Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Multiple Myeloma

A CME/MOC-Accredited Live Webinar

Thursday, June 25, 2026
5:00 PM – 6:00 PM ET

Faculty

Amrita Krishnan, MD
Robert Z Orlowski, MD, PhD

Moderator

Neil Love, MD

RTP Year in Review 2026

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Amrita Krishnan, MD
Director of the Judy and Bernard Briskin Center
for Multiple Myeloma Research
Nason Hollingsworth Family Chair in Myeloma
Professor of Hematology/Hematopoietic Cell Transplantation
Executive Medical Director of Hematology
City of Hope Orange County
City of Hope Cancer Center
Duarte, California

Robert Z Orlowski, MD, PhD
Florence Maude Thomas Cancer Research Professor
Department of Lymphoma and Myeloma
Professor, Department of Experimental Therapeutics
Vice Chair, Myeloma Translational Research
Division of Cancer Medicine
The University of Texas MD Anderson Cancer Center
Houston, Texas

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

Commercial Support

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Contracted Research	Asylia Therapeutics Inc, Biotheryx, Heidelberg Pharma, Regeneron Pharmaceuticals Inc
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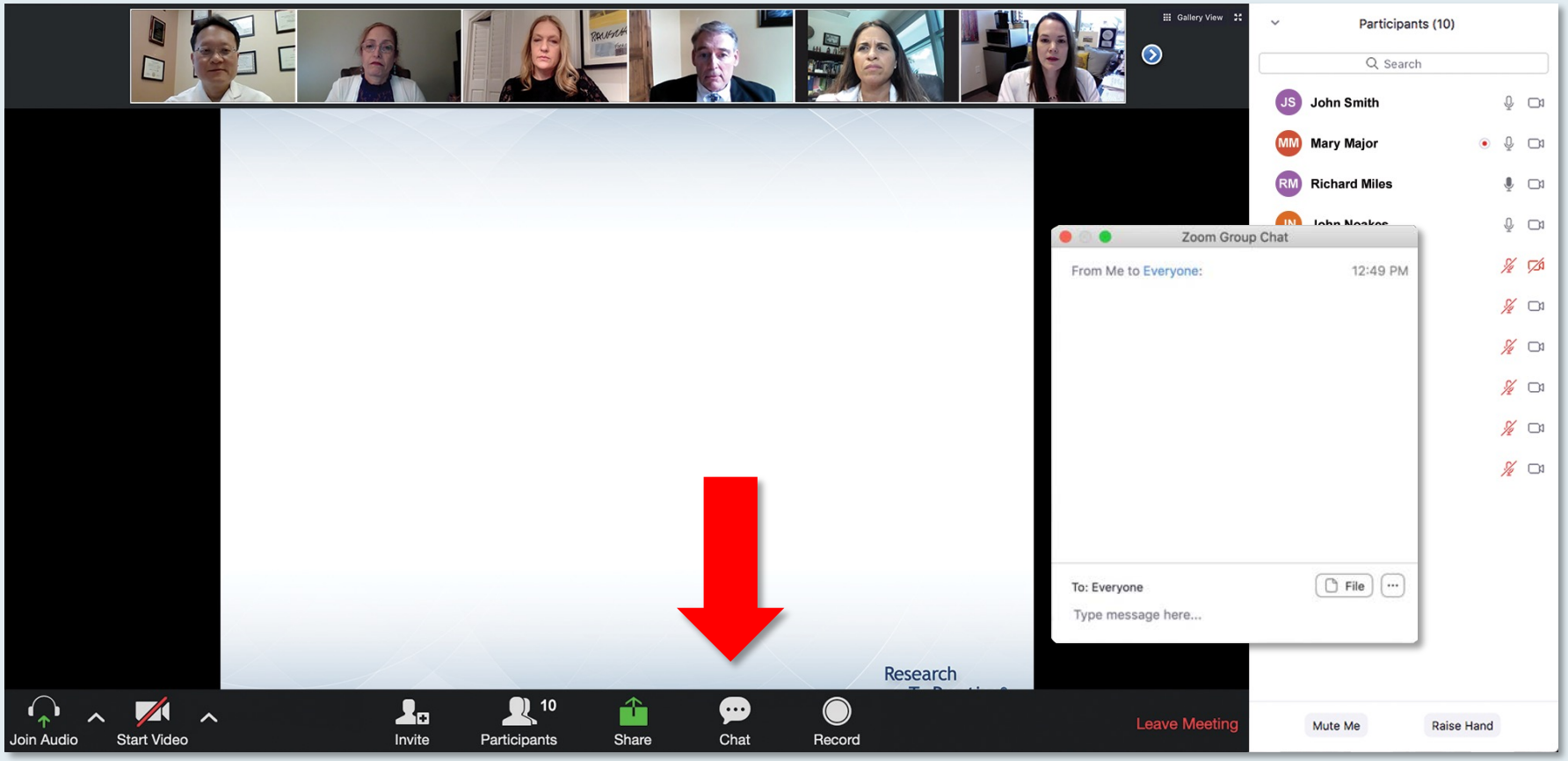

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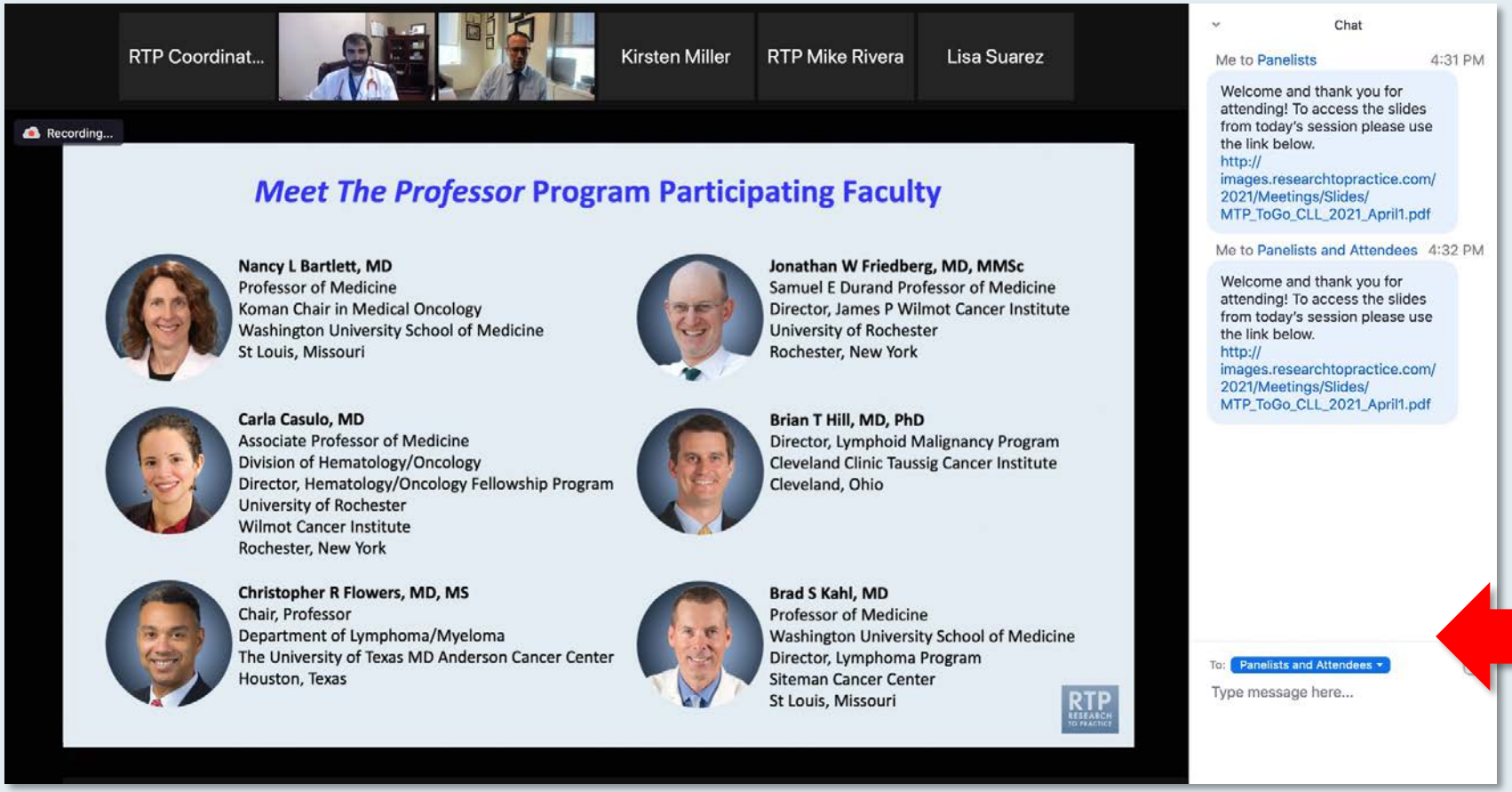

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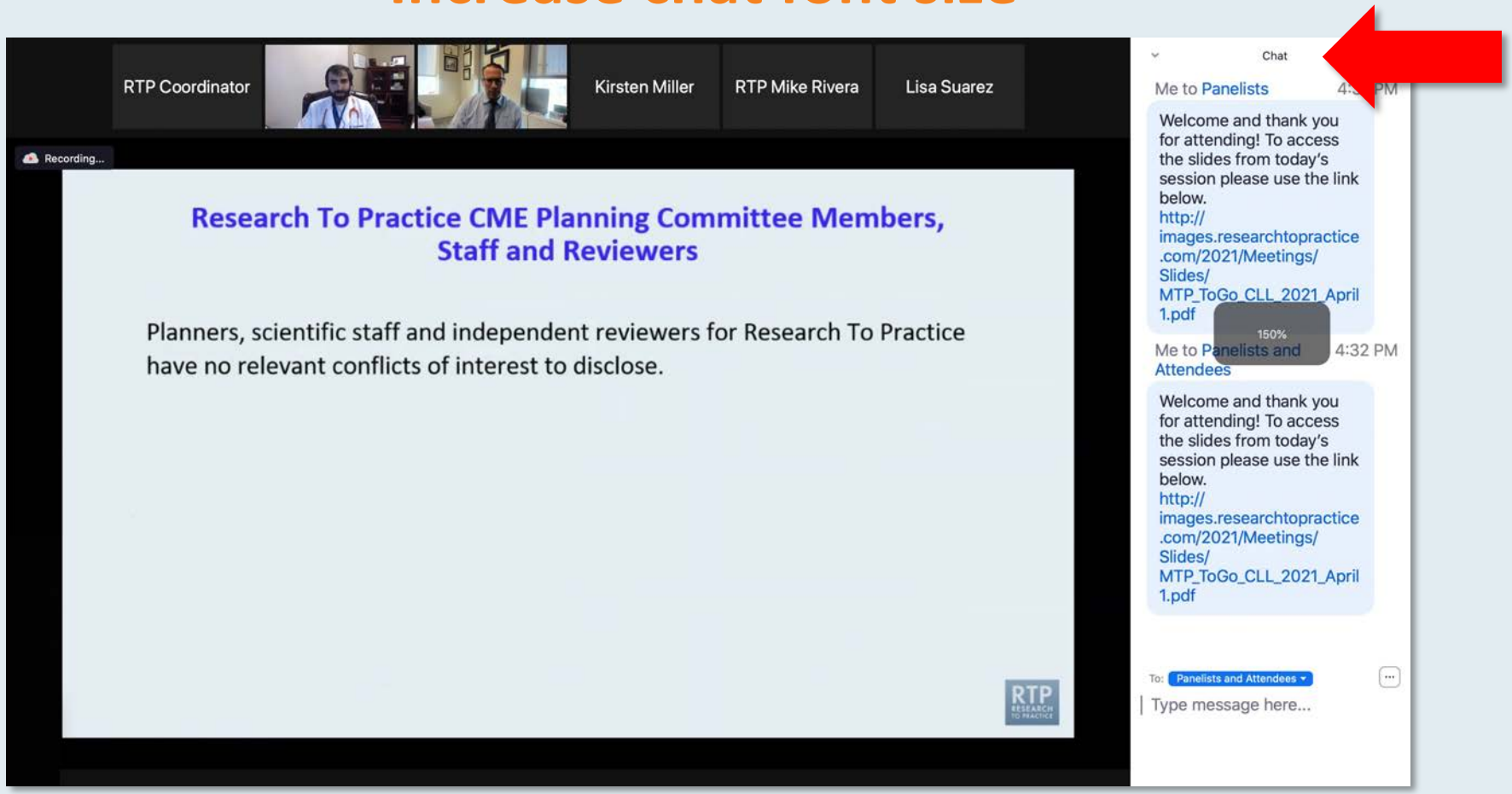

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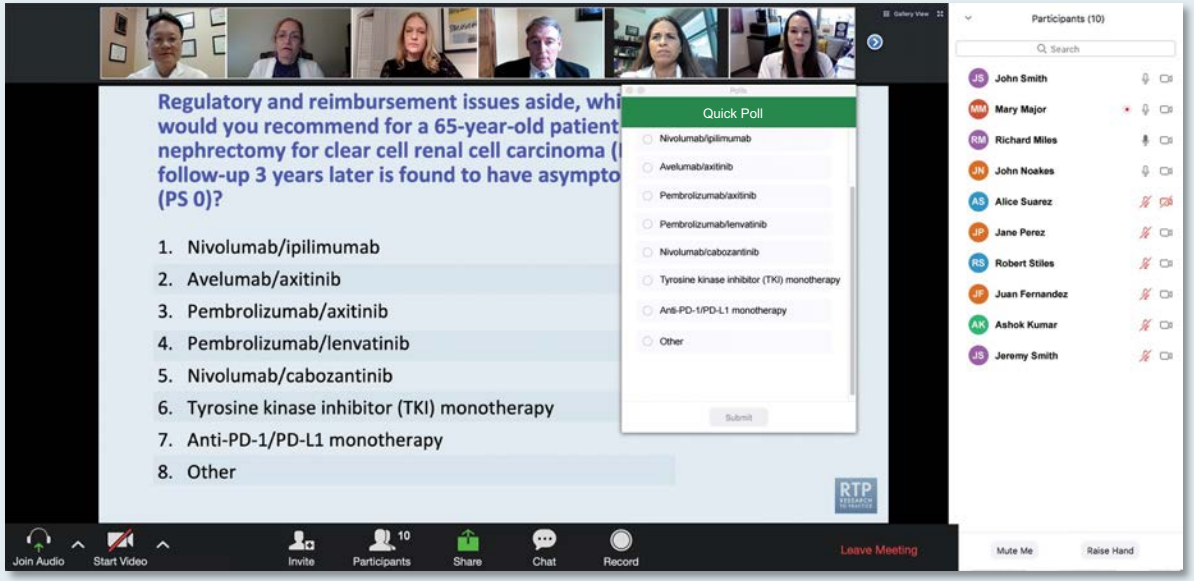

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WITH DR NEIL LOVE

Multiple Myeloma — Fifth Annual National General Medical Oncology Summit

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Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Therapeutic Targets Beyond EGFR for Non-Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, June 30, 2026

5:00 PM – 6:00 PM ET

Faculty

John V Heymach, MD, PhD

Maurice Pérol, MD

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Neil Love, MD

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Patterns of Care: Exploring How Community Oncologists Manage HR-Positive, HER2-Positive Metastatic Breast Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, July 1, 2026
5:00 PM – 6:00 PM ET

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Lisa A Carey, MD, ScM, FASCO
Reshma L Mahtani, DO

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RESEARCH TO PRACTICE

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Multiple Myeloma

INTRODUCTION: Up-Front PFS for Standard-Risk Disease — 2006, 2016

MODULE 1: Current and Emerging Therapeutic Approaches — Dr Orlowski

MODULE 2: Chimeric Antigen Receptor T-Cell Therapy, Bispecific Antibodies and Antibody-Drug Conjugates — Dr Krishnan

MODULE 3: ASCO and EHA 2026

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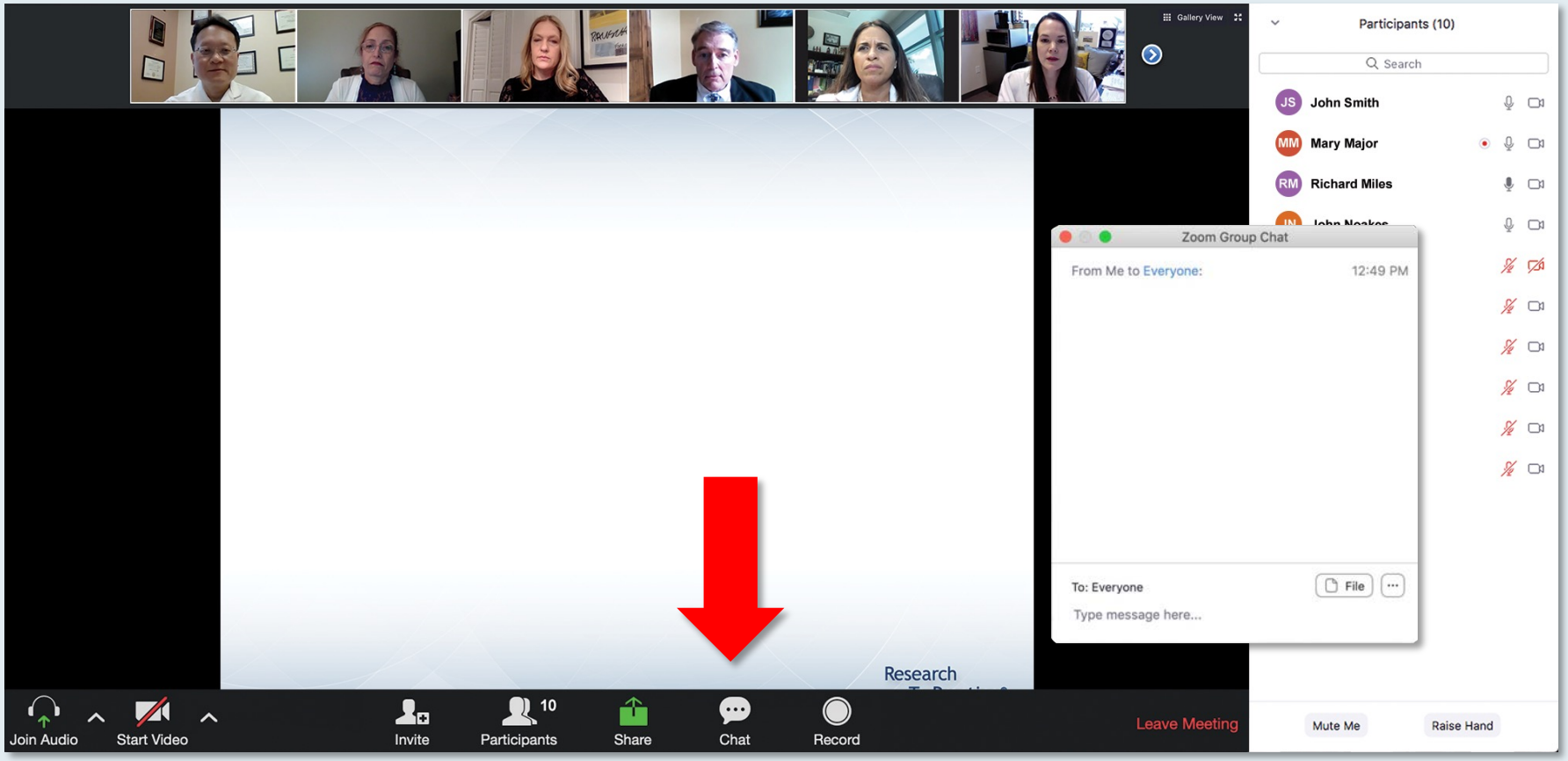

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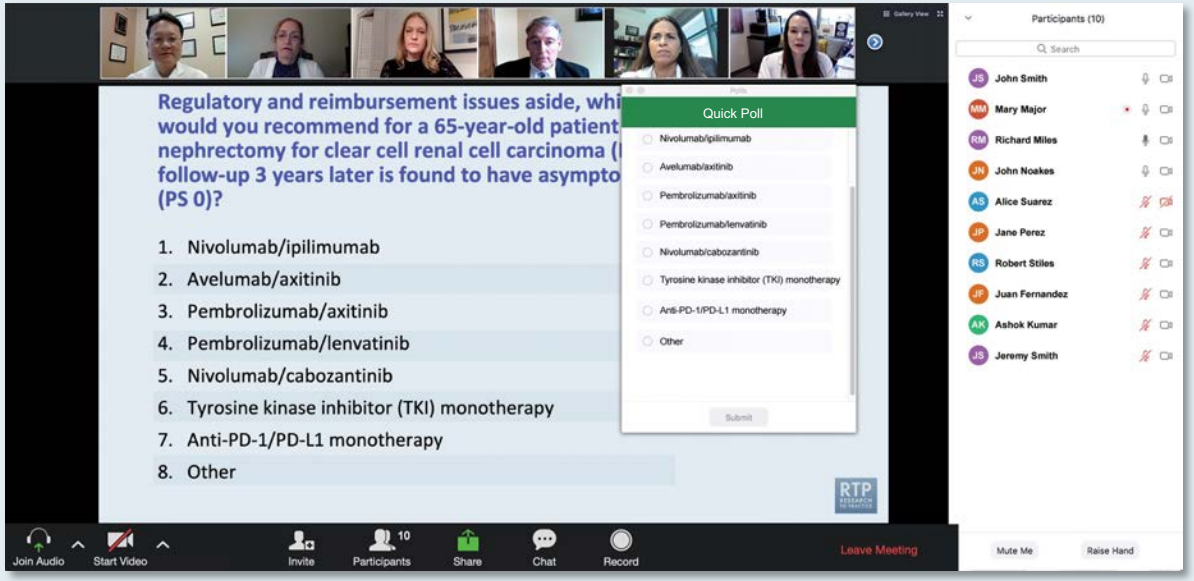

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Year in Review:
Current & Emerging Therapies in Multiple Myeloma

Research To Practice®

Robert Z. Orlowski, M.D., Ph.D.

Deputy Chair, Department of Lymphoma/Myeloma

Florence Maude Thomas Cancer Research Professor

Principal Investigator, High Risk Myeloma Moon Shot

Director, Myeloma Translational Research

Cancer
UT MD Anderson

City of Hope

Myeloma Updates ASCO/EHA

Amrita Krishnan MD FACP :

Director Judy and Bernard Briskin Center for Myeloma City of Hope Cancer Center:
Professor of Hematology/HCT: Nason Hollingsworth Family Chair in Myeloma

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Key Datasets

Robert Z Orlowski, MD, PhD

- Dimopoulos MA et al. Daratumumab or active monitoring for high-risk smoldering multiple myeloma. *N Engl J Med* 2025;392(18):1777-88.
- Bertamini L et al. New IMS/IMWG risk criteria by next-generation sequencing (NGS): Analysis of daratumumab benefit in both high- and standard-risk patients (pts) in the PERSEUS study. ASCO 2026;Abstract 7505.
- Gay F et al. Isatuximab, carfilzomib, lenalidomide and dexamethasone in newly diagnosed multiple myeloma: A randomized phase 3 trial. *Nat Med* 2026;32(5):1773-82.
- Usmani S et al. Daratumumab plus bortezomib, lenalidomide, and dexamethasone (DVRd) in patients (pts) with newly diagnosed multiple myeloma (NDMM): Final analysis of transplant-ineligible (TIE) pts in the phase 3 CEPHEUS study. ASCO 2026;Abstract 7513.
- Orlowski RZ et al. Isatuximab, bortezomib, lenalidomide, dexamethasone for multiple myeloma: Dynamics of MRD negativity in the IMROZ study. *Blood* 147(23):2760-9.

Key Datasets

Robert Z Orlowski, MD, PhD (continued)

- Bobin A et al. Sustained minimal residual disease (sMRD) negativity in transplant ineligible newly diagnosed multiple myeloma treated with isatuximab plus lenalidomide and dexamethasone with bortezomib (Isa-VRd) versus Isa-Rd: 12-24-month data from the phase 3 benefit trial (IFM 2020-05). ASH 2025;Abstract 368.
- Ailawadhi S et al. Isatuximab subcutaneous by on-body injector versus isatuximab intravenous plus pomalidomide and dexamethasone in relapsed/refractory multiple myeloma: Phase III IRAKLIA study. *J Clin Oncol* 2025;43(22):2527-37.
- Anderson LD et al. Updated efficacy and safety results of subcutaneous daratumumab plus lenalidomide versus lenalidomide alone as maintenance therapy in newly diagnosed multiple myeloma after transplant: AURIGA study. International Myeloma Society (IMS) 2025;Abstract OA-47.
- Richardson P et al. Mezigdomide, carfilzomib, and dexamethasone (MeziKd) vs carfilzomib and dexamethasone (Kd) in relapsed/refractory multiple myeloma (RRMM): Results from the phase 3 SUCCESSOR-2 trial. ASCO 2026;Abstract LBA7506.
- Kapoor P et al. Safety and efficacy of iberdomide-based quadruplet for patients with newly diagnosed multiple myeloma: The IDEAL phase I/II trial results. EHA 2026;Abstract S199.

Key Datasets

Amrita Krishnan, MD

- Jagannath S et al. Long-term (≥5-year) remission and survival after treatment with ciltacabtagene autoleucel in CARTITUDE-1 patients with relapsed/refractory multiple myeloma. *J Clin Oncol* 2025;43(25):2766-71.
- Einsele H et al. Cilta-cel in lenalidomide-refractory multiple myeloma (CARTITUDE-4): An updated analysis including overall survival from an open-label, multicentre, randomised, phase 3 trial. *Lancet Oncol* 2026;27(2):254-68.
- Costa L J et al. Teclistamab plus daratumumab in relapsed or refractory multiple myeloma. *N Engl J Med* 2026;394(8):739-52.
- Mina R et al. MajesTEC-9: A phase 3 randomized study of teclistamab monotherapy vs investigator's choice of pomalidomide, bortezomib, and dexamethasone or carfilzomib and dexamethasone (PVd/Kd) in patients (pts) with relapsed refractory multiple myeloma (RRMM). ASCO 2026;Abstract 7507.
- Lee HC et al. Linvoseltamab in patients with relapsed/refractory multiple myeloma in the LINKER-MM1 study: Longer follow-up and subgroup analyses. *Clin Lymphoma Myeloma Leuk* 2026;26(2):e201-12.
- Wechalekar A et al. First results from the phase 1/2 LINKER-AL2 trial of linvoseltamab (LINVO) in patients (pts) with relapsed or refractory (RR) systemic light chain (AL) amyloidosis. ASCO 2026;Abstract 7502.

Key Datasets

Amrita Krishnan, MD (continued)

- Chari A et al. Safety and activity of talquetamab in patients with relapsed or refractory multiple myeloma (MonumenTAL-1): A multicentre, open-label, phase 1-2 study. *Lancet Haematol* 2025;12(4):e269-81.
- Voorhees P et al. Phase 3, randomized study of talquetamab (tal) plus daratumumab (dara) ± pomalidomide (pom) vs dara plus pom and dexamethasone (DPd) in relapsed/refractory multiple myeloma (RRMM): MonumenTAL-3. EHA 2026;Abstract S100.
- Hungria V et al. Belantamab mafodotin plus bortezomib and dexamethasone in patients with relapsed or refractory multiple myeloma (DREAMM-7): Updated overall survival analysis from a global, randomised, open-label, phase 3 trial. *Lancet Oncol* 2025;26(8):1067-80.
- Trudel S et al. Long-term outcomes with sustained minimal residual disease (MRD) negativity in belantamab mafodotin–treated patients (pts) with relapsed/refractory multiple myeloma (RRMM): An update from DREAMM-8. ASCO 2026;Abstract 7515.

Year in Review:
Multiple Myeloma

INTRODUCTION: Up-Front PFS for Standard-Risk Disease — 2006, 2016

MODULE 1: Current and Emerging Therapeutic Approaches — Dr Orlowski

MODULE 2: Chimeric Antigen Receptor T-Cell Therapy, Bispecific Antibodies and Antibody-Drug Conjugates — Dr Krishnan

MODULE 3: ASCO and EHA 2026

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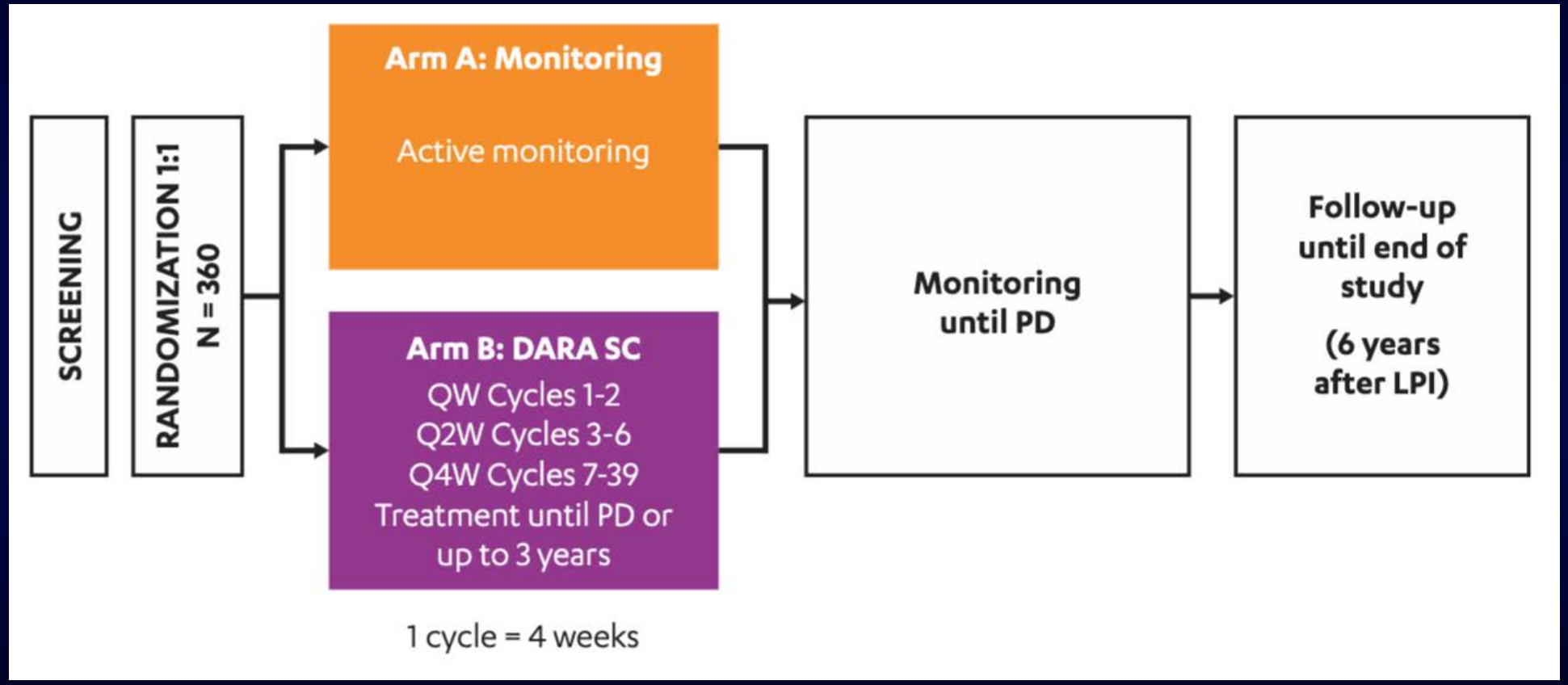
Daratumumab for Smoldering Myeloma

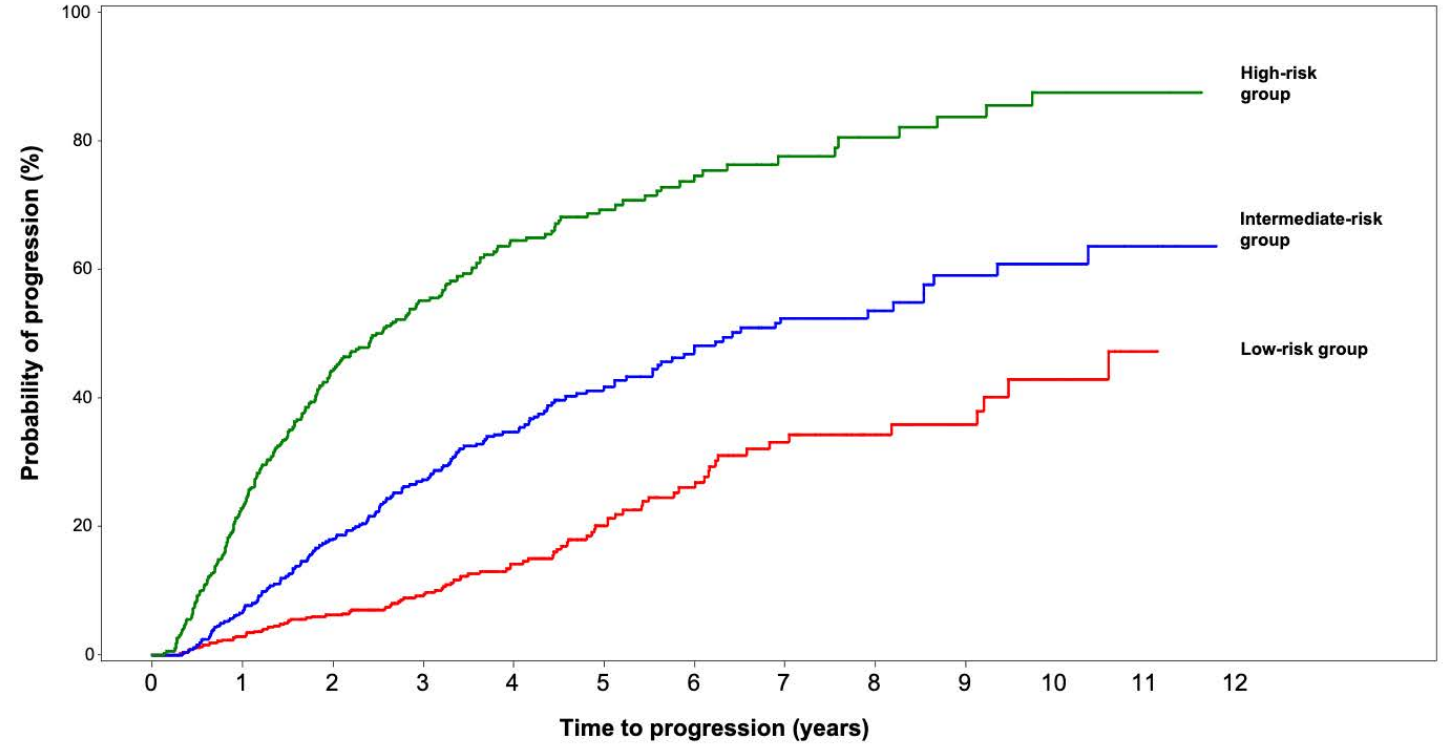
AQUILA : Daratumumab for HR SMM

M-protein >2 g/dL



Mateos, M-V et al. Blood Cancer J. 2020 Oct 16;10(10):102.
Dimopoulos, MA et al. N Engl J Med. 2025 May 8;392(18):1777-1788.

AQUILA : Daratumumab for HR SMM



Risk Stratification groups	Number of risk factors	Hazard Ratio (95% CI)	Risk of progression (2 years)	# of patients
Low-Risk	0	Reference	6.2%	522 (38.3%)
Intermediate	1	2.99 (1.97 – 4.54)	17.9%	445 (32.7%)
High	2-3	9.02 (6.15 – 13.2)	44.2%	396 (29.1%)

Mateos, M-V et al. Blood Cancer J. 2020 Oct 16;10(10):102.
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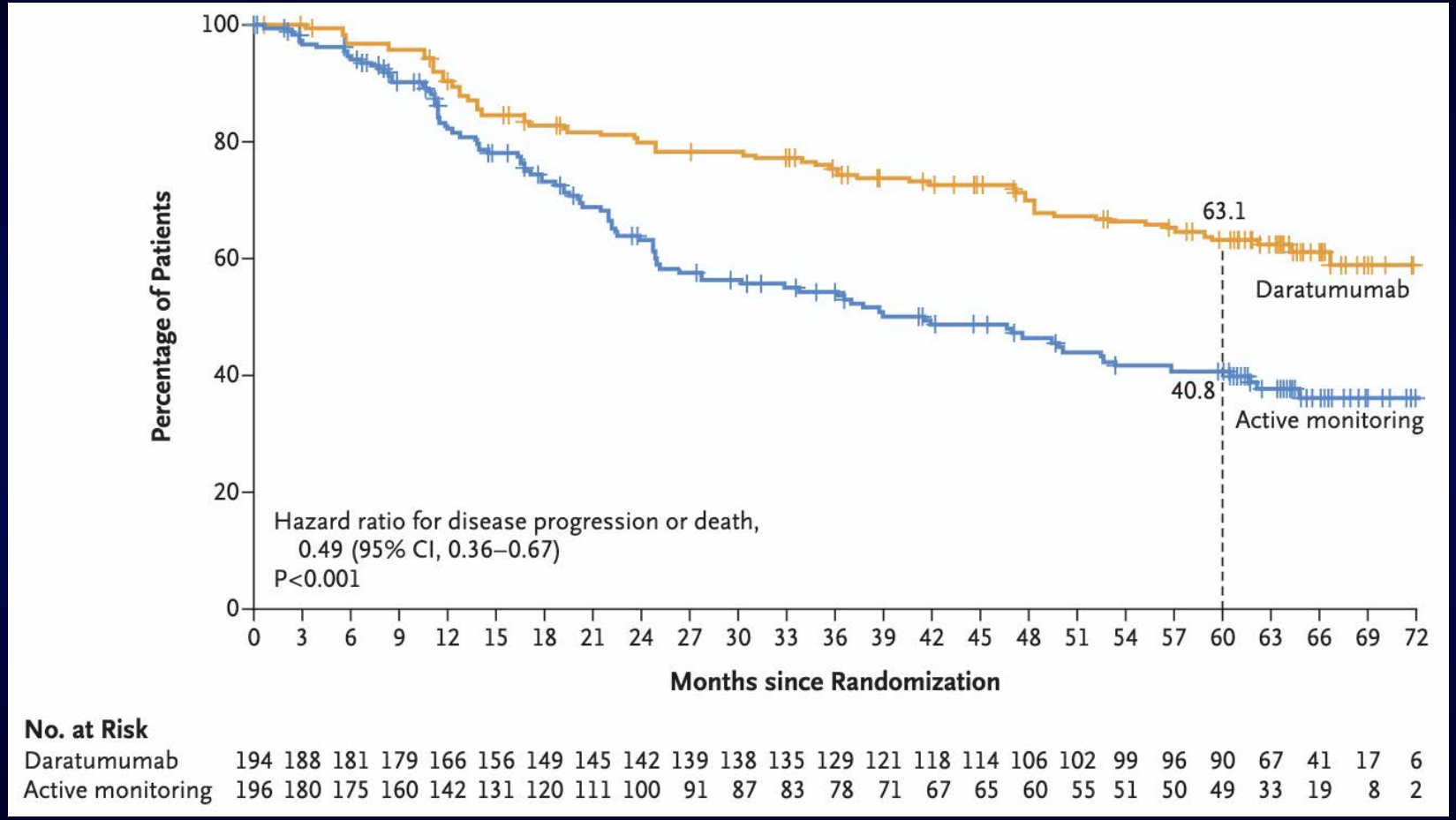
AQUILA : Outcomes



- Lower risk of progression & trend towards better survival

Dimopoulos, MA et al. N Engl J Med. 2025 May 8;392(18):1777-1788.

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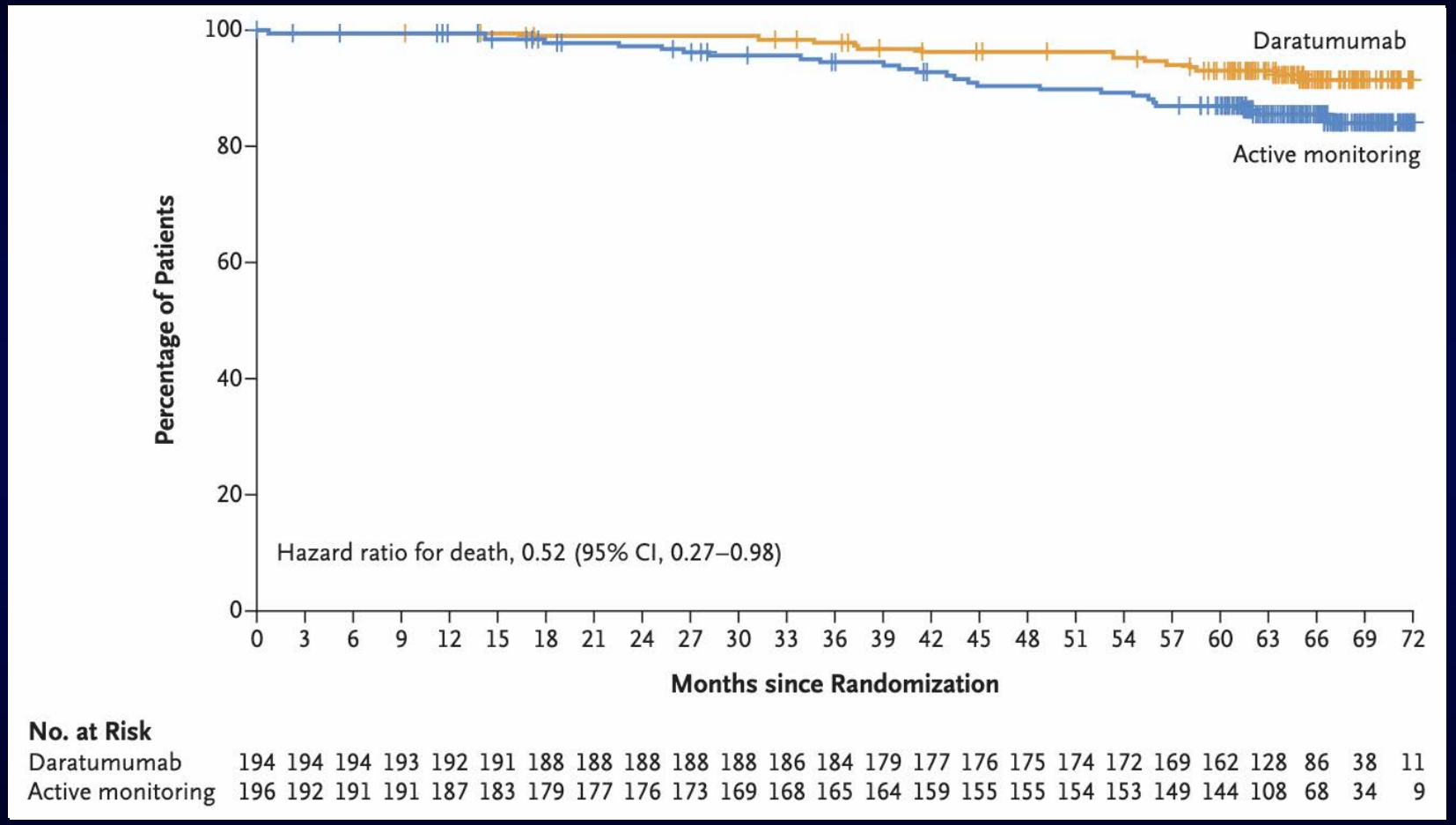

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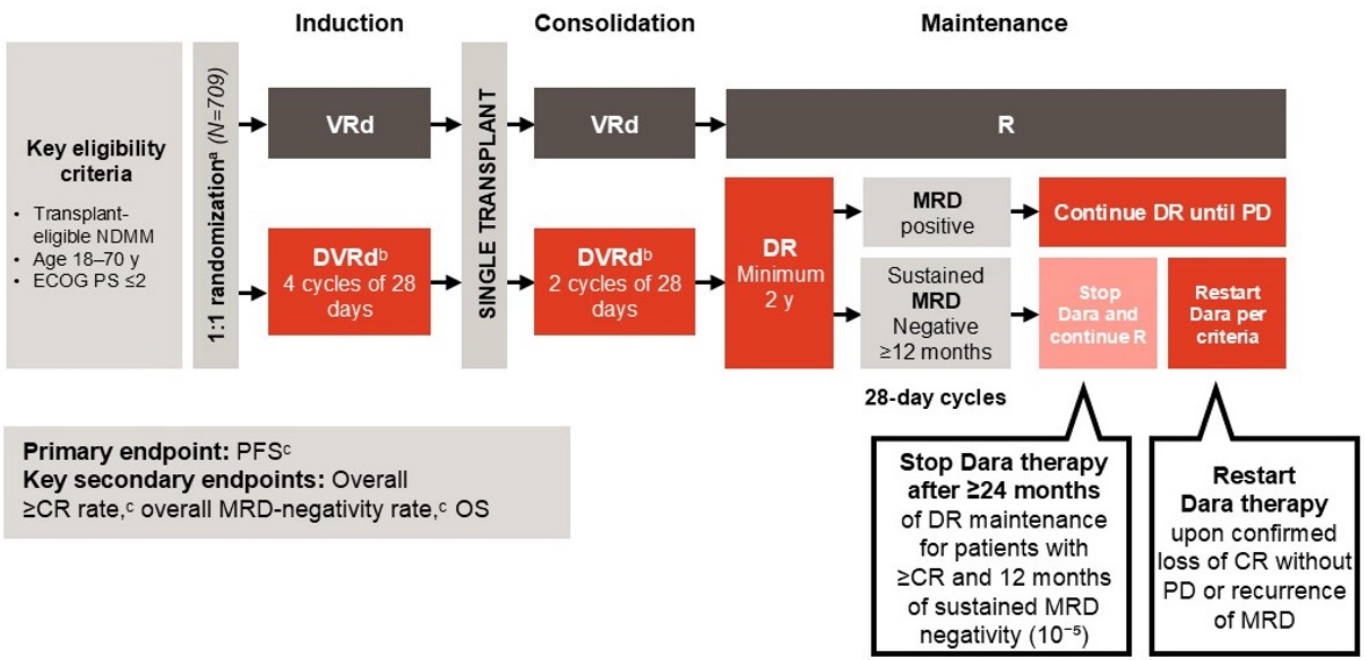
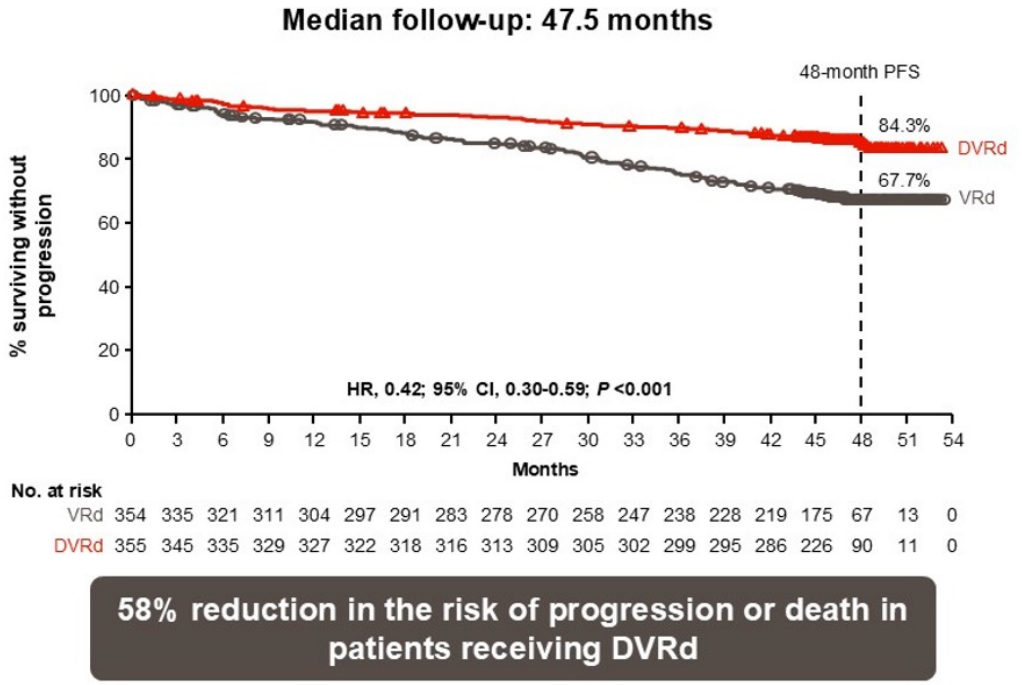
Quadruplet Therapy for Transplant-Eligible Newly Diagnosed MM

PERSEUS : Risk by New IMS/IMWG





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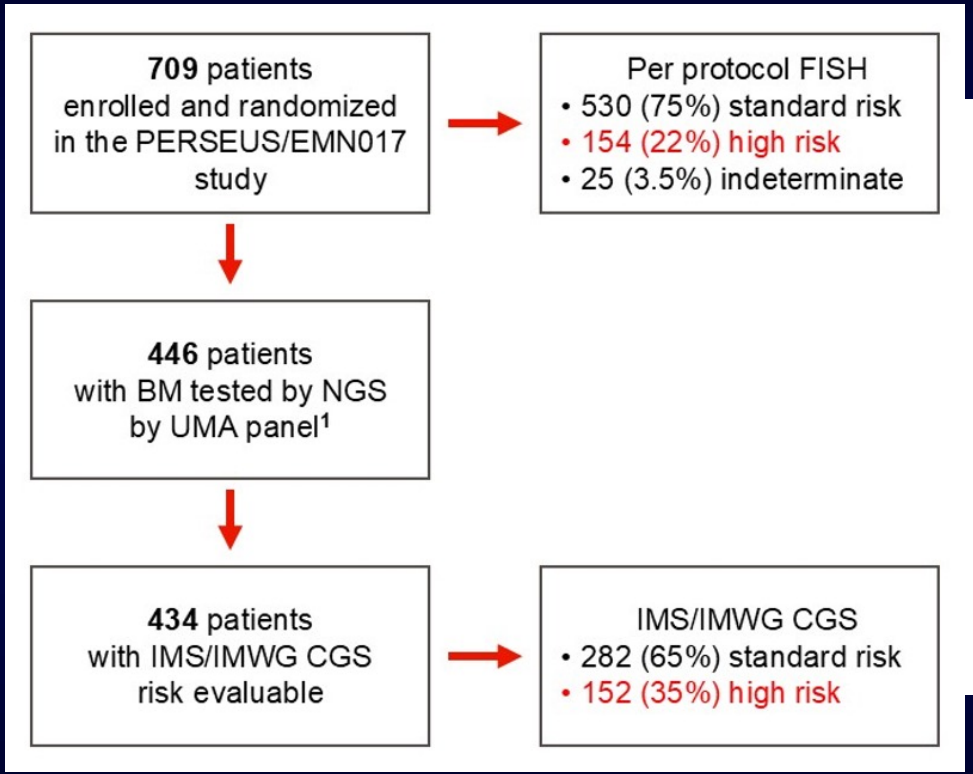
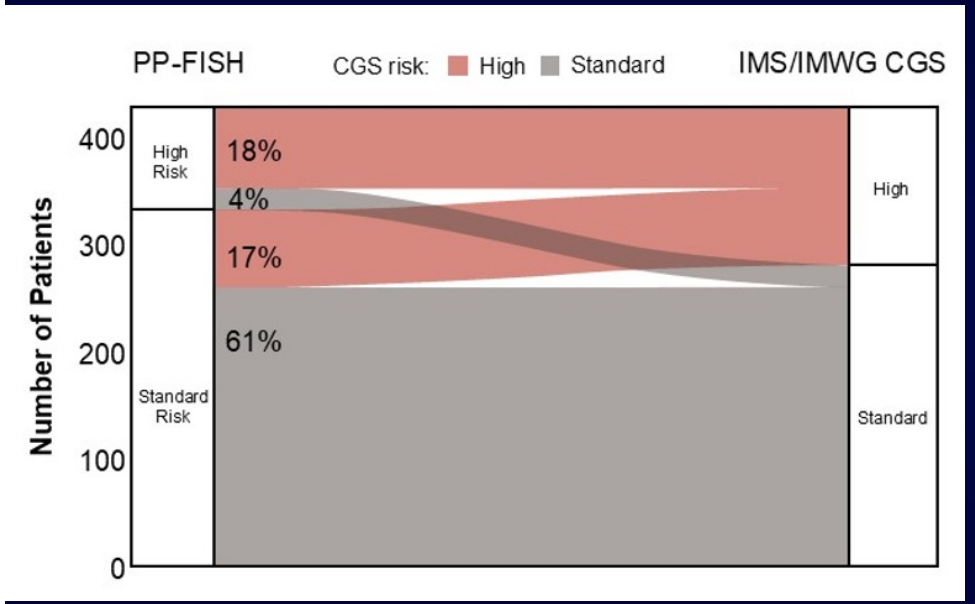
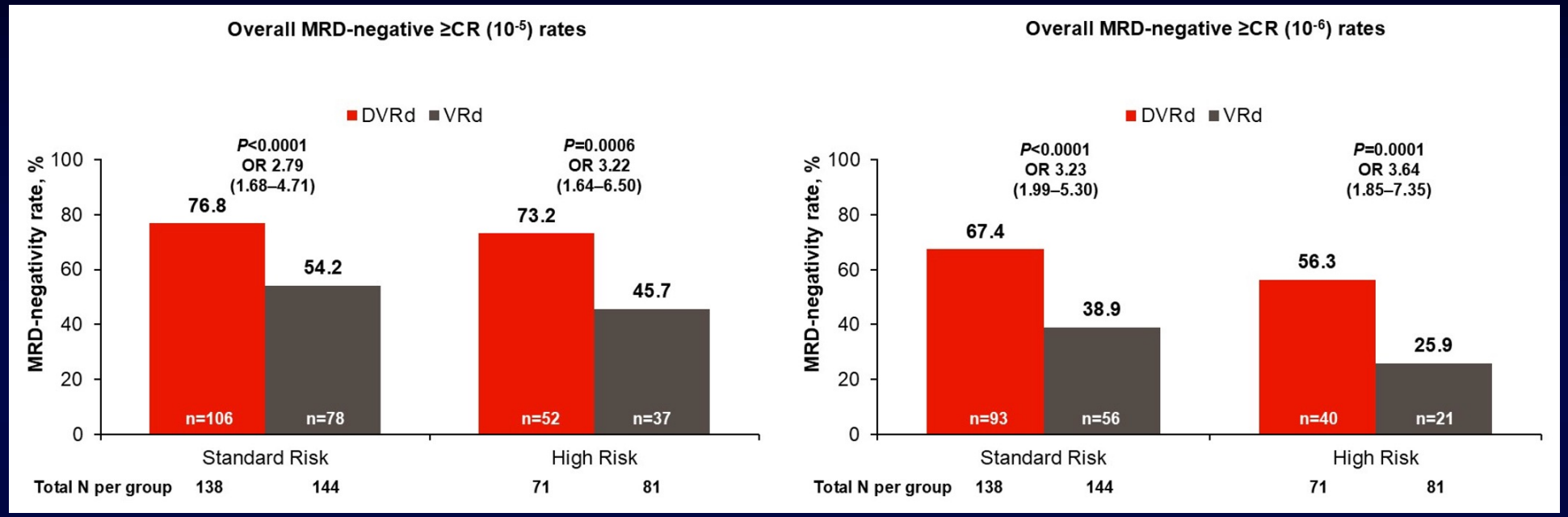




Bertamini, L et al. ASCO 2026;Abstract 7505.

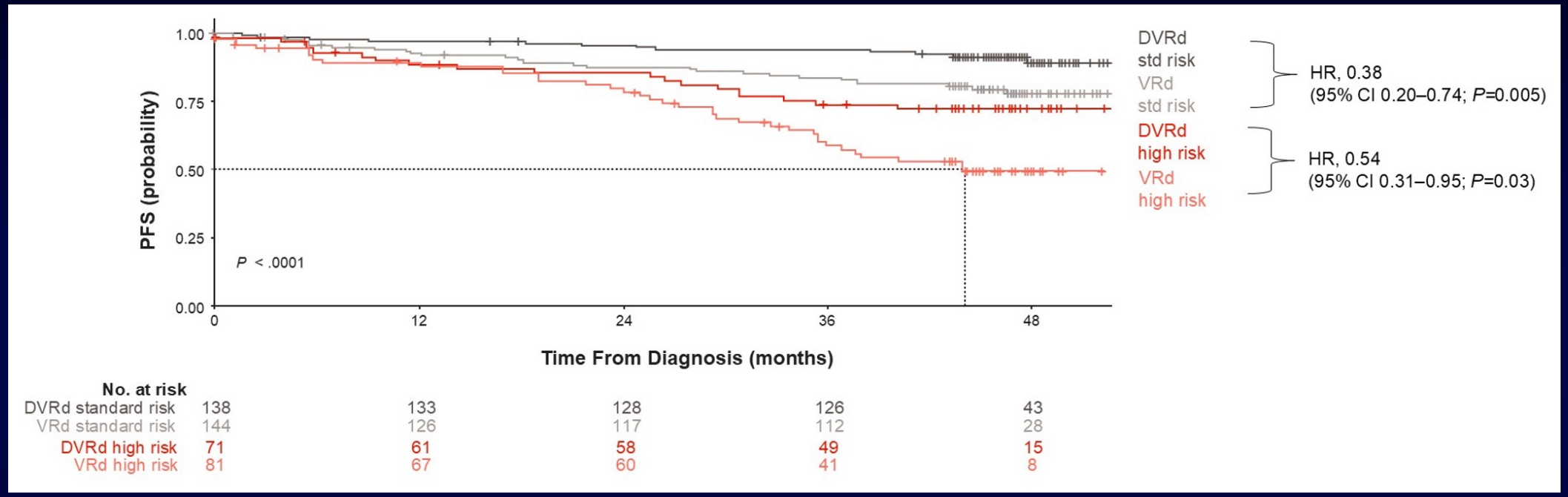
MRD & Outcomes Data



- Dara improves outcomes in both SR & HR MM, but HRMM still doesn't do as well

Bertamini, L et al. ASCO 2026;Abstract 7505.

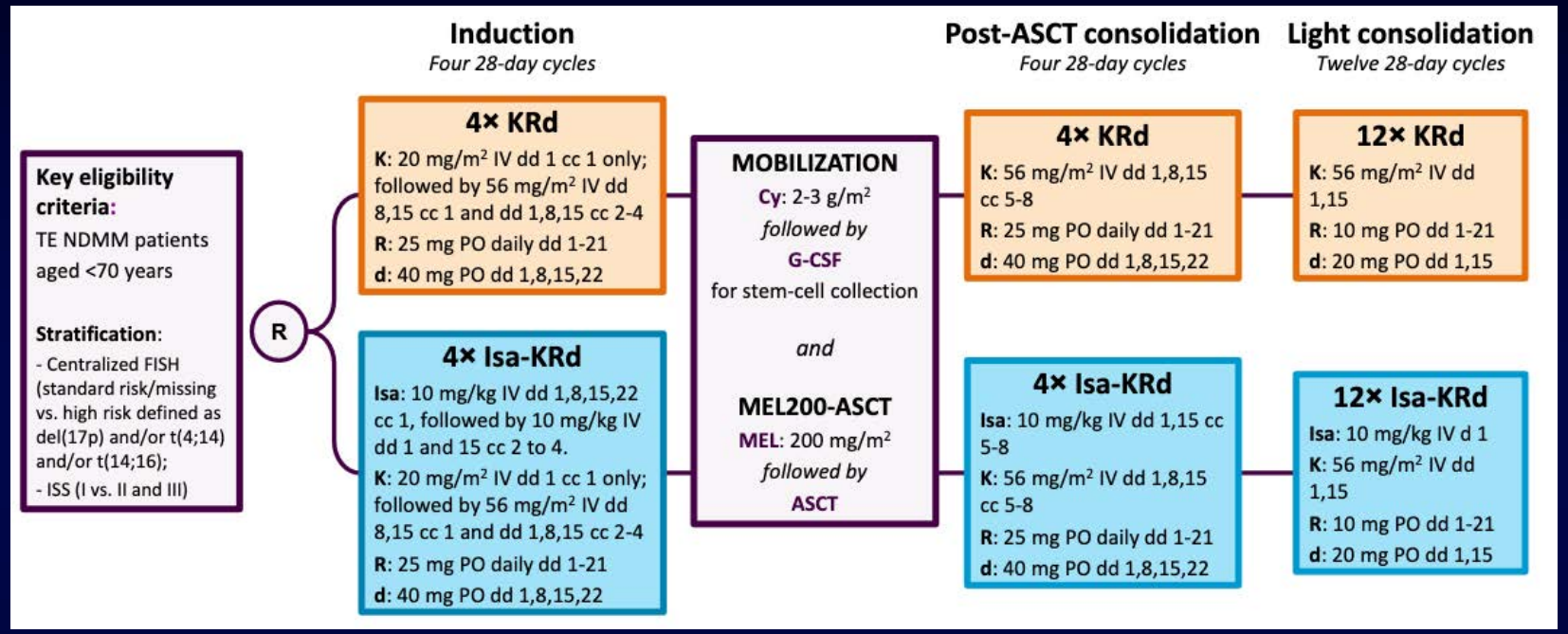
MRD & Outcomes Data



- Dara improves outcomes in both SR & HR MM, but HRMM still doesn't do as well

Bertamini, L et al. ASCO 2026;Abstract 7505.

IsKia : Isa-KRd vs. KRd in TE NDMM



- Randomized 302 patients ≤70 years 1:1 to Isa-KRd versus KRd pre-transplant induction and post-transplant consolidation
- Primary endpoint was rate of MRD negativity (10^{-5} or better) by NGS after consolidation

Gay, F et al. Nat Med. 2026 May;32(5):1773-1782.

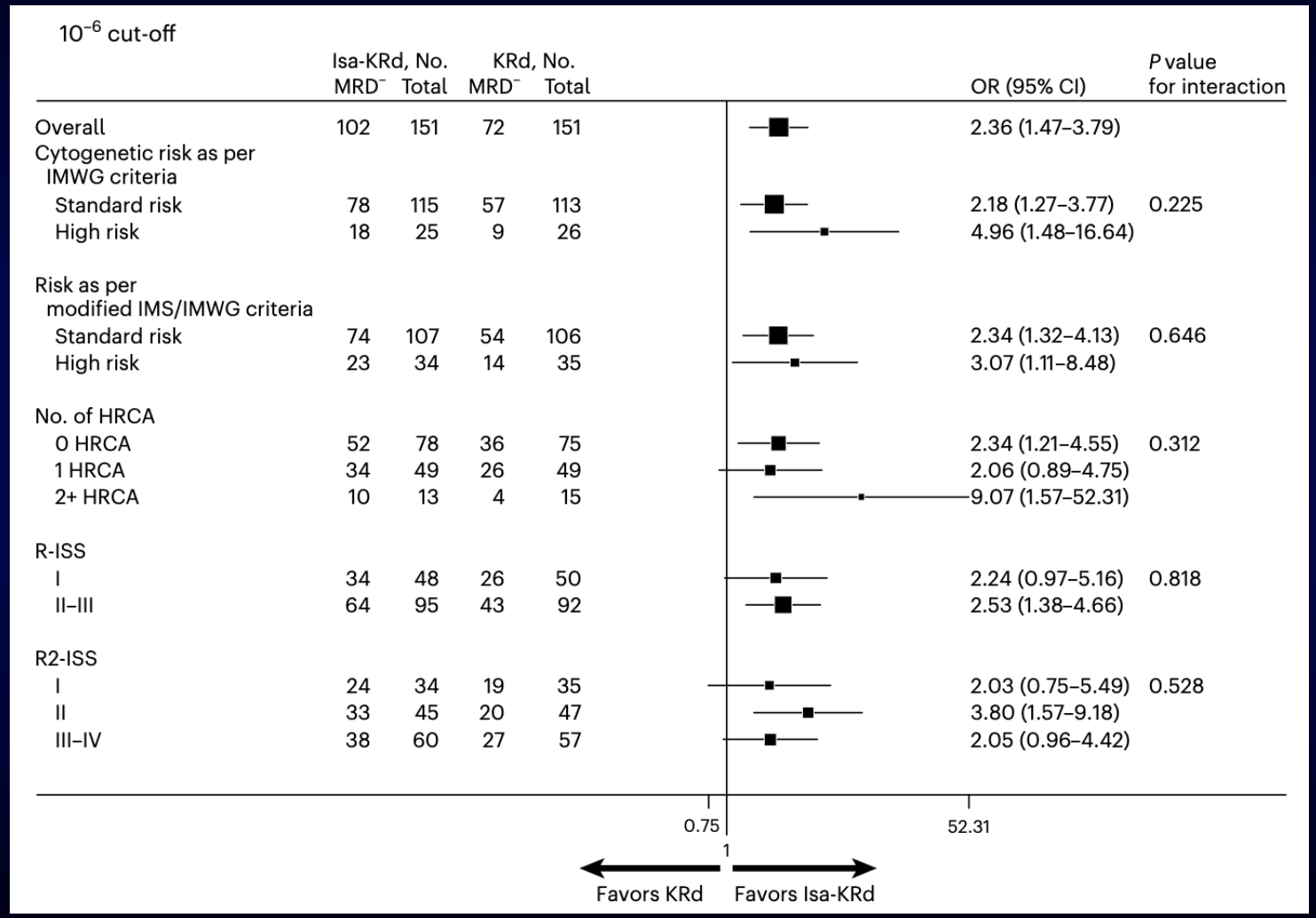
Outcomes : IsaKRd Better

	Post induction		Post ASCT		Post-ASCT full-dose consolidation		Post light consolidation		1-year sustained MRD negativity	
	Isa-KRd (*n*=151)	KRd (*n*=151)	Isa-KRd (*n*=151)	KRd (*n*=151)	Isa-KRd (*n*=151)	KRd (*n*=151)	Isa-KRd (*n*=151)	KRd (*n*=151)	Isa-KRd (*n*=151)	KRd (*n*=151)
10^{-5} MRD (95% CI)	46% (38%–54%)	27% (20%–35%)	64% (56%–72%)	50% (41%–58%)	77% (69%–83%)	67% (59%–74%)	79% (71%–85%)	74% (66%–81%)	66% (57%–73%)	59% (51%–67%)
10^{-6} MRD (95% CI)	28% (21%–36%)	14% (9%–20%)	52% (44%–60%)	27% (20%–35%)	68% (59%–75%)	48% (40%–56%)	74% (66%–80%)	64% (55%–71%)	52% (44%–60%)	38% (31%–47%)

- Isa-KRd produced higher rates of MRD-negativity at every timepoint studied

Gay, F et al. Nat Med. 2026 May;32(5):1773-1782.

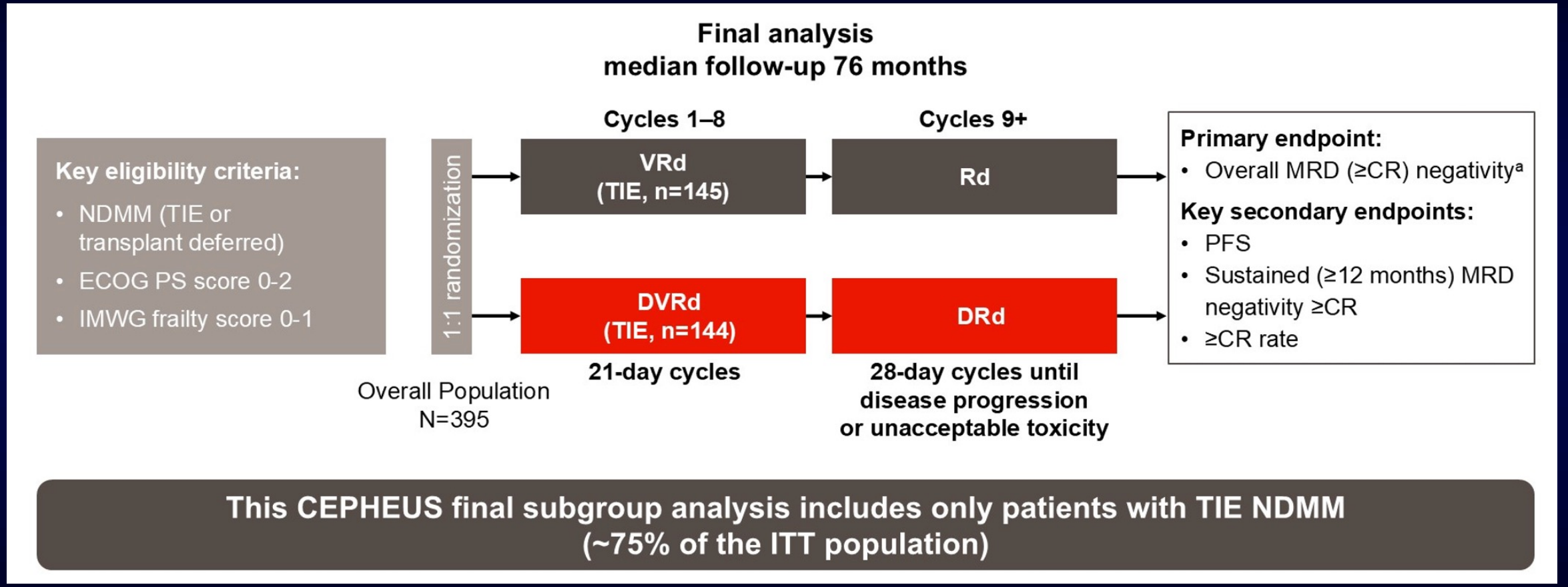
Outcomes : IsaKRd Better



Gay, F et al. Nat Med. 2026 May;32(5):1773-1782.

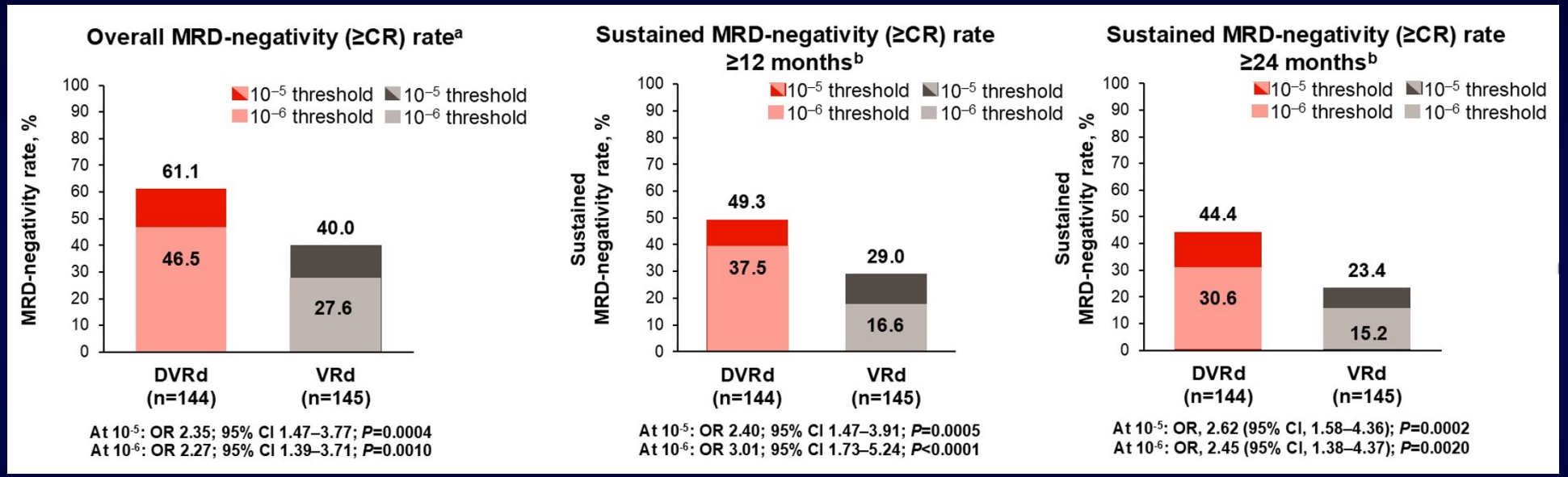
Quadruplet Therapy for Transplant-Ineligible Newly Diagnosed MM

CEPHEUS Update : DVRd in TIE NDMM



Usmani, SZ et al. ASCO 2026;Abstract 7513.

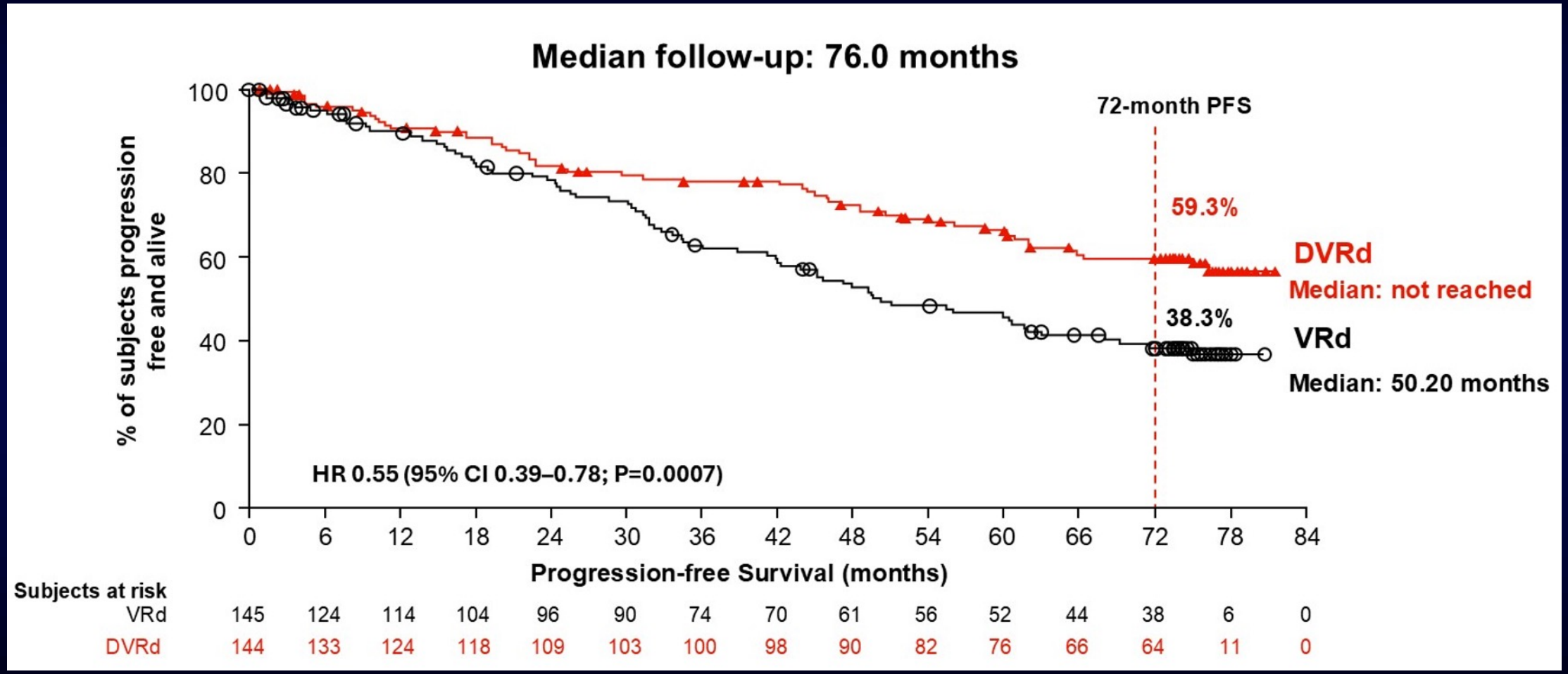
CEPHEUS Update : DVRd in TIE NDMM



- Better MRD-negative CR rate overall, and at 12 & 24 months

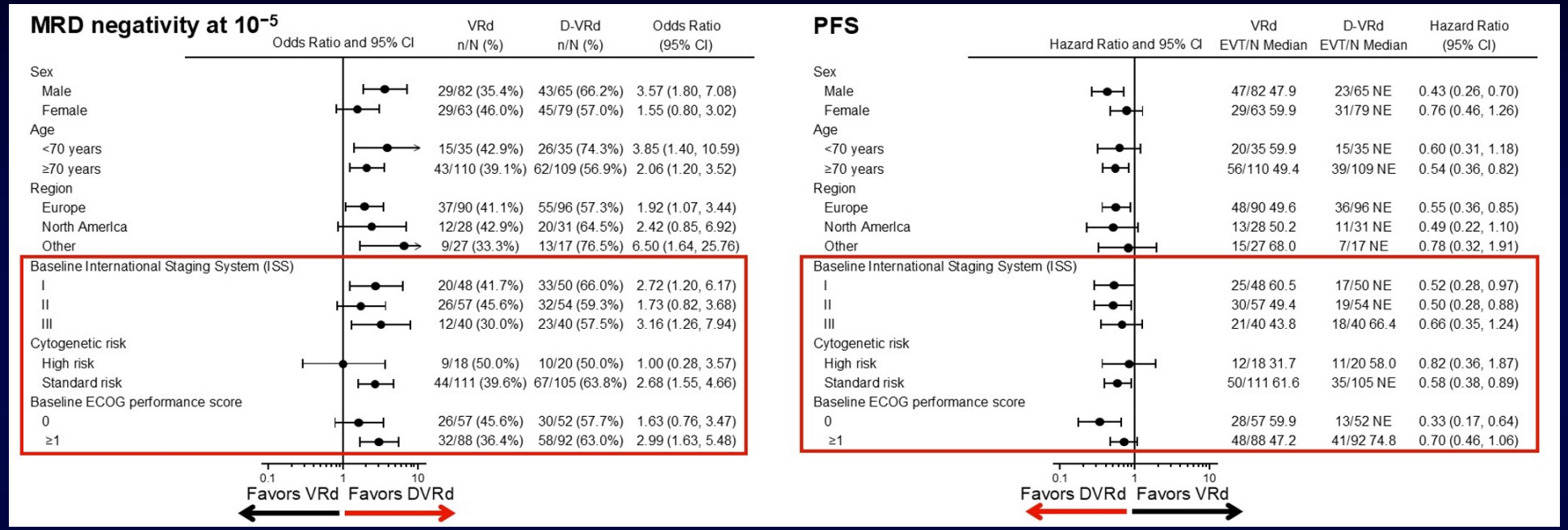
Usmani, SZ et al. ASCO 2026;Abstract 7513.

Final PFS & Subgroup Data



Usmani, SZ et al. ASCO 2026;Abstract 7513.

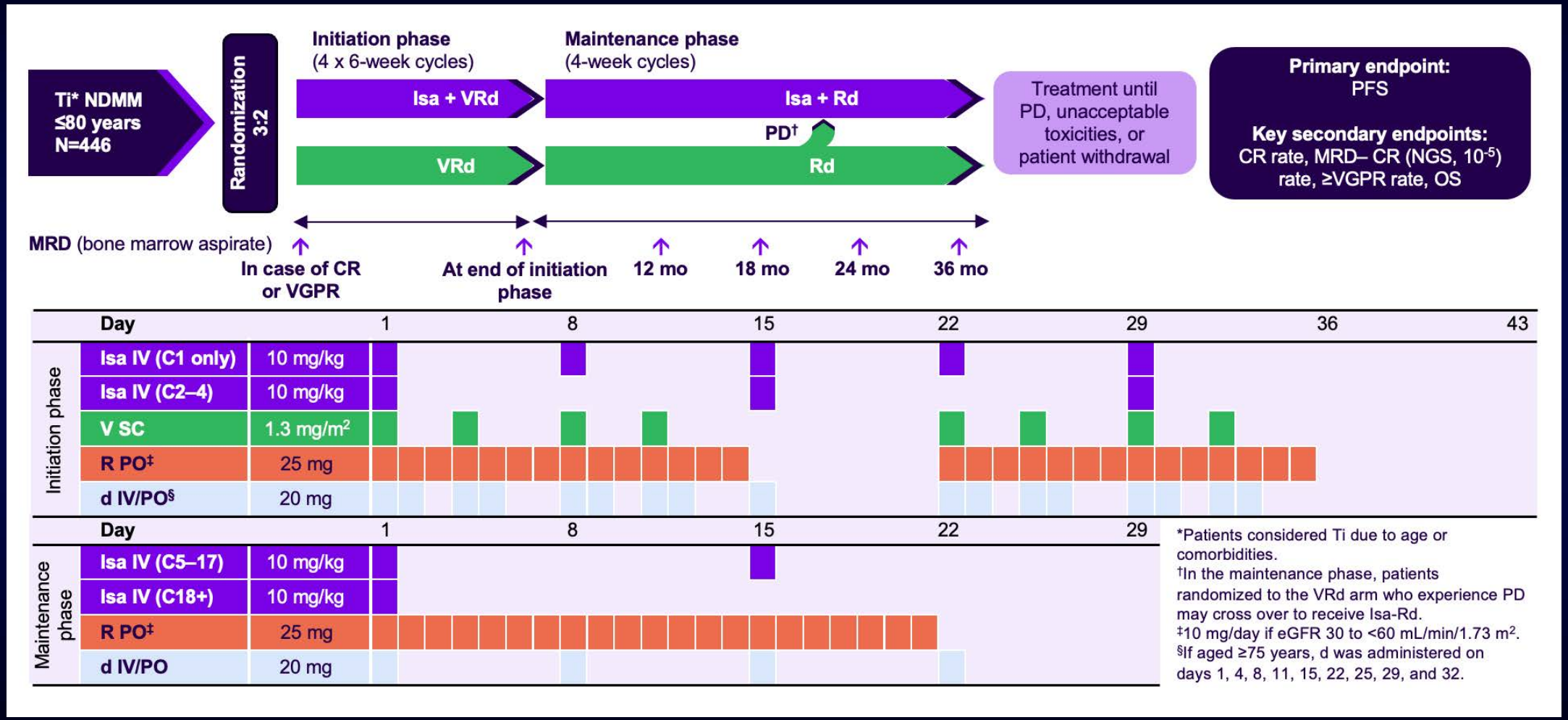
Final PFS & Subgroup Data



- Treatment effect consistent across most subgroups except a few where N was too small

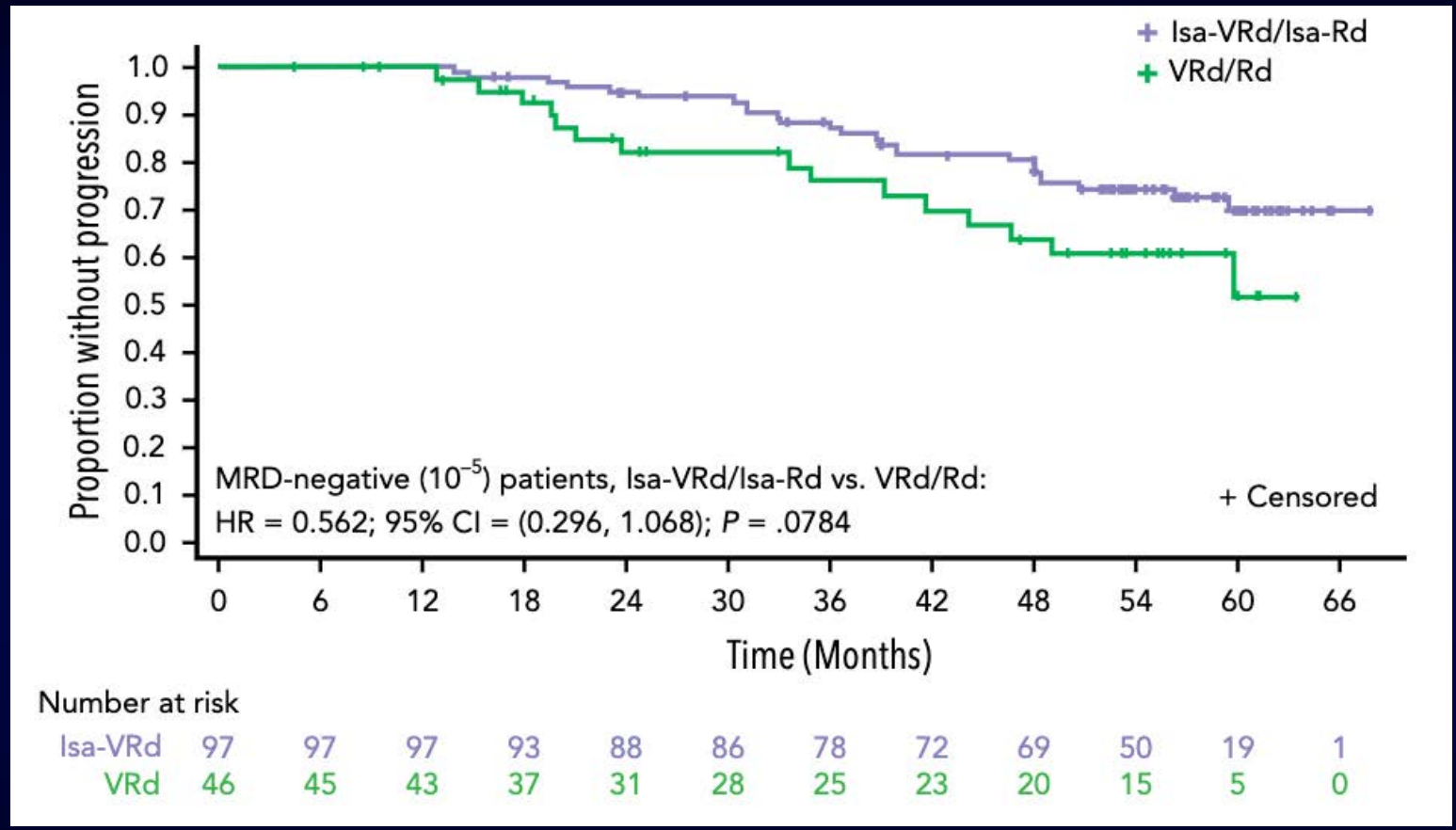
Usmani, SZ et al. ASCO 2026;Abstract 7513.

IMROZ : Isa-VRd Better During Induction



Orlowski, RZ et al. Blood. 2026 Jun 4;147(23):2760-2769.

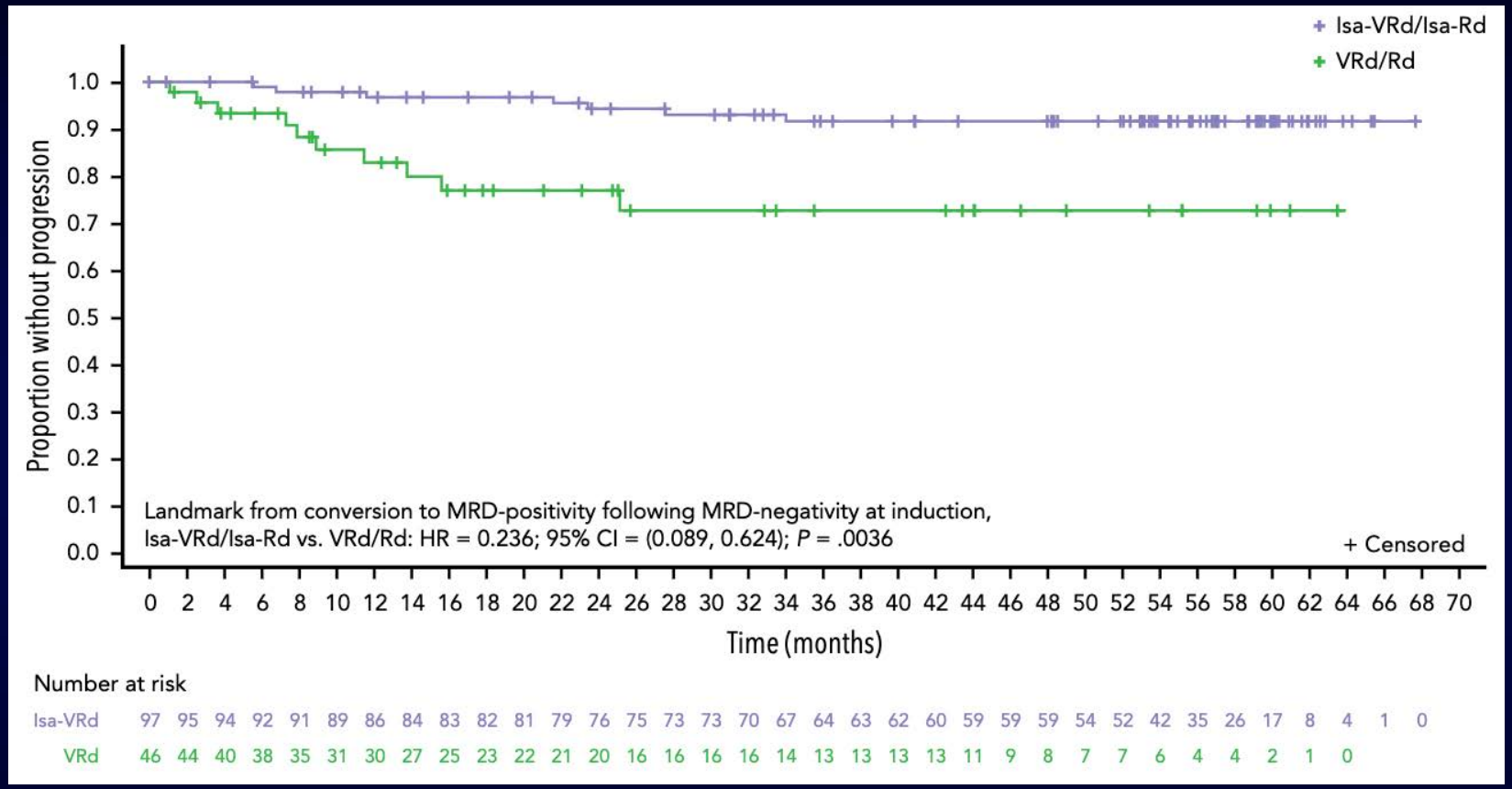
IMROZ : Isa-VRd Better During Induction



- PFS in patients by MRD-negativity (10^{-5}) @ 6 months

Orlowski, RZ et al. Blood. 2026 Jun 4;147(23):2760-2769.

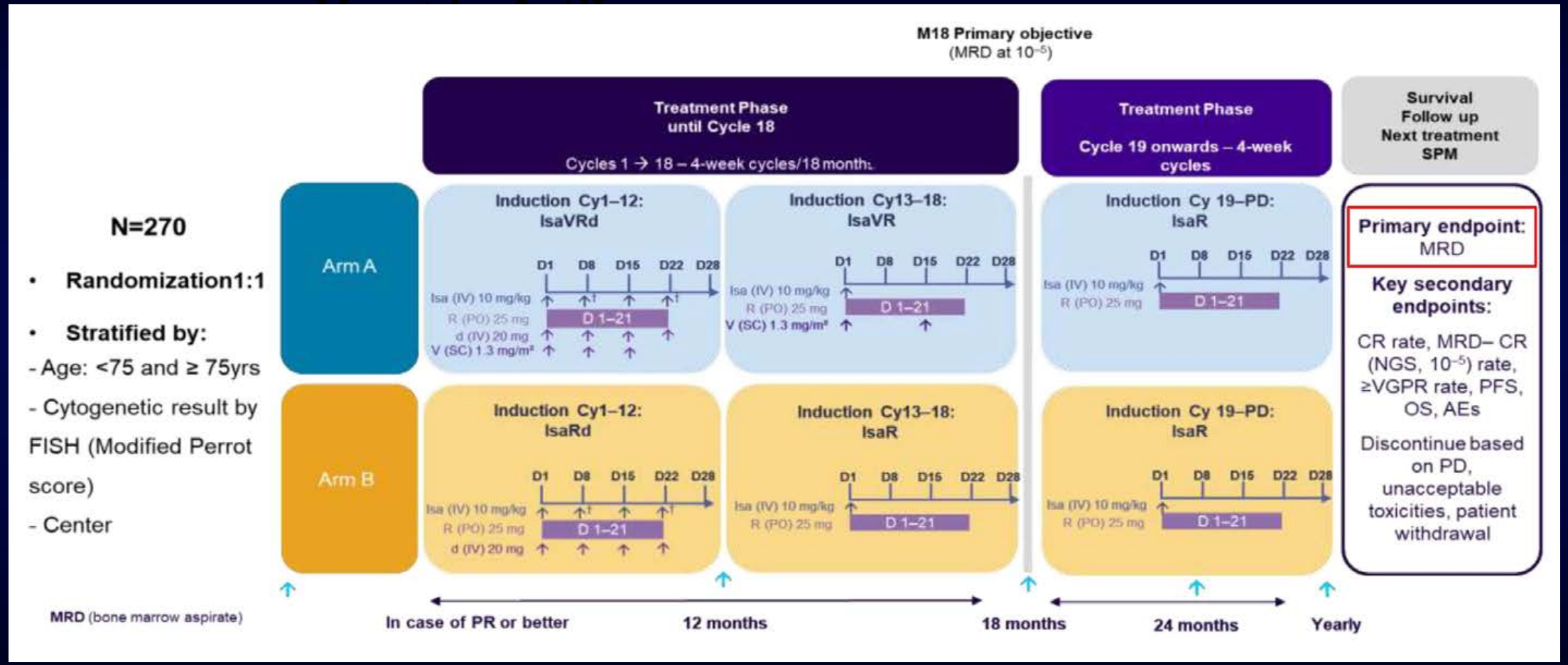
Isa-VRd Better Even After MRD+



- Group that converts from MRD- to MRD+ still does better if they had prior Isa-VRd

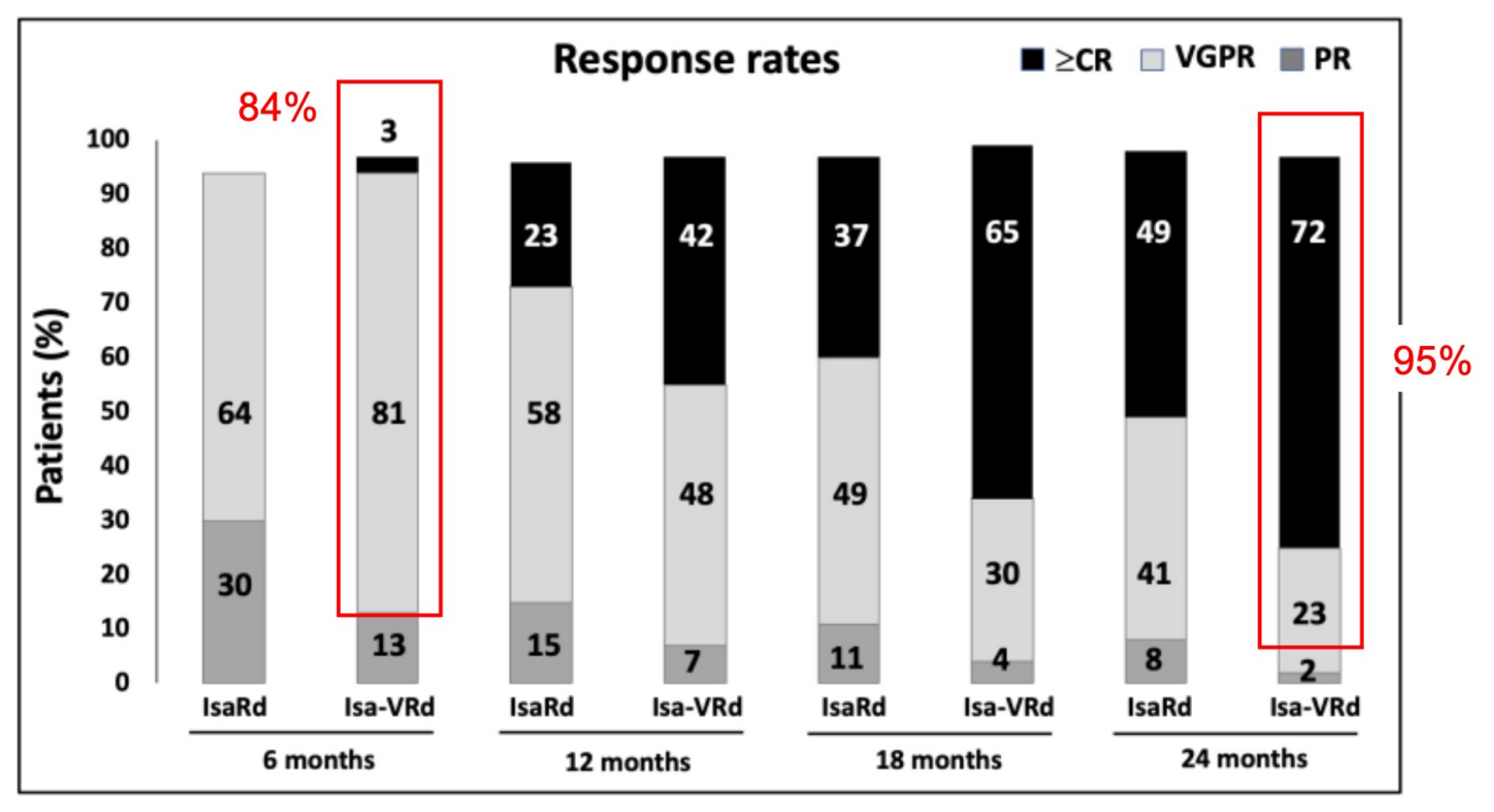
Orlowski, RZ et al. Blood. 2026 Jun 4;147(23):2760-2769.

BENEFIT Trial Update



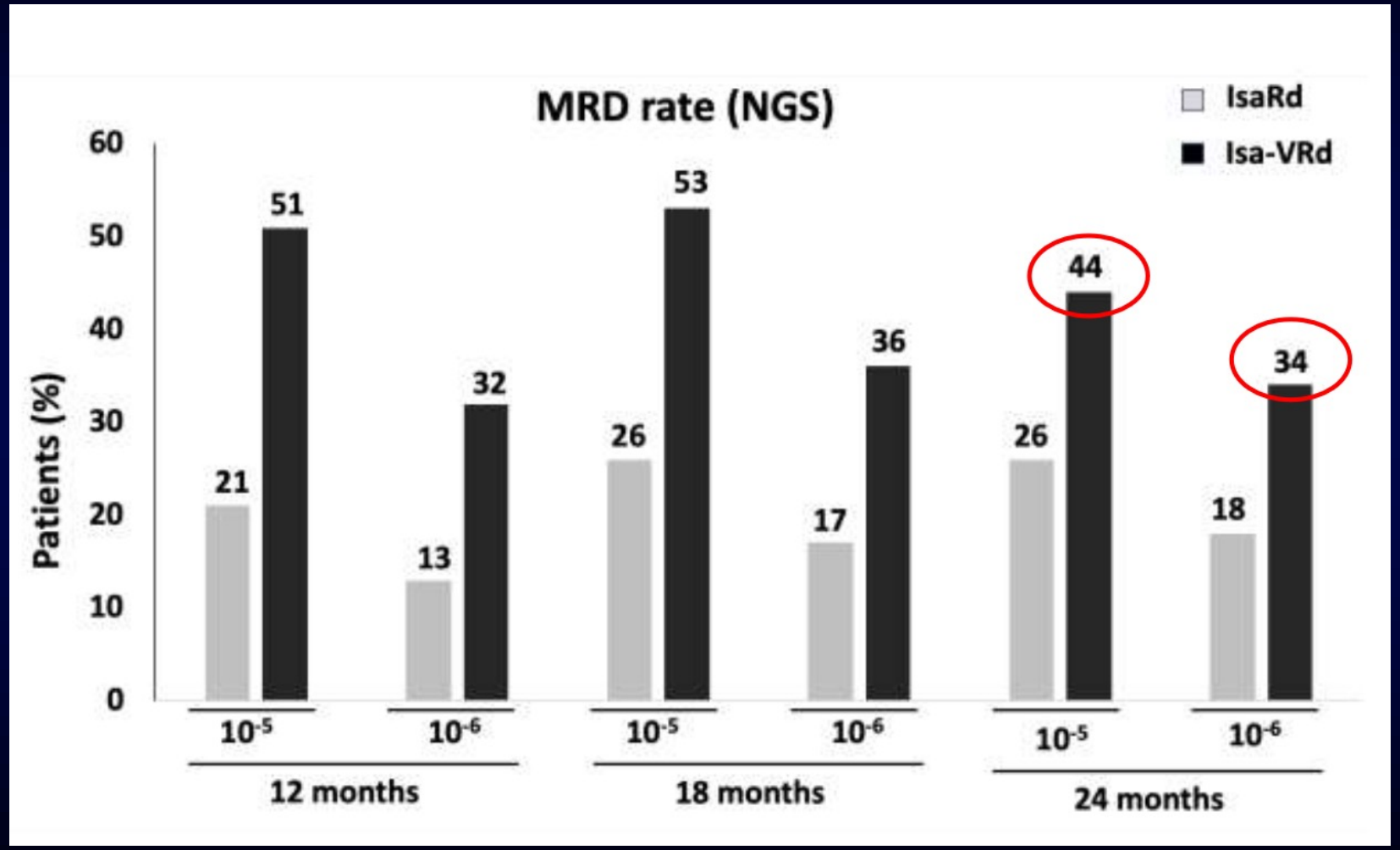
Bobin, A et al. ASH 2025;Abstract 368.

BENEFIT Trial Update



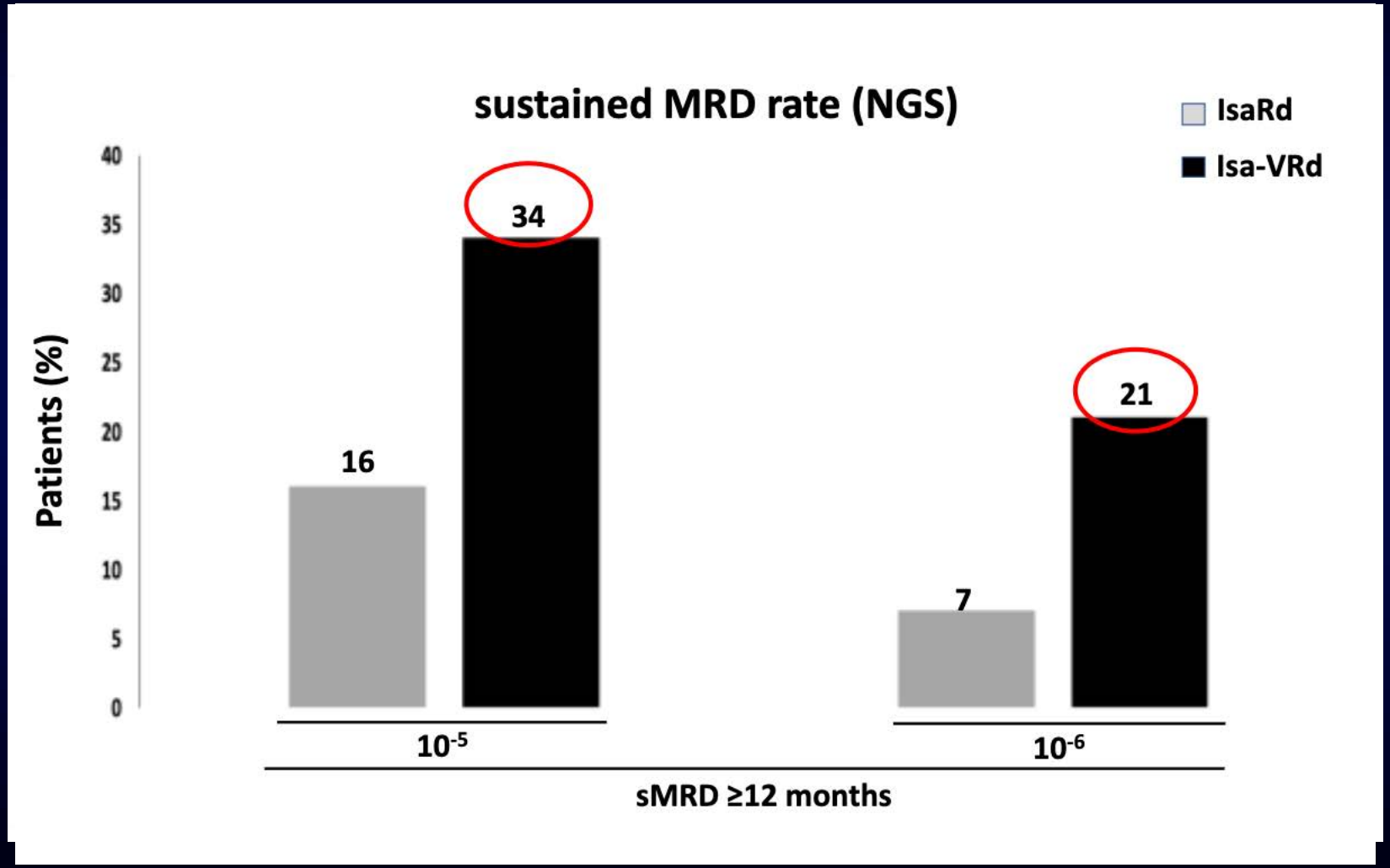
Bobin, A et al. ASH 2025;Abstract 368.

MRD & Sustained MRD^{-}



Bobin, A et al. ASH 2025;Abstract 368.

MRD & Sustained MRD^{-}



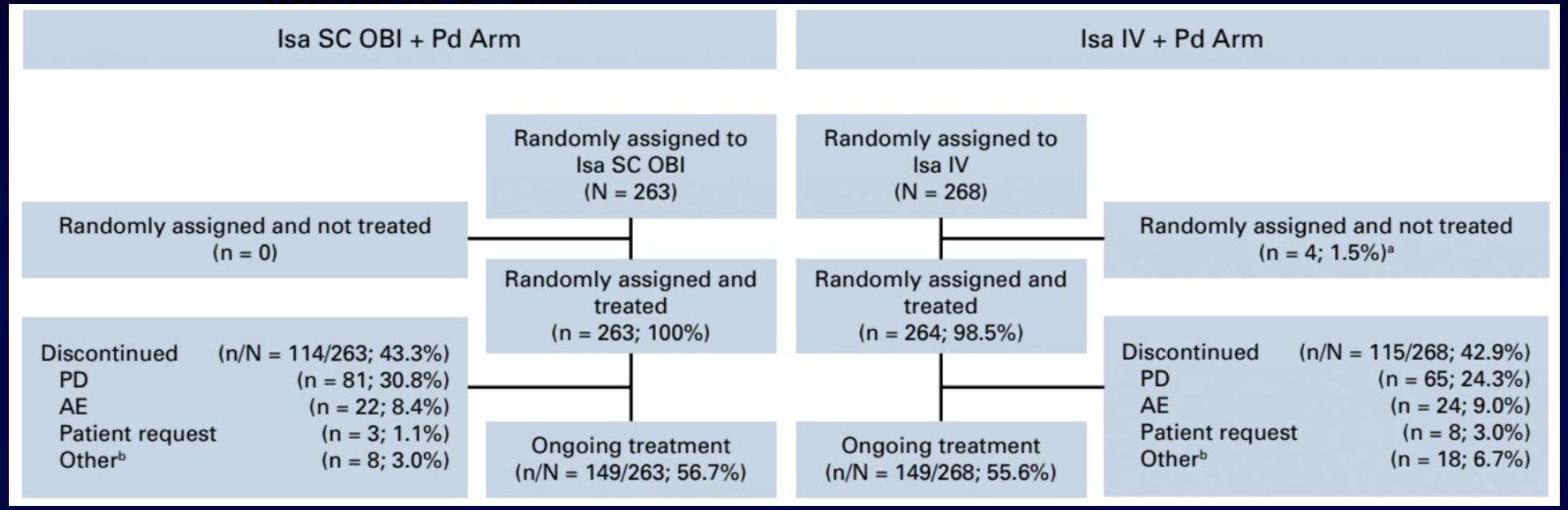
Bobin, A et al. ASH 2025;Abstract 368.

Subcutaneous Isatuximab

IRAKLIA : Isatuximab OBI

Ailawadhi, S et al. J Clin Oncol. 2025 Aug;43(22):2527-2537.

IRAKLIA : Isatuximab OBI

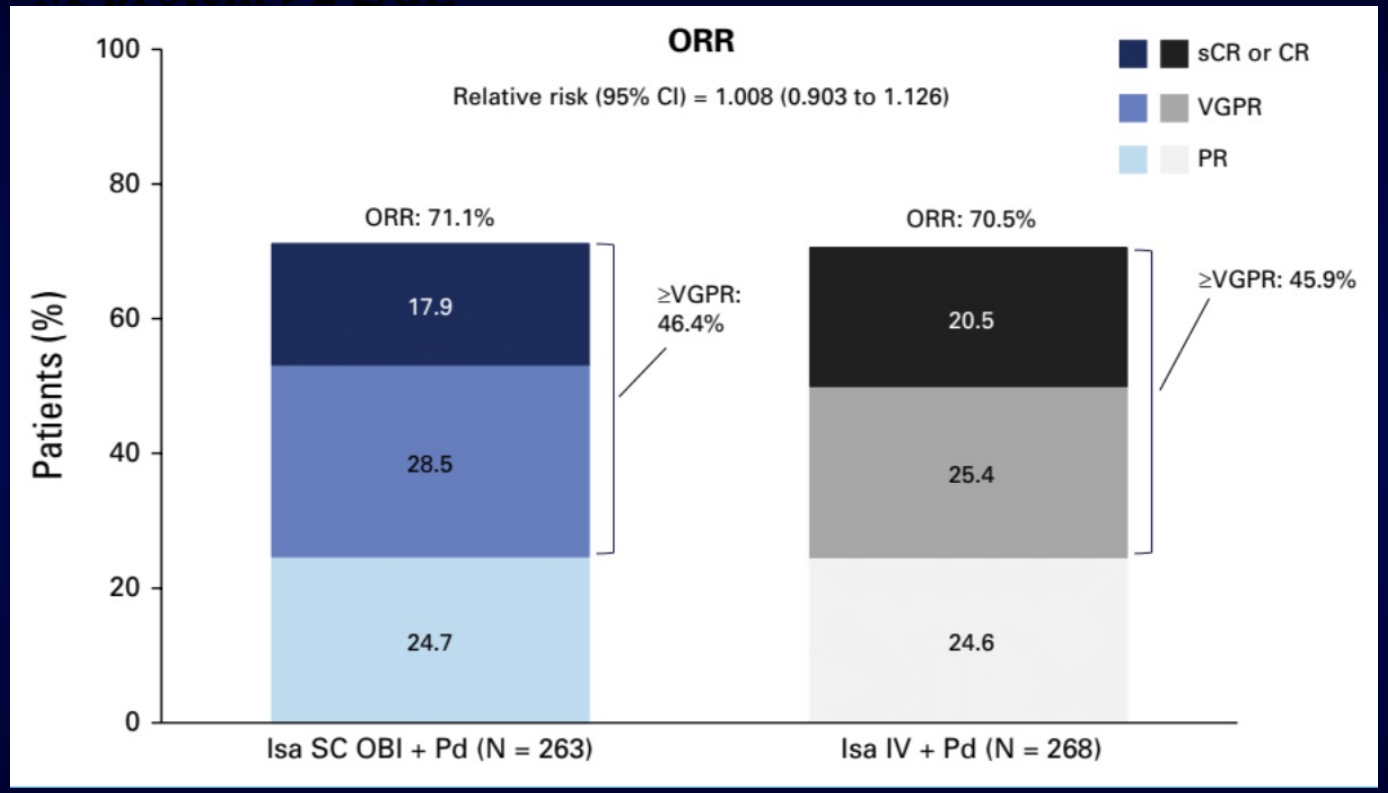


- Phase III study comparing Isa^{IV}Pd to Isa^{SC}Pd in patients with 1 or more prior lines, including lenalidomide and a PI

Ailawadhi, S et al. J Clin Oncol. 2025 Aug;43(22):2527-2537.

Results : Non-inferiority

M-protein >2 g/dL



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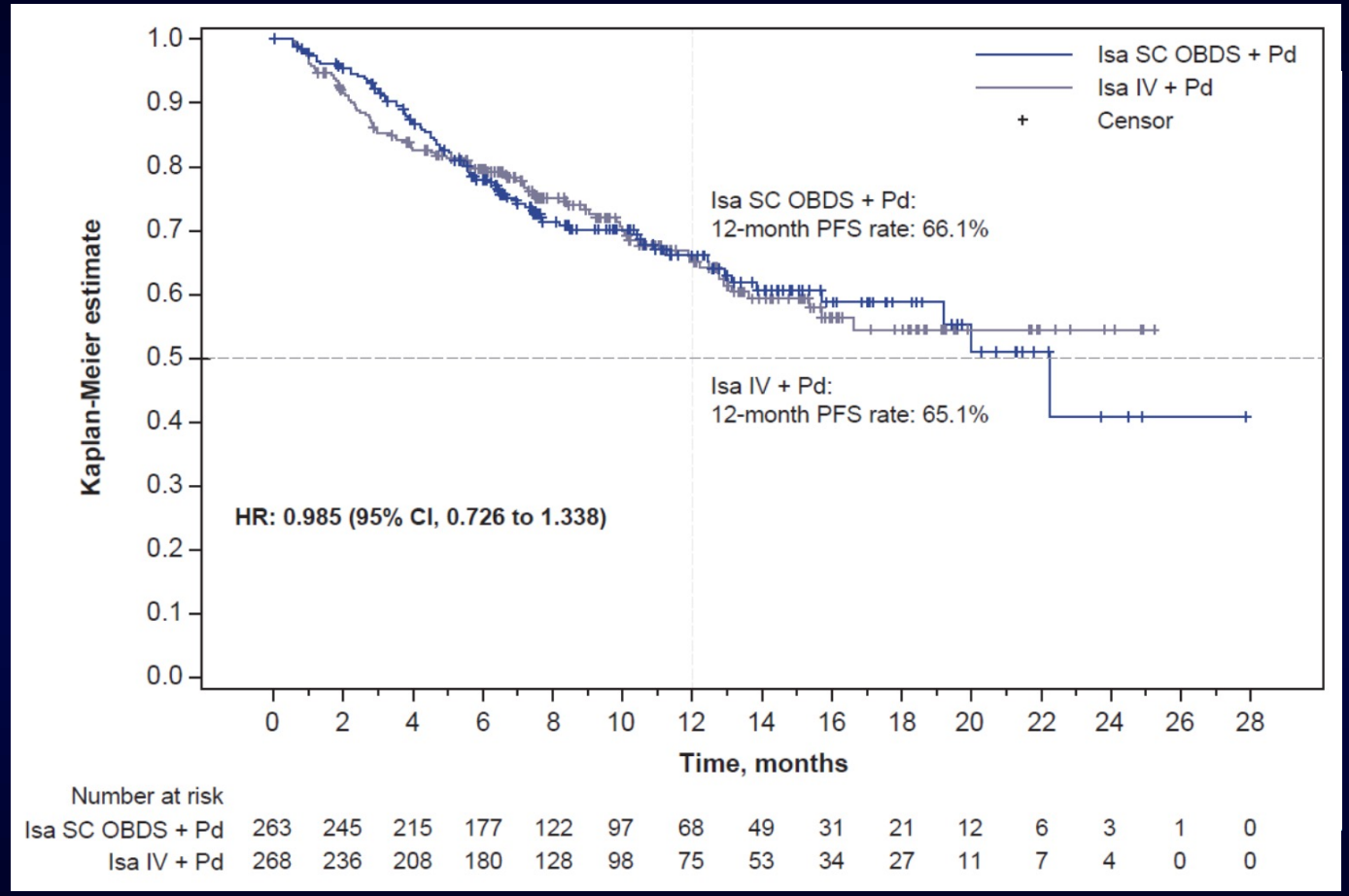

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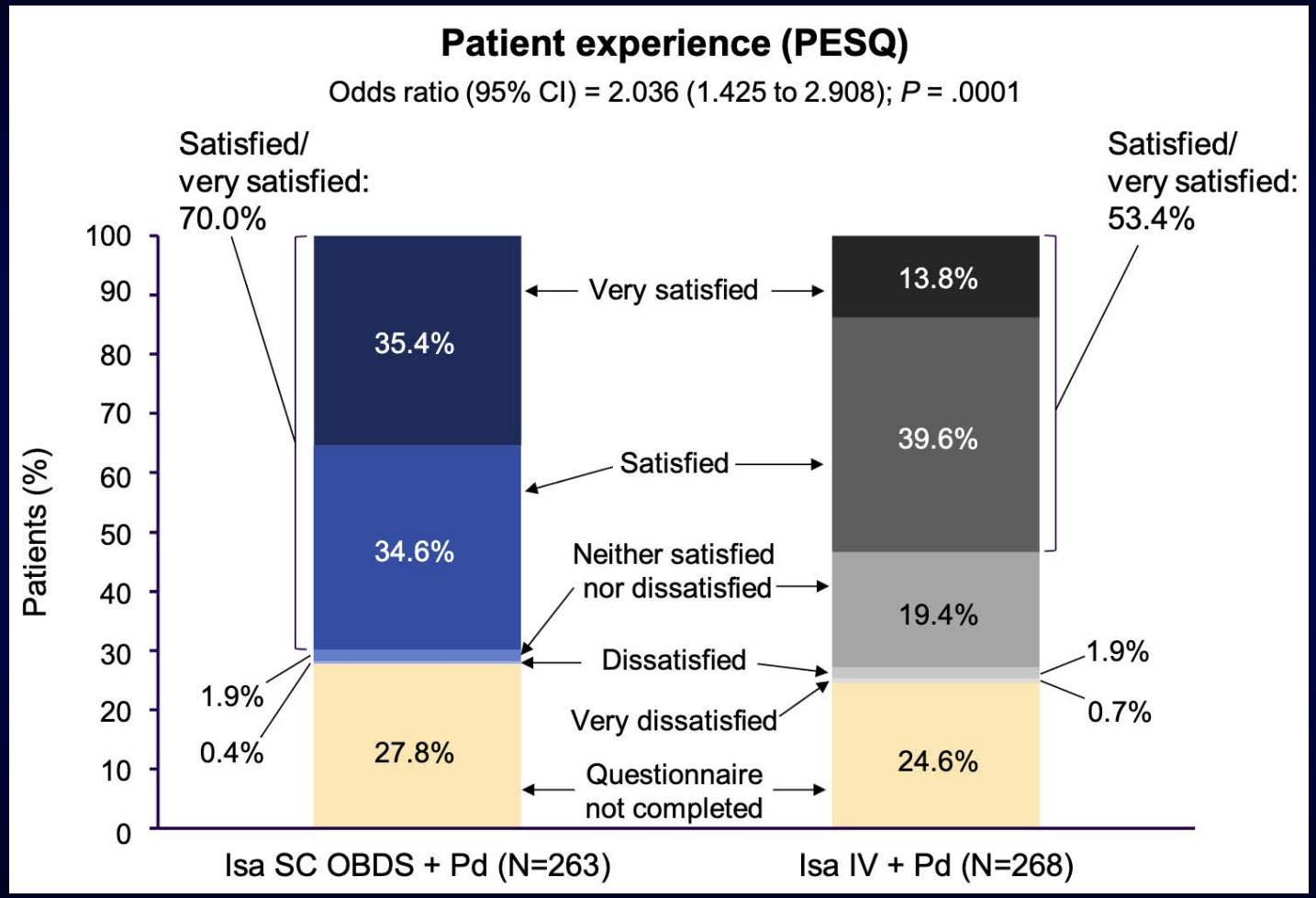
Results : Non-inferiority

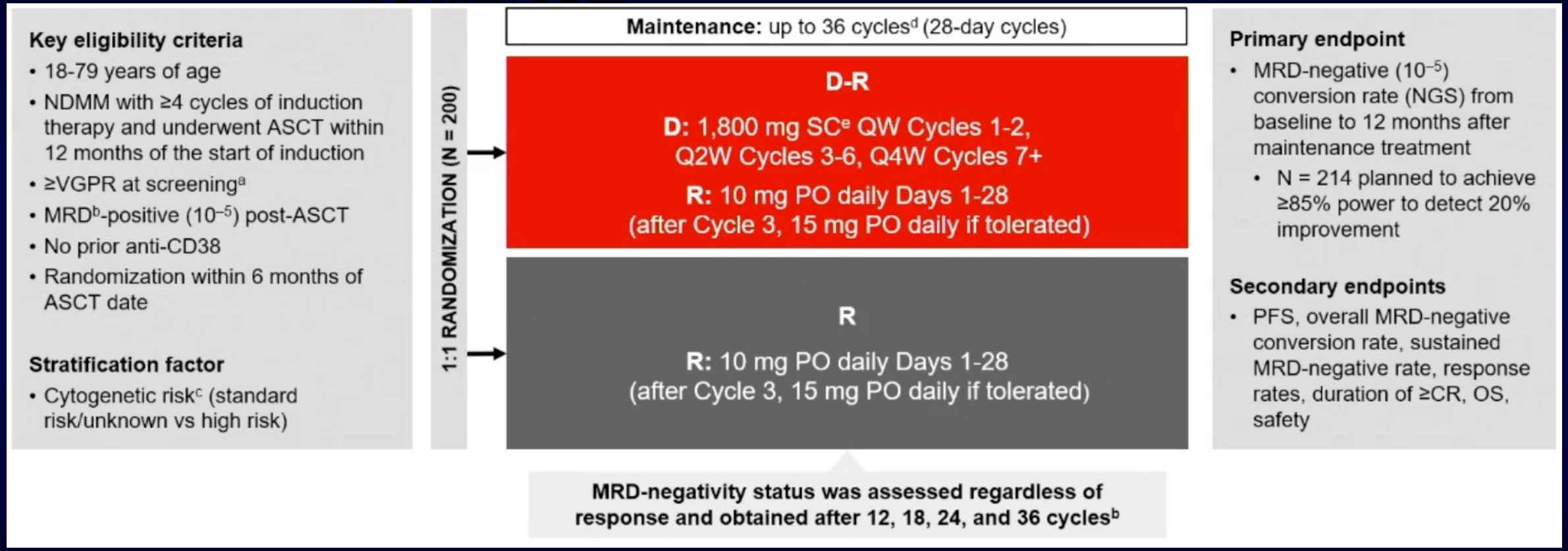


- Improved patient experience

Ailawadhi, S et al. J Clin Oncol. 2025 Aug;43(22):2527-2537.

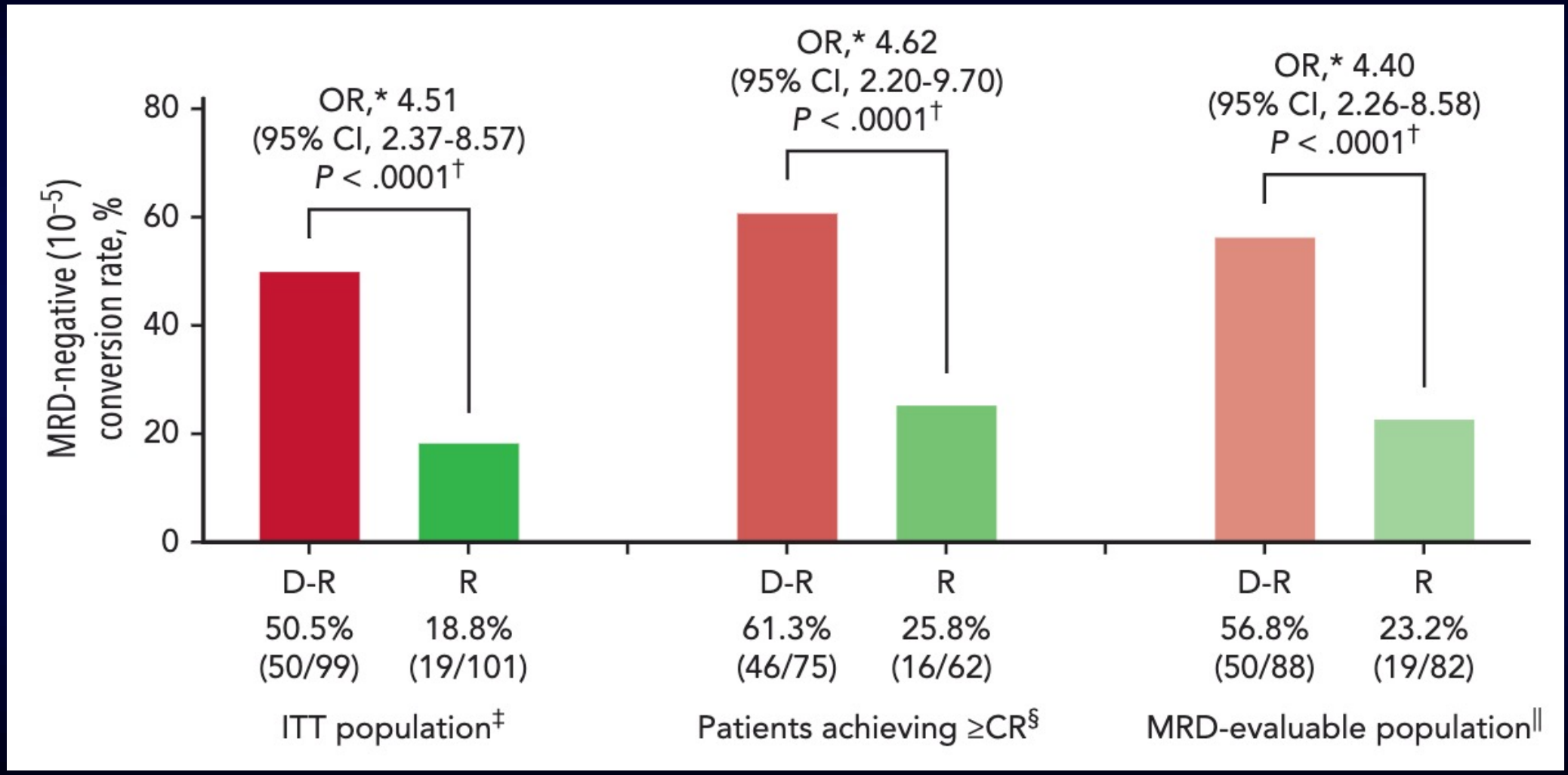
Addition of Daratumumab to Maintenance Therapy

AURIGA Study Update



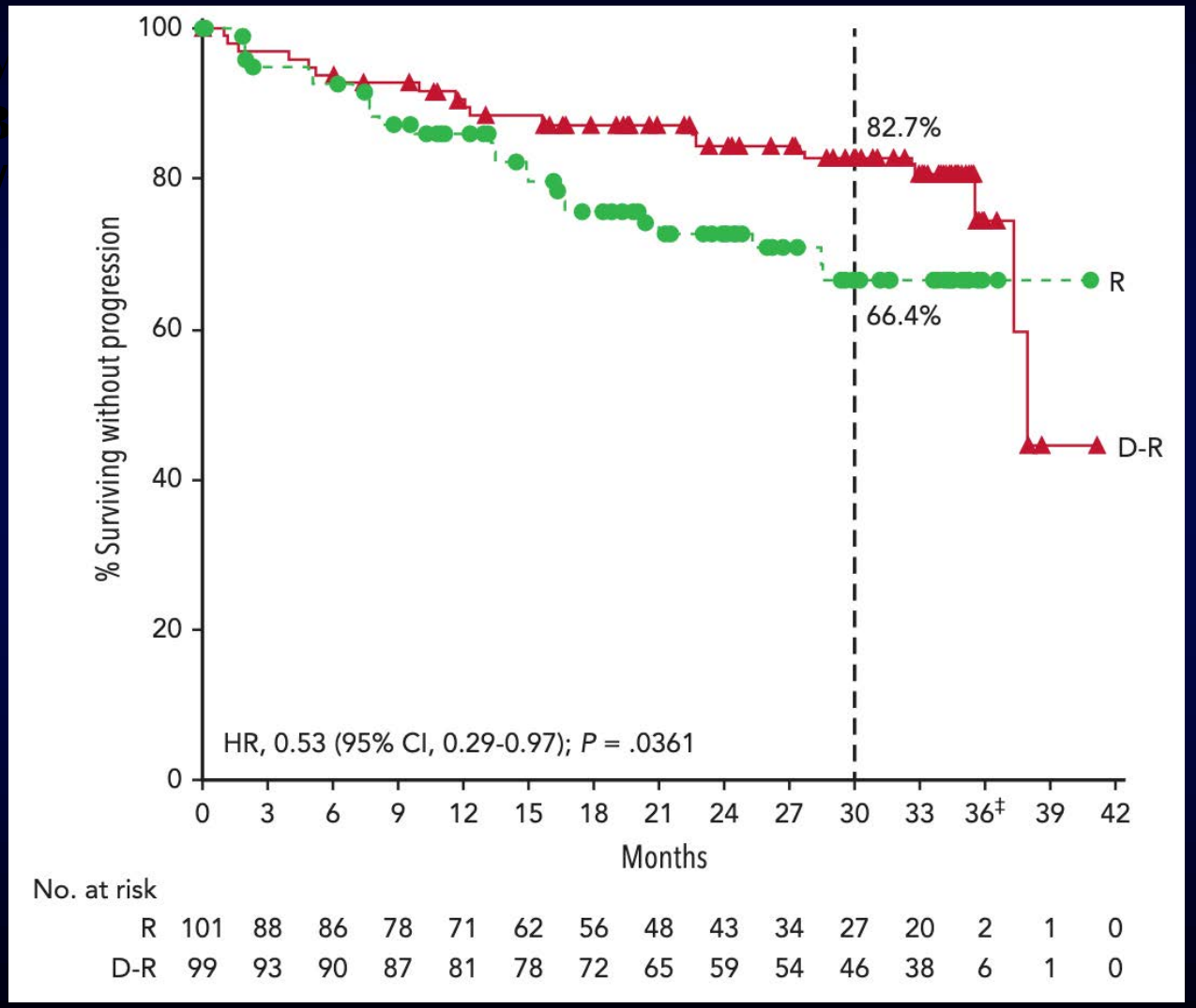
Badros, A et al. Blood. 2025 Jan 16;145(3):300-310.

AURIGA Study Update



Badros, A et al. Blood. 2025 Jan 16;145(3):300-310.

AURIGA Study Update



Badros, A et al. Blood. 2025 Jan 16;145(3):300-310.

Updated Data From IMS

M-protein >2 g/dL
BM PC >20%

- Per investigator assessment, a 45% reduction in the risk of PD or death was seen with D-R versus R, with estimated 36-mo PFS rates of 76.8% for D-R and 61.4% for R

Anderson, L et al. IMS 2025;Abstract OA-47.

CELMoDs for Relapsed/Refractory MM

SUCCESSOR-2 : MeziKD vs. Kd

	Mezigdomide–carfilzomib–dexamethasone (n=288)	Carfilzomib–dexamethasone (n=191)	All patients (N=479)
(Continued from previous page)			
Proteasome inhibitor (triple-class exposed)	265 (92%)	176 (92%)	441 (92%)
BCMA-targeted therapy§	23 (8%)	12 (6%)	35 (7%)
T-cell engager	12 (4%)	9 (5%)	21 (4%)
CAR T cell therapy	9 (3%)	3 (2%)	12 (3%)
Antibody-drug conjugate	5 (2%)	3 (2%)	8 (2%)
T-cell-redirecting therapy	28 (10%)	12 (6%)	40 (8%)
Refractory status¶			
Anti-CD38 antibody	248 (86%)	163 (85%)	411 (86%)
Immunomodulatory agent	247 (86%)	154 (81%)	401 (84%)
Lenalidomide	220 (76%)	143 (75%)	363 (76%)
Pomalidomide	99 (34%)	56 (29%)	155 (32%)
Proteasome inhibitor	138 (48%)	102 (53%)	240 (50%)
Triple-class refractory‖	111 (39%)	75 (39%)	186 (39%)
Refractory to last line of therapy	264 (92%)	181 (95%)	445 (93%)

- 1 or more prior lines (including anti-CD38 antibodies and lenalidomide) on which they had MR or better

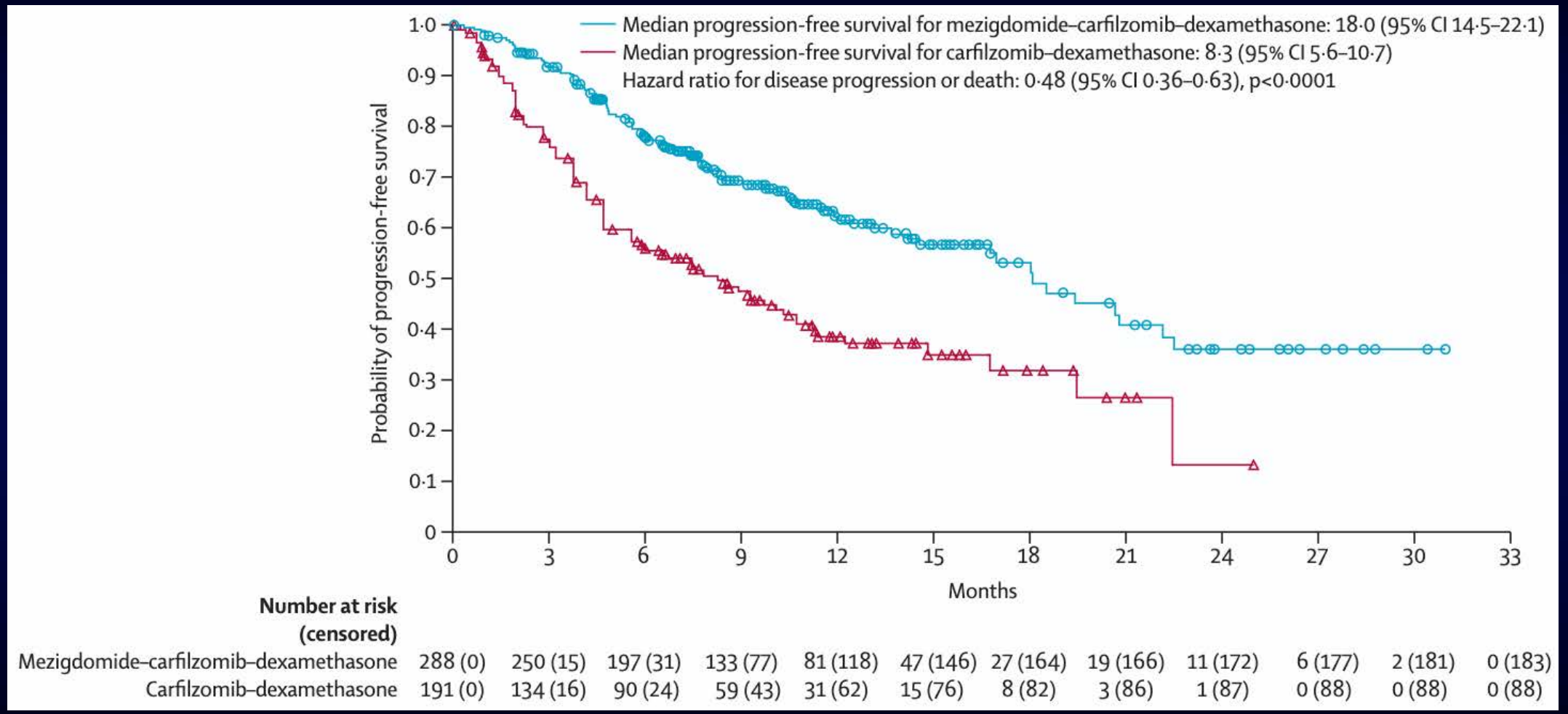
Dimopoulos, MA et al. Lancet. 2026 Jun 14:S0140-6736(26)01088-3.

Outcomes & AE Data

	Mezigdomide–carfilzomib–dexamethasone (n=288)	Carfilzomib–dexamethasone (n=191)	Difference*
Overall response†	231	102	..
Rate	80% (75–85)	53% (46–61)	27% (18–35)
Best response			
Stringent complete response	72 (25%)	16 (8%)	..
Complete response	5 (2%)	1 (1%)	..
Very good partial response	96 (33%)	42 (22%)	..
Partial response	58 (20%)	43 (23%)	..
Minimal response	6 (2%)	5 (3%)	..
Stable disease	38 (13%)	62 (32%)	..
Progressive disease	3 (1%)	14 (7%)	..
Not evaluable	2 (1%)	0	..
Missing	8 (3%)	8 (4%)	..
Complete response or better	77	17	..
Rate	27% (22–32)	9% (5–14)	18% (11–24)
Very good partial response or better	173	59	..
Rate	60% (54–66)	31% (24–38)	29% (20–37)
Time to response, months‡	1·1 (1·0–1·9)	1·1 (1·0–1·9)	..

Dimopoulos, MA et al. Lancet. 2026 Jun 14:S0140-6736(26)01088-3.

Outcomes & AE Data



Number at risk (censored)												
Mezigdomide–carfilzomib–dexamethasone	288 (0)	250 (15)	197 (31)	133 (77)	81 (118)	47 (146)	27 (164)	19 (166)	11 (172)	6 (177)	2 (181)	0 (183)
Carfilzomib–dexamethasone	191 (0)	134 (16)	90 (24)	59 (43)	31 (62)	15 (76)	8 (82)	3 (86)	1 (87)	0 (88)	0 (88)	0 (88)

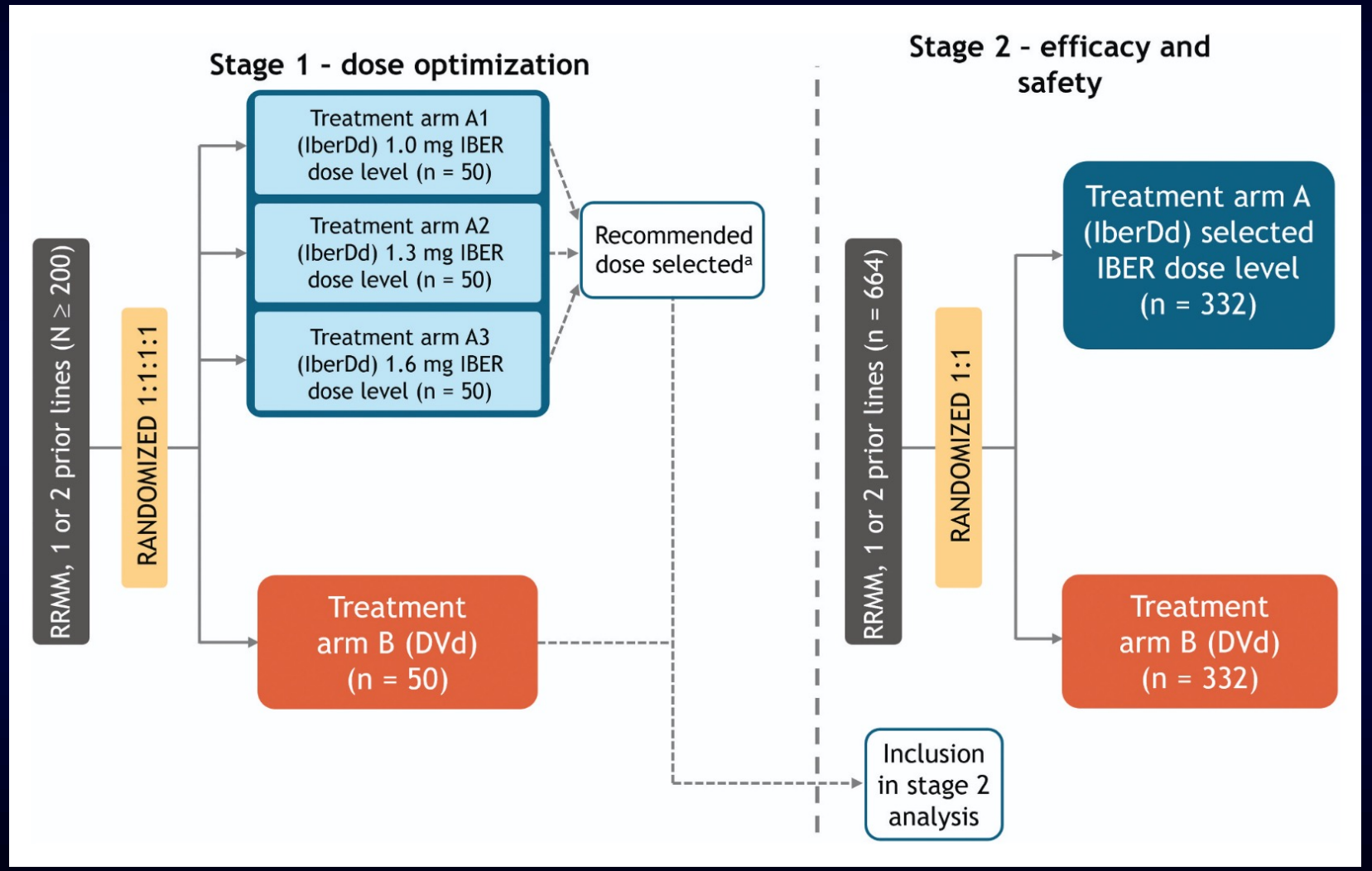
Dimopoulos, MA et al. Lancet. 2026 Jun 14:S0140-6736(26)01088-3.

Outcomes & AE Data

	Mezigdomide–carfilzomib–dexamethasone (n=288)		Carfilzomib–dexamethasone (n=186)	
	Any grade	Grade 3 or 4	Any grade	Grade 3 or 4
Patients with an adverse event	286 (99%)	241 (84%)	178 (96%)	105 (56%)
Haematological				
Neutropenia*	199 (69%)	176 (61%)	32 (17%)	17 (9%)
Thrombocytopenia†	174 (60%)	113 (39%)	77 (41%)	42 (23%)
Anaemia	149 (52%)	75 (26%)	66 (35%)	28 (15%)
White blood cell count decrease	67 (23%)	54 (19%)	23 (12%)	7 (4%)
Non-haematological				
Diarrhoea	112 (39%)	10 (3%)	33 (18%)	1 (1%)
Upper respiratory tract infection	79 (27%)	13 (5%)	31 (17%)	3 (2%)
Fatigue	67 (23%)	9 (3%)	39 (21%)	7 (4%)
Cough	66 (23%)	1 (<1%)	22 (12%)	0
Pneumonia	58 (20%)	45 (16%)	21 (11%)	11 (6%)
Dyspnoea	58 (20%)	11 (4%)	26 (14%)	5 (3%)
Hypertension	31 (11%)	11 (4%)	40 (22%)	17 (9%)
Patients with a serious adverse event	188 (65%)	157 (55%)	63 (34%)	52 (28%)
Pneumonia	44 (15%)	38 (13%)	12 (6%)	10 (5%)
Acute kidney injury	14 (5%)	13 (5%)	3 (2%)	3 (2%)
Thrombocytopenia†	13 (5%)	13 (5%)	3 (2%)	3 (2%)
Febrile neutropenia	13 (5%)	13 (5%)	0	0
Neutropenia*	11 (4%)	11 (4%)	0	0
Upper respiratory tract infection	11 (4%)	9 (3%)	0	0

Dimopoulos, MA et al. Lancet. 2026 Jun 14:S0140-6736(26)01088-3.

EXCALIBER-RRMM Study



Lonial, S et al. Future Oncol. 2025 Jun;21(14):1761-1769.

Phase III 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

Press Release: September 23, 2025

"[The manufacturer] today announced that the Phase 3 EXCALIBER-RRMM study evaluating iberdomide, an investigational cereblon E3 ligase modulator (CELMoD™), combined with standard therapies (daratumumab + dexamethasone) in patients with relapsed or refractory multiple myeloma (RRMM) demonstrated a **statistically significant improvement in minimal residual disease (MRD) negativity rates,** compared with the control arm, in a planned interim analysis of the MRD endpoint. In accordance with the trial design and based on the recommendation from the Data Monitoring Committee, the trial will continue without changes to evaluate the other dual-primary endpoint of progression-free survival (PFS), and the key secondary endpoint of overall survival and safety. The safety profile of iberdomide in combination with daratumumab and dexamethasone in this study is generally consistent with previous studies.

The company plans to discuss these results with health authorities."

https://news.bms.com/news/corporate-financial/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

CELMoDs for Newly Diagnosed MM

Phase I/II IDEAL Study : Iber-DVd

M-protein >2 g/dL

Key Eligibility Criteria

- TD/TIE NDMM
- Measurable disease
- Untreated or ≤ 1 previous cycle of any SOC regimens
- ECOG PS ≤ 2

Phase 1
3+3 Design

DL3 IBER 1.6mg[a] +DVd

DL2 IBER 1.3mg[a] +DVd

DL1 IBER 1.0 mg[a] +DVd

DL-1 IBER 0.75mg[a] +DVd

[a]Orally once daily, D1-21;
GCSF use was NOT permitted during the DLT evaluation period

Primary Endpoints

Phase 1: Maximal tolerated dose
Phase 2: Confirmed CR rate measured **by mass spectrometry-based assay** during induction

Secondary/Exploratory Endpoints

ORR, VGPR, PFS, OS, TTR, MRD- rate by next-generation flow cytometry(10^{-5}), and safety

Phase 2

Induction (C1-12)

Iberdomide: Oral at RP2D, Days 1-21

Daratumumab:1800 SQ q week (C1 & 2), q other week (C3-6), q4 weeks (C7-C12)

Bortezomib 1.3 mg/m^2 SQ weekly

Dexamethasone 40 mg oral weekly; 20 mg in patients ≥75 years

Cycle (C) length: 28 days May interrupt therapy for stem cell collection anytime after completion of C4

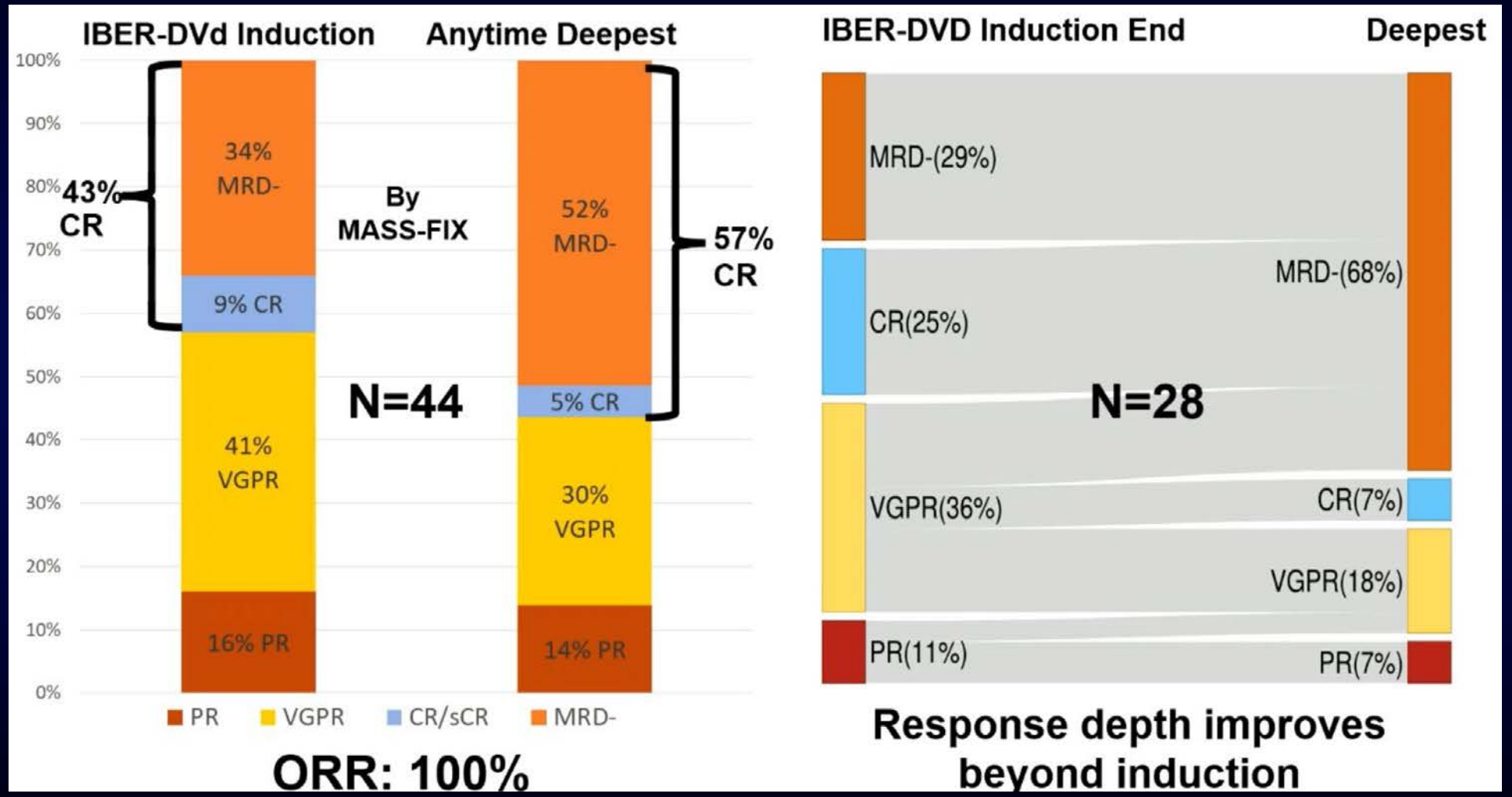
Maintenance (C13-36)

Iberdomide:1 mg (max) orally, Days 1-21

Cycle (C) length: 28 days

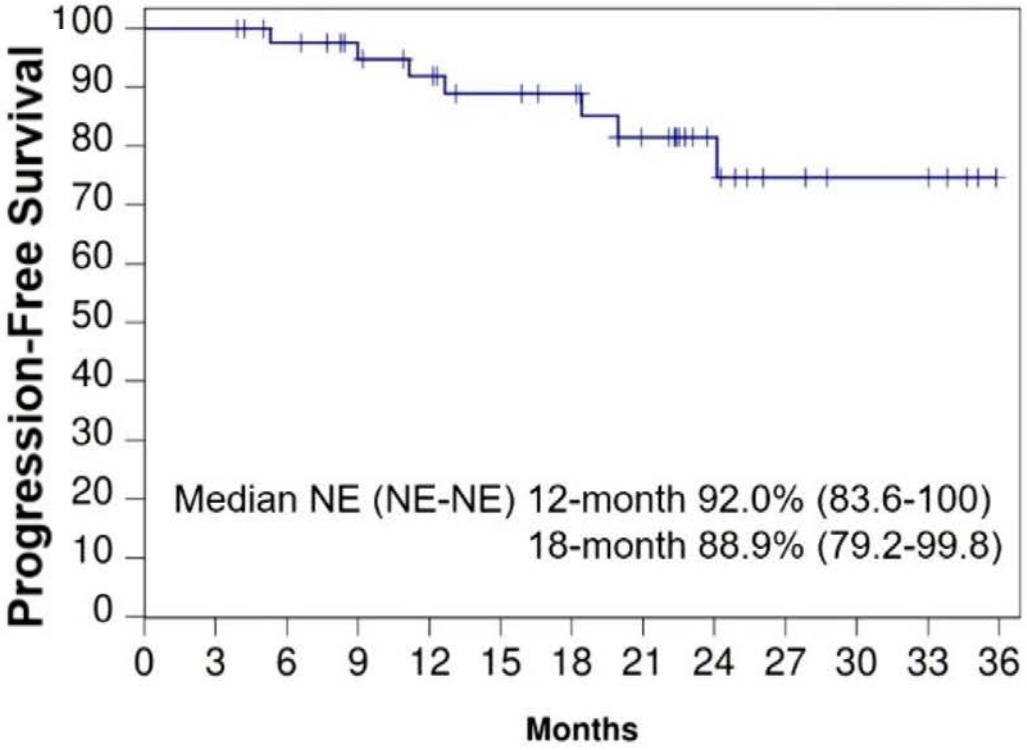
Kapoor, P et al. EHA 2026;Abstract S199.

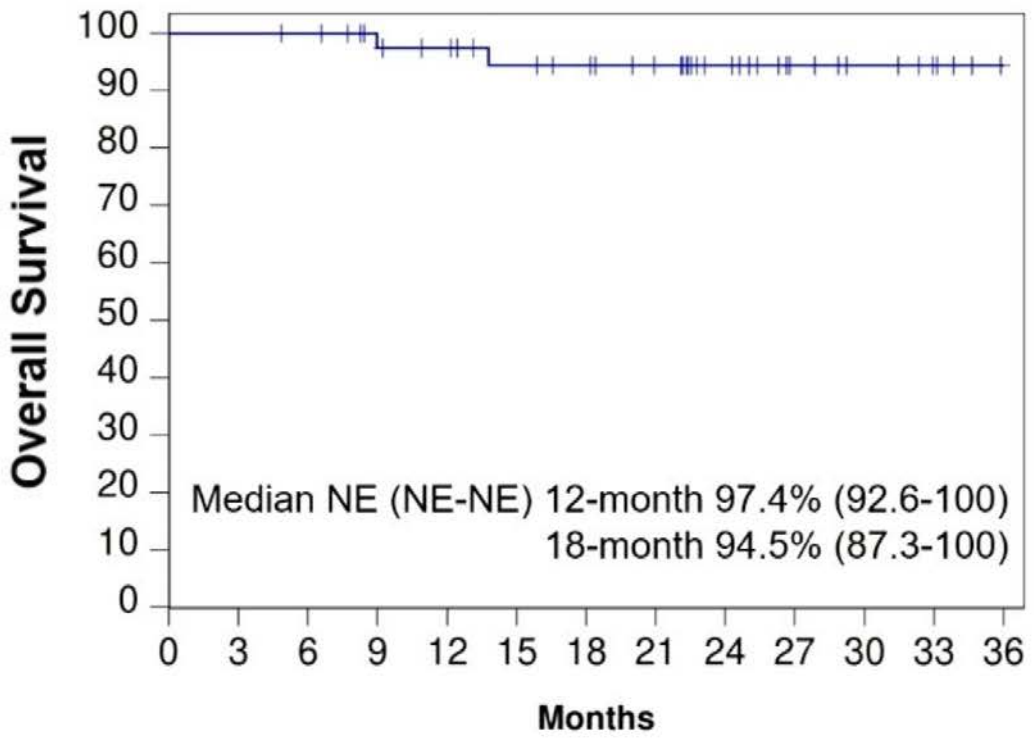
Phase I/II IDEAL Study : Iber-DVd



Kapoor, P et al. EHA 2026;Abstract S199.

Long-term Data & AEs





Median follow up for alive patients 22.8 months

Kapoor, P et al. EHA 2026;Abstract S199.

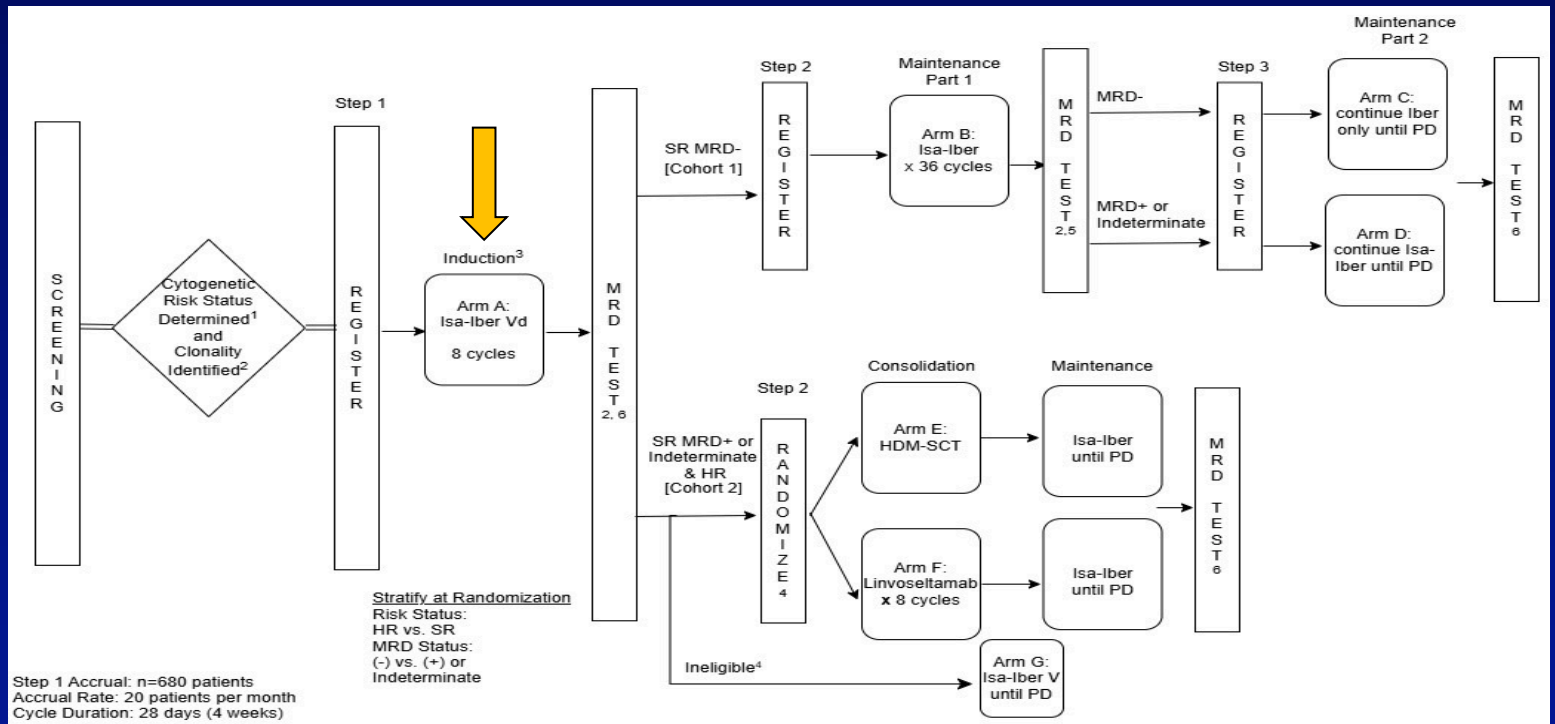
Long-term Data & AEs

Common Treatment-Emergent Adverse Event[a] n (%)	Iber-DVd NDMM (N=44)		
	All Grade	Grade 3	Grade 4
Any TEAE	44 (100)	40 (90.9)	16 (36.4)
Hematologic TEAEs	39 (88.6)	34 (77.3)	13 (29.5)
Neutropenia	34 (77.3)	18 (40.9)	8(18.2)
Anemia	4 (9)	2 (4.5)	0
Lymphopenia	34 (77.3)	21 (47.7)	3 (6.8)
Leukopenia	30 (68.1)	10 (22.7)	3 (6.8)
Thrombocytopenia	6 (13.6)	1 (2.3)	2 (4.5)
All Infections	16 (36.4)	6 (13.6)	1 (2.3)
Lung Infection[b]	6 (13.6)	4 (9.1)	0
URTI	4 (9)	1 (2.3)	0
Skin Infections	2 (4.5)	0	0
UTI	3 (6.8)	2 (4.5)	0
Conjunctivitis	1 (2.3)	0	0
Other Infections/Infestations	6 (13.6)	1 (2.3)	1 (2.3)

Common TEAEs and TEAEs of interest[a] n(%)	IberDVd NDMM (N=44)		
	All Grade	Grade 3	Grade 4
Any non-hematologic TEAE	44 (100)	29 (65.9)	5 (11.4)
Gastrointestinal	35 (79.5)	4 (9.1)	1 (2.3)
Nausea	27 (61.3)	1 (2.3)	0
Vomiting	13 (29.5)	0	0
Diarrhea	23 (52.3)	2 (4.5)	0
Constipation	4 (9.1)	0	1 (2.3)
Fatigue	13 (29.5)	2 (4.5)	0
Rash[c]	31 (70.5)	3 (6.8)	0
Peripheral Sensory Neuropathy	33 (75.0)	1 (2.3)	0
Venous Thromboembolism	3 (6.8)	2 (4.5)	0
Second Primary Malignancies	0	0	0

Kapoor, P et al. EHA 2026;Abstract S199.

DETERMINATION 2 Schema (Revised for N = 720 Patients)



[1]Cytogenetic risk status based on FISH and next-generation sequencing (NGS) by PlasmaSEQ (TP53 mutational testing); Patients without risk established at screening are registered as Standard-Risk (SR)

[2]Clonality ID type test and all subsequent MRD tests based on NGS using Adaptive Biotechnologies clonoSEQ® assay; Patients with no dominant sequences identified at screening will be followed by next-generation flow cytometry (NGF)

[3]Stem cell mobilization to occur between 4-6 cycles of induction

[4]Only eligible patients are randomized to consolidation; Ineligible patients may continue on-study in Arm G

[5]Step 2 treatment and Step 3 [Cohort 1] assignments are dependent on post-induction and post-3 years maintenance MRD tests, respectively; Patients therefore must have completed treatment per protocol to be eligible to continue on study; Only patients who achieve IMWG very good partial response (VGPR) or better status require an evaluable sample at these timepoints for MRD testing; Patients with indeterminate MRD test results along with patients not achieving IMWG VGPR status are assumed to be MRD-positive

[6]MRD test conducted 1-year post-registration [Cohort 1] and 1-year post-randomization [Cohort 2] for the outcome of MRD-negative complete response (CR); Only patients who achieve IMWG VGPR or better status require an evaluable sample at these timepoints for MRD testing

Courtesy of Paul G Richardson, MD

DETERMINATION 2
Discussion Points

- **Isatuximab-iberdomide Vd backbone**
- **MRD guided**
- **Linvoseltamab versus autologous stem cell transplant**

Year in Review:
Multiple Myeloma

INTRODUCTION: Up-Front PFS for Standard-Risk Disease — 2006, 2016

MODULE 1: Current and Emerging Therapeutic Approaches — Dr Orlowski

MODULE 2: Chimeric Antigen Receptor T-Cell Therapy, Bispecific Antibodies and Antibody-Drug Conjugates — Dr Krishnan

MODULE 3: ASCO and EHA 2026

Myeloma Updates ASCO/EHA

Amrita Krishnan MD FACP :

Director Judy and Bernard Briskin Center for Myeloma City of Hope Cancer Center:
Professor of Hematology/HCT: Nason Hollingsworth Family Chair in Myeloma

Long-Term Outcomes with Ciltacabtagene Autoleucel (Cilta-cel) CAR T-Cell Therapy

CAR T CELLS

"All the News That's Fit to Print"

The New York Times

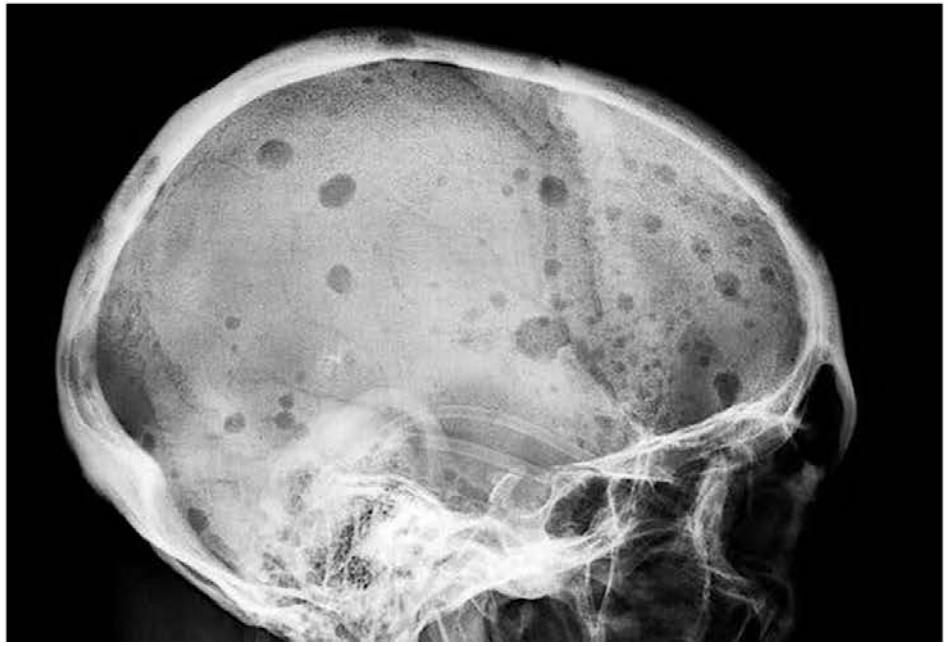
THE WEATHER
Today, very warm, humid, high 89. **Tonight,** partly cloudy, warm, low 70. **Tomorrow,** warm, humid, some sun, a spotty thunderstorm, high 86. Weather map appears on Page A19.

VOL. CLXXIV .... No. 60,541 THURSDAY, JUNE 5, 2025

Prices in Canada may be higher $4.00

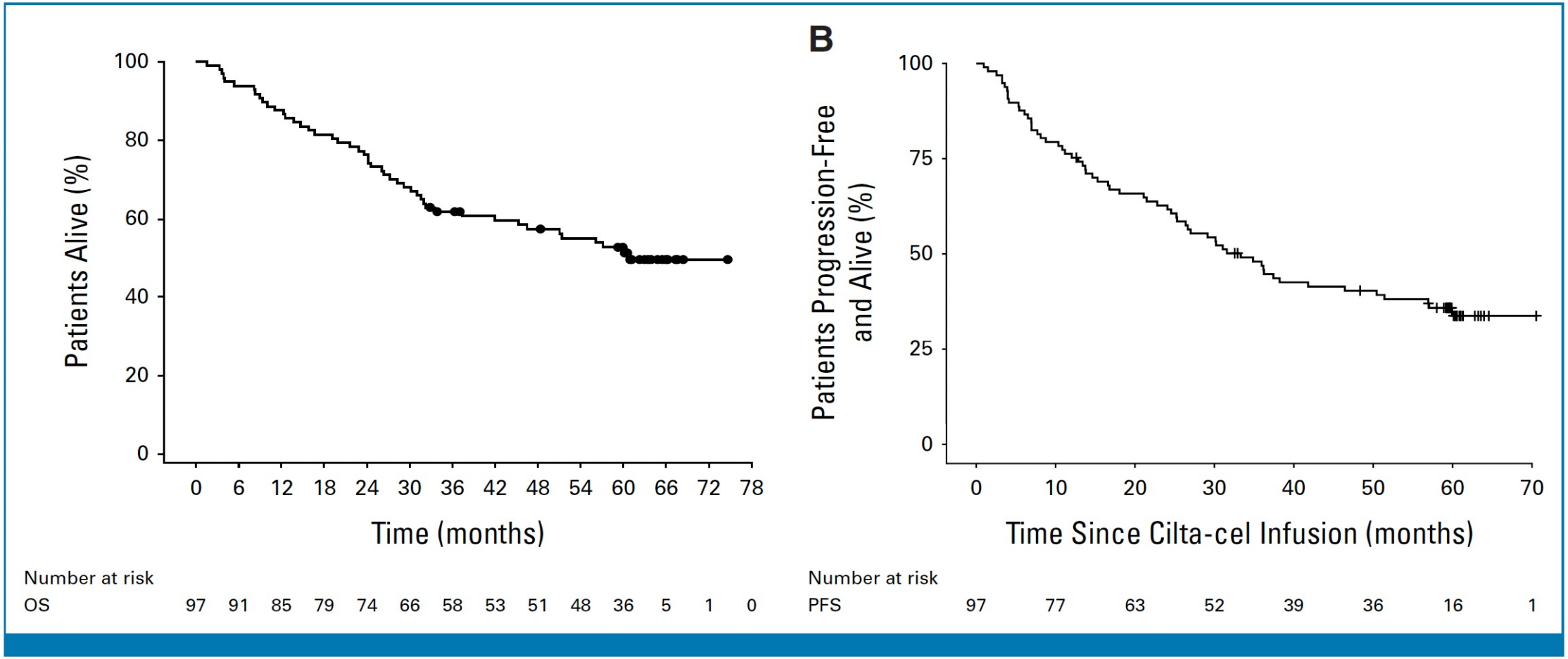
From No Hope to a Potential Cure for a Deadly Blood Cancer

Multiple myeloma is considered incurable, but a third of patients in a Johnson & Johnson clinical trial have lived without detectable cancer for years after facing certain death.



An X-ray of the skull of a patient with multiple myeloma, showing its telltale bone lesions, in dark patches. "This is the first time we are really talking seriously about cure in one of the worst malignancies imaginable," said one doctor.

Long Term Remission after Cilta-cel

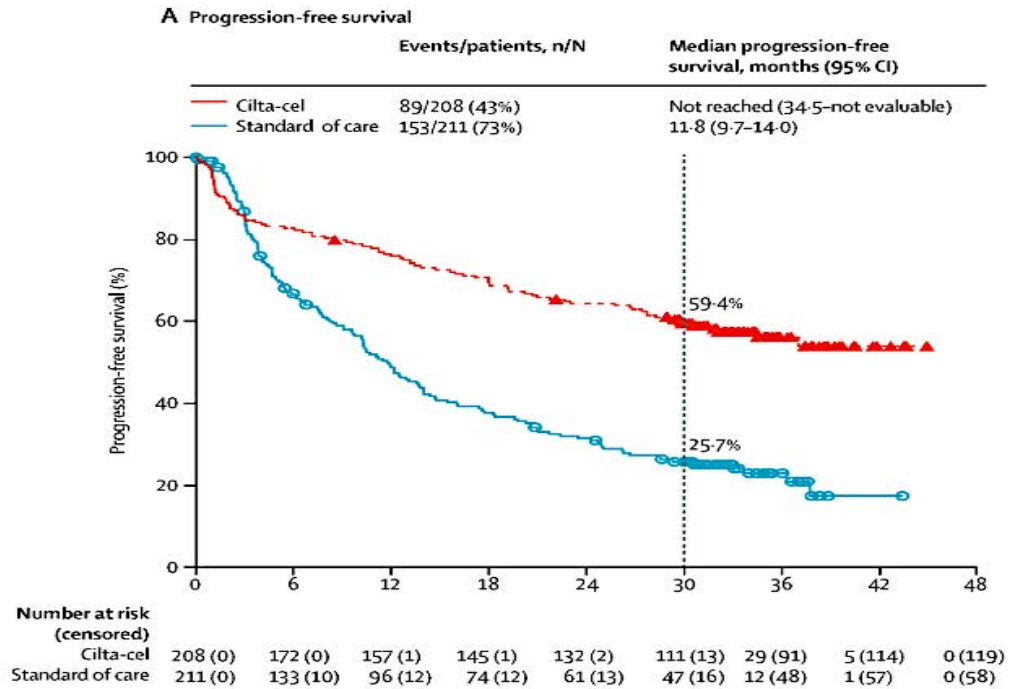


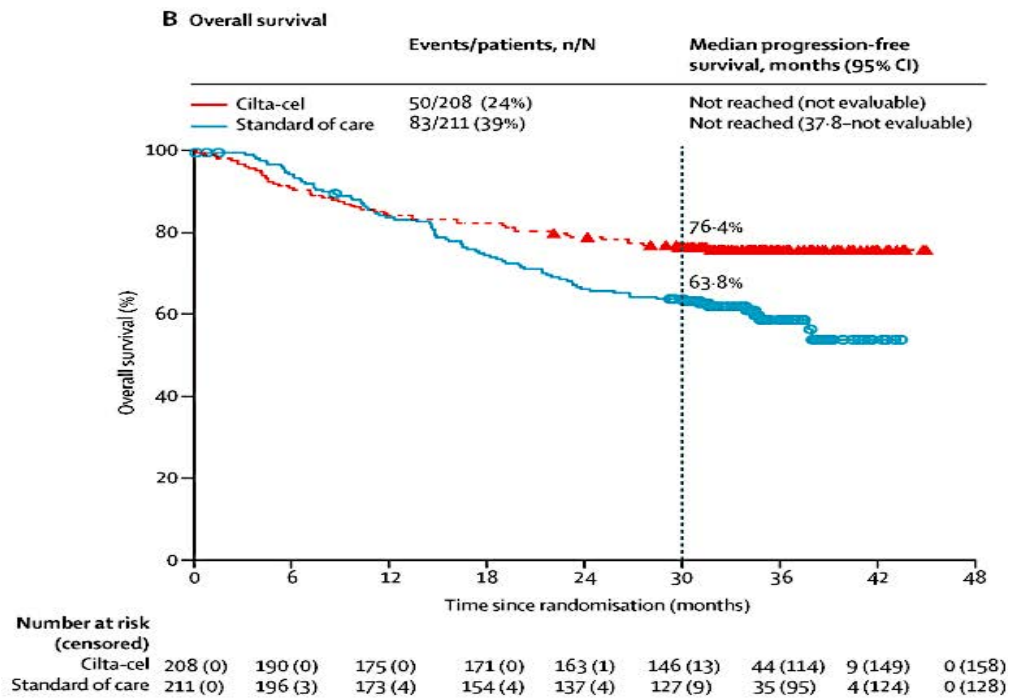
Clinical implication: Cilta-cel demonstrates durable remission supporting earlier use in treatment sequencing.

FIG 2. (A) OS. (B) Progression-free survival. Cilta-cel, ciltacabtagene autoleucel; OS, overall survival.

Published in: Sundar Jagannath; Thomas G. Martin; Yi Lin; Adam D. Cohen; Noopur Raje; Myo Htut; Abhinav Deol; Mounzer Agha; Jesus G. Berdeja; Alexander M. Lesokhin; Jessica J. Liegel; Adriana Rossi; Alex Lieberman-Cribbin; Saad Z. Usmani; Binod Dhakal; Samir Parekh; Hui Li; Feng Wang; Rocio Montes de Oca; Vicki Plaks; Huabin Sun; Arnob Banerjee; Jordan M. Schecter; Nikoletta Lendvai; Deepu Madduri; Tamar Lengil; Jieqing Zhu; Mythili Koneru; Muhammad Akram; Nitin Patel; Octavio Costa Filho; Andrzej J. Jakubowiak; Peter M. Voorhees J Clin Oncol 2025 06-3
DOI: 10.1200/JCO-25-00760

Cilta-cel Shows an Overall Survival Benefit over SOC





Einsele Lancet 2026

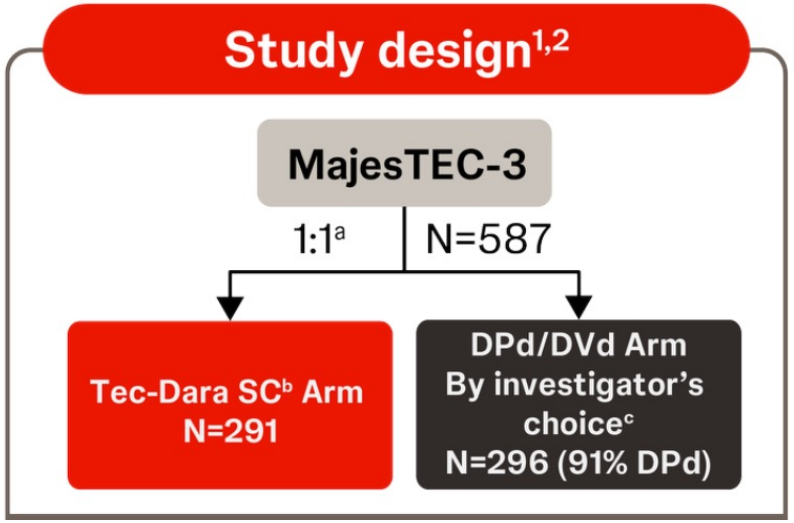
MajesTEC-3 Trial versus CARTITUDE-4 Trial

MajesTEC-3 suggests that bsAb and CAR T cells are similarly effective (comparing to CARTITUDE-4)

Key eligibility criteria for both:

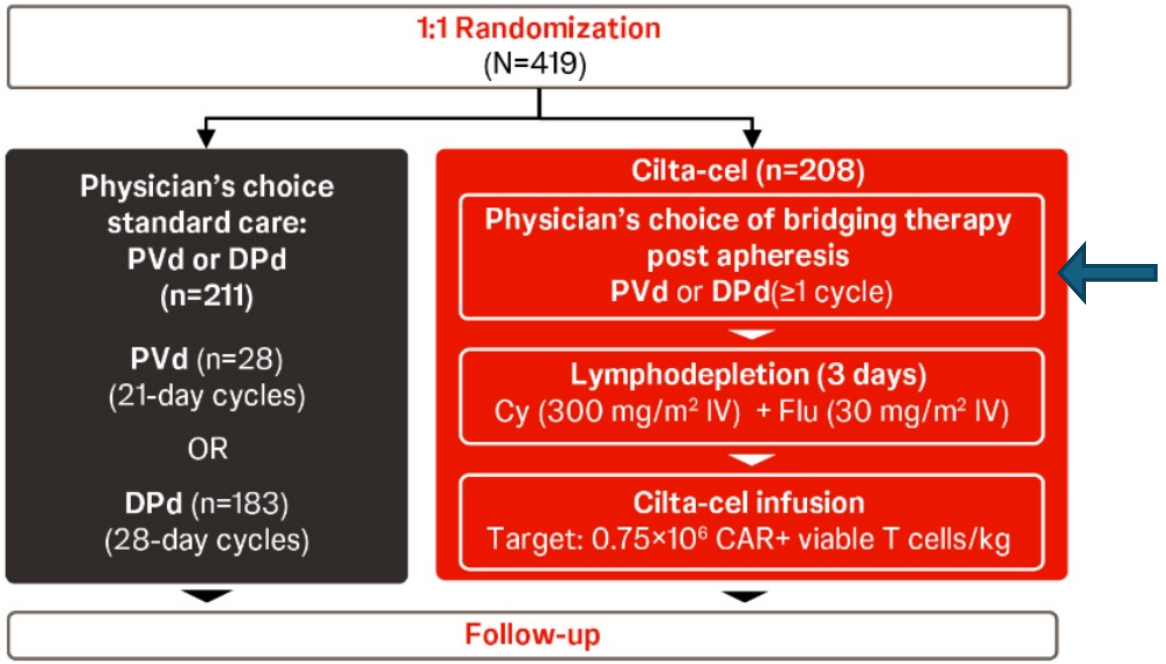
- 1-3 prior lines of therapy including PI/imid
- Lenalidomide-refractory
- Refractory to last line of therapy

MajesTEC-3



Clinical implication: Bispecific antibodies provide a practical alternative to CAR-T with comparable efficacy signals.

CARTITUDE-4



MajesTEC-3 suggests that bsAb and CAR T cells are similarly effective (comparing to CARTITUDE-4)

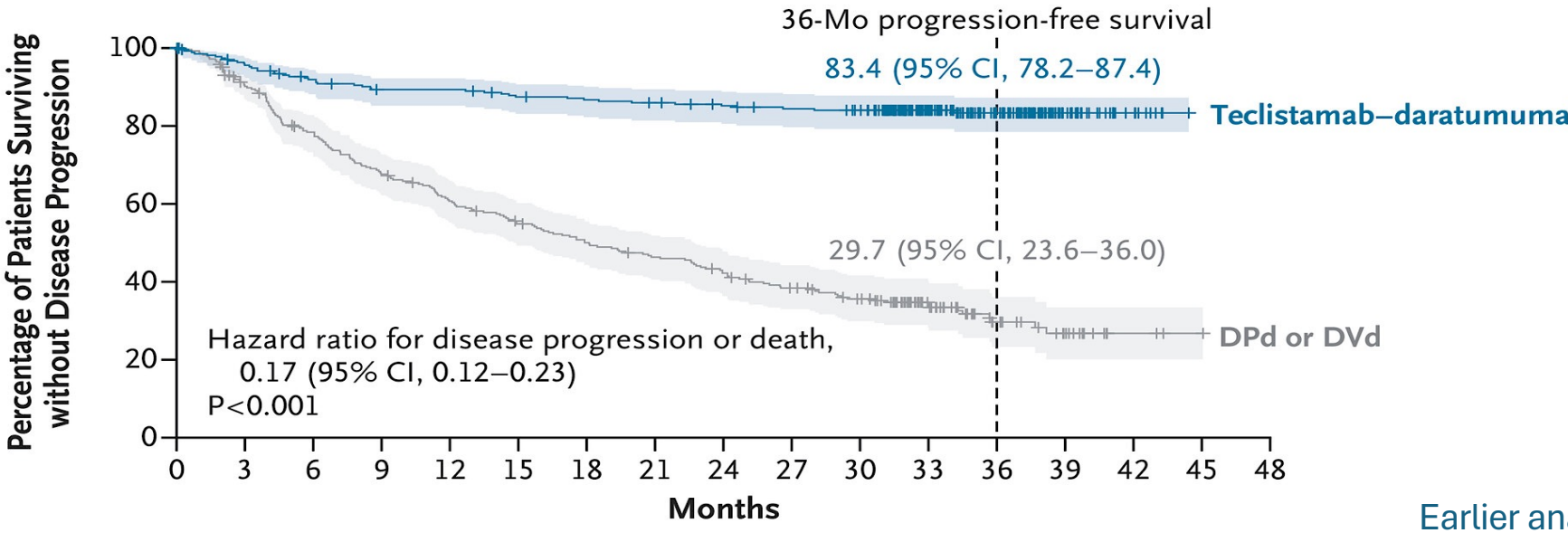
Key eligibility criteria for both:

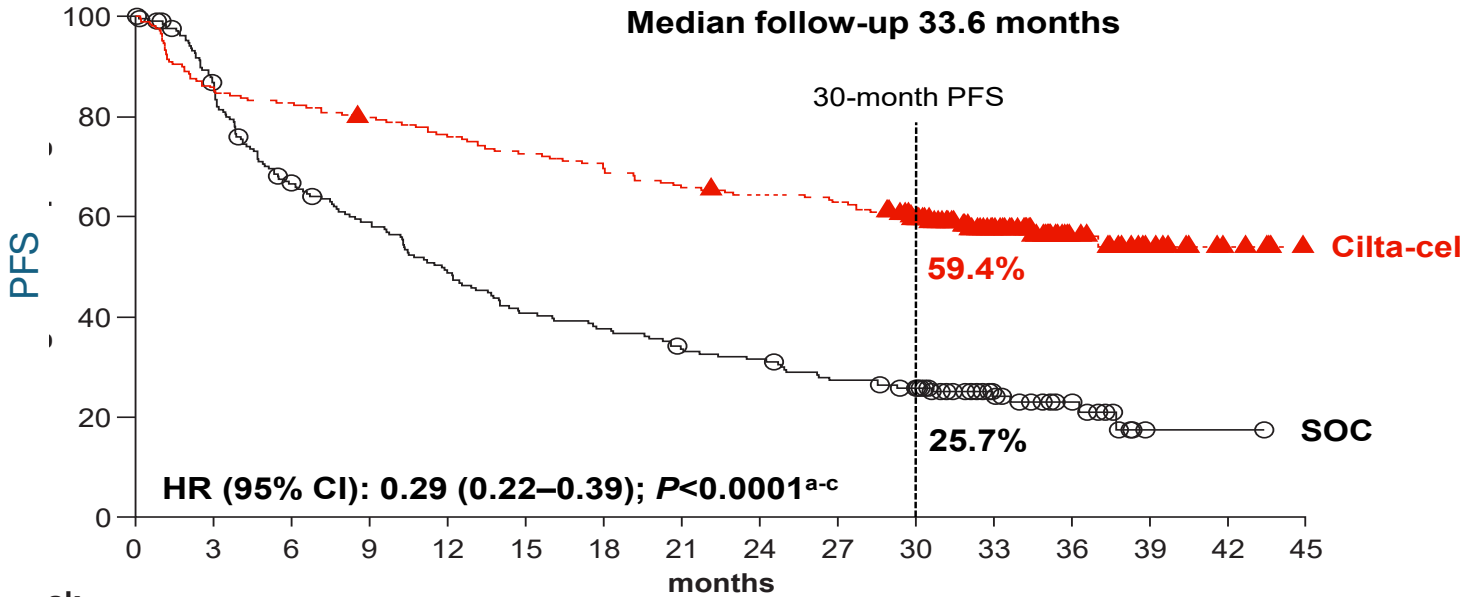
- 1-3 prior lines of therapy including PI/imid
- Lenalidomide-refractory
- Refractory to last line of therapy

	MajesTEC-3	CARTITUDE-4
Median prior lines	2 (1-3)	1: 32% 2: 40% 3: 27%
Time from diagnosis (yr)	3.7	3.0
HR Cytogenetics	36.5%	33.6%
ISS stage 3	8.0%	6.2%
Anti-CD38 exposed	5.2%	25%

Costa et al. NEJM 2025
Mateos et al. IMS 2024

MajesTEC-3 suggests that bsAb and CAR T cells are similarly effective (comparing to CARTITUDE-4)





Clinical implication: Treatment choice between CAR-T and bsAb may be guided by access, logistics, and patient factors.

Earlier analysis at ODAC:

	Cilta-cel (N = 208)	SoC (N = 211)
mPFS, months (95% CI)	**NE** (22.8, NE)	**11.8** (9.7, 13.8)
Prespecified HR [Weighted] *8 weeks post-randomization*	**0.26** (0.18, 0.38),	**p < 0.0001**
ITT HR [Standard "Unweighted"] *from randomization*	**0.40** (0.29, 0.55),	**p < 0.0001**

Sources
- Costa et al. NEJM 2025
- Mateos et al. IMS 2024
- FDA ODAC materials (https://www.fda.gov/media/176988/download)

- Similar eligibility populations between MajesTEC-3 and CARTITUDE-4 CAR-T trials may reflect **selection bias and exclusion of non-infused patients**
- Fixed-duration teclistamab strategies are emerging (e.g., Limi-Tec)
- Bispecifics: Easier to deliver
- No manufacturing delay
- Potential for outpatient initiation
- CAR-T: One-time therapy but **toxicity and access limitations remain**

MajesTEC-9 Trial

MajesTEC-9: Phase 3 Study Design

Key inclusion criteria

- RRMM
- 1–3 prior LOTs including an anti-CD38 mAb and lenalidomide
- ECOG PS score of 0–2

Key exclusion criteria

- Prior BCMA-directed therapy

1:1 randomization N=593

April 28, 2023–
April 3, 2025

Tec
n=296

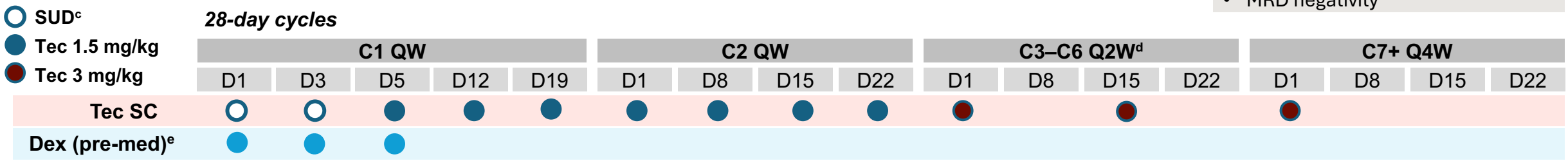
PVd/Kd[a]
by investigator's choice
n=297 (69% Kd)

Primary endpoint
- PFS per IRC[b]

Key secondary endpoints
- ≥CR[b]
- OS
- MySIm-Q Total Symptom score

Other secondary endpoints
- ORR
- Safety
- PK and immunogenicity

Exploratory endpoints
- MRD negativity



Monthly Tec dosing from C7 (earlier if ≥VGPR); steroid free after C1D5

Mina R et al. ASCO 2026;Abstract 7507

MajesTEC-9: Baseline Demographic and Disease Characteristics

Characteristic	Tec (n=296)	PVd/Kd (n=297)
Age		
Median (range), years	70 (34–85)	70 (36–86)
≥75 years, n (%)	84 (28.4)	89 (30.0)
Sex, n (%)		
Male	150 (50.7)	153 (51.5)
Female	146 (49.3)	144 (48.5)
Race, n (%)		
White	190 (64.2)	198 (66.7)
Asian	62 (20.9)	56 (18.9)
Black or African American	10 (3.4)	10 (3.4)
Other[a]	34 (11.5)	33 (11.1)

Characteristic	Tec (n=296)	PVd/Kd (n=297)
Baseline ECOG PS score, n (%)		
0	156 (52.7)	135 (45.5)
1	121 (40.9)	137 (46.1)
2	19 (6.4)	24 (8.1)
3	0	1 (0.3)
ISS stage, n (%)		
I	168 (56.8)	170 (57.2)
II	86 (29.1)	82 (27.6)
III	42 (14.2)	45 (15.2)
BMPCs ≥60%,[b] n/N (%)	31/292 (10.6)	40/295 (13.6)
Soft-tissue plasmacytomas, n (%)	54 (18.2)	65 (21.9)
Extramedullary plasmacytomas[b]	19 (6.4)	22 (7.4)
Paraskeletal plasmacytomas[b]	43 (14.5)	52 (17.5)
High-risk cytogenetics,[c] n/N (%)	105/294 (35.7)	104/296 (35.1)

Balanced baseline characteristics are reflective of a RRMM population, including high-risk disease

Mina R et al. ASCO 2026;Abstract 7507

MajesTEC-9: Prior LOTs

Characteristic	Tec (n=296)	PVd/Kd (n=297)
Prior LOTs		
Median (range), n	2 (1–3)	2 (1–3)
1 prior LOT	64 (21.6)	64 (21.5)
2 prior LOTs	131 (44.3)	137 (46.1)
3 prior LOTs	101 (34.1)	96 (32.3)
Prior transplantation, n (%)	145 (49.0)	147 (49.5)
Autologous	145 (49.0)	146 (49.2)
Prior therapy exposure, n (%)		
PI	256 (86.5)	254 (85.5)
IMiD	296 (100)	297 (100)
Anti-CD38, n (%)	296 (100)	297 (100)

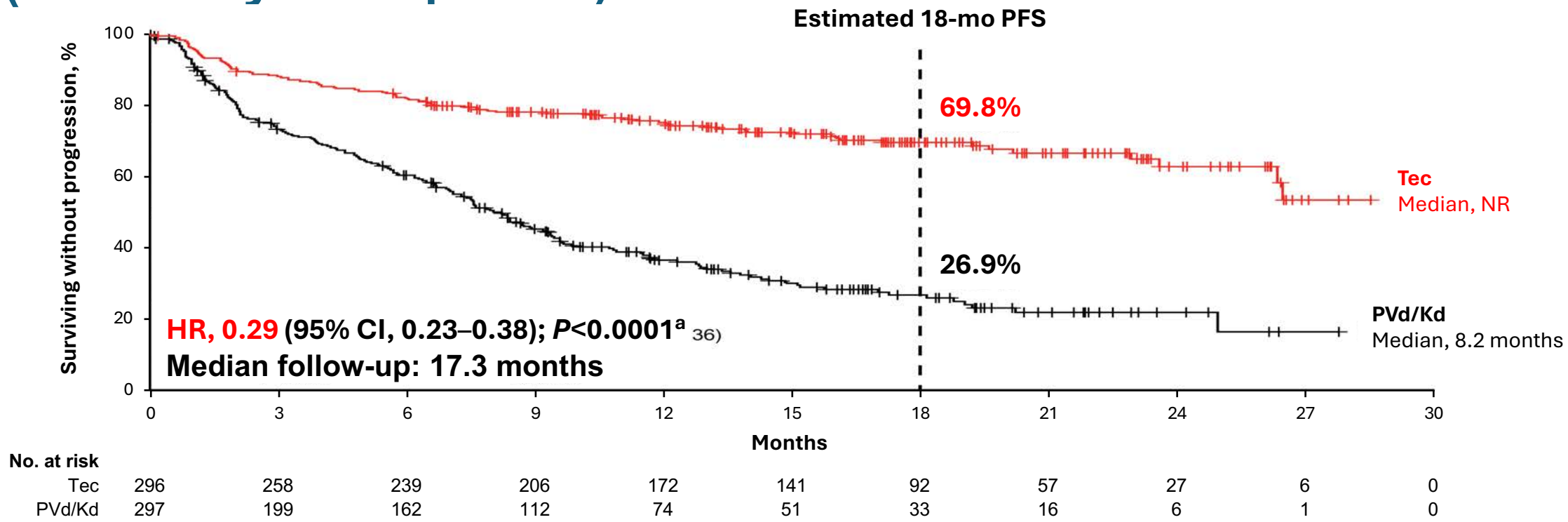
Characteristic	Tec (n=296)	PVd/Kd (n=297)
Refractory status, n (%)		
To last prior LOT	274 (92.6)	273 (91.9)
Any PI	122 (41.2)	128 (43.1)
Any IMiD	245 (82.8)	251 (84.5)
Lenalidomide	234 (79.1)	240 (80.8)
Any anti-CD38	253 (85.5)	252 (84.8)
Double refractory (IMiD and anti-CD38)	218 (73.6)	221 (74.4)
Triple refractory (IMiD, anti-CD38, and PI)	102 (34.5)	98 (33.0)

Clinical implication: Optimized dosing strategies enable safer outpatient bispecific administration.

Approximately 75% of patients were double refractory to an IMiD and anti-CD38 mAb

Mina R et al. ASCO 2026;Abstract 7507

MajesTEC-9: Tec Significantly Improved PFS (Primary Endpoint)



Clinical implication: Bispecific sequencing after prior BCMA therapy remains feasible in heavily pretreated patients.

Tec significantly improved PFS, with a 71% reduction in the risk of disease progression or death in a highly refractory population

Mina R et al. ASCO 2026;Abstract 7507

Linvoseltamab for R/R MM and Systemic Amyloidosis

LINKER-MM1 (NCT03761108)

- Phase 1/2 study of linvoseltamab (BCMA × CD3 bispecific antibody) in patients with relapsed/refractory multiple myeloma
- *Lee et al. Clin Lymphoma Myeloma Leuk. 2025*

Patient population

- Triple-class exposed or double refractory multiple myeloma
- ≥3 prior lines of therapy (PI, IMiD, anti-CD38 mAb)
- ECOG PS ≤2

Study design

Phase 1: Dose escalation

- Linvoseltamab 50 mg and 200 mg IV

Phase 2: Dose optimization

- Linvoseltamab 200 mg IV
- N=117 at 200 mg dose

Dosing schedule

- IV linvoseltamab QW through Wk 14–16
- Then Q2W thereafter

Endpoints

Primary endpoint

- Overall response rate (ORR)

Key secondary endpoints

- Duration of response (DOR)
- Progression-free survival (PFS)
- Overall survival (OS)
- MRD negativity rate

BCMA, B-cell maturation antigen; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; IMiD, immunomodulatory drug; IV, intravenous; mAb, monoclonal antibody; MM, multiple myeloma; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PFS, progression-free survival; PI, proteasome inhibitor; Q2W, every 2 weeks; QW, every week.

Lee et al. Clin Lymphoma Myeloma Leuk. 2025. ClinicalTrials.gov. NCT03761108.

LINKER-MM1: Efficacy at 21.3 Months Median Follow-up

Linvoseltamab 200 mg (N=117) | Lee et al. Clin Lymphoma Myeloma Leuk. 2025 | Data cutoff: July 23, 2024

Endpoint	Linvoseltamab 200 mg
ORR	71%
≥CR rate	52%
MRD negativity (10^{-5}) Among evaluable ≥CR patients	94%
Median DOR	29.4 months
Median PFS	Not reached
Median OS	31.4 months

Key Safety Findings

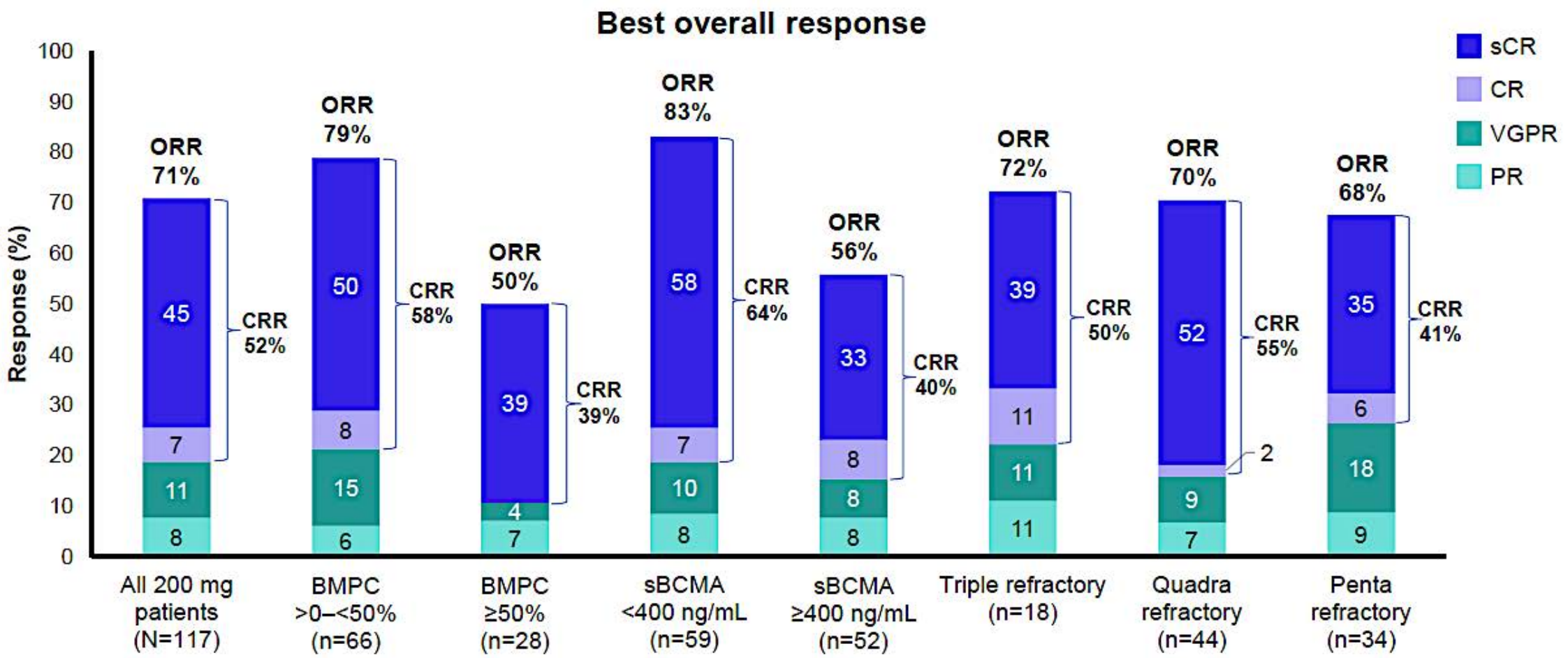
- CRS: 46% (Grade 3: 1%); most events during step-up dosing
- Neutropenia: 44% (Grade ≥3: 43%)
- Infections: 75% (Grade ≥3: 48%); rate decreasing after 6 months
- No new safety signals with longer follow-up

Subgroup Highlights

- ORR ≥50% across all subgroups assessed
- Consistent responses across age, race, penta-refractory status
- Favorable outcomes in high disease burden and difficult-to-treat RRMM (EMP, ISS stage 3, high-risk cytogenetics)

Long-term linvoseltamab 200 mg provided deep and durable responses with no new safety signals in RRMM

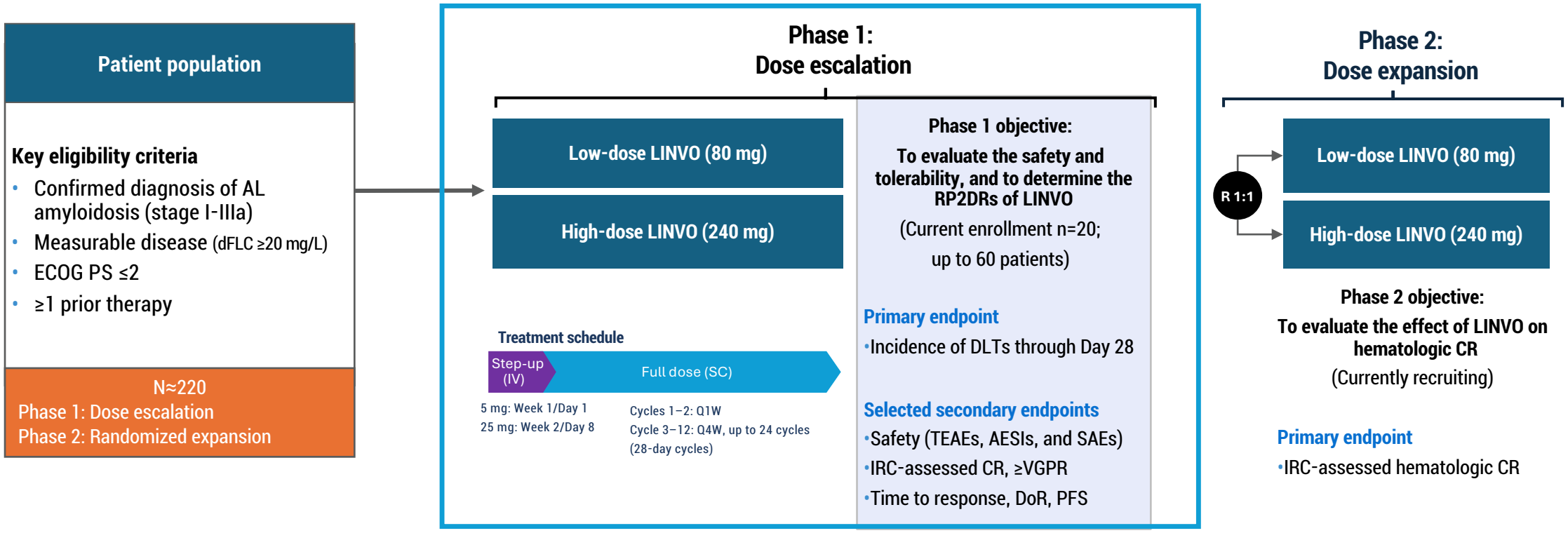
LINKER-MM1: Efficacy in Patients Across Key Subgroups



Presented at COMy 2025 by Manshi Shah, MD
Lee H et al. ASCO 2023;Abstract 8006

LINKER-AL2 (NCT06292780)

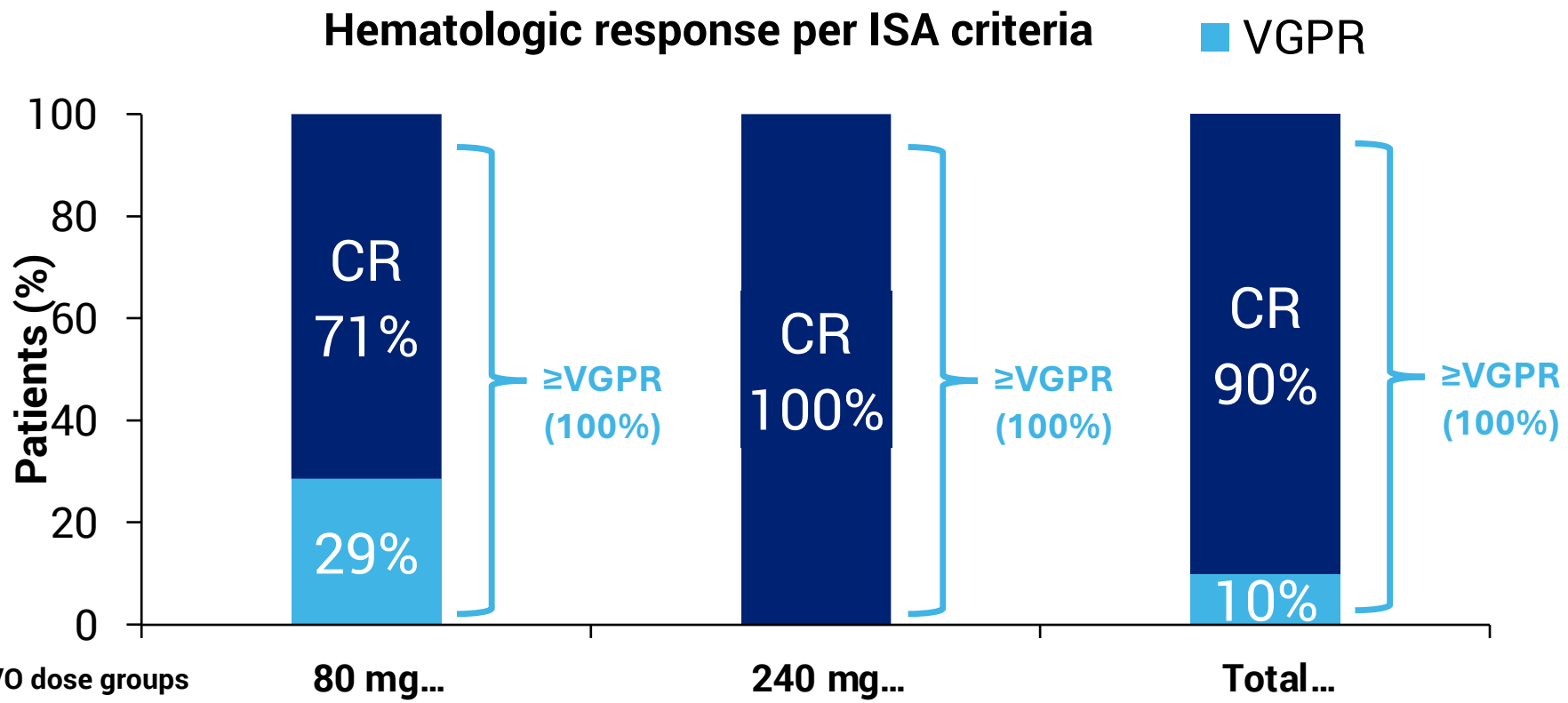
- An open-label, Phase 1/2 study evaluating linvoseltamab monotherapy in patients with RR systemic AL amyloidosis
- Here we report results from Phase 1 of LINKER-AL2



AESI, adverse event of special interest; AL, amyloid light chain; CR, complete response; dFLC, difference between involved free light chain and uninvolved free light chain; DLT, dose-limiting toxicity; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; IRC, Independent Review Committee; IV, intravenous; LINVO, linvoseltamab; PFS, progression-free survival; PR, partial response; Q1W, every 1 week; Q4W, every 4 weeks; R, randomization; RP2DR, recommended Phase 2 dose regimen; RR, relapsed/refractory; SAE, serious adverse event; SC, subcutaneous; TEAE, treatment-emergent adverse event; VGPR, very good partial response.

Wechalekar A al. ASCO 2026;Abstract 7502
ClinicalTrials.gov. NCT06292780. https://clinicaltrials.gov/study/NCT06292780 (accessed May 06, 2026).

RESULTS: Efficacy—Hematological response rate and depth



Time to CR, median (range)	1.0 (0.5–4.2) months	1.6 (0.2–7.9) months	1.5 (0.2-7.9) months
Study follow up, median (range)	10.6 (1.6–13.3) months	9.0 (6.6–11.7) months	9.5 (1.6–13.3) months

High rate of deep hematologic responses at 9.5 months of follow-up:

- ≥VGPR: 100%
- CR: 90%

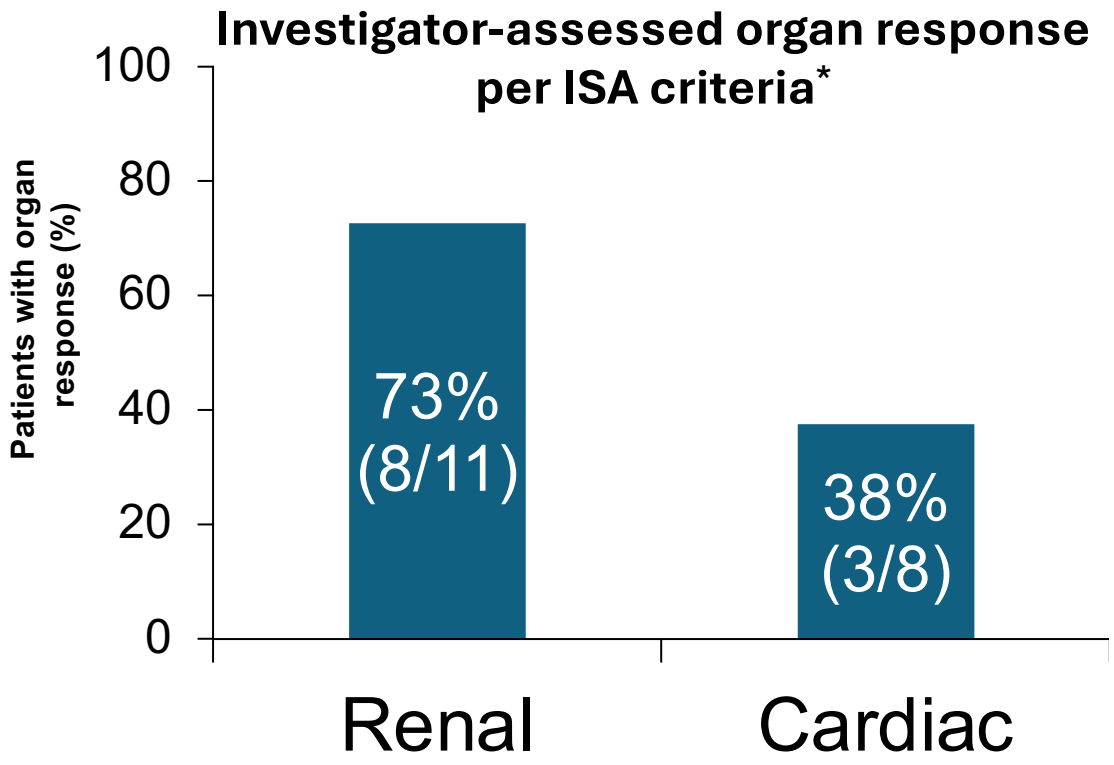
Data cutoff: April 22, 2026.

For patients with baseline dFLC 20-50 mg/L, achieving low dFLC (<10 mg/L) was included in VGPR.

CR, complete response; dFLC, difference between involved free light chain and uninvolved free light chain; ISA, International Society of Amyloidosis; LINVO, linvoseltamab; VGPR, very good partial response.

Wechalekar A al. ASCO 2026;Abstract 7502

RESULTS: Efficacy—Organ responses



At median follow up of 9.5 months：

- Renal response: 73% (8/11)
  - Median time to response: 6.2 weeks (1.1–15.3)
- Cardiac response: 38% (3/8)
  - Response at Cycle 1 (n=1) and Cycle 4 (n=2)

High rate of deep hematologic responses (100% ≥VGPR; 90% CR)
Rapid iFLC level normalization by Day 15; no hematologic progression events
Cardiac and renal responses observed, even with short treatment duration
No DLTs observed and generally manageable safety

Data cutoff: April 22, 2026.

*Investigator-assessed response per ISA criteria, among patients evaluable for organ response. Renal response criteria: 30% reduction in 24-hour urine protein excretion or a drop of proteinuria <0.5 g per 24 hours in the absence of renal progression. Cardiac response criteria: NT-proBNP reduction of >30% and >300 ng/L decrease (in patients with NT-proBNP involvement at baseline); or ≥2 class decrease in NYHA class (in patients with NYHA class involvement at baseline). Median follow-up for all patients (N=20).

ISA, International Society of Amyloidosis; NT-proBNP, N-terminal pro-B-type natriuretic peptide; NYHA, New York Heart Association.

Wechalekar A al. ASCO 2026;Abstract 7502

Talquetamab: GPRC5D Bispecific Antibody Therapy

MonumenTAL-1: Study Design

- Multicenter, open-label phase I/II trial

Adults with measurable MM

Phase I: progression on or intolerance to all established therapies; ECOG PS 0-1

Phase II: ≥3 prior lines of therapy that included a PI, an IMiD, and an anti-CD38 antibody; ECOG PS 0–2

Talquetamab 0.4 mg/kg SC QW*
(n = 143)

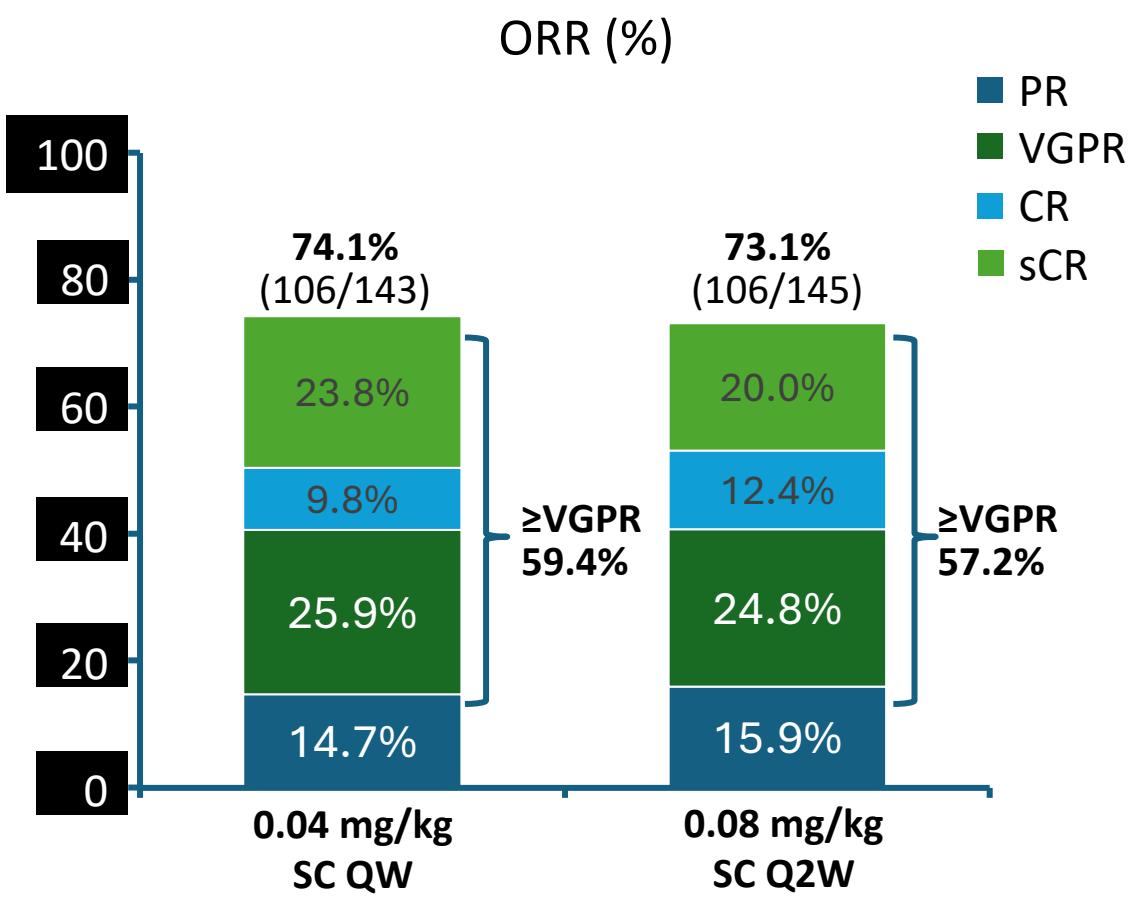
Talquetamab 0.8 mg/kg SC Q2W*
(n = 145)

Prior T-Cell Redirection Group: Talquetamab
Either 0.4 mg/kg SC QW or 0.8 mg/kg SC Q2W
(n = 51)

- **Primary endpoint (phase II):** ORR
- **Secondary endpoints (phase II):** DoR, ≥ VGPR rate, ≥ CR, sCR rate, TTR, PFS, OS, MRD, safety

Chari. ASH 2022. Abstr 157. NCT03399799. NCT04634552.

MonumenTAL-1: ORR

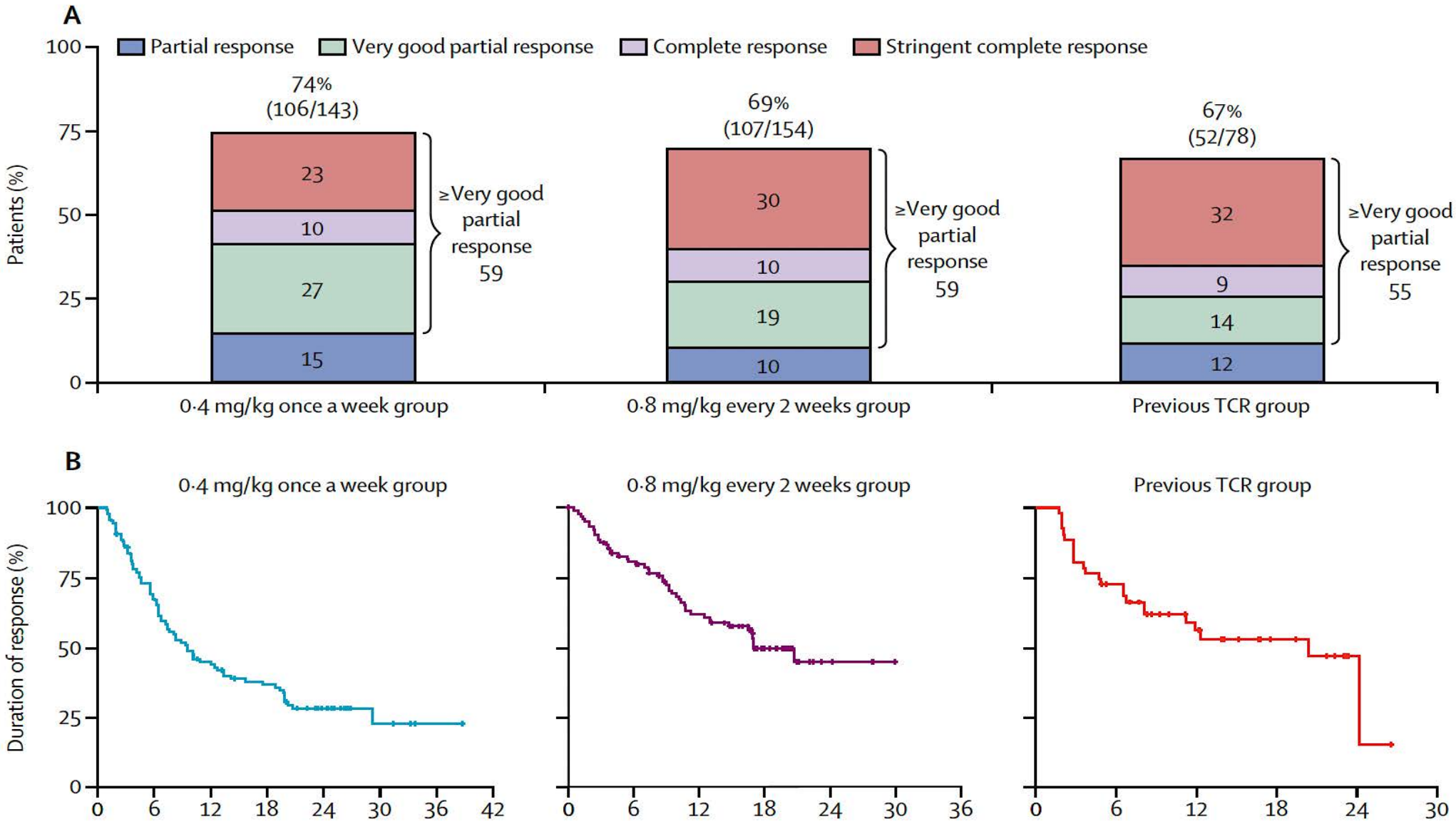


- Similar ORR among all subgroups examined, including refractory status, except for patients with BL plasmacytoma
- ORR was similar for both dosing schedules
  - Triple-class refractory: 72.6% (63.1-80.9) QW and 71.0% (61.1–79.6) Q2W
  - Penta-drug refractory: 71.4% (55.4–84.3) QW and 70.6% (52.5–84.9) Q2W

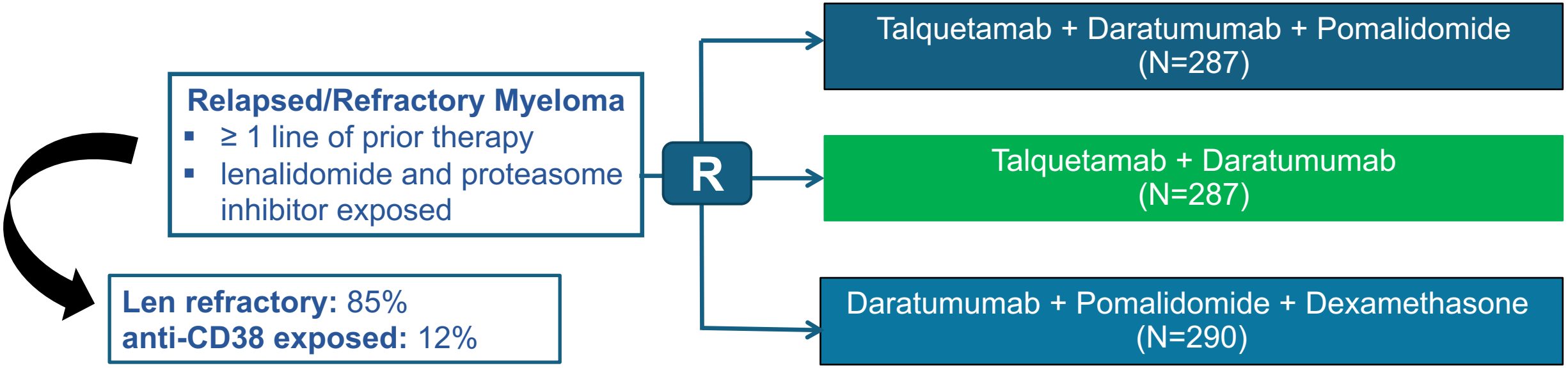
Timing	0.4 mg/kg SC QW (n = 143)	0.8 mg/kg SC Q2W (n = 145)
Median follow-up for efficacy, mo (range)	14.9 (0.5-29.0)	8.6 (0.2-22.5)
Median time to first response, mo (range) (n = 106 in each group)	1.2 (0.2-10.9)	1.3 (0.2-9.2)
Median time to best response, mo (range) (n = 106 in each group)	2.2 (0.8-12.7)	2.7 (0.3-12.5)

Chari. ASH 2022. Abstr 157. Reproduced with permission.

MonumenTAL 1 (Chari Lancet Hem 2025)



MONUMENTAL-3: Tal + Dara + Pom vs. Tal + Dara vs. Dara + Pom + Dex

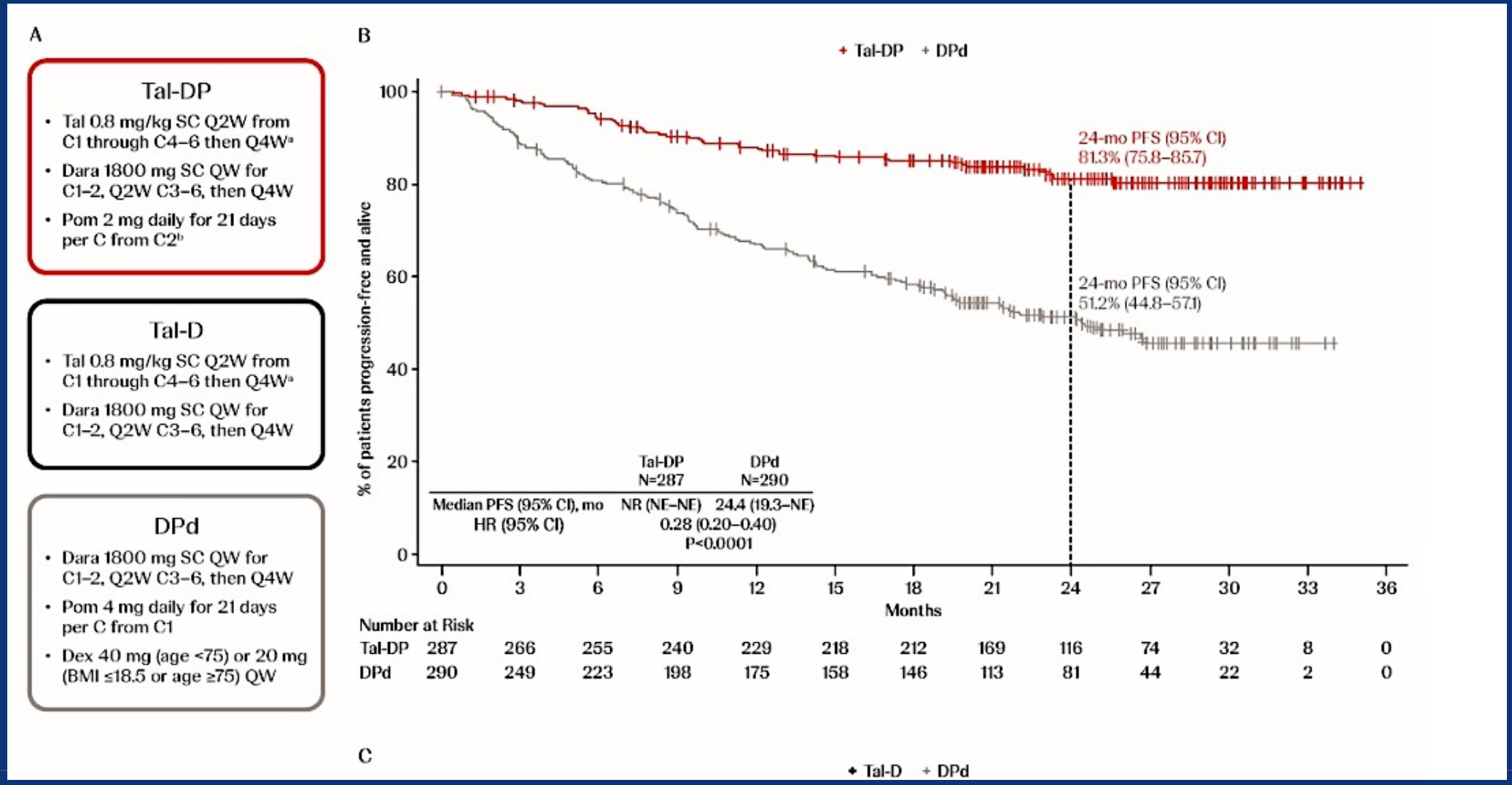


Efficacy: Tal/Dara/Pom vs. Tal/Dara vs. Dara/Pom/Dex

- **MRD neg ≥ CR rate:** 52.3% vs. 46.3% vs. 15.9%
- **Significant PFS** benefit of Tal/Dara/Pom and Tal/Dara vs Dara/Pom/Dex; HRs 0.28 and 0.33, respectively
- **24-month PFS**: 81.3% vs 77.6% vs. 51.2%.

Voorhees et al. *EHA*. 2026.

Tal shows PFS benefit



Belantamab Mafodotin

DREAMM-7: study design

Recruitment period
≈13 months from FPI (May 7, 2020) to LPI (June 28, 2021)

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

Follow-up period

Eligibility criteria

- Adults with MM
- ≥1 prior line of MM therapy and documented PD during or after most recent therapy
- No prior treatment with anti-BCMA
- Not refractory to or intolerant of daratumumab or bortezomib

1:1 randomization

	Cycles 1-8	Cycle 9+
Arm A (BVd)	**Belamaf** 2.5 mg/kg IV q3w + **bortezomib** 1.3 mg/m² SC on days 1, 4, 8, and 11 of cycles 1-8 (21-day cycles) + **dexamethasone** 20 mg on the day of and day after bortezomib[a] in cycles 1-8	**Belamaf monotherapy** 2.5 mg/kg IV q3w
Arm B (DVd)	**Daratumumab** 16 mg/kg IV qw in cycles 1-3; and q3w in cycles 4-8 + **bortezomib** 1.3 mg/m² SC on days 1, 4, 8, and 11 of cycles 1-8 (21-day cycles) + **dexamethasone** 20 mg on the day of and day after bortezomib[a] in cycles 1-8	**Daratumumab monotherapy** 16 mg/kg IV q4w in cycle 9+

End-of-treatment visit

Follow-up for PFS q3w
(for patients who discontinue due to reasons other than PD)

Disease assessments q3w

Follow-up for OS q12w
(for patients who discontinue due to PD or other reasons)

Median follow-up (ITT)
28.2 months (range, 0.10-40.02 months)

Stratification:
- Prior lines of treatment (1 vs 2 or 3 vs ≥4)
- R-ISS stage (I vs II/III)
- Prior bortezomib (yes vs no)

Disease assessment visits: q3w from cycle 1 day 1 until PD

Primary endpoint:
PFS (IRC assessed)

Key secondary endpoints:
OS, DOR, and MRD

Additional secondary endpoints:
CRR, ORR, CBR, TTR, TTP, PFS2, AEs, ocular findings, and QOL

AE, adverse event; BCMA, B-cell maturation antigen; CBR, clinical benefit rate; CRR, complete response rate; DOR, duration of response; FPI, first patient in; IRC, independent review committee; ITT, intent-to-treat; IV, intravenous; LPI, last patient in; MM, multiple myeloma; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; q3w, every 3 weeks; q4w, every 4 weeks; q12w, every 12 weeks; QOL, quality of life; qw, once weekly; R-ISS, Revised International Staging System; SC, subcutaneous; TTP, time to progression; TTR, time to response.
[a] Reduce starting dose of dexamethasone to 10 mg for patients aged >75 years who have a body mass index of <18.5, previous unacceptable side effects associated with glucocorticoid therapy, or inability to tolerate the starting dose.

DREAMM-7: ITT population
Prior treatments

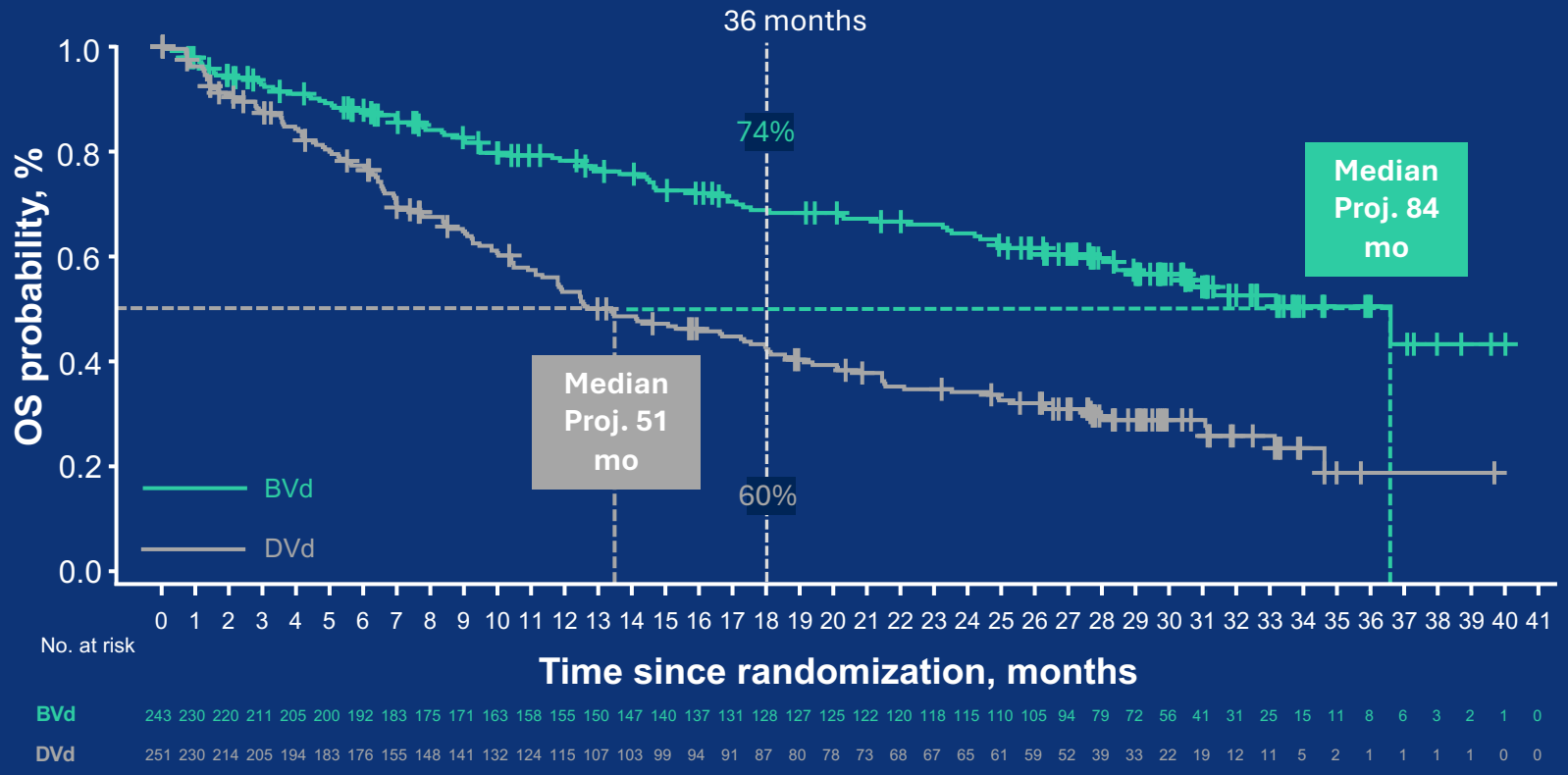
Prior treatments, n (%)	ITT population	
	BVd (N=243)	DVd (N=251)
Prior LOT		
1	125 (51)	125 (50)
2 or 3	88 (36)	99 (39)
4+	30 (12)	27 (11)
Prior proteasome inhibitor	218 (90)	216 (86)
Prior bortezomib	210 (86)	211 (84)
Prior carfilzomib	31 (13)	35 (14)
Prior immunomodulatory drugs	198 (81)	216 (86)
Prior thalidomide	121 (50)	144 (57)
Prior pomalidomide	25 (10)	19 (8)
Prior lenalidomide	127 (52)	130 (52)
Refractory to lenalidomide	79 (33)	87 (35)
Prior daratumumab	3 (1)	4 (2)
Prior ASCT	164 (67)	173 (69)

In both arms, approximately one-third of patients had disease that was refractory to prior lenalidomide; refractoriness to lenalidomide has been previously associated with a poor prognosis

ASCT, autologous stem cell transplant; ITT, intent to treat; LOT, line of therapy.

DREAMM-7: Updated Overall Survival (OS)

BVd showed a significant overall survival benefit vs DVd



OS[a]	BVd (N=243)	DVd (N=251)
Deaths, n (%)	63 (26)	100 (40)
OS, median (95% CI), months[b]	NR (NR-NR)	NR (NR-NR)
HR (95% CI)[c]	0.58 (0.43-0.79)	
P value[d]	.00023	

BVd demonstrated a statistically significant 42% reduction in the risk of death vs DVd
3-year OS rate: 74% (BVd) vs 60% (DVd); median follow-up 39.4 months

HR, hazard ratio; ITT, intent to treat; NR, not reached; OS, overall survival; R-ISS, Revised International Staging System.
[a] Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. [b] CIs were estimated using the Brookmeyer-Crowley method. [c] HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib, and R-ISS stage at screening (I vs II/III), with a covariate of treatment. [d] *P* value from 1-sided stratified log-rank test.

Hungria V et al. Lancet Oncol 2025;26(8):1067-80

Study Design DreaMM8

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)

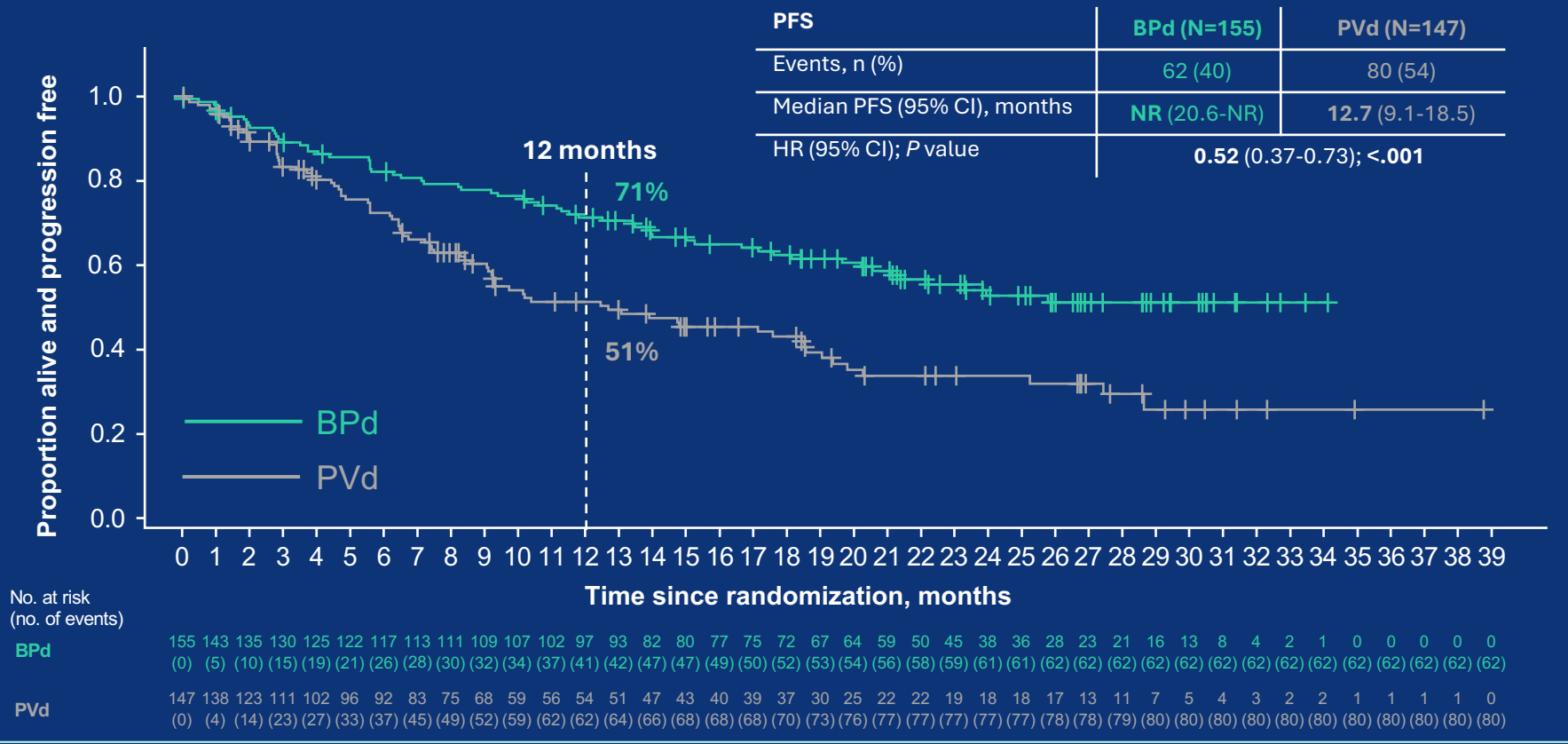
Key secondary endpoints:
OS, MRD negativity, DOR

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)

AE, adverse event; BCMA, B-cell maturation antigen; BPd, belamaf, pomalidomide, and dexamethasone; CD, cluster of differentiation; CRR, complete response rate; DOR, duration of response; HRQOL, health-related quality of life; IMWG, International Myeloma Working Group; IRC, independent review committee; ISS, International Staging System; IV, intravenous; LEN, lenalidomide; MM, multiple myeloma; MRD, minimal residual disease; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PFS2, progression-free survival on subsequent line of therapy; PRO, patient-reported outcome; PVd, pomalidomide, bortezomib, and dexamethasone; Q3W, every 3 weeks; Q4W, every 4 weeks; SC, subcutaneous; TTBR, time to best response; TTP, time to progression; TTR, time to response; VGPR, very good partial response.
[a] Patients aged >75 years, with comorbidities, or intolerant to 40 mg dose in Arm A or 20 mg dose in Arm B could have dose level reduced to half per investigator discretion. [b] Some patients were stratified by ISS status (I vs II/III); the protocol was amended on 20 April 2021 to replace this randomization factor with prior anti-CD38 treatment (yes vs no).

BPd Led to a Significant PFS Benefit vs PVd



BPd led to a statistically significant and clinically meaningful reduction in risk of disease progression or death vs PVd (HR, 0.52; 95% CI, 0.37-0.73; *P*<.001)

Median follow-up, 21.8 months (range, 0.03-39.23 months)

The treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model, and the *P* value was produced based on the 1-sided stratified log-rank test. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use.

BPd, belamaf, pomalidomide, and dexamethasone; HR, hazard ratio; NR, not reported; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.

Suzanne Trudel, MD

DREAMM-8: MRD Negativity Favors BPd Over PVd

MRD Negativity Rates (10^{-5} by NGS)	BPd (n=155)	PVd (n=147)
≥CR-based MRD neg (ITT)	**28%**	**6%**
≥VGPR-based MRD neg (ITT)	35%	7%
≥CR-based MRD neg (among ≥CR responders)	64%	36%
≥VGPR-based MRD neg (among ≥VGPR responders)	56%	19%
Sustained MRD neg ≥12 months (≥CR-based, ITT)	**15%**	**3%**

Key Findings

- BPd achieved **5–7x higher MRD-negativity rates** vs PVd in the ITT population and across key subgroups
- CR-based MRD neg associated with **86% lower risk of progression or death** (PFS HR 0.14; 95% CI, 0.06–0.32)
- MRD negativity correlated with improved PFS and OS outcomes **regardless of treatment arm**
- Among patients who did not achieve MRD neg, **BPd still showed clinically meaningful PFS benefit vs PVd**

BPd, belantamab mafodotin, pomalidomide, and dexamethasone; CR, complete response; HR, hazard ratio; ITT, intent-to-treat; MM, multiple myeloma; MRD, minimal residual disease; neg, negativity; NGS, next-generation sequencing; OS, overall survival; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone; RRMM, relapsed/refractory multiple myeloma; VGPR, very good partial response.

Trudel S, Dimopoulos MA, et al. ASCO 2025; Abstract 7515

Conclusions

- Myeloma is evolving quickly
- Bispecifics conclusively show benefits in early relapse (tec3/tec9)
- Dara refractory vs Dara Exposed (Tec Dara vs Dara)
- Bispecifics will be easier to use in community (Monviso ppx toci)
- Talquetamab combinations
- CART cells have also shown OS benefit in early relapse (Cartitude4)
- Belantamab also shown OS benefit in early relapse(Dreamm7/8)

Year in Review:
Multiple Myeloma

INTRODUCTION: Up-Front PFS for Standard-Risk Disease — 2006, 2016

MODULE 1: Current and Emerging Therapeutic Approaches — Dr Orlowski

MODULE 2: Chimeric Antigen Receptor T-Cell Therapy, Bispecific Antibodies and Antibody-Drug Conjugates — Dr Krishnan

MODULE 3: ASCO and EHA 2026

2026 ASCO ANNUAL MEETING

Highlights of the Year

Immunotherapy in Plasma Cell Disorders in 2026

How Early, How Deep, and How to Sequence?

Suzanne Lentzsch, MD, PhD
Columbia University, New York | ASCO Annual Meeting 2026

2026 ASCO ANNUAL MEETING

Education Session

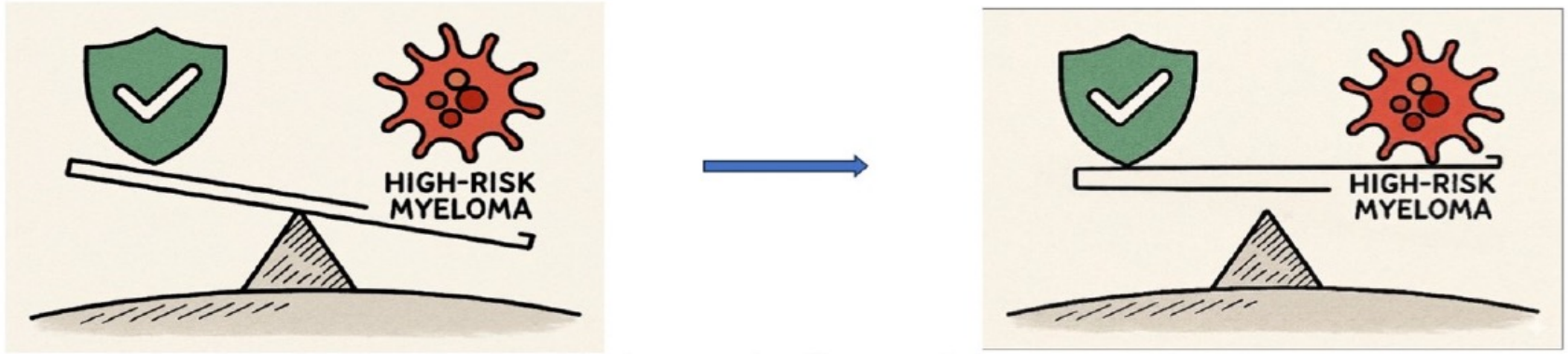
High Risk Multiple Myeloma Redefining Risk and Rethinking Therapy

A MODERN FRAMEWORK FOR CONSIDERING HRMM

Gareth J Morgan, Professor Medicine, NYU Langone Health

PRESENTED BY: Gareth J Morgan, MD, PhD.

Can Immunotherapy Level the Playing Field for High-Risk Myeloma?



- *Our treatment goal is **to neutralize** resistance mechanisms and bring high-risk survival closer to standard-risk outcomes.*

Jesus San-Miguel
Universidad Navarra

Clínica Universidad de Navarra | Cancer Center

cima
CENTER FOR APPLIED MEDICAL RESEARCH
UNIVERSITY OF NAVARRA

Education Session

Hematologic Malignancies

Smoldering Multiple Myeloma: From Clinical to Immunogenomic Risk Stratification and Therapeutic Implications of Early Intervention

Nizar J. Bahlis, MD[1]; María V. Mateos, MD, PhD[2]; and Ajay K. Nooka, MD, MPH[3]

Am Soc Clin Oncol Educ Book 46:e517488 (2026).

Hematologic Malignancies

High-Risk Multiple Myeloma: Redefining Risk and Rethinking Therapy

Gareth J. Morgan, MD, PhD[1]; Dennis D. Lee, MD[2]; Nisha S. Joseph, MD[3]; Sagar Lonial, MD[3]; Paula Rodriguez-Otero, MD[3]; and Jesús F. San-Miguel, MD, PhD[3]

Am Soc Clin Oncol Educ Book 46:e517494 (2026).

Hematologic Malignancies

Management of Bispecific Antibody Toxicities: A Focus on Multiple Myeloma

Eden Biltibo, MD, MS[1]; Rajshekhar Chakraborty, MD[2]; and Michael R. Bishop, MD[3,4]

Am Soc Clin Oncol Educ Book 46:e517460 (2026).

Elranatamab Significantly Improves PFS for Double-Class-Exposed Relapsed or Refractory Multiple Myeloma

Press Release: April 29, 2026

"[On April 29, 2026, the manufacturer] announced positive topline results from the Phase 3 MagnetisMM-5 study evaluating elranatamab as monotherapy in adults with relapsed or refractory multiple myeloma (RRMM) who received at least one prior line of treatment. The study demonstrated a statistically significant and clinically meaningful improvement in the primary endpoint of progression-free survival (PFS), as assessed by blinded independent central review (BICR), versus standard-of-care daratumumab plus pomalidomide and dexamethasone (DPd). The safety and tolerability of elranatamab was consistent with its known safety profile.

The PFS results exceeded the pre-specified interim analysis target hazard ratio for efficacy, with most elranatamab-treated patients remaining progression-free. The trial remains ongoing to assess overall survival, a key secondary endpoint, which was not yet mature at the time of this interim analysis. These data will be discussed with global health authorities, and detailed results from MagnetisMM-5 will be submitted for presentation at a future medical congress."

https://www.pfizer.com/NEWS/PRESS-RELEASE/PRESS-RELEASE-DETAIL/PFIZERS-ELREXFIO-SIGNIFICANTLY-IMPROVES-PROGRESSION-FREE

2026 ASCO ANNUAL MEETING

Safety and efficacy of elranatamab as early intervention in patients with high-risk smoldering myeloma: First results from the phase 2 ERASMM (EMN34) Study

Cyrille Touzeau, MD, PhD[1]; Fredrik Schjesvold, MD, PhD[2]; Claudio Cerchione, MD, PhD[3]; Xavier Leleu, MD, PhD[4]; Renato Zambello, MD[5]; Carmine Liberatore, MD[6]; Inger Nijhof, MD, PhD[7]; Elisa Dama, MSc, PhD[8]; Thomas Chalopin, MD[9]; Pellegrino Musto, MD[10]; Alessandro Rambaldi, MD[11]; Andrea Crespo, BSc[8]; Silvia Mangiacavalli, MD[12]; Komivi Agbetsivi, MD[13]; Laure Vincent, MD[14]; Mario Boccadoro, MD[8]; Pieter Sonneveld, MD, PhD[15]; Annemiek Broijl, MD, PhD[16]

1) University Hospital of Nantes, Nantes, France; 2) Oslo Myeloma Center, Department of Hematology, Oslo University Hospital, Oslo, Norway; 3) IRCCS Istituto Romagnolo per lo Studio dei Tumori (IRST) "Dino Amadori", Meldola, Italy; 4) Hématologie and Inserm CIC 1082, Poitiers, France; 5) Department of Medicine (DIMED), Hematology, Padua University, Padua, Italy; 6) Hematology Unit, Pescara Hospital, Pescara, Italy, and Department of Medicine and Aging Sciences, "G D'Annunzio" University, Chieti, Italy; 7) Department of Internal Medicine - Hematology, St. Antonius Hospital, Nieuwegein, the Netherlands; 8) European Myeloma Network, EMN, Italy; 9) Hematology department, Hôpital Bretonneau, CHRU Tours, Tours, France; 10) Department of Precision and Regenerative Medicine and Ionian Area, "Aldo Moro" University School of Medicine and Hematology and Stem Cell Transplantation Unit, AOU Consorziale Policlinico, Bari, Italy; 11) Department of Oncology and Hematology, Azienda Socio-Sanitaria Territoriale Papa Giovanni XXIII, Bergamo, Italy; 12) Division of Hematology, IRCCS Fondazione Policlinico San Matteo, Pavia, Italy; 13) Department of Internal Medicine, Centre Hospitalier de La Roche-sur-Yon, Les Oudairies 85000, La Roche-sur-Yon, France; 14) Department of Clinical Hematology, Montpellier University Hospital Center, Montpellier, France; 15) Department of Hematology, Erasmus MC Cancer Institute, Rotterdam, the Netherlands and European Myeloma Network, EMN, the Netherlands; 16) Department of Hematology, Erasmus MC Cancer Institute, Rotterdam, the Netherlands

Abstract 7500

Etentamig: A Novel BCMA Bispecific Antibody

MONVISO (NCT05650632): multicenter, open-label, Phase 1b study

Treatment arms

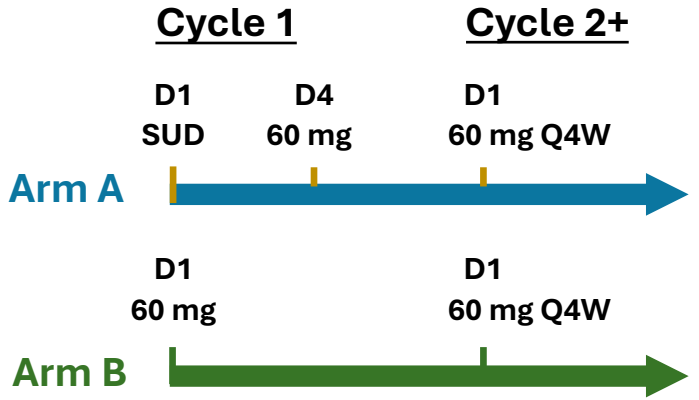
- **Arm A:** Etentamig with **SUD**
- **Arm B:** Etentamig after prior **BCMA exposure (no SUD)**
- **Arm C:** **Outpatient** etentamig with **SUD**
- **Arm D:** **Outpatient** etentamig with **SUD** in US community sites

Key eligibility criteria

- Adults (aged ≥18 years) with RRMM; ECOG PS ≤2

	Arm A	Arm B
Prior LoT	≥3	≥2
Prior exposure to:		
PI, IMiD, and anti-CD38 mAb	Required	Required
BCMA (CAR-T and/or ADC)	Not allowed	Required[a]
Outpatient administration	Allowed	Allowed

Etentamig monthly dosing



Endpoints

- **Primary safety:**
  - **Arm A:** Grade ≥2 CRS (Cycle 1)
  - **Arm B:** CRS and ICANS
- **Exploratory efficacy:**
  - ORR[b]
  - DoR and PFS

MONVISO defined the OPTIMAL ETENTAMIG INITIATION SCHEDULE to reduce CRS and enable safe outpatient administration for ALL PATIENTS

[a]Prior BCMA CAR-T or BCMA ADC must be completed >6 months or >30 days prior to first dose of study treatment, respectively. Prior BCMA-directed therapies included CAR-T preferred terms: CAR-T cells not otherwise specified, idecabtagene vicleucel, ciltacabtagene autoleucel, or ADC preferred terms: belantamab mafodotin and belantamab. Prior BCMA bispecific or trispecific antibody therapy is not permitted. [b]IMWG 2016 criteria. ADC, antibody-drug conjugate; BCMA, B-cell maturation antigen; CAR-T, chimeric antigen receptor T cell; CRS, cytokine release syndrome; D, day; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; ICANS, immune effector cell-associated neurotoxicity syndrome; IMiD, immunomodulatory drug; IMWG, International Myeloma Working Group; LoT, line of therapy; mAb, monoclonal antibody; ORR, objective response rate; PFS, progression-free survival; PI, proteasome inhibitor; Q4W, every 4 weeks; RRMM, relapsed/refractory multiple myeloma; SUD, step-up dose.

Chhabra S et al. ASCO 2026;Abstract 7508

Baseline characteristics demonstrate a heavily pretreated patient population with difficult-to-treat disease

Characteristics	Prior BCMA CAR-T n=24	Any prior BCMA N=41
Median age, years (range)	68 (43–79)	68 (43–89)
≥75 years, n (%)	2 (8.3)	8 (19.0)
Sex, n (%)		
Female	7 (29.2)	18 (42.9)
Male	17 (70.8)	24 (57.1)
Race, n (%)		
White	22 (91.7)	38 (92.7)
Black/African American	2 (8.3)	3 (7.3)
Ethnicity, n (%)		
Hispanic or Latino	0	2 (4.8)
Not Hispanic or Latino	24 (100)	40 (95.2)
ECOG PS [at entry], n (%)		
0	11 (45.8)	14 (34.1)
1	12 (50.0)	23 (56.1)
2	1 (4.2)	4 (9.8)
R-ISS [at entry],[a] n (%)		
I	8 (33.3)	12 (30.0)
II	9 (37.5)	17 (42.5)
III	5 (20.8)	8 (20.0)

Characteristics	Prior BCMA CAR-T n=24	Any prior BCMA N=41
Cytogenetic risk,[a,b] n (%)		
Standard	13 (54.2)	19 (46.3)
High risk	7 (29.2)	10 (24.4)
Plasmacytomas,[c] n (%)		
Presence	**5 (20.8)**	**11 (26.8)**
Absence	**19 (79.2)**	**30 (73.2)**
Number of prior LoT, median (range)	**6 (3–9)**	**6 (3–15)**
≥6 prior LoT, n (%)	**14 (58.3)**	**25 (61.0)**
BCMA-directed therapy as last LoT, n (%)	**12 (50.0)**	**21 (51.2)**
Median time from last prior BCMA-directed therapy to first dose of etentamig, months (range)	16.4 (7.1–29.9)	14.9 (1.4–45.2)
Non-responder to prior BCMA CAR-T/ADC,[d] n (%)	**6 (25.0)**	**17 (41.5)**

61% received ≥6 pLoT and 42% were non-responders to prior BCMA-directed therapy

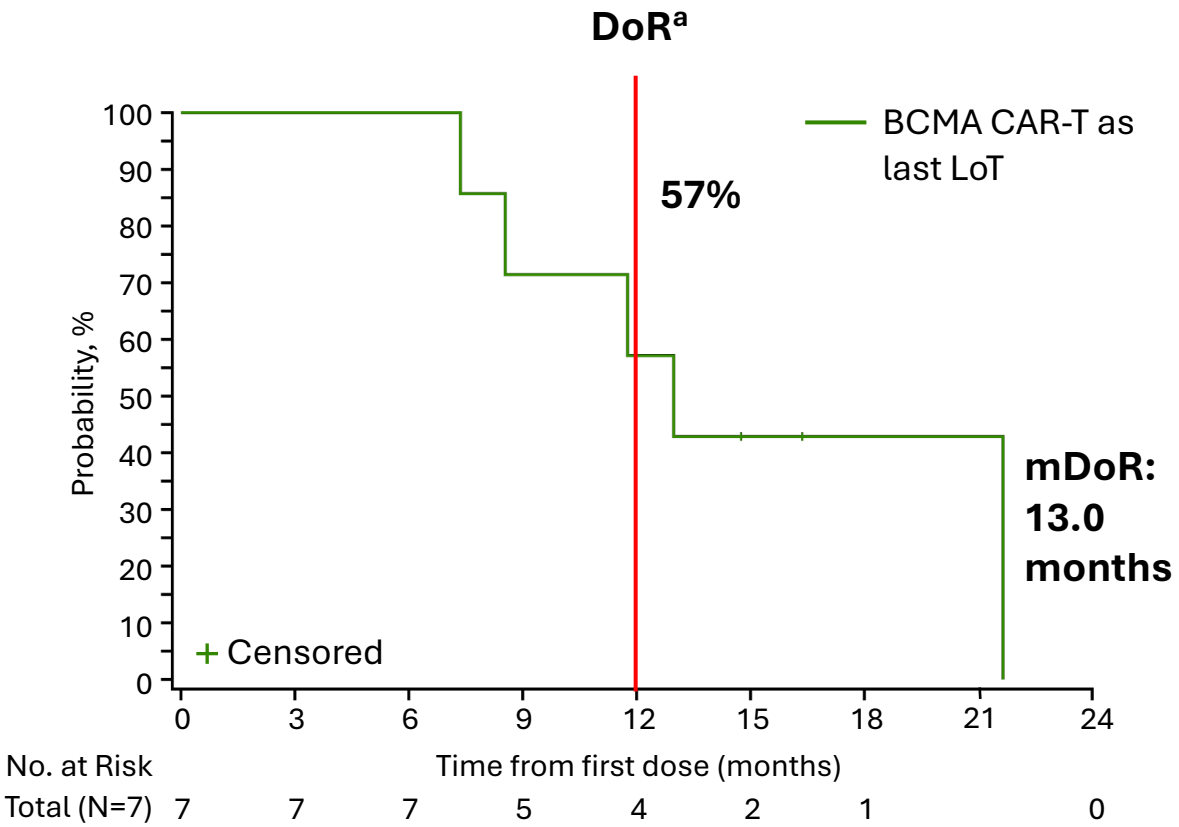
Note: Percentages calculated on nonmissing values. Baseline demographics for age, sex, race, and ethnicity were calculated using N=42, as one patient who did not meet eligibility criteria was inadvertently enrolled. [a]R-ISS unknown for 2 patients with prior CAR-T and 3 patients with any prior BCMA and missing for 1 patient in any prior BCMA. Cytogenetic risk unknown for 4 patients with prior CAR-T and 12 patients with any prior BCMA. [b]High risk: ≥1 of the following genetic abnormalities detected: t(4;14), t(14;16), or del(17p). Standard risk: None of the following genetic abnormalities detected: t(4;14), t(14;16), or del(17p). [c]CT, PET-CT, or MRI was used to assess for the presence of extramedullary or paramedullary/paraskeletal plasmacytoma. [d]Patients who did not achieve a PR or better. ADC, antibody-drug conjugate; BCMA, B-cell maturation antigen; CAR-T, chimeric antigen receptor T cell; CT, computed tomography; ECOG PS, Eastern Cooperative Oncology Group performance status; LOT, line of therapy; PR, partial response; MRI, magnetic resonance imaging; PET, positron emission tomography; R-ISS, Revised International Staging System.

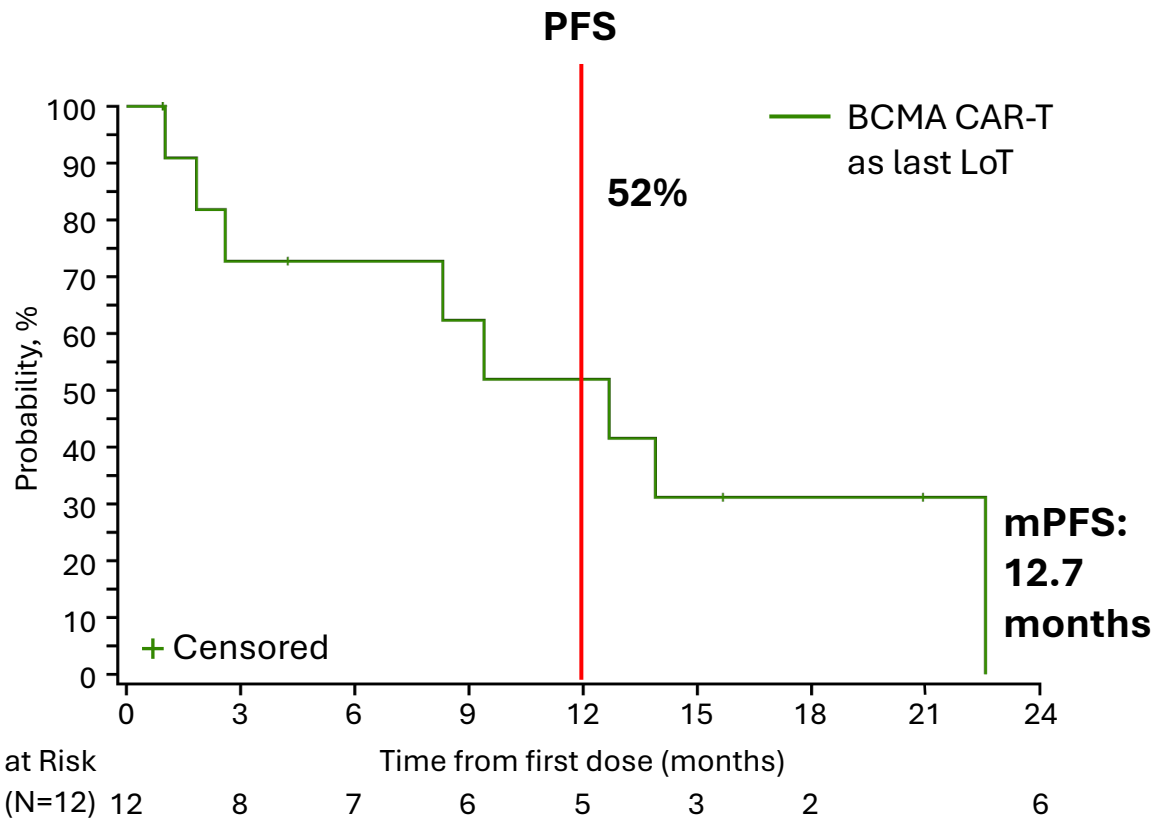
Data cutoff: March 31, 2026

Arm B

Chhabra S et al. ASCO 2026;Abstract 7508

Etentamig showed clinically meaningful outcomes immediately after receiving BCMA CAR-T as last LoT





Clinical implication: Linvoseltamab shows strong early efficacy with high complete response rates in AL amyloidosis.

Etentamig use immediately following BCMA CAR-T therapy is feasible without compromising efficacy

Median (range) follow-up[b]: 14.3 (0.2–26.1) months

[a]Among patients who achieved a PR or better. [b]Full analysis set. BCMA, B-cell maturation antigen; CAR-T, chimeric antigen receptor T cell; DoR, duration of response; LoT, line of therapy; m, median; No., number; PR, partial response; PFS, progression-free survival.

Arm B

Data cutoff: March 31, 2026

Chhabra S et al. ASCO 2026;Abstract 7508

MONVISO (NCT05650632): multicenter, open-label, Phase 1b study

Treatment arms

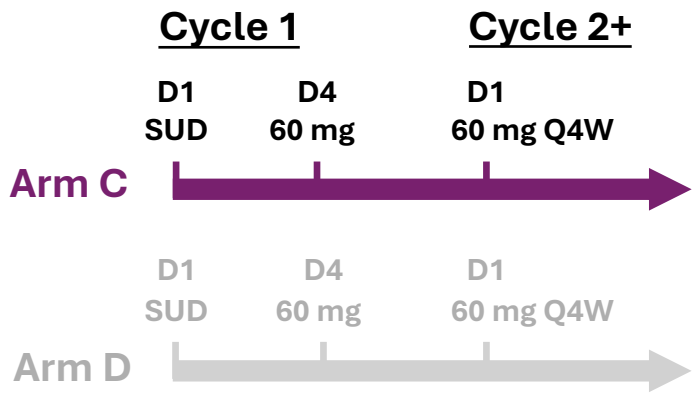
- **Arm A:** Etentamig with **SUD**
- **Arm B:** Etentamig after prior **BCMA exposure (no SUD)**
- **Arm C:** **Outpatient** etentamig with **SUD**
- **Arm D:** **Outpatient** etentamig with **SUD** in US community sites

Key eligibility criteria

- Adults (aged ≥18 years) with RRMM; ECOG PS ≤1

	Arm C	Arm D
Prior LoT	≥2	1–3
Prior exposure to:		
PI, IMiD, and anti-CD38 mAb	Required	Required[a]
BCMA (CAR-T and/or ADC)	Allowed[b]	Allowed[b]
Outpatient administration	Required	Required

Etentamig monthly dosing



Endpoints

- **Primary safety:**
  - **Arm C** and **Arm D**: Grade ≥2 CRS (Cycle 1)
- **Exploratory efficacy:**
  - ORR[c]
  - DoR and PFS

Clinical implication: Early organ responses suggest meaningful clinical benefit even with short follow-up.

Here we present initial etentamig safety data in the outpatient treatment setting

[a]Prior exposure to at least one of the following drug classes (PI, IMiD, and anti-CD38 mAb) is sufficient. [b]Prior BCMA CAR-T or BCMA ADC must be completed >6 months or >30 days prior to first dose of study treatment, respectively. Prior BCMA-directed therapies included CAR-T preferred terms: CAR-T cells not otherwise specified, idecabtagene vicleucel, ciltacabtagene autoleucel, or ADC preferred terms: belantamab mafodotin and belantamab. Prior BCMA bispecific or trispecific antibody therapy is not permitted. [c]IMWG 2016 criteria. ADC, antibody-drug conjugate; BCMA, B-cell maturation antigen; CAR-T, chimeric antigen receptor T cell; CRS, cytokine release syndrome; D, day; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; IMiD, immunomodulatory drug; IMWG, International Myeloma Working Group; LoT, line of therapy; mAb, monoclonal antibody; ORR, objective response rate; PFS, progression-free survival; PI, proteasome inhibitor; Q4W, every 4 weeks; RRMM, relapsed/refractory multiple myeloma; SUD, step-up dose.

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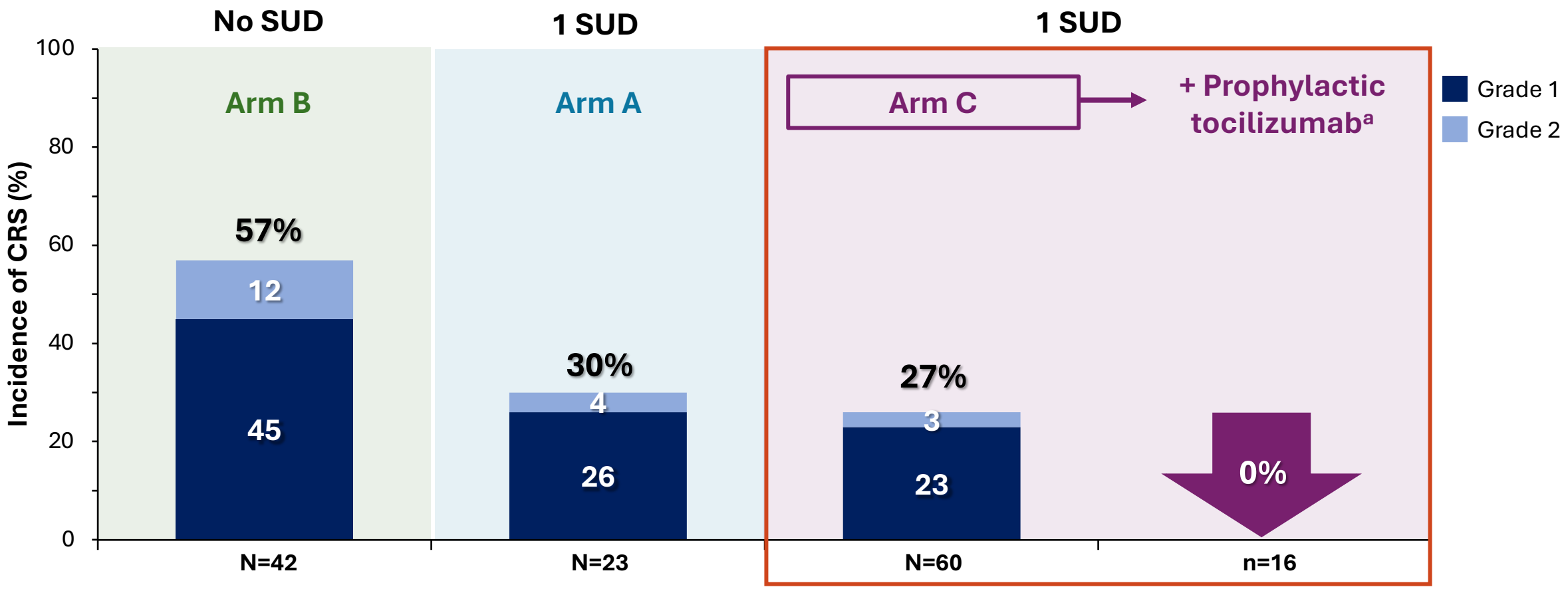
Prophylactic tocilizumab use with etentamig resulted in a 0% CRS incidence



Etentamig's safety profile can overcome bispecific antibody implementation barriers and improve accessibility across treatment settings

[a]Prophylactic tocilizumab given per investigator discretion. CRS, cytokine release syndrome; dex, dexamethasone; mod, modified; SUD, step-up dose.

Arm A data cutoff: July 12, 2024; Arm B data cutoff: March 31, 2026; Arm C data cutoff: March 31, 2026.

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2026 ASCO ANNUAL MEETING

DREAMM-9 Final Analysis: Belantamab Mafodotin, Bortezomib, Lenalidomide, and Dexamethasone (BVRd) for Transplant-Ineligible Newly Diagnosed Multiple Myeloma

Saad Z. Usmani, MD[1], Michał Mielnik, MD, PhD[2], Aránzazu Alonso Alonso, MD[3,4], Al-Ola Abdallah, MD, PhD[5], Mamta Garg, MD, FRCP, FRCPath[6], Wojciech Janowski, MD[7], Youngil Koh, MD[8], Enrique M. Ocio, MD, PhD[9], Hang Quach, MD[10], Karthik Ramasamy, MD[11], Albert Oriol, MD[12], Paula Rodriguez-Otero, MD[13], Irwindeep Sandhu, MD, FRCPC[14], Katja Weisel, MD[15], Zeyad Khalaf, MPharm, MSc[16], Jorge Mouro, MS[17], Chris Brawley, MSc[18], Miguel M. Murillo, PhD[19], Farrah Pompilus, PhD[20], Jacqueline L. Egger, PhD[21], Morrys C. Kaisermann, MD, PhD[22], Marek Hus, MD[2]

Abstract 7503

2026 ASCO ANNUAL MEETING

OPTec/OPTal: A Phase 2 study to evaluate outpatient (OP) step-up administration of teclistamab (Tec) or talquetamab (Tal) with prophylactic tocilizumab (prophyToci) in patients (pts) with relapsed/refractory multiple myeloma (RRMM)

Peter Forsberg, MD[1], David Andorsky, MD[2], Robert Rifkin, MD, FACP[3], Christopher Yasenchak, MD[4], Mohit Narang, MD[5], Jason Melear, MD[6], Henning Schade, MD[1], Mitul Gandhi, MD[7], Gary Simmons, DO, MSHA[8], Muhamed Baljevic, MD, FACP[9], Habte Yimer, MD[10], Kruti Patel, MD[11], Amanda Gillespie-Twardy[12], Sudhir Manda, MD[13], John Renshaw, MD[14], Jessica Fowler, PhD[15], Thomas S. Lin, MD, PhD[15], Tonya Le Blanc[15], and Weiming Xu, MD, PhD[16]

[1]Colorado Blood Cancer Institute, Denver, CO; [2]Rocky Mountain Cancer Centers, Boulder, CO; [3]UCHealth Yampa Valley Medical Center, Steamboat Springs, CO; [4]Willamette Valley Cancer Institute and Research Center, Eugene, OR; [5]Maryland Hematology Oncology Associates, Columbia, MD; [6]Texas Oncology PA, Austin, TX; [7]Virginia Cancer Specialists, Gainesville, VA; [8]Virginia Oncology Associates, Norfolk, VA; [9]Vanderbilt University Medical Center, Nashville, TN; [10]Texas Onc Tyler, Tyler, TX; [11]OHC (Oncology Hematology Care)/US Oncology Network, Cincinnati, OH; [12]Blue Ridge Cancer Care, Roanoke, VA; [13]TMC Health Cancer Center, Tucson, AZ; [14]Texas Oncology–San Antonio Medical Center, The US Oncology Network, San Antonio, TX; [15]Johnson & Johnson US Hematology Medical Affairs, Horsham, PA; [16]Sarah Cannon Research Institute, Development Innovations, Nashville, TN

Abstract 7510

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2026 ASCO ANNUAL MEETING

Abstract 7512

BELANTAMAB MAFODOTIN WITH DARATUMUMAB, LENALIDOMIDE AND DEXAMETHASONE IN TRANSPLANT-INELIGIBLE NEWLY DIAGNOSED MULTIPLE MYELOMA PATIENTS: PHASE 1/2 BELADRD STUDY

E. TERPOS[1], I. NTANASIS-STATHOPOULOS[1], M. GAVRIATOPOULOU[1], N. KANELLIAS[1], P. MALANDRAKIS[1], E. SOLIA[1], F. THEODORAKAKOU[1], E. VASALOU[2], M. MIGKOU[1], E. ELEUTHERAKIS-PAPAIAKOVOU[1], E. KASTRITIS[1], M. A. DIMOPOULOS[1,3]

[1]Department of Clinical Therapeutics, National and Kapodistrian University of Athens, School of Medicine, Athens, Greece
[2]Veeda Lifesciences, Dublin, Ireland
[3]Department of Medicine, Korea University, Seoul, South Korea, Athens, Greece

HIGH MRD NEGATIVITY RATES AND PROLONGED PFS WITH BELANTAMAB MAFODOTIN PLUS DARATUMUMAB, LENALIDOMIDE, AND DEXAMETHASONE IN TRANSPLANT INELIGIBLE NEWLY-DIAGNOSED MYELOMA: RESULTS OF THE BELA-DRD STUDY

E.TERPOS[1], I.NTANASIS-STATHOPOULOS[1], M.GAVRIATOPOULOU[1], N.KANELLIAS[1], P.MALANDRAKIS[1], E.SOLIA[1], F.THEODORAKAKOU[1], Y.VYAS[2], M.MIGKOU[1], E.ELEFTHERAKIS-PAPAIAKOVOU[1], E.KASTRITIS[1], M.A.DIMOPOULOS[1,3]

[1]National and Kapodistrian University of Athens, School of Medicine, Department of Clinical Therapeutics, Athens, Greece
[2]Veeda Lifesciences, Athens, Greece
[3]Korea University, Department of Medicine, Seoul, South Korea

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RTP Year in Review 2026

TPS7577

Trial in progress: QUINTESSENTIAL-2—a phase 3 study of arlocabtagene autoleucel versus standard of care in adult patients with relapsed and refractory multiple myeloma (RRMM) exposed to lenalidomide

Eyal Lebel,[1] Ahmed Abdulgawad,[2] Stefania Bramanti,[3] Gonzalo Garate,[4] Phoebe Joy Ho,[5] Mikko Keränen,[6] Yael Cohen,[7] Maja Vase,[8] Amit Khot,[9] Ida Bruun Kristensen,[10] Richard LeBlanc,[11] Cindy Lee,[12] Wojciech Legiec,[13] Hila Magen,[14] Maria-Victoria Mateos,[15] Danielle Oh,[16] Ludek Pour,[17] Natalia Schutz,[18] Alexandros Spyridonidis,[19] Katja Weisel,[20] Jan Zaucha,[21] Sarah Larson,[22] Asya Varshavsky-Yanovsky,[23] Kimberly Grazioli,[24] Debashree Basudhar,[24] Hongxiang Hu,[24] Ya Meng,[24] Lamis Eldjerou,[24] Susan Bal,[25] Simon Harrison,[9] Rakesh Popat,[26] Marc Raab,[27] Paula Rodriguez-Otero[28]

Abstract TPS7577

Teclistamab Improves Depth of Response and PFS versus Lenalidomide-Dexamethasone in High-Risk Smoldering Multiple Myeloma: Results from the phase 2 ImmunoPRISM Trial

Omar Nadeem, David Cordas dos Santos, Sophie Magidson, Jeffrey Matous, Eva Medvedova, Elizabeth O'Donnell, Robert A Redd, Yuxin Liu, Shonali Midha, Adam Sperling, Frances Arters, Marjorie Marto, Amy Bergeron, Christine Davie, Caroline Ricciardi, Nayda Bidikian, Francesco Corrado, Rosa Toenges, Daniel Addonizio, Siham Mohamed, Ashlee Sturtevant, Lorenzo Trippa and **Irene M. Ghobrial**

Center for Early Detection and Interception of Blood Cancers
Dana-Farber Cancer Institute
Harvard Medical School
Boston, MA

Dana-Farber Cancer Institute

EHA 2026; Abstract LB5008

AZD0120, a Dual BCMA/CD19 CAR-T Cell Therapy, Demonstrates a Naïve/Central Memory Phenotype and Induces a Rapid Decline in Soluble BCMA in Relapsed/Refractory Multiple Myeloma

Binod Dhakal, MD[1], Shambavi Richard, MD[2], Patricia Cheung, PhD[3], Liang Li, PhD[4], Meiyue G Hong, MD[5], Yu-Feng Lin, DrPH[6], Jennifer Ma[7], Rebecca Shah[3], Scott R Goldsmith, MD[8]

[1]Medical College of Wisconsin, Milwaukee, WI; [2]Icahn School of Medicine at Mount Sinai, New York, NY; [3]AstraZeneca, South San Francisco, CA; [4]AstraZeneca, Gaithersburg, MD; [5]AstraZeneca, Boston, MA; [6]AstraZeneca, Waltham, MA; [7]AstraZeneca, Santa Monica, CA; [8]City of Hope Comprehensive Cancer Center, Duarte, CA

EHA 2026; Abstract S187

Teclistamab +/- Lenalidomide Versus Lenalidomide Alone as Maintenance Therapy Post-Transplant in Newly Diagnosed Multiple Myeloma: Updated Safety Run-In Results From EMN30/MajesTEC-4*

*ClinicalTrials.gov Identifier: NCT05243797; sponsored by EMN in collaboration with Johnson & Johnson

Niels WCJ van de Donk,[1] Tobias Silzle,[2] Ivan Špička,[3] Sabrin Tahri,[4] Inger S Nijhof,[5] Antonietta Pia Falcone,[6] Evangelos Terpos,[7] Jakub Radocha,[8] Roberto Mina,[9] Güldane Cengiz Seval,[10] Meral Beksac,[10,11] Cesar Rodriguez,[12] Marcelo C Pasquini,[13] Alfred Garfall,[14] Murali Janakiram,[15] Michel Delforge,[16] Vania Hungria,[17] Donna Reece,[18] Cyrille Touzeau,[19] Yael C Cohen,[20] Kihyun Kim,[21] Dominik Dytfeld,[22] Jiří Minařík,[23] Irene Strassl,[24] Thomas Melchardt,[25] Jelena Bila,[26] Martin Schreder,[27] Janusz Krawczyk,[28] Fredrik Schjesvold,[29] Caroline Cicin-Sain,[2] Christoph Driessen,[2] Maria Atta,[30] Lugui Qiu,[31] Gonzalo M Garate,[32] Agoston Gyula Szabo,[33] Roman Hájek,[34] Marc S Raab,[35] Silvia Mangiacavalli,[36] Cristina João,[37] Hermann Einsele,[38] Andrew Spencer,[39] Mario Boccadoro,[40] Helen Vassalou,[41] Jagoda Jasielec,[42] Kayleigh Philips,[43] Caline Sakabedoyan,[44] Maria Krevvata,[45] Rebbecca Wilson,[45] Pieter Sonneveld,[46] Elena Zamagni[47]

EHA 2026; Abstract S197

Teclistamab Plus Daratumumab (Tec-Dara) in Patients (Pts) With Relapsed Refractory Multiple Myeloma (RRMM): Analysis of MajesTEC-3 Based on Cytogenetic and Functional Risk

Rahul Banerjee,[1,2] Niels WCJ van de Donk,[3] Roberto Mina,[4] Maria Victoria Mateos,[5] Nizar J Bahlis,[6] Aurore Perrot,[7] Ajay K Nooka,[8] Jin Lu,[9] Charlotte Pawlyn,[10,11] Gaston Caeiro,[12] Alain Kentos,[13] Vania Hungria,[14] Anne K Mylin,[15] Charlotte Toftmann Hansen,[16] Raphael Teipel,[17] Britta Besemer,[18] Meletios A Dimopoulos,[19,20] Elena Zamagni,[21,22] Satoshi Yoshihara,[23] Kihyun Kim,[24] Paul Geerts,[25] Elena Van Leeuwen-Segarceanu,[26] Agata Tyczynska,[27] Markus Hansson,[28] Mark Grey,[29] Surbhi Sidana,[30] Paula Rodriguez-Otero,[31] Joaquin Martinez-Lopez,[32] Hamza Hashmi,[33] Larry D Anderson Jr,[34] Claudio Cerchione,[35] Salomon Manier,[36] Jesús San-Miguel,[37] Muhamed Baljevic,[38] Robin Carson,[39] Weili Sun,[40] Kristen Lantz,[39] Anne Seifert,[41] Deborah Briseno-Toomey,[42] Lisa O'Rourke,[39] Maria Rubin,[43] Diego Vieyra,[39] Lijuan Kang,[39] Hongmei Xu,[44] Ricardo Attar,[39] Christopher Chiu,[43] Luciano J Costa[45]

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Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Therapeutic Targets Beyond EGFR for Non-Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, June 30, 2026

5:00 PM – 6:00 PM ET

Faculty

John V Heymach, MD, PhD

Maurice Pérol, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

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