**WELCOME & INTRODUCTIONS**  
*Car T-Cell Therapy in Children and Adults with Blood Cancers*

To register or to view the BCC schedule, visit [www.LLS.org/bcc](http://www.LLS.org/bcc).

<table>
<thead>
<tr>
<th>Southern California Blood Cancer Conference</th>
<th>Florida Blood Cancer Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaheim, CA</td>
<td>Fort Lauderdale, FL</td>
</tr>
<tr>
<td>March 2, 2019</td>
<td>March 30, 2019</td>
</tr>
</tbody>
</table>

**Program will begin shortly**

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**BLOOD CANCER CONFERENCES**

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**BEATING CANCER IS IN OUR BLOOD.**

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**CAR T-CELL THERAPY IN CHILDREN AND ADULTS WITH BLOOD CANCERS**

*Speakers*

Loretta Nastoupil, MD  
Assistant Professor  
Department of Lymphoma/Myeloma  
Division of Cancer Medicine  
The University of Texas MD Anderson Cancer Center  
Houston, TX

Rayne H. Rouce, MD  
Assistant Professor  
Department of Pediatrics  
Texas Children's Cancer Center for Cell and Gene Therapy  
Baylor College of Medicine  
Houston, TX
CAR T-Cell Therapy in Children with Blood Cancers

Rayne H. Rouce, MD
Assistant Professor
Texas Children’s Cancer Center
Center for Cell and Gene Therapy

Dr. Rayne Rouce has affiliations with Kite Pharma, A Gilead Company, Novartis and Tessa Pharmaceuticals.
What exactly is a CAR T-cell?

- **Chimeric Antigen Receptor T-cell**: a T cell engineered in the lab to express artificial receptors that specifically target a protein on the surface of a cancer cell.

Pediatrics: Who qualifies for CD19 CAR T-cell therapy?

- Initially CD19 CAR T cells only available on a clinical trial (research study)
  - various trials across the country & world available for relapsed patients

- Different criteria for each trial, BUT common features
  - CD19 must be expressed on surface of malignancy
    - Most commonly ALL, but also lymphomas
  - not available for upfront “initial” therapy, only in case of relapse or refractory tumor
Major discoveries from preclinical and early clinical trials

- CAR T cells require additional “help” to expand and endure in the body
- Some of this help comes from “within” the CAR T-cell
  - additional stimulatory molecules that can be added to the cell
- Some of the help comes from “outside”
  - lymphodepleting chemo

CAR T-cell structure can affect performance in the body

Antigen recognition

CD28: rapid expansion shorter persistence

4-1BB: longer persistence

CD28 4-1BB ζ

Qualities of both?
What does CAR T-cell therapy involve?

Collect white cells from patient

Introduce new gene carrying CAR (designed to attack protein on tumor cells) into T cells

Expand CAR+ T cells and give back through an IV or central line

Preconditioning (lymphodepleting) chemo

Adapted from Klebanoff, Nature Reviews Clinical Oncology 11, 685–686 (2014)

CD19 CAR T-cell therapy in 2019

- High complete remission rates in multiply relapsed patients across most studies
  - overall response between 65 and 90%
  - some patients remain in remission for years
- Larger trials, longer follow-up and high remission rates led to partnerships with industry
- Efforts to make widely available & “prescribable”
- August 2017: First FDA approval of a CAR T cell therapy!!

KYMRIAH® (tisagenlecleucel)
August 2017: First FDA approval of a CAR T-cell therapy!!

**KYMRIAH® (tisagenlecleucel)**

KYMRIAH® is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of:

- Patients up to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse

Consider KYMRIAH for pediatric and young adult patients with any of the following clinical characteristics:

- Have not gone into remission following frontline treatment (primary refractory)
- Have relapsed and cannot achieve remission (chemorefractory)
- Have had second or subsequent relapse following complete remission or HSCT

Please see Important Safety Information throughout deck and full Prescribing Information, including Boxed WARNING, and Medication Guide.
The Future of CAR T-cell therapy for children with cancer

• CD19 CAR Therapy
  – Moving therapy earlier
    • treating patients in first relapse
    • treating patients with persistent measurable disease (even small amounts aka “minimal residual disease”) early on in treatment
  – Targeting multiple antigens in addition to CD19
  – Combination therapy to enhance benefit
  – “off-the-shelf”options
  – Extending approval to CD19+ lymphoma in pediatric patients
Beyond CD19: other CAR T cells in clinical trials

**Step 1**: Go to clinicaltrials.gov

**Step 2**: Type in “CAR T cells for....”
- be as specific or general as possible
- can even search by hospital, city, whether trial actively recruiting or not

88 Studies found for: CAR T cells for leukemia and lymphoma

Also searched for Chimeric antigen receptor and Chimeric Antigen Receptor T-cells. See Search Details

CAR T cell therapies for leukemia and lymphoma in clinical trials

**B-ALL, B-NHL**
- CD19
- CD22
- CD19/22

**AML**
- CD123
- CD33
- CLL-1
- NKG2D

**T-ALL/T-cell lymphoma**
- CD5
- CD7

**Hodgkin Lymphoma/ALCL**
- CD30
CAR T-Cell Therapy for NHL: Current and Future Directions

Loretta J. Nastoupil, M.D.
Assistant Professor
Department of Lymphoma and Myeloma
The University of Texas MD Anderson Cancer Center
Houston, TX

Disclosures

- Research support: Celgene, Genentech, Janssen, Karus, Merck, TG Therapeutics
- Honorarium: Celgene, Genentech, Gilead, Janssen, Novartis
CAR T-cell Development: From Discovery to FDA Approval

Discovery to FDA approval ~25 years

- Dec 01, 1989: First Ab-TCR CAR (Z. Eschhar)
- Jan 15, 1993: First scFv-CAR (Z. Eschhar)
- Aug 01, 1995: In vivo demonstration of anti-tumor activity of scFv-CAR (Hwu, Eschhar, Rosenberg)
- Oct 15, 2006: First clinical data with scFv-CAR (Kershaw, Eschhar, Rosenberg, Hwu)
- May 28, 2009: First CD19 CAR in NHL (Kochenderfer and Rosenberg)
- Aug 25, 2011: First clinical data with CD19 CAR in CLL (Porter and June)
- Jul 14, 2010: First clinical data with CD19 CAR (NCI) in NHL (Kochenderfer and Rosenberg)
- Apr 18, 2013: First clinical data with CD19 CAR in ALL (Grupp and June)
- Oct 18, 2017: Yescarta

FDA approvals
- Aug 30, 2017: Kymriah

Multicenter ALL/lymphoma trials

T Cell Activation Requires 2 Signals

APC, antigen-presenting cell; MHC-Ag, major histocompatibility antigen; TCR, T cell receptor.
**CD19 CAR T-cell Products in Pivotal Trials in NHL**

**NCI**
- CD19 Ab
- Hinge
- Transmembrane
- Signal 2
- Signal 1
- Gene transfer
  - Retrovirus
    - Kite Pharma
      - KTE-C19
      - Axicabtagene ciloleucel
      - Axi-cel
  - Lentivirus
    - Novartis
      - CTL-019
      - Tisagenlecleucel
    - Juno Therapeutics
      - JCAR017 (CD4:CD8 = 1:1)
      - Lisocabtagene maraleucel
      - Liso-cel

Adapted from van der Steegen et al. Nat Rev Drug Discov, 2015

**Unmet Need in Chemorefractory Aggressive B-cell NHL**

**(SCHOLAR - Retrospective Non-Hodgkin Lymphoma Research)**

- Meta-analysis to evaluate the outcomes in chemorefractory DLBCL
- CORAL, CCTG-LY12, MDACC, Mayo-Iowa
- Chemorefractory patient population
  - SD/PD after primary or later-lines of therapy
  - Relapse ≤12 months after ASCT
- N = 635
- ORR = 26%; CR rate = 8%
- Median OS = 6.6 months

Crump et al, SOHO 2016
ZUMA1: Phase I/II Study Design

Key eligibility criteria
- No response to last chemotherapy or relapse ≤ 12 mo post-ASCT
- Prior anti-CD20 monoclonal antibody and anthracycline

Conditioning regimen
- Cyclophosphamide 500 mg/m² + fludarabine 30 mg/m² for 3 days
- **Axi-cel**: $2 \times 10^5$ CAR+ cells/kg
- 91% enrolled were successfully manufactured
- 17-day average turnaround time from apheresis to delivery to clinical site

ZUMA1: Duration of Response by Best Objective Response

- Median duration of CR has not been reached
- 3/7 (43%) phase 1 patients have ongoing CR at 24 months

Neelapu et al. N Eng J Med 2017
ZUMA1: Safety

Pivotal cohort (N=101)

<table>
<thead>
<tr>
<th></th>
<th>CRS</th>
<th>NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>All grades</td>
<td>93%</td>
<td>64%</td>
</tr>
<tr>
<td>Grade ≥3</td>
<td>13%</td>
<td>28%</td>
</tr>
<tr>
<td>Time to onset [Median (Range)]</td>
<td>2 (1-12) days</td>
<td>5 (1-17) days</td>
</tr>
<tr>
<td>Time to resolution (Median)</td>
<td>8 days</td>
<td>17 days</td>
</tr>
<tr>
<td>Tocilizumab usage</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Corticosteroids usage</td>
<td>27%</td>
<td></td>
</tr>
</tbody>
</table>

- 3 deaths due to AEs – 1 cardiac arrest, 1 HLH, 1 pulmonary embolism
- Lee criteria used for CRS grading
- CTCAE criteria used for neurological event (NE) grading

Neelapu et al. N Eng J Med 2017

JULIET: Tisagenlecleucel Study Design

JULIET is a single-arm, open-label, multicenter, global phase 2 trial of
CTL019 in adult patients with r/r DLBCL (NCT02445248)

Screening
Apheresis and Cryopreservation

Bridging Chemotherapy

Enrollment
CTL019 Manufacturing
Restaging Lymphodepletion

Safety and Efficacy
Follow-Up
Imaging at months 1, 3, 6, 9, 12...

Antigen binding (anti-CD19) domain
C6-alpha hinge and transmembrane
4-1BB costimulatory domain
CD3-zeta signaling domain

CTL019 Infusion

* Eligibility criteria confirmed.
* To prevent rapid disease progression during CTL019 manufacturing.
* To be completed 2 to 14 days prior to CTL019 infusion.
* Infusion conducted in- or out-patient at investigator discretion.
* Long-term follow-up for 15 years (NCT02445222).
### Multicenter CD19 CAR T-cell Trials in Aggressive NHL

<table>
<thead>
<tr>
<th>Study / Sponsor</th>
<th>ZUMA1 / Kite</th>
<th>JULIET / Novartis</th>
<th>TRANSCEND / Juno</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAR T design</strong></td>
<td>CD19/CD3ζ/CD28</td>
<td>CD19/CD3ζ/4-1BB</td>
<td>CD19/CD3ζ/4-1BB</td>
</tr>
<tr>
<td><strong>CAR T dose</strong></td>
<td>2 x 10^6/kg</td>
<td>0.6-6 x 10^8</td>
<td>0.5-1 x 10^8</td>
</tr>
<tr>
<td><strong>Conditioning therapy</strong></td>
<td>Cy/Flu</td>
<td>Cy/Flu or Bendamustine</td>
<td>Cy/Flu</td>
</tr>
<tr>
<td><strong>Lymphoma subtypes</strong></td>
<td>DLBCL / PMBCL / TFL</td>
<td>DLBCL / TFL</td>
<td>DLBCL / TFL / FL Gr 3B</td>
</tr>
<tr>
<td><strong>Treated/Enrolled</strong></td>
<td>101/111 (91%)</td>
<td>111/165 (67%)</td>
<td>108/140 (77%)</td>
</tr>
<tr>
<td><strong>Relapsed/Refractory</strong></td>
<td>Refractory</td>
<td>Relapsed or refractory</td>
<td>Relapsed or refractory</td>
</tr>
<tr>
<td><strong>Relapse post-ASCT</strong></td>
<td>21%</td>
<td>49%</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Bridging therapy</strong></td>
<td>None</td>
<td>Allowed</td>
<td>Allowed</td>
</tr>
<tr>
<td><strong>Manufacturing success</strong></td>
<td>99%</td>
<td>93%</td>
<td>98%</td>
</tr>
<tr>
<td><strong>ORR / CR (%)</strong></td>
<td>82 / 54</td>
<td>52 / 40</td>
<td>80 / 55</td>
</tr>
</tbody>
</table>
Cytokine Release Syndrome and Neurotoxicity: Multicenter CD19 CAR T trials in adult NHL

<table>
<thead>
<tr>
<th>Study/Sponsor</th>
<th>Product</th>
<th>N</th>
<th>CRS All Grades</th>
<th>CRS Grade ≥3</th>
<th>NT All Grades</th>
<th>NT Grade ≥3</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZUMA1 / Kite</td>
<td>CD19/CD3ζ/CD28</td>
<td>101</td>
<td>93%</td>
<td>13%</td>
<td>64%</td>
<td>28%</td>
<td>Neelapu et al, NEJM 2017</td>
</tr>
<tr>
<td>JULIET / Novartis</td>
<td>CD19/CD3ζ/4-1BB</td>
<td>111</td>
<td>58%</td>
<td>22%</td>
<td>21%</td>
<td>12%</td>
<td>Schuster et al, NEJM 2018</td>
</tr>
<tr>
<td>TRANSCEND / Juno</td>
<td>CD19/CD3ζ/4-1BB</td>
<td>67</td>
<td>36%</td>
<td>1%</td>
<td>21%</td>
<td>15%</td>
<td>Abramson et al, ASH 2017</td>
</tr>
</tbody>
</table>

- Lee criteria used for CRS grading on ZUMA1 and TRANSCEND
- U Penn criteria used for CRS grading on JULIET
- All trials used CTCAE criteria for neurotoxicity (NT) grading
- 3 deaths on ZUMA1 due to AEs – 2 CRS and 1 pulmonary embolism

Outcomes with Standard of Care Axi-Cel
Study Design: Outcomes with SOC Axi-Cel

- **Objective:** Delineate the characteristics and real world outcomes of patients undergoing standard of care axi-cel.
- Retrospective analysis of data from **17 US academic centers**.
- All patients **leukapheresed as of August 31, 2018** with intention to manufacture commercial axi-cel were included in these analyses.

N = 295 from 17 centers

Characteristics Differentiating Patients in the Real World from ZUMA-1

- 124 of 286* (43%) patients would not have met eligibility for ZUMA-1 at the time of leukapheresis.

<table>
<thead>
<tr>
<th>Criteria Excluded from ZUMA-1</th>
<th>N=124</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platelets &lt; 75</td>
<td>37 (13)</td>
</tr>
<tr>
<td>Active DVT/PE</td>
<td>27 (9)</td>
</tr>
<tr>
<td>Prior CD19 or CAR T cell therapy</td>
<td>24 (8)</td>
</tr>
<tr>
<td>GFR &lt; 60</td>
<td>22 (8)</td>
</tr>
<tr>
<td>History of CNS lymphoma</td>
<td>22 (8)</td>
</tr>
<tr>
<td>Symptomatic pleural effusion</td>
<td>11 (4)</td>
</tr>
<tr>
<td>LVEF &lt; 50%</td>
<td>10 (4)</td>
</tr>
<tr>
<td>Prior allogeneic SCT</td>
<td>7 (2)</td>
</tr>
</tbody>
</table>

* Missing data on 7 subjects enrolled on ZUMA 9
## Safety of Axi-Cel in the Real World

<table>
<thead>
<tr>
<th></th>
<th>SOC Axi-cel N = 274 (mITT)</th>
<th>ZUMA-1 N = 108</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Grades of CRS</strong>, N (%)</td>
<td>240 (92%)</td>
<td>100 (93%)</td>
</tr>
<tr>
<td><strong>Grade ≥ 3 CRS, N (%)</strong></td>
<td>18 (7%)</td>
<td>14 (13%)</td>
</tr>
<tr>
<td><strong>Median time to onset of CRS</strong></td>
<td>3 days</td>
<td>2 days</td>
</tr>
<tr>
<td><strong>All Grades of NT</strong>, N (%)</td>
<td>181 (69%)</td>
<td>70 (65%)</td>
</tr>
<tr>
<td><strong>Grade ≥ 3 NT, N (%)</strong></td>
<td>85 (33%)</td>
<td>33 (31%)</td>
</tr>
<tr>
<td><strong>Median time to onset of NT</strong></td>
<td>6 days</td>
<td>5 days</td>
</tr>
</tbody>
</table>

* Lee criteria used for grading CRS
** CTCAE or CARTOX criteria used for grading neurotoxicity


### Ongoing Clinical Trials

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ZUMA 7: Axicabtagene Ciloleucel vs. Standard of Care in Subjects with R/R DLBCL

Eligible patients:
First relapse of DLBCL including tFL
• primary refractory
• SD
• PR with relapsed ≤ 12 months
Candidate for HDT/ASCT

TRANSFORM Study Design: JCAR017

- Subjects from Arm A may be allowed to cross over and receive JCAR017 upon confirmation of an EFS event
- JCAR017 will be manufactured once the investigator confirms the request for a cross over and the IRC confirm the EFS event (Progression; Start of new antineoplastic therapy [for subjects with SD after 2 cycles of SOC; for subjects with PR after 3 cycles of SOC]; Relapse)
- Subjects who cross over will be followed up for 1 year
BELINDA: Study Design

**CTL019H2301 Amended Design Proposal**

*Randomization upfront at time of 1st relapse (<12 months from R-CHOP)*

**Arm A: CTL019**

- n=338 randomized 1:1, stratification by refractory/relapsed <6m vs. 6-12m, P1 (<2 vs. ≥2)
- Patients in CR at enrollment
- HD-ASCT
- Follow-up:
  - Week 6 for treatment decision
  - Week 12 +/-1w for disease assessment
  - q3m to M12
  - q6m to M24
  - Annual to M60

**Arm B: SOC**

- n=159
- Patients in CR at enrollment
- Follow-up:
  - HD-ASCT
  - q3m to M12
  - q6m to M24
  - Annual to M60

**Crossover allowed, if no response at 12 weeks by IRC**

**1st Endpoint:** EFS
- EFS event:
  - SD/PD by IRC after week 12 ± 1w
  - Death at any time

**Outcomes:** Safety and Efficacy

---

**Phase I/II Study of Umbilical Cord Blood-derived CAR-engineered NK cells in Patients with Relapsed/refractory B-lymphoid malignancies**

- Transduction of NK cells with retroviral vector
  - Day -15

- Expand NK cells on clone 9 + IL-2
  - 1x10e5/kg, 1x10e6/kg, 1x10e7/kg

- Cyclophosphamide, 300 mg/m²
- Fludarabine 30 mg/m²

- D-4, D-3, D-2

- Patients with relapsed/refractory ALL, CLL or NHL

- Outcomes:
  - Safety
  - Efficacy
ACTR707, an Autologous T Cell in Combination with Rituximab

- Autologous T cells with chimeric antigen receptor
- CD16 binds Fc
- Results in a CAR T with rituximab as target
- Potential use in CD19- B cell NHL
- Potential use to titrate potency of CAR T

CD19 CAR T in NHL: Current Management of DLBCL

Aggressive B-cell NHL

R-CHOP or similar → Relapse / Progression

~60% cured

2nd line chemo → Relapse / Progression

Chemo-sensitive

HDT + ASCT → CD19 CAR T

Future Directions:

CD19 CAR T in high-risk aggressive B-cell NHL
Randomized trials of CD19 CAR T vs. ASCT
CD19 CAR T in high-risk indolent B-cell NHL, MCL
## CAR T-cell in Multiple Myeloma

<table>
<thead>
<tr>
<th>Center/Sponsor</th>
<th>Bb21217</th>
<th>JCARH125</th>
<th>MCARH171</th>
<th>FCARH143</th>
<th>LCAR-B38M</th>
<th>Native TCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor</td>
<td>Autologous</td>
<td>Autologous</td>
<td>Autologous</td>
<td>Autologous</td>
<td>Autologous</td>
<td>Autologous</td>
</tr>
<tr>
<td>scFv</td>
<td>anti-BCMA scFv, cultured in perfusion bioreactor; biomarker b8007 (less differentiated)</td>
<td>Human anti-BCMA scFv</td>
<td>Human anti-BCMA scFv</td>
<td>Human anti-BCMA scFv</td>
<td>llama anti-BCMA non- scFv, 2 variable heavy chain domains = 2 different epitopes</td>
<td>MAGEA4, PRAME, Survivin, NYESO-1, SSX2 TCRs (enriching native specificity)</td>
</tr>
<tr>
<td>Co stim</td>
<td>4-1BB</td>
<td>4-1BB</td>
<td>4-1BB</td>
<td>4-1BB</td>
<td>4-1BB</td>
<td>n/a</td>
</tr>
<tr>
<td>Transduction</td>
<td>Lentivirus</td>
<td>Lentivirus</td>
<td>Retrovirus</td>
<td>Lentivirus</td>
<td>Lentivirus</td>
<td>n/a</td>
</tr>
<tr>
<td>Lines of therapy</td>
<td>6 (4-17)</td>
<td>7 (3-23)</td>
<td>6</td>
<td>11</td>
<td>3 (1-9)</td>
<td>2-10</td>
</tr>
<tr>
<td>High risk pts</td>
<td>58%</td>
<td>77%</td>
<td>64%</td>
<td>73%</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>CRS/CRES</td>
<td>CRS 67% (1 gr 3); CRES 24% (1 gr 4)</td>
<td>9% CRS 3/4 (80% all gr); 7% neuro 3/4 (25% all)</td>
<td>6/11 CRS (Gr3/4 – 4); 1 gr 2 neuro</td>
<td>10/11 (&lt;= gr 2); 1 gr 3 neuro</td>
<td>90% (grade 3 &gt; 7%); Grade 1 neuro = 1</td>
<td>none</td>
</tr>
<tr>
<td>ORR &gt;= PR</td>
<td>83% (150x10^6, 11 pts); 25% sCR/CR; 4/4 MRD neg</td>
<td>82%, 48% &gt;= VGPR, CR, sCR, CR 27%</td>
<td>64% ORR; 4 CR, 5 VGPR, 2 PR</td>
<td>100% ORR; 4 CR, 5 VGPR, 2 PR</td>
<td>88% in 74 patients; 74% CR; mDOR 16 mo; mDOR (MRD-22 mo)</td>
<td>3 PR, 1 CR/12 pts with active disease</td>
</tr>
</tbody>
</table>

### Q&A SESSION

**Car T-Cell Therapy in Children and Adults with Blood Cancers**

- **Ask a question by phone:**
  - Press star (*) then the number 1 on your keypad.

- **Ask a question by web:**
  - Click “Ask a question”
  - Type your question
  - Click “Submit”

Due to time constraints, we can only take one question per person. Once you’ve asked your question, the operator will transfer you back into the audience line.

---

**BEATING CANCER IS IN OUR BLOOD.**
LLS EDUCATION & SUPPORT RESOURCES

- Information Specialists
  Master’s level oncology professionals, available to help cancer survivors navigate the best route from diagnosis through treatment, clinical trials and survivorship.
  - EMAIL: infocenter@LLS.org
  - TOLL-FREE PHONE: 1-800-955-4572
- CAR T-cell Immunotherapy: www.LLS.org/cart
- Caregiver Support: www.LLS.org/caregiver
- Free Education Booklets: www.LLS.org/booklets
- Free Telephone/Web Programs: www.LLS.org/programs
- Live, weekly Online Chats: www.LLS.org/chat
- LLS Community: www.LLS.org/community

BEATING CANCER IS IN OUR BLOOD.

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LLS EDUCATION & SUPPORT RESOURCES

- LLS Podcast, *The Bloodline with LLS*
  Listen in as experts and patients guide listeners in understanding diagnosis, treatment, and resources available to blood cancer patients: www.thebloodline.org
- Education Videos
  Free education videos about survivorship, treatment, disease updates and other topics: www.LLS.org/educationvideos
- Patti Robinson Kaufmann First Connection Program
  Peer-to-peer program that matches newly diagnosed patients and their families: www.LLS.org/firstconnection
- Free Nutrition Consults
  Telephone and email consultations with a Registered Dietitian: www.LLS.org/nutrition
- LLS Copay Assistance Program:
  Provides financial assistance towards copayments and insurance premiums: www.LLS.org/copay
- Financial Assistance Programs for approved CAR T-cell therapies:
  - Kymriah®- 1-844-459-6742
  - Yescarta®- 1-844-454-5483
We have one goal: A world without blood cancers

THANK YOU