



FROM RESEARCH TO REAL-WORLD

*ADCs, IO Combinations,
and Sequencing
in Metastatic NSCLC*

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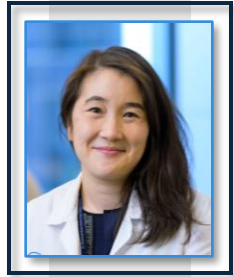
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All identified conflicts of interest have been mitigated.

LEARNING OBJECTIVES

1

Differentiate the class-wide and agent-specific characteristics of ADCs, including mechanisms, biomarkers, efficacy, toxicity, and considerations for sequencing and IO integration, in biomarker-selected mNSCLC.

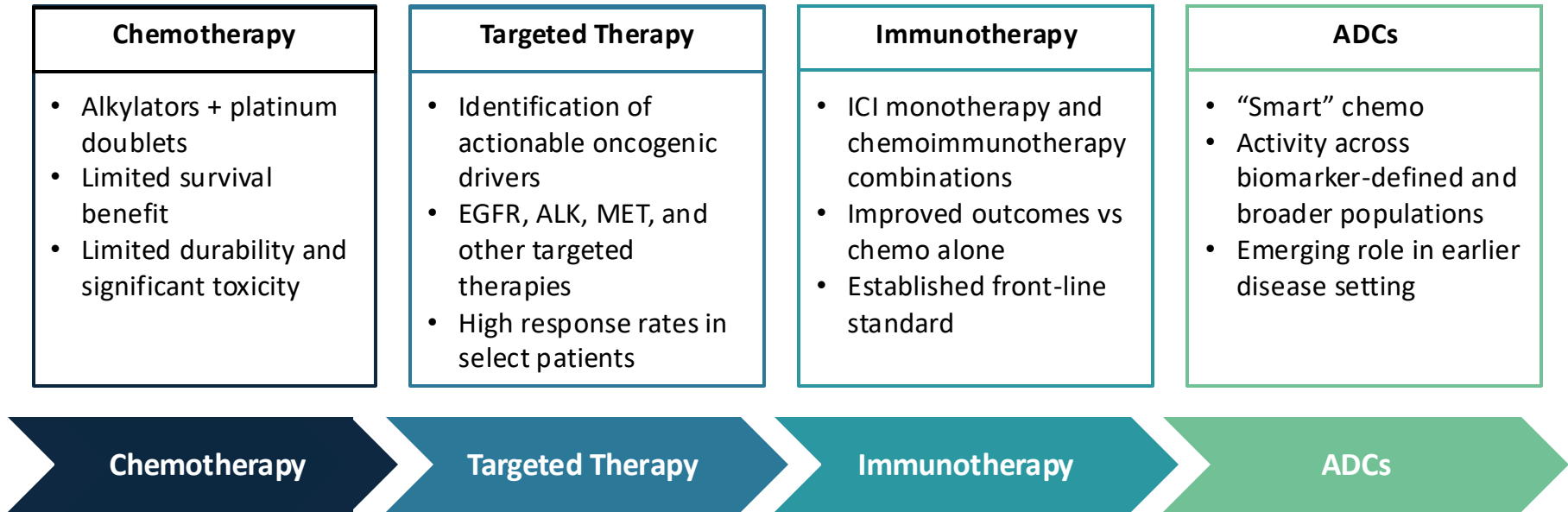
2

Interpret emerging clinical evidence and biomarker data for TROP2-directed ADCs to determine their potential role across diverse mNSCLC patient populations.

3

Evaluate the toxicity profiles and monitoring considerations of ADCs and immune checkpoint inhibitors in metastatic NSCLC to support accurate recognition and timely management of treatment-related and overlapping adverse events.

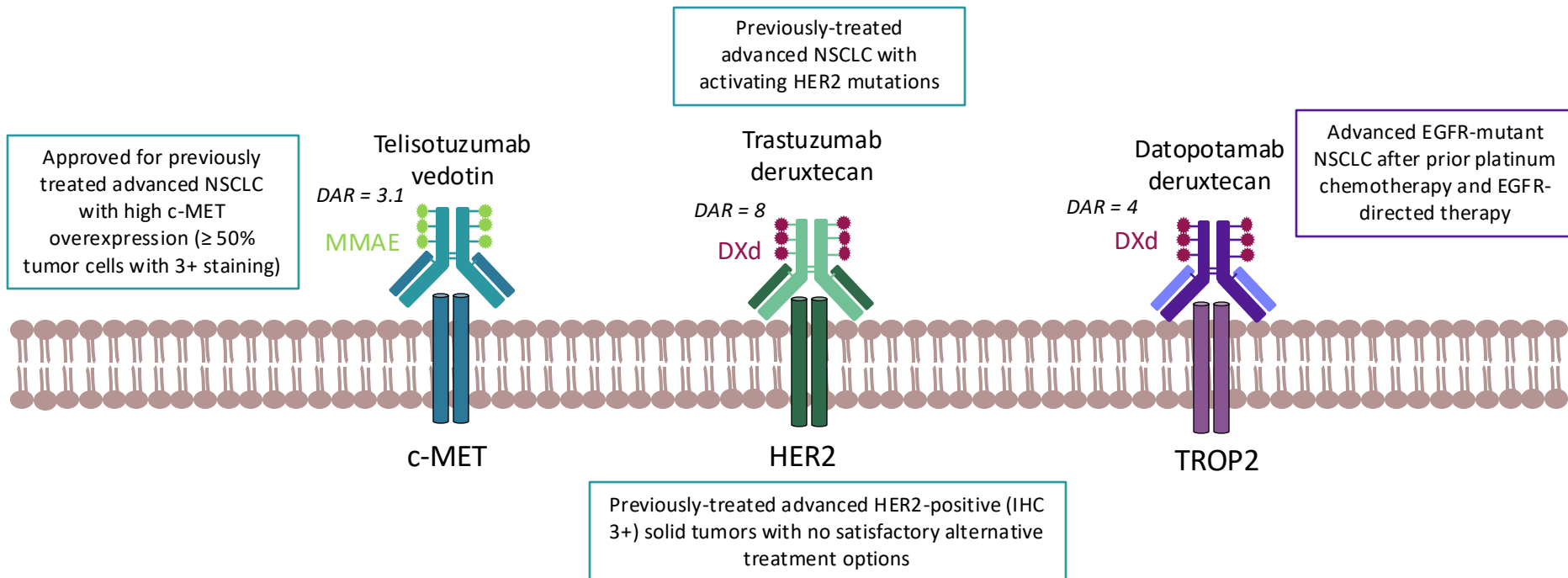
Evolution of Systemic Therapy in mNSCLC



ADC = antibody-drug conjugate; mNSCLC = metastatic non-small cell lung cancer; EGFR = epidermal growth factor receptor; ALK = anaplastic lymphoma kinase; MET = mesenchymal-epithelial transition factor proto-oncogene; ICI = immune checkpoint inhibitor.

Naidoo J, et al. *J Thorac Oncol.* 2025;20(10):1392-1422. Gallina M, et al. *Pharmaceutics.* 2025;17(5):608.

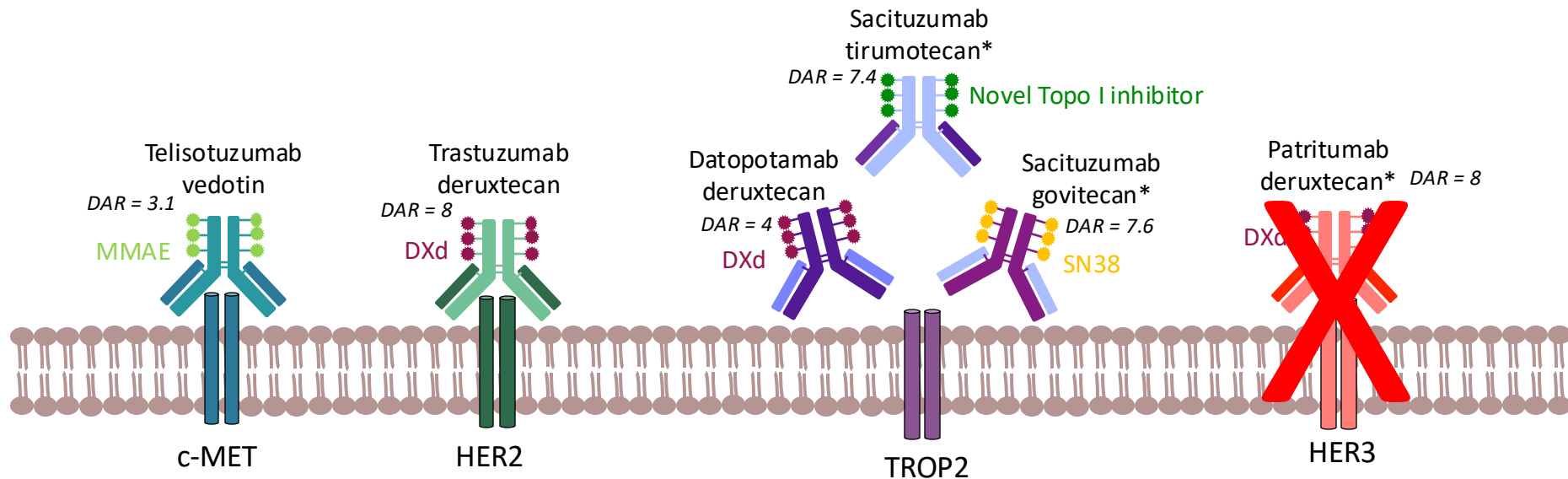
FDA-Approved ADCs in NSCLC



MMAE = monomethyl auristatin E; DXd = deruxtecan; c-MET = cellular mesenchymal-epithelial transition factor proto-oncogene; HER2 = human epidermal growth factor receptor 2; TROP2 = tumor-associated calcium signal transducer; DAR = drug antibody ratio; mEGFR = EGFR-mutated; IHC = immunohistochemistry.

Passaro A, et al. *J Clin Oncol.* 2023;41(21):3747-3761. Fang W, et al. *BMJ.* 2025;389:e085680. Steuer CE, et al. *J Clin Oncol.* 2025;43(25):2816-2826.

ADCs in NSCLC



*This agent is not FDA-approved for the management of mNSCLC.

HER3 = human epidermal growth factor receptor 3; SN38 = 7-ethyl-10-hydroxycamptothecin; Topo I = topoisomerase I.

Passaro A, et al. *J Clin Oncol.* 2023;41(21):3747-3761. Fang W, et al. *BMJ.* 2025;389:e085680. Steuer CE, et al. *J Clin Oncol.* 2025;43(25):2816-2826.

Efficacy of FDA-Approved ADCs in mNSCLC

Trial	Phase	Setting	Intervention	Primary Endpoints	Efficacy Results	FDA Approval
DESTINY Lung-02 NCT04644237	II	Previously treated HER2-mutated mNSCLC	T-DXd 5.4 or 6.4 mg/kg	cORR	cORR: 50.0% and 56.0%	Previously treated advanced NSCLC with HER2-activating mutations
TROPION Lung-01 NCT04656652	III	Previously treated advanced NSCLC	Dato-DXd 6 mg/kg vs docetaxel 75 mg/m ²	PFS, OS	PFS: 4.4 months vs 3.7 months [HR 0.75, <i>p</i> = 0.004] OS: 12.9 months vs 11.8 months [HR 0.94, <i>p</i> = 0.530] *Improved outcomes driven by nonsquamous histology*	Advanced mEGFR NSCLC after prior EGFR-directed therapy and platinum-based chemotherapy
TROPION Lung-05 NCT04484142	II	Advanced NSCLC with AGAs after progression on targeted therapy and platinum chemo	Dato-DXd 6 mg/kg	ORR	cORR overall: 35.8% cORR mEGFR: 43.6% cORR rALK: 23.5%	
LUMINOSITY NCT03539536	II	Previously treated c-MET overexpressing advanced nonsquamous EGFR-WT NSCLC	Telisotuzumab vedotin 1.9 mg/kg	ORR	ORR: 28.6% ORR c-MET high: 34.6% ORR c-MET intermediate: 22.9%	Advanced nonsquamous NSCLC with high c-MET protein overexpression (≥ 50% tumor cells with strong 3+ staining)

AGA = actional genomic alteration; ORR = objective response rate; cORR = confirmed objective response rate; T-DXd = trastuzumab deruxtecan; Dato-DXd = datopotamab deruxtecan; HR = hazard ratio; PFS = progression-free survival; OS = overall survival; DoR = duration of response; rALK = ALK rearranged, WT = wildtype.
 Jänne PA, et al. *J Thorac Oncol.* 2025;20(12):1814-1828. Ahn MJ, et al. *J Clin Oncol.* 2025;43(3):260-272. Sands J, et al. *J Clin Oncol.* 2025;43(10):1254-1265. Camidge DR, et al. *J Clin Oncol.* 2024;42(25):3000-3011. Trastuzumab deruxtecan [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761139s028lbl.pdf. Datopotamab deruxtecan [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761394s000lbl.pdf. Telisotuzumab vedotin [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761384s000lbl.pdf.

Investigational ADCs in mNSCLC

Trial	Phase	Setting	Intervention	Primary endpoints	Efficacy Results
EVOKE-01 NCT05089734	III	mNSCLC and progression on/after platinum chemotherapy, anti-PD-L1, and targeted therapy for AGAs	*Sacituzumab govitecan 10 mg/kg vs docetaxel 75 mg/m ²	OS	OS: 11.2 months vs 9.8 months [HR = 0.84, <i>p</i> = 0.534)
EVOKE-02	II	First-line mNSCLC with no AGAs	*Sacituzumab govitecan 10 mg/kg + pembrolizumab 200 mg	ORR	ORR PD-L1 ≥ 50%: 66.7% – Nonsquamous = 67% – Squamous = 67% ORR PD-L1 < 50%: 29.0%
OptiTROP-Lung03 NCT05631262	II	Advanced mEGFR NSCLC with progression after EGFR TKI and platinum chemotherapy	*Sacituzumab tirumotecan 5 mg/kg vs docetaxel 75 mg/m ²	ORR	45.1% vs 15.6% ³ <i>p</i> = 0.0004
OptiTROP-Lung04	III	Advanced mEGFR NSCLC and progression after EGFR-TKI	*Sacituzumab tirumotecan vs pemetrexed + platinum chemotherapy	PFS	PFS: 8.3 months vs 4.3 months [HR = 0.49] ¹
TROPION-Lung02	I	First-line advanced NSCLC	**Datopotamab deruxitecan 4.0 mg/kg + pembrolizumab 200 mg +/- platinum chemotherapy ²	DLTs/TEAEs	≥ Grade 3 TEAEs: 40.5% doublet therapy vs 55.6% triplet therapy cORR doublet: 55% cORR triplet: 56%

¹*p* value not reported. ²Carboplatin (AUC 5) or Cisplatin 75 mg/m². ³By blinded independent review committee.

*This agent is not FDA-approved for the management of NSCLC. **This combination is not FDA-approved for the management of NSCLC.

TKI = tyrosine kinase inhibitor; DLT = dose-limiting toxicity; TEAE = treatment-emergent adverse event; PD-L1 = programmed death ligand 1. Paz-Ares LG, et al. *J Clin Oncol.* 2024;42(24):2860-2872. Reck M, et al. *J Thorac Oncol.* 2025:S1556-0864(25)02890-4. Zhang L, et al. *J Clin Oncol.* 2025;43(Suppl 16):8507. Fang W, et al. *N Engl J Med.* 2026;394(1):13-26. Levy BP, et al. *J Clin Oncol.* 2025;43(Suppl 16):8501.

Ongoing Trials in mNSCLC

Trial	Phase	Population	Intervention
*TeliMET NSCLC-01	III	Previously treated patients with c-MET overexpressing EGFR-WT advanced nonsquamous NSCLC	Telisotuzumab vedotin vs docetaxel
*DESTINY-Lung04	III	First-line advanced NSCLC with HER2 exon 19 or 20 mutations	Trastuzumab deruxtecan vs platinum/pemetrexed/pembrolizumab
*DESTINY-Lung06	III	First-line HER2-overexpressing advanced NSCLC with PD-L1 TPS < 50%	Trastuzumab deruxtecan + pembrolizumab vs platinum/pemetrexed/pembrolizumab
*TROPION-Lung10	III	Nonsquamous advanced NSCLC with high PD-L1 and no AGAs	Datopotamab deruxtecan + rilvegostomig vs rilvegostomig or pembrolizumab
*TROPION-Lung14	III	First-line advanced mEGFR NSCLC	Datopotamab deruxtecan + osimertinib vs osimertinib
*TROPION-Lung15	III	Advanced mEGFR NSCLC after progression on osimertinib	Datopotamab deruxtecan + osimertinib vs datopotamab deruxtecan
*EVOKE-03	III	First-line mNSCLC with PD-L1 TPS ≥ 50%	Sacituzumab govitecan + pembrolizumab vs pembrolizumab
*OptiTROP Lung05	III	First-line PD-L1-positive advanced mNSCLC	Sacituzumab tirumotecan + pembrolizumab vs pembrolizumab

*These strategies are not FDA-approved for the management of NSCLC.

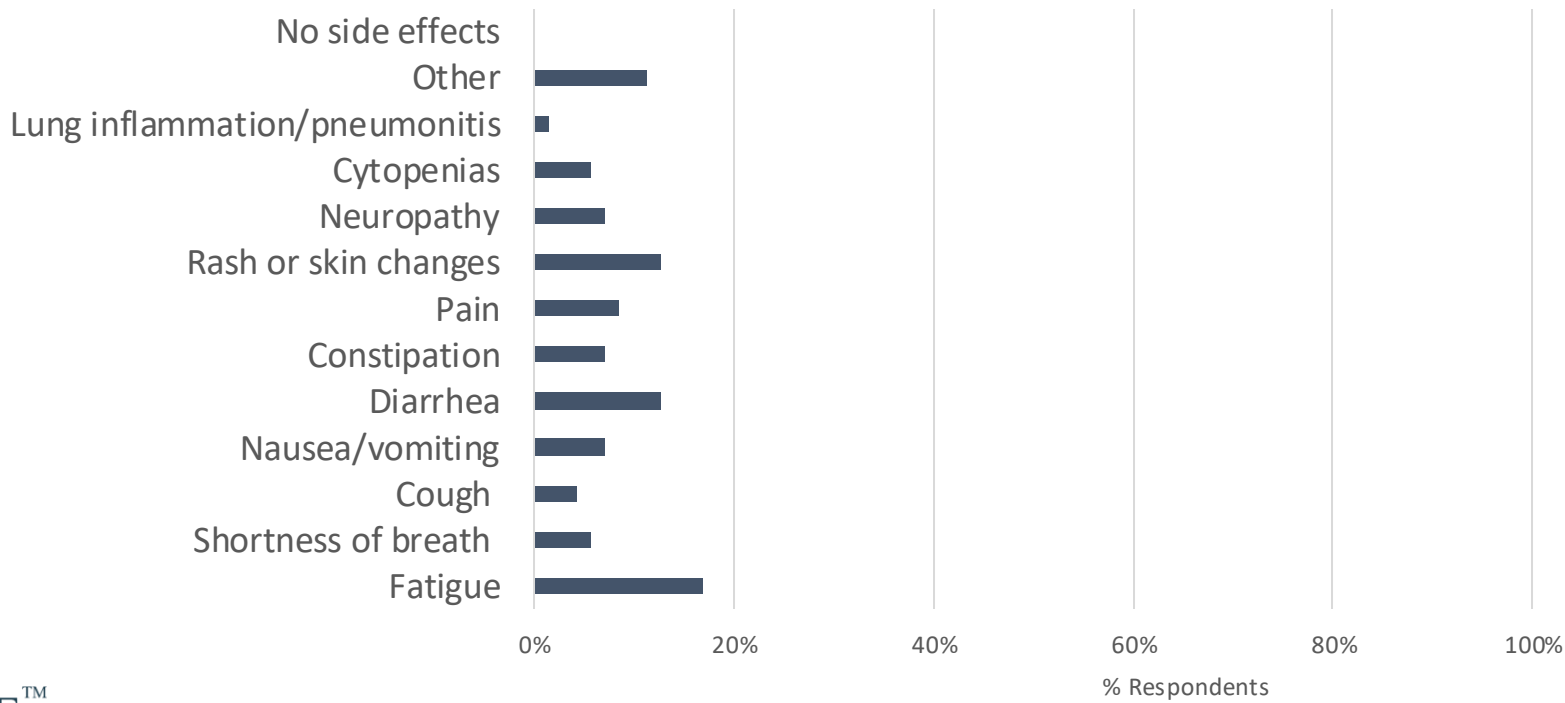
TPS = tumor proportion score.

Newsom-Davis T, et al. *J Thorac Oncol.* 2025;20(3):S85-S86. Goldberg SB, et al. *J Thorac Oncol.* 2025;20(3):S86-S87. Nadal E, et al. *J Thorac Oncol.* 2025;20(3):S87-S88. Moskovitz M, et al. *Cancer Res.* 2023;83(Suppl 8):CT067. ClinicalTrials.gov. Identifier: NCT06448312. Lu S, et al. *J Clin Oncol.* 2024;42(Suppl 16):TPS8656. Jänne PA, et al. *J Thorac Oncol.* 2025;20(10):S569-S570. ClinicalTrials.gov. Identifier: NCT05048797.

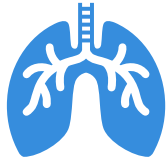


Patient/Caregiver Survey

What side effects or symptoms have been most difficult for you or your loved one? Select all that apply.



ADC-Related Adverse Events



Interstitial Lung Disease (ILD)/Pneumonitis

Most common with: T-DXd, Dato-DXd, Teliso-V

Red flag symptoms:

- New or worsening cough, dyspnea, hypoxia, fever
- New or progressive pulmonary findings on imaging

Suspected ILD (any grade):

- Hold ADC, order high-res chest CT, rule out infection

Symptomatic or progressive ILD:

- Permanently discontinue ADC

Mild/asymptomatic and resolved:

- Consider cautious rechallenge per agent PI

ADC-Related ILD vs IO-Related Pneumonitis Overlapping Features

- Similar symptoms
- Diagnostic evaluations often overlap
- Corticosteroids are critical to management

ADC-Related ILD

Symptomatic disease generally requires permanent discontinuation of the ADC
Rechallenge is limited and agent-specific

IO-Related Pneumonitis

May require escalation of immunosuppression
Rechallenge may be considered after complete resolution in select cases

Prior IO exposure, timing of symptom onset, and imaging patterns may help guide attribution.

CT = computed tomography; PI = prescribing information.

Datopotamab deruxtecan [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761394s000lbl.pdf.

Telisotuzumab vedotin [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761384s000lbl.pdf.

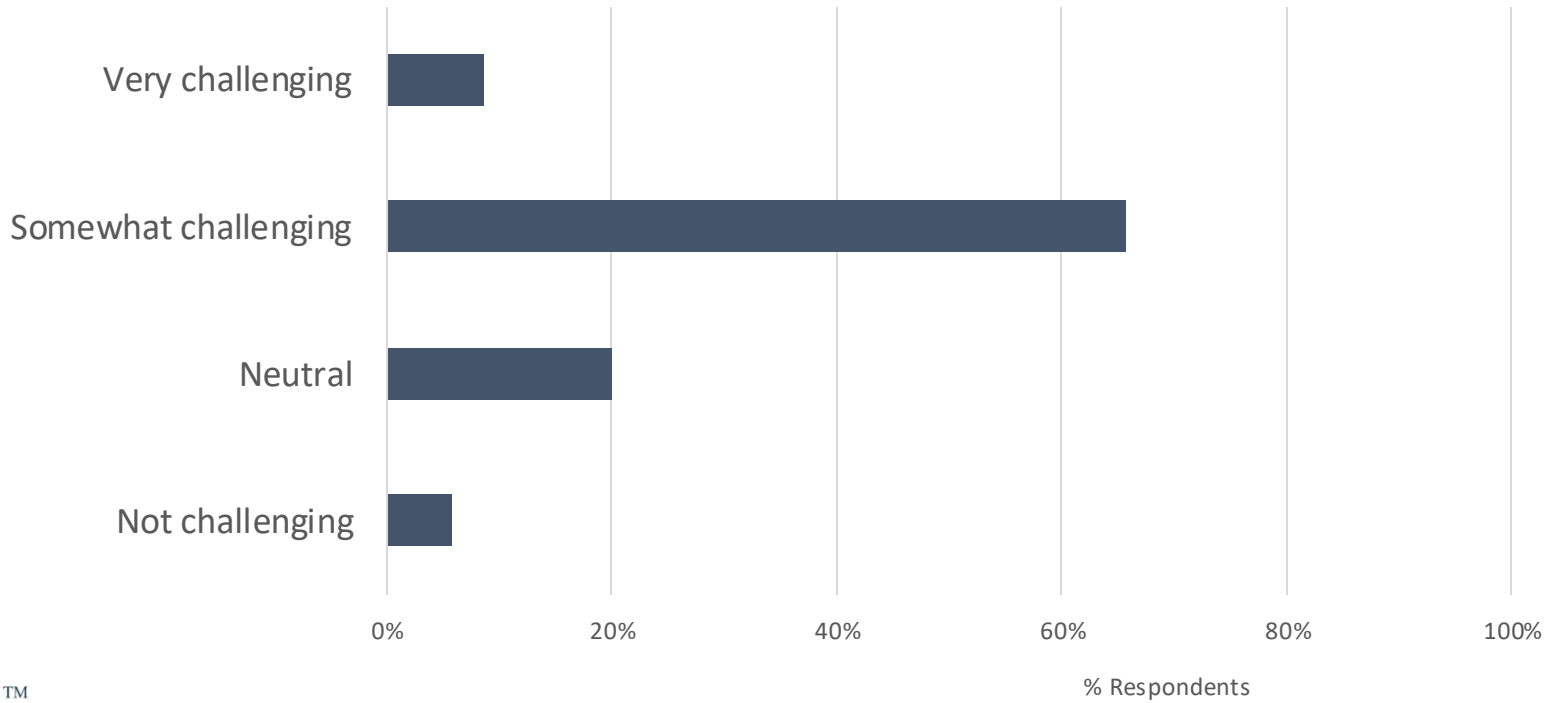
Trastuzumab deruxtecan [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761139s032s035lbl.pdf.

National Comprehensive Cancer Network [NCCN]. *Management of Immunotherapy-Related Toxicities. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Version 1.2026.* 2026. https://www.nccn.org/professionals/physician_gls/pdf/ici_tox.pdf.



Health Care Professionals Survey

How challenging do you find it to distinguish ADC-related ILD/pneumonitis from respiratory symptoms or imaging changes caused by disease progression in mNSCLC?



ADC-Related Adverse Events



Oral Mucositis/Stomatitis

Most common with: Dato-DXd

Red flag symptoms:

- Oral pain, ulcerations, difficulty eating, drinking, or speaking

Mild:

- Steroid mouthwash, gentle oral hygiene, hydration

Moderate:

- Hold ADC until resolved to \leq Grade 1; consult PI for dose modifications

Severe (Grade 4):

- Permanently discontinue ADC



Ocular Toxicity

Most common with: Dato-DXd, Teliso-V

Red flag symptoms:

- Dry eye, irritation, eye pain, blurred vision, photophobia, visual changes

Suspected toxicity (mild):

- Continue ADC with lubricating eye drops, avoid contact lenses, consider referral to ophthalmology

Vision or function-affecting:

- Hold ADC, refer to ophthalmology

Severe, progressive, or recurrent:

- Permanently discontinue ADC

ADC-Related Adverse Events



Neutropenia

Most common with: Sacituzumab govitecan, T-DXd

Red flag symptoms:

- Decline in ANC
- Fever, chills, other signs of infection

Clinically significant/worsening neutropenia:

- Hold therapy, monitor and assess risk for febrile neutropenia

Febrile neutropenia or infection:

- Hold ADC, initiate urgent evaluation and treat per standard febrile neutropenia protocols

Recurrent or prolonged severe neutropenia:

- Consider alternative therapy



Peripheral Neuropathy

Most common with: Teliso-V

Red flag symptoms:

- New or worsening numbness, tingling, burning
- Sensory loss or motor symptoms

Mild symptoms:

- Continue therapy with close monitoring

Function-interfering or progression symptoms:

- Hold ADC, assess impact on daily activities/safety
- Consider dose modification per PI

Severe, progressive, or recurrent:

- Permanently discontinue ADC

ANC = absolute neutrophil count.

Sacituzumab govitecan [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/761115s009lbl.pdf.

Telisotuzumab vedotin [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761384s000lbl.pdf.

Trastuzumab deruxtecan [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761139s032s035lbl.pdf.



PATIENT VOICE

Sylvia

- 58-year-old woman with mNSCLC, bilateral pulmonary nodules, mediastinal lymphadenopathy, and no evidence of CNS metastases
- ECOG PS = 1
- Former smoker, 30 pack-years (quit 20 years ago)
- Comorbidities: peripheral neuropathy and intermittent exertional dyspnea





PATIENT VOICE

Sylvia

- PD-L1 CPS: 80%
- EGFR exon 20 insertion mutation





PATIENT VOICE

Sylvia

- Palliative radiation for mediastinal disease
- First-line: carboplatin/pemetrexed/pembrolizumab (partial response) with progression after ~5 months
- Second-line: amivantamab + lazertinib (partial response + symptomatic improvement) with progression after ~7 months





AUDIENCE POLLING

Which systemic therapy would you most likely recommend next?

- A. Cytotoxic chemotherapy (e.g., gemcitabine)
- B. Taxane chemotherapy (e.g., docetaxel +/- ramucirumab, nab-paclitaxel)
- C. ICI
- D. TROP2 ADC
- E. TKI
- F. I'm not sure





Community Oncologist (Rural)

Case 1 – Sylvia



Which systemic therapy would you most likely recommend next?

- A. Cytotoxic chemotherapy (e.g., gemcitabine)
- B. Taxane chemotherapy (e.g., docetaxel +/- ramucirumab, nab-paclitaxel)
- C. ICI
- D. TROP2 ADC
- E. TKI**
- F. I'm not sure

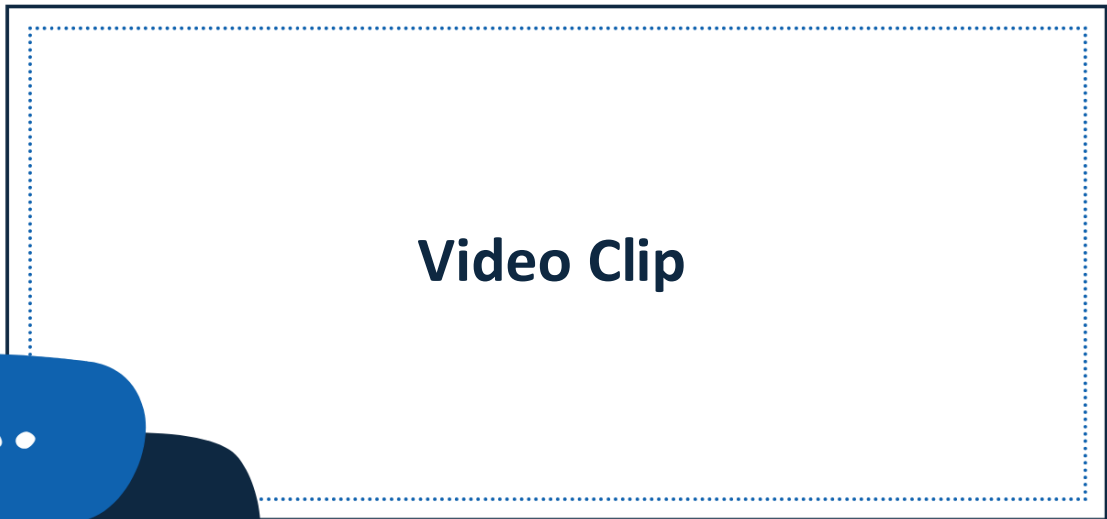


Clinical Investigator: Biagio Ricciuti

Case 1 – Sylvia



TROP2 ADC



Video Clip





AI: ChatGPT 5.2

Case 1 – Sylvia



Taxane chemotherapy: docetaxel +/- ramucirumab

Docetaxel \pm ramucirumab is a guideline-supported standard with proven survival benefit in the post-platinum setting. ECOG 1 supports further cytotoxic therapy.

- **Gemcitabine:** acceptable but less robust survival data vs docetaxel \pm ramucirumab.
- **ICI:** prior progression on pembrolizumab; limited efficacy in mEGFR disease despite high PD-L1.
- **TROP2 ADC:** promising, but not yet established standard over taxane-based therapy in this setting.
- **TKI:** no proven next-line targeted option after progression on amivantamab/lazertinib.



Faculty Discussion

Case 1 – Sylvia



Which systemic therapy would you most likely recommend next?

- A. Cytotoxic chemotherapy (e.g., gemcitabine)
- B. Taxane chemotherapy (e.g., docetaxel +/- ramucirumab, nab-paclitaxel)
- C. ICI
- D. TROP2 ADC**
- E. TKI
- F. I'm not sure



PATIENT VOICE

Peter

- 62-year-old man with newly diagnosed nonsquamous mNSCLC, bilateral pulmonary nodules, bulky mediastinal lymphadenopathy, and no evidence of CNS metastases
- ECOG PS = 1
- Former smoker, 25-pack-years (quit 10 years ago)
- Comorbidities: well-controlled hypertension





PATIENT VOICE

Peter

- PD-L1 CPS: 60%
- No AGAs identified on initial molecular testing





AUDIENCE POLLING

Which first-line systemic therapy would you most likely recommend?

- A. Best supportive care
- B. Enrollment in a clinical trial of a TROP2 ADC + ICI
- C. ICI monotherapy
- D. Platinum chemotherapy + ICI
- E. I'm not sure





Community Oncologist (Urban)

Case 2 – Peter



Which systemic therapy would you most likely recommend next?

- A. Best supportive care
- B. Enrollment in a clinical trial of a TROP2 ADC + ICI**
- C. ICI monotherapy
- D. Platinum chemotherapy + ICI
- E. I'm not sure



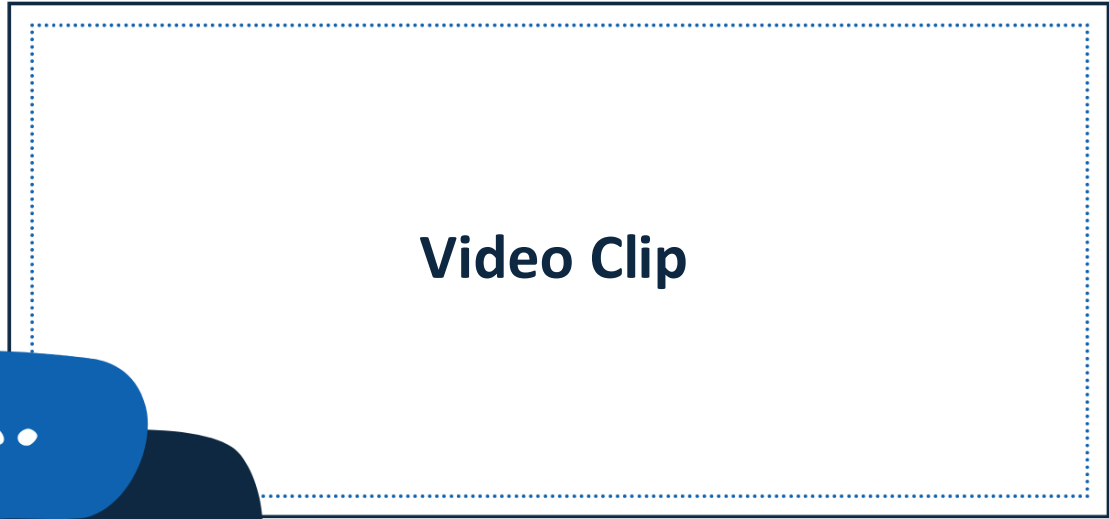


Clinical Investigator: Biagio Ricciuti

Case 2 – Peter



Platinum chemotherapy + ICI/TROP2 ADC + ICI trial



Video Clip





AI: ChatGPT 5.2

Case 2 – Peter



Platinum chemotherapy + ICI

Platinum-based chemotherapy plus immunotherapy is a preferred first-line standard. Compared with ICI monotherapy, chemoimmunotherapy provides higher response rates and improved disease control – particularly important in patients with bulky, symptomatic disease and high tumor burden.

- **Best supportive care:** ECOG PS = 1 and good organ function support active systemic treatment.
- **TROP2 ADC + ICI trial:** reasonable consideration, but outside of a trial, chemoimmunotherapy remains established standard of care.
- **ICI monotherapy:** acceptable in PD-L1 \geq 50%, but lower response rate and higher early progression risk compared with chemoimmunotherapy.





Faculty Discussion

Case 2 – Peter



Which systemic therapy would you most likely recommend next?

- A. Best supportive care
- B. Enrollment in a clinical trial of a TROP2 ADC + ICI**
- C. ICI monotherapy
- D. Platinum chemotherapy + ICI**
- E. I'm not sure



Health Care Professionals Survey

A patient with previously treated mNSCLC is being considered for a TROP2-directed ADC. TROP2 IHC shows low expression by standard scoring. How would this result affect your management decision?



I would still offer a TROP2-directed ADC



I would consider alternative therapy



I am unsure how to interpret TROP2 IHC in this setting





Clinical Investigator: Helena Yu, MD



TROP2 as a biomarker



Video Clip





PATIENT VOICE

Marcus

- A 66-year-old man with mNSCLC and new onset pulmonary symptoms. O₂: 95% on room air; no fever, sputum production, or other infectious symptoms
- Gradually progressive dyspnea on exertion
- New dry cough over 2-3 weeks
- No fever, sputum production, or other infectious symptoms





PATIENT VOICE

Marcus

Biomarker profile:

- HER2 mutation

Imaging findings:

- New bilateral patchy ground-glass opacities
- Subtle interlobular septal thickening
- Scattered sub centimeter nodular opacities
- Findings were not present on prior imaging





PATIENT VOICE

Marcus


- First-line: cisplatin/pemetrexed/pembrolizumab → disease progression
 - Last pembrolizumab dose was ~4 months ago
- Currently receiving T-DXd with partial response on first on-treatment imaging





AUDIENCE POLLING

How would you most likely proceed to determine the etiology of the new pulmonary symptoms?

- 
- A. Hold treatment and initiate a focused diagnostic evaluation (e.g., detailed imaging review, infectious workup, pulmonology consultation ± bronchoscopy)
 - B. Hold treatment and initiate high-dose systemic corticosteroids
 - C. Continue study treatment with close clinical and radiographic monitoring
 - D. Treat empirically for infection while continuing current therapy
 - E. Discontinue treatment and change systemic therapy due to concern for disease progression
 - F. Refer for urgent inpatient evaluation
 - G. I'm not sure



Community Oncologist (Urban)

Case 3 – Marcus



Which systemic therapy would you most likely recommend next?

- A. Hold treatment and initiate a focused diagnostic evaluation (e.g., detailed imaging review, infectious workup, pulmonology consultation ± bronchoscopy)
- B. Hold treatment and initiate high-dose systemic corticosteroids
- C. Continue study treatment with close clinical and radiographic monitoring
- D. Treat empirically for infection while continuing current therapy
- E. Discontinue treatment and change systemic therapy due to concern for disease progression**
- F. Refer for urgent inpatient evaluation
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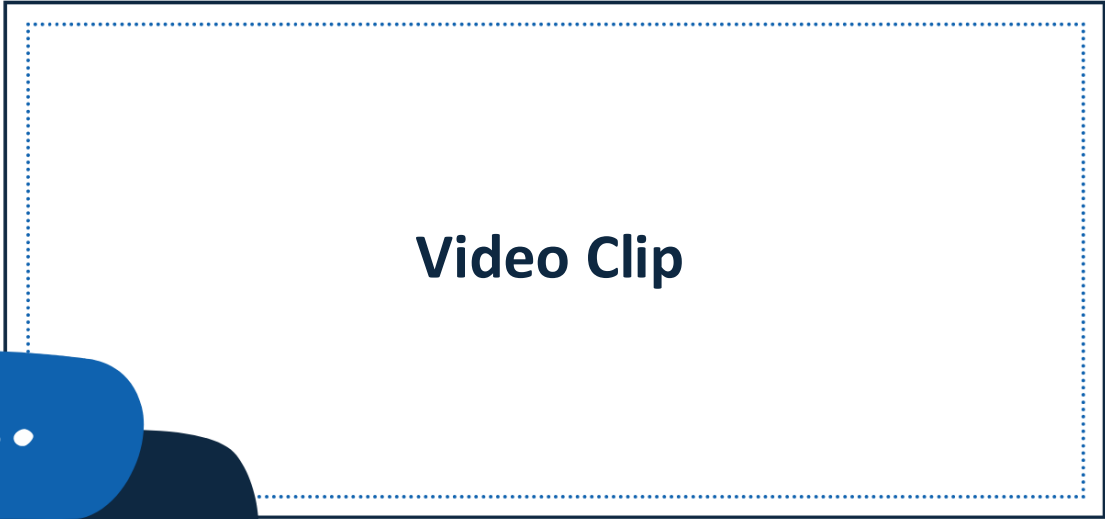


Clinical Investigator:

Case 3 – Marcus



Hold treatment and initiate focused diagnostic evaluation, potentially with empiric corticosteroids





Faculty Discussion

Case 3 – Marcus



Which systemic therapy would you most likely recommend next?

- A. Hold treatment and initiate a focused diagnostic evaluation (e.g., detailed imaging review, infectious workup, pulmonology consultation ± bronchoscopy)
- B. Hold treatment and initiate high-dose systemic corticosteroids
- C. Continue study treatment with close clinical and radiographic monitoring
- D. Treat empirically for infection while continuing current therapy
- E. Discontinue treatment and change systemic therapy due to concern for disease progression
- F. Refer for urgent inpatient evaluation
- G. I'm not sure



AI: ChatGPT 5.2

Case 3 – Marcus



Hold treatment and initiate a focused diagnostic evaluation

This patient has concerning findings for drug-related ILD/pneumonitis, a known and potentially serious toxicity of T-DXd. With mild symptoms, the appropriate first step is to hold T-DXd immediately, initiate diagnostic evaluation (imaging review, infectious workup, pulmonology consultation \pm bronchoscopy), and confirm suspected drug-related ILD before initiating steroids.

- **Immediate high-dose steroids:** premature without excluding infection; appropriate once ILD is confirmed or strongly suspected at \geq Grade 2.
- **Continue treatment:** not appropriate – possible T-DXd ILD requires immediate treatment interruption.
- **Empiric antibiotics while continuing therapy:** infection is possible, but therapy should still be held given ILD risk.
- **Discontinue for progression:** imaging pattern (ground-glass opacities) and clinical presentation are more consistent with pneumonitis than progression.
- **Urgent inpatient evaluation:** not required at this time given stable oxygenation and mild symptoms.





FACULTY DISCUSSION

What have we learned from each of the diverse groups?

Patients

- 1 • Tolerability and side effects drive decision-making
- 2 • Fear of serious or permanent toxicities influences willingness to continue therapy
- 3 • Clear communication about monitoring and reversibility is critical

Takeaway: Treatment selection must balance efficacy with anticipated quality-of-life impact.



FACULTY DISCUSSION

What have we learned from each of the diverse groups?

Community Oncologists

1

- Preference for familiar mechanisms (e.g., TKIs, chemoimmunotherapy)

2

- Strong interest in clinical trial options, particularly earlier-line ADC strategies
- Greater tendency to act quickly at signs of progression

3

Takeaway: Continued education on ADC positioning, toxicity management, and attribution remains important.



FACULTY DISCUSSION

What have we learned from each of the diverse groups?

Clinical Investigators

1

- Greater comfort with earlier adoption of ADCs
- Emphasis on diagnostic confirmation before changing therapy

2

- Higher threshold for discontinuation when toxicity attribution is uncertain

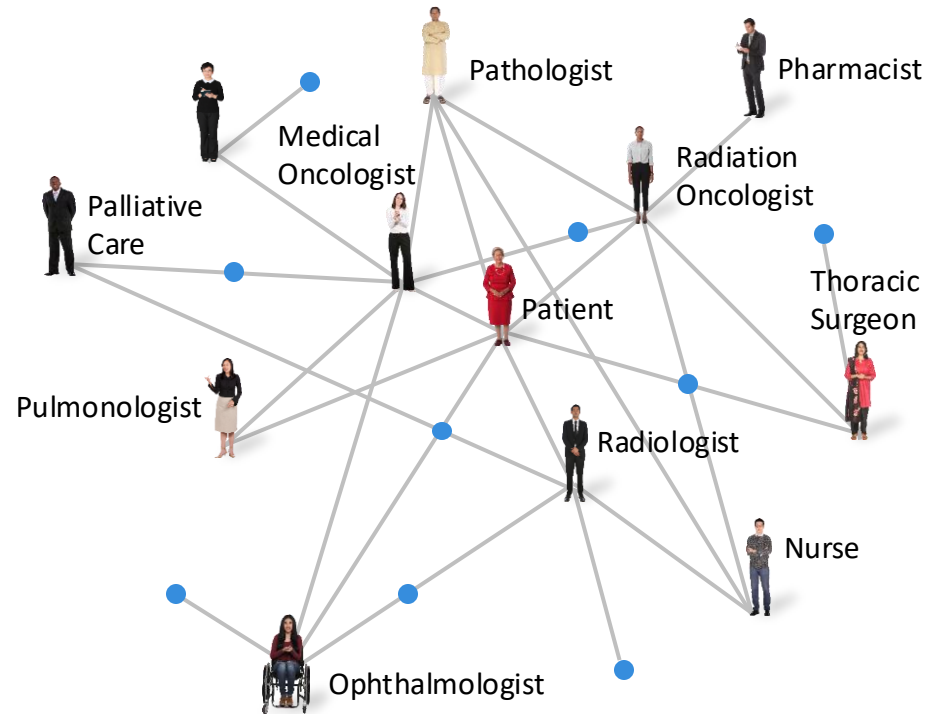
3

Takeaway: Nuanced interpretation of emerging data and toxicity patterns shapes decision-making.

Team-Based Approach for the Management of mNSCLC

- Multidisciplinary collaboration
- Toxicity monitoring and specialty referral
- Care coordination
- Patient-centered support

What strategies have you implemented in your practice to improve care coordination for patients with mNSCLC?





Put information into action!

Takeaways from this program can be implemented into your practice to improve patient care.

- **Increase** the number of patients with mNSCLC who undergo comprehensive biomarker review prior to second- or later-line treatment selection.
- **Increase** the number of eligible patients considered for ADC therapy based on tumor biology, prior therapy, and performance status.
- **Increase** the frequency of early screening for ADC-associated toxicities (e.g., ILD, ocular toxicity, mucositis, cytopenias) during routine visits.
- **Improve** timely differentiation between ADC-related toxicities and immune-related adverse events in patients previously treated with immunotherapy.
- **Increase** multidisciplinary collaboration (e.g., pulmonology, ophthalmology) when managing suspected treatment-related adverse events.

Additional Resources

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