

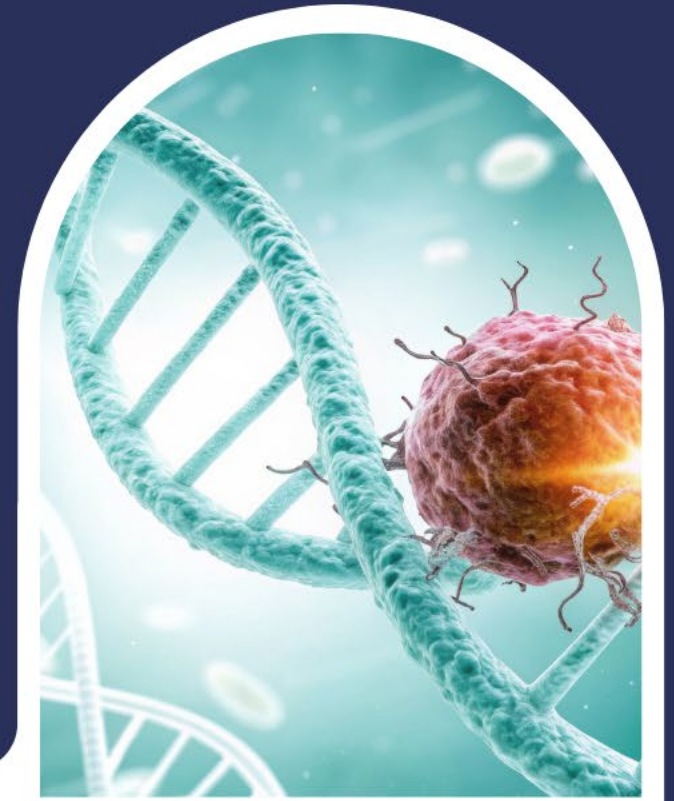
An Educational Symposium at the FSGO 2026 Annual Meeting

Evolving Evidence and Treatment Strategies in Platinum Resistant Ovarian Cancer: From Biology to Bedside

Friday, June 12, 2026

11:45 am – 1:00 pm ET

Long Boat Key, Florida



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

CME for this Educational Symposium is provided by The GOG Foundation, Inc. Credit is available only for live, in-person attendance and completion of the activity evaluation. CME credit will not be awarded for virtual attendance or viewing of recorded materials.

Faculty Disclosure Information

Evolving Evidence and Treatment Strategies in Platinum Resistant Ovarian Cancer: From Biology to Bedside
Industry Supported Symposium

Friday, July 12, 2026 | Long Boat Key, Florida

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

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

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

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

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



Faculty Disclosure Information

LAST NAME	FIRST NAME	Individual's Role(s) in Activity	Name of Ineligible Company(s)	Nature of Relevant Financial Relationship(s)
Planning Disclosures				
Herzog, MD	Thomas	Moderator	Aadi BioScience; AbbVie; AstraZeneca; Caris; Corcept; DSI; Eisai; Epsilon; Genmab; GSK; Merck; Mersana; Natera; Pfizer; Pharma&; PMV Pharma; Sutro; Tempus; Zentalis	Scientific Advisory Board (Aadi BioScience; AbbVie; AstraZeneca; Caris; Corcept; DSI; Eisai; Epsilon; Genmab; GSK; Merck; Mersana; Natera; Pfizer; Pharma&; PMV Pharma; Sutro; Tempus; Zentalis) Honorarium (Aadi; Corcept; Merck; Natera)
Speaker Disclosures				
Arend, MD	Rebecca	Speaker	AstraZeneca; Merck; Sharp; Dohme;	Leadership/Advisory (AstraZeneca) Consultant (Merck; Sharp; Dohme)
Naumann, MD	R. Wendel	Speaker	Amgen; Johnson & Johnson; MedTech; Merck Sharp & Dohme; AstraZeneca; Eisai; Bristol-Meyers Squibb; Seagen; Agenus; SturoBio; GOG Partners; GSK/Tesaro; Genelux; Laekna; Immunogen; EMD Serono; Virtual Incision; Incyclix Bio; Genmab/Seattle Genetics; Nimbus; Aadi Bioscience; AbbVie; Incyte; Gilead Sciences; Tubulis GmbH; Tract Bio; Seagen; OncoMed; Sutro-Bio; GOG; Mersana; Schrodinger	Stock/Other Ownership Interests (Amgen) Honoraria (Johnson & Johnson; MedTech) Consulting or Advisory Role (Merck Sharp & Dohme; AstraZeneca; Eisai; Bristol-Myers Squibb; Seagen; Agenus; SturoBio; GOG Partners; GSK/Tesaro; Genelux; Laekna; Immunogen; EMD Serono; Virtual Incision; Incyclix Bio; Genmab/Seattle Genetics; Nimbus; Aadi Bioscience; AbbVie; Incyte; Gilead Sciences; Tubulis GmbH; Tract Bio) Speakers' Bureau (Seagen) Research Funding (Bristol-Myers Squibb; OncoMed; Sutro-Bio; GOG; Mersana; GSK/Tesaro; Schrodinger)
Engbert	Holley	Staff	Nothing to disclose	
Rush	Heather	Staff	Nothing to disclose	
Shumaker	Kara	Reviewer/Staff	Nothing to disclose	
Small, MPH	Michelle N	Reviewer/Staff	Nothing to disclose	
Alvarez Secord, MD	Angeles	Reviewer/Edu-Chair	AbbVie; Aravive; AstraZeneca; Daiichi Sankyo; Ellipses Pharma; Genmab; GSK; Immunogen; Karyopharm; Merck; Mersana; Myriad; Oncoquest/Canaria Bio; Oncoquest; Roche/Genentech; TORL Biotherapeutics; Zentalis; Foundation Medicine; Gilead; Histosonics; Medtronic; Porject Nana; Up to Date; SGO; FWC; GOG Foundation; Amgen; Johnson & Johnson	Research funds to Institution (AbbVie; Aravive; AstraZeneca; Daiichi Sankyo; Ellipses Pharma; Genmab; GSK; Immunogen; Karyopharm; Merck; Mersana; Myriad; Oncoquest/Canaria Bio; Oncoquest; Roche/Genentech; TORL Biotherapeutics; Zentalis) Honorarium (Merck; GSK) Advisory Board with Honoraria (AbbVie; AstraZeneca; Daiichi Sankyo; Foundation Medicine; GSK; Genmab; Gilead; Histosonics; Medtronic; Merck) Medical Advisory Board (Porject Nana) Steering Committee Uncomp. (Oncoquest; Genmab) Royalties (Up to Date) Board of Directors (SGO; FWC; GOG Foundation) Stock-Divested in June 2024 (Amgen; Johnson & Johnson)
Duska, MD	Linda	Edu-Co-Chair/ Reviewer	Merck; Corcept	Honoraria (Merck) Speakers Bureau (Corcept) Research Funding (Merck)
Blank, MD	Stephanie	Reviewer	American Board of Obstetrics and Gynecology; Merck; AstraZeneca; GlaxoSmithKline; Pfizer; Seattle Genetics/Astellas; Acrivon; Zentalis; NX Development Corp.	Leadership (American Board of Obstetrics and Gynecology) Research Funding (Merck; AstraZeneca; GlaxoSmithKline; Pfizer; Seattle Genetics/Astellas; Acrivon; Zentalis; NX Development Corp.)
Gien, MD	Lilian	Reviewer	Glaxo Smith Kline; Merck; Abbvie; AstraZeneca	Speaker Honoraria (Glaxo Smith Kline; Merck) Advisory Board (Abbvie; AstraZeneca)
Mutch, MD	David	Reviewer	Nothing to disclose	
Zweizig, MD	Susan	Reviewer	Nothing to disclose	

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

Disclaimer

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

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



THANK YOU

Corcept Therapeutics

**For Supporting This Activity With
An Independent Medical Education Grant**



Moderator

Faculty



Thomas Herzog, MD

University of Cincinnati



Rebecca C. Arend, MD, MSPH

University of Alabama at Birmingham
Division of Gynecologic Oncology



R. Wendel Naumann, MD

Atrium Health Wake Forest Baptist
Comprehensive Cancer Center

Learning Objectives

After participating in this activity, learners will be able to:

1. Summarize the current U.S. treatment landscape and unmet needs in platinum resistant ovarian cancer, including survival benchmarks and patterns of progression.
2. Explain key biological drivers of resistance (e.g., DNA damage repair, replication stress, microenvironmental/immune factors) and how they inform therapeutic rationale and trial design.
3. Critically interpret Phase 3 evidence (HRs, PFS/OS hierarchy, censoring, subgroup analyses, external validity) to guide evidence based practice.
4. Apply biomarker information (e.g., FR α , BRCA, HRD) pragmatically—recognizing testing access, turnaround, and interpretation challenges—without referencing specific products.
5. Engage in case based decision making and articulate how pending FDA decisions and guideline updates may shape future patient selection and sequencing.



Agenda

- | | |
|---------------|--|
| 10
minutes | Welcome, Needs, and Pre-Assessment
Thomas Herzog, MD |
| 15
minutes | Current U.S. Management & Unmet Needs in PROC
Rebecca C. Arend, MD, MSPH |
| 15
minutes | Why Resistance Happens: Clinical Implications of Tumor Biology
R. Wendel Naumann, MD |
| 15
minutes | Interpreting New Phase 3 Evidence: A Methodology Masterclass
All Faculty |
| 15
minutes | Case Based Application
All Faculty |
| 5
minutes | Panel Q&A, Post Assessment
Thomas Herzog, MD |



Current U.S. Management & Unmet Needs in PROOC

Rebecca C. Arend, MD, MSPH

University of Alabama at Birmingham
Division of Gynecologic Oncology



FDA Approved Drugs for Ovarian Cancer - Timeline

1978	➤ 1978	Cisplatin
	➤ 1990	Altretamine
	➤ 1991	Carboplatin
	➤ 1992	Paclitaxel
	➤ 1996	Topotecan
	➤ 1999	Liposomal Doxorubicin (Accelerated)
	➤ 2005	Liposomal Doxorubicin (Full)
	➤ 2006	Gemcitabine
	➤ 2014	Olaparib (BRCA mutation carriers)
	➤ 2014	Bevacizumab
2015		

Source: U.S. FDA Oncology Drug Approvals Database; NCCN Guidelines.



Clinical Trials – Ovarian Cancer Experience

GOG 22

- 3 arm trial
- N=233
- 1° Stage III/IV or recurrent disease
- Working towards the modern backbone

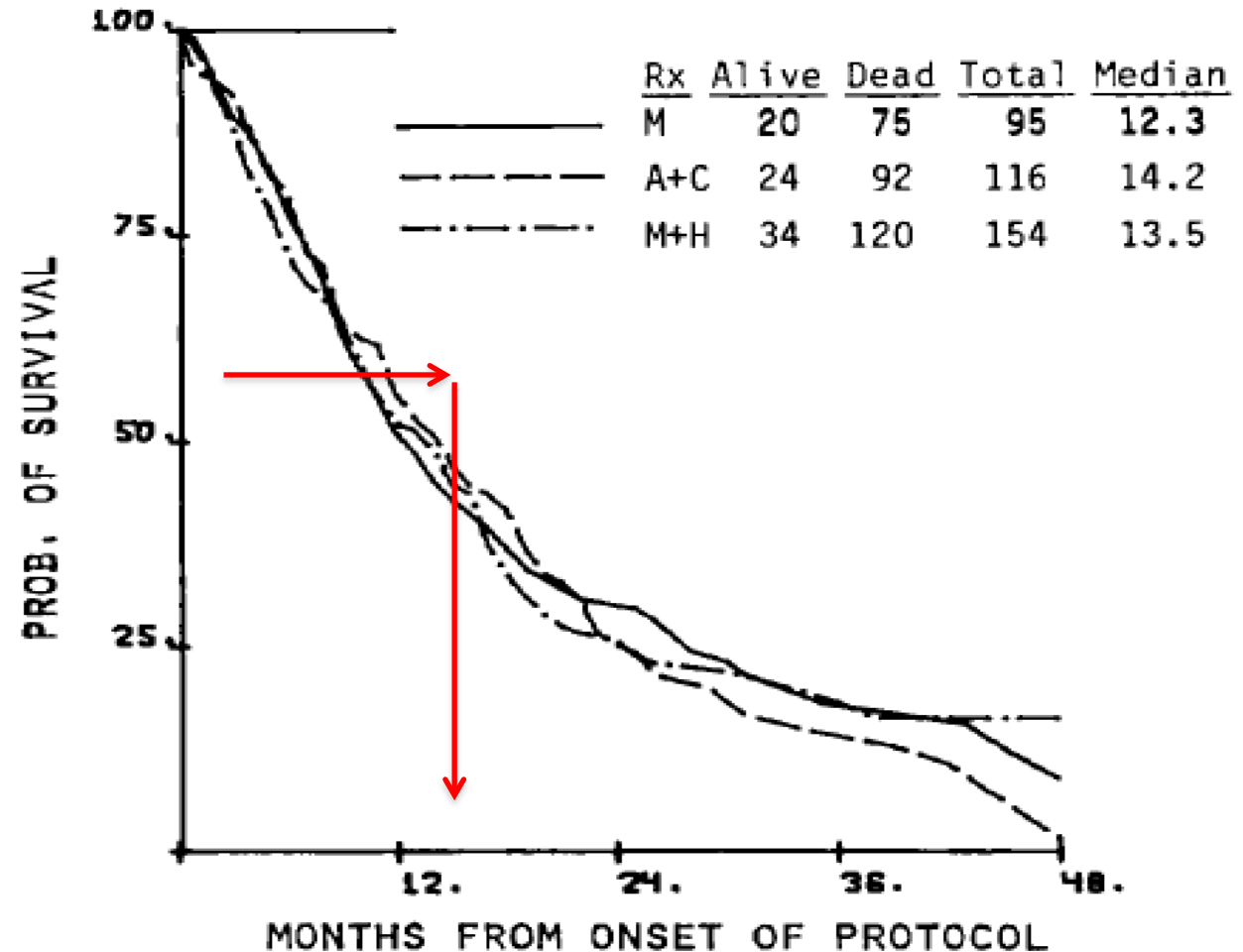
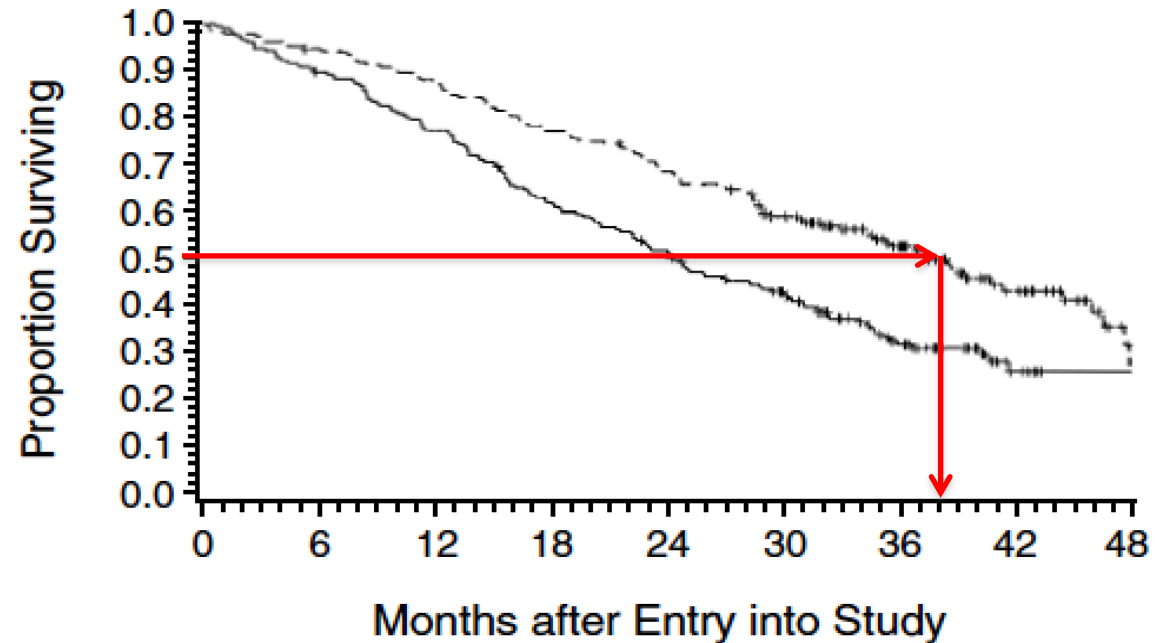


FIG. 3. Survival probability (by Rx).

Clinical Trials – Ovarian Cancer Experience

GOG 111

- 2 arm trial
- N=410
- 1° Stage III/IV
- Addition of “wonder drug” paclitaxel



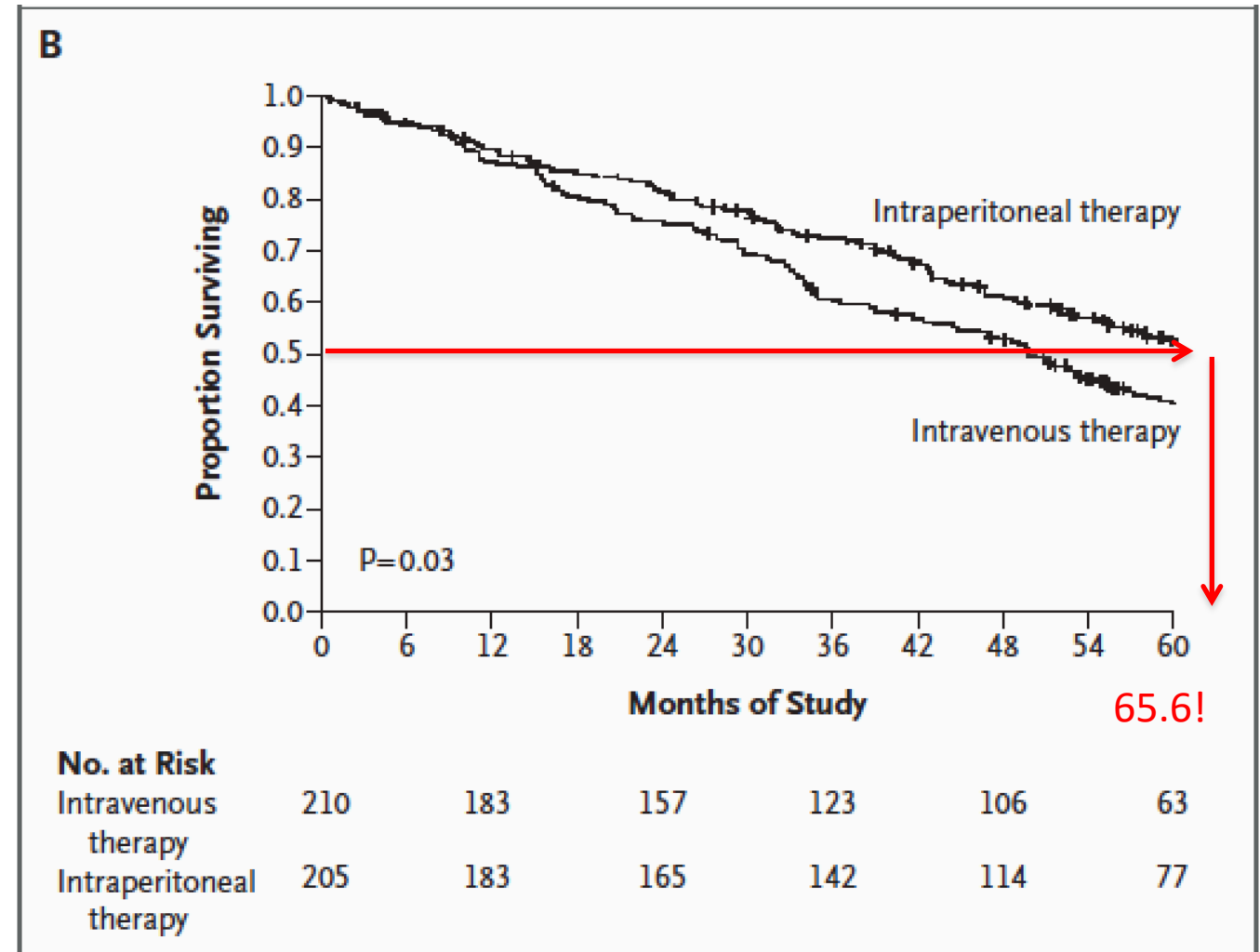
Treatment	No. Alive	No. Dead	Total	Median Survival (mo)
— Cisplatin + cyclophosphamide	65	137	202	24
- - - Cisplatin + paclitaxel	86	98	184	38

Figure 2. Survival According to Treatment Group.

Clinical Trials – Ovarian Cancer Experience

GOG 172

- 2 arm trial
- N=415
- Optimal 1° Stage III
- Different route



Treatment

Stage I/II

- Hysterectomy, BSO, Staging Procedures
- Post-operative chemotherapy for most

Stage III/IV

- Triage to PDS vs. NACT+IDS / Role of HIPEC?
- “Cytoreductive” or “debulking” surgery
- All require post-operative chemotherapy
- Determine maintenance approach

Treatment – Maintenance

Regimen	Setting	Dose/Administration	Duration
Olaparib + bevacizumab ¹	Maintenance post primary chemotherapy + bevacizumab	• Olaparib 300 mg PO twice daily • Bevacizumab 15 mg/kg IV every 21 days	• Olaparib: Until disease progression or unacceptable toxicity or up to 2 years • Bevacizumab: Until disease progression or unacceptable toxicity or up to 15 months
Niraparib + bevacizumab ²	Maintenance post primary chemotherapy + bevacizumab	• Niraparib: 300 mg PO once daily (or 200 mg once daily for patients with a baseline body weight of <77 kg, and/or a platelet count of <150,000/mm³) • Bevacizumab: 15 mg/kg IV every 21 days	• Niraparib: Until disease progression or unacceptable toxicity or up to 3 years • Bevacizumab: Until disease progression or unacceptable toxicity or up to 15 months
Niraparib monotherapy ^{3,4}	Maintenance post primary chemotherapy	300 mg PO once daily (or 200 mg once daily for patients with a baseline body weight of <77 kg, and/or a platelet count of <150,000/mm ³)	Until disease progression or unacceptable toxicity or up to 36 months
	Maintenance post recurrence chemotherapy	300 mg PO once daily (or an initial dose of 200 mg once daily for patients with a baseline body weight of <77 kg, and/or a platelet count of <150,000/mm ³ ; after 2 to 3 months, in the absence of hematologic toxicity, may consider escalation to 300 mg once daily)	Until disease progression or unacceptable toxicity
Olaparib monotherapy ⁵⁻⁷	Maintenance post primary chemotherapy	300 mg PO twice daily ^b	Until disease progression or CR (no evidence of disease) at 2 years ^b or unacceptable toxicity
	Maintenance post recurrence chemotherapy	300 mg PO twice daily ^b	Until disease progression or unacceptable toxicity
Rucaparib monotherapy ^{8,9}	Maintenance post primary chemotherapy	600 mg PO twice daily	Until disease progression or unacceptable toxicity or up to 24 months
	Maintenance post recurrence chemotherapy	600 mg PO twice daily	Until disease progression or unacceptable toxicity

Primary Systemic Therapy

Primary Systemic Therapy Recommended Dosing

Paclitaxel/carboplatin every 3 weeks^{9,l}

- Paclitaxel 175 mg/m² IV followed by carboplatin^m AUC 5–6 IV Day 1
- Repeat every 21 days x 3–6 cycles^l

Paclitaxel/cisplatin every 3 weeks^{10,11}

- Paclitaxel 175 mg/m² IV followed by cisplatin 75 mg/m² IV
- Repeat every 21 days x 3–9 cycles

IV/IP Paclitaxel/cisplatin

- Paclitaxel 135 mg/m² IV continuous infusionⁿ Day 1; cisplatin 75–100 mg/m² IP Day 2 after IV paclitaxel; paclitaxel 60 mg/m² IP Day 8
- Repeat every 21 days x 6 cycles

IV/IP Paclitaxel/carboplatin¹²

- Paclitaxel 80 mg/m² IV on days 1, 8, and 15; carboplatin AUC 6 IP Day 1 after IV paclitaxel
- Repeat every 21 days x 6–8 cycles

Paclitaxel weekly/carboplatin every 3 weeks⁹

- Dose-dense paclitaxel 80 mg/m² IV Days 1, 8, and 15 followed by carboplatinⁿ AUC 5–6 IV Day 1
- Repeat every 21 days x 6 cycles

Paclitaxel weekly/carboplatin weekly⁹

- Paclitaxel 60 mg/m² IV followed by carboplatin AUC 2 IV
- Days 1, 8, and 15; repeat every 21 days x 6 cycles (18 weeks)^k

Docetaxel/oxaliplatin/bevacizumab + maintenance bevacizumab

- Docetaxel 75 mg/m² IV followed by oxaliplatin 85 mg/m² IV, and bevacizumab 15 mg/kg IV
- Repeat every 21 days x 6 cycles
- Continue bevacizumab 15 mg/kg IV every 21 days to complete 1 year of therapy

Individuals >70 Years and/or Those with Comorbidities

Paclitaxel 135/carboplatin^{9,13}

- Paclitaxel 135 mg/m² IV + carboplatin AUC 5 IV given every 21 days x 3–6 cycles^l

Paclitaxel weekly/carboplatin weekly⁹

- Paclitaxel 60 mg/m² IV over 1 hour followed by carboplatin AUC 2 IV over 30 minutes
- Days 1, 8, and 15; repeat every 21 days x 6 cycles (18 weeks)

Docetaxel/carboplatin^l

- Docetaxel 60–75 mg/m² IV followed by carboplatin^m AUC 5–6 IV Day 1
- Repeat every 21 days x 3–6 cycles^k

Carboplatin/liposomal doxorubicin^l

- Carboplatin AUC 5 IV + pegylated liposomal doxorubicin 30 mg/m² IV
- Repeat every 28 days for 3–6 cycles^k

Paclitaxel/carboplatin/bevacizumab + maintenance bevacizumab⁹ (ICON-7)

- Paclitaxel 175 mg/m² IV followed by carboplatin^m AUC 5–6 IV, and bevacizumab 7.5 mg/kg IV Day 1
- Repeat every 21 days x 5–6 cycles
- Continue bevacizumab for up to 12 additional cycles

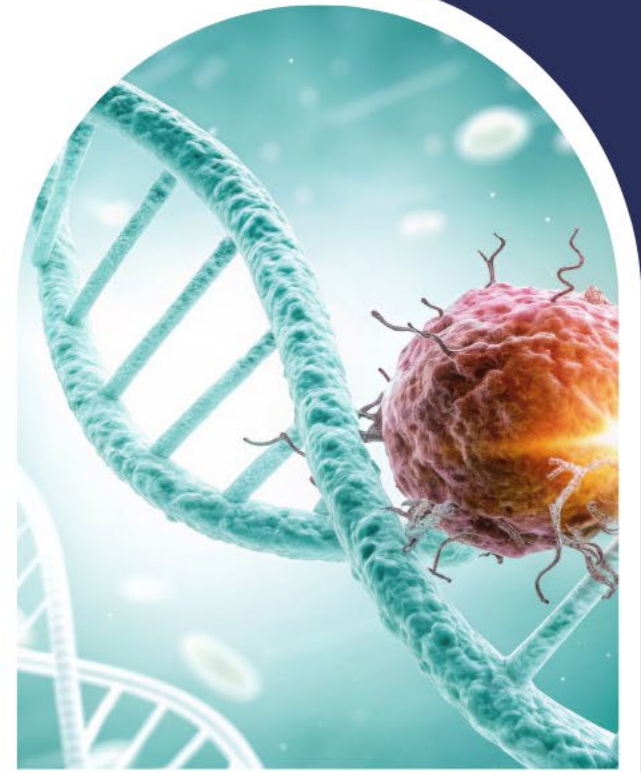
Paclitaxel/carboplatin/bevacizumab + maintenance bevacizumab⁹ (GOG-218)

- Paclitaxel 175 mg/m² IV followed by carboplatin^m AUC 6 IV Day 1. Repeat every 21 days x 6 cycles
- Starting Day 1 of cycle 2, give bevacizumab 15 mg/kg IV every 21 days for up to 22 cycles

Docetaxel/carboplatin/bevacizumab + maintenance bevacizumab (GOG-218)

- Docetaxel 75 mg/m² IV followed by carboplatin^m AUC 6 IV Day 1. Repeat every 21 days x 6 cycles
- Starting Day 1 of cycle 2, give bevacizumab 15 mg/kg IV every 21 days for up to 22 cycles

PROC Management



PROC Treatment Options

- EOC/FTCA/PPC that has progressed/recurred within 6 months of the last line of platinum-based therapy
 - Primary platinum refractory excluded from most clinical trials
- Median PFS 2-6 months most therapies
- Median OS 12-18 months
- Traditionally non-platinum cytotoxic chemotherapies
- Should we use platinum eligible or ineligible instead?
- How do we fully integrate biomarkers?

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	Other Recommended	Useful in Certain Circumstances
<u>Cytotoxic Therapy</u> - Albumin-bound Paclitaxel/Relacorilant - Docetaxel - Gemcitabine - Liposomal Doxorubicin - Liposomal Doxorubicin + Bevacizumab - Paclitaxel (Weekly) - Paclitaxel (Weekly) + Bevacizumab - Oral Cyclophosphamide + Bevacizumab - Topotecan - Topotecan + Bevacizumab <u>Targeted Therapy (single agents)</u> - Mirvetuximab soravtansine-gynx (for FRα-expressing tumors [≥75% positive tumor cells] (category 1))	<u>Cytotoxic Therapy</u> - Albumin-bound Paclitaxel - Capecitabine - Carboplatin - Carboplatin/Docetaxel - Carboplatin/Paclitaxel (Weekly) - Carboplatin/Gemcitabine ± Bevacizumab - Carboplatin/Liposomal Doxorubicin ± Bevacizumab - Carboplatin/Paclitaxel ± Bevacizumab - Cisplatin/Gemcitabine - Cyclophosphamide - Doxorubicin - Gemcitabine ± Bevacizumab - Ifosfamide/Mesna - Irinotecan - Ixabepilone ± Bevacizumab (category 2B) - Oral Cyclophosphamide + Pembrolizumab + Bevacizumab - Oral Etoposide - Oxaliplatin - Paclitaxel - Pemetrexed - Sorafenib/Topotecan - Vinorelbine <u>Targeted Therapy (single agents)</u> - Bevacizumab - Pazopanib (category 2B) <u>Hormone Therapy</u> - Aromatase inhibitors (Anastrozole, Exemestane, Letrozole) - Goserelin acetate - Leuprolide acetate - Megestrol acetate - Tamoxifen	- Albumin-bound Paclitaxel/Carboplatin (for confirmed taxane hypersensitivity) - Carboplatin/Paclitaxel (for age >70) <u>Immunotherapy</u> - Dostarlimab-gxly (for dMMR/MSI-H recurrent or advanced tumors) - Paclitaxel + Pembrolizumab ± Bevacizumab (for PD-L1- positive tumors [CPS≥1]) - Pembrolizumab (for patients with MSI-H or dMMR solid tumors, or TMB-H tumors ≥10 mutations/megabase) - For clear cell carcinoma: - Ipilimumab + Nivolumab <u>Hormone Therapy</u> - Fulvestrant (for low-grade serous carcinoma) <u>Targeted Therapy</u> - Dabrafenib/Trametinib (for BRAF V600E positive tumors) - Entrectinib or Larotrectinib or Repotrectinib (for <i>NTRK1/2/3</i> gene fusion-positive tumors) - Fam-trastuzumab deruxtecan-nxki (for HER2-positive tumors [IHC 3+ or 2+]) - Mirvetuximab soravtansine-gynx + Bevacizumab (for FRα- expressing tumors [≥25% positive tumor cells]) - Selpercatinib (for RET gene fusion-positive tumors) - For low-grade serous carcinoma: - Avutometinib/Defactinib (for KRAS-mutated tumors) - Trametinib - Binimetinib (category 2B) - For mucinous carcinoma: - FOLFIRI ± Bevacizumab (category 2B)

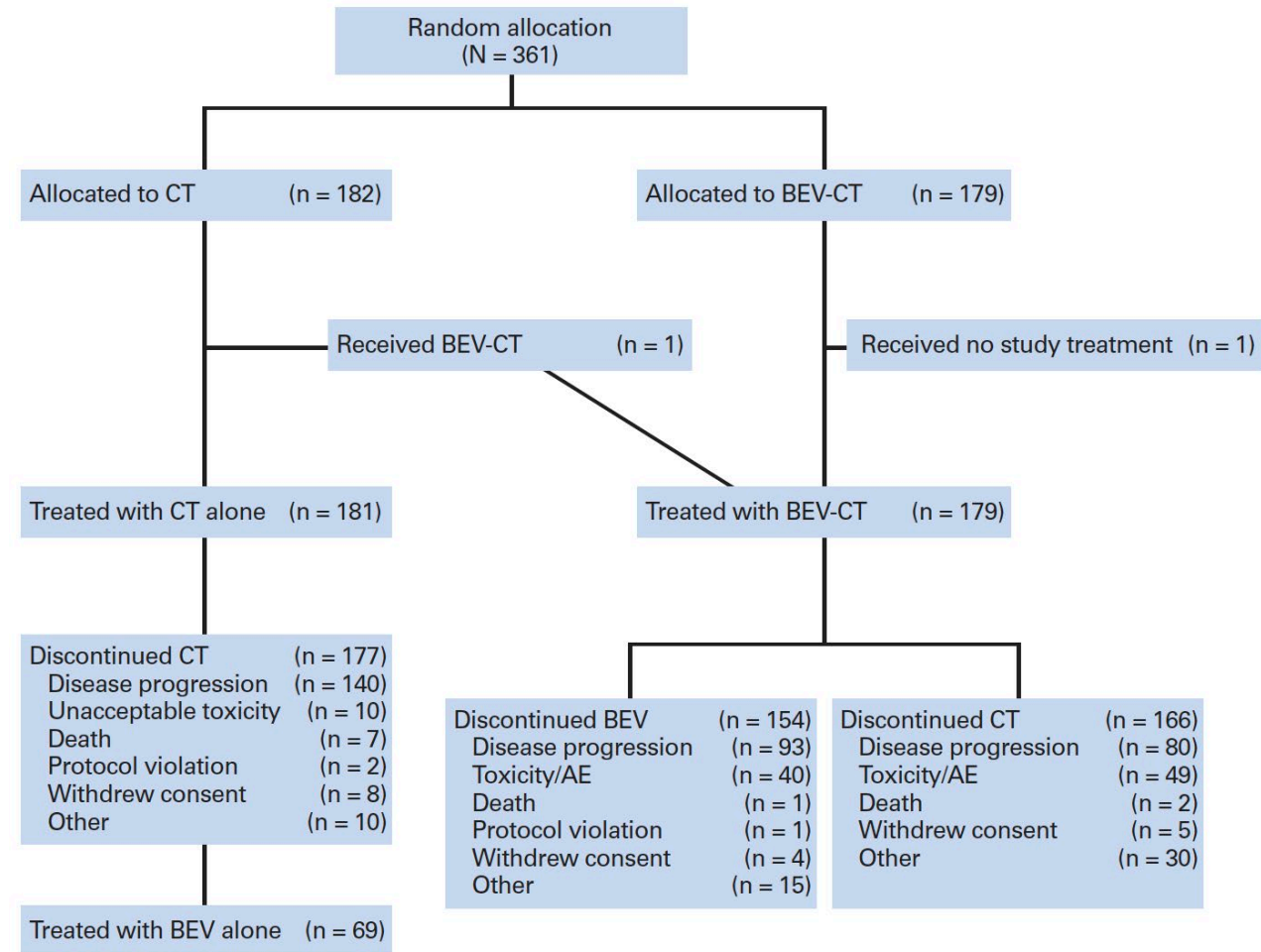
Adapted with permissions from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines® for Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer V.4.2026 © 2026 National Comprehensive Cancer Network, Inc. All rights reserved. The NCCN Guidelines® and illustrations herein may not be reproduced in any form for any purpose without the express written permission of NCCN To view the most recent and complete version of the NCCN Guidelines, go online to NCCN.org. The NCCN Guidelines are a work in progress that may be refined as often as new significant data becomes available. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

**Some Successes, Miss(es),
and To Be Determined...**



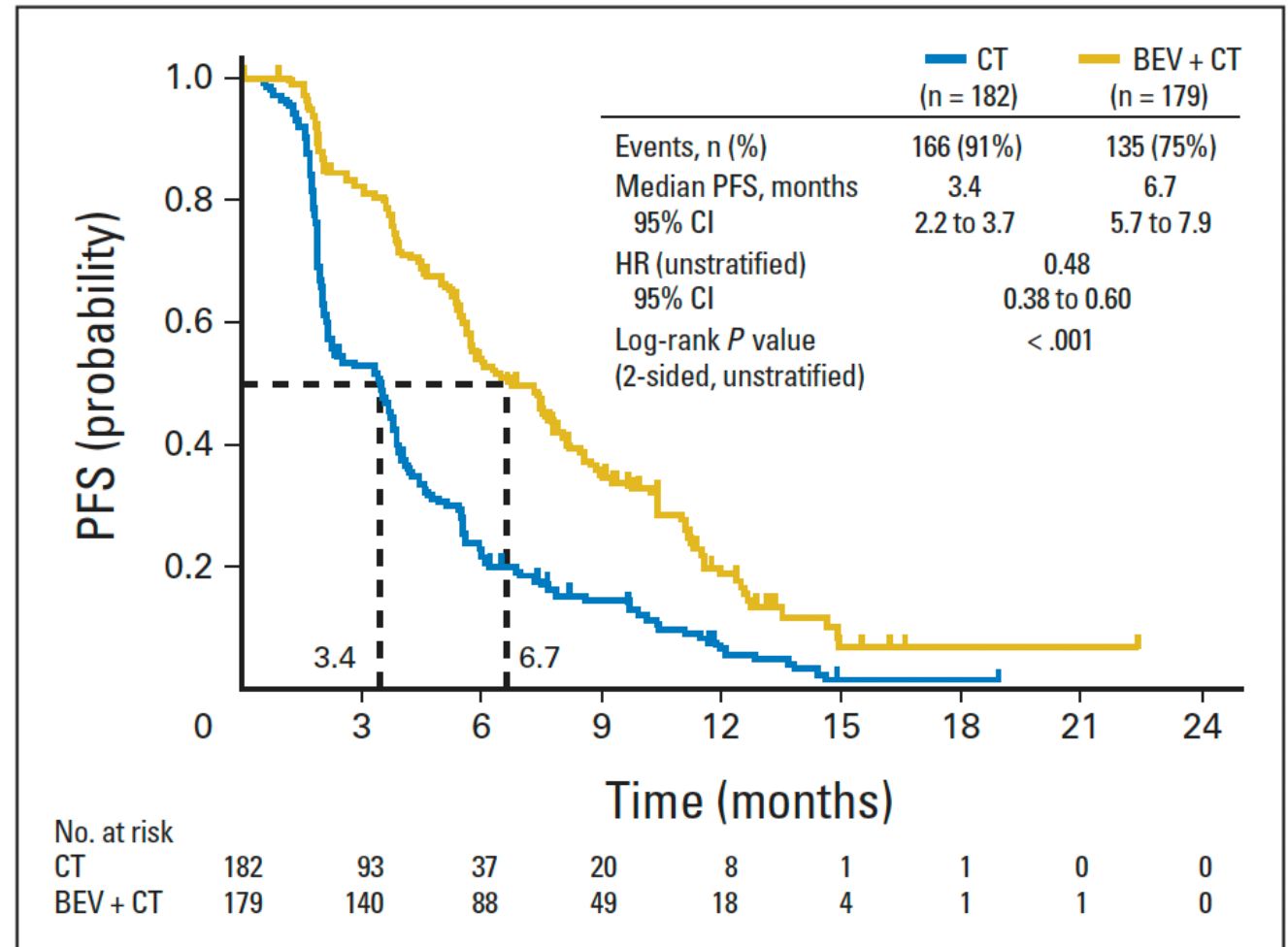
AURELIA – Chemotherapy +/- Bevacizumab

- Phase III, Open-label RCT 1:1 (Weekly paclitaxel/PLD/topotecan +/- bevacizumab)
- EOC/FTCA/PPC by RECIST or GCIG CA-125
- ECOG PS 0-2
- Progression <6 months last platinum
 - Platinum refractory excluded
- 1-2 prior lines of therapy
- Standard bevacizumab exclusions
 - Bowel obstruction, Fistula, perforation, etc.
- Prior anti-angiogenic therapy allowed (7.2%)
- Primary endpoint
 - PFS Investigator per RECIST



AURELIA – PFS

- N=361
- Statistics
 - Predicted to be 5.56 vs. 4 months
- 6.7 vs. 3.4 months
- HR 0.48 (0.38-0.60, $P < 0.001$)



AURELIA – OS

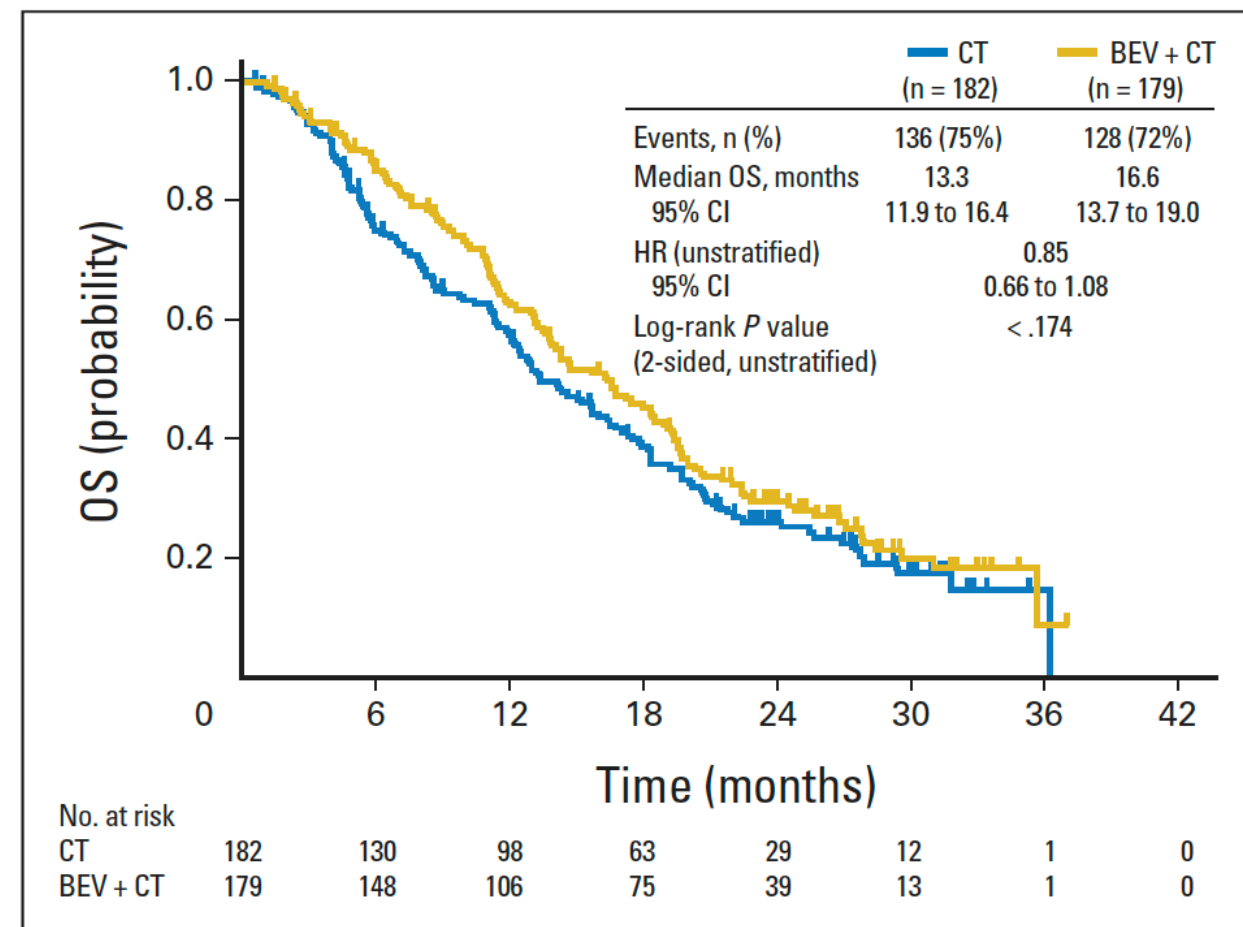
- 16.6 vs. 13.3 months
- HR 0.85 (0.66-1.08, $p < 0.174$)

Media / News Feature

FDA Approves Genentech Medicine for Women with Platinum-Resistant Recurrent Ovarian Cancer

November 14th, 2014

On November 14, 2014, the FDA approved bevacizumab in combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan chemotherapy for the treatment of women with platinum-resistant, recurrent, epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have received no more than two prior chemotherapy regimens.



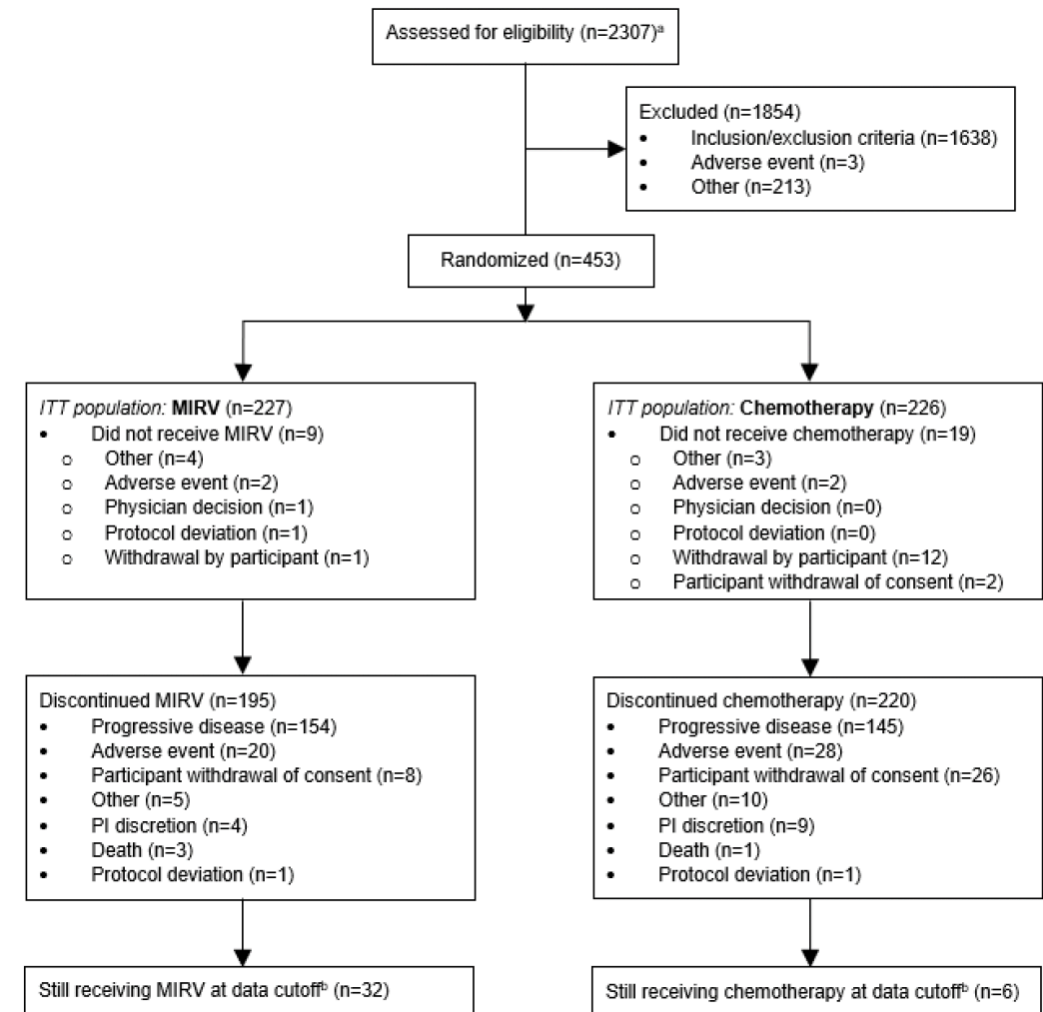
Abbreviations: CT, chemotherapy; BEV, bevacizumab; HR, hazard ratio; OS, overall survival.

Pujade-Lauraine E, et al. J Clin Oncol. 2014;32(13):1302-1308; Genentech. Genentech medicine FDA approved for women with platinum-resistant recurrent ovarian cancer; 2014.

MIRASOL – Mirvetuximab vs. Physician's Choice

Figure S1. Participant flow diagram

- Phase III, Open-label RCT 1:1 (mirvetuximab vs. paclitaxel/PLD/topotecan)
- HGSOc
- FOLR1 75% PS2 Scoring
- ECOG PS 0-1
- Progression 3-6 months if only 1 platinum vs. <6 months
- 1-3 prior lines of therapy
- Neuropathy and ocular exclusions
- Primary endpoint
 - PFS Investigator Assessed



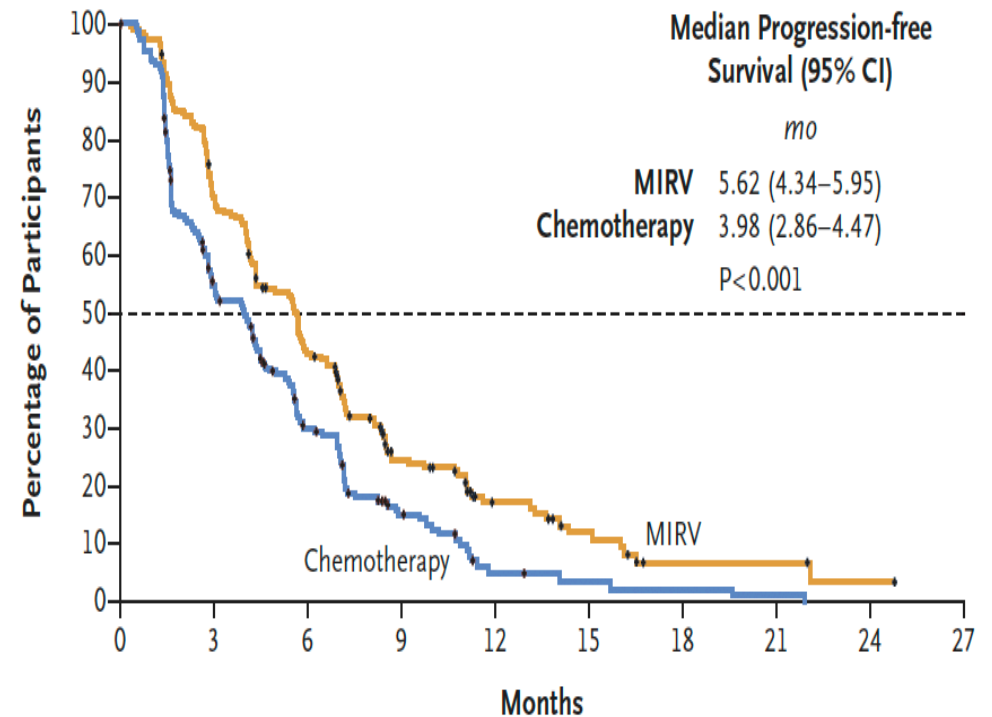
Abbreviations: ECOG PS, Eastern Cooperative Oncology Group performance status; FOLR1, folate receptor alpha 1; HGSOc, high-grade serous ovarian cancer; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; RCT, randomized controlled trial.

Moore KN, et al. N Engl J Med. 2023;389:2165-2177; ClinicalTrials.gov number, NCT04209855

MIRASOL – PFS

- N=453
 - 2-3 prior lines (86.1%)
 - 62% prior bevacizumab
 - 55.4% prior PARPi
- Statistics
 - Predicted to be 5.0 vs. 3.5 month
- 5.62 vs. 3.98 months, $p < 0.001$
- Restricted mean PFS @ 12 months
 - MIRV 6.13 mo (5.62-6.64 mo)
 - Chemo 4.72 mo (4.21-5.23 mo)

A Progression-free Survival



No. at Risk
MIRV
Chemotherapy

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

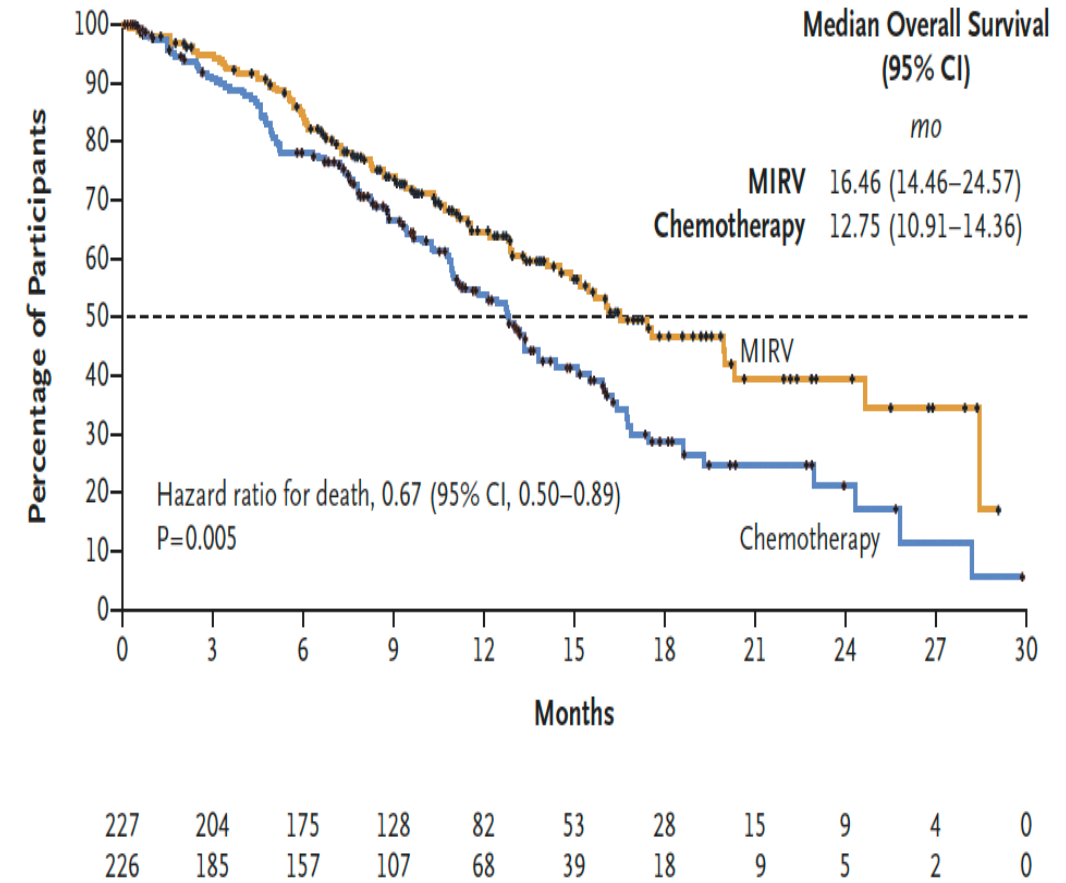
MIRASOL – OS

B Overall Survival

- 16.46 vs. 12.75 months
- HR 0.67 (0.50-0.89, $p=0.005$)

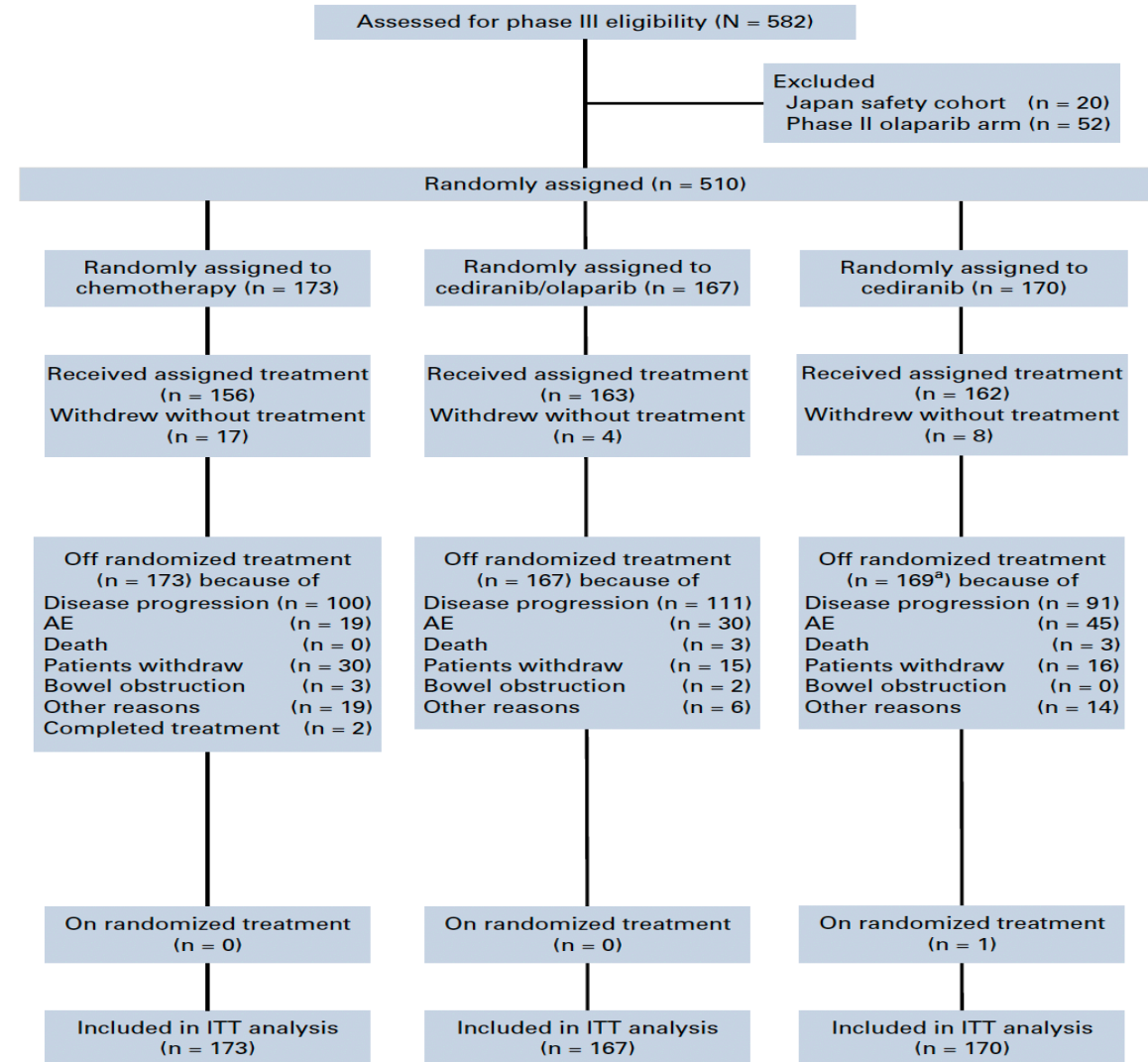
FDA approves mirvetuximab soravtansine-gynx for FR α positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer

On March 22, 2024, the Food and Drug Administration approved mirvetuximab soravtansine-gynx for adult patients with FR α positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have received one to three prior systemic treatment regimens. Patients are selected based on an FDA-approved test. Mirvetuximab soravtansine-gynx previously received accelerated approval for this indication.



GY005 – PHASE II/III – 4 Arms

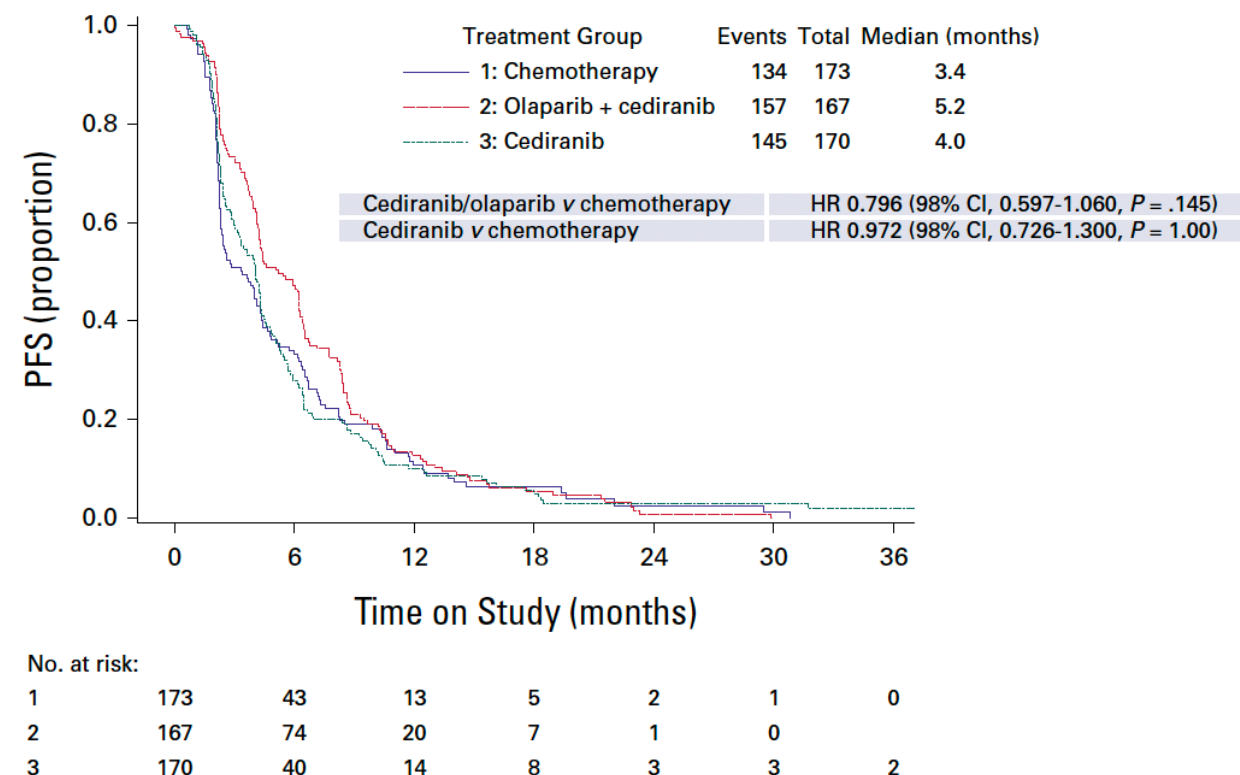
- Phase II/III, Open-label RCT 1:1:1:1 (Cediranib, Cediranib+Olaparib, Olaparib vs. paclitaxel/PLD/Topotecan)
 - Single agent olaparib excluded from PIII
- HG Serous / Endometrioid OC /FTCA/PPC
- ECOG PS 0-2
- Platinum resistant and refractory patients
- 1-3 prior lines of therapy
- Primary endpoint
 - Phase II – PFS Investigator Assessed
 - Phase III – Co-primary PFS & OS



GY005 – PFS

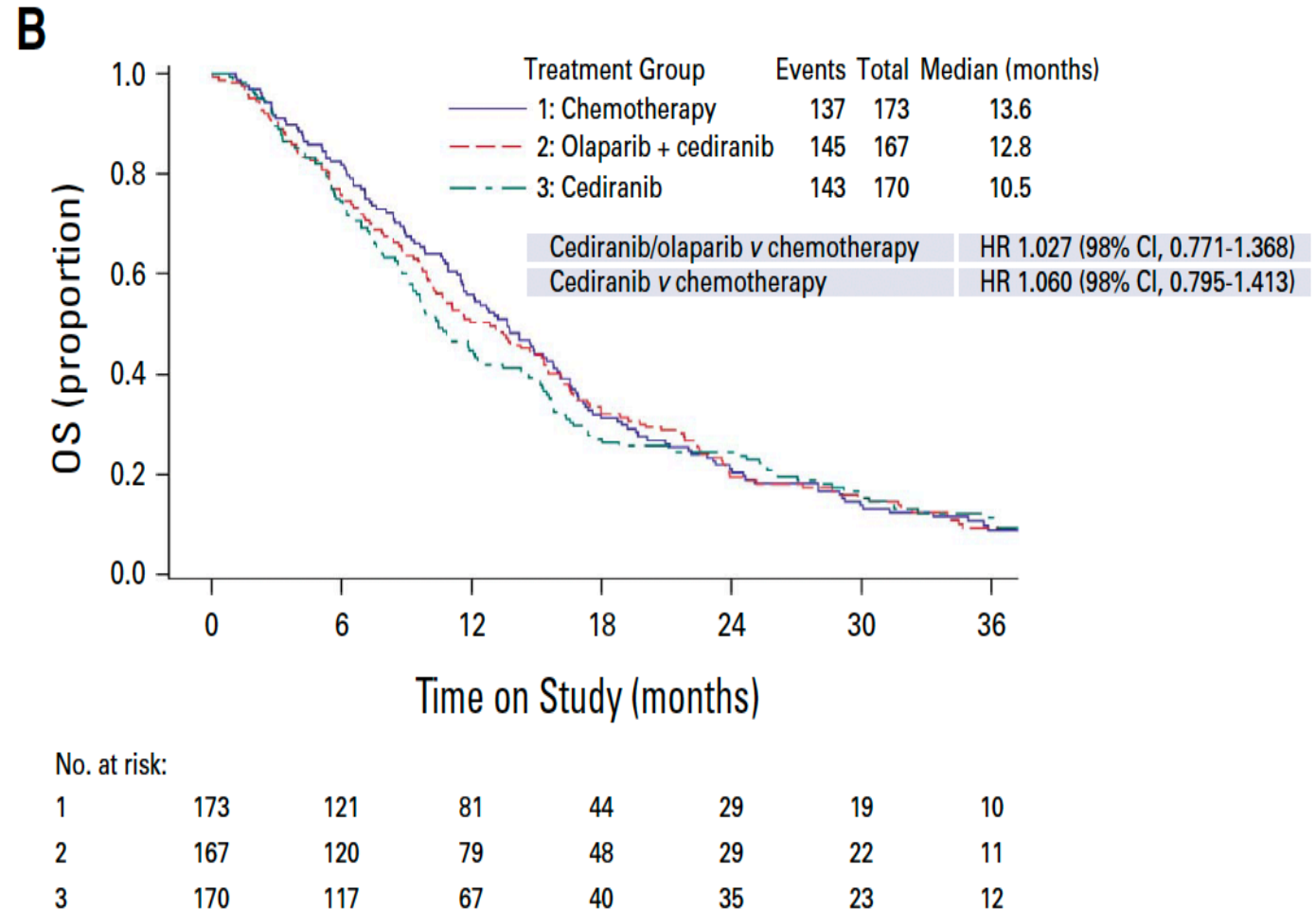
- N=562
 - 1 prior line (53.9%)
 - 19.2% prior antiangiogenic therapy
 - 31.6% primary platinum refractory
 - 52 Phase II Olaparib pts excluded
- 3.4 SOC vs. 5.2 Ola+Ced vs. 4.0 Ced months, p=NS

A



GY005 – OS

- 13.6 SOC vs. 12.8 Ola+Ced vs. 10.5 Ced months
- Ola+Ced vs. SOC HR 1.027 (98% CI 0.771-1.368)
- Ced vs. SOC HR 1.060 (98% CI 0.795-1.1413)
- Is phase II/III the best design?
- Role of inclusion of platinum refractory pts?



PROC Therapeutic Activity

TABLE 1. Reported Response Rates in Recent PROC Trials

Trial	Population	Control Arm	ORR, %	PFS, Months	OS, Months
AURELIA ¹⁰ (2014)	≤2 previous lines 8% previous Bev	PLD, Pac, Topo	13	3.4	13.3
PENELOPE ¹¹ (2016)	HER3 low PROC 30% previous Bev	Gem, Pac, Topo	8.7	2.6	7.9
CORAIL ¹² (2021)	≤3 previous lines 46% previous Bev	PLD, Topo	12	3.6	10.9
FORWARD1 ¹³ (2021)	1-3 previous lines (FRα high) 33% previous Bev	Pac, PLD, Topo	12	4.4	14
Javelin Ovarian 200 ¹⁴ (2021)	≤3 previous lines 28% previous Bev	PLD	4	3.5	17.4
NINJA ¹⁵ (2021)	≤1 platinum-resistant line	PLD, Gem	13	3.8	12.1
OVAL (2023) ¹⁶	<2 platinum-resistant 70% previous Bev	Pac	29.6	5.4	13.1
MIRASOL ¹⁷ (2023)	1-3 previous lines 62% previous Bev	PLD, Pac, Topo	15.9	4.0	12.8
AXLerate-OC ¹⁸ (2023)	50% previous Bev	Pac	—	5.5	—

Abbreviations: Bev, bevacizumab; FRα, folate receptor alpha; Gem, gemcitabine; HER3, human epidermal growth factor receptor 3; ORR, objective response rate; OS, overall survival; Pac, paclitaxel; PFS, progression-free survival; PLD, pegylated liposomal doxorubicin; PROC, platinum-resistant ovarian cancer; Topo, topotecan.

Cross-trial comparison must be interpreted with caution

PROC Therapeutic Activity

Author (y) trial name, trial registration no.	Trial design	Experimental drug type	Max no. of prior lines	Platinum refractory (no. exp/control)	Patient no. (exp/control)	Biomarker selection	Primary end point	Progression-free survival mo (exp/control) HR (95% CI)	Overall survival mo (exp/control) HR (95% CI)
Colombo and colleagues ¹⁴ (2012), EPO906 NCT00262990	Patupilone vs PLD	Chemotherapy	No limit	Yes (83/78)	828 (412/416)	No	Overall survival	3.7/3.2 HR 0.99 (0.84-1.16)	13.2/12.7 HR 0.93 (0.79-1.09)
Gaillard and colleagues ¹⁵ (2021), CORAIL NCT02421588	Lurbinectedin vs PLD or topotecan	Chemotherapy	3	No	442 (221/221)	No	Progression-free survival	3.5/3.6 HR 0.99 (0.81-1.21)	11.4/10.9 HR 0.96 (0.77-1.18)
Monk and colleagues ¹⁶ (2010), OVA301 NCT00113607	Trabectedin + PLD vs PLD	Chemotherapy	1	No	232 (115/117)	No	Progression-free survival	4.0/3.7 HR 0.95 (0.7-1.3)	14.2/12.4 HR 0.92 (0.70-1.21)
Vergote and colleagues ¹⁷ (2010), NA NCT00350948	Canfosfamide + PLD vs PLD	Chemotherapy	2	Yes (13/8)	125 (65/60)	No	Progression-free survival	5.6/3.7 HR 0.92 (95% CI NR)	NR
Monk and colleagues ^{18,19} (2014, 2016), TRINOVA1 NCT01204749	Trebananib + paclitaxel vs paclitaxel	Anti-angiogenic	3	No ^a	490 (235/245)	No	Progression-free survival	NR HR 0.70 (0.58-0.84)	NR HR 0.97 (0.79-1.19)
Pujade-Lauraine and colleagues ²⁰ (2014), AURELIA NCT04209855	Bevacizumab + Cht vs Cht	Anti-angiogenic	2	No	361 (182/179)	No	Progression-free survival	6.7/3.4 HR 0.48 (0.38-0.60)	16.6/13.3 HR 0.85 (0.66-1.08)
Kristeleit and colleagues ²¹ (2022), ARIEL4 NCT02855944	Rucaparib vs paclitaxel	Targeted agent	No limit	No	179 (120/59)	Yes <i>BRCA1/2</i>	Progression-free survival	6.4/5.7 HR 0.78 (0.54-1.13)	14.2/22.2 HR 1.51 (1.05-2.17)
Kurzeder and colleagues ²² (2016), PENELOPE NCT01684878	Pertuzumab + Cht vs placebo + Cht	Targeted agent	2	Yes (19/21) ^b	156 (78/78)	Yes HER3	Progression-free survival	4.1/2.6 HR 0.86 (0.59-1.25)	10.2/8.4 HR 0.90 (0.61-1.32)
Hamanishi and colleagues ²³ (2021), NINJA JapicCTI-153004	Nivolumab vs PLD or gemcitabine	Immune checkpoint inhibitor	No limit	Yes (51/46)	316 (157/159)	No	Overall survival	2.0/3.8 HR 1.5 (1.2-1.9)	10.1/12.1 HR 1.0 (0.8-1.3)

Cross-trial comparison must be interpreted with caution

Adapted from: Martorana F, et al. Can we learn from failures? A systematic review of phase III trials in platinum-resistant ovarian cancer. *Int J Gynecol Cancer*. 2025;35(1):100009.

PROC Therapeutic Activity

Pujade-Lauraine and colleagues ²⁴ (2021), JAVELINE 200 NCT02580058	Avelumab + PLD vs avelumab vs PLD	Immune checkpoint inhibitor	3	Yes (47/47/48)	568 (190/190/188)	No	Progression-free survival/overall survival	3.7/1.9/3.5 HR A + P vs P 0.78 (1.59-1.24) ^c HR A vs P 1.68 (1.32-2.60) ^c	15.7/11.8/13.1 HR A + P vs P 0.85 (0.74-1.24) ^d HR A vs P 1.14 (0.95-1.58) ^d
Moore and colleagues ²⁵ (2021), FORWARD1 NCT02631876	Mirvetuximab vs Cht	Antibody-drug conjugate	3	No	366 (248/148)	Yes FR α	Progression-free survival	4.1/4.4 HR 0.98 (0.73-1.131)	16.4/14.0 HR 0.85 (0.64-1.13)
Moore and colleagues ²⁶ (2023), MIRASOL NCT04209855	Mirvetuximab vs Cht	Antibody-drug conjugate	3	No	453 (227/226)	Yes FR α	Progression-free survival	5.62/3.98 NR	16.46/12.75 HR 0.67 (0.50-0.89)
Arend and colleagues ²⁷ (2024), OVAL/ GOG3018 NCT03398655	Ofra-vec + paclitaxel vs placebo + paclitaxel	Other (gene-based therapy)	5	No	409 (204/205)	No	Progression-free survival/overall survival	5.29/5.36 HR 1.03 (0.83-1.29)	13.37/13.14 HR 0.97 (0.75-1.27)
Fotopoulou and colleagues ²⁸ (2014), OVATURE NCT00382811	Phenoxodiol vs phenoxodiol + CBDCA	Other (apoptosis inducer)	No limit	Yes (NR)	142 (70/72)	No	Progression-free survival	3.6/4.6 HR 1.22 (0.84-1.22)	8.8/10.5 HR 1.20 (0.83-1.73)
Lindemann and colleagues ²⁹ (2017), OVARESIST NCT02728622	Tamoxifen vs PLD or paclitaxel	Other (endocrine therapy)	No limit	Yes (6/10)	238 (82/156)	No	HR-QoL	1.9/2.9 HR 1.54 (1.16-2.05)	NR

Cross-trial comparison must be interpreted with caution

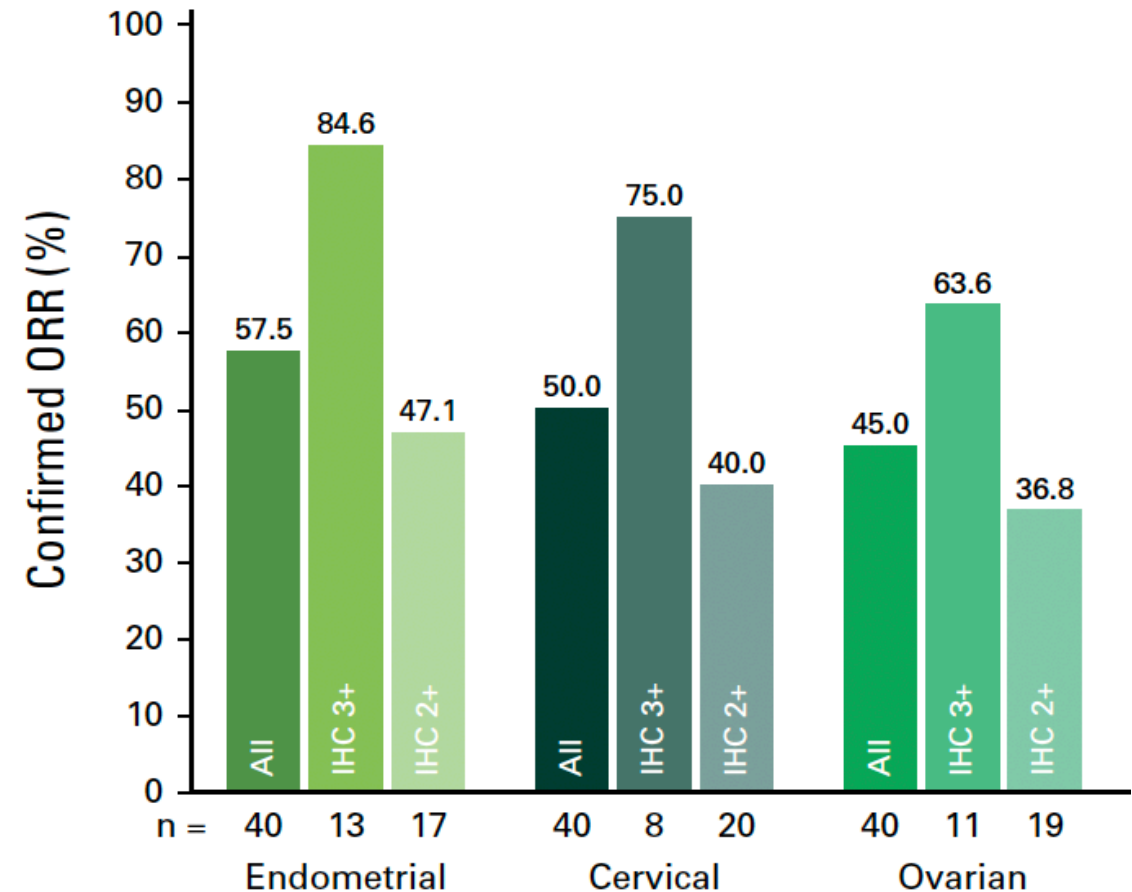
Abbreviations: Bev, bevacizumab; CBDCA, carboplatin; ChT, chemotherapy; FR α , folate receptor alpha; HR, HR-QoL, health-related quality of life; NR, not reported; Pac, paclitaxel; PLD, pegylated liposomal doxorubicin; PROC, platinum-resistant ovarian cancer; A, avelumab; P, PLD.

Adapted from: Martorana F, et al. Can we learn from failures? A systematic review of phase III trials in platinum-resistant ovarian cancer. *Int J Gynecol Cancer*. 2025;35(1):100009.

DESTINY-PanTumor02 – Trastuzumab Deruxtecan (T-DXd)

- Phase II, Single arm Open-label trial
T-DXd 5.4 mg/kg Q 3 weeks
- 40 patients with HER2 2/3+ EOC
- ECOG PS 0-1
- Progression $\geq$ 1 prior therapy
- 1-3 prior lines of therapy
- ILD/pneumonitis excluded
- Primary endpoint
 - ORR Investigator

A



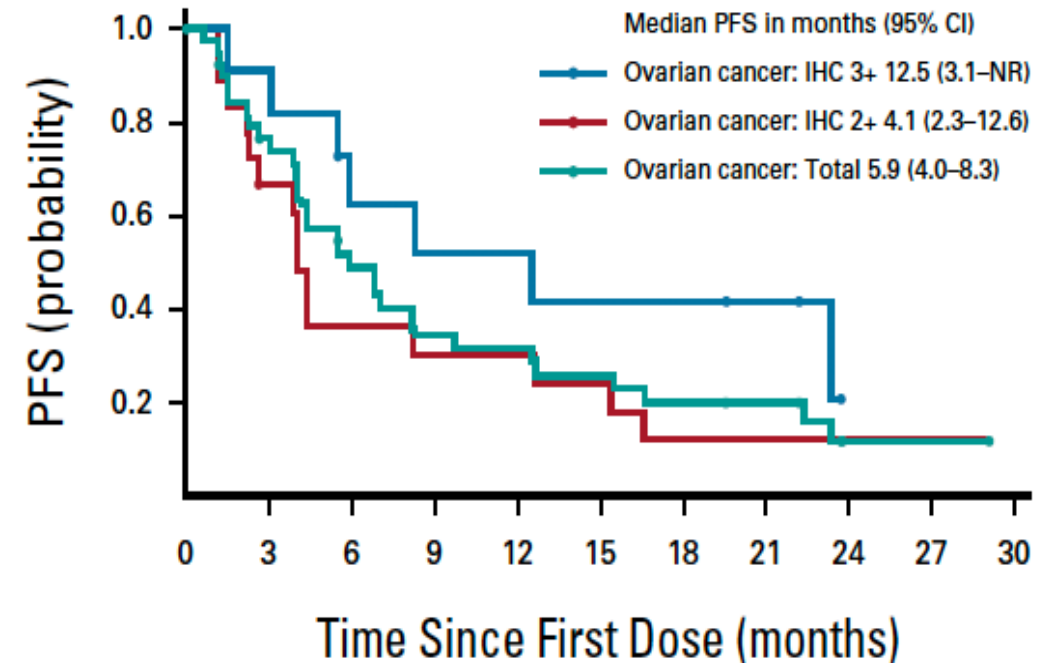
Abbreviations: ECOG PS, Eastern Cooperative Oncology Group performance status; EOC, epithelial ovarian cancer; ILD, interstitial lung disease; HER2, human epidermal growth factor receptor 2; IHC, immunohistochemistry; T-DXd, trastuzumab deruxtecan.

Meric-Bernstam F, et al. J Clin Oncol. 2024;42(1):47-58. ClinicalTrials.gov NCT04482309.

DESTINY-PanTumor02 – PFS

- N=40
 - 2+ prior lines (80%)
 - ECOG PS=0 (65%)
 - Central review with 12.5% HER2 1+ and 12.5% HER2 0
- IHC 3+ 12.5 vs. IHC 2+ 4.1 months

C



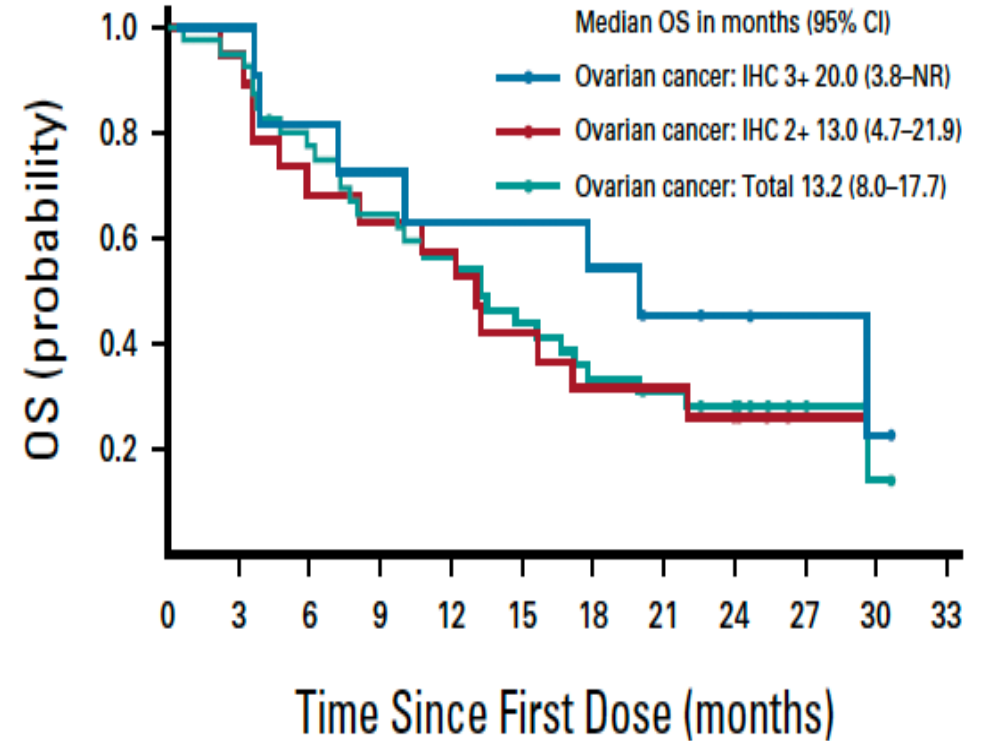
No. at risk:

Ovarian cancer: IHC 3+	11	10	6	5	5	4	4	3	0		
Ovarian cancer: IHC 2+	19	11	6	5	5	4	2	2	1	1	0
Ovarian cancer: Total	40	28	17	12	11	9	7	6	1	1	0

DESTINY-PanTumor02 – OS

- HER2 3+: 20.0 mo (95 CI 3.8 – NR)
- HER2 2+: 13.0 mo (95% CI 4.7 – 21.9)

C



No. at risk:

Ovarian cancer: IHC 3+	11	11	9	8	7	7	6	4	3	2	1	0
Ovarian cancer: IHC 2+	19	18	13	12	11	8	6	6	4	1	0	
Ovarian cancer: Total	40	38	30	25	22	17	13	11	8	3	1	0

Why Resistance Happens: Clinical Implications of Tumor Biology

R. Wendel Naumann, MD

Atrium Health Wake Forest Baptist
Comprehensive Cancer Center



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	Other Recommended	Useful in Certain Circumstances
<u>Cytotoxic Therapy</u> - Albumin-bound Paclitaxel/Relacorilant - Docetaxel - Gemcitabine - Liposomal Doxorubicin - Liposomal Doxorubicin + Bevacizumab - Paclitaxel (Weekly) - Paclitaxel (Weekly) + Bevacizumab - Oral Cyclophosphamide + Bevacizumab - Topotecan - Topotecan + Bevacizumab <u>Targeted Therapy (single agents)</u> - Mirvetuximab soravtansine-gynx (for FRα-expressing tumors [≥75% positive tumor cells] (category 1))	<u>Cytotoxic Therapy</u> - Albumin-bound Paclitaxel - Capecitabine - Carboplatin - Carboplatin/Docetaxel - Carboplatin/Paclitaxel (Weekly) - Carboplatin/Gemcitabine ± Bevacizumab - Carboplatin/Liposomal Doxorubicin ± Bevacizumab - Carboplatin/Paclitaxel ± Bevacizumab - Cisplatin/Gemcitabine - Cyclophosphamide - Doxorubicin - Gemcitabine ± Bevacizumab - Ifosfamide/Mesna - Irinotecan - Ixabepilone ± Bevacizumab (category 2B) - Oral Cyclophosphamide + Pembrolizumab + Bevacizumab - Oral Etoposide - Oxaliplatin - Paclitaxel - Pemetrexed - Sorafenib/Topotecan - Vinorelbine <u>Targeted Therapy (single agents)</u> - Bevacizumab - Pazopanib (category 2B) <u>Hormone Therapy</u> - Aromatase inhibitors (Anastrozole, Exemestane, Letrozole) - Goserelin acetate - Leuprolide acetate - Megestrol acetate - Tamoxifen	- Albumin-bound Paclitaxel/Carboplatin (for confirmed taxane hypersensitivity) - Carboplatin/Paclitaxel (for age >70) <u>Immunotherapy</u> - Dostarlimab-gxly (for dMMR/MSI-H recurrent or advanced tumors) - Paclitaxel + Pembrolizumab ± Bevacizumab (for PD-L1- positive tumors [CPS≥1]) - Pembrolizumab (for patients with MSI-H or dMMR solid tumors, or TMB-H tumors ≥10 mutations/megabase) - For clear cell carcinoma: - Ipilimumab + Nivolumab <u>Hormone Therapy</u> - Fulvestrant (for low-grade serous carcinoma) <u>Targeted Therapy</u> - Dabrafenib/Trametinib (for BRAF V600E positive tumors) - Entrectinib or Larotrectinib or Repotrectinib (for <i>NTRK1/2/3</i> gene fusion-positive tumors) - Fam-trastuzumab deruxtecan-nxki (for HER2-positive tumors [IHC 3+ or 2+]) - Mirvetuximab soravtansine-gynx + Bevacizumab (for FRα- expressing tumors [≥25% positive tumor cells]) - Selpercatinib (for RET gene fusion-positive tumors) - For low-grade serous carcinoma: - Avutometinib/Defactinib (for KRAS-mutated tumors) - Trametinib - Binimetinib (category 2B) - For mucinous carcinoma: - FOLFIRI ± Bevacizumab (category 2B)

Adapted with permissions from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines® for Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer V.4.2026 © 2026 National Comprehensive Cancer Network, Inc. All rights reserved. The NCCN Guidelines® and illustrations herein may not be reproduced in any form for any purpose without the express written permission of NCCN To view the most recent and complete version of the NCCN Guidelines, go online to NCCN.org. The NCCN Guidelines are a work in progress that may be refined as often as new significant data becomes available. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

NCCN Guidelines Footnotes



For patients who have been treated with up to three lines of therapy and prior bevacizumab.



Steroid premedication should not be used.

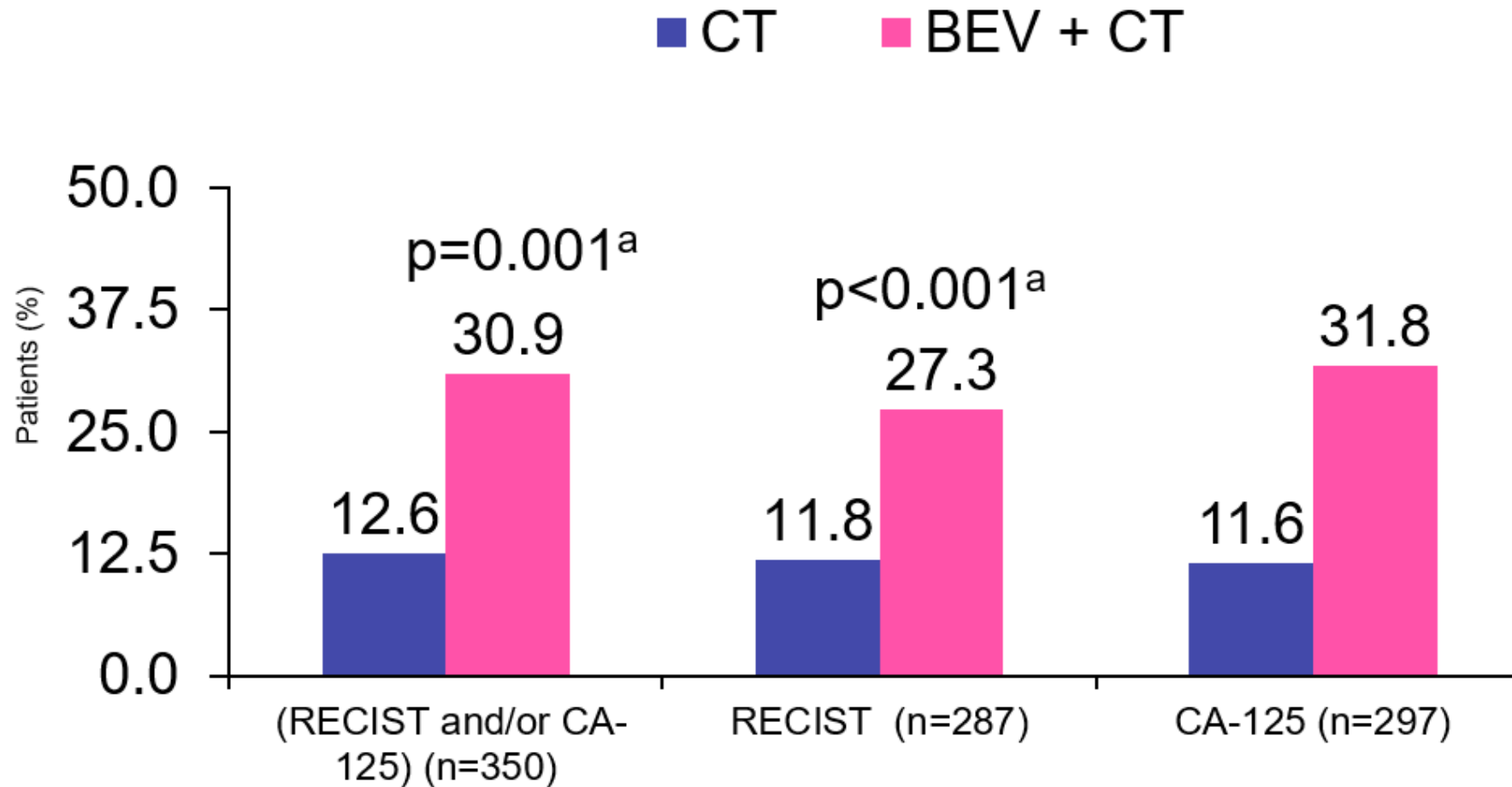
Randomized Studies in PROOC

Author	Agents	N	RR (%)	TTP (months)	OS (months)
Ten Bokkel Huinink	Topotecan	112 (60 PR)	13%	5.3	14.2
	Paclitaxel	114 (59 PR)	7%	3.2	10.0
Gordon	Topotecan	235 (124 PR)	8%	3.2	9.5
	PLD	239 (130 PR)	16%	2.1	8.1
O'Byrne	PLD	106 (60% PR)	19%	5.1	10.9
	Paclitaxel	107 (63% PR)	24%	5.1	13.0
Vermorken	Oxaliplatin	79 (51 PR)	4%	—	—
	Topotecan	79 (53 PR)	6%	—	—
Ferrandina	PLD	76 (43 PR)	16%	3.7	13.0
	Gemcitabine	77 (43 PR)	29%	4.6	1.9
Mutch	PLD	96 PR	6%	3.6	12.7
	Gemcitabine	99 PR	8%	3.1	13.5
Sehouli	Topotecan	97 PR	14%	4.4	9.6
	Topotecan weekly	97 PR	7%	3.0	9.3

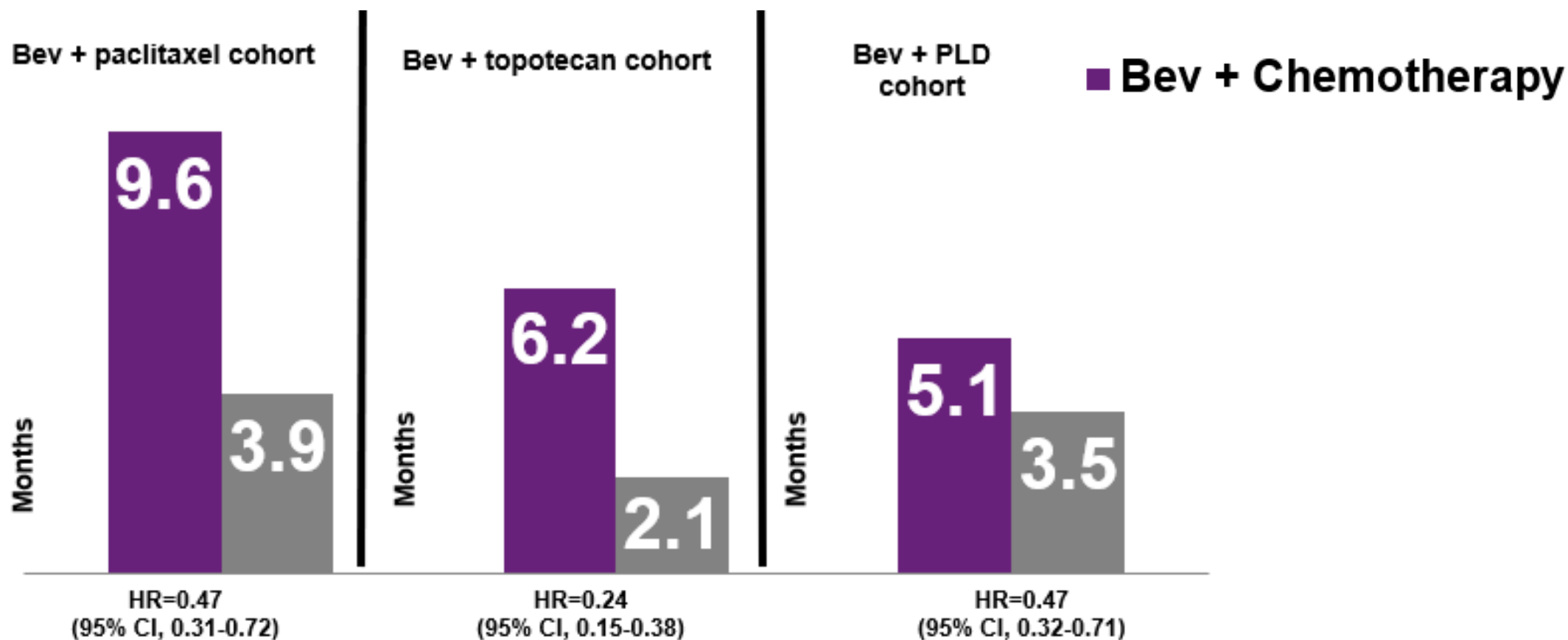
RR 6%-14%

AURELIA:

Summary of best overall response rates



AURELIA: Summary of Median PFS Outcomes in Chemotherapy Cohorts



Cohort analysis was exploratory. This analysis was not designed to evaluate statistical significance between treatment arms or compare among the three chemotherapy cohorts

Components of Antibody Drug Conjugate (ADC)

1. ANTIBODY

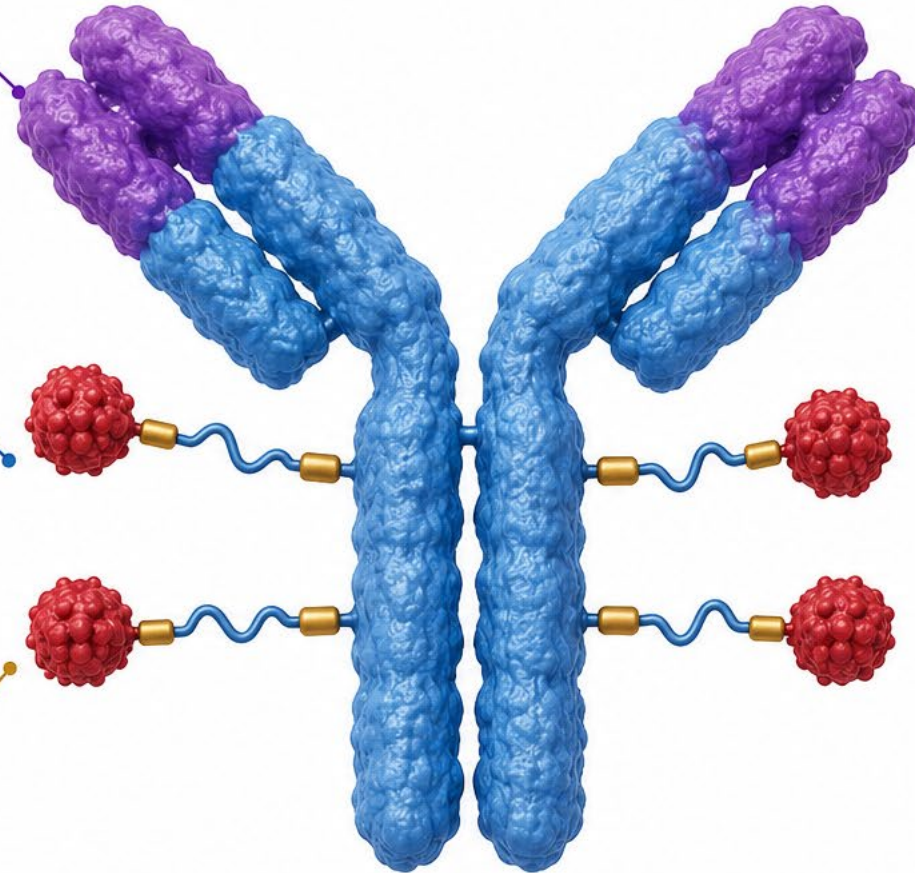
Monoclonal antibody that specifically binds to an antigen on the surface of target cells.

2. LINKER

Chemical linker that covalently attaches the drug payload to the antibody.

3. DRUG PAYLOAD

Potent cytotoxic agent that kills target cells after internalization and release.



ANTIBODY DRUG CONJUGATE (ADC)

The antibody, linker, and drug payload work together to selectively deliver cytotoxic therapy to target cancer cells.



1. ANTIBODY

Provides target specificity by binding to an antigen on cancer cells.



2. LINKER

Ensures stability in circulation and enables release of the drug payload inside the target cell.



3. DRUG PAYLOAD

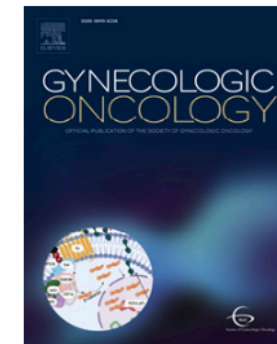
Delivers a potent cytotoxic effect to kill the target cell and inhibit tumor growth.



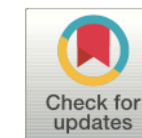
Contents lists available at ScienceDirect

Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno



Safety and efficacy of mirvetuximab soravtansine, a folate receptor alpha (FR α)-targeting antibody-drug conjugate (ADC), in combination with bevacizumab in patients with platinum-resistant ovarian cancer



Lucy Gilbert^a, Ana Oaknin^b, Ursula A. Matulonis^c, Gina M. Mantia-Smaldone^d, Peter C. Lim^e, Cesar M. Castro^f, Diane Provencher^g, Sanaz Memarzadeh^h, Michael Methodⁱ, Jiuzhou Wangⁱ, Kathleen N. Moore^{j,k}, David M. O'Malley^{l,*}

Mirvetuximab + Bev in PROC with FOLR1 25% - 100%

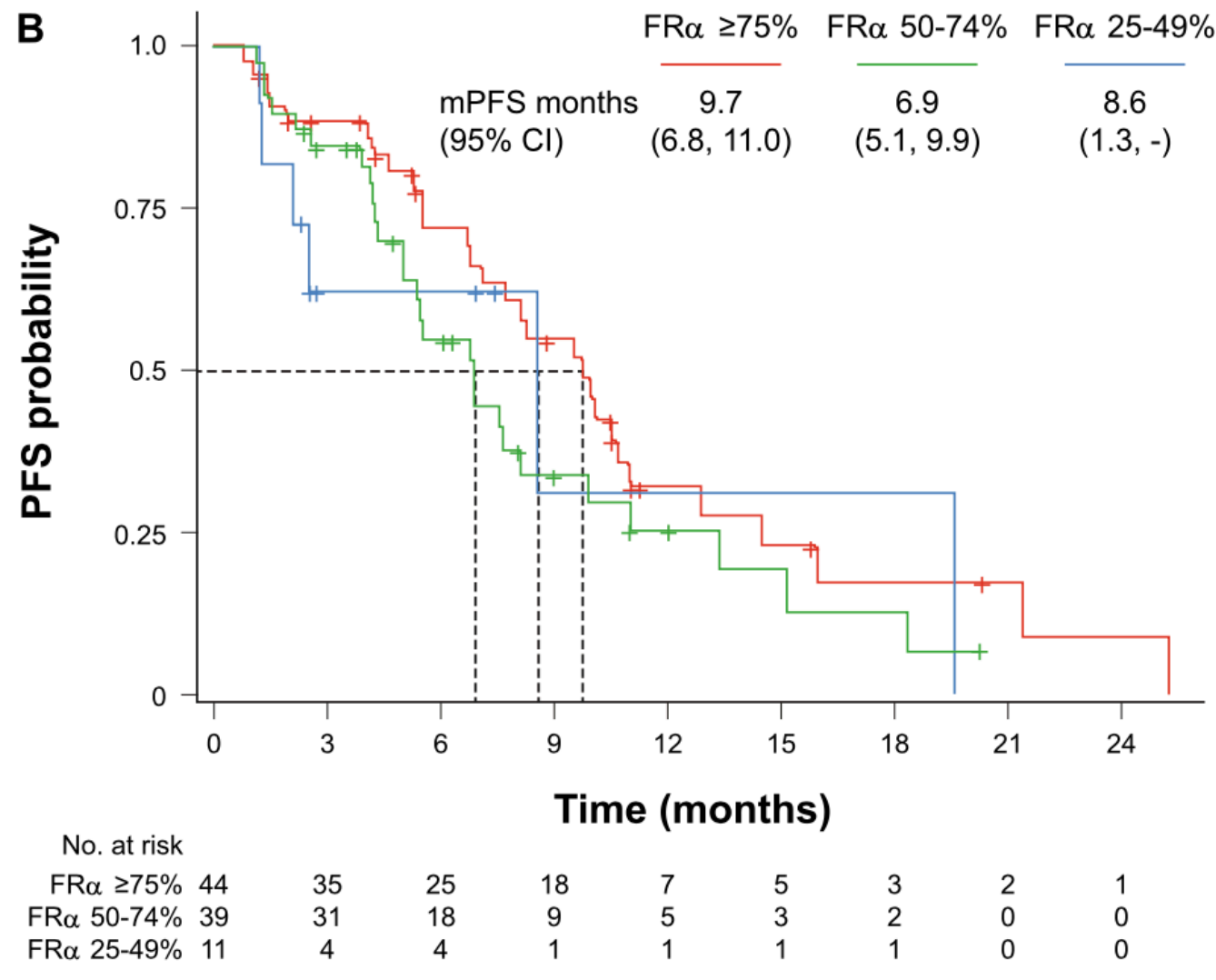
Table 1
Patient demographics and baseline characteristics.

Characteristic	N = 94
Age, years	
Median (range)	62 (39–81)
Primary diagnosis, n (%)	
Epithelial ovarian cancer	72 (77)
Fallopian tube cancer	17 (18)
Primary peritoneal cancer	5 (5)
ECOG PS, n (%)	
0	60 (64)
1	34 (36)
No. of prior systemic therapies, n (%)	
1–2	45 (48)
≥3 ^a	49 (52)
FRα expression, ^b n (%)	
≥75%	44 (47)
50–74%	39 (42)
25–49%	11 (12)
Prior exposure, n (%)	
Taxane	91 (97)
Bevacizumab	55 (59)
PARP inhibitor	25 (27)

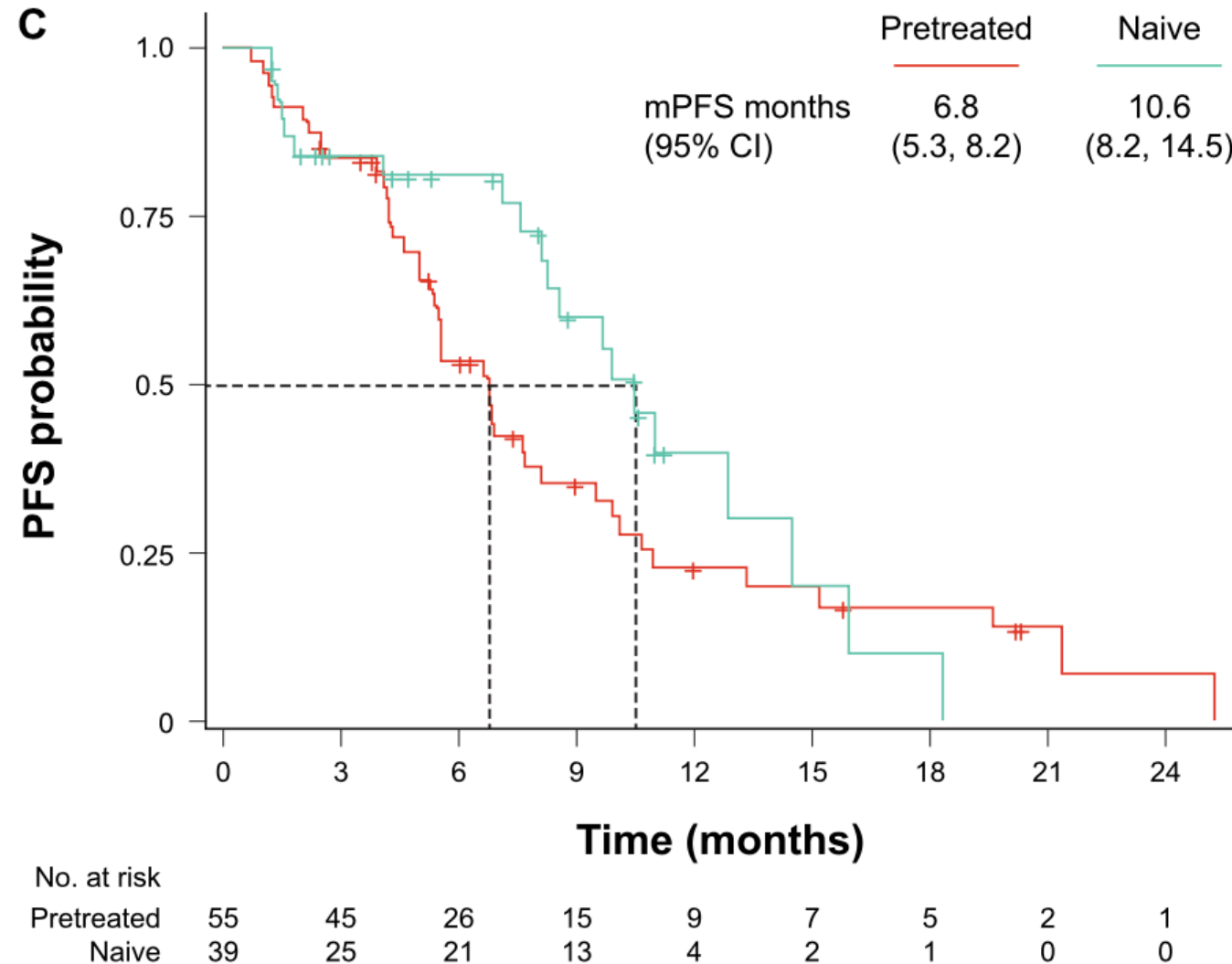
Almost 50% were
FOLR1 high

Abbreviations: Bev, bevacizumab; FRα, folate receptor alpha; PARPi, poly(ADP-ribose) polymerase inhibitor; PROC, platinum-resistant ovarian cancer.
Gilbert L, et al. Gynecol Oncol, 2023;170:241. Clinicaltrials.gov, NCT0260630

Mirvetuximab: PFS by FOLR1 Expression in PROOC



Mirvetuximab: PFS by prior Bev Exposure in PROC

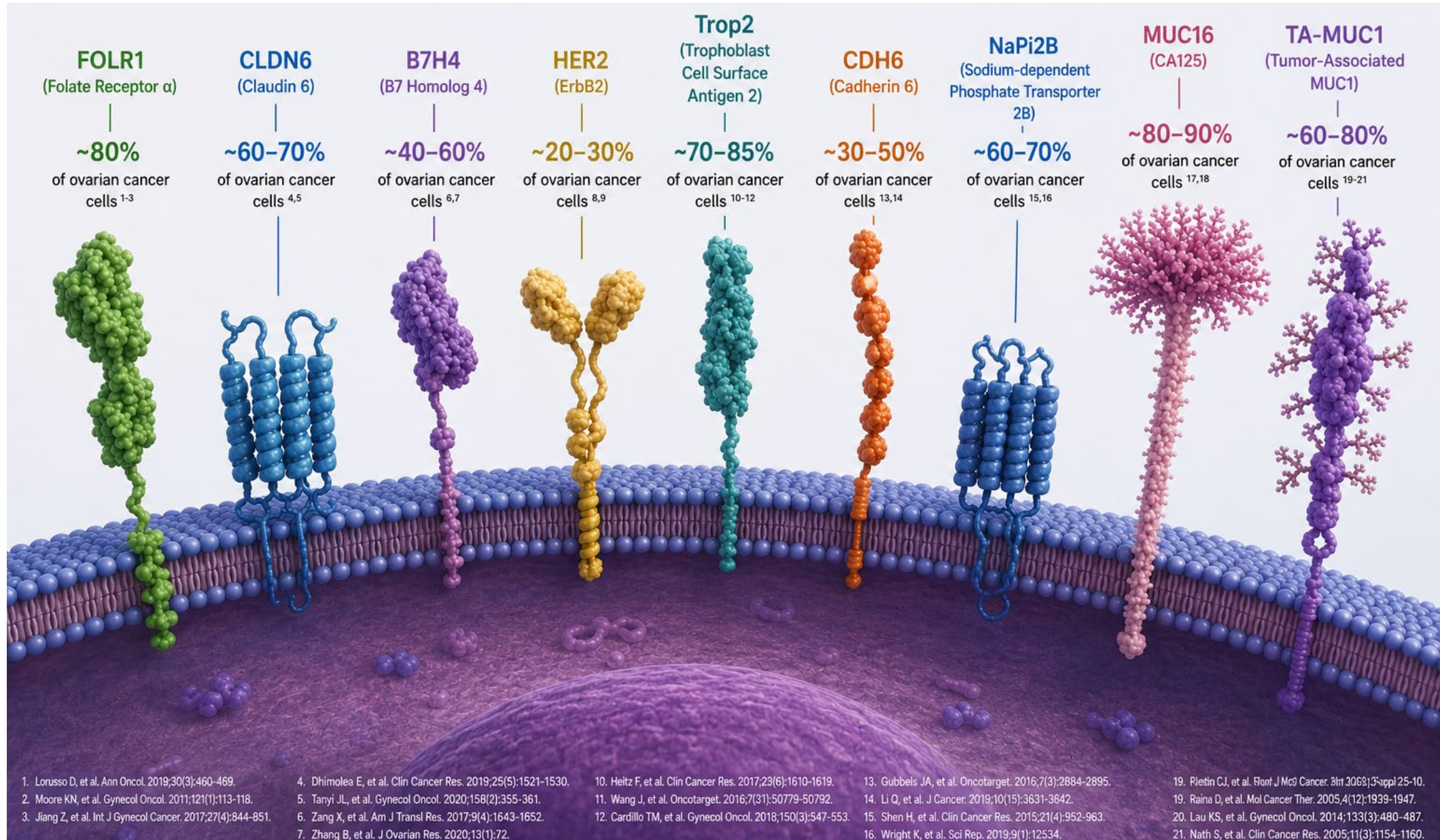


Mirvetuximab in PROC: RR by Expression

Table 3
Summary of efficacy in patients by subgroups.

Endpoint	FRα ≥ 75% (n = 44)	FRα 50–74% (n = 39)	FRα 25–49% (n = 11)	BEV-naïve (n = 39)	BEV-pretreated (n = 55)
Confirmed objective response rate, n (%)	21 (48)	16 (41)	4 (36)	22 (56)	19 (35)
95% CI	(33, 63)	(26, 58)	(11, 69)	(40, 72)	(22, 49)
Median duration of response, (months)	9.7	9.7	18.5	10.4	9.7
95% CI	(6.0, 12.0)	(3.0, NR)	(NE)	(6.9, 14.5)	(4.2, NR)
Median progression-free survival, (months)	9.7	6.9	8.6	10.6	6.8
95% CI	(6.8, 11.0)	(5.1, 9.9)	(1.3, NR)	(8.2, 14.5)	(5.3, 8.2)

Ovarian Cancer Cell Surface Targets and Reported Expression



Expression rates vary across studies due to differences in antibodies, scoring methods and patient populations.

FRα Mirvetuximab soravtansine-gynx, (FR α DM4 ADC)  MAYTANSINOID (DM4)	FRα MGN151 (FR α DM21 ADC)  MAYTANSINOID (DM21)	FRα ZW191 (FR α Top1i ADC)  TOP1 INHIBITOR (DXd)	HER2 Fam-trastuzumab deruxtecan-nxii, Enhertu, T-DXd (HER2 Top1i ADC)  TOP1 INHIBITOR (DXd)	TROP2 SHR-1921 (TROP2 Top1i ADC)  TOP1 INHIBITOR (DXd)	CDH6 Rafusetatug deruxtecan, R-DXd (CDH6 Top1i ADC)  TOP1 INHIBITOR (DXd)	B7H4 AZD6305, Puositatug samrotectan (B7H4 Top1i ADC)  TOP1 INHIBITOR (DXd)	B7H3 Rinastamab deruxtecan (B7H3 Top1i ADC)  TOP1 INHIBITOR (DXd)
FRα Luvectamab tazevibulin, Luvecta, STRO-502 (FR α hemasterlin ADC)  MICROTUBULE DISRUPTOR (HEMASTERLIN)	FRα Torvetatug samrotectan, AZD5335 (FR α Top1i ADC)  TOP1 INHIBITOR (DXd)	FRα CBP1008 (FR α /TRPV6 bispecific MMAE ADC)  TUBULIN INHIBITOR (MMAE)	HER2 Disitamab vedotin, RC48, Aildea (HER2 MMAE ADC)  TUBULIN INHIBITOR (MMAE)	TROP2 BNT325/D8-1305 (TROP2 Top1i ADC)  TOP1 INHIBITOR (DXd)	CDH6 CUSP-06 (CDH6 Top1i ADC)  TOP1 INHIBITOR (DXd)	B7H4 SGNB-7H4V (B7H4 MMAE ADC)  TUBULIN INHIBITOR (MMAE)	CLDN6 TORL-1-23 (CLDN6 MMAE ADC)  TUBULIN INHIBITOR (MMAE)
FRα Rinastamab sorotectan, Rina-S*, GEN1184 (FR α Top1i ADC)  TOP1 INHIBITOR (DXd)	FRα BAT8006 (FR α Top1i ADC)  TOP1 INHIBITOR (DXd)	NaPi2b TUB-0400 (NaPi2b Exatecan ADC)  TUBULIN INHIBITOR (EXATECAN)	HER2 JSKN003 (HER2 Top1i ADC)  TOP1 INHIBITOR (DXd)	TROP2 Sacituzumab tirumotecan, sac-TMT, SKB264/MM-2876 (TROP2 Top1i ADC)  TOP1 INHIBITOR (TOP1i)	CDH6 SMA-0505 (CDH6 Top1i ADC)  TOP1 INHIBITOR (DXd)	B7H4 LNCE74 (B7H4 MMAE ADC)  TUBULIN INHIBITOR (MMAE)	
FRα Fametrastumab ecteribulin, FZEC (formerly MGRAb-202) (FR α ecteribulin ADC)  MICROTUBULE DISRUPTOR (ECTERIBULIN)	FRα LY4175156 Sofetastamab mipectecan (FR α Top1i ADC)  TOP1 INHIBITOR (TOP1i)	EGFR x HER3 Izalontamab brengitecan, Iza-bres, BL-801D1 (EGFR x HER3 TOP1i ADC)  TOP1 INHIBITOR (TOP1i)	TROP2 Datopotamab deruxtecan, Datroway, Data-DXd (TROP2 Top1i ADC)  TOP1 INHIBITOR (DXd)	TROP2 Sacituzumab govitecan, Trodelvy (TROP2 SH28 ADC)  TOP1 INHIBITOR (SH28)	MSLN RC88 (MSLN MMAE ADC)  TUBULIN INHIBITOR (MMAE)	B7H4 GSK5733584 (B7H4 Top1i ADC)  TOP1 INHIBITOR (TOP1i)	

WARHEAD (PAYLOAD) CLASS

 TOP1 INHIBITOR (DXd / TOP1i)

 TOP1 INHIBITOR (SH28)

 TUBULIN INHIBITOR (MMAE)

 MICROTUBULE DISRUPTOR (HEMASTERLIN)

 MICROTUBULE DISRUPTOR (ECTERIBULIN)

 MAYTANSINOID (DM4 / DM21)

 TUBULIN INHIBITOR (EXATECAN)

Top1i = Topoisomerase I inhibitor

FRα Mirvetuximab soravtansine-gynx, (FR α DM4 ADC)  MAYTANSINOID (DM4)	FRα IMGN151 (FR α DM21 ADC)  MAYTANSINOID (DM21)	FRα ZW191 (FR α Top1i ADC)  TOP1 INHIBITOR (DM4)	HER2 Fam-trastuzumab deruxtecan-mkkl, Enhertu, T-DXd (HER2 Top1i ADC)  TOP1 INHIBITOR (DM4)	TROP2 SHR-1921 (TROP2 Top1i ADC)  TOP1 INHIBITOR (DM4)	CDH6 Rafolotetug deruxtecan, R-DXd (CDH6 Top1i ADC)  TOP1 INHIBITOR (DM4)	B7H4 AZD6205, Purixitug samnotecan (B7H4 Top1i ADC)  TOP1 INHIBITOR (DM4)	B7H3 Ifinatamab deruxtecan (B7H3 Top1i ADC)  TOP1 INHIBITOR (DM4)
FRα Luvelitamab tazevitulin, Luvelta, STRO-002 (FR α hemasterlin ADC)  MICROTUBULE DISRUPTOR (HEMASTERLIN)	FRα Tortuzatug samnotecan, AZD5335 (FR α Top1i ADC)  TOP1 INHIBITOR (DM4)	FRα CBP1008 (FR α /TRPV6 bi-specific MMAE ADC)  TUBULIN INHIBITOR (MMAE)	HER2 Disitamab vedotin, RC48, Aideal (HER2 MMAE ADC)  TUBULIN INHIBITOR (MMAE)	TROP2 BHT325/DB-1305 (TROP2 Top1i ADC)  TOP1 INHIBITOR (DM4)	CDH6 CUSPD6 (CDH6 Top1i ADC)  TOP1 INHIBITOR (DM4)	B7H4 SGNB-7H4V (B7H4 MMAE ADC)  TUBULIN INHIBITOR (MMAE)	CLDN6 TORL-1-23 (CLDN6 MMAE ADC)  TUBULIN INHIBITOR (MMAE)
FRα Rinastart deruxtecan, Rina-S*, GEN1184 (FR α Top1i ADC)  TOP1 INHIBITOR (DM4)	FRα BAT8006 (FR α Top1i ADC)  TOP1 INHIBITOR (DM4)	NaPi2b TUB-0400 (NaPi2b Exatecan ADC)  TUBULIN INHIBITOR (EXATECAN)	HER2 J5KN003 (HER2 Top1i ADC)  TOP1 INHIBITOR (DM4)	TROP2 Sacituzumab trumotecan, sac-TMT, SKB264/MK-2870 (TROP2 Top1i ADC)  TOP1 INHIBITOR (TOP1i)	CDH6 SIM-0505 (CDH6 Top1i ADC)  TOP1 INHIBITOR (DM4)	B7H4 LNCB74 (B7H4 MMAE ADC)  TUBULIN INHIBITOR (MMAE)	
FRα Farletuzumab ecteribulin, F20C (formerly MORAb-202) (FR α eribulin ADC)  MICROTUBULE DISRUPTOR (ERIBULIN)	FRα LY4170156 Sofetuzumab mipitotecan (FR α Top1i ADC)  TOP1 INHIBITOR (TOP1i)	EGFR x HER3 Izalontamab brigitecan, Iza-bres, BL-B01D1 (EGFR x HER3 TOP1i ADC)  TOP1 INHIBITOR (TOP1i)	TROP2 Datopotamab deruxtecan, Datnoway, Data-DXd (TROP2 Top1i ADC)  TOP1 INHIBITOR (DM4)	TROP2 Sacituzumab govitecan, Trodelvy (TROP2 SN38 ADC)  TOP1 INHIBITOR (SN38)	MSLN RC88 (MSLN MMAE ADC)  TUBULIN INHIBITOR (MMAE)	B7H4 GSK5733584 (B7H4 Top1i ADC)  TOP1 INHIBITOR (TOP1i)	

WARHEAD (PAYLOAD) CLASS

 TOP1 INHIBITOR (DM4 / TOP1i)

 TOP1 INHIBITOR (SN38)

 TUBULIN INHIBITOR (MMAE)

 MICROTUBULE DISRUPTOR (HEMASTERLIN)

 MICROTUBULE DISRUPTOR (ERIBULIN)

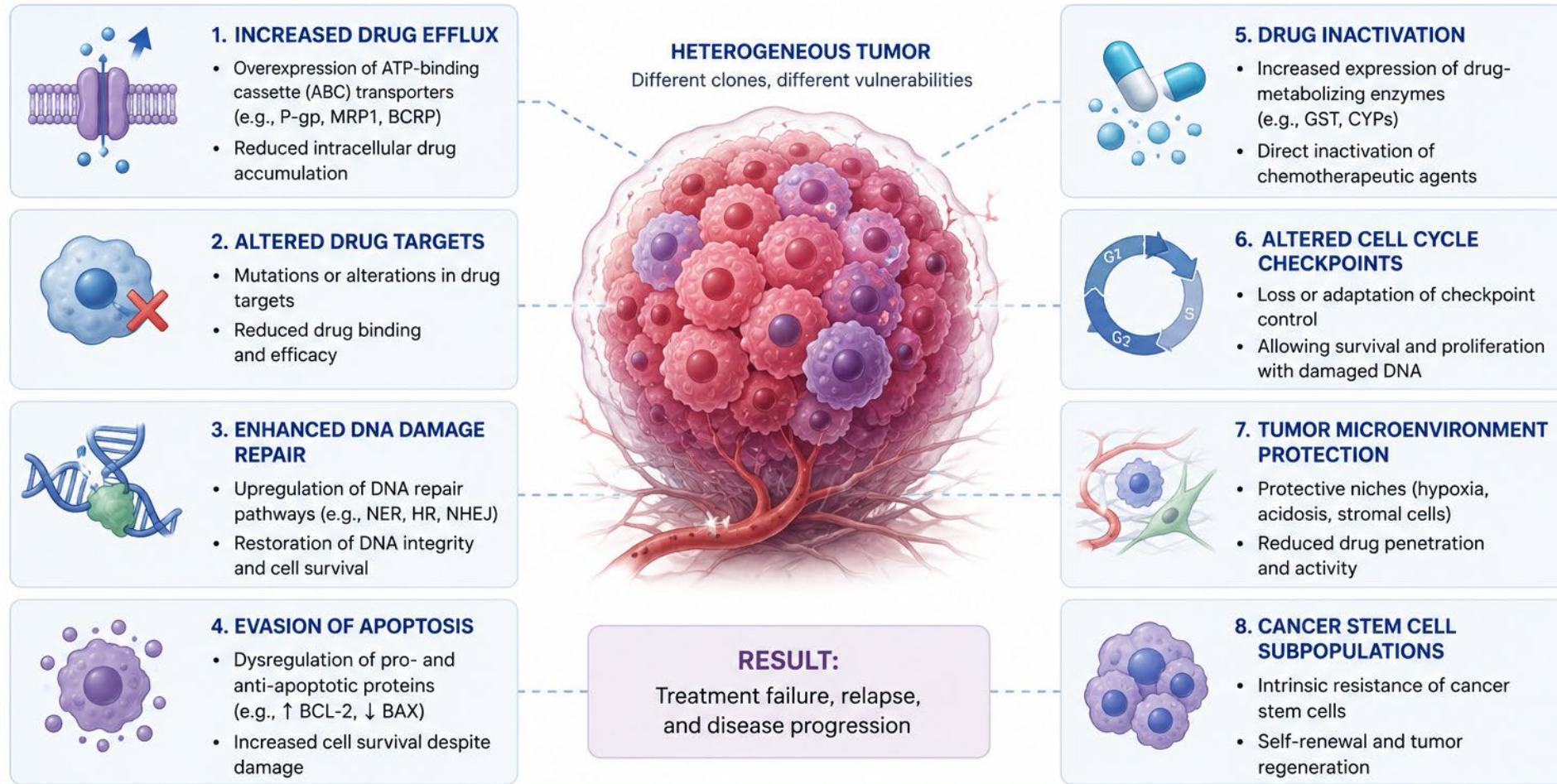
 MAYTANSINOID (DM4 / DM21)

 TUBULIN INHIBITOR (EXATECAN)

Top1i = Topoisomerase I inhibitor

Mechanisms of Resistance to Chemotherapy

Cancer cells acquire diverse strategies to survive and proliferate despite chemotherapy exposure



Resistance is often multifactorial.

Combining therapies and targeting resistance pathways are key to improving patient outcomes.



STRATEGIC APPROACHES

Biomarker-driven therapy • Combination regimens • Targeting resistance pathways
Overcoming microenvironmental barriers • Eliminating cancer stem cells

NON ADC AGENTS IN DEVELOPMENT

Selective glucocorticoid receptor modulator (relacorilant) + nab-paclitaxel  MOA: Selective glucocorticoid receptor antagonism	PD-L1 (pembrolizumab) + paclitaxel +/- bevacizumab  MOA: PD-L1 inhibitor (Immune checkpoint blockade)	Oncolytic viral immunotherapy Olvi-Vec, olvimulogene nanivecirepvec  MOA: Oncolytic virus induces tumor cell lysis and anti-tumor immunity	IL-2 + PD-L1i Nemvaleukin + pembrolizumab  MOA: IL-2 cytokine agonist + PD-L1 checkpoint inhibition	CHK1/2i ACR-368, prexasertib  MOA: CHK1/2 inhibitor (Disrupts DNA damage response)	CDK2i INCB123667  MOA: CDK2 inhibitor (Cell cycle arrest in S phase)
ATP-competitive pan-AKTi Afuresertib + paclitaxel  MOA: Pan-AKT inhibitor (Blocks PI3K/AKT/mTOR signaling)	LIPA ERX-208  MOA: LIPA enzyme replacement (Restores lipase activity)	IL-12 IMHN-001 + paclitaxel and carboplatin  MOA: IL-12 cytokine agonist (Enhances anti-tumor immunity)	MUC16 x CD3 REGN4018  MOA: Bispecific antibody (T cell engager targeting MUC16 and CD3)	PARP1-specific PARPi NMS-03305293 + topotecan  MOA: PARP1 inhibitor (Inhibits DNA repair in HR-deficient cells)	mRNA bispecific mAb targeting CD3 and CLDN6 BNT142  MOA: Bispecific antibody (Recruit T cells to CLDN6+ tumor cells)
WEE1 inhibitor AZD1775 (Azenosertib)  MOA: WEE1 kinase inhibitor (Abrogates G2/M checkpoint)	WEE1 inhibitor SGR-3515  MOA: WEE1 kinase inhibitor (Abrogates G2/M checkpoint)	anti-VEGF mAb BD00801 (suvercicug)  MOA: VEGF inhibitor (Blocks angiogenesis)	MSLN x CD47 bispecific antibody HI-1801  MOA: Bispecific antibody (Blocks CD47 "don't eat me" signal + targets MSLN)	IL-2Rβ/γ-selective IL-2 analogue TransCon IL-2 β/γ  MOA: IL-2Rβ/γ-selective agonist (Enhances T and NK cell activity)	
MECHANISM OF ACTION (MOA) LEGEND:  Immune checkpoint modulation  Oncolytic virus  DNA damage response / DNA repair  Cell cycle regulation  PI3K/AKT/mTOR signaling  Enzyme replacement  Angiogenesis inhibition  Cytokine therapy  Bispecific antibody / T cell engager					

NON ADC AGENTS IN DEVELOPMENT

Selective glucocorticoid receptor modulator (relacorilant) + nab-paclitaxel  MOA: Selective glucocorticoid receptor antagonism	PD-L1 (pembrolizumab) + paclitaxel +/- bevacizumab  MOA: PD-L1 inhibitor (Immune checkpoint blockade)	Oncolytic viral immunotherapy Oltiv-Vec, oncolytic virus nanivacrepvec  MOA: Oncolytic virus induces tumor cell lysis and anti-tumor immunity	IL-2 + PD-L1i Nemvaleukin + pembrolizumab  MOA: IL-2 cytokine agonist + PD-L1 checkpoint inhibition	CHK1/2i ACR-368, prexasertib  MOA: CHK1/2 inhibitor (Disrupts DNA damage response)	CDK2i INC123667  MOA: CDK2 inhibitor (Cell cycle arrest in S phase)
ATP-competitive pan-AKTi Afuresertib + paclitaxel  MOA: Pan-AKT inhibitor (Blocks PI3K/AKT/mTOR signaling)	LIPA ERX-208  MOA: LIPA enzyme replacement (Restores lipase activity)	IL-12 IMN-001 + paclitaxel and carboplatin  MOA: IL-12 cytokine agonist (Enhances anti-tumor immunity)	MUC16 x CD3 REGN4018  MOA: Bispecific antibody (T cell engager targeting MUC16 and CD3)	PARP1-specific PARPi HMS-03305293 + topotecan  MOA: PARP1 inhibitor (Inhibits DNA repair in HR-deficient cells)	mRNA bispecific mAb targeting CD3 and CLDN6 BNT142  MOA: Bispecific antibody (Recruit T cells to CLDN6+ tumor cells)
WEE1 inhibitor AZD1775 (Azenosertib)  MOA: WEE1 kinase inhibitor (Abrogates G2/M checkpoint)	WEE1 inhibitor SGR-3515  MOA: WEE1 kinase inhibitor (Abrogates G2/M checkpoint)	anti-VEGF mAb BDO0801 (suvencitug)  MOA: VEGF inhibitor (Blocks angiogenesis)	MSLN x CD47 bispecific antibody NI-1801  MOA: Bispecific antibody (Blocks CD47 "don't eat me" signal + targets MSLN)	IL-2Rβ/γ-selective IL-2 analogue TransCon IL-2 β/γ  MOA: IL-2Rβ/γ-selective agonist (Enhances T and NK cell activity)	

MECHANISM OF ACTION (MOA) LEGEND:



Immune Checkpoint Inhibitors in Ovarian Cancer: Phase 3 Trials

1st-Line

• JAVELIN-100	(Avelumab)	CHT + IO	X
• IMAgyn050	(Atezo)	CHT + IO + Bev	X
• DUO-O	(Durva)	CHT + IO + Bev + PARPi	X
• ATHENA Combo	(Nivo)	CHT + IO + PARPi	X
• FIRST	(Dostar)	CHT + IO + PARPi	X
• KEYLINK 001	(Pembro)	CHT + IO ± Bev + PARPi	X

Multiple phase 3 trials have shown no clinically meaningful activity of immune checkpoint inhibitors

Platinum-sensitive

• ATALANTE	(Atezo)	CHT + IO + Bev	X
• ANITA	(Atezo)	CHT + IO + PARPi	X

Irrespective of:

- line of treatment
- Combination (Bev & PARPi)

Platinum-resistant

• JAVELIN-200	(Aveluamb)	CHT + IO	X
• NRG GY 009	(Atezo)	CHT + IO + Bev	X
• AGO OVAR 2.29	(Atezo)	CHT + IO + Bev	X
• KEYNOTE-B96	(Pembro)	CHT + IO ± Bev	✓

Except in KEYNOTE B96.....

Immune Checkpoint Inhibitors in Ovarian Cancer: Phase 3 Trials

Abbreviations: Atezo, atezolizumab; Avel, avelumab; Bev, bevacizumab; CHT, chemotherapy; Dosta, dostarlimab; Durva, durvalumab; ICI, immune checkpoint inhibitor; IO, immunotherapy; Nivo, nivolumab; PARPi, poly(ADP-ribose) polymerase inhibitor; Pembro, pembrolizumab; PLD, pegylated liposomal doxorubicin.

NCT02718417. Monk BJ, et al. *Lancet Oncol.* 2021 Sep;22(9):1275-1289; NCT03038100. Moore KN, et al. *J Clin Oncol.* 2021;39:1842-1855; NCT03737643. Harter P, et al. *Ann Oncol.* 2026;37(4):503-520; NCT03522246. Monk BJ, et al. *J Clin Oncol.* 2022;40(34):3952-3964; NCT03602859. Hardy-Bessard AC, et al. *Ann Oncol.* 2025;36(12):1503-1513; NCT03740165. Powell M, et al. *Gynecologic Oncology*, 200, 348-349. NCT02891824. Kurtz JE, et al. *J Clin Oncol.* 2023;41(30):4768-4778; NCT03598270. González-Martín A, et al. *J Clin Oncol.* 2024;42(36):4294-4304; NCT02580058. Pujade-Lauraine E, et al. *Lancet Oncol.* 2021;22(7):1034-1046; NCT02839707. O'Cearbhaill R, et al. *Int J Gynecol Cancer*, 34A10; NCT03353831. Harter P, et al. *J Clin Oncol.* 2026;44(2):103-116; NCT05116189. Colombo N, et al. *The Lancet*, 2026; 407, 1525-1537

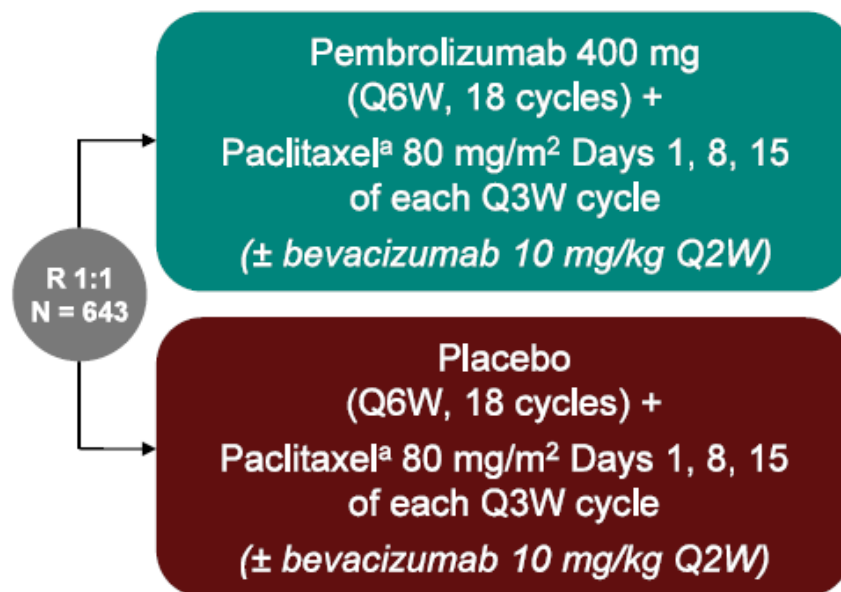
ENGOT-ov65/KEYNOTE-B96 Study Design

Key Eligibility Criteria

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

Stratification Factors

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



Primary Endpoint: PFS per RECIST v1.1 by investigator
Key Secondary: OS

^aDocetaxel (75 mg/m² Q3W) may be considered in participants with severe hypersensitivity reaction to paclitaxel or an adverse event requiring discontinuation of paclitaxel after consultation with the Sponsor.

^bThe combined positive score (CPS) was assessed at a central laboratory using PD-L1 IHC 22C3 pharmDx and defined as the number of PD-L1 CPS ≥1 cells (tumor cells, lymphocytes, macrophages) divided by the total number of tumor cells × 100.

Abbreviations: CPS, combined positive score; ECOG, Eastern Cooperative Oncology Group; OS, overall survival; PARPi, poly(ADP-ribose) polymerase inhibitor; PD-1, programmed cell death protein 1; PD-L1, programmed death ligand 1; PFS, progression-free survival; Q2W, every 2 weeks; Q3W, every 3 weeks; Q6W, every 6 weeks; RECIST, Response Evaluation Criteria in Solid Tumors.

Baseline Characteristics

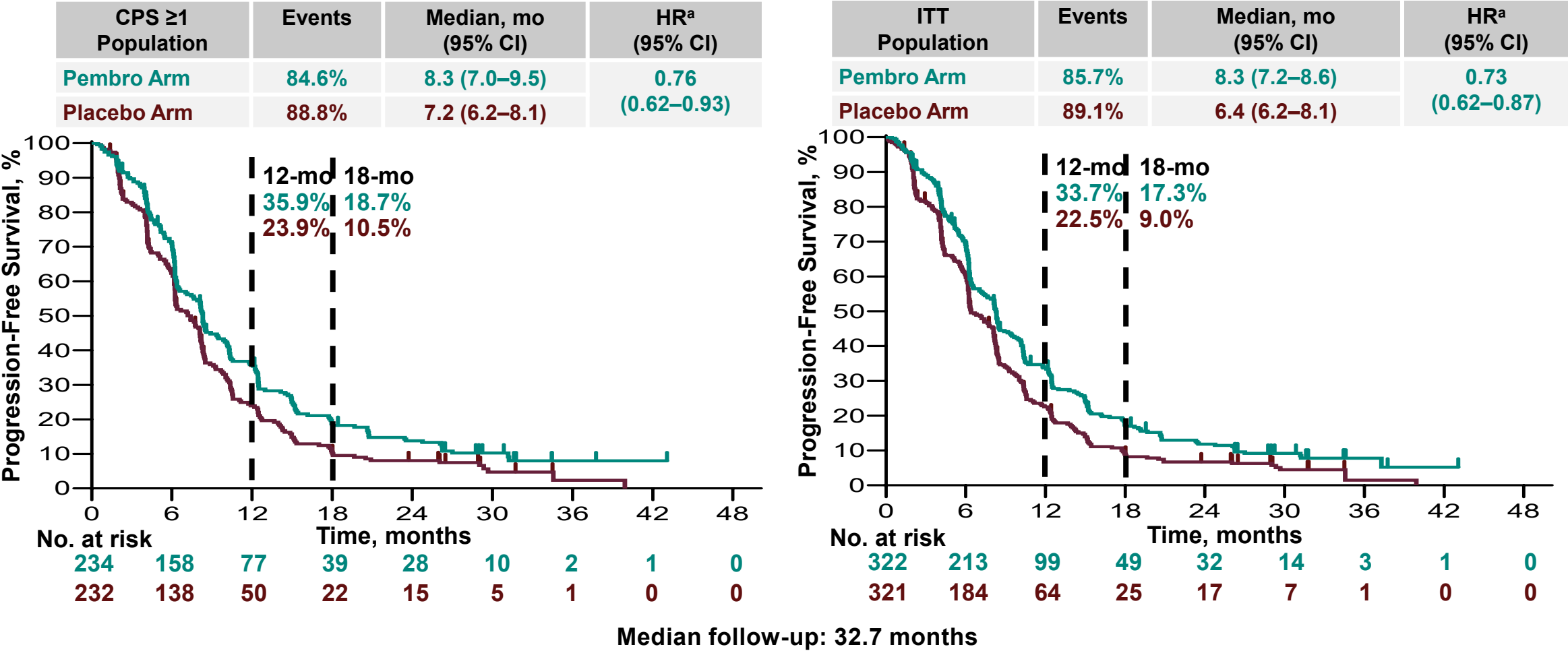
	Pembro Arm (N = 322)	Placebo Arm (N = 321)
Age, median (range), y	62 (37–85)	61 (37–82)
Race, ^a n (%)		
White	207 (64.3)	217 (67.6)
Asian	72 (22.4)	58 (18.1)
Multiple	12 (3.7)	17 (5.3)
Black or African American	8 (2.5)	6 (1.9)
Hawaiian/Pacific Islander	1 (0.3)	1 (0.3)
PD-L1 CPS, n (%)		
<1	88 (27.3)	89 (27.7)
1 to <10	133 (41.3)	132 (41.1)
≥10	101 (31.4)	100 (31.2)
Stage at diagnosis (FIGO 2014 criteria), n (%)		
IA–IIB	24 (7.4)	26 (8.1)
III–IIIC	183 (56.9)	189 (58.9)
IVA–IVB	115 (35.7)	106 (33.0)

^a44 participants had missing information for race, 22 (6.8%) in the pembro arm and 22 (6.9%) in the placebo arm. ^bOther histology subtypes in the pembro and placebo arms, respectively, were clear cell in 24 (7.5%) and 26 (8.1%), endometrioid in 9 (2.8%) and 4 (1.2%), low-grade serous in 6 (1.9%) and 10 (3.1%), carcinosarcoma in 3 (0.9%) and 5 (1.6%), and other carcinoma in 2 (0.6%) and 1 (0.3%). ^c2 participants had 3 prior lines of therapy, 1 (0.3%) in each treatment arm. Data cutoff date: September 5, 2025.

	Pembro Arm (N = 322)	Placebo Arm (N = 321)
ECOG PS 1, n (%)	142 (44.1)	144 (44.9)
High-grade serous histology, ^b n (%)	278 (86.3)	275 (85.7)
Bevacizumab use, n (%)	235 (73.0)	236 (73.5)
Prior lines of therapy, ^c n (%)		
1 line	121 (37.6)	113 (35.2)
2 lines	200 (62.1)	207 (64.5)
Prior anticancer therapy, n (%)		
Anti-PD-1 or PD-L1	7 (2.2)	7 (2.2)
Bevacizumab	149 (46.3)	146 (45.5)
PARP inhibitor	112 (34.8)	123 (38.3)
Platinum-free interval, n (%)		
<3 mo	137 (42.5)	161 (50.2)
≥3 to ≤6 mo	183 (56.8)	155 (48.3)
>6 mo	2 (0.6)	5 (1.6)

Abbreviations: CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; FIGO, International Federation of Gynecology and Obstetrics; PARPi, poly(ADP-ribose) polymerase inhibitor; PD-1, programmed cell death protein 1; PD-L1, programmed death ligand 1.

PFS in CPS ≥1 and ITT Populations at Final Analysis

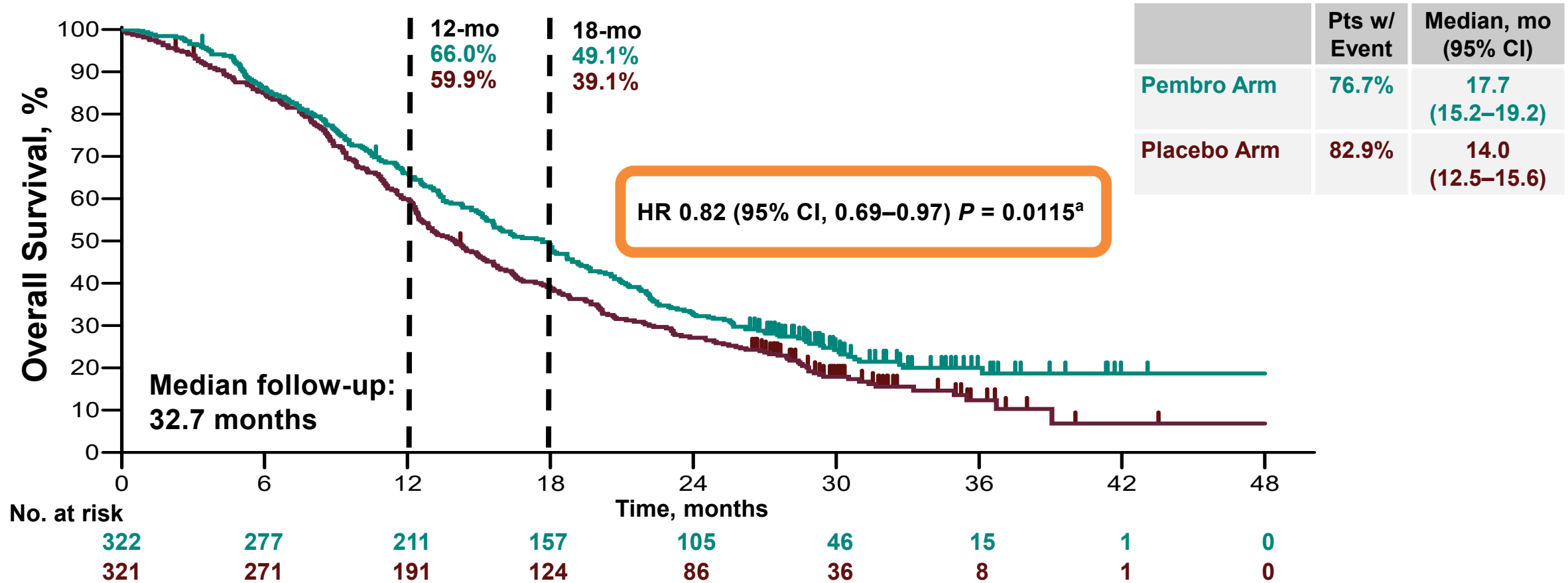


Response assessed per RECIST v1.1 by investigator review. ^aHazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors.
Data cutoff date: September 5, 2025.

Abbreviations: CPS, combined positive score; HR, hazard ratio; ITT, intention-to-treat; mo, months; PFS, progression-free survival

Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537.

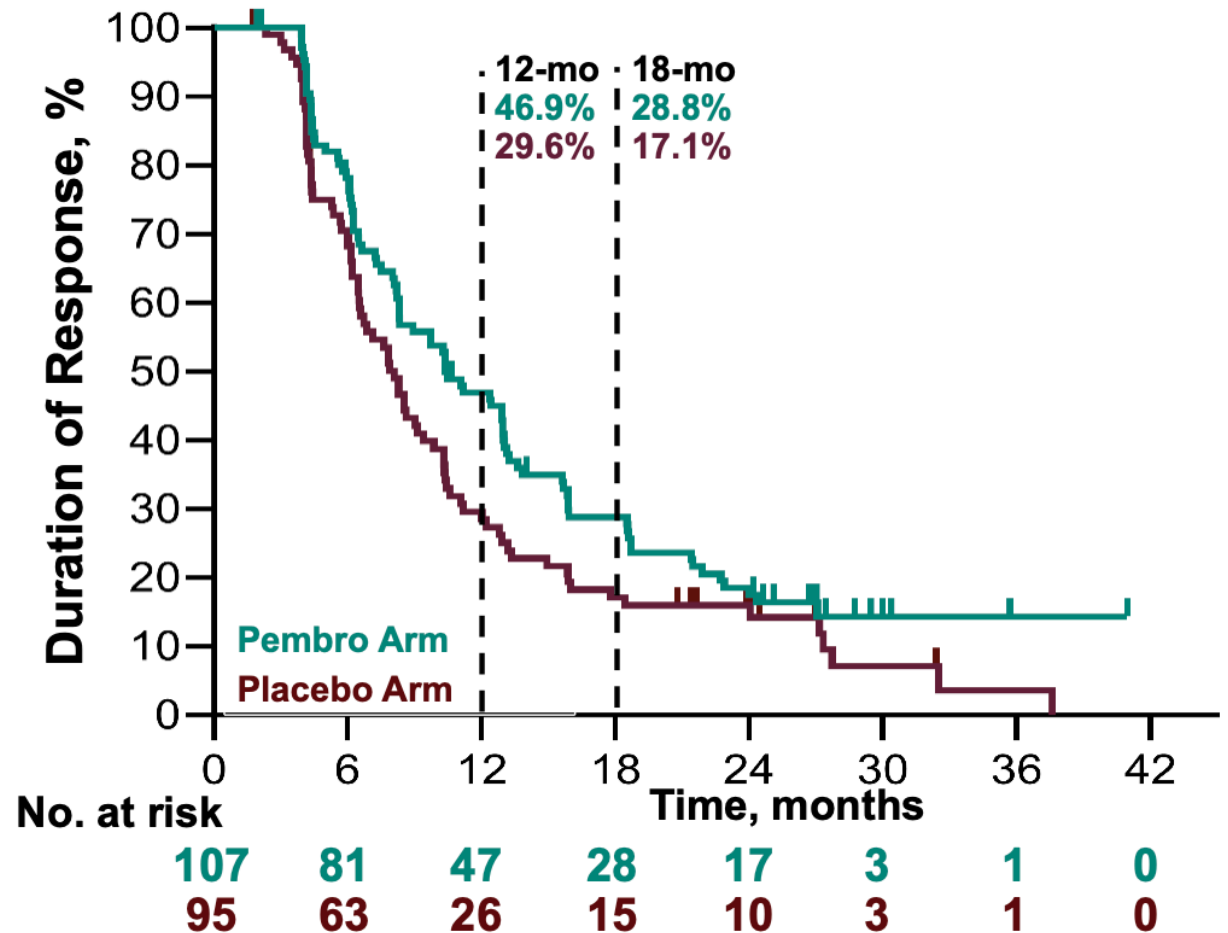
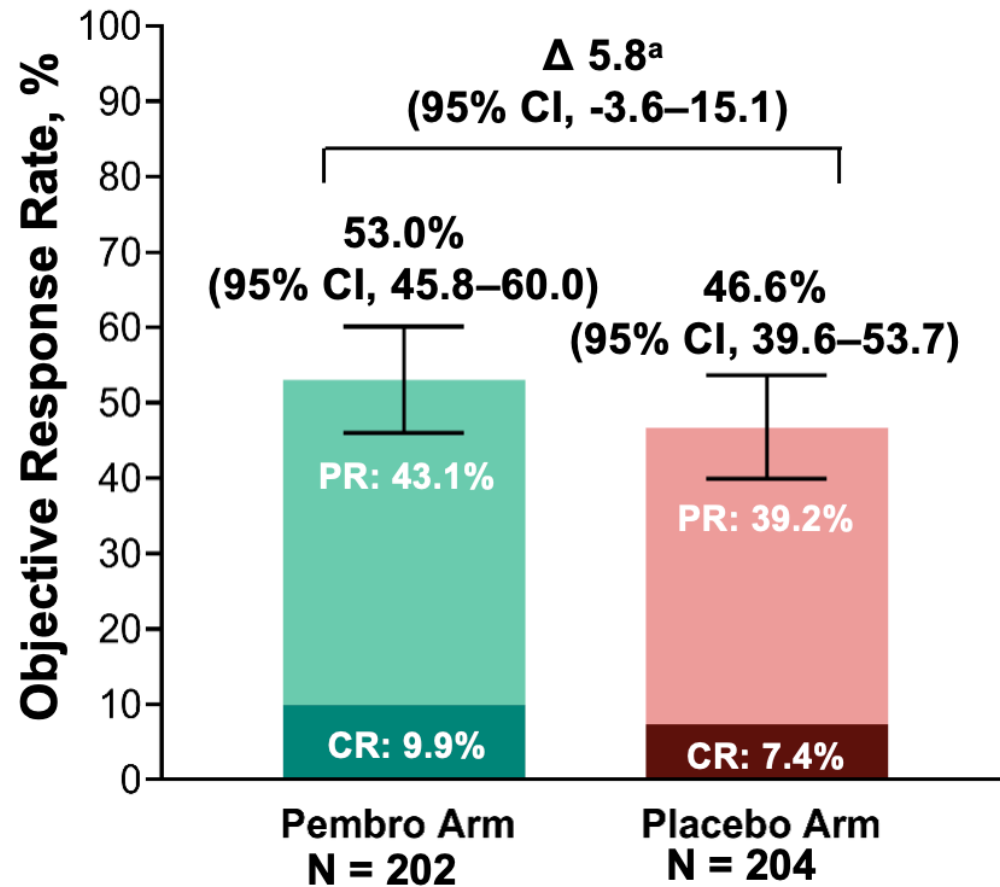
OS in ITT Population at Final Analysis



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

Monk BJ, et al. Presented at SGO Annual Meeting 2026. Figure adapted from Monk BJ, et al. ClinicalTrials.gov, NCT05116189; Colombo N, et al. Lancet. 2026;407(10538):1525-1537.

ORR and DOR in CPS ≥ 1 Population*

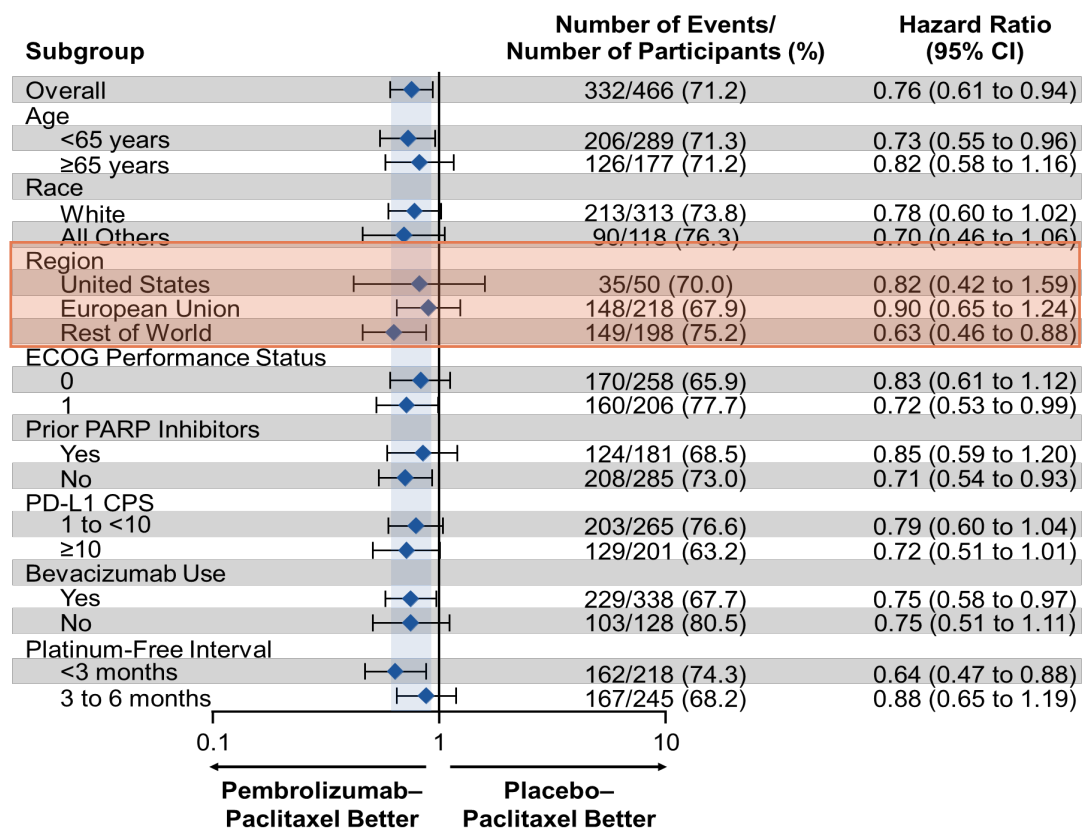


* Final Analysis

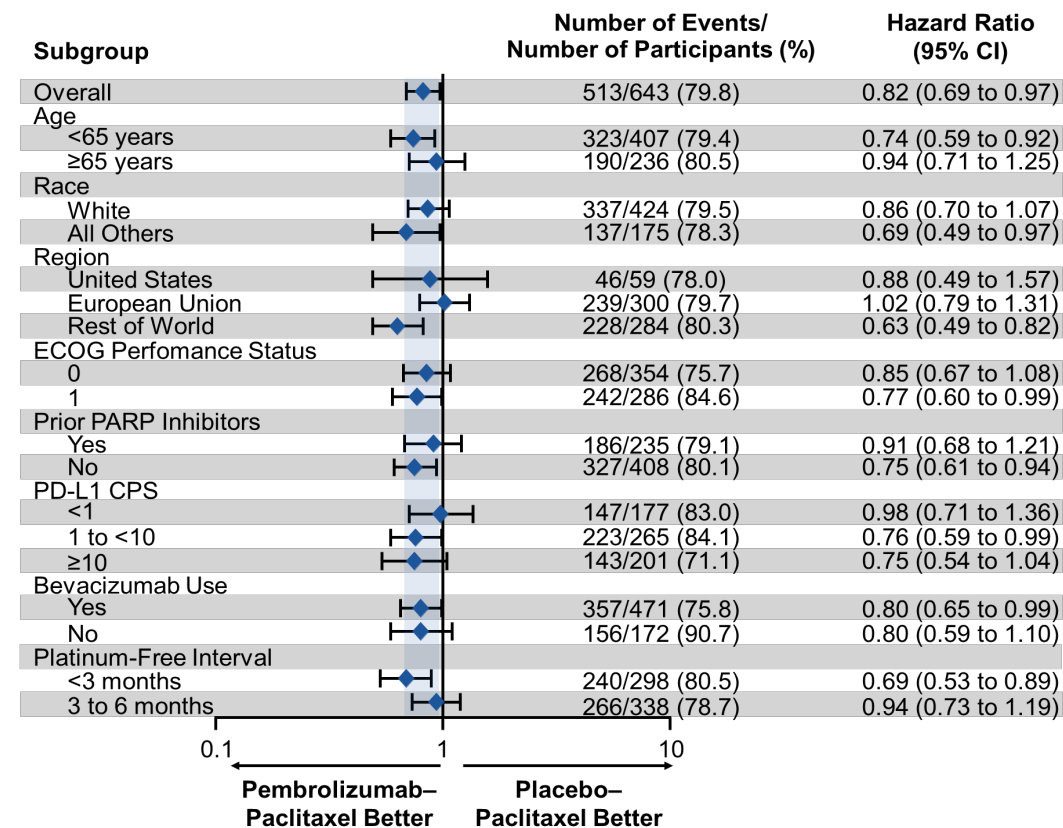
Response assessed per RECIST v1.1 by investigator review. ^aDelta estimated using Miettinen & Nurminen method stratified by the randomization stratification factors. Data cutoff date: September 5, 2025.

OS in Subgroups

CPS ≥ 1 Population



ITT Population



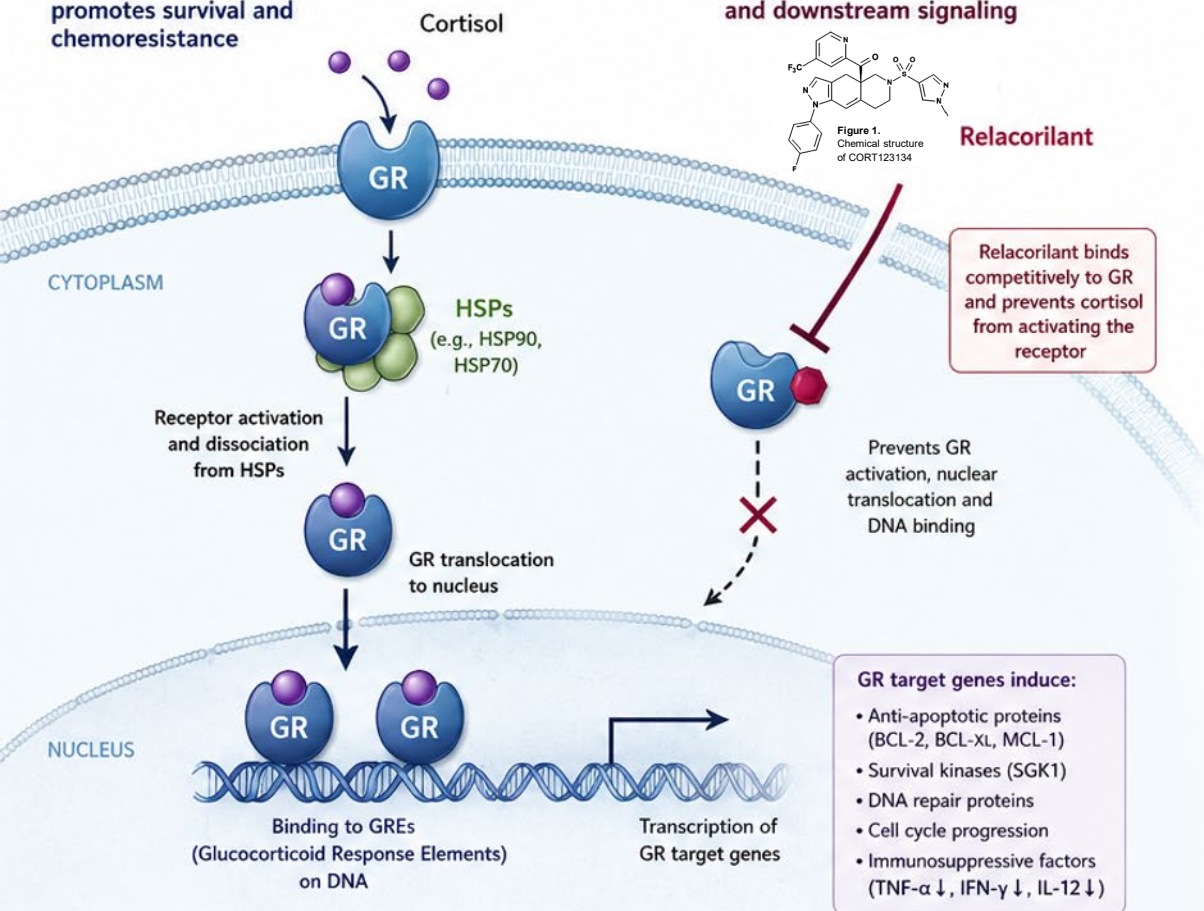
Response assessed per RECIST v1.1 by investigator review. The subgroup results shown in the forest plot were based on an unstratified Cox model, so the results for CPS ≥ 1 may differ slightly compared with those of the primary analysis, which were based on a stratified Cox model. Data cutoff dates: March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

Relacorilant (CORT125134): Mechanism of Action

Selective Glucocorticoid Receptor (GR) Antagonist

1. Cortisol signaling in cancer cells promotes survival and chemoresistance

2. Relacorilant blocks GR activation and downstream signaling



By blocking cortisol-GR signaling, relacorilant reverses survival programs and restores cancer cell sensitivity to chemotherapy and immune attack

Downstream Impact on Key Cellular Pathways

A. Apoptosis / Cell Survival



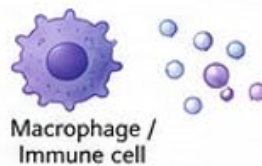
Effect of cortisol-GR signaling

↑ Anti-apoptotic proteins (BCL-2, BCL-xL, MCL-1)
↓ Pro-apoptotic proteins (BAX, BAK)
→ Apoptosis inhibited

Effect of relacorilant

↓ Anti-apoptotic proteins
↑ Pro-apoptotic proteins
→ Apoptosis restored

B. Immune Modulation (Tumor Microenvironment)



Effect of cortisol-GR signaling

↓ Pro-inflammatory cytokines (TNF- α , IFN- γ , IL-12)
↑ Anti-inflammatory cytokines (IL-10)
→ Immunosuppression

Effect of relacorilant

↑ Pro-inflammatory cytokines (TNF- α , IFN- γ , IL-12)
↓ Anti-inflammatory cytokines (IL-10)
→ Immune activity restored

Hunt HJ et al., J Med Chem. 2017 Apr 27;60(8):3405-3421, refer to Figure 5. Chemical structure of Compound 7 for the relacorilant structure
Hunt H et al. Clin Pharm Drug Dev. 2018 May;7(4):408-421n refer to Figure 1 Chemical structure of CORT125134

References: Int J Gynecol Cancer 2025;35:100009. Gynecol Oncol 2017;146:153. Oncotarget 2021;12:1243. Clin Cancer Res 2009;15:3196. Gynecol Oncol. 2015;138:656. Clin Cancer Res. 2022;28:3214. Nat Commun 2021;12:7041, J Clin Invest 2023;133:e164599, Immunity 2020;53:658, Endocrinol 2026;167:bqag019, Int Immunopharmacol 2023;120:110312, Horm Cancer 2018;9:95-107, Clin Cancer Res 2022;28:3214, Eur J Med Chem 2014;87:89, Nat Rev Cancer 2004;4:253, Front Pharmacol 2022;13:933112, Biomolecules 2023;13:653, Trends Pharmacol Sci 2013;34:518, Mol Cancer 2018;17:104, Oncogene 2008;27:6245.

Functional Outcome



With cortisol-GR signaling:

- Cancer cell survival
- Chemoresistance (e.g., to taxanes)
- Immune evasion

Relacorilant + Chemotherapy (e.g., nab-paclitaxel)



With relacorilant:

- Increased apoptosis
- Restored chemosensitivity
- Enhanced anti-tumor immunity

Improved tumor response and progression-free survival



Final Overall Survival Results From the Phase 3 ROSELLA Trial: 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)

Alexander B Olawaiye,¹ Stanislas Quesada, Lucy Gilbert, Jae-Weon Kim, Mariana Scaranti, Elena Giudice, Elizabeth Hopp, Linda Mileskin, Toon Van Gorp, Michael E McCollum, Ana Oaknin, Aliza L Leiser, Philippe Follana, Chiara Cassani, Boglárka Balázs, Andrew Clamp, Hristina I. Pashova, Sachin G Pai, Nicoletta Colombo and Domenica Lorusso

¹University of Pittsburgh School of Medicine and UPMC Magee-Women's Hospital, Gynecologic Oncology Group, Pittsburgh, PA, USA.

Scan to access:

Copies of this presentation obtained through QR code are for personal use only and may not be reproduced without written permission of the authors.

Presentation



Plain Language Summary



In collaboration with:

Presented By: Alexander B. Olawaiye, MD

GOG FOUNDATION®
Transforming the standard of care

ENGOT
European Network of
Gynaecological Oncological Trial groups

APGOT
Asia-Pacific
Gynecologic Oncology
Trials Group

LACOG
LATIN AMERICAN COOPERATIVE
ONCOLOGY GROUP

**ANZ
GOG**

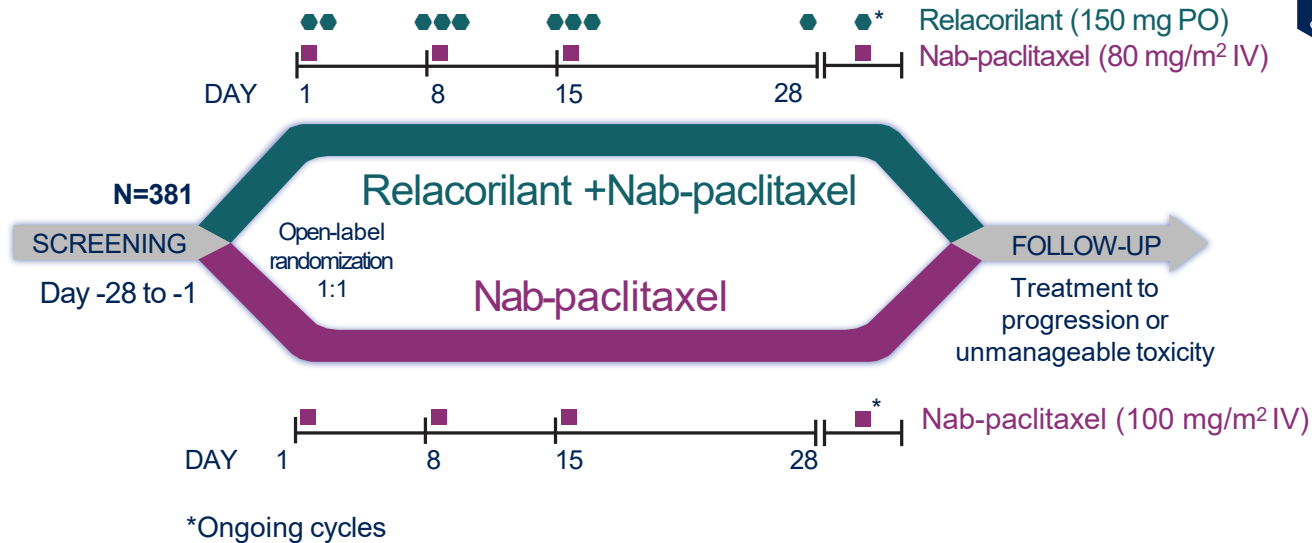
ROSELLA | Study Schema



Population

- Epithelial ovarian, primary peritoneal, or fallopian tube cancer
- ECOG performance status 0 or 1
- Progression <6 months after the last dose of platinum therapy (excluding no response to or progression in <1 month of primary platinum)
- 1–3 prior lines of therapy
- Prior bevacizumab required

[NCT05257408](https://clinicaltrials.gov/ct2/show/study/NCT05257408)



Stratification Factors

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

As nab-paclitaxel does not require steroid pre-treatment, it is a rational combination partner for relacorilant, a selective glucocorticoid receptor antagonist.



Dual Primary Endpoints

- Progression-free survival (PFS) by RECIST v1.1 per blinded independent central review
- Overall survival (OS)

Secondary Endpoints

- PFS by RECIST v1.1 per investigator
- ORR, DoR, CBR (RECIST v1.1)
- Response by CA-125 GCIG criteria
- Combined response (RECIST v1.1 and CA-125 GCIG criteria)
- Safety

First patient enrolled: Jan 5, 2023
Last patient enrolled: Apr 8, 2024
Primary results data cutoff: Feb 24, 2025
Final OS data cutoff: Jan 8, 2026
Conducted at 117 sites in 14 countries.

CA, cancer antigen; CBR, clinical benefit rate; DoR, duration of response; ECOG, Eastern Cooperative Oncology Group; GCIG, Gynecologic Cancer Intergroup; IV, intravenous; ORR, objective response rate; PO, by mouth; RECIST, Response Evaluation Criteria in Solid Tumors.

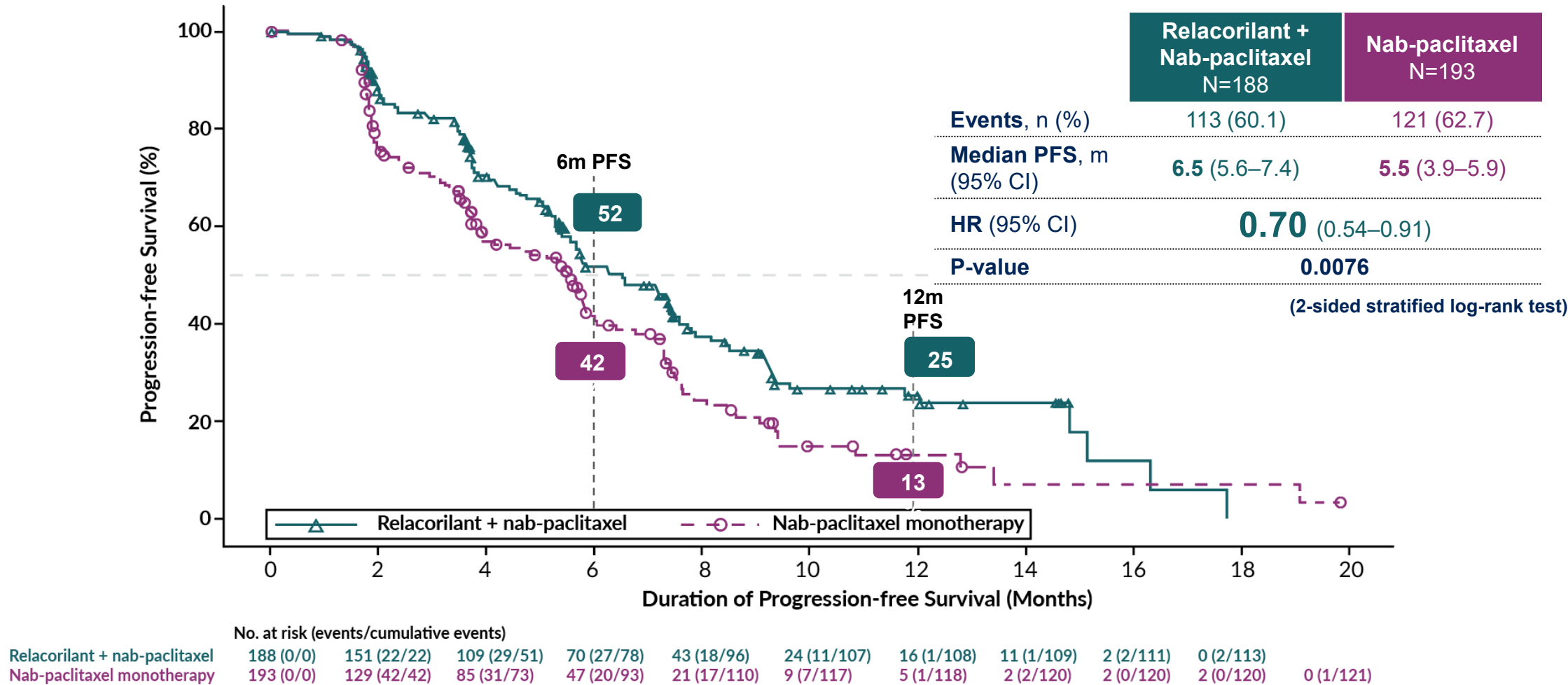
ROSELLA | Baseline Characteristics Were Well Balanced

		Relacorilant + Nab-paclitaxel (N=188)	Nab-paclitaxel (N=193)
Age, median (range), years		61 (26–85)	62 (33–86)
Race, n (%)	White	136 (72.3)	135 (69.9)
	Black or African-American	3 (1.6)	2 (1.0)
	Asian (92% Korean)	22 (11.7)	26 (13.5)
	Other / not reported	27 (14.4)	30 (15.5)
Ethnicity, n (%)	Hispanic	16 (8.5)	17 (8.8)
Region	North America	45 (23.9)	45 (23.3)
	Europe	107 (56.9)	109 (56.5)
	Korea, Australia, and Latin America	36 (19.1)	39 (20.2)
ECOG performance status, n (%)*	1 or 2	53 (28.2)	63 (32.6)
BRCA1/2 mutation, n (%)	Yes	23 (12.2)	24 (12.4)
Prior lines of therapy, n (%)	1	15 (8.0)	18 (9.3)
	2	92 (48.9)	89 (46.1)
	3	81 (43.1)	86 (44.6)
Primary platinum refractory, n (%)†	Yes	13 (6.9)	13 (6.7)
Prior lines of therapy in the platinum-resistant setting, n (%)	≥1	67 (35.6)	82 (42.5)
Prior therapies, n (%)	Bevacizumab	188 (100)	193 (100)
	Taxanes	187 (99.5)	192 (99.5)
	Pegylated liposomal doxorubicin	121 (64.4)	125 (64.8)
	PARP inhibitor	114 (60.6)	120 (62.2)
Prior taxane in the platinum-resistant setting, n (%)	Yes	8 (4.3)	7 (3.6)
Taxane-free interval, n (%)	≤ 6 months	22 (11.7)	33 (17.1)
	> 6 months	165 (87.8)	159 (82.4)
Taxane in the last regimen, n (%)	Yes	35 (18.6)	38 (19.7)
	No	153 (81.4)	155 (80.3)

*In the nab-paclitaxel monotherapy arm, 1 patient had an ECOG performance status of 2. †Progressed within 3 months of the last dose of platinum from their first-line platinum regimen. 97% of patients had high-grade serous carcinoma, 8 patients had high-grade endometrioid carcinoma, and 2 patients had carcinosarcoma. BRCA, Breast Cancer Gene; ECOG, Eastern Cooperative Oncology Group; PARP, poly(ADP-ribose) polymerase.

Data cutoff: Feb 24, 2025

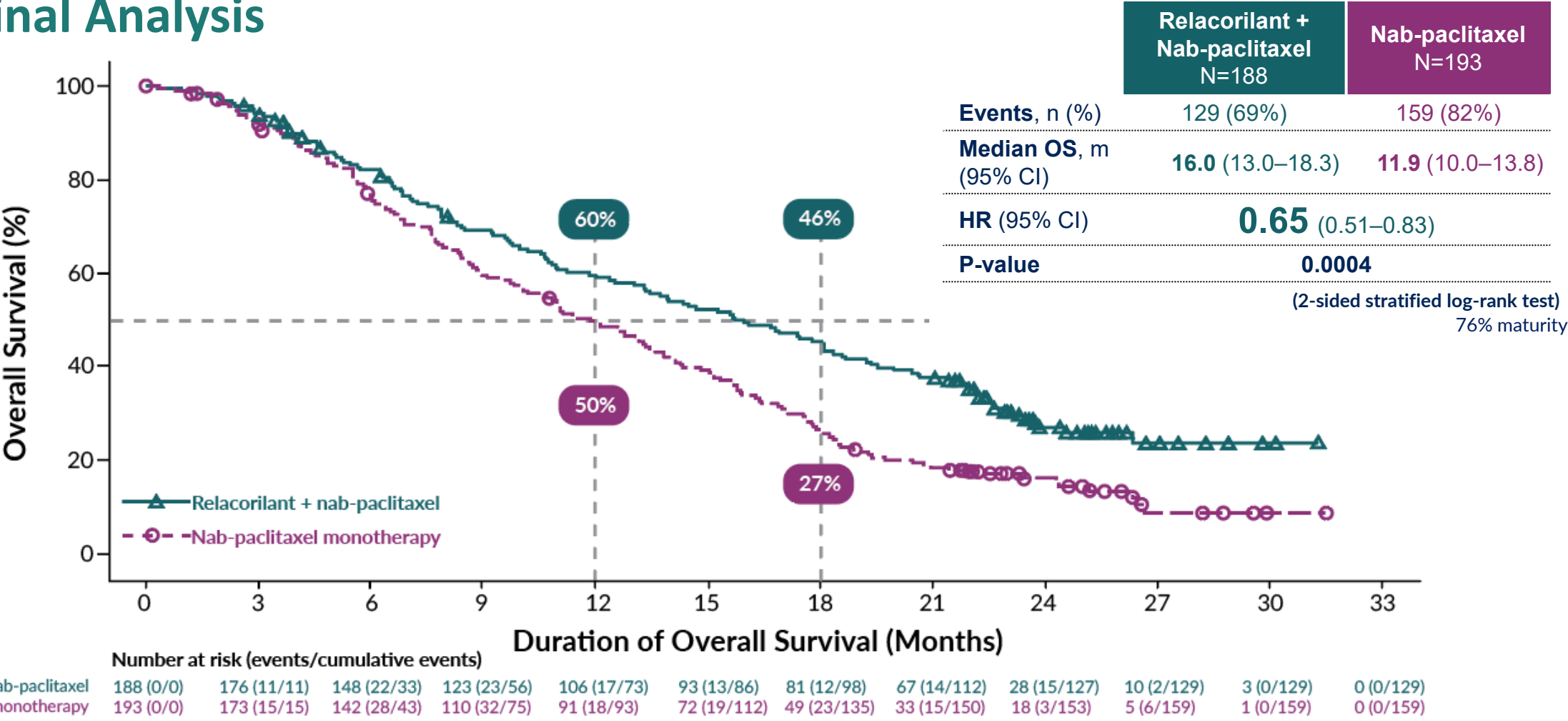
ROSELLA | Relacorilant Significantly Improved Progression-Free Survival Assessed by Blinded Review at the Primary Analysis



Data cutoff: Feb 24, 2025

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

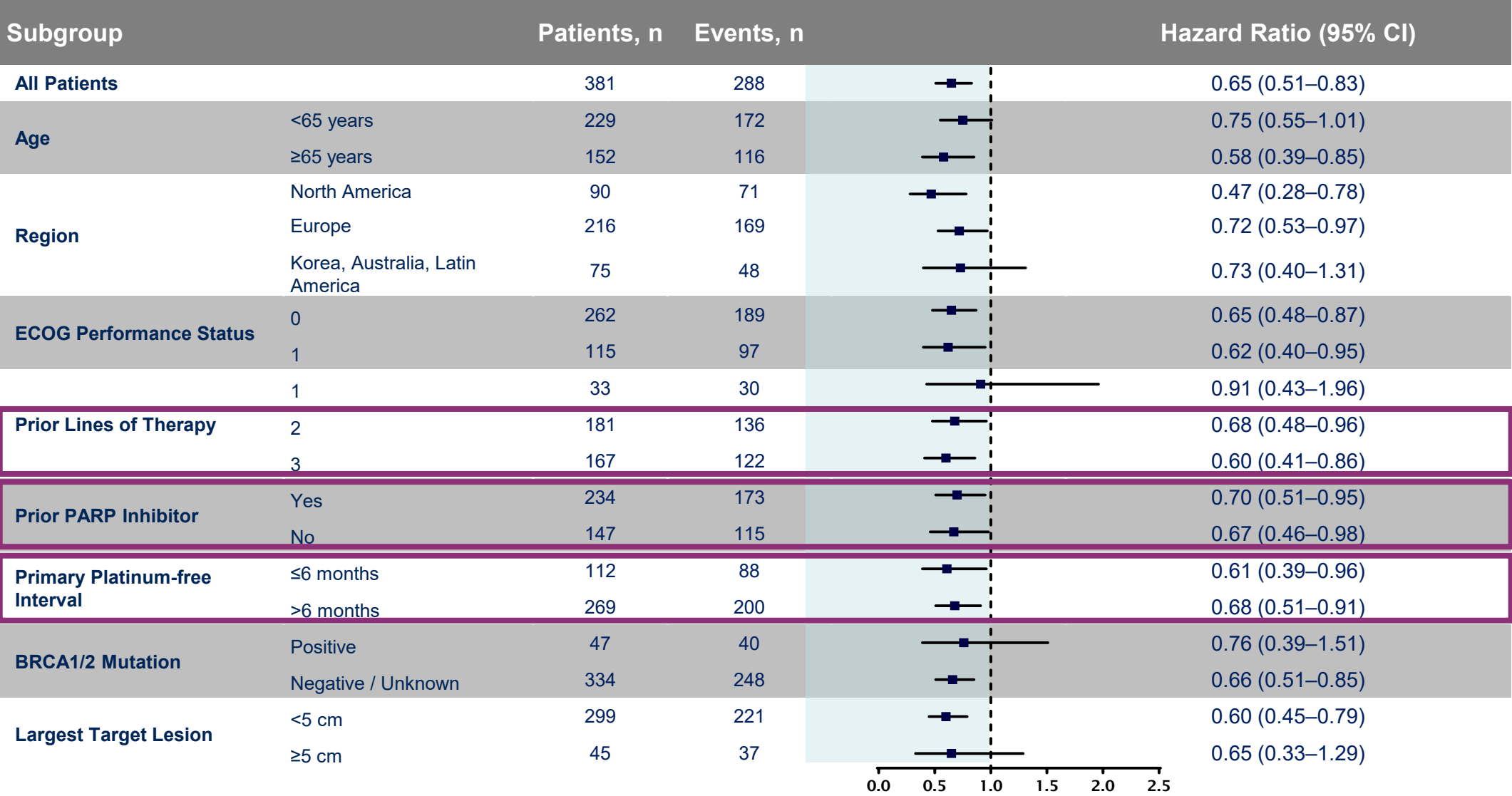
ROSELLA | Relacorilant Significantly Improved Overall Survival at the Final Analysis



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

Data cutoff: Jan 8, 2026

ROSELLA | Relacorilant Improved Overall Survival Across Key Subgroups



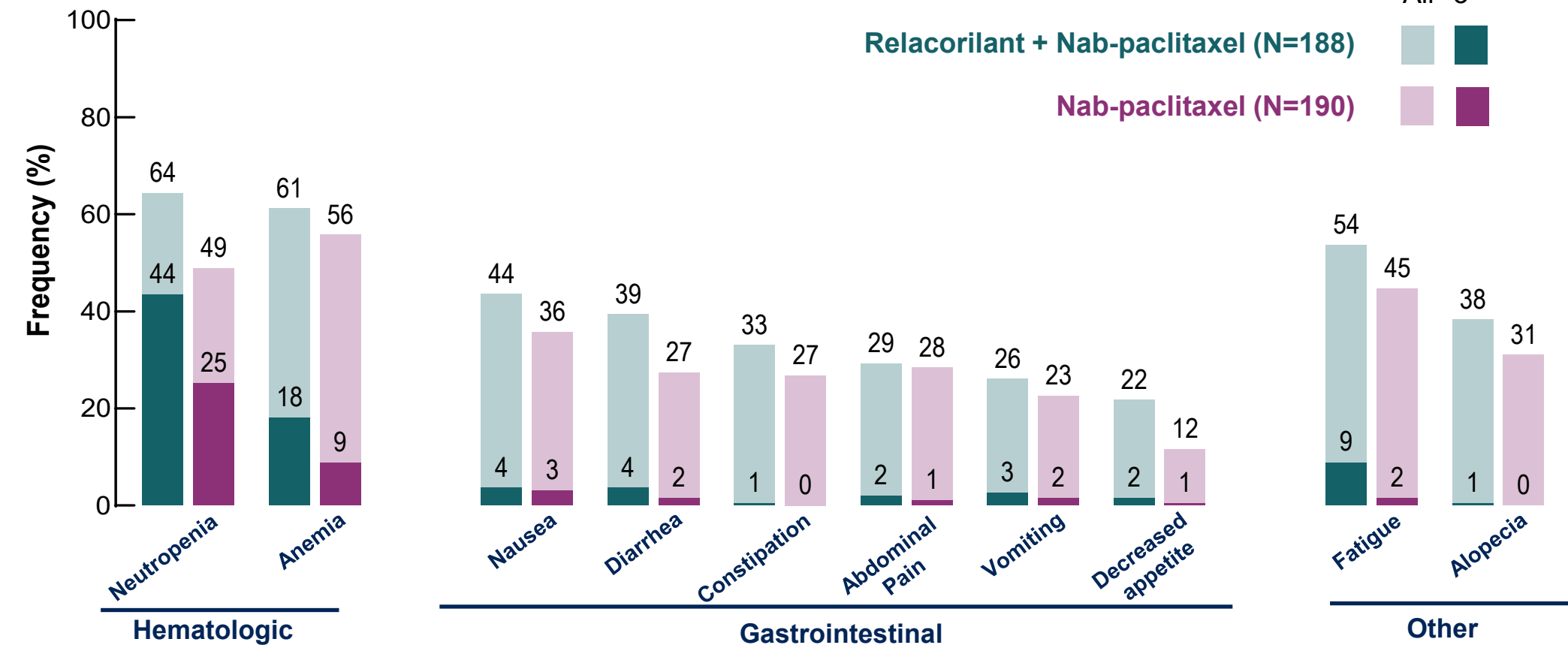
BICR, blinded independent central review; BRCA, Breast Cancer Gene; CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; OS, overall survival; PARP, poly(ADP-ribose) polymerase.



Data cutoff: Jan 8, 2026

ROSELLA | Common (>20%) Adverse Events

Grade
All 3+



When adjusted for duration of exposure, the incidence rates of neutropenia and anemia were similar between study arms.
Peripheral neuropathy occurred with similar frequency in both arms (19.1% and 17.4%).
5 SAEs of febrile neutropenia: 4 (2.1%) vs 1 (0.5%).* 5 SAEs of sepsis: 3 (1.6%) vs 2 (1.1%).*

Treatment-emergent adverse events that occurred in >20% of patients. Assessed in the safety population of patients who received at least one dose of study drug, N=378. Combined terms are presented for neutropenia (neutropenia, reduced neutrophil count, and febrile neutropenia), anemia (anemia, reduced hemoglobin, and reduced red blood cell count) and fatigue (fatigue and asthenia). SAEs, serious adverse events. *Comparing the relacorilant combination arm to the nab-paclitaxel monotherapy arm, respectively.

ROSELLA | Safety Summary

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

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

There were no relacorilant-related fatal AEs and no cases of adrenal insufficiency.

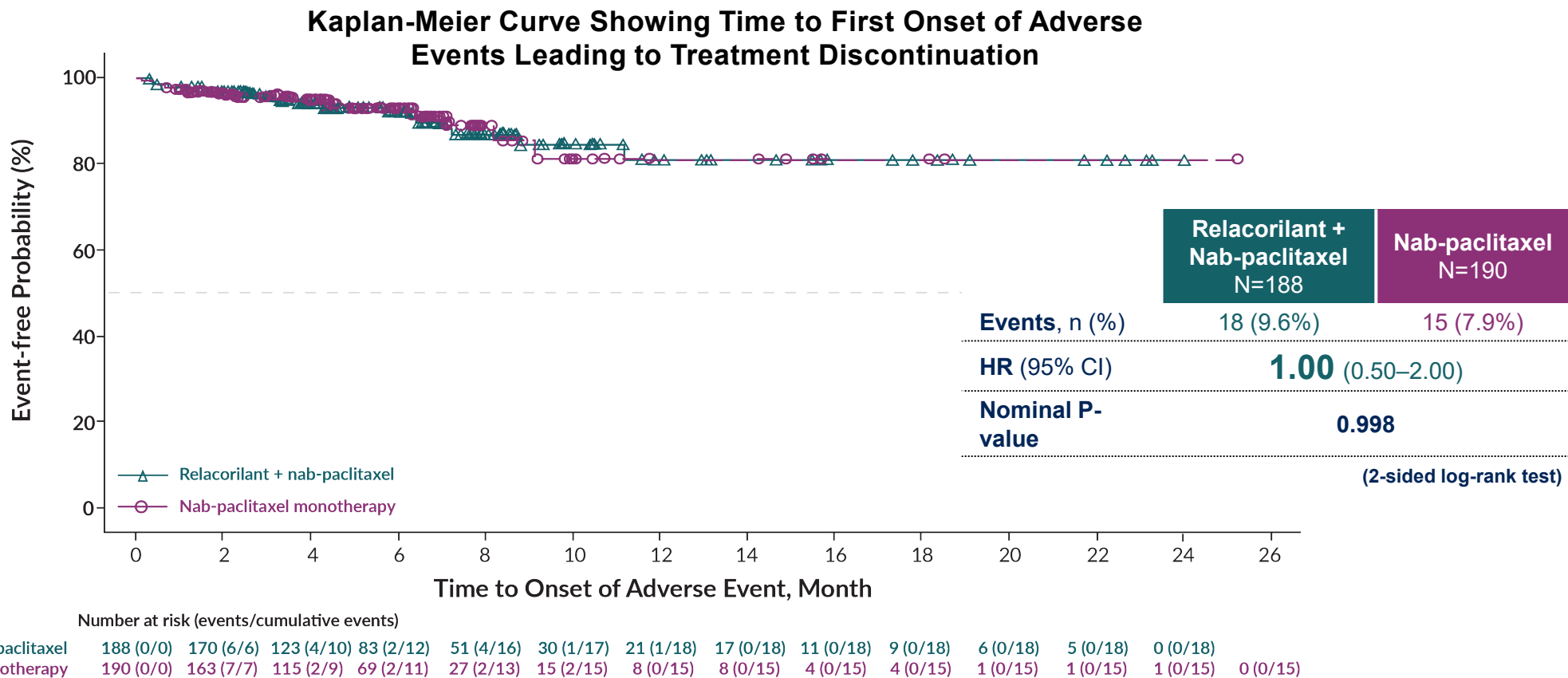
At the final OS analysis, the safety profile was consistent with that at the time of the primary analysis.

No new safety signals were identified with longer follow-up.

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

Data cutoff: Jan 8, 2026

ROSELLA | Treatment Discontinuations Due to Adverse Events Were Infrequent



Discontinuations due to AEs were infrequent, well balanced across arms, and occurred in a similar timeframe in both arms

AEs, adverse events.

Data cutoff: Jan 8, 2026

Presented By: Alexander B. Olawaiye, MD

Which Way To Go?



Differences in PROC FDA Indications

	N	Biomarker	Prior Lines	Cell Types	Platinum Refractory	Prior Bev
Bevacizumab	361	None	1-2	All including LGSOC	Yes unless progressed on platinum	7%
Mirvetuximab	453	FOLR1 (2+, 75%)	1-3	Serous only	No (<3 mo)	61%
Pembrolizumab	643	PD-L1 (CPS $\geq$ 1)	1-2	All including LGSOC and MMT	No (<3 mo)	46%
Relacorilant	381	None	1-3	High grade epithelial	Yes unless <1 mo	100%

*Platinum refractory patients were included in the B-96 trial but not mentioned in the package insert

Abbreviations: CPS, combined positive score; FDA, U.S. Food and Drug Administration; FOLR1/FR α , folate receptor alpha; PROC, platinum-resistant ovarian cancer.

References: U.S. Food and Drug Administration Oncology Center of Excellence. Hematology/Oncology (Cancer) Approvals & Safety Notifications; bevacizumab Prescribing Information. Genentech, Inc.; mirvetuximab soravtansine-gynx Prescribing Information. ImmunoGen, Inc.; pembrolizumab Prescribing Information. Merck & Co., Inc.; Colombo N, et al. Lancet. 2026; 407(10538):1525-1537.

Outcomes in PROC

		Median PFS (control)	Median OS (control)	PFS (95%tile)	OS (95%tile)
AURELIA (NCT00976911)	IC ± Bev	3.4 mo	13.3 mo	0.48 (0.38-0.60)	0.85 (0.66-1.08)
MIRASOL (NCT04209855)	Mirvetuximab vs IC Chemo	4.0 mo	12.8 mo	0.65* (0.52-0.81)	0.67* (0.50 - 0.89)
Keynote B-96 (NCT05116189)	Weekly paclitaxel ± Pembrolizumab (bev optional)	7.2 mo	14.0 mo	0.76* (0.62-0.93)	0.76* (0.62-0.93)
ROSELLA (NCT05257408)	Weekly nab- Paclitaxel ± Relacorilant	5.5 mo	11.9 mo	0.70 (0.54-0.91)	0.65 (0.51-0.83)

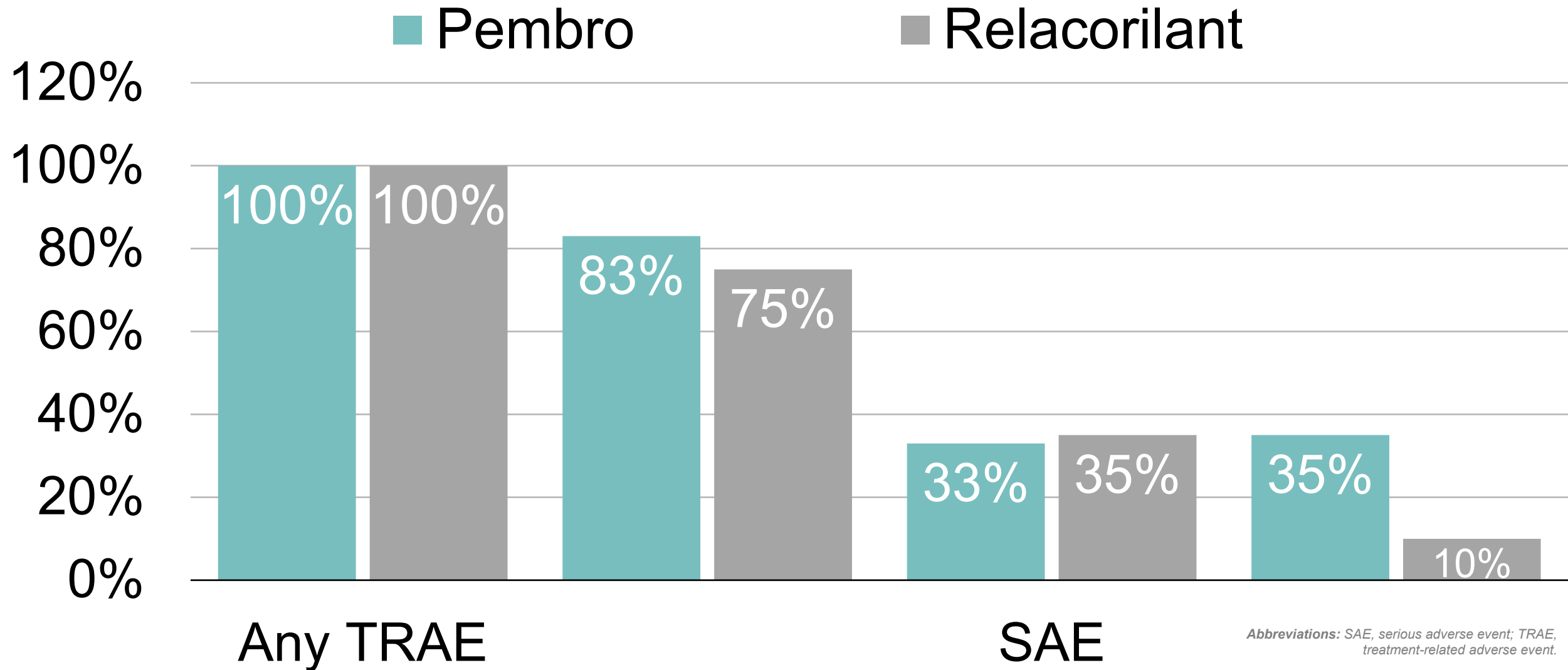
*Biomarker selected

Abbreviations: Bev, bevacizumab; CI, confidence interval; HR, hazard ratio; IC, investigator's choice; mo, months; OS, overall survival; PFS, progression-free survival; PROC, platinum-resistant ovarian cancer.

*Cross-trial comparisons should be interpreted cautiously due to differences in study populations, treatment backbones, and trial designs.

Pujade-Lauraine E, et al. J Clin Oncol. 2014;32:1302-1308; Moore KN, et al. N Engl J Med. 2023;389:2165-2177; Colombo N, et al. Lancet. 2026;407(10538):1525-1537; Olawaiye AB, et al. Lancet. 2025;405(10496):2205-2216.

Adverse Events and Discontinuation Rates



Immune-Mediated AEs (B-96 Study Only)

Immune-mediated adverse event§	126 (39%)	38 (12%)	60 (19%)	11 (3%)
Hypothyroidism	58 (18%)	0	19 (1%)	0
Infusion reaction	19 (6%)	6 (2%)	15 (5%)	2 (1%)
Hyperthyroidism	16 (5%)	0	2 (1%)	0
Adrenal insufficiency	15 (5%)	7 (2%)	0	0
Pneumonitis	15 (5%)	2 (1%)	6 (2%)	3 (1%)

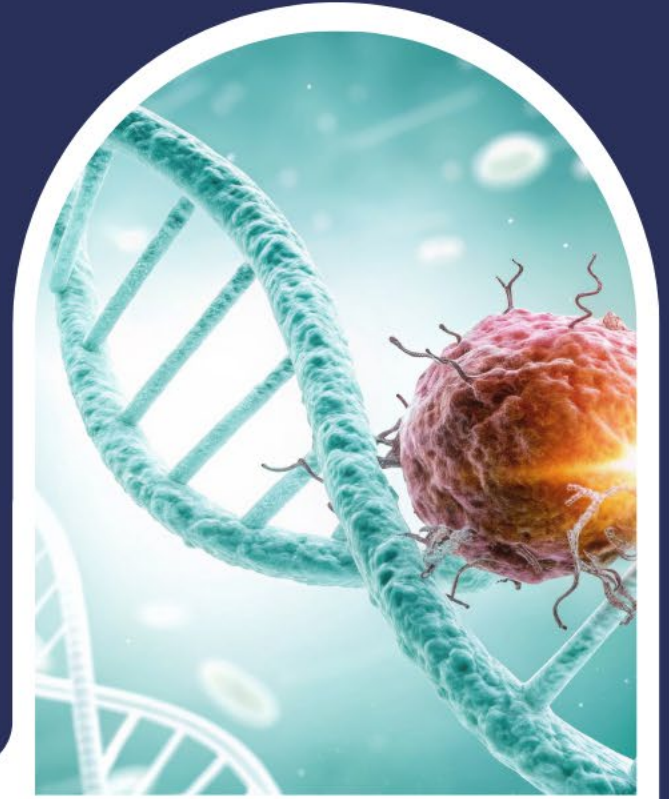
Conclusions

- Bevacizumab plus chemotherapy reasonable if patients have not been exposed
- Weekly taxane plus pembrolizumab or relacorilant are options in PROC
 - Relacorilant has a low discontinuation rate and no immune mediated side effects
 - Pembrolizumab can be given with bevacizumab



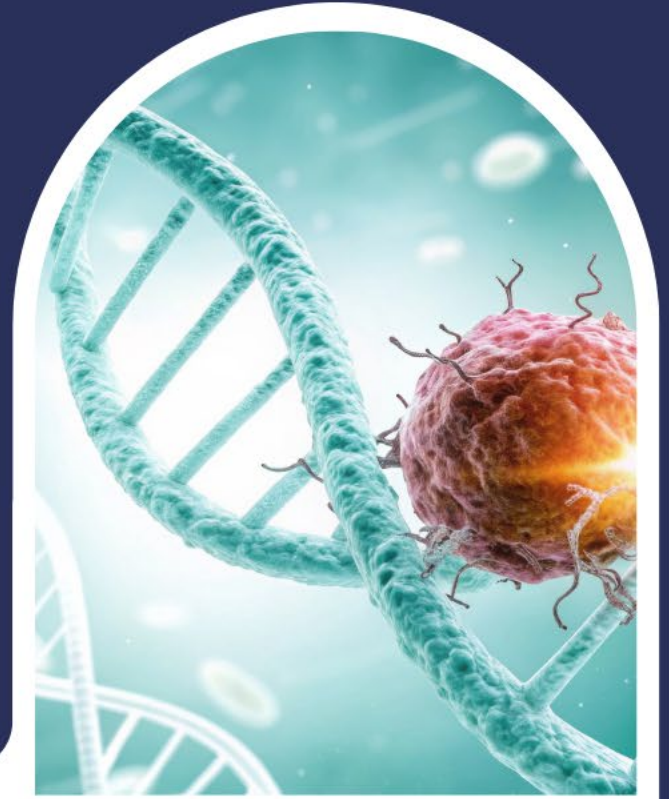
Interpreting New Phase 3 Evidence

All Faculty



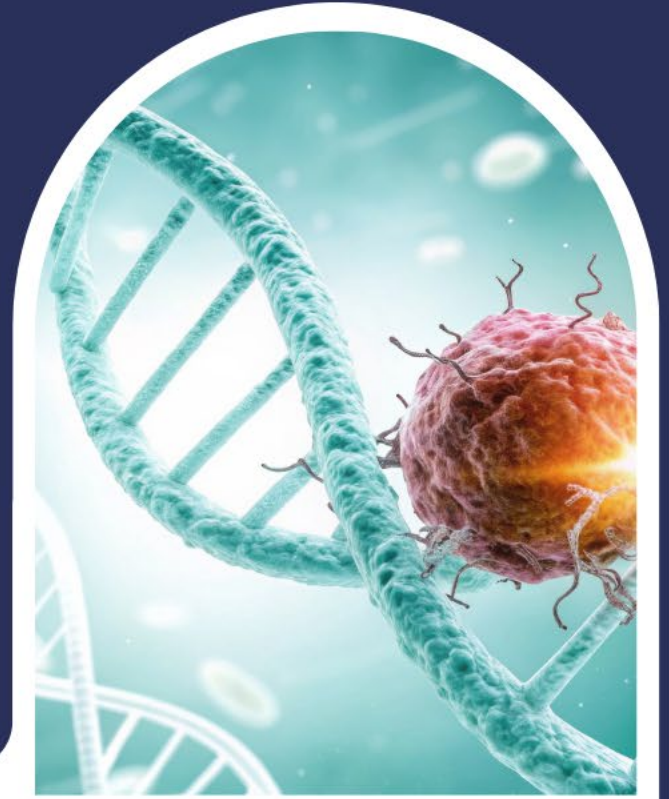
Case Based Application

All Faculty



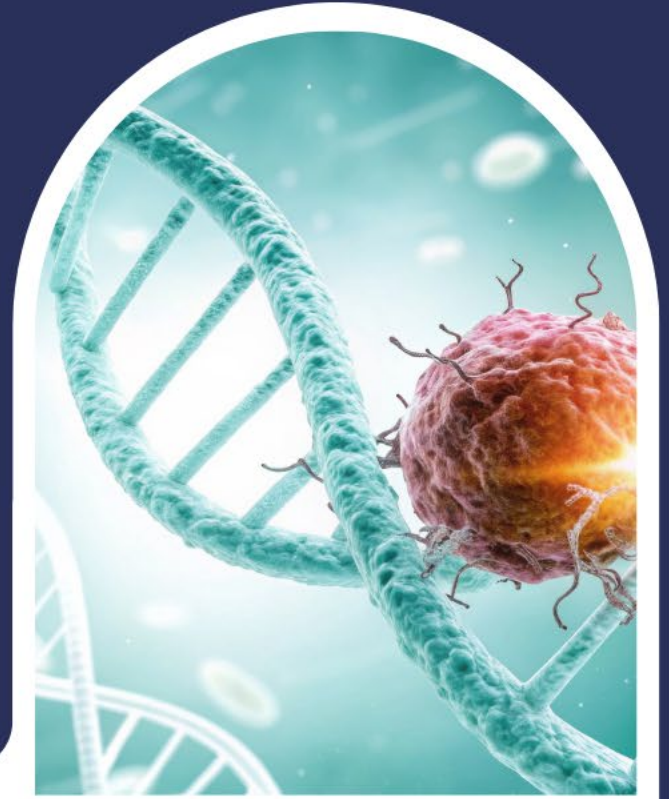
Clinical Case

- 58 yo Platinum Resistant HGSOc, PS 0
- HRD Test Negative
- Recurs 2.5 mo after Carboplatin Paclitaxel + Bev with multifocal pelvic & peritoneal nodules
- FOLR1 = 75% 2+
- CPS>1
- HER2 1+



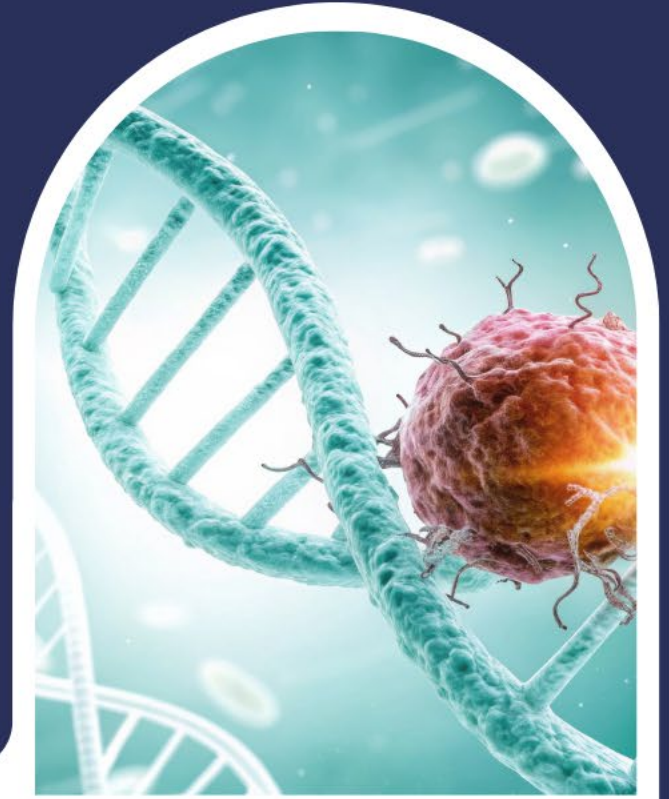
What would you do?...

1. Chemo +/- Bev
2. MIRV
3. Paclitaxel/Pembro +/- Bev
4. TDX-d
5. Relacorilant/Nab-Paclitaxel
6. Other



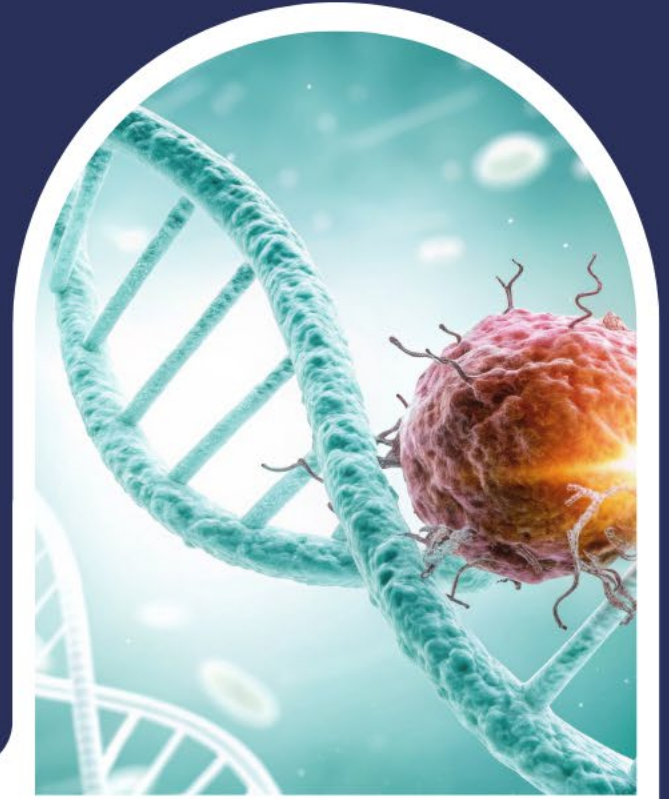
What if her recurrence presented with...

Large volume symptomatic ascites



What would you do?...

1. Chemo +/- Bev
2. MIRV
3. Paclitaxel/Pembro +/- Bev
4. TDX-d
5. Relacorilant/Nab-Paclitaxel
6. Other



Panel Q&A, Post Assessment

Thomas Herzog, MD

University of Cincinnati



GOG Continuing Education

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

Accreditation Statement

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

AMA PRA Category 1 Credits™

The GOG Foundation, Inc. designates this live activity for a maximum of 1.25 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Declaration

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. All relevant financial relationships listed for these individuals have been mitigated to ensure a bias-free presentation. Please see the faculty disclosure list for detailed information.

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



THANK YOU

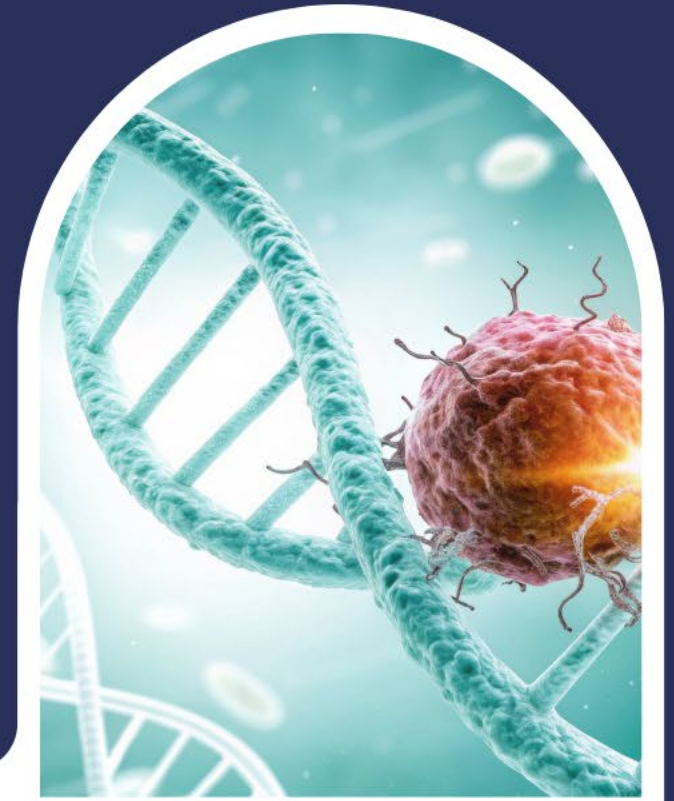
Corcept Therapeutics

**For Supporting This Activity With
An Independent Medical Education Grant**



Thank You

View this symposium on-demand at www.gog.org



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

CME for this Educational Symposium is provided by The GOG Foundation, Inc. Credit is available only for live, in-person attendance and completion of the activity evaluation. CME credit will not be awarded for virtual attendance or viewing of recorded materials.