Alectinib (ALECENSA®): The preferred first-line standard of care treatment for patients with advanced *ALK*+ NSCLC[1,2]

Roche

BURDEN OF *ALK*+ NSCLC

Advanced *ALK*+ NSCLC is an aggressive disease and has a significant burden on the patient[3,4]

~89,000 new cases globally per year[5–7]

CNS metastases present in **~20–30% of patients** at time of diagnosis[8,9]

Median survival **6–20 months** without effective targeted therapy[10]

ALEX: Global, randomised phase III trial of alectinib vs crizotinib in advanced *ALK*+ NSCLC[11]

EFFICACY

3x longer efficacy benefit with alectinib vs crizotinib[12]

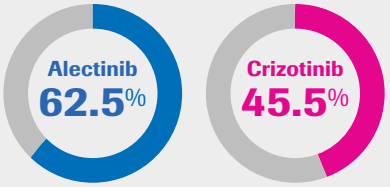
Mature mPFS[12]

Alectinib		Crizotinib
34.8 months (95% CI 17.7–NE)	vs	**10.9** months (95% CI 9.1–12.9)

HR 0.43 (95% CI 0.32–0.58)

Consistent mPFS benefit in alectinib-treated patients, irrespective of **CNS metastases** at baseline[12,13]

Clinically meaningful improvement in **OS** with alectinib vs crizotinib at **5 years**[12]



OS remains **immature** (37% of events recorded)
Generally consistent across **all patient** subgroups

Patients still on study treatment at 5 years[12]
Alectinib: **34.9%**
Crizotinib: **8.6%**

First study with a next-generation ALK TKI in first-line *ALK*+ NSCLC to have demonstrated a clinically meaningful improvement in both mPFS and OS vs crizotinib[12]

CNS PROTECTION AND EFFICACY

Superior CNS benefit with alectinib vs crizotinib[11]

84% reduction

Treatment with **alectinib** led to an **84% reduction** in risk of CNS progression (as the first progression event)[11]

12% Alectinib vs **45%** Crizotinib
csHR 0.16 (95% CI 0.10–0.28); p<0.001

Alectinib protects against the development of new CNS metastases[11]

12 month CIR for CNS progression[11]

9.4% Alectinib (95% CI 5.4–14.7) vs **41.4%** Crizotinib (95% CI 33.2–49.4)

Alectinib treats existing CNS metastases at baseline[11]

CNS ORR[11]
81% Alectinib vs **50%** Crizotinib

CNS CR[11]
38% Alectinib vs **5%** Crizotinib

SAFETY AND TOLERABILITY

Alectinib is well tolerated and has a well-characterised, manageable safety profile across multiple clinical trials and in clinical practice[11–18]

~3x longer median treatment duration

~3x longer median treatment duration with alectinib (28.1 months) vs crizotinib (10.8 months)[12]

Dose reductions[12]
20.4% Alectinib vs **19.9%** Crizotinib

Treatment discontinuations[12]
14.5% Alectinib vs **14.6%** Crizotinib

Most common Grade ≥3 AEs[12]

Alectinib		Crizotinib	
• **5.9%** Anaemia	• **4.6%** Increased ALT	• **15.9%** Increased ALT	• **5.3%** Neutropenia
• **5.3%** Increased AST	• **4.6%** Pneumonia	• **10.6%** Increased AST	• **4.0%** Increased blood CPK

Consistent safety profile of alectinib with no new safety signals at 5 years with longer treatment duration vs crizotinib[12]

WEALTH OF EVIDENCE

Alectinib has a **wealth of evidence** in the first-line setting, with **consistent results** in 380 patients treated in three phase III trials (ALEX, J-ALEX and ALESIA),[11–15,19,20] which are now translating into real-world clinical practice[21]

Alectinib is the **preferred first-line treatment** option for patients with advanced *ALK*+ NSCLC in both the NCCN guidelines and the ESMO Clinical Practice Guidelines[1,2]

AE, adverse event; ALK, anaplastic lymphoma kinase; ALT, alanine aminotransferase; AST, aspartate transaminase; CI, confidence interval; CIR, cumulative incidence rate; CNS, central nervous system; CPK, creatine phosphokinase; CR, complete response csHR, cause-specific hazard ratio; ESMO, European Society for Medical Oncology; HR, hazard ratio; NCCN, National Comprehensive Cancer Network; NE, not evaluable; NSCLC, non-small cell lung cancer; ORR, objective response rate; OS, overall survival mPFS, median progression-free survival; TKI, tyrosine kinase inhibitor

1. NCCN NSCLC Guidelines version 6.2020; **2.** Planchard D, et al. Ann Oncol 2019;29 (Supp 4):iv192–237; **3.** Yang P, et al. J Thorac Oncol 2012;7:90–7; **4.** Roughley A, et al. Value Health 2014;17:A650; **5.** Ferlay J, et al. Int J Cancer 2019;144:1941–53; **6.** Gandhi S, et al. Lung Cancer 2015;6:71–82; **7.** Itchins M, et al. Asia Pac J Clin Oncol 2017;13 (Suppl 3):3–13; **8.** Johung KL, et al. J Clin Oncol 2016;34:107; **9.** Guérin A, et al. J Med Econ 2014;18:312–22; **10.** Shaw AT, et al. Lancet Oncol 2011;12:1004–12; **11.** Peters S, et al. N Eng J Med 2017;377:829–38; **12.** Mok T, et al. Ann Oncol 2020; 31;1056-64; **13.** Camidge DR, et al. J Thorac Oncol 2019;14:1233–43; **14.** Zhou C, et al. Lancet Respir Med 2019;7:437–46; **15.** Nakagawa K, et al. Lung Cancer 2020;139:195–9; **16.** Shaw AT, et al. Lancet Oncol 2016;17:234–42; **17.** Ou SI, et al. J Clin Oncol 2016;34:661–8; **18.** Novello S, et al. Ann Oncol 2018;29:1409–16; **19.** Hida T, et al. Lancet 2017;390:29–39; **20.** Takiguchi Y, et al. J Clin Oncol 2017;35(Suppl15):9064; **21.** Krebs MG, et al. Ann Oncol 2019;30(Suppl 5):v602–660

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