

ABOUT THE TEST FoundationOne®CDx is a next-generation sequencing (NGS) based assay that identifies genomic findings within hundreds of cancer-related genes.

PATIENT

DISEASE Nasopharynx and paranasal sinuses esthesioneuroblastoma
NAME Cheng, Yuan-Hao
DATE OF BIRTH 26 September 1977
SEX Male
MEDICAL RECORD # 44463221

PHYSICIAN

ORDERING PHYSICIAN Mu-Hsin Chang, Peter
MEDICAL FACILITY Taipei Veterans General Hospital
ADDITIONAL RECIPIENT None
MEDICAL FACILITY ID 205872
PATHOLOGIST Not Provided

SPECIMEN

SPECIMEN SITE Lymph Node
SPECIMEN ID S110-30459 B (PF21024)
SPECIMEN TYPE Slide Deck
DATE OF COLLECTION 08 September 2021
SPECIMEN RECEIVED 01 October 2021

Biomarker Findings

Microsatellite status - MS-Stable
Tumor Mutational Burden - 0 Muts/Mb

Genomic Findings

For a complete list of the genes assayed, please refer to the Appendix.

ATRX K739fs*14

0 Therapies with Clinical Benefit

0 Clinical Trials

0 Therapies with Resistance

BIOMARKER FINDINGS

Microsatellite status - MS-Stable

Tumor Mutational Burden - 0 Muts/Mb

THERAPY AND CLINICAL TRIAL IMPLICATIONS

No therapies or clinical trials. see Biomarker Findings section

No therapies or clinical trials. see Biomarker Findings section

No therapies or clinical trials are associated with the Genomic Findings for this sample.

If you have questions or comments about this result, please contact your Foundation Medicine customer support representative.

Phone: 1-888-988-3639
Online: foundationmedicine.com
Email: client.services@foundationmedicine.com

GENOMIC FINDINGS WITH NO REPORTABLE THERAPEUTIC OR CLINICAL TRIAL OPTIONS

For more information regarding biological and clinical significance, including prognostic, diagnostic, germline, and potential chemosensitivity implications, see the Genomic Findings section.

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NOTE Genomic alterations detected may be associated with activity of certain approved therapies; however, the agents listed in this report may have varied clinical evidence in the patient's tumor type. Therapies and the clinical trials listed in this report may not be complete and exhaustive. Neither the therapeutic agents nor the trials identified are ranked in order of potential or predicted efficacy for this patient, nor are they ranked in order of level of evidence for this patient's tumor type. This report should be regarded and used as a supplementary source of information and not as the single basis for the making of a therapy decision. All treatment decisions remain the full and final responsibility of the treating physician and physicians should refer to approved prescribing information for all therapies.

Therapies contained in this report may have been approved by the US FDA.

ORDERED TEST # ORD-1201774-01

BIOMARKER FINDINGS

BIOMARKER

Microsatellite status

RESULT
MS-Stable

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

On the basis of clinical evidence, MSS tumors are significantly less likely than MSI-H tumors to respond to anti-PD-1 immune checkpoint inhibitors¹⁻³, including approved therapies nivolumab and pembrolizumab⁴. In a retrospective analysis of 361 patients with solid tumors treated with pembrolizumab, 3% were MSI-H and

experienced a significantly higher ORR compared with non-MSI-H cases (70% vs. 12%, $p=0.001$)⁵.

FREQUENCY & PROGNOSIS

MSI-H has been reported in 0.5% of pediatric neuroblastoma samples⁶. For patients with neuroblastoma whose treatment did not include stem cell transplant (SCT), higher MSI was significantly associated with worse outcome; if treatment included SCT, MSI>1 was significantly associated with improved 5-year event-free survival (EFS) whereas MSI=1 was not a predictor of EFS⁷.

FINDING SUMMARY

Microsatellite instability (MSI) is a condition of

genetic hypermutability that generates excessive amounts of short insertion/deletion mutations in the genome; it generally occurs at microsatellite DNA sequences and is caused by a deficiency in DNA mismatch repair (MMR) in the tumor⁸. Defective MMR and consequent MSI occur as a result of genetic or epigenetic inactivation of one of the MMR pathway proteins, primarily MLH1, MSH2, MSH6, or PMS2⁸⁻¹⁰. This sample is microsatellite-stable (MSS), equivalent to the clinical definition of an MSS tumor: one with mutations in none of the tested microsatellite markers¹¹⁻¹³. MSS status indicates MMR proficiency and typically correlates with intact expression of all MMR family proteins^{8,10,12-13}.

BIOMARKER

Tumor Mutational Burden

RESULT
0 Muts/Mb

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

On the basis of clinical evidence in solid tumors, increased TMB may be associated with greater sensitivity to immunotherapeutic agents, including anti-PD-L1¹⁴⁻¹⁶, anti-PD-1 therapies¹⁴⁻¹⁷, and combination nivolumab and ipilimumab¹⁸⁻²³. In multiple pan-tumor studies, higher TMB has been reported to be associated with increased ORR and OS from treatment with immune checkpoint inhibitors^{14-17,24}. Higher TMB was found to be significantly associated with improved OS upon immune checkpoint inhibitor treatment for patients with 9 types of advanced tumors¹⁴. Analyses across several solid tumor types reported

that patients with higher TMB (defined as ≥ 16 -20 Muts/Mb) achieved greater clinical benefit from PD-1 or PD-L1-targeting monotherapy, compared with patients with higher TMB treated with chemotherapy²⁵ or those with lower TMB treated with PD-1 or PD-L1-targeting agents¹⁵. However, the KEYNOTE 158 trial of pembrolizumab monotherapy for patients with solid tumors found significant improvement in ORR for patients with TMB ≥ 10 Muts/Mb (based on this assay or others) compared to those with TMB < 10 Muts/Mb, in a large cohort that included multiple tumor types; similar findings were observed in the KEYNOTE 028 and 012 trials^{17,24}. Together, these studies suggest that patients with TMB ≥ 10 Muts/Mb may derive clinical benefit from PD-1 or PD-L1 inhibitors.

FREQUENCY & PROGNOSIS

Neuroblastoma harbors a median TMB of 2.7 mutations per megabase (mut/Mb), and 0.4% of cases have high TMB (> 20 muts/Mb)²⁶. In one study, patients with high or intermediate risk tumors had a higher average number of variants compared to low risk tumors²⁷. Increased TMB

has been reported in relapsed neuroblastoma samples compared to samples analyzed at diagnosis²⁸.

FINDING SUMMARY

Tumor mutation burden (TMB, also known as mutation load) is a measure of the number of somatic protein-coding base substitution and insertion/deletion mutations occurring in a tumor specimen. TMB is affected by a variety of causes, including exposure to mutagens such as ultraviolet light in melanoma²⁹⁻³⁰ and cigarette smoke in lung cancer³¹⁻³², treatment with temozolomide-based chemotherapy in glioma³³⁻³⁴, mutations in the proofreading domains of DNA polymerases encoded by the POLE and POLD1 genes³⁵⁻³⁹, and microsatellite instability (MSI)^{35,38-39}. This sample harbors a TMB level associated with lower rates of clinical benefit from treatment with PD-1- or PD-L1-targeting immune checkpoint inhibitors compared with patients with tumors harboring higher TMB levels, based on several studies in multiple solid tumor types^{15-16,24}.

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GENOMIC FINDINGS

GENE

ATRX

ALTERATION

K739fs*14

TRANSCRIPT ID

NM_000489

CODING SEQUENCE EFFECT

2216_2217delAA

VARIANT ALLELE FREQUENCY (% VAF)

91.8%

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

No targeted therapies are available to directly address ATRX inactivation. Based on preclinical⁴⁰⁻⁴¹ and limited clinical data⁴², ATRX alterations may confer sensitivity to combination strategies involving WEE1 inhibition. In a Phase 2 study evaluating the WEE1 inhibitor adavosertib plus irinotecan for the treatment of pediatric patients with neuroblastoma, prolonged SD was reported for 44% (4/9) of patients with ATRX-deficient tumors and responses were seen in two tumors that had evidence of ALT⁴². Preclinical evidence also suggests that ATRX deficiency may impart sensitivity to synthetic lethal approaches

involving PARP inhibition and irinotecan⁴³, combined PARP and ATR inhibition⁴¹, or double-strand break-induction with agents such as doxorubicin, irinotecan, and topotecan⁴⁴; however, these approaches have not been demonstrated clinically.

FREQUENCY & PROGNOSIS

Somatic mutation of ATRX has been reported in a number of solid tumor types, often associated with ALT⁴⁵. ATRX mutation correlating with ALT has been reported in 10-20% of pancreatic neuroendocrine tumors (PNETs)⁴⁵⁻⁴⁷, 12.6% of pheochromocytomas and paragangliomas⁴⁸, and 48% of adolescent and young adult (AYA) patients with glioblastoma (GBM) or neuroblastoma⁴⁹⁻⁵³. ATRX loss in PNET^{46,54} and melanoma⁵⁵ and mutation in other neuroendocrine tumors⁴⁸ is associated with poor prognosis. Pediatric patients with high-grade glioma and ATRX mutation were shown to have more aggressive disease but are more responsive to treatment with double-strand break therapy⁴⁴. ATRX mutation or loss of expression is more frequent in Grade 2/3 astrocytoma and secondary GBM than primary GBM, oligodendroglioma, and oligoastrocytoma⁵⁶⁻⁵⁹ and has been proposed as a distinguishing biomarker⁵⁷⁻⁵⁹. ATRX mutation has not been detected in concurrence with MYCN

amplification in glioma and neuroblastoma⁵⁰⁻⁵³. Low-grade gliomas with both IDH1/2 mutation and ATRX mutation are associated with worse prognosis than those with IDH1/2 mutation but no ATRX mutation⁵⁷. Loss of ATRX protein expression has been reported in 33-39% of incidences of leiomyosarcoma (LMS) associating with ALT, a poor prognostic factor across all LMS subtypes, and with poor prognosis in extrauterine LMS but not in uterine LMS⁶⁰⁻⁶¹.

FINDING SUMMARY

ATRX encodes a SWI/SNF chromatin remodeling protein implicated in histone variant H3.3 deposition, transcriptional regulation, and telomere maintenance⁶²⁻⁶³. ATRX inactivation or loss of expression is associated with alternative lengthening of telomeres (ALT)^{45,61,64-65}. Alterations that disrupt the ADD domain (aa 167-270) or helicase domain (aa 2010-2280) of ATRX are predicted to result in loss of ATRX function⁶⁶⁻⁶⁸; however, the loss of ATRX function is not sufficient to induce ALT, which requires other undetermined factors^{62,69}. Germline mutations in ATRX give rise to alpha-thalassemia X-linked intellectual disability syndrome (ATR-X syndrome)⁷⁰.

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APPENDIX
Variants of Unknown Significance

NOTE One or more variants of unknown significance (VUS) were detected in this patient's tumor. These variants may not have been adequately characterized in the scientific literature at the time this report was issued, and/or the genomic context of these alterations makes their significance unclear. We choose to include them here in the event that they become clinically meaningful in the future.

JAK2
V392M

PARP3
A235V and H146Y

TSC1
G939V

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APPENDIX
Genes Assayed in FoundationOne®CDx

FoundationOne CDx is designed to include genes known to be somatically altered in human solid tumors that are validated targets for therapy, either approved or in clinical trials, and/or that are unambiguous drivers of oncogenesis based on current knowledge. The current assay interrogates 324 genes as well as introns of 36 genes involved in rearrangements. The assay will be updated periodically to reflect new knowledge about cancer biology.

DNA GENE LIST: ENTIRE CODING SEQUENCE FOR THE DETECTION OF BASE SUBSTITUTIONS, INSERTION/DELETIONS, AND COPY NUMBER ALTERATIONS

ABL1	ACVR1B	AKT1	AKT2	AKT3	ALK	ALOX12B	AMER1 (FAM123B)	APC
AR	ARAF	ARFRP1	ARID1A	ASXL1	ATM	ATR	ATRX	AURKA
AURKB	AXIN1	AXL	BAP1	BARD1	BCL2	BCL2L1	BCL2L2	BCL6
BCOR	BCORL1	BRAF	BRCA1	BRCA2	BRD4	BRIP1	BTG1	BTG2
BTB	C11orf30 (EMSY)	C17orf39 (GID4)	CALR	CARD11	CASP8	CBFB	CBL	CCND1
CCND2	CCND3	CCNE1	CD22	CD274 (PD-L1)	CD70	CD79A	CD79B	CDC73
CDH1	CDK12	CDK4	CDK6	CDK8	CDKN1A	CDKN1B	CDKN2A	CDKN2B
CDKN2C	CEBPA	CHEK1	CHEK2	CIC	CREBBP	CRKL	CSF1R	CSF3R
CTCF	CTNNA1	CTNNB1	CUL3	CUL4A	CXCR4	CYP17A1	DAXX	DDR1
DDR2	DIS3	DNMT3A	DOT1L	EED	EGFR	EP300	EPHA3	EPHB1
EPHB4	ERBB2	ERBB3	ERBB4	ERCC4	ERG	ERRF1	ESR1	EZH2
FAM46C	FANCA	FANCC	FANCG	FANCL	FAS	FBXW7	FGF10	FGF12
FGF14	FGF19	FGF23	FGF3	FGF4	FGF6	FGFR1	FGFR2	FGFR3
FGFR4	FH	FLCN	FLT1	FLT3	FOXO2	FUBP1	GABRA6	GATA3
GATA4	GATA6	GNA11	GNA13	GNAQ	GNAS	GRM3	GSK3B	H3F3A
HDAC1	HGF	HNF1A	HRAS	HSD3B1	ID3	IDH1	IDH2	IGF1R
IKBKE	IKZF1	INPP4B	IRF2	IRF4	IRS2	JAK1	JAK2	JAK3
JUN	KDMSA	KDMS5C	KDM6A	KDR	KEAP1	KEL	KIT	KLHL6
KMT2A (MLL)	KMT2D (MLL2)	KRAS	LTK	LYN	MAF	MAP2K1 (MEK1)	MAP2K2 (MEK2)	MAP2K4
MAP3K1	MAP3K13	MAPK1	MCL1	MDM2	MDM4	MED12	MEF2B	MEN1
MERTK	MET	MITF	MKNK1	MLH1	MPL	MRE11A	MSH2	MSH3
MSH6	MST1R	MTAP	MTOR	MUTYH	MYC	MYCL (MYCL1)	MYCN	MYD88
NBN	NF1	NF2	NFE2L2	NFKB1A	NKX2-1	NOTCH1	NOTCH2	NOTCH3
NPM1	NRAS	NSD3 (WHSC1L1)	NT5C2	NTRK1	NTRK2	NTRK3	P2RY8	PALB2
PARK2	PARP1	PARP2	PARP3	PAX5	PBRM1	PDCD1 (PD-1)	PDCD1LG2 (PD-L2)	PDGFRA
PDGFRB	PDK1	PIK3C2B	PIK3C2G	PIK3CA	PIK3CB	PIK3R1	PIM1	PMS2
POLD1	POLE	PPARG	PPP2R1A	PPP2R2A	PRDM1	PRKAR1A	PRKCI	PTCH1
PTEN	PTPN11	PTPRO	QKI	RAC1	RAD21	RAD51	RAD51B	RAD51C
RAD51D	RAD52	RAD54L	RAF1	RARA	RB1	RBM10	REL	RET
RICTOR	RNF43	ROS1	RPTOR	SDHA	SDHB	SDHC	SDHD	SETD2
SF3B1	SGK1	SMAD2	SMAD4	SMARCA4	SMARCB1	SMO	SNCAIP	SOC3
SOX2	SOX9	SPEN	SPOP	SRC	STAG2	STAT3	STK11	SUFU
SYK	TBX3	TEK	TET2	TGFBR2	TIPARP	TNFAIP3	TNFRSF14	TP53
TSC1	TSC2	TYRO3	U2AF1	VEGFA	VHL	WHSC1	WT1	XPO1
XRCC2	ZNF217	ZNF703						

DNA GENE LIST: FOR THE DETECTION OF SELECT REARRANGEMENTS

ALK	BCL2	BCR	BRAF	BRCA1	BRCA2	CD74	EGFR	ETV4
ETV5	ETV6	EWSR1	EZR	FGFR1	FGFR2	FGFR3	KIT	KMT2A (MLL)
MSH2	MYB	MYC	NOTCH2	NTRK1	NTRK2	NUTM1	PDGFRA	RAF1
RARA	RET	ROS1	RSP02	SDC4	SLC34A2	TERC*	TERT**	TPMRS2

*TERC is an NCRNA

**Promoter region of TERT is interrogated

ADDITIONAL ASSAYS: FOR THE DETECTION OF SELECT CANCER BIOMARKERS

Loss of Heterozygosity (LOH) score
Microsatellite (MS) status
Tumor Mutational Burden (TMB)

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APPENDIX

About FoundationOne®CDx

FoundationOne CDx fulfills the requirements of the European Directive 98/79 EC for in vitro diagnostic medical devices and is registered as a CE-IVD product by Foundation Medicine's EU Authorized Representative, Qarad b.v.b.a, Cipalstraat 3, 2440 Geel, Belgium.


ABOUT FOUNDATIONONE CDx

FoundationOne CDx was developed and its performance characteristics determined by Foundation Medicine, Inc. (Foundation Medicine). FoundationOne CDx may be used for clinical purposes and should not be regarded as purely investigational or for research only. Foundation Medicine's clinical reference laboratories are qualified to perform high-complexity clinical testing.

Please refer to technical information for performance specification details:
www.rochefoundationmedicine.com/f1cdxtech.

INTENDED USE

FoundationOne®CDx (F1CDx) is a next generation sequencing based in vitro diagnostic device for detection of substitutions, insertion and deletion alterations (indels), and copy number alterations (CNAs) in 324 genes and select gene rearrangements, as well as genomic signatures including microsatellite instability (MSI), tumor mutational burden (TMB), and for selected forms of ovarian cancer, loss of heterozygosity (LOH) score, using DNA isolated from formalin-fixed, paraffin-embedded (FFPE) tumor tissue specimens. The test is intended as a companion diagnostic to identify patients who may benefit from treatment with therapies in accordance with approved therapeutic product labeling. Additionally, F1CDx is intended to provide tumor mutation profiling to be used by qualified health care professionals in accordance with professional guidelines in oncology for patients with solid malignant neoplasms.

TEST PRINCIPLES

FoundationOne CDx will be performed exclusively as a laboratory service using DNA extracted from formalin-fixed, paraffin-embedded (FFPE) tumor samples. The proposed assay will employ a single DNA extraction method from routine FFPE biopsy or surgical resection specimens, 50-1000 ng of which will undergo whole-genome shotgun library construction and hybridization-based capture of all coding exons from 309 cancer-related genes, one promoter region, one non-coding (ncRNA), and select intronic regions from 34 commonly rearranged genes, 21 of which also include the coding exons. The assay therefore includes detection of alterations in a total of 324 genes.

Using an Illumina® HiSeq platform, hybrid capture-selected libraries will be sequenced to high uniform depth (targeting >500X median coverage with >99% of exons at coverage >100X). Sequence data will be processed using a customized analysis pipeline designed to accurately detect all classes of genomic alterations, including base substitutions, indels, focal copy number amplifications, homozygous gene deletions, and selected genomic rearrangements (e.g., gene fusions). Additionally, genomic signatures including loss of heterozygosity (LOH), microsatellite instability (MSI) and tumor mutational burden (TMB) will be reported.

THE REPORT

Incorporates analyses of peer-reviewed studies and other publicly available information identified by Foundation Medicine; these analyses and information may include associations between a molecular alteration (or lack of alteration) and one or more drugs with potential clinical benefit (or potential lack of clinical benefit), including drug candidates that are being studied in clinical research. The F1CDx report may be used as an aid to inform molecular eligibility for clinical trials. Note: A finding of biomarker alteration does not necessarily indicate pharmacologic effectiveness (or lack thereof) of any drug or treatment regimen; a finding of no biomarker alteration does not necessarily indicate lack of pharmacologic effectiveness (or effectiveness) of any drug or treatment regimen.

Diagnostic Significance

FoundationOne CDx identifies alterations to select cancer-associated genes or portions of genes (biomarkers). In some cases, the Report also highlights selected negative test results regarding biomarkers of clinical significance.

Qualified Alteration Calls (Equivocal and Subclonal)

An alteration denoted as "amplification – equivocal" implies that the FoundationOne CDx assay data provide some, but not unambiguous, evidence that the copy number of a gene exceeds the threshold for identifying copy number amplification. The threshold used in FoundationOne CDx for identifying a copy number amplification is four (4) for ERBB2 and six (6) for all other genes. Conversely, an alteration denoted as "loss – equivocal" implies that the FoundationOne CDx assay data provide some, but not unambiguous, evidence for homozygous deletion of the gene in question. An alteration denoted as "subclonal" is one that the FoundationOne CDx analytical methodology has identified as being present in <10% of the assayed tumor DNA.

Ranking of Therapies and Clinical Trials
Ranking of Therapies in Summary Table

Therapies are ranked based on the following criteria: Therapies with clinical benefit (ranked alphabetically within each evidence category), followed by therapies associated with resistance (when applicable).

Ranking of Clinical Trials

Pediatric trial qualification → Geographical proximity → Later trial phase.

NATIONAL COMPREHENSIVE CANCER NETWORK® (NCCN®) CATEGORIZATION

Biomarker and genomic findings detected may be associated with certain entries within the NCCN Drugs & Biologics Compendium® (NCCN Compendium®) (www.nccn.org). The NCCN Categories of Evidence and Consensus indicated reflect the highest possible category for a given therapy in association with each biomarker or genomic finding. Please note, however, that the accuracy and applicability of these NCCN categories within a report may be impacted by the patient's clinical history, additional biomarker information, age, and/or co-occurring alterations. For additional information on the NCCN categories, please refer to the NCCN Compendium®. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). © National Comprehensive Cancer Network, Inc. 2021. All rights reserved. To view the most recent and complete version of the guidelines, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

Limitations

1. The MSI-H/MSS designation by FMI F1CDx test is based on genome wide analysis of 95 microsatellite loci and not based on the 5 or 7 MSI loci described in current clinical practice guidelines. The threshold for MSI-H/MSS was determined by analytical concordance to comparator assays (IHC and PCR) using uterine, cecum and colorectal cancer FFPE tissue. The clinical validity of the qualitative MSI designation has not been established. For Microsatellite Instability (MSI) results, confirmatory testing using a validated orthogonal method should be considered.
2. TMB by F1CDx is determined by counting all synonymous and non-synonymous variants present at 5% allele frequency or greater (after filtering) and the total number is reported as mutations per megabase (mut/Mb) unit. Observed TMB is dependent on characteristics

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- of the specific tumor focus tested for a patient (e.g., primary vs. metastatic, tumor content) and the testing platform used for the detection; therefore, observed TMB results may vary between different specimens for the same patient and between detection methodologies employed on the same sample. The TMB calculation may differ from TMB calculations used by other assays depending on variables such as the amount of genome interrogated, percentage of tumor, assay limit of detection (LoD), filtering of alterations included in the score, and the read depth and other bioinformatic test specifications. Refer to the SSED for a detailed description of these variables in FMI's TMB calculation https://www.accessdata.fda.gov/cdrh_docs/pdf17/P170019B.pdf. The clinical validity of TMB defined by this panel has been established for TMB as a qualitative output for a cut-off of 10 mutations per megabase but has not been established for TMB as a quantitative score.
- The LOH score is determined by analyzing SNPs spaced at 1Mb intervals across the genome on the FoundationOne CDx test and extrapolating an LOH profile, excluding arm- and chromosome-wide LOH segments. Detection of LOH has been verified only for ovarian cancer patients, and the LOH score result may be reported for epithelial ovarian, peritoneal, or Fallopian tube carcinomas. The LOH score will be reported as "Cannot Be Determined" if the sample is not of sufficient quality to confidently determine LOH. Performance of the LOH classification has not been established for samples below 35% tumor content. There may be potential interference of ethanol with LOH detection. The interfering effects of xylene, hemoglobin, and triglycerides on the LOH score have not been demonstrated.
 - Alterations reported may include somatic (not inherited) or germline (inherited) alterations; however, the test does not distinguish between germline and somatic alterations. The test does not provide information about susceptibility.
 - Biopsy may pose a risk to the patient when archival tissue is not available for use with the assay. The patient's physician should determine whether the patient is a candidate for biopsy.
 - Reflex testing to an alternative FDA approved companion diagnostic should be performed for patients who have an *ERBB2* amplification result detected with copy number equal to 4 (baseline ploidy of tumor +2) for confirmatory testing. While this result is considered negative by FoundationOne®CDx (F1CDx), in a clinical concordance study with an FDA approved FISH test, 70% (7 out of 10 samples) were positive,

and 30% (3 out of 10 samples) were negative by the FISH test with an average ratio of 2.3. The frequency of *ERBB2* copy number 4 in breast cancer is estimated to be approximately 2%. Multiple references listed in <https://www.mycancergenome.org/content/disease/breast-cancer/ERBB2/238/> report the frequency of HER2 overexpression as 20% in breast cancer. Based on the F1CDx HER2 CDx concordance study, approximately 10% of HER2 amplified samples had copy number 4. Thus, total frequency is conservatively estimated to be approximately 2%.

VARIANT ALLELE FREQUENCY

Variant Allele Frequency (VAF) represents the fraction of sequencing reads in which the variant is observed. This attribute is not taken into account for therapy inclusion, clinical trial matching, or interpretive content. Caution is recommended in interpreting VAF to indicate the potential germline or somatic origin of an alteration, recognizing that tumor fraction and tumor ploidy of samples may vary.

Precision of VAF for base substitutions and indels

BASE SUBSTITUTIONS	%CV*
Repeatability	5.11 - 10.40
Reproducibility	5.95 - 12.31
INDELS	%CV*
Repeatability	6.29 - 10.00
Reproducibility	7.33 - 11.71

*Interquartile Range = 1st Quartile to 3rd Quartile

VARIANTS TO CONSIDER FOR FOLLOW-UP GERMLINE TESTING

The variants indicated for consideration of follow-up germline testing are 1) limited to reportable short variants with a protein effect listed in the ClinVar genomic database (Landrum et al., 2018; 29165669) as Pathogenic, Pathogenic/Likely Pathogenic, or Likely Pathogenic (by an expert panel or multiple submitters), 2) associated with hereditary cancer-predisposing disorder(s), 3) detected at an allele frequency of >10%, and 4) in select genes reported by the ESMO Precision Medicine Working Group (Mandelker et al., 2019; 31050713) to have a greater than 10% probability of germline origin if identified during tumor sequencing. The selected genes are *ATM*, *BAP1*, *BRCA1*, *BRCA2*, *BRIP1*, *CHEK2*, *FH*, *FLCN*, *MLH1*, *MSH2*, *MSH6*, *MUTYH*, *PALB2*, *PMS2*, *POLE*,

RAD51C, *RAD51D*, *RET*, *SDHA*, *SDHB*, *SDHC*, *SDHD*, *TSC2*, and *VHL*, and are not inclusive of all cancer susceptibility genes. The content in this report should not substitute for genetic counseling or follow-up germline testing, which is needed to distinguish whether a finding in this patient's tumor sequencing is germline or somatic. Interpretation should be based on clinical context.

VARIANTS THAT MAY REPRESENT CLONAL HEMATOPOIESIS

Variants that may represent clonal hematopoiesis (CH) are limited to select reportable short variants in defined genes identified in solid tumors only. Variant selection was determined based on gene tumor-suppressor or oncogene status, known role in solid tumors versus hematological malignancies, and literature prevalence. The defined genes are *ASXL1*, *CBL*, *DNMT3A*, *IDH2*, *JAK2*, *KMT2D* (*MLL2*), *MPL*, *MYD88*, *SF3B1*, *TET2*, and *U2AF1* and are not inclusive of all CH genes. The content in this report should not substitute for dedicated hematological workup. Comprehensive genomic profiling of solid tumors detects nontumor alterations that are due to CH. Patient-matched peripheral blood mononuclear cell sequencing is required to conclusively determine if this alteration is present in tumor or is secondary to CH. Interpretation should be based on clinical context.

LEVEL OF EVIDENCE NOT PROVIDED

Drugs with potential clinical benefit (or potential lack of clinical benefit) are not evaluated for source or level of published evidence.

NO GUARANTEE OF CLINICAL BENEFIT

This Report makes no promises or guarantees that a particular drug will be effective in the treatment of disease in any patient. This Report also makes no promises or guarantees that a drug with potential lack of clinical benefit will in fact provide no clinical benefit.

NO GUARANTEE OF REIMBURSEMENT

Foundation Medicine makes no promises or guarantees that a healthcare provider, insurer or other third party payor, whether private or governmental, will reimburse a patient for the cost of FoundationOne CDx.

TREATMENT DECISIONS ARE RESPONSIBILITY OF PHYSICIAN

Drugs referenced in this Report may not be suitable for a particular patient. The selection of any, all or none of the drugs associated with potential clinical benefit (or potential lack of clinical benefit) resides entirely within the discretion of the treating

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physician. Indeed, the information in this Report must be considered in conjunction with all other relevant information regarding a particular patient, before the patient's treating physician recommends a course of treatment. Decisions on patient care and treatment must be based on the independent medical judgment of the treating physician, taking into consideration all applicable information concerning the patient's condition, such as patient and family history, physical examinations, information from other diagnostic tests, and patient preferences, in accordance with the standard of care in a given community. A treating physician's decisions should not be based on a single test, such as this Test, or the information contained in this Report. Certain sample or variant characteristics may result in reduced sensitivity. FoundationOne CDx is performed using DNA derived from tumor, and as such germline events may not be reported.

SELECT ABBREVIATIONS

ABBREVIATION	DEFINITION
CR	Complete response
DCR	Disease control rate
DNMT	DNA methyltransferase
HR	Hazard ratio
ITD	Internal tandem duplication
MMR	Mismatch repair
mut/m	Mutations per megabase
NOS	Not otherwise specified
ORR	Objective response rate
OS	Overall survival
PD	Progressive disease
PFS	Progression-free survival
PR	Partial response
SD	Stable disease
TKI	Tyrosine kinase inhibitor

MR Suite Version 5.0.0

The median exon coverage for this sample is 852x

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Electronically signed by Erik Williams, M.D. | 07 October 2021
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 Post-Sequencing Analysis: 150 Second St., 1st Floor, Cambridge, MA 02141 · CLIA: 22D2027531

ORDERED TEST # ORD-1201774-01

APPENDIX
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