Genitourinary Masterclass

Understanding data for EV monotherapy in 2L

Dr Alejo Rodriguez-Vida, MD, PhD

Consultant Medical Oncologist, Genitourinary Cancer Unit & Early Drug Development Unit; Associate Professor, Pompeu Fabra University Barcelona, Hospital del Mar, Barcelona, Spain

EV as first-line therapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer. Combination therapy with pembrolizumab.

EV as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who have previously received a programmed death receptor-1 or programmed death-ligand 1 inhibitor, and have received a platinum-containing chemotherapy

EV, enfortumab vedotin.
PADCEV® (enfortumab vedotin). Prescribing Information

July 2025 | MAT-KR-PAD-2025-00065

Adverse events should be reported.
For Korea, healthcare professionals are asked to report any suspected adverse reactions to Astellas Pharma Korea. Inc
(Telephone: +82 10 5254 3389; Email: safety-kr@kr.astellas.com)

Prescribing information is available at the end of this presentation. This promotional meeting is fully sponsored and supported by Astellas, including speaker-related honoraria and production of materials. It is intended for healthcare professionals only.

PADCEV®
enfortumab vedotin
Injection for IV infusion 20 mg & 30 mg vials

astellas

Disclaimers

The information, views and opinions presented herein are those of the presenter, and the presenter is solely responsible for the materials being introduced in this presentation. Although patients' cases mentioned herein are actual cases, treatment may differ from local approval product information.

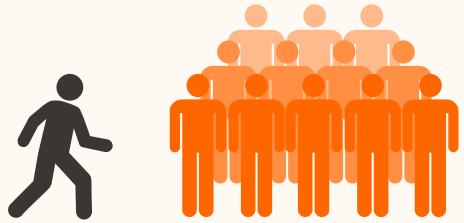
Such information, views and opinions of the presenter do not necessarily reflect the information, views and opinions of Astellas Pharma Ltd. Astellas Pharma Ltd. does not recommend the use of any product in any different manner than as described in the local approval information, and complies with all applicable laws, regulations, and company policies.

Speaker disclosures

- I have provided scientific advice to: Astellas Pharma, AstraZeneca, Bayer, Bristol-Myers Squibb, Johnson & Johnson Global Services, Merck KGaA, Merck Sharp & Dohme, Pfizer & Roche
- I have participated in medical meetings organised by: Astellas Pharma, AstraZeneca, Bayer, Bristol-Myers Squibb, Johnson & Johnson Global Services, Merck KGaA, Merck Sharp & Dohme, Pfizer & Roche

EV-301 compared the efficacy and safety of EV with chemotherapy in patients with previously treated LA/mUC

An international, open-label, randomised Phase III study



Adult patients with unresectable LA/mUC (N=608)

- ECOG PS 0 or 1
- Disease progression during or after PD-1/L1 inhibitor treatment
- Prior platinum-based chemotherapy*

R† 1:1

EV (n=301)
1.25 mg/kg 30-minute IV infusion on Days 1, 8, and 15 of a 28-day cycle

Investigator-chosen chemotherapy (n=307)**
Either of the following as an IV infusion on Day 1 of a 21-day cycle:
- Docetaxel 75 mg/m^2 over 1 hour (n=117)
- Paclitaxel 175 mg/m^2 over 3 hours (n=112)
- Vinflunine‡ 320 mg/m^2 over 20 minutes (n=78)

Until radiological disease progression or other treatment discontinuation criteria are met

Primary endpoint
- OS

Secondary endpoints
- PFS ††
- ORR ††
- DCR ††
- CRR ††
- DOR ††
- QoL
- PROs
- Safety and tolerability

A pre-specified interim analysis was performed after 65% of patients had died. The results of the interim analysis were published in 2021 after a median follow-up of 11.1 months and are presented herein. Trial met superiority threshold at the time of interim analysis

*In EV-301 for patients who had received platinum chemotherapy as neoadjuvant or adjuvant therapy, progression must have occurred within 12 months after completion of treatment. †Stratification variables were ECOG PS (0 or 1), geographic region (USA, Western Europe, or rest of the world), and presence of liver metastasis; ‡Regimen selected by the investigator before randomisation;
**The use of vinflunine was limited to 35% of patients in the trial and was an option only in regions where it was approved for the treatment of UC; ††According to RECIST v1.1.
CRR, complete response rate; DCR, disease control rate; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; IV, intravenous; LA/mUC, locally advanced/metastatic urothelial carcinoma; ORR, overall response rate; OS, overall survival; PD-1/L1, programmed cell death protein 1/ligand 1; PFS, progression-free survival; PRO, patient-reported outcome; QoL, quality of life; R, randomisation; RECIST, Response Evaluation Criteria in Solid Tumours.
Powles T et al. *N Engl J Med* 2021;384:1125–1135.

EV-301 compared the efficacy and safety of EV with chemotherapy in patients with previously treated LA/mUC

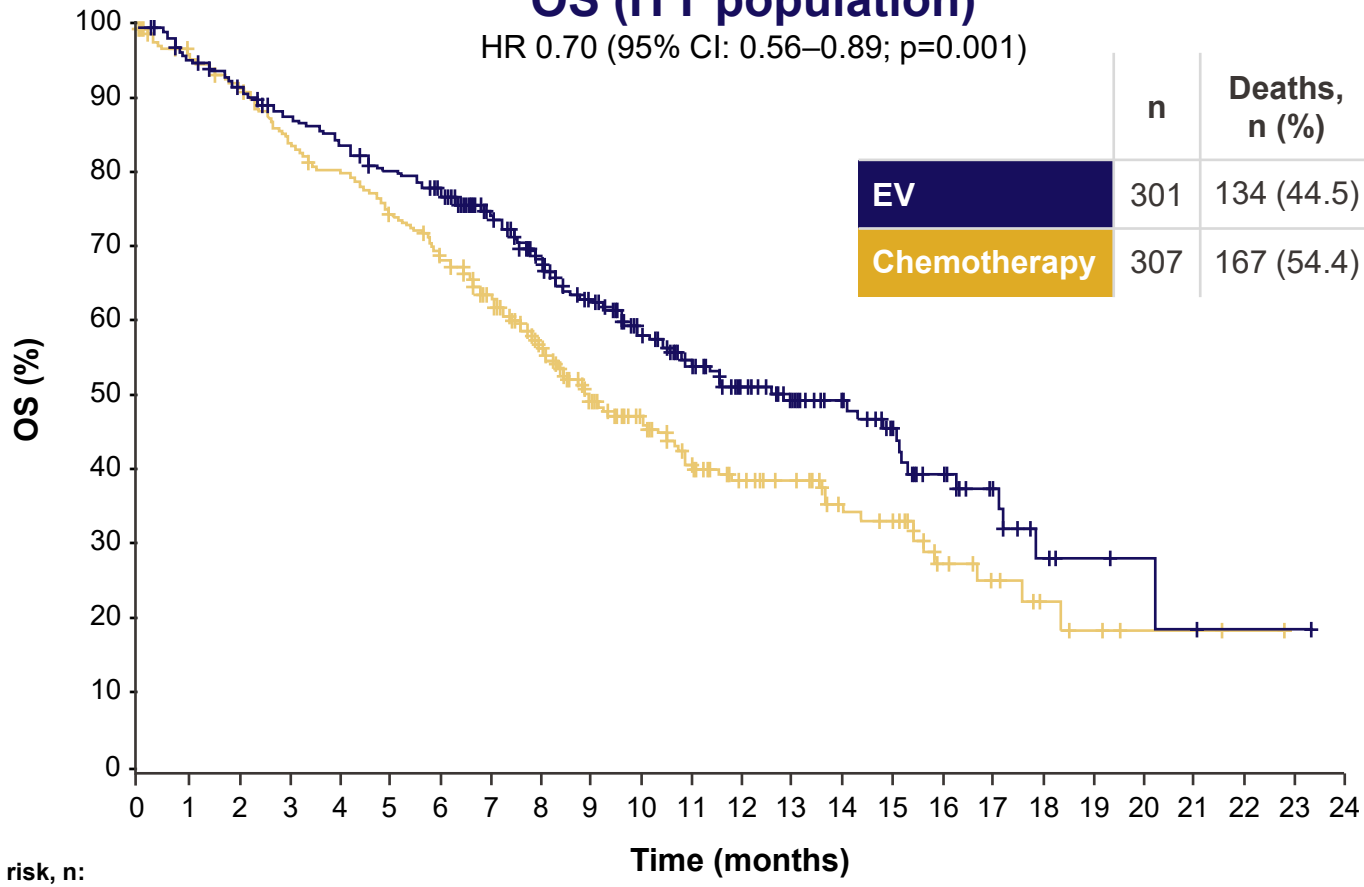
Baseline Characteristics	EV (n=301)	Chemotherapy (n=307)
Median age, years (range)	68 (34.0-85.0)	68 (30.0-88.0)
Sex, n (%)		
Male	238 (79.1)	232 (75.6)
Female	63 (20.9)	75 (24.4)
ECOG PS, n (%)		
0	120 (39.9)	124 (40.4)
1	181 (60.1)	183 (59.6)
Primary tumour location, n (%)		
Upper urinary tract	98 (32.6)	107 (34.9)
Bladder or other site	203 (67.4)	200 (65.1)
Site of metastasis, n (%)		
Visceral	234/301 (77.7)	250/306 (81.7)
Liver	93/301 (30.9)	95/307 (30.9)
Lymph node only	34/301 (11.3)	28/306 (9.2)
Best response among patients who previously received checkpoint inhibitor treatment, n (%)*		
Response	61 (20.3)	50 (16.3)
No response	207 (68.8)	215 (70.0)
Previous systemic therapies, n(%)		
1–2	262 (87.0)	270 (87.9)
≥3	39 (13.0)	37 (12.1)

*The best response among patients who had a response was defined as a confirmed complete or partial response; among patients who did not have a response, the best response was defined as stable disease or progressive disease.
ECOG PS, Eastern Cooperative Oncology Group performance status
Powles T et al. *N Engl J Med* 2021;384:1125-1135.

At a median follow-up of 11.1 months, mortality was significantly reduced with EV by 30% compared with chemotherapy

OS (ITT population)

HR 0.70 (95% CI: 0.56–0.89; p=0.001)



	n	Deaths, n (%)	Median OS, months (95% CI)	Estimated 12-month OS rate, % (95% CI)
EV	301	134 (44.5)	**12.88** (10.58–15.21)	**51.5** (44.6–58.0)
Chemotherapy	307	167 (54.4)	**8.97** (8.05–10.74)	**39.2** (32.6–45.6)

Due to a **significant improvement in OS compared with chemotherapy**, EV-301 was prematurely stopped after the interim analysis of the ITT population

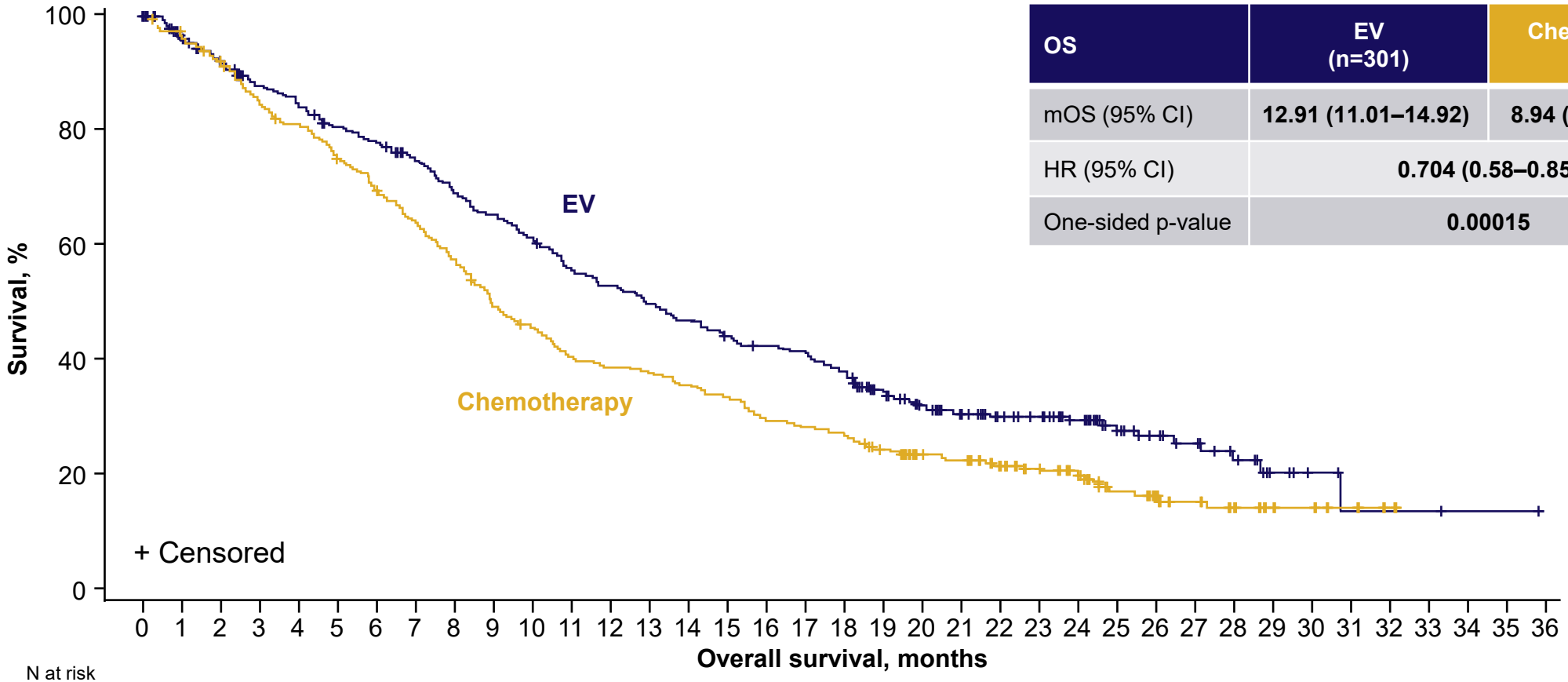
Patients at risk, n:

EV	301	286	272	257	246	234	222	190	158	130	105	85	63	52	42	33	23	15	7	4	3	2	1	1	0
Chemotherapy	307	288	274	250	238	219	198	163	131	101	84	66	51	44	32	29	16	11	6	4	2	2	1	0	0

Figure adapted from Powles T et al. 2021.
Median follow-up: 11.1 months.
CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention to treat; OS, overall survival.
Powles T et al. *N Engl J Med* 2021;384:1125–1135.

At a median follow-up of 24 months, the risk of death was reduced by 30% with EV vs. chemotherapy

24-month OS analysis*



OS	EV (n=301)	Chemotherapy (n=307)
mOS (95% CI)	**12.91 (11.01–14.92)**	**8.94 (8.25–10.325)**
HR (95% CI)	**0.704 (0.58–0.85)**	
One-sided p-value	**0.00015**	

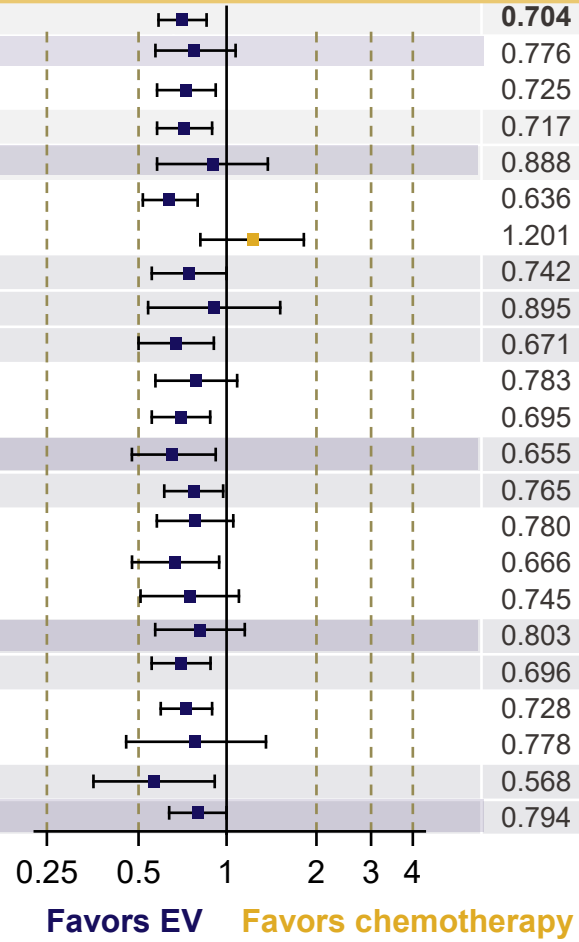
N at risk

EV	301	286	272	257	246	234	226	213	197	186	174	159	150	141	133	124	118	115	106	86	73	63	55	50	41	31	24	20	14	7	4	2	2	2	1	1	0
Chemotherapy	307	288	274	250	238	219	203	186	168	142	132	116	111	108	102	96	85	81	78	65	58	54	46	40	32	22	17	13	10	6	5	3	1	0	0	0	0

*This was an exploratory analysis. The study met threshold for superiority at time of interim analysis.
CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; OS, overall survival.
Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

At a median follow-up of 24 months, a trend for improved OS with EV vs. chemotherapy was observed in most patient subgroups in EV-301, including patients with harder-to-treat disease

Subgroup		Number of events/number of patients		HR (95% CI)
		EV	Chemotherapy	
All patients	**All patients**	**207/301**	**237/307**	**0.704 (0.581–0.852)**
Age group: 65 years	<65 years	76/108	84/111	0.776 (0.568–1.058)
	≥65 years	131/193	153/196	0.725 (0.573–0.916)
Age group: 75 years	<75 years	171/249	182/239	0.717 (0.582–0.884)
	≥75 years	36/52	55/68	0.888 (0.581–1.355)
Sex	Male	159/238	187/239	0.636 (0.514–0.786)
	Female	48/63	50/75	1.201 (0.806–1.789)
Geographic region	Western Europe	92/126	104/129	0.742 (0.560–0.983)
	United States	31/43	30/44	0.895 (0.540–1.484)
	Rest of the world	84/132	103/134	0.671 (0.503–0.896)
ECOG PS score	0	71/120	81/124	0.783 (0.569–1.077)
	1	136/181	156/183	0.695 (0.552–0.876)
Liver metastasis	Yes	71/93	82/95	0.655 (0.475–0.902)
	No	136/208	155/212	0.765 (0.607–0.963)
Pre-selected control therapy	Paclitaxel	100/141	83/112	0.780 (0.582–1.044)
	Docetaxel	59/87	94/117	0.666 (0.480–0.924)
	Vinflunine	48/73	60/78	0.745 (0.509–1.090)
Primary site of tumour	Upper urinary tract	62/98	76/107	0.803 (0.574–1.123)
	Bladder or other site	145/203	161/200	0.696 (0.556–0.872)
Prior lines of systemic therapy	1/2	181/262	208/270	0.728 (0.596–0.889)
	≥3	26/39	29/37	0.778 (0.455–1.332)
Best response to prior checkpoint inhibitor	Responder	33/61	39/50	0.568 (0.357–0.904)
	Non-responder	150/207	165/215	0.794 (0.636–0.991)



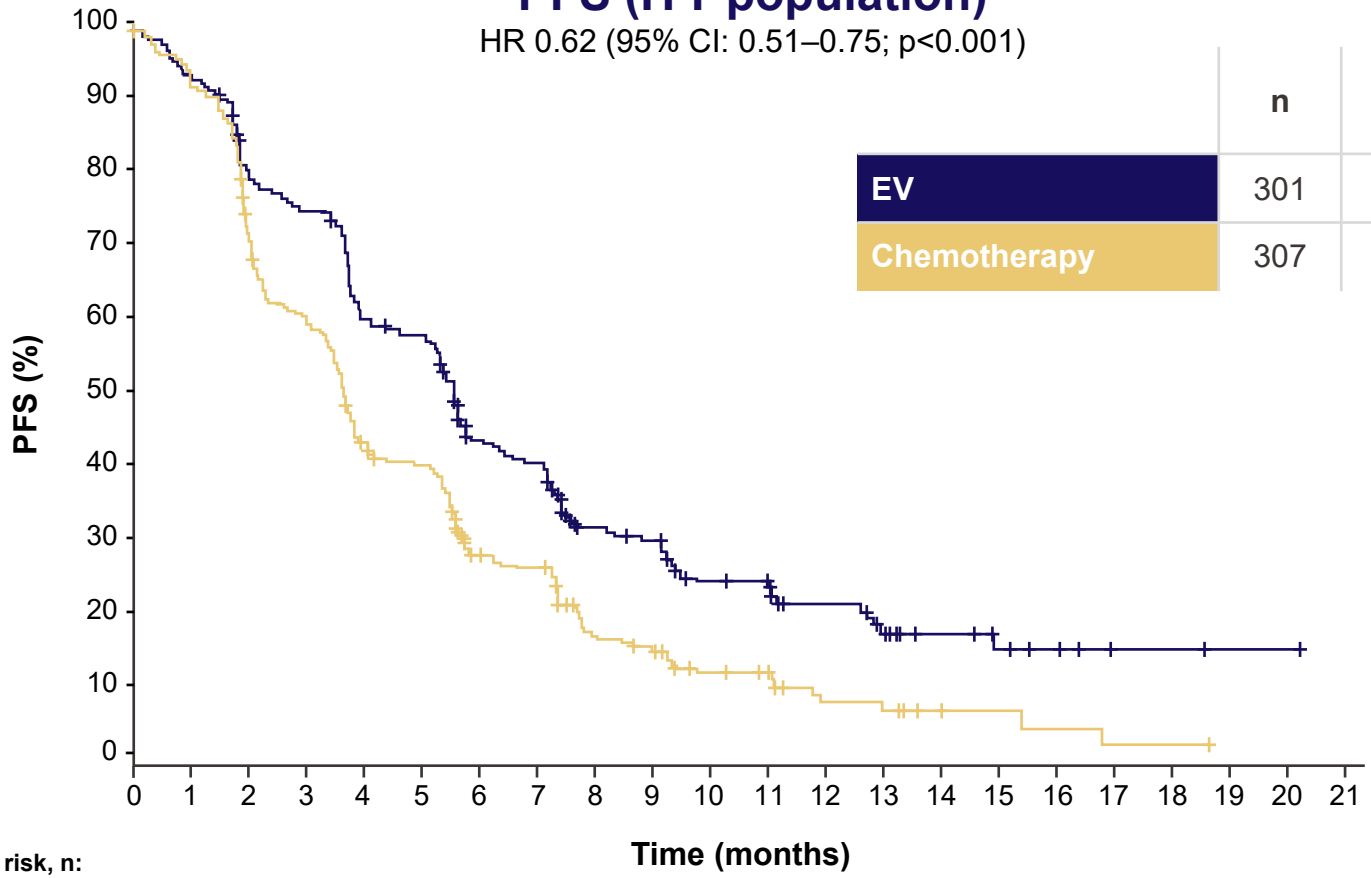
CI, confidence interval; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; HR, hazard ratio; OS, overall survival.

Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

At a median follow-up of 11.1 months, the risk of progression or death was significantly reduced with EV by 38% compared with chemotherapy

PFS (ITT population)

HR 0.62 (95% CI: 0.51–0.75; p<0.001)



	n	Events, n (%)	Median PFS, months (95% CI)
EV	301	201 (66.8)	**5.55** (5.32–5.82)
Chemotherapy	307	231 (75.2)	**3.71** (3.52–3.94)

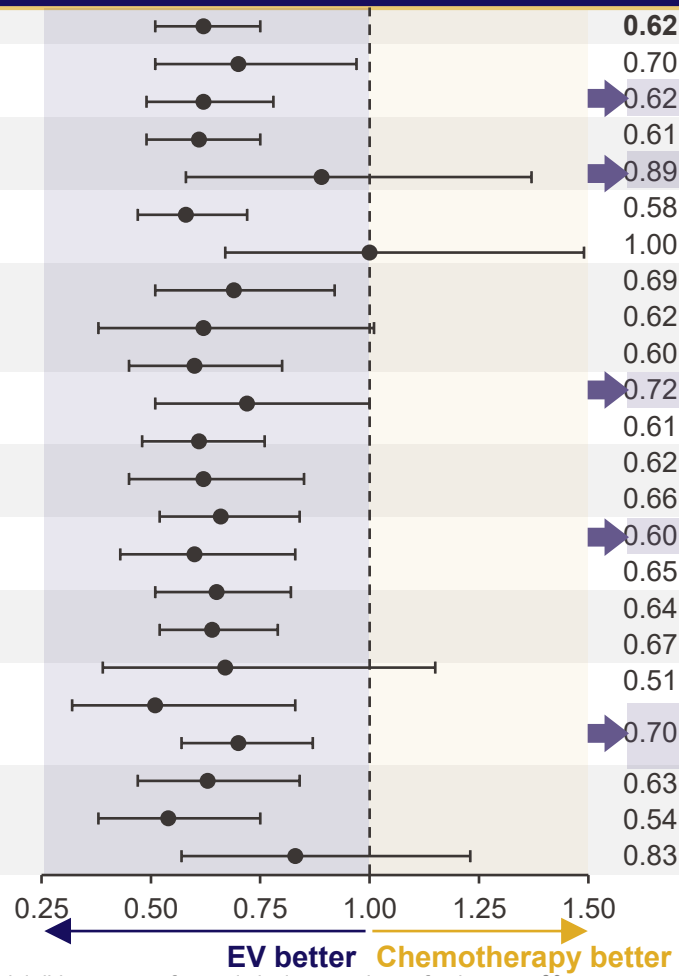
Patients at risk, n:

EV	301	269	224	208	165	158	102	95	60	56	38	36	23	17	11	7	5	2	2	1	1	0
Chemotherapy	307	259	200	166	116	107	62	57	33	29	18	16	8	8	4	3	2	1	1	0	0	0

Figure adapted from Powles T et al. 2021.
Median follow-up: 11.1 months.
CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention to treat; PFS, progression-free survival.
Powles T et al. *N Engl J Med* 2021;384:1125–1135.

EV demonstrated a trend for improved PFS compared with chemotherapy in most patient subgroups in EV-301, including patients who are harder to treat[1]

Analysis population (N=608)[2]		Number of events/number of patients* EV	Chemotherapy	HR (95% CI)
All patients	**All patients**	**201/301**	**231/307**	**0.62 (0.51–0.75)**
Age group: 65 years	<65 years	75/108	80/111	0.70 (0.51–0.97)
	≥65 years	126/193	151/196	0.62 (0.49–0.78)
Age group: 75 years	<75 years	166/249	180/239	0.61 (0.49–0.75)
	≥75 years	35/52	51/68	0.89 (0.58–1.37)
Sex	Male	153/238	180/232	0.58 (0.47–0.72)
	Female	48/63	51/75	1.00 (0.67–1.49)
Geographic region	Western Europe	86/126	95/129	0.69 (0.51–0.92)
	United States	30/43	35/44	0.62 (0.38–1.01)
	Rest of the world	85/132	101/134	0.60 (0.45–0.80)
Primary site of tumour	Upper urinary tract	63/98	74/107	0.72 (0.51–1.00)
	Bladder or other site	138/203	157/200	0.61 (0.48–0.76)
ECOG PS score	0	71/120	86/124	0.62 (0.45–0.85)
	1	130/181	145/183	0.66 (0.52–0.84)
Liver metastasis	Yes	71/93	75/95	0.60 (0.43–0.83)
	No	130/208	156/212	0.65 (0.51–0.82)
Previous systemic therapies	1–2	175/262	203/270	0.64 (0.52–0.79)
	≥3	26/39	28/37	0.67 (0.39–1.15)
Best response among patients who previously received CPI treatment	Response†	32/61	36/50	0.51 (0.32–0.83)
	No response‡	146/207	160/215	0.70 (0.57–0.87)
Pre-selected chemotherapy	Paclitaxel	96/141	90/112	0.63 (0.47–0.84)
	Docetaxel	56/87	87/117	0.54 (0.38–0.75)
	Vinflunine	49/73	54/78	0.83 (0.57–1.23)
	Hard-to-treat populations[1]			



Median follow-up: 11.1 months. Pre-specified subgroup analyses of the intention-to-treat population (all patients who underwent randomization). The trial did not power for statistical comparison of subgroups.[2,3]

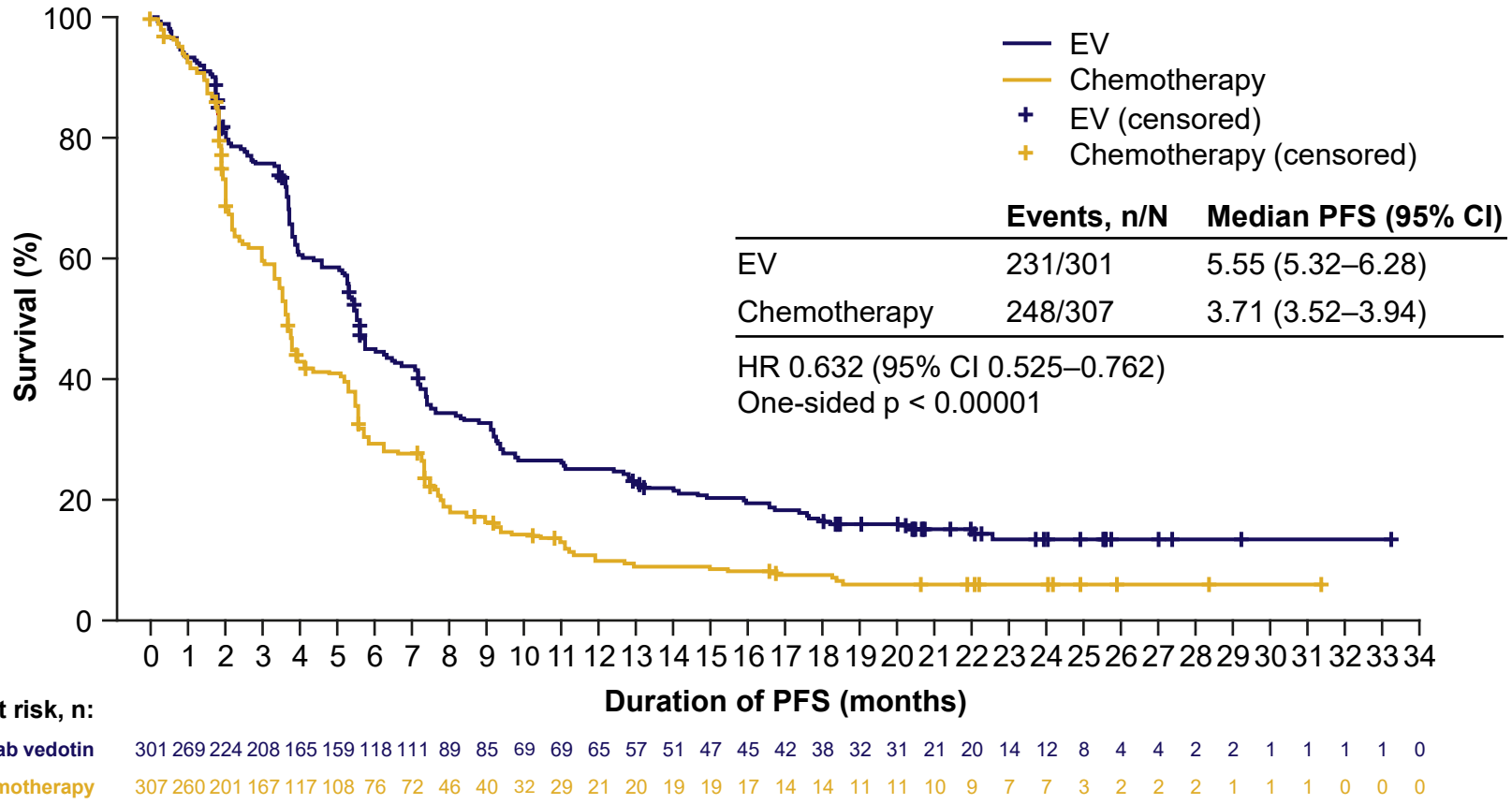
*PFS according to RECIST v1.1 or death from any cause. Investigator-assessed PFS; †Confirmed complete response or partial response; ‡Stable disease or progressive disease.[3]

CI, confidence interval; CPI, checkpoint inhibitor; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; HR, hazard ratio; PFS, progression-free survival; RECIST, Response Evaluation Criteria in Solid Tumours.

1. Rosenberg JE et al. Presented at ESMO 2021. 698P; 2. Powles T et al. *N Engl J Med* 2021;384:1125–1135 (supplementary appendix); 3. Powles T et al. *N Engl J Med* 2021;384:1125–1135.

At a median follow-up of 24 months, the risk of progression or death was significantly reduced with EV by 37% compared with chemotherapy

PFS (ITT population)



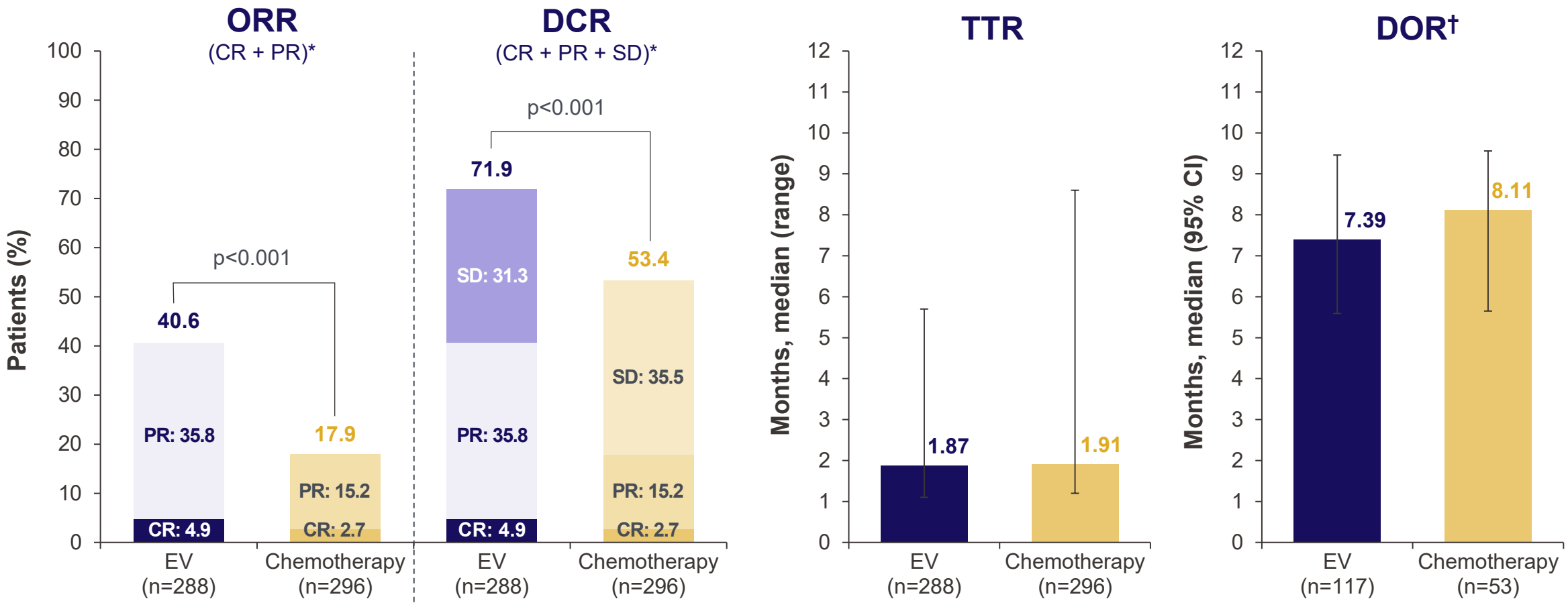
	Events, n/N	Median PFS (95% CI)
EV	231/301	5.55 (5.32–6.28)
Chemotherapy	248/307	3.71 (3.52–3.94)

HR 0.632 (95% CI 0.525–0.762)
One-sided p < 0.00001

Patients at risk, n:																															
Enfortumab vedotin	301	269	224	208	165	159	118	111	89	85	69	69	65	57	51	47	45	42	38	32	31	21	20	14	12	8	4	4	2	2	1	1	1	1	0
Chemotherapy	307	260	201	167	117	108	76	72	46	40	32	29	21	20	19	19	17	14	14	11	11	10	9	7	7	3	2	2	2	1	1	1	0	0	0

CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; ITT, intention to treat; PFS, progression-free survival.
Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

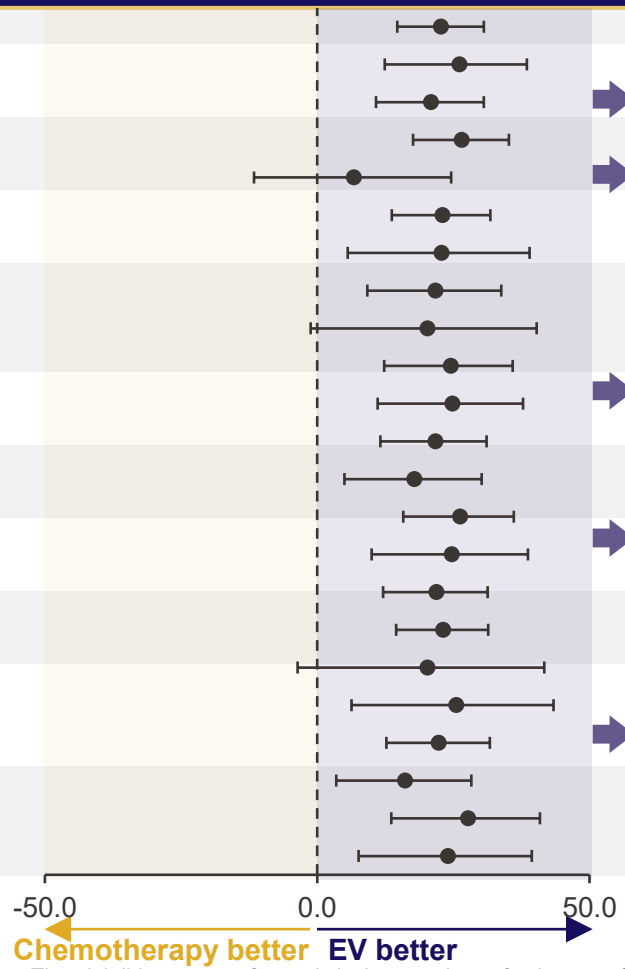
Tumour responses were significantly higher with EV compared with chemotherapy



Median follow-up: 11.1 months.
*Best overall responses according to RECIST v1.1; †In patients with CR or PR. Investigator-assessed responses.
CI, confidence interval; CR, complete response; DCR, disease control rate; DOR, duration of response; EV, enfortumab vedotin; ORR, overall response rate; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumours; TTR, time to response; SD, stable disease.
Powles T et al. *N Engl J Med* 2021;384:1125–1135 (supplementary appendix).

EV demonstrated a trend for improved ORR compared with chemotherapy across patient subgroups in EV-301, including patients who are harder to treat[1]

Analysis population (N=589)[2]		Number of events/number of patients* EV	Chemotherapy	Absolute difference, % (95% CI)
All patients	**All patients**	**117/288**	**53/296**	**22.7 (14.7–30.6)**
Age group: 65 years	<65 years	42/104	15/105	26.1 (12.4–38.5)
	≥65 years	75/184	38/191	20.9 (10.8–30.6)
Age group: 75 years	<75 years	102/237	38/230	26.5 (17.6–35.2)
	≥75 years	15/51	15/66	6.7 (−11.6–24.6)
Sex	Male	90/228	37/224	23.0 (13.7–31.8)
	Female	27/60	16/72	22.8 (5.6–39.0)
Geographic region	Western Europe	46/117	22/125	21.7 (9.2–33.8)
	United States	15/43	6/41	20.2 (−1.2–40.3)
	Rest of the world	56/128	25/130	24.5 (12.3–35.9)
Primary site of tumour	Upper urinary tract	43/98	20/105	24.8 (11.1–37.8)
	Bladder or other site	74/190	33/191	21.7 (11.6–31.1)
ECOG PS score	0	49/115	30/121	17.8 (5.0–30.2)
	1	68/173	23/175	26.2 (15.8–36.1)
Liver metastasis	Yes	33/93	10/93	24.7 (10.0–38.7)
	No	84/195	43/203	21.9 (12.1–31.3)
Previous systemic therapies	1–2	103/251	47/262	23.1 (14.5–31.4)
	≥3	14/37	6/34	20.2 (−3.6–41.7)
Best response among patients who previously received CPI treatment	Response*	28/56	12/49	25.5 (6.3–43.4)
	No response†	79/199	36/207	22.3 (12.7–31.7)
Pre-selected chemotherapy	Paclitaxel	56/134	28/109	16.1 (3.5–28.3)
	Docetaxel	33/84	13/112	27.7 (13.6–40.9)
	Vinflunine	28/70	12/75	24.0 (7.6–39.4)
	Hard-to-treat populations[1]			



Median follow-up: 11.1 months. Pre-specified subgroup analyses of all patients who underwent randomization and had measurable disease at baseline. The trial did not power for statistical comparison of subgroups.[2,3]
*Best overall responses according to RECIST v1.1. Investigator-assessed responses; †Confirmed complete response or partial response; ‡Stable disease or progressive disease.[3]
CI, confidence interval; CPI, checkpoint inhibitor; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; ORR, overall response rate; RECIST, Response Evaluation Criteria in Solid Tumours.
1. Rosenberg JE et al. Presented at ESMO 2021. 698P; 2. Powles T et al. *N Engl J Med* 2021;384:1125–1135 (supplementary appendix); 3. Powles T et al. *N Engl J Med* 2021;384:1125–1135.

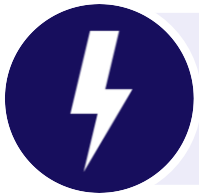
TRAE rates at 24 months in the EV and chemotherapy groups were consistent with the interim analysis

TRAEs, n (%)*	EV group (n=296)†		Chemotherapy group (n=291)†	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Any AE	278 (93.9)	155 (52.4)	267 (91.8)	147 (50.5)
Alopecia	135 (45.6)	NR	108 (37.1)	NR
Peripheral sensory neuropathy	103 (34.8)	15 (5.1)	63 (21.6)	6 (2.1)
Pruritus	96 (32.4)	4 (1.4)	14 (4.8)	1 (0.3)
Fatigue	93 (31.4)	20 (6.8)	66 (22.7)	13 (4.5)
Decreased appetite	92 (31.1)	9 (3.0)	69 (23.7)	5 (1.7)
Diarrhoea	74 (25.0)	10 (3.4)	49 (16.8)	5 (1.7)
Dysgeusia	73 (24.7)	NR	22 (7.6)	NR
Nausea	71 (24.0)	3 (1.0)	64 (22.0)	4 (1.4)
Maculopapular rash	50 (16.9)	22 (7.4)	5 (1.7)	0
Anaemia	34 (11.5)	8 (2.7)	63 (21.6)	23 (7.9)
Decreased neutrophil count	31 (10.5)	18 (6.1)	51 (17.5)	41 (14.1)
Neutropenia	20 (6.8)	14 (4.7)	25 (8.6)	18 (6.2)
Decreased white-cell count	15 (5.1)	4 (1.4)	32 (11.0)	21 (7.2)
Febrile neutropenia	2 (0.7)	2 (0.7)	16 (5.5)	16 (5.5)

Disclaimer: PADCEV (enfortumab vedotin) can cause severe skin reactions, including SJS and TEN (predominantly during the first cycle of treatment).
*Occurring in ≥20% of patients in either treatment group or Grade ≥3 TRAEs occurring in ≥5% of patients in either treatment group. †Safety population.
AE, adverse event; EV, enfortumab vedotin; NR not reported; TRAE, treatment-related adverse event.
Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

EV maintained baseline QoL with less variability versus chemotherapy when assessed over the first 12 weeks, and meaningfully improved most QoL domains

Over the first 12 weeks of treatment, overall patient-reported QoL, assessed using EORTC QLQ-C30 Global Health Status, was **maintained** with EV, and was more stable with EV compared with chemotherapy[1]



EV was associated with a **significant reduction in pain** from baseline compared with chemotherapy at Week 12, although loss of appetite was significantly increased[1]

Patients who received EV experienced a confirmed improvement in 10 of 15 QLQ-C30 subscales, including **all functioning domains** and **most symptom domains**, including pain, fatigue, dyspnoea and constipation[1]

These results should be interpreted in the context of the open-label study design, meaning that patients knew which treatment they were receiving; this could have influenced their perceptions when completing the QoL questionnaire[2]

EORTC, European Organisation for Research and Treatment of Cancer; EV, enfortumab vedotin; QLQ-C30, Quality of Life Questionnaire Core 30; QoL, quality of life.

1. Rosenberg JE et al. *Eur Urol* 2024;85:574–585; 2. US FDA. Guidance for Industry. Patient-Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims. Available at: https://www.fda.gov/media/77832/download. Last accessed October 2024.

Summary

- The EV-301 study compared EV with chemotherapy for the treatment of LA/mUC in patients previously treated with platinum-based CT and a PD-1/L1 inhibitor[1]
- In EV-301, key outcomes (such as OS, PFS and ORR) were significantly improved with EV vs. chemotherapy in patients with LA/mUC previously treated with platinum-based CT and a PD-1/L1 inhibitor[1,2]
- At a median follow-up of 24 months, key outcomes (such as OS and PFS) were significantly improved with EV vs. chemotherapy in patients with LA/mUC previously treated with platinum-based CT and a PD-1/L1 inhibitor[3]
- Baseline QoL was maintained with EV, with less variability vs. chemotherapy when assessed over the first 12 weeks of treatment, and most QoL domain scores were meaningfully improved[4]

CT, chemotherapy; EV, enfortumab vedotin; LA, locally advanced; mUC, metastatic urothelial carcinoma; ORR, objective response rate; OS, overall survival; PD-1/L1, programmed cell death protein 1/ligand 1; PFS, progression-free survival; QoL, quality of life.

1. Powles T et al. *N Engl J Med* 2021;384:1125–1135; 2. Powles T et al. *N Engl J Med* 2021;384:1125–1135 (supplementary appendix); 3. Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054; 4. Rosenberg JE et al. *Eur Urol* 2024;85:574–585.

Genitourinary Masterclass

astellas

Please refer to the Korean PI for PADCEV® (enfortumab vedotin) via the following link or QR Code:

<PADCEV 20mg>

<PADCEV 30mg>

Astellas Pharma Korea., Inc.
(7F Parnas tower, 521, Teheran-ro, Gangnam-gu, Seoul, Republic of Korea)

PI, Prescribing Information

Genitourinary Masterclass

Insights from RWE for EV monotherapy

Dr Kumar Vaid

Medanta Hospital, Gurugram, India

EV as first-line therapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer. Combination therapy with pembrolizumab.

EV as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who have previously received a programmed death receptor-1 or programmed death-ligand 1 inhibitor, and have received a platinum-containing chemotherapy

1L, first line; EV, enfortumab vedotin;
LA/mUC, locally advanced/metastatic urothelial carcinoma; P, pembrolizumab;
PD-1/L1, programmed cell death-1/ligand 1.
PADCEV® (enfortumab vedotin). Prescribing Information
July 2025 | MAT-KR-PAD-2025-00066

PADCEV®
enfortumab vedotin
Injection for IV infusion 20 mg & 30 mg vials

astellas

Disclaimers

The information, views and opinions presented herein are those of the presenter, and the presenter is solely responsible for the materials being introduced in this presentation. Although patients' cases mentioned herein are actual cases, treatment may differ from local approval product information.

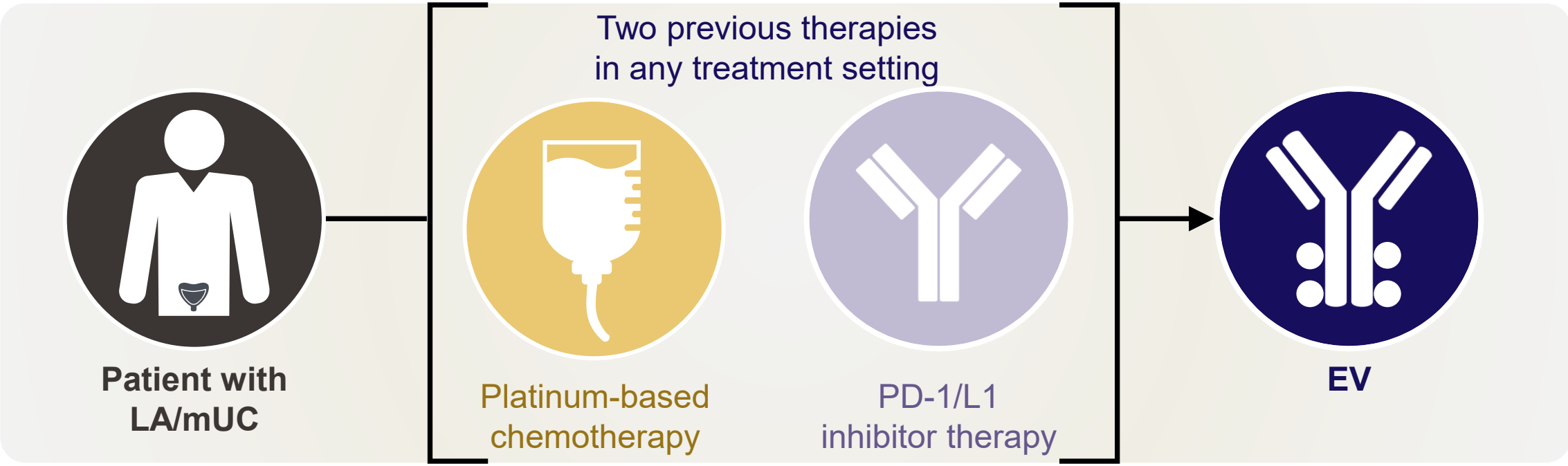
Such information, views and opinions of the presenter do not necessarily reflect the information, views and opinions of Astellas Pharma Ltd. Astellas Pharma Ltd. does not recommend the use of any product in any different manner than as described in the local approval information, and complies with all applicable laws, regulations, and company policies.

Speaker disclosures

- Speaker fees and advisory role:
  - Astellas, Cipla, Datar Cancer Genetics, Dr. Reddy’s Laboratories, Eli Lilly, Intas Pharmaceuticals, Reliance Life Sciences, Zydus Lifesciences

EV monotherapy is a treatment for patients with LA/mUC who have received previous platinum-based chemotherapy and a PD-1/L1 inhibitor

Based on the efficacy and safety data from the pivotal **Phase III EV-301 study**, EV as monotherapy is indicated for the treatment of **adult patients with LA/mUC** who have previously received a platinum-based chemotherapy and a PD-1/L1 inhibitor



EV, enfortumab vedotin; LA/mUC, locally advanced/metastatic urothelial carcinoma; PD-1/L1, programmed cell death protein 1/ligand 1.
PADCEV™ (enfortumab vedotin). Summary of Product Characteristics.

Does real-world evidence reflect clinical trial data?

- There were limited options for patients with inadequate response to platinum-based chemotherapy and an immune checkpoint inhibitor as 1L therapy for LA/mUC[1]
- EV is a novel therapy combining the benefit of a two-in-one approach as a targeted agent carrying a chemotherapy payload[2]
- From an efficacy and safety standpoint, RWE reflects the trial data[3,4]
- In addition, RWE also included patients who were not included in clinical trials including EV-301, such as:[3]
  - Patients with diabetes
  - Patients with neuropathy
  - Patients with *FGFR3* alterations*
  - Patients with an eGFR rate <30 ml/min*

*These patient groups were not included as part of the exclusion criteria for EV-301 however they were not included within the study results. Patients were excluded from EV-301 if they had preexisting grade 2 or higher sensory or motor neuropathy or ongoing clinically significant toxic effects associated with previous treatment, active central nervous system metastases, uncontrolled diabetes, or active keratitis or corneal ulcerations or if they had received more than one previous chemotherapy regimen for LA/mUC, including neoadjuvant or adjuvant treatment.[4]

1L, first line; eGFR, estimated glomerular filtration rate; EV, enfortumab vedotin; FGFR, fibroblast growth factor; LA/mUC, locally advanced/metastatic urothelial carcinoma; RWE, real-world evidence.

1. Powles T et al. *Ann Oncol* 2022;33:244–258; 2. PADCEV™ (enfortumab vedotin). Summary of Product Characteristics; 3. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 4. Powles T et al. *N Eng J Med* 2021;384:1125–1135.

The UNITE study: RWE supplementing learnings from EV-301

Design:
Retrospective, multicentre, US, real-world study

Aim:
Evaluate efficacy outcomes for patients with LA/mUC treated with recently approved therapies, including EV

Cohort:
Most patients included in UNITE received EV outside of a clinical trial setting (78%)

Patients with baseline renal impairment, diabetes, neuropathy, *FGFR3* alterations, an eGFR <30 ml/min and significant comorbidities were included

Baseline characteristic	Subgroup	EV monotherapy (N=260)
Median age, years	–	71
Sex, %	Male	79
ECOG PS, %	0	29
	1	50
	2–4	20
Location of primary tumour, %	Bladder	73
	Upper urinary tract	25
	Urethra	<1
	Unknown	2
Histology, %	Pure urothelial	68
	Mixed urothelial predominant	27
	Mixed variant predominant	2
	Pure variant	1
	Unknown	2
Metastatic disease sites, %	LN or locoregional recurrence only	20
	Liver	32
	Visceral non-liver	48
Lines of therapy for metastatic disease before receiving EV, %	None	5
	1	28
	2	42
	3	18
	≥4	7

Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics.
Median time from the initial diagnosis to progression to advanced disease was 10.9 months. Median follow-up from the initial UC diagnosis to the last follow-up was 35.9 months.
ECOG PS, Eastern Cooperative Oncology Group performance status; eGFR, estimated glomerular filtration rate; EV, enfortumab vedotin; LA/mUC, locally advanced/metastatic urothelial carcinoma; LN, lymph node; RWE, real-world evidence; UC, urothelial carcinoma; UNITE, Urothelial Cancer Network to Investigate Therapeutic Experiences.
Koshkin VS et al. *Cancer* 2022;128:1194–1205.

The UNITE study: RWE supplementing learnings from EV-301[1]

Design:
Retrospective, multicentre, US, real-world study

Aim:
Evaluate efficacy outcomes for patients with LA/mUC treated with recently approved therapies, including EV

Cohort:
Most patients included in UNITE received EV outside of a clinical trial setting (78%)

Patients with baseline renal impairment, diabetes, neuropathy, *FGFR3* alterations, an eGFR <30 ml/min and significant comorbidities were included[1]

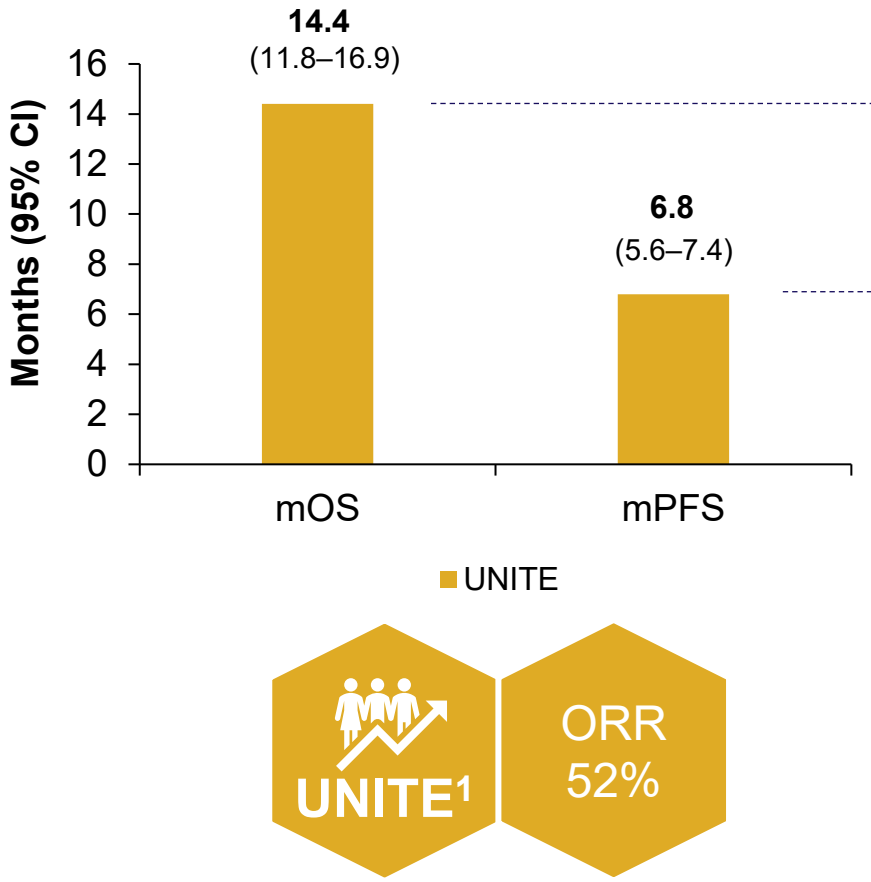
Baseline characteristic	Subgroup	EV monotherapy (N=260)
Median age, years	–	71
Sex, %	Male	79
ECOG PS, %	0	
	1	
	2–4	
Location of primary tumour, %	Bla	
	Upp	
	Urethra	<1
	Unknown	2
Histology, %	Pure urothelial	68
	Mixed urothelial predominant	27
	Mixed variant predominant	2
	Pure variant	1
	Unknown	2
Metastatic disease sites, %	LN or locoregional recurrence only	20
	Liver	32
	Visceral non-liver	48
Lines of therapy for metastatic disease before receiving EV, %	None	5
	1	28
	2	42
	3	18
	≥4	7

The proportion of patients with variant histologies was close to 30% patients in the UNITE study vs. 15% in the EV 301 trial[1,2]

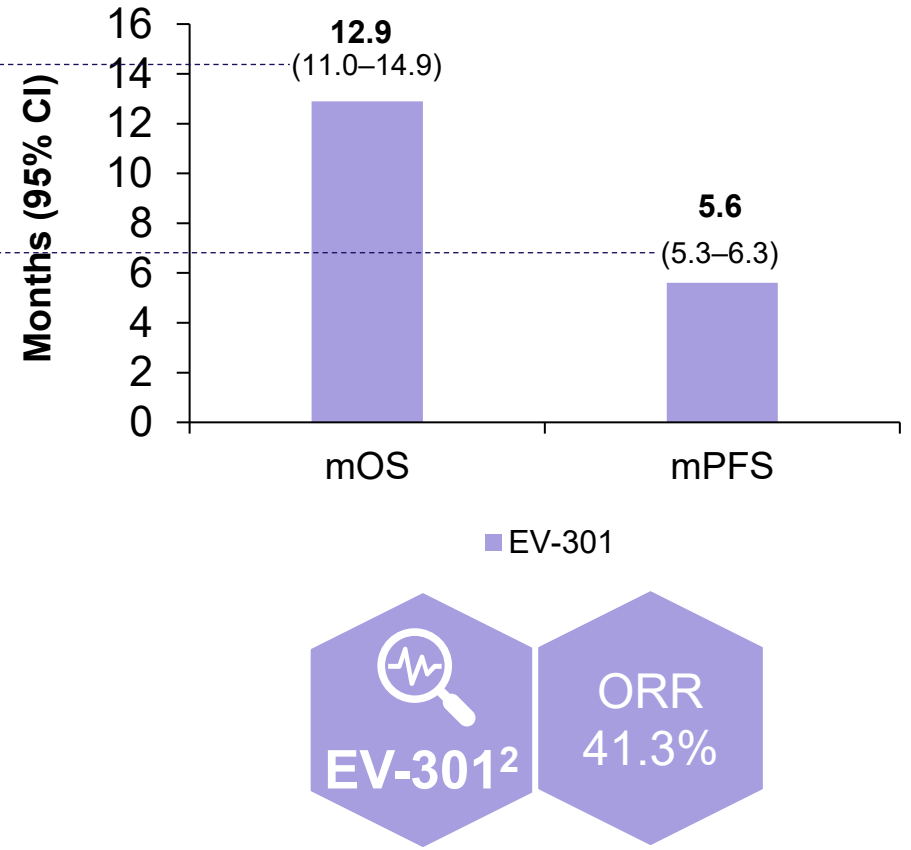
Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics.
Median time from the initial diagnosis to progression to advanced disease was 10.9 months. Median follow-up from the initial UC diagnosis to the last follow-up was 35.9 months.
ECOG PS, Eastern Cooperative Oncology Group performance status; eGFR, estimated glomerular filtration rate; EV, enfortumab vedotin; LA/mUC, locally advanced/metastatic urothelial carcinoma; LN, lymph node; RWE, real-world evidence; UC, urothelial carcinoma; UNITE, Urothelial Cancer Network to Investigate Therapeutic Experiences.
1. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 2. Powles T et al. *N Eng J Med* 2021;384:1125–1135.

The UNITE study: Clinical outcomes for patients treated with EV were similar to outcomes in EV-301[1,2]

Efficacy outcomes for patients receiving EV in RWE[1]



Efficacy outcomes for patients receiving EV in EV-301[2]



Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics

UNITE and EV-301 are two different studies and so cannot be compared.

CI, confidence interval; EV, enfortumab vedotin; mOS, median overall survival; mPFS, median progression-free survival; ORR, overall response rate; RWE, real-world evidence; UNITE, Urothelial Cancer Network to Investigate Therapeutic Experiences.

1. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 2. Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

The UNITE study: Clinical outcomes for patients treated with EV were similar to outcomes in EV-301[1,2]

ORR was higher in pure urothelial carcinoma histology vs. VH (58% vs. 42%; p=0.06)[1]

Responses to EV were notable in patients with VH, except for NE* and pure histology. Patients with VH types associated with poor outcomes, such as sarcomatoid and plasmacytoid, demonstrated responses to EV[3]

UNITE[1]

ORR 52%

>40% in all reported subsets of interest, including patients with comorbidities previously excluded from clinical trials* and patients with FGFR3 alterations[1]

EV-301[2]

ORR 41.3%

Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics

UNITE and EV-301 are two different studies and so cannot be compared.

*NE/Small cell.

CI, confidence interval; EV, enfortumab vedotin; mOS, median overall survival; mPFS, median progression-free survival; NE, neuroendocrine; ORR, overall response rate; UC, urothelial carcinoma; UNITE, Urothelial Cancer Network to Investigate Therapeutic Experiences; VU, variant histology.

1. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 2. Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054; 3. Jindal T et al. *J Clin Oncol* 2024;42:652.

The UNITE study: EV was efficacious in patient subgroups that were not included in the EV-301 trial[1,2]

Subgroup[1]	Patients, n	ORR, % (95% CI)
ECOG PS		
0/1	173	56 (48–63)
2/3	34	41 (25–59)
Baseline neuropathy		
No	139	48 (40–57)
Yes	71	62 (50–73)
Baseline diabetes mellitus		
No	183	51 (44–59)
Yes	29	59 (39–76)
FGFR3		
Wild type	102	54 (44–64)
Altered	28	57 (37–75)

Patient response rates to EV were similar regardless of whether they met the **EV-301 inclusion criteria**[1]

There were fewer patients who did not meet the EV-301 inclusion criteria than patients who did, resulting in **non-matched patient comparison numbers**[1]

UNITE study data also showed outcomes were similar among patients with aUC who had neuropathy or diabetes mellitus at baseline who were treated with EV[3]

Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics.

aUC, advanced urothelial carcinoma; CI, confidence interval; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; FGFR, fibroblast growth factor receptor; ORR, overall response rate; UNITE, Urothelial Cancer Network to Investigate Therapeutic Experiences.

1. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 2. Powles T et al. *N Eng J Med* 2021;384:1125–1135; 3. Jang A et al. *Ann Oncol* 2024;35:S1150–S1151.

European RWE: RWE to supplement learnings from EV-301

Design:
Retrospective, real-world study collecting data from 23 hospitals across Europe

Aim:
Assess safety and efficacy of EV in patients with mUC

Cohort:
Patients (N=125) with mUC treated with EV

Baseline characteristic	Subgroup	EV monotherapy (N=125)
Median age at EV initiation, years	–	66
Sex, %	Male	70
ECOG PS, %	0	36
	1	40
	2–4	14
Location of primary tumour, %	Bladder	65
	Upper urinary tract	22
	Unknown	13
Histology, %	Urothelial carcinoma	98
	Squamous cell carcinoma	>1
	Unknown	>1
Metastatic disease sites, %	LN	81
	Lung	49
	Bone	50
	Liver	37
	Brain	6
Prior treatment lines, %	1	>1
	2	54
	3	23
	≥4	22

Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics

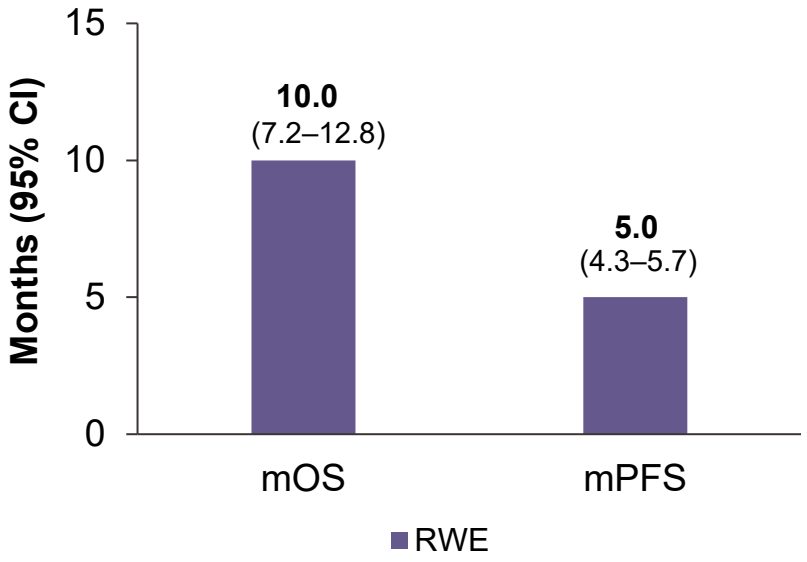
Median follow-up was 8.0 months.

ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; LN, lymph node; mUC, metastatic urothelial carcinoma; RWE, real-world evidence.

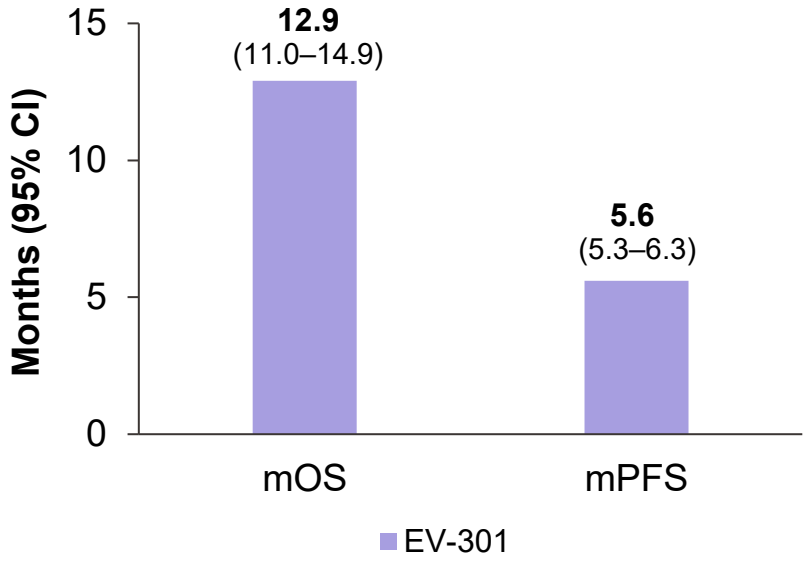
Zschäbitz S et al. *Eur Urol Open Sci* 2023;53:31–37.

European RWE: Clinical outcomes for patients treated with EV were similar to outcomes in EV-301[1,2]

Efficacy outcomes for patients receiving EV in RWE[1]



Efficacy outcomes for patients receiving EV in EV-301[2]



Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics

European RWE and EV-301 are two different studies and so cannot be compared.

CI, confidence interval; EV, enfortumab vedotin; mOS, median overall survival; mPFS, median progression-free survival; ORR, overall response rate; RWE, real-world evidence.

1. Zschäbitz S et al. *Eur Urol Open Sci* 2023;53:31–37; 2. Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

European RWE: No new safety signals associated with EV were identified

AE, %	European RWE (N=125)	
	Any grade	Grade ≥3
Any TRAE	69.6	31.3
Most common TRAEs		
Peripheral sensory neuropathy	25.6	9.6
Skin (rash)	24.8	3.2
Fatigue	17.6	3.2
Haematotoxicity	12.0	7.2
General deterioration	12.0	4.0
Infection	9.6	4.8
Diarrhoea	8.8	1.6
Respiratory	6.4	3.2
Dysgeusia	6.4	–
Nausea	5.6	0.8
Eye disorder	5.6	–
Pruritis	4.8	–
Loss of appetite	3.2	0.8
Hyperglycaemia	2.4	1.6
Constipation	2.4	0.8
Liver toxicity	0.8	0.8

Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics

European RWE and EV-301 had different study designs and so cannot be compared.

AE, adverse event; EV, enfortumab vedotin; TRAE, treatment-related adverse event; RWE, real-world evidence.

Zschäbitz S et al. *Eur Urol Open Sci* 2023;53:31–37.

European RWE: No new safety signals associated with EV were identified

AE, %	EV-301, EV (n=296)	
	Any grade	Grade ≥3
Any TRAE	93.9	52.4
Most common TRAEs		
Alopecia	45.6	–
Peripheral sensory neuropathy	34.8	5.1
Pruritus	32.4	1.4
Fatigue	31.4	6.8
Decreased appetite	31.1	3.0
Diarrhoea	25.0	3.4
Dysgeusia	24.7	–
Nausea	24.0	1.0
Maculopapular rash	16.9	7.4
Anaemia	11.5	2.7
Decreased neutrophil count	10.5	6.1
Neutropenia	6.8	4.7
Decreased white cell count	5.1	1.4
Febrile neutropenia	0.7	0.7

Disclaimer: PADCEV (enfortumab vedotin) should only be used according to the Summary of Product Characteristics

European RWE and EV-301 had different study designs and so cannot be compared.

AE, adverse event; EV, enfortumab vedotin; TRAE, treatment-related adverse event; RWE, real-world evidence.

Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

RWE supports the findings of EV-301 and demonstrates efficacy of EV in a broad patient population

RWE can help inform findings from RCTs through investigation of a **broader patient population**[1]

RWE on EV in the US and Europe obtained **OS and PFS data consistent with EV-301**[2–4]

RWE used to show **efficacy in patient subgroups** that were **not included in the EV-301 trial**[2]

RWE provides evidence that EV induces **consistent OS and PFS** benefits for **male and female patients**[3]

RWE identified **no new safety signals** associated with EV[3]

Together, these findings demonstrate the **value of EV** outside of the RCT setting

EV, enfortumab vedotin; OS, overall survival; PFS, progression-free survival; RCT, randomized controlled trial. RWE, real-world evidence.

1. Sherman R et al. *N Engl J Med* 2016;375:2293–2297; 2. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 3. Zschäbitz S et al. *Eur Urol Open Sci* 2023;53:31–37; 4. Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054.

EVOLVE FRANCE

Epidemiology and Treatment Patterns of Patients With Locally Advanced or Metastatic Urothelial Cancer in France: A Non-interventional Database Study

Florence Joly, Morgan Rouprêt, Stéphane Culine, Aurore Tricotel, Emilie Casarotto, Rafaël Minacori, Torsten Strunz-McKendry, Khalil Karzazi, Kirsten Leyland, Marthe Vuillet, Marie-Catherine Thomas

Joly F et al. Presented at ESMO 2024. Poster Number: 2001P.

Background

- In France, the treatment landscape of LA/mUC has recently changed[1]
  - Avelumab was approved in 2021 as first-line maintenance treatment for patients with LA/mUC who have not progressed after PBCT[2]
  - EV was approved in 2022 for patients with LA/mUC who have previously received treatment with a PD-1/PD-L1 inhibitor and was available through early access[3]

Here, the authors analyzed epidemiology and the treatment patterns of patients with la/mUC in France from 2020 to 2022[1]

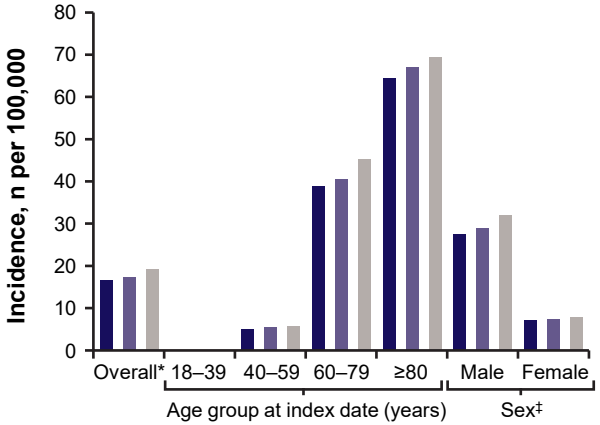
EV, enfortumab vedotin; LA/mUC, locally advanced/metastatic urothelial carcinoma; PBCT, platinum-based chemotherapy; PD-1, programmed death receptor-1; PD-L1, programmed death-ligand 1.
1. Joly F et al. Presented at ESMO 2024. Poster Number: 2001P; 2. BAVENCIO (avelumab). Summary of Product Characteristics; 3. PADCEV™ (enfortumab vedotin). Summary of Product Characteristics.

Study design

EVOLVE-2 was a descriptive, retrospective, longitudinal non-interventional study aimed to describe and assess the epidemiology and treatment patterns of patients with LA/mUC in France.

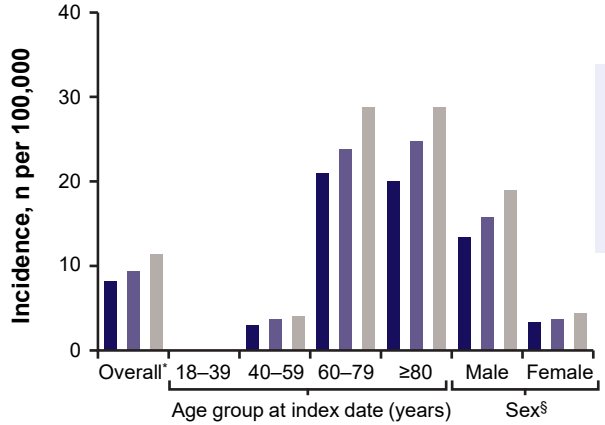
- Adult patients with LA/mUC were identified from *the Programme de Médicalisation des Systèmes d'Information*, the French national database for hospitalization records
- Data were extracted from 1 Jan 2015 to 31 Dec 2022

Incidence in population 1



Population 1: Patients with LA/mUC (both prevalent and incident) between 1 Jan 2020 and 31 Dec 2022: n=39,857
Prevalent at 1 Jan 2020: n=11,339
Incident from 2020 to 2022: n=28,518

Incidence in population 2A



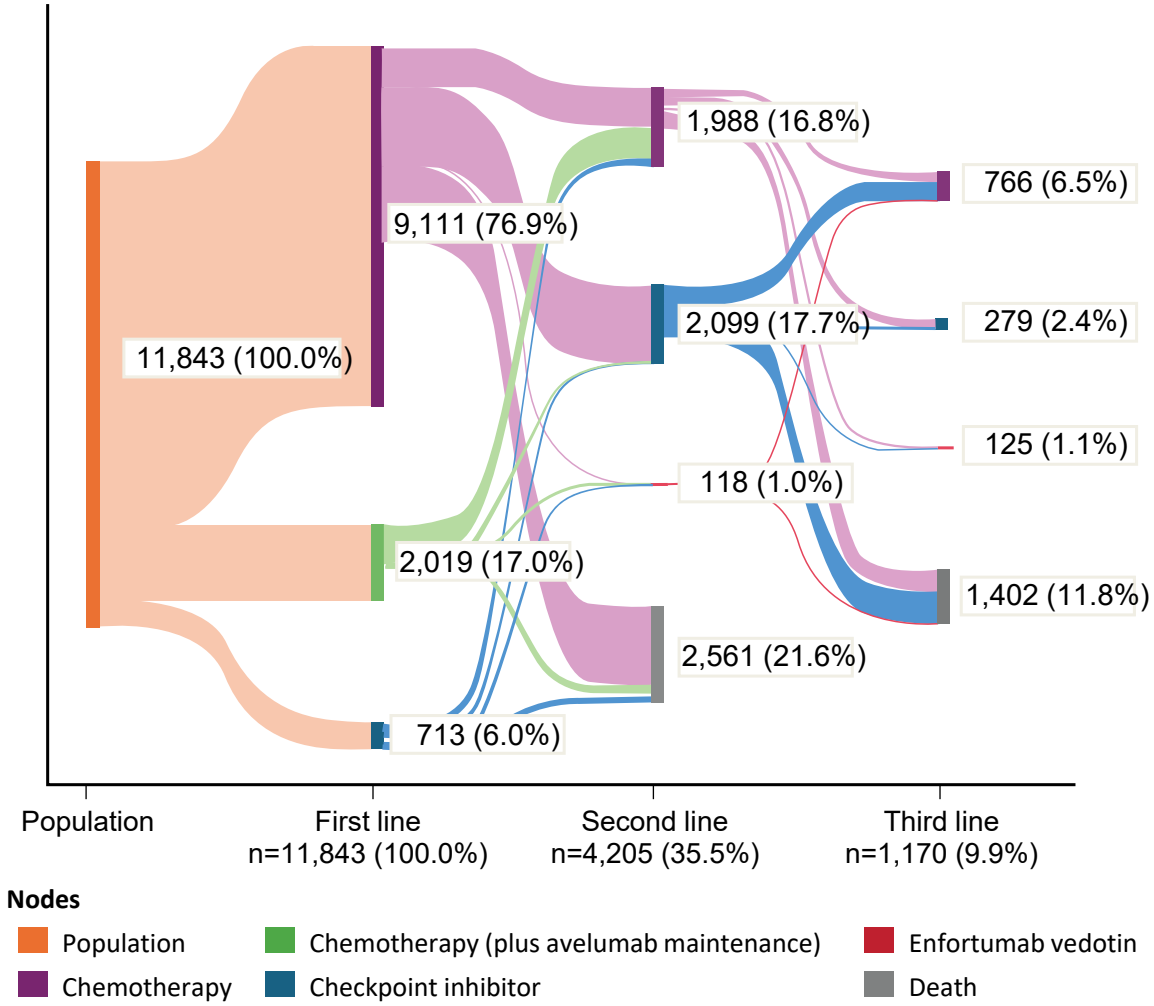
Population 2A¶: Patients with LA/mUC starting 1L treatment between 1 Jan 2020 and 31 Dec 2022: n=15,101

*Overall population (reference population): 52,909,737 people in 2020; 53,160,117 people in 2021; and 53,416,701 people in 2022; †Data were missing for one and four patients in 2021 and 2022, respectively, in population 1; ‡Data were missing for three patients in 2022 in population 2A; §The number of patients identified as newly diagnosed in 2022 may have been slightly overestimated by the construction of the study cohort due to lack of sufficient follow-up period (4 months follow-up is typically needed to definitively characterise patients' status regarding LA/mUC diagnosis); ¶Population 2B consisted of la/mUC patients without evidence of treatment (n=9605) and was not included in the primary or secondary endpoints. 511 patients, for whom the treatment line was considered indeterminate, were not included in the primary or secondary endpoints; An additional 511 patients, for whom the treatment line was considered indeterminate, were not included in the primary or secondary endpoints.
1L, first line; LA/mUC, locally advanced/metastatic urothelial carcinoma; UC, urothelial carcinoma.
Joly F et al. Presented at ESMO 2024. Poster Number: 2001P.

Treatment patterns and characteristics of patients with LA/mUC starting 1L treatment between 1 Jan 2020 and 30 Jun 2022* (Population 3)

- The mean (standard deviation) age of patients was 71 (9.8) years, and 79.5% of patients were male
- The most common comorbidities (≥10%) at index date were other cancers (including lung and prostate cancers), peripheral vascular disease, chronic pulmonary disease, moderate or severe renal disease, and myocardial infarction

- 64.5% of treated patients received only 1L treatment
  - Almost all (93.6%) received platinum-based chemotherapy as 1L treatment
- Overall, 17.0% of patients received subsequent avelumab maintenance therapy:†
  - 11.9% (497/4,163) in 2020
  - 19.9% (986/4,947) in 2021
  - 19.3% (536/2,783) in 2022



*A total of 50 patients who received avelumab as 1L treatment without any evidence of prior chemotherapy were excluded from the analysis. The maximum follow-up period for incident patients was 3 years and patients included more recently may have not had sufficient time to experience a relapse during the study period and then begin a subsequent line of treatment; †Percentage may be limited due to restricted availability of avelumab during this period.
1L, first line; LA/mUC, locally advanced/metastatic urothelial carcinoma.
Joly F et al. Presented at ESMO 2024. Poster Number: 2001P.

Authors' conclusions

- Incidence rates of LA/mUC increased over time in France during the study period (from Jan 2020 to Dec 2022)
- Most patients who received 1L treatment from Jan 2020 to Jun 2022 had only chemotherapy as their 1L modality
  - More than 60% of patients only received 1L treatment
  - Avelumab use was low overall but increased over time (11.9% to 19.3%)
  - Only 17.7% of patients received 2L checkpoint inhibitors after 1L and 1.0% of patients received EV

1/2L, first/second line; EV, enfortumab vedotin; LA/mUC, locally advanced/metastatic urothelial carcinoma.
Joly F et al. Presented at ESMO 2024. Poster Number: 2001P.

Summary

Treatment options were limited for patients with LA/mUC who experience disease progression post platinum-based chemotherapy and CPI, and EV monotherapy helped to address previous unmet needs for an effective ≥2L therapy in patients with LA/mUC[1,2]

Data from EV-301 show the superior clinical efficacy of EV vs. chemotherapy, as well as similar overall rates of TRAEs[2]

Long-term data show the sustained benefit of EV and this was consistent with RWE[2–4]

2L, second line; CPI, checkpoint inhibitor; EV, enfortumab vedotin;. LA/mUC, locally advanced/metastatic urothelial carcinoma; RWE, real-world evidence; TRAE, treatment-related adverse event.

1. Powles T et al. *Ann Oncol* 2022;33:244–258; 2. Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054; 3. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 4. Zschäbitz S et al. *Eur Urol Open Sci* 2023;53:31–37.

Genitourinary Masterclass

astellas

Please refer to the Korean PI for PADCEV® (enfortumab vedotin) via the following link or QR Code:

<PADCEV 20mg>

<PADCEV 30mg>

Astellas Pharma Korea., Inc.
(7F Parnas tower, 521, Teheran-ro, Gangnam-gu, Seoul, Republic of Korea)

PI, Prescribing Information

Genitourinary Masterclass

Applying learnings from clinical trials and RWE to clinical practice

Dr Mark Igorevich Gluzman

Associate Professor of the Department of Oncology of the Medical Institute of St. Petersburg State University

EV as first-line therapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer. Combination therapy with pembrolizumab.

EV as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who have previously received a programmed death receptor-1 or programmed death-ligand 1 inhibitor, and have received a platinum-containing chemotherapy

1L, first line; EV, enfortumab vedotin;
LA/mUC, locally advanced/metastatic urothelial carcinoma; P, pembrolizumab;
PD-1/L1, programmed cell death-1/ligand 1.
PADCEV® (enfortumab vedotin). Prescribing Information
June 2025 | MAT-KR-PAD-2025-00067

Adverse events should be reported.
For Korea, healthcare professionals are asked to report any suspected adverse reactions to Astellas Pharma Korea. Inc
(Telephone: +82 10 5254 3389; Email: safety-kr@kr.astellas.com)

Prescribing information is available at the end of this presentation. This promotional meeting is fully sponsored and supported by Astellas, including speaker-related honoraria and production of materials. It is intended for healthcare professionals only.

PADCEV®
enfortumab vedotin
Injection for IV infusion 20 mg & 30 mg vials

astellas

Disclaimers

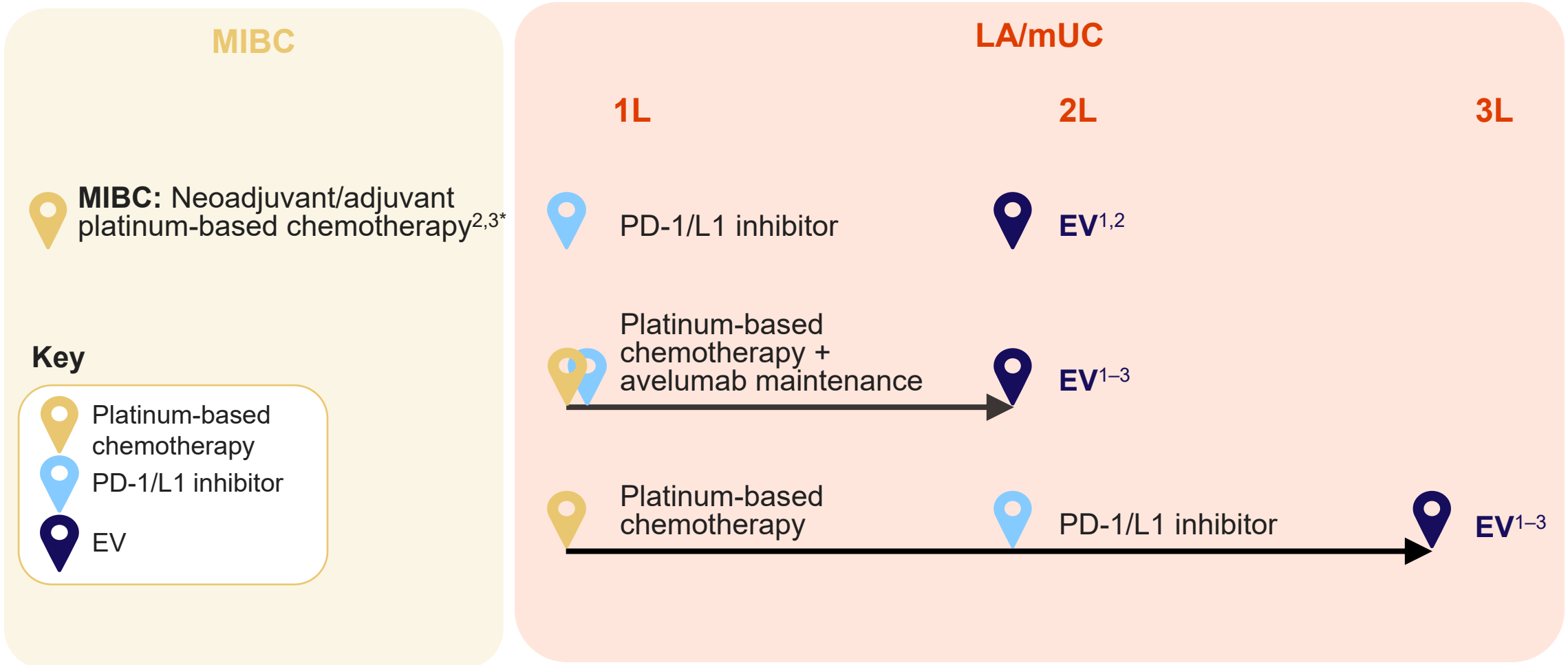
The information, views and opinions presented herein are those of the presenter, and the presenter is solely responsible for the materials being introduced in this presentation. Although patients' cases mentioned herein are actual cases, treatment may differ from local approval product information.

Such information, views and opinions of the presenter do not necessarily reflect the information, views and opinions of Astellas Pharma Ltd. Astellas Pharma Ltd. does not recommend the use of any product in any different manner than as described in the local approval information, and complies with all applicable laws, regulations, and company policies.

Speaker disclosures

- Head of the Medical Oncology Department in State Oncology Center
- Main focus is breast and genitourinary cancer
- Treat in department approximately 700 patients per month

Prior to the approval of EV+P in 1L, EV as a monotherapy expanded options for adult patients with LA/mUC who have previously received a platinum-containing chemotherapy and a PD-1/L1 inhibitor[1,2]



Disclaimer: Please note that the use of EV after a PD-1/L1 inhibitor is only approved in certain countries. All HCPs should refer to their own country's specific Prescribing Information.

*In EV-301 for patients who had received platinum chemotherapy as neoadjuvant or adjuvant therapy, progression must have occurred within 12 months after completion of treatment.[3]

EV, enfortumab vedotin; HCP, healthcare professional; LA/mUC, locally advanced/metastatic urothelial carcinoma; LA-UC, locally advanced urothelial carcinoma; MIBC, muscle-invasive bladder cancer; PD-1/L1, programmed cell death protein 1/ligand 1; UC, urothelial carcinoma.

1. Powles T et al. *Ann Oncol* 2022;33:244–258; 2. PADCEV™ (enfortumab vedotin). Summary of Product Characteristics; 3. Powles T et al. *N Engl J Med* 2021;384:1125–1135.

In 2L, EV monotherapy is a preferred regimen by the National Comprehensive Cancer Network® (NCCN® Guidelines) clinical guidelines for the treatment of unresectable/mUC following disease progression

2L Systemic therapy for LA/MUC (Stage IV)

Previous immunotherapy and EV (no previous chemotherapy)

Preferred regimens	Other recommended regimens	Useful in certain circumstances
• ddMVAC with growth factor support • Gemcitabine and cisplatin • Gemcitabine and carboplatin • Biomarker-directed therapy	• Paclitaxel or docetaxel • Gemcitabine	• Gemcitabine, cisplatin, and nivolumab

Previous chemotherapy (no previous immunotherapy or EV)

Preferred regimens	Other recommended regimens	Useful in certain circumstances
• Pembrolizumab (post-platinum) • EV + pembrolizumab • EV • Nivolumab • Avelumab • Biomarker-directed therapy	• Paclitaxel or docetaxel • Gemcitabine	• ddMVAC with growth factor support • Ifosfamide, doxorubicin, and gemcitabine • Gemcitabine and paclitaxel • Gemcitabine and cisplatin

Previous immunotherapy (no previous chemotherapy or EV)

Preferred regimens	Other recommended regimens	Useful in certain circumstances
• EV • EV + pembrolizumab • Gemcitabine and carboplatin • Gemcitabine and cisplatin • ddMVAC with growth factor support • Biomarker-directed therapy	• Paclitaxel or docetaxel • Gemcitabine	• Gemcitabine, cisplatin, and nivolumab • Ifosfamide, doxorubicin, and gemcitabine • Gemcitabine and paclitaxel

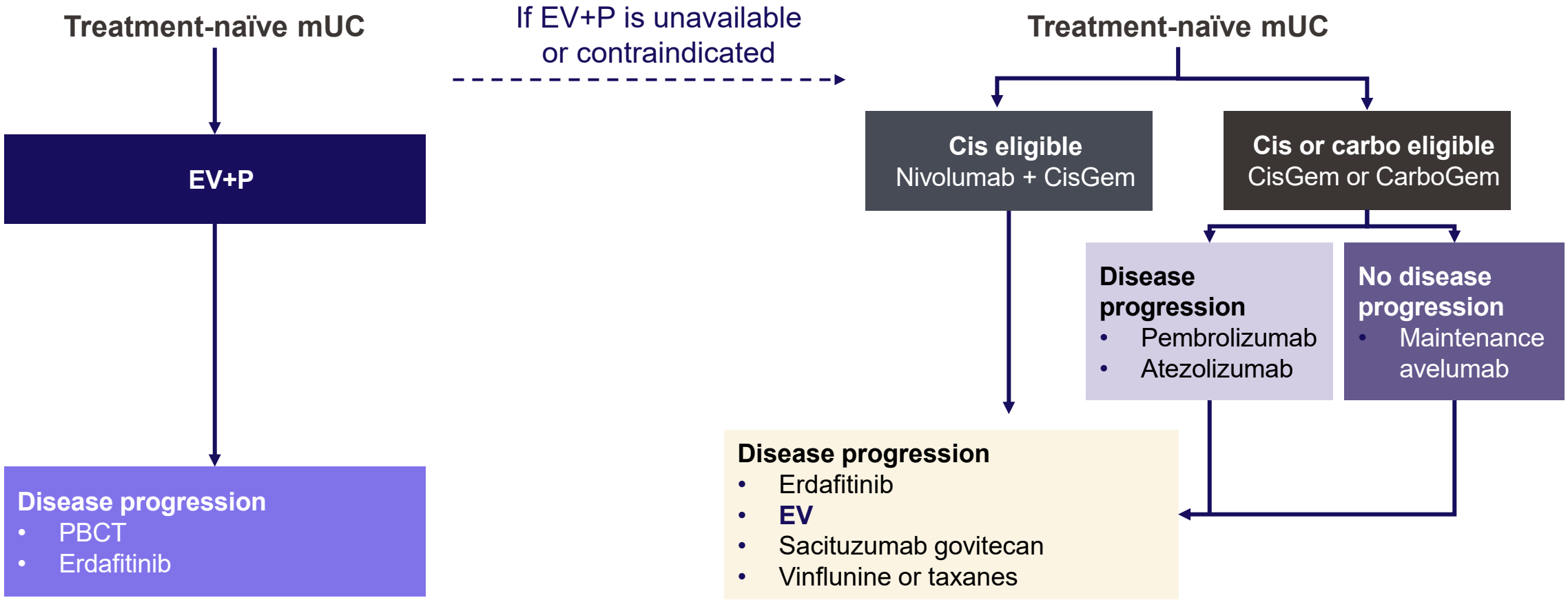
Previous chemotherapy and immunotherapy (no previous EV)

Preferred regimens	Other recommended regimens	Useful in certain circumstances
• EV • Biomarker-directed therapy	• EV + pembrolizumab • Paclitaxel or docetaxel • Gemcitabine • Gemcitabine and cisplatin • ddMVAC with growth factor support • Ifosfamide, doxorubicin, and gemcitabine • Gemcitabine and paclitaxel	• Sacituzumab govitecan

Disclaimer: EV + pembrolizumab is not approved for the 1L treatment of unresectable or mUC in adults in some countries/regions. All HCPs should refer to their own country's specific Prescribing Information.

1L/2L, first/second line; ddMVAC, dose-dense methotrexate, vinblastine, doxorubicin + cisplatin; EV, enfortumab vedotin; EV+P, enfortumab vedotin + pembrolizumab; HCP, healthcare professional; mUC, metastatic urothelial carcinoma;

In 2L, EV monotherapy is recommended by the ESMO clinical guidelines treatment of unresectable/mUC following disease progression



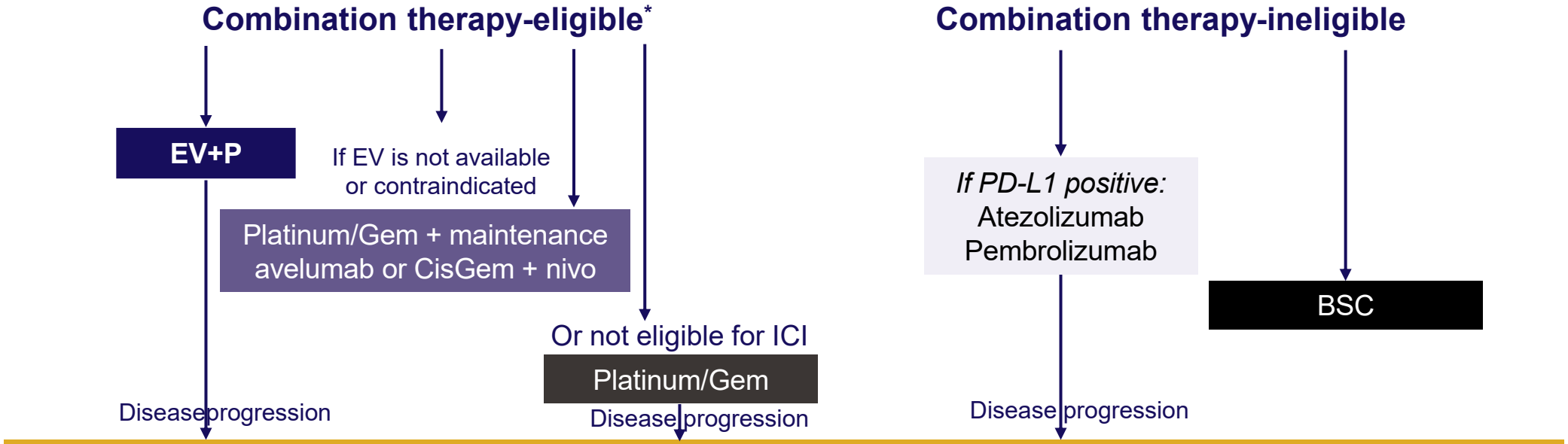
Disclaimer: EV+P is not approved for the 1L treatment of unresectable or mUC in adults in some countries/regions. All HCPs should refer to their own country's specific Prescribing Information.

Figure adapted from Powles T et al. 2024.

1L, first line; Carbo; carboplatin; Cis, cisplatin; ESMO, European Society for Medical Oncology; EV, enfortumab vedotin; Gem, gemcitabine; HCP, healthcare professional; m, metastatic; P, pembrolizumab; PBCT, platinum-based chemotherapy; UC, urothelial carcinoma.

Powles T et al. *Ann Oncol* 2024;35:485–490.

In 2L, EV monotherapy is recommended by the EAU clinical guidelines for the treatment of unresectable/mUC



Later-line therapy options

Pretreated with EV and ICI
- PBCT
- Erdafitinib if FGFR positive
- Sacituzumab govitecan
- Single agent chemotherapy
- Trials

Pretreated with platinum +/- ICI
- EV
- Erdafitinib if FGFR positive
- ICI
- Platinum/Gem
- Sacituzumab govitecan
- Single agent chemotherapy
- Trials

Pretreated with single agent
- EV†
- Erdafitinib if FGFR positive
- ICI
- Sacituzumab govitecan
- Chemotherapy
- Trials

Disclaimer: EV+P is not approved for the 1L treatment of unresectable or metastatic UC in adults in some countries/regions. All HCPs should refer to their own country's specific Prescribing Information.

Figure adapted from 2024 EAU Muscle-invasive and metastatic bladder cancer Guidelines.

*PS 0-2, GFR > 30 ml/min, adequate rogan functions, for cisplatin: GFR > 50 ml/min; †The indication for enfortumab vedotin monotherapy as per the SmPC requires patients to have previously received a platinum-containing chemotherapy and a PD-1/-L1 inhibitor.

1L, first line; BSC, best supportive care; Carbo; carboplatin; Cis, cisplatin; EAU, European Association of Urology; EV, enfortumab vedotin; HCP, healthcare professional; ICI, immune checkpoint inhibitor; Gem, gemcitabine; m, metastatic; P, pembrolizumab; PBCT, platinum-based chemotherapy; PD-L1, programmed death-ligand 1; UC, urothelial carcinoma.

EAU. Muscle-invasive and metastatic bladder cancer. Available at: https://www.uroweb.org/guidelines/muscle-invasive-and-metastatic-bladder-cancer. Last accessed: June 2025.

Patient case study: Julia

Julia

- White, female
- **Age: 76** years
- **ECOG PS: 1**
- **Leukocytes:** 5,500/µl
- **Hb:** 10.6 g/dl
- **Platelets:** 123,000/µl
- **Creatinine:** 1.1 mg/dl

Disease history

- **mUC** at time of diagnosis
- **1L cisplatin + gemcitabine**
- Disease spread to lymph nodes and lungs
- **2L pembrolizumab**
- Further pulmonary, peritoneal, and pelvic progression

Comorbidities:
- Hypercholesterolemia
- DM2

Concomitant medications:
- Enalapril 10mg
- Omeprazole 20mg
- Metformin 850mg
- Paracetamol (as needed)

Other personal history:
- Ex-smoker (between 13 and 76 years old)
- Hysterectomy for uterine myoma at 43 years old
- Oophorectomy after perforation of uterine tube by IUD at 40 years old

Fictitious patient case study created for illustrative purposes.

1L/2L, first/second line; DM2, diabetes mellitus type 2; ECOG PS, Eastern Cooperative Oncology Group performance status; Hb, haemoglobin; IUD, intrauterine device; mUC, metastatic urothelial carcinoma.

Question for the audience

Based on the patient case and international guidelines, what treatment approach would you use with this patient?

- A EV monotherapy
- B Erdafitinib if FGFR-positive
- C ICI
- D Platinum/Gem
- E Single-agent chemotherapy
- F Enrollment in clinical trials

EV, enfortumab vedotin; FGFR, fibroblast growth factor receptor; Gem, gemcitabine; ICI, immune checkpoint inhibitor.

Patient case study: Julia

Julia

- White, female
- **Age: 76** years
- **ECOG PS: 1**
- **Leukocytes:** 5,500/µl
- **Hb:** 10.6 g/dl
- **Platelets:** 123,000/µl
- **Creatinine:** 1.1 mg/dl

Disease history

- **mUC** at time of diagnosis
- **1L cisplatin + gemcitabine**
- Disease spread to lymph nodes and lungs
- **2L pembrolizumab**
- Further pulmonary, peritoneal, and pelvic progression
- **3L EV**

Deterioration of renal function and haematological toxicity

EV received via IV infusion at a dose of 1.25 mg/kg on Days 1, 8, and 15 of a 28-day cycle

Fictitious patient case study created for illustrative purposes.

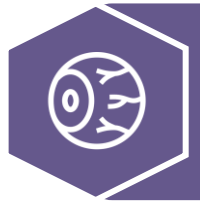
1L/2L/3L, first/second/third line; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; Hb, haemoglobin; mUC, metastatic urothelial carcinoma.

HCPs, patients and carers should be aware of AESIs before initiating treatment with EV

Skin toxicities[1,2]

Hyperglycaemia[1,2]

Peripheral neuropathies[1,2]



Ocular disorders[1,3]

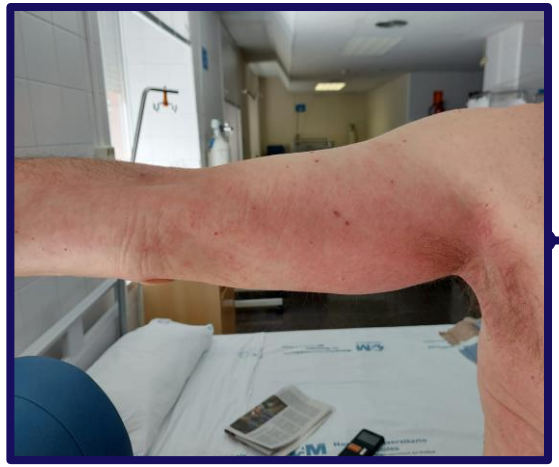
Pneumonitis/ILD[1]

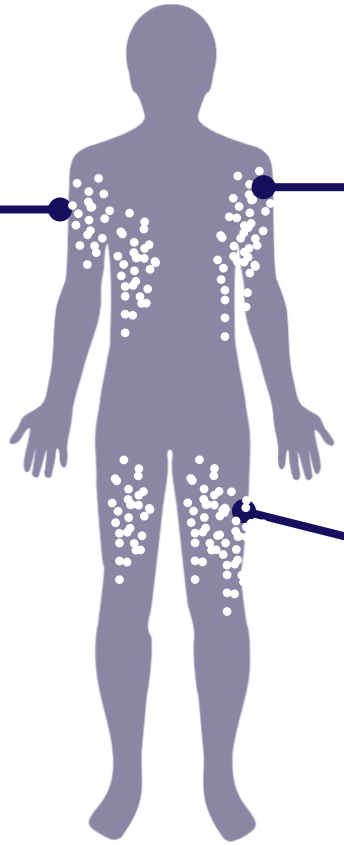
HCPs should be aware and educate patients on the AEs that may occur with EV

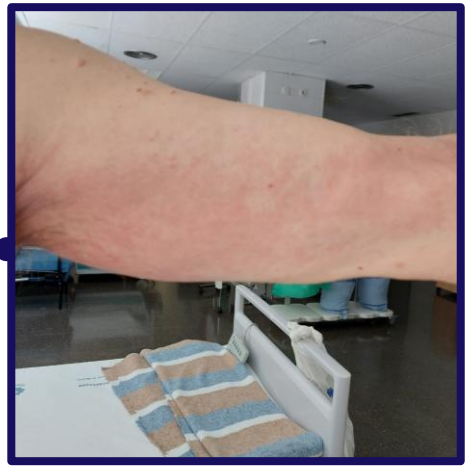
AESI, adverse event of special interest; EV, enfortumab vedotin; ILD, interstitial lung disease.

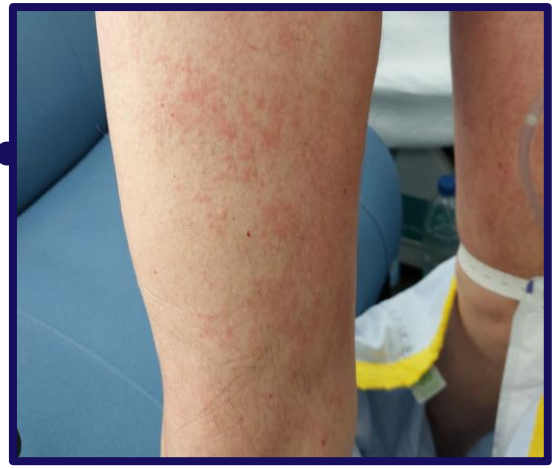
1. PADCEV™ (enfortumab vedotin). Summary of Product Characteristics; 2. Powles T et al. *N Engl J Med* 2021;384:1125–1135. 3. Powles T et al. *N Engl J Med* 2021;384:1125–1135 (suppl appendix).

Julia experienced Grade 2 worsening skin toxicity after 4 weeks of EV treatment









Erythematous pruritic papules predominately in intertriginous, flexural, and acral areas

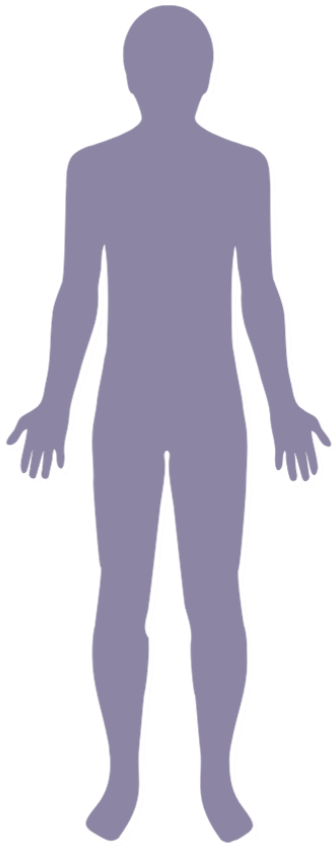
Fictitious patient case study created for illustrative purposes. These images are used with permission from Dr Javier Puente.
AE, adverse event; EV, enfortumab vedotin.

Follow good practice when monitoring for EV-related skin toxicities throughout the course of treatment

Examine and inspect the skin at each visit and educate patients on how to examine their skin[1–4]

Photograph skin lesions where possible[3]

Refer to standardized skin assessment tools (e.g., CTCAE grading system)[3,6]



Educate on **symptoms**, which can indicate **severe reactions*** e.g. rash or itching that continues to get worse, skin blistering or peeling, painful sores or ulcers†, fever or flu-like symptoms, swollen lymph nodes[1,5]

Monitor for **secondary skin infections**[2]

*Severe cutaneous adverse reactions, including SJS and TEN, with fatal outcome have also occurred in patients treated with enfortumab vedotin, predominantly during the first cycle of treatment;[1] †In mouth or nose, throat, or genital area.[1]
AE, adverse event; CTCAE, Common Terminology Criteria for Adverse Events; EV, enfortumab vedotin.

1. PADCEV™ (enfortumab vedotin). Summary of Product Characteristics 2023; 2. Pace A et al. *Clin J Oncol Nurs* 2021;25:E1–E9; 3. Barton-Burke M et al. *Nurs Clin North Am* 2017;52:83–113;
4. Tattersall IW & Leventhal JS. *Yale J Biol Med* 2020;93:123–132; 5. Lacouture ME et al. *Oncologist* 2022;27:e223–e232; 6. US Department of Health and Human Services. Common Terminology Criteria for Adverse Events (CTCAE) Version 5.0. Available at: https://ctep.cancer.gov/protocolDevelopment/electronic_applications/docs/CTCAE_v5_Quick_Reference_5x7.pdf. Last accessed: June 2025.

Question for the audience

How would you manage this patient's skin toxicity?

- **A** Refer to a dermatologist
- **B** Prescribe topical agents
- **C** Withhold EV until Grade ≤1
- **D** Permanently discontinue EV

EV, enfortumab vedotin.

Question for the audience

How would you manage this patient's skin toxicity?

- A **Refer to a dermatologist**
- B **Prescribe topical agents**
- C **Withhold EV until Grade ≤1[1]**
- D **Permanently discontinue EV**

EV, enfortumab vedotin.

1. PADCEV™ (enfortumab vedotin). Summary of Product Characteristics.

How should skin toxicities associated with EV treatment be managed?

Prior to skin toxicities

Prophylactic measures, e.g., daily showers, drying well, avoiding skin irritants[1,2]

Educate patients to increase awareness of skin toxicities[1,2]

After development of skin toxicities

Grade 1 Symptomatic treatment, e.g., topical steroids. Patients should be monitored for infection[1,2]

Grade ≥2 Referral to a dermatologist if a large area of skin is involved, or for non-classical lesions[1,2]

Hospitalise the patient for severe lesions[1–3]

EV, enfortumab vedotin.

1. Lacouture ME et al. *Oncologist* 2022;27:e223–e232; 2. Pace A et al. *Clin J Oncol Nurs* 2021;25:E1–E9; 3. US Department of Health and Human Services. Common Terminology Criteria for Adverse Events (CTCAE) Version 5.0. Available at: https://ctep.cancer.gov/protocolDevelopment/electronic_applications/docs/CTCAE_v5_Quick_Reference_5x7.pdf. Last accessed: June 2025.

Julia’s AE management

Topical diphenhydramine was effective in **relieving the pruritus** during Cycle 2

Over Cycles 2 and 3, the **rash continued to progress** despite the use of **topical** clobetasol, emollient and barrier treatment, and **topical and systemic antihistamines**

EV was withheld for 3 weeks

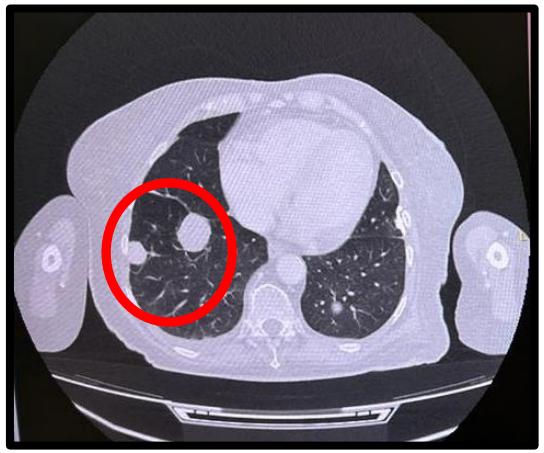
At the next follow-up, the **skin reaction had improved to Grade 1**, and EV was resumed at a **lower dose level (1 mg/kg)**

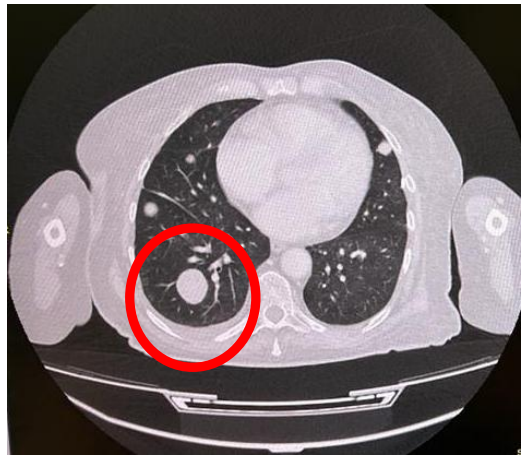
Fictitious patient case study created for illustrative purposes.

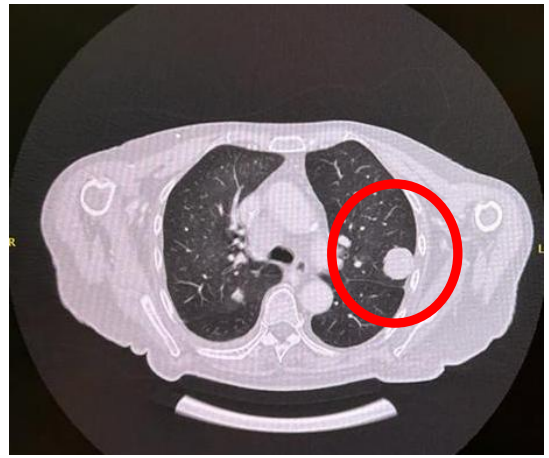
AE, adverse event; EV, enfortumab vedotin.

Julia experienced clinical benefit from EV, with tumour shrinkage over 12 weeks

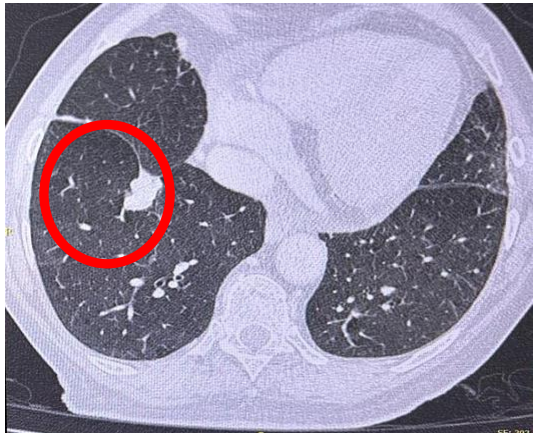
Baseline

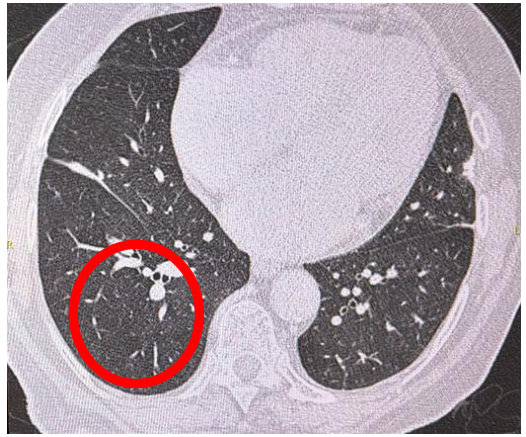


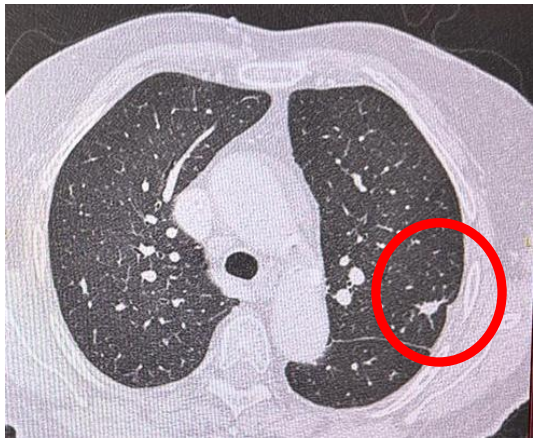




12 weeks after initiation of EV







Fictitious patient case study created for illustrative purposes. These images are used with permission from Dr Javier Puente

EV, enfortumab vedotin.

Julia’s LA/mUC journey since beginning treatment with EV

Symptomatic improvement, with disappearance of dyspnoea and improvement in ability to carry out physical activity

A **partial response** was observed after 12 weeks

After 4 months, Julia **remains on EV** treatment

Fictitious patient case study created for illustrative purposes.

EV, enfortumab vedotin; LA/mUC, locally advanced/metastatic urothelial carcinoma.

Summary

- EV is recommended as a 2L treatment option by current guidelines[1–3]
- Real-world data correlate with data from RCTs[4–6]
- Most AEs can be managed effectively and do not require discontinuation of treatment[7]
- Based on clinical guidelines, there are several options available for patients with LA/mUC in 2L[1–3]

2L, second line; AE, adverse event; LA, locally advanced; mUC, metastatic urothelial carcinoma; RCT, randomized controlled trial.

1. Referenced with permission from the NCCN Clinical Practice Guidelines In Oncology (NCCN Guidelines®) for Bladder Cancer. V.1.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed 28 May 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way; 2. Powles T et al. *Ann Oncol* 2024;35:485–490; 3. EAU. Muscle-invasive and metastatic bladder cancer. Available at: https://www.uroweb.org/guidelines/muscle-invasive-and-metastatic-bladder-cancer. Last accessed: June 2025; 4. Rosenberg JE et al. *Ann Oncol* 2023;13:1047–1054; 5. Koshkin VS et al. *Cancer* 2022;128:1194–1205; 6. Zschäbitz S et al. *Eur Urol Open Sci* 2023;53:31–37; 7. PADCEV™ (enfortumab vedotin). Summary of Product Characteristics; 8. Speaker's own opinion.

Genitourinary Masterclass

astellas

Please refer to the Korean PI for PADCEV® (enfortumab vedotin) via the following QR Code:

<PADCEV 20mg>

<PADCEV 30mg>

Astellas Pharma Korea., Inc.
(7F Parnas tower, 521, Teheran-ro, Gangnam-gu, Seoul, Republic of Korea)

PI, Prescribing Information