



CLL SOCIETY

CLL Society's Virtual Event: Playing CLL/SLL Chess: Planning Your Therapy Moves

Wednesday, October 26, 2022

Audience Questions and Answers

SYMPTOMS AND PROGRESSION

1. What are some CLL symptoms?

Here is a link to an article which explains common CLL symptoms: <https://cclsociety.org/newly-diagnosed/symptoms/>.

2. How is the stage of CLL determined? What are the stages?

RAI staging is used in CLL. Here is a great article on it: <https://cclsociety.org/cll-sll-patient-education-toolkit/cll-staging-and-other-prognostic-factors/>

3. Is there a good guide as to how to read the labs? I have a couple of dozen labs but not sure how to determine what type of CLL I have.

Please visit this resource from CLL Society regarding normal lab values: <https://cclsociety.org/cll-sll-patient-education-toolkit/normal-lab-values/>. Best of luck! Stay in touch with CLL Society if you have any additional questions. We are here for you!

4. What are B symptoms? With no symptoms is treatment sometimes recommended? No typically not. There is an ongoing study right now looking at treating certain individuals in the watch and wait period, but it is too early to report out data from that just yet. B Symptoms include unexplained weight loss >10% of body weight in the previous six months, severe fatigue (unable to work or perform usual activities), fevers >38°C or 100.5°F for at least 2 weeks without evidence of infection, and drenching night sweats (soaking the bed sheets) for more than a month without evidence of infection.

5. Does a doubling of my lymphocytes mean my disease has progressed again after treatment? If not, what does in my CBC?

Typically, no one single lab result should result in any change in your treatment plan typically. Instead, this is why labs are obtained/repeated over time because trends in your labs are more important than any one abnormal result. We recommend using the "Keeping Track of Lab Results" resource to help you track these lab trends, <https://cclsociety.org/cll-sll-patient-education-toolkit/keeping-track-of-lab-results/>.

6. What exactly determines relapse?

Lab results trending over time in the wrong direction and/or re-emergence of "B Symptoms".

7. What is a "good" length of remission? Especially for patients with very bad markers?

There is no exact time period, but some would say that a good estimate would be approximately 2-3 years.



TESTING

- 1. What is MRD stand for?**
Measurable Residual Disease (or some used to say minimal residual disease).
- 2. Can you discuss the Clonoseq test? When is it used and what does it measure?**
ClonoSeq measures MRD, or measurable residual disease. Please visit this webpage which includes an archived version of a webinar we did on MRD testing:
<https://cllsociety.org/treatment-and-research/mrd-and-disease-monitoring/>.
- 3. What are other prognostic tests called, besides the IgVH status?**
FISH and TP53. You can read more on our Test Before Treat campaign about this topic in this section of our website: <https://cllsociety.org/newly-diagnosed/test-before-treat/>. The downloadable one-pager is a great resource!
- 4. I've been told finding out my IgVH status was hard to do. How important is that test? How do I go about trying to have it done again?** IgVH mutation status is generally stable and does not change over time. So if you already have results, you shouldn't need to have the test ran again. If you have not previously had the IgVH test, we strongly recommend that you advocate to have it done (and make sure the results are being applied to your treatment plan). I encourage you to learn more about necessary CLL testing located within the Test Before Treat section of our website. Please especially make sure and read through the one-pager: [:https://cllsociety.org/newly-diagnosed/test-before-treat/](https://cllsociety.org/newly-diagnosed/test-before-treat/).
- 5. Why is CLL generally more aggressive with people diagnosed earlier in their life even if they have the more favorable prognostic markers 13q mutation?** That is not necessarily always the case, as many individuals diagnosed later in life also have aggressive CLL biomarkers. One of the important factors that contributes to those diagnosed earlier in life is that the longer you live with CLL, the more treatments you will most likely have to go through in your lifetime. There are only a finite number of treatments that can help control CLL. For example, at this time, there are only three approved drug classes for CLL (BTK inhibitors such as ibrutinib, BCL2 inhibitors such as venetoclax, and PI3K inhibitors such as duvelisib). While there might be several drugs in each drug class, once you relapse on any one medication in each class, no other drug in that same class will work any longer as well. So additional treatment options become somewhat limited (this will be touched on within the webinar today). The older you are diagnosed, then less amount of time left in your life that you will have to “try” the limited number of available drugs. The more time you have left in your life the higher chance you might have of having to try multiple drugs throughout your lifetime, thus the increased possibility eventually running out of treatment options.
- 6. Question for Terry Evans: Did you have all the bad markers from the beginning, or did you acquire them over time?**
Yes. Terry had all of them except for 17p deletion, which was acquired after going through chemotherapy (this is a very common occurrence).



CLL SOCIETY

7. **I was on a BTK inhibitor for three years and stopped due to intolerance. I had a great result and have now been in remission for three more years since stopping the drug. Do you think it would be a good idea to be tested for BTK resistance before my next treatment? I am thinking about trying a second generation BTK inhibitor next time to see if I can tolerate the side effects better.**

Given your circumstances surrounding stopping the drug due to intolerance and not because your CLL progressed while you were on the drug, some healthcare providers will run the test if you advocate.

8. **This is more of a comment, regarding being proactive about your future treatment options. I have been treated with Ibrutinib and Venetoclax. I have asked what my next treatment might be if/when I relapse. The answer is always unclear with my healthcare provider saying, “it depends” which I understand. I think they are saying this because the science changes constantly and newer and better drugs are constantly in development. And I think it also depends on where my labs are at the time when I need to be treated next. Is that correct?**

Those things are both true. Be sure to advocate for getting your FISH and TP53 biomarker tests repeated again before starting any subsequent treatment. Dr. Koffman mentioned “Test Before Treat” in his introduction. You can find more about that here: https://cllsociety.org/wp-content/uploads/2021/08/CLL-ToolKIT-Test-Before-Treat-Page-v1R1-012321_Updated-PO-Box.pdf.

9. **With a person in their mid-40s currently in watch and wait, what is the best plan regarding testing in light of planning my future treatment?**

We would highly recommend you review the Test Before Treat section of our website here: <https://cllsociety.org/newly-diagnosed/test-before-treat/> and specifically become very familiar with the one-pager that explains the testing you need to have and when you need to have it repeated. You can find this information here: https://cllsociety.org/wp-content/uploads/2021/08/CLL-ToolKIT-Test-Before-Treat-Page-v1R1-012321_Updated-PO-Box.pdf.

TREATMENTS

1. **If a drug is approved for CLL/SLL, is it always approved?**

Not necessarily. Case in point right now is the PI3K inhibitors that are under review by the FDA for safety concerns, some of which have already had their approved status removed.

2. **Is it required to have a port in place to receive Gazyva treatment?**

No, it is not required.

3. **When is Calquence being used?**

Calquence (acalabrutinib) may be the BTK inhibitor of choice for some CLL healthcare providers as an alternative to ibrutinib and other BTK inhibitors due to different side effect profiles. Generally, if a patient is already on a BTKi and doing well, there is no reason to switch to another drug.



CLL SOCIETY

4. **What effect does taking acalabrutinib have on the environment?** Acalabrutinib (Calquence) is not expected to pose a risk to the environment (it is not a form of chemotherapy).
5. **Is the tablet form of acalabrutinib available?**
Yes, it was just recently made available in tablet form. You can read more about that here: <https://cllsociety.org/2022/08/astrazeneca-newly-approved-acalabrutinib-tablet-formulation-for-patients-with-cll-sll-allows-use-of-acid-reducing-agents/>.
6. **I've been on acalabrutinib for almost 8 years, and I have been MRD negative for about 6 months. Even so, is it likely that at some point my CLL will just become resistant to acalabrutinib? Does this happen with most patients who take BTKi's?**
Dr. Koffman likes to say, "If you know one CLL patient, you know one CLL patient" meaning that everyone really does have unique "flavor" of CLL with different experiences. It is common for those with CLL to develop resistance to BTKi's (and any other treatments they are on after a period of time). But this isn't always the case.
7. **After being on watch and wait for 8 years I was given Calquence and Allopurinol. I had a very bad response and after 8 days and both medications were terminated. What will my choices be now?**
Talk with your healthcare provider as we are not aware of your specific medical condition. But generally, just because you had a bad response to one of the medications within the BTK inhibitor drug class it does not preclude you from trying one of the others.
8. **I had a bad infusion reaction to obinutuzumab, can it be tried again, currently on Calquence, at a lower and slower infusion rate?**
Talk to your healthcare provider. It is possible, but we are not fully aware of the circumstances surrounding your reaction.
9. **Wouldn't discontinuing a BTK inhibitor when in remission reduce the likelihood of becoming resistant to the drug?**
Dr. O'Brien addresses this in greater detail in her presentation. She mentions the opposite in that that she personally does not like discontinuing a drug when it is working well, as discontinuation can actually increase the chance of drug resistance.
10. **Question for Terry Evans: Can you tell us what BTK inhibitor you were on that you became resistant to after treatment?**
It was Ibrutinib after being administered for 3.5 years, but Terry stayed on ibrutinib for an additional 4.5 years in combination with adding venetoclax.
11. **If a patient's lymph nodes "blow up" after a five day holiday from ibrutinib, what does this mean?**
Talk to your healthcare provider, but you may not want to pause or temporarily go off this medication in the future.



12. If you have relapsed while being on ibrutinib will LOXO-305 (pirtobrutinib) probably not work for me as well?

No, not necessarily. LOXO-305 is a non-covalent BTK inhibitor, which means it works a bit differently from covalent BTK inhibitors even though it is technically in the same drug class. This is one of the advantages of LOXO-305 (pirtobrutinib). You can read more about this here: <https://cillsociety.org/2021/10/eha-2021-top-pick-5-pirtobrutinib-loxo-305-a-next-generation-highly-selective-non-covalent-btk-inhibitor-in-previously-treated-cll-sll-results-from-the-phase-1-2-bruin-study/>

13. In terms of finding the best next treatment move, if a person was on a BTK inhibitor for only 6 months, and then had intolerable side effects, does that automatically eliminate that same BTK inhibitor? Does it eliminate all BTK inhibitors, or could you try one again.

Talk with your healthcare provider, but it does not negate all other BTK inhibitors within the same drug class if side effects were the reason for discontinuing the medication. Newer next generation medications within the drug class tend to have differing side effect profiles.

14. Do you see zanubrutinib being approved for first line CLL treatment in the near future?

We can never guarantee what will happen with FDA approvals, but based on how clinical trials are going for zanubrutinib, we anticipate that Zanubrutinib will be approved as a CLL frontline therapy in the very near future.

15. Any sense of when CAR-T therapy will become FDA approved? Are we close?

Unfortunately, we don't have the answer to this question. However, there is hope that FDA approval might come in the next year or two for CLL. There are active ongoing CAR-T trials going on for those with CLL, but there are limited sites that are able to do it. Stay tuned to the CLL Society website, as we will let our audience know as soon as we hear any updates.

16. What do you think of Pirtobrutinib and a new version of it, PC 168?

We are very excited about Pirtobrutinib and the development of non-covalent BTK inhibitors. There is a lot of information on our website if you use the search terms 'BRUIN Study' or 'Pirtobrutinib': <https://cillsociety.org/?s=pirtobrutinib>.

17. What are the results of the venetoclax and ibrutinib trial?

This article and video interview will answer your question: <https://cillsociety.org/2022/09/ash-2021-dr-talha-munir-on-measurable-residual-disease-after-fixed-duration-ibrutinib-plus-venetoclax/>.

18. What are the risks of FCR (the chemotherapy used to treat CLL in rare instances)? Would it make sense to try FCR as a first line treatment for someone who is young and healthy to see if they can be cured?

CLL Society believes that with the development of novel drug therapies for CLL, that using FCR to treat CLL should only be reserved for *extremely* rare circumstances. And FCR should



never be administered if someone has not had biomarker testing performed first, as FCR comes with many bad side effects and does not work in a large proportion of those with CLL depending on their biomarkers. Please see this page on our website:

https://cllsociety.org/docs/CLL%20Genetics%20Test%20Before%20Treat%20Page%20v1R1%20012321_Updated%20PO%20Box.pdf.

19. Regarding tolerating FCR, what are the side effects that are typical of chemotherapy treatments? Is there a typical cutoff age for suggesting FCR if it's otherwise appropriate?

Side effects are the same as other forms of chemotherapy. There is no set age cut off. The bigger determining factor is making sure biomarker testing has been performed first before starting any treatment, as chemotherapy will oftentimes not work for those with CLL depending on the person's biomarkers. FCR should only be reserved for extremely rare circumstances in those with appropriate biomarkers, who are young, and have minimal comorbidities and are otherwise healthy individuals.

20. Do people with compromised immune systems ever recover their immunity as a result of treatment?

It can improve somewhat, but since CLL is a cancer of the immune system and cause B cells to be dysfunctional, there is still an immune system impairment to some degree even in those who have never received treatment.

21. Is kidney damage a concern during CLL treatment?

Not typically, with the possible exception of chemotherapy.

22. I'm on watch and wait. It is time to choose a drug plan for Medicare enrollment purposes. Are there specific medications that I will be taking in the future that I need to consider when I am choosing my insurance coverage?

Please discuss this question with your healthcare provider. Without knowing your specific medication conditions, it is impossible to say what your best treatment option might be should it become time for you to receive treatment. Generally, your options are going to include an oral BTK inhibitor (ibrutinib, acalabrutinib, zanubrutinib, etc.), or a BTK inhibitor (venetoclax). You can start being looking at those medications and seeing what Medicare drug plan will provide the best coverage.

CLINICAL TRIALS

1. Is there one best online site to search for ongoing CLL/SLL clinical trials?

Please visit www.clinicaltrials.gov, which is the database for ongoing clinical studies conducted around the world. Under the status bar, you can narrow down the search by selecting "recruiting and not yet recruiting studies," then type in the disease name "CLL", and then choose the United States as the country. This will provide you with a list of ongoing CLL trials. Unfortunately, you will need to check back on this website from time to time as new studies are added frequently.



CLL SOCIETY

2. How can we apply to be in a clinical trial?

We would suggest starting by reviewing our FAQ on clinical trials. If you find one that you believe might be right for you, consult with your treating CLL healthcare provider. Here is the link to the clinical trial FAQ: <https://cclsociety.org/2022/02/clinical-trials-frequently-asked-questions-faq/>.

3. What does the term “crossover” mean in terms of clinical trials?

Researchers typically compare two or more drugs in a clinical trial, usually the new drug and an older/already approved drug. In the story Terry Evans shared, he was assigned to receive the older approved drug in the clinical trial and was not allowed initially to “crossover” and receive the newer and possibly better drug being studied in the trial.

COVID-19 AND CLL

1. Does venetoclax alone have less immune suppression than venetoclax that is co-administered with a cancer monoclonal antibody therapy. If so, is it a good treatment choice during COVID-19?

Anti-CD20 monoclonal antibody therapies do tend to be more immunosuppressive and result in a much less robust response to COVID-19 vaccines. Due to those with CLL/SLL being at higher risk for poor outcomes if they become infected with COVID-19, healthcare providers have had a tendency to utilize Anti-CD20 monoclonal antibody as a chosen therapy option for those with CLL/SLL during the pandemic.

2. Are some CLL drug therapies better treatment options due to being in the midst of a pandemic and us being at high risk if we get COVID-19?

Yes. While all of those with CLL/SLL are considered immunocompromised, regardless of whether or not they have ever undergone treatment, there are some treatments that further dampen the immune system’s ability to create antibodies in response to vaccines as well as prevent the body from being able to fight off infection should they ever get COVID-19. These especially include Anti-CD20 monoclonal antibody therapies. You can read more about this on our website here: <https://cclsociety.org/2021/07/lls-covid-19-vaccine-trial-antibody-response-to-sars-cov-2-vaccines-in-patients-with-hematologic-malignancies/> It is important to still receive all recommended COVID-19 vaccinations, even if antibody responses are not robust, and remember that Evusheld (at this moment) provides an additional layer of protection against developing severe disease should you become infected.

3. Any thoughts on Evusheld? Should we still receive it every 6 months even though it’s predicted to be less effective against new variants that are predicted to be coming to the US?

At this particular point in time of the webinar, the answer is that it is still recommended for those with CLL to receive their next dose of Evusheld. There are minimal downsides to getting it, even if sometime in the near future it is less effective (or not effective at all). At the time of this webinar, it is still very much effective against the dominant variant in the US (BA.5).

However, we anticipate that just like we have seen with the vaccines over the past 2.5 years, it



CLL SOCIETY

is going to be less and less effective as the virus mutates and new variants emerge. Stay tuned to our website. And as always, we continue to recommend utilizing multiple layers of protection and use extra precautions for those with CLL/SLL.

4. Tell me about convalescent plasma used immediately after testing positive for COVID-19?

It is not widely available and/or currently a recommended treatment by the FDA or NIH. However, it is something that we encourage you to discuss with your treating physician as some studies do show benefits for those who are immunocompromised. And unfortunately, we are not sure quite yet if convalescent plasma will be effective against the new upcoming variants (BQ.1, BQ1.1, XBB, and BF.7) as it is looking more and more that these variants might evade all previous natural immunity created in the community from infection with previous COVID-19. If that is truly the case, then any immunity found in CP might not be as effective. See the [COVID-19 Action Plan](#) where there is more information in the instructions document on CP. You can also read more about CP for those who are immunocompromised here: <https://cllsociety.org/2022/10/dr-michael-joyner-on-convalescent-plasma-for-treating-covid-19-in-immunocompromised-patients-including-those-with-chronic-lymphocytic-leukemia-ll-and-small-lymphocytic-lymphoma-sll/>

5. What are the implications among various CLL treatments as it pertains to creating a poor outcome if I get COVID-19? For example, which treatments are most likely to lead to the worst outcomes or death from COVID-19?

We know that venetoclax in combination with an anti-CD20 monoclonal antibody (i.e. obinutuzumab) tends to be the most immune suppressing of all the therapy options. Although there are several additional factors that will come into play should you become infected with COVID-19. For instance, did you receive the full vaccination series before treatment began? Did you get started on Paxlovid or Remdesivir within the first few days of infection? Did you receive Evusheld and how long ago? What variant were you infected with? So, it is difficult to say in the large mix of things what treatment might lead to the worst outcome. There is a good article where you can read about this here: <https://cllsociety.org/2021/07/lls-covid-19-vaccine-trial-antibody-response-to-sars-cov-2-vaccines-in-patients-with-hematologic-malignancies/>. The good news is that right now, we know that death rates amongst those with CLL/SLL have greatly improved when compared to the beginning of the pandemic. However, we know with the new variants that are expected to be dominant in the next couple of months that we must all remain diligent and take extra precautions whenever we are able.

6. Is there any update as to whether Medicare will continue to cover Evusheld in 2023? Thank you for your support in this issue.

We are aggressively and tirelessly working on that behind the scenes! Right now, it looks like the drug itself is going to be covered, but perhaps not the administration fees from the healthcare provider's office. But this could all change and nothing is set in stone yet. And this will only apply if Evusheld becomes commercialized (which we have no idea at this point if or when that will ever happen). There is also the factor of whether Evusheld will still remain effective in the coming months against the newly emerging variants. So, stay tuned.



CLL SOCIETY

7. I had a strong positive antibody response to the COVID-19 vaccines. Do I need to worry about COVID-19?

We do not yet know how to best interpret COVID-19 antibody levels. Mainly, we do not know what antibody range or level correlates with protection, nor do we know the duration of protection that maxed-out antibody levels may or may not provide for the immunocompromised. For these reasons, we still encourage all of those with CLL to obtain Evusheld, have your COVID-19 Action Plan in place, and continue to take extra levels of infection control precautions such as wearing an N95.

PHYSICIAN CONSIDERATIONS

1. How do you find a CLL "Specialist" since many oncologists say they treat CLL?

This may be a good resource for you: <https://cclsociety.org/newly-diagnosed/cll-doctors/>. This list is not 100% complete but we do our best to identify CLL experts. A lot of hematologists and oncologists do treat CLL, but we try to find people who truly specialize in CLL, meaning it's their primary area of focus. Usually, these experts have published scientific papers in CLL, so that's one thing you can look for. If there is no CLL expert in your area, you can always get a free online consultation with one of the leading CLL experts in the U.S. through our Expert Access™ Program: <https://cclsociety.org/programs-and-support/expert-access/>. People who have participated in Expert Access have overwhelmingly positive experiences. Best of luck, and please stay in touch with CLL Society. We are here for you!

2. I have an oncologist. Do I need a CLL specialist? How do I find one?

We do strongly recommend seeing someone who specializes in CLL, as studies have proven that outcomes are much better. We have a list here: <https://cclsociety.org/newly-diagnosed/cll-doctors/>. Also, you can get a free online consultation with a leading CLL expert through our Expert Access Program: <https://cclsociety.org/programs-and-support/expert-access/>. I hope this is helpful!

3. I am very happy with my Hematologist, but she is not a CLL expert. How can I find a listing of CLL experts to add to my decision-making team?

Great question. At the very bottom of any of our web pages, you will right underneath the blue "testing and imaging" box something that says, "List of CLL Healthcare Providers." You can then select the state you live in (or live closest to) and view all providers listed there. Here is the direct link: <https://cclsociety.org/newly-diagnosed/cll-doctors/>

4. How can one research the background of cancer doctor? Like what percent of the patients they see are CLL patients, etc.

Anyone can go to Google Scholar and type in the doctor's name followed by the word "CLL". Then you will see how well published the person is (if at all in CLL). Then when interviewing the physician you can ask how many new patients they see weekly in their clinic with CLL, do they refer people to clinical trials (this should be a resounding yes), how often do they treat CLL patients with chemotherapy (it should be extremely rare), and what percentage of patients do they see weekly in their practice who have CLL (ideally this should be approximately 30% of their patient load-however this can vary depending on demographic location).



CLL SOCIETY

5. How do I get a referral to a CLL specialist? Through my PCP or Oncologist?

Do your research first to determine who you would like to be referred to. Then confirm that they take your insurance. It is also a good idea to call the specialist's office to confirm they are taking new patients. You can then have a conversation with your primary care provider and advocate for them providing you a referral to that particular CLL specialist.

LIFESTYLE AND HEALTH

1. Has there been any indication that a vegan or vegetarian diet is beneficial?

Data are lacking on this question. There is one study that has been done which indicates that a Mediterranean diet may have some benefit in those with CLL. Here is an article from our website on the impact of diet in CLL. <https://cillsociety.org/2018/09/the-impact-of-diet-on-ctl/>.

2. How about alcoholic drinks with CLL? Is it possible to have 2 drinks daily once in a while?

Drinking alcohol in moderation should be fine. However, there are circumstances like liver conditions and some medications that are factors to consider. So please discuss this question with your treating healthcare provider who has access to your entire medical history.

3. I'm 53 years old and my lymphocytes have been slowly increasing for a few years and confirmed with flow cytometry. What should I be doing during this watch and wait period?

Keep yourself healthy. Eating healthy, exercise, continuing your regular check-ups (including secondary cancer screenings like mammograms, etc.) is very important. Also make sure you are obtaining all of the recommended vaccines (such as pneumonia, shingles, influenza, COVID-19, etc.). This is because your immune system is the best it will ever be right now before you receive treatment, so you have the best chance during this time of your body mounting antibody responses to vaccines right now. There is no one thing that you can do to reverse or eliminate CLL.

MISCELLANEOUS

1. What is being done to address the immune dysfunction that is common in CLL?

This is a complex question that will require a complex answer. Please see this video interview and written summary which will help answer your question in more detail:

<https://cillsociety.org/2019/10/ash-2018-dr-wiestner-on-the-immune-system-in-ctl-chronic-lymphocytic-leukemia/>

2. Are CLL and SLL treated the same way?

Yes, that is correct. They are the same disease. It is just differentiated depending upon where the cancer cells are located within the body (bone marrow, blood, or lymph nodes). You can find more about the distinction here: <https://cillsociety.org/ctl-sll-patient-education-toolkit/what-is-ctl-chronic-lymphocytic-leukemia-and-what-is-sll-small-lymphocytic-lymphoma/>.



CLL SOCIETY

3. I heard some people will never need treatment. Is there a risk assessment regarding who will need treatment vs. no treatment?

You are correct in that there are some individuals with CLL/SLL who do not ever require treatment. There is not a risk assessment per se because each person's type of CLL is slightly different. The aggressiveness of the disease is highly dependent upon biomarker results and treatment is completely dependent upon if or when "B symptoms" arise. You can read through the section on our website that speaks a little bit more about indications for treatment here: <https://cillsociety.org/treatment-and-research/indications-for-treatment/>.

4. Is the incidence of CLL increasing? If so, do we have any idea why?

The short answer is yes. We don't have all the answers concerning why, but it could be because more people are getting correctly diagnosed now. Also, the number of those with CLL has increased each year in part due to more people living with CLL because people are living longer, thanks to treatment advances.

5. How much does Medicare support CLL treatments and drug costs?

This is a broad question with a complicated answer, but this recent article may be helpful for you: <https://cillsociety.org/2022/10/some-good-news-about-costs-for-targeted-oral-anti-cancer-drugs-for-chronic-lymphocytic-leukemia-small-lymphocytic-lymphoma/>.

6. What is the age range for being considered a younger vs. older patient with CLL?

This is somewhat of a generalization, but the average age of diagnosis for a CLL patient is around 71 years old. Usually a "younger patient" with CLL may be in their fifties, however individuals have been diagnosed in their early twenties. And an "older patient" may refer to someone in their late seventies or older.

7. How much Aleve would you say I could safely take given that I'm taking 140 mg of Ibrutinib? I had a bad fall on vacation and took some Aleve here and there, as well as Tylenol. Sometimes Tylenol doesn't do the trick and I'd like something stronger.

CLL Society cannot give medical advice, so please talk to your healthcare provider. Oftentimes, non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and Aleve are not recommended while on Ibrutinib due to the additional bleeding risks. You might talk with your healthcare provider about the possibility of Tramadol for pain that is uncontrolled with Tylenol alone.