Case Studies in Immunotherapy for the Treatment of Acute Leukemia

November 15, 2021
11:30 a.m. – 12:30 p.m. ET
Webinar faculty

Steven D. Gore, MD – National Cancer Institute*

Jorge Cortes, MD – Georgia Cancer Center

*Dr. Gore is serving in his personal capacity
Learning objectives

• Plan immunotherapy treatment regimens for challenging patient populations

• Identify management strategies for uncommon and/or atypically responsive toxicities

• Select appropriate treatment strategies for patients with relapsed and/or unresponsive acute leukemia

• Articulate the potential risks and benefits for proceeding with any other possible interventions specific to acute leukemia in the context of an immunotherapy treatment plan
Webinar outline

• Development of the guideline
• CAR T cells
• Bispecifics (AML)
• Antibody-drug conjugates
• Key takeaways
Development of the Guideline

The Society for Immunotherapy of Cancer (SITC) clinical practice guideline on immunotherapy for the treatment of acute leukemia

Michael M Boyiadzis,1 Ivan Aksentijevich,2 Daniel A Arber,3 John Barrett,4 Renier J Brentjens,5 Jill Brufsky,1 Jorge Cortes,6 Marcos De Lima,7 Stephen J Forman,8 Ephraim J Fuchs,9 Linda J Fukas,10 Steven D Gore,11 Mark R Litzow,12 Jeffrey S Miller,13 John M Pagel,14 Edmund K Waller,15 Martin S Tallman5
Development of the Guideline

• Developed according to the Institute of Medicine’s Standards for Developing Trustworthy Clinical Practice Guidelines
• Panel consisted of 17 experts in the field
• Recommendations are based upon published literature evidence, or clinical evidence where appropriate
• Consensus was defined at 75% approval among voting members
Webinar outline

• Development of the guideline
• CAR T cells (new approvals in adults)
• Bispecifics (AML)
• Antibody-drug conjugates
• Key takeaways
Case 1: CAR T (new approvals in adults)

• 42 year old female
• Diagnosed with ALL with t(4;11); no CNS leukemia
• Received HCVAD; CR after 1 cycle
  • MRD+ after induction
• Relapse after 4 cycles of therapy
• Received FLAG-Ida with no response
• Inotuzumab ozogamicin: no response after 2 cycles
• POMP x1 cycle to bridge to CART cells
• Initiated lymphodepletion followed by Brexucabtagene autoleucel (Tecartus)
POLL QUESTION

What treatment would you consider now?

a) Blinatumomab
b) Brexucabtagene autoleucel
c) Stem cell transplant
d) Pediatric chemotherapy regimen
e) Supportive care only
Case 1: CAR T (new approvals in adults)

- POMP x1 cycle to bridge to CART cells
- Initiated lymphodepletion with fludarabine
- Received Brexucabtagene autoleucel (Tecartus)
Blinatumomab or Inotuzumab vs Standard Chemotherapy in R-R ALL

**Marrow CR:**
- Blina vs SOC: 44% vs 25%
- Ino vs SOC: 74% 31%

**Survival Analysis:**
- Median OS (95% CI): Blinatumomab, 7.7 mos vs SOC, 4.0 mos
- Stratified log-rank p = 0.012
- Hazard ratio: 0.71

Kantarjian et al. NEJM 2017; 376: 836-47
Kantarjian et al. NEJM 2019; 375: 740
Antigen Targets in CAR-T Trials

CAR T development: From discovery to FDA approval

Discovery to FDA approval ~25 years

- **Dec 01, 1989**: First Ab-TCR CAR (Z. Eschhar)
- **Jan 15, 1993**: First scFv-CAR (Z. Eschhar)
- **Aug 01, 1995**: In vivo demonstration of anti-tumor activity of scFv-CAR (Hwu, Eschhar, Rosenberg)
- **May 28, 2009**: First CD19 CAR in NHL (Kochenderfer and Rosenberg)
- **Aug 25, 2011**: First clinical data with CD19 CAR in CLL (Porter and June)
- **Oct 15, 2006**: First clinical data with scFv-CAR (Kershaw, Eschhar, Rosenberg, Hwu)
- **Jul 28, 2010**: First clinical data with CD19 CAR (NCI) in NHL (Kochenderfer and Rosenberg)
- **Apr 18, 2013**: First clinical data with CD19 CAR in ALL (Grupp and June)
- **Aug 25, 2011**: First clinical data with CD19 CAR in NHL (Kochenderfer and Rosenberg)
- **Oct 15, 2006**: First clinical data with scFv-CAR (Kershaw, Eschhar, Rosenberg, Hwu)
- **Aug 30, 2017**: FDA approvals
  - **Aug 30, 2017**: Kymriah
  - **Oct 18, 2017**: Yescarta

Slide Courtesy, Sattva Neelapu, MDACC
Brexucabtagene autoleucel: A new Indication

**TECARTUS®** (brexucabtagene autoleucel) suspension for intravenous infusion
Initial U.S. Approval: 2020

**WARNING: CYTOKINE RELEASE SYNDROME AND NEUROLOGIC TOXICITIES**
See full prescribing information for complete boxed warning.
- Cytokine Release Syndrome (CRS), including life-threatening reactions, occurred in patients receiving TECARTUS. Do not administer TECARTUS to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids (2.2.2.3, 5.1).
- Neurologic toxicities, including life-threatening reactions, occurred in patients receiving TECARTUS, including concurrently with CRS or after CRS resolution. Monitor for neurologic toxicities after treatment with TECARTUS. Provide supportive care and/or corticosteroids, as needed (2.2.2.3, 5.2).
- TECARTUS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the YSCARTA and TECARTUS REMS Program (5.3).

**RECENT MAJOR CHANGES**

<table>
<thead>
<tr>
<th>Indications and Usage (1.2)</th>
<th>10/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dosage and Administration (2.1, 2.2)</td>
<td>10/2021</td>
</tr>
<tr>
<td>Warning and Precautions. Hemophagocytic Lymphohistocytosis/Macrophage Activation Syndrome (5.4)</td>
<td>10/2021</td>
</tr>
<tr>
<td>Warning and Precautions. Severe Infections (5.6)</td>
<td>02/2021</td>
</tr>
</tbody>
</table>

**INDICATIONS AND USAGE**

TECARTUS is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of:
- Adult patients with relapsed or refractory mantle cell lymphoma (MCL).
  This indication is approved under accelerated approval based on overall response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
- Adult patients with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).
KTE-X19 for relapsed or refractory adult B-cell acute lymphoblastic leukaemia: phase 2 results of the single-arm, open-label, multicentre ZUMA-3 study

Bijal D Shah, Armin Ghobadi, Olalekan O Oluwole, Aaron C Logan, Nicolas Boissel, Ryan D Cassaday, Thibaut Leguay, Michael R Bishop, Max S Topp, Dimitrios Tzachantis, Kristen M O’Dwyer, Martha L Arellano, Yi Lin, Maria R Baer, Gary J Schiller, Jae H Park, Marion Subklewe, Mehrdad Abedi, Monique C Minnema, William G Wierda, Daniel J DeAngelo, Patrick Stiff, Deepa Jeyakumar, Chaoling Feng, Jinghui Dong, Tong Shen, Francesca Milletti, John M Rossi, Remus Vezan, Behzad Kharabi Masouleh, Roch Hovot

Lancet 2021; 398: 491-502

- Autologous anti-CD19 CAR-T
- R/R B-ALL aged ≥ 18 yrs with >5% marrow blasts
KTE-X19 in Adult B-ALL (ZUMA-3)

38/39 were MRD negative - 1 pt missed MRD sample

10 pts had a subsequent allo-SCT; Median DOR same with or without censoring for allo-SCT (12.8 months)

CD19-CD28z CAR (MSKCC)
Responses by tumor burden

- High tumor burden
  - BM blasts ≥5% (n=27)
  - BM blasts <5% + EM disease (n=5)
- Low tumor burden (MRD+ disease) (n=21)

### Median EFS

<table>
<thead>
<tr>
<th>Tumor Burden</th>
<th>Median EFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>10.6 mos</td>
</tr>
<tr>
<td>High</td>
<td>5.3 mos</td>
</tr>
</tbody>
</table>

### Median OS

<table>
<thead>
<tr>
<th>Tumor Burden</th>
<th>Median OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>20.1 mos</td>
</tr>
<tr>
<td>High</td>
<td>12.4 mos</td>
</tr>
</tbody>
</table>

KTE-X19 in Adult B-ALL (ZUMA-3)

Safety

- Median time to CRS = 5 days
  - Grade ≥3 CRS = 24%
- Median time to ICANS = 9 days
  - Grade ≥3 ICANS = 25%
    - 1 pt died on day 8 from brain herniation
- Median duration of hospitalization after infusion was 22 days and median duration of ICU stay was 5 days
- Toci = 80%
- Steroids = 75%
- Vasopressors = 40%
Management of CRS

<table>
<thead>
<tr>
<th>Symptom or sign of CRS</th>
<th>CRS grade 1*</th>
<th>CRS grade 2*</th>
<th>CRS grade 3*</th>
<th>CRS grade 4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature &gt;38°C (fever)</td>
<td>Yes</td>
<td>Any</td>
<td>Any</td>
<td>Any</td>
</tr>
<tr>
<td>Systolic blood pressure &lt;90 mmHg (hypotension)</td>
<td>No</td>
<td>Responds to IV fluids or low-dose vasopressors</td>
<td>Needs high-dose or multiple vasopressors</td>
<td>Life-threatening</td>
</tr>
<tr>
<td>Needing oxygen for SaO₂ &gt;90% (hypoxia)</td>
<td>No</td>
<td>FiO₂ &lt; 40%</td>
<td>FiO₂ ≥ 40%</td>
<td>Needing ventilator support</td>
</tr>
</tbody>
</table>

**Organ toxicities:**
- Cardiac: tachycardia, arrhythmias, heart block, low ejection fraction
- Respiratory: tachypnea, pleural effusion, pulmonary oedema
- Gastrointestinal: vomiting, diarrhoea
- Hepatic: increased serum ALT, AST, or bilirubin levels
- Renal: acute kidney injury (increased serum creatinine levels), decreased urine output
- Dermatological: rash (less common)
- Coagulopathy: disseminated intravascular coagulation (less common)

**Grade 1**
- Fever or organ toxicity
  - Acetaminophen and hypothermia blanket for the treatment of fever
  - Ibuprofen can be used as second treatment option for fever, if not contraindicated
  - Assess for infection using blood and urine cultures, and chest radiography
  - Empiric broad-spectrum antibiotics and filgrastim if neutropenic
  - Maintenance intravenous (IV) fluids for hydration
  - Symptomatic management of constitutional symptoms and organ toxicity
  - Consider tocilizumab 5 mg/kg IV or siltuximab 11 mg/kg IV for persistent (lasting ≥ 3 days) and refractory fever

**Grade 2**
- Hypotension
  - IV fluid bolus of 500-1000 ml of normal saline
  - Can give a second IV fluid bolus if systolic blood pressure (SBP) remains <80 mmHg
  - Tocilizumab 6 mg/kg IV or siltuximab 11 mg/kg IV for the treatment of hypotension that is refractory to fluid boluses; tocilizumab can be repeated after 6 h if needed
  - If hypotension persists after two fluid boluses and anti-IL-6 therapy, start vasopressors, consider transfer to intensive care unit (ICU), obtain echocardiogram, and initiate other methods of haemodynamic monitoring
  - In patients at high risk or if hypotension persists after 1-2 doses of anti-IL-6 therapy, dexamethasone can be used at 10 mg IV every 6 h
  - Manage fever and constitutional symptoms as in grade 1

**Grade 3**
- Hypotension
  - Supplemental oxygen
  - Tocilizumab or siltuximab 5 corticosteroids and supportive care, as recommended for the management of hypotension

**Grade 4**
- Hypotension
  - Supplemental oxygen including high-flow oxygen delivery and non-invasive positive pressure ventilation
  - Tocilizumab or siltuximab plus corticosteroids and supportive care, as described above

**Organ toxicities**
- Symptomatic management of organ toxicities, as per standard guidelines
  - Tocilizumab or siltuximab plus corticosteroids and supportive care, as indicated for hypotension

**Hypoxia**
- Supplemental oxygen including high-flow oxygen delivery and non-invasive positive pressure ventilation
  - Tocilizumab or siltuximab plus corticosteroids and supportive care, as described above

**Organ toxicity**
- Symptomatic management of organ toxicities as per standard guidelines
  - Tocilizumab or siltuximab plus corticosteroids and supportive care, as described above

---

Neelapu et al. Nature Reviews Clinical Oncology 2018; 14: 47-62
Webinar outline

• Development of the guideline
• CAR T cells
• Bispecifics (AML)
• Antibody-drug conjugates
• Key takeaways
# Novel Antibodies for AML

<table>
<thead>
<tr>
<th>Approach</th>
<th>Target</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naked</td>
<td>CD123</td>
<td>CSL362</td>
</tr>
<tr>
<td>Immunotoxin</td>
<td>CD123</td>
<td>DT-IL3</td>
</tr>
<tr>
<td></td>
<td>CD33</td>
<td>GO, SGN-CD33A, IMGN779</td>
</tr>
<tr>
<td>Bivalent</td>
<td>CD33</td>
<td>AMG 330, AMG 673</td>
</tr>
<tr>
<td></td>
<td>CD123</td>
<td>Flotetuzumab, XmAb 14045</td>
</tr>
<tr>
<td>Tetravalent</td>
<td>CD33</td>
<td>TandAb</td>
</tr>
<tr>
<td>Novel targets</td>
<td>CLEC12A</td>
<td>MCLA-117</td>
</tr>
<tr>
<td></td>
<td>PR1</td>
<td>HuBf4</td>
</tr>
<tr>
<td></td>
<td>EphA3</td>
<td>KB004</td>
</tr>
<tr>
<td></td>
<td>CD98</td>
<td>IGN523</td>
</tr>
</tbody>
</table>
Selected Bispecific Antibody Formats

- **Intact IgG**
  - $V_H$
  - $V_L$
  - Fab
  - Fc region

- **BiTE**
  - scFv1
  - scFv2

- **DART**
  - $V_H$
  - $V_L$
  - Extra disulfide bond

- **Diabody**

- **Tandem Diabody**

- **Heterodimeric IgG-Like Bispecific**
Flotetuzumab (CD123 x CD3 DART) in R-R AML

• Bispecific CD3ε and CD123 antibody (dual-affinity re-targeting (DART))
• FLZ 500 ng/kg/D CI x 4 then 4d on/3d off
• 88 adults with R/R AML (42 dose-finding, 46 phase 2)
• Recommended phase 2 dose (RP2D) of 500 ng/kg per day
• Median age 64 yrs
• CRS in 82 pts (3-4 in 7 (8%))
• Grade 3 neurologic effects in 2: 1 headache, 1 delirium (both transient, 1-4 days)
• Mitigation strategies for IRR/CRS: step-up LID schedules, temporary dose reduction or interruption, and prompt use of tocilizumab.
## Flotetuzumab for refractory acute myeloid leukemia

<table>
<thead>
<tr>
<th></th>
<th>R/R AML, % (n) n = 50</th>
<th>PIF/ER AML, % (n) n = 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR</td>
<td>12.0 (6)</td>
<td>16.7 (5)</td>
</tr>
<tr>
<td>CR/CRh</td>
<td>18.0 (9)</td>
<td>26.7 (8)</td>
</tr>
<tr>
<td>CR/CRh/CRi</td>
<td>20.0 (10)</td>
<td>30.0 (9)</td>
</tr>
<tr>
<td>CR/CRh/CRi/MLFS/PR</td>
<td>24.0 (12)</td>
<td>30.0 (9)</td>
</tr>
</tbody>
</table>

Uy et al. Blood 137(6):751-762
Biomarkers for response to Flotetuzumab

Response by inflammatory chemokine and tumor inflammation signature (TIS) scores

Response by immune-infiltrating signature score (based on 770 immune-related genes)

Uy et al. Blood 137(6):751-762
AMG 673: Background and Mechanism of Action

- BiTE® technology is based on a targeted immuno-oncology platform that engages T cells toward malignant cells

- AMG 673 is a HLE BiTE® molecule that binds CD3 on T cells and CD33 on AML blasts

- CD33 is expressed on ~99% of AML blasts and is a validated therapeutic target in AML

AMG 673: Relationships Between CRS, Exposure, and Anti-AML Activity

- Severity of CRS correlated with exposure to AMG 673 and leukemic burden
- Reduction in blasts was observed in 11/27 (41%) patients
  - ≥ 50% reduction in blasts in 5 patients
  - One pt (cohort 9) achieved Cri (85% reduction BM blasts)
- Reduction in blast numbers observed in patients with higher exposure to AMG 673

*The percentage change in blasts from baseline 469
XmAb® 14045: CD123 x CD3 Bispecific Antibody

- Full-length immunoglobulin molecule, dosed intermittently, in contrast to “DART” or “BiTE” antibodies that require a continuous infusion

- Stimulates targeted T cell-mediated killing of CD123-expressing cells, regardless of T cell antigen specificity

- $F_{\gamma}$ receptor binding knock-out removes potential for receptor-mediated crosslinking and activation of T cells
XmAb14045 in R/R Hematologic Malignancies: Preliminary Efficacy

- CR/CRi in 5 out of 18 patients (28%) dosed with ≥ 1.3 μg/kg
- SD lasting > 3 mos in 3 patients (17%)
- BM blast reduction in 56% of patients
- Blast reduction observed in first cycle
- Clinical hematologic recovery from CRi to CR sometimes took 1-2 more cycles

Webinar outline

• Development of the guideline
• CAR T cells
• Bispecifics (AML)
• Antibody-drug conjugates
• Key takeaways
Case 3: Antibody-drug Conjugates

• 38 year old man presented with 3 weeks of fatigue, malaise and easy bruising
• Hgb 7, platelets 24,000
• WBC 26000.
  • 46% blasts, some with Auer Rods
  • Occasional Auer Rod seen in maturing elements
• Bone marrow: Acute myeloid leukemia, 60% blasts
• Ongoing maturation of myeloid series, with dysplastic changes
POLL QUESTION

• Emergent FISH: t(8;21)
  • Confirmed by PCR RUNX1-RUNX1T1. N-RAS mutated.

What therapy would you prescribe?
   a) Azacitidine with venetoclax
   b) Cytarabine and daunorubicin
   c) Cytarabine and daunorubicin with gemtuzumab ozagomycin
   d) Gemtuzumab Ozagomycin monotherapy
   e) azacitidine with venetoclax and gemtuzumab ozagomycin
Alfa Study. Lancet 2012

• New AML age 50 – 70
• 7 plus 3 versus 7 plus 3 plus three doses of gemtuzumab
• 280 patients
• Two consolidations
  • Anthracycline containing
  • Plus minus gemtuzumab

B

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Gemtuzumab ozogamicin</th>
<th>Hazard ratio (CI*)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deaths</td>
<td>Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;60</td>
<td>28</td>
<td>53</td>
<td>0.76 (0.44-1.20)</td>
<td>0.32</td>
</tr>
<tr>
<td>≥60</td>
<td>44</td>
<td>86</td>
<td>0.51 (0.22-1.20)</td>
<td></td>
</tr>
<tr>
<td>Cytogenetics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Favourable or intermediate</td>
<td>43</td>
<td>97</td>
<td>0.59 (0.32-1.09)</td>
<td></td>
</tr>
<tr>
<td>Unfavourable</td>
<td>23</td>
<td>30</td>
<td>1.44 (0.65-3.18)</td>
<td>0.31</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
<td>12</td>
<td>0.51 (0.10-2.43)</td>
<td></td>
</tr>
<tr>
<td>NPM1 status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wild type</td>
<td>48</td>
<td>90</td>
<td>0.79 (0.46-1.36)</td>
<td></td>
</tr>
<tr>
<td>Mutated</td>
<td>24</td>
<td>48</td>
<td>0.50 (0.21-1.20)</td>
<td>0.25</td>
</tr>
<tr>
<td>FLT3-ITD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D

ELN-Favorable/Intermediate

- Go arm/ No sign
- Control arm/ No sign

Event-free survival (probability)

Time (years)

Interaction, p=0.02

p=0.85

p<0.001

E

ELN-Favorable/Intermediate

- Go arm/ No sign
- Control arm/ No sign
- Go arm/ Sign+
- Control arm/ Sign+

Overall survival (probability)

Time (years)

Interaction, p=0.07

p=0.79

p=0.01
Should GO be included in all patients with good risk leukemias?

• ALFA data not confirmed elsewhere
• Chemotherapy is a bit different
• Information regarding ras and other signaling mutations may not be available at time of treatment
• Therapy does have increased toxicity
$^{131}$I-antiCD45 Apamistamab (Iomab-B)

- Age >50, R/R
- Single Institution
- With Flu/TBI/SCT
- 58 patients

Sierra Study

• Age > 55
• R/R
• Randomize: Iomab transplant as immediate next treatment versus further chemotherapy first, transplant on non-response or progression
• Fully accrued September 2021 (150 patients)
• ASH Abstract 1791 (135 patients)
• Median age 65
• Prior lines: median 3 (1 – 7)
Sierra – 2

• Early Iomab arm (50 patients)
  • All engrafted
  • Dose to marrow: 14.7 Gy
  • Time to neutrophils: 14.5
  • Time to platelets: 18

• Crossover patients
  • All engrafted
Lintuzumab-AC225

• Anti-CD33
• Alpha emitter
• ASH 616: Schiller et al (UCLA)
• Phase I lintuzumab-AC225 with venetoclax
• ASH 3414: Abedin et al. (Med College Wis)
• CLAG-M with LIN-AC225
• 10/15 CR/CRi; 7 MRD undetectable
Practical Management Pearls for Immunotherapy for the Treatment of Breast Cancer
November 17, 2021, 11:30 a.m. – 12:30 p.m. ET

Case Studies in Immunotherapy for the Treatment of Breast Cancer
December 1, 2021, 11:30 a.m. – 12:30 p.m. ET

Practical Management Pearls in Immunotherapy for the Treatment of Hepatocellular Carcinoma
December 6, 2021, 5:30 – 6:30 p.m. ET

Learn more and register at: https://www.sitcancer.org/CPG-webinars
Targets for Cancer Immunotherapy: A Deep Dive Seminar Series

Eight online seminars will address key questions in the field of cancer immunotherapy drug development

SEMINAR 7: T CELL FUNCTIONAL STATES
November 18, 2021, 4:30 – 6:30 p.m. ET

SEMINAR 8: T CELL SELECTION FOR ADOPTIVE CELL THERAPY
January 25, 2022, 11:30 a.m. – 1:30 p.m. ET

Learn more and register at: https://www.sitcancer.org/education/deepdive
A Focus on Gastrointestinal Cancers
November 17, 2021, 12 – 4 p.m. ET
CME-, CPE-, CNE-, MOC-certified

A Focus on Gynecological Cancers
December 14, 2021, 12 – 4 p.m. ET
CME-, CPE-, CNE-, MOC-certified

Learn more and register at:
https://www.sitcancer.org/aci
Earn CME Credit as a *JITC* Reviewer

*JITC* also cooperates with reviewer recognition services (such as Publons) to confirm participation without compromising reviewer anonymity or journal peer review processes, giving reviewers the ability to safely share their involvement in the journal.

Learn how to become a reviewer at sitcancer.org/jitc
Cancer ImmunotherapyClinical Practice GuidelinesMobile App

sitcancer.org/CPG-app
Thank you for attending the webinar!

Questions or comments: connectED@sitcancer.org