Questions from the Community: Investigators Discuss Available Research Guiding the Care of Patients with Relapsed/Refractory Multiple Myeloma

Monday, June 2, 2025
6:00 PM – 7:00 PM CT (7:00 PM – 8:00 PM ET)

Faculty

Ajay K Nooka, MD, MPH
Paul G Richardson, MD

Moderator

Neil Love, MD

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Faculty

Ajay K Nooka, MD, MPH
Professor, Department of Hematology
and Medical Oncology
Director, Myeloma Program
Associate Director of Clinical Research
Winship Cancer Institute
Emory University School of Medicine
Atlanta, Georgia

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Neil Love, MD
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Paul G Richardson, MD
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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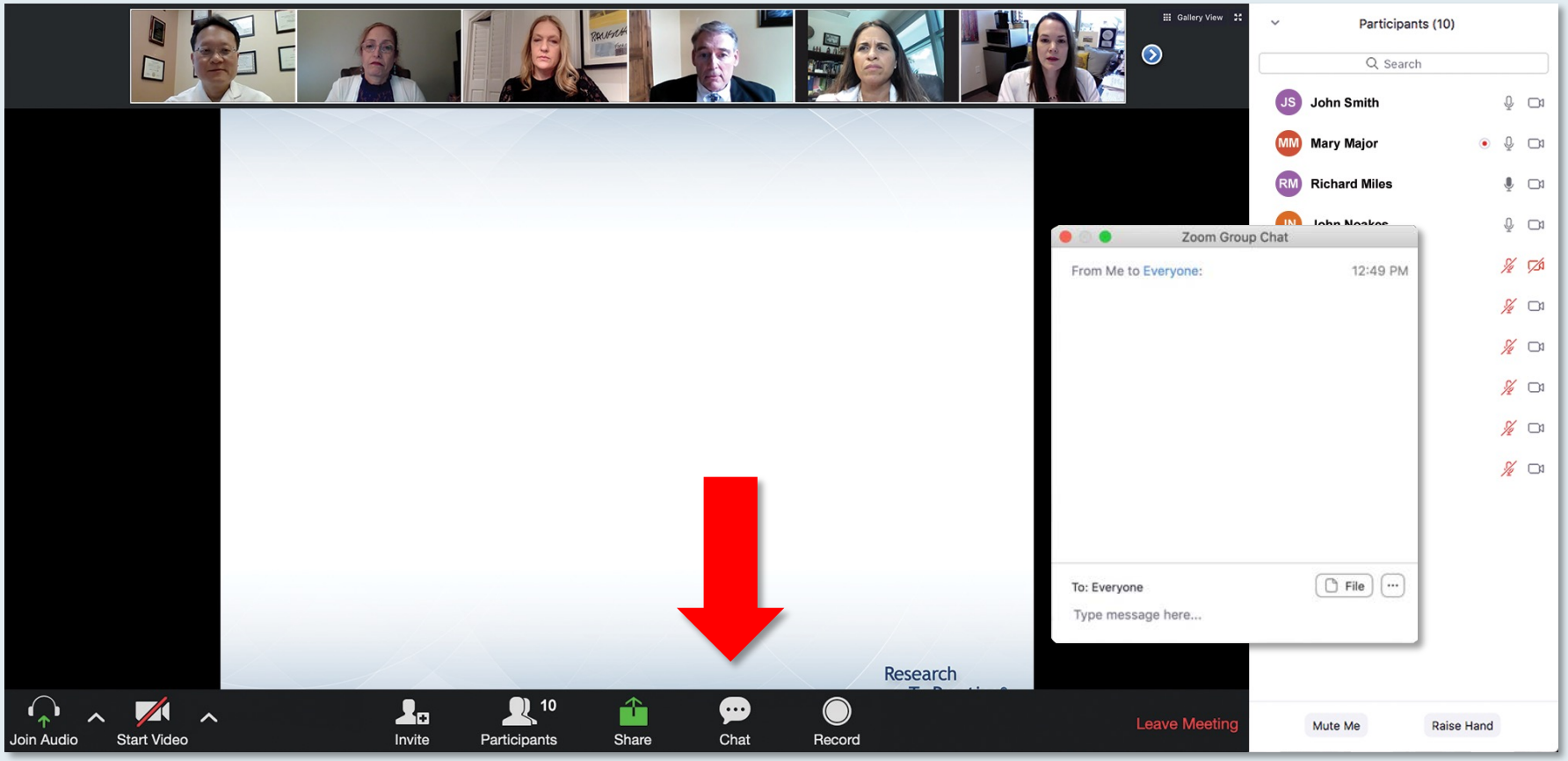
We Encourage Clinicians in Practice to Submit Questions



Feel free to submit questions now before the program begins and throughout the program.

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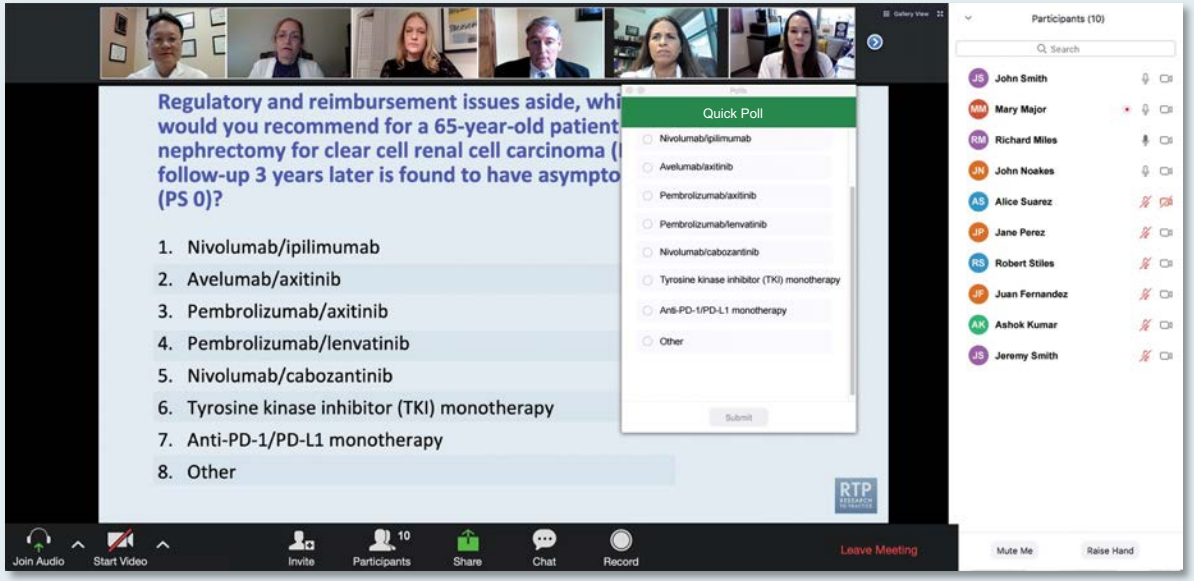
Clinicians in the Audience, Please Complete the Pre- and Postmeeting Surveys



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Friday May 30	**Immunotherapy and Antibody–Drug Conjugates in Lung Cancer** 11:15 AM – 12:45 PM CT (12:15 PM – 1:45 PM ET)
	Colorectal Cancer 6:30 PM – 8:30 PM CT (7:30 PM – 9:30 PM ET)
	EGFR Mutation–Positive Non–Small Cell Lung Cancer 6:30 PM – 8:30 PM CT (7:30 PM – 9:30 PM ET)
Saturday May 31	**Urothelial Bladder Cancer** 6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)
	Non–Hodgkin Lymphoma 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
	Prostate Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Sunday June 1	**Chronic Lymphocytic Leukemia (Webinar)** 7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)
	HER2–Positive Gastrointestinal Cancers 7:00 PM – 8:30 PM CT (8:00 PM – 9:30 PM ET)
	Ovarian and Endometrial Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Monday June 2	**Renal Cell Carcinoma (Webinar)** 7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)
	Multiple Myeloma (Webinar) 6:00 PM – 7:00 PM CT (7:00 PM – 8:00 PM ET)
	Metastatic Breast Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Tuesday June 3	**Soft Tissue Sarcoma and Other Connective Tissue Neoplasms (Webinar)** 7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)

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Consensus or Controversy? Clinical Investigators Provide Perspectives on the Current and Future Clinical Care of Patients with Metastatic Breast Cancer

Monday, June 2, 2025

7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Harold J Burstein, MD, PhD
Javier Cortés, MD, PhD
Rebecca A Dent, MD, MSc
Kevin Kalinsky, MD, MS
Joyce O'Shaughnessy, MD

Moderator

Hope S Rugo, MD

RTP RESEARCH TO PRACTICE

RTP Live from Chicago: Investigator Perspectives on Available Research Findings and Challenging Questions in the Management of Soft Tissue Sarcoma and Other Connective Tissue Disorders

Tuesday, June 3, 2025
7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)

Faculty

Rashmi Chugh, MD
Mrinal Gounder, MD

Moderator

Neil Love, MD

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Paul G Richardson, MD

Moderator

Neil Love, MD

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Dr Nooka — Disclosures
Faculty

Advisory Boards and Consulting Agreements (Honoraria)	Adaptive Biotechnologies Corporation, AstraZeneca Pharmaceuticals LP, Cellectar Biosciences Inc, GSK, Janssen Biotech Inc, K36 Therapeutics, Kite, A Gilead Company, ONK Therapeutics, Opna Bio, Pfizer Inc, Sanofi, Sebia
Data and Safety Monitoring Boards/Committees	Janssen Biotech Inc
Grant/Research Support (for Investigator-Initiated Studies)	Amgen Inc, GSK, Janssen Biotech Inc, Merck, Takeda Pharmaceuticals USA Inc
Grant/Research Support (to University)	Amgen Inc, Arch Oncology, Bristol Myers Squibb, Cellectis, Chinook Therapeutics, Genentech, a member of the Roche Group, GSK, Janssen Biotech Inc, Karyopharm Therapeutics, Kite, A Gilead Company, Merck, Opna Bio, Pfizer Inc, Takeda Pharmaceuticals USA Inc

Dr Richardson — Disclosures
Faculty

Consulting Agreements	Bristol Myers Squibb, Celgene Corporation, GSK, Karyopharm Therapeutics, Oncopeptides, Regeneron Pharmaceuticals Inc, Sanofi
Contracted Research	Oncopeptides

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Dr Love — Disclosures

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This activity is supported by an educational grant from GSK.

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Agenda

Introduction: ASCO 2025 Showstoppers

Module 1: Up-Front Treatment of Multiple Myeloma (MM) – Survey Questions

Module 2: Emerging Novel Therapies for Relapsed/Refractory (R/R) MM – Faculty Presentation

Module 3: Emerging Novel Therapies for R/R MM – Survey Questions

Module 4: Current Management of R/R MM – Faculty Presentation

Module 5: Current Management of R/R MM – Survey Questions

Module 6: ASCO and EHA 2025

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Module 6: ASCO and EHA 2025

Randomized Trial of Standard Chemotherapy Alone or Combined with Atezolizumab as Adjuvant Therapy for Patients with Stage III Deficient DNA Mismatch Repair (dMMR) Colon Cancer (Alliance A021502; ATOMIC)

Sinicrope F et al.
ASCO 2025;Abstract LBA1.

Three-year DFS was 86.4 % in the atezolizumab/mFOLFOX6 arm and 76.6 % in the mFOLFOX6 arm (HR, 0.50; 95% CI, 0.35–0.72).

Camizestrant + CDK4/6 Inhibitor (CDK4/6i) for the Treatment of Emergent ESR1 Mutations During First-Line (1L) Endocrine-Based Therapy (ET) and Ahead of Disease Progression in Patients (pts) with HR+/HER2– Advanced Breast Cancer (ABC): Phase 3, Double-Blind ctDNA-Guided SERENA-6 Trial

Turner N et al.
ASCO 2025;Abstract LBA4.

Hazard ratio for PFS was 0.44 (95% CI 0.31–0.60, p<0.00001; median PFS 16.0 vs 9.2 months).

PFS rate at 24 months was 29.7% vs 5.4%.

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Trastuzumab Deruxtecan (T-DXd) + Pertuzumab (P) vs Taxane + Trastuzumab + Pertuzumab (THP) for First-Line (1L) Treatment of Patients (pts) with Human Epidermal Growth Factor Receptor 2-Positive (HER2+) Advanced/Metastatic Breast Cancer (a/mBC): Interim Results from DESTINY-Breast09

Tolaney S et al.
ASCO 2025;Abstract LBA1008.

T-DXd + P significantly improved PFS by BICR (hazard ratio 0.56; 95% CI 0.44, 0.71; *P* < 0.00001).

ILD occurred in 12.1% of 383 patients (predominantly Grade 1/2) who received T-DXd + P. Grade 5 ILD occurred in 2 patients.

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Module 6: ASCO and EHA 2025

Survey of 50 Community-Based General Medical Oncologists
May 14-24, 2025

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Questions from General Medical Oncologists — First-Line Treatment of MM

- **Myeloma is so complicated now.**

Questions from General Medical Oncologists — First-Line Treatment of MM; Smoldering Myeloma

- The juice has to be worth the squeeze — there are so many options already, for MM to stand out there has to be a definite advantage in PFS, OS, or tox
- Should all patients get an anti-CD38 and which one?
- I basically never use isatuximab. Much less chair time with subcutaneous dara
- In what situations (reimbursement aside) would you recommend daratumumab for smoldering myeloma — what dose and for how long?

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2025 ASCO ANNUAL MEETING
May 30 – June 3, 2025
McCormick Place | Chicago, IL & Online
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Emerging Novel Therapies for Relapsed/Refractory (R/R) MM, With A Focus On Belantamab Mafodotin and the CELMoDs

Paul G. Richardson, MD
RJ Corman Professor of Medicine
Harvard Medical School

Clinical Program Leader, Director of Clinical Research
Jerome Lipper Multiple Myeloma Center
Dana-Farber Cancer Institute
Boston, Massachusetts

Dana-Farber Cancer Institute

DANA-FARBER CANCER INSTITUTE

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Treatment of MM in 2025: multiple therapies approved or under investigation

Backbone/standard-of-care agents

IMiDs	PIs	mAbs	HDACis
Lenalidomide	Bortezomib*	Daratumumab (CD38)	Panobinostat‡
Pomalidomide	Carfilzomib	Isatuximab (CD38)	Vorinostat†,#
Thalidomide	Ixazomib	Elotuzumab (SLAMF7)	
	Marizomib†,#		

Recent approvals / later relapse

ADCs	Targeted therapies	CAR T cell therapies
Belantamab mafodotin‡	Selinexor	Idecabtagene vicleucel
AZD0305†	Melflufen‡	Ciltacabtagene autoleucel
Belantamab†	Venetoclax†,#	CAR T cell therapies
	Lisaftoclax†	Arlocabtagene autoleucel†
	Sonrotoclax†	Anitocabtagene autoleucel†
		Durcabtagene autoleucel†

Emerging therapies for MM**

BiTEs® / bispecifics	BiTEs® / bispecifics	CELMoDs®
Teclistamab (BCMAxCD3)	ABBV-383† (BCMAxCD3)	Iberdomide†
Elranatamab (BCMAxCD3)	Alnuctamab†# (BCMAxCD3)	Mezigdomide†
Talquetamab (GPRC5DxCD3)	Linvoseltamab† (BCMAxCD3)	Others
	Forimtamig† (GPRC5DxCD3)	Cemsidomide, Inobrodib†
	Cevostamab† (FcRH5xCD3)	CAR NK cell therapies†
		ICIs, Immuno-cytokines†,#

Strategies for managing MM, including doublet, triplet, and quadruplet combination regimens both upfront and in relapse, as well as treatment sequencing, are rapidly evolving in the context of this expanding therapeutic armamentarium

*Also approved in combination with
†Not currently approved in RRMM. ‡
ADCs, antibody–drug conjugates; B
cell engagers; CAR, chimeric antige
CHMP, Committee for Medicinal Pro
myeloma; EMA, European Medicines
and Drug Administration; GPRC5D, G protein-coupled receptor family C group 5 member D; ICIs, immune checkpoint inhibitors; IMiDs®, immunomodulatory drugs; mAbs, monoclonal antibodies; PIs, proteasome inhibitors; RRMM, relapsed/refractory multiple myeloma.

Adapted from Richardson PG. 5th Oxford Myeloma Workshop, January 30–31, 2025, Oxford, UK.

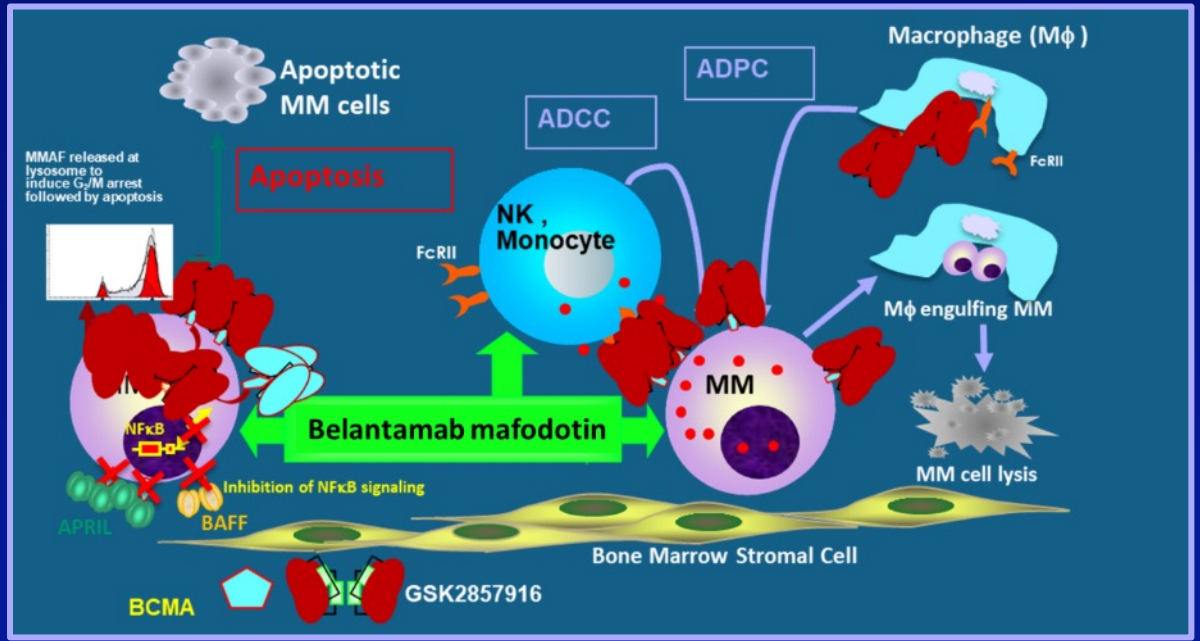
BCMA-targeted antibody–drug conjugate (ADC) therapy for RRMM

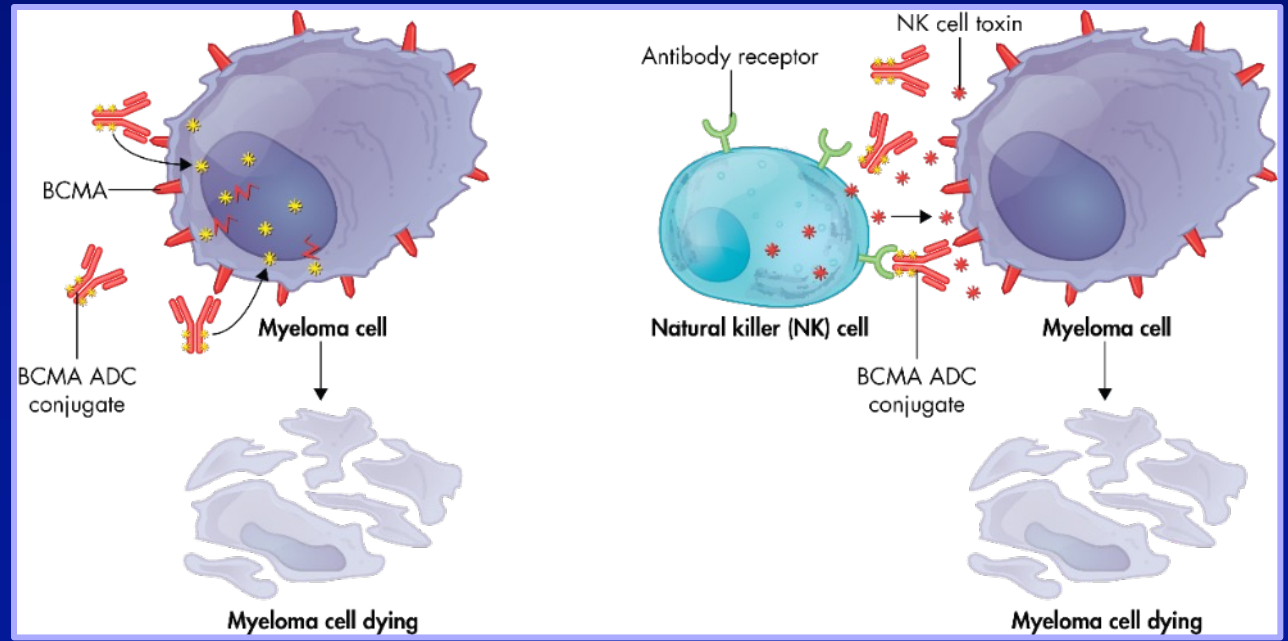
Ongoing development of belantamab mafodotin[1,2]

First ADC approved in RRMM (2020)

US and EU marketing authorisation withdrawn following DREAMM-3 not meeting its primary endpoint[3,4]

Remains under investigation in combination regimens in multiple studies, with positive results from the DREAMM-7[5] and DREAMM-8[6] phase 3 trials in RRMM





Humanized IgG1 Fc-engineered ADC comprising a BCMA-targeted antibody covalently linked via a cysteine linker to the microtubule inhibitor monomethyl auristatin F (MMAF)

1. Trudel S, et al. Lancet Oncol 2018;19(12):1641–53. 2. Richardson PG, et al. Blood Cancer J 2020;10(10):106. 3. Dimopoulos MA, et al. Lancet Haematol 2023;10(10):e801–12. 4. Mukhopadhyay P, et al. Blood Cancer J 2025;15(1):15. 5. Hungria V, et al. N Engl J Med 2024;391(5):393–407. 6. Dimopoulos MA, et al. N Engl J Med 2024;391(5):408–21.
Left-hand figure adapted from Tai YT, Anderson KC. Immunotherapy 2015;7(11):1187–99. Right-hand figure adapted from Cho S-F, et al. Front Immunol 2018;9:1821.

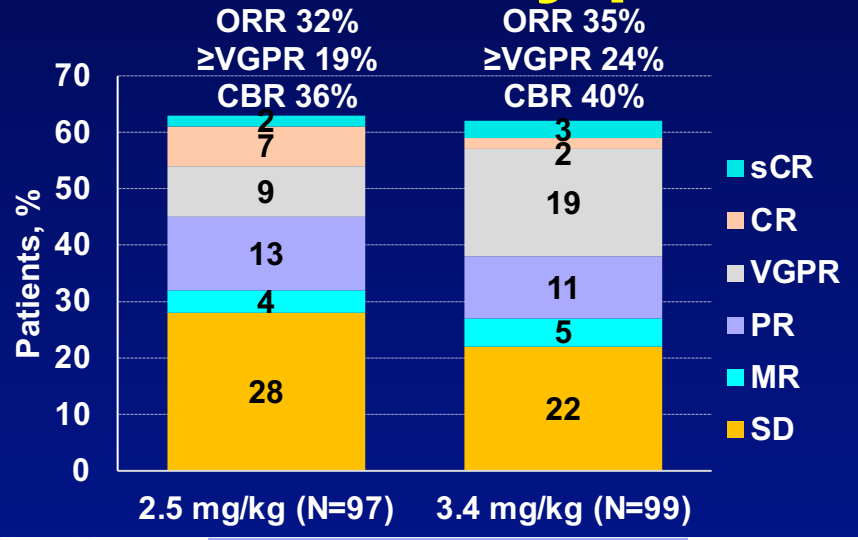
Belantamab mafodotin: initial approval based on DREAMM-2 in heavily pretreated RRMM

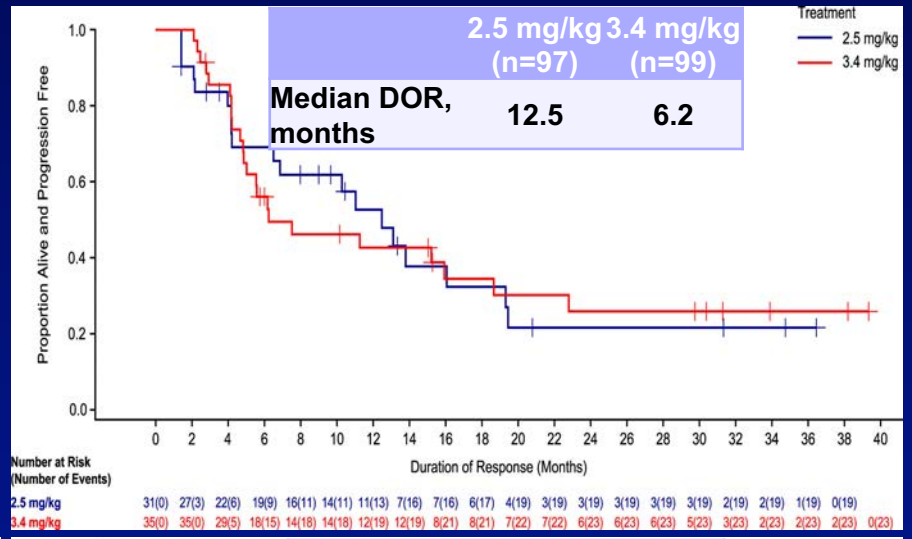
Patients

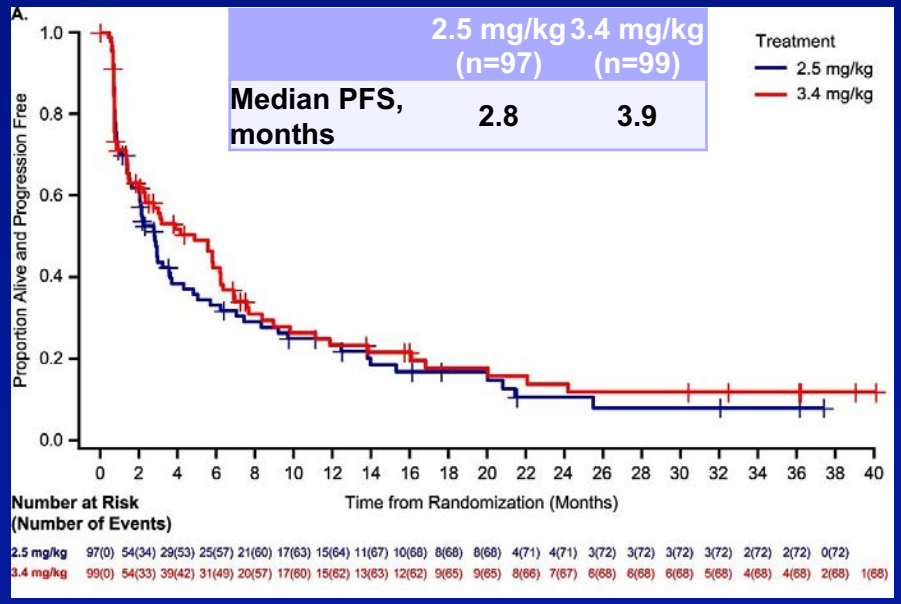
- N=97 and N=99 in 2.5 and 3.4 mg/kg cohorts
- Median age: 65 and 67 years
- High-risk cytogenetics: 42% and 47%
- Median prior lines of therapy: 7 and 6
- 90% and 89% lenalidomide-refractory
- 87% and 78% pomalidomide-refractory
- 76% and 75% bortezomib-refractory
- 100% and 92% daratumumab-refractory
- 100% and 100% triple-class-refractory

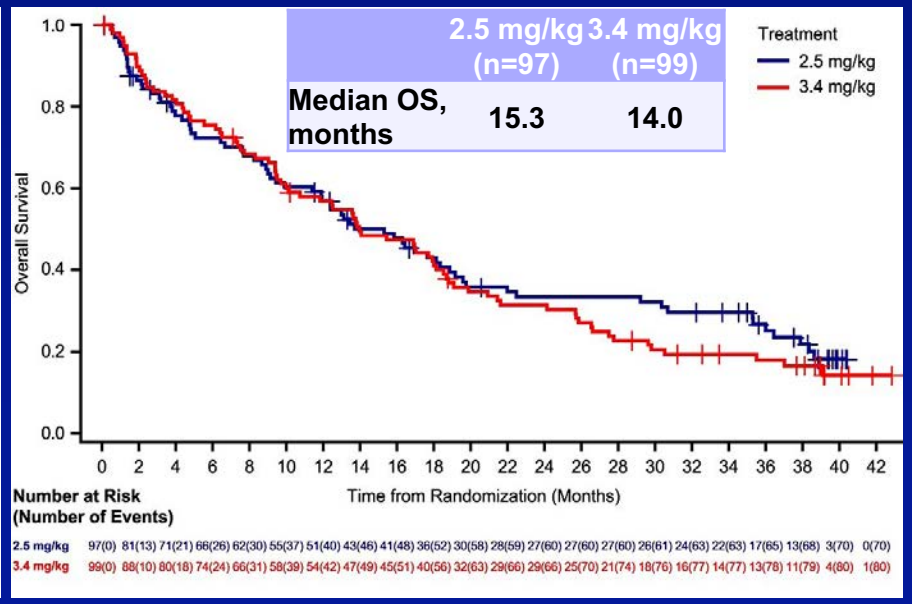
Safety (2.5 and 3.4 mg/kg cohorts)

- Keratopathy: 71% and 75%
- Grade 3/4 keratopathy: 31% and 25%
- Any Grade 3/4 AE: 84% and 83%
- Grade 3/4 thrombocytopenia: 22% and 32%; anemia 21% and 28%; neutropenia 11% and 16%
- Infections: 45% and 55%
- Grade ≥3 infections: 20% and 44%
- Discontinuations: 12% and 12%









Lonial S, et al. Lancet Oncol 2020;21(2):207–21. Lonial S, et al. Cancer 2021;127(22):4198–212. Nooka A, et al. Cancer 2023;129(23):3746–60.

DREAMM-2: belantamab mafodotin lyophilised presentation cohort

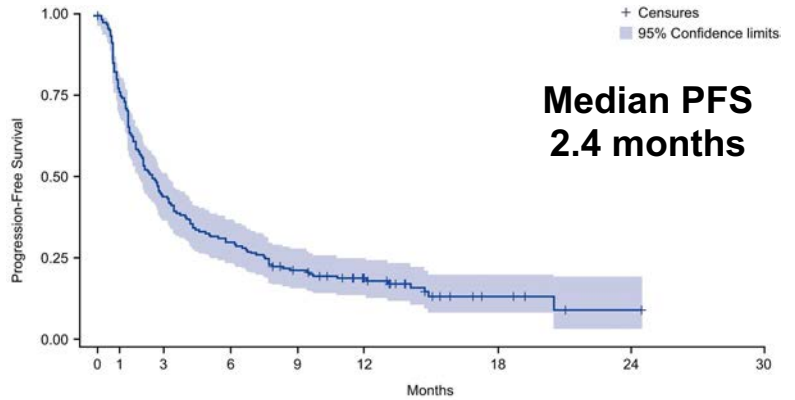
European Journal of Haematology

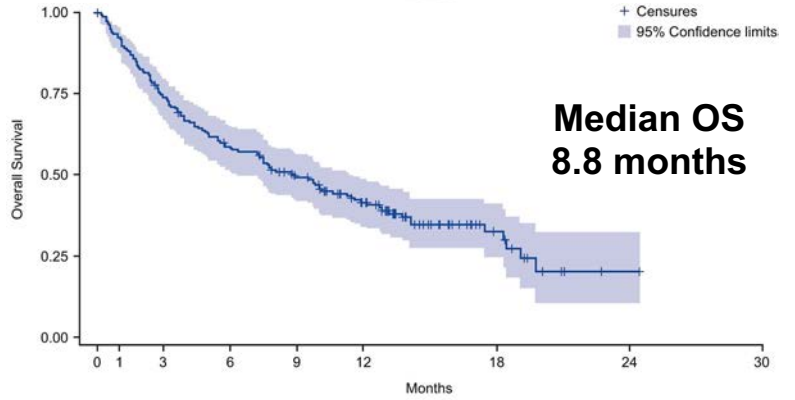
ALFA: Real-world study of belantamab mafodotin in RRMM

- Non-interventional, retrospective study of 184 patients; median age 70 years
- 32.5% high-risk cytogenetics
- Median 5 prior therapies; 97% prior R, 98% prior V, 89% prior Dara, 79% penta-exposed

- Median follow-up 7.8 months
- ORR 33%, including 20% ≥VGPR
- CBR 36%

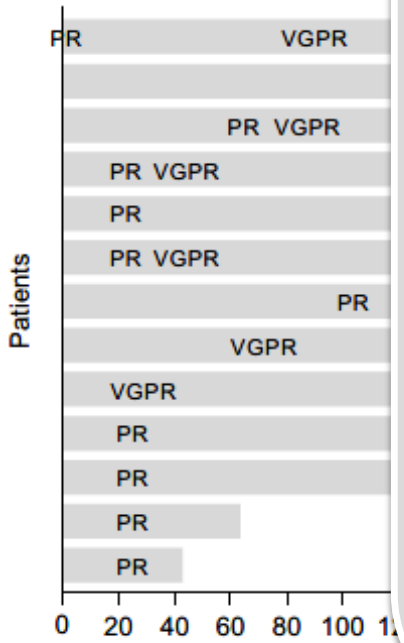
- Ophthalmologic AEs (grade 3/4): any 56% (29%), keratopathy/keratitis 42% (8%), decreased visual acuity 11% (1%), other ocular disorders 13% (2%), resulting in discontinuation 12.5%





Roussel M, et al. Eur J Haematol 2024; 113(3):310–20. Figures reproduced under Creative Commons CC BY-NC 4.0 license

- Median age: 68 years
- ISS III: 40%; EMD: 24
- High-risk cytogeneti
- Median prior lines of
- 100% triple-class ref



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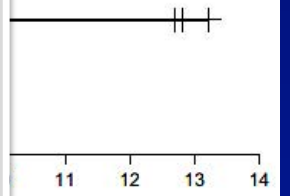

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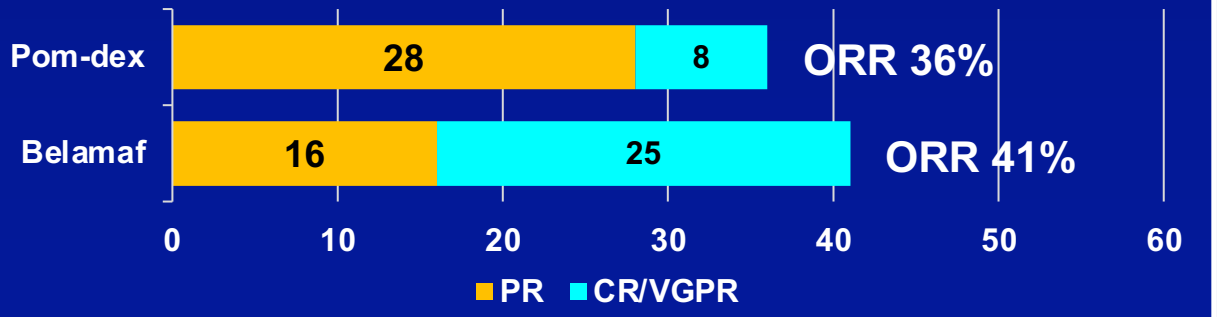
DREAMM-3: Belantamab mafodotin vs Pom-dex as 3rd-line therapy[1]

Patients (N=325)

- 218 received belamaf 2.5 mg/kg Q3W vs 107 Pom-dex
- Median age 68 years
- 54% vs 62% male
- 24% vs 26% ISS stage III
- Median 4 vs 3 prior lines
- 40% vs 38% prior dara

Exposure

- Median belamaf exposure 4.1 (range 0.4–22.9) months
- Median Pom-dex exposure 5.3 (range 0.4–24.0) months



Outcomes

- Median follow-up: 11.5 vs 10.8 months
- Median PFS: 11.2 vs 7.0 months (HR 1.03, stratified Cox model, not significant)
- MRD-neg ≥VGPR 7% vs 0
- 1-year DOR 77% vs 48%
- Median PFS2 18.7 vs 12.7 months
- Median OS 21.2 vs 21.1 months

Safety

- AEs 97% vs 93%
- Grade 3/4 AEs 76% vs 70%
- Grade 5 AEs 7% vs 11%
- SAEs 43% vs 39%
- AEs leading to discontinuation 15% vs 17%
- Consistent safety profile in 50 patients receiving belamaf for ≥52 weeks[2]

1. Dimopoulos MA, et al. Lancet Haematol 2023;10(10):e801–12. 2. Hungria VTM, et al. Blood 2023;142(suppl 1):abstract 3357.

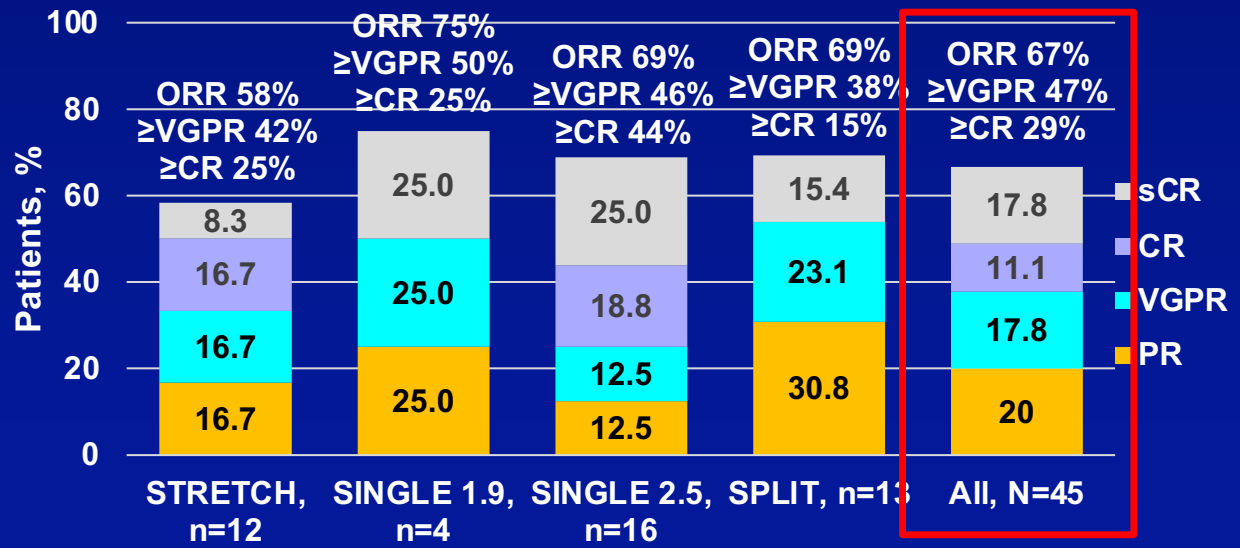
DREAMM-6: Belantamab mafodotin + Rd (Arm A)[1]

Multiple belantamab mafodotin doses

- Cohort 1, 'STRETCH': 1.9 mg/kg Q8W – n=12
- Cohort 2, 'SINGLE': 1.9 mg/kg Q4W – n=4
- Cohort 3, 'SINGLE': 2.5 mg/kg Q4W – n=16
- Cohort 4, 'SPLIT': 2.5 mg/kg D1/8 Q4W – n=13

45 patients enrolled

- Median age 68 years, 18% aged ≥75 years
- 31% high-risk cytogenetics
- 13% EMD
- Median of 3 prior lines of therapy
- 58% R-exposed, 31% Dara-exposed



Outcomes

- Median follow-up: 23.7 months
- Median PFS 18.4 months

Safety

- No clinically meaningful differences in safety profile across cohorts
- Grade ≥3 AEs 87%: keratopathy 53%, neutrophil count decreased 22%, platelet count decreased 22%, visual acuity reduced 22%
- Any ocular AEs 80% (Grade 3/4 69%)
- SAEs 53%

Belantamab mafodotin 2.5 mg/kg SINGLE + Vd (Arm B)[2,3]

- N=18, median 3 prior lines, 89% V-exposed, 50% Dara-exposed
- ORR 78% (50% VGPR); CBR 83%
- Median DOR not reached
- AEs leading to permanent discontinuation of any study treatment 28% (0% leading to discontinuation of belantamab mafodotin)
- AEs leading to dose reductions 72%
  - Keratopathy 39%, thrombocytopenia 33%
- AEs leading to dose interruptions 100%
  - Keratopathy 83%, thrombocytopenia 39%

1. Popat R, et al. Blood Cancer J 2024;14(1):184.
2. Nooka A, et al. J Clin Oncol 2020;38(15_suppl):abstract 8502. 3. Popat R, et al. Blood 2020;136(suppl 1):abstract 1419.

BCMA-targeted ADC for early-relapse RRMM
DREAMM-7: Belantamab mafodotin + Vd vs Dara-Vd as ≥2nd-line therapy

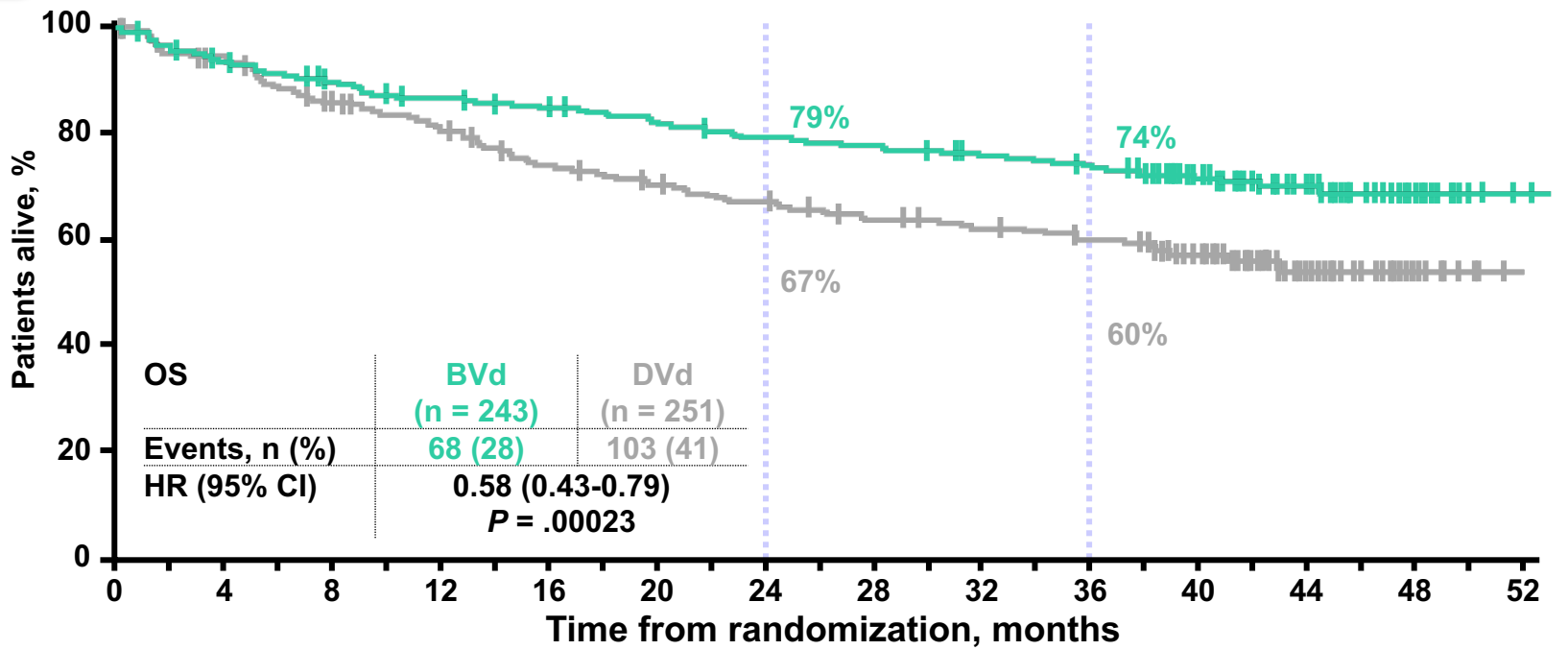
The NEW ENGLAND JOURNAL of MEDICINE

AMERICAN SOCIETY OF HEMATOLOGY 2024

- Belamaf+Vd x
- Dara-Vd x 8 cycles

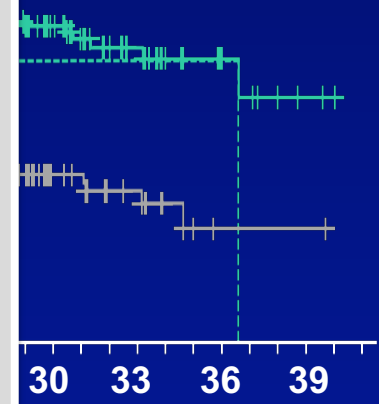
Patients		
Median age, years		
Age ≥75 years		
High-risk cytogen		
EMD		
1 / 2-3 / ≥4 prior lin		
Prior PI		
Prior IMiD		
R-refractory		
Prior Dara		
Prior ASCT	67%	69%

Updated analysis of OS in DREAMM-7 (median follow-up 39.4 months)



Hungria V, et al. Blood 2024;144(supplement 1):772.

BVd	DVd
36.6 (28.4-NR)	13.4 (11.1-17.5)
0.41 (0.31-0.53), P<0.00001	



…cified subgroups, …ients with high- …th prior V (HR 0.45)

- Early OS trend favoring belamaf-Vd – 18-month OS 84% vs 73% (HR 0.57)

Hungria V, et al. N Engl J Med 2024;391(5):393–407.

BCMA-targeted ADC for early-relapse RRMM
DREAMM-7: Belantamab mafodotin + Vd vs Dara-Vd as ≥2nd-line therapy

The NEW ENGLAND JOURNAL of MEDICINE

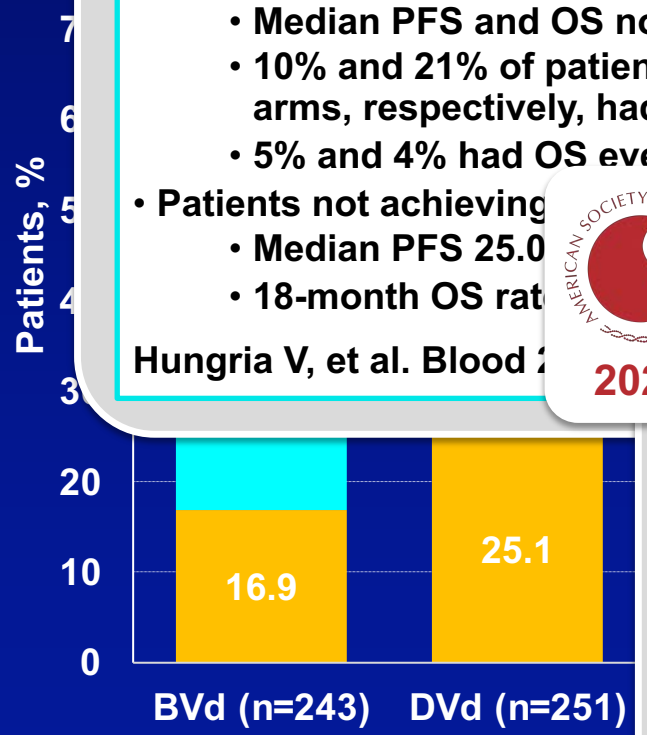
2024 AMERICAN SOCIETY OF HEMATOLOGY

2025 ASCO ANNUAL MEETING

PFS in patients by MRD status

- Patients achieving CR MRD-neg status
  - Median PFS and OS not reached in either arm
  - 10% and 21% of patients in the Belamaf-Vd and Dara-Vd arms, respectively, had PFS events
  - 5% and 4% had OS events
- Patients not achieving [illegible]neg status
  - Median PFS 25.0 [illegible]nths
  - 18-month OS rat[illegible]

Hungria V, et al. Blood 2[illegible]



Median DOR 40.8 vs 17.8 months

Outcomes in patients with high-risk cytogenetics (HRC)

- 50% vs 46% had HRC
  - 17% vs 17% t(4;14); 3% vs 2% t(14;16)
  - 12% vs 14% del17p
  - 39% vs 31% amp1q
- With belantamab mafodotin + Vd vs Dara-Vd in patients with ≥1 HRC
  - Median PFS 33.2 vs 11.1 months
  - [illegible] 38%
  - [illegible] 39% vs 17%)

[illegible] 2025;43(16_supplement):7546.

	33%	20%
	12%	4%
	79% (34%)	29% (3%)
	68% (24%)	11% (<1%)
	51% (7%)	7% (0)
	47% (2%)	2% (0)
	43% (5%)	5% (0)

Phase 1 study of Bela-RVd in RRMM with 1–3 prior lines

- 19 patients; median age 63 years
- 53% high-risk cytogenetics
- 42% R-refractory, 11% V-refractory, 26% Dara-refractory
- Median follow-up 16.1 months
- ORR 100%, including 74% ≥VGPR and 53% ≥CR
- MRD-neg 53% (10^{-5}) / 37% (10^{-6})
- Common AEs (grade ≥3): eye disorders 95% (32%), blurred vision 90% (37%), fatigue 58% (0%), hypokalemia 53% (11%)

Atrash S, et al. Blood 2024;144(supplement 1):4751.

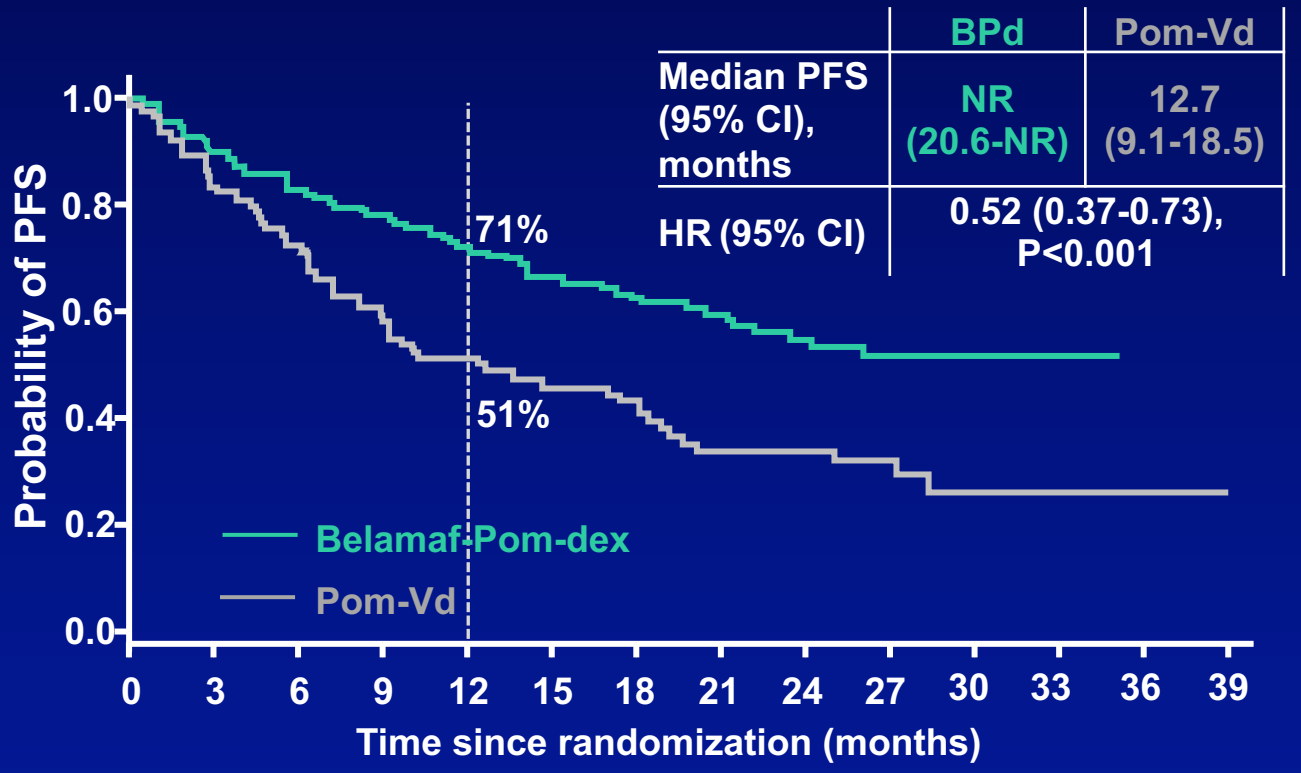
Hungria V, et al. N Engl J Med 2024;391(5):[illegible]

BCMA-targeted ADC for early-relapse RRMM
DREAMM-8: Belantamab mafodotin + Pom-dex vs Pom-Vd as ≥2nd-line therapy

Phase 3 DREAMM-8 study

- Patients with ≥1 prior line, including lenalidomide
- Belamaf-Pom-dex until PD/death, N=155
- Pom-Vd until PD/death, N=147

Patients	Belamaf-Pom-dex, N=155	Pom-Vd, N=147
Median age, years	67	68
Age ≥75 years	12%	24%
High-risk cytogenetics	34%	32%
EMD	13%	7%
1 / 2 or 3 / ≥4 prior lines	53 / 35 / 12%	52 / 33 / 15%
Prior PI	90%	93%
Prior IMiD	100%	100%
IMiD-refractory	82%	76%
Prior CD38 mAb	25%	29%
CD38 mAb-refractory	23%	24%
Prior ASCT	64%	56%



Outcomes

- Significant PFS benefit – seen across prespecified subgroups, including R-refractory patients (HR 0.45), CD38 mAb-refractory patients (HR 0.65), and patients with high-risk cytogenetics (HR 0.57)
- Early OS trend favoring belamaf-Pom-dex – 12-month OS 83% vs 76% (HR 0.77)

Dimopoulos MA, et al. N Engl J Med 2024;391(5):408–421.

BCMA-targeted ADC for early-relapse RRMM
DREAMM-8: Belantamab mafodotin + Pom-dex vs Pom-Vd as ≥2nd-line therapy

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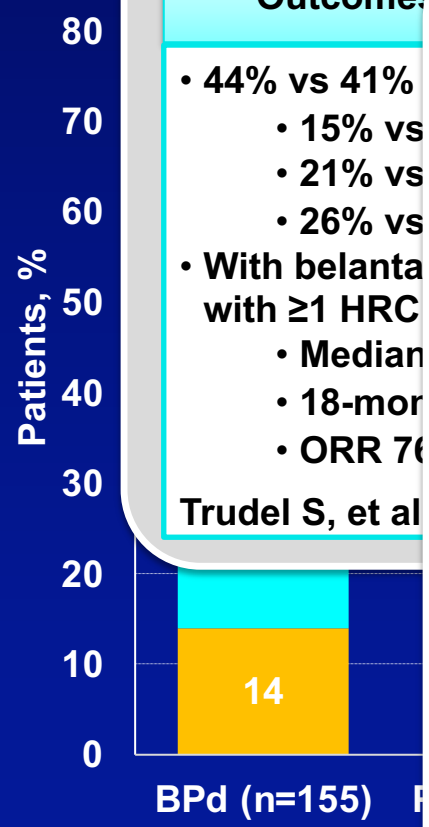
nature medicine

Outcomes

- 44% vs 41%
  - 15% vs
  - 21% vs
  - 26% vs
- With belanta
  with ≥1 HRC
  - Median
  - 18-mor
  - ORR 76

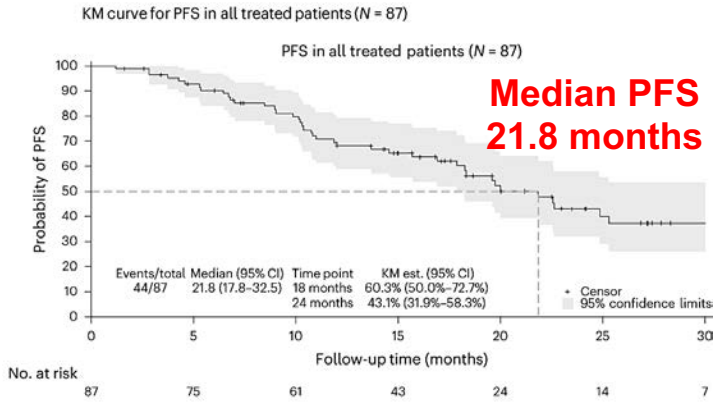
Trudel S, et al

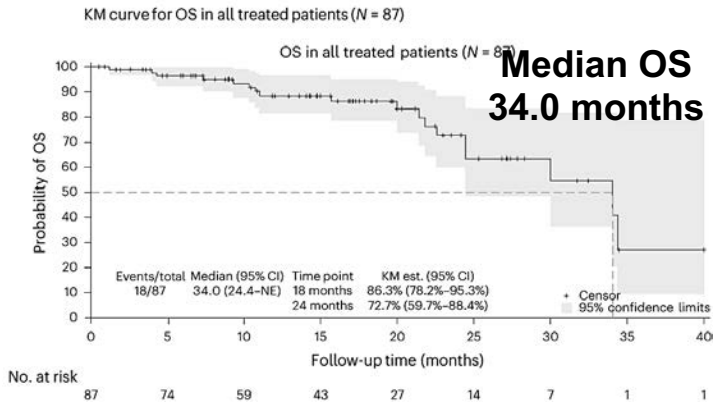


12-month DOR 7

ALGONQUIN: Phase 1/2 study of Bela-Pom-dex in RRMM

- 87 patients; median age 67 years
- 18% high-risk cytogenetics
- Median 3 prior therapies; 97% R-refractory, 86% PI-refractory, 67% CD38 mAb-refractory; 55% triple-class-refractory
- Median follow-up 14.5 months
- ORR 88%, including 73% ≥VGPR and 33% ≥CR
- Common AEs (grade 3/4): keratopathy 71% (55%), decreased visual acuity 78% (44%), fatigue 60% (12%), infection 51% (21%), neutropenia 49% (41%), thrombocytopenia 44% (33%)





Trudel S, et al. Nat Med 2024;30(2):543–51.

	Belamaf-Pom-	Pom-Vd,
	61% (8%)	10% (0)
	61% (6%)	6% (0)
	50% (4%)	9% (0)
	44% (3%)	4% (0)
	33% (2%)	5% (0)
	27% (6%)	10% (4%)
	23% (13%)	6% (1%)

14.0 months)
9%)
Pom-Vd:
nonths
%
plement):7533.

Dimopoulos MA, et al. N Engl J

AMaRC 19-02 BelaCarD study: Belantamab mafodotin + Kd in RRMM

Phase 1/2 study

2025 ASCO ANNUAL MEETING

- Belamaf + Kd in RRM
- N=65, median age 69
- 33% high-risk cytoge
- 25.5% / 38.2% / 34.6% lines
- 42% / 50% / 45% / 33% Pom- / CD38 mAb-ref

Efficacy

- By end of cycle 2, OR
- Median follow-up 13 m
- 24-month PFS 56.1%

Treatment exposure

DREAMM-20: Belantamab (naked BCMA mAb) in RRMM

- 18 patients with RRMM after ≥3 prior lines
  - Median age 76 years
  - 17/18 triple-class exposed, 2/18 prior BCMA-targeted therapy
- ORR 28% (2 VGPR, 3 PR)
- Treatment-related AEs 67%
  - 4 infusion-related reactions, 4 neutrophil count decreased, 2 anemia, 2 vision blurred, 2 platelet count decreased
- No belantamab-related grade ≥2 corneal events

Quach H, et al. J Clin Oncol 2025;43(16_supplement):7550.

Es

3/4 AEs):

%)

(16%)

- BCVA decline 77% (68%)
- Keratopathy 75% (47%)

Lasica M, et al. Blood 2023;142(suppl 1):abstract 2012.

Risk of ocular toxicity with belantamab mafodotin in RRMM

2025 ASCO ANNUAL MEETING

Risk of ocular events in DREAMM-7/DREAMM-8[1]

Analysis of risk

- 392 patients treated with belantamab mafodotin in DREAMM-7/DREAMM-8

Baseline ocular conditions 62%

- Cataract 50%
- Keratopathy 14%
- Dry eye 14%

Treatment-emergent ocular AEs

- In DREAMM-7 and DREAMM-8,
- 74% and 87% in patients with b
- 79% and 91% in patients withou conditions

Baseline ocular conditions did not increase risk of ocular AEs

EHA2025 Congress

Clinical management of ocular toxicity

- Presentation at EHA 2025
  - Clinical management of belantamab-mafodotin-associated ocular events: practical guidance from the Belamaf Expert Experience Program

Terpos E, et al. Abstract PS1752.

Risk of ocular toxicity: systematic review and meta-analysis[2]

- Analysis of 1102 patients from 3 phase 3 trials

Ocular toxicity, %	Belamaf	Comparator	Risk ratio
Any-grade ocular AE	77%	25%	3.3
High-grade	35%	2%	17.6
	%[illegible]	7%	7.5
	%[illegible]	10%	6.5
	%[illegible]	3%	15.6
	%[illegible]	5%	7.6
	%[illegible]	3%	9.4
Foreign body eye sensation	42%	4%	10.7
Cataract	17%	9%	2.1

1. Quach H, et al. J Clin Oncol 2025;43(16_supplement):7544. 2. Hattin R, et al. J Clin Oncol 2025;43(16_supplement):12040.

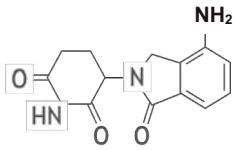
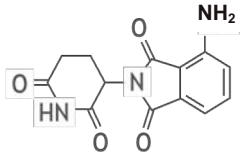
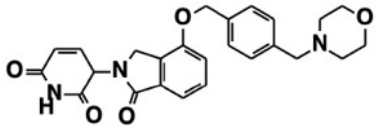
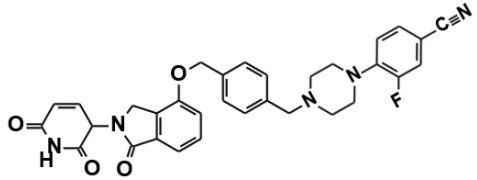
CELMoDs ~ targeting cereblon: novel immunomodulators and protein degraders for RRMM

1. The ubiq
proteasome
(UPS) ta
substrate pr
for degrad

2. The UPS has multiple E3 ligases with

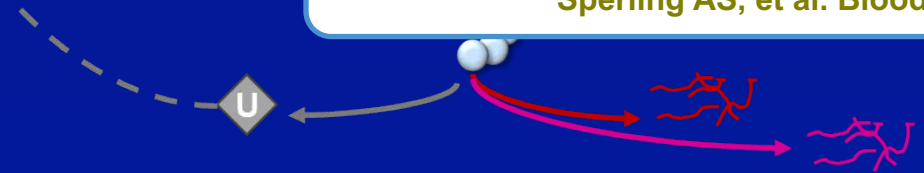
ch as
blon are
s

o cereblon

	Immunomodulatory drugs		Iberdomide	Mezigdomide
	Lenalidomide	Pomalidomide		
				
Cereblon binding	✓	✓	✓✓	✓✓✓
Targeted protein degradation	✓	✓	✓✓	✓✓✓
Tumor antiproliferation	✓	✓	✓✓	✓✓✓
Tumor apoptosis	✓	✓	✓✓	✓✓✓
Immune stimulation	✓✓	✓✓	✓✓✓	✓✓✓
Synergistic combinations	✓✓	✓✓	✓✓✓	✓✓✓

Potential reduced risk of second malignancy with CELMoDs
Preclinical data suggestive, confirmatory clinical observation ongoing
Sperling AS, et al. Blood 2022;140(16):1753–63.

reblon in
nformation:
– 20%
- 50%
– 100%

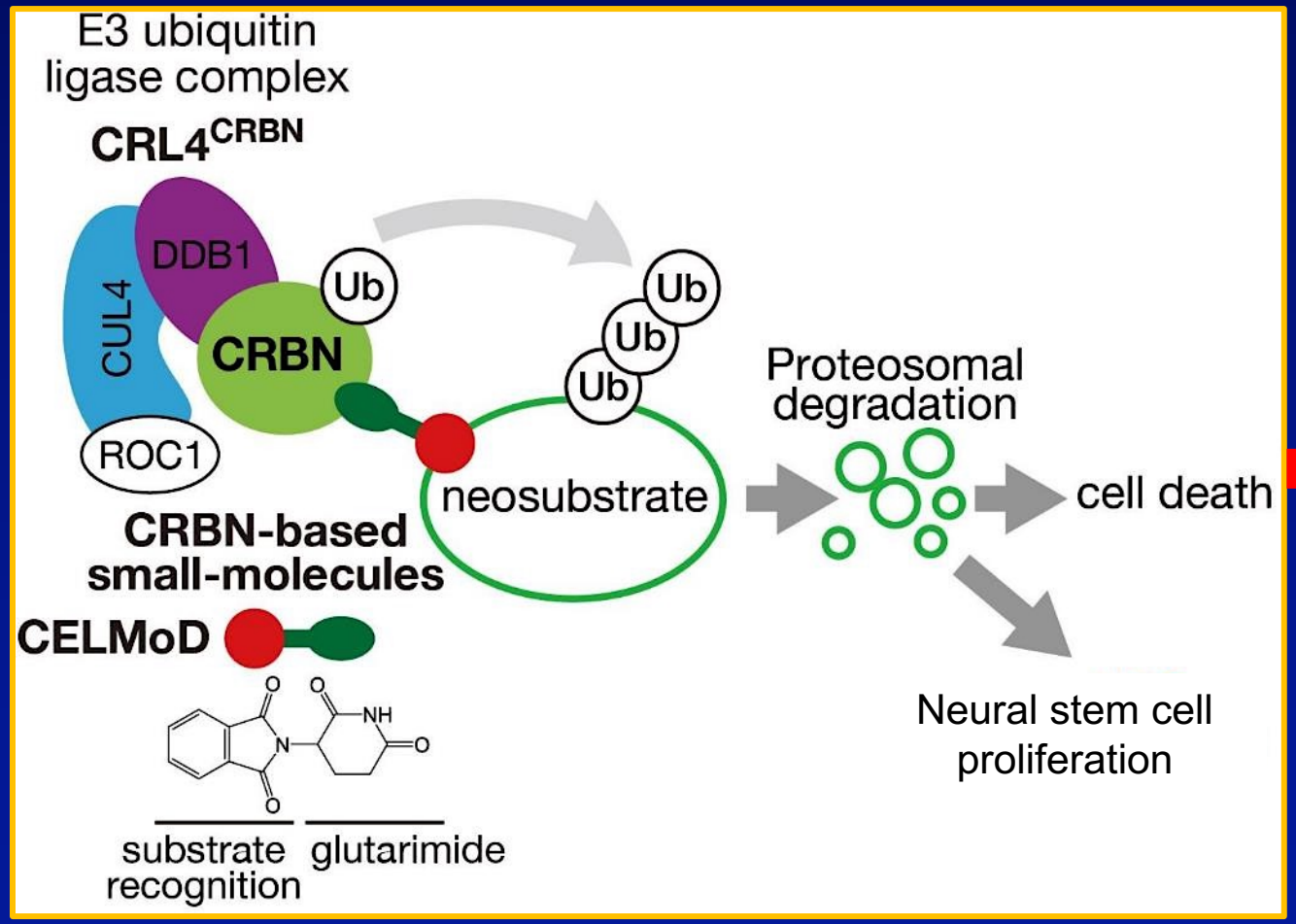


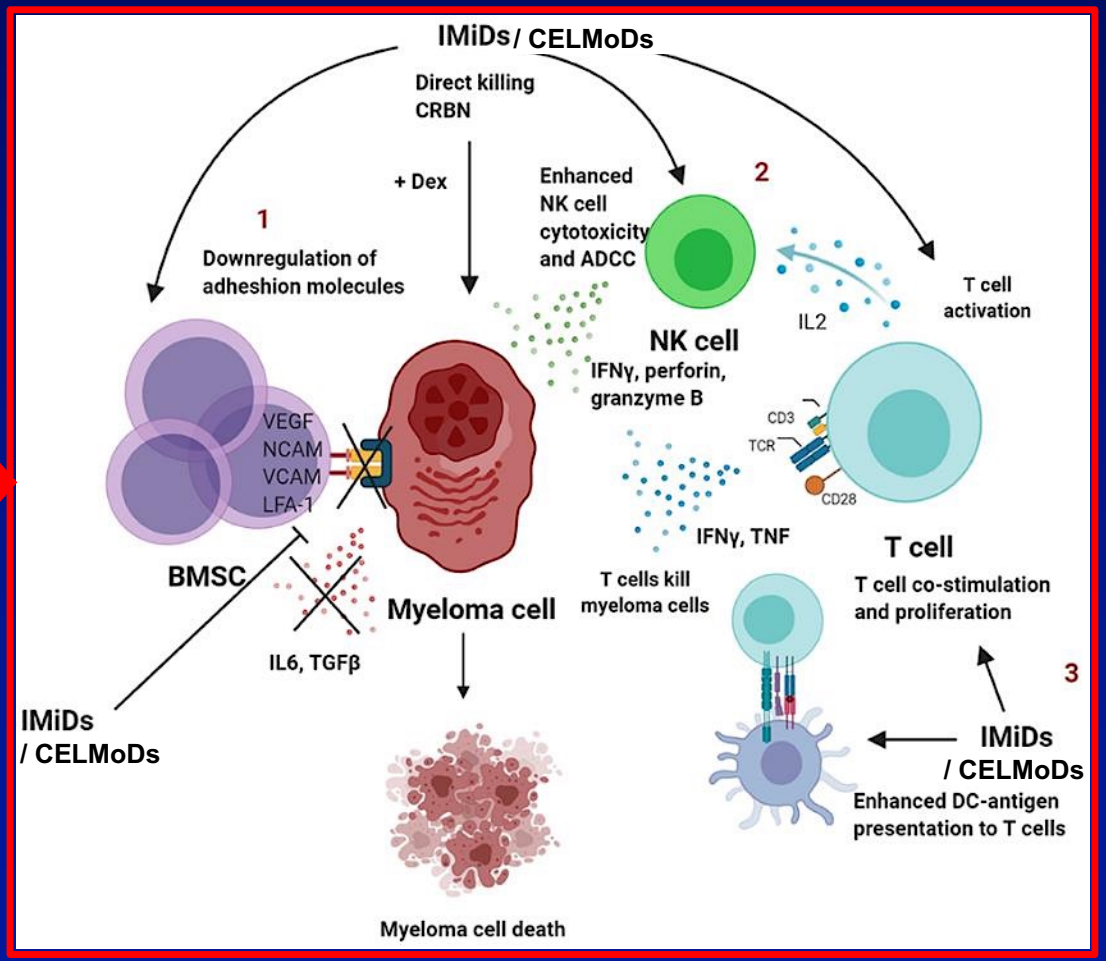
IKZF3 Aiolos

Hartley-Brown MA, et al. Cancers (Basel) 2024;16(6):1166.
Liu Y, et al. Expert Rev Hematol 2024;17(8):445–65

Novel immunomodulators for RRMM

CELMoDs®: iberdomide[1] and mezigdomide[2]





1. Lonial S, et al. Lancet Haematol 2022;9(11):e822–32. 2. Richardson PG, et al. N Engl J Med 2023;389(11):1009–22.
Figures adapted from: (left) Sato T, et al. Front Cell Dev Biol 2021;9:629326; (right) D'Souza C, et al. Front Immunol 2021;12:632399.

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CELMoD doublets for RRMM

Mezigdomide + dex: Phase 1/2 study, N=178

CC-92480-MM-001 first-in-human phase 1 trial: Mezigdomide + Dex

Dose escalation

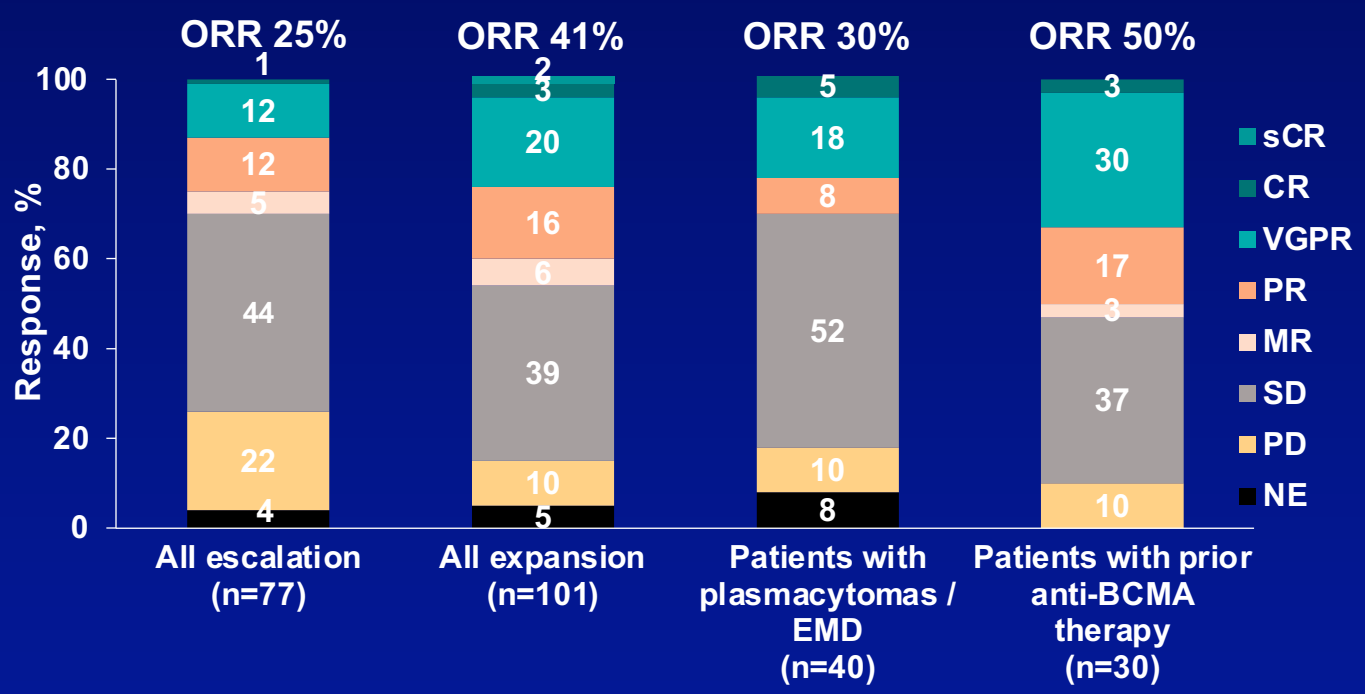
- 77 heavily pretreated RRMM patients
- 30% high-risk cytogenetics, 35% EMD
- Median 6 prior therapies
- 56% triple-class-refractory

Dose expansion at RP2D

- 101 heavily pretreated RRMM patients
- 37% high-risk cytogenetics, 40% EMD
- Median 6 prior therapies
- 100% triple-class-refractory

Efficacy in dose expansion cohort

- Median DOR 7.6 months
- Median PFS 4.4 months
- In patients with prior anti-BCMA therapy, median DOR 6.9 months and median PFS 5.4 months



Safety in dose escalation/expansion cohorts

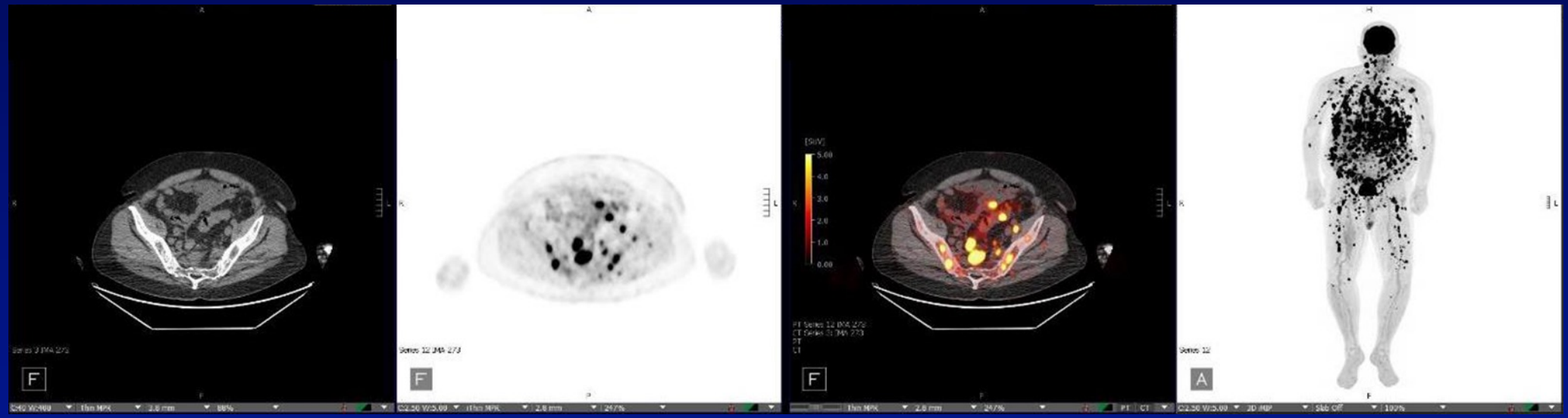
- Grade 3/4 neutropenia 71%/76%, anemia 38%/36%, thrombocytopenia 24%/28%, febrile neutropenia 9%/15%
- Infections 74%/65% (Grade 3/4 40%/35%)
- Treatment discontinuation due to AEs NR/6%

Richardson PG, et al. N Engl J Med 2023;389(11):1009–22.

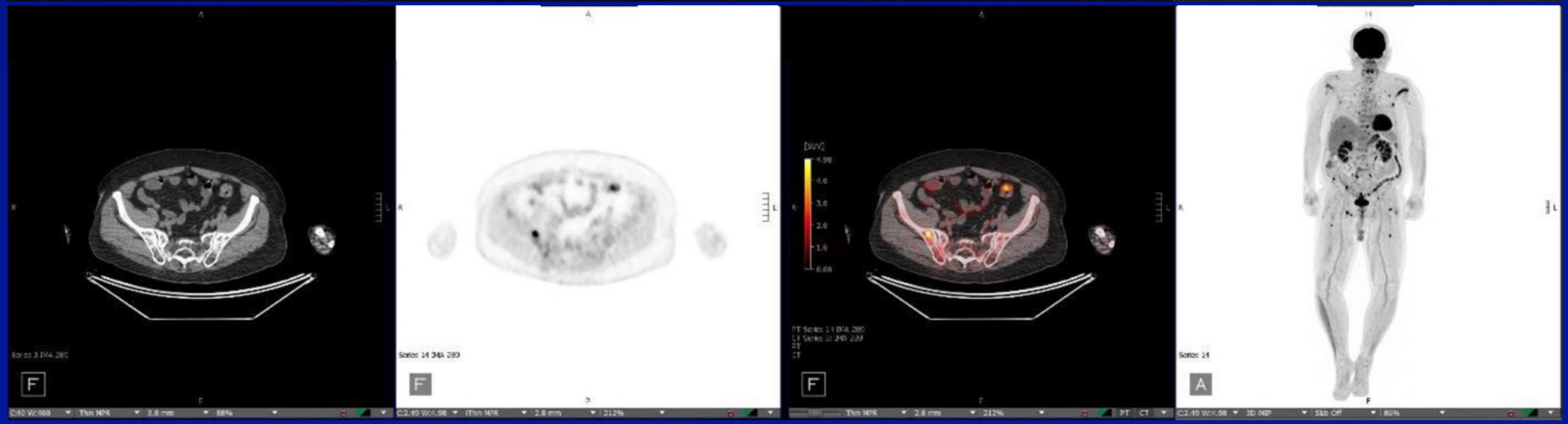
CELMoD doublets for RRMM

Mezigdomide + dex induces responses in patients with EMD

At start of treatment (study entry)



After 4 months of treatment with Mezi 1.0 mg, D1–21 every 28 days, + Dex



Richardson PG, et al. Blood 2022;140(Supplement 1):1366–8. Richardson PG, et al. N Engl J Med 2023;389(11):1009–22.

CELMoD triplets for RRMM

Mezigdomide + Vd or Kd

CC-92480-MM-002 Phase 1/2 Study: Mezigdomide + Vd / Kd[1,2]

Mezigdomide + Vd (N=28)

- 42.9% high-risk cytogenetics
- Median 3 prior therapies
- 82.1% R-refractory
- 50.0% PI-refractory
- 50.0% CD38 mAb-refractory
- Median duration of treatment: 12.5 cycles

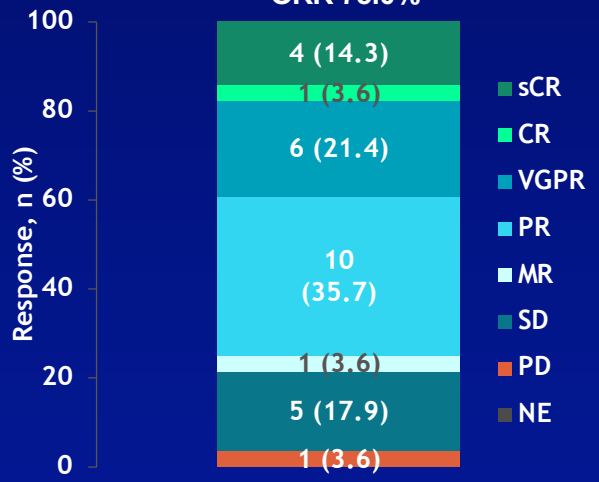
Mezigdomide + Vd 1.0mg (N=38) / 0.6 mg (N=11)

- 53.1% high-risk cytogenetics
- Median 1 prior therapy
- 63.3% R-refractory
- 16.3% PI-refractory
- 34.7% CD38 mAb-refractory
- Median duration of treatment: 15 cycles

Mezigdomide + Kd (N=27)

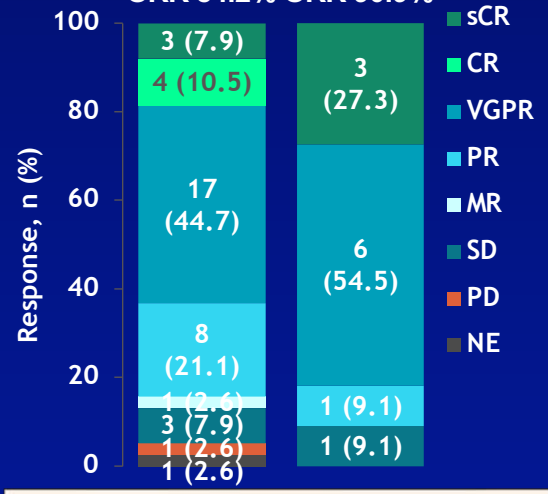
- 59.3% high-risk cytogenetics
- Median 2 prior therapies
- 77.8% R-refractory
- 51.9% PI-refractory
- 74.1% CD38 mAb-refractory
- Median duration of treatment: 12 cycles

Mezigdomide + Vd (N=28, dose escalation)



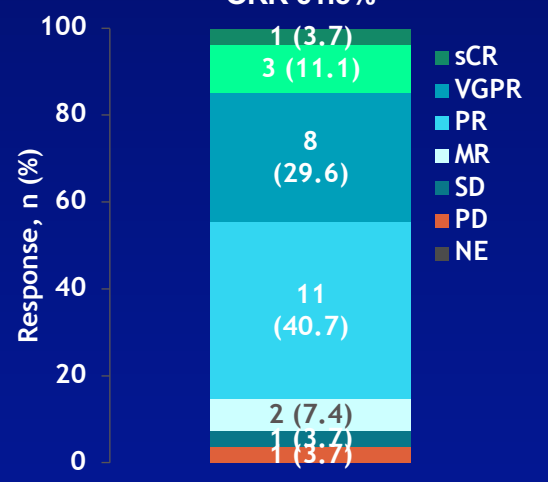
- Median DOR 10.9 months
- Median PFS 11.2–13.4 months
- Grade 3/4 neutropenia 35.7%
- Grade 3/4 thrombocytopenia 21.4%
- Grade 3 anemia 14.3%
- Infections 71.4% (Grade 3/4 17.9%)
- Grade 3/4 pneumonia 10.7%

Mezigdomide + Vd (1.0 mg, N=38 / 0.6 mg, N=11)



- Median DOR 19.4 months
- Median PFS 16.6 / 20.8 months
- Grade 3/4 neutropenia 63.3%
- Grade 3/4 thrombocytopenia 26.5%
- Grade 3 anemia 6.1%
- Infections 79.6% (Grade 3/4 32.7%)
- Grade 3/4 pneumonia 22.4%

Mezigdomide + Kd (N=27)



- Median DOR 11.9 months
- Median PFS 11.7–13.8 months
- Grade 3/4 neutropenia 44.4%
- Grade 3/4 thrombocytopenia 14.8%
- Grade 3/4 anemia 14.8%
- Infections 70.4% (Grade 3/4 33.3%)
- Grade 3/4 pneumonia 3.7%

1. Oriol A, et al. Clin Lymphoma Myeloma Leukemia 2023;23(Suppl 2):S31.
2. Sandhu A, et al. Blood 2024;144(supplement 1):1025.

CELMoD triplets for RRMM

Mezigdomide + Dara-dex or Elo-dex

CC-92480-MM-002 Phase 1/2 Study: Mezigdomide + Dara-dex / Elo-dex[1]

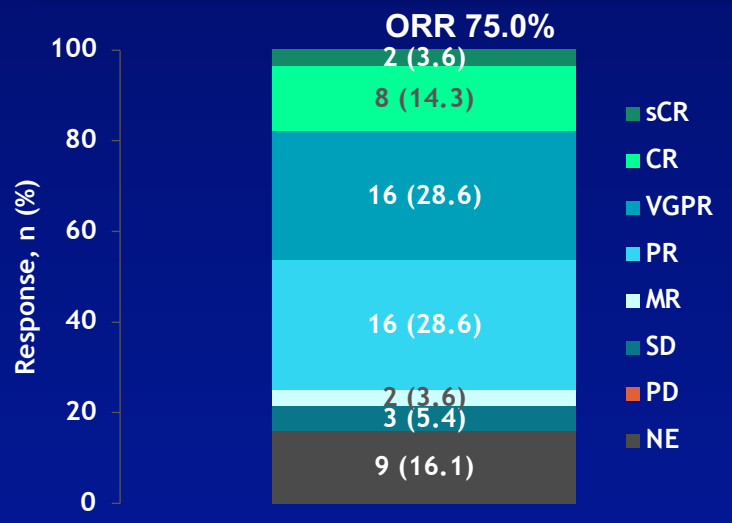
Mezigdomide + Dara-dex (N=56)

- Median age 67 years
- Median time since diagnosis 8.2 years
- Median 2 prior therapies
- 82.5% IMiD-refractory
- 61.4% PI-refractory
- 15.8% prior ASCT
- 8.8% prior CD38 mAb

Mezigdomide + Elo-dex (N=20)

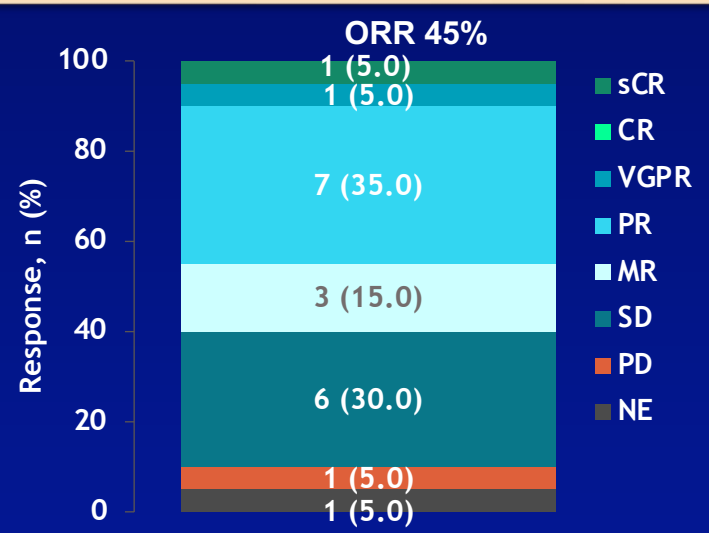
- Median 3 prior therapies
- 85% prior CD38 mAb

Mezigdomide + Dara-dex (N=56)



- DOR / PFS not mature
- Grade 3/4 neutropenia 53.6%
- Grade 3/4 thrombocytopenia 7.1%
- Grade 3/4 anemia 10.7%
- Grade 3/4 infections 19.6%

Mezigdomide + Elo-dex (N=20)



- DOR / PFS not mature
- Grade 3/4 neutropenia 40%
- Grade 3/4 thrombocytopenia 10%
- Grade 3/4 anemia 20%
- Grade 3/4 infections 35%

1. Richardson PG, et al. Blood 2023;142(supplement 1):1013.

CELMoD triplets for RRMM

Mezigdomide-dex + tazemetostat (EZH2 inhibitor) / BMS-986158 (BET inhibitor) / trametinib (MEK inhibitor)

2024

CA057-003 (NCT05372354) Phase 1/2 trial in patients with RRMM

Mezi-dex + Taz (N=16)

- 31.3% high-risk cytogenetics
- Median 5 prior lines
- 68.8% prior T-cell redirecting therapy
- 87.5% CD38 mAb-refractory
- 81.3% triple-class refractory

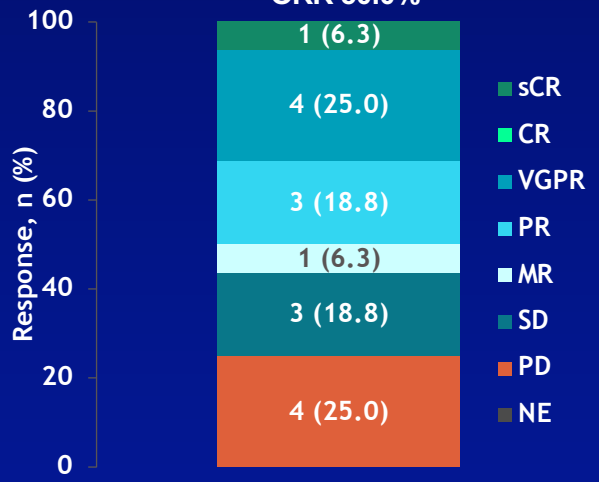
Mezi-dex + BMS-986158 (N=20)

- 30.0% high-risk cytogenetics
- Median 5 prior lines
- 60.0% prior T-cell redirecting therapy
- 85.0% CD38 mAb-refractory
- 75.0% triple-class refractory

Mezi-dex + Tram (N=20)

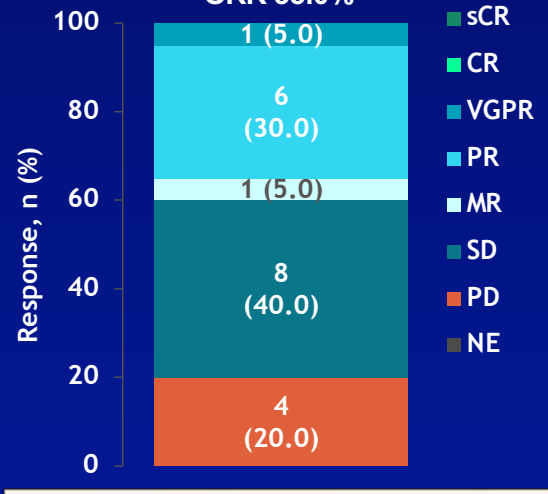
- 15.0% high-risk cytogenetics
- Median 4 prior lines
- 45.0% prior T-cell redirecting therapy
- 90.0% CD38 mAb-refractory
- 90.0% triple-class refractory

Mezi-dex + Taz (N=16, dose escalation)



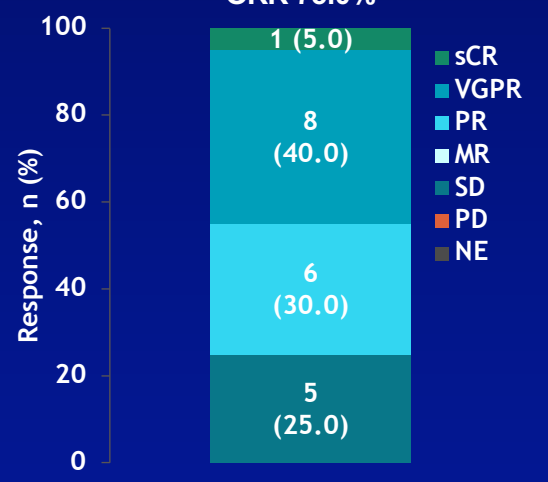
- Median DOR not reached
- Median PFS 6.7 months
- Grade 3/4 neutropenia 50.0%
- Grade 3/4 thrombocytopenia 6.1%
- Grade 3 anemia 12.5%
- Infections 68.8% (Grade 3/4 25.0%)
- Grade 3/4 pneumonia 12.5%

Mezi-dex + BMS-986158 (N=20, dose escalation)



- Median DOR not reached
- Median PFS 4.6 months
- Grade 3/4 neutropenia 65.0%
- Grade 3/4 thrombocytopenia 40.0%
- Grade 3 anemia 35.0%
- Infections 50.0% (Grade 3/4 15.0%)
- Grade 3/4 pneumonia 5.0%

Mezi-dex + Tram (N=20, dose escalation)



- Median DOR 6.5 months
- Median PFS 8.7 months
- Grade 3/4 neutropenia 80.0%
- Grade 3/4 thrombocytopenia 15.0%
- Grade 3/4 anemia 15.0%
- Infections 85.0% (Grade 3/4 25.0%)
- Grade 3/4 pneumonia 5.0%

Costa LJ, et al. Blood 2024;144(supplement 1):677.

THE LANCET Haematology

CELMoD doublets for RRMM + NDMM

Iberdomide + dex

2025 ASCO ANNUAL MEETING

CC-220-MM-001: Iberdomide-dex expansion cohorts[1–4]

Cohort D (N=107)[1,2]

- 29.9% high-risk cytogenetics
- Median 6 prior therapies
- 100% IMiD-refractory
- 97.2% PI-refractory
- 100% CD38 mAb-refractory
- 97.2% triple-class refractory
- Median duration of treatment: 4 cycles

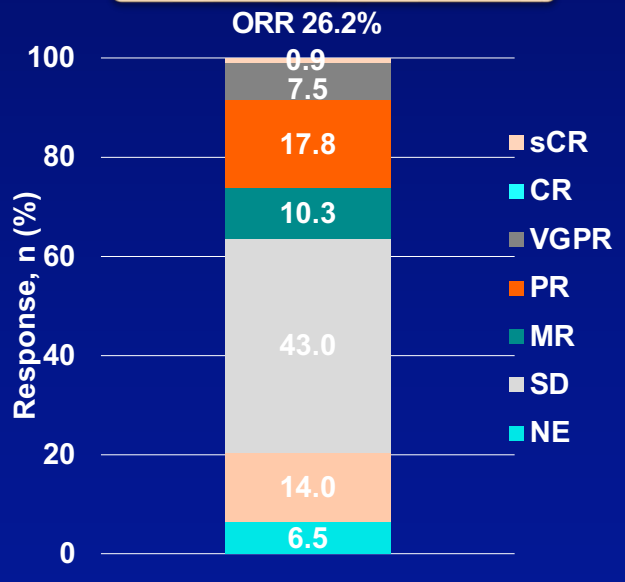
Cohort I (N=38, BCMA-exposed)[3]

- 31.6% high-risk cytogenetics
- Median 7 prior therapies
- 100% triple-class exposed
- 100% exposed to BCMA-targeted therapy: 36.8% prior CAR T cell therapy, 34.2% prior ADC, 23.7% prior T-cell engager
- Median duration of treatment: 3.5 cycles

Cohort J1 (N=18, NDMM)

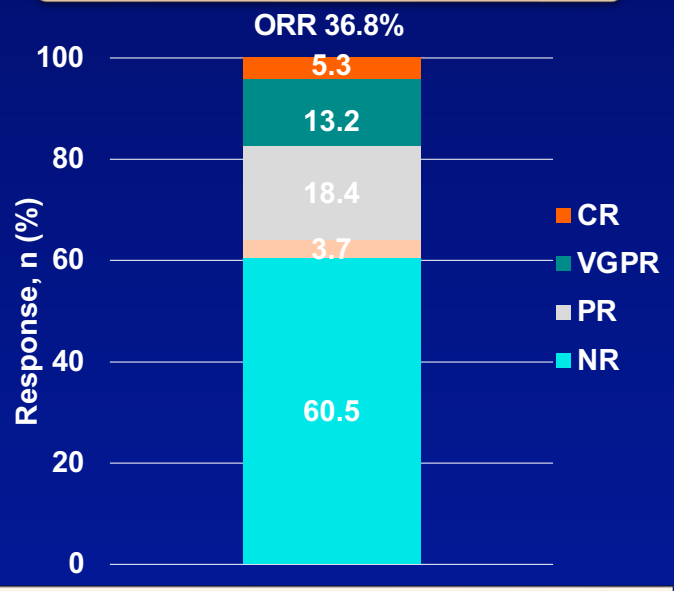
- Median age 77.5 years
- 61% high-risk cytogenetics

Cohort D, Iberdomide-dex (N=107)[1,2]



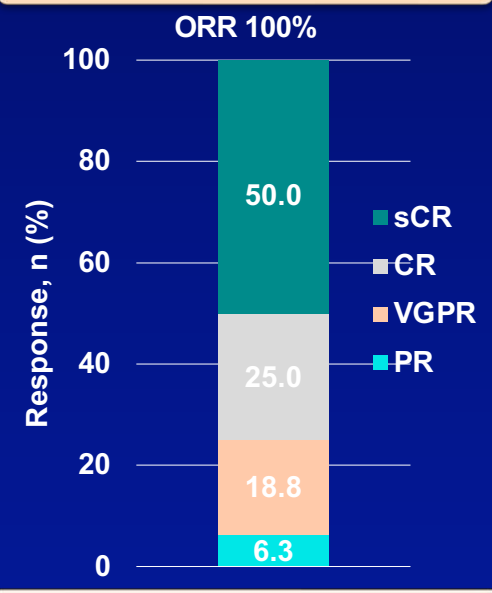
- Median DoR 7.0 months
- Median PFS 3.0 months
- Median OS 10.4 months
- Grade 3/4 neutropenia 25.2/19.6%, anemia 28.0/0%, thrombocytopenia 6.5/15.0%, infections 24.3/2.8% (COVID-19 4.7/1.9%)

Cohort I, Iberdomide-dex (N=38)[3]



- Median DoR 7.5 months
- Median PFS 2.4 months
- Grade 3/4 AEs in 78/9%, including neutropenia 50.0%, anemia 28.9%, leukopenia 23.7%, thrombocytopenia 21.1%, infections 23.7% (pneumonia 21.1%)
- No patients discontinued iberdomide due to AEs

Cohort J1, Iberdomide-Vd (N=18)[4]



- Median follow-up 25 months
- Median DoR NR
- Grade 3/4 AEs in 82%, including infections 47% (pneumonia 18%), neutropenia 29%, PN 12%
- Dose reductions due to AEs 59%

1. Lonial S, et al. Blood 2021;138(suppl 1):abstract 162. 2. Lonial S, et al. Lancet Haematol 2022;9(11):e822–32.
3. Lonial S, et al. Blood 2022;140(suppl 1):abstract 1918. 4. White D, et al. J Clin Oncol 2025;43(16_supplement):7532.

CELMoD triplets for RRMM

Iberdomide + Dara-dex, Vd, or Kd

CC-220-MM-001: Iberdomide + Dara-dex, Vd, or Kd[1]

Iberdomide-Dara-dex (N=43)

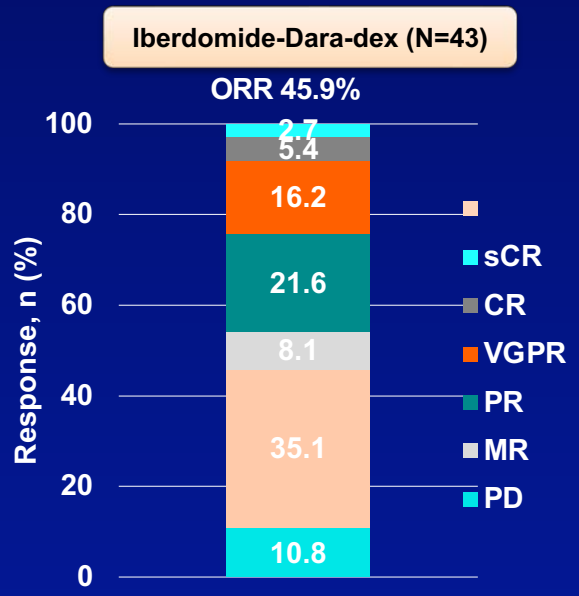
- 16.3% EMD
- Median 4 prior therapies
- 95.3% IMiD-refractory
- 86.0% PI-refractory
- 37.2% CD38 mAb-refractory
- 32.6% triple-class refractory
- Median duration of treatment: 4 cycles

Iberdomide-Vd (N=25)

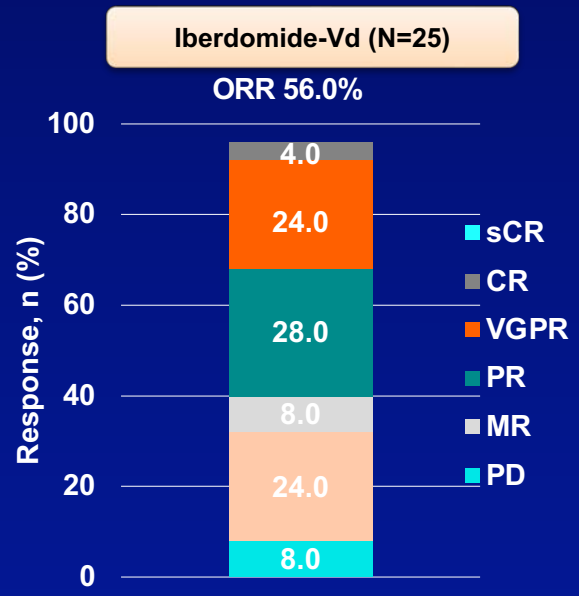
- 16.0% EMD
- Median 5 prior therapies
- 80.0% IMiD-refractory
- 68.0% PI-refractory
- 80.0% CD38 mAb-refractory
- 48.0% triple-class refractory
- Median duration of treatment: 6 cycles

Iberdomide-Kd (N=9)

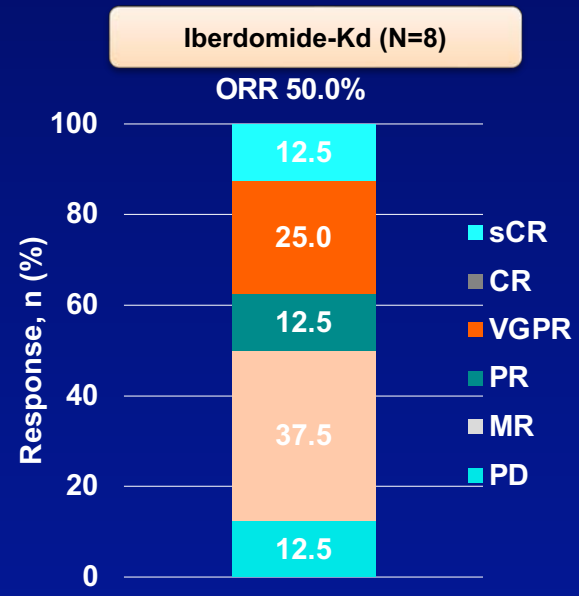
- 22.2% EMD
- Median 6 prior therapies
- 88.9% IMiD-refractory
- 66.7% PI-refractory
- 77.8% CD38 mAb-refractory
- 55.6% triple-class refractory
- Median duration of treatment: 5 cycles



- Median DoR not reached
- Grade 3/4 hematologic AEs: neutropenia 12.8/53.8%, anemia 20.5/0%, thrombocytopenia 7.7/5.1%
- Grade 3 nonhematologic AEs: fatigue 2.6%, diarrhea 2.6%
- Infections 59.0% (grade 3/4: 10.3/5.1%)



- Median DoR 35.7 weeks
- Grade 3/4 hematologic AEs: neutropenia 20/8%, anemia 12/0%, thrombocytopenia 4/20%
- Grade 3 nonhematologic AEs: diarrhea 4%, rash 4%
- Infections 68% (grade 3/4: 16/4%)



- Median DoR not reached
- Grade 3/4 hematologic AEs (N=9): neutropenia 22.2/11.1%, anemia 0%, thrombocytopenia 0/11.1%
- Grade 3 nonhematologic AEs: fatigue 11.1%
- Infections 77.8% (grade 3/4: 22.2/11.1%)

1. Lonial S, et al. HemaSphere 2021;5(S2):49–50, abstract S187.

CELMoD triplets for RRMM

Iberdomide + Ixa-dex or Cy-dex

Iberdomide + Ixa-dex as all-oral 2nd line therapy for RRMM (IFM Phase 2 I2D study)[1]

70 RRMM patients aged >70 years at first relapse

- Median age 76 years (
- 50% with IMWG frailty
- On FISH in evaluable patients, t(4;14)
- Prior R in 87% (74% refractory

Efficacy, median follow-up 12 m

- ORR 64% (VGPR 33%)
- Median PFS 13 months (10 mo R and Dara)
- 12-month OS 85%

Safety

- Grade 3/4 neutropenia 46%, thr
- Infections 30% (grade 3/4 8%)
- PN 20%
- Diarrhea 19%
- Discontinuation due to severe AE, n = 4

2025 ASCO ANNUAL MEETING

MagnetisMM-30: Elranatamab + iberdomide in RRMM

- Phase 1b, open-label, prospective study (NCT06215118)
  - Dose-escalation and dose-optimization study, up to 36 and 60 patients, respectively
  - Patients with RRMM following 2–4 and 1–3 prior lines of therapy, respectively, and refractory to last line
  - All patients must have received prior IMiD and PI
- Primary endpoint: DLTs and AEs
  - Secondary endpoints: ORR, CRR, time-to-event outcomes, PK, MRD-neg rate, immunogenicity

Lesokhin A, et al. J Clin Oncol 2025;43(16_supplement):TPS7566.

Iberdomide + Cy-dex in RRMM (Phase 2 ICON study)[2]

61 RRMM patients after 2–4 prior lines

- Median age 67 years (range 46–81); 30% high-risk cytogenetics
- osed (52% refractory); 85% CD38)

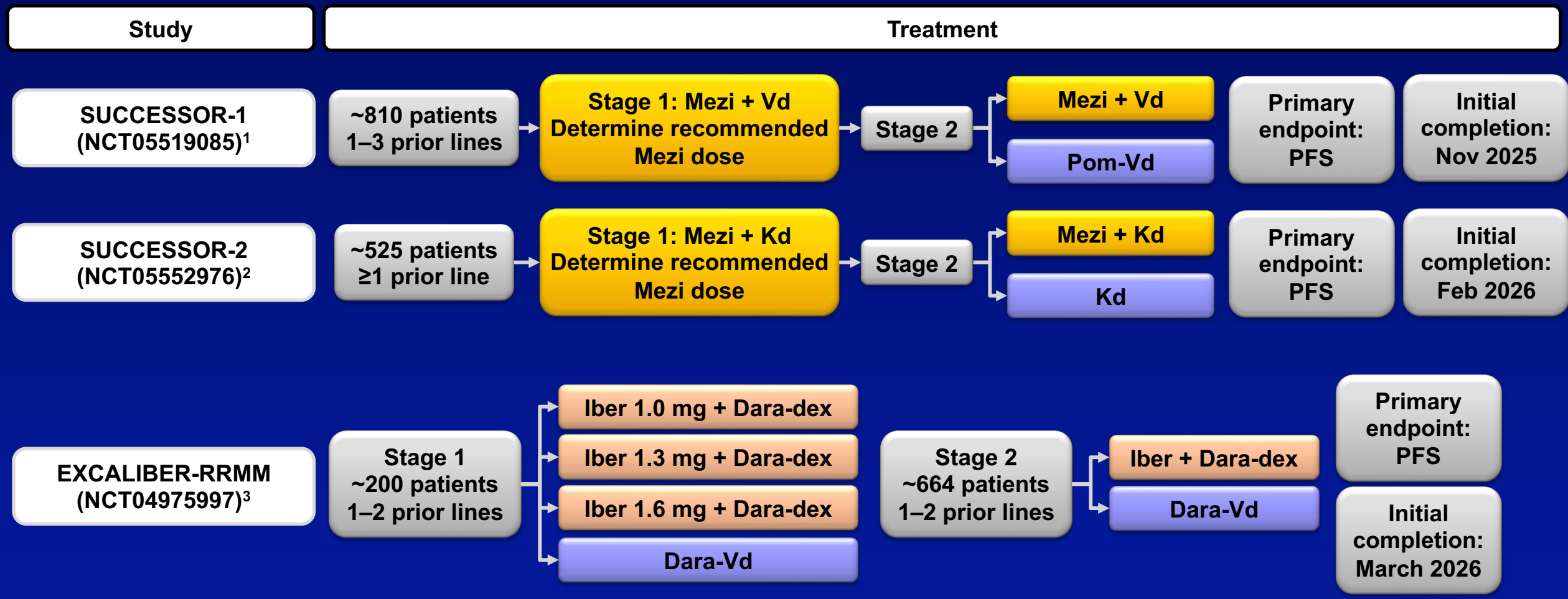
4 months

- 6 and 17.8 months in patients erapy, respectively; 16.6 months nts)

- penia, 33% infections, 11% thrombocytopenia, 10% anemia, 3% fatigue, 2% TE events
- Grade 3 polyneuropathy in 2 patients with pre-existing grade 1 neuropathy

1. Touzeau C, et al. HemaSphere 2024;8(S1):1621–2. 2. Korst CLBM, et al. HemaSphere 2024;8(S1):1589–90.

Phase 3 studies of CELMoD triplets in RRMM



1. Richardson PG, et al. Clin Lymphoma Myeloma Leuk 2023;23(Supplement 1):S495–6, abstract MM-372.
2. Richardson PG, et al. J Clin Oncol 2023;41(16_suppl):abstract TPS8070.
3. Lonial S, et al. Future Oncol 2025; doi: 10.1080/14796694.2025.2501920.

Conclusions and Future Directions

Belantamab mafodotin re-emerging as potential treatment option for RRMM

- Positive findings from two phase 3 trials of belantamab mafodotin in RRMM[1,2] suggesting new possible opportunities for belantamab mafodotin-based regimens in this setting
- Under review for re-approval at the US FDA, EU EMA, and elsewhere
- Novel triplet and quadruplet combinations demonstrating substantial efficacy in RRMM
- Challenges include management of ocular toxicity and integration with other BCMA-targeted T-cell engaging therapies in the RRMM treatment algorithm[3]
- Building on belantamab mafodotin: next-generation ADCs with novel targets also emerging

Phase 2 studies and ongoing Phase 3 trials of CELMoDs – Mezigdomide and Iberdomide – in RRMM

- Encouraging activity of Mezigdomide[4] and Iberdomide[5] in heavily pretreated RRMM with numerous partner drugs/drug classes – addressing an urgent unmet medical need
- Multiple CELMoD combination strategies currently under investigation in RRMM – e.g. SUCCESSOR-1, SUCCESSOR-2, EXCALIBER
- Oral agents with potential to enhance activity of immune-based therapy and ease of real-world application[6]
- Importance of optimizing use and treatment sequencing of CELMoDs in the context of immune therapies, with studies ongoing

Increasingly busy novel therapeutic landscape

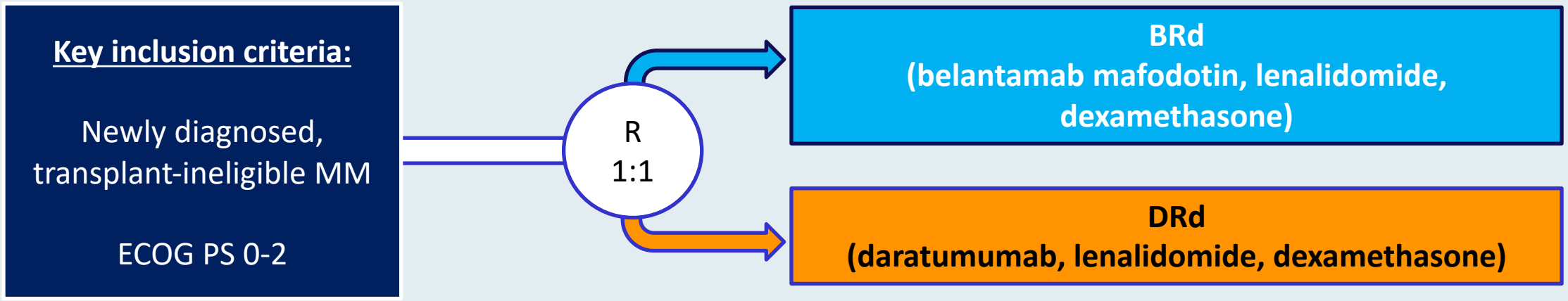
- Large number of novel therapies and potential targets resulting in an increasingly busy landscape
- Development of novel therapies within the context of huge progress with immunotherapies (CAR Ts, BsAbs)[7,8]
- Challenging fiscal environment
- Importance of optimizing the use of all available and emerging treatment options and novel targets to improve patient outcome – critical importance of patient subgroups, and immune exhaustion making small molecular approaches additionally important

1. Hungria V, et al. N Engl J Med 2024;391(5):393–407. 2. Dimopoulos MA, et al. N Engl J Med 2024;391(5):408–21. 3. Rees MJ, Kumar S. Leuk Lymphoma 2024;65(3):287–300.
4. Richardson PG, et al. N Engl J Med 2023;389(11):1009–22. 5. Lonial S, et al. Lancet Haematol 2022;9(11):e822–32. 6. Liu Y, et al. Exp Rev Hematol 2024;17(8):445–65.
7. Rodriguez-Otero P, et al. Lancet Oncol 2024;25(5):e205–16. 8. Martino M, et al. Expert Rev Hematol 2024;17(7):375–90.

Appendix

DREAMM-10 Trial: Phase III Study of Belantamab Mafodotin with Lenalidomide and Dexamethasone (BRd) versus Daratumumab with Lenalidomide and Dexamethasone (DRd) in Transplant-Ineligible Newly Diagnosed MM

Trial identifier: NCT06679101
Estimated enrollment: 520



Lonial S et al. ASCO 2025;Abstract TPS7567; www.clinicaltrials.gov. NCT06679101. Accessed May 2025.

Agenda

Introduction: ASCO 2025 Showstoppers

Module 1: Up-Front Treatment of Multiple Myeloma (MM) – Survey Questions

Module 2: Emerging Novel Therapies for Relapsed/Refractory (R/R) MM – Faculty Presentation

Module 3: Emerging Novel Therapies for R/R MM – Survey Questions

Module 4: Current Management of R/R MM – Faculty Presentation

Module 5: Current Management of R/R MM – Survey Questions

Module 6: ASCO and EHA 2025

Questions from General Medical Oncologists — Belantamab Mafodotin

- I need an update on the trials, I know nothing
- Would like to learn
- Do you see belantamab being used as part of first-line treatment in the future?

Questions from General Medical Oncologists — Belantamab Mafodotin

- **Based on the latest Phase III data, in what clinical scenarios would belantamab mafodotin in combination therapy be preferable to bispecific antibodies in relapsed/refractory settings?**
- **Which is the best partner for belantamab and which is the best dosing schedule?**
- **How are you planning to space belamaf doses once it's approved – DREAMM-8 protocol and beyond?**

Questions from General Medical Oncologists — Belantamab Mafodotin

- How do community providers manage the occular toxicities of belantamab when local ophthalmologists have limited experience dealing with these side effects?
- I am only informed because my wife is an ophthalmologist, but in general how often is screening done and can an optometrist do it?

Questions from General Medical Oncologists — Belantamab Mafodotin

- In practice, it is very difficult to get patients to do their ocular screenings — how do investigators get their patients (not on trial, where there is a lot of support) to the eye specialist and communicate what needs to be done to clear for therapy? The eye specialist has no knowledge of the therapy, and communication is very challenging between providers because it goes through multiple levels of phone trees and providers.
- Would you be comfortable giving belantamab if you did not have rapid access to optho?

Questions from General Medical Oncologists — CELMoDs

- **What do you see as the future role of iberdomide and mezigdomide? How do they differ from lenalidomide and pomalidomide?**

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Module 5: Current Management of R/R MM – Survey Questions

Module 6: ASCO and EHA 2025

RTP RESEARCH TO PRACTICE

Current Management of Relapsed/Refractory (R/R) Multiple Myeloma (MM)

Ajay K Nooka, MD, MPH
Professor, Department of Hematology and Medical Oncology
Director, Myeloma Program
Associate Director of Clinical Research
Winship Cancer Institute
Emory University School of Medicine
Atlanta, Georgia

Research database documenting the effectiveness of idecabtagene vicleucel (ide-cel) and ciltacabtagene autoleucel (cilta-cel) in patients with heavily pretreated MM

- Chimeric antigen receptor T-cell (CAR-T) therapies, idecabtagene vicleucel (IC) and ciltacabtagene autoleucel (CC) are approved for specific indications in RRMM patients.
- Comparative real-world (RW) efficacy data are limited.
- Evaluated overall survival (OS) and time to next treatment (TTNT) for IC versus CC in a RW setting using the TriNetX, a global RW data platform, providing insights to inform therapeutic decision-making.
- Adult RRMM pts (ICD-10 code C90.0) treated with IC (n=485) or CC (n=392) between 2021 and 2024 were included in analysis.

Khan E, Ilyas R, Jin M, Ramesh N, Mewawalla P, Sadashiv S, et al. Comparative efficacy of idecabtagene vicleucel and ciltacabtagene autoleucel in relapsed/refractory multiple myeloma: Real-world analysis of overall survival and time to next treatment. Journal of Clinical Oncology. 2025;43(16_suppl):e19532-e.

Propensity score matching with 37 variables (demographic, patient and disease characteristics) balanced cohorts

Characteristic	Ide-cel (IC) (252)	Cilta-cel (CC) (252)	P-value
Age at CAR-T (mean +/-SD yrs)	65.3 +/-9.4	65.2 +/-9.5	0.94
Female vs Male (%)	42 vs 58	44 vs 56	0.65
White and African American race (%)	76 vs 15	76 vs 17	1.0/0.46
Bortezomib/Carfilzomib/Ixazomib (%)	37/28/8	38/30/8	0.93/0.62/0.87
Lenalidomide/Pomalidomide/Thalidomide (%)	50/44/8	51/45/7	0.72/0.86/0.50
Daratumumab/Isatuximab/Elotuzumab (%)	36/4/6	36/4/6	0.85/1.0/0.71
Belantamab/Teclistamab/Talquetamab (%)	4/4/4	4/4/4	1.0/1.0/1.0
Elevated LDH (>220U; %)	75	75	0.92
Albumin ≥3.5 g/dL/ β2-microglobulin ≥5.5 mg/L	95/15	95/15	0.69/1.0

Khan E, Ilyas R, Jin M, Ramesh N, Mewawalla P, Sadashiv S, et al. Comparative efficacy of idecabtagene vicleucel and ciltacabtagene autoleucel in relapsed/refractory multiple myeloma: Real-world analysis of overall survival and time to next treatment. Journal of Clinical Oncology. 2025;43(16_suppl):e19532-e.

- Median follow up (f/u) was 14.2 months for IC and 8.5 months for CC.
- Median OS was not reached (NR) in either group.
  - 48 patients in IC and 32 patients in CC died during f/u.
  - Estimated 2-year survival probabilities IC vs CC: 77% vs 73% (HR: 1.051; 95% CI: 0.636–1.734; p=0.847).
- Median TTNT was 17.7 months for IC and NR for CC.
  - 118 pts in IC and 58 pts in CC had a TTNT event.
  - At 2 years, TTNT probabilities IC vs CC: 36% vs 52% (P<0.0001; HR for CC vs IC: 0.60; 95% CI: 0.44-0.83).
- In this RW analysis, CC showed improved durability in delaying subsequent therapy compared to IC.
- This advantage did not translate into improved OS, likely from shorter follow-up period.
- Differences in follow-up duration and RW data limitations, including potential missing data, may have influenced outcomes.

Khan E, Ilyas R, Jin M, Ramesh N, Mewawalla P, Sadashiv S, et al. Comparative efficacy of idecabtagene vicleucel and ciltacabtagene autoleucel in relapsed/refractory multiple myeloma: Real-world analysis of overall survival and time to next treatment. Journal of Clinical Oncology. 2025;43(16_suppl):e19532-e.

Ide-cel in MM: Real world vs. Trial Data

	CIBMTR[1] N=821	US RWE[2] N=159	KarMMa[3] N=128
CRS - Any grade Grade 3 or higher	80% 3%	82% 3%	84% 5%
ICANS– Any grade Grade 3 or higher	28% 5%	18% 6%	18% 3%
Overall response rate	73%	84%	73%
Very good partial response rate	56%	62%	52%
Complete response rate	25%	42%	33%
Progression free survival, median	9.0 months	8.5 months	8.8 months
Median follow-up	11.6 months	6.1 months	13.3 months

- Real world data: Most patients would not have met trial eligibility criteria
- 75% in the multi-center US MM consortium study did not meet eligibility criteria
- CIBMTR study: 77% had significant comorbidities

Cilta-cel in MM: Real world vs. Trial Data

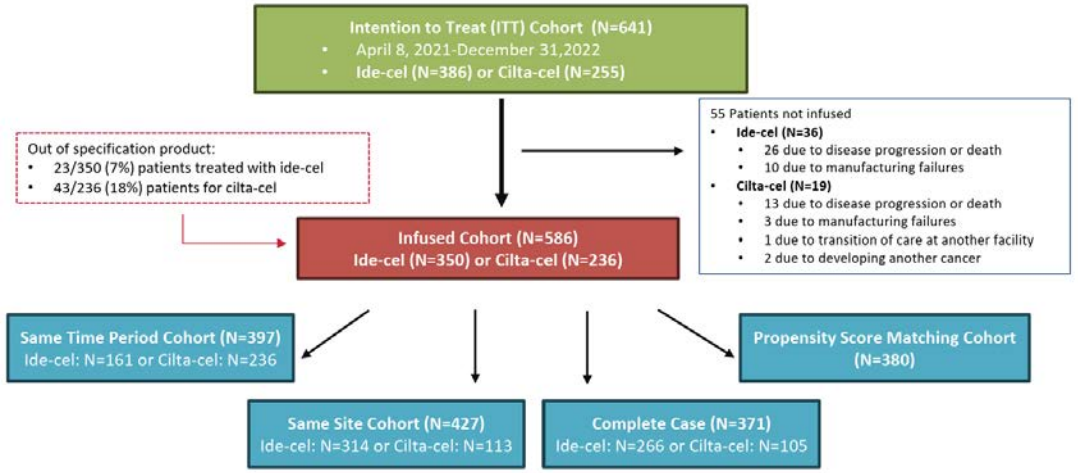
	US RWE[1] N=236	CARTITUDE-1 [2-4] N=97
CRS - Any grade; grade ≥ 3	75%; 5%	95%; 4%
ICANS– Any grade; grade ≥ 3	14%; 4%	17%; 2%
Delayed neurotoxicity Parkinsonism Cranial nerve palsy	10% 2% 5%	12% 6% -
Non-relapse mortality	10%	6%**
Second primary malignancy	8.5%*	1 y: 7%; 2 y:16.5%
Overall response rate	89%#	98%
Complete response rate	70%#	83%
Progression free survival	1 year: 68%#	1 year : 77%[2]; Median: 34.9 m[4]

#ORR, CR rate and PFS: higher in patients receiving conforming products

*SPM excluding non-melanoma skin cancer: 13 (5.5%); Myeloid neoplasm/acute leukemia: 3 (1.3%); T cell lymphoma: 1. **NRM in CARTITUDE-1:16 deaths due to reasons other than progression. Only 6 of 16 deaths non-myeloma related deaths attributed to cilta-cel per investigator assessment (6%).

1. Sidana et al. Blood. 2025;145(1):85-97; 2. Berdeja et al. Lancet 398:314-324, 2021. 3. Martin et al. J Clin Oncol 41:1265-1274, 2023. 4. Lin et al ASCO 2023

Ide-cel vs Cilta-cel: Retrospective, ≥ 4 LOT



Hansen et al. J Clin Oncol. 2025

Safety and Response

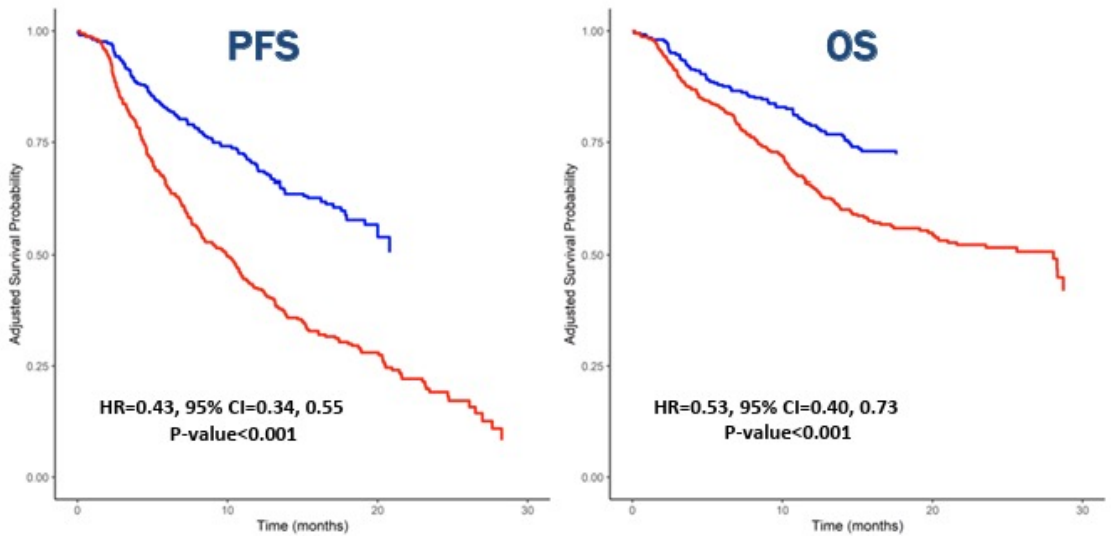
	Ide-cel		Cilta-cel		
Outcomes	**n (%)**	**OR (95% CI)**	**n (%)**	**OR (95% CI)**	**P**
Safety					
Any CRS	294 (84)	1.00 (Referent)	176 (75)	0.69 (0.45, 1.08)	0.10
Severe CRS (≥ Grade 3)	6 (2)	1.00 (Referent)	12 (5)	6.80 (2.28, 20.33)	**<0.001**
Any ICANS	72 (22)	1.00 (Referent)	30 (14)	0.82 (0.49, 1.37)	0.4
Severe ICANS (≥ Grade 3)	14 (4)	1.00 (Referent)	8 (4)	1.54 (0.53, 4.48)	0.4
Delayed neurotoxicity	2 (0.6)	1.00 (Referent)	24 (10)	20.07 (4.46, 90.20)	**<0.001**
Infections	122 (35)	1.00 (Referent)	112 (47)	2.03 (1.41, 2.92)	**<0.001**
Second Malignancies (SPM)	18 (5)	1.00 (Referent)	20 (9)	1.77 (0.89, 3.56)	0.11
SPM: MDS, AML, lymphoma	6 (2)	1.00 (Referent)	4 (2)	0.94 (0.26, 3.47)	>0.9
Severe cytopenia, day 30	199 (58)	1.00 (Referent)	111 (50)	0.97 (0.68, 1.39)	0.9
Severe cytopenia, day 90	92 (31)	1.00 (Referent)	41 (25)	0.92 (0.61, 1.38)	0.7
Response					
Best ORR (≥ PR)	275 (79)	1.00 (Referent)	205 (89)	1.60 (0.90, 2.83)	0.11
Best CR or better	165 (47)	1.00 (Referent)	161 (70)	2.42 (1.63, 3.60)	**<0.001**

Models were fitted using IPTW weights

Hansen et al. J Clin Oncol. 2025

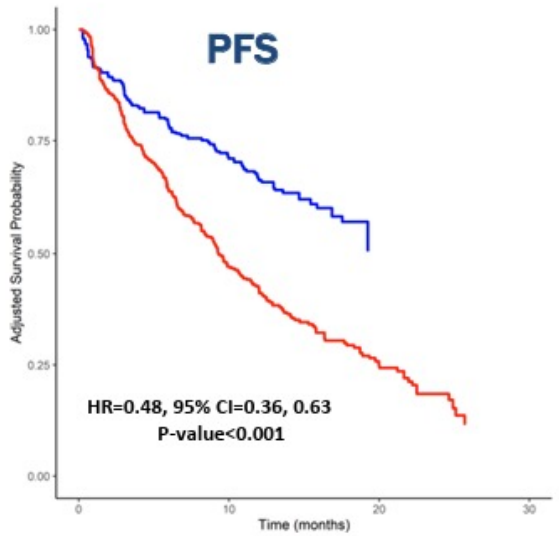
Cilta-cel vs Ide-cel: PFS and OS

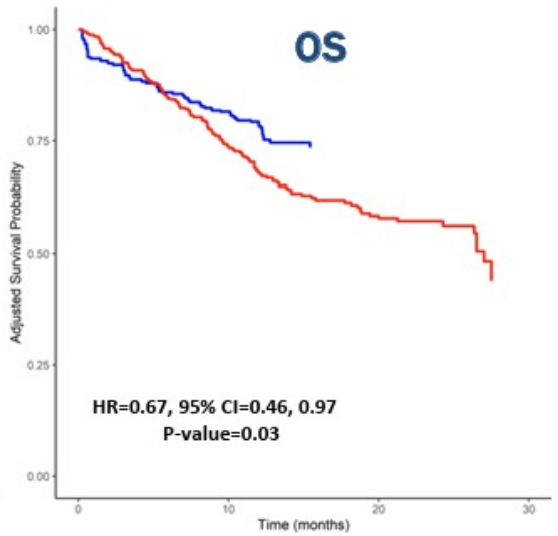
Intention to Treat Cohort (ITT)



CAR-T Type — Cilta-cel — Ide-cel

Infused Cohort





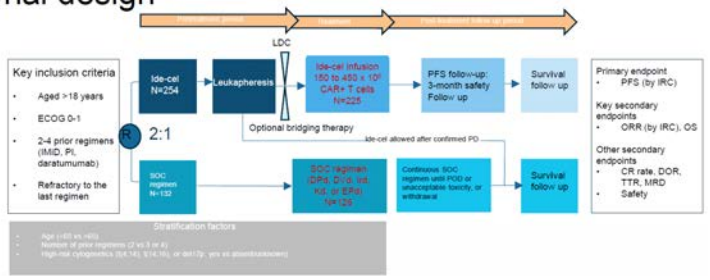
CAR-T Type — Cilta-cel — Ide-cel

Hansen et al. J Clin Oncol. 2025

Published data from the Phase III KarMMa-3 and CARTITUDE-4 trials of ide-cel and cilta-cel, respectively, in earlier lines of treatment; recently presented overall survival findings from CARTITUDE-4

KarMMa-3: Ide-cel vs SOC After 2-4 Lines

Trial design



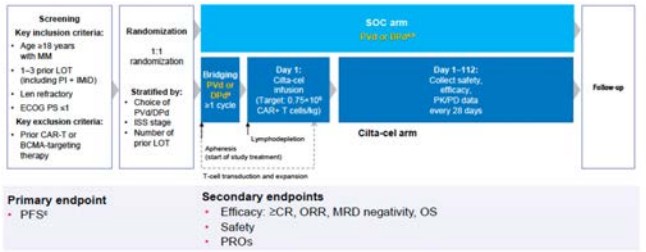
Baseline characteristics

Median age	63 yrs
Median time since diagnosis	4.1 yrs
Median prior therapies	N=3
Triple-class refractoriness	66%
Daratumumab refractoriness	95%
High-risk cytogenetics	44%

Phase 3 KarMMa-3 study compared ide-cel vs SOC in R/R patients MM after 2-4 prior lines

CARTITUDE-4: Cilta-cel vs DPd/PVd After 1-3 Lines

Trial design



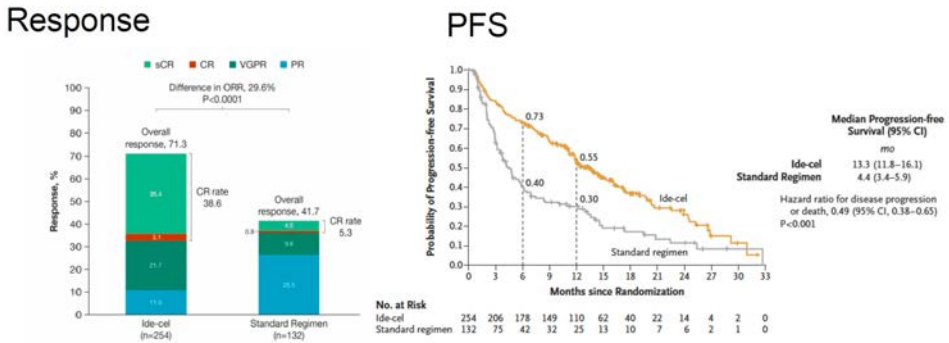
Baseline characteristics

Median age	61.5 yrs
Median time since diagnosis	3 yrs
Median prior therapies	N=2
Triple-class refractoriness	14.4%
Daratumumab refractoriness	23.1%
High-risk cytogenetics	59.4%

Phase 3 CARTITUDE-4 compared cilta-cel vs SOC in R/R patients MM after 1-3 prior lines

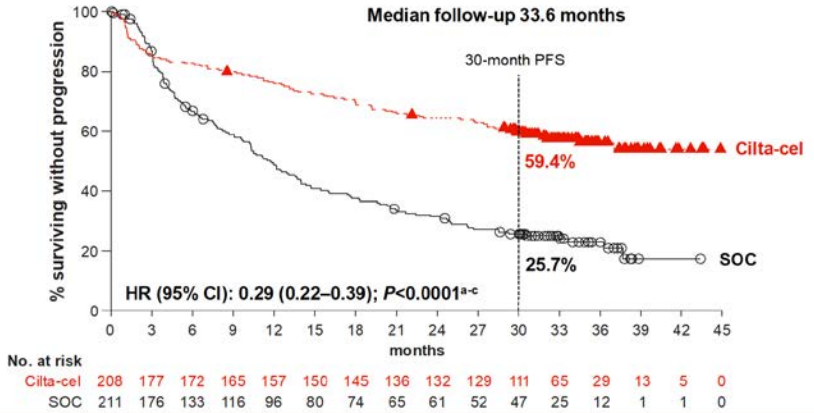
Sidana S, Martinez-Lopez J, Khan AM, Oriol A, Spencer A, Dhakal B, et al. Ciltacabtagene autoleucel (cilta-cel) vs standard of care (SOC) in patients (pts) with relapsed/refractory multiple myeloma (MM): CARTITUDE-4 survival subgroup analyses. Journal of Clinical Oncology. 2025;43(16_suppl):7539-.

KarMMa-3: Response and PFS



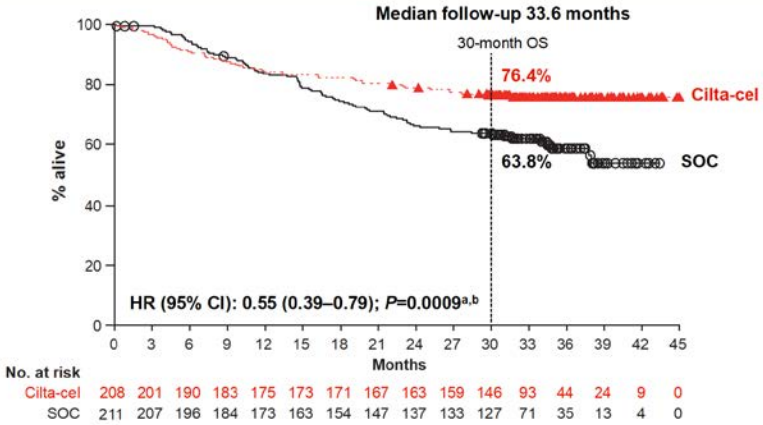
Phase 3 KarMMa-3 study compared ide-cel vs SOC in R/R patients MM after 2-4 prior lines

Long-Term CARTITUDE-4 Update (34 Months): Cilta-cel Maintained Significant Improvement in Progression-Free Survival



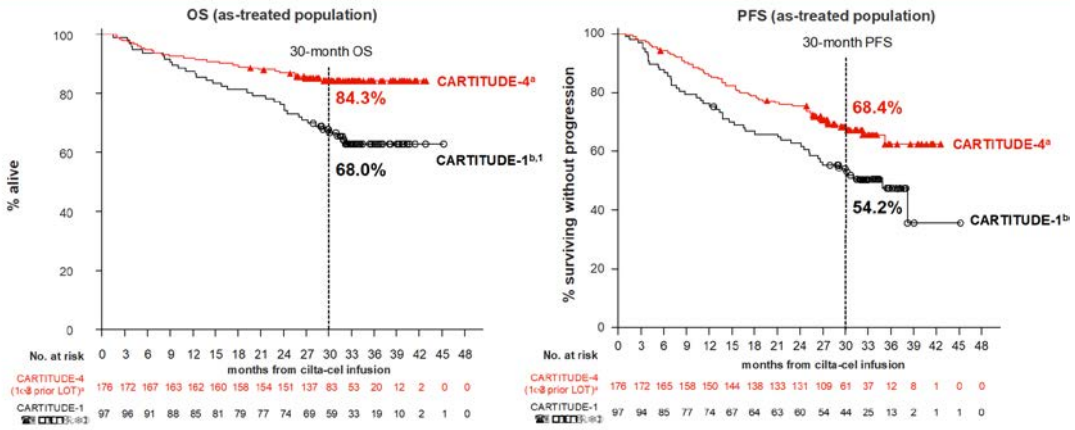
~70% reduction in the risk of progression or death in patients who received cilta-cel and mPFS has not been reached

Long-Term CARTITUDE-4 Update (34 Months): Cilta-cel Significantly Improved Overall Survival



First CAR-T to demonstrate overall survival benefit in multiple myeloma

Long-Term CARTITUDE-4 Update (34 Months): Numerically Higher Overall and Progression-Free Survival Rates Versus CARTITU



Cilta-cel use in earlier lines demonstrated numerically higher rates of overall and progression-free survival

Sidana S, Martinez-Lopez J, Khan AM, Oriol A, Spencer A, Dhakal B, et al. Ciltacabtagene autoleucel (cilta-cel) vs standard of care (SOC) in patients (pts) with relapsed/refractory multiple myeloma (MM): CARTITUDE-4 survival subgroup analyses. Journal of Clinical Oncology. 2025;43(16_suppl):7539-.

At a median follow-up was 33.6 months, the PFS and OS benefit of cilta-cel over SOC in the ITT analysis was consistent across pts with standard-risk cytogenetics and high-risk cytogenetics, defined as del(17p), t(4;14), t(14;16), or gain/amp(1q)

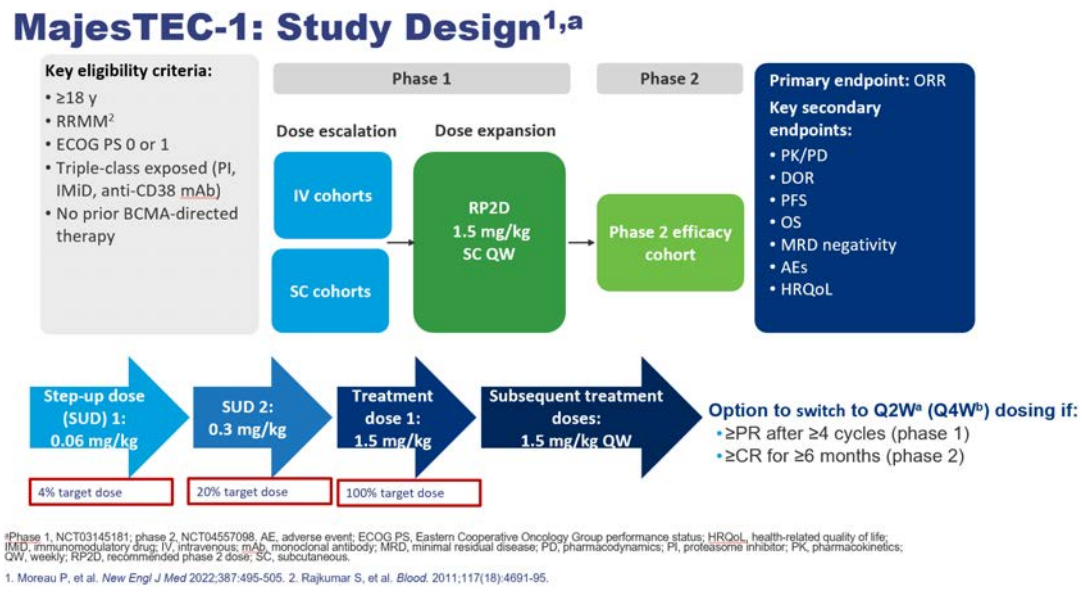
Cilta-cel, n	SOC, n	Median PFS cilta-cel, mo	Median PFS SOC, mo	HR (95% CI)	Median OS cilta-cel, mo	Median OS SOC, mo	HR (95% CI)
Standard-risk cytogenetics	69	70	NR	21	0.43 (0.26–0.72)	NR	NR
High-risk cytogenetics[a]	123	132	37	10	0.38 (0.27–0.52)	NR	38
del(17p)	49	43	30	9	0.40 (0.24–0.68)	NR	NR
t(4;14)	30	30	37	7	0.34 (0.17–0.68)	NR	27
gain/amp(1q)	89	107	37	10	0.39 (0.27–0.57)	NR	38
≥2 cytogenetic abnormalities[a]	43	49	30	7	0.43 (0.25–0.73)	NR	23

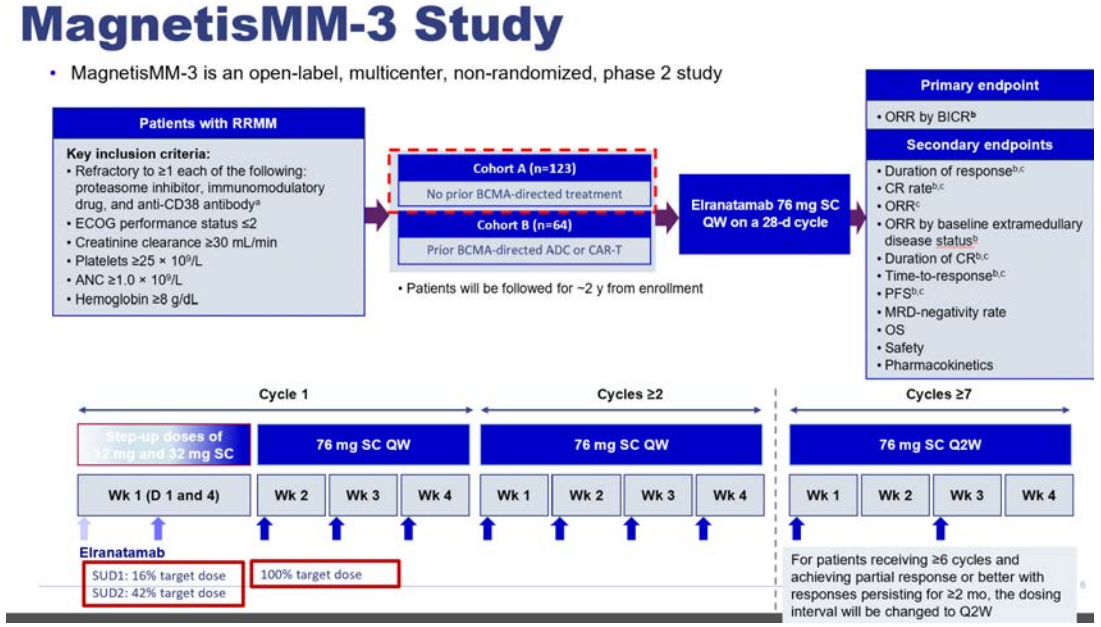
Sidana S, Martinez-Lopez J, Khan AM, Oriol A, Spencer A, Dhakal B, et al. Ciltacabtagene autoleucel (cilta-cel) vs standard of care (SOC) in patients (pts) with relapsed/refractory multiple myeloma (MM): CARTITUDE-4 survival subgroup analyses. Journal of Clinical Oncology. 2025;43(16_suppl):7539-.

- Comparing cilta-cel (n=21) vs SOC (n=18) in pts with extramedullary disease (EMD)
  - median PFS was 13 mo vs 4 mo (HR, 0.71 [95% CI, 0.34–1.49])
  - median OS was not reached (NR) vs 16 mo (HR, 0.61 [95% CI, 0.26–1.47])
- Comparing cilta-cel vs SOC by prior LOT
  - median PFS for 1 pLOT [Ciltacel (N=68) vs SOC (N=68)]: NR vs 17 mo (HR, 0.41 [95% CI, 0.25–0.67]), median OS NR vs NR
  - median PFS for 2 pLOT [Ciltacel (N=83) vs SOC (N=87)]: NR vs 12 mo (HR, 0.30 [95% CI, 0.19–0.49]), median OS NR vs NR
  - median PFS for 3 pLOT [Ciltacel (N=57) vs SOC(N=56)]: NR vs 8 mo (HR, 0.20 [95% CI, 0.11–0.34]), median OS NR vs 34 mo (HR, 0.49 [95% CI, 0.26–0.91])
- Compared with SOC, cilta-cel improved PFS and OS in pts with high-risk cytogenetics, suggesting it may overcome the poor prognosis associated with these high-risk features
- These data continue to support a positive benefit-risk ratio for cilta-cel in pts with lenalidomide-refractory MM as early as after first relapse

Sidana S, Martinez-Lopez J, Khan AM, Oriol A, Spencer A, Dhakal B, et al. Ciltacabtagene autoleucel (cilta-cel) vs standard of care (SOC) in patients (pts) with relapsed/refractory multiple myeloma (MM): CARTITUDE-4 survival subgroup analyses. Journal of Clinical Oncology. 2025;43(16_suppl):7539-.

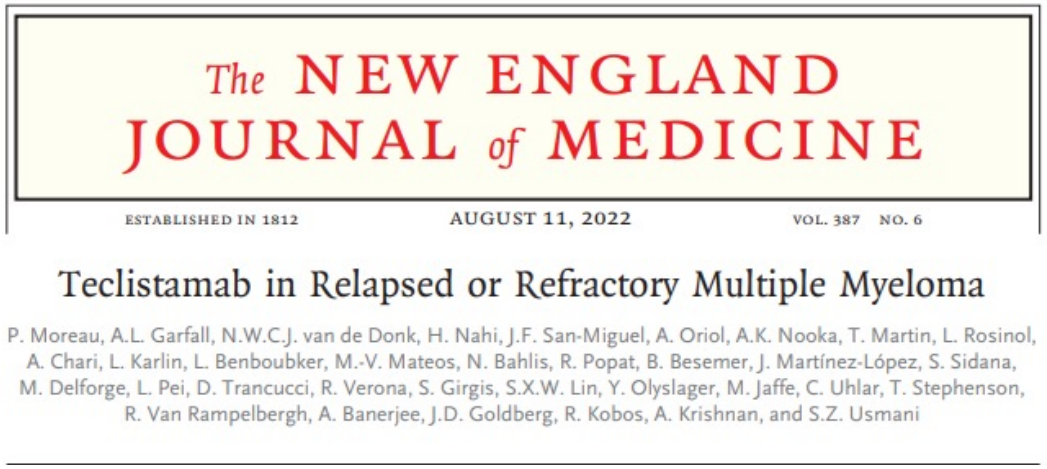
Available efficacy and safety findings with the BCMA-directed bispecific antibodies teclistamab and elranatamab in R/R MM





Teclistamab and Elranatamab approvals

MajesTEC-1



The NEW ENGLAND JOURNAL of MEDICINE

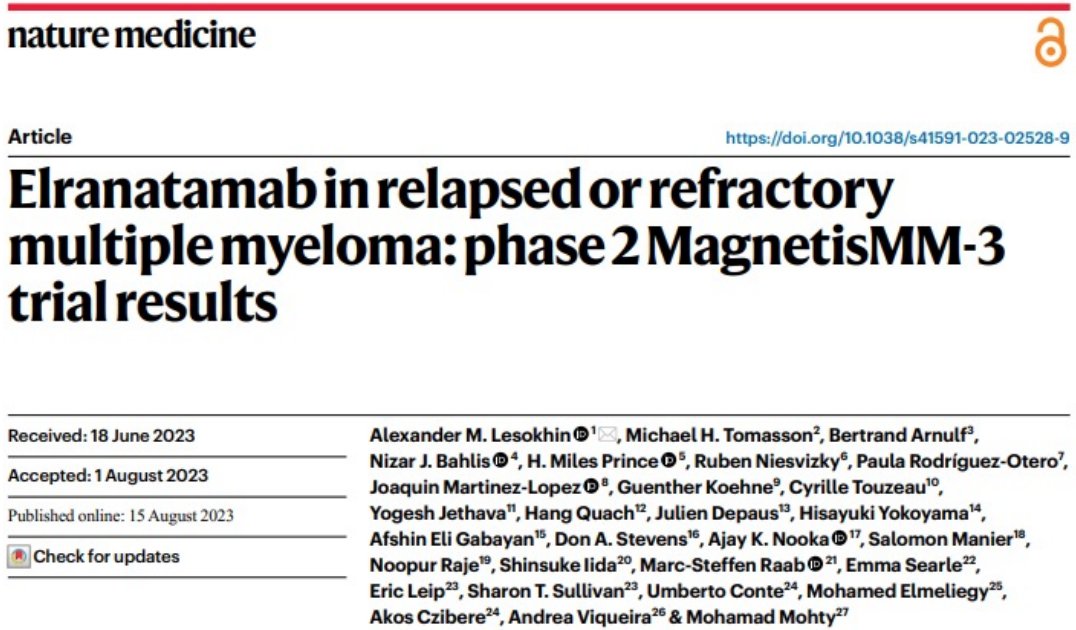
ESTABLISHED IN 1812 AUGUST 11, 2022 VOL. 387 NO. 6

Teclistamab in Relapsed or Refractory Multiple Myeloma

P. Moreau, A.L. Garfall, N.W.C.J. van de Donk, H. Nahi, J.F. San-Miguel, A. Oriol, A.K. Nooka, T. Martin, L. Rosinol, A. Chari, L. Karlin, L. Benboubker, M.-V. Mateos, N. Bahlis, R. Popat, B. Besemer, J. Martínez-López, S. Sidana, M. Delforge, L. Pei, D. Trancucci, R. Verona, S. Girgis, S.X.W. Lin, Y. Olyslager, M. Jaffe, C. Uhlar, T. Stephenson, R. Van Rampelbergh, A. Banerjee, J.D. Goldberg, R. Kobos, A. Krishnan, and S.Z. Usmani

EMA approval: Both teclistamab and elranatamab are indicated as monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.

MagnetisMM-3



nature medicine

Article

https://doi.org/10.1038/s41591-023-02528-9

Elranatamab in relapsed or refractory multiple myeloma: phase 2 MagnetisMM-3 trial results

Received: 18 June 2023

Accepted: 1 August 2023

Published online: 15 August 2023

Check for updates

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FDA approval: Teclistamab and elranatamab are indicated as monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, who have received at least four prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.

Key differences in study design and baseline characteristics

Key differences

MajesTEC-1

- ≥3 prior lines of therapy Triple-class exposed (proteasome inhibitor, immunomodulatory drug, and anti-CD38 antibody)
- ECOG PS 0 or 1
- No prior BCMA-directed therapy
- Option to switch to Q2W (phase 1) or Q4W dosing (phase 2) if:
  - ≥PR after ≥4 cycles (phase 1)
  - ≥CR for ≥6 months (phase 2)

MagnetisMM-3

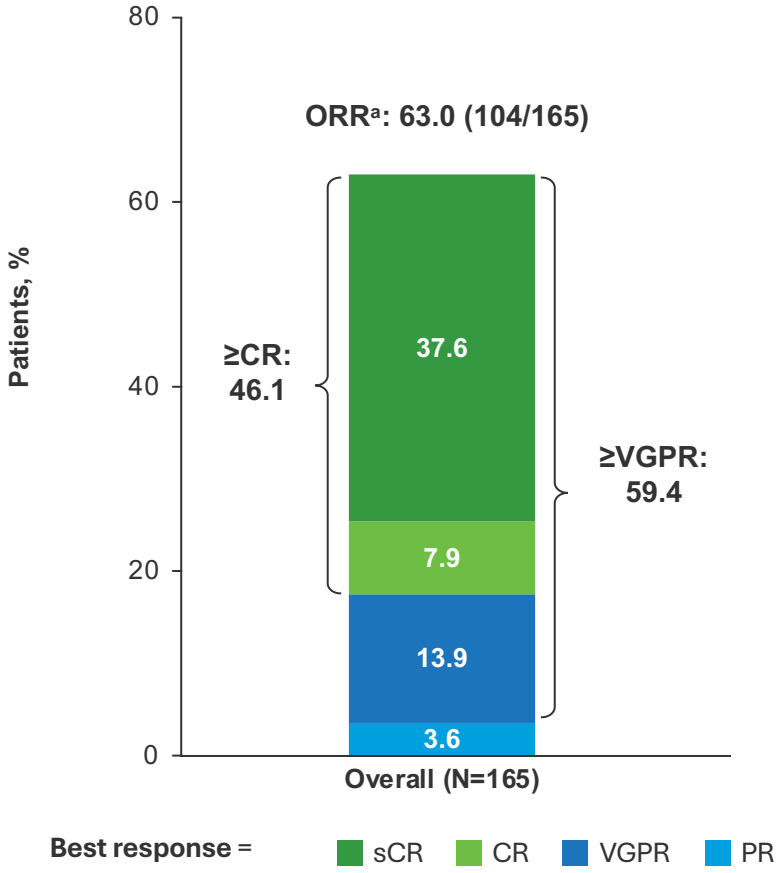
- Refractory to ≥1 each of the following: proteasome inhibitor, immunomodulatory drug, and anti-CD38 antibody
- ECOG performance status ≤2
- Prior BCMA cohort (B) included
- Q2W dosing if
  - ≥PR after ≥6 cycles, with responses persisting for ≥2 months

Similar inclusion/exclusion criteria

Baseline Characteristics

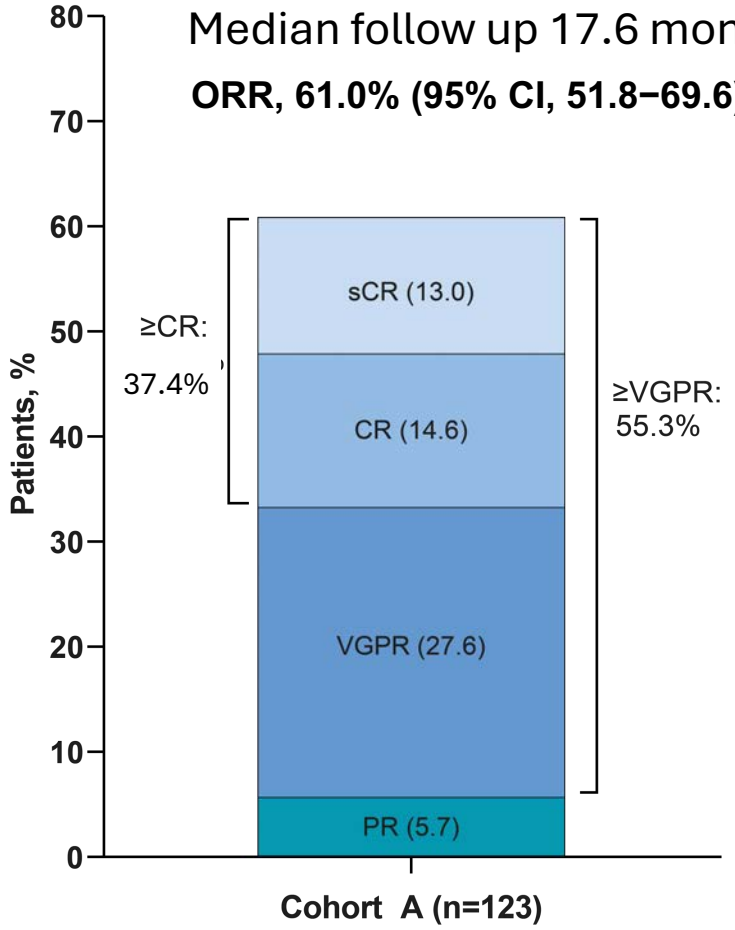
	MajesTEC-1 (N=165)	MagnetisMM-3 (N=123)
Median age (range)	64 (33–84)	68 (36-89)
Males	96 (58.2)	68 (55.3)
Black	21 (12.7)	9 (7.3)
EMD	28 (17.0)	39 (31.7)
Prior lines of therapy	5 (2–14)	5 (2–22)
ISS*	52.5/35.2/12.3	22.8/55.3/15.4
High-risk cytogenetics	38 (25.7)	31 (25.2)
Triple class exposed	165 (100)	123 (100)
Penta drug exposed	116 (70.3)	87 (70.7)
Triple class refractory	128 (77.6)	119 (96.7)
Penta drug refractory	50 (30.3)	52 (42.3)
Prior stem cell transplant	135 (81.8)	87 (70.7)
Anti-CD38 refractory	148 (89.7)	118 (95.9)

MajesTEC-1 and MagnetisMM-3: ORR



85.7% (48/56) of minimal residual disease (MRD)-evaluable pts were MRD negative (10–5 threshold)

Responses were reached quickly, at a median of 1.2 months, with deep responses taking approximately 4.5 months

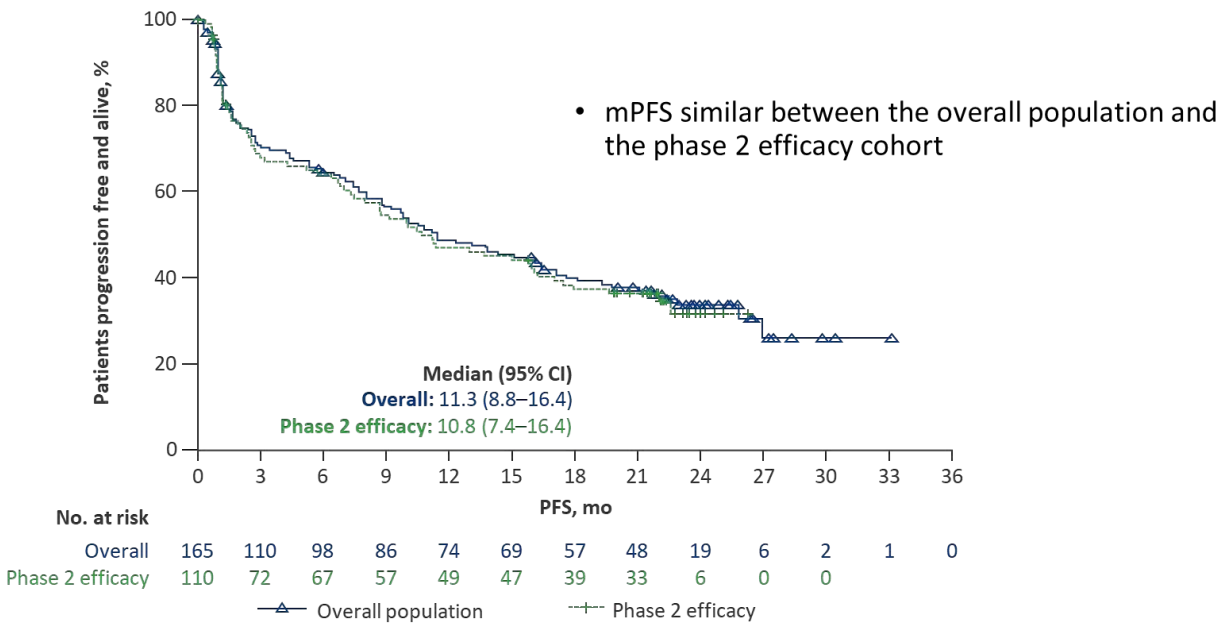


MRD negativity rate was 90.0% in sCR/CR patients who were MRD evaluable (n=30)

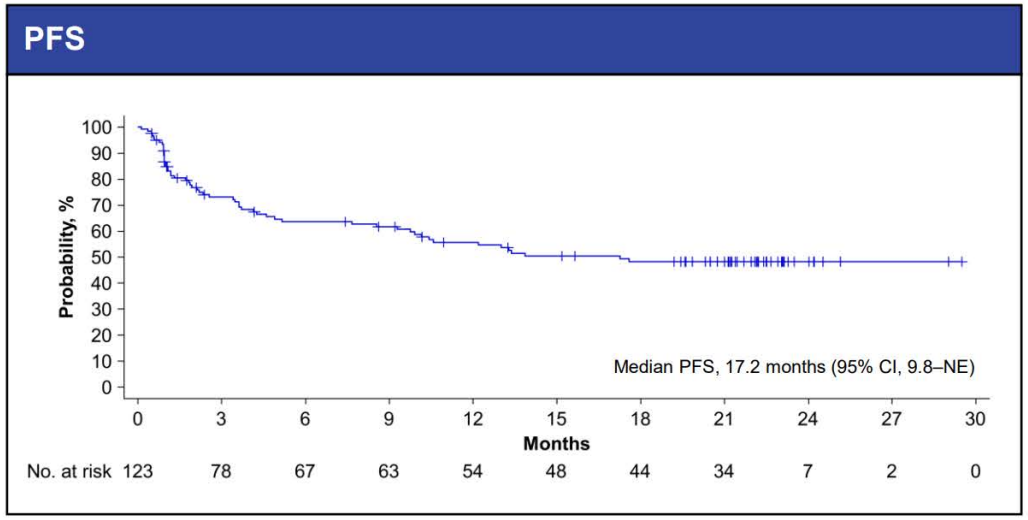
Responses were reached quickly, at a median of 1.2 months, with deep responses taking approximately 4.6 months

Usmani SZ, et al. Presented at ASCO; June 2–6, 2023; Chicago, IL, USA & Virtual. Poster # 8034.
Garfall AL, et al. ASCO 2024; Abstract 7540.
Tomasson MH, et al. ASH 2023 Blood (2023) 142 (Supplement 1): 3385.

MajesTEC-1 and MAgnetisMM-3: PFS



- mPFS similar between the overall population and the phase 2 efficacy cohort



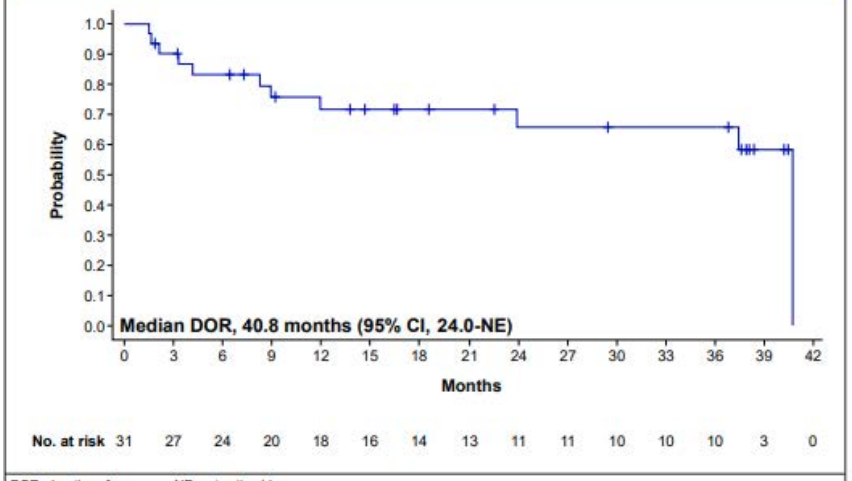
- Kaplan-Meier median PFS was 17.2 months

Median progression-free survival (mPFS): 11.4 months
Median overall survival (mOS): 22.2 months

Usmani SZ, et al. Presented at ASCO; June 2–6, 2023; Chicago, IL, USA & Virtual. Poster # 8034.
Garfall AL, et al. ASCO 2024; Abstract 7540.

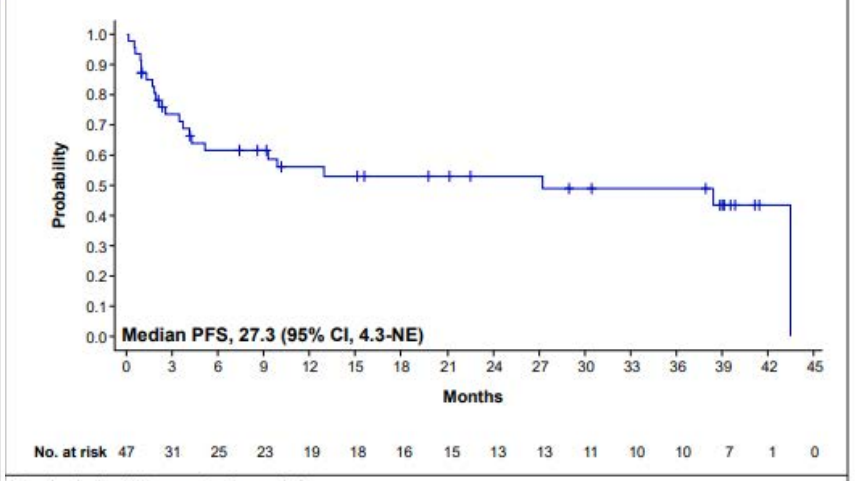
Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3

Figure 1. Duration of response



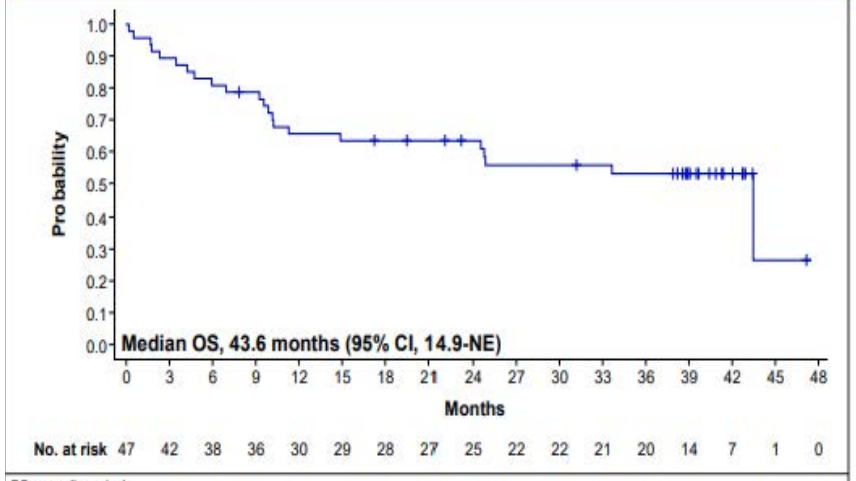
DOR=duration of response; NE=not estimable

Figure 2. Progression-free survival



NE=not estimable; PFS=progression-free survival

Figure 3. Overall survival



OS=overall survival

Among the 123 BCMA-naive patients in Cohort A, 47 were enrolled in the US

With a median follow-up of 39.6 months

- Median ORR was 66.0%, median DOR was 40.8 months but may not yet be mature
- Median PFS was 27.3 months
- Median OS was 43.6 months but may not yet be mature

Nooka AK, Strouse CS, Larson SM, Lesokhin AM, Yanovsky AV, Vesole DH, et al. Efficacy and safety of less frequent dosing with elranatamab (ELRA) in patients with relapsed or refractory multiple myeloma (RRMM): A US subgroup analysis from MagnetisMM-3. Journal of Clinical Oncology. 2025;43(16_suppl):7549-.

Extended follow-up from the pivotal Phase I/II MonumenTAL-1 study of talquetamab in R/R MM

- Talquetamab (Tal) is the first and only approved anti-GPRC5D bispecific antibody (BsAb) for relapsed/refractory multiple myeloma (RRMM)
  - Extended mFU of 30–38 mo at ASCO 2025
- 3 cohorts
  - Prior TCR naïve 0.4 mg/kg weekly (QW) (n=143) - 38.2 months
  - Prior TCR naïve 0.8 mg/kg every other week (Q2W) (n=154) - 31.2 months
  - Prior TCR exposed 0.4 mg/kg QW or 0.8 mg/kg Q2W (n=78) - 30.3 months
- ORR unchanged (QW vs Q2W vs prior TCR) - 74.1% vs 69.5% vs 66.7%
- mDOR (QW vs Q2W vs prior TCR) - 9.5 vs 17.5 vs 19.2 months
- mPFS (QW vs Q2W vs prior TCR) - 7.5 vs 11.2 vs 7.7 months
- mOS (QW vs Q2W vs prior TCR) - 34.0 vs NR vs 28.3 months
- 36-month OS rates (QW vs Q2W vs prior TCR) - 49% vs 61% vs 45%

Rasche L, Schinke CD, Touzeau C, Minnema M, Donk NWCJvd, Rodríguez-Otero P, et al. Efficacy and safety from the phase 1/2 MonumenTAL-1 study of talquetamab, a GPRC5D × CD3 bispecific antibody, in patients with relapsed/refractory multiple myeloma: Analyses at an extended median follow-up. Journal of Clinical Oncology. 2025;43(16_suppl):7528

- Most common AEs
  - CRS all grades, unchanged (QW vs Q2W) - 79% vs 72.4%
  - CRS grade 2, unchanged (QW vs Q2W) - 14.7% vs 17.2%
  - GPRC5D-associated AEs (taste related) (QW vs Q2W vs prior TCR) - 72% vs 71.4% vs 75.6%
    - rates of dose reductions due to taste related AEs – 7 vs 3.9% vs 5.1%
    - rates of discontinuation due to taste related AEs – 0 vs 1.9% vs 0%
  - GPRC5D-associated AEs (skin related) (QW vs Q2W vs prior TCR) - 56.6% vs 73.4% vs 64.1%
    - rates of dose reductions due to skin related AEs – 3.5 vs 0.6% vs 2.6%
    - rates of discontinuation due to skin related AEs – 1.4 vs 0.6% vs 0%
  - GPRC5D-associated AEs (nail related) (QW vs Q2W vs prior TCR) - 55.2% vs 53.2% vs 59%
    - rates of dose reductions due to nail related AEs – 0.7 vs 0.6% vs 1.3%
    - rates of discontinuation due to nail related AEs – 0 vs 0% vs 0%
  - GPRC5D-associated AEs (rash related) (QW vs Q2W vs prior TCR) - 39.9% vs 29.9% vs 32.1%
    - rates of dose reductions due to rash related AEs – 0.7 vs 0.6% vs 0%
    - rates of discontinuation due to rash related AEs – 0 vs 0% vs 0%
  - Infections, any-grade (QW vs Q2W vs prior TCR) occurred in 61% vs 71% vs 78%
  - Infections, grade 3 and 4 (QW vs Q2W vs prior TCR) occurred in 23% vs 21% vs 26%
- A new safety signal, ataxia/balance disorders, was recently identified in association with Talquetamab and had low prevalence in MonumenTAL-1
- No death reported due to Talquetamab-related AEs

Rasche L, Schinke CD, Touzeau C, Minnema M, Donk NWCJvd, Rodríguez-Otero P, et al. Efficacy and safety from the phase 1/2 MonumenTAL-1 study of talquetamab, a GPRC5D × CD3 bispecific antibody, in patients with relapsed/refractory multiple myeloma: Analyses at an extended median follow-up. Journal of Clinical Oncology. 2025;43(16_suppl):7528

Agenda

Introduction: ASCO 2025 Showstoppers

Module 1: Up-Front Treatment of Multiple Myeloma (MM) – Survey Questions

Module 2: Emerging Novel Therapies for Relapsed/Refractory (R/R) MM – Faculty Presentation

Module 3: Emerging Novel Therapies for R/R MM – Survey Questions

Module 4: Current Management of R/R MM – Faculty Presentation

Module 5: Current Management of R/R MM – Survey Questions

Module 6: ASCO and EHA 2025

Questions from General Medical Oncologists — CAR T-Cell Therapy

- **I live in an area where the nearest CAR T center is 1 hour away and crosses state lines. The closest within my state is 1-1/2 hours away. What can be done for community practice to be able to give cellular therapy and to increase access?**

RTP RESEARCH TO PRACTICE

Questions from General Medical Oncologists — CAR T-Cell Therapy

- How should we sequence CAR T-cell therapy relative to bispecifics and other novel agents in a patient with triple-class refractory MM and rapid disease progression?
- When should we be referring for CAR T? In the second line? What should we give to prepare for CAR T in terms of regimens that optimize CAR T and control disease?

Questions from General Medical Oncologists — CAR T-Cell Therapy

- What are the most effective real-world strategies for mitigating prolonged cytopenias and neurotoxicity in patients post-CAR T-cell therapy for MM?
- What is the incidence of CAR T-associated secondary lymphomas and are there particular subsets of patients more likely to develop this complication?

Questions from General Medical Oncologists — CAR T-Cell Therapy

- How to decrease incidence of neurotoxicity (Parkinsonism like) AEs for patients who received ciltacabtagene autoleucel)?
- How do you view the efficacy of Anito-Cel vs. ciltacabtagene autoleucel?

Questions from General Medical Oncologists — CAR T-Cell Therapy

- Specific considerations of long term toxicities that should be considered after 1 year of therapy
- I have one patient developed CMV infection and severe fatigue after CART. No myeloma recurrence. CMV finally cleared but remains very fatigued and depressed. Other than providing IVIG and monitoring myeloma, what should a community oncologist do for post-CART patients?
- How can the community-based oncologist assist the academic center in the management of these patients? What can we be doing better?

Questions from General Medical Oncologists — Bispecific Antibodies

- A significant barrier is access to timely CAR T-cell therapy or bispecifics for eligible patients due to insurance delays and logistical challenges at treatment centers, which can lead to disease progression before therapy initiation.
- What is the correct sequence?
- How do teclistamab and elranatamab compare in terms of response durability and infection risk, and what patient factors influence selection between them?

Questions from General Medical Oncologists — Bispecific Antibodies

- **Given the proliferation of cellular/immunotherapies available across disease states, these are going to need to be given in the community. How can community docs team up better to be qualified and competent to choose and manage these medications?**
- **Have you used two different bsA molecules back-to-back (BCMA followed by GPRC5D or vice versa), and how have the outcomes been? I have a patient with RRMM who received BsA (Teclistamab) in the 5th line but had to be discontinued due to Grade 4 infections. For such patients with significant infection risk on 1 bsA, what do you recommend next to keep the disease in check and allow them to recover for the next line of different BsA, like Talquetamab?**

Agenda

Introduction: ASCO 2025 Showstoppers

Module 1: Up-Front Treatment of Multiple Myeloma (MM) – Survey Questions

Module 2: Emerging Novel Therapies for Relapsed/Refractory (R/R) MM – Faculty Presentation

Module 3: Emerging Novel Therapies for R/R MM – Survey Questions

Module 4: Current Management of R/R MM – Faculty Presentation

Module 5: Current Management of R/R MM – Survey Questions

Module 6: ASCO and EHA 2025

RTP RESEARCH TO PRACTICE

Isatuximab (Isa) subcutaneous (SC) via an on-body delivery system (OBDS) vs Isa intravenous (IV), plus pomalidomide and dexamethasone (Pd) in relapsed/refractory multiple myeloma (RRMM): Results of the randomized, non-inferiority, phase 3 IRAKLIA study.

Leleu XP et al.

ASCO 2025; Abstract 7506

Belantamab mafodotin plus lenalidomide/dexamethasone in newly diagnosed intermediate-fit & frail multiple myeloma patients: Long-term efficacy and safety from the phase 1/2 BELARD clinical trial.

Terpos E et al

ASCO 2025; Abstract 7512

Design of the phase 3 DREAMM-10 study: Belantamab mafodotin plus lenalidomide and dexamethasone (BRd) vs daratumumab plus lenalidomide and dexamethasone (DRd) in transplant-ineligible, newly diagnosed multiple myeloma (TI-NDMM).

Lonial S et al

ASCO 2025;Abstract TPS7567

ASCO 2025 | ORAL ABSTRACT SESSION | JUNE 1-3

RTP RESEARCH TO PRACTICE

Long-term (≥5 year) remission and survival after treatment with ciltacabtagene autoleucel (cilta-cel) in CARTITUDE-1 patients (pts) with relapsed/refractory multiple myeloma (RRMM).

Vorhees PM et al

ASCO 2025; Abstract 7507

First-in-human study of JNJ-79635322 (JNJ-5322), a novel, next-generation trispecific antibody (TsAb), in patients (pts) with relapsed/refractory multiple myeloma (RRMM): Initial phase 1 results.

Van de Donk N et al.

ASCO 2025; Abstract 7505

EHA 2025
Upcoming Abstracts in MM
June 12-15, 2025

S201 Kaur G et al. **Phase 2 registrational study of anitocabtagene autoleucel for relapsed and/or refractory multiple myeloma (RRMM): Updated results from iMMAGINE-1.**

S203 Leleu X et al. **Isatuximab subcutaneous via an on-body delivery system versus isatuximab intravenous, plus pomalidomide and dexamethasone, in relapsed/refractory multiple myeloma: The randomized phase 3 IRAKLIA study.**

S192 Jagannath S et al. **Long-term (≥5 year) remission and survival after treatment with ciltacabtagene autoleucel in CARTITUDE-1 patients with relapsed/refractory multiple myeloma.**

S100 Popat R et al. **First-in-human study of JNJ-79635322 (JNJ-5322), a novel, next-generation trispecific antibody, in patients with relapsed/refractory multiple myeloma: Initial phase 1 results.**

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EHA 2025
Upcoming Abstracts in MM
June 12-15, 2025

PS1793 Dimopoulos M et al. **Phase 3 DREAMM-10 study design: Belantamab mafodotin plus lenalidomide and dexamethasone vs daratumumab plus lenalidomide and dexamethasone in transplant-ineligible newly-diagnosed multiple myeloma.**

PF733 Terpos E et al. **Extended dosing schedule of belantamab mafodotin in combination with daratumumab, lenalidomide and dexamethasone in patients with newly diagnosed multiple myeloma: The phase 1/2 BELADRD study.**

PS1741 Cavo M et al **Real-world effectiveness and safety of belantamab mafodotin (belamaf) monotherapy in patients (pts) with relapsed/refractory multiple myeloma (RRMM) treated in Europe.**

PS1752 Terpos E et al. **Clinical management of belantamab mafodotin-associated ocular events: Practical guidance from the belamaf expert experience program.**

PF783 Quach H et al. **Belantamab for the treatment of multiple myeloma: Results from part 1 of the first-in-human phase 1/2 DREAMM-20 trial.**

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Consensus or Controversy? Clinical Investigators Provide Perspectives on the Current and Future Clinical Care of Patients with Metastatic Breast Cancer

Monday, June 2, 2025
7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty

Harold J Burstein, MD, PhD
Javier Cortés, MD, PhD
Rebecca A Dent, MD, MSc
Kevin Kalinsky, MD, MS
Joyce O'Shaughnessy, MD

Moderator

Hope S Rugo, MD

RTP RESEARCH TO PRACTICE

Dear Attendees,

If you are interested in joining our Breast Cancer symposium webcast starting at 7:00 PM central time (8:00 PM ET), please use the link below to register on Zoom. THIS LINK IS ALSO POSTED IN THE ZOOM CHAT ROOM.

https://us02web.zoom.us/webinar/register/WN_O9YZp8BaS2-uCMIWtt-hFg#/registration

If you have already registered for the Breast Cancer webcast, you should have received an email directly from Zoom with the viewing instructions for the webcast. If not, please use the link above to register again and you will be automatically redirected to the Zoom event.

Thank you for your participation!

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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. The survey will remain open for 5 minutes after the meeting ends.

Information on how to obtain CME 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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