

Lessons Learned from Oncology Dose Finding Workshops

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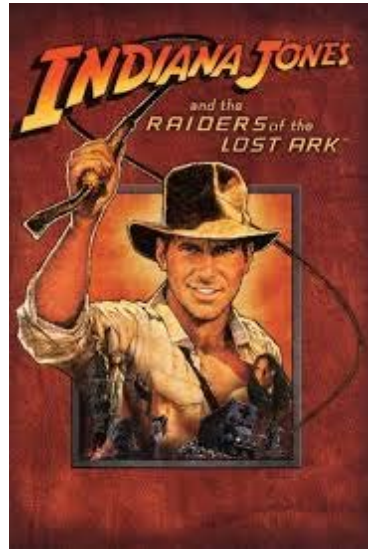
Director, DOP1

OHOP/CDER/FDA

The Dose Optimization Issue

- High rate of dose reductions and discontinuations in clinical trials
- Adherence to therapy in the “real world”
- Redundant drug development process with inefficiencies
- More potential permutations of combinations than eligible patients
- Incomplete characterization of compounds and lack of full understanding of mechanisms of actions
- HIGHLY competitive and rapidly changing landscape

DFW:Part 1

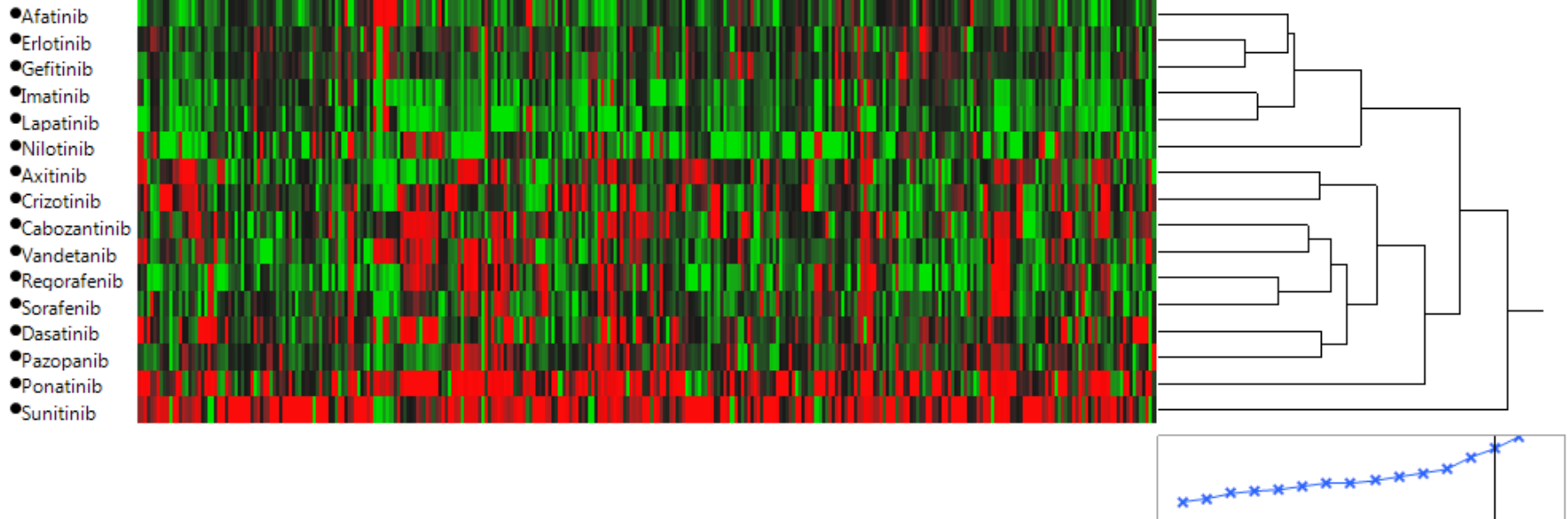


Small Molecule Kinase Inhibitors

- Exposure response relationships are rarely defined nor interpatient variability adequately evaluated during early clinical development
 - Poor solubility and high variability of exposure
- AEs in Phase 2/3 clinical trials result in dose reductions, complicating study interpretation and determination of FDA-recommended dose
- Sponsor's have to conduct additional dose optimization studies as PMRs

Broad target selectivity for many FDA-approved kinase inhibitors

Dendrogram



1 μ M kinase inhibitor profiled against 300 kinases in a biochemical enzymatic assay

Uitdehaag et. al, PLOS one (2014)

General Considerations

- Interdisciplinary Communication
- Revisit and retest when signals emerge
- Purposeful selection of trial designs

DFW: Part 2



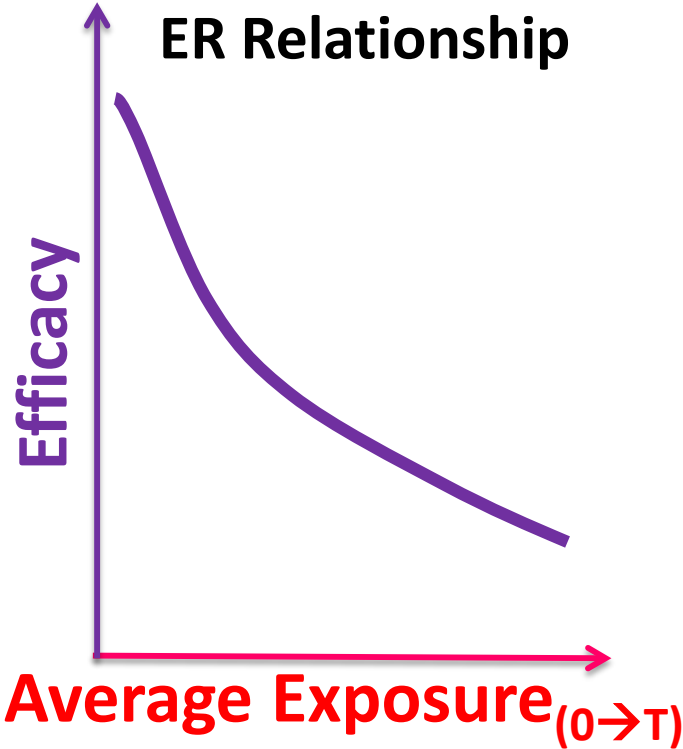
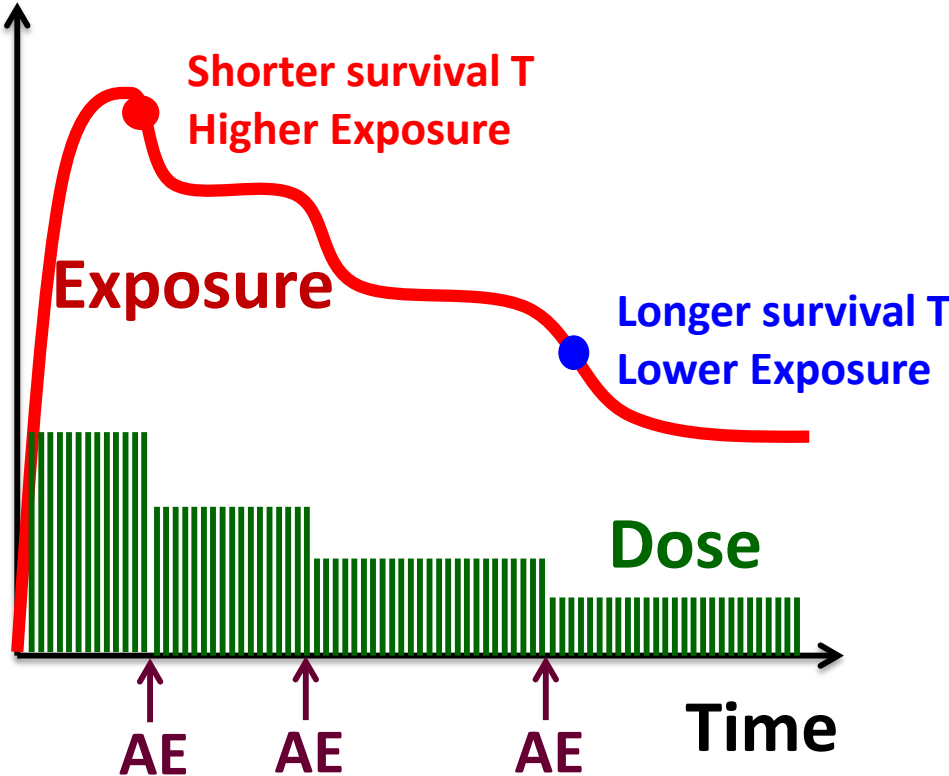
Large Molecules

- FIH dose selection (Saber et al Regul Toxicol Pharmacol 2016)
 - MABEL approach: Minimally Anticipated Biological Effect Level
 - Use receptor occupancy or pharmacologic activity to start
 - Use strategies such as Intra-patient dose escalation and n=1 escalation cohorts to minimize patients exposed to dose levels not expected to have biologic effects

Large Molecules

- RO and saturation may inform safe start dose, but % saturation may not equate to optimal dose
 - May be thought of as lower bound?
- PK-PD models may be informative
- E-R relationships
 - Contribution of disease status

Dose Adjustment: Challenges for E-R Relationship Estimation



- Exposure not constant over time
- Biased ER relationship

All Products and Combinations

- Systems pharmacology approaches may be informative
- Integration of multiple sources
- Consider time as a key factor
 - Dose adjustment Integrated E-R analysis

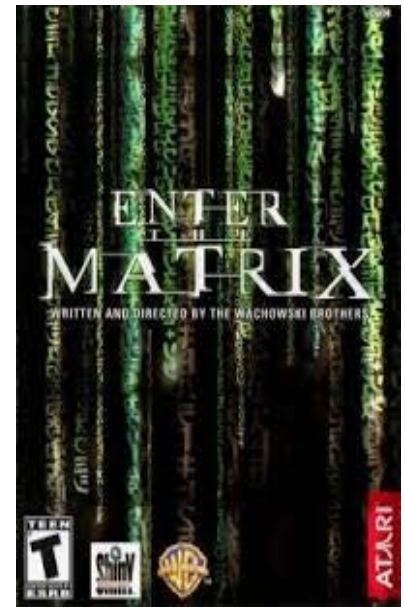
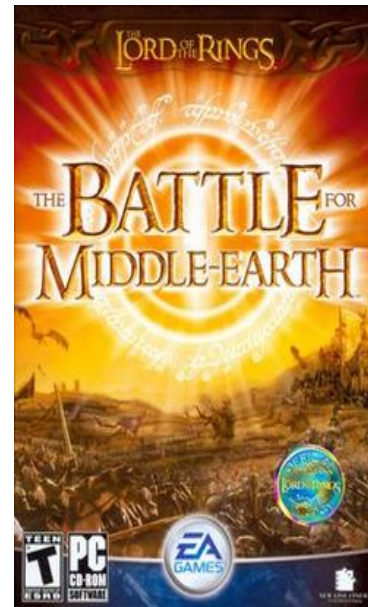
DFW: Part 2.5



Dose-Finding: IO Agents and Combinations

- Fixing dose and schedule of agents that are already approved or well characterized
- Safety attribution in combination studies
- Disease specificity for dose/schedule of combinations
- Benefits of larger sample sizes and randomized evaluation

DFW 2.75



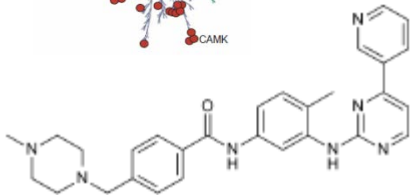
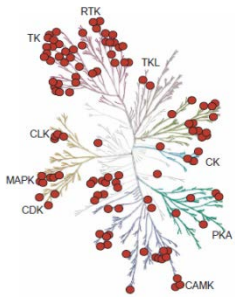
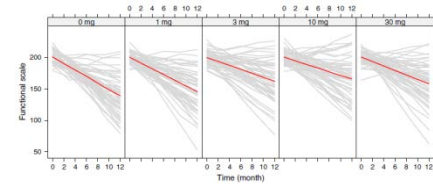
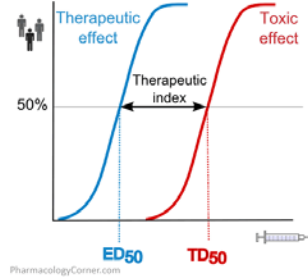
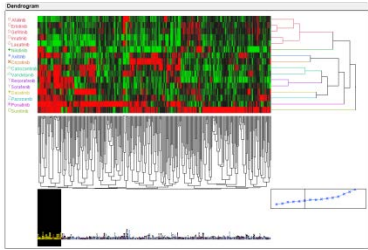
AACR 2017

- Biomarkers and IO combination
 - SITC working group
 - Industry perspective
 - Use of biomarkers in modeling and simulation approaches
- How can you find the right dose if you cannot find the right patient?
- Is survival the only endpoint?

DFW 3!!



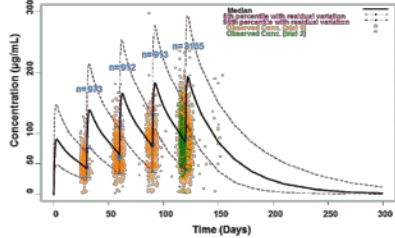
In an Ideal (?) World



$$f(x, \theta) = \theta_0 + \theta_1 f^0(x, \theta^0)$$

$$\hat{\Psi}(\theta) = (\bar{\mu} - f(x, \theta))' A_n (\bar{\mu} - f(x, \theta))$$

$$\sqrt{a_n}(\hat{\theta} - \theta_0) \xrightarrow{d} N(0, B(\theta_0)' M(\theta_0) B(\theta_0))$$



Study	Study Type	Phase	Design	Primary Endpoint	Secondary Endpoints	Number of Subjects	Number of Events	Number of Deaths	Number of Dropouts	Number of Lost to Follow-up	Number of Censored	Number of Completed
1	Phase I	Randomized	Parallel	Overall Survival	Quality of Life	100	50	10	20	10	10	50
2	Phase II	Randomized	Parallel	Overall Survival	Quality of Life	200	100	20	40	20	20	100
3	Phase III	Randomized	Parallel	Overall Survival	Quality of Life	500	250	50	100	50	50	250

