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

A Live Webinar for Patients, Developed in Partnership with Cancer*Care*®

Wednesday, July 23, 2025
6:00 PM – 7:00 PM ET

Faculty

Natalie S Callander, MD
Sagar Lonial, MD, FACP

Moderator

Neil Love, MD

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Faculty

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Dr Love — Disclosures

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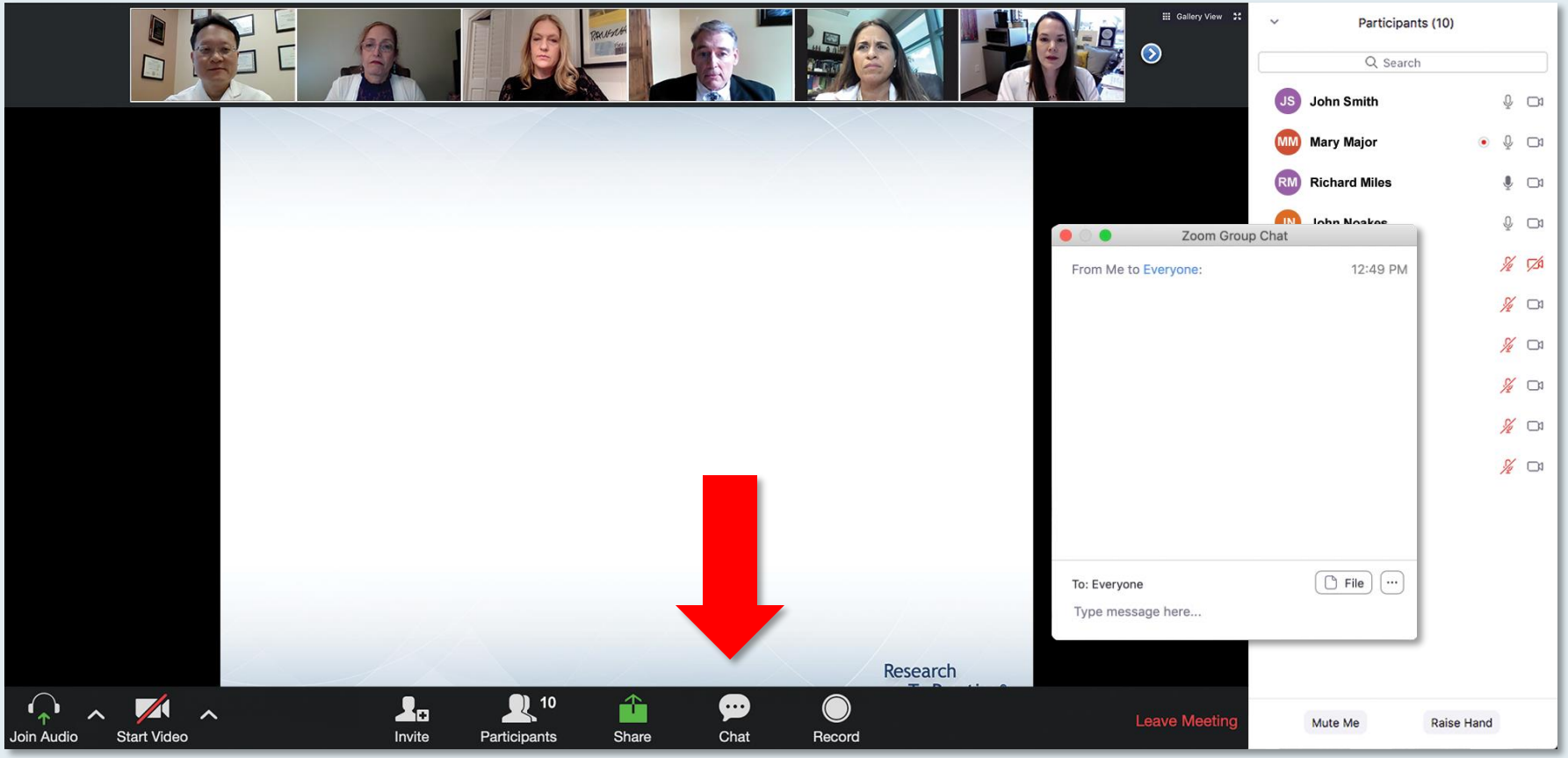

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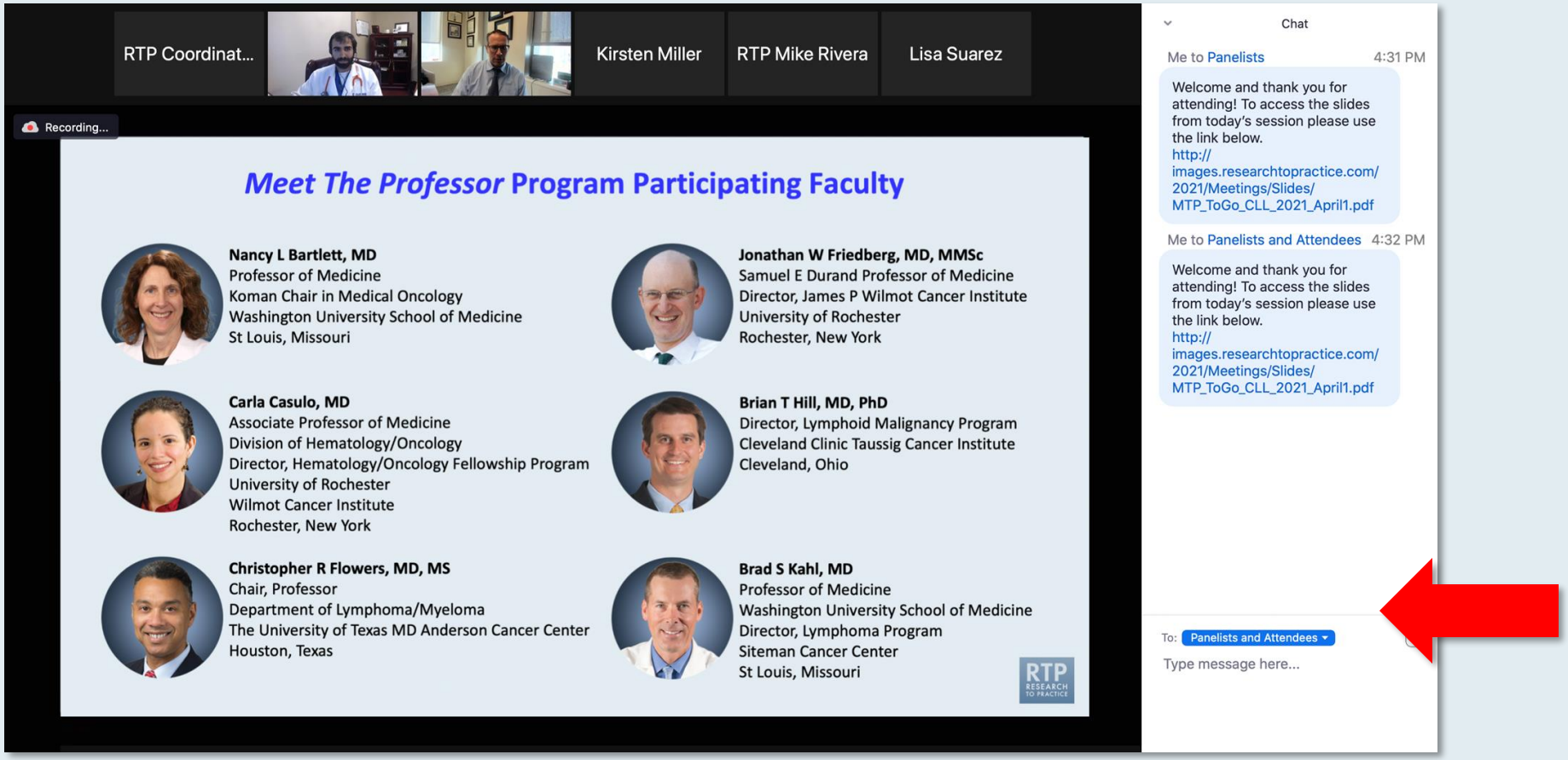

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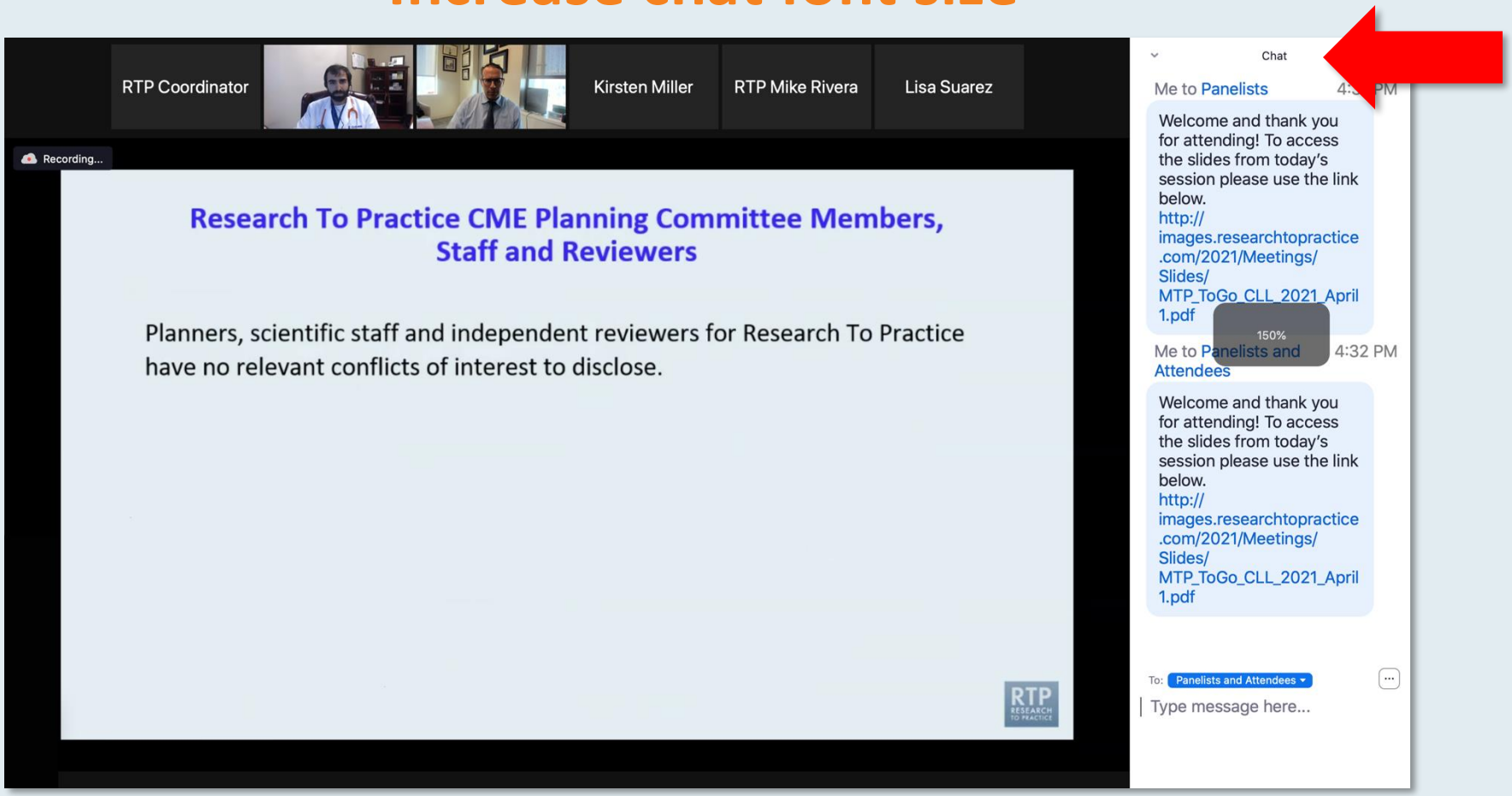

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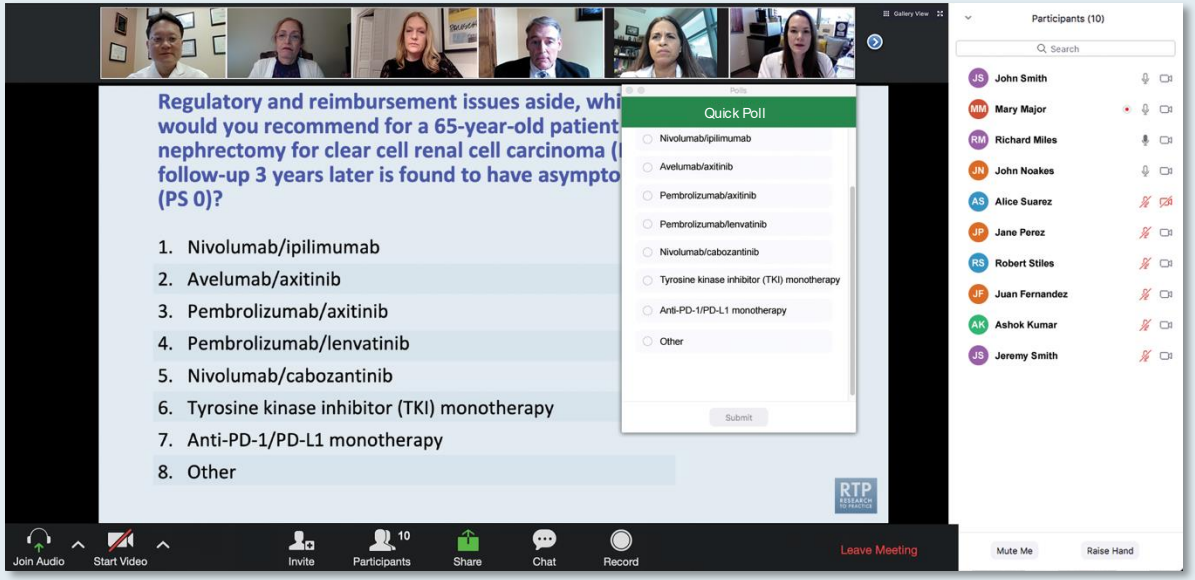

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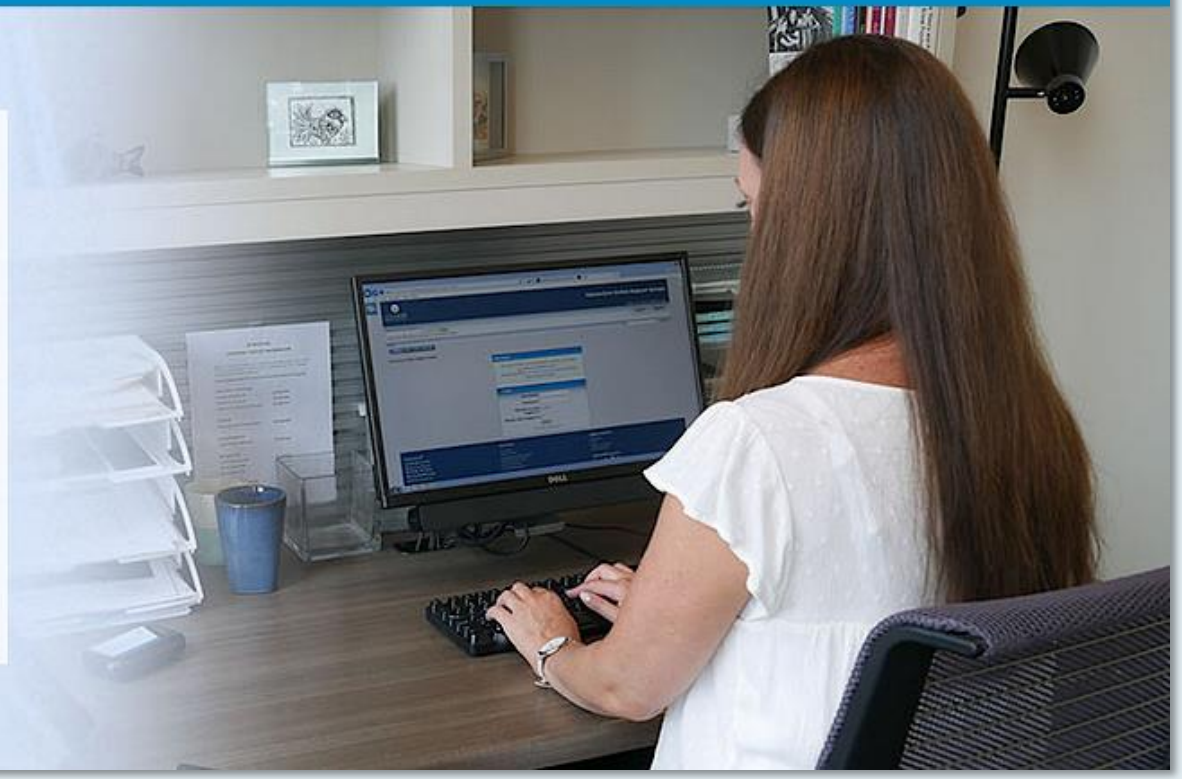

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Blood Cancers Patient Support Group

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

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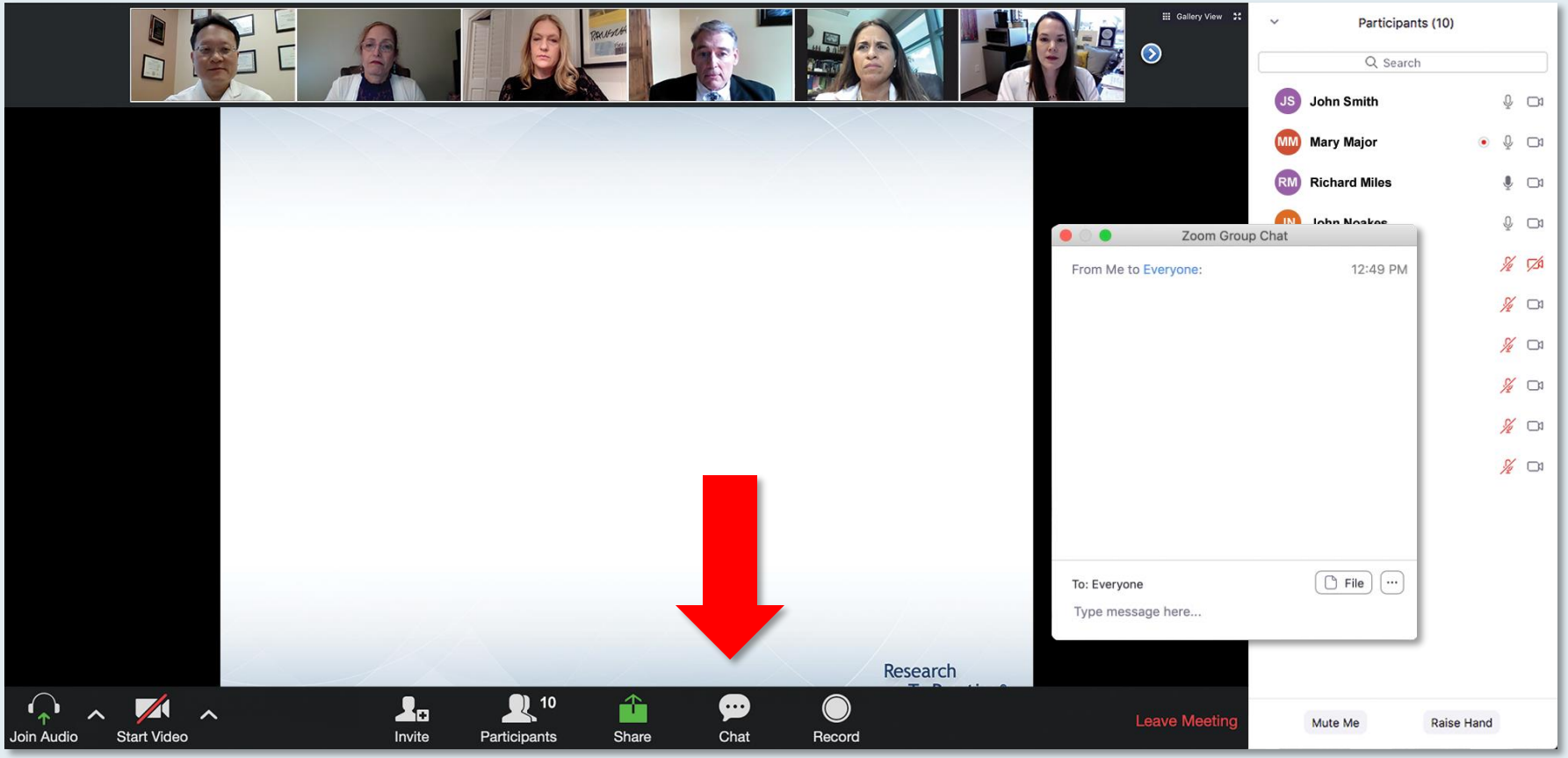

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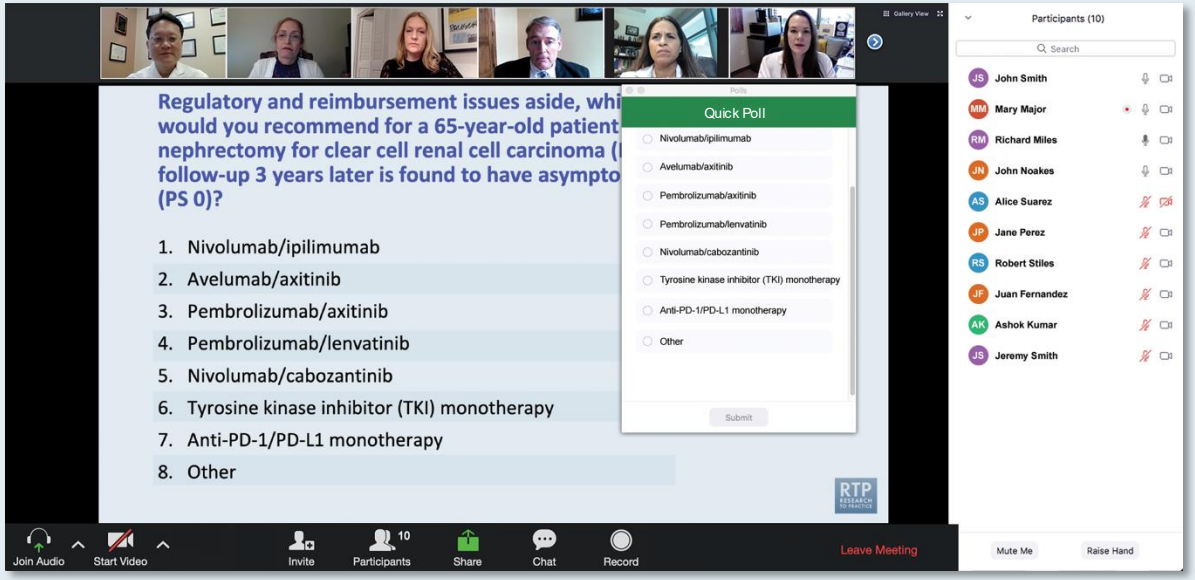

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Sagar Lonial, MD, FACP

Moderator

Neil Love, MD

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Dr Callander — Disclosures
Faculty

No relevant conflicts of interest to disclose.

Dr Lonial — Disclosures
Faculty

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

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

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

Faculty

Natalie S Callander, MD
Sagar Lonial, MD, FACP

Moderator

Neil Love, MD

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Oncology Q&A: Addressing Common Questions Posed by Patients with Metastatic Triple-Negative Breast Cancer

A Live Webinar for Patients, Developed in Partnership with the Triple Negative Breast Cancer Foundation

Wednesday, November 13, 2024
6:00 PM – 7:00 PM ET

Faculty

Lisa A Carey, MD, ScM, FASCO
Rita Nanda, MD

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Oncology Q&A: Discussing Common Questions Posed by Patients with Metastatic Triple-Negative Breast Cancer

A CME/MOC- and NCPD-Accredited Webinar Developed in Partnership with the Triple Negative Breast Cancer Foundation

Tuesday, January 7, 2025
5:00 PM – 6:00 PM ET

Faculty

Lisa A Carey, MD, ScM, FASCO
Rita Nanda, MD

Moderator

Neil Love, MD

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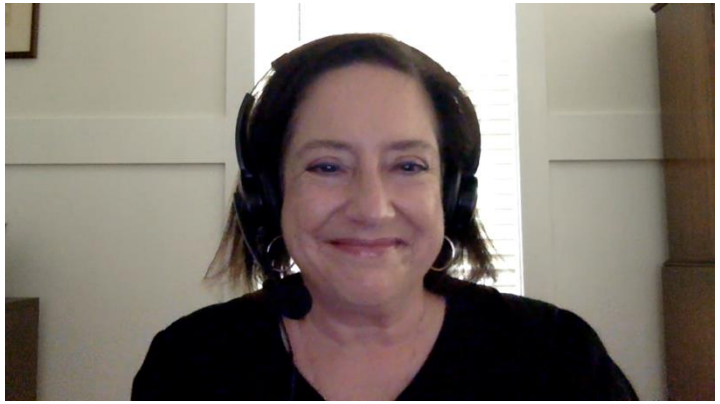



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Cancer Q&A
Relapsed/Refractory Multiple Myeloma

Introduction: Multiple myeloma — 2005 to 2025

Module 1: Questions from the beginning

Module 2: Choosing options

Module 3: Clinical trials

Module 4: Neuropathy

Module 5: Chimeric antigen receptor (CAR) T-cell therapy

Module 6: Bispecific antibodies

Module 7: Antibody-drug conjugates

Module 8: Interacting with the oncology team

Module 9: Other questions

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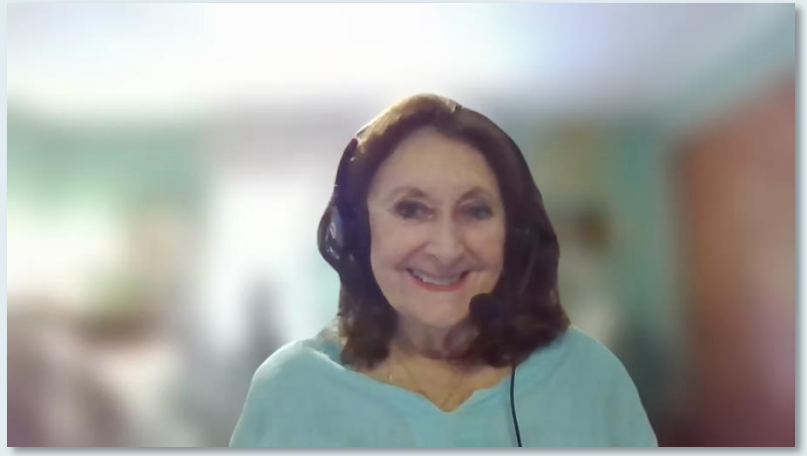
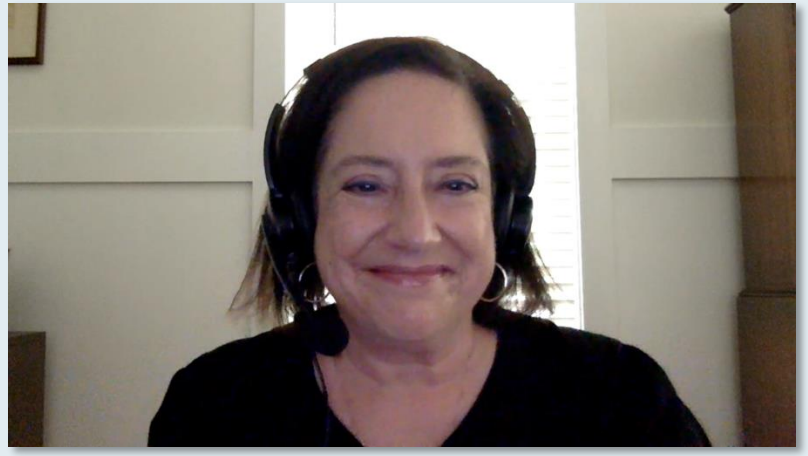
Questions from the beginning





For a patient with newly diagnosed standard-risk multiple myeloma (MM), what are the chances of cure?

 Dr Callander	We still cannot cure MM for most patients, but we hope to be able to keep your myeloma controlled for many years
 Dr Lonial	15%-20% can experience functional cure
 Dr Fonseca	We have much better treatments so that patients can now live many years, and we are likely curing about 20%-30% of patients with today's best options
 Dr Orlowski	About 10% of standard-risk patients will not experience relapse from their first line of therapy and could thus be considered cured
 Dr Raje	Chance of cure for standard-risk MM is 50% to 60%
 Dr Richardson	Estimated overall survival is now 10-15 years, but MM remains incurable in the longer term

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For a patient who is receiving first-line treatment for standard-risk MM, on average how long will it be before a different therapy is needed?

 Dr Callander	Today's therapies offer good control for many years, often 10 or more, before a treatment may have to be changed
 Dr Lonial	Median time for patients receiving D-RVd induction and transplant is >10 years
 Dr Fonseca	Greater than 5 years should be expected
 Dr Orlowski	For a standard-risk patient, PFS is about 7 years so treatment with a second therapy will be needed in 7-8 years
 Dr Raje	Close to 10 years
 Dr Richardson	If quadruplet therapy is used as initial therapy, then a median of 7-8 years of PFS is expected

D-RVd = daratumumab with lenalidomide/bortezomib/dexamethasone; PFS = disease progression-free survival

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Will I likely require continuous treatment for MM?

 Dr Callander	This will depend on whether your MM is more aggressive or not
 Dr Lonial	For now, yes
 Dr Fonseca	It is likely that after some time, 3 to 4 years, you will be completely off therapy
 Dr Orlowski	Continuous treatment is part of the standard for initial therapy, but emerging data suggest a low relapse risk for patients who achieve and maintain MRD negativity 3-5 years
 Dr Raje	Using MRD-adapted therapy, we should be able to discontinue therapy. High-risk disease will likely require more continuous therapy
 Dr Richardson	Yes

MRD = minimal residual disease

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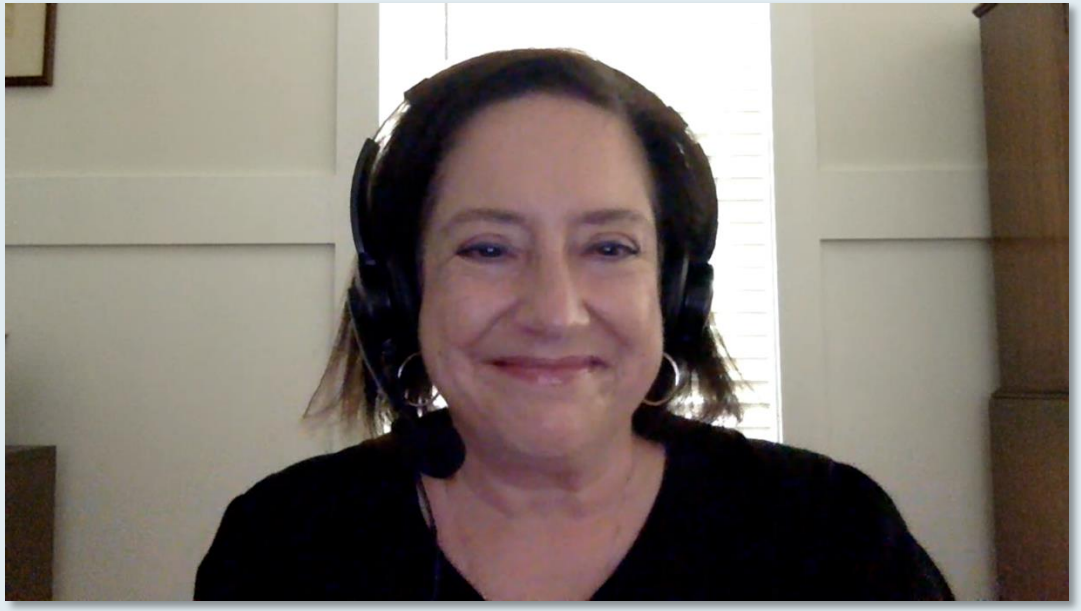
Choosing options



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Clinical trials

How likely is it that I will be able to participate in a clinical trial with a reasonable probability of benefitting?

 Dr Callander	We will look for a clinical trial for you at every step, whether you have smoldering myeloma or have experienced relapse many times. We try to maintain a portfolio of many trials
 Dr Lonial	80% or higher
 Dr Fonseca	Most patients on trials benefit, and have a greater degree of scrutiny of their case
 Dr Orlowski	It is likely that you will be eligible for a clinical trial at least once during your myeloma journey. The probability of benefitting will depend on several factors
 Dr Raje	Very likely
 Dr Richardson	Very high likelihood

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What are some new therapies on the horizon that you consider to be promising for patients with R/R MM?

 Dr Callander	Mezigdomide (CELMoD), trispecific antibodies, anitocabtagene autoleucel (anito-cel)
 Dr Lonial	CELMoDs, p300 inhibitors
 Dr Fonseca	We have so many developments including the trispecific antibodies
 Dr Orlowski	CELMoDs, trispecific T-cell engagers, CAR T cells targeted against more than one antigen, and combinations of these drug classes with each other and with our current agents
 Dr Raje	Cevostamab, anitocabtagene autoleucel (anito-cel), arlocabtagene autoleucel (arlo-cel), CELMoDs mezigdomide and iberdomide
 Dr Richardson	CELMoDs

CELMoDs = cereblon E3 ligase modulatory drugs

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Neuropathy

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Chimeric antigen receptor (CAR) T-cell therapy

What is the likelihood that my disease will respond to CAR T-cell therapy? What is the typical duration of response?

 Dr Callander	Response rates, meaning obtaining a remission, are very high. Some patients may not need any other treatments for several years
 Dr Lonial	90% of patients will respond to CAR T, and the average is 2-3 years of remission
 Dr Fonseca	Most patients respond (>90%), and in general we think it can last for about 3 years
 Dr Orlowski	Response rates are quite high and better than those seen with most other therapies available to us. The exact response rate and duration of response depends on several factors
 Dr Raje	Response is 40%-80%, and the duration is 1 year to 3.6 years, depending on the type of CAR T construct used
 Dr Richardson	80% chance of response with a duration of 1 to 2 years

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What are the most likely side effects associated with CAR T-cell therapy?

 Dr Callander	Increased risk of infections; most patients experience fever in the first week after infusion, and rarely more significant side effects called cytokine release syndrome
 Dr Lonial	Infusion-related toxicity (CRS) and risk of longer-term side effects such as immune-related GI side effects and neurologic side effects
 Dr Fonseca	The major and most likely toxicities include a heightened risk of infections. There are other serious toxicities, but fortunately they are rare
 Dr Orlowski	Common side effects include CRS, ICANS, decreased blood counts and infections
 Dr Raje	CRS, ICANS, low blood cell counts (cytopenias) and infections
 Dr Richardson	CRS and ICANS

CRS = cytokine release syndrome; GI = gastrointestinal; ICANS = immune effector cell-associated neurotoxicity syndrome

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Bispecific antibodies

What is the likelihood that my disease will respond to bispecific antibody therapy? What is the typical duration of response?

 Dr Callander	About 7/10 pts respond. Those who get a deep response can be in remission for years. On average, the response is about 1 year
 Dr Lonial	70%, the average is 1-2 years
 Dr Fonseca	About 2 out of 3 patients will respond, but what matters more is the depth of response — those who respond very well (CR or better) can have results that are as good a CAR Ts
 Dr Orlowski	Bispecific antibody response rates run from 60% to 75%, while the duration of response varies from about 12 to 24 months, depending on the bispecific used
 Dr Raje	Likelihood of response is 60% with 18 to 24 months duration
 Dr Richardson	70% chance of response with a duration of 12 months

CR = complete response

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What are the most likely side effects associated with bispecific antibodies?

 Dr Callander	Bispecifics that target BCMA are associated with a high risk of infection and patients need prophylactic antibiotics and antibodies (IVIG)
 Dr Lonial	Similar to those of CAR T-cell therapy (CRS, neurologic effects, immune-related GI effects) but lower severity
 Dr Fonseca	Mainly infections and the need to be very proactive with IgG replacement
 Dr Orlowski	CRS, ICANS, decreased blood counts and infections
 Dr Raje	CRS, ICANS, low blood cell counts (cytopenias) and infections
 Dr Richardson	CRS and infections

IVIG = intravenous immunoglobulin; CRS = cytokine release syndrome; GI = gastrointestinal; IgG = immunoglobulin;
ICANS = immune effector cell-associated neurotoxicity syndrome

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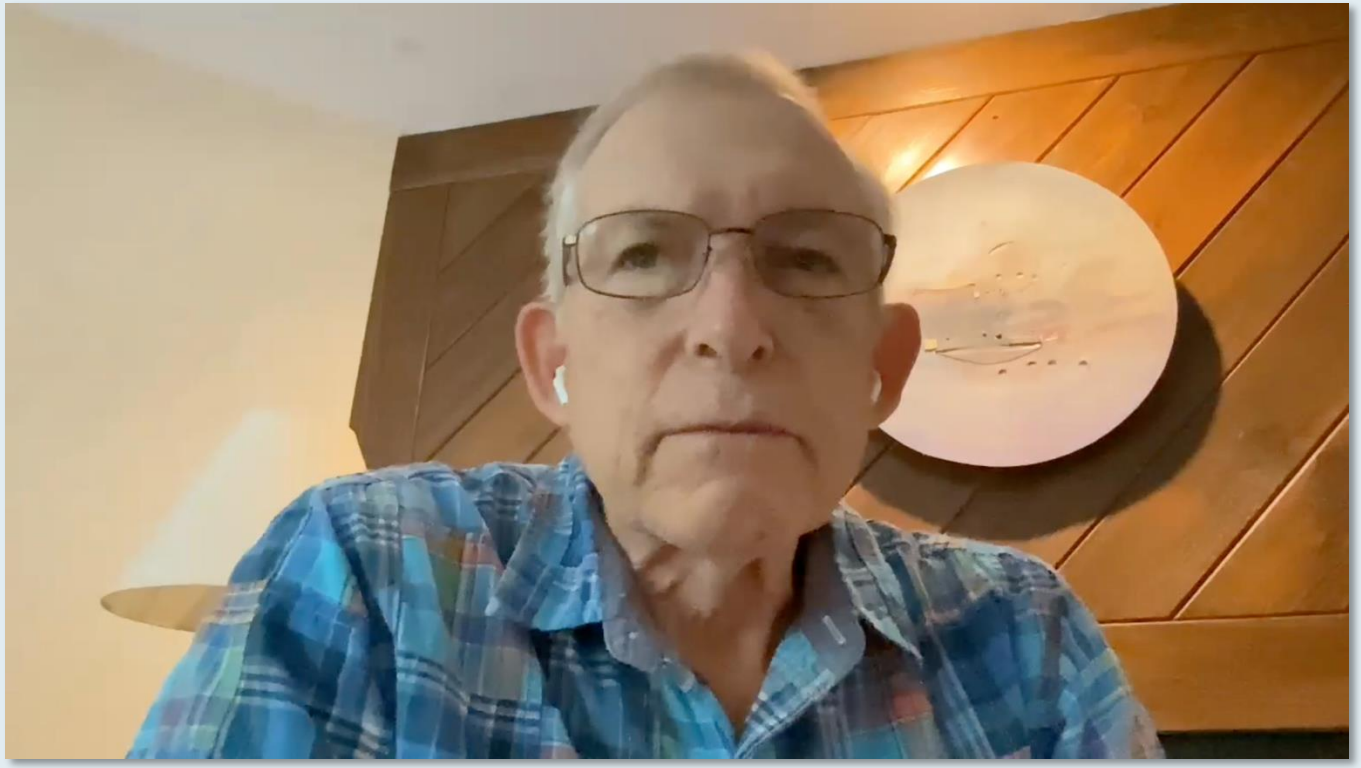
Antibody-drug conjugates



What is the likelihood that my disease will respond to belantamab mafodotin? What is the typical duration of response?

 Dr Callander	If given alone, about 1/3 of patients respond, and they tend to have long response durations, often about 1 year or more. If given in combination, most will have a response that can last several years
 Dr Lonial	In combinations, chances of response are 85% or higher, and the duration is 2-3 years
 Dr Fonseca	We can see responses that are very durable, sometimes close to 3 years
 Dr Orlowski	The response rate for belantamab combined with bortezomib/dex was about 83%, while the average combined with pomalidomide/dex was 77%
 Dr Raje	Likelihood of response is 30%, and response duration is 9 to 12 months
 Dr Richardson	In combination, the chance of response is 70%-80%, and the median PFS is 3 years

dex = dexamethasone; PFS = disease progression-free survival

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What are the ocular side effects associated with belantamab mafodotin? What signs or symptoms of ocular toxicity do I need to be aware of? Are the ocular side effects associated with belantamab mafodotin reversible?

 Dr Callander	If belantamab is given in short intervals (eg, 3 weeks) dry eye is common, as well as blurry vision and rarely pain and inflammation
 Dr Lonial	Impact on vision, changes in visual acuity, ability to read or drive, dry eyes, itchy eyes; these effects are reversible
 Dr Fonseca	Symptoms range from scratchy eyes to blurred vision. With newer dosing and schedule approaches we can make the eye toxicities more manageable. They can be very uncomfortable, but know they are always reversible
 Dr Orlowski	Dry eyes or excessive tearing, inflammation of the eyelids or cornea with eye pain and reduced sharpness of vision; these effects typically resolve over time
 Dr Raje	Blurry vision — due to cysts in the conjunctiva; reversible with dose decrease and delays
 Dr Richardson	Keratopathy, which is manageable and reversible

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How are the ocular side effects associated with belantamab mafodotin prevented and managed? Will I need to see an optometrist or an ophthalmologist to monitor for ocular toxicities? How often?

 Dr Callander	Side effects are managed by using a longer interval between doses, lubricating eye drops. Before every dose, we will have you see an ophthalmologist or optometrist familiar with the drug
 Dr Lonial	Holding or reducing the dose or spreading out the dose to reduce future risk; monitoring by eye care professional is done once every 3-4 weeks depending on severity
 Dr Fonseca	We will engage with the ophthalmology team, usually once a month, and monitor. We are able to manage these better now
 Dr Orlowski	We currently do not have good prevention strategies for the ocular side effects. You would typically see an optometrist or ophthalmologist before starting belantamab and then before each next dose
 Dr Raje	Side effects may be managed by decreasing belantamab dose and decreasing dose intensity
 Dr Richardson	Side effects are manageable utilizing KVA monitoring, eye drops, dose reduction and schedule change; initially will need to consult eye specialist monthly x 4, then as needed

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Interacting with the oncology team

What do you recommend to your patients with R/R MM in terms of exercise, diet and nutrition and complementary treatments like acupuncture and meditation?

 Dr Callander	I always advocate for exercise, even chair exercises may be helpful. I ask patients to be skeptical of supplements; acupuncture often not covered by insurance
 Dr Lonial	Balanced diet, limited use of supplements, keep as fit as they are able
 Dr Fonseca	Just follow your normal life
 Dr Orlowski	For patients with lytic/erosive bony lesions, I recommend exercise after evaluation by orthopedics/physical therapy; I obtain a consult with a nutritionist and refer patients to our Integrative Medicine team
 Dr Raje	Healthy diet with adequate hydration, daily exercise
 Dr Richardson	A comprehensive and proactive approach with exercise, diet/nutrition and certain complementary therapies

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At what point do you introduce discussion about palliative care with your patients with R/R MM? Do you discuss advanced directives and other issues related to end-of-life preparation?

 Dr Callander	Yes, particularly before high-dose therapy, when we encourage patients to have an advanced directive
 Dr Lonial	When symptoms are challenging to manage, or patients have exhausted many treatment options
 Dr Fonseca	It is hard as patients have so many options. It is not unusual for MM patients to only have a few days or weeks when they enroll in hospice. I use palliative care support for symptom control as needed
 Dr Orlowski	I start mentioning palliative care as an option at the first sign of refractory disease; our institutional policy is to discuss advanced directives no later than the third visit of the patient in our system
 Dr Raje	Usually when performance status decreases and treatment options are narrowing
 Dr Richardson	Later in the disease course, typically after 3 to 4 lines of therapy

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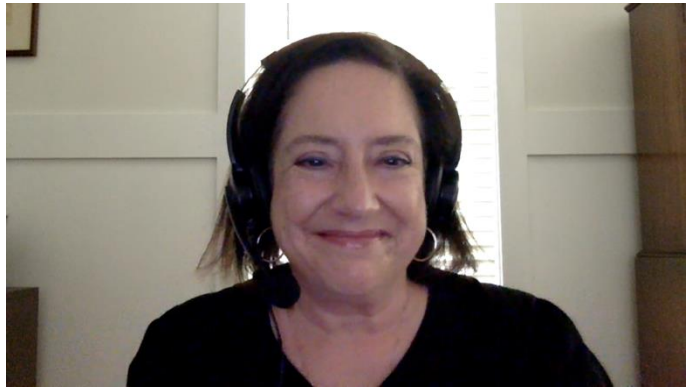
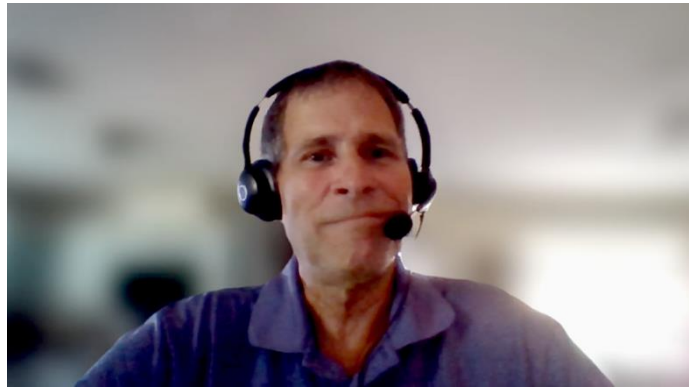
Other questions

Thank you



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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.