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Learn more at www.sitcancer.org

[Image: Immunotherapy for the Treatment of Melanoma]

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6 Treatment Options
8 Side Effects
10 About Clinical Trials
13 Patient Assistance Resources

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I received exceptional care throughout my treatment, and my medical team did an excellent job of educating me about my condition and immunotherapy.
– Adam Capezzuto, Stage III melanoma survivor

Survivor Story: Adam Capezzuto

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Immunotherapy is the newest type of treatment available for people with cancer. For decades, doctors and researchers have conducted clinical trials to further the progress in immunotherapy as cancer treatment. Former President Jimmy Carter’s success with immunotherapy for advanced melanoma and Vice President Joe Biden’s Cancer Moonshot Initiative have brought this new treatment type, as well as cancer treatments in general, into the spotlight for the general public.

Cancer cells have a sneaky way of fooling the body into not recognizing they are dangerous. If the body can’t tell the difference between cancer cells and healthy cells, the cancer cells may be able to hide. Immunotherapy uses the body’s own immune system to slow the growth of and kill cancer cells by using substances made either by the body or in a laboratory. These substances allow the immune system to identify cancer cells as a threat and target them for destruction.

Different types of immunotherapy exist. Each works in a unique way to slow and stop the growth of cancer cells, stop cancer cells from spreading to other parts of the body and help the immune system work better overall at destroying cancer cells. Some types of immunotherapy boost the body’s immune system, and others train the immune system to attack cancer cells:

- **Checkpoint inhibitors** are an important part of the immune system due to their ability to keep immune cells from attacking normal cells in the body. Checkpoints are proteins on immune cells that need to be turned on or off to start or stop an immune response. The immune system uses checkpoints to turn on an immune response, when appropriate, and turn it off, when necessary, to prevent itself from attacking normal cells in the body. But melanoma cells sometimes use these checkpoints to avoid being attacked by the immune system. Checkpoint inhibitors target the checkpoint proteins, helping to restore the immune response against melanoma cells.

- **Cytokines** are proteins that enable cells to send messages to each other. Cytokines work together to make sure that the immune response is of the right strength and length of time. Laboratory-made versions of cytokines are sometimes used to boost the immune system in people with melanoma.

- **Oncolytic viruses** are viruses altered in a laboratory so that they infect and kill mainly cancer cells. Along with killing the cells directly, the viruses can also alert the immune system to attack the cancer cells.

- **Cancer vaccines** are substances that stimulate the immune system to fight infection or disease. Cancer vaccines strengthen the immune system against cancer cells.

- **Nonspecific immune stimulators** boost the immune system in a general way to help the immune system attack cancer cells.

Although certain immunotherapies work well when given alone, others work better in combination with additional treatments.

The opportunity to have an improved quality of life is making immunotherapy an attractive choice for people who have this treatment option. Although traditional treatments, such as chemotherapy, for example, target cancer cells, healthy cells also are damaged, resulting in side effects such as alopecia (hair loss) and nausea. With immunotherapy, side effects may still occur, but they are primarily the result of an overactive immune system, not the destruction of healthy cells. Because not as many healthy cells are damaged, some patients have reported fewer and less severe side effects (see page 8). Additionally, immunotherapy has the potential to remain effective long after the treatment is over, a feature called “memory.” This feature is the same one that allows a tetanus vaccine, for example, to remain effective for many years. For people with cancer, this effect can lead to long-term, cancer-free remission and better overall survival.

It is important to note that immunotherapy is effective for some patients but not for others, even when they seem to have the same cancer. Doctors and scientists continue to study this puzzling characteristic, along with how to improve existing therapies and develop new ones, through clinical trials. If immunotherapy is not an option for you, your doctor will recommend one or more of the treatments considered “standard of care” (approved and recommended) (see page 6). Additionally, you may be able to take advantage of treatments that are not yet FDA-approved by participating in a clinical trial (see page 10). Before you make any treatment decisions, talk to your doctor about whether you are eligible for a clinical trial.

### A LONG HISTORY

- Cancer treatments are not discovered overnight. More than a century ago, Dr. William B. Coley worked with doctors and people with cancer to study how cancer tumors reacted to bacterial infections. His treatments for people with inoperable tumors consisted of injecting a combination of bacteria directly into the tumors. The treatment shrunk the tumors and sometimes even led to a cure. Dr. Coley believed the body’s increased response to the bacteria also helped fight off the cancer.

- More recently, in the 1960s, Dr. Donald Morton began experimenting with a vaccine that was intended not to prevent cancer but to stimulate the body’s immune system to attack cancer cells once they had developed. An early proponent of immunotherapy, particularly cancer vaccines, Dr. Morton was at the forefront of global cancer research and treatment, with a focus on melanoma. His work with bacillus Calmette-Guerin (BCG) for melanoma led to the approval of BCG for bladder cancer, the first successful immunotherapy against a human tumor.

### ADDITIONAL RESOURCES

- American Cancer Society: www.cancer.org
  - What is Cancer Immunotherapy?
- American Society of Clinical Oncology: www.cancer.net
  - Understanding Immunotherapy
- Society for Immunotherapy of Cancer: www.sitcancer.org

### WORDS TO KNOW

- **Cancer cells** – Cells with damaged DNA that causes mutations in normal cell growth and division. New cancer cells grow uncontrollably and old cancer cells don’t die when they should, resulting in a malignant tumor or cancer.

- **Immunotherapy** – A type of cancer treatment that focuses on using the body’s own immune system to fight cancer.

- **Standard of care** – A treatment regimen that is accepted by medical experts as a proper treatment for a specific type of cancer and is used widely by healthcare professionals to treat patients. This can also be called best practice, standard medical care and standard therapy.
Immunotherapy may sound complicated, but when you think about how it uses the same natural defenses your body uses every day to fight infection, you may be able to better understand how it works. Sometimes your body’s own defenses aren’t enough to wipe out something as intense as cancer, so doctors use immunotherapy to build on the healing capabilities of your immune system with drugs and other techniques (see The Role of Monoclonal Antibodies).

HOW THE IMMUNE SYSTEM WORKS

The immune system is the body’s natural defense against infection and disease, including cancer, and protects the body from substances that can cause harm, such as bacteria and viruses (also called germs). The cells of the immune system continuously flow through the body, looking for germs that may be invading the body. The immune system recognizes invaders by their antigens, which are proteins on the surface of the invading cells (see Figure 1). Every cell or substance has its own specific antigens, and a person’s cells carry “self-antigens” that are unique to that individual. People carry self-antigens on normal cells, such as liver, colon, and thyroid cells. Cells with self-antigens are typically not a threat. Invading germs, however, do not originate in the body and so do not carry self-antigens; instead, they carry what are called “nonself-antigens.”

The immune system is designed to identify cells with nonself-antigens as harmful and respond appropriately. Most immune cells release cytokines (messengers) to help them communicate with other immune cells and control the response to any threats.

THE ROLE OF MONOCLONAL ANTIBODIES

One of the body’s natural immune responses to foreign substances is the creation of antibodies specific to the antigens (proteins) found on the surface of invading germ cells. Some antibodies can recognize portions of proteins on the surface of cancer cells. Monoclonal antibodies (mAbs) are antibodies made in a laboratory that are designed to target specific tumor antigens. They work in different ways:

- **Flagging targeted cancer cells for destruction.** The mAb acts as a flag that attaches to parts found only on the surface of specific cancer cells, marking them for destruction by other immune cells.
- **Blocking growth signals and receptors.** Some mAbs are designed to block the mechanisms that cancer cells use to grow, such as access to the blood vessels necessary for growth.
- **Delivering other therapeutic agents directly to targeted cancer cells.** The mAbs can be made to carry cancer drugs, radiation particles or laboratory-made cytokines directly to cancer cells. When a mAb is combined with a toxin, such as a chemotherapy drug, it travels through the system until it reaches the targeted cancer cell, where it attaches to the surface, gets swallowed by the tumor cell and breaks down inside the cell, releasing the toxin and causing cell death. Combining mAbs with radiation particles, a treatment known as radioimmunotherapy, allows for radiation to be delivered in lower doses over a longer period of time directly to specific cancer cells. This direct form of radiation delivery typically damages only the targeted cells (see figure below).

FACING A NORMAL INVADER

Your immune system works constantly to keep your body free from infection. Understanding how your immune system responds in an ordinary situation will make it easier to see how it can be enhanced to face a more serious condition such as cancer.

When you skin your knee, for example, the immune system’s first barrier, the skin, is broken, and harmful substances can easily enter the body (see Figure 2). As soon as the injury occurs, immune cells in the injured tissue begin to respond and also call other immune cells that have been circulating in your body to gather at the site and release cytokines to call other immune cells to help defend the body against invasion. The immune cells can recognize any bacteria or foreign substances as invaders. Immune cells, known as natural killer cells, begin to destroy the invaders with a general attack. Although this attack can kill some of the invaders, it may not be able to destroy all of them or prevent them from multiplying.

At the same time, other immune cells called dendritic cells start to “eat” the invaders and their nonself-antigens. This process causes the dendritic cells to transform into antigen-presenting cells (APCs). These APCs expose the invader cells to the primary immune cells of the immune system—the B and T cells—so that these cells can recognize the invading cells. B cells work rapidly to produce antibodies which help identify and stop the invading bacteria cells. Viruses, unlike bacteria, like to hide inside normal cells and may

**FIGURE 1**

**TYPES OF ANTIGENS**

All cells, including normal body cells, have antigens, or proteins, on their surface. Self-antigens are proteins that are specific to an individual person, and cells with self-antigens are usually not a threat to the body. People carry self-antigens on normal cells, such as liver, colon and thyroid cells. However, invading cells are not part of the body and do not have self-antigens. Instead, they have nonself-antigens. The immune system can identify cells with nonself-antigens as harmful and begin an attack on those cells.

**FIGURE 2**

**NORMAL IMMUNE RESPONSE**

- **Skinned knee:** First barrier of protection is broken.
- **An invader enters the body through the cut, where immune cells have begun to gather to protect the body.**
- **The immune cells begin to destroy and digest the invader and its antigens.**
- **Monoclonal antibodies can be directed against proteins on the surface of cancer cells to target them for immune destruction or they can be directed against receptors on immune cells to regulate their function.**
- **Chemotherapy drug**
- **Monoclonal antibody (mAb)**
- **The tumor cell engulfs the mAb.**
- **As the mAb is digested, the toxic particles are released, causing cell death from within.**

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be more difficult for the immune system to recognize. T cells, however, are designed to find abnormal fragments of viruses inside normal cells. Before these T cells have been activated to fight viruses and other invaders, they're known as “naïve” T cells.

APCs communicate with and activate the naïve T cells by connecting to them through protein molecules on their surfaces. A specific set of proteins on the APC, called the major histocompatibility complex (MHC), must connect to the receptor on each T cell. This first important connection is sometimes referred to as Signal 1. This connection allows the T cell to recognize antigens on invading cells as a threat.

Before a T cell can be fully activated, however, additional molecules on the surfaces of both cells must also be connected to confirm that an attack against the invader is necessary. This second signal is known as the co-stimulatory signal, or Signal 2. If a T cell receives Signal 1 but not Signal 2, the T cell will die, and the attack is shut down before it even started.

When a T cell receives both Signal 1 and Signal 2, it is able to recognize the invading cells and destroy them. This fully activated T cell then multiplies to develop an army of T cells that is equipped with the necessary weapons to defeat the threat (see Figure 3). Multiple generations of immune cells are created by the same immune response, and then some T cells transform into regulatory T cells, which work to slow and shut down the immune response once the threat is gone.

Other T cells may become memory T cells. They can stay alive for months or years, continuing to fight off the same invaders again. Memory is the basis of immune protection against disease in general and explains why we don’t become infected with some diseases, such as measles or chickenpox, more than once.

FACING CANCER
Your immune system uses the same method to attack cancer, but the process is more complicated because cancer cells are created by the body. Because of this, the normal ways to find and fight invading cells from outside the body aren’t always effective. If the body can’t tell the difference between tumor cells and normal cells, the tumor cells may be able to “hide” from the immune system.

As an example, think of allergy shots given to relieve the symptoms of a pollen allergy. Increasing doses of a specific allergen are injected into a person over a series of visits to the doctor, which causes the body to develop a tolerance to pollen. This type of therapy can provide temporary or permanent relief of symptoms. However, the body no longer sees the pollen as an invader, so the immune system stops attacking it. The case with cancer cells is often similar. In early stages, cancer cells may shed proteins into the body. As these proteins circulate through the bloodstream, the body begins to develop a tolerance for the cancer cells. And once that tolerance exists, the immune system may not recognize these cancer cells as a threat. Then, just like the pollen, the cancer cells may be safe from an immune system attack.

In some cases, the DNA changes (mutations) that cause the cancer may be different enough to stimulate an immune response similar to the response described for invading virus cells. If the immune system detects the cancer, the APCs show cancer cell materials to T cells, the primary players in the fight against cancer (see Figure 4). The MHC on APCs must connect to receptors on T cells, and the T cells must receive both Signal 1 and Signal 2 in order to become activated and multiply. If Signal 2 is not received, the response will shut down. A T cell can function properly against the cancer only if it recognizes the cancer as harmful, receives the proper signals to become activated, and continues to get signals to continue the attack.

Tumor cells can create cytokines, which means that cancer cells can communicate with and confuse other immune cells, allowing the cancer to take control of certain parts of the process that the body uses to regulate the immune response. So, even if the immune system recognizes the cancer, it may not be able to successfully start or maintain an attack long enough to kill the cancer cells.

The ability of T cells to become activated and attack cancer is at the heart of immunotherapy research. One specific area of research focuses on how cancer cells can trick the immune system into turning on “checkpoint pathways” early. Checkpoint pathways are part of the system of checks and balances that allow the immune cells to evaluate the attack against the threat at multiple stages. The pathways essentially function as the “brakes” when the body determines the response is no longer needed. By using signals to confuse other immune cells into putting on the brakes, the cancer can shut down the attack before it has responded effectively and thus, the cancer cells continue to grow. Blocking the effect of these checkpoint pathways can restore the normal function of the immune cells.

FIGURE 3
T CELL ACTIVATION

A: Inactive T cells are activated when antigen-presenting cells (APCs) connect with the T cell.
B: Two signals (see 1 & 2) are necessary for complete activation.
C: Activated T cells then multiply to defeat the threat.

(©Patient Resource LLC)

FIGURE 4
HOW THE IMMUNE SYSTEM ATTACKS CANCER

Tumor antigens
APC
Naïve T cell
Activated T cell
Activated T cell
Destroyed tumor cell

Tumor cells release tumor antigens.
APCs gather tumor antigens and prepare to present to naïve T cells.
T cells are activated by the APC.
Activated T cells find the tumor cells with the same tumor antigens and destroy them.

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(continued on page 9)
Once your cancer is diagnosed, your physician will determine the stage of the cancer. Melanoma is categorized into one of five main stages (0 through IV). The size, location and whether the melanoma has spread are used to determine the stage. Following your diagnosis, your doctor will use the staging information to select the best treatment options for you.

Melanoma is usually staged twice. First, your physician will consider the results of your physical exam and any imaging tests that were done, and assign a clinical stage. Then, after a biopsy or surgical procedure, a pathologist will examine tissue taken from the tumor (and possibly nearby lymph nodes) and assign a pathologic stage. Because the pathologic stage is based on more details about your specific melanoma, this second staging is more precise and is the key to deciding which treatment options may be best.

Both the clinical and pathologic stages of melanoma are classified according to the tumor (T), node (N) and metastasis (M) categories to describe the number of cancer cells in the tumor, lymph nodes and other distant sites.

The first classification of the primary melanoma in the TNM system is for the thickness of the tumor (T). Each T classification is further divided into groups according to whether ulceration (a break in the outer layer of skin over the melanoma) is absent (subcategory a) or present (subcategory b). For example, a non-ulcerated melanoma 3 millimeters (mm) thick is classified as T3a, whereas an ulcerated melanoma 2 mm thick is classified as T2b. Another factor for thin melanomas (less than 1 mm thick) is the mitotic rate, which measures how fast the cancer cells are dividing and multiplying.

The node (N) classification is used to describe how many lymph nodes contain melanoma cells. The N category includes subcategories to describe the number of cancer cells in the lymph nodes. If the cancer cells in the nodes can be seen only with a microscope, the metastasis (spread) is considered to be microscopic (a). If enough cancer cells are in the lymph node that the doctor can feel the mass during a physical exam or can see the mass on an X-ray, it’s said to be “macroscopic” lymph node involvement (b). Another subcategory (c) indicates whether melanoma has spread to the lymphatic vessels leading to a lymph node. This is known as “in-transit melanoma,” which is metastatic melanoma found between the original tumor and the nearby cluster of lymph nodes.

The metastasis (M) category is used to classify the melanoma according to whether the cancer has spread beyond the region where the melanoma started to distant sites in the body.

### TABLE 1

<table>
<thead>
<tr>
<th>Stage</th>
<th>T</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Tis</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IA</td>
<td>T1a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IB</td>
<td>T1b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T2a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIA</td>
<td>T2b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T3a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIB</td>
<td>T3b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T4a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIIC</td>
<td>T4b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIA</td>
<td>T1-T4a</td>
<td>N1-T4a</td>
<td>M0</td>
</tr>
<tr>
<td>IIIIB</td>
<td>T1-T4b</td>
<td>N1-T4b</td>
<td>M0</td>
</tr>
<tr>
<td>IIIIC</td>
<td>T1-T4b</td>
<td>N1-T4b</td>
<td>M0</td>
</tr>
<tr>
<td>IV</td>
<td>Any T</td>
<td>Any N</td>
<td>M1</td>
</tr>
</tbody>
</table>

### TABLE 2

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumor.</td>
</tr>
<tr>
<td>Tis</td>
<td>Also known as &quot;melanoma in situ,&quot; melanoma cells are found only between the outer layer (epidermis) and the inner layer (dermis) of skin and have not yet invaded these layers. This lesion is considered precancerous.</td>
</tr>
<tr>
<td>T1</td>
<td>Melanoma is no more than 1 millimeter (mm) thick (about the thickness of a credit card).</td>
</tr>
<tr>
<td>T1a</td>
<td>Melanoma found in three or fewer lymph nodes, with ulceration and a mitotic rate of less than 1/mm².</td>
</tr>
<tr>
<td>T1b</td>
<td>Melanoma found in three or fewer lymph nodes, with ulceration and a mitotic rate of 1/mm² or greater.</td>
</tr>
<tr>
<td>T2</td>
<td>Melanoma is thicker than 1 mm but not more than 2 mm thick.</td>
</tr>
<tr>
<td>T2a</td>
<td>Melanoma is thicker than 1 mm but not more than 2 mm thick, without ulceration.</td>
</tr>
<tr>
<td>T2b</td>
<td>Melanoma is thicker than 1 mm but not more than 2 mm thick, with ulceration.</td>
</tr>
<tr>
<td>T3</td>
<td>Melanoma is thicker than 2 mm but not more than 4 mm thick.</td>
</tr>
<tr>
<td>T3a</td>
<td>Melanoma is thicker than 2 mm but not more than 4 mm thick, without ulceration.</td>
</tr>
<tr>
<td>T3b</td>
<td>Melanoma is thicker than 2 mm but not more than 4 mm thick, with ulceration.</td>
</tr>
<tr>
<td>T4</td>
<td>Melanoma is thicker than 4 mm.</td>
</tr>
<tr>
<td>T4a</td>
<td>Melanoma is thicker than 4 mm, without ulceration.</td>
</tr>
<tr>
<td>T4b</td>
<td>Melanoma is thicker than 4 mm, with ulceration.</td>
</tr>
<tr>
<td>Nx</td>
<td>Regional lymph nodes cannot be assessed.</td>
</tr>
<tr>
<td>N0</td>
<td>No melanoma found in regional lymph nodes.</td>
</tr>
<tr>
<td>N1</td>
<td>Melanoma found in one lymph node.</td>
</tr>
<tr>
<td>N1a</td>
<td>Melanoma found in one lymph node, microscopic metastasis found in one lymph node.</td>
</tr>
<tr>
<td>N1b</td>
<td>Macroscopic metastasis found in one lymph node.</td>
</tr>
<tr>
<td>N2</td>
<td>Melanoma found in two to three lymph nodes.</td>
</tr>
<tr>
<td>N2a</td>
<td>Melanoma found in two to three lymph nodes, microscopic metastasis found in two to three lymph nodes.</td>
</tr>
<tr>
<td>N2b</td>
<td>Melanoma found in two to three lymph nodes, macroscopic metastasis found in two to three lymph nodes.</td>
</tr>
<tr>
<td>N2c</td>
<td>In-transit melanoma or satellite lesions are found, without metastasis to lymph nodes.</td>
</tr>
<tr>
<td>N3</td>
<td>Melanoma is found in four or more lymph nodes, or in two or more lymph nodes that appear to be joined together (known as matted lymph nodes). Or, melanoma is found as in-transit lesions or as satellite lesions that have spread to the lymph nodes.</td>
</tr>
<tr>
<td>Mx</td>
<td>Metastasis cannot be assessed.</td>
</tr>
<tr>
<td>M0</td>
<td>No metastasis.</td>
</tr>
<tr>
<td>M1a</td>
<td>Metastasis to skin, subcutaneous tissues or distant lymph nodes.</td>
</tr>
<tr>
<td>M1b</td>
<td>Metastasis to lung.</td>
</tr>
<tr>
<td>M1c</td>
<td>Metastasis to any other distant organs.</td>
</tr>
</tbody>
</table>
Once the melanoma is classified according to the TNM system, an overall stage of disease is assigned (see Table 1). Stage 0 is known as “melanoma in situ” and is considered to be precancerous. Stage I and II melanomas are considered to be local (or localized) disease. Stage III melanoma is referred to as regional disease, and Stage IV is known as distant metastatic or advanced disease.

**WORDS TO KNOW**

- **Biopsy** – A procedure to remove tissue for examination to determine if melanoma is present.
- **Dermis** – The dense inner layer of skin below the epidermis.
- **Epidermis** – The upper layer of skin.
- **Lymph node** – Found throughout the body, lymph nodes are small organs in the lymphatic system that filter lymph fluid, trapping bacteria, viruses and other foreign substances which are then destroyed by special white blood cells called lymphocytes. Cancer can spread to nearby lymph nodes.
- **Macrometastases** – The spread (metastasis) of cancer from its original location to other sites in the body with the tumor large enough to be seen by the naked eye.
- **Micrometastases** – The spread (metastasis) of cancer from its original location to other sites in the body with the newly formed tumors being too small to be detected by the naked eye. A microscope must be used.
- **Subcutaneous tissue** – A deep layer of loose, irregular connective tissue beneath the skin.
TREATMENT OPTIONS

Immunotherapy is one of several types of treatment considered to be standard of care for melanoma. The common types of treatment are the following:

- Surgery is the removal of the melanoma and surrounding normal tissue.
- Chemotherapy includes drugs to stop the growth of cancer cells. How it is given depends on the type and stage of the cancer.
- Radiation therapy is the use of high-energy X-rays or other types of radiation to kill cancer cells or stop them from growing.
- Targeted therapy includes drugs or other substances to attack cancer cells directly, usually by targeting a specific abnormal gene or protein.
- Immunotherapy activates the body’s immune system to enable immune cells to attack and destroy cancer cells.

The use of the body’s own immune system makes immunotherapy fundamentally different from other cancer treatments. Many immunotherapy strategies currently exist (see Table 1). Additional immunotherapies, used alone and in conjunction with other treatments, are being studied in clinical trials (see page 10).

Immunotherapy depends on a functioning immune system, so it will likely be important to make sure that you do not have an autoimmune disorder or are not taking any immunosuppressive medications. After taking into consideration these and other factors, such as your overall health, type and stage of your melanoma and your treatment history, your doctor will recommend one or a combination of treatments.

Once treatment begins, monitoring is key. More monitoring and follow-up occur with immunotherapy than with most other forms of treatment. You will likely undergo testing to allow your doctor to evaluate how well treatment is working by measuring the size of the tumor as treatment progresses.

If immunotherapy is not suggested for you, do not be disappointed. All of the approved treatments for melanoma are extremely effective strategies. In addition, you may be a candidate for a clinical trial that offers access to a leading-edge treatment that is not yet available (see page 10). Ask your doctor about all your options, taking into consideration possible side effects, before making any treatment decisions.

### CHECKPOINT INHIBITORS

**Checkpoint inhibitors** – Drugs that block the activation of specific immune checkpoint pathways and prevent T cells from shutting down.

**Immune checkpoint pathways** – The system of checks and balances in place to prevent overactivation of the immune system. Different pathways function at different stages of the immune response to help regulate the length and intensity of T cell activity; turning on an immune checkpoint typically results in shutting down the immune system response.

**Interleukin** – A protein produced by cells of the immune system that helps regulate the production of certain immune cells, how they function during an immune response and their production of cytokines. The laboratory-made version of this protein, aldesleukin (Proleukin), is currently FDA-approved to treat metastatic renal cell carcinoma (kidney cancer).

**Oncolytic virus** – A virus that can infect and multiply within cancer cells, leading them to die. These viruses may be manufactured or naturally occurring, and can be used to target and destroy specific tumor cells. They may also induce an immune response.

### WORDS TO KNOW

**CTLA-4 (cytotoxic T-lymphocyte-associated antigen-4)** – A protein receptor found on the surface of T cells. This protein is part of the CTLA-4 checkpoint pathway, which can shut down an immune system response in its early stages. Certain cancer cells have the ability to turn on this checkpoint, which stops the immune response against the cancer cells.

**Checkpoint inhibitors** – Drugs that block the activation of specific immune checkpoint pathways and prevent T cells from shutting down.

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### TABLE 1

<table>
<thead>
<tr>
<th>Class of treatment</th>
<th>Purpose</th>
<th>Type of treatment</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checkpoint inhibitors</td>
<td>Prevent the immune system from shutting down in the body and restore the immune response against melanoma cells</td>
<td>CTLA-4 inhibitor</td>
<td>ipilimumab (Yervoy)</td>
</tr>
<tr>
<td>Cytokines</td>
<td>Boost the immune system overall</td>
<td>PD-1 inhibitor</td>
<td>nivolumab (Opdivo) pembrolizumab (Keytruda) Combination therapy of ipilimumab with nivolumab</td>
</tr>
<tr>
<td>Oncolytic viruses</td>
<td>Kill tumors, primarily those that cannot be surgically removed</td>
<td>Oncolytic virus therapy</td>
<td>talimogene laherparepvec (Imlygic/T-VEC)</td>
</tr>
<tr>
<td>Vaccines</td>
<td>Activate the immune system</td>
<td>Vaccine</td>
<td>bacillus Calmette-Guerin (BCG) vaccine</td>
</tr>
<tr>
<td>Non-specific immune stimulators</td>
<td>Boost the immune system overall</td>
<td>Toll-like receptor agonists</td>
<td>imiquimod (Aldara)</td>
</tr>
</tbody>
</table>
In August 2014, I felt a lump under my arm while I was showering. I had an upcoming appointment with my endocrinologist, so I asked her about it. She wrote a prescription for an ultrasound. I work in the medical field, so I knew something was wrong when the ultrasound technician called in the radiologist instead of sending me home after the test. He performed a second ultrasound and told me he wanted to do a biopsy. The results showed a malignant neoplasm, but the report couldn’t pinpoint what it was so he sent the samples to an oncologist. On my 33rd birthday, I was diagnosed with poorly differentiated melanoma.

The oncologist referred me to several cancer centers, one being a well-known center within driving distance of my home. Several doctors there reviewed my case and came back with several different treatment plans. I wasn’t comfortable with any of the plans, so I reached out to another melanoma specialist also suggested by my oncologist. I clicked with him immediately and embarked on my treatment journey.

Because the melanoma was poorly differentiated, we decided to remove only the tumor for more study, leaving the lymph nodes intact. My oncologist also suggested a clinical trial, but that scared me. I didn’t want to be a guinea pig. While I was considering it, I was shopping with my mom when we ran into her oncologist (my mom is a breast cancer survivor). She told me to absolutely do the clinical trial because it would give me access to the most leading-edge treatment available. That was all I needed to hear.

To complicate matters, I was set to be married on October 25. After discussions with my surgeons, we agreed to wait until after the wedding to remove the tumor, if we postponed the honeymoon. After the tumor was removed and tested, it was confirmed as Stage III melanoma. This led to a follow-up surgery in early February to remove the lymph nodes in the area, and all of the lymph nodes came back clear.

After the surgery in February, I let my body heal for three or four months before beginning the clinical trial. It was good timing because an immunotherapy clinical trial using two drugs was just opening up. It was a double-blind study, meaning no one would know which of the two immunotherapy drugs I would receive. One drug would take down the shields around the cancer cells, while the other one would boost my immune cells.

The clinical trial lasted a year. I didn’t have many side effects at all. I was fatigued, but not enough to take any extra time off from work. I also was a little depressed. I’m not sure if that was due to the treatment or just the fact that I was going through this situation in general. It was minor, and I never had to see a doctor for it. I keep a close eye on lymphedema, a known complication resulting from the removal of lymph nodes. If I start to experience swelling, I will probably begin wearing a compression sleeve.

Based on my side effects and the ones that other people in my clinical trial had, I think I know which drug I received. If I’m right, I believe I am the first Stage III person in the country to receive Opdivo in a melanoma clinical trial. I asked my doctor if I would ever know, but he told me the only way I’d ever be unblinded is if the melanoma returns. In that case, they would have to give me the other drug. That answer was good enough for me—I won’t ask again! I’m cancer-free, I feel great and I’m following up with frequent scans.

I had a tremendous support system. My family constantly checked on me and prayed for me. My friends were there for my surgeries, and my wife was incredible. She’s a nurse, which was a big help. This situation put some big dents in the “princess view” she had of our wedding, but she was a trooper. I made it up to her by finally taking her on a honeymoon to a resort in Grenada. We went big—private hut, Butler service and lots of sunblock.

I received exceptional care throughout my treatment, and my medical team did an excellent job of educating me about my condition and immunotherapy. I had some frustrations regarding my clinical trial. I encourage everyone to read the fine print on their consent forms. There are often hidden costs that you don’t expect to have to pay for, so I would address everything with the hospital and clinical trial administrators before getting started. But don’t let that discourage you. Health care is always complicated. It’s just best to have a solid understanding of every facet of your treatment plan.

I feel very fortunate that everything worked out like it did. I think it was a combination of being in the right place at the right time and cashing in on some good karma I had out there. If you are considering a clinical trial, my advice is to go for it. You’re not a guinea pig. You’re helping expand the reach of what that drug offers. For me, I found value in helping others who may walk a similar path. Gather opinions, research credible resources and understand the studies.

Most important, stay positive but allow yourself to feel your emotions. You’re wholly entitled to feel and express them however you see fit. It’s not the time to put on a brave face for others. Your emotions guide you through a journey of feelings. Let that happen without guilt, resentment or embarrassment.
Although using immunotherapy to treat melanoma typically results in fewer side effects that are less severe than those associated with other forms of cancer treatment, some side effects still can occur, and some can be severe. Not everyone will experience the same side effects with immunotherapy, and some people may not experience any side effects at all. Symptoms can vary in severity and differ according to the type of immunotherapy (see Table 1).

Many side effects can be managed with over-the-counter medications. However, if your symptoms are severe, it is important to contact your health care professional immediately. With immunotherapy, side effects can indicate that your immune system is too active and could put you at risk for an autoimmune disorder. If treated early, these symptoms can be corrected with corticosteroid medications and your treatment can be resumed at a later date. Your doctor may be able to adjust the immunotherapy medication to prevent future autoimmunity if the symptoms are noted early enough. So, it is important for you to communicate with your doctor’s office frequently so they can help monitor you and your symptoms. Seek treatment immediately for any medical emergencies, including high fever, severe abdominal pain or shortness of breath.

Common side effects associated with immunotherapy include the following.

### Immune-mediated adverse reactions

Not everyone will experience side effects with immunotherapy, but they can occur with certain types of immunotherapy medications. This type of reaction, which occurs when the immune system is overstimulated by the treatment, may cause inflammation, swelling or redness, which may or may not be painful. Some organs may become inflamed, which can lead to hepatitis (liver), dermatitis (skin) and enterocolitis (small intestine, colon). It can also damage the nerves and endocrine glands. One of the more common side effects with the checkpoint inhibitors and cytokines is a change in the function of the thyroid gland. This can sometimes be corrected with thyroid replacement medication. Your doctor will likely monitor your thyroid function through a blood test.

Talk to your doctor about how to recognize an immune-mediated adverse reaction, as some side effects may not produce obvious symptoms you can feel. These reactions will need to be confirmed through blood tests. It is important to tell your doctor if you think you may have this reaction so that you can receive treatment as soon as possible to avoid any life-threatening complications.

### Fatigue

Fatigue and feeling tired are often found in the class of therapies known as checkpoint inhibitors, cytokines and oncolytic virus therapy.

The fatigue associated with cancer is different than simply feeling tired because you haven’t had enough rest. Fatigue from cancer or its treatment may cause you to feel physically, emotionally or mentally tired and exhausted. If you begin to miss work, spend less time with friends and family, sleep more, have difficulty remembering things or can’t think clearly, talk with your doctor or nurse.

An evaluation of your fatigue level throughout your treatment and recovery, including doing a distress screening, is recommended.

### Flu-like symptoms

Flu-like symptoms, such as fever, chills, aches, headache, drowsiness, nausea, vomiting, loss of appetite and low blood cell counts, can occur if your treatment includes cytokines or oncolytic virus therapy. These symptoms can range from mild to severe.

To manage flu-like symptoms, get enough rest. Ask your doctor if you can take acetaminophen. Consider taking any oral treatments at bedtime to help minimize symptoms, if your doctor approves. If a cough develops, drink plenty of water and other fluids to keep your throat moist.

### Diarrhea

Diarrhea is a common side effect with the checkpoint inhibitor class of immunotherapies for melanoma, specifically PD-1 and CTLA-4 inhibitors.

The symptoms can vary in severity and duration. It is important to talk with your health care team about what to expect with this side effect, how long it may last and when to consider emergency treatment. Diarrhea can lead to severe dehydration and electrolyte imbalance, but also could be a

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**TABLE 1:** COMMON SIDE EFFECTS OF IMMUNOTHERAPIES FOR MELANOMA

<table>
<thead>
<tr>
<th>Name or Type of Drug</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>bacillus Calmette-Guerin (BCG) vaccine</strong></td>
<td>Injection-site pain; flu-like symptoms with a headache, aches and high temperature</td>
</tr>
<tr>
<td><strong>imiquimod (Aldara)</strong></td>
<td>Injection-site reactions or local skin reactions such as itching, burning, superficial reddening of the skin, flaking/scaling/dryness, scabbing/crusting, swelling, hardening of normally soft tissues or organs as a reaction to inflammation</td>
</tr>
<tr>
<td><strong>interferons, interleukins, hematopoietic growth factors aldesleukin (Interleukin-2; Proleukin)</strong></td>
<td>Flu-like symptoms such as fever, chills, aches and fatigue, severe allergic reaction; lowered blood counts, changes in blood chemistry, organ damage (usually to heart, lungs, kidneys, liver or brain)</td>
</tr>
<tr>
<td><strong>ipilimumab (Yervoy)</strong></td>
<td>Fatigue, diarrhea, itching, rash, and other immune-mediated adverse reactions such as enterocolitis, hepatitis, dermatitis, neuropathy and endocrinopathy</td>
</tr>
<tr>
<td><strong>peginterferon alfa-2b (Sylatron)</strong></td>
<td>Depression and other neuro-psychiatric disorders, fatigue, elevated liver enzymes, fever, headache, decreased appetite, muscle pain, nausea, chills, injection-site reaction</td>
</tr>
<tr>
<td><strong>pembrolizumab (Keytruda)</strong></td>
<td>Fatigue, itchy skin, rash, constipation, diarrhea, nausea, decreased appetite, change in thyroid function</td>
</tr>
<tr>
<td><strong>nivolumab (Opdivo)</strong></td>
<td>Rash, fatigue, muscle or joint pain, bone pain, diarrhea, itchy skin, nausea, change in thyroid function</td>
</tr>
<tr>
<td><strong>talimogene laherparepvec (Imlygic, T-VEC)</strong></td>
<td>Fatigue, chills, fever, nausea, flu-like symptoms, injection-site pain</td>
</tr>
</tbody>
</table>
The longer the cancer cells face a weakened immune response, the more they’re able to adapt, and the easier it is for them to manipulate immune cells inside the tumor’s location (sometimes called the microenvironment area). The area, typically contains cancer cells, normal connective tissues that form the structure of the tumor, access to blood vessels that drive tumor growth and several cell types that contribute to tumor development. Immune cells found in this area are often referred to as tumor-infiltrating lymphocytes (TILs). Because the tumor can control cells in this area, the tumor can trick TILs into becoming useless or even helping the tumor grow. For example, APCs may be confused by signals from tumor cells, preventing the APCs from functioning properly, and making them incapable of sounding the alarm about a threat. In some cases, tumors can upregulate (increase) the activity of regulatory T cells inside the area. With this increased activity, regulatory T cells are actually working to reduce the immune response around the tumor by turning off the other cancer-fighting T cells. It’s as if the tumor recruits the body’s own immune cells to fight off the attack, using the very processes that normally protect the body. The longer the immune system is exposed to the tumor, the weaker the immune response becomes. Immunotherapy research focuses on identifying different ways tumors manipulate the immune system and how to reverse those processes.

**WORDS TO KNOW**

**Antibody** – A protein created by B cells in direct response to specific antigens. An antibody attaches itself to its respective antigen, marking it for other immune cells to “see” and destroy.

**Antigen** – A protein produced by a cell, virus or bacteria. In the case of cancer antigens, the protein or part of a protein on the surface of the cancer cell or substance that alerts the immune system. This causes the production of antibodies or creates T cells that can recognize and potentially destroy the cancer cell expressing that antigen.

**Antigen-presenting cells (APCs)** – Special cells that digest invading cells or soluble protein antigens and present them to the T cells and B cells so they know what to attack.

**B cells** – Immune cells that produce antibodies for specific antigens that will bind to the antigens and mark them for destruction by other immune cells.

**Cytokines** – Proteins released by immune cells to communicate with other immune cells; certain cytokines, such as interferon and interleukin, help regulate specific immune system functions.

**Major histocompatibility complex (MHC)** – A set of proteins on the surface of certain immune cells that influence the interaction of normal cells with immune cells. Antigen-presenting cells show digested antigens to T cells through the MHC on their surface, which allows the T cell to “see” the antigen and recognize it as foreign. The connection between the MHC and the receptor on the T cell is the first signal necessary to activate the T cell to respond to a tumor and destroy it.

**Monoclonal antibodies (mAbs)** – Antibodies made in a laboratory that are designed to target specific parts of cancer cells, which may include certain proteins or molecules on the surface of the cancer cells; they are meant to stimulate an immune response in the same way as naturally produced antibodies do.

**T cells** – Immune cells that recognize specific antigens during antigen presentation; T cells are the major players in the immune system’s fight against cancer. Their activation and activity are two of the main focuses in immunotherapy research.

**Upregulate** – Increase either the overall immune system response or the specific responses of certain immune cells.

Discuss any concerns you have about any potential side effects with your doctor before starting treatment. Communication with your health care team is crucial in managing all side effects during immunotherapy. Once you start treatment, ask your doctor about whom to contact if you have urgent questions about side effects, especially after normal office hours.

**ADDITIONAL RESOURCES**

- **American Cancer Society:** [www.cancer.org](http://www.cancer.org)
  Immunotherapy: Using the Immune System to Treat Cancer
- **American Society of Clinical Oncology:** [www.cancer.net](http://www.cancer.net)
  Understanding Immunotherapy
- **I’m the Answer to Cancer:** [www.theanswertocancer.org](http://www.theanswertocancer.org)
  Cancer Immunotherapy Treatments
**ABOUT CLINICAL TRIALS**

Hundreds of clinical trials throughout the United States are currently being held to evaluate immunotherapy drugs as new treatments for melanoma, either alone or in combination with other treatments.

Every cancer treatment being used today came from a clinical trial, like chemotherapy and radiation therapy, yet people are sometimes hesitant to volunteer because they do not know much about the clinical trial process. Don’t let fear of the unknown keep you from having access to leading-edge treatments. Ask questions of your medical team to help you make an informed decision.

You may consider participating in a clinical trial for the following reasons:

1. Your current treatment may not be working as well as expected, and a clinical trial may offer a worthwhile alternative.
2. A clinical trial may significantly improve your quality of life. Discuss your personal situation with your medical team, so they are aware of your expectations regarding side effects.
3. You may have a rare type of melanoma that hasn’t been studied as much as other types.
4. By simply participating, you play an integral role in helping refine and improve the way millions of people with all types and stages of melanoma are treated. Your participation will help researchers not only identify those treatments that are effective but also those that aren’t.

**GETTING STARTED**

In addition to having a properly functioning immune system, you must meet certain eligibility criteria (cancer type, overall health, treatment history, etc.) to qualify for a clinical trial. Current clinical trials using immunotherapy for melanoma with open recruitment as of September 16, 2016, are displayed in this section. Each trial listed is categorized as “cancer immunotherapy” on www.clinicaltrials.gov.

To learn about a specific trial, enter the trial record number into the search box located at the top of the Web page. The trial record number is a unique identification code assigned to each clinical study. The trial will be “Recruiting” or “Not yet recruiting,” which means the studies are either actively looking for participants or getting ready to look for participants.

If you locate a clinical trial that is not recruiting, don’t be discouraged. New studies are happening all the time, so be sure to keep checking to find available trials.

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**SURVIVOR VOICE**

**Janice | Stage III melanoma**

“If you have the opportunity to try immunotherapy, I recommend it. It took a little bit longer for the entire treatment, but it was easier on my body—and I feel great.”

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**MELANOMA IMMUNOTHERAPY CLINICAL TRIALS**

Includes all open and/or recruiting studies categorized as “cancer immunotherapy” (as of September 16, 2016) by the U.S. National Institutes of Health at www.clinicaltrials.gov

<table>
<thead>
<tr>
<th>Title</th>
<th>Cancer Type</th>
<th>Treatment</th>
<th>Location</th>
<th>NCT Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation for NCI Surgery Branch Clinical Studies</td>
<td>Synovial Cell Cancer; Melanoma; Colorectal Cancer; Lung Cancer; Bladder Cancer</td>
<td>Biological: Young TIL</td>
<td>MD</td>
<td>NCT00001823</td>
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<td>Immunotherapy Using Tumor Infiltrating Lymphocytes for Patients With Metastatic Cancer</td>
<td>Metastatic Colorectal Cancer; Metastatic Gastric Cancer; Metastatic Pancreatic Cancer; Metastatic Hepato cellular Carcinoma; Metastatic Cholangiocarcinoma</td>
<td>Biological: Young TIL; Drug: Aldesleukin; Drug: Cyclophosphamide; Drug: Fludarabine; Drug: Pembrolizumab</td>
<td>MD</td>
<td>NCT01774121</td>
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<td>Vaccine Immunotherapy for Recurrent Medulloblastoma and Primitive Neuroectodermal Tumor</td>
<td>Medulloblastoma; Neuroectodermal Tumor</td>
<td>Biological: TTNA-ALT; Biological: TTNA-DCs</td>
<td>CA, DC, FL, NC</td>
<td>NCT01326104</td>
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<td>Comparison of High-dose IL-2 and High-dose IL-2 With Radiation Therapy in Patients With Metastatic Melanoma</td>
<td>Metastatic Melanoma</td>
<td>Other: Radiation therapy and high-dose IL-2; Drug: High-dose IL-2</td>
<td>OR</td>
<td>NCT01418831</td>
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<td>Vemurafenib With Lymphodepletion Plus Adoptive Cell Transfer &amp; High Dose IL-2 Metastatic Melanoma</td>
<td>Metastatic Melanoma</td>
<td>Drug: High Dose Interleukin-2 [IL-2]; Procedure: ACT with TIL Infusion; Drug: Vemurafenib; Drug: Lymphodepletion</td>
<td>FL</td>
<td>NCT01659151</td>
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<td>Ipilimumab and Imatinib Mesylate in Advanced Cancer</td>
<td>Advanced Cancers</td>
<td>Drug: Ipilimumab; Drug: Imatinib Mesylate</td>
<td>TX</td>
<td>NCT01738139</td>
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<td>Dendritic Cell Activating Scaffold in Melanoma</td>
<td>Melanoma</td>
<td>Biological: WDVAX</td>
<td>MA</td>
<td>NCT01753089</td>
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<td>Tumor-Infiltrating Lymphocytes After Combination Chemotherapy in Treating Patients With Metastatic Melanoma</td>
<td>Stage IIIA Skin Melanoma; Stage IIIB Skin Melanoma; Stage IIIC Skin Melanoma; Stage IV Skin Melanoma</td>
<td>Biological: Aldesleukin; Drug: Cyclophosphamide; Drug: Fludarabine Phosphate; Other: Laboratory Biomarker Analysis; Biological: Therapeutic Tumor Infiltrating Lymphocytes</td>
<td>WA</td>
<td>NCT01807182</td>
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<td>The Effects of Vemurafenib + Cabozantinib on Immunity in Patients With Melanoma</td>
<td>Melanoma</td>
<td>Drug: Vemurafenib</td>
<td>DC, MA, TX, VA</td>
<td>NCT01813214</td>
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<td>Immunotherapy Using Tumor Infiltrating Lymphocytes for Patients With Metastatic Ocular Melanoma</td>
<td>Metastatic Ocular Melanoma; Metastatic Uveal Melanoma</td>
<td>Drug: Aldesleukin; Drug: Cyclophosphamide; Drug: Fludarabine; Biological: Young TIL</td>
<td>MD</td>
<td>NCT01814046</td>
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<td>Dendritic Cell Vaccines + Dasatinib for Metastatic Melanoma</td>
<td>Metastatic Melanoma</td>
<td>Biological: DC vaccine; Drug: Dasatinib</td>
<td>PA</td>
<td>NCT01876212</td>
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<td>Epacadostat and Vaccine Therapy in Treating Patients With Stage III-IV Melanoma</td>
<td>Melanoma; Recurrent Melanoma; Stage IIA Uveal Melanoma; Stage IIB Skin Melanoma; Stage IIIC Skin Melanoma; Stage IV Skin Melanoma</td>
<td>Drug: Epacadostat; Other: Laboratory Biomarker Analysis; Biological: MELITAC 12.1 Peptide Vaccine</td>
<td>GA, NC, OH, VA</td>
<td>NCT01961115</td>
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<td>Immunotherapy Using Tumor Infiltrating Lymphocytes for Patients With Metastatic Melanoma</td>
<td>Melanoma; Prostate Cancer; Ovarian Cancer; Renal Cell Carcinoma; Colorectal Carcinoma; Pancreatic Carcinoma; Non-small Cell Lung Carcinoma; Solid Tumors; Breast Cancer</td>
<td>Drug: Pembrolizumab</td>
<td>MD</td>
<td>NCT01993719</td>
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<td>A Phase 1 Study of AM0010 in Patients With Advanced Solid Tumors</td>
<td>Melanoma; Stage IIIC Skin Melanoma; Stage IV Skin Melanoma; Stage IIIC Uveal Melanoma; Stage IV Uveal Melanoma</td>
<td>Drug: AM0010; Drug: Paclitaxel or Docetaxel and Carboplatin or Cisplatin; Drug: DFO-FOLFOX (Doxilipsatin/Leucovorin/5-Fluorouracil); Drug: Gemcitabine/nab-paclitaxel; Drug: Capecepitabine; Drug: Pazopanib; Drug: Pembrolizumab; Drug: Pemetrexed; Drug: Gemcitabine/carboplatin</td>
<td>CA, CO, FL, MA, NY, OK, TN, TX</td>
<td>NCT02009449</td>
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<td>Cellular Adoptive Immunotherapy Using Autologous CD8+ Antigen-Specific T Cells and Anti-CTLA4</td>
<td>Melanoma</td>
<td>Drug: Cyclophosphamide; Procedure: CD8+ T Cells; Drug: Interleukin-2; Drug: Ipilimumab</td>
<td>TX</td>
<td>NCT02027935</td>
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<td>Immunotherapy Study for Patients With Stage IV Melanoma</td>
<td>Stage IV Melanoma; Metastatic Melanoma</td>
<td>Drug: HyperAcute-Melanoma (HAM) Immunotherapy; Drug: Ipilimumab; Drug: Pembrolizumab</td>
<td>IA, IL, NC, TN</td>
<td>NCT02054520</td>
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<td>Study of IDO Inhibitor in Combination With Checkpoint Inhibitors for Adult Patients With Metastatic Melanoma</td>
<td>Melanoma; Stage III Melanoma; Stage IV Melanoma</td>
<td>Drug: Indoximod; Drug: Ipilimumab; Drug: Pembrolizumab; Drug: Pembrolizumab</td>
<td>GA, IA, MN, NM, PA, UT</td>
<td>NCT02073123</td>
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<td>Molecularly Targeted Therapy in Treating Patients With BRAF Wild-type Melanoma That is Metastatic</td>
<td>Recurrent Melanoma; Stage IIIA Melanoma; Stage IIIB Melanoma; Stage IIIC Melanoma; Stage IV Melanoma</td>
<td>Other: cytology specimen collection procedure; Drug: MEK 162 therapy or molecularly targeted therapy; Procedure: therapeutic procedure; Other: laboratory biomarker analysis; Other: quality-of-life assessment</td>
<td>AZ, CT, FL, IN, MD, MI, MN, TN, TX</td>
<td>NCT02094872</td>
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<td>A Phase I Trial of T Cells Expressing an Anti-GD2 Chimeric Antigen Receptor in Children and Young Adults With GD2+ Solid Tumors</td>
<td>Sarcoma; Osteosarcoma; Neuroblastoma; Melanoma</td>
<td>Biological: Anti-GD2-CAR engineered T cells; Drug: AP1903; Drug: Cyclophosphamide</td>
<td>MD</td>
<td>NCT02107963</td>
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<td>Galectin Inhibitor (GR-MD-02) and Ipilimumab in Patients With Metastatic Melanoma</td>
<td>Metastatic Melanoma</td>
<td>Biological: 1 mg/kg GR-MD-02; Biological: 2 mg/kg GR-MD-02; Biological: 4 mg/kg GR-MD-02; Biological: 8 mg/kg GR-MD-02; Biological: Ipilimumab</td>
<td>OR</td>
<td>NCT02117362</td>
</tr>
<tr>
<td>Phase 1 Study of Intradermal LV305 in Patients With Locally Advanced, Relapsed or Metastatic Cancer Expressing NY-ESO-1</td>
<td>Melanoma - Currently Enrolling; Non-small Cell Lung Cancer - Enrollment Completed; Ovarian Cancer - Enrollment Completed; Sarcoma - Enrollment Completed</td>
<td>Biological: ID-LV305</td>
<td>CA, CT, MA, MN, NJ, SC, TX, WA</td>
<td>NCT02122661</td>
</tr>
<tr>
<td>Adoptive Therapy Using Antigen-Specific CD4 T-Cells</td>
<td>Melanoma; Sarcoma</td>
<td>Drug: Ipilimumab; Drug: Cyclophosphamide; Biological: CD4+ T cells</td>
<td>TX</td>
<td>NCT02210104</td>
</tr>
<tr>
<td>Dabrafenib and Trametinib Followed by Ipilimumab and Nivolumab Followed by Dabrafenib and Trametinib in Treating Patients With Stage III-IV BRAFV600 Melanoma</td>
<td>Recurrent Melanoma; Stage IIIB Melanoma; Stage IIIC Skin Melanoma; Stage IIIIC Skin Melanoma; Stage IV Skin Melanoma</td>
<td>Drug: Dabrafenib; Biological: Ipilimumab; Other: Laboratory Biomarker Analysis; Biological: Nivolumab; Other: Quality-of-life Assessment; Drug: Trametinib</td>
<td>AK, AL, AR, CA, CD, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, MD, MI, MN, ND, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, WA, WI, WV</td>
<td>NCT02224781</td>
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<tr>
<td>RTA 408 Capsules in Patients With Melanoma - REVEAL</td>
<td>Melanoma; Unresectable (Stage III) Melanoma; Metastatic (Stage IV) Melanoma</td>
<td>Drug: Omalizumab Capsules (2.5 mg/capsule); Drug: Ipilimumab (3 mg/kg); Drug: Nivolumab (3 mg/kg)</td>
<td>AL, AR, CA, DC, DE, FL, MA, NC, NJ, TX</td>
<td>NCT02259231</td>
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<tr>
<td>Neoadjuvant Pembrolizumab for Unresectable Stage III and Unresectable Stage IV Melanoma</td>
<td>Unresectable Malignant Neoplasm; Melanoma; Metastatic Melanoma; Stage IV Melanoma; Stage III Melanoma</td>
<td>Drug: Pembrolizumab</td>
<td>MD</td>
<td>NCT02368550</td>
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<tr>
<td>Study Of OX40 Agonist PF-04518600 Alone And In Combination With 4-1BB Agonist PF-05082566</td>
<td>Neoplasms</td>
<td>Drug: PF-04518600; Drug: PF-04518600; Drug: PF-04518600 plus PF-05082566; Drug: PF-04518600 plus PF-05082566</td>
<td>CA, TX, WA</td>
<td>NCT02315066</td>
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<tr>
<td>Ex Vivo-Activated Lymph Node Lymphocytes in Treating Patients With Stage III-IV Melanoma</td>
<td>Stage IIIC Skin Melanoma; Stage IV Melanoma</td>
<td>Procedure: lymph node; Biological: X-ACT</td>
<td>OH</td>
<td>NCT02327390</td>
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<tr>
<td>A Comparison of Matured Dendritic Cells and Montanide in Study Subjects With High Risk of Melanoma Recurrence</td>
<td>Melanoma</td>
<td>Biological: DC Vaccine; Biological: Montanide Vaccine; Biological: Poly-ICLC</td>
<td>NY</td>
<td>NCT02347375</td>
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<tr>
<td>Study of Pembrolizumab (MK-3475) Versus Placebo After Complete Resection of High-Risk Stage III Melanoma (MK-3475-054/KEYNOTE-054)</td>
<td>Melanoma</td>
<td>Biological: pembrolizumab; Other: placebo</td>
<td>CA, FL, GA, IA, IL, MD</td>
<td>NCT02362594</td>
</tr>
<tr>
<td>Title</td>
<td>Cancer Type</td>
<td>Treatment</td>
<td>Location</td>
<td>NCT Number</td>
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<td>In Situ, Autologous Therapeutic Vaccination Against Solid Cancers With Intratumoral Hiltonol</td>
<td>Melanoma; Head and Neck Cancer; Sarcoma; Non-Melanoma Skin Cancers</td>
<td>Biological: Hiltonol</td>
<td>GA; MD; NY; PA</td>
<td>NCT02423863</td>
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<tr>
<td>Trial of Vemurafenib and Cobimetinib in Patients With Advanced BRAFV600 Mutant Melanoma</td>
<td>Melanoma</td>
<td>Drug: Cobimetinib; Drug: Vemurafenib</td>
<td>MD</td>
<td>NCT02427893</td>
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<tr>
<td>A Pilot Study to Evaluate PBR PET in Brain Tumor Patients Treated With Chemoradiation or Immunotherapy</td>
<td>Intracranial Tumors; Glioblastoma; Melanoma</td>
<td>Other: PBR PET; Biological: Cancer Immunotherapy; Radiation: Radiation and chemotherapy</td>
<td>MA</td>
<td>NCT02431572</td>
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<tr>
<td>A Study Of Avelumab In Combination With Other Cancer Immunotherapies In Advanced Malignancies (JAVELIN Medley)</td>
<td>Advanced Cancer</td>
<td>Drug: Avelumab; Drug: PF-05082566; Drug: PF-04518600; Drug: PF-04518600</td>
<td>CA; DC; FL; GA; MA; MI; NC; PA; TN; TX; WA</td>
<td>NCT02554812</td>
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<tr>
<td>Pilot Study of Vigil + Pembrolizumab for Advanced Melanoma</td>
<td>Melanoma Recurrent; Malignant Melanoma; Melanoma</td>
<td>Biological: Vigil; Drug: Pembrolizumab</td>
<td>TX</td>
<td>NCT02574333</td>
</tr>
<tr>
<td>GR-MD-02 Plus Pembrolizumab in Melanoma Patients</td>
<td>Melanoma</td>
<td>Drug: GR-MD-02; Drug: Pembrolizumab</td>
<td>OR</td>
<td>NCT02575404</td>
</tr>
<tr>
<td>Pembrolizumab in Treating Patients With HIV and Relapsed, Refractory, or Disseminated Malignant Neoplasms</td>
<td>AIDS-Related Non-Hodgkin Lymphoma; Classical Hodgkin Lymphoma; HIV Infection; Locally Advanced/Malignant Neoplasm; Metastatic Malignant Neoplasm; Recurrent Hepatocellular Carcinoma; Recurrent Hodgkin Lymphoma; Recurrent Kaposi Sarcoma; Recurrent Malignant Neoplasm; Recurrent Melanoma of the Skin; Recurrent Non-Hodgkin Lymphoma; Recurrent Non-Small Cell Lung Carcinoma; Refractory Hodgkin Lymphoma; Refractory Malignant Neoplasm; Solid Neoplasm; Stage IIA Hepatocellular Carcinoma; Stage IIA Non-Small Cell Lung Cancer; Stage IIA Skin Melanoma; Stage IIB Hepatocellular Carcinoma; Stage IIB Non-Small Cell Lung Cancer; Stage IIIB Skin Melanoma; Stage IIC Hepatocellular Carcinoma; Stage IIC Skin Melanoma; Stage IV Non-Small Cell Lung Cancer; Stage IV Skin Melanoma; Stage N/A Hepatocellular Carcinoma; Stage IVB Hepatocellular Carcinoma</td>
<td>Other: Laboratory Biomarker Analysis; Biological: Pembrolizumab</td>
<td>MD; WA</td>
<td>NCT02595866</td>
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<tr>
<td>A Prospective Randomized and Phase 2 Trial for Metastatic Melanoma Using Adoptive Cell Therapy With Tumor Infiltrating Lymphocytes Plus IL-2 Either Alone or Following the Administration of Pembrolizumab</td>
<td>Melanoma</td>
<td>Drug: Cyclophosphamide; Drug: Fludarabine; Drug: Aldesleukin; Drug: Pembrolizumab; Biological: young TIL</td>
<td>MD</td>
<td>NCT02621021</td>
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<tr>
<td>Combining PD-1 Blockade, CD137 Agonism and Adoptive Cell Therapy for Metastatic Melanoma</td>
<td>Melanoma (Skin); Skin Cancer</td>
<td>Drug: Nivolumab; Procedure: Surgery to Remove Tumor for Growth of TIL; Drug: CD137; Drug: Cyclophosphamide; Drug: Fludarabine; Biological: TIL Infusion; Drug: Interleukin-2</td>
<td>FL</td>
<td>NCT02652455</td>
</tr>
<tr>
<td>A Pilot Study to Evaluate the Safety and Efficacy of Combination Checkpoint Blockade Plus External Beam Radiotherapy in Subjects With Stage IV Melanoma</td>
<td>Melanoma</td>
<td>Drug: Ipilimumab; Drug: Nivolumab; Radiation: Radiotherapy</td>
<td>CA; NY; TN</td>
<td>NCT02659540</td>
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<tr>
<td>Phase I Study of Ipilimumab (Immunotherapy) and MGN1703 (TLR Agonist) in Patients With Advanced Solid Malignancies</td>
<td>Advanced Cancers; Melanoma</td>
<td>Drug: MGN1703; Drug: Ipilimumab</td>
<td>TX</td>
<td>NCT02666770</td>
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<tr>
<td>Phase I Study of GRN-1201 in HLA-A*02 Subjects With Resected Melanoma</td>
<td>Melanoma</td>
<td>Biological: GRN-1201</td>
<td>OH; OR; PA; UT</td>
<td>NCT02690356</td>
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<tr>
<td>Ipilimumab vs Ipilimumab Plus Nivolumab in Patients With Stage III-IV Melanoma Who Have Progressed or Relapsed on PD-1 Inhibitor Therapy</td>
<td>Melanoma</td>
<td>Drug: ipilimumab; Drug: nivolumab</td>
<td>NY</td>
<td>NCT02731729</td>
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<tr>
<td>GI Complications in Cancer Immunotherapy Patients</td>
<td>Malignant Melanoma</td>
<td></td>
<td>MA</td>
<td>NCT02784386</td>
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<tr>
<td>A Phase 1 Study of TSR-022, an Anti-TIM-3 Monoclonal Antibody, in Patients With Advanced Solid Tumors</td>
<td>Advanced or Metastatic Solid Tumors</td>
<td>Drug: TSR-022; Drug: anti PD-1 antibody</td>
<td>AZ; CA; CO; FL; IL; TN</td>
<td>NCT02817633</td>
</tr>
<tr>
<td>Adoptive T Cell Immunotherapy for Advanced Melanoma Using Engineered Lymphocytes</td>
<td>Melanoma</td>
<td>Biological: Escalating Doses</td>
<td>IL</td>
<td>NCT02970244</td>
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<tr>
<td>Trial of Intratumoral Injections of TTI-621 in Subjects With Relapsed and Refractory Solid Tumors and Mycosis Fungoides</td>
<td>Solid Tumors; Mycosis Fungoides; Melanoma; Merkel-cell Carcinoma; Squamous Cell Carcinoma; Breast Carcinoma; Human Papillomavirus-Related Malignant Neoplasm; Soft Tissue Sarcoma</td>
<td>Drug: TTI-621</td>
<td>CA; OR; PA; WA</td>
<td>NCT02903988</td>
</tr>
<tr>
<td>A Personalized Cancer Vaccine (NEO-PV-01) w/ Nivolumab for Patients With Melanoma, Lung Cancer or Bladder Cancer</td>
<td>Urinary Bladder Cancer; Bladder Tumors; Transitional Cell Carcinoma of the Bladder; Malignant Melanoma; Melanoma; Skin Cancer; Carcinoma; Non-Small-Cell Lung; Lung Cancer</td>
<td>Biological: NEO-PV-01; Biological: Nivolumab; Other: Adjuvant</td>
<td>CA; MA; TX</td>
<td>NCT02897765</td>
</tr>
</tbody>
</table>
PATIENT ASSISTANCE RESOURCES

CAREGIVERS & SUPPORT

4th Angel Patient & Caregiver Mentoring Program ............................................. www.4thangel.org
Bioch Cancer Hotline .............................................................................. 800-433-0464
CanCare ........................................................................................................ www.canarcare.org
CancerCare .................................................................................................. www.cancer.org
Cancer Support Community ........................................................................ www.cancer.org/cancer-community
The Hope Light Foundation ........................................................................... www.hopelightfoundation.org
Immerman Angels ....................................................................................... www.immerman.org
LIVESTRONG Foundation ........................................................................... www.livestrong.org
MyLifeLine.org Cancer Foundation ............................................................... www.mylifeline.org
PearlPoint Cancer Support ........................................................................... www.org

CLINICAL TRIALS

ACCESS ........................................................................................................... www.access.centria.com
AccruaNet ...................................................................................................... http://accruanet.cancer.gov
ACT (About Clinical Trials) ........................................................................... www.aacts.org
Center for Information and Study on Clinical Research Participation ............ www.searchclinicaltrials.org
CenterWatch .................................................................................................. www.centerwatch.com
Coalition of Cancer Cooperative Groups ....................................................... www.cancertrialshelp.org
My Clinical Trial Locator ................................................................................ http://myclinicaltriallocator.com
National Cancer Institute ............................................................................. www.cancer.gov
National Institutes of Health .......................................................................... www.nih.gov
TrialCheck ........................................................................................................ www.trialcheck.org

IMMUNOTHERAPY

The Answer to Cancer ..................................................................................... www.theanswertocancer.org
Cancer Research Institute ............................................................................. www.cancerresearch.org
Immu-Oncoloogy ........................................................................................... www.immunoncology.com
Society for Immunotherapy of Cancer ........................................................... www.sitcancer.org

MELANOMA

A Cure in Sight (ocular melanoma) .................................................................. http://acurenetsight.net
AIM at Melanoma Foundation ....................................................................... www.aimatmelanoma.org
American Academy of Dermatology .............................................................. www.aad.org
Basal Cell Carcinoma Nexus Syndrome Life Support Network ......................... www.bccns.org
Melanoma Hope Network ............................................................................ www.melanomahopenetwork.org
Melanoma International Foundation .............................................................. www.melanoma.org
Melanoma International Foundation Forum ................................................. www.melanomaforum.org
Melanoma Patients Information Page ............................................................ www.melanoma.org/community/mpip-melanoma-patients-information-page
Melanoma Research Alliance ........................................................................ www.curemelanoma.org
Melanoma Research Foundation ................................................................... www.melanoma.org
Mollie’s Fund .................................................................................................. http://molliesfund.org
Ocular Melanoma Foundation ....................................................................... www.ocularmelanoma.org
Outrun the Sun ............................................................................................... www.outrunthesun.org
The Skin Cancer Foundation ........................................................................... www.skincancer.org
Skin of Steel ...................................................................................................... http://skinofsteel.org
Sunwise ............................................................................................................ www.sunwise.com

PRESCRIPTION EXPENSES

CancerCare Co-Payment Assistance Foundation ............................................. www.cancercarecopay.org, 866-552-8729
Cancer Financial Assistance Coalition ............................................................. www.cancerfac.org
The CHAIN Fund Inc. ..................................................................................... www.thechainfund.org, 203-691-5905
Foundation for Health Coverage Education .................................................. www.coverageforall.org
GoodDays ........................................................................................................ www.gooddaysfromcn.org, 972-608-7141
HealthWell Foundation .................................................................................. www.healthwellfoundation.org, 800-675-8416
NeedyMeds ...................................................................................................... www.needymeds.org, 900-503-6897
Partnership for Preservation Assistance ......................................................... www.pparx.org, 888-APRX-NOW
Patient Access Network Foundation ............................................................... www.panfund.org, 888-316-PANF
Patient Advocate Foundation Co-Pay Relief .................................................... www.copays.org, 866-512-3861
Patient Services, Inc. ....................................................................................... www.patientservicesinc.org, 800-366-7741
RxAssist ............................................................................................................ www.rxassist.org
RxHope ............................................................................................................ www.rxhope.org, 877-267-0517
Rx Outreach ..................................................................................................... www.rxoutreach.com, 888-786-1234
Together Rx Access ........................................................................................ www.togetherrxaccess.com, 844-440-1106

REIMBURSEMENT & PATIENT ASSISTANCE PROGRAMS

AbbVie Patient Assistance Foundation ......................................................... www.abbviepaf.org, 800-222-6885
Amgen First Step ............................................................................................ www.amgenfirststep.com, 888-657-8371
ARID Patient Access and Support ..................................................................... www.aridpass.org, 865-447-7277
Abrelast Pharma Support Solutions ................................................................ www.astralastpharma.com, 800-477-8672
AstraZeneca Prescription Savings Program (AZ&ME) ....................................... www.astrazeneca.com, 800-292-6368
Bayer Healthcare Pharmaceuticals ................................................................. 866-575-5002
Bayer Healthcare Pharmaceuticals REACH Co-Pay Assistance Program .... www.reachaccessteam.com, 866-639-2827
Boehringer Ingelheim Cares Foundation Patient Assistance Program ............ http://us.boehringer-ingelheim.com, 800-556-8317
Boehringer Ingelheim Solutions Plus .............................................................. www.bisolutions.com, 877-814-3915
Bristol-Myers Squibb Access Support ............................................................. www.bmsaccesssupport.com, 800-981-0049
Bristol-Myers Squibb Patient Assistance Foundation ....................................... www.bmspaf.org, 800-736-0003
Eisai Reimbursement Resources .................................................................... www.eisaius.com
Genentech Access Solutions ........................................................................... www.genentechaccess.com, 866-422-2377
Genzyme Patient Support Services ................................................................... www.genzyme.com/patients/patient-support-services, 800-745-4447
Gilead Patient Access ....................................................................................... www.gilead.com/responsibility/us-patient-access
GSK Access ...................................................................................................... www.gsk-access.com, 800-518-4357
IMLYSGC Cost Assistance ............................................................................... www.imlysgc.com, Patient, 888-427-7476
Janssen Prescription Assistance ...................................................................... www.janssenscriptioanlp.com
Johnson & Johnson Patient Assistance Foundation, Inc. .................................. www.jpif.org, 800-652-6227
Keytruda Patient Assistance ........................................................................... www.merckaccessprogram-keytruda.com, 855-257-3932
Lyrica CoPay Savings Card ............................................................................. www.lyrica.com/Lyrica_Co-pay_Download, 800-576-7076
Merck Access Program ................................................................................... www.merckaccessprogram.com, 855-257-3932
Merck Helps ...................................................................................................... www.merckhelps.com, 800-727-5400
Novartis Patient Assistance Now .................................................................... www.novartis.com/novartisnow, 800-345-5366
Onyx 360 ........................................................................................................... www.onyx360.com, 855-669-9360
Pfizer RePathways ............................................................................................ www.pfizerpathways.com, 866-706-2400
Prolia Co-Pay Program ................................................................................... www.proliaaccess.com, 877-776-5421
Sandzox One Source ....................................................................................... www.sandzox.com, 844-726-3891
Sanofi Patient Connection .............................................................................. www.sanofipatientconnection.com, 888-847-4877
Sylatron Patient Assistance .............................................................................. www.sylatronaccess.com, 855-257-3932
Takeda Patient Assistance ............................................................................... www.takedaus/responsibility/patient_assistance_program.asp, 800-630-9159
Teva Cares Foundation Patient Assistance Programs ....................................... www.tevacares.org, 877-237-4881
Teva Oncology Core Reimbursement Assistance & Support .......................... www.tevacoare.com, 888-587-3263
Together with TESARO .................................................................................. www.togetherwithtesaro.com, 844-283-7276
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