2026 CALIFORNIA

Head & Neck Cancer Consortium

FOSTERING COLLABORATION & SCIENTIFIC ADVANCEMENT

Hosted by City of Hope®

June 13, 2026

City of Hope | Duarte, CA

2026 California Head and Neck Cancer Consortium

Welcome to the 2026 California Head and Neck Cancer Consortium, in Duarte, CA!

On behalf of City of Hope and the Department of Continuing Medical Education, we would like to thank you for joining us for this educational activity.

Consortium Highlights Include:

- Interdisciplinary Collaboration Focused on Head and Neck Cancer Best of Class Diagnosis, Treatment and Survivorship
- Case Discussions and Review of Available Clinical Trials in California
- Networking Opportunities with Key Opinion Leaders and Multidisciplinary Experts from Top Institutions Fostering Scientific Advancement
- **Speech-Language Pathology Sessions Available!**

Our goal is to provide the desired information and skills which physicians and allied health care providers need in order to better serve their patient populations and research. Your thoughts are valuable and important, so please share them with us on the evaluation that will be emailed to you.

The link to the *Evaluation* can also be accessed under the **Evaluation & Notes** tab of this handout.

Should you have any questions, please visit the consortium staff at the registration desk.

For post-consortium CME information, please contact:

City of Hope
Department of Continuing Medical Education
1500 E. Duarte Road
Duarte, CA 91010
cme@coh.org
(626) 218-5622

Yuman Fong, MD, The Sangiacomo Family Chair in Surgical Oncology, and the Department of Surgery at City of Hope proudly welcomes you to the

2026 California
Head & Neck Cancer Consortium

June 13, 2026

City of Hope, Duarte

Co-Chaired by:

Ellie Maghami, MD

Professor and Chief
Division of Head and Neck Surgery
Norman and Sadie Lee Professor of Head and Neck Cancer
Department of Surgery
City of Hope

Sagus Sampath, MD

Associate Professor
Department of Radiation Oncology
Medical Director, Duarte Radiation
Section Chief, Head & Neck and Musculoskeletal Malignancies
City of Hope

Aditya Shreenivas, MD, MS

Assistant Professor
Department of Head & Neck Medical Oncology
Early Phase and Experimental Therapeutics Program
Interim Chief, Head & Neck Medical Oncology, City of Hope
Research Champion- Regional Clinical Research Hub (South Bay)
City of Hope

Taylor Wilde, MS, CCC-SLP

Speech-Language Pathology Supervisor
Rehabilitation Services
City of Hope

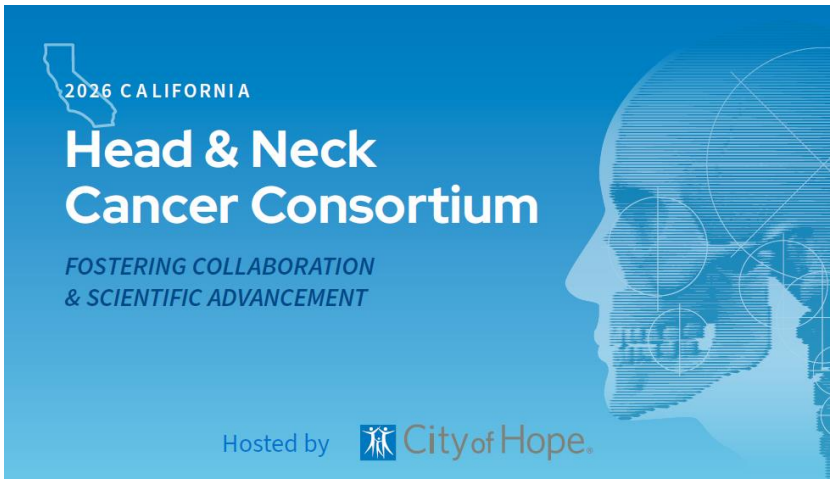
A Special Thank You!

We are deeply grateful for all the expert providers from varied institutions across California, and honored to have the out-of-state Honorary Guest and Keynote Speakers participating in this year's consortium, whose main focus is to foster collaboration and scientific advancement.

With diverse perspectives and expertise, we come together to share ideas and work together to advance the field and create meaningful impact in our fight against head and neck cancer.

Institutions represented in this year's program include:

Cedars-Sinai Medical Center
City of Hope
Clarkson Regional Health Services
Kaiser Permanente Medical Group
Keck Medicine of USC
LA County
Moffitt Cancer Center
Stanford University
UC San Diego Health
UC San Francisco
UCI Health
UCLA Medical Center
University of Texas MD Anderson Cancer Center
USC Norris Comprehensive Cancer Center
West Los Angeles VA Medical Center



♦General Information♦

2026 California Head and Neck Cancer Consortium

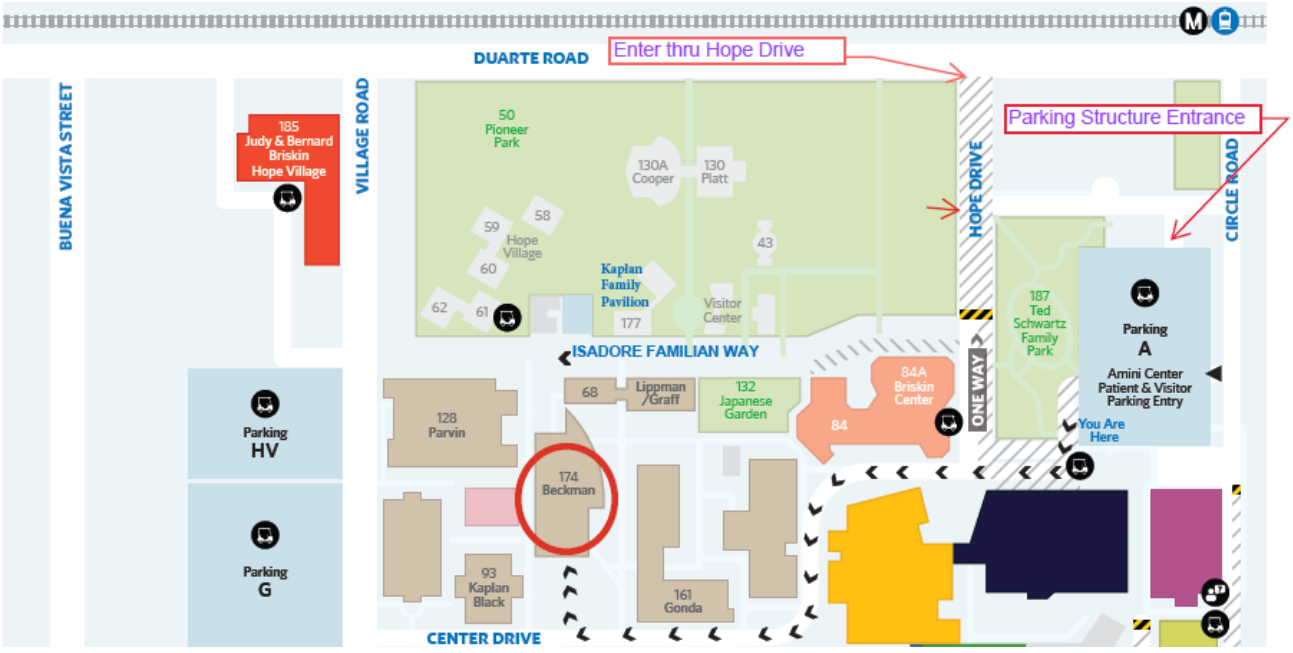
VENUE LOCATION
City of Hope | 1500 E. Duarte Road, Duarte CA 91010

PARKING INSTRUCTIONS
Enter through Hope Drive and follow parking signage to **Parking Structure A**.

PATHWAY TO CONSORTIUM LOCATION

Once parked, walk to Beckman Building following the "Special Event" and Consortium-branded signage to **Center Drive** street. **Walking pathway noted by black arrows below.**

Shuttle Service will also be available.



♦General Information♦

2026 California Head and Neck Cancer Consortium

MEETING MATERIALS
Check-in at the registration desk to receive consortium materials and name badge.

CONSORTIUM NAME BADGE
Official consortium name badge ***must*** be worn at all times to gain and maintain access to meeting rooms and meals.

EDUCATIONAL SESSIONS
General Session: Argyros Auditorium, in Beckman Building
Breakout Sessions: Room 5201, in Beckman Building

REGISTRATION DESK - HOURS OF OPERATION

DATE	*TIME*	*LOCATION*
Saturday, June 13	7:00 AM – 3:30 PM	Beckman Lobby

CONSORTIUM MEALS & BREAKS

DATE	*DESCRIPTION*	*TIME*	*LOCATION*
Saturday, June 13	Breakfast	7:00 – 8:00 AM	Argyros Family Garden
Saturday, June 13	Refreshment Break	10:00 – 10:30 AM	Argyros Family Garden
Saturday, June 13	Lunch	12:20 – 1:05 PM	Argyros Family Garden
Saturday, June 13	**Meet the Faculty Reception**	**3:30 – 5:00 PM**	**Argyros Family Garden**

EXHIBIT HALL & HOURS

DATE	*TIME*	*LOCATION*
Saturday, June 13	7:00 – 8:00 AM; 10:00 – 10:30 AM; 12:20 – 1:05 PM	Argyros Family Garden

♦ WiFi Information ♦

2026 California Head and Neck Cancer Consortium

WiFi Networks

City of Hope

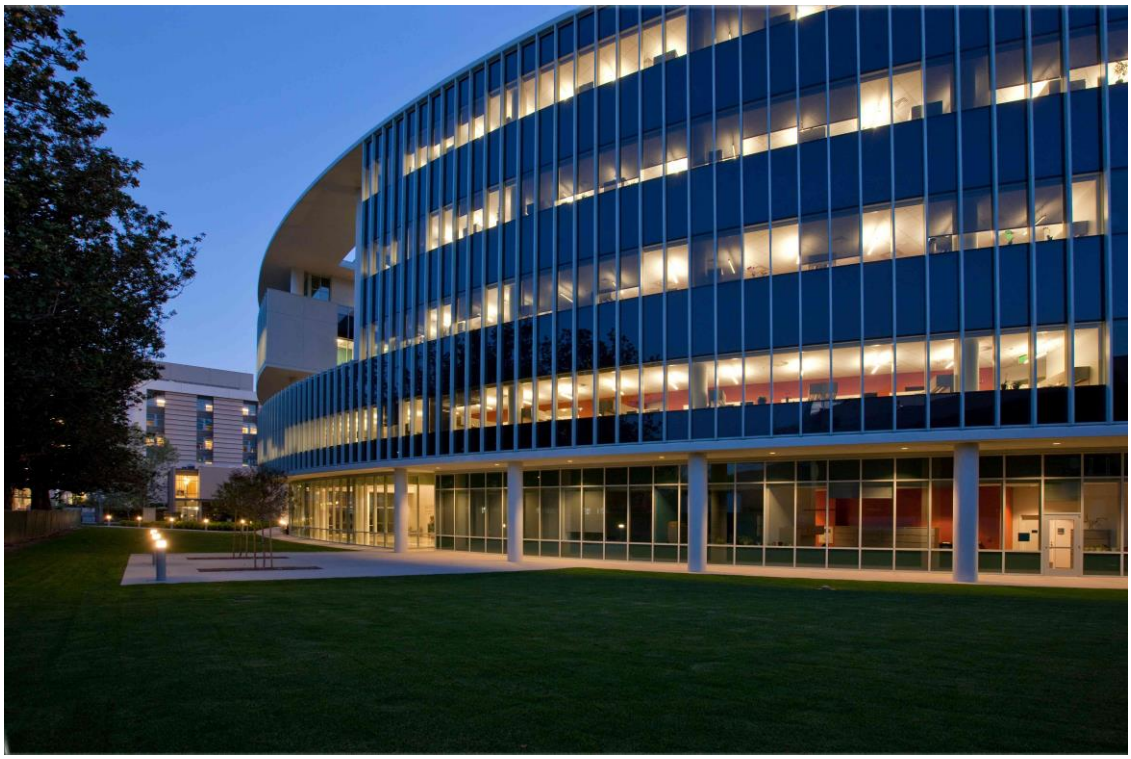
♦ Meet the Faculty Reception ♦

2026 California Head and Neck Cancer Consortium

You're Invited!

Meet the Faculty Reception

Immediately after consortium adjourns



Argyros Family Garden

3:30 – 5:00 pm

Consortium badge must be worn for admittance.

♦Upcoming Symposia♦

Upcoming Symposia

Scan QR codes for additional information

City of Hope™

♦Sponsors & Exhibitors♦

2026 California Head and Neck Cancer Consortium

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♦Conference Schedule ♦

2026 California Head and Neck Cancer Consortium

CME-Accredited Lectures in General Session from 8:10 – 10:00 AM Only.

AI in Head and Neck Imaging: Current State and Future Directions

Luke Ledbetter, MD
Professor, Department of Radiology
Neuroradiology Section Chief
Oncologic Imaging Fellowship Director
City of Hope

Classification of Sinonasal Carcinomas: From Histology to Molecular Diagnostics and Back

Juan C. Hernandez-Prera, MD
Associate Member
Section Head of Head & Neck and Endocrine Pathology
Department of Pathology
Moffitt Cancer Center

Multidisciplinary Management of Sinonasal Cancers: Lessons Learned and Future Directions

Ehab Hanna, MD
Professor and Vice Chairman
Director of Skull Base Surgery
Department of Head and Neck Surgery
Medical Director Head and Neck Center
University of Texas MD Anderson Cancer Center

Role of Radiation Therapy in Sinonasal Tumors

Sagus Sampath, MD
Associate Professor, Department of Radiation Oncology
Medical Director, Duarte Radiation
Section Chief, Head & Neck and Musculoskeletal Malignancies
City of Hope

Redefining the Systemic Landscape in Sinonasal Malignancies: From Chemotherapy to Immunotherapy and Targeted Therapy

Aditya Shreenivas, MD, MS
Assistant Professor
Department of Head & Neck Medical Oncology
Early Phase and Experimental Therapeutics Program
Interim Chief, Head & Neck Medical Oncology, City of Hope
Research Champion- Regional Clinical Research Hub (South Bay)
City of Hope

For the full CME and Disclosure Information, visit: https://cme.cityofhope.org/CME-Disclosures

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♦ Conference Schedule ♦

2026 California Head & Neck Cancer Consortium

SATURDAY, JUNE 13, 2026

ACCREDITED SESSION: GENERAL SESSION ROOM FROM 8:10 – 10:00 AM ONLY
SPEECH-LANGUAGE PATHOLOGY BREAKOUT SESSIONS: ROOM 5201

7:00 – 8:00 AM	**BREAKFAST/REGISTRATION/EXHIBITS**	
8:00 – 8:10 AM	**Welcome & Opening Remarks** **Ellie Maghami, MD | City of Hope**	
	GENERAL SESSION ***(CME-Accredited Session)***	**SPEECH-LANGUAGE PATHOLOGY BREAKOUT SESSION**
8:10 – 8:30 AM	**AI in Head and Neck Imaging: Current State and Future Directions** Luke Ledbetter, MD | *City of Hope*	8:10 – 8:15 AM ***Transition to SLP Breakout in Argyros*** 8:15 - 8:30 AM **SLP Opening Remarks** Taylor Wilde | *City of Hope*
8:30 – 8:50 AM	**HONORARY GUEST SPEAKER** **Classification of Sinonasal Carcinomas: From Histology to Molecular Diagnostics and Back** Juan C. Hernandez-Prera, MD | *Moffitt Cancer Center*	8:30 – 10:00 AM **Head & Neck Cancer Dysphagia Case Presentations** Kaitlin Valdez-Sanqui | *City of Hope* Alexa Wilde | *West Los Angeles VA Medical Center* Melea Balwan | *LA County* Stephanie Wong, MD | *Keck Medicine of USC*
8:50 – 9:30 AM	**KEYNOTE SPEAKER** **Multidisciplinary Management of Sinonasal Cancers: Lessons Learned and Future Directions** Ehab Hanna, MD *University of Texas MD Anderson Cancer Center*	
9:30 – 9:45 AM	**Role of Radiation Therapy in Sinonasal Tumors** Sagus Sampath, MD | *City of Hope*	
9:45 – 10:00 AM	**Redefining the Systemic Landscape in Sinonasal Malignancies: From Chemotherapy to Immunotherapy and Targeted Therapy** Aditya Shreenivas, MD, MS | *City of Hope*	
10:00 – 10:30 AM	**BREAK/EXHIBITS**	

City of Hope

♦Conference Schedule ♦

2026 California Head & Neck Cancer Consortium

SATURDAY, JUNE 13, 2026 *cont'd*

	GENERAL SESSION	SPEECH-LANGUAGE PATHOLOGY BREAKOUT SESSION
10:30 – 11:00 AM	**Moderated Case Presentation** **Tumor Board Part I** **Sinonasal Tumors** ***Moderators:*** Krupal Patel, MD & Sepehr Shabani, MD | *City of Hope* **Panelists:** Edward C. Kuan, MD | *UCI Health* Jeffrey D. Suh, MD | *UCLA Medical Center* Evan Walgama, MD | *Cedars- Sinai Medical Center* Zain Husain, MD| *Kaiser Permanente Medical Group* Sean Maroongroge, MD, MBA | *City of Hope* Jacob Thomas, MD *USC Norris Comprehensive Cancer Center* Deborah J. Wong, MD, PhD | *UCLA Medical Center* Tom Z. Liang, MD | *City of Hope* Thomas L. Beaumont, MD, PhD | *UC San Diego*	**Trismus Assessment and Management** Taylor Wilde | *City of Hope*
11:00 AM – 12:20 PM	**Clinical Trials** ***Moderator:*** Amanda Reyes, MD | *City of Hope* **Speakers:** Allen S. Ho, MD | *Cedars-Sinai Medical Center* Krupal Patel, MD | *City of Hope* Arya Amini, MD | *City of Hope* Fangdi Sun, MD | *Stanford University* Shirin Attarian, MD | *UCI Health* Wanxing Chai- Ho, MD | *UCLA Medical Center* Karen Yun, MD| *UC San Diego Health* Robert Hsu, MD *USC Norris Comprehensive Cancer Center* Jacob Thomas, MD *USC Norris Comprehensive Cancer Center*	11:00 – 11:30 AM **Palliative Care in Head and Neck Cancer** Sanora Yonan | *City of Hope* 11:30 AM – 12:00 PM **Dysphagia & Nutrition Panel** Brenda Villegas | *Keck Medicine of USC* Amy Wilke | *Keck Medicine of USC* Heather Thompson *Cedars-Sinai Medical Center* Alexandra Sullivan *Cedars-Sinai Medical Center* 12:00 – 12:15 PM **Insurance Barriers** Mercedes Currier | *City of Hope* 12:15 – 12:30 PM **Open Discussion** Taylor Wilde | *City of Hope*
12:20 – 1:05 PM	**LUNCH/EXHIBITS**	

♦Conference Schedule ♦

2026 California Head & Neck Cancer Consortium

SATURDAY, JUNE 13, 2026 *cont'd*

1:05 – 1:45 PM **KEYNOTE SPEAKER**
Survivorship and the Power of Community
William M. Lydiatt, MD, EMBA | *Clarkson Regional Health Services*

1:45 – 2:00 PM **Pantry of Hope: Addressing Nutrition Affordability in Dysphagia Care for Head and Neck Cancer Patients**
Taylor Wilde & Mercedes Currier | *City of Hope*

2:00 – 2:15 PM **Digital Health for Improved Outcomes and Quality Cancer Care Delivery**
Virginia Sun, PhD | *City of Hope*

2:15 – 3:30 PM **Moderated Case Presentation/Tumor Board Part II**
Salivary
Moderators:
Ellie Maghami, MD | *City of Hope* & Alice Lin, MD | *Kaiser Permanente Medical Group*

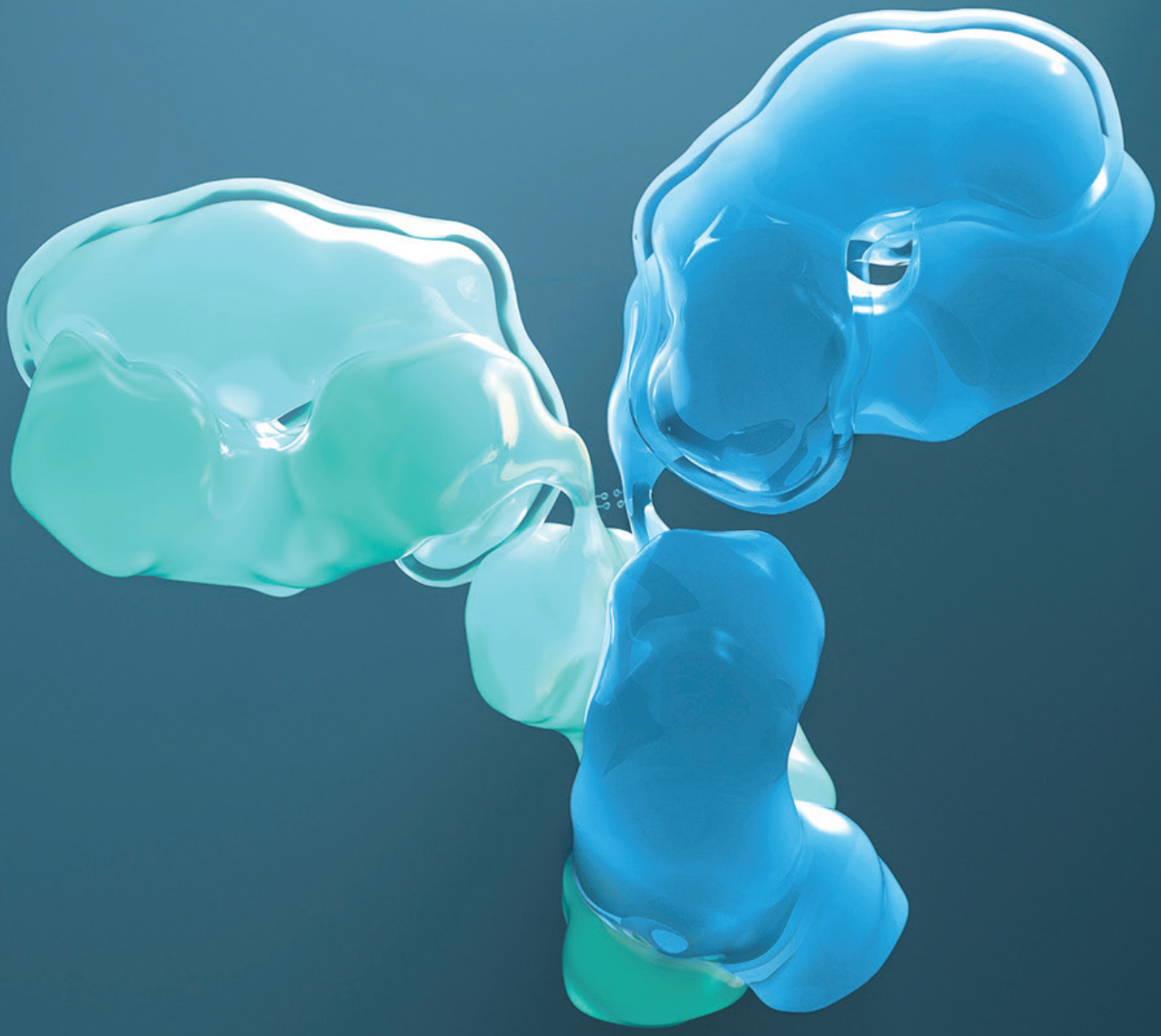
Speakers:
Fang Fan, MD, PhD | *City of Hope*
Yarah Haidar, MD | *UCI Health*
Colton Ladbury, MD | *City of Hope*
Amanda Reyes, MD | *City of Hope*
Panelists:
Joseph Califano, MD | *UC San Diego*
Uttam K. Sinha, MD | *Keck Medicine of USC*
Patrick Ha, MD | *UC San Francisco*
Babak Larian, MD | *Cedars-Sinai Medical Center*
Ricky R. Savjani, MD, PhD | *UCLA Medical Center*
Adam Garsa, MD | *USC Norris Comprehensive Cancer Center*
Aditya Shreenivas, MD, MS | *City of Hope*
Dipti P. Sajed, MD, PhD | *UCLA Medical Center*

3:30 PM **ADJOURN**

3:30 – 5:00 PM **MEET THE FACULTY RECEPTION** ***Sponsored in part by Natera & SUN Pharma***

City of Hope may find it necessary to substitute faculty with comparable expertise on those rare occasions necessitated by illness, unforeseen scheduling conflicts or extraordinary occurrences.

Leading antibody science for better futures



genmab.com

Genmab

Welcome to Rakuten Medical's ASP-1929-381 Trial

A Phase 3 Multicenter, Randomized, Open-label Study of ASP-1929 Photoimmunotherapy in Combination With Pembrolizumab Versus Standard of Care in the First-line Treatment of Patients With Locoregional Recurrence of Squamous Cell Carcinoma of the Head and Neck (HNSCC) With No Distant Metastases (NCT06699212)

Eligibility:

- Evidence of HNSCC (no nasopharynx, cuSCC)
- No distant metastases
- Anti-PD-1- and anti-PD-L1-treatment naïve
- CPS≥ 1
- Eligible for treatment with pembrolizumab plus chemotherapy in first line setting

2 : 2 : 1

Experimental Arm
ASP-1929 PIT (320mg/m2) + Pembrolizumab

Dose Selection
ASP-1929 PIT (640mg/m2) + Pembrolizumab

Standard of Care Arm
Pembrolizumab
OR
Pembrolizumab + Chemotherapy
Physician's Choice

Optimized dose based on IA1

2 : 1

Survival follow-up

PIT, photoimmunotherapy; HNSCC, head and neck squamous cell carcinoma; CPS, Combined Positive Score

Primary endpoint : OS

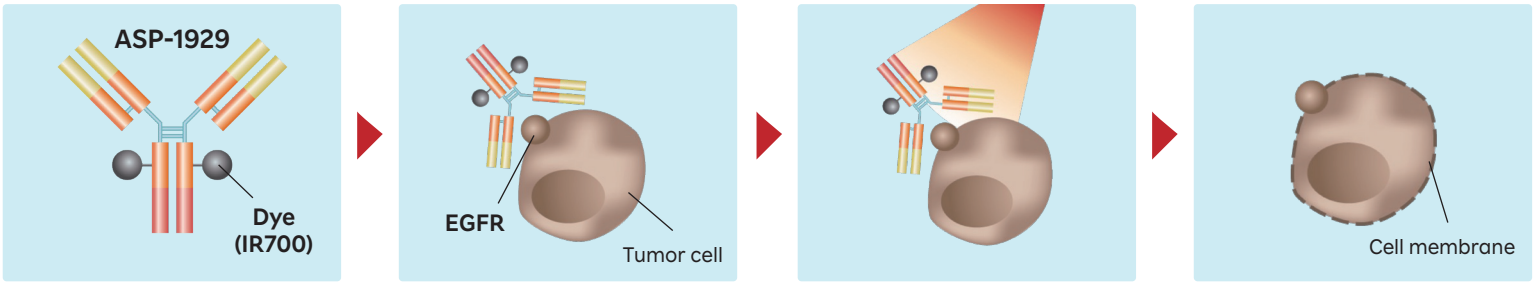
Key secondary endpoints : CRR and ORR

Planned Enrollment : 412
Currently enrolling patients at 30+ sites across U.S., Japan, Taiwan, and Ukraine; Poland to be added

For more information
ClinicalTrial.gov

What is ASP-1929 Photoimmunotherapy?

Treatment with ASP-1929 photoimmunotherapy involves injecting a drug (ASP-1929) that contains a light-activatable dye (IR700) into the body. ASP-1929 binds to EGFR on cells, such as head and neck cancer tumors. IR700 in ASP-1929 reacts when illuminated with 690 nm red light directed at the tumor as part of the treatment. Preclinical studies have shown that, following this reaction, ASP-1929 photoimmunotherapy may damage the tumor cell surface and may lead to tumor cell death.

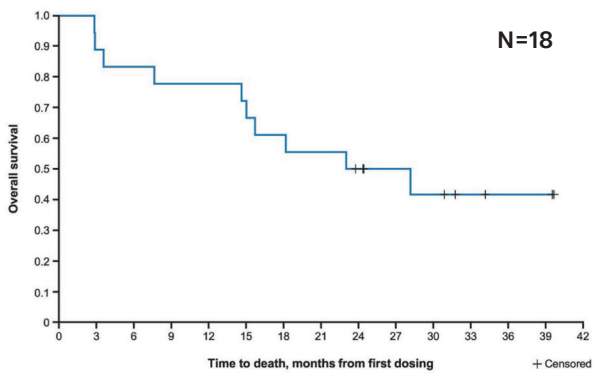


The mechanism of action illustrated in this diagram is based on preclinical observations and has not been established in clinical settings.

Open-Label Phase 1b/2 Data Has Led to Design of ASP-1929-381 Trial

This phase 1b/2 open-label study evaluated ASP-1929 photoimmunotherapy plus pembrolizumab in patients with recurrent/metastatic HNSCC (≥ 1 accessible lesion, PD-L1 combined positive score ≥ 1, ineligible for standard locoregional therapy).

Median OS: 25.6 months



Safety (N=19):

- All patients experienced at least one TEAE
- Most common TEAEs: fatigue (57.9%), oral pain (52.6%), constipation (36.8%)
- Serious TEAEs observed in 63.2% of patients, most commonly dysphagia and tongue edema (2 patients 10.5% each)
- No fatal treatment-related AEs; overall safety profile consistent with prior ASP-1929 photoimmunotherapy and pembrolizumab experiences

ORR: 27.8%, CRR: 22.2%

Cognetti etal., Head & Neck, 2026.
https://doi.org/10.1002/hed.70014

Rakuten Medical

BALANCE THAT MATTERS

UNLOXCYT™ is an evolution in checkpoint inhibition for the treatment of adults with metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced CSCC (laCSCC) who are not candidates for curative surgery or curative radiation.[1-4]

UNLOXCYT™
(cosibelimab-ipdl) Injection 300mg

CLINICAL BALANCE[1]

UNLOXCYT demonstrated durable efficacy and a proven tolerability profile in advanced cutaneous squamous cell carcinoma (aCSCC).[1,2]

The efficacy and safety of UNLOXCYT was evaluated in a multicenter, multicohort, open-label study of aCSCC patients, including many with comorbidities.[1,2,5] The pivotal study had comparable size and patient population to other studies of checkpoint inhibitors in aCSCC.[1,2,6,7]

Durable Efficacy (N=109)[1]

Met primary endpoint in both patient populations[1,2]

mCSCC: 50% ORR*
n=39/78, 95% CI: 38% to 62%

laCSCC: 55% ORR*
n=17/31, 95% CI: 36% to 73%

Most respondents were still in response at 1 year[1,*,†,‡,§]

mCSCC: 67%
n=26/39

laCSCC: 88%
n=15/17

Proven Tolerability[1]

- The most common ARs were fatigue, musculoskeletal pain, rash, diarrhea, and hypothyroidism (N=141)[1]
- imARs were primarily Grade 1 or 2; 0.9% were Grade 3 (dermatologic only), with no Grade ≥4 imARs (N=223; 141 aCSCC patients, 82 patients with other cancers[¶])[1]
- 8% permanent discontinuation rate (N=141 aCSCC patients)[1]

See the results behind UNLOXCYT

AR=adverse reaction; CI=confidence interval; ICR=independent central review; imAR=immune-mediated adverse reaction; MOA=mechanism of action; ORR=objective response rate; PD-L2=programmed death-ligand 2; RECIST=Response Evaluation Criteria in Solid Tumors; WHO=World Health Organization.

MULTIFACETED MOA[1-4,#]

UNLOXCYT is the **first and only** checkpoint inhibitor in aCSCC that helps restore the adaptive immune response and engage the innate immune system while preserving PD-L2 signaling.[1-4,6,7]

Helps restore the adaptive immune response[1-3]

Engages the innate immune system[1-3]

Preserves PD-L2 signaling[1-4]

*Evaluated by ICR per RECIST v1.1.[1,2,8] For patients with laCSCC with lesions not assessable by radiologic imaging, ORR was determined by ICR assessment per WHO criteria by digital photography.[1,2]
†Duration of response (DOR) was a secondary endpoint in the UNLOXCYT trial. DOR at 6 months: mCSCC: 85% (n=33/39); laCSCC: 100% (n=17/17).[1,8]
‡The median follow-up time was 29.3 months for mCSCC and 24.1 months for laCSCC.[1,8]
§The numerator includes the number of patients whose observed DOR reached at least the specified times of 6 months or 12 months. Patients who did not have the opportunity to reach the specified timepoint were included in the denominator only.[1]
¶Other tumors were solid tumors and hematologic malignancies.[1]
#The MOA of UNLOXCYT is based on in vitro data. Preclinical in vitro data may not translate to clinical outcomes.[1,9]

References: 1. UNLOXCYT™ [prescribing information]. Waltham, MA: Checkpoint Therapeutics, Inc. November 2025. **2.** Ruiz ES, Muñoz-Couselo E, Montaudié H, et al. Efficacy and safety of cosibelimab in advanced cutaneous squamous cell carcinoma: results from a Pivotal Open-label Study with a median follow-up of ≥2 years. *J Am Acad Dermatol.* 2026;94(1):48-56. doi:10.1016/j.jaad.2025.09.009 **3.** Idris OA, Westgate D, Saadaie Jahromi B, Shebrain A, Zhang T, Ashour HM. PD-L1 inhibitor cosibelimab for cutaneous squamous cell carcinoma: comprehensive evaluation of efficacy, mechanism, and clinical trial insights. *Biomedicines.* 2025;13(4):889. doi:10.3390/biomedicines13040889 **4.** Chen RY, Zhu Y, Shen YY, et al. The role of PD-1 signaling in health and immune-related diseases. *Front Immunol.* 2023;14:1163633. doi:10.3389/fimmu.2023.1163633 **5.** Data on file. CK-301-101 Clinical Study Report Table 14.1.4.1. Sun Pharmaceuticals, Inc. Princeton, NJ. **6.** KEYTRUDA® [prescribing information]. Rahway, NJ: Merck & Co., Inc. February 2026. **7.** LIBTAYO® [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc. October 2025. **8.** Data on file. CK-301-101 Clinical Study Report Overview. Sun Pharmaceuticals, Inc. Princeton, NJ. **9.** Gorelik L, Avgerinos G, Kunes Y, Marasco WA. Preclinical characterization of a novel fully human IgG1 anti-PD-L1 mAb CK-301. Abstract #4606. Presented at: American Association for Cancer Research (AACR) Annual Meeting; April 1-5, 2017; Washington, DC.

INDICATIONS AND USAGE

UNLOXCYT (cosibelimab-ipdl) is indicated for the treatment of adults with metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced CSCC (laCSCC) who are not candidates for curative surgery or curative radiation.

It is not known if UNLOXCYT is safe and effective in children

The recommended dosage of UNLOXCYT is 1,200 mg as an intravenous infusion over 60 minutes every 3 weeks.

IMPORTANT SAFETY INFORMATION

WARNING AND PRECAUTIONS

Immune-mediated Adverse Reactions:
Immune-mediated adverse reactions, which can be severe or fatal, can occur in any organ system or tissue, including immune-mediated pneumonitis, colitis, hepatitis, endocrinopathies, dermatologic adverse reactions, nephritis and renal dysfunction, and solid organ transplant rejection. Immune-mediated adverse reactions affecting more than one body system can occur simultaneously. While such adverse reactions usually manifest during treatment, they can also manifest after discontinuation of PD-1/PD-L1–blocking antibodies.

Monitor for early identification and management. Evaluate liver enzymes, creatinine, and thyroid function at baseline and periodically during treatment. Withhold or permanently discontinue UNLOXCYT based on the severity of reaction.

Infusion-Related Reactions:
Infusion-related reactions were reported in 11% (24/223) of patients, including Grade 2 in 5.8% (13/223) of patients receiving UNLOXCYT. Monitor patients for signs and symptoms of infusion-related reactions. Interrupt or slow the rate of infusion or permanently discontinue UNLOXCYT based on severity of reaction. Consider premedication with an antipyretic and/or an antihistamine for patients who have had previous systemic reactions to infusions of therapeutic proteins.

Complications of Allogeneic HSCT:
Fatal and other serious complications can occur in patients who receive allogeneic Hematopoietic Stem Cell Transplantation (HSCT) before or after being treated with a PD-1/PDL1 blocking antibody. Follow patients closely for evidence of transplant-related complications and intervene promptly. Consider the benefit versus risks of treatment with a PD-1/PD-L1–blocking antibody prior to or after an allogeneic HSCT.

Embryo-Fetal Toxicity/Females and Males of Reproductive Potential:
UNLOXCYT can cause fetal harm when administered to a pregnant woman. Verify pregnancy status in females of reproductive potential prior to initiating UNLOXCYT. Females should use effective contraception during treatment with UNLOXCYT and for 4 months after the last dose. Advise female patients not to breastfeed during treatment with UNLOXCYT and for 4 months after the last dose.

ADVERSE REACTIONS

The most common adverse reactions (≥10%) were fatigue, musculoskeletal pain, rash, diarrhea, hypothyroidism, constipation, nausea, headache, pruritus, edema, localized infection, and urinary tract infection.

To report side effects of UNLOXCYT to FDA: visit www.fda.gov/medwatch or call 1-800-FDA-1088. Report SUSPECTED ADVERSE REACTIONS or any side effects or ADEs (adverse drug events) to our Drug Safety Department at 1-800-406-7984 or DrugSafety.USoperations@sunpharma.com (preferred) with as much information as available.

Please see the Brief Summary of Full Prescribing Information on the following page.

SUN PHARMA

PM-US-ULX-0213 04/26

UNLOXCYT™
(cosibelimab-ipdl) Injection 300mg

Brief Summary of Prescribing Information for UNLOXCYT™ (cosibelimab-ipdl) injection, for intravenous use. This Brief Summary does not include all the information needed to use UNLOXCYT safely and effectively. See full Prescribing Information for UNLOXCYT (https://unloxcyt.com/prescribing-information.pdf).

INDICATIONS AND USAGE UNLOXCYT is indicated for the treatment of adults with metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced CSCC (laCSCC) who are not candidates for curative surgery or curative radiation.

CONTRAINDICATIONS None.

WARNINGS AND PRECAUTIONS Severe and Fatal Immune-Mediated Adverse Reactions UNLOXCYT is a monoclonal antibody that belongs to a class of drugs that bind to either the programmed death receptor-1 (PD-1) or PD-ligand 1 (PD-L1), blocking the PD-1/PD-L1 pathway, thereby removing inhibition of the immune response, potentially breaking peripheral tolerance and inducing immune-mediated adverse reactions. Important immune-mediated adverse reactions listed in WARNINGS AND PRECAUTIONS may not include all possible severe and fatal immune-mediated reactions. Immune-mediated adverse reactions, which can be severe or fatal, can occur in any organ system or tissue. Immune-mediated adverse reactions can occur at any time after starting a PD-1/PD-L1–blocking antibody. While immune-mediated adverse reactions usually manifest during treatment with PD-1/PD-L1–blocking antibodies, they can also manifest after discontinuation of PD-1/PD-L1–blocking antibodies. Immune-mediated adverse reactions affecting more than one body system can occur simultaneously. Early identification and management of immune-mediated adverse reactions are essential to ensure safe use of PD-1/PD-L1–blocking antibodies. Monitor closely for symptoms and signs that may be clinical manifestations of underlying immune-mediated adverse reactions. Evaluate liver enzymes, creatinine, and thyroid function tests at baseline and periodically during treatment. In cases of suspected immune-mediated adverse reactions, initiate appropriate workup to exclude alternative etiologies, including infection. Institute medical management promptly, including specialty consultation as appropriate. Withhold or permanently discontinue UNLOXCYT depending on severity. In general, if UNLOXCYT requires interruption or discontinuation, administer systemic corticosteroids (1 to 2 mg/kg/day prednisone or equivalent) until improvement to Grade 1 or less. Upon improvement to Grade 1 or less, initiate corticosteroid taper and continue to taper over at least 1 month. Consider administration of other systemic immunosuppressants in patients whose immune-mediated adverse reaction is not controlled with corticosteroids. Toxicity management guidelines for adverse reactions that do not necessarily require systemic steroids (e.g., endocrinopathies, dermatologic reactions) are discussed below. Immune-Mediated Pneumonitis UNLOXCYT can cause immune-mediated pneumonitis. In patients treated with other PD-1/PD-L1–blocking antibodies, the incidence of pneumonitis is higher in patients who have received prior thoracic radiation. Immune-mediated pneumonitis occurred in 1% (3/223, Grade 2) of patients receiving UNLOXCYT. Pneumonitis led to withholding of UNLOXCYT in 0.4% (1/223) of patients. All 3 patients required systemic corticosteroids and pneumonitis did not resolve. One patient in whom UNLOXCYT was withheld for pneumonitis had UNLOXCYT reinitiated after symptom improvement and had recurrence of pneumonitis. Immune-Mediated Colitis UNLOXCYT can cause immune-mediated colitis, which may present with diarrhea, abdominal pain, and lower gastrointestinal (GI) bleeding. Cytomegalovirus infection/reactivation has occurred in patients with corticosteroid-refractory immune-mediated colitis treated with PD-1/PD-L1–blocking antibodies. In cases of corticosteroid-refractory colitis, consider repeating infectious workup to exclude alternative etiologies. Immune-mediated colitis occurred in 0.4% (1/223, Grade 1) of patients receiving UNLOXCYT. Systemic corticosteroids were required in the patient experiencing colitis. The event of colitis did not resolve, and UNLOXCYT was not reinitiated. Immune-Mediated Hepatitis UNLOXCYT can cause immune-mediated hepatitis, defined as requiring the use of systemic corticosteroids and the absence of a clear alternate etiology. Immune-Mediated Endocrinopathies *Adrenal Insufficiency* UNLOXCYT can cause primary or secondary adrenal insufficiency. For Grade 2 or higher adrenal insufficiency, initiate symptomatic treatment per institutional guidelines, including hormone replacement as clinically indicated. Withhold or permanently discontinue UNLOXCYT depending on severity. Adrenal insufficiency occurred in 0.9% (2/223) of patients receiving UNLOXCYT, including Grade 2 in 0.4% (1/223) of patients. UNLOXCYT was withheld for adrenal insufficiency in one of these patients and was reinitiated after symptom improvement. Systemic corticosteroids were required in both patients with adrenal insufficiency. *Hypophysitis* UNLOXCYT can cause immune-mediated hypophysitis. Hypophysitis can present with acute symptoms associated with mass effect such as headache, photophobia, or visual field cuts. Hypophysitis can cause hypopituitarism. Initiate hormone replacement as clinically indicated. Withhold or permanently discontinue UNLOXCYT depending on severity. *Thyroid Disorders* UNLOXCYT can cause immune-mediated thyroid disorders. Thyroiditis can present with or without endocrinopathy. Hypothyroidism can follow hyperthyroidism. Initiate hormone replacement or medical management of hyperthyroidism as clinically indicated. Withhold or permanently discontinue UNLOXCYT depending on severity. *Hypothyroidism:* Hypothyroidism occurred in 10% (22/223) of patients receiving UNLOXCYT, including Grade 2 in 5% (10/223) of patients. Hypothyroidism resolved in 7 of the 22 patients. *Hyperthyroidism:* Hyperthyroidism occurred in 5% (12/223) of patients receiving UNLOXCYT, including Grade 2 in 0.4% (1/223) of patients. Hyperthyroidism resolved in 10 of the 12 patients. *Type 1 Diabetes Mellitus, which can present with diabetic ketoacidosis* UNLOXCYT can cause type 1 diabetes mellitus, which can present with diabetic ketoacidosis. Monitor patients for hyperglycemia or other signs and symptoms of diabetes. Initiate treatment with insulin as clinically indicated. Withhold or permanently discontinue UNLOXCYT depending on severity. Immune-Mediated Nephritis with Renal Dysfunction UNLOXCYT can cause immune-mediated nephritis, defined as the required use of systemic corticosteroids or other immunosuppressants and the absence of a clear alternate etiology. Immune-Mediated Dermatologic Adverse Reactions UNLOXCYT can cause immune-mediated rash or dermatitis. Bullous and exfoliative dermatitis, including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug rash with eosinophilia and systemic symptoms (DRESS), have occurred with PD-1/PD-L1–blocking antibodies. Topical emollients and/or topical corticosteroids may be adequate to treat mild to moderate non-bullous/exfoliative rashes. Withhold or permanently discontinue UNLOXCYT depending on severity. Immune-mediated dermatologic adverse reactions occurred in 7% (15/223) of patients receiving UNLOXCYT, including Grade 3 in 0.9% (2/223) of patients and Grade 2 in 4% (9/223) of patients. Dermatologic adverse reactions led to permanent discontinuation of UNLOXCYT in 0.4% (1/223) of patients and withholding of UNLOXCYT in 0.9% (2/223) of patients. Systemic corticosteroids were required in 33% (5/15) of patients with dermatologic adverse reactions. Dermatologic adverse reactions resolved in 7 of the 15 patients. Of the 2 patients in whom UNLOXCYT was withheld for dermatologic adverse reactions, 1 patient reinitiated UNLOXCYT after symptom improvement and had recurrence of the dermatologic adverse reaction, which resolved after UNLOXCYT was withheld a second time. Other Immune-Mediated Adverse Reactions The following clinically significant immune-mediated adverse reactions occurred in <1% of the 223 patients who received UNLOXCYT or were reported with the use of other PD-1/PD-L1–blocking antibodies. Severe or fatal cases have been reported for some of these adverse reactions. *Cardiac/Vascular:* Myocarditis, pericarditis, vasculitis. *Nervous System:* Meningitis, encephalitis, myelitis and demyelination, myasthenic syndrome/myasthenia gravis (including exacerbation), Guillain-Barre syndrome, nerve paresis, autoimmune neuropathy. *Ocular:* Uveitis, iritis, other ocular inflammatory toxicities. Some cases can be associated with retinal detachment. Various grades of visual impairment to include blindness can occur. If uveitis occurs in combination with other immune-mediated adverse reactions, consider a Vogt-Koyanagi-Harada–like syndrome, as this may require treatment with systemic steroids to reduce the risk of permanent vision loss. *Gastrointestinal:* Pancreatitis, including increases in serum amylase and lipase levels, gastritis, duodenitis. *Musculoskeletal and Connective Tissue:* Myositis/polymyositis, rhabdomyolysis and associated sequelae including renal failure, arthritis, polymyalgia rheumatica. *Endocrine:* Hypoparathyroidism. *Other (Hematologic/Immune):* Autoimmune hemolytic anemia, aplastic anemia, hemophagocytic lymphohistiocytosis, systemic inflammatory response syndrome, histiocytic necrotizing lymphadenitis (Kikuchi lymphadenitis), sarcoidosis, immune thrombocytopenia, solid organ transplant rejection, other transplant (including corneal graft) rejection. **Infusion-Related Reactions** UNLOXCYT can cause severe or life-threatening infusion-related reactions. Infusion-related infusion reactions were reported in 11% (24/223) of patients, including Grade 2 in 5.8% (13/223) of patients receiving UNLOXCYT. Monitor patients for signs and symptoms of infusion-related reactions. Interrupt or slow the rate of infusion or permanently discontinue UNLOXCYT based on severity of reaction. Consider premedication with an antipyretic and/or an antihistamine for patients who have had previous systemic reactions to infusions of therapeutic proteins. **Complications of Allogeneic HSCT** Fatal and other serious complications can occur in patients who receive allogeneic hematopoietic stem cell transplantation (HSCT) before or after being treated with a PD-1/PD-L1–blocking antibody. Transplant-related complications include hyperacute graft-versus-host disease (GVHD), acute GVHD, chronic GVHD, hepatic veno-occlusive disease after reduced intensity conditioning, and steroid-requiring febrile syndrome (without an identified infectious cause). These complications may occur despite intervening therapy between PD-1/PD-L1 blockade and allogeneic HSCT. Follow patients closely for evidence of transplant-related complications and intervene promptly. Consider the benefit versus risks of treatment with a PD-1/PD-L1–blocking antibody prior to or after an allogeneic HSCT. **Embryo-Fetal Toxicity** Based on its mechanism of action, UNLOXCYT can cause fetal harm when administered to a pregnant woman. Animal studies have demonstrated that inhibition of the PD-1/PD-L1 pathway can lead to increased risk of immune-mediated rejection of the developing fetus, resulting in fetal death. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with UNLOXCYT and for 4 months after the last dose.

ADVERSE REACTIONS The following clinically significant adverse reactions are described elsewhere in the labeling:
- Severe and fatal immune-mediated adverse reactions
- Infusion-related reactions
- Complications of Allogeneic HSCT

Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug and may not reflect the rates observed in practice. The pooled safety population described in WARNINGS AND PRECAUTIONS reflects exposure to UNLOXCYT as a single agent in 223 patients in two open-label, single-arm, multicohort studies, including 141 patients with advanced CSCC and 82 patients with other solid tumors and hematologic malignancies. UNLOXCYT was administered intravenously at doses of 800 mg every 2 weeks (n=174), 1,200 mg every 3 weeks (n=35), or other doses (n=14). Among the 223 patients, 54% were exposed for ≥24 weeks and 17% were exposed for ≥72 weeks. The safety of UNLOXCYT was evaluated in Study CK-301-101 in 141 patients with metastatic or locally advanced disease CSCC *[see Clinical Studies (14)]*. Patients received UNLOXCYT 800 mg every 2 weeks (n=115) or 1,200 mg every 3 weeks (n=26) as an intravenous infusion until disease progression or unacceptable toxicity. The median duration of exposure was 36 weeks (2 weeks to 3.7 years). Serious adverse reactions occurred in 31% of advanced patients with CSCC who received UNLOXCYT. The most frequent serious adverse reactions (≥ 2% of patients) were sepsis (2.8%), pneumonia (2.8%) and pyrexia (2.1%). Permanent discontinuation of UNLOXCYT due to an adverse reaction occurred in 8% of patients. Adverse reactions resulting in permanent discontinuation of UNLOXCYT were COVID-19, COVID-19 pneumonia, sepsis, ulcerative keratitis, tumor thrombosis, axillary pain, paresthesia, cholestasis, hepatic cytolysis, wound hemorrhage, neck pain, pemphigoid, and eye pain (1 patient each). Dosage interruptions due to an adverse reaction occurred in 36% of patients who received UNLOXCYT. The adverse reaction that required dosage interruption in ≥ 2% of patients who received UNLOXCYT was COVID-19 (2%). The most common (≥ 10%) adverse reactions were fatigue, musculoskeletal pain, rash, diarrhea, hypothyroidism, constipation, nausea, headache, pruritus, edema, localized infection, and urinary tract infection. Table 2 and Table 3 summarize adverse reactions and laboratory abnormalities, respectively in CK-301-101.

Table 2: Adverse Reactions in ≥ 10% of Patients with Metastatic or Locally Advanced CSCC Receiving UNLOXCYT in Study CK-301-101

	UNLOXCYT N = 141 (%)	
System Organ Class Preferred Term	**All Grades, %**	**Grade 3 or 4, %**
General disorders and administrative site conditions		
Fatigue*	33	3
Edema*	11	0
Musculoskeletal and connective tissue disorders		
Musculoskeletal pain*	25	3
Skin and subcutaneous tissue disorders		
Rash*	23	1
Pruritus*	12	0
Endocrine disorder		
Hypothyroidism*	14	0
Gastrointestinal disorders		
Diarrhea	14	0
Nausea	13	0
Constipation	13	0
Nervous system disorders		
Headache*	12	0
Infections and infestations		
Localized infection	10	0.7
Urinary tract infection*	10	0

Toxicity was graded per National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE) v.4.03 (or later version)
*Represents a composite of multiple related terms

Table 3: Laboratory Abnormalities that Worsened from Baseline to Grade 3 or 4 Occurring in ≥ 1% of Patients with Metastatic or Locally Advanced CSCC Receiving UNLOXCYT in Study CK-301-101

	UNLOXCYT (N = 141)	
Laboratory Abnormality	**All Grades, %[a]**	**Grade 3 or 4, %[a]**
Hematology		
Hemoglobin decreased	45	4
Lymphocytes decreased	41	6
Platelets decreased	14	1
Leukocytes decreased	10	1
Chemistry		
Sodium decreased	38	5
Alkaline phosphatase increased	26	1
Alanine transferase increased	25	4
Lipase increased	25	3
Aspartate transaminase increased	24	3
Potassium increased	23	3
Calcium increased	14	2

Toxicity graded per NCI CTCAE v5
[a] The denominator used to calculate the rate varied from 122-140 based on the number of patients with a baseline value and at least one post-treatment value.

USE IN SPECIFIC POPULATIONS Pregnancy Risk Summary Based on its mechanism of action, UNLOXCYT can cause fetal harm when administered to a pregnant woman. There are no available data on the use of UNLOXCYT in pregnant women. Animal studies have demonstrated that inhibition of the PD-1/PD-L1 pathway can lead to increased risk of immune-mediated rejection of the developing fetus resulting in fetal death *(see Data)*. Human IgG1 immunoglobulins (IgG1) are known to cross the placental barrier; therefore, cosibelimab-ipdl has the potential to be transmitted from the mother to the developing fetus. Advise women of the potential risk to a fetus. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively. Data *Animal Data:* Animal reproduction studies have not been conducted with cosibelimab-ipdl to evaluate its effect on reproduction and fetal development. A central function of the PD-1/PD-L1 pathway is to preserve pregnancy by maintaining maternal immune tolerance to the fetus. In murine models of pregnancy, blockade of PD-L1 signaling has been shown to disrupt tolerance to the fetus and to result in an increase in fetal loss; therefore, potential risks of administering UNLOXCYT during pregnancy include increased rates of abortion or stillbirth. As reported in the literature, there were no malformations related to the blockade of PD-1/PD-L1 signaling in the offspring of these animals; however, immune-mediated disorders occurred in PD-1 and PD-L1 knockout mice. Based on its mechanism of action, fetal exposure to UNLOXCYT may increase the risk of developing immune-mediated disorders or altering the normal immune response. **Lactation** Risk Summary There is no information regarding the presence of cosibelimab-ipdl in human milk or its effects on the breastfed child or on milk production. Because of the potential for serious adverse reactions in a breastfed child, advise women not to breastfeed during treatment and for 4 months after the last dose of UNLOXCYT. **Females and Males of Reproductive Potential** UNLOXCYT can cause fetal harm when administered to a pregnant woman. Pregnancy Testing Verify pregnancy status in females of reproductive potential prior to initiating UNLOXCYT. Contraception *Females:* Advise females of reproductive potential to use effective contraception during treatment with UNLOXCYT and for 4 months after the last dose. **Pediatric Use** The safety and effectiveness of UNLOXCYT have not been established in pediatric patients. **Geriatric Use** Of the 141 patients treated with UNLOXCYT as a single agent, 21% (29) were younger than 65 years, 31% (44) were aged 65 through 75 years, and 48% (68) were 75 years or older. No overall differences in safety or effectiveness were observed between these patients and younger patients.

CLINICAL PHARMACOLOGY Immunogenicity The observed incidence of anti-drug antibodies is highly dependent on the sensitivity and specificity of the assay. Differences in assay methods preclude meaningful comparisons of the incidence of anti-drug antibodies in the studies described below with the incidence of anti-drug antibodies in other studies, including those of UNLOXCYT or of other cosibelimab products. Anti-drug antibody (ADA) and neutralizing antibody (nAb) responses were monitored throughout the treatment period where the benefit to risk ratio was assessed. ADAs were detected in 65/133 (49%) of patients treated with UNLOXCYT and nAbs were detected in 2/65 (3.0%) of the patients. UNLOXCYT-treated patients who developed anti-cosibelimab antibodies had reduced UNLOXCYT concentrations (20% lower compared to UNLOXCYT-treated subjects who did not develop anti-cosibelimab-ipdl antibodies). There was no clinically significant effect of anti-cosibelimab-ipdl antibodies on the efficacy or safety of cosibelimab-ipdl.

For detailed information, please read the full Prescribing Information.

SUN PHARMA

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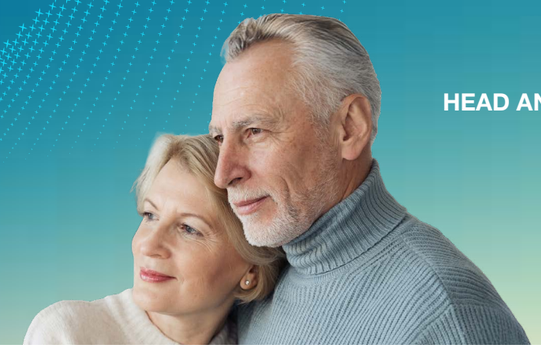
Residual disease test (MRD)

HEAD AND NECK CANCERS

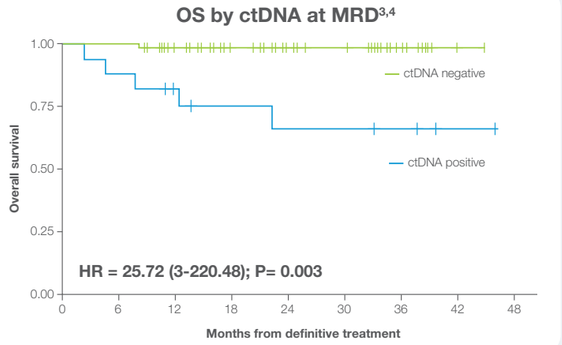
Signatera™ ctDNA helps answer critical questions across HPV-negative and HPV-positive HNSCC



Better tools are needed to risk-stratify and surveil HNSCC patients

Up to 30% of HNSCC patients develop distant metastases after frontline treatment, and surveillance can be challenging due to complex anatomy and post-treatment changes[1,2]

Signatera™ status identified patients remaining at high risk after curative intent treatment across stages and HPV status[3,4]



Signatera™ positivity after curative intent treatment identified patients with a >25x higher risk of death[3,4]

- **Signatera™ positive:** 56% 2-year OS
- **Signatera™ negative:** 98% 2-year OS

Signatera™ identified recurrence earlier and more accurately than standard of care imaging[3-5]

>4-month median lead time

Test	Specificity	Sensitivity	PPV	NPV
ctDNA	100%	78%	100%	91%
PET-CT	68%	78%	54%	86%

- Signatera™-positivity preceded imaging-confirmed progression by a median of 4.44 months[3,4]
- Signatera™ outperformed PET-CT in detecting recurrence, showing superior specificity and predictive value[5]

Signatera™ ctDNA dynamics can help tailor R/M HNSCC treatment decisions

Current R/M HNSCC treatment remains suboptimal. Front-line treatment of recurrent/metastatic head and neck squamous cell carcinoma (R/M HNSCC) with pembrolizumab (pembro) with or without chemotherapy (chemo) remains the standard of care based on KEYNOTE-048 trial, but is limited by efficacy and toxicity concerns[6]

SINERGY trial: Proactively escalating and de-escalating chemotherapy based on ctDNA dynamics resulted in high response rates and lower toxicity exposure relative to the standard of care[6,7]

- 27 immunotherapy-naive R/M HNSCC patients were initially stratified to receive pembro monotherapy (CPS≥20) or pembro + chemo (CPS<20), and then evaluated to maintain, de-escalate, or escalate treatment every two cycles based on ctDNA dynamics[7]

63% ORR
Compared favorably to the 36% (chemo + pembro) and 19% (pembro monotherapy) ORRs from KEYNOTE-048

74% of patients de-escalated
Almost 3/4 of patients were de-escalated from chemo + pembro to pembro monotherapy at least once

48% ≥3 AE rate
Compared favorably to the 85% (chemo + pembro) and 55% (pembro monotherapy) grade ≥3 adverse event rate from KEYNOTE-048

2 cycles of chemotherapy
Patients received a median of 2 cycles of chemotherapy, a substantial reduction from the current standard of care (6 cycles)

Signatera™ is covered by Medicare for any patient being treated with an ICI

Learn more about **Signatera™ for HNSCC**

References: 1. Ionna F, et al., *Cancers.* 2021 May 14;13(10):2371. doi: 10.3390/cancers13102371. **2.** Honore N, et al., *Clin Cancer Res* 2025; https://doi.org/10.1158/1078-0432.CCR-25-1309. **3.** Peddada et al. Post treatment Head & Neck cancer surveillance with ctDNA. Pennington Cancer Institute presentation, 2025. **4.** Natera Data on File. **5.** Lele S, et al., C.-A.O. (2024). *Otolaryngol Head Neck Surg*, 171: 439-444. https://doi.org/10.1002/ohn.760. **6.** Burtness B, et al., The Lancet, 2019, doi:10.1016/S0140-6736(19)32591-7. **7.** Rosenberg A, et al., Presented at the Multidisciplinary Head and Neck Cancers Symposium, February 2026.

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In the management of HPV-driven anal and oropharyngeal cancer surveillance

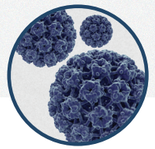
Let their blood TTMV® help achieve a new standard of care

NavDx reliably informs disease status so you can optimize the utility of imaging, physical exams and salvage therapy, reassuring patients their disease is being effectively managed[1,2]

References: 1. Hanna GJ, Roof SA, Jabalee J, et al. Negative predictive value of circulating tumor tissue modified viral (TTMV)-HPV DNA for HPV-driven oropharyngeal cancer surveillance. Clin Cancer Res 2023. doi: 10.1158/1078-0432.CCR-23-1478. 2. Berger BM, Hanna GJ et al. Detection of Occult Recurrence Using Circulating Tumor Tissue Modified Viral HPV DNA among Patients Treated for HPV-Driven Oropharyngeal Carcinoma. Clin Cancer Res 2022;28(19):4292–4301.

NavDx-1025-166/R2

NavDx®
Optimizing HPV+ Cancer Care



NavDx® Surveillance Testing Program

The NavDx® Surveillance Testing Program combines clinical flexibility, operational simplicity, and patient-centered access to support long-term post-treatment recurrence monitoring for HPV+ head & neck and anal squamous cell cancer. With a **single, annual test order** that covers a full 12 months of surveillance testing, providers and patients are set up to successfully remain on track for recurrence monitoring. Start any time; no baseline/pre-treatment test is required to use the NavDx test for surveillance monitoring.

How the Program Works

1

Healthcare provider places one annual test order with provider-directed cadence

Providers place a single NavDx test order that covers a 12-month period.

Testing frequency (e.g., every 3, 4, or 6 months) is set by the provider based on clinical need and can be adjusted at any time.

2

Provider selects phlebotomy options

In addition to blood draws at the provider's office/facility, Naveris can arrange blood draws at convenient locations for patients. **When Naveris® arranges phlebotomy, patients are more likely to complete testing compared to relying on in-office/facility blood draws.** *(Naveris data on file).*

3

Receive test results prior to patient office visits

Providers generally receive results within 7 business days of the specimen being received in our laboratory.

When providers and patients opt for Naveris-arranged phlebotomy, NavDx tests can be completed in advance and providers can have test results available at the time of their follow-up appointments.

4

Reduce administrative burden and improve patient compliance

With Naveris-arranged phlebotomy, we will actively help your patients stay on schedule. As their next testing period approaches, Naveris's in-house Patient Navigation Team will reach out to patients to schedule their blood draw and help them stay on track with their surveillance plan.

Benefits for Physicians

- Reduces administrative burden by eliminating the need to place multiple test orders
- Maintains provider control over testing cadence and clinical decisions
- Improves patient adherence to long-term monitoring

Benefits for Patients

- Convenient blood draw options that offer minimal disruption to daily life
- Clear and consistent surveillance plan following treatment
- Fewer barriers to testing and reduced chance of missed tests

NavDx®
Optimizing HPV+ Cancer Care

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Leading with precision. Driven by expertise.

Pioneering the next chapter of head and neck cancer care at City of Hope.

Head and neck cancer care requires highly specialized expertise. It demands precision across many disciplines, at every stage.

Across our multidisciplinary teams, world-renowned cancer experts are advancing treatments and delivering coordinated care designed to improve outcomes while preserving function and quality of life. With expertise across surgery, radiation oncology, medical oncology and precision medicine, we bring the full depth of City of Hope to every patient.

The program advances innovation through clinical trials in robotic surgery, novel immunotherapies, cellular therapies and precision oncology. We're moving science forward at the speed every diagnosis demands and every patient deserves, advancing toward a cancer-free future.

As one of the nation's largest and most advanced cancer research and treatment organizations, City of Hope delivers world-renowned head and neck cancer expertise through a growing national system of care. We treat patients across the country through an expanding network of locations.

The future of head and neck cancer care.

4,200+ Patient visits
Annually through surgical care

4,900+ Patient visits
Annually through radiation oncology care

24+ Studies
In national clinical trial programs, other clinical research and in the queue for activation

"Head and neck cancers demand precision at every decision point. Our multidisciplinary teams work as one to deliver coordinated care that achieves oncologic precision while preserving the functions that define quality of life."

— Dr. Ellie Maghami, Surgeon
Norman and Sadie Lee Foundation Endowed Professor in Head and Neck Cancer

Duarte & Orange County Head and Neck Treating Physicians

Treating head and neck cancers demands expert care and precision. Our teams plan together from day one, aligning diagnostics, surgical, medical and radiation expertise to best address each patient's unique condition and life priorities.

Diagnostics

Subspecialized head and neck pathologists provide expert histopathologic interpretation supported by advanced molecular diagnostics, ensuring precise tumor classification and risk stratification. Integrated digital pathology platforms enable multidisciplinary consultation, image sharing and efficient correlation of morphologic, immunohistochemical and molecular findings.

Fellowship-trained radiologists with head and neck imaging expertise leverage magnetic resonance imaging, computed tomography, ultrasound and nuclear medicine techniques to ensure precise diagnosis and confident treatment planning for every cancer patient.

Surgery

Fellowship-trained surgeons treat cancers of the oral cavity, pharynx, larynx, nasal cavity, paranasal sinuses, salivary glands, thyroid and skin. Capabilities include transoral robotic surgery, transoral laser microsurgery, expanded endoscopic skull base approaches and immediate microvascular reconstruction. Reconstructive care is designed to preserve speech, swallowing and appearance while maintaining oncologic principles.

Radiation Oncology

Radiation oncologists deliver image-guided treatment using advanced imaging technologies that precisely target tumor locations. They collaborate closely with surgical and medical teams on treatment sequencing, applying techniques that minimize long-term functional impairment while maximizing therapeutic outcomes.

Medical Oncology

Medical oncologists personalize systemic therapy across chemotherapy, targeted agents and immunotherapy, with treatment selection guided by molecular profiling and biomarker analysis. Patients may also have access to clinical trials evaluating cellular immunotherapies, molecularly targeted therapies, novel surgical technologies and combination approaches before they become standard practice.

Comprehensive Care

Rehabilitative services include speech-language pathology, physical therapy and occupational therapy. Our team coordinates comprehensive care throughout treatment including nutrition counseling, psychosocial support, dental oncology and dedicated patient navigation. Survivorship planning addresses functional outcomes, tobacco cessation and long-term quality of life.

We partner with referring physicians to ensure seamless communication and continuity of care from consultation through survivorship.

Thyroid Program

A dedicated multidisciplinary team provides comprehensive management of thyroid tumors. Advanced molecular diagnostics inform risk stratification and treatment decision-making. Coordinated surgical, endocrine, medical oncology and radiation oncology expertise spans the full spectrum of thyroid disease.

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Pursuing cancer cures at the speed of life.

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