Cancer Q&A: Addressing Common Questions Posed by Patients with Relapsed/Refractory Multiple Myeloma

A CME/MOC-Accredited Webinar Developed in Partnership with Cancer*Care*®

Thursday, August 7, 2025
5:00 PM – 6:00 PM ET

Faculty

Natalie S Callander, MD
Sagar Lonial, MD, FACP

Moderator

Neil Love, MD

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Faculty

Natalie S Callander, MD
Director, Myeloma Clinical Program
University of Wisconsin Carbone Cancer Center
Madison, Wisconsin

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Chair and Professor
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Chief Medical Officer
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Emory University School of Medicine
Atlanta, Georgia

MODERATOR
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Research To Practice
Miami, Florida

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Clinical Program Leader and Director of Clinical Research
Jerome Lipper Multiple Myeloma Center
Dana-Farber Cancer Institute
RJ Corman Professor of Medicine
Harvard Medical School
Boston, Massachusetts

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Dr Callander — Disclosures

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Dr Lonial — Disclosures

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Dr Fonseca — Disclosures
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Dr Orlowski — Disclosures
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Dr Raje — Disclosures
Survey Participant

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Dr Richardson — Disclosures
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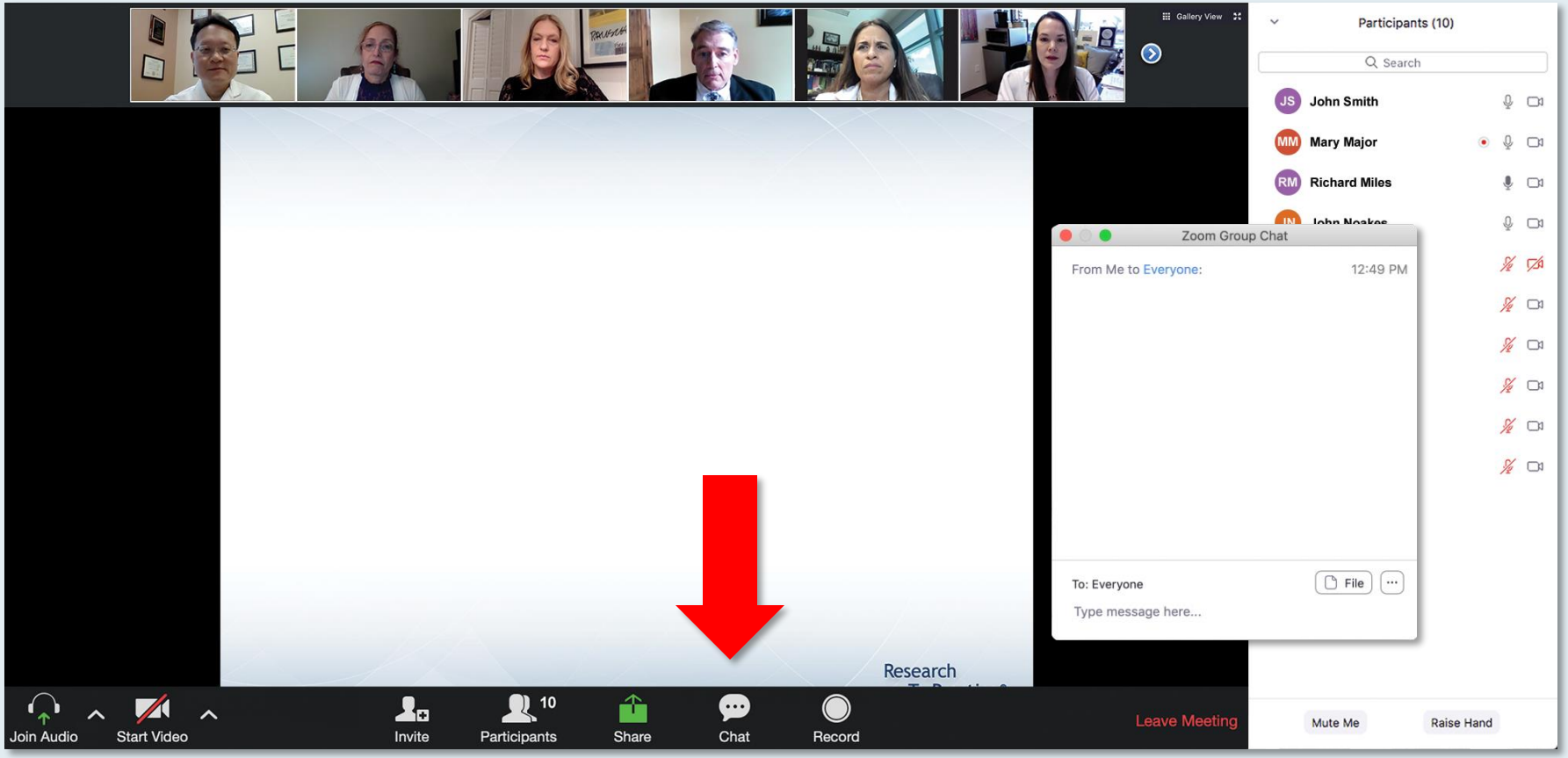

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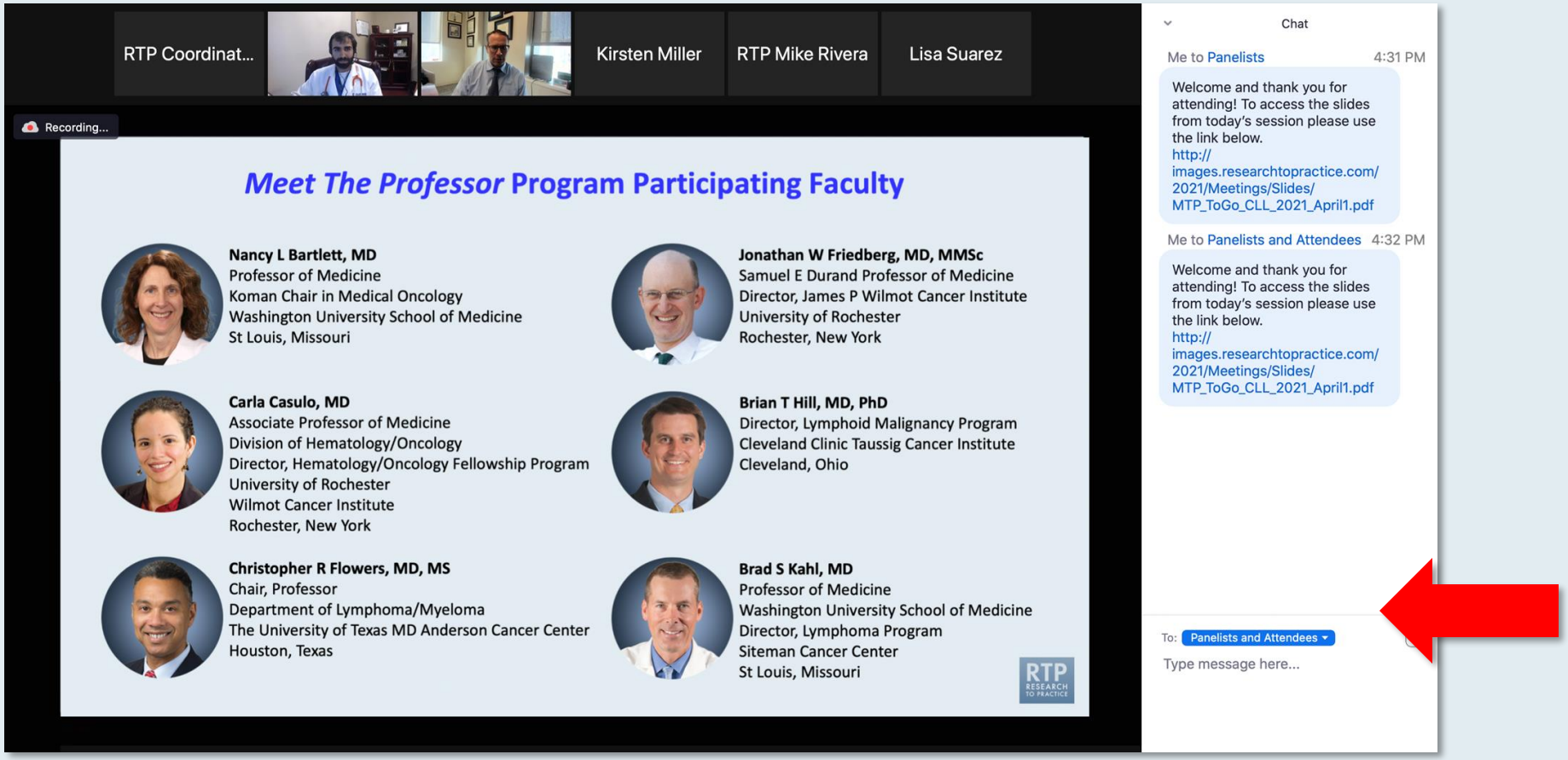

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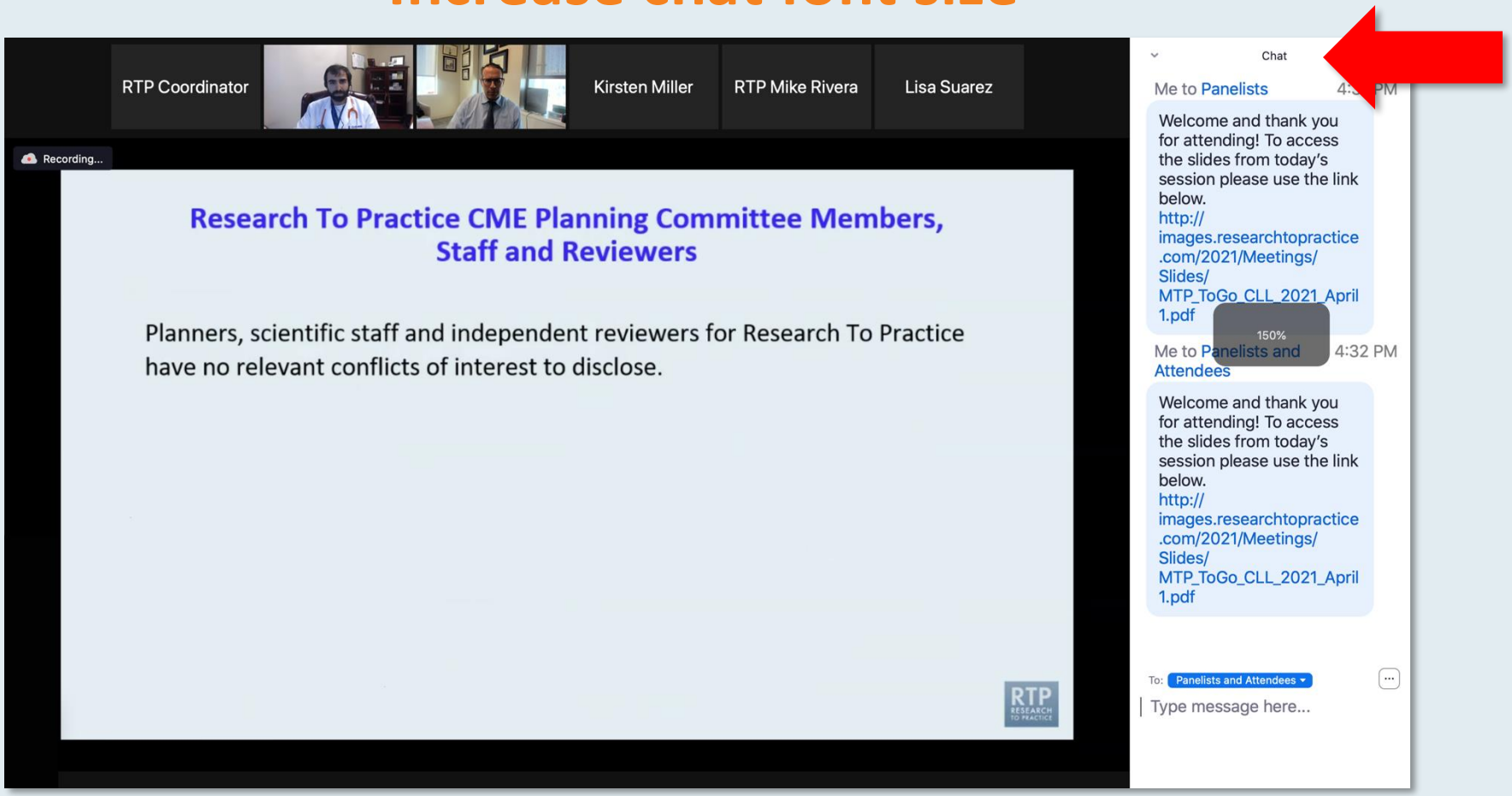
Increase chat font size



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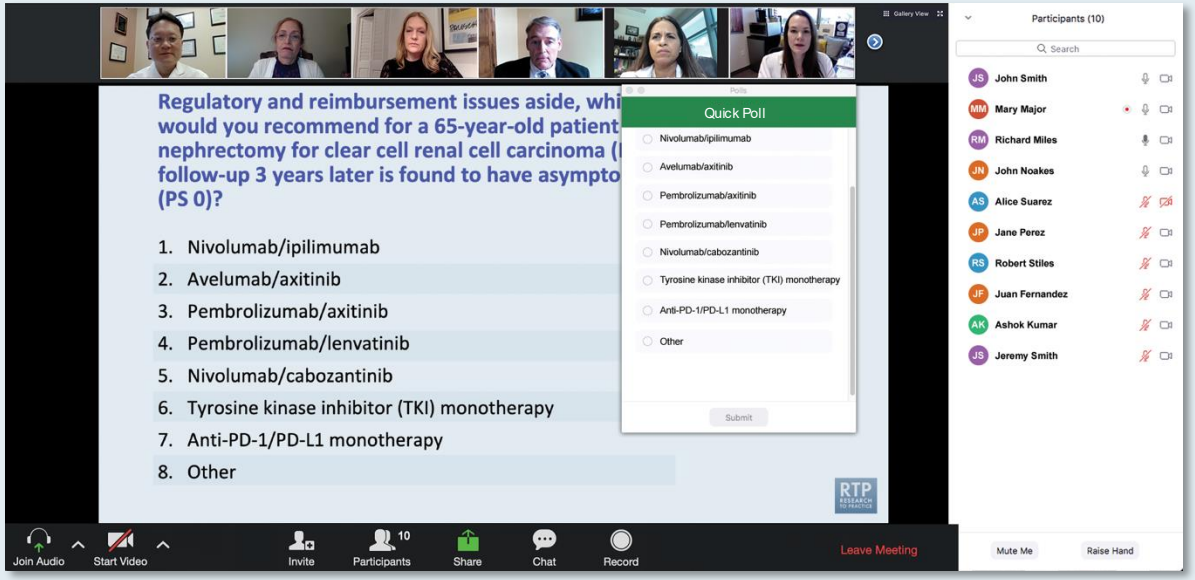

Multiple Myeloma — Year in Review Series on Relevant New Datasets and Advances

PROF MELETIOS-ATHANASIOS (THANOS) C DIMOPOULOS
NATIONAL AND KAPODISTRIAN UNIVERSITY OF ATHENS

DR ROBERT Z ORLOWSKI
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The Implications of Recent Datasets for the Current and Future Management of Breast Cancer — An ASCO 2025 Review

A CME/MOC-Accredited Live Webinar

Wednesday, August 13, 2025
5:00 PM – 6:00 PM ET

Faculty

Sara A Hurvitz, MD, FACP
Sara M Tolaney, MD, MPH

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Selection and Sequencing of Therapy for Metastatic Triple-Negative Breast Cancer

A CME/MOC-Accredited Live Webinar

Thursday, August 28, 2025
5:00 PM – 6:00 PM ET

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Ana C Garrido-Castro, MD
Professor Peter Schmid, FRCP, MD, PhD

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Consensus or Controversy? Clinical Investigators Provide Perspectives on the Current and Future Care of Patients with Relapsed/Refractory Multiple Myeloma

Part 1 of a 2-Part CME/MOC-, NCPD- and ACPE-Accredited Satellite Symposium Series During the Society of Hematologic Oncology 2025 Annual Meeting

Thursday, September 4, 2025
6:42 PM – 7:42 PM CT

Faculty

Meletios-Athanasios (Thanos) C Dimopoulos, MD
Hans Lee, MD
Noopur Raje, MD

Moderator

Joseph Mikhael, MD, MEd

RTP RESEARCH TO PRACTICE

Consensus or Controversy? Clinical Investigators Provide Perspectives on the Current and Future Care of Patients with Follicular Lymphoma

Part 2 of a 2-Part CME/MOC-, NCPD- and ACPE-Accredited Satellite Symposium Series During the Society of Hematologic Oncology 2025 Annual Meeting

Friday, September 5, 2025

11:47 AM – 12:47 PM CT

Faculty

Jennifer Crombie, MD

Laurie H Sehn, MD, MPH

Moderator

Jeremy S Abramson, MD, MMSc

RTP RESEARCH TO PRACTICE

Addressing Current Knowledge and Practice Gaps in the Community — Optimizing the Use of Oral Selective Estrogen Receptor Degraders for Metastatic Breast Cancer, Part 2

A CME/MOC-Accredited Live Webinar

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5:00 PM – 6:00 PM ET

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Rinath M Jeselsohn, MD

Joyce O'Shaughnessy, MD

Moderator

Neil Love, MD

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Thank you for joining us! Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us.

Information on how to obtain CME and ABIM MOC credit will be provided at the conclusion of the activity in the Zoom chat room. Attendees will also receive an email in 1 to 3 business days with these instructions.

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Blood Cancers Patient Support Group

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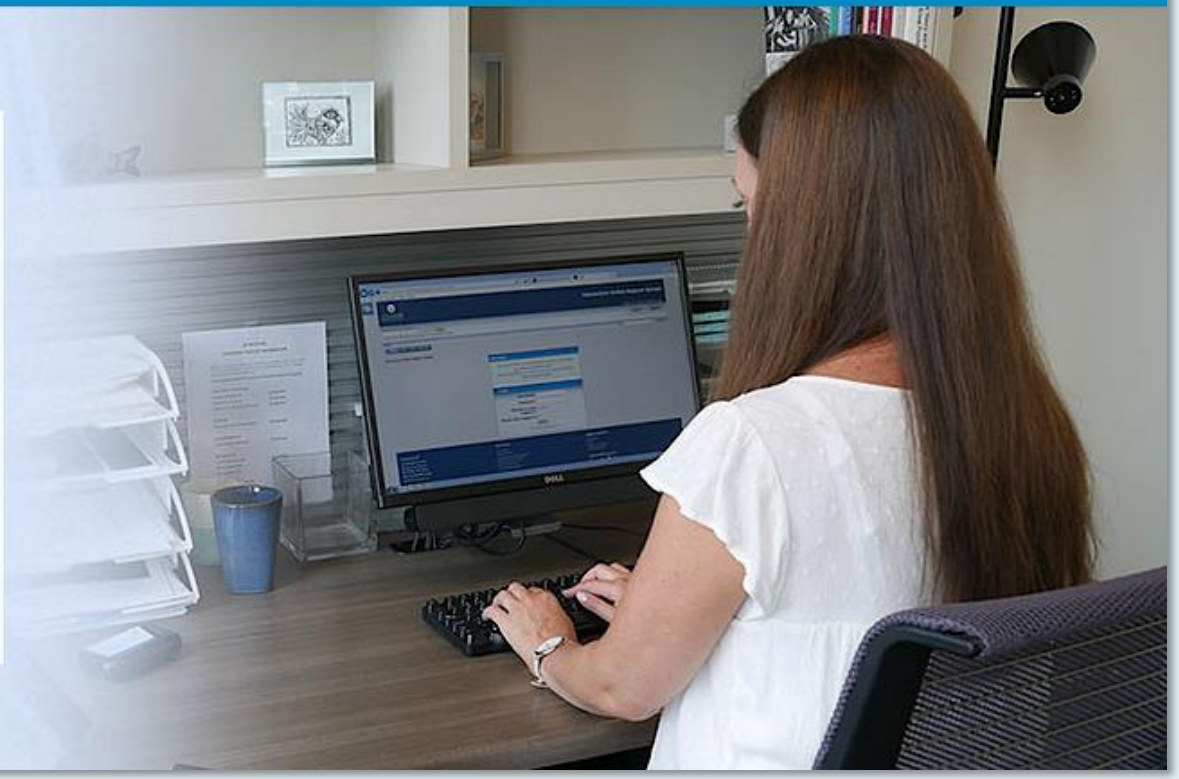
Our blood cancers patient support group **provides a safe space to connect with others** coping with a blood cancer and is **led by an oncology social worker** who provides emotional and practical support.



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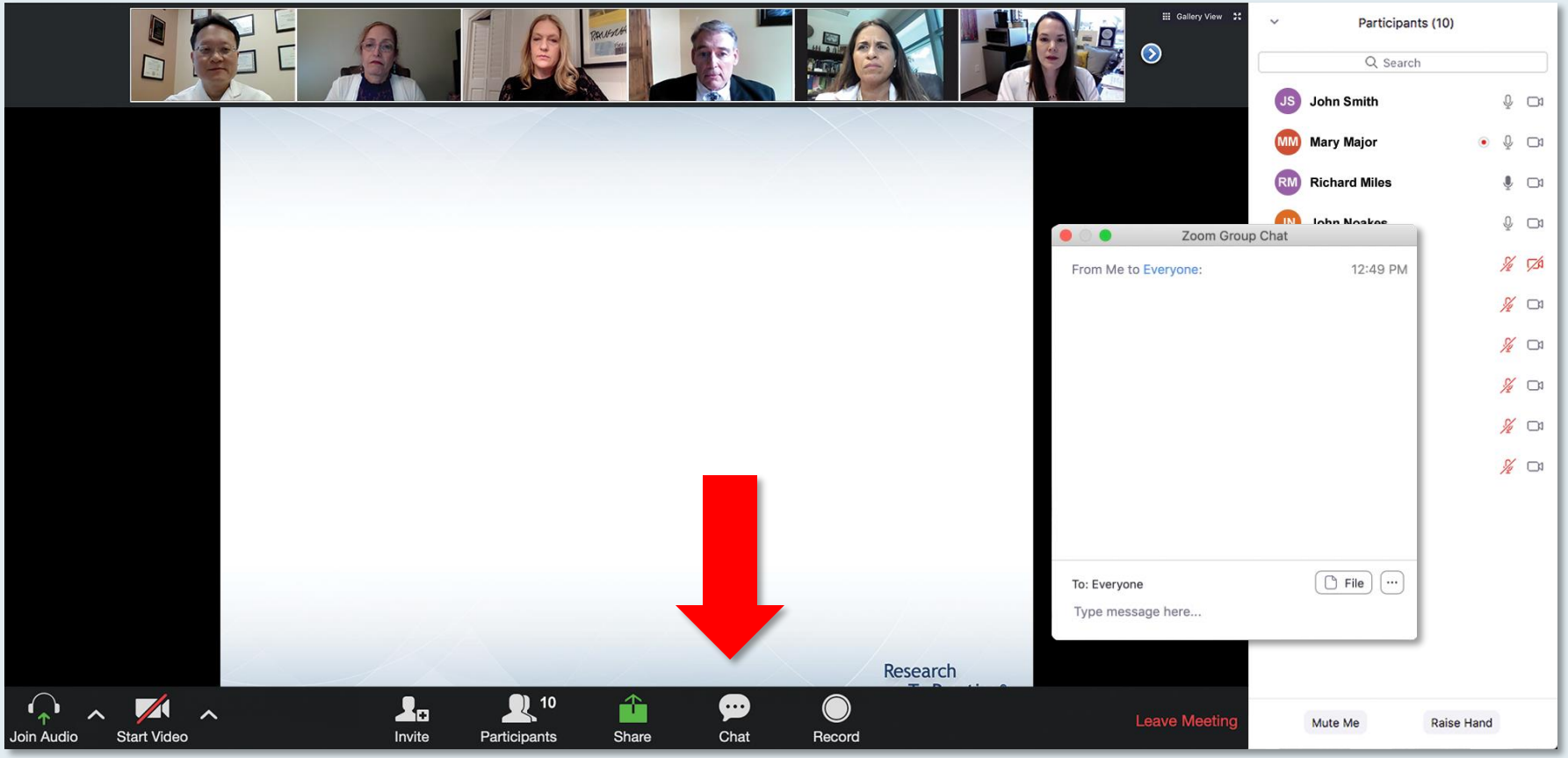

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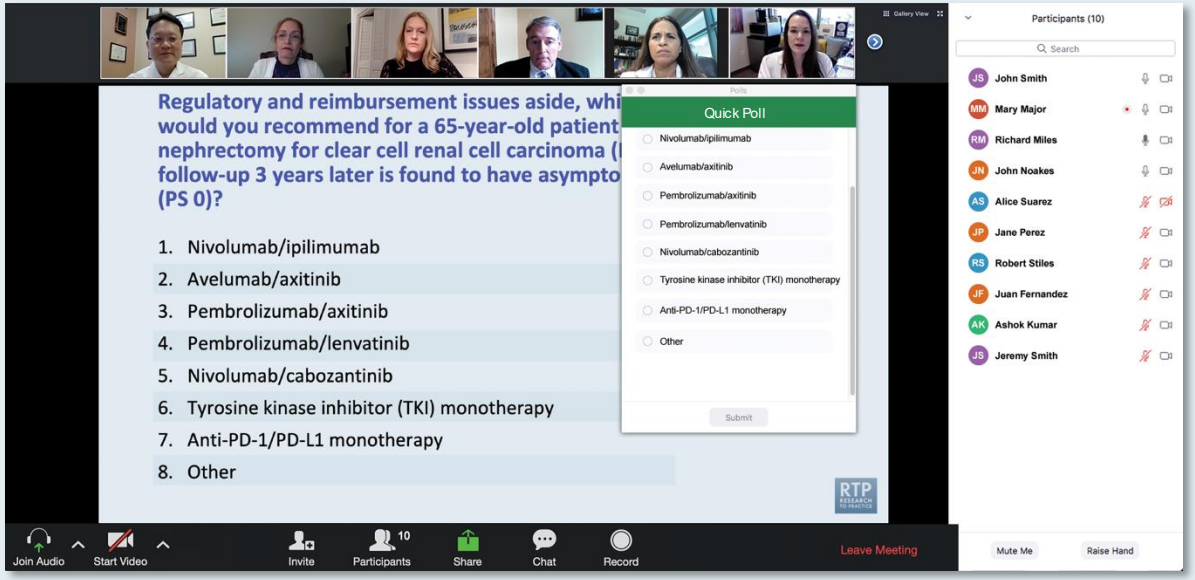

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Dr Callander — Disclosures

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Dr Lonial — Disclosures

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Survey Participant

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Sagar Lonial, MD, FACP

Moderator

Neil Love, MD

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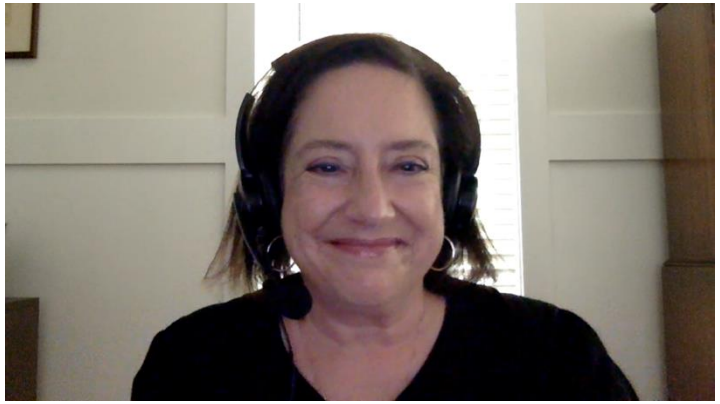



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Cancer Q&A
Relapsed/Refractory Multiple Myeloma

Module 1: A farmer with myeloma; is myeloma the new CML?

Module 2: Clinical trials

Module 3: Chimeric antigen receptor (CAR) T-cell therapy

Module 4: Bispecific antibodies

Module 5: Antibody-drug conjugates; a patient on belantamab mafodotin for 3 years

Module 6: Treatment options for relapsed disease

Module 7: Neuropathy

Module 8: Alternative therapies

Module 9: 164 questions

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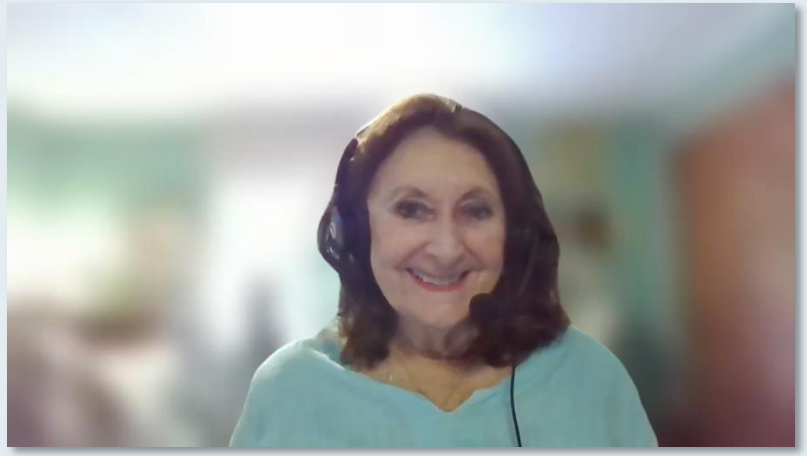
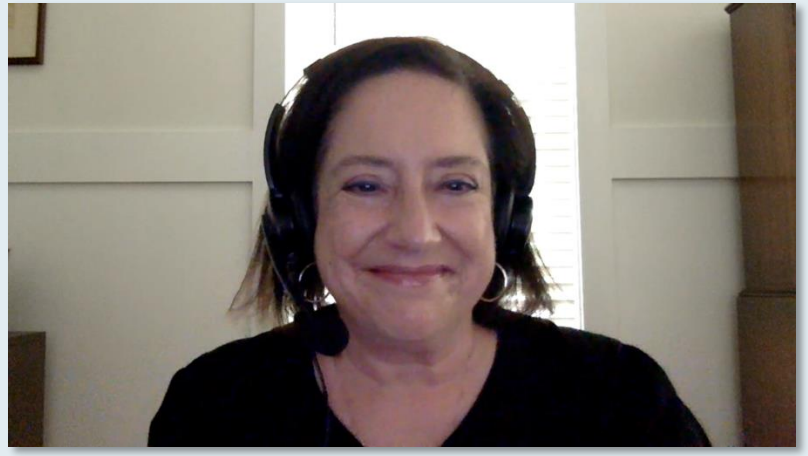
A farmer with myeloma; is myeloma the new CML?





Based on available data and your personal clinical experience, do you believe that insecticides or other environmental toxins contribute to the development of MM?

 Dr Callander	Yes, agree epidemiological data is quite suggestive — Agent Orange- or radiation-exposed, exterminators, 9/11 responders all seem to have an increased risk to develop MM or MGUS
 Dr Lonial	Yes, pesticides, petroleum exposure. We see higher incidence among farmers, gas station attendants, and other factories where workers are exposed to chemical solvents
 Dr Fonseca	No. Most myeloma is just an accident in nature. A bad outcome of our normal immune response
 Dr Orlowski	Yes. However, most patients do not have a history of exposure to the extent needed (ie, in an industrial setting) for this to be an issue
 Dr Raje	Yes — chemical exposure — not so much in the recent past though
 Dr Richardson	Yes. Agent Orange is the sentinel example, with multiple others since

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In general, how would you respond if a 65-year-old transplant-eligible patient with newly diagnosed standard-risk MM asked you to estimate survival with your preferred initial treatment approach?

	2005		2025	
	PFS (months)	OS (months)	PFS (months)	OS (months)
 Dr Callander	36	60	120	180
 Dr Lonial	40	69	120+	170+
 Dr Fonseca	40	60	120	180
 Dr Orlowski	~24	~48	~70	~120
 Dr Raje	72	144	120	240
 Dr Richardson	60	90	96	180

PFS = progession-free survival; OS = overall survival

In general, how would you respond if a 65-year-old transplant-eligible patient with newly diagnosed high-risk MM asked you to estimate survival with your preferred initial treatment approach?

	2005		2025	
	PFS (months)	OS (months)	PFS (months)	OS (months)
 Dr Callander	24	36	60	90
 Dr Lonial	15	36	65	96
 Dr Fonseca	30	40	100	120
 Dr Orlowski	~12	~30	~30	~60
 Dr Raje	24	72	36	84
 Dr Richardson	24	48	48	90

In general, how would you respond if an 80-year-old transplant-ineligible patient with newly diagnosed standard-risk MM asked you to estimate survival with your preferred initial treatment approach?

	2005		2025	
	PFS (months)	OS (months)	PFS (months)	OS (months)
 Dr Callander	24	48	80	140
 Dr Lonial	18	24-36	60	75
 Dr Fonseca	24	36	75	100
 Dr Orlowski	~12	~24	~22	~36
 Dr Raje	48	72	72	120
 Dr Richardson	40	80	80	120

In general, how would you respond if an 80-year-old transplant-ineligible patient with newly diagnosed high-risk MM asked you to estimate survival with your preferred initial treatment approach?

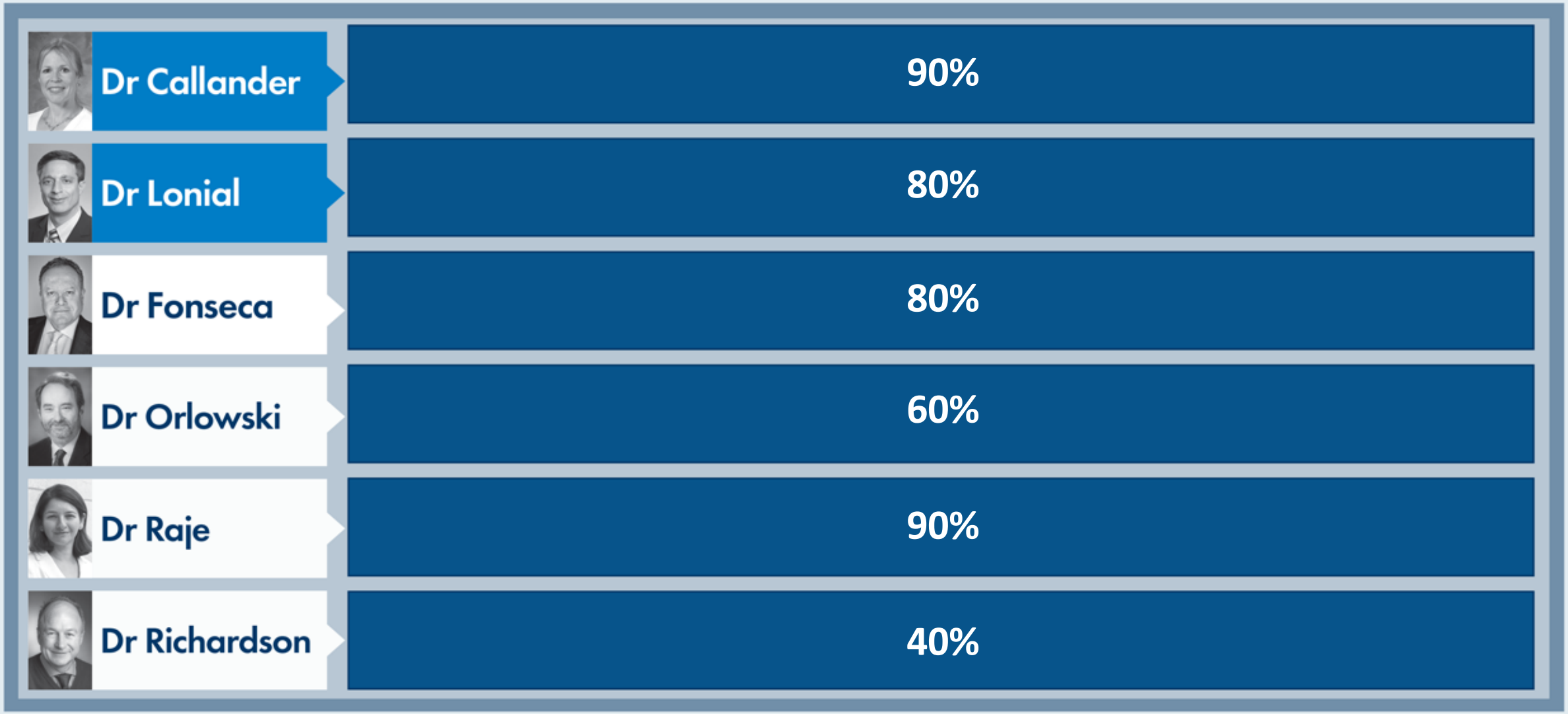
	2005		2025	
	PFS (months)	OS (months)	PFS (months)	OS (months)
 Dr Callander	12	36	40	80
 Dr Lonial	9	18	36	48
 Dr Fonseca	12	24	55	70
 Dr Orlowski	~6	~18	~12	~24
 Dr Raje	24	48	48	120
 Dr Richardson	20	30	40	60

In general, for an 80-year-old patient with newly diagnosed standard-risk MM and typical age-associated comorbidities (eg, hypertension, Type 2 diabetes) but otherwise healthy, how would you respond if the patient asked you about the percent chance of dying due to something other than MM?

 Dr Callander	80%
 Dr Lonial	75%
 Dr Fonseca	70%
 Dr Orlowski	80%
 Dr Raje	70%
 Dr Richardson	60%

RTP RESEARCH TO PRACTICE

In general, for a 90-year-old patient with newly diagnosed standard-risk MM and typical age-associated comorbidities (eg, hypertension, Type 2 diabetes) but otherwise healthy, how would you respond if the patient asked you about the percent chance of dying due to something other than MM?



RTP RESEARCH TO PRACTICE

Cancer Q&A
Relapsed/Refractory Multiple Myeloma

Module 1: A farmer with myeloma; is myeloma the new CML?

Module 2: Clinical trials

Module 3: CAR T-cell therapy

Module 4: Bispecific antibodies

Module 5: Antibody-drug conjugates; a patient on belantamab mafodotin for 3 years

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Module 9: 164 questions

RTP
RESEARCH TO PRACTICE

Clinical trials

Based on available data and your personal clinical experience, do you believe it is reasonable to consider minimal residual disease (MRD) assay results in making decisions about starting or continuing maintenance therapy?

 Dr Callander	No — still think this is a research question. I believe we are getting closer to figuring out which populations could have treatment shaped by MRD, but I would like to know that salvage after relapse then remains possible
 Dr Lonial	No — the use of early MRD is an unconfirmed endpoint. I don't think that early MRD can be used to de-escalate therapy, but rather to escalate therapy when not MRD-negative
 Dr Fonseca	Yes, I use it routinely to decide and do patient guidance and counseling
 Dr Orlowski	No, I do not yet feel comfortable stopping maintenance in any high-risk cases, and even with standard risk the risk of relapse is on the order of 20% even with MRD at 10-6
 Dr Raje	Yes — for continuing therapy such as lenalidomide maintenance for patients with standard risk
 Dr Richardson	Yes, but importantly maintenance is a standard of care but MRD may help dictate intensity of maintenance

RTP RESEARCH TO PRACTICE

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RESEARCH TO PRACTICE

CAR T-cell therapy

In general, for a patient with relapsed/refractory MM who is eligible to receive both chimeric antigen receptor (CAR) T-cell therapy and a bispecific antibody, which do you administer first and in what line of therapy?

	Treatment	Line of therapy
 Dr Callander	CAR T	Early relapse, high-risk 2nd line Standard risk — considered at 3rd line or later Would use ahead of CAR T in frail pts or for relapsed disease
 Dr Lonial	CAR T	2-3
 Dr Fonseca	CAR T	First relapse, later
 Dr Orlowski	CAR T	2nd line if high risk; 3rd or 4th line if standard risk
 Dr Raje	CAR T	After 2-3 LOT
 Dr Richardson	Bispecific	2-3

LOT = lines of therapy

Approximately what is the percent chance that a patient with relapsed/refractory MM who receives idecabtagene vicleucel (ide-cel) will experience either immediate or delayed neurologic symptoms?

 Dr Callander	1%
 Dr Lonial	<10%
 Dr Fonseca	2%
 Dr Orlowski	15% (all grades)
 Dr Raje	<1%
 Dr Richardson	15% to 20%

RTP RESEARCH TO PRACTICE

Approximately what is the percent chance that a patient with relapsed/refractory MM who receives ciltacabtagene autoleucel (cilta-cel) will experience either immediate or delayed neurologic symptoms?

 Dr Callander	6%
 Dr Lonial	10% to 15%
 Dr Fonseca	10%
 Dr Orlowski	20% (all grades)
 Dr Raje	10%
 Dr Richardson	20%

RTP RESEARCH TO PRACTICE

What is the age of the oldest person with relapsed/refractory MM to whom you administered or whom you referred for CAR T-cell therapy, and which agent did you administer?

	Age	Agent
 Dr Callander	84	Cilta-cel
 Dr Lonial	84	Cilta-cel
 Dr Fonseca	82	Cilta-cel
 Dr Orlowski	82	Ide-cel
 Dr Raje	84	Ide-cel
 Dr Richardson	77 (He died of TRM)	Cilta-cel

TRM = treatment-related mortality

Cancer Q&A
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Module 8: Alternative therapies

Module 9: 164 questions

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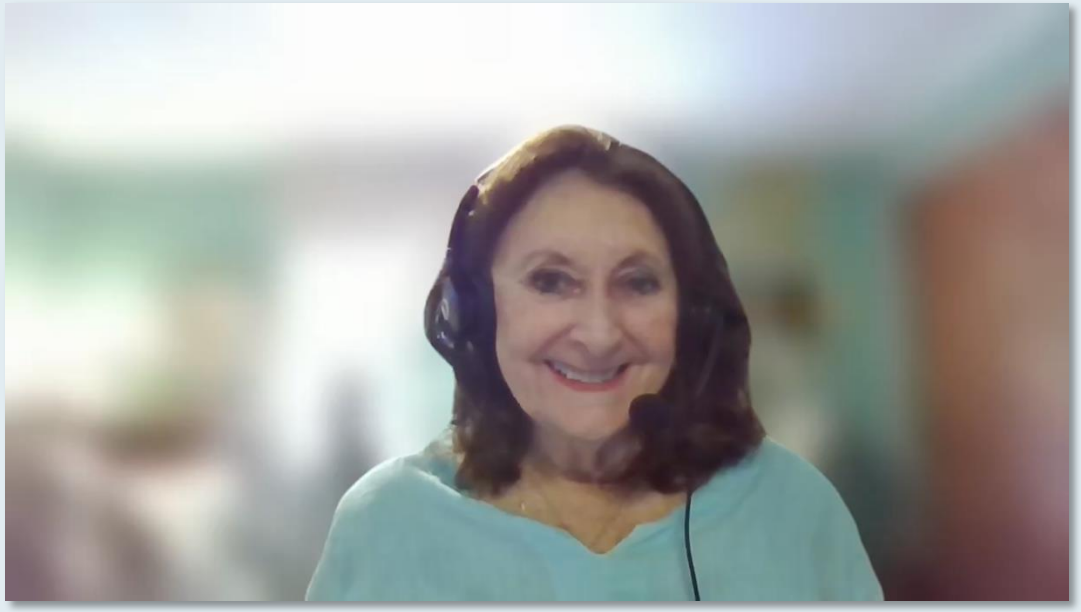
RESEARCH TO PRACTICE

Bispecific antibodies



In general, for a patient with relapsed/refractory MM who is NOT eligible for CAR T-cell therapy but is eligible to receive a bispecific antibody, in which line of therapy would you administer a bispecific antibody?

 Dr Callander	Limited by labeling but really as soon as possible and would look for a trial
 Dr Lonial	4+ that is the label
 Dr Fonseca	If I could I would use at second line, but often is at fourth
 Dr Orlowski	Fourth line as that is the earliest approval (for talquetamab)
 Dr Raje	3-4
 Dr Richardson	3-4

RTP RESEARCH TO PRACTICE

What is the age of the oldest person with relapsed/refractory MM to whom you administered a bispecific antibody, and which agent did you administer?

	Age	Agent
 Dr Callander	87	Elranatamab
 Dr Lonial	81	Teclistamab
 Dr Fonseca	85	Elranatamab
 Dr Orlowski	85	Talquetamab
 Dr Raje	91	Elranatamab
 Dr Richardson	82	Teclistamab was poorly tolerated and had to be abandoned

In what situations, if any, do you utilize preemptive tocilizumab prior to administering a bispecific antibody to a patient with relapsed/refractory MM?

 Dr Callander	Typically don't use
 Dr Lonial	All patients receive preemptive toci
 Dr Fonseca	None (yet)
 Dr Orlowski	High disease burden or baseline ferritin
 Dr Raje	High disease burden
 Dr Richardson	Low threshold to use now

RTP RESEARCH TO PRACTICE

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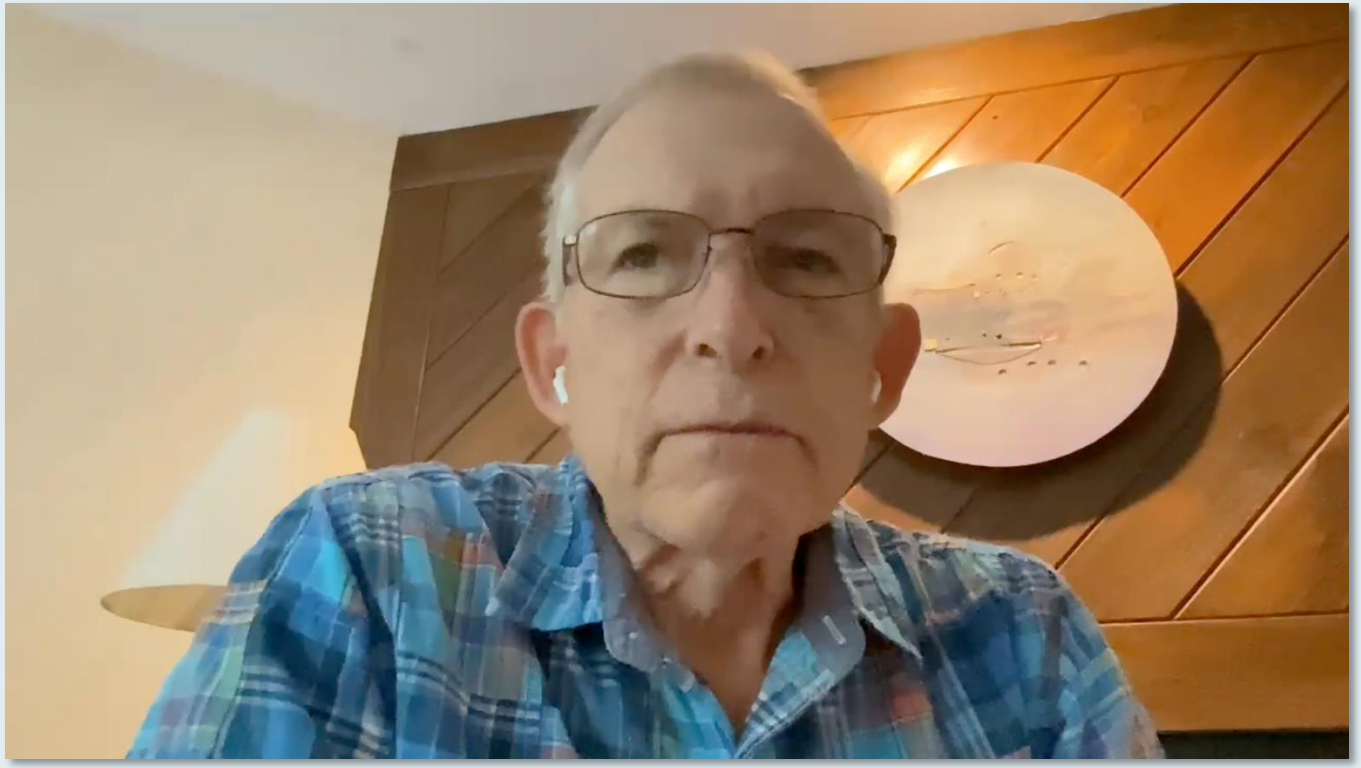
RESEARCH TO PRACTICE

Antibody-drug conjugates; a patient on belantamab mafodotin for 3 years



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RESEARCH
TO PRACTICE

If belantamab mafodotin were available, to approximately how many patients currently in your practice would you want to administer it as their next line of treatment?

 Dr Callander	20 patients
 Dr Lonial	10 to 15 patients
 Dr Fonseca	5 patients
 Dr Orlowski	20 patients
 Dr Raje	20%
 Dr Richardson	20% to 30%

RTP RESEARCH TO PRACTICE

If belantamab mafodotin were to become available again, for which patients with relapsed/refractory MM, if any, would you prioritize its use?

 Dr Callander	I would consider at second line for patients when CAR T is either not available or would take too long to coordinate
 Dr Lonial	Many patients don't want the risk and complicated schedule with a TCE or CAR T. In first relapse the PFS is the same as a CAR T
 Dr Fonseca	After CAR T and bispecifics
 Dr Orlowski	Frail, older patients who would not be candidates for CAR T or TCE
 Dr Raje	After CAR T and bispecifics
 Dr Richardson	Early relapse after CD38, also after CAR T or bispecific failure

TCE = bispecific T-cell engager

RTP RESEARCH TO PRACTICE

If belantamab mafodotin were to become available again, what's the earliest timepoint in the treatment algorithm that you would want to administer it to patients with MM?

 Dr Callander	I am interested in trials showing benefit in first line, but certainly second line
 Dr Lonial	First relapse
 Dr Fonseca	Likely third line and beyond
 Dr Orlowski	Second line
 Dr Raje	After 3-4 LOT
 Dr Richardson	First relapse

RTP RESEARCH TO PRACTICE

If belantamab mafodotin were to become available again, do you believe that avoiding significant morbidity from ophthalmic toxicity can be achieved by modifying the dose and schedule of administration?

 Dr Callander	Yes, patients who are receiving every 3-month dosing rarely have significant eye problems
 Dr Lonial	Yes, I would dose every 8 to 12 weeks as was functionally done in the trial
 Dr Fonseca	Yes, reduced dosing and more prolonged schedule seem to help with serious toxicity
 Dr Orlowski	Yes, I believe some reduction is possible, though not complete avoidance
 Dr Raje	Yes, dose reduce and decrease frequency
 Dr Richardson	Yes, ocular toxicity in combination is moderate to mild, manageable and fully reversible

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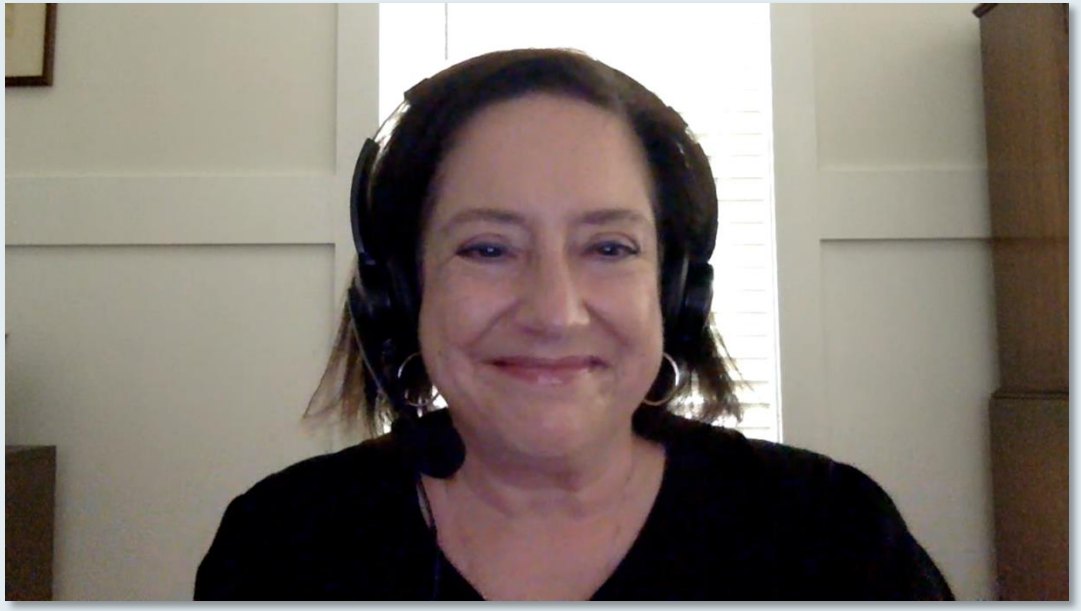
RTP RESEARCH TO PRACTICE

Treatment options for relapsed disease



Cancer Q&A
Relapsed/Refractory Multiple Myeloma

Neuropathy

Based on available data and your personal clinical experience, how effective is gabapentin in the management of MM treatment-associated neuropathy? (5 = extremely effective; 1 = not effective at all)

 Dr Callander	3 — Some pt find it helpful, but I would say only about 50% and usually does not produce complete abatement
 Dr Lonial	3
 Dr Fonseca	3
 Dr Orlowski	3
 Dr Raje	3
 Dr Richardson	4

RTP RESEARCH TO PRACTICE

Based on available data and your personal clinical experience, how effective is acupuncture in the management of MM treatment-associated neuropathy?
(5 = extremely effective; 1 = not effective at all)

 Dr Callander	4 — Helpful but access and expense are issues
 Dr Lonial	4
 Dr Fonseca	2
 Dr Orlowski	4
 Dr Raje	4
 Dr Richardson	3

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Module 9: 164 questions

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Alternative therapies

A patient with MM who is about to begin treatment with daratumumab/RVd informs you that they take daily green tea supplements. How would you counsel the patient?

 Dr Callander	I would advise them that in vitro studies indicate that green tea interferes with bortezomib activity
 Dr Lonial	Avoid this as it interacts with bortezomib
 Dr Fonseca	Stop taking it
 Dr Orlowski	Hold green tea on days of bortezomib
 Dr Raje	Avoid on days of bortezomib
 Dr Richardson	Not on days of bortezomib

RTP RESEARCH TO PRACTICE

A patient with MM who is about to begin treatment with daratumumab/RVd informs you that they take daily vitamin C supplements. How would you counsel the patient?

 Dr Callander	I would advise them that high-dose vitamin C has not proven to improve cancer outcomes
 Dr Lonial	Avoid this as it interacts with bortezomib
 Dr Fonseca	Not a concern unless the sFLC is very high (>100 mg/dL) as changes in urine pH could precipitate cast nephropathy
 Dr Orlowski	Hold vitamin C on days of bortezomib
 Dr Raje	Avoid on days of bortezomib
 Dr Richardson	Not on days of bortezomib

sFLC = serum free light chain

RTP RESEARCH TO PRACTICE

In general, do you proactively ask your patients with MM about their use of dietary supplements or alternative therapies?

 Dr Callander	Yes but probably not consistently enough
 Dr Lonial	Yes
 Dr Fonseca	No
 Dr Orlowski	Yes
 Dr Raje	Sometimes
 Dr Richardson	Yes

RTP RESEARCH TO PRACTICE

Approximately what proportion of your patients with MM do you estimate take dietary supplements or alternative therapies?

 Dr Callander	30%
 Dr Lonial	75%
 Dr Fonseca	25% to 30%
 Dr Orlowski	40%
 Dr Raje	60% to 70%
 Dr Richardson	50%

RTP RESEARCH TO PRACTICE

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Module 9: 164 questions

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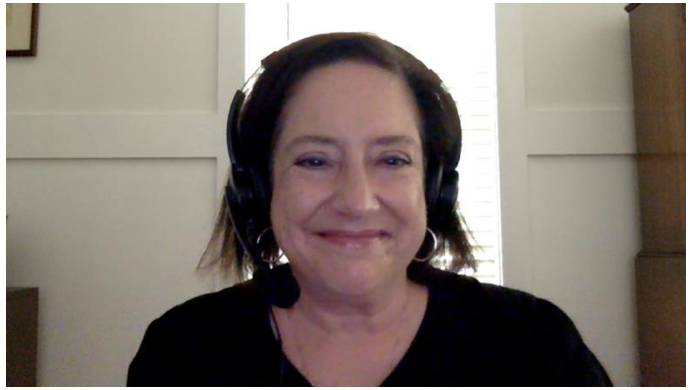
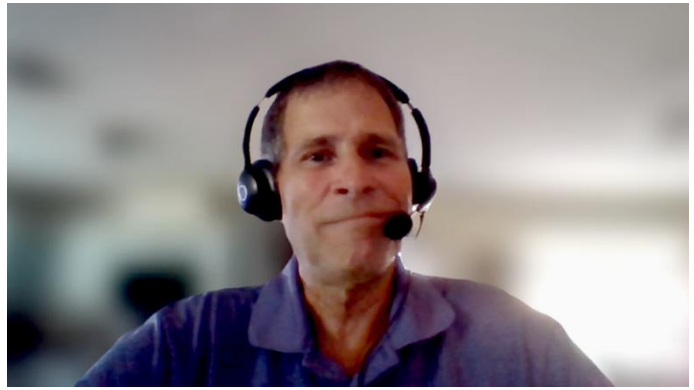
164 Questions

Thank you






RTP RESEARCH TO PRACTICE

The Implications of Recent Datasets for the Current and Future Management of Breast Cancer — An ASCO 2025 Review

A CME/MOC-Accredited Live Webinar

Wednesday, August 13, 2025
5:00 PM – 6:00 PM ET

Faculty

Sara A Hurvitz, MD, FACP
Sara M Tolaney, MD, MPH

Moderator

Neil Love, MD

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Thank you for joining us!

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Information on how to obtain CME and ABIM MOC credit is provided in the Zoom chat room. Attendees will also receive an email in 1 to 3 business days with these instructions.

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