Recent Advances in Cancer Care — New Paradigms, Novel Agents and What It Means for the Oncology Nurse

A Complimentary NCPD Symposium Series Held During the 51st Annual ONS Congress

Relapsed/Refractory Multiple Myeloma

Saturday, May 16, 2026

12:15 PM – 1:45 PM

Faculty

Beth Faiman, PhD, MSN, APN-BC, AOCN, BMTCN, FAAN, FAPO
Hans Lee, MD
Mary Steinbach, PhD-c, DNP, FNP-C, APRN

Moderator

Natalie S Callander, MD

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Faculty

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Moderator

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University of Wisconsin Carbone
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Dr Faiman — Disclosures

Advisory Committees and Consulting Agreements	Janssen Biotech Inc, Sanofi

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Dr Lee — Disclosures

Consulting Agreements (Paid to Institution)	AbbVie Inc, Alexion Pharmaceuticals, Allogene Therapeutics, AstraZeneca Pharmaceuticals LP, Bristol Myers Squibb, GSK, Janssen Biotech Inc, Legend Biotech, Medline, Pfizer Inc, Predicta Biosciences, Regeneron Pharmaceuticals Inc, Sanofi, Takeda Pharmaceuticals USA Inc
Consulting Agreements (Paid to Self)	Alexion Pharmaceuticals, Allogene Therapeutics, Bristol Myers Squibb, GSK, Janssen Biotech Inc, Menarini Group, Pfizer Inc, Regeneron Pharmaceuticals Inc, Sanofi, Takeda Pharmaceuticals USA Inc
Contracted Research	AbbVie Inc, Alexion Pharmaceuticals, Amgen Inc, AstraZeneca Pharmaceuticals LP, Bristol Myers Squibb, GSK, Janssen Biotech Inc, Menarini Group, Moderna, Regeneron Pharmaceuticals Inc, Takeda Pharmaceuticals USA Inc
Data and Safety Monitoring Boards/Committees	Allogene Therapeutics, Takeda Pharmaceuticals USA Inc

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Ms Steinbach — Disclosures

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Dr Callander — Disclosures

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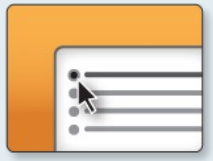
Clinicians in the Meeting Room

Networked iPads are available.

Review Program Slides: Tap the Program Slides button to review speaker presentations and other program content.



Answer Survey Questions: Complete the pre- and postmeeting surveys. Survey questions will be discussed throughout the meeting.

Ask a Question: Tap Ask a Question to submit a challenging case or question for discussion. We will aim to address as many questions as possible during the program.

For assistance, please raise your hand. Devices will be collected at the conclusion of the activity.

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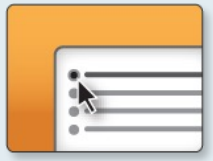
Clinicians Attending via Zoom

Review Program Slides: A link to the program slides will be posted in the chat room at the start of the program.



Answer Survey Questions: Complete the pre- and postmeeting surveys. Survey questions will be discussed throughout the meeting.

Ask a Question: Submit a challenging case or question for discussion using the Zoom chat room.

Get NCPD Credit: An NCPD credit link will be provided in the chat room at the conclusion of the program.

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About the Enduring Program

- The live meeting is being video and audio recorded.
- The proceedings from today will be edited and developed into an enduring web-based program. An email will be sent to all attendees when the activity is available.
- To learn more about our education programs, visit our website, **www.ResearchToPractice.com**

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RTP RESEARCH TO PRACTICE ONCOLOGY NURSING UPDATE WITH NEIL LOVE, MD

NONMELANOMA SKIN CANCERS
Check out our recent program with Dr Nikhil I Khushalni from Moffitt Cancer Center in Tampa, Florida. Published May 7, 2026.

Overview of nonmelanoma skin cancers (12 min)

Systemic therapy for nonmelanoma skin cancers (8 min)

Immune checkpoint inhibitors for special patient populations (12 min)

Hedgehog inhibitors for basal cell carcinoma (6 min)

New developments in therapy for nonmelanoma skin cancers (5 min)

CASE: A man in his early 70s with cutaneous squamous cell carcinoma receives cemiplimab (8 min)

CASE: A man in his mid 70s with a history of basal cell carcinoma presents with disease of the ocular surface and receives immunotherapy (6 min)

CASE: A man in his early 70s with recurrent metastatic basal cell carcinoma receives vismodegib followed by cemiplimab on disease progression (6 min)

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Feedback (Please!)

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“Recent Advances in Cancer Care — New Paradigms, Novel Agents and What It Means for the Oncology Nurse”
Eighteenth Annual RTP-ONS NCPD Symposium Series

Wednesday May 13	**Antibody-Drug Conjugates** 11:15 AM – 12:45 PM CT
	Ovarian Cancer 6:00 PM – 7:30 PM CT
Thursday May 14	**Immunotherapeutic Approaches for Endometrial Cancer** 6:00 AM – 7:30 AM CT
	Prostate Cancer 12:15 PM – 1:45 PM CT
	Non-Muscle-Invasive and Muscle-Invasive Bladder Cancer 6:00 PM – 7:30 PM CT
Friday May 15	**Pancreatic Cancer** 6:00 AM – 7:30 AM CT
	Targeting the PI3K/AKT/mTOR Pathway in HR-Positive Metastatic BC 12:15 PM – 1:45 PM CT
	Non-Hodgkin Lymphoma and Chronic Lymphocytic Leukemia 6:00 PM – 8:00 PM CT
Saturday May 16	**CDK4/6 Inhibitors for HR-Positive Breast Cancer** 6:00 AM – 7:30 AM CT
	Relapsed/Refractory Multiple Myeloma 12:15 PM – 1:45 PM CT
	Oral SERDs for Breast Cancer 6:00 PM – 7:30 PM CT

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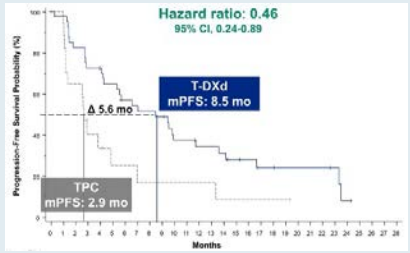
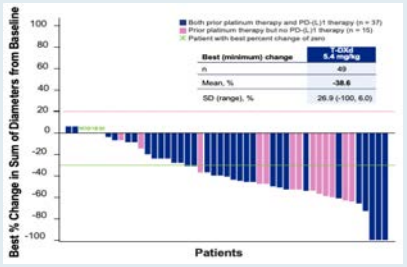
Recent Advances in Cancer Care — New Paradigms, Novel Agents and What It Means for the Oncology Nurse

New Agents, Therapies and Regimens

- When should it be used, for whom and why?
- How to prevent and manage side effects: dose holds and reductions
  - Kaplan Meier curves — HR and absolute benefit



  - Waterfall plots



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RTP RESEARCH TO PRACTICE

Agenda

Introduction: The Multiple Myeloma (MM) Treatment Journey

Module 1: Role of Chimeric Antigen Receptor T-Cell Therapy in Relapsed/ Refractory (R/R) MM

Module 2: Role of BCMA- and Non-BCMA-Targeted Bispecific Antibodies in R/R MM

Module 3: Utility of Belantamab Mafodotin in R/R MM

Module 4: Potential Role of Cereblon E3 Ligase Modulators in MM

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Discussion Questions

At a very basic level, how do you counsel your patients with MM about the nature of their disease and what their treatment journey might look like?

What sorts of discussions do you typically have with your patients at the time of disease relapse, and how do they typically react?

Agenda

Introduction: The Multiple Myeloma (MM) Treatment Journey

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Module 4: Potential Role of Cereblon E3 Ligase Modulators in MM

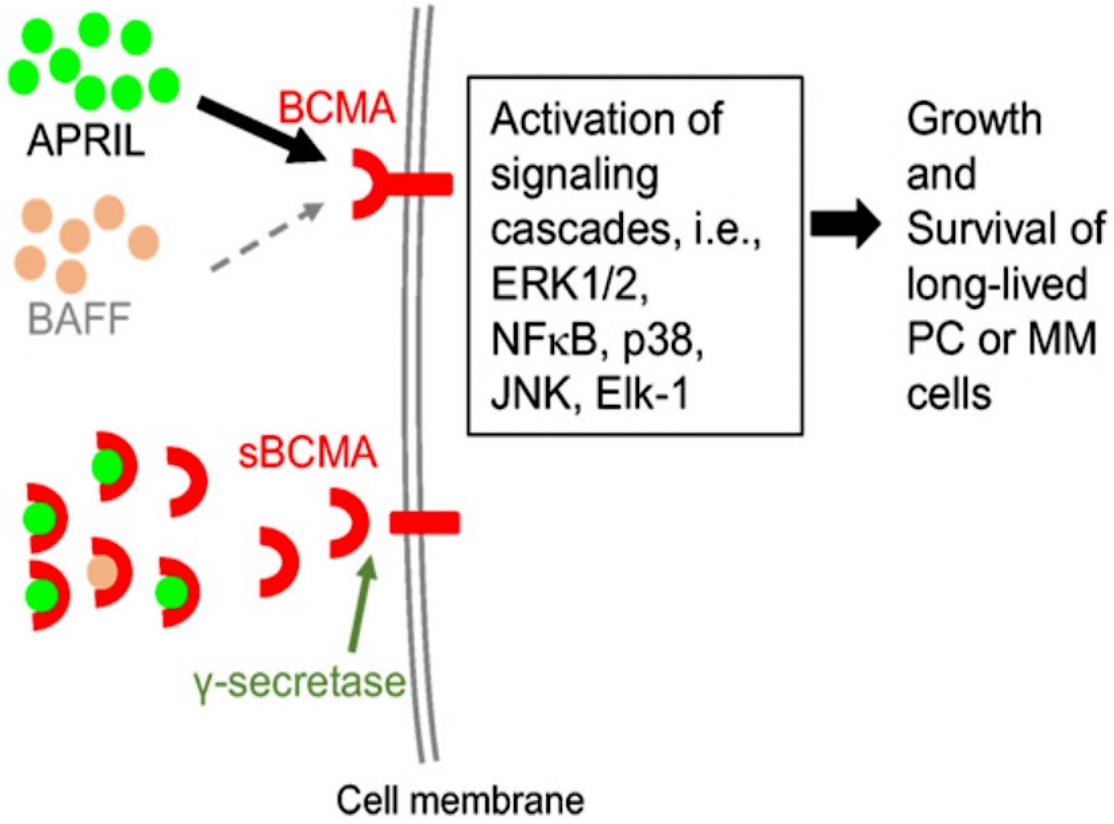
Role of Chimeric Antigen Receptor (CAR) T-Cell Therapy in Relapsed/Refractory (R/R) Multiple Myeloma (MM)

Natalie S Callander, MD
Professor of Medicine
Director, Myeloma Clinical and Cellular Therapy Program
University of Wisconsin Carbone Cancer Center
Madison, Wisconsin

What makes a good CAR-T target

- Target should be essential for the growth and development of the (tumor) cell
- Expression of target should be stable and highly expressed on cell of interest
- Target should be absent from normal cells

DOMINANCE OF BCMA AS BiSPECIFIC/CAR-T TARGET IN MYELOMA



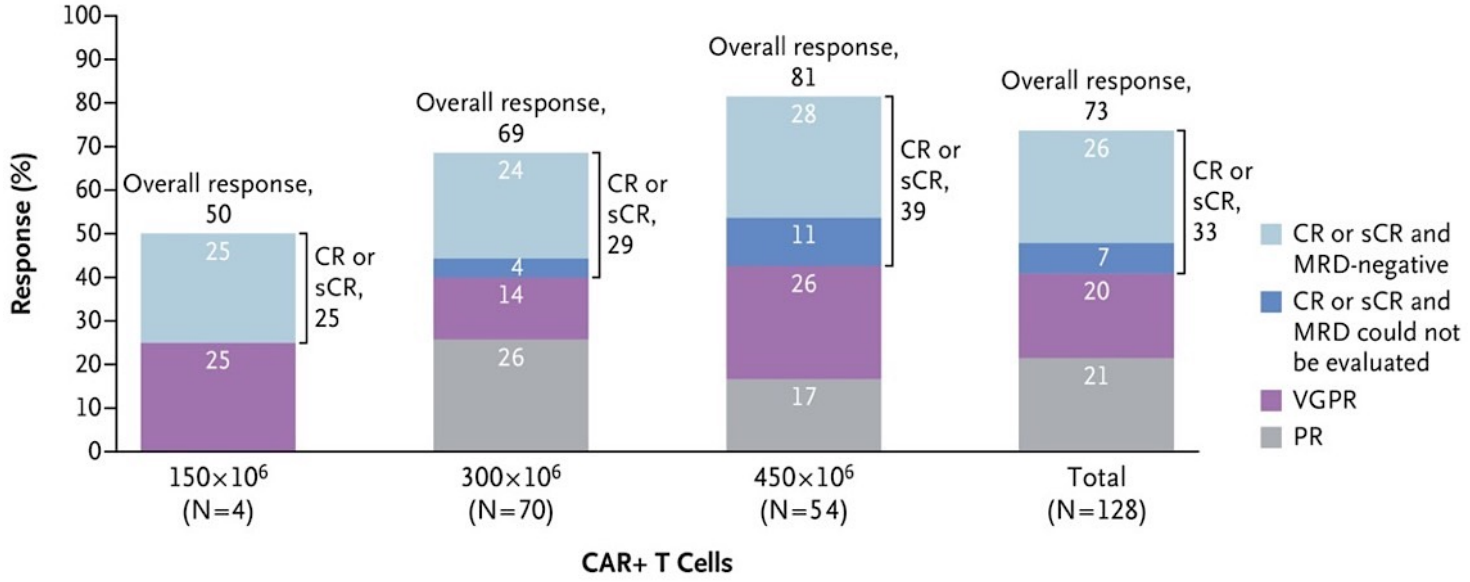
BCMA expression in PC

In normal physical functions
- Support survival of long-lived PCs
- Production of antibodies
- Class switch of immunoglobulin

In MM
- Promote proliferation and survival of MM cells.
- Associated with immunosuppressive BM microenvironment.
- Increased sBCMA level is associated with disease progression and poorer outcome.

Cho Front Immunol 2018

KarMMa: idecabtagene vicleucel, the “OG”



Variable	Any Grade	Grade 3 or 4
	no. of patients (%)	
Adverse event*		
Any	128 (100)	127 (99)
Hematologic		
Neutropenia	117 (91)	114 (89)
Anemia	89 (70)	77 (60)
Thrombocytopenia	81 (63)	67 (52)
Leukopenia	54 (42)	50 (39)
Lymphopenia	35 (27)	34 (27)
Febrile neutropenia	21 (16)	20 (16)
Gastrointestinal		
Diarrhea	45 (35)	2 (2)
Nausea	37 (29)	0
Constipation	20 (16)	0
Other		
Hypokalemia	45 (35)	3 (2)
Fatigue	43 (34)	2 (2)
Hypophosphatemia	38 (30)	20 (16)
Hypocalcemia	34 (27)	10 (8)
Pyrexia	32 (25)	3 (2)
Hypomagnesemia	30 (23)	0
Decreased appetite	27 (21)	1 (<1)
Headache	27 (21)	1 (<1)
Hypogammaglobulinemia	27 (21)	1 (<1)
Cough	26 (20)	0
Hyponatremia	24 (19)	7 (5)
Hypoalbuminemia	22 (17)	4 (3)
Aspartate aminotransferase level increased	21 (16)	2 (2)
Hypotension	21 (16)	1 (<1)
Cytokine release syndrome†	107 (84)	7 (5)
Neurotoxic effect‡	23 (18)	4 (3)

Munshi NC et al. N Engl J Med 2021;384:705-716

CARTITUDE-1: A Phase 1b/2

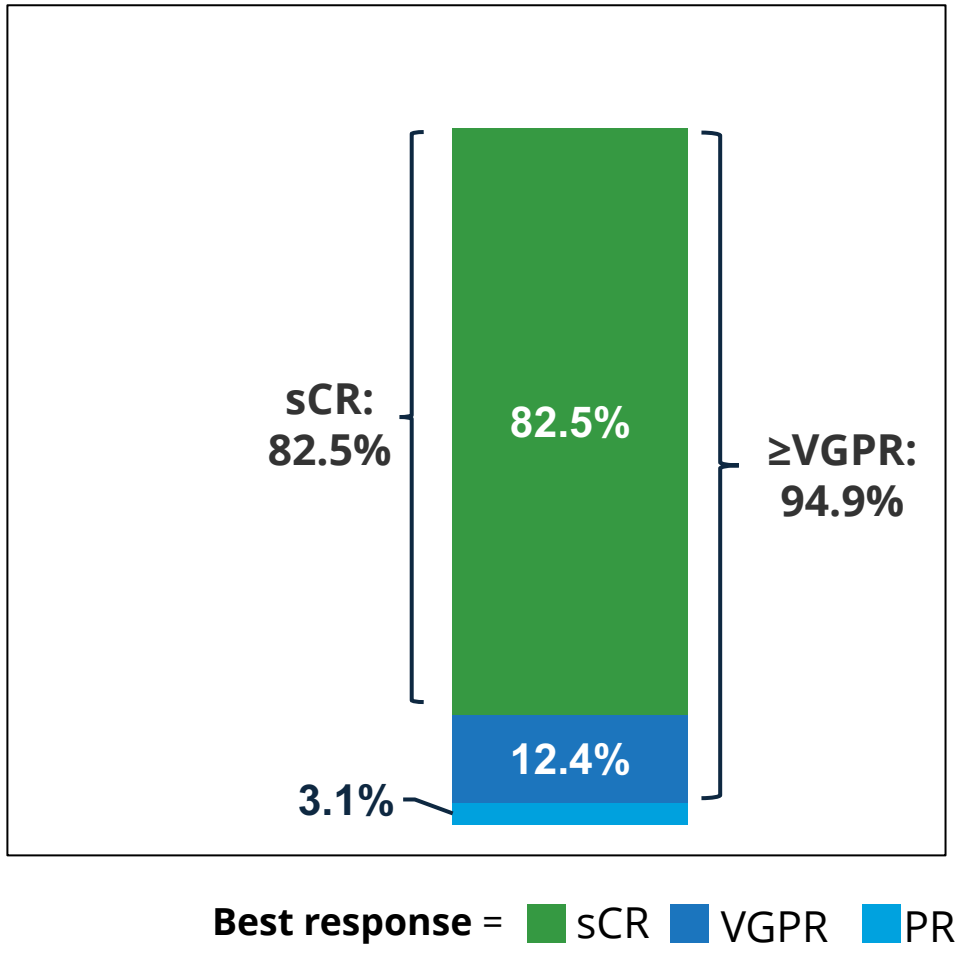
- Primary objectives
  - Phase 1b: Characterize the safety of cilta-cel and confirm the recommended phase 2 dose
  - Phase 2: Evaluate the efficacy of cilta-cel
- Key eligibility criteria
  - Progressive MM per IMWG criteria
  - ECOG PS ≤1
  - Measurable disease
  - ≥3 prior therapies or double refractory
  - Prior PI, IMiD, anti-CD38 antibody exposure

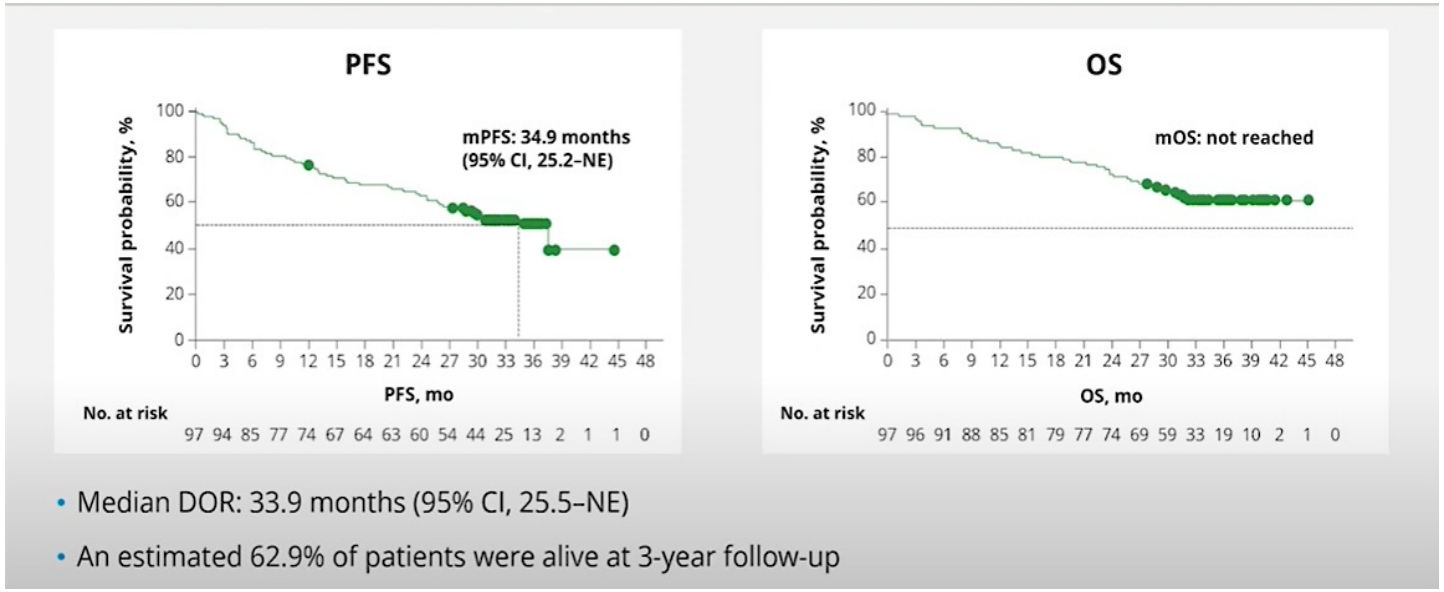
Median administered dose:
$0.71x10^6$ (range $0.51–0.95x10^6$) CAR+ viable T cells/kg

Baseline characteristic[1,2]	Patients (N=97)
Age, median (range), years	61.0 (43–78)
Male, n (%)	57 (58.8)
Black/African American, n (%)	17 (17.5)
Tumor BCMA expression ≥50%, n (%)	57 (91.9)[a]
Prior lines of therapy, median (range)	6.0 (3–18)
Bone marrow plasma cells ≥60%, n (%)	21 (21.9)
Time since diagnosis, median (range), years	5.9 (1.6–18.2)
All plasmacytomas,[b] n (%)	**19 (19.6)**
Extramedullary plasmacytomas, n (%)	13 (13.4)
Bone-based plasmacytomas, n (%)	6 (6.2)
High-risk cytogenetic profile, n (%)	**23 (23.7)**
del17p	19 (19.6)
t(14;16)	2 (2.1)
t(4;14)	3 (3.1)
Previous stem cell transplantation, n (%)	
Autologous	87 (89.7)
Allogeneic	8 (8.2)
Refractory status, n (%)	
Triple-class refractory[c]	85 (87.6)
Penta-drug refractory[d]	41 (42.3)
Refractory to last LOT	96 (99.0)

Martin et al, ASH 2021

CARTITUDE-1: Efficacy Response

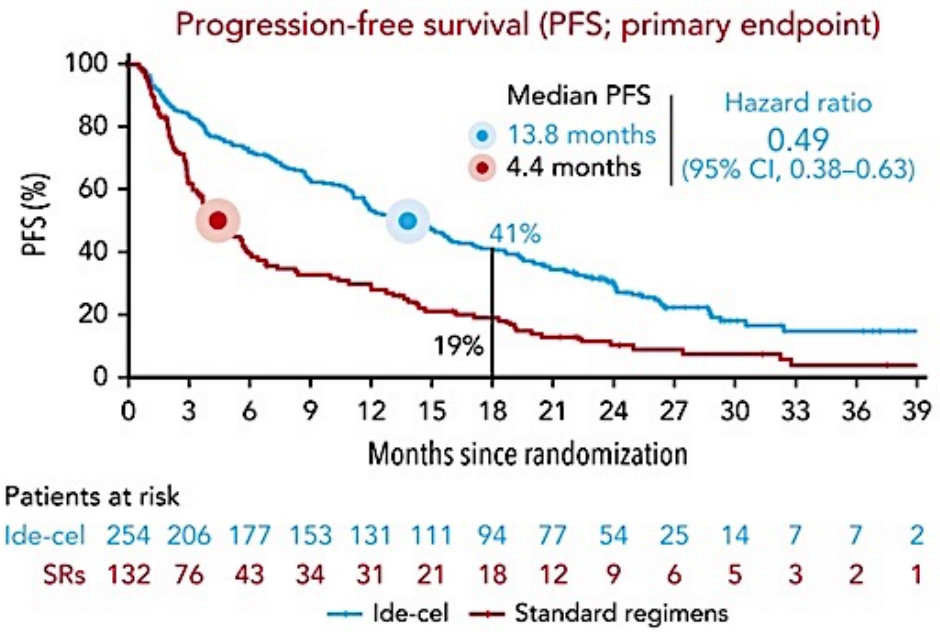


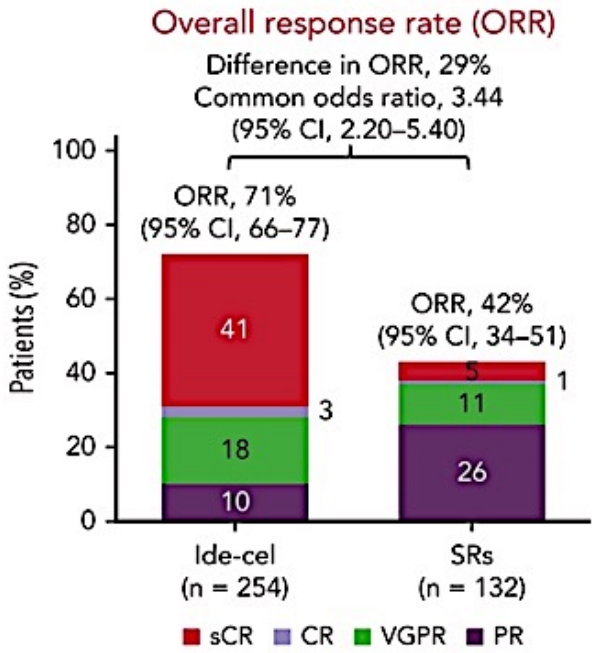


- Median time to first response was 1 month (range, 0.9–10.7)
- Median time to best response was 2.6 months (range, 0.9–17.8)
- Median time to CR or better was 2.9 months (range, 0.9–17.8)
- Median duration of response: 33.9 MO
- After 5 yr follow up, 33% had not progressed
- Obtaining CR and/or sustained MRD associated with best PFS

Munshi, EHA 2023; Vorhees P ASCO 2025, Abstract 7507

Ide-cel vs. SOC –KarMMa 3

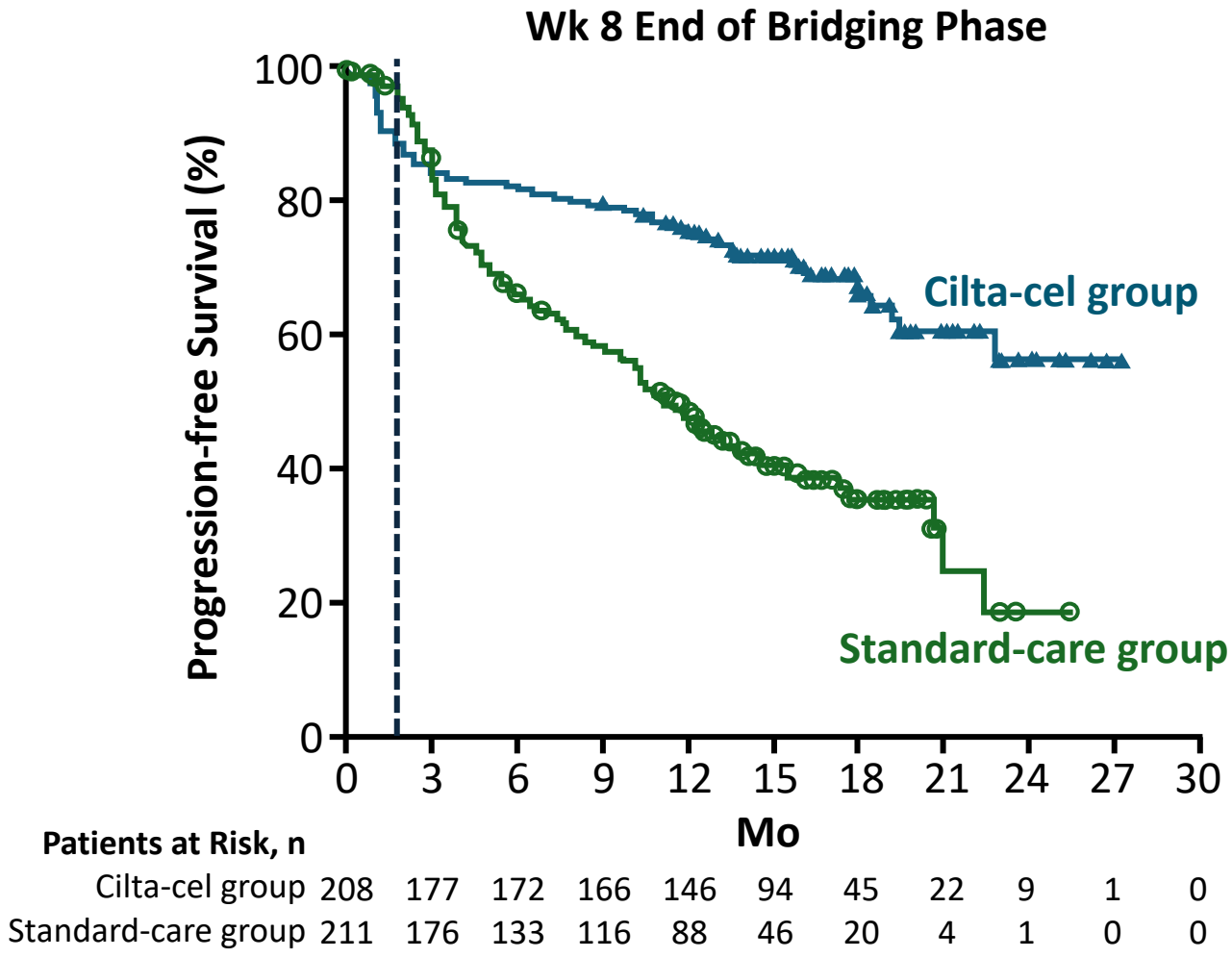




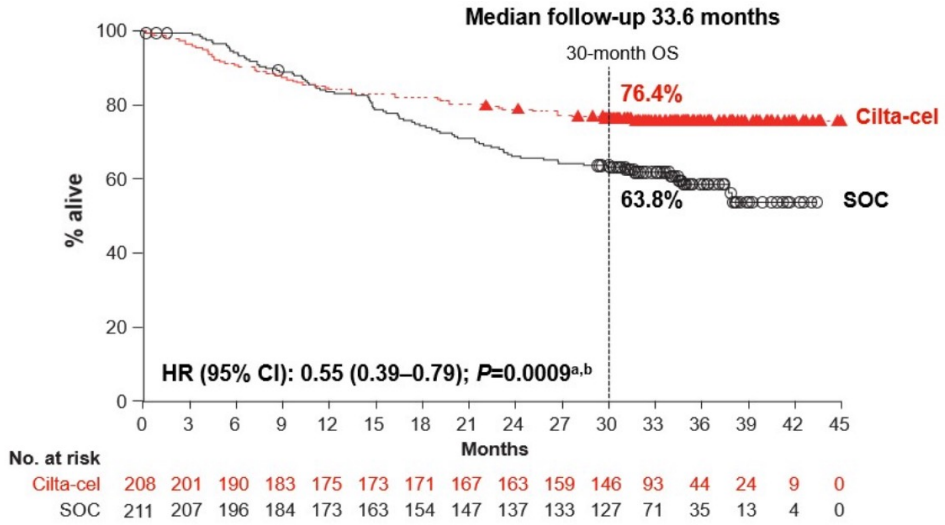
- Median (95% CI) overall survival (OS) was 41.4 (30.9–not reached [NR]) with ide-cel vs 37.9 (23.4–NR) months with SR (hazard ratio, 1.01; 95% CI, 0.73–1.40)
  - OS was confounded by crossover from SRs to ide-cel
  - Crossover adjustment showed a trend of improved OS with ide-cel vs SRs
- Extended health-related quality of life benefits were observed in patients receiving a one-time ide-cel infusion vs SRs
- Safety profile of ide-cel was consistent with previous reports with no parkinsonism, Guillain–Barré syndrome, or second primary malignancies of T-cell origin reported

Ailawadhi S et al. Blood. 2024 Dec 5;144(23):2389-2401.

CARTITUDE-4: Cilta-cel vs. SOC: approved for "2nd line"



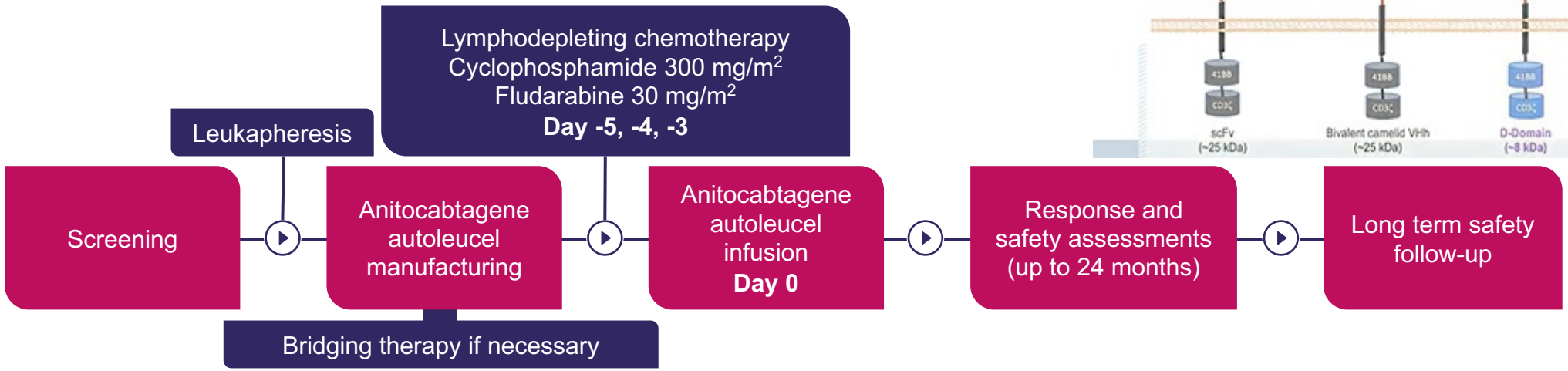
	Cilta-Cel (n = 208)	SoC (n = 211)
mPFS, mo (95% CI)	NR (22.8-NE)	11.8 (9.7-13.8)
	HR: 0.26 (95% CI: 0.18-0.38; P <.0001)	
12-mo PFS, %	76	49
PR or better	NR	16.6 mo

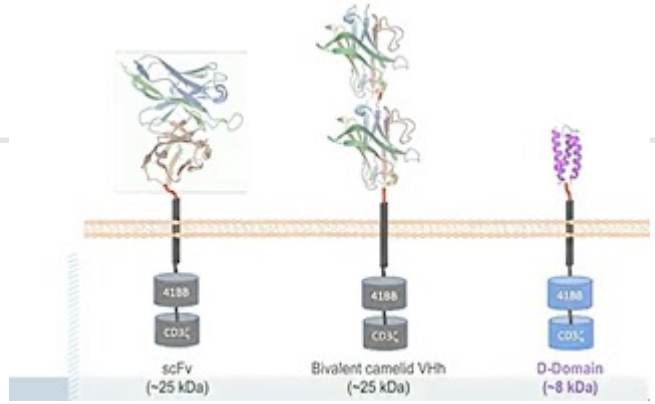


San-Miguel. NEJM. 2023;389:355.

Mateos IMS Brazil 2024

iMMagine-1: Phase 2 Study Design





Key Eligibility Criteria

- Prior IMiD, PI, and CD38-targeted therapy
- Received ≥3 prior lines of therapy
- Refractory to the last line of therapy
- ECOG PS of 0 or 1
- Evidence of measurable disease

Primary Endpoint:

- ORR, per 2016 IMWG criteria

Key Secondary Endpoints:

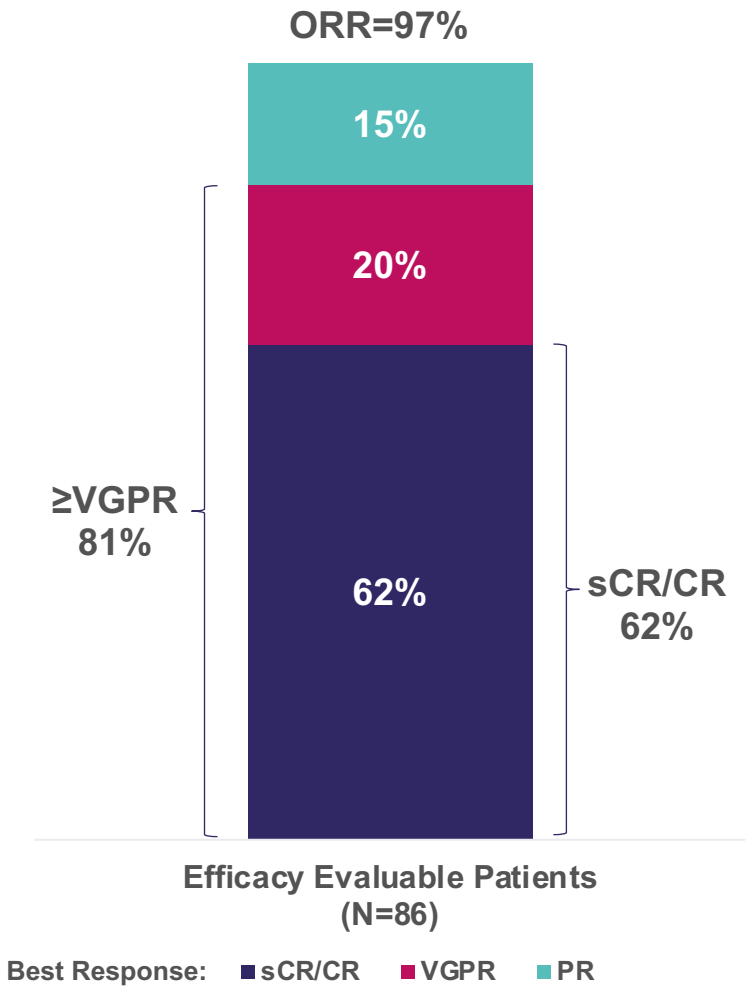
- CR/sCR rate, per 2016 IMWG criteria
- ORR in patients limited to 3 prior LOT, per 2016 IMWG criteria

Target Dose of 115 x 10^6 CAR+ T cells

Primary and key secondary endpoints to be assessed per Independent Review Committee (IRC); Investigator assessment of response per IMWG also permitted per protocol.
CR, complete response; ECOG PS, Eastern Cooperative Oncology Group Performance Status Scale; IMiD, immunomodulatory drug; IMWG, International Myeloma Working Group; LOT, line of therapy; ORR, overall response rate; PI, proteasome inhibitor; sCR, stringent complete response.

iMMagine-1: Overall Response Rate and MRD Negativity

Efficacy Evaluable Patients (N=86)



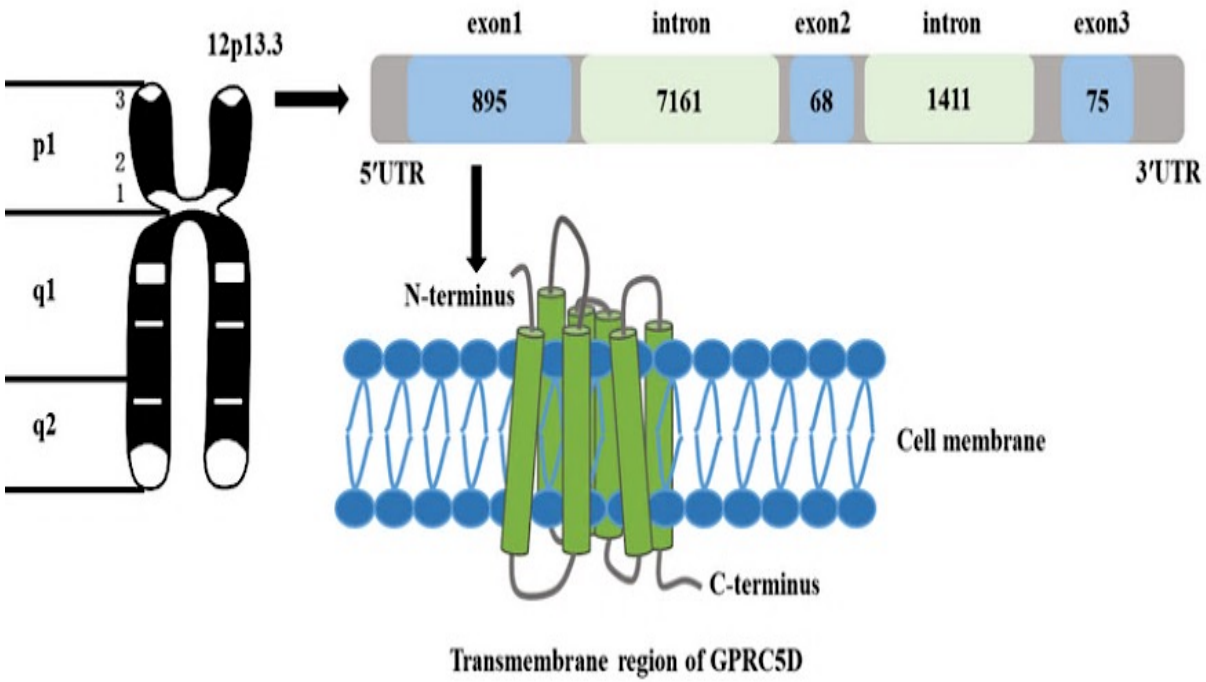
- At a median follow-up of 9.5 months, responses were ongoing in 80.2% of 86 patients
- 93.1% (n=54/58) of evaluable* patients MRD negative at minimum of 10^{-5} sensitivity

	Evaluable Patients	Months (min - max)
Median time to first response	84	1 (0.9 - 7.3)
Median time to MRD negativity of 10^{-5} or lower	58	1.0 (0.9 - 6.4)

- No late neurotoxicity observed
- PDUFA date Dec 2026

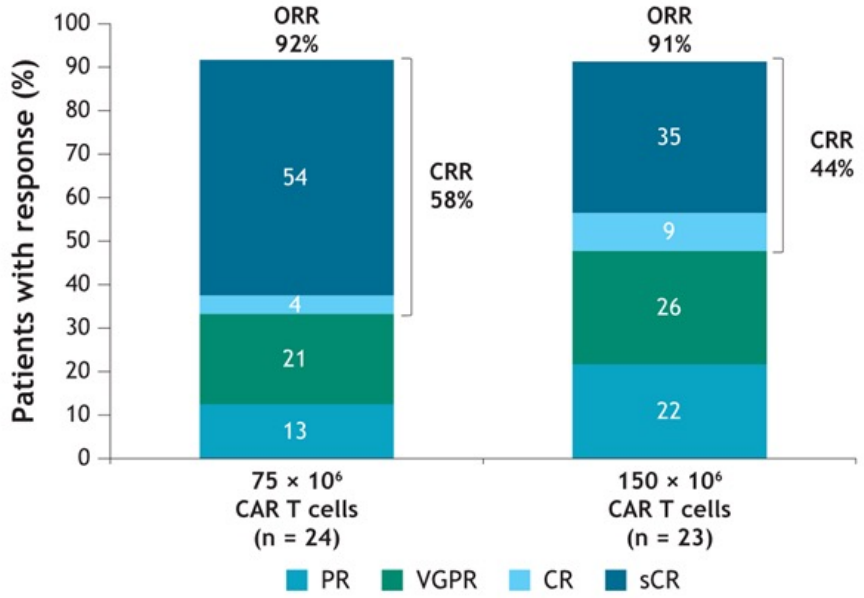
*Responses are investigator assessed, ORR defined as partial response or better; *Evaluable patients had identifiable malignant clone in the baseline bone marrow aspirate*
CR, complete response; MRD, minimal residual disease; ORR, overall response rate; PR, partial response; sCR, stringent complete response; VGPR, very good partial response

ARLOCABTAGENE targets GPRC5D: phase 2 trial underway



GPRC5D complex

Arlo-cel CAR-T targets GPRC5D
Study includes pts who have received previous BCMA directed therapies



Rates may not add exactly due to rounding.
CAR, chimeric antigen receptor; CR, complete response; CRR, complete response rate; ORR, overall response rate; PR, partial response; sCR, stringent complete response; VGPR, very good partial response.

Table 2. Most frequent treatment-emergent adverse events (TEAEs)

TEAEs, n (%)	75 × 10⁶ CAR T cells (n = 24)	150 × 10⁶ CAR T cells (n = 26)
Patients with ≥ 1 TEAE	24 (100.0)	26 (100.0)
Hematologic TEAEs[a]		
Neutropenia	16 (66.6)	22 (84.6)
Anemia	12 (50.0)	13 (50.0)
Thrombocytopenia	8 (33.3)	10 (38.5)
Non-hematologic TEAEs[a]		
Hypokalemia	10 (41.7)	12 (46.2)
Diarrhea	10 (41.7)	10 (38.5)
Hypophosphatemia	6 (25.0)	11 (42.3)
Fatigue	4 (16.7)	13 (50.0)
Dysgeusia	7 (29.2)	9 (34.6)
Headache	6 (25.0)	9 (34.6)
Nausea	2 (8.3)	8 (30.8)

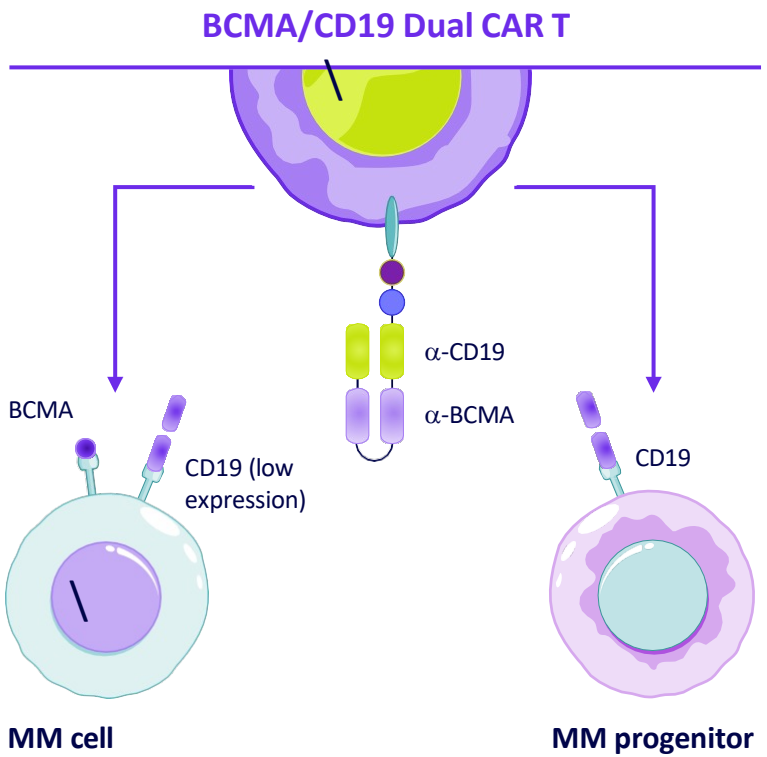
[a]TEAE reported in ≥ 30% of either dose cohort.
CAR, chimeric antigen receptor.

Patel K et al. ASCO 2025;Abstract TPS7563
Bal S et al. IMS 2025;Abstract PA-076

BETTER RESPONSE BY TARGETING 2 RECEPTORS:

AZD0120: A Novel BCMA/CD19 Dual CAR T

Dual Target



Next-Generation Manufacturing

Faster to Patients

Manufactured in

<3 days

Better T Cells

Younger, fitter naive T cells

Safety profile enabling outpatient administration and monitoring

Making cell therapy available to more patients

AZD0120 was formerly named GC012F, and next-generation manufacturing refers to the FasTCAR platform.
BCMA, B-cell maturation antigen; CAR T, chimeric antigen receptor T-cell therapy; MM, multiple myeloma.

OVER COME RESISTANCE BY DUAL TARGETING

Study Design

Study Schema

Key inclusion criteria

- ≥3 prior LOT (exposure to PI, IMiD, and anti-CD38 Ab required)
- Documented evidence of PD with most recent LOT
- Prior exposure to BCMA-directed therapy permitted[a]

Phase 1b primary objectives

- Safety/tolerability
- RP2D determination

[a]If prior BCMA-directed therapy occurred >6 months before the study.
Ab, antibody; BCMA, B-cell maturation antigen; DL, dose level; Flu/Cy, fludarabine/cyclophosphamide; IMiD, immunomodulatory drug; LOT, line(s) of therapy; PD, progressive disease; PI, proteasome inhibitor; RP2D, recommended phase 2 dose; tx, therapy.

Case Presentation

- 58 y.o. female presented with knee pain 6/2013; kappa LC 304 mg/dl, BMBX 83% PCs,
  - XRT, lenalidomide/dex
  - Auto PBSCT 2/2014, len maintenance
  - 4/2018 new lytic lesions, lcd,
  - IxaPomD, Ikd, XPd
  - 5/2022 referred for CAR-T-idecabtagene-no CRS, ICANS
  - Currently in CR

Discussion Questions

How do you choose patients for anti-BCMA CAR T-cell therapy, and when do you typically employ it?

Do you have a preference for ide-cel over cilta-cel or vice versa for any specific types of patients or in any particular clinical situations?

In your experience, how long do responses with anti-BCMA CAR T-cell therapy typically last? How much of an advantage do your patients who have been administered CAR T-cell therapy find it to not receive ongoing treatment for a period of time?

Tolerability and Other Practical Considerations with CAR T-Cell Therapy

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Member, Cancer Population and Health, Case Western Reserve University
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Overview of the CAR T-cell manufacturing and delivery processes

Patient Identification (meets FDA label)

- No age cutoff
- 1 prior LOT for ciltacel; 2LOT ide cel
- CAR centers will have variable eligibility criteria, so best to refer and let them decide
- Patients can be CAR candidates who are not auto-transplant candidates
- The earlier the referral, the better!

Referral to CAR T Specialist

- Eligibility evaluation
- Insurance authorization
- Consent and education

T-Cell Collection via Apheresis

LD Chemotherapy and T-Cell Infusion

- LD chemo mostly outpatient (ie, Flu/Cy x 3 days)
- CAR T-cell infusion can be inpatient or outpatient
- Postinfusion monitoring involves daily labs, close vital sign monitoring, and exams for at least 7 days to assess for CRS/NT

Close Monitoring ± Bridging Therapy

- Is the patient experiencing significant symptoms or at risk for organ function impairment?
- Bridging could include steroids, palliative RT, chemotherapy, and/or newer targeted agents *(e.g talquetamab)*

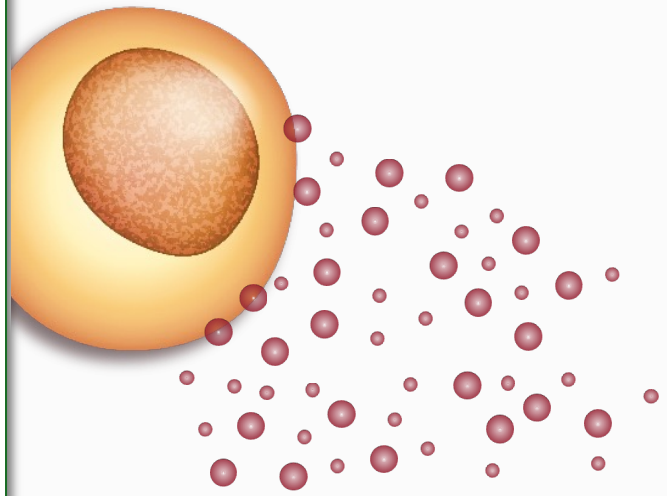
Can be outpatient or inpatient depending on the center

- Patient remains within 2 hr of CAR center for 4 wk from infusion
- Monitor for late CRS/NT and/or ongoing cytopenias
- First response assessment often at 4-wk mark

Assessment of toxicities and response is critical in the acute and delayed Post–CAR T stages

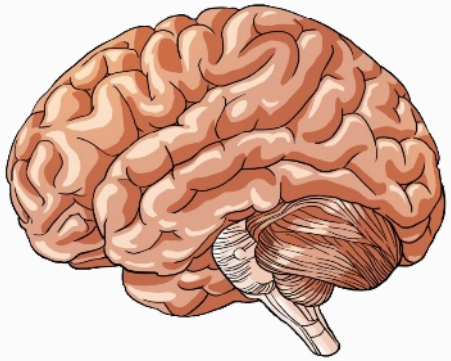
Three main considerations: Acute and delayed

Cytokine Release Syndrome (CRS)



Cilta-cel (~7–8 days)
ide-cel (~1–2 days)

Immune effector cell–associated neurotoxicity syndrome (ICANS)



Neuro Toxicity

Incidence less in earlier LOT (4.5%)

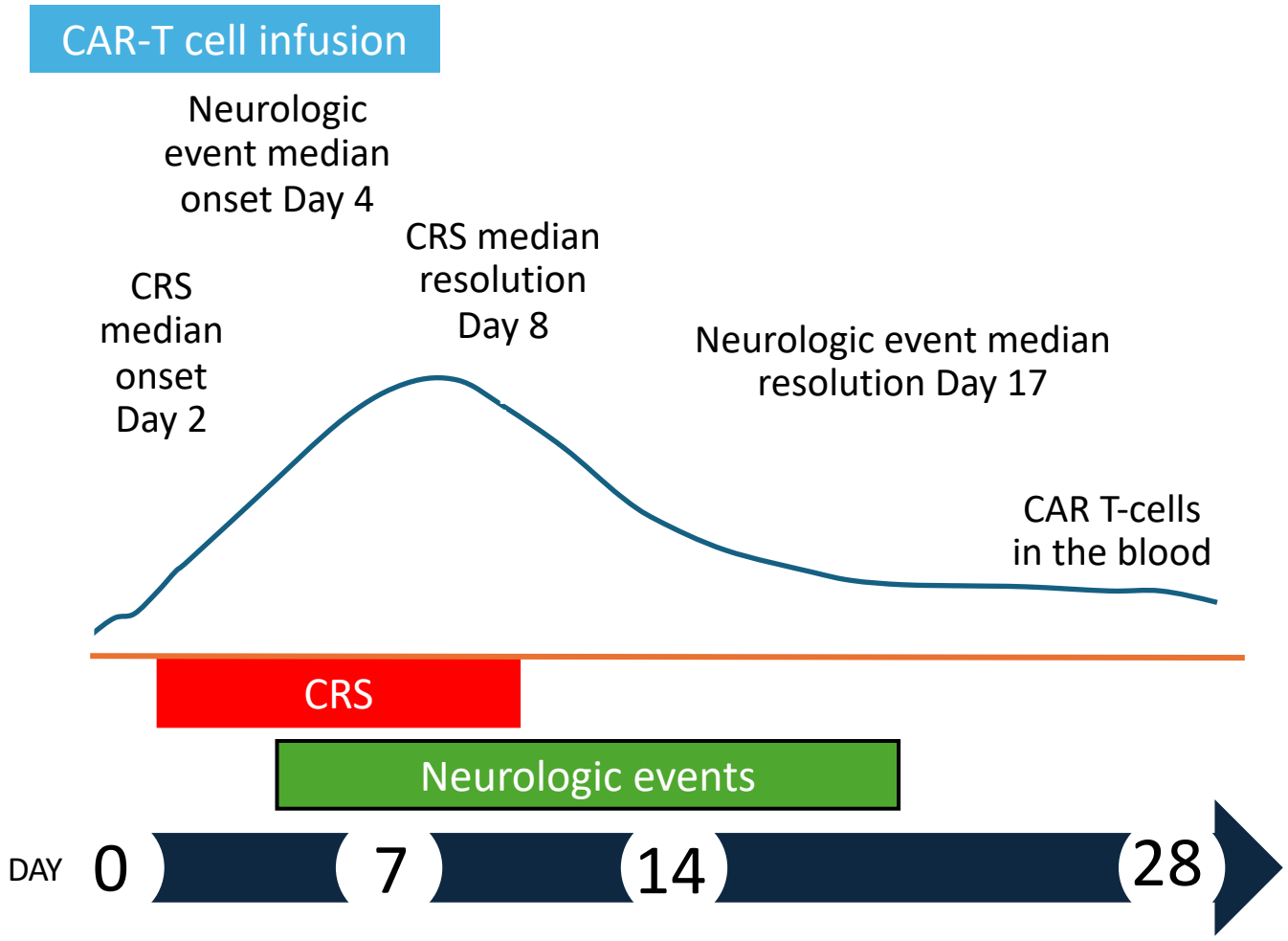
Infection

Range 45–69% and highest cause of non-relapse mortality

Understanding CRS and Neurologic Events

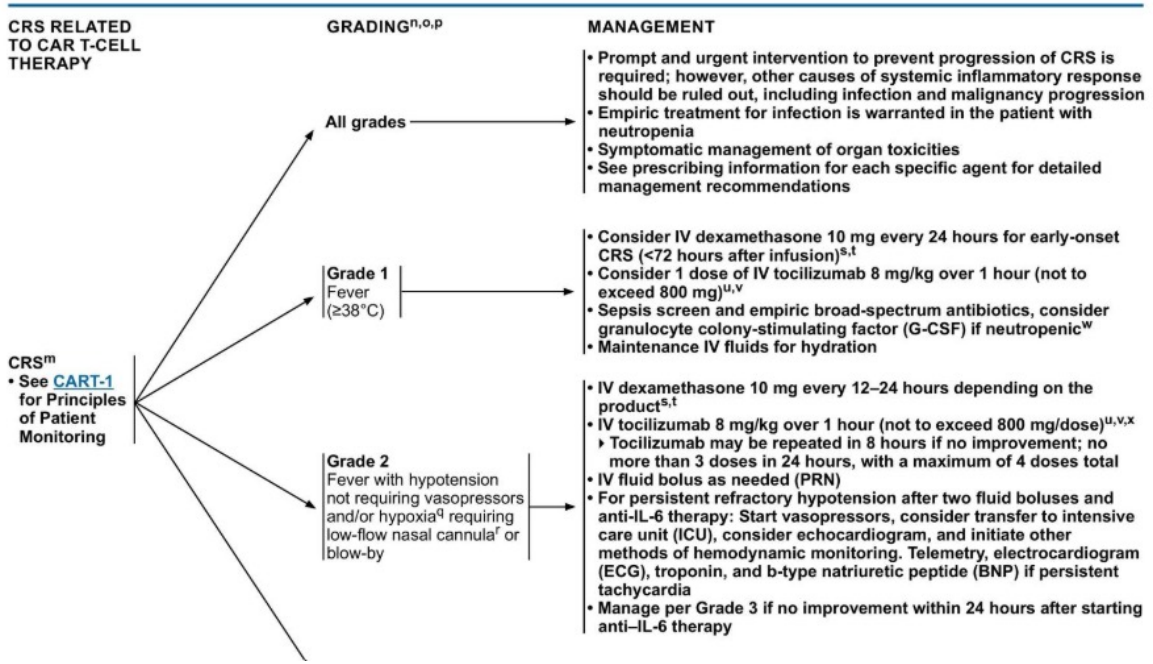
CRS Symptoms	
Common	**Potentially Serious**
Fever Hypotension Tachycardia Hypoxia Chills	Atrial fibrillation Ventricular tachycardia Cardiac arrest Cardiac failure Renal insufficiency Capillary leak syndrome Hypotension Hypoxia HLH/MAS

Neurologic Event Symptoms	
Common	**Potentially Serious**
Encephalopathy Tremor Dizziness Delirium Confusion Agitation	Seizures Leukoencephalopathy Cerebral edema Aphasia Obtundation



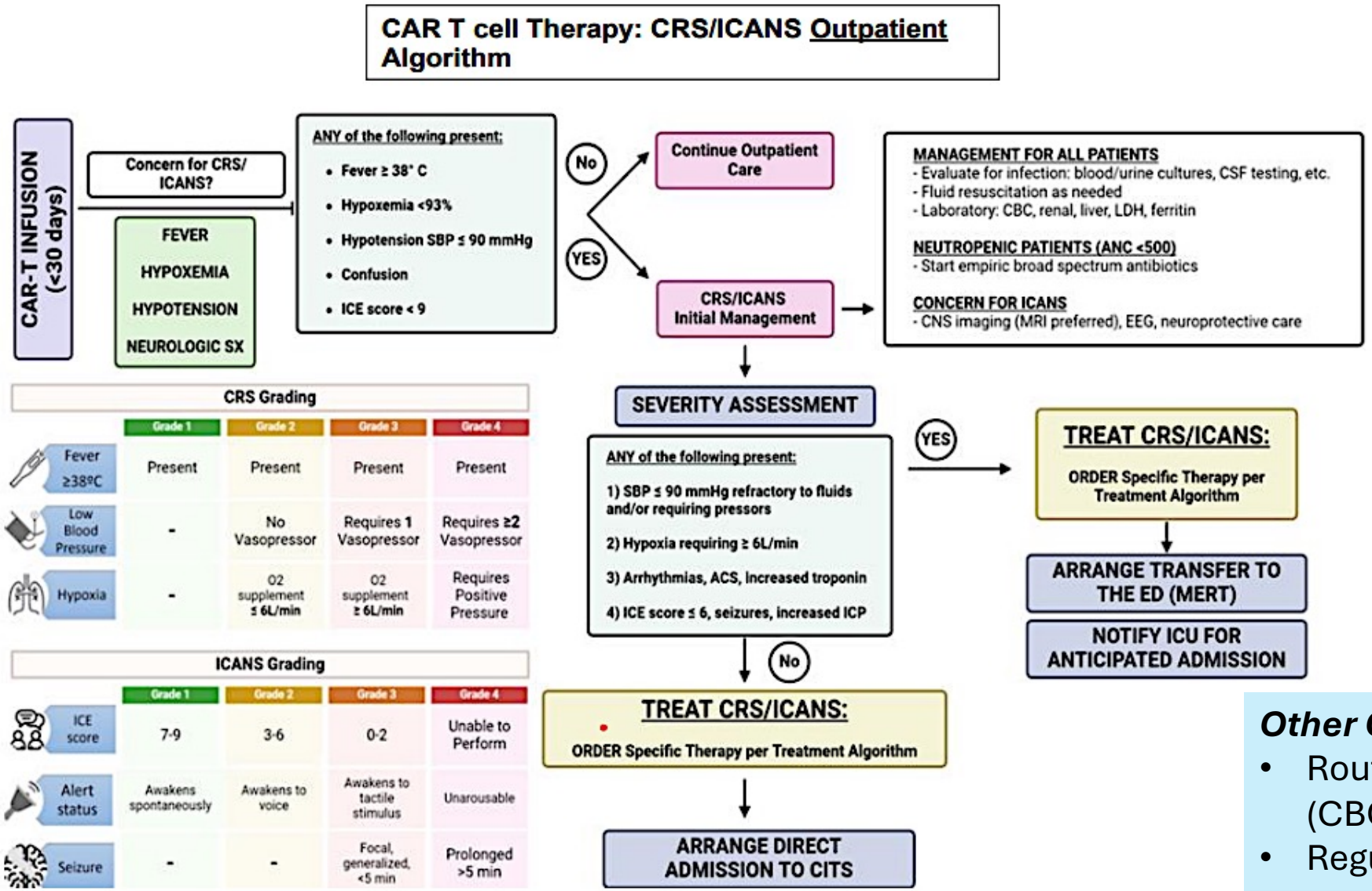
Guideline-endorsed approaches for mitigation and management of CRS, neurotoxicity/ICANS and other AEs with CAR T-cell therapy

ICANS Grade	Management (No Concurrent CRS)	Additional if Concurrent CRS
All grades	Neuro assessment ≥ twice daily (ICE score); MRI brain for ≥Gr 2; neurology consult; EEG for ≥Gr 2; aspiration precautions; consider prophylactic anakinra for high-risk patients	—
Grade 1	Supportive care; consider 1 dose IV dexamethasone 10 mg	Add tocilizumab 8 mg/kg IV (max 800 mg) for CRS component
Grade 2	IV dexamethasone 10 mg, may repeat q6-12h if no improvement	Anti-IL-6 therapy as per Gr 1; consider ICU transfer if ≥Gr 2 CRS
Grade 3	ICU care; IV dexamethasone 10 mg q6h or IV	Anti-IL-6 therapy as per Gr 1



Domain	Recommendation
Cardiac	Baseline echocardiogram; cardiology consult if prior cardiac history
Vascular access	Central venous access (double/triple lumen) for IV fluids and vasopressors
Seizure prophylaxis	Levetiracetam 500–750 mg PO q12h × 30 days if high ICANS risk based on patient factors or product type
Neurologic baseline	ICE score (adults), baseline brain MRI consideration
Labs	Baseline CRP and ferritin (pre-lymphodepletion) to calculate CAR-HEMATOTOX score; HIV, HBV, HCV screening; consider CMV
Tumor lysis prophylaxis	Per institutional guidelines for patients with large tumor burden
Infection prophylaxis	PJP prophylaxis (TMP-SMX or alternatives) ≥6 months; VZV/HSV prophylaxis ≥1 year (indefinite preferred); antibacterial/antifungal prophylaxis while neutropenic
Immunoglobulin	In myeloma, IVIG should be considered if IgG 400 mg/dL prior to BCMA-directed CAR T-cell therapy

Outpatient considerations



Other Considerations

- Routine lab and disease monitoring (CBC, CMP, Cytokines)
- Regular assessments by Advanced practitioner or Physician

Medications to minimize infection risk

Type of Infection Risk	Medication Recommendation(s) for Healthcare Team Consideration
Viral: Herpes Simplex (HSV/VZV); CMV	Acyclovir prophylaxis
Bacterial: blood, pneumonia, and urinary tract infection	Consider prophylaxis with levofloxacin
PJP (*P. jirovecii* pneumonia)	Consider prophylaxis with trimethoprim-sulfamethoxazole
Fungal infections	Consider prophylaxis with fluconazole
COVID-19 and Influenza	Antiviral therapy if exposed or positive for covid per institution recommendations
IgG < 400 mg/dL (general infection risk)	IVIg recommended
ANC < 1000 cells/μL (general infection risk)	Consider GCSF 2 or 3 times/wk (or as frequently as needed) to maintain ANC > 1000 cells/μL and maintain treatment dose intensity

Some people receiving CART therapies have experienced infections that are less common like CMV, PJP and fungal infections

ANC = absolute neutrophil count; BCMA = B-cell maturation antigen; CAR = chimeric antigen receptor; CMV, cytomegalovirus; GCSF = granulocyte colony-stimulating factor; HSV = herpes simplex virus; IVIg = intravenous immunoglobulin; PJP = *Pneumocystis jirovecii* pneumonia; VZV = varicella zoster virus.

Raje NS, et al. *Lancet Haematol*.2022;9(2):143–161; NCCN v 5.2026; Shahid Z, et al., *Transplant Cell Ther*. 2024;30(10):955-969.

Adverse Event	Incidence	Key Features	Management
Delayed Neurotoxicity (Non-ICANS)	**IEC-Parkinsonism:** ~5% (CARTITUDE-1) **Cranial nerve palsy:** 2.5–9% with cilta-cel; rare with ide-cel.	Onset 11–108 days post-infusion (later than ICANS). Parkinsonism: bradykinesia, rigidity, tremor, micrographia, personality change; levodopa-unresponsive. Cranial nerve palsy: facial paralysis, peripheral neuropathy. Risk factors: high tumor burden, grade ≥2 CRS, prior ICANS, high CAR T-cell expansion	Parkinsonism — Variable strategies from dexamethasone 10 mg 2–4×/day × 3–5 days; Severe/refractory: high-dose cyclophosphamide (2 g/m^2) to ablate CAR T cells; alternatives include intrathecal chemotherapy or ruxolitinib. No consensus
Prolonged Cytopenias (ICAHT)	Grade ≥3 cytopenias at day 28: ~30–52%; persistent grade ≥3 at day 100: ~19%; may persist >1 year in 64% of those with day-100 cytopenias	Neutropenia, thrombocytopenia, anemia persisting weeks to months. Associated w/ worse PFS and OS. Risk factors: baseline inflammation, clonal hematopoiesis (CH), CRS severity, prior therapy burden. CAR-HEMATOTOX score can predict risk	First-line: transfusion support + G-CSF Refractory: consider autologous stem cell boost if available. Evaluate for MDS if cytopenias persist. Monitor CBC closely for months post-infusion
Hypogamma-globulinemia	Post-BCMA CAR T: 68–80% develop hypogammaglobulinemia; 42–68% persist >12 months	BCMA-directed therapy targets plasma cells, impacting pre-existing pathogen-specific immunity while preserving naïve/memory B cells (unlike CD19 CAR T). Lower IgG and greater IgG decline post-CAR T associated with increased infection risk and mortality	In myeloma: IVIG should be considered if IgG 400 mg/dL prior to BCMA-directed CAR T (not guided by presence of infections
Infections	Any grade: 45–69%; Grade ≥3: 20–27%. Bacterial: first 30 days; viral infections (especially respiratory) 30 days and up to >1 year. Invasive fungal infections: ~8%. ****leading cause of non-relapse mortality***	Risk factors: CRS severity, prolonged neutropenia, hypogammaglobulinemia, prior therapies, lymphopenia. CRS may mimic sepsis	See previous chart; — empiric antibiotics recommended if neutropenic with fever
Secondary Malignancies	Overall SPM: **~6%** (meta-analysis, median follow-up 22 months); 2–10% within 5 years. Hematologic SPM most common T-cell malignancies extremely rare. Solid tumors and NMSC also reported	Hematologic SPMs (MDS/AML) associated with clonal hematopoiesis, especially TP53-mutated CH (67% MDS incidence if baseline TP53 CH). -(pre-existing mutations, viral infections, possible insertional mutagenesis). Randomized trial data show similar SPM risk vs. standard-of-care	Survivorship monitoring, health maintenance

Case Presentation

Case Presentation

- 78 YO PMHx HTN, DM2, hyperlipidemia diagnosed in 2018 with high risk, IgA Lambda MM (gain 1q; t(4;14), 80% bone marrow plasmacytosis
- **LOT1:** Induction KRd – ASCT – Kd maintenance (FORTE trial) until March 2022; PD with progression on surveillance PET scan
- **LOT2:** Dara + Pom + dex , March 2022-April 2023; PD biochemical (doubling lambda light chains)
- **LOT3:** Cilta-cel May 2023. Admitted Day +7 for CRS management until day +11. On day 28, admitted after onset of L-sided facial droop w/ progressive lip numbness.
- High dose dexamethasone given for 7 day course w/ taper for delayed cranial nerve VII palsy
- MRI no significant findings. Completed 7day course of dexamethasone, and Palsy resolved within 10 days. Continues to be MRD negative.

Discussion Questions

What steps can nurses in community-based practice take to ensure a smooth transition for patients who receive CAR T-cell therapy at tertiary care centers and then return to them for routine care? What clinical pearls would you offer nurses in this situation?

Agenda

Introduction: The Multiple Myeloma (MM) Treatment Journey

Module 1: Role of Chimeric Antigen Receptor T-Cell Therapy in Relapsed/ Refractory (R/R) MM

Module 2: Role of BCMA- and Non-BCMA-Targeted Bispecific Antibodies in R/R MM

Module 3: Utility of Belantamab Mafodotin in R/R MM

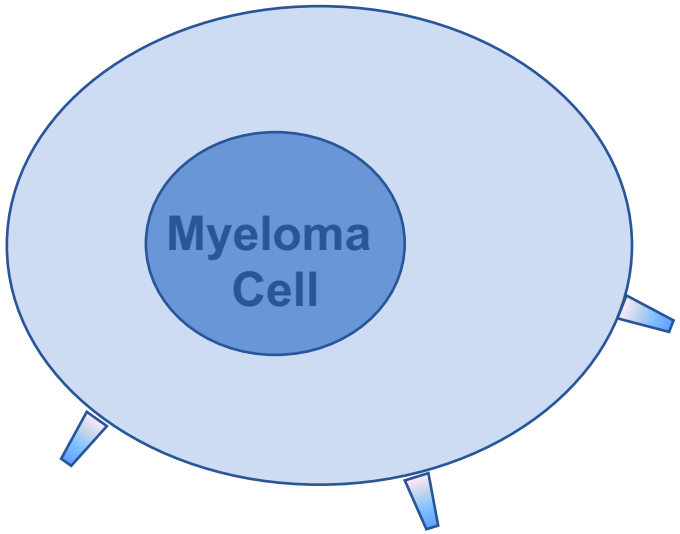
Module 4: Potential Role of Cereblon E3 Ligase Modulators in MM

Role of BCMA- and Non-BCMA-Targeted Bispecific Antibodies in Multiple Myeloma

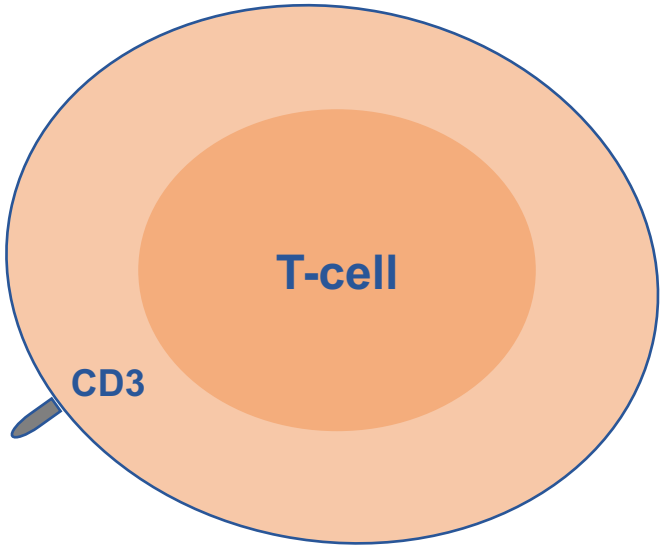
May 16, 2026

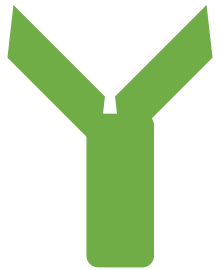
Hans Lee, MD
Director, Multiple Myeloma Research
Sarah Cannon Research Institute

What is a Bispecific T-cell Antibody?



Myeloma Cell Death



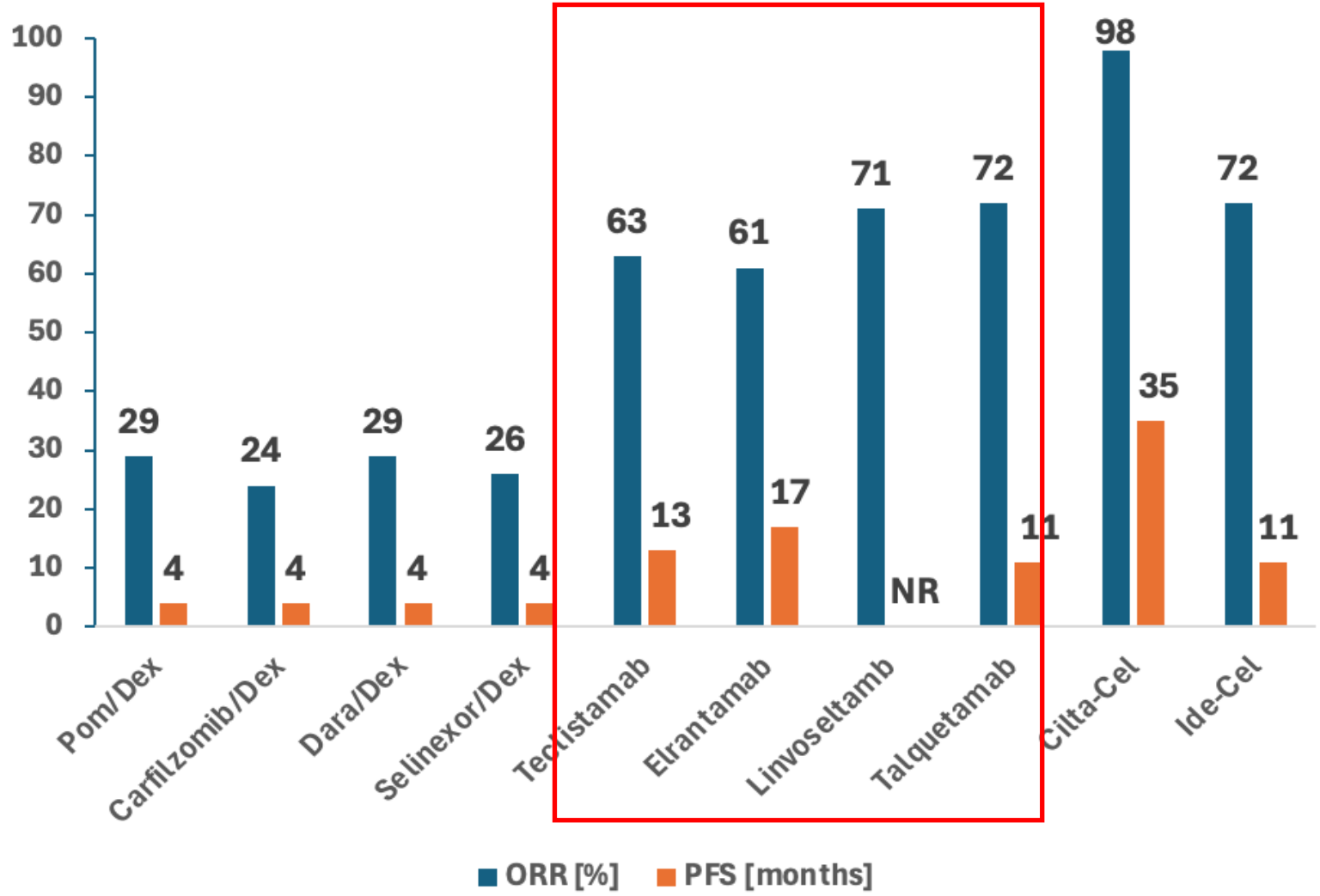


Bispecific T-cell antibody

BCMA

SCRI Sarah Cannon Research Institute

Overall Response Rate (ORR) and Progression Free Survival (PFS) of Recently Approved Drugs in Relapsed/Refractory Myeloma



SCRI Sarah Cannon Research Institute

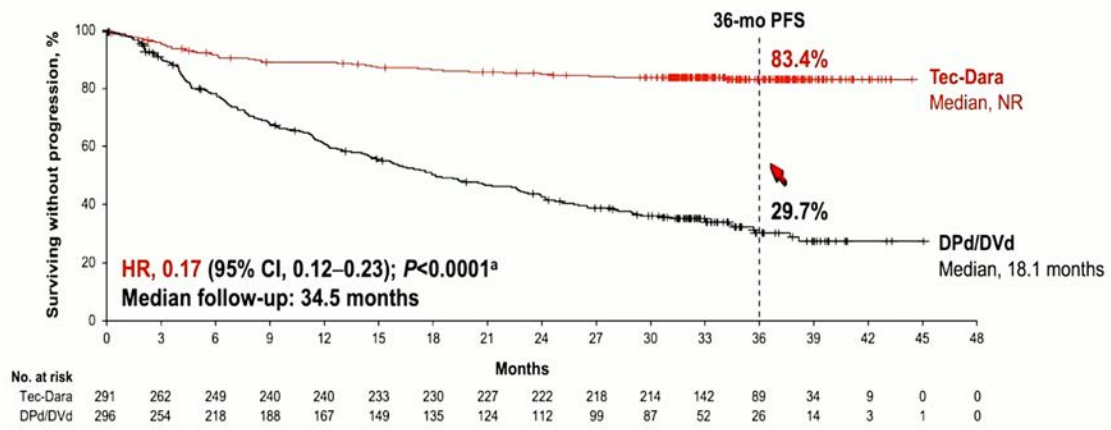
Moreau P, et al. *N Engl J Med.* 2022;387:495-505; Lesokhin AM, et al. *Nat Med.* 2023;29:2259-2267; Bumma N, et al. *J Clin Oncol.* 2024;42:2702-2712; Chari A, et al. *N Engl J Med.* 2022;12:e269-e281.

Bispecific T-Cell Antibodies Summary

Drug	Target	Administration Route	Which Patients Can Receive?
Teclistamab **FDA approved, 2022**	BCMA	Subcutaneous	≥ 4 lines of therapy **OR** ≥ 1 line of therapy in combination with daratumumab
Elranatamab **FDA approved, 2023**	BCMA	Subcutaneous	≥ 4 lines of therapy
Linvoseltamab **FDA approved, 2025**	BCMA	Intravenous	≥ 4 lines of therapy
Talquetamb **FDA approved, 2023**	GPRC5D	Subcutaneous	≥ 4 lines of therapy
Etentamig **(in clinical development)**	BCMA	Intravenous	Clinical trial only
Cevostamab **(in clinical development)**	FCRH5	Intravenous	Clinical trial only

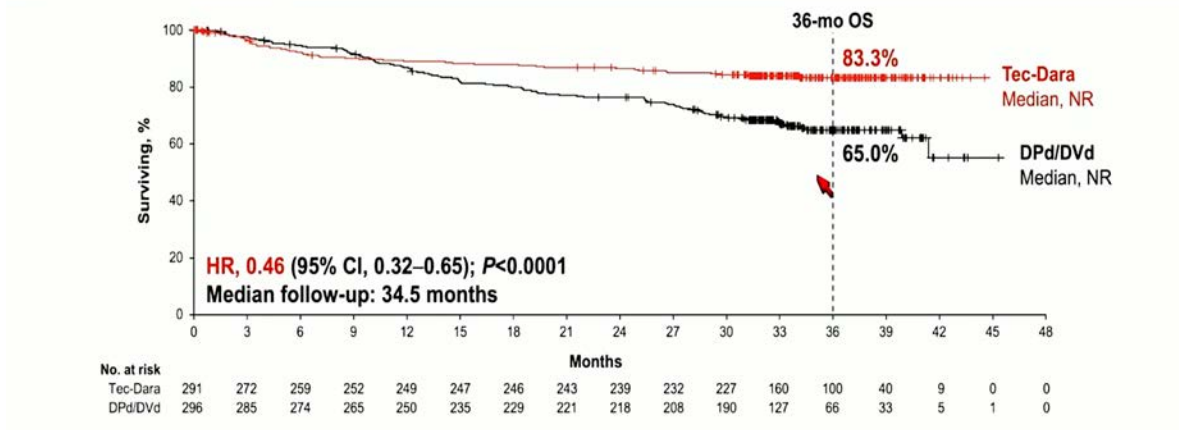
MajesTEC-3: Teclistamab + Daratumumab vs. Standard Therapies (1-3 prior lines of therapy)

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

MajesTEC-3: OS



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

Teclistamab + Daratumumab combination significant longer survival compared to conventional therapies!

FDA Approved on March 5, 2026

SCRI Sarah Cannon Research Institute

Costa et al. *NEJM.* 2025.

MajesTEC-9 Phase III Trial Design

Screening (28 days)

- ≥18 ye
- RRMM progre respon
- ECOG
- 1-3 pri of an a cycles
- No pri

January 14, 2026 – "[A] worldwide leader in multiple myeloma therapies, today announced positive topline results from the investigational Phase 3 MajesTEC-9 study of teclistamab-cqyv monotherapy, showing a 71% reduction in the risk of disease progression or death and a 40% reduction in the risk of death in a patient population that was predominantly refractory to anti-CD38 therapy and lenalidomide. Data confirm superior progression-free survival (PFS) and overall survival (OS) with teclistamab-cqyv compared to standard of care as early as second line."

https://www.jnj.com/media-center/press-releases/tecvayli-monotherapy-demonstrates-superior-progression-free-and-overall-survival-versus-standard-of-care-as-early-as-first-relapse-in-patients-with-multiple-myeloma-predominantly-refractory-to-anti-cd38-therapy-and-lenalidomide

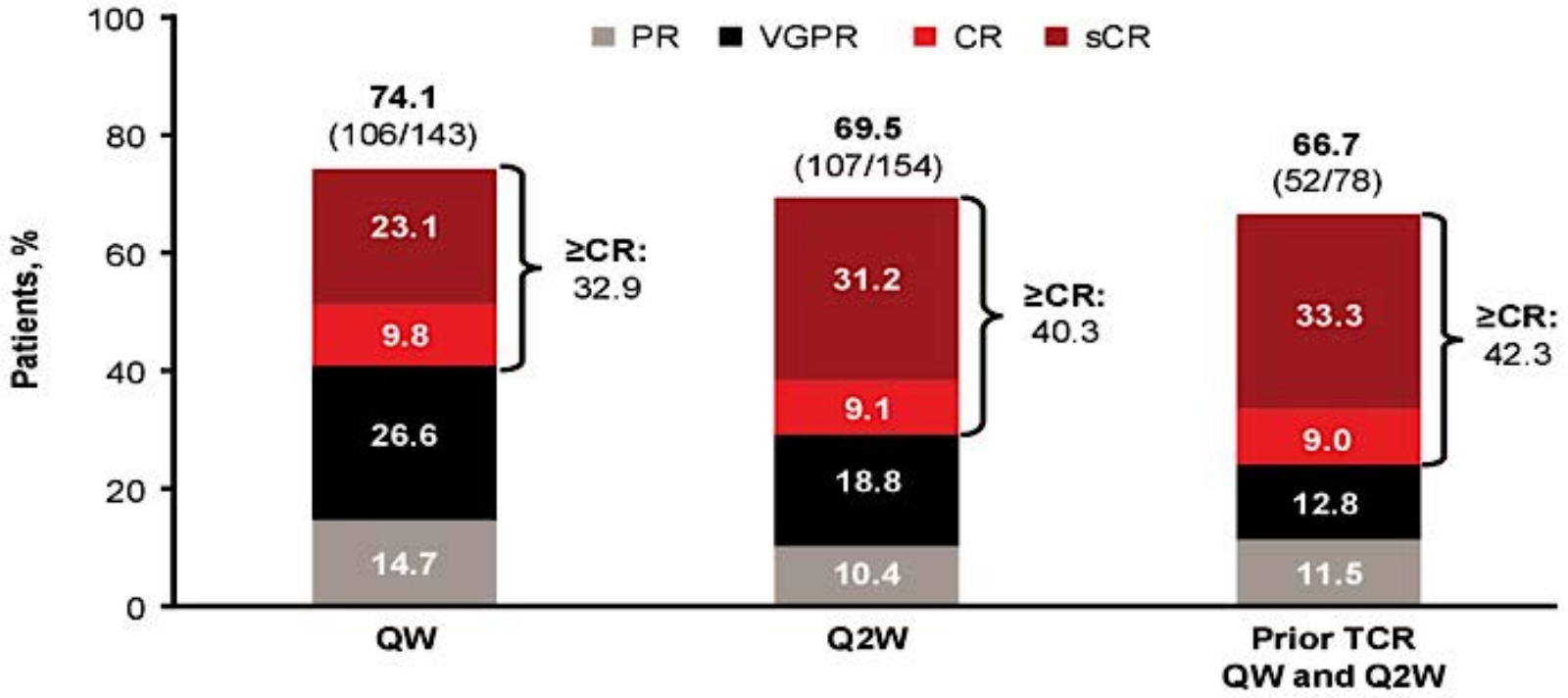
Primary endpoint: Progression-free survival per IMWG 2016 criteria

SCRI Sarah Cannon Research Institute

https://clinicaltrials.gov/ct2/show/NCT05572515. Accessed April 2026.

Phase I/II MonumenTAL-1 Study: ORR

Figure 1. ORR[a] remained high, consistent with previous results[4]



[a]Due to rounding, individual response rates may not sum to the ORR. Since previous disclosure, 1 patient in the prior TCR QW and Q2W cohort deepened in response (CR to sCR). PR, partial response; sCR, stringent complete response.

SCRI Sarah Cannon Research Institute

Rasche L et al. ASCO 2025

Myeloma Bispecific Antibody Summary

- **Bispecific antibodies represent major therapeutic advance for patients with myeloma**
  - Very strong efficacy
  - Accessible (“off-the-shelf”)
  - Side effect profile manageable so that most patients can receive them

- **Future directions**
  - Will form backbone for newly diagnosed myeloma treatment in future
  - Fixed duration therapy approaches
  - Multi-antigen targeting (multiple bispecifics or trispecifics)

Case Presentation

Patient Case

82 yo male with relapsed/refractory multiple myeloma

Diagnosed in 2022, high-risk disease with del 17p. Presented with renal failure and bone lesions

Line 1: -CyBorD x 1 cycle, then Dara-VRd induction x 5 cycles (stopped bortezomib due to neuropathy), then DRd maintenance with very good partial response (VGPR)
-Disease progression in May, 2024

Line 2: -Carfilzomib, Cyclophosphamide, Dexamethasone x 5 cycles, then carfilzomib QOW + dexamethasone maintenance with VGPR
-**Rapid** disease progression in October, 2025 with M-protein 2.8 g/dL, serum free kappa light chain 1004 g/dL, FLC ratio 225

Patient Case (Cont)

82 yo male with relapsed/refractory multiple myeloma

Discussed treatment options with patient. Very functionally independent, lives alone, has adult son/family that lives locally with strong support system.

- **Comorbidities include**
  - Residual intermittent grade 1 peripheral neuropathy
  - Chronic kidney disease (baseline creatinine 1.5)
  - Hypertension
  - Prostate cancer that is being observed

- Discussed CART; however given rapidly progressing disease, high-disease burden, and advanced age, decided to proceed with BCMA bispecific antibody option with **linvoseltamab** as the best next treatment course

Patient Case (Cont)

82 yo male with relapsed/refractory multiple myeloma

- **Linvoseltamab initiated in October, 2025**
  - Prophylactic tocilizumab given prior to first step-up dose of linvoseltamab
  - Grade 1 CRS (single fever) on cycle 1, day 2 (1 day after first step-up dose); managed with acetaminophen, resolved.
  - No recurrent CRS. No ICANS.

- **Best response** VGPR (deepest response patient has attained to-date for his myeloma).

- **Linvoseltamab** was de-escalated to q4 week dosing after 6 cycles

- **Supportive care:** valacyclovir for VZV prophylaxis, sulfamethoxazole/trimethoprim for PJP prophylaxis, monthly IVIG

Discussion Questions

How are you currently sequencing bispecific antibodies relative to other currently available therapies for R/R MM?

How do you choose among the available BCMA-targeted bispecific antibodies — teclistamab, elranatamab and linvoseltamab — as monotherapy? When are you more likely to opt for teclistamab/daratumumab? What about talquetamab?

ONS 2026 SYMPOSIUM · PRESENTATION 4

Toxicities & Practical Issues with Bispecific Antibodies in Multiple Myeloma

Mary Steinbach, DNP, APRN
Huntsman Cancer Institute · University of Utah

Saturday, May 16, 2026

WHAT WE'RE TALKING ABOUT

Bispecific antibodies: the MM landscape today

How they work — in plain language

A bispecific is a single Y-shaped antibody with two grips. One grip grabs a marker on the myeloma cell (BCMA or GPRC5D). The other grip grabs the patient's own T-cells. Pulling the two together tells the T-cell to kill the cancer cell.

All four are FDA-approved after ≥4 prior lines (PI, IMiD, anti-CD38).

Teclistamab
BCMA × CD3
SC

Elranatamab
BCMA × CD3
SC

Linvoseltamab
BCMA × CD3
IV

Talquetamab
GPRC5D × CD3
SC

ROUTES & SCHEDULES

Step-up dosing: the on-ramp matters

Agent	Step-up doses	Target dose	Frequency at target
Teclistamab (SC)	0.06 → 0.3 mg/kg	1.5 mg/kg	Weekly; q2wk option after ≥6 mo CR
Elranatamab (SC)	12 mg → 32 mg	76 mg	Weekly × 24 wk → q2wk
Linvoseltamab (IV)	5 mg → 25 mg	200 mg	Weekly → q2wk → q4wk by response
Talquetamab (SC)	0.01 → 0.06 → 0.4 mg/kg (or to 0.8 for q2wk)	0.4 mg/kg wkly or 0.8 mg/kg q2wk	Weekly or q2wk schedule

Why it matters: Step-up doses are intentionally small to lower the cytokine surge — the patient's first full dose is the highest-risk window for CRS.

BEFORE EACH STEP-UP

Premedications & where the patient stays

Premedications (each step-up + first full dose)

- Acetaminophen 650–1000 mg PO
- Diphenhydramine 25–50 mg PO/IV
- Dexamethasone 16 mg IV/PO (20 mg elranatamab; 40 mg linvoseltamab)
- Consider tocilizumab 8 mg/kg prophylactically before first full dose at high-volume centers
- Anti-infective prophylaxis: HSV/VZV, PJP, IVIG when IgG <400 mg/dL

Hospitalization during step-up

Inpatient (per label):

Teclistamab — 48 h after each step-up + first full dose
Elranatamab — 48 h after dose 1, 24 h after dose 2
Linvoseltamab — 24 h after each step-up

Outpatient pathways (institution-specific):

24/7 access to non-ED clinical contact
Dedicated caregiver × 48 h, no driving
Patient stays within 30 min of hospital
Wallet card + rescue meds at home

MOST-COMMON TOXICITY

Cytokine release syndrome (CRS): what to expect

~60-75%	<3%	1–3 d	<2 d
any-grade CRS (tec, elra, linvo)	Grade ≥3 CRS across BCMA agents	typical onset after step-up dose	typical duration (once tx started)

What it looks like at the bedside

- Fever ≥38°C is almost always the first sign — treat empirically until proven otherwise
- Hypotension: tachycardia first, then BP drop — watch trends, not single readings
- Hypoxia: subtle desat on ambulation often precedes resting hypoxia
- Rigors, headache, fatigue — patients describe it as “the worst flu I’ve ever had”

ASTCT GRADING + TOCILIZUMAB ALGORITHM

Grading & treating CRS

Grade	What you see	First moves
1	Fever ≥38°C only	Acetaminophen, IV fluids, blood cultures, tocilizumab 8 mg/kg
2	Fever + hypotension responsive to fluids, or O_2 by NC ≤6 L/min	Tocilizumab ± dexamethasone 10 mg IV q6h; vasopressor if no response
3	Fever + hypotension on ≥1 pressor, or O_2 >6 L/min	ICU; tocilizumab + high-dose dex; consider anakinra if refractory
4	Multiple pressors, mechanical ventilation	ICU; methylprednisolone 1000 mg/day; anakinra; siltuximab

Pearls: *max 4 toc doses in 24 h (3 max in label). Don't hold antibiotics waiting for cultures. Most CRS resolves in 24–48 h once treated.*

LESS COMMON

Neurotoxicity (ICANS): catch it early

- Lower incidence than CAR-T — ICANS in ~3–10% on bispecifics (≤3% Grade ≥3)
- Onset within 1–2 weeks — often during or just after CRS
- Tremor, dysgraphia, expressive aphasia, confusion — often subtle first
- Talquetamab also causes a distinct, non-ICANS neuro picture (cranial-nerve palsies, paresthesias)
- First-line: dexamethasone 10 mg IV q6h — it crosses the BBB. Anakinra if refractory.

ICE Score (10 points)

Use BID during peak risk

Orientation × 4 (year, month, city, hospital)
Naming × 3 (name 3 objects)
Following commands × 1
Writing × 1 (write a standard sentence)
Attention × 1 (count 100 backwards by 10s)
10 = normal 0–2 = G4 3–6 = G2/3 7–9 = G1

BEYOND THE FIRST CYCLE

Persisting toxicities: infections & cytopenias

Infections

~70%

any-grade with BCMA bispecifics

- Any-grade ~50% with talquetamab; Grade ≥3 ~25% with BCMA agents
- Hypogammaglobulinemia is the rule — IgG <400 mg/dL or recurrent infections → IVIG
- PJP, HSV/VZV prophylaxis; CMV PCR if febrile or unexplained cytopenias
- Vaccinate ahead of therapy: COVID, flu, RSV (≥60 y), pneumococcal

Cytopenias

~60%

neutropenia (G3/4) on label

- Neutropenia, anemia, thrombocytopenia are common in cycles 1–3
- G-CSF support; transfusions per institutional thresholds
- Re-check CBC before each dose during weekly schedule
- Hold dose for ANC <1.0 or platelets <50

Hepatic & other

<5%

Grade ≥3 LFT elevations

- Transaminitis usually mild and self-limited — monitor each cycle
- Talquetamab: dysgeusia, weight loss, nail/skin (next slide)
- Rare: PML, hepatic failure (case-level reports with teclistamab)
- Injection-site reactions — rotate sites, cool compresses

GPRC5D: ON-TARGET, OFF-TUMOR

Talquetamab's signature: skin, nails, taste

Why it happens

GPRC5D lives on myeloma cells — but also on healthy tissues that make keratin (skin, nails, tongue). Hitting GPRC5D shrinks the tumor and irritates those tissues at the same time.

62%
skin AEs (rash, peeling)

52%
nail AEs

48%
dysgeusia

What helps the patient

Skin: thick fragrance-free moisturizers BID; antihistamines for itch; topical steroid for persistent rash; gentle exfoliation of peeling palms/soles
Nails: keep short, file edges; dimethicone; avoid acrylics; protect with gloves for cleaning
Mouth & taste: frequent sips of water, sugar-free gum, saliva substitutes; nutrition referral if ≥5% wt loss; dose-reduce or extend interval to q4wk after ≥PR

TAKE-HOME POINTS

What I want you to remember

1. **The first full dose is the riskiest dose.**
   CRS shows up in 60–75% of patients during step-up. Watch the temperature curve, treat ≥38°C aggressively, and have toc at the bedside.

2. **Tocilizumab is your friend, don’t wait.**
   Early, low-grade CRS treated promptly almost always resolves quickly and prevents escalation.

3. **Neuro changes are subtle. Use ICE.**
   Tremor, hesitant speech, or trouble writing a sentence are early signs. BID ICE during peak risk catches it.

4. **Infections are the long game.**
   Vaccinate ahead. Trend IgG. Replace with IVIG. Counsel patients to call for any fever, even months in.

5. **Talquetamab needs proactive skin/mouth care.**
   Set patients up with moisturizer, saliva substitute, and a nutrition plan before cycle 1 , not after they’re struggling.

Case Presentation

CASE PRESENTATION

62-year-old woman with R-ISS II IgA Lambda Multiple Myeloma

On talquetamab + pomalidomide (MonumenTAL-6)

Patient

Diagnosis · 4/22/24

- IgA λ MM · R-ISS II · ISS I
- Advanced bone disease
- FISH: 1q gain (40%), 16q23 gain (61%)
- Hgb 13.1, Ca 9.3, Cr 0.7, β2M 2.7

Treatment course

Line 1 (4/29/24 – 1/15/26) → CR/MRD+, then relapse

- DKRd → Auto-HSCT (mel 200)
- RAMP-Up trial: isatuximab + lenalidomide

Line 2 (2/9/26 – ongoing) · current

Talquetamab → pomalidomide added cycle 2 · MonumenTAL-6

Toxicities

EARLY

- **CRS G1 × 2**
- Fevers after day 1 (2/11) and day 4 (2/14) doses; recurrent G1 fevers 2/22 & 2/25 with ↑ CRP → tocilizumab 2/26; no fevers since.
- **Skin G2 rash (~12% BSA, arms + chest)**
- Triamcinolone BID; ointment for hands. CeraVe + Aquaphor. Derm consult if worsening.
- **Dysgeusia G2**
- Miracle-berry lozenges, sour candies.
- **Dry mouth & dry/peeling skin**
- Dex + nystatin swish-and-spit; CeraVe, AmLactin, triamcinolone.

LATE

- **Infections**
- Non-neutropenic fevers; recent Gemella bacteremia.
- Fungal concern — BDG > 500.

Discussion Questions

Can bispecific antibodies be safely delivered in a community oncology setting, and what role can nurses play in helping this happen?

Do any of the available BCMA-targeted bispecific antibodies — teclistamab, elranatamab or linvoseltamab — offer any advantages over the others in terms of global tolerability or convenience and ease of administration? How, if at all, do these factors affect your selection among them?

Agenda

Introduction: The Multiple Myeloma (MM) Treatment Journey

Module 1: Role of Chimeric Antigen Receptor T-Cell Therapy in Relapsed/ Refractory (R/R) MM

Module 2: Role of BCMA- and Non-BCMA-Targeted Bispecific Antibodies in R/R MM

Module 3: Utility of Belantamab Mafodotin in R/R MM

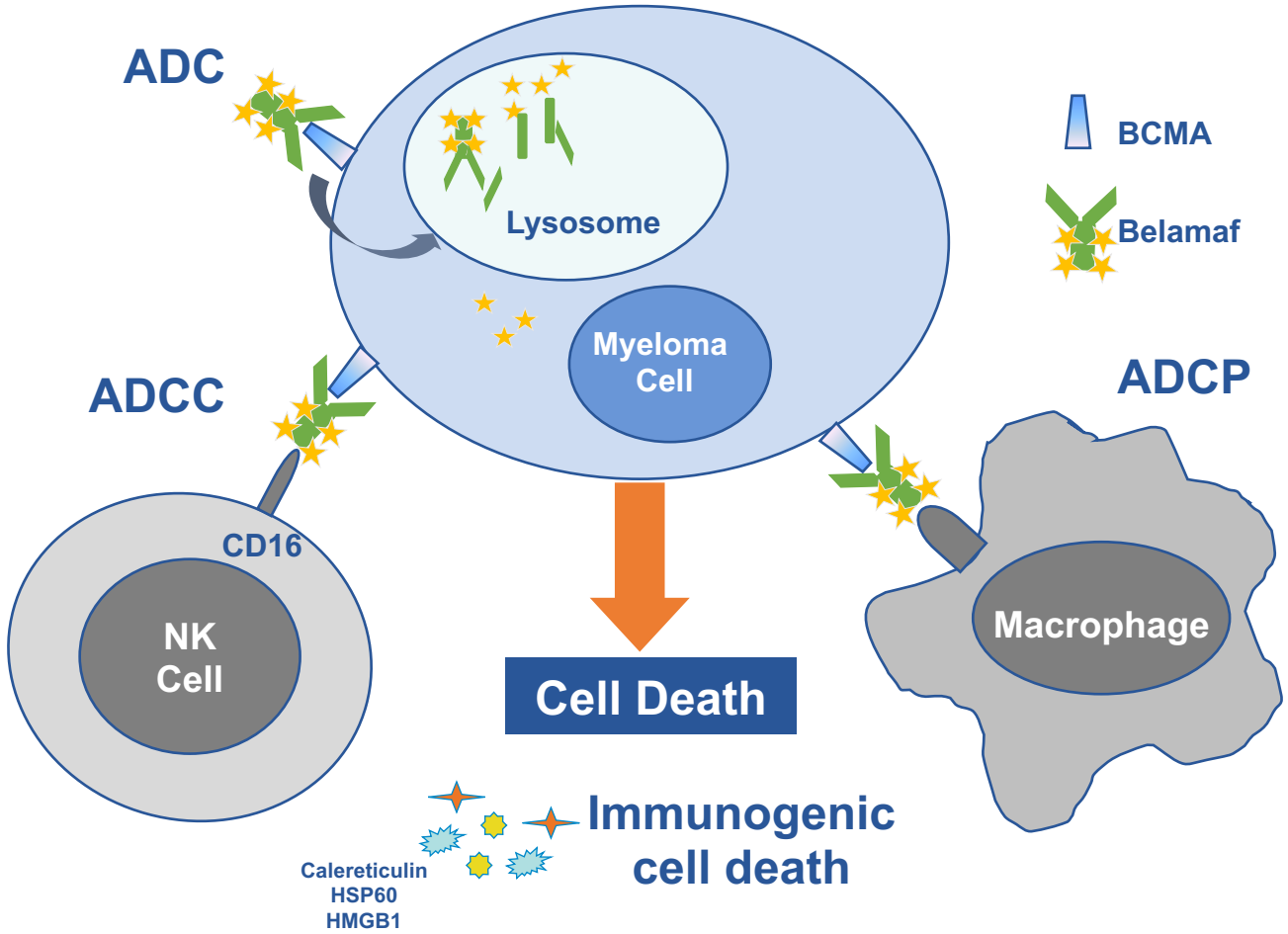
Module 4: Potential Role of Cereblon E3 Ligase Modulators in MM

Utility of Belantamab Mafodotin in Relapsed/Refractory Multiple Myeloma

May 16, 2026

Hans Lee, MD
Director, Multiple Myeloma Research
Sarah Cannon Research Institute

Belantamab Mafodotin (Belamaf)



- **Antibody:** BCMA afucosylated monoclonal IgG1
- **Conjugate:** monomethyl auristatin F (anti-microtubulin drug)
- **Noncleavable** linker

SCRI Sarah Cannon Research Institute

Tai YT et al *Blood,* 2014; de Oca RM et al, *Mol Cancer Ther, 2021*

Belamaf Efficacy (DREAMM-2)

Relapsed/Refractory Myeloma

-
-
-

Belamaf 2.5 mg/kg q3 weeks

FDA Accelerated Approval (2020)
EMA Approval (2020)

Relapsed or refractory multiple myeloma ≥ 4 prior therapies including an anti-CD38 monoclonal antibody, a proteasome inhibitor, and an immunomodulatory agent

OR		
≥ V		
Me		
Me		
Median OS	13.7 mo	13.8 mo

ents

SCRI Sarah Cannon Research Institute

Lonial S, et al, *Lancet Oncology* 2019; Lonial S et al, ASCO Abstract # 8536, 2020

Belamaf vs Pomalidomide/Dexamethasone (DREAMM-3)

Belamaf withdrawn by FDA in February, 2023 based on negative DREAMM-3 study

…but that's not the end of the story

≥ VGPR	25%	8%
Median PFS*	11.2 mo	7 mo
Median OS	21.2 mo	21.2 mo

*Not statistically significant

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Dimopoulos et al, *Lancet Haematology*, 2023

DREAMM-7: BelaVd vs. DVd

RRMM, ≥1 line of therapy; with PD on/after most recent therapy; (N = 494)

Stratified by prior lines of tx (1 vs 2-3 vs ≥4), prior bortezomib (yes vs no), R-ISS (I vs II/III)

Belantamab Mafodotin + Bortezomib + Dexamethasone 21-day cycles (n = 243)	**Belantamab Mafodotin** 2.5 mg/kg IV Q3W
Daratumumab + Bortezomib + Dexamethasone 21-day cycles (n = 251)	**Daratumumab** 16 mg/kg IV Q4W

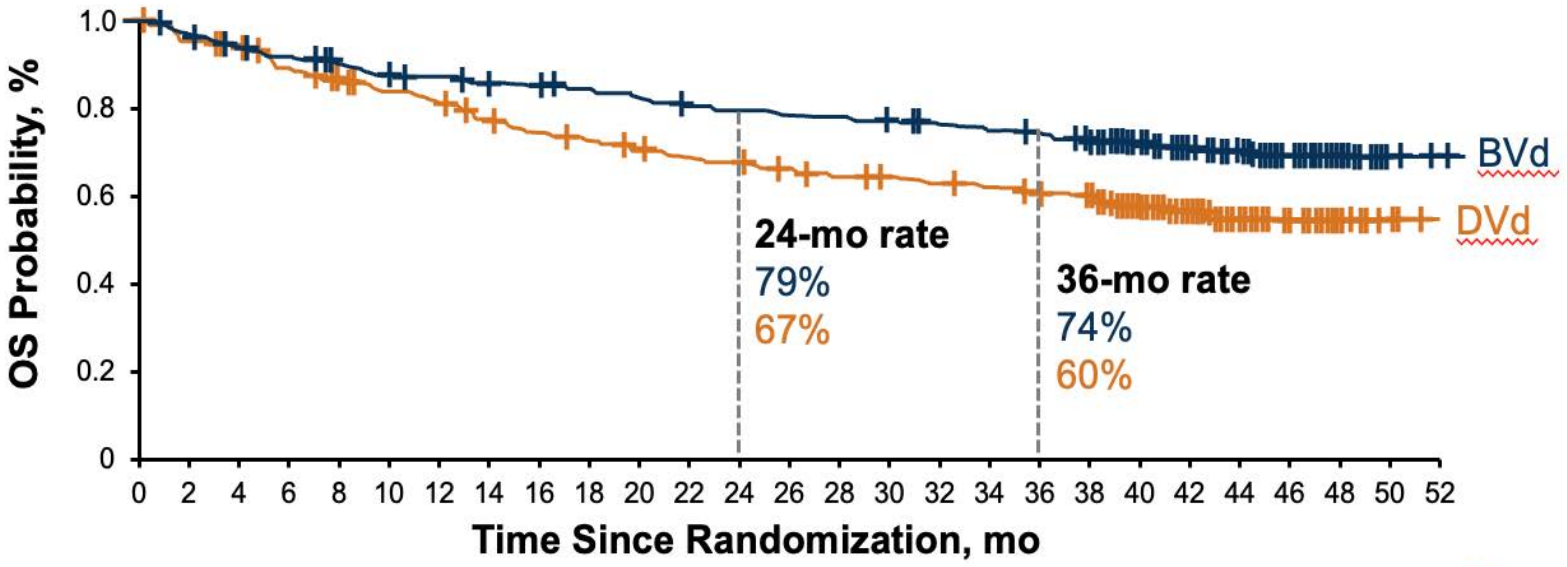
Tx continued until PD, unacceptable toxicity, end of study, or consent withdrawal

Belantamab mafodotin: 2.5 mg/kg IV Q3W cycle 1-8.
Bortezomib: 1.3 mg/m^2 SC Days 1, 4, 8, 11 cycles 1-8 (21-day cycle).
Daratumumab: 16 mg/kg IV cycle 1-3 QW and 16 mg/kg IV Cycle 4-8 Q3W.
Dexamethasone: 20 mg on day of and day after bortezomib in cycle 1-8 in BVd and DVd regimens.

- **Primary endpoint:** PFS
- **Key secondary endpoints:** OS, DoR, MRD negativity

Hungria V. et al., *NEJM*, 2024.

DREAMM-7: PFS and OS



	BVd (N = 243)	DVd (N = 251)
ORR, %	83%	71%
≥CR, %	36%	18%
Median PFS, mo	**36.6**	**13.4**
Median OS, mo	**NR, HR = 0.58; *P* = .0002**	

Median follow-up: 39.4 mo

BelaVd with significant PFS and OS benefit vs DVd

BelaVd approved now in ≥2 prior lines of therapy in US (October, 2025)

SCRI Sarah Cannon Research Institute

Hungria V. et al., *NEJM*, 2024.
Hungria V. et al, *Lancet Oncology,* 2025

DREAMM-8: BelaPd versus PVd

Recruitment period
October 2020 to December 2022

Treatment period
Until PD, death, unacceptable toxicity, end of study, or withdrawal of consent

Eligibility criteria

- Adults with MM
- ≥1 prior line of MM therapy including LEN
- Documented PD during or after their most recent therapy
- No prior treatment with anti-BCMA or pomalidomide; not refractory/intolerant to bortezomib

N=302

1:1 randomization

BPd (Q4W)

Belantamab mafodotin
2.5 mg/kg IV (cycle 1) then 1.9 mg/kg IV Q4W from cycle 2 onward
+
Pomalidomide 4 mg orally on days 1-21 (28-day cycles)
+
Dexamethasone 40 mg[a] on days 1, 8, 15, and 22

PVd (Q3W)

Bortezomib
1.3 mg/m^2 SC on days 1, 4, 8, and 11 of cycles 1-8 then days 1 and 8 (21-day cycles)
+
Pomalidomide 4 mg orally on days 1-14 (21-day cycles)
+
Dexamethasone 20 mg[a] on the day of and day after bortezomib

End-of-treatment visit

Primary endpoint:
PFS (IRC assessed per IMWG)

Key secondary endpoints:
OS, MRD negativity, DOR

Additional secondary endpoints include:
ORR, CRR, ≥VGPR,TTBR, TTR, TTP, PFS2, AEs, ocular findings, HRQOL, and PROs

Stratification[b]:
- Prior lines of treatment (1 vs 2 or 3 vs ≥4)
- Prior bortezomib (yes vs no)
- Prior anti-CD38 therapy (yes vs no)

In the BPd group:

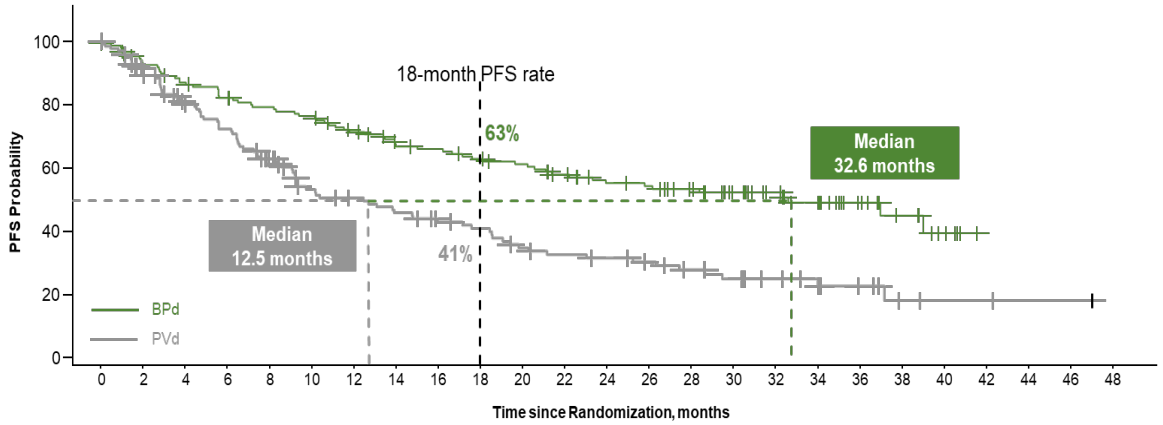
- 53% had received 1 prior LOT
- 90% received prior PI
- 81% were Lenalidomide refractory
- 23% were anti-CD38 refractory

SCRI Sarah Cannon Research Institute

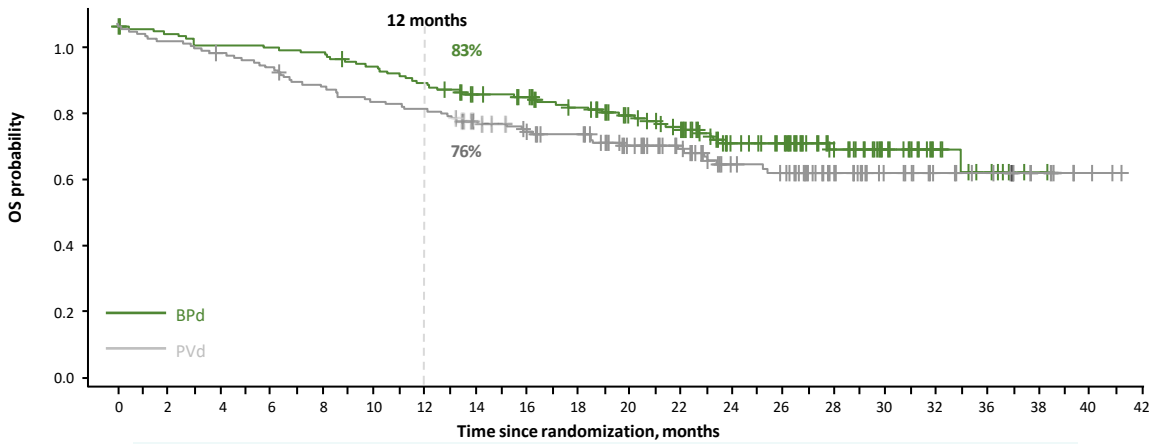
Dimopoulos MA, et al. N Engl J Med. 2024 Aug 1;391(5):408-421

DREAMM-8: PFS and OS

Progression-free Survival



Overall Survival



		BPd (N=155)	PVd (N=147)
PFS	PFS, median (95% CI), months	**32.6 (21.1, NR)**	**12.5 (9.1, 17.6)**
	HR (95% CI)	0.49 (0.35-0.68)	
OS	OS, median (95% CI), months	NR (33.0, NR)	NR (25.2, NR)
	HR (95% CI)‡	0.77 (0.53, 1.14)	

BelaPd with significant PFS benefit versus PVd

BelaPd approved now in European Commission (EC) ≥ 1 line of therapy + lenalidomide exposed (2025)

SCRI Sarah Cannon Research Institute

Dimopoulos MA, et al. N Engl J Med. 2024 Aug 1;391(5):408-421

Belantamab Mafodotin Summary

- **Belamaf generally well tolerated off-the-shelf approach with no CRS/ICANS monitoring**
  - Therapeutic option in frail/elderly patients.
  - Can be given in community oncology setting

- **Belamaf in combination with bortezomib/dexamethasone (Bela-Vd) approved in US for RRMM ≥2 prior lines of therapy (October, 2025)**
  - Significant PFS and OS benefit of BelaVd vs. daratumumab, bortezomib, dexamethasone in DREAMM-7 study

Case Presentation

Patient Case

79 y.o. woman with relapsed/refractory myeloma.

Diagnosed in 2019. Standard risk disease. Initial presentation with bone lesions and anemia.

Line 1: VRd induction. Declines transplant. Continues on lenalidomide maintenance until disease progression in 2024. Best response very good partial response (VGPR).

Line 2: Daratumumab, pomalidomide, dexamethasone. Disease progression in January, 2026 with slowly rising M-protein of 1.1 g/dL from nadir of 0.4 g/dL.

Patient Case (Cont)

79 y.o. woman with relapsed/refractory myeloma.

Discussed treatment options with patient

- Lives alone about 45 minutes from local oncology office. Has a pet dog that she cares for.
- Has 2 adult children that live out-of-state
- Other medical history includes type 2 diabetes, hypertension, osteoarthritis of bilateral knees

- CART discussed, not feasible due to lack of caregiver support. Lives 3 hours from nearest CART center.

- Bispecific also discussed (although not yet approved at the time with 3rd line therapy). Still needs caregiver support during step-up dosing period which she doesn't have.

Patient Case (Cont)

79 y.o. woman with relapsed/refractory myeloma.

- Patient decides to proceed with belantamab mafodotin, bortezomib, dexamethasone
  - Dosing started at 1.9 mg/kg (lower dose than 2.5 mg/kg in label) q4 weeks
  - **Pre-C2 evaluation**
    - M-protein downtrending from 1.1 g/dL to 0.7 g/dL
    - Grade 1 keratopathy (no visual acuity changes pre-Cycle 2)
    - Belamaf 1.9 mg/kg given for cycle 2, but dosing interval preemptively changed to q8 week thereafter
  - Best response VGPR. Continues on q8 week dosing with maximum grade 1 keratopathy. No visual acuity changes.

Discussion Questions

How are you sequencing belantamab mafodotin/bortezomib/dexamethasone relative to other treatment strategies for R/R MM, and how does this vary for individual patients?

Does belantamab mafodotin still have activity after BCMA-targeted CAR T-cell therapy and/or bispecific antibodies?

Can belantamab mafodotin be combined with agents other than bortezomib/dexamethasone?

ONS 2026 SYMPOSIUM · PRESENTATION 6

Tolerability Considerations with Belantamab Mafodotin

Mary Steinbach, DNP, APRN
Huntsman Cancer Institute · University of Utah

Saturday, May 16, 2026

WHAT IT IS

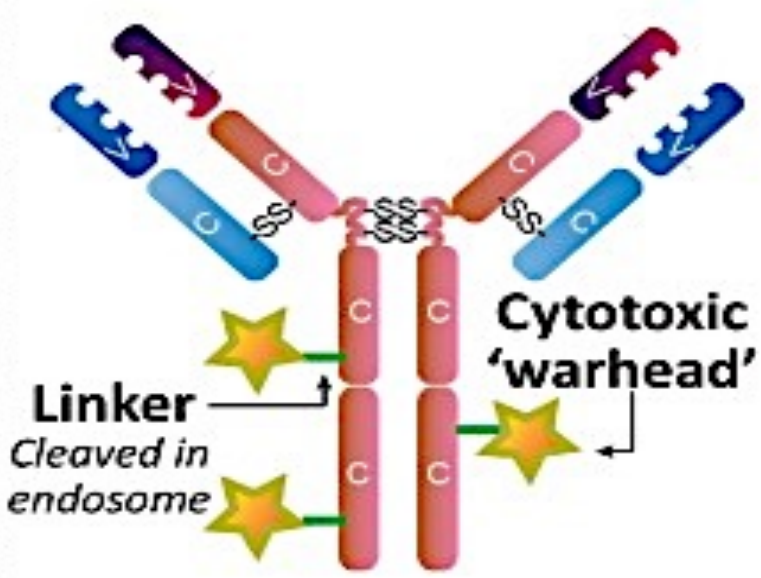
Belantamab mafodotin: an Antibody Drug Conjugate

How I explain it to patients

Belantamab is an antibody-drug conjugate — a “smart bomb.” An antibody finds BCMA on the myeloma cell, and a tiny chemo payload (MMAF) is delivered directly inside. It also recruits the immune system. Given as a 30–60 minute IV infusion, every 3 to 8 weeks depending on regimen.

No step-up dosing. No mandatory hospitalization. Outpatient infusion.

How it works



The same payload also reaches corneal cells — that’s where ocular AEs come from.

PHASE 3 EVIDENCE — KEY TAKEAWAYS ONLY

Where belantamab fits today: DREAMM-7 & DREAMM-8

DREAMM-7

Bela + Vd vs Dara + Vd

≥1 prior line of therapy

Median PFS: 36.6 vs 13.4 mo

HR 0.41 · OS at 36 mo: 74% vs 60%

Belantamab arm doubled PFS.

DREAMM-8

Bela + Pd vs Bortezomib + Pd

≥1 prior line incl. lenalidomide

Median PFS: NR vs 12.7 mo

HR 0.52 · ≥CR rate: 40% vs 16%

Belantamab arm doubled PFS.

Bottom line: Both phase-3 trials show meaningful PFS gains over standard triplets — **the trade-off is ocular toxicity, which is what the rest of this talk is about.**

INCIDENCE & SEVERITY

Ocular adverse events - how often and how bad?

~70-80%	~30-45%	~25%	~95%
any-grade ocular AE (DREAMM-2, -7, -8)	Grade 3+ ocular AE at label dose	best-corrected vision decline ≥2 lines	events that resolve with dose modification

What patients describe

- Blurry or fluctuating vision — “like looking through wax paper”
- Dry, gritty eyes; foreign-body sensation; light sensitivity
- Trouble reading or driving — usually 1–2 cycles in
- Nearly all symptoms reverse with dose hold/reduction; permanent visual loss is rare

How ocular AEs are graded — the KVA scale

Grade	Corneal exam (MEC)	Best-corrected visual acuity (BCVA)	Action
1	Mild superficial keratopathy	Decline 1 line from baseline	Continue at current dose
2	Moderate superficial keratopathy	Decline 2–3 lines (no worse than 20/200)	Hold until ≤G1; resume at reduced dose
3	Severe superficial keratopathy	Decline >3 lines (worse than 20/200, better than 20/2000)	Hold; resume at reduced dose when ≤G1
4	Corneal epithelial defect	Worse than 20/2000 in better eye	**Discontinue**

Document at every visit: *BCVA in each eye, slit-lamp findings (MEC grade), and any patient-reported visual symptoms. Always grade by the worst eye.*

BASELINE OPHTHALMOLOGY EVALUATION

Set up the eye care plan before cycle 1

1

Refer everyone — before the first dose

Send every patient to ophthalmology before cycle 1. Don’t wait for symptoms. Establish baseline so you can compare later.

2

Document baseline exam

Visual acuity (best corrected, both eyes); slit-lamp; corneal exam. Treat any pre-existing dry eye, blepharitis, or contact-lens damage now.

3

Counsel & equip

Preservative-free lubricating drops 4–8×/day, starting before cycle 1. Pause contact lens wear during therapy. Sunglasses for photosensitivity.

ONGOING MONITORING

On treatment: who looks at the eyes, and when?

When	Eye assessment	Done by
Before every dose	BCVA (Snellen / hand-held card), symptom check, dry-eye review	Infusion-clinic RN or APP
Before each dose (per label)	Slit-lamp + corneal exam (MEC grading)	Ophthalmology
Anytime symptoms change	Same-day or next-day ophthalmology re-evaluation	Ophthalmology
After dose hold/reduction	Re-grade KVA before resuming; confirm ≤G1	Ophthalmology

Patient action plan: Call same-day for any new blurry vision, eye pain, foreign-body sensation, or sensitivity to light. Don’t wait for the next infusion.

MANAGEMENT FRAMEWORK

When ocular AEs happen: hold, reduce, restart

G1: keep going	Continue full dose. Reinforce lubricating drops. Re-check at the next visit.
G2: hold the dose	Hold belantamab. Continue lubricating drops. Re-evaluate q3wk. Resume at one dose level lower (1.9 → 1.4 mg/kg) once ≤G1.
G3: hold longer, reduce more	Hold; co-manage with ophthalmology. Resume at the next reduced dose (1.4 → 0.95 mg/kg) once ≤G1. Some regimens extend interval to q8wk.
G4: discontinue	Permanent discontinuation. Refer to ophthalmology for ongoing care.

OTHER COMMON & UNCOMMON AES

Beyond the eyes: other toxicities to watch

Thrombocytopenia

55%

any-grade · ~25% G3+

- Most common hematologic AE
- Check CBC before each dose
- Hold for platelets <50; transfuse <10 or per institutional threshold
- Resolves with dose hold/modification

Infusion reactions

~20%

mostly first infusion

- Fever, chills, rash, hypotension during/within hours
- Premedicate at first sign or with prior reaction
- Slow rate, hold, treat with steroids/antihistamines
- Most patients can continue therapy

Infections & misc.

varies

URTI, pneumonia, herpes

- URI/pneumonia — flu, COVID, RSV vaccines beforehand
- Pyrexia, fatigue, nausea — supportive care
- Mild LFT elevations — monitor each cycle
- Less infection risk than BCMA bispecifics

TAKE-HOME PEARLS FOR THE INFUSION NURSE

What I want you to remember

1. **Set up ophthalmology BEFORE cycle 1.**
   A baseline exam, lubricating drops, and patient counseling done up front prevents most surprises later.

2. **Eye AEs are the price of efficacy — but they're reversible.**
   DREAMM-7 and -8 doubled PFS over standard triplets. ~95% of ocular events resolve with dose modification.

3. **Grade by the worst eye. Hold early, restart slow.**
   Symptoms + BCVA + slit-lamp. Don't push through G2 — a brief hold with dose reduction usually fixes it.

4. **Lubricating drops are mandatory, not optional.**
   Preservative-free, 4–8×/day, starting before cycle 1. Counsel patients to keep them in pocket and purse.

5. **Empower the patient to call early.**
   Any new blur, dryness, pain, or light sensitivity → call. This is the single biggest predictor of a good ocular outcome.

Case Presentation

CASE PRESENTATION

67-year-old woman, IgA κ MM — sequencing after CAR-T

≥4th line, post BCMA-directed therapy · considering belantamab mafodotin

Diagnosis

- IgA κ multiple myeloma
- R-ISS Stage 1
- Complex karyotype

Treatment course

L1 Induction (DRd / VRd) → Auto-HSCT → maintenance

L2 1st relapse — anti-CD38–based triplet

L3 Anito-cel (CAR-T) · ARC-112A — remarkable response

L4 (next line) · belantamab mafodotin

Regimen: BVd or BPd

Why belantamab — and why now?

WHY ADC, NOT ANOTHER T-CELL ENGAGER

- **Avoids T-cell redirection.**
- After CAR-T, T-cell fitness is a real concern: an ADC sidesteps it.
- **Different mechanism, same target.**
- Belantamab still hits BCMA, but via a payload: not via T cells.
- **Outpatient infusion every 3–8 weeks.**
- No step-up, no hospitalization: protects QoL and independence.

DISCUSSION · WHAT MATTERS TO HER

- **Values QoL and independence above all.**
- *Drove herself to every CAR-T visit; living independently: protect both.*
- **Rural vs academic care setting.**
- *Frequency of ophthalmology + slit-lamp visits may be the deciding factor.*

Agenda

Introduction: The Multiple Myeloma (MM) Treatment Journey

Module 1: Role of Chimeric Antigen Receptor T-Cell Therapy in Relapsed/ Refractory (R/R) MM

Module 2: Role of BCMA- and Non-BCMA-Targeted Bispecific Antibodies in R/R MM

Module 3: Utility of Belantamab Mafodotin in R/R MM

Module 4: Potential Role of Cereblon E3 Ligase Modulators in MM

RTP RESEARCH TO PRACTICE

Potential Role of Cereblon E3 Ligase Modulators (CELMoDs) in MM

Natalie S Callander, MD
Professor of Medicine
Director, Myeloma Clinical and Cellular Therapy Program
University of Wisconsin Carbone Cancer Center
Madison, Wisconsin

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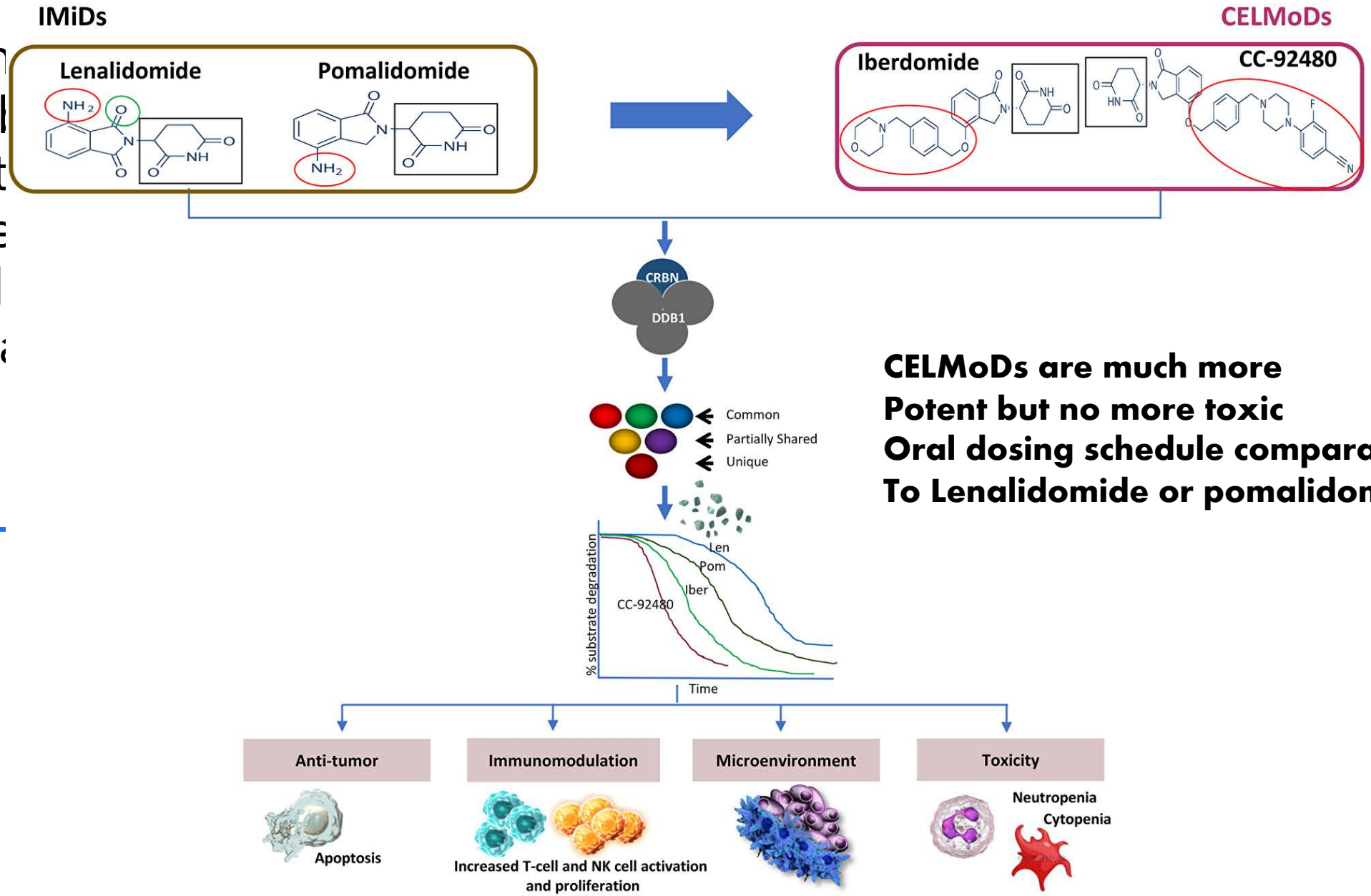
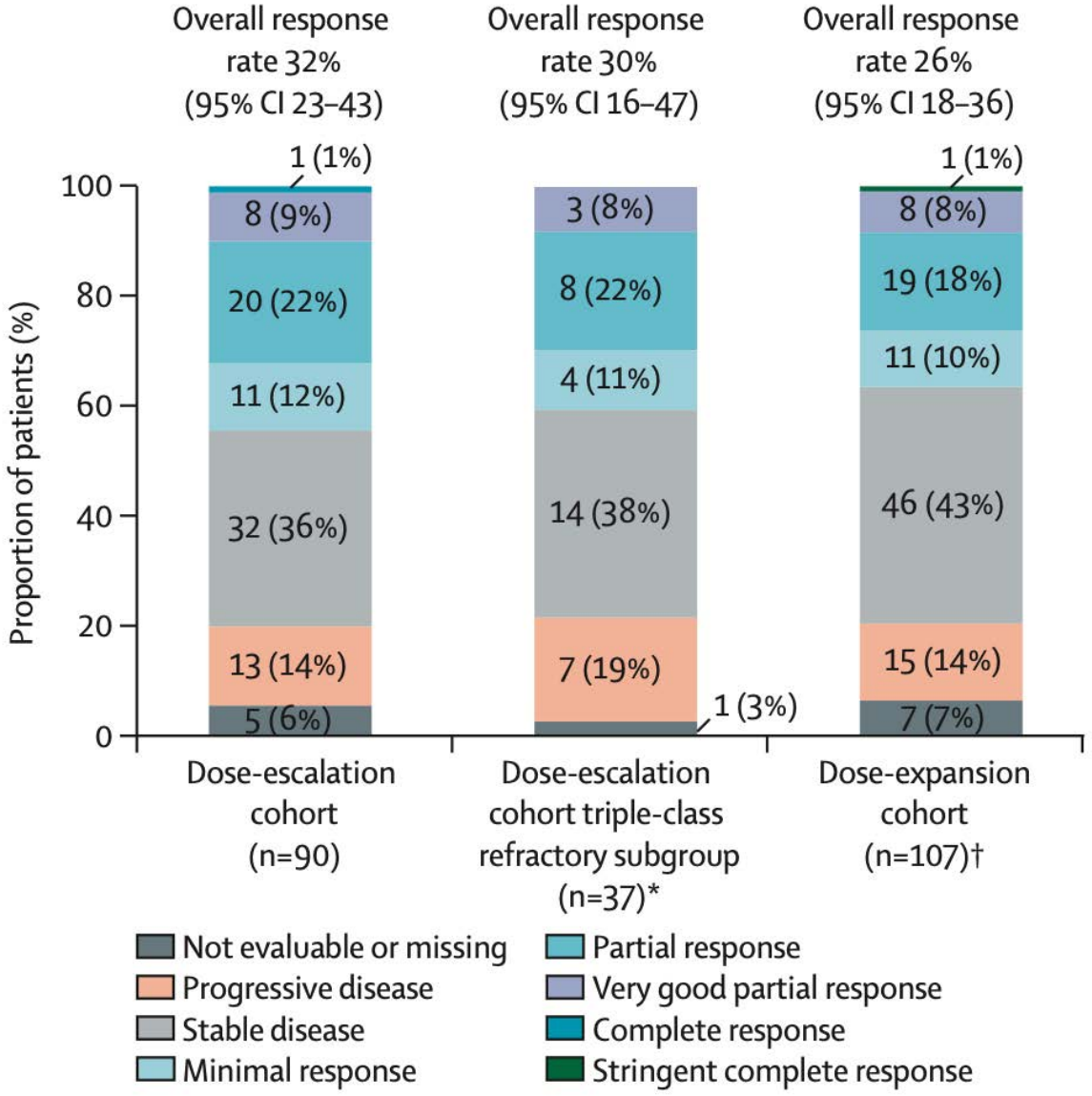


CELMoDs are much more
Potent but no more toxic
Oral dosing schedule comparable
To Lenalidomide or pomalidomide

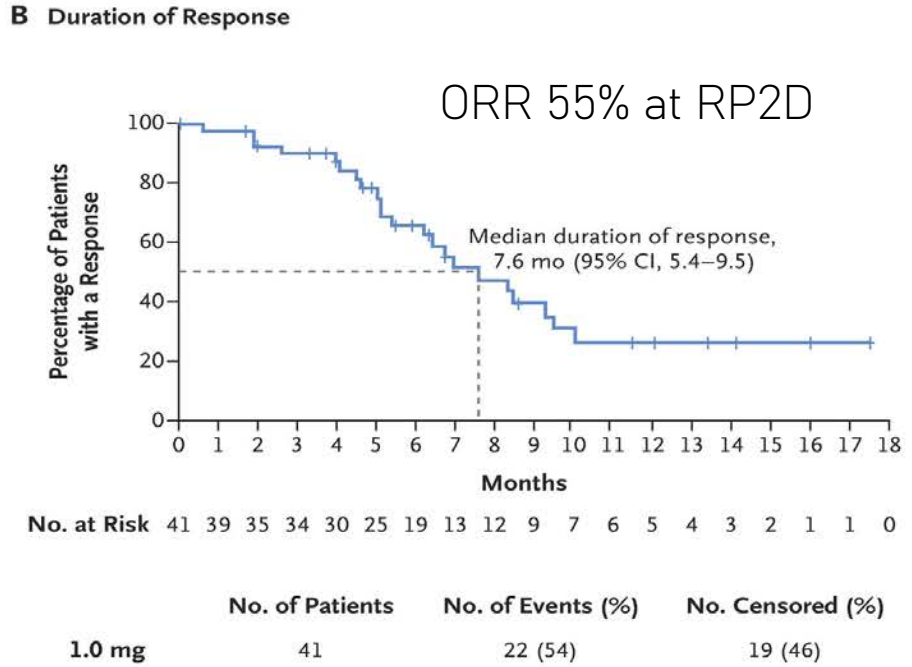
Patel T Clin Lym Mye 2024 24:762

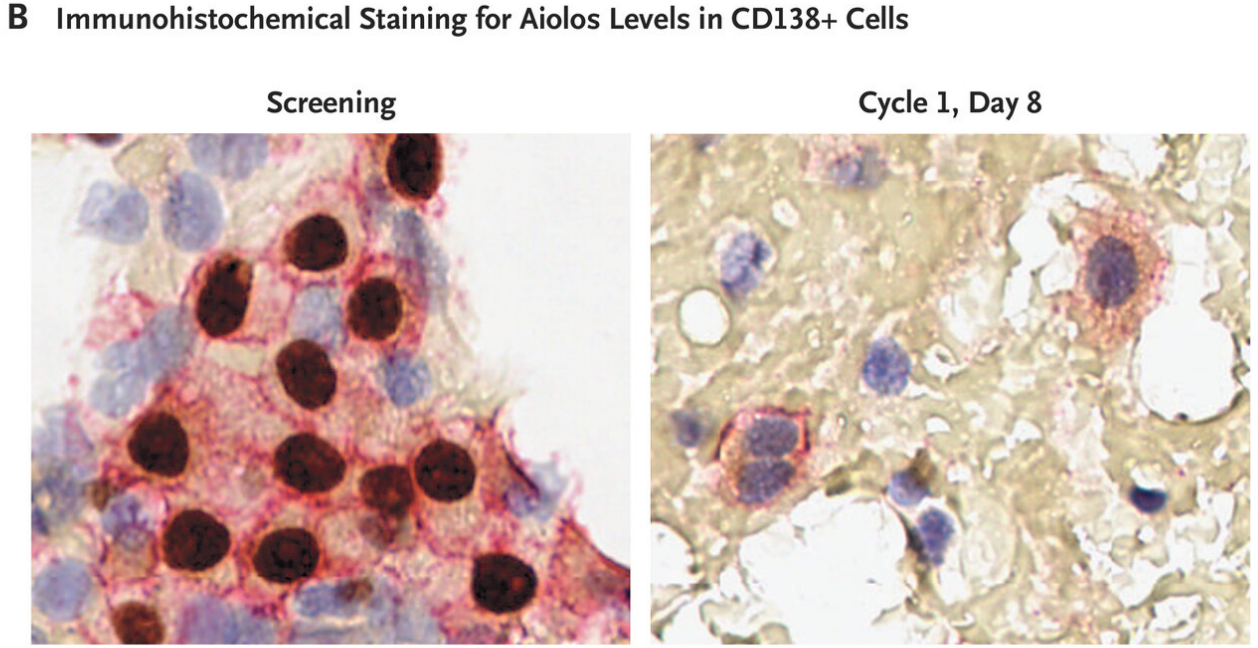
Both IBERDOMIDE AND MEZIGDOMIDE HAVE ACTIVITY In VERY HEAVILY PRETREATED MM PTS



Lonial S Lancet 2022 e822

ORR 55% at RP2D

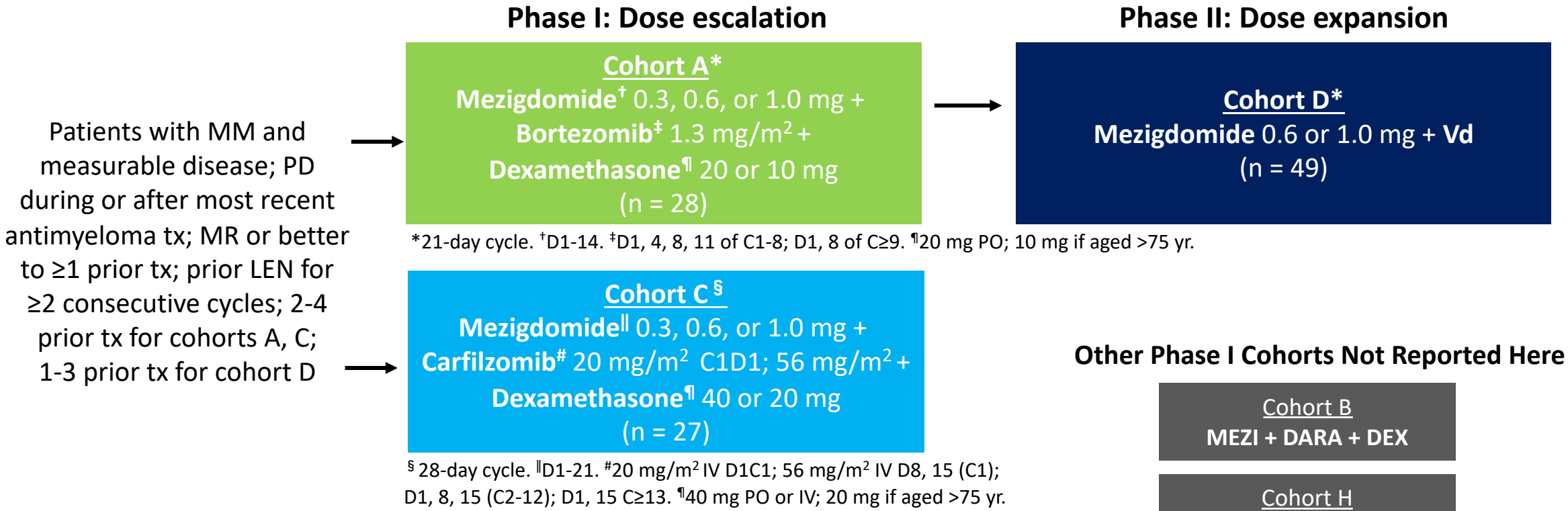




Richardson P NEJM 2023

Mezigdomide Plus Vd or Kd in R/R MM: Study Design

- Multicenter, open-label phase I/II dose-finding and expansion trial



- **Coprimary endpoints**: recommended dose, safety, ORR

Sandhu. ASH 2024. Abstr 1025.

Mezigdomide Plus Vd or Kd in R/R MM: PFS and Response

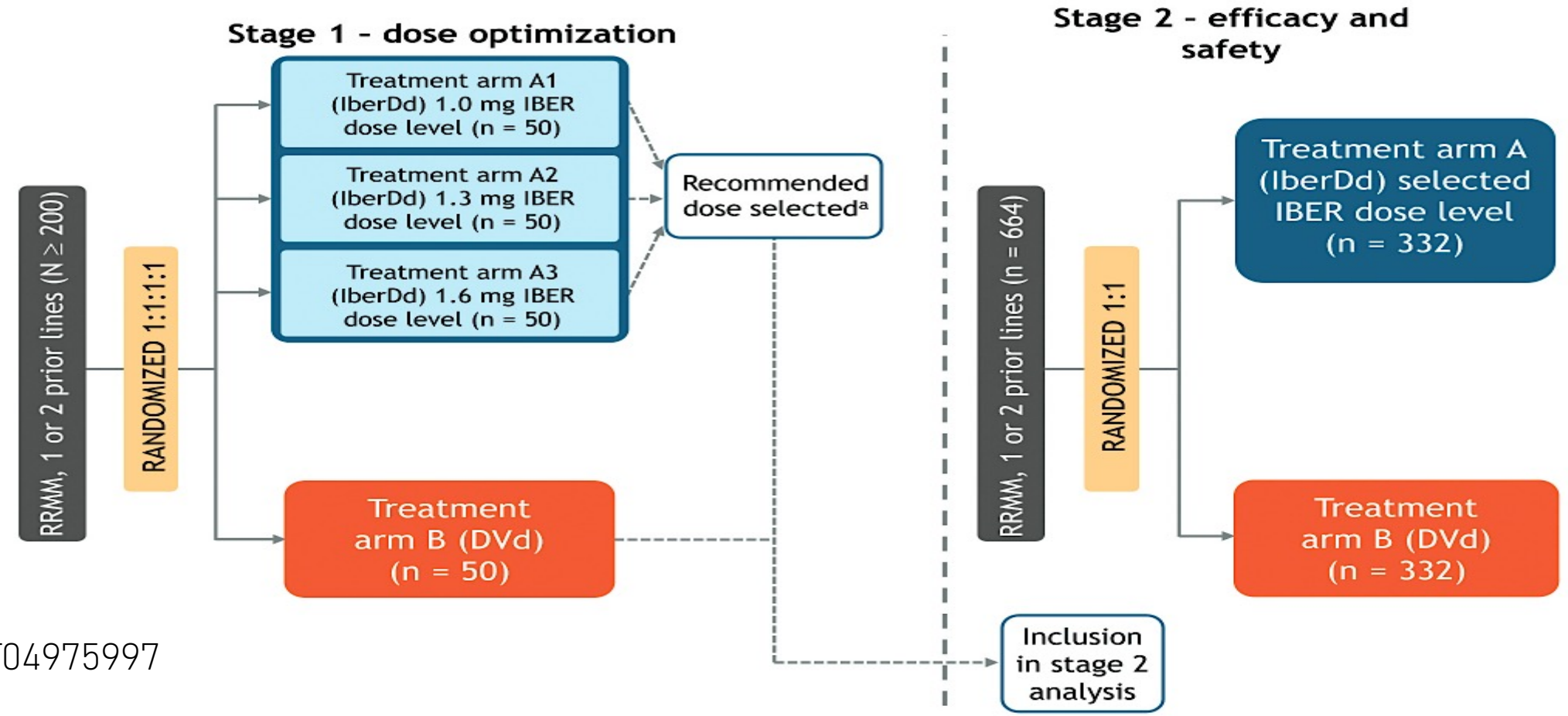
Efficacy Measure	Cohort A: MEZI-Vd (n = 28)	Cohort D: MEZI-Vd (n = 49)	Cohort C: MEZI-Kd (n = 27)
Overall mPFS, mo	12.3	17.5	13.5
ORR, % (95% CI)	75.0 (55.1-89.3)	85.7 (72.8-94.1)	85.2 (66.3-95.8)
Median DoR, mo (95% CI)	10.9 (8.8-18.7)	19.4 (9.7-NA)	11.9 (6.4-35.9)

Efficacy Measure	Cohort A: MEZI-Vd (n = 28)			Cohort D: MEZI-Vd (n = 49)		Cohort C: MEZI-Kd (n = 27)		
	0.3 mg (n = 9)	0.6 mg (n = 9)	1.0 mg (n = 10)	0.6 mg (n = 11)	1.0 mg (n = 38)	0.3 mg (n = 9)	0.6 mg (n = 9)	1.0 mg (n = 9)
mPFS, mo	13.4	11.2	12.3	20.8	16.6	11.7	13.5	13.8
ORR, % (95% CI)	NR	NR	60.0 (55.1-89.3)	NR	84.2 (68.7-94.0)	NR	NR	77.8 (40.0-97.2)
Median DoR, mo (95% CI)	NR	NR	11.6 (5.3-NA)	NR	19.4 (7.0-NA)	NR	NR	11.9 (0.2-NA)

- MEZI-Vd and MEZI-Kd showed efficacy at all doses tested
- Pharmacodynamic activity was observed with MEZI-Vd and MEZI-Kd at all doses, as measured by Aiolos degradation in T-cells and within tumors

Sandhu. ASH 2024. Abstr 1025.

EXCALIBER Phase III trial:
coprimary endpoints of MRD negativity and PFS: met endpoint!
Expected accelerated FDA approval 8/2026



NCT04975997

SUCCESSOR-2: phase III study met primary endpoint of improved PFS

Eligibility:
At least 1 line of Rx
Exposure to len and
At least 2 cycles of
Anti CD38 Ab

*Patients entrolled in stage 1 on a dose of mezidomide that is not chosen for stage 2 will have the possiblity to move to that dose if some criteria are met.

Richardson P et al. ASCO 2026;Abstract LBA7506

Stay tuned for many CELMoDs combinations: drugs may enhance the activity of T cell redirecting therapies

Mezigdomide plus elranatamab (MELT trial)[1]

Magnetismm 30 trial: elranatamab and iberdomide, 22 pts, refractory population: with 7.8mo of follow up the ORR 95.5% [2]

Iberdomide post CAR-T

Teclistamab/Iberdomide

[1]Byun ASH 2025;Abstract 5835, [2]Suvannasankha ASH 2025;Abstract 100

Case Presentation

- 68 year old male with IgG kappa myeloma, R-ISS III on basis of Beta-2 mg 5.6mg/L, high LDH 1/2018
- VRD induction, stem cell transplant, lenalidomide maintenance
- New bone pain, rising kappa light chains in 2/2023
- 6/2023 started iberdomide, daratumumab, dexamethasone. MRD negative in 4 cycles, remains on treatment at this time.
- Side effects: developed pneumocystis pneumonia in 11/2023
- Performs regularly with his band

Discussion Questions

How do you see CELMoDs fitting into the treatment of R/R MM?

Are iberdomide and mezigdomide essentially interchangeable, or are there scenarios in which one would be more appropriate than the other should they eventually reach the clinic?

Tolerability/Toxicity Considerations with the Use of CELMoDs in MM

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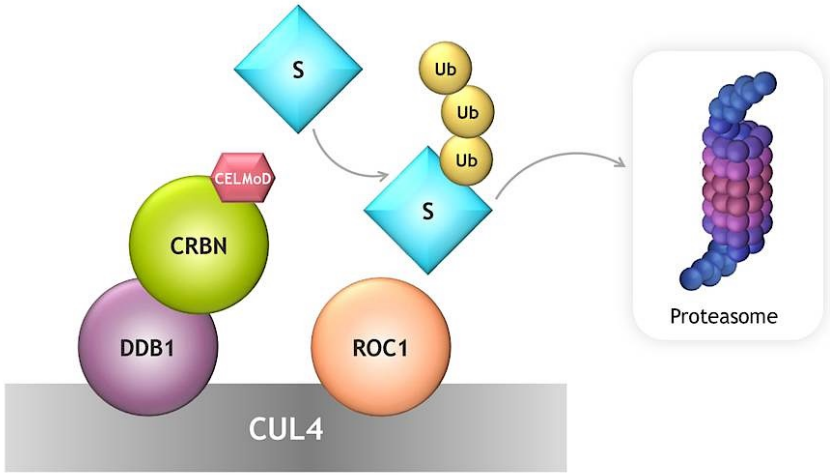
CELMoDs induce degradation of the transcription factors Ikaros and Aiolos, promoting immune-modulatory activity in MM cells. They may mitigate T-cell exhaustion, improving efficacy of T cell–engaging therapy.



- **Iberdomide**

  Oral CELMoD (new drug class)

  Phase 3 EXCALIBER-RRMM (NCT04975997: IberDd vs DVd) met primary MRD-negativity endpoint in pts with RRMM (Sept 2025).

  FDA NDA accepted Feb 17, 2026; PDUFA August 17, 2026.
- **Mezigdomide**

  Oral CELMoD targeting Ikaros/Aiolos.
- SUCCESSOR-2 (NCT05552976: MeziKd vs Kd) met primary PFS endpoint in pts with RRMM March 2026.
- Approval expected after NDA submission

CELMoD = cereblon E3 ligase modulator; Dd = daratumumab, dexamethasone; FDA = US Food and Drug Administration; IberDd = iberdomide, daratumumab, dexamethasone; IMiD = immunomodulatory drug; Kd = carfilzomib, dexamethasone; MeziKd = mezigdomide, carfilzomib, dexamethasone; MRD = minimal residual disease; NDA – new drug application; PDUFA = Prescription Drug User Fee Act; PFS = progression-free survival; RRMM = relapsed/refractory multiple myeloma; SMM = smoldering multiple myeloma; TEAE = treatment-emergent adverse event; Vd = bortezomib, dexamethasone; VGPR = very good partial response.

The Manufacturer Announces Phase 3 EXCALIBER-RRMM Study Evaluating Iberdomide in Combination with Standard Therapies Demonstrated a Significant Improvement in Minimal Residual Disease Negativity Rates in Relapsed or Refractory Multiple Myeloma. https://news.bms.com/news/details/2025/Bristol-Myers-Squibb-Announces-Phase-3-EXCALIBER-RRMM-Study-Evaluating-Iberdomide-in-Combination-with-Standard-Therapies-Demonstrated-a-Significant-Improvement-in-Minimal-Residual-Disease-Negativity-Rates-in-Relapsed-or-Refractory-Multiple-Myeloma/default.aspx Accessed March 26, 2026. The Manufacturer Announces Positive Phase 3 Results from the SUCCESSOR-2 Study of Oral Mezigdomide in Relapsed or Refractory Multiple Myeloma. https://news.bms.com/news/details/2026/Bristol-Myers-Squibb-Announces-Positive-Phase-3-Results-from-the-SUCCESSOR-2-Study-of-Oral-Mezigdomide-in-Relapsed-or-Refractory-Multiple-Myeloma/default.aspx Accessed March 26, 2026.

Trial	Agent	Experimental Arm	Comparator	Population	Primary Endpoint	Status	NCT ID	References
SUCCESSOR-1	Mezigdomide	MeziVd	Vd	RRMM, ≥1 prior line (incl. len + anti-CD38)	PFS	Enrolling	NCT05519085	[1]
SUCCESSOR-2	Mezigdomide	MeziKd	Kd	RRMM, ≥1 prior line (incl. len + anti-CD38), no prior CFZ	PFS (HR 0.667)	Enrolling (since Oct 2022)	NCT05552976	[2]
EXCALIBER-RRMM	Iberdomide	IberDd	DVd	RRMM, 1–2 prior lines	PFS (HR 0.75)	Enrolling (since Jun 2022)	NCT04975997	[3-4]
EXCALIBER-Maintenance	Iberdomide	Iber maintenance	Standard maintenance	NDMM, post-transplant	Not reported	Enrolling	NCT04564703	[5]

Non-Hematologic AE	Mezigdomide + Dex (Ph 2, N=101) Any Grade	Mezigdomide + Dex (Ph 2, N=101) Gr 3–4	Mezigdomide + Dex (Ph 2, N=101) Estimated Gr 1–2	Iberdomide + Dex (Ph 2, N=107) Gr 3–4	Iberdomide + Dex (Ph 1, N=90) Gr 3–4	IberCd (ICON, N=61) Gr ≥3
Infections (all)	65%	35%	~30%	27%	26%	34%
Fatigue	36%	5%	**~31%**	3%	2%	3%
Diarrhea	31%	3%	**~28%**	1%	1%	NR
Nausea	21%	1%	**~20%**	1%	0%	NR
Constipation	24%	0%	**~24%**	NR	NR	NR
Decreased appetite	21%	2%	**~19%**	NR	NR	NR
Dyspnea	22%	5%	**~17%**	NR	NR	NR
Arthralgia	21%	2%	**~19%**	NR	NR	NR
Insomnia	20%	1%	**~19%**	NR	NR	NR
Pyrexia	15%	3%	**~12%**	NR	NR	NR
Peripheral edema	8%	0%	**~8%**	NR	NR	NR
Rash	NR	NR	NR	3%	0%	NR
Peripheral neuropathy	7%	1%	**~6%**	0%	1%	3% (Gr 3)
GI disorders (combined)	—	—	—	6%	3%	NR
DVT/VTE	3%	1%	~2%	0%	0%	2%

Case Presentation

Case Presentation

- 81 year old, IgG Kappa MM diagnosed 2014
- LOT1 – lenalidomide+ dexamethasone on a clinical trial until 2017
- LOT2- carfilzomib, pom + dex 2017-2020
- LOT3- clinical trial with daratumumab, iberdomide and dexamethasone
- Side effects: neutropenia grade 2; dose reduce iberdomide
- Hypogammaglobulinemia – IVIg started with IgG level 280 (700-1400 range)
- Best response: Complete remission

Discussion Questions

How do you currently counsel your patients with MM who are going to receive standard IMiDs, such as lenalidomide, about how these agents work and what to expect in terms of tolerability?

How do these conversations play out with CELMoDs? How, if at all, do they differ for iberdomide versus mezigdomide?

What has been your personal experience with cytopenias with CELMoDs? What about GI toxicities? What advice about management of these toxicities would you offer a nurse who was about to enroll a patient on a clinical trial evaluating a CELMoD?

Discussion Questions

If CELMoDs were to be approved, are there any comorbidities that might dissuade you from using them? Do you anticipate that iberdomide and mezigdomide can be safely offered to older or frail patients?

What is the route of administration of CELMoDs? What dosing schedules of iberdomide and mezigdomide are being employed in the emerging and ongoing Phase III clinical trials in the R/R setting?

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Faculty

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