Updated Safety and Antileukemic Activity Data for Sonrotoclax (BGB-11417), a Potent and Selective BCL2 Inhibitor, in Patients With Relapsed/Refractory Acute Myeloid Leukemia

PF491

Pau Montesinos,[1] Paul Cannell,[2] Jake Shortt,[3] Teng Fong Ng,[4] Sundra Ramanathan,[5] Carolyn Grove,[6] Jianyu Weng,[7] Uwe Platzbecker,[8] Chun Yew Fong,[9] Andrew H. Wei,[10] Zaixing Shi,[11] Vaibhav Mundra,[12] Wai Y. Chan,[12] Oleg Zernovak,[12] Amit Agarwal,[12] Courtney DiNardo[13]

[1]Hospital Universitari I Politècnic La Fe, Valencia, Spain; [2]Fiona Stanley Hospital, Murdoch, WA, Australia; [3]Monash Health and Monash University, Clayton, VIC, Australia; [4]Gold Coast University Hospital and Griffith University, QLD, Australia; [5]St George Hospital, Kogarah, NSW, Australia; [6]Linear Clinical Research, Sir Charles Gairdner Hospital and University of Western Australia, Nedlands, WA, Australia; [7]Guangdong Provincial People's Hospital, Guangzhou, China; [8]Universitaetsklinikum Leipzig Aör, Leipzig, Germany; [9]Austin Health, Melbourne, VIC, Australia; [10]Peter MacCallum Cancer Centre, Royal Melbourne Hospital, Melbourne, VIC, Australia; [11]BeOne Medicines Ltd, Shanghai, China; [12]BeOne Medicines Ltd, San Carlos, CA, USA; [13]MD Anderson Cancer Center, Houston, TX, USA

CONCLUSIONS

- Sonrotoclax + azacitidine combination treatment was generally well tolerated and demonstrated antileukemic activity in patients with R/R AML without prior BCL2 inhibitor exposure, across all dose cohorts
  - One DLT of grade 4 thrombocytopenia occurred
  - The ORR was 60.3%; CR was achieved by 27.9% and CR/CRh by 42.6%
  - Overall, 23.5% of patients proceeded to transplant
- The safety stopping criteria have not been met in any of the dose cohorts
- Exploratory exposure-response analysis for the 14-d cohorts showed that antileukemic activity at exposures associated with the 320-mg dose was higher than exposures associated with 80 and 160 mg
- Follow-up evaluation of 14-d dosing cohorts is ongoing in 80-mg, 160-mg, and 320-mg cohorts to determine the recommended phase 2 dose
- Data for patients with treatment naive AML are presented in poster PF477

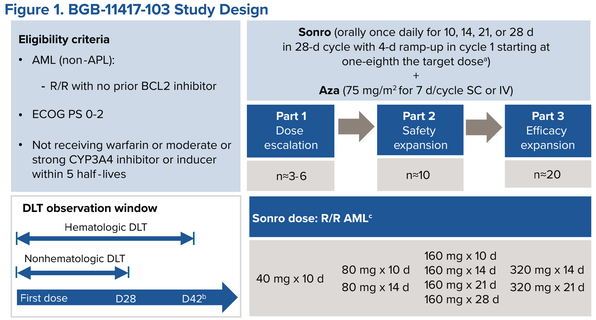
INTRODUCTION

- Acute myeloid leukemia (AML), the most common acute form of leukemia in adults, has an aggressive disease course[1,2]
- Although treatment with venetoclax, a B-cell lymphoma 2 (BCL2) inhibitor, has improved outcomes in some patients with newly diagnosed AML,[3] it is not approved in relapsed/refractory (R/R) AML[4]
- Sonrotoclax (BGB-11417), a next-generation BCL2 inhibitor, is a more selective and pharmacologically potent inhibitor of BCL2 than venetoclax, with a shorter half-life and no drug accumulation[5]
- Updated safety and antileukemic activity data for sonrotoclax + azacitidine in R/R AML from the phase 1b part of the BGB-11417-103 study are presented

METHODS

- BGB-11417-103 (NCT04771130) is an ongoing, phase 1b/2, global, dose-finding and -expansion study evaluating the safety and antileukemic activity of sonrotoclax + azacitidine in patients with AML, myelodysplastic syndromes (MDS), or MDS/myeloproliferative neoplasms (**Figure 1**)

Figure 1. BGB-11417-103 Study Design



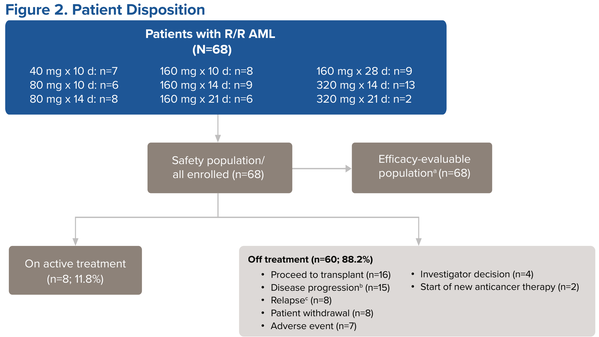
[a]Initial 4-day ramp-up to mitigate potential risk of TLS. As a precautionary measure for TLS monitoring, patients were hospitalized during the ramp-up period. [b]Or C2 initiation. [c]Dose reductions were done first by reducing the number of dosing days/cycles of sonro. Once 10-d dosing was reached, aza dosing was reduced and then sonro daily dose. [d]Response and MRD status were assessed at end of C1 (C2 if remission not yet achieved) and then every six cycles until C13, then every six cycles. [e]MRD-negative was defined as ≤1 residual leukemic blasts per 1,000 leukocytes or 10^{-3} at any time on the study.

Abbreviations: APL, acute promyelocytic leukemia; aza, azacitidine; C, cycle; CYP3A4, cytochrome P450 3A4; d, day; DLT, dose-limiting toxicity; ECOG PS, Eastern Cooperative Oncology Group performance status; ELN, European LeukemiaNet; IV, intravenous; MRD, minimal residual disease; RP2D, recommended phase 2 dose; SC, subcutaneous; sonro, sonrotoclax; TLS, tumor lysis syndrome.

RESULTS

- As of January 10, 2025, 68 patients with R/R AML were enrolled and treated with sonrotoclax + azacitidine; 8 (11.8%) remained on treatment (**Figure 2**)
- The median age was 60 years and the median number of prior lines of therapy was 1.0 (**Table 1**)
- The median number of study treatment cycles was 2; median average cycle length was 35.0 days (d)
- The median relative dose intensity of sonrotoclax was >80%, except in the 80-mg × 10-d cohort (74.9%)

Figure 2. Patient Disposition



Data cutoff: January 10, 2025. [a]Patients who (1) completed ≥1 treatment cycle (initiated the second cycle) or 42 days, whichever is earlier, or discontinued treatment during the first cycle or (2) had ≥1 response assessment. [b]Defined as evidence of an increase in bone marrow blast percentage and/or in absolute blast counts in the blood, both per ELN 2017 response criteria. [c]Hematologic relapse (after CR/CRi) defined as bone marrow blasts ≥5%, reappearance of blasts in the blood, or development of extramedullary disease.

Abbreviations: CR, CR with incomplete hematologic recovery; ELN, European LeukemiaNet.

Table 1. Baseline Patient Characteristics and Treatment Exposure in R/R AML

	Sonro dose + aza									
	40 mg × 10 d (n=7)	80 mg × 10 d (n=6)	80 mg × 14 d (n=8)	160 mg × 10 d (n=8)	160 mg × 14 d (n=9)	160 mg × 21 d (n=6)	160 mg × 28 d (n=9)	320 mg × 14 d (n=13)	320 mg × 21 d (n=2)	Total (N=68)
Study follow-up time, median (range), months	15.4 (9.2-39.5)	20.8 (1.5- 37.8)	5.0 (2.2-10.2)	6.8 (0.2-24.5)	5.5 (1.5-11.1)	6.8 (4.6-16.5)	4.9 (1.2-31.2)	5.9 (0.9-17.0)	12.1 (2.6-21.6)	6.2 (0.2-39.5)
Age, median (range), years	64.0 (36-80)	70.0 (54-78)	57.5 (48-83)	52.5 (36-71)	53.0 (27-72)	53.0 (42-66)	57.0 (29-69)	64.0 (43-81)	70.0 (67-73)	60.0 (27-83)
Male, n (%)	3 (42.9)	3 (50.0)	5 (62.5)	5 (62.5)	5 (55.6)	4 (66.7)	6 (66.7)	9 (69.2)	1 (50.0)	41 (60.3)
AML type, n (%)										
De novo	7 (100)	4 (66.7)	7 (87.5)	7 (87.5)	5 (55.6)	6 (100)	8 (88.9)	12 (92.3)	1 (50.0)	57 (83.8)
Secondary	0	2 (33.3)	1 (12.5)	1 (12.5)	4 (44.4)	0	1 (11.1)	1 (7.7)	1 (50.0)	11 (16.2)
HMA failure, n (%)[a]	0	0	1 (12.5)	0	1 (11.1)	1 (16.7)	1 (11.1)	2 (15.4)	1 (50.0)	7 (10.3)
ELN 2017 AML risk stratification,[a] n (%)										
Favorable	2 (28.6)	1 (16.7)	0	2 (25.0)	2 (22.2)	0	3 (33.3)	5 (38.5)	0	15 (22.1)
Intermediate	1 (14.3)	1 (16.7)	4 (50.0)	2 (25.0)	3 (33.3)	2 (33.3)	1 (11.1)	1 (7.7)	0	15 (22.1)
Adverse	4 (57.1)	4 (66.7)	4 (50.0)	4 (50.0)	4 (44.4)	4 (66.7)	5 (55.6)	7 (53.8)	2 (100)	38 (55.9)
Positive genetic abnormality, n (%)[b]										
IDH1/IDH2	2 (28.6)	3 (50.0)	1 (12.5)	3 (37.5)	1 (11.1)	1 (16.7)	3 (33.3)	1 (7.7)	0	15 (22.1)
FLT3	0	1 (16.7)	1 (12.5)	1 (12.5)	0	1 (16.7)	2 (22.2)	2 (15.4)	1 (50.0)	9 (13.2)
NPM1	2 (28.6)	1 (16.7)	0	2 (25.0)	1 (11.1)	0	3 (33.3)	1 (7.7)	0	10 (14.7)
TP53 aneuploidy or -17/abn(17p)	1 (14.3)	1 (16.7)	1 (12.5)	0	0	1 (16.7)	0	1 (7.7)	1 (50.0)	6 (8.8)
Prior therapy										
Prior aza exposure, n (%)	0	1 (16.7)	3 (37.5)	0	2 (22.2)	1 (16.7)	1 (11.1)	3 (23.1)	1 (50.0)	12 (17.6)
No. of lines of prior systemic therapy, median (range)	1.0 (1-2)	1.0 (1-2)	1.5 (1-5)	2.0 (1-2)	2.0 (1-4)	2.0 (1-6)	1.0 (1-3)	1.0 (1-3)	1.5 (1-2)	1.0 (1-6)
Treatment exposure										
No. of cycles, median (range)	2.0 (2.0-15.0)	10.5 (1.0-36.0)	2.0 (1.0-8.0)	2.5 (1.0-20.0)	2.0 (1.0-5.0)	2.0 (1.0-7.0)	2.0 (1.0-4.0)	3.0 (1.0-12.0)	3.5 (1.0-6.0)	2.0 (1.0-36.0)
Average cycle duration, median (range), days	35.0 (29.5-41.5)	33.3 (21.0-40.9)	34.8 (28.0-44.0)	35.0 (5.0-48.7)	33.2 (22.0-44.0)	36.8 (22.0-44.0)	36.8 (25.0-53.0)	35.0 (25.3-55.0)	42.3 (35.7- 49.0)	35.0 (5.0-55.0)
Relative sonro dose intensity, median (range), %	100.0 (76.5-100.0)	74.9 (57.0-112.7)	91.1 (47.9-100.0)	100.0 (33.9-100.0)	100.0 (79.4-103.9)	89.8 (54.9-100.0)	90.0 (54.9-100.0)	96.3 (50.7-116.8)	82.1 (64.3-100.0)	97.6 (22.0-156.0)
Relative aza dose intensity, median (range), %	100.0 (52.3-100.3)	85.5 (45.8-101.0)	99.9 (69.5-101.5)	99.8 (73.0-101.1)	99.5 (79.2-100.8)	99.5 (64.9-103.4)	100.0 (69.9-100.9)	99.7 (52.5-109.1)	92.7 (84.3-101.1)	99.7 (45.8-109.1)

[a]HMA failure received ≥1 cycle of HMA and had PD or no PR or better hematologic improvement after four cycles of >75% of planned dose. [b]As reported by investigator.

Abbreviations: aza, azacitidine; ELN, European LeukemiaNet; HMA, hypomethylating agent; PD, progressive disease; PR, partial response; sonro, sonrotoclax.

- Treatment-emergent adverse events (TEAEs) were similar in frequency and severity across doses (**Table 2**)
- The most common any-grade and grade ≥3 TEAEs were neutropenia, infections and infestations, and thrombocytopenia (**Figure 3**)
- No cases of laboratory or clinical tumor lysis syndrome were reported
- One dose-limiting toxicity (DLT), grade 4 thrombocytopenia, occurred with 320 mg × 14 d
- Six patients (8.8%) had a TEAE leading to death; 2 cases were treatment related (160 mg × 28 d, neutropenic sepsis; 320 mg × 14 d, pneumonia); the 30-d mortality rate was 1.5%
- Treatment discontinuation due to TEAEs occurred in 7 patients (10.3%)
  - The most common TEAE classes leading to discontinuation of sonrotoclax (n=4, 5.9%) or azacitidine (n=4, 5.9%) were infection and infestations
- TEAEs leading to dose reduction occurred in 8 patients (11.8%) and 2 patients (2.9%) with sonrotoclax and azacitidine, respectively
  - The most common TEAE class leading to dose reduction of sonrotoclax was neutropenia (n=7, 10.3%) and of azacitidine was neutropenia and thrombocytopenia (n=1 each, 1.5%)

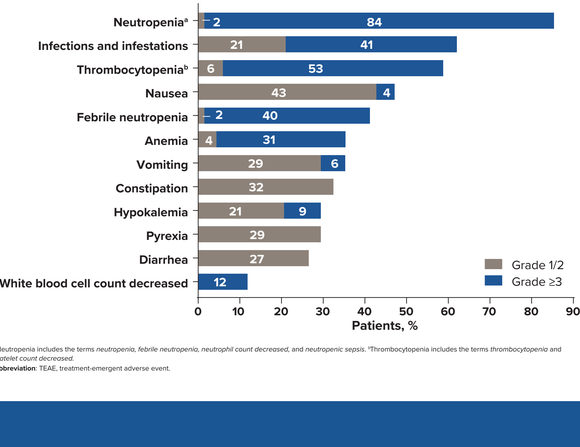
Table 2. TEAE Summary in R/R AML

	Sonro dose + aza									
Patients, n (%)	40 mg × 10 d (n=7)	80 mg × 10 d (n=6)	80 mg × 14 d (n=8)	160 mg × 10 d (n=8)	160 mg × 14 d (n=9)	160 mg × 21 d (n=6)	160 mg × 28 d (n=9)	320 mg × 14 d (n=13)	320 mg × 21 d (n=2)	Total (N=68)
Any TEAEs	7 (100)	6 (100)	8 (100)	8 (100)	9 (100)	6 (100)	9 (100)	13 (100)	2 (100)	68 (100)
Grade ≥3	7 (100)	5 (83.3)	7 (87.5)	7 (87.5)	8 (88.9)	5 (83.3)	9 (100)	13 (100)	2 (100)	63 (92.6)
Neutropenia[a]	5 (71.4)	5 (83.3)	7 (87.5)	6 (75.0)	8 (88.9)	5 (83.3)	9 (100)	11 (84.6)	1 (50.0)	57 (83.8)
Thrombocytopenia[b]	2 (28.6)	2 (33.3)	4 (50.0)	7 (87.5)	4 (44.4)	1 (16.7)	7 (77.8)	9 (69.2)	0	36 (52.9)
Infection and infestation	4 (57.1)	4 (66.7)	0	5 (62.5)	6 (66.7)	1 (16.7)	2 (22.2)	4 (30.8)	2 (100)	28 (41.2)
Serious TEAEs	5 (71.4)	4 (66.7)	4 (50.0)	7 (87.5)	8 (88.9)	4 (66.7)	7 (77.8)	8 (61.5)	2 (100)	49 (72.1)
DLT, n/N (%)	0	0	0	0	0	0	0	1/12 (8.3)[c]	0	1/62 (1.6)
Led to death[d]	0	0	0	1 (12.5)	1 (11.1)	0	3 (33.3)	1 (7.7)	0	6 (8.8)
Led to discontinuation										
Aza	1 (14.3)	0	0	2 (25.0)	1 (11.1)	1 (16.7)	1 (11.1)	2 (15.4)	0	8 (11.8)
Sonro	1 (14.3)	0	0	2 (25.0)	1 (11.1)	1 (16.7)	1 (11.1)	2 (15.4)	0	8 (11.8)
Led to reduction										
Aza	0	1 (16.7)	0	0	0	0	0	1 (7.7)	0	2 (2.9)
Sonro	0	2 (33.3)	1 (12.5)	1 (12.5)	0	1 (16.7)	1 (11.1)	1 (7.7)	1 (50.0)	8 (11.8)
Led to interruption										
Aza	0	2 (33.3)	0	2 (25.0)	3 (33.3)	1 (16.7)	0	0	0	8 (11.8)
Sonro	0	1 (16.7)	0	2 (25.0)	2 (22.2)	2 (33.3)	2 (22.2)	0	0	9 (13.2)

[a]Neutropenia includes the terms *neutropenia, febrile neutropenia, neutrophil count decreased,* and *neutropenic sepsis.* [b]Thrombocytopenia includes the terms *thrombocytopenia* and *platelet count decreased.* [c]Achieved best response of CR/CRh and continued treatment with a dose (duration) reduction after count recovery. [d]Aorto-bronchial fistula (160 mg × 28 d), bone marrow failure (160 mg × 28 d; related to PD), Klebsiella sepsis (160 mg × 10 d), neutropenic sepsis (160 mg × 28 d; related to aza, sonro, and disease), pneumonia (320 mg × 14 d; related to aza, sonro, and disease), and pulmonary mucormycosis (160 mg × 14 d; related to PD).

Abbreviations: aza, azacitidine; CR, complete response; CRh, CR with partial hematologic recovery; CRi, CR with incomplete hematologic recovery; DLT, dose-limiting toxicity; PD, progressive disease; sonro, sonrotoclax.

Figure 3. TEAEs in ≥20% (All Grades) or ≥10% (Grade ≥3) of Patients With R/R AML



[a]Neutropenia includes the terms *neutropenia, febrile neutropenia, neutrophil count decreased,* and *neutropenic sepsis.* [b]Thrombocytopenia includes the terms *thrombocytopenia* and *platelet count decreased.*

Abbreviation: TEAE, treatment-emergent adverse event.

- With a median follow-up of 6.2 months (m), the overall response rate (ORR) in all patients was 60.3% (**Figure 4A**)
  - Complete response (CR)/CR with partial hematologic recovery (CRh) was achieved in 42.6% (95% CI, 30.7%-55.2%) of patients by a median time of 1.7 m; CR was achieved in 27.9% (95% CI, 17.7%-40.1%) of patients by a median of 1.9 m (**Table 3** and **Figure 4B**)
  - In the cohorts with the longest follow-up (40, 80, and 160 mg × 10 d), 50%, 75% and 100% of patients who achieved CR/CRh, respectively, remained alive and progression free at 12 m since the first determination of response
- Overall, 23.5% of patients proceeded to transplant
- Minimal residual disease–negative status was achieved by 20.6% of patients (**Figure 4C**)

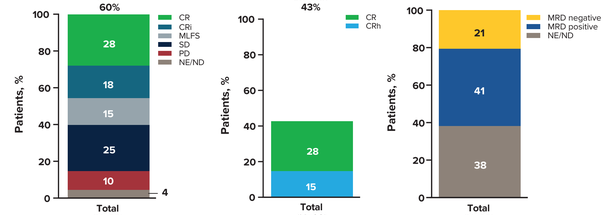
Table 3. Summary of Disease Responses in R/R AML[a]

	Sonro dose + aza									
	40 mg × 10 d (n=7)	80 mg × 10 d (n=6)	80 mg × 14 d (n=8)	160 mg × 10 d (n=8)	160 mg × 14 d (n=9)	160 mg × 21 d (n=6)	160 mg × 28 d (n=9)	320 mg × 14 d (n=13)	320 mg × 21 d (n=2)	Total (N=68)
CR, n (%)	2 (28.6)	3 (50.0)	2 (25.0)	2 (25.0)	1 (11.1)	2 (33.3)	2 (22.2)	5 (38.5)	0	19 (27.9)
Time to CR, median (range), months	3.2 (1.5-4.9)	4.1 (3.7-4.6)	1.9 (1.7-2.1)	3.2 (1.9-4.4)	2.3 (2.3-2.3)	1.4 (0.9-1.9)	1.3 (1.1-1.4)	1.2 (0.8-5.1)	–	1.9 (0.8-5.1)
By end of cycle 2, n (%)	1 (14.3)	0	2 (25.0)	1 (12.5)	1 (11.1)	2 (33.3)	2 (22.2)	4 (30.8)	0	13 (19.1)
CR/CRh, n (%)	5 (71.4)	4 (66.7)	2 (25.0)	3 (37.5)	1 (11.1)	2 (33.3)	3 (33.3)	8 (61.5)	1 (50.0)	29 (42.6)
Time to CR/CRh, median (range), months	2.4 (1.2-3.5)	3.9 (1.1-4.6)	1.9 (1.7-2.1)	1.9 (1.0-1.9)	1.4 (1.4-1.4)	1.4 (0.9-1.9)	1.1 (0.8-1.4)	1.3 (0.8-5.1)	7.7 (7.7-7.7)	1.7 (0.8-7.7)
CR/CRi, n (%)	4 (57.1)	4 (66.7)	4 (50.0)	3 (37.5)	1 (11.1)	2 (33.3)	3 (33.3)	9 (69.2)	1 (50.0)	31 (45.6)
Time to CR/CRi, median (range), months	2.0 (1.2-3.2)	3.0 (1.1-4.1)	1.9 (0.8-2.4)	1.0 (0.8-1.9)	1.4 (1.4-1.4)	1.4 (0.9-1.9)	1.1 (0.8-1.4)	1.2 (0.8-5.1)	7.7 (7.7-7.7)	1.4 (0.8-7.7)
Proceeded to transplant, n (%)	3 (42.9)	1 (16.7)	2 (25.0)	2 (25.0)	3 (33.3)	2 (33.3)	2 (22.2)	1 (7.7)	0	16 (23.5)
MRD negative, n (%)	2 (28.6)	1 (16.7)	0	1 (12.5)	1 (11.1)	2 (33.3)	1 (11.1)	5 (38.5)	1 (50.0)	14 (20.6)
MRD NE/ND, n (%)	2 (28.6)	1 (16.7)	3 (37.5)	2 (25.0)	5 (55.6)	2 (33.3)	7 (77.8)	3 (23.1)	1 (50.0)	26 (38.2)

[a]Responses were determined using the ELN 2017 criteria and partial hematology recovery criteria for AML.

Abbreviations: aza, azacitidine; CR, complete response; CRh, CR with partial hematologic recovery; CRi, CR with incomplete hematologic recovery; ELN, European LeukemiaNet; MRD, minimal residual disease; ND, not done; NE, not estimable; sonro, sonrotoclax.

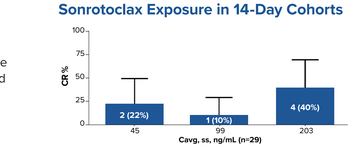
Figure 4. (A) ORR, (B) CR/CRh Rate, and (C) MRD Status in R/R AML



[a]ORR included CR, CRi, MLFS, and PR.

Abbreviations: CR, CR with incomplete hematologic recovery; MLFS, morphologic leukemia-free state; MRD, minimal residual disease; ND, not done; NE, not evaluable; PD, progressive disease; PR, partial response; SD, stable disease.

Figure 5. CR Rate by End of Cycle 2 by Sonrotoclax Exposure in 14-Day Cohorts



- In the 14-d cohorts with comparable follow-up, exploratory exposure-response analysis showed that CR rates by the end of cycle 2 for the third (highest) tertile of sonrotoclax exposure were higher than those in lower tertiles (**Figure 5**)

Median Cavg, ss for the 80-mg, 160-mg, and 320-mg dose levels was 60 ng/mL, 86 ng/mL, and 176 ng/mL, respectively.

Abbreviations: Cavg, ss, average sonrotoclax concentration at steady state; CR, complete response.

REFERENCES

1. Shimony S, et al. *Am J Hematol.* 2023;98(3):502-526.
2. Yi M, et al. *J Hematol Oncol.* 2021;13(1):72.
3. Bazarbachi A. *Bone Marrow Transplant.* 2022;57(2):147-148.
4. Venetoclax. Prescribing information. AbbVie, Inc. 2024.
5. Guo Y, et al. *J Med Chem.* 2024;67(10):7838-7858.
6. Döhner H, et al. *Blood.* 2017;129(4):424-447.
7. Bloomfield CD, et al. *Blood Rev.* 2018;32(5):416-425.

ACKNOWLEDGMENTS

The authors thank the patients and their families, investigators, co-investigators, and the study teams at each of the participating centers. This study was sponsored by BeOne Medicines, Ltd. Medical writing was provided by Brittany Gifford, PharmD, of Nucleus Global, an Inizio company, and supported by BeOne Medicines.

DISCLOSURES

PM: Consultancy: Daiichi Sankyo, Jazz Pharma, AbbVie, Servier, Pfizer, Novartis, Kura Oncology, Syndax, Glycomimetics; Research funding and speakers bureau: Daiichi Sankyo, Jazz Pharma, AbbVie, Servier, Pfizer, Novartis. **JS:** Consultant or advisory role: Novartis, BMS, Otsuka; Research funding: AstexTaiho; Speakers bureau: Novartis, Mundipharma. **TFN:** Travel, accommodations, or expenses: Johnson & Johnson, Sobi, Novartis. **CG:** Consulting or advisory role: Otsuka, Astellas; Research funding: SCGH, Linear, Syndax, Ei eun, Servier, Johnson & Johnson; Speakers bureau: Astellas. **UP:** Honoraria: Novartis, BMS, Janssen, AbbVie, Curis, Geron, Jazz Pharma, Akeso, Gilead, Servier; Consulting or advisory role: AbbVie, BMS, Janssen, Novartis, GSK, Hemavant; Speakers bureau: Novartis, BMS, Janssen, Jazz Pharma, Takeda, Sobi, Blueprint, AstraZeneca; Travel, accommodations, or expenses: AbbVie, Janssen. **CYF:** Honoraria: AstraZeneca; Consulting or advisory role: Amgen, Adaptive, Otsuka; Research funding: Jazz Pharma; Speakers bureau: Pfizer, AbbVie, Novartis, Servier. **AHW:** Consultant: Servier, BeOne Medicines Ltd; AbbVie, Novartis; Research funding: Novartis, AbbVie, Servier, Janssen, BMS, Syndax, Astex, AstraZeneca, Amgen; Honoraria: Novartis, AstraZeneca, Astellas, Janssen, Amgen, Roche, Pfizer, AbbVie, Servier, Gilead, BMS, Shyrotinx, Macrogenics, Agios; Patents and royalties: Servier; Speakers bureau: AbbVie, Novartis, BMS, Servier, Astellas; Travel, accommodations, or expenses: Novartis, Servier. **WYC:** Employment: BeOne Medicines Ltd; Stock or other ownership: BeOne Medicines Ltd, BMS. **ZS, VM, OZ, AA:** Employment and may own stock: BeOne Medicines Ltd. **CD:** Consulting or advisory role: AbbVie, Astellas, AZD, BMS, Daiichi Sankyo, Gemnab, GSK, Immune Onc, Rigel, Schrodinger, Servier, Solu; Research funding: AbbVie, Astex, BMS, BeOne Medicines Ltd, Foghorn, Jazz Pharma, Immune Onc, Remix, Servier, Schrodinger. **PC, SR, JW:** No disclosures.

Presented at the EHA2025 Congress; June 12-15, 2025; Milan, Italy