

SITC 2019

Gaylord National Hotel
& Convention Center

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NATIONAL HARBOR, MARYLAND



Society for Immunotherapy of Cancer



The Role of T-VEC and Other Oncolytic Viruses in Priming the Tumor Microenvironment for Immunotherapy

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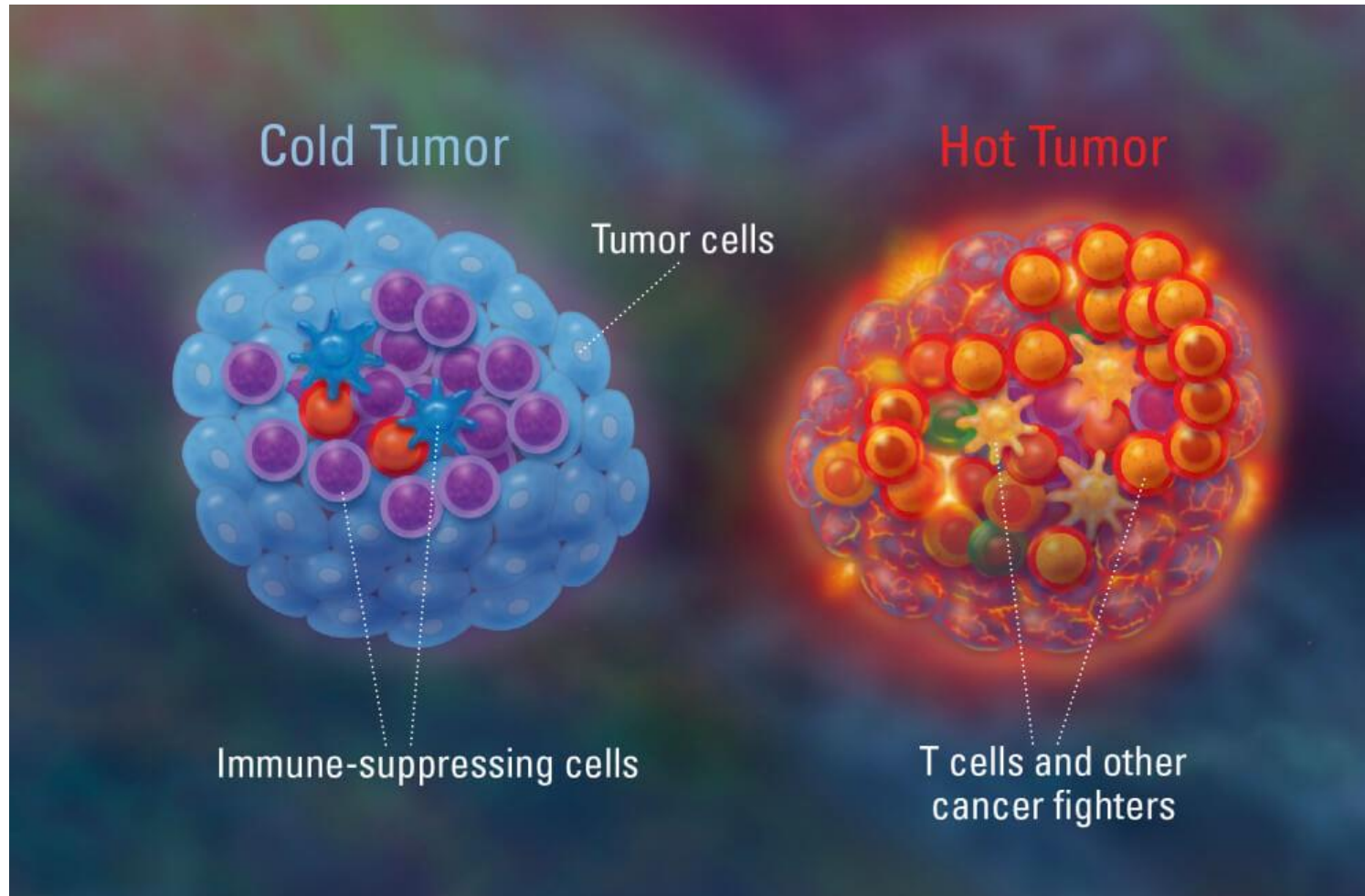
Society for Immunotherapy of Cancer

#SITC2019

Disclosures

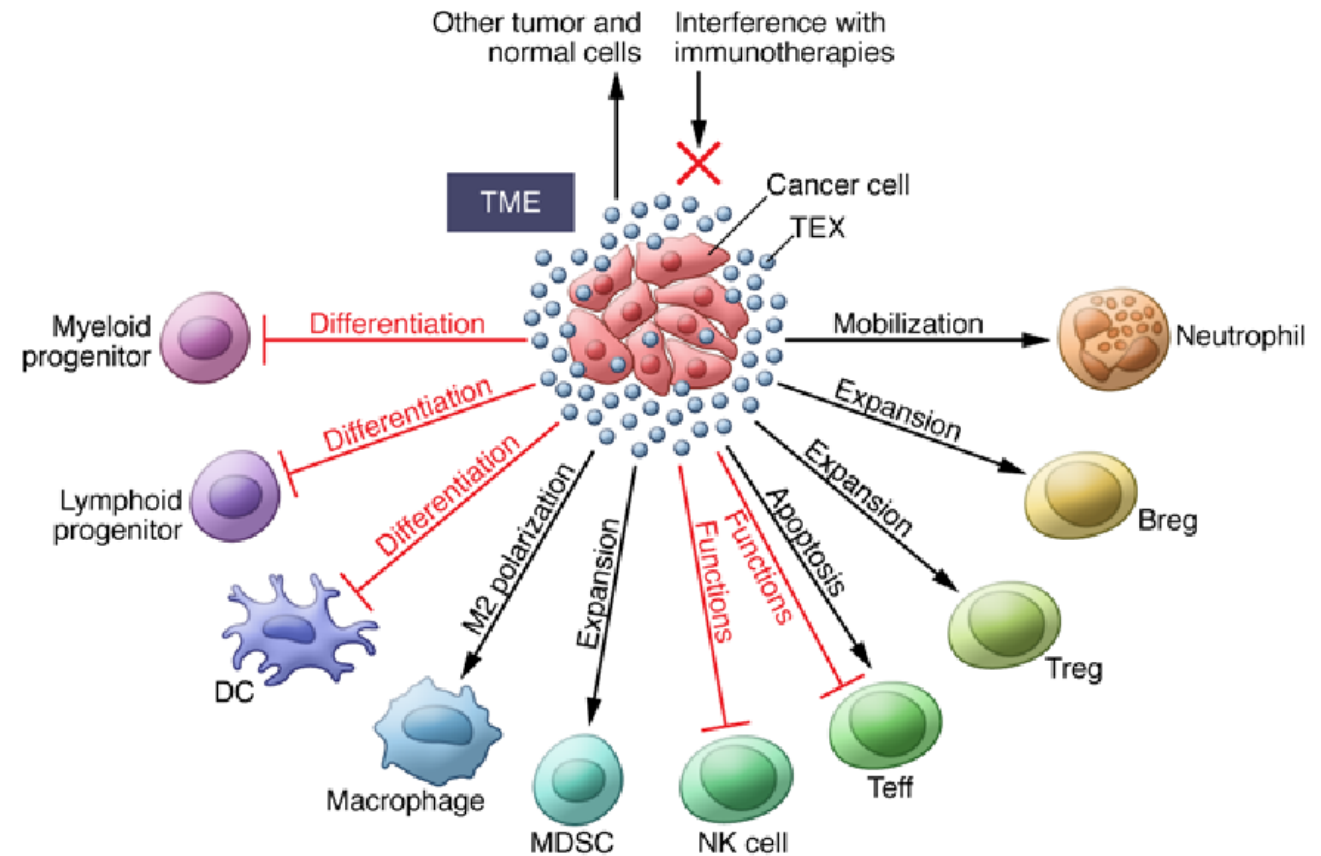
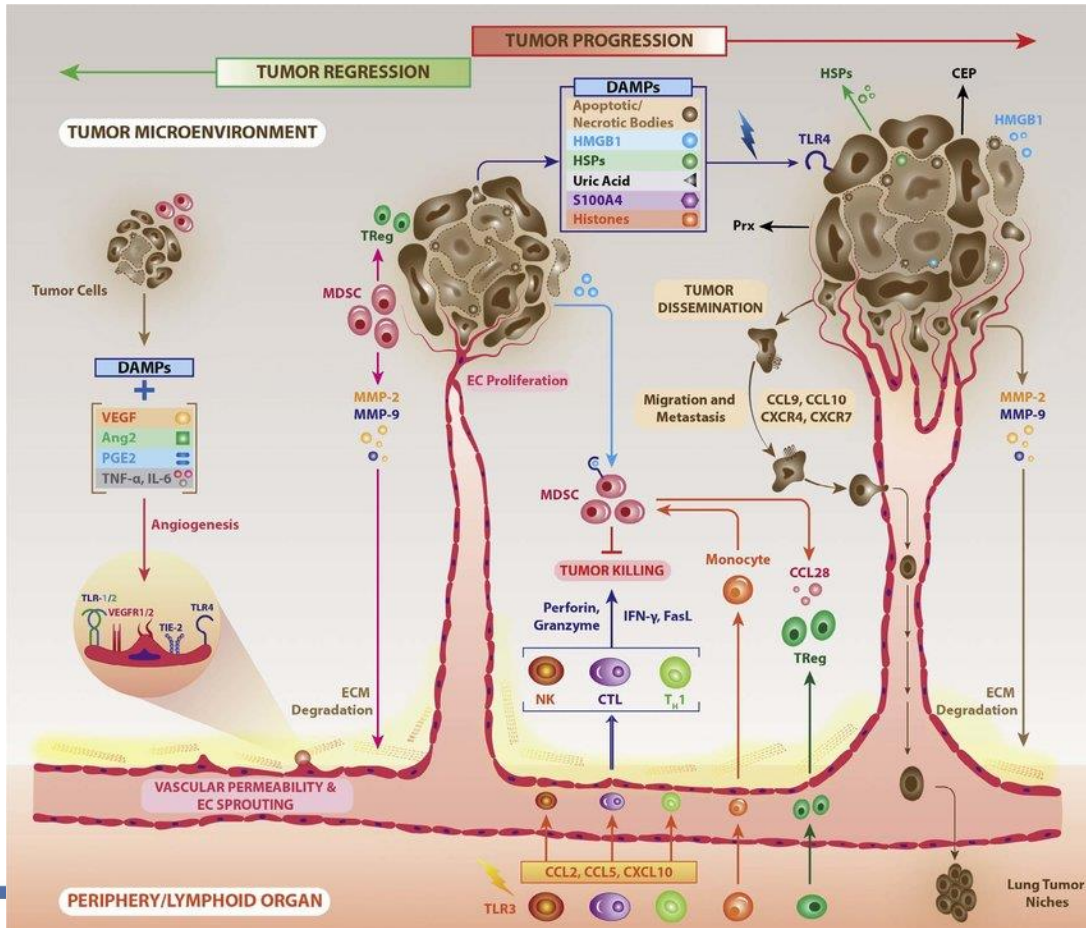
- I am an employee of Replimune, Inc.
- I served on advisory board for SapVax
- Data relating to T-VEC relates to prior work from MGH & at Rutgers University prior to joining Replimune, Inc

Cold vs. Hot Tumor Microenvironment

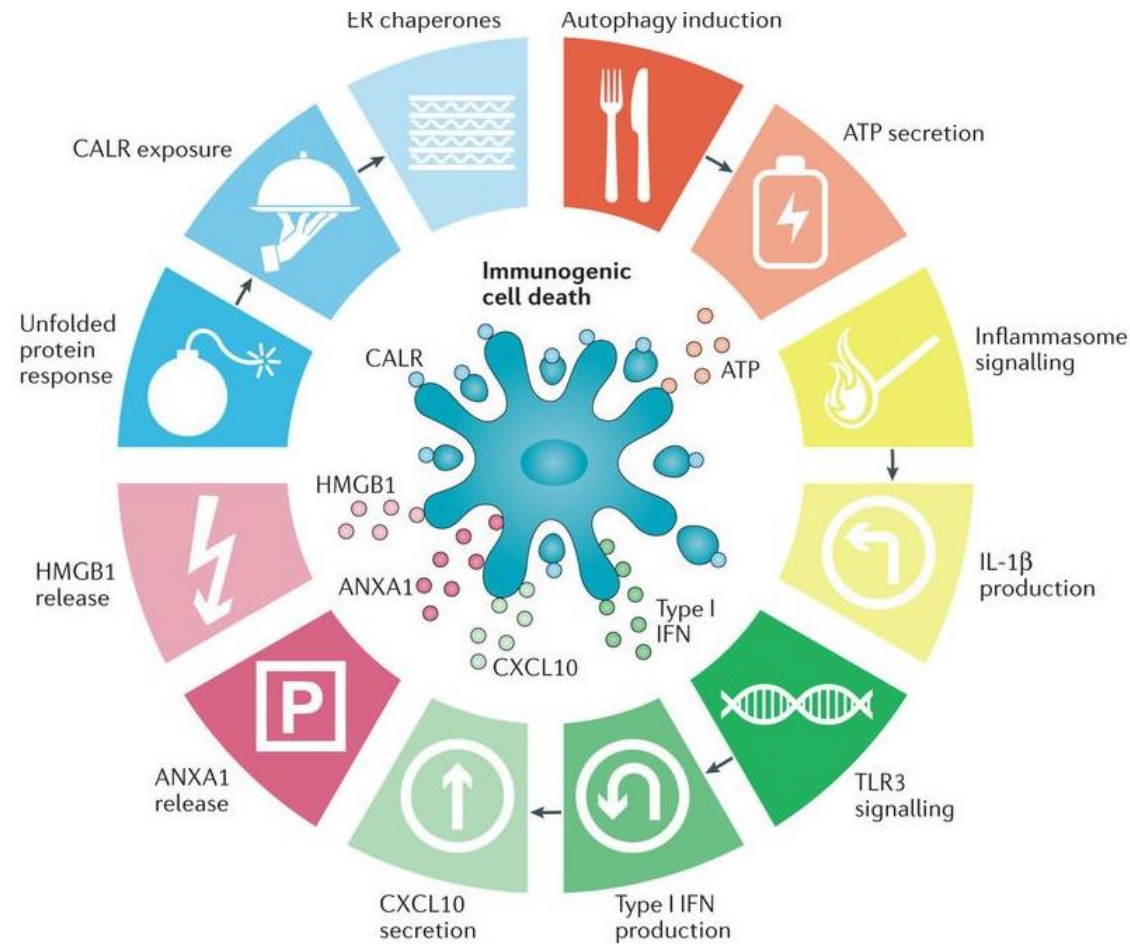


Courtesy Gordon Freeman, DFCI

The Tumor Microenvironment is Complex and Inhibits Anti-tumor Immunity

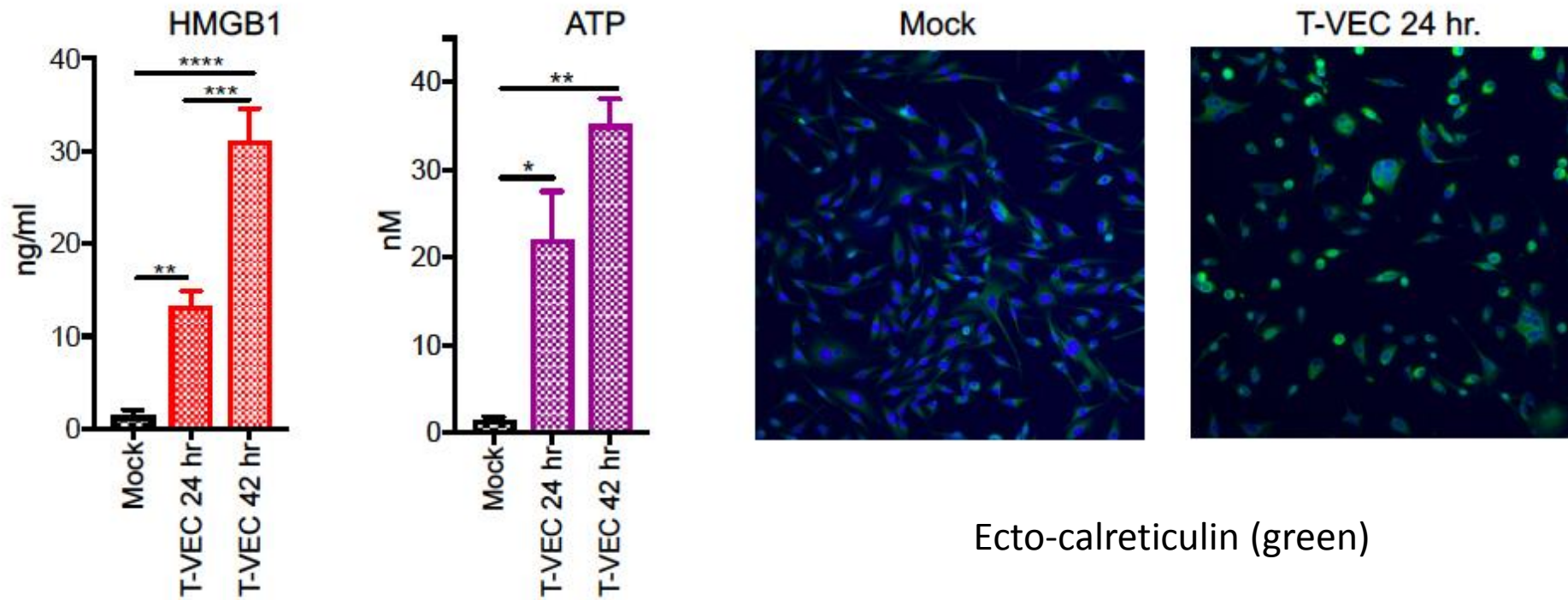


Immunogenic cell death

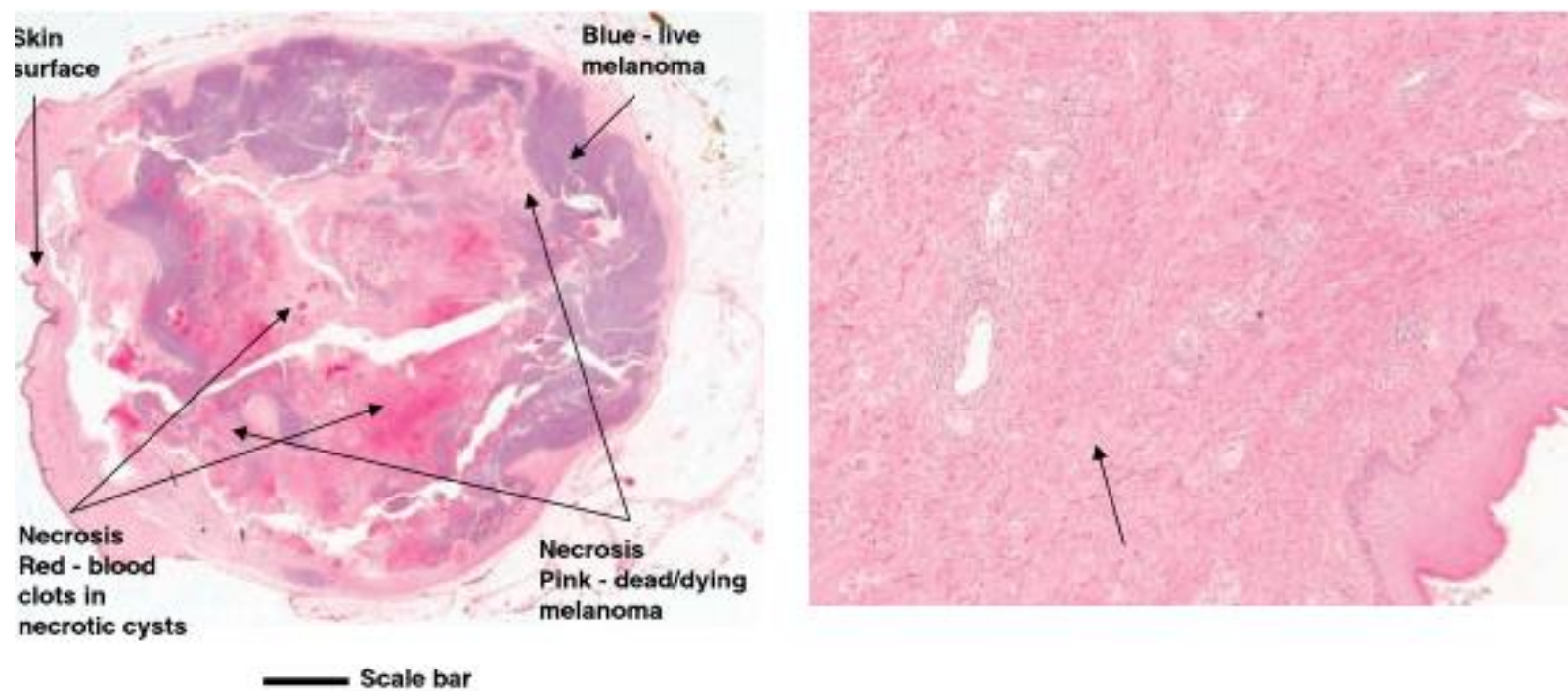


Galluzzi et al. Nature Immunol. 2017

T-VEC induces ICD in SK-MEL-28 melanoma cell lines



T-VEC induces central necrosis following injection



T-VEC improves objective and durable response rate

ITT Set	GM-CSF (N=141)	T-VEC (N= 295)	Treatment Difference (T-VEC – GM-CSF)
Overall Response Rate (95% CI)	5.7% (1.9, 9.5)	26.4% (21.4, 31.5)	20.8% (14.4, 27.1) <i>P</i> < 0.0001 ^a descriptive
CR	0.7%	10.8%	
PR	5.0%	15.6%	
ITT Set	GM-CSF (N=141)	T-VEC (N= 295)	Treatment Difference (T-VEC – GM-CSF)
Durable Response Rate	2.1%	16.3%	14.1% 95% CI: (8.2, 19.2) <i>P</i> < 0.0001 ^a

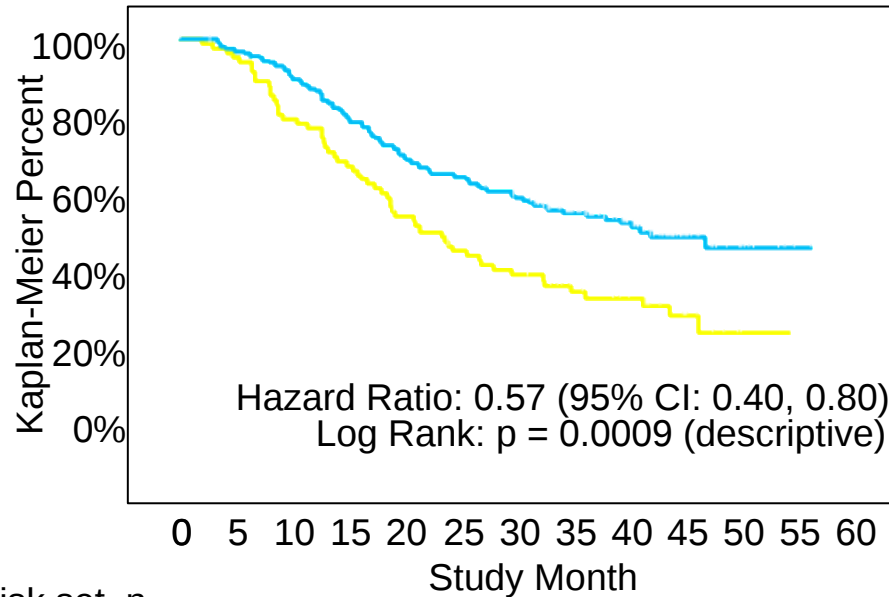
Final analysis of OPTiM study (median follow-up of 49 months)

- DRR 19% vs. 1.4% (unadjusted odds ratio 16.6; 95% CI, 4.0-69.2; $p < 0.0001$)
- ORR 31.5% vs. 6.4%

Exploratory OS subgroup analysis by disease stage

Stage IIIB/C, IVM1a

Stage IVM1b/c

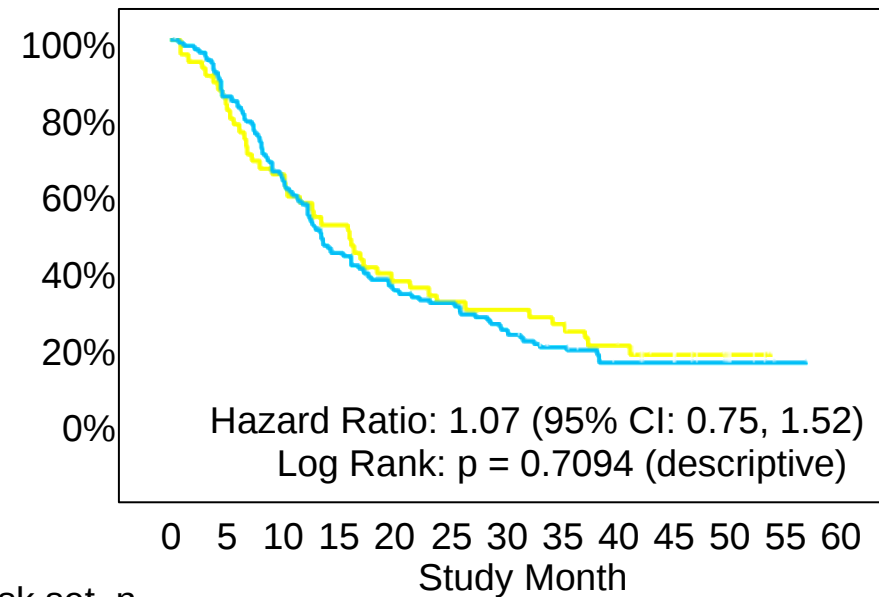


Risk set, n

T-VEC	163	157	146	129	113	104	93	73	51	23	10	1	0
GM-CSF	86	78	65	55	43	35	30	22	17	10	2	0	0

Events / N (%) Median (95% CI), mos

T-VEC	60 / 183 (49)	41.1 (30.6, NE)
GM-CSF	57 / 86 (66)	21.5 (17.4, 29.6)



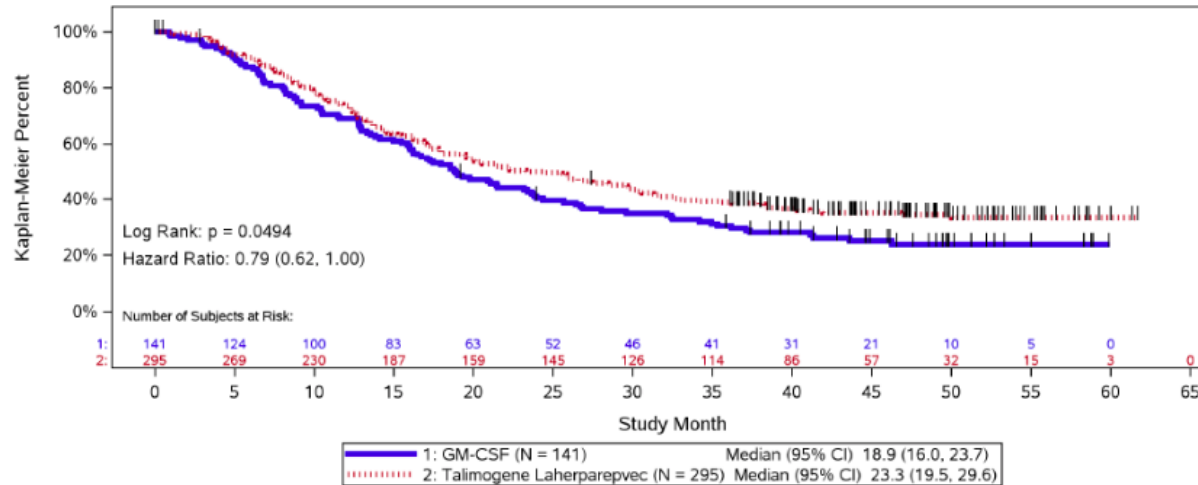
Risk set, n

T-VEC	131	112	84	58	46	41	32	22	15	13	6	1	0
GM-CSF	55	46	35	28	20	17	16	14	10	5	3	0	0

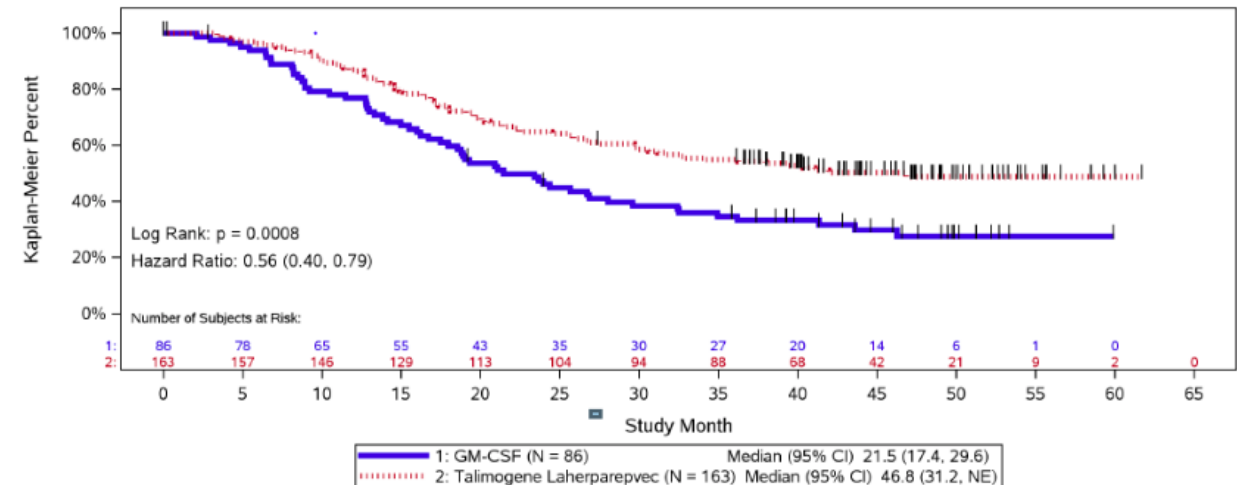
Events / N (%) Median (95% CI), mos

T-VEC	109 / 131 (83)	13.4 (11.4-16.2)
GM-CSF	44 / 55 (80)	15.9 (10.2-19.7)

T-VEC improves OS in final analysis (median follow-up 49 months)



ITT population

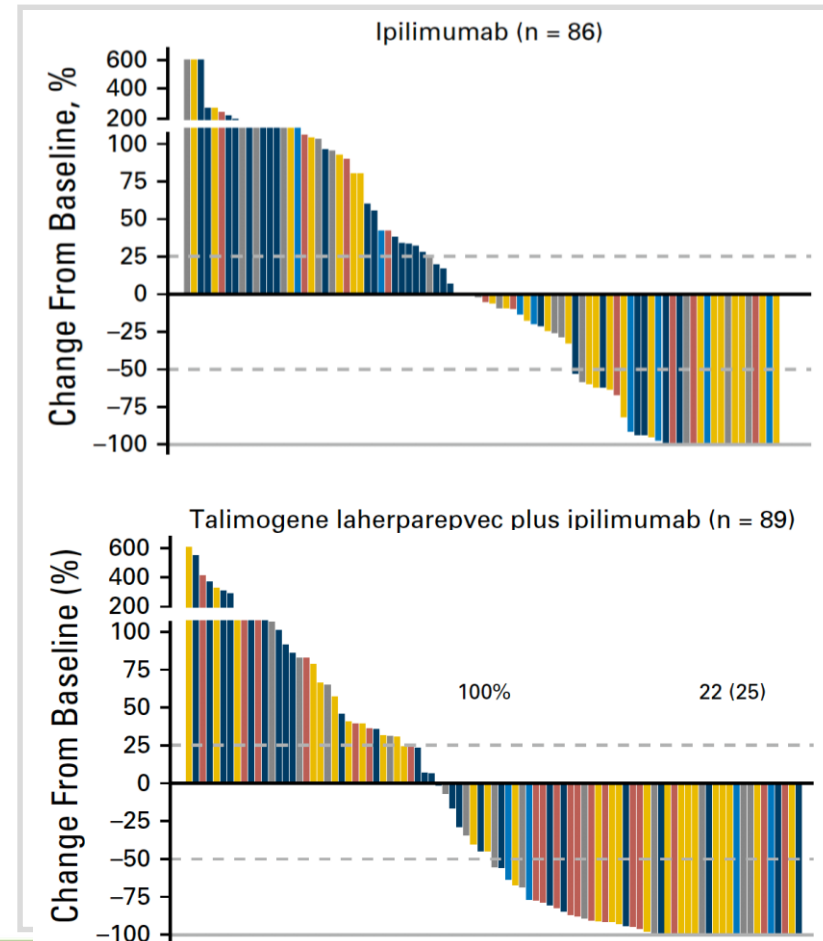


Stage III—IVM1a population

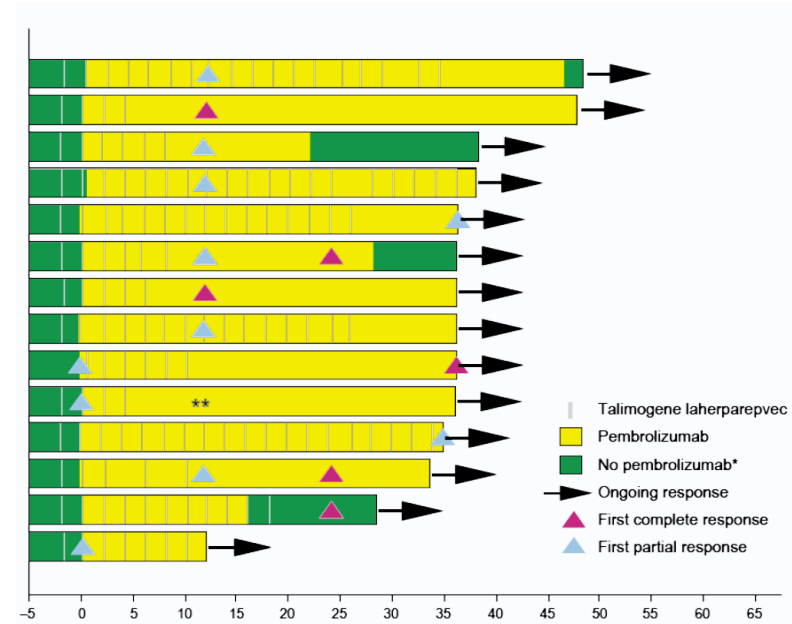
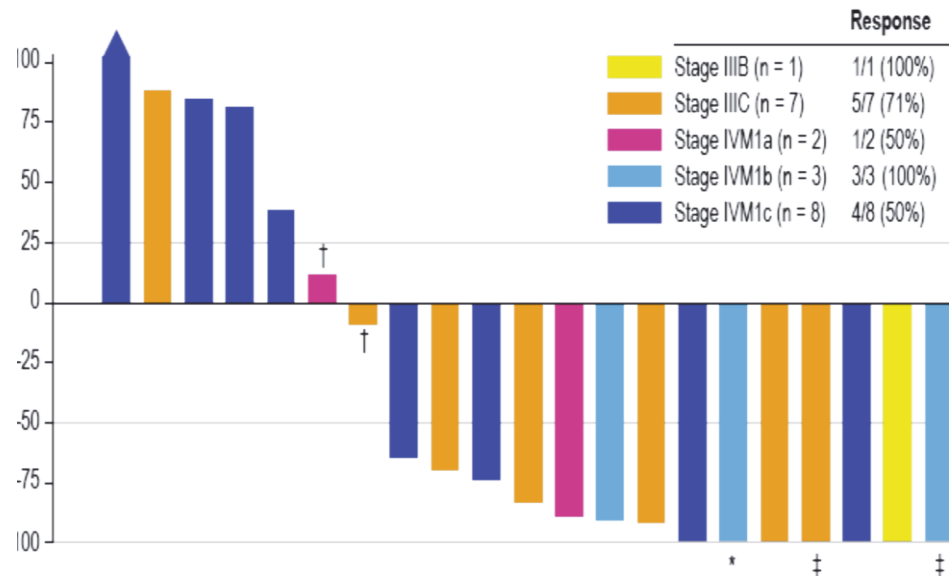
Randomized Phase 2 Clinical Trial: T-VEC + ipilimumab improves ORR

- T-VEC + ipilimumab vs. ipilimumab alone Stage IIb-IVM1c melanoma
- Response rates (N=198) more than doubled with T-VEC + ipilimumab vs. ipilimumab alone (38% vs. 18%)
- For visceral lesions (none injected), the response rate was 35% for T-VEC + ipilimumab vs. 14% for ipilimumab alone
- No additional toxicity as compared to ipilimumab alone

Chesney et al JCO, 2017



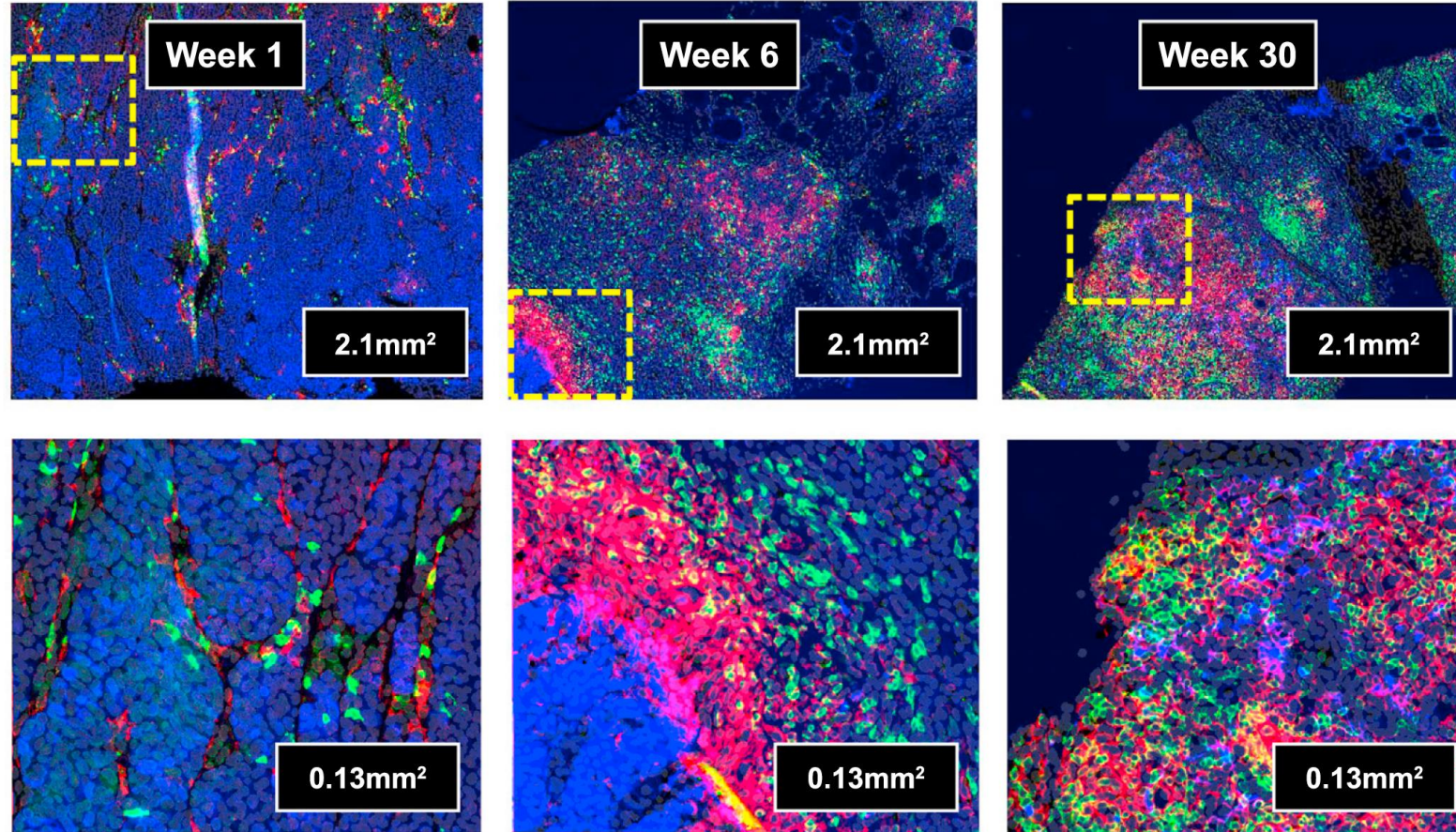
Phase 1 clinical trial of T-VEC and pembrolizumab in melanoma



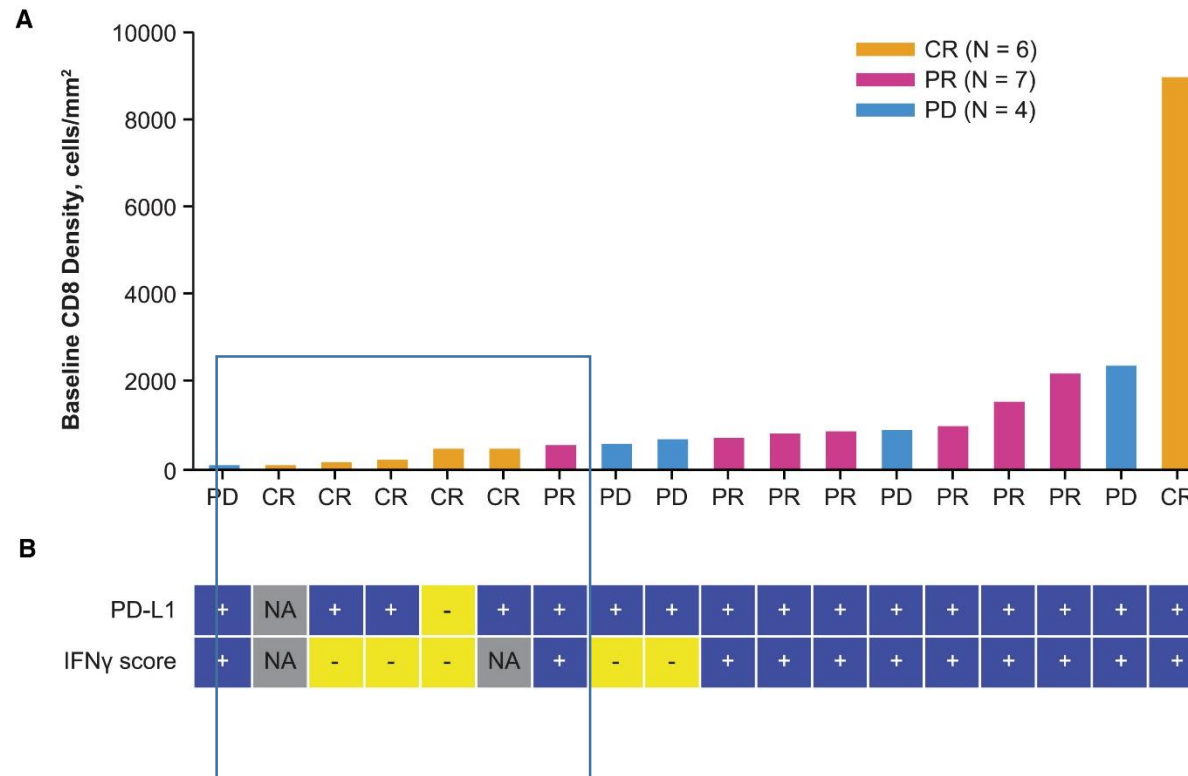
Without added toxicity

T-VEC induces CD8+ T cell recruitment and PD-L1 expression in the TME

PD-L1 CD8 S100

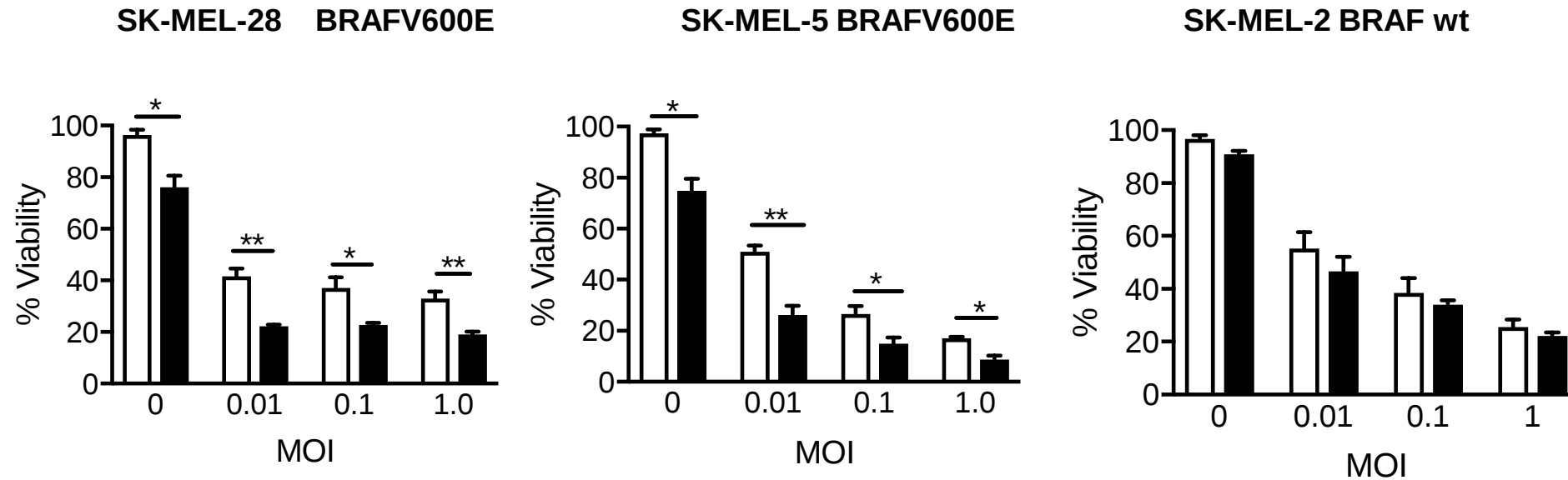


T-VEC + pembrolizumab induces CR in immunologically deserted tumors

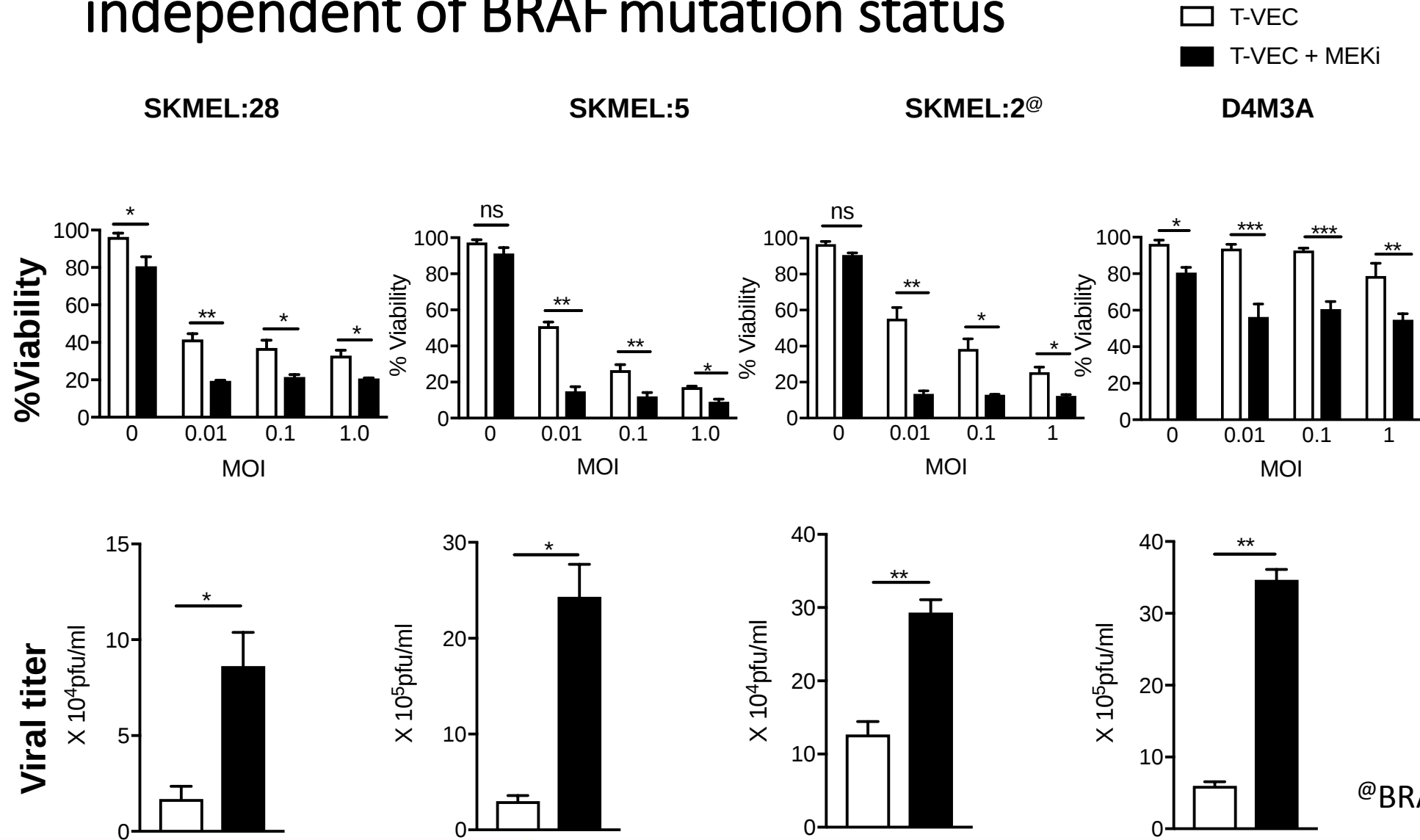


Vemurafinib augments T-VEC mediated oncolysis in BRAF^{V600E} melanoma cells

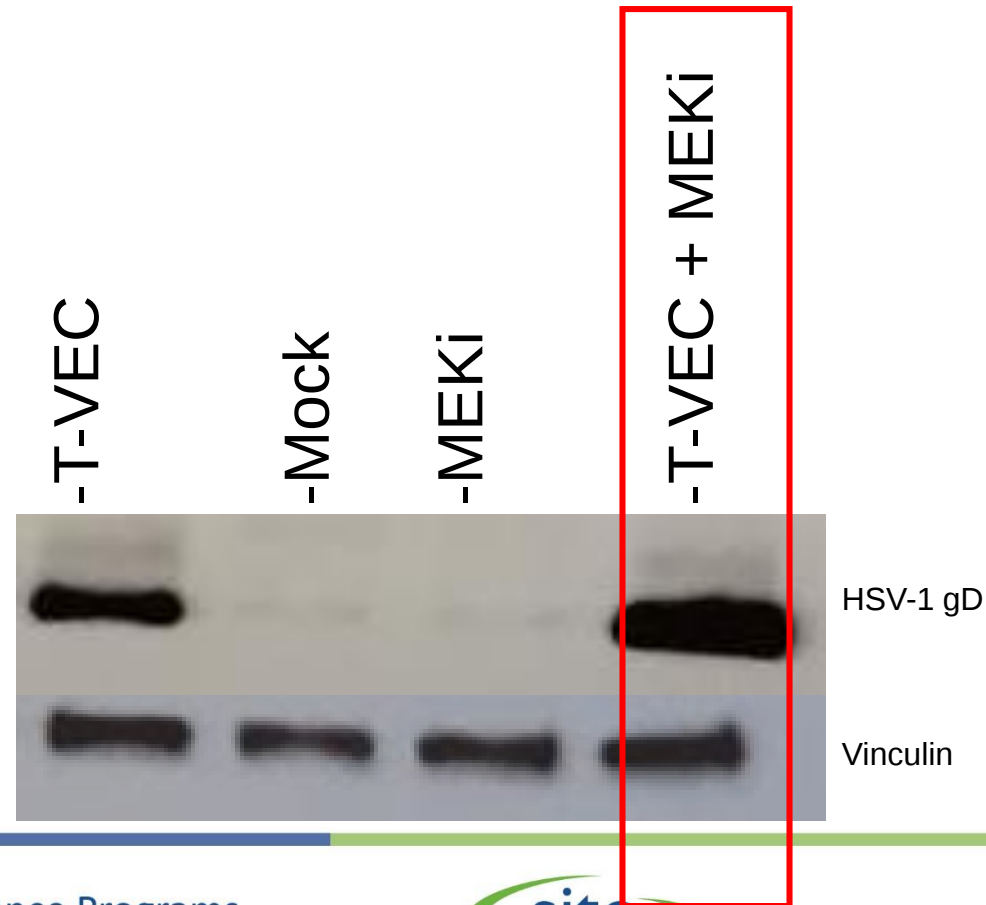
□ T-VEC
■ T-VEC + BRAFi



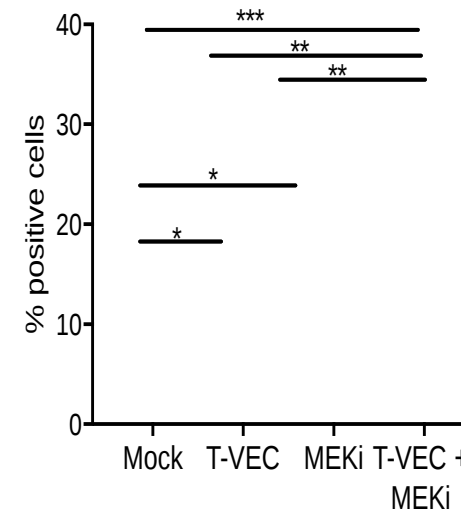
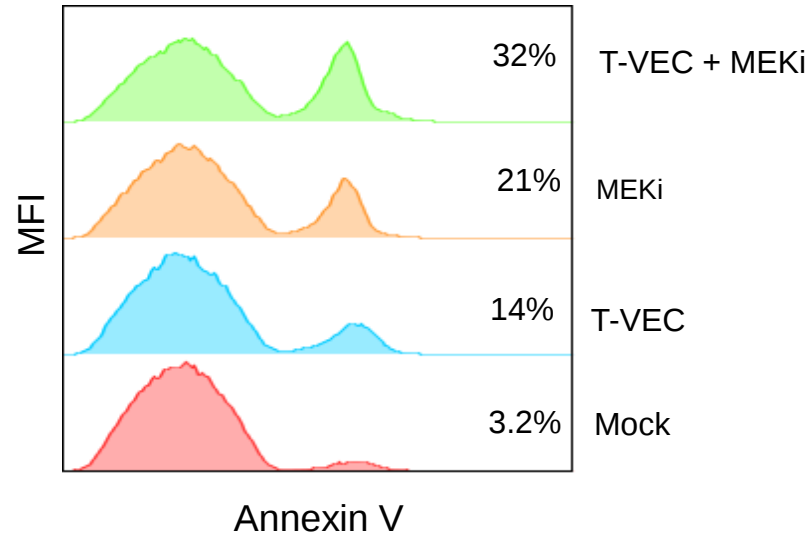
Trametinib augments T-VEC mediated oncolysis independent of BRAF mutation status



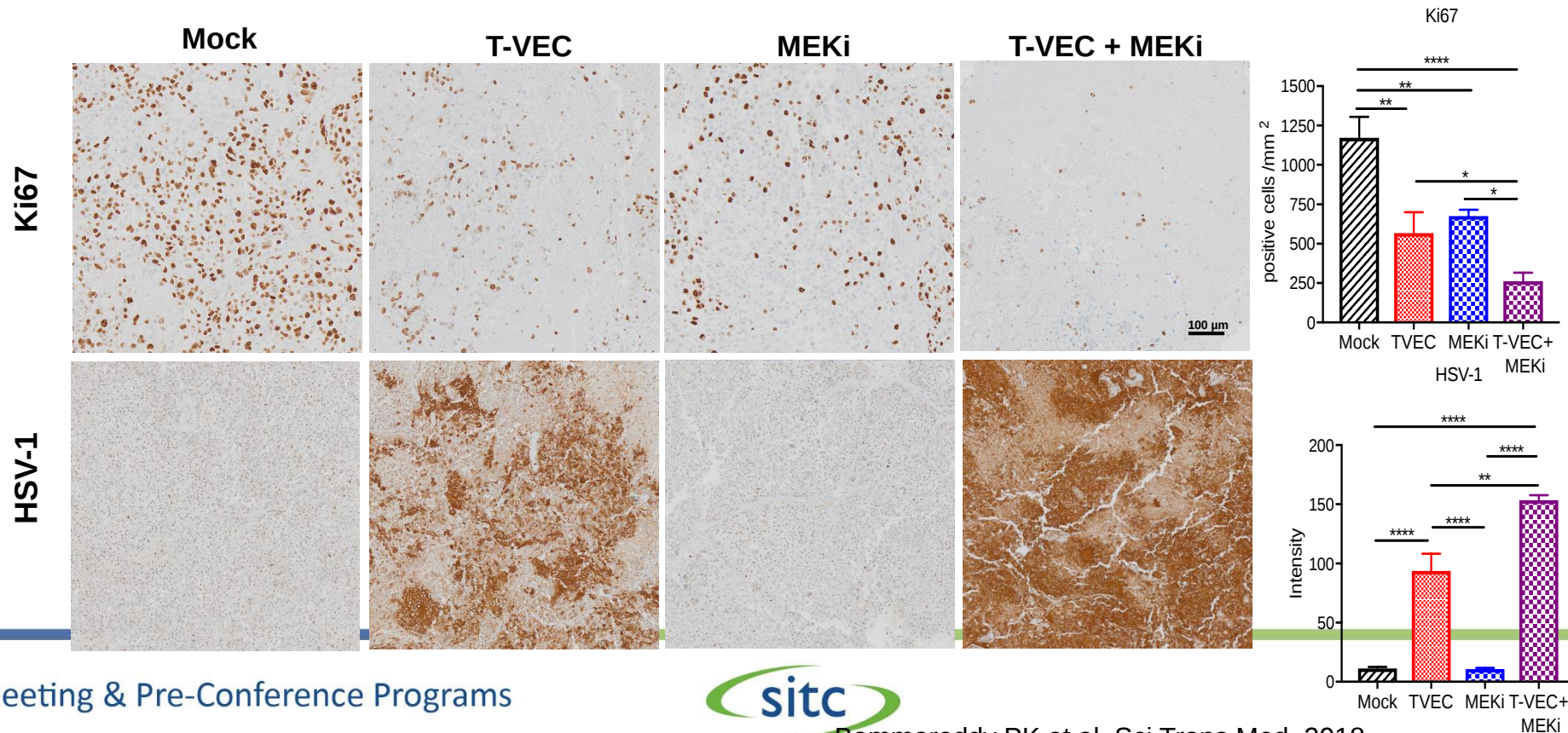
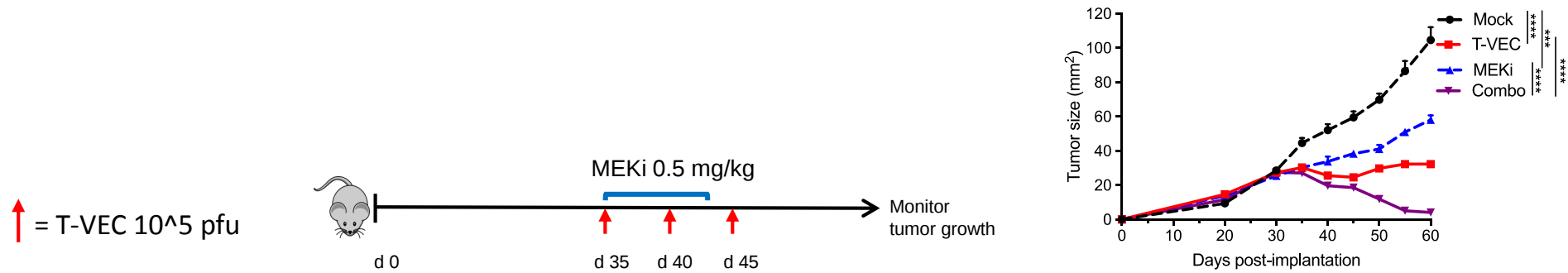
MEK inhibition enhances T-VEC protein production



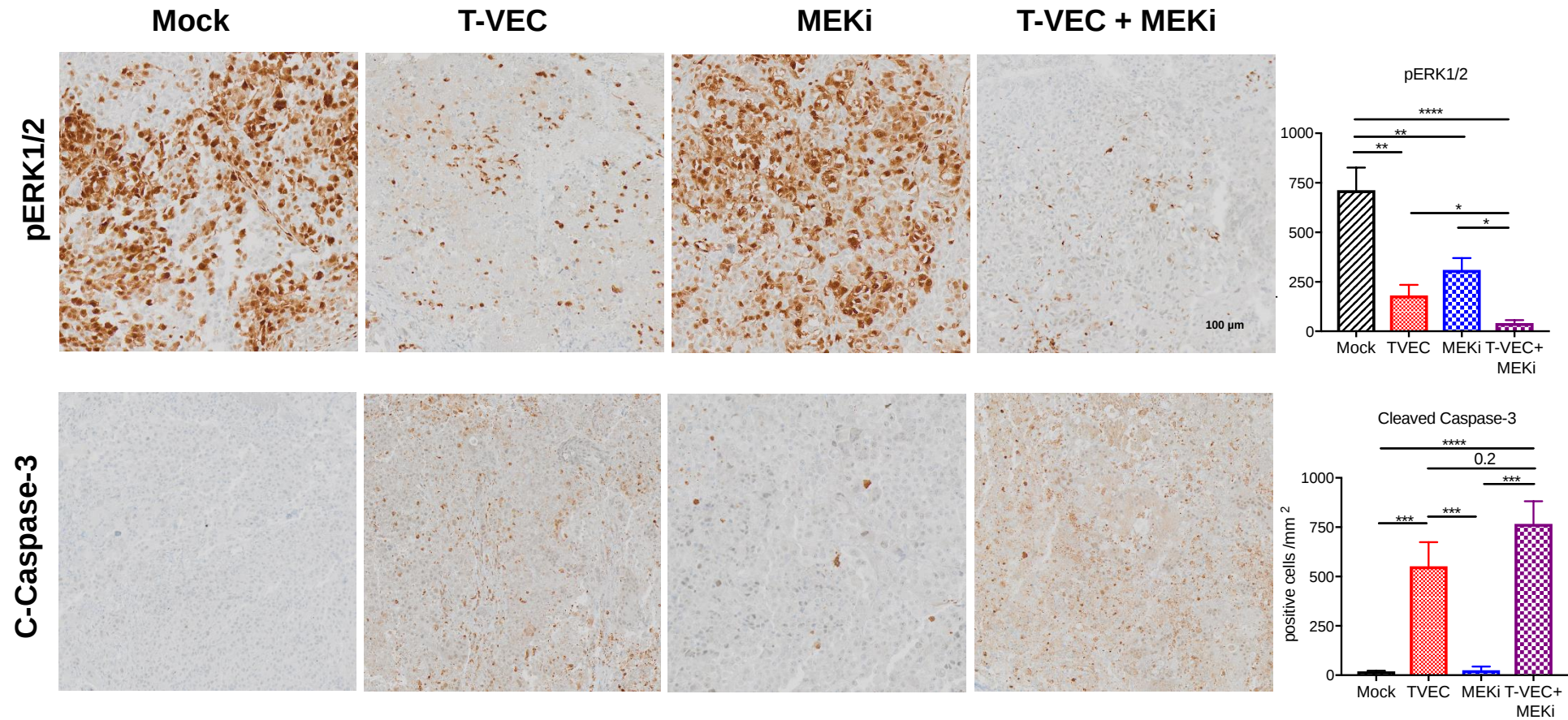
MEKi augments apoptosis induced by T-VEC in SK-MEL-28 melanoma cells



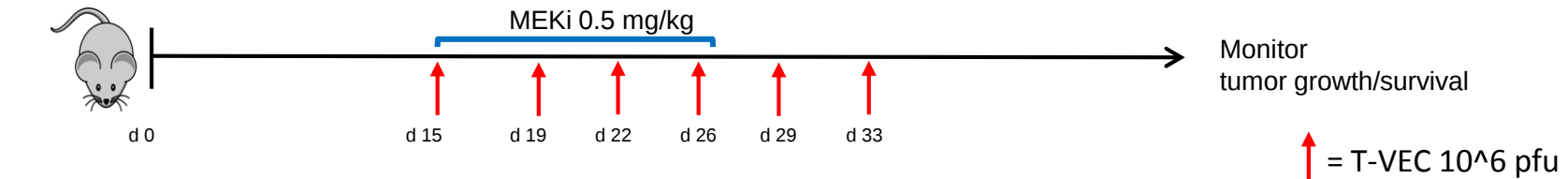
Trametinib (MEKi) augments T-VEC mediated oncolysis in SKMEL-28 human Melanoma xenograft model



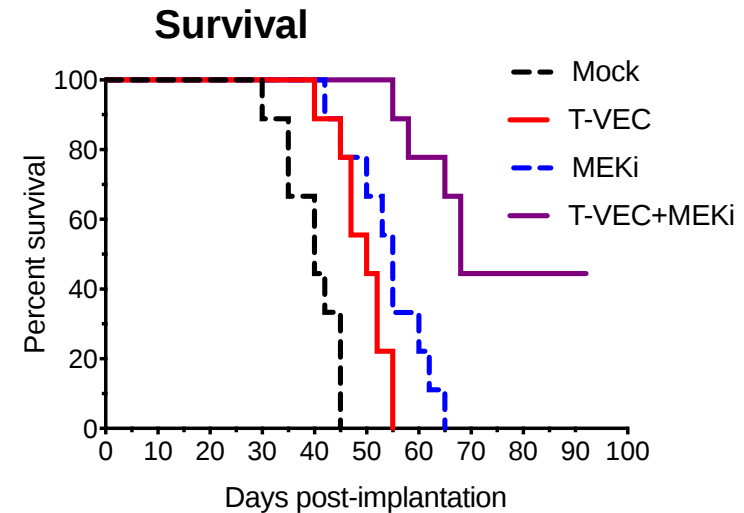
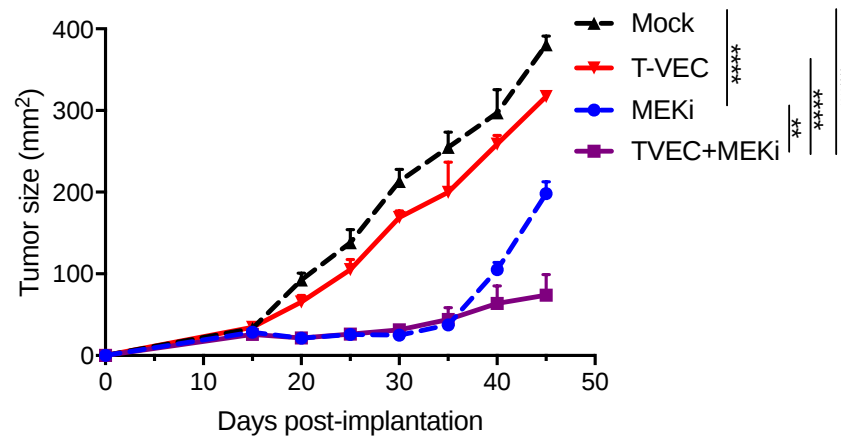
Combination of T-VEC and MEKi increased apoptosis *in vivo*



TVEC and MEKi reduces tumor growth in syngeneic murine melanoma model (D4M3A)



N = 9

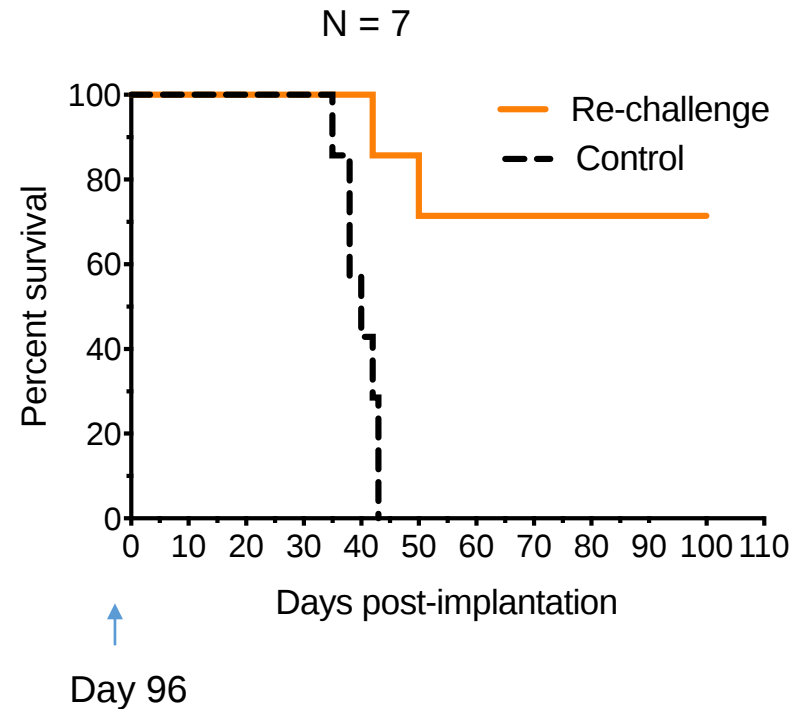


T-VEC and MEKi induces immune memory

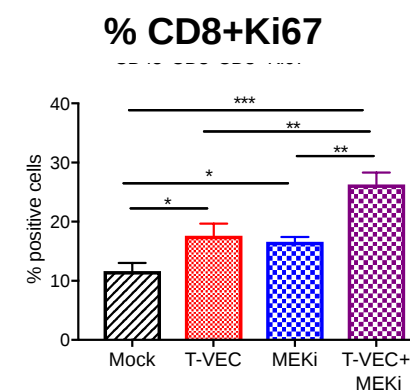
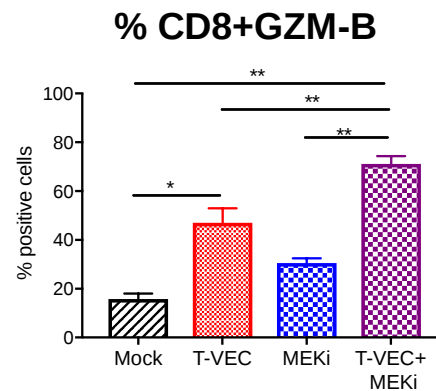
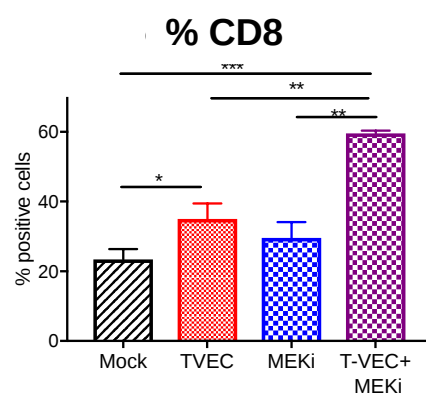
Mice rejected
primary tumor

Re-challenge mice
D4M 600K

Monitor tumor
growth/survival



T-VEC and MEKi enhances T cell activation

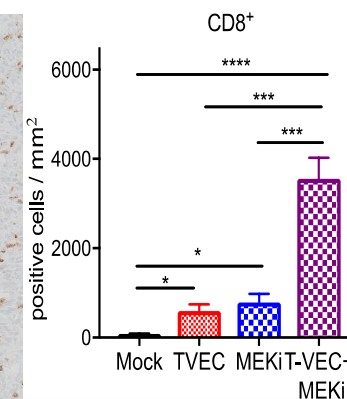
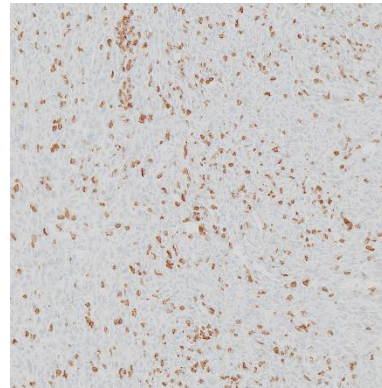
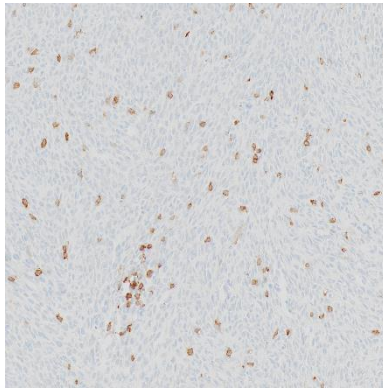
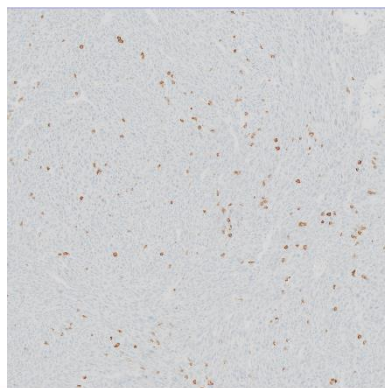
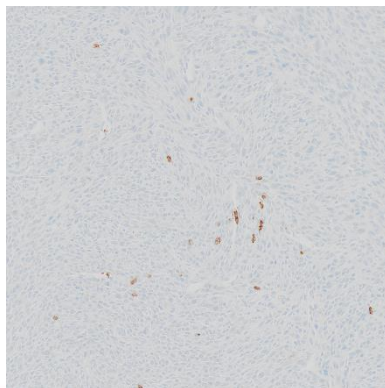


Mock

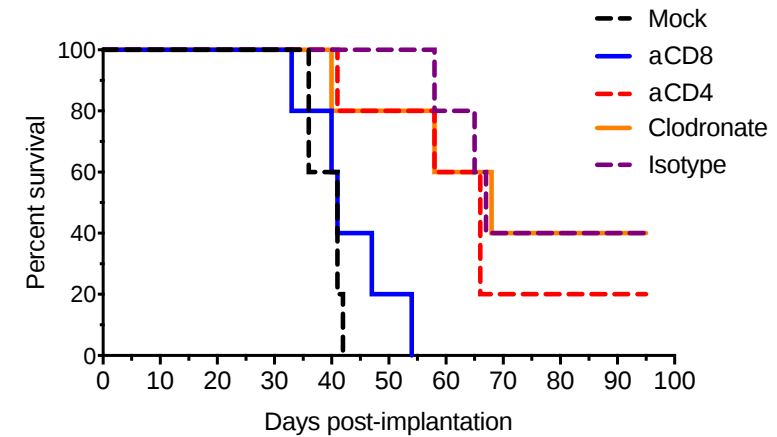
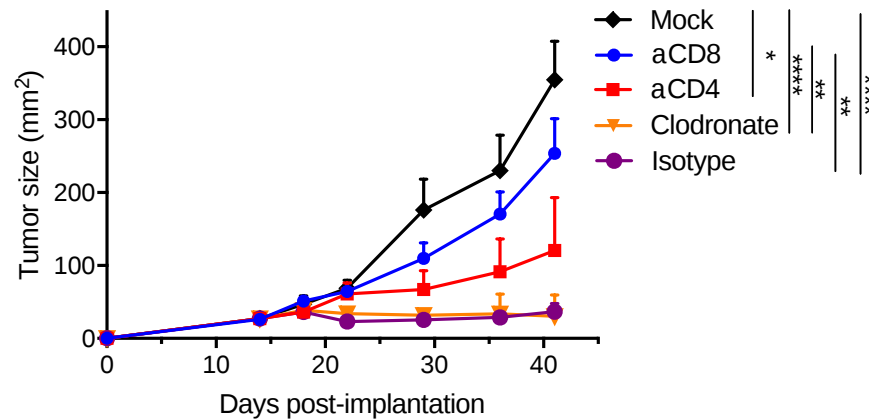
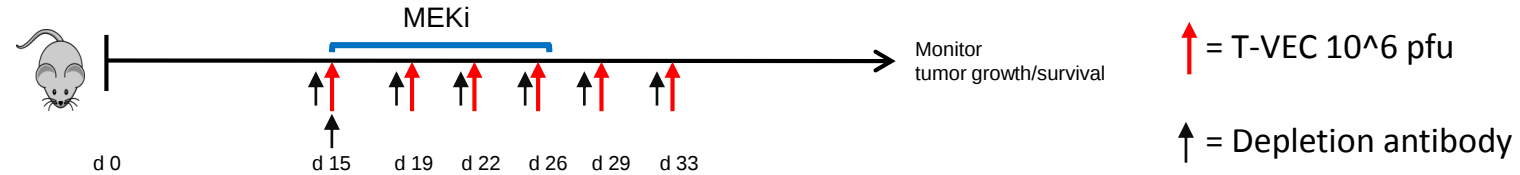
T-VEC

MEKi

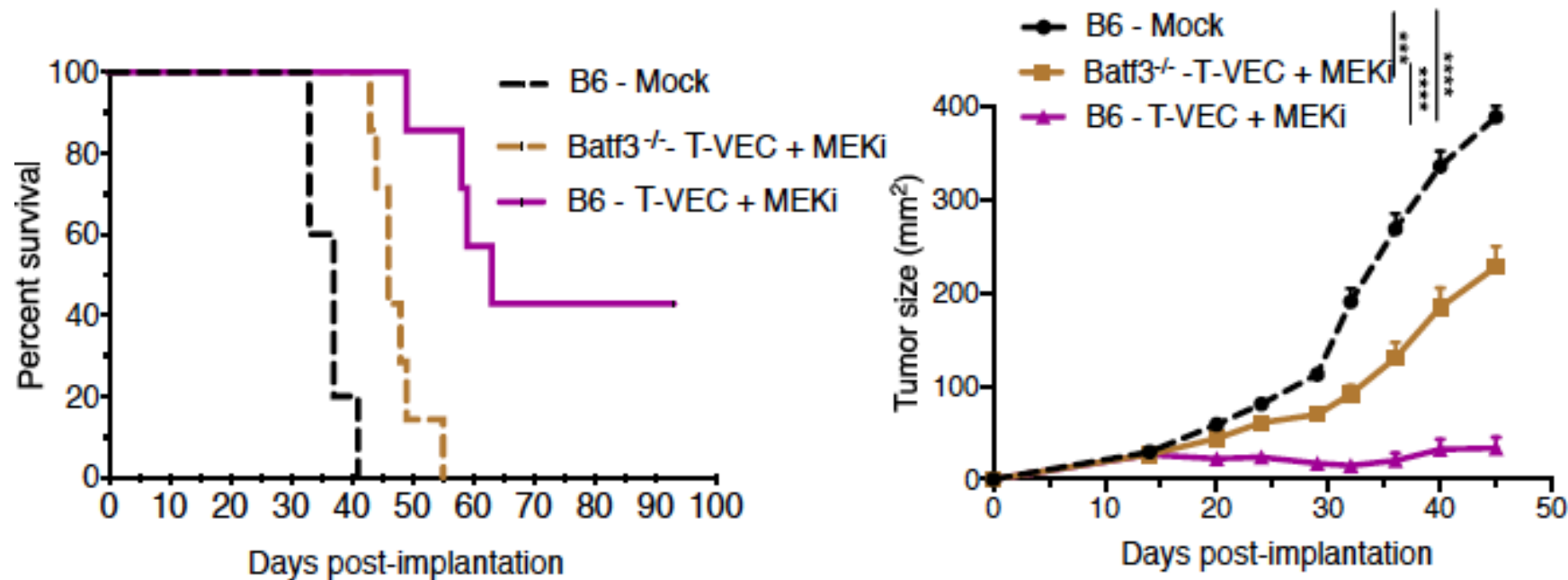
Combo



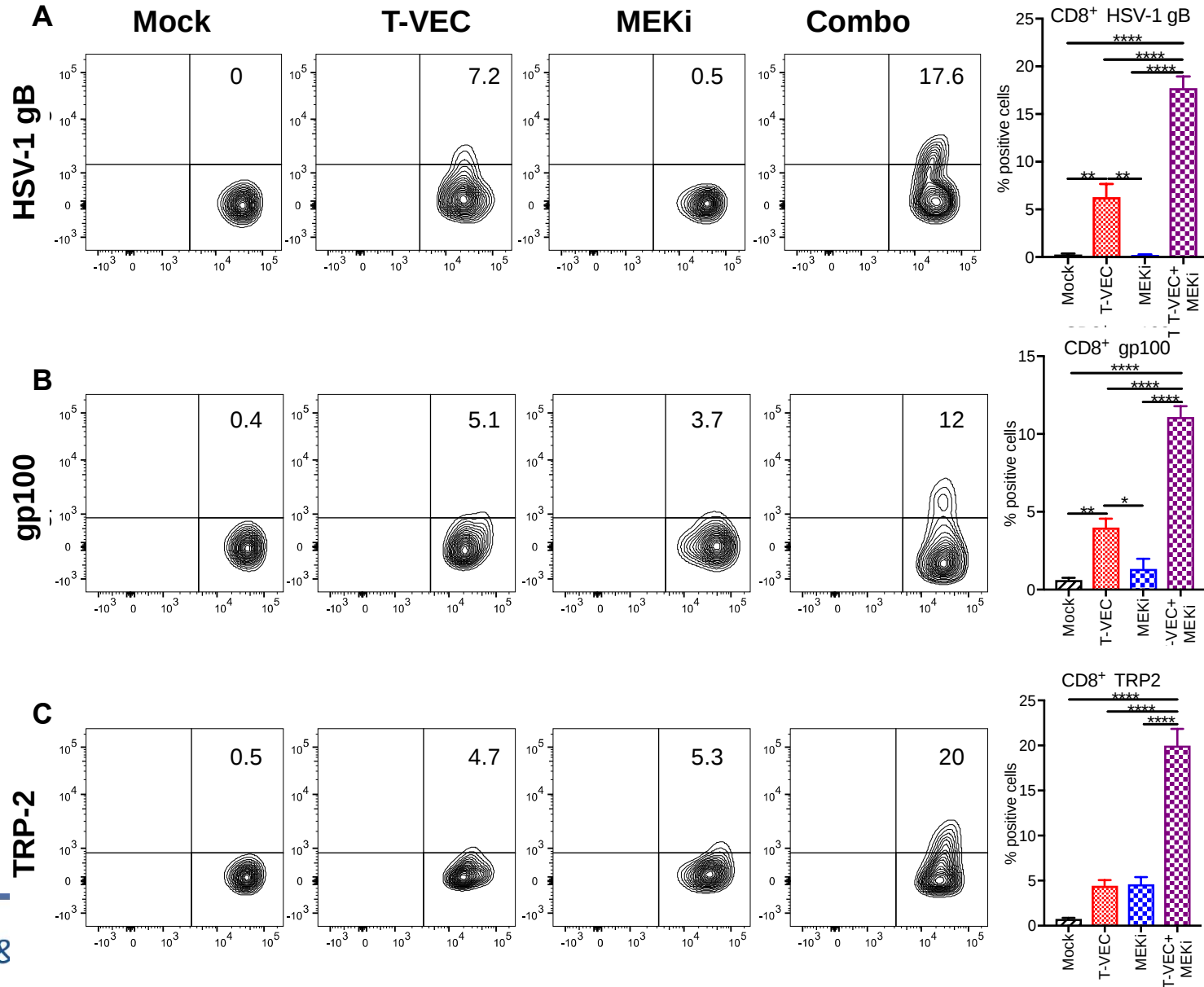
T-VEC and MEKi effects are CD8+ T cell dependent



T-VEC and MEKi anti-tumor activity depend on Batf3 dendritic cells



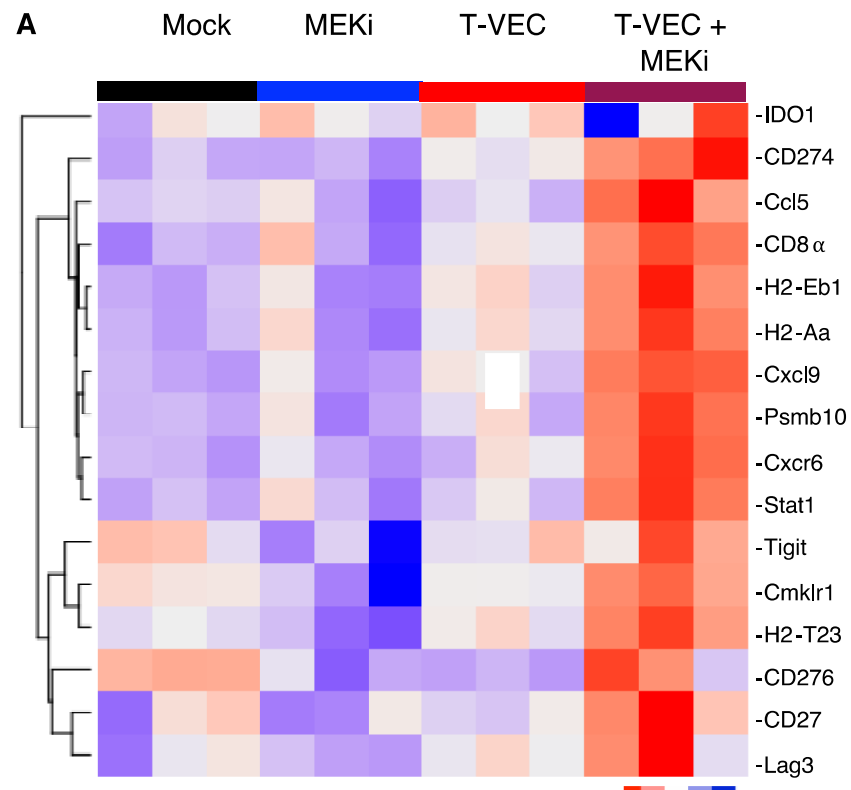
Combination enhances HSV-1 and melanoma antigen specific T cell responses



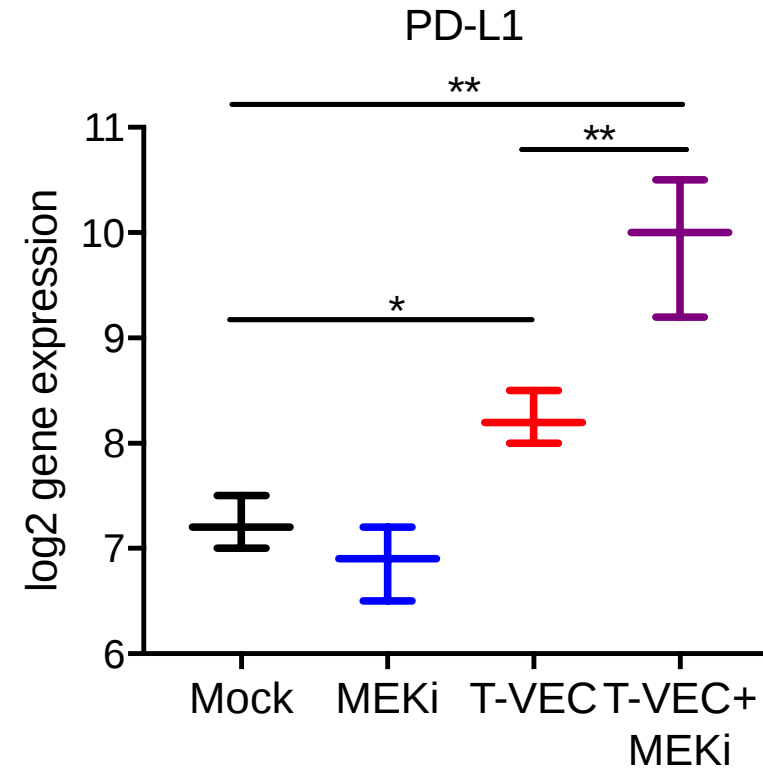
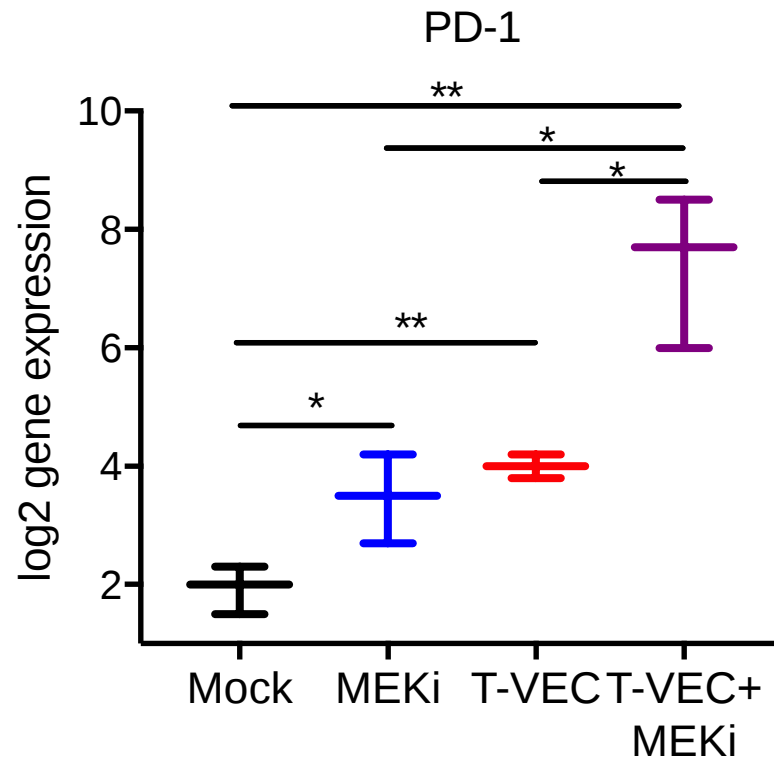
Single-Live+ CD45+CD3+CD8

T-VEC and MEKi reprograms TME and increases PD-1 and PD-L1 expression

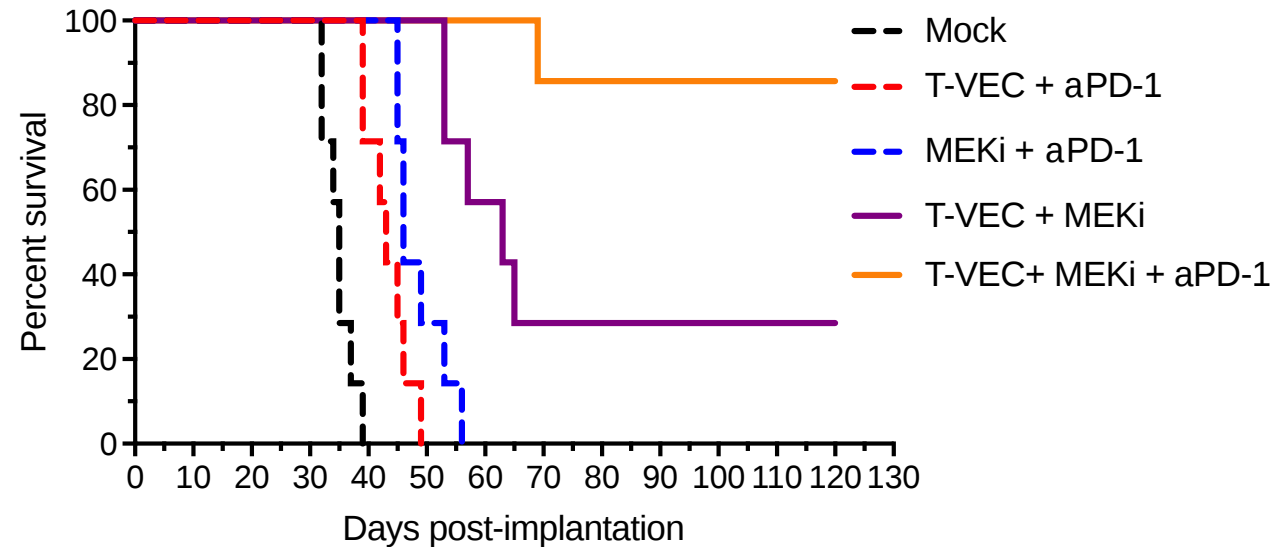
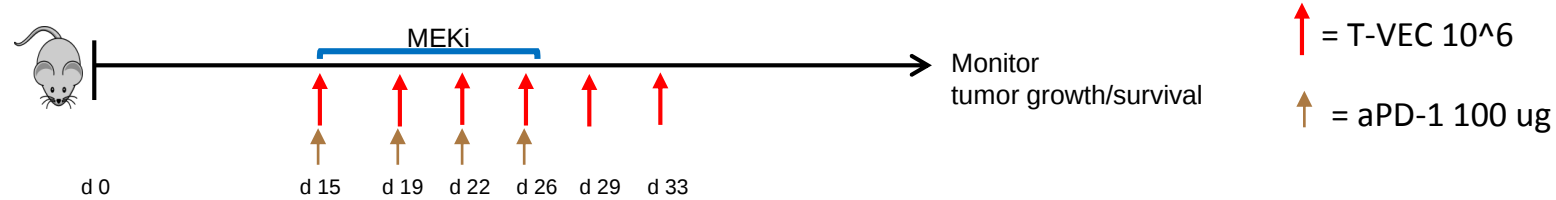
Tumor immune inflammatory (TIS) signature



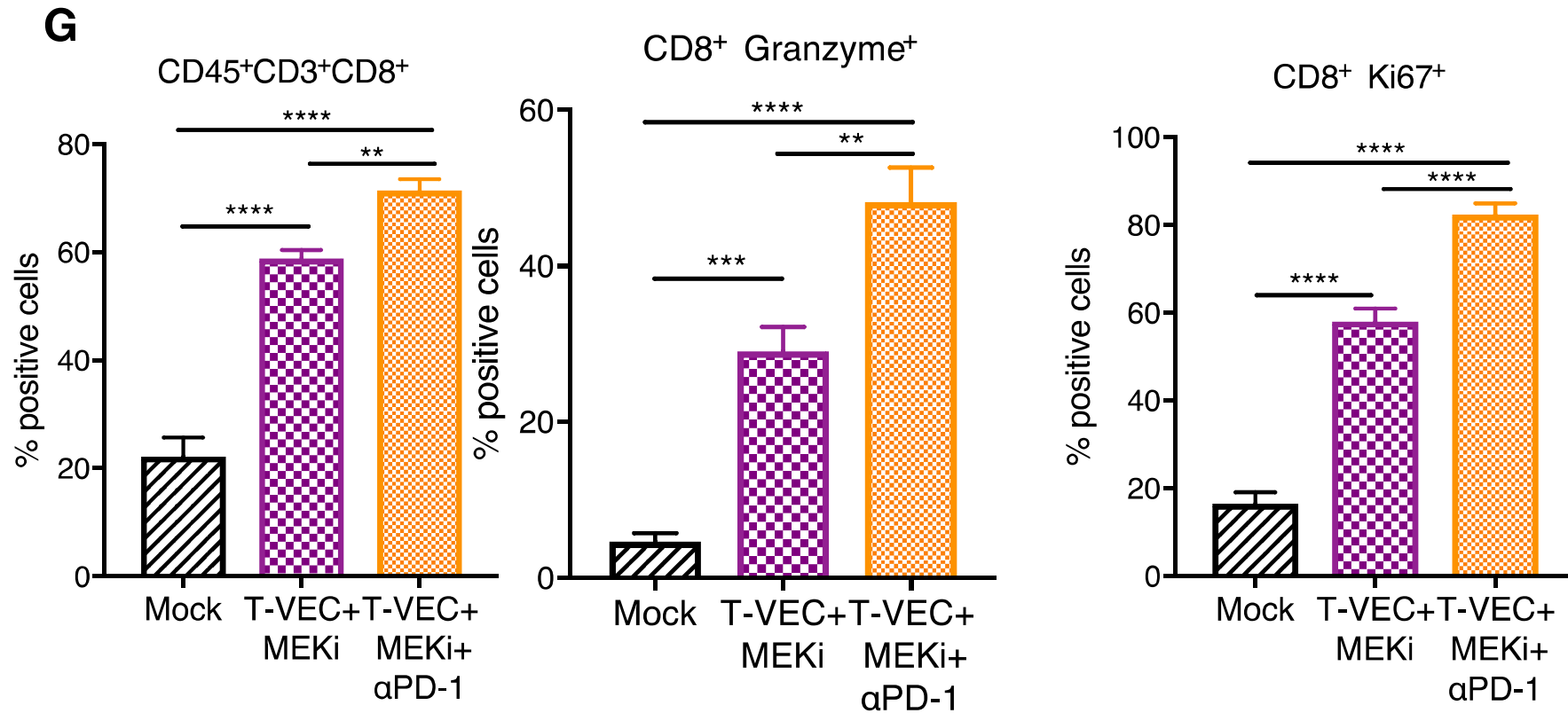
PD-1/PD-L1 expression is increased by treatment with T-VEC and MEK inhibition



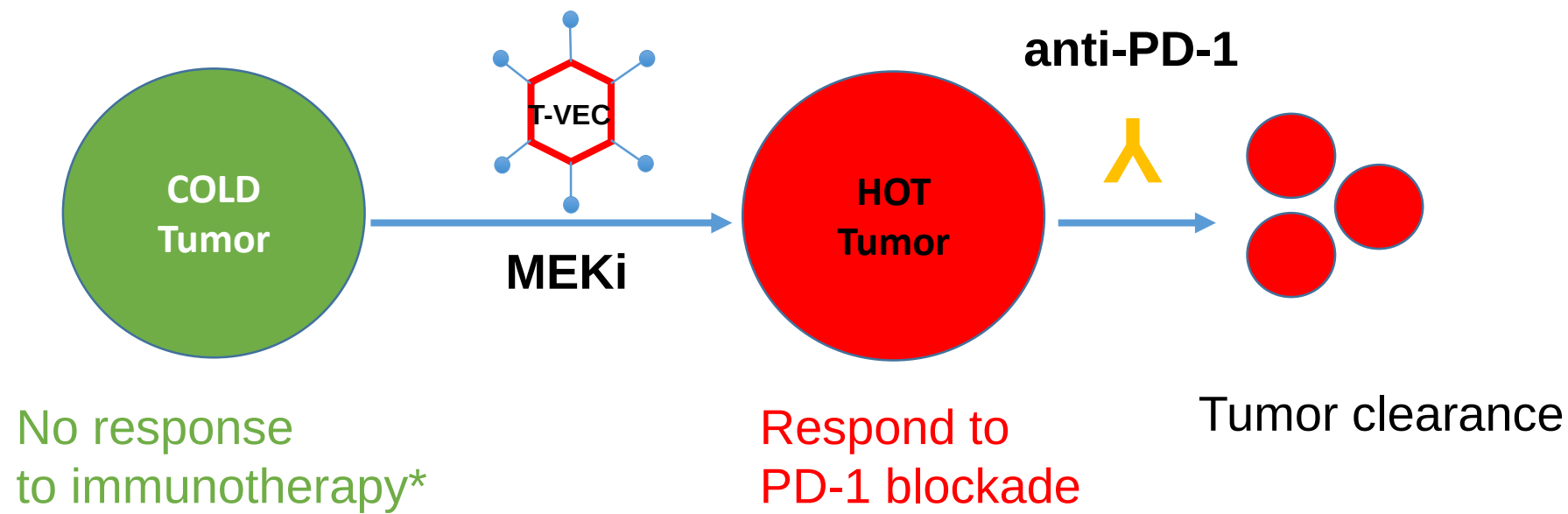
PD-1 blockade augments T-VEC + MEKi combination treatment



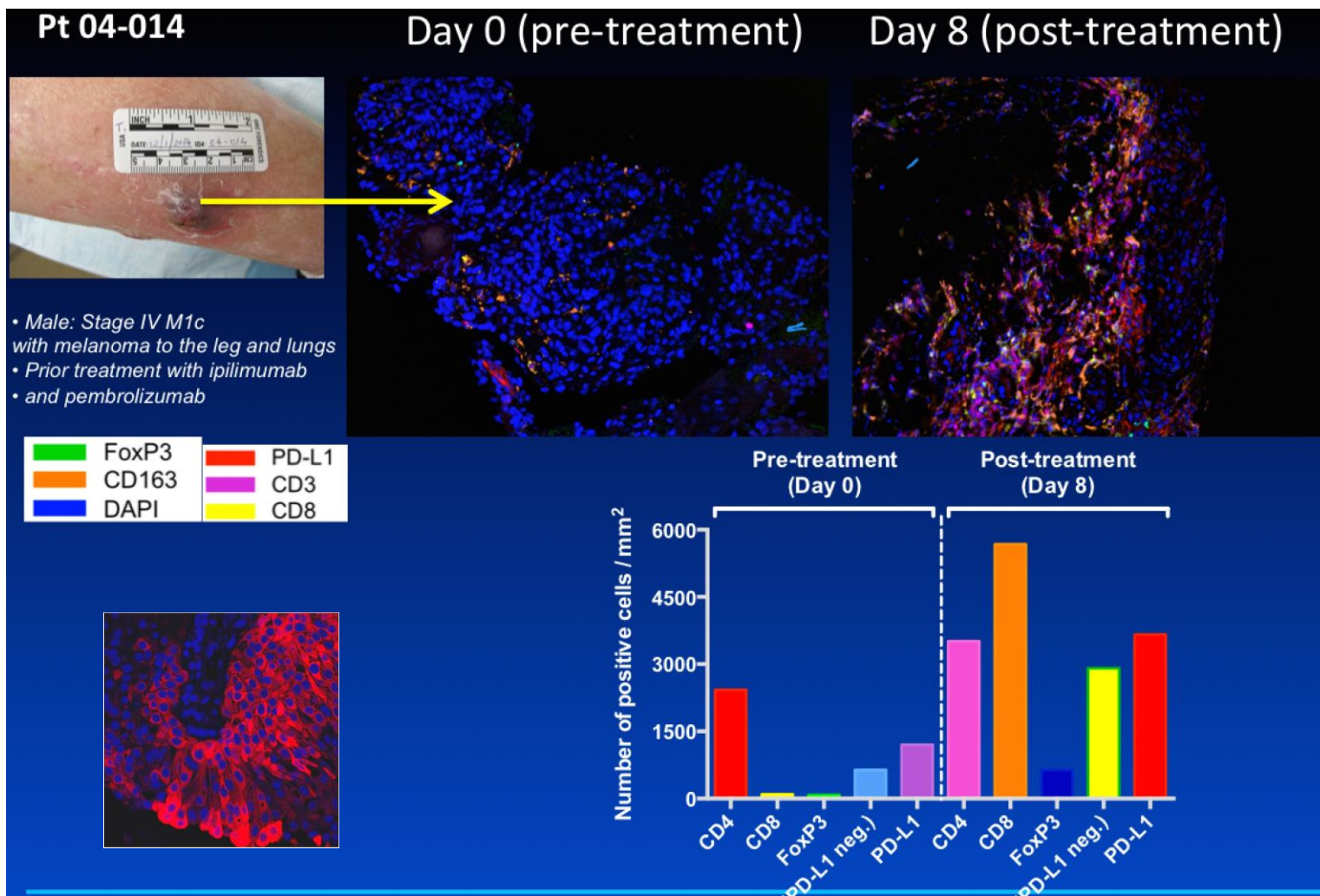
Triple therapy further drives effector T cell recruitment



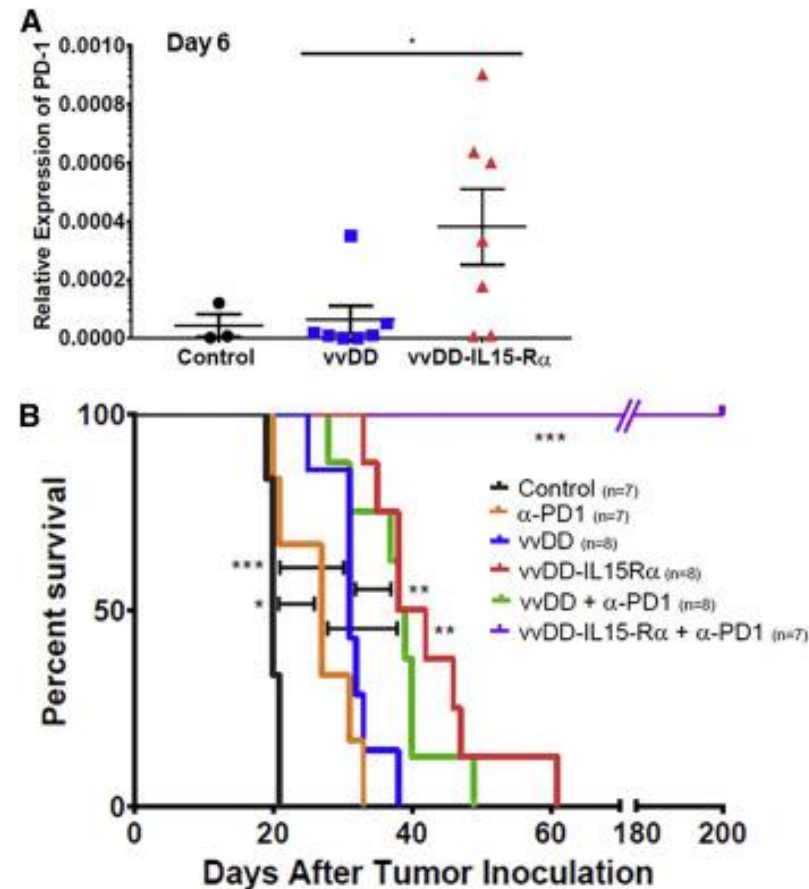
Triple combination therapy: a more rational approach to tumor immunotherapy



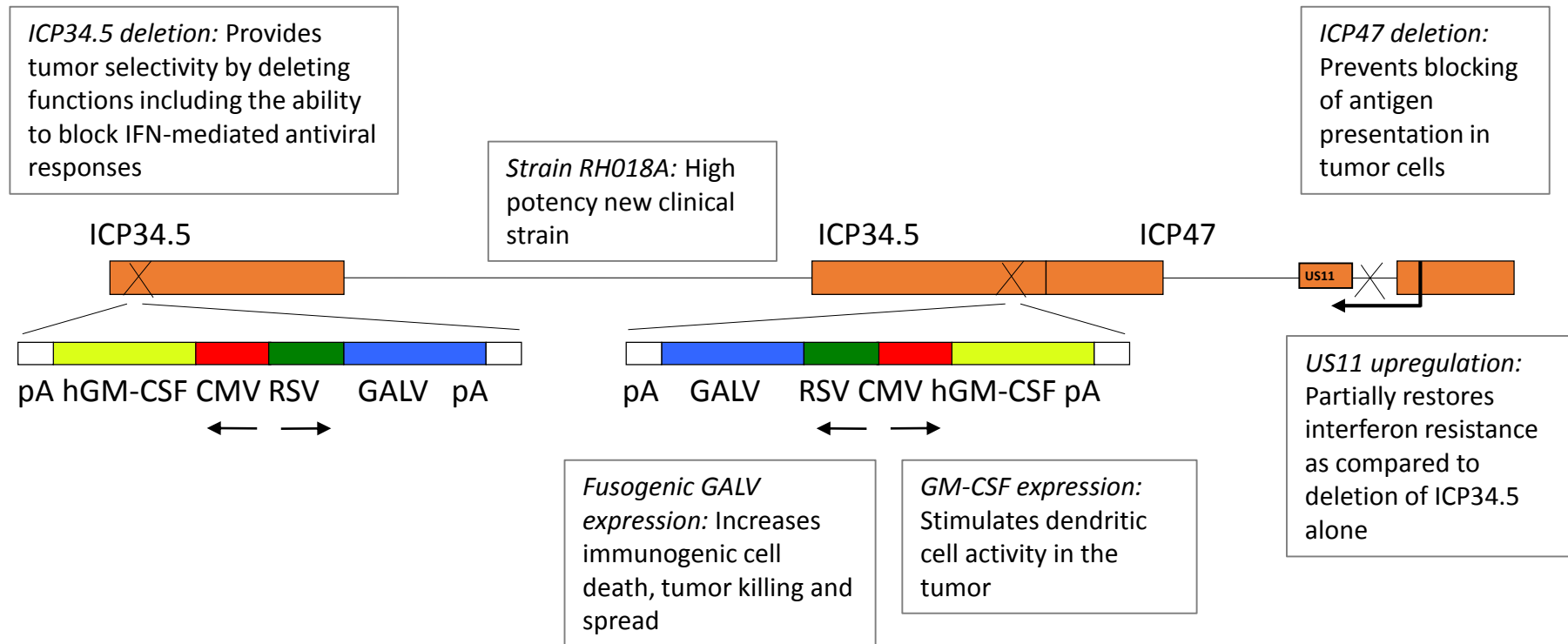
Oncolytic coxsackievirus, CVA21, also induces immune cell infiltrates and increased PD-L1 expression



Oncolytic VV encoding superagonist IL-15 induces PD-1 expression and has anti-tumor activity with PD-1 blockade in the MC38 murine model



Replimune's Immulytic HSV-based backbone - RP1



RP1- HSV1, high potency new clinical strain (RH018A), ICP34.5 deleted, ICP47 deleted, US11 upregulated, codon optimized GM-CSF expressed, codon optimized GALV-GP R- expressed

Not to scale – the HSV genome is 152Kb

RP1 clinical efficacy in CSCC (RP1+nivolumab phase 1/2 clinical trial)

16th June 2019
(baseline)



1st July 2019
(post one dose of RP1, no Opdivo)

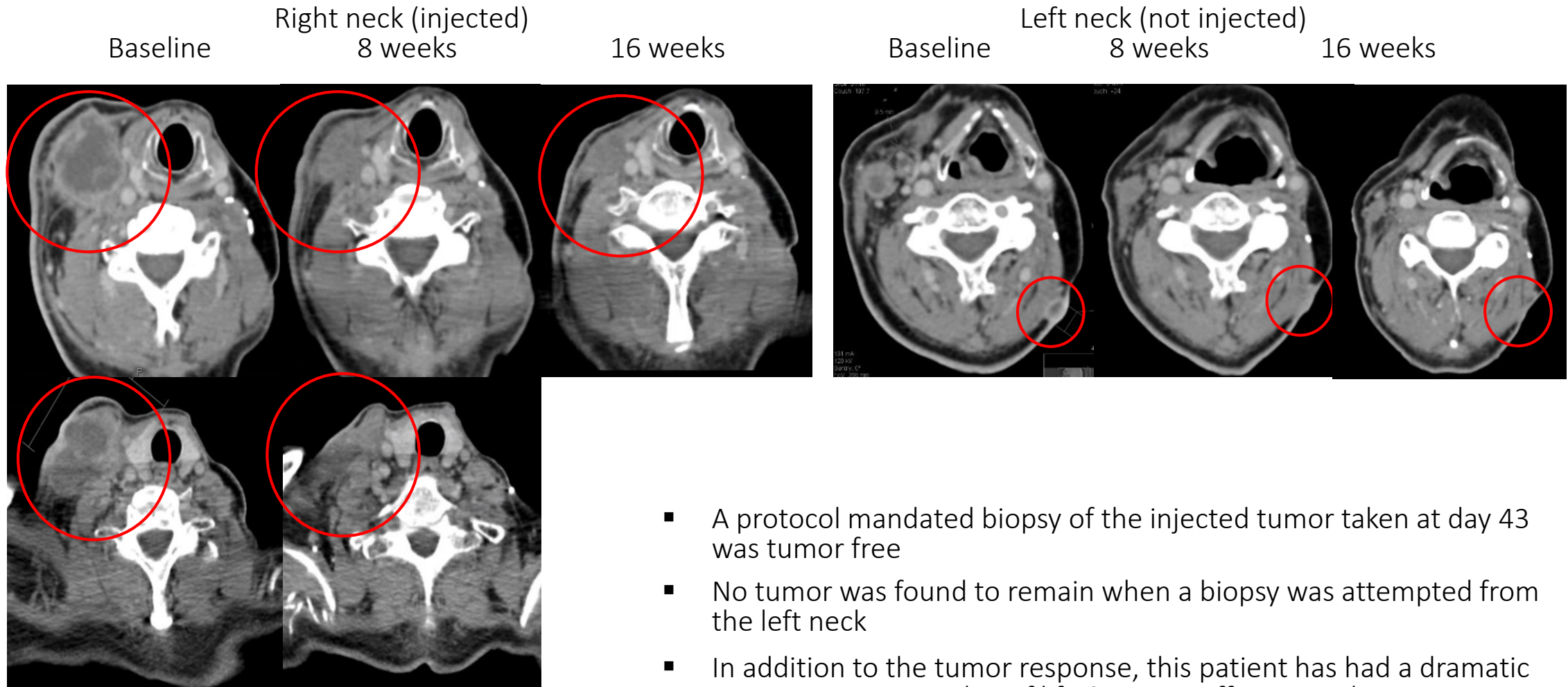


16th July 2019
(post 2 doses of RP1 & 1 dose
of Opdivo)



- Patient with recurrent CSCC of the neck (bilateral), previously treated with cisplatin-based chemoradiation & six cycles of carboplatin/5-FU, prior to entering the clinical trial
- Both the large injected tumor & the smaller contralateral tumor in the neck reduced considerably before the first Opdivo dose, i.e. after the first dose of RP1

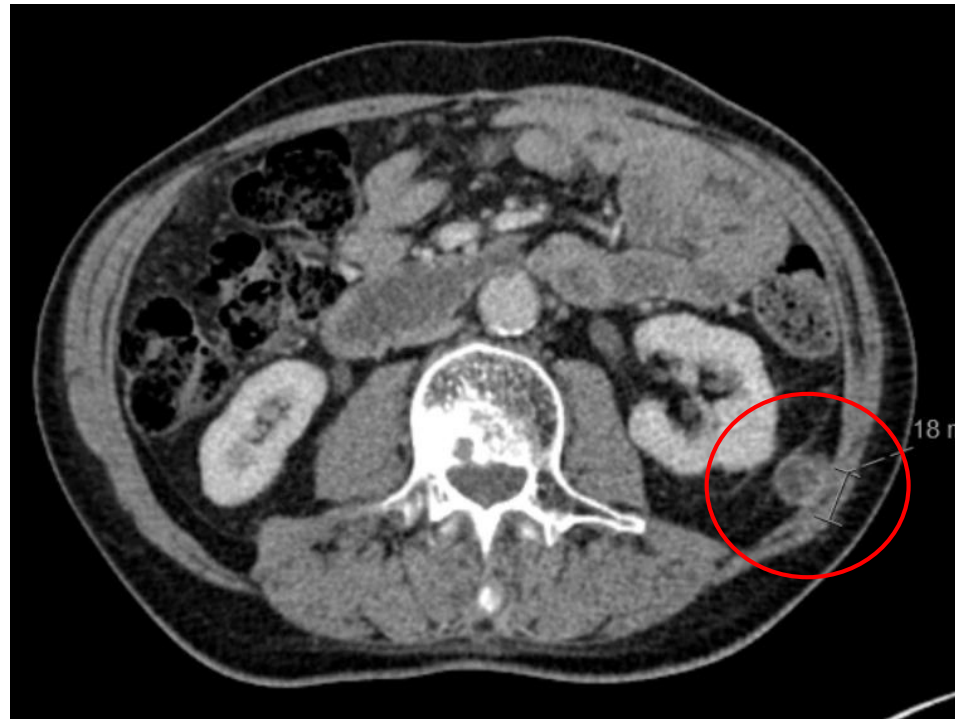
RP1 clinical efficacy in CSCC (RP1+nivolumab phase 1/2 clinical trial)



- A protocol mandated biopsy of the injected tumor taken at day 43 was tumor free
- No tumor was found to remain when a biopsy was attempted from the left neck
- In addition to the tumor response, this patient has had a dramatic improvement in quality of life & is now off pain medication

RP1 clinical efficacy in CSCC (RP1+nivolumab phase 1/2 trial)

Baseline



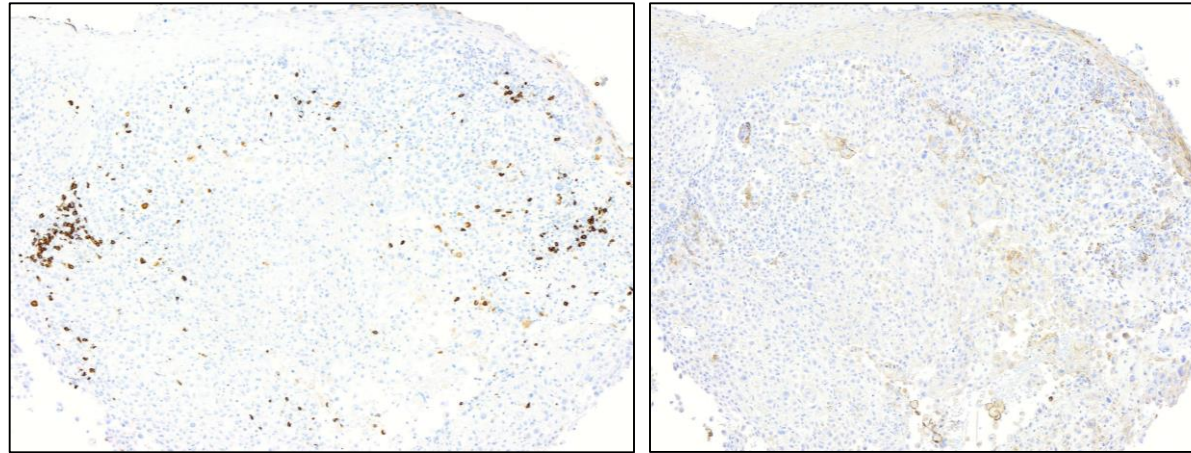
16 weeks



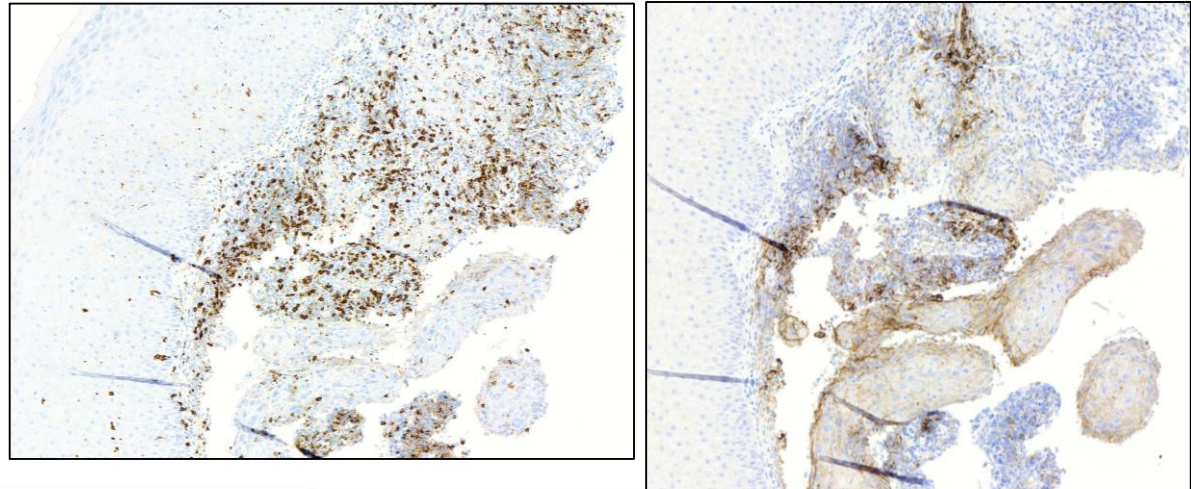
- The patient also had baseline retroperitoneal tumors which have completely resolved
- The only remaining disease are a number of non-measurable bone metastases, which were the main source of the cancer pain which has now resolved. These are now sclerotic, also suggestive of a treatment response

RP1 and nivolumab induces CD8+ T cell recruitment and PD-L1 expression

Baseline



Day 43



Conclusions

- T-VEC is the first oncolytic virus - approved for advanced melanoma
- T-VEC kills melanoma cells through immunogenic cell death
- T-VEC induces systemic immunity and local T cell recruitment
 - Depends on CD8+ T cells and Batf3+ DC
 - Promotes antigen spreading
- MEK inhibition enhances T-VEC-induced PD-1/PD-L1 expression; and anti-tumor activity is further improved with PD-1 blockade
- Other oncolytic viruses also appear to enhance immunity and therapeutic activity in combination with other cancer therapeutics
- Clinical combination studies with T-VEC, and other OV, are warranted in melanoma and perhaps other cancers as well

Acknowledgments

T-VEC Clinical Trial Investigators

- Robert Andtbacka, MD
- Jason Chesney, MD
- Frances Collichio, MD
- Philip Friedlander, MD
- Claus Garbe, MD
- John Glaspay, MD
- Omid Hamid, MD
- Axel Hauschild, MD
- Celeste Lebbe, MD
- Ted Logan, MD
- Mohammed Milhem, MD
- Igor Puzanov, MD
- Merrick Ross, MD
- Parminder Singh, MD

Study Participants

& Supporters

- Patients and Families

Amgen

- Jennifer Gansert, MD, PhD

Rutgers University

- Ann Silk, MD
- Andrew Zloza, MD, PhD
- Praveen Bommareddy, PhD



**Replimune Inc & the clinical
investigators on the RP1+nivolumab
Phase 1/2 clinical trial**

Mass General Hospital

- Sam Rabkin, PhD
- Robert Martuza, PhD
- Don Lawrence, MD
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- Ryan Sullivan, MD
- David Miller, MD, PhD
- Ken Tanabe, MD
- Genevieve Boland, MD, PhD
- Sara Pai, MD, PhD

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