Cell Therapy Talks

INFUSED WITH KNOWLEDGE

IS A CURE IN R/R LYMPHOMAS ON THE HORIZON?

Is CAR T-cell therapy proving its curative potential in real-world settings?

Real-world evidence supports clinical trial efficacy and safety of axicabtagene ciloleucel▼ in broader patient populations[1]

CIBMTR (n=446)[a] — 12-month EFS

All patients	53%
ZUMA-7 eligible	58%
ZUMA-7 ineligible	48%

Real-world evidence shows CAR T-cell therapy delivers clinical outcomes in broader patient populations[2,3]

Patients aged ≥75 years (n=66.7)

Axi-cel — Medium OS[b]: 21.4 months

People living with HIV (N=24)

Axi-cel — 12-month OS[c]: 55%

Rapid and reliable manufacturing of axi-cel in real-world settings ensures timely treatment[4,5,d]

Dana-Farber Cancer Institute[s]

REFERRAL → ENROLLMENT → APHERESIS → CAR T INFUSION

Median time from CAR T service referral to CAR T-cell infusion (days)

Liso-cel	81 days
Axi-cel	57 days

24 fewer days

RWE of patients with R/R LBCL receiving axi-cel

Manufacturing: 94% success rate[p]

Delivery: 99% success rate[q]

Axi-cel provides timely and reliable treatment for broader patient populations, with real-world evidence supporting its efficacy, safety, and curative potential[1–4]

How can proactive management enhance outcomes and support curative potential?

Choosing an appropriate BT strategy can reduce both tumour burden and toxicity, optimising CAR T outcomes for patients[6,7]

12-month PFS rate[e]

RT alone	75%
Systemic therapy	49%

Toxicity by BT response[f]

	CRS Grade ≥3 (p=0.58)	ICANS Grade ≥3 (p=0.005)
CR (n=21)	4.8%	9.5%
PR (n=83)	6.0%	6.0%
NR (n=115)	10.4%	21.7%

Prophylactic AE management strategies mitigate the impact of AEs following CAR T-cell therapy[8,g]

	DEX	NO DEX
Grade 3–4 CRS (p=0.34)	5%	12%
Grade 3–4 ICANS (p=0.14)	5%	20%

Prophylactic DEX (vs. no DEX) reduced:

- Readmission length of stay (4 vs 6.5 days; p=0.16)
- Admission to ICU for CRS/ICANS management (1 vs 7 patients; p=0.19)

Early and proactive AE management reduces the incidence and severity of CRS and ICANS[4,9,d]

CIBMTR

Increased use of tocilizumab, corticosteroids, anakinra and BT between 2017–2023

Decreased incidence of Grade ≥3 CAR T toxicity between 2017–2023

Dana-Farber Cancer Institute[s]

Similar rates of Grade ≥3 toxicity

	Axi-cel	Liso-cel
Grade ≥3 CRS (p=0.64)	6%	5%
Grade ≥3 ICANS (p>0.99)	20%	11%

Proactive CAR T toxicity management through optimised BT selection and early AE intervention improves patient outcomes and can shorten hospital stays[4,6-9]

Have we seen cure with CAR T in R/R lymphomas?

How might we define cure in lymphoma?[r]

Treatment stopped[10,11] · Survival curve plateaus[10–13] · ≥3-year OS data[10–12] · ≥2-year EFS data[11]

CAR T-cell therapy has a wealth of data supporting its curative potential in R/R lymphomas

Axicabtagene ciloleucel▼[14–17]

R/R 2L LBCL[h]	R/R 3L+ LBCL[i]	3L+ R/R FL[j]
4-year OS rate	5-year OS rate	5-year OS rate
54.6%	42.6%	68.9%

Brexucabtagene autoleucel▼[18]

3L+ R/R MCL[k,l]
5-year OS rate
39%

BsAbs may provide an option for salvage therapy post-CAR T, but longer follow-up is needed to assess curative potential[19–21]

Epcoritamab (3L+)	Glofitamab (3L+)	STARGLO[o] Glofit-GemOx (2L+)
24-month PFS[m]	12-month PFS[n]	12-month PFS
27.8%	37%	51.7%

CAR T-cell therapy offers curative potential in R/R DLBCL[14–16]

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IS A CURE IN R/R LYMPHOMAS ON THE HORIZON?

Please access the axicabtagene ciloleucel▼ prescribing information by clicking the link below or scanning the QR codes

UK prescribing information

Please access the brexucabtagene autoleucel▼ prescribing information by clicking the link below or scanning the QR codes

UK prescribing information

Adverse events should be reported. Healthcare professionals should report any adverse event via their national reporting system. In Great Britain and Northern Ireland, reporting forms and information can be found at www.mhra.gov.uk/yellowcard or via the Yellow Card app. Adverse events should also be reported to Gilead to safety_FC@gilead.com or +44 (0) 1223 897500. For other countries, visit https://public.gsir.gilead.com/.

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- Axicabtagene ciloleucel is indicated for the treatment of adult patients with R/R DLBCL and PMBCL, after two or more lines of systemic therapy
- Axicabtagene ciloleucel is indicated for the treatment of adult patients with DLBCL and HGBL that relapses within 12 months from completion of, or is refractory to, first-line chemoimmunotherapy
- Axicabtagene ciloleucel is indicated for the treatment of adult patients with R/R FL after three or more lines of systemic therapy
- Brexucabtagene autoleucel is indicated for the treatment of adult patients with relapsed or refractory MCL after two or more lines of systemic therapy including a BTK inhibitor
- Brexucabtagene autoleucel is indicated for the treatment of adult patients 26 years of age and above with relapsed or refractory B-cell precursor ALL
- ▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions.

Footnotes:

[a]Real-world analysis of patients with R/R LBCL receiving axi-cel (Apr 2022–Jul 2023; N=446); [b]DESCAR T registry retrospective analysis of patients receiving axi-cel or tisa-cel for R/R LBCL in patients aged ≥75 years (N=125); [c]DESCAR T registry analysis of HIV+ patients receiving axi-cel for BCL (N=24); [d]Single-centre retrospective real-world analysis of patients receiving 2L axi-cel (N=50) or liso-cel (N=37) for R/R LBCL; [e]Australian single centre retrospective analysis of adult patients with R/R LBCL receiving either radiotherapy alone or systemic therapy as bridging therapy to axi-cel (N=99); [f]Retrospective analysis of adult patients with R/R LBCL undergoing leukapheresis for axi-cel or tisa-cel (N=375); [g]Comparison of CRS- and ICANS-related outcomes for large B-cell lymphoma patients treated with commercial axicabtagene ciloleucel with or without prophylactic dexamethasone (DEX, n=22; No DEX, n=41); [h]ZUMA-7 analysis of adult patients with 2L LBCL receiving axi-cel (n=180) or historical SoC (n=179); [i]ZUMA-1 exploratory, long-term survival assessment of axi-cel in patients with R/R LBCL (N=101); [j]ZUMA-5 analysis of adult patients with R/R iNHL receiving axi-cel (N=159); [k]ZUMA-2 analysis of patients with R/R MCL receiving brexu-cel (Cohort 1: N=68); [l]Data for Cohort 1: 2×106 anti-CD19 CAR T cells/kg; [m]EPCORE NHL-1 analysis for patients with R/R LBCL receiving 3L+ epcoritamab (N=128); [n]NCT03075696 analysis for patients with R/R LBCL receiving 3L+ glofitamab (N=154); [o]STARGLO analysis for patients with R/R LBCL receiving Glofit-GemOx (n=183) or R-GemOx (n=91); [p]First-pass manufacturing success rate: The percentage of axi-cel lots dispositioned for release out of the total first-attempt lots dispositioned(determination of product release or rejection based on evaluation of release criteria), plus those terminated but not withdrawn, in the time period; [q]Delivery success rate: The percentage of axi-cel lots shipped to an authorized treatment center out of the total patients within the time period(excluding lots in process and withdrawn patients); [r]Survival outcomes across different studies cannot be directly compared due to differences in study design and patient population; [s]These data are from a retrospective analysis conducted at a single treatment centre (Dana-Farber Cancer Institute) and may not reflect the experience of other centres.

Abbreviations:

2L, second line; 3L, third line; AE, adverse event; BsAb, bispecific antibody; BT, bridging therapy; CAR, chimeric antigen receptor; CIBMTR, Center for International Blood and Marrow Transplant Research; CR, complete response; CRS, cytokine release syndrome; DEX, dexamethasone; EFS, event-free survival; FL, follicular lymphoma; ICANS, immune effector cell-associated neurotoxicity syndrome; ICU, intensive care unit; LBCL, large B-cell lymphoma; MCL, mantle cell lymphoma; NR, no response; OS, overall survival; PFS, progression-free survival; PR, partial response; QoL, quality of life; R/R, relapsed/refractory; RT, radiotherapy: RWE, real-world evidence.

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