Survey Report

Perception Mapping of Indian Physician on Eribulin and its Therapy Indication

Version No.: 1.1

The study was conducted according to the approved protocol and in compliance with the protocol, Good Clinical Practice (GCP), and other applicable local regulatory requirements.

Table of content

1 INTRODUCTION

Metastatic triple-negative breast cancer (mTNBC) represents one of the most challenging subtypes of breast cancer, characterized by aggressive behavior and limited therapeutic options. In India, TNBC accounts for 27-35% of all breast cancers, a significantly higher proportion compared to Western populations (10-15%), presenting unique therapeutic challenges in the Indian healthcare context [1,2]. The evolution of treatment paradigms, particularly with the advent of immunotherapy and novel cytotoxic agents, has created a complex decision-making landscape for clinicians managing mTNBC [3].

Eribulin mesylate, a synthetic analogue of the marine-derived compound halichondrin B, functions as a microtubule-depolymerizing agent with demonstrated effectiveness in treating breast cancer. The EMBRACE trial demonstrated a survival benefit for pretreated patients with locally recurrent or metastatic breast cancer treated with Eribulin compared to treatment of physician's choice. Additionally, a pooled analysis of two key phase III trials has shown that Eribulin improves overall survival across various patient subgroups, including those with HER2-negative and triple-negative breast cancer [4,5].Recent evidence also suggests potential synergistic effects when combined with immunotherapy, although optimal sequencing strategies remain under investigation [6].

The implementation of Eribulin therapy in the Indian context presents unique considerations, including patient body surface area (BSA) variations, cost implications, and healthcare system-specific challenges in drug administration. While international guidelines support Eribulin use in later-line settings, real-world data regarding its utilization patterns, patient selection criteria, and treatment outcomes in the Indian population remains limited [7]. Understanding physician perspectives and prescribing patterns is crucial for optimizing treatment strategies and addressing practical challenges in resource-diverse settings.

This survey-based study aims to analyze Indian oncologists' perceptions and clinical experience with Eribulin in mTNBC and hormone receptor-positive (HR+) breast cancer settings.

2 RATIONALE OF THE STUDY

mTNBC presents unique therapeutic challenges in India, where TNBC prevalence (27-35%) significantly exceeds global averages. While Eribulin has demonstrated significant survival benefits in heavily pretreated patients, its integration into clinical practice involves complex decisions regarding patient selection, treatment sequencing, and practical implementation challenges, particularly in the Indian healthcare context.

The Indian healthcare setting, with its diverse patient population and resource considerations, requires specific understanding of how Eribulin is utilized in real-world practice. Currently, there is limited comprehensive data on Indian physicians' perspectives regarding patient selection criteria, treatment sequencing decisions, and management of practical challenges in Eribulin administration.

This survey-based study aimed to map Indian oncologists' perceptions and experiences with Eribulin in mTNBC and HR+ breast cancer settings, focusing on practical implementation aspects and treatment optimization strategies. The findings will contribute to developing evidence-based guidelines tailored to the Indian context and identify areas requiring additional support to improve patient outcomes in metastatic breast cancer management.

3 STUDY OBJECTIVE

The primary objective of this study was to assess the perceptions, practice patterns, and clinical experiences of Indian oncologists regarding the use of Eribulin in the management of mTNBC.

4 METHODS

This study employed a cross-sectional, questionnaire-based approach to gather data from a sample of Indian oncologists who manage patients with metastatic triple-negative breast cancer (mTNBC) and HR+ breast cancer. The primary objective was to evaluate the clinical practices, perceptions, and decision-making regarding the use of Eribulin in the treatment of these breast cancer subtypes.

A structured 15-question survey was developed, focusing on key aspects such as the frequency of mTNBC cases, patient eligibility for immunotherapy, treatment combinations, dosing considerations, and challenges associated with the use of

Eribulin. The survey also explored factors influencing its use, including efficacy, tolerability, cost, and administration challenges.

Physicians were identified and invited to participate through professional networks and medical associations. Prior to participation, detailed information about the study was provided to ensure informed consent. Participants were assured of their right to withdraw from the study at any time without consequences.

The survey was distributed electronically to facilitate ease of completion and maximize participation. Responses were collected securely, anonymized, and stored to protect participant confidentiality. Incomplete or partially filled questionnaires were excluded from the final analysis.

Descriptive statistics were used to analyze the collected data, with key trends identified in treatment practices and physician perceptions. Inferential statistics were applied to explore potential associations between physician characteristics and treatment decisions. The findings were summarized and compiled into a comprehensive report.

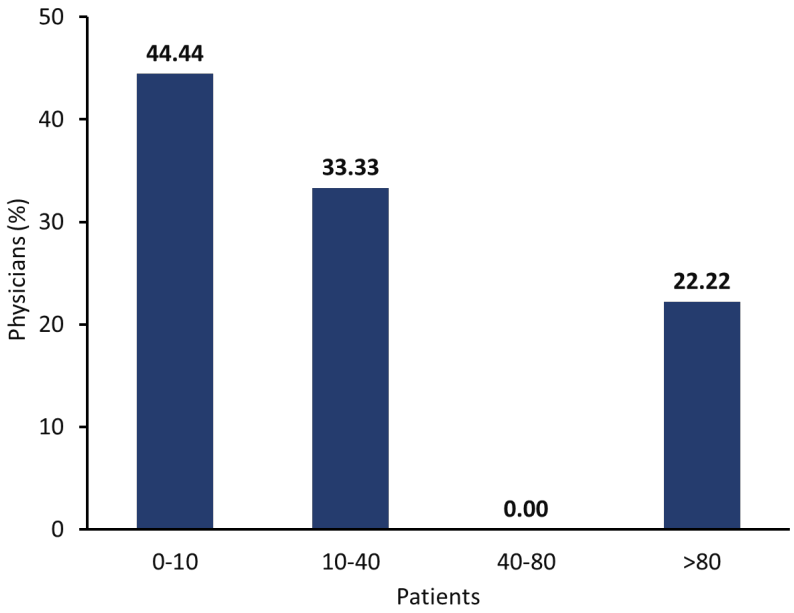
The target sample size was 75 Indian oncologists who regularly treat mTNBC or HR+ breast cancer patients and have experience with Eribulin. Ethical approval was obtained from an Independent Ethics Committee, and the study adhered to ethical guidelines, including the Declaration of Helsinki. No treatment was administered, as the study aimed to gather physicians' perspectives on Eribulin use. Results were shared through scientific publications and presentations at relevant conferences.

5 RESULTS

A total of 63 HCPs participated in the survey. Below is the summary of the responses.

Question 1: How many mTNBC patients do you see every month?

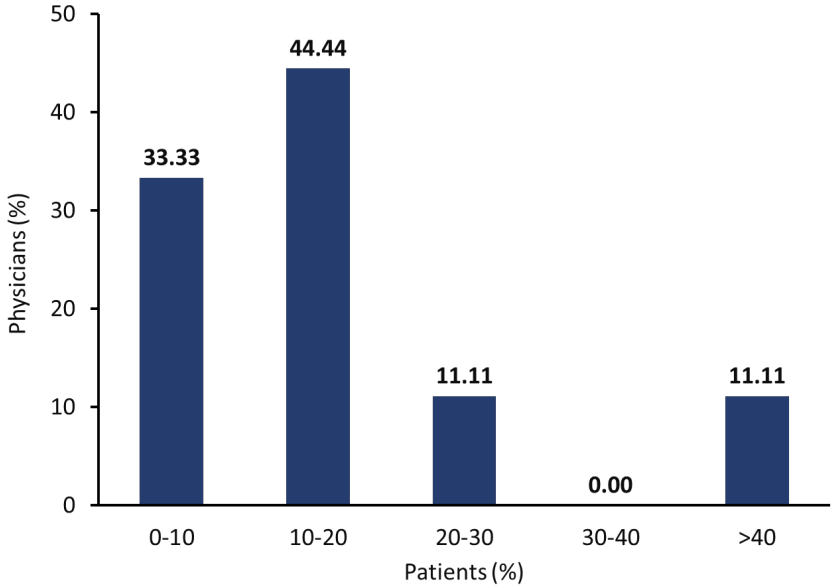
Options	Number of Physicians (N=63)
0-10	28 (44.44)
10-40	21 (33.33)
40-80	0 (0.00)
>80	14 (22.22)
Data presented as n (%)	



- The majority (44.44%) of physicians reported 0-10 mTNBC patients per month in their clinical practice.
- Around 33.33% of physicians reported 10-40 mTNBC patients per month in their clinical practice.
- A smaller portion (22.22%) of physicians indicated more than 80 mTNBC patients per month in their clinical practice.
- None of the physicians reported seeing 40-80 mTNBC patients per month.

Question 2: What % of your patients are eligible for first line immunotherapy?

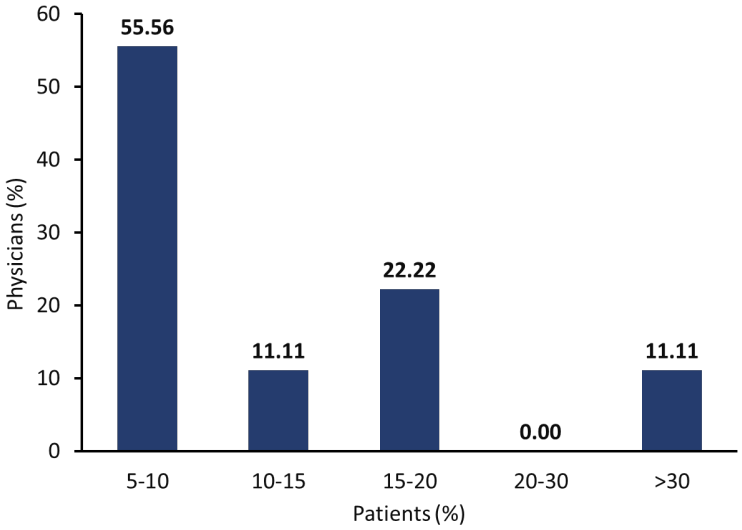
Options	Number of Physicians (N=63)
0-10%	21 (33.33)
10-20%	28 (44.44)
20-30%	7 (11.11)
30-40%	0 (0.00)
More than 40%	7 (11.11)
Data presented as n (%).	



- The majority (44.44%) of physicians indicated that 10-20% of their patients were eligible for first-line immunotherapy.
- Around 33.33% of physicians reported that 0-10% of their patients were eligible for first-line immunotherapy.
- A smaller portion (11.11%) of physicians mentioned that 20-30% of their patients were eligible for first-line immunotherapy.
- Approximately 11.11% of physicians reported that more than 40% of their patients were eligible for first-line immunotherapy.
- None of the physicians noted that 30-40% of their patients were eligible for first-line immunotherapy.

Question 3: What percentage of your mTNBC patients afford immunotherapy and continue with it?

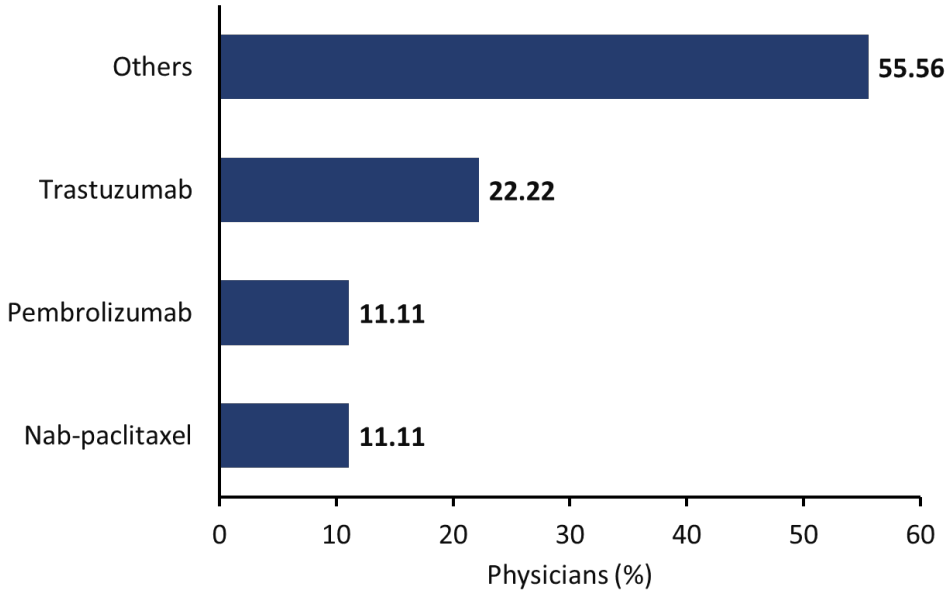
Options	Number of Physicians (N=63)
5-10%	35 (55.56)
10-15%	7 (11.11)
15-20%	14 (22.22)
20-30%	0 (0.00)
More than 30%	7 (11.11)
Data Presented as n (%).	



- The majority (55.56%) of physicians reported that 5-10% of their mTNBC patients could afford and continued with immunotherapy.
- Around 22.22% of physicians mentioned that 15-20% of their mTNBC patients could afford and continued with immunotherapy.
- A smaller portion (11.11%) of physicians stated that 10-15% of their mTNBC patients could afford and continued with immunotherapy.
- Approximately 11.11% of physicians reported that more than 30% of their mTNBC patients could afford and continued with immunotherapy.
- None of the physicians observed that 20-30% of their mTNBC patients could afford and continued with immunotherapy.

Question 4: Any combination treatment you prefer with Eribulin?

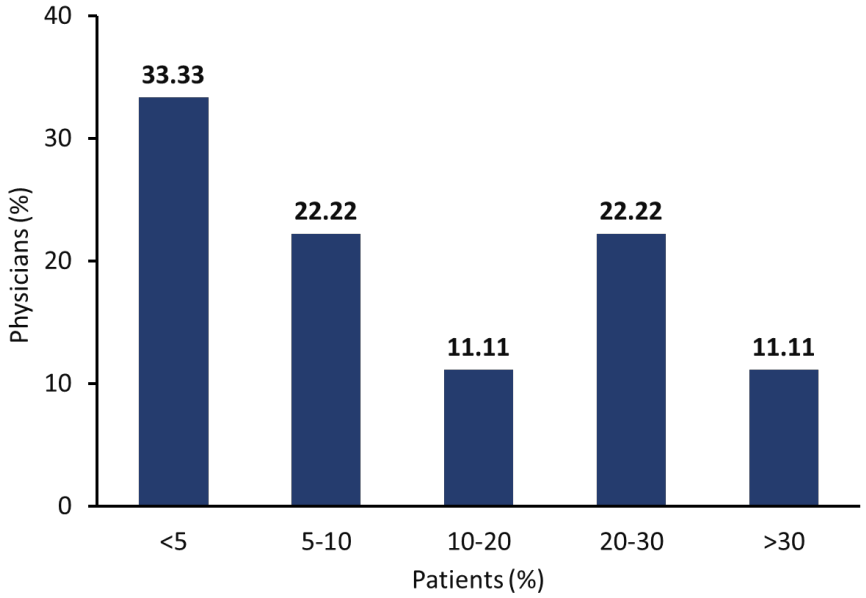
Options	Number of Physicians (N=63)
Trastuzumab	14 (22.22)
Nab-paclitaxel	7 (11.11)
Pembrolizumab	7 (11.11)
Others	35 (55.56)
Data Presented as n (%).	



- The majority (55.56%) of physicians preferred other combination treatments with Eribulin.
- Around 22.22% of physicians reported combining trastuzumab with Eribulin.
- A smaller portion (11.11%) of physicians preferred combining nab-paclitaxel with Eribulin.
- Another 11.11% of physicians opted for combining pembrolizumab with Eribulin.

Question 5: What percentage of your TNBC patients are overweight/obese?

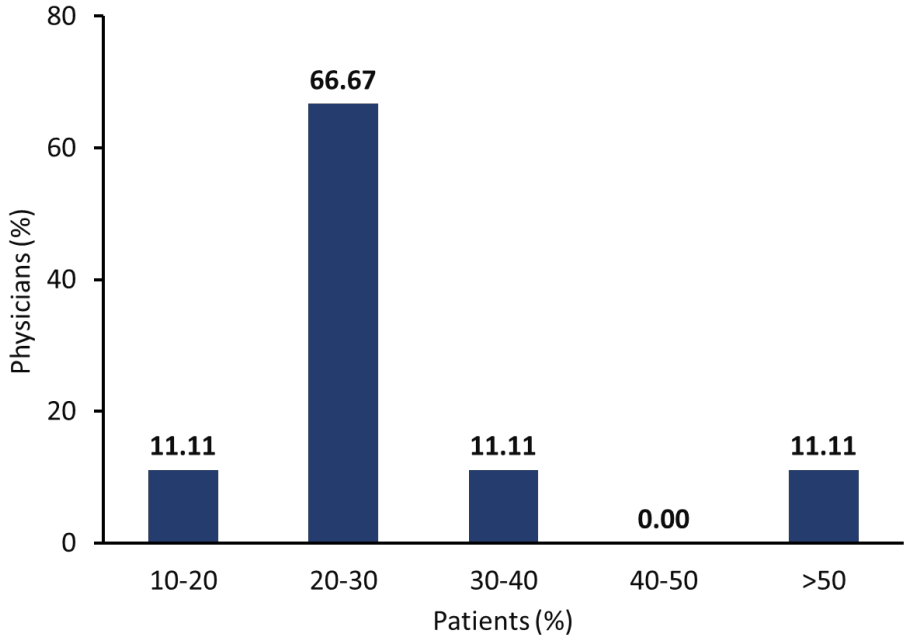
Options	Number of Physicians (N=63)
Less than 5%	21 (33.33)
5-10%	14 (22.22)
10-20%	7 (11.11)
20-30%	14 (22.22)
More than 30%	7 (11.11)
Data Presented as n (%).	



- A significant portion (33.33%) of physicians reported that less than 5% of their TNBC patients are overweight or obese.
- Around 22.22% of physicians stated that 5-10% of their TNBC patients are overweight or obese.
- Approximately 22.22% of physicians observed that 20-30% of their TNBC patients are overweight or obese.
- A similar portion (11.11%) of physicians mentioned that 10-20% and more than 30% of their TNBC patients are overweight or obese.

Question 6: Since dose of Eribulin is BSA based, what percentage of your patients have BSA less than 1.4 m^2?

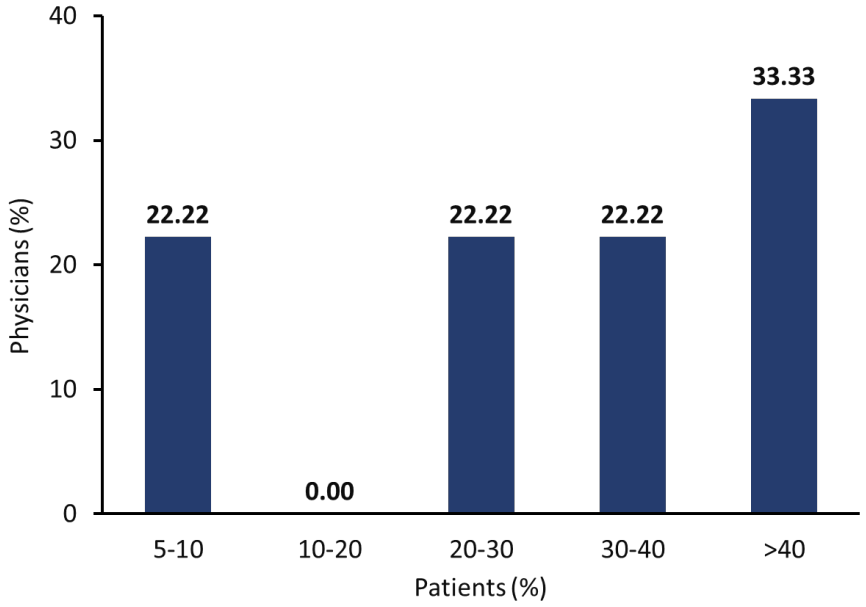
Options	Number of Physicians (N=63)
10-20%	7 (11.11)
20-30%	42 (66.67)
30-40%	7 (11.11)
40-50%	0 (0.00)
More than 50%	7 (11.11)
Data Presented as n (%).	



- The majority (66.67%) of physicians reported that 20-30% of their patients have a BSA of less than 1.4 m^2.
- A similar portion (11.11%) of physicians mentioned that 10-20% and 30-40% of their patients have a BSA of less than 1.4 m^2.
- Around 11.11% of physicians reported that more than 50% of their patients have a BSA of less than 1.4 m^2.
- None of the physicians observed that 40-50% of their patients have a BSA of less than 1.4 m^2.

Question 7: Since dose of Eribulin is BSA based, what percentage of your patients have BSA 1.4 m^2 or more?

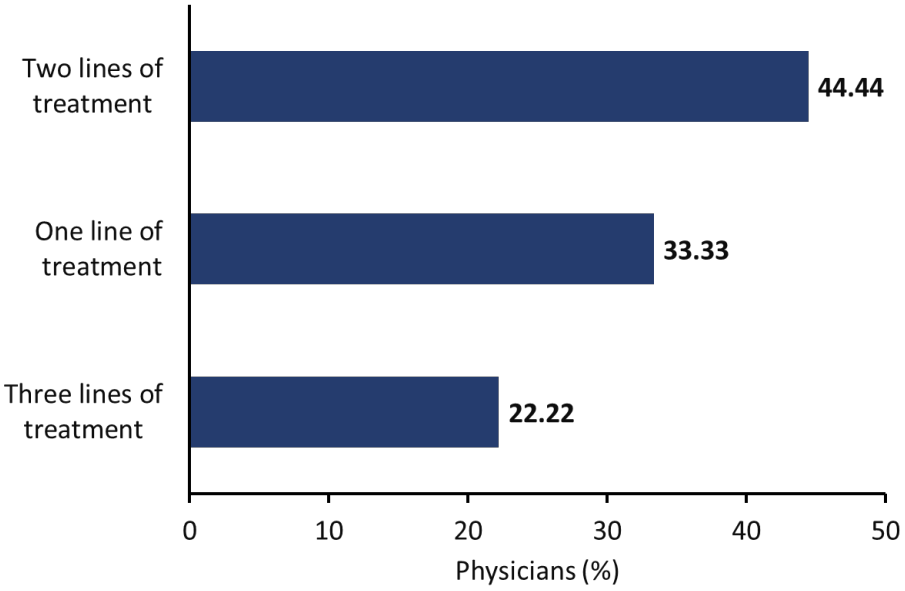
Options	Number of Physicians (N=63)
5-10%	14 (22.22)
10-20%	14 (22.22)
20-30%	14 (22.22)
30-40%	0 (0.00)
More than 40%	21 (33.33)
Data Presented as n (%).	



- A significant portion (33.33%) of physicians reported that more than 40% of their patients have a BSA of 1.4 m^2 or more.
- Around 22.22% of physicians stated that 5-10% of their patients have a BSA of 1.4 m^2 or more.
- An equal portion (22.22%) of physicians mentioned that 10-20% and 20-30% of their patients have a BSA of 1.4 m^2 or more.
- None of the physicians observed that 30-40% of their patients have a BSA of 1.4 m^2 or more.

Question 8: In your patients who have received Eribulin in metastatic setting, how many previous lines of therapy patient received before Eribulin?

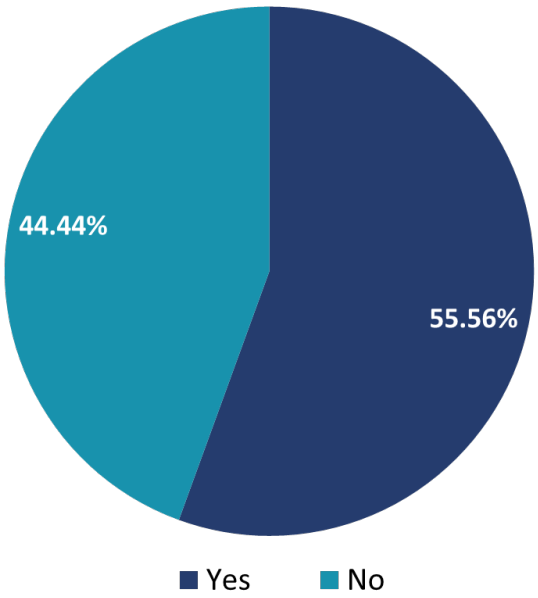
Options	Number of Physicians (N=63)
One line of treatment	21 (33.33)
Two lines of treatment	28 (44.44)
Three lines of treatment	14 (22.22)
Data Presented as n (%).	



- The majority (44.44%) of physicians reported that their patients had received two lines of treatment before starting Eribulin in the metastatic setting.
- Around 33.33% of physicians stated that their patients had received one line of treatment prior to Eribulin.
- A smaller portion (22.22%) of physicians reported that their patients had received three lines of treatment before Eribulin.

Question 9: Have you considered Eribulin in HR+ve breast cancer patient post CDK4/6 inhibitor?

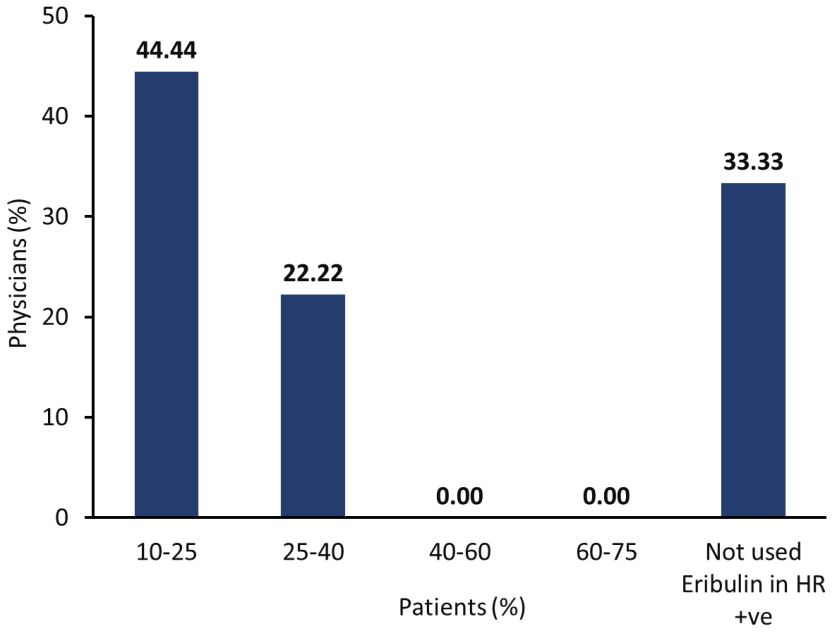
Options	Number of Physicians (N=63)
Yes	35 (55.56)
No	28 (44.44)
Data Presented as n (%).	



- The majority (55.56%) of physicians have considered Eribulin for HR+ve breast cancer patients after treatment with a CDK4/6 inhibitor.
- Around 44.44% of physicians have not considered Eribulin for HR+ve breast cancer patients post-CDK4/6 inhibitor.

Question 10: In what percentage of patients you have considered Eribulin in HR+ve breast cancer patients in any lines?

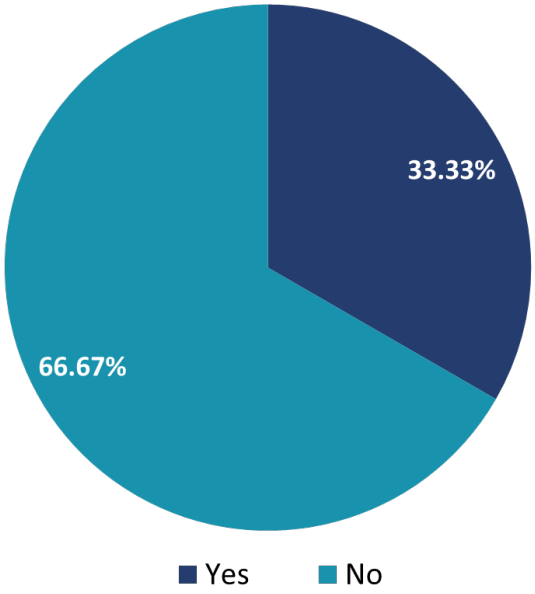
Options	Number of Physicians (N=63)
10-25%	28 (44.44)
25-40%	14 (22.22)
40-60%	0 (0.00)
60-75%	0 (0.00)
Not used Eribulin in HR +ve	21 (33.33)
Data Presented as n (%).	



- The majority (44.44%) of physicians reported considering Eribulin in 10-25% of their HR+ve breast cancer patients across any lines of treatment.
- Approximately 33.33% of physicians reported that they have not used Eribulin in HR+ve breast cancer patients.
- Around 22.22% of physicians reported using Eribulin in 25-40% of their HR+ve breast cancer patients.
- None of the physicians reported considering Eribulin in 40-60% or 60-75% of their HR+ve breast cancer patients.

Question 11: Since Eribulin is only available in 1mg per vial, do you or your nursing staff face any administration challenges in using multiple vials for patients during dosing?

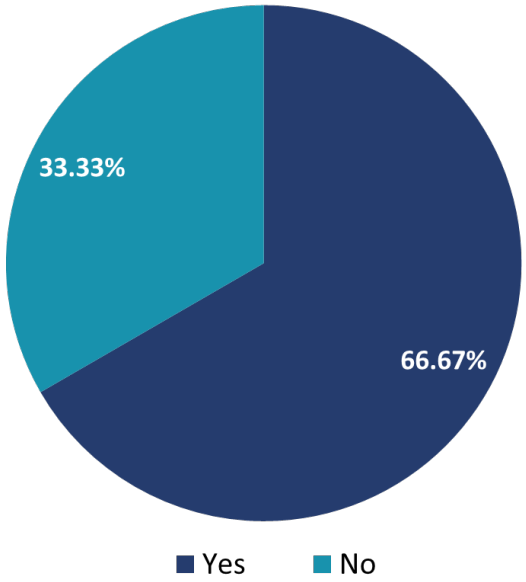
Options	Number of Physicians (N=63)
Yes	21 (33.33)
No	42 (66.67)
Data Presented as n (%).	



- The majority (66.67%) of physicians reported that they do not face any administration challenges related to using multiple vials of Eribulin during dosing.
- Around 33.33% of physicians reported that they or their nursing staff face administration challenges when using multiple vials of Eribulin during dosing.

Question 12: With IO usage in TNBC, will you consider Eribulin post IO?

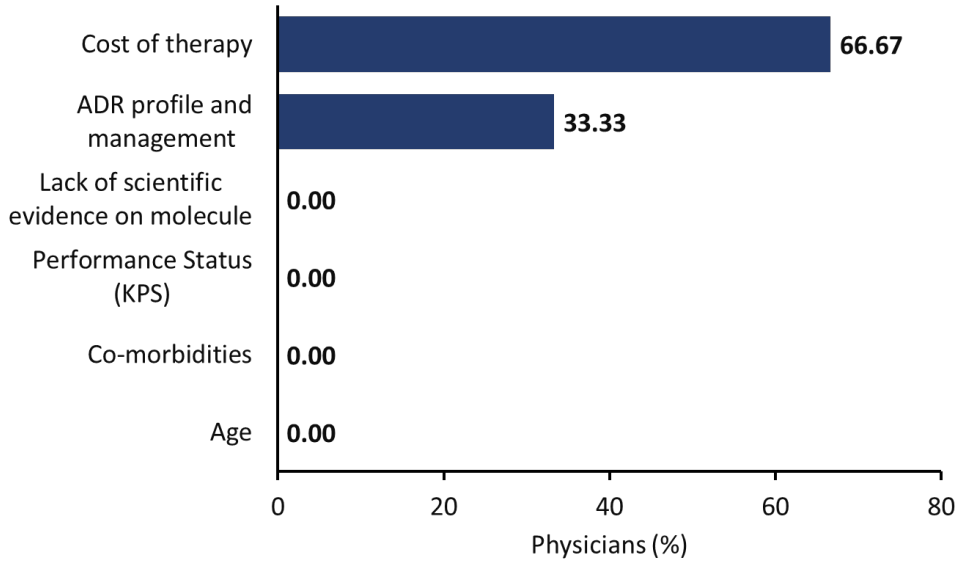
Options	Number of Physicians (N=56)
Yes	49 (87.50)
No	7 (12.50)
Data Presented as n (%).	



- The majority (87.50%) of physicians reported that they would consider Eribulin post-IO in TNBC patients.
- A smaller portion (12.50%) of physicians stated that they would not consider Eribulin after IO in TNBC patients.

Question 13: According to you, what are challenges to therapy and use of Eribulin?

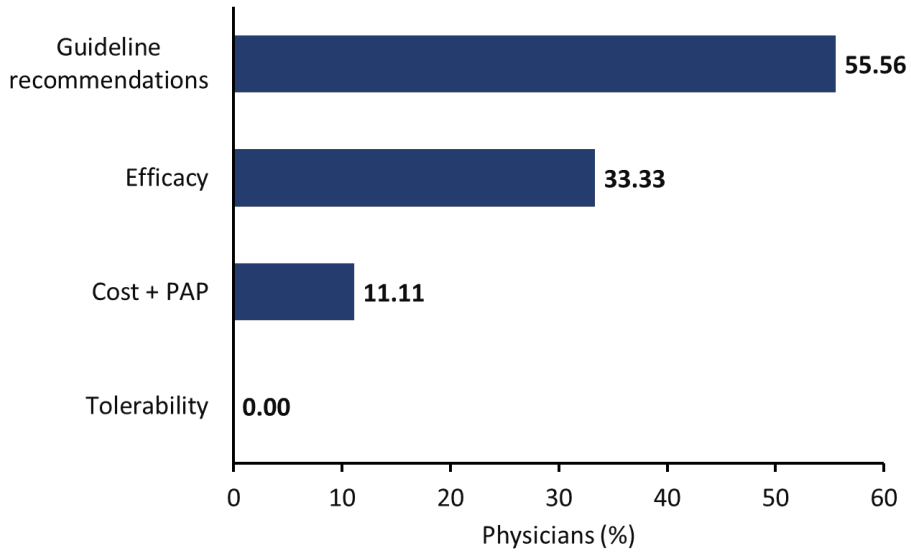
Options	Number of Physicians (N=63)
Cost of therapy	42 (66.67)
Performance Status (KPS)	0 (0.00)
Age	0 (0.00)
Lack of scientific evidence on molecule	0 (0.00)
Co-morbidities	0 (0.00)
ADR profile and management	21 (33.33)
Data Presented as n (%).	



- The majority (66.67%) of physicians identified the cost of therapy as a key challenge to the use of Eribulin.
- A smaller portion 33.33% of physicians highlighted the ADR profile and management as a challenge in using Eribulin.
- No physicians reported challenges related to performance status (KPS), age, lack of scientific evidence on the molecule, or co-morbidities in the use of Eribulin.

Question 14: In treatment, what are your key reasons for using Eribulin in MBC/TNBC patients? (Or its subtypes)

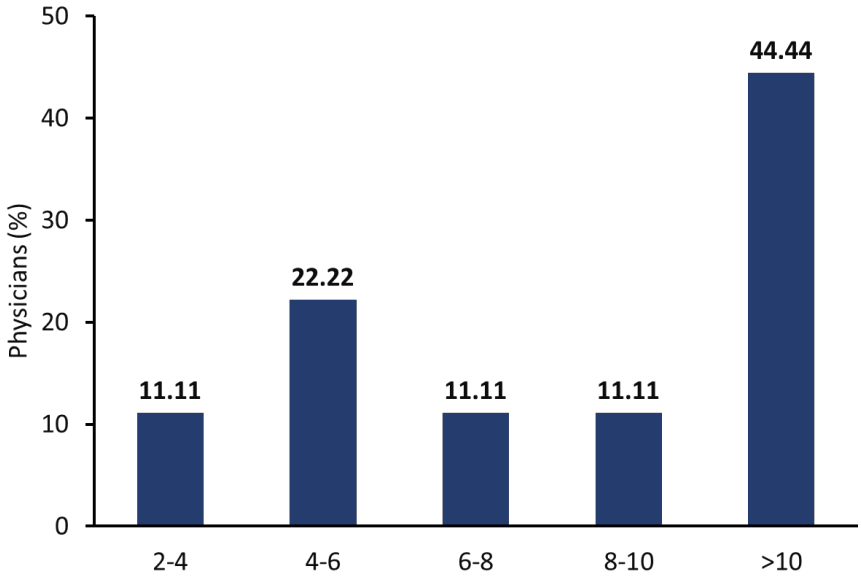
Options	Number of Physicians (N=63)
Efficacy	21 (33.33)
Cost + PAP	7 (11.11)
Tolerability	0 (0.00)
Guideline recommendations	35 (55.56)
Data Presented as n (%).	



- The majority (55.56%) of physicians reported guideline recommendations as a key reason for using Eribulin in MBC/TNBC patients (or its subtypes).
- Around 33.33% of physicians considered efficacy as a key reason for using Eribulin in these patients.
- A smaller portion (11.11%) of physicians highlighted cost and PAP as a reason for using Eribulin.
- None of the physicians mentioned tolerability as a key reason for using Eribulin in MBC/TNBC patients.

Question 15: In real world scenario in your clinical practice in TNBC, how many cycles of Eribulin patients receive?

Options	Number of Physicians (N=63)
2-4	7 (11.11)
4-6	14 (22.22)
6-8	7 (11.11)
8-10	7 (11.11)
More than 10	28 (44.44)
Data Presented as n (%).	



- The majority (44.44%) of physicians reported that TNBC patients in their clinical practice typically receive more than 10 cycles of Eribulin.
- Around 22.22% of physicians indicated that patients receive 4-6 cycles of Eribulin.
- A smaller portion (11.11%) of physicians mentioned that patients receive 2-4, 6-8, or 8-10 cycles of Eribulin.

6 SUMMARY

The study assessed the clinical practices of Indian oncologists regarding the use of Eribulin in treating mTNBC and HR+ breast cancer. The findings revealed key insights into treatment patterns, patient eligibility, and challenges faced in real-world practice.

Regarding mTNBC, most physicians (44.44%) reported seeing 0-10 patients per month, while 33.33% treated 10-40 patients. A smaller group (22.22%) observed more than 80 mTNBC patients monthly. For first-line immunotherapy, 44.44% of physicians indicated that 10-20% of their patients were eligible, and 33.33% noted that 0-10% of their patients qualified for it.

In terms of affordability, 55.56% of physicians reported that 5-10% of their mTNBC patients could afford and continue with immunotherapy. Combination treatments with Eribulin were common, with 55.56% of physicians preferring alternatives, such as trastuzumab (22.22%). Concerning patient characteristics, 33.33% of physicians noted that less than 5% of their TNBC patients were overweight or obese. Regarding body surface area (BSA), 66.67% reported that 20-30% of their patients had a BSA of less than 1.4 m^2, while 33.33% noted that more than 40% had a BSA of 1.4 m^2 or greater.

When considering HR+ breast cancer, 55.56% of physicians had used Eribulin post-CDK4/6 inhibitor treatment. Challenges identified included cost (66.67%) and ADR profile management (33.33%). Lastly, most physicians (44.44%) reported that their patients typically received more than 10 cycles of Eribulin. These findings highlight treatment preferences, patient eligibility, and key challenges in managing mTNBC and HR+ breast cancer in India.

7 DISCUSSION

The results of this study offer a detailed insight into the clinical practices surrounding the use of Eribulin in the treatment of mTNBC and HR+ breast cancer in India. The findings reveal several key aspects of how oncologists approach these conditions in everyday clinical settings.

The study indicates that mTNBC remains a prevalent concern among oncologists, with most physicians reporting treating a modest number of cases each month. Specifically, 44.44% of physicians reported managing 0-10 mTNBC patients, with a smaller group (22.22%) seeing over 80 patients. This distribution reflects the relatively high burden of metastatic breast cancer in clinical practice, but also suggests that specialized centers or high-volume practices may be handling more cases.

A significant number of physicians (44.44%) noted that 10-20% of their patients were eligible for first-line immunotherapy, while others reported a lower proportion of eligible patients. This suggests that while immunotherapy is an important treatment option for mTNBC, its use may still be limited by factors such as patient selection criteria or accessibility. Additionally, affordability emerged as a critical issue, with more than half of the physicians indicating that only 5-10% of their patients could afford immunotherapy and continue with it. This highlights the challenge of high treatment costs in India, which may impact patient access to newer therapies.

The use of Eribulin in combination with other therapies such as trastuzumab, nab-paclitaxel, and pembrolizumab was preferred by a majority of oncologists, indicating a tailored approach based on individual patient needs and tumor characteristics. However, the findings also underscore the complexity of treatment decisions, with 55.56% of physicians opting for other combination therapies, suggesting that the choice of treatment is multifactorial, involving factors like patient response, tolerability, and cost.

Regarding patient characteristics, a notable proportion of oncologists reported challenges with patients' overweight/obesity status and body surface area (BSA), both of which can impact dosing and treatment efficacy. Specifically, a significant

portion of patients had a BSA less than 1.4 m², which could complicate dosing and therapy monitoring.

Furthermore, the study revealed that administration challenges with multiple vials of Eribulin were not a significant issue for most physicians, suggesting that despite potential logistical challenges, Eribulin is manageable in the real-world setting. Finally, the preference for guideline recommendations and efficacy as the key factors driving the use of Eribulin highlights the importance of established treatment protocols and the emphasis on treatment outcomes in decision-making.

In conclusion, this study provides valuable insights into the practical use of Eribulin in mTNBC and HR+ breast cancer treatment in India. While physicians generally follow established guidelines, challenges such as affordability, patient characteristics, and combination treatment preferences persist, influencing the overall treatment landscape. These findings suggest that further efforts are needed to optimize access to treatments like Eribulin, while also considering real-world challenges such as cost and patient eligibility.

8 CLINICAL RECOMMENDATIONS

The findings of this study provide several key clinical recommendations for managing mTNBC and HR+ breast cancer, particularly regarding the use of Eribulin. A significant proportion of physicians report treating a moderate to high volume of mTNBC patients each month, indicating the need for efficient treatment protocols. Given the frequency of these cases, healthcare providers should prioritize a structured, evidence-based approach for managing metastatic TNBC, particularly when selecting appropriate therapies like Eribulin. This should include ensuring proper patient selection based on clinical criteria and guidelines.

The study also highlights the importance of combining Eribulin with other treatment options. A substantial number of physicians prefer combination regimens, such as Eribulin with trastuzumab, nab-paclitaxel, or pembrolizumab, to enhance treatment efficacy. Healthcare providers should continue to explore these combination therapies in clinical settings, as they may offer improved outcomes in patients with mTNBC or HR+ breast cancer. Additionally, the use of Eribulin post-immunotherapy (IO) in TNBC patients was favored by the majority of physicians. This suggests that

Eribulin may be an effective option in the treatment sequence following IO therapies, although further clinical data is needed to optimize this approach.

Another critical consideration is the affordability of Eribulin. A significant number of physicians report challenges with patient access due to cost, emphasizing the need for cost-reduction strategies or patient assistance programs to ensure more widespread use. Physicians should also monitor patients for potential administration challenges, especially regarding the need for multiple vials per dose, and provide adequate training or resources to ease this process.

Lastly, adherence to clinical guidelines and regular assessment of treatment efficacy and tolerability are crucial. With a substantial number of physicians reporting that patients receive more than 10 cycles of Eribulin, it is important to continue monitoring long-term outcomes to ensure optimal treatment efficacy and patient quality of life.

9 CONSULTANT OPINION

Based on the survey results, Eribulin appears to be a valuable treatment option for both metastatic triple-negative breast cancer (mTNBC) and HR+ breast cancer in the Indian clinical setting. A significant number of physicians have reported using Eribulin in combination with other agents, such as trastuzumab, nab-paclitaxel, or pembrolizumab, to enhance treatment efficacy, which suggests that combination therapies are a promising approach in managing these cancers. Given its positive impact in clinical practice, Eribulin should be considered as part of first-line or later-line regimens, especially in patients who have progressed after previous treatments or immunotherapy

Additionally, Eribulin's use following immunotherapy (IO) in TNBC patients is supported by the majority of physicians, reflecting growing confidence in its efficacy in this setting. As immunotherapies become more integrated into TNBC management, Eribulin could serve as a valuable option post-IO to continue disease control, although further data on long-term outcomes will be important to refine this practice.

Cost remains a significant barrier to broader Eribulin use, with many physicians highlighting affordability challenges for patients. In light of this, healthcare providers should explore mechanisms to address these barriers, such as patient assistance programs or cost-effective treatment pathways, to improve accessibility. Finally, the administration challenges related to the use of multiple vials of Eribulin should not be overlooked. Efforts should be made to streamline the dosing process, including proper training for healthcare providers and staff to minimize any logistical barriers.

In conclusion, Eribulin remains a key therapeutic option in the management of mTNBC and HR+ breast cancer in India, with appropriate combination strategies, cost management, and attention to administration procedures being essential to optimize patient outcomes.

10 MARKET OPPORTUNITIES

Eribulin presents significant market opportunities in the treatment of metastatic triple-negative breast cancer (mTNBC) and HR+ breast cancer, with an expanding role in both first-line and later-line therapy settings. The results from this study highlight that Eribulin is increasingly considered for combination treatments, including with agents like trastuzumab, pembrolizumab, and nab-paclitaxel. This trend indicates growing recognition of Eribulin's efficacy and versatility, positioning it as a key treatment option in mTNBC management. Moreover, its potential use after immunotherapy in TNBC patients further strengthens its place in sequential treatment regimens.

Cost is identified as a primary barrier to wider Eribulin use, which presents a clear opportunity for pharmaceutical companies to introduce patient assistance programs (PAPs), flexible pricing models, or value-based care strategies to mitigate financial challenges and enhance patient access. Such initiatives could significantly improve adherence, particularly in patients undergoing long-term treatment, as indicated by the frequent use of Eribulin for more than 10 cycles in clinical practice.

In addition, the administration of Eribulin in multiple vials presents challenges, suggesting an opportunity for innovation in drug delivery systems. Solutions such as pre-filled syringes, vial consolidation, or more convenient dosing options could reduce healthcare provider burden and improve the patient experience.

With increasing use across different treatment lines, including its emerging role in HR+ breast cancer after CDK4/6 inhibitors, Eribulin's market share can be expanded further through greater incorporation into clinical guidelines and oncology treatment protocols. Furthermore, with physicians prioritizing its efficacy, adherence support programs that address common side effects and administration challenges can enhance compliance, further driving Eribulin's position in the oncology market.

In summary, Eribulin offers substantial market potential through enhanced support services, cost management strategies, and innovations in drug delivery systems, strengthening its role as a cornerstone treatment for mTNBC and HR+ breast cancer.

11 MARKET POSITIONING

Eribulin has established a strong position in the treatment landscape for metastatic triple-negative breast cancer (mTNBC) and HR+ breast cancer, particularly in later-line therapy. A significant proportion of oncologists prefer combining Eribulin with agents such as trastuzumab, pembrolizumab, and nab-paclitaxel, highlighting its effectiveness in multi-drug regimens. This versatility positions Eribulin as a key treatment option in mTNBC and HR+ breast cancer, offering improved survival outcomes in patients who have exhausted other therapeutic options.

However, the cost of Eribulin remains a notable barrier to wider adoption. As a result, there is a clear opportunity to enhance market positioning through patient access programs, discounts, or value-based pricing models, particularly in price-sensitive markets like India. Addressing cost-related challenges can improve patient access, increase adherence, and ultimately strengthen Eribulin's role in routine clinical practice.

Eribulin is also frequently used in extended treatment regimens, with many physicians administering more than 10 cycles for patients with mTNBC, suggesting that the drug's long-term effectiveness is well recognized. This presents an opportunity to streamline administration, particularly addressing challenges associated with multiple vials per dose. Innovations such as pre-filled syringes or vial consolidation could improve convenience for both healthcare providers and patients.

As Eribulin's use continues to expand, especially in post-immunotherapy settings for mTNBC and following CDK4/6 inhibitors in HR+ breast cancer, its inclusion in clinical guidelines is likely to grow. This creates an opportunity for targeted marketing efforts, educational initiatives, and collaborations with key opinion leaders to solidify Eribulin's position in the treatment algorithms for both mTNBC and HR+ breast cancer.

12 REFERENCES

1. Jonnada PK, Sushma C, Karyampudi M, Dharanikota A. Prevalence of Molecular Subtypes of Breast Cancer in India: a Systematic Review and Meta-analysis. Indian J Surg Oncol. 2021 Apr;12(Suppl 1):152-163.
2. Maqbool M, Bekele F, Fekadu G. Treatment Strategies Against Triple-Negative Breast Cancer: An Updated Review. Breast Cancer (Dove Med Press). 2022 Jan 11;14:15-24.
3. Marra A, Viale G, Curigliano G. Recent advances in triple negative breast cancer: the immunotherapy era. BMC Med. 2019 May 9;17(1):90.
4. Dybdal-Hargreaves NF, Risinger AL, Mooberry SL. Eribulin mesylate: mechanism of action of a unique microtubule-targeting agent. Clin Cancer Res. 2015 Jun 1;21(11):2445-52.
5. Cortes J, O'Shaughnessy J, Loesch D, Blum JL, Vahdat LT, Petrakova K, et al. Eribulin monotherapy versus treatment of physician's choice in patients with metastatic breast cancer (EMBRACE): a phase 3 open-label randomised study. The Lancet. 2011 Mar 12;377(9769):914-23.
6. Tolaney SM, Barroso-Sousa R, Keenan T, Li T, Trippa L, Vaz-Luis I, et al. Effect of Eribulin With or Without Pembrolizumab on Progression-Free Survival for Patients With Hormone Receptor-Positive, ERBB2-Negative Metastatic Breast Cancer: A Randomized Clinical Trial. JAMA Oncol. 2020 Oct 1;6(10):1598-1605.
7. Tolaney SM, Kalinsky K, Kaklamani VG, D'Adamo DR, Gursel Aktan, Tsai ML, et al. Eribulin Plus Pembrolizumab in Patients with Metastatic Triple-Negative Breast Cancer (ENHANCE 1): A Phase Ib/II Study. 2021 Mar 16;27(11):3061–8.