
# Multiple Myeloma Webinar

Thursday, September 3, 2020

7:00-8:00 p.m. ET

*Jointly provided by Postgraduate Institute for Medicine and the Society for Immunotherapy of Cancer*

This webinar is supported, in part, by independent medical education grant funding from Amgen, AstraZeneca Pharmaceuticals LP, Celgene Corporation and Merck & Co., Inc.

# Webinar Agenda

| | |
|---|---|
| 7:00–7:05 p.m. ET | Welcome, Introductions and Overview |
| 7:05–7:40 p.m. ET | Presentation of SITC Cancer Immunotherapy Guideline – Multiple Myeloma |
| 7:40-7:55 p.m. ET | Question and Answer Session |
| 7:55–8:00 p.m. ET | Closing Remarks |

# How to Submit Questions

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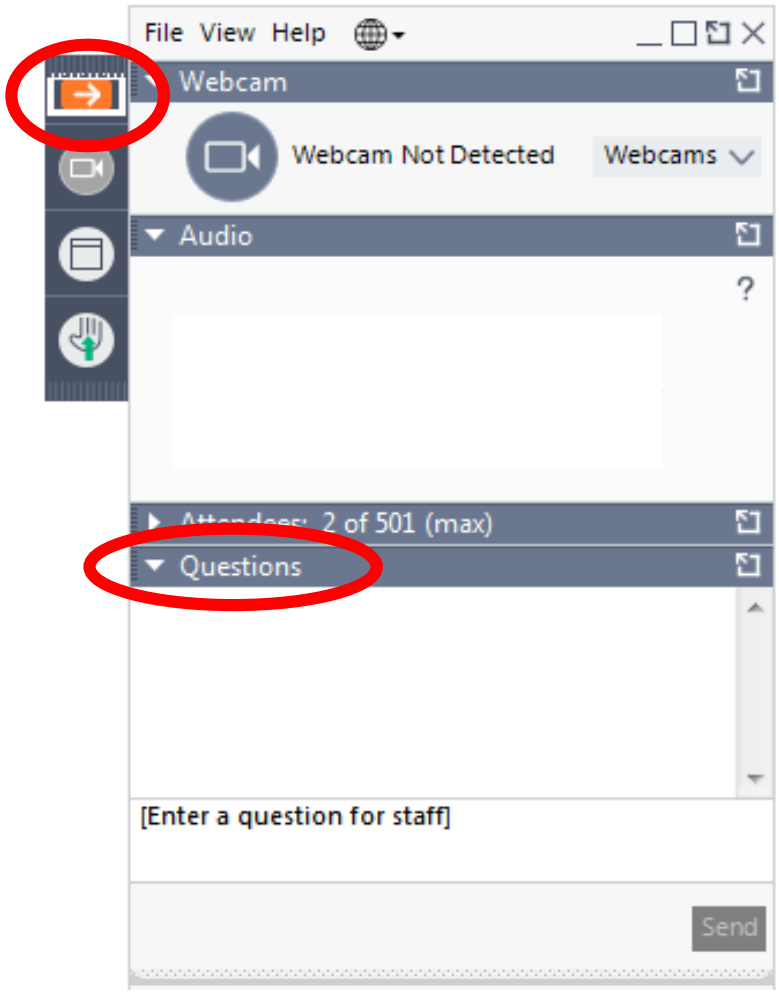


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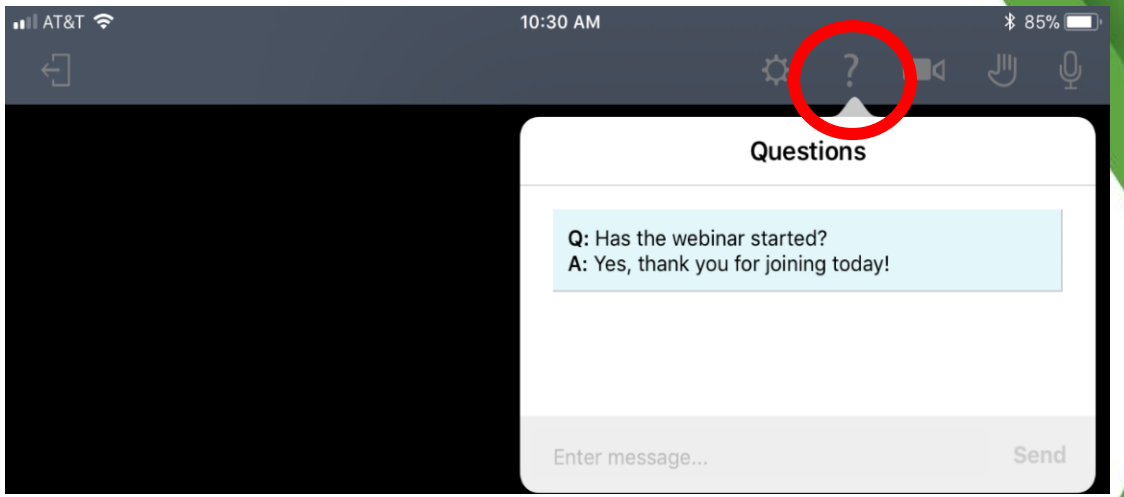


# Webinar Faculty

Expert Panel Chair:
Nina Shah, MD –
*University of California San Francisco Medical Center*

Ajai Chari, MD – *Icahn School of Medicine at Mount Sinai*

Adam Cohen, MD –
*Abramson Cancer Center at the University of Pennsylvania*

Journal for ImmunoTherapy of Cancer

# The Society for Immunotherapy of Cancer consensus statement on immunotherapy for the treatment of multiple myeloma

Nina Shah,[1] Jack Aiello,[2] David E Avigan,[3] Jesus G Berdeja,[4] Ivan M Borrello,[5] Ajai Chari,[6] Adam D Cohen,[7] Karthik Ganapathi,[8] Lissa Gray,[9] Damian Green,[10] Amrita Krishnan,[11] Yi Lin,[12,13] Elisabet Manasanch,[14] Nikhil C Munshi,[15] Ajay K Nooka,[16] Aaron P Rapoport,[17] Eric L Smith,[18] Ravi Vij,[19] Madhav Dhodapkar[20]

# Development of clinical practice guidelines

- 19 participants – 17 medical oncologists, 1 nurse practitioner, 1 patient advocate
- Developed using the Institute of Medicine's Standards for Developing Trustworthy Clinical Practice Guidelines
- Panel participated in surveys and discussions to develop recommendations

# Multiple myeloma by the numbers

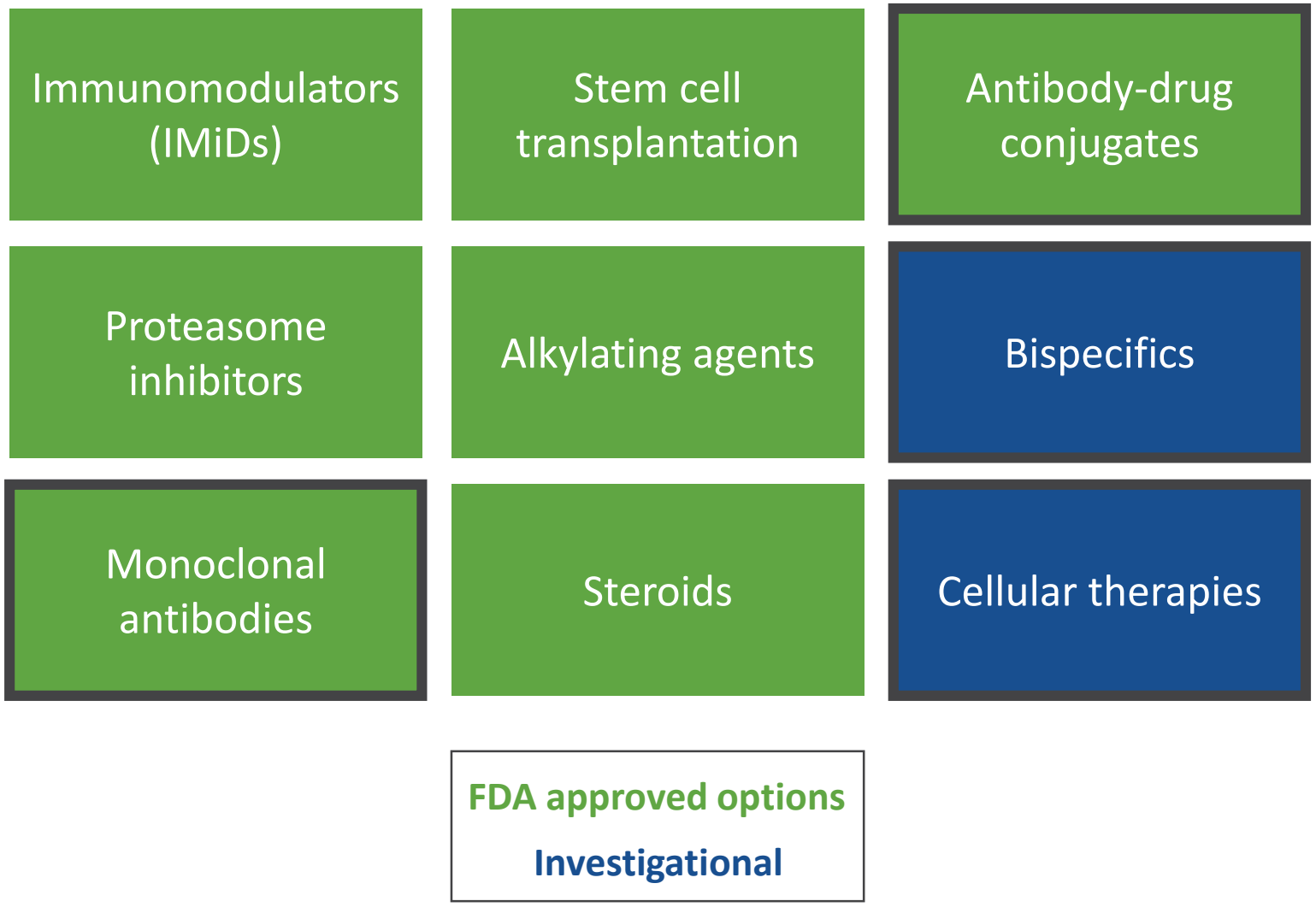
**32,270**
Estimated new cases in 2020 in US

**12,830**
Estimated deaths in 2020 in US

**74%**
Historical 5-year survival if diagnosed at early stage

**51%**
Historical 5-year survival if diagnosed at late stage

# Treatment options for MM



# Outline

- Monoclonal antibodies
  - Daratumumab
  - Isatuximab
  - Elotuzumab
- Antibody-drug conjugates
- Bispecifics
- Cellular therapies

# Daratumumab

- CD38-directed cytolytic antibody
- First monoclonal antibody approved for MM

| Regimen | Indication |
|---|---|
| Daratumumab + bortezomib + dexamethasone | R/R MM after ≥1 prior therapy |
| Daratumumab + lenalidomide + dexamethasone | R/R MM after ≥1 prior therapy |
| Daratumumab + pomalidomide + dexamethasone | R/R MM after ≥2 prior therapies, including lenalidomide and proteasome inhibitor |
| Daratumumab + carfilzomib + dexamethasone | R/R MM after 1-3 prior therapies |
| Daratumumab | R/R MM after≥3 prior therapies |
| Daratumumab + lenalidomide + dexamethasone | Newly diagnosed patients, ineligible for stem cell transplant |
| Daratumumab + bortezomib + melphalan + prednisone | Newly diagnosed patients, ineligible for stem cell transplant |
| Daratumumab + bortezomib + thalidomide + dexamethasone | Newly diagnosed patients, eligible for stem cell transplant |

# Daratumumab for relapsed/refractory MM

| Trial | Phase | Treatment arms | N | ORR | Median PFS | PFS HR |
|---|---|---|---|---|---|---|
| POLLUX | 3 | Dara + lenalidomide + dexamethasone | 286 | 93% | 45.8 months | 0.43 |
| | | Lenalidomide + dexamethasone | 283 | 76% | 17.5 months | |
| CASTOR | 3 | Dara + bortezomib + dexamethasone | 251 | 82.9% | 12-month: 60.7% | 0.39 |
| | | Bortezomib + dexamethasone | 247 | 63.2% | 12-month: 26.9% | |
| EQUULEUS | 1b | Dara + pomalidomide + dexamethasone | 103 | 60% | 8.8 months | - |
| CANDOR | 3 | Dara + carfilzomib + dexamethasone | 466 | 84.3% | NR (>16.9 months) | 0.63 |
| | | Carfilzomib + dexamethasone | | 74.7% | 15.8 months | |

# Daratumumab for front-line MM

| Trial | Phase | Patient population | Treatment arms | N | MRD-neg rate | PFS | PFS HR |
|---|---|---|---|---|---|---|---|
| GRIFFIN | 2 | Transplant-eligible | Dara + bortezomib + lenalidomide + dexamethasone | 207 | 51.0% | 24-month: 95.8% | - |
| | | | Bortezomib + lenalidomide + dexamethasone | | 20.4% | 24-month: 89.8% | |
| CASSIOPEIA | 3 | Transplant-eligible | Dara + bortezomib + thalidomide + dexamethasone | 1085 | 64% | 18-month: 93% | 0.47 |
| | | | Bortezomib + thalidomide + dexamethasone | | 44% | 18-month: 85% | |
| MAIA | 3 | Transplant-ineligible | Dara + lenalidomide + dexamethasone | 737 | 24.2% | 30-month: 70.6% | 0.56 |
| | | | Lenalidomide + dexamethasone | | 7.3% | 30-month: 55.6% | |
| ALCYONE | 3 | Transplant-ineligible | Dara + bortezomib + melphalan + prednisone | 706 | 28% | Median: 36.4 mo | 0.55 |
| | | | Bortezomib + melphalan + prednisone | | 7% | Median: 19.3 mo | |

# Panel recommendations

The panel recommends daratumumab for all FDA-approved indications:

| Regimen | Indication |
|---|---|
| Daratumumab + bortezomib + dexamethasone | R/R MM after ≥1 prior therapy |
| Daratumumab + lenalidomide + dexamethasone | R/R MM after ≥1 prior therapy |
| Daratumumab + pomalidomide + dexamethasone | R/R MM after ≥2 prior therapies, including lenalidomide and proteasome inhibitor |
| Daratumumab + carfilzomib + dexamethasone | R/R MM after 1-3 prior therapies |
| Daratumumab | R/R MM after≥3 prior therapies |
| Daratumumab + lenalidomide + dexamethasone | Newly diagnosed patients, ineligible for stem cell transplant |
| Daratumumab + bortezomib + melphalan + prednisone | Newly diagnosed patients, ineligible for stem cell transplant |
| Daratumumab + bortezomib + thalidomide + dexamethasone | Newly diagnosed patients, eligible for stem cell transplant |

# Panel recommendations

*The panel recommends the following options based on emerging evidence, though <u>not yet FDA-approved:</u>*

- Daratumumab + bortezomib + lenalidomide + dexamethasone as an induction regimen for newly diagnosed, transplant-eligible patients (GRIFFIN)
- Daratumumab + carfilzomib + dexamethasone for patients with R/R multiple myeloma (CANDOR)

*The panel could not reach consensus on:*

- Daratumumab + carfilzomib + lenalidomide + dexamethasone for newly-diagnosed, transplant-eligible patients

# Dosing and administration of daratumumab

- Standard **pre-medication** to limit infusion-related reactions
  - Dexmethasone, acetaminophen, diphenhydramine, and montelukast
  - Steroids may be omitted after first infusion if no IRRs
  - For patients with severe IRRs or respiratory co-morbidities, administer oral corticosteroids on each of the two days following infusions
- **Subcutaneous dosing** is a feasible, patient-friendly option
- First dose may be **split** across two days (8 mg/kg, 4 hour infusion)
- For dose 4 and beyond, can be given over **90 minutes**
- **IVIG** should be administered to reduce infections following treatment

# Monitoring responses to daratumumab

- In patients with IgG kappa myeloma, **serologic measurement** of response may be confounded by daratumumab
- In the presence of a measurable **M-spike**, daratumumab will have a minimal effect on disease measurement. When patients reach undetectable levels, however, mass spectrometry or other antibody interference testing methods should be considered.

# Outstanding questions with daratumumab

- Use in patients with high-risk cytogenics
- Re-treatment with daratumumab

# Outline

- Monoclonal antibodies
  - Daratumumab
  - Isatuximab
  - Elotuzumab
- Antibody-drug conjugates
- Bispecifics
- Cellular therapies

# Isatuximab

- CD38 antibody
- Like daratumumab, reduces Tregs and inhibits immunosuppressive cytokine production
- Can also directly kill MM cells (without cross-linking)
- Panel recommends isatuximab for its FDA-approved indication

| Regimen | Indication |
|---|---|
| Isatuximab + pomalidomide + dexamethasone | R/R MM after ≥2 prior therapies |

# Clinical trials with isatuximab

| Trial | Phase | Patient population | Treatment arms | N | ORR | PFS | PFS HR |
|---|---|---|---|---|---|---|---|
| ICARIA-MM | 3 | R/R multiple myeloma | Isatuximab + pomalidomide + dexamethasone | 154 | 60% | Median: 11.53 mo | 0.596 |
| | | | Pomalidomide + dexamethasone | 153 | 35% | Median: 6.47 mo | |
| GMMG-CONCEPT | 2 | Newly diagnosed MM | Induction: Isatuximab + carfilzomib + lenalidomide + dexamethasone<br>Maintenance: Isatuximab + carfilzomib + lenalidomide | 153 | 100%, 90% ≥ VGPR | *ongoing* | - |
| IKEMA | 3 | R/R multiple myeloma | Isatuximab + carfilzomib + dexamethasone | 302 | 86.6% | NR | 0.531 |
| | | | Carfilzomib + dexamethasone | | 82.9% | Median: 19.15 months | |
| IMROZ | 3 | Newly diagnosed MM | Induction: isatuximab + bortezomib + lenalidomide + dexamethasone<br>Maintenance: isatuximab + lenalidomide + dexamethasone | 475 | *Ongoing – anticipated December 2022* | | - |
| | | | Induction: bortezomib + lenalidomide + dexamethasone<br>Maintenance: lenalidomide + dexamethasone | | | | |

# Dosing and administration of isatuximab

- Standard **pre-medications** to limit infusion-related reactions
- Initial infusion at 175 mg/hour over **2-7 hours**
- **Antibody interference testing** by mass spectrometry recommended for monitoring in Ig G kappa patients with m spike < 0.5 g/dl with suspected complete remission
- **IVIG** should be administered to manage infections

# Outstanding questions with isatuximab

- Treating patients with prior daratumumab exposure

# CD38 case study

- 78 yo Female with history of HTN, osteoporosis presents with hypercalcemia, anemia, lytic lesions and is diagnosed with IgG Kappa MM  - ISS 2, LDH nl, FISH normal
- She is treated with Daratumumab Lenalidomide 15 mg and dexamethasone 20 mg with progressive improvement in her symptoms/improvement in quality of life and achieves a complete response
- She remains in remission 4 years since her diagnosis

# Outline

- Monoclonal antibodies
  - Daratumumab
  - Isatuximab
  - Elotuzumab
- Antibody-drug conjugates
- Bispecifics
- Cellular therapies

# Elotuzumab

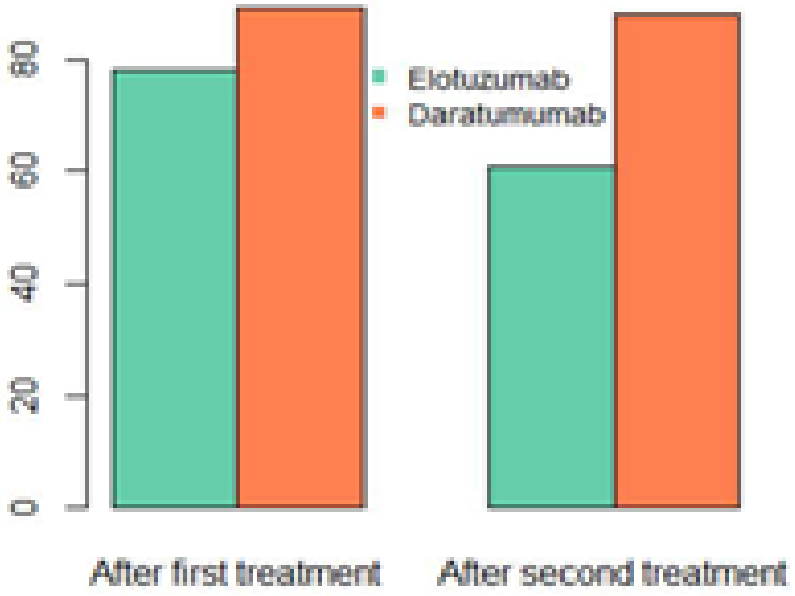
- Antibody targeting SLAMF7
- Anti-tumor effects through ADCC and direct activation of NK cells
- Panel recommends use of elotuzumab for FDA-approved indications

| Regimen | Indication |
|---|---|
| Elotuzumab + lenalidomide + dexamethasone | R/R MM after 1-3 prior therapies |
| Elotuzumab + pomalidomide + dexamethasone | R/R MM after $\geq$ 2 prior therapies |

# Clinical trials with elotuzumab

| Trial | Phase | Patient population | Treatment arms | N | ORR | PFS |
|---|---|---|---|---|---|---|
| ELOQUENT-2 | 3 | R/R MM after 1-3 prior treatments | Elotuzumab + lenalidomide + dexamethasone | 321 | 79% | 5-year: 18% |
| | | | Lenalidomide + dexamethasone | 325 | 66% | 5-year: 12% |
| ELOQUENT-3 | 2 | R/R MM after lenalidomide and PI | Elotuzumab + pomalidomide + dexamethasone | 60 | 53% | Median: 10.3 mo |
| | | | Pomalidomide + dexamethasone | 57 | 26% | Median: 4.7 mo |
| GMMG-HD6 | 3 | Newly diagnosed, transplant-eligible MM | Elotuzumab + bortezomib + lenalidomide + dexamethasone | 564 | ≥PR: 82.4% | *Ongoing* |
| | | | Bortezomib + lenalidomide + dexamethasone | | ≥PR: 85.6% | |
| SWOG 1211 | 1/2 | Newly diagnosed, high risk MM | Elotuzumab + bortezomib + lenalidomide + dexamethasone | 134 | 83% | Median: 31 months |
| | | | Bortezomib + lenalidomide + dexamethasone | | 88% | Median: 34 months |
| ELOQUENT-1 | 3 | Newly diagnosed, transplant-ineligible MM | Elotuzumab + lenalidomide + dexamethasone | 68 | *Ongoing – anticipated September 2020* | |

# Sequencing elotuzumab and anti-CD38 agents




MDACC, n=50
32 elo first, 18 dara first

| | Dara-first ($n = 23$) | Elo-first ($n = 14$) | $p$-value |
|---|---|---|---|
| ORR to first antibody, *n* (%) | 13 (56.5%) | 9 (64.3%) | .641 |
| ORR to second antibody, *n* (%) | 8 (34.8%) | 9 (64.3%) | .081 |

Michigan, n=37
14 elo first, 23 dara first

*Retrospective analyses*

"Response rates to daratumumab may be preserved irrespective of sequence. However, response rates to elotuzumab may diminish with prior daratumumab exposure."

Hoylman, Leuk Lymphoma 2019.
Becnel, Blood 2018.

# Panel recommendations for elotuzumab

- The panel recommends use of elotuzumab for its **FDA-approved** indications.
- Patients with **high-risk cytogenetics** may benefit from elotuzumab.
- At present, there is no approved indication for the use of elotuzumab in the **initial management** of myeloma.
- *By consensus, elotuzumab-containing regimens may be considered for patients who have **progressed on dara-containing** regimens.*
- Elotuzumab should not be used as a **single agent**.
- Prior treatment with elotuzumab is **not a contraindication** for treatment with anti-CD38 antibodies.
- *By consensus, elotuzumab-containing regimens are not recommended for patients with a **rapidly growing disease burden**.*

# Outstanding questions for elotuzumab

- Front-line applications
- Use in patients with hepatic impairment or plasma cell leukemia
- Biomarkers of response and resistance

# Outline

- Monoclonal antibodies
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  - Elotuzumab
- Antibody-drug conjugates
- Bispecifics
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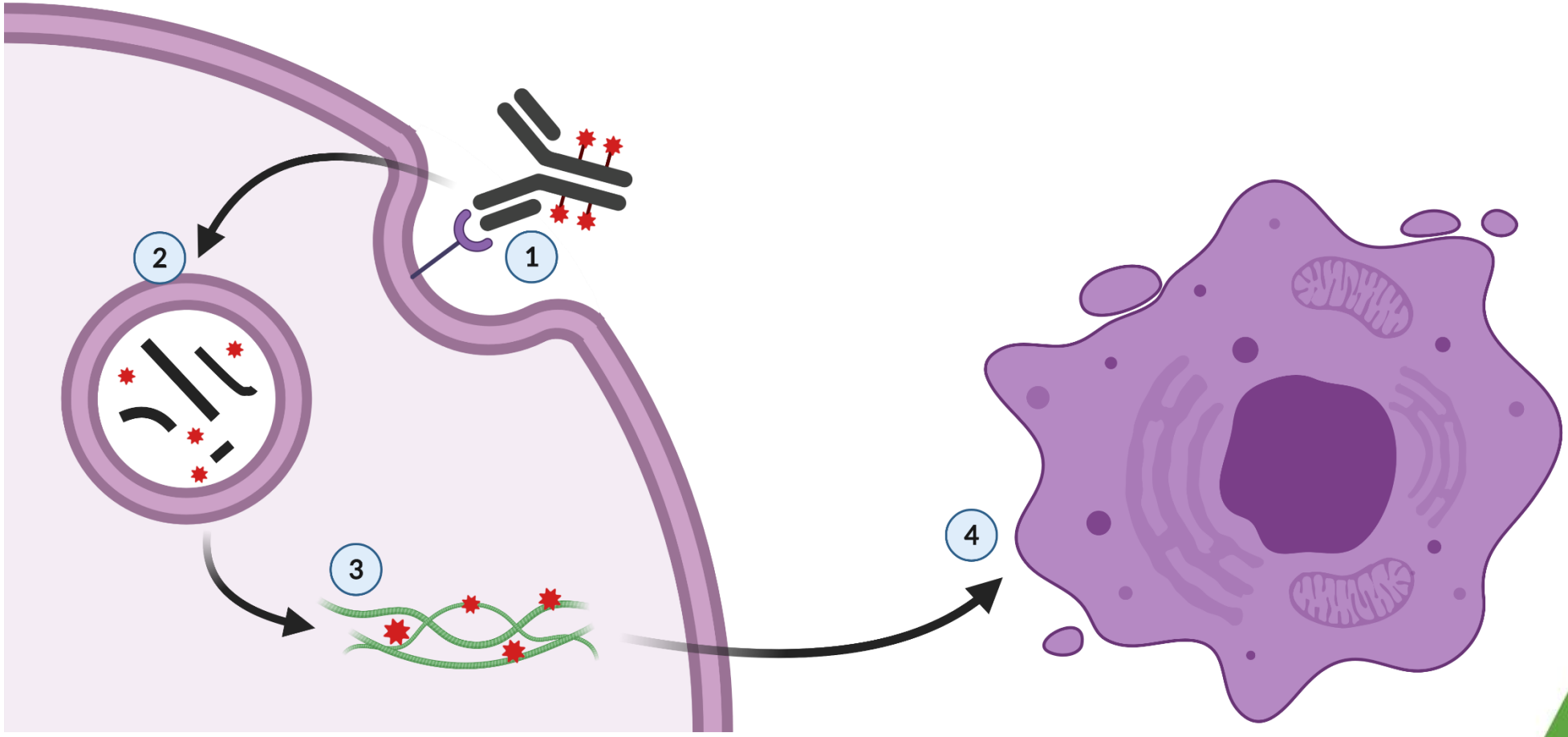
# Antibody-drug conjugates



# Belantamab mafodotin

- FDA-approved August 2020 (this guideline published July 2020)
- Anti-BCMA humanized antibody conjugated to MMAF

| Regimen | Indication |
|---|---|
| Belantamab mafodotin | R/R MM after ≥4 prior therapies, including anti-CD38, PI, and IMiD. |

# Clinical trials of belantamab mafodotin

| Trial | Phase | Patient population | N | Treatment arm(s) | ORR | Median PFS |
|---|---|---|---|---|---|---|
| DREAMM-1 | 1 | R/R MM after ASCT, alkylators, PI, and IMiD | 35 | 3.4 mg/kg belantamab mafodotin Q3W | 60% | 12 months |
| DREAMM-2 | 2 | R/R MM after IMiD, PI, and anti-CD38 | 196 | 2.5 mg/kg belantamab mafodotin Q3W | 31% | 2.9 months |
| | | | | 3.4 mg/kg belantamab mafodotin Q3W | 34% | 4.9 months |

# Administration of belantamab mafodotin

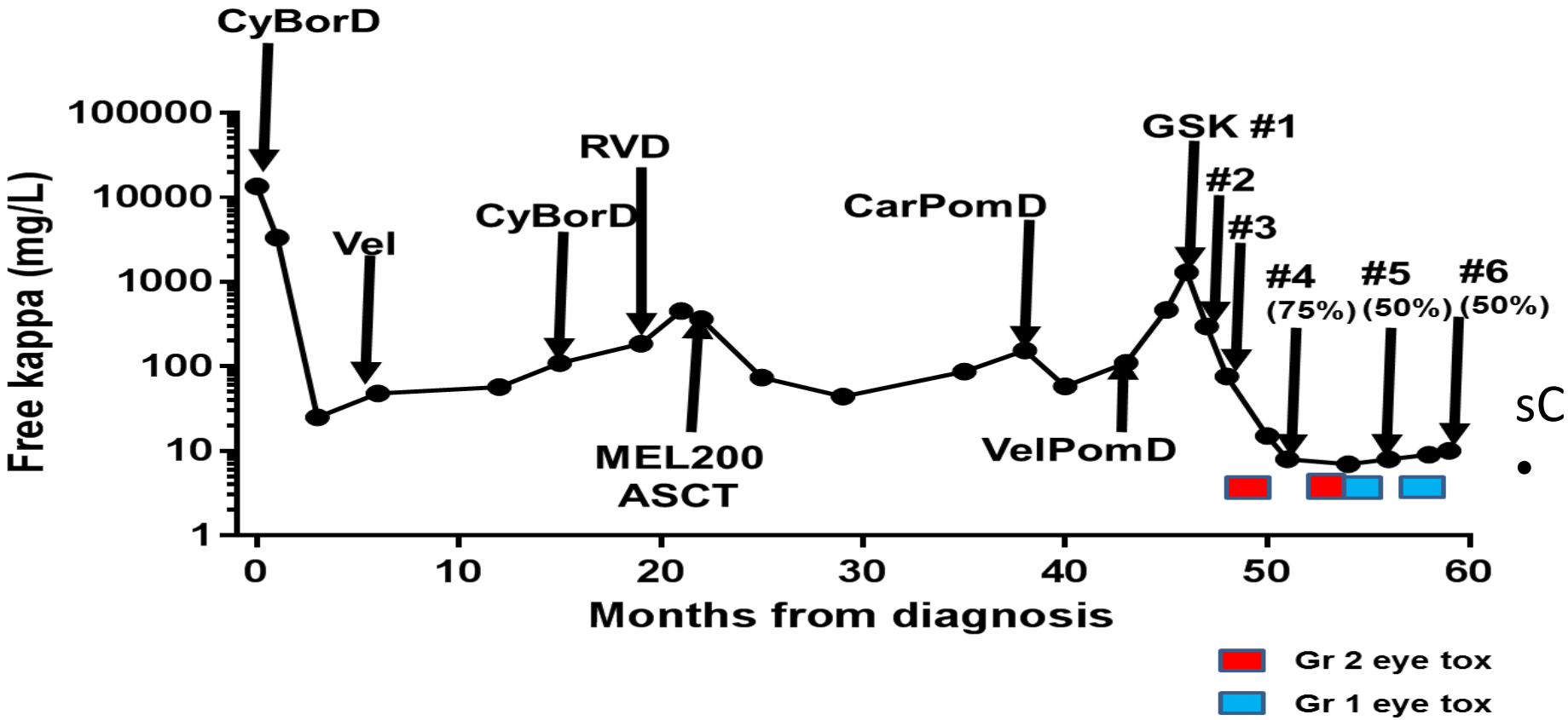
- Patients with severe **cytopenias** or pre-existing **corneal disease** may not be suitable for treatment
- Corneal toxicity can **be managed** through lubricating eye drops, holding therapy until grade 1 or less, or dose reductions
- Co-management with an **eye healthcare professional** required
- Based on MOA of belantamab mafodotin, patients with **prior allo-HSCT** may be considered for treatment

# Other ADCs in development for myeloma

| Target | Agent | Type (toxin) | Clinicaltrials.gov # |
|---|---|---|---|
| CD38 | TAK-079 | Naked | NCT03439280 |
| CD38 | TAK-573 | ADC (IFNα) | NCT03215030 |
| CD38 | TAK-169 | ADC (shiga-like toxin A subunit) | Pre-clinical |
| BCMA | SEA-BCMA | Naked | NCT03582033 |
| BCMA | MEDI-2228 | ADC (PBD) | NCT03489525 |
| BCMA | HDP-101 | ADC (Amanatin) | Pre-clinical |
| BCMA | CC-99712 | ADC (maytansinoid) | NCT04036461 |
| CD46 | FOR46 | ADC (MMAF) | NCT03650491 |
| CD56 | IMGN901 | ADC (DM1) | NCT00346255 |
| CD74 | STRO-001 | ADC (SC236) | NCT03424603 |

# ADC case study

- 44M, Kappa LC MM dx'd 2012, FISH -14.  6 prior therapies
- Enrolled on GSK2857916 (belantamab mafadotin) phase 1 in April 2016




sCR lasting 18 mos.

- 9 total doses

# Outline

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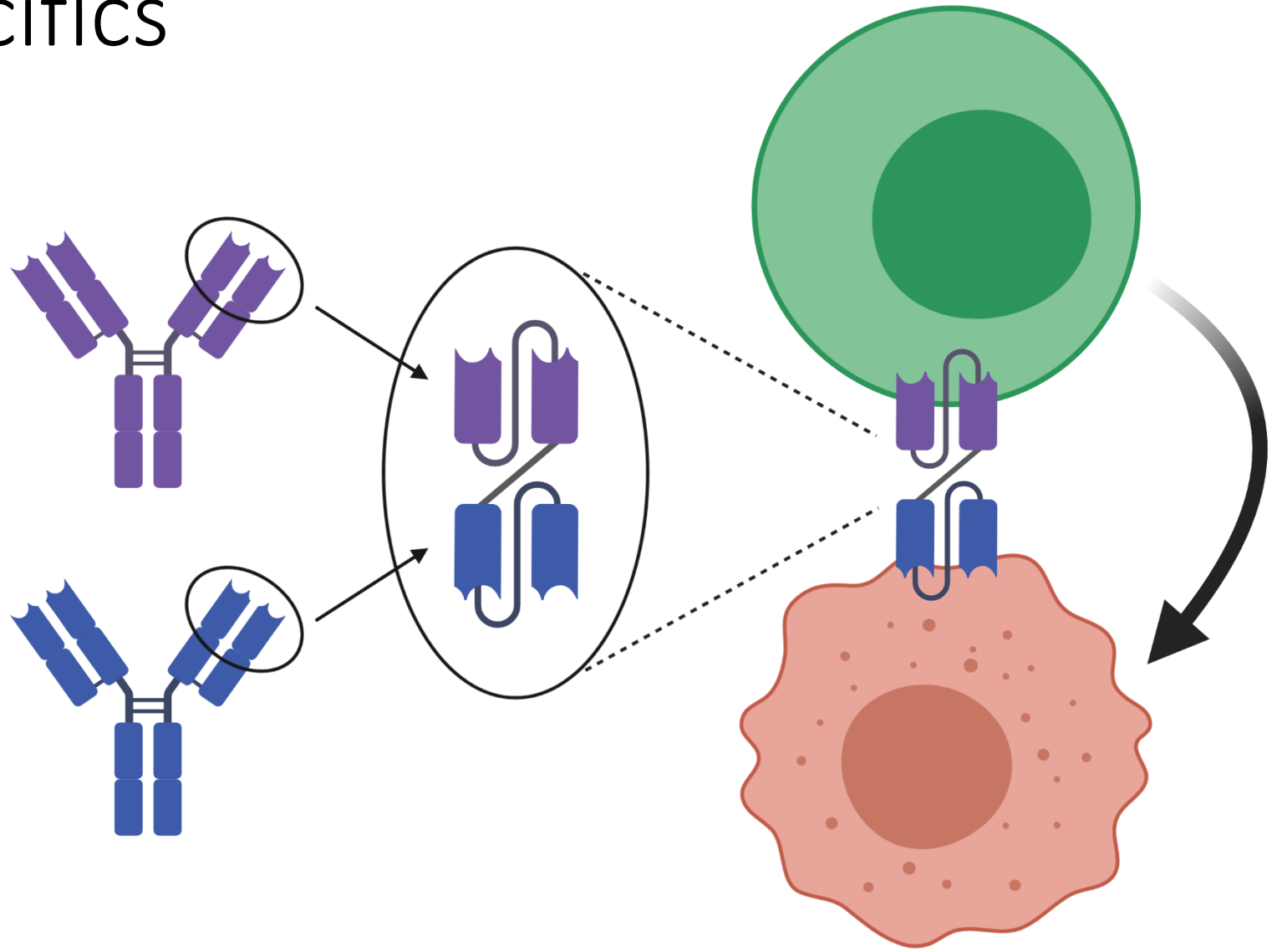
# Bispecifics

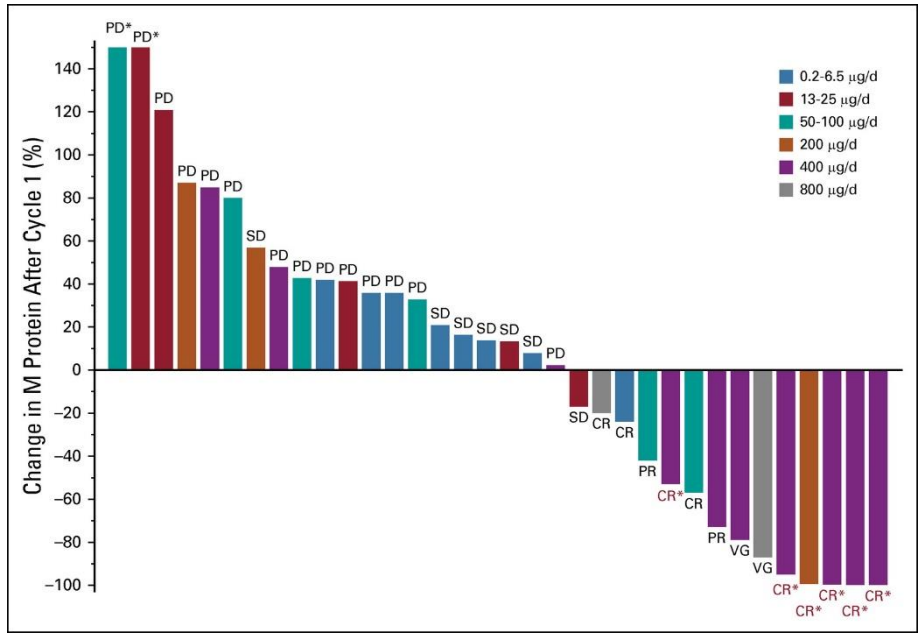


# Ongoing trials of bispecifics for MM

| Agent name | Target antigen | Phase | Clinical trials number |
|---|---|---|---|
| AMG-420 | BCMA | 1 | NCT02514239 |
| AMG-701 | BCMA | 1/2 | NCT03287908 |
| CC-93269 | BCMA | 1 | NCT03486067 |
| PF-06863135 | BCMA | 1 | NCT03269136 |
| REGN-5458 | BCMA | 1/2 | NCT03761108 |
| TNB-383B | BCMA | 1 | NCT03933735 |
| JNJ-64007957 | BCMA | 1 | NCT03145181 |
| JNJ-64007564 | GPRC5d | 1 | NCT03399799 |
| GBR-1342 | CD38 | 1/2 | NCT03309111 |
| BCFR4350A | FCRH5 | 1 | NCT03275103 |

# Clinical data for bispecifics in MM: AMG-420

- Targeting BCMA and CD3
- No correlation of response and BCMA levels
- Development stopped for this agent in favor of one with longer half-life



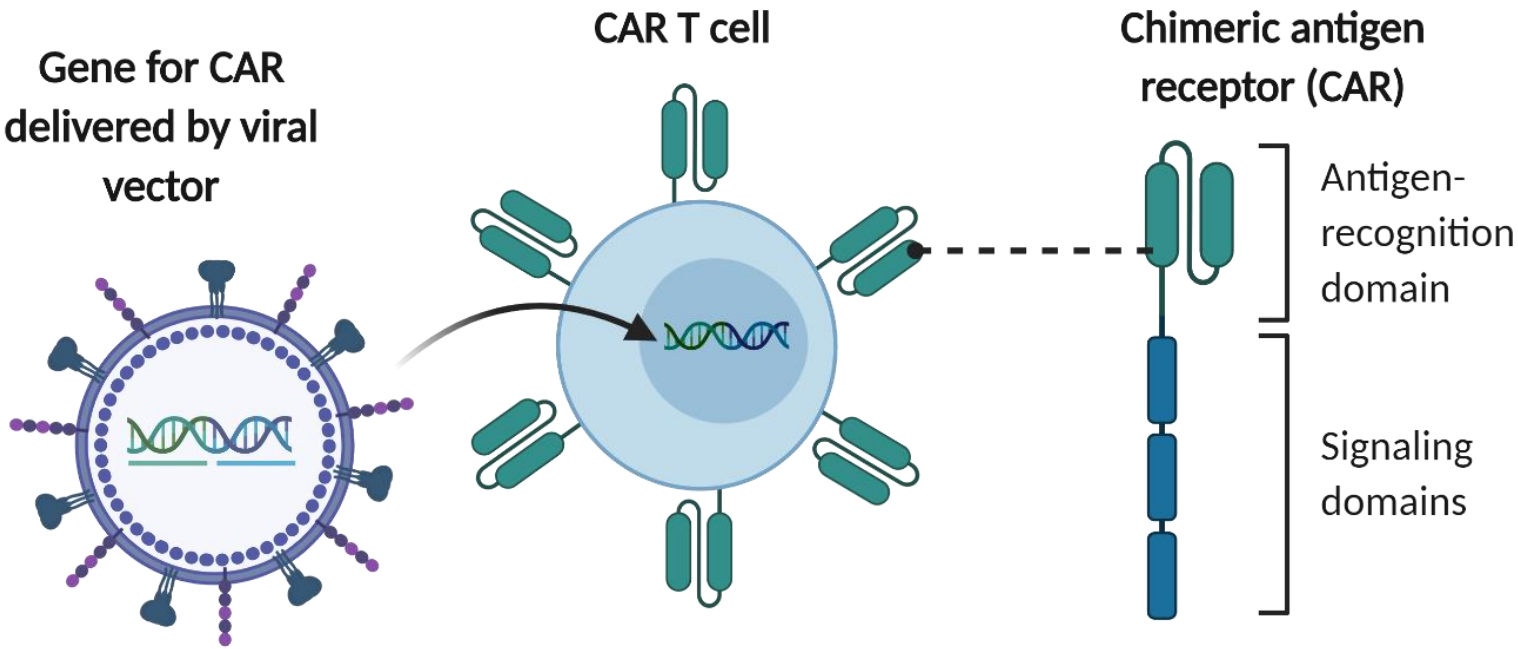

| Variable | No. (%) | No. of Patients With AEs at Each Grade | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| No. of patients | 42 | | | | | |
| Infections serious AEs | | | | | | |
| All | 14 (33) | — | 4 | 8 | — | 2[b] |
| Pulmonary[a] | 6 (14) | — | 3 | 3 | — | — |
| Central line/port infections | 5 (12) | — | — | 5 | — | — |
| Adenovirus[b,c] | 1 (2) | — | — | — | — | 1 |
| Aspergillosis/influenza[b] | 1 (2) | — | — | — | — | 1 |
| Infection of unknown origin (fever)[d] | 1 (2) | — | 1 | — | — | — |
| Treatment-related serious AEs | | | | | | |
| Peripheral polyneuropathy | 2 (5) | — | — | 2 | — | — |
| Edema | 1 (2) | — | — | 1 | — | — |
| Cytokine release syndrome | | | | | | |
| All treatment related, maximum grade | 16 (38) | 13 | 2 | 1 | — | — |

Topp, J Clin Oncol 2020.

# Outline

- Monoclonal antibodies
  - Daratumumab
  - Isatuximab
  - Elotuzumab
- Antibody-drug conjugates
- Bispecifics
- Cellular therapies

# Cellular therapies – CAR T cells



# Ongoing trials of CAR T cells for MM

| Agent name | Target antigen | Clinical trials number |
|---|---|---|
| bb2121 | BCMA | NCT03651128 |
| JNJ-682684528 | BCMA | NCT04181827 |
| JCARH125 | BCMA | NCT03430011 |
| P-BCMA-101 | BCMA | NCT03288493 |
| CT053 | BCMA | NCT03915184 |
| CART-BCMA ± huCART19 | BCMA; CD19 | NCT03549442 |
| Anti-SLAMF7 CAR T | SLAMF7 | NCT03958656 |

# BCMA CAR-T Cells ASCO 2020

## Safety

| | KarMMa | EVOLVE | CARTITUDE-1 |
|---|---|---|---|
| ↓ ANC ≥G3, % | 89 | 90 | 100 |
| ↓ Plts ≥G3, % | 52 | 47 | 69 |
| CRS: all, ≤G3, % | 84, 6 | 89, 3 | 93, 7 |
| Med. Time to CRS, duration, days | 1 (1-12)<br>5 (1-63) | 2 (1-4)<br>4 (1—10) | 7 (2-12)<br>4 (2-64) |
| ICANS: all, ≤G3, % | 17, 3 | 13, 3 | 10, 3 |
| HLH/MAS, % | -- | 5 | ? 7 (lfts) |
| Infections: all, ≥G3 % | 69, -- | 40, 13 | --, 19 |
| Toci / steroid / anakinra use, % | 52/15/0 | 76/52/23 | 79/21/21 |

## Efficacy

| | KarMMa (n = 128) | EVOLVE (n = 62) | CARTITUDE-1 (n = 29) |
|---|---|---|---|
| ORR, % | 73 (66-82) | 92 | 100 |
| sCR/CR, % | 33 | 36 | 86 |
| MRD neg ≥$10^{-5}$, % evaluable | 94 | 84 | 81 |
| PFS/DoR, months | 8.8/10.7 | NR | NR |
| Screened<br>Apheresed<br>Treated | 150<br>140<br>128 | -- | 35<br>35<br>29 |

Munshi NC et al. ASCO 2020. Abstract 8503; Mailankody S et al. ASCO 2020. Abstract 8504; Berdeja JG et al. ASCO 2020. Abstract 8505.

# Panel recommendations for CAR T administration

- Patients should be **re-evaluated & re-staged** if they received bridging therapy or >30 days have passed since lymphodepletion
- *If bridging therapy induces a CR, CAR T therapy should **still proceed** (even though data are currently limited)*
- Patients with appropriate characteristics may receive CAR T therapy as **outpatient infusion**

# Panel recommendations for CAR T toxicity management

- **ASTCT grading** for CRS and ICANS
- Grade 2+ CRS requires **prompt tocilizumab** treatment
- Tocilizumab may be considered for **grade 1 CRS** in elderly patients, those with comorbidities, or for prolonged high fevers
- **ICANS should be managed** with supportive care, escalating to steroids and possible use of levetiracetam
- For persistent (>3 months) cytopenia, evaluate for **alternative causes** like infections and MDS
- *Panel **does not recommend CAR T** therapy for patients with renal failure or hepatic impairment*

# Outstanding questions for bispecifics and cell therapies

- Interpretation of MRD status
- Management of steroid and tocilizumab-refractory CRS (anakinra vs siltuximab)
- Impact of prior ADC or bispecific exposure on CAR T efficacy

# Cell therapy case study

- 65 yo pt with MM, R-ISS stage II
- Initially treated with VRD→ ASCT→ lenalidomide maintenance x 30 months (stopped d/t side effects)
- Progressed 6 mo later→ received KRD→ VGPR, 13 months
- Progressed→ DPD→ PR x 8 months
- Progressed with new sacral plasmacytoma and increase in M protein
- ECOG 0, mild neuropathy from treatment
- Wants to be considered for CAR T therapy

# Patient quality of life and education

- Patients and caregivers should be informed about **potential side effects** and when to contact their provider
- Recommend patient referral to **support groups,** advocacy organizations, and survivorship programs
- Utilize validated tools like EORTC QLQ-C30 and PROMIS to evaluate **quality of life impacts**

# Conclusions

- Immunotherapies are impacting the management of multiple myeloma
- There is potential for these options to move into earlier stages of disease management
- Combinations of immunotherapies are likely in the future
- Evaluation of response is still complicated

# How to Submit Questions

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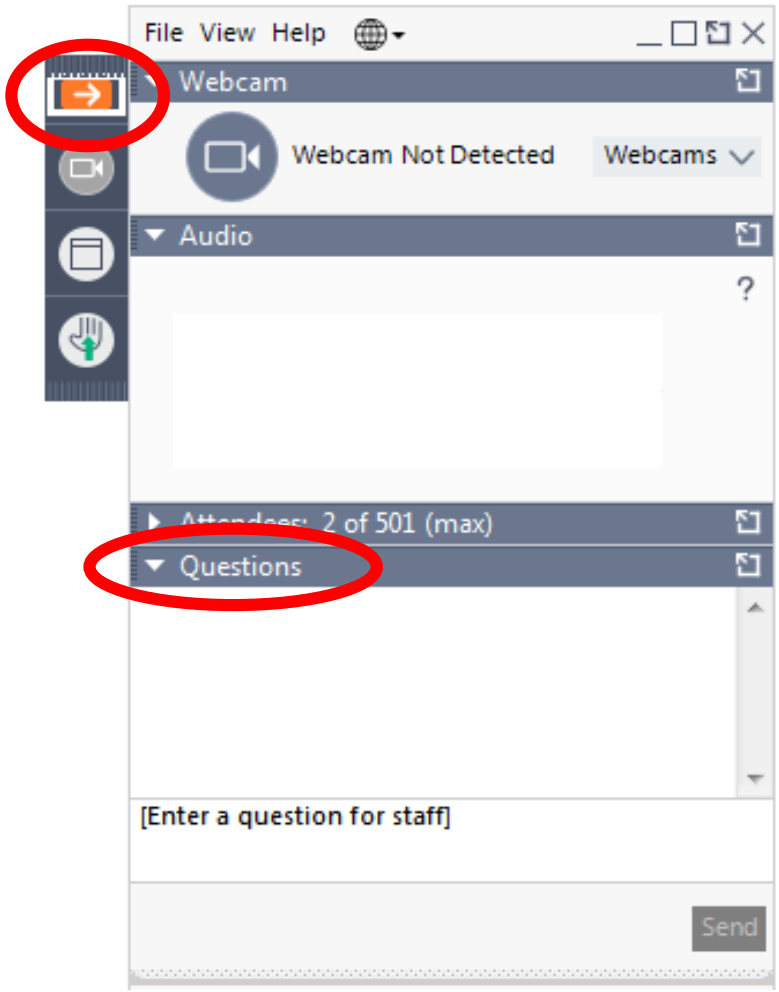


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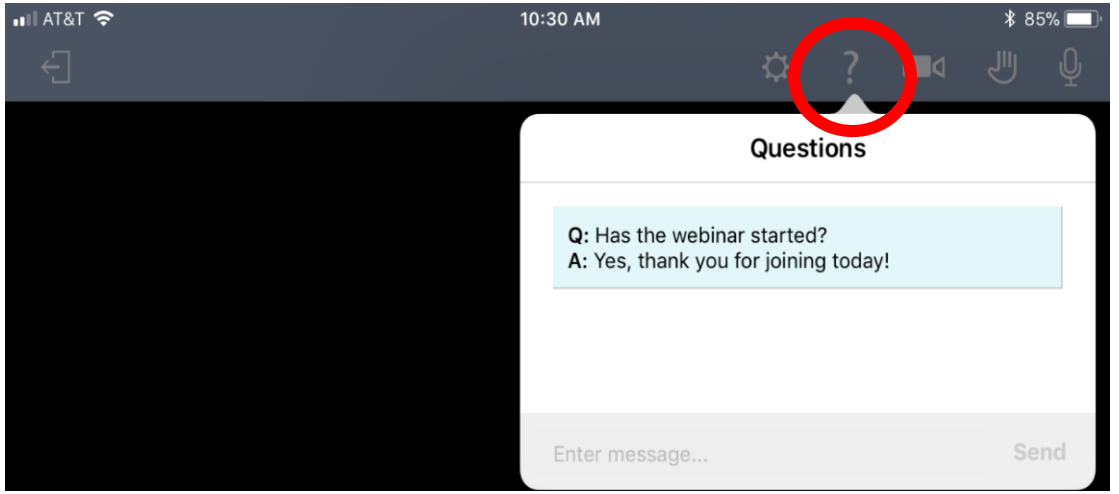

# Journal for ImmunoTherapy of Cancer

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# Upcoming Advances in Cancer Immunotherapy™ Webinar:
## Clinical Updates from ASCO20 Virtual

## Thursday, September 10, 2020, 5:00-6:00 p.m. ET

**Faculty:**

Michael Atkins, MD – *Georgetown-Lombardi Comprehensive Cancer Center*
Shailender Bhatia, MD – *University of Washington*
Stephan Grupp, MD, PhD – *University of Pennsylvania*
Jose Lutzky, MD, FACP – *University of Miami Sylvester Cancer Center*

To register and view complete accreditation information visit sitcancer.org/acionline

*The 2019–2020 ACI series is jointly provided by Postgraduate Institute for Medicine and the Society for Immunotherapy of Cancer.*

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- Continuing Education Credits are offered for Physicians, PA's, NP's, RN's and Pharmacists
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- Questions and comments: connectED@sitcancer.org

## Thank you for attending the webinar!

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# Acknowledgements


- Some figures created using biorender.com