did not differ with respect to age, HCT-CI score, IPI, number of prior therapies or CRS grade (Table 2).

Conclusion: In this single institutional experience of using Axi-cel therapy for R/R BCL, we demonstrated utilization of substantial resources in terms of hospitalization, ICU stay, diagnostic studies and pharmaceutical products. Patients with favorable PS and no or minimal CRES spend a higher number of days at home (alive and out-of-hospital), in first 100 days of Axi-cel therapy.

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Transplant Physicians' Attitudes on Candidacy for Allogeneic Hematopoietic Cell Transplantation (HCT) in Older Patients: The Need for a Standardized Geriatric Assessment (GA) Tool

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Background: Despite improvements in conditioning regimens and supportive care having expanded the curative potential of HCT, underutilization of HCT in older adults persists (Bhatt VR et al, BMT 2017). Therefore, we conducted a survey of transplant physicians (TP) to determine their perceptions of the impact of older age (≥60 years) on HCT candidacy and utilization of tools to gauge candidacy.

Methods: We conducted a 23-item, online cross-sectional survey of adult physicians recruited from the Center for International Blood and Marrow Transplant Research between May and July 2019.

Results: 175/770 (22.7%) TP completed the survey; majority of respondents were 41-60 years old, male, and practicing in a teaching hospital. Over 75% were at centers performing ≥50 HCT per year. When considering regimen intensity, most (96%, n=168) had an upper age limit (UAL) for using a myeloablative regimen (MAC), with only 29 physicians (17%) stating they would consider MAC for patients ≥70 years. In contrast, when considering a reduced intensity/non-myeloablative conditioning (RIC/NMA), 8%, (n=13), 54% (n=93), and 20% (n=35) stated that age 70, 75, and 80 years respectively would be the UAL to use this approach, with 18% (n=31) reporting no UAL. TP agreed that Karnofsky Performance Score (KPS) could exclude older pts for HCT, with 39.1% (n=66), 42.6% (n=72), and 11.4% (n=20) requiring KPS of ≥70, 80, and 90, respectively. The majority (n=92, 52.5%) indicated an HCT-comorbidity index threshold for exclusion, mostly ranging from ≥3 to ≥ 5. Almost all (89.7%) endorsed the need for a better health assessment of pre-HCT vulnerabilities to guide candidacy for pts ≥60 with varied assessments being utilized beyond KPS (Figure 1). However, the majority of centers rarely (33.1%) or never (45.7%) utilize a dedicated geriatrician/geriatric-oncologist to assess

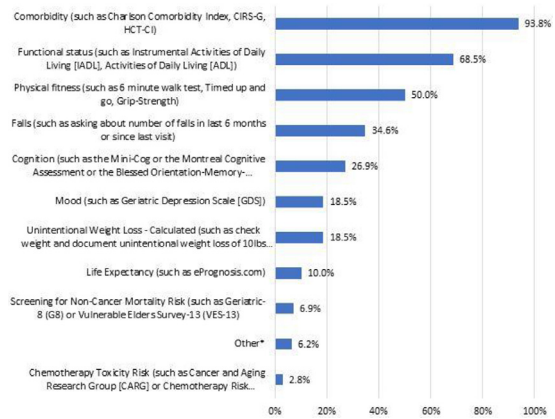

Figure 1. Assessments used by transplant physicians in addition to performance status used to evaluate alloHCT candidates ≥ 60 years

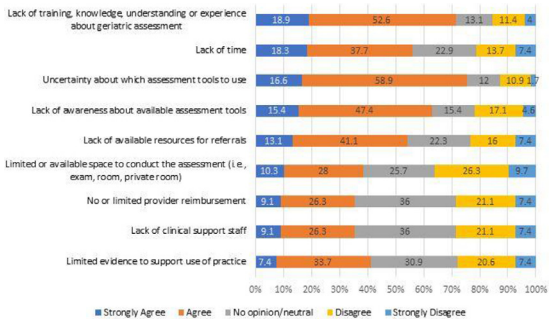

Figure 2. Barriers to performing geriatric assessments for alloHCT candidates ≥60 years.

alloHCT candidates ≥60 yrs. The largest barriers to performing GA included uncertainty about which tools to use, lack of knowledge and training, and lack of appropriate clinical support staff (Figure 2). Approximately half (n=78, 45%) endorsed GA now routinely influences candidacy.

Conclusions: The vast majority of TP will consider RIC/NMA alloHCT for patients ≥70 years. However, there is heterogeneity in assessing candidacy. Incorporation of GA into a standardized and easily applied health assessment tool for risk stratification is an unmet need. The recently opened BMT CTN 1704 may aid in addressing this gap.

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Stem Cell Transplant Minimizes Insurance Coverage-Driven Outcome Disparities for Multiple Myeloma Patients

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Advent of novel anti-myeloma agents and broader use of stem cell transplant has led to significant improvement in survival of patients (pts) with Multiple Myeloma (MM). However, there are well-described issues with affordability of novel drugs and rapidly escalating price of these agents (Shih et al. JCO 2017), leading to significant disparity among different sociodemographic groups. Hereby, we interrogated the National Cancer Database (NCDB) (which covers 70% of MM patient diagnosed nationwide) to assess impact of insurance type on survival. We also sought to investigate if autologous transplant may overcome socioeconomic effects on survival, by potentially minimizing the need for chronic use of expensive drugs.

Methods: Data from 117,926 MM pts diagnosed with MM (ICD-O 9732) between 2005 and 2014 were analyzed.

Results: Median age at diagnosis was 67 (19-90); 55% were males. 57% of pts lived in areas where the median income was < $46k/year (individual income data was not available); Primary insurance was Medicare (52%), private insurance (35%) or Medicaid (5%), and 3% were uninsured. 40% were treated in academic institutions. Median follow up was 30.2 (range, 0-145.2) months. By univariate analysis, better OS was observed in pts with primary MM, lower Charlson Comorbidity Index (CCI), treatment in academic institutions, higher median regional income, or private insurance ($p<0.001$ for all) (Table-1). 96% of pts were treated in facilities located ≤ 120 miles from area of residence. Amongst pts younger than 65 years, 33% of pts with private insurance received transplant compared to 20% of those on Medicare ($p<0.001$). For those 65 years and older, 11% of privately insured pts were transplanted compared to only 6 % for those on Medicare ($p<0.001$). Median age of pts on Medicare and private insurance, was 74 and 57 years old, respectively. When restricting the analysis to pts ≥ 65 years old, pts with private insurance had longer OS compared to Medicare pts ($p<0.001$). Table-2 shows the results of multivariate analysis. There was a statistically significant difference in survival between patients with private insurance and those with Medicare in favor of the private insurance among pts older than 65 years old (41.9 vs. 30.8 months, $p<0.001$ (Fig-1)). Similarly insurance type was a significant predictor of survival among pts who received therapies other than transplant among pts younger or older than 65 (Fig-2), however when considering pts who received transplant, there was no difference in survival between privately insured pts and Medicare in both age group (Fig-3).

Conclusions: Although insurance type and regional income are associated with MM survival among pts who relied on non-transplant modalities, there was no significant impact of these socioeconomic factors on survival of pts that received an autologous transplant in this large database. This finding merits further investigation.

ORAL ABSTRACT - SESSION H - ACUTE REGIMEN-RELATED TOXICITY AND SUPPORTIVE CARE

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The Effect of Folinic Acid (FA) Rescue Following MTX Gvhd Prophylaxis on Regimen Related Toxicity and Transplantation Outcome: A Double Blind Randomized Controlled Study

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Background: The use of MTX for GVHD prophylaxis is associated with increased rates of oral mucositis (OM), delayed engraftment, hepatotoxicity and nephrotoxicity. Based on limited data, the EBMT and ELN working group recommend the use of FA-rescue to reduce MTX toxicity after alloHCT. We aimed to determine whether FA-rescue reduces the rate of MTX-induced toxicity in patients who receive post-transplant MTX for GVHD prophylaxis.

Methods: This is a double blind RCT conducted in 3 centers. We enrolled patients undergoing alloHCT from MSD or MUDs with a MAC regimen and PBSC grafts, and GVHD prophylaxis consisting CSA/MTX, plus ATG for MUDs. Patients were randomized to oral FA or placebo, stratified by center and conditioning intensity (standard *vs.* reduced toxicity MAC). FA administration started 24h after each MTX dose: 15 mg TID after MTX administration on day +1 and QID after MTX administration on days +3 and +6. The primary endpoint was the rate of grade 3-4 OM according to the WHO scale. A sample size of 58 subjects in each group was estimated to detect a difference in grade 3-4 OM of 50% *vs.* 25%.