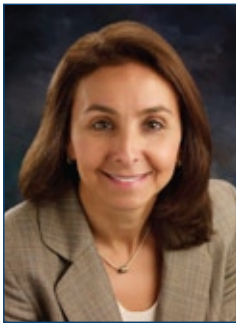


» On-Conversation with Liz Barrett, VP and General Manager, Cephalon



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Cephalon's oncology business has been growing on the shoulders of the successful approval and launch of Treanda® (bendamustine HCl), synthesized to combine an alkylating group and a benzimidazole component, approved by the FDA in March '08 for patients with chronic lymphocytic leukemia (CLL). Remarkably, 7

months later Treanda now has a second FDA approval for patients with non-Hodgkin's Lymphoma (NHL). Given this exciting year at Cephalon, we spoke with Liz Barrett, VP and General Manager of the oncology business unit, to catch up on the progress they've made with Treanda, what the future holds for the drug, and the oncology business unit at Cephalon.

OBR: First, what is the background on Treanda, for example it's MOA?

LB: Well, we received our first indication on March 20 of this year for CLL. This was the first chemotherapy approved for a CLL indication since 1991. We're not really sure of its exact MOA, but Treanda was purposefully synthesized to be a unique molecule. It has a dual structure as an alkylating agent as well as a purine-like ring. The really great thing about Treanda is that it appears to kill cancer cells via different pathways and also prevents cancer cells from dividing.

OBR: Can you tell us about the new indication and the disease setting it is approved for?

LB: Last week, we received a new indication for the treatment of patients with indolent NHL

who have progressed during or within 6 months of Rituxan-based therapy. NHL originates in cells of the immune system and spreads throughout the lymphatic system. There are many different types of NHL, but the good news is that the 5-year survival rate hovers around 65% (even higher in indolent NHL), and the median age of diagnosis is 67. The ACS estimates that there are more than 66,000 new cases each year, and more than 30,000 of those cases is indolent NHL. The indolent disease progresses slower than the aggressive disease; the median survival is about 10 years with long, treatment-free intervals.

OBR: What were the results of your pivotal study that led to the new NHL indication?

LB: We did a multicenter, non-randomized, open-label study in about 100 patients. The primary endpoint was overall response rate and duration of response and the secondary endpoint was progression free survival. In patients that had relapsed, we saw a 74% overall response rate with durable responses including a 9.2 month median duration of response and a 9.3 month median progression free survival. We have found in our research that CHOP + Rituxan is a pretty standard first-line treatment for indolent NHL, but after that in the refractory setting there doesn't seem to be a standard of care, which is where we hope Treanda will prove to be an excellent choice.

OBR: Do you have other studies in NHL with Treanda that you can discuss?

LB: We have conducted a study in combination with Rituxan in the refractory setting and that study was published recently. The response rate in that study was in the 90% range, and based on this study the combination of Rituxan and Treanda has made it into the NCCN guidelines and has been accepted by the Foundation for Evidence-Based Medicine compendium.

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OBR: Do you have any projections for Treanda in NHL that you can share with us?

LB: If you look at the relapsed indolent NHL population, the incidence is approximately the same as the CLL population. We expect the numbers for the new indication to be similar to the numbers in CLL. We expect Treanda to be reimbursed by Medicare and private payers so we don't foresee any significant access issues.

OBR: How has Treanda performed commercially to date in CLL?

LB: In terms of demand through September, we have sold more than \$36 million of Treanda, and have seen month over month growth. Physicians have expressed satisfaction with the performance of the drug, and it is being used across the spectrum in CLL according to our research. In most cases, we find it being used as a single agent in the relapsed setting.

OBR: We're also interested in where Treanda fits in with the rest of the business at Cephalon and especially your pipeline.

LB: We expect Treanda to become the cornerstone of Cephalon Oncology to help grow this business over the long term. In the summer of '05 we licensed Trisenox from CTI and built a relatively small commercial organization around it. Now we've got two commercial products. We're very proud of the pipeline at Cephalon. CEP-701 (lestaurtinib), our most advanced product candidate, is in Phase 3 for AML and we are currently enrolling for our pivotal study. If successful, we hope to have an approval in 2010. Other product candidates include CEP-11981 (VEGF-R/TIE2 Kinase Inhibitor) in Phase 1 and CEP-18770, a proteasome inhibitor in Phase 1. We have other product candidates in preclinical development.

OBR: Lastly, how does your business unit fit in with the rest of the company?

LB: When I joined Cephalon about two and a half years ago we had about 4 people here in oncology and today we have about 150. In our structure, sales, marketing, medical affairs, and scientific communications for oncology all report into me. But within Cephalon, the oncology business unit is small in comparison to the other businesses. Our other businesses, such as Provigil and Fentora, have much larger sales organizations which make them much larger overall than us. **OBR**



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