Cases from the Community: Investigators Discuss Available Research Guiding the Management of Relapsed/Refractory Multiple Myeloma — What Happened at ASH 2025?

A CME/MOC-Accredited Live Webinar

Monday, December 15, 2025

5:00 PM – 6:00 PM ET

Faculty

Sagar Lonial, MD, FACP, FASCO

María-Victoria Mateos, MD, PhD

Moderator

Neil Love, MD

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Faculty

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Chair and Professor
Department of Hematology and Medical Oncology
Chief Medical Officer
Winship Cancer Institute
Emory University School of Medicine
Atlanta, Georgia

MODERATOR
Neil Love, MD
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Miami, Florida

María-Victoria Mateos, MD, PhD
Consultant Physician in the Haematology Department
Associate Professor of Medicine
Director of the Myeloma Program
Clinical Trials Unit
University Hospital of Salamanca
Salamanca, Spain

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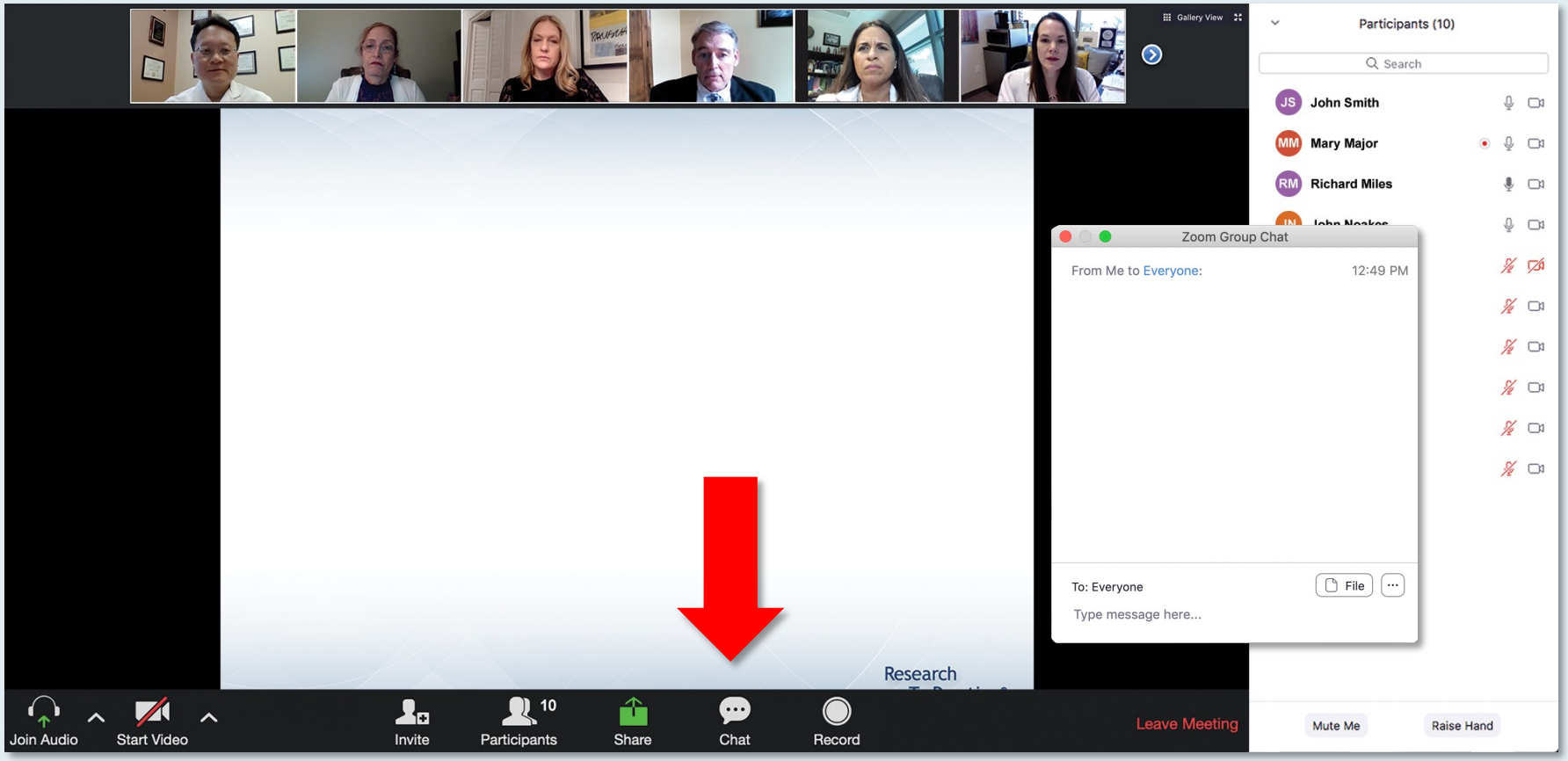

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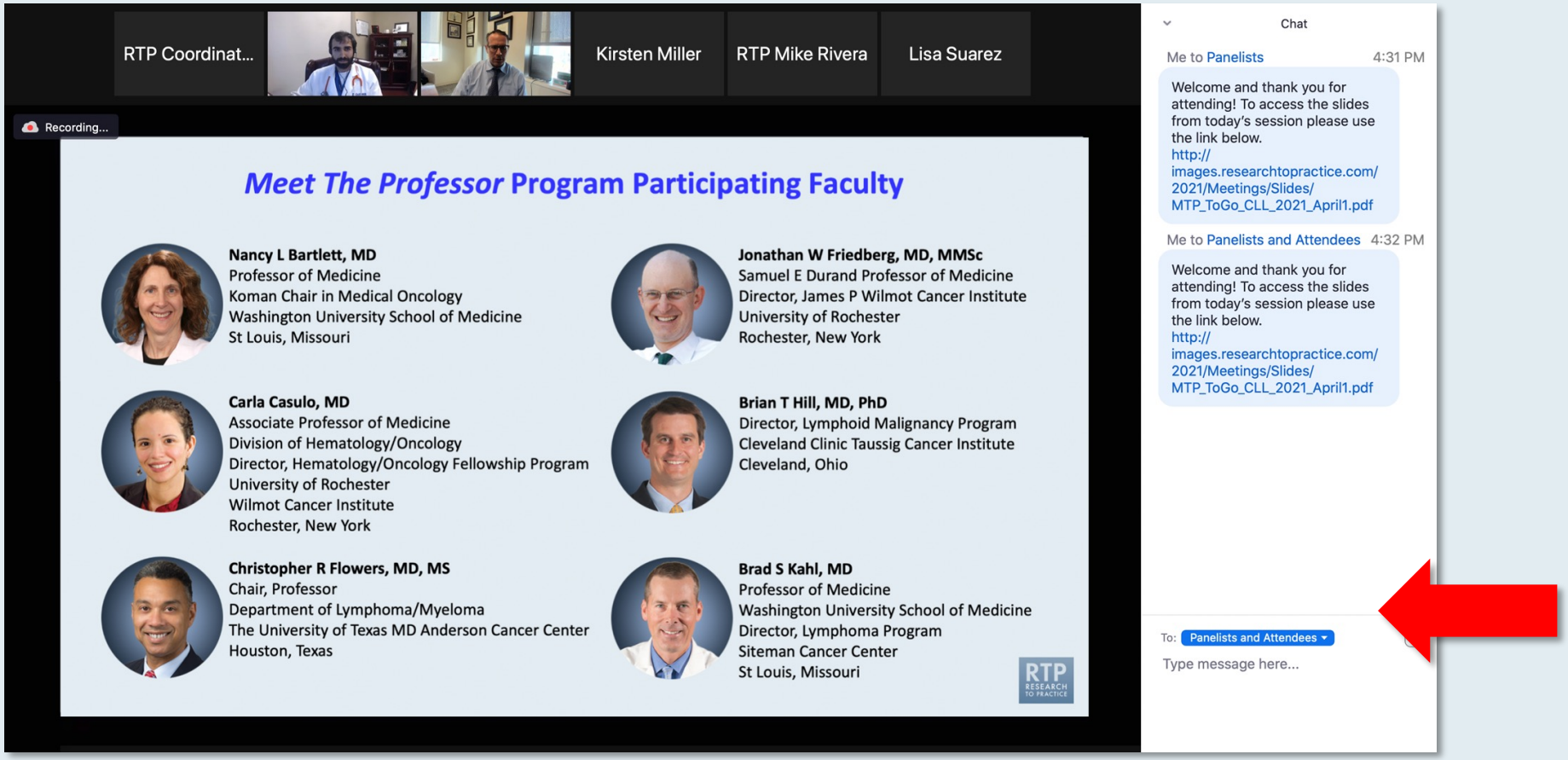

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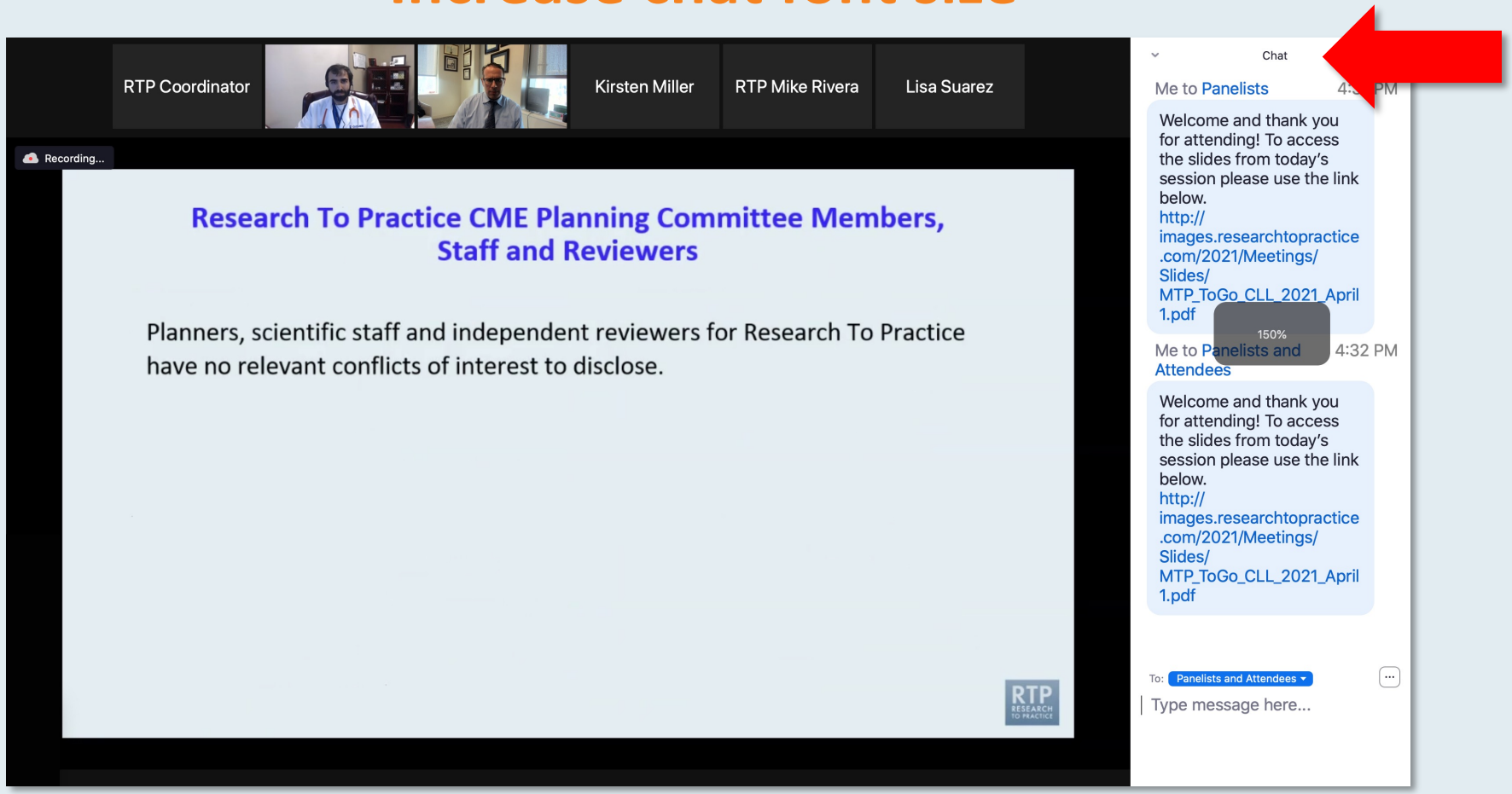

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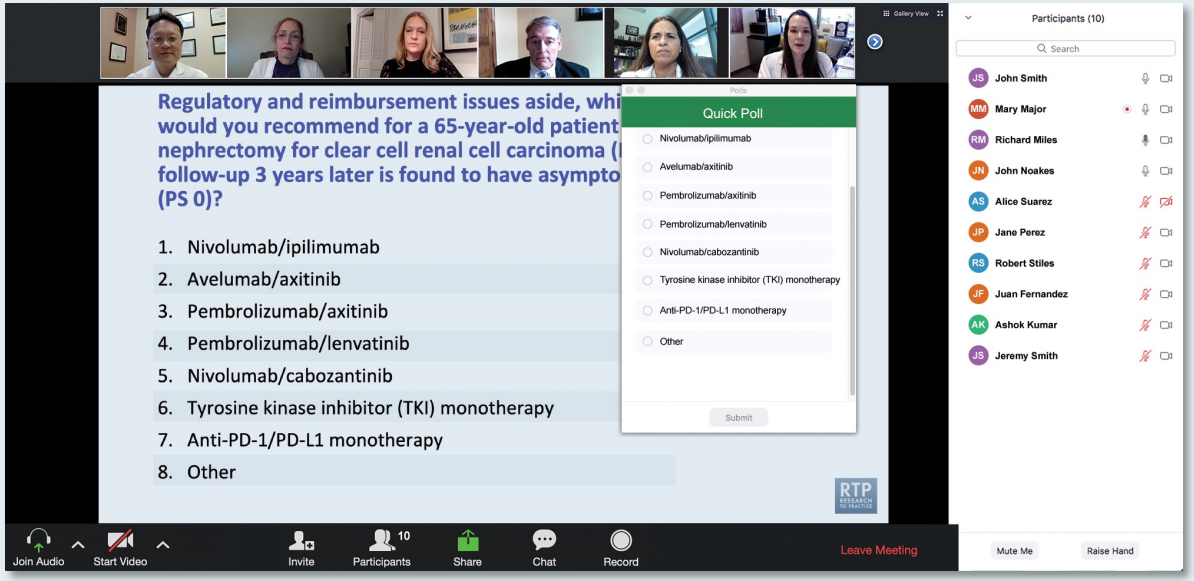

Relapsed/Refractory Multiple Myeloma — Proceedings from a Session Held During the Society of Hematologic Oncology 2025 Annual Meeting

PROF MELETIOS-ATHANASIOS (THANOS) C DIMOPOULOS, MD
ALEXANDRA HOSPITAL

DR NOOPUR RAJE
MASSACHUSETTS GENERAL HOSPITAL CANCER CENTER

DR HANS LEE
SARAH CANNON RESEARCH INSTITUTE

Moderator

DR JOSEPH MIKHAEL
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Practical Perspectives on the Current and Future Management of Immune Thrombocytopenia — What Happened at ASH 2025?

A CME/MOC-Accredited Live Webinar

Tuesday, December 16, 2025
5:00 PM – 6:30 PM ET

Faculty

Hanny Al-Samkari, MD
Cindy Neunert, MD, MSCS
Professor Francesco Zaja

Moderator

Neil Love, MD

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Practical Perspectives on the Current Role of Bispecific Antibodies in the Management of Lymphoma — What Happened at ASH 2025?

A CME/MOC-Accredited Live Webinar

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5:00 PM – 6:00 PM ET

Faculty

Michael Dickinson, MD
Laurie H Sehn, MD, MPH

Moderator

Neil Love, MD

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Expert Second Opinion: Investigators Discuss the Optimal Management of Gastrointestinal Cancers

A CME Symposium Series Held Adjunct to the 2026 ASCO® Gastrointestinal Cancers Symposium

HER2-Positive Gastrointestinal Cancers

Thursday, January 8, 2026

7:15 PM – 8:45 PM PT
(10:15 PM – 11:45 PM ET)

Localized Colorectal Cancer

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Advanced Gastroesophageal Cancers

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Friday to Sunday, April 24 to 26, 2026

The Ritz-Carlton Orlando, Grande Lakes | Orlando, Florida

Moderated by Neil Love, MD

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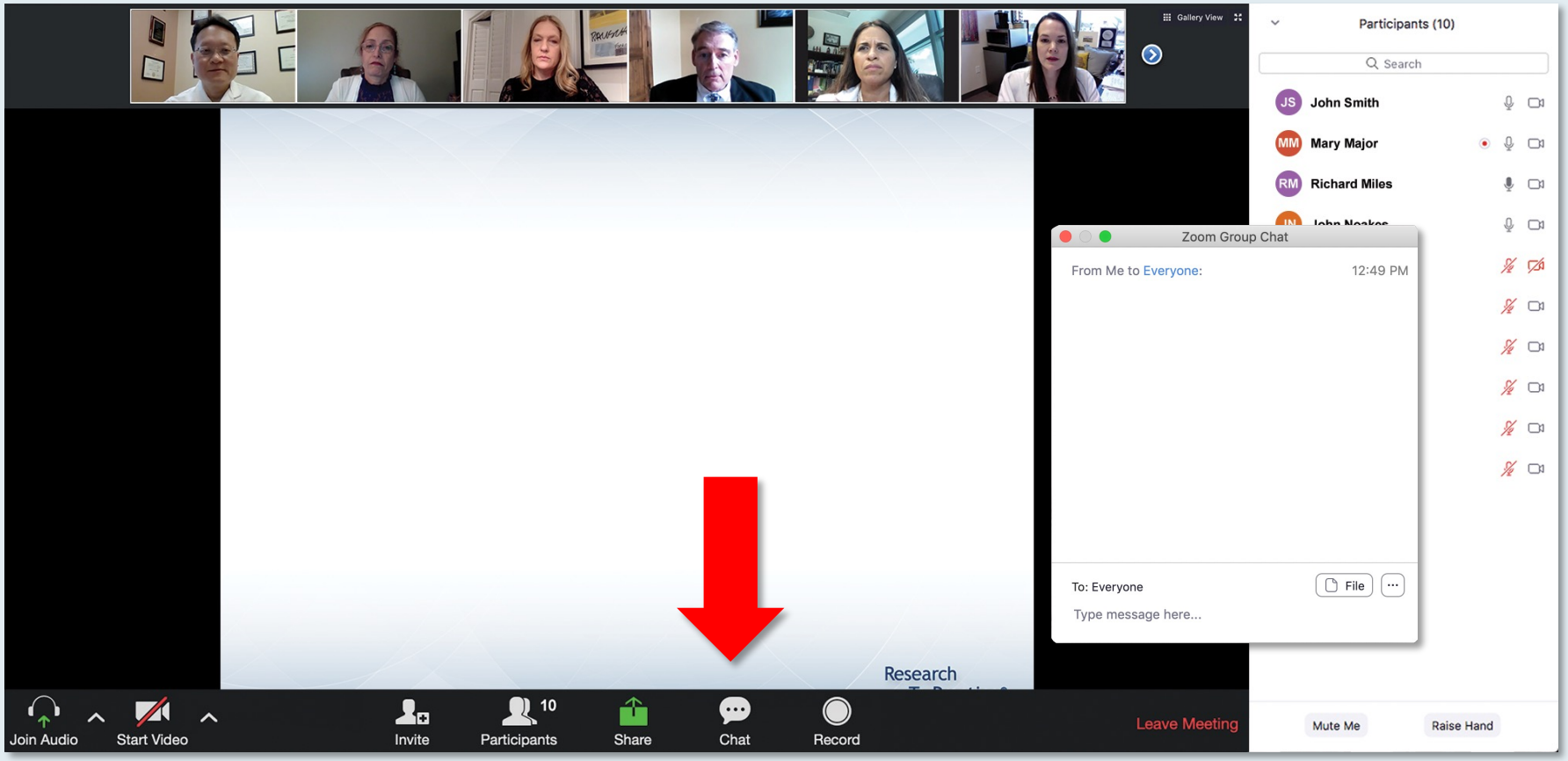

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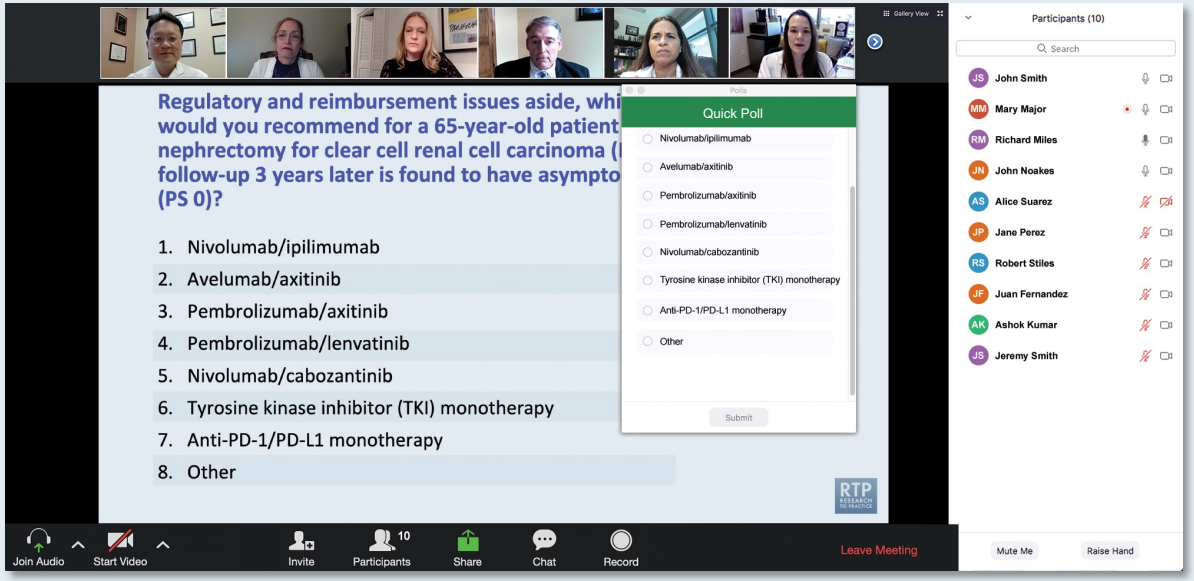

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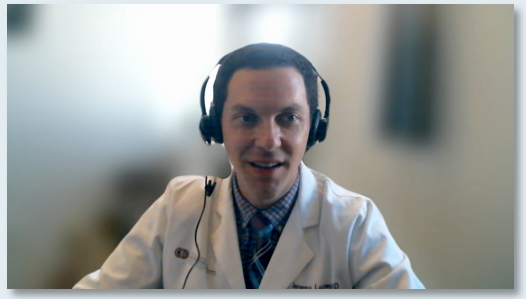

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Neil Morganstein, MD
Atlantic Health System
Summit, New Jersey

Priya Rudolph, MD, PhD
Georgia Cancer Specialists
Athens, Georgia

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Key Datasets

Sagar Lonial, MD

- Hungria V et al. **Long-term responders** from the **phase 3 DREAMM-7** study of **belantamab mafodotin plus bortezomib and dexamethasone** vs daratumumab plus bortezomib and dexamethasone in relapsed/refractory multiple myeloma. ASH 2025;Abstract 7236.
- Trudel S et al. Deep responses and durable outcomes in patients treated with **belantamab mafodotin plus pomalidomide and dexamethasone** from **long-term follow-up** of the phase 3 **DREAMM-8 study**. ASH 2025;Abstract 7677.
- Lonial S et al. **Health-related quality of life with belantamab mafodotin** in patients with relapsed or refractory multiple myeloma (RRMM): An **exploratory analysis** of overall quality of life **in DREAMM-7**. ASH 2025;Abstract 143.
- Lonial S et al. **Belantamab mafodotin (belamaf) ocular events** are **manageable and reversible** with dose modifications guided by standard assessments. ASH 2025;Abstract 12045.
- Usmani S et al. **Belantamab mafodotin (belamaf) in combination with bortezomib, lenalidomide, and dexamethasone (VRd)** for patients (pts) with transplant-ineligible (TI) newly diagnosed multiple myeloma (NDMM): A focus on treatment efficacy and management/resolution of ocular events in the **phase 1 DREAMM-9 study**. ASH 2025;Abstract 13646.

Key Datasets

Sagar Lonial, MD (continued)

- Landgren O et al. A phase 2 trial of **iberdomide, carfilzomib, daratumumab and dexamethasone** quadruplet therapy for relapsed/refractory multiple myeloma: **The ReKInDLE study**. ASH 2025;Abstract 4108.
- Sim S et al. **Interim analysis** of efficacy and safety for **ALLG MM25 (Viber-M)**: A phase I b/II study of **venetoclax, iberdomide and dexamethasone** for patients in first or second relapse of multiple myeloma with t(11;14). ASH 2025;Abstract 7320.

Key Datasets

María-Victoria Mateos, MD, PhD

- Costa L et al. **Long-term progression-free survival benefit** with **ciltacabtagene autoleucel** in standard-risk relapsed/refractory multiple myeloma. ASH 2025;Abstract 9129.
- Parekh S et al. **Earlier use** of **ciltacabtagene autoleucel (cilta-cel)** is associated with **better immune fitness and stronger immune effects** as shown by correlative analysis of peripheral blood and the bone marrow tumor microenvironment (TME) from the **CARTITUDE-4** study. ASH 2025;Abstract 8211.
- Ailawadhi S et al. **KarMMa-3** subgroup analysis in **older patients** with relapsed/refractory multiple myeloma treated with **idecabtagene vicleucel.** ASH 2025;Abstract 9044.
- Patel K et al. Phase 2 registrational study of **anitocabtagene autoleucel** for the treatment of patients with relapsed and/or refractory multiple myeloma: **Updated results from iMMagine-1**. ASH 2025;Abstract 4541.
- Ho PJ et al. **Minimal residual disease (MRD)-negative outcomes** following a **novel, in vivo gene therapy** generating anti–B-cell maturation antigen **(BCMA) chimeric antigen receptor (CAR)-T cells** in patients with relapsed and refractory multiple myeloma (RRMM): **Preliminary results from inMMyCAR**, the first-in-human phase 1 study of KLN-1010. ASH 2025;Abstract LBA-1.

Key Datasets

María-Victoria Mateos, MD, PhD (continued)

- Ho PJ et al. **Subcutaneous cevostamab** demonstrates manageable safety and clinically meaningful activity in relapsed/refractory multiple myeloma (RRMM): First results from the **phase Ib CAMMA 3 study**. ASH 2025;Abstract 8172.
- Mateos M-V et al. Safety and efficacy of **talquetamab + teclistamab** in patients with relapsed/refractory multiple myeloma from **Phase 1b of RedirecTT-1**: Results with an **extended median follow-up of 3 years**. ASH 2025;Abstract 7712.
- Mateos M-V et al. Phase 3 randomized study of **teclistamab plus daratumumab** versus investigator's choice of daratumumab and dexamethasone with either pomalidomide or bortezomib (DPd/DVd) in patients (Pts) with relapsed refractory multiple myeloma (RRMM): **Results of MajesTEC-3**. ASH 2025;Abstract LBA-6.
- Voorhees P et al. **Etentamig plus pomalidomide-dexamethasone** combination therapy in relapsed or refractory multiple myeloma: A **phase 1b dose-escalation** and safety expansion study. ASH 2025;Abstract 1875.
- Hamadeh I et al. **Low dose tocilizumab** for mitigation of **cytokine release syndrome** with **bispecific antibodies** in relapsed/refractory multiple myeloma. ASH 2025;Abstract 7258.
- Krishnan A et al. **Updated efficacy and safety** results of **JNJ-5322**, a novel, next-generation **BCMA × GPRC5D × CD3 trispecific antibody**, in patients with relapsed/refractory multiple myeloma. ASH 2025;Abstract 7875.

Agenda

Introduction	Best of ASH Multiple Myeloma
Case 1	Dr Lorber – 59-year-old man
■ Faculty Presentation: Antibody-Drug Conjugates and Other Emerging Novel Therapies for Relapsed/Refractory (R/R) Multiple Myeloma (MM) — Dr Lonial	
Case 2	Dr Morganstein – 84-year-old man
Case 3	Dr Favaro – 64-year-old man
Case 4	Dr Bhatnager – 71-year-old man
Case 5	Dr Lee – 71-year-old man
■ Faculty Presentation: Integrating CAR T-Cell Therapy and Bispecific Antibodies into the Management of R/R MM — Dr Mateos	
Case 6	Dr Rudolph – 56-year-old man

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LBA-1

MRD-negative outcomes following a novel, *in vivo* gene therapy generating anti-BCMA CAR-T cells in patients with RRMM: Preliminary results from inMMyCAR, the first-in-human Phase 1 study of KLN-1010

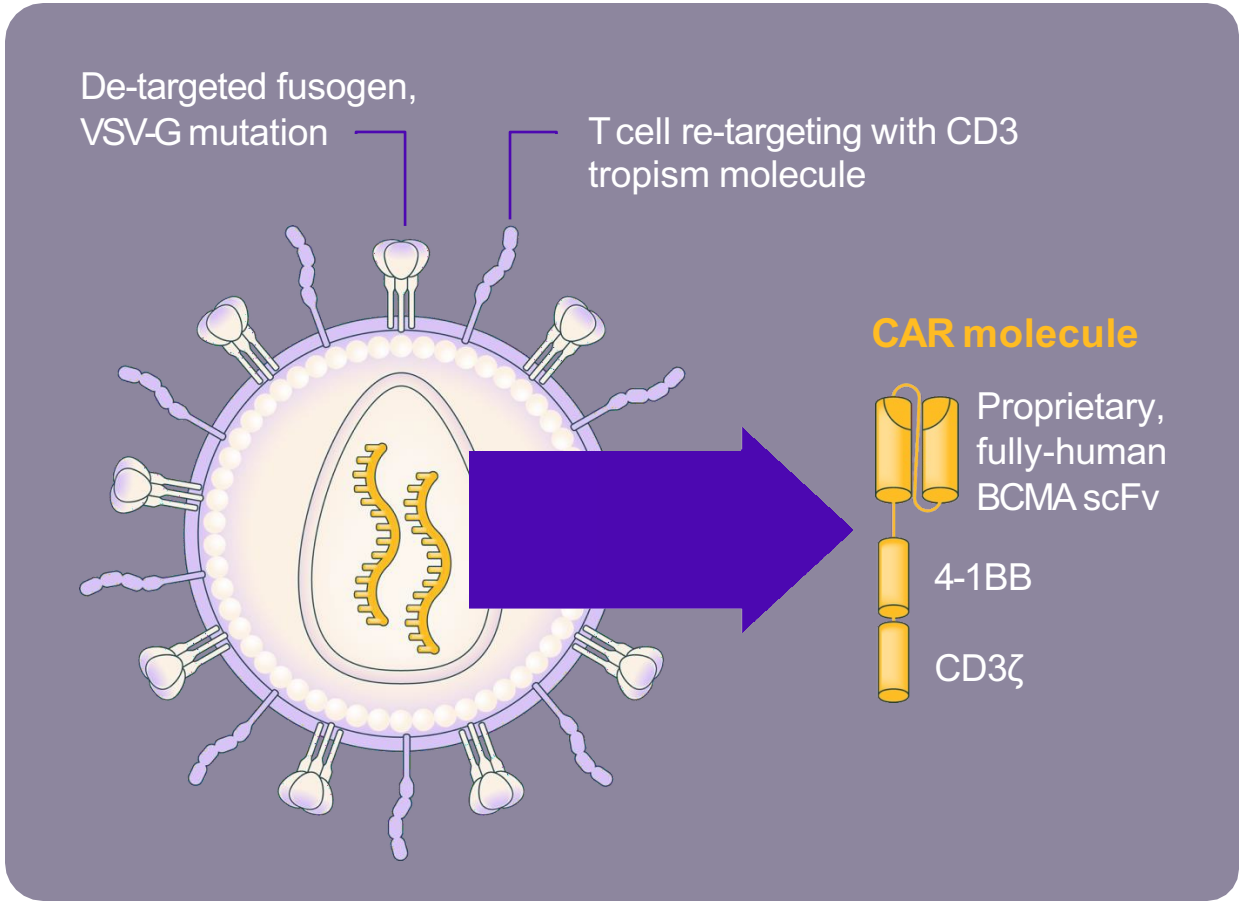
Simon Harrison[1], P. Joy Ho[2], Sueh-li Lim[3], Stephanie Talam[2], Hannah Pahl[1], Dharmesh Dingar[4], Scott Currence[4], Travis Quigley[4], Andrew Spencer[3]

[1]Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia; [2]Royal Prince Alfred Hospital, Sydney, New South Wales, Australia; [3]The Alfred Hospital, Melbourne, Victoria, Australia; [4]Kelonia Therapeutics, Inc., Boston, Massachusetts, United States.

Presented at the 67th ASH Annual Meeting and Exposition; December 6-9, 2025; Orlando, FL, USA.

KLN-1010: a modified LVV generating anti-BCMA CAR-T cells *in vivo*

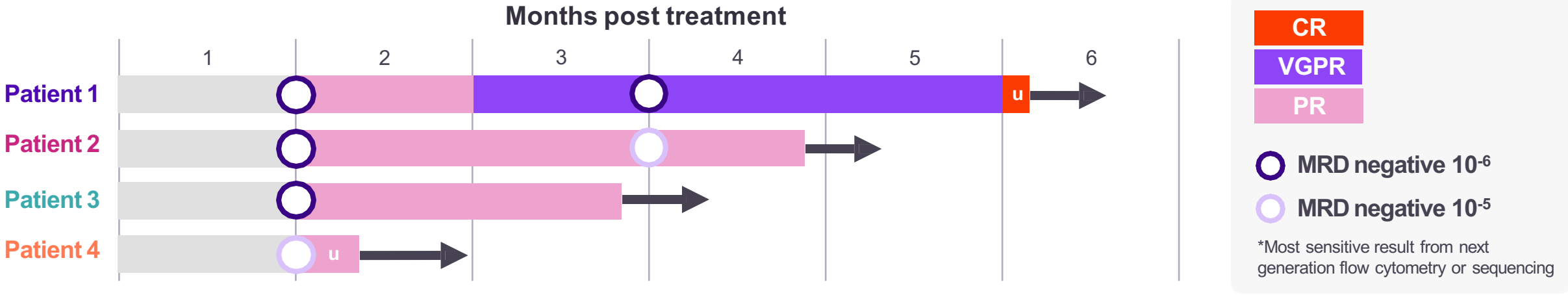
- **Envelope-modified, replication-incompetent, self-inactivating lentiviral vector**
- **De-targeted VSV-G fusogen** avoids delivery to LDL-expressing cells while maintaining high transduction efficiency
- **Precise re-targeting to T cells** with a CD3 scFv; avoids liver uptake and drug sinks
- Anti-BCMA CAR was **selected based on high levels of activity to BCMA-positive tumors**



BCMA, anti–B-cell maturation antigen; CAR, chimeric antigen receptor; CD3, cluster of differentiation 3; CD3ζ, cluster of differentiation 3 zeta chain; LDL, low-density lipoprotein; LVV, lentiviral vector;scFv, single-chain variable fragment; VSV-G, vesicular stomatitis virus glycoprotein.

Wood JT et al. Toward treatment with gene-modified B cells engineered *in vivo* using iGPS particles (abstract #1281). Poster presented at: ASGCT 28th Annual Meeting; May 13-17, 2025.

Deep, ongoing MRD-negative responses were observed across first 4 patients



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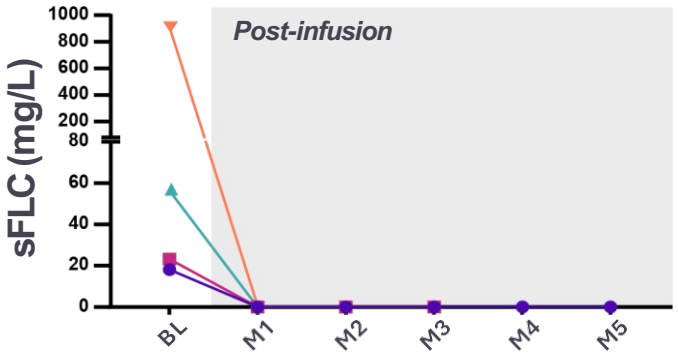
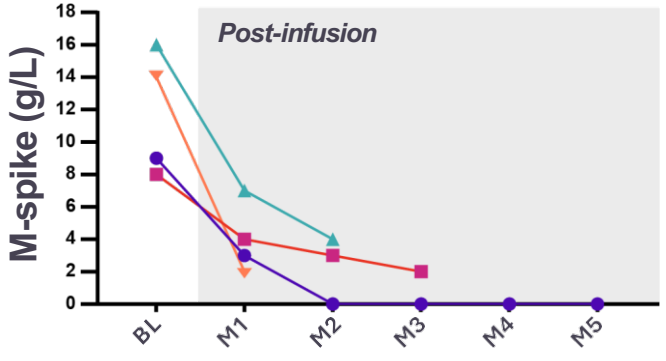
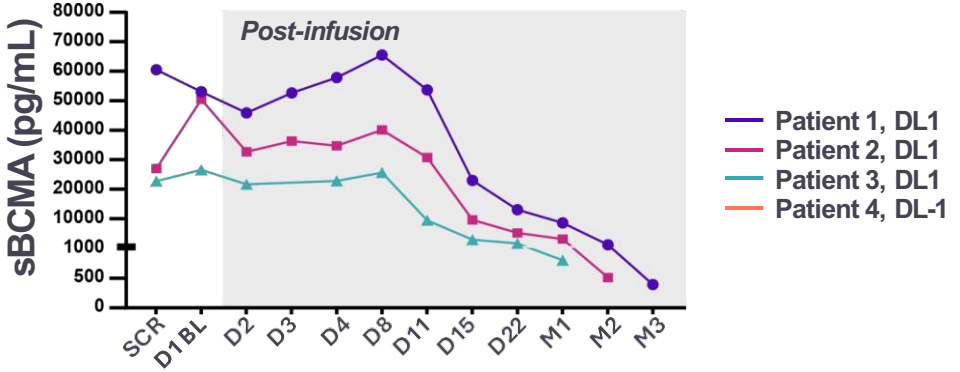


M-spike levels



Soluble BCMA



BCMA, B-cell maturation antigen; BL, baseline; CR, complete response; D, study day; M, study month; M-spike, monoclonal protein spike; MRD, minimal residual disease; PR, partial response; SCR, screening; sFLC, serum free light chain; u, unconfirmed response; VGPR, very good partial response.

Favorable toxicity profile compared to *ex vivo* CAR T

- Minimal events of cytopenia; only 1 case of Grade 4 (transient neutropenia related to margination)
- Markedly lower number of events compared to *ex vivo* CAR-T therapies

TEAEs in >1 patient	Grade 1-2, n	Grade ≥3, n
IRR	2	1 (DLT)
Lymphocytosis	1	1
Hypomagnesemia	2	0
Hypokalemia	2	0

TEAEs Grade ≥3	Patients, n	Study day	Duration, days
Febrile neutropenia	1	1	2
IRR	1	1	3
Lymphopenia	1	2, 8	2, 5
Lymphocytosis	1	13	3
Anemia	1	15	2
Vasovagal syncope	1	27	1
Pneumonia	1	86	8

Cytopenia			
	Grade ≥3, n	Study day	Duration, days
Anemia	1	15	2
Thrombocytopenia	1	16	2
Neutropenia	2	1, 15	2, 2
		14	3

Infusion-related reactions			
	Grade 1-2, n	Grade ≥3, n	Supportive care
Dose level 1	1	1	Tocilizumab, steroid
Dose level -1	1	0	Paracetamol

CAR, chimeric antigen receptor; DLT, dose-limiting toxicity; IRR, infusion-related reaction; TEAE, treatment-emergent adverse event.

Phase 3 Randomized Study of Teclistamab Plus Daratumumab Versus Investigator's Choice of Daratumumab and Dexamethasone With Either Pomalidomide or Bortezomib (DPd/DVd) in Patients With Relapsed Refractory Multiple Myeloma (RRMM): Results of MajesTEC-3

Maria-Victoria Mateos,[1] Nizar J. Bahlis,[2] Aurore Perrot,[3] Ajay K. Nooka,[4] Jin Lu,[5] Charlotte Pawlyn,[6,7] Roberto Mina,[8] Gaston Caeiro,[9] Alain Kentos,[10] Vania Hungria,[11] Donna Reece,[12] Ting Niu,[13] Anne K. Mylin,[14] Charlotte Toftmann Hansen,[15] Raphael Teipel,[16] Britta Besemer,[17] Meletios A. Dimopoulos,[18,19] Elena Zamagni,[20,21] Satoshi Yoshihara,[22] Kihyun Kim,[23] Chang Ki Min,[24] Paul Geerts,[25] Elena Van Leeuwen-Segarceanu,[26] Agata Tyczynska,[27] Juan Luis Reguera Ortega,[28] Magnus Johansson,[29] Markus Hansson,[30] Mehmet Turgut,[31] Mark Grey,[32] Surbhi Sidana,[33] Paula Rodriguez-Otero,[34] Joaquin Martinez-Lopez,[35] Hamza Hashmi,[36] Robin Carson,[37] Rachel Kobos,[38] Weili Sun,[39] Kristen Lantz,[37] Anne Seifert,[40] Deborah Briseno-Toomey,[41] Lisa O'Rourke,[37] Maria Rubin,[38] Diego Vieyra,[37] Lijuan Kang,[39] Luciano J. Costa[42]

[1]Hospital Universitario de Salamanca, Instituto de Investigación Biomédica de Salamanca, Instituto de Biología Molecular y Celular del Cáncer (Universidad de Salamanca-Consejo Superior de Investigaciones Científicas), CIBERONC, Salamanca, Spain; [2]Arnie Charbonneau Cancer Institute, University of Calgary, Calgary, AB, Canada; [3]Universite de Toulouse, Centre Hospitalier Universitaire, Service d'Hematologie, IUCT Oncopole CRCT, Toulouse, France; [4]Emory University, Winship Cancer Institute, Atlanta, GA, USA; [5]Peking University People's Hospital, Peking University Institute of Hematology, National Clinical Research Center for Hematologic Disease, Beijing, China; [6]The Royal Marsden NHS Foundation Trust, London, UK; [7]The Institute of Cancer Research, London, UK; [8]AOU Città della Salute e della Scienza di Torino, University of Torino, Torino, Italy; [9]Hospital Privado Universitario de Córdoba – Instituto Universitario de Ciencias Biomédicas de Córdoba, Córdoba, Argentina; [10]Hôpital de Jolimont, Haine-Saint-Paul, Belgium; [11]Clinica São Germano, São Paulo, Brazil; [12]Princess Margaret Cancer Centre, Toronto, ON, Canada; [13]West China Hospital, Sichuan University, Chengdu, China; [14]Rigshospitalet, Copenhagen, Denmark; [15]Odense University Hospital, Odense, Denmark; [16]Medizinische Klinik und Poliklinik I Universitätsklinikum Carl Gustav Carus an der Technischen Universität Dresden, Dresden, Germany; [17]University Tübingen, Tübingen, Germany; [18]National and Kapodistrian University of Athens, School of Medicine, Athens, Greece; [19]Korea University, Seoul, South Korea; [20]IRCCS Azienda Ospedaliero-Universitaria di Bologna, Istituto di Ematologia "Seràgnoli," Bologna, Italy; [21]Università di Bologna, Bologna, Italy; [22]Hyogo Medical University Hospital, Nishinomiya, Japan; [23]Sungkyunkwan University School of Medicine, Samsung Medical Center, Seoul, Korea; [24]Seoul St. Mary's Hospital, The Catholic University of Korea, Seoul, Korea; [25]Isala Klinieken, Zwolle, The Netherlands; [26]St. Antonius Hospital Nieuwegein, Nieuwegein, The Netherlands; [27]Medical University of Gdansk; University Clinical Center, Gdansk, Poland; [28]University Hospital Virgen del Rocío, Instituto de Biomedicina de la Universidad de Sevilla, Seville, Spain; [29]Medicinkliniken, Sunderby Sjukhus, Luleå, Sweden; [30]Sahlgrenska University Hospital, Göteborg, Sweden; [31]Ondokuz Mayis University, Samsun, Turkey; [32]The Lancashire Haematology Centre, Blackpool Teaching Hospitals NHS Foundation Trust, Blackpool Victoria Hospital, Blackpool, UK; [33]Stanford University School of Medicine, Palo Alto, CA, USA; [34]Cancer Center Clínica Universidad de Navarra, University of Navarra, Pamplona, Spain; [35]Hospital 12 de Octubre, i+12, Universidad Complutense, MIC, Centro Nacional de Investigaciones Oncológicas, CIBERONC, Madrid, Spain; [36]Memorial Sloan Kettering Cancer Center, New York, NY, USA; [37]Johnson & Johnson, Spring House, PA, USA; [38]Johnson & Johnson, Raritan, NJ, USA; [39]Johnson & Johnson, Los Angeles, CA, USA; [40]Johnson & Johnson, High Wycombe, UK; [41]Johnson & Johnson, Yorba Linda, CA, USA; [42]University of Alabama at Birmingham, Birmingham, AL, USA.

Presented by M-V Mateos at the 67th American Society of Hematology (ASH) Annual Meeting and Exposition; December 6-9, 2025; Orlando, FL, USA.

https://www.congresshub.com/ASH2025/Oncology/Teclistamab/Mateos-LBA

MajesTEC-3: Phase 3 Study Design

Key inclusion criteria

- RRMM
- 1-3 prior LOTs including a PI and lenalidomide
  - Patients with only 1 prior LOT must have been lenalidomide refractory per IMWG criteria
- ECOG PS score of 0-2

Key exclusion criteria

- Prior BCMA-directed therapy
- Refractory to anti-CD38 mAbs[a]

1:1 randomization N=587

22 Oct 2021 to 29 Sept 2023[b]

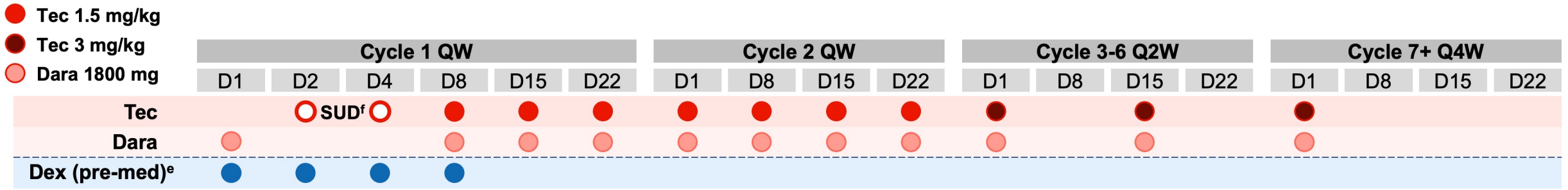
Tec-Dara
N=291
SC dosing following Dara schedule

DPd/DVd
N=296 (91% DPd)
by investigator's choice[c]

Primary endpoint
- PFS per IRC

Key secondary endpoints
- ≥CR[d] and ORR[d]
- MRD negativity (10^{-5})
- OS
- MySIm-Q Total Symptom score

Other secondary endpoints
- Safety
- PK and immunogenicity



SC dosing aligned with Dara schedule, with monthly dosing after 6 cycles; steroid sparing after Cycle 1 Day 8

[a]Prior exposure to anti-CD38 mAbs was permitted. [b]During the COVID-19 pandemic. [c]DPd/DVd were administered per the approved schedules. [d]Response and disease progression were assessed by a blinded IRC per IMWG criteria. [e]Dexamethasone, acetaminophen, and diphenhydramine pre-medication was required for the first 2 weeks; subsequent dexamethasone was not required thereafter. [f]Patients received SUD of 0.06 mg/kg and 0.3 mg/kg on Days 2 and 4, respectively.

CR, complete response; D, day; Dex, dexamethasone; DPd, daratumumab, pomalidomide, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; IMWG, International Myeloma Working Group; IRC, independent review committee; MRD, minimal residual disease; MySIm-Q, Multiple Myeloma Symptom and Impact Questionnaire; ORR, overall response rate; PFS, progression-free survival; PI, proteasome inhibitor; PK, pharmacokinetics; pre-med, pre-medication; QW, weekly; Q2W, every 2 weeks; Q4W, every 4 weeks; SC, subcutaneous; SUD, step-up dosing.

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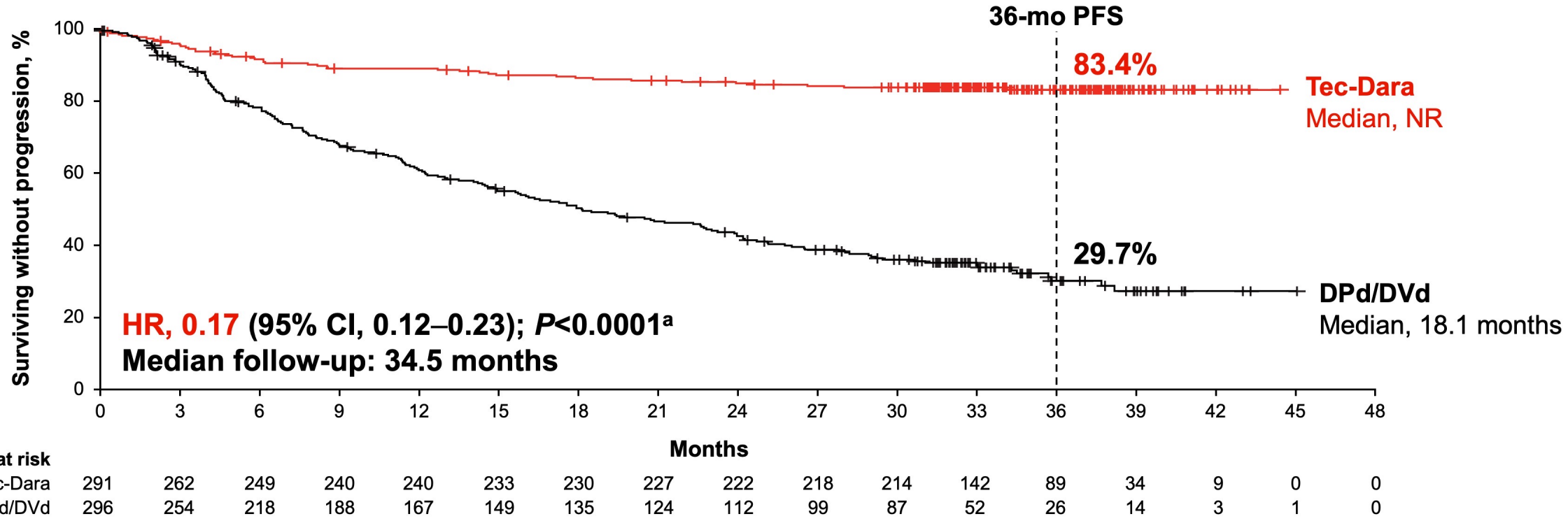
MajesTEC-3: PFS (Primary Endpoint)



Tec-Dara significantly improved PFS, with a plateauing curve after ~6 months and >90% of patients progression-free at 6 months sustaining such a benefit at 3 years

[a]The *P* value crossed the prespecified stopping boundary for superiority for the first interim analysis (*P*=0.0139).
CI, confidence interval; HR, hazard ratio; NR, not reached.

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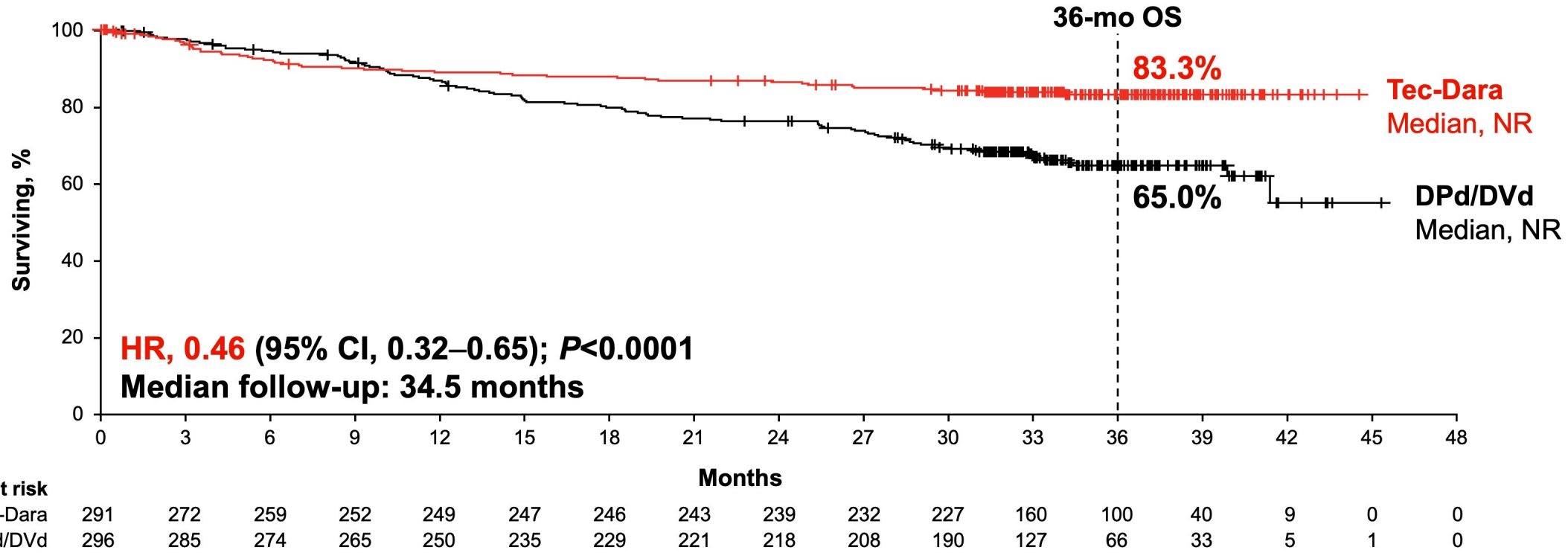
MajesTEC-3: OS



No. at risk																	
Tec-Dara	291	272	259	252	249	247	246	243	239	232	227	160	100	40	9	0	0
DPd/DVd	296	285	274	265	250	235	229	221	218	208	190	127	66	33	5	1	0

Tec-Dara significantly improved OS versus DPd/DVd, with 83% of patients alive at 3 years

Analysis of RMST demonstrated an OS benefit for Tec-Dara versus DPd/DVd (RMST difference, 2.15 months; *P*=0.0088).
RMST, restricted mean survival time.

Presented by M-V Mateos at the 67th American Society of Hematology (ASH) Annual Meeting and Exposition; December 6-9, 2025; Orlando, FL, USA.

Agenda

Introduction	Best of ASH Multiple Myeloma
Case 1	Dr Lorber – 59-year-old man
■ Faculty Presentation: Antibody-Drug Conjugates and Other Emerging Novel Therapies for Relapsed/Refractory (R/R) Multiple Myeloma (MM) — Dr Lonial	
Case 2	Dr Morganstein – 84-year-old man
Case 3	Dr Favaro – 64-year-old man
Case 4	Dr Bhatnager – 71-year-old man
Case 5	Dr Lee – 71-year-old man
■ Faculty Presentation: Integrating CAR T-Cell Therapy and Bispecific Antibodies into the Management of R/R MM — Dr Mateos	
Case 6	Dr Rudolph – 56-year-old man

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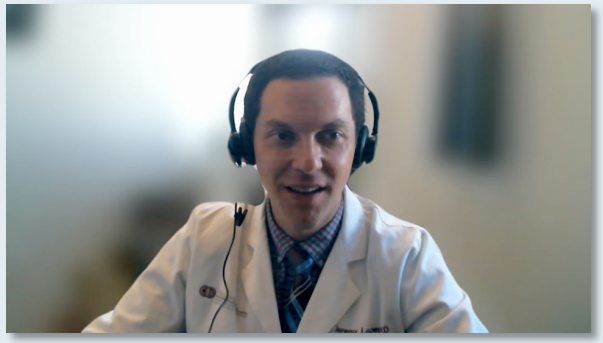

Dr Jeremy Lorber
(Beverly Hills, California)

Case Presentation: 59-year-old man with t (11;14) IgA kappa myeloma discovered during workup for new Stage IV kidney disease. Chest wall plasmacytoma. Receives daratumumab with CyBorD and radiation therapy to the plasmacytoma with minimal response

Dr Warren Brenner
(Boca Raton, Florida)

Questions for the faculty

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Agenda

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FDA Approves Belantamab Mafodotin-blmf for Relapsed or Refractory Multiple Myeloma

Press Release: October 23, 2025

"The Food and Drug Administration approved belantamab mafodotin-blmf, a B-cell maturation antigen (BCMA)-directed antibody and microtubule inhibitor conjugate, with bortezomib and dexamethasone for adults with relapsed or refractory multiple myeloma who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

Efficacy was evaluated in DREAMM-7 (NCT04246047), an open-label, randomized, multicenter trial in adults with relapsed or refractory multiple myeloma who had received at least one line of prior therapy. ... Patients were randomized (1:1) to receive either belantamab mafodotin-blmf, bortezomib, and dexamethasone (BVd) or daratumumab, bortezomib, and dexamethasone (DVd).

Efficacy was established based on progression-free survival (PFS) and overall survival (OS). The median PFS was 31.3 months (95% confidence interval [CI]: 23.5, not reached [NR]) in the BVd arm and 10.4 months (95% CI: 7, 13.4) in the DVd arm (hazard ratio [HR] 0.31, 95% CI: 0.21, 0.47). The median OS was NR and 35.7 months (95% CI: 21.1, NR) in respective arms (HR 0.49, 95% CI: 0.32, 0.76)."

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https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-belantamab-mafodotin-blmf-relapsed-or-refractory-multiple-myeloma

EMORY WINSHIP CANCER INSTITUTE

A Cancer Center Designated by the National Cancer Institute

EMORY UNIVERSITY SCHOOL OF MEDICINE

Antibody Drug Conjugates and Other Emerging Novel Therapies for R/R MM

Sagar Lonial, MD
Professor and Chair
Department of Hematology and Medical Oncology
Anne and Bernard Gray Professor in Cancer
Chief Medical Officer, Winship Cancer Institute
Emory University School of Medicine

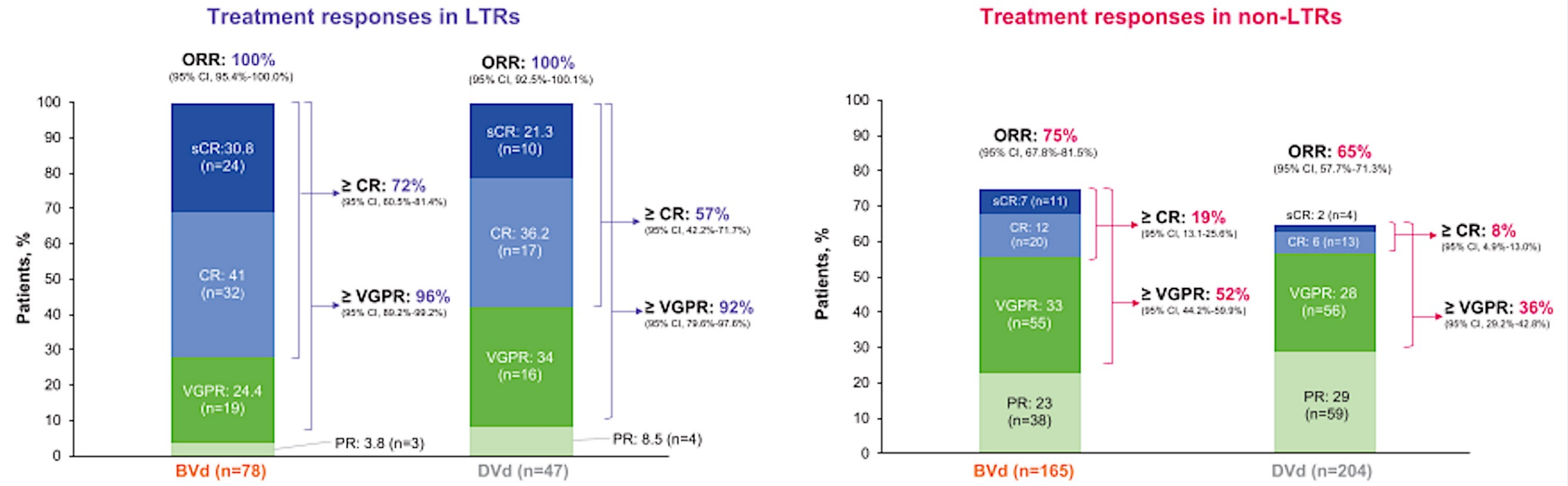
Long-term Responders From the Phase 3 DREAMM-7 Study of Belantamab Mafodotin Plus Bortezomib and Dexamethasone vs Daratumumab Plus Bortezomib and Dexamethasone in Relapsed/Refractory Multiple Myeloma

Vania Hungria,[1] Paweł Robak,[2] Marek Hus,[3] Vera Zherebtsova,[4] Christopher Ward,[5] P. Joy Ho,[6] Roman Hájek,[7] Kihyun Kim,[8] Sebastian Grosicki,[9] Hanlon Sia,[10] Adam Bryant,[11] Marcelo Pitombeira de Lacerda,[12] Gracia Aparecida Martinez,[13] Anna Sureda Balarí,[14] Michał Mielnik,[3] Maureen Nichols,[15] Jorge Mouro,[16] Zeyad Khalaf,[17] Hena Baig,[18] Margaret Polinkovsky,[19] Nick Pirooz,[19] Sybil Varghese,[19] Joe Lee,[17] Lydia Eccersley,[17] María-Victoria Mateos[20]

[1]Clinica São Germano, São Paulo, Brazil; [2]Medical University of Łódź, Łódź, Poland; [3]Medical University of Lublin, Lublin, Poland; [4]Gorodskaya Klinicheskaya Bol'nitsa Im. S.p. Botkina, Moscow, Russian Federation; [5]The Royal North Shore Hospital, Sydney, NSW, Australia; [6]Royal Prince Alfred Hospital and University of Sydney, Camperdown, NSW, Australia; [7]Department of Hematooncology, University Hospital Ostrava, Ostrava and Department of Hematooncology, University of Ostrava, Ostrava, Czech Republic; [8]Samsung Medical Center, Sungkyunkwan University, Seoul, Republic of Korea; [9]Medical University of Silesia, Katowice, Poland; [10]Pindara Private Hospital, Gold Coast, QLD, Australia; [11]Liverpool Hospital, Sydney, Australia; [12]Universidade da Região de Joinville and Centro de Hematologia e Oncologia, Joinville, Santa Catarina, Brazil; [13]Hospital das Clínicas and Instituto do Câncer do Estado de São Paulo, Universidade de São Paulo, São Paulo, Brazil; [14]Clinical Hematology Department, Institut Català d'Oncologia - L'Hospitalet, Institut de Ciències Biomèdiques de Bellvitge (IDIBELL), Universitat de Barcelona, Spain;[15]GSK, Durham, NC, USA; [16]GSK, Baar, Switzerland; [17]GSK, London, UK; [18]GSK, Mississauga, ON, Canada; [19]GSK, Collegeville, PA, USA; [20]Hematology Department, University Hospital of Salamanca/IBSAL/Cancer Research Center-IBMCC (USAL-CSIC), Salamanca, Spain

ASH 2025;Abstract 7236.

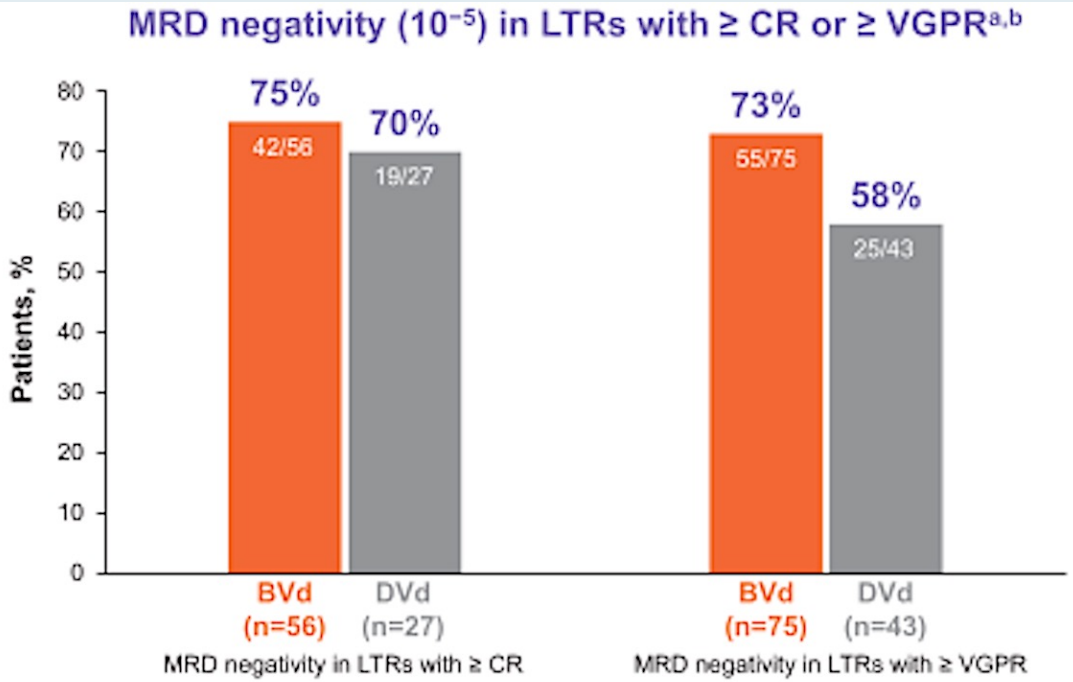
DREAMM-7: Responses in Long-Term Responders (LTRs) and Non-LTRs



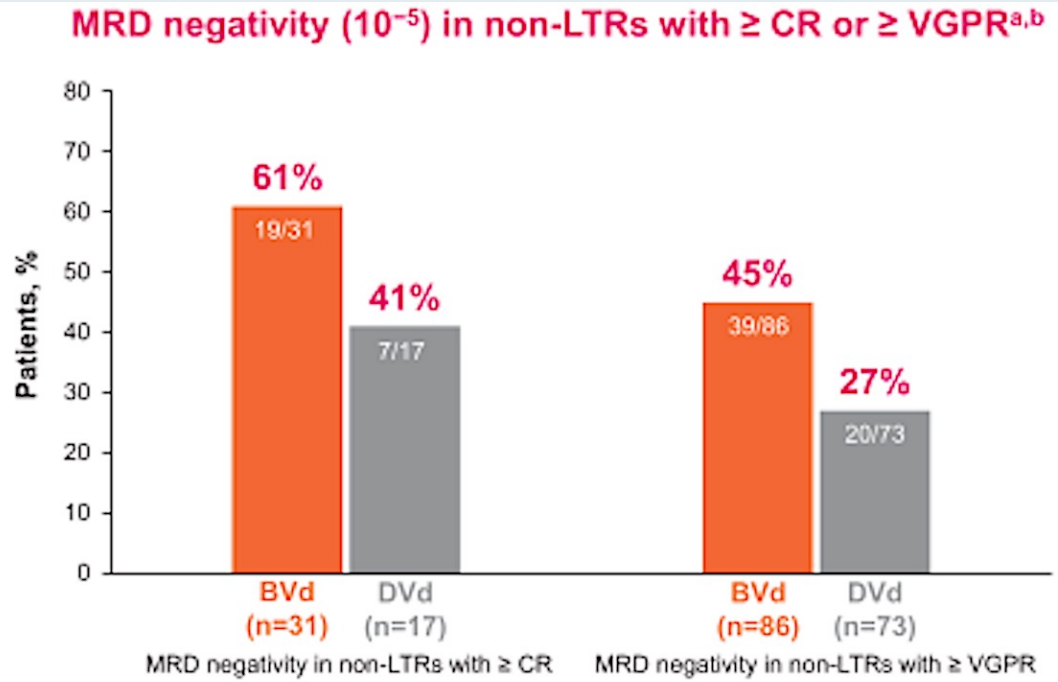
ORR = overall response rate; CR = complete response; VGPR = very good partial response; PR = partial response; BVd = belantamab mafodotin/bortezomib/dexamethasone; DVd = daratumumab/bortezomib/dexamethasone

Hungria V et al. ASH 2025;Abstract 7236.

DREAMM-7: Minimal Residual Disease (MRD) Negativity in Long-Term Responders (LTRs) and Non-LTRs



Overall MRD negativity in LTRs, n/n (%)	BVd (n=78)	DVd (n=47)
≥ CR and MRD negativity in LTRs[a,c]	42/78 (54)	19/47 (40)
≥ VGPR and MRD negativity in LTRs[a,c]	55/78 (71)	25/47 (53)
≥ CR and MRD negativity sustained for ≥12 months	29/78 (37)	11/47 (23)



Overall MRD negativity in non-LTRs, n/n (%)	BVd (n=165)	DVd (n=204)
≥ CR and MRD negativity in non-LTRs[a,c]	19/165 (12)	7/204 (3)
≥ VGPR and MRD negativity in non-LTRs[a,c]	39/165 (24)	20/204 (10)
≥ CR and MRD negativity sustained for ≥12 months	6/165 (3.6)	0

Hungria V et al. ASH 2025;Abstract 7236.

DREAMM-7: Authors' Conclusions

Across both arms, LTRs had **slightly different baseline characteristics** compared with non-LTRs; baseline characteristics **between treatment arms** were **generally well balanced**

Overall, LTRs had **fewer prior lines of therapy** than non-LTRs, suggesting that **earlier treatment with BVd** may be associated with **long-term clinical benefits**

BVd-treated LTRs had **deeper** and **more durable responses** compared with DVd-treated LTRs

The presented **safety outcomes in LTRs** (PFS ≥36 months) were **consistent with previous reports** in the overall safety population[3,4]

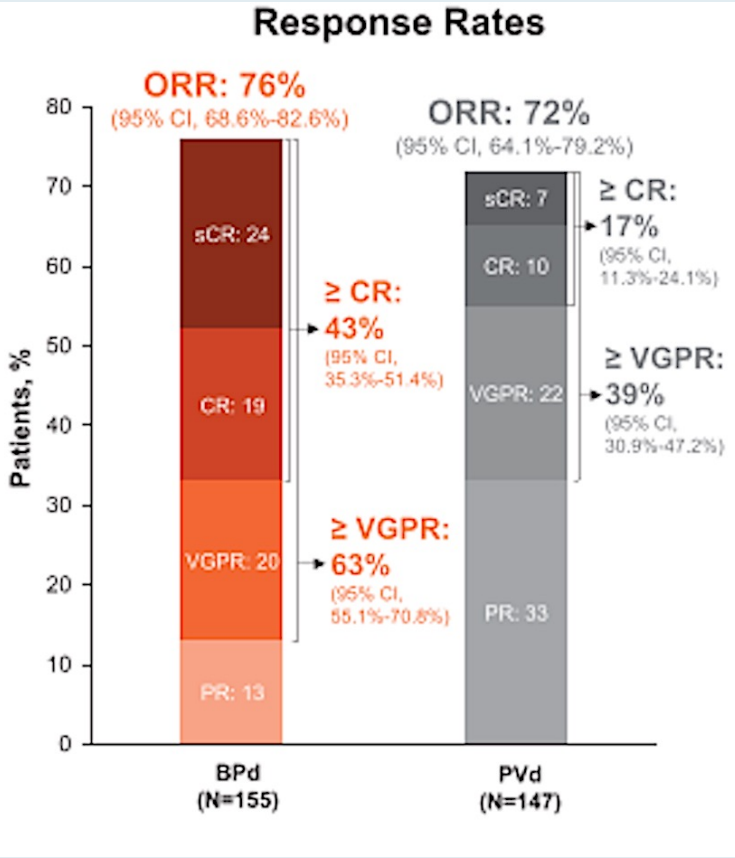
Hungria V et al. ASH 2025;Abstract 7236.

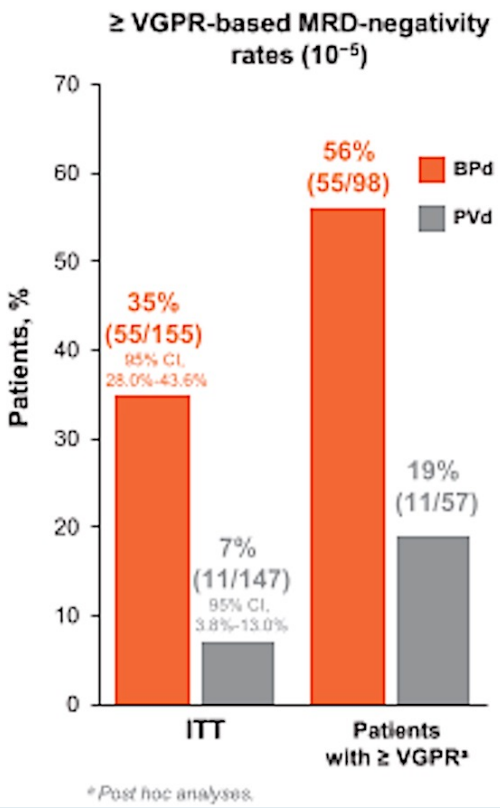
Deep responses and durable outcomes in patients treated with belantamab mafodotin plus pomalidomide and dexamethasone from long-term follow-up of the phase 3 DREAMM-8 study

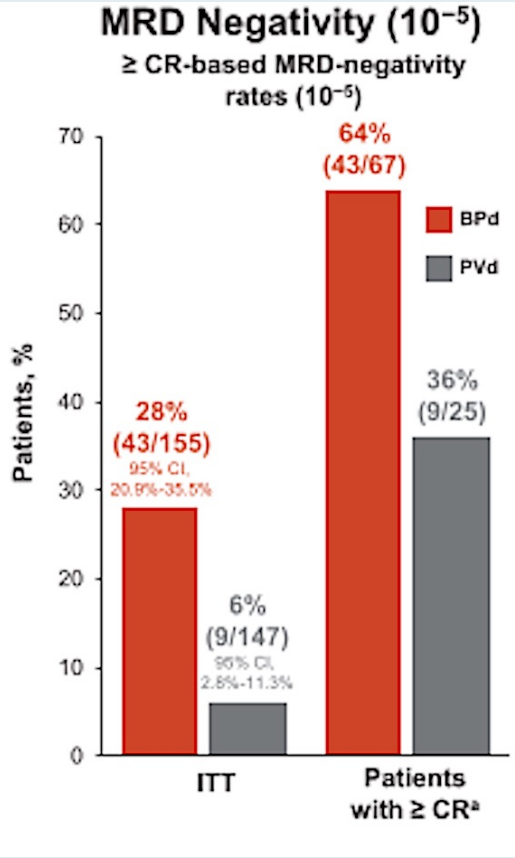
Suzanne Trudel,[1] Meral Beksaç,[2] Ludek Pour,[3] Sosana Delimpasi,[4] Vladimir Vorobyev,[5] Hang Quach,[6] Ivan Spicka,[7] Jakub Radocha,[8] Paweł Robak,[9] Kihyun Kim,[10] Michele Cavo,[11] Kazuhito Suzuki,[12] Syed Zafar,[13] Ainslee Moore,[14] Marie Duggan,[14] Kristin Morris,[15] Amy Phillips-Jones,[14] Margaret Polinkovsky,[16] Joanna Grams,[17] Ianire Garrobo-Calleja,[18] Elisabet E. Manasanch,[16] Brandon Kremer,[16] Joanna Opalinska,[16] María-Victoria Mateos,[19] Meletios A. Dimopoulos[20,21]

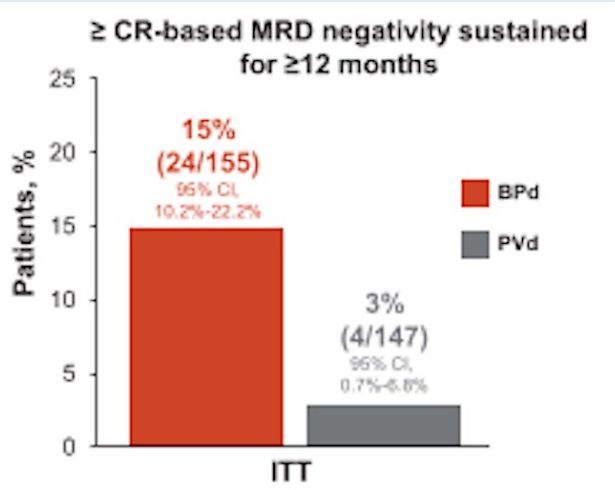
ASH 2025;Abstract 7677.

DREAMM-8 Long-Term Follow-Up: Response Rates and MRD Negativity









- In patients who were ≥ CR-based MRD negative,[a] 56% (24/43) in the BPd arm and 44% (4/9) in the PVd arm had sustained MRD negativity for ≥12 months

BPd = belantamab mafodotin/pomalidomide/dexamethasone; PVd = pomalidomide/bortezomib/dexamethasone; ITT = intent to treat

Trudel S et al. ASH 2025;Abstract 7677.

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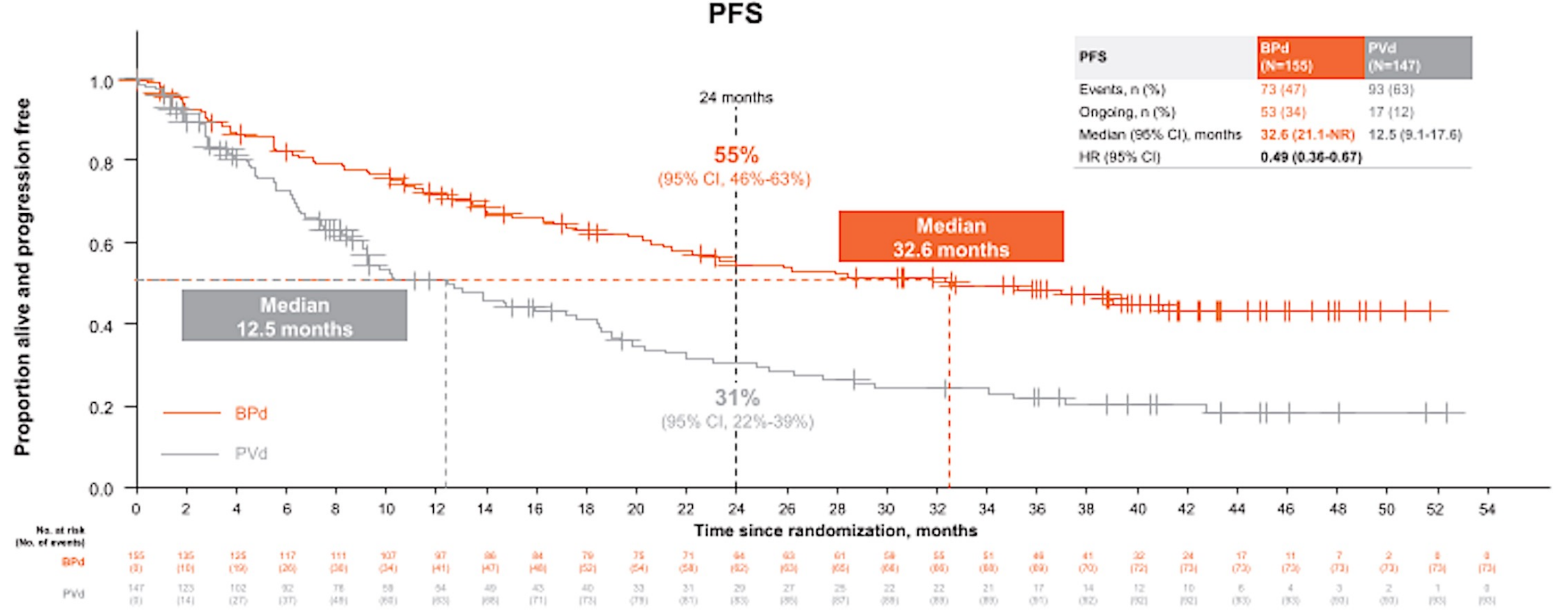
DREAMM-8 Long-Term Follow-Up: Progression-Free Survival (PFS)



PFS	BPd (N=155)	PVd (N=147)
Events, n (%)	73 (47)	93 (63)
Ongoing, n (%)	53 (34)	17 (12)
Median (95% CI), months	32.6 (21.1-NR)	12.5 (9.1-17.6)
HR (95% CI)	0.49 (0.36-0.67)	

Trudel S et al. ASH 2025;Abstract 7677.

RTP RESEARCH TO PRACTICE

DREAMM-8: Authors' Conclusions

BPd led to a 5-fold increase in MRD negativity and sustained MRD negativity vs PVd in patients with RRMM, most of whom had lenalidomide-refractory disease and a quarter of whom had disease refractory to anti-CD38 monoclonal antibodies

BPd was associated with an approximately 3-fold greater median PFS vs PVd (increase of >20 months), with greater than double the benefit following subsequent antimyeloma therapy (median PFS2); follow-up for OS is ongoing

Long-term follow-up from the DREAMM-8 trial demonstrated that **BPd maintained superiority over PVd** across all efficacy endpoints, including **PFS**, **MRD negativity, sustained MRD negativity, and DOR.** Importantly, **benefit was maintained following subsequent antimyeloma therapy**

Collectively, findings **support BPd as a new outpatient** and **off-the-shelf BCMA treatment as standard of care in MM at first relapse**

DOR = duration of response

Trudel S et al. ASH 2025;Abstract 7677.

RTP RESEARCH TO PRACTICE

Health-related quality of life with belantamab mafodotin in patients with relapsed or refractory multiple myeloma: an exploratory analysis of overall quality of life in DREAMM-7

Sagar Lonial,[1] Craig Cole,[2] Angely Loubert,[3] Laurine Bunod,[3] Manal Mhari,[3] Pralay Mukhopadhyay,[4] Sandhya Sapra,[4] Molly Purser,[4] Jacqueline Nielsen,[5] Benga Kazeem,[6] Farrah Pompilus,[7] Paul G. Richardson[8]

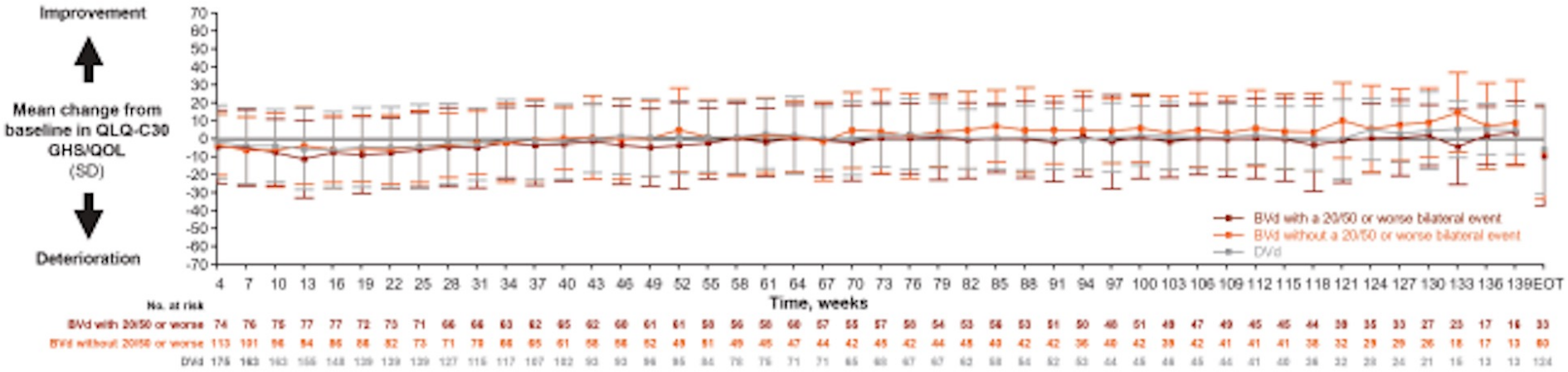
ASH 2025;Abstract 143.

DREAMM-7 Exploratory Analysis: Global Health Status (GHS) and Quality of Life (QoL)

In BVd-treated patients who experienced a bilateral BCVA decline to 20/50 or worse, HRQOL outcomes were stable over time and comparable to those with DVd

- In patients who did not experience a bilateral BCVA decline to 20/50 or worse, a trend toward improvement in GHS/QOL was observed with BVd vs DVd

GHS/QOL



Only visits with >30 participants (total) are displayed. The n values include all participants with available data at the time point. Error bars correspond to the mean change in score and SD of the distribution.

Among patients who experienced a bilateral BCVA decline to 20/50 or worse, the impact on HRQOL subscales was transient and did not meaningfully impact activities of daily life

Lonial S et al. ASH 2025;Abstract 143.

HRQOL = health-related quality of life; BCVA = best corrected visual acuity

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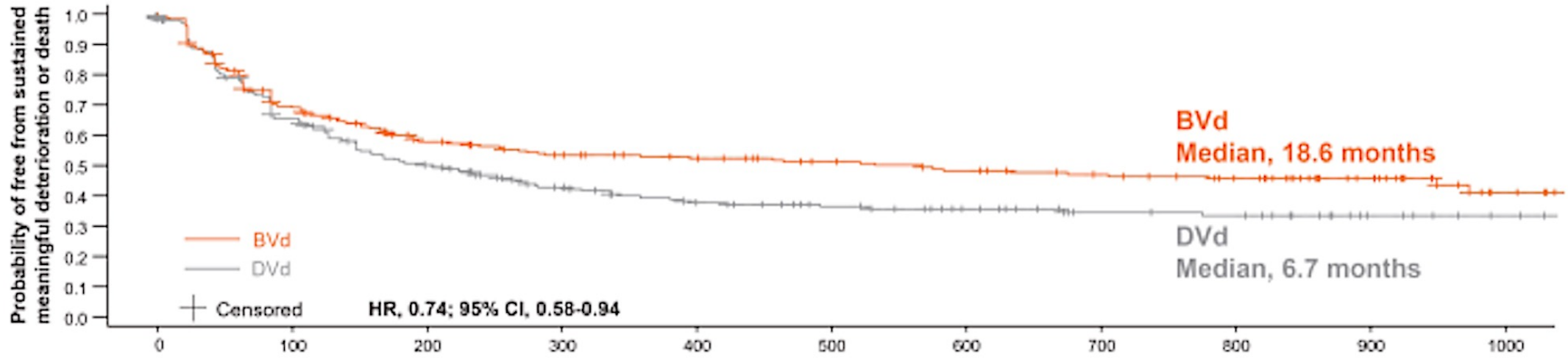
DREAMM-7 Exploratory Analysis: Treatment Benefit

Treatment with BVd demonstrated a trend toward delayed onset of sustained deterioration in physical functioning

Physical Functioning



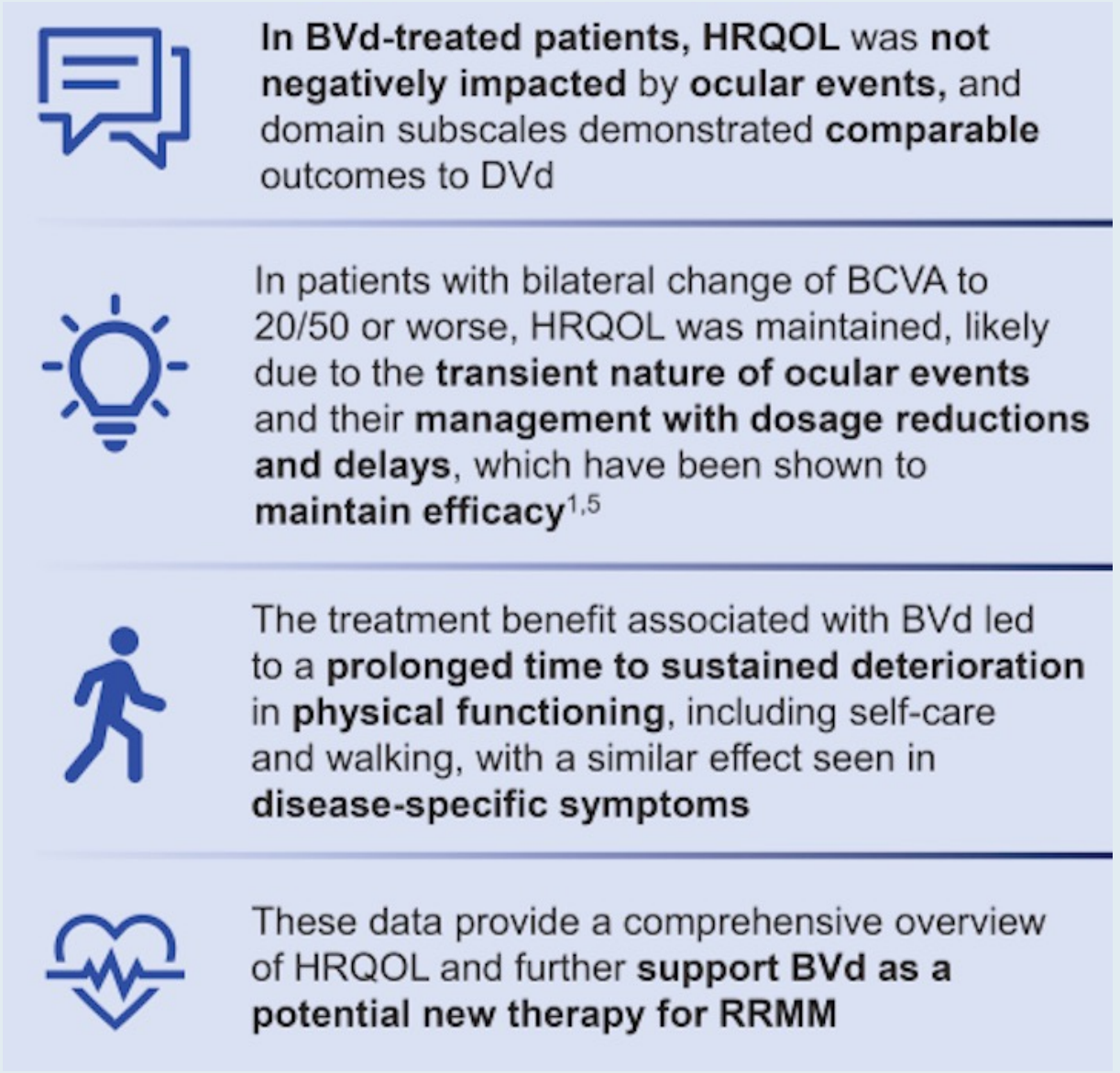
No. at risk																					
BVd	251	187	151	121	109	94	80	71	65	58	52	48	41	36	30	29	28	22	15	9	6
DVd	243	194	159	140	122	116	108	103	100	95	88	84	80	76	73	70	62	47	40	19	13

[a] Meaningful deterioration was defined as a change of ≥10 points from baseline.

A similar trend toward a delay in worsening of disease-specific symptoms was observed.

Lonial S et al. ASH 2025;Abstract 143.

DREAMM-7 HRQoL: Authors' Conclusions



NDMM = newly diagnosed multiple myeloma

Lonial S et al. ASH 2025;Abstract 143.

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Belantamab Mafodotin (Belamaf) Ocular Events Are Manageable and Reversible With Dose Modifications Guided by Standard Assessments

Sagar Lonial,[1] Paul G. Richardson,[2] Craig E. Cole,[3] Asim V. Farooq,[4] Meghan Berkenstock,[5] Julie Byrne,[6] Sumita Roy-Ghanta,[6] Rachel Rogers,[6] Amy Phillips-Jones,[7] Astrid McKeown,[7] Natalie A. Afshari[8]

[1]Winship Cancer Institute, Emory University Hospital, Atlanta, GA, USA; [2]Dana-Farber Cancer Institute, Boston, MA, USA; [3]Karmanos Cancer Institute, Wayne State University, Detroit, MI, USA, and Michigan State University, Lansing, MI, USA; [4]University of Chicago Medical Center, Chicago, IL, USA; [5]Johns Hopkins Wilmer Eye Institute, Baltimore, MD, USA; [6]GSK, Collegeville, PA, USA; [7]GSK, Stevenage, UK; [8] Shiley Eye Institute, Viterbi Family Department of Ophthalmology, University of California, San Diego, CA, USA

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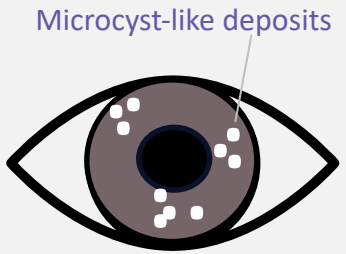
Poster number 4055
Presented at 67th ASH Annual Meeting and Exposition | December 6-9, 2025 | Orlando, FL, USA

The KVA Scale Used to Grade OEFs Has a Sensitive Criteria for Belamaf Dose Modifications

Corneal exam finding (slit lamp exam)[a]

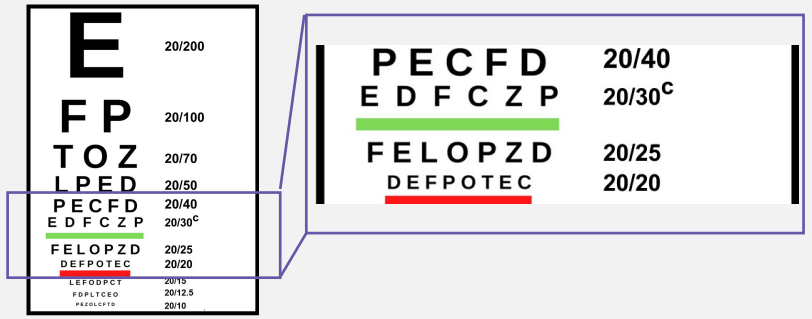


Grade 2 = eg, patchy microcyst-like deposits

Dose delay until resolution to grade 1 or better[d]

BCVA change (Snellen or equivalent assessment)

Representative Snellen Eye Chart[b]



Grade 2 = 2- or 3-line decrease in BCVA from baseline (eg, 20/20 to 20/30 or 20/40)

Dose delay until resolution to grade 1 or better[e]

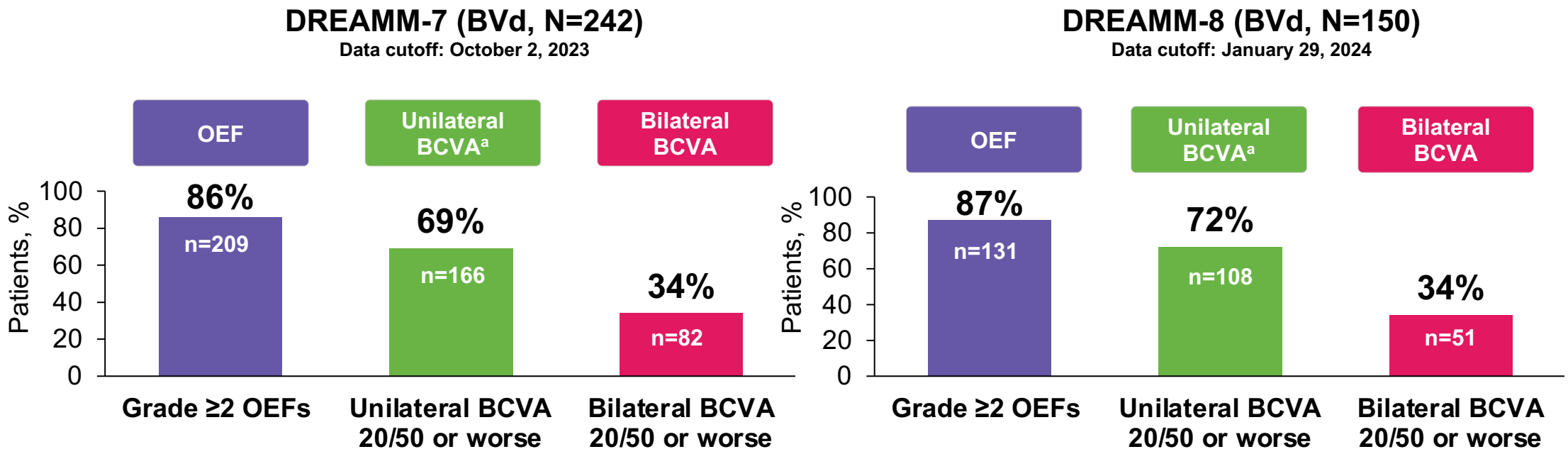
BCVA, best-corrected visual acuity; belamaf, belantamab mafodotin; KVA, Keratopathy and Visual Acuity; OEF, ocular exam finding.

[a] The most common corneal exam findings in the trial were superficial punctate keratitis, microcyst-like changes, epithelial haze, and stromal opacity. [b] Not all distances are depicted here.

[c] Included 20/30 or 20/32. [d] Mild superficial keratopathy. [e] Decline from baseline of 1 line on Snellen Visual Acuity.

Belamaf Dose Modifications Were Conservatively Guided by OEFs

Incidence and onset of events



	DREAMM-7 (BVd, N=242)			DREAMM-8 (BVd, N=150)		
	Grade ≥2 OEFs	Unilateral BCVA 20/50 or worse	Bilateral BCVA 20/50 or worse	Grade ≥2 OEFs	Unilateral BCVA 20/50 or worse	Bilateral BCVA 20/50 or worse
Onset of the first event, median (range)	6 weeks (2-87)	9 weeks (2-132)	11 weeks (2-108)	5 weeks (3-76)	12 weeks (3-109)	16 weeks (4-109)
Last event resolved	42%	61%	83%	43%	60%	73%

Grade ≥2 OEFs had a higher incidence and earlier median time to onset than vision changes

BCVA, best-corrected visual acuity; belamaf, belantamab mafodotin; BVd, belantamab mafodotin, bortezomib, and dexamethasone; OEF, ocular exam finding.
[a] Post hoc analyses.

Ocular Events Were Reversible in the Majority of Patients

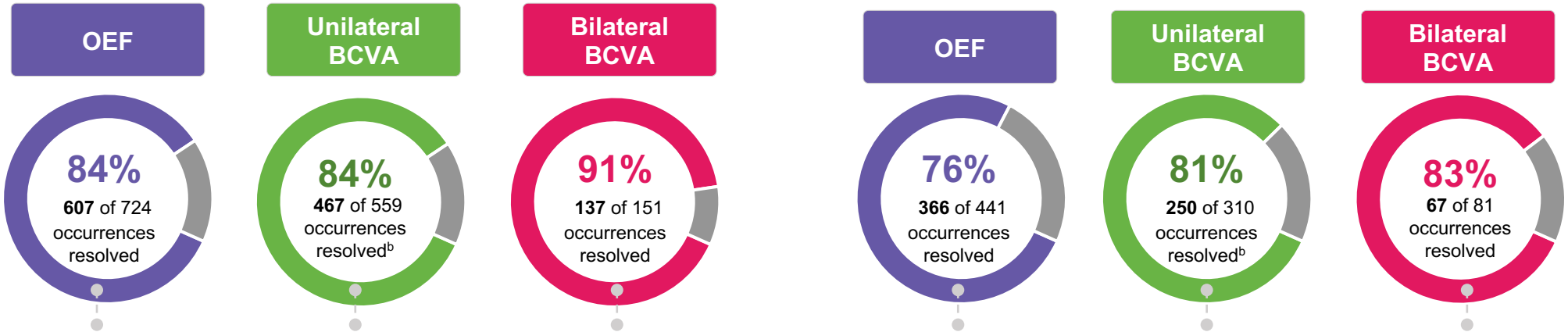
Resolution of all occurrences[a]

DREAMM-7 (BVd, N=242)

Data cutoff: October 2, 2023

DREAMM-8 (BVd, N=150)

Data cutoff: January 29, 2024



	DREAMM-7 (BVd, N=242)			DREAMM-8 (BVd, N=150)		
	OEF	Unilateral BCVA	Bilateral BCVA	OEF	Unilateral BCVA	Bilateral BCVA
Time to resolution, median (range)	12 weeks (0.7-116)	9 weeks (0.4-129)	7 weeks (1-130)	12 weeks (2-107)	8 weeks (0.7-124)	8 weeks (2-64)
Improvement of all events	NA	94% **612** of 652 improved[c]	96% **176** of 183 improved	NA	91% **303** of 332 improved[c]	89% **85** of 95 improved
Time to improvement, median (range)	NA	3 weeks (0.4-75)	3 weeks (1-37)	NA	4 weeks (1-69)	4 weeks (1-28)

Patients who experienced a bilateral worsening to 20/50 or worse did so for a median of 7% to 8% of their time on treatment

BCVA, best-corrected visual acuity; BVd, belantamab mafodotin, bortezomib, and dexamethasone; NA, not applicable; OEF, ocular exam finding.

[a] Post hoc analysis. [b] For patients with baseline 20/50 or worse, resolution must additionally be better than 20/50. [c] Only patients with baseline visual acuity better than 20/50 in ≥1 eye are included.

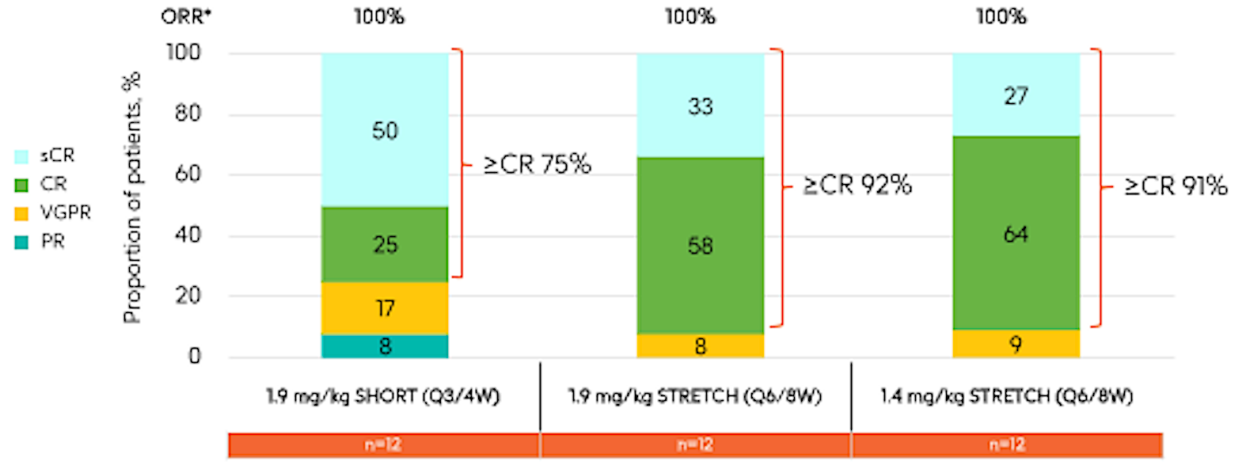
Belantamab Mafodotin (Belamaf) in Combination With Bortezomib, Lenalidomide, and Dexamethasone (VRd) for Patients (Pts) With Transplant-Ineligible (TI) Newly Diagnosed Multiple Myeloma (NDMM): a Focus on Treatment Efficacy and Management/Resolution of Ocular Events in the Phase 1 DREAMM-9 Study

Saad Z. Usmani, MD[1], Michał Mielnik, MD, PhD[2], Aránzazu Alonso Alonso, MD[3,4], Al-Ola Abdallah, MD, PhD[5], Mamta Garg, MD, FRCP, FRCPath[6], Wojciech Janowski, MD[7], Youngil Koh, MD[8], Chang-Ki Min, MD[9], Enrique M. Ocio, MD, PhD[3], Hang Quach, MD[10], Karthik Ramasamy, MD[11] , Albert Oriol, MD[3,12], Paula Rodriguez-Otero, MD[13], Ricarda Garcia Sanchez, MD[14], Irwindeep Sandhu, MD, FRCPC[15], Katja Weisel, MD[16], Chris Brawley, MSc[17], Miguel M. Murillo, PhD[18], Fernando Carreño, PhD[19], Jacqueline L. Egger, PhD[20], Morrys C. Kaisermann, MD, PhD[21], Marek Hus, MD[2]

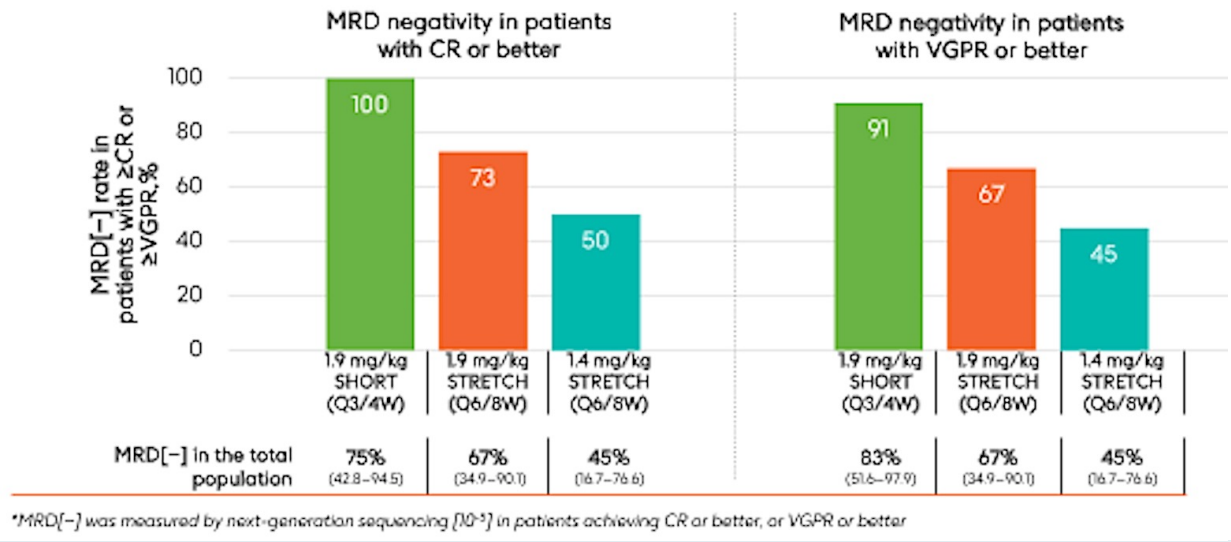
ASH 2025;Abstract 13646.

DREAMM-9 Efficacy: Overall Response Rate (ORR) and MRD Negativity Rates

- ORR was ≥71% across all dosing cohorts
- **ORR was 100%** in 1.9 SHORT, 1.9 STRETCH, and 1.4 STRETCH cohorts



- MRD negativity* in patients with CR or better **was higher in cohorts with the highest planned doses**, 1.9 SHORT, and 1.9 STRETCH



*MRD[−] was measured by next-generation sequencing [10^{-5}] in patients achieving CR or better, or VGPR or better

Usmani SZ et al. ASH 2025;Abstract 13646.

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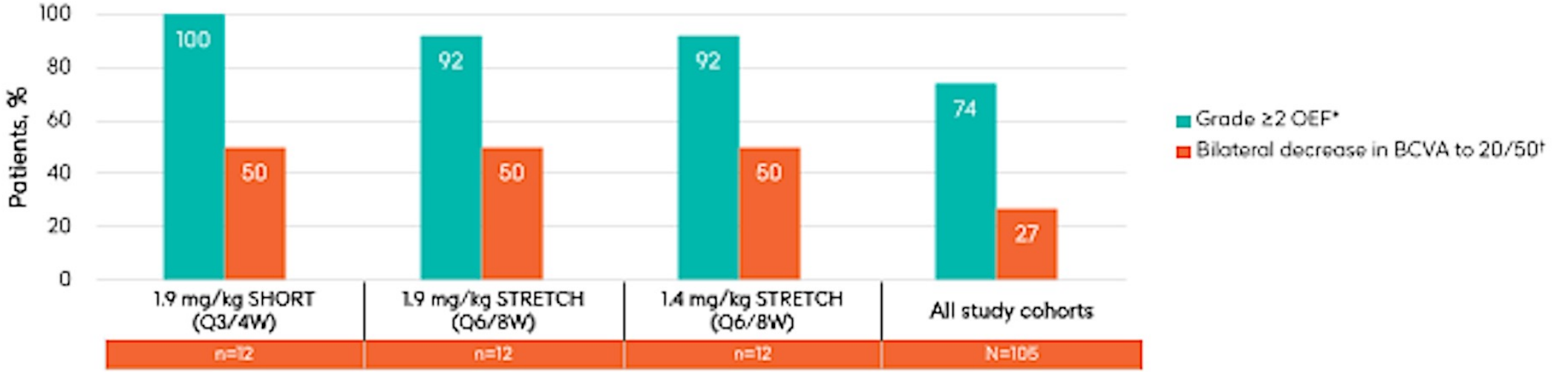
DREAMM-9 Efficacy: Ocular Event Findings (OEFs)

- In the selected cohorts, occurrence of Gr≥2 OEFs* and bilateral BCVA worsening to 20/50 or worse† were similar
- Ocular events were generally managed with dose modifications and discontinuation rates due to Grade ≥2 OEF events **were low at 6% across all 8 cohorts**



*OEF were measured on the protocol defined KVA scale comprising corneal findings during a slit lamp examination and/or changes in BCVA. BCVA is visual acuity with the assistance of corrective lenses, assessed using a Snellen chart. BCVA of 20/50 may affect ability to read small print but not activities of daily life or driving. †In patients in 20/25 BCVA at baseline.

- OEFs were managed by dose delays and schedule extensions and **generally reversed** when adequate follow up was available

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DREAMM-9: Authors' Conclusions

While BVRd demonstrated high ORRs across all cohorts, MRD[−] rates were higher in the 1.9 mg/kg cohorts

Lower-dose-intensity cohorts trended to lower OEF incidence; across cohorts, adverse events including OEFs were manageable via dose reductions/schedule extensions[8] and rates of discontinuations due to OEFs were low overall

OEFs were **generally reversible and transient**: in the 1.9 mg/kg cohorts, ≥91% of first OEF and 100% of first bilateral BCVA reductions to 20/50 or worse resolved

In line with clinical observations, **ER analyses indicated the potential for higher exposure (as expected with a 1.9 mg/kg dose) to improve responses and longer schedules to improve tolerability**

Together, in the BVRd regimen, an initial 1.9 mg/kg dose of belamaf with a Q6/8W schedule in patients with NDMM may induce deeper responses, and subsequent schedule extensions (e.g., Q12W) may allow OEF resolution and improve tolerability

These results supported selection of the dose and schedule for belamaf in NDMM including for DREAMM-10 (BRd vs DRd in TI NDMM)[9,14]

NDMM = newly diagnosed multiple myeloma

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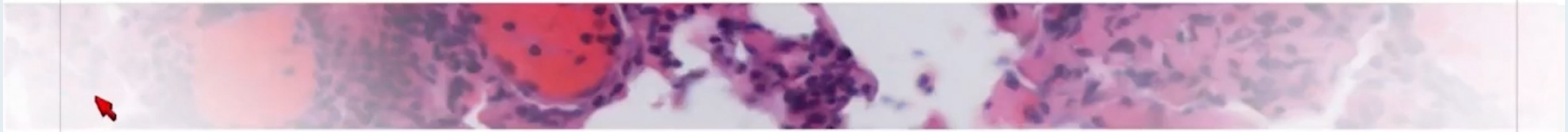

A phase 2 trial of iberdomide, carfilzomib, daratumumab and dexamethasone quadruplet therapy for relapsed/refractory multiple myeloma: The **ReKInDLE** study

Ola Landgren, James Hoffman, Abhishek Pandey, Andrew Kowalski, Michael Durante, David Coffey, Marcella Kaddoura, Brian Walker, Leslie Gallardo, Elizabeth Lyubchenko, Massiel Lopez, Fiorela Flores, Liettel Ortega, Rabia Bukhari, Kellye Koubek, Caterine Diaz, Stephanie Mompoint, Sindy Gutierrez, Faika Shah, Stephanie Fernandes, Michelle Armogan, Dickran Kazandjian, **Benjamin Diamond**

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SYLVESTER COMPREHENSIVE CANCER CENTER UNIVERSITY OF MIAMI HEALTH SYSTEM | MYELOMA INSTITUTE

NCT05896228

ASH 2025;Abstract 4108.

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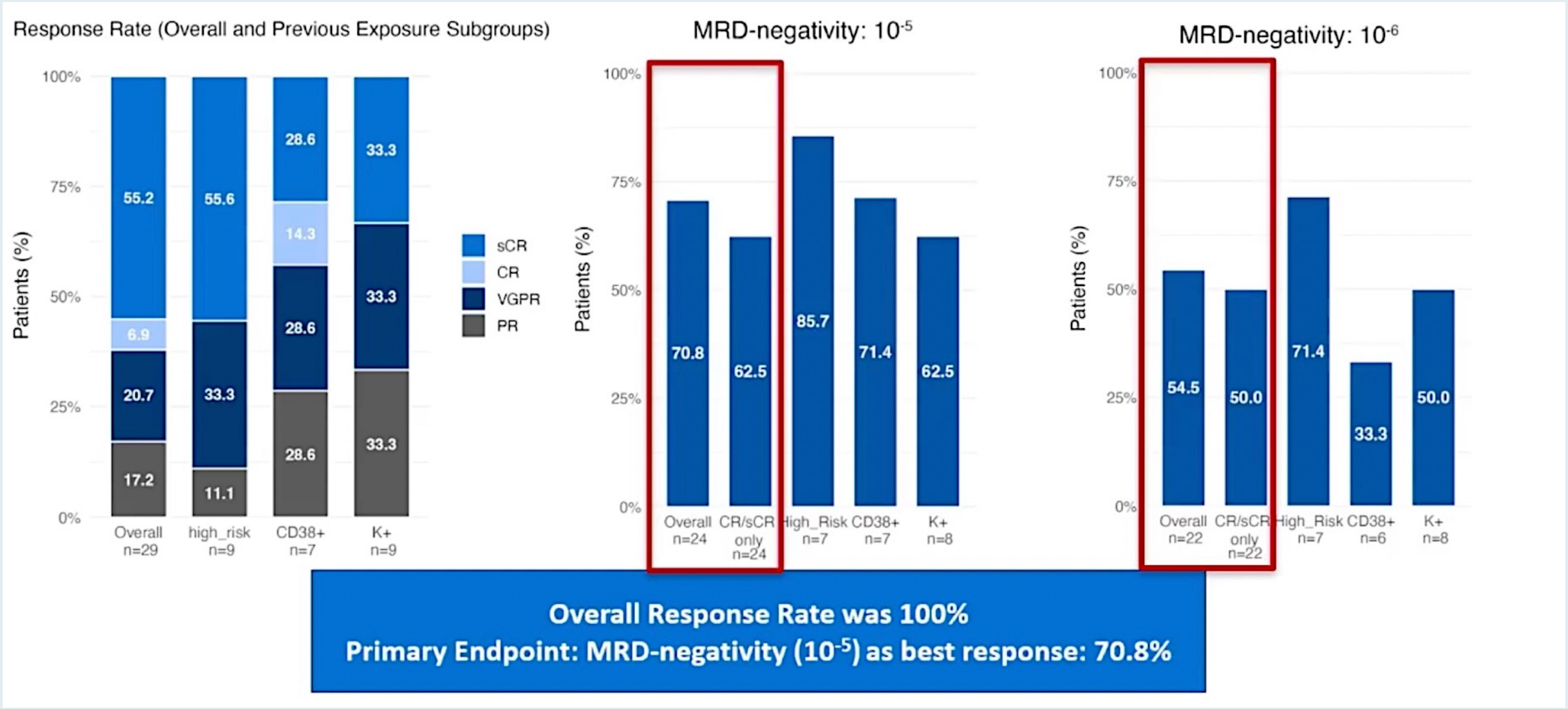
ReKInDLE: Response Rates and MRD Analysis



Landgren O et al. ASH 2025;Abstract 4108.

ReKInDLE: Authors' Conclusions

- Iber-DKd appears to be a potent regimen in lenalidomide-refractory multiple myeloma.
- MRD-negativity rate (10^{-5}) of 70.8% (62.5% in ≥CR only)
  - DKd (CANDOR: MRD-negative CR; 21.8%, Lenalidomide-Refractory; 32%)
  - DPd (APOLLO: MRD-negativity; 9%, Lenalidomide Refractory; 79%)
  - Activity despite prior exposures to K and anti-CD38 therapy.
- Favorable safety profile with predominantly [expected] hematologic toxicity.
  - Further strategies could leverage early growth factor support to further improve dose intensity.
- Deep responses permit time-limited combination therapy and de-escalation to monotherapy.
  - All [n=18] patients in response at time of de-escalation to monotherapy remain in response.
- With the current reality of triple-class exposure and lenalidomide-refractoriness at first relapse, time-limited or response-adapted iberdomide-based combination therapy is worthy of further investigation.
  - EXCALIBER-RRMM (phase III) to report Iber-Dara-Dex (vs Dara-Bor-Dex) in the early relapse setting

DKd = daratumumab/carfilzomib/dexamethasone

Landgren O et al. ASH 2025;Abstract 4108.

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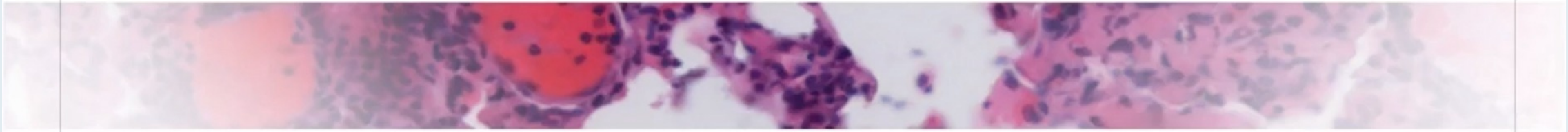

Interim analysis of efficacy and safety for Viber-M (ALLG MM25): A Phase Ib/II study of Venetoclax, Iberdomide and Dexamethasone for patients in first or second relapse of Multiple Myeloma with t(11;14)

Shirlene Sim[1,2], Adam Bryant[3], Cecily Forsyth[4], Olga Motorna[5], Jennifer Brotchie[6], Jay Hocking[7], Angelina Yong[8], Nicole Chien[9], Ian Kerridge[10], Hock Choong Lai[11], Ann Solterbeck[12], Robert Traficante[12], Maritsa Jocic[13], Hang Quach[1,2]

[1]St Vincent's Hospital Melbourne, Fitzroy, Victoria, Australia, [2]The University of Melbourne, Victoria, Australia, [3]Liverpool Hospital, Liverpool, New South Wales, Australia, [4]Gosford Hospital, Gosford, New South Wales, Australia, [5]Eastern Health, Box Hill, Victoria, Australia, [6]South West Healthcare, Warrnambool, Victoria, Australia, [7]Austin Health, Heidelberg, Victoria, Australia, [8]Royal Adelaide Hospital, Adelaide, South Australia, Australia, [9]Auckland City Hospital, Auckland, New Zealand, [10]Royal North Shore Hospital, St Leonards, New South Wales, Australia, [11]Townsville University Hospital, Douglas, Queensland, Australia, [12]Statistical Revelations, Australia, [13]Australasian Leukaemia and Lymphoma Group, Australia.

Corresponding author: Hang.Quach@svha.org.au

ASH 2025;Abstract 7320.

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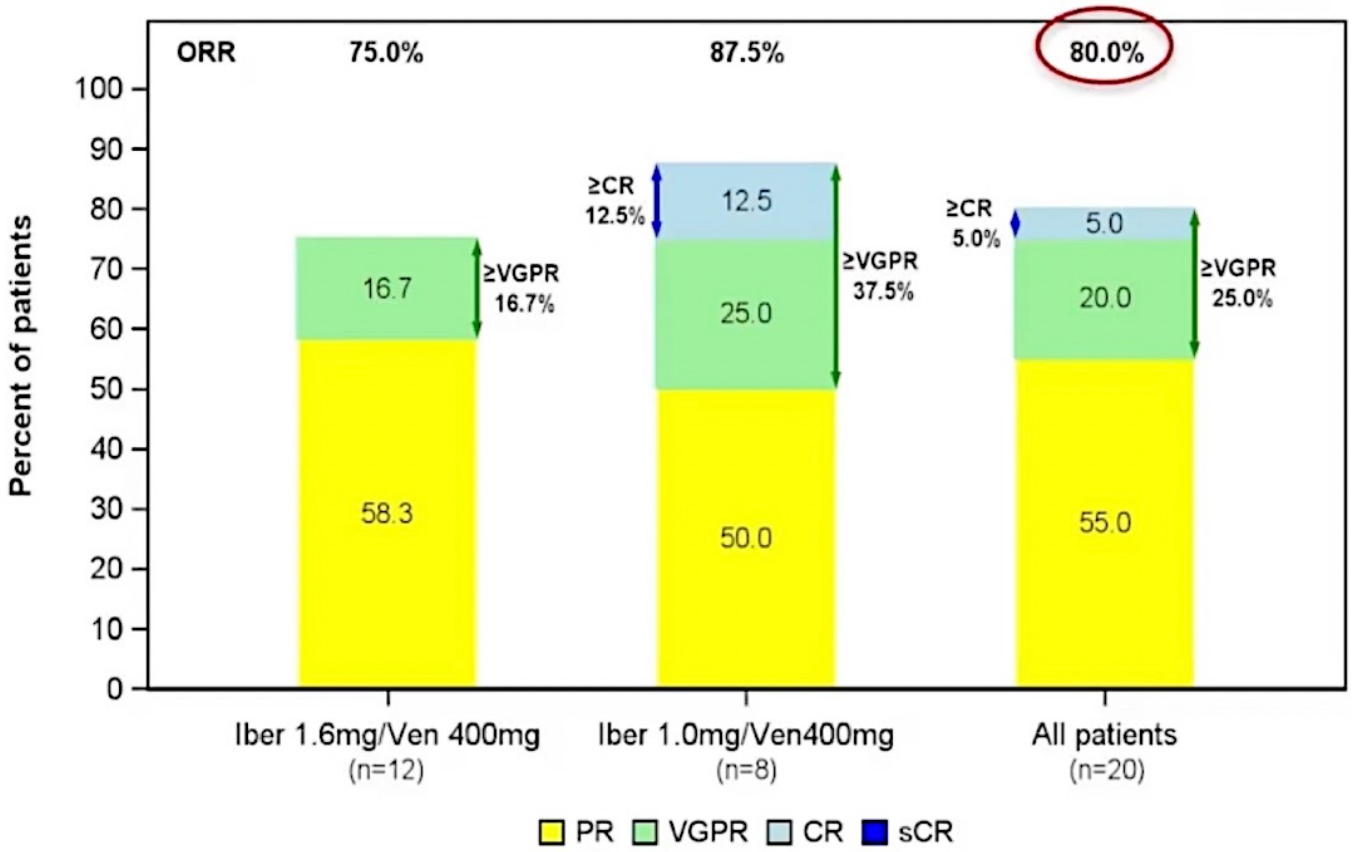
Viber-M (ALLG MM25): Response at the End of Cycle 3



- ORR 80%
  - ≥VGPR 25%
  - ≥CR 5%
- Median time to first response: 41.5 days (range 28 – 62 days)
- Lenalidomide refractory patients (n=13):
  - ORR 85%
  - ≥VGPR 23%
- Daratumumab refractory (n=4):
  - ORR 75%
  - ≥VGPR 25%

Sim S et al. ASH 2025;Abstract 7320.

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Viber-M (ALLG MM25): Authors' Conclusions

- **The combination of venetoclax, iberdomide and dexamethasone is deliverable at a dose of venetoclax 400mg and iberdomide 1.0mg in a 28-day cycle**
  - Main side effect was neutropenia (50%), but this was manageable
  - Other side effects (e.g. diarrhoea, fatigue, insomnia) were mild, mainly grade 1/2 only
  - Of note, infection rate was low (all grade 35%; grade 3/4 10%)
- **This triplet combination demonstrates encouraging early efficacy in t(11;14) MM patients who have had 1-2 prior lines of therapy, including in Len-refractory patients**
  - ORR of 80% and ≥VGPR rate of 25% at the end of cycle 3 of treatment, with similar responses demonstrated in Len- and Dara-refractory patients
  - At median follow up of 12.2 months, 33/47 patients remain on treatment, with the longest duration on treatment of 26 months and ongoing

→ The Viber-M study is ongoing with 47/50 patients recruited thus far

Sim S et al. ASH 2025;Abstract 7320.

100

Safety and Efficacy of Elranatamab in Combination With Iberdomide in Patients With Relapsed or Refractory Multiple Myeloma: Results from the Phase 1b MagnetisMM-30 Trial

Attaya Suvannasankha,[1] Jonathan L. Kaufman,[2] Ashraf Badros,[3] Michel Pavic,[4] Hock-Choong Lai,[5] Muhammad S Raza,[6] Parth S Shah,[7] Patrick Y. Muller,[8] Jorge Acosta,[8] Margaret Hoyle,[9] Erik R Vandendries,[10] Jay Cheng,[11] Alexander Lesokhin[12]

[1]Melvin and Bren Simon Comprehensive Cancer Center, Indiana University, Indianapolis, IN, USA; [2]Winship Cancer Institute, Emory University, Atlanta, GA, USA; [3]Greenebaum Comprehensive Cancer Center, University of Maryland, Baltimore, MD, USA; [4]Centre Intégré Universitaire de Santé et de Services Sociaux de l'Estrie - Centre Hospitalier Universitaire de Sherbrooke, Quebec, QC, Canada; [5]Icon Cancer Centre Townsville, Queensland, AU; [6]Dr. Everett Chalmers Hospital, Halifax, NS, Canada; [7]Dartmouth Hitchcock Medical Center, Hanover, NH, USA; [8]Bristol Myers Squibb, Boudry, Switzerland; [9]Pfizer Inc, Milan, Italy; [10]Pfizer Inc, Cambridge, MA, USA; [11]Pfizer Inc, Bothell, WA, USA; [12]Memorial Sloan Kettering Cancer Center, New York, NY, USA

Presented at the 67th ASH Annual Meeting and Exposition | December 6-9, 2025 | Orlando, FL

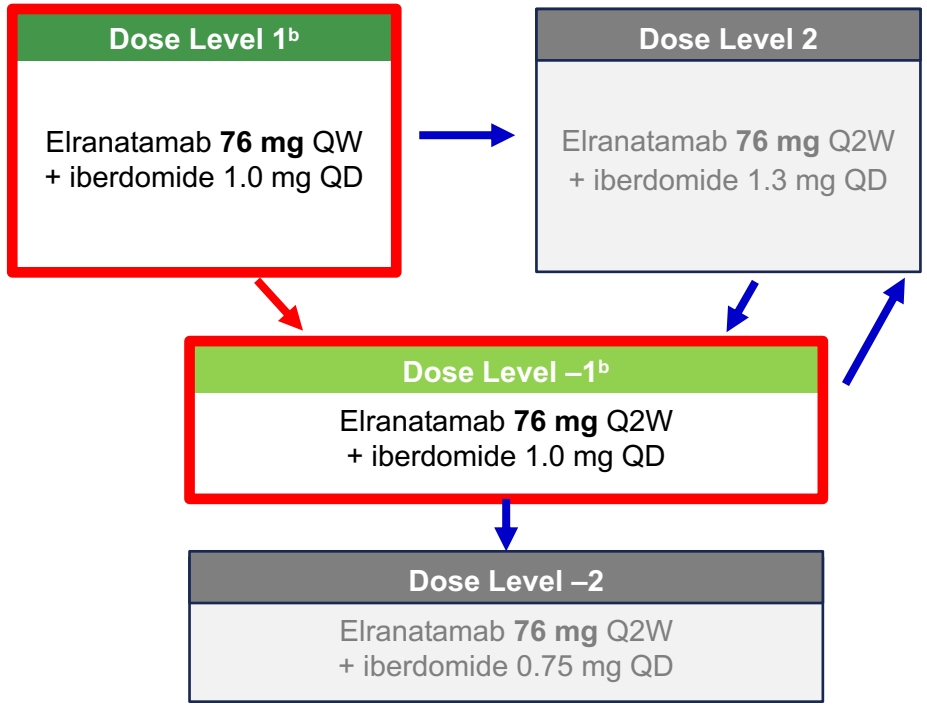
MagnetisMM-30 Study Design

- MagnetisMM-30 (NCT06215118) is a phase 1b, open-label, multicenter, prospective study
- **Part 1** (dose escalation) primary objective was to assess the tolerability and safety of elranatamab in combination with iberdomide to determine the recommended doses of the combination for evaluation in **Part 2** (randomized dose optimization)
  - A BOIN approach was used to guide dose escalation/de-escalation in **Part 1**

Patients with RRMM

Key inclusion criteria
- Age ≥18 years with MM per IMWG criteria
- ECOG PS 0-1
- 2-4 prior LOTs, including ≥1 IMiD and ≥1 PI[a]
- Relapsed or refractory to last LOT

Key exclusion criterion
- Stem cell transplant ≤12 weeks prior to enrollment or active GVHD
- Ongoing grade ≥2 peripheral sensory or motor neuropathy; history of grade ≥3 peripheral motor polyneuropathy



Primary endpoint
- DLTs during DLT observation period

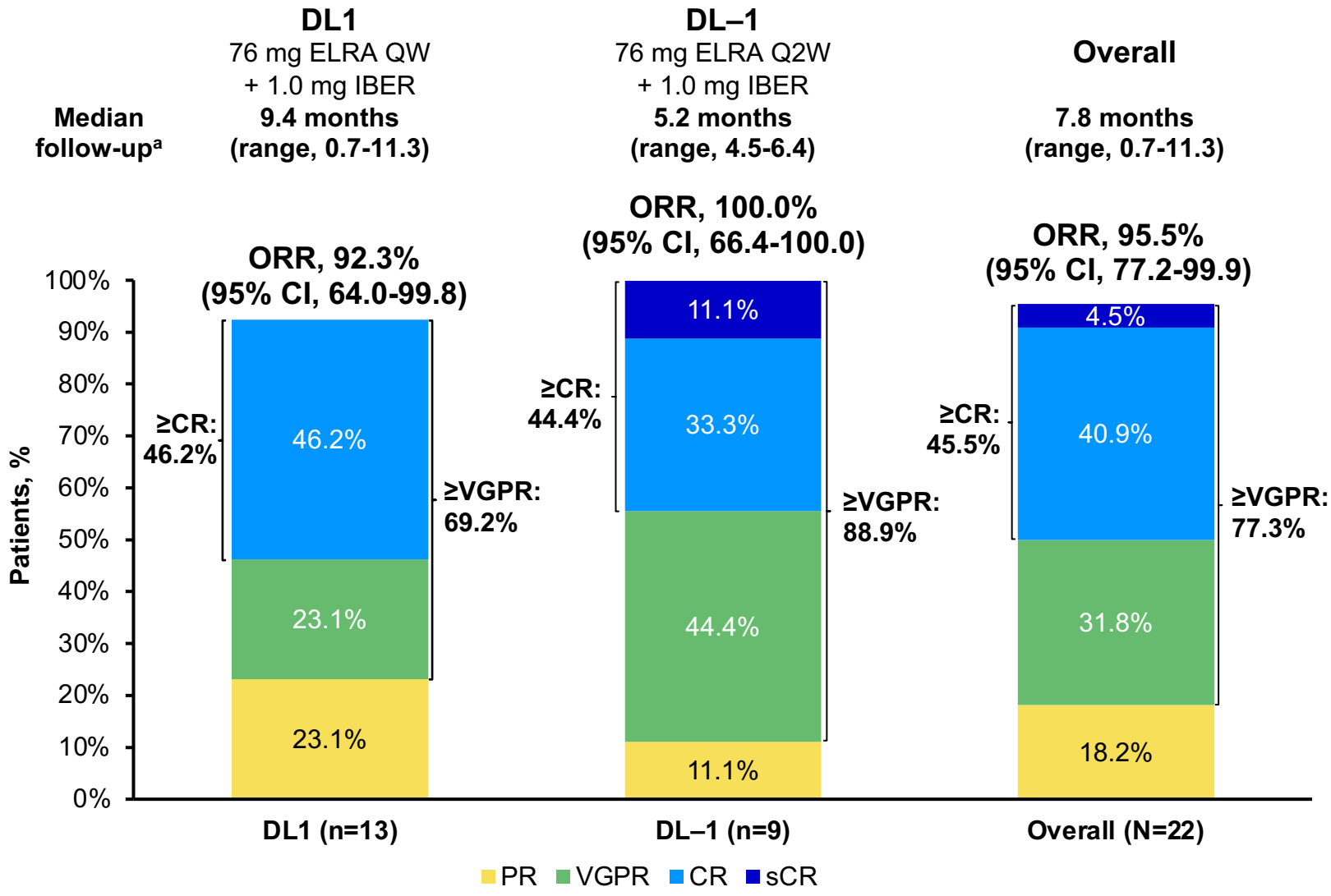
Secondary endpoints
- AEs and laboratory abnormalities
- ORR[c]
- CR rate[c]
- Time-to-event endpoints[c]
- PK
- MRD negativity rate[c]
- Immunogenicity

[a] All patients must have received ≥2 consecutive cycles of an IMiD-containing regimen and ≥2 consecutive cycles of a PI or PI-containing regimen; [b] All patients received an initial 14-day cycle of elranatamab (12 mg on day 1, 32 mg on day 4, 76 mg on day 8) without iberdomide. Iberdomide was dosed at 21 out of 28 days for subsequent cycles; [c] Per IMWG criteria

AE=adverse event; BOIN=Bayesian Optimal Interval Design; CR rate=complete response rate; DLT=dose-limiting toxicity; ECOG PS=Eastern Cooperative Oncology Group performance status; GVHD=graft vs host disease; IMiD=immunomodulatory drug; IMWG=International Myeloma Working Group; LOT=line of therapy; MM=multiple myeloma; MRD=minimal residual disease; ORR=objective response rate; PI=proteasome inhibitor; PK=pharmacokinetics; QD=once daily; QW=once weekly; Q2W=once every 2 weeks

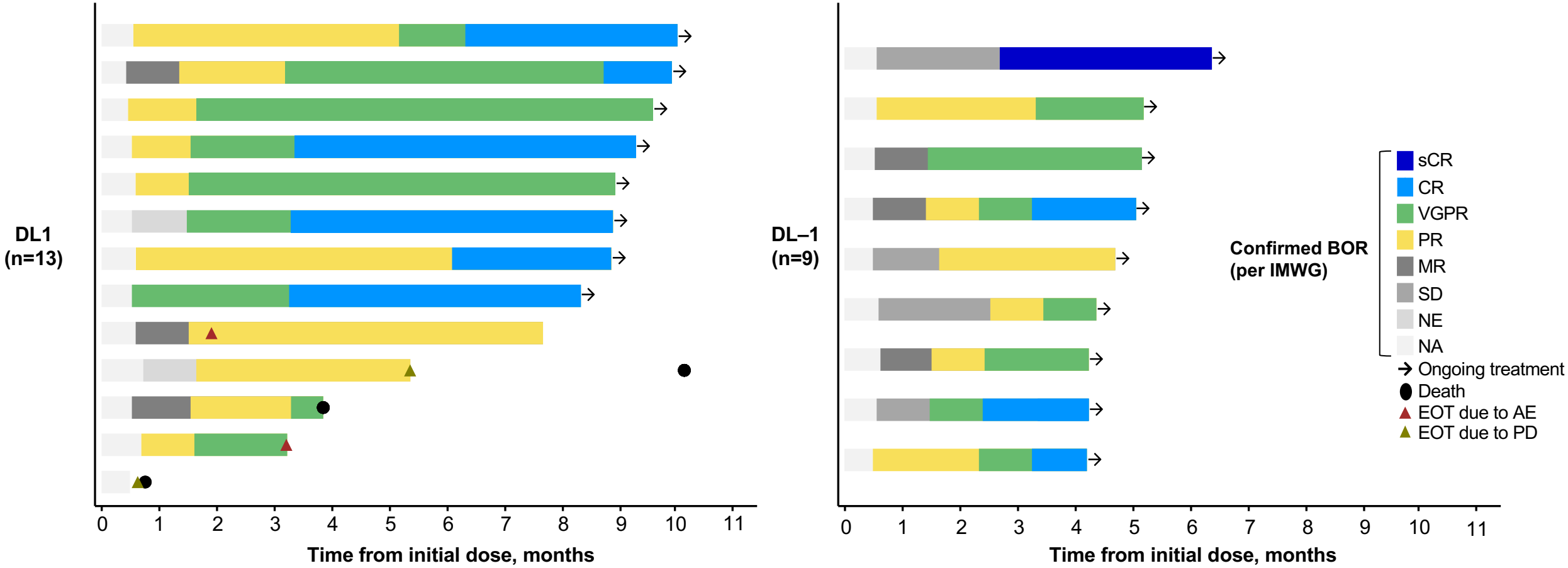
ORR

- Overall, the confirmed ORR by investigator was 95.5% (95% CI, 77.2-99.9)
- Responses occurred early
  - Median time to response was 1.4 months (range, 0.5-2.7)



[a] Simple median of observation times.
CR=complete response; DL=dose level; ELRA=elranatamab; IBER=iberdomide; ORR=objective response rate; PR=partial response; sCR=stringent complete response; VGPR=very good partial response

Swimmer Plot: Response and PFS per investigator



Grade 5 treatment-emergent adverse events were progressive disease and pancreatic cancer (patient died with VGPR).

AE=adverse event; BOR=best overall response; CR=complete response; DL=dose level; IMWG=International Myeloma Working Group; EOT=end of treatment; MR=minimal response; NA=not assessed; NE=not evaluable; PD=progressive disease; PR=partial response; sCR=stringent complete response; SD=stable disease; VGPR=very good partial response

Agenda

Introduction	Best of ASH Multiple Myeloma
Case 1	Dr Lorber – 59-year-old man
■ Faculty Presentation: Antibody-Drug Conjugates and Other Emerging Novel Therapies for Relapsed/Refractory (R/R) Multiple Myeloma (MM) — Dr Lonial	
Case 2	Dr Morganstein – 84-year-old man
Case 3	Dr Favaro – 64-year-old man
Case 4	Dr Bhatnager – 71-year-old man
Case 5	Dr Lee – 71-year-old man
■ Faculty Presentation: Integrating CAR T-Cell Therapy and Bispecific Antibodies into the Management of R/R MM — Dr Mateos	
Case 6	Dr Rudolph – 56-year-old man

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Case Presentation: 84-year-old morbidly obese man with CAD, CHF and sleep apnea with multiregimen-relapsed myeloma eventually, as part of expanded access, receives belantamab mafodotin with low-dose pomalidomide

Dr Neil Morganstein (Summit, New Jersey)

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Agenda

Introduction	Best of ASH Multiple Myeloma
Case 1	Dr Lorber – 59-year-old man
■ Faculty Presentation: Antibody-Drug Conjugates and Other Emerging Novel Therapies for Relapsed/Refractory (R/R) Multiple Myeloma (MM) — Dr Lonial	
Case 2	Dr Morganstein – 84-year-old man
Case 3	Dr Favaro – 64-year-old man
Case 4	Dr Bhatnager – 71-year-old man
Case 5	Dr Lee – 71-year-old man
■ Faculty Presentation: Integrating CAR T-Cell Therapy and Bispecific Antibodies into the Management of R/R MM — Dr Mateos	
Case 6	Dr Rudolph – 56-year-old man

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Dr Justin Favaro
(Charlotte, North Carolina)

Case Presentation: 64-year-old man s/p CVA with aphasia who has multiregimen-relapsed MM after daratumumab, PIs, IMIDs and selinexor receives teclistamab

Dr Priya Rudolph
(Athens, Georgia)

Questions for the faculty

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Case 6	Dr Rudolph – 56-year-old man

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Case Presentation: 71-year-old man with kappa light chain myeloma experiences CR on cilta-cel CAR T-cell therapy with hypogammaglobulinemia requiring IVIG, develops melanoma of the abdominal wall

Dr Tina Bhatnagar (Wheeling, West Virginia)

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Case 6	Dr Rudolph – 56-year-old man

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Case Presentation: 71-year-old man with light chain MM receives daratumumab/RVd with VGPR, subsequently completes ASCT → maintenance ixazomib and 2 years later is diagnosed with locally advanced prostate cancer treated with radiation therapy and ADT. Now with myeloma progression

Dr Eric Lee (Fountain Valley, California)

RTP RESEARCH TO PRACTICE

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HOSPITAL UNIVERSITARIO DE SALAMANCA

IBSAL Instituto de Investigación Biomédica de Salamanca

CIC Centro de Investigación del Cáncer

University of Salamanca

Integrating CAR-T cell therapy and BsAbs into the management of RRMM patients

María-Victoria Mateos
Salamanca, Spain

Treatment landscape in Multiple Myeloma today: realistic situation

1st line

ASCT eligible

AntiCD38 + PI + IMiD + Dex

ASCT

Len/Dara-Len

ASCT ineligible

Dara-Len-dex

Dara-VMP/RVd

AntiCD38 + PI + IMiD + Dex

2nd line

Based on sensitivity/refractoriness to Daratumumab and Lenalidomide

Anti-CD38 + Carfilzomib-dex

Anti-CD38 + Pomalidomide-dex

Pomalidomide-bortezomib-dex

Selinexor-bortezomib-dex

Carfilzomib-dex

3rd line

Anti-CD38 + Pomalidomide-dex

Elotuzumab-Pomalidomide-dex

Previous combos if pt eligible

4th line

BCMA-targeted therapy

CAR-T: Ide-cel, Cilta-cel

BsAbs: Teclistamab, Elranatamab, Linvoseltamab

GPRC5D-targeted therapy

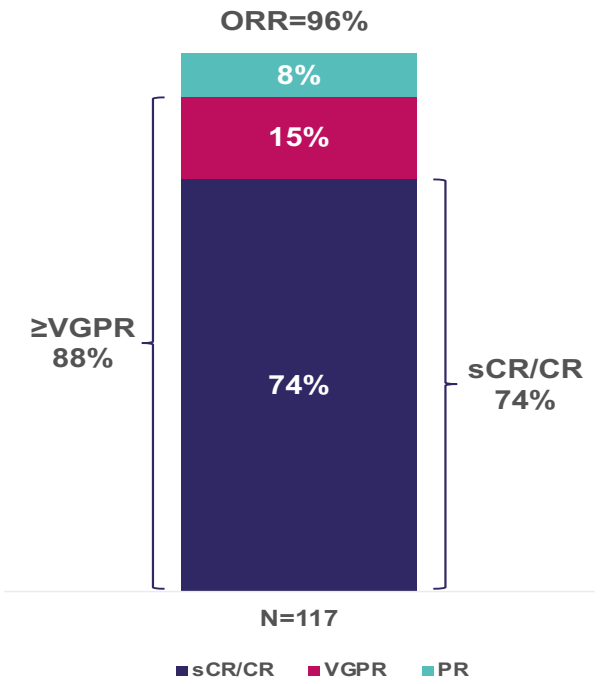
BsAbs: Talquetamab

The label is for RRMM after at least 4 PL of therapy including PI, IMiD and antiCD38 and refractory to the last line of therapy

Mateos MV, personal communication. Dimopoulos MA et al. EHA/ESMO guidelines. Annals of Oncology 2021

Phase 2 Registrational Study of Anitocabtagene Autoleucel for the Treatment of Patients with (RRMM): Updated Results from iMMagine-1

- Anito-cel is an autologous BCMA-directed CAR T-cell therapy using a novel D-Domain binder
- 117 TCE RRMM pts were dosed: median age 64; 18% EMD; 18% high tumor burden and 40% HRCA
- Median number of PL: 3, TCR 87% and PCR 41%. 76% received bridging therapy. Median f/u: 16 months



N=117	PFS Rate (%) (95% CI)	OS Rate (%) (95% CI)
6-Month	93.1 (86.7, 96.5)	95.7 (90.0, 98.2)
12-Month	82.1 (73.6, 88.1)	94.0 (87.8, 97.1)
18-Month	67.4 (55.4, 76.8)	88.0 (78.8, 93.4)
24-Month	61.7 (48.0, 72.8)	83.0 (70.7, 90.5)

MRD Negativity at 10^{-5} Sensitivity Level	
Overall MRD negativity, % (n/N)	95% (91/96)
Median time to MRD negativity, months (min – max)	1.0 (0.9 – 6.4)
MRD negativity sustained for ≥ 6 months, % (n/N)	83% (54/65)
MRD Negativity at 10^{-6} Sensitivity Level	
Overall MRD negativity, % (n/N)	78% (68/87)

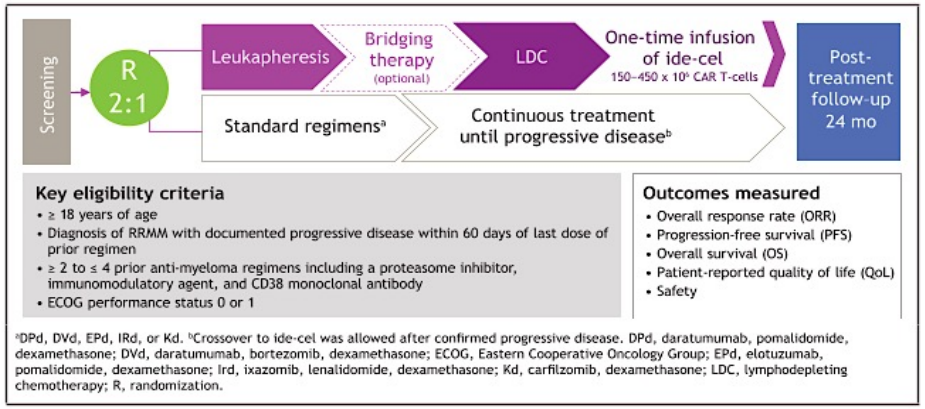
- Safety profile: CRS in 85% (G1 in 68% and G2 in 17); ICANS in 8%
- No delayed NT; no SPM; no enterocolitis
- G3-4 neutropenia: 70% and G3-4 infections: 9%

KarMMa-3: Ide-cel in RRMM after 2-4PL: outcomes in the older population

Methods

- KarMMa-3 (NCT03651128) is an open-label, phase 3 trial in patients with RRMM (**Figure 1**)[1,4]

Figure 1. Study design, key eligibility criteria, and study objectives



[a]DPd, DVd, EPd, IRd, or Kd. [b]Crossover to ide-cel was allowed after confirmed progressive disease. DPd, daratumumab, pomalidomide, dexamethasone; DVd, daratumumab, bortezomib, dexamethasone; ECOG, Eastern Cooperative Oncology Group; EPd, elotuzumab, pomalidomide, dexamethasone; Ird, ixazomib, lenalidomide, dexamethasone; Kd, carfilzomib, dexamethasone; LDC, lymphodepleting chemotherapy; R, randomization.

Table 3. Treatment-emergent adverse events of special interest/select adverse events grade ≥3 (safety population)

AESI/Select AE, n (%)	Age < 70 years		Age ≥ 70 years	
	Ide-cel (n = 178)	Standard regimens (n = 99)	Ide-cel (n = 47)	Standard regimens (n = 27)
At least one AESI/Select AE[a]	70 (39.3)	29 (29.3)	14 (29.8)	13 (48.1)
CRS	8 (4.5)	-	3 (6.4)	-
Infections	48 (27.0)	20 (20.2)	12 (25.5)	6 (22.2)
iiNT	4 (2.2)	-	3 (6.4)	-

[a]Includes CRS, neurologic toxicity - Focused 2.0 FDA, and infections.
AE, adverse event; AESI, AE of special interest; CRS, cytokine release syndrome; iiNT, investigator identified neurotoxicity.

- 20% of pts approximately were older than 70 years
- Patients older than 70 years were, overall: with less HRCA, less TCR and with longer time from the last line of therapy

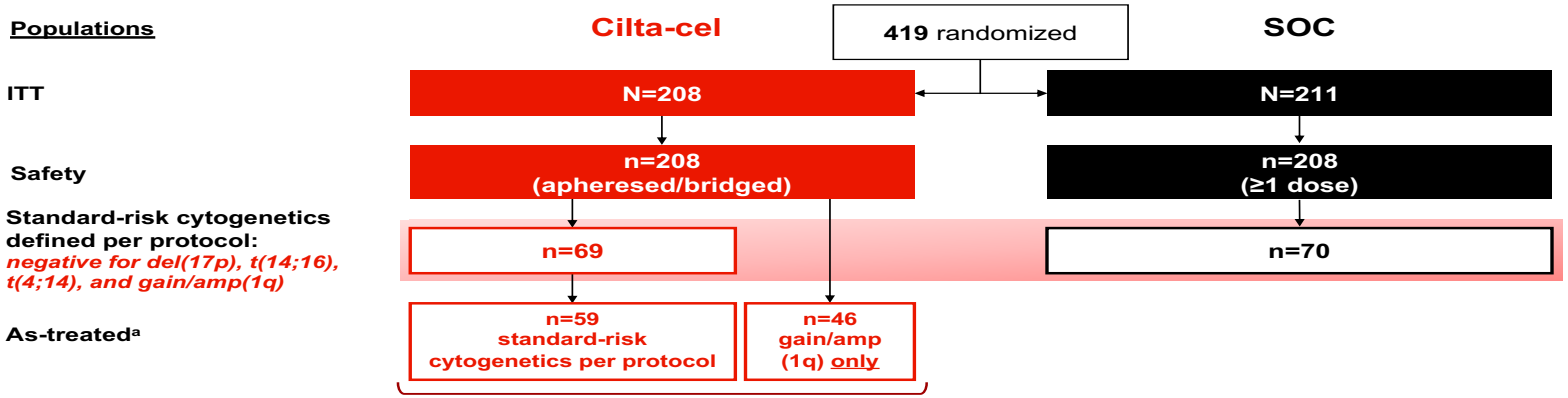
Table 2. Response rates

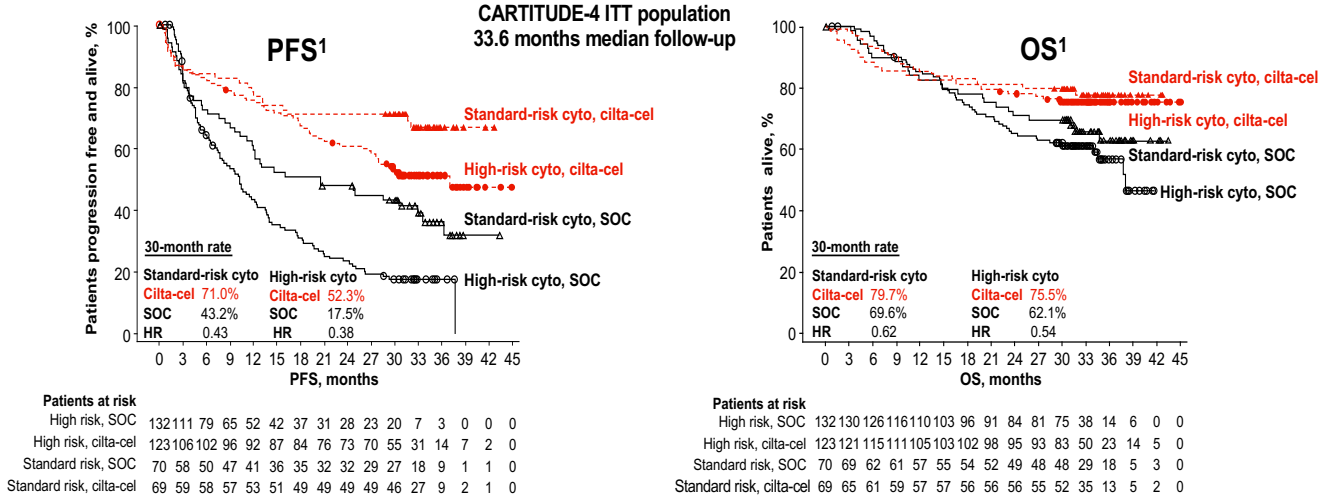
Outcomes	Age < 70 years		Age ≥ 70 years	
	Ide-cel (n = 205)	Standard regimens (n = 105)	Ide-cel (n = 49)	Standard regimens (n = 27)
ORR, % (95% CI)	68.8 (62.4, 75.1)	41.0 (31.5, 50.4)	81.6 (70.8, 92.5)	48.1 (29.3, 67.0)
P value	< 0.0001		0.0037	
PFS, median (95% CI)	12.5 (11.2-15.4)	4.2 (3.5-5.7)	18.9 (12.1-24.5)	5.7 (2.2-12.2)
P value	< 0.0001		0.0012	

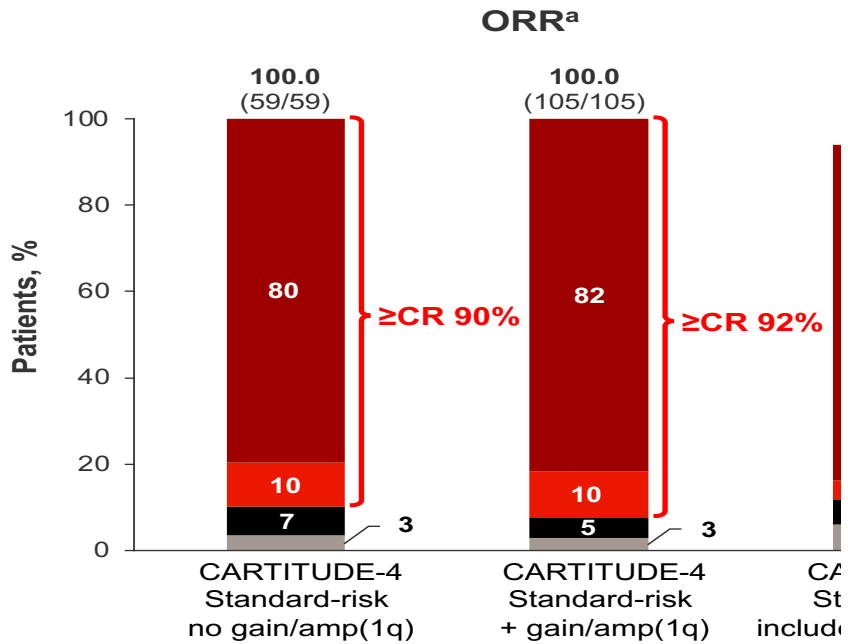
Conclusions:

Patients aged ≥ 70 years from the KarMMa-3 trial experienced benefit from ide-cel treatment, as evidenced by a longer median PFS and notable ORR compared with patients treated with standard regimens

What is the subgroup of patients treated with Cilta-cel in C4 with better outcomes?







Safety profile of cilta-cel in standard-risk population was consistent with overall study population[1,b]

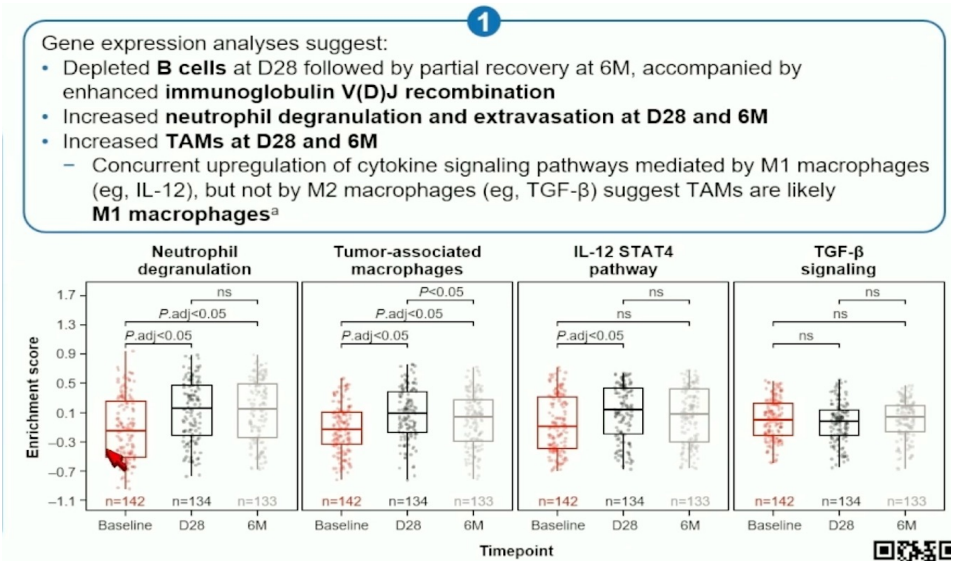
The better outcomes for standard risk patients in C4 are applicable to C1

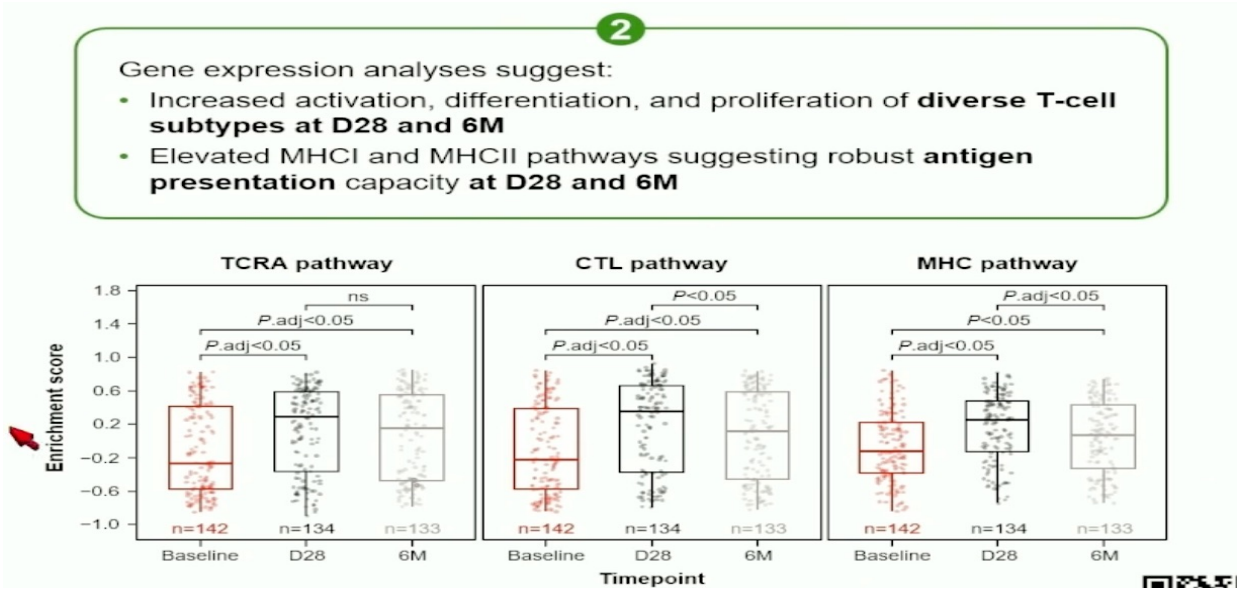
	30-month PFS rate, %	30-month OS rate, %
CARTITUDE-4 (median 2 prior lines)	**59.4%**	**76.4%**
Cilta-cel ***Standard-risk cytogenetics per protocol***	80.5	87.3
Cilta-cel ***Standard-risk cytogenetics per protocol + gain/amp(1q)***	71.7	86.1
CARTITUDE-1 (median 6 prior lines)	**Median PFS 36 m and OS 60 m**	
Cilta-cel ***Standard-risk cytogenetics per protocol including gain/amp(1q)***	59.9	70.6

Earlier use of Cilta-cel is associated with better immune fitness and stronger immune effects

- Cilta-cel in both C1 and C4 trials showed better outcomes in earlier lines of therapy (especially after 1 or 2 PL)
- Evaluation included PB samples at D28 and M6:
  - Bulk RNA sequencing
  - TCR repertoire in C-1
  - Immunophenotyping by FCM

Cartitude-4

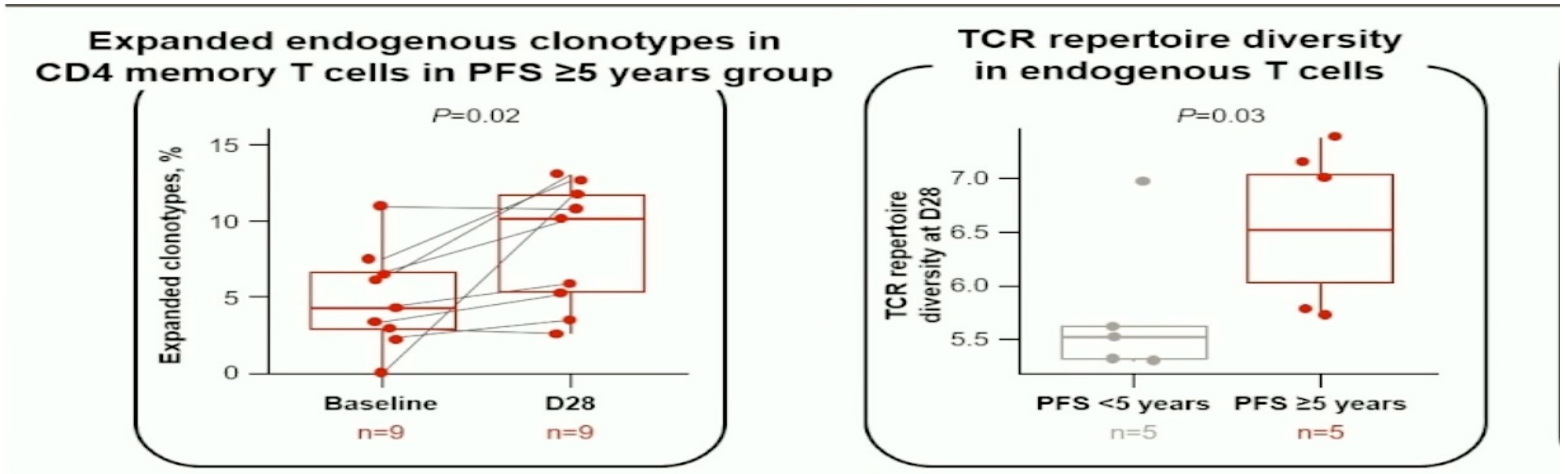




Parek S et al. ASH 2025: oral presentation. abstract number 8211

Earlier use of Cilta-cel is associated with better immune fitness and stronger immune effects

Cartitude-1: 33% of pts remain alive and progression-free at 5 years



Cartitude-4

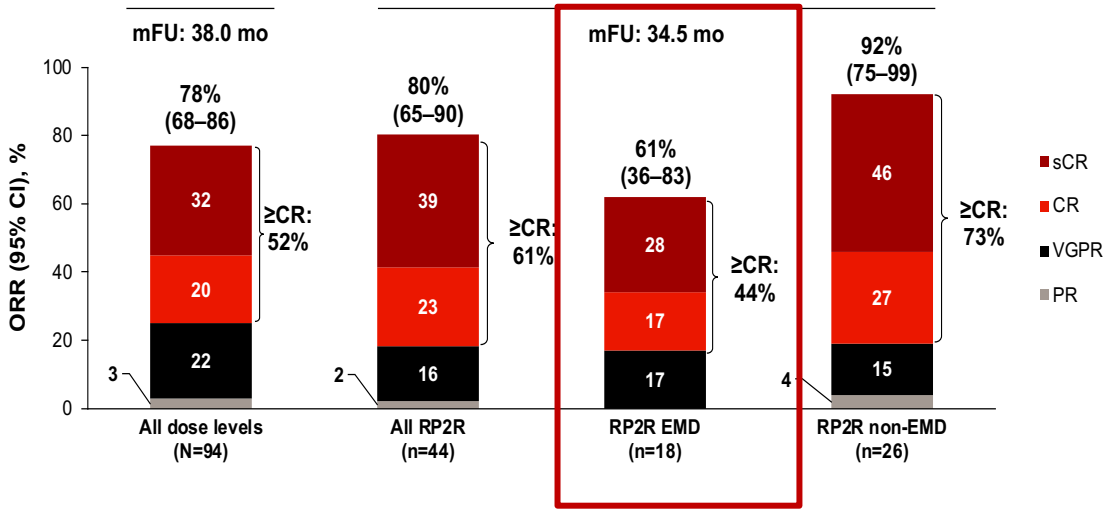
Earlier use of cilta-cel may support longer PFS by leveraging a more immunocompetent TME at baseline

CARTITUDE-4 TME: Patients With Shorter PFS (≤18M) and Patients With More pLOT had a More Suppressive TME

Parek S et al. ASH 2025: oral presentation. abstract number 8211

Teclistamab-Talquetamab in RRMM patients: phase 1b of RedirecTT-1 trial

- 94 pts overall and 43 at the RP2R were included. Median number of PL: 4 (86% TCR and 46% with true EMD)



	All dose levels (N=94)	All RP2R (n=44)	RP2R EMD (n=18)	RP2R non-EMD (n=26)
Median PFS, months (95% CI)	38.6 (21.6–NE)	NR (21.6–NE)	21.6 (2.4–NE)	NR (32.5–NE)
24-month PFS rate, % (95% CI)	57.6 (46.5–67.2)	63.6 (47.0–76.3)	39.7 (17.0–61.8)	79.4 (57.4–90.9)
36-month PFS rate, % (95% CI)	52.6 (41.5–62.6)	57.9 (41.0–71.5)	39.7 (17.0–61.8)	70.5 (47.8–84.8)

	All dose levels (N=94)	All RP2R (n=44)	RP2R EMD (n=18)	RP2R non-EMD (n=26)
Median OS, months (95% CI)	NR (39.1–NE)	NR (NE–NE)	NR (3.9–NE)	NR (NE–NE)
24-month OS rate, % (95% CI)	68.6 (57.2–77.5)	73.9 (56.6–85.1)	57.0 (26.5–78.8)	83.2 (61.1–93.4)
36-month OS rate, % (95% CI)	65.8 (54.2–75.1)	73.9 (56.6–85.1)	57.0 (26.5–78.8)	83.2 (61.1–93.4)

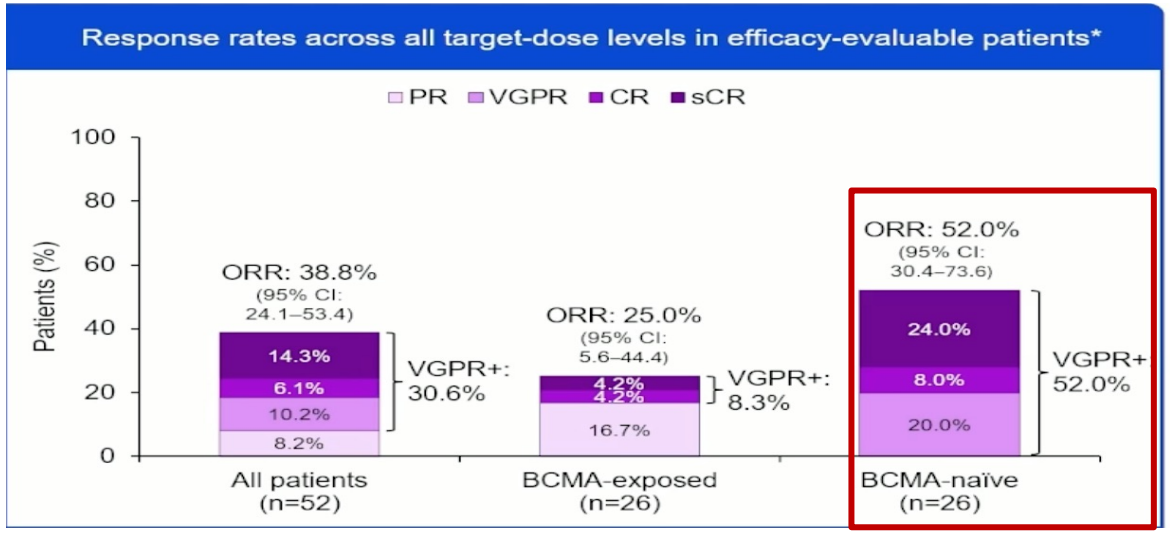
- Safety profile: Infections are the most relevant ones (43% G3-4 at the RP2R); opportunistic infections in 17% of pts; any-grade infection risk peaked early and stabilized by ~6 months; grade ≥3 infection risk was highest in the first 6 months and decreased over time
- On target off tumor toxicity related with GPRC5D are frequent but most are G1-2

Tec-Tal today has a role in patients with true EMD because this population has an unmet need.

MonumenTAL-9 study will confirm its role in all RRMM patients

Subcutaneous Cevostamab (a novel FcRH5xCD3 bispecific T-cell engager — BiTE) in RRMM patients: Phase Ib CAMMA 3 study

- 58 pts included. Median number of PL: 5 (64% TCR and 48.3% BCMA-TT exposed including CAR-T, ADC and BsAbs)
- Cevostamab was evaluated at different doses and dose > 120 mg is effective. Fixed duration: 13 c



	All patients (N=52)	BCMA-naïve (n=26)	BCMA-exposed (n=26)
Ongoing response, n/N (%)	11/19 (57.9%)	8/13 (61.5%)	3/6 (50.0%)
Median DOR among responders, months (95% CI)	12.3 (8.3, NE)	NR (11.7, NE)	8.3 (4.9, NE)

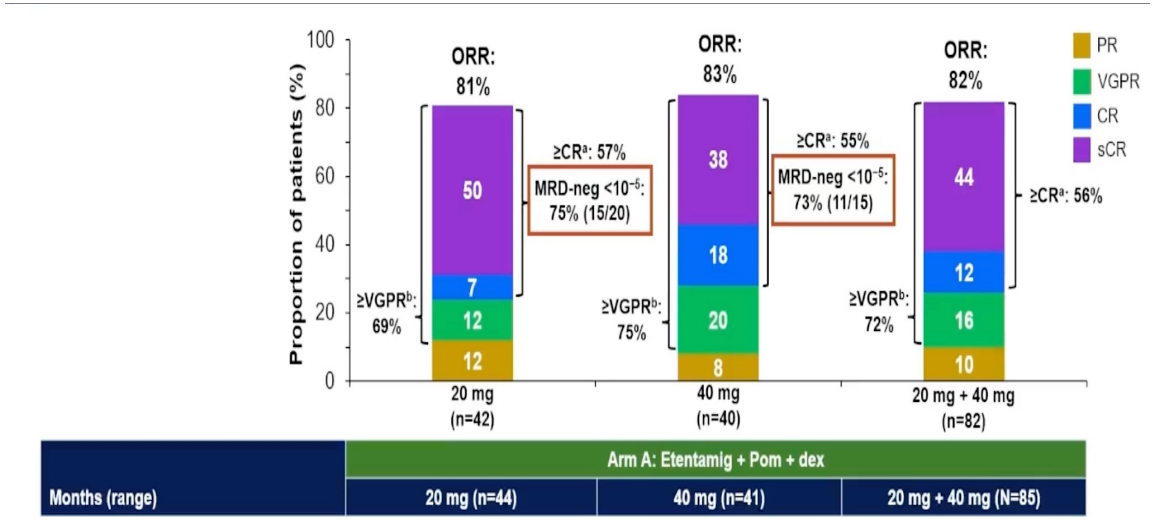
- Safety profile: Infections (44.8% and G3-4 12%); CRS in 69% and injection-site reaction in 58.6%; neutropenia in 31% (most G3-4)

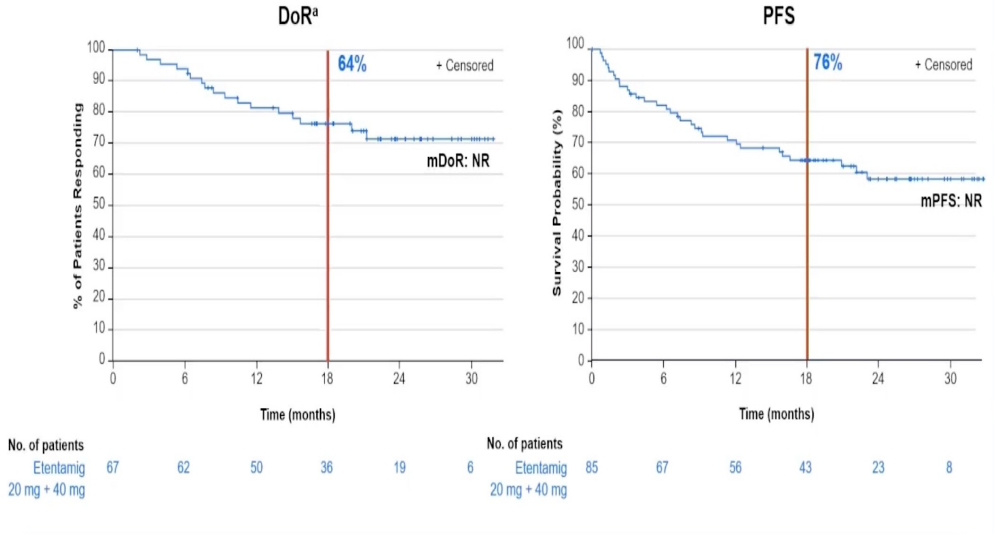
The role of Cevostamab is interesting for the sequencing of T-cell redirecting therapies but.. more data are required and its role is maybe in combination

Ho PJ et al. ASH 2025: oral presentation: abstract number 8172

Etentamig (BCMAxCD3 BiTE) plus Pom-dex in RRMM patients: Cohort A of the clinical trial

- 85 pts included. Median number of PL: 4 (73% TCR and 51% refractory to pomalidomide)
- Etentamig was given in this cohort with no SUD, no premedication and Q4W
- Pom and dex at conventional doses from C1D1 and dose for etentamig was 20 or 40 mg





- Safety profile: Infections (89% and G3-4 52%); CRS in 35% (no G3-4); neutropenia G3-4 in 78%. Hepatic toxicity in 25% (G3-4 in 8%)
- Cohort E included some modifications: SUD 1 and Pom included at C2D1. Dose of etentamig 60 mg and less pretreated but the f/u was short

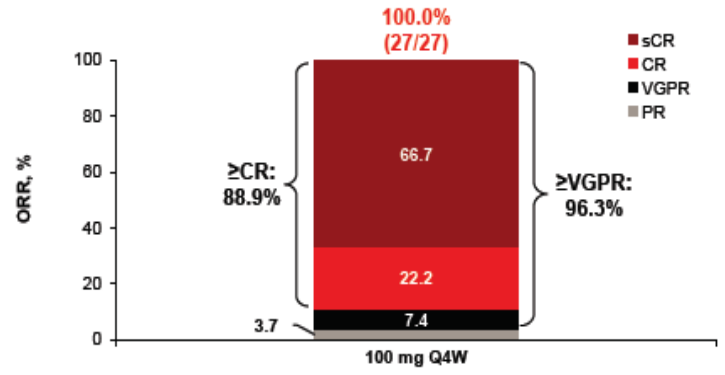
Voorhees P et al. ASH 2025: oral presentation: abstract number 1875

Ramantamig, BCMA-GPRC5D trispecific mAB in RRMM patients

- 36 pts received ramantamig at the RP2D (1 SUD followed by 100 mg flat dose Q4W). Median number of 4 PL (53% TCR and 25% previously exposed to BCMA/GPRc5D)

At the RP2D: ORR of 86.1% (n=31/36), ≥CR rate of 75.0%, and MRD-negativity rate of 100.0% at 10^{-5} (n=10/10) and 10^{-6} (n=7/7)

Figure 4: At the RP2D, triple-class exposed patients naïve to T cell redirection therapies achieved an ORR of 100.0% with deepening responses since the last report[3]



PR, partial response; sCR, stringent complete response.

Figure 5: In triple-class exposed patients naïve to T cell redirection therapies treated with the RP2D, 92.6% and 79.6% remained progression free and alive at 12 months and 18 months, respectively

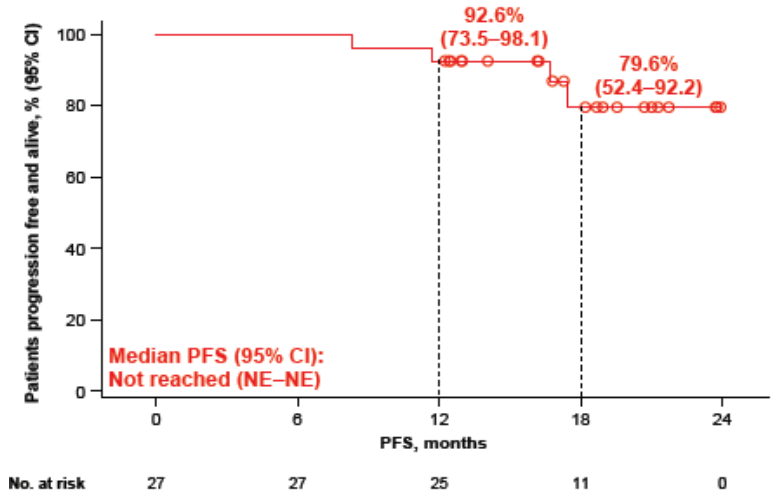
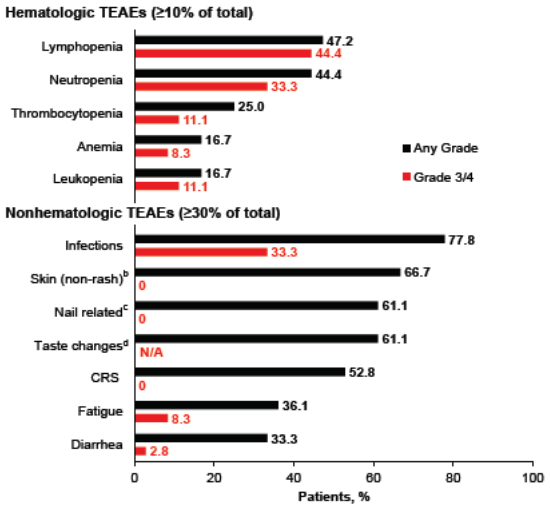


Figure 1: The safety profile of the RP2D was consistent with previous results[3,a]; CRS occurred in 53% of patients (grade 1, 42%; grade 2, 11%), inclusive of patients who received prophylactic tocilizumab



*1 patient died while in very good partial response (VGPR) (due to pneumonia in the setting of hypogammaglobulinemia <200 mg/dL). [b]Skin exfoliation, dry skin, pruritus, and palmar-plantar erythrodysesthesia syndrome. [c]Nail discoloration, nail disorder, onycholysis, onychomadesis, onychoclasis, nail dystrophy, nail toxicity, and nail ridging. [d]Dysgeusia, ageusia, hypogeusia, and taste disorder; maximum grade is 2 per CTCAE.

- Prophylactic tocilizumab decreased CRS incidence (from 69.2% to 20.0%) and severity (no grade ≥2 events) in patients who received ramantamig 100 mg (Supplemental Table 1)
- No ICANS was reported at the RP2D

Ramantamig has a great efficacy in patients naïve to T-Cell Redirecting therapy similar to CAR-T

It is pending to know the activity in patients previously exposed as well as in specific populations like patients with EMD

Low dose Tocilizumab for mitigation of CRS with BsAbs in RRMM

FIGURE 1. STUDY DESIGN FLOW DIAGRAM

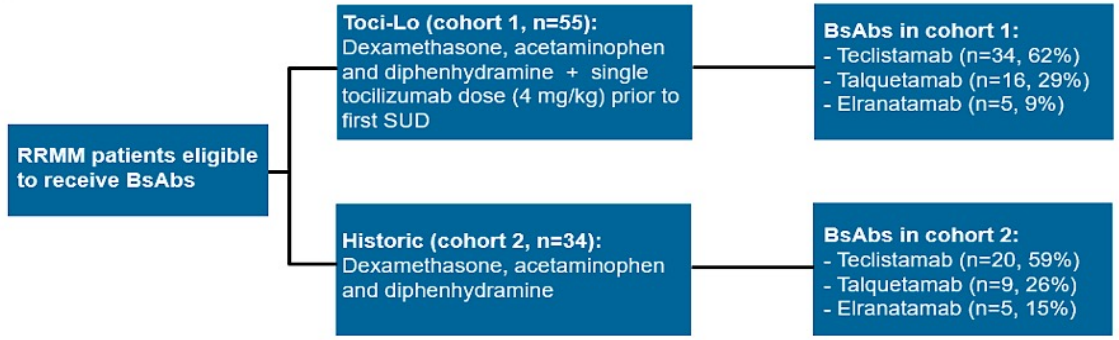


FIGURE 4. CRS RATES

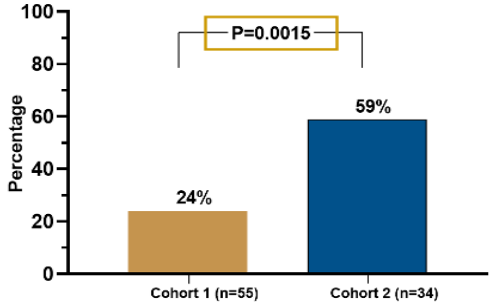
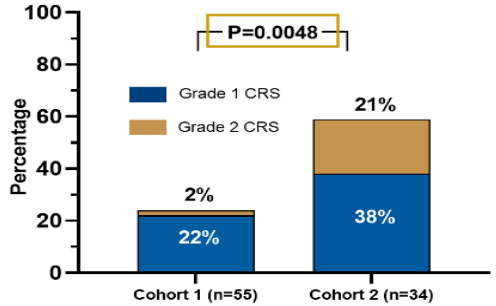


FIGURE 5. CRS GRADES



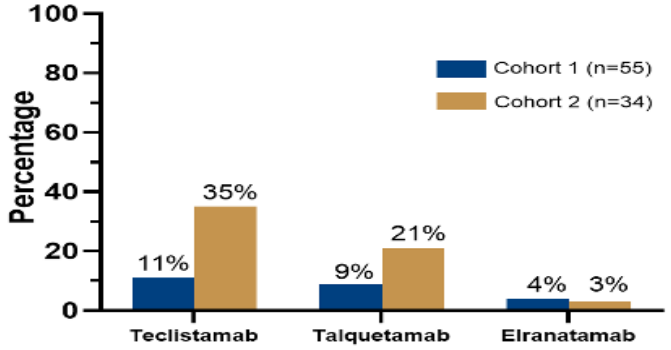
- Of the 13 CRS events in cohort 1, 5 occurred after SUD1 (38%); in cohort 2, 12 occurred after SUD1 (60%).
- Recurrent CRS was noted in 1 patient in cohort 1 compared to 6 patients in cohort 2; both received tocilizumab for management.

TABLE 2. RESULTS OF LOGISTIC REGRESSION ANALYSIS

	Odds ratio	95% confidence interval	P-value
Univariate logistic regression			
Tocilizumab prophylaxis (yes vs. no)	0.22	0.08-0.53	0.005
Multivariate logistic regression			
Tocilizumab prophylaxis (yes vs. no)	0.23	0.08-0.62	0.0001
High risk cytogenetics (yes vs. no)	0.64	0.21-1.86	
Prior T-cell redirecting therapy (yes vs no)	1.33	0.32-5.50	
Elevated LDH (yes vs. no)	0.34	0.11-1.00	
High ALC (yes vs. no)	1.94	0.60-7.10	
Presence of EMD (yes vs. no)	0.78	0.30-2.25	

- The rates of neurotoxicity/ICANS were 5% in cohort 1 (n=3) and 6% cohort 2 (n=2). One patient in each cohort developed grade 2 neurotoxicity/ICANS which resolved more than 48 hours following management per institutional guidelines.

FIGURE 2. CRS RATES BY BSAB



Prophylactic single Toci-lo proved to be an effective strategy at reducing CRS incidence and severity during the SUD phase of BsAbs treatment. This low dose instead of the standard (8 mg/kg) may be a cost-effective strategy.

Hamadeh I et al. ASH 2025: poster presentation: abstract number 7258

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Case 2	Dr Morganstein – 84-year-old man
Case 3	Dr Favaro – 64-year-old man
Case 4	Dr Bhatnager – 71-year-old man
Case 5	Dr Lee – 71-year-old man
■ Faculty Presentation: Integrating CAR T-Cell Therapy and Bispecific Antibodies into the Management of R/R MM — Dr Mateos	
Case 6	Dr Rudolph – 56-year-old man

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Case Presentation: 56-year-old man with heavily relapsed MM who received multiple prior lines of therapy, including CAR T-cell therapy, is now on talquetamab

Dr Priya Rudolph (Athens, Georgia)

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Practical Perspectives on the Current and Future Management of Immune Thrombocytopenia — What Happened at ASH 2025?

A CME/MOC-Accredited Live Webinar

Tuesday, December 16, 2025
5:00 PM – 6:30 PM ET

Faculty

Hanny Al-Samkari, MD
Cindy Neunert, MD, MSCS
Professor Francesco Zaja

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

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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