The GOG Highlight Reel January 2026

A GOG Foundation, Inc. Educational Program

Date: Friday, January 23, 2026
Time: 6:30 pm – 9:00 pm PT
Location: Parc 55 San Francisco, San Francisco, California

GOG Highlight Reel

PROGRAM EMCEES

Thomas Herzog, MD

University of Cincinnati
Cincinnati, Ohio

Bradley Monk, MD

Florida Cancer Specialists &
Research Institute
West Palm Beach, Florida

GOG Highlight Reel

OUR MISSION

The mission of the GOG Foundation is to transform patient-centered gynecologic cancer care through innovation, research and education.

OUR VISION

The vision of the GOG Foundation is to be the premier collaborative network for transformative research in gynecologic malignancies.

GOG HIGHLIGHT REEL PRE-TEST

SCAN ME

GOG Highlight Reel

FACULTY

Robert Coleman, MD
Texas Oncology
Austin, Texas

Ramez Eskander, MD
University of California
San Diego Moores
Cancer Center
San Diego, California

Kathleen Moore, MD
University of Oklahoma
Stephenson Cancer Center
Oklahoma City, Oklahoma

David O'Malley, MD
The Ohio State University
James Cancer Center
Columbus, Ohio

Bhavana Pothuri, MD, MS
NYU Langone
New York City, New York

Leslie Randall, MD
Inova Schar Cancer Institute
Inova Health
Fairfax, Virginia

Brian Slomovitz, MD
Mount Sinai
Medical Center
Miami Beach, Florida

INVITED GUEST SPEAKERS

Rachel Grisham, MD

Memorial Sloan Kettering
Cancer Center
New York, New York

Emese Zsiros, MD, PhD

Roswell Park Comprehensive
Cancer Center
Buffalo, New York

AGENDA

6:30 PM – 6:35 PM **WELCOME & INTRODUCTIONS**
Dr. Thomas Herzog, Dr. Bradley Monk

6:35 PM – 7:35 PM **PART 1: OVARIAN CANCER: NEW THERAPEUTIC OPPORTUNITIES & NOVEL DRUGS UNDER INVESTIGATION**
Dr. Ramez N. Eskander, Dr. David O'Malley, Dr. Rachel Grisham, Dr. Emese Zsiros

- Weekly paclitaxel combinations, understanding potential clinical implications
- Navigating the wave of ADCs in Ovarian Cancer
- Understanding sequencing and management of clinical trials in your practice
- Non-ADCs
- Low Grade Serous Ovarian Cancer

7:35 PM – 8:15 PM **PART 2: THE EVOLVING ENDOMETRIAL CANCER TREATMENT LANDSCAPE: APPROVALS, EVIDENCE, AND IMPACT**
Dr. Brian Slomovitz, Dr. Kathleen Moore

- Relevance of biomarkers in the management of 1L advanced stage/recurrent endometrial cancer.
- "ADC Mania?" Navigating the wave of ADCs in Endometrial Cancer
- Panel Discussion and Q&A

8:15 PM – 8:35 PM **PART 3: CERVICAL CANCER CARE: NEW REGIMENS AND INNOVATIVE TREATMENT APPROACHES**
Dr. Leslie Randall, Dr. Bhavana Pothuri

- LACC
- Recurrent First line
- Evolving the CxCa treatment landscape, the role of ADCs
- IO combinations

8:35 PM – 8:55 PM **PART 4: PANEL DISCUSSION AND AUDIENCE Q&A**
All Faculty

8:55 PM – 9:00 PM **PART 5: FINAL COMMENTS, FUTURE PERSPECTIVES**
Dr. Thomas Herzog

LEARNING OBJECTIVES

Upon completion of the activities in this series, learners will demonstrate:

THE OVERALL OBJECTIVE FOR THIS SESSION IS TO SHOWCASE CLINICAL TRIALS AND OTHER NEWSWORTHY EDUCATION FROM MAJOR MEDICAL MEETINGS THROUGHOUT THE YEAR

Increased knowledge regarding:

- The current agents and regimens used in treating advanced, persistent, or recurrent cervical, endometrial, and ovarian cancers
- The key trial data for newly approved therapies in treating advanced, persistent, or recurrent cervical, endometrial, and ovarian cancers
- The current investigational agents and regimens under evaluation for the treatment of advanced, persistent, or recurrent cervical, endometrial, and ovarian cancers

Greater competence related to:

- Understanding the available therapies and selecting treatments for women with cervical, endometrial, and ovarian cancers
- Interpret and understand the application of recent data into clinical practice
- Learn about current clinical trials in gynecologic cancers and understand what opportunities exist in the public domain

GOG FACULTY DISCLOSURE INFORMATION

The GOG Highlight Reel:
An Education Series Highlighting Newsworthy Data Distillation and Emerging Global Therapies in Clinical Trials
Friday, January 23, 2026 | San Francisco, California

In accordance with the ACCME Accreditation Criteria, The GOG Foundation, Inc., as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any ineligible company *(formally known as commercial interests). All **Committee/Planning/Faculty members** were required to disclose all financial relationships and speakers were required to disclose any financial **relationship as it pertains to the content of the presentations.**

The ACCME does not consider providers of clinical service directly to patients to be an ineligible company. “Relevant” financial relationships are financial transactions (in any amount) occurring within the past 24 months that may create a conflict of interest.

Please note the presentations may include information and discussions on the use of a device, product, or drug that is not FDA approved or the off-label use of an approved device, product, or drug or unapproved usage. The requirement for disclosure is not intended to imply any impropriety of such relationships, but simply to identify such relationships through full disclosure, and to allow the audience to form its own judgments regarding the presentation.

All of the relevant financial relationships listed for these individuals have been mitigated. However, if you perceive a bias during a session, please report the circumstances on the session evaluation form.

NEW TERM *An “**ineligible company**” is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

GOG FACULTY DISCLOSURE INFORMATION

Name	Individual's Role(s) in Activity	Nothing To Disclose	Name of Ineligible Company(s)	Nature of Relevant Financial Relationship(s)
Planning Disclosures				
Herzog, Thomas, MD	**Planner/ Moderator**		Astra Zeneca; Caris; Clovis; Eisai; Epsilogen; Genentech; GSK; J&J; Merck; Mersana; Novocure; Seattle Genetics	Scientific Advisory Boards
Monk, Bradley, MD	**Planner/ Moderator**		Acrivon Adaptimmune ; Agenus; Akeso Bio; Amgen; AstraZeneca; Biohaven; BMS; Corcept; Easai; Eli Lilly; Genmab; Seagen; Pfizer; Genalux; GOG Foundation; Gradalis; GSK; HengRui; Immunogen; Abbvie; Karyopharm; Iovance; Merck; Mersana; Mural; Alkermes; Myriad; Novartis; Novocure; OncoC4; Panavance; Profound Bio; Regeneron; Roche; Genentech; Sutro; Verastem; Zentalis; Zymeworks	Consultant (Acrivon Adaptimmune ; Agenus; Akeso Bio; Amgen; AstraZeneca; Biohaven; BMS; Corcept; Easai; Eli Lilly; Genmab; Seagen; Pfizer; Genalux; GOG Foundation; Gradalis; GSK; HengRui; Immunogen; Abbvie; Karyopharm; Iovance; Merck; Mersana; Mural; Alkermes; Myriad; Novartis; Novocure; OncoC4; Panavance; Profound Bio; Regeneron; Roche; Genentech; Sutro; Verastem; Zentalis; Zymeworks) Speaker (AstraZeneca; Easai; GSK; Immunogen; Abbvie; Merck)
Speaker Disclosures				
Coleman, Robert, MD	**Speaker**		Mural; AstraZeneca; Pharma&; Eisai; Genentech USA Inc; GSK; Gradalis; Mersana; Novocure; Abbvie; Immunogen, Abbvie; Merck; Novrtis; Valero/Valbio; Seagen/Genmab/Pfizer; VBL; Eisai; GOG-Partners; Karyopharm	Consultant (Mural; AstraZeneca; Pharma&; Eisai; Genentech USA Inc; GSK; Gradalis; Mersana; Novocure; Seagen/Genmab/Pfizer) Grant Contract (Genentech USA Inc; Abbvie; Immunogen, Abbvie; Merck; Novrtis; Valero/Valbio; Seagen/Genmab/Pfizer; Karyopharm)
Eskander, Ramez, MD	**Speaker**		AstraZeneca, MSD, Regeneron, PMV Pharmaceuticals, Daiichi Sanyo, GSK, Myriad, Seagen, Abbvie, Pfizer, Novocure, BioNTech, Eisai, Roche, Mersana; Nuvectis Pharma, Merck, Loxo @ Lilly, Genmab/Seagen, Clovis Oncology, Acrivon therapeutics, Zentalis, Eisai, Gilead, Roche	Consultant (AstraZeneca, MSD, Regeneron, PMV Pharmaceuticals, Daiichi Sankyo, GSK, Myriad, Seagen, Abbvie, Pfizer, Novocure, BioNTech, Eisai, Roche, Mersana) Research Funding (Nuvectis Pharma, GSK, Merck, Daiichi Sankyo, Loxo @ Lilly, AstraZeneca, Genmab/Seagen, Clovis Oncology, Acrivon Therapeutics, Zentalis, Eisai, Gilead, Roche)
Moore, Kathleen, MD	**Speaker**		Research To Practice; Great Debates and Updates; Astellas Medivation; Clearity Foundation; IDEOlogy Health; Medscape; OncLive/MJH Life Sciences; MD Outlook; Curio Science; Plexus; University of Florida; University of Arkansas for Medical Sciences; Congress Channel; BIOPHARM; CEA/CCO; Physician Education Resource (PER); Med Learning Group; Peerview; PeerVoice; CME Outfitters; virtual incision; GOG Partners; NRG Ovarian Committee; Immunogen; AstraZeneca; Merck; Eisai; Verastem/Pharmacyclics; AADi; Caris Life Sciences; Iovance Biotherapeutics; Janssen Oncology; Regeneron; zentalis; Daiichi Sankyo Europe GmbH; BioNTech SE; immunocore; seagen; Takeda Science Foundation; zymeworks; profound bio; ADC Therapeutics; Corcept Therapeutics; Third Arc; Loxo/Lilly; Bristol Meyers Sqibb Foundation; Tango Therapeutics; Abbvie; T knife; F Hoffman LaRoche; Tubulis GnbH; Clovis Oncology; Kivu; Genmab/Seagen; Whitehawk; OnCusp Therapeutics; Natera; BeiGene; Karyopharm Therapeutics; Day One Biopharmaceuticals; Debiopharm Group; Foundation Medicine; Novocure; Mersana; GSK/Tesaro; Duality Biologics; Schrodinger; Regeneron; Verastem; Daiichi Sankyo/Lilly; Torl Biotherapeutics; Allerity Therapeutics; IDEAYA Biosciences; Zymeworks; International Gynecologic Cancer Society	Honoraria (Research To Practice; Great Debates and Updates; Astellas Medivation; Clearity Foundation; IDEOlogy Health; Medscape; OncLive/MJH Life Sciences; MD Outlook; Curio Science; Plexus; University of Florida; University of Arkansas for Medical Sciences; Congress Channel; BIOPHARM; CEA/CCO; Physician Education Resource (PER); Med Learning Group; Peerview; PeerVoice; CME Outfitters; virtual incision) Leadership (GOG Partners; NRG Ovarian Committee Chair) Consulting or Advisory Role (Genentech/Roche; Immunogen; AstraZeneca; Merck; Eisai; Verastem/Pharmacyclics; AADi; Caris Life Sciences; Iovance Biotherapeutics; Janssen Oncology; Regeneron; zentalis; Daiichi Sankyo Europe GmbH; BioNTech SE; immunocore; seagen; Takeda Science Foundation; zymeworks; profound bio; ADC Therapeutics; Corcept Therapeutics; Third Arc; Loxo/Lilly; Bristol Meyers Sqibb Foundation; Tango Therapeutics; Abbvie; T knife; F Hoffman LaRoche; Tubulis GnbH; Clovis Oncology; Kivu; Genmab/Seagen; Whitehawk; OnCusp Therapeutics; Natera; BeiGene; Karyopharm Therapeutics; Day One Biopharmaceuticals; Debiopharm Group; Foundation Medicine; Novocure; Mersana; GSK/Tesaro; Duality Biologics; Schrodinger) Research Funding to Institution (Merck; Regeneron; Verastem; AstraZeneca; Immunogen; Daiichi Sankyo/Lilly; Immunocore; Torl Biotherapeutics; Allerity Therapeutics; IDEAYA Biosciences; Zymeworks; Schrodinger) Uncomp Relationships (International Gynecologic Cancer Society) Other Relationship (GOG Partners)

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Speaker Disclosures				
O'Malley, David, MD	**Speaker**		AbbVie; AdaptImmune; Advaxis; Agenus,Inc; Alkermes; Aravive, Inc.; Arcus Biosciences, Inc.; Arquer Diagnostics; AstraZeneca; Atossa Therapeutics; BeiGene USA,Inc.; Boston Biomedical; Bristol Myers Squibb; Cardiff Oncology; Celcuity; Clovis Oncology; Corcept Therapeutics; Deciphera Pharma; Duality Bio; Eisai; Elevar; EMD Serono, Inc.; Exelixis; Genentech Inc; Genmab; Genelux; GlaxoSmithKline; GOG Foundation; Hoffmann-La Roche Inc; ImmunoGen, Inc; Imvax; InterVenn; INXMED; Incyte Corporation; IOVANCE Biotherapeutics; Jazz Pharmaceuticals; Karyopharm; Laekna; Leap Therapeutics, Inc.; Ludwig Institute for Ca; Luzsana Biotechology; Merck & Co; Merck Sharp & Dohme Corp.; Mersana Therapeutics,Inc.; Myriad; NCI; Novartis; NovoCure; NRG Oncology; OncoC4, Inc.; OncoQuest Inc.; Onconova; Pfizer Inc; Precision Therapeutics, Inc.; Prelude Therapeutics; Regeneron Pharmaceuticals, Inc; RTOG; Rubius Therapeutics; RepImmune; R Pharm; Roche Diagnostics; Seattle Genetics (SeaGen); Sorrento; Sutro Biopharma; SWOG; ; Tarveda Therapeutics; Toray; Trillium; Umoja; Verastem, Inc; VBL Therapeutics; Vincerx Pharma; Xencor; Zentalis	Institution Received Funds for research (AbbVie; Advaxis; Agenus,Inc; Alkermes; Aravive, Inc.; Arcus Biosciences, Inc.; AstraZeneca; BeiGene USA,Inc.; Boston; Biomedical; Bristol Myers Squibb; Clovis Oncology; Deciphera Pharma; Eisai; EMD Serono, Inc.; Exelixis; Genentech Inc; Genmab; GlaxoSmithKline; GOG Foundation; Hoffmann-La Roche Inc; ImmunoGen, Inc; Incyte Corporation; IOVANCE Biotherapeutics; Karyopharm; Leap Therapeutics, Inc.; Ludwig Institute for Ca; Merck & Co; Merck Sharp & Dohme Corp.; Mersana Therapeutics,Inc.; NCI; Novartis; NovoCure; NRG Oncology; OncoC4, Inc.; OncoQuest Inc.; Pfizer Inc; Precision Therapeutics, Inc.; Prelude Therapeutics; Regeneron Pharmaceuticals, Inc; RTOG; Rubius Therapeutics; Seattle Genetics (SeaGen); Sutro Biopharma; SWOG; Verastem, Inc) Ad Board/Consultant (AbbVie; AdaptImmune; Agenus,Inc; Arquer Diagnostics; Arcus Biosciences, Inc.; AstraZeneca; Atossa Therapeutics; Boston Biomedical; Cardiff Oncology; Celcuity; Clovis Oncology; Corcept Therapeutics; Duality Bio; Eisai; Elevar; Exelixis; Genentech Inc; Genelux; GlaxoSmithKline; GOG Foundation; Hoffmann-La Roche Inc; ImmunoGen, Inc; Imvax; InterVenn; INXMED; Jazz Pharmaceuticals; Laekna; Leap Therapeutics, Inc.; Luzsana Biotechology; Merck & Co; Merck Sharp & Dohme Corp.; Mersana Therapeutics,Inc.; Myriad; Novartis; NovoCure; OncoC4, Inc.; Onconova; Regeneron Pharmaceuticals, Inc; RepImmune; R Pharm; Roche Diagnostics; Seattle Genetics (SeaGen); Sorrento; Sutro Biopharma; Tarveda Therapeutics; Toray; Trillium; Umoja; Verastem, Inc; VBL Therapeutics; Vincerx Pharma; Xencor; Zentalis
Pothuri, Bhavana, MD, MS	**Speaker**		AstraZeneca; celsion/Immunon; Clovis Oncology, Inc.; Genentec; Eisai; GlaxoSmithKline; GOG foundation; Imab; Immunogen; Incyte Corporation; Karyopharm Therapeutics; Merck; Mersana; Seagen Inc.; Sutro; Toray Industries	Consultant (AstraZeneca; Eisai; GlaxoSmithKline; GOG foundation; Merck; Mersana; Seagen Inc.; Sutro) Grant/Contract (AstraZeneca; celsion/Immunon; Clovis Oncology, Inc.; Genentec; GlaxoSmithKline; Imab; Immunogen; Incyte Corporation; Karyopharm Therapeutics; Merck; Mersana; Seagen Inc.; Sutro; Toray Industries)
Randall, Leslie, MD	**Speaker**		AstraZeneca; Genmab; Pfizer; GSK; Eisai; Merck; AbbVie; GOG Foundation; GOG Foundation	Consultant (AstraZeneca; Genmab; Pfizer; GSK, Eisai; Merck; Abbvie; GOG Foundation) Research Funding (Merck; AbbVie; GOG Foundation)
Slomovitz, Brian, MD	**Speaker**		Seagen, Novocure; AstraZeneca; Aadi; Regeneron; Immunocore; Merck; Gilead, Eisai; Incyte	Consultant
Rachel Grisham, MD	**Speaker**		AstraZeneca; GSK; Incyte; GenMab; Verastem; SpringWorks; Myriad	Consultant
Emese Zsiros, MD, PhD			Merck and Co; Takeda Oncology; Abbvie; 92Biotech; Iovance; Apellis	Advisor (Merck and Co; Takeda Oncology; Abbvie; 92Biotech; Iovance; Apellis) Clinical Trial Support (Merck and Co)
Holley Engbert	**Staff**	**X**		
Heather Rush	**Staff**	**X**		
Kara Shumaker	**Reviewer/Staff**	**X**		
Michelle N Small, MPH	**Reviewer/Staff**	**X**		
Angeles Alvarez-Secord, MD	**Reviewer/Edu-Chair**		AbbVie; Aravive; AstraZeneca; Daiichi Sankyo; Ellipses Pharma; Genmab; GSK; Immunogen; Karyopharm; Merck; Mersana; Myriad; Oncoquest/Canaria Bio; Oncoquest; Roche/Genentech; TORL Biotherapeutics; Zentalis; Foundation Medicine; Gilead; Histosonics; Medtronic; Porject Nana; Up to Date; SGO; FWC; GOG Foundation; Amgen; Johnson & Johnson	Research funds to Institution (AbbVie; Aravive; AstraZeneca; Daiichi Sankyo; Ellipses Pharma; Genmab; GSK; Immunogen; Karyopharm; Merck; Mersana; Myriad; Oncoquest/Canaria Bio; Oncoquest; Roche/Genentech; TORL Biotherapeutics; Zentalis) Honorarium (Merck; GSK) Advisory Board with Honoraria (AbbVie; AstraZeneca; Daiichi Sankyo; Foundation Medicine; GSK; Genmab; Gilead; Histosonics; Medtronic; Merck) Medical Advisory Board (Porject Nana) Steering Committee Uncomp. (Oncoquest; Genmab) Royalties (Up to Date) Board of Directors (SGO; FWC; GOG Foundation) Stock-Divested in June 2024 (Amgen; Johnson & Johnson)
Linda Duska, MD	**Reviewer/Edu-Co-Chair**		Merck; Corcept	Honoraria (Merck) Speakers Bureau (Corcept) Research Funding (Merck)
Stephanie Blank, MD	**Reviewer**		AstraZeneca; Merck; Zentalis; Acrivon; Seattle Genetics; GSK	Research Funding to Institution
David Mutch, MD	**Reviewer**	**X**	Nothing to disclose	
Susan Zweizig, MD	**Reviewer**	**X**	Nothing to disclose	

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Please note that some of the presentations and discussions may include off-label use of products/devices.

All presentations will discuss details that are in the public domain.

GOG CONTINUING EDUCATION

In support of improving patient care, this activity has been planned and implemented by The GOG Foundation, Inc. (GOG).

Accreditation Statement
The GOG Foundation, Inc. is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide Continuing Medical Education for physicians.

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Participants who complete the educational activity, pre- and post-test, and evaluation will receive a certificate of credit.

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THANK YOU

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AGENDA

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6:35 PM – 7:35 PM	**PART 1: OVARIAN CANCER: NEW THERAPEUTIC OPPORTUNITIES & NOVEL DRUGS UNDER INVESTIGATION** Dr. Ramez N. Eskander, Dr. David O'Malley, Dr. Rachel Grisham, Dr. Emese Zsiros
7:35 PM – 8:15 PM	**PART 2: THE EVOLVING ENDOMETRIAL CANCER TREATMENT LANDSCAPE: APPROVALS, EVIDENCE, AND IMPACT** Dr. Brian Slomovitz, Dr. Kathleen Moore
8:15 PM –8:35 PM	**PART 3: CERVICAL CANCER CARE: NEW REGIMENS AND INNOVATIVE TREATMENT APPROACHES** Dr. Leslie Randall, Dr. Bhavana Pothuri
8:35 PM – 8:55 PM	**PART 4: PANEL DISCUSSION AND AUDIENCE Q&A** All Faculty
8:55 PM – 9:00 PM	**PART 5: FINAL COMMENTS, FUTURE PERSPECTIVES** Dr. Thomas Herzog

GOG Highlight Reel

Part 1: Ovarian Cancer: New Therapeutic Opportunities & Novel Drugs Under Investigation

Ramez Eskander, MD

University of California
San Diego Moores
Cancer Center
San Diego, California

David O'Malley, MD

The Ohio State University
James Cancer Center
Columbus, Ohio

Rachel Grisham, MD

Memorial Sloan Kettering
Cancer Center
New York, New York

Emese Zsiros, MD, PhD

Roswell Park Comprehensive
Cancer Center
Buffalo, New York

GOG Highlight Reel

Pembrolizumab vs Placebo Plus Weekly Paclitaxel With or Without Bevacizumab for Platinum-Resistant Recurrent Ovarian Cancer:

Results from the Randomized, Double-Blind Phase 3 ENGOT-ov65/ KEYNOTE-B96 Study

Emese Zsiros, MD, PhD

Roswell Park Comprehensive Cancer Center
Buffalo, New York

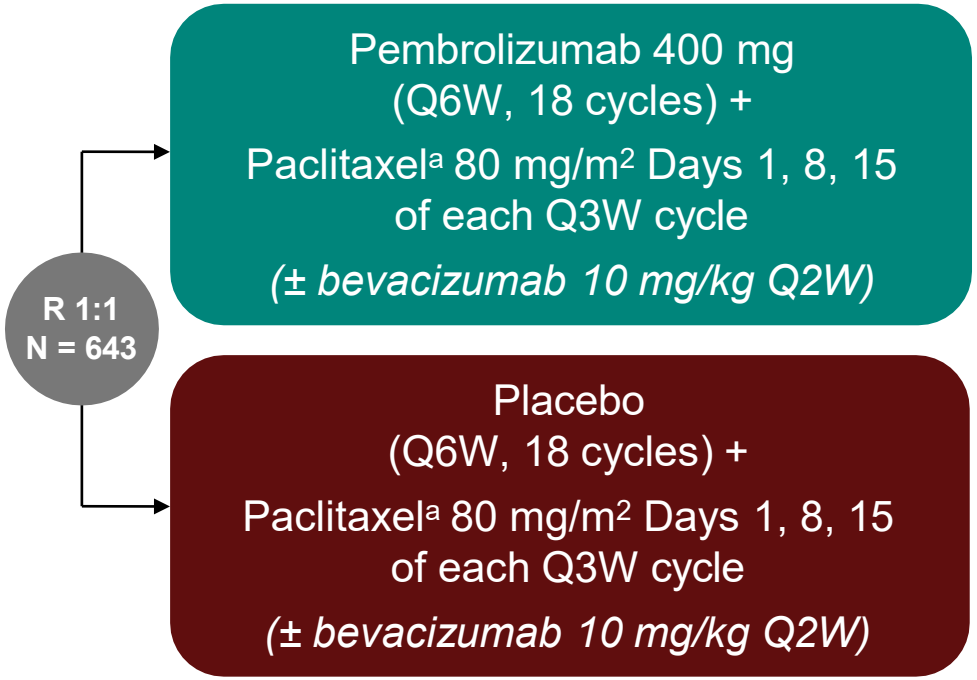
Presented at ESMO: 18 October 2025

Colombo N, et al. Annals of Oncology. 2025 Sep 1;36:S1697. https://www.annalsofoncology.org/article/S0923-7534(25)04819-7/fulltext

ENGOT-ov65/KEYNOTE-B96 Study Design (NCT05116189)

Key Eligibility Criteria

- Histologically confirmed epithelial ovarian, fallopian tube, or primary peritoneal carcinoma
- 1 or 2 prior lines of therapy; at least 1 platinum-based chemotherapy
  - Prior anti-PD-1 or anti-PD-L1, PARPi and bevacizumab permitted
- Radiographic progression within 6 months after the last dose of platinum-based chemotherapy
- ECOG PS 0 or 1



Stratification Factors

- Planned bevacizumab use (yes vs no)
- Region (US vs EU vs ROW)
- PD-L1 CPS (<1 vs 1 to <10 vs ≥10)[b]

Primary Endpoint: PFS per RECIST v1.1 by investigator

Key Secondary: OS

[a]Docetaxel (75 mg/m² Q3W) may be considered in participants with severe hypersensitivity reaction to paclitaxel or an adverse event requiring discontinuation of paclitaxel after consultation with the Sponsor. [b]The combined positive score (CPS) was assessed at a central laboratory using PD-L1 IHC 22C3 pharmDx and defined as the number of PD-L1 CPS ≥1 cells (tumor cells, lymphocytes, macrophages) divided by the total number of tumor cells × 100.

Colombo N, et al. Annals of Oncology. 2025 Sep 1;36:S1697. https://www.annalsofoncology.org/article/S0923-7534(25)04819-7/fulltext

Baseline Characteristics

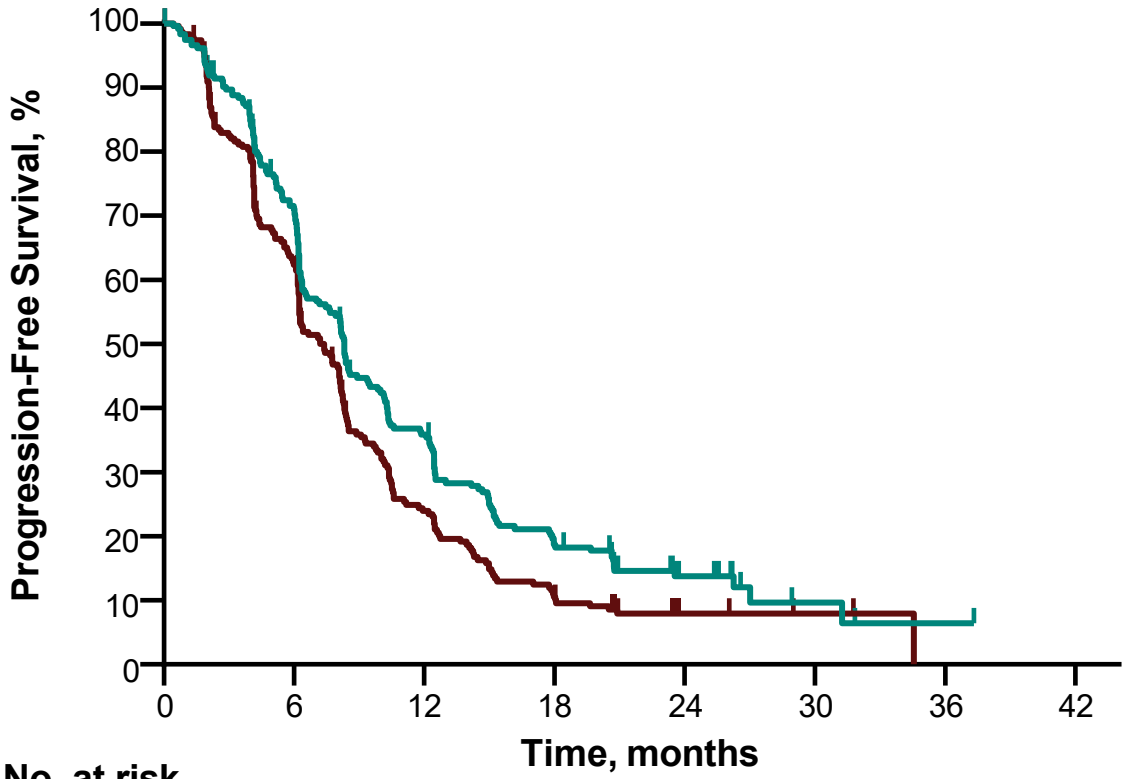
	Pembro Arm (N = 322)	Placebo Arm (N = 321)
Age, median (range)	62 y (37-85)	61 y (37-82)
Race[a]		
White	207 (64.3%)	217 (67.6%)
Asian	72 (22.4%)	58 (18.1%)
Multiple	12 (3.7%)	17 (5.3%)
Black or African American	8 (2.5%)	6 (1.9%)
Hawaiian/Pacific Islander	1 (0.3%)	1 (0.3%)
PD-L1 CPS		
<1	88 (27.3%)	89 (27.7%)
1 to <10	133 (41.3%)	132 (41.1%)
≥10	101 (31.4%)	100 (31.2%)
Stage at diagnosis (FIGO 2014 criteria)		
IA-IIB	25 (7.8%)	26 (8.1%)
III-IIIC	183 (56.8%)	189 (58.9%)
IVA-IVB	114 (35.4%)	106 (33.0%)

	Pembro Arm (N = 322)	Placebo Arm (N = 321)
High-grade serous histology[b]	278 (86.3%)	275 (85.7%)
Bevacizumab use	235 (73.0%)	236 (73.5%)
Prior lines of therapy[c]		
1 line	121 (37.6%)	113 (35.2%)
2 lines	200 (62.1%)	207 (64.5%)
Prior anticancer therapy		
Anti-PD-1 or PD-L1	7 (2.2%)	7 (2.2%)
Bevacizumab	149 (46.3%)	146 (45.5%)
PARP inhibitor	112 (34.8%)	123 (38.3%)
Platinum-free interval[d]		
<3 mo	137 (42.5%)	162 (50.5%)
≥3 to ≤6 mo	183 (56.8%)	154 (48.0%)
>6 mo	2 (0.6%)	4 (1.2%)

Colombo N, et al. Annals of Oncology. 2025 Sep 1;36:S1697.
https://www.annalsofoncology.org/article/S0923-7534(25)04819-7/fulltext

Progression-Free Survival in the CPS ≥1 and ITT Populations at IA2

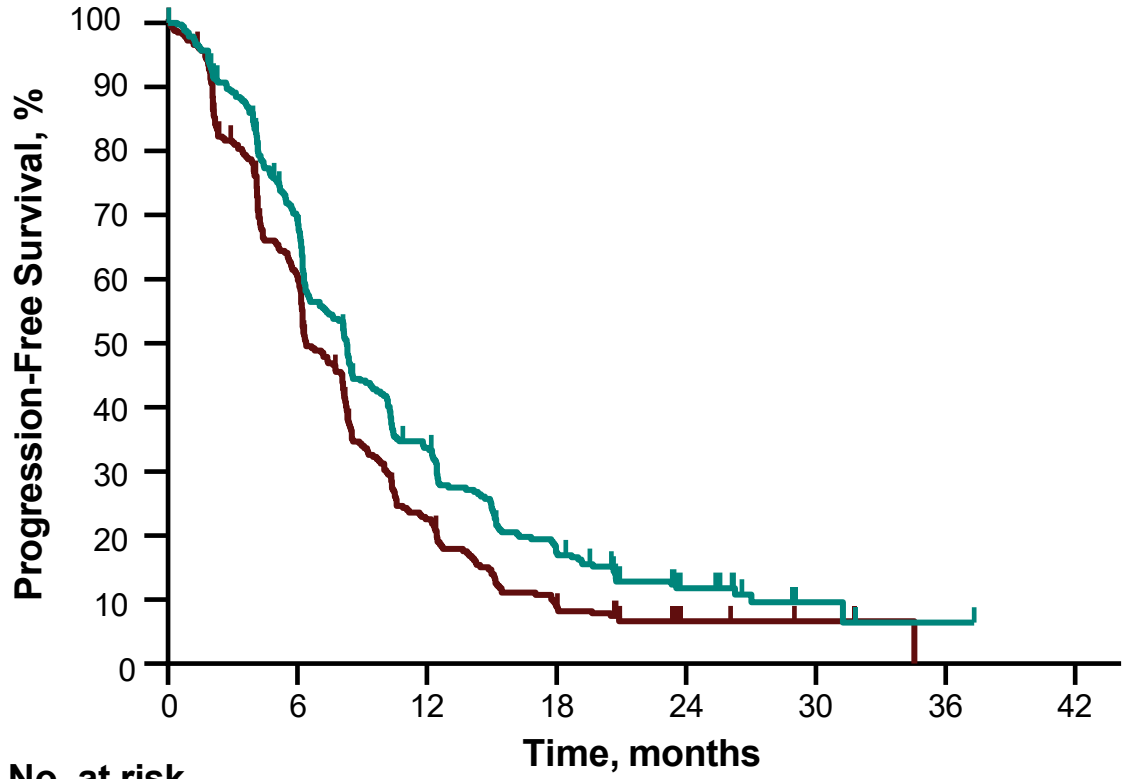
CPS ≥1 Population	Median, months	Events	HR (95% CI)
Pembro Arm	8.3	81.6%	0.75[a] (0.61-0.91)
Placebo Arm	7.2	86.6%	



No. at risk

234	158	77	39	12	3	1	0
232	138	50	22	5	2	0	0

ITT Population	Median, months	Events	HR (95% CI)
Pembro Arm	8.3	83.2%	0.73[a] (0.62-0.86)
Placebo Arm	6.4	87.2%	



No. at risk

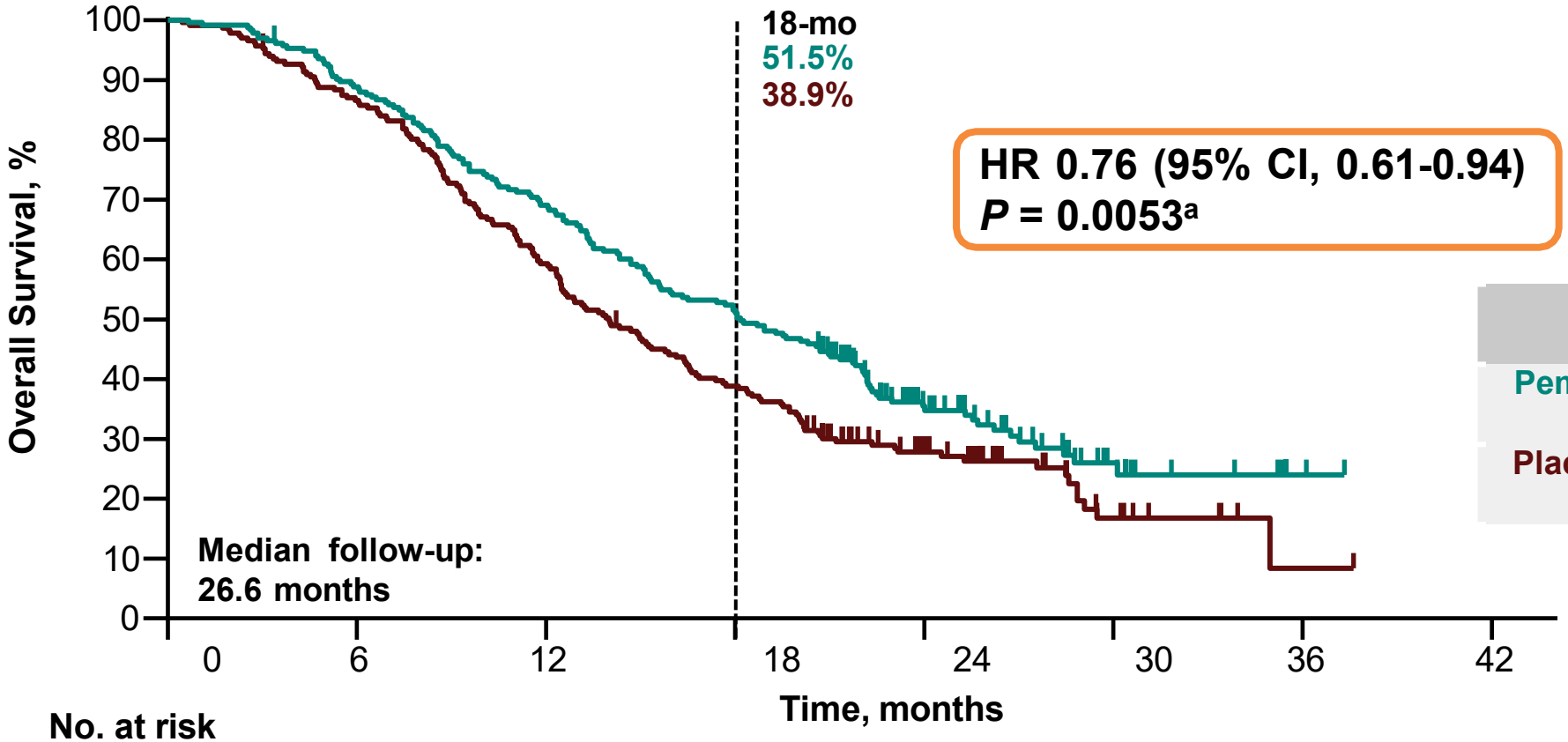
322	213	99	49	16	3	1	0
321	184	64	25	6	2	0	0

Median follow-up: 26.6 months

Data cutoff: March 5, 2025

Colombo N, et al. Annals of Oncology. 2025 Sep 1;36:S1697.
https://www.annalsofoncology.org/article/S0923-7534(25)04819-7/fulltext

Key Secondary Endpoint: Overall Survival in the CPS ≥1 Population at IA2



HR 0.76 (95% CI, 0.61-0.94)
***P* = 0.0053[a]**

	Pts w/ Event	Median, mo (95% CI)
Pembro Arm	67.1%	18.2 (15.3-21.0)
Placebo Arm	75.4%	14.0 (12.5-16.1)

No. at risk

234	207	161	120	49	13	3	0
232	200	137	89	41	10	1	0

Scan Me

Data cutoff: March 5, 2025

Colombo N, et al. Annals of Oncology. 2025 Sep 1;36:S1697.
https://www.annalsofoncology.org/article/S0923-7534(25)04819-7/fulltext

GOG FOUNDATION

Summary of Adverse Events at IA2

	All-Cause AEs		Treatment-Related AEs[a]		Immune-Mediated AEs[b]	
	Pembro Arm (N = 320)	Placebo Arm (N = 318)	Pembro Arm (N = 320)	Placebo Arm (N = 318)	Pembro Arm (N = 320)	Placebo Arm (N = 318)
Any grade	318 (99.7%)	316 (99.4%)	313 (97.8%)	303 (95.3%)	125 (39.1%)	60 (18.9%)
Grade ≥3	264 (82.5%)	225 (70.8%)	216 (67.5%)	176 (55.3%)	37 (11.6%)	11 (3.5%)
Serious	178 (55.6%)	122 (38.4%)	106 (33.1%)	62 (19.5%)	35 (10.9%)	7 (2.2%)
Led to discontinuation of any treatment	132 (41.3%)	108 (34.0%)	115 (35.9%)	89 (28.0%)	22 (6.9%)	8 (2.5%)

GOG Highlight Reel

Navigating the Wave of ADCs and Non-ADC Trial Options

Ramez Eskander, MD

University of California San Diego
Moores Cancer Center
San Diego, California

David O'Malley, MD

The Ohio State University
James Cancer Center
Columbus, Ohio

PROC Landscape

	MIRVETUXIMAB (N=453)	Relacorilant + Nab-P (N=381) PDUFA Date: July 2026	Pembro +chemo+/-bev (N=616) PDUFA Date: Feb 2026
Clinical Trial	**MIRASOL (NCT04209855)**	**ROSELLA (NCT05257408)**	**KEYNOTE-B96 (NCT05116189)**
MOA	Anti-FRα ADC	Anti-glucocorticoid + chemotherapy	ICI + chemo/bevacizumab
Biomarker	**FR-alpha high ≥ 75% viable tumor cells PS2+**	**All-comers**	**PD-L1/all-comers (?)**
Prior lines	1-3 prior lines **47% 3 prior lines**	1-3 prior lines (prior bevacizumab required) **43% 3 prior lines (allowed progression 1-3 months after 1L platinum)**	1-2 prior lines
ORR	**42.3%**	**36.9%**	**50.4% (ITT)**
DCR	**80.2%**	**51.1%**	**Not Reported**
Key Grade ≥3 TEAEs	**Blurred Vision Keratopathy Neuropathy Nausea**	**Neutropenia Anemia Nausea Fatigue**	**Neutropenia Anemia Peripheral Neuropathy Fatigue**
mPFS (months)	**5.62**	**6.45**	**8.3**
mOS (months)	**16.46 HR 0.67 (95% CI, 0.50-0.89)**	**15.97 HR 0.69 (95% CI, 0.52-0.92)**	**18.2 HR 0.76 (95% CI, 061-0.94)**

Moore KN, et al. N Engl J Med. 2023;389(23):2162-2174;
Olawaiye A, et al. The Lancet. 2025 Jun 21;405(10496):2205-16; Colombo N, et al. Annals of Oncology. 2025 Sep 1;36:S1697.5

Evolving Landscape (ADCs)

	Raludotatug deruxtecan (R-Dxd)	Rina-S	LY41701563	Torvutatug Samrotecan (AZD5335)
Clinical Trial	REJOICE-Ovarian01[1] (all-comers PROC, N=107)	RAINFOL-01[2] (all-comers ROC; N=42)	LY4170156[3] (FRα ≥75% or <75% at 2+ and/or 3+ intensity; N=104)	FONTANA[4] **(FRα ≥ 25% IHC 1+; N=183)**
MOA	Anti-CDH6 ADC	Anti-FRα ADC	Anti-FRα ADC	Anti-FRα ADC
Prior lines	1-3 prior lines (prior bev)	1-5 prior lines	1-10 prior lines	1-3 prior lines
Doses investigated	4.8, 5.6, and 6.4 mg/kg	100 and 120 mg/m^2	2-6 mg/kg	1.6, 2.0, and 2.4 mg/kg
ORR	**50.0% (5.6 mg/kg)**	**55.6% (120 mg/m^2)**	**50% (ITT)**	**53.6% (ITT)**
DCR	**80.6% (5.6 mg/kg)**	**88.9% (120 mg/m^2)**	**78% (ITT)**	**Not Reported**
Biomarker	**Currently, no correlation between CDH6 expression and efficacy**	**Responses observed regardless of FRα expression levels**	**ORR 40% in 0-24% FRα** **ORR 54% in FRα ≥75%**	**ORR 47.5% in low FRα** **ORR 60.7% in high FRα**
Key Grade ≥3 TEAEs	Neutropenia Anemia Asthenia	Neutropenia Anemia Thrombocytopenia	Anemia Neutropenia	Anemia Neutropenia

Ovarian Cancer ADC Trials (ESMO & IGCS)

Drug Name	Target	Payload	Preliminary Efficacy (ORR)*	Presented At
Torvutatug Samrotecan (AZD5335)	FRalpha	TOPO1 inhibitor	53.6% (ITT)	ESMO
Sofetabart Mipitecan (LY4170156)	FRalpha	TOPO1 inhibitor	33 – 61%	ESMO
Raludotatug deruxtecan (R-Dxd)	CDH6	TOPO1 inhibitor	50.5%	ESMO
TUB-040	NaPi2b	TOPO1 inhibitor	50%	ESMO
DS-3939a	TA-MUC1	TOPO1 inhibitor	1 confirmed CR (N=8)	ESMO
Mo-Rez (GSK5733584) (HS-20089)	B7-H4	TOPO1 inhibitor	48.5%	ESMO
JSKN003	HER2	TOPO1 inhibitor	64.4%	ASCO
Disitimab vedotin + anlotinib	HER2	Multi-target TKI + MMAE ADC	29.4%	ESMO

***Data are NOT intended for cross-trial comparison**

Phase 3 ADC Ovarian Cancer Clinical Trials

Clinical Situation	Drug Name	Trial ID	NCT
First-line (maintenance)	Trastuzumab Deruxtecan	GOG-3112 (DESTINYOvarian-01)	NCT06819007
Platinum sensitive	Sofetabart Mipitecan	GOG-3133 (FRAmework-01)	NCT07213804
Platinum sensitive (maintenance)	Sacituzumab Tirumotecan (Sac-TMT)	GOG-3103/ENGOT-ov84 (TroFuse-022)	NCT06824467
Platinum sensitive (maintenance)	Rinatabart Sesutecan (Rina-S)	GOG-3134 (RAINFOL-04)	NCT07225270
Platinum resistant	Rinatabart Sesutecan (Rina-S)	GOG-3107 (RAINFOL-OV2)	NCT06619236
Platinum resistant	Raludotatug Deruxtecan (R-Dxd)	GOG-3096 (REJOICE-Ovarian-01)	NCT06161025
Platinum resistant	Torvutatug Samrotecan (AZD5335)	GOG-3127 (TREVI-OC-01)	NCT07218809
Platinum resistant	Sofetabart Mipitecan	GOG-3133 (FRAmework-01)	NCT07213804

Evolving Landscape: Non-ADC Options in the PROC space

	GOG-3129/MAESTRA 1 (NCT07023672)[1]	GOG-3066/DENALI[2] (NCT05128825)	GOG-3076/OnPrime[3] (NCT05281471)	GOG-3121/ULTIMUS-1 (NCT07109414)
MOA	CDK2 inhibitor	Wee-1 inhibitor	Oncolytic vaccinia virus-based immunotherapy	Fascin inhibitor
Prior lines	2-4 prior lines of treatment	Up to 3 prior lines (4 prior lines permitted, if prior mirvetuximab)	Unlimited prior lines	Not reported
Biomarker	Cyclin E1 overexpression	Cyclin E1 + overexpression	All comers	All comers

	PYNNACLE (NCT04585750)[4]	MUC16xCD3 Bispecific (NCT06787612)
MOA	P53 reactivator	MUC16xCD3 Bispecific
Prior lines	Unlimited prior lines	Not Reported
Biomarker	TP53 Y220C mutation	Elevated CA125

1. *Thaker PH, et al. Annals of Oncology. 2025 Sep 1;36:S790; 2. Leary A, et al. Molecular Cancer Therapeutics. 2025 Oct 22;24(10_Supplement):B013; 3. Holloway RW, et al. International Journal of Gynecological Cancer. 2023 Sep 1;33(9):1458-63; 4. Alison M. Schram et al. J Clin Oncol 2025, 43, TPS11581-TPS11581.*

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

PRIMARY TREATMENT FOR STAGE II-IV DISEASE

Preferred Regimens:
Paclitaxel/carboplatin ± bev

Other Recommended Regimens:
Weekly paclitaxel with weekly or Q3W carboplatin
Carboplatin with docetaxel or liposomal doxorubicin
Docetaxel/carboplatin/bev

Useful in Certain Circumstances:
Paclitaxel/cisplatin
Docetaxel/oxaliplatin/bev
IV/IP paclitaxel and carboplatin or cisplatin (for optimally debulked stage II-III disease)

PLATINUM-SENSITIVE RECURRENT (PFI ≥ 6 months)

Preferred Regimens:
Carboplatin + gemcitabine, liposomal doxorubicin, or paclitaxel ± bev
Cisplatin/gemcitabine
Bev monotherapy

Other Recommended Regimens:
Chemotherapy: capecitabine, carboplatin (± docetaxel or weekly paclitaxel), cisplatin, cyclophosphamide, doxorubicin, ifosfamide, irinotecan, melphalan, oxaliplatin, paclitaxel, pemetrexed, vinorelbine
^^*Targeted Therapy*: niraparib ± bev, olaparib, pazopanib, rucaparib
Hormonal Therapy: AIs, goserelin, leuprolide, megestrol, tamoxifen

Useful in Certain Circumstances:
^^*Targeted Therapy*: dabrafenib/trametinib (*BRAF* V600E), *NTRK* fusion treatments (entrectinib, larotrectinib, repotrectinib), T-DXd (HER2+), **MIRV ± bev (FRα+),** selpercatinib (*RET* fusion)
Immunotherapy: dostarlimab (dMMR/MSI-H), pembrolizumab (dMMR/MSI-H or TMB-H)

MAINTENANCE THERAPY (After CR/PR with Primary Therapy)

No Bev in Primary Treatment:

BRCAwt/unk: **niraparib (HRD),** olaparib (HRD), rucaparib, or observation (if CR), *Note, category 2A Recommendation*

BRCAm: olaparib, niraparib, rucaparib, or observation (stage II with CR), *Note, category 1 Recommendations*

Bev in Primary Treatment:

BRCAwt/unk → HRP/unknown : bev

BRCAwt/unk → HRD : **olaparib** ± bev*****, bev + niraparib (if unable to tolerate olaparib), bev

BRCAm: bev**** + olaparib, bev+ niraparib (if unable to tolerate olaparib), olaparib, niraparib, or rucaparib
**Olaparib, *Category 2B*
****Olaparib + Bev, Category 1*

PLATINUM-RESISTANT (PFI < 6 months)

Preferred Regimens:
Chemotherapy: Cyclophosphamide, liposomal doxorubicin, weekly paclitaxel, or topotecan ± bev, docetaxel, etoposide, gemcitabine

Targeted Therapy: Bev monotherapy, **MIRV *(FRα ≥ 75%),* Category 1**

Other Recommended Regimens:
Chemotherapy: capecitabine, carboplatin (± docetaxel, weekly paclitaxel, liposomal doxorubicin, or gemcitabine ± bev), cisplatin, cyclophosphamide (± pembrolizumab/bev), doxorubicin, gemcitabine + bev/cisplatin, irinotecan, melphalan, oxaliplatin, paclitaxel, pemetrexed, vinorelbine sorafenib/topo
^^*Targeted Therapy*: niraparib, olaparib, pazopanib, rucaparib
Hormonal Therapy: AIs, goserelin, leuprolide, megestrol, tamoxifen

Useful in Certain Circumstances:
^^*Targeted Therapy*: dabrafenib/trametinib (*BRAF* V600E), *NTRK* fusion treatments (entrectinib, larotrectinib, repotrectinib), **T-DXd (HER2+), MIRV + bev (FRα+),** selpercatinib (*RET*)
Immunotherapy: dostarlimab (dMMR/MSI-H), pembrolizumab (dMMR/MSI-H or TMB-H)

^^Note, targeted therapies have different categories, please reference the latest guidelines for information

AI, aromatase inhinitor; Bev, bevacizumab; BRCA, breast cancer gene; CR, complete response; dMMR, mismatch repair deficient; FRα. Folate receptor alpha; HER2, human epidermal growth factor receptor 2; HRD/P, homologous recombination deficient/proficient; IP, intraperitoneal; IV, intravenous; m, mutant; MIRV, mirvetuximab soravtansine; MSI-H, high microsatellite instability; PFI, platinum-free interval; PR, partial response; Q3W, every 3 weeks; T-DXd, trastuzumab deruxtecan;TMB-H, high tumor mutational burden; topo, topotecan; wt/unk, wildtype or unknown. National Comprehensive Cancer Network. Ovarian cancer (version 3.2025). Accessed November 20, 2025, Referenced From the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer V.3.2025.

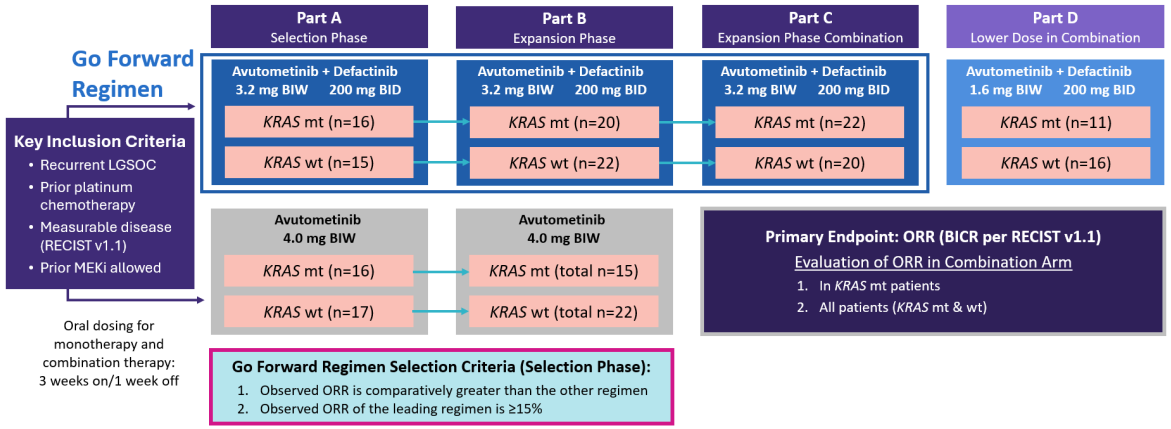
GOG Highlight Reel

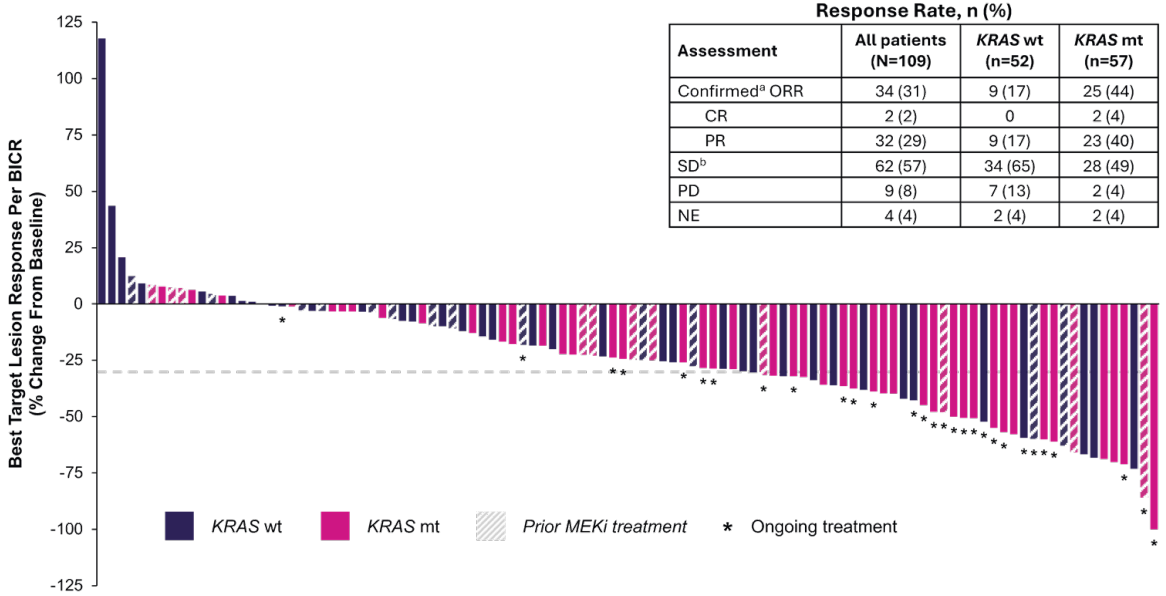
Emerging Treatments for Women With Low Grade Serous Ovarian Cancer

Rachel Grisham, MD
Memorial Sloan Kettering Cancer Center
New York, New York

Avutometinib in Combination with Defactinib: The First FDA Approved Treatment for Women with Low Grade Serous Ovarian Cancer

ENGOT-ov60/GOG-3052/RAMP 201





Response Rate, n (%)

Assessment	All patients (N=109)	*KRAS* wt (n=52)	*KRAS* mt (n=57)
Confirmed[a] ORR	34 (31)	9 (17)	25 (44)
CR	2 (2)	0	2 (4)
PR	32 (29)	9 (17)	23 (40)
SD[b]	62 (57)	34 (65)	28 (49)
PD	9 (8)	7 (13)	2 (4)
NE	4 (4)	2 (4)	2 (4)

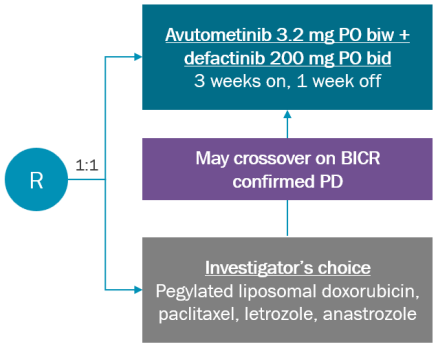
- **Avutometinib 3.2 mg BIW and Defactinib 200 mg BID is active in women with recurrent LGSOC**

	Response Rate	Median PFS	Median DOR
KRAS Mutant	44%	22 months	31.1 months
KRAS WT	17%	12.8 months	9.2 months

- **All women with LGSOC should have somatic tumor testing performed to determine *KRAS* mutation status (TUMOR NOT BLOOD)**

- **GOG-3097/ENGOT-ov81/RAMP 301 – Confirmatory Phase III Study**

Key Eligibility Criteria
- Confirmed LGSOC diagnosis
- Recurrent disease after prior platinum therapy
- Documented *KRAS* mutation status (wt or mut)
- Measurable disease per RECIST v1.1
- Prior MEKi allowed
- Prior bevaciumab allow



Primary Endpoint
PFS (BICR); sequential evaluation of PFS in (1) *KRAS*mut LGSOC; (2) all recurrent LGSOC

Key Secondary Endpoints
OS, PFS per INV assessment, ORR, DOR, DCR, safety, PK, PROs

Stratification Factors
- *KRAS* mutation status (wt vs mut)
- Number of prior lines of therapy (1-3 vs ≥4)
- Geography (North America/Europe vs ROW)

Grisham RN, et al. SGO 2025. Banerjee et al, JCO, 2025. Grisham R, et al. Int J Gynecol Cancer. 2025 Nov;35(11):101832.

Management of Toxicity: Avutometinib and Defactinib

TRAEs (All Grade >20%), n (%)		Avutometinib + Defactinib N=115	
		All grade	Grade ≥3
Nonlaboratory	Nausea	77 (67.0)	3 (2.6)
	Diarrhea	67 (58.3)	9 (7.8)
	Peripheral edema	61 (53.0)	1 (0.9)
	Rash	**58 (50.4)**	**3 (2.6)**
	Fatigue	50 (43.5)	3 (2.6)
	Vomiting	49 (42.6)	3 (2.6)
	Vision blurred	**47 (40.9)**	**0**
	Dermatitis acneiform	**39 (33.9)**	**5 (4.3)**
	Dry skin	**30 (26.1)**	**0**
	Anemia	26 (22.6)	6 (5.2)
Laboratory-related	**Increased blood CPK**	**69 (60.0)**	**28 (24.3)**
	Increased blood bilirubin	**38 (33.0)**	**5 (4.3)**
	AST increased	**36 (31.3)**	**2 (1.7)**

AEs of Interest

Blurred vision

- Blurred vision was the most common treatment-related ocular event (41%)
- Median onset was 4 days
- Events often resolved without treatment interruption (treatment d/c not needed)

Skin and subcutaneous tissue AEs

- Included rash (50%), dermatitis acneiform (34%), and dry skin (26%)
- Median onset and duration was 15 and 35 days, respectively
- 6% had treatment-related skin reactions leading to dose interruption/reduction, 1 patient d/c due to dermatitis acneiform

10% of patients discontinued treatment due to AE

- **Ocular toxicities:** Perform comprehensive ophthalmic evaluation at baseline, prior to cycle 2, every 3 cycles thereafter, and as clinically indicated. Permanently discontinue for any grade 4 toxicity.

- **Skin toxicities:** Prophylactic antibiotics with minocycline or doxycycline for ≥ first 4 months of treatment . Topical steroid PRN. Avoid UV exposure.

- **Hepatotoxicity:** Monitor LFTS prior to each cycle, on day 15 of the first 4 cycles, and as clinically indicated. Increased bilirubin attributed to defactinib due to the inhibition of enzymes responsible for metabolizing (UGT1A1) and transporting bilirubin

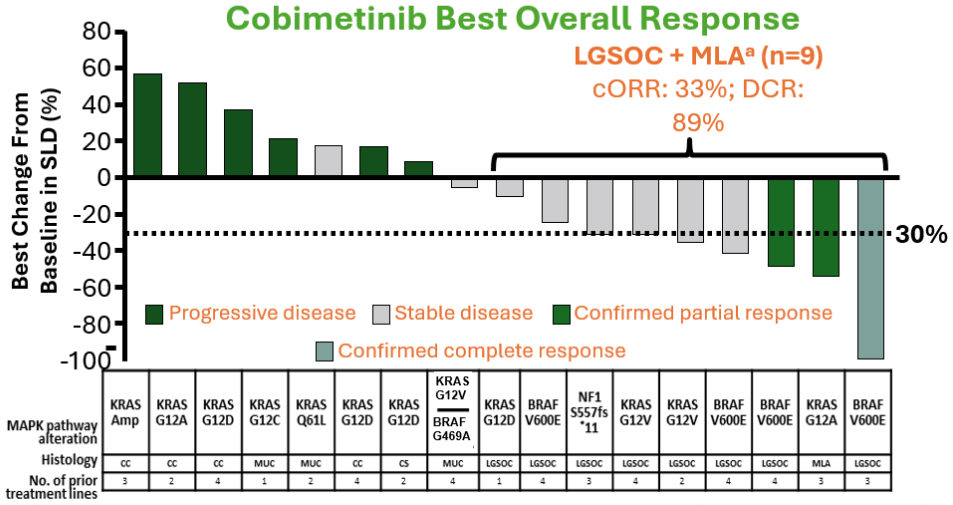
- **Elevated CPK:** Monitor CPK prior to the start of each cycle, on day 15 of the first 4 cycles, and as clinically indicated. If Grade 3 CPK occurs, evaluate patients for rhabdomyolysis and hold treatment. Avoid new or excessive exercise, maintain good hydration.

Current and Upcoming Options for Women with Recurrent LGSOC : Single Agent MEK Inhibitors

Trial	Number of Priors (range)	Prior MEKi allowed?	Treatment	ORR	Image Assessment	Median PFS in Months (95% CI)	D/C Rate due to AEs
GOG 281	3 (1-10)	No	Physician's Choice	6%	Local	7.2 (5.6-9.9)	12%
			Trametinib	26% (50% MAPK mutant; 9% MAPK WT)	Local	13 (9.9-15)	35%
MILO/ ENGOT-ov11	2 (1-8)	No	Physician's Choice	13%	BICR	10.6 (9.2-14.5)	17%
			Binimetinib	16% (44% KRAS mutant; 19% KRAS WT)	BICR	9.1 (7.3-11.3)	31%

	Avutometinib + Defactinib	Trametinib	Binimetinib	Cobimetinib
Simplicity of Schedule		√	√	√
Tolerability	√			
Allowed Prior MEKi	√			
Availability	FDA approved and NCCN 2a for LGSOC with a KRAS mutation	NCCN 2a indication for LGSOC	NCCN 2b Indication for LGSOC	Not Approved or NCCN listed for LGSOC

BOUQUET: ORR (interim analysis)

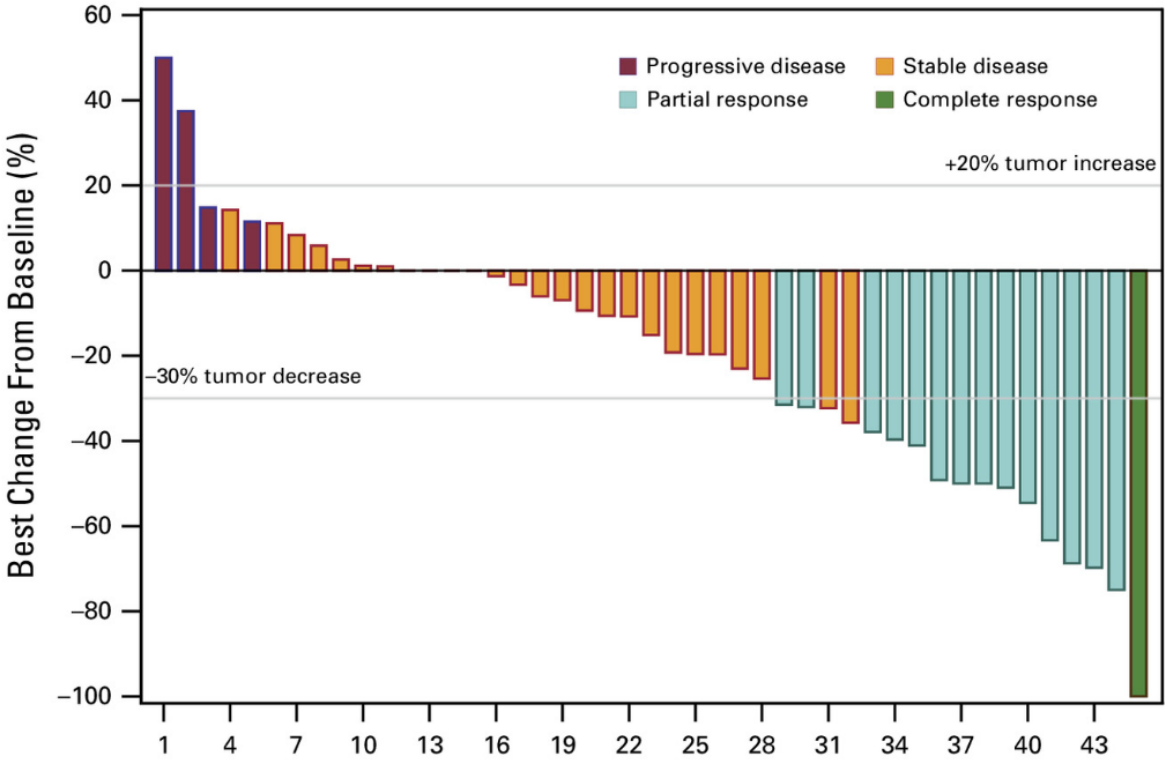


Response	Cobi (n=19)	Atezo + Bev (n=21)
Confirmed ORR, n (%)	3 (16)[b]	3 (14)
LGSOC + MLA[a]	3/9 (33)	2/15 (13)
DCR, n (%)	8 (42)[b]	15 (71)
LGSOC + MLA[a]	8 (89)	2/15 (13)
6-mo PFS rate, % (95% CI)	41 (18-63)	75 (56-94)

Monk, Grisham at al, JCO, 2020; Grisham et al, CCR, 2023; Gershenson et al, Lancet, 2022; Ray-Coquard I, et al. ESMO 2023. Abstract 747MO.

Current and Upcoming Options for Women with Recurrent LGSOC: CDK 4/6 inhibitors and ADCs

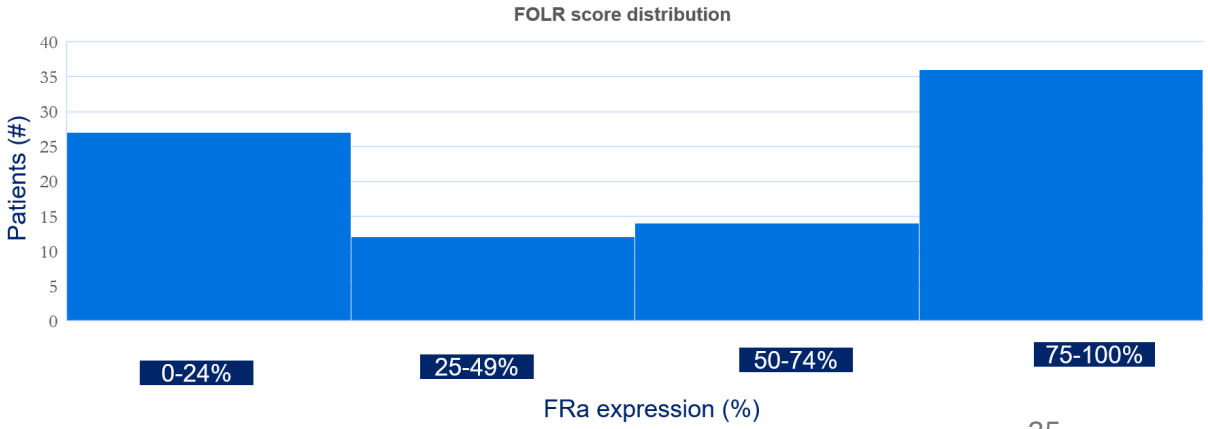
GOG-3026: Phase II Trial of Ribociclib Plus Letrozole in Women With recurrent LGSOC



	ORR	DOR, median	PFS, median	Treatment D/C due to AE
Ribociclib +Letrozole	30.6%	21.2 mo	14.5 mo	4%

FOLR1α Expression is Frequent in LGSOC and Inversely Correlated with Presence of MAPK Alteration

- Of **89** low grade serous ovarian cancer samples
  - FRα positive: 36 (40.4%) (median FR+ expression 85.5%, range 77.5-100.0%)
- Overall, 45 of 78 sequenced tumors (58%) had MAPK alteration.
  - **20%** (9 of 45) of LGSOC **with MAPK** alteration were **FRα positive**.
  - **61%** (20 of 33) of LGSOC **without MAPK** alteration were **FRα positive**



Slomovitz et al, JCO, 2025. Manning-Geist, Grisham Chui et al, Gynecologic Oncology, 2024

Panel Discussion and Audience Q&A

GOG Highlight Reel

Part 2: The Evolving Endometrial Cancer Treatment Landscape: Approvals, Evidence and Impact

Kathleen Moore, MD
University of Oklahoma
Stephenson Cancer Center
Oklahoma City, Oklahoma

Brian Slomovitz, MD
Mount Sinai
Medical Center
Miami Beach, Florida

GOG Highlight Reel

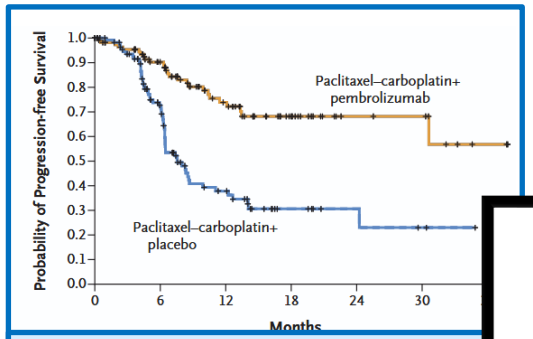
Evolution of Biomarkers in Endometrial Cancer From MMR→?

Kathleen Moore, MD
University of Oklahoma
Stephenson Cancer Center
Oklahoma City, Oklahoma

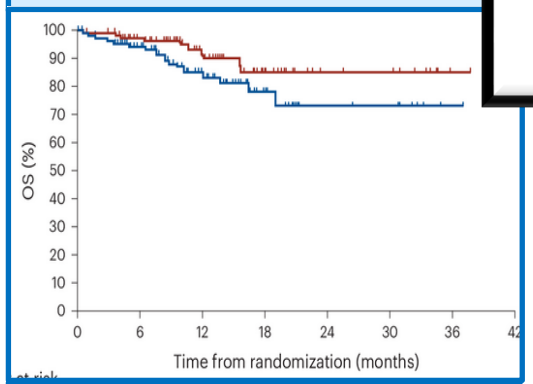
ICI + chemotherapy with significant PFS & OS benefit in dMMR EC

NRG-GY018[1]

Pembrolizumab



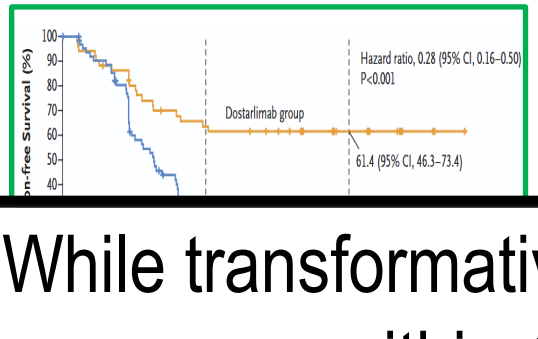
HR 0.30
95% CI 0.19-0.48

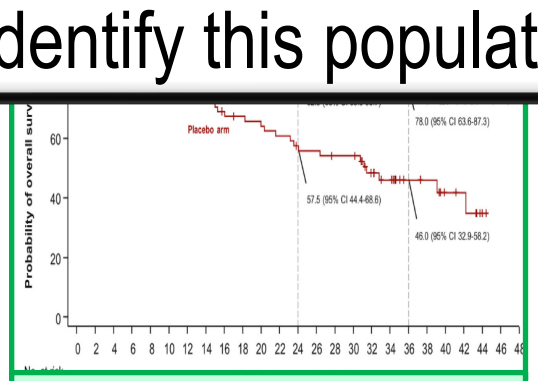


HR 0.55
95% CI 0.25-1.19

RUBY[2]

Dostarlimab

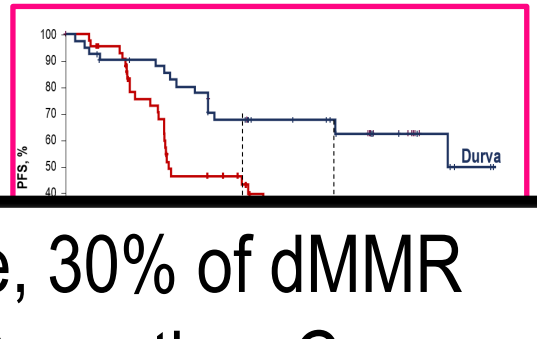


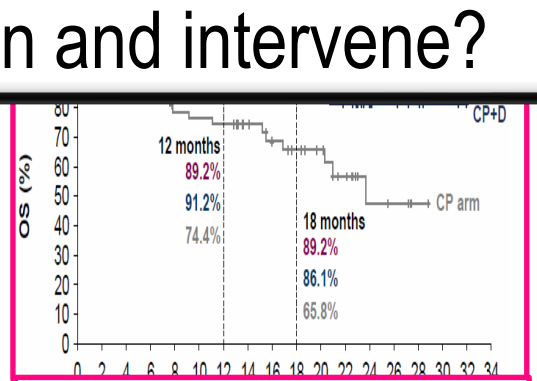


HR 0.32
95% CI 0.17-0.63

DUO-E[3]

Durvalumab

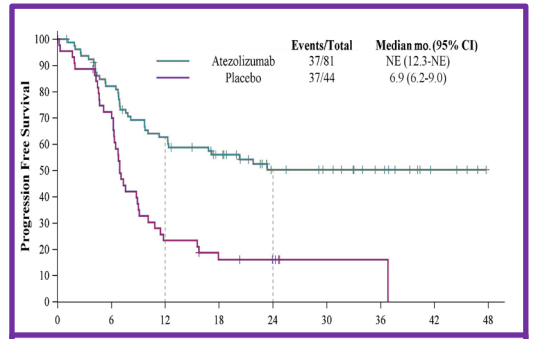




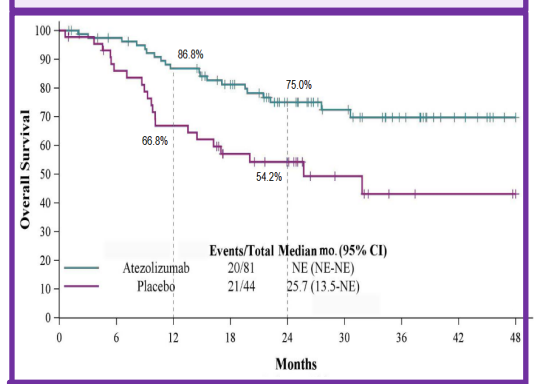
HR 0.34
95% CI 0.13-0.79

AtTEnd[4]

Atezolizumab



HR 0.36
95% CI 0.23-0.57



HR 0.41
95% CI 0.22-0.76

While transformative, 30% of dMMR tumors recur within 12 months. Can we identify this population and intervene?

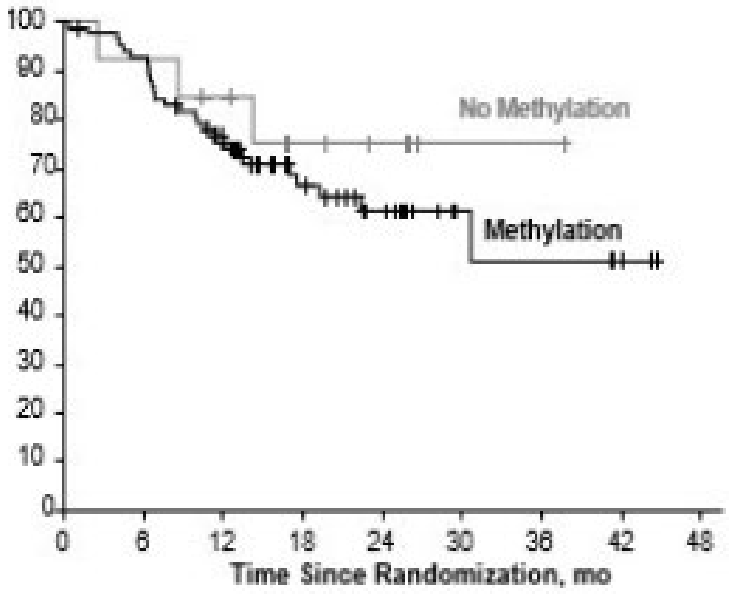
Eskander RN, et al. NEJM. 2023 Jun 8;388(23):2159-70; Mirza MR, et al. NEJM. 2023 Jun 8;388(23):2145-58; Westin SN, et al. J Clin Oncol. 2024 Jan 20;42(3):283-299; Colombo N, et al. Lancet Oncol. 2024 Sep;25(9):1135-1146.

Methylation Status Does NOT Appear Prognostic nor Predictive

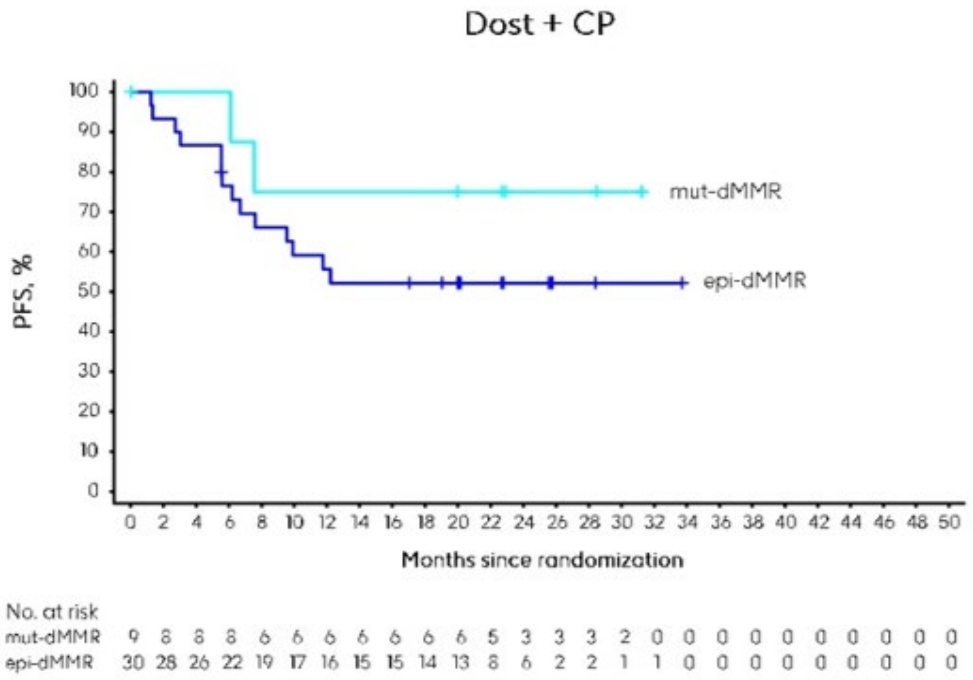
NRG GY018

Methylation Status
Pembro + CP Arm

	Events n/N	Median (95% CI), mo
No Methylation	3/13	NR (14.2-NR)
Methylation	28/83	NR (22.3-NR)



RUBY

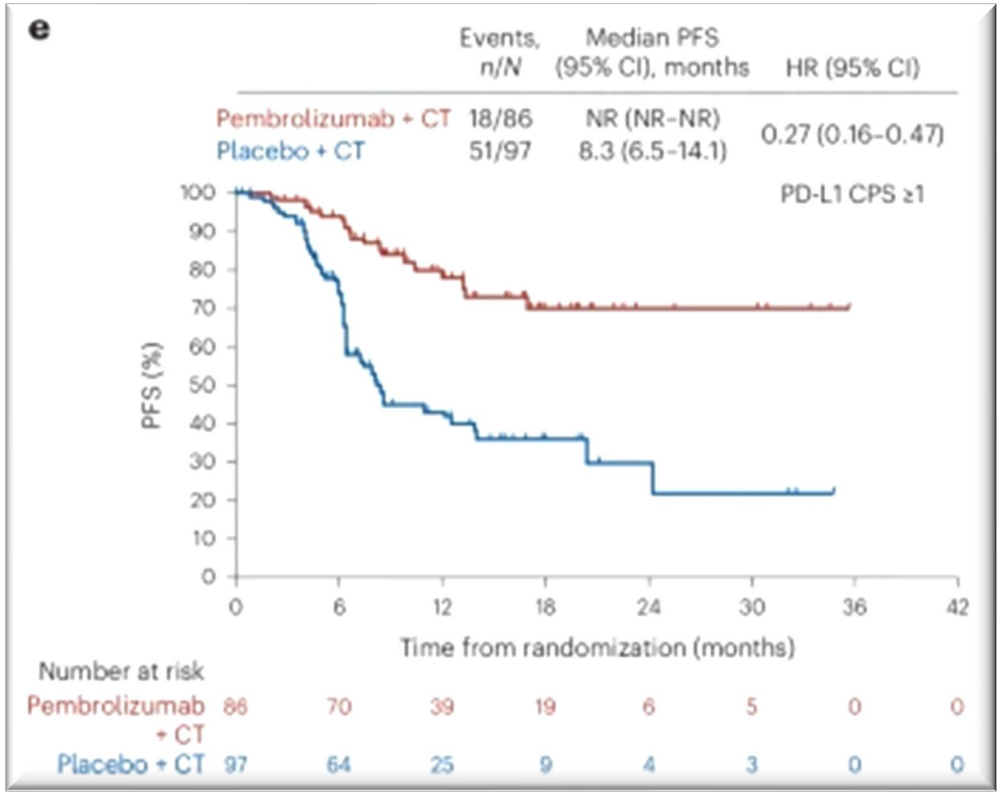


1. Eskander RN et al. ESMO 2023. Abstract 6564. 2. Mirza MR et al. ASCO 2024. Abstract 5606.

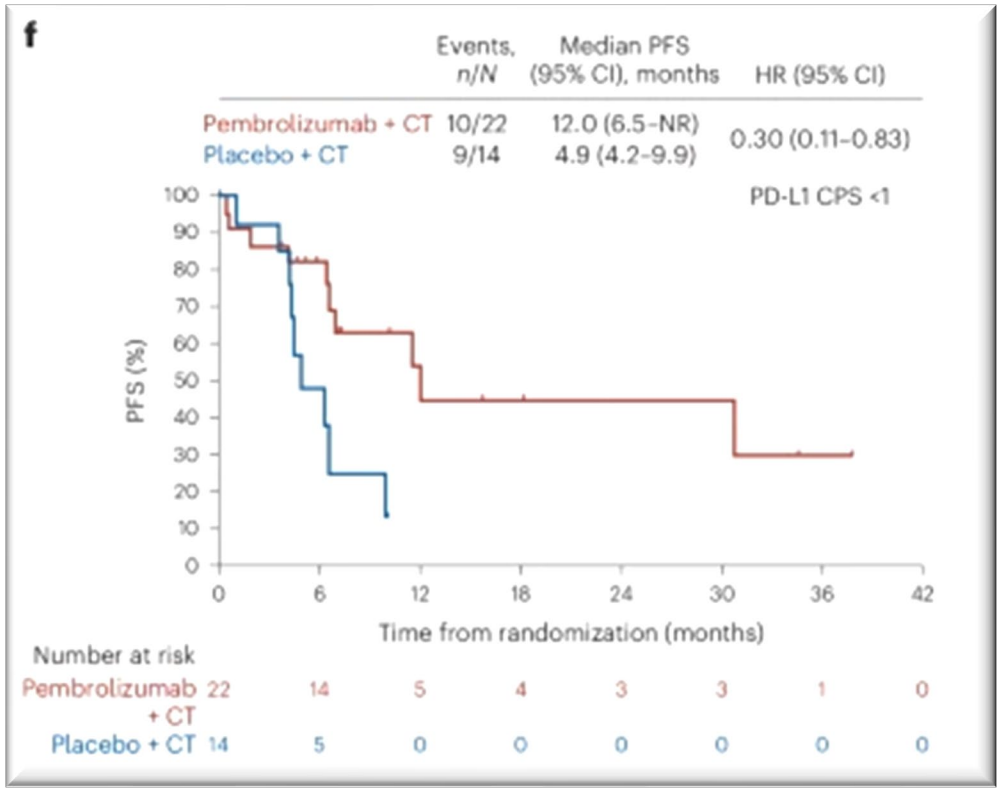
PDL1 Status Specifically in dMMR: No impact on efficacy

NRG GY018

dMMR PD-L1
CPS ≥ 1



dMMR PD-L1
CPS < 1

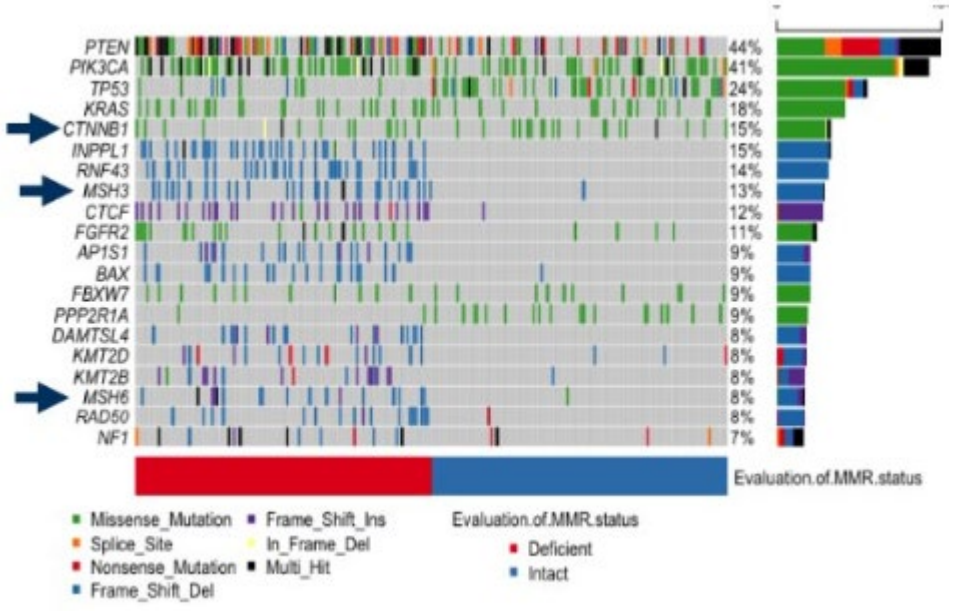


The pMMR population similarly demonstrated no impact on efficacy based on CPS status

Eskander et al. Nature Medicine (2025)

What have we learned in 2025? CTNNB1 as a neg prognostic marker in dMMR

AtTEnd



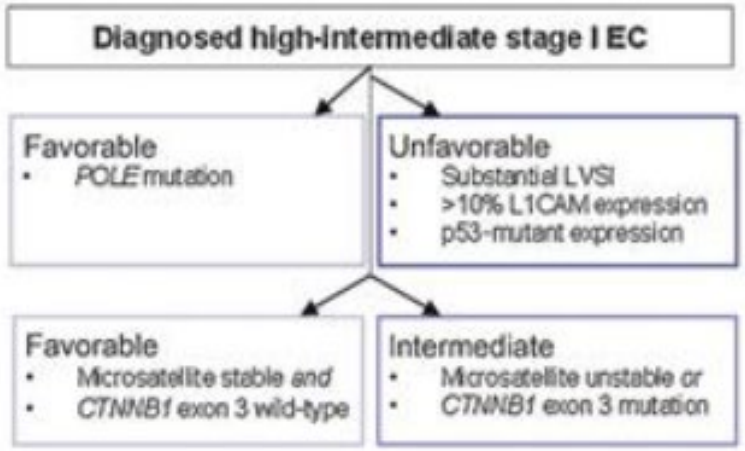
CTNNB1 and/or APC mutations (WNT pathway)

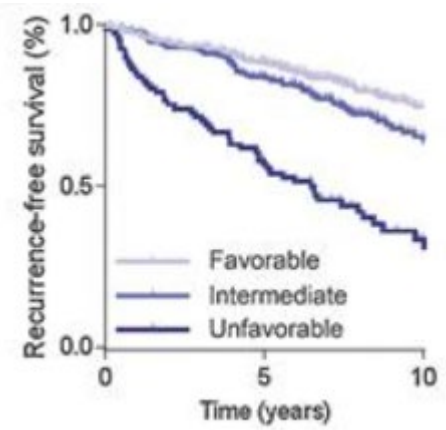
23 out of 110 (20.9%) MMRd tumors

HR for PFS [Mut vs WT] **1.91**
95% CI 1.10-3.33, p=0.0201

Mazzarella L et al. ESMO 2025. Abstract LBA40.

PORTEC Combined Analysis (2016)



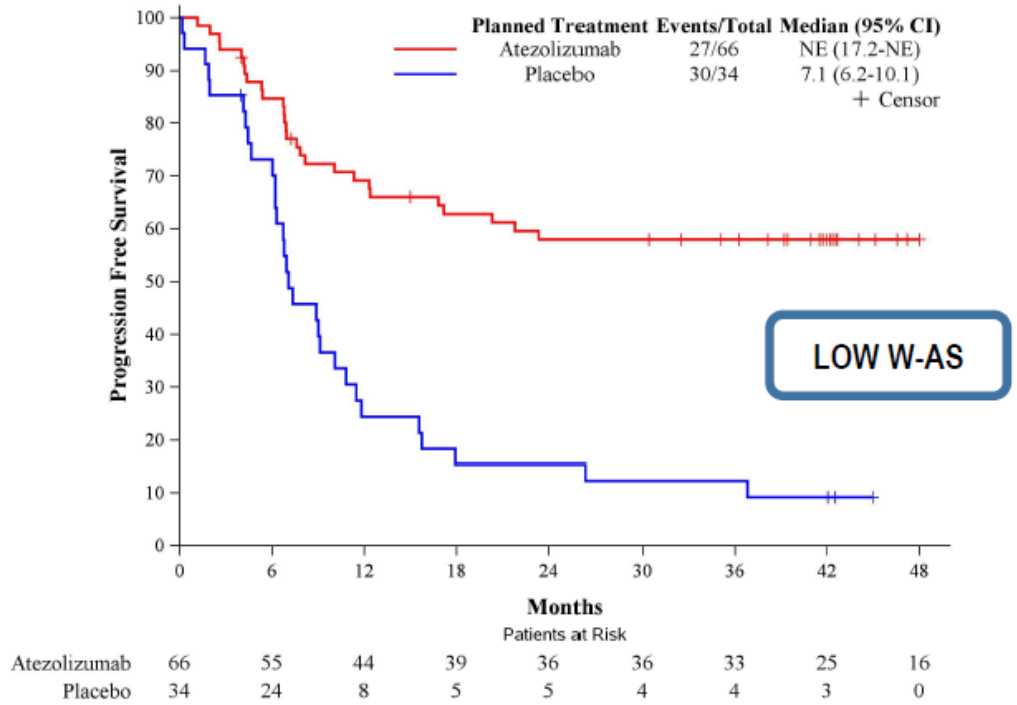


This isn't really new: CTNNB1 exon 3 mutations were identified among NSMP tumors as negatively prognostic and included in PORTEC4a

Stelloo E et al. CCR 2016

Does High Aneuploidy Identify dMMR tumors at risk for early progression?

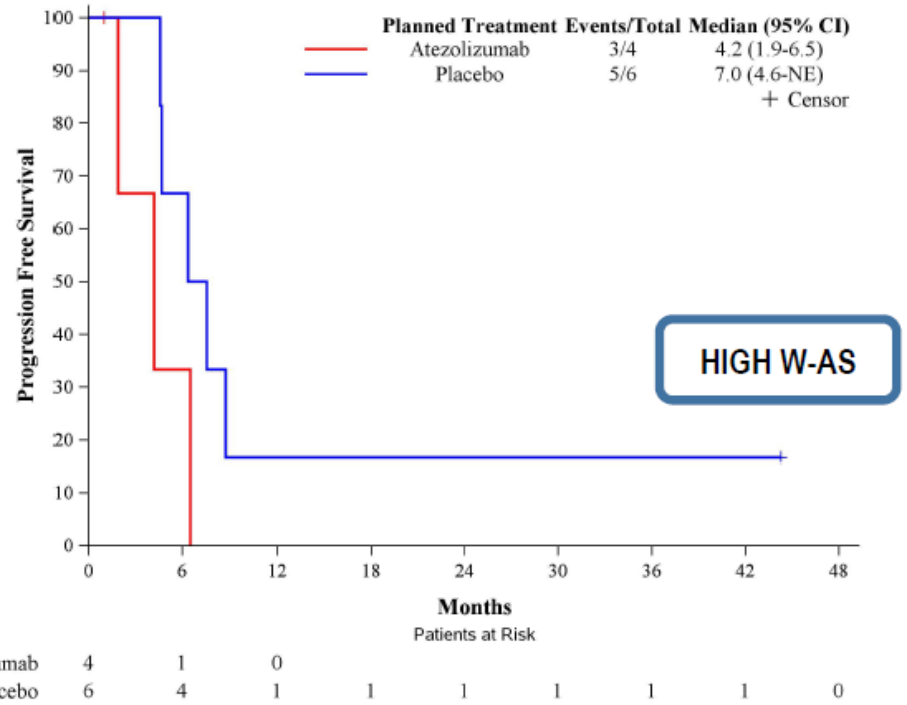
WES High Aneuploidy Score (9% of dMMR) was prognostic and negatively predictive of benefit from Atezo



LOW W-AS

Logrank test p-value<0.0001

HR 0.28 95%CI 0.16-0.47



HIGH W-AS

Interaction test, p-value= 0.0016

Logrank test p-value=0.1006

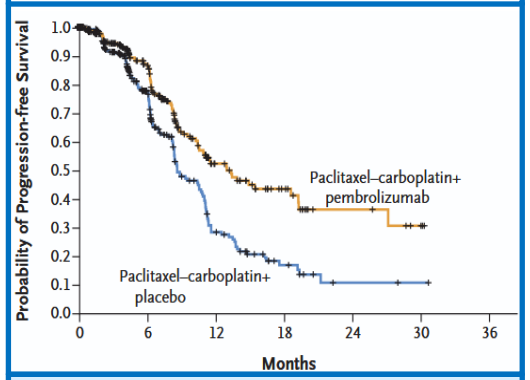
HR 3.60 95%CI 0.71-18.29

Mazzarella L et al. ESMO 2025. Abstract LBA40.

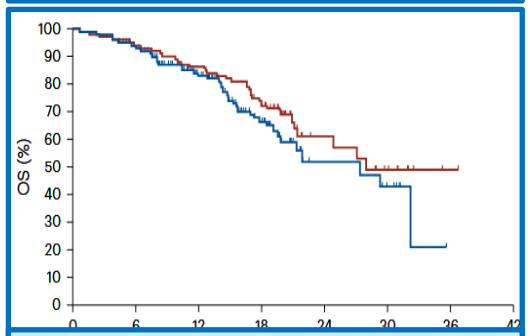
ICI + chemotherapy with some PFS benefit and no OS in pMMR EC: Can we tell who benefits?

NRG-GY018[1]

Pembrolizumab



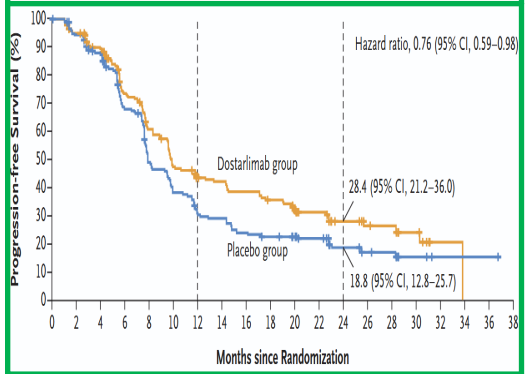
HR 0.54
95% CI 0.41-0.71



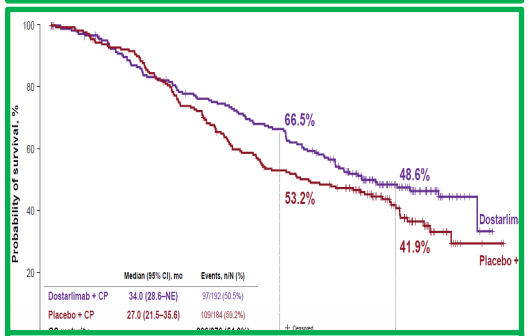
HR 0.79
95% CI 0.53-1.17

RUBY[2]

Dostarlimab



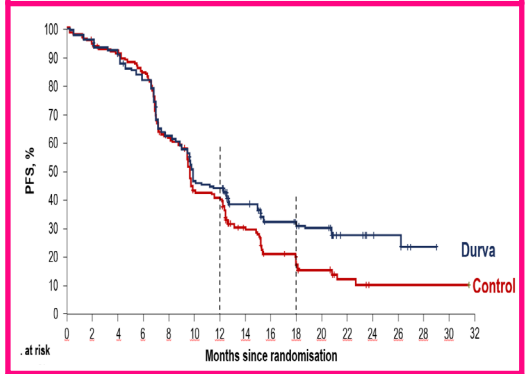
HR 0.76
95% CI 0.59-0.98



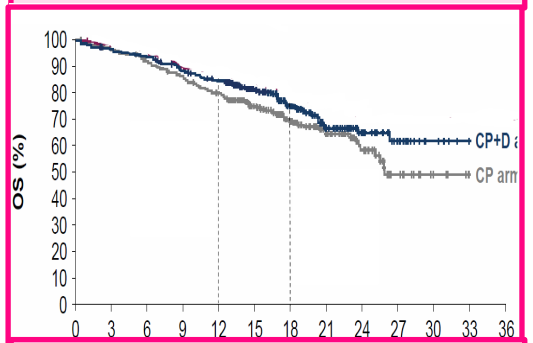
HR 0.79
95% CI 0.60-1.04

DUO-E[3]

Durvalumab



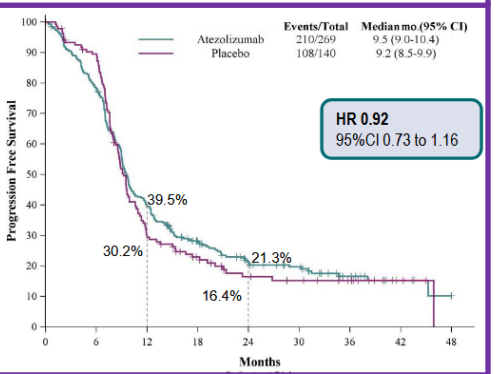
HR 0.77
95% CI 0.60-0.97



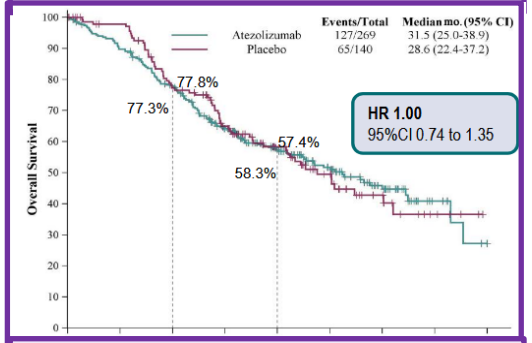
HR 0.77
95% CI 0.56-1.07

AtTEnd[4]

Atezolizumab



HR 0.92
95% CI 0.73-1.16



HR 1.00
95% CI 0.74-1.35

Eskander RN, et al. NEJM. 2023 Jun 8;388(23):2159-70; Mirza MR, et al. NEJM. 2023 Jun 8;388(23):2145-58; Westin SN, et al. J Clin Oncol. 2024 Jan 20;42(3):283-299; Colombo N, et al. Lancet Oncol. 2024 Sep;25(9):1135-1146.

DUO-E: Impact of TMB Status on Benefit from Durvalumab +/- Olaparib

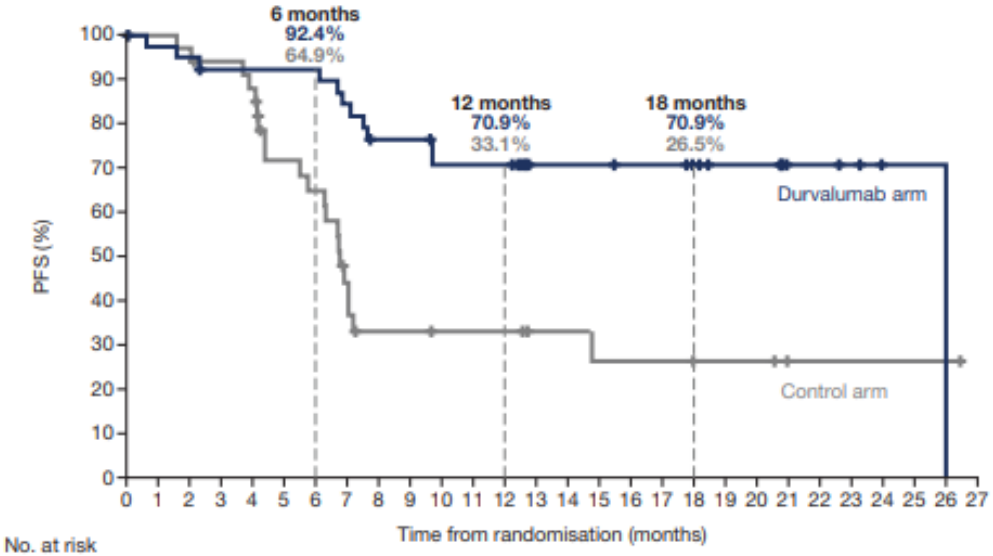
Olaparib did not appear to add anything to durvalumab among a TMB-H subpopulation
The dMMR/TMB-L subpopulation was too small to study

TMB-H
dMMR
TMB and MMR concordance

Subpopulation, n (%)	dMMR	pMMR	
TMB-H	92 (19.2%)	32 (6.7%)	124/479 (25.9%)
TMB-L	14 (2.9%)	341 (71.2%)	
	106/479 (22.1%)		433/479 (90.4%)

Concordance between TMB and MMR status: 90.4% (95% CI, 87.4–92.7)
Positive concordance between TMB-H and dMMR status: 86.8% (95% CI, 79.0–92.0)

- 13% of dMMR tumors were TMB low
- 10% of dMMR tumors were not MSI-H
- 8.6% of pMMR tumors were TMB high



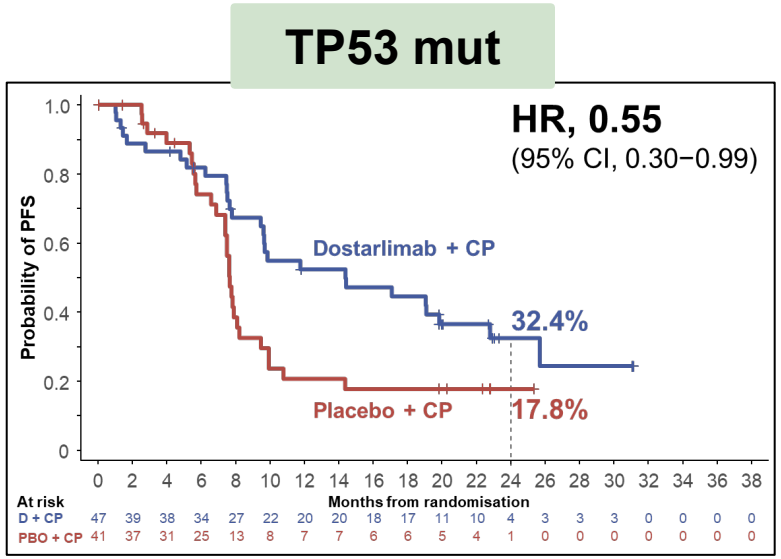
	Control arm (N=36)	Durvalumab arm (N=43)
Events, n (%)	21 (58.3)	12 (27.9)
Median PFS (95% CI), months	**6.8** (5.5–14.8)	**26.0** (NR–NR)
HR (95% CI) versus control	**0.30** (0.14–0.60)	

Eskander et al. Nature Medicine (2025)

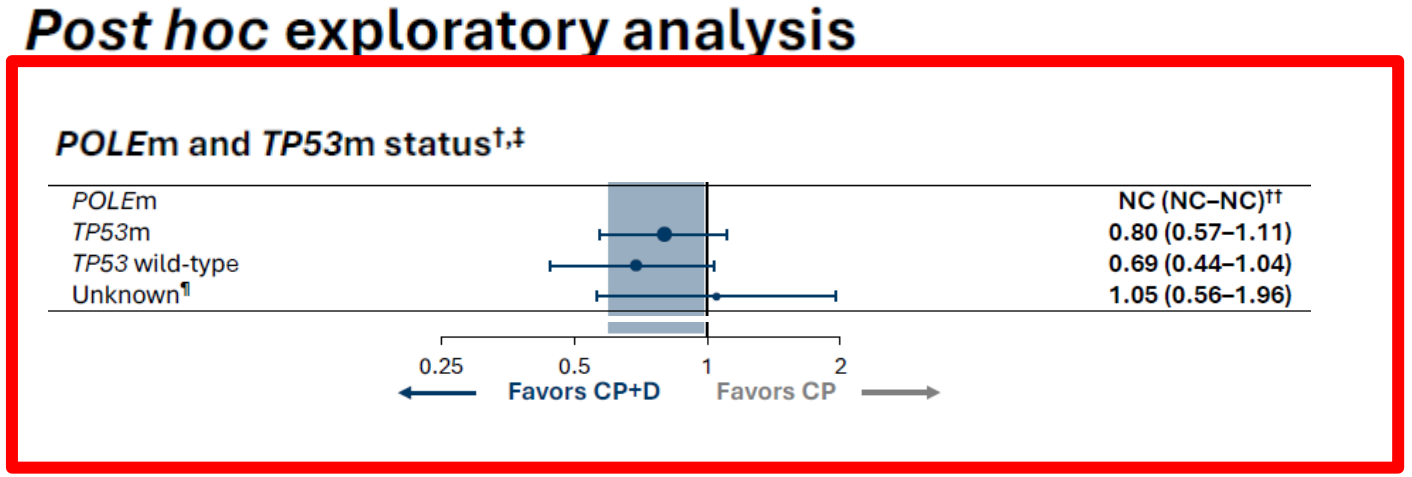
Westin SN et al. ESMO 2025 Abstract 1117P.

Can molecular subtype identify tumors who will benefit from ICI? Post hoc analysis from 2 studies are not consistent for *TP53*

RUBY



DUO-E



Mirza MR, et al. Annals of Oncology. 2023 Oct 1;34:S507.

Moore K, et al. Presented at: 2025 SGO

dMMR : Additional Biomarkers Under Evaluation to Further Characterize Tumors and Guide Treatment

Study	dMMR	Methylation	PD-L1	Other
NRG GY018	**PFS: HR 0.30 95% CI 0.18-0.48; p < 0.001** OS: HR 0.55 (95% CI 0.25-1.19 p=0.0617)	PFS: HR 0.30 (0.18-0.50) vs HR 0.17 (0.04-0.79) for unmethylated	**CPS ≥ or < 1** dMMR/CPS ≥ 1 HR 0.27 (0.16-0.47) dMMR/CPS < 1 HR 0.30 (0.11-0.83)	
RUBY	**PFS: HR 0.28 (95% CI 0.16-0.50; p<0.0001)** OS: HR 032 (95% CI 0.17-0.63)	No HR given but KM curves look consistent		
DUO-E	PFS Durva: HR 0.42 (95% CI 0.22-0.80) Durva/O HR 0.41 (95% CI 0.21-0.75) HR for Durva/O vs Durva 0.97 OS: not mature		TAP ≥1% Durva: HR 0.63 (95% CI 0.48-0.82) TAP < 1% HR 0.89 (95% CI 0.59-1.34) TAP ≥1% Durva/O HR 0.42 (95% CI 0.31-0.57) TAP< 1% HR 0.80 (95%CI 0.55-1.16)	HRR Durva: HR 0.57 (95% CI 0.27- 1.13) Non HRR HR 0.72 (95% CI 0.54-0.97) Durva/O HRR: HR 0.30 (95% CI 0.15-0.58) HR 0.59 (95% CI 0.44-0.8)
ATTEND	**PFS:** **HR 0.36 (95% CI 0.23-0.57; p=0.0005)** OS: HR 0.41 (95% CI 0.22- 0.76)		IC (tumor infiltrating immune cells) Positive: HR = 0.39 Negative HR = 0.34	dMMR CTNNB1 and/or APC mut (21% dMMR) HR 1.91 (95% CI 1.1-3.33) High Aneuploid Score (9% dMMR) HR 3.6 (95% CI 0.71-18.29)

47

Eskander RN et al. Nature Medicine 31 (2025): Eskander NEJM (2023); Powell MA et al. Gynecol Oncol (2025); Westin SN J Clin Oncol (2024); Mazzarella L et al. ESMO (2025)

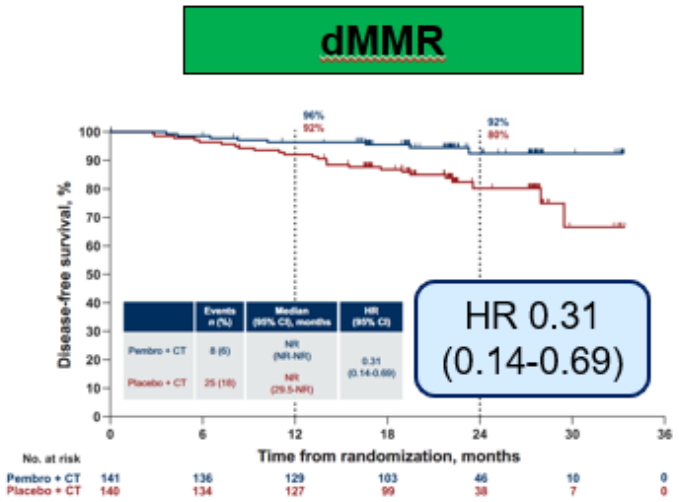
pMMR : Additional Biomarkers Under Evaluation to Further Characterize Tumors and Guide Treatment

Study	pMMR	PD-L1	*TP53*	Other
NRG GY018	**PFS:** **HR 0.54 (95% CI 0.41-0.71; p< 0.001)** OS: HR 0.79 (95% CI 0.53-1.17; p=0.1157)	CPS ≥ or < 1 pMMR/ CPS ≥ 1 HR 0.59 (0.43-0.80) pMMR/CPS < 1 HR 0.44 (0.26-0.75)		
RUBY	PFS: HR 0.76 (95% CI 0.59-0.98) OS: HR 0.73 (95% CI 0.52- 1.02)		pMMR HR 0.55 (95% CI .30 - .99)	
DUO-E	PFS Durva: HR 0.77 (95% CI 0.60-0.97) Durva/O HR 0.57 (0.44-0.73) HR for Durva/O vs Durva 0.76 (95% CI 0.59-0.99)	TAP ≥1% Durva: HR 0.63 (95% CI 0.48-0.82) TAP < 1% HR 0.89 (95% CI 0.59-1.34) TAP ≥1% Durva/O HR 0.42 (95% CI 0.31-0.57) TAP< 1% HR 0.80 (95%CI 0.55-1.16)	pMMR Durva: HR 0.80 (95% CI 0.57-1.11) Durva/O: HR 0.47 (0.32-0.67)	HRR Durva: HR 0.57 (95% CI 0.27- 1.13) Non HRR HR 0.72 (95% CI 0.54-0.97) Durva/O HRR: HR 0.30 (95% CI 0.15-0.58) HR 0.59 (95% CI 0.44-0.8)
ATTEND	PFS: HR 0.92 (95% CI 0.73-1.16) OS: HR 1.0	IC (tumor infiltrating immune cells) Positive: HR = 0.39 Negative HR = 0.34		

Eskander RN et al. Nature Medicine 31 (2025): Eskander NEJM (2023); Powell MA et al. Gynecol Oncol (2025); Westin SN J Clin Oncol (2024); Mazzarella L et al. ESMO (2025)

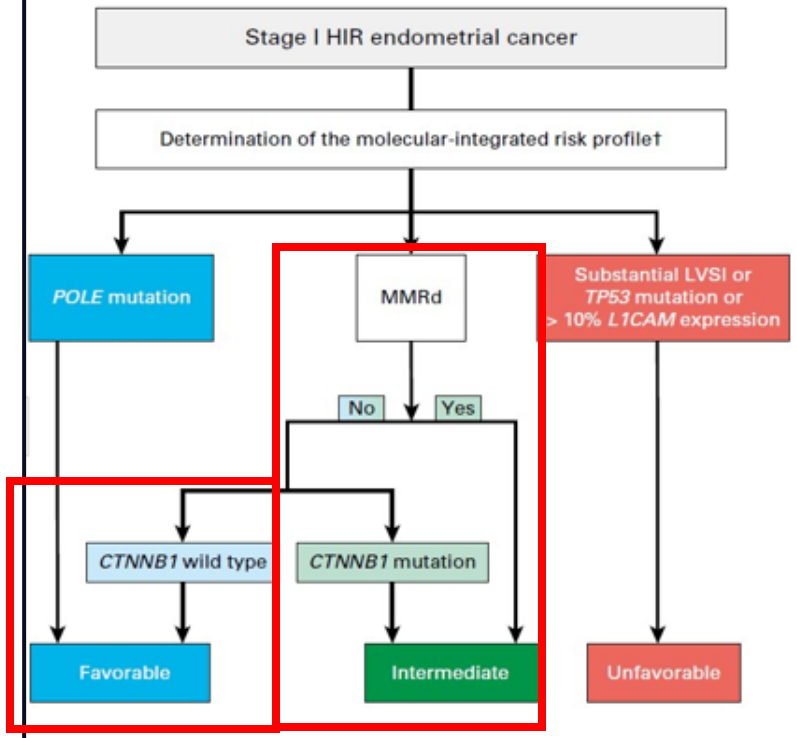
Are we ready to start using molecular profile +/- additional biomarkers to individualize therapy? We already are….

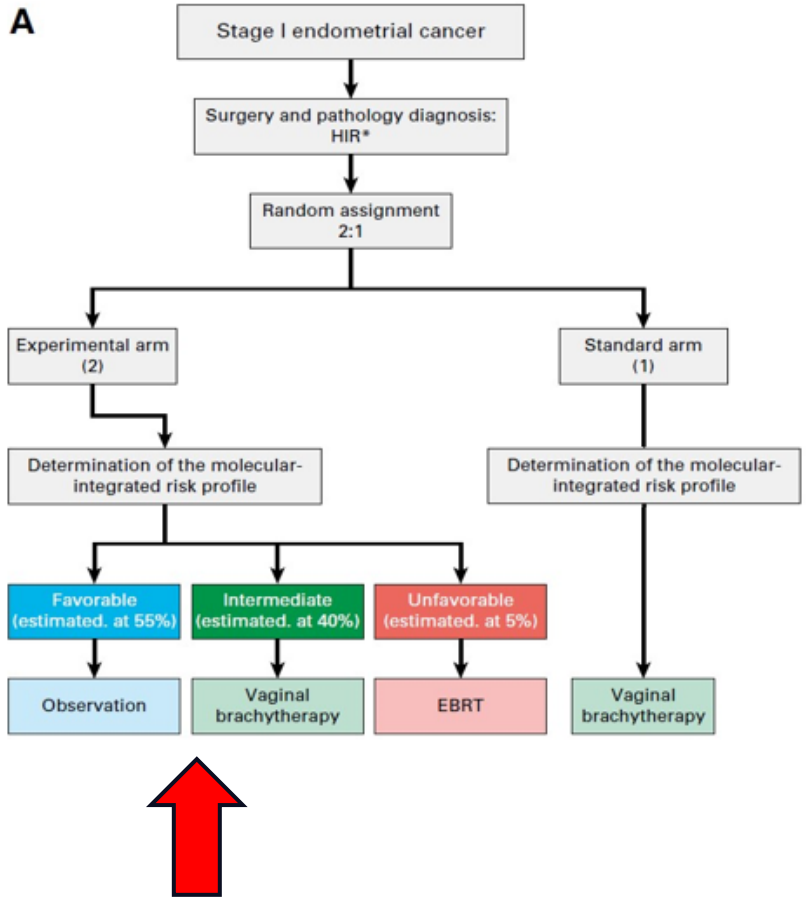
Adjuvant High Risk:
B21 dMMR



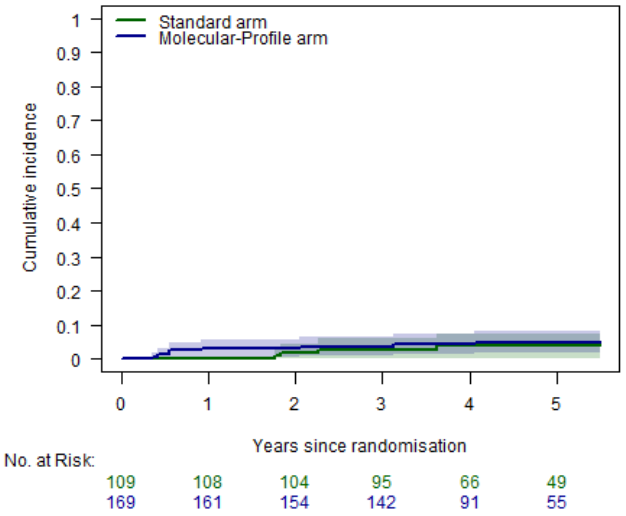
Slomovitz et al. 2025

Adjuvant HIR Stage I:
PORTEC-4a

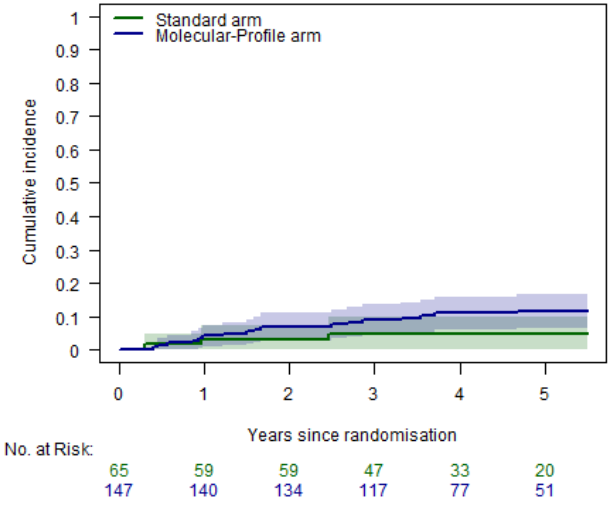




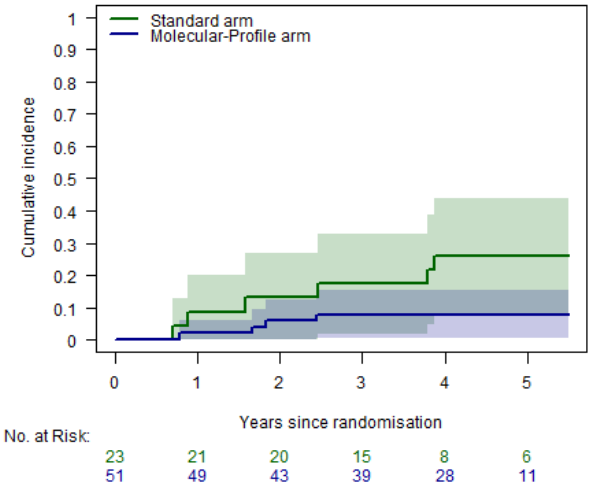
PORTEC 4a suggests that tailoring adjuvant RT (no ICI) based on molecular profile is non-inferior to SOC VCB



Favorable profile



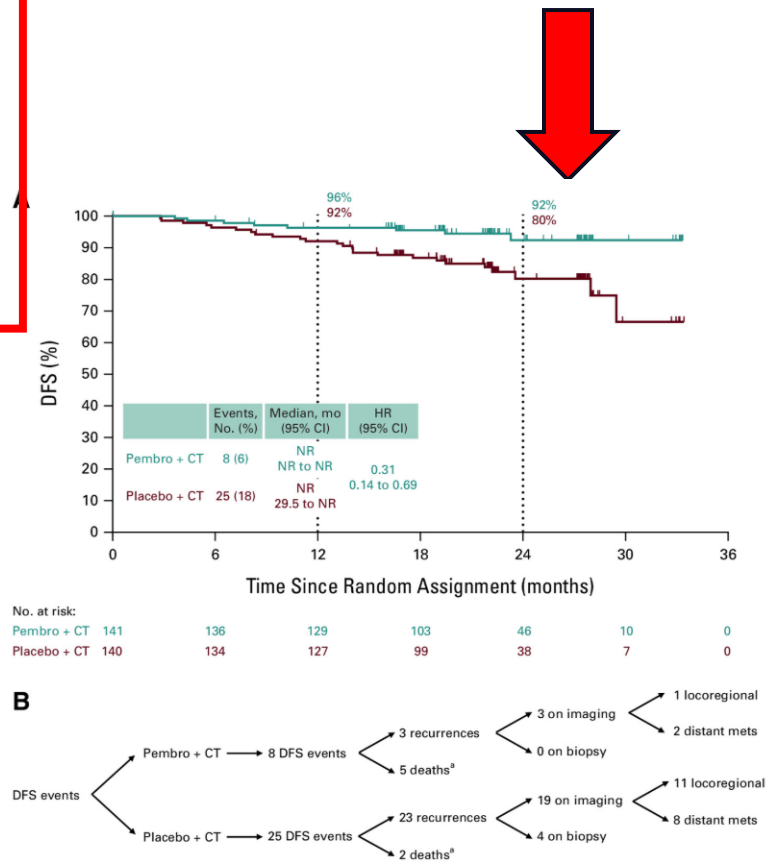
Intermediate profile



Unfavorable profile

But is this too, true and irrelevant?

Local regional recurrence in the intermediate profile (dMMR) group was 13% with VCB.
Remember these are all clinical stage I tumors (only 25% had LND)



dMMR from b21:
75% Stage III (n=140 in ICI group) with 1 local-regional recurrence

HIR-randomization

SIGNAL- EMC 101

888 Assay Designs
888 CGP Test *

888 pts

Stage I HIR

Powered to 85% DFS

ctDNA genome
4 wks +/- 2 wks post-op
+ CGP Test

710 pts

ctDNA -

R 1:1

355 pts

VBT

Surveillance

Q3 months until 24 months

355 pts

Observation

8 weeks
+/- 2 wks

12 weeks
+/- 2 wks

Physician notified if conversion to positive within 12 weeks

ctDNA +

TPC

Surveillance/ Maintenance

Q3 months until 24 months

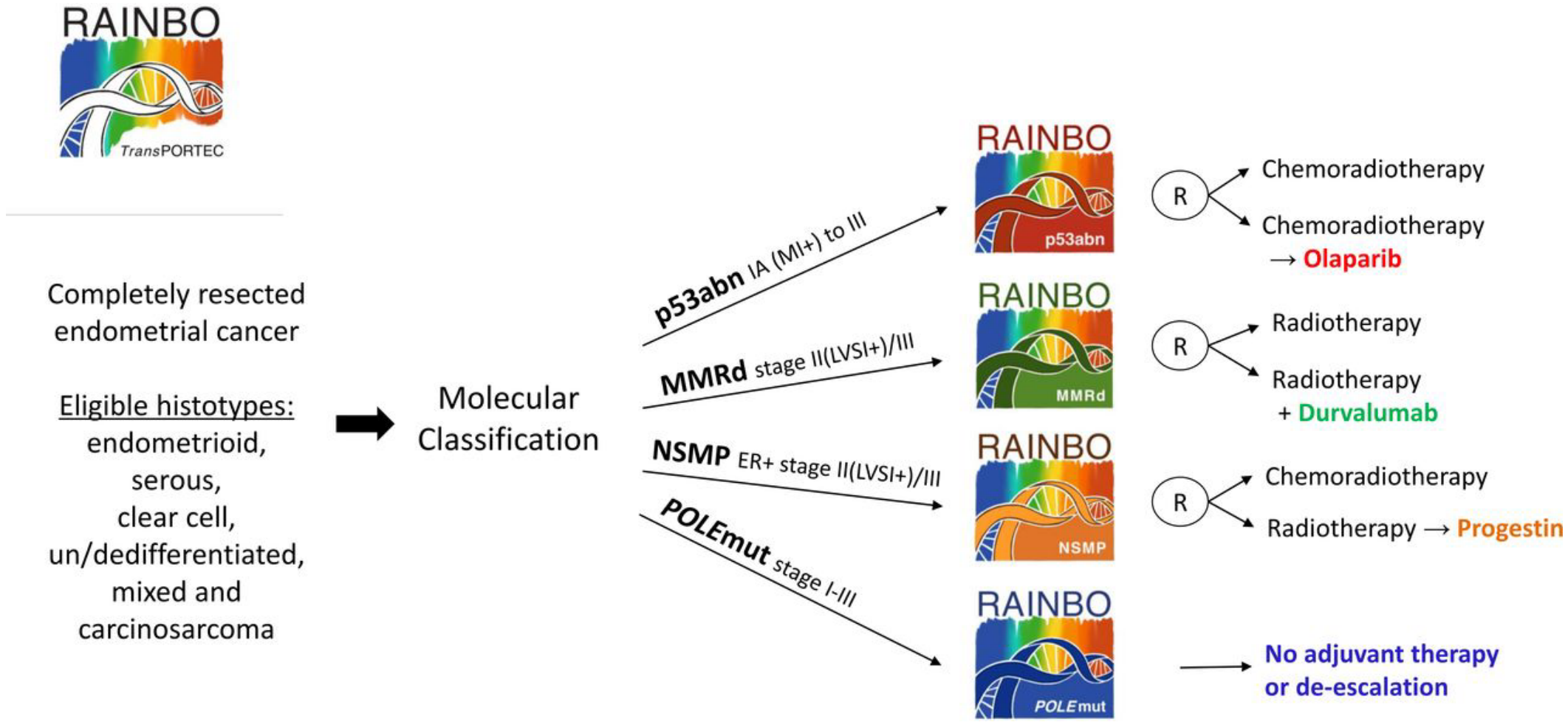
ctDNA + arm will be capped at 100 pts for serial monitoring

Will utilize an adaptive design allowing interim analysis to determine effect size and move towards pivotal trial.

*Comprehensive Genomic Profiling

NCT07339384

How do we “prove” what is the best adjuvant therapy and whether adjuvant therapy is needed at all?



RAINBO Research Consortium Int J Gynecol Cancer 2022;ijgc-2022-004039

Panel Discussion and Audience Q&A

GOG Highlight Reel

ADC Mania, Navigating the Wave of ADCs in Endometrial Cancer

Brian Slomovitz, MD
Mount Sinai Medical Center
Miami Beach, Florida

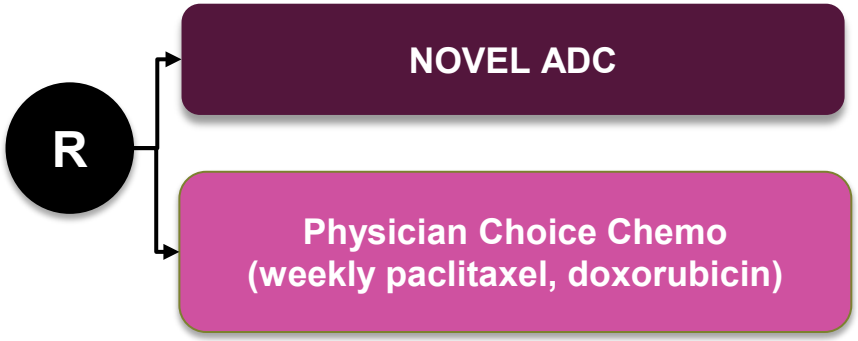
Key Data on ADCs in Endometrial Cancer

Agent (Trial)	Sacituzumab govitecan (TROPiCS-03)[1] (Phase 2) (NCT03964727)	T-DXd (DESTINY-PanTumor02)[2] (Phase 2) (NCT04482309)	RINA-S (RAINFOL-O1)[3] (Phase 1/2 dose exp) (NCT05579366)	Sac-TMT (2870-001)[4] (Phase 1/2) (NCT04152499)	Puxitatug samrotecan (BLUESTAR)[5] (Phase 1/2a) (NCT05276548)	R-DXd (REJOICE-PanTumor01)[6] (Phase 2) (NCT06660654)	Trastuzumab pamirtecan (Fern-EC-01)[7] (Phase 3) (NCT06340568)
Pts	Advanced/metastatic EC after platinum-based chemo and PD-L1 therapy	Locally advanced or metastatic EC after ≥1 prior systemic treatment	Advanced/recurrent EC with 1-3 prior LOT (incl. PBC & PD-L1 in advanced setting)	Recurrent or metastatic EC after 1+ LOT (PBC)	Relapsed or metastatic EC	EC with 1-3 prior LOT (incl PBC & PD-L1 in advanced setting)	Recurrent HER2+ EC with 1-3 prior LOT (incl PBC & PD-L1)
Target/ payload	**TROP2/SN-38**	**HER2/TOP1**	**FRa/Exatecan**	**TROP2/belotecan-derived TOP1**	**B7-H4/TOP1**	**CDH6/TOP1**	**HER2/TOP1**
Efficacy	▪ mFU: 5.8 mo ▪ **ORR**: 22% ▪ **CBR**: 32% ▪ **mDOR**: 8.8 mo ▪ **mPFS**: 4.8 mo	▪ mFU: 13.0 mo ▪ **ORR** (all pts/IHC 3+): 58%/85% ▪ **mPFS** (all pts/IHC 3+): 11/28 mo ▪ **mOS** (all pts/IHC 3+): 24/34 mo	▪ mFU (100/120 mg/m^2): 12/14 mo ▪ **ORR** (100/120 mg/m^2): 50%/44% ▪ **DCR** (100/120 mg/m^2): 100%/82%	▪ mFU (4/5 mg/kg): 12 mo/22 mo ▪ **ORR** (all): 32% ▪ **DCR** (all): 75% ▪ **mPFS** (4/5 mg/kg): 6/7 mo ▪ **mOS** (4/5 mg/kg): 14/18 mo	▪ mFU (2/2.4 mg/kg): 4.1/4.0 mo ▪ **ORR** (2/2.4 mg/kg): 35%/39% ▪ **DCR** (2/2.4 mg/kg): 81%/85%	N/A	N/A
Safety	▪ Any TEAE: 98% ▪ Gr3+ TEAEs: 80% ▪ Any TRAE: 93% ▪ Gr3+ TRAEs: 73% ▪ TRAEs leading to discontinuation: 5%	All tumor types ▪ Any AE: 98% ▪ Any TRAE: 85% ▪ Gr3+ TRAEs: 42% ▪ TRAEs leading to discontinuation: 10% ▪ Adj drug-related ILD/ pneumonitis: 12%	▪ Any TEAE: 100% ▪ Gr3+ TEAEs (100/120 mg/m^2): 17%/35% ▪ TEAEs leading to discontinuation: 3%	▪ Any TRAE: 99% ▪ Gr3+ TRAEs: 59% ▪ TRAEs leading to discontinuation: 2%	▪ Serious TRAEs (2/2.4 mg/kg): 40%/34% ▪ TRAEs leading to discontinuation 0%	N/A	N/A

1. Santin AD, et al. J Clin Oncol. 2024;42(29):3421-3429. 2. Makker V, et al. ESMO 2025. Abstract 4136. 3. Cloven N, et al. ESMO 2025. Abstract 6468. 4. Wang K, et al. ESMO 2025. Abstract 4356. 5. Gaillard S, et al. SGO 2025. Abstract 933087. 6. Albiges L, et al. ASCO 2025. Abstract TPS3158. 7. NCT06340568. Accessed Nov 5, 2025; https://clinicaltrials.gov/study/NCT06340568.

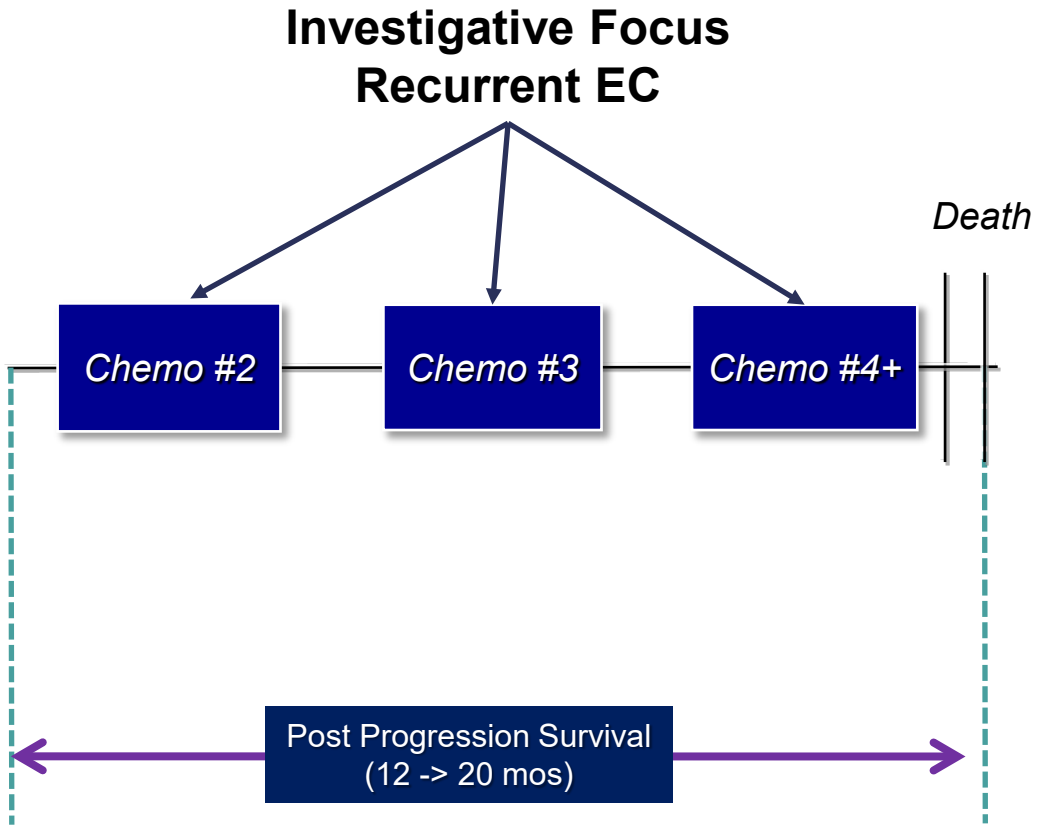
Endometrial Cancer: 2L ADC Development

Common Design for Recurrent EC, Post IO (either 1L or Recurrent) where single agent chemo is SOC



Current Portfolio (so far):

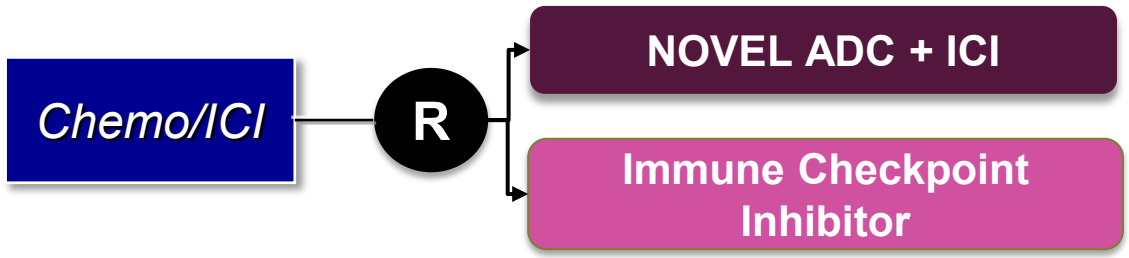
- Sacituzumab Tirumotecan (Topo1i, Trop-2)[1]
- Sacituzumab Govitecan (Topo1i, Trop-2)[2]
- BNT-323 (Topo1i, Her2)[3]
- Trastuzumab Deruxtecan (Topo1i, Her2) (approved)[4]
- Puxitatug Samrotecan (Topo1i, B7H4)[5]
- GSK-5733584 (Topo1i, B7H4)
- Rinatabart Sesutecan (Topo1i, FR-a)
- *More…*



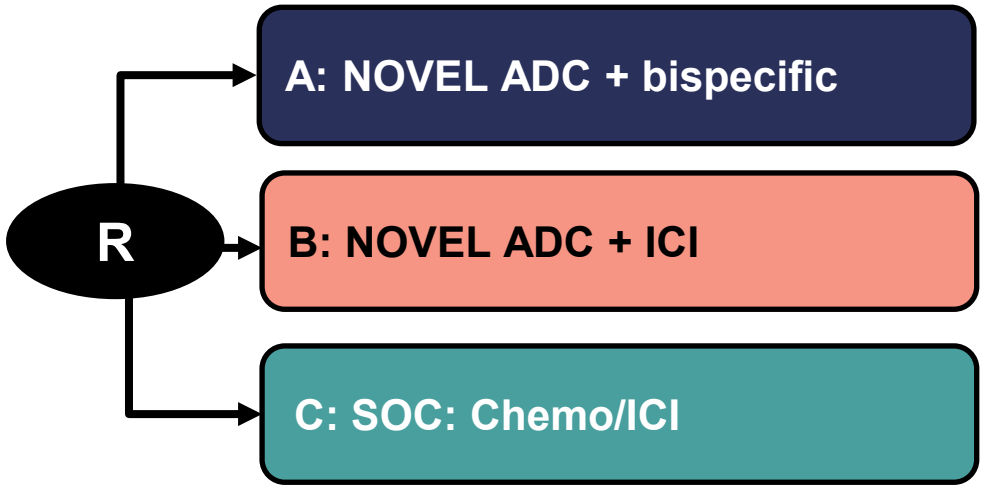
1. MK-2870-001: Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT04152499. 2. Santin AD, et al. J Clin Oncol. 2024;42(29):3421-3429. 3. NCT06340568. Accessed Nov 5, 2025; https://clinicaltrials.gov/study/NCT06340568. 4. Makker V, et al. ESMO 2025. Abstract 4136. 5. Gaillard S, et al. SGO 2025. Abstract 933087. 6. McKean W, et al. Cancer Research. 2025 Apr 25;85(8_Supplement_2):CT188.. 7. Cloven N, et al. ESMO 2025. Abstract 6468.

Endometrial Cancer: 1L ADC Development

Common Design for 1L Maintenance Therapy (pMMR, IO naïve)



Common Design for 1L Therapy (pMMR, IO naïve)



Current Portfolio (so far):

- Trastuzumab deruxtecan (Topo1i, Her2)[1]
- Sacituzumab tirumotecan (Topo1i, Trop2) [2]
- 2 more undisclosed

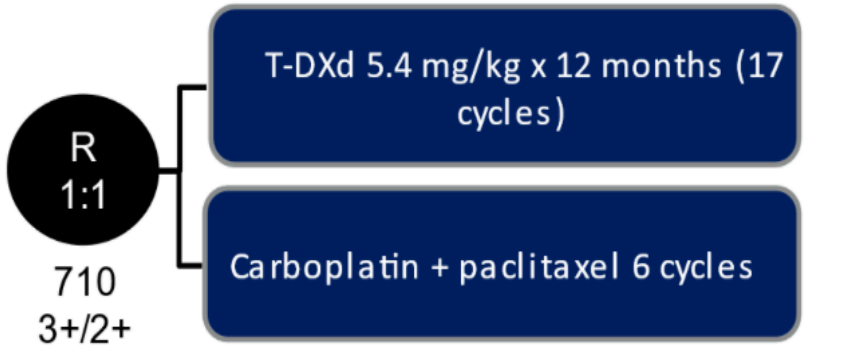
1. DESTINY-PanTumor02: NCT04482309 Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT04482309;
2. MK-2870-001: Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT04152499

GOG-3122: DESTINY-Endometrial-02 Primary Adjuvant

Patient Population

- Histologic diagnosis of endometrial cancer (any histology)
- Stage IICmp53abn or III or IVA or IVB FIGO 2023
- HER2 expression per ASCO CAP gastric guidelines IHC (2+/3+) by central testing. Min of 40% IHC 3+
- Undergone surgery with curative intent. No evidence of disease post surgery.
- No evidence of metastatic disease.
- Randomization within 8 weeks of surgery (or 12w from surgery if EBRT is given before RDZ)
- Treatment naïve (systemic therapy) in any setting including the neoadjuvant setting for endometrial cancer (EC).
- POLE excluded (local testing or central testing).
- EBRT will be allowed before rdz. VCB may be given as per investigator discretion (before or after rdz)

Adjuvant Treatment



Stratification factors
- HER2 IHC 3+ vs 2+
- Stage IICmp53abn vs Stage III vs Stage IV
- RT: RT (any modality) vs no RT

Notes:
- option to include IHC 1+ gated on DP02 data ~Feb2027
- blinding of the study to be considered and further work-up needed
- Further refinement and assessment of feasibility under review

Endpoints

Primary
- DFS ITT (BICR or pathology)

Key Secondary
- OS ITT

Other Secondary
- DFS ITT by investigator
- Distant disease-free survival
- HRQoL
- Safety

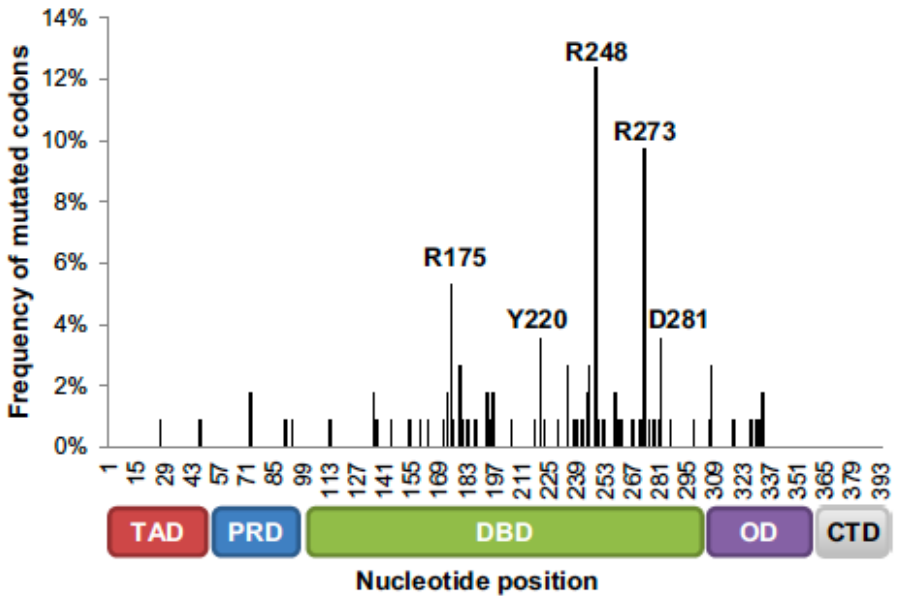
Stats

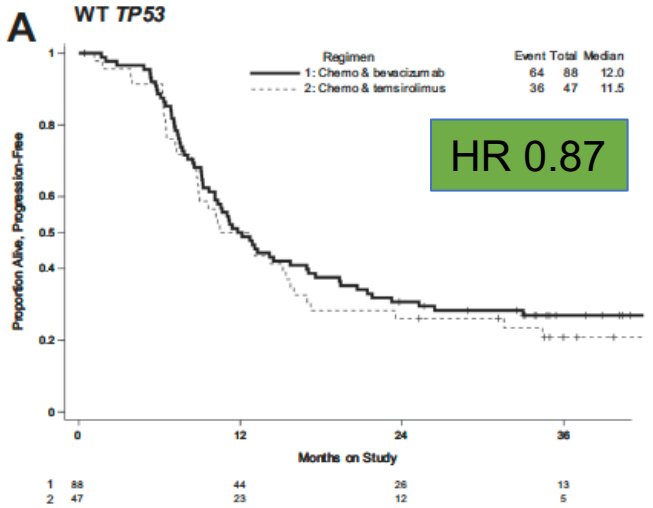
Hypothesis testing on primary endpoint:
- ITT population, 0 - 48m (EOS) , N=710, Events=214
- Effect size: Hazard Ratio=0.66
- 85% power (or >=83% adjusting for IA #1 for futility),
- 1-sided type 1 error rate α=0.02496 (adjusting for IA #2 for efficacy)

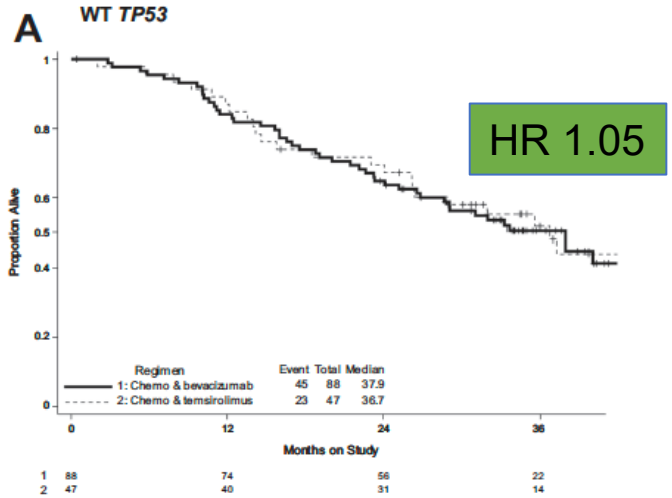
Planned analyses in DFS:
- IA #1 (30%) to assess for futility (no α -spent)
- IA #2 (75%) to assess for efficacy (very small α -spent, 0.00004 1 -sided)
- Primary/EOS analysis (0 -48m)
- Final analysis key secondary endpoint (60m).

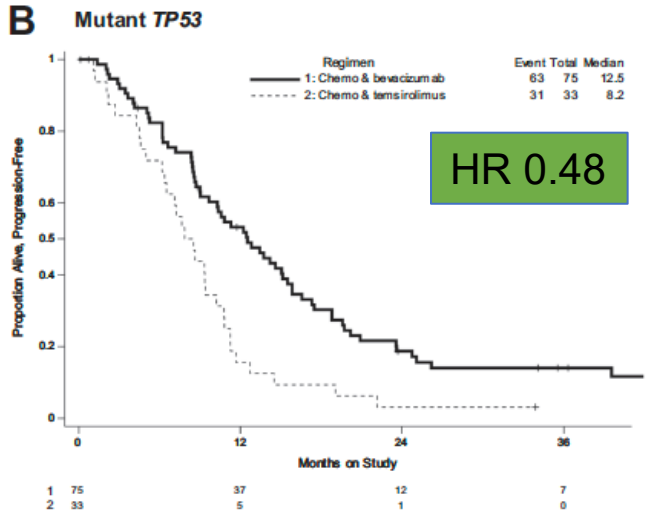
DESTINY-Endometrial-02: Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT07022483

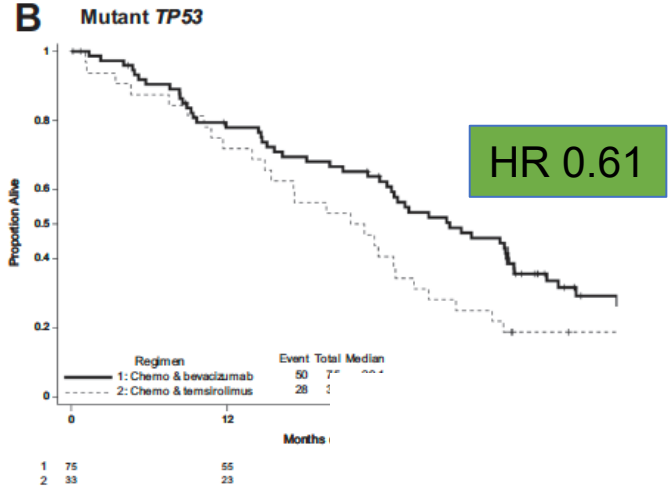
P53 mutation as a “biomarker” for response to Bevacizumab in Endometrial Cancer: Ancillary Investigation of GOG 86P









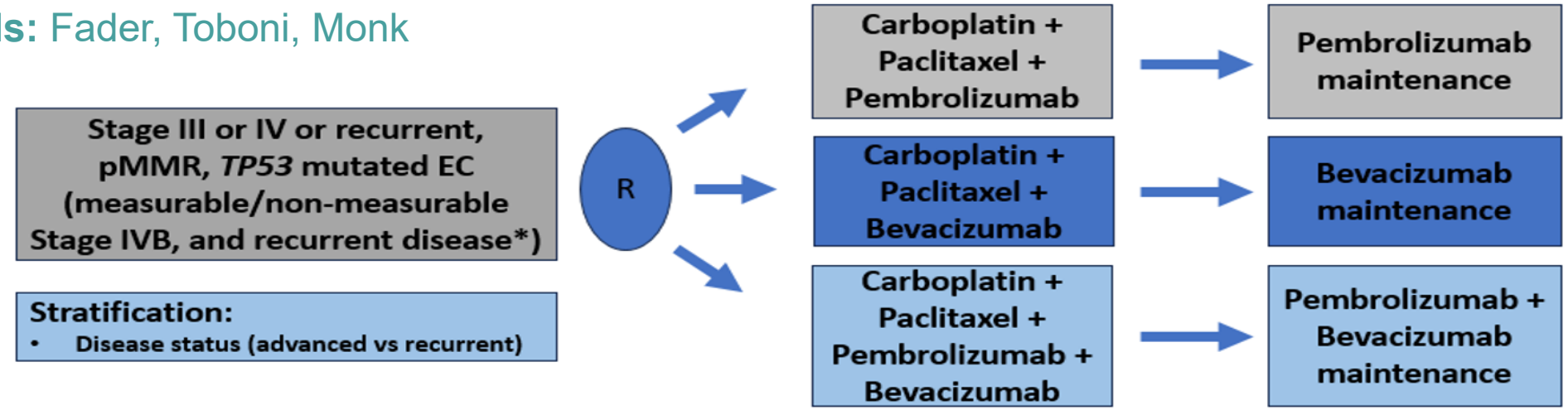


Leslie K. et al. Gyncol Oncol 2021

GY035 (UC2323): Prelim trial design building on results of GY018 & 86P in *TP53* mutated Endometrial cancer patients: approved by CTEP

Randomized Phase II/III Study of Carboplatin + Paclitaxel + Pembrolizumab vs. Carboplatin + Paclitaxel + Bevacizumab vs. Carboplatin + Paclitaxel + Pembrolizumab + Bevacizumab in Patients with Advanced or Recurrent, pMMR and *TP53* mutated Endometrial Cancer

PIs: Fader, Toboni, Monk

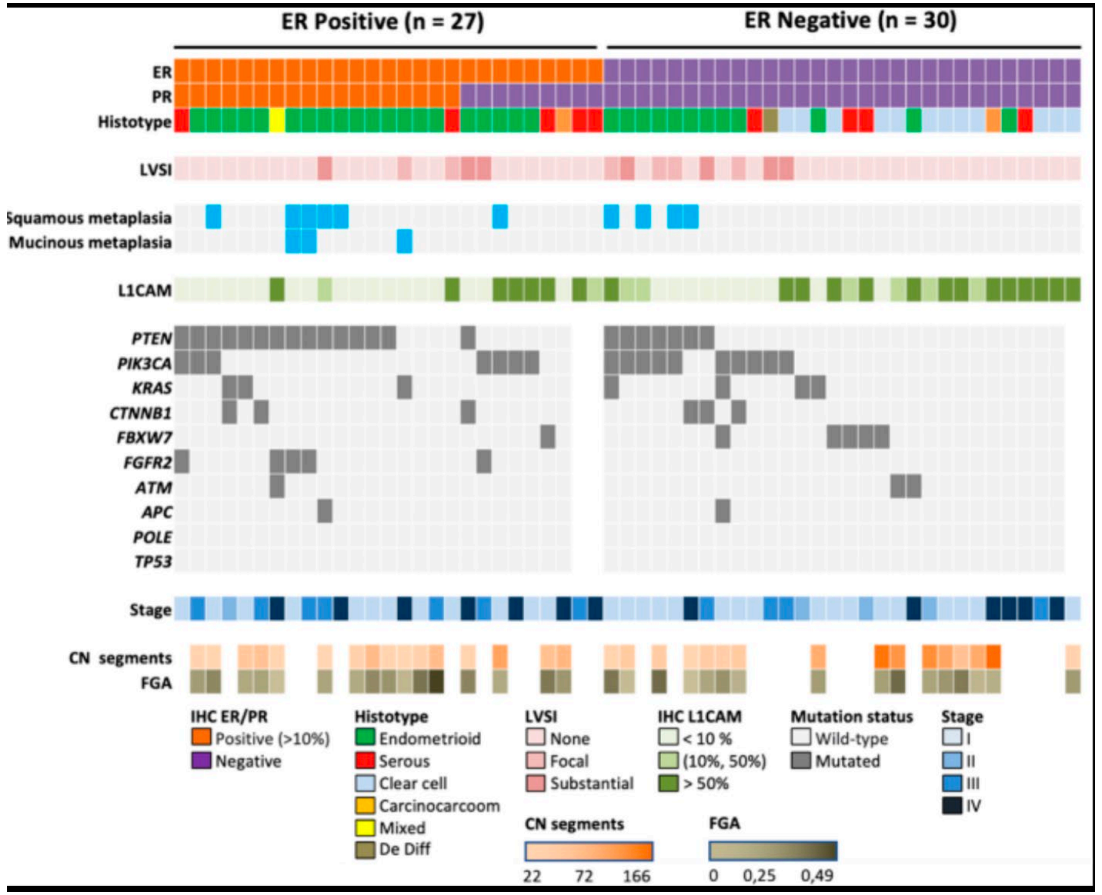


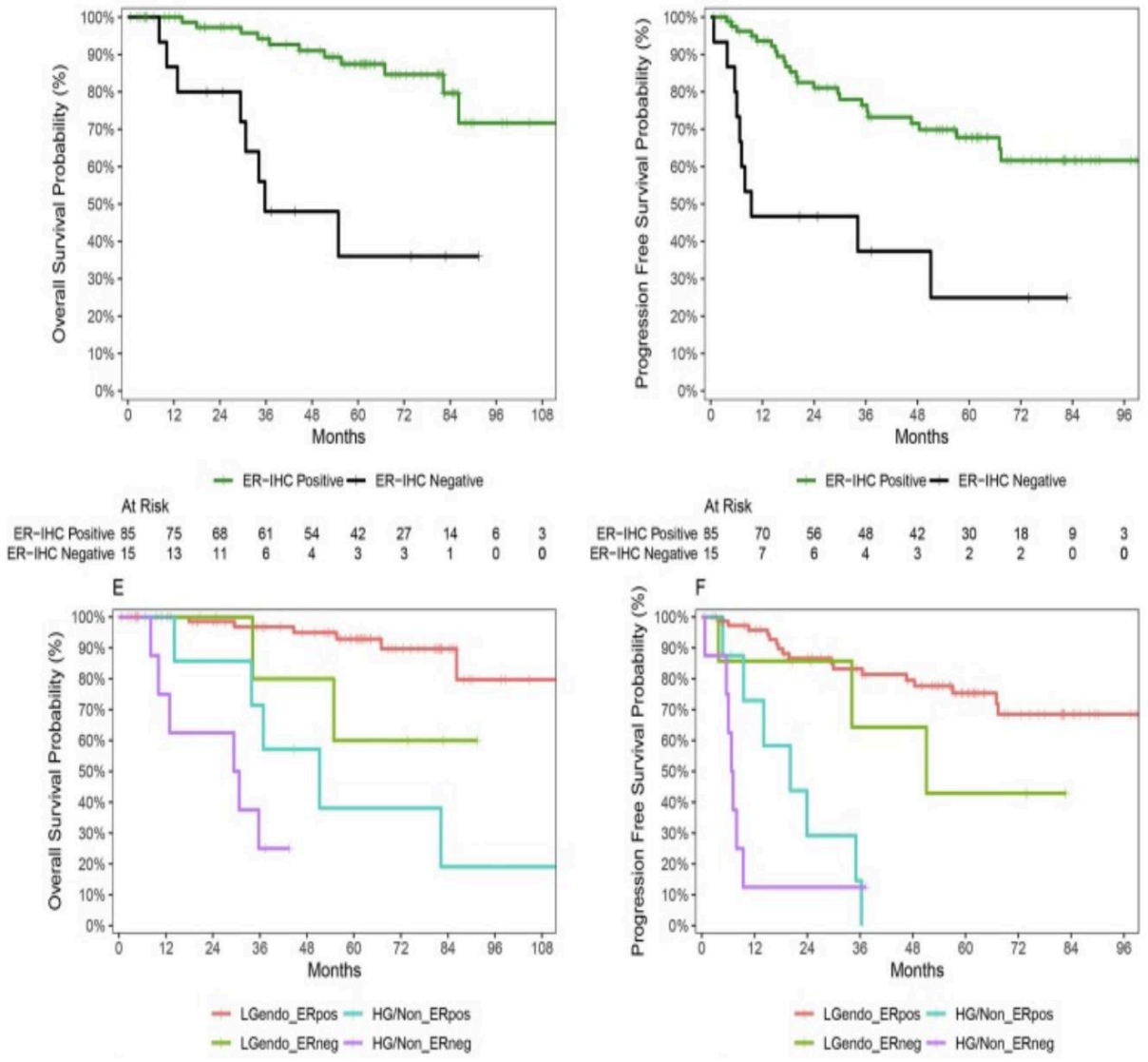
*Primary Phase II endpoint: PFS by RECIST V1.1
*Primary Phase III endpoint: OS

Treatment Plan:
Arm 1: IV carboplatin AUC 5 + IV paclitaxel 175 mg/m^2 + IV pembrolizumab 200 mg on day 1 every 3 weeks x 6-10 cycles followed by 14 additional cycles of pembrolizumab 400 mg IV maintenance every 6 weeks.
Arm 2: IV carboplatin AUC 5 + IV paclitaxel 175 mg/m^2 + bevacizumab 15 mg/kg on day 1 every 3 weeks x 6-10 cycles followed by 28 additional cycles of bevacizumab 15 mg/kg maintenance every 3 weeks.
Arm 3: IV carboplatin AUC 5 + IV paclitaxel 175 mg/m^2 + IV pembrolizumab 200 mg + bevacizumab 15 mg/kg on day 1 every 3 weeks x 6-10 cycles followed by 14 additional cycles of pembrolizumab 400 mg IV maintenance every 6 weeks and 28 additional cycles of bevacizumab 15 mg/kg IV maintenance every 3 weeks.
*Patients with recurrent disease who have received prior adjuvant therapy must have a platinum-free interval of >/=12 months.

1. GY035: NCT07198074 Accessed Jan 14, 2026; https://www.clinicaltrials.gov/study/NCT07198074

NSMP: ER Predicts Outcome

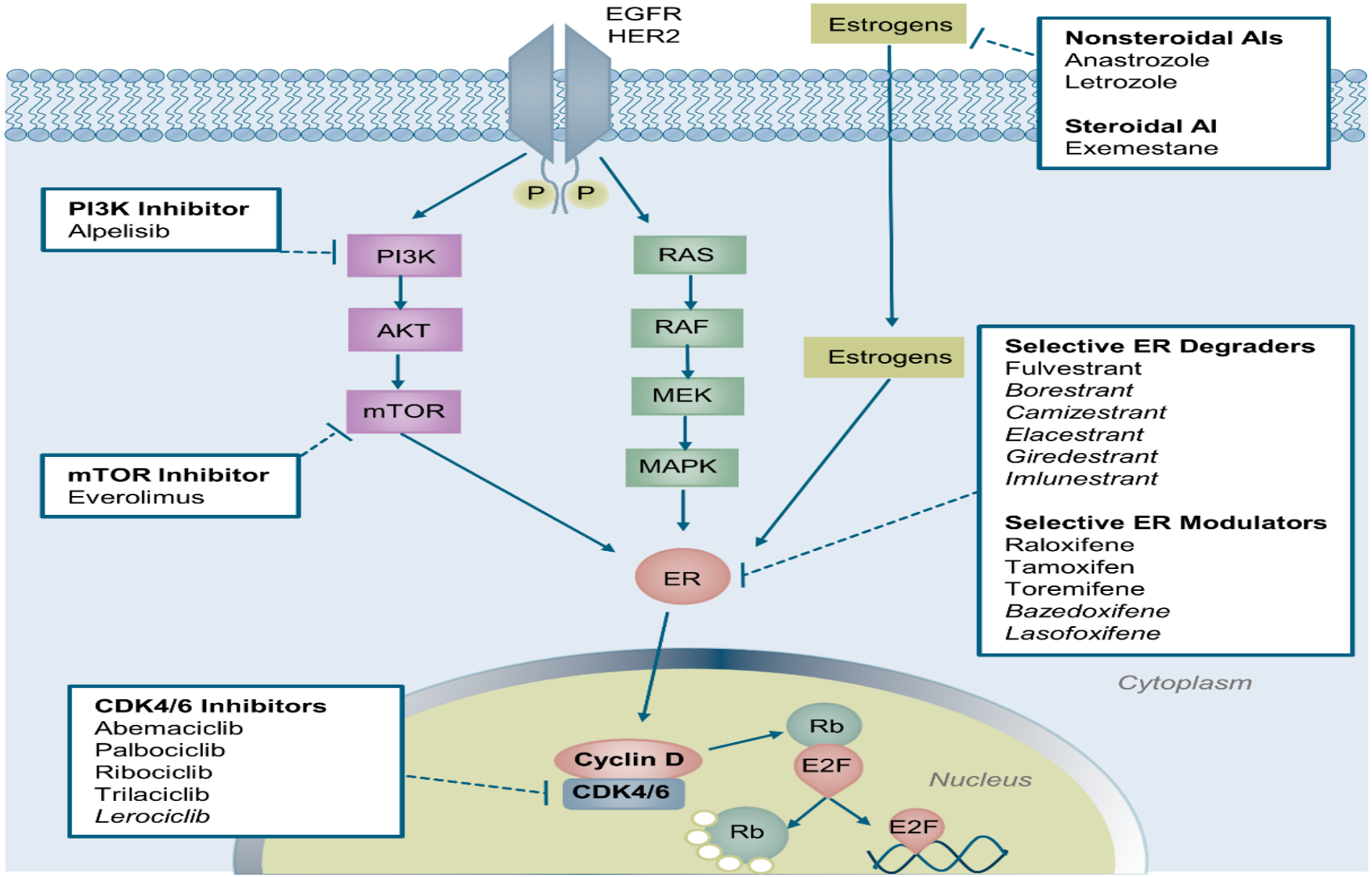




Timmermans PT et al. Int J Gynecol Pathol. 2026

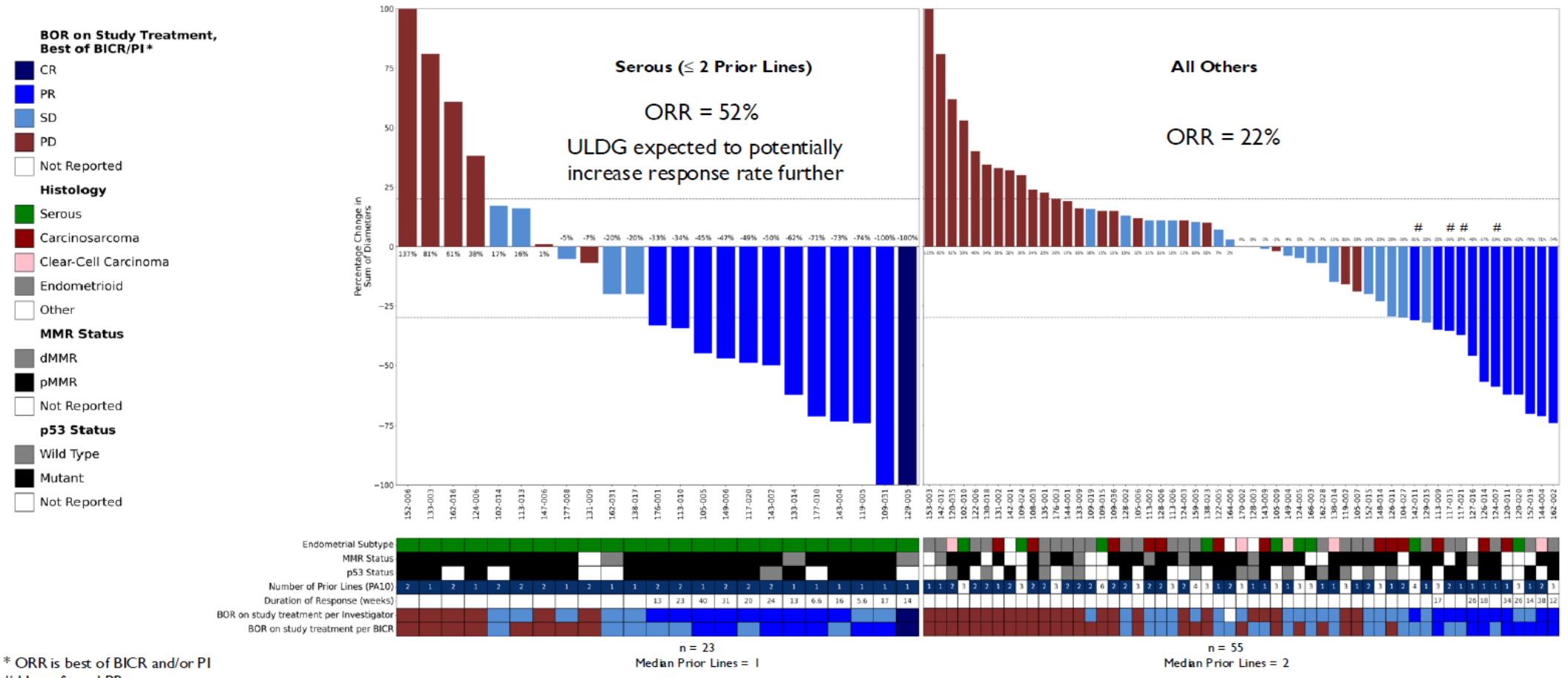
Lam C et al. Gynecol Oncol. 2025.

Combining Endocrine and Targeted Therapies to Overcome Resistance



Ray-Coquard I, et al. International Journal Gynecologic Cancers, 2023

BOR IN *ALL* SEROUS SUBJECTS WITH ≤ 2 PRIOR LINES VS *ALL* OTHER SUBJECTS (BIOMARKER-UNSELECTED)



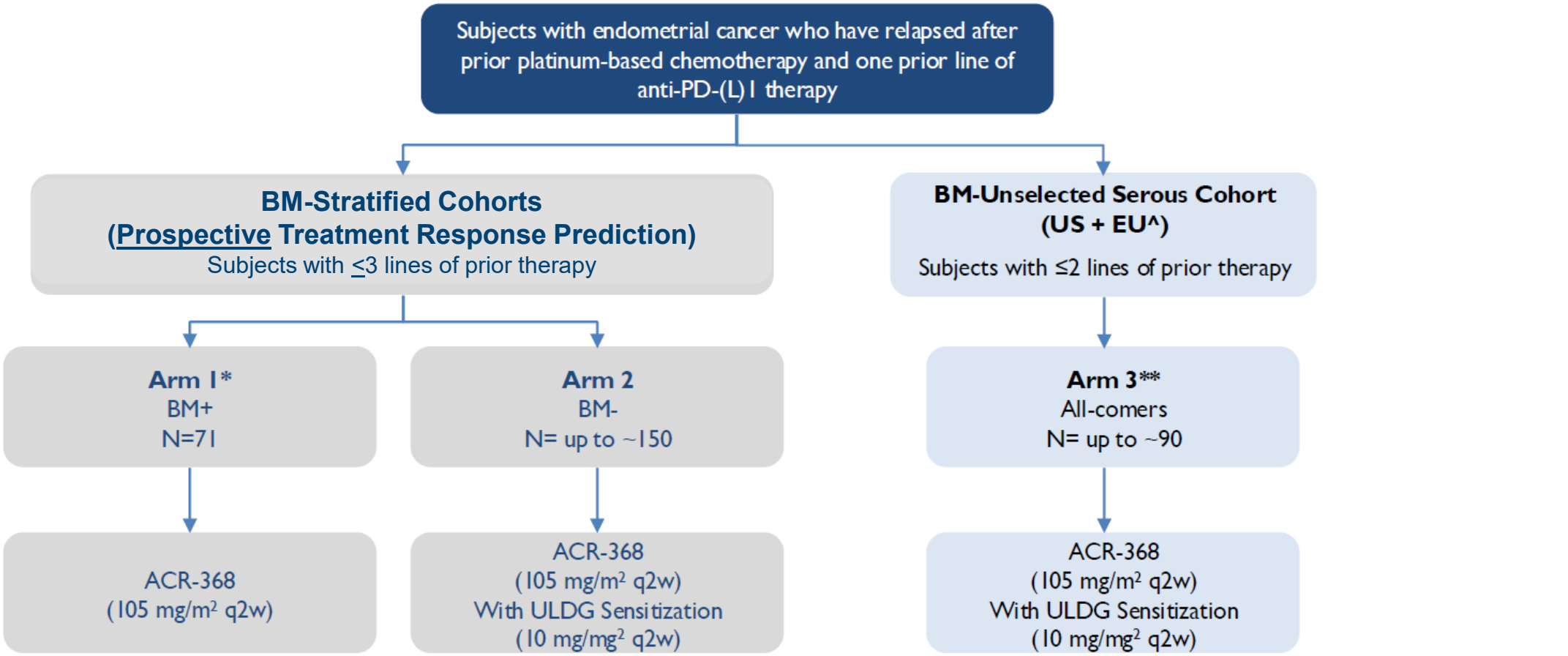
* ORR is best of BICR and/or PI
\# Unconfirmed PR

Non QC'ed data based on EDC data extract as of 12/04/2025 with sponsor verification, and if needed correction, of histopathology/molecular alterations, and BOR in last prior line

GOG-3082 (ACR-368-201)

A PHASE 2 STUDY OF ACR-368 THERAPY IN SUBJECTS WITH ENDOMETRIAL CANCER

PI: Panagiotis A Konstantinopoulos



Registrational intent

***Enrollment completion Q4 2026 (potential early interim validation)*

^ >20 selected sites in 4 major EU countries

NCT05548296

ULDG, Ultra-low dose gemcitabine

Biomarker-Based Therapies Under Development

- GOG-3039: Abemaciclib and Letrozole
- GOG-3069: Apelisib and Ffulvestrant
- GOG-3111: Sapanisertib and Serabelisib (PIKTOR) with Paclitaxel
- EEC201: Nab-Sirolimus and Letrozole
- MK-5684-015/OMAHA-015: CYP 11A1 Inhibitor

1. GOG-3039: NCT04393285 Accessed Jan 14, 2026; https://www.clinicaltrials.gov/study/NCT04393285; 2. Stephanie Gaillard et al. J Clin Oncol, 2024. 42, TPS5639-TPS5639. 3. David Starks et al. J Clin Oncol, 2025 43, TPS5633-TPS5633. 4. Dockery LE, et al. Ann Oncol. 2025;36(suppl 2):S746-S747. 5. MK-5684-015: NCT06979596 Accessed Jan 14, 2026; https://www.clinicaltrials.gov/study/NCT06979596.

Panel Discussion and Audience Q&A

GOG Highlight Reel

Part 3: Cervical Cancer Care: New Regimens and Innovative Treatment Approaches

Bhavana Pothuri, MD, MS

NYU Langone
New York City, New York

Leslie Randall, MD

Inova Schar Cancer Institute
Inova Health
Fairfax, Virginia

Cervical Cancer Highlights and Emerging Treatment Strategies

Leslie Randall, MD
Inova Schar Cancer Institute, Inova Health
Fairfax, Virginia

State of Science in Locally Advanced Cervical Cancer

Trial/Citation	Approach	N	PFS HR (95% CI)	OS HR (95% CI)
CALLA[1] (NCT03830866)	CRT-durvalumab with maintenance	770	0.84 (0.65-1.08) p=0.17	Not reported
KEYNOTE A18[2] (NCT04221945)	CRT-pembrolizumab with maintenance	1060	0.68 (0.56-0.84)	0.67 (0.50-0.90) p=0.0040
INTERLACE[3] (NCT01566240)	Induction cis/paclitaxel to CRT	500	0.65 (0.46-0.91) p=0.013	0.60 (0.40-0.91) p=0.015

1. Monk et al. Lancet Oncol. 2023;24(12):1334-48; 2. Lorusso et al. Lancet. 2024 Oct 5; 404 (10460):1321-1332. 3. McCormack Lancet. 2024 Oct 19; 404 (10462):1525-1535

NRG-GY037:

Induction Pembrolizumab and Chemotherapy Followed by Pembrolizumab Before Chemoradiation and Pembrolizumab Maintenance Compared to Standard Chemoradiation With Pembrolizumab Followed by Pembrolizumab Maintenance in High-Risk Cervical Cancer

PI Jyoti Mayadev, MD

- Newly diagnosed histologically confirmed FIGO (2018) Stage IIIA(T3aN0), IIIB (T3bN0); Stage IIIC1 (T3aN1, T3bN1) IIIC2 (T3aN2, T3bN2); IVA
- Squamous cell, adenocarcinoma, adenosquamous cervical cancer

Stratification: PALN + vs. –
Stage III vs. IVA

N=336

R
1:1

Power: 90%
Alpha: (one sided 5%)

Arm 1: SOC
Cisplatin 40 mg/m^2 QW for
5 cycles + EBRT followed by brachytherapy
+
Pembrolizumab 200 mg Q3W for 5 cycles
Pembrolizumab 400mg Q6W for 15 cycles

Arm 2: Induction
Induction chemotherapy with carboplatin/paclitaxel q wk. +
pembrolizumab 200mg q 3wks 2 cycles (6 wks.)

RT to start ASAP: wk. 7
Cisplatin 40 mg/m2 QW for
5 cycles + EBRT followed by brachytherapy
+
Pembrolizumab 200 mg Q3W for 5 cycles
Pembrolizumab 400mg Q6W for 14 cycles

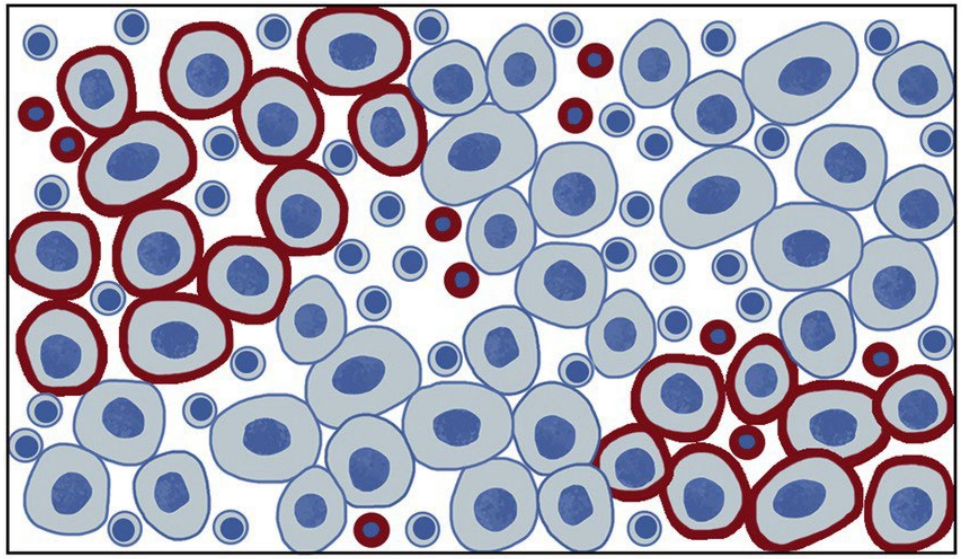
NCT04158141 Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT05548296

State of Science in 1L Recurrent Metastatic Cervical Cancer

Trial/Citation		n	ITT PFS HR (95% CI)	PDL1+ PFS HR (95% CI)	PFS HR bev treated (95% CI)	ITT OS HR (95% CI)
KEYNOTE 826 (NCT03635567)	Cis or carbo/paclitaxel/ ±bev ± pembrolizumab	617	0.65 (0.53 - 0.79) p<0.001	0.62 (0.50-0.77)	0.61 (0.47-0.80)	0.63 (0.52-0.77)
BEATcc (NCT03556839)	Cis or carbo/paclitaxel/ bev ± atezolizumab	519	0.62 (0.49-0.78) p<0.0001	0.54 (0.32-0.91)	0.62 (0.49-0.78) p<0.0001	0.68 (0.52-0.88)

Colombo et al. NEJM 2021 Nov 11; 385(20):1856-1867 Monk JCO 2023 Dec 20;41(36):5505-5511 Lorusso et al. Ann Oncol. 2025 Jan;36(1):65-75. Oaknin Lancet 2024 Jan 6;403(10421) :31-43 Lindemann et al ESMO Gynae 2025

Does PD-L1 Scoring Method Matter?
Does PD-L1 Matter?



$$TPS = \frac{\text{No. PD-L1 positive tumor cells}}{\text{Total No. of viable tumor cells}} \times 100$$

$$CPS = \frac{\text{No. PD-L1 positive cells (tumor cells, lymphocytes, macrophages)}}{\text{Total No. of viable tumor cells}} \times 100$$

de Ruiter, Emma et al. Modern Pathology. 34. 10.1038/s41379-020-0644-7.

Trial Scoring method Biomarker evaluable #	ITT n PFS HR	PDL1<1 n PFS HR	PDL1 1+ n PFS HR	PDL1 10+ n PFS HR
KN 826[1] CPS 617/617	617 0.65	69/617 (11%) NR	231/617 0.62	317/617 0.61
BEATcc[2] CPS 313/519	519 0.62	93/313 (29.7%) 0.48	220/313 0.54	101/313 0.54

1. Colombo et al. NEJM 2021 Nov 11; 385(20):1856-1867; 2. Lindemann et al ESMO Gynae 2025

GOG-3123/ENGOT-cx22/ Trofuse-036 (Part 1 Safety Run-In)

US PI Brian Slomovitz

Key Eligibility Criteria for Enrollment:

- **Persistent, recurrent, or newly diagnosed metastatic cervical cancer that is not amenable to curative treatment**
- **Histologically confirmed diagnosis of squamous cell carcinoma, adenosquamous carcinoma, or adenocarcinoma of cervix**
- **PD-L1 CPS ≥1 as assessed locally**
- **ECOG PS 0 to 1**
- **Completed 6 cycles of induction therapy**
- **Without PD per RECIST 1.1 by Investigator**
- **Excluded if have received prior systemic anticancer therapy other than what is specified in this protocol**

Sac-TMT 4 mg/kg Q2W +
Pembrolizumab 400 mg Q6W
+Bevacizumab 15 mg/kg Q3W

Primary Endpoint:
- Safety and tolerability

Follow-up

- **Participants will receive sac-TMT 4 mg/kg q2w and pembrolizumab 400 mg q6w for up to 14 cycles.**
- **Bevacizumab 15 mg/kg q3w will be administered until a treatment discontinuation criterion is met.**
- **Each cycle will be 6 weeks long.**

NCT07216703 Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT07216703

GOG-3123/ENGOT-cx22/ Trofuse-036 (Part 2)

US PI Brian Slomovitz

Screening for Enrollment

Key Eligibility Criteria for Enrollment:

- Persistent, recurrent, or newly diagnosed metastatic cervical cancer that is not amenable to curative treatment
- Histologically confirmed diagnosis of squamous cell carcinoma, adenosquamous carcinoma, or adenocarcinoma of cervix
- Measurable disease
- No prior systemic treatment, including prior IO
- Prior radiation + radiosensitizing chemotherapy is allowed
- PD-L1 CPS >1 per Central Laboratory
- ECOG PS 0 to 1
- Excluded if have received prior systemic anticancer therapy other than what is specified in this protocol

Induction (6 x 3-weeks cycles)

Cisplatin 50 mg/m2 or Carboplatin AUC 5 mg/mL/min, Paclitaxel 175 mg/m2, Pembrolizumab 200 mg +/- Bevacizumab 15 mg/kg per investigator Q3W

Randomize

Maintenance (14 x 6-week cycles)

Arm A
Sac-TMT 4 mg/kg Q2W + Pembrolizumab 400 mg Q6W +/- Bevacizumab 15 mg/kg Q3W per investigator

Arm B
Pembrolizumab 400 mg Q6W +/- Bevacizumab 15 mg/kg Q3W per investigator

NCT07216703 Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT07216703

GOG Highlight Reel

Cervical Cancer Care: New Regimens and Innovative Treatment Approaches

Bhavana Pothuri, MD, MS
NYU Langone
New York City, New York

Evolving the Recurrent Cervix Cancer Treatment Landscape, the Role of ADCs

ADC/ Phase Trial	Target	Payload	Prior Lines	N	ORR (%, CI)	DOR (mos)	PFS (mos)	Any Gr 3/4 AE's (%)	D/C (%)
Tisotumab Vedotin/ Phase III [1] **FDA Approved**	TF	MMAE	1 line 63% Prior IO 28%	250	17.8% (13.3 to 23.1)		4.2 (4-4.4) [4]	52	15
Sacituzimab Tirumotecan 4mg/kg q 2 wks Phase I/II[2]	TROP2	TOPO-I	➢ 2 lines 62% ➢ Prior IO: 57%	153	24 (17.6–31.8)	7.5 (1.4- 12.2)	5.5 (5.3-7.1)	53	2
Sacituzimab Govitecan/ Phase II EVER 123-003[3]	TROP2	SN-38	Median 2 (1-5) Prior IO 68%	40	43 (23-59)	9.2 (4.6-11.7)	7.1 (4.2-8.4)	63	8

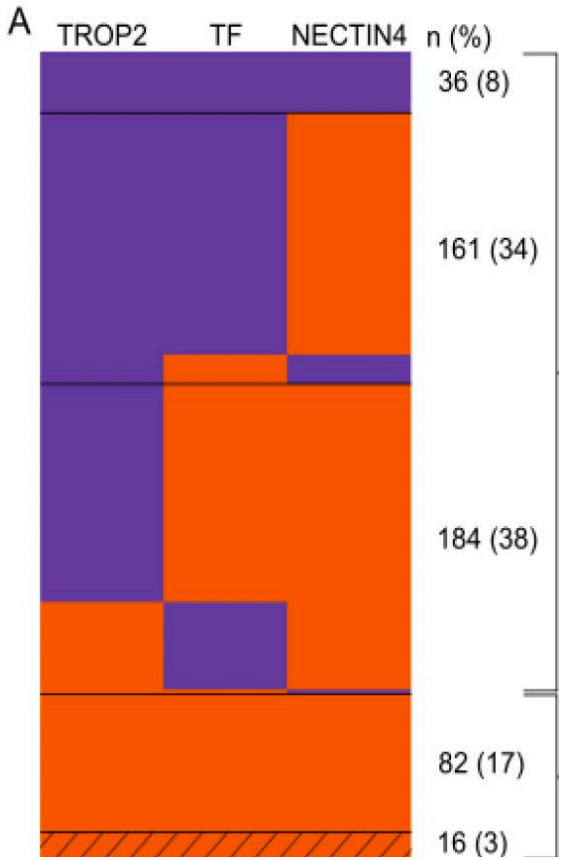
GOG Highlight Reel

[1] *Vergote et al. N Engl J Med 2024;391:44-55*
[2] *Wang et al. ESMO 2025 Berlin*
[3] *An et al ESMO TAT 2025*

Target Antigen Expression in Cervix Cancer

TROP2 AND TISSUE FACTOR ARE HIGHLY EXPRESSED IN CERVICAL CANCER

Protein expression	TROP2, n (%)	Tissue Factor, n (%)	NECTIN4, n (%)
n, total	n = 501	n = 500	n = 511
3+	185 (37 %)	144 (29 %)	21 (4 %)
2+	157 (31 %)	97 (19 %)	42 (8 %)
1+	127 (25 %)	159 (32 %)	170 (33 %)
0	32 (7 %)	100 (20 %)	278 (55 %)
High (3+ and 2+)	342 (68 %)	241 (48 %)	63 (12 %)
Low (1+ and 0)	159 (32 %)	259 (52 %)	448 (88 %)



PRIMARY AND MATCHED RECURRENT LESIONS

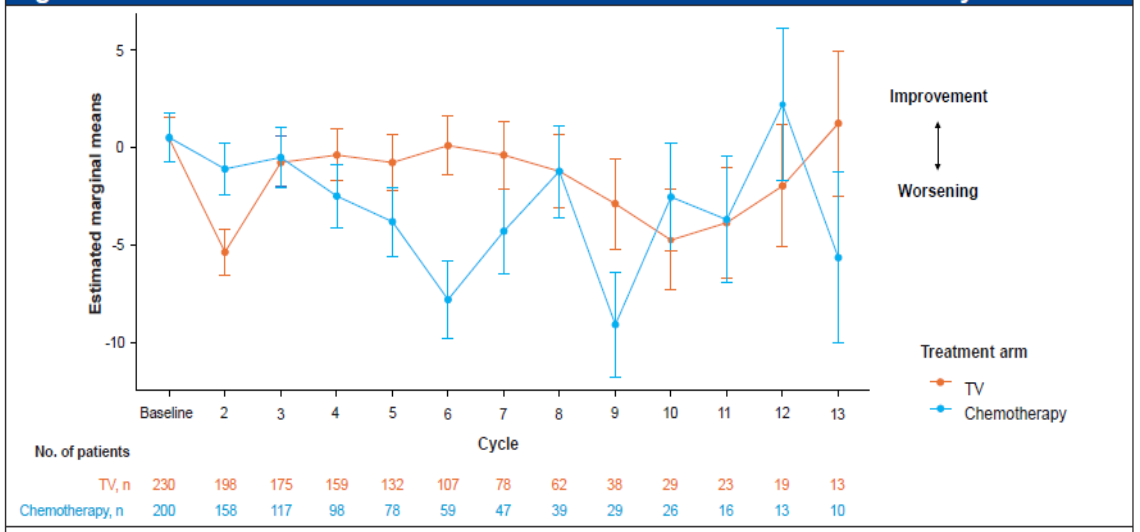
Level of high (2+, 3+) recurrent lesion expression:
- TROP2: 56%
- Tissue Factor: 46%
- NECTIN4: 35%

Level of concordance (low *versus* high) between primary and matched recurrent lesion:
- TROP2: 15/22 (68%)
- Tissue Factor: 20/22 (91%)
- NECTIN4: 15/22 (68%)

Patient reported outcomes from GOG 3057/ENGOT-cx12/innovaTV301 (n=434/502)

- Global health status/QoL was maintained from baseline to cycle 13 in both arms (**Figure 4**)

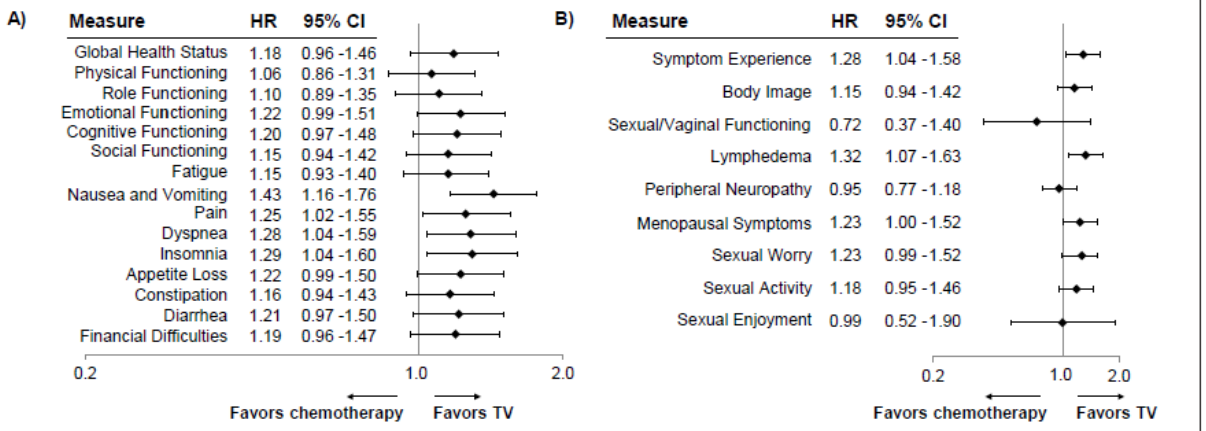
Figure 4. EORTC QLQ-C30 Global Health Status/QoL score from baseline to cycle 13



Higher scores represent a higher quality of life. EORTC, European Organisation for Research and Treatment of Cancer; QLQ-C30, Quality of Life Questionnaire-C30; QoL, quality-of-life; TV, tisotumab vedotin.

- Median time to clinically meaningful deterioration (≥10-point change)[a] was longer with TV compared with chemotherapy across most of the key domains for QLQ-C30 and QLQ-CX24 (**Figure 5**)

Figure 5. Forest plots for time to deterioration of (A) EORTC QLQ-C30 subscales and (B) EORTC QLQ-CX24 subscales



EORTC, European Organisation for Research and Treatment of Cancer; HR, hazard ratio; QLQ-C30, Quality of Life Questionnaire; QLQ-CX24, Quality of Life Questionnaire-Cervical Cancer Module; QoL, quality-of-life; TV, tisotumab vedotin. [a]Clinically meaningful deterioration was defined as a ≥10-point change from baseline, progression or death.

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Current Phase III/IV GOG ADC Cervix Trials

Trial	GOG PI	ADC	Line of tx	Phase/ N GOG	Endpoint	Status
GOG-3116, ocular assessments[1] (NCT06952660)	Dr. Scott Jordan	Tisotumab Vedotin (TV)	Recurrent/ metastatic	IV/ 100	Safety, Ocular AE's	Active, accruing
GOG 3101-Trofuse 020[2] (NCT06459180)	Dr. Ritu Salani	Sacituzumab Tirumotecan	2nd or 3rd Line Recurrent	III/ 100	OS	Active, accruing
GOG 3123-Trofuse 036[3] (NCT07216703)	Dr. Brian Slomovitz	Sacituzumab Tirumotecan	First Line	III/ 150	Dual: PFS BICR and OS	Active, accruing

1. GOG 3116: NCT06952660 Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT06952660. 2. GOG 3101: NCT06459180 Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT06459180. 3. GOG 3123: NCT07216703 Accessed Jan 14, 2026; https://clinicaltrials.gov/study/NCT07216703

IO Combinations/ Bispecifics

Study/Phase	Agent	Prior Lines	N/Evaluable	ORR (%)	DOR (mos)	PFS (mos)	Any Gr 3/4
RAPIDS/Ph 2 (O'Malley ESMO 2025)	Balstilimab/Zalifrelimab (PD-1/CTLA-4)	100% prior platinum 39% prior bev	106	24 (17-33)	23 (11-NR)	4.2 (2.8-5.6)	Zal 23% Bal 22% TRAE
Compassion 16/Ph 3 (Wu el al, Lancet, 2024)	Cadolinimab (PD-1/CTLA-4 bispecific) vs placebo in addition to chemo	0 L (prior Chemo/RT only)	222	79 vs 68 (placebo)	15.7 (6·2–27·4) vs 8.5 (4.6–15.0)	12.7 (11.6–16.1) vs 8.1 (7·7–9·6) HR= 0.62 (0.49–0.80)	85% TEAE
Innova TV205-GOG 3024/ Ph 1B/2 (Monk, ESMO 2025)	1L TV + carbo 1L TV + pembro 2nd/3rdL TV + pembro	100% 0L 100% 0L 71% 1L	33/33 33/32 35/34	55 (36–72) 41(24-59) 35 (20-54)	8.6 (4-12) NE (NE-NE) 14.1(4-NE)	6.9 (4-11) 5.3 (4-12) 5.6 (3-14)	39% 12% 29% TEAE
AK001/Ph 2 (GU, et al ESMO 2025)	Cadolinimab+ Disitmab vedotin (HER2 1-3+) Cadolinimab +Nab-paclitaxel (HER2 Neg)	25% 2-3L 33% Prior IO 19% 2-3L 19% prior IO	32/22 42/21	50 (28-72) 53 (30-74)			12.5% 19% TRAE
Ph 1B/2 (Li, et al, ESMO 2025)	WX390 (Dual PI3K-MTORi) +toripalimab	46% prior IO 33% prior Bevacizumab	24/19	47 (24-71)	N/R	41 (2.3-6.9)	58% TRAE

Part 4: Panel Discussion and Audience Q&A

Part 5: Final Comments, Future Perspectives

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Cincinnati, Ohio

GOG Highlight Reel

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