The GOG Highlight Reel
July 2026

A GOG Foundation, Inc. Educational Program

Date: Friday, July 17, 2026
Time: 7:00 – 9:30 pm MDT Time
Location: Sheraton Denver Downtown

GOG FACULTY DISCLOSURE INFORMATION

The GOG Highlight Reel:
An Education Series Highlighting Newsworthy Data Distillation and Emerging Global Therapies in Clinical Trials
Friday, July 17, 2026 | Denver, Colorado

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.**

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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		Name of Ineligible Company(s)	Nature of Relevant Financial Relationship(s)
Herzog, Thomas, MD	**Planner/ Moderator**		Aadi Bioscience; AbbVie; AstraZeneca; Caris; Corcept; DSI; Eisai; Epsilogen; GenMab; GSK; Merck; Mersana; Natera; Pfizer; Pharma&; PMV Pharma; Sutro; Tempus; Zentalis	**Scientific Advisory Boards** (Aadi Bioscience, Abbvie, AstraZeneca, Caris, Corcept, DSI, Eisai, Epsilogen, Genmab, GSK, Merck, Mersana, Natera, Pfizer, Pharma&, PMV Pharma, Sutro, Tempus, Zentalis) **Honorarium** (Aadi; Corcept; Merck; Natera)
Monk, Bradley, MD	**Planner/ Moderator**		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**
Barlin, Joyce, MD	**Speaker**		AstraZeneca; Clovis; Mersana; Onco4; AbbVie; Eisai; Merck; Genmab; Verastem; Precision; Corcept; Daiichi Sankyo; Faeth; GSK; Lilly	**Advisory Boards** (AstraZeneca; Clovis; Mersana; Onco4; AbbVie; Eisai; Merck; Genmab; Verastem; Precision; Corcept; Daiichi Sankyo; Faeth; GSK; Lilly) **Speaker's Bureau** (AstraZeneca; Merck; Daiichi Sankyo; Corcept)
Coleman, Robert, MD	**Speaker**		BioNTech; BMS; BeOne; Lilly; Pharma&; Genentech/Roche; AstraZeneca; GenMab; Pfizer; Immunogen/AbbVie; Merck; Daiichi Sankyo; Gilead/Tubulis; Eisai; Panavance; GSK; Karyopharm; TORL; Incyte; Regeneron; Faeth	**Consultant/Advisory Role** (BioNTech; BMS; BeOne; Lilly; Pharma&; Genentech/Roche; AstraZeneca; GenMab; Pfizer; Immunogen; AbbVie; Merck; Daiichi Sankyo; Gilead/Tubulis; Eisai; Panavance; GSK; Karyopharm; TORL; Incyte; Regeneron; Faeth) **Research Funding** (AstraZeneca; AbbVie; Karyopharm; Merck; GSK; Genentech/Roche; Genmab; Pharma&)
Eskander, Ramez, MD	**Speaker**		AstraZeneca; MSD; Regeneron; PMV Pharmaceuticals; Daiichi Sanyo; GSK; Myriad; Seagen; AbbVie; Pfizer; Novocure; BioNTech; Mersana; Nuvectis Pharma; GSK; Merck; Daiichi Sankyo; Loxo @ Lilly; Genmab/Seagen; Clovis Oncology; Acrivon therapeutics; Zentalis; Eisai; Gilead; Roche	**Consultant** (AstraZeneca; MSD; Regeneron; PMV Pharmaceuticals; Daiichi Sanyo; 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)
Grisham, Rachel, MD	**Speaker**		AstraZeneca, GSK, Incyte, GenMab, Verastem, SpringWorks, Myriad	**Consultant**
Moore, Kathleen, MD, MS	**Speaker**		GOG Partners; NRG Ovarian Committee Chair; Astellas Medivation; Clearity Foundation; IDEOlogy Health; Medscape; Great Debates and Updates; OncLive/MJH Life Sciences; MD Outlook; Curio Science; Plexus; University of Florida; University of Arkansas for Medical Sciences; Congress Chanel; BioPharm; CEA/COO; Physician Education Resource (PER); Research to Practice; Med Learning Group; Peerview; Peervoice; CME Outfitters; Virtual Incision; Genentech/Roche; Immunogen; AstraZeneca; Merck; Eisai; Verastem/Pharmacyclics; AADi; Caris Life Services; 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 Myers Squibb Foundation; Tango Therapeutics; AbbVie; T Knife; F Hoffman La Roche; Tubulis GmbH; 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; Torl Biotherapeutics; Allarity Therapeutics; IDEAYA Biosciences; International Gynecologic Cancer Society	**Leadership** (GOG Partners; NRG Ovarian Committee Chair) **Honoraria** (Astellas Medivation; Clearity Foundation; IDEOlogy Health; Medscape; Great Debates and Updates; OncLive/MJH Life Sciences; MD Outlook; Curio Science; Plexus; University of Florida; University of Arkansas for Medical Sciences; Congress Chanel; BioPharm; CEA/COO; Physician Education Resource (PER); Research to Practice; Med Learning Group; Peerview; Peervoice; CME Outfitters; Virtual Incision) **Consulting/Advisory** (Genentech/Roche; Immunogen; AstraZeneca; Merck; Eisai; Verastem/Pharmacyclics; AADi; Caris Life Services; 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 Myers Squibb Foundation; Tango Therapeutics; AbbVie; T Knife; F Hoffman La Roche; Tubulis GmbH; 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** (Merck; Regeneron; Verastem; AstraZeneca; Immunogen; Daiichi Sankyo/Lilly; Immunocore; Torl Biotherapeutics; Allarity Therapeutics; IDEAYA Biosciences; Zymeworks; Schrodinger) **Uncompensated Relationships** (International Gynecologic Cancer Society)

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Name	Individual's Role(s) in Activity	Nothing To Disclose	Name of Ineligible Company(s)	Nature of Relevant Financial Relationship(s)
Speaker Disclosures				
O'Malley, David, MD	**Speaker**		AbbVie; AstraZeneca; BeOne; Corcept Therapeutics; Duality Bio; DSI; Eli Lilly; GlaxoSmithKline; GenMab; GOG Foundation; Merck & Co,; Merck Sharp & Dohme Corp; Pfizer; Regeneron Pharmaceuticals, Inc; Verastem, Inc.; Zentalis; Amarex/Frants Viral	**Consultant/Advisory** (AbbVie; AstraZeneca; BeOne; Corcept Therapeutics; Duality Bio; DSI; Eli Lilly; GlaxoSmithKline; GenMab; GOG Foundation; Merck & Co,; Merck Sharp & Dohme Corp; Pfizer; Regeneron Pharmaceuticals, Inc; Verastem, Inc.; Zentalis) DSMB (Amarex/Frantz Viral)
Pothuri, Bhavana, MD, MS	**Speaker**		Duality Bio; GSK; Clovis Oncology; Merck; Celsion/Immunon; AstraZeneca; Mersana; Karyopharm Therapeutics; Quantas; Sutro; Cybrexa; Incyte; Acrivon; Toray; Onconova; VBL Therapeutics; Celgene; Loxo/Lily; AbbVie; Agenus; Alkermes; Seagen; Immunogen; NRG Oncology; Eisai; OnCusp; Genmab; Xencor; Tesaro; Beigene; Corcept; Daiichi; Imvax; GOG Foundation; Inxmed; Novocure; R. Pharma; Regeneron; Incyclix Bio; Signatera; BioNTech; Bioascend; Onclive; PERS; Aptitude; Vanium; Peerview; Prime; Celsion/Immunon; Toray; Nuvation; Tubulis; Quantas; SGO Board of Directors; GOG Board of Directors; GOG Partners; NYOB Society President	**Grants/Contracts** (Duality Bio; GSK; Clovis Oncology; Merck; Celsion/Immunon; AstraZeneca; Mersana; Karyopharm Therapeutics; Quantas; Sutro; Cybrexa; Incyte; Acrivon; Toray; Onconova; VBL Therapeutics; Celgene; Loxo/Lily; AbbVie; Agenus; Alkermes; Seagen; Immunogen; NRG Oncology; Eisai; OnCusp; Genmab; Xencor) **Consulting** (Tesaro/GSK; Beigene; AstraZeneca; Sutro Biopharma; Corcept; Daiichi; Duality Bio; Imvax; Immunogen; Incyte Corporation; GOG Foundation; InxMed; SeaGen; Onconova Therapeutics; Novocure; R Pharm; Eisai; Regeneron; Incyclix Bio; Signatera; BioNtech; Karyopharm; Mersana; OnCusp; Merck) **Honoraria** (Bioascend; Onclive; PERS; Aptitude; Vanium; Peerview; Prime) **Travel/Meeting Support** (GOG Partners; GSK; Merck) **Data Safety Monitoring/Advisory Board** (Sutro; Imvax; Imab; AstraZeneca; Tesaro/GSK; GOG Foundation; Merck; Celsion/Immunon; Mersana; Toray; Nuvation; InxMed; BioNtech; Immunogen/AbbVie; Beigene; Loxo/Lily; Daiichi Sankyo; Onconova; OnCusp; Corcept; Quantas; Tubulis; Pfizer) **Leadership Roles** (SGO Board of Directors; GOG Board of Directors; GOG Partners; NYOB Society President)
Randall, Leslie, MD	**Speaker**		AstraZeneca; Genmab; Pfizer; GSK; Eisai; Merck; AbbVie; GOG Foundation	**Consultant** (AstraZeneca; Genmab; Pfizer; GSK, Eisai; Merck; Abbvie; GOG Foundation) **Research Funding** (Merck; AbbVie; GOG Foundation)
Slomovitz, Brian, MD	**Speaker**		Merck; Daiichi; Incyte; AstraZeneca; Aadi; Corcept; AbbVie; BeOne; BioNTech; GenMab; Karyopharm; Eisai; GSK	**Consultant**
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**
Gien, Lilian, MD	**Reviewer**		Glaxo Smith Kline; Merck; Abbvie; AstraZeneca	**Speaker Honoraria** (Glaxo Smith Kline; Merck) **Advisory Board** (Abbvie; AstraZeneca)
David Mutch, MD	**Reviewer**	**X**		
Susan Zweizig, MD	**Reviewer**	**X**		

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

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Pfizer
Verastem

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Joyce Barlin, MD

Women's Cancer Care
Associates
Albany, New York

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.

AGENDA

GOG Highlight Reel

7:00 PM – 7:05 PM	**WELCOME & INTRODUCTIONS** Dr. Thomas Herzog, Dr. Bradley Monk
7:05 PM – 7:55 PM	**PART 1: OVARIAN CANCER** Dr. Ramez N. Eskander, Dr. David O'Malley, Dr. Rachel Grisham
7:55 PM – 8:45 PM	**PART 2: ENDOMETRIAL CANCER** Dr. Brian Slomovitz, Dr. Bhavana Pothuri, Dr. Joyce Barlin
8:45 PM – 9:05 PM	**PART 3: CERVICAL CANCER** Dr. Leslie Randall
9:05 PM – 9:20 PM	**PART 4: AUDIENCE ENGAGEMENT AND Q&A** All Faculty
9:20 PM – 9:30 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

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Part 1: Ovarian Cancer

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

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Contemporary Data & Clinical Practice

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

CASE 1

- 70-year-old patient who presented with abdominal bloating, pain and constipation, progressing over the prior 3 months
- CT imaging demonstrated an 8 cm complex pelvic mass with concurrent ascites and suggestion of peritoneal carcinomatosis
- Primary CRS achieving a complete gross resection

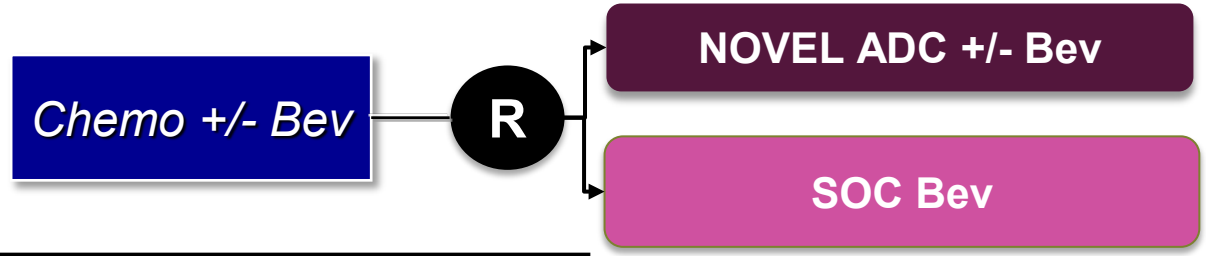
Final Pathology:

- Stage 3C high grade serous fallopian tube cancer
- Germline testing negative for pathogenic mutation
- Additional tumor testing: HRD test negative; HER2 0+; PD-L1 CPS 1; FRalpha 65% 2+

NRG Oncology and GOG-P Open Trials: 1L

Study Number	Sponsor	Subtype	Lead Group	GOG PI	Study Title
NRG-GY036	NCI	First-line	NA	Ying Liu	A Phase 3 Trial of **One vs. Two Years of Maintenance Olaparib**, with or Without Bevacizumab, in Patients with BRCA1/2 Mutated or Homologous Recombination Deficient (HRD+) Ovarian Cancer Following Response to First Line Platinum-Based Chemotherapy (NCT06580314)
GOG-3102 TroFuse-021	Merck	First-line	ENGOT	David O'Malley	A Phase 3, Randomized, Open-label, Multicenter Study of **Sacituzumab Tirumotecan (Sac-TMT, MK-2870) Maintenance Treatment With or Without Bevacizumab Versus Standard of Care** in Participants With Newly Diagnosed Advanced Non-HRD Positive Ovarian Cancer Following First-line Platinum-based Chemotherapy (NCT07318558)
GOG-3112	Daiichi Sankyo	First-line	ENGOT	Joyce Liu	A Phase 3, Open-label, Multicenter, Randomized Trial of **Trastuzumab Deruxtecan with Bevacizumab Versus Bevacizumab Monotherapy** as First-line Maintenance Therapy in **HER2-Expressing Ovarian Cancer (NCT06819007)**
GOG-3115	AbbVie	First-Line	NA	Rebecca Arend	A Single-Arm, Phase 2 Study of **Neoadjuvant Carboplatin and Mirvetuximab Soravtansine** in Subjects With FRα-Expressing Advanced-Stage Serous Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer (NCT06890338)
GOG-3126 FLORENZA	AbbVie	Sub study 1 (First-Line)	NA	Casey Cosgrove	A Study to Assess Adverse Events and Change in Disease Activity of Multiple Treatment Combinations With Intravenous **Mirvetuximab Soravtansine** in Adult Participants With Ovarian Cancer (NCT07059845)

Common Design for 1L Maintenance Therapy (NOT HRD positive)



…multiple in development

ADC, antibody-drug conjugate; Bev, bevacizumab; CT, chemotherapy; ENGOT, European Network of Gynaecological Oncological Trial Groups; HRD, homologous recombination deficiency; HRP, homologous recombination proficient; NCI, National Cancer Institute; SOC, standard of care.

CASE 1

- GY036 is the only first line trial open at your site
- Patient was treated with carboplatin, paclitaxel + bevacizumab followed by bevacizumab maintenance therapy
- She completed 6 cycles of adjuvant therapy as well as the maintenance bevacizumab
- After 24 months, radiographic imaging was ordered to evaluate nonspecific RUQ pain – suggesting hepatic recurrence
- IR image guided biopsy confirmed recurrent high grade serous fallopian tube carcinoma
- Platinum sensitive recurrent disease

CASE 1

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Platinum sensitive recurrent disease (24-month platinum free interval)

- Treatment of choice in this clinical setting?
- Do you commonly re-use bevacizumab?
- ADC maintenance versus treatment clinical trial opportunity?
- Secondary cytoreduction…how commonly is this employed?

NRG Oncology and GOG-P Open Trials: PSOC

Study Number	Sponsor	Subtype	Lead Group	GOG PI	Study Title
GOG-3103/ TroFuse-022	Merck	PSOC	ENGOT	Katherine Fuh	A Phase 3, Randomized, Open-label, Multicenter Study to Evaluate the Efficacy and Safety of **Sacituzumab Tirumotecan Maintenance Treatment With or Without Bevacizumab Versus Standard of Care** After Second-line Platinum-based Doublet Chemotherapy in Participants With Platinum-sensitive Recurrent Ovarian Cancer (NCT06824467)
GOG-3124	AbbVie	PSOC	NA	Debra Richardson	A Phase 1b Dose Escalation and Expansion Study of IMGN151 as Monotherapy and in Combination With Other Anti-Cancer Therapies in Subjects With Gynecologic Cancers (NCT07024784)
GOG-3126/ FLORENZA	AbbVie	PSOC	NA	Casey Cosgrove	A Study to Assess Adverse Events and Change in Disease Activity of Multiple Treatment Combinations With Intravenous **Mirvetuximab Soravtansine** in Adult Participants With Ovarian Cancer (NCT07059845)
GOG-3134 RAINFOL-04	Genmab	PSOC	ENGOT	Alexander Olawaiye	A Randomized, Open-Label, Phase 3 Study of **Rinatabart Sesutecan Plus Standard of Care Versus Standard of Care** as Maintenance Treatment After 2L Platinum-Based Doublet Chemotherapy in Participants With Recurrent Platinum-Sensitive Ovarian Cancer (NCT07225270)
GOG-3133-S GOG-3133-R	Eli Lilly	PSOC PROC	GOG ENGOT	Bhavana Pothuri Roisin O'Cearbhaill	FRAmework-01: A Three-Part Phase 3 Study of Sofetabart Mipitecan (LY4170156) versus Chemotherapy or Mirvetuximab Soravtansine in Platinum-Resistant Ovarian Cancer, and **Sofetabart Mipitecan plus Bevacizumab versus Platinum-Based Chemotherapy plus Bevacizumab** in Platinum-Sensitive Ovarian Cancer (NCT07213804)

…multiple in development

Both **maintenance** *and* **treatment** opportunities

PSOC, platinum-sensitive ovarian cancer; PROC, platinum-resistant ovarian cancer; GOG-P, GOG Partners; ENGOT, European Network of Gynaecological Oncology Trial Groups; NCT, ClinicalTrials.gov identifier; NA, not applicable.

CASE 1

Platinum sensitive recurrent disease (24-month platinum free interval)

- Patient was enrolled and treated on a PSOC clinical trial (randomized to the control arm)
- She received carboplatin, PLD + bevacizumab, followed by bevacizumab maintenance.
- 3 months into maintenance, UA suggested 3+ protein with 24-hour UTP showing 2549 mg of protein
- Bevacizumab held
- Interval imaging with disease progression 4 months after completion of combination platinum based therapy

CASE 1

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Platinum resistant recurrent disease (4-month platinum free interval)

- What is your SOC treatment of choice in this clinical setting (FR-alpha 65% 2+; PD-L1 CPS: 1)
- How do you select and discuss clinical trial versus SOC with your patient (does the control arm of the trial impact your decision)?
- Impact of ADC clinical trial versus non-ADC opportunities?

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer

Principles of Systemic Therapy:

Acceptable Recurrence Therapies for Epithelial Ovarian (including LCOC)/Fallopian Tube/Peritoneal Cancer

Recurrence Therapy for Platinum-Resistant Disease (alphabetical order)

Preferred

Cytotoxic Therapy

- Albumin-bound Paclitaxel/Relacorilant[x,y,44]
- Docetaxel[45]
- Gemcitabine[46,47]
- Liposomal Doxorubicin[46,47]
- Liposomal Doxorubicin + Bevacizumab[r,48]
- Paclitaxel (Weekly)[h,49]
- Paclitaxel (Weekly) + Bevacizumab[h,r,48]
- Oral Cyclophosphamide + Bevacizumab[r,50]
- Topotecan[51,52]
- Topotecan + Bevacizumab[r,48]

Targeted Therapy (single agents)

- Mirvetuximab soravtansine-gynx (for FRα-expressing tumors [≥75% positive tumor cells]) (category 1)[v,53,54]

Other Recommended

Cytotoxic Therapy†

- Albumin-bound Paclitaxel
- Capecitabine
- Carboplatin[z]
- Carboplatin/Docetaxel[z]
- Carboplatin/Paclitaxel (Weekly)[h,z]
- Carboplatin/Gemcitabine[15] ± Bevacizumab[r,s,z,16]
- Carboplatin/Liposomal Doxorubicin[17] ± Bevacizumab[r,z,18]
- Carboplatin/Paclitaxel[19] ± Bevacizumab[r,s,z,20]
- Cisplatin/Gemcitabine [z,21]
- Cyclophosphamide
- Doxorubicin
- Gemcitabine ± Bevacizumab[r,55]
- Ifosfamide/Mesna
- Irinotecan
- Ixabepilone ± Bevacizumab (category 2B)[r,aa,56]
- Oral Cyclophosphamide + Pembrolizumab + Bevacizumab[r,57,58]
- Oral Etoposide[59]
- Oxaliplatin
- Paclitaxel
- Pemetrexed
- Sorafenib/Topotecan[60]
- Vinorelbine

Targeted Therapy (single agents)

- Bevacizumab[r,25,26]
- Pazopanib (category 2B)[28]

Hormone Therapy

- Aromatase inhibitors (Anastrozole, Exemestane, Letrozole)
- Goserelin acetate
- Leuprolide acetate
- Megestrol acetate
- Tamoxifen[k]

Useful in Certain Circumstances

- Albumin-bound Paclitaxel/Carboplatin (for confirmed taxane hypersensitivity)[z]
- Carboplatin/Paclitaxel (for age >70)[h,u,z]

Immunotherapy[v]

- Dostarlimab-gxly (for dMMR/MSI-H recurrent or advanced tumors)[42]
- Paclitaxel + Pembrolizumab ± Bevacizumab (for PD-L1- positive tumors [CPS≥1])[h,r,s,bb,61]
- Pembrolizumab (for patients with MSI-H or dMMR solid tumors, or TMB-H tumors ≥10 mutations/megabase)[43]
- For clear cell carcinoma:
  - Ipilimumab + Nivolumab[62,63]

Hormone Therapy

- Fulvestrant (for low-grade serous carcinoma)

Targeted Therapy[v]

- Dabrafenib/Trametinib (for BRAF V600E positive tumors)[30]
- Entrectinib[31] or Larotrectinib[32] or Repotrectinib[33] (for *NTRK1/2/3* gene fusion-positive tumors)
- Fam-trastuzumab deruxtecan-nxki (for HER2-positive tumors [IHC 3+ or 2+])[34]
- Mirvetuximab soravtansine-gynx + Bevacizumab (for FRα- expressing tumors [≥25% positive tumor cells])[r,36,64,65]
- Selpercatinib (for RET gene fusion-positive tumors)[37]
- For low-grade serous carcinoma:
  - Avutometinib/Defactinib (for KRAS-mutated tumors)[38]
  - Trametinib[39]
  - Binimetinib (category 2B)[40,41]
- For mucinous carcinoma:
  - FOLFIRI ± Bevacizumab[r] (category 2B)[66-69]

Note: All recommendations are Category 2A unless otherwise indicated.

See Pages 56-59 of NCCN Guidelines®

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PROC Landscape

	MIRVETUXIMAB (N=453)	Relacorilant + Nab-P (N=381)	Pembro +chemo+/-bev (N=616)
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** **(progression 1-3 months after 1L platinum allowed)**	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)**

Cross-trial comparisons should be interpreted cautiously because of differences in patient selection, biomarker eligibility, prior therapies, and study design.

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

GOG Highlight Reel

ADC, antibody-drug conjugate; CI, confidence interval; DCR, disease control rate; FRα, folate receptor alpha; HR, hazard ratio; ITT, intention-to-treat; mOS, median overall survival; mPFS, median progression-free survival; MOA, mechanism of action; ORR, objective response rate; PD-L1, programmed death-ligand 1; PS, proportion score; TEAE, treatment-emergent adverse event.

GOG FOUNDATION

PROC Landscape

	MIRVETUXIMAB (N=453)	Relacorilant + Nab-P (N=381)	Pembro +chemo+/-bev (N=616)
Clinical Trial	**MIRASOL (NCT04209855)**		
MOA	Anti-FRα ADC		
Biomarker	**FR-alpha high (≥ 75% viable tumor cells PS2+)**		
Prior lines	1-3 prior lines **47% 3 prior lines**		
ORR	**42.3%**		
DCR	**80.2%**		
Key Grade ≥3 TEAEs	**Blurred Vision Keratopathy Neuropathy Nausea**		
mPFS (months)	**5.62**		
mOS (months)	**16.46 HR 0.67 (95% CI, 0.50-0.89)**		

FDA APPROVAL
March 25, 2026

Relacorilant — a selective glucocorticoid receptor antagonist — approved in combination with nab-paclitaxel for adults with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received 1–3 prior systemic regimens, at least one of which included bevacizumab.

FDA APPROVAL
February 10, 2026

Pembrolizumab approved in combination with paclitaxel, with or without bevacizumab, for adults with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal carcinoma whose tumors express PD-L1 (CPS ≥ 1) and who have received one or two prior systemic regimens.

Companion diagnostic: PD-L1 IHC 22C3 pharmDx assay — required to identify CPS ≥ 1 tumors.

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; FDA. Relacorilant approval. Mar 25, 2026; FDA. Pembrolizumab approval. Feb 10, 2026.

NRG Oncology and GOG-P Open Trials: PROC

Study Number	Sponsor	Subtype	Lead Group	GOG PI	Study Title
GOG-3066/ DENALI	Zentalis	PROC	NA	Fiona Simpkins	A Study of **Azenosertib (ZN-c3)** in Subjects With Platinum-Resistant High-Grade Serous Ovarian, Fallopian Tube or Primary Peritoneal Cancer (NCT05128825)
GOG-3072	Zentalis	PROC	NA	Premal Thaker	A Phase 1b Study of ZN-c3 in Combination with Chemotherapy or Bevacizumab in Subjects with ovarian, Peritonial, or Fallopian Tube Cancer (NCT04516447)
GOG-3076/ OnPrime	Genelux	PROC	NA	Robert Holloway	A Randomized Phase 3 Study Assessing the Efficacy and Safety of **olvimulogene nanivacirepvec (Olvi-Vec) followed by Platinum-doublet Chemotherapy and Bevacizumab Compared with Chemotherapy and Bevacizumab** in Women with Platinum-Resistant/Refractory Ovarian Cancer (NCT05281471)
GOG-3096/ REJOICE-01	Daiichi-Sankyo	PROC	ENGOT	Debra Richardson	A Phase 2/3 , Multicenter, Randomized Study of **Raludotatug Deruxtecan (R-DXd), a CDH6-directed Antibody-drug Conjugate, in Subjects with Platinum-resistant, High-grade Ovarian, Primary Peritoneal, or Fallopian Tube Cancers** (NCT06161025)
GOG-3129 MAESTRA-1	Incyte	PROC	GOG	Premal Thaker	A Study of **INCB123667** in Participants With Platinum-Resistant Ovarian Cancer With Cyclin E1 Overexpression (NCT07023627)
GOG-3132 BEHOLD-Ovarian01	GSK	PROC	GOG	Floor Backes	A Randomized, Open-label, Multicenter, Phase 3 Study to Investigate **GSK5733584 Compared With Chemotherapy in Participants With Platinum-resistant Ovarian Cancer** (NCT07286266)
GOG-3137 MAESTRA-2	Incyte	PROC	ENGOT	Wendel Naumann	A Phase 3, Randomized, Open-Label Study of **INCB123667 Versus Investigator's Choice of Chemotherapy** in Participants With Platinum-Resistant Ovarian Cancer With **Cyclin E1 Overexpression** (NCT07214779)
GOG-3147 ASPENOVA	Zentalis	PROC	GOG	Fiona Simpkins	A Randomized, Open-Label Phase 3 Study of **Azenosertib Versus Investigator's Choice of Chemotherapy** in Platinum-Resistant High-Grade Serous Ovarian, Primary Peritoneal, or Fallopian Tube Cancers Positive for Cyclin E1 Protein Expression (NCT07546500)

…both **biomarker selective and agnostic** opportunities (ADC and non-ADC)

2026 ASCO® ANNUAL MEETING

Overall survival subgroup analyses for prior taxane use in the phase 3 ROSELLA trial of relacorilant plus nab-paclitaxel vs nab-paclitaxel monotherapy in patients with platinum-resistant ovarian cancer

(GOG-3073, ENGOT-ov72, APGOT-Ov10, LACOG-0223, and ANZGOG-2221/2023)

Lucy Gilbert,[1] Benoit You, Alexander B. Olawaiye, Chel Hun Choi, Mariana Scaranti, Giorgio Valabrega, John K. Chan, Linda R. Mileshkin, Toon Van Gorp, Mary E. Gordinier, Cristina Churruca, Carolyn Y. Muller, Laurene Gavoille, Claudia Andreetta, Kofi Agyemang-Prempeh, Andrew R. Clamp, Hristina I. Pashova, Priya Choudhry, Maria Lapresa, Domenica Lorusso

[1]Division of Gynecologic Oncology, McGill University Health Centre, Women's Health Research Unit, Research Institute of the McGill University Health Centre, Gerald Bronfman Department of Oncology, McGill University, Montreal, QC, Canada

In collaboration with: GOG Foundation; ENGOT European Network of Gynaecological Oncological Trial groups; APGOT Asia-Pacific Gynecologic Oncology Trials Group; LACOG Latin American Cooperative Oncology Group; ANZGOG

Scan QR code to access presentation

Primary publication: *Lorusso D et al. Lancet 2026*
Long-term update: *Gilbert L et al., ASCO 2026 (oral presentation)*

ROSELLA — Does Prior Taxane Use Impact Benefit?

The Question

Nearly all patients in ROSELLA had received a taxane (paclitaxel) before. Two clinical worries shaped this subgroup analysis:

- Does the benefit of relacorilant + nab-paclitaxel still hold if the most recent prior therapy was a taxane?
- Does a SHORT taxane-free interval (≤6 months) negate the benefit?

Why it matters

Re-treating with a taxane after recent taxane failure has an unknown clinical benefit. If relacorilant restores taxane sensitivity, that could provide additional treatment options.

The Answer

Benefit was consistent regardless of prior taxane use.

Taxane-free interval ≤6 months (n=55):
Median OS 16.7 vs 11.0 months; HR 0.60 (0.31-1.15)

Taxane-free interval >6 months (n=324):
Median OS 15.7 vs 12.1 months; HR 0.66 (0.51-0.81)

Taxane in MOST RECENT regimen — Yes (n=73):
OS HR 0.67 (95% CI 0.38 – 1.19)

Taxane in MOST RECENT regimen — No (n=224):
OS HR 0.63 (95% CI 0.48 – 0.82

Source: Gilbert L et al., ROSELLA subgroup analysis, ASCO 2026

Evolving Landscape (ADCs in Ovarian Cancer)

ADC (study)	Target	Payload	N	ORR	DoR	PFS	
Sofe-M	FRα	TOP1 inhibitor	105	53%	9.1 months	8.1 months	ESMO GYNAECOLOGICAL CANCERS
Mo-Rez	B7-H4	TOP1 inhibitor	34	62%	Maturing	Maturing	ESMO GYNAECOLOGICAL CANCERS
Temab-A	c-Met	TOP1 inhibitor	41	44%	5.7 months	5.4 months	2026 ASCO ANNUAL MEETING
TUB-040	NaPi2b	TOP1 inhibitor	67	58.2%	Not yet reached	11 months	2026 ASCO ANNUAL MEETING
SYS6043	B7-H3	TOP1 inhibitor	70	45.7%	6.9 months	8.3 months	SGO ANNUAL MEETING ON WOMEN'S CANCER
DB-1311 / BNT324	B7-H3	TOP1 inhibitor	30	53.3%	8.0 months	9.5 months	SGO ANNUAL MEETING ON WOMEN'S CANCER
IMGN853-0420: Carboplatin+ Mirvetuximab	FRα	Microtubule inhibitor	125	68.0% (≥25% FRα)	11.2 months	11.0 months	SGO ANNUAL MEETING ON WOMEN'S CANCER
MIROVA / AGO-OVAR 2.34	FRα	Microtubule inhibitor	145	66.2% (Carbo + Mirv) vs 32.8% (Carbo+PLD) (≥75% FRα)	Maturing	9.5 vs 9.8 months	2026 ASCO ANNUAL MEETING

ADC, antibody-drug conjugate; DoR, duration of response; FRα, folate receptor alpha; NaPi2b, sodium-dependent phosphate transport protein 2B; NR, not reached; ORR, objective response rate; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; TOP1, topoisomerase I.

PROC
Panel Discussion

Low Grade Serous Ovarian Cancer

Rachel Grisham, MD

Memorial Sloan Kettering
Cancer Center
New York, New York

CASE 2

GOG Highlight Reel

- A 34-year-old woman presents with 6 months of pelvic pain and abdominal bloating, she was referred to GI by her PCP and upper and lower endoscopies were unrevealing
- Two weeks later she presents to local ER with worsening pain and CT of abdomen and pelvis shows bilateral adnexal masses, pelvic ascites and bulky omental disease. Chest imaging is clear and CA125 is elevated at 175 u/ml. Inhibin B and CEA are WNL
- She has a paracentesis performed which shows malignant cells, PAX8 and ER+
- She is seen by a local oncologist who recommends to start neoadjuvant chemotherapy with IV carboplatin, IV paclitaxel and IV bevacizumab

CASE 2

What would you recommend at this time?

A. Proceed with neoadjuvant chemotherapy IV carboplatin/IV paclitaxel/IV bevacizumab

B. Refer to Gynecologic Oncologist for consideration of primary debulking and/or laparoscopic biopsy

C. Refer to IR for biopsy

D. Order a PET scan

Tissue is Essential for Treatment Planning

Biomarker	Therapy	Modality
BRCA germline mutation	PARP inhibitor	Germline testing (blood/saliva)
BRCA somatic mutation	PARP inhibitor	Tumor Testing NGS
p53	Letrozole	IHC or NGS
HRD	PARP inhibitor ± bevacizumab	Tumor Testing
HER2	Trastuzumab deruxtecan	Tumor Testing IHC
FRα	Mirvetuximab soravtansine	Tumor Testing IHC
dMMR/MSI/MMR/TMB	Pembrolizumab, Dostarlimab	Tumor Testing IHC and NGS
KRAS	Avutometinib+Defactinib	Tumor NGS
BRAF	Dabrafenib+Trametinib	Tumor NGS
RET	Selpercatinib	NGS
NTRK1/2/3	Entrectinib/Larotrectinib/Repotretcinib	NGS

NCCN Guidelines ® for Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer V.4.2026
BRCA, *Breast Cancer* susceptibility gene; dMMR, mismatch repair deficient; FRα, folate receptor alpha; HER2, human epidermal growth factor receptor 2; HRD, homologous recombination deficiency; IHC, immunohistochemistry; MSI-H, microsatellite instability-high; NGS, next-generation sequencing; PARP, poly(ADP-ribose) polymerase; RET, rearranged during transfection; TMB-H, tumor mutational burden-high.

Primary Debulking Surgery (PDS) Is Associated With Improved Outcomes For Patients With Low Grade Serous Ovarian Cancer

Study (first author)	N (LGSOC)	Key Findings
Papazyan et al. 2025	230	PDS: median OS 146 mo; PDS independent prognostic factor on MVA
Di Lorenzo et al. 2022	92	NACT independently predicted worse PFS (p=0.010) and OS (p=0.030)
Bonsang-Kitzis et al. 2022	127	NACT offered no surgical benefit; CC2/CC3 after NACT-IDS had worst prognosis
Johnson et al. 2021	37	Complete cytoreduction strongest OS predictor; no chemo benefit
Manning-Geist et al. 2023 (MSK)	50	Only 9% NACT response rate in LGSOC

Papazyan T, et al. Int J Gynecol Cancer. 2025. Di Lorenzo P, et al. Front Oncol. 2022. Bonsang-Kitzis H, et al. (Basel). 2022. Johnson RL, et al. J Clin Med. 2021. Manning-Geist BL, et al. Cancer. 2023.
CC2, residual tumor >2.5 mm to ≤2.5 cm after cytoreduction; CC3, residual tumor >2.5 cm after cytoreduction; IDS, interval debulking surgery; LGSOC, low-grade serous ovarian cancer; MVA, multivariable analysis; NACT, neoadjuvant chemotherapy; OS, overall survival; PDS, primary debulking surgery; PFS, progression-free survival.

CASE 2

- The patient is referred to a gynecologic oncologist and undergoes a laparoscopy where she is found to have disease amenable to PDS
- A complete gross resection of all disease is achieved
- Final pathology is consistent with Stage IIIC low grade serous ovarian cancer
- The patient is otherwise healthy, has good social support, and is recovering well from surgery

CASE 2

What adjuvant therapy do you recommend?

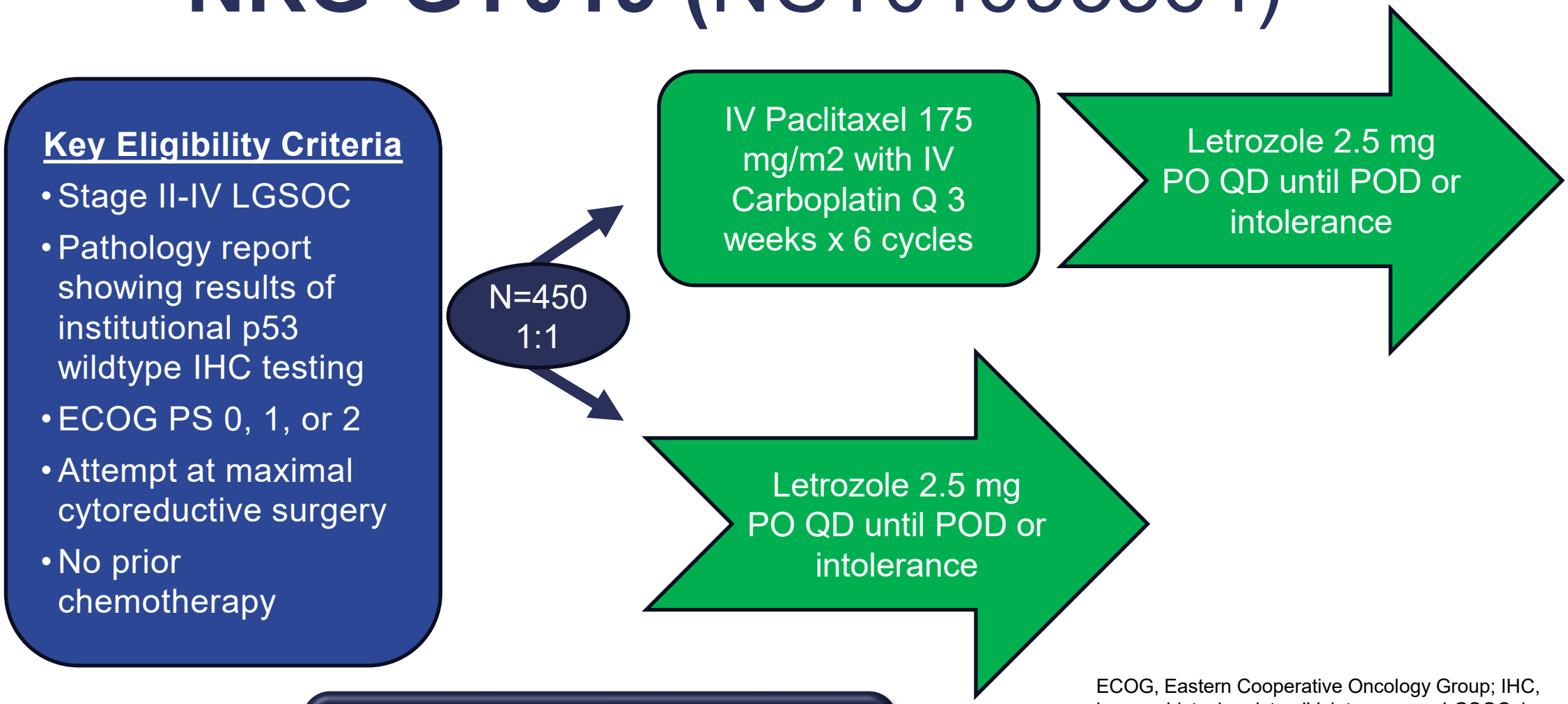
A. IV carboplatin/ IV paclitaxel/ IV bevacizumab-> bevacizumab maintenance

B. IV carboplatin/IV paclitaxel-> letrozole

C. Letrozole

D. Observation

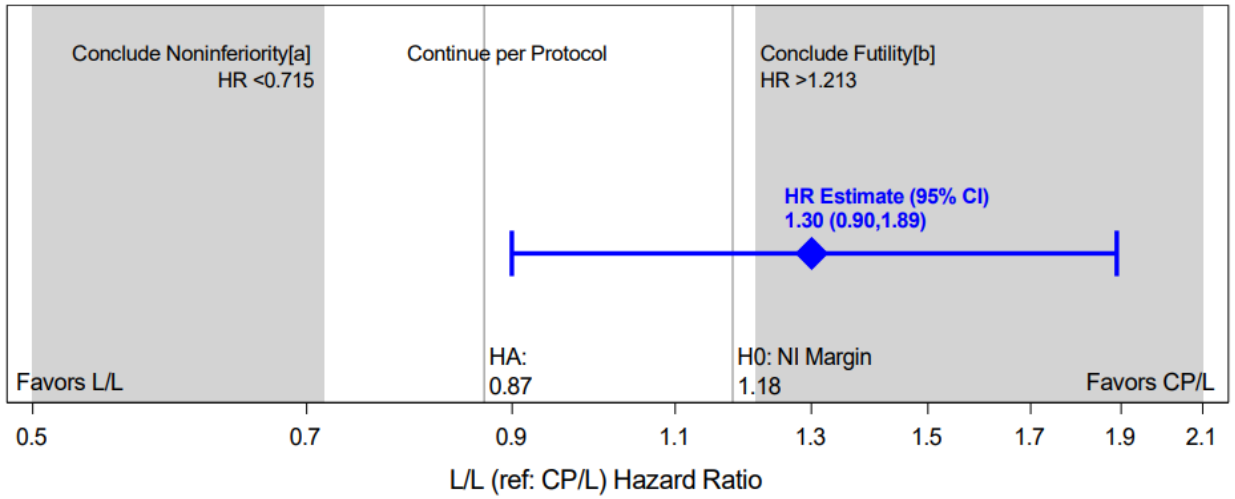
NRG-GY019 (NCT04095364)



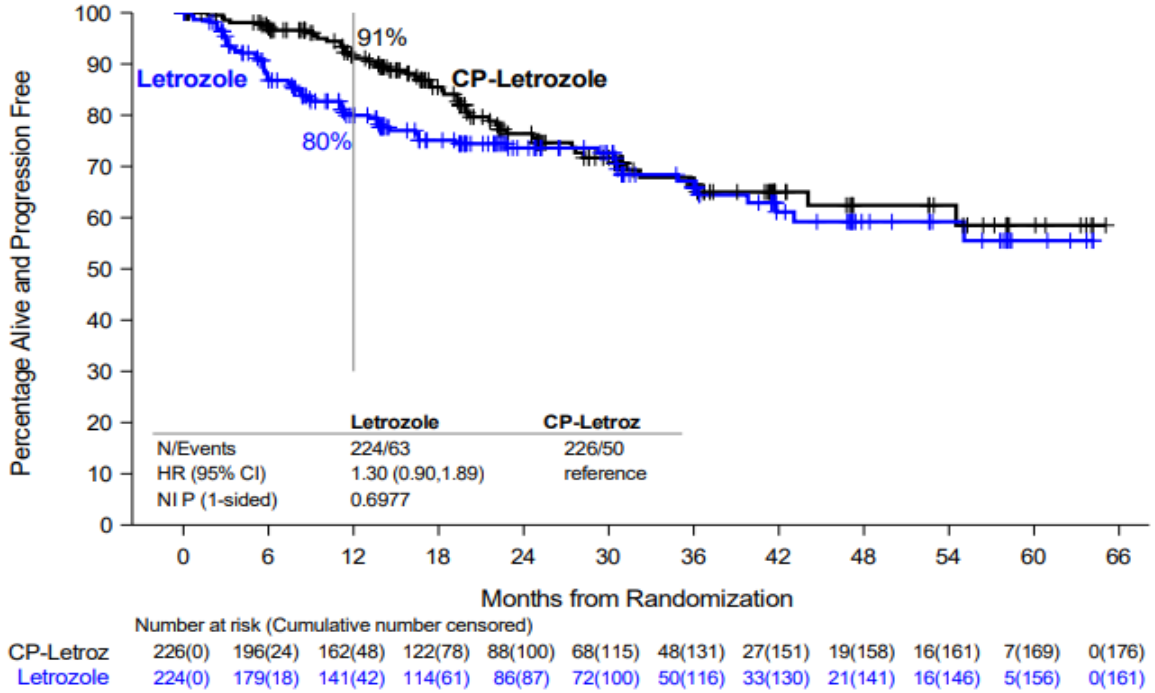
ECOG, Eastern Cooperative Oncology Group; IHC, immunohistochemistry; IV, intravenous; LGSOC, low-grade serous ovarian cancer; N, number of patients; PO, orally; PS, performance status; Q3 weeks, every 3 weeks; QD, once daily; POD, progressive disease.

PI: Dr. Amanda Fader

NRG-GY019:PFS-Noninferiority Margin Plot and PFS Curve (Interim Analysis #2)



[a] Conclude L/L is not inferior to CP/L.
[b] Conclude L/L is not likely to demonstrate noninferiority at the end of the trial.



NCT04095364

77.9% of patients on CP/L and 71.9% of those on L remain alive and progression-free

GOG Highlight Reel

Fader AN, et al. Paper presented during the Plenary Session at the SGO 2026.
Fader A, et al. Gynecologic Oncology, 208S452.
CI, confidence interval; CP, carboplatin plus paclitaxel; HR, hazard ratio; L, letrozole; NI, noninferiority; PFS, progression-free survival.

GOG FOUNDATION

CASE 2

- The patient is treated with IV carboplatin and IV paclitaxel for 6 cycles, at the end of chemo she is found to be NED and initiates treatment with letrozole
- After 3 months her CA125 has increased from 14-> 26. At 6 months her CA125 increases to 50. She has a CT scan of CAP that shows peritoneal carcinomatosis, pelvic ascites, and 3 subcapsular liver mets measuring up to 2.4 cm
- IHC testing on her initial pathology showed FOLR1 2+ in < 25% of cells, PDL 1 negative, and HER2 0
- She has a liquid biopsy performed that shows no mutations

CASE 2

GOG Highlight Reel

What do you recommend at this time ?

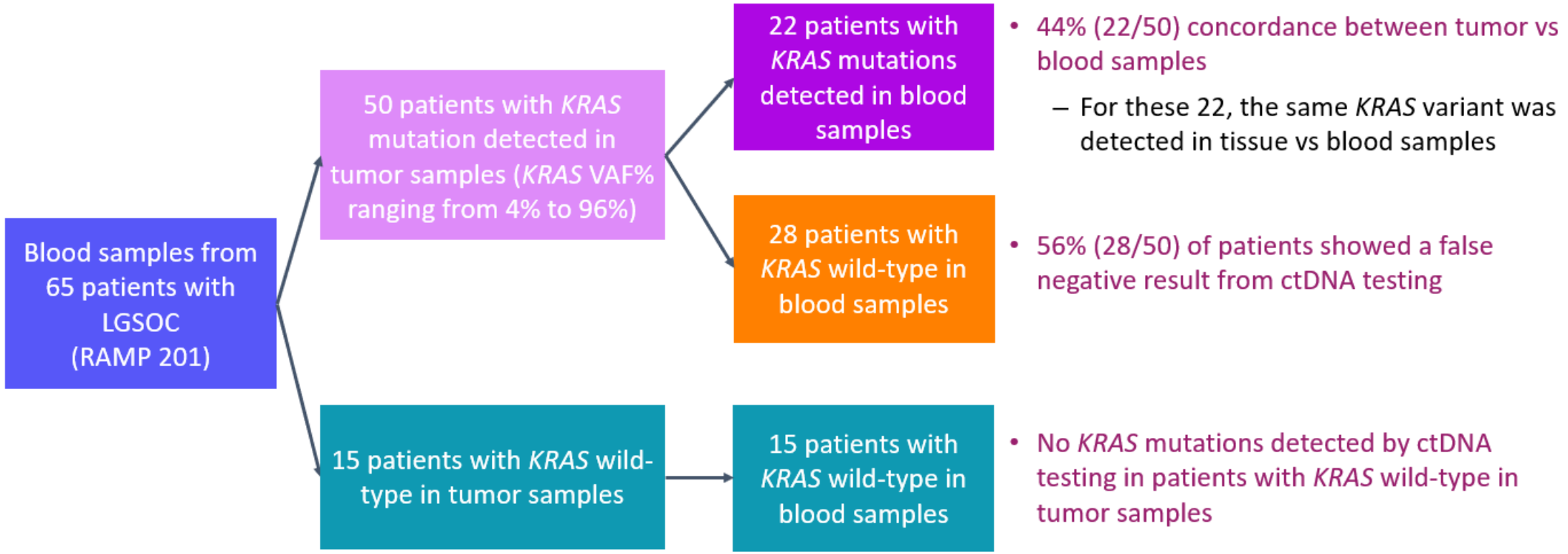
A. Submit her archival tumor tissue for NGS sequencing

B. Start treatment with carboplatin/PLD +/- bevacizumab

C. Start treatment with mirvetuximab

D. Submit her archival tissue for MMR testing

Liquid Biopsy Is Not Sufficient to Detect KRAS Mutation in Patients With LGSOC

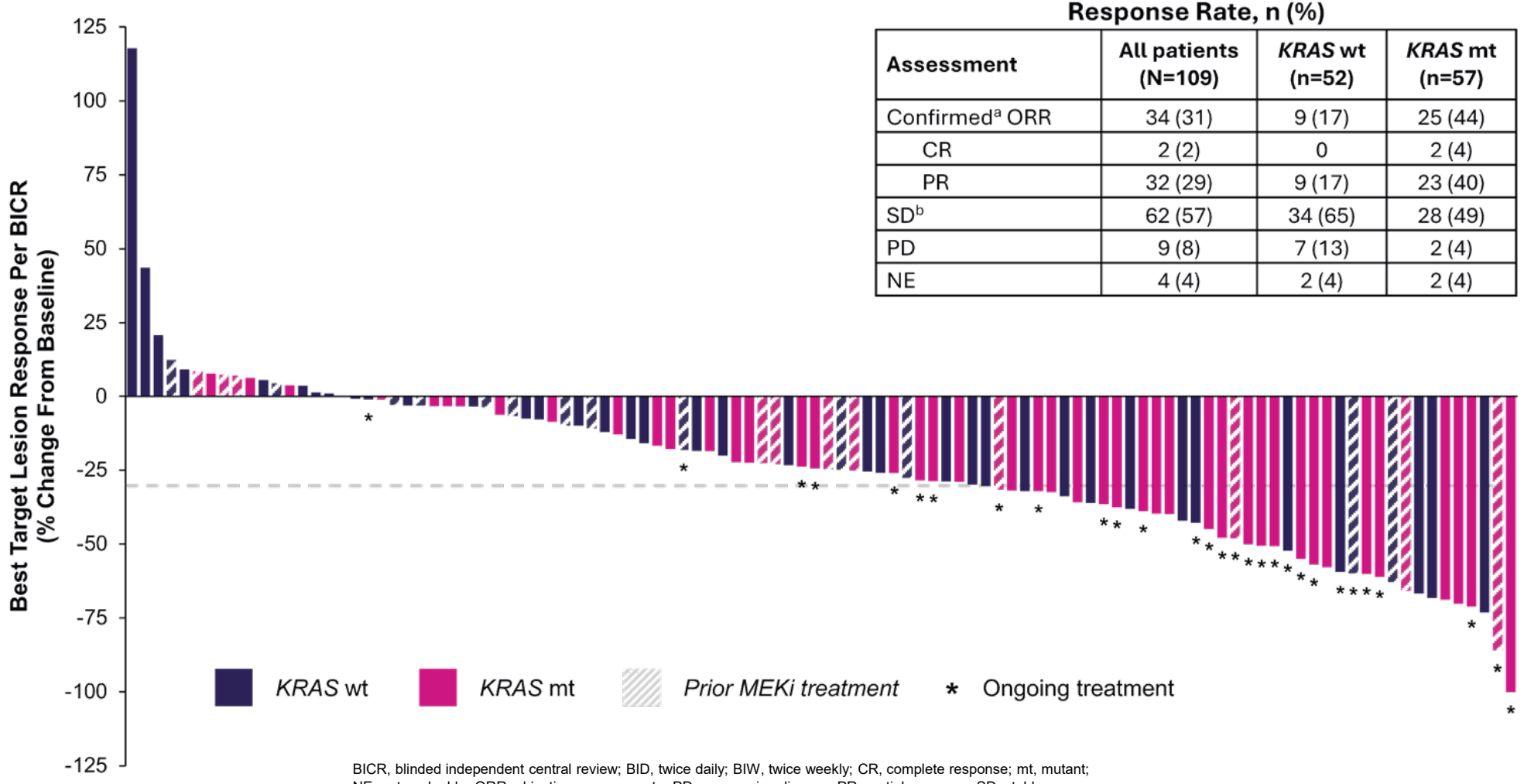


Only 32% of patients with measurable disease had ctDNA tumor fraction above the limit of detection at study entry

Presented by Dr. Van Nieuwenhuysen, ESMO Gyn 2025

ENGOT-ov60/GOG-3052/RAMP 201

Avutometinib 3.2 mg BIW + defactinib 200 mg BID



Response Rate, n (%)

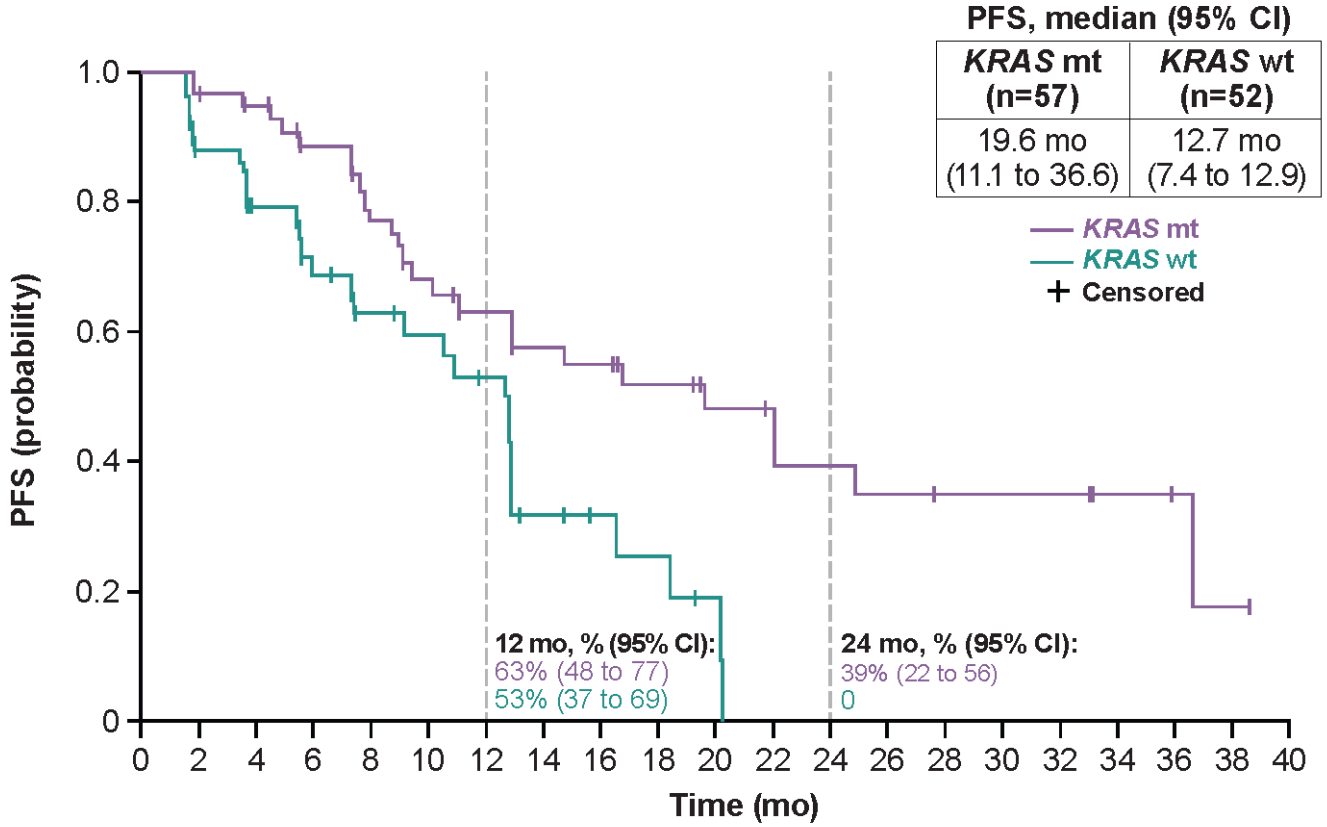
Assessment	All patients (N=109)	*KRAS* wt (n=52)	*KRAS* mt (n=57)
Confirmed[a] ORR	34 (31)	9 (17)	25 (44)
CR	2 (2)	0	2 (4)
PR	32 (29)	9 (17)	23 (40)
SD[b]	62 (57)	34 (65)	28 (49)
PD	9 (8)	7 (13)	2 (4)
NE	4 (4)	2 (4)	2 (4)

BICR, blinded independent central review; BID, twice daily; BIW, twice weekly; CR, complete response; mt, mutant; NE, not evaluable; ORR, objective response rate; PD, progressive disease; PR, partial response; SD, stable disease; wt, wild-type.

Grisham RN, et al. Presented at the SGO Annual Meeting; 2026. Figure created from Grisham RN, et al; ClinicalTrials.gov NCT06072781.

RAMP 201: Progression-Free Survival in Patients with *KRAS* mt and *KRAS* wt Tumors

Avutometinib 3.2 mg BIW and Defactinib 200 mg BID



Number at risk:

KRAS mt	57	53	49	41	33	28	24	21	20	17	12	11	9	8	7	7	7	5	2	1	0
KRAS wt	52	41	32	25	20	18	15	8	5	4	2	0									

Data cutoff date of August 12, 2025.

BID, twice daily; BIW, twice weekly; *KRAS*, Kirsten rat sarcoma virus; mt, mutant; PFS, progression-free survival; wt, wild-type.

GOG Highlight Reel

Grisham RN, et al. Presented at the SGO Annual Meeting; 2026. Figure created from Grisham RN, et al.

GOG FOUNDATION

CASE 2

GOG Highlight Reel

- You send the patients archival tissue for NGS and she is found to have a *KRAS G12V* mutation
- You counsel her regarding the expected efficacy of chemotherapy (RR of 6-13% and Median PFS of 7.2-10.6 months) vs targeted therapies:

	Avutometinib and Defactinib		Binimetinib		Trametinib		Ribociclib and letrozole
	All (n=109)	KRASmut (n=57)	All (n=198)	KRASmut (n=43)	All (n=198)	MAPKalt (n=48)	All (N=49)
Median PFS (95% CI), mo	12.9 (10.9-19.6)	19.6 (11.1-36.6)	10.4 (7.5-12.9)	14.6 (9.4-NE)	13 (9.9- 15)	13.2 (9.4-20.8)	14.5 (10.1-28.8)*
Median DOR (95% CI), mo	31.1 (14.8-NE)	31.1 (21.2-NE)	8.05 (5.6-NE)	NR	13.6 (8.1-18.1)	NR	21.2
Confirmed ORR, n (%)	34 (31%)	25 (44%)	32 (16%)	19 (44%)	51 (26%)	11 (50%)	15 (30.6%)

1. Banerjee SN, et al. J Clin Oncol. 2025;43(25):2782-2792. **2.** *Grisham RN, et al. SGO 2026.* **3.** *Monk BJ, et al. J Clin Oncol. 2020;38(32):3753-3762.* **4.** *Gershenson DM, et al. Lancet. 2022;399(10324):541-553* 5.Slomovitz et al, J Clin Oncol. 2026 153-163. *90% Confidence Interval

BID, twice daily; BIW, twice weekly; CI, confidence interval; KRAS, *Kirsten rat sarcoma viral oncogene homolog*; MAPK, mitogen-activated protein kinase; mo, months; NE, not estimable; NR, not reached; ORR, objective response rate; PFS, progression-free survival; RR, response rate.

LGSOC
Panel Discussion

GOG Highlight Reel

Part 2: Endometrial Cancer

Brian Slomovitz, MD

Mount Sinai
Medical Center
Miami Beach, Florida

Bhavana Pothuri, MD

NYU Langone
New York City, New York

Joyce Barlin, MD

Women's Cancer Care Associates
Albany, New York

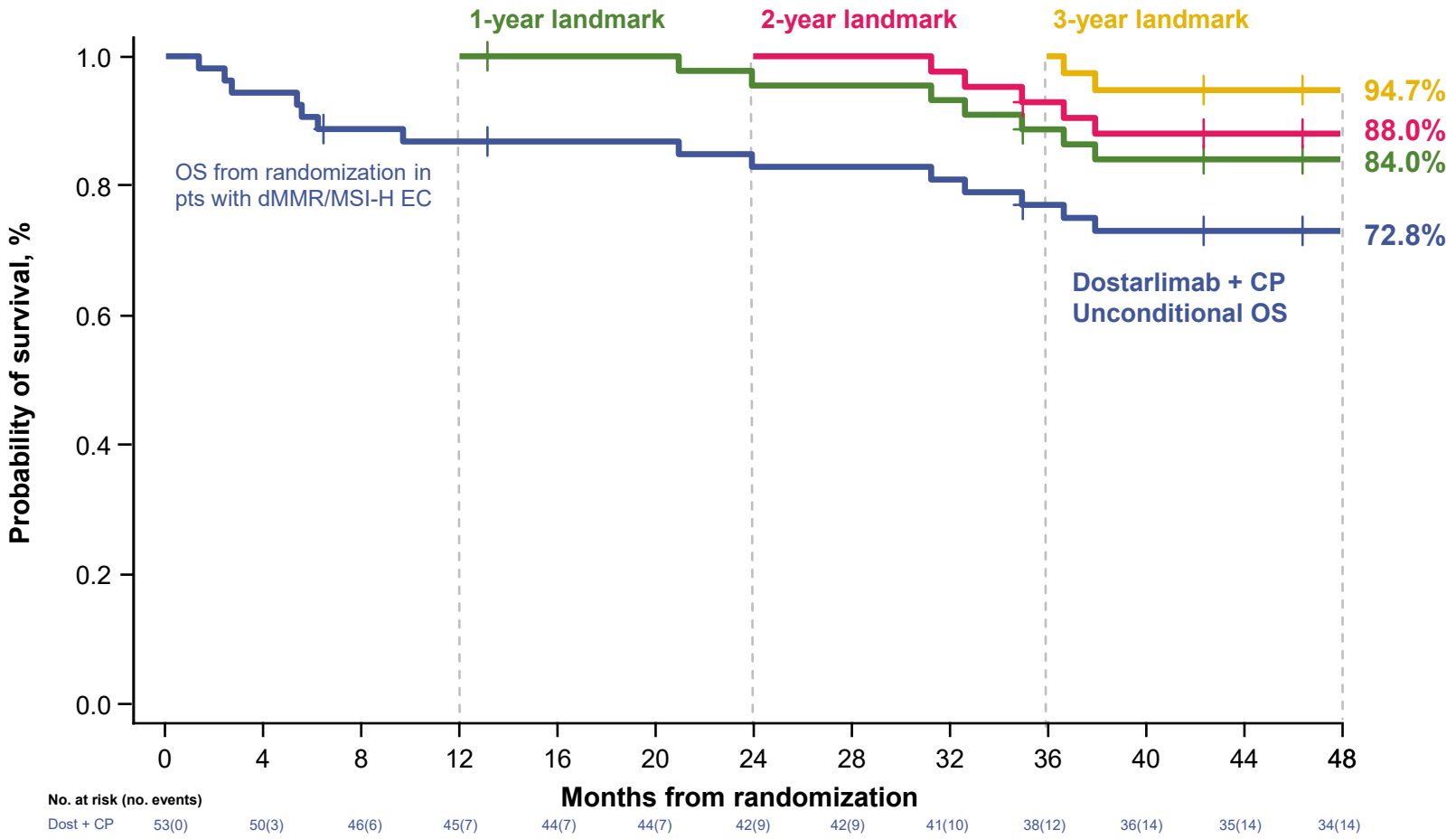
GOG Highlight Reel

Highlights from ESGO, SGO, ASCO, ESMO-GYN

Brian Slomovitz, MD

Mount Sinai
Medical Center
Miami Beach, Florida

ENGOT-EN6-NSGO/GOG-3031/RUBY Trial (NCT03981796): Conditional OS: Pts Alive at 1 and 2 Years had >80% Probability of Remaining Alive at 4 Years

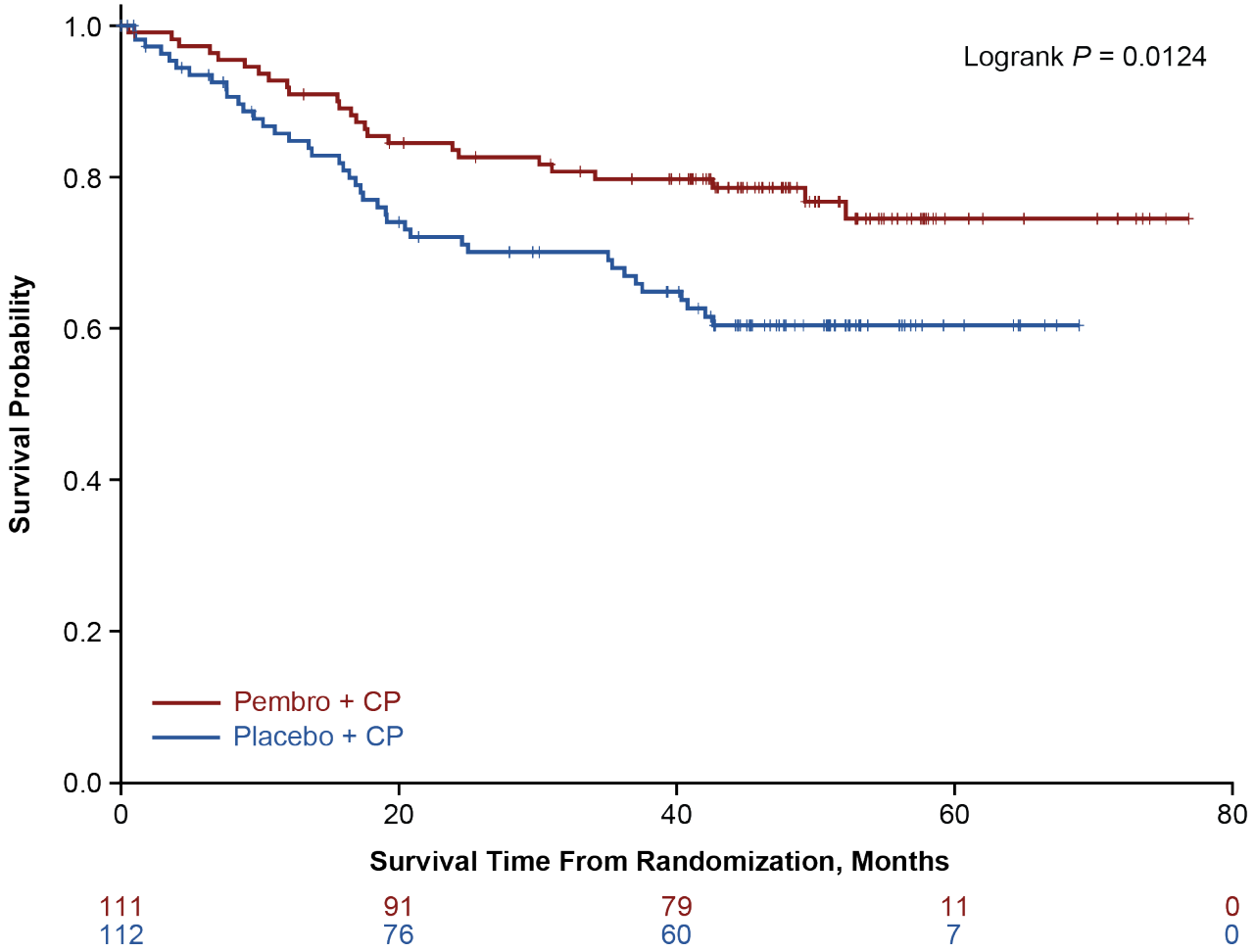


dMMR/MSI-H population	Dostarlimab + CP
3-year survival probability from 1-year landmark	84.0% (95% CI, 69.3%–92.0%)
2-year survival probability from 2-year landmark	88.0% (95% CI, 73.5%–94.8%)
1-year survival probability from 3-year landmark	94.7% (95% CI, 80.6%–98.7%)

Conditional OS evaluates the probability of being alive for additional time from a specified time point (eg, 1-year, 2-year, 3-year landmark).

Post hoc analysis. Median expected follow-up, 55.6 months (range, 49.9–67.7 months); Figure originally presented at Society of Gynecologic Oncology (SGO) 2026 Annual Meeting on Women's Cancer, April 10–13, 2026, San Juan, Puerto Rico, USA. (Powell MA, et al).
CP, carboplatin-paclitaxel; dMMR, mismatch repair deficient; dost, dostarlimab; MSI-H, microsatellite instability-high; OS, overall survival.

KN 868/GY-018: Extended Follow-Up Suggests OS Benefit for pembrolizumab + CP in the dMMR Cohort (NCT03914612)



	Pembro + CP	Placebo + CP
Events, n/N	25/111	40/112
Median OS	**Not reached**	**Not reached**
Survival at 24 mo (95% CI), %	83.5 (75.2–89.3)	72.1 (62.4–79.7)
Survival at 36 mo (95% CI), %	79.7 (70.9–86.2)	68.0 (58.0–76.1)
Survival at 48 mo (95% CI), %	78.6 (69.6–85.2)	60.4 (50.0 – 69.2)
HR (95% CI)[a]	**0.56 (0.34–0.92)**	

- Information fraction of 43.3%
- Median follow-up across both treatment arms was 49 months
- Amongst participants receiving post study therapy, **93.2% of patients in the control arm received an ICI**

[a]*Based on Cox regression model stratified by ECOG PS and prior adjuvant chemo.*

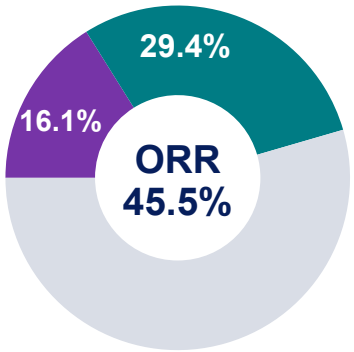
Proportion of participants who withdrew study consent: Pembro + CP = 5.4%; Placebo + CP = 7.1%

GARNET 6-Year Follow-Up (NCT02715284): Deepening Responses with dostarlimab Monotherapy

dostarlimab monotherapy in dMMR/MSI-H Advanced/Recurrent Endometrial Cancer (GARNET Trial)

PREVIOUS ANALYSIS (2021)

Median follow-up: ~24 months[1]



- **CR** Complete Response
- **PR** Partial Response
- **SD/PD** Stable Disease / Progressive Disease

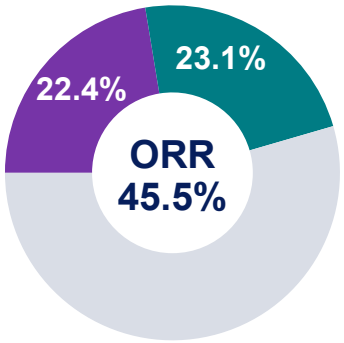
RESPONSES CONTINUE TO MATURE

PR → **9 PATIENTS** converted from **PR → CR** during extended follow-up → CR

Continued immune control and deeper responses over time

SIX-YEAR FOLLOW-UP (2025)

Median follow-up: 69 months[1]



- **CR** Complete Response
- **PR** Partial Response
- **SD/PD** Stable Disease / Progressive Disease

[1] Previous analysis data cut: 01 Nov 2021; Six-year follow-up data cut: 13 Mar 2025.

Increase in complete response rate
16.1% → 22.4%

Sustained overall response rate
45.5% → 45.5%

Durable benefit with deepening responses over time

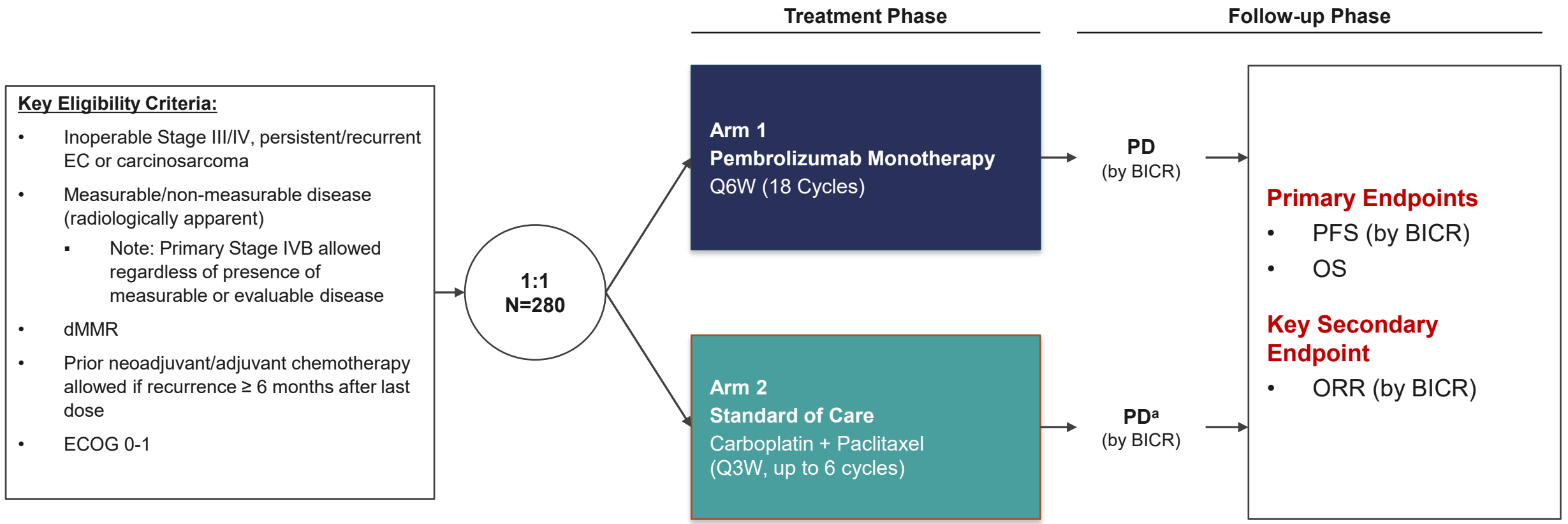
GOG Highlight Reel *Brian M. Slomovitz*

Pothuri B, et al. ESMO Gynae 2026; Abstract 69O

CR, complete response; dMMR, mismatch repair deficient; MSI-H, microsatellite instability-high; ORR, objective response rate; PD, progressive disease; PR, partial response; SD, stable disease.

GOG FOUNDATION

Chemo-Free Strategies: KN-C93



Stratification Factors:

- Newly diagnosed advanced EC or recurrent EC
- Histology (endometrioid vs nonendometrioid)
- Prior neoadjuvant/adjuvant chemotherapy (yes vs no)

[a] *Participants who were randomized to Arm 2 (chemotherapy) and experience BICR-assessed disease progression per RECIST 1.1, will have an opportunity to participate in the Crossover Phase to receive up to 18 cycles of pembrolizumab 400 mg Q6W*

Chemo-Free Strategies: KEYNOTE-C93 Press Release

July 15, 2026

Phase 3 KEYNOTE-C93 Trial met its primary endpoint of progression-free survival (PFS) for the treatment of patients with mismatch repair deficient (dMMR) advanced or recurrent endometrial cancer

NIVEC Trial: A Phase II Study of Induction PD-1 Blockade (Nivolumab) in Surgically Resectable dMMR Endometrial Cancer (NCT05795244)

NIVEC Phase II Study – Key Results

TRADITIONAL APPROACH

1. Diagnosis
2. Surgery
3. Adjuvant Therapy
4. Recurrence
5. Immunotherapy (at recurrence)

PARADIGM SHIFT

"Move immunotherapy from recurrent disease to the earliest phase of disease"

NIVEC APPROACH

- Diagnosis
- dMMR Testing
- Neoadjuvant Nivolumab (PD-1 blockade)
- Clinical Complete Response
- Surgery Omission in Selected Patients

STUDY POPULATION

INCLUDED PATIENTS

- Clinical stage I–IIIC2
- Surgically resectable endometrial cancer
- Mismatch repair deficient (dMMR) by IHC or MSI

ENROLLED N = 26

NOT EVALUABLE (n=4)
- Early withdrawal (n=2)
- Lost to follow-up (n=1)
- No post-treatment assessment (n=1)

EVALUABLE FOR RESPONSE N = 22

ANALYZED FOR RESPONSE (n=22)

KEY RESULTS (EVALUABLE PATIENTS, N = 22)

68.2%	31.8%	7	NO	NO	NO GRADE ≥3	EXCELLENT
CLINICAL COMPLETE RESPONSE	MAJOR PATHOLOGIC RESPONSE	PATIENTS DID NOT UNDERGO SURGERY	RECURRENCES	PROGRESSION EVENTS	ADVERSE EVENTS	TOLERABILITY
(15 patients)	(7 patients)	Patients with clinical complete response proceeded without surgery and/or adjuvant therapy.	No cases of recurrence reported during follow-up.	No progression events reported during follow-up.	No Grade 3 or higher adverse events reported.	No treatment-related adverse events leading to discontinuation.

Lee YJ, et al. ESMO Gynaecological Cancers Congress 2026; Abstract 70O

dMMR, mismatch repair deficient; IHC, immunohistochemistry; MSI, microsatellite instability; PD-1, programmed cell death protein 1

Evolving ADCs Landscape in Endometrial Cancer

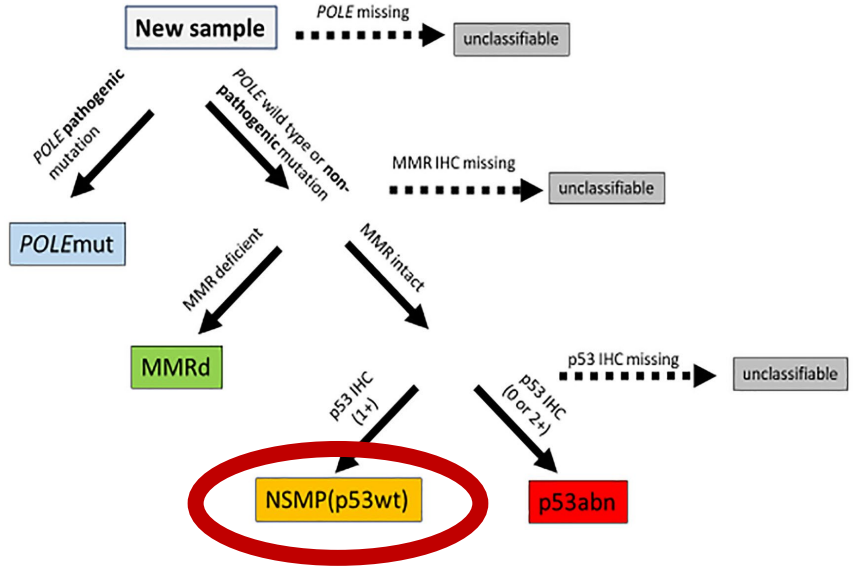
ADC	Target	Payload	Biomarker	ORR	DoR	PFS
T-DXd	HER2	TOPO I	All EC	57.5%	NE	11.1 mo
T-DXd	HER2	TOPO I	HER2 IHC 3+	84.6%	NR	NR
Tras-pamir	HER2	TOPO I	HER2+ (central)	47.9%	10.3 mo	8.1 mo
Tras-pamir	HER2	TOPO I	HER2 IHC 3+	73.1%	NR	11.0 mo
Sacituzumab govitecan	TROP2	TOPO I	Not required	28.0%	9.3 mo	5.5 mo
Sac-TMT	TROP2	TOPO I	Not required	35.0%	NR	NR
Dato-DXd	TROP2	TOPO I	Not required	27.6%	NR	6.3 mo
AZD8205	B7-H4	TOPO I	Not required	37.5%	NR	NR
Mo-Rez	B7-H4	TOPO I	Not required	67.0%	NR	NR
RINA-S	FRα	TOPO I	FRα-positive	50.0%	NR	NR

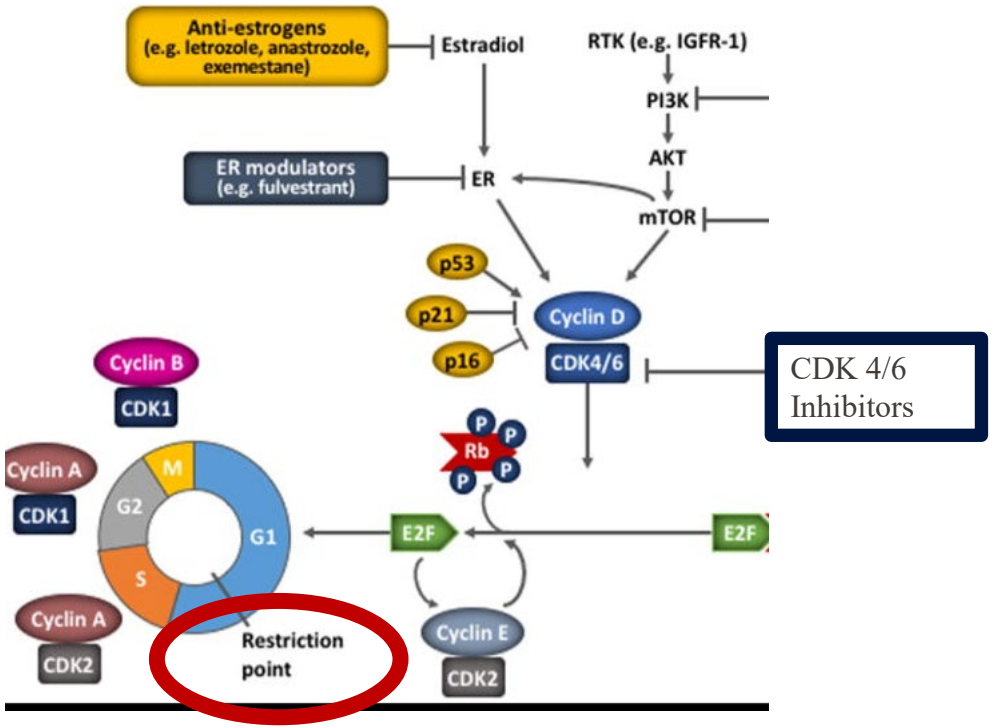
Lee JY, et al. J Gynecol Oncol. 2026;37:e65. Hsieh TYJ, et al. Presented at the Society of Gynecologic Oncology (SGO) Annual Meeting; 2026. Santin AD, et al. Clin Cancer Res. 2026. Lorusso D, et al. Presented at the ASCO Annual Meeting 2026. Ray-Coquard IL, et al. Presented at the ESMO Gynaecological Cancers Congress 2026. Cloven N, et al. Presented at the ASCO Annual Meeting 2025.

ADC, antibody-drug conjugate; DoR, duration of response; DXd, deruxtecan; EC, endometrial cancer; FRα, folate receptor alpha; HER2, human epidermal growth factor receptor 2; IHC, immunohistochemistry; mo, months; NR, not reached; ORR, objective response rate; PFS, progression-free survival; SG, sacituzumab govitecan; TOP1, topoisomerase I; TROP2, trophoblast cell-surface antigen 2.

Rationale CDK 4/6i + Endocrine Therapy

- NSMP cohort accounts for 50% of Endometrial Cancers (ECs)
- ~80% of endometroid ECs are hormone receptor positive (HR+)
- Estrogen signaling activates the cyclin D–CDK4/6 complex.
- CDK4/6 inhibitors induce G1–S cell-cycle arrest through inhibition of RB phosphorylation.





GOG Highlight Reel

Talhouk A et al. Cancer. 2017; Tripathy D, et al. Clin Cancer Res, 2017

CDK4/6i + Hormonal Therapy: MORE DATA!

Phase II Study of Abemaciclib Plus Letrozole in Advanced or Recurrent Endometrioid Endometrial Carcinoma: A GOG Partners Trial (GOG 3039)

SGO ANNUAL MEETING ON WOMEN'S CANCER
SAN JUAN, PR
APRIL 10-13, 2026

Marilyn Huang[1], Gloria Huang[2], Michael Sill[3], J Matthew Pearson[4], Sarah Gill[5], Robert Holloway[6], John Moroney[7], Theresa L. Werner[8], Aliza Leiser[9], Susan Zweizig[10], Sarah Paraghamian[11], Michael A. Gold[12], Kari Ring[1], Krista S. Pfaendler[13], Hope Cottrill[14], Mitchell Edelson[15], Mary J. Cunningham[16], Sharyn N. Lewin[17], Thomas J. Herzog[18], Brian M. Slomovitz[19]

[1]University of Virginia of School of Medicine, Charlottesville, VA; [2]Yale Cancer Center, New Haven, CT; [3]Roswell Park Comprehensive Cancer Center, Buffalo, NY; [4]University of Miami/Sylvester Comprehensive Cancer Center, Miami, FL; 5St Joseph's Candler, Savannah, GA; [6]AdventHealth Cancer Institute, Orlando, FL; [7]University of Chicago Pritzker School of Medicine, Chicago, IL; [8]University of Utah/Huntsman Cancer Institute, Salt Lake City, UT; [9]Rutgers Cancer Institute New Brunswick, NJ; [10] University of Massachusetts School of Medicine, Amherst, MA; [11]Tufts University School of Medicine, Boston, MA; 12Oklahoma Cancer Specialists, Tulsa, OK; [13]West Virginia School of Medicine, Morgantown, W VA; [14]Baptist Health Medical Group, Lexington, KY; [15]Jefferson Abington Hospital Hanjani Institute, Willow Grove, PA; [16]Upstate Medical University, Syracuse, NY; [17]Holy Name Medical Center, Teaneck, NJ; [18]University of Cincinnati, Cincinnati, OH; [19]Mount Sinai Medical Center, Miami Beach, FL

ADVANCING SCIENCE • EMPOWERING TEAMS • EMBRACING CHANGE

2026 ASCO ANNUAL MEETING

Updated efficacy, safety, and exploratory biomarker analyses of a phase II trial of abemaciclib plus hormonal therapy in recurrent ovarian (OC) and endometrial cancer (EC)

Jordyn Silverstein[1], Ivonne Kriss Grande[1], Lisa Del Rio[1], Christine Kivork[1], Bridget Johnson[1], Chi-Hong Tseng[3], Nasim Herrington[1], Evelyn Garcia[1], Kari Kubalanza[1], James Chauv[1], Neda Moatamed[4], Jianyu Rao[4], Gottfried E. Konecny[1,2]

[1]Division of Hematology/Oncology, UCLA, CA [2]Division of Gynecologic Oncology, UCLA, Los Angeles, CA [3]Department of Medicine Statistics Core, UCLA, Los Angeles, CA [4]Department of Pathology and Laboratory Medicine, University of California Los Angeles, Los Angeles, CA

Jordyn Silverstein, MD
Hematology/Oncology Fellow
University of California, Los Angeles

2026 ASCO ANNUAL MEETING #ASCO26

PRESENTED BY: Jordyn Silverstein, MD

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Confirmation of Activity of These Regimens

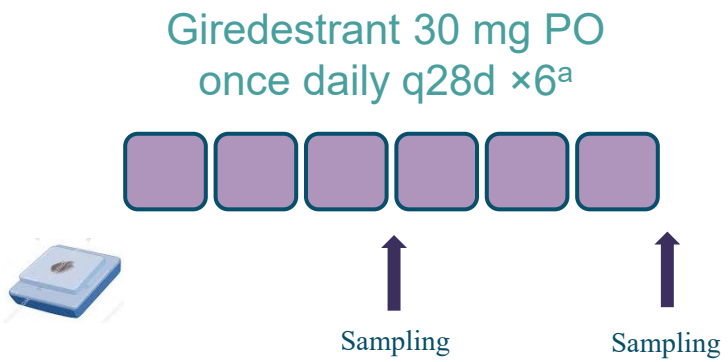
	Abemaciclib + HT *Silverstien et al. ASCO 2026*	Abemaciclib + Letrozole *(GOG-3039, Huang et al.[1])*	Abemaciclib + Fulvestrant *(Green et al.2)*	Abemaciclib + Letrozole *(Konstantinopoulos et al.[3])*	Palbociclib + Letrozole *(Mirza et al. (PALEO)[4])*	Ribociclib + Letrozole *(Colon-Otero et al.[5])*
N	**21**	**51**	**25**	**30**	**36**	**20**
Population	**ER ≥ 1%;** Any histology, any line	**No ER cutoff;** Endometrioid only; ≤1 chemo; ≤2 lines	**ER ≥ 1%;** Any histology; ≤2 chemos	**ER ≥ 1%;** Any histology, any line	**ER ≥ 10%;** ≥1 prior therapy	**ER ≥ 10%;** Any line, no prior AI
24-wk PFS	**56%**	**56.9%**	NR	**55.6%**	**60%**	**35%**
mPFS (mo)	**9**	**9.5**	**9**	**9.1**	**8.3**	**5.4**
ORR	**21%**	**39%**	**44%**	**30%**	**9%**	**10%**

✓ Overall 6-month PFS of 50-60% and mPFS ~9 months across studies, and in ER+ EC

Silverstein J, et al. J Clin Oncol. 2026;44(16_suppl):5516.
Huang M, et al. Gynecologic Oncology, 208, S31-S32 (NCT04393285); 2. Green AK, et al. Clin Cancer Res. 2025;31(11):2088-2096 ; 3. Konstantinopoulos PA, et al. J Clin Oncol. 2023;41(3):599-608 (NCT03675893); 4. Mirza MR, et al. Gynecol Oncol. 2025;192:128-136 (NCT02730429); 5. Colon-Otero G, et al. ESMO Open. 2020;5(5):e000926 (NCT02657928).

endomERA: Primary Results from The Phase 2 endomERA Study of giredestrant for Patients with Grade 1 Endometrioid Endometrial Cancer (NCT05634499)

- Centrally confirmed grade 1 endometrioid histology
- MRI-verified <50% myoinvasive disease (clinical stage 1A)
- No evidence of extra-uterine disease
- No prior therapy for EC



Primary endpoints:

- **Safety and tolerability**
- **6-month pathologic regression rate** per central pathology review
  - **Complete regression** (no evidence of cancer and/or atypical hyperplasia)
  - **Partial regression** (↓ cancer vs baseline but not complete regression)

Giredestrant - next-generation oral SERD, full ER antagonist and degrader that inhibits ligand-dependent and -independent ER signaling

Biomarker analyses:

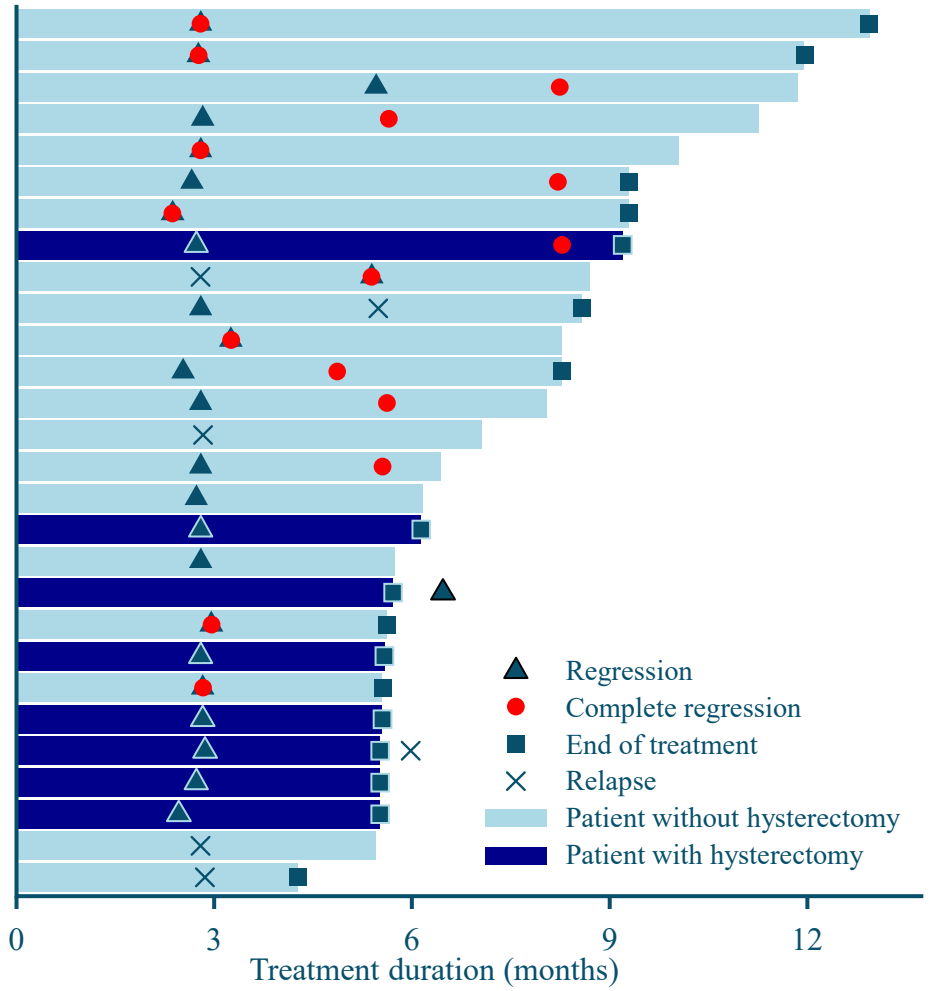
- Central NGS (324 cancer-associated genes, TMB, and MSI status)
- ER and PgR by IHC

[a]LHRH was not mandatory. After 6 cycles, patients underwent definitive hysterectomy, switched to local standard-of-care, or opted to continue giredestrant for up to 18 additional cycles

IHC = immunohistochemistry; LHRH = luteinizing hormone-releasing hormone; MRI = magnetic resonance imaging; MSI = microsatellite instability; NGS = next-generation sequencing; PgR = progesterone receptor; PO = oral; q28d = every 28 days; TMB = tumor mutational burden

Gilbert, et al. Presented at SGO 2026
Gilbert L, et al. Gynecologic Oncology, 208S56.

Giredestrant Shows Single-Agent Anti-Tumor Activity



- 6-month tumor regression, all evaluable patients
  - 23/28 (**82%,** 95% CI 63–94%)
    - Complete regression: 11 (39%)
    - Partial regression: 12 (43%)
- 6-month tumor regression, premenopausal women
  - 9/10 (90%)
    - Complete regression: 6 (60%)
- Sustained regression for ≥6 months: 21/28 (**75%**)
- Non-responders:
  - 5 patients had increased cancer at month 6 vs baseline
- 1 patient's histology changed from grade 1 to grade 2

GOG Highlight Reel

Gilbert, et al. Presented at SGO 2026; Figure adapted from Gilbert, et al.

[a]*5 patients not evaluable for primary endpoint (2 insufficient tissue, 3 early discontinuation)*

GOG FOUNDATION

GLP-1 Receptor Agonists (RA) May Reduce the Risk of Endometrial and Other Cancers in Obese Adults

Hazard ratios for adults taking GLP-1 RA vs. not taking GLP-1 RA (2014–2024)

Outcome	Hazard Ratio (95% CI)
Endometrial cancer	0.75 (0.57–0.99)
Colorectal cancer	0.88 (0.64–1.22)
Thyroid cancer	0.77 (0.54–1.11)
Prostate cancer	0.91 (0.73–1.15)
Breast cancer	0.86 (0.71–1.03)
Lung cancer	0.76 (0.55–1.04)
Pancreatic cancer	0.84 (0.54–1.30)
Kidney cancer	1.38 (0.99–1.93)
Ovary cancer	0.53 (0.29–0.96)
Liver cancer	0.91 (0.60–1.38)
Multiple myeloma	0.79 (0.46–1.35)
Bladder cancer	0.97 (0.63–1.50)
Meningioma	0.69 (0.48–0.97)
Upper gastrointestinal cancer	0.60 (0.29–1.24)
Overall cancer	0.83 (0.76–0.91)

Decreased Cancer Risk

Increased Cancer Risk

Dai H, et al. JAMA oncology. 2025.

GLP-1RA Plus Progestin Reduces Hysterectomy Risk in Fertility-Sparing Management of Endometrial Cancer

Study Design

- Retrospective cohort (TriNetX; 112 healthcare organizations)
- Women <45 years with EIN or endometrial cancer (2017–2024)
- GLP-1RA + progestin vs progestin alone
- Primary outcome: **hysterectomy at 6, 12, and 18 months**

Key Findings

- **Hysterectomy Risk Reduction**
  - GLP-1RA + progestin → **significantly lower risk across all time points**
    - **6 months: HR 0.34 (0.22–0.53)**
    - **12 months: HR 0.38 (0.26–0.54)**
    - **18 months: HR 0.41 (0.29–0.58)**
- **Subgroup benefit**
  - **Age <40 years:** HR 0.26–0.40
  - **Endometrial cancer subgroup:** HR ~0.31–0.33

Adapted from Hsieh TYJ, et al. Presented at the Society of Gynecologic Oncology (SGO) Annual Meeting; 2026, and Hsieh TYJ, et al. Gynecol Oncol. 2026;207(Suppl):23-29.

Endometrial Cancer Case 1
pMMR EC, p53WT

Bhavana Pothuri, MD

NYU Langone
New York City, New York

CASE 1

Patient with pMMR EC, p53 WT

GOG Highlight Reel

- 62-year-old hx of PMB starting Oct. 2008 (Dx age 40)
- Em bx: 10/2008: Endometrium, biopsy: Endometrial adenocarcinoma, endometrioid type FIGO grade 1
- Underwent EUA, robotic hysterectomy, SLN Bx
- Final PATH Endometriod endometrial ca, 10% myoinvasion, no LVSI, SLN neg- Stage IA, Gr1 endometroid endometrial ca, ER+, PR+
- Germline genetic testing: 28 gene panel: CDK-4 VUS
- Had F/U for 5 years and was discharged to gen gyn clinic
- PT was a former smoker and PCP, screened her for lung ca and found gradually increasing LLL nodule initially seen 9/2019, and increased in size in 2020

CASE 1

Patient with pMMR EC, p53 WT

GOG Highlight Reel

- Had IR bx 5//2020 - adenocarcinoma of mullerian origin
- 6/2020 PET/CT: Minimally FDG-avid left lower lobe nodule is compatible with the proven adenocarcinoma, no evidence of FDG-avid regional nodal or distant metastases
- 7/2020 underwent bronchoscopy, robotic left lower lobectomy, mediastinal lymph node dissection
- Pathology: left lower lobectomy- metastatic adenocarcinoma consistent with mullerian origin, tumor 0.8 cm, MMR IHC intact, p53 WT, HER2 1+, ER+, PR+

CASE 1

Patient with pMMR EC, p53 WT

GOG Highlight Reel

Next Steps:

A. No further tx

B. Paclitaxel/carboplatin

C. Paclitaxel/carboplatin/checkpoint inhibitor, followed by check point inhibitor maintenance

D. Paclitaxel/carboplatin followed by selinexor maintenance

E. Megesterol acetate

CASE 1

Patient with pMMR EC, p53 WT

GOG Highlight Reel

- PT started on RUBY trial 9/2020- completed paclitaxel/carboplatin/dostarlimab (9/2022)
- PT developed Gr 3 pancreatitis- treated with steroids with complete resolution
- Last seen 6/2026 and NED and CtDNA neg

CASE 1

Patient with pMMR EC

GOG Highlight Reel

- What is your standard for pMMR EC?
- Do you think pMMR/P53 WT receive less benefit from IO?
- What future therapies will be most beneficial frontline for P53Wt/pMMR subgroup?

Front Line Endometrial Cancer Trial Options

CASE 1

Patient with P53wt/MMRp EC

GOG Highlight Reel

If relapses, next option:

A. Doxorubicin or paclitaxel

B. Clinical trial with TROP2, HER2, FRα, or B7H4 ADC

C. Best Supportive Care

D. Lenvatinib plus pembrolizumab

E. Hormonal Therapy

2 Randomized Phase 3 Trials of TROP2 ADC in Recurrent Endometrial Cancer

Phase 3 ENGOT-en23/GOG-3095/MK-2870-005[1]
N=710

Key Eligibility Criteria

- Histologically confirmed endometrial carcinoma or carcinosarcoma
- Radiographically evaluable disease, either measurable or nonmeasurable per RECIST v1.1 (by BICR)
- Must have received prior platinum-based chemo and anti–PD-1/anti–PD-L1 therapy, either separately or in combination
- Has not received >3 prior lines of therapy

R

MK-2870 4 mg/kg IV on day 1 of each 14-day cycle

Doxorubicin 60 mg/m² IV on day 1 of each 21-day cycle
or
Paclitaxel 80 mg/m² IV on days 1, 8, and 15 of each 28-day cycle

NCT06132958

- **Primary endpoints**: PFS, OS
- **Secondary endpoints**: ORR, DOR, safety, HRQOL

GOG Global PI: Pothuri
Mentored PI:Lightfoot

Phase 3 GOG-3104/ENGOT-en26
N=520

Key Eligibility Criteria

- Histologically confirmed endometrial carcinoma or carcinosarcoma
- Radiographically evaluable disease, either measurable or nonmeasurable per RECIST v1.1 (by BICR)
- Must have received prior platinum-based chemo and anti–PD-1/anti–PD-L1 therapy, either separately or in combination
- Has not received >3 prior lines of therapy

R

Sacituzumab govitecan 10mg/kg D1, D8

Doxorubicin 60 mg/m² IV on day 1 of each 21-day cycle
or
Paclitaxel 80 mg/m² IV on days 1, 8, and 15 of each 28-day cycle

NCT06486441

- **Primary endpoints**: PFS, OS
- **Secondary endpoints**: ORR, DOR, safety, HRQOL

GOG Global PI: Eskander
Mentored PI:Corr

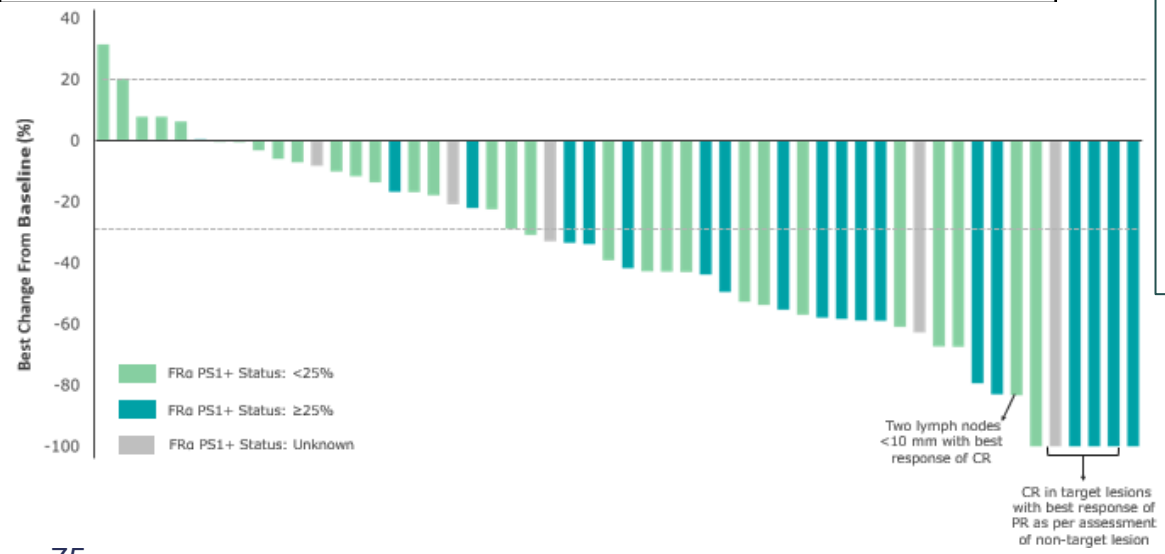
1. NCT06132958 via ClinicalTrials.gov. Accessed April 29, 2024.; 2. NCT05382268 via ClinicalTrials.gov. Accessed Sept 1, 2024 .

Rina-S for Patients with Recurrent Endometrial Cancer

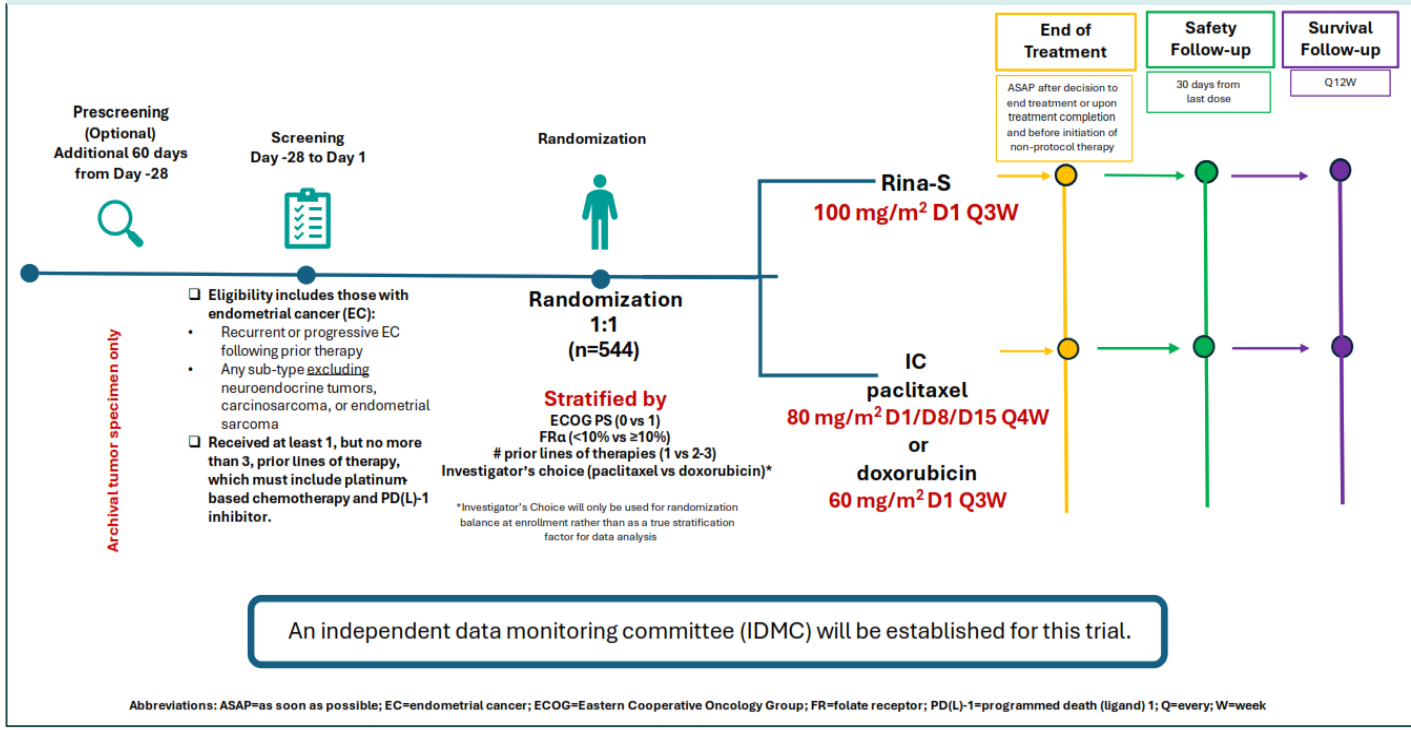
Antitumor Activity- RAINFOL-01

	100 mg/m² (n=22)	120 mg/m² (n=34)[a]
Median on-study follow-up[b], months (95% CI)	11.7 (11.3-12.4)	13.8 (11.5-16.5)
Confirmed ORR[c], % (95% CI)	50.0 (28.2-71.8)	44.1 (27.2-62.1)
Confirmed response, n (%)		
CR	2 (9.1)	1 (2.9)
PR	9 (40.9)	14 (41.2)
SD	11 (50.0)	13 (38.2)
NE	0	1 (2.9)
DCR, % (95% CI)	100 (84.6-100.0)	82.4 (65.5-93.2)

[a]Response-evaluable population (includes patients with ≥1 post-baseline scan). [b]Median on-study follow-up is the median time from first dose to censoring for all patients at data cutoff. [c]Based on investigator assessment.



RAINFOL-03- Global, Open-label, Randomized Phase 3

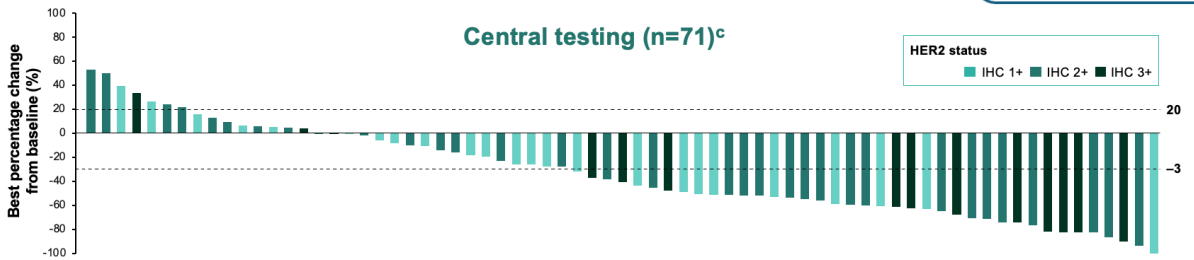


Cloven et al ESMO 2025

Trastuzumab Pamirtecan (T-Pam) for Patients Recurrent Endometrial Cancer

Cohort 2B: Recurrent EC, HER 2 expressing

	HER2-expressing (central testing)	
	Prior ICI (n=73)	All patients (N=96)
Confirmed ORR,[a] % (95% CI)	49.3 (37.4, 61.3)	47.9 (37.6, 58.4)
Median DoR,[a] months (95% CI)	9.9 (7.0, NE)	11.1 (9.0, 18.3)
DCR,[a,b] % (95% CI)	79.5 (68.4, 88.0)	83.3 (74.4, 90.2)
Median PFS,[c] months (95% CI)	(n=74) 6.8 (5.4, 11.0)	(N=97) 8.1 (5.5, 11.8)



FERN EC-01: Global, Randomized Phase 3 trial

Phase 3, randomized, open-label trial of trastuzumab pamirtecan versus ICI in patients with previously treated HER2-expressing recurrent EC

SGO ANNUAL MEETING ON WOMEN'S CANCER
SAN JUAN, PR
APRIL 10-13, 2026

Key inclusion criteria

- Recurrent EC (HER2 1+, 2+, or 3+ on IHC by central testing)
- Prior anti PD-1/anti–PD-L1 therapy
- Recurrence of EC <12 months from completing platinum-based chemotherapy in the adjuvant setting for stage I–III, or recurrence after platinum-based chemotherapy in the recurrent/metastatic setting
- Up to 3 lines of prior therapy[a]
- Measurable disease per RECIST v1.1
- ECOG PS 0–2

Cohort 1: HER 2 IHC 1+/2+

2:1 R

n=280 — Trastuzumab pamirtecan

n=140 — ICI (doxorubicin or paclitaxel[b])

Stratification factors:
- HER2 expression (IHC 1+ vs 2+) by central laboratory
- Number of prior lines of treatment (1 vs ≥2)

Primary endpoints: PFS (by BICR)

Key Secondary Endpoints: OS

Secondary Endpoints: PFS (by investigator), ORR, DoR, safety

Cohort 2: HER 2 IHC 3+

n=60 — Trastuzumab pamirtecan

Primary endpoints: ORR (by BICR)

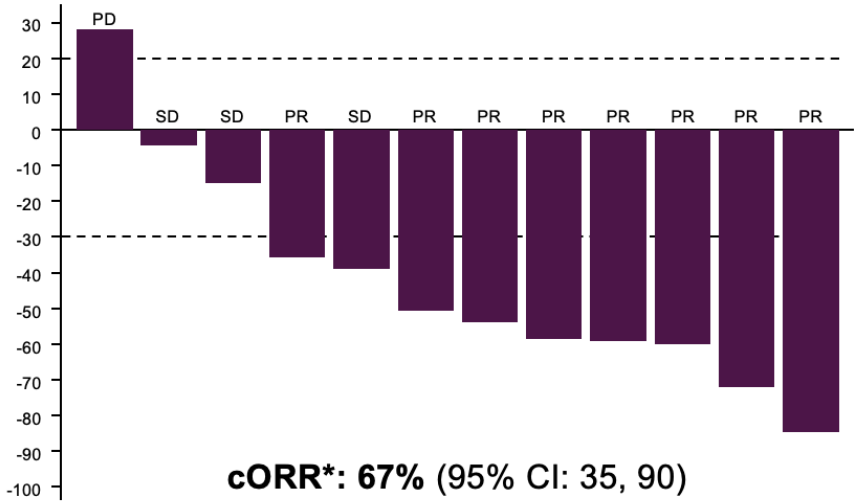
Secondary Endpoints: ORR (by investigator), DoR, PFS, OS, safety

Pothuri, SGO 2026

Mocertatug Rezetecan (Mo-Rez) for Patients Recurrent Endometrial Cancer

Phase IB -BEHOLD 1 Recurrent Endometrial Cancer

Mo-Rez 4.8 mg/kg (N=12)



cORR*: 67% (95% CI: 35, 90)

BEHOLD Endometrial01 GOG-3131/ENGOT-en34: Randomized, Global Phase III Trial

BEHOLD-Endometrial01: Mo-Rez is being compared with chemotherapy in participants with recurrent EC

BEHOLD Endometrial01 — Randomized, open-label, phase 3 study (N ≈ 600)

Key inclusion criteria
- ≥ 18 years old
- Histologically confirmed recurrent or persistent EC[a]
- 1 to 3 prior LOTs[b]
- Prior platinum-based chemotherapy and anti–PD-1/PD-L1 therapy (either separately or combined)[c]
- PFI of < 12 months if platinum-based therapy was given only in the adjuvant setting[d]
- FFPE tumor tissue sample
- ECOG PS score of 0 or 1
- Adequate organ function

Key exclusion criteria
- Non-eligible tumor types, including
  - Mesenchymal tumors of the uterus (uterine sarcomas)
  - Neuroendocrine uterine cancer
- Any other malignancy that progressed or required treatment within the past 36 months[e]
- Untreated or progressive brain or CNS metastases at screening
- Current or prior ILD or pneumonitis or history of non-infectious pneumonitis
- Prior treatment with a TOP1i, or an ADC with a TOP1i warhead, or B7-H4–targeted therapy

R 1:1

Study treatment
- Mo-Rez
- Investigator's choice: Paclitaxel or Doxorubicin

Endpoints

Primary:
- ORR and PFS per RECIST v1.1 by BICR

Secondary:
- OS
- ORR and PFS per RECIST v1.1 by IA
- DoR per RECIST 1.1 by BICR and IA
- Safety
- Quality of life
- Immunogenicity

Study start (estimated): March 5, 2026 **Primary completion (estimated): January 19, 2028**

[a] Including endometroid, serous, and clear cell carcinoma, and endometrial carcinosarcoma; [b] Up to 3 lines of prior systemic treatment are acceptable if 1 line was administered in the adjuvant/neoadjuvant setting; [c] Participants deemed unsuitable for a prior PD-1/PD-L1 inhibitor therapy (contraindications such as immunodeficiency, autoimmune disease that required systemic treatment) as determined by the investigator or treating physician are eligible; [d] If PD-L1/PD-1 inhibitor therapy was administered with platinum-based treatment, the participant is eligible regardless of the PFI exceeds 12 months; [e] Except for BCC or SCC of the skin or in situ carcinomas (eg, breast, cervix, or bladder) that have been resected with no evidence of metastatic disease or that are otherwise considered cured by the investigator.

ADA = anti-drug antibody; ADC = antibody-drug conjugate; AESI = adverse event of special interest; B7-H4 = B7 homolog 4; BCC = basal cell carcinoma; BICR = blinded independent central review; CNS = central nervous system; DoR = duration of response; EC = endometrial cancer; ECOG PS = Eastern Cooperative Oncology Group Performance Status; ECG = electrocardiogram; EORTC QLQ-C30 = European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire Core 30; EORTC QLQ-EN24 = European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire-Endometrial Cancer Module 24; FFPE = formalin-fixed, paraffin-embedded; IA = investigator assessment; ILD = interstitial lung disease; LOT = line of therapy; Mo-Rez = Mocertatug Rezetecan; ORR = overall response rate; OS = overall survival; PD-1 = programmed cell death 1; PD-L1 = programmed cell death ligand 1; PFI = platinum-free interval; PFS = progression-free survival; PRO-CTCAE = Patient-Reported Outcome Common Terminology Criteria for Adverse Events; R = randomization; RECIST v1.1 = Response Evaluation Criteria In Solid Tumours version 1.1; SAE = serious adverse event; SCC = squamous cell carcinoma; TEAE = treatment-emergent adverse event; TOP1i = topoisomerase 1 inhibitor.

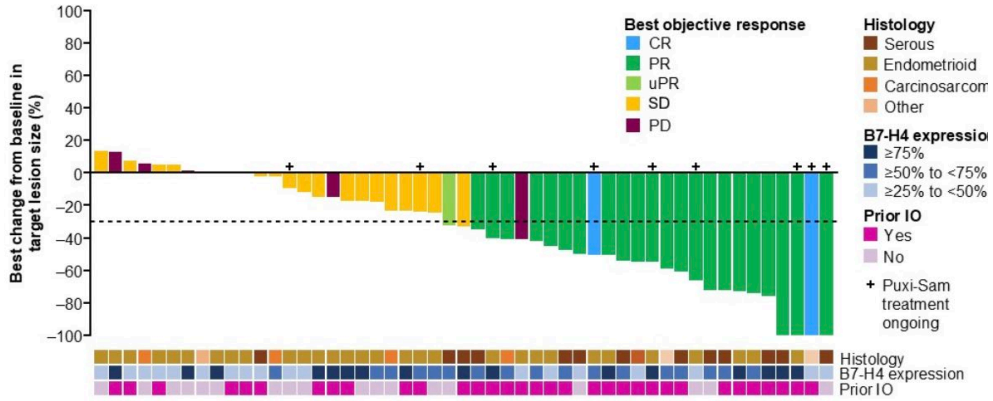
MED-US-12823 v 102

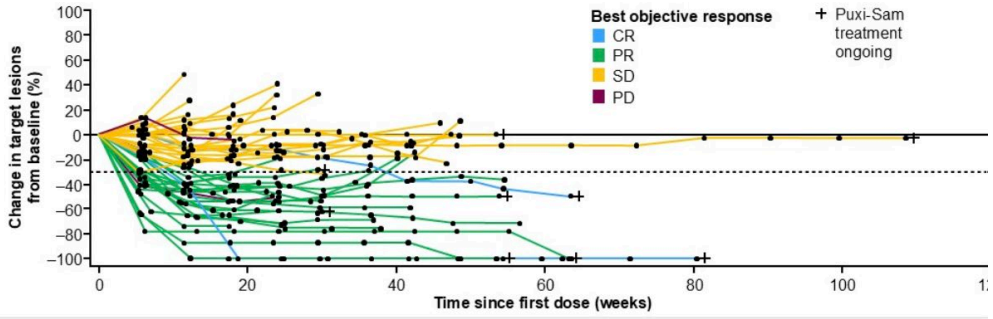
NYU Langone

Puxi-Sam in Patients with Recurrent Endometrial Cancer

Puxi-Sam Efficacy: BLUESTAR Ph IB

	2.0 mg/kg (n=42)	2.4 mg/kg (n=51)
ORR, % (95% CI)*	33.3 (19.6–49.6)	47.1 (32.9–61.5)
Median DoR, months (95% CI)	6.0 (4.9–9.7)	7.1 (4.5–13.3)
DCR at 12 weeks, % (95% CI)	71.4 (55.4–84.3)	84.3 (71.4–93.0)
Median PFS, months (95% CI)	5.7 (4.5–8.3)	7.2 (5.6–9.2)





BLUESTAR-Endometrial01/GOG 3110/ ENGOT-en28: Randomized Global Phase 3 Trial

Puxitatug Samrotecan (Puxi-sam) Monotherapy vs Chemotherapy in B7-H4 Selected Advanced/Metastatic Endometrial Cancer Who Progressed On or After Platinum Based Chemotherapy and Anti-PD-1/Anti-PD-L1 Therapy

Key Eligibility Criteria

- Histologically confirmed endometrial cancer (EC) or carcinosarcoma
- Advanced or recurrent/metastatic EC
- B7-H4 expression
- Prior platinum-based chemotherapy and anti-PD-1/anti-PD-L1 therapy, either separately or in combination
- Has received no more than 2 prior lines of therapy in advanced/metastatic setting
- Neoadjuvant ± adjuvant platinum-based chemotherapy would count as 1 line of therapy if the recurrence occurred within 12 months after the date of the last platinum dose.
- WHO/ECOG 0 or 1
- At least 1 measurable lesion per RECIST 1.1
- No prior TOP1 inhibitors or B7-H4 agents

R 1:1

- **Arm A: Puxi-sam IV Q3W**
- **Arm B: Investigator's Choice of Chemotherapy***

*Doxorubicin 60 mg/m² IV Q3W or Paclitaxel 80 mg/m² IV on Days 1, 8, and 15 in a Q4W cycle

Dual primary endpoints
PFS, OS

Secondary endpoints
ORR, DoR, PFS2, TFST, TSST, TDT, Time to worsening, Safety

PFS, Progression Free Survival; OS, Overall Survival; ORR, Overall Response Rate; DoR, Duration of Response; TFST, Time until first subsequent anticancer therapy; TSST, Time until second subsequent anticancer therapy; TDT, Time until discontinuation of treatment; IV, intravenous

Mileshkin, ASCO 2026

CASE 1

Patient with P53wt/MMRp EC

GOG Highlight Reel

Suppose patient enrolls on TROP2 trial, tolerates therapy well and relapses after 9 months on therapy with excellent PS, next option:

A. Doxorubicin or paclitaxel

B. Clinical trial with HER2, FRα, or B7H4 ADC if prior topo ADC allowed

C. Best Supportive Care

D. CDK4/6i plus letrozole

CASE 1

Patient with pMMR EC

GOG Highlight Reel

- What is role of lenvatinib/pembrolizumab after frontline IO?
- How will TROP2 ADC 2L data impact EC landscape and trials in this space?
- Do you consider hormonal therapy in this group? If so, when in disease course?

Endometrial Cancer Case 2

Joyce Barlin, MD

Women's Cancer Care Associates
Albany, New York

CASE 2

- 75-year-old presented w/ postmenopausal bleeding
- PMH: HTN, HLD, DM
- Pelvic sono: uterus 8.5 cm w/ 1.2 cm endometrium
- EMBx: grade 3 endometrioid endometrial carcinoma, possible serous component
- CA-125 of 26
- CT C/A/P negative

CASE 2

- RATLH, BSO, SLN, omentectomy
- Final path: grade 3 endometrioid endometrial carcinoma, 70% invasion, positive LVSI, **SLN+, omentum + microscopic disease**
- **Tumor testing:**
  - –pMMR
  - –ER-/PR-
  - –HER2 (2+)
  - –TP53 mutated

CASE 2

GOG Highlight Reel

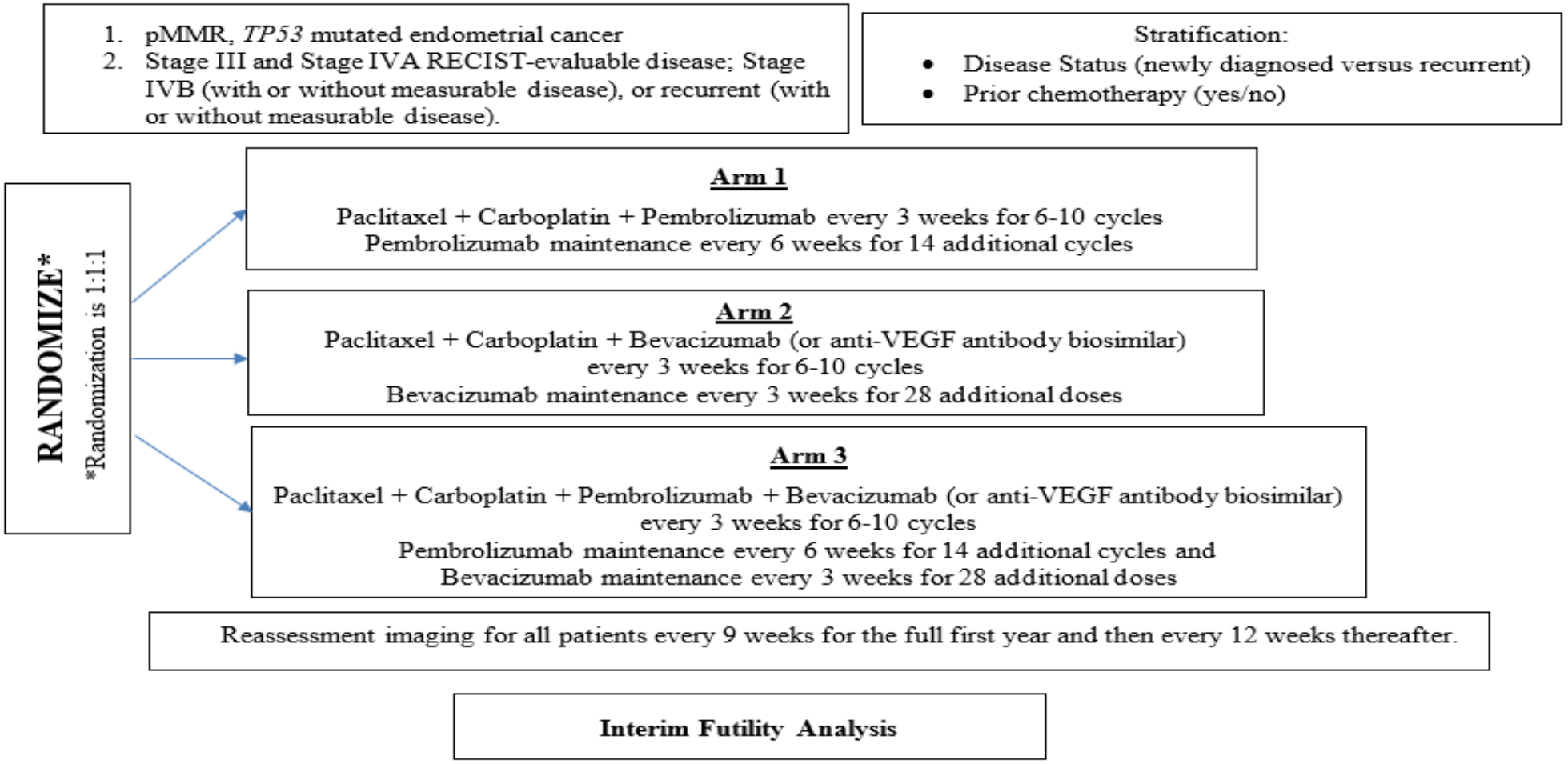
What do you recommend for treatment?

A. Clinical Trial

B. Standard of Care

A. Paclitaxel + Carboplatin + IO
B. Paclitaxel + Carboplatin + Bevacizumab
C. Paclitaxel + Carboplatin + IO + Bevacizumab
D. Paclitaxel + Carboplatin + Trastuzumab
E. Other

NRG-GY035: A Randomized Phase III Trial of Carboplatin, Paclitaxel, Pembrolizumab Versus Carboplatin, Paclitaxel, Bevacizumab Versus Carboplatin, Paclitaxel, Pembrolizumab, Bevacizumab in the Treatment of pMMR, *TP53* Mutated Advanced or Recurrent Endometrial Cancer



Primary endpoint is PFS. **PFS will not be reported until all accrual is completed.**

PI: Amanda Nickles Fader, MD

SYMBIOTIC-GYN-18/GOG-3145/ENGOT-en37/APGOT-EN6/LACOG 0426-EVA
Phase 3 Randomized Open Label Study in Advanced or Recurrent Endometrial Cancer Patients with Proficient MMR Status

PI: Kathleen Moore, MD

PF-08634404 is an investigational tetravalent bispecific antibody that simultaneously targets PD-1 and VEGF

- pMMR only
- Measurable stage III*
- Stage IV* (with or without measurable disease) or
- Recurrent (with or without measurable disease) disease where the potential for cure by surgery alone or in combination with other modalities is poor
- No prior systemic therapy except for adjuvant chemotherapy for recurrent disease
- Time from prior adjuvant chemotherapy to relapse > 6 months
- Carcinosarcoma is allowed
- ECOG 0 or 1

*FIGO 2023 classification

1:1

N=600

Carboplatin and Paclitaxel Q3W for 6 cycles
+
PF-08634404 10 mg/kg QW3, followed by PF-08634404 maintenance 10mg/kg Q3W (for 2 years/total 35 cycles)

Carboplatin and Paclitaxel Q3W for 6 cycles
+
Pembrolizumab 200mg Q3W, followed by pembrolizumab maintenance 400mg Q6W (for 2 years/total 20 cycles)

Primary endpoints:
- Progression Free Survival (BICR)

Key Secondary Endpoint:
- Overall Survival

Secondary Endpoints:
- ORR
- DOR
- Safety
- PK
- Other: Biomarkers, PROs

GOG Highlight Reel

NCT07578649

GOG FOUNDATION

DESTINY-Endometrial01/GOG-3098/ENGOT-EN24

A Phase III Study of Trastuzumab Deruxtecan Plus Rilvegostomig or Pembrolizumab as First-Line Treatment of HER2-Expressing (IHC 3+/2+), Mismatch Repair Proficient (pMMR) Endometrial Cancer

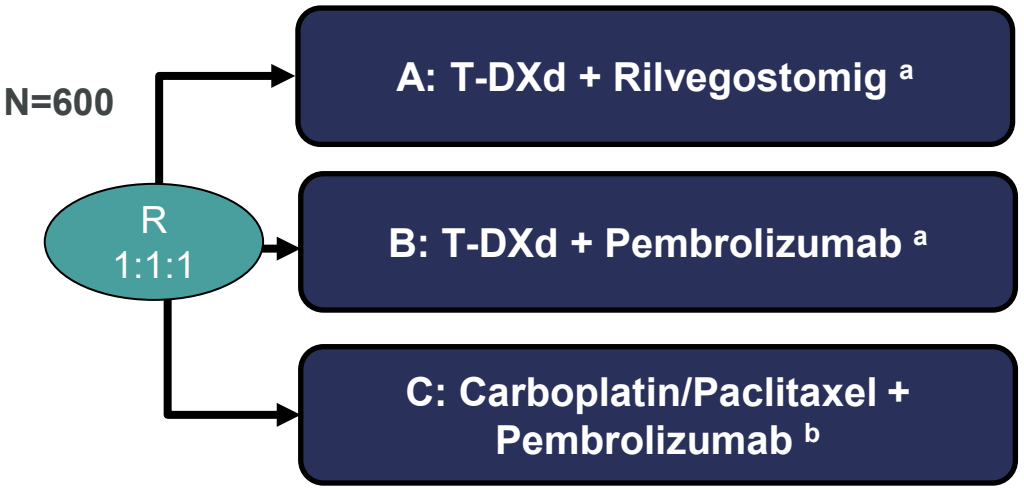
PI: Vicky Makker, MD | Co-PI: Melissa Geller, MD

Rilvegostomig is a bispecific monoclonal antibody that simultaneously targets PD-1 and TIGIT

Patient Population

- Stage III, Stage IV, or recurrent, histologically-confirmed endometrial cancer
- Stage III must have measurable disease
- pMMR EC by central test
- HER2 expressing (IHC 3+/2+) EC by central test
- Any histological subtype except for sarcomas
- No prior chemotherapy for the treatment of EC, except for one prior line of adjuvant/neoadjuvant chemotherapy with curative intent (chemotherapy or chemoradiation) if completed ≥ 6 months prior to signature of the main ICF.
- No prior exposure to ADCs or ICIs
- ECOG PS 0 or 1

IHC 3+25%; IHC 2+ 75% (capped)



Stratification factors:
- HER2 IHC 3+ vs 2+
- PD-L1 TAP ≥1% vs TAP <1%
- Asia vs Non-Asia

Endpoints

Primary:
- PFS (BICR) in ITT

Secondary:
- OS (key secondary endpoint)
- PFS (Investigator)
- ORR
- DoR
- PFS2
- HRQoL

[a] Treatment will continue until objective disease progression according to RECIST v1.1 as assessed by the Investigator and confirmed by BICR or until other discontinuation criteria is met, whichever occurs first.
[b] Carboplatin AUC5, paclitaxel 175 mg/m2, and pembrolizumab 200 mg IV once Q3W x 6 cycles, followed by pembrolizumab 400 mg IV Q6W x 14 cycles. Treatment with pembrolizumab will continue for up to 20 total cycles (approximately 24 months, accounting for combination and maintenance phases) or until other discontinuation criteria is met, whichever occurs first. At the discretion of the treating Investigator, participants may continue to receive carboplatin, paclitaxel and pembrolizumab Q3W for up to 10 cycles.*

Global CSP v3.0 19-Mar-2026

GOG Highlight Reel

NCT06989112

ENGOT European Network of Gynaecological Oncological Trial groups

NSGO-CTU Nordic Society of Gynaecological Oncology - Clinical Trial Unit

GOG FOUNDATION

TroFuse-033/GOG-3119/ENGOT-en29
A Phase 3 Study to Compare Sacituzumab Tirumotecan in Combination With Pembrolizumab Vs Pembrolizumab Alone as Treatment in Participants With MMR-P Endometrial Cancer

PI: Bradley Monk, MD

Key eligibility criteria:

- Primary advanced/recurrent endometrial carcinoma
- pMMR
- No prior systemic therapy OR recurred after adjuvant (no PFI required)
- No prior anti-PD-1/PD-L1
- Radiologically apparent disease (measurable for St. III, measurable or non-measurable for St. IV & recurrent disease)
- Available tissue to test for TROP2 / MMR / p53
- ECOG 0 to 1

N ~ 1123

Induction

6 cycles[1]

Carboplatin
Paclitaxel
Pembrolizumab
q3w

Without PD

Eligibility for Randomization:

- Without PD as determined by INV
- Completed 6 cycles of Induction
- AEs resolved to ≤ Grade 1
- Adequate organ function
- ECOG 0 to 1
- Valid TROP2 result from central lab

Maintenance

Randomize 1:1
N ~ 842

sac-TMT 4 mg/kg D1, 15, 29 q6w + Pembrolizumab 400mg q6w

Pembrolizumab 400mg q6w

PD

Subsequent Treatment[3]:

sac-TMT +/- Pembrolizumab

Treatment duration:
Treat until intolerable toxicities or PD per RECIST 1.1 by BICR or up to ~1.5 years (42 doses of sac-TMT in 14 cycles of pembrolizumab)[d]

Dual Primary Endpoints[4]
PFS (BICR) ; OS
(using a TROP2 enrichment strategy)

[1] If pt. needs more time to recover after 6 cycles of Carboplatin/ Paclitaxel/ Pembrolizumab, two additional cycles of pembrolizumab (cycle 7 + 8) may be administered after sponsor consultation; [2] Pts. with confirmed CR by BICR (following Induction or Maintenance) may discontinue sac-TMT after 6 months of sac-TMT after sponsor consultation; [3]Patients with PD on Induction Treatment will be randomized to sac-TMT vs. sac-TMT + pembrolizumab if eligible per safety criteria outlined in IC/EC; Subsequent Treatment is an exploratory part of the study [4]From start of randomization to Maintenance;

GOG Highlight Reel

NCT06952504

ENGOT European Network of Gynaecological Oncological Trial groups

GOG FOUNDATION

CASE 2

What do you recommend for treatment?

A. Clinical Trial

Which Clinical Trial?

B. Standard of Care

A. Paclitaxel + Carboplatin + IO
B. Paclitaxel + Carboplatin + Bevacizumab
C. Paclitaxel + Carboplatin + IO + Bevacizumab
D. Paclitaxel + Carboplatin + Trastuzumab
E. Other

CASE 2

GOG Highlight Reel

Change the scenario to dMMR patient

- Adjuvant paclitaxel + carboplatin + pembrolizumab
- Pembrolizumab maintenance
- Pt progresses 10 months after starting pembrolizumab maintenance w/ mediastinal and retroperitoneal lymphadenopathy
- **Tumor testing:**

  ~~–pMMR~~

  –ER-/PR-

  –HER2 (2+)

  –TP53 mutated

CASE 2

GOG Highlight Reel

What do you recommend for treatment?

A. What do we do post IO?

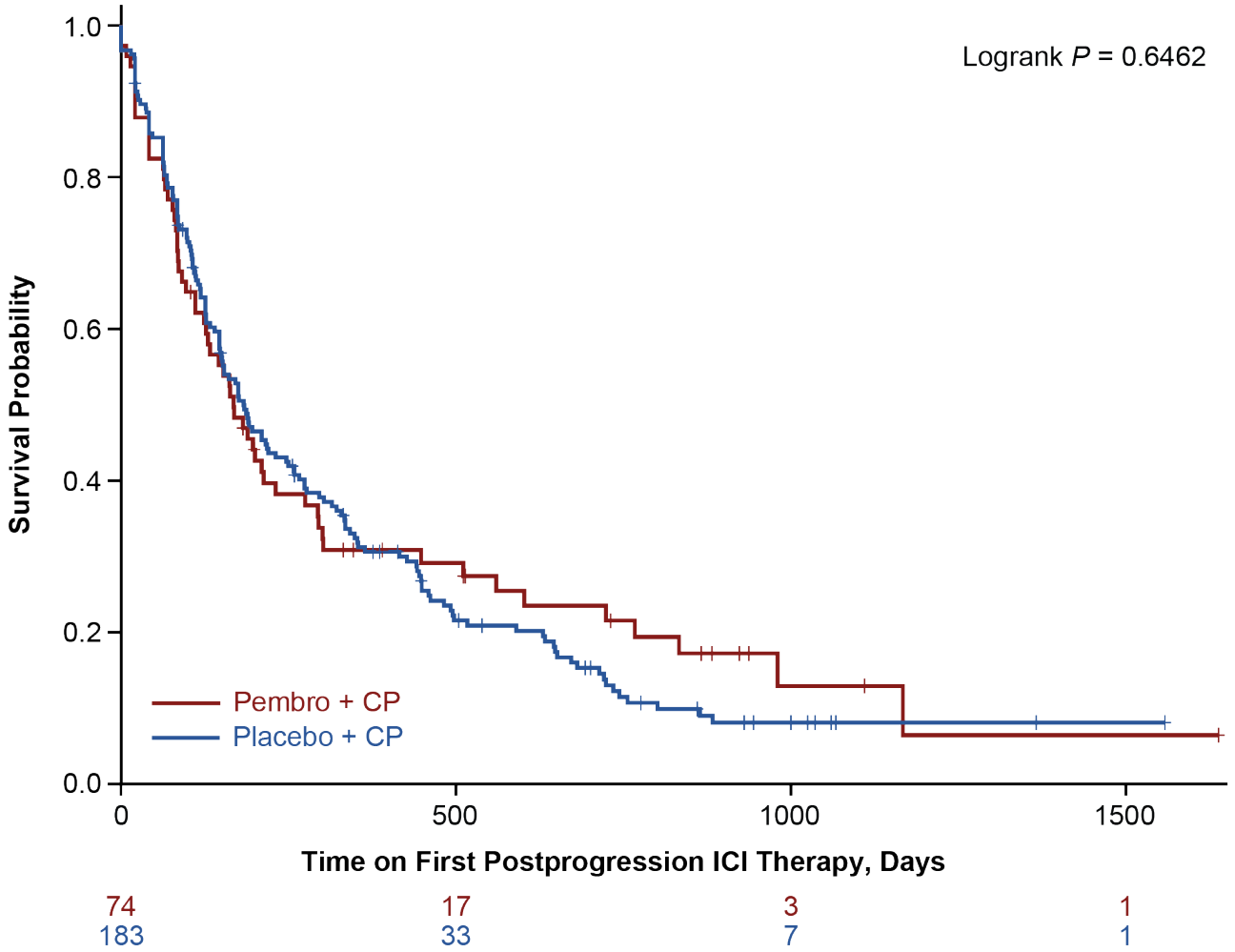
B. Standard of Care

A. Paclitaxel + Carboplatin + Bevacizumab
B. Paclitaxel + Carboplatin + Trastuzumab
C. Trastuzumab Deruxtecan
D. Add Lenvatinib to Pembrolizumab
E. Other (single agent chemotherapy)

Lenvatinib + Pembrolizumab: FDA Approval and NCCN Guidelines Limited to pMMR Patients

- dMMR pts were included on KEYNOTE-775, but endpoints powered for pMMR population
- Rationale for pMMR only approval:
  - dMMR tumors respond robustly to checkpoint inhibitor monotherapy
  - Adding lenvatinib adds toxicity
- **Are you adding lenvatinib to pembrolizumab in practice?**

Time on Post Progression ICI Therapy in the pMMR Cohort



Within this cohort:

- N = 48 in the pembrolizumab + CP arm received lenvatinib + pembrolizumab
- N = 136 in the placebo + CP arm received lenvatinib + pembrolizumab
- Median time on postprogression ICI therapy was:
  - **6.0 (95% CI, 4.8–8.1) months in placebo + CP arm**
  - **5.5 (95% CI, 4.1–5.7) months in pembrolizumab + CP arm**

GOG Highlight Reel

Ramez N. Eskander, MD

GOG FOUNDATION

The Socratic Method at Work - Thank you!

Endometrial Cancer Panel Discussion

GOG Highlight Reel

Part 3: Cervical Cancer

Leslie Randall, MD

Inova Health
Fairfax, Virginia

CASE 1

GOG Highlight Reel

- 38-year-old with abnormal uterine bleeding and pelvic pain
- Last pap 4 years ago with last pregnancy
- Exam:
  - 6 cm exophytic cervical mass
  - Parametrial extension to sidewall on left
  - Punch biopsy adenosquamous carcinoma
- Imaging
  - PET/CT- confirms exam, additional hydronephrosis on left, 3 pelvic nodes and 1 para-aortic node at L3 with SUV >9, no distant disease

CASE 1

GOG Highlight Reel

Treatment Choice?

A. Cisplatin-EBRT-brachytherapy (cisRT)

B. Induction cis/paclitaxel to cisRT (INTERLACE)

C. cisRT + pembrolizumab to pembro maintenance (KN A18)

D. Clinical trial

CASE 2

- 62-year-old with postmenopausal bleeding
- Remote history of LEEP for CIN 3 (20 years prior)
- Exam:
  - 4 cm exophytic cervical mass
  - Parametrial extension <1/3 to sidewall on right
  - Punch biopsy squamous cell carcinoma
- Imaging
  - PET/CT- consistent with exam, 1 pelvic node with SUV 4.3, no distant disease

CASE 2

GOG Highlight Reel

Treatment Choice?

A. Cisplatin-EBRT-brachytherapy (cisRT)

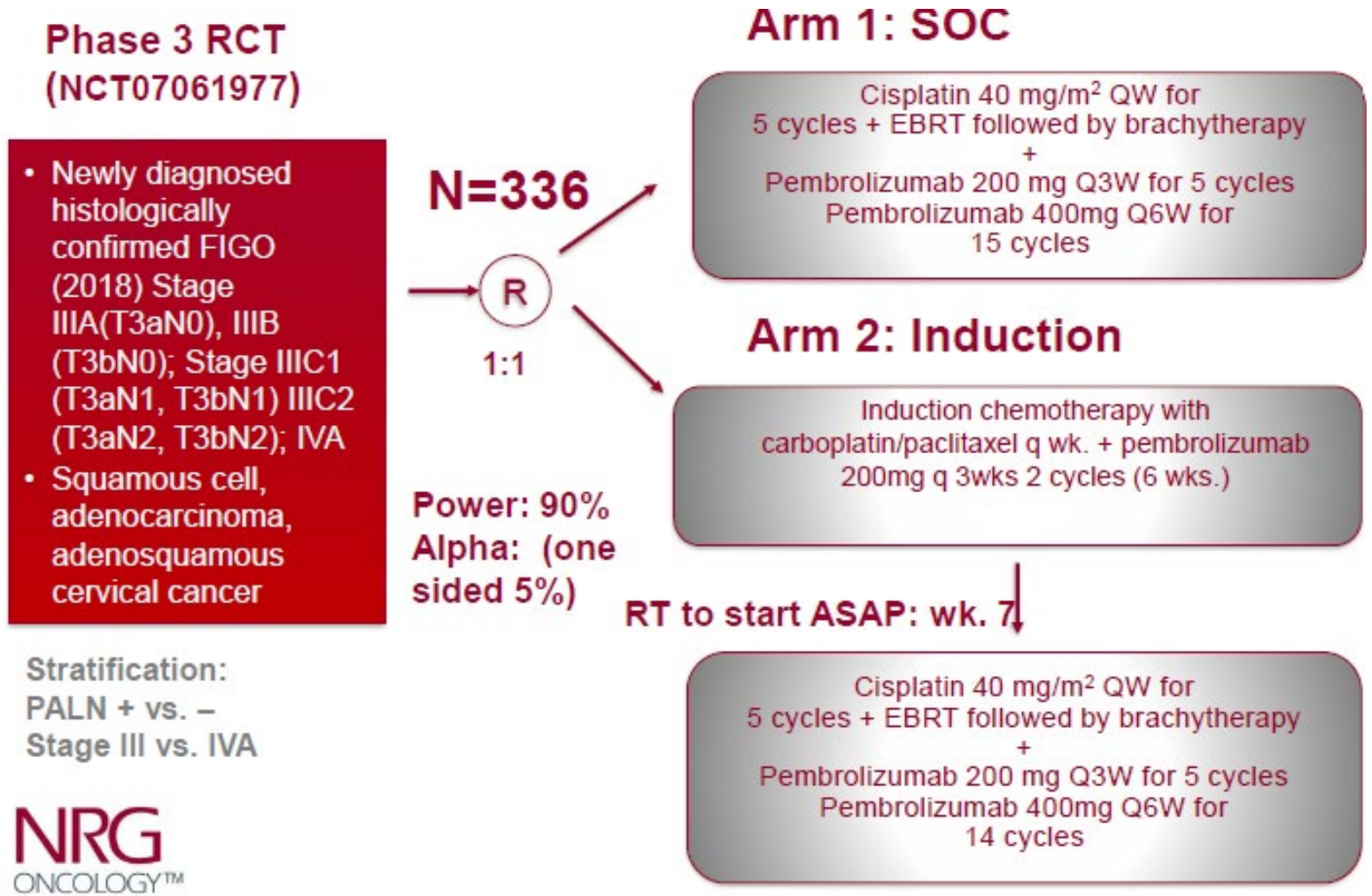
B. Induction cis/paclitaxel to cisRT (INTERLACE)

C. cisRT + pembrolizumab to pembro maintenance (KN A18)

D. Clinical trial

NRG-GY037: A Phase III Study of Induction Pembrolizumab and Chemotherapy Followed by Chemoradiation and Pembrolizumab vs Chemoradiation and Pembrolizumab Both Followed by Pembrolizumab for High Risk Locally Advanced Cervical Cancer

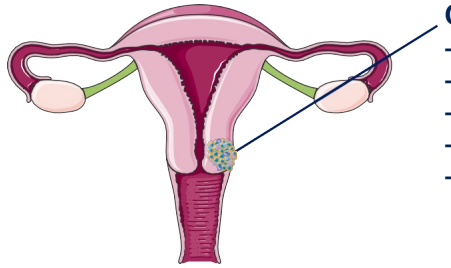
KN A18?
INTERLACE?
OR
BOTH?



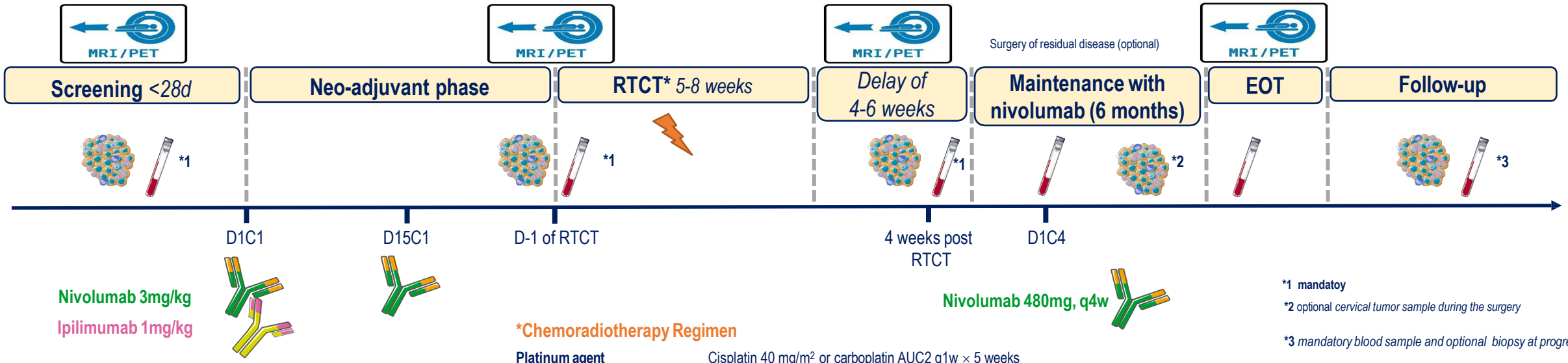
NRG ONCOLOGY™

Mayadev JS, et al. Presented at the ASCO Annual Meeting; 2026. Abstract TPS5622. ClinicalTrials.gov Identifier: NCT07061977.

Phase 2 – COLIBRI-1 inclusion criteria & Study design



Cervical cancer
- Women aged ≥18 years
- Histologically confirmed cervical (adeno)squamous carcinoma
- LACC (FIGO 2018) stage IB3-IVA
- ECOG performance status of 0 or 1
- Multicentric single arm pilot study



*1 mandatoy

*2 optional *cervical tumor sample during the surgery*

*3 *mandatory blood sample and optional biopsy at progression*

Tumor biopsy

Blood sample

*Chemoradiotherapy Regimen

Platinum agent	Cisplatin 40 mg/m² or carboplatin AUC2 q1w × 5 weeks
EBRT	45 Gy in 25 fractions at 1.8 Gy/fraction, 5 fractions per week
Brachytherapy	High-dose rate: 27.5–30 Gy; Low/pulsed-dose rate: 35–40

Primary endpoint : To measure the $CD8^+/FOXP3^+$ ratio, in pre- versus post-ICB therapy

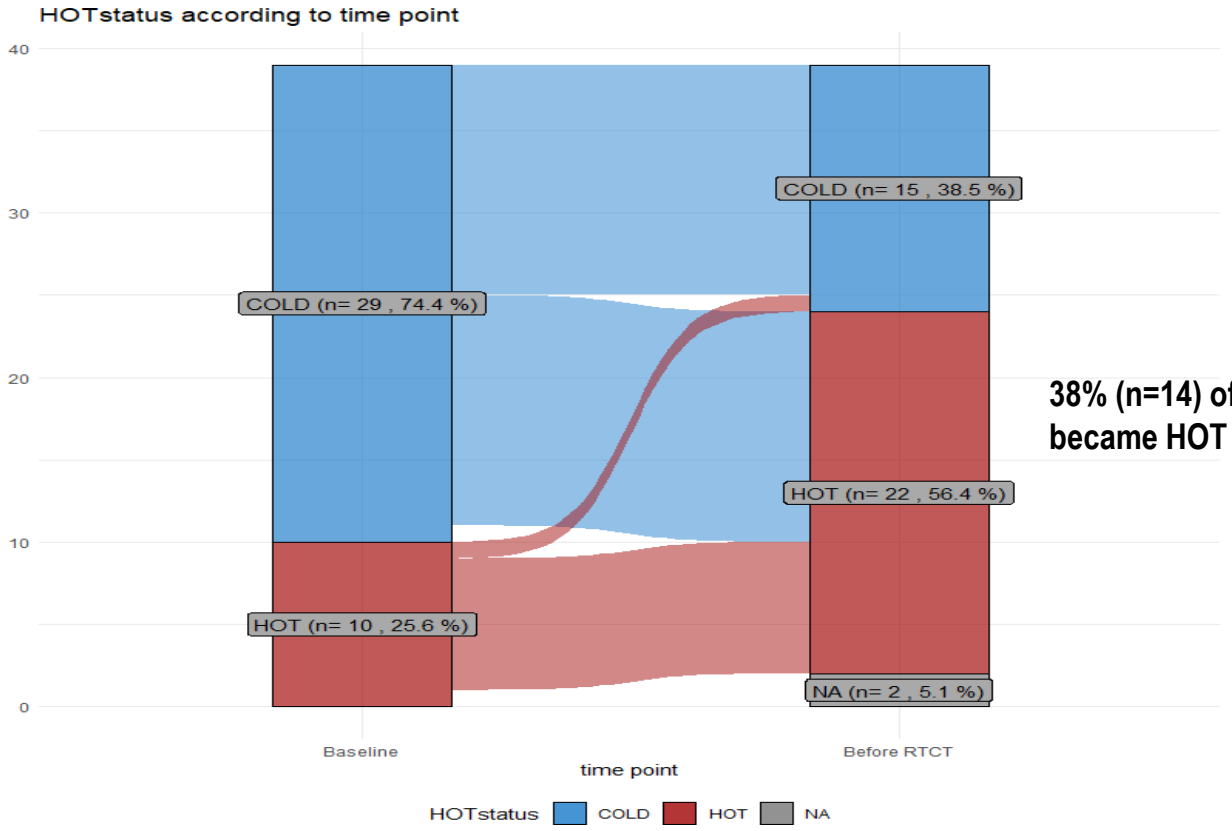
Secondary endpoints : - Safety,
- Response rate, **Survival outcomes (3 yrs PFS, OS),**
-Evolution of **immune microenvironment** and **correlation with outcomes**

PRESENTED BY : Florence JOLY

PFS and OS according to evolution of immune signature from baseline to post IC

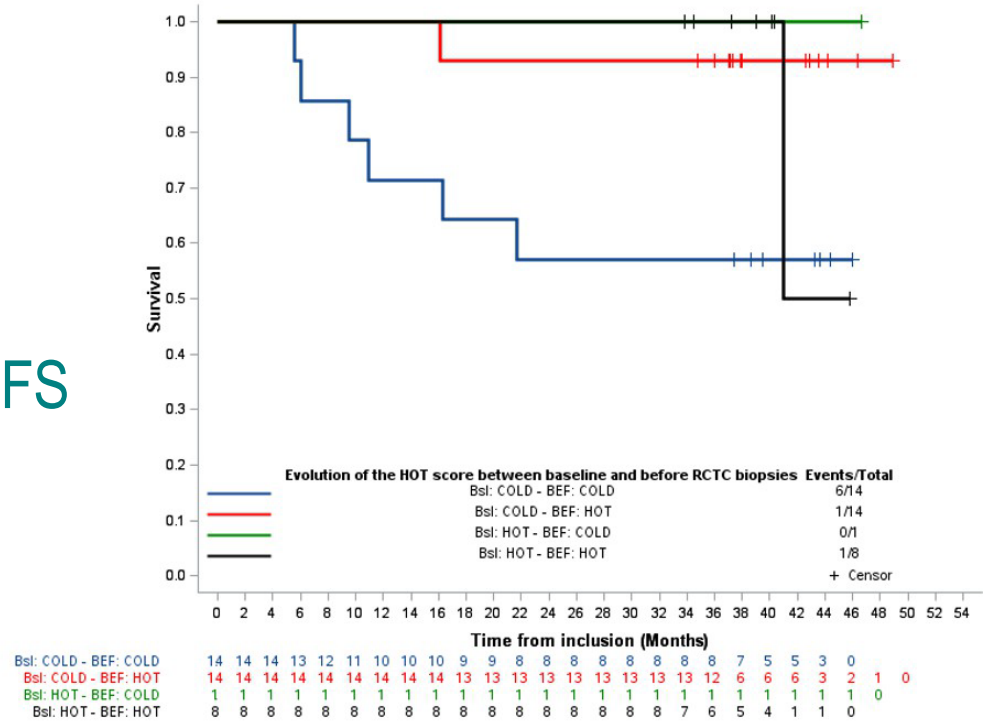
➔ Poor outcomes for cold tumors

Evolution of the 'HOT' score after induction ICB

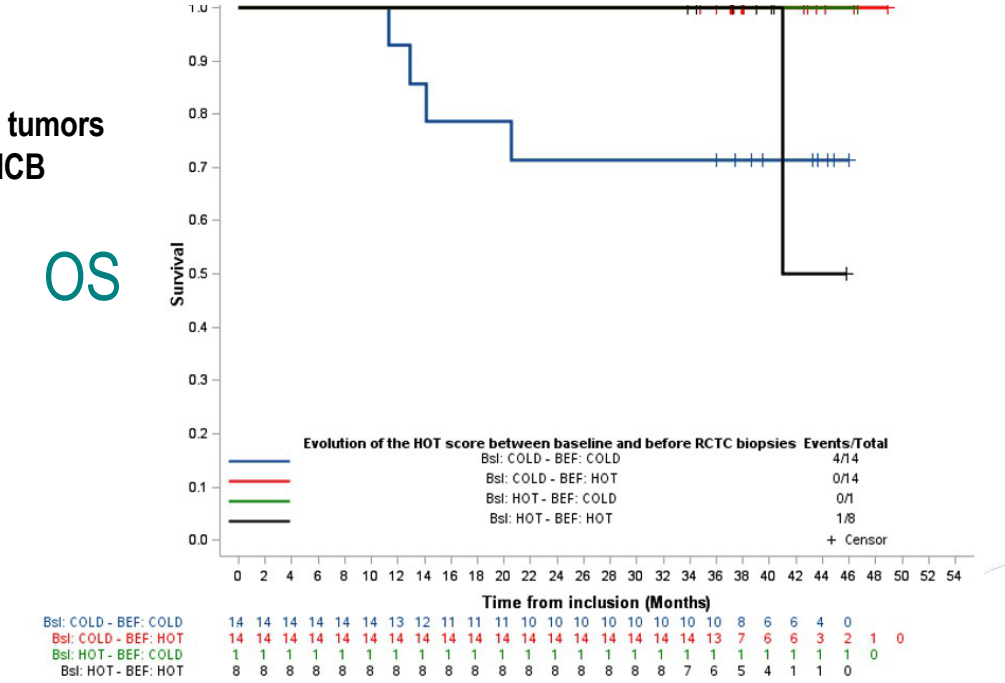


38% (n=14) of Cold tumors became HOT after ICB

PFS



OS



PRESENTED BY : Florence JOLY

CASE

1ST RECURRENCE

GOG Highlight Reel

CASE 1

- Disease free for 1 year after completion of pembrolizumab maintenance, recurs in lung and left supraclavicular node
  - Lung biopsy confirms adenosquamous recurrence
  - PDL1 CPS 5%, HER2 2+, PIK3CA mut

CASE 2

- Disease free for 3 years after completion of cisRT, recurrence in sigmoid colon and liver
  - Liver biopsy confirms squamous cell recurrence
  - PDL1 CPS 50%, HER2 0, p53mut

CASE 1

1ST RECURRENCE

GOG Highlight Reel

Preferred treatment option?

A. Cisplatin/paclitaxel/bevacizumab (GOG 240)

B. Cisplatin/paclitaxel/bevacizumab/pembrolizumab (KN 826)

C. Carboplatin/paclitaxel/bevacizumab/atezolizumab (BEATcc)

D. Carboplatin/paclitaxel/pembrolizumab (KN 826)

E. Trastuzumab deruxtecan (IHC HER 2+)

F. Clinical trial

CASE 2

1ST RECURRENCE

GOG Highlight Reel

Preferred treatment option?

A. Cisplatin/paclitaxel/bevacizumab (GOG 240)

B. Cisplatin/paclitaxel/bevacizumab/pembrolizumab (KN 826)

C. Carboplatin/paclitaxel/bevacizumab/atezolizumab (BEATcc)

D. Carboplatin/paclitaxel/pembrolizumab (KN 826)

E. Clinical trial

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

TroFuse ONCOLOGY CLINICAL TRIALS

A Phase 3, Randomized, Open-label, Multicenter Study to Evaluate the Efficacy and Safety of Sacituzumab Tirumotecan (MK-2870) in Combination With Pembrolizumab With or Without Bevacizumab Compared With Standard of Care as Firstline Maintenance Treatment for Participants With Persistent, Recurrent, or Newly Diagnosed Metastatic Cervical Cancer With PD-L1 CPS Greater Than or Equal to 1

PI: Brian Slomovitz, MD

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/m^2 or Carboplatin AUC 5 mg/mL/min, Paclitaxel 175 mg/m^2, 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

Primary Endpoints:

- **PFS per RECIST v. 1.1 by BICR**
- **OS**

SCAN ME

Slomovitz B, et al. Presented at the ASCO Annual Meeting; 2026.

ADC, antibody-drug conjugate; BICR, blinded independent central review; CPS, combined positive score; IV, intravenous; N, number of patients; OS, overall survival; PD-L1, programmed death-ligand 1; PFS, progression-free survival; PI, principal investigator; Q2W, every 2 weeks; Q3W, every 3 weeks; Q6W, every 6 weeks; RECIST, Response Evaluation Criteria in Solid Tumors; Sac-TMT, sacituzumab tirumotecan.

NCT07216703.

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CASE

2nd RECURRENCE

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CASE 1

- Progression on bevacizumab maintenance, 8 months post platinum
  - PDL1 CPS 5%, HER2 2+, PIK3CA mut

CASE 2

- Progression on pembrolizumab + bevacizumab maintenance, 18 months post platinum
  - PDL1 CPS 50%, HER2 0, p53mut

CASE 1

2ND RECURRENCE

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Recommended next line of treatment?

A. Tisotumab vedotin

B. Trastuzumab deruxtecan

C. Tisotumab vedotin + pembrolizumab

D. Pemetrexed

E. Clinical trial

CASE 2

2ND RECURRENCE

GOG Highlight Reel

Recommended next line of treatment?

A. Tisotumab vedotin

B. Trastuzumab deruxtecan

C. Tisotumab vedotin + pembrolizumab

D. Pemetrexed

E. Clinical trial

Current ADC status in 2L+ cervical cancer

	Trial(s)	Target	Payload	ORR % (95% CI)	mDOR (mos.)	AESI
FDA-approved						
Tisotumab vedotin (TV)	InnovaTV 204[1] InnovaTV 301[2]	Tissue factor	MMAE	24 (16-33) 17 (13.3-23.1)	5.3 (4.2-8.3)	• Ocular • Motor neuropathy
TV+ pembrolizumab	InnovaTV 205[3]	Tissue factor PD-1	MMAE	38.2 (22.2-56.4)		• Non overlapping
Trastuzumab deruxtecan	DESTINY pantumor[4]	HER2	DXd	50 (33.8-66.2)	12.6 (0.9–31.0)	• Nausea • ILD
Investigational						
Sacituzumab govitecan	EVER-132-003[5]	Trop2	SN-38	43 (27-59)	9.2 (4.6-11.7)	• Heme
Sacituzumab tirumotecan (Sac-TMT)	TroFuse 010[6]	Trop2	Belinotecan derivative	28 (17–41)	NR	• Heme • Mucositis
SacTMT +pembrolizumab	TroFuse 020[7]	Trop2 PD1	Belinotecan derivative	51 (39-64)	NR (1.9-25.4+)	• Non overlapping

1. Coleman RL et al. Lancet Oncol. 2021 May;22(5):609-619. 2. Vergote I et al. N Engl J Med. 2024 Jul 4;391(1):44-55. 3. van Nieuwenhuysen E et al Gynecol Oncol 2026Apr:207S:3-13. 4. Lee JY et al J Gynecol Oncol. 2026 May;37(3):e65. 5. An J et al. Gynecol Oncol 2025 Nov:202:33-40. 6. Wang D et al ESMO 2025. 7. Wu X et al SGO 2026

ADC, antibody-drug conjugate; AESI, adverse event of special interest; BICR, blinded independent central review; CI, confidence interval; DXd, deruxtecan; HER2, human epidermal growth factor receptor 2; ILD, interstitial lung disease; mDOR, median duration of response; MMAE, monomethyl auristatin E; NR, not reached; ORR, objective response rate; PD-1, programmed cell death protein 1.

Investigational ADC Updates: Newer Targets

ADC (study)	Target	Payload	N	ORR	DoR	PFS	
SYS6043 [1]	B7-H3	TOP1 inhibitor	39	35.9%	Maturing	5.8 months	
DB-1311 / BNT324 [2]	B7-H3	TOP1 inhibitor	33	42.4%	Not reached	7.0 months	
BFv, 9MW2821 [3]	Nectin-4	Microtubule inhibitor	53	32%	6.0 months	3.9 months	ESMO GYNAECOLOGICAL CANCERS
CRB-701 [4]	Nectin-4	Microtubule inhibitor	32	34.4%	8.0 months	4.3 months	2026 ASCO ANNUAL MEETING

1. Zhou J, et al. 2. Winer IS, et al. 3. Yang H, et al. 4. Mantia C, et al. J Clin Oncol 44, 6062 (2026)

Table courtesy of Dr. Ramez Eskander

GOG-3116/C5721005

PI: Scott Jordan, MD

Single-arm, prospective, low-interventional study of tisotumab vedotin in adult participants in the US with r/mCC who have received prior systemic therapy for recurrent or metastatic disease

Patient Population

r/m CC with disease progression on or after chemotherapy, following prior systemic therapy

No active ocular disease at baseline

No prior TV treatment

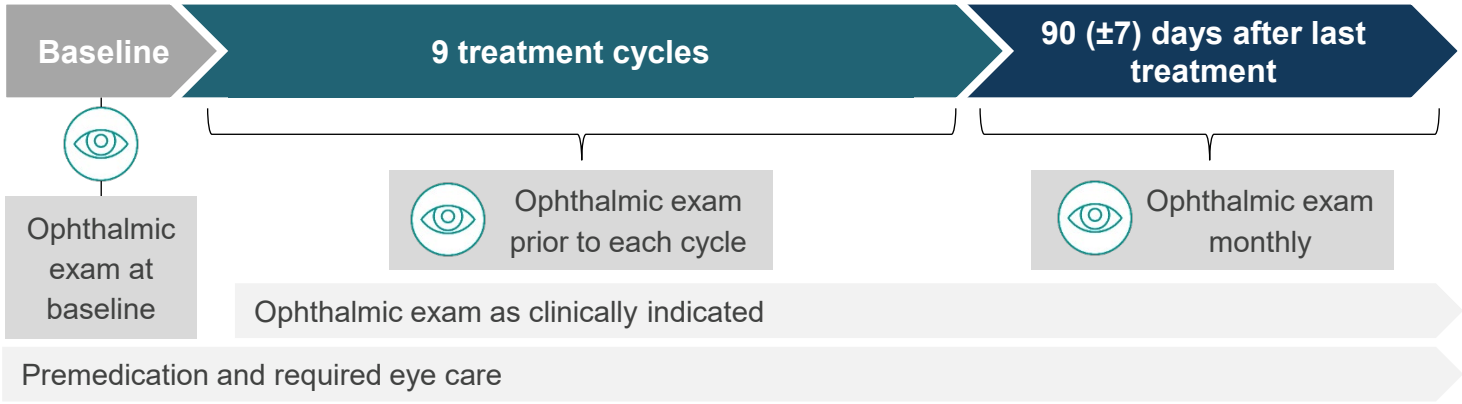
Tisotumab vedotin
2.0 mg/kg IV on Day 1 of a 21-day cycle (Q3W)

N=100

Intervention

Scheduled ocular assessments conducted by eye care providers

- Slit lamp exam of the anterior segment of the eye
- Visual acuity
- Assessment of normal eye movement
- Elicitation of visual symptoms



Endpoints

Primary endpoint

- Type, incidence and severity of ocular AEs

Secondary endpoints

- Time to onset, time to resolution, and outcome of ocular AEs
- Incidence of serious AEs
- AEs leading to dose modifications including treatment discontinuation

Objective: to further characterize the incidence and severity of tisotumab vedotin-related ocular events with prospectively pre-specified, scheduled ocular assessments in patients receiving tisotumab vedotin for r/mCC

AE, adverse event; IV, intravenous; mCC, cervical cancer; N, number of patients; PI, principal investigator; Q3W, every 3 weeks; TV, tissue factor–directed antibody-drug conjugate; r/mCC, recurrent or metastatic cervical cancer.

NCT06952660

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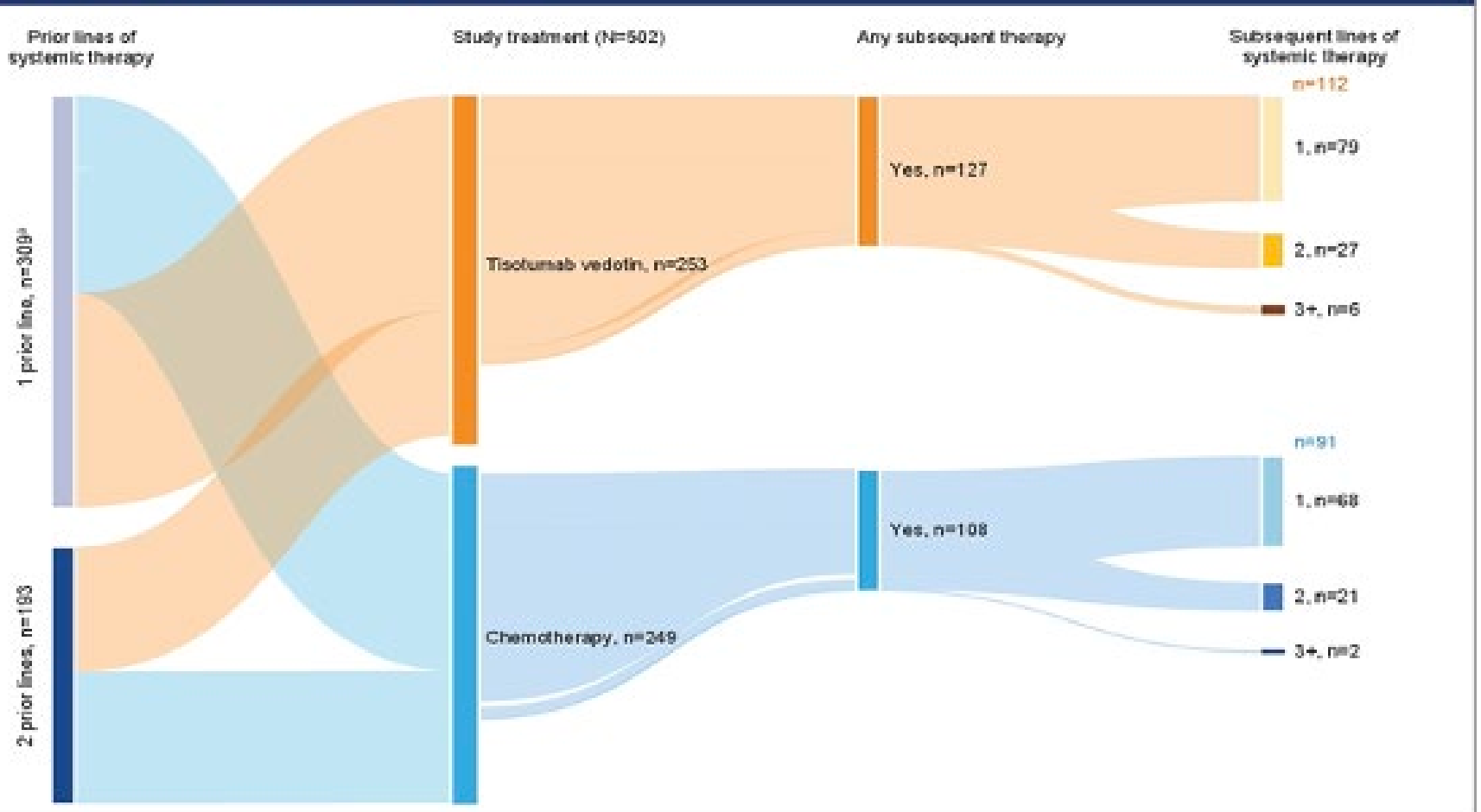
How Many Receive Subsequent Therapy?

Abstract 5531

Tisotumab Vedotin in 2L/3L Recurrent or Metastatic Cervical Cancer: Subsequent Therapy Data From ENGOT-cx12/GOG-3057/innovaTV 301

Figure 4: Prior and subsequent therapy



Sanchez LM, et al. Abstract 5531 ASCO 2024

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Conclusions

- ADCs dominate the trial landscape
- Refinements in immunotherapy are a close second
  - Sequencing in the LACC setting
  - Combinations in all settings
- Clinical trial access remains paramount
- Keep patients on therapy
- Remove bias of who should get novel treatments or any treatment

Cervical Cancer Panel Discussion

Part 4: Audience Engagement and Q&A

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Part 5: Final Comments, Future Perspectives

Thomas Herzog, MD

University of Cincinnati
Cincinnati, Ohio

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THANK YOU

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THANK YOU

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Friday January 29, 2027

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