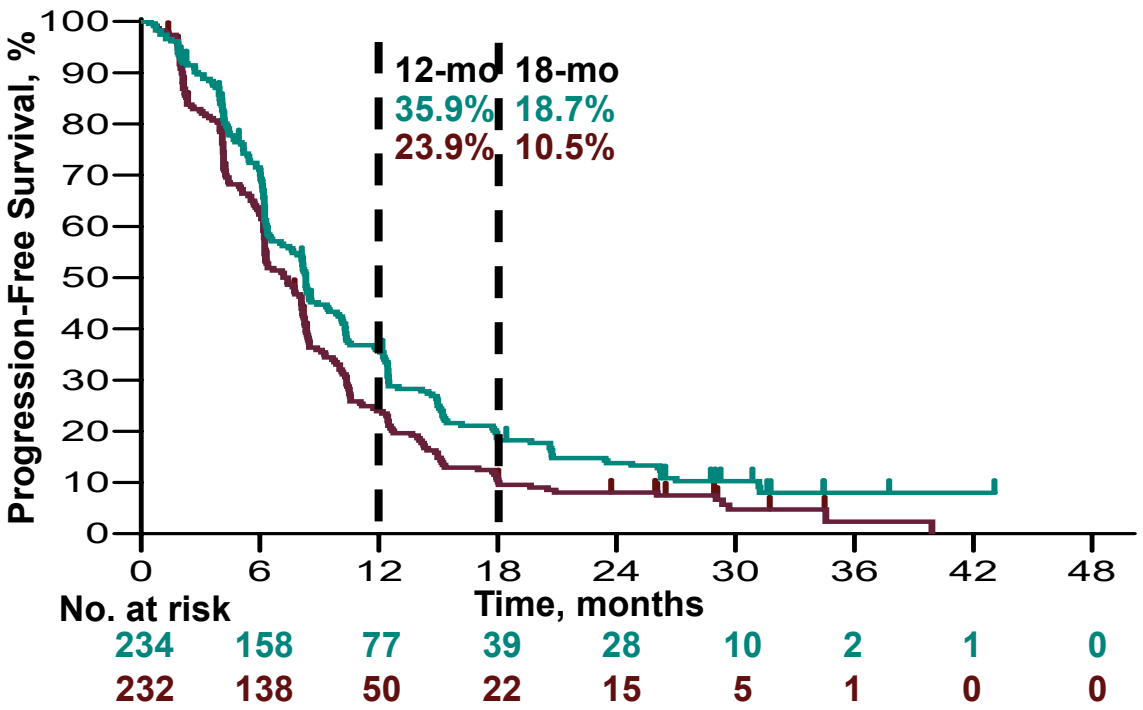
[a]44 participants had missing information for race, 22 (6.8%) in the pembro arm and 22 (6.9%) in the placebo arm. [b]Other histology subtypes in the pembro and placebo arms, respectively, were clear cell in 24 (7.5%) and 26 (8.1%), endometrioid in 9 (2.8%) and 4 (1.2%), low-grade serous in 6 (1.9%) and 10 (3.1%), carcinosarcoma in 3 (0.9%) and 5 (1.6%), and other carcinoma in 2 (0.6%) and 1 (0.3%). [c]2 participants had 3 prior lines of therapy, 1 (0.3%) in each treatment arm. Data cutoff date: September 5, 2025.

Abbreviations: CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; FIGO, International Federation of Gynecology and Obstetrics; PARPi, poly(ADP-ribose) polymerase inhibitor; PD-1, programmed cell death protein 1; PD-L1, programmed death ligand 1.

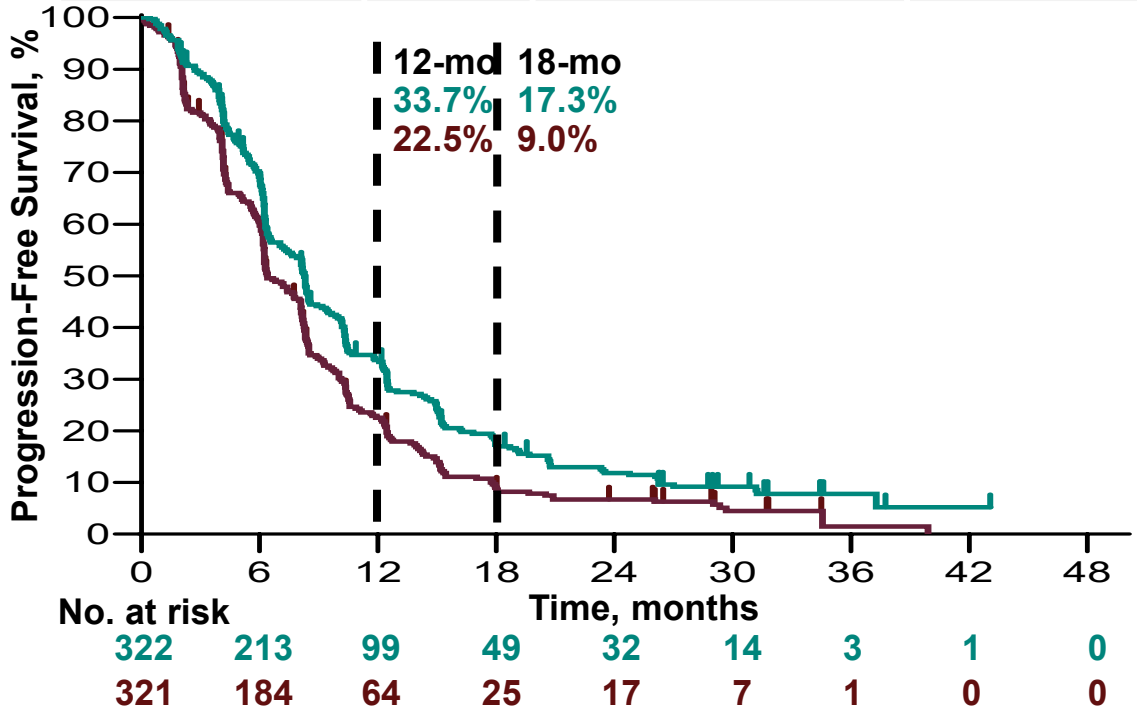
Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537

PFS in CPS ≥1 and ITT Populations at Final Analysis

CPS ≥1 Population	Events	Median, mo (95% CI)	HR[a] (95% CI)
Pembro Arm	84.6%	8.3 (7.0–9.5)	0.76 (0.62–0.93)
Placebo Arm	88.8%	7.2 (6.2–8.1)	



ITT Population	Events	Median, mo (95% CI)	HR[a] (95% CI)
Pembro Arm	85.7%	8.3 (7.2–8.6)	0.73 (0.62–0.87)
Placebo Arm	89.1%	6.4 (6.2–8.1)	



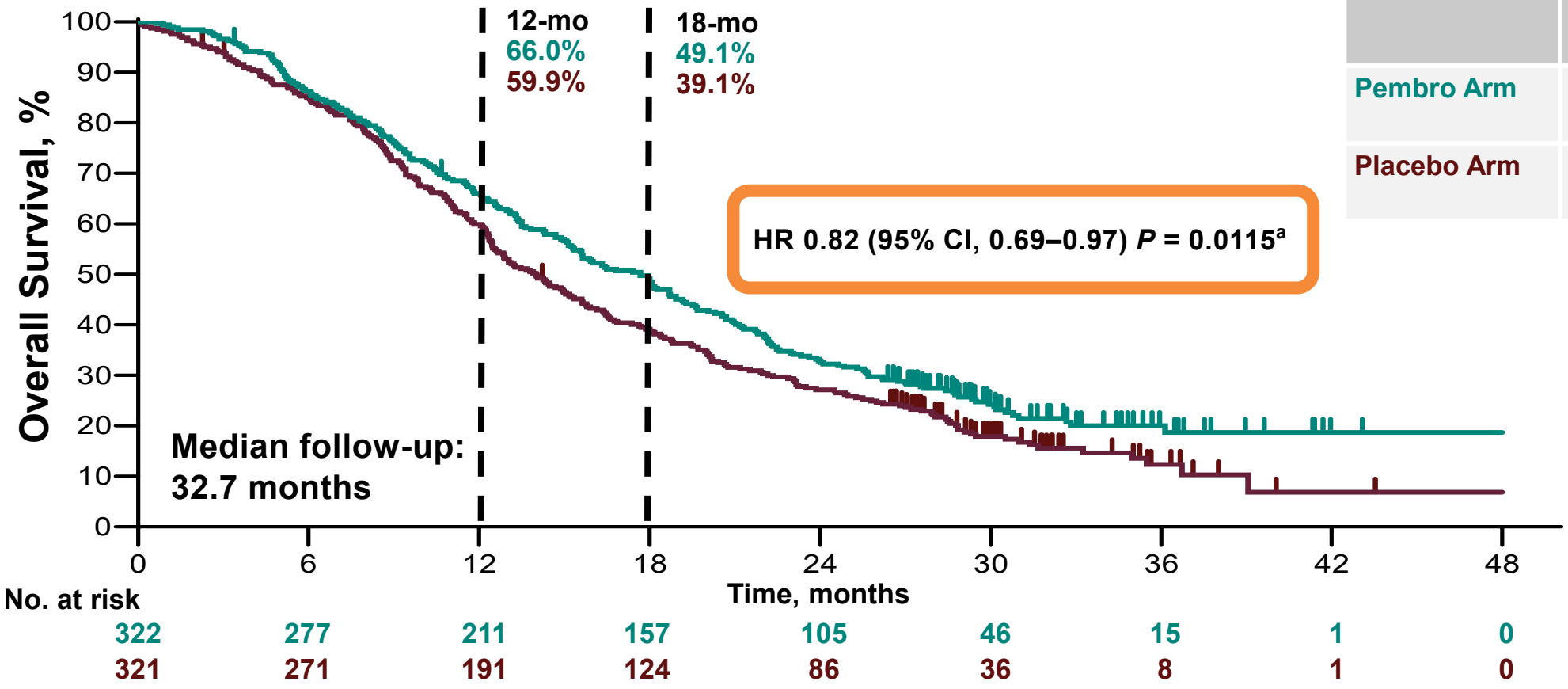
Median follow-up: 32.7 months

Response assessed per RECIST v1.1 by investigator review. [a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

Abbreviations: CPS, combined positive score; HR, hazard ratio; ITT, intention-to-treat; mo, months; PFS, progression-free survival

Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537.

OS in ITT Population at Final Analysis

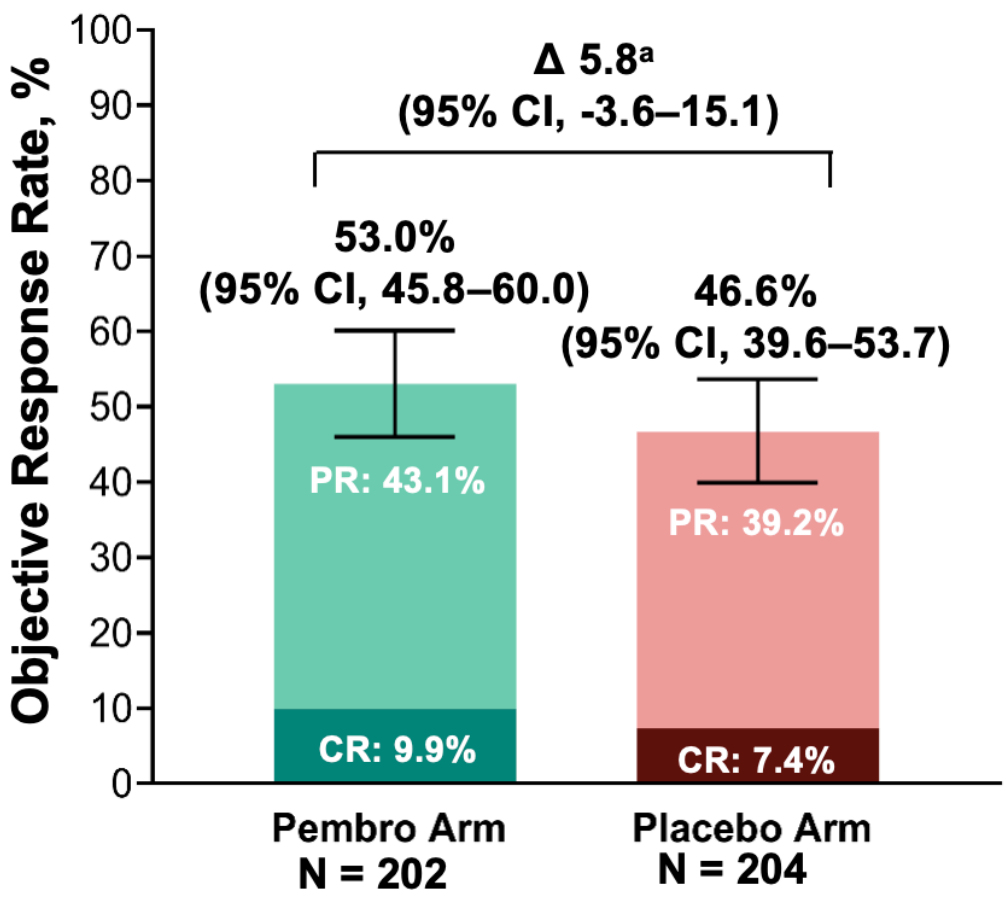


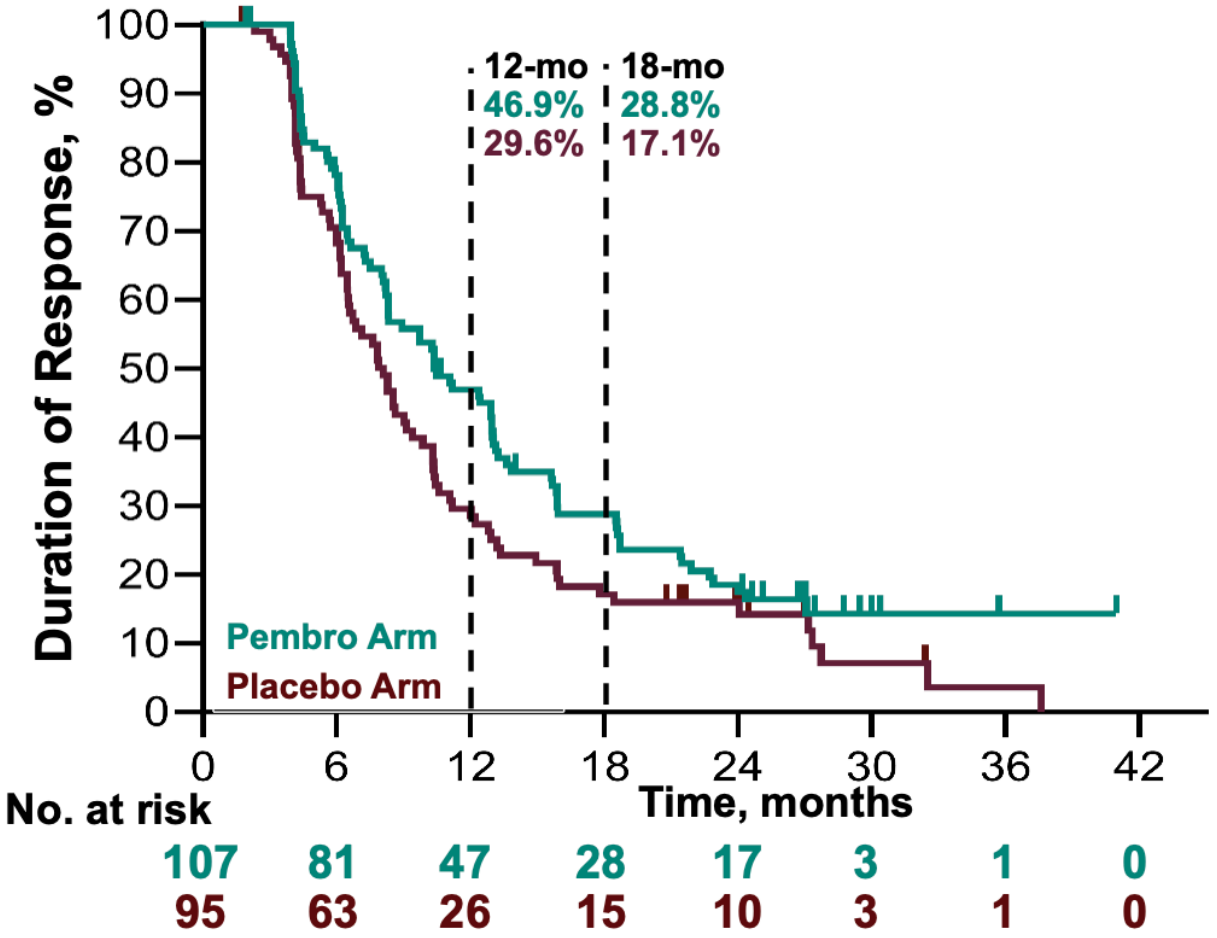
	Pts w/ Event	Median, mo (95% CI)
Pembro Arm	76.7%	17.7 (15.2–19.2)
Placebo Arm	82.9%	14.0 (12.5–15.6)

[a]*Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors. The observed p-value crossed the prespecified nominal boundary of 0.0242 at this planned final analysis. Data cutoff date: September 5, 2025.*

Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537.

ORR and DOR in CPS> Population*





* Final Analysis

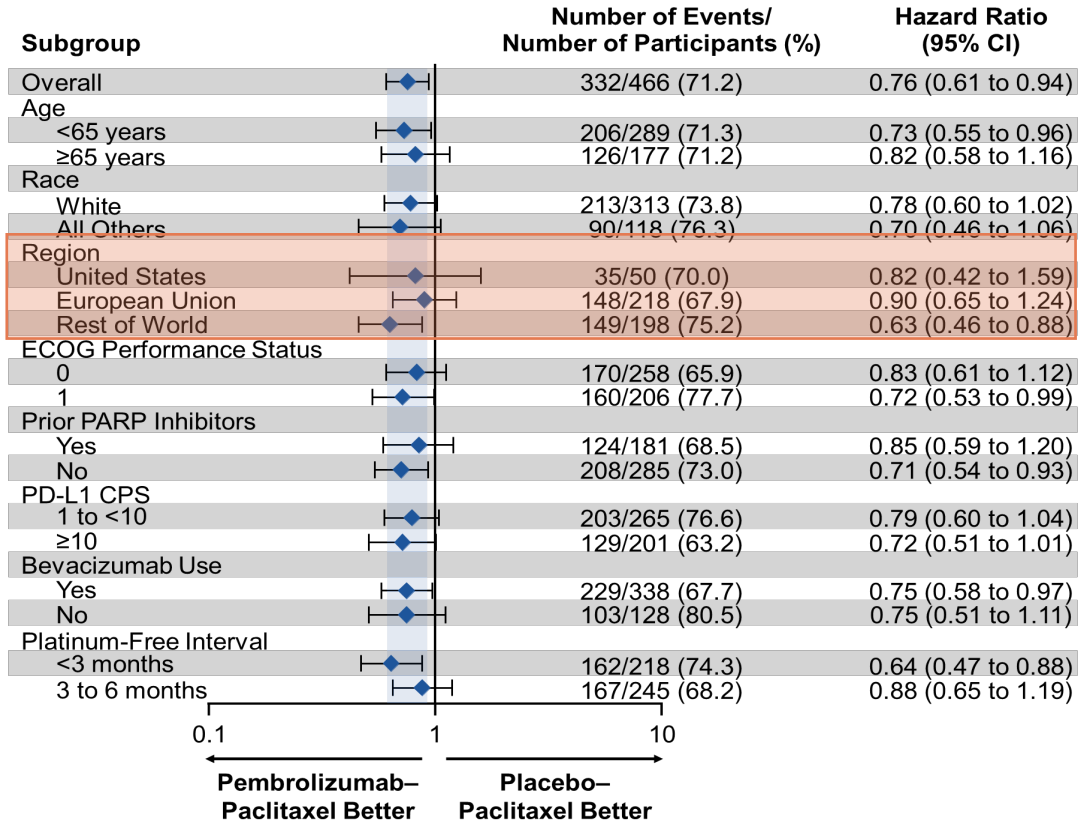
Response assessed per RECIST v1.1 by investigator review. [a]Delta estimated using Miettinen & Nurminen method stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

Abbreviations: CR, complete response; DOR, duration of response; ORR, objective response rate; PR, partial response.

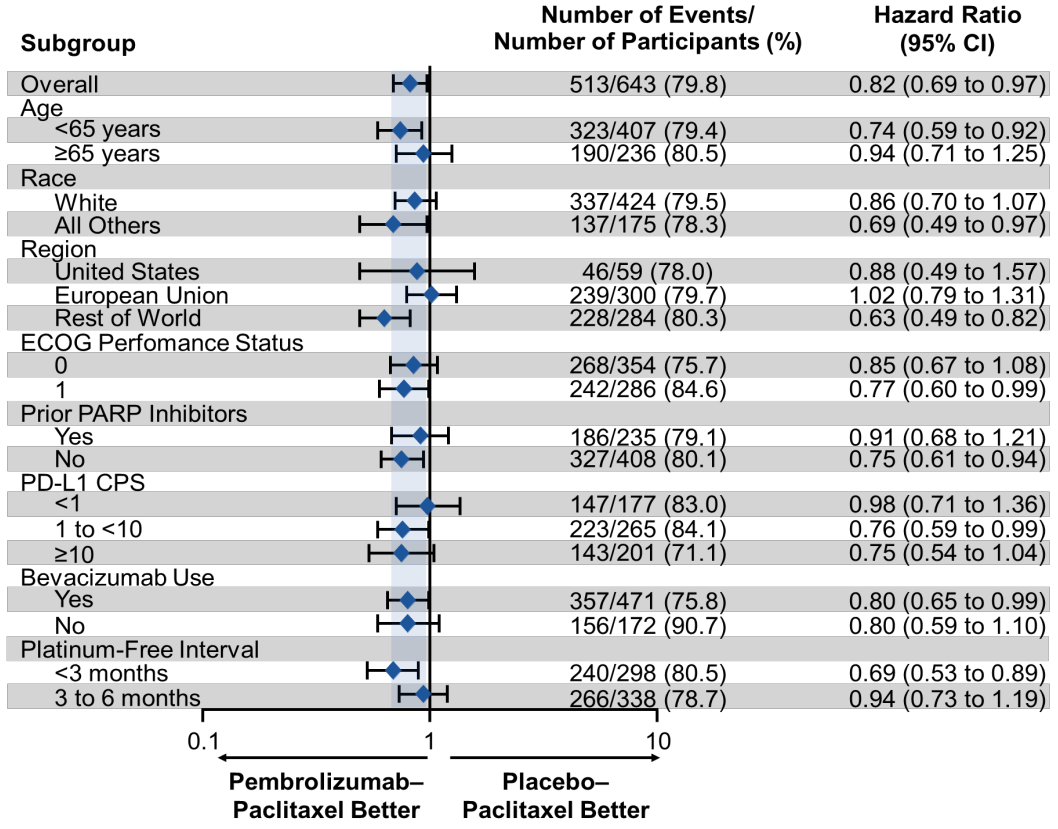
Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537.

OS in Subgroups

CPS ≥1 Population



ITT Population



Response assessed per RECIST v1.1 by investigator review. The subgroup results shown in the forest plot were based on an unstratified Cox model, so the results for CPS ≥1 may differ slightly compared with those of the primary analysis, which were based on a stratified Cox model. Data cutoff dates: March 5, 2025, for CPS ≥1 population and September 5, 2025, for the ITT population.

Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537.

Relacorilant (CORT125134): Mechanism of Action

Selective Glucocorticoid Receptor (GR) Antagonist

1. Cortisol signaling in cancer cells promotes survival and chemoresistance

Cortisol

GR

CYTOPLASM

GR

HSPs (e.g., HSP90, HSP70)

Receptor activation and dissociation from HSPs

GR

GR translocation to nucleus

NUCLEUS

GR GR

Binding to GREs (Glucocorticoid Response Elements) on DNA

Transcription of GR target genes

2. Relacorilant blocks GR activation and downstream signaling

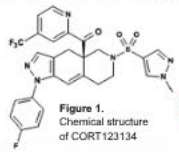


Figure 1. Chemical structure of CORT123134

Relacorilant

Relacorilant binds competitively to GR and prevents cortisol from activating the receptor

GR

Prevents GR activation, nuclear translocation and DNA binding

GR target genes induce:

- Anti-apoptotic proteins (BCL-2, BCL-XL, MCL-1)
- Survival kinases (SGK1)
- DNA repair proteins
- Cell cycle progression
- Immunosuppressive factors (TNF-α ↓, IFN-γ ↓, IL-12 ↓)

By blocking cortisol–GR signaling, relacorilant reverses survival programs and restores cancer cell sensitivity to chemotherapy and immune attack

Downstream Impact on Key Cellular Pathways

A. Apoptosis / Cell Survival

Effect of cortisol–GR signaling

- ↑ Anti-apoptotic proteins (BCL-2, BCL-XL, MCL-1)
- ↓ Pro-apoptotic proteins (BAX, BAK)
- → Apoptosis inhibited

Effect of relacorilant

- ↓ Anti-apoptotic proteins
- ↑ Pro-apoptotic proteins
- → Apoptosis restored

B. Stress & Survival Kinase Pathways

Cortisol–GR → SGK1 → AKT

Effect of cortisol–GR signaling

- ↑ SGK1
- ↑ AKT signaling
- ↑ Cell survival, proliferation and chemoresistance

Effect of relacorilant

- ↓ SGK1
- ↓ AKT signaling
- ↓ Survival signaling and chemoresistance

C. DNA Damage Response / Repair

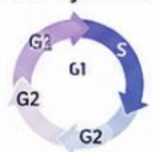
Effect of cortisol–GR signaling

- ↑ Expression of DNA repair proteins (e.g., GADD45β, ERCC1, BRCA1)
- → Enhanced DNA repair
- → Chemotherapy resistance

Effect of relacorilant

- ↓ DNA repair proteins
- → Impaired DNA repair
- → Increased DNA damage from chemotherapy

D. Cell Cycle Progression



Effect of cortisol–GR signaling

- ↑ Cyclins (D1, E)
- ↑ CDKs
- ↓ CDK inhibitors (p21, p27)
- → Cell cycle progression

Effect of relacorilant

- ↓ Cyclins, CDKs
- ↑ CDK inhibitors (p21, p27)
- → Cell cycle arrest / slowed proliferation

E. Immune Modulation (Tumor Microenvironment)

Macrophage / Immune cell

Effect of cortisol–GR signaling

- ↓ Pro-inflammatory cytokines (TNF-α, IFN-γ, IL-12)
- ↑ Anti-inflammatory cytokines (IL-10)
- → Immunosuppression

Effect of relacorilant

- ↑ Pro-inflammatory cytokines (TNF-α, IFN-γ, IL-12)
- ↓ Anti-inflammatory cytokines (IL-10)
- → Immune activity restored

Functional Outcome

With cortisol–GR signaling:

- Cancer cell survival
- Chemoresistance (e.g., to taxanes)
- Immune evasion

Relacorilant + Chemotherapy (e.g., nab-paclitaxel)

With relacorilant:

- Increased apoptosis
- Restored chemosensitivity
- Enhanced anti-tumor immunity

Improved tumor response and progression-free survival

Hunt HJ et al., J Med Chem. 2017 Apr 27;60(8):3405-3421, refer to Figure 5. Chemical structure of Compound 7 for the relacorilant structure

Hunt H et al. Clin Pharm Drug Dev. 2018 May;7(4):408-421n refer to Figure 1 Chemical structure of CORT125134

Final Overall Survival Results From the Phase 3 ROSELLA Trial: Relacorilant Plus Nab-Paclitaxel vs Nab-Paclitaxel Monotherapy in Patients With Platinum-Resistant Ovarian Cancer

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

Alexander B Olawaiye,[1] Stanislas Quesada, Lucy Gilbert, Jae-Weon Kim, Mariana Scaranti, Elena Giudice, Elizabeth Hopp, Linda Mileshkin, Toon Van Gorp, Michael E McCollum, Ana Oaknin, Aliza L Leiser, Philippe Follana, Chiara Cassani, Boglárka Balázs, Andrew Clamp, Hristina I. Pashova, Sachin G Pai, Nicoletta Colombo and Domenica Lorusso

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

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Presentation

Plain Language Summary

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

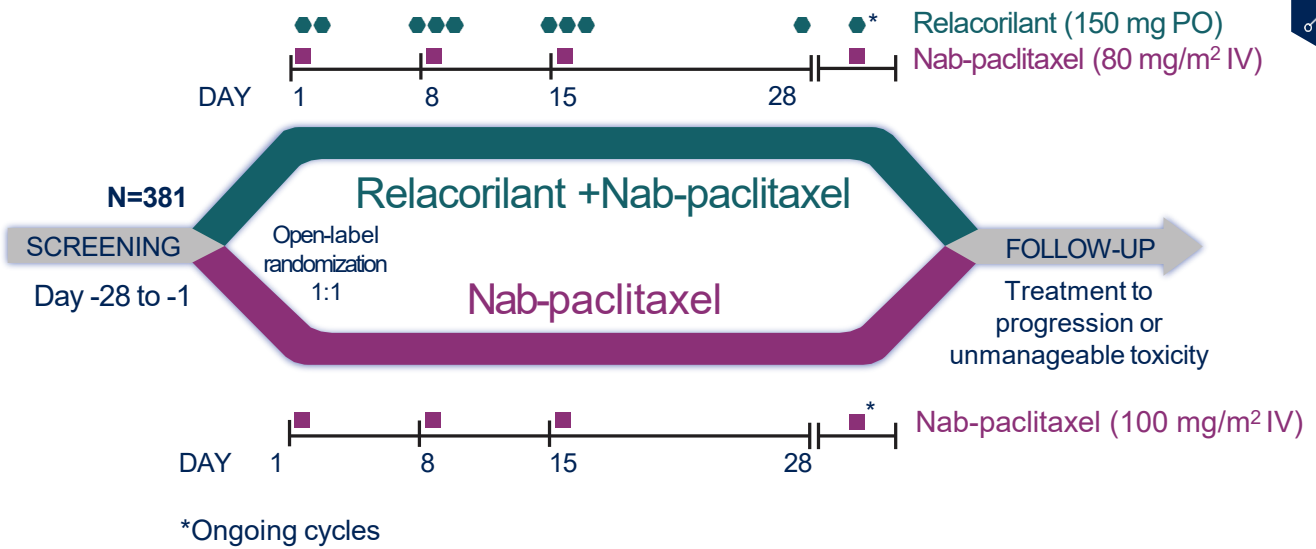
Presented By: Alexander B. Olawaiye, MD

ROSELLA | Study Schema

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

NCT05257408



Stratification Factors

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

As nab-paclitaxel does not require steroid pre-treatment, it is a rational combination partner for relacorilant, a selective glucocorticoid receptor antagonist.

Dual Primary Endpoints

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

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: Jan 5, 2023
Last patient enrolled: Apr 8, 2024
Primary results data cutoff: Feb 24, 2025
Final OS data cutoff: Jan 8, 2026
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; PO, by mouth; RECIST, Response Evaluation Criteria in Solid Tumors.

ROSELLA | Baseline Characteristics Were Well Balanced

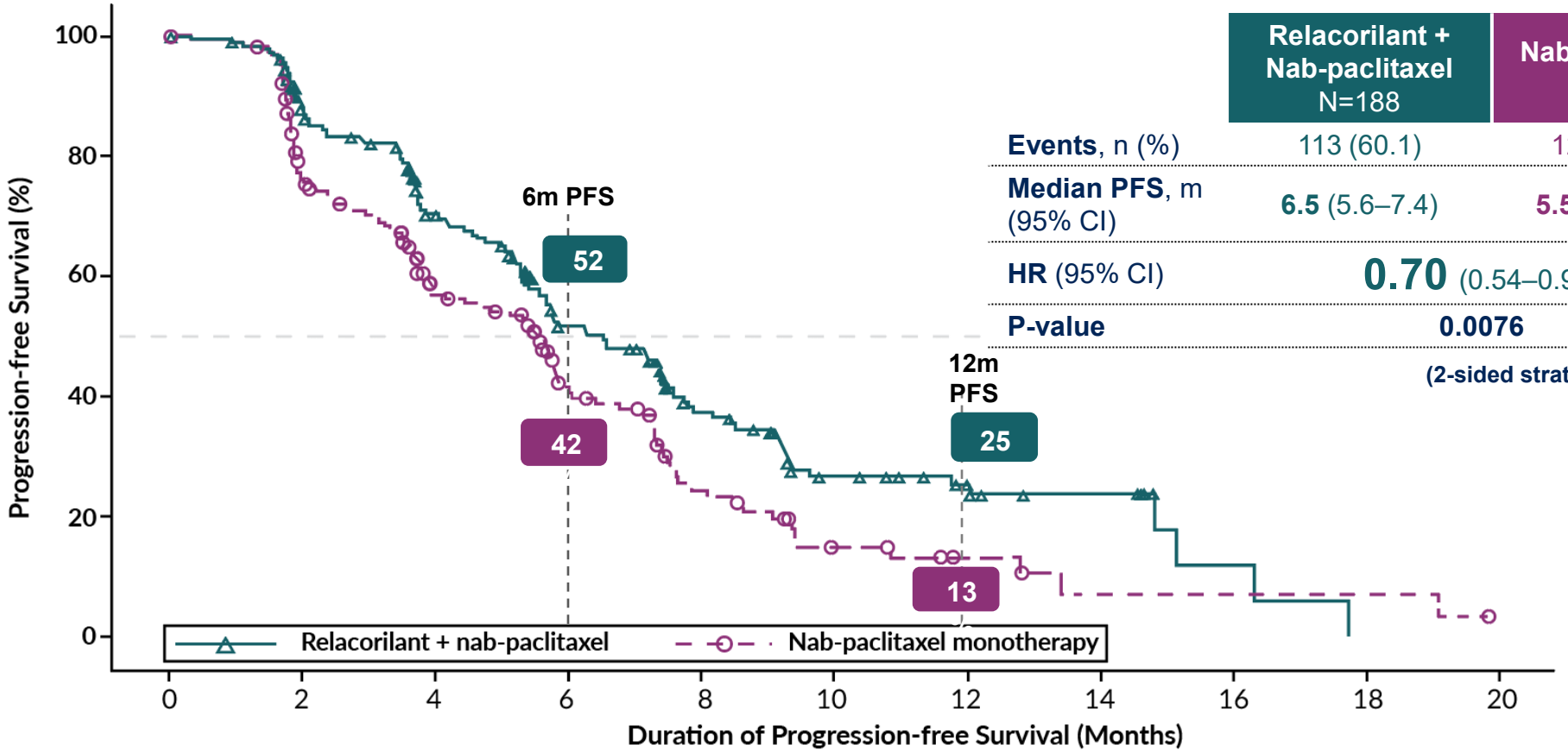
		Relacorilant + Nab-paclitaxel (N=188)	Nab-paclitaxel (N=193)
Age, median (range), years		**61** (26–85)	**62** (33–86)
Race, n (%)	White	136 **(72.3)**	135 **(69.9)**
	Black or African-American	3 **(1.6)**	2 **(1.0)**
	Asian (92% Korean)	22 **(11.7)**	26 **(13.5)**
	Other / not reported	27 **(14.4)**	30 **(15.5)**
Ethnicity, n (%)	Hispanic	16 **(8.5)**	17 **(8.8)**
Region	North America	45 **(23.9)**	45 **(23.3)**
	Europe	107 **(56.9)**	109 **(56.5)**
	Korea, Australia, and Latin America	36 **(19.1)**	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	15 **(8.0)**	18 **(9.3)**
	2	92 **(48.9)**	89 **(46.1)**
	3	81 **(43.1)**	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 therapies, n (%)	Bevacizumab	188 **(100)**	193 **(100)**
	Taxanes	187 **(99.5)**	192 **(99.5)**
	Pegylated liposomal doxorubicin	121 **(64.4)**	125 **(64.8)**
	PARP inhibitor	114 **(60.6)**	120 **(62.2)**
Prior taxane in the platinum-resistant setting, n (%)	Yes	8 **(4.3)**	7 **(3.6)**
Taxane-free interval, n (%)	≤ 6 months	22 **(11.7)**	33 **(17.1)**
	> 6 months	165 **(87.8)**	159 **(82.4)**
Taxane in the last regimen, n (%)	Yes	35 **(18.6)**	38 **(19.7)**
	No	153 **(81.4)**	155 **(80.3)**

*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; PARP, poly(ADP-ribose) polymerase.

Data cutoff: Feb 24, 2025

PRESENTED BY: Lucy Gilbert, MD, MSc, FRCOG

ROSELLA | Relacorilant Significantly Improved Progression-Free Survival Assessed by Blinded Review at the Primary Analysis



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	113 (60.1)	121 (62.7)
Median PFS, m (95% CI)	**6.5** (5.6–7.4)	**5.5** (3.9–5.9)
HR (95% CI)	**0.70** (0.54–0.91)	
P-value	**0.0076**	

(2-sided stratified log-rank test)

No. at risk (events/cumulative events)

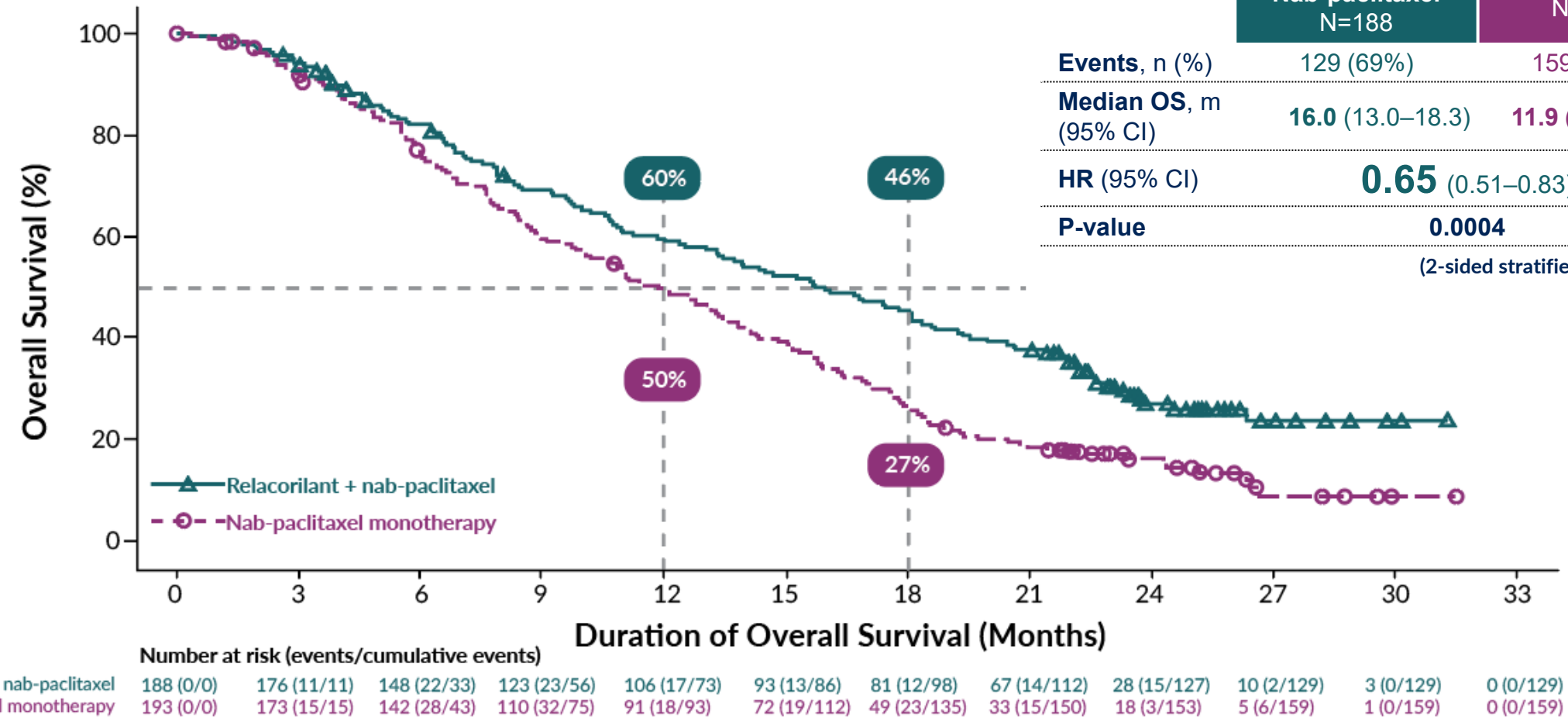
Relacorilant + nab-paclitaxel	188 (0/0)	151 (22/22)	109 (29/51)	70 (27/78)	43 (18/96)	24 (11/107)	16 (1/108)	11 (1/109)	2 (2/111)	0 (2/113)	
Nab-paclitaxel monotherapy	193 (0/0)	129 (42/42)	85 (31/73)	47 (20/93)	21 (17/110)	9 (7/117)	5 (1/118)	2 (2/120)	2 (0/120)	2 (0/120)	0 (1/121)

Data cutoff: Feb 24, 2025

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.
CI, confidence interval; HR, hazard ratio; m, months; PFS, progression-free survival.

Olawaiye AB, et al. Presented at SGO Annual Meeting 2026 (Abstract LBA01). Figure adapted from Olawaiye AB, et al. ClinicalTrials.gov, NCT05257408

ROSELLA | Relacorilant Significantly Improved Overall Survival at the Final Analysis



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	129 (69%)	159 (82%)
Median OS, m (95% CI)	**16.0** (13.0–18.3)	**11.9** (10.0–13.8)
HR (95% CI)	**0.65** (0.51–0.83)	
P-value	**0.0004**	

(2-sided stratified log-rank test)
76% maturity

Number at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	176 (11/11)	148 (22/33)	123 (23/56)	106 (17/73)	93 (13/86)	81 (12/98)	67 (14/112)	28 (15/127)	10 (2/129)	3 (0/129)	0 (0/129)
Nab-paclitaxel monotherapy	193 (0/0)	173 (15/15)	142 (28/43)	110 (32/75)	91 (18/93)	72 (19/112)	49 (23/135)	33 (15/150)	18 (3/153)	5 (6/159)	1 (0/159)	0 (0/159)

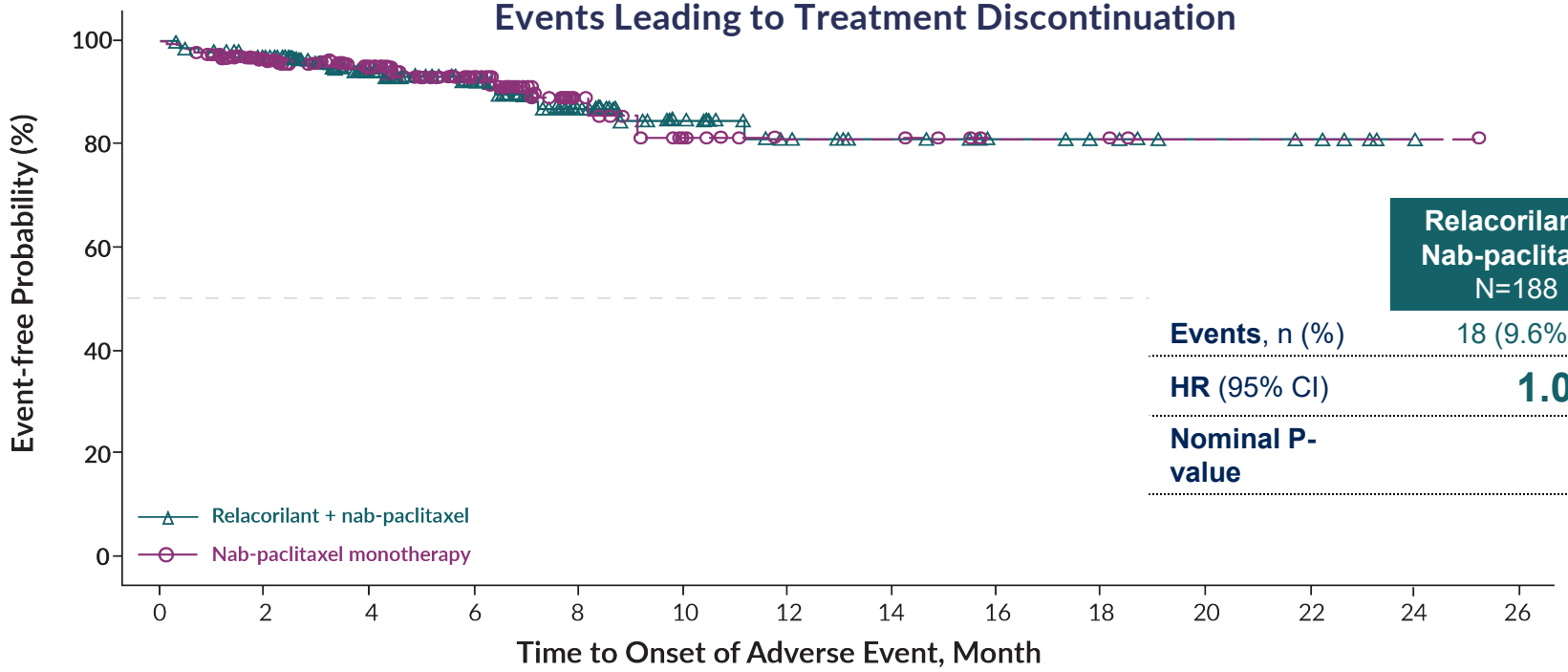
Median follow-up time: 24.8 months; statistical significance threshold at the final analysis: P≤0.0499. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for OS in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.
CI, confidence interval; HR, hazard ratio; m, months; OS, overall survival.

Data cutoff: Jan 8, 2026

Olawaiye AB, et al. Presented at SGO Annual Meeting 2026 (Abstract LBA01). Figure adapted from Olawaiye AB, et al. ClinicalTrials.gov, NCT05257408

ROSELLA | Treatment Discontinuations Due to Adverse Events Were Infrequent

Kaplan-Meier Curve Showing Time to First Onset of Adverse Events Leading to Treatment Discontinuation



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=190
Events, n (%)	18 (9.6%)	15 (7.9%)
HR (95% CI)	**1.00** (0.50–2.00)	
Nominal P-value	**0.998**	

(2-sided log-rank test)

Number at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	170 (6/6)	123 (4/10)	83 (2/12)	51 (4/16)	30 (1/17)	21 (1/18)	17 (0/18)	11 (0/18)	9 (0/18)	6 (0/18)	5 (0/18)	0 (0/18)	
Nab-paclitaxel monotherapy	190 (0/0)	163 (7/7)	115 (2/9)	69 (2/11)	27 (2/13)	15 (2/15)	8 (0/15)	8 (0/15)	4 (0/15)	4 (0/15)	1 (0/15)	1 (0/15)	1 (0/15)	0 (0/15)

Discontinuations due to AEs were infrequent, well balanced across arms, and occurred in a similar time frame in both arms

AEs, adverse events.

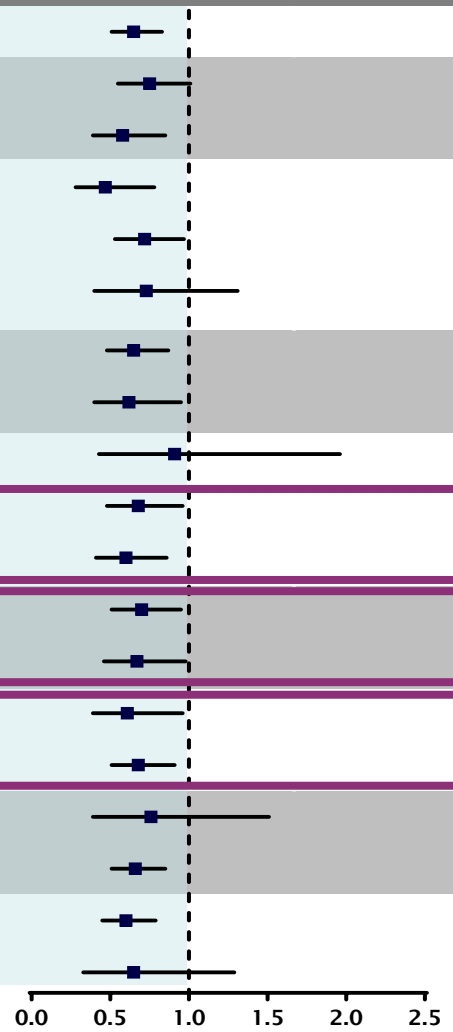
Data cutoff: Jan 8, 2026

Abbreviations: AE, adverse event; CI, confidence interval; HR, hazard ratio; KM, Kaplan-Meier.
Olawaiye AB, et al. Presented at SGO Annual Meeting 2026 (Abstract LBA01). Figure adapted from Olawaiye AB, et al. ClinicalTrials.gov, NCT05257408

Presented By: Alexander B. Olawaiye, MD

ROSELLA | Relacorilant Improved Overall Survival Across Key Subgroups

Subgroup		Patients, n	Events, n	Hazard Ratio (95% CI)
All Patients		381	288	0.65 (0.51–0.83)
Age	<65 years	229	172	0.75 (0.55–1.01)
	≥65 years	152	116	0.58 (0.39–0.85)
Region	North America	90	71	0.47 (0.28–0.78)
	Europe	216	169	0.72 (0.53–0.97)
	Korea, Australia, Latin America	75	48	0.73 (0.40–1.31)
ECOG Performance Status	0	262	189	0.65 (0.48–0.87)
	1	115	97	0.62 (0.40–0.95)
	1	33	30	0.91 (0.43–1.96)
Prior Lines of Therapy	2	181	136	0.68 (0.48–0.96)
	3	167	122	0.60 (0.41–0.86)
Prior PARP Inhibitor	Yes	234	173	0.70 (0.51–0.95)
	No	147	115	0.67 (0.46–0.98)
Primary Platinum-free Interval	≤6 months	112	88	0.61 (0.39–0.96)
	>6 months	269	200	0.68 (0.51–0.91)
BRCA1/2 Mutation	Positive	47	40	0.76 (0.39–1.51)
	Negative / Unknown	334	248	0.66 (0.51–0.85)
Largest Target Lesion	<5 cm	299	221	0.60 (0.45–0.79)
	≥5 cm	45	37	0.65 (0.33–1.29)



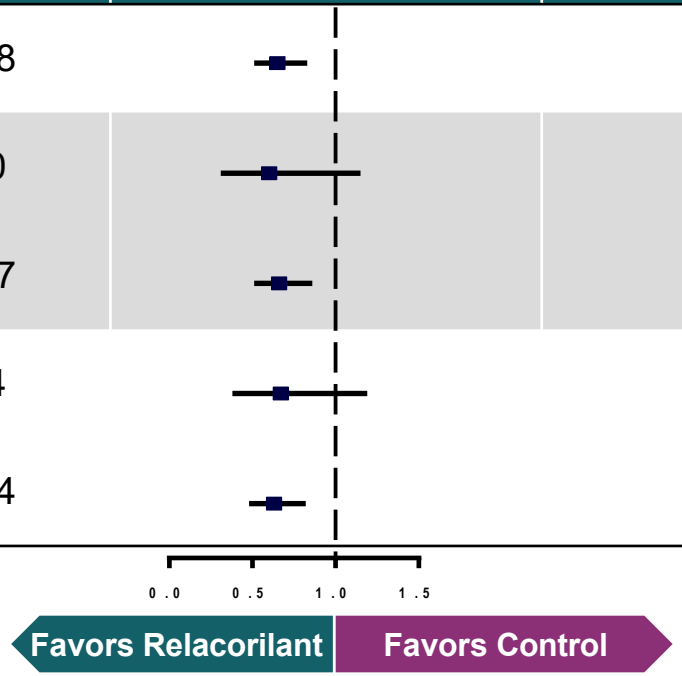
BICR, blinded independent central review; BRCA, Breast Cancer Gene; CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; OS, overall survival; PARP, poly(ADP-ribose) polymerase.

Data cutoff: Jan 8, 2026

Olawaiye AB, et al. Presented at SGO Annual Meeting 2026 (Abstract LBA01). Figure adapted from Olawaiye AB, et al. ClinicalTrials.gov, NCT05257408

ROSELLA | Relacorilant Improved Overall Survival Across Prior Taxane Subgroups

Subgroup		Patients, n	Events, n	Hazard Ratio (95% CI)
All patients		381	288	0.65 (0.51–0.83)
Taxane-free interval	≤6 months	55	50	0.60 (0.31–1.15)
	>6 months	324	237	0.66 (0.51–0.86)
Taxane in the last regimen	Yes	73	64	0.67 (0.38–1.19)
	No	308	224	0.63 (0.48–0.82)



CI, confidence interval.

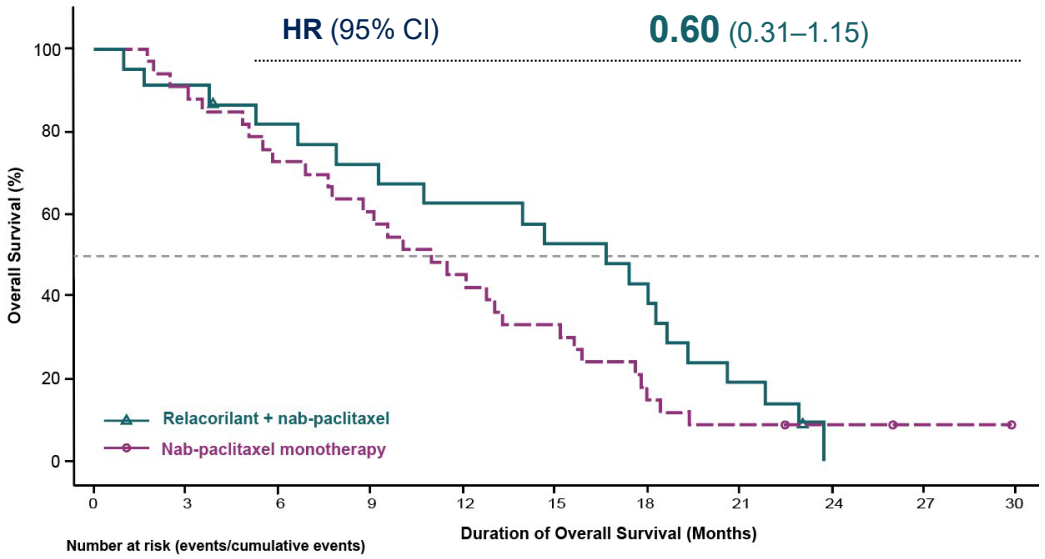
Data cutoff: Jan 8, 2026

PRESENTED BY: Lucy Gilbert, MD, MSc, FRCOG

ROSELLA | Relacorilant + Nab-paclitaxel Showed Similar Overall Survival Benefits Irrespective of the Taxane-free Interval

Taxane-free Interval ≤6 Months

	Relacorilant + Nab-paclitaxel N=22	Nab-paclitaxel N=33
Events, n (%)	20 (91%)	30 (91%)
Median OS, m (95% CI)	**16.7** (7.9–18.7)	**11.0** (7.6–13.3)
HR (95% CI)	**0.60** (0.31–1.15)	

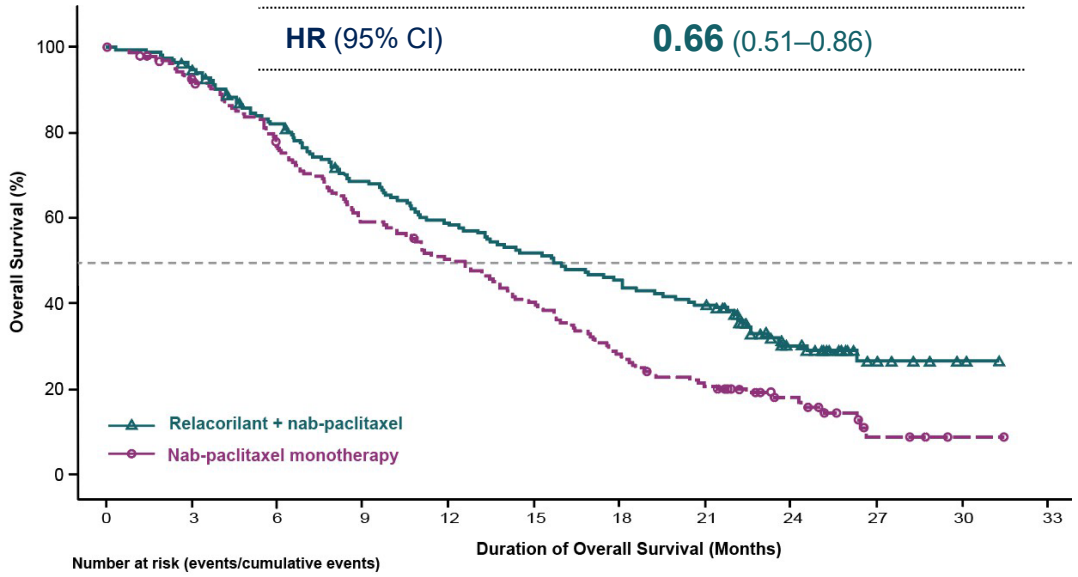


Number at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	22 (0/0)	20 (2/2)	17 (2/4)	15 (2/6)	13 (2/8)	11 (2/10)	9 (2/12)	4 (5/17)	0 (3/20)		
Nab-paclitaxel monotherapy	33 (0/0)	30 (3/3)	24 (6/9)	20 (4/13)	15 (5/18)	11 (4/22))	6 (5/27)	3 (3/30)	2 (0/30)	1 (0/30)	0 (0/30)

Taxane-free Interval >6 Months

	Relacorilant + Nab-paclitaxel N=165	Nab-paclitaxel N=159
Events, n (%)	109 (66%)	128 (81%)
Median OS, m (95% CI)	**15.7** (12.4–19.3)	**12.1** (9.8–14.3)
HR (95% CI)	**0.66** (0.51–0.86)	



Number at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	165 (0/0)	155 (9/9)	130 (20/29)	107 (21/50)	92 (15/65)	81 (11/76)	71 (10/86)	62 (9/95)	28 (12/107)	10 (2/109)	3 (0/109)	0 (0/109)
Nab-paclitaxel monotherapy	159 (0/0)	142 (12/12)	117 (22/34)	89 (28/62)	75 (13/75)	60 (15/90)	42 (18/108)	30 (11/119)	16 (3/122)	4 (6/128)	1 (0/128)	0 (0/128)

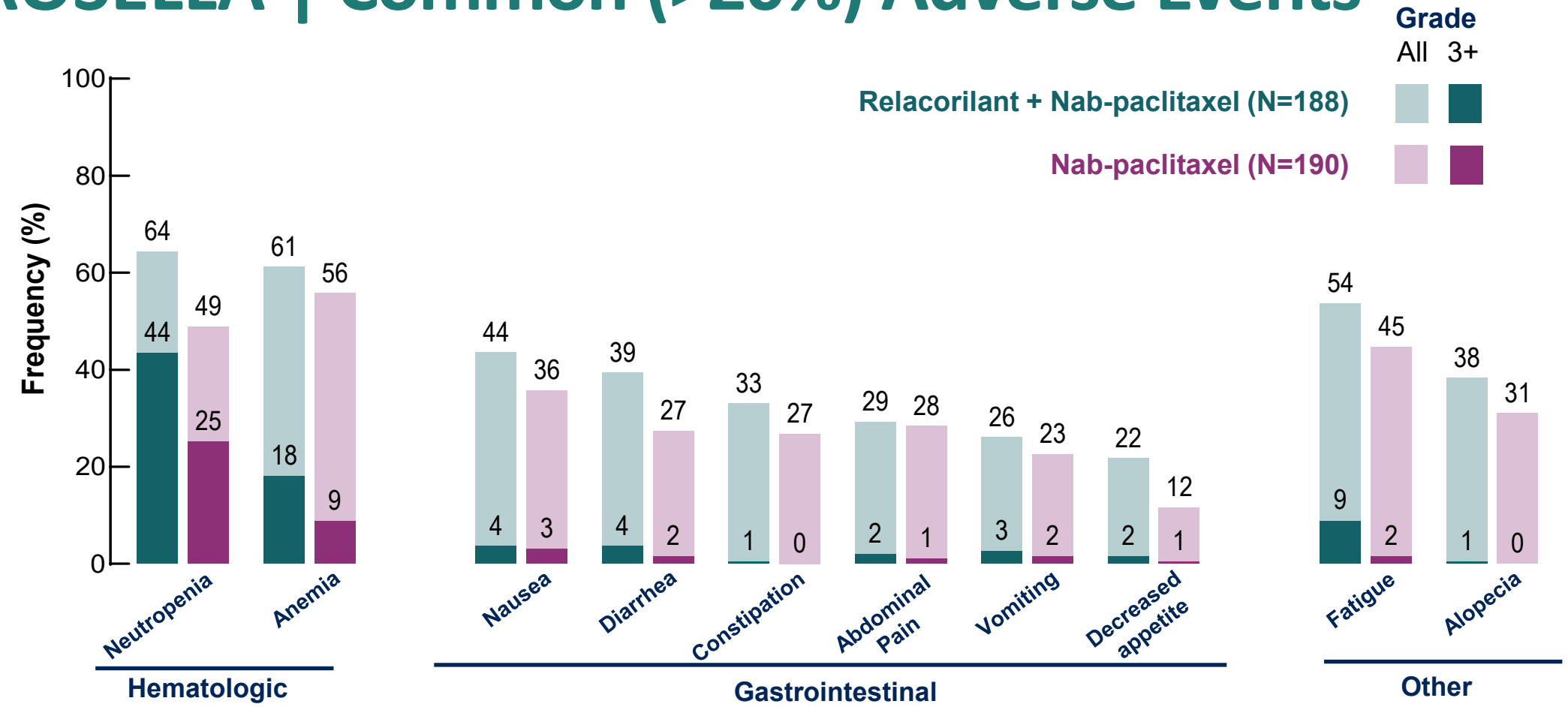
The Kaplan-Meier method was used to estimate the curves, median estimates, and the 95% CIs for OS in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.

Data cutoff: Jan 8, 2026

CI, confidence interval; HR, hazard ratio; m, months; OS, overall survival.

PRESENTED BY: **Lucy Gilbert, MD, MSc, FRCOG**

ROSELLA | Common (>20%) Adverse Events



When adjusted for duration of exposure, the incidence rates of neutropenia and anemia were similar between study arms.
Peripheral neuropathy occurred with similar frequency in both arms (19.1% and 17.4%).
5 SAEs of febrile neutropenia: 4 (2.1%) vs 1 (0.5%).* 5 SAEs of sepsis: 3 (1.6%) vs 2 (1.1%).*

Treatment-emergent adverse events 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. *Comparing the relacorilant combination arm to the nab-paclitaxel monotherapy arm, respectively.

Data cutoff: Jan 8, 2026

ROSELLA | Safety Summary

Relacorilant + Nab-paclitaxel was Well-Tolerated, with a Favorable and Consistent Safety Profile

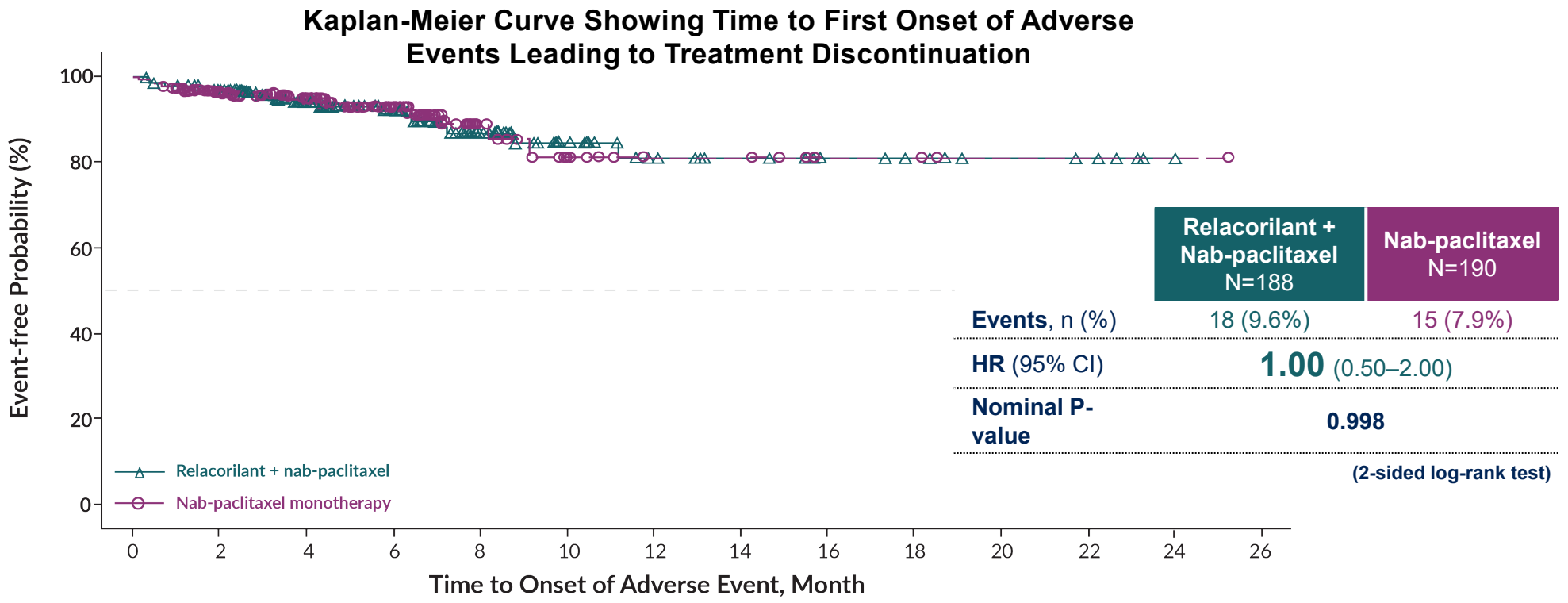
Safety Population Who Received at Least One Dose of Study Drug (N=378)	Relacorilant + Nab-paclitaxel (N=188)	Nab-paclitaxel (N=190)
Weeks of nab-paclitaxel therapy, mean (range)	**24.5** (0.1–102.4)	**19.3** (0.1–109.6)
Any AEs, n (%)	188 **(100)**	189 **(99.5)**
Grade ≥3 AEs, n (%)	141 **(74.5)**	113 **(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)**
Any AEs leading to relacorilant discontinuation, n (%)	19 **(10.1)**	—
Any AEs leading to nab-paclitaxel discontinuation, n (%)	18 **(9.6)**	15 **(7.9)**

There were no relacorilant-related fatal AEs and no cases of adrenal insufficiency.
At the final OS analysis, the safety profile was consistent with that at the time of the primary analysis.
No new safety signals were identified with longer follow-up.

**There were 4 deaths on study treatment in the combination arm due to adverse events (1 each due to cardiac arrest, intestinal perforation, ischemic stroke, and septic shock).1 death was considered related to nab-paclitaxel by the investigator.*
AEs, adverse events; OS, overall survival.

Data cutoff: Jan 8, 2026

ROSELLA | Treatment Discontinuations Due to Adverse Events Were Infrequent



Number at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	170 (6/6)	123 (4/10)	83 (2/12)	51 (4/16)	30 (1/17)	21 (1/18)	17 (0/18)	11 (0/18)	9 (0/18)	6 (0/18)	5 (0/18)	0 (0/18)
Nab-paclitaxel monotherapy	190 (0/0)	163 (7/7)	115 (2/9)	69 (2/11)	27 (2/13)	15 (2/15)	8 (0/15)	8 (0/15)	4 (0/15)	4 (0/15)	1 (0/15)	1 (0/15)	1 (0/15)	0 (0/15)

Discontinuations due to AEs were infrequent, well balanced across arms, and occurred in a similar timeframe in both arms

AEs, adverse events.

Data cutoff: Jan 8, 2026

Presented By: Alexander B. Olawaiye, MD

Which Way To Go?

Differences in PROC FDA Indications

	N	Biomarker	Prior Lines	Cell Types	Platinum Refractory	Prior Bev
Bevacizumab	**361**	None	1-2	All including LGSOC	Yes unless progressed on platinum	7%
Mirvetuximab	**453**	FOLR1 (2+, 75%)	1-3	Serous only	No (<3 mo)	61%
Pembrolizumab	**643**	PD-L1 (CPS ≥ 1)	1-2	All including LGSOC and MMT	No (<3 mo)	46%
Relacorilant	**381**	None	1-3	High grade epithelial	Yes unless <1 mo	100%

*Platinum refractory patients were included in the B-96 trial but not mentioned in the package insert

Abbreviations: *CPS, combined positive score; FDA, U.S. Food and Drug Administration; FOLR1/FRα, folate receptor alpha; PROC, platinum-resistant ovarian cancer.*

References: *U.S. Food and Drug Administration Oncology Center of Excellence. Hematology/Oncology (Cancer) Approvals & Safety Notifications; bevacizumab Prescribing Information. Genentech, Inc.; mirvetuximab soravtansine-gynx Prescribing Information. ImmunoGen, Inc.; pembrolizumab Prescribing Information. Merck & Co., Inc.; Colombo N, et al. Lancet. 2026; 407(10538):1525-1537.*

Outcomes in PROC

		Median PFS (control)	Median OS (control)	PFS (95%tile)	OS (95%tile)
AURELIA (NCT00976911)	IC ± Bev	3.4 mo	13.3 mo	0.48 (0.38-0.60)	0.85 (0.66-1.08)
MIRASOL (NCT04209855)	Mirvetuximab vs IC Chemo	4.0 mo	12.8 mo	0.65* (0.52-0.81)	0.67* (0.50 - 0.89)
Keynote B-96 (NCT05116189)	Weekly paclitaxel ± Pembrolizumab (bev optional)	7.2 mo	14.0 mo	0.76* (0.62-0.93)	0.76* (0.62-0.93)
ROSELLA (NCT05257408)	Weekly nab-Paclitaxel ± Relacorilant	5.5 mo	11.9 mo	0.70 (0.54-0.91)	0.65 (0.51-0.83)

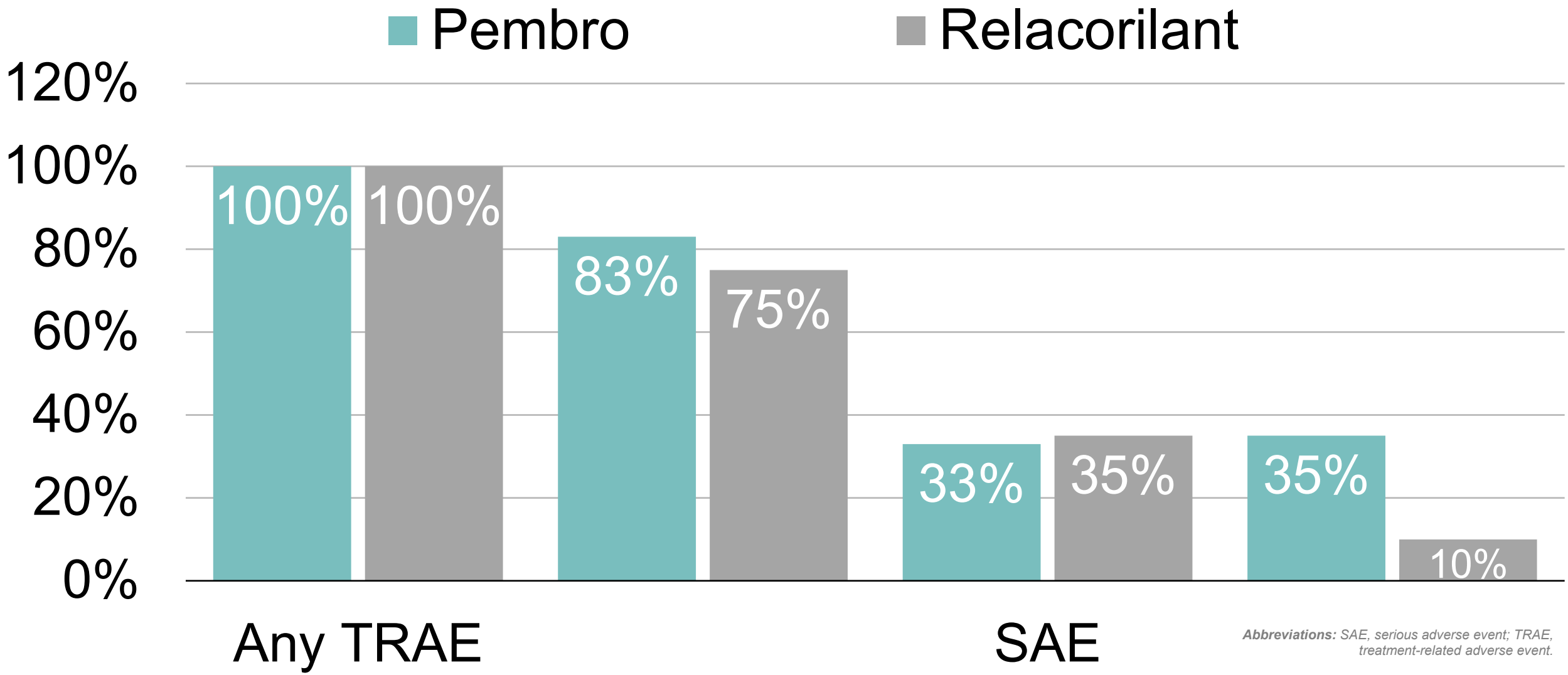
*Biomarker selected

**Cross-trial comparisons should be interpreted cautiously due to differences in study populations, treatment backbones, and trial designs.*

Abbreviations: Bev, bevacizumab; CI, confidence interval; HR, hazard ratio; IC, investigator's choice; mo, months; OS, overall survival; PFS, progression-free survival; PROC, platinum-resistant ovarian cancer.

Pujade-Lauraine E, et al. J Clin Oncol. 2014;32:1302-1308; Moore KN, et al. N Engl J Med. 2023;389:2165-2177; Colombo N, et al. Lancet. 2026;407(10538):1525-1537; Olawaiye AB, et al. Lancet. 2025;405(10496):2205-2216.

Adverse Events and Discontinuation Rates



Abbreviations: *SAE, serious adverse event; TRAE, treatment-related adverse event.*

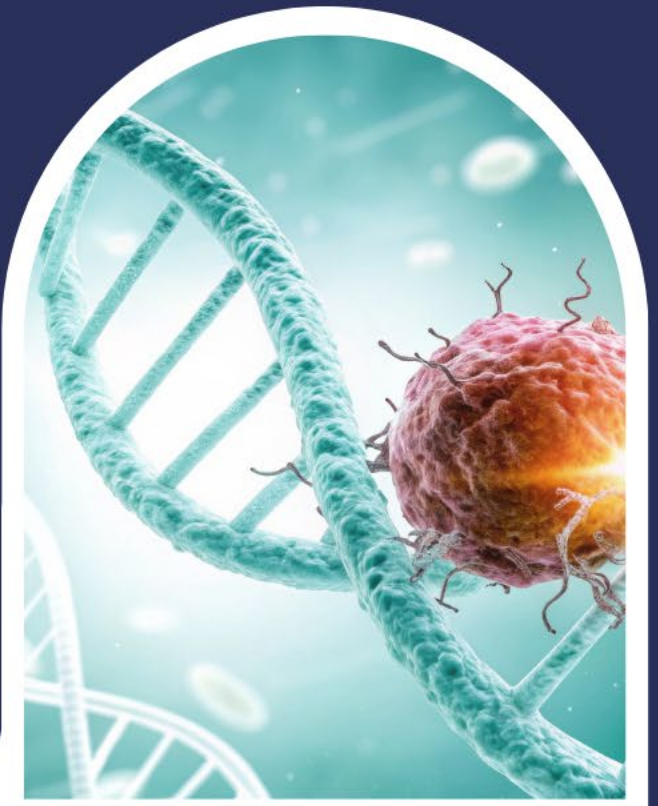
Immune-Mediated AEs (B-96 Study Only)

Immune-mediated adverse event§	126 (39%)	38 (12%)	60 (19%)	11 (3%)
Hypothyroidism	58 (18%)	0	19 (1%)	0
Infusion reaction	19 (6%)	6 (2%)	15 (5%)	2 (1%)
Hyperthyroidism	16 (5%)	0	2 (1%)	0
Adrenal insufficiency	15 (5%)	7 (2%)	0	0
Pneumonitis	15 (5%)	2 (1%)	6 (2%)	3 (1%)

Conclusions

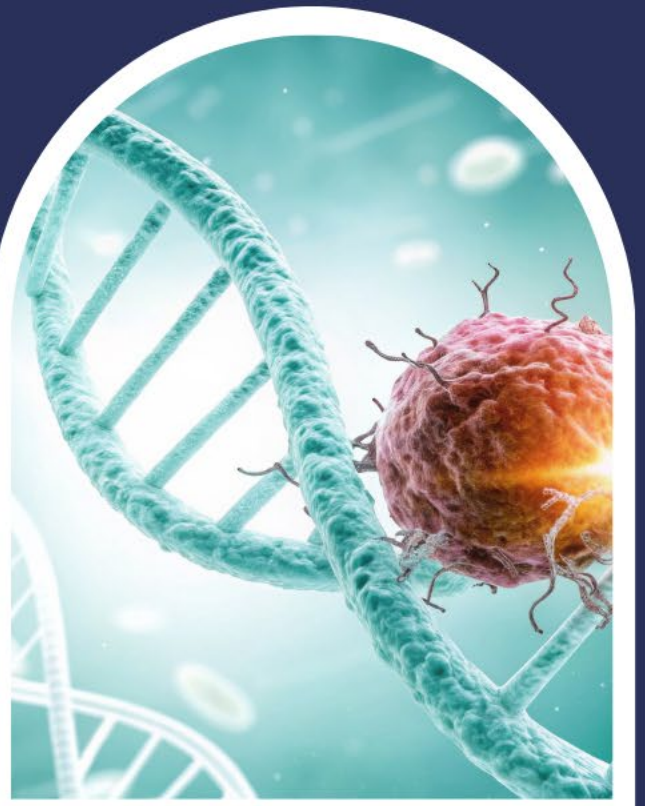
- Bevacizumab plus chemotherapy reasonable if patients have not been exposed
- Weekly taxane plus pembrolizumab or relacorilant are options in PROC
  - Relacorilant has a low discontinuation rate and no immune mediated side effects
  - Pembrolizumab can be given with bevacizumab

Interpreting New Phase 3 Evidence



All Faculty

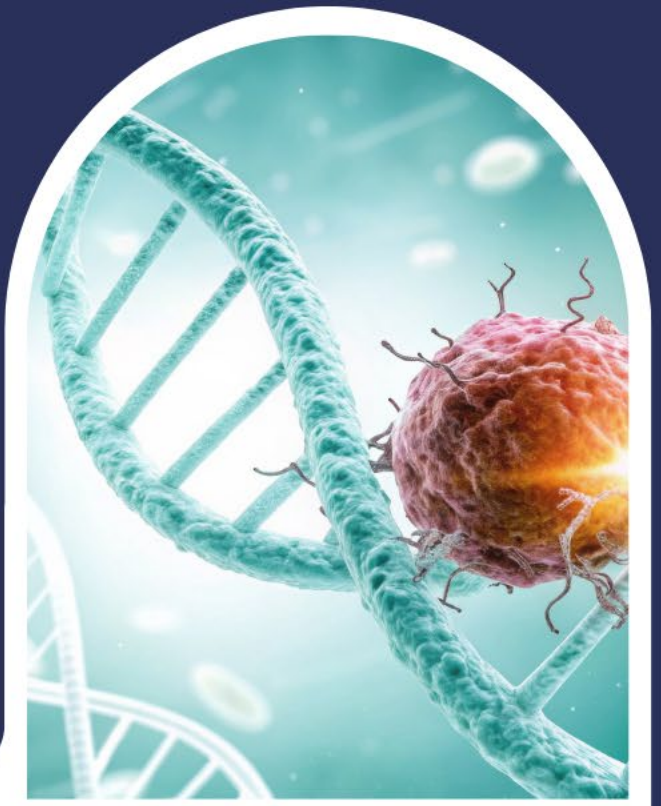
Case Based Application



All Faculty

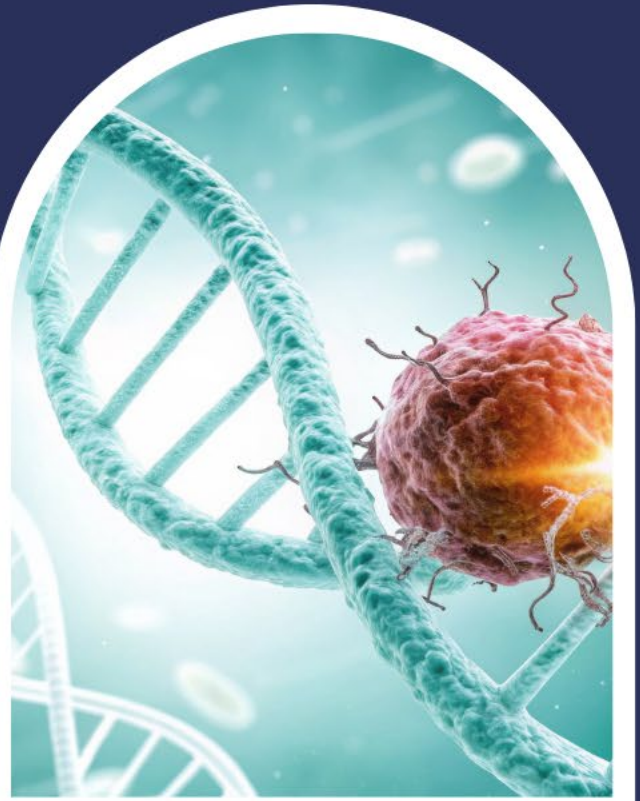
Clinical Case

- 58 yo Platinum Resistant HGSOC, PS 0
- HRD Test Negative
- Recurs 2.5 mo after Carboplatin Paclitaxel + Bev with multifocal pelvic & peritoneal nodules
- FOLR1 = 75% 2+
- CPS>1
- HER2 1+



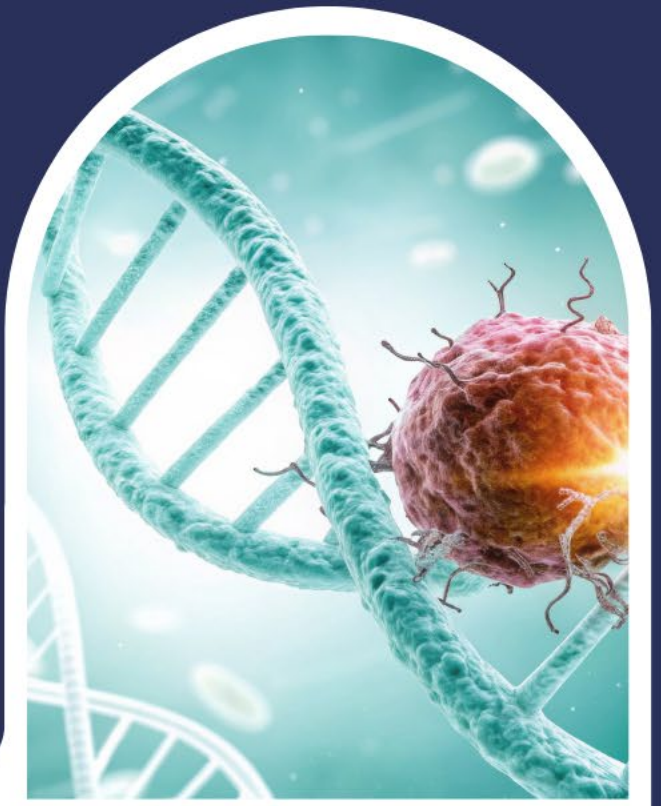
What would you do?...

1. Chemo +/- Bev
2. MIRV
3. Paclitaxel/Pembro +/- Bev
4. TDX-d
5. Relacorilant/Nab-Paclitaxel
6. Other



What if her recurrence presented with…

Large volume symptomatic ascites



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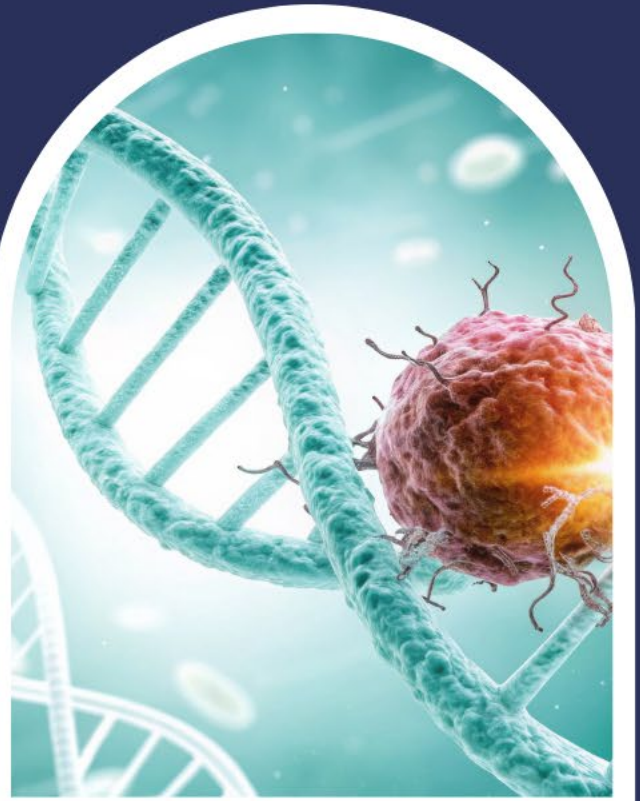
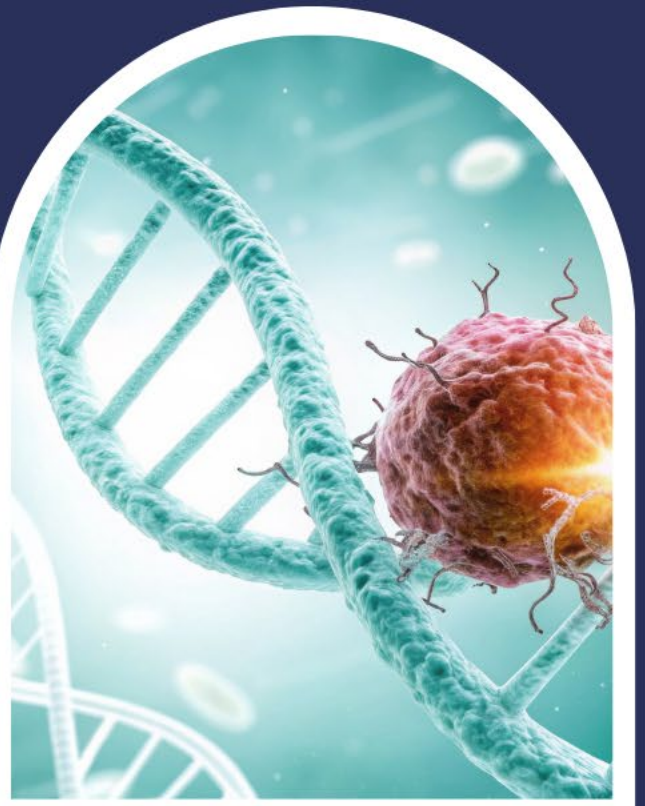


Panel Q&A, Post Assessment



Katherine Fuh, MD, PhD

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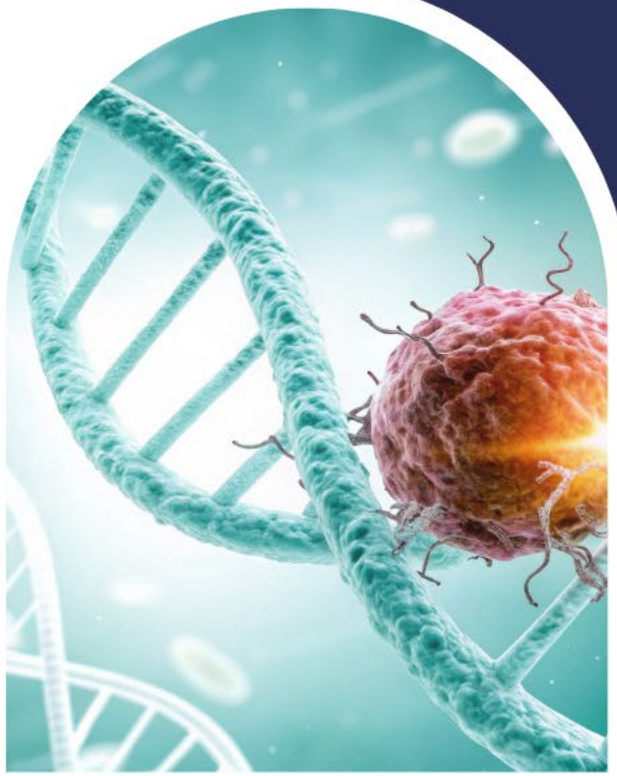

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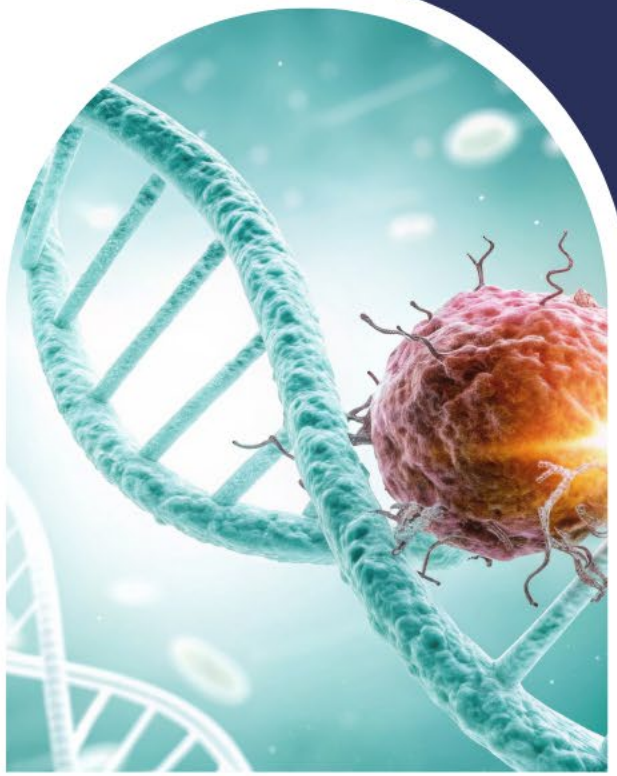

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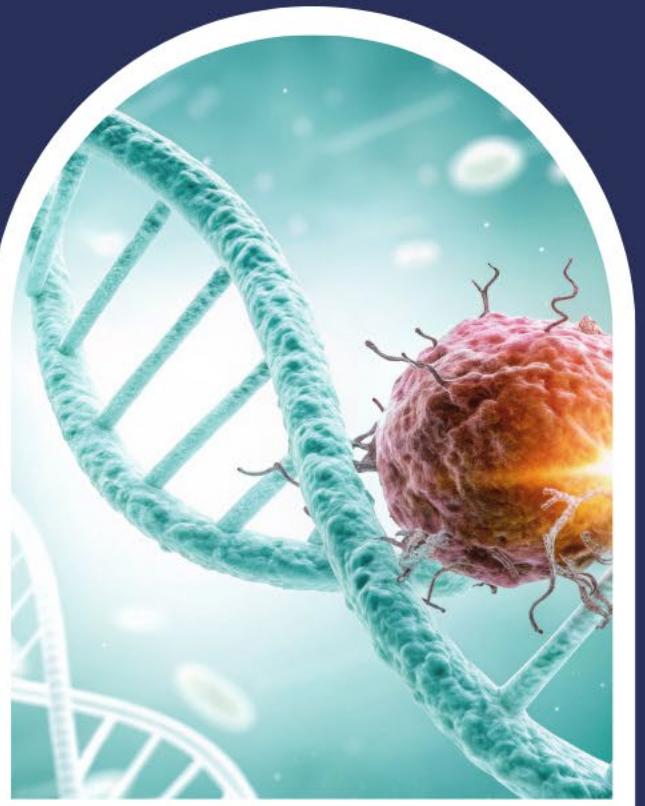

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