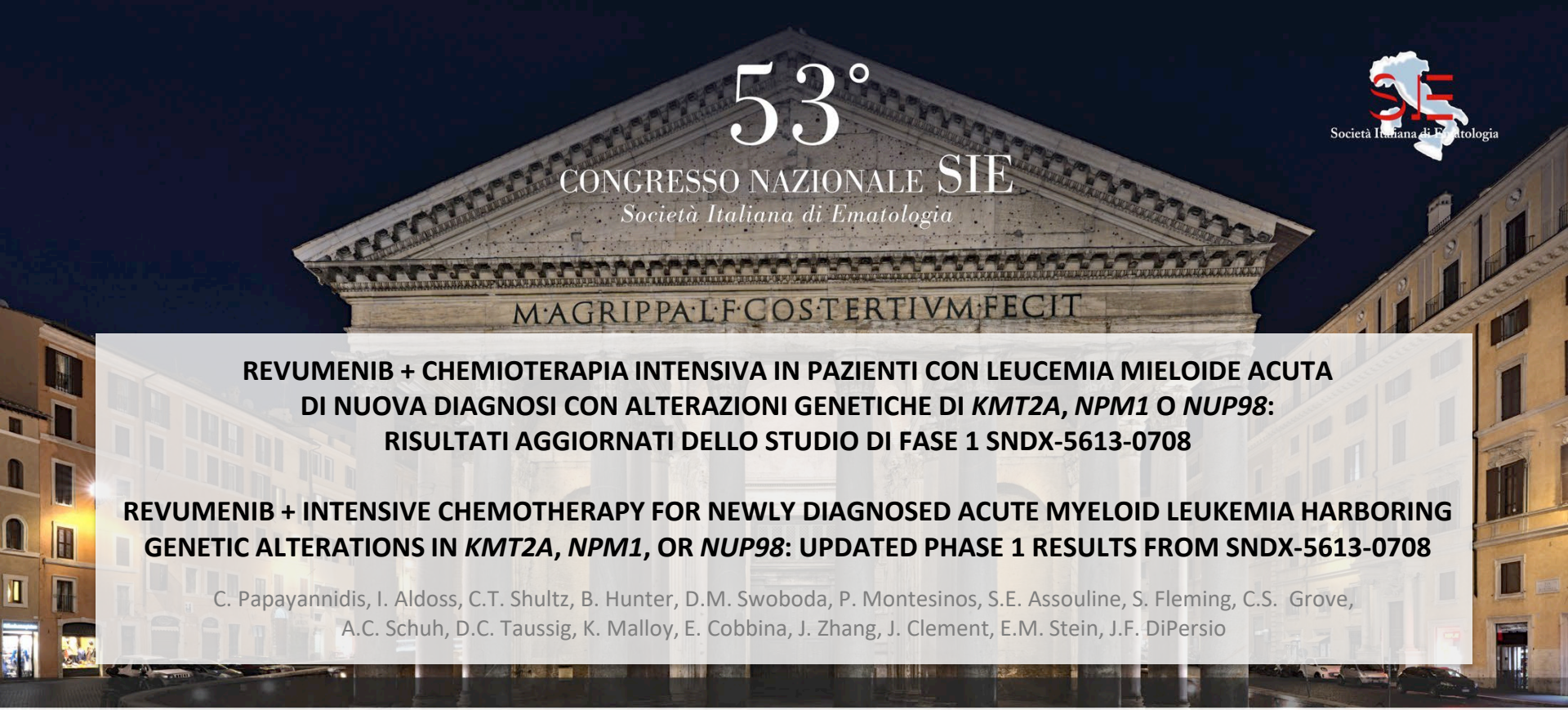

REVUMENIB + CHEMIOTERAPIA INTENSIVA IN PAZIENTI CON LEUCEMIA MIELOIDE ACUTA DI NUOVA DIAGNOSI CON ALTERAZIONI GENETICHE DI *KMT2A*, *NPM1* O *NUP98*: RISULTATI AGGIORNATI DELLO STUDIO DI FASE 1 SNDX-5613-0708

REVUMENIB + INTENSIVE CHEMOTHERAPY FOR NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA HARBORING GENETIC ALTERATIONS IN *KMT2A*, *NPM1*, OR *NUP98*: UPDATED PHASE 1 RESULTS FROM SNDX-5613-0708

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ROMA, 21-23 Settembre 2026
Roma Convention Center La Nuvola

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Disclosures of Cristina Papayannidis

Consultancy	Honoraria
Pfizer, GSK, AbbVie, Delbert Laboratoires, Astellas, Blueprint, Jazz Pharmaceuticals, Novartis, Janssen	BMS, Menarini/Stemline, Pfizer, AbbVie, Astellas, Amgen, Novartis, Janssen, Servier

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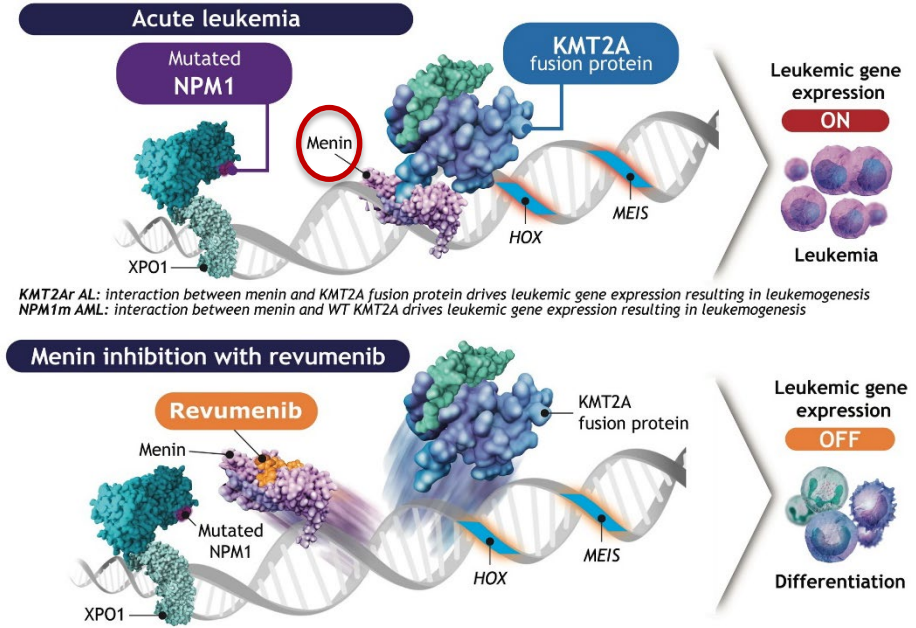
Targeting menin-KMT2A in newly diagnosed AML

- Genetic alterations such as *KMT2A*r and *NUP98r* promote leukemogenesis and are associated with poor clinical outcomes in acute leukemia[1-4]
- Revumenib, a first-in-class, oral, potent, and selective inhibitor of the menin-KMT2A interaction, is used for the treatment of R/R AML harboring an ***NPM1* mutation** or R/R AL with a ***KMT2A* translocation** in adult and pediatric patients ≥1 year[5,6]
- Adding revumenib to IC may further decrease leukemic cell proliferation and enhance differentiation, improving overall response to treatment



Here we report updated findings from the dose level 1 and 2 cohorts of the dose-escalation portion of the phase 1 study of revumenib + IC in newly diagnosed AML with *NPM1*m, *KMT2A*r, or *NUP98*r

HOX, homeobox; IC, intensive chemotherapy; *KMT2Ar*, *KMT2A* rearranged; *MEIS*, Meis homeobox; *NPM1*m, *NPM1* mutated; *NUP98r*, *NUP98* rearranged; XPO1, exportin-1.

1. Issa GC, et al. *Blood Cancer J.* 2021;11(9):162. 2. Hollink IHIM, et al. *Blood*. 2011;118(13):3645–3656. 3. Nadiminti KVG, et al. *J Hematol Oncol.* 2024;17(1):113. 4. Yokoyama A, et al. *Cell*. 2005;123(2):207–218. 5. Issa GC, et al. *J Clin Oncol*. 2025;43(1):75–84. 6. Arellano ML, et al. *Blood*. 2025;146(9):1065–1077.

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Study design (NCT06226571)

- Multicenter, open-label, nonrandomized, dose-escalation and -expansion study of revumenib + IC

Phase 1: Revumenib + IC induction, IC and/or HSCT consolidation, and post-consolidation maintenance

Patient eligibility

- 18–75 y of age
- Newly diagnosed *NPM1*m, *KMT2A*r, or *NUP98r*[a] AML by WHO 2022 criteria
- ECOG PS score of 0–2 (0 or 1 if >65 y of age)
- Candidate for IC
- <3% *FLT3*-ITD or *FLT3*-TKDm or no plan to receive FLT3i

Study schema

Dose escalation[b]

- DL2[c]: Revumenib q12h 160 mg/270 mg ± strong CYP3A4i
- DL1: Revumenib q12h 110 mg/220 mg ± strong CYP3A4i
- DL (-1)[d]: Revumenib q12h 75 mg/160 mg ± strong CYP3A4i

Dose expansion

20 patients each at RP2D

HR *NPM1*m | *KMT2A*r

Treatment overview

Induction (up to 2 cycles)
Revumenib (D8–D28) + 7 + 3[e]

HiDAC consolidation (up to 4 cycles)
Revumenib (D6–D26) + HiDAC[f]

Eligible[g] patients who achieve remission may initiate HSCT at any point after induction and before completing 4 cycles of HiDAC

HSCT

Revumenib maintenance (D1–D28)[h]

Until disease progression or toxicity[i]

Endpoints[j]

Primary
- Occurrence of DLTs[k]
- Frequency and severity of TEAEs, TRAEs, and SAEs[l]

Secondary
- PK parameters

Exploratory[m]
- CR rate
- CRc rate[n]
- ORR[o]
- TTR
- MRD–negativity rate[p]

[a]While *NUP98r* patients were eligible, none had enrolled at time of analysis. [b]Study uses a "rolling 6" design with a backfill of approximately 6 patients at tolerated doses for a total of 12 evaluable patients per DL. Alternate dosing schedules (eg, 14 days) may be explored. [c]Highest dose not to exceed the RP2D from AUGMENT-101. [d]For dose de-escalation only. [e]5 + 2 schedule used in Cycle 2. Chemotherapy doses: cytarabine 100–200 mg/m^2, idarubicin 12 mg/m^2, or daunorubicin 60 mg/m^2. [f]Chemotherapy doses: cytarabine 1.5 g/m^2 (≥60 years of age; Days 1, 3, and 5) or 3.0 g/m^2 (<60 years of age; Days 1–3 or 1, 3, and 5). [g]Patient must have achieved CR or CRi. [h]Patient must have achieved CR or CRi after ≥3 cycles. [i]Treatment can continue for up to 2 years. [j]Relevant to the current analysis. [k]DLTs were predefined in the protocol and assessed by investigator per NCI CTCAE v5.0[1]; all were reviewed and confirmed by the safety review committee. [l]AESIs (differentiation syndrome, grade ≥2 QTcF prolongation, and potential Hy's Law cases) will also be assessed, though not as a per-protocol primary endpoint. [m]For response and MRD assessments, bone marrow aspirate was collected following evidence of progressive disease in peripheral blood. [n]CRc = CR + CRi. [o]ORR = CRc + MLFS. [p]Assessed locally.

AESI, adverse event of special interest; CR, complete remission; CRc, composite CR; CRi, CR with incomplete hematologic recovery; CTCAE v5.0, Common Terminology Criteria for Adverse Events v5.0; CYP3A4i, cytochrome P450 3A4 inhibitor; D, day; DL, dose level; DLT, dose-limiting toxicity; ECOG PS, Eastern Cooperative Oncology Group performance status; FLT3i, FLT3 inhibitor; HiDAC, high-dose cytarabine; HR, high-risk; IC, intensive chemotherapy; ITD, internal tandem duplication; MLFS, morphologic leukemia-free state; MRD, measurable residual disease; NCI, National Cancer Institute; ORR, overall response rate; SAE, serious adverse event; TEAE, treatment-emergent adverse event; TKDm, tyrosine kinase domain mutation; TRAE, treatment-related adverse event; TTR, time to response; WHO, World Health Organization.

1. National Cancer Institute, Cancer Therapy Evaluation Program. Common Terminology Criteria for Adverse Events (CTCAE), Version 5.0. National Institutes of Health, U.S. Department of Health and Human Services; November 27, 2017. Accessed [September 2, 2026]. https://ctep.cancer.gov/protocoldevelopment/electronic_applications/docs/CTCAE_v5_Quick_Reference_8.5x11.pdf

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Demographics

Characteristic	DL1 (n = 15)	DL2 (n = 20)	Total (N = 35)
Age, median (range), y	43.0 (20.0–73.0)	57.5 (19.0–68.0)	50.0 (19.0–73.0)
Female, n (%)	10 (67)	16 (80)	26 (74)
Race, n (%)			
White	10 (67)	17 (85)	27 (77)
Black or African American	1 (7)	0	1 (3)
Asian	2 (13)	1 (5)	3 (9)
Not reported	2 (13)	1 (5)	3 (9)
Other	0	1 (5)	1 (3)
Ethnicity, not Hispanic, n (%)	11 (73)	19 (95)	30 (86)

Characteristic	DL1 (n = 15)	DL2 (n = 20)	Total (N = 35)
ECOG PS score, n (%)			
0	8 (53)	8 (40)	16 (46)
1	4 (27)	12 (60)	16 (46)
2	3 (20)	0	3 (9)
Genetic aberration, n (%)			
*NPM1*m	2 (13)	12 (60)	14 (40)
*KMT2A*r	13 (87)	8 (40)	21 (60)
Co-occurring mutations, n (%)[a]			
FLT3-ITD (allelic ratio of <3% *FLT3*-ITD/total *FLT3*)	0	3 (15)	3 (9)
FLT3-TKDm (no plan for FLT3-targeted therapy)	1 (7)	0	1 (3)

- As of 30 November 2025, 15 patients were dosed at DL1 and 20 were dosed at DL2

[a]No *NUP98r* patients were enrolled. No other co-occurring mutations were planned for detection.
DL, dose level; ECOG PS, Eastern Cooperative Oncology Group performance status; ITD, internal tandem duplication; *KMT2A*r, *KMT2A* rearranged; *NPM1*m, *NPM1* mutated; TKDm, tyrosine kinase domain mutation.

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Safety: treatment-emergent AEs

Parameter, n (%)	DL1 (n = 15)		DL2 (n = 20)		Total (N = 35)	
	Any grade	Grade ≥3	Any grade	Grade ≥3	Any grade	Grade ≥3
Any TEAE[a]	14 (93)	13 (87)	20 (100)	19 (95)	34 (97)	32 (91)
Thrombocytopenia/platelet count decreased[b]	8 (53)	7 (47)	13 (65)	13 (65)	21 (60)	20 (57)
Febrile neutropenia	8 (53)	8 (53)	13 (65)	11 (55)	21 (60)	19 (54)
Diarrhea	6 (40)	0	13 (65)	1 (5)	19 (54)	1 (3)
Neutropenia/neutrophil count decreased[b]	8 (53)	7 (47)	9 (45)	9 (45)	17 (49)	16 (46)
Nausea	6 (40)	0	7 (35)	0	13 (37)	0
Anemia	4 (27)	4 (27)	7 (35)	7 (35)	11 (31)	11 (31)
Hypokalemia	3 (20)	0	8 (40)	4 (20)	11 (31)	4 (11)
Vomiting	4 (27)	1 (7)	6 (30)	0	10 (29)	1 (3)
Hypophosphatemia	4 (27)	0	5 (25)	0	9 (26)	0
White blood cell count decreased	4 (27)	4 (27)	4 (20)	4 (20)	8 (23)	8 (23)

- Rates of thrombocytopenia were not unexpected for a population receiving IC

[a]Any grade TEAEs occurring in ≥25% of patients and grade ≥3 TEAEs occurring in ≥15% of patients. [b]Platelet count decreased" and "neutrophil count decreased" were likely laboratory-defined and graded per CTCAE v5.0 criteria, whereas thrombocytopenia is typically investigator-reported as a clinical adverse event though graded similarly. As a result, some events may have been captured in both categories.
CTCAE v5.0, Common Terminology Criteria for Adverse Events v5.0; DL, dose level; IC, intensive chemotherapy; TEAE, treatment-emergent adverse event.

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Safety: revumenib-related treatment-emergent AEs

Parameter, n (%)	DL1 (n = 15)		DL2 (n = 20)		Total (N = 35)	
	Any grade	Grade ≥3	Any grade	Grade ≥3	Any grade	Grade ≥3
Revumenib-related TEAEs[a]	10 (67)	5 (33)	13 (65)	12 (60)	23 (66)	17 (49)
Anemia	3 (20)	3 (20)	3 (15)	3 (15)	6 (17)	6 (17)
Thrombocytopenia[b]	2 (13)	1 (7)	3 (15)	3 (15)	5 (14)	4 (11)
Platelet count decreased[b]	2 (13)	2 (13)	2 (10)	1 (5)	4 (11)	3 (9)
Neutropenia[b]	1 (7)	1 (7)	3 (15)	2 (10)	4 (11)	3 (9)
Neutrophil count decreased[b]	4 (27)	3 (20)	2 (10)	2 (10)	6 (17)	5 (14)
QTcF prolongation[c]	3 (20)	1 (7)	5 (25)	2 (10)	8 (23)	3 (9)

- 1 DLT of grade 3 QTcF prolongation was reported in DL1; the patient discontinued revumenib during Cycle 1 and achieved MRD–negative CR at the end of Cycle 1 and proceeded to HSCT

[a]Any grade TRAEs occurring in ≥15% of patients and grade ≥3 TRAEs occurring in ≥10% of patients. [b]"Platelet count decreased" and "neutrophil count decreased" were likely laboratory-defined and graded per CTCAE v5.0 criteria, whereas thrombocytopenia is typically investigator-reported as a clinical adverse event though graded similarly. As a result, some events may have been captured in both categories. [c]In DL1, events were grade 1, grade 2, and grade 3 (n = 1 each); in DL2, events were grade 1 (n = 3) and grade 3 (n = 2).
CR, complete remission; CTCAE v5.0, Common Terminology Criteria for Adverse Events v5.0; DL, dose level; DLT, dose-limiting toxicity; HSCT, hematopoietic stem cell transplant; MRD, measurable residual disease; TEAE, treatment-emergent adverse event.

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Safety: serious TEAEs and TEAEs of special interest

Parameter, n (%)	DL1 (n = 15)	DL2 (n = 20)	Total (N = 35)
Serious TEAEs[a]	7 (47)	10 (50)	17 (49)
Febrile neutropenia	3 (20)	2 (10)	5 (14)
Sepsis	1 (7)	2 (10)	3 (9)
Gastroenteritis viral	1 (7)	1 (5)	2 (6)
Pneumonia	2 (13)	0	2 (6)
TEAEs of special interest	3 (20)	5 (25)	8 (23)
QTcF prolongation[b]	2 (13)	4 (20)	6 (17)
Differentiation syndrome	0	1 (5)	1 (3)
ALT increased	1 (7)	0	1 (3)
TEAEs leading to dose modifications			
Interruption	7 (47)	12 (60)	19 (54)
Reduction	2 (13)	0	2 (6)
TEAEs leading to discontinuation[c]	3 (20)	1 (5)	4 (11)
TEAEs leading to death[d]	0	1 (5)	1 (3)

- Rate of patients who experienced QTcF prolongation was similar across both DLs; these AEs were manageable per protocol guidance
- Rate of patients who experienced differentiation syndrome was low, occurring only in 1 patient in DL2, and was manageable per protocol guidance
- Rate of patients who experienced ALT increased was low, occurring only in DL1
- No discontinuations were due to thrombocytopenia

[a]Any serious TEAE reported by ≥2 patients from the total population. [b]Classified as grade ≥2 based on average of triplicate electrocardiograms. [c]Due to QTcF prolongation, neutropenia/neutrophil count decreased, and pneumonitis (n = 1 each) in DL1 and intracranial hemorrhage (n = 1) in DL2. [d]Due to intracranial hemorrhage (n = 1) in DL2; deemed not related to revumenib.
ALT, alanine aminotransferase; DL, dose level; TEAE, treatment-emergent adverse event.

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Exposure and pharmacokinetics

Summary of revumenib exposure

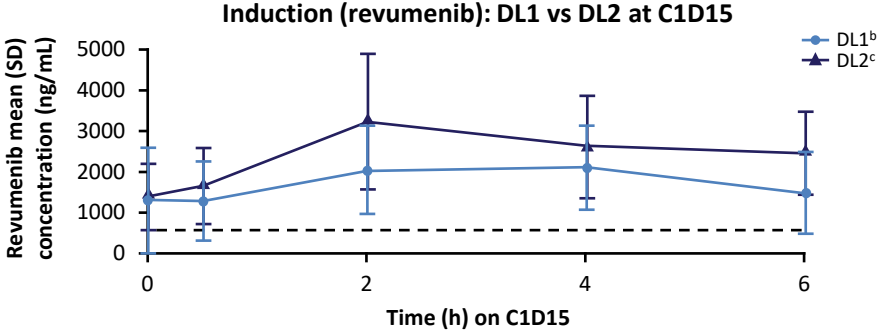
Parameter, median (range)	DL1 (n = 15)	DL2 (n = 20)
Duration of follow-up, mo	4.8 (1.5–16.0)	2.9 (0.7–6.2)
No. of revumenib cycles received	3 (1–8)	2 (1–5)
Relative dose intensity	89.3% (56.3–104.8)	92.5% (19.1–160.7)

Summary of steady-state[a] PK parameters of plasma revumenib

Parameter, GM (% GCV)	DL1[b] (n = 8)	DL2[c] (n = 13)
C_{max}, ng/mL	2710 (31)	3250 (46)
C_{avg}, ng/mL	1690 (55)	2410 (45)
AUC, ng·h/mL	10,100 (55)	14,400 (45)

- Pharmacokinetic profiles of revumenib combination therapy in this study are consistent with those in the AUGMENT-101 monotherapy study[1]
- Drug concentrations exceeded the concentration resulting in the IC_{90} threshold at both DL1 and DL2, indicating potential for effective antileukemic activity through sustained menin inhibition

Revumenib plasma concentration at steady state[a]



[a]C1D15 (induction phase). [b]Revumenib was given twice daily at 110 or 220 mg with or without a strong CYP3A4i, respectively. [c]Revumenib was given twice daily at 160 or 270 mg with or without a strong CYP3A4i, respectively.

AUC, area under the curve; C, Cycle; C_{avg}, average concentration; C_{max}, maximum concentration; CYP3A4i, cytochrome P450 3A4 inhibitor; D, Day; DCO, data cutoff; DL, dose level; GCV, geometric coefficient of variation; GM, geometric mean; IC_{90}, concentration resulting in 90% of maximum inhibition.

1. Issa GC, et al. *Nature*. 2023;615(7954):920–924. DCO: 30 Oct 2025. Horizontal dashed line indicates the IC_{90} of revumenib against menin-KMT2A interaction.

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Efficacy: response[a]

Parameter, n (%)	DL1 (n = 15)	DL2 (n = 20)	Total (N = 35)
ORR,[b] n (%)	15 (100)	19 (95.0)	34 (97.1)
95% CI	78.2–100.0	75.1–99.9	85.1–99.9
CRc rate,[c] n (%)	15 (100)	19 (95.0)	34 (97.1)
95% CI	78.2–100.0	75.1–99.9	85.1–99.9
CR rate, n (%)	12 (80.0)	15 (75.0)	27 (77.1)
95% CI	51.9–95.7	50.9–91.3	59.9–89.6
Time to CR, median (range), d	21.0 (18.0–35.0)	26.0 (18.0–70.0)	23.0 (18.0–70.0)
MRD–negative status,[d,e] n/N (%)			
CRc	10/12 (83.3)	15/17 (88.2)	25/29 (86.2)
CR	9/9 (100)	11/14 (78.6)	20/23 (87.0)
Time to MRD–negative status, median (range), d			
CRc	31.0 (28.0–65.0)	46.0 (28.0–77.0)	33.0 (28.0–77.0)
CR	31.0 (28.0–65.0)	34.0 (28.0–77.0)	31.5 (28.0–77.0)

[a]Among the response-evaluable population. [b]ORR = CRc + MLFS. [c]CRc = CR + CRi. [d]For patients who had available MRD-negativity results in the response-evaluable population. [e]MRD-negative status determined locally: DL1 (flow cytometry: n = 10; PCR: n = 1; NGS: n = 1); DL2 (flow cytometry: n = 13; PCR: n = 3; other: n = 1).

HSCT and maintenance

- 9/15 (60.0%) patients in DL1 and 2/20 (10.0%) in DL2 had proceeded to HSCT
- All patients who proceeded to HSCT had *KMT2A*r AML; of these:
  - 6/9 (66.7%) patients in DL1 resumed revumenib maintenance monotherapy following HSCT at the last tolerated dose
  - 3/6 (50.0%) were continuing treatment as of the data cutoff
- One patient in DL2 received revumenib as post-consolidation maintenance therapy without undergoing HSCT

CR, complete remission; CRc, composite CR; CRi, CR with incomplete hematologic recovery; CRp, CR with incomplete platelet recovery; DL, dose level; *KMT2A*r, *KMT2A* rearranged; MLFS, morphologic leukemia-free state; MRD, measurable residual disease; ORR, overall response rate.

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Efficacy: neutrophil and platelet recovery

Neutrophil and platelet recovery among CRc responders during induction Cycle 1

	DL1 (n = 15)	DL2 (n = 19)	Total (N = 34)
Neutrophil recovery (≥1000 cells/µL),[a] n (%)	13 (86.7)	15 (78.9)	28 (82.4)
Time to count recovery, median (range), d	29.0 (8.0–42.0)	29.0 (22.0–55.0)	29.0 (8.0–55.0)
Platelet recovery (≥100,000 cells/µL),[a] n (%)	13 (86.7)	17 (89.5)	30 (88.2)
Time to count recovery, median (range), d	28.0 (22.0–43.0)	29.0 (22.0–47.0)	29.0 (22.0–47.0)

- Time to neutrophil and platelet count recovery was comparable across DLs and consistent with time to count recovery with IC alone[1,2]

[a]From induction Cycle 1 Day 1.
CRc, composite complete remission; DL, dose level; IC, intensive chemotherapy.
1. Stone RM, et al. *N Engl J Med*. 2017;377(5):454–464. 2. Lancet JE, et al. *J Clin Oncol*. 2018;36(26):2684–2692.

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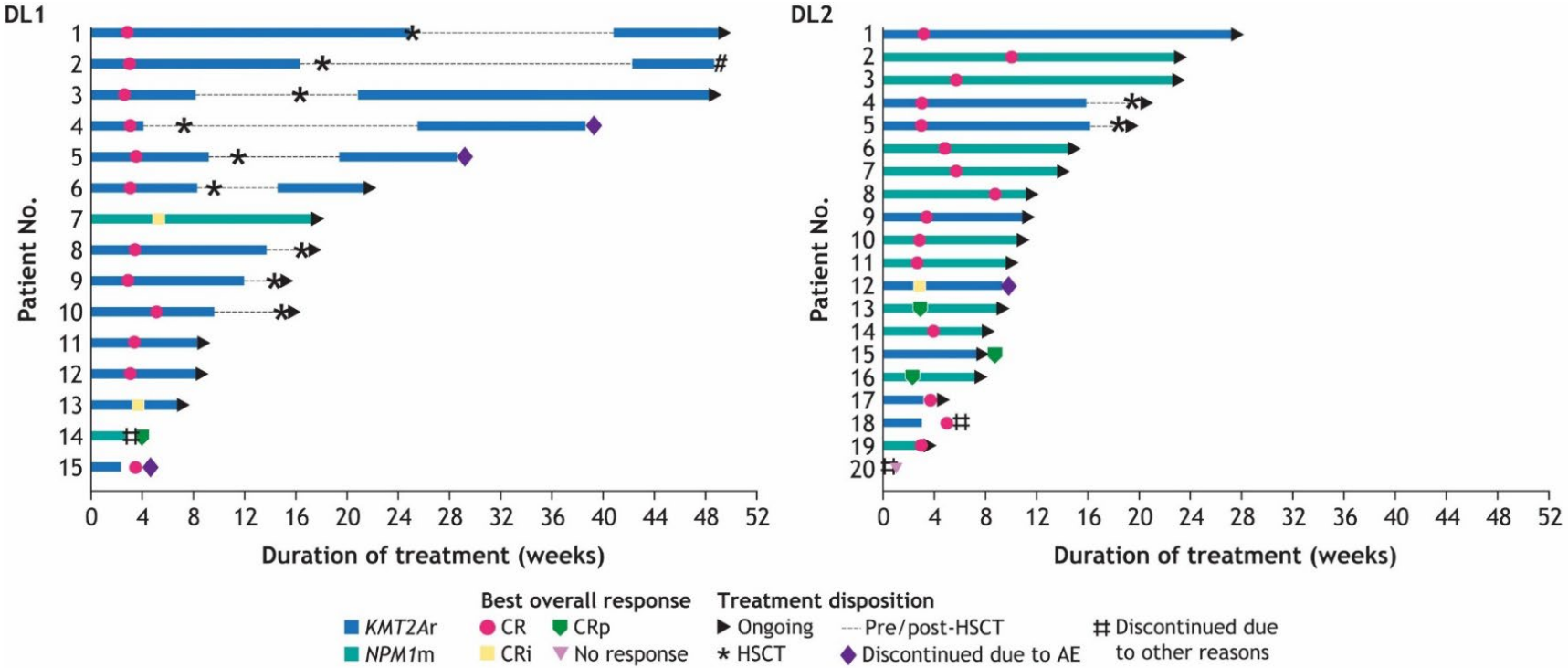
Efficacy: duration of treatment in *NPM1*m and *KMT2A*r AML[a]



[a]In the safety population.
CR, complete remission; CRi, CR with incomplete hematologic recovery; CRp, CR with incomplete platelet recovery; DL, dose level; *KMT2Ar*, *KMT2A* rearranged; *NPM1*m, *NPM1* mutated.

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Conclusions

Efficacy

- These updated preliminary efficacy data as of 30 November 2025 build upon findings showing deep responses across both DLs, with high MRD–negative CR rates

Safety

- Revumenib + IC continued to demonstrate a manageable safety profile that was broadly consistent across both DLs and comparable with IC alone[1]
- No new safety signals were detected for revumenib + IC, and no overlapping toxicity with combination use was observed
- Time to neutrophil and platelet recovery was comparable to that of IC alone[2,3]

Next Steps

Overall, these safety and efficacy findings are consistent in patients with *NPM1*m and *KMT2A*r AML and support continued evaluation of revumenib + IC at DL2 in the phase 3 REVEAL-ND NPM1 trial (NCT07211958)

CR, complete remission; DL, dose level; IC, intensive chemotherapy; *KMT2A*r, *KMT2A* rearranged; MRD, measurable residual disease; *NPM1*m, *NPM1* mutated.

1. Stone RM, et al. *N Engl J Med*. 2017;377(5):454–464. 2. Lancet JE, et al. *J Clin Oncol*. 2018;36(26):2684–2692. 3. Erba HP, et al. *Lancet*. 2023;401(10388):1571–1583.

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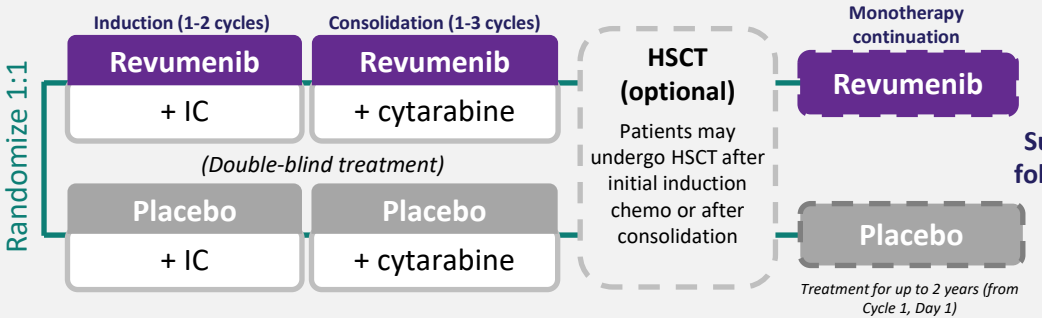
REVEAL-ND NPM1: a phase 3, randomized, double-blind trial in newly diagnosed AML (open to enrollment)

REVEAL-ND NPM1 Revumenib + IC in newly diagnosed *NPM1*m AML

Patient population (N ≈ 468)
- Age ≥12 years and ≥40 kg
- Newly diagnosed, untreated AML
- *NPM1*m AML (locally determined, centrally confirmed)



Primary endpoints
- EFS
- MRD– CR

Secondary endpoints
- OS
- CR
- ORR
- DoCR
- DoCRc
- DoR
- QoL

REVEAL-ND NPM1

REVEAL-ND NPM1: NCT07211958
CR, complete remission; DoCR, duration of CR; DoCRc, duration of composite CR; DoR, duration of response; EFS, event-free survival; IC, intensive chemotherapy; MRD-CR, MRD-negative CR; ND, newly diagnosed; *NPM1*m, *NPM1* mutated; ORR, overall response rate; OS, overall survival; QoL, quality of life.

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Acknowledgments

- The authors would like to thank the participants who were enrolled in the study and their families and caregivers, physicians and nurses who cared for participants, staff members who supported this clinical trial, and staff members at the study sites and involved in data collection/analyses.
- The authors would like to acknowledge Mila Ayash-Rashkovsky, formerly of Syndax Pharmaceuticals, Inc., for her contributions to the study.

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- SNDX-5613-0708 is sponsored by Syndax Pharmaceuticals, Inc.
- Medical writing and editorial assistance were provided by Kirsty Lee, MPH, of Lumanity Communications Inc., and were funded by Syndax Pharmaceuticals, Inc.
- These data were previously presented as a poster at the 31st Congress of the European Hematology Association (EHA); 11–14 June 2026; Stockholm, Sweden.

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