ICLIO National Conference

I-O in Real Time

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accc-iclio.org

Discussion Points

- implications with radiology
- CNS disease
- uptake in your setting
- payer criteria and issues

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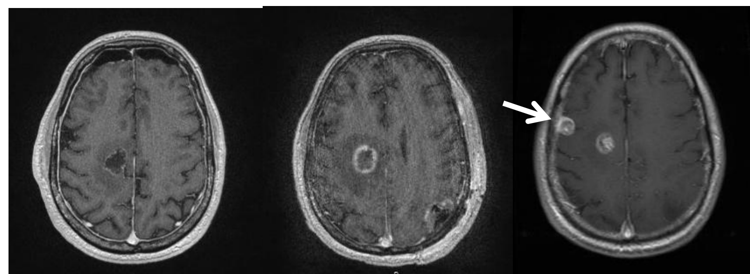
Issues Affecting Radiology

- Peculiar characteristics of responses to immunotherapy
- Dual response criteria: RECIST and irRC
- Treatment beyond progression
- Additional imaging tests to confirm progression vs. delayed response
- Considerations in the differential diagnosis, e.g., immune related pneumonitis vs infectious vs progressive disease

Factor	RECIST	irRC
Measurement of tumor burden	• Unidimensional	• Bidimensional
Complete Response (CR)	• Disappearance of all target and non-target lesions • Lymph nodes must regress to <10mm short axis • No new lesions • Requires confirmation	• Same as RECIST
Partial Response (PR)	• ≥30% decrease in tumor burden compared to baseline • Requires confirmation	• ≥50% decrease in tumor burden compared to baseline • Requires confirmation
Progressive Disease (PD)	• ≥20% plus 5mm absolute increase in tumor burden compared with nadir • Progression of non-target lesions and/or appearance of new lesions (at any single time point)	• ≥25% increase in tumor burden compared to most recent prior evaluation • New lesions added to tumor burden • Requires confirmation
Stable Disease (SD)	• Any response pattern that does not meet criteria for CR, PR, or PD	• Same as RECIST

Agarwala SS. *Semin Oncol*. 2015.

Radiologic response after “progression”



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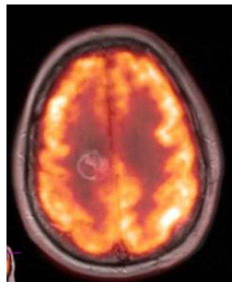

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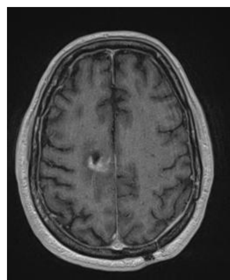

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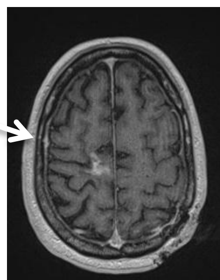

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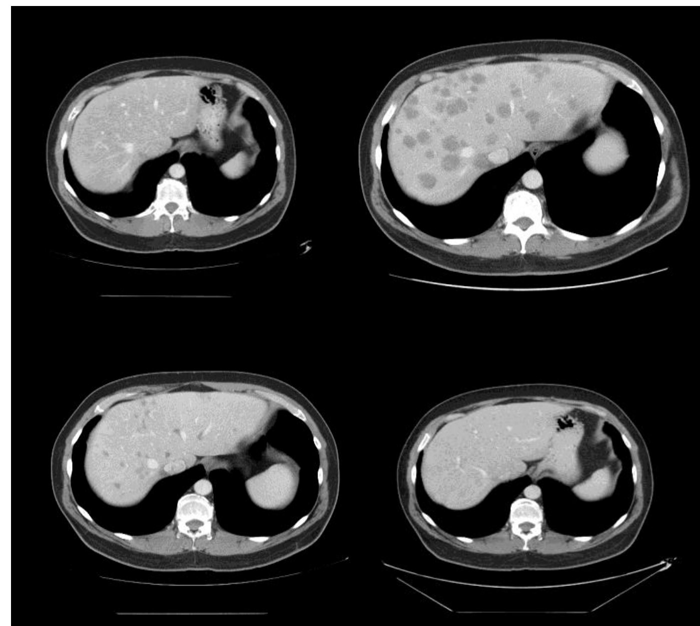


Saenger YM, Wolchok JD. *Cancer Immun*. 2008.

Issues Related to CNS Disease/AEs

- Metastatic disease vs hypophysitis: need to evaluate CNS for non-specific signs and symptoms
- RT/SRS CNS inflammatory flare vs progression vs. radionecrosis
- Use of high dose steroids/ bevacizumab to control edema
- Indications for brain PET, biopsy
- Brain involvement and decision to treat with immunotherapy

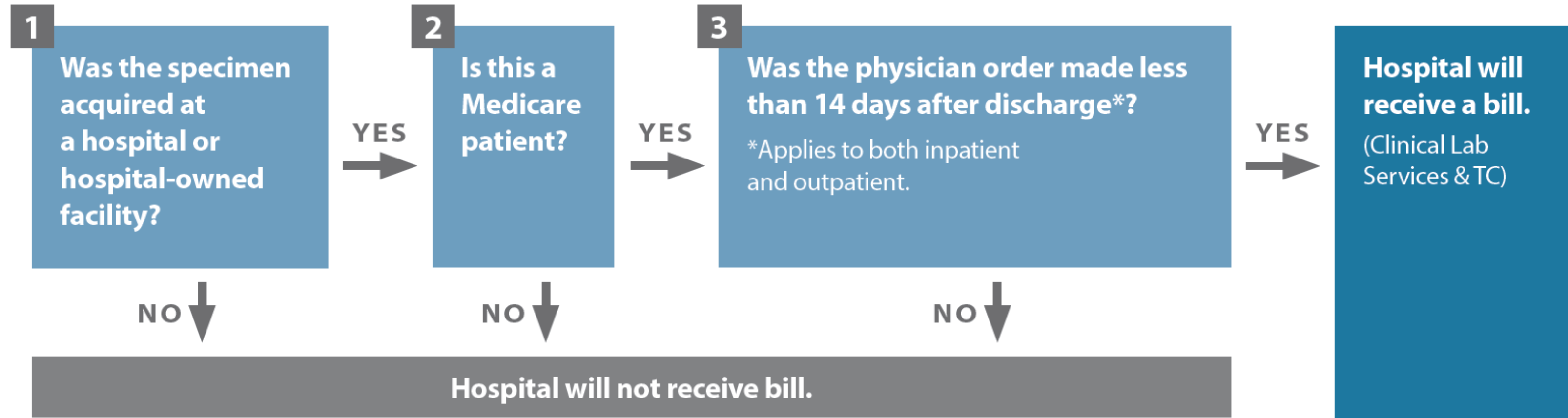
Immunotherapy Uptake in Our Setting

- 700 bed community teaching hospital
- Self-standing cancer center housing medical oncology, surgical oncology, gyn oncology, radiation therapy, nutrition and psychosocial services.
- Disease-specific tumor boards: breast, GI, cutaneous, head/neck, GU, general.
- Active clinical trials program: cooperative group, pharmaceutical and investigator initiated trials
- Familiarity of medical/radiation oncologists with immunotherapy through early investigational use exposure
- Most feel generally comfortable using modality

Immuno-Oncology

- Involvement of multiple specialties: endocrinology, gastroenterology, neurology, rheumatology, dermatology, ophthalmology
- Education beyond Cancer Center: PCPs, ER personnel, ICU personnel, surgeons, house staff
- Resource avid treatment: close follow up, RN calls, extensive patient education, unscheduled visits
- Pathology: immunohistochemistry of tumor infiltrates, mutational load, new predictive tests (response/AEs) e.g. PD-L1, immune signature genomic profiles, etc.
- 14 day rule: limits access to tumor blocks.

The "14 Day Rule" is a regulation set by CMS that requires laboratories, including Caris Life Sciences, to bill the hospital for clinical laboratory services and the technical component of pathology services provided to Medicare patients when services are ordered less than 14 days after the patient was discharged.



http://www.carismolecularintelligence.com/pdf/TN0177-14-Day%20Rule%20FAQ.pdf

Barriers to Delivery of Immuno-Oncology Rx

- Other barriers
  - Off label use with available positive clinical trial data
  - Uninsured patients
  - Annual deductibles
  - Annual income: “too rich” for financial assistance
- Solutions
  - Expanded access trials, other trials
  - Pharma access programs, co-pay assistance, disease-oriented foundations
  - Team effort: physicians, PAs/NPs, social workers, nurses, pharmacists, authorizations office
  - Patient resources:
    - Patient Advocate Foundation : www.copays.org
    - Cancer Care :
    - Patient Access Network: www.patientaccessnetwork.org

Barriers to Delivery of Immuno-Oncology Rx

- Insurance coverage and authorizations process
  - FDA label vs. NCCN guidelines vs. phase III data: prior lines of treatment, mutation testing results, etc. All information must be sent in before approval. Payors' guidelines lag behind recent FDA approvals, accepted guidelines
  - Drug replacement plans: invariably delays treatment; usually with high co-pays; drug not delivered until co-pays cleared.
  - Frequent denial of imaging and laboratory studies: scans for confirmation of progression, stat biochemical profiles before each immunotherapy dose; lots of peer-to-peer calls.

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