Fred Hutch
Cancer Center

Chronic Lymphocytic Leukemia
and
Hairy Cell Leukemia

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Disclosures

Consulting, advisory boards, steering committees or data safety monitoring committees: Abbvie, Genentech, AstraZeneca, Genmab, Janssen, BeOne Medicines, Bristol Myers Squibb, Morphosys/Incyte, Kite Pharma, Eli Lilly, Fate therapeutics, Nurix, Pierre Fabre, Pfizer , Legend Bio and Merck.

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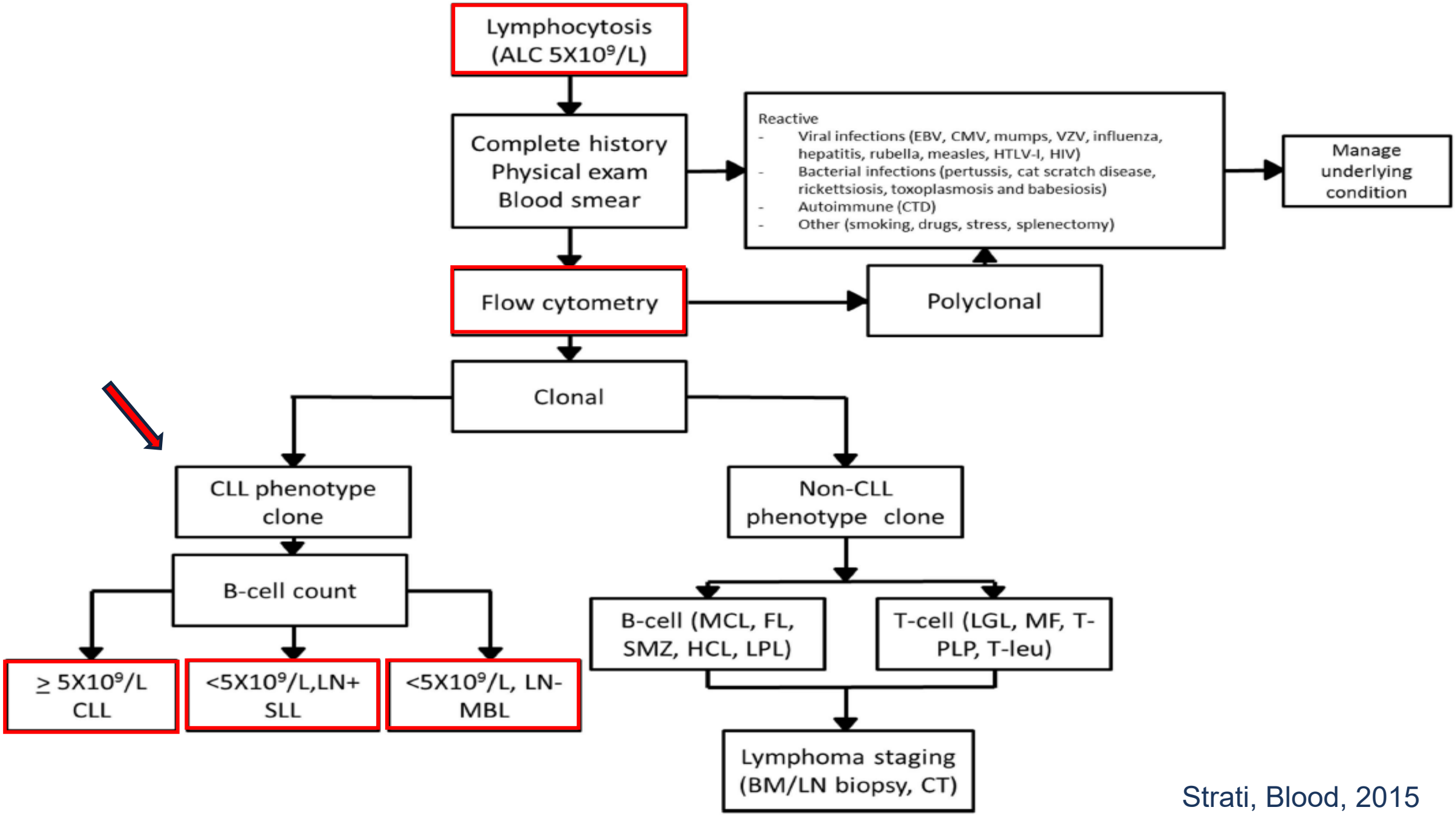
Stock options: Koi Biotherapeutics.

CLL/SLL

Epidemiology

- CLL/SLL is the most common leukemia in adults in western countries
  - 4.5 cases per 100,000
- Median age ~ 70 years
- Slight male predominance (1.7:1)
- Familial risk (7-8 fold)
- Caucasians > African Americans > Asian Pacific Islanders
- Genetic > Environmental

Initial diagnosis and appropriate work-up



Strati, Blood, 2015

Immunophenotypic Features

	CD5	CD10	CD23	CD103	BCL6	CD20	Cyclin D1
CLL/SLL	+	-	+	-	-	+ (weak)	-

Immunophenotypic Features

	CD5	CD10	CD23	CD103	BCL6	CD20	Cyclin D1
CLL/SLL	+	-	+	-	-	+ (weak)	-
MCL	+	-	-	-	-	+	+
LPL	-	-	-	-	-	+	-
sMZL	-	-	-	-	-	+	-
FL	-	+/-	-/+	-	+	+	-
HCL	-	-	-	+	-	+	+/-

	CD23	Cyclin D1	t(11,14)
CLL/SLL	+	-	-
MCL	-	+	+

MBL (monoclonal B cell lymphocytosis)

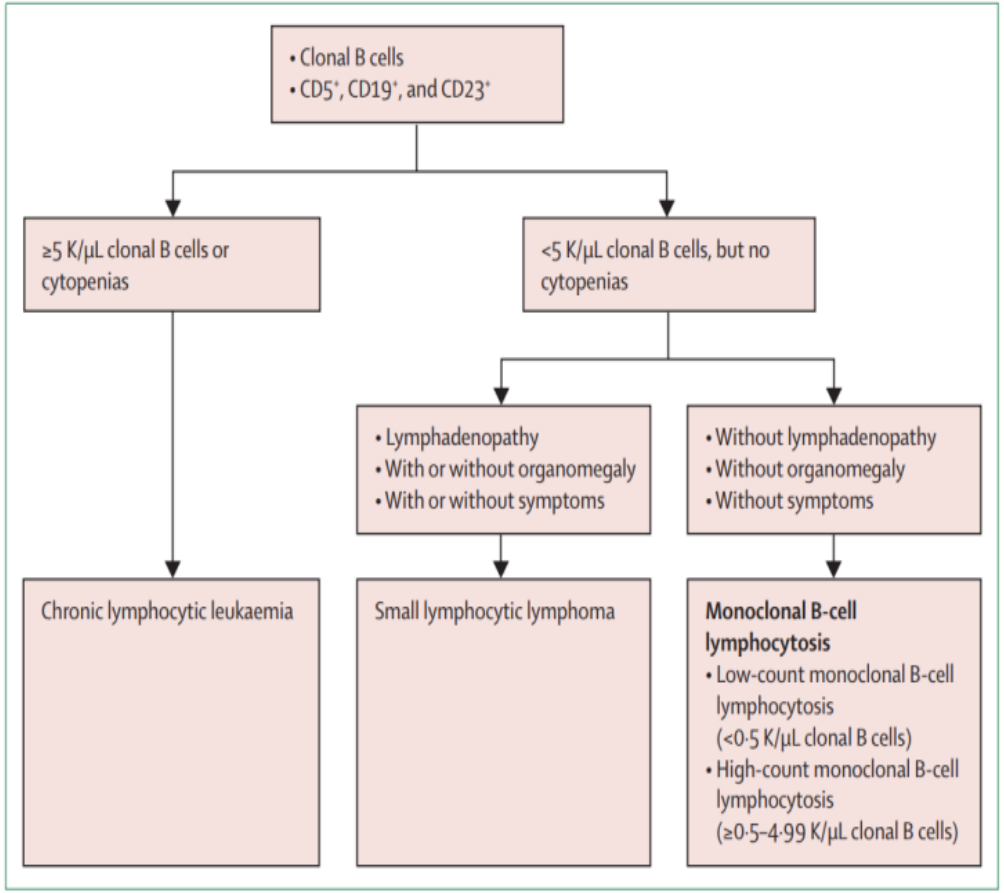
- < 5x 10^9/L monoclonal B- cells in the PB AND no lymphadenopathy

- Almost all cases of CLL are preceded by MBL but only a small percentage of persons with MBL will ultimately develop CLL

- **Low-count MBL (< 0.5x 10^9/L) ➔ rarely progresses to CLL**
  - No need for hematology follow-up
  - Higher risk for serious infections
  - OS similar to general population
- **High-count MBL (0.5-4.9 x 10^9/L) ➔ progresses to CLL at a rate of 1-2% /year**
  - CLL-IPI can predict the risk
  - Higher risk for serious infections and secondary malignancies
  - OS similar to general population

- Up to 17 percent of first-degree family members of patients with CLL were found by flow cytometry to have MBL

- **Screening of family members is NOT recommended**



Jain, Lancet, 2024

WHO-HAEM5 Terminology

- **Monoclonal B-cell lymphocytosis (MBL)**
  - **Low-count MBL or clonal B-cell expansion**: clonal CLL/SLL phenotype B-cell count <0.5 x 10^9 /L with no other features diagnostic of B-lymphoproliferative disorder
  - **CLL/SLL-type MBL**: monoclonal CLL/SLL-phenotype B-cell count ≥0.5 x 10^9 /L and total B-cell count less than 5 x 10^9 /L with no other features diagnostic of CLL/SLL
  - **Non-CLL/SLL-type MBL**: ANY monoclonal non-CLL/SLL phenotype B-cell expansion with no symptoms or features diagnostic of another mature B-cell neoplasm (majority of cases have features consistent with MZL)
- **Chronic lymphocytic leukemia (CLL)**:
  - Monoclonal CLL/SLL-phenotype B-cell count ≥5 x 10^9 /L
  - Cytopenias with marrow infiltration even if monoclonal CLL/SLL-phenotype B-cell count <5 x 10^9 /L
- **Small lymphocytic lymphoma (SLL)**: Monoclonal CLL/SLL-phenotype B-cell count < 5 x 10^9 /L but with evidence of lymphadenopathy
- **B-prolymphocytic leukemia (B-PLL)** is no longer recognized in WHO-HAEM5 in view of its heterogeneous nature.
- **Richter Transformation**: CLL ➔NHL or CLL➔ HL. The term is recommended over “Richter Syndrome”

Alaggio, Leukemia, 2022

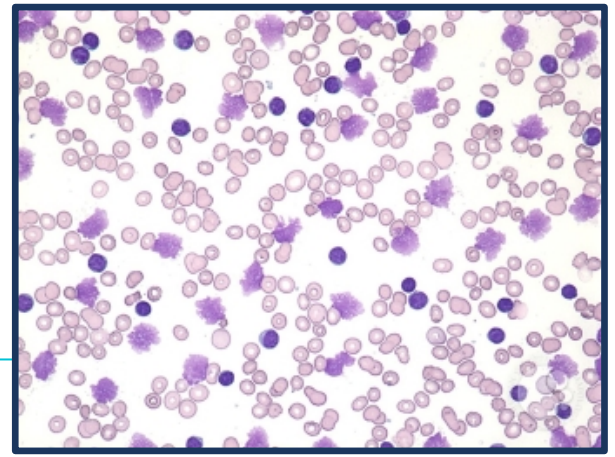
Diagnosis

- **Flow cytometry** of **blood** is **essential and adequate** to make the diagnosis
- Biopsy may be needed if PB flow cytometry is not conclusive
- Cytogenetic and molecular studies are informative for prognostic and/or therapy determination .
- Baseline CT scan (or PET) is **NOT** required for asymptomatic patients

  (The ASH "Choosing Wisely" List)

American Society of Hematology
Helping hematologists conquer blood diseases worldwide

American Board of Internal Medicine



Prognostic and predictive markers

Staging for CLL

Rai staging			Binet staging	
Stage	Risk category	Findings	Stage	Findings
0	Low	Lymphocytosis[a]	A	No cytopenia and ≤2 lymphoid area involvement
1	Intermediate	Lymphadenopathy[b]	B	No cytopenia and >3 lymphoid area involvement
2	Intermediate	Hepatosplenomegaly[b]	C	Presence of anemia or thrombocytopenia
3	High	Anemia[c]		
4	High	Thrombocytopenia[d]		

[a] Lymphocyte count greater than 5×10^9/L.

[b] On physical examination.

[c] Hemoglobin level less than 11 g/dL.

[d] Platelet count less than 100 000/μL

Use Ann Arbor staging for SLL

Molecular Biomarkers for CLL

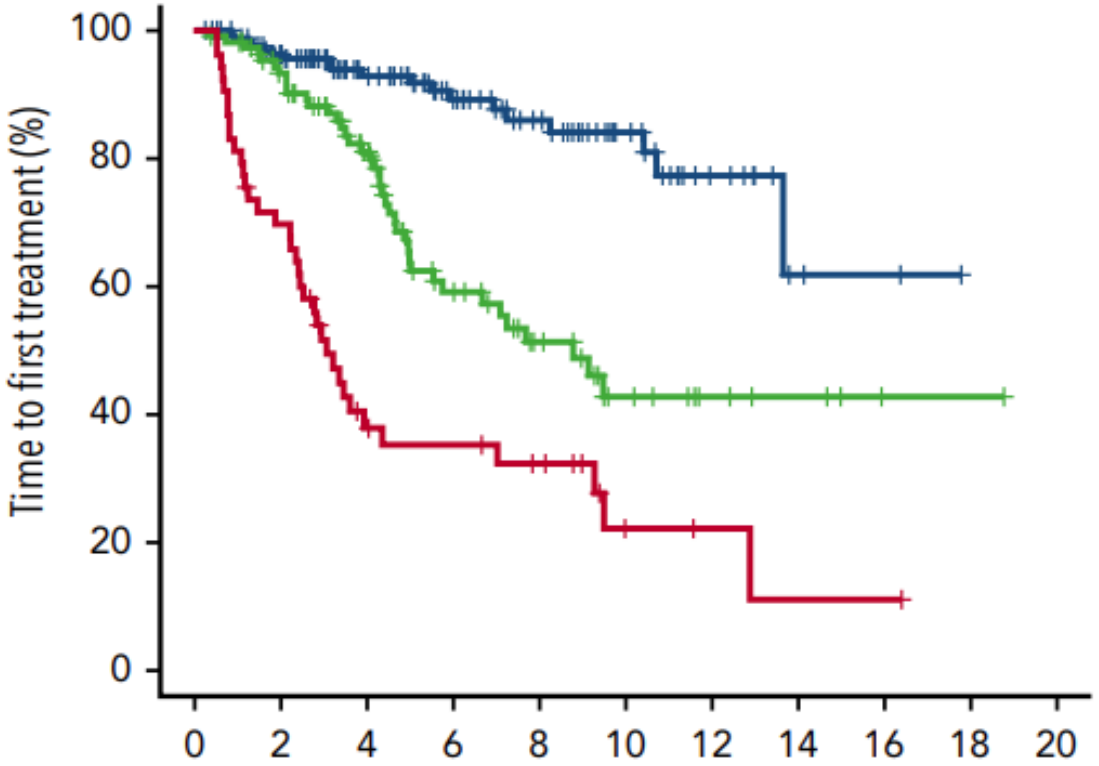
	FISH	Karyotype	Mutations
Unfavorable	del (17p) del (11q)	Complex (>3 abnormalities) (> 5?)	TP53 unmutated IGHV (≤ 2%) * NOTCH-1 SF3B1 BIRC3 ATM
Neutral	Normal +12		
Favorable	del (13q) (sole abnormality)		mutated IGVH (>2%)

* If chemotherapy is used

Time to first treatment (TTFT): IPS-ES

Variable	Point
Unmutated IGHV	1
ALC > 15 x 10^9/L	1
Palpable lymph node	1

Risk category	Score	5-year cumulative risk for treatment start
Low risk	0	8.4%
Intermediate risk	1	28.4%
High risk	2-3	61.2%



Condoluci, Blood, 2020

Impact of Recurrent Gene Mutations on Time to First Treatment

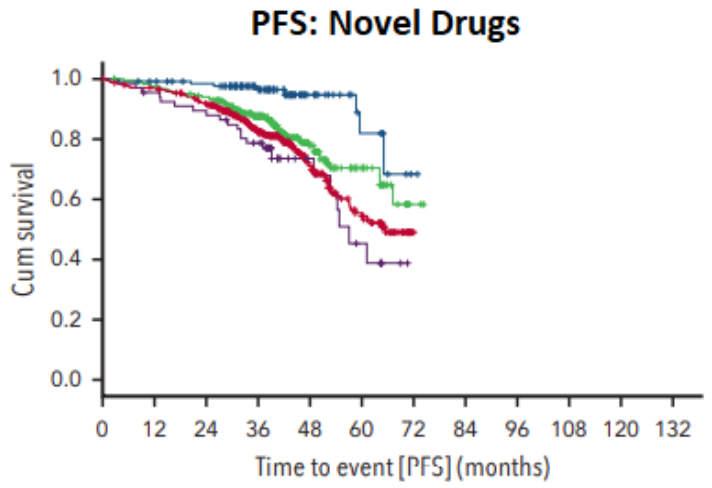
Predictors of shorter time from diagnosis to first treatment

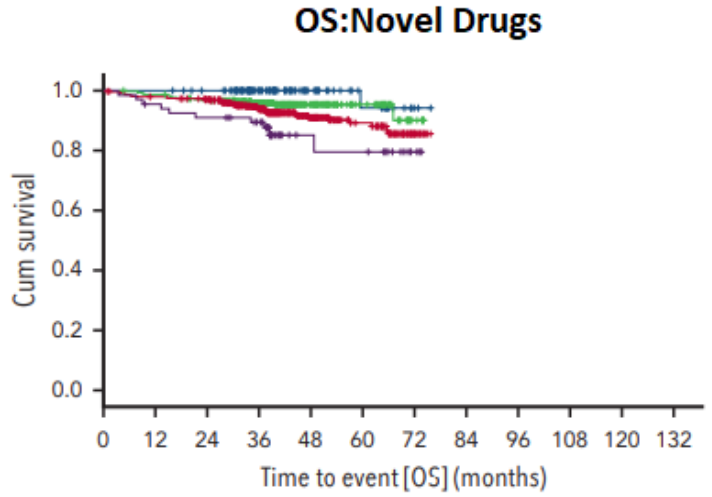
	SF3B1	XPO1	NOTCH1	NFKBIE	TP53	BIRC3	EGR2
Mutated IGHV	X	X	X	X			
Unmutated IGHV	X	X			X	X	X

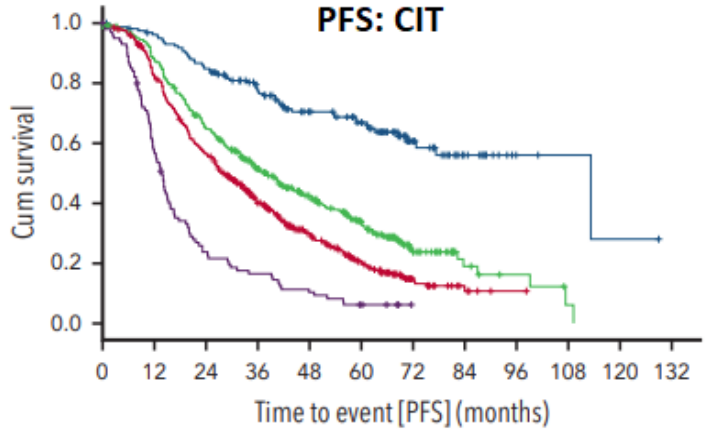
Prognostic Models: CLL-IPI

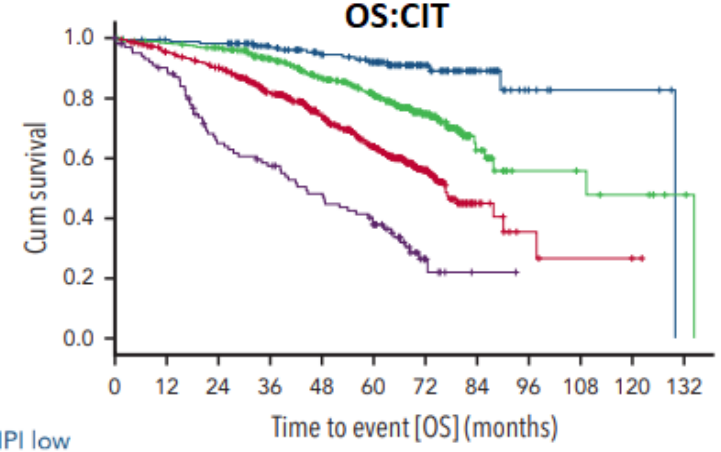
Characteristic	Points
Del(17p) or TP53 mutation	4
Serum beta-2-macroglobulin ≥ 3.5mg/L	2
Un-mutated IgVH	2
Rai Stage I-IV	1
Age > 65 years	1

Points	Risk Group	5-y OS (%)	10-yr OS (%)
0-1	Low	93	79
2-3	Int	79	39
4-6	High	63	22
7-10	Very High	23	4









CLL-IPI low
CLL-IPI intermediate
CLL-IPI high
CLL-IPI very high

Langerbeins, Blood, 2024

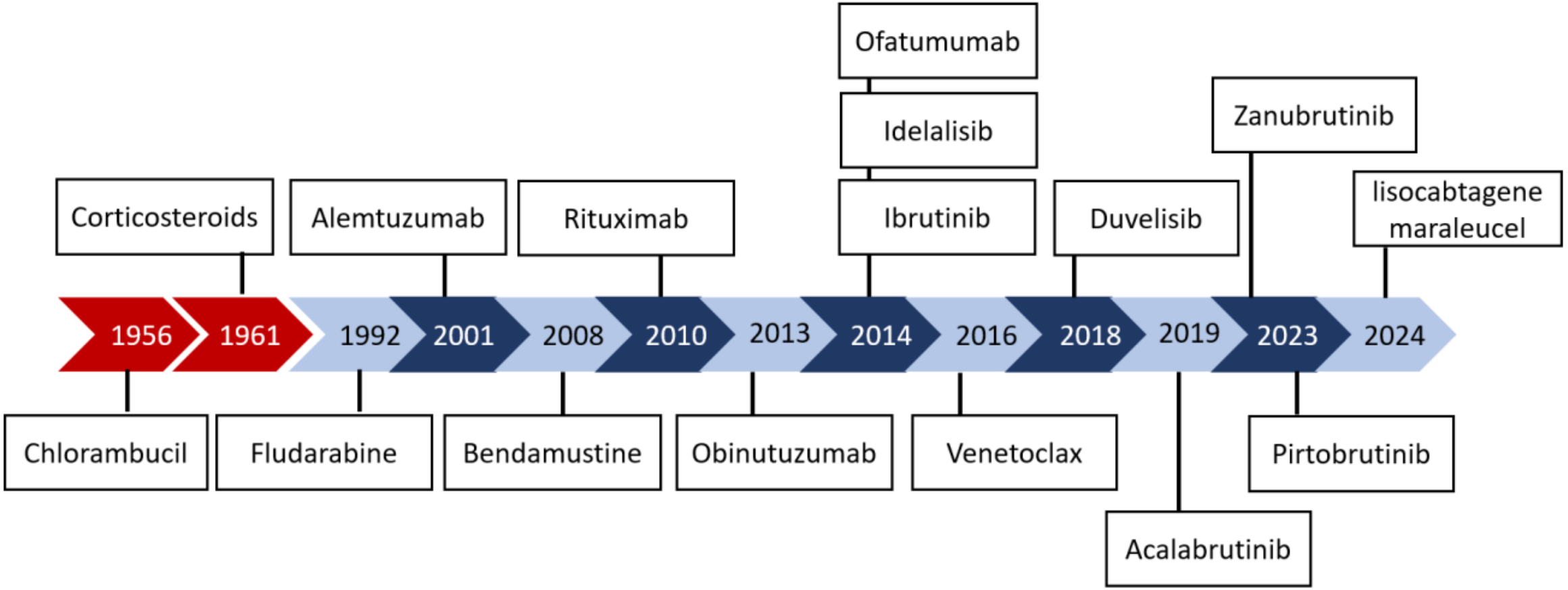
Supportive Care

Supportive Care Recommendations

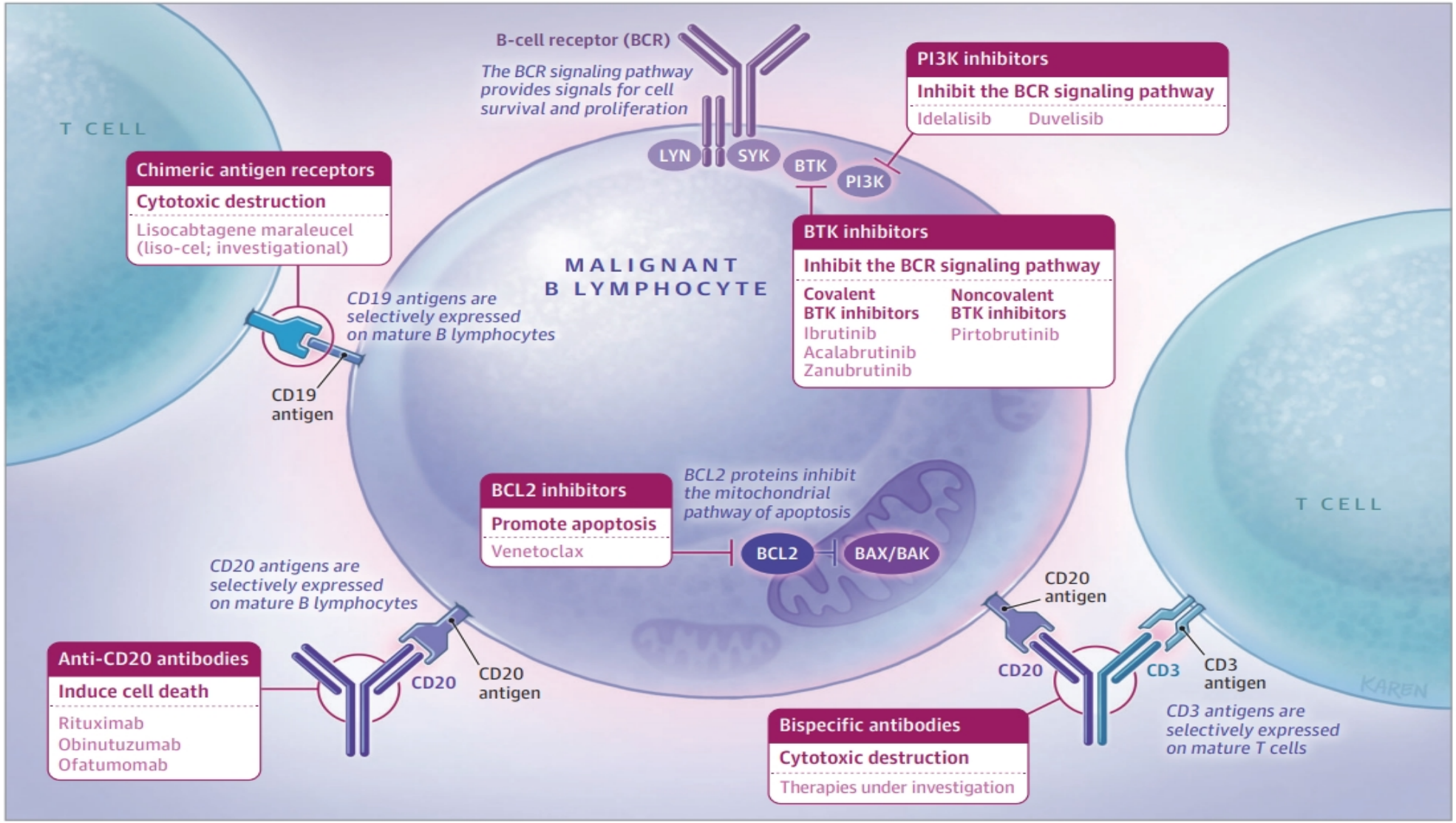
- Avoid live vaccines
- Patients should receive annual influenza vaccine and recombinant zoster vaccine
- The 20-valent pneumococcal conjugate vaccine (PCV20) is recommended in previously unvaccinated patients or those with prior receipt of 23-valent pneumococcal polysaccharide vaccine (PPSV23), 1 year apart
- Patients should be informed that their immune response to vaccinations is lower than that of the general population For COVID-19 vaccination, follow the Centers for Disease Control and Prevention recommendations for patients with moderate and severe immunocompromised state, and protective measures should be continued in high-risk conditions such as viral pandemics
- Patients with frequent sinus or lung infections who have hypogammaglobulinemia (IgG level <500 mg/dL) benefit from intravenous immunoglobulin infusions every 6 to 8 weeks if the levels remain low
- Age-specific cancer screening guidelines should be followed in patients with CLL
- Patients with CLL have a higher risk for recurrence of basal cell carcinoma and squamous cell carcinoma of skin compared with those without CLL; routine examinations and skin protection measures are recommended
- There is no indication for screening or genetic testing in family members

Important therapeutic agents for CLL

Treatment Options for CLL/SLL



Therapeutic Agents for CLL



Shadman, JAMA,2023

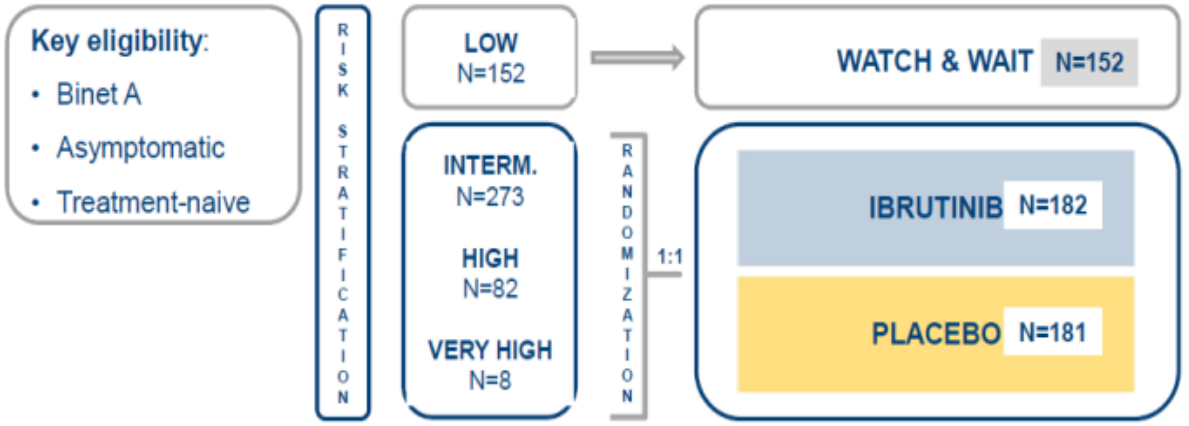
Who needs to be treated?

Indications for treatment

- Progressive marrow failure
- Massive , progressive or symptomatic lymphadenopathy or organomegaly
- Constitutional symptoms
- Autoimmune anemia and/or thrombocytopenia that is poorly responsive to corticosteroids or other standard therapy
- ~~Lymphocyte doubling time~~

Is there a role for early intervention in “high-risk” patients?

CLL-12 Study – Early intervention with Ibrutinib



Phase 3, placebo-controlled, double-blind, multicenter trial

Primary endpoint EFS: time from randomization until symptomtatic PD, new treatment, death

Secondary endpoints: survival, PFS, TFS, TTNT, ORR, safety

π_2 : median EFS from 24 to 48 months with ibrutinib (superiority test)

- **EFS, PFS, and TTNT :** Improved with ibrutinib
- **OS**: No difference (HR, 0.791; 95% CI, 0.358-1.748; *P* = .562)

Early intervention with ibrutinib is NOT recommended

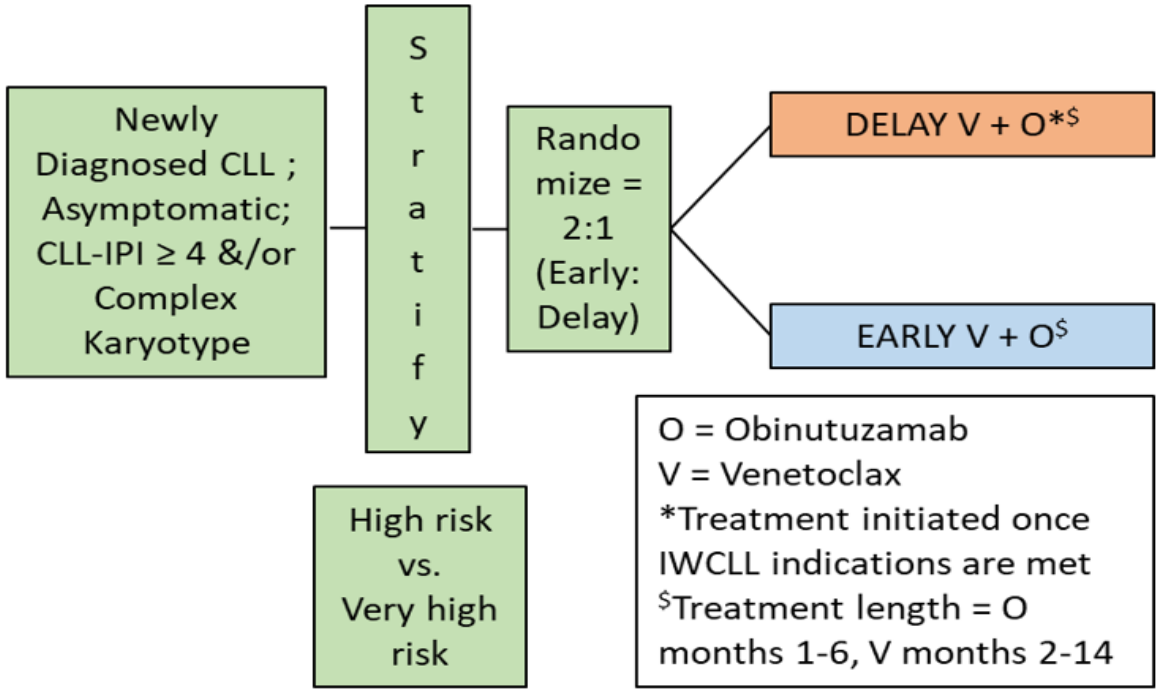
Langerbeins, Lugano (17-ICML) meeting , 2023

Ongoing US Intergroups Early Intervention Trial

CLL-IPI

Characteristic	Points
Del(17p) or TP53 mutation	4
Serum beta-2-macroglobulin ≥ 3.5mg/L	2
Un-mutated IgVH	2
Rai Stage I-IV	1
Age > 65 years	1

Points	Risk Group
0-1	Low
2-3	Int
4-6	High
7-10	Very High

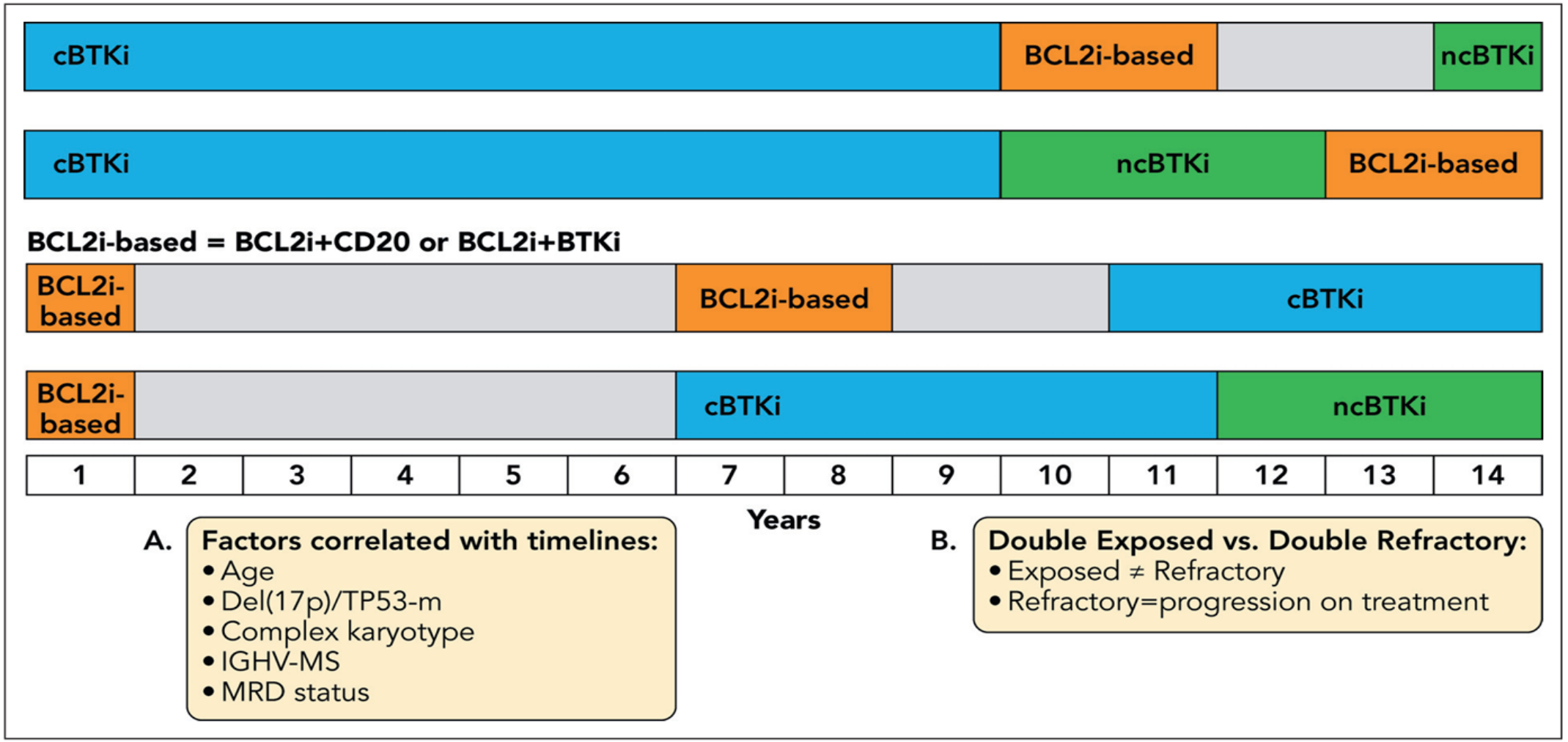


Primary Endpoint: Overall Survival

Open 2020

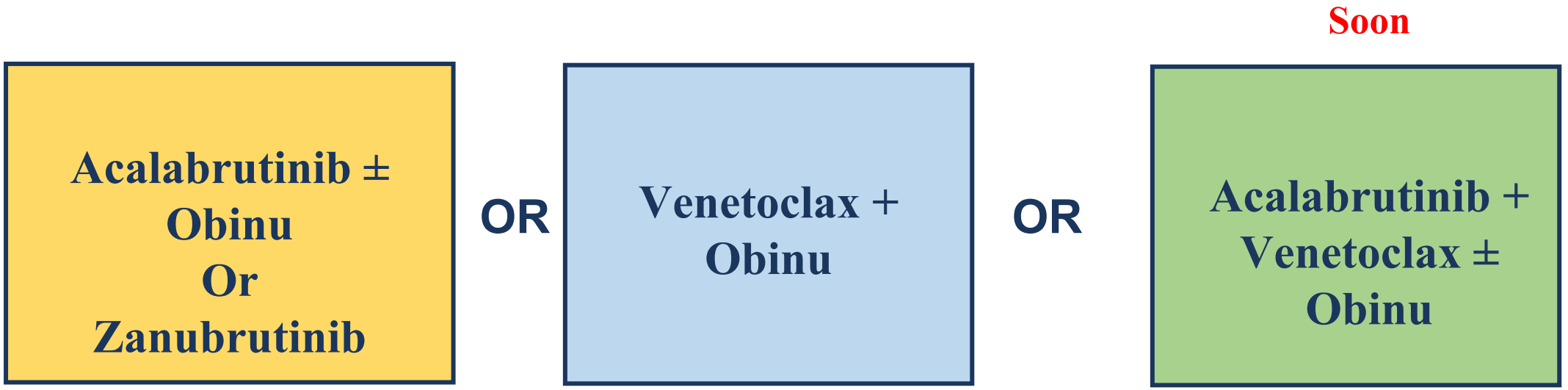
Treatment Strategy and Recommendations for treatment-naïve patients

Treatment Strategies in CLL/SLL



Wierda, et al, Blood, 2025

First line treatment: for patients with normal TP53

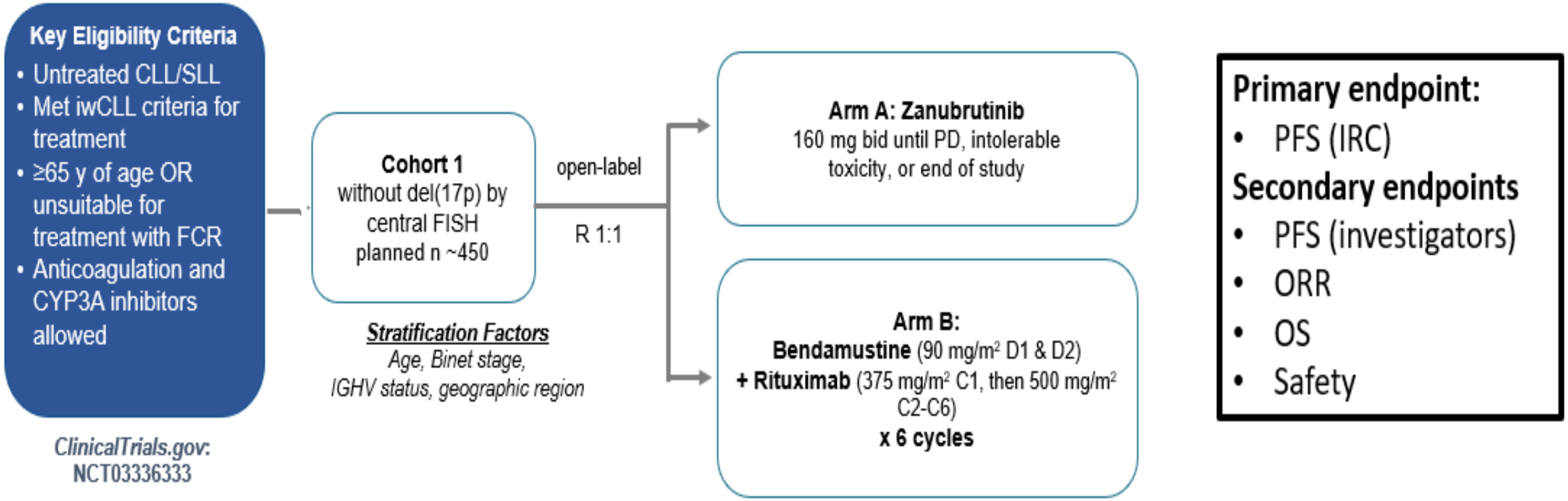


Novel agents are superior to CIT in first line

Study	Investigational arm	Control arm	Primary endpoint	Winner
E1912	Ibrutinib + R	FCR	PFS	**Ibrutinib + R**
A041202	Ibrutinib ± R	BR	PFS	**Ibrutinib ± R**
Amplify	Acalabrutinib + Venetoclax ± G	FCR/BR	PFS	**Acalabrutinib + Venetoclax ± G**
Sequoia	Zanubrutinib	BR	PFS	**Zanubrutinib**
Elevate TN	Acalabrutinib ± G	Chl+G	PFS	**Acalabrutinib ± G**
CLL14	Venetoclax + G	Chl+G	PFS	**Venetoclax + G**
Glow	Ibrutinib + Venetoclax	Chl+G	PFS	**Ibrutinib + Venetoclax**

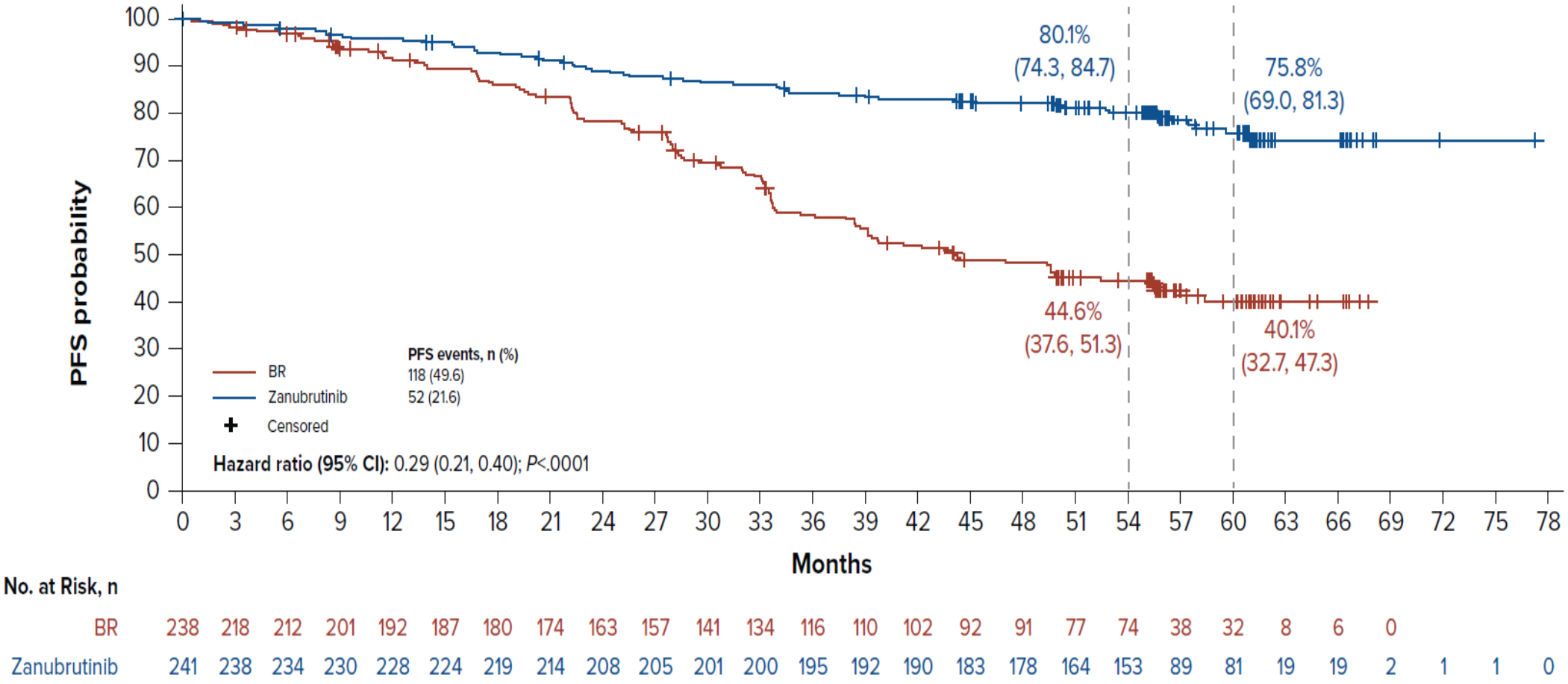
CIT=chemoimmunotherapy ; G = Obinutuzumab; R = rituximab

Zanubrutinib vs. BR (SEQUOIA)



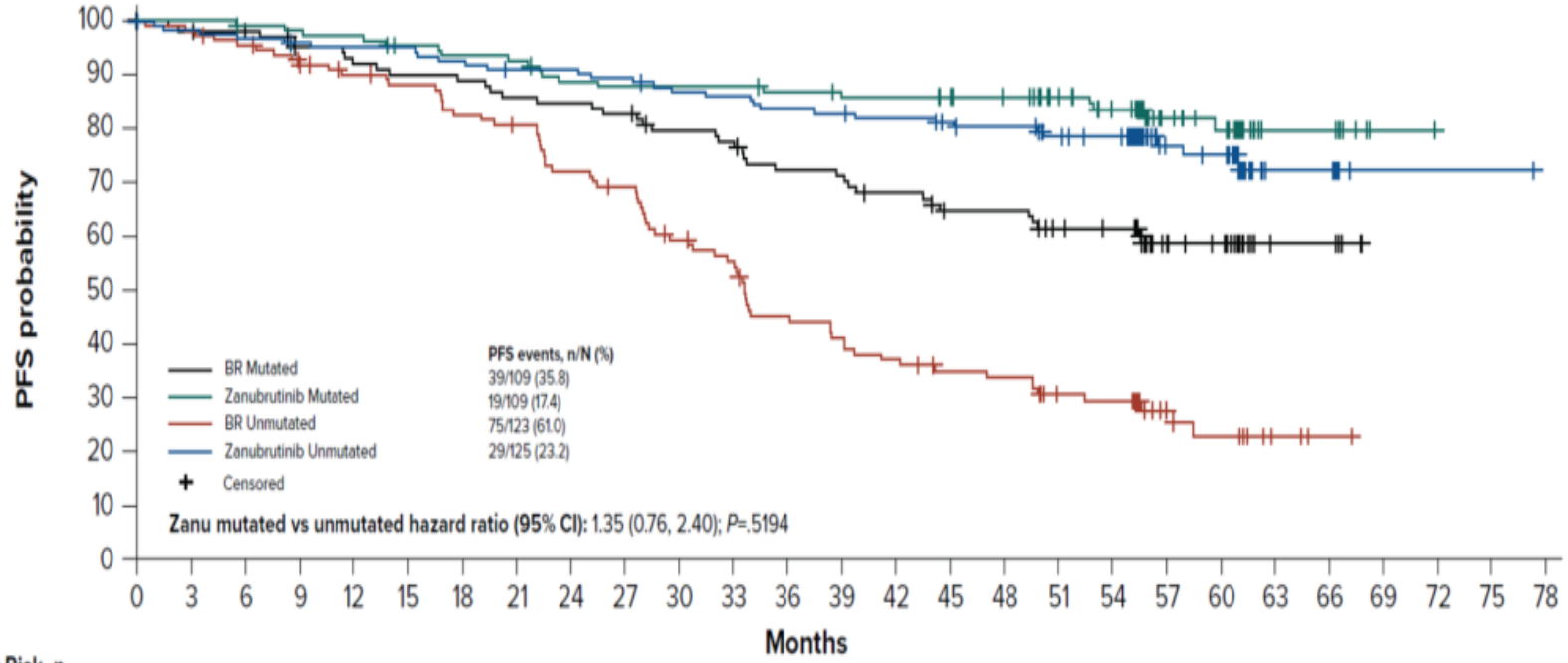
Shadman M, et al, JCO, 2025

Zanubrutinib vs. BR (SEQUOIA)



Shadman M, et al, JCO, 2024

Zanubrutinib vs. BR (SEQUOIA)

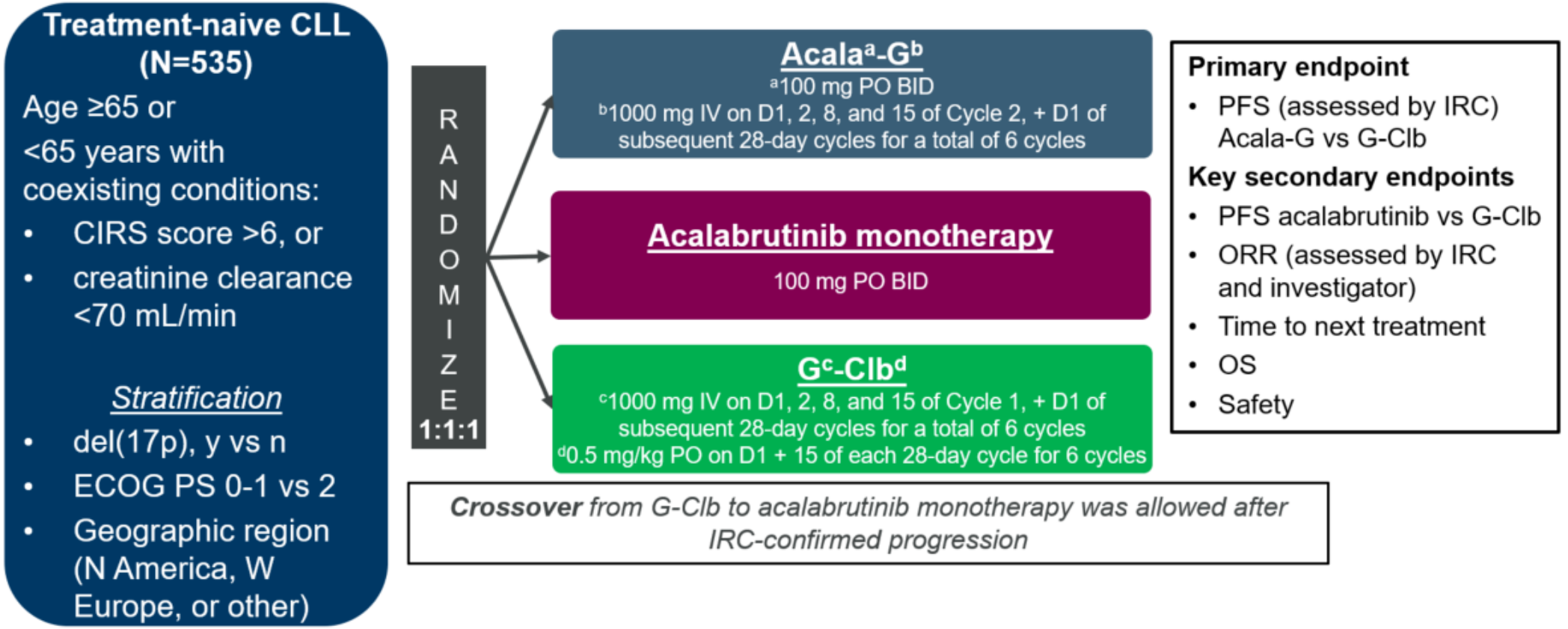


No. at Risk, n																									
BR Mutated	109	100	98	93	90	88	87	84	83	81	76	74	68	67	63	58	58	52	50	25	22	5	5	0	
Zanubrutinib Mutated	109	109	107	106	105	101	99	98	93	92	92	92	90	88	88	86	83	77	69	41	36	11	11	1	0
BR Unmutated	123	112	108	102	96	93	87	84	75	71	60	55	44	40	36	32	31	24	23	12	9	3	1	0	
Zanubrutinib Unmutated	125	122	120	118	117	117	114	111	111	109	105	104	101	100	98	93	91	84	81	45	43	8	8	1	1	1	0

- **Continued favorable safety profile**
- **Superior to BT irrespective of IGHV**
- **CR/CRi rate ~ 21%**

Shadman M, et al, JCO, 2024

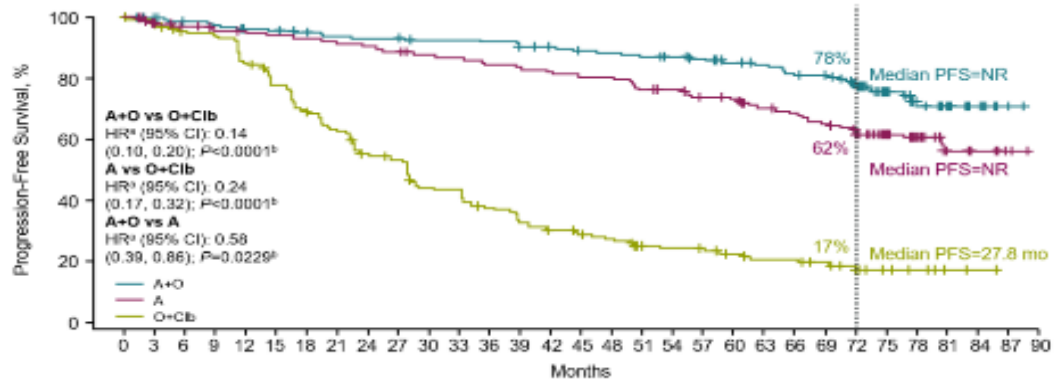
Acalabrutinib ± O vs. CHL+O:(ELEVATE TN)



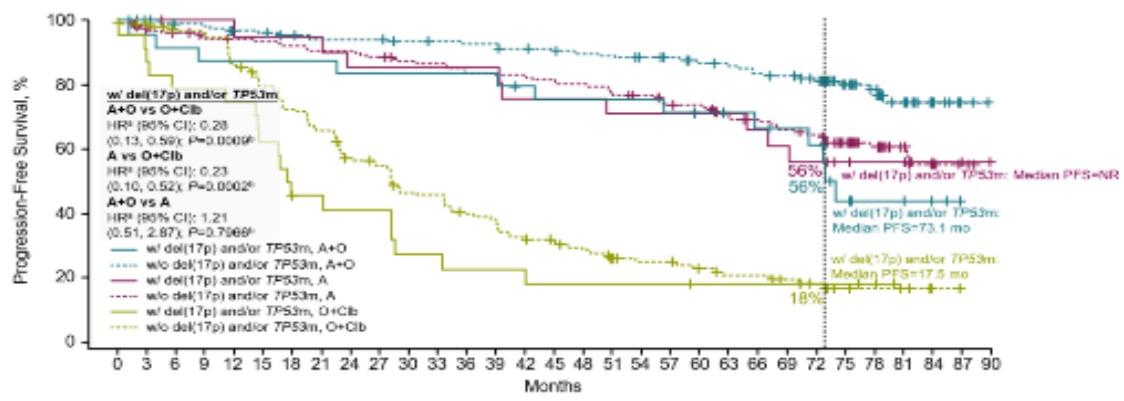
Sharman et. al, Blood, 2025

Acalabrutinib ± O vs Clb + O: ELEVATE-TN – 6-Year Update

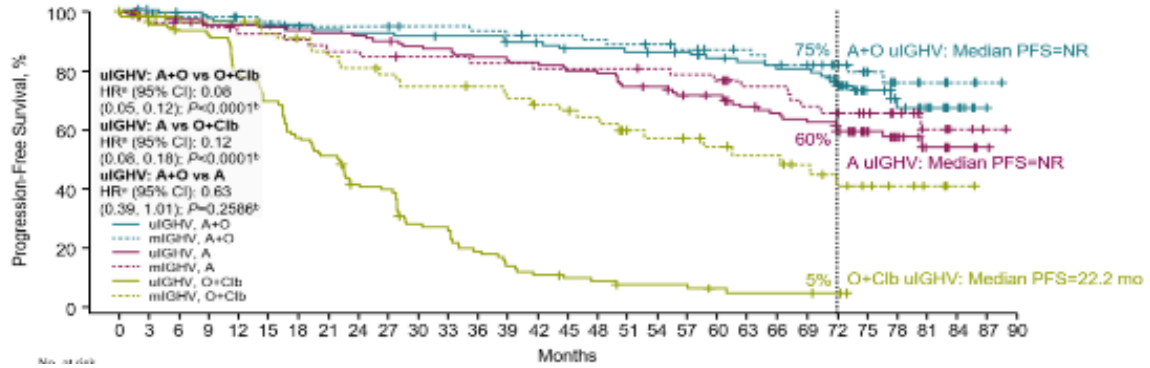
INV-Assessed PFS (median follow-up: 74.5 months)



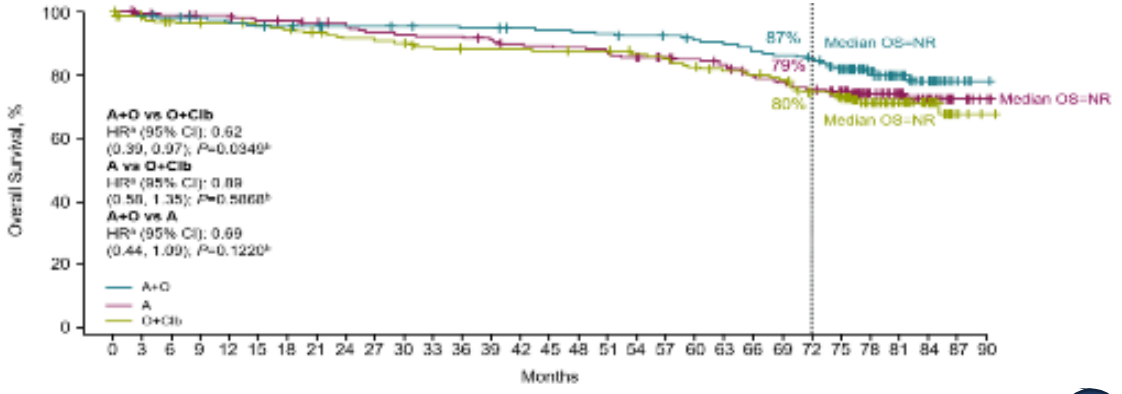
INV-Assessed PFS in Del(17p) and/or *TP53* Mutated



INV-Assessed PFS in Unmutated *IGHV*

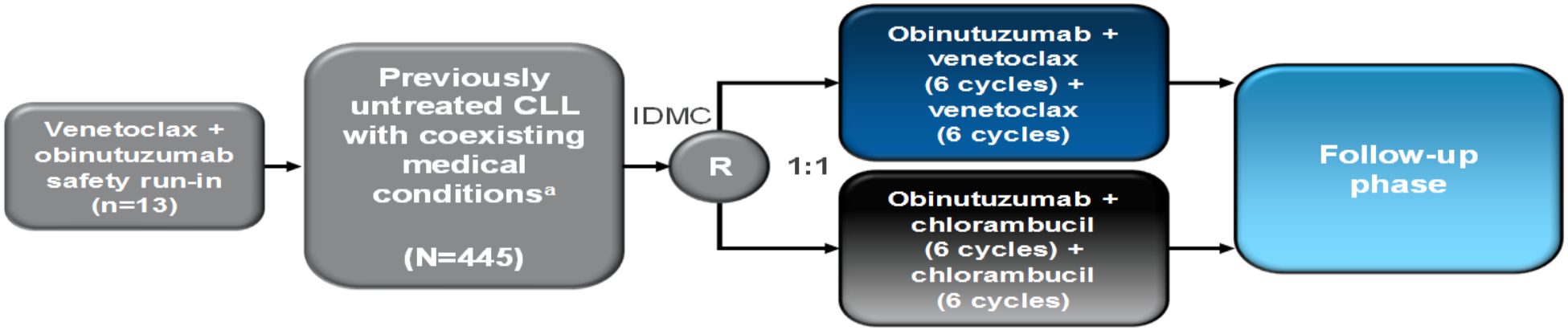


Overall Survival



Sharman et. al, Blood, 2025

Venetoclax + O vs CHL + O: (CLL-14)



Primary endpoint:

- PFS as assessed by investigator[3]

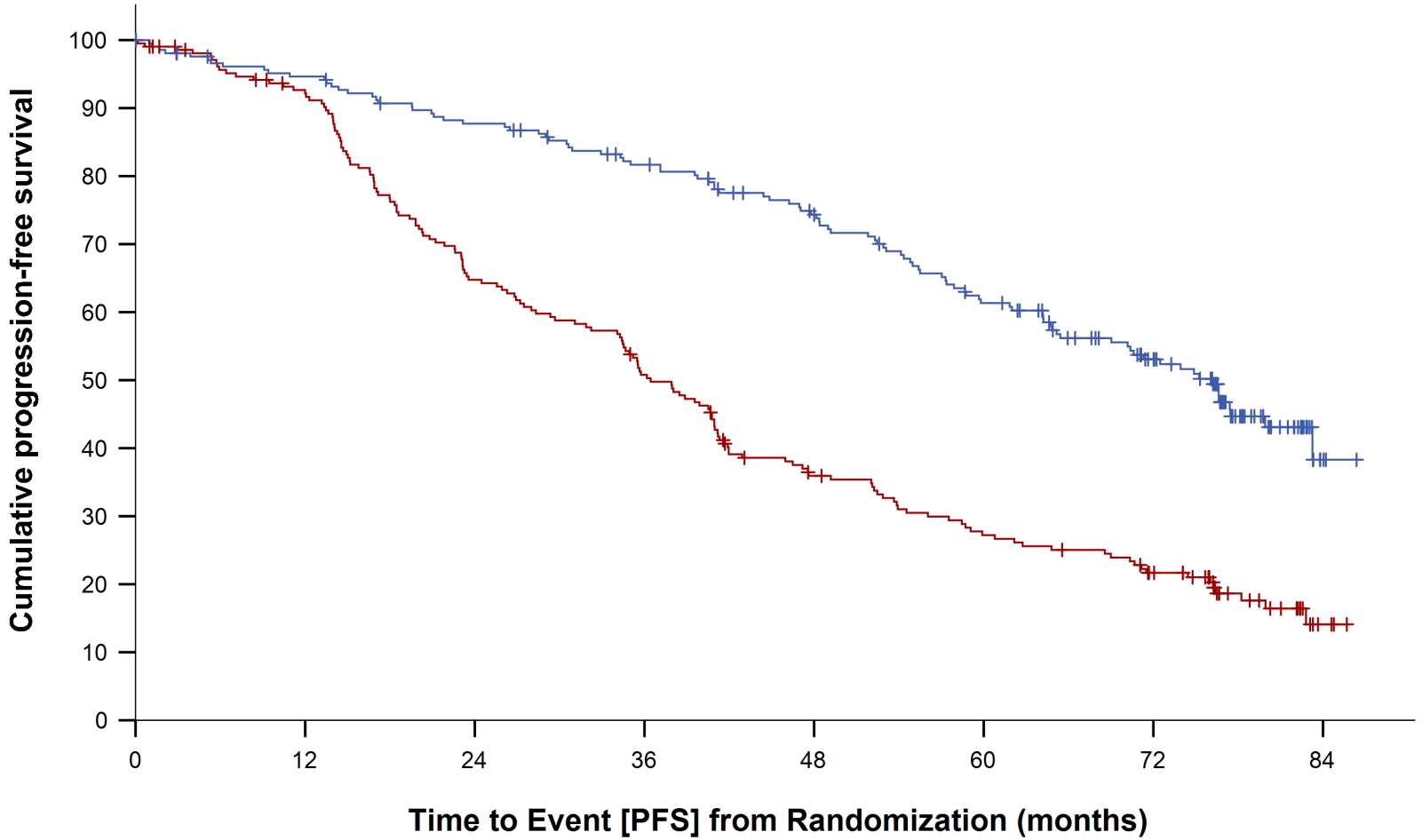
Secondary endpoints[3]:

- PFS as assessed by IRC
- MRD
- ORR
- CR rate
- DOR
- EFS
- OS
- TTNT
- Safety

[a]CIRS >6 and/or CrCl <70 mL/min

Al-Sawaf et. al, Blood, 2024

Venetoclax + O vs Clb + O: CLL-14 – 6-Year Follow-Up



Ven-Obi	216	193	177	160	139	112	79	3
Clb-Obi	216	185	130	101	67	50	36	3

Median PFS
Ven-Obi: 76.2 months
Clb-Obi: 36.4 months

6-year PFS rate
Ven-Obi: 53.1%
Clb-Obi: 21.7%

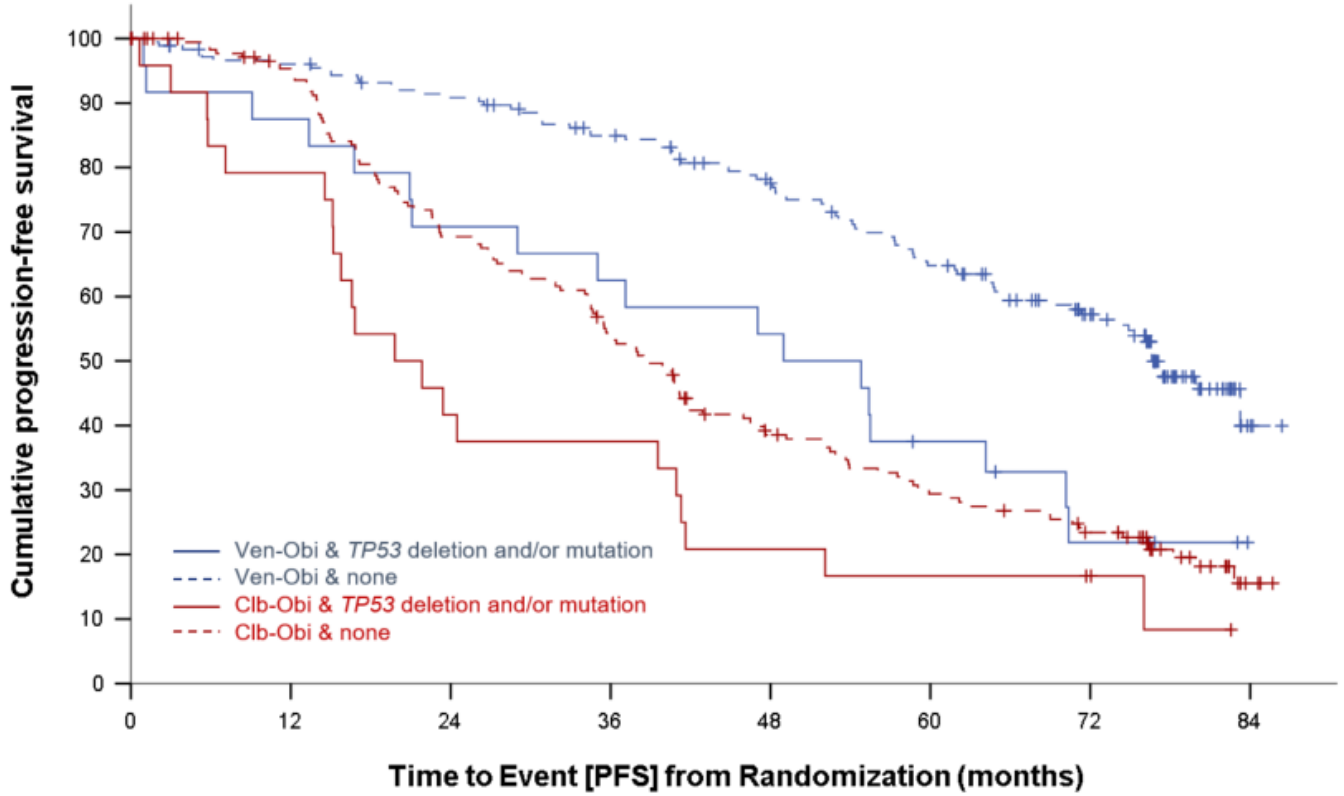
HR 0.40, 95% CI (0.31–0.52)
P <.0001

Al-Sawaf et. al, Blood, 2024

Venetoclax + O vs Clb + O: CLL-14 – 6-Year Follow-Up

PROGRESSION-FREE SURVIVAL – *TP53* status

Median observation time 76.4 months



Median PFS

Ven-Obi & no *TP53*del/mut: 76.6 m

Ven-Obi & *TP53*del/mut: 51.9 m

HR 2.29, 95% CI [1.37-3.83], p=0.001

Clb-Obi & no *TP53*del/mut: 38.9 m

Clb-Obi & *TP53*del/mut: 20.8 m

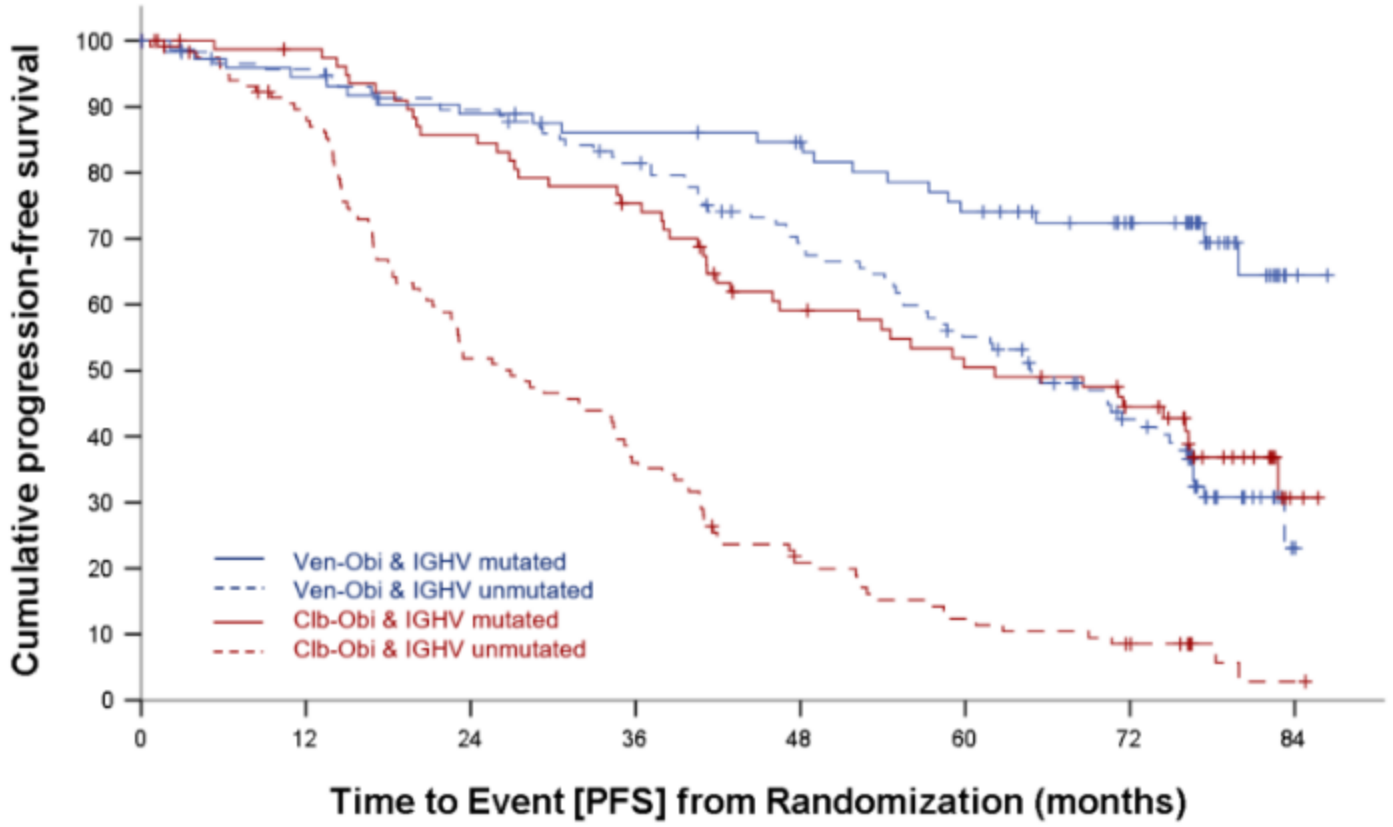
HR 1.66, 95% CI [1.05-2.63], p=0.03

Al-Sawaf et. al, Blood, 2024

Venetoclax + O vs Clb + O: CLL-14 – 6-Year Follow-Up

PROGRESSION-FREE SURVIVAL – IGHV status

Median observation time 76.4 months



Median PFS

Ven-Obi & IGHVmut: NR

Ven-Obi & IGHVunmut: 64.8 m

HR 0.38, 95%CI [0.23-0.61], p<0.001

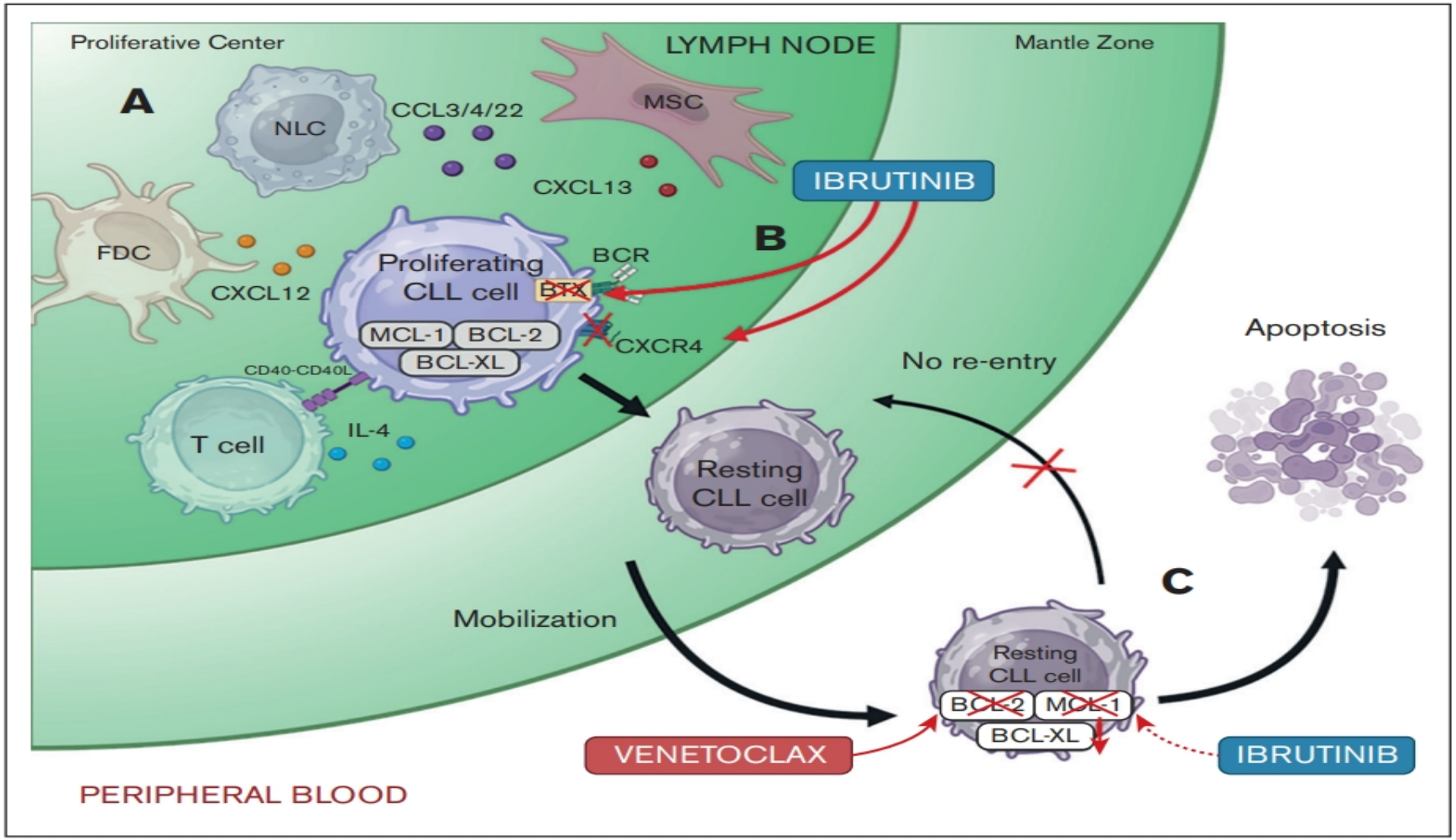
Clb-Obi & IGHVmut: 62.2 m

Clb-Obi & IGHVunmut: 26.9 m

HR 0.33, 95% CI [0.23-0.47], p<0.001

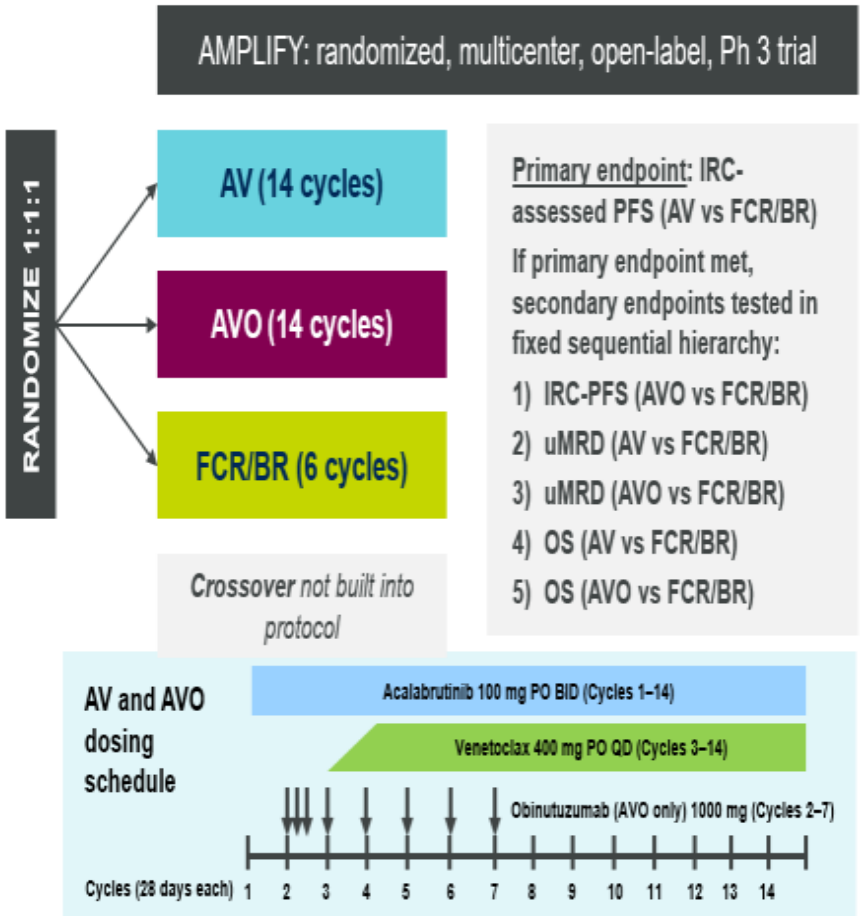
Al-Sawaf et. al, Blood, 2024

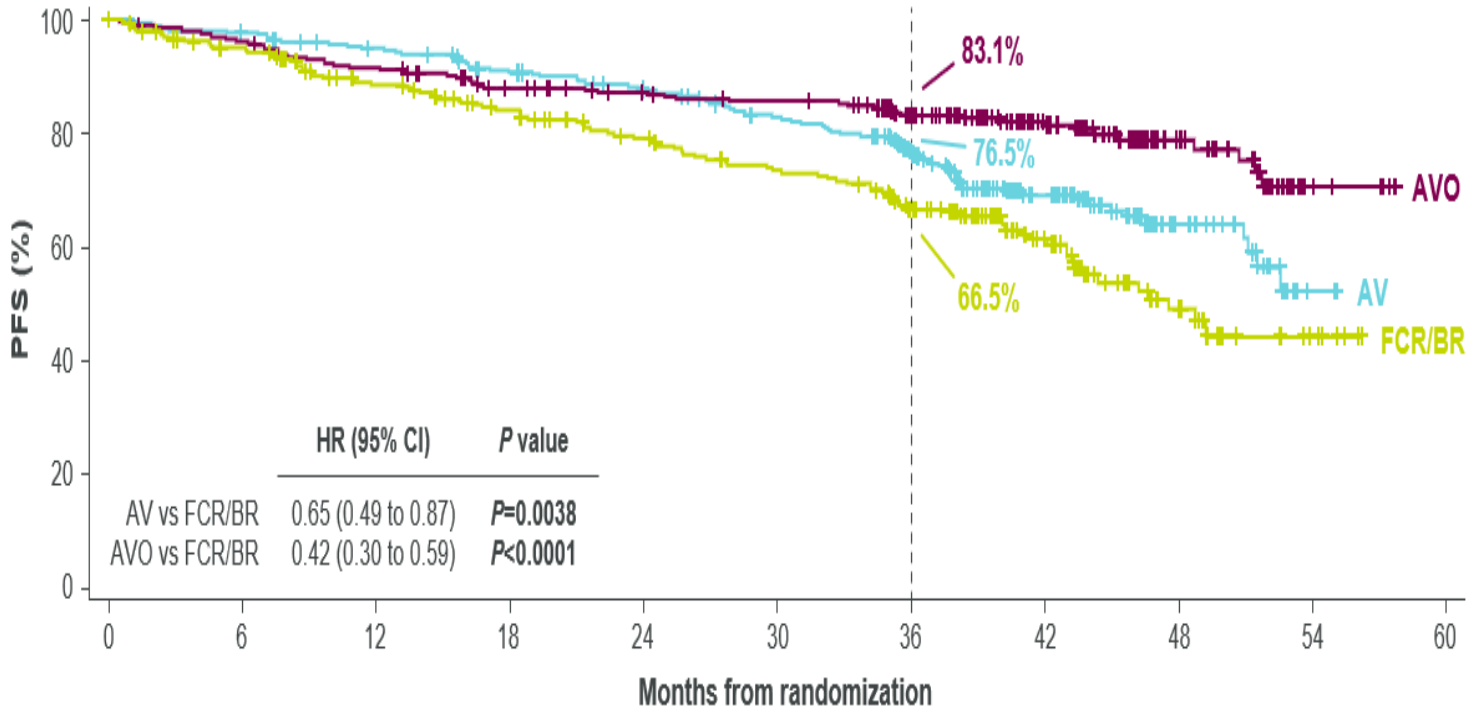
Rationale for combining BTKi and BCL2i



Timofeeva, Blood Neoplasia,2024

AMPLIFY: Acalabrutinib + Venetoclax ± Obinutuzumab



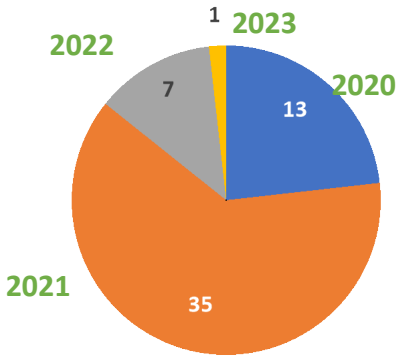


Median PFS was NR for AV and AVO, and was 47.6 mo for FCR/BR

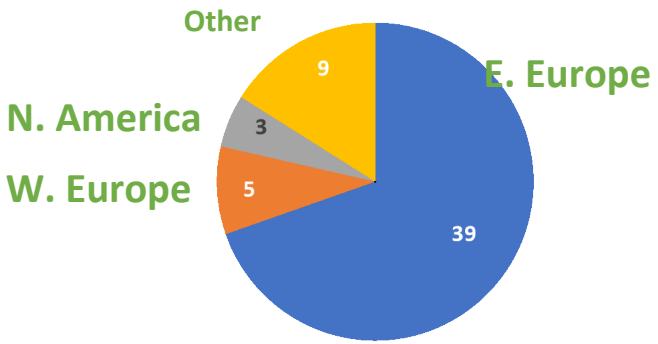
Brown J et al., NEJM, 2025

AMPLIFY: COVID-19 AEs, Treatment Discontinuations, and Deaths

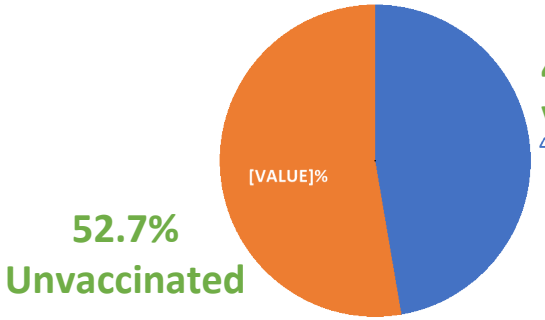
	AV (n=291)	AVO (n=284)	FCR/BR (n=259)
Any confirmed/suspected COVID-19 AE	64 (22.0)	69 (24.3)	10 (3.9)
Any confirmed/suspected COVID-19 AE leading to discontinuation of any treatment	7 (2.4)	23 (8.1)	3 (1.2)
Deaths due to COVID-19*	10 (3.4)	25 (8.7)	21 (7.2)



COVID-19 Deaths by Year



COVID-19 Deaths by Region



% COVID-19 Vaccinated

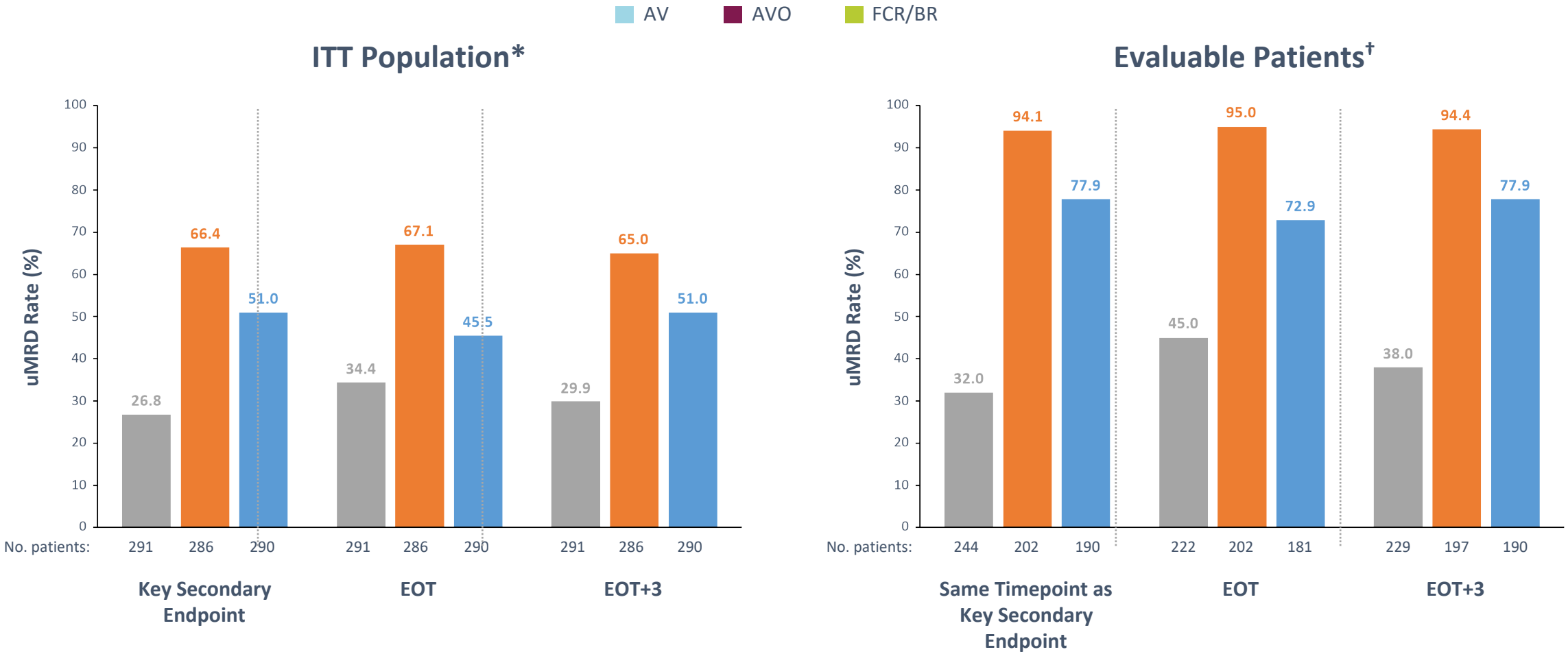
82% in 2020 or 1H2021

- Vaccination timing did not seem to differ by region

Data are n (%).
*Deaths due to COVID-19 are based on the ITT population (AV, n=291; AVO, n=286; FCR/BR, n=290).
AE, adverse event; AV, acalabrutinib-venetoclax; AVO, acalabrutinib-venetoclax-obinutuzumab; BR, bendamustine-rituximab; FCR, fludarabine-cyclophosphamide-rituximab.
AEs with an onset date or that worsened on or after the date of first dose and up to and including 30 days following the date of last dose of treatment or up to the day prior to start of subsequent anti-CLL therapy, whichever came first. Deaths included all deaths reported throughout the study.

Brown J et al., NEJM, 2025

AMPLIFY: Acalabrutinib + Venetoclax ± Obinutuzumab



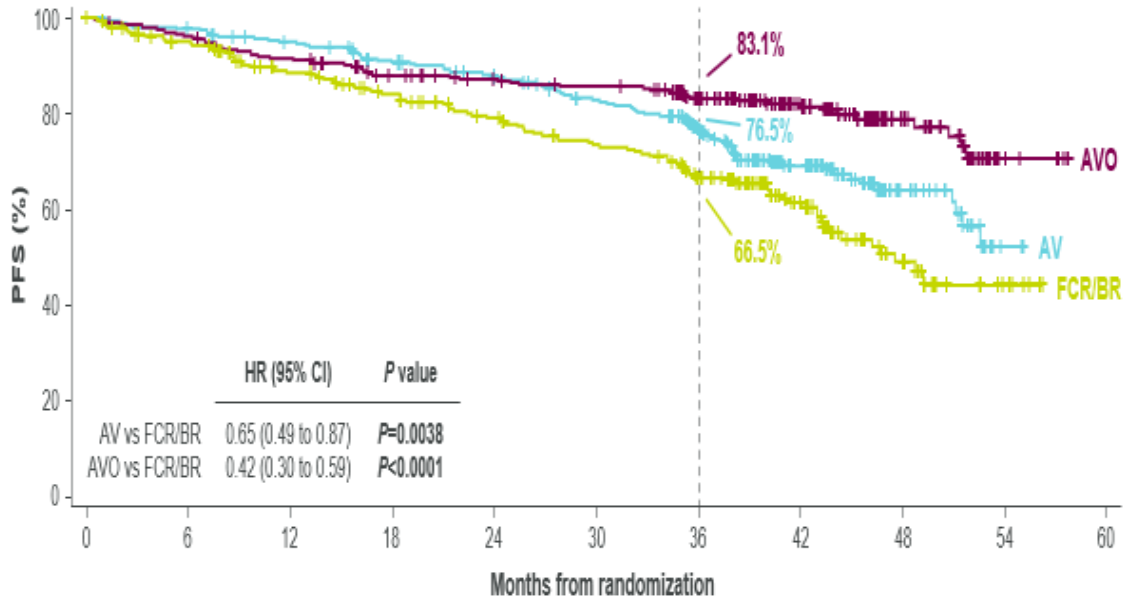
Key secondary endpoint timing: cycle 9, day 1 (AV arm), cycle 10, day 1 (AVO arm), and cycle 6, day 1 plus 12 weeks (FCR/BR)

uMRD Rates (Flow Cytometry [$<10^{-4}$] in PB)

Brown J et al., NEJM, 2025

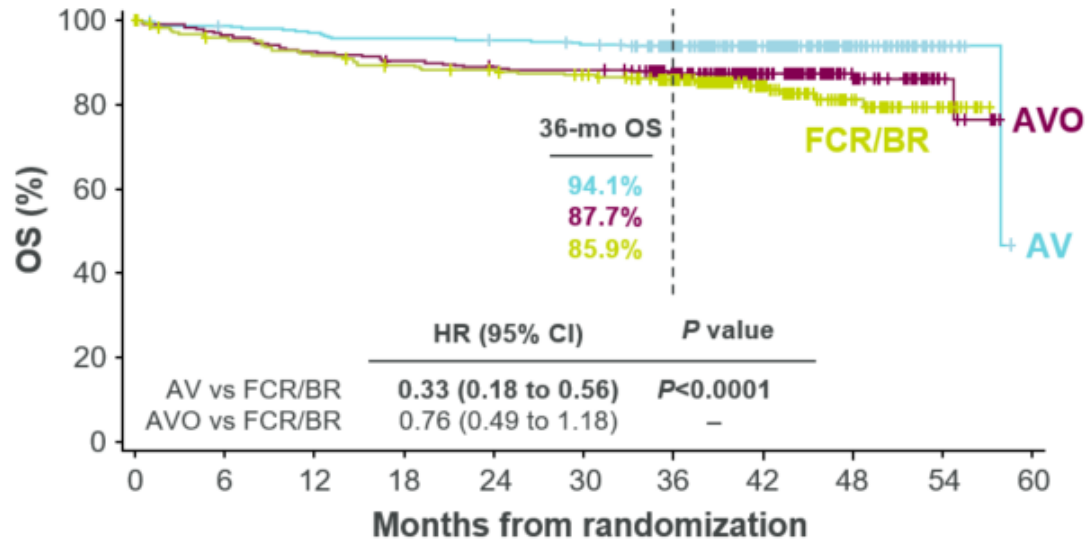
AMPLIFY: Acalabrutinib + Venetoclax ± Obinutuzumab

PFS



Median PFS was NR for AV and AVO, and was 47.6 mo for FCR/BR

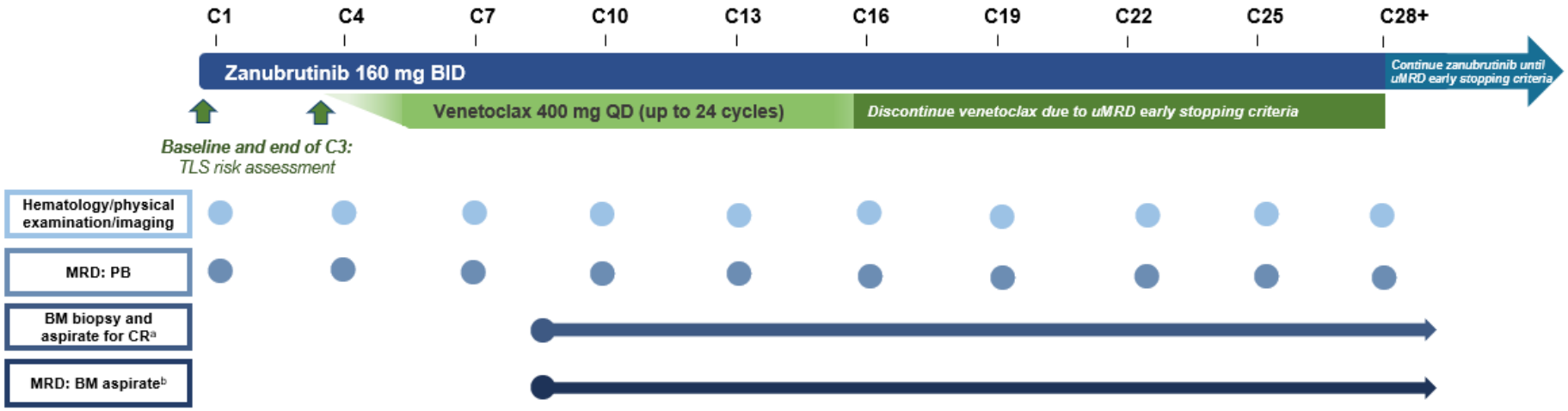
OS



Patients at risk

AV	291	286	281	277	275	270	233	142	58	10	0
AVO	286	276	265	257	252	250	223	143	64	10	0
FCR/BR	290	247	236	228	223	217	182	98	45	13	0

SEQUOIA arm D: Zanubrutinib + Venetoclax



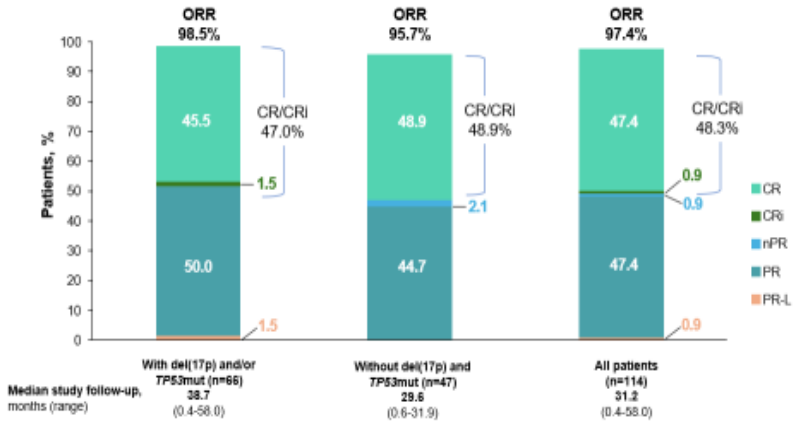
Stringent uMRD-guided stopping criteria

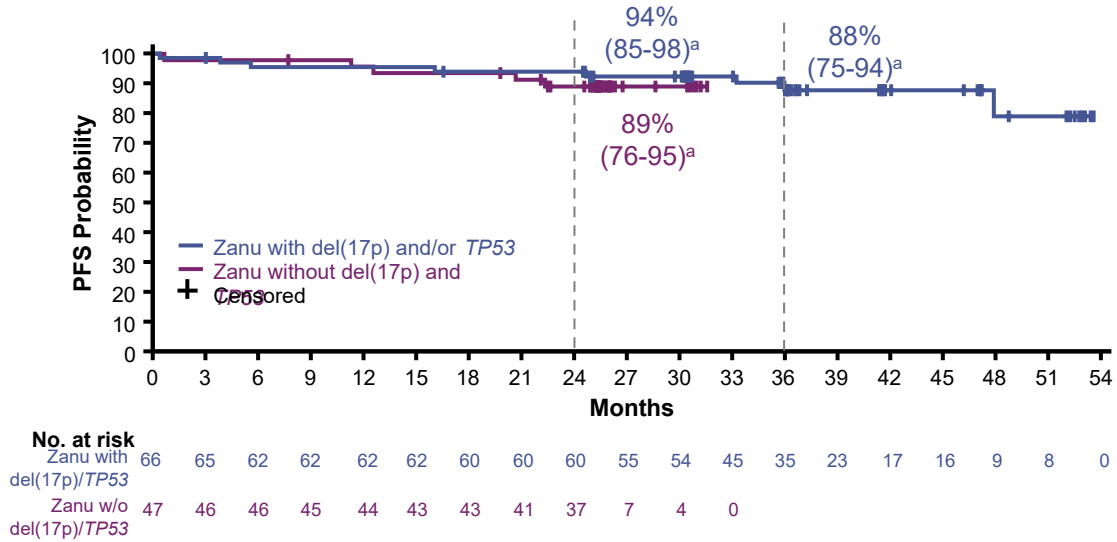
All conditions must be met:

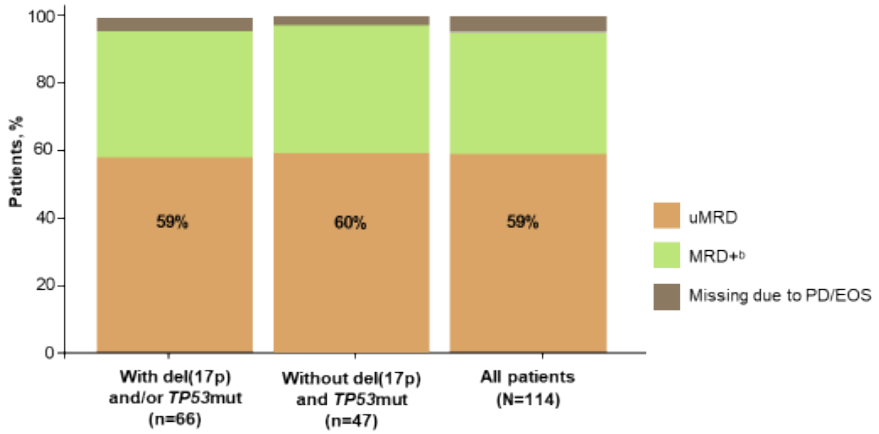
1. Response assessed as CR or CRi confirmed by a BM biopsy
2. uMRD $<1\times10^{-4}$ (uMRD4) achieved in 2 consecutive peripheral blood MRD tests conducted ≥12 weeks apart
3. uMRD4 achieved in 2 consecutive BM aspirate MRD tests conducted ≥12 weeks apart
4. Received
   - i) Minimum of 12 cycles of venetoclax (to stop venetoclax early)
   - ii) Minimum of 27 cycles of zanubrutinib (to stop zanubrutinib early)

Shadman M, et al. JCO, 2025

SEQUOIA arm D: Zanubrutinib + Venetoclax



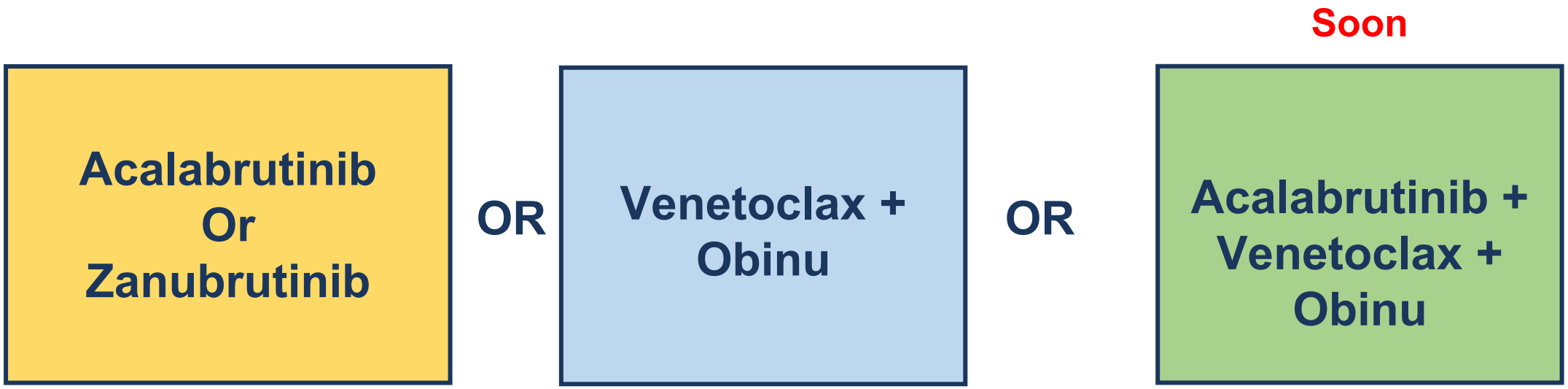




	Without del(17p) and *TP53*mut (n=47)	With del(17p) and/or *TP53*mut (n=66)
Best PB-uMRD, n (%)		
By cycle 16	**20 (43)**	14 (21)
By cycle 28	**28 (60)**	32 (49)

Shadman M, et al. JCO, 2025

First line treatment: for patients with abnormal TP53



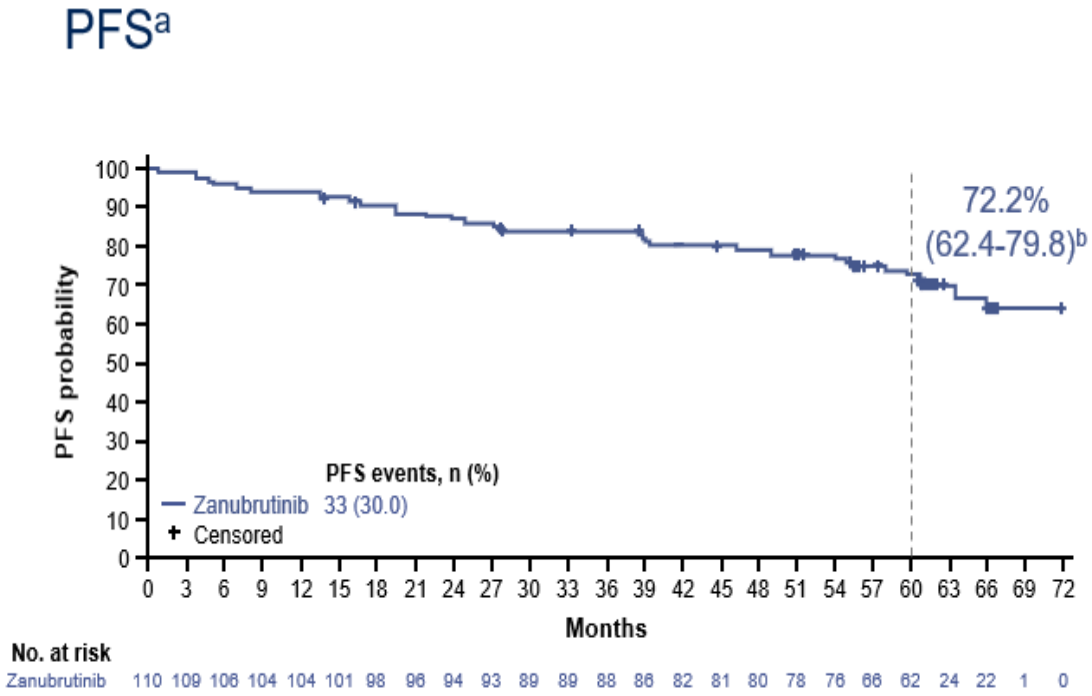
G = Gazyva = obinutuzumab

BTKis and TN CLL with abnormal TP53

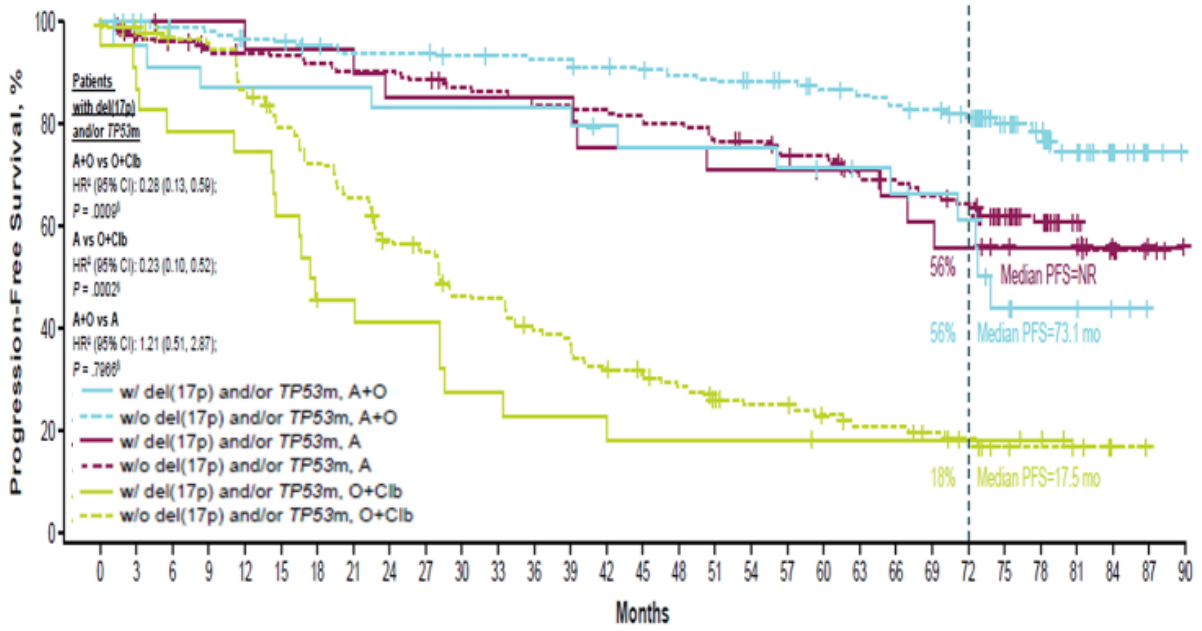
	ibrutinib	acalabrutinib	zanubrutinib
Study	Pooled analysis	ELEVATE TN	SEQUOIA
N	89	48	109
Median follow-up	49.8 months	46.9	48
Anti-CD20	44/89	23/48	0
Del17p	53%	68%, 69%	100%
Mutated TP53	59%	84% , 83%	Not reported
PFS	79% (48-months)	74.8% and 76.2% (mono) (48-months)	79.4 (42 months)
Reference	Allan, BJH, 2021	Sharman, Leukemia,2021	Shadman,17-ICML,2023

BTKis for abnormal TP53

Zanubrutinib



Acalabrutinib



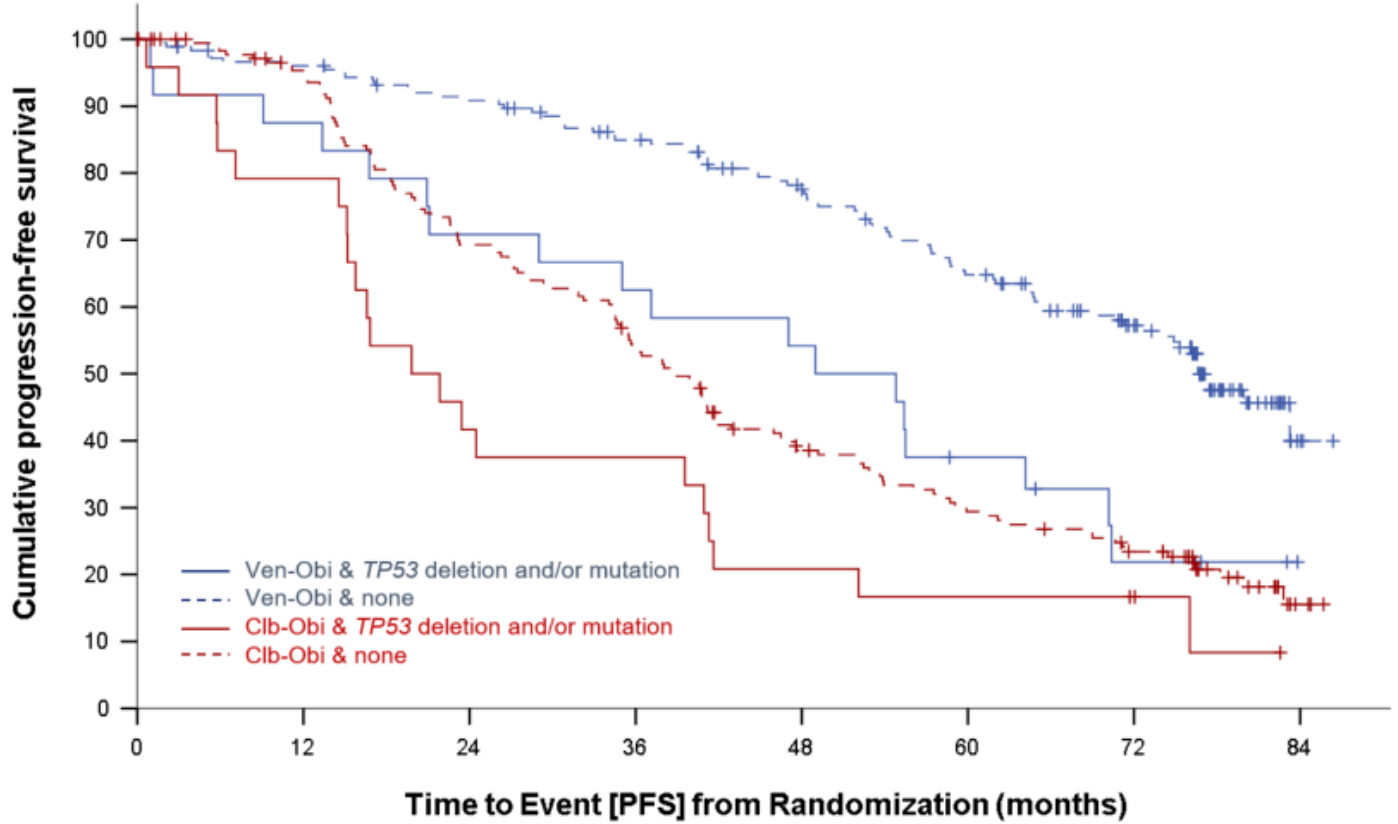
Tam C, et al, ASCO ,2025

Sharman J et al , Blood,2025

Venetoclax and Obino with abnormal TP53

PROGRESSION-FREE SURVIVAL – *TP53* status

Median observation time 76.4 months



Median PFS

Ven-Obi & no *TP53*del/mut: 76.6 m

Ven-Obi & *TP53*del/mut: 51.9 m

HR 2.29, 95% CI [1.37-3.83], p=0.001

Clb-Obi & no *TP53*del/mut: 38.9 m

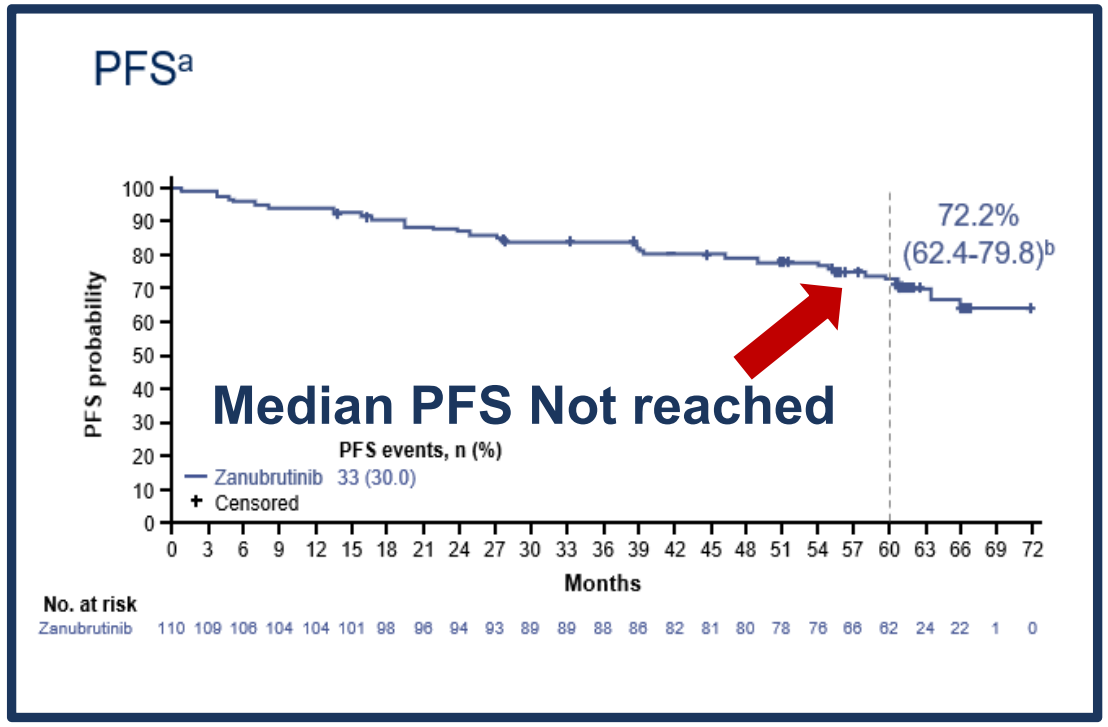
Clb-Obi & *TP53*del/mut: 20.8 m

HR 1.66, 95% CI [1.05-2.63], p=0.03

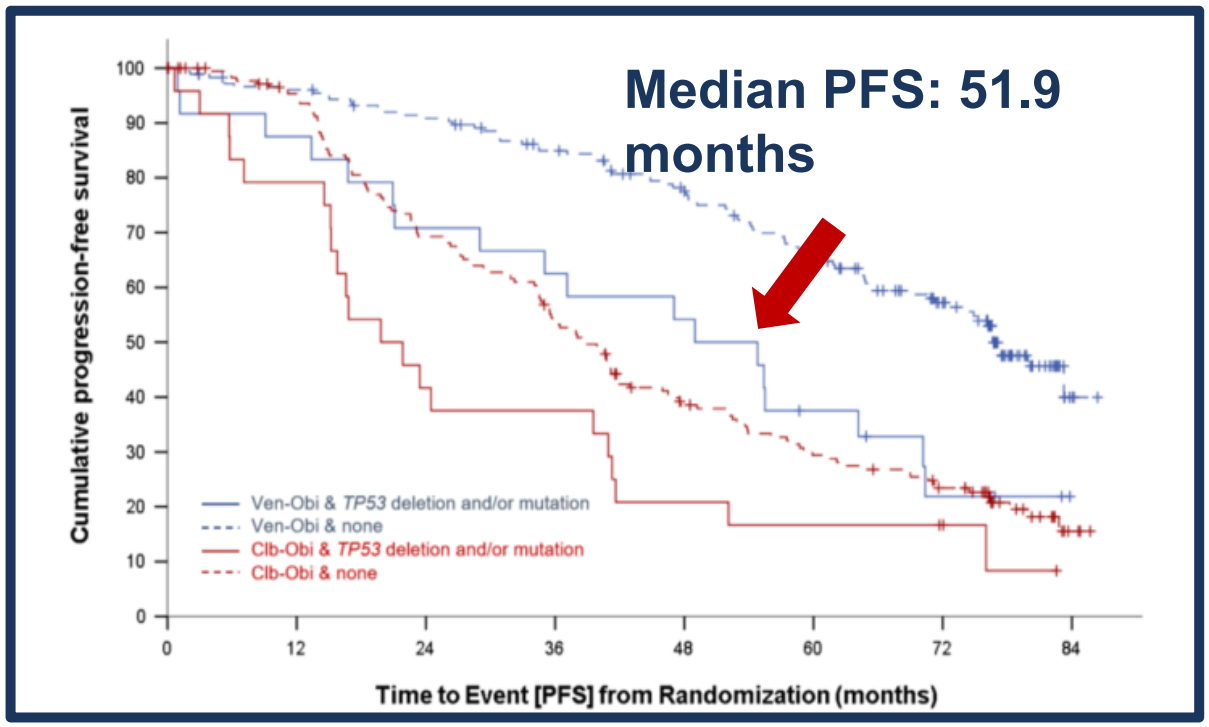
Al-Sawaf, Blood, 2024

Ibrutinib vs. Ven-G for first-line treatment in CLL patients with abnormal TP53

Zanubrutinib



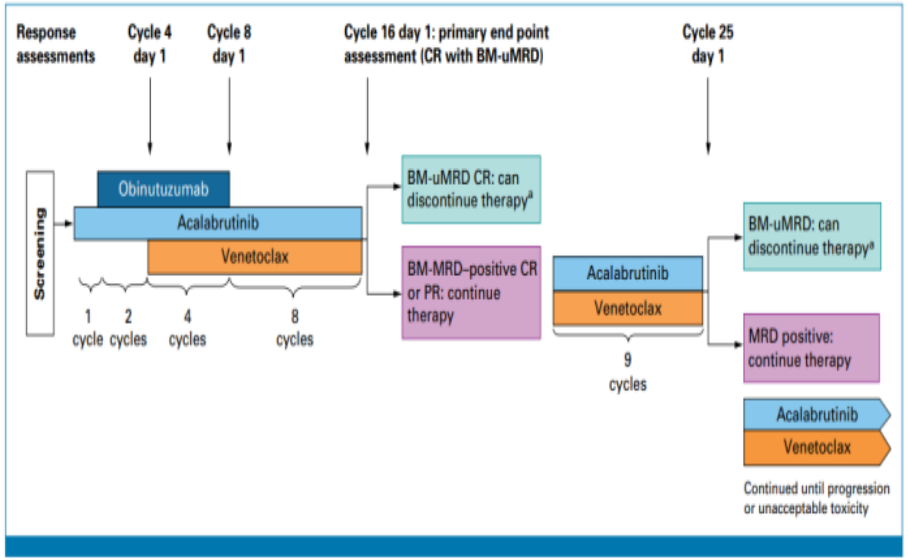
Venetoclax + Obinu

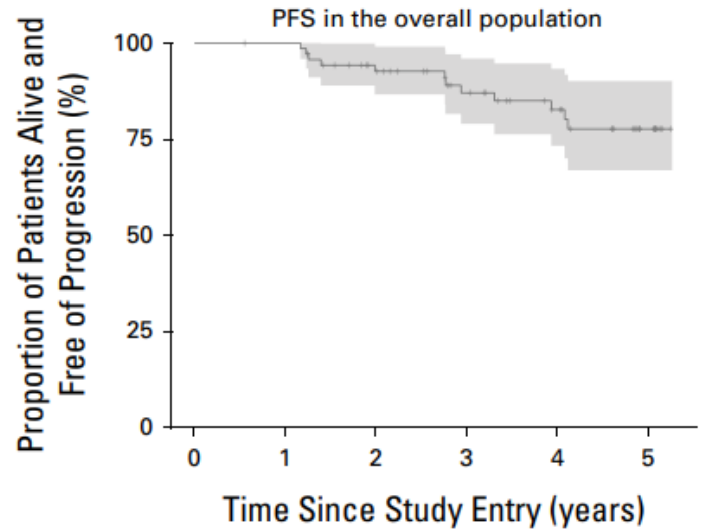


Tam C, et al, ASCO ,2025

Al-Sawaf,Blood,2024

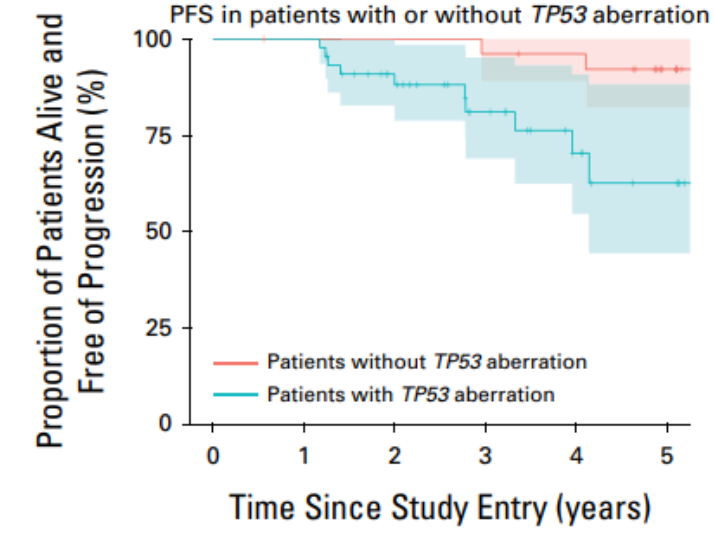
AVO in patients with abnormal TP53





Number at risk:

All	72	71	58	45	35	21



Number at risk:

Patients without *TP53* aberration	27	26	26	25	24	15
Patients with *TP53* aberration	45	45	32	20	11	6

Davids MS et al., JCO,2025

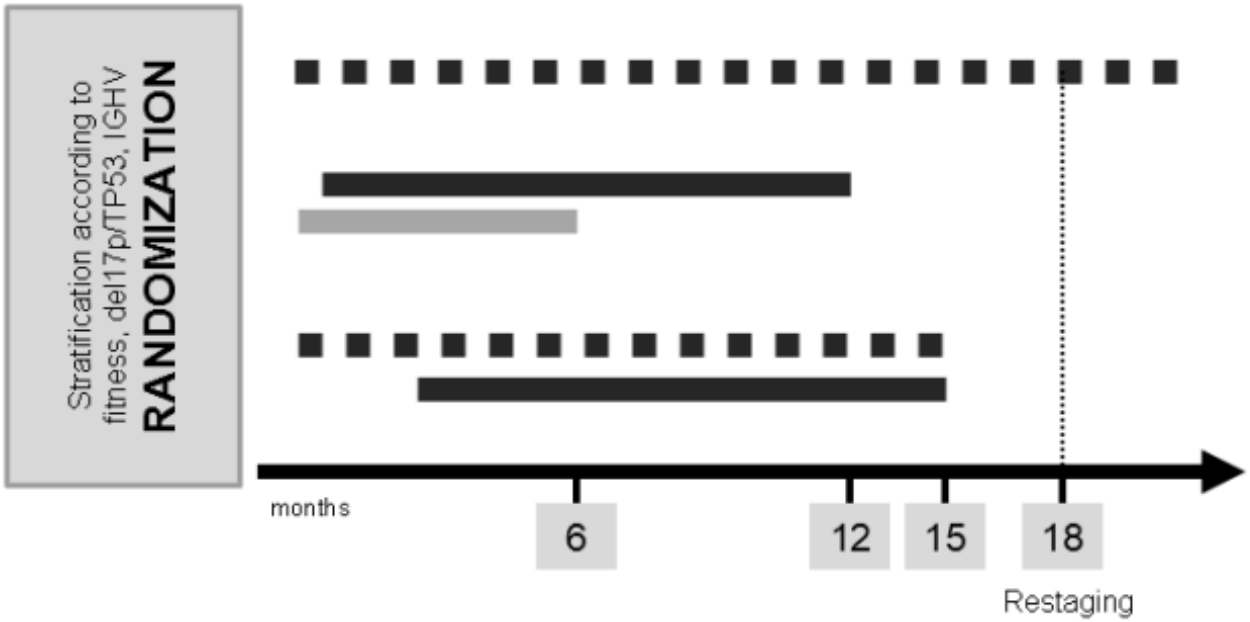
BTKis vs. Ven-Based

Class	BTKis (Acalabrutinib/Zanubrutinib/Ibrutinib)	Ven-Based Regimens
Duration	Indefinite therapy	Time-limited
Deep responses	Not expected / Not relevant	High CR and uMRD rate
Convenience	Easy to start	Frequent visits initially
Not preferred if:	• Significant cardiac history (structural, HTN, arrythmia) • Major bleeding issues	
TP53 abnormal	Not a predictors of response	Shorter PFS; discuss with the pt
unmutated IGHV	Not a predictors of response	Shorter PFS ; discuss with the pt

- **No head-to-head comparison**
- **Both are reasonable options**
- **Consider patient and disease factors**
- **Look at pros and cons for each**

Major Frontline Studies Awaiting Data

GCLLSG: CLL17 Trial



Ibrutinib d1 420 mg po daily until PD or intolerance

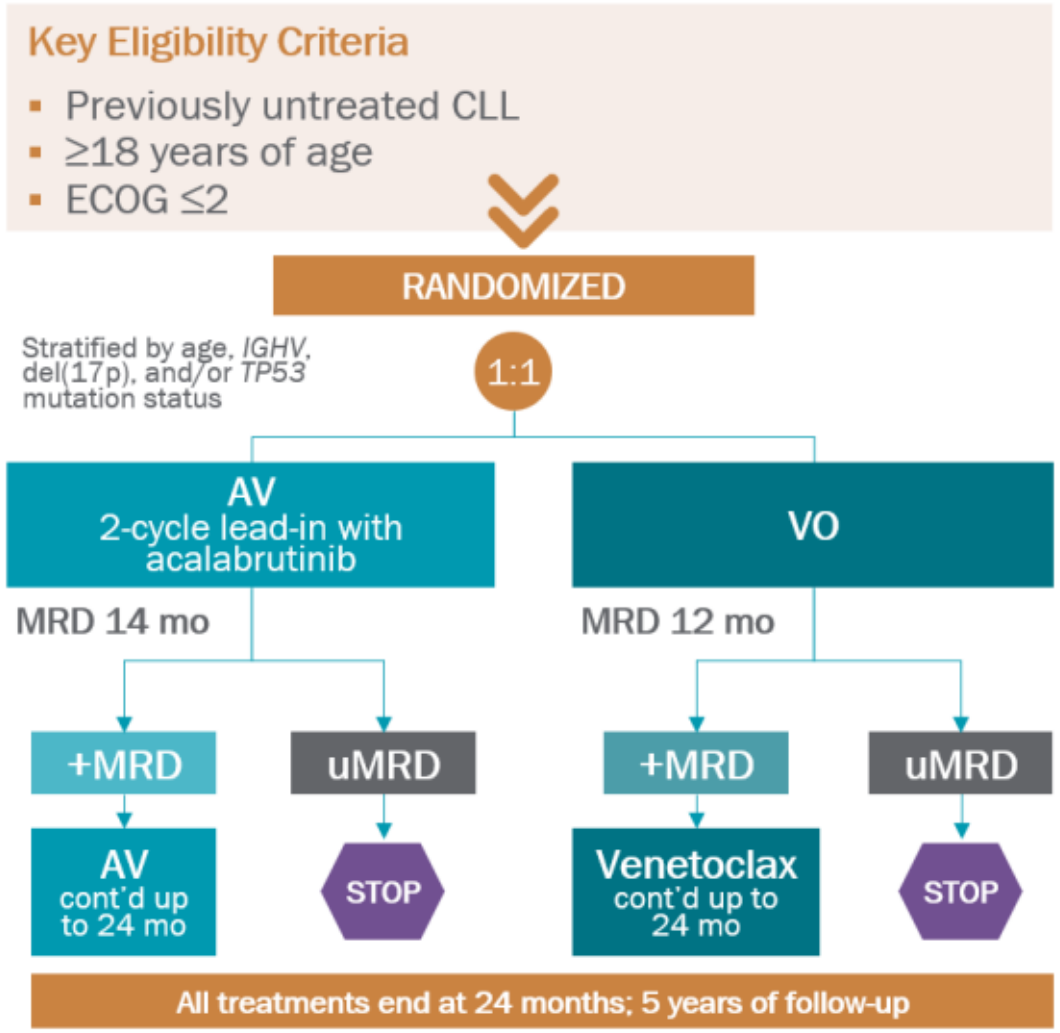
Venetoclax 400 mg po daily (c1 d22 – c12 d28)
Obinutuzumab 1000 mg iv (c1 d1(2)/8/15, c 2-6 d1)

Ibrutinib 420 mg po daily (c1 d1 – c15 d28)
Venetoclax 400 mg po daily (c4 d1 – c15 d28)

DEUTSCHE STUDIENGRUPPE

University of Cologne

MAJIC: Phase 3 Study of Acalabrutinib + Venetoclax (AV) vs Venetoclax + Obinutuzumab (VO) – Study Design



Primary endpoint

- INV-assessed PFS

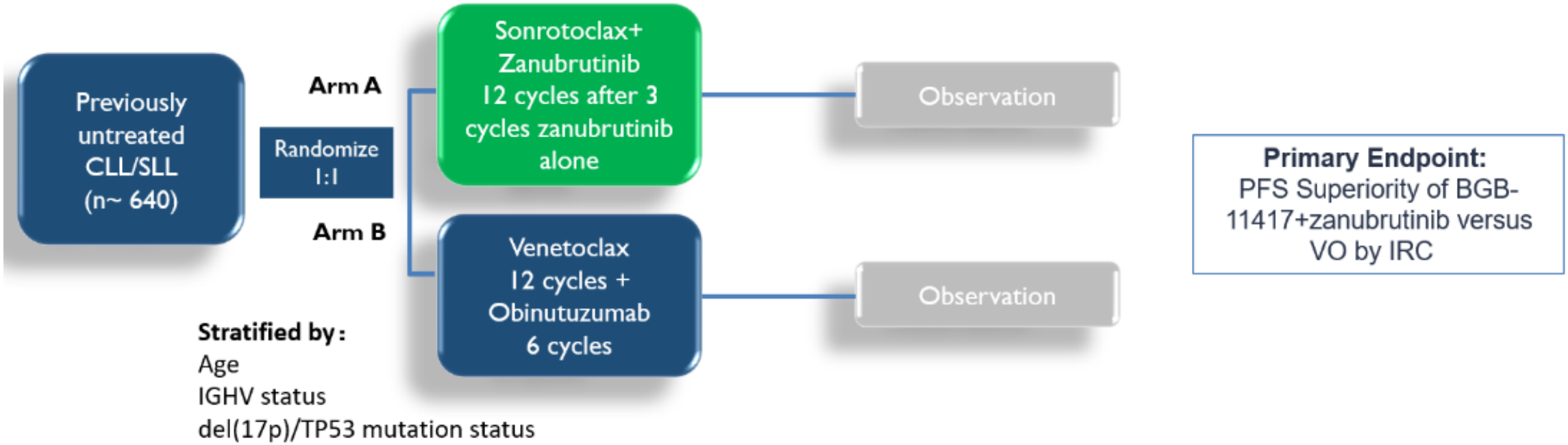
Key secondary endpoints

- uMRD rates at sequential timepoints (after 6 and 12 cycles of V and yearly thereafter [key timepoint: after 12 cycles of V])
- OS
- EFS
- ORR
- CR rate (per uMRD)
- Quality of life/patient-reported outcomes
- Safety and tolerability

CELESTIAL-CLLTN: Sonrotoclax + Zanubrutinib

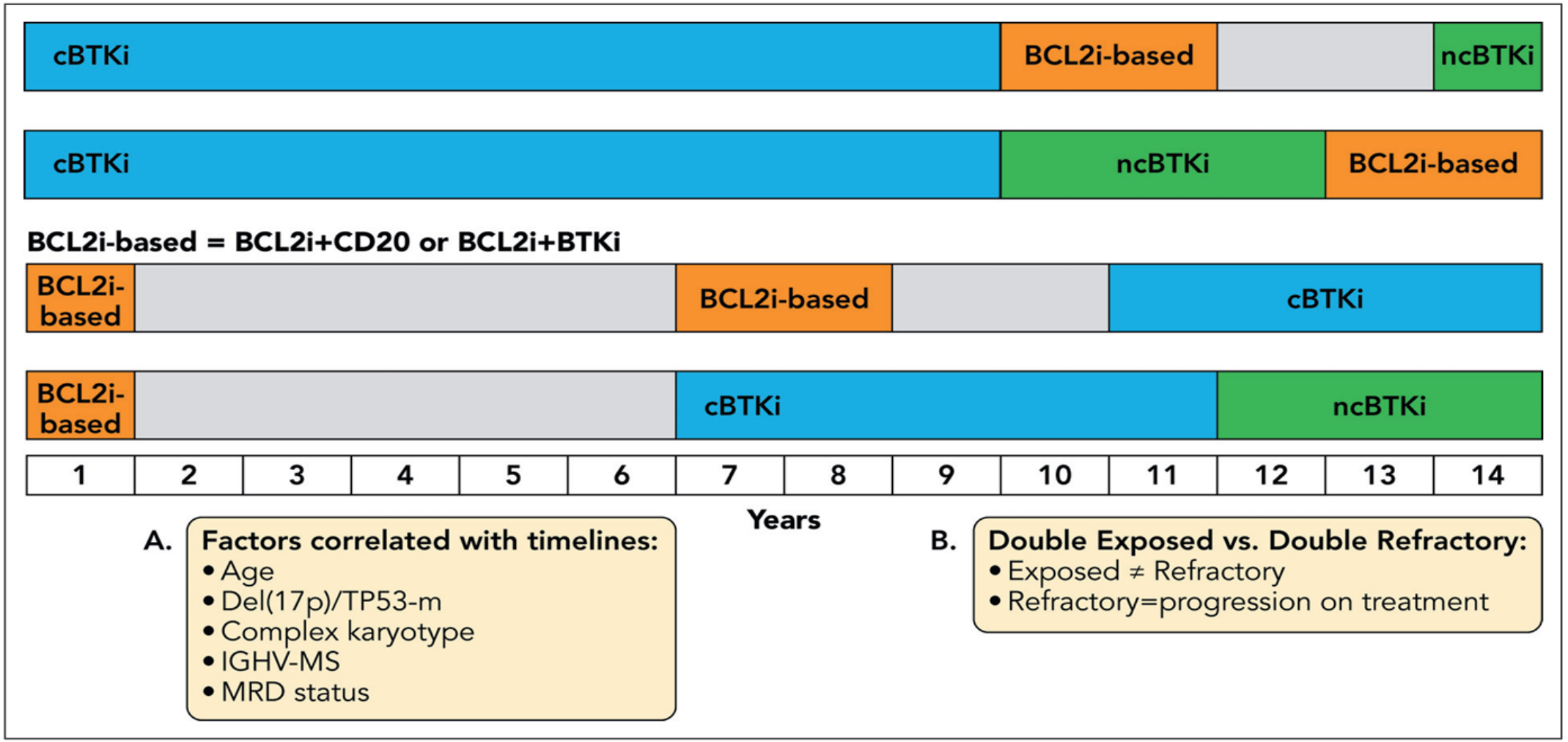
BGB-11417-301: 2-arm fixed duration study design

Phase 3 registrational trial



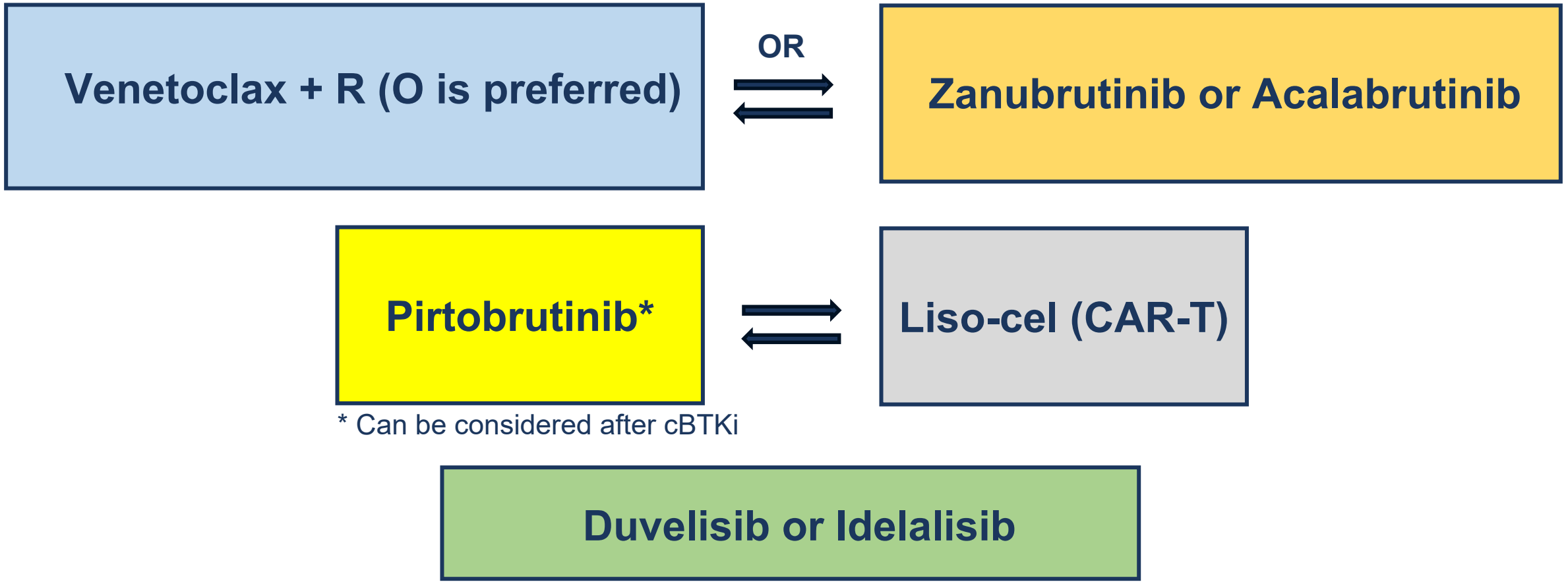
Treatment options for previously treated patients

Treatment Strategies in CLL/SLL



Wierda, et al, Blood, 2025

Previously Treated CLL Summary



R = rituximab

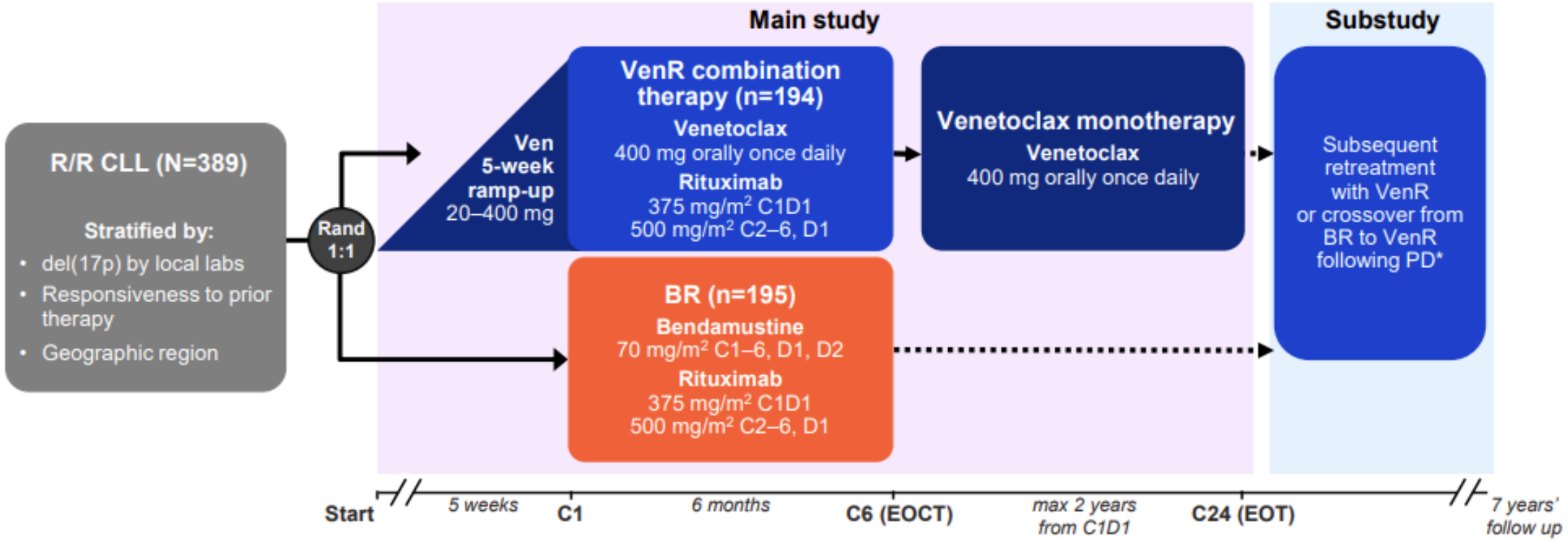
Previously treated CLL : Principles

1. **Repeat FISH panel - look for del (17p) or TP53 mutation**

1. Bone marrow needs to be repeated to assess for MDS if prior FCR

1. Very limited role for chemoimmuntherapy (almost never)

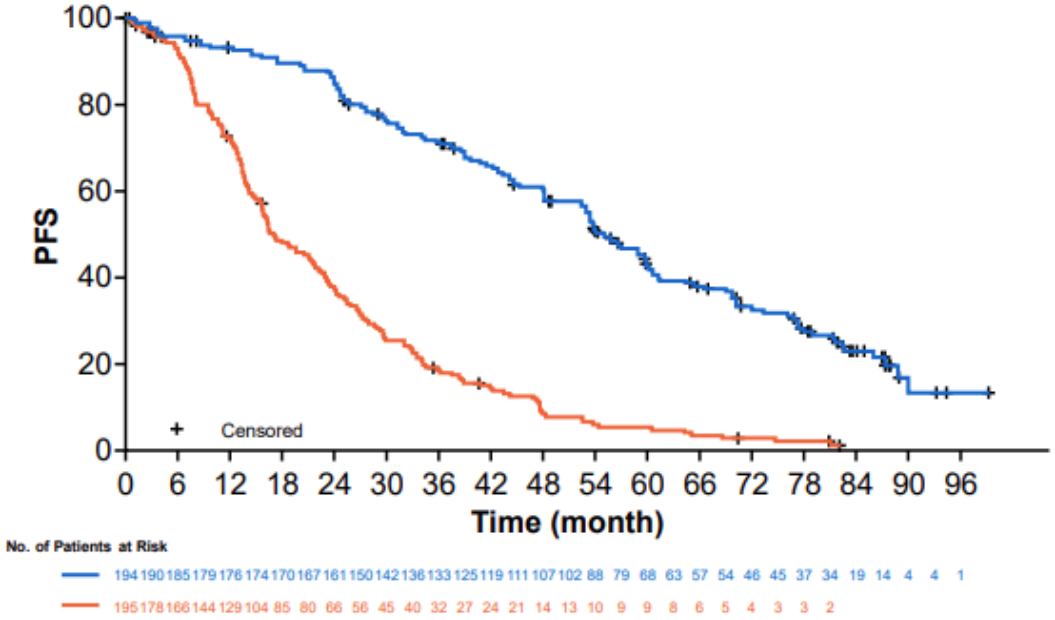
Ven-R vs. BR in R/R CLL (MURANO Study)



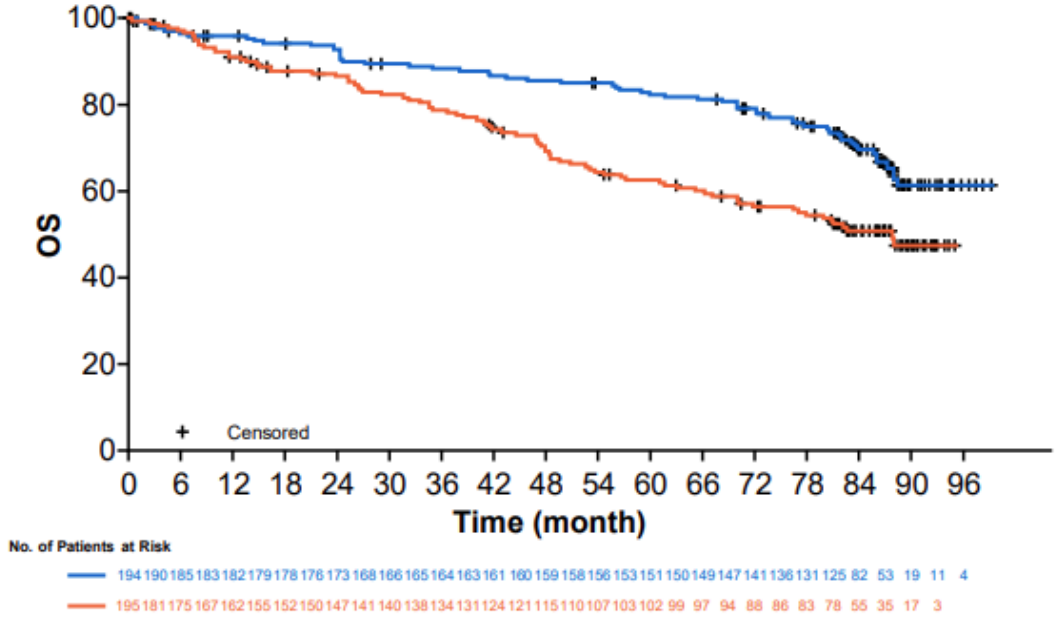
Kater, 17-ICML,

Ven-R vs. BR in R/R CLL (MURANO Study): 7-year follow-up

	Median PFS (95% CI), months	HR* (95% CI)	7-year PFS (%)
VenR (n=194)	54.7 (52.3–59.9)	0.23 (0.18–0.29) Stratified P-value <0.0001†	23.0
BR (n=195)	17.0 (15.5–21.7)		NE



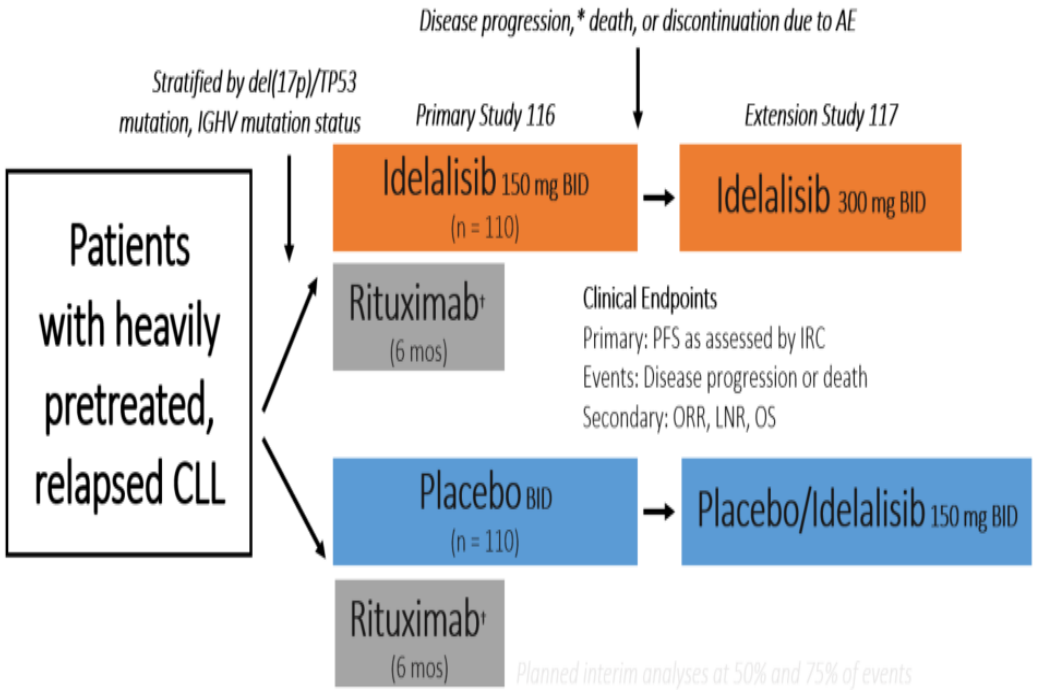
	Median OS (95% CI), months	HR‡ (95% CI)	7-year OS (%)
VenR (n=194)	NE	0.53 (0.37–0.74) Stratified P-value <0.0002†	69.6
BR (n=195)	87.8 (70.1–NE)		51.0

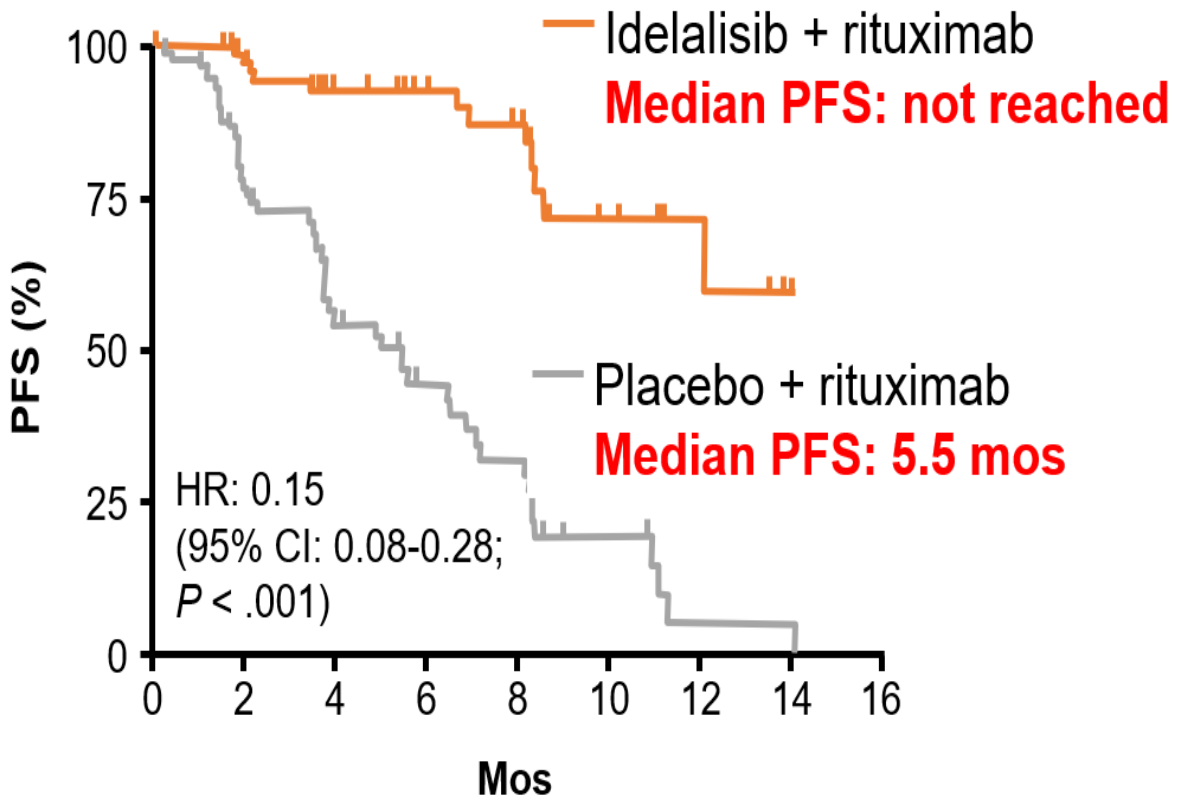


- Median follow up for efficacy (range) was 86.8 months (0.3–99.2) for VenR and 84.4 months (0.0−95.0) for BR
- No new safety signals were identified since the 5-year data cut,[1] with all patients outside of the AE reporting window§

Kater, 17-ICML,

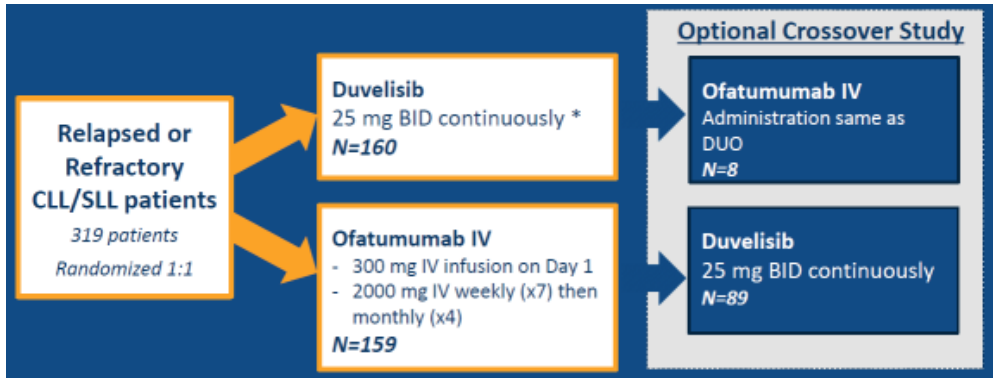
Idelalisib and Rituximab for Previously Treated Patients





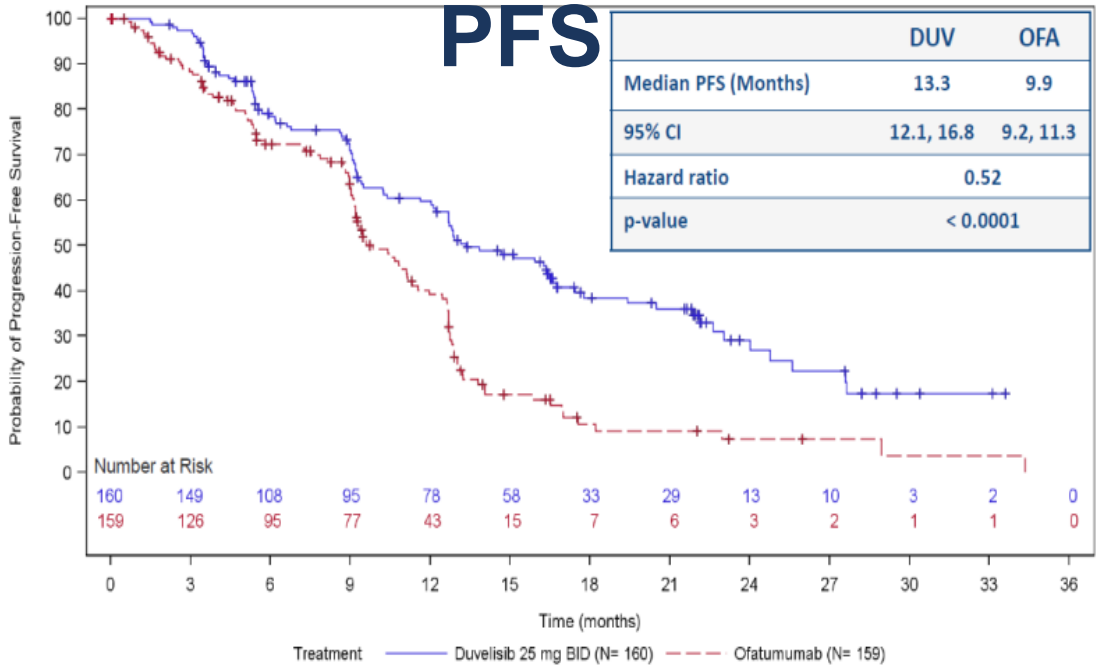
Furman, NEJM,2014

Duvelisib vs Ofatumumab (DUO trial) - Relapsed/Refractory



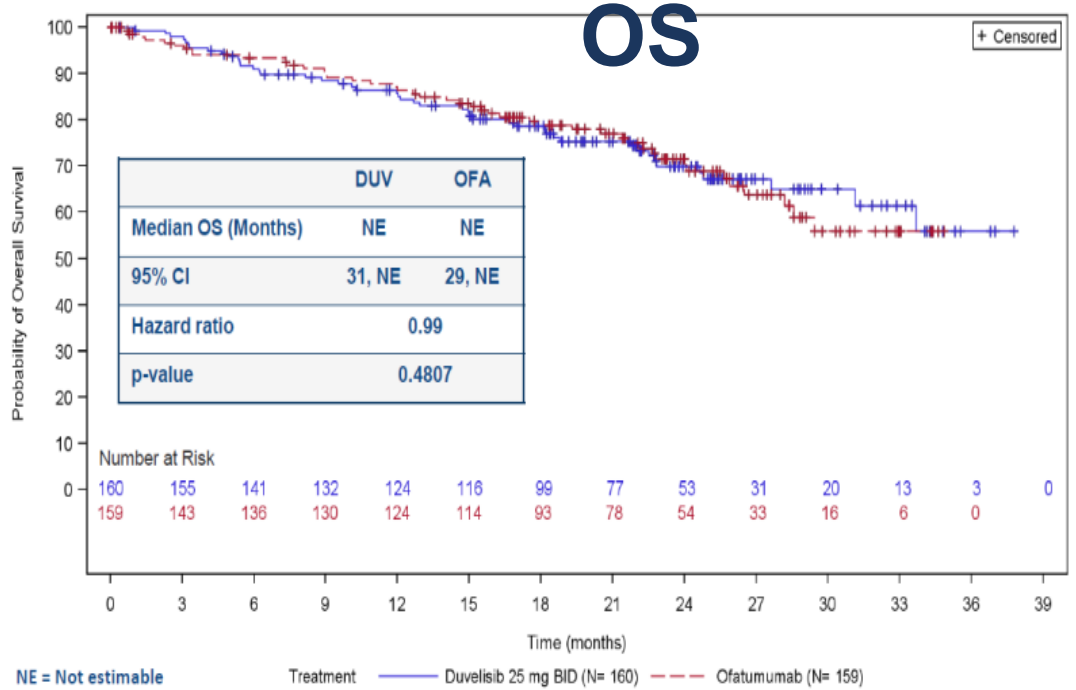
PFS

	DUV	OFA
Median PFS (Months)	13.3	9.9
95% CI	12.1, 16.8	9.2, 11.3
Hazard ratio	0.52	
p-value	< 0.0001	



OS

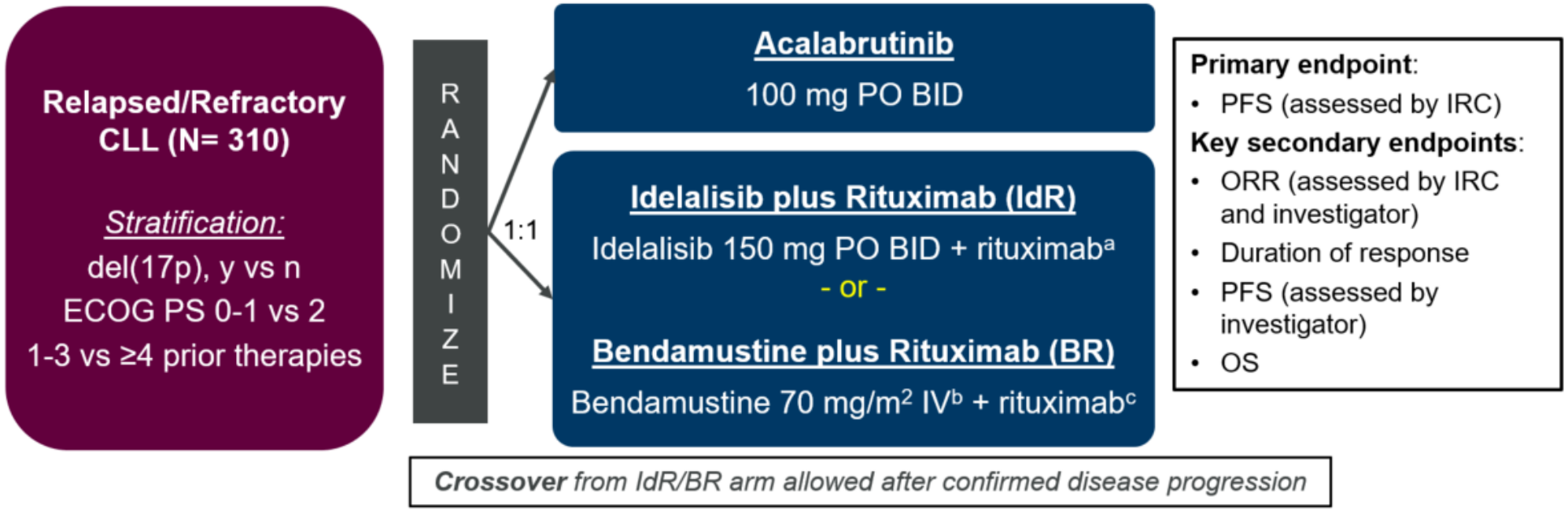
	DUV	OFA
Median OS (Months)	NE	NE
95% CI	31, NE	29, NE
Hazard ratio	0.99	
p-value	0.4807	



NE = Not estimable

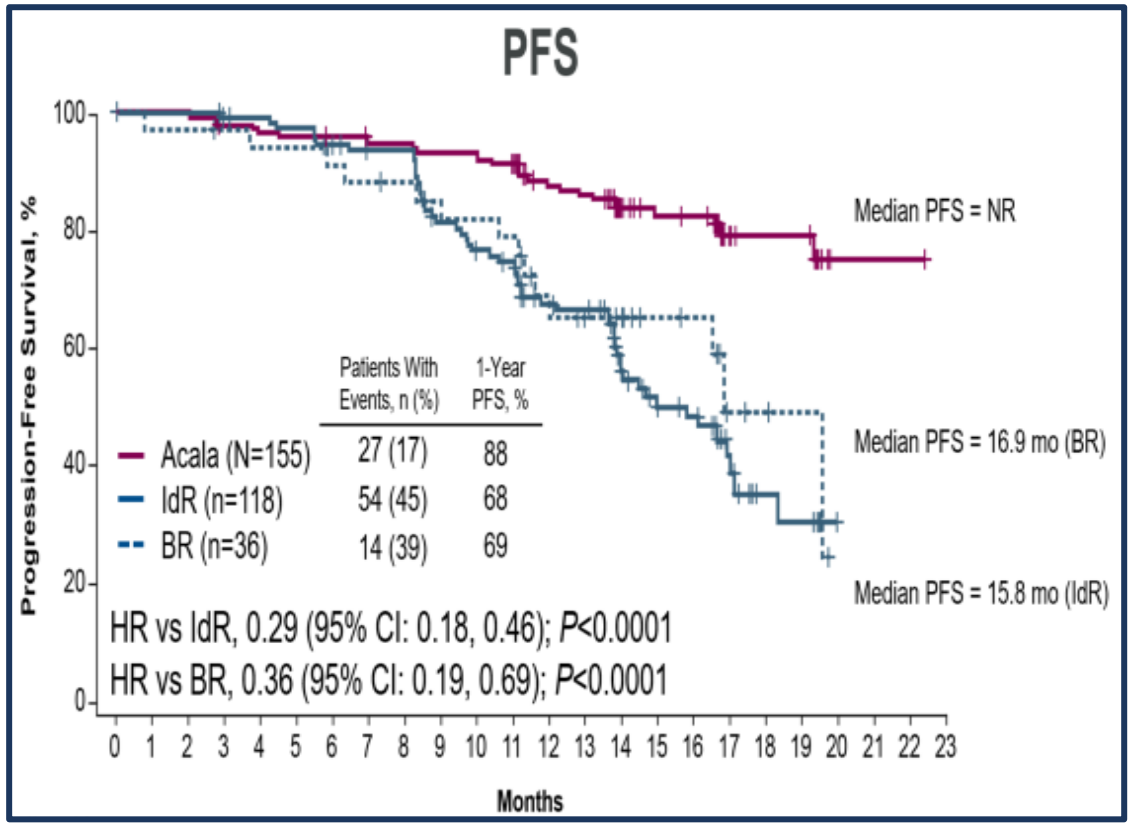
Flinn, Blood, 2018

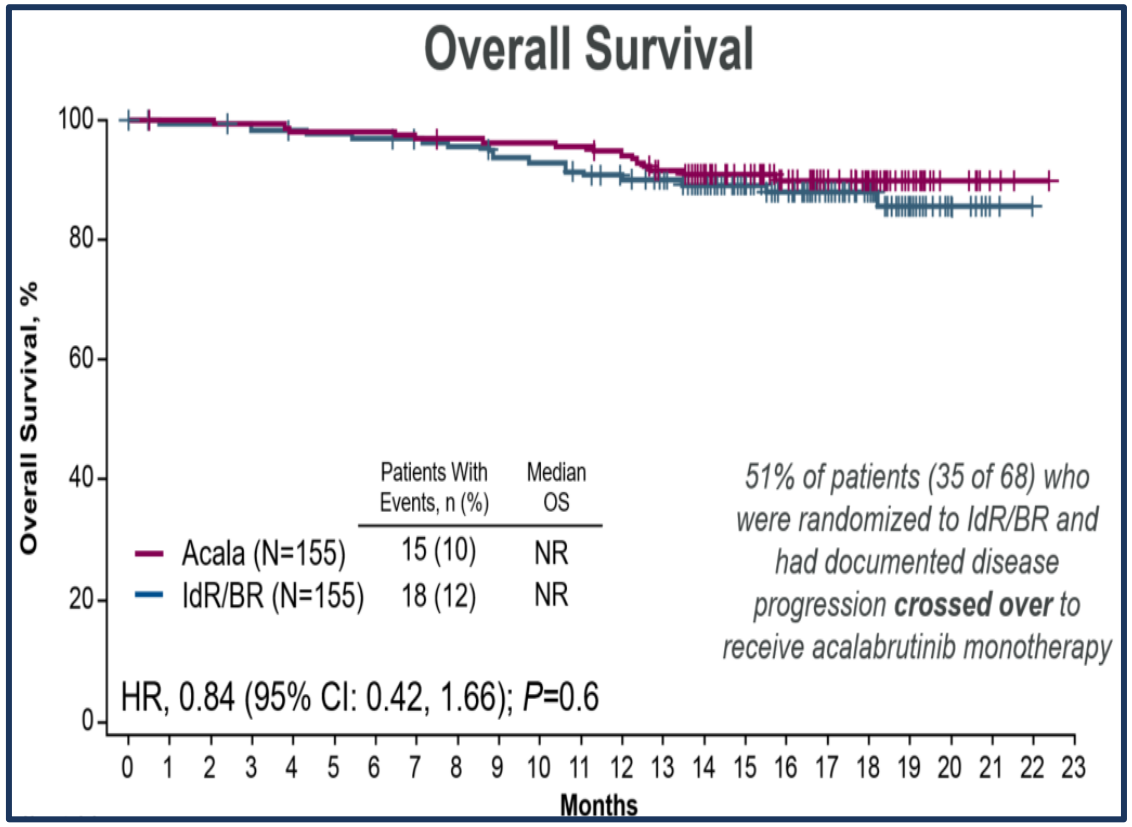
Acalabrutinib vs. Investigator choice for relapsed CLL: (ASCEND Study)



Ghia,JCO,2020

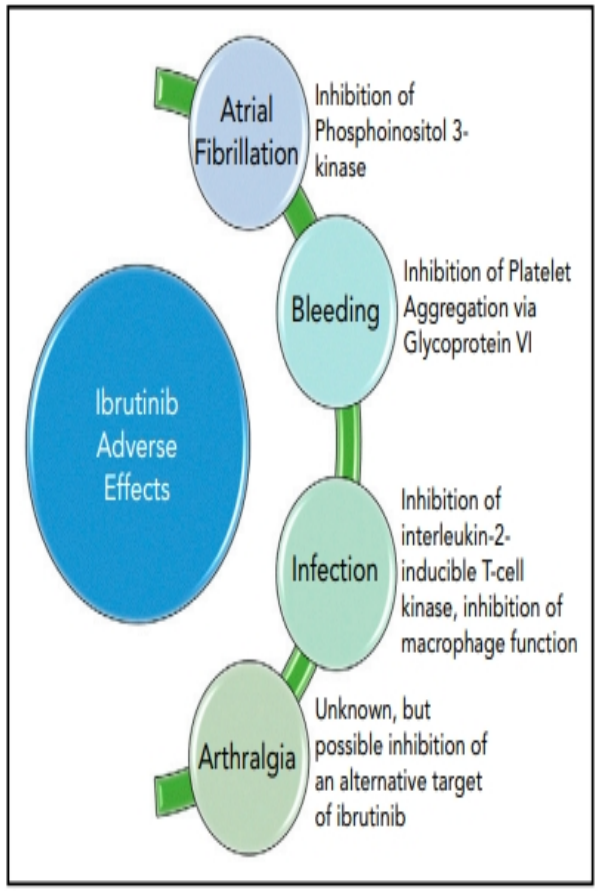
Acalabrutinib vs. Investigator choice for relapsed CLL: (ASCEND Study)





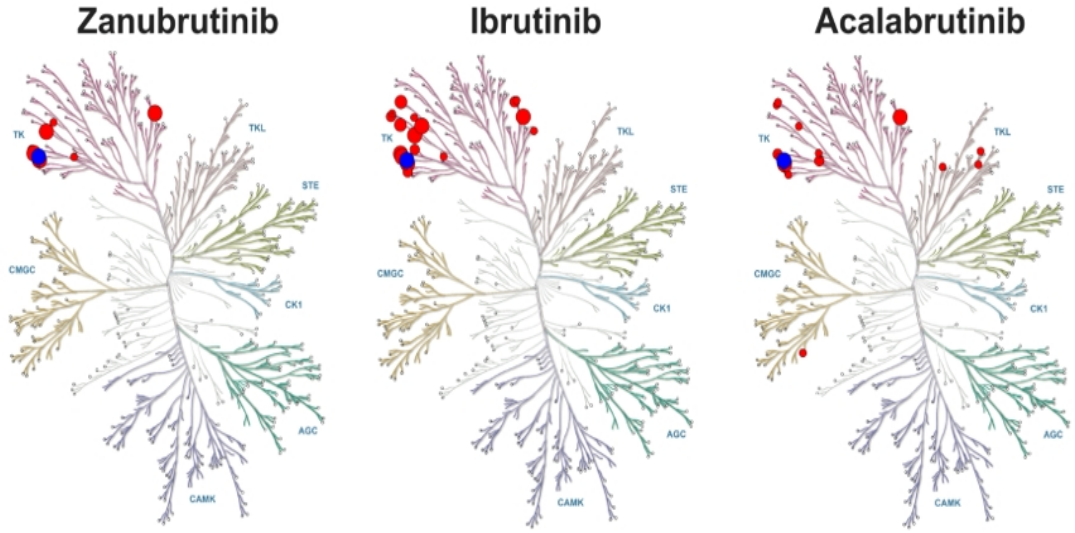
Ghia, JCO, 2020

Choice of BTKi



Treatment discontinuation rates due to toxicity

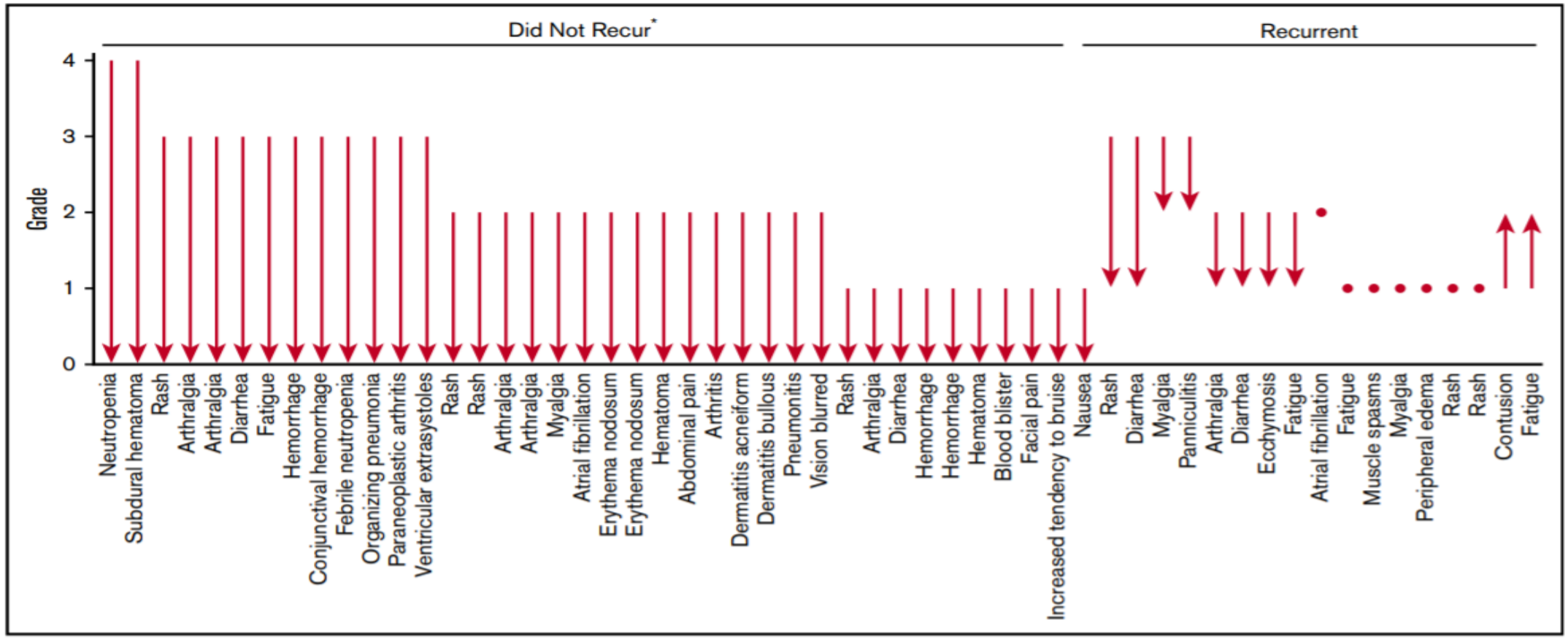
Ibrutinib	Frontline: 15% Relapsed: 22%
Acalabrutinib	Frontline: no data Relapsed: 12%



Assayed by Reaction Biology Corp. at 100X of IC_{50} (against BTK) concentration with IC_{50} (BTK)s of 0.71±0.09, 0.32±0.09, 24±9.2, 63±28 and 15±5.5nM (n=3), for zanubrutinib, ibrutinib, acalabrutinib, M27, and orelabrutinib, respectively.

Mato, Haematologica, 2018 ; Yazdi,ASH,2019; Roeker, Clin Cancer Research, 2019 ;Shadman, ASH,2019; Stephens, Blood, 2019

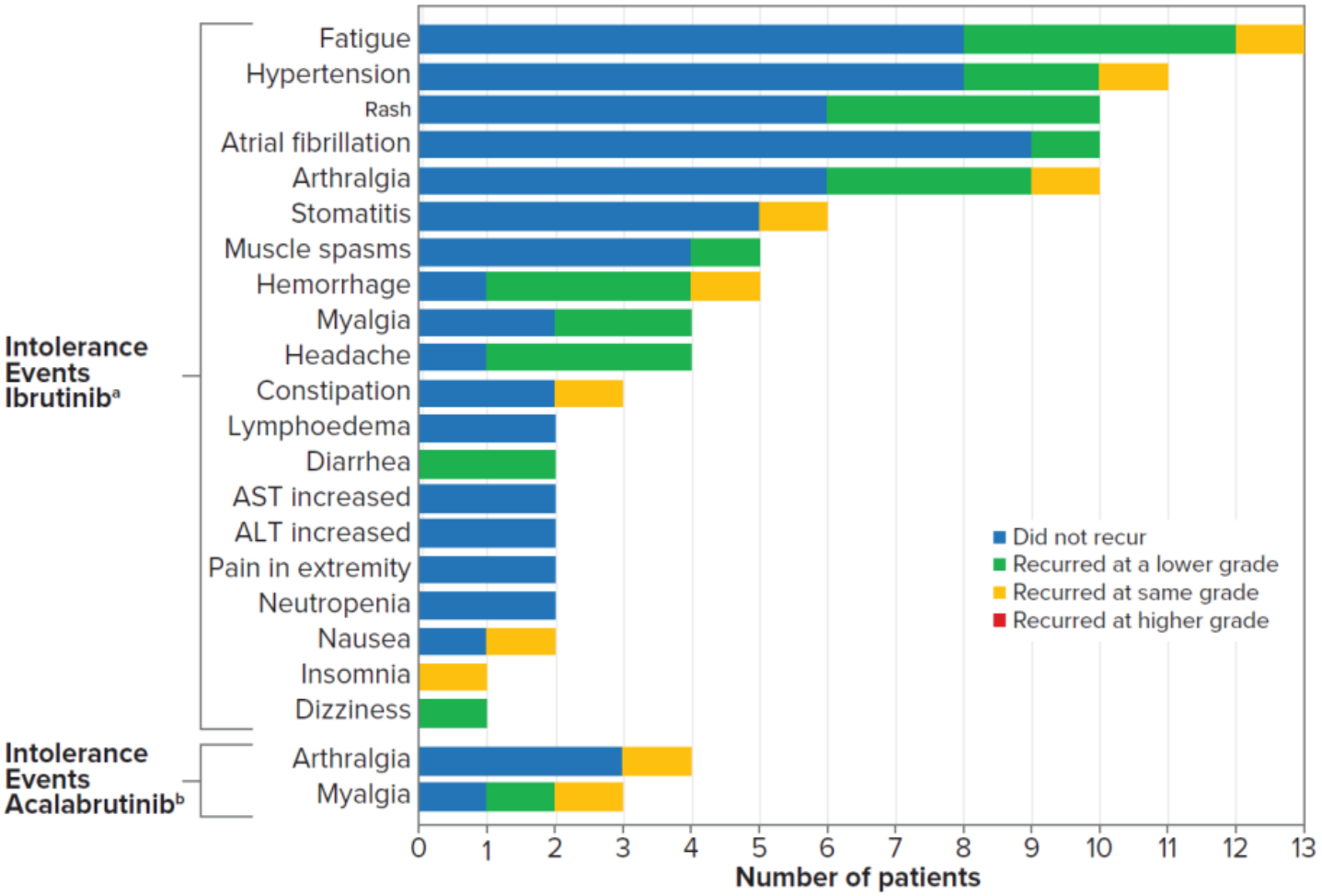
Acalabrutinib in Ibrutinib intolerant patients



of 61 ibrutinib-related AEs associated with intolerance, 72% did not recur and 13% recurred at a lower grade with acalabrutinib

Awan, Blood Adv, 2019

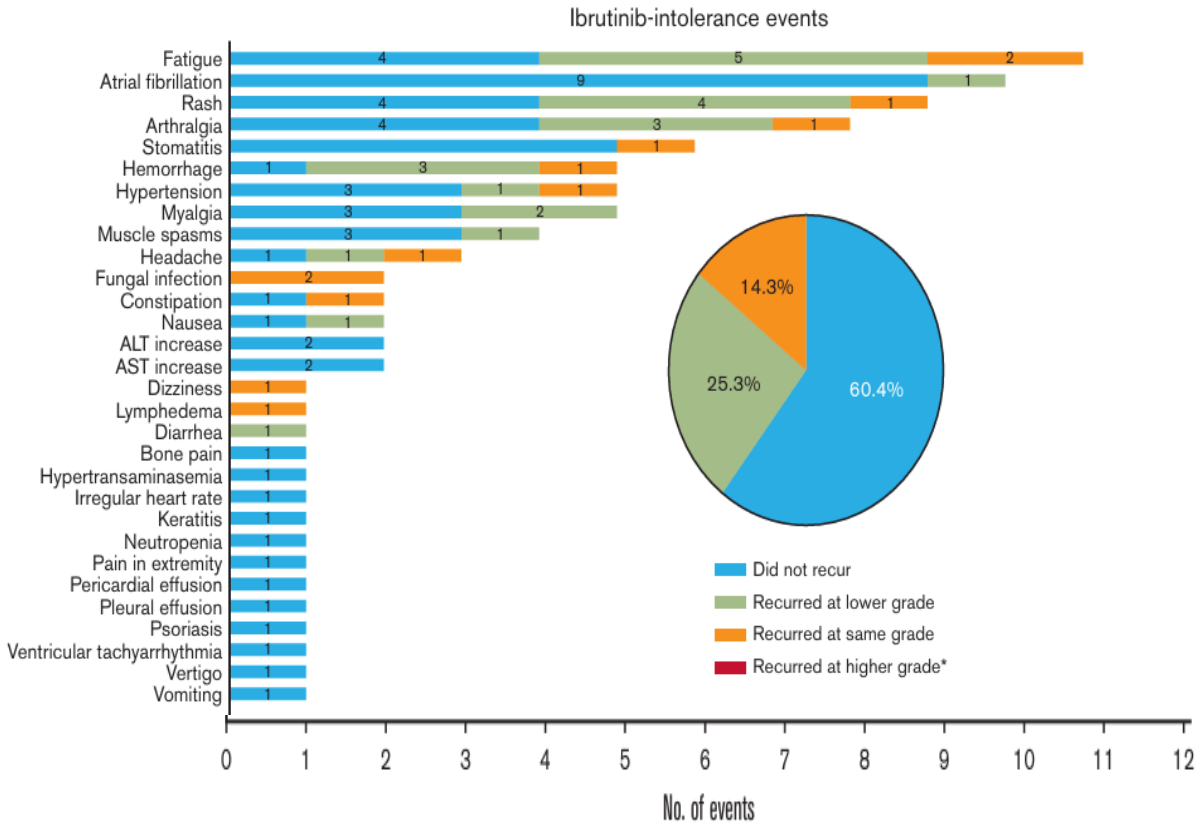
Zanubrutinib in Ibrutinib intolerant patients

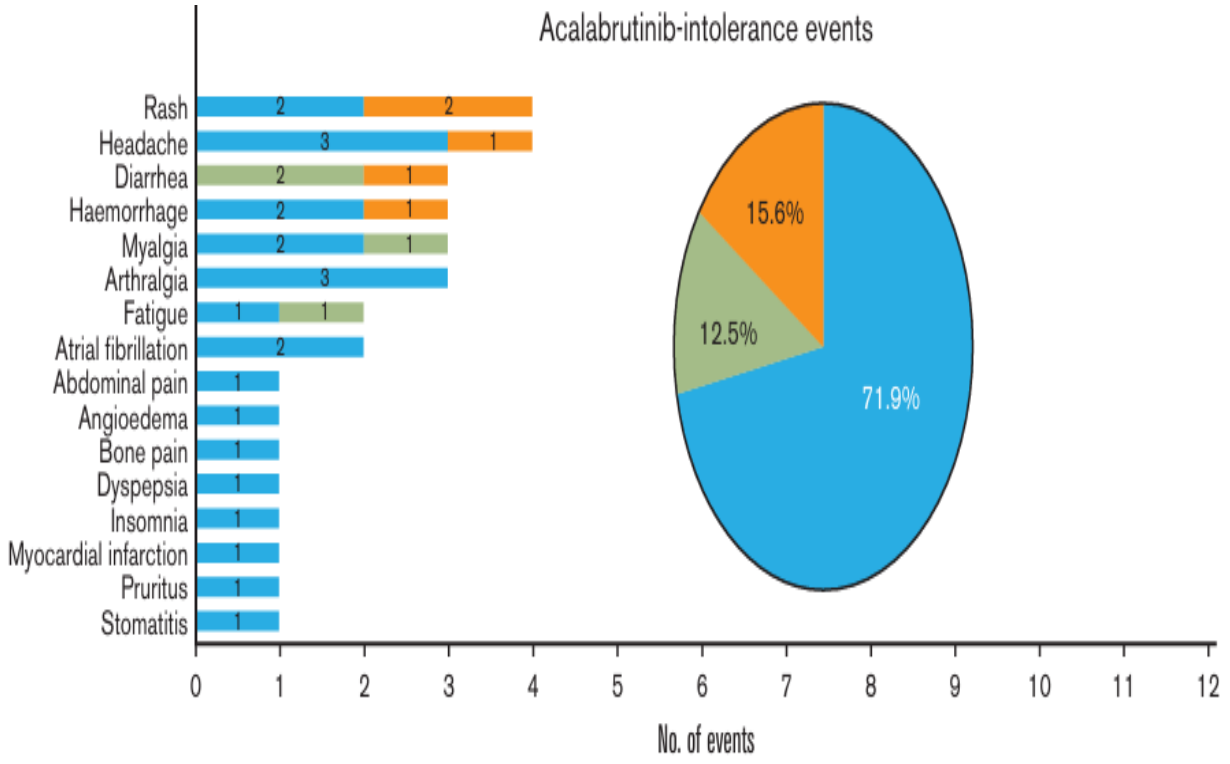


- 34/57 (59.6%) of patients who took ibrutinib and 7/10 (70.0%) of patients who took acalabrutinib did not have recurrence of any intolerance event
- No ibrutinib or acalabrutinib intolerance events recurred at a higher severity
- 81/115 (70.4%) ibrutinib intolerance events and 15/18 (83.3%) acalabrutinib intolerance events did not recur
- 25/38 (65.8%) grade 3 ibrutinib intolerance events and 3/4 (75.0%) grade 3 acalabrutinib intolerance events did not recur while on zanubrutinib
- All grade 4 intolerance events (neutropenia [n=2], ALT increase [n=1], AST increase [n=1]) did not recur on zanubrutinib
- 1 patient (1.5%) discontinued zanubrutinib due to recurrence of a prior intolerant event (myalgia; acalabrutinib)

Shadman, Lancet Haematology, 2023

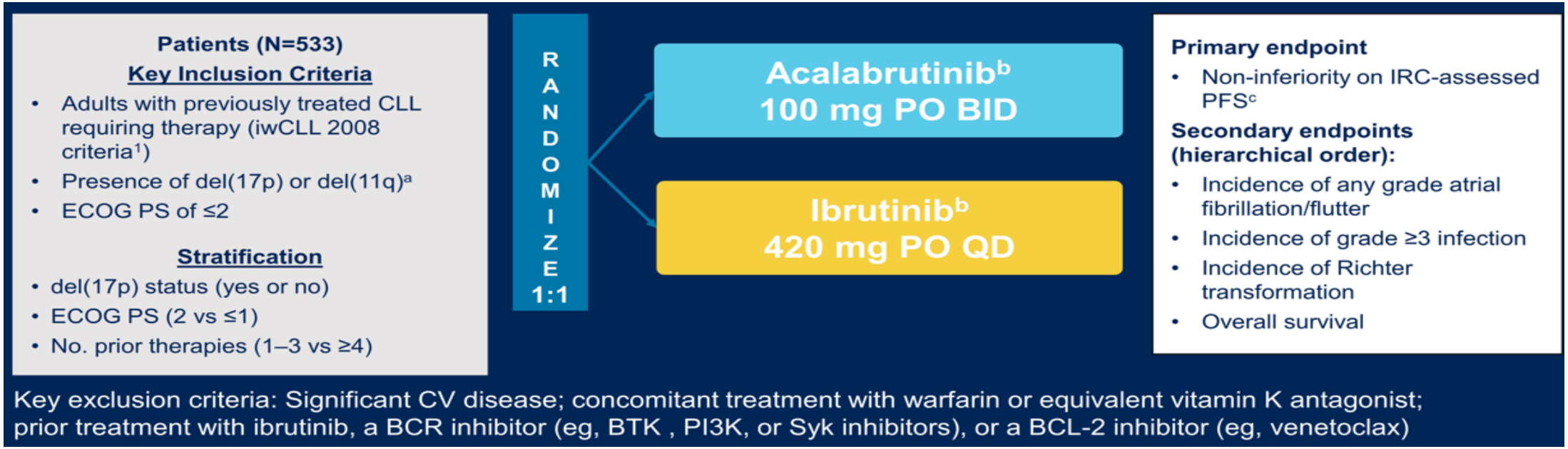
Zanubrutinib in Ibrutinib/Acalabrutinib-Intolerant Patients

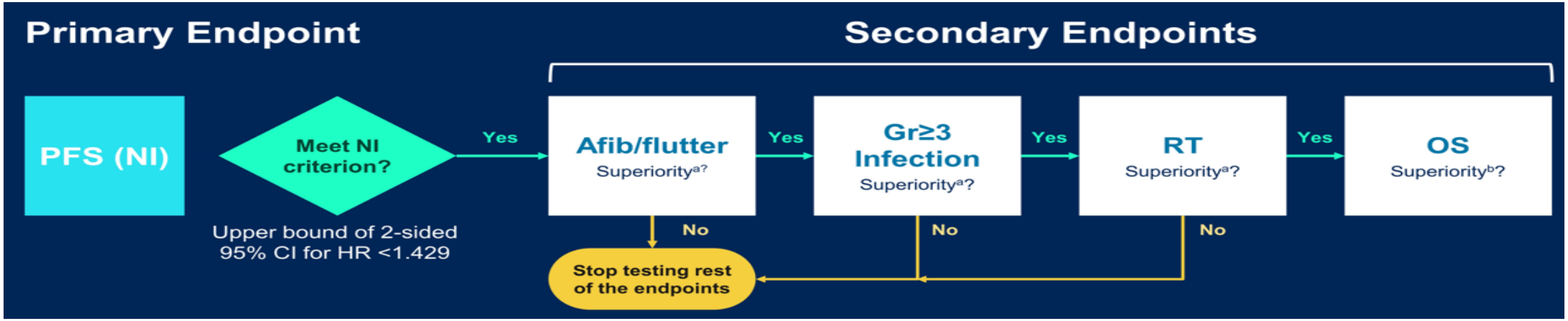




Shadman et al, Blood Adv, 2025

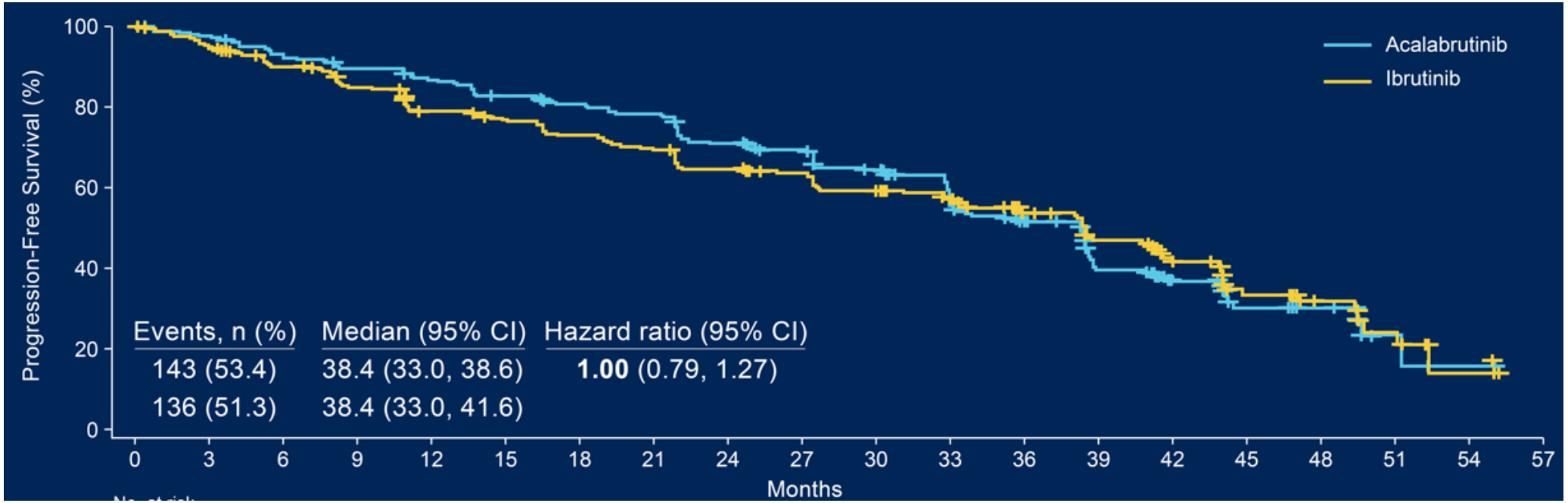
Ibrutinib vs. Acalabrutinib (ELEVATE-RR)





Byrd, ASCO, 2021

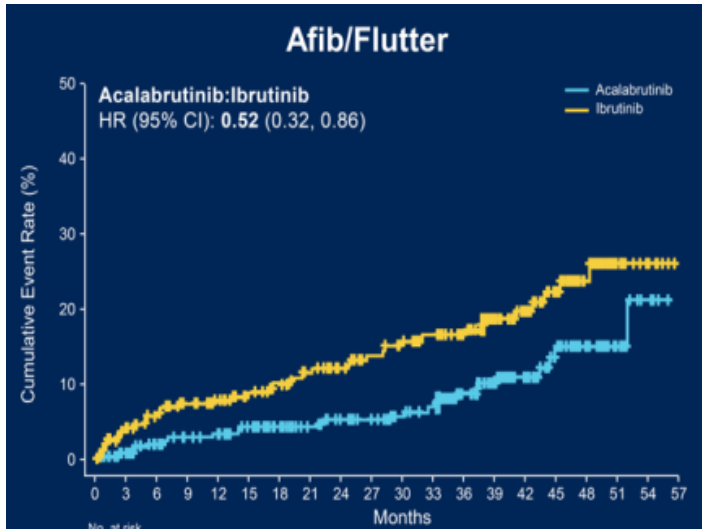
Ibrutinib vs. Acalabrutinib (ELEVATE-RR)

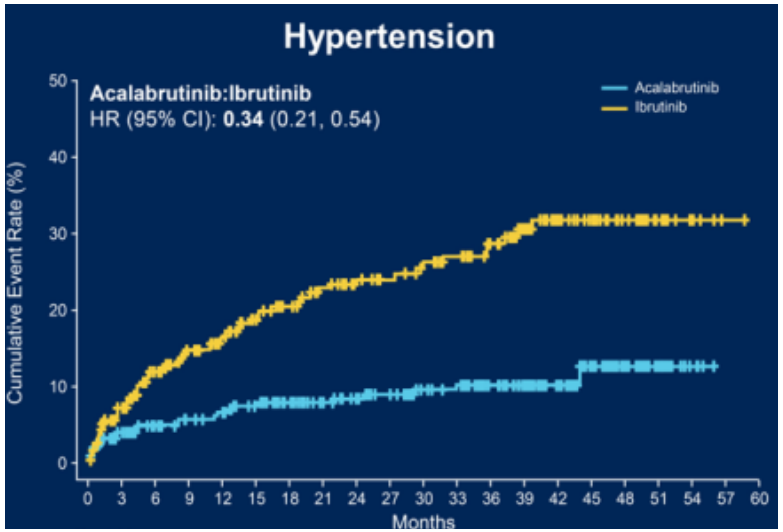


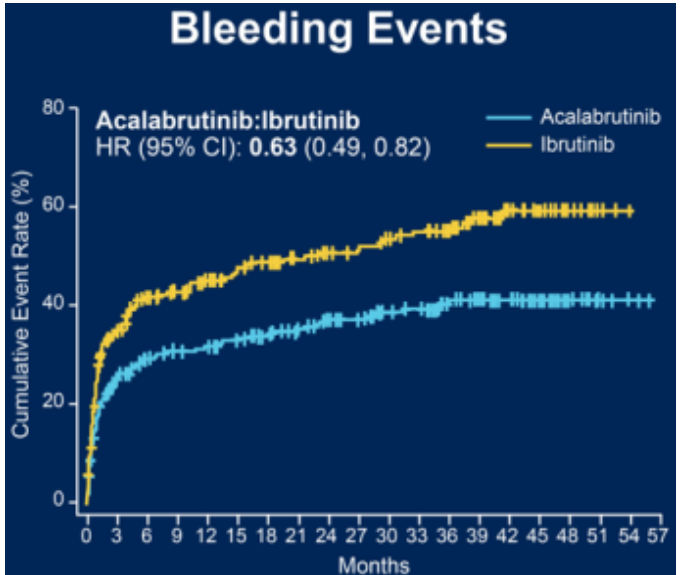
- High-risk patients only:
  - Del 17p: 45%
  - TP53 mutated 37-42%
  - Unmutated IGVH 82-89%
- Stopped because of adverse events:
  - 14.9% in acalabrutinib and 22.3% in ibrutinib group

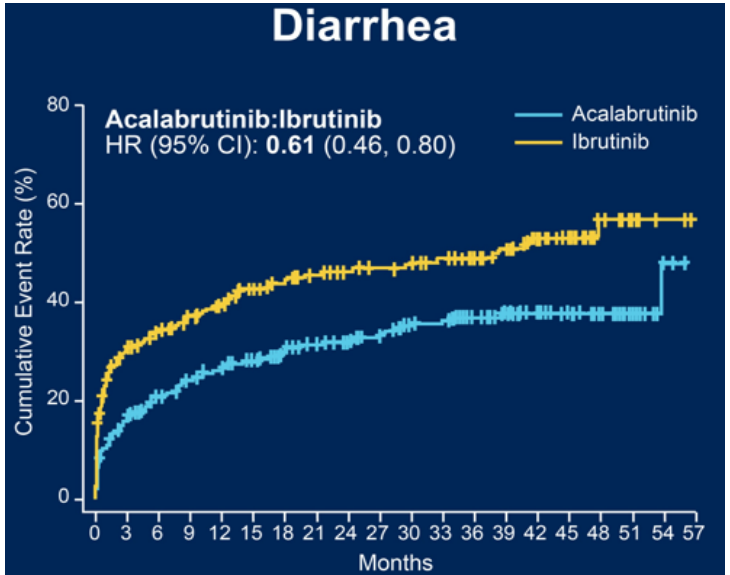
Byrd, ASCO, 2021

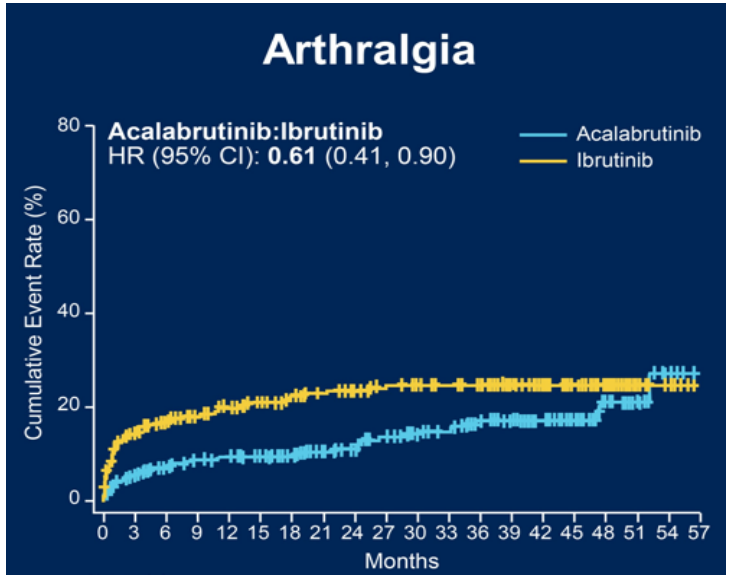
Ibrutinib vs. Acalabrutinib (ELEVATE-RR)











Zanubrutinib vs Ibrutinib in r/r CLL (ALPINE)

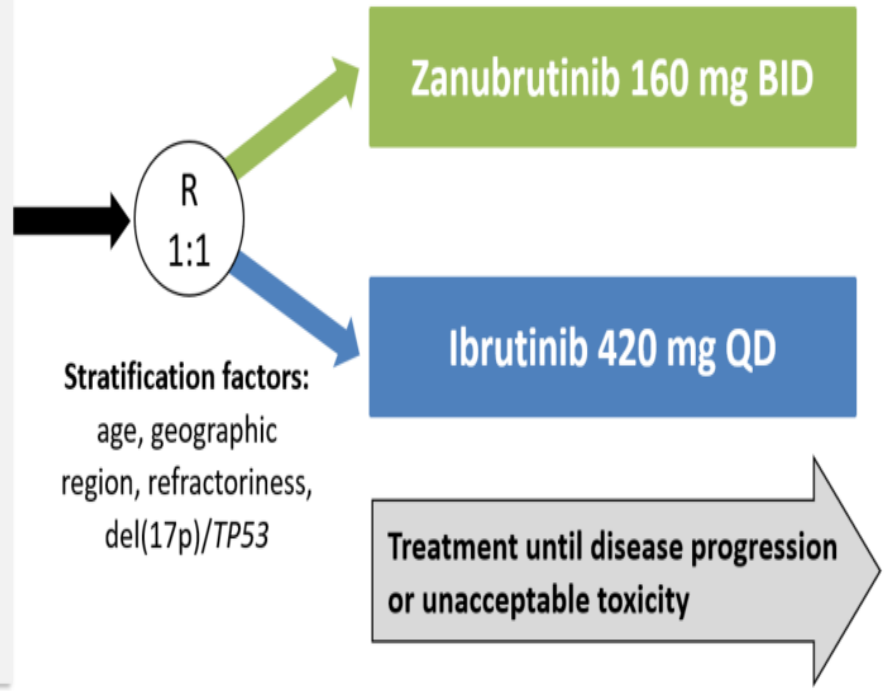
R/R CLL/SLL with ≥ 1 prior treatment
(Planned N=600, Actual N=652)

Key Inclusion Criteria

- R/R to ≥1 prior systemic therapy for CLL/SLL
- Measurable lymphadenopathy by CT or MRI

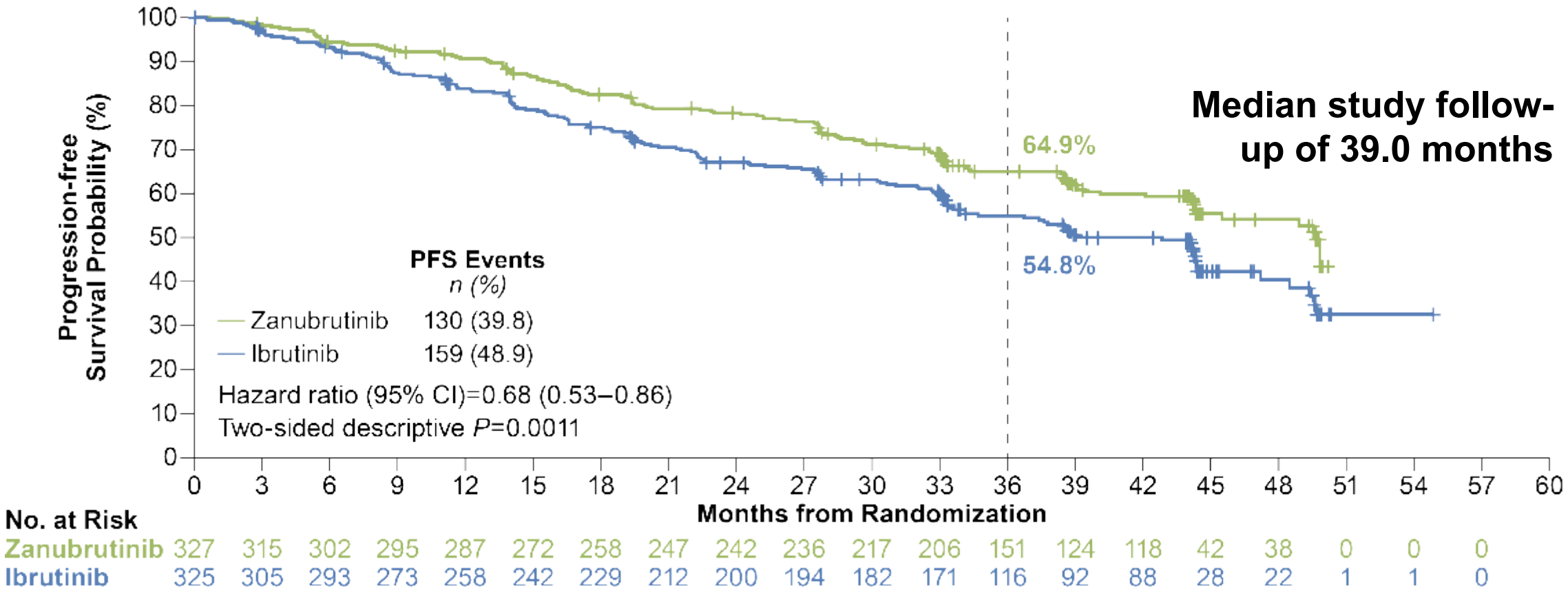
Key Exclusion Criteria

- Prior BTK inhibitor therapy
- Treatment with warfarin or other vitamin K antagonists



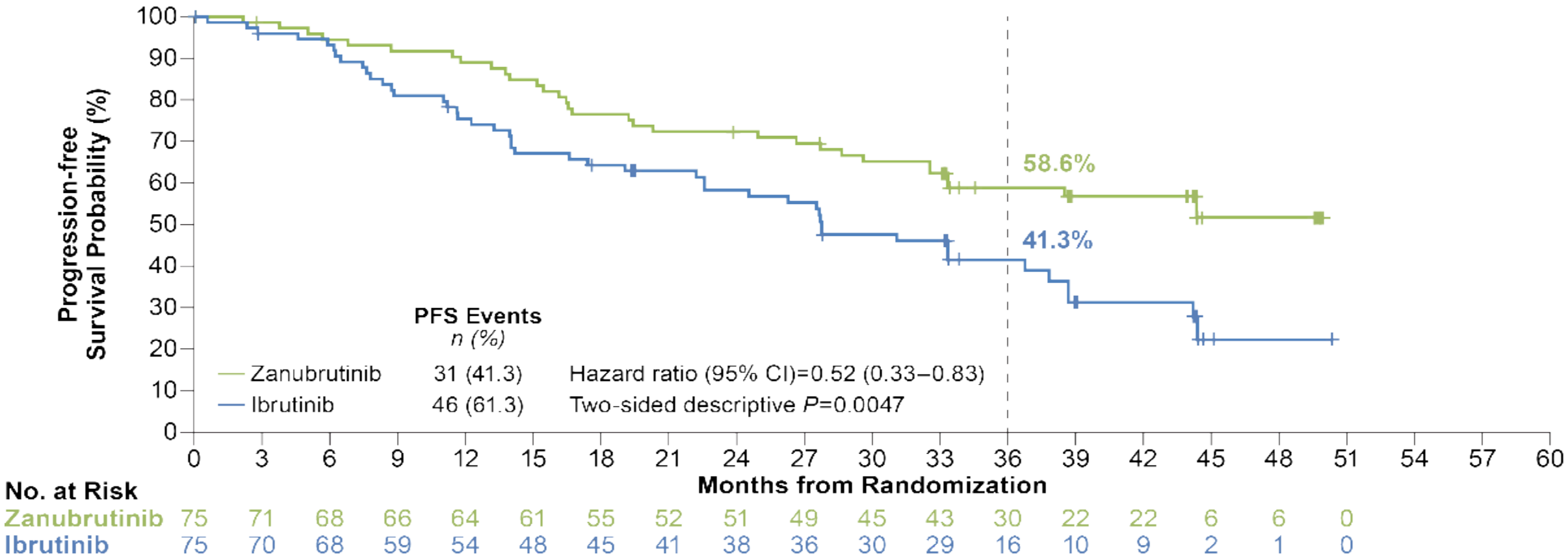
Brown, NEJM,2023

ALPINE Efficacy: PFS Extended Follow-Up



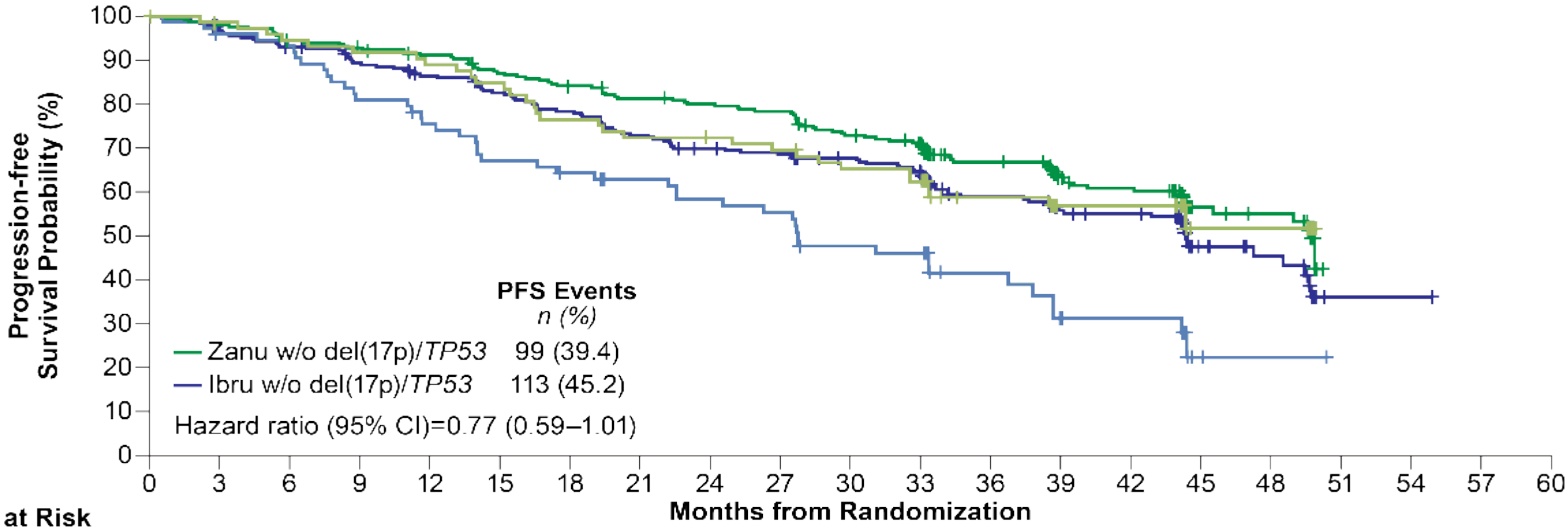
Brown JR, et al. *N Engl J Med.* 2023; 388:319-332; Brown JR, et al. ASH 2023. Abstract 202. Brown JR, Blood, *in press*

ALPINE Efficacy: PFS in Del(17p)/*TP53*^{mut} Extended Follow-Up



Brown JR, et al. *N Engl J Med.* 2023; 388:319-332; Brown JR, et al. ASH 2023. Abstract 202. Brown JR, Blood, *in press*

ALPINE: Zanubrutinib Demonstrated Robust PFS Benefit Independent of Del(17p)/*TP53* Mutation Status

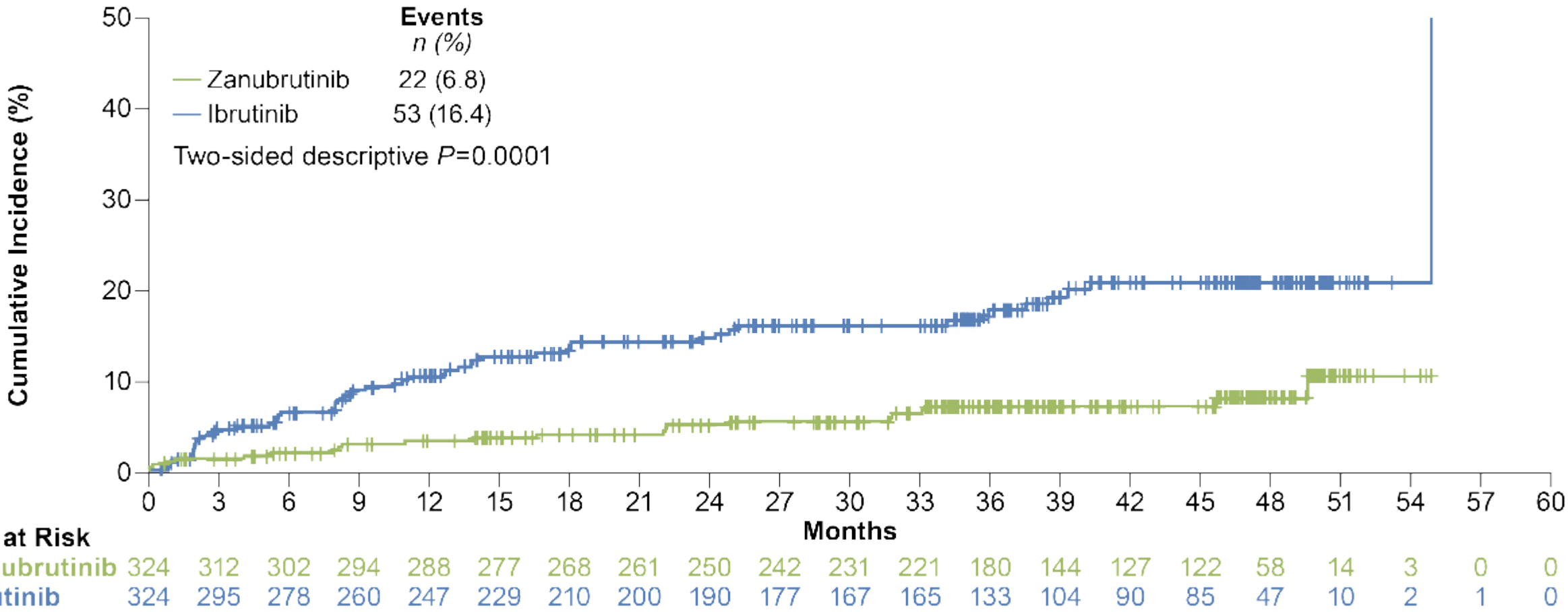


No. at Risk

Zanu with del(17p)/*TP53*	75	71	68	66	64	61	55	52	51	49	45	43	30	22	22	6	6	0	0	0
Ibru with del(17p)/*TP53*	75	70	68	59	54	48	45	41	38	36	30	29	16	10	9	2	1	0	0	0
Zanu w/o del(17p)/*TP53*	251	243	233	228	222	211	203	195	191	187	172	163	121	102	96	36	32	0	0	0
Ibru w/o del(17p)/*TP53*	250	235	225	214	204	194	184	171	162	158	152	142	100	82	79	26	21	1	1	0

Brown JR, et al. *N Engl J Med.* 2023; 388:319-332; Brown JR, et al. ASH 2023. Abstract 202. Brown JR, Blood, *in press*

ALPINE: Atrial Fibrillation/Flutter Events

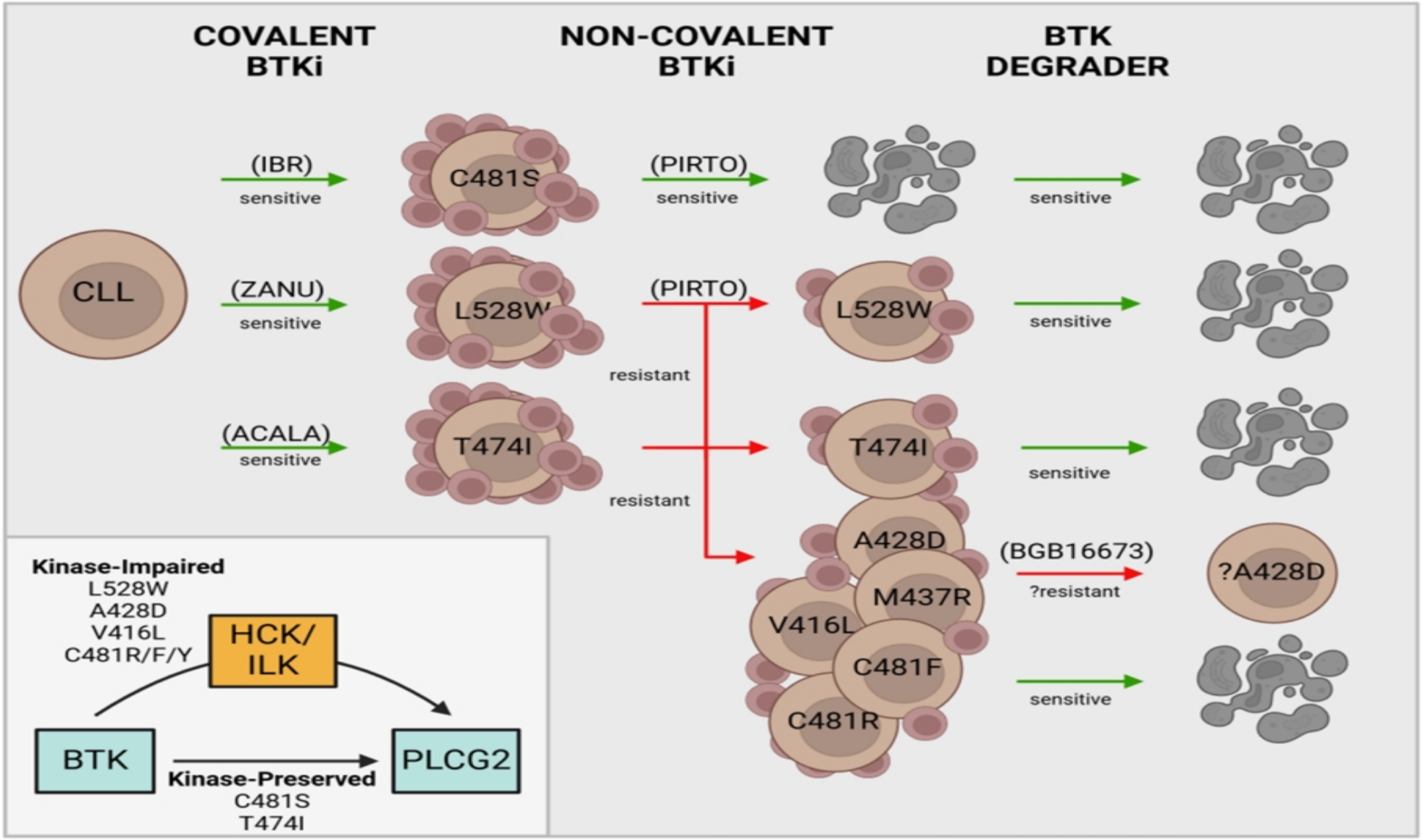


Brown JR, et al. *N Engl J Med.* 2023; 388:319-332; Brown JR, et al. ASH 2023. Abstract 202. Brown JR, Blood, *in press*

BTKi inhibitors

Drug	Binding to BTK	Reversibility	BTKi generation	Use after progression after a 1st or 2nd gen BTKI?	Selectivity for BTK	Use after intolerance to other BTKis?
Ibrutinib	Covalent	Irreversible	First	No	No	Yes, but unlikely to be helpful
Acalabrutinib	Covalent	Irreversible	Second	No	Yes	Yes
Zanubrutinib	Covalent	Irreversible	Second	No	Yes	Yes
Pirtobrutinib	Non-Covalent	Reversible	Third	yes	Yes	Yes
Nemtabrutinib*	Non-Covalent	Reversible	Third	Potentially	Maybe	Need more data
BGB-16673*	Degrader		Fourth			
NX-5948*	Degrader		Fourth			

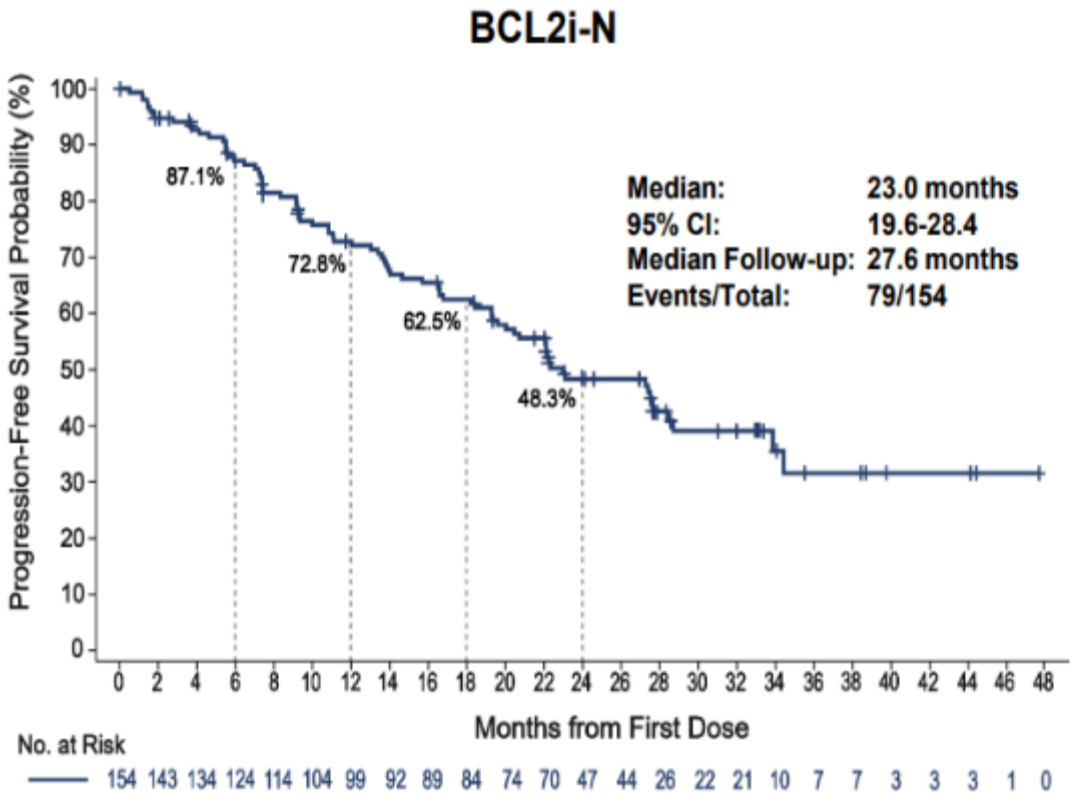
* Not FDA approved for CLL as of September 2024

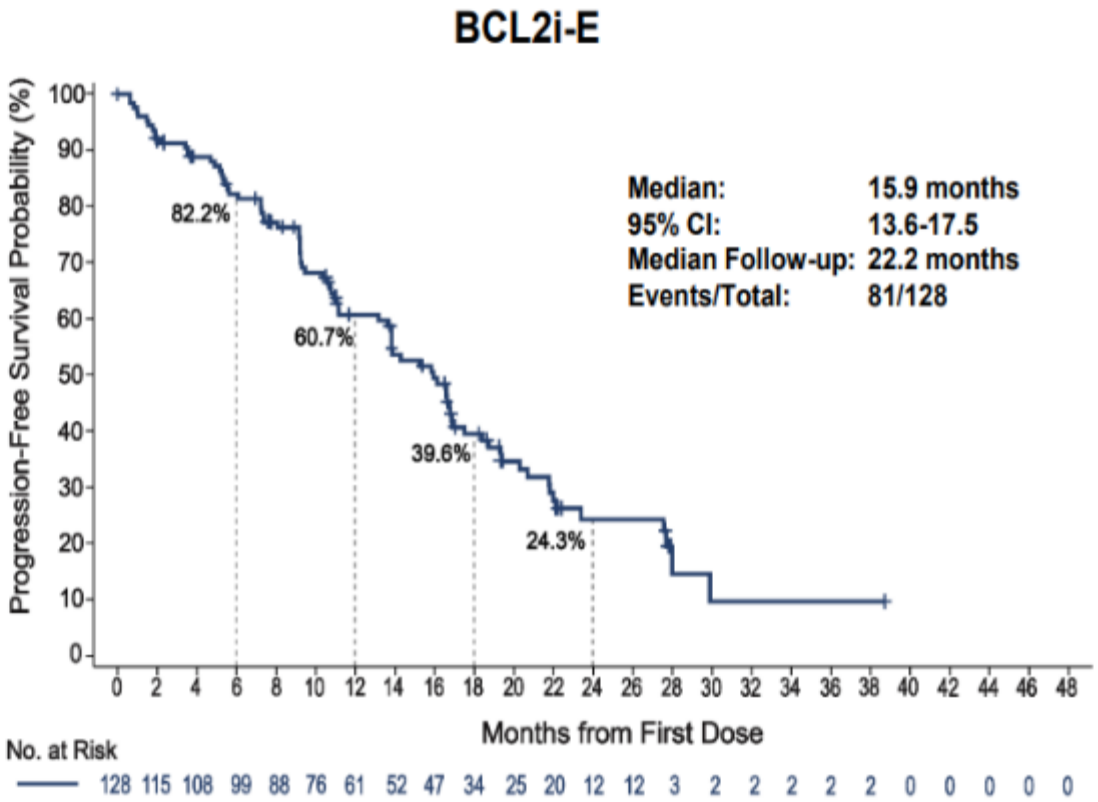


Tam C et al., Blood,2025

Pirtobrutinib for r/r CLL

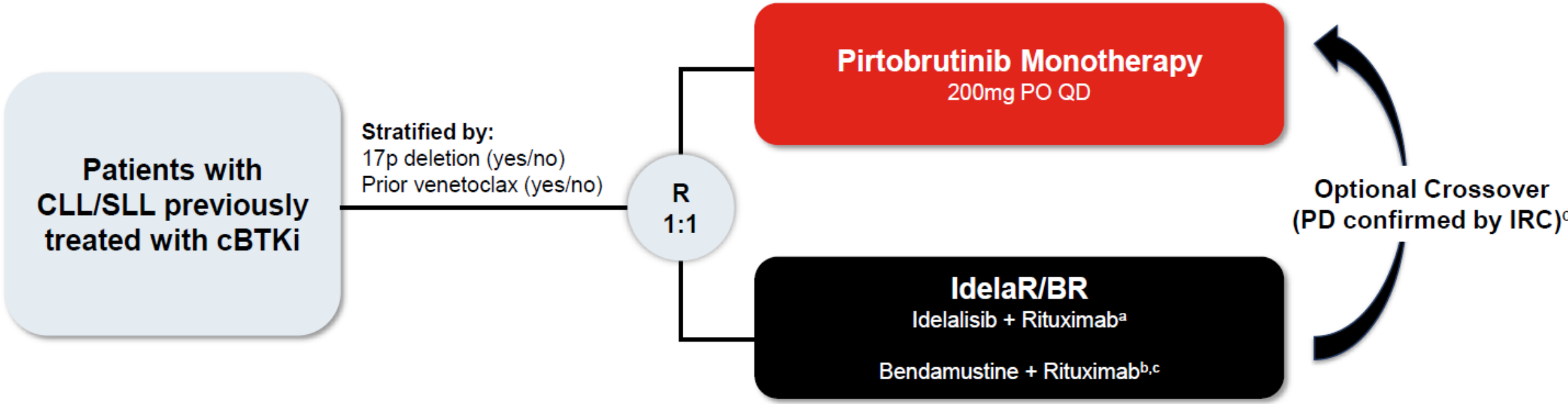
Pirtobrutinib Progression-free Survival With Prior cBTKi, With or Without Prior BCL2i





Mato, NEJM,2023; Woyach JA, et al. ASH 2023. Abstract 325.

BRUIN CLL-321 Study Design



Key Eligibility

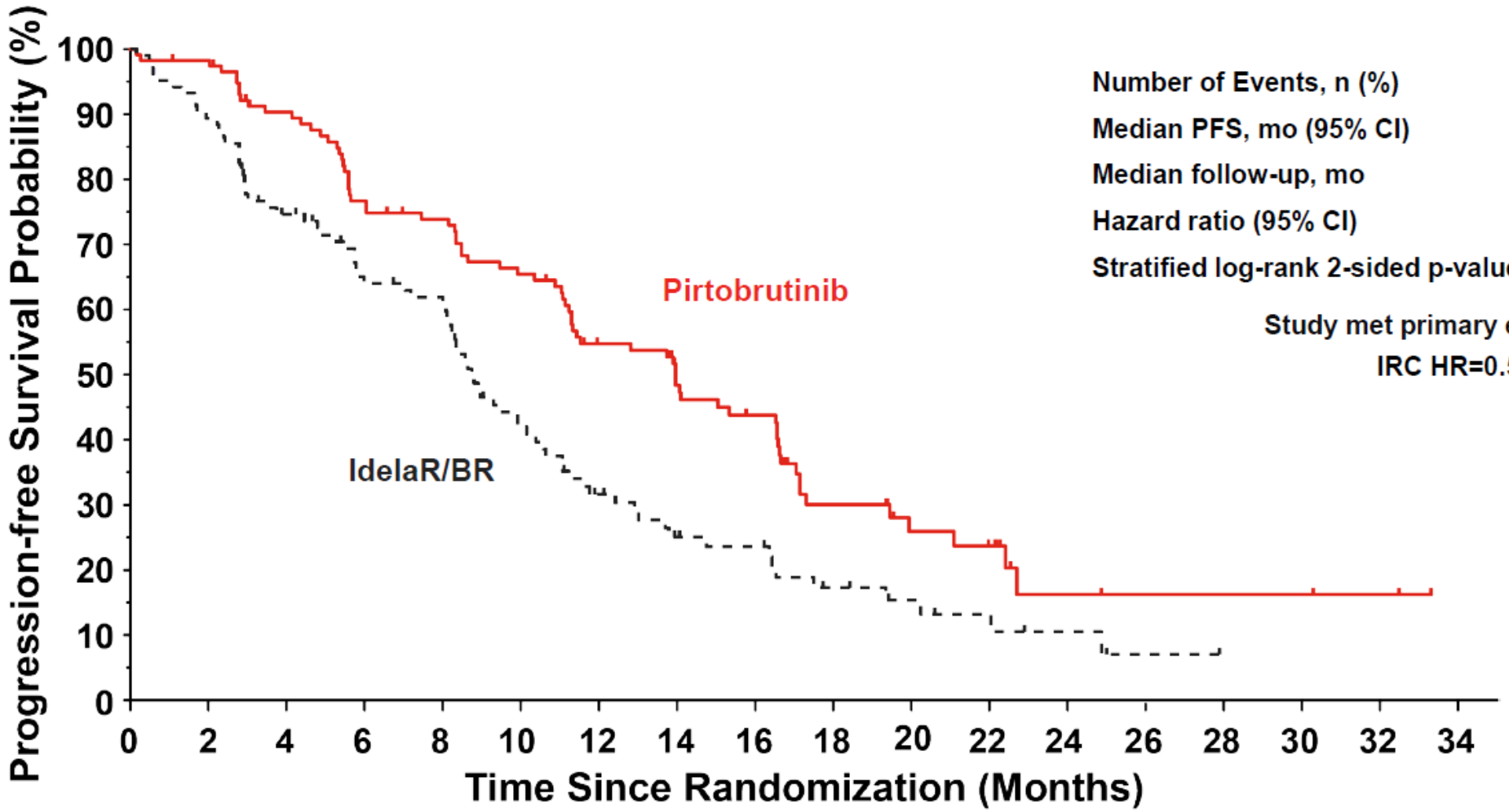
- Age ≥18
- ECOG PS 0-2
- Confirmed CLL/SLL requiring treatment per iwCLL 2018
- **Prior cBTKi required**
- **No limit on prior lines of therapy**
- **Prior history of atrial fibrillation allowed**

Key Endpoints

- **Primary Endpoint: PFS assessed by IRC**
- PFS assessed by investigator
- Event-Free Survival
- Time to Next Treatment
- Overall survival
- Safety

Sharman J, ASH, 2024

IRC-Assessed Progression-free Survival



	Pirtobrutinib n=119	IdelaR/BR n=119
Number of Events, n (%)	74 (62)	79 (66)
Median PFS, mo (95% CI)	**14.0** (11.2-16.6)	**8.7** (8.1-10.4)
Median follow-up, mo	19.4	17.7
Hazard ratio (95% CI)	**0.54 (0.39-0.75)**	
Stratified log-rank 2-sided p-value	0.0002*	

Study met primary endpoint at earlier data cut (Aug 2023)
IRC HR=0.58 (95% CI 0.38-0.89); p=0.01

Pirtobrutinib reduced risk of progression or death by 46% according to IRC assessment

Number at Risk

Pirtobrutinib	119	113	100	84	79	69	54	44	36	19	12	10	4	3	3	3	2	0
IdelaR/BR	119	92	73	60	57	37	25	18	16	10	7	5	3	1	0	0	0	0

Sharman J, ASH, 2024

Cellular therapies for CLL

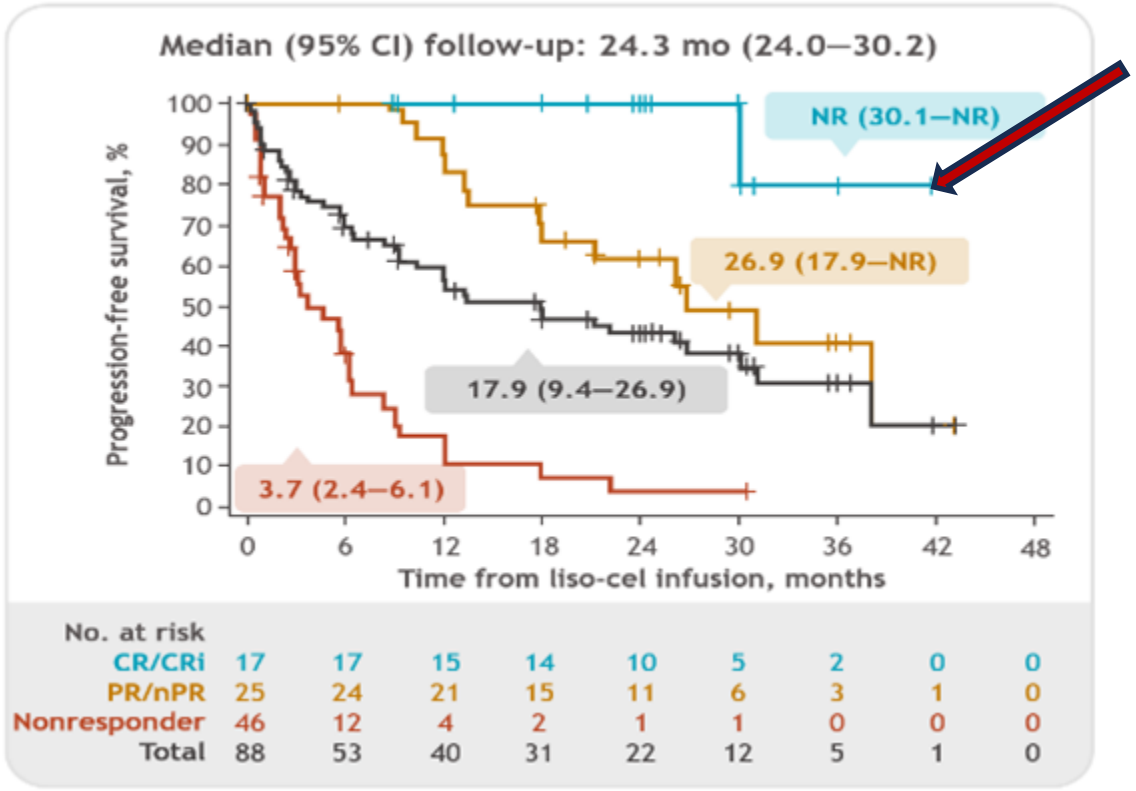
Liso-cel ± ibrutinib

	Liso-cel N=118	Liso-cel plus ibrutinib N=56
ORR	44%	86%
CR	21%	45%
CRS (any grade)	85%	80%
CRS 3-4	8%	4%
ICANS (any grade)	45%	41%
ICANS 3-4	19%	11%

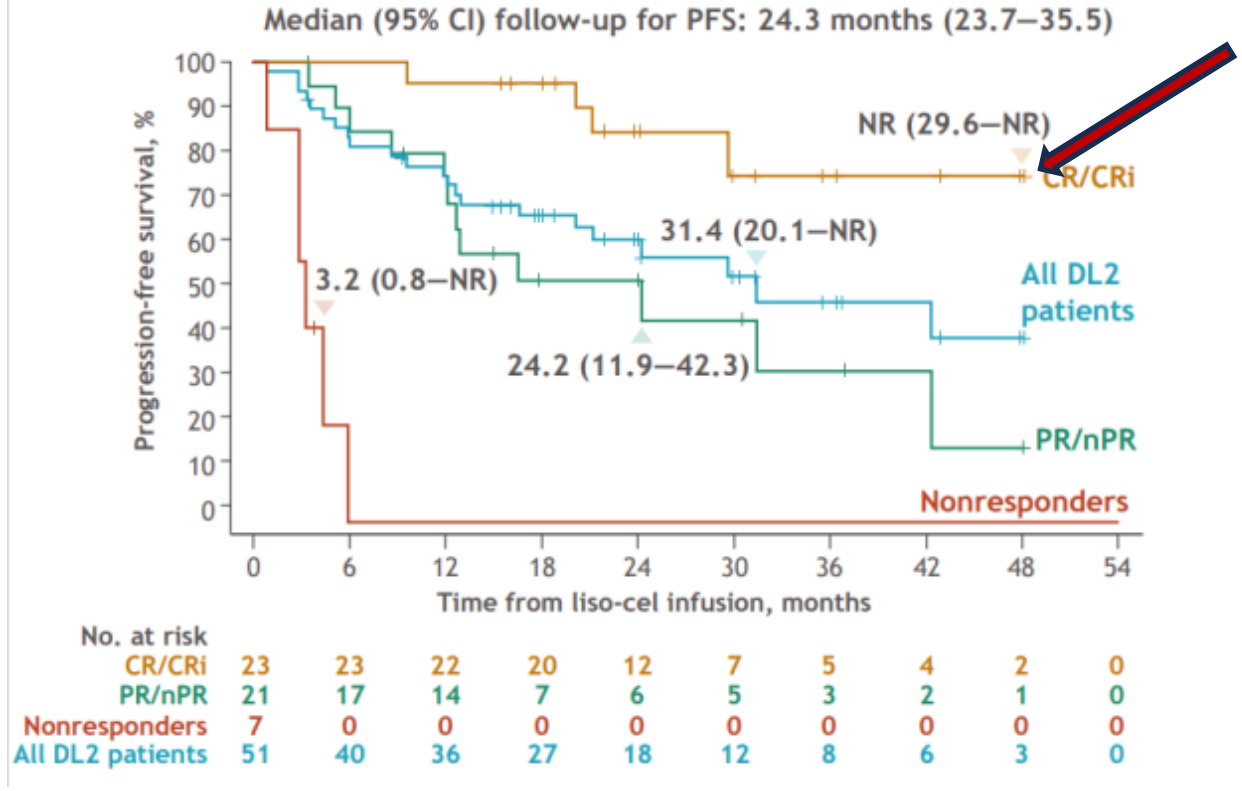
Siddiqi T et al., ASH,2023; Wierda W et al.,ASH,2024

Liso-cel ± ibrutinib

Liso-cel



Liso-cel plus ibrutinib



Siddiqi T, et al. ASH 2023 ; Wierda W. et al.,ASH,2024

Allogeneic SCT for High Risk CLL

- Reduced intensity/ Nonmyeloablative allogeneic transplant

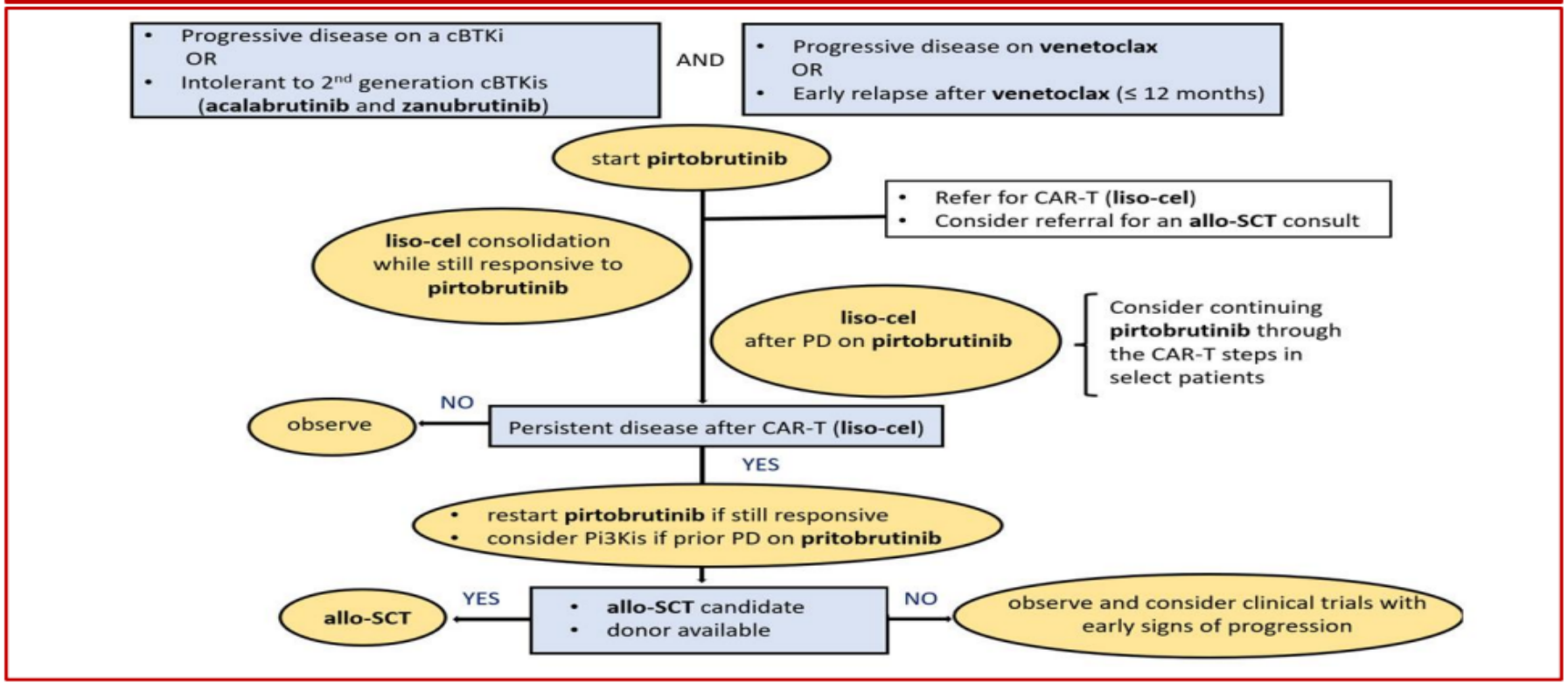
Author	Kim	Roeker	Paul	Shadman	Andersen
Year	**2020**	**2020**	**2020**	**2019**	**2019**
N	108	65	64	55	432
Conditioning	RIC	RIC	RIC (haplo)	NMA	RIC/NMA
Follow-up (yr)	3	2	4	3	5
OS	**69-87**	**81**	**52**	**54**	**46-52**
PFS	**58-72**	**63**	**37**	**45**	**38-43**
NRM	**7-17**	**13**	**24**	**38 (<12)***	**32-35**
aGVHD (3-4)	8-13	24	3	20	?
Extensive cGVHD	45-57	27	7	66	?

50
40
20-25

*** in pts without comorbidities**

Shadman, Hematol Oncol Clin N Am, 2021

How I treat patients with CLL after prior treatment with covalent BTK inhibitor and BCL-2 inhibitor



Conclusions: **In patients with CLL previously treated with BTKi and BCL2i:**

1. **Every effort should be taken to differentiate "double refractory" from "double exposed" disease.**
2. **ncBTKi (pirtobrutinib) is an effective treatment in this setting but duration of response is limited.**
3. **Referral and counselling about CAR-T (liso-cel) and allogeneic transplant should be discussed while patient is responsive to pirtobrutinib and not after progression on pirtobrutinib**

blood Visual Abstract

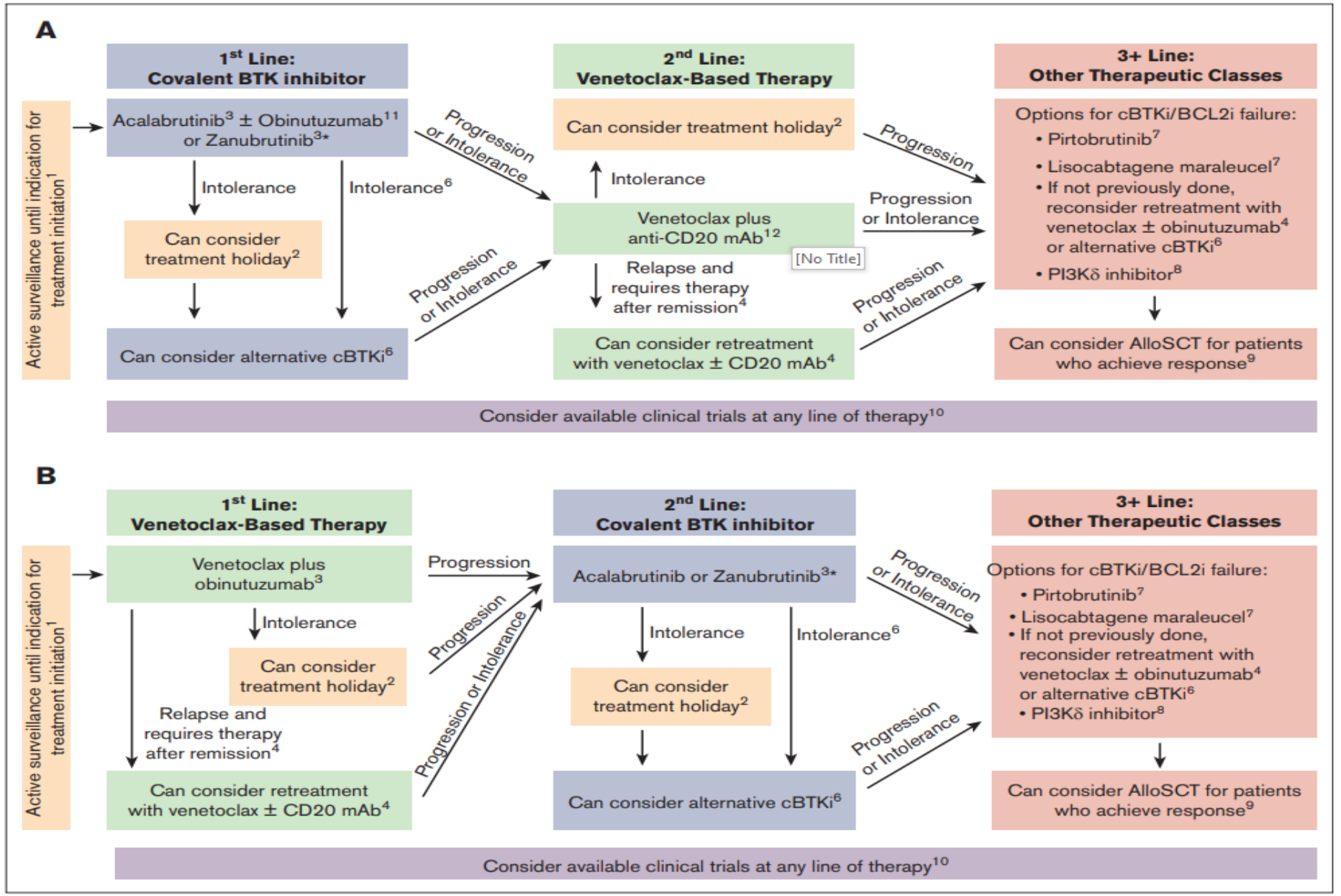
Shadman M & Davids MS, Blood, 2025

Summary facts:

1. Covalent BTKis (indefinite) and venetoclax + anti CD20 abs (fixed-duration) are the first 2 options and they are both reasonable to be used in first-line. Acala+Ven ± obino will be (is) the third option soon.
2. Second generation cBTKis (zanubrutinib or acalabrutinib) are preferred over ibrutinib
3. Obinutuzumab is the preferred anti CD20 ab (vs. rituximab) in CLL
4. MRD is an important prognostic marker for time-limited therapies (chemo, Venetoclax, CAR-T). However, MRD-guided therapy is considered investigational at the current time. Studies are ongoing.
5. The field is moving toward combination therapy with a BCL2i as the backbone plus a BTKi with or without the CD20 antibodies.
6. Pirtobrutinib, liso-cel (CD19 CART) are options for patients with "double refractory" disease after covalent BTKi and BCL2 inhibitors
7. It is critical to have good disease control before CAR-T therapy. Refer for CAR-T when disease is stable on pirtobrutinib
8. Venetoclax + Ibrutinib is approved in Europe and Canada <u>but not in the US.</u>
9. Expected approvals: venetoclax+acalabrutinib, already on NCCN guidelines
10. In the pipeline: BTK degraders, bispecific abs (CD20/CD30; CD20/CD8), Novel autologous and allogeneic immune effector cell therapy, new BCL2 inhibitors, etc.

CLL (Night before the test)

1. Flow cytometry is critical (and adequate) to make the diagnosis
2. Remember CLL immunophenotype (and differences with MCL and other lymphomas)
3. Review Indications for treatment. This hasn't change even with new agents.
4. Check FISH before each line of treatment (r/o del 17p/P53 mutation)
5. Frontline: Ven-O or BTKi (acalabrutinib or zanubrutinib) or acala+Ven ± obino
6. Relapsed setting: Ven-R(or O is available) or BTKi (acalabrutinib or zanubrutinib), Pirtobrutinib. Liso-cel, idelalisib/duvelisib.
7. BTKi AEs (less with 2nd gen): initial lymphocytosis (is OK), bleeding, Afib, HTN, body pain.
8. Idelalisib/duvelisib: lymphocytosis (is OK), colitis, pneumonitis, hepatitis (more with idela), PJP, CMV – Don't use in frontline setting
9. Venetoclax: watch for TLS at the beginning. Ramp-up HAS to be done!
10. Liso-cel: CRS,ICANS, prolonged cytopenia, infection



Soumerai et al. Blood Adv., 2024

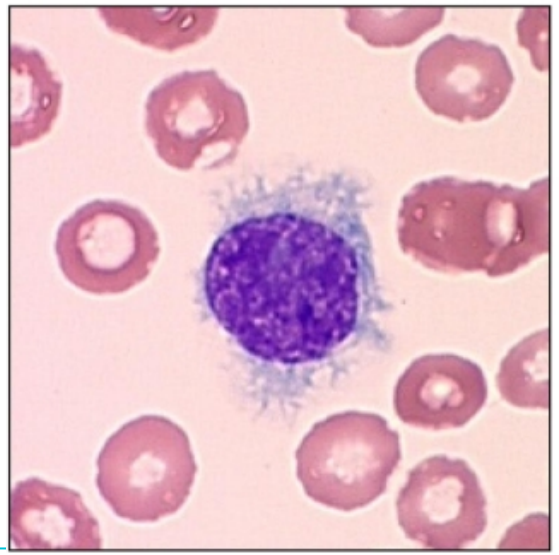
Hairy Cell Leukemia

Hairy Cell Leukemia

- Uncommon chronic B cell lymphoid neoplasm

- Small mature B cell lymphoid cells with abundant cytoplasm and "hairy" projections within the peripheral blood, bone marrow, and splenic red pulp

- Splenomegaly and cytopenias



Hairy cell Leukemia: (Diagnosis)

	CD11c	CD25	CD103	CD123	CD10	CD21	CD23	CD5	CD20	CD19	CD22	Annexin A1
HCL	+	+	+	+	-	-	-	-	+	+	+	+

BRAF V600E mutation is a disease-defining event

HCL variant:

CD25 (-) , CD123 (-), annexin A1 (-) and BRAF V600E (-)

Hairy cell Leukemia

- **Clinical presentation**
  - Splenomegaly
  - Cytopenias (infections, bleeding)
  - Constitutional symptoms

- **Treatment Indications:**
  - Systemic symptoms
  - Splenic discomfort
  - Recurrent infections
  - Cytopenias (Hb <11, ANC < 1000, bleeding due to plt <100,000)

Hairy Cell Leukemia: Treatment

- **First Line**
  - Purine analogs
    - **Cladrabine (2-CdA) + rituximab** – Up to 80% CR with a CR duration of 57 months (7 – 246) after a single cycle
    - **Pentostatin**
- **Refractory (failure in less than a year) or Relapsed disease**
  - purine analogs ± Rituximab
  - INF-alfa
  - rituximab
  - **BRAF targeting agents (Vemurafenib) ± rituximab**
  - **moxetumomab Pasudotox** (anti CD22 immunotoxin conjugate) (discontinued)

Please Consider Clinical Trials!

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Fred Hutch
Cancer Center

W Medicine
UNIVERSITY of WASHINGTON