An Educational Symposium at the FSGO 2026 Annual Meeting

Precision Decision Making in Platinum Resistant Ovarian Cancer: Folate Receptor Alpha Expression and Other Biomarkers Into Contemporary Care

Friday, June 12, 2026

7:35 am – 8:25 am ET

Long Boat Key, Florida

This session is not included in main conference CME/CPD credit

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Precision Decision Making in Platinum Resistant Ovarian Cancer: Folate Receptor Alpha Expression and Other Biomarkers Into Contemporary Care
Educational Symposium
Friday, July 12, 2026 | Long Boat Key, FL

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Faculty Disclosures

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Planning Disclosures				
Jordan, MD	Scott	**Moderator**	AbbVie; AstraZeneca; Corcept; GenMab; GSK; Merck; Pfizer; Caris; Natera	Consultant
Speaker Disclosures				
Monk, MD	Bradley	**Speaker**	AstraZeneca; BioNtech; Corcept; DSI; Eisai; Eli Lilly; GenMab/Seagen/Pfizer; GOG Foundation; GSK; Immunogen/AbbVie; Incyte; Karyopharm; Merck; Mersana; Myriad; Natera; Novartis; OncoC4; Oncocusp; Panavance; Pharma&; Regeneron; Roche/Genentech; Takeda; Taiho; Tubulis; Verastem; Zai Labs; Zentalis; Zymeworks	Consultant
Engbert	Holley	**Staff**	Nothing to disclose	
Rush	Heather	**Staff**	Nothing to disclose	
Shumaker	Kara	**Reviewer/Staff**	Nothing to disclose	
Small, MPH	Michelle N	**Reviewer/Staff**	Nothing to disclose	
Alvarez Secord, MD	Angeles	**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)
Duska, MD	Linda	**Edu-Co-Chair/ Reviewer**	Merck; Corcept	Honoraria (Merck) Speakers Bureau (Corcept) Research Funding (Merck)
Blank, MD	Stephanie	**Reviewer**	American Board of Obstetrics and Gynecology; Merck; AstraZeneca; GlaxoSmithKline; Pfizer; Seattle Genetics/Astellas; Acrivon; Zentalis; NX Development Corp.	Leadership (American Board of Obstetrics and Gynecology) Research Funding (Merck; AstraZeneca; GlaxoSmithKline; Pfizer; Seattle Genetics/Astellas; Acrivon; Zentalis; NX Development Corp.)
Gien, MD	Lilian	**Reviewer**	Glaxo Smith Kline; Merck; Abbvie; AstraZeneca	Speaker Honoraria (Glaxo Smith Kline; Merck) Advisory Board (Abbvie; AstraZeneca)
Mutch, MD	David	**Reviewer**	Nothing to disclose	
Zweizig, MD	Susan	**Reviewer**	Nothing to disclose	

This presentation includes discussion of off-label uses or investigational agents not approved by the FDA for the indications discussed. The opinions expressed are those of the presenters and are not necessarily those of the GOG Foundation, Inc. Please refer to the official prescribing information for each product for approved indications, contraindications, and warnings.

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

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Welcome and Program Overview

Scott Jordan, MD
Broward Health

Moderator

Scott Jordan, MD
Broward Health Medical Center

Faculty

Bradley Monk, MD
Florida Cancer Specialist &
Research Institute

Learning Objectives

Upon completion of this activity, participants should be able to:

1. **Describe the clinical relevance of folate receptor alpha (FRα) expression** in platinum-resistant ovarian cancer and its role in identifying patients for targeted therapeutic approaches.
2. **Apply biomarker-informed decision-making**—including FRα status, HER2 PD-L1 expression, and clinical eligibility for weekly paclitaxel and/or Bevacizumab to individualized treatment selection in platinum-resistant disease.
3. **Evaluate real-world patient cases** to understand appropriate sequencing of therapies and integration of emerging evidence into contemporary management strategies.

Agenda

5 minutes	**Welcome and Program Overview** Scott Jordan, MD
15 minutes	**Setting the Clinical Framework: Decision Making in Platinum Resistant Disease** Bradley Monk, MD
15 minutes	**Case Based Discussion I: Introducing Biomarkers Into Practice** All Faculty
10 minutes	**Case Based Discussion II: Sequencing and Real World Application** All Faculty
5 minutes	**Key Take Aways and Closing Remarks** All Faculty

Setting the Clinical Framework: Decision Making in Platinum Resistant Disease

Bradley Monk, MD

Florida Cancer Specialist & Research Institute

Natural History of Ovarian Cancer Evolution

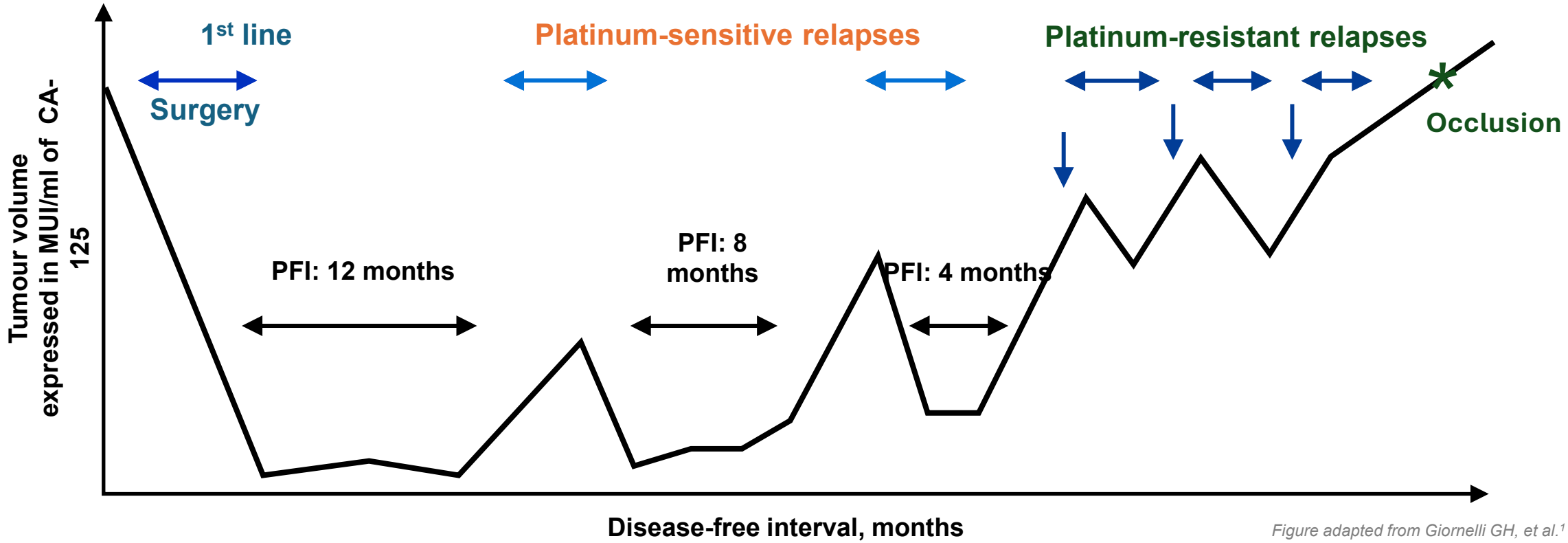


Figure adapted from Giornelli GH, et al.[1]

"Most patients will relapse within the first 2 years after diagnosis, even after an optimal primary cytoreductive surgery and six cycles of the standard adjuvant chemotherapy with carboplatin/paclitaxel"

Giornelli GH. Springerplus. 2016;5(1):1197.

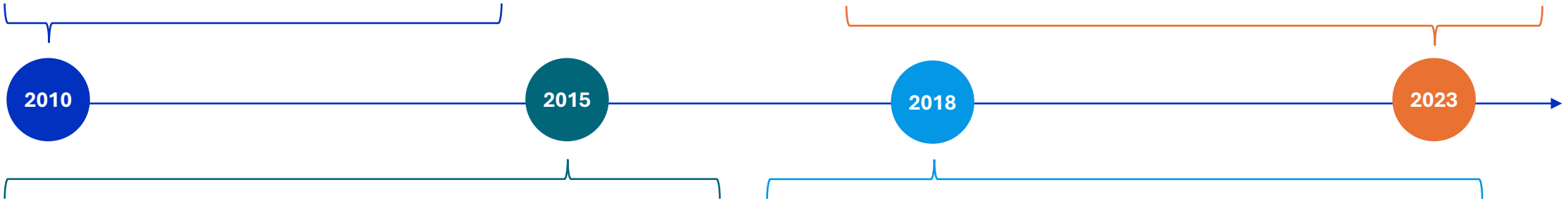
‘Platinum-Resistant’ OC Redefined as ’Not Suitable for Further Platinum Therapy ’

Historical definition (regulatory trial standard):
Fourth International Ovarian Cancer Consensus Meeting, Vancouver[1]

- **Platinum-free interval (PFI)**

Contemporary definition (clinical standard): ESMO Guidelines[4]

- **For some patients with recurrent ovarian cancer, platinum rechallenge may not be considered clinically appropriate**



Fifth Gynecological Cancer InterGroup (GCIG) Ovarian Cancer Consensus Conference, Tokyo[2]

- **Treatment-free interval (TFI)**
- **PFI as a continuous variable,** rather than a single fixed time point (6 months)

ESMO-ESGO Consensus Conference on Ovarian Cancer, Milan[3]

- **Patients for whom platinum-based therapy is no longer an option**

  Includes:
  - Symptomatic relapse soon after Pt-based CTx

OC = ovarian cancer; Pt-based CTx = platinum-based chemotherapy

1. Friedlander M, et al. Int J Gynecol Cancer. 2011;21(4):771-5. 2. Wilson MK, et al. Ann Oncol. 2017;28(4):727-732. 3. Colombo N et al. Ann Oncol. 2019;30(5):672–705. 4. González-Martín A, et al. Ann Oncol. 2023 Oct;34(10):833-848.

ESMO Guidelines for the Management of Recurrent Ovarian Cancer:
Criteria to be considered when deciding if platinum is the best option

Recurrent epithelial ovarian cancer

Assessment of the following factors [I-II, A]:

- Histotype
- *BRCA1/2* status
- Number of prior lines
- Exposure and response to prior treatment
- TFIp
- Potential for surgery
- Residual toxicity
- Patient's general condition
- Patient preference

→ Unfit or not willing to receive anticancer therapy → Best supportive care (BSC)

Platinum **is the best option** when:

- Prior response to platinum
- No contraindication

Platinum is not the best option when[a] [II-IV, A]:

- Progression during platinum
- Early symptomatic progression
- Platinum intolerance[b]

"There are currently no molecular biomarkers to predict platinum response"[1]

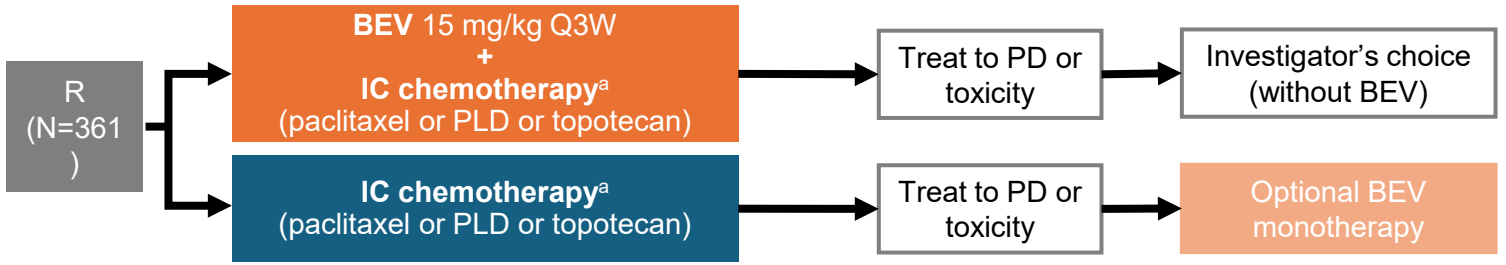
Figure adapted from González-Martín A, et al.[1]

González-Martín A, et al. Ann Oncol. 2023 Oct;34(10):833-848, and supplementary appendix.

Bevacizumab in Combination with Single Agent Chemotherapy: AURELIA Trial[1]

Eligible patients:

- **Platinum-resistant OC**
  - ≤2 prior anticancer regimens
  - No history of bowel obstruction / abdominal fistula, or clinical / radiological evidence of rectosigmoid involvement



Bevacizumab improved PFS[1]

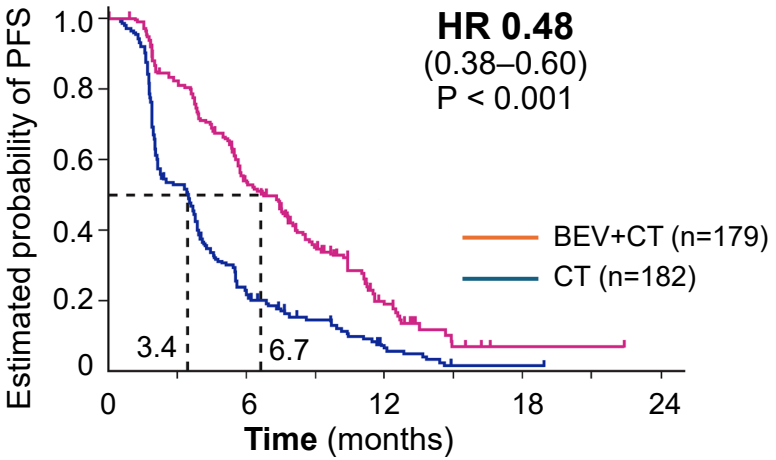


Figure adapted from Pujade-Lauraine E, et al.[1]

Bevacizumab did not improve OS[1]

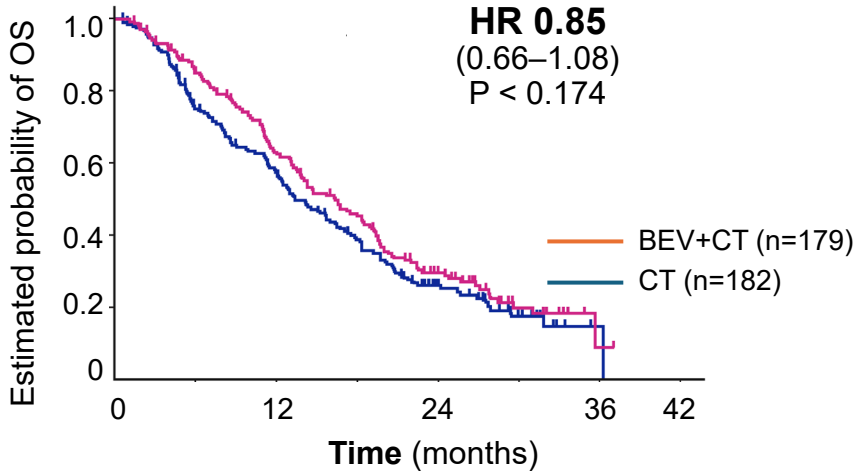


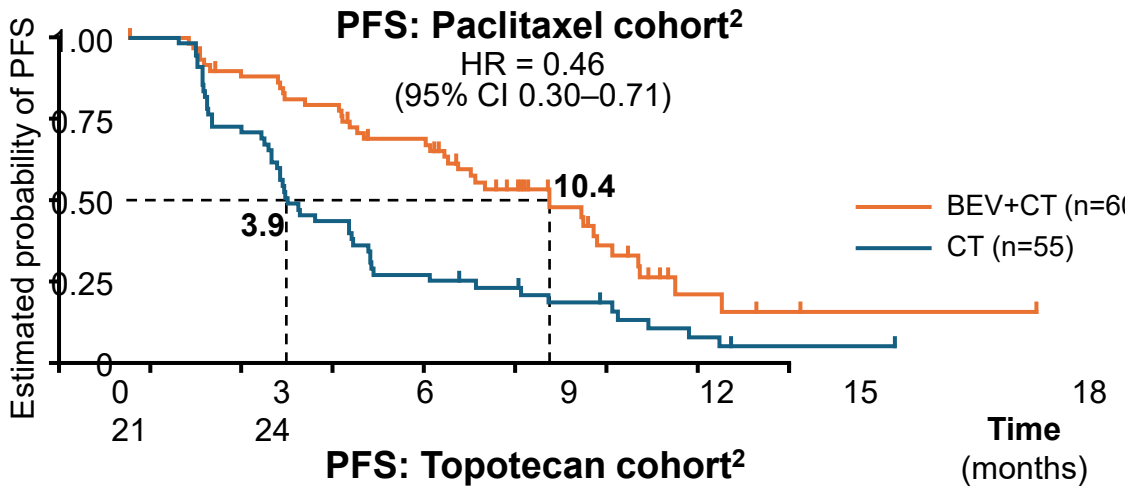
Figure adapted from Pujade-Lauraine E, et al.[1]

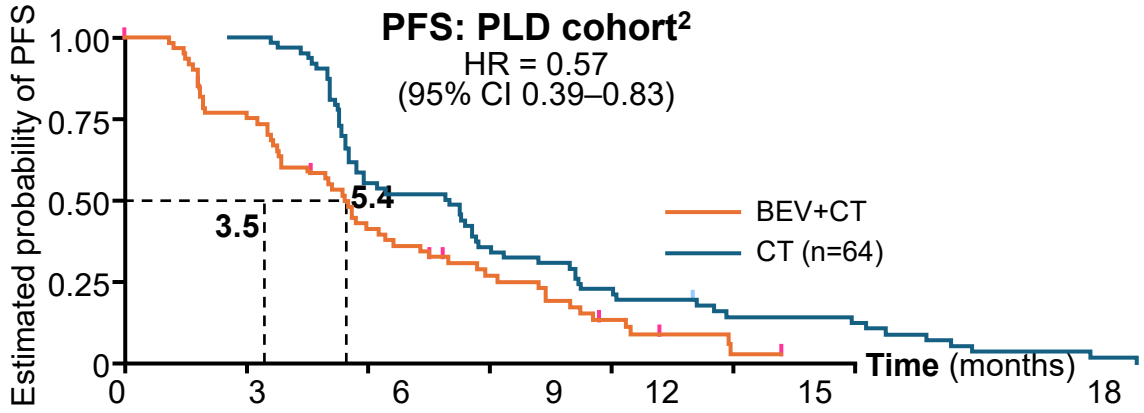
BEV, bevacizumab; CT, chemotherapy; IC, investigator's choice; OC, ovarian cancer; OS, overall survival; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; PROC, platinum-resistant ovarian cancer; Q3W, every 3 weeks

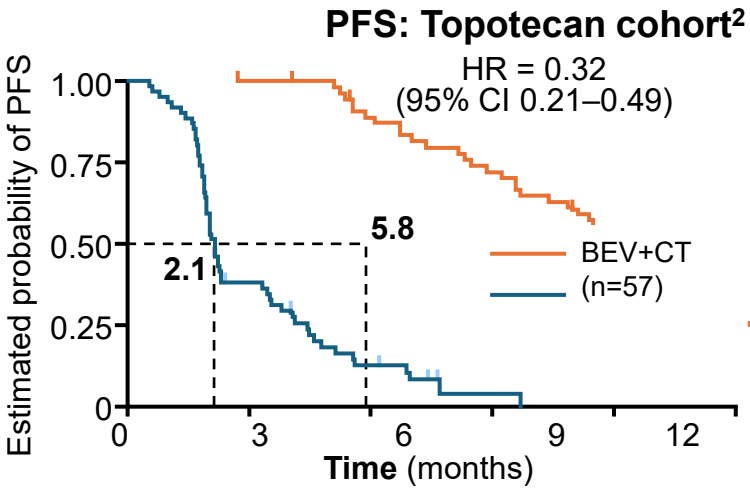
1. Pujade-Lauraine E et al. J Clin Oncol. 2014;32(13):1302-1308.

Bevacizumab in Combination with Single Agent Chemotherapy AURELIA Trial[1]

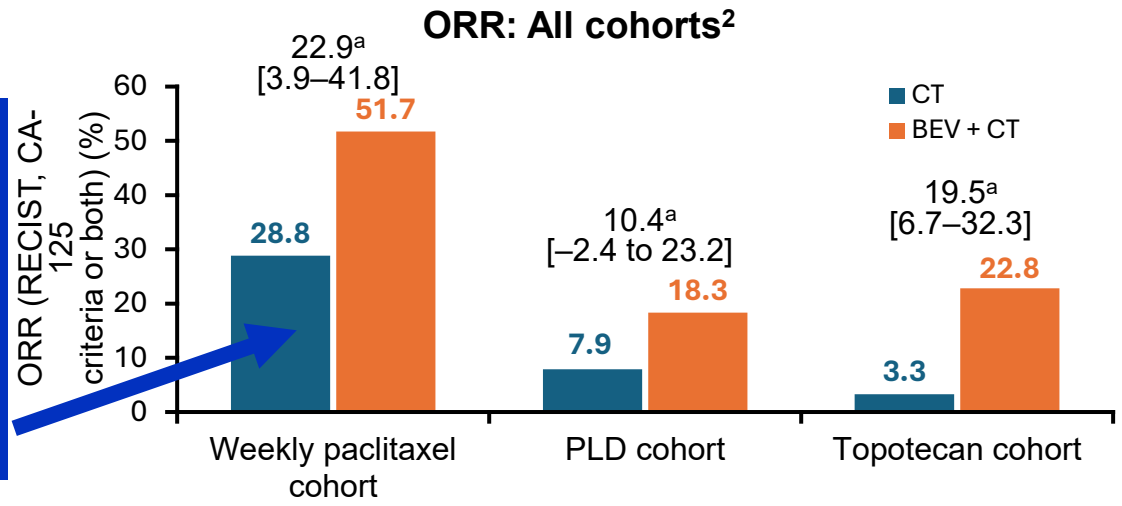
Exploratory analyses according to chemotherapy cohort







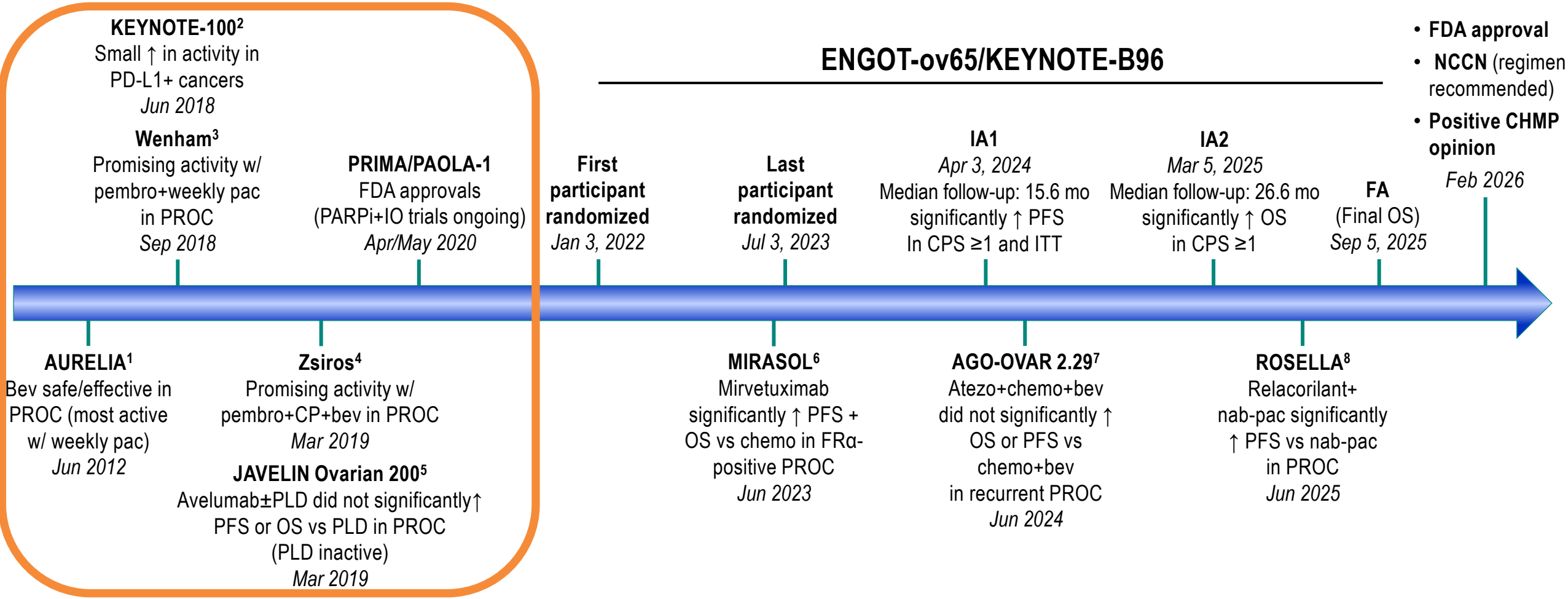
Weekly paclitaxel emerges as a "different chemo choice" amid the rest of single-agents Can weekly paclitaxel be improved?



Figures adapted from Poveda, et al.[2]

1. Poveda AM, et al. J Clin Oncol. 2015;33(32):3836-8.

Timeline and Milestones



1. Pujade-Lauraine E, et al. ASCO 2012. 2. Matulonis UA, et al. ASCO 2018. 3. Wenham RM, et al. IGCS 2018. 4. Zsiros E, et al. SGO 2019. 5. Pujade-Lauraine E, et al. SGO 2019. 6. Moore KN, et al. ASCO 2023. 7. Marmé F, et al. ASCO 2024. 8. Olawaiye A, et al. ASCO 2025.

Monk BJ. et al. Presented at SGO Meeting, 2026

Combining Pembrolizumab Plus Weekly Paclitaxel +/- Bevacizumab for Platinum-Resistant Recurrent Ovarian Cancer

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]

R 1:1
N = 643

Pembrolizumab 400 mg
(Q6W, 18 cycles) +
Paclitaxel[a] 80 mg/m^2 Days 1, 8, 15
of each Q3W cycle
(± bevacizumab 10 mg/kg Q2W)

Placebo
(Q6W, 18 cycles) +
Paclitaxel[a] 80 mg/m^2 Days 1, 8, 15
of each Q3W cycle
(± bevacizumab 10 mg/kg Q2W)

Primary Endpoint: PFS per RECIST v1.1 by investigator

Key Secondary: OS

aDocetaxel (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.
bThe 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.

Abbreviations: CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; HRD, homologous recombination deficiency; ITT, intention-to-treat; PARPi, poly(ADP-ribose) polymerase inhibitor; PD-L1, programmed death-ligand 1; PFS, progression-free survival; Q2W, every 2 weeks; Q3W, every 3 weeks; Q6W, every 6 weeks; RECIST, Response Evaluation Criteria in Solid Tumors.

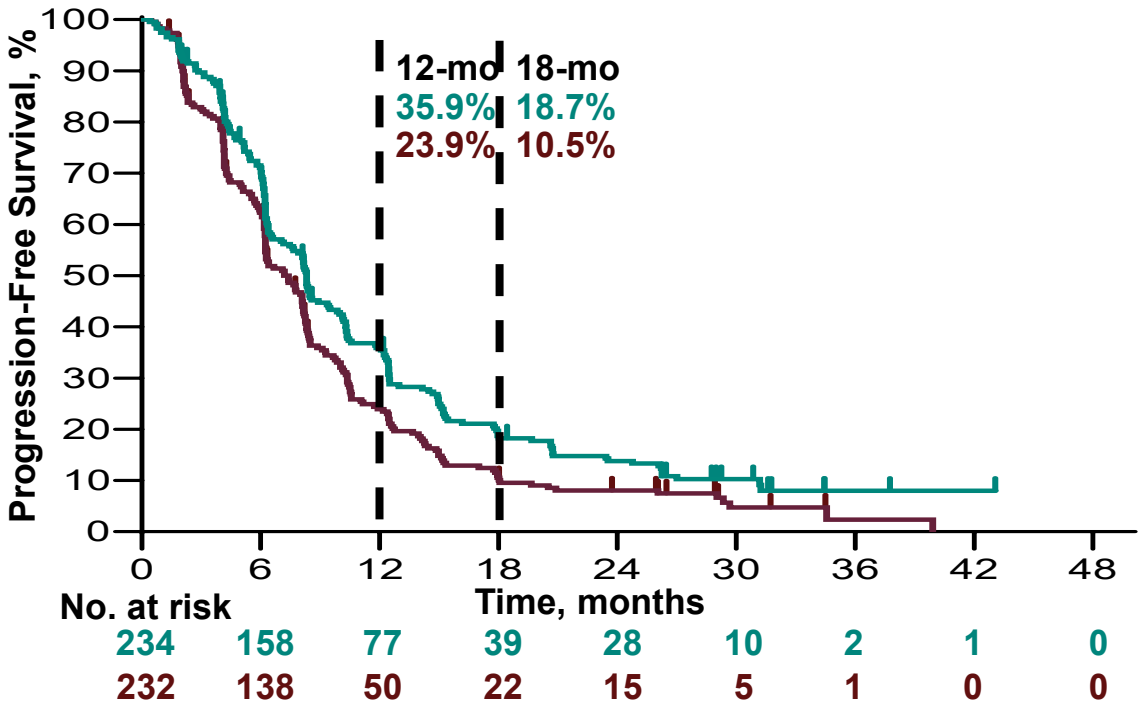
Colombo N. et al. Presented at ESMO Meeting, 2025 Lancet. 2026 Apr 18;407(10538):1525-1537.

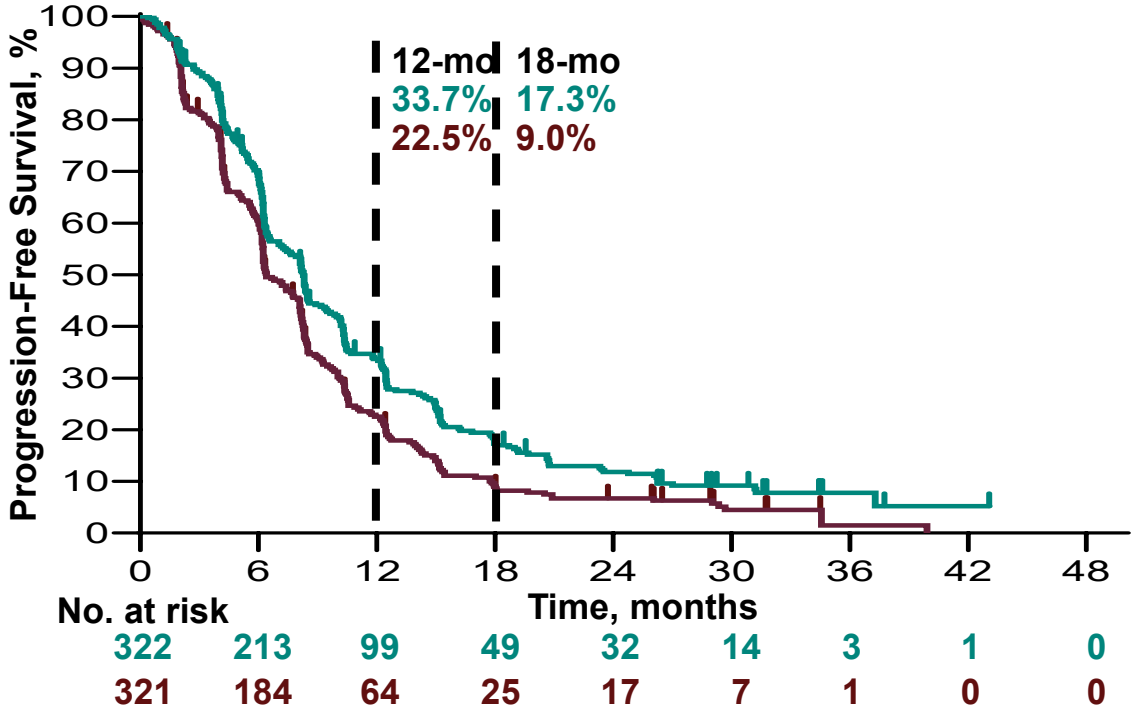
KEYNOTE B96

PFS in CPS ≥1 and ITT Populations at Final Analysis

CPS ≥1 Population	Events	Median, mo (95% CI)	HR[a] (95% CI)
Pembro Arm	84.6%	8.3 (7.0–9.5)	0.76 (0.62–0.93)
Placebo Arm	88.8%	7.2 (6.2–8.1)	

ITT Population	Events	Median, mo (95% CI)	HR[a] (95% CI)
Pembro Arm	85.7%	8.3 (7.2–8.6)	0.73 (0.62–0.87)
Placebo Arm	89.1%	6.4 (6.2–8.1)	





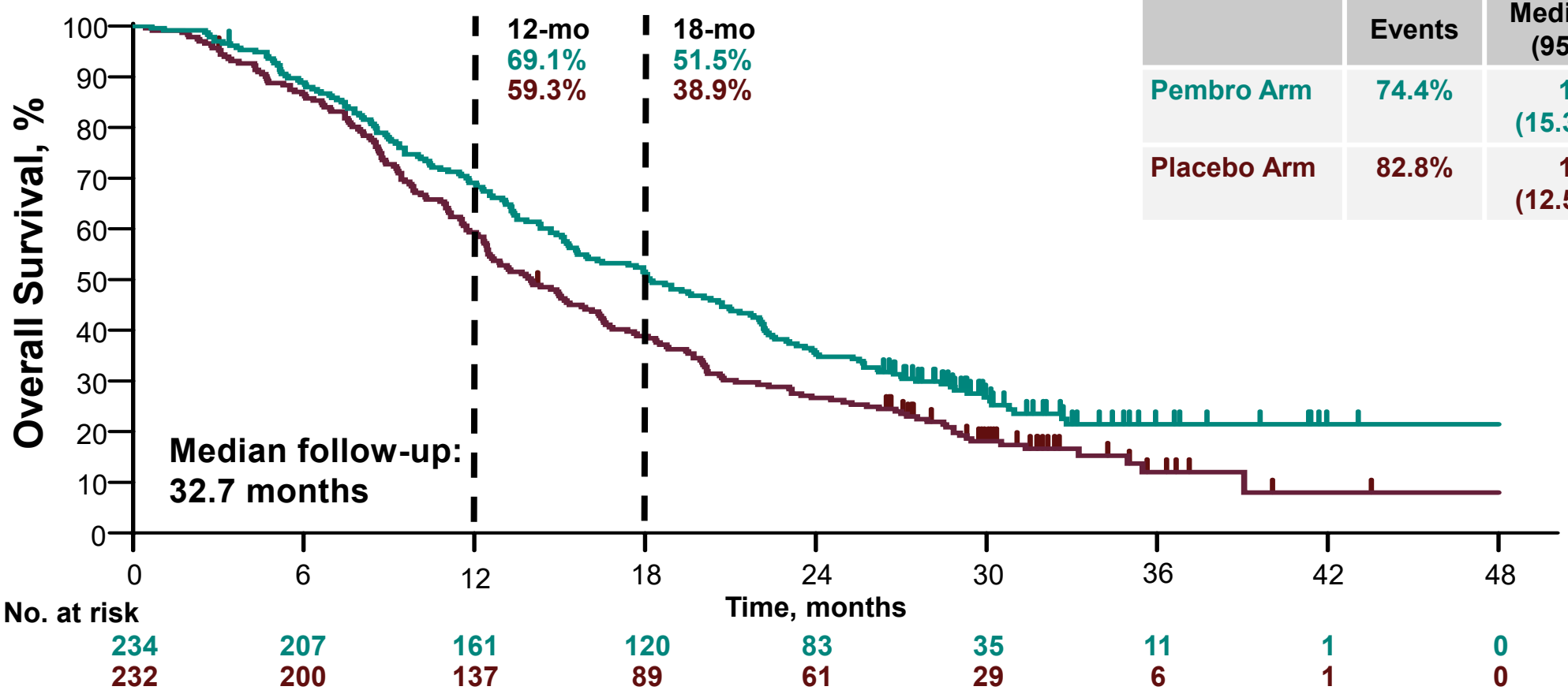
Median follow-up: 32.7 months

Response assessed per RECIST v1.1 by investigator review. [a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

Colombo N. et al. Presented at ESGO Annual Meeting, 2025; Colombo N. et al. Lancet. 2026 Apr 18;407(10538):1525-1537.

KEYNOTE B96

OS in CPS ≥1 population at Final Analysis



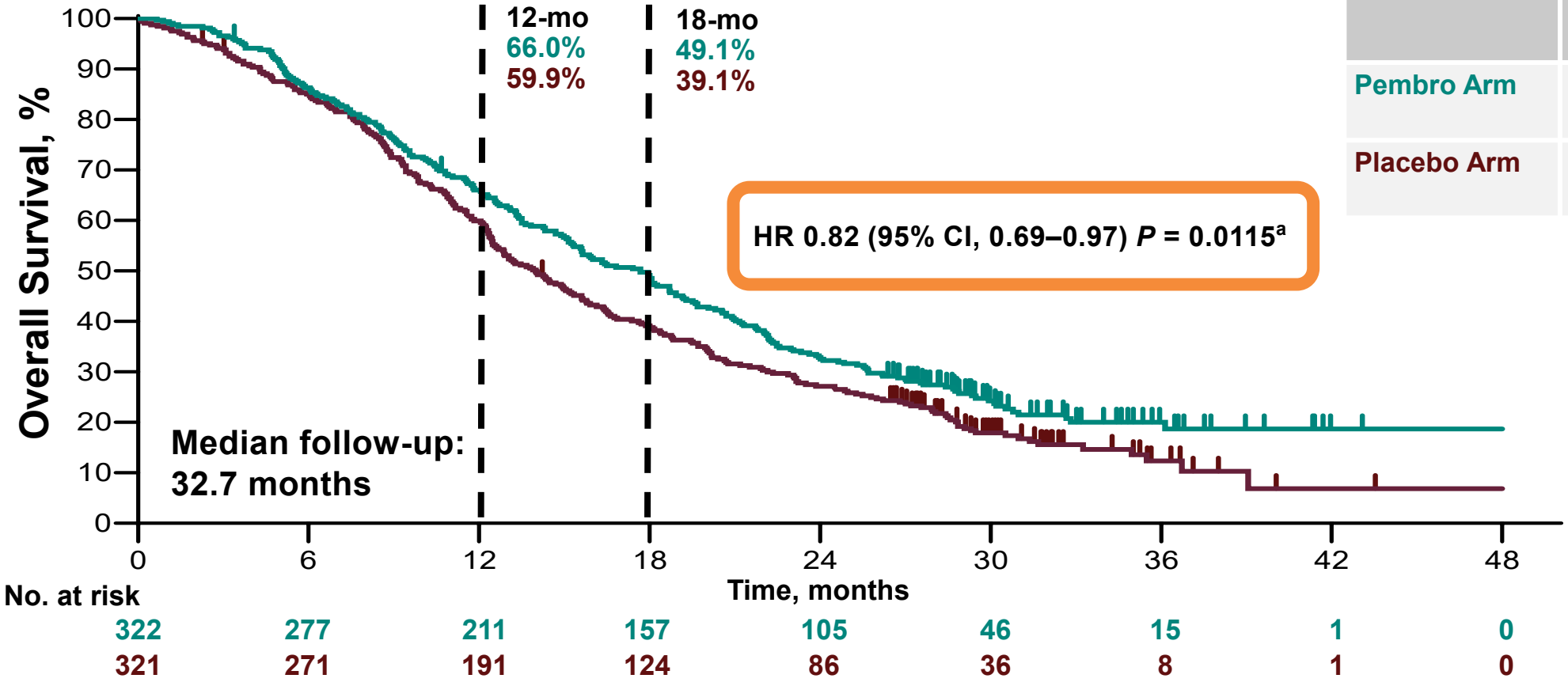
	Events	Median, mo (95% CI)	HR (95% CI)
Pembro Arm	74.4%	18.2 (15.3–21.3)	0.76 (0.62–0.93)
Placebo Arm	82.8%	14.0 (12.5–16.1)	

[a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

Colombo N. et al. Presented at ESGO Annual Meeting, 2025; Colombo N. et al. Lancet. 2026 Apr 18;407(10538):1525-1537.

KEYNOTE B96

OS in ITT population at Final Analysis



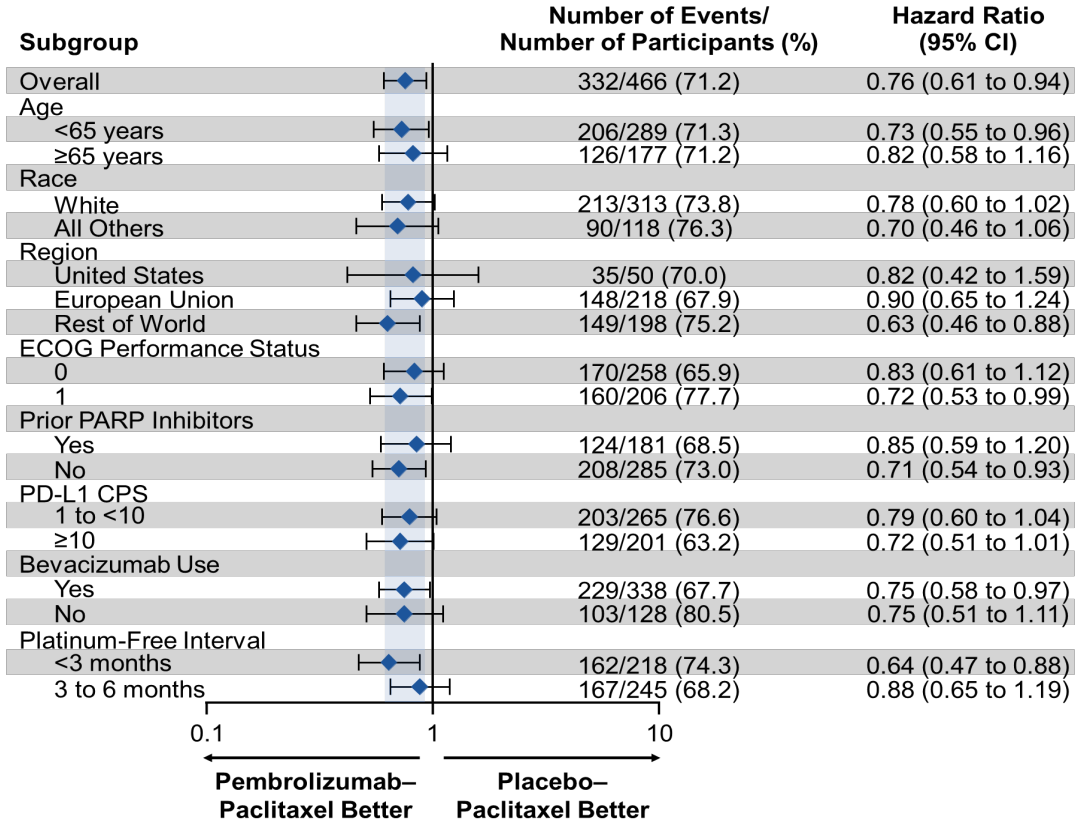
	Pts w/ Event	Median, mo (95% CI)
Pembro Arm	76.7%	17.7 (15.2–19.2)
Placebo Arm	82.9%	14.0 (12.5–15.6)

[a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors. The observed p-value crossed the prespecified nominal boundary of 0.0242 at this planned final analysis. Data cutoff date: September 5, 2025.

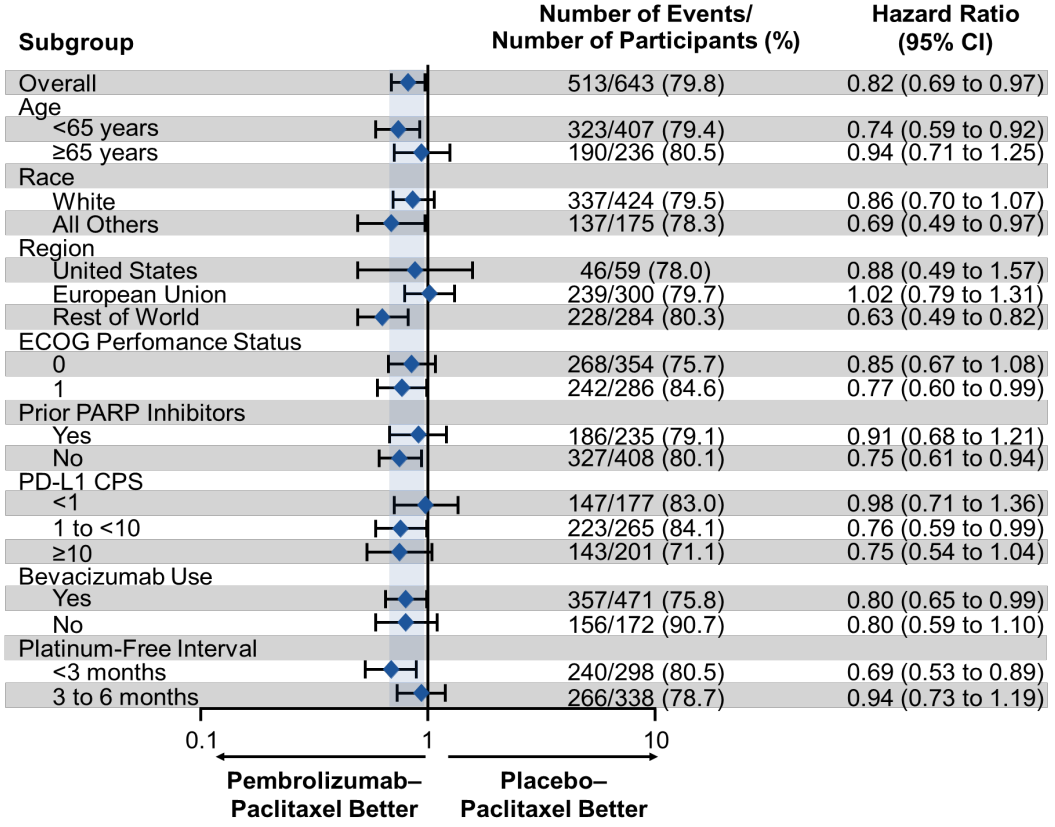
Colombo N. et al. Presented at ESGO Annual Meeting, 2025; Colombo N. et al. Lancet. 2026 Apr 18;407(10538):1525-1537.

KEYNOTE B96
OS in Subgroups

CPS ≥1 Population



ITT Population

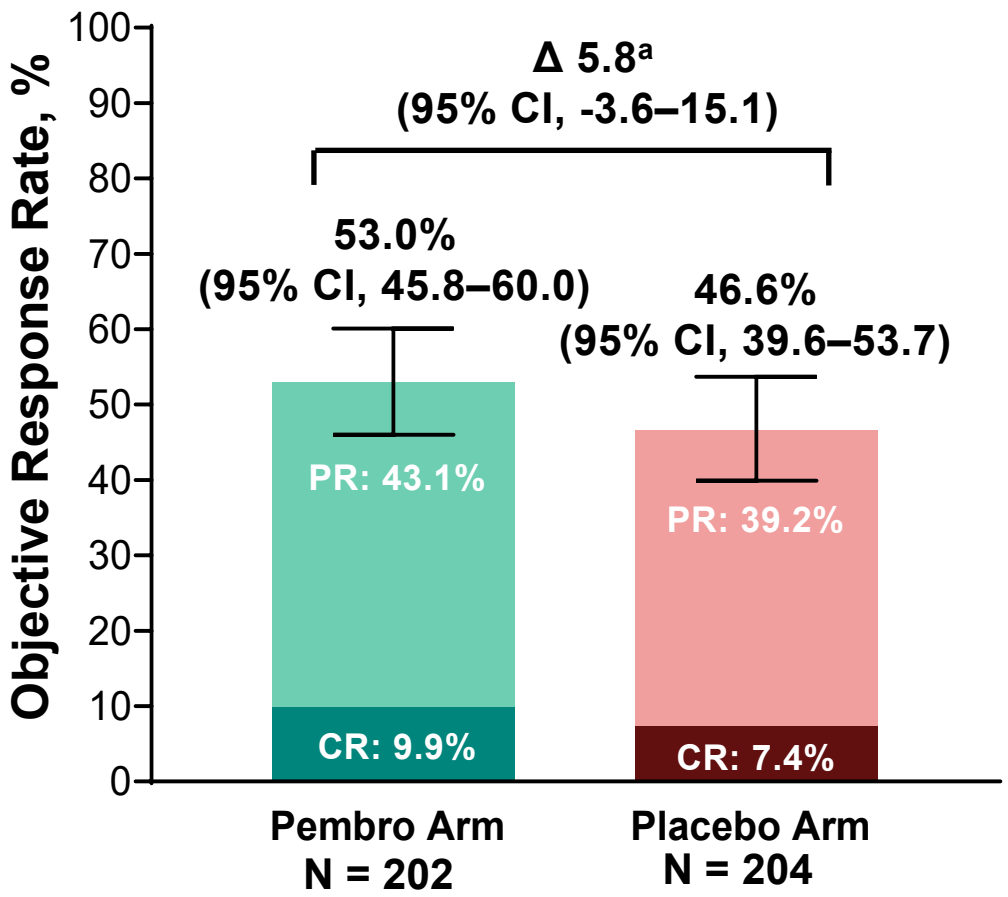


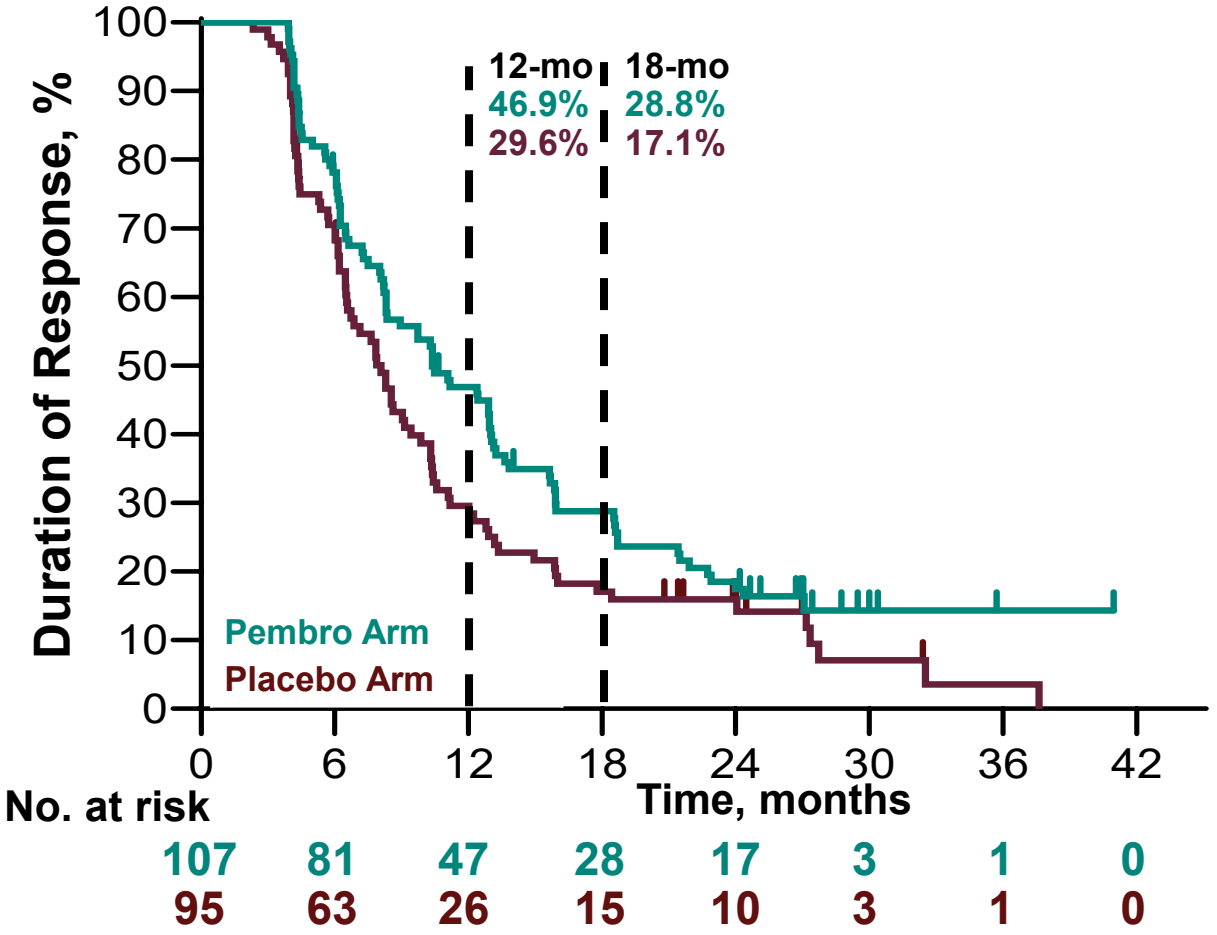
Response assessed per RECIST v1.1 by investigator review. The subgroup results shown in the forest plot were based on an unstratified Cox model, so the results for CPS ≥1 may differ slightly compared with those of the primary analysis, which were based on a stratified Cox model. Data cutoff dates: March 5, 2025, for CPS ≥1 population and September 5, 2025, for the ITT population.

Colombo N. et al. Presented at ESGO Annual Meeting, 2025; Colombo N. et al. Lancet. 2026 Apr 18;407(10538):1525-1537.

KEYNOTE B96

ORR and DOR in CPS ≥1 Population*





* Final Analysis

Response assessed per RECIST v1.1 by investigator review. [a]Delta estimated using Miettinen & Nurminen method stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

Colombo N. et al. Presented at ESGO Annual Meeting, 2025; Colombo N. et al. Lancet. 2026 Apr 18;407(10538):1525-1537.

KEYNOTE B96
Summary of Adverse Events (AEs)*

AEs, n (%)	All-Cause AEs		Treatment-Related AEs[a]		Immune-Mediated AEs and Infusion Reactions[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	319 (99.7)	316 (99.4)	313 (97.8)	303 (95.3)	126 (39.4)	60 (18.9)
Grade ≥3	265 (82.8)	225 (70.8)	217 (67.8)	176 (55.3)	38 (11.9)	11 (3.5)
Serious	180 (56.3)	123 (38.7)	107 (33.4)	63 (19.8)	36 (11.3)	7 (2.2)
Led to death	16 (5.0)	14 (4.4)	4 (1.3)[c]	5 (1.6)[d]	2 (0.6)[e]	0
Led to discontinuation						
Any treatment	136 (42.5)	109 (34.3)	120 (37.5)	90 (28.3)	23 (7.2)	8 (2.5)
Pembro/placebo	50 (15.6)	32 (10.1)	37 (11.6)	20 (6.3)	16 (5.0)	5 (1.6)
Paclitaxel	101 (31.6)	90 (28.3)	91 (28.4)	78 (24.5)	13 (4.1)	7 (2.2)
Bevacizumab	63 (19.7)	47 (14.8)	46 (14.4)	33 (10.4)	8 (2.5)	1 (0.3)

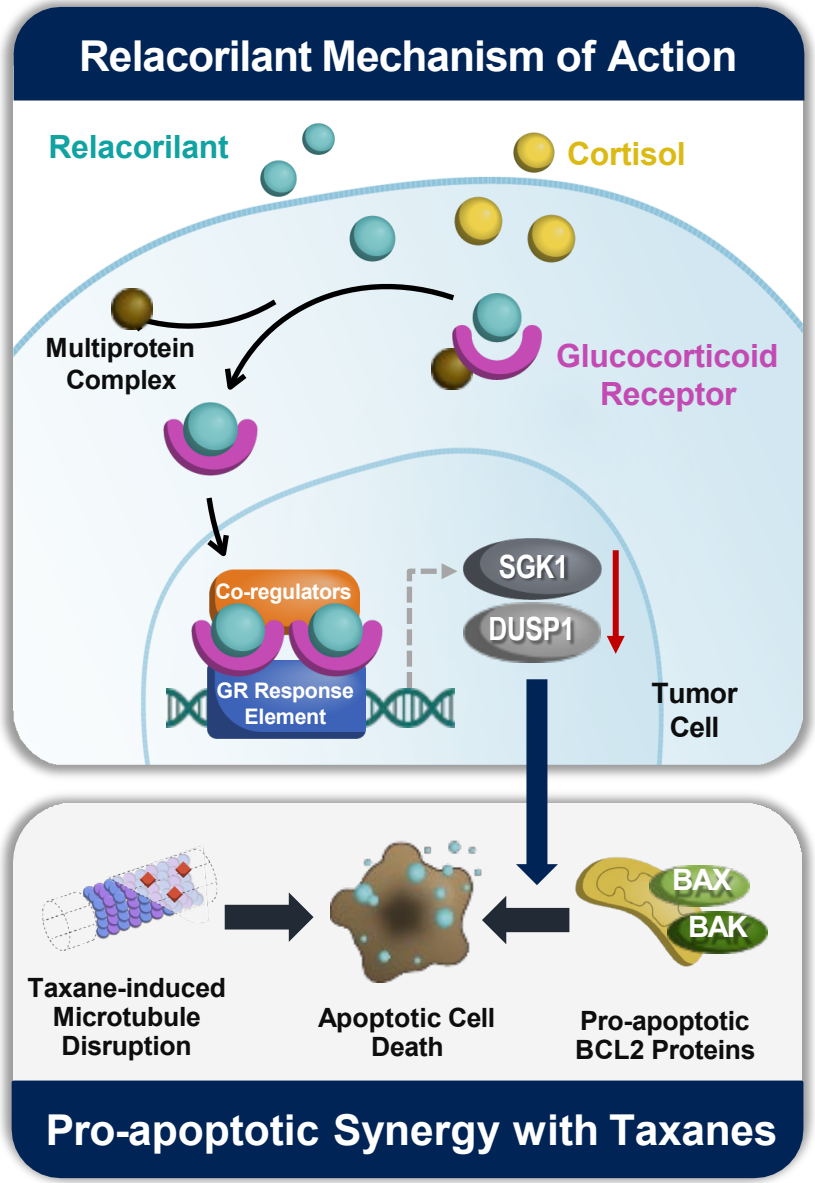
* Final Analysis

The median duration of therapy was 33 weeks in the pembro arm and 28 weeks in the placebo arm. [a]Per investigator assessment. [b]Events were based on a list of preferred terms intended to capture the known risks of pembrolizumab and considered regardless of attribution to treatment by the investigator. [c]Colitis, interstitial lung disease, acute myeloid leukemia, and intestinal perforation. [d]Cardiac failure, intestinal perforation (in 2), and large intestine perforation (in 2). [e]Colitis and pneumonitis (reported by the investigator as treatment-related interstitial lung disease). Data cutoff date: September 5, 2025.

Colombo N. et al. Presented at ESGO Annual Meeting, 2025; Colombo N. et al. Lancet. 2026 Apr 18;407(10538):1525-1537.

Background

- Patients with platinum-resistant ovarian cancer (PROC) have a poor prognosis with an overall survival of ~1 year[1]
- Cortisol-mediated survival signals through the glucocorticoid receptor (GR) reduce the sensitivity of tumor cells to chemotherapy[2,3]
- Relacorilant is a novel, selective GR antagonist (SGRA) that restores the sensitivity of cancers to cytotoxic chemotherapy[2,4-6]
- The addition of relacorilant to weekly nab-paclitaxel is associated with prolonged survival in trials of patients with PROC[5,6]
- Prior taxane use may influence outcomes to future taxane-based regimens.[7] Therefore, the survival benefit of relacorilant + nab-paclitaxel was evaluated in subgroups defined by prior taxane use



1. Martorana, et al. Int J Gynecol Cancer. 2025;35(1):100009. 2. Greenstein, et al. Oncotarget. 2021;12(13):1243-55. 3. Melhelm, et al. Clin Cancer Res. 2009;15(9):3196-3204. 4. Stringer-Reasor, et al. Gynecol Oncol. 2015;138(3):656-62. 5. Munster, et al. Clin Cancer Res. 2022;28(15):3214-24. 6. Colombo N, et al. J Clin Oncol. 2023;41(30):4779-4789. 7. Ghamande, et al. Int J Gynecol Cancer 2003;13(2):142-7.

Nab-Paclitaxel: A Rational Partner for Relacorilant

Nab-paclitaxel

- A solvent-free, albumin-bound nanoparticle form of paclitaxel[1]
- Addresses toxicities associated with paclitaxel, including hypersensitivity reactions[1]

Guideline Recommendations

- Nab-paclitaxel monotherapy is a guideline-preferred regimen for patients with PROC[2,a]

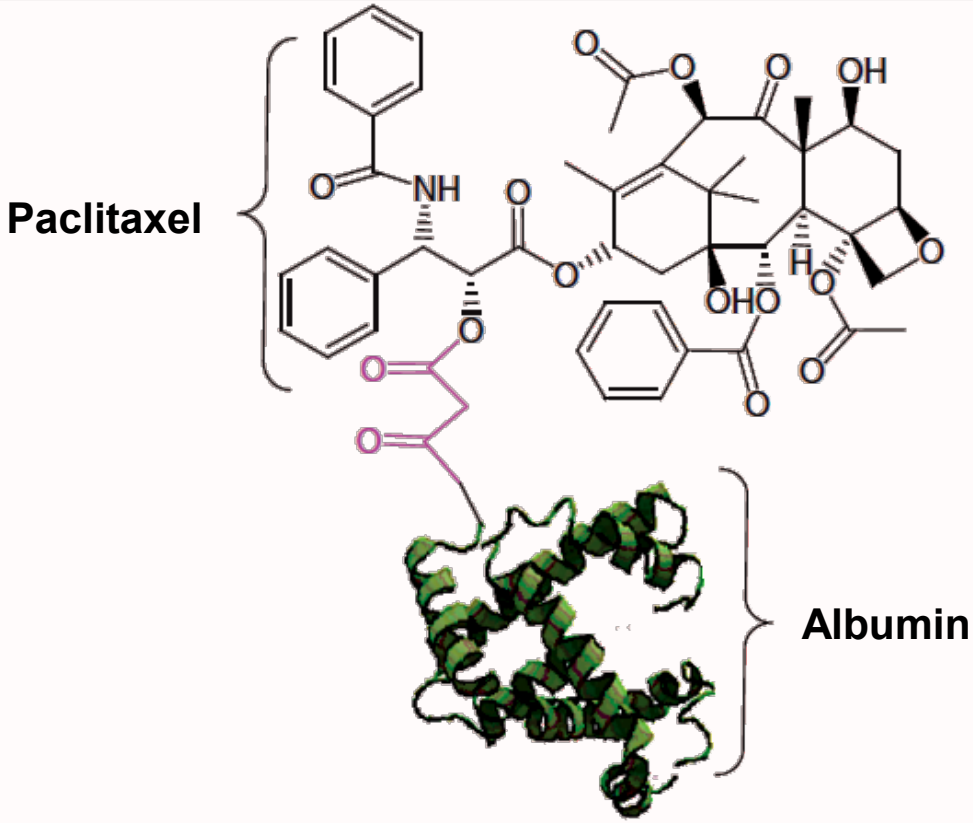
Dosing

- Nab-paclitaxel does not require coadministration with corticosteroids[3,4]

Relacorilant

- Relacorilant is a selective GR antagonist which should not be administered with steroids, making nab-paclitaxel a rational combination partner[3,4]

ADDED TO SELECTIVE GLUCOCORTICOID RECEPTOR (GR) ANTAGONIST[5,6]



- [a]*Nab-paclitaxel is not FDA-approved as a monotherapy for the management of patients with PROC.*[6]
- *FDA, United States Food and Drug Administration; PROC, platinum-resistant ovarian cancer.*
- *1. Colombo N, et al. J Clin Oncol. 2023;41(30):4779-4789; 2. NCCN Guidelines® Ovarian Cancer. V3.2025. 3. Relacorilant. Prescribing information. Corcept Therapeutics Incorporated; 2026; 4. Olawaiye AB, et al. Lancet. 2025;405(10496):2205-2216; 5. Cucinotto I, et al. J Drug Deliv. 2013;2013:905091. 6. Nab-paclitaxel. Prescribing information. Bristol Myers Squibb. 2022.*

ROSELLA: Relacorilant + Nab-Paclitaxel vs Nab-Paclitaxel monotherapy in patients with PROC[1,2]

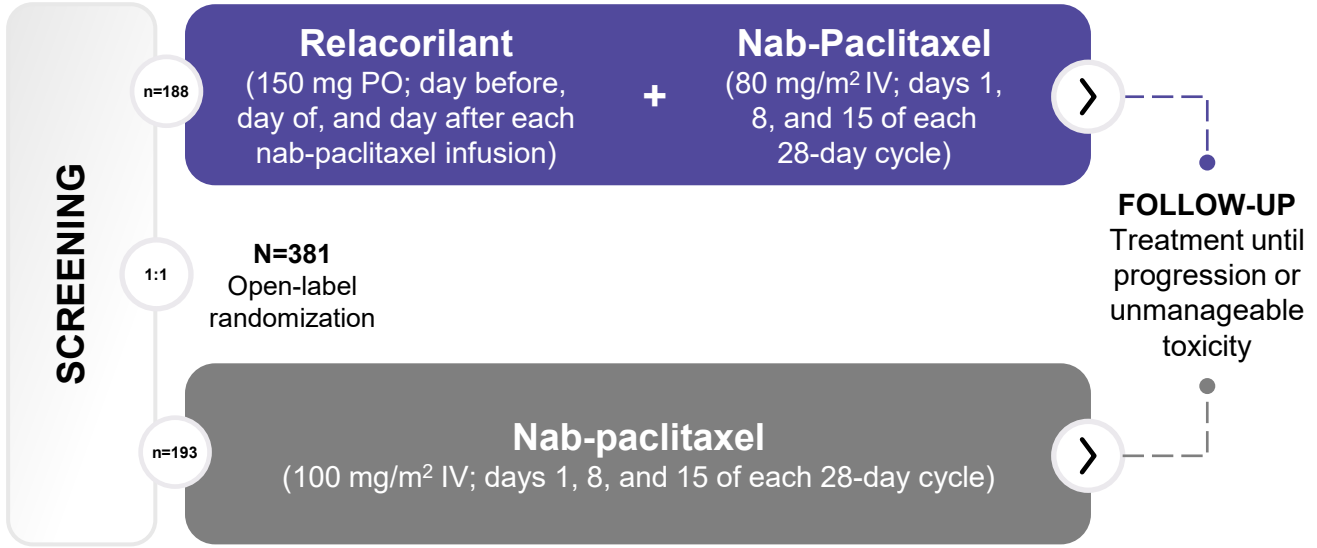
- The efficacy of Relacorilant was evaluated in ROSELLA (NCT05257408), a phase 3, multicenter, open-label, active-controlled, randomized trial in patients (intent-to-treat population N=381) with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer

Key Eligibility Criteria

- Platinum-resistant disease: PFI >1 month and <6 months
- ECOG PS 0 or 1
- 1 to 3 prior lines of therapy
- Prior bevacizumab
- Excluded chronic, systemic corticosteroids

Stratification Factors

- Prior lines of therapy (1 vs >1)
- Region (North America vs Europe vs Korea, Australia, & Latin America)



The 80 mg/m² dose of nab-paclitaxel, in combination with Relacorilant (a CYP3A4 inhibitor), provided exposure comparable to the 100 mg/m² monotherapy dose in the Phase 2 study.[1,3]

Dual Primary Endpoints

- OS[a]
- PFS by RECIST BICR[b]

Select Secondary Endpoints

- ORR
- CBR at 24 weeks
- Safety

Conducted at 117 sites in 14 countries

Fully enrolled in 15 months

Data cutoff: January 8, 2026.

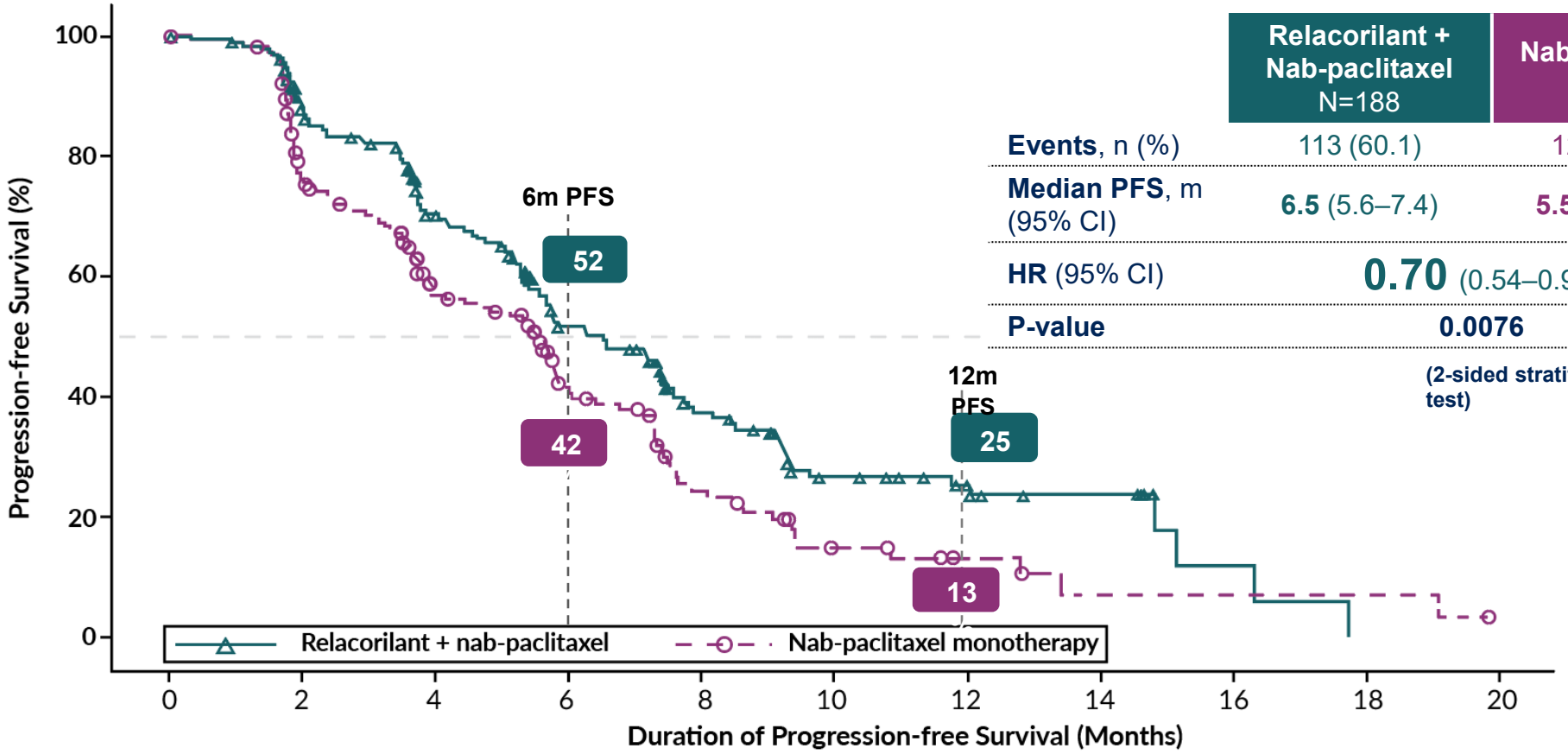
[a]Defined as the time from randomization to death; [b]Defined as the time from randomization until first documented progressive disease by RECIST v1.1 per BICR, or death, whichever occurred first.

BICR, blinded independent central review; CBR, clinical benefit rate; ECOG, Eastern Cooperative Oncology Group; IV, intravenous; ORR, objective response rate; OS, overall survival; PFI, platinum-free interval; PFS, progression-free survival; PO, by mouth; PS, performance status; RECIST, Response Evaluation Criteria in Solid Tumors.

1. Relacorilant. Prescribing information. Corcept Therapeutics Incorporated; 2026; 2. Olawaiye AB, et al. Lancet. 2025;405(10496):2205-2216;

3. Colombo N, et al. J Clin Oncol. 2023;41(30):4779-4789

ROSELLA | Relacorilant Improved Progression-Free Survival Assessed by Blinded Review at the Primary Analysis



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	113 (60.1)	121 (62.7)
Median PFS, m (95% CI)	**6.5** (5.6–7.4)	**5.5** (3.9–5.9)
HR (95% CI)	**0.70** (0.54–0.91)	
P-value	**0.0076**	

(2-sided stratified log-rank test)

No. at risk (events/cumulative events)

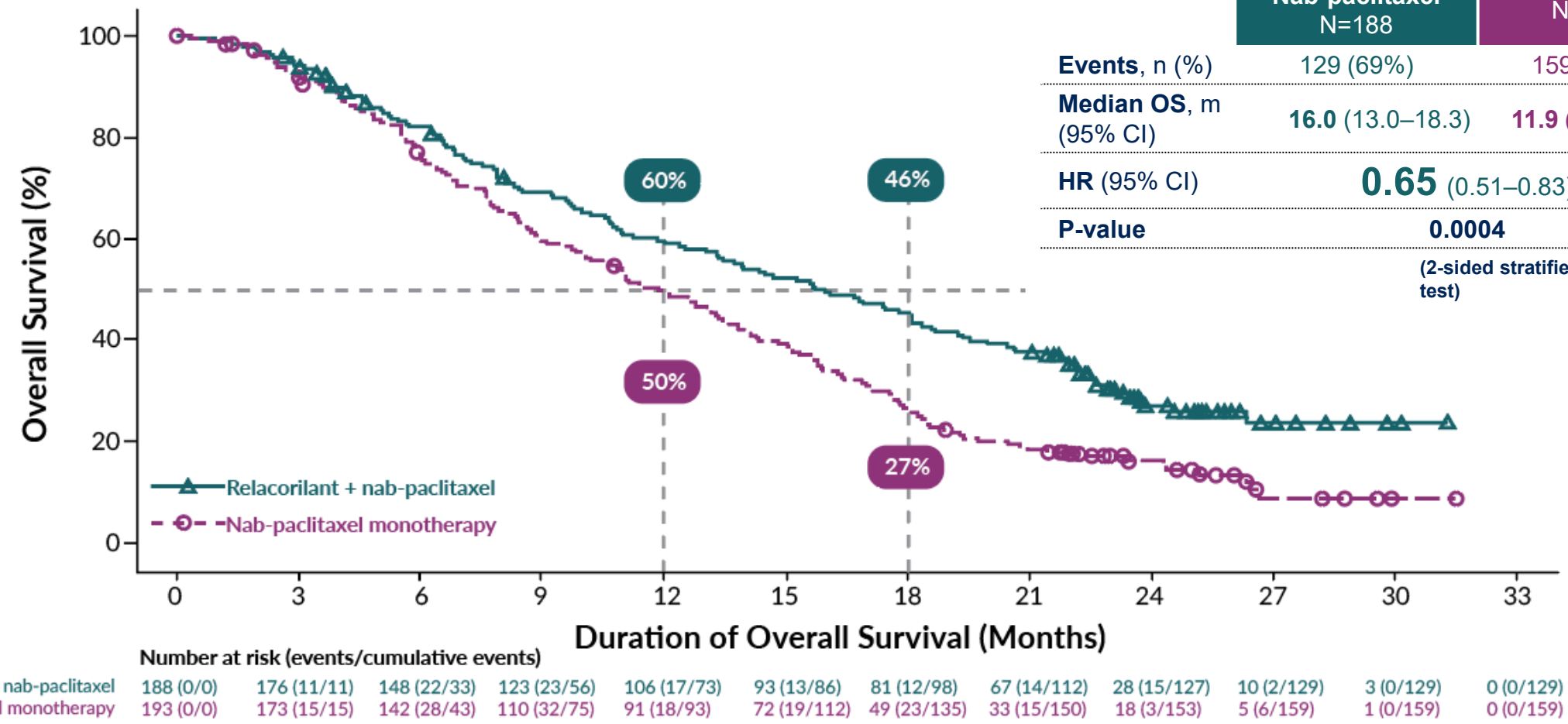
Relacorilant + nab-paclitaxel	188 (0/0)	151 (22/22)	109 (29/51)	70 (27/78)	43 (18/96)	24 (11/107)	16 (1/108)	11 (1/109)	2 (2/111)	0 (2/113)	
Nab-paclitaxel monotherapy	193 (0/0)	129 (42/42)	85 (31/73)	47 (20/93)	21 (17/110)	9 (7/117)	5 (1/118)	2 (2/120)	2 (0/120)	2 (0/120)	0 (1/121)

Median follow-up time: 9.0 months; statistical significance threshold: P≤0.04. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for progression-free survival in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.
CI, confidence interval; HR, hazard ratio; m, months; PFS, progression-free survival.

Data cutoff: Feb 24, 2025

Olawaiye AB. et al. Presented at SGO Meeting, 2026; Lorusso D, et al. Lancet. 2026 Apr 18;407(10538):1513-1524; figure adapted from Olawaiye AB et al.

ROSELLA | Relacorilant Improved Overall Survival at the Final Analysis



	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	129 (69%)	159 (82%)
Median OS, m (95% CI)	**16.0** (13.0–18.3)	**11.9** (10.0–13.8)
HR (95% CI)	**0.65** (0.51–0.83)	
P-value	**0.0004**	

(2-sided stratified log-rank test)

76% maturity

Number at risk (events/cumulative events)

Relacorilant + nab-paclitaxel	188 (0/0)	176 (11/11)	148 (22/33)	123 (23/56)	106 (17/73)	93 (13/86)	81 (12/98)	67 (14/112)	28 (15/127)	10 (2/129)	3 (0/129)	0 (0/129)
Nab-paclitaxel monotherapy	193 (0/0)	173 (15/15)	142 (28/43)	110 (32/75)	91 (18/93)	72 (19/112)	49 (23/135)	33 (15/150)	18 (3/153)	5 (6/159)	1 (0/159)	0 (0/159)

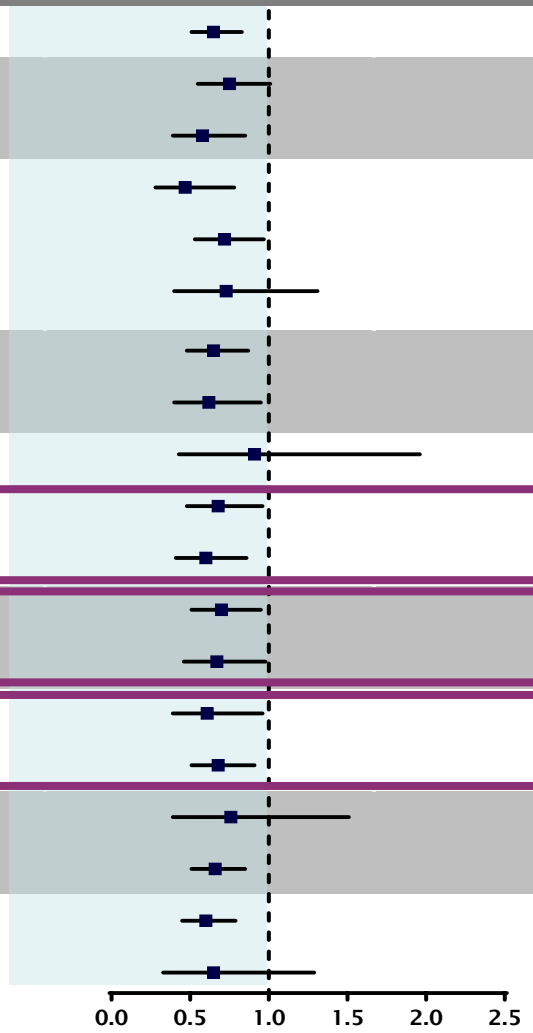
Median follow-up time: 24.8 months; statistical significance threshold at the final analysis: P≤0.0499. The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% CIs for OS in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.
CI, confidence interval; HR, hazard ratio; m, months; OS, overall survival.

Data cutoff: Jan 8, 2026

Olawaiye AB. et al. Presented at SGO Meeting, 2026; Lorusso D, et al. Lancet. 2026 Apr 18;407(10538):1513-1524; figure adapted from Olawaiye AB. et al.

ROSELLA | Relacorilant Improved Overall Survival Across Key Subgroups

Subgroup		Patients, n	Events, n	Hazard Ratio (95% CI)
All Patients		381	288	0.65 (0.51–0.83)
Age	<65 years	229	172	0.75 (0.55–1.01)
	≥65 years	152	116	0.58 (0.39–0.85)
Region	North America	90	71	0.47 (0.28–0.78)
	Europe	216	169	0.72 (0.53–0.97)
	Korea, Australia, Latin America	75	48	0.73 (0.40–1.31)
ECOG Performance Status	0	262	189	0.65 (0.48–0.87)
	1	115	97	0.62 (0.40–0.95)
	1	33	30	0.91 (0.43–1.96)
Prior Lines of Therapy	2	181	136	0.68 (0.48–0.96)
	3	167	122	0.60 (0.41–0.86)
Prior PARP Inhibitor	Yes	234	173	0.70 (0.51–0.95)
	No	147	115	0.67 (0.46–0.98)
Primary Platinum-free Interval	≤6 months	112	88	0.61 (0.39–0.96)
	>6 months	269	200	0.68 (0.51–0.91)
BRCA1/2 Mutation	Positive	47	40	0.76 (0.39–1.51)
	Negative / Unknown	334	248	0.66 (0.51–0.85)
Largest Target Lesion	<5 cm	299	221	0.60 (0.45–0.79)
	≥5 cm	45	37	0.65 (0.33–1.29)



BICR, blinded independent central review; BRCA, Breast Cancer Gene; CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; OS, overall survival; PARP, poly(ADP-ribose) polymerase.

Data cutoff: Jan 8, 2026

Olawaiye AB. et al. Presented at SGO Meeting, 2026; Lorusso D, et al. Lancet. 2026 Apr 18;407(10538):1513-1524; figure adapted from Olawaiye AB. et al.

ROSELLA | Safety Summary

Relacorilant + Nab-paclitaxel was Well-Tolerated, with a Favorable and Consistent Safety Profile

Safety Population Who Received at Least One Dose of Study Drug (N=378)	Relacorilant + Nab-paclitaxel (N=188)	Nab-paclitaxel (N=190)
Weeks of nab-paclitaxel therapy, mean (range)	**24.5** (0.1–102.4)	**19.3** (0.1–109.6)
Any AEs, n (%)	188 **(100)**	189 **(99.5)**
Grade ≥3 AEs, n (%)	141 **(74.5)**	113 **(59.5)**
Serious AEs, n (%)	66 **(35.1)**	45 **(23.7)**
All deaths on treatment or within 30 days of the last dose, n (%)*	10 **(5.3)**	8 **(4.2)**
Any AEs leading to relacorilant discontinuation, n (%)	19 **(10.1)**	—
Any AEs leading to nab-paclitaxel discontinuation, n (%)	18 **(9.6)**	15 **(7.9)**

There were no relacorilant-related fatal AEs and no cases of adrenal insufficiency.
At the final OS analysis, the safety profile was consistent with that at the time of the primary analysis.
No new safety signals were identified with longer follow-up.

**There were 4 deaths on study treatment in the combination arm due to adverse events (1 each due to cardiac arrest, intestinal perforation, ischemic stroke, and septic shock).1 death was considered related to nab-paclitaxel by the investigator.*
AEs, adverse events; OS, overall survival.

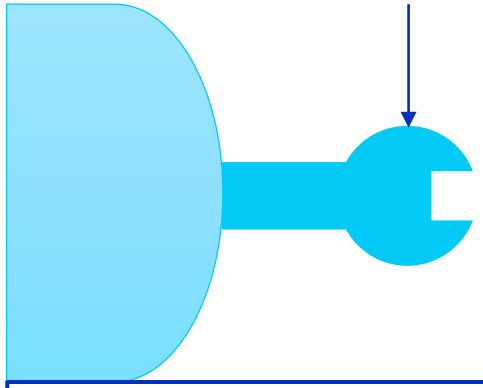
Data cutoff: Jan 8, 2026

Olawaiye AB. et al. Presented at SGO Meeting, 2026; Lorusso D, et al. Lancet. 2026 Apr 18;407(10538):1513-1524; figure adapted from Olawaiye AB. et al.

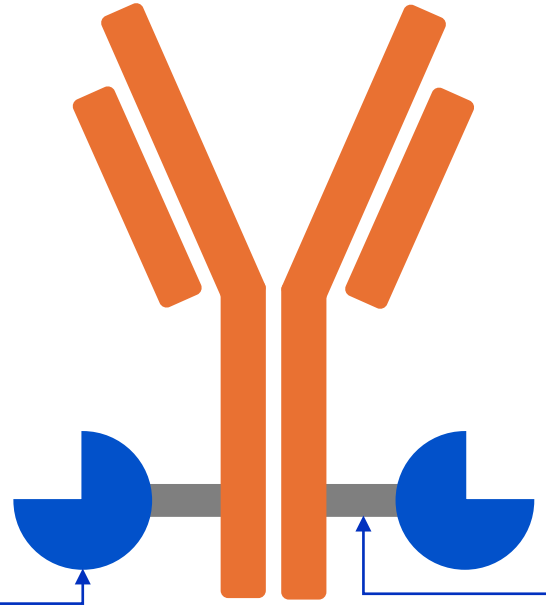
ADCs: A Paradigm Shift in the Treatment of Ovarian Cancer

Understanding their composition and structure

Tumor associated antigen/target
- High homogeneous expression in tumor
- Limited/absent expression in normal tissue
- Limited heterogeneity
- Efficient internalization following ADC binding



Drug/payload
- Highly potent chemotherapy (e.g., microtubule inhibitor, DNA-damaging agents)
- Amenable to linker attachment
- Maximized drug-to-antibody ratio



Antibody
- High affinity and avidity for target antigen
- Long half-life
- Conjugation sites with minimal impact on ADC stability, internalization, and pharmacokinetics (e.g., cysteine, lysine)
- Chimeric or humanized (decreasing immunogenicity)

Linker
- Controlled release of payload at the target site:
- Non-cleavable (e.g., lysosomal degradation of mAb)
- Cleavable (e.g., acid/redox/lysosomal sensitive)

Figure adapted from Marks S, Naidoo J.[1]

1. Marks S, Naidoo J. Lung Cancer. 2022;163:59-68.

Plenty of Payloads: Multiple ADCs are Approved, and Others are Being Actively Evaluated

ADC	Target	Antibody	Linker	Payload	Regulatory Status
Tisotumab vedotin (TV)	Tissue factor	IgG1-κ	Cleavable	MMAE	**Cervical:** Accelerated FDA approval; Full FDA approval.
Mirvetuximab soravtansine (MIRV)	FRα	IgG1-κ	Cleavable	DM4	**Ovarian:** Accelerated FDA approval; Full FDA approval.
Trastuzumab deruxtecan T-DXd)	HER2	IgG1	Cleavable	Topoisomerase I inhibitor	**HER2 IHC3+ tumor agnostic:** FDA accelerated approval.

Other transmembrane glycoproteins are highly expressed in gynecologic tumors, often associated with poor prognosis, and under study as ADC targets

TROP2 **B7-H4** **CDH6**

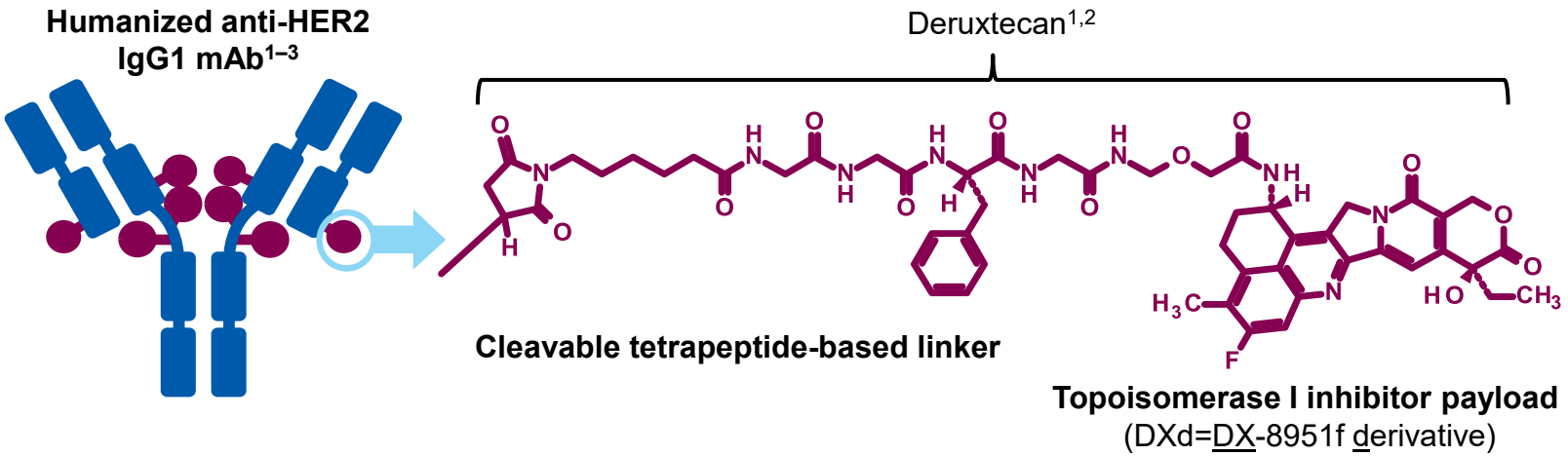
Mirvetuximab soravtansine Prescribing Information. AbbVie; 2025; Trastuzumab deruxtecan Prescribing Information. Daiichi Sankyo; 2026; Tisotumab vedotin Prescribing Information. Pfizer and Genmab; 2025.

Abbreviations: ADC, antibody-drug conjugate; DM4, maytansinoid payload DM4; FDA, US Food and Drug Administration; FRα, folate receptor alpha; HER2, human epidermal growth factor receptor 2; IgG, immunoglobulin G; IHC, immunohistochemistry; MMAE, monomethyl auristatin E; T-DXd, trastuzumab deruxtecan; TV, tisotumab vedotin.

Trastuzumab Deruxtecan (T-DXd): ADC Targeting HER2

T-DXd is an ADC with three components:

1. A humanized anti-HER2 IgG1 mAb with the same amino acid sequence as trastuzumab
2. A topoisomerase I inhibitor payload, an exatecan derivative
3. A tetrapeptide-based cleavable linker



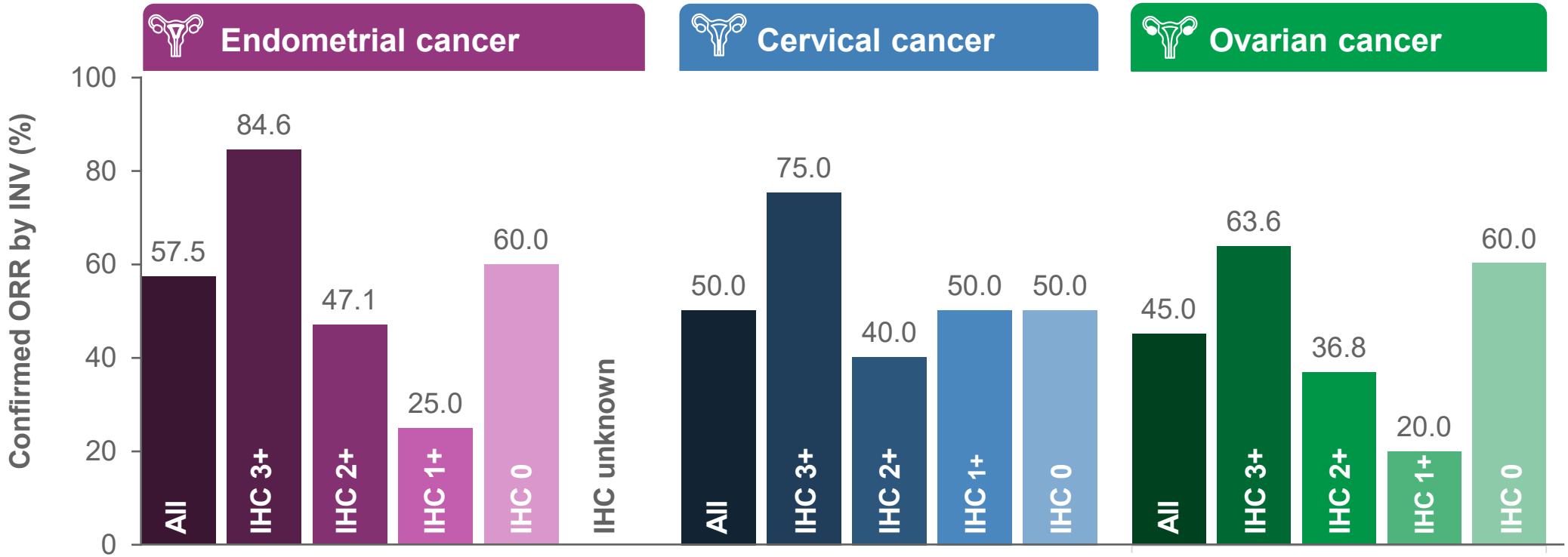
Seven Key Attributes[a,1–5]
Payload mechanism of action: topoisomerase I inhibitor
High potency of payload
High drug-to-antibody ratio ≈8
Payload with short systemic half-life
Stable linker payload
Tumor-selective cleavable linker
Bystander antitumor effect

[a]*The clinical relevance of these features is under investigation.*

ADC, antibody–drug conjugate; HER2, human epidermal growth factor receptor 2; IgG1, immunoglobulin G1; mAb, monoclonal antibody; T-DXd, trastuzumab deruxtecan.

1. Nakada T, et al. Chem Pharm Bull (Tokyo). 2019;67(3):173–185. 2. Ogitani Y, et al. Clin Cancer Res. 2016;22(20):5097–5108. 3. Trail PA, et al. Pharmacol Ther. 2018;181:126–142. 4. Okamoto H, et al. Xenobiotica. 2020;50(10):1242–1250. 5. Nagai Y, et al. Xenobiotica. 2019;49(9):1086–1096.

ORR and DOR (INV)*



	Endometrial cancer						Cervical cancer					Ovarian cancer				
	All	IHC 3+	IHC 2+	IHC 1+	IHC 0	IHC unknown	All	IHC 3+	IHC 2+	IHC 1+	IHC 0	All	IHC 3+	IHC 2+	IHC 1+	IHC 0
Total n in subgroup	40	13	17	4	5	1	40	8	20	8	4	40	11	19	5	5
n of responders	23	11	8	1	3	0	20	6	8	4	2	18	7	7	1	3
Median DOR, months†	**NR**	**NR**	**18.2**	**NR**	**9.9**	**-**	**14.2**	**NR**	**3.8**	**14.2**	**NR**	**11.3**	**22.1**	**11.3**	**8.3**	**4.5**
95% CI‡	9.9, NE	9.6, NE	3.0, NE	-	2.8, NE	-	4.1, NE	9.3, NE	2.8, NE	8.3, NE	6.8, NE	4.1, 22.1	4.2, NE	2.8, NE	-	2.6, NE

HER2 status by central testing

*Similar ORR and DOR results were reported by retrospective independent central review; †median DOR reported for patients with a confirmed an objective response only; ‡CI not shown where n=1 responder

CI, confidence interval; DOR, duration of response; HER2, human epidermal growth factor receptor 2; IHC, immunohistochemistry; INV, investigator; NE, not evaluable; NR, not reached; ORR, objective response rate

Presented by Jung-Yun Lee et al. PO007 LBA, IGCS annual global meeting 2023

Rationale for Targeting FRα in Ovarian Cancer

"**FRα has emerged as one of the most attractive candidates** for molecularly targeted approaches for OC due to its **almost ubiquitous expression on the surface of HGSOC** and its **ability to internalize large molecules containing a cytotoxic payload**"[1]

FRα in ovarian tumours

- Expression **varies by sub-type**, e.g., a consortium-based analysis of data from 12 studies showed FRα expression in:[2]
  - **76%** of high-grade serous
  - **50%** of low-grade serous
  - **32%** of clear cell carcinomas
- Expression is **retained in recurrent and metastatic** tumours and is **not significantly altered in response to chemotherapy**[3-5]

FRα in non-malignant ovarian tissues

- FRα is **scarcely expressed** in non-malignant ovarian tissues[6]
- Limited to polarized epithelia, such as in the choroid plexus, kidney, lung, and placenta[3,7]
- FRα has a **minimal physiological role in non-malignant tissues** after embryogenesis[6]

Following the disappointing activity of FRα-targeted antibodies and early folate–drug conjugates, reproducible single-agent activity has been seen with FRα-targeted antibody–drug conjugates and small molecules[6]

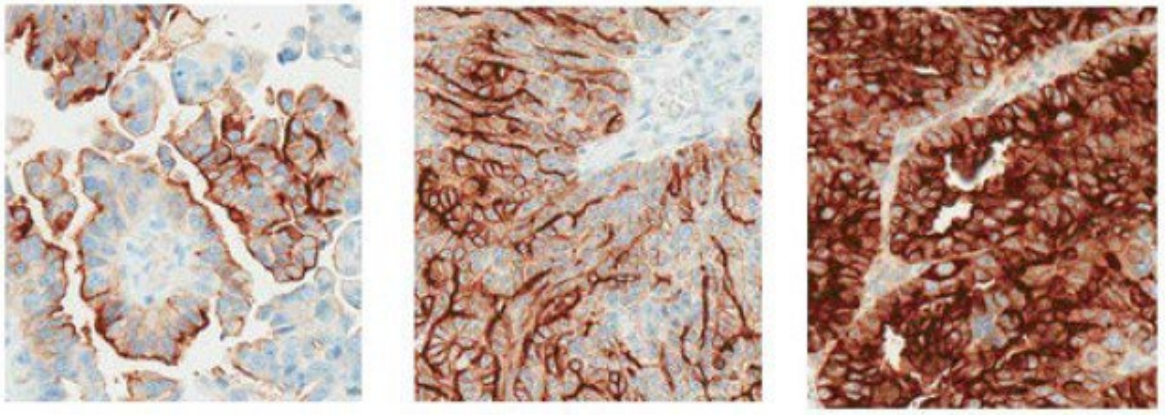
FR, folate receptor; HGSOC, high-grade serous ovarian cancer; OC, ovarian cancer.

1. Chelariu-Raicu A, et al. Int J Gynecol Cancer. 2023;33(3):420-429. 2. Köbel M, et al. Br J Cancer. 2014;111(12):2297-307. 3. Birrer MJ, et al. Oncologist. 2019;24(4):425-429. 4. Despierre E, et al. Gynecol Oncol. 2013;130(1):192-9. 5. Rubinsak LA, et al. Appl Immunohistochem Mol Morphol. 2018;26(8):567-572.

6. Scaranti M, et al. Nat Rev Clin Oncol. 2020;17(6):349-359. 7. Elnakat H, et al. Adv Drug Deliv Rev. 2004;56(8):1067-84. Elnakat

Characterization of Folate Receptor Alpha (FRα) Expression

Representative low, medium, and high staining patterns for FRα from archival tumor specimens[1]



Low
25–49% of cells with ≥2+ intensity

Medium
50–74% of cells with ≥2+ intensity

High
≥75% of cells with ≥2+ intensity

Figure adapted from Martin LP, et al.[1]

Prevalence of PS2+ FRα expression in 2,869 pooled samples from patients with HGSOC[2]

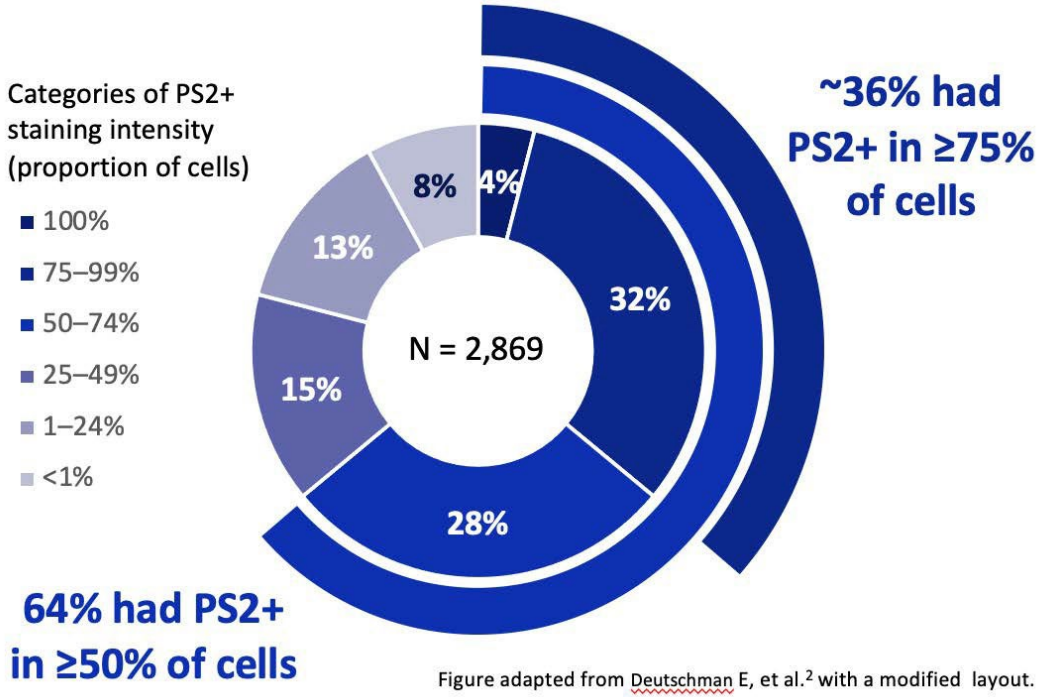
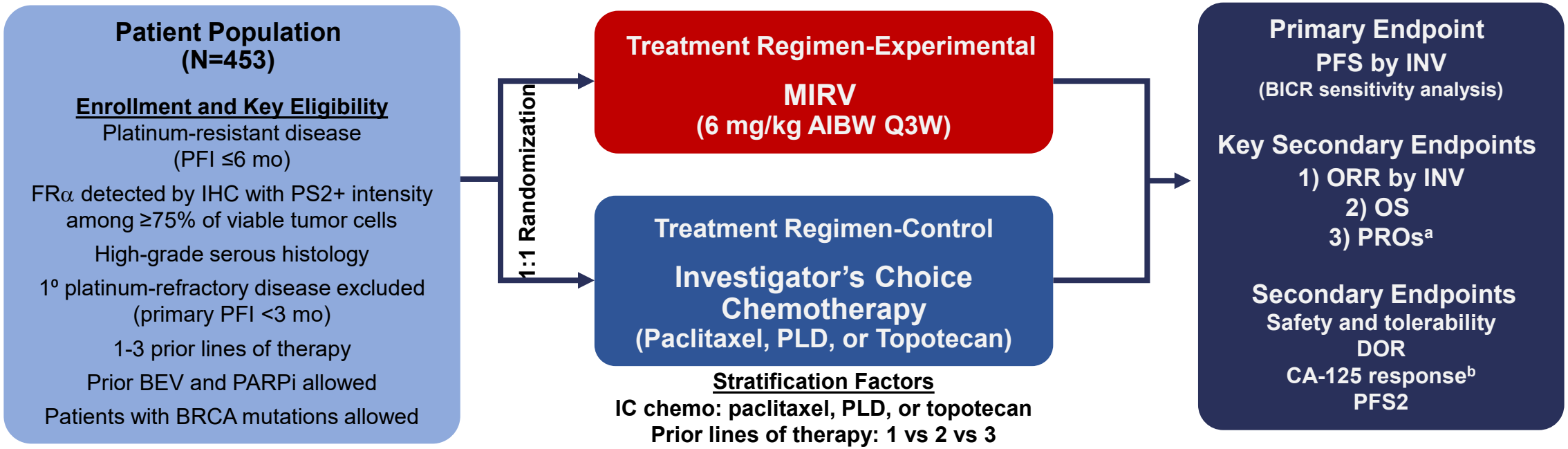


Figure adapted from Deutschman E, et al.[2] with a modified layout.

MIRASOL/ GOG 3045/ENGOT-ov55 – Study Design

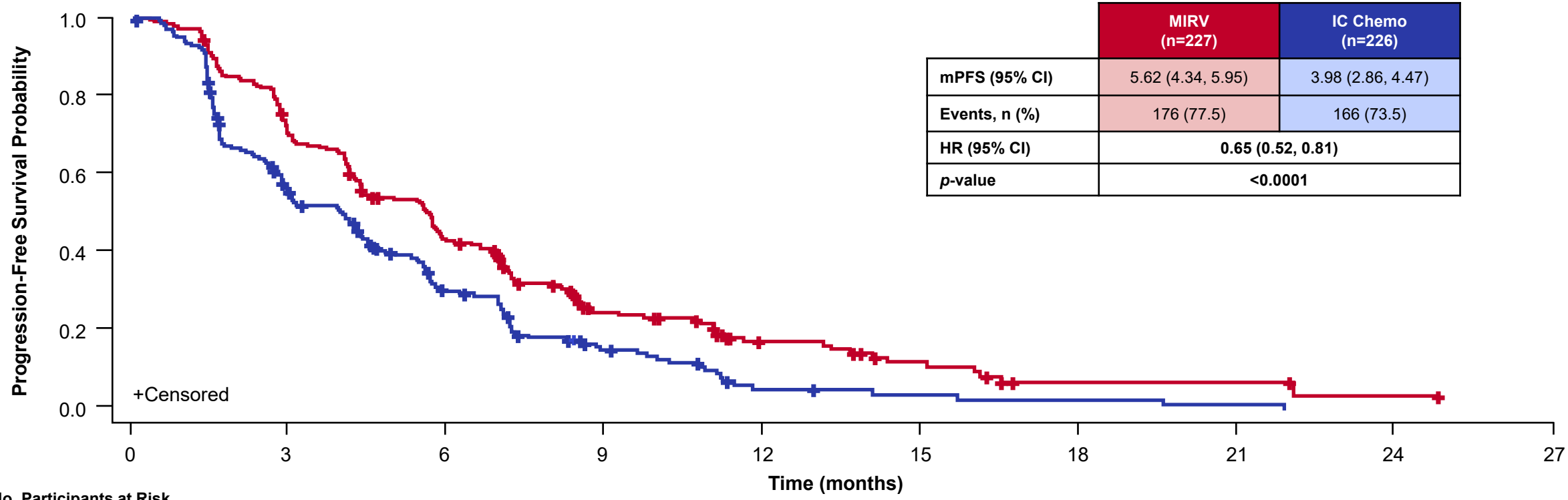
An open-label, phase 3 randomized trial of MIRV vs investigator's choice chemotherapy in patients with FRα-high platinum-resistant ovarian cancer



AIBW, adjusted ideal body weight; BEV; bevacizumab; BICR, blinded independent central review; BRCA, BReast CAncer gene; CA-125, cancer antigen 125; chemo, chemotherapy; DOR, duration of response; FRα, folate receptor alpha; IC, investigator's choice; IHC, immunohistochemistry; INV, investigator; MIRV, mirvetuximab soravtansine; ORR, objective response rate; OS, overall survival; PARPi, poly (ADP-ribose) polymerase inhibitors; PFI, platinum-free interval; PFS, progression-free survival; PFS2, time from randomization until second disease progression; PLD, pegylated liposomal doxorubicin; PROs, patient-reported outcomes; PS2+, positive staining intensity ≥2; Q3W, every 3 weeks.
[a]PROs will be measured using the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire, 28-item Ovarian Cancer Module (OV28) study instrument.
[b]Gynecological Cancer InterGroup (GCIG) criteria..

Moore KN. et al; LBA 5507 Presented at ASCO Meeting 2023; Moore KN et al; N Engl J Med 2023; 389:2162-2174; Figure adapted from Moore KN. et al.

MIRASOL: Progression-Free Survival by Investigator



	MIRV (n=227)	IC Chemo (n=226)
mPFS (95% CI)	5.62 (4.34, 5.95)	3.98 (2.86, 4.47)
Events, n (%)	176 (77.5)	166 (73.5)
HR (95% CI)	0.65 (0.52, 0.81)	
p-value	<0.0001	

No. Participants at Risk

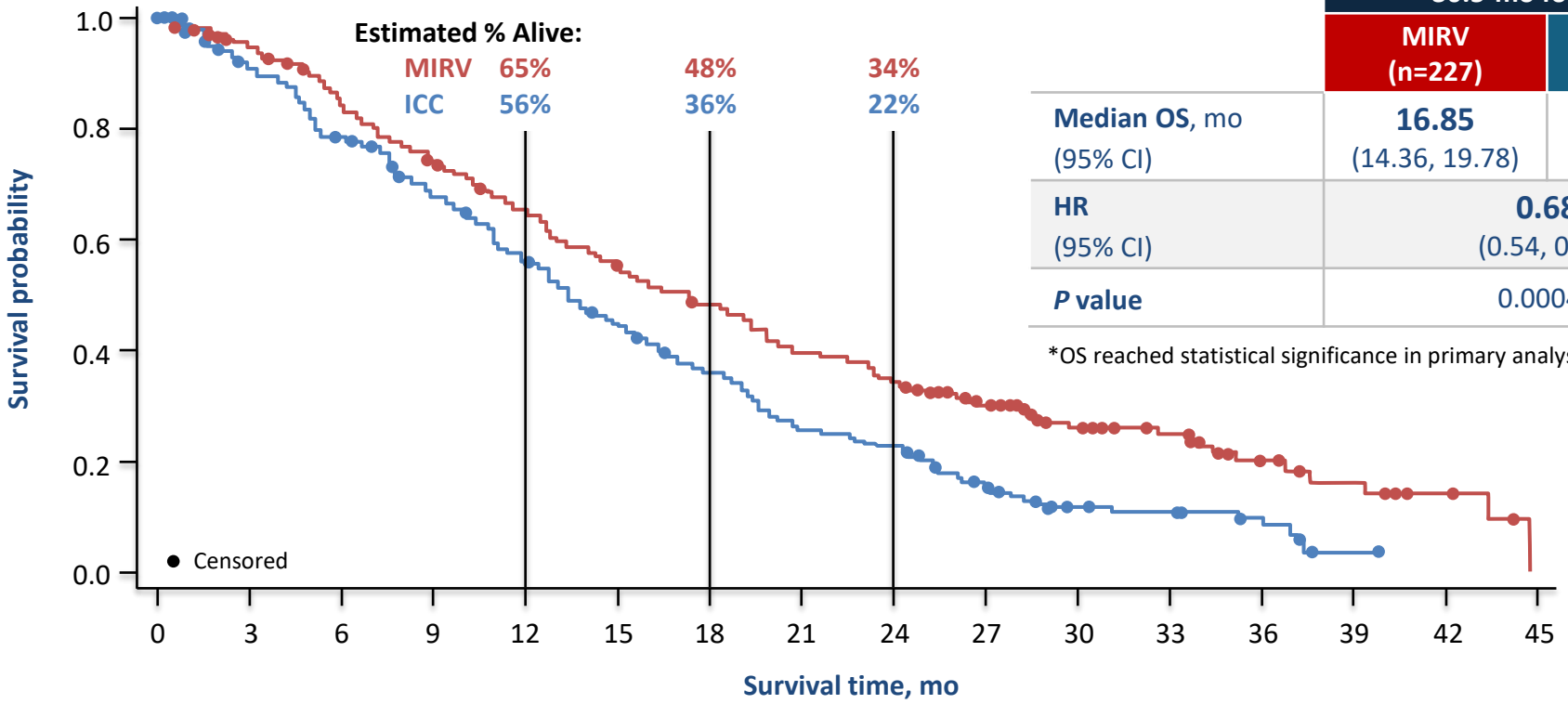
MIRV	227	151	89	38	18	10	3	3	1	0
IC Chemo	226	98	48	19	5	3	2	1	0	

Data cutoff: March 6, 2 Data cutoff: March 6, 2023.
CI, confidence interval; HR, hazard ratio; IC Chemo, investigator's choice chemotherapy; MIRV, mirvetuximab soravtansine; mPFS, median progression-free survival; ORR, objective response rate; HR, hazard ratio; OR, odds ratio 023. CI,

Moore KN. et al; LBA 5507, Presented at ASCO Meeting 2023; Moore KN et al; N Engl J Med 2023; 389:2162-2174; Figure adapted from Moore KN. et al.

MIRASOL: Final Overall Survival

(median follow-up of **30.5 months**)



	Final analysis[a] 30.5-mo follow-up		Primary analysis[b] 13.1-mo follow-up	
	MIRV (n=227)	ICC (n=226)	MIRV (n=227)	ICC (n=226)
Median OS, mo (95% CI)	**16.85** (14.36, 19.78)	**13.34** (11.37, 15.15)	16.46 (14.46, 24.57)	12.75 (10.91, 14.36)
HR (95% CI)	**0.68** (0.54, 0.84)		0.67 (0.50, 0.89)	
***P* value**	0.0004*		0.0046	

*OS reached statistical significance in primary analysis. The *P* value at the final analysis is descriptive.

Number of patients at risk:

MIRV	227	204	178	156	135	114	98	80	70	50	33	25	12	8	4	0
ICC	226	186	159	134	110	85	67	48	42	25	13	11	7	1	0	

At the final analysis, the HR for OS (0.68) **continued to favor MIRV** over ICC, with patients treated with MIRV exhibiting a **32% reduction in risk of death**

HR, hazard ratio; ICC, investigator's choice chemotherapy; ITT, intent-to-treat; MIRV, mirvetuximab soravtansine-gynx; OS, overall survival; PFS, progression-free survival.

[a]Data cutoff: September 26, 2024. [b]Data cutoff: March 6, 2023.

Moore KN. et al; LBA5507, Presented at ASCO Meeting 2023; Moore KN et al; N Engl J Med 2023; 389:2162-2174; Slide adapted from: Van Gorp et al. LBA08, Presented at SGO Meeting, 2025

Adverse events in ≥10% of Patients Who Received Mirvetuximab Soravtansine in MIRASOL

Adverse event	Mirvetuximab| Soravtansine (n=218)		Standard chemotherapy (n=207)[a]	
	All Grades (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Gastrointestinal disorders				
Abdominal pain[b]	34	3	23	2
Diarrhea	29	1	17	0.5
Constipation	27	0	19	1
Nausea	27	2	29	2
Vomiting	18	3	18	1
Eye disorders				
Blurred vision[c]	45	9	3	0
Keratopathy[d]	37	11	0	0
Dry eye[e]	29	3	5	0
Photophobia	18	0.5	0.5	0
Cataract[f]	16	3	0.5	0

[a]Chemotherapy: paciltaxel; pegylated liposomal doxorubicin (PLD), topotecan. [b]Abdominal pain includes abdominal pain, abdominal pain upper, abdominal pain lower, and abdominal discomfort. [c]Blurred vision includes vision blurred, vitreous floaters, visual acuity reduced, diplopia, presbyopia, accommodation disorder, and visual impairment. [d]Keratopathy includes corneal disorder, corneal epithelial microcysts, keratitis, keratopathy, corneal deposits, punctate keratitis, and corneal opacity. [e]Dry eye includes dry eye and lacrimation increased. [f]Cataract includes cataract and cataract nuclear.

Adverse Events in ≥10% of Patients Who Received Mirvetuximab Soravtansine in MIRASOL *(continued)*

Adverse event	Mirvetuximab Soravtansine (n=218)		Standard chemotherapy (n=207)[a]	
	All Grades (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
General disorders and administration site conditions				
Fatigue[b]	47	3	41	7
Nervous system disorders				
Peripheral neuropathy[c]	37	4	23	4
Headache	14	0	10	0
Musculoskeletal and connective tissue disorders				
Musculoskeletal pain[d]	31	1	21	2
Metabolism and nutrition disorders				
Decreased appetite	18	1	14	1
Respiratory, thoracic, and mediastinal disorders				
Pneumonitis[e]	10	0.5	0.5	0

[a]Chemotherapy: paciltaxel; pegylated liposomal doxorubicin (PLD), topotecan. [b]Fatigue includes fatigue and asthenia. [c]Peripheral neuropathy includes neuropathy peripheral, peripheral sensory neuropathy, peripheral motor neuropathy, paresthesia, hypoesthesia, polyneuropathy, neurotoxicity, and peripheral sensorimotor neuropathy. [d]Musculoskeletal pain includes back pain, myalgia, neck pain, arthralgia, musculoskeletal pain, non-cardiac chest pain, bone pain, pain in extremity, musculoskeletal stiffness, musculoskeletal chest pain, and musculoskeletal discomfort. [e]Pneumonitis includes pneumonitis, interstitial lung disease, respiratory failure, and organizing pneumonia.

Leading Targets for ADCs in Gynecologic Cancers

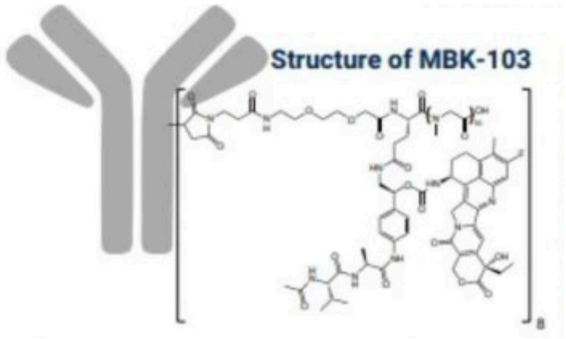
1. FRα
2. HER2
3. TROP2
4. CDH6
5. B7H4
6. NaPi2b
7. CLND6

Bujnak A, et al. Gynecol Oncol, 2025; 195, 180-191.

Targeting the Folate Receptor

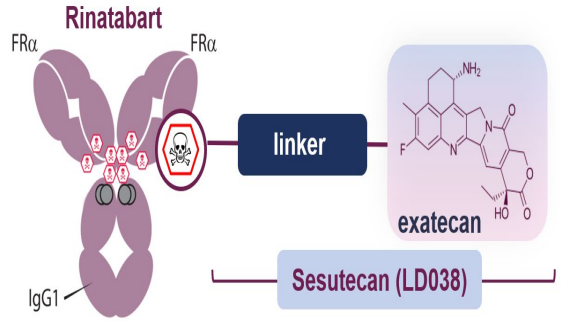
Sofetabart mipitecan * (LY4170156 / MBK-102)

- Fc-silenced FRα IgG1 that binds at low nm affinities
- Polysaccharide hydrophobic linker with a high DAR (8) Cleavable linker
- Proprietary orthogonally embedded dipeptide (VAL-Ala)
- Exatecan payload (topoisomerase inhibitor)



Rinatabart sesutecan (Rina-S)

- A human monoclonal antibody directed at FRα
- A novel hydrophilic protease-cleavable linker
- DNA-damaging agents: Exatecan payload (topoisomerase inhibitor
- Rina-S features a high, homogenous DAR=8



Torvutatug samrotecan (AZD5335)

- Targeted ADC with a potent TOP1i payload
- The cleavable peptide linker is bystander-capable and serum-stable.
- AZD5335 has an average DAR of 8.

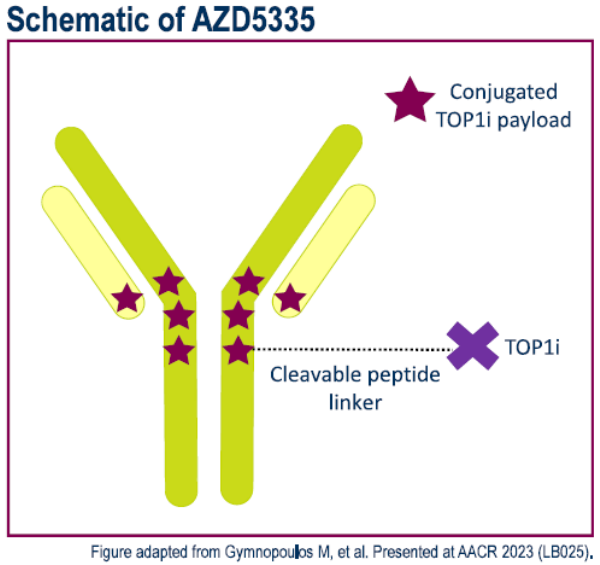


Figure adapted from Gymnopoulos M, et al. Presented at AACR 2023 (LB025).

FDA.gov

* Breakthrough Therapy designation for the treatment of certain patients with platinum-resistant ovarian
# Breakthrough Therapy designation in advanced endometrial cancer

Lilly news release, 2026; Ray-Coquard IL et al. Ann Oncol. 2025;36:S671-S672; Genmab news release, 2025; Winer IS et al. J Clin Oncol. 2025;43(suppl 16):3039; Zoeller JJ et al. Clin Cancer Res. 2025;31:5261-5275.

Response Rates, Non-Biomarker-Selected PROC Patients

Agent	Modality (Biomarker)	Trial	N	ORR	DCR	mDOR
FDA approved or NCCN recommended for PROC						
Relacorilant (+ chemo)	GR antagonist	Phase 3 (NCT05257408)	188[1]	37%	NR	NR
Bevacizumab (+ chemo)	Anti-VEGF mAb (none)	Phase 3 (NCT00976911)	179[2]	27%	NR	NR
Proof-of-Concept Data for Therapies in Development						
Mo-Rez	B7-H4 ADC (none)	Phase 1 (NCT06431594)	34[3]	62%	NR	NR
Rina-S	FRα ADC (none)	Phase 1/2 (NCT05579366)	18[4]	56%	88.9%	NR
Torvu-Sam	FRα ADC (none)	Phase 1/2 (NCT05797168)	57[5]	56%	NR	NR
Olvi-Vec (+ chemo + bev)	Oncolytic virus (none)	Phase 1/2 (NCT02759588)	24[6]	54%	88%	7.6
R-Dxd	CDH6 ADC (none)	Phase 2/3 (NCT06161025)	36[7]	50%	80.6%	NR
TUB-040	NaPi2b ADC (none)	Phase 1/2 (NCT06303505)	46[8]	50%	96%	NR
Sofe-M*	FRα ADC (none)	Phase 1 (NCT06400472)	104[9]	50%	78%	NR
Iza-bren	EGFR × HER3 ADC (none)	Phase 1/2 (NCT05803018)	49[10]	47%	NR	NR

NR: not reported

*ORR for all dose levels and FRα expression levels.

- Where possible, PoC data are from pivotal dose level and pt population.
- Agents are dosed as a monotherapy unless specified otherwise.
- Response rates were generated from the hyperlinked trial.
- N is the number of OC pts reflected by ORR values.

Data Sources

1. *OncLive Mar '26 PR*
2. *The ASCO Post May '14*
3. *Oaknin A, et. al. SGO 2026 presentation*
4. *Genmab Mar '25 PR*
5. *Oaknin A, et. al. ESMO 2025 presentation*
6. *Holloway RW, et. al. JAMA Oncology 2023*
7. *Ray-Coquard I, et. al. ESMO 2025 presentation*
8. *Tubulis Oct '25 PR*
9. *Ray-Coquard I, et. al. ESMO 2025 poster*
10. *Wu X, et. al. ESMO 2025 abstract*

Response Rates Biomarker-Selected PROC Patients

Agent [1]	Modality (Biomarker)		Trial	N	ORR	DCR	mDOR
FDA approved or NCCN recommended for PROC							
Pembro (+ chemo +/- bev)	Anti-PD-1 mAb (PD-L1+)		Phase 3 (NCT05116189)	202[1]	53%	NR	NR
T-DXd	HER2 ADC	(HER2+ IHC3+) (HER2+ IHC2+)	Phase 2 (NCT04482309)	11[2] 19[2]	64% 37%	NR NR	12.5 4.1
MIRV	FRα ADC (FRα+)		Phase 3 (NCT04209855)	227[3]	42%	80.2%	6.77
Proof-of-Concept Data for Therapies in Development							
INCB123667	CDK2i (Cyclin E oex)		Phase 1 (NCT05238922)	16[4]	31%	75.0%	NR
Azenosertib	WEE1 inhibitor (Cyclin E+)		Phase 2 (NCT05128825)	16[5]	31%	NR	4.2
Puxi-Sam	B7H4		Phase 1/2A (NCT05123482)	51[6]	47%	84%	7.1

NR: not reported

Data Sources

1. *Colombo N, et. al. ESMO 2025 presentation*
2. *Meric-Bernstam F, et. al. JCO 2023*
3. *Moore KN, et. al. NEJM 2023*
4. *BanerIncyte ESMO '24 investor presentation Sep '24*
5. *Zentalis corporate presentation Apr '25*
6. *Mileshkin L, et. al. ASCO presentation Jun 2026*

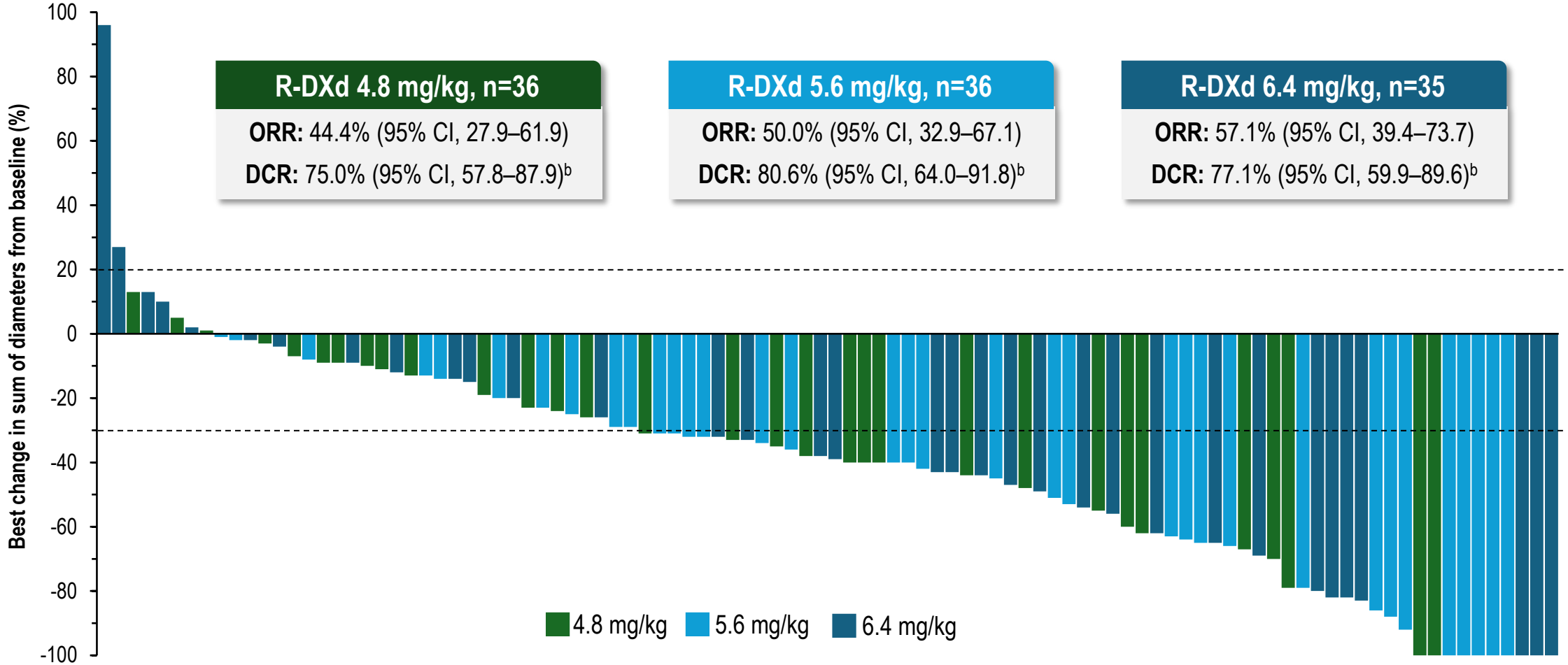
- Where possible, PoC data are from pivotal dose level and pt population.
- Agents are dosed as a monotherapy unless specified otherwise.
- Response rates were generated from the hyperlinked trial.
- N is the number of OC pts reflected by ORR values.

ADCs approved and in late-phase development in PROC

	Mirvetuximab soravtansine	Torvutatug samrotecan	Sofetabart mipitecan	Rinatabart sesutecan	Trastuzumab deruxtecan	Mocertatug rezetecan	Raludotatug deruxtecan	TUB-040
Target	FRα				HER2	B7-H4	CDH6	NaPi2b
Payload	*MT inhibitor* **DM4**	*TOPO1 inhibitor* **AZ proprietary**	*TOPO1 inhibitor* **Exatecan**	*TOPO1 inhibitor* **Exatecan**	*TOPO1 inhibitor* **Deruxtecan**	*TOPO1 inhibitor* **Exatecan derivative**	*TOPO1 inhibitor* **Deruxtecan**	*TOPO1 inhibitor* **Exatecan**
Linker	Sulfo-SPDB	PEG8-valine-alanine	Proprietary poly-sarcosine (PSARlink)	Proprietary hydrophilic linker	Tetrapeptide	Tetrapeptide	Tetrapeptide	P5 Conjugation Technology
Dar · Dosing	**DAR 3.4** 6 mg/kg Q3W	**DAR 8** 2 mg/kg* Q3W	**DAR 8** 4 mg/kg Q3W	**DAR 8** 120 mg/m² q3wk	**DAR 8** 5.4 mg/kg Q3W	**DAR 6** 5.8 mg/kg* Q3W	**DAR 8** 5.6 mg/kg* Q3W	**DAR 8** 1.67 mg/kg
Approved for	FRα+ PROC	None	None	None	HER2+ IHC3+ solid tumor pts including PROC	None	None	None
Stage of Development in PROC	Phase 3 **MIRASOL** (NCT04209855) *Full approval*	Phase 3 **TREVI-OC-01** (NCT07218809)	Phase 3 **FRAmework-01** (NCT07213804)	Phase 3 **RAINFOL-02** (NCT06619236) *Closed to recruitment*	Phase 2 **DESTINY-PanTumor02** (NCT04482309) *Closed to recruitment*	Phase 3 **BEHOLD-Ovarian01** (NCT07286266) *Not yet recruiting*	Phase 2/3 **REJOICE-Ovarian01** (NCT06161025)	Phase 1/2a **NAPISTAR1-01** (NCT06303505)

Trials are actively recruiting unless specified otherwise; AA: accelerated approval. * Likely to be P3 dose but not yet publicly announced.

Targeting CDH6: Tumor Responses to RD-X-d Were Seen Irrespective of Dose[a]



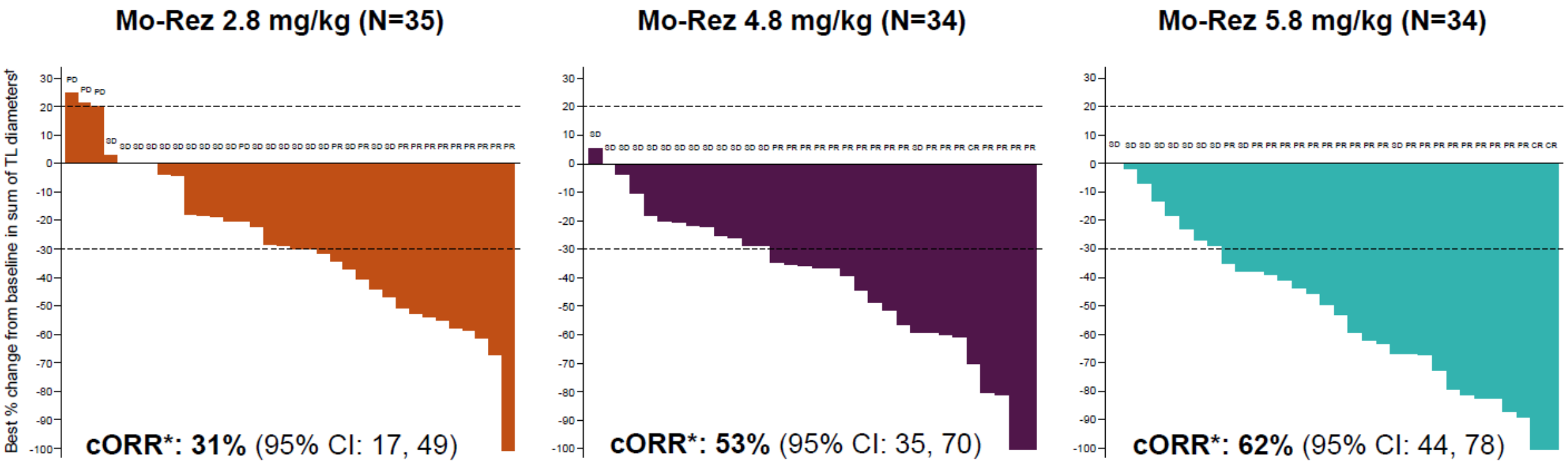
Data cutoff: February 26, 2025. The median follow-up for 4.8-mg/kg, 5.6-mg/kg, and 6.4-mg/kg cohorts was 5.6 months (95% CI, 4.7–6.3), 5.6 months (95% CI, 4.6–5.8), and 5.2 months (95% CI, 4.9–5.8), respectively.

[a]Antitumor response assessed by BICR per RECIST 1.1. Only patients with measurable disease at baseline and ≥1 post-baseline tumor scan, both by BICR, were included in the waterfall plot (n=100). Six patients (R-DXd 4.8 mg/kg [n=5]; 6.4 mg/kg [n=1]) did not have measurable disease at baseline and one patient (R-DXd 5.6 mg/kg) had no adequate post-baseline tumor assessment. [b]DCR was defined as percentage of patients with BOR of CR, PR, or SD (per RECIST 1.1).

BICR, blinded independent central review; CI, confidence interval; DCR, disease control rate; ORR, objective response rate; RECIST 1.1, Response Evaluation Criteria in Solid Tumours, version 1.1.

Ray Coquard I. et al. LBA42 Presented at ESMO Annual Meeting, 2025

Targeting B7-H4—Mocertatug Rezetecan



Responses were observed across a range of B7-H4 expression levels

Oaknin, A. et al., LBA-06 presented at SGO 2026

Median (IQR) follow-up was 6.1 (4.7, 6.8) months for the overall cohort (N=131)

BEHOLD-1

Efficacy population: N=103.
*Confirmed ORR reported in all randomized patients who had the opportunity for ≥18 weeks of follow-up;†waterfall plots show confirmed best overall response for patients with at least one post-baseline tumor assessment.
B7-H4, B7 homolog 4 protein; c, confirmed; CI, confidence interval; CR, complete response; Mo-Rez, mocertatug rezetecan; ORR, objective response rate; PD, progressive disease; PR, partial response; PROC, platinum-resistant ovarian cancer; Q3W, every 3 weeksSD, stable disease; TL, target lesion.

Conclusions

- The optimal treatment for patients with PROC is still an unmet clinical need
- Until recently, the options were single agent chemotherapy +/- bevacizumab (**AURELIA**)
- To date, 2 additional regimens have improved wPaclitaxel in phase 3 trials :
  - **B96:** Pembrolizumab + wPaclitaxel +/- Bevacizumab in up to 2 lines of therapy
  - **ROSELLA**: Relacorilant + nab paclitaxel in up to 3 lines of therapy
- ADCs are changing the Ovarian cancer treatment
- Mirvetuximab (**MIRASOL**), an ADC against Fra MIRV is the first novel treatment to show statistically significant and clinically meaningful OS benefit over IC chemotherapy in PROC[1,2]
- There is a plethora of ADCs in clinical development that have demonstrated strong initial signals for efficacy in patients who have limited treatment options:
  - Many open questions are still present, such as biomarkers selection, duration of treatment, correct sequence and how to overcome mechanisms of resistance

An evolving paradigm change is just happening on the PROC setting:
How can we sequence all these new therapies in the better way?

Case Based Discussion I: Introducing Biomarkers Into Practice

Case #1: Recurrent High Grade Serous Ovarian Cancer

- 09/2013: TAH, BSO, pelvic and paraaortic lymphadenectomy, omentectomy and resection of abdominal wall nodule high grade serous carcinoma of the ovary - stage IIIB
- Completed 6 cycles of Carbo/Paclitaxel (dose dense)
- 10/2017 CT C/A/P with significant increase in size of right paracolic gutter soft tissue mass, mild free fluid, thickening of the urinary bladder wall, enlarged lymph node within the upper abdomen
- 12/2017: CT biopsy of right paracolic gutter mass- High grade serous carcinoma
- 2018: Completed 7 cycles of Carbo/Gem
- Progressed within 3 months of completing therapy

Adapted from Dr David O'Malley at The Ohio State University

Tissue Testing

- NGS testing of Recurrence 12/2017: EGFR D314N, NF1 exon 1 loss, MYC amplification, TP53 D281E, MLH1 R325Q.
- Microsatellite Stable. TMB-intermediate.

- HER2 IHC 1+
- PD-L1 CPS 11
- FRα 80% 2+

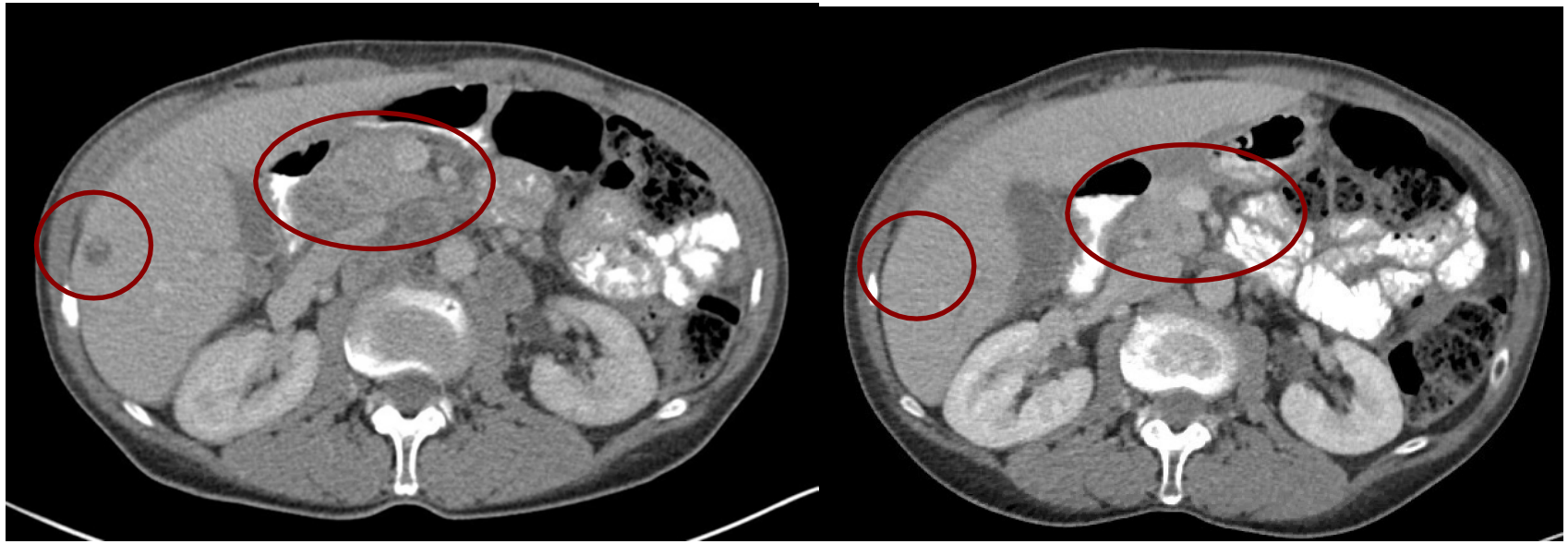
Clinical Trial

- 2018: Clinical trial Olaparib and AZD6738 (WEE1i) x 3 cycles - progressed
- **1/2019: On clinical trial: C1D1 mirvetuximab 6 mg/kg & Bevacizumab 15 mg/kg**
- **8/2020: C27 delayed 2 weeks due to Grade 2 neuropathy, Mirv reduced to 5 mg/kg**
- 2/2021: Received 35 cycles of mirvetuximab + Bev; clinical trial closed
- 3/2021: Started treatment on Compassionate Use mirvetuximab and Bev (commercial supply) on single patient compassionate use trial.
- Continued on therapy until Oct, 2022 when she elected to take a holiday
- 5/2023: Presented with Brain Mets.

Response

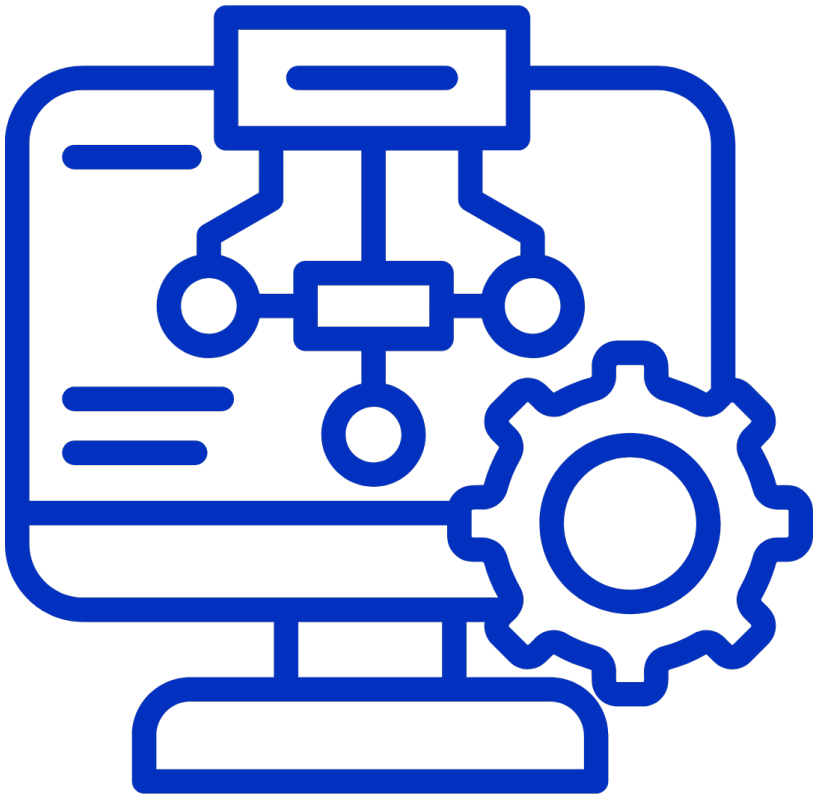
Pre Cycle 1 – multi-focal disease

Cycle 33 – near CR



CA 125 Results	Notes
272	C1 Imgn/Bev
170	C2
96	C3
34	C4
12	C5
7	C6
5	C7

PROC Algorithm



1. Is the patient appropriate for weekly taxane?
2. Is the patient appropriate for bevacizumab?
3. Can she tolerate oral anticancer therapies?
4. What are her number of lines of therapy?
5. What is the IHC biomarker status?
   - ✓ PD-L1
   - ✓Folate receptor alpha
   - ✓HER2

Case Based Discussion II: Sequencing and Real-World Application

Case #2: 59-Year-Old Woman with Abdominal Pain

Diagnostic Work-Up

- High-grade serous OC
- FIGO stage IIIC

Germline Testing (48 genes, normal)

- Confirmed gBRCAwt; HRD score 44, HER2 IHC 1+, FR-alpha 70% 2+, PD-L1 CPS 6
- Surgeon recommends neoadjuvant therapy

First-Line Treatment

Three cycles of:

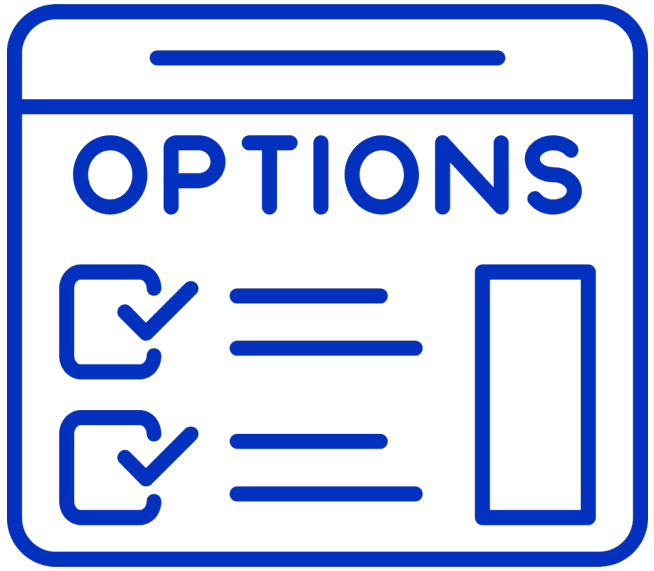
- **Paclitaxel (175 mg/m² IV over 3h) + carboplatin (AUC6) + bevacizumab (15mg/kg cycles 1,2 5,6 and maintenance)**
- **Interval debulking, R0, three additional cycles**
- **Normal CA-125: 25 IU/mL**

Second line:

- Platinum-sensitive recurrence at 2 years treated with carboplatin and liposomal doxorubicin
- Second recurrence 4 months later

PAOLA-1: Added olaparib in the maintenance phase

Treatment options



- Weekly paclitaxel/bevacizumab/pembrolizumab
- Weekly paclitaxel/relacorilant
- Mirv/bev
- Clinical trial

Key Take Aways and Closing Remarks

GOG Continuing Education

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

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