2020 Target Therapy Forum

NTRK, BRAF, RET & MET Question and Answer Panel

Qualifying for a Clinical Trial

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Dr. Jacob Sands: So Justin, how often do you see patients that could enroll on a trial? So maybe, you know, someone has a, HER2 mutation, KRAS G12C mutation and they come in for a second opinion. They've already started on some kind of treatment. But that was on the panel. There just isn't a standard of care option, but there was a clinical trials option. Is that something that I imagine that must come up from time to time?

Dr. Justin Gainor: It does. So I think you raise the point, which is, okay. So, if we're looking outside of the seven targets for which we have approved therapies, and I'll pick up on the two that you just described HER2. Actually let's focus on HER2, cause I think that's a good example. So HER2 mutations you know, prior to this, so what goes into my decision-making is, you know so just because there's a mutation there you know, so we, is it a driver? So, for HER2, I would say, you know, depending on what the mutation is, but say let's pick the most common one the YVMA yes, that's a driver. If we know that that that's important. But then in terms of clinical trials, how promising is the clinical trial relative to what a standard of care option is?

So, you know, if you know, historically many of the, HER2 drugs you know, trying to use just targeted therapies has produced pretty, pretty low response rates. And in that era I would still fit even knowing it. I would still favor chemotherapy as a first-line treatment over some of those early targeted therapies, because the response rates we saw with some of those targeted therapies, there's less than 10%. More recently though, we've

seen with antibodies targeting HER2, we call them antibody, drug conjugates w we're now seeing, you know, response rates 60%. So for that then, you know, once you've established some, some data then you start having, you know, balancing that against the standard options. And then you can say, okay, here it makes a lot more sense, but it takes some understanding of what the data is already in order to match that against what you know, what the standard of care options are?

Dr. Jacob Sands: I think just a final word, it's a follow up actually, on what, on the point Dr. Gainor was making, is that just because there's an alteration doesn't mean that being on one of these treatments or clinical trials or being on one of these clinical trials is the right initial treatment, but it is worth just getting the information. And so getting broad panel testing is very important to knowing your options, and then you can make decisions based on that. And it's not always the first treatment, but it's good to be aware of what is out there. So making sure that you've gotten the broad testing and seeing a lung cancer specialist can also be really valuable to just knowing what options and what the landscape looks like going forward.