

Tisagenlecleucel cellular kinetics, dose, and immunogenicity in relation to clinical factors in relapsed/refractory DLBCL

Rakesh Awasthi,¹ Lida Pacaud,² Edward Waldron,² Constantine S. Tam,³ Ulrich Jäger,⁴ Peter Borchmann,⁵ Samantha Jaglowski,⁶ Stephen Ronan Foley,⁷ Koen van Besien,⁸ Nina D. Wagner-Johnston,⁹ Marie José Kersten,¹⁰ Stephen J. Schuster,¹¹ Gilles Salles,¹² Richard T. Maziarz,¹³ Özlem Anak,² Christopher del Corral,² Jufen Chu,² Irina Gershgorin,² Iulian Pruteanu-Malinici,¹ Abhijit Chakraborty,¹ Karen Thudium Mueller,¹ and Edmund K. Waller¹⁴

¹Novartis Institutes for BioMedical Research, East Hanover, NJ; ²Novartis Pharmaceuticals Corporation, East Hanover, NJ; ³Hematology Department, Peter MacCallum Cancer Center, University of Melbourne, Melbourne, Australia; ⁴Division of Hematology and Hemostaseology, Department of Medicine I, Medical University of Vienna, Vienna, Austria; ⁵Department of Hematology and Oncology, University Hospital of Cologne, Cologne, Germany; ⁶The James Cancer Hospital and Solove Research Institute, The Ohio State University Comprehensive Cancer Center, Columbus, OH; ⁷Juravinski Hospital and Cancer Center, McMaster University, Hamilton, ON, Canada; ⁸Division of Hematology and Oncology, Weill Cornell Medicine and New York-Presbyterian Hospital, New York, NY; ⁹The Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins University, Baltimore, MD; ¹⁰Department of Hematology, Amsterdam UMC, University of Amsterdam, Amsterdam, The Netherlands; ¹¹Lymphoma Program, Abramson Cancer Center, University of Pennsylvania, Philadelphia, PA; ¹²Department of Hematology, CHU Lyon-Sud Hospital, Hospices Civils de Lyon, Lyon, France; ¹³Center for Hematologic Malignancies, Oregon Health & Science University Knight Cancer Institute, Portland, OR; and ¹⁴Bone Marrow and Stem Cell Transplant Center, Winship Cancer Institute of Emory University, Atlanta, GA

Key Points

- Tisagenlecleucel mean expansion (lower vs B-ALL; not related to response) and baseline tumor burden in DLBCL correlated with CRS severity.
- Impact of dose on estimated probability of severe CRS was not statistically significant after adjusting for baseline tumor burden.

The anti-CD19 chimeric antigen receptor (CAR)-T cell therapy tisagenlecleucel was evaluated in the global, phase 2 JULIET study in adult patients with relapsed/refractory diffuse large B-cell lymphoma (DLBCL). We correlated tisagenlecleucel cellular kinetics with clinical/product parameters in 111 patients treated in JULIET. Tisagenlecleucel persistence in responders and nonresponders, respectively, was demonstrated for 554 and 400 days maximum by flow cytometry and for 693 and 374 days maximum by quantitative polymerase chain reaction (qPCR). No relationships were identified between cellular kinetics (qPCR) and product characteristics, intrinsic/extrinsic factors, dose, or immunogenicity. Most patients with 3-month response had detectable transgene at time of response and continued persistence for ≥ 6 months. Expansion (maximal expansion of transgene/CAR-positive T-cell levels in vivo postinfusion [C_{max}]) was potentially associated with response duration but this did not reach statistical significance (hazard ratio for a twofold increase in C_{max} , 0.79; 95% confidence interval, 0.61-1.01). Tisagenlecleucel expansion was associated with cytokine-release syndrome (CRS) severity and tocilizumab use; no relationships were observed with neurologic events. Transgene levels were associated with B-cell levels. Dose was associated with CRS severity, but this was not statistically significant after adjusting for baseline tumor burden. In contrast to the results from B-cell precursor acute lymphoblastic leukemia (B-ALL) and chronic lymphocytic leukemia, similar exposure was observed in DLBCL in this study regardless of response and expansion was lower in DLBCL than B-ALL, likely from differences in cancer location and/or T-cell intrinsic factors. Relationships between expansion and CRS severity, and lack of relationships between dose and exposure, were similar between DLBCL and B-ALL. Tisagenlecleucel cellular kinetics in adult relapsed/refractory DLBCL improve current understanding of in vivo expansion and its relationships with safety/efficacy endpoints. This trial was registered at www.clinicaltrials.gov as #NCT02445248.

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The full-text version of this article contains a data supplement.

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Introduction

The anti-CD19 chimeric antigen receptor (CAR)-T cell therapy tisagenlecleucel has demonstrated efficacy in the treatment of pediatric/young adult patients with relapsed/refractory B-cell precursor acute lymphoblastic leukemia (B-ALL) and adult patients with relapsed/refractory diffuse large B-cell lymphoma (DLBCL).¹⁻⁶ JULIET is a global, phase 2 study of tisagenlecleucel that demonstrated durable responses in patients with relapsed/refractory DLBCL.⁵ Unlike pharmacokinetics for conventional drugs, cellular kinetics describe net kinetics resulting from in vivo proliferation and cell death of the administered modified T-cell product.⁷ Correlation of CAR-T cellular kinetics with efficacy/safety outcomes is important for improving our understanding of expansion and persistence of this “living drug” with regard to safety/efficacy endpoints and for optimizing a safe and efficacious dose range.⁸

Tisagenlecleucel cellular kinetics in peripheral blood are well characterized for tumors primarily located in peripheral blood/bone marrow (such as B-ALL).^{3,7,9} DLBCL is a B-cell malignancy localized primarily in lymph nodes and extranodal/extramedullary sites; it is important to determine if tisagenlecleucel cellular kinetics in peripheral blood correlate with safety/efficacy endpoints (because current understanding of CAR-T cell infiltration in tumor tissue and interaction with the microenvironment is limited). Data from JULIET showed comparable tisagenlecleucel exposure in peripheral blood by quantitative polymerase chain reaction (qPCR; quantification of CAR transgene levels) in responders and non-responders, with longer persistence in patients with sustained response.⁵ To improve our understanding of cellular kinetics of CAR-based therapy, especially for tumors in lymph nodes and extranodal/extramedullary sites, we report an analysis of correlations between cellular kinetics and the following parameters in DLBCL in JULIET: product characteristics, intrinsic/extrinsic factors, tumor characteristics (CD19 expression, baseline tumor burden), efficacy/safety, B-cell aplasia (including correlations between B-cell aplasia and baseline rituximab levels), dose (including correlations between dose and efficacy/safety), and immunogenicity (including correlations between immunogenicity and efficacy).

Methods

Study design, patients, and treatment

JULIET (NCT02445248) is a single-arm, open-label, multicenter, global, phase 2 study evaluating tisagenlecleucel efficacy/safety in patients ≥ 18 years with relapsed/refractory DLBCL (see supplemental Methods for additional information).⁵ Tisagenlecleucel is manufactured by transduction of patient cells obtained by leukapheresis.¹⁰ The study was approved by institutional review boards at participating institutions. Patients provided written informed consent.

Bioanalytical methods

Peripheral blood and bone marrow aspirates were collected from patients for evaluation of postinfusion tisagenlecleucel transgene levels via qPCR and CAR⁺ viable T cells (percentage of CD3⁺/CAR⁺ cells) via flow cytometry. The details related to the analytical methods have been previously published.⁹ qPCR and flow cytometry

measurements were made before lymphodepleting chemotherapy (or within 3 weeks of infusion if no lymphodepleting chemotherapy was given); just after infusion; days 4, 7, 11, 14, 17, 21, and 28; and months 2, 3, 6, 9, 12, 18, and 60. Based on previous experience in ALL, qPCR analyses appeared to be more sensitive than flow cytometry⁷; therefore, additional qPCR measurements were done on day 2 and months 24, 30, 36, 42, 48, and 54. Bone marrow collection occurred at screening, day 28 if the patient was in complete response (CR), and month 3. Partitioning of tisagenlecleucel transgene was assessed by the ratio of bone marrow concentrations to peripheral blood levels.

Cellular kinetics exposure parameters included maximal expansion of transgene/CAR-positive T-cell levels in vivo postinfusion (C_{max}), time to maximal expansion (t_{max}), exposure up to 28 days (area under the curve [AUC]_{0-28d}), and persistence (duration transgene/CAR-T cells are present in peripheral blood and tissues [t_{last}]). Results are reported as transgene copies/microgram of genomic DNA for qPCR and percent of CAR-positive cells among CD3-positive T cells in blood for flow cytometry. Assuming white blood cell counts of 2000 cells/ μ L, lymphocyte DNA content of 7 pg/cell,¹¹ and 1 transgene copy/cell (for illustrative purposes; multiple transgene copies/cell have been observed), 1000 copies/ μ g corresponds to ~ 14 CAR-T cells/ μ L.

Supplemental Figure 1 presents relationships between cellular kinetics and the endpoints analyzed. Associations were made between cellular kinetic parameters and select product characteristics (T cells percentage, cell viability, transduction efficiency, total cell count, interferon- γ release, CD4:CD8 ratio), intrinsic/patient factors (age, race, sex, body weight, prior disease status, disease stage, burden of disease), and extrinsic/treatment factors (prior hematopoietic stem cell transplant status, type of lymphodepleting chemotherapy, number of prior lines of therapy). Quantitative immunofluorescent staining for CD19, assessed by automated quantitative analysis on archival/new biopsies collected before enrollment (supplemental Methods) was used to retrospectively assess influence of CD19 expression on cellular kinetics. Impact of baseline tumor burden, quantified using positron emission tomography (supplemental Methods), on in vivo cellular kinetics was investigated. Total metabolic tumor volume (total volume of all individual nodal/extranodal lesions and focal organ involvement) was selected as an indicator of overall disease burden.¹²

Associations were evaluated between cellular kinetic parameters and clinical efficacy (3-month response status [an indicator of clinically meaningful benefit],⁵ duration of response [DOR]), and safety parameters (cytokine-release syndrome [CRS] severity, tocilizumab use for CRS management, neurologic event severity).

CD19⁺ B-cell levels were evaluated pre-/postinfusion to monitor B-cell aplasia (an on-target/off-tumor effect of CAR-T therapy that can lead to hypogammaglobulinemia and related infections, but can also be used as a pharmacodynamic measure of tisagenlecleucel function).¹³ Because rituximab can cause long-term B-cell aplasia (lasting approximately 6 to 12 months),^{14,15} rituximab levels were evaluated at baseline (day -1) and post-tisagenlecleucel infusion (days 7, 21) to distinguish tisagenlecleucel effects on B cells (prolongation of B-cell aplasia) in peripheral blood from that of prior rituximab treatment (supplemental Methods).

Effects of dose on tisagenlecleucel exposure, clinical response, and safety endpoints were assessed to determine the recommended

dose range for clinical use. Positive relationships were previously observed between CRS severity and baseline tumor burden in pediatric B-ALL (tumor burden defined by percentage bone marrow blasts)⁷ and DLBCL (tumor burden defined by active tumor volume or presence of bulky disease).¹⁶ Therefore, influence of baseline tumor burden on the dose-CRS relationship was investigated.

Preexisting and postinfusion antibodies (humoral immunogenicity) and T-cell responses (cellular immunogenicity) were summarized, and influence on cellular kinetics and efficacy were analyzed. Methods for assessment of humoral immunogenicity have been published elsewhere (supplemental Methods).^{9,17} Cellular immunogenicity against tisagenlecleucel was evaluated by measuring CD4⁺/CD8⁺ T-cell activation (percentage of interferon γ -positive cells detected by intracellular staining and subsequent flow cytometric analysis) in response to mCAR19-derived peptides. The assay measure is referred to as net responses (mCAR19 peptide pool response—dimethylsulfoxide negative control response) and was calculated for 2 nonidentical mCAR19 peptide pools (pool 1 and pool 2, comprising 60 and 59 overlapping 15-mer peptides derived from the mCAR19 protein sequence, respectively). The maximum net responses were related to the exposure metrics and clinical outcome for both peptide pools.

Statistical analysis

Cellular kinetics exposure parameters were estimated using non-compartmental methods using Phoenix WinNonlin, version 6.4 (Pharsight Corp., St. Louis, MO). Associations between cellular kinetics, select product characteristics, and intrinsic/extrinsic factors were explored using linear models and scatter plots for continuous variables, and summary statistics and box plots for categorical variables. Associations between cellular kinetics, CD19 expression, and baseline tumor burden were assessed using linear regression. Effects of cellular kinetics on 3-month response were evaluated using summary statistics, concentration-time profiles, and logistic regression. Effects on DOR were assessed using the Kaplan-Meier method by median estimate of cellular kinetic parameters and Cox regression. Effects on CRS and neurologic events were explored using box plots and logistic regression. The time course of B-cell levels by presence of baseline rituximab was explored. Additionally, the time course of B-cell levels and tisagenlecleucel transgene levels were plotted. Associations between cellular kinetics and dose were explored using scatter plots. Effects of dose on 3-month response and safety were assessed using logistic regression analysis with associated odds ratios (OR). The influence of baseline tumor burden on the dose-CRS relationship was investigated using an additional logistic regression model including dose, tumor burden, and an interaction between the 2. A multivariate analysis was also performed to evaluate the impact of C_{max}, dose, and tumor burden on probability of high-grade CRS and neurologic events. The influence of humoral and cellular immunogenicity on cellular kinetics and efficacy were explored using scatter plots and box plots, respectively, as well as summary statistics. It should be noted that these analyses were exploratory in nature, rather than confirmatory.

Results

Tisagenlecleucel cellular kinetics

Data from 111 patients who received tisagenlecleucel were included in the full, safety, and pharmacokinetics analysis sets, of

Table 1. Summary of peripheral blood cellular kinetic parameters by flow cytometry for tisagenlecleucel by response at month 3

Parameter	CR/PR	SD/PD/unknown
AUC_{0-28d}, %CD3⁺CAR⁺ cells* × d	n = 35†	n = 44†
Geometric mean (% CV)	36.9 (214.7)	42.0 (299.3)
C_{max}, %CD3⁺CAR⁺ cells*	n = 34	n = 50
Geometric mean (% CV)	4.81 (169.7)	4.18 (232.9)
Range	(0.600-40.9)	(0.300-61.5)
t_{max}, d	n = 34	n = 50
Median (range)	6.35 (2.91-271)	7.64 (2.82-25.9)
C_{last}, %CD3⁺CAR⁺ cells*	n = 35	n = 50
Geometric mean (% CV)	0.289 (165.2)	0.539 (313.2)
t_{last}, d	n = 35	n = 50
Median (range)	280 (21-554)	28.1 (9.01-400)

CV, coefficient of variation; PR, partial response; SD, stable disease.

*Percentage of CAR⁺ cells among CD3⁺ T cells.

†Patients who had ≥ 1 sample with evaluable cellular kinetics data were included.

which 93 patients with ≥ 3 months of follow-up were included in the efficacy analysis set (supplemental Results).⁵ Median and maximum follow-up were similar in responders (15.3 and 23.6 months, respectively; n = 35) and nonresponders (14.6 and 26.2 months, respectively; n = 58); 38 nonresponders received additional anticancer therapy following tisagenlecleucel infusion. Tisagenlecleucel cellular kinetics have been previously reported in pediatric B-ALL and in adult DLBCL using qPCR.^{5,9} Results by flow cytometry are included in Table 1. A moderate correlation was observed between expansion and exposure in transgene levels by qPCR and CAR-positive cells by flow cytometry in DLBCL (C_{max}, $r^2 = 0.47$; AUC_{0-28d}, $r^2 = 0.49$; supplemental Figure 2). qPCR was a more sensitive assay than flow cytometry; hence, correlations were performed using qPCR data, unless otherwise specified. C_{max} and AUC_{0-28d} by qPCR were observed to be highly correlated ($r^2 = 0.93$). Representative profiles of tisagenlecleucel cellular kinetics in DLBCL and B-ALL (from the ELIANA study^{3,9}) are presented in the supplemental Results (see text; supplemental Figure 3). Individual tisagenlecleucel cellular kinetics profiles in DLBCL by response have been previously published.⁵

qPCR data from bone marrow biopsy samples were available from a limited number of patients (14 patients at day 28 and 33 patients at month 3) following tisagenlecleucel infusion. Bone marrow transgene levels at day 28 were nearly 70% of that in blood in both responders and nonresponders. At month 3, bone marrow levels were $\sim 50\%$ of blood levels, demonstrating a high extent of bone marrow persistence.

No apparent relationships were identified between cellular kinetics and select final product characteristics (Figure 1) or baseline intrinsic (Figure 2) or extrinsic (Figure 3) factors. Baseline CD19 expression by quantitative immunofluorescent staining of tumor samples (supplemental Figure 4A) and baseline tumor burden (supplemental Figure 4B) was not associated with in vivo C_{max}. Baseline CD19 expression was also not associated with median overall survival (12.5 months; 95% confidence interval [CI], 6.5 to not estimable vs 10.3 months; 95% CI, 4.0 to not estimable).

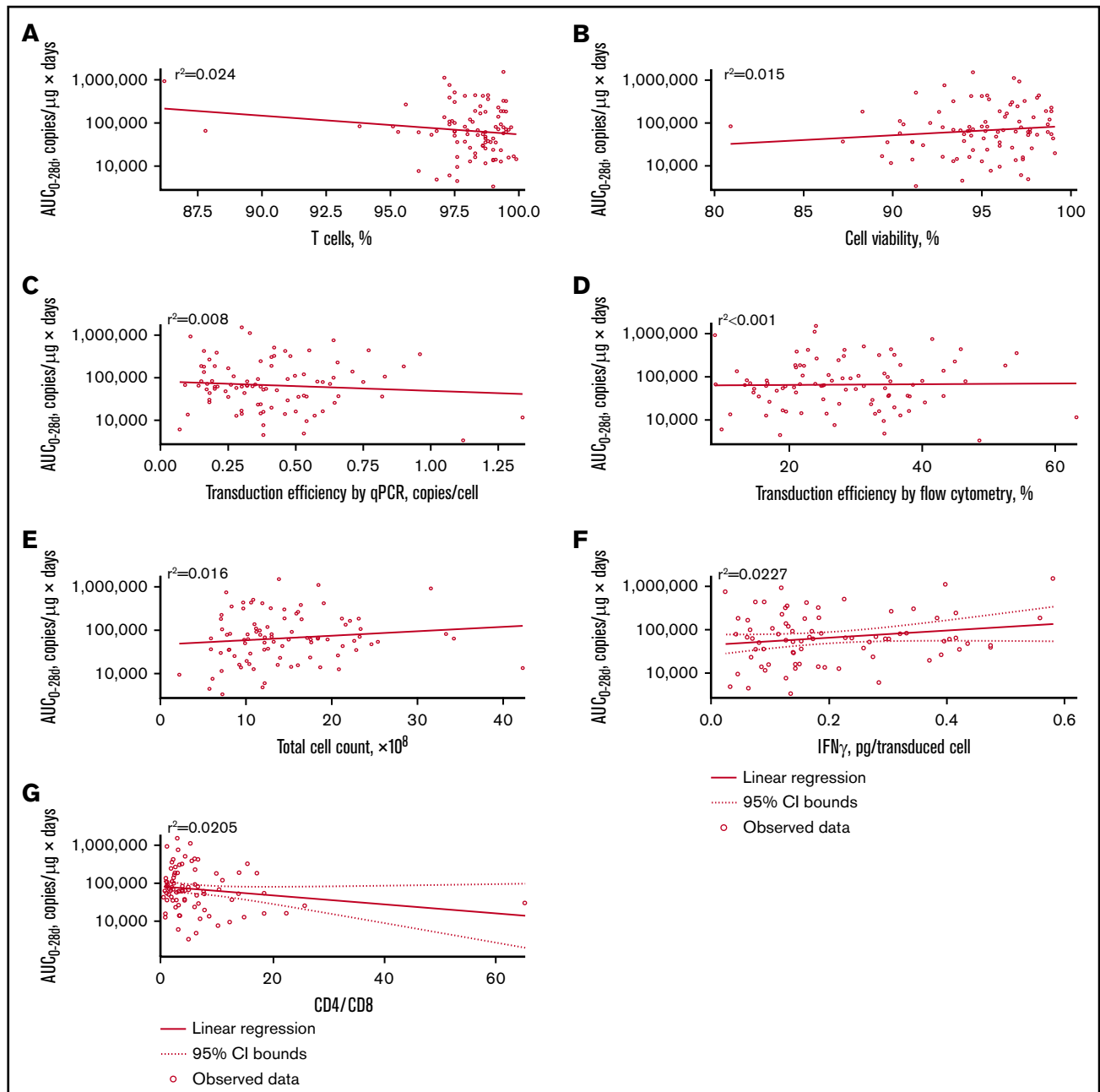


Figure 1. Relationship between product characteristics and tisagenlecleucel cellular kinetics. Relationship between percentage of T cells (A), cell viability (B), transduction efficiency by qPCR (C), transduction efficiency by flow cytometry (D), total cell count (E), interferon- γ (IFN- γ) release (F), and CD4:CD8 ratio vs AUC_{0-28d} (G).

Cellular kinetics (by flow cytometry) were similar between responders and nonresponders (Table 1). Median t_{last} by flow cytometry was 280 days in responders and 28 days in nonresponders; however, no differences in C_{max} were observed between responders and nonresponders. No statistically significant relationship was observed between C_{max} and 3-month response (Figure 4A). Patients with higher-than-median C_{max} had a potentially longer DOR versus those with lower-than-median C_{max} (Figure 4B), but stratification by median C_{max} or concentration at month 3 (Figure 4C) did not result in statistically significant differences in DOR.

Grade 3/4 CRS was associated with higher C_{max} (Figure 4D; supplemental Table 1) and AUC_{0-28d} (data not shown) vs no/low-grade CRS. Higher C_{max} was associated with increased estimated probability of any-grade (Figure 4E) or grade 3/4 CRS (OR with twofold increase in C_{max} , 1.70 [95% CI, 1.254-2.294]), based on logistic regression models. Geometric mean C_{max} was also higher among patients who received tocilizumab for CRS management ($n = 13$) vs those who did not ($n = 78$; 18 700 vs 4840 copies/ μ g). Higher AUC_{0-28d} was observed in patients treated with corticosteroids ($n = 9$) than in patients who did not receive corticosteroids ($n = 81$). Most patients who received tocilizumab also received

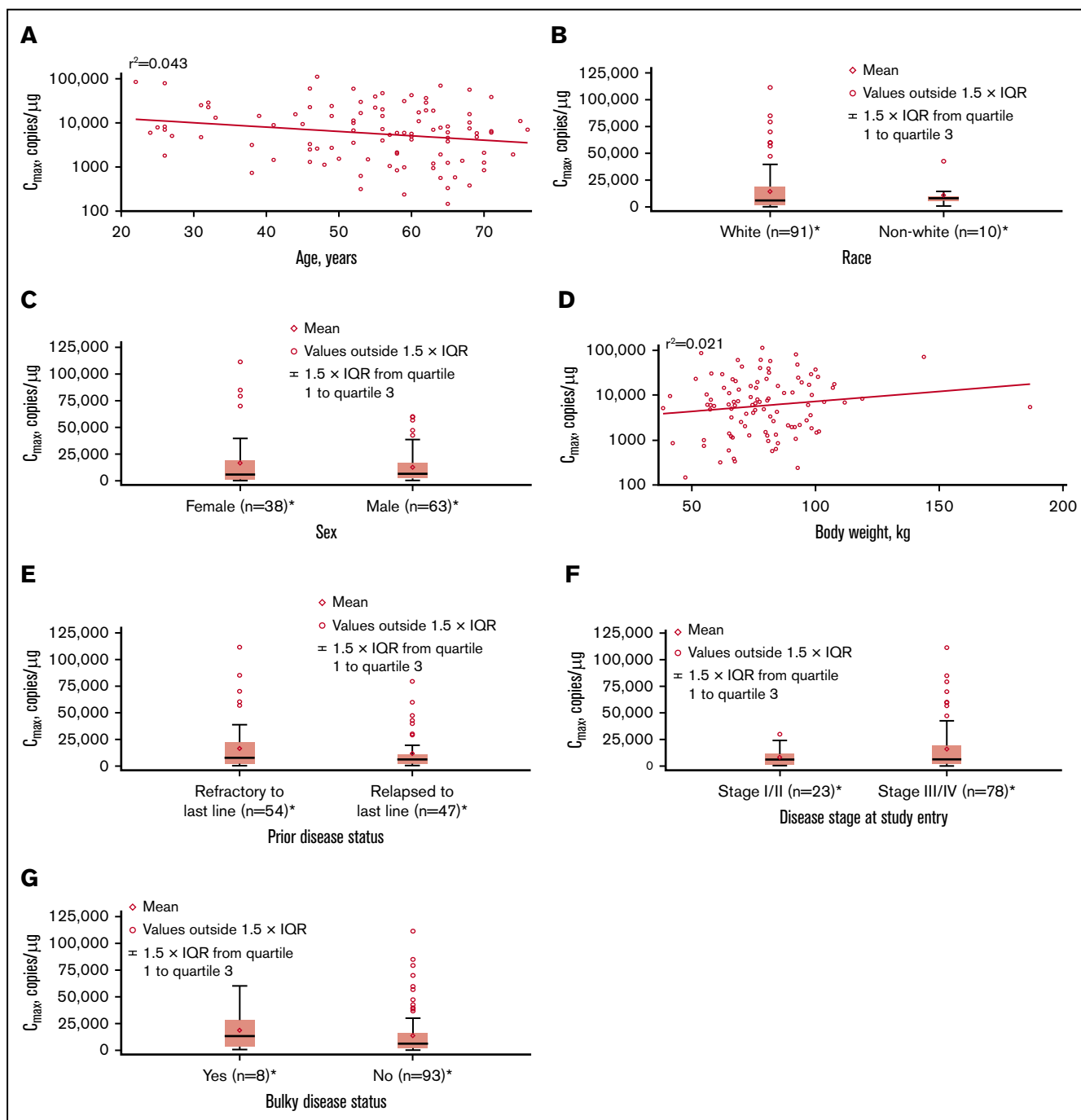


Figure 2. Influence of intrinsic factors on tisagenlecleucel cellular kinetics. Influence of age (A), race (B), sex (C), body weight (D), prior disease status (E), disease stage at study entry (F), and burden of disease (G) on C_{max} . *Patients who had ≥ 1 sample with evaluable cellular kinetics data were included. IQR, interquartile range.

corticosteroids. No relationship was observed between C_{max} and any-grade (Figure 4F) or grade 3/4 neurologic events (supplemental Table 1).

B-cell aplasia

Most patients received rituximab and/or other CD20 antibodies (known to cause long-term B-cell aplasia) as treatment for lymphoma before tisagenlecleucel infusion; 70% received rituximab ≤ 6 months preinfusion (supplemental Table 2). Most patients had

measurable baseline rituximab levels. Rituximab levels at baseline and at 7 and 21 days post-tisagenlecleucel infusion reflected the expected concentrations based on its known half-life (~ 22 days¹⁴). Eight patients received other CD20 antibodies during the bridging therapy phase before tisagenlecleucel infusion (obinutuzumab, $n = 7$; ofatumumab, $n = 1$).

Only 1 patient had normal baseline peripheral blood CD19⁺ B-cell levels (80-616 cells/ μ L); most patients had levels below the lower

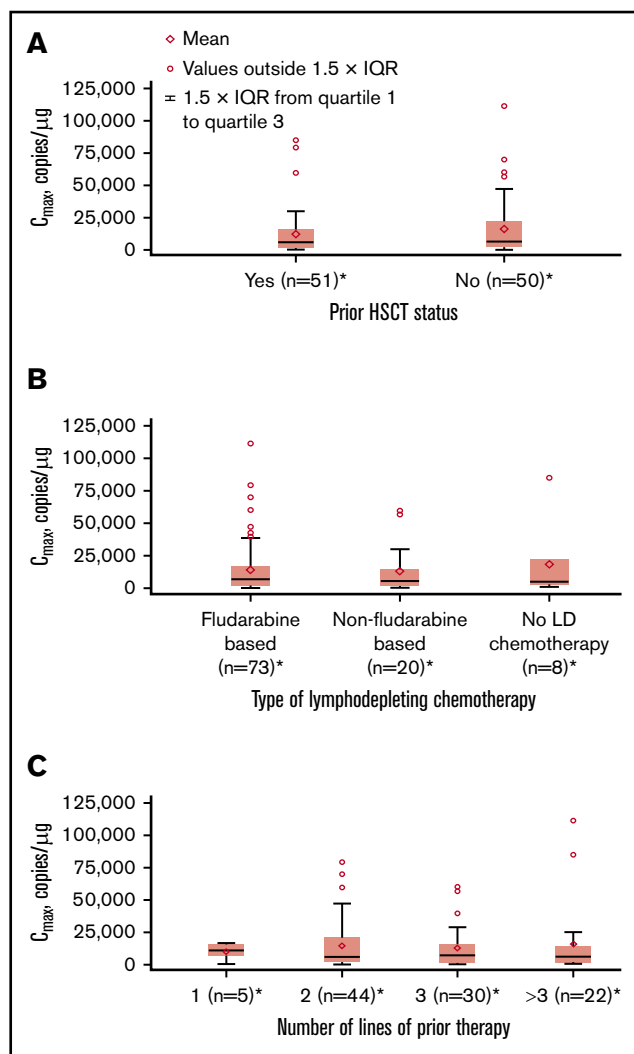


Figure 3. Influence of extrinsic factors on tisagenlecleucel cellular kinetics. Influence of prior hematopoietic stem cell transplant (HSCT) status (A), type of lymphodepleting (LD) chemotherapy (B), and number of lines of prior therapy (C) on C_{max} . *Patients who had ≥ 1 sample with evaluable cellular kinetics data were included.

limit of quantification (LLOQ; 0.2 cells/ μ L).⁵ CD19⁺ B-cell levels over time versus baseline rituximab are shown in supplemental Figure 5A.

Representative plots for 12 patients with B-cell levels >30 cells/ μ L indicated a clear trend toward increasing B-cell levels with declining tisagenlecleucel transgene levels (supplemental Figure 5B). Patient 2 experienced a partial response, patients 1 and 5 experienced progressive disease (PD), and the remaining 9 patients experienced CR. At last follow-up, 6 patients had ongoing CR with B-cell recovery in normal range (80-616 cells/ μ L), 4 of whom also had transgene persistence.

Dose justification

CAR⁺ viable T-cell doses in this study ranged from 0.089×10^8 to 6.0×10^8 , and showed no relationship with C_{max} (Figure 5A). Dose-efficacy analyses showed responses across doses from 0.6×10^8

to 6.0×10^8 CAR⁺ viable T cells, with no apparent effect on 3-month response (Figure 5B). The patient who received a 0.089×10^8 CAR⁺ viable T-cell dose did not achieve a favorable clinical response. DOR was similar above and below the median dose (3.0×10^8 CAR⁺ viable T cells; Figure 5C).

Logistic regression analyses showed increased estimated probability of grade 3/4 CRS with higher tisagenlecleucel dose (Figure 5D). However, after adjusting for baseline tumor burden, there was no significant relationship between dose and grade 3/4 CRS (OR for twofold increase in dose at median tumor volume was 2.246 [95% CI, 0.684-7.375]). The estimated probabilities of grade 3/4 CRS for 5.0×10^8 to 6.0×10^8 CAR⁺ viable T cells were comparable (0.363 to 0.428, respectively). Multivariate analysis confirmed that dose had no significant impact on the estimated probability of grade 3/4 CRS, whereas tumor burden did have a statistically significant impact (supplemental Table 1). There was no apparent effect of dose on estimated probability of grade 3/4 neurologic events (Figure 5E; supplemental Table 1). Based on all available data, the recommended dose was determined to be 0.6×10^8 to 6.0×10^8 CAR⁺ viable T cells.

Immunogenicity

Most patients (91.4%) had detectable preexisting anti-mCAR19 antibodies at baseline, which had no effect on C_{max} in this study (Figure 6A). Increased titers of treatment-induced anti-mCAR19 antibodies postinfusion occurred in 5% of patients. The maximum fold-change in the anti-mCAR19 antibody response postinfusion relative to baseline had no impact on 3-month response (Figure 6B).¹⁸

Cellular responses to mCAR19 peptides, determined by percentage of T cells activated at preinfusion and up to 12 months postinfusion, were consistently low ($\sim 1\%$) over time for individual patients. There was no relationship between cellular immunogenicity and 3-month response for peptide pools 1 (Figure 6C) and 2 (data not shown).

Discussion

In adult patients with relapsed/refractory DLBCL, tisagenlecleucel showed rapid *in vivo* expansion and persistence for up to 24 months (693 days by qPCR).⁵ Although similar patterns of expansion and biexponential decline were observed in DLBCL and B-ALL, geometric mean tisagenlecleucel expansion in peripheral blood was nearly sixfold lower in DLBCL vs B-ALL (C_{max} by qPCR, 6210 vs 34 700 copies/ μ g in responders).^{5,9} Differences in CAR⁺ cell trafficking to target sites (lymph nodes, bone marrow, other extranodal/extramedullary sites in DLBCL vs blood/marrow in B-ALL) or intrinsic T-cell differences were potentially responsible for the lower tisagenlecleucel C_{max} seen in peripheral blood of DLBCL patients. Most patients with 3-month response had detectable transgene at the time of response assessment and continued persistence in peripheral blood ≥ 6 months postinfusion, and some patients who experienced relapse had detectable transgene at the time of relapse.⁵ A distinguishing feature in responders with DLBCL was the long terminal clearance phase observed (geometric mean tisagenlecleucel apparent terminal half-life by qPCR, 91.3 days¹⁹ vs 16.8 days in pediatric B-ALL).⁹ In DLBCL, CAR-T cells partition between target tissues (lymph nodes, extranodal/extramedullary sites) and blood; therefore, cell trafficking between these sites may result

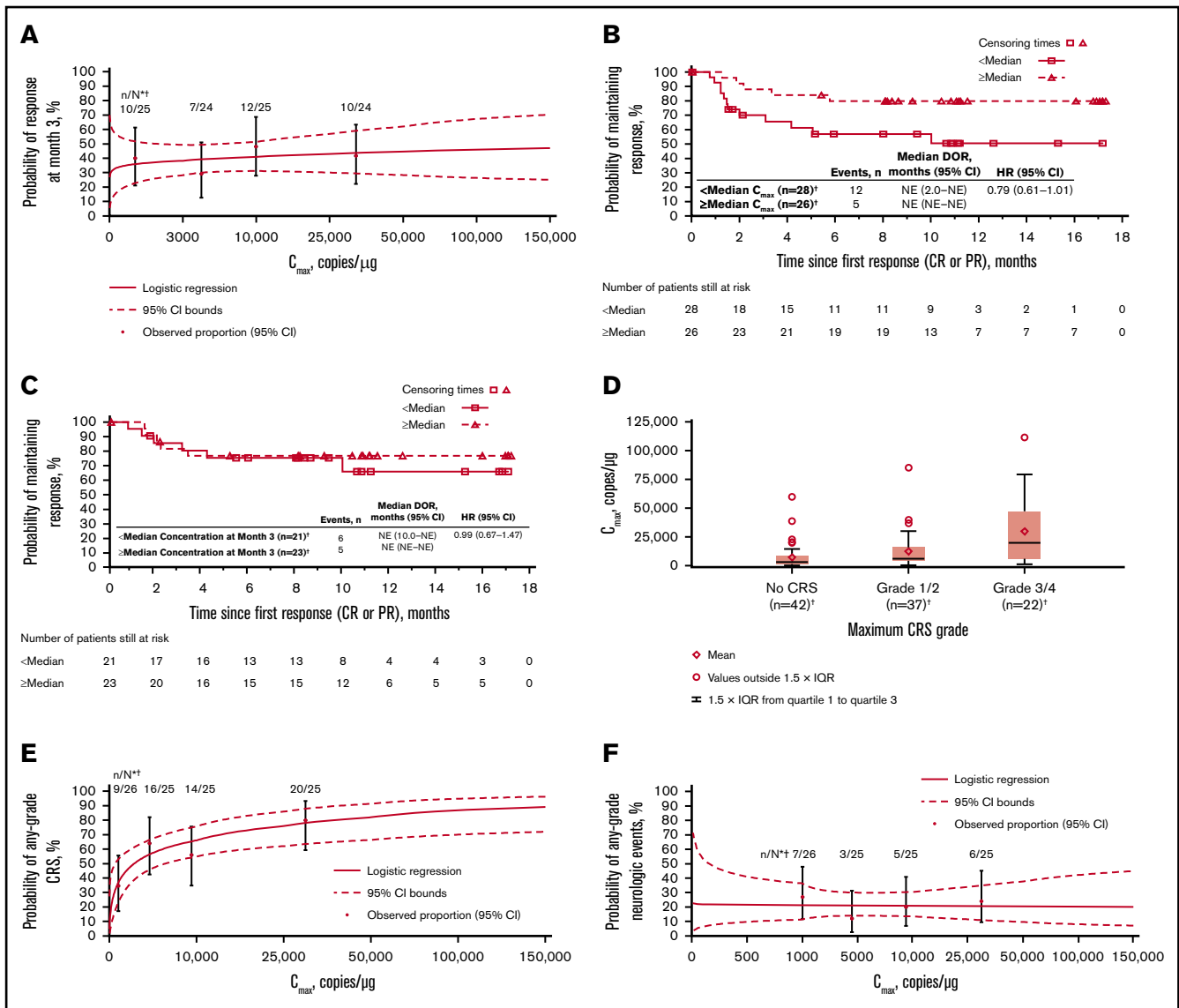


Figure 4. Exposure-efficacy and exposure-safety analyses. (A) Logistic regression of 3-month response vs C_{max} overlaid with observed proportions (95% CI) by quartile. The estimated OR for having a 3-month response with a twofold increase in C_{max} was 1.09 (95% CI, 0.897-1.321). Kaplan-Meier plots of DOR, based on response at any time, by median C_{max} (B) and by median concentration (C) at month 3. Based on the Cox regression model of DOR by log of C_{max} (B), the hazard ratio for a twofold increase in C_{max} was 0.79 (95% CI, 0.61-1.01). (D) Tisagenlecleucel exposure by CRS grade. Geometric mean C_{max} was 3200, 6210, and 16000 copies/ μ g in patients with no (n = 42), grade 1/2 (n = 37), and grade 3/4 (n = 22) CRS, respectively. Diamonds represent mean values and circles represent values outside of $1.5 \times$ IQR. Lower and upper whiskers extend to the most extreme points within $1.5 \times$ IQR of quartile 1 and quartile 3, respectively. (E) Logistic regression of any-grade CRS vs C_{max} by qPCR, overlaid with observed proportions (95% CI) by quartile. The estimated OR for having any-grade CRS with a twofold increase in C_{max} was 1.44 (95% CI, 1.159-1.794). (F) Logistic regression of any-grade neurologic events vs C_{max} by qPCR, overlaid with observed proportions (95% CI) by quartile. *n/N is the number of patients with 3-month response/total number of patients in the quartile range. [†]Patients who had ≥ 1 sample with evaluable cellular kinetics data were included. NE, not estimable.

in a longer half-life compared with B-ALL where the target is predominantly in blood. Maximal expansion by qPCR and flow cytometry were correlated in DLBCL, although the qPCR assay was more sensitive, similar to previously reported results in pediatric B-ALL.⁷ The shorter persistence detected by flow cytometry (554 days maximum in responders) compared with qPCR (693 days maximum in responders⁵) may be attributed to loss of CAR surface expression, CAR-T cell sequestration from blood into tissues, and/or the relatively lower sensitivity of flow cytometry.

Tisagenlecleucel product characteristics, including CD4:CD8 ratio, did not influence in vivo cellular kinetics, providing clinical justification for the specification range for these characteristics. The intrinsic/extrinsic patient characteristics evaluated in this study and baseline CD19 tumor expression did not influence cellular kinetics. The limitation of assessing CD19 expression based on a single baseline biopsy should be noted and heterogeneity of CD19 expression from different lesions or areas of lymph nodes could exist. As reported previously, baseline CD19 tumor expression did not influence overall response rates (49% [95% CI, 34-64] with

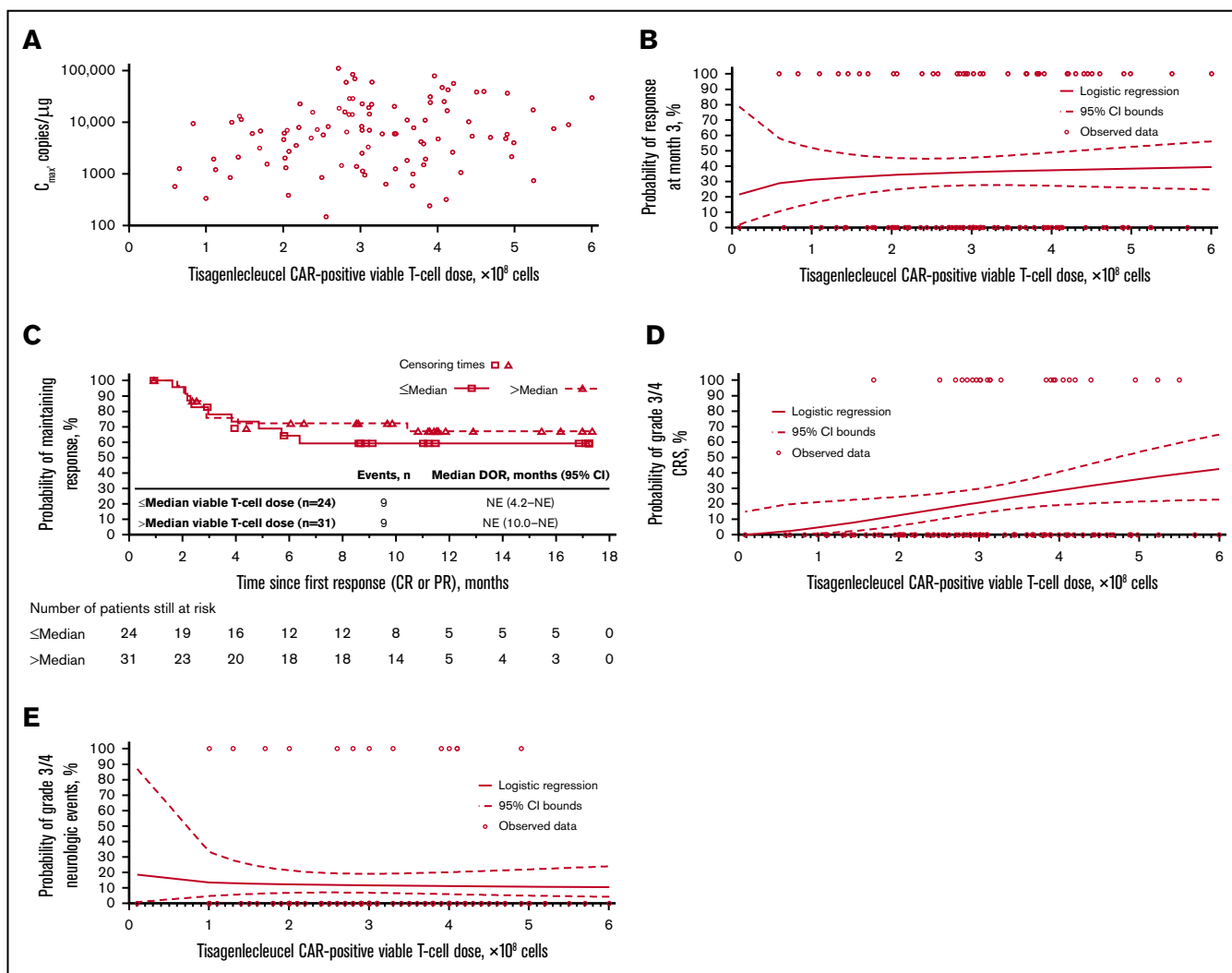


Figure 5. Tisagenlecleucel dose-exposure, dose-response, and dose-safety analyses. Dose-exposure analysis: (A) Scatter plot of C_{max} vs CAR⁺ viable T-cell dose. Dose-response analysis: (B) Logistic regression of 3-month response vs CAR⁺ viable T-cell dose, overlaid with individual data. (C) Kaplan-Meier plot of DOR, based on response at any time, by median CAR⁺ viable T-cell dose. Dose-safety analysis: (D) Logistic regression of grade 3/4 CRS vs CAR⁺ viable T-cell dose, overlaid with individual data. The estimated OR for having grade 3/4 CRS with a twofold increase in dose was 2.82 (95% CI, 1.116-7.150). After adjusting for baseline tumor burden, the estimated OR for having grade 3/4 CRS with a twofold increase in dose was 2.246 (95% CI, 0.684-7.375). (E) Logistic regression of grade 3/4 neurologic events vs CAR⁺ viable T-cell dose, overlaid with individual data. The estimated OR for having grade 3/4 neurologic events with a twofold increase in dose was 0.89 (95% CI, 0.445-1.801).

CD19⁺ expression vs 50% [95% CI, 29-71] with CD19-low/⁻ expression),⁵ and our analysis also found no effect on median overall survival. Based on these exploratory analyses, low/undetectable CD19 expression may be sufficient for tisagenlecleucel efficacy, and there is no lower threshold level of CD19 expression in DLBCL tissue which could be used to exclude DLBCL patients from tisagenlecleucel treatment. Similar response rates between patients with CD19⁻ and CD19⁺ disease at baseline have been observed in the ZUMA-1 study, which underscores the limitation in CD19 detection.²⁰ Notably, no association was observed between baseline tumor burden and cellular kinetics, perhaps because cellular kinetics measured in peripheral blood may not fully reflect tisagenlecleucel interactions with antigens at tumor sites.

Similar cellular kinetics by flow cytometry in peripheral blood were observed for responders and nonresponders, consistent with qPCR

results⁵ and peak expansion results from a single-center study in relapsed/refractory DLBCL patients.⁶ In contrast, greater expansion and persistence were seen in responders vs nonresponders in previous studies in chronic lymphocytic leukemia (CLL) and B-ALL.^{7,21} Most responders demonstrated persistence in this analysis using flow cytometry (median t_{last} , 280 days) and based on previous qPCR results (median t_{last} , 289 days),⁵ an important consideration in this patient population with limited treatment options. Median t_{last} in nonresponders was 28 days by flow cytometry and 57 days by qPCR.⁵ It is important to note that persistence can be influenced by data cutoff and length of follow-up, with limited follow-up generally observed in nonresponders; therefore, comparison between responders and nonresponders was possibly confounded. Patients with higher-than-median C_{max} had longer DOR vs patients with lower-than-median C_{max} ; however, the difference was not statistically significant; this should continue

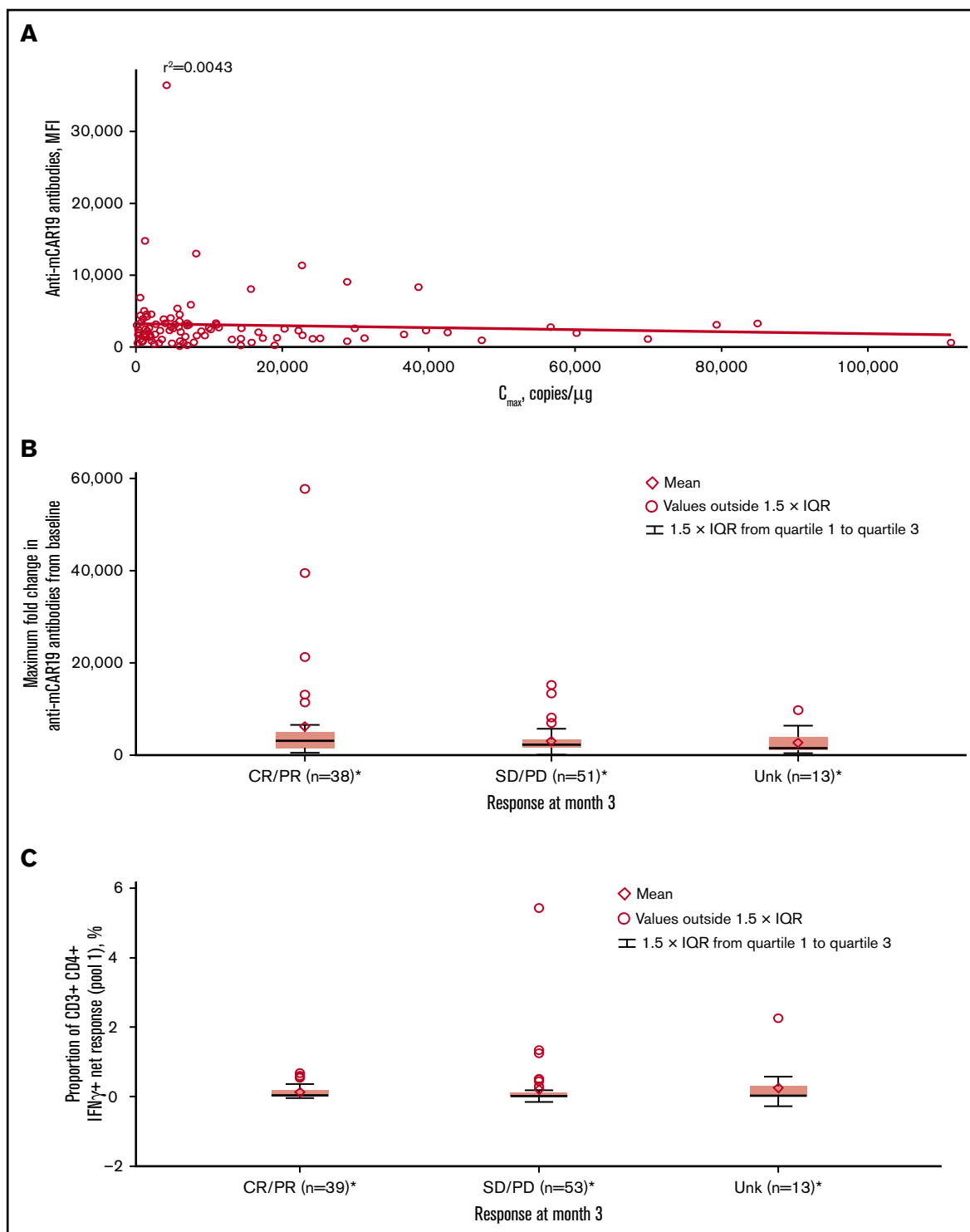


Figure 6. Associations between immunogenicity, cellular kinetics, and response rate. (A) Anti-mCAR19 antibodies at enrollment vs tisagenlecleucel cellular kinetics (C_{max}). (B) Maximum fold change from baseline for anti-mCAR19 antibodies by 3-month response. (C) Cellular immunogenicity vs 3-month response. *Patients who had ≥ 1 sample with evaluable cellular kinetics data were included. mCAR19, murine anti-CD19 chimeric antigen receptor; MFI, mean fluorescence intensity; SD, stable disease; Unk, unknown.

to be monitored with additional follow-up. The separation in DOR curves based on C_{max} was greater than that observed with stratification by median concentrations at 3 months, suggesting

maximal expansion may contribute more to longer DOR in responders than the effect of transgene persistence. It has been previously shown that although persistent transgene has been

observed in most responders, some patients maintained response despite loss of transgene.¹⁹ Therefore, it seems plausible that the extent of expansion drives durable responses in patients with DLBCL.

CRS, an on-target toxicity that can be managed with the CRS management algorithm,³ is the most commonly observed adverse event related to CAR-T cell therapies.^{3,22} There were no CRS-related deaths in the study, and CRS was generally manageable using the CRS management algorithm.⁵ The trend for higher tisagenlecleucel expansion with increasing CRS severity seen in DLBCL patients is consistent with pediatric B-ALL and CLL studies,⁷ despite lower expansion in DLBCL. This suggests that transgene levels in peripheral blood, irrespective of indication, are related to CRS severity. It is likely that following target engagement, proinflammatory cytokines secreted by CAR-T cells and bystander cells promote expansion.²³ Patients who received tocilizumab for CRS management experienced greater tisagenlecleucel expansion. However, patients with higher grade CRS generally have greater expansion and require tocilizumab per the CRS algorithm³; hence, the observed effects cannot be attributed to tocilizumab use. Patients treated with corticosteroids had greater tisagenlecleucel exposure. This effect might have been confounded by tocilizumab administration (because most patients who received tocilizumab also received corticosteroids), CRS, or baseline tumor burden. Most patients treated with corticosteroids in JULIET received <2 mg/kg methylprednisolone/day for a short duration and were weaned rapidly, per the CRS management algorithm. The effect of corticosteroids on efficacy could not be determined as only a limited number of patients required intervention with steroids for CRS management. However, previous model-based analyses indicated no effect of tocilizumab or corticosteroids on rate of tisagenlecleucel transgene expansion in pediatric/young adult patients with B-ALL.²⁴ Our analysis found no relationships between exposure and neurologic events, consistent with results reported in patients with B-ALL and CLL.⁷

Analyses of B-cell aplasia following tisagenlecleucel infusion were confounded because of prior rituximab use. Most patients had baseline B-cell aplasia, which was expected given measurable preinfusion rituximab levels.⁵ Mean baseline CD19⁺ B-cell levels were higher in patients with baseline rituximab below the LLOQ compared with those above LLOQ.⁵ Nevertheless, there was a trend toward increasing B-cell levels with declining transgene levels postinfusion. Additionally, despite transgene persistence, normal B cells often recovered in patients with DLBCL who remained in remission.⁵ These results differ from those in patients with B-ALL, where transgene persistence and durable clinical responses were more closely related to ongoing B-cell aplasia.^{3,9}

Determination of a safe/efficacious dose range is based on understanding dose-response/exposure/safety analyses. Analyses conducted for dose justification indicated no apparent relationship between tisagenlecleucel dose and exposure. CAR-T cells have demonstrated the ability to undergo a rapid multilog expansion beyond the initial infused dose⁹; therefore, there is no relationship between dose and peak expansion or exposure. In DLBCL, CAR-T cells can further traffic to tumor sites and therefore transgene levels measured in blood may not represent the overall expansion of CAR-T cells. Responses were observed across a wide dose range (0.6 × 10⁸ to 6.0 × 10⁸ CAR⁺ T cells) and no impact of infused

tisagenlecleucel dose on DOR was observed because variation in degree of expansion was greater than variation in infused dose. An association was previously observed between baseline tumor volume and CRS severity.¹⁶ The relationship between dose and high-grade CRS in this analysis was not significant after adjusting for baseline tumor burden measured by tumor volume using positron emission tomography, indicating the important effect of baseline disease burden on CRS severity and consistent with observations in pediatric/young adult patients with B-ALL.⁷ No relationships were found between dose and neurologic events, consistent with results reported in patients with B-ALL with persistence measured beyond 1 year.⁹ Based on all available data, the recommended dose for tisagenlecleucel in DLBCL patients was determined to be a single intravenous infusion of 0.6 × 10⁸ to 6.0 × 10⁸ CAR⁺ viable T cells.

Although most patients had detectable preexisting anti-mCAR19 antibodies at baseline, this had no effect on tisagenlecleucel expansion. Similar preexisting antibodies (usually low affinity, low titer) have been detected for a variety of biotherapeutics and generally do not affect efficacy, safety, or risk of posttreatment antidrug antibody development.²⁵ Postinfusion antibodies and cellular immunogenicity did not affect overall responses.

Other studies evaluating anti-CD19 CAR-T cell therapies in patients with non-Hodgkin lymphoma (NHL), including DLBCL, have demonstrated associations between cellular kinetics and clinical outcomes. The ZUMA-1 trial with axicabtagene ciloleucel (CD28 costimulation) in patients with relapsed/refractory NHL found that CAR-T expansion was associated with response, exposure was associated with response, and peak expansion and AUC were associated with neurologic events (grade ≥3).^{20,26} A phase 1 JCAR017 (4-1BB costimulation) trial in patients with relapsed/refractory aggressive B-NHL demonstrated an association between higher mean peak levels and 3-month durable responses.²⁷ Data on a CAR-T therapy from Fred Hutchinson Cancer Research Center (4-1BB costimulation)²⁸ revealed that higher peak CAR-T cell numbers were associated with high-grade CRS in patients with relapsed/refractory B-ALL, CLL, or NHL,⁹ similar to our study. In contrast, ZUMA-1 with axicabtagene ciloleucel did not report any associations between peak expansion or AUC and high-grade CRS.²⁰ Relationships between baseline tumor burden and CRS were also not observed with axicabtagene ciloleucel^{20,29}; however, the sample size was limited. The discordance between the observations noted in JULIET and other CAR-T studies in DLBCL may be due to differences in costimulatory domains (4-1BB vs CD28), reported units (copies/μg vs cells/μL), or other study or population-related differences.

In summary, tisagenlecleucel demonstrated rapid expansion reaching maximum transgene levels approximately 9 days postinfusion, followed by sustained persistence for up to 24 months in relapsed/refractory DLBCL. Most patients who responded to therapy had tisagenlecleucel persistence in blood >6 months, and those who experienced high-grade CRS were more likely to have greater tisagenlecleucel expansion. This report characterizes tisagenlecleucel cellular kinetics in adult patients with relapsed/refractory DLBCL. Delineating tisagenlecleucel cellular kinetics and its relationship with other endpoints including safety, efficacy, and dose in DLBCL improved our understanding of how cellular kinetics affect efficacy and safety and how various factors affect cellular

kinetics. Furthermore, the analyses investigating the effect of dose on in vivo expansion, safety, and efficacy endpoints helped establish the recommended dose for DLBCL.

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Authorship

Contribution: All authors substantially contributed to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; and the drafting of the work or revising it critically for important intellectual content; and provided final approval of the version to be published; and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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lysates" (#9,688,959) with royalties paid to Cambium Medical Technologies, a patent "Compositions and Uses of Vasoactive Intestinal Peptide (VIP) Antagonists licensed to Cambium Oncology", a patent "Methods of treating cancer and infectious diseases using cell based therapies" (PCT/US2017/026222) licensed to Cambium Oncology, a patent "Antagonism of the VIP signaling pathway" (PCT/US2012/023268) licensed to Cambium Oncology, a patent "VIP Antagonists, Nanoparticles, and Uses in Treating Cancer" (#62/661,236) licensed to Cambium Oncology, a patent "Nanoparticles conjugated with an antagonist for VIP" (#62/584,196)

licensed to Cambium Oncology, and a patent "VIP and VIP Agonists, Nanoparticles, and Uses in Inflammatory T-Cell Mediated Disease" (#62/661,214) licensed to Cambium Oncology.

ORCID profiles: L.P., 0000-0002-7803-2366; S.J., 0000-0002-4335-2554; K.v.B., 0000-0002-8164-6211; G.S., 0000-0002-9541-8666; E.K.W., 0000-0003-0816-6729.

Correspondence: Rakesh Awasthi, Novartis Institutes for Biomedical Research, 3540C Building 315, One Health Plaza, East Hanover, NJ 07936; e-mail: rakesh.awasthi@novartis.com.

References

1. Kymriah (tisagenlecleucel). Full prescribing information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; 2018.
2. Buechner J, Kersten MJ, Fuchs M, Salmon F, Jäger U. Chimeric antigen receptor-T cell therapy: practical considerations for implementation in Europe. *Hemasphere*. 2018;2(1):e18.
3. Maude SL, Laetsch TW, Buechner J, et al. Tisagenlecleucel in children and young adults with B-cell lymphoblastic leukemia. *N Engl J Med*. 2018;378(5):439-448.
4. Kymriah (tisagenlecleucel). Summary of product characteristics. Dublin, Ireland: Novartis Europharm Limited, 2018.
5. Schuster SJ, Bishop MR, Tam CS, et al; JULIET Investigators. Tisagenlecleucel in adult relapsed or refractory diffuse large B-cell lymphoma. *N Engl J Med*. 2019;380(1):45-56.
6. Schuster SJ, Svoboda J, Chong EA, et al. Chimeric antigen receptor T cells in refractory B-cell lymphomas. *N Engl J Med*. 2017;377(26):2545-2554.
7. Mueller KT, Maude SL, Porter DL, et al. Cellular kinetics of CTL019 in relapsed/refractory B-cell acute lymphoblastic leukemia and chronic lymphocytic leukemia. *Blood*. 2017;130(21):2317-2325.
8. Hay KA, Hanafi LA, Li D, et al. Kinetics and biomarkers of severe cytokine release syndrome after CD19 chimeric antigen receptor-modified T-cell therapy. *Blood*. 2017;130(21):2295-2306.
9. Mueller KT, Waldron E, Grupp SA, et al. Clinical pharmacology of tisagenlecleucel in B-cell acute lymphoblastic leukemia. *Clin Cancer Res*. 2018;24(24):6175-6184.
10. Vairy S, Garcia JL, Teira P, Bittencourt H. CTL019 (tisagenlecleucel): CAR-T therapy for relapsed and refractory B-cell acute lymphoblastic leukemia. *Drug Des Devel Ther*. 2018;12:3885-3898.
11. Gillyooly JF, Hein A, Damiani R. Nuclear DNA content varies with cell size across human cell types. *Cold Spring Harb Perspect Biol*. 2015;7(7):a019091.
12. Buvat I, Nioche C, Dupont A, et al. Multicenter variability of total metabolic tumor volume estimates in FDG PET. *J Nucl Med*. 2017;58(suppl 1):609.
13. Maude SL, Frey N, Shaw PA, et al. Chimeric antigen receptor T cells for sustained remissions in leukemia. *N Engl J Med*. 2014;371(16):1507-1517.
14. RITUXAN (rituximab). South San Francisco, CA: Full prescribing information. Genentech, Inc. A Member of the Roche Group; 2012.
15. Dotan E, Aggarwal C, Smith MR. Impact of rituximab (rituxan) on the treatment of B-cell non-Hodgkin's lymphoma. *P&T*. 2010;35(3):148-157.
16. Maziarz RT, Schuster SJ, Ericson SG, et al. Cytokine release syndrome and neurotoxicity by baseline tumor burden in adults with relapsed or refractory diffuse large B-cell lymphoma treated with tisagenlecleucel. *Hematol Oncol*. 2019;37:307.
17. Potthoff B, McBlane F, Spindeldreher S, Sickert D. A cell-based immunogenicity assay to detect antibodies against chimeric antigen receptor expressed by tisagenlecleucel. *J Immunol Methods*. 2020;476:112692.
18. Mueller KT, Grupp S, Maude S, et al. Immunogenicity of tisagenlecleucel in relapsed/ refractory (R/R) B-cell acute lymphoblastic leukemia (B-ALL) and diffuse large B-cell lymphoma (DLBCL) patients [abstract]. *J Clin Oncol*. 2018;36(suppl). Abstract 3044.
19. Awasthi R, Mueller KT, Yanik GA, et al. Evaluation of in vivo CAR transgene levels in relapsed/refractory pediatric and young adult ALL and adult DLBCL tisagenlecleucel-treated patients [abstract]. *Blood*. 2018;132(suppl 1). Abstract 899.
20. Neelapu SS, Locke FL, Bartlett NL, et al. Axicabtagene ciloleucel CAR T-cell therapy in refractory large B-cell lymphoma. *N Engl J Med*. 2017;377(26):2531-2544.
21. Porter DL, Hwang WT, Frey NV, et al. Chimeric antigen receptor T cells persist and induce sustained remissions in relapsed refractory chronic lymphocytic leukemia. *Sci Transl Med*. 2015;7(303):303ra139.
22. Schuster SJ, Bishop MR, Tam C, et al. Global pivotal phase 2 trial of the CD19-targeted therapy CTL019 in adult patients with relapsed or refractory (R/R) diffuse large B-cell lymphoma (DLBCL)-an interim analysis. *Hematol Oncol*. 2017;35(suppl):27.
23. Makita S, Yoshimura K, Tobinai K. Clinical development of anti-CD19 chimeric antigen receptor T-cell therapy for B-cell non-Hodgkin lymphoma. *Cancer Sci*. 2017;108(6):1109-1118.
24. Stein A, Grupp S, Levine JE, et al. CTL019 model-based cellular kinetic analysis of chimeric antigen receptor (CAR) T cells to characterize the impact of tocilizumab on expansion and to identify correlates of cytokine release syndrome severity [abstract]. *Blood*. 2017;130 (suppl 1). Abstract 2561.

25. Xue L, Rup B. Evaluation of pre-existing antibody presence as a risk factor for posttreatment anti-drug antibody induction: analysis of human clinical study data for multiple biotherapeutics. *AAPS J*. 2013;15(3):893-896.
26. Neelapu SS, Locke FL, Bartlett NL, et al. Axicabtagene ciloleucel (axi-cel; KTE-C19) in patients with refractory aggressive non-Hodgkin lymphomas (NHL): primary results of the pivotal trial ZUMA-1 [abstract]. *Hematol Oncol*. 2017;35:8.
27. Abramson JS, Palomba ML, Gordon LI, et al. CR rates in relapsed/refractory (R/R) aggressive B-NHL treated with the CD19-directed CAR T-cell product JCAR017 (TRANSCEND NHL 001) [abstract]. *J Clin Oncol*. 2017;35(15). Abstract 7513.
28. Turtle CJ, Hanafi LA, Berger C, et al. CD19 CAR-T cells of defined CD4+:CD8+ composition in adult B cell ALL patients. *J Clin Invest*. 2016;126(6):2123-2138.
29. Dean E, Lu H, Lazaryan A, et al. Association of high baseline metabolic tumor volume with response following axicabtagene ciloleucel in refractory large B-cell lymphoma. *J Clin Oncol*. 2019;37(15 suppl):7562.