I "LINFOMI INDOLENTI"

FONDAZIONE ITALIANA LINFOMI

Milano, Best Western Hotel Madison
26-27 gennaio 2026

Dalla parte della terapia con bispecifici nella malattia recidivata

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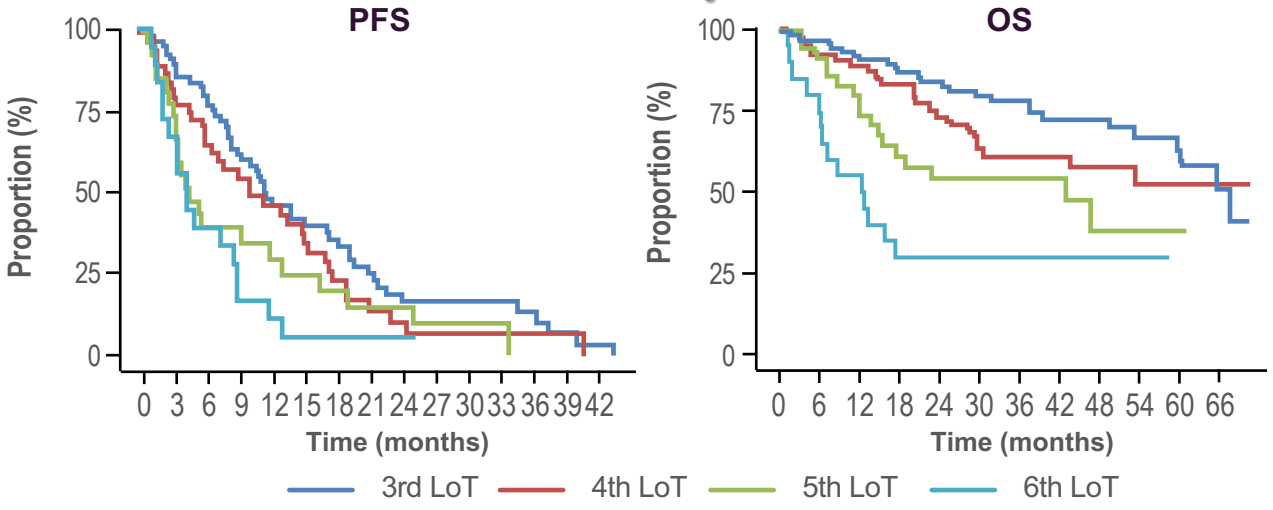
Disclosures of Name Surname

Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
Roche	x				x	x	
BeOne	x					x	
Incyte					x	x	
Abbvie						x	
Novartis						x	
BMS					x	x	
Kite					x	x	
Regeneron					x	x	

Worsening Outcomes With Additional Lines of Therapy: Results From the International SCHOLAR-5 Study

Ghione, et al. (SCHOLAR-5)	
N	128
Median age, years (range)	65 (36–86)
Stages 3–4	86%
FLIPI 3–5	39%
POD24	27%
Prior ASCT	18%
Prior anti-CD20+ alkylating agent	89%



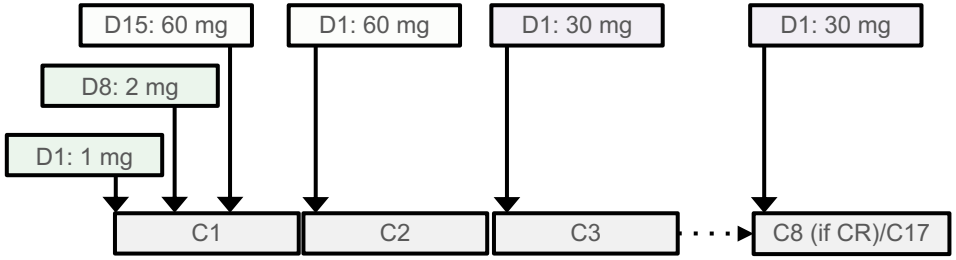
	3rd LoT	4th LoT	5th+ LoT
ORR (%)	68	63	37
CRR (%)	44	27	22
5-year OS (%)	62	52	38
mPFS (median mo)	11	9.7	3.9
TTNT (median mo)	20.1	17.9	7.1

ASCT, autologous stem cell transplant; CRR, complete response rate; FLIPI, Follicular lymphoma international prognostic index; LoT, lines of therapy; mo, months; mPFS, median PFS; OS, overall survival; ORR, objective response rate; PFS, progression-free survival; POD24, progression of disease within 24 months; TTNT, time to next treatment. Adapted from Ghione P, et al. *Haematologica*. 2023;108(3):822-832.

Different Strategies for the Administration of BsAbs in FL

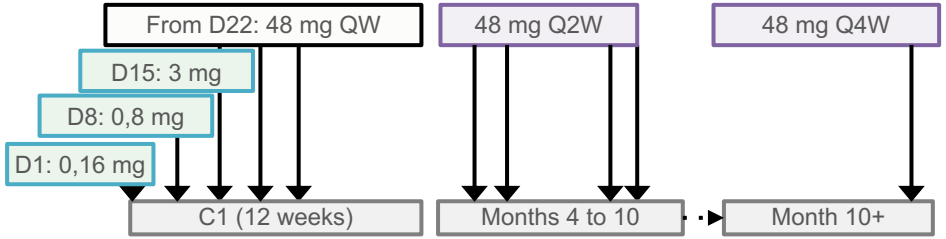
Mosunetuzumab

- IV mosunetuzumab administered weekly during C1 and then in 21-day cycles
- Step-up dosing in C1
- Fixed-duration treatment
- No mandatory hospitalization



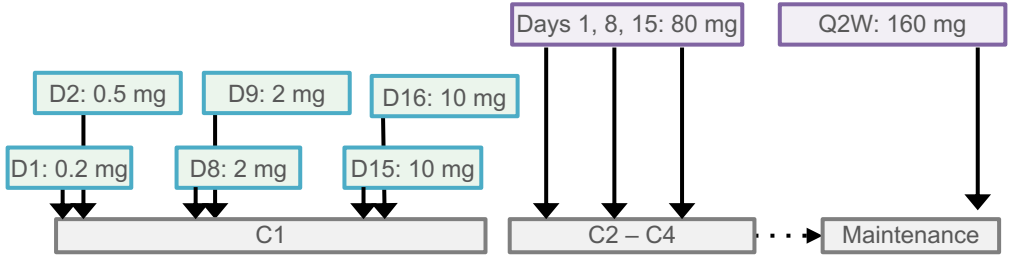
Epcoritamab

- SC epcoritamab administered weekly for 8 weeks then monthly
- Optimized Step-up dosing in C1 (4, 12, 48 mg)
- Treatment until progression
- Steroid prophylaxis
- Hospitalization at D22



Odronextamab

- IV odronextamab administered
- This was modified to 0.7/4/20 mg during C1 to further mitigate the risk of CRS
- Treatment until progression
- 48-hour hospital admission required at each split until nominal dose achieved



- BsAb, bispecific antibody; C, cycle; CRS, cytokine release syndrome; D, day; FL, follicular lymphoma; IV, intravenous; Q2W, every 2 weeks; Q4W, every 4 weeks; QW, every week; SC, subcutaneous.

Adapted from: 1. Dreyling M, et al. *J Clin Oncol*. 2017;35(35):3898-3905. 2. Budde LE, et al. *Lancet Oncol*. 2022;23(8):1055-1065. 3. Kim T-M, et al. Presented at: ASH 2022.

GO29781: a pivotal Phase II study evaluating mosunetuzumab IV in patients with R/R FL

- Mosunetuzumab is the first CD20xCD3 T-cell engaging bispecific antibody approved by the United States Food and Drug Administration and the European Medicines Agency for the treatment of patients with R/R FL after ≥2 prior lines of therapy[1–3]
- In a pivotal Phase II study (NCT02500407), fixed-duration mosunetuzumab demonstrated high response rates, durable remissions, and a manageable safety profile in patients with R/R FL[4]
- **We report updated efficacy and safety data for mosunetuzumab in patients with R/R FL after a median follow-up of 5 years**

Key inclusion criteria

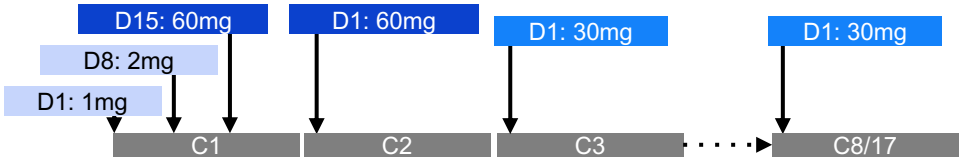
- R/R FL Grade 1–3a
- ≥2 prior therapies including an anti-CD20 antibody and an alkylator
- ECOG PS 0–1

Endpoints

- Primary: CR rate (IRC-assessed) as best response
- Secondary: CR (INV-assessed), ORR,* DOR,* DOCR,* PFS,* OS, and safety

Mosunetuzumab administration

- IV administration in 21-day cycles with C1 step-up dosing
- Fixed-duration treatment: 8 cycles if CR after C8 or 17 cycles if PR/SD after C8
- No mandatory hospitalization



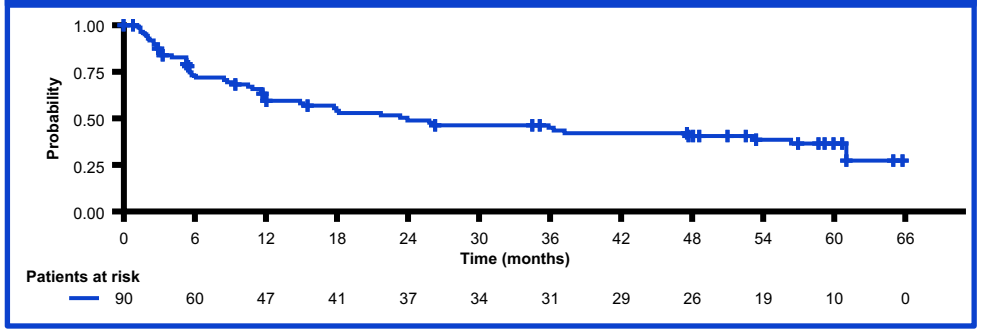
IRC and INV assessments were done using the Cheson 2007 criteria.[5] *Assessed by IRC and INV.
C, cycle; CR, complete response; D, day; DOCR, duration of complete response; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; INV, investigator; IRC, independent review committee; IV, intravenous; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; PR, partial response; SD, stable disease.

1. Sun LL, et al. Sci Transl Med 2015;7:287ra70; 2. Lunsumio US PI. Available from: https://www.accessdata.fda.gov [Accessed November 2025]; 3. Lunsumio SmPC. Available from: https://www.ema.europa.eu [Accessed November 2025];
4. Budde LE, et al. Lancet Oncol 2022;23:1055–65;
5. Cheson BD, et al. J Clin Oncol 2007;25:579–86.

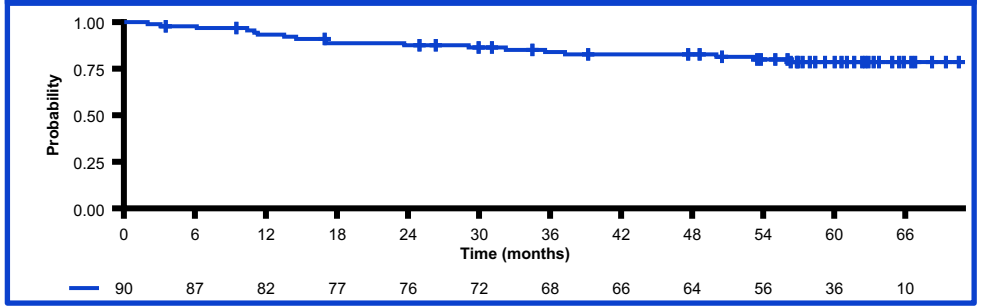
Long-term survival benefits continue to be observed in the overall population

- Mosunetuzumab continued to induce durable responses in the overall population (N=90):
  - The ORR and CR rate were 78% and 60%, respectively
  - The median DOCR was not reached (95% CI: 44.1–NE) and the 5-year DOCR rate was 52.1% (95% CI: 36.2–67.9)
  - The median PFS was 24 months (95% CI: 12.0–53.2) and the 5-year PFS rate was 36.5% (95% CI: 25.3–47.7)
  - The median OS was not reached, and the 5-year OS rate was 78.5% (95% CI: 69.6–87.4)
  - The median TTNT was 64.1 months (95% CI: 21.7–NE)

PFS in the overall population



OS in the overall population



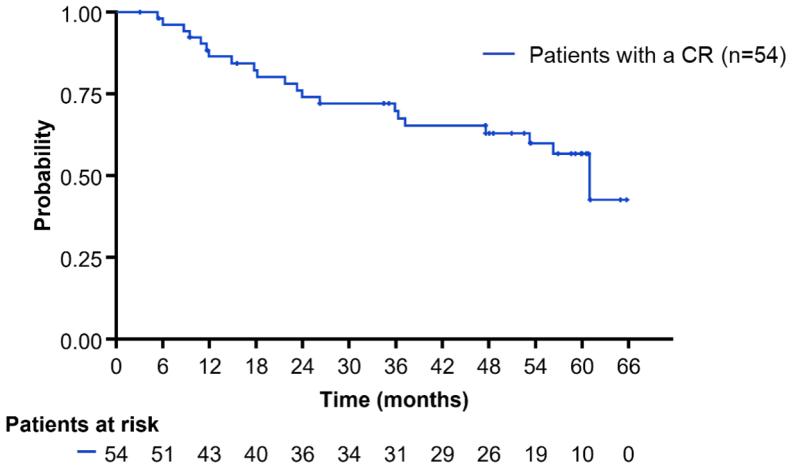
CCOD: May 1, 2025.
CCOD, clinical cut-off date; CI, confidence interval; NE, not estimable; TTNT, time to next treatment.

Budde LE, et al. ASH 2025; Poster presentation (abstract #5352).

Mosunetuzumab prolongs survival in patients with a CR

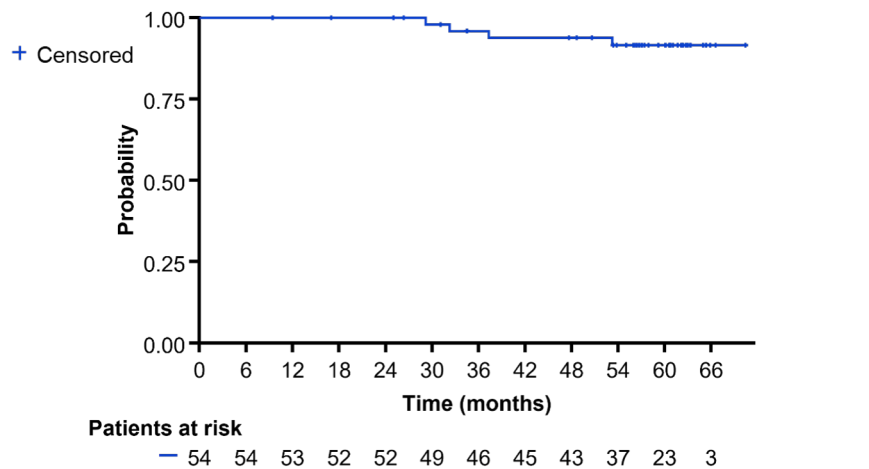
5-year follow up

PFS of patients with a CR



Of patients with a CR	n=54
Median PFS, months (95% CI)*	**61 (47.6-NE)**
5-year PFS, % (95% CI)	56.8% (42.0-71.6)

OS of patients with a CR



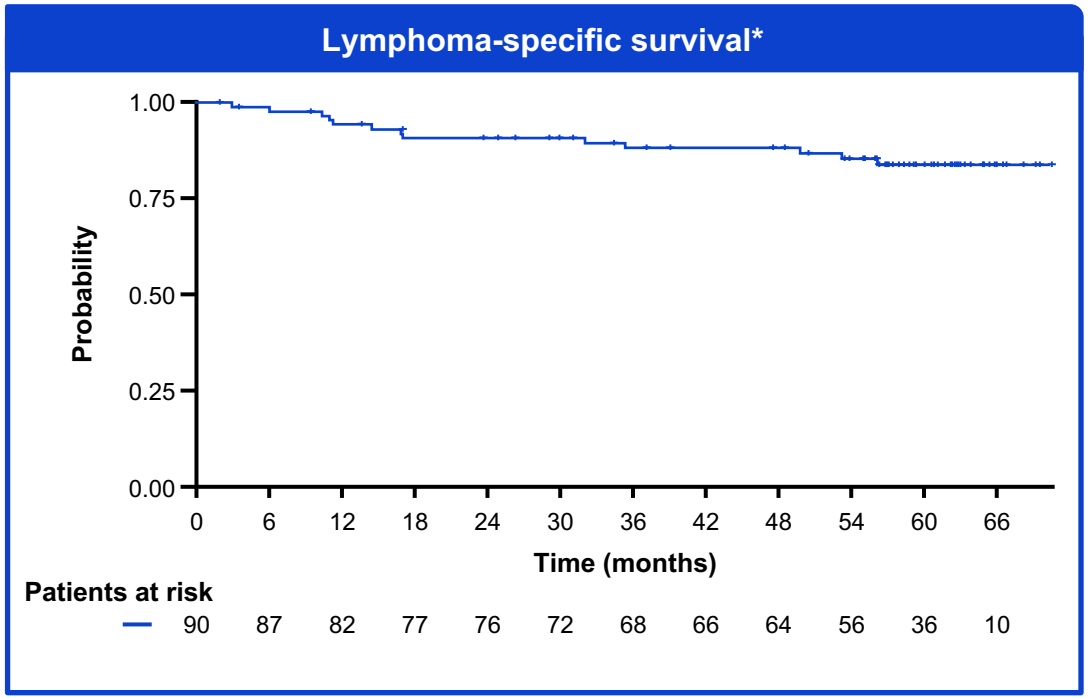
Of patients with a CR	n=54
Median OS months (95% CI)†	**NR (NE-NE)**
5-year OS rate, % (95% CI)	91.6% (83.7-99.5)

With a median follow up of 5 years, nearly all patients with a CR are alive.

Data cut-off date: May 1, 2025.

Budde LE, et al. ASH 2025; Poster presentation (abstract #5352).

The incidence of lymphoma-specific deaths and deaths due to other causes were both low



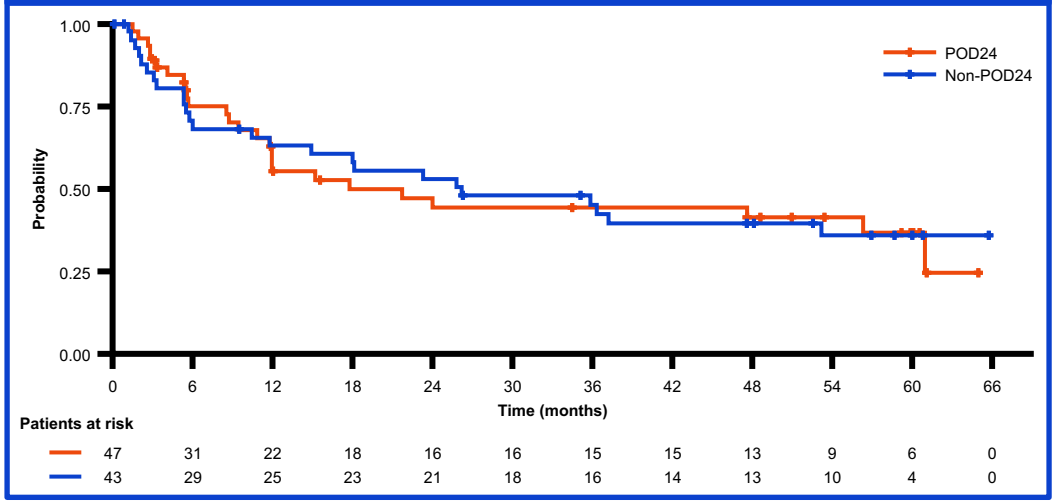
- The 5-year lymphoma-specific survival rate was 83.7% (95% CI: 75.5–91.9) in the overall population
- After the 3-year landmark analysis, only three lymphoma-specific deaths occurred
- A total of 18 deaths were reported; 13 were lymphoma-specific, one each due to unexplained death, cardiac arrest and sepsis, and two with unknown cause

CCOD: May 1, 2025.*Patients were censored by death due to other or unknown causes, withdrawal from study, and the data cut-off.

Consistent efficacy is observed with fixed-duration mosunetuzumab in patients with POD24

- Mosunetuzumab continued to induce durable responses in high-risk subgroups
- In patients with POD24 (n=47):
  - The ORR was 81% and the CR rate was 60%
  - The median PFS was 22 months (95% CI: 11.6–61.0), the 5-year PFS rate was 36.9% (95% CI: 20.7–53.1)
- In patients without POD24 (n=43):
  - The median PFS was 26 months (95% CI: 11.8–NE)
  - The 5-year PFS rate was 36.0% (95% CI: 20.4–51.5)

PFS in POD24 and non-POD24 patients



Long-term survival was observed in patients with high-risk disease characteristics such as POD24

CCOD: May 1, 2025.
POD24, history of disease progression within 24 months from start of first-line therapy.

Budde LE, et al. ASH 2025; Poster presentation (abstract #5352).

Mosunetuzumab continues to demonstrate a manageable safety profile in R/R FL with no new toxicities reported

n (%) patients with ≥1 AE	N=90
Number of patients with at least one AE	90 (100)
Grade 3/4 AE	62 (68.9)
Serious AEs	43 (47.8)
Grade 5 AEs*	2 (2.2)
AEs leading to treatment discontinuation	4 (4.4)
Infections	45 (50.0)
Serious infections	18 (20.0)
Grade 3/4 infections	15 (16.7)
Infection AEs leading to treatment withdrawal	1 (1.1)†

n (%) patients with ≥1 AE	N=90
Most common infection AEs, any grade	
Unspecified pathogens	28 (31.1)
Upper respiratory tract infection	8 (8.9)
Viral infections	14 (15.6)
COVID-19/suspected COVID-19	3 (3.3)
Fungal infections	7 (7.8)
Oral candidiasis	2 (2.2)
Bacterial infections	7 (7.8)
Cellulitis	2 (2.2)
Opportunistic infections	1 (1.1)
Pneumocystis jirovecii pneumonia	1 (1.1)

- CRS remained the most common AE (44%)
  - Most events were Grade 1/2: Grade 1 (26%), Grade 2 (17%), Grade 3 (1%), Grade 4 (1%); all CRS events were resolved
- No serious infections related to mosunetuzumab were reported after 13.4 months

No new AEs were reported since the 4-year follow-up

CCOD: May 1, 2025. *Preferred term malignant neoplasm progression (n=1) and preferred term death (n=1); no treatment-related Grade 5 AEs occurred. †Grade 4 Epstein-Barr viremia. AE, adverse event; COVID-19, coronavirus disease 2019; CRS, cytokine release syndrome.

Mosunetuzumab SC had a manageable safety profile including among retreated patients

- No new CRS events or fatal, serious, or Grade ≥3 AEs were reported since the previous analysis[1]
- Injection site reactions remained the most common AE (n=65; 69.1%)
  - All were either Grade 1 (n=56; 59.6%) or Grade 2 (n=9; 9.6%)
- Two patients experienced Grade 3 febrile neutropenia
- No immune effector cell-associated neurotoxicity syndrome events were reported
- The safety profile during retreatment was consistent with initial therapy, with only 2 (10%) Grade 1 CRS events, 1 serious AE, and no fatal AEs

n (%) unless stated	Mosunetuzumab SC (N=94)	Mosunetuzumab SC retreatment (n=9)
AE	93 (98.9)	8 (88.9)
Grade 3/4 AE	46 (48.9)	3 (33.3)
Serious AE	37 (39.4)	1 (11.1)
Grade 5 (fatal) AE	5 (5.3)*	0
AE leading to Mosun SC discontinuation	7 (7.4)	0
Any grade CRS by ASTCT	28 (29.8)	2 (22.2)
Grade 1	19 (20.2)	2 (22.2)
Grade 2	7 (7.4)	0
Grade 3	2 (2.1)	0
Any grade infections	52 (55.3)	4 (44.4)
Grade 1	13 (13.8)	3 (33.3)
Grade 2	21 (22.3)	0
Grade 3/4	15 (16.0)	1 (11.1)
Grade 5	3 (3.2)†	0

Clinical cut-off date: May 1, 2025. *COVID-19 pneumonia, n=2; COVID-19, n=1; hemophagocytic lymphohistiocytosis, n=1 (with active Epstein-Barr virus, cytomegalovirus, and lymphoma transformation); general physical health deterioration, n=1.
†COVID-19 pneumonia, n=2; COVID-19, n=1.
ASTCT, American Society for Transplantation and Cellular Therapy.[2]

1. Bartlett NL, et al. ASH 2024; Poster 1645.
2. Lee DW, et al. Biol Blood Marrow Transplant 2019;25:625–38.

EHA2025 Congress
June 12 - 15, 2025 | Milan, Italy

Epcoritamab Demonstrates deep and durable responses at 3-years follow up in patients with relapse/refractory follicular Lymphoma

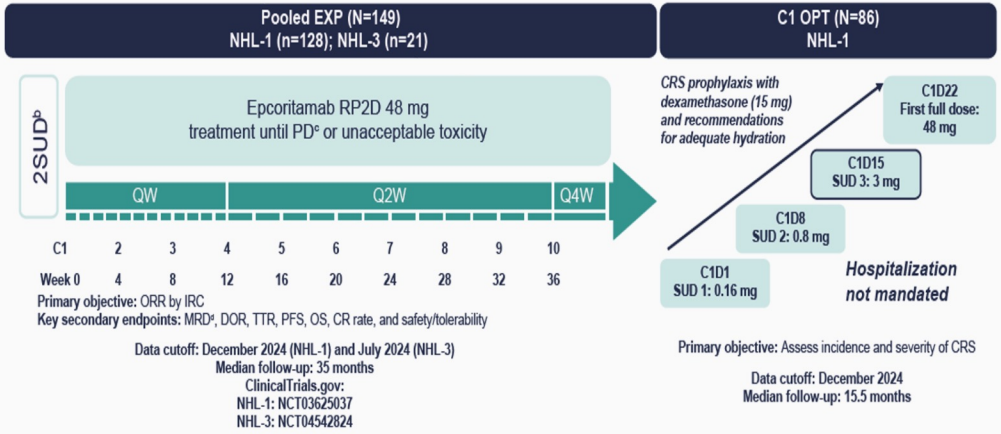
Vitolo et al, PF881, EHA 2025

Updated Data Presented At EHA 2025

STUDY DESIGN

Key inclusion criteria[a]:

- R/R CD20+ FL grade 1–3A
- ECOG PS score 0–2
- ≥2 prior lines of antineoplastic therapy, including ≥1 regimen with an anti-CD20 mAb
- Prior treatment with an alkylating agent or lenalidomide
- FDG-avid disease by PET/CT
- Prior CAR T cell therapy allowed



[a]Patients enrolled in this trial (and excluded from trials of other T-cell–engaging therapies) included those with worse anemia, lymphopenia, and/or renal function. [b]SUD (priming [SUD 1] 0.16 mg and intermediate [SUD 2] 0.8 mg dosing before first full dose) and corticosteroid prophylaxis were used to mitigate CRS. [c]≥2 measurable (by CT/MRI) and FDG PET–positive lesions; radiographic disease evaluation was performed every 6 weeks for the first 24 weeks (6, 12, 18, and 24 weeks), then every 12 weeks (36 and 48 weeks), and every 6 months thereafter. [d]MRD was assessed in PBMC using the clonoSEQ® next-generation sequencing assay.

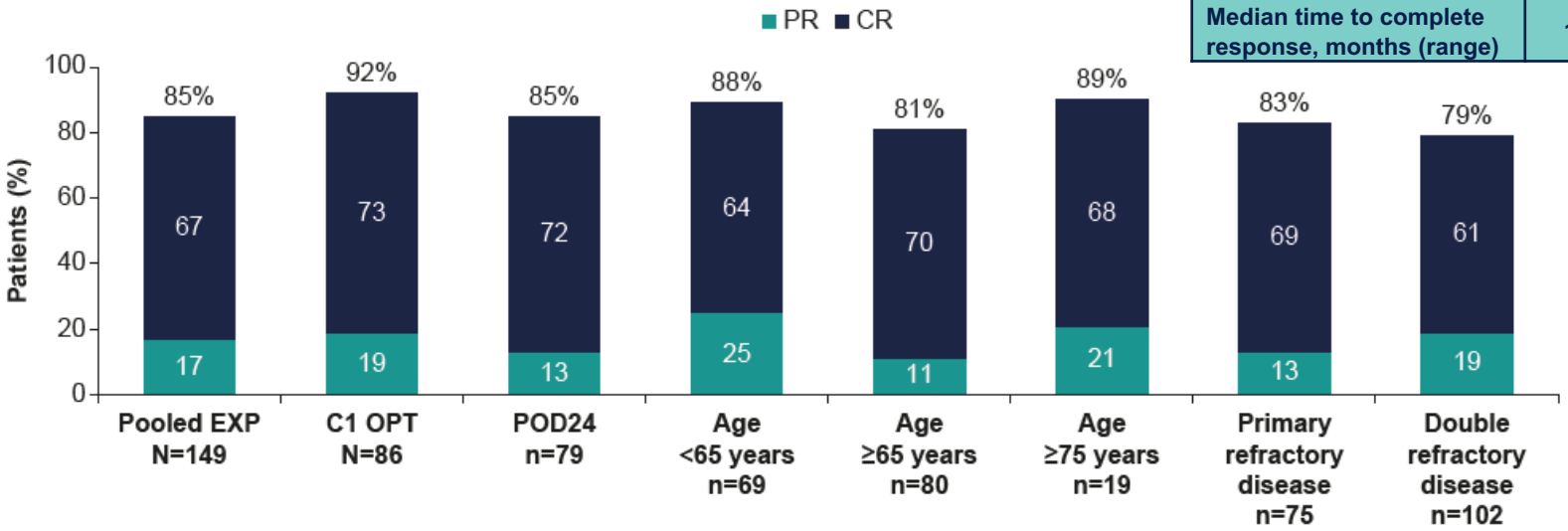
- To increase diversity and expand the patient population, the EXP cohorts of NHL-1 and NHL-3 were pooled
- The approved SUD regimen is based on C1 OPT data, which showed reduced CRS and ICANS incidence and severity with mitigation strategies, and consistent response rates, supporting outpatient administration; time-to-event analyses in the C1 OPT cohort of NHL-1 are still maturing and not presented
- In the pooled EXP cohort, sensitivity analyses for PFS and OS were performed based on an adjusted population excluding deaths on study related to COVID-19; a conservative analysis was performed since the study was conducted during the COVID-19 pandemic (enrollment dates: NHL-1: June 2020–April 2023; NHL-3: January 2021–November 2021)

Vitolo et al, PF881, EHA 2025

Responses Across Subgroups

Epcoritamab Treatment Resulted in Deep Responses Across Subgroups[a]

Median time to response, months (range)	**1.4 (1.0–3.0)**
Median time to complete response, months (range)	**1.5 (1.2–11.1)**

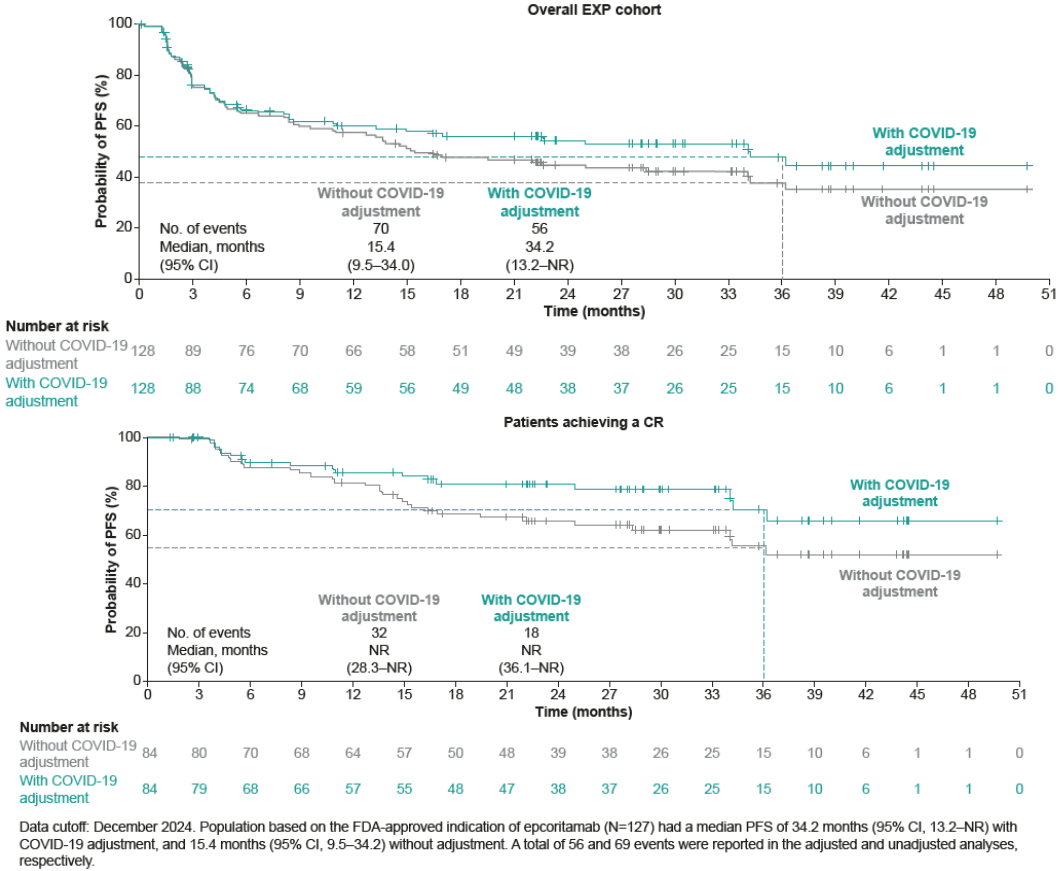


[a]Subgroups were evaluated in the pooled EXP cohort.
Data cutoff: December 2024. Population based on the FDA-approved indication of epcoritamab (N=127) had an ORR of 83%, including a CR rate of 65% and a PR rate of 17%.

Vitolo et al, PF881, EHA 2025

PFS and OS in the pooled exp Cohort

Sustained PFS With Epcoritamab in the Pooled EXP Cohort



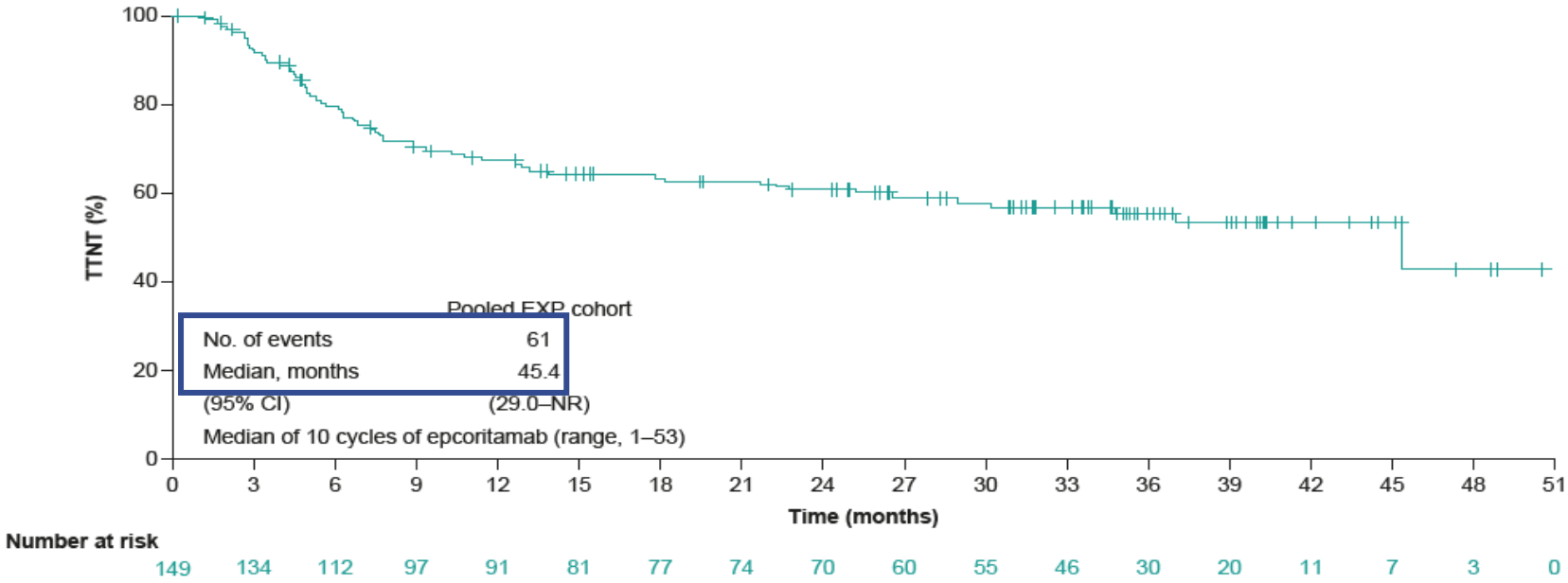
Data cutoff: December 2024. Population based on the FDA-approved indication of epcoritamab (N=127) had a median PFS of 34.2 months (95% CI, 13.2–NR) with COVID-19 adjustment, and 15.4 months (95% CI, 9.5–34.2) without adjustment. A total of 56 and 69 events were reported in the adjusted and unadjusted analyses, respectively.

In the pooled EXP cohort median PFS was 15.4 mo
<u>However</u>
After adjustment for COVID-19 deaths it was 34.2 mo and NR in patients in CR

OS was NR regardless od COVID adjustment
The exstimated COVID- adjusted 30-month OS rate was 79%

Time to Next Treatment

Extended TTNT With Epcoritamab in the Pooled EXP Cohort



Data cutoff: December 2024. Population based on the FDA-approved indication of epcoritamab (N=127) had a median TTNT of 45.4 months (95% CI, 22.7–NR).

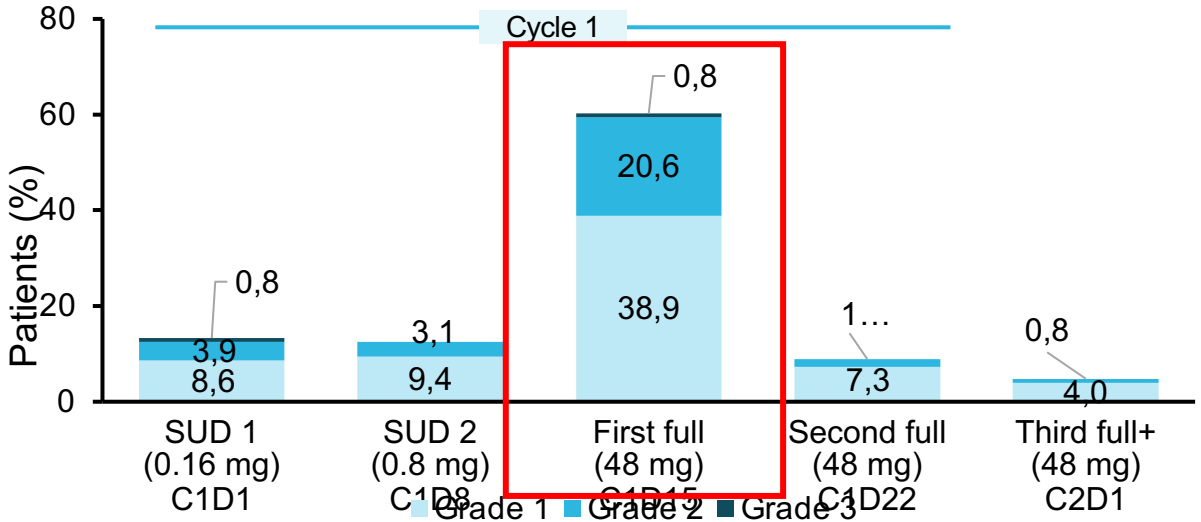
MRD negativity (10^{-6} cutoff;PBMC, clonoSEQ® assay) was achieved in 70% of MRD evaluable patients

Vitolo et al, PF881, EHA 2025

EPCORE® NHL-1: CRS Events by Dosing Period, Time to Onset, and Resolution

Expansion Cohort

CRS Events[a] by Dosing Period (Subject Level[b]; FL, N=128)



Most CRS events occurred in Cycle 1 and were associated with the first full dose of epcoritamab

76 (60%) patients experienced CRS following the first full dose

CRS resolved in 100% of patients

Median time to resolution = 2 d

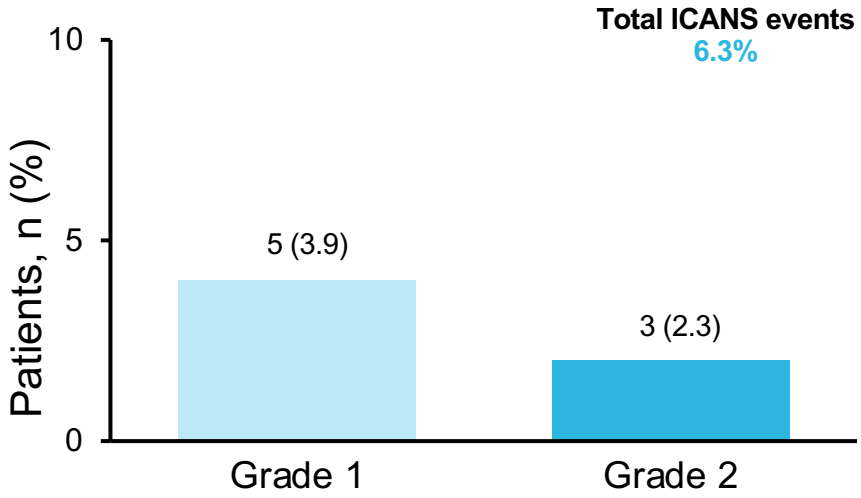
Data cutoff: April 21, 2023. Information is provided for the 128 patients with R/R FL. Please note, due to variations in data classification and/or calculations, 127 patients with R/R FL received a 2 step-up dosage schedule per the prescribing information, which does not include 1 patient who had transformation from FL to DLBCL. A 3-step up dosage schedule is recommended per the prescribing information[2]; a 2-step up dosage schedule was used for the clinical trial only.
[a]Graded by Lee et al 2019 criteria. [b]Subject-level data is the number of subjects who experienced at least one event of CRS. [c]Among all 128 patients.
C, cycle; CRS, cytokine release syndrome; d, day; DLBCL, diffuse large B-cell lymphoma; FL, follicular lymphoma; h, hour; R/R, relapsed or refractory.

1. Linton KM, et al. *Lancet Haematol.* 2024 Jun 15. doi: 10.1016/S2352-3026(24)00166-2. Online ahead of print. 2. EPKINLY® [package insert]. Plainsboro, NJ: Genmab US, Inc and North Chicago, IL: AbbVie Inc.

EPCORE® NHL-1: ICANS Occurrence, Time to Onset, and Resolution

Expansion Cohort

Incidence of ICANS[a] (FL, N=128)



Median time to onset from most recent dose = 3.5 d

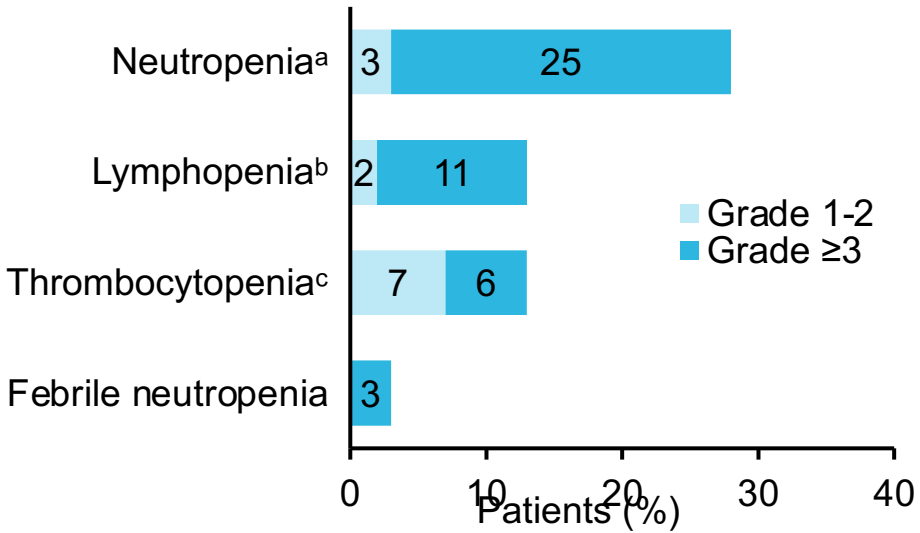
ICANS resolved in 100% of patients
Median time to resolution = 2 d

Data cutoff: April 21, 2023. Information is provided for the 128 patients with R/R FL. Please note, due to variations in data classification and/or calculations, 127 patients with R/R FL received a 2 step-up dosage schedule per the prescribing information, which does not include 1 patient who had transformation from FL to DLBCL. [a]Graded by Lee et al 2019 criteria.
D, day; DLBCL, diffuse large B-cell lymphoma; FL, follicular lymphoma; ICANS, immune effector cell–associated neurotoxicity syndrome; R/R, relapsed or refractory.
Linton KM, et al. *Lancet Haematol*. 2024 Jun 15. doi: 10.1016/S2352-3026(24)00166-2. Online ahead of print.

EPCORE® NHL-1: Incidence of Cytopenias

Expansion Cohort

Cytopenia adverse events occurring in ≥10% of patients (FL, N=128)



In 36 (28%) patients who experienced neutropenia:

- 23/128 (18%) required treatment with G-CSF

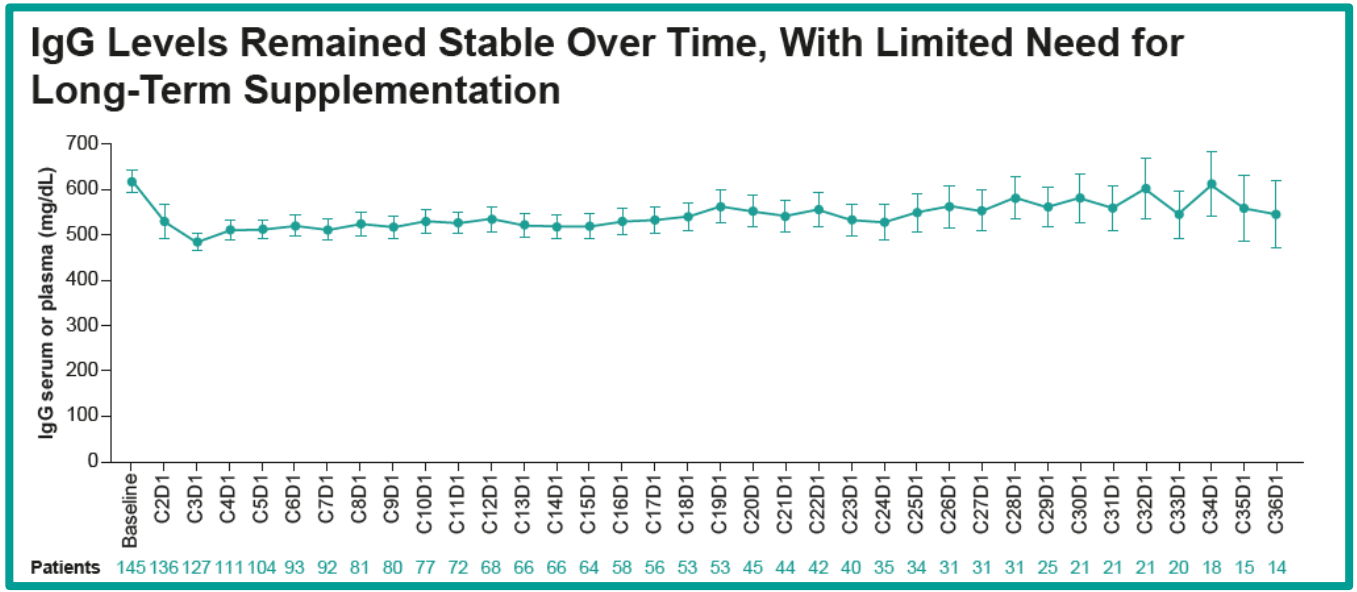
Median time to resolution = 27.5 d

In 4 (3%) patients who experienced febrile neutropenia:

- All were Grade 3
- All required G-CSF

Percentages are rounded to the nearest whole number.
Data cutoff: April 21, 2023. Information is provided for the 128 patients with R/R FL. Please note, due to variations in data classification and/or calculations, 127 patients with R/R FL received a 2 step-up dosage schedule per the prescribing information, which does not include 1 patient who had transformation from FL to DLBCL. [a]Neutropenia includes neutropenia and decreased neutrophil count. [b]Lymphopenia includes lymphopenia and decreased lymphocyte count. [c]Thrombocytopenia includes thrombocytopenia and decreased platelet count.
d, day; DLBCL, diffuse large B-cell lymphoma; FL, follicular lymphoma; G-CSF, granulocyte colony-stimulating factor; R/R, relapsed or refractory.
Linton KM, et al. *Lancet Haematol*. 2024 Jun 15. doi: 10.1016/S2352-3026(24)00166-2. Online ahead of print.

Safety Profile – IgG Levels over the Time



- After an initial decline, mean IgG levels (serum or plasma) remained generally stable through C36 in the pooled EXP cohort
  - In the pooled EXP cohort, 22 out of 149 patients received IgG supplementation, of whom 4 received IgG supplementation both before and after the 2-year landmark

Vitolo et al, PF881, EHA 2025

Treatment Discontinuations while in CR

EHA2025 Congress
June 12 - 15, 2025 | Milan, Italy

- In the pooled EXP cohort, 35 patients discontinued epcoritamab treatment while in CR for a reason other than PD or death, and had ≥1 response measurement following treatment discontinuation
  - Reasons for discontinuation included AEs (n=16), withdrawal by patient (n=9), no longer clinically benefiting (n=3), other (n=6), and decision to proceed with transplant (n=1; transplant not received)
  - Median time on treatment was 15.9 months (range, 1.5–36.2)
  - 94% (33/35) of patients had sustained CR on a subsequent scan after treatment discontinuation; median time in CR post treatment discontinuation was 13.1 months (range, 0.4–28.3); 2 patients experienced PD following discontinuation

Vitolo et al, PF881, EHA 2025

ELM-2 study design: R/R FL cohort

ELM-2: Phase 2, open-label, multicohort, multicenter study of odronextamab monotherapy in patients with R/R B-NHL (NCT03888105)

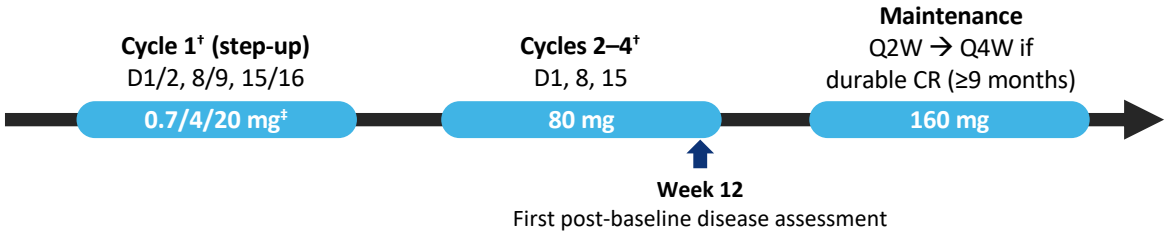
Key eligibility criteria

- Age ≥18 years
- FL Grade 1–3a*
- ECOG PS 0 or 1
- Refractory to or relapsed after ≥2 prior lines of systemic therapy including an anti-CD20 antibody and an alkylating agent

Measures taken to facilitate diverse, inclusive enrollment:[1]

- Diverse trial sites
- Translated consent forms
- Extended screening windows
- Broad eligibility criteria

Odronextamab IV administration



Primary endpoint

- ORR§ by ICR

Secondary endpoints

- ORR§ by local investigator
- CR,§ DOR,§ PFS,§ and OS
- Safety and tolerability
- Patient-reported outcomes

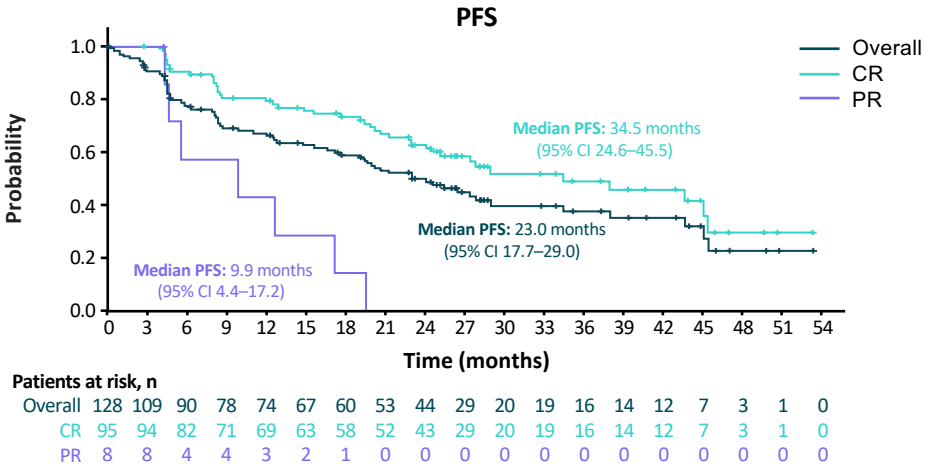
Anti-infection prophylaxis including IVIg supplementation and antivirals was recommended, and PJP prophylaxis was mandated

*Per WHO 2017 classification;[2] †Each cycle = 21 days; ‡The study initiated with a Cycle 1 step-up regimen of 1/20 mg. This was modified to 0.7/4/20 mg to further mitigate the risk of CRS. Premedication administered during Cycle 1 step-up included dexamethasone, diphenhydramine, and acetaminophen; §According to Lugano criteria.[3]

B-NHL, B-cell non-Hodgkin lymphoma; CD, cluster of differentiation; CR, complete response; CRS, cytokine release syndrome; D, Day; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; ICR, independent central review; IV, intravenous; IVIg, intravenous immunoglobulin; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PJP, *Pneumocystis jirovecii* pneumonia; Q2W, once every 2 weeks; Q4W, once every 4 weeks; R/R, relapsed/refractory; WHO, World Health Organization.

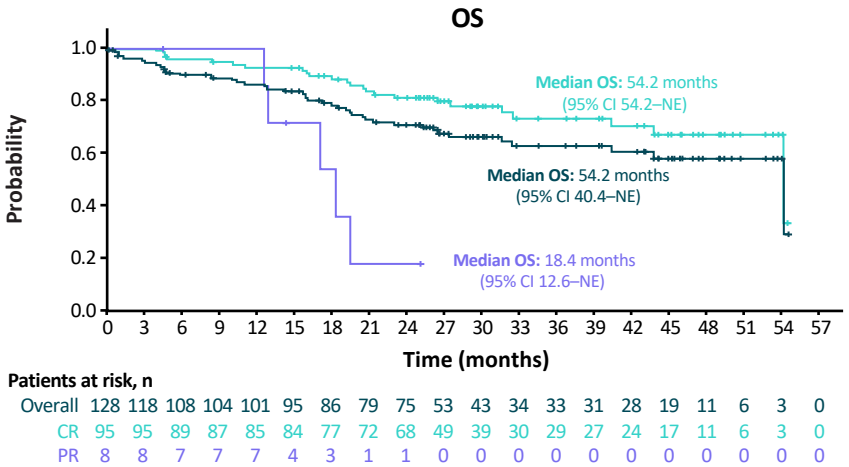
1. Kim TM, et al. *Ann Oncol* 2024;35(11):1039–47; 2. Swerdlow SH, et al. IARC Publications. Geneva, Switzerland: IARC Press; 2017; 3. Cheson BD, et al. *J Clin Oncol* 2014;32(27):3059–68.

PFS was prolonged and OS was similar in patients with a CR compared with those in the overall population



Patients at risk, n

Overall	128	109	90	78	74	67	60	53	44	29	20	19	16	14	12	7	3	1	0
CR	95	94	82	71	69	63	58	52	43	29	20	19	16	14	12	7	3	1	0
PR	8	8	4	4	3	2	1	0	0	0	0	0	0	0	0	0	0	0	0



Patients at risk, n

Overall	128	118	108	104	101	95	86	79	75	53	43	34	33	31	28	19	11	6	3	0
CR	95	95	89	87	85	84	77	72	68	49	39	30	29	27	24	17	11	6	3	0
PR	8	8	7	7	7	4	3	1	1	0	0	0	0	0	0	0	0	0	0	0

PFS rate, % (95% CI)	All patients (N=128)	CR (n=95)	PR (n=8)
24 months	49.8 (40.1–58.7)	62.8 (51.6–72.2)	0 (NE–NE)
36 months	37.5 (27.2–47.8)	48.8 (35.9–60.6)	0 (NE–NE)

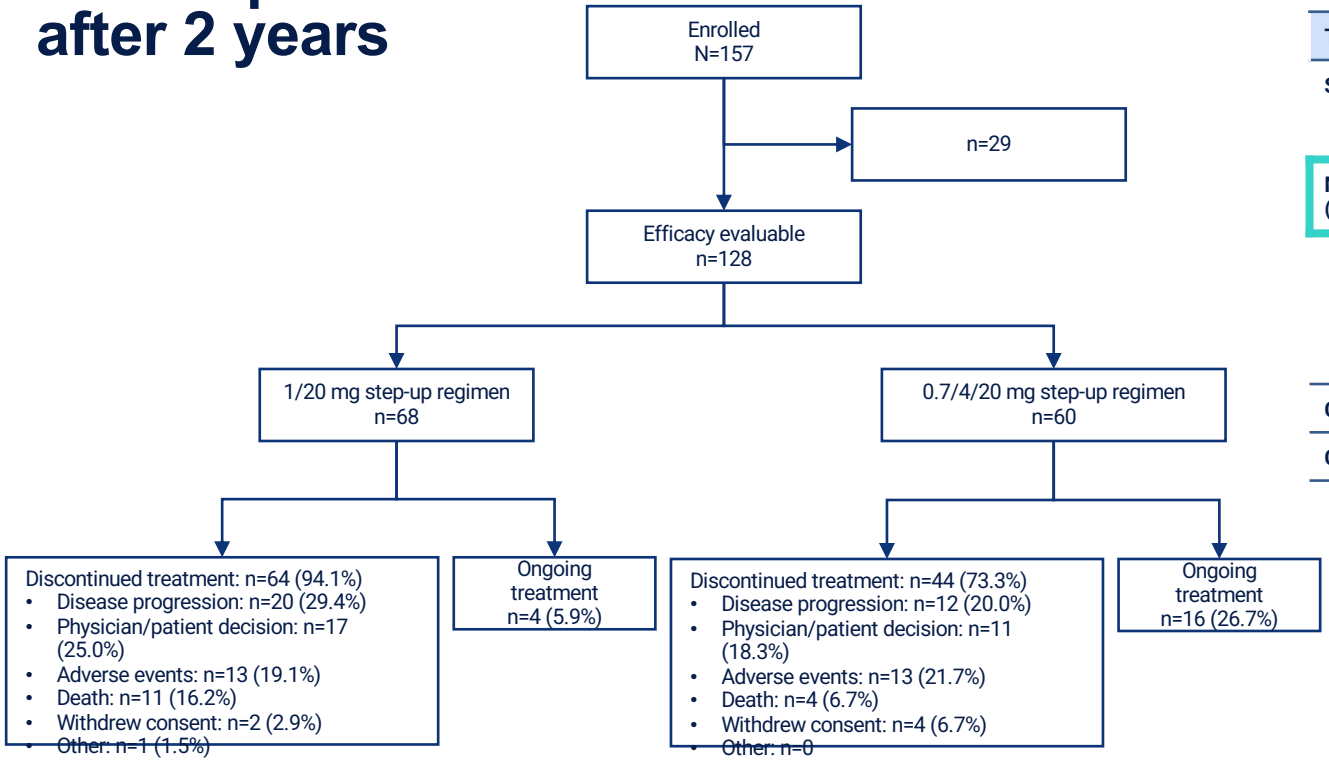
OS rate, % (95% CI)	All patients (N=128)	CR (n=95)	PR (n=8)
24 months	70.9 (61.7–78.3)	81.1 (71.3–87.8)	17.9 (0.8–53.8)
36 months	62.6 (52.1–71.5)	73.2 (61.0–82.1)	NE (NE–NE)

Median PFS in patients who were event-free* at:

- 1 year (n=74): 43.7 months (95% CI 27.8–NE)
- 2 years (n=44): 45.5 months (95% CI 38.0–NE)

Data cutoff date: August 15, 2024. Efficacy per ICR. *Events of either progressive disease or death.
CAR-T, chimeric antigen receptor T cell; CI, confidence interval; CR, complete response; ICR, independent central review; NE, not evaluable; OS, overall survival; PFS, progression-free survival; PR, partial response.

Patient disposition and treatment exposure: 16% of patients remained on treatment after 2 years



Treatment exposure	N=128
Step-up dosing regimen, n (%)	
1/20 mg	68 (53.1)
0.7/4/20 mg	60 (46.9)
Median duration of exposure (range), weeks	42.86 (0.4–238.6)
In patients who discontinued odronextamab treatment without progressive disease*	42.07 (0.4–200.0)
Completed ≥1 cycle, n (%)	122 (95.3)
Completed ≥4 cycles, n (%)	109 (85.2)

Data cutoff date: August 15, 2024.
*n=76.

Bsabs combos are highly active in RR FL

IV Mosunetuzumab + Lenalidomide in 2L+ FL: Study Design, Patients, Efficacy

NCT04246086

Eligibility
- CD20+ FL Grade 1-3a
- R/R to ≥1 prior CIT regimen including anti-CD20 antibody
- Prior len allowed
- ECOG PS 0-2

C1: 21-day cycle; C2-12: 28-day cycles

Mosunetuzumab IV
- C1 step-up dosing: D1: 1 mg, D8: 2 mg, D15: 30 mg
- C2-12 D1: 30 mg

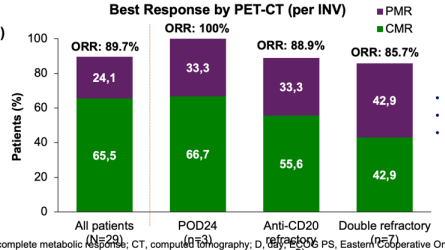
Lenalidomide PO 20 mg
- C2-12 D1-21 (11 total cycles)

Primary Objective
- Safety/tolerability of mosun-len

Other Objectives
- Efficacy (response, durability of response), PK

Select Baseline Characteristics (N=29)
- **Age, median (range):** 59 y (30–79)
- **FLIPI score 3-5:** 48.3%
- **Prior LOT, median (range):** 1 (1-6)
- **Double refractory:** 24.1%
- **POD24:** 10.3%

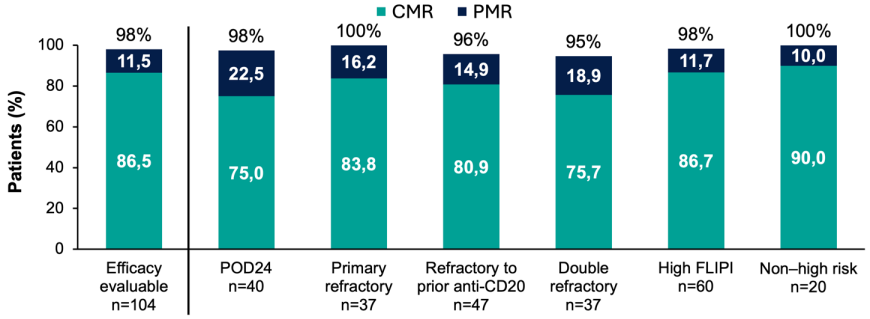
Median follow-up: 5.4 mo (range: 3–12)



- 86.2% had ongoing response
- All patients in CMR were still in CMR
- 2 patients experienced deepening of response (at approximately 5 months and 10.5 months)

2L, second-line; C, cycle; CIT, chemoimmunotherapy; CMR, complete metabolic response; CT, computed tomography; D, day; ECOG PS, Eastern Cooperative Oncology Group performance status; FL, follicular lymphoma; FLIPI, Follicular Lymphoma International Prognostic Index; INV, investigator assessed; IV, intravenous; Len, lenalidomide; LOT, line of therapy; Mosun, mosunetuzumab; ORR, overall response rate; PET: positron emission tomography; PK, pharmacokinetics; PMR, partial metabolic response; PO, oral; POD24, progression of disease within 24 months from the start of initial therapy; R/R, relapsed/refractory.
Morschhauser F, et al. ASH 2021. Abstract 129.

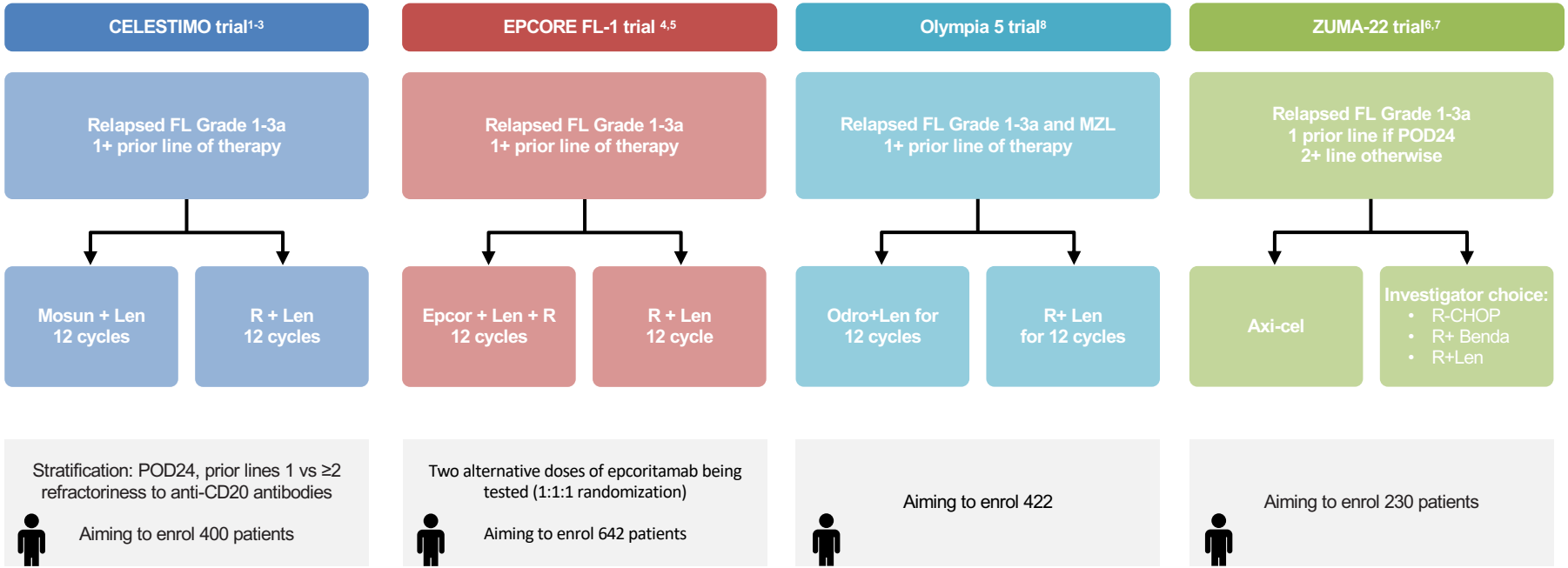
Epcoritamab + R^2 in R/R FL: Antitumor Activity in Subgroups



Overall response and CMR rates were consistently high across all subgroups

Median follow-up: 11.4 mo (range, 2.1–22.1).
Data cutoff: January 31, 2023. Definitions for all subgroups available in Study Design and Patient Disposition.
1. Merryman RW, et al. ASCO 2023. Oral 7506. 2. Sureda A, et al. EHA 2023. Oral S222. 3. Belada D, et al. ICML 2023. Oral 84.

Ongoing Phase III trials with BsAbs and CARTs in RR FL



axi-cel, axicabtagene ciloleucel; benda, bendamustine; CHOP, cyclophosphamide+hydroxydaunomycin+oncovin+prednison; epcor, epcoritamab; mosun, mosunetuzumab.

7. Flinn IW, et al. *J Clin Oncol*. 2025; 43(Suppl 16); TPS7590; 8. ClinicalTrials.gov: [illegible]. Accessed May 2025.

Primary Phase 3 Results From the EPCORE FL-1 Trial of Epcoritamab With Rituximab and Lenalidomide (R^2) Versus R^2 for Relapsed or Refractory Follicular Lymphoma

Lorenzo Falchi,[1*] Marcel Nijland,[2] Huiqiang Huang,[3] Kim M. Linton,[4] John F. Seymour,[5] Rong Tao,[6] Michal Kwiatek,[7] Abel Costa,[8] Theodoros P. Vassilakopoulos,[9] Richard Greil,[10] Ana Jiménez-Ubieto,[11] Shane Gangatharan,[12] Ohad Benjamini,[13] Catherine Thieblemont,[14] Alessandra Tucci,[15] Anna Elinder-Camburn,[16] Arpad Illes,[17] Jan Novak,[18] Miguel Pavlovsky,[19] Andrew McDonald,[20] Dok Hyun Yoon,[21] Yuko Mishima,[22] Gauri Sunkersett,[23] JP Mei,[23] Nabanita Mukherjee,[23] Feng Zhu,[23] Elena Favaro,[24] Franck Morschhauser[25]

*Presenting author

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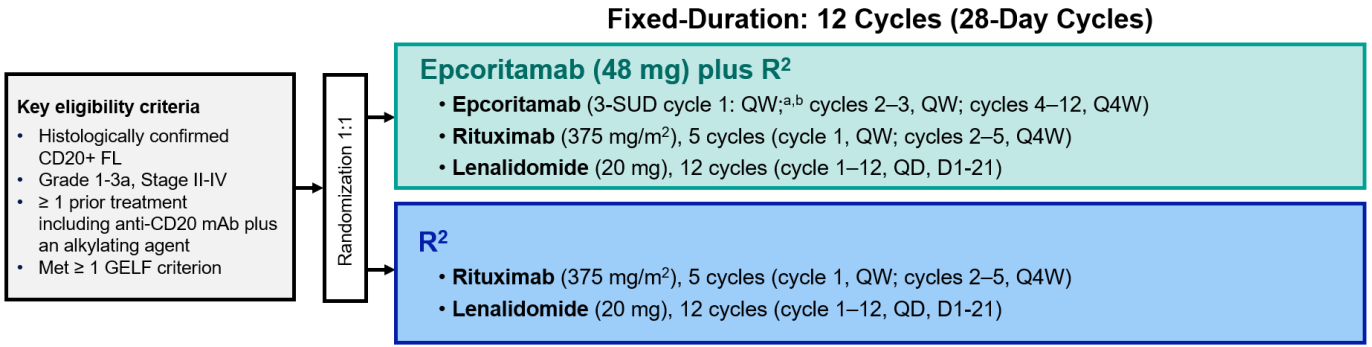
Presented at the American Society of Hematology; December 6–9, 2025; Orlando, FL, USA; DV-017521

EPCORE FL-1: Phase 3, Global, Randomized, Open-Label Study



Stratification factors

- Disease status:
  - 2L: > or ≤ 2 years since last therapy
  - 3L+: > or < 6 months since last therapy
- Region: US/EU vs Rest of World

- **Dual primary endpoints: ORR per IRC and PFS per IRC**
- Key secondary endpoints: CR rate per IRC, OS, and MRD[c]
- Additional secondary endpoints: DOR, DOCR, TTNLT, safety, and PRO assessments

Data cutoff: May 24, 2025; median follow-up: 14.8 months[d]
Enrollment period: October 2022 - January 2025

[a]Two step-up dosing (SUD) regimens during cycle 1 to mitigate the risk of cytokine release syndrome: either a 2-SUD (0.16 mg on cycle 1 day 1, 0.8 mg on cycle 1 day 8), or 3-SUD (0.16 mg on cycle 1 day 1, 0.8 mg on cycle 1 day 8, 3 mg on cycle 1 day 15) regimen, followed by full dose 48 mg. The 3-SUD regimen was implemented after reduced CRS severity and incidence had been observed in the EPCORE NHL-1 FL trial (NCT03625037).[1] [b]The 24 mg epcoritamab plus R² arm was closed to enrollment based on the superior efficacy for the 48 mg dose from EPCORE NHL-2.[2] Only the data for the optimal dose explored (48 mg) are presented here. [c]Minimal residual disease data are forthcoming in a future analysis. [d]The data presented here are from the second planned interim analysis (May 24, 2025) after 78% Information Fraction for PFS had occurred.

1. Vose J, et al. *J Clin Oncol.* 2024;42(16_suppl):7015–7015. 2. Falchi L, et al. *Blood.* 2024;144(Supplement 1):342–342.

Baseline Demographics and Disease Characteristics Were Generally Balanced

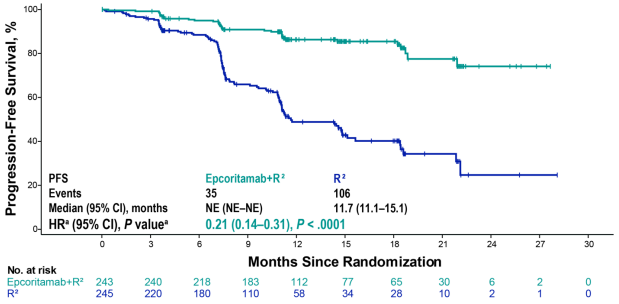
Characteristic	Epcoritamab+R² (N = 243)	R² (N = 245)	Overall (N = 488)
Median age, y (range)	60 (30, 84)	63 (24, 89)	61 (24, 89)
≥ 65, n (%)	88 (36)	106 (43)	194 (40)
Male, n (%)	139 (57)	138 (56)	277 (57)
Race, n (%)			
Asian	63 (26)	54 (22)	117 (24)
Black	6 (2)	2 (< 1)	8 (2)
White	168 (69)	184 (75)	352 (72)
Ethnicity, n (%)			
Hispanic	29 (12)	28 (11)	57 (12)
ECOG, n (%)			
0	166 (68)	170 (69)	336 (69)
1-2	77 (32)	75 (31)	152 (31)
Ann Arbor stage, n (%)			
II	37 (15)	44 (18)	81 (17)
III-IV	206 (85)	201 (82)	407 (83)
FLIPI score, n (%)			
0–1	63 (26)	56 (23)	119 (24)
2	79 (33)	76 (31)	155 (32)
3–5	100 (41)	113 (46)	213 (44)
Bulky disease (≥ 7 cm), n (%)	47 (19)	61 (25)	108 (22)

Treatment History Was Generally Balanced Across Epcoritamab+R² and R²

	Epcoritamab+R² (N = 243)	R² (N = 245)	Overall (N = 488)
Median time from initial diagnosis to randomization, years (range)	4.5 (0.2, 30.3)	5.3 (0.1, 43.0)	5.0 (0.1, 43.0)
Number of prior lines of therapy, median (range)	1 (1, 7)	1 (1, 6)	1 (1, 7)
1, n (%)	145 (60)	141 (58)	286 (59)
2, n (%)	58 (24)	61 (25)	119 (24)
≥ 3, n (%)	40 (16)	43 (18)	83 (17)
Prior anti-CD20 antibody, n (%)	243 (100)	245 (100)	488 (100)
Prior anti-CD20 antibody containing chemotherapy, n (%)	239 (98)	240 (98)	479 (98)
Prior bendamustine in last line, n (%)	53 (22)	47 (19)	100 (20)
Prior R², n (%)	8 (3)	9 (4)	17 (3)
POD24,[a] n (%)	106 (44)	93 (38)	199 (41)
Refractory to 1L therapy, n (%)	86 (35)	81 (33)	167 (34)
Refractory to anti-CD20 antibody, n (%)	104 (43)	103 (42)	207 (42)
Refractory to last line of therapy, n (%)	84 (35)	82 (33)	166 (34)
Double refractory[b]	91 (37)	91 (37)	182 (37)

[a]POD24 is defined as progression of disease ≤ 2 years from the date of initiation of frontline therapy. [b]Double refractory is refractory to prior anti-CD20 therapy and prior alkylator therapy.

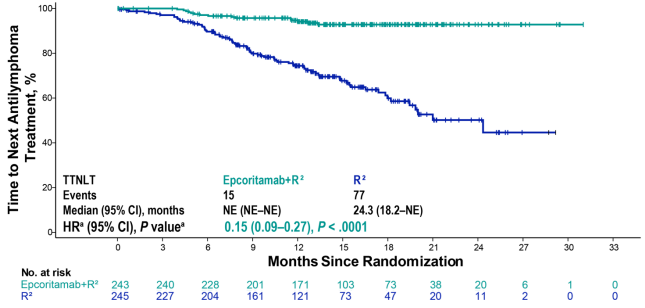
Epcoritamab+R² Resulted in Superior PFS per IRC With 79% Risk Reduction



- Concordance rate was 94% for PFS between IRC and investigator assessment
- The estimated 16-month PFS was 85.5% (95% CI: 79.7, 89.7) for epcoritamab+R² and 40.2% (95% CI: 31.8, 48.4) for R²

Median follow-up for PFS: epcoritamab+R² (14.4m), R² (11.5m). The first planned interim analysis (January 10, 2025) achieved statistical significance on PFS, HR 0.21 (95% CI 0.13, 0.33) $P < 0.0001$, with a 1-sided significance level of 0.0023.
[a]Nominal *P* value is based on stratified log-rank test. Hazard ratio is estimated using stratified Cox proportional hazards model. This analysis was performed on the 78% information fraction.

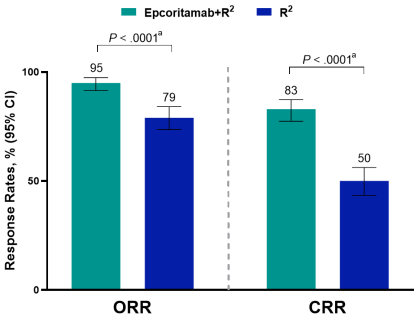
Epcoritamab+R² Extended Time to Next Treatment



- At 16 months, 92.8% of patients treated with epcoritamab+R² remained free from new antilymphoma treatment compared with 64.9% of patients treated with R²

Median follow-up for TTNLT: epcoritamab+R² (14.8m), R² (14.1m). TTNLT results are for descriptive purposes only.
[a]Nominal *P* value is based on stratified log-rank test. Hazard ratio is estimated using stratified Cox proportional hazards model.

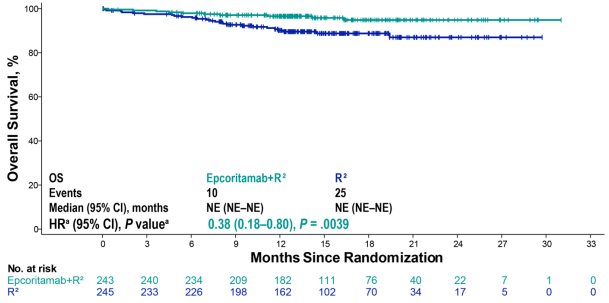
Epcoritamab+R² Resulted in Higher Response Rates Versus R²



	Epcoritamab+R² (N = 243)	R² (N = 245)
ORR, n (%)	231 (95)	194 (79)
CRR, n (%)	201 (83)	122 (50)
PR, n (%)	30 (12)	72 (29)
SD, n (%)	1 (< 1)	17 (7)
PD, n (%)	7 (3)	16 (7)
NE,[b] n (%)	4 (2)	18 (7)

The first planned interim analysis (January 10, 2025) achieved statistical significance for ORR (N = 232; 95.7% vs 81.0%; $P < 0.0001$, with a 1-sided significance level of 0.005) and CR (74.5% vs 43.3%; $P < 0.0001$, with a 1-sided significance level of 0.025).
[a]Nominal *P* value by stratified Cochran-Mantel-Haenszel method. [b]Patients with no post-baseline disease assessment were also included.

Positive Trend for Overall Survival With Epcoritamab+R²



- The 16-month estimate for OS was 95.8% with epcoritamab+R² and 88.8% with R²

Median follow-up for OS: epcoritamab+R² (14.8m), R² (14.6m). The OS data is based on the 24% (35/146 events) information fraction and has not yet reached statistical significance; additional analyses are forthcoming.
[a]*P* value is based on stratified log-rank test with 1-sided significance level of 0.000005. Hazard ratio is estimated using stratified Cox proportional hazards model.

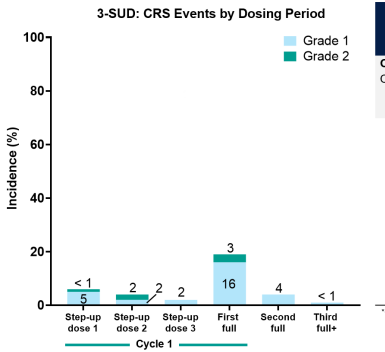
Manageable AEs With No New Safety Signals

Adverse Event, n (%)	Epcoritamab+R² (N = 243)		R² (N = 238)	
	Any Grade	Grade ≥ 3	Any Grade	Grade ≥ 3
Any adverse event	242 (100)	219 (90)	235 (99)	161 (68)
Serious adverse event	135 (56)	-	69 (29)	-
Adverse event leading to treatment discontinuation	46 (19)	-	29 (12)	-
Epcoritamab	21 (9)	-	-	-
Rituximab	7 (3)	-	12 (5)	-
Lenalidomide	45 (19)	-	29 (12)	-
Adverse event of clinical interest > 20%[a,b]				
Infections[c]	188 (77)	81 (33)	125 (53)	37 (16)
Neutropenia	180 (74)	167 (69)	123 (52)	100 (42)
Cytokine release syndrome	85 (35)	-	1 (< 1)	-
Anemia	68 (28)	19 (8)	41 (17)	11 (5)
Thrombocytopenia	67 (28)	23 (9)	44 (18)	15 (6)
Pyrexia	58 (24)	1 (< 1)	33 (14)	3 (1)
Rash	58 (24)	19 (8)	53 (22)	9 (4)
COVID-19	54 (22)	7 (3)	32 (13)	4 (2)

- Neutropenia was manageable and few patients discontinued any study drug (epcoritamab+R², 3%; R², 2%)
  - Incidence of febrile neutropenia: epcoritamab+R², 6%; R², 3%
- Infections were manageable and few patients discontinued any study drug (epcoritamab+R², 6%; R², 1%)
- Fatal adverse events were rare (epcoritamab+R², 2%; R², 4%)
- Despite higher rates of AEs in the epcoritamab+R² arm, most patients completed the prescribed regimen (median relative dose intensity ≥ 90% for epcoritamab+R²)

[a]Neutropenia, anemia, pyrexia, rash and COVID-19 are grouped terms comprising multiple clinically related Preferred Terms. [b]This includes the AESI of CRS. [c]Events were in the MedDRA system organ class "Infections and Infestations." No grade 5 infections were reported.

CRS Was Low Grade and Predictable With Epcoritamab+R²



	Epcoritamab+R² 2-SUD N = 110	Epcoritamab+R² 3-SUD[a] N = 133
CRS, n (%)	50 (45)	35 (26)
CRS grade, n (%)		
1	40 (36)	28 (21)
2	10 (9)	7 (5)
CRS signs and symptoms, n (%)*		
Fever	49 (98)	33 (94)
Hypotension	9 (18)	6 (17)
Hypoxia	1 (2)	2 (6)
Time to first CRS onset from first full dose, days, median (range)	1 (< 1, 6)	1.5 (< 1, 10)
Time to CRS resolution, days, median (range)	1 (< 1, 12)	1 (< 1, 26)
CRS interventions, n (%)*		
Treated with tocilizumab	12 (24)	9 (26)
Treated with corticosteroid	23 (46)	13 (37)

*Of patients who had CRS

- Hydration and dexamethasone were utilized for CRS prophylaxis
- One event of ICANS was observed and was grade 1
- No discontinuations due to CRS and ICANS. All events resolved.
- No events of CTLS were reported

[a]The 3-SUD regimen was implemented based off the EPCORE NHL-1 FL trial (NCT03825037).[1]
[1]Vose J, et al. *J Clin Oncol* 2024; 42 (suppl 16): 7015.

CELESTIMO (GO42909): Study design

Randomised, open-label, multicentre Phase III study of mosunezutumab (IV) and lenalidomide compared with rituximab and lenalidomide in patients with R/R FL

Eligibility

- Age ≥18 years
- Grade 1–3a CD20+ FL
- ECOG PS 0–2
- ≥1 prior systemic anti-lymphoma therapy
- Target enrolment (Randomised cohort): 400

Stratification factors

- POD 24 status
- Prior lines of therapy (1 vs ≥2)
- Refractoriness to anti-CD20 therapy

Randomised 1:1*

Arm A

Mosunetuzumab + lenalidomide

- Mosunetuzumab IV on C1 [D1 (1 mg), D8 (2 mg), D15 (30 mg)] q3w and C2–12 D1 (30 mg) q4w
- Lenalidomide on C2–12 D1-21 (20 mg)

Arm B

Rituximab + lenalidomide

- Rituximab IV on C1 D1/D8/D15/22 and C3, 5, 7, 9. 11 D1 (375 mg/m²) q4w
- Lenalidomide on C1–12 D1-21 (20 mg)

Arm C

Mosunetuzumab + lenalidomide
(US extension cohort, n=54 pts)

1º endpoint

PFS (IRC-assessed) in ITT

Efficacy follow-up: 5 years from time of randomisation

Secondary and other endpoints†

- PFS (INV-assessed) in ITT, CR rate (by PET-CT), ORR, OS, DOR, DOCR, time to deterioration in physical functioning and fatigue by EORTC QLQC30, safety, PK, immunogenicity, biomarker

IRC, Independent Review Committee.

https://clinicaltrials.gov/study/NCT04712097#study-plan
Nastoupil L, et al. EHA 2022; Poster presentation (#P1125)

Baseline characteristics

n (%), unless otherwise stated		2L+ FL US cohort (n=54)
Age, years	Median (range)	62.0 (37–82)
Sex	Male	32 (59.3)
Race	Asia Black or African American White Multiple* Unknown	3 (5.6) 2 (3.7) 47 (87.0) 1 (1.9) 1 (1.9)
Ethnicity	Hispanic or Latino Not Hispanic or Latino	12 (22.2) 42 (77.8)
ECOG PS	0 1 2	40 (74.1) 13 (24.1) 1 (1.9)
Ann Arbor stage	I/II III/IV	9 (16.7) 45 (83.3)

n (%)		2L+ FL US cohort (n=54)
FLIPI score		n=52†
	0/1	13 (25.0)
	2	18 (34.6)
	3	17 (32.7)
	4	3 (5.8)
	5	1 (1.9)
FL grade		n=47†
	1/2	28 (59.6)
	3a	19 (40.4)
POD24	Yes	16 (29.6)
Number of prior lines of therapy	1	30 (55.6)
	≥2	24 (44.4)
Refractory to prior CD20 therapy		n=48†
	Yes	19 (39.6)
Relapsed after prior CD20 therapy		n=48†
	Yes	17 (35.4)
Double refractory		n=53†
	Yes	9 (17.0)

Data cut-off: June 9, 2025. *American Indian or Alaska Native, White. †Missing or partial data.
2L+, at least one prior therapy; FLIPI, Follicular Lymphoma International Prognostic Index; POD24, progressive disease within 24 months of first systemic therapy.

Sano D, et al. ASH 2025; Poster presentation (abstract #1800).

Mosun-Len achieved high response rates in patients with R/R FL

n (%)	2L+ FL US cohort (n=54)
ORR	52 (96.3)
CR	47 (87.0)
PR	5 (9.3)
Stable disease	0
Progressive disease	2 (3.7)

The **median duration of follow-up** was **12.7 months** (range: 5–20)

Data cut-off: June 9, 2025.
PR, partial response.

Sano D, et al. ASH 2025; Poster presentation (abstract #1800).

Mosun-Len had manageable safety

n (%)	2L+ FL US cohort (n=54)
Any grade AE	54 (100)
Mosunetuzumab related	48 (88.9)
Lenalidomide related	50 (92.6)
AE leading to discontinuation of mosunetuzumab	6 (11.1)
AE leading to discontinuation of lenalidomide	10 (18.5)
Grade 3/4 AE	31 (57.4)
Grade 5*	1 (1.9)
Serious AE	15 (27.8)
Mosunetuzumab related	9 (16.7)
Lenalidomide related	4 (7.4)

n (%)	2L+ FL US cohort (n=54)
CRS by ASTCT grading	15 (27.8)
Grade 1	12 (22.2)
Grade 2	2 (3.7)
Grade 3	1 (1.9)
Infections†	31 (57.4)
Grade 1	2 (3.7)
Grade 2	24 (44.4)
Grade 3	3 (5.6)
Grade 4	1 (1.9)
Grade 5	1 (1.9)
Neutropenia/neutrophil count decreased	22 (40.7)
Grade 3/4	18 (33.3)
Febrile neutropenia (Grade 3)	2 (3.7)

CRS events were mainly low grade and all resolved

- Median duration of CRS: 4.0 days (range: 1.0–23.0)
- Median time to onset of first CRS event: 2.0 days (range: 1.0–27.0)

The most common AEs (any grade, by preferred term) were fatigue (57.4%), maculo-papular rash (42.6%), and constipation (42.6%)

Data cut-off: June 9, 2025. *Pneumonia, considered to be mosunetuzumab related. †The most common infections were: COVID-19, 20.4%; sinusitis, 18.5%; and upper respiratory tract infection, 16.7%; which were mainly Grade 2 (44.4%) in severity.

Sano D, et al. ASH 2025; Poster presentation (abstract #1800).

To discuss….

- Risk benefit ratio assessment is the key today…
  - Favor efficacy…then CART
  - Favor safety an manageability…then BsAbs
- And Tomorrow
  - 2nd line will be completely reshaped
    - BsaBs combo
    - TafaR2
  - 3rd line +
    - CART if pt is eligible
    - Other pts…obi-zanu, ADC, new agents ?