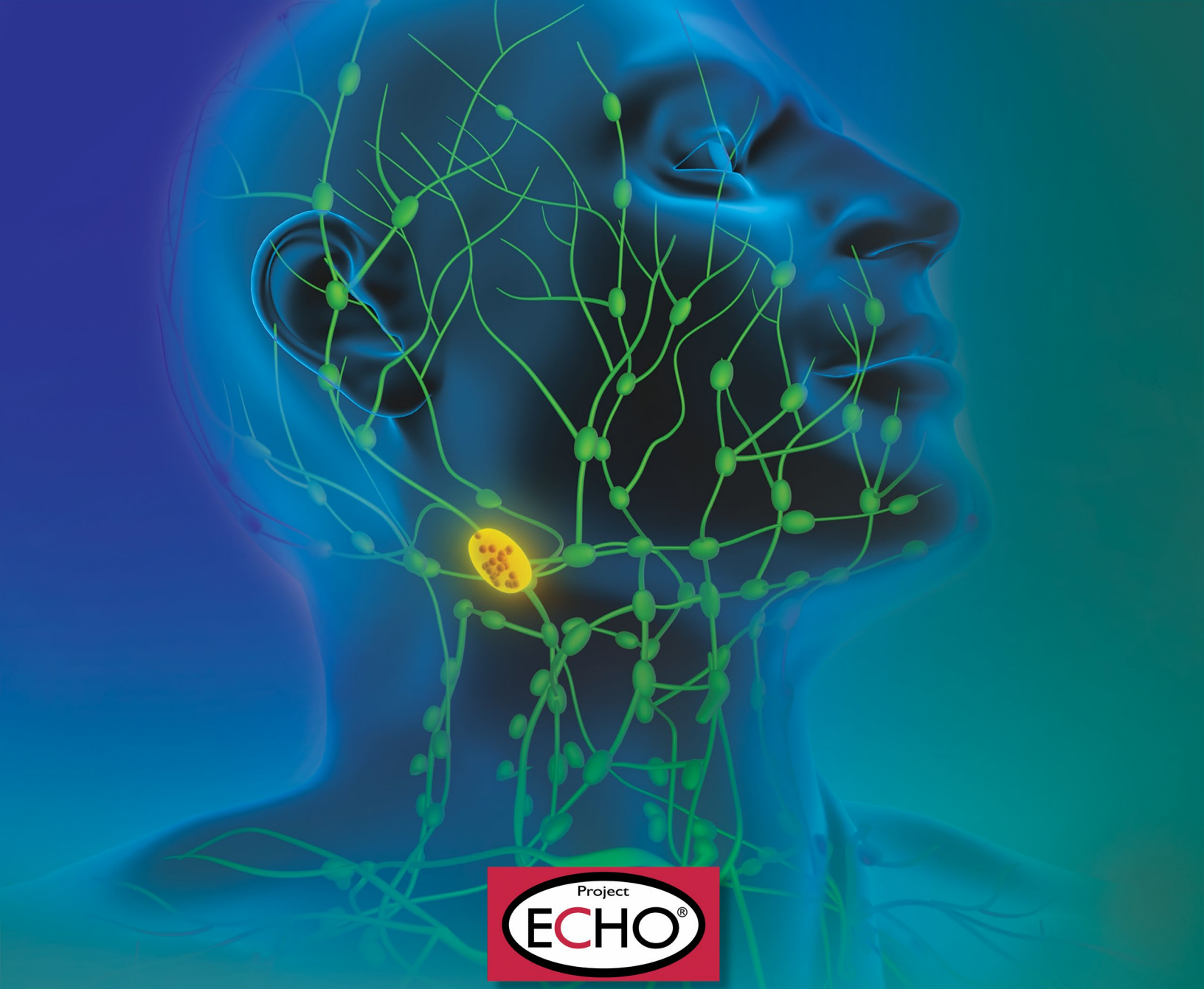

Project ECHO®

Updates in DLBCL MANAGEMENT—

The Role of Antibody Drug Therapeutics in Frontline and Later-Line Management

MED LEARNING GROUP

This activity is provided by Med Learning Group.
This activity is supported by educational grants from ADC Therapeutics America, Inc., Genentech, a member of the Roche group, and Pfizer, Inc.

Updates in DLBCL Management—The Role of Antibody Drug Therapeutics in Frontline and Later-Line Management

PROGRAM CHAIR & FACULTY PRESENTER

Mehdi Hamadani, MD
Chief of Hematologic Malignancies
Endowed Professor and Associate Director of Clinical Research
Medical College of Wisconsin
Milwaukee, WI

PROGRAM OVERVIEW

This interactive educational activity aims to enhance the ability of hematologists/oncologists and the broader multidisciplinary oncology team with the latest insights into the evolving treatment landscape of relapsed/refractory (R/R) diffuse large B-cell lymphoma (DLBCL). Expert-led discussion will explore the clinical significance of key biomarkers in guiding treatment decisions, the most recent safety and efficacy data on available therapies, and patient-specific factors influencing treatment choices. Additionally, the program will highlight strategies for recognizing and managing potential adverse events associated with current treatment options. Attendees will gain actionable knowledge to optimize care for patients with R/R DLBCL.

TARGET AUDIENCE

The proposed educational activities are specifically designed to meet the educational needs of academic and community medical hematologists/oncologists, as well as members of the multidisciplinary oncology team, such as oncology NPs/PAs, and oncology pharmacists.

LEARNING OBJECTIVES

Upon the completion of this program, attendees should be able to:

- Evaluate the role of specific biomarkers to inform clinical decisions in R/R DLBCL
- Summarize the efficacy and safety of specific therapies in R/R DLBCL and patient-specific factors informing choice of therapy in the setting of resistance to prior therapy
- Describe potential adverse events associated with available therapies for the management of R/R DLBCL

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Faculty Member	Disclosures
Mehdi Hamadani	**Consulting fees**: Genmab, CRISPR, AlloVir, Caribou Biosciences, Autolus, Forte Biosciences, Byondis, Kite Pharma, and Daiichi Sankyo **Speakers Bureau**: AstraZeneca, ADC Therapeutics America, Inc., BeiGene, Kite Pharma, and Sobi **Contracted Research** ADC Therapeutics America, Inc., Spectrum Pharmaceuticals, and Astellas Pharma

All relevant financial relationships have been mitigated.

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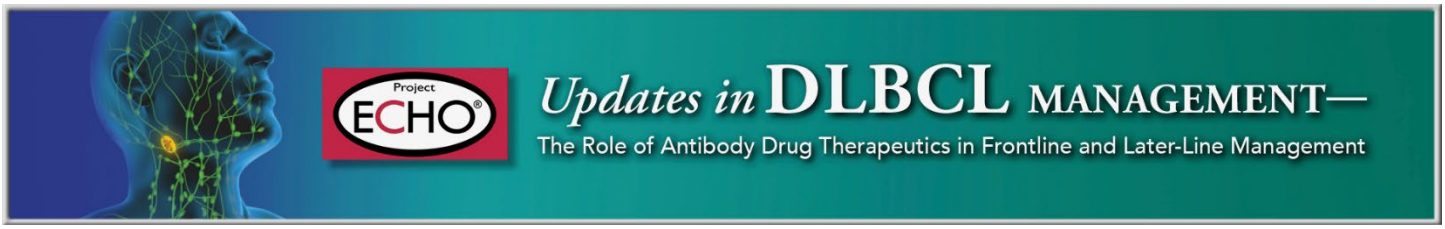

Program Agenda

Introduction

- Incidence and prevalence of diffuse large B-cell lymphoma (DLBCL)
- Challenges in management of DLBCL, with 25% to 40% of patients failing to respond to rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP) or polatuzumab vedotin with rituximab, cyclophosphamide, doxorubicin, and prednisone (Pola-R-CHP) and progressing to later-line forms of chemotherapy
- Review the role of antibody-drug conjugates in relapsed/refractory (R/R) disease, as well as bispecific and chimeric antigen receptor T-cell (CAR-T) therapies in the later-line setting

Assessment and Treatment of DLBCL: Considering the Role of Antibody Therapeutics as Part of a Novel Treatment Paradigm

- Characterizing DLBCL
    - Relevance of immunohistochemistry and flow cytometry assessment
    - Relevance of karyotype, translocations, and presence or absence of gene rearrangements
    - Assessment of multiple molecular markers

- DLBCL therapy and gaps in management therapies
    - Frontline options (eg, R-CHOP and Pola-R-CHOP in the POLARIX trial)
    - Later-line options including antibody drug conjugates, bispecific antibodies, and CAR-T therapy
    - Sequencing and selection of bispecific agents, antibody-drug conjugate therapy, and other antibody therapeutics for DLBCL in the management of resistance to previously used mechanisms (eg, anti-CD20 agents)

- Clinical data informing use of specific treatment options in the relapsed/refractory setting of DLBCL, including safety and efficacy data
    - Antibody-drug conjugates (eg, brentuximab vedotin, polatuzumab vedotin, loncastuximab tesirine)
    - Bispecific antibodies (eg, glofitamab, epcoritamab)
    - Other antibodies (eg, tafasitamab)
    - Contrasting with CAR-T therapy (eg, axicabtagene ciloleucel, tisagenlecleucel, or lisocabtagene maraleucel)

Best Practices in Assessing Safety and Multidisciplinary Management in R/R DLBCL

- Discussing specific therapeutic options in the management of B-cell lymphomas
    - Recognizing and managing potential adverse events with antibody-drug conjugates, including blood dyscrasias and pneumonitis
    - Monitoring and management of adverse events associated with CAR-T therapy and bispecific antibodies, such as cytokine release syndrome (CRS) and immune effector cell–associated neurotoxicity syndrome (ICANS)
    - Best practices for discussing therapeutic options and multidisciplinary care

Conclusions

- Opportunities and best practices for the use of novel therapeutic combinations in DLBCL to overcome resistance to prior therapy
- Key takeaways

Updates in DLBCL Management—The Role of Antibody Drug Therapeutics in Frontline and Later-Line Management

Mehdi Hamadani, MD
Professor and Chief of Hematologic Malignancies
Cancer Center Scholar Endowed Chair
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Milwaukee, WI

Disclosures

- **Dr Hamadani** discloses the following
  - **Consulting fees**: AlloVir, Autolus Therpeutics, Byondis, Caribou Biosciences, CRISPR Therapeutics, Daiichi Sankyo, Forte Biosciences, Genmab, Kite Pharma
  - **Speakers Bureau**: ADC Therapeutics, AstraZeneca, BeiGene, Kite Pharma, Sobi
  - **Contracted research**: ADC Therapeutics, Astellas Pharma, Spectrum Pharmaceuticals
- During this lecture the use of medications for both US Food and Drug Administration (FDA)-approved and non-FDA-approved indications may be discussed
- All relevant financial relationships have been mitigated

This activity is supported by educational grants from ADC Therapeutics America, Inc., Genentech, a member of the Roche group, and Pfizer, Inc.

Learning Objectives

- Evaluate the role of specific biomarkers to inform clinical decisions in relapsed/refractory (R/R) diffuse large B-cell lymphoma (DLBCL)
- Summarize the efficacy and safety of specific therapies in R/R DLBCL and patient-specific factors informing choice of therapy in the setting of resistance to prior therapy
- Describe potential adverse events associated with available therapies for the management of R/R DLBCL

Diffuse Large B-Cell Lymphoma (DLBCL)

Most common NHL in United States and worldwide

Median age: 67 years


Male: 55%


Approximately half of patients present with advanced-stage disease


Elevated LL: ~50%


Any extranodal involvement: ~70%


Bone marrow involvement: 10%–20%


CNS involvement at diagnosis: ~5%


Clinically and biologically heterogeneous

CNS = central nervous system; LDH = lactate dehydrogenase; NHL = non-Hodgkin lymphoma.

Abramson JS, Shipp MA. *Blood*. 2005;106:1164-1174. Armitage JO, Weisenburger DD. *J Clin Oncol*. 1998;16:2780-2795. Eyre TA, et al. *Lancet Oncol*. 2022;23:e416-e426. National Cancer Institute (NCI). Cancer stat facts: NHL—DLBCL (https://seer.cancer.gov/statfacts/html/dlbcl.html). Accessed 3/11/2025.

Treatment of Advanced-Stage DLBCL: R-CHOP Standard for >20 Years!!!

Long-term follow-up of LNH-98.5 trial

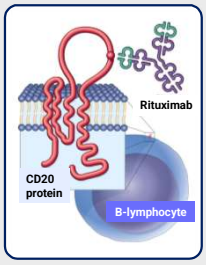
Stage II–IV DLBCL
n = 399

CHOP x 8

10-year PFS = 20.1%
10-year OS = 27.6%

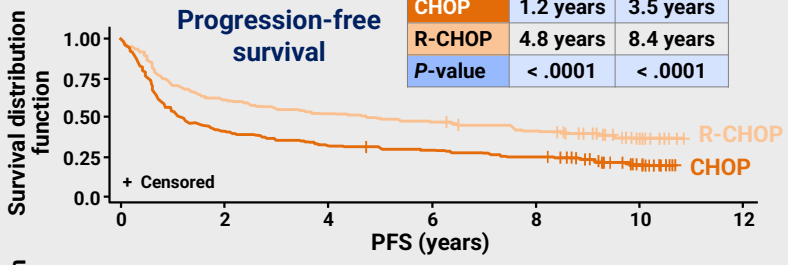
R-CHOP x 8

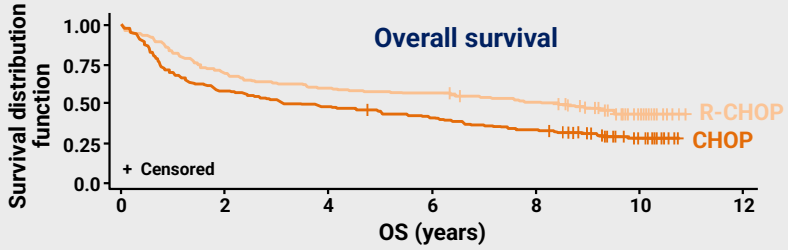
10-year PFS = 36.5%
10-year OS = 43.5%



CD20 molecule as expressed on B cells

	mPFS	mOS
CHOP	1.2 years	3.5 years
R-CHOP	4.8 years	8.4 years
P-value	< .0001	< .0001

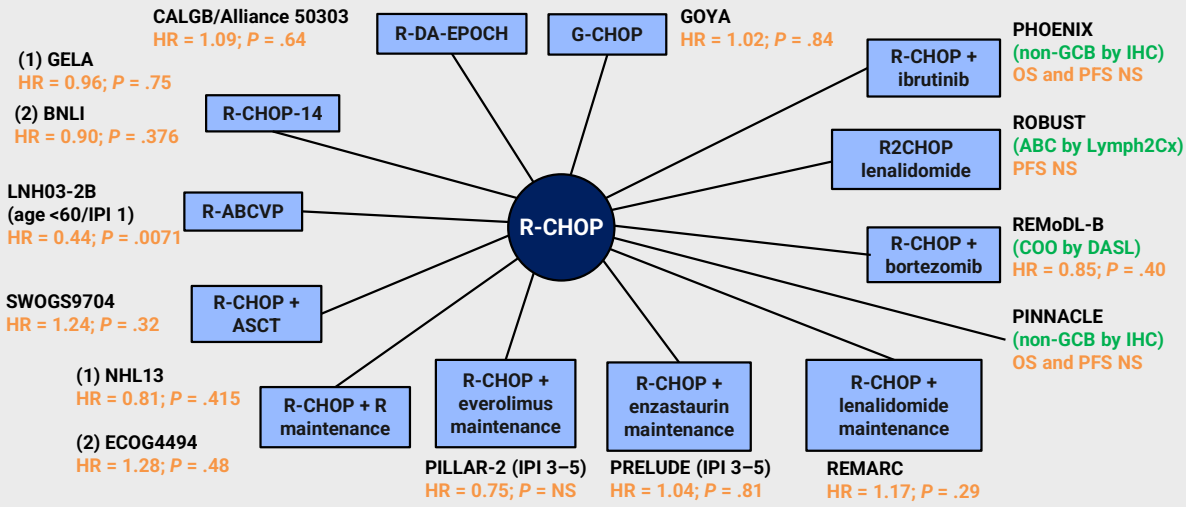




m = median; OS = overall survival; PFS = progression-free survival.

Coiffier B, et al. *N Engl J Med*. 2002;346:235-242. Coiffier B, et al. *Blood*. 2010;116:2040-2045. Pescovitz MD. *Am J Transplantat*. 2006,6:859-866.

Unsuccessful Phase 3 Trials Trying to Improve Outcomes for DLBCL



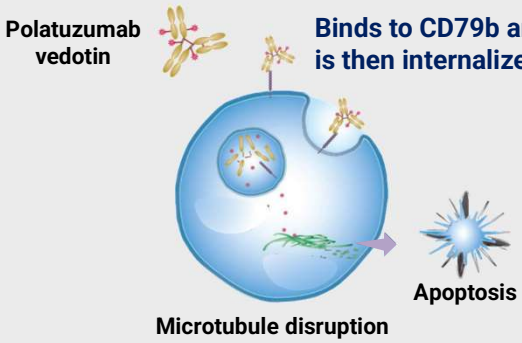
ABC = activated B-cell (subtype); COO = cell of origin; DASL = whole-genome cDNA-mediated annealing, selection, extension, and ligation (assay); G-CHOP = obinutuzumab + CHOP; HR = hazard ratio; IHC = immunohistochemistry; NS = not significant; R = rituximab; R2CHOP = lenalidomide + R-CHOP; R-ABCVP = R + doxorubicin, bleomycin, cyclophosphamide, vindesine, prednisone.

Bartlett NJ, et al. *J Clin Oncol*. 2019;37:1790-1799. Crump M, et al. *Blood*. 2013;122:371. Cunningham D, et al. *J Clin Oncol*. 2011;29(suppl 15):8000. Davies A, et al. *Lancet Oncol*. 2019;20:649-662. Habermann TM, et al. *J Clin Oncol*. 2006;24:3121-3127. Jaeger U, et al. *Haematologica*. 2015;100:955-963. Lamy T, et al. *Blood*. 2018;131:174-181. Lowry L, et al. *Radiother Oncol*. 2011;100:86-92. Nowakowski GS, et al. *J Clin Oncol*. 2021;39:1317-1328. Récher C, et al. *Lancet*. 2011;378:1858-1867. Sehn LH, et al. *J Hematol Oncol*. 2020;13:71. Stiff PJ, et al. *J Clin Oncol*. 2011;29:8001. Thieblemont C, et al. *Blood*. 2020;136(suppl 1):16-17. Witzig TE, et al. *Ann Oncol*. 2018;29:707-714. Younes A, et al. *J Clin Oncol*. 2019;37:1285-1295.

POLARIX: Polatuzumab Vedotin* vs Vincristine in R-CHOP

CD79B is ubiquitously expressed in B-cell NHL.

Polatuzumab vedotin is an anti-CD79b ADC FDA-approved with BR for R/R DLBCL.



Eligibility criteria
- Previously untreated DLBCL
- Aged 18 to 80 years
- IPI score 2–5
- ECOG-PS 0–2

R 1:1

6 cycles: Pola-R-CHP 2 additional cycles of rituximab	6 cycles: R-CHOP 2 additional cycles of rituximab

Primary endpoint: Investigator-assessed PFS

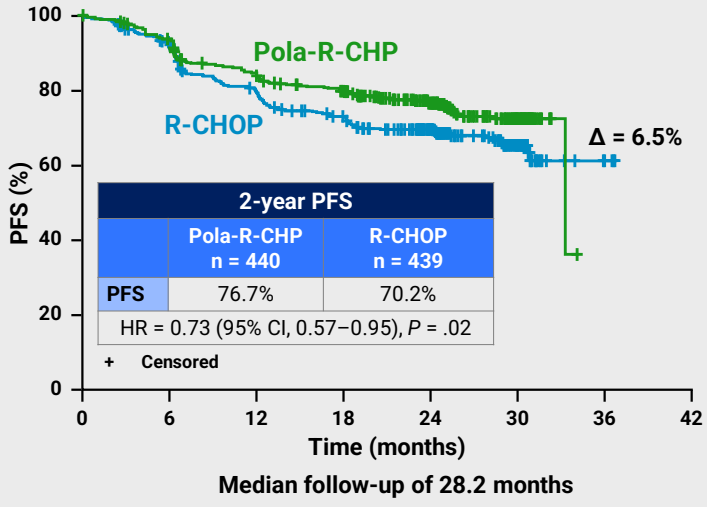
Baseline characteristics
- Median age: 65 years
- Advanced stage: 89%
- IPI 3–5: 62%
- DHL/THL: 8%
- DE: 38%

ADC = antibody-drug conjugate; BR = bendamustine; DE = dual/double expresser; DHL = double-hit lymphoma; Pola = polatuzumab; Pola-R-CHP = polatuzumab, rituximab, cyclophosphamide, doxorubicin, and prednisone; R = randomization; R/R = relapsed/refractory; THL = triple-hit lymphoma.

Tilly H, et al. *N Engl J Med*. 2022;386:351-363. Polatuzumab vedotin (Polivy®). Prescribing information (PI) 2023 (www.gene.com/download/pdf/polivy_prescribing.pdf). Modified from Creative Biolabs. ADC development for NHL (www.creative-biolabs.com/adc/adc-development-for-nhl.htm). URLs accessed 3/17/2025.

POLARIX—Primary Endpoint: PFS

Pola-R-CHP significantly improved PFS vs R-CHOP

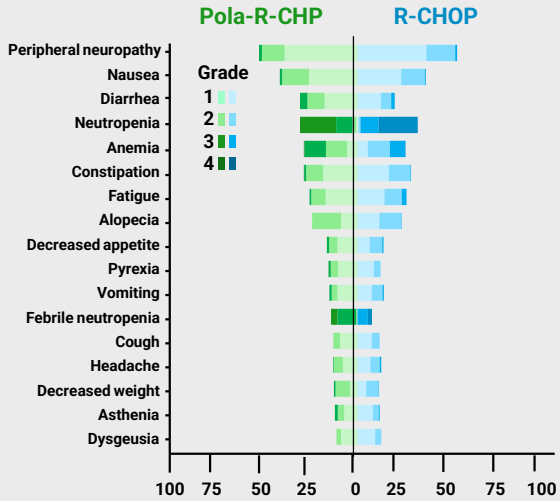


2-year PFS	Pola-R-CHP n = 440	R-CHOP n = 439
PFS	76.7%	70.2%
HR = 0.73 (95% CI, 0.57–0.95), *P* = .02		

\+ Censored

Median follow-up of 28.2 months

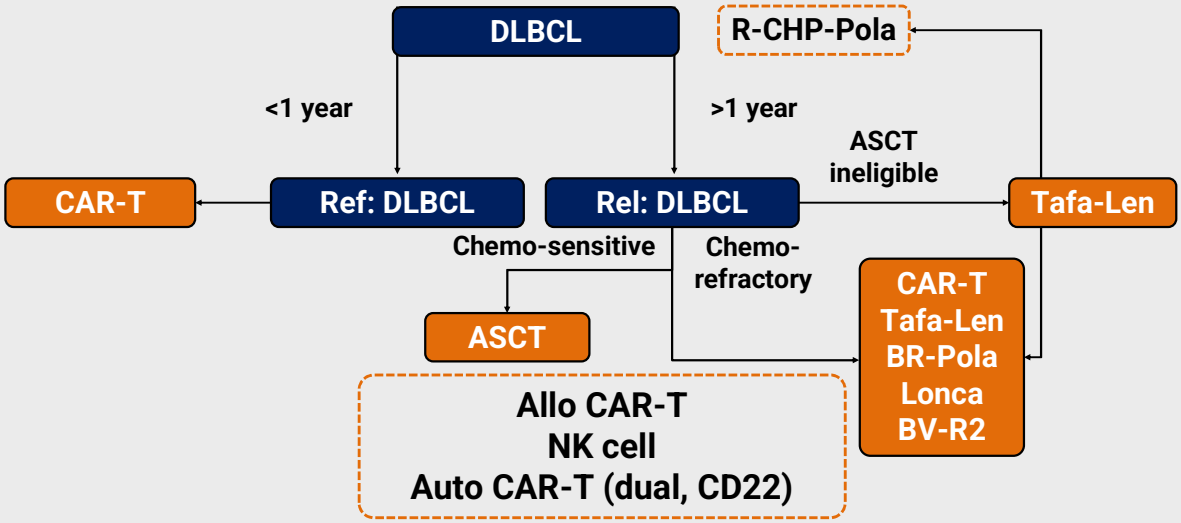
With no excess toxicity



CI = confidence interval.

Tilly H, et al. *N Engl J Med*. 2022;386:351-363.

Treatment Landscape: DLBCL—The Relapsed/Refractory Setting



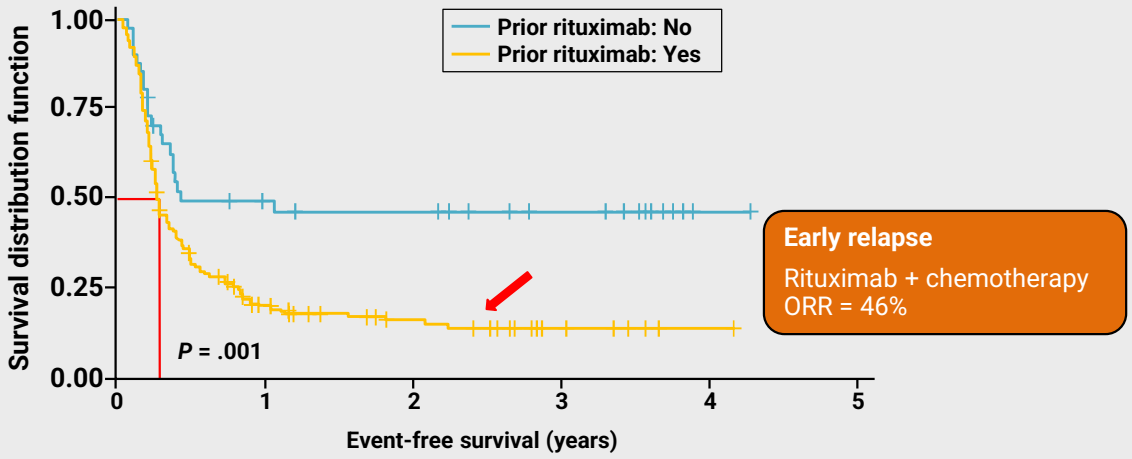
R-CHP-Pola is FDA-approved for DLBCL (not otherwise specified [NOS]) or high-grade B-cell lymphoma (HGBL).

allo = allogeneic; ASCT = autologous stem cell transplant; auto = autologous; BR-Pola = polatuzumab vedotin, bendamustine, and rituximab; BV-R2 = brentuximab vedotin, lenalidomide, and rituximab; Lonca = loncastuximab tesirine; R-CHP-Pola = rituximab, cyclophosphamide, doxorubicin, and prednisone plus polatuzumab vedotin; Ref = refractory; Rel = relapsed; Tafa-Len = tafasitamab plus lenalidomide.

Modified from National Comprehensive Cancer Network (NCCN) guidelines for B-cell lymphoma, V3.2023 (www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf). Accessed 3/17/2025.

Early Relapse: Autologous HCT Is Often Not Applicable

Relapse within 1 year of "initial diagnosis"



ORR = overall response rate.

Gisselbrecht C, et al. *J Clin Oncol*. 2010;28:4184-4190.

2nd-Line CAR-T vs Chemoimmunotherapy Trials (ZUMA-7, BELINDA, and TRANSFORM)

Key eligibility
- Age 18+ years (capped at age 75 years for TRANSFORM)
- Aggressive NHL
- Refractory or **relapsed ≤12 months after finishing first-line treatment**
- ECOG-PS ≤1
- Eligible for HCT
- Secondary CNS lymphoma allowed (TRANSFORM)
- Good organ function

Screening + leukapheresis → 1:1 randomization

Bridging therapy varied

CAR-T arm (axi-cel, dose varied)

Standard-arm salvage therapy (BELINDA allowed second salvage), followed by HDT + auto-HCT

Crossover specified?
- Liso-cel trial
- Tisa-cel trial*

Initial response assessments varied
- Days 50, 100, and 150 (ZUMA-7)
- Weeks 6 and 12 (BELINDA)
- Weeks 9 and 18 (TRANSFORM)

- **Primary endpoint:** EFS
- **Stratified by** refractory vs relapsed, sAAIPI or IPI, geographic region (BELINDA)

auto-HCT = autologous hematopoietic cell transplantation; axi-cel = axicabtagene ciloleucel; HDT = high-dose chemotherapy; sAAIPI = second-line/secondary AAIPI.

Locke FL, et al. *N Engl J Med*. 2022;386:640-654 and supplement. Bishop MR, et al. *N Engl J Med*. 2022;386:629-639. Kamdar M, et al. *Lancet*. 2022;399:2294-2308.

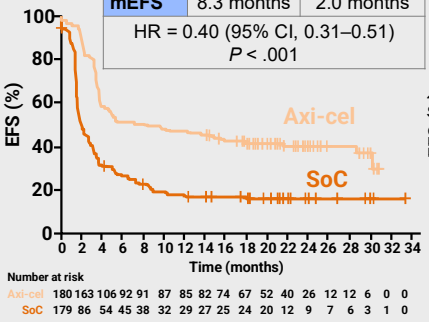
*Tisa-cel is not FDA approved as second-line treatment for DLBCL.

EFS in Randomized Trials of CAR-T vs SoC as Second-Line Therapy Primary Refractory or Early Relapsed DLBCL

Axi-cel vs SoC (N = 359)[1]

	axi-cel	SoC
mEFS	8.3 months	2.0 months

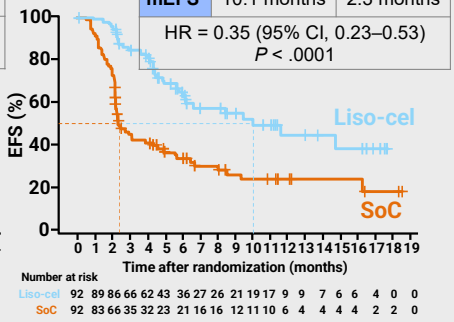
HR = 0.40 (95% CI, 0.31–0.51)
P < .001



Liso-cel vs SoC (N = 184)[2]

	liso-cel	SoC
mEFS	10.1 months	2.3 months

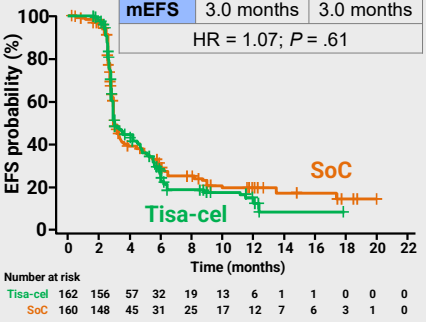
HR = 0.35 (95% CI, 0.23–0.53)
P < .0001



Tisa-cel* vs SoC (N = 322)[3]

	tisa-cel	SoC
mEFS	3.0 months	3.0 months

HR = 1.07; *P* = .61



Median follow-up = 24.9 months	Median follow-up = 6.2 months	Median follow-up = 10 months
Grade ≥3 CRS/neurologic events		
6%/21%	1%/4%	5%/2%

axi-cel = axicabtagene ciloleucel; CRS = cytokine release syndrome; liso-cel = lisocabtagene maraleucel; mEFS = median EFS; SoC = standard of care; tisa-cel = tisagenlecleucel.

1. Locke FL, et al. *N Engl J Med*. 2022;386:640-654. 2. Kamdar M, et al. *Lancet*. 2022;399:2294-2308. 3. Bishop MR, et al. *N Engl J Med*. 2022;386:629-639.

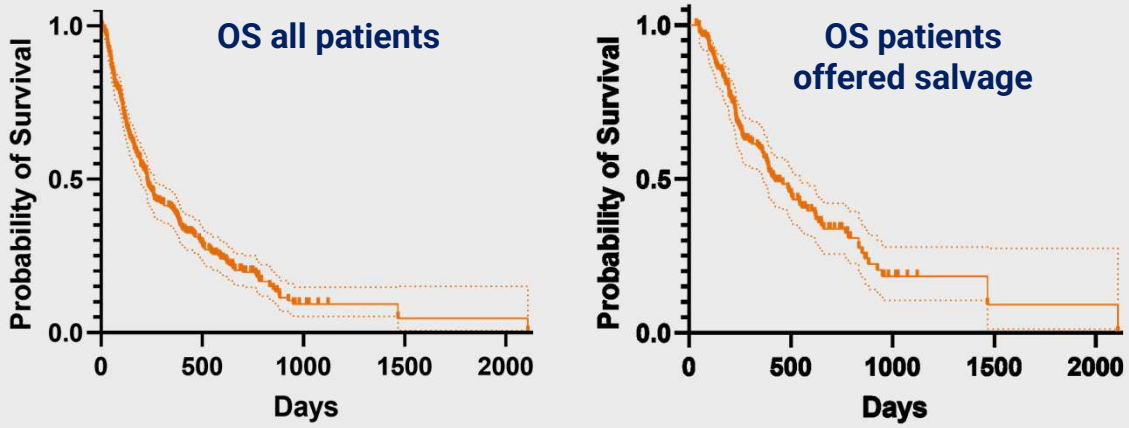
*Tisa-cel is not FDA approved as second-line treatment for DLBCL.

US Retrospective Analysis of Patients for Whom CAR-T Therapy Failed (n = 284)

From time of progression post-CAR-T

- Median OS for all patients with PD: 5.5 months
- Median OS for patients who received salvage: 9.0 months

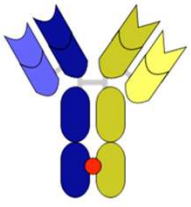
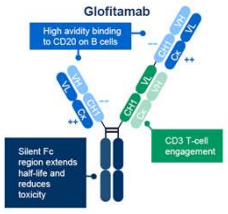
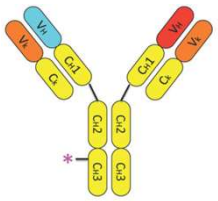
*Median follow-up for surviving patients: **15.9 months** (range: 2.6–36.9)



CAR-T = chimeric antigen receptor T-cell; DLBCL = diffuse large B-cell lymphoma; OS = overall survival; PD = progressive disease.

Zurko JC, et al. *Blood Adv*. 2023;7(12):2657-2669.

New and Emerging Bispecific Antibodies in Non-Hodgkin Lymphomas

Anti-CD20/CD3 bispecific monoclonal antibodies in the development for B-cell NHL			
Epcoritamab[1]	Mosunetuzumab[2,3] (approved in FL)	Glofitamab[4]	Odronextamab[5,6]
			
DuoBody—CD3 x CD20 Knobs-into-holes Fc BsAb SC	CD3 x CD20 Knobs-into-holes Fc BsAb IV/SC	CD3 (Fab) x CD20 (Fab x2) Fc BsAb IV	CD3 x CD20 common LC Fc BsAb IV

Odronextamab is an investigational therapy for the management of NHL.

BsAb = bispecific antibody; Fc = crystallizable fragment; FL = follicular lymphoma; Fab = fragment antigen binding; IV = intravenous; LC = liquid chromatography; SC = subcutaneous.

1. Hutchings M, et al. *Lancet*. 2021;398:1157-1169. 2. Budde LE, et al. *J Clin Oncol*. 2022;40:481-491. 3. Hosseini I, et al. *NPJ Syst Biol Appl*. 2020;6:28. 4. Minson A, Dickinson M. *Leuk Lymphoma*. 2021;62:3098-3108. 5. Zhu M, et al. *Clin Transl Sci*. 2022;15:954-966. 6. Smith EJ, et al. *Sci Rep*. 2015;5:17943.

Approved Bispecifics in Lymphoma: Administration Schedules

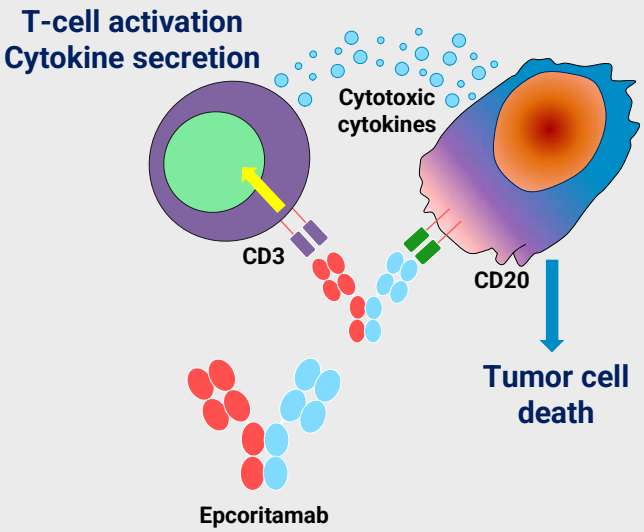
Bispecific	Route	Schedule	Duration
Glofitamab	IV	Weekly C1, every 3 weeks	12 cycles
Mosunetuzumab	IV	Weekly C1, every 3 weeks	8 cycles if complete response (CR); 17 cycles if partial response (PR)
Epcoritamab	SC	Weekly C1 to C3, every 2 weeks C4 to C9, every 4 weeks C ≥10	Until PD

C = Cycle; IV = intravenous; PD = progressive disease; SC = subcutaneous.

Glofitamab-gxbm (COLUMVI™). Prescribing information (PI) 2023 (https://www.columvi.com/). Mosunetuzumab-axgb (Lunsumio™). PI 2024 (https://www.lunsumio.com/). Epcoritamab-bysp (Epkinly®) PI 2024 (https://www.epkinly.com/). URLs accessed 3/17/2025.

Epcoritamab: CD3 x CD20 Bispecific Antibody (SC administration)

- Epcoritamab: CD3 × CD20 bispecific antibody (humanized mouse IgG1-based)
- Induces T-cell activation by binding to CD3 on T cells and CD20 on malignant B cells
- Promotes immunologic synapse between bound cells, resulting in apoptosis of B cells
- Binds to a distinct epitope on CD20 differently from epitopes of rituximab or obinutuzumab
- Retains activity in the presence of CD20 monoclonal antibodies (mAbs)



Epcoritamab is FDA-approved for refractory/relapsed (R/R) DLBCL.

Hutchings M, et al. *Blood.* 2020;136(suppl 1):402. Engelberts PJ, et al. *EBioMedicine.* 2020;52:102625. Chiu C, et al. European Hematology Association (EHA) 2020: Poster EP1330. Hutchings M, et al. *Lancet.* 2021;398:1157-1169.

Epcoritamab in R/R LBCL: EPCORE NHL-1 LBCL Expansion Cohort

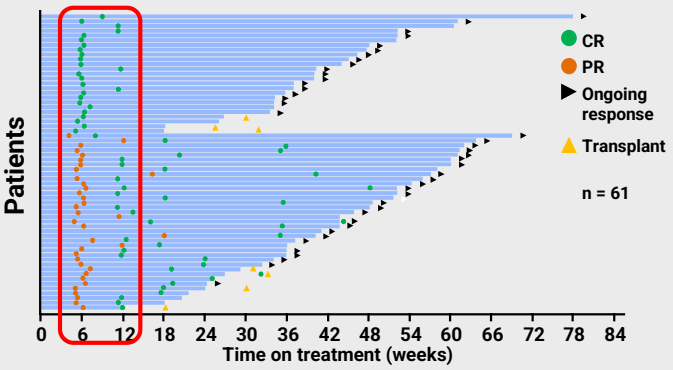
Step-up dosing protocol

Patient group	n	ORR, %	CR, %
All LBCL	157	63	39
• <65 years of age • 65 to <75 years • >75 years	80 48 29	56 69 72	35 40 48
• De novo DLBCL • Transformed DLBCL • Primary refractory	97 40 96	61 68 55	37 45 30
• CAR T-cell therapy naïve • CAR T-cell therapy exposed • CAR T-cell therapy refractory	96 61 46	69 54 46	42 34 28
• 2 prior lines • 3 prior lines • 4 prior lines	46 50 61	65 64 61	35 40 41

Received FDA approval on May 19, 2023, for R/R DLBCL after 2 prior therapy lines

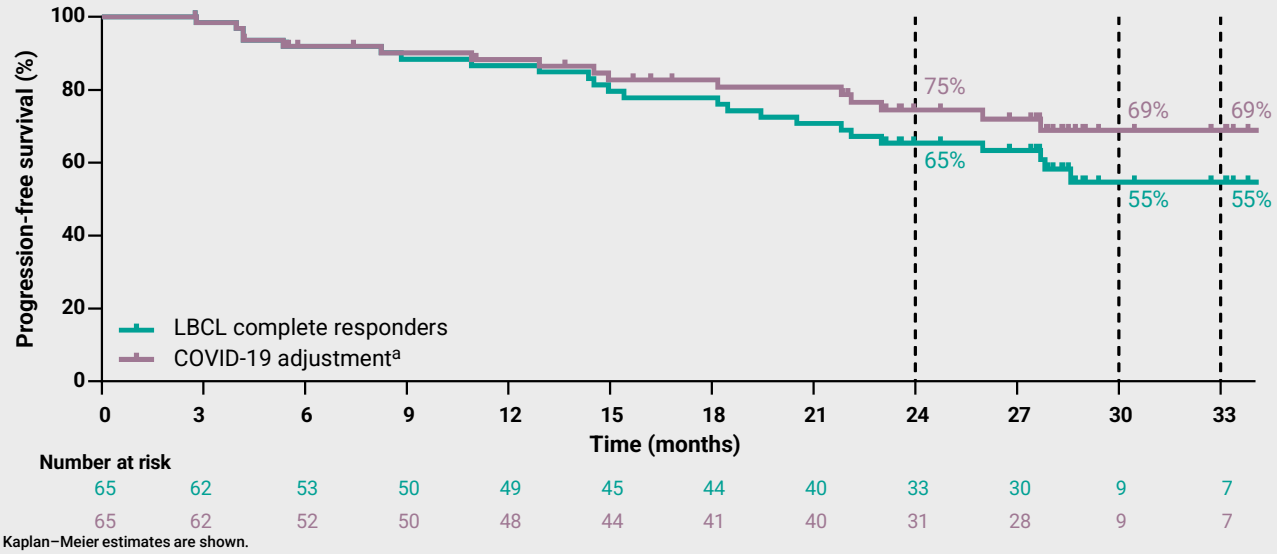
ICANS = Immune effector cell-associated neurotoxicity syndrome.

Thieblemont C, et al. *J Clin Oncol.* 2022;41:2238-2247.



CRS parameter	LBCL (N = 157)
CRS events, n (%)	78 (49.7)
Grade 1 to 2	74 (47.1)
Grade 3	4 (2.5)
Median time to resolution from first full dose, days	2
Treated with tocilizumab, n (%)	22 (14.0)
ICANS grade 1 to 2	5.7%
ICANS grade 3 or more	1 (0.6)

EPCORE NHL-1: Favorable Long-Term Outcomes Among Complete Responders



Number at risk

65	62	53	50	49	45	44	40	33	30	9	7
65	62	52	50	48	44	41	40	31	28	9	7

Kaplan–Meier estimates are shown.

[a] Based on COVID-19–adjusted sensitivity analyses, which censored deaths due to COVID-19.

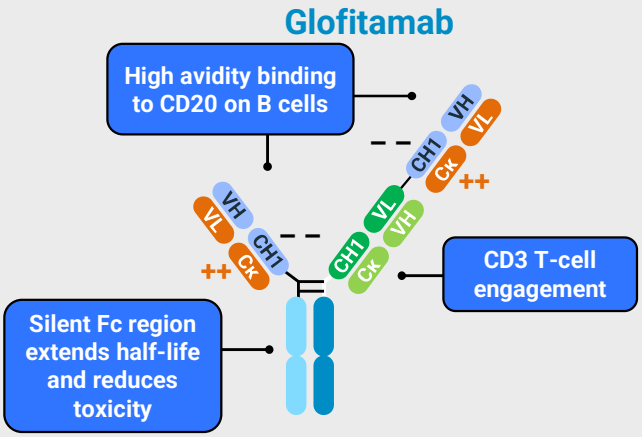
COVID-19 = coronavirus disease 2019; LBCL = large B-cell lymphoma.

Karimi Y, et al. American Society of Clinical Oncology (ASCO) 2024; Poster 7039 (https://meetings.asco.org/abstracts-presentations/232717). Kaimi Y, et al. Society of Hematologic Oncology (SOHO) 2024; Poster ABCL-191. URLs accessed 3/17/2025.

Glofitamab: Bispecific Antibody Targeting CD20 and CD3 in 2:1 Ratio

Glofitamab is CD3/CD20 bispecific antibody for DLBCL

- Humanized mouse IgG1-based antibody
- Unique 2:1 molecular configuration allows "double binding" to CD20 (highlighted in blue zones)
- Advantages of 2:1 design
  - Associated with superior potency under experimental conditions as compared with 1:1 binding bispecific agents
  - Allows concomitant treatment with anti-CD20 antibodies—pre-dosing



Glofitamab is FDA-approved for R/R DLBCL.

Dickinson M, et al. *N Engl J Med*. 2022;387:2220-2231; Hutchings M, et al. *J Clin Oncol*. 2021;39:1959-1970.

Glofitamab Monotherapy at RP2D Induces Durable Complete Responses

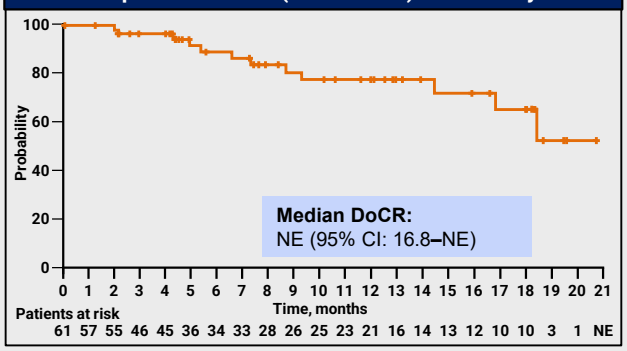
Heavily pretreated, highly refractory population

Pivotal phase 2 results presented at ASCO 2022

- DLBCL NOS, HGBCL, trFL or PMBCL; ≥2 prior therapies
- Glofitamab 2.5/10/30 mg (N = 155)
- Efficacy
  - CR rate: 39.4% (61/155)
  - ORR: 51.6% (80/155)

Received FDA approval on June 15, 2023, for R/R DLBCL after 2 prior therapy lines

Pivotal phase 2 cohort (ASCO 2022) – DoCR* by IRC



	N = 61
Median DoCR follow-up, months (range)	10.6 (0–21)
12-month DoCR, % (95% CI)	**77.6 (64.3–90.8)**
CRs ongoing at CCOD, n (%)	49 (80.3)

Clinical cutoff date: March 14, 2022. *Time from the initial occurrence of a CR until PD or death due to any cause, whichever occurs first.

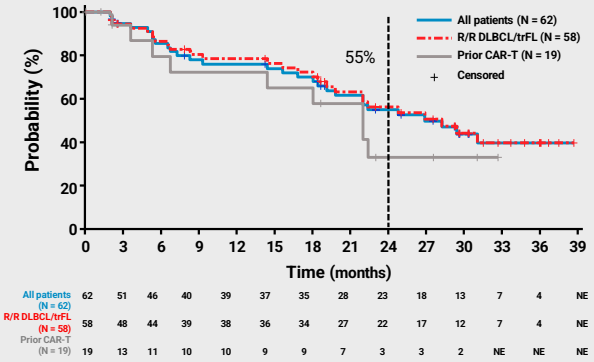
CCOD = clinical cutoff date; CI = confidence interval; CRS = cytokine release syndrome; DoCR = duration of complete response; IRC = independent review committee; PD = progressive disease; PMBCL = primary mediastinal large B-cell lymphoma; RP2D = recommended phase 2 dose; trFL = transformed follicular lymphoma.

Dickinson M, et al. ASCO 2022; Abstract 7500. Dickinson M, et al. *N Engl J Med*. 2022;387:2220-2231.

Response Rates and DoCR: Update Follow-Up ASH 2023

	All patients (N = 155)*	R/R DLBCL/trFL (N = 132)[1†‡]	Prior CAR-T (N = 52)[†]
ORR, n (%) [95% CI]	80 (52)	74 (56)	26 (50)
	[43.5–59.7]	[47.2–64.7]	[35.8–64.2]
CR rate, n (%) [95% CI]	62 (40)	58 (44)	19 (37)
	[32.2–48.2]	[35.3–52.8]	[23.6–51.0]
Median DoCR, months (95% CI)	26.9	28.3	22.0
	(19.8–NR)	(19.8–NR)	(6.7–NR)
24-month DoCR, % (95% CI)	55.0	56.2	33.1
	(41.1–68.8)	(41.9–70.4)	(7.2–59.0)
Median CR follow-up, months (range)	29.6	29.6	23.0
	(0–39)	(0–39)	(0–33)
Ongoing CRs, n/N (%)	34/62 (55)	32/58 (55)	10/19 (53)

DoCR by IRC



- Median time on study: 32.1 months (range: 0–43)

With 32 months median follow-up, glofitamab showed high response rates and durable remissions across subgroups.

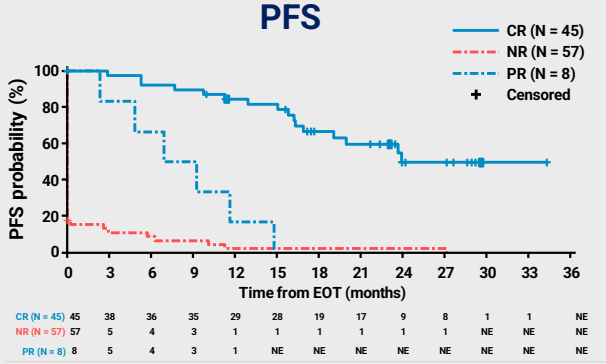
*Intent-to-treat population (DLBCL, trFL, HGBCL, and PMBCL). †Patients in this subgroup had similar baseline characteristics to the overall population. ‡Primary efficacy population reported in the glofitamab USPI, all patients received at least 1 dose of glofitamab.

ASH = American Society of Hematology; CI = confidence interval; NE = not estimable; NR = not reached; USPI = United States prescribing information.

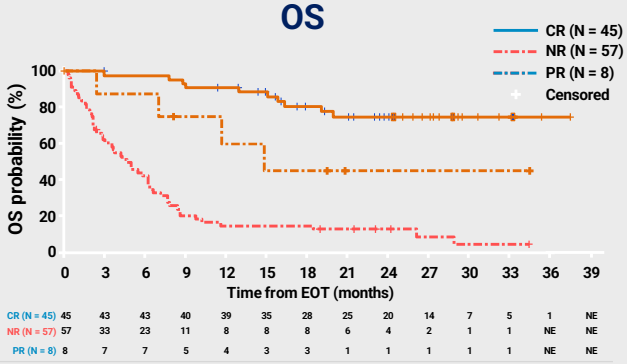
1. Hutchings M, et al. American Society of Hematology 2023.; Abstract 433. 2. Glofitamab-gxbm (Columvi™). PI 2023 (https://www.gene.com/download/pdf/columvi_prescribing.pdf). Accessed 3/17/2025.

Landmark Analysis by Response at EOT

PFS



OS



Landmark PFS from EOT in patients with CR at EOT*	N = 45
Median PFS, months (95% CI)	24.0 (19.1–NE)
18-month PFS rate, % (95% CI)	66.6 (51.0–82.2)

Landmark OS from EOT in patients with CR at EOT	N = 45
Median OS, months (95% CI)	NE (NE)
18-month OS rate, % (95% CI)	80.7 (68.6–92.8)

The majority of patients with a CR at EOT remained progression-free and alive at 18 months after EOT.

EOT = end-of-treatment.

Hutchings M, et al. American Society of Hematology 2023; Abstract 433.

CRS and ICANS: Bispecifics

	N/disease	Grade 1 to 4 CRS	Grade ≥3 CRS	Grade 1 to 4 neurotoxicity	Grade ≥3 neurotoxicity
Glofitamab	N = 155/ DLBCL	63%	3% (Grade ≥2 12%)	8%	3%
Mosunetuzumab*	N = 90/FL	44%	2%	5%	1%
Epcoritamab	N = 157/ LBCL	49.7%	2.5%	6.4%	0.6%

Mosunetuzumab* is not indicated for DLBCL

Dickinson M, et al. *N Engl J Med*. 2022;387(24):2220-2231. Budde LE, et al. *Lancet Oncol*. 2022;23(8):1055-1065. Thieblemont C, et al. *J Clin Oncol*. 2022;41(12):2238-2247.

Potential Adverse Events Considerations: Bispecific Antibodies

- Cytopenias are frequent and manageable; rates of neutropenic fevers are not high
- Infectious disease prophylaxis (eg, pneumocystis jirovecii pneumonia [PJP] prophylaxis, antivirals) and monitoring immunoglobulin levels are important supportive care considerations
- Important to recognize the unique adverse event (AE) profile of bispecific antibodies
  - Cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS) are potential AEs associated with CAR-T therapy and bispecific T-cell engagers

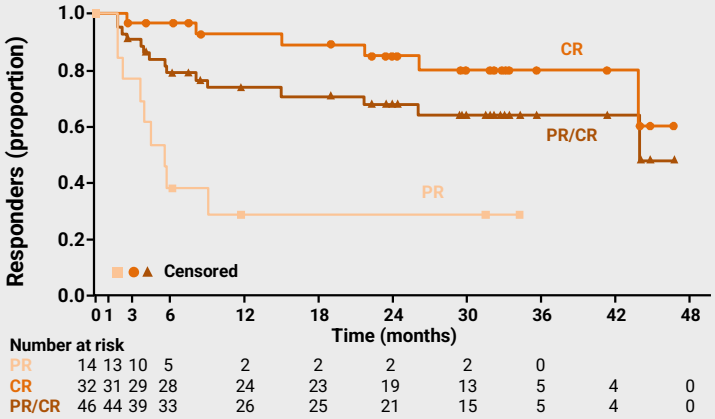
Lee DW, et al. *Blood*. 2014;124(2):188-195. NCCN guidelines for B-cell lymphoma, V3.2023 (www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf). Accessed 2/24/2024. Hutchings M, et al. *Blood*. 2020;136(suppl 1):45-46. Hutchings M, et al. *Lancet*. 2021;398:1157-1691. Bannerji R, et al. ASH 2020; Abstract 400. Engelberts PJ, et al. *EBioMedicine*. 2020;52:10262.

L-MIND Phase 2 Trial of Tafasitamab/Lenalidomide in R/R DLBCL

Tafasitamab: 12 mg/kg C1–3 D1, D8, D15, D22; C4+ D1 and 15, up to 12 cycles
Lenalidomide: 25 mg D1–21 (28-day cycles)

Baseline characteristics	N = 81
Median age, years	72 (41–86)
Primary refractory, n (%)	15 (18.5)
Median prior treatment, n (range)	2 (1–4)
Non–GCB-like, n (%)	22 (27)

Response (N = 80)			
	% or months		Months (95% CI)
ORR	57.5%	PR	5.6 (2.2–NR)
CR rate	40.0%	CR	NR (43.9–NR)
PFS	11.6 months	PR/CR	43.9 (26.1–NR)
mDoR	43.9 months	TTR	2.1 months



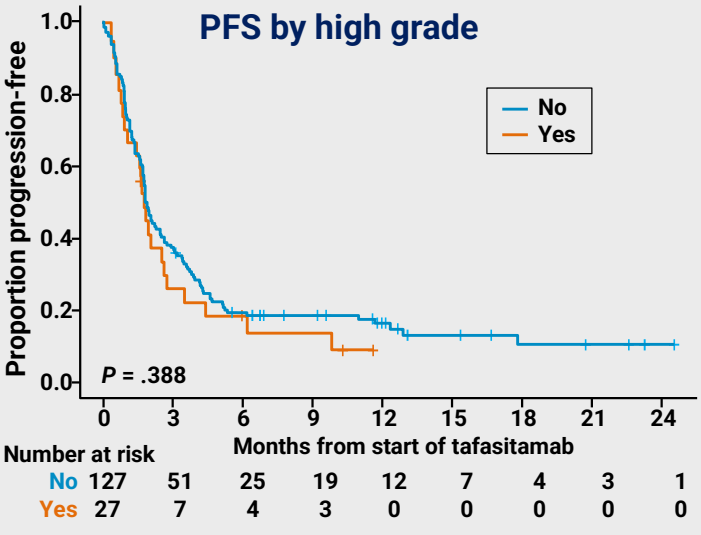
This study included second-line DLBCL and excluded patients with primary refractory and DHL.

The primary toxicities of tafasitamab/lenalidomide are cytopenias and diarrhea.

C = Cycle; D = Day; DoR = duration of response; mDoR = median DoR; NR = not reached; PR = partial response; TTR = time to response.

Duell J, et al. *Haematologica*. 2021;106:2417-2426.

Real-World Evidence of Tafasitamab-Lenalidomide's Activity in HGBCL and Post CAR-T



TLOC study	
DHL/THL	n = 27
ORR	18%
CR rate	15%

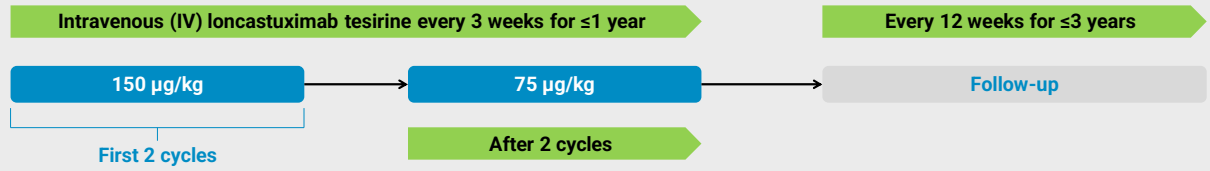
Response to tafasitamab/lenalidomide according to CAR-T response		
DoR after CAR-TI	≥6 months (n = 11)	<6 months (n = 15)
ORR	36%	7%
CR	36%	7%

DHL = double-hit lymphoma; THL = triple-hit lymphoma.

Qualls D, et al. *Blood*. 2022;140(suppl 1):787-789. Qualls D, et al. *Blood*. 2023;142(26):2327-2331. Qualls D, et al. American Society of Hematology (ASH) 2022; Abstract 323. TLOC unpublished data, courtesy Dr. David Qualls.

LOTIS-2 Study of Loncastuximab Teserine in R/R DLBCL

- Patients with R/R DLBCL for whom salvage chemotherapy/stem cell transplantation (SCT) is unsuccessful and who have a poor prognosis and limited treatment options[1,2]
- Loncastuximab tesirine comprises a humanized anti-CD19 antibody conjugated to a potent pyrrolobenzodiazepine (PBD) dimer toxin[3]
- LOTIS-2 is a multicenter, open-label, single-arm, phase 2 study in patients aged ≥18 years with pathologically defined R/R DLBCL and ≥2 prior systemic treatments[4-6]
  - Included patients with high-risk characteristics such as double-hit, triple-hit, transformed, or primary refractory DLBCL[4]

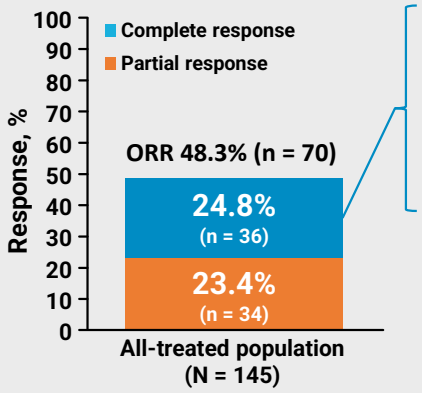


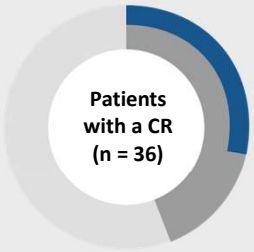
- Primary efficacy and safety data have been published (**≥6 months** since first dose)[4]
- Presented are updated results (**≥17 months** since first dose)

Study findings were previously presented as a poster at the International Conference on Malignant Lymphoma (ICML) Virtual Congress, June 18–22, 2021.

1. Crump M, et al. *Blood*. 2017;130:1800-1808. 2. Gisselbrecht C, et al. *Br J Haematol*. 2018;182:633-643. 3. Zammarchi F, et al. *Blood*. 2018;131:1094-1105. 4. Caimi PF, et al. *Lancet Oncol*. 2021;22:790-800. 5. Caimi PF, et al. ASH 2020; Abstract 1183. 6. Caimi PF, et al. ASCO 2021; Abstract 7546.

Overall Response Rate and Long-Term Responses Observed in the All-Treated Population





Of the patients with a CR, **44% (16 of 36)** were event-free for ≥1 year.

Of the patients with a CR, **31% (11 of 36)** were event-free for ≥2 years.

Median (range) number of treatment cycles	
All-treated population	3.0 (1–26)
Patients with a CR	8.0 (1–26)
Patients with a CR, event-free ≥1 year[a]	12.5 (1–26)
Patients with a CR, event-free ≥2 years[a]	13.0 (1–22)

Data cutoff: September 15, 2022.

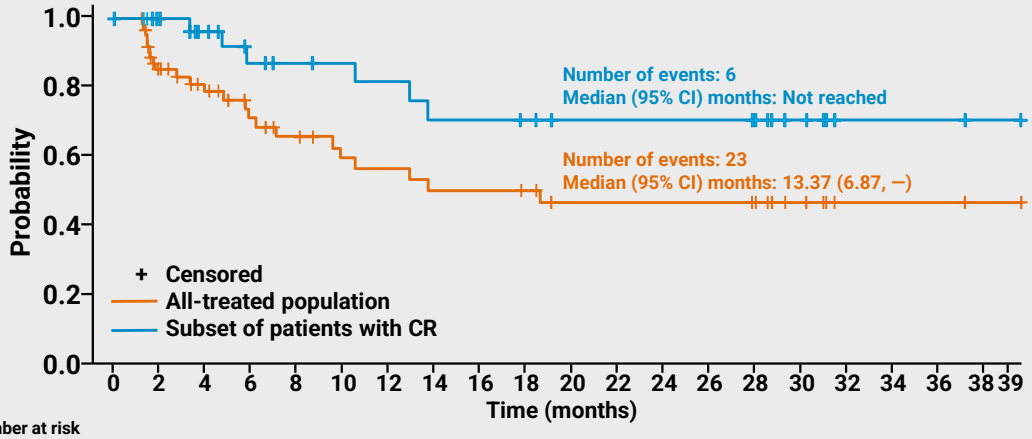
The median duration of follow-up was 7.8 months (range, 0.3–42.6 months) in the all-treated population and 35.0 months (range, 4.4–42.6 months) in patients with a CR.

[a]Event-free is defined as no progressive disease or death starting from Day 1, Cycle 1 of Lonca treatment.

CR = complete response; Lonca = loncastuximab tesirine-lpyl; ORR = overall response rate.

Caimi PF, et al. *Haematologica*. 2023. (https://doi.org/10.3324/haematol.2023.283459). Accessed 3/17/2025.

DOR: All-Treated Population and Patients With a CR



Number at risk																				
All-treated population	70	42	33	25	21	18	17	15	15	13	11	11	11	11	7	5	2	2	2	1 0
Subset of patients with CR	36	30	25	20	18	17	16	14	14	12	11	11	11	11	7	5	2	2	2	1 0

The median (range) time to response was 41 (35–247) days in the all-treated population and 42 (36–247) days for patients with a CR.

Data cutoff: September 15, 2022.

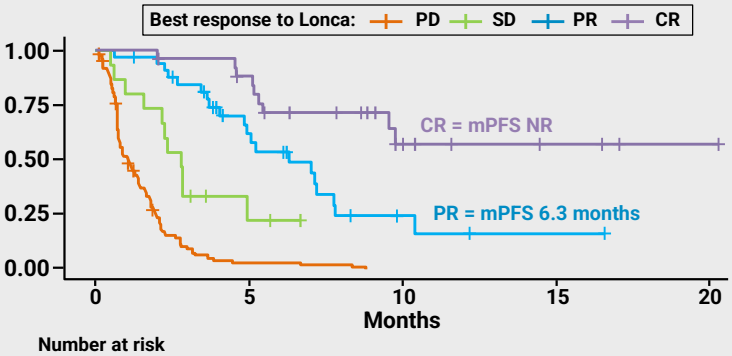
CR = complete response; DOR = duration of response.

Caimi PF, et al. *Haematologica*. 2023. (https://doi.org/10.3324/haematol.2023.283459). Accessed 3/17/2025.

Real-World Data for Loncastuximab

N = 187	ORR (%)	CR (%)
Overall study population	**32**	**14**
CD19 status		
Positive	32	14
Negative	26	21
Bulky disease (N = 32)	16	0
Prior CAR-T		
Yes (N = 112)	30	15
No	35	12
Number of prior therapies		
<4	33	14
4+	30	13
Age >75 years		
Yes	32	14
No	26	21

PFS by Response to Lonca



Number at risk					
PD	112	3	0	0	0
SD	15	2	0	0	0
PR	33	15	3	1	0
CR	26	21	7	3	1

Ayers E, et al. ASH 2023; Abstract 312. Zelikson V et al. *Haematologica*. 2025;110:706-714.

ECHELON-3: Study Design

- Multicenter, double-blind, placebo-controlled, randomized phase 3 trial

Stratified by CD30 status (≥1% vs <1%), cell of origin (GCB vs non-GCB), prior CAR-T therapy (yes vs no), prior SCT (yes vs no)

Patients with R/R DLBCL* after ≥2 lines of systematic therapy (no prior BV or lenalidomide), ineligible for/PD after HSCT or CAR-T treatment, ECOG-PS ≤2, FDG-avid measurable disease, and no active cerebral/meningeal disease or grade ≥2 peripheral neuropathy (N = 230)

→ **BV** 1.2 mg/kg Q3W + **rituximab** 375 mg/m^2 IV Q3W + **lenalidomide** 20 mg PO QD (n = 112)

→ **Placebo** + **rituximab** 375 mg/m^2 IV Q3W + **lenalidomide** 20 mg PO QD (n = 118)

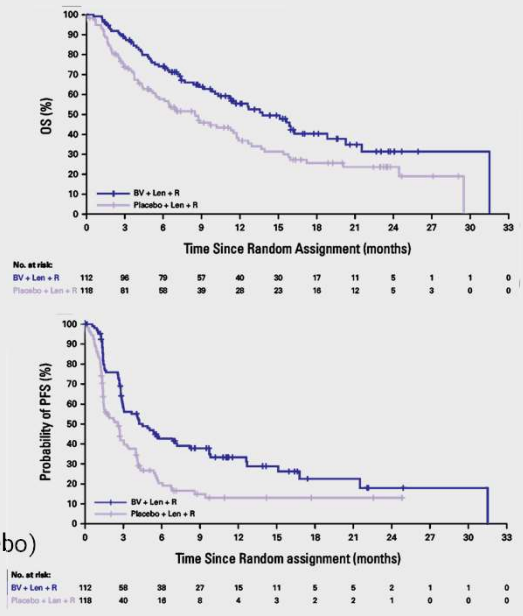
*Including but not limited to transformed DLBCL, high-grade DH/TH lymphoma, DLBCL-NOS.

- **Primary endpoint**: OS in ITT population
- **Key secondary endpoints**: PFS and ORR by investigator in ITT population, CR and DoR by investigator, OS in patients with CD30+ disease, safety/tolerability

FDG = fluorodeoxyglucose; ITT = intention-to-treat; PO = by mouth; Q3W = every 3 weeks; QD = every day.
Kim JA, et al. ASCO 2024; Abstract LBA7005. NCT04404283 (https://clinicaltrials.gov/study/NCT04404283?tab=history&a=37). Accessed 3/17/2025.

ECHELON-3: OS and PFS in ITT Population

	BV + Len + R	Placebo + Len + R
OS	**n = 112**	**n = 118**
Median OS, months	13.8	8.5
HR (95% CI)	0.629 (0.445–0.891)	
P	.0085	
Median follow-up, months	15.5	18.9
PFS	**n = 112**	**n = 118**
Median PFS, months	4.2	2.6
HR (95% CI)	0.527 (0.380–0.729)	
P	<.0001	
Median follow-up, months	11.1	8.8



- OS prespecified efficacy boundary was crossed at interim analysis
- Median duration of treatment: 3.6 months (BV) vs 2.0 months (placebo)

BV = brentuximab vedotin; ITT = intention-to-treat; Len = lenalidomide; OS = overall survival; PFS = progression-free survival; R = rituximab.
Kim JA, et al. ASCO 2024; Abstract LBA7005.

ECHELON-3: Response

All patients	BV + Len + R (n = 112)	Placebo + Len + R (n = 118)	*P*
ORR, % ▪ CR	64.3 40.2	41.5 18.6	.0006
With CD30-negative disease (<1%)	**n = 76**	**n = 80**	***P***
ORR, % ▪ CR	60.5 40.8	37.5 15.0	.0063
With CD30-positive disease (≥1%)	**n = 36**	**n = 38**	***P***
ORR, % ▪ CR	72.2 38.9	50.0 26.3	.0602

- Median DoR
  - All patients: 8.3 months (BV) vs 3.0 months (placebo)
  - In patients who achieved a CR: 18.9 months (BV) vs not reached (placebo)
- Median time to CR onset: 1.58 months (BV) vs 1.61 months (placebo)

BV = brentuximab vedotin; CR = complete response; DoR = duration of response; Len = lenalidomide; ORR = overall response rate; R = rituximab.

Kim JA, et al. ASCO 2024; Abstract LBA7005.

Conclusions

- R-CHOP remains SoC treatment for patient with newly diagnosed DLBCL; however, Pola + CHP is also a standard option for patients with IPI score 2–5, advanced-stage
- Second-line therapies for patients who are ineligible for or decline transplant and CAR-T therapy include tafasitamab/lenalidomide, polatuzumab/BR, or other chemoimmunotherapy (ie, R-GemOx)
- Available third-line and later-line options for patients who are ineligible for or decline CAR-T therapy or those who have progressed on CAR-T therapy include bispecifics, tafasitamab/lenalidomide, polatuzumab/BR, loncastuximab tesirine, and selinexor
- CAR-T therapy has been approved as treatment of choice for DLBCL in third line and now in second line for patients with primary refractory disease and early relapse

Thank you!

Q&A

Program Resources

https://linktr.ee/DLBCLManagement

- CREATE a free personalized office poster
- REGISTER for a variety of CME activities
- VIEW supplemental resources and animations

Overview of Diffuse Large B-Cell Lymphoma Front-Line Therapy

Resource	Address
Bartlett NL, Wilson WH, Jung SH, et al. Dose-adjusted EPOCH-R compared with R-CHOP as frontline therapy for diffuse large B-cell lymphoma: Clinical outcomes of the phase III intergroup trial Alliance/CALGB 50303. *J Clin Oncol*. 2019;37:1790-1799.	https://ascopubs.org/doi/10.1200/JCO.18.01994
Coiffier B, Lepage E, Briere J, et al. CHOP chemotherapy plus rituximab compared with CHOP alone in elderly patients with diffuse large-B-cell lymphoma. *N Engl J Med.* 2002;346:235-242.	https://www.nejm.org/doi/10.1056/NEJMoa011795
Coiffier B, Thieblemont C, Van Den Neste E, et al. Long-term outcome of patients in the LNH-98.5 trial, the first randomized study comparing rituximab-CHOP to standard CHOP chemotherapy in DLBCL patients: A study by the Groupe d'Etudes des Lymphomes de l'Adulte. *Blood*. 2010;116:2040-2045.	https://ashpublications.org/blood/article/116/12/2040/27477/Long-term-outcome-of-patients-in-the-LNH-98-5
Davies A, Cummin TE, Barrans S, et al. Gene-expression profiling of bortezomib added to standard chemoimmunotherapy for diffuse large B-cell lymphoma (REMoDL-B): An open-label, randomised, phase 3 trial. *Lancet Oncol*. 2019;20:649-662.	https://www.sciencedirect.com/science/article/pii/S1470204518309355
Jaeger U, Trneny M, Melzer H, et al. Rituximab maintenance for patients with aggressive B-cell lymphoma in first remission: Results of the randomized NHL13 trial. *Haematologica*. 2015;100:955-963.	https://haematologica.org/article/view/7441
Lamy T, Damaj G, Soubeyran P, et al. R-CHOP 14 with or without radiotherapy in nonbulky limited-stage diffuse large B-cell lymphoma. *Blood.* 2018;131:174-181.	https://ashpublications.org/blood/article/131/2/174/37014/R-CHOP-14-with-or-without-radiotherapy-in-nonbulky
Nowakowski GS, Chiappella A, Gascoyne RD, et al. ROBUST: A phase III study of lenalidomide plus R-CHOP versus placebo plus R-CHOP in previously untreated patients with ABC-type diffuse large B-cell lymphoma. *J Clin Oncol*. 2021;39:1317-1328.	https://ascopubs.org/doi/10.1200/JCO.20.01366
Sehn LH, Martelli M, Trněný M, et al. A randomized, open-label, Phase III study of obinutuzumab or rituximab plus CHOP in patients with previously untreated diffuse large B-Cell lymphoma: Final analysis of GOYA. *J Hematol Oncol*. 2020;13:71.	https://jhoonline.biomedcentral.com/articles/10.1186/s13045-020-00900-7
Stiff PJ, Unger JM, Cook J, et al. Randomized phase III U.S./Canadian intergroup trial (SWOG S9704) comparing CHOP ± R for eight cycles to CHOP ± R for six cycles followed by autotransplant for patients with high-intermediate (H-Int) or high IPI grade diffuse aggressive non-Hodgkin lymphoma (NHL). *Clin Oncol*. 2011;29(15_suppl):8001.	https://ascopubs.org/doi/10.1200/jco.2011.29.15_suppl.8001
Thieblemont C, Phillips T, Ghesquieres H, et al. Epcoritamab, a novel, subcutaneous CD3xCD20 bispecific T-cell-engaging antibody, in relapsed or refractory large B-cell lymphoma: Dose expansion in a phase I/II trial. *J Clin Oncol.* 2023;41:2238-2247.	https://ascopubs.org/doi/10.1200/JCO.22.01725

Tilly H, Morschhauser F, Sehn LH, et al. Polatuzumab vedotin in previously untreated diffuse large B-cell lymphoma. *N Engl J Med*. 2022;386:351-363.	https://www.nejm.org/doi/10.1056/NEJMoa2115304
Witzig TE, Tobinai K, Rigacci L, et al. Adjuvant everolimus in high-risk diffuse large B-cell lymphoma: Final results from the PILLAR-2 randomized phase III trial. *Ann Oncol*. 2018;29:707-714.	https://www.annalsofoncology.org/article/S0923-7534(19)35489-4/fulltext
Younes A, Sehn LH, Johnson P, et al. Randomized phase III trial of ibrutinib and rituximab plus cyclophosphamide, doxorubicin, vincristine, and prednisone in non-germinal center B-cell diffuse large B-cell lymphoma. *J Clin Oncol*. 2019;37:1285-1295.	https://ascopubs.org/doi/10.1200/JCO.18.02403

Treatment for Relapsed/Refractory Diffuse Large B-Cell Lymphoma

Resource	Address
Bannerji R, Arnason JE, Advani RH, et al. Odronextamab, a human CD20×CD3 bispecific antibody in patients with CD20-positive B-cell malignancies (ELM-1): Results from the relapsed or refractory non-Hodgkin lymphoma cohort in a single-arm, multicentre, phase 1 trial. *Lancet Haematol.* 2022;9:e327-e339.	https://pmc.ncbi.nlm.nih.gov/articles/PMC10681157/
Bartlett NL, Hahn U, Kim WS, et al. Brentuximab vedotin combination for relapsed diffuse large B-cell lymphoma. *J Clin Oncol. 2025*;43:1061-1072.	https://ascopubs.org/doi/10.1200/JCO-24-02242
Bishop MR, Dickinson M, Purtill D, et al. Second-line tisagenlecleucel or standard care in aggressive B-cell lymphoma. *N Engl J Med*. 2022;386:629-639.	https://www.nejm.org/doi/10.1056/NEJMoa2116596
Budde LE, Assouline S, Sehn LH, et al. Single-agent mosunetuzumab shows durable complete responses in patients with relapsed or refractory B-cell lymphomas: Phase I dose-escalation study. *J Clin Oncol*. 2022;40:481-491.	https://ascopubs.org/doi/10.1200/JCO.21.00931
Budde LE, Sehn LH, Matasar M, Schuster SJ, et al. Safety and efficacy of mosunetuzumab, a bispecific antibody, in patients with relapsed or refractory follicular lymphoma: a single-arm, multicentre, phase 2 study. *Lancet Oncol.* 2022:23:1055-1065.	https://www.sciencedirect.com/science/article/abs/pii/S1470204522003357
Caimi PF, Ai W, Alderuccio JP, et al. Loncastuximab tesirine in relapsed or refractory diffuse large B-cell lymphoma (LOTIS-2): A multicentre, open-label, single-arm, phase 2 trial. *Lancet Oncol.* 2021;22:790-800.	https://www.sciencedirect.com/science/article/abs/pii/S147020452100139X
Crump M, Neelapu SS, Farooq U, et al. Outcomes in refractory diffuse large B-cell lymphoma: Results from the international SCHOLAR-1 study. *Blood.* 2017;130:1800-1803.	https://ashpublications.org/blood/article/130/16/1800/36474/Outcomes-in-refractory-diffuse-large-B-cell
Dickinson MJ, Carlo-Stella C, Morschhauser F, et al. Glofitamab for relapsed or refractory diffuse large B-cell lymphoma. *N Engl J Med.* 2022;387:2220-2231.	https://www.nejm.org/doi/10.1056/NEJMoa2206913

Duell J, Maddocks KJ, González-Barca E, et al. Long-term outcomes from the Phase II L-MIND study of tafasitamab (MOR208) plus lenalidomide in patients with relapsed or refractory diffuse large B-cell lymphoma. *Haematologica*. 2021;106:2417-2426.	https://haematologica.org/article/view/haematol.2020.275958
Hosseini I, Gadkar K, Stefanich E, et al. Mitigating the risk of cytokine release syndrome in a phase I trial of CD20/CD3 bispecific antibody mosunetuzumab in NHL: Impact of translational system modeling. *NPJ Syst Biol Appl*. 2020;6:28.	https://www.nature.com/articles/s41540-020-00145-7
Hutchings M, Mous R, Clausen MR, et al. Dose escalation of subcutaneous epcoritamab in patients with relapsed or refractory B-cell non-Hodgkin lymphoma: An open-label, phase 1/2 study. *Lancet*. 2021;398:1157-1169.	https://www.sciencedirect.com/science/article/abs/pii/S0140673621008898
Gisselbrecht C, Van Den Neste E. *Br J Haematol.* How I manage patients with relapsed/refractory diffuse large B cell lymphoma. *Br J Haematol.* 2018;182:633-643.	https://onlinelibrary.wiley.com/doi/10.1111/bjh.15412
Kamdar M, Solomon SR, Arnason J, et al. Lisocabtagene maraleucel versus standard of care with salvage chemotherapy followed by autologous stem cell transplantation as second-line treatment in patients with relapsed or refractory large B-cell lymphoma (TRANSFORM): Results from an interim analysis of an open-label, randomised, phase 3 trial. *Lancet*. 2022;399:2294-2308.	https://www.sciencedirect.com/science/article/abs/pii/S0140673622006626
Lee DW, Gardner R, Porter DL, et al. Current concepts in the diagnosis and management of cytokine release syndrome. *Blood.* 2014;124:188-195.	https://ashpublications.org/blood/article/124/2/188/32896/Current-concepts-in-the-diagnosis-and-management
Locke FL, Miklos DB, Jacobson CA, et al. Axicabtagene ciloleucel as second-line therapy for large B-cell lymphoma. *N Engl J Med*. 2022;386:640-654.	https://www.nejm.org/doi/10.1056/NEJMoa2116133
Minson A, Dickinson M. Glofitamab CD20-TCB bispecific antibody. *Leuk Lymphoma*. 2021;62:3098-3108.	https://www.tandfonline.com/doi/10.1080/10428194.2021.1953016
Qualls DA, Lambert N, Caimi PF, et al. Tafasitamab and lenalidomide in large B-cell lymphoma: Real-world outcomes in a multicenter retrospective study. *Blood*. 2023;142:2327-2331.	https://ashpublications.org/blood/article/142/26/2327/498041/Tafasitamab-and-lenalidomide-in-large-B-cell
Smith EJ, Olson K, Haber LJ, et al. A novel, native-format bispecific antibody triggering T-cell killing of B-cells is robustly active in mouse tumor models and cynomolgus monkeys. *Sci Rep*. 2015;5:17943.	https://www.nature.com/articles/srep17943
Thieblemont C, Phillips T, Ghesquieres H, et al. Epcoritamab, a novel, subcutaneous CD3xCD20 bispecific T-cell-engaging antibody, in relapsed or refractory large B-cell lymphoma: Dose expansion in a phase I/II trial. *J Clin Oncol.* 2022;41:2238-2247.	https://ascopubs.org/doi/10.1200/JCO.22.01725

Zammarchi F, Corbett S, Adams L, et al. ADCT-402, a PBD dimer-containing antibody drug conjugate targeting CD19-expressing malignancies. *Blood.* 2018;131:1094-1105.	https://ashpublications.org/blood/article/131/10/1094/36428/ADCT-402-a-PBD-dimer-containing-antibody-drug
Zhu M, Olson K, Kirshner JR, et al. Translational findings for odronextamab: From preclinical research to a first-in-human study in patients with CD20+ B-cell malignancies. *Clin Transl Sci*. 2022;15:954-966.	https://ascpt.onlinelibrary.wiley.com/doi/10.1111/cts.13212
Zurko J, Nizamuddin I, Epperla N, et al. Peri-CAR-T practice patterns and survival predictors for all CAR-T patients and post-CAR-T failure in aggressive B-NHL. *Blood Adv*. 2023;7:2657-2669.	https://ashpublications.org/bloodadvances/article/7/12/2657/486571/Peri-CAR-T-practice-patterns-and-survival

All URLs accessed March 24, 2025