

Strategic Treatment Sequencing in Relapsed Multiple Myeloma: A 2026 Algorithmic Approach

Philippe Moreau
Nantes, France



DISCLOSURES

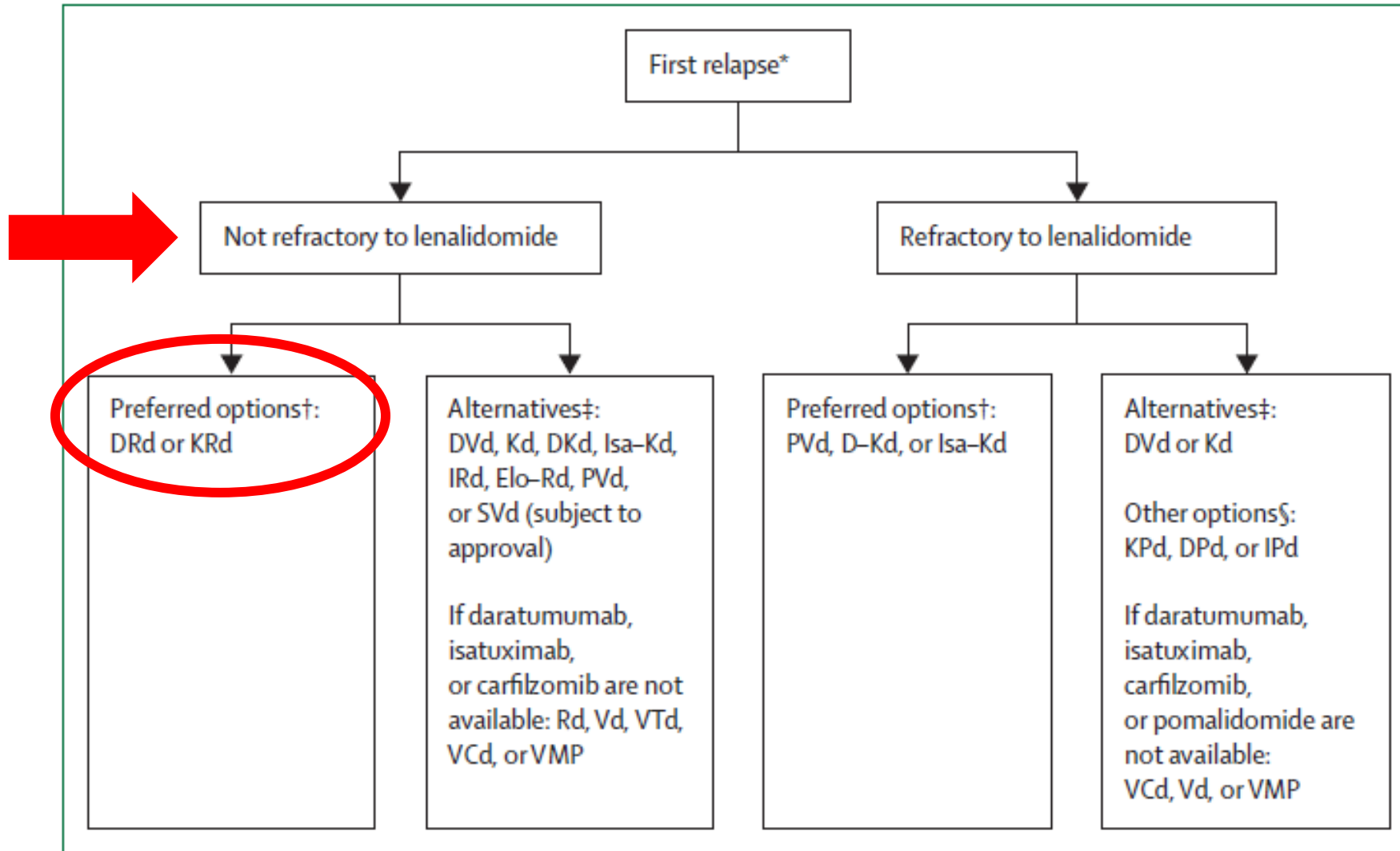
**Honoraria & advisory boards:
Janssen, Celgene, Takeda, Amgen, Abbvie, Sanofi,
GSK, Pfizer, BD**

Treatment of relapsed and refractory multiple myeloma: recommendations from the International Myeloma Working Group



Philippe Moreau, Shaji K Kumar, Jesús San Miguel, Faith Davies, Elena Zamagni, Nizar Bahlis, Heinz Ludwig, Joseph Mikhael, Evangelos Terpos, Fredrik Schjesvold, Thomas Martin, Kwee Yong, Brian G M Durie, Thierry Facon, Artur Jurczyszyn, Surbhi Sidana, Noopur Raje, Niels van de Donk, Sagar Lonial, Michele Cavo, Sigurdur Y Kristinsson, Suzanne Lentzsch, Roman Hajek, Kenneth C Anderson, Cristina João, Hermann Einsele, Pieter Sonneveld, Monika Engelhardt, Rafael Fonseca, Annette Vangsted, Katja Weisel, Rachid Baz, Vania Hungria, Jesus G Berdeja, Fernando Leal da Costa, Angelo Maiolino, Anders Waage, David H Vesole, Enrique M Ocio, Hang Quach, Christoph Driessen, Joan Bladé, Xavier Leleu, Eloisa Riva, Peter Leif Bergsagel, Jian Hou, Wee Joo Chng, Ulf-Henrik Mellqvist, Dominik Dytfeld, Jean-Luc Harousseau, Hartmut Goldschmidt, Jacob Laubach, Nikhil C Munshi, Francesca Gay, Meral Beksac, Luciano J Costa, Martin Kaiser, Parameswaran Hari, Mario Boccadoro, Saad Z Usmani, Sonja Zweegman, Sarah Holstein, Orhan Sezer, Simon Harrison, Hareth Nahi, Gordon Cook, Maria-Victoria Mateos, S Vincent Rajkumar, Meletios A Dimopoulos, Paul G Richardson

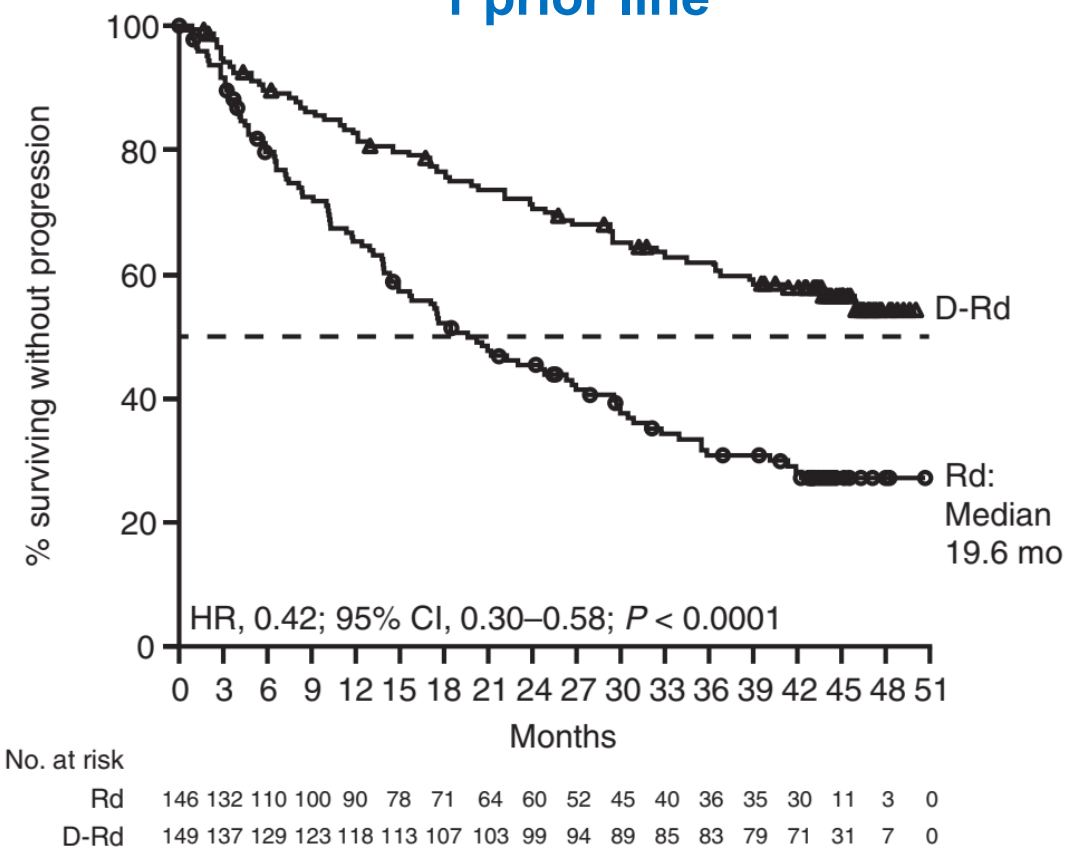
First relapse



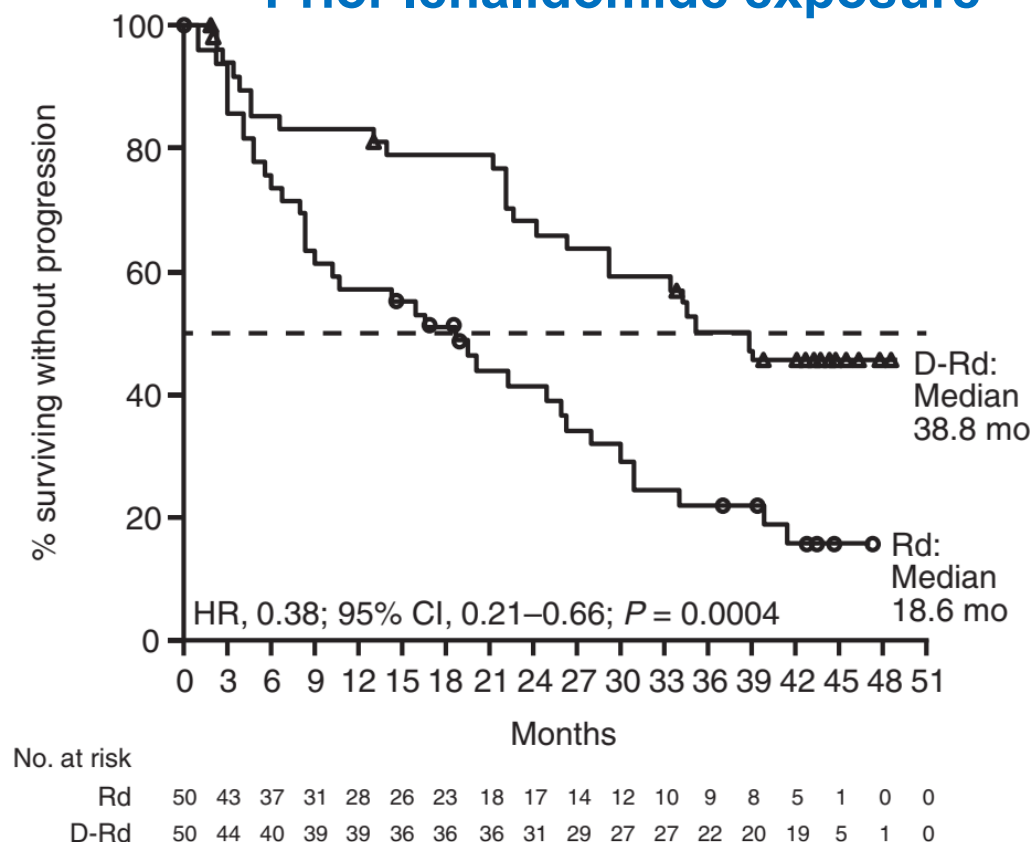
POLLUX: Rd vs Rd-Dara; updated PFS

Ongoing, randomized, open-label, multicenter, phase 3 study in patients with RRMM
(ClinicalTrials.gov Identifier: NCT02076009); N=569

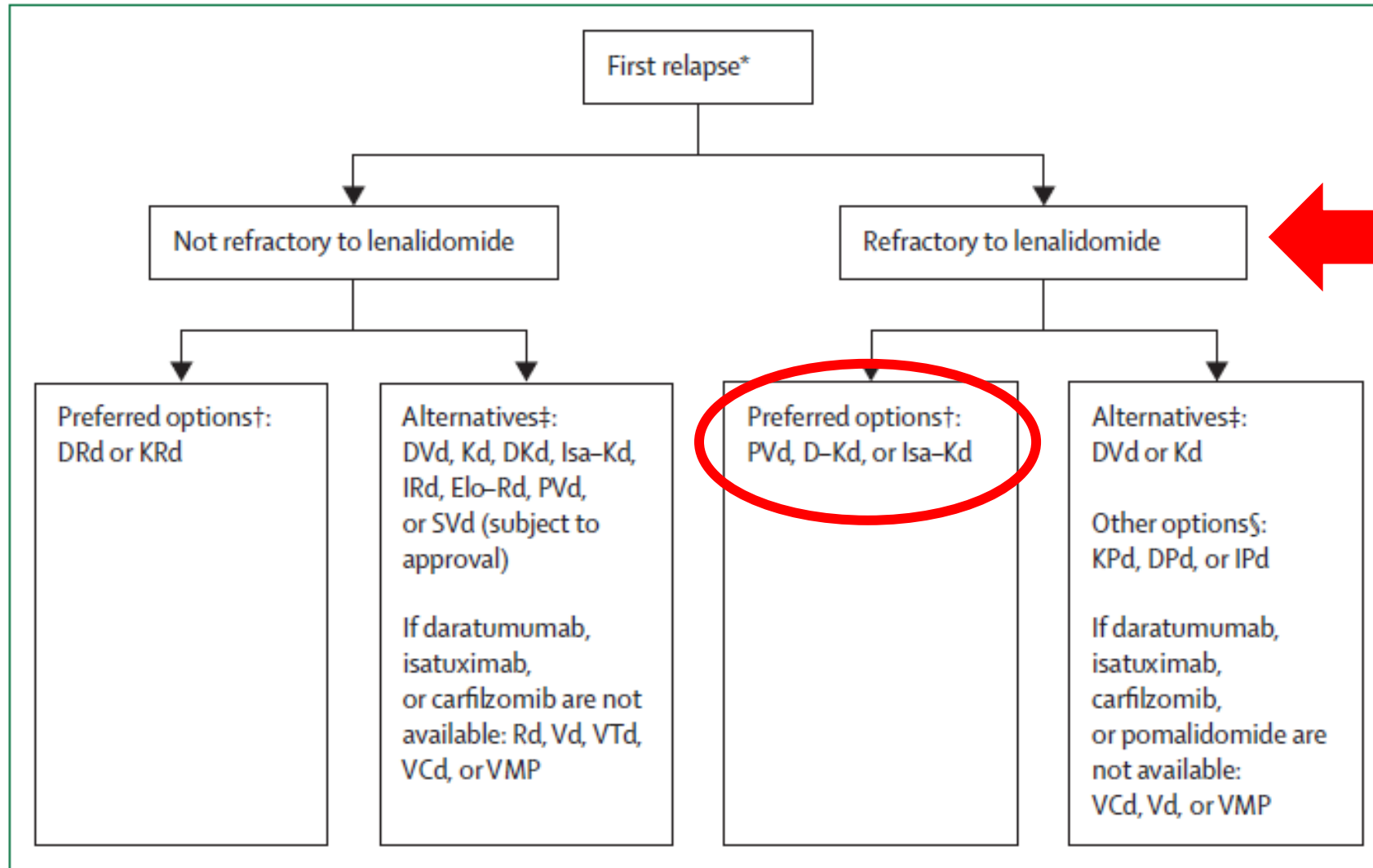
1 prior line



Prior lenalidomide exposure

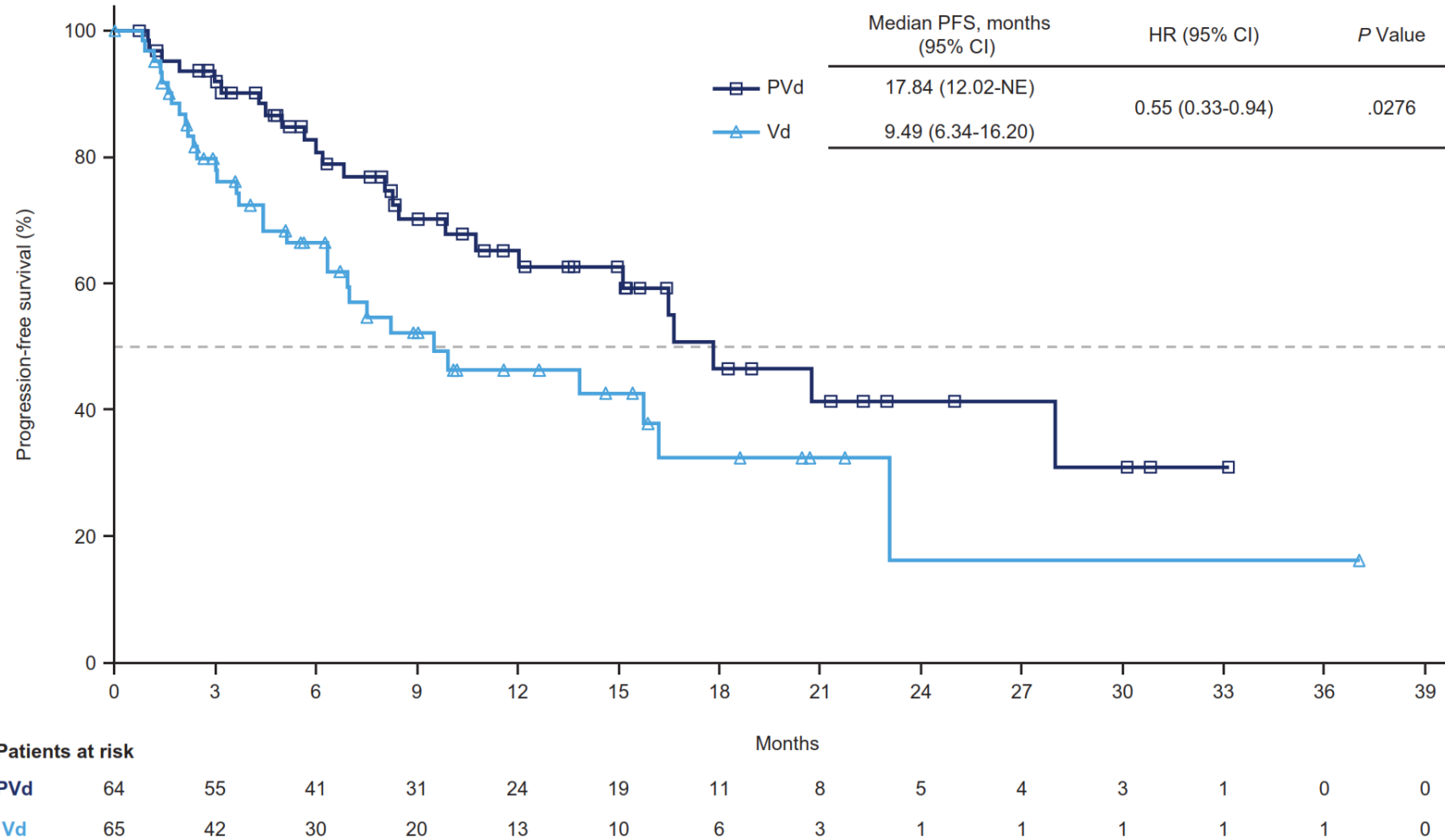


First relapse

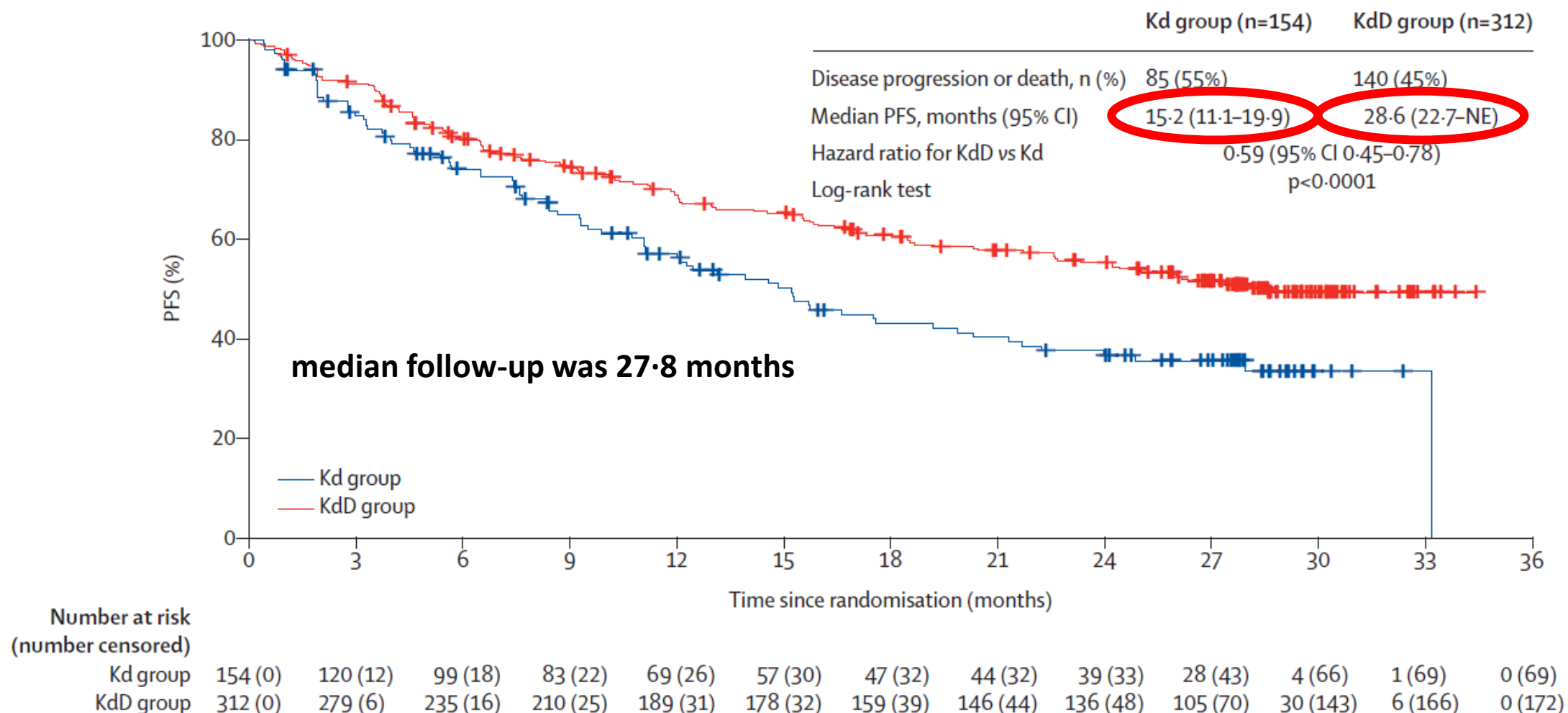


OPTIMISMM: PVD vs Vd; 1st relapse, Len-refractory patients

A

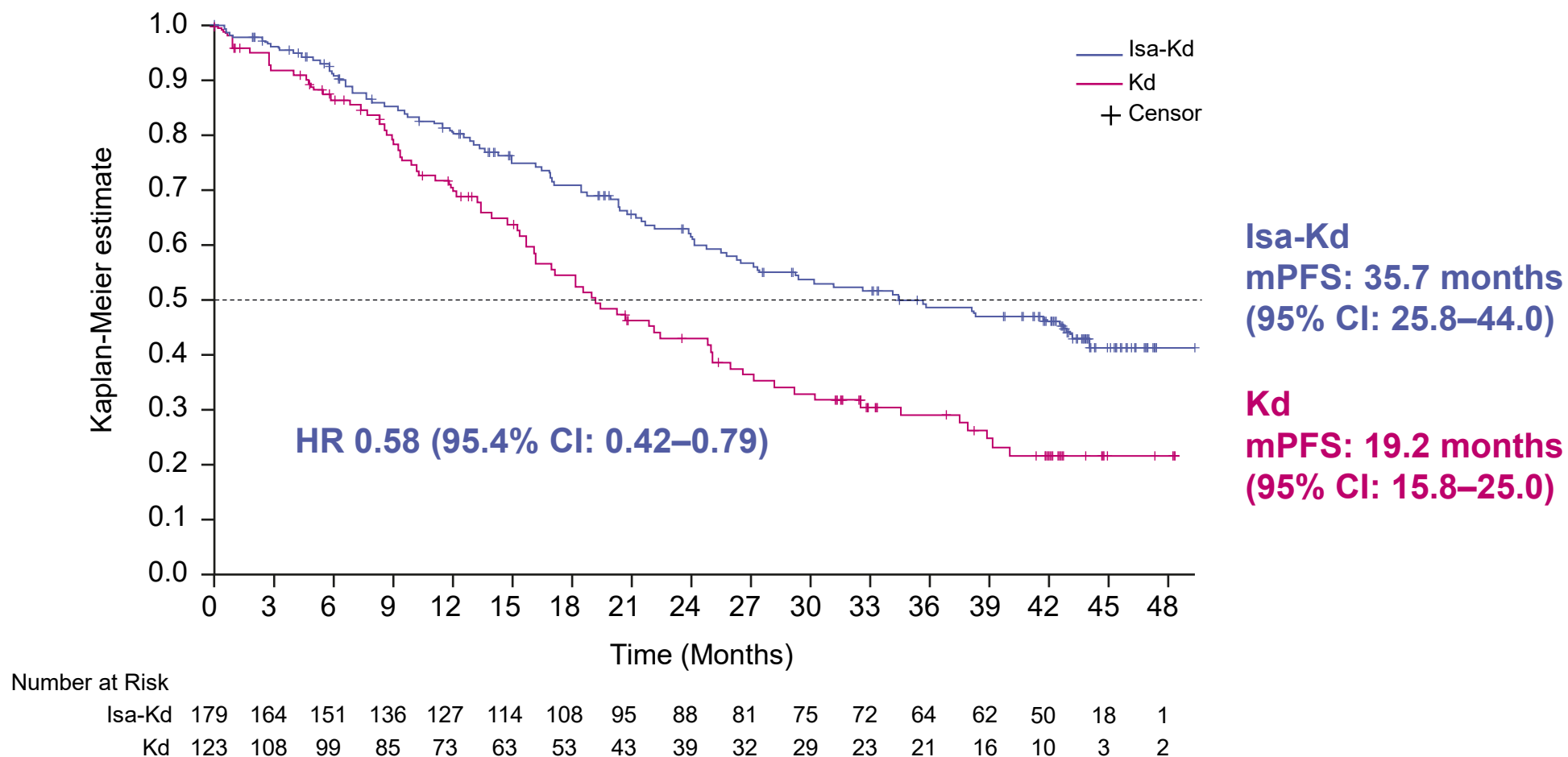


41% reduction in the risk of progression/death and a 13.4-month improvement in median PFS with KdD versus Kd



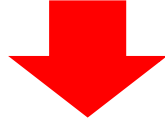
Usmani et al. Lancet Oncol. 2022 Jan;23(1):65-76

Updated PFS (primary endpoint) – IRC assessment (ITT)



With 2 additional years of follow-up, Isa-Kd showed the longest PFS on a PI-based backbone in the relapsed MM setting, with 42% reduction vs Kd in the risk of progression or death

Myeloma: Second or higher relapse



Preferred Options



- Any first relapse options that have not been tried
- **Isa-Pd; Dara-Kd, Isa-Kd, Dara-Pd (based on phase 3)**
- Elo-Pd, KPd (based on phase 2)
- When dara / K / elo not available: PCD, PD

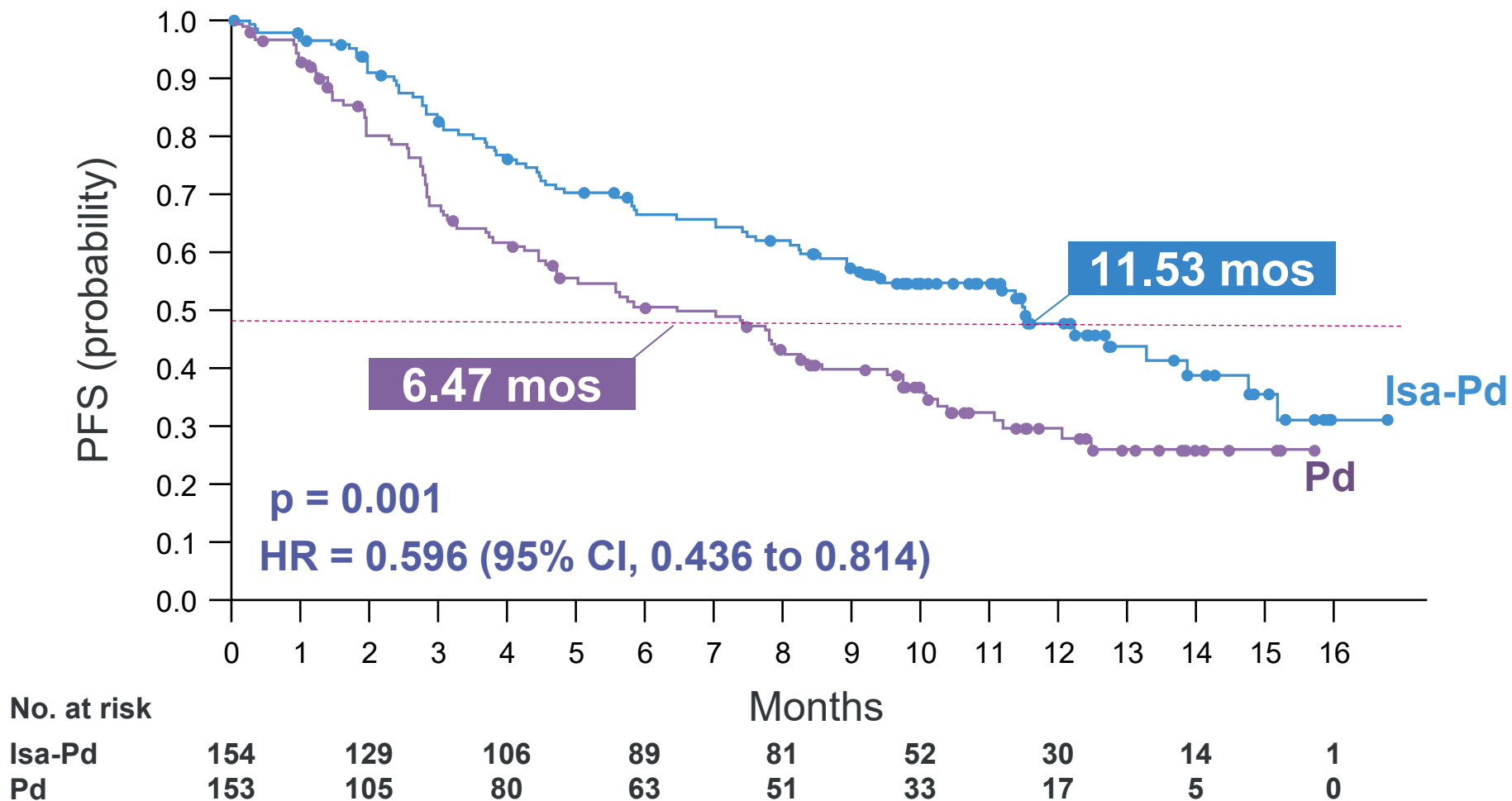
IKEMA and CANDOR

K or Pom as backbone + antiCD38 antibody

ICARIA and APPOLO

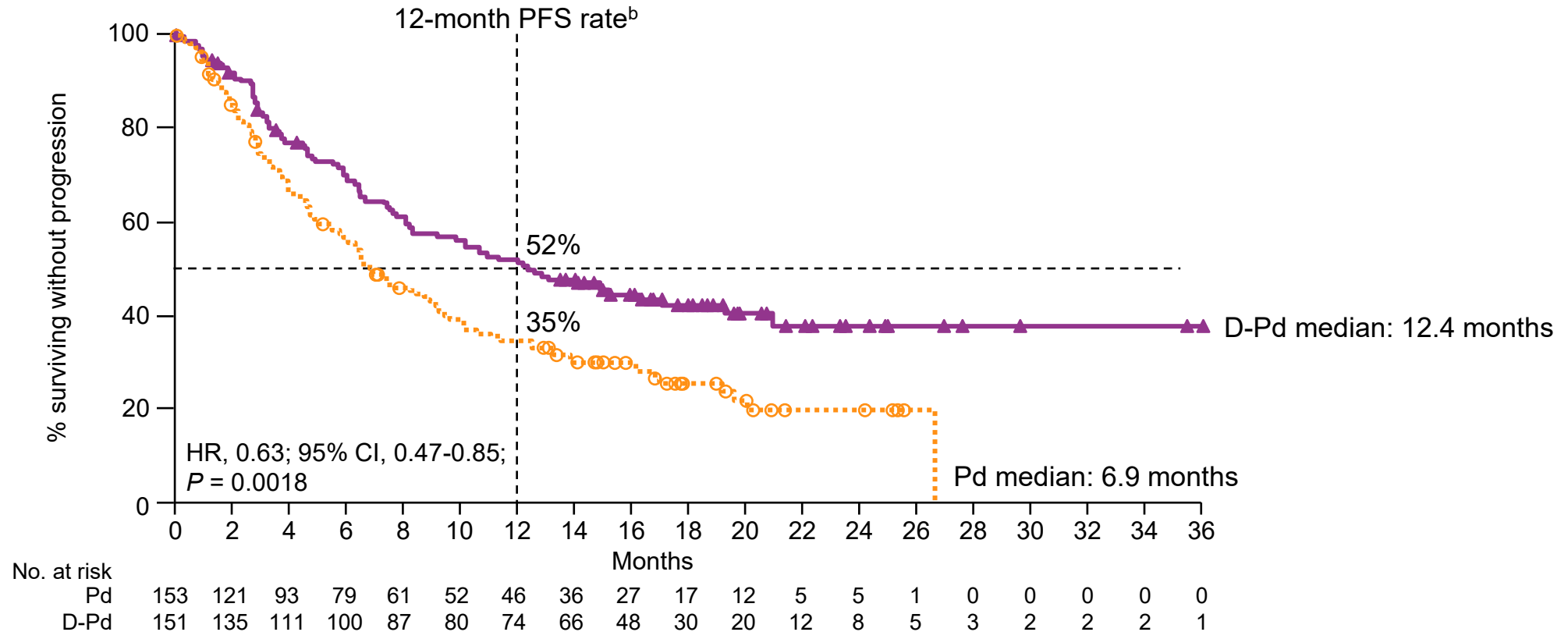
BCMA, B-cell maturation antigen; CAR, chimeric antigen receptor;
DKd, daratumumab/carfilzomib/dexamethasone; DPd, daratumumab/pomalidomide/dexamethasone;
Elo-Pd, elotuzumab/pomalidomide/dexamethasone; Isa-Kd, isatuximab/carfilzomib/dexamethasone;
Isa-Pd, isatuximab/pomalidomide/dexamethasone; KPd, carfilzomib/pomalidomide/dexamethasone;
PCd, pomalidomide/cyclophosphamide/dexamethasone; Pd, pomalidomide/
Dexamethasone; VdT-PACE, bortezomib/dexamethasone/thalidomide/cisplatin/
doxorubicin/cyclophosphamide/etoposide.

ICARIA : PFS primary endpoint – IRC assessment



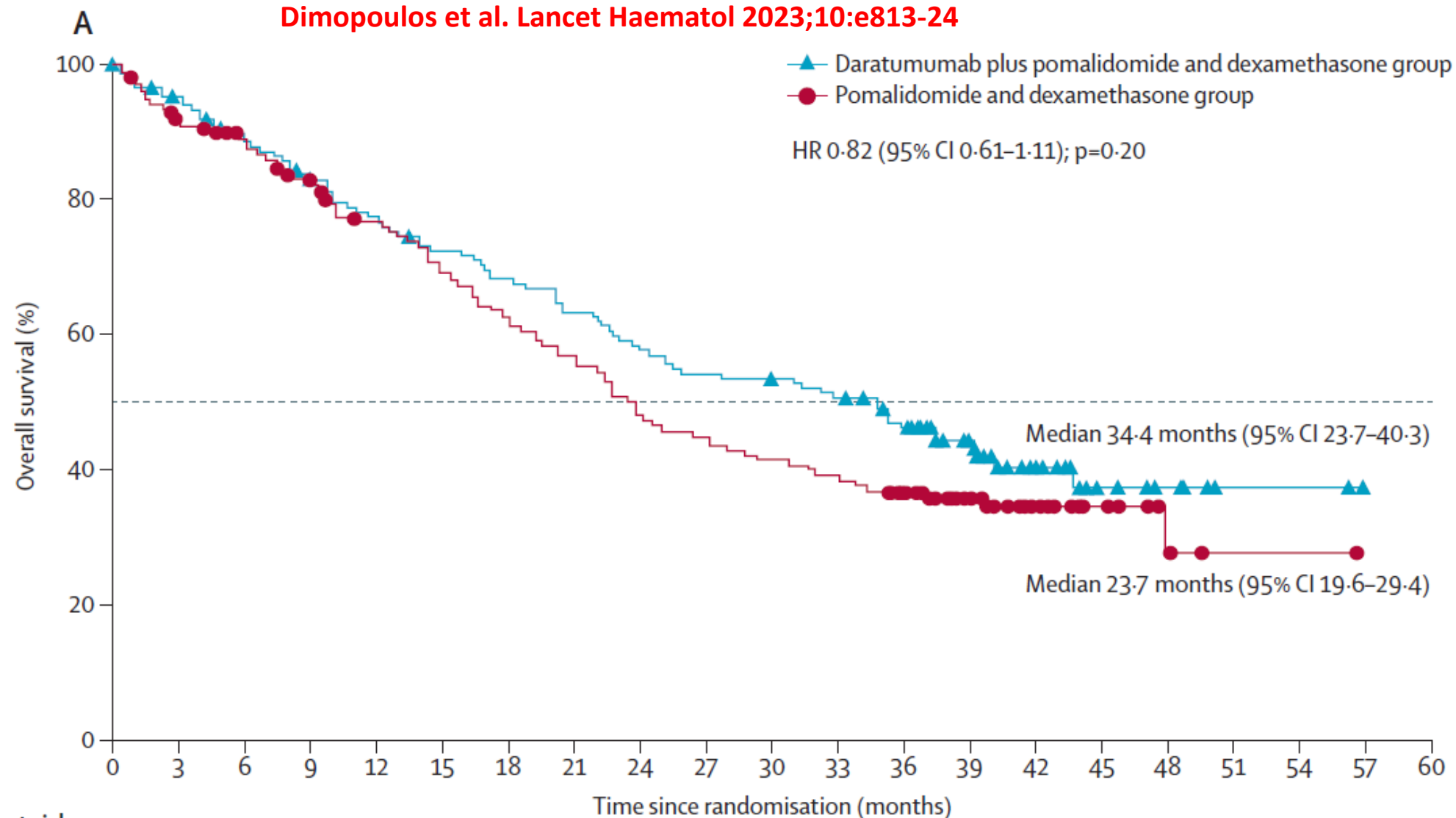
Statistically significant and clinically meaningful improvement in PFS

APOLLO: PFS at a median follow-up of 16.9 months^a



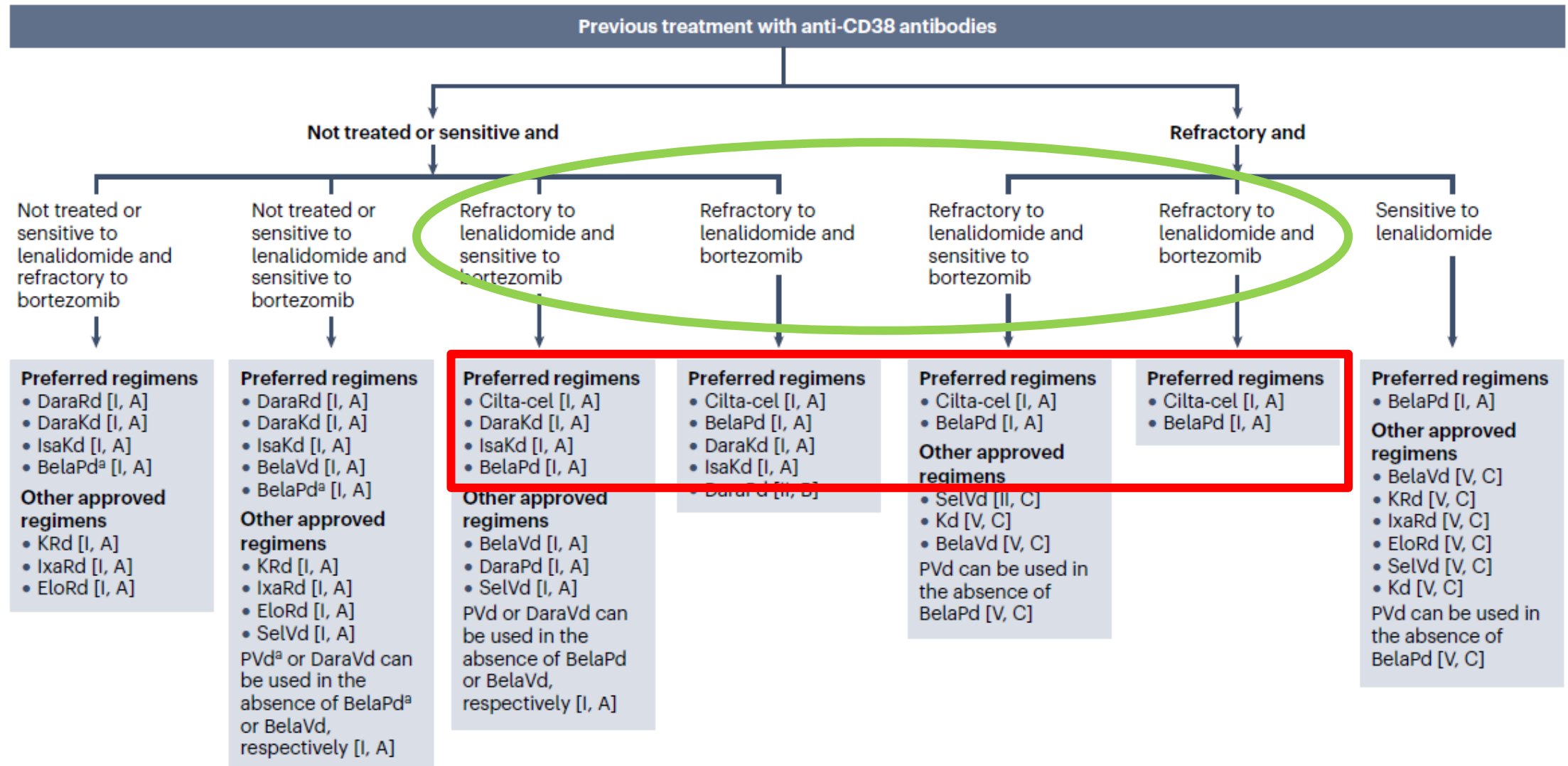
- Median PFS among patients refractory to lenalidomide was 9.9 months for D-Pd and 6.5 months for Pd

Addition of DARA SC to Pd improved PFS, with a 37% reduction in the risk of progression or death

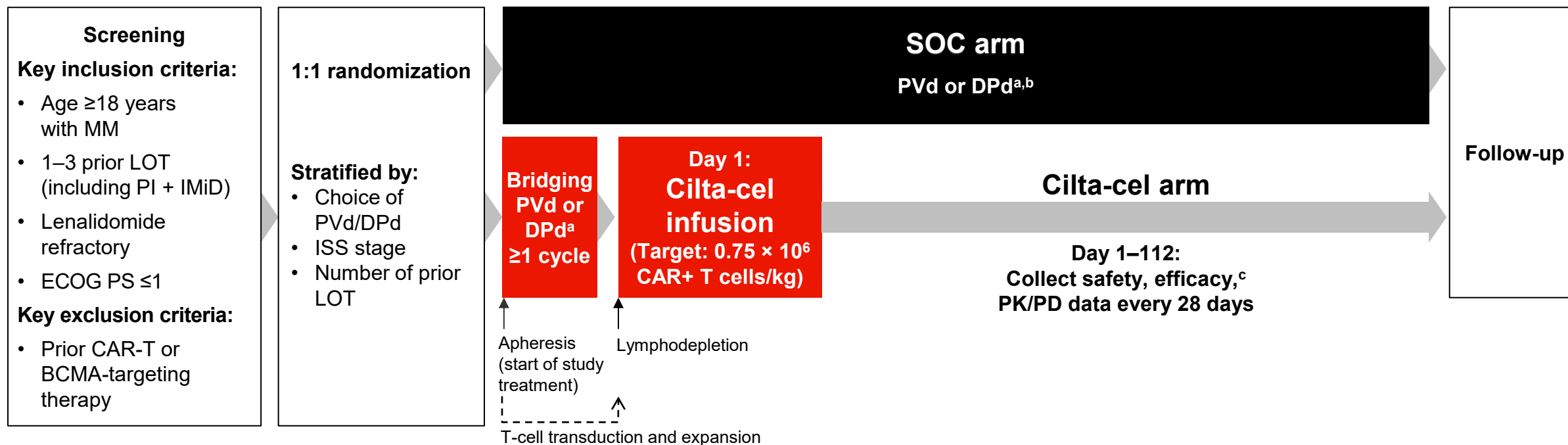


	Number at risk (number censored)																			
Daratumumab plus pomalidomide and dexamethasone group	151 (0)	140 (3)	129 (6)	119 (7)	111 (7)	103 (8)	97 (8)	90 (8)	82 (8)	77 (8)	76 (8)	72 (9)	62 (13)	39 (33)	19 (50)	9 (59)	6 (62)	2 (66)	2 (66)	0 (68)
Pomalidomide and dexamethasone group	153 (0)	137 (3)	128 (8)	117 (11)	104 (15)	94 (15)	85 (15)	77 (15)	65 (15)	61 (15)	56 (15)	53 (15)	45 (20)	29 (35)	18 (45)	12 (51)	4 (48)	1 (61)	1 (61)	0 (62)

SECOND-LINE



CARTITUDE-4: Study Design¹



Primary endpoint

- PFS^d

Secondary endpoints

- Efficacy: \geq CR, ORR, MRD negativity, OS
- Incidence and severity of AEs

^aPhysician's choice. ^bAdministered until disease progression. ^cEfficacy data were collected after Day 112 every 28 days. ^dTime from randomization to disease progression/death. AE, adverse event; BCMA, B-cell maturation antigen; CAR, chimeric antigen receptor; CTCAE, Common Terminology Criteria for Adverse Events; DPd, daratumumab, pomalidomide, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; IMiD, immunomodulatory drug; ISS, International Staging System; ORR, overall response rate; PD, pharmacodynamics; PI, proteasome inhibitor; PK, pharmacokinetics; PVd, pomalidomide, bortezomib, and dexamethasone. 1. San-Miguel J, et al. *N Engl J Med* 2023;389:335-47.

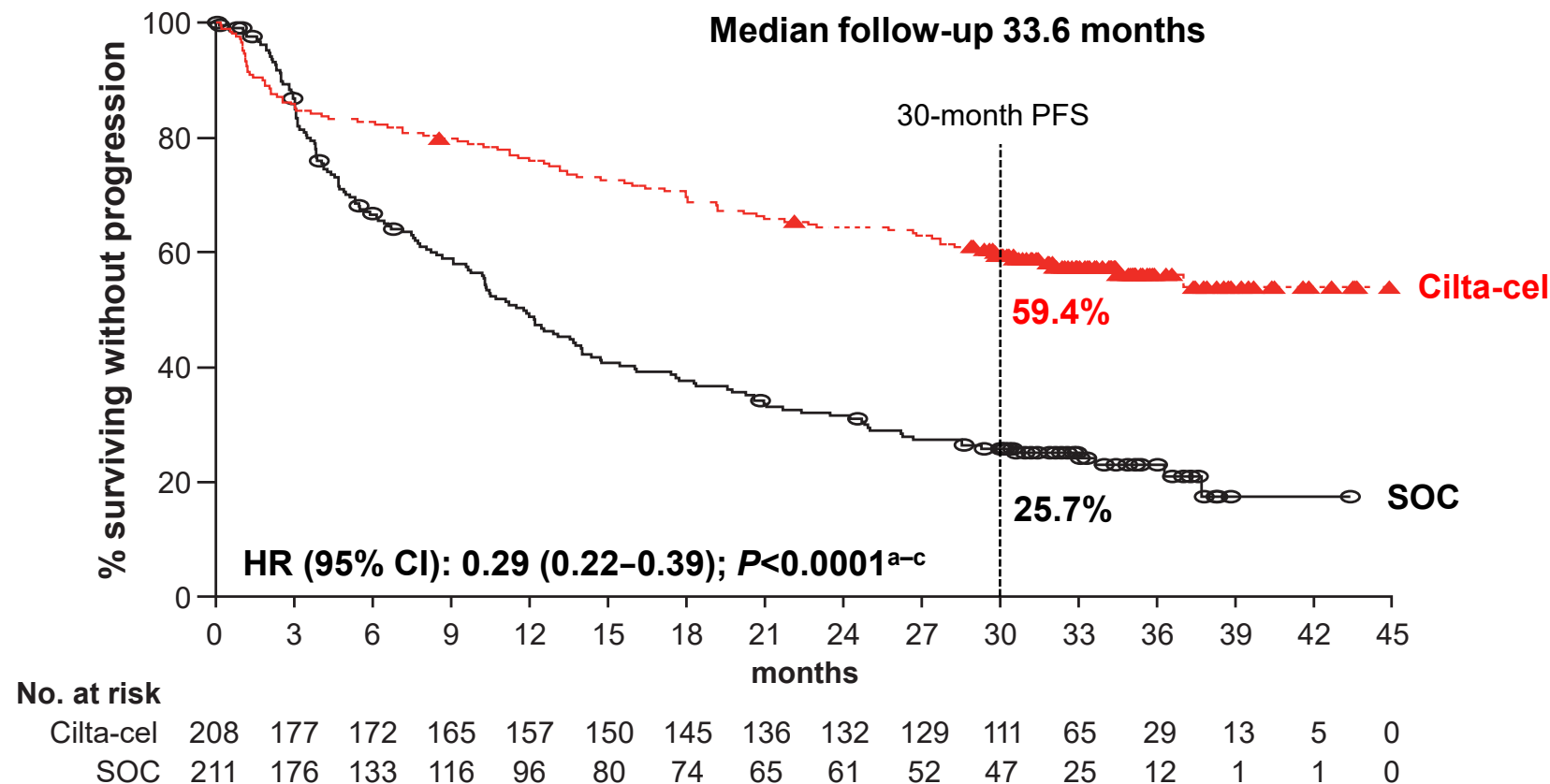


CARTITUDE-4 : Baseline Demographics and Disease Characteristics

Baseline characteristic	ITT population	
	Cilta-cel (n=208)	SOC (n=211)
Age, median (range), years	61.5 (27–78)	61.0 (35–80)
Male, n (%)	116 (55.8)	124 (58.8)
White, n (%)	157 (75.5)	157 (74.4)
ECOG PS ≤1, n (%) ^{a,b}	207 (99.5)	210 (99.5)
ISS stage, n (%)		
I	136 (65.4)	132 (62.6)
II	60 (28.8)	65 (30.8)
III	12 (5.8)	14 (6.6)
Bone marrow plasma cells ≥60%, ^c n (%)	42 (20.4)	43 (20.7)
Presence of soft tissue plasmacytomas, ^d n (%)	44 (21.2)	35 (16.6)
Years since diagnosis, median (range)	3 (0.3–18.1)	3.4 (0.4–22.1)
Prior LOT, median (range)	2 (1–3)	2 (1–3)
1 prior LOT, n (%)	68 (32.7)	68 (32.2)
2 or 3 prior LOT, n (%)	140 (67.3)	143 (67.8)

Baseline characteristic	ITT population	
	Cilta-cel (n=208)	SOC (n=211)
Cytogenetic high risk, n (%) ^e	123 (59.4)	132 (62.9)
del(17p)	49 (23.7)	43 (20.5)
t(14;16)	3 (1.4)	7 (3.3)
t(4;14)	30 (14.5)	30 (14.3)
gain/amp(1q)	89 (43.0)	107 (51.0)
2 or more high-risk cytogenetic features	43 (20.8)	49 (23.3)
del(17p), t(14;16), or t(4;14)	73 (35.3)	69 (32.9)
Triple-class ^f exposed, n (%)	53 (25.5)	55 (26.1)
Penta-drug ^g exposed, n (%)	14 (6.7)	10 (4.7)
Refractory status, n (%)		
Triple-class refractory ^{f,h}	30 (14.4)	33 (15.6)
Bortezomib	55 (26.4)	48 (22.7)
Pomalidomide	8 (3.8)	9 (4.3)
Daratumumab	48 (23.1)	45 (21.3)
Any PI	103 (49.5)	96 (45.5)

Long-term CARTITUDE-4 Update (34 months): Cilta-cel Maintained Significant Improvement in Progression-free Survival



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

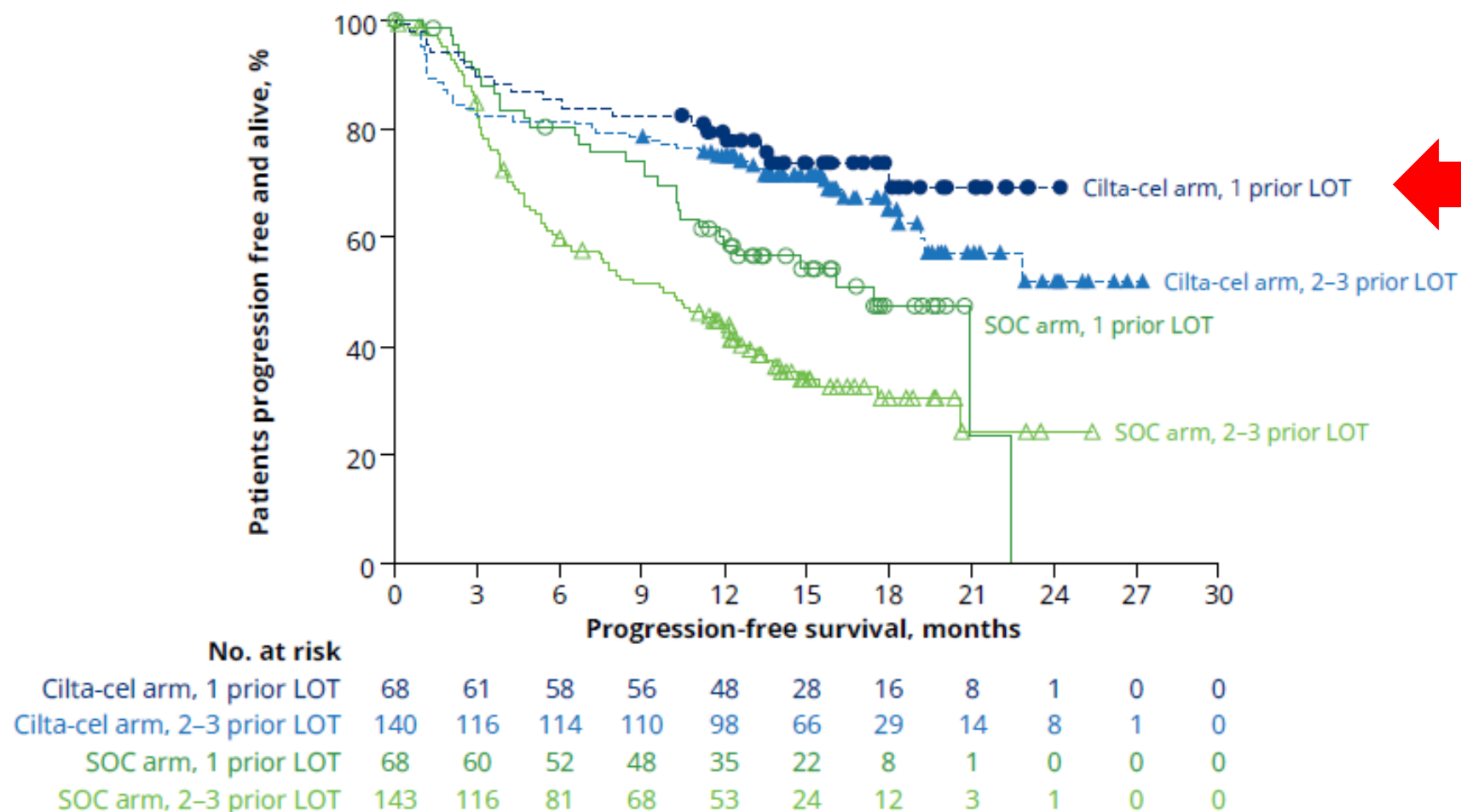
^aConstant piecewise weighted log-rank test. ^bHR and 95% CI from a Cox proportional hazards model with treatment as the sole explanatory variable, including only PFS events that occurred >8 weeks post randomization. ^cNominal *P*-value.
Cilta-cel, ciltacabtagene autoleucel; HR, hazard ratio; mPFS, median progression-free survival; SOC, standard of care.



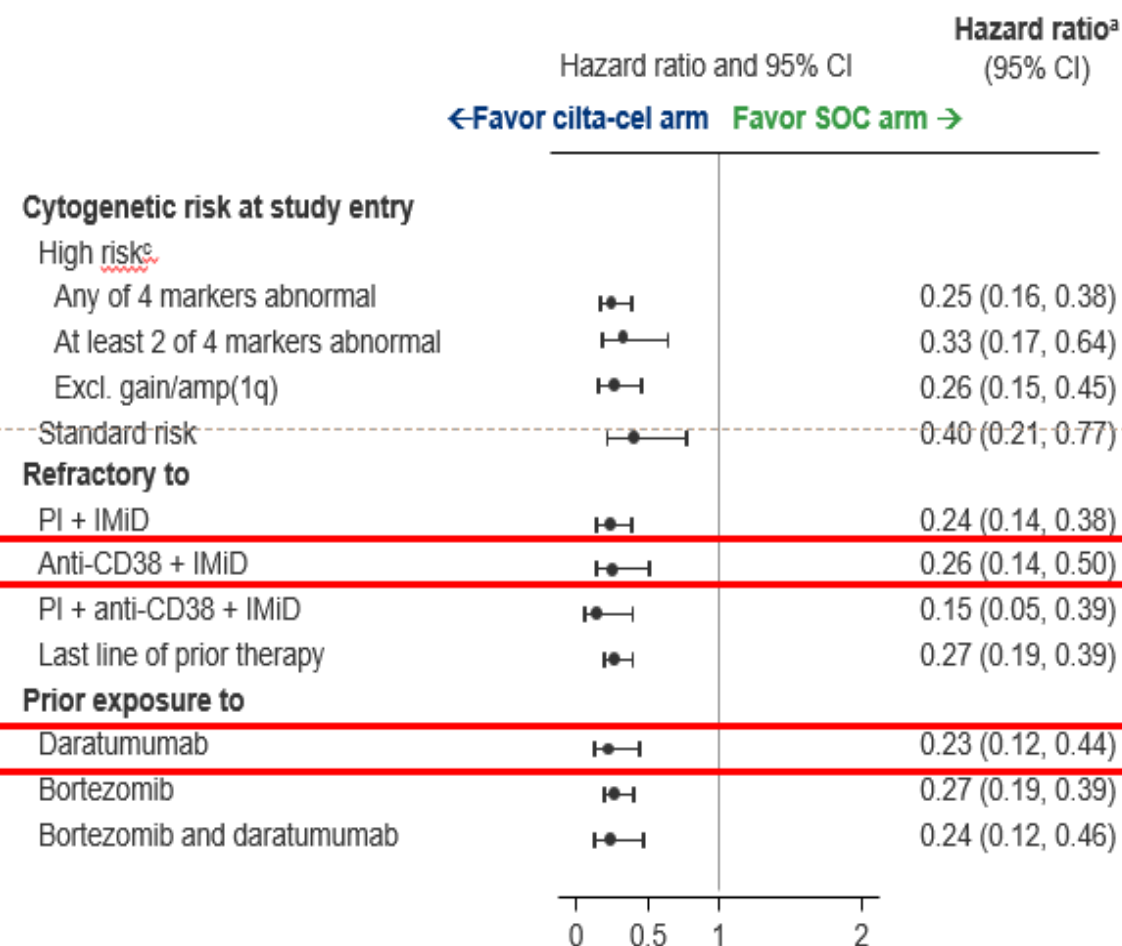
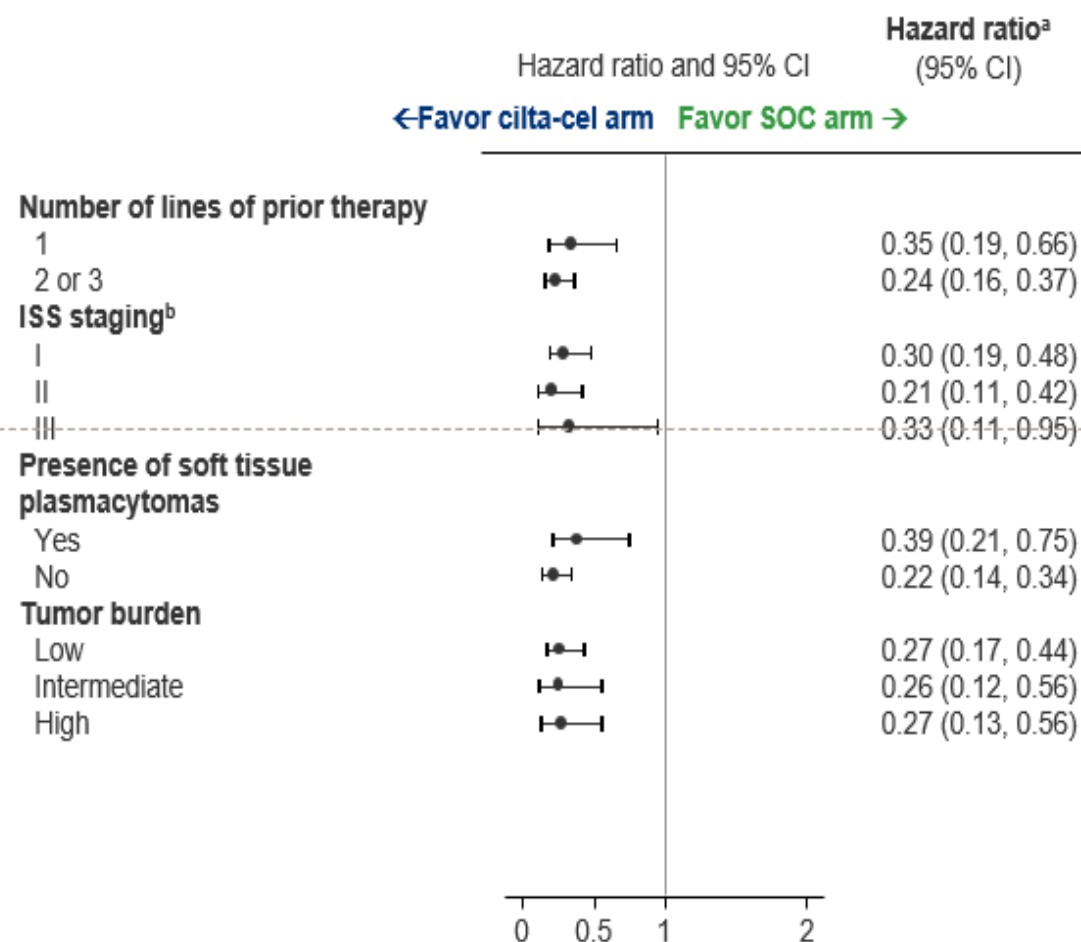
CARTITUDE-4: PFS by Prior Line of Therapy

- Cilta-cel improved PFS vs SOC whether patients had 1 or 2-3 prior LOT

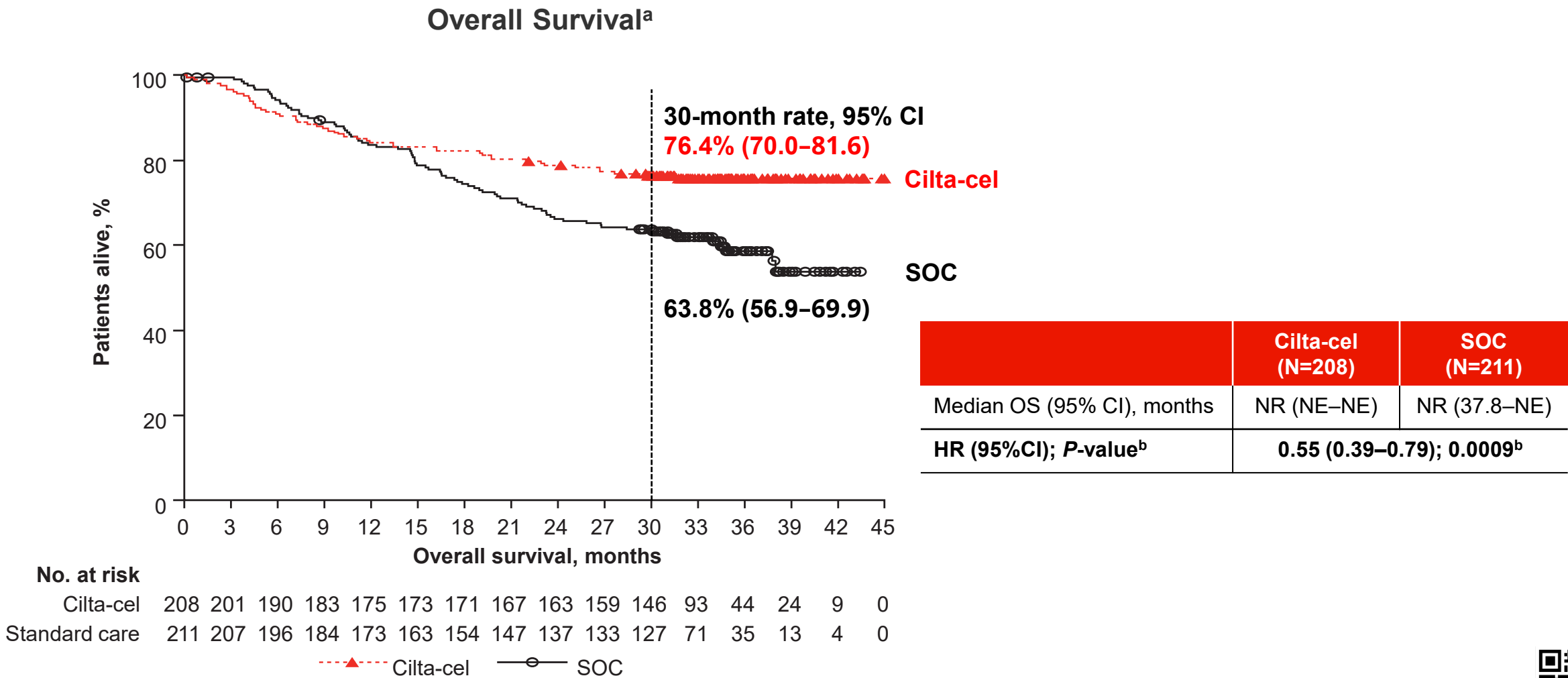
Progression-free survival by treatment and number of prior lines in the ITT set



CARTITUDE-4: Key Subgroup Analysis (ITT)



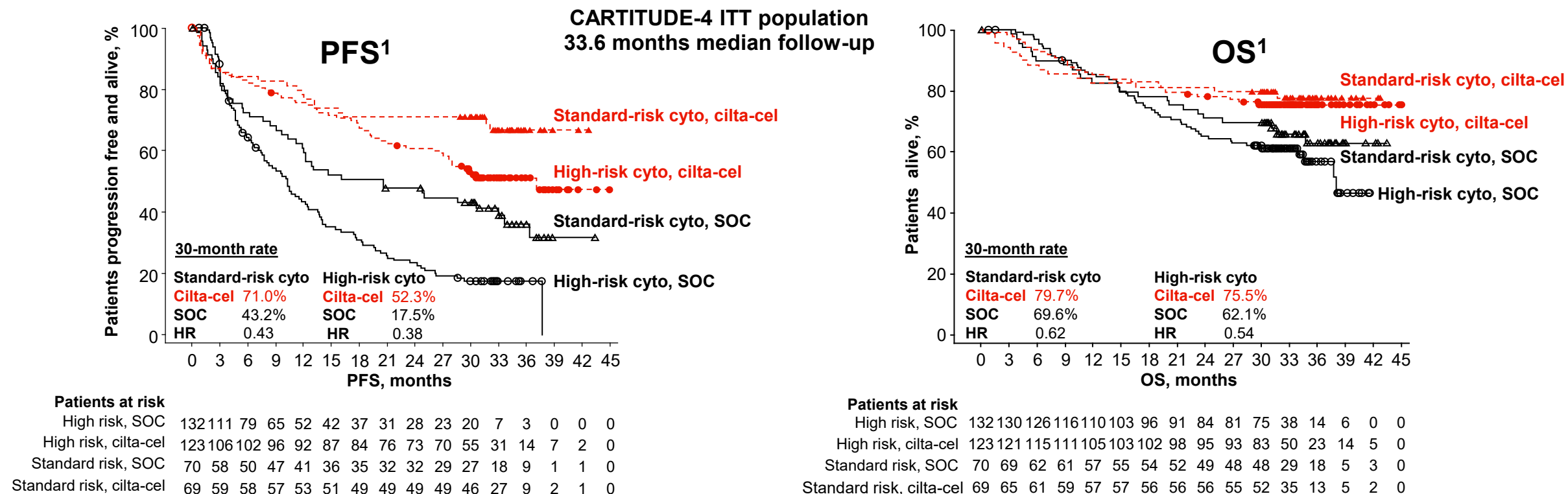
34-Month Update of CARTITUDE-4 : OS Was Significantly Prolonged With Cilta-cel vs SOC



^aMedian follow-up, 33.6 months. ^b*P*-value, 0.0009, crossed the prespecified boundary of 0.0108 as implemented by the Kim-DeMets spending function with parameter=2. Cilta-cel, ciltacabtagene autoleucel; HR, hazard ratio; mOS, median overall survival; NE, not estimable; NR, not reached; OS, overall survival; SOC, standard of care.



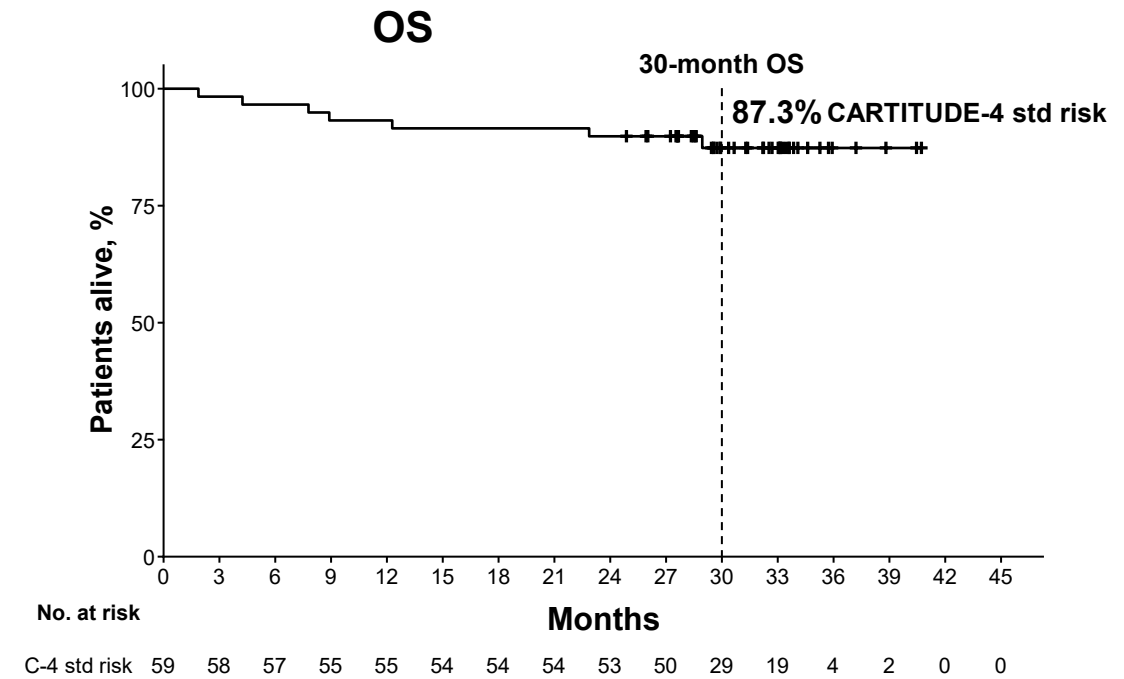
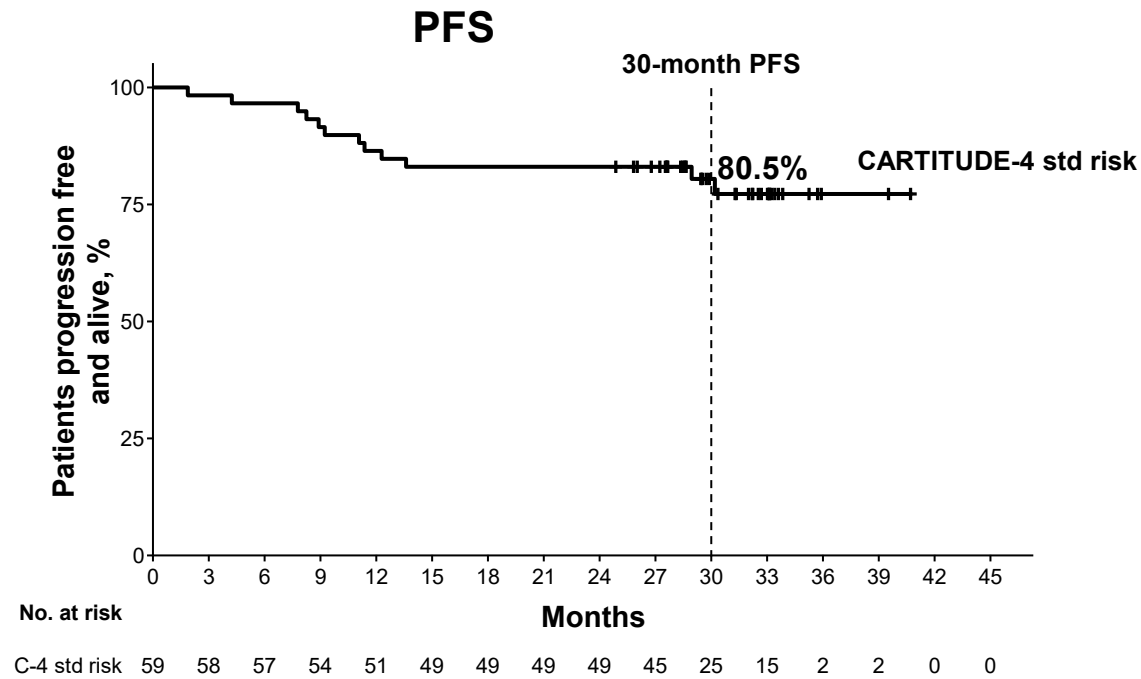
PFS and OS in Patients With High-Risk and Standard-Risk Cytogenetics (ITT)



In CARTITUDE-4, cilta-cel improved PFS and OS in prespecified subgroups with standard- and high-risk cytogenetics¹



CARTITUDE-4: PFS and OS in Patients With Standard-Risk Cytogenetics (As-Treated)



80% of CARTITUDE-4 patients with standard-risk disease who received cilta-cel as study treatment remained progression free and off treatment at 30 months



CARTITUDE-4: CRS and CAR-T Cell-Related Neurotoxicity

AEs, n, %	As-treated patients (n=176)				
	Any grade	Grade 3/4	Median time to onset, days	Median duration, days	Resolved, n
CRS	134 (76.1)	2 (1.1)	8	3	134
Neurotoxicity ^a	36 (20.5)	5 (2.8)			
ICANS	8 (4.5)	0 ^b	10	2	8
Other ^c	30 (17.0)	4 (2.3)			
Cranial nerve palsy ^d	16 (9.1)	2 (1.1)	21	77	14
Peripheral neuropathy	5 (2.8)	1 (0.6)	63	201	3
MNT	1 (0.6)	0	85	-	0

In the cilta-cel as-treated population:

- 30 patients had non-ICANS neurotoxicities^e
 - 16 cranial nerve palsies (14 recovered)
 - 5 peripheral neuropathies
 - 1 MNT (grade 1)
 - Patient was refractory to DPd bridging therapy and had grade 2 CRS after cilta-cel infusion (risk factors for MNTs)
- Lower incidence and severity of CRS, ICANS, MNTs, and some cytopenias^e observed with CARTITUDE-4 vs CARTITUDE-1**
 - Cilta-cel may be better tolerated when used earlier in treatment
 - Effective bridging therapy enables better control of tumor burden prior to CAR-T infusion
 - MNTs were lower likely related to patient management strategies implemented to mitigate this risk

Long-term CARTITUDE-4 Update (34 months): Safety Profile Consistent With Previous Analysis

Infections	Cilta-cel (n=208)	SOC (n=208)
Treatment-emergent infections, %		
All grade	63.5	76.4
Grade 3/4	28.4	29.8
Deaths due to TE- and non-TE infections, n	16	17
In first year, n	13	8
In second year, n	2	8

Cause of Death	Cilta-cel (n=208)	SOC (n=208)
Deaths, n	50	82
Due to progressive disease	21	51
Due to TEAE	12	8

- Both arms had grade 3/4 TEAE around 97%; most frequently cytopenia

SPM	Cilta-cel (n=208)	SOC (n=208)
SPMs, n (%)	27 (13.0)	24 (11.5)
Hematologic	7 (3.4)	1 (0.5)
MDS, n	4	0
Progressed to AML, n	2	–
AML, n	1	0
Peripheral T-cell lymphoma, n	2	0
EBV-associated lymphoma, n	0	1

- New cases of SPM since previous report^a**
 - Cilta-cel, n=18
 - SOC, n=10
- No new cases of cranial nerve palsy or MNT for the cilta-cel arm since the previous report^a**

^aIncludes 3 new cases of MDS and 1 new case of T-cell lymphoma for the cilta-cel arm and 1 new case of EBV-associated lymphoma for the SOC arm.

AE, adverse event; AML, acute myeloid lymphoma; cilta-cel, ciltacabtagene autoleucel; CNP, cranial nerve palsy; EBV, Epstein-Barr virus; MDS, myelodysplastic syndrome; MNT, movement and neurocognitive treatment-emergent adverse event; TE, treatment-emergent; TEAE, treatment-emergent adverse event; SOC, standard of care; SPM, second primary malignancy.



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

Maria-Victoria Mateos,¹ Nizar J. Bahlis,² Aurore Perrot,³ Ajay K. Nooka,⁴ Jin Lu,⁵ Charlotte Pawlyn,^{6,7} Roberto Mina,⁸ Gaston Caeiro,⁹ Alain Kentos,¹⁰ Vania Hungria,¹¹ Donna Reece,¹² Ting Niu,¹³ Anne K. Mylin,¹⁴ Charlotte Toftmann Hansen,¹⁵ Raphael Teipel,¹⁶ Britta Besemer,¹⁷ Meletios A. Dimopoulos,^{18,19} Elena Zamagni,^{20,21} Satoshi Yoshihara,²² Kihyun Kim,²³ Chang Ki Min,²⁴ Paul Geerts,²⁵ Elena Van Leeuwen-Segarceanu,²⁶ Agata Tyczynska,²⁷ Juan Luis Reguera Ortega,²⁸ Magnus Johansson,²⁹ Markus Hansson,³⁰ Mehmet Turgut,³¹ Mark Grey,³² Surbhi Sidana,³³ Paula Rodriguez-Otero,³⁴ Joaquin Martinez-Lopez,³⁵ Hamza Hashmi,³⁶ Robin Carson,³⁷ Rachel Kobos,³⁸ Weili Sun,³⁹ Kristen Lantz,³⁷ Anne Seifert,⁴⁰ Deborah Briseno-Toomey,⁴¹ Lisa O'Rourke,³⁷ Maria Rubin,³⁸ Diego Vieyra,³⁷ Lijuan Kang,³⁹ Luciano J. Costa⁴²

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

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

The QR code is intended to provide scientific information for individual reference, and the information should not be altered or reproduced in any way.



MajesTEC-3: Phase 3 Study Design

Key inclusion criteria

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

Key exclusion criteria

- Prior BCMA-directed therapy
- Refractory to anti-CD38 mAbs^a

**1:1
randomization
N=587**
22 Oct 2021 to
29 Sept 2023^b

Tec-Dara
N=291
SC dosing following Dara schedule

DPd/DVd
N=296 (266/30)
by Investigator's choice^c

Primary endpoint

- PFS per IRC

Key secondary endpoints

- \geq CR^d and ORR^d
- MRD negativity (10^{-5})
- OS
- MySIm-Q Total Symptom score

Other secondary endpoints

- Safety
- PK and immunogenicity

● Tec 1.5 mg/kg

● Tec 3 mg/kg

● Dara 1800 mg

	Cycle 1 QW						Cycle 2 QW				Cycle 3-6 Q2W				Cycle 7+ Q4W			
	D1	D2	D4	D8	D15	D22	D1	D8	D15	D22	D1	D8	D15	D22	D1	D8	D15	D22
Tec		○ SUD ^f ○		●	●	●	●	●	●	●	●		●		●			
Dara	●			●	●	●	●	●	●	●	●		●		●			
Dex (Pre-med) ^e	●	●	●	●														

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

^aPrior exposure to anti-CD38 mAbs was permitted. ^bDuring the COVID-19 pandemic. ^cDPd/DVd were administered per the approved schedules. ^dResponse and disease progression were assessed by a blinded IRC per IMWG criteria. ^eDexamethasone, acetaminophen, and diphenhydramine premedication was required for the first 2 weeks; subsequent dexamethasone was not required thereafter. ^fPatients received SUD of 0.06 mg/kg and 0.3 mg/kg on Days 2 and 4, respectively.

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



MajesTEC-3: Baseline Demographic and Disease Characteristics

Characteristic	Tec-Dara (n=291)	DPd/DVd (n=296)
Age		
Median (range), years	64 (36–88)	63 (25–84)
≥75 years, n (%)	31 (10.7)	25 (8.4)
Sex, n (%)		
Male	156 (53.6)	169 (57.1)
Female	135 (46.4)	127 (42.9)
Race, n (%)		
White	190 (65.3)	194 (65.5)
Asian	68 (23.4)	63 (21.3)
Black or African American	13 (4.5)	20 (6.8)
Other ^a	20 (6.9)	19 (6.4)

Characteristic	Tec-Dara (n=291)	DPd/DVd (n=296)
Baseline ECOG PS score, n (%)		
0	167 (57.4)	160 (54.1)
1	108 (37.1)	127 (42.9)
2	16 (5.5)	9 (3.0)
ISS stage, n/N (%)		
I	182 (62.5)	185 (62.5)
II	85 (29.2)	88 (29.7)
III	24 (8.2)	23 (7.8)
BMPCs ≥60%, ^b n/N (%)	28/286 (9.8)	24/293 (8.2)
Presence of soft-tissue plasmacytomas, n (%)	41 (14.1)	41 (13.9)
Extramedullary plasmacytomas	14 (4.8)	17 (5.7)
High-risk cytogenetics, ^c n/N (%)	104/285 (36.5)	104/294 (35.4)

Baseline demographics well balanced and reflective of patients seen in real-world practice

^a“Other” includes Native Hawaiian or Pacific Islander (Tec-Dara, n=1 [0.3%]; DPd/DVd, n=0; total, n=1 [0.2%]), American Indian or Alaska Native (Tec-Dara, n=0; DPd/DVd, n=1 [0.3%]; total, n=1 [0.2%]), not reported (Tec-Dara, n=14 [4.8%]; DPd/DVd, n=16 [5.4%]; total, n=30 [5.1%]), and unknown (Tec-Dara, n=5 [1.7%]; DPd/DVd, n=2 [0.7%]; total, n=7 [1.2%]). ^bMaximum value from bone marrow biopsy or bone marrow aspirate was selected if both results were available. ^cPresence of ≥1 of del(17p), t(4;14), or t(14;16). BMPC, bone marrow plasma cell; ISS, International Staging System.



MajesTEC-3: Prior Lines of Therapy

Characteristic	Tec-Dara (n=291)	DPd/DVd (n=296)
Prior LOTs		
Median (range), n	2 (1–3)	2 (1–3)
1 prior LOT	108 (37.1)	114 (38.5)
2 prior LOTs	134 (46.0)	134 (45.3)
3 prior LOTs	49 (16.8)	48 (16.2)
Prior transplantation, n (%)	210 (72.2)	226 (76.4)

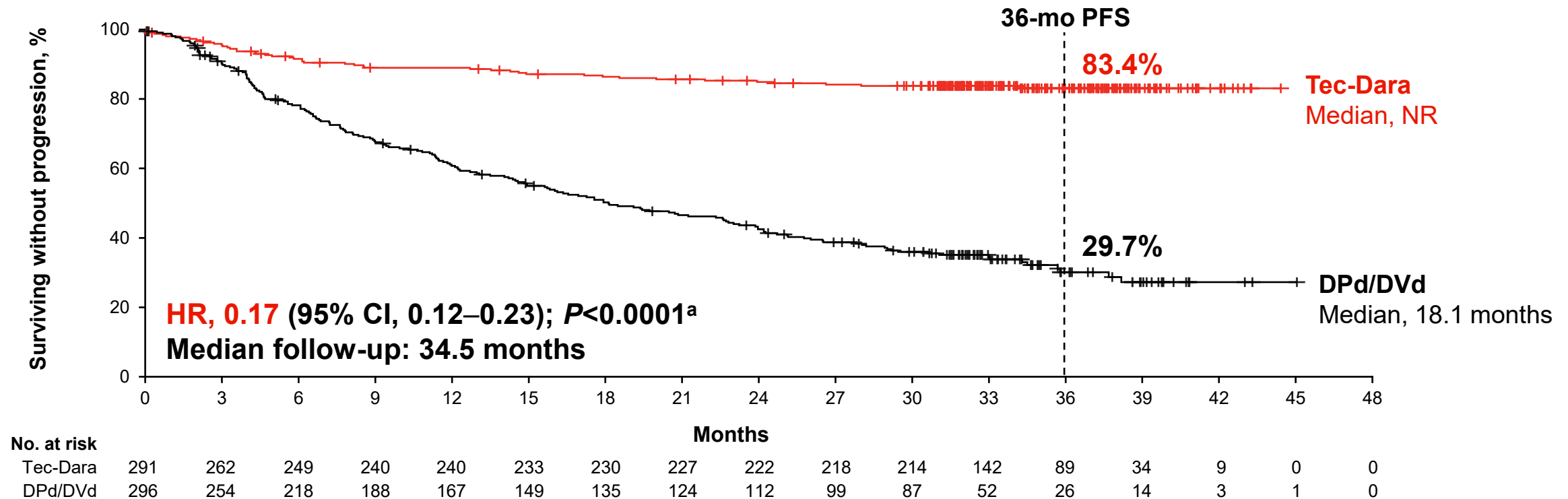
- 5% of patients were Dara exposed
- In real-world data sets, 70% of patients in 2L are Dara naïve or exposed

Characteristic	Tec-Dara (n=291)	DPd/DVd (n=296)
Prior therapy exposure, n (%)		
PI	290 (99.7)	296 (100)
IMiD	291 (100)	296 (100)
Anti-CD38, n (%)	15 (5.2)	16 (5.4)
Refractory status, n (%)		
To last prior LOT	250 (85.9)	251 (84.8)
Any PI	117 (40.2)	104 (35.1)
Any IMiD	247 (84.9)	253 (85.5)
Lenalidomide	240 (82.5)	251 (84.8)
Double (PI and IMiD)	99 (34.0)	88 (29.7)

Median of 2 prior LOTs and >85% of patients were refractory to an IMiD



MajesTEC-3: PFS (Primary Endpoint)

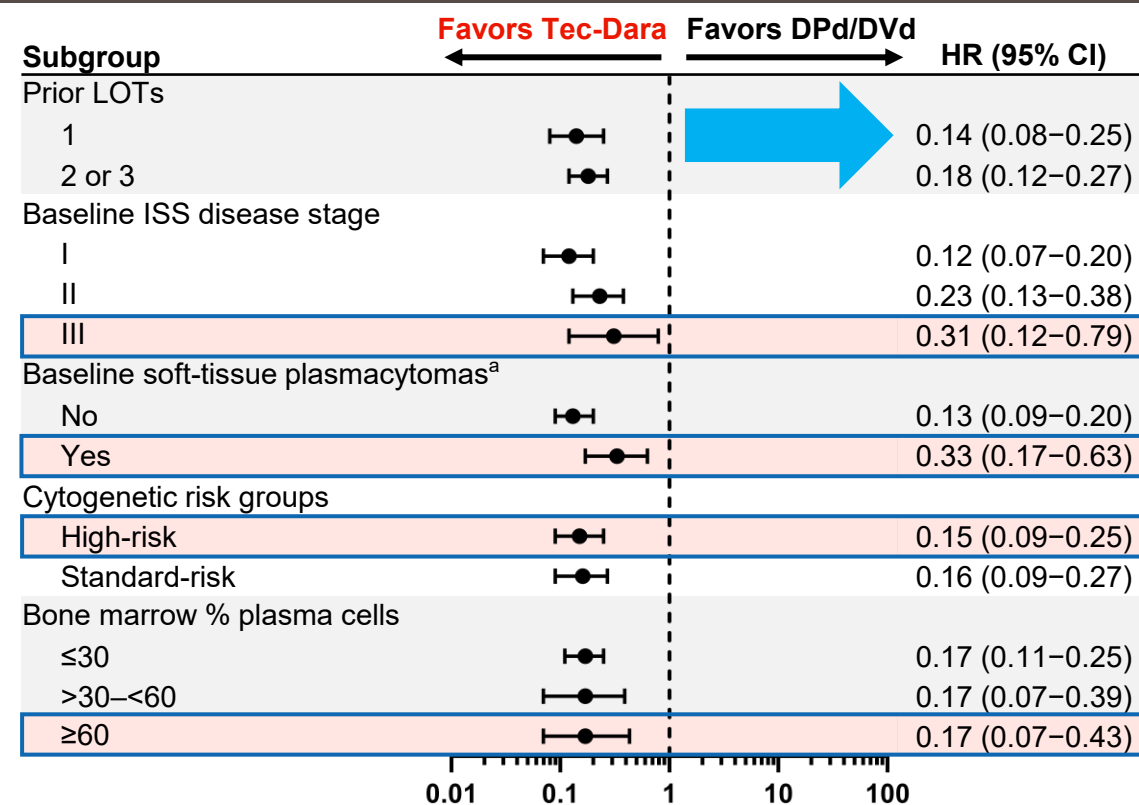
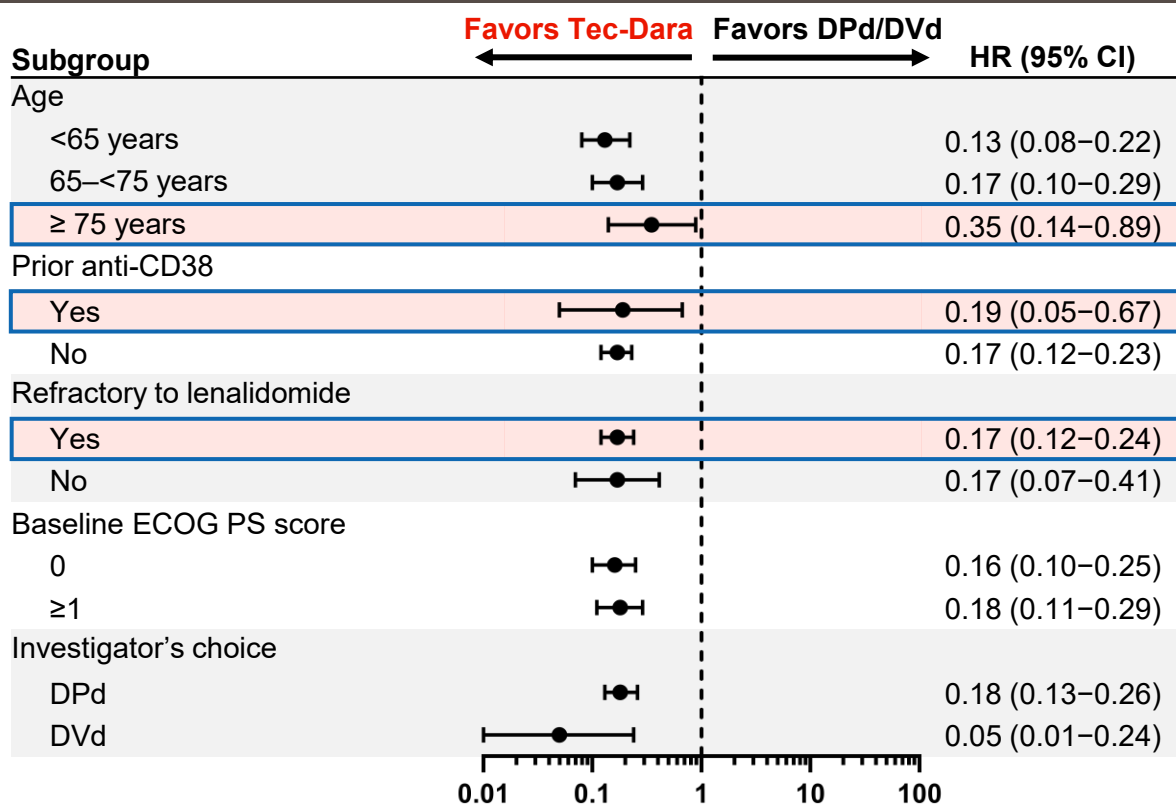


Tec-Dara significantly improved PFS, with a plateauing curve after ~6 months and >90% of patients progression-free at 6 months sustaining such a benefit at 3 years

^aThe P value crossed the prespecified stopping boundary for superiority for the first interim analysis ($P=0.0139$).
CI, confidence interval; HR, hazard ratio; NR, not reached.



MajesTEC-3: PFS Subgroup Analysis

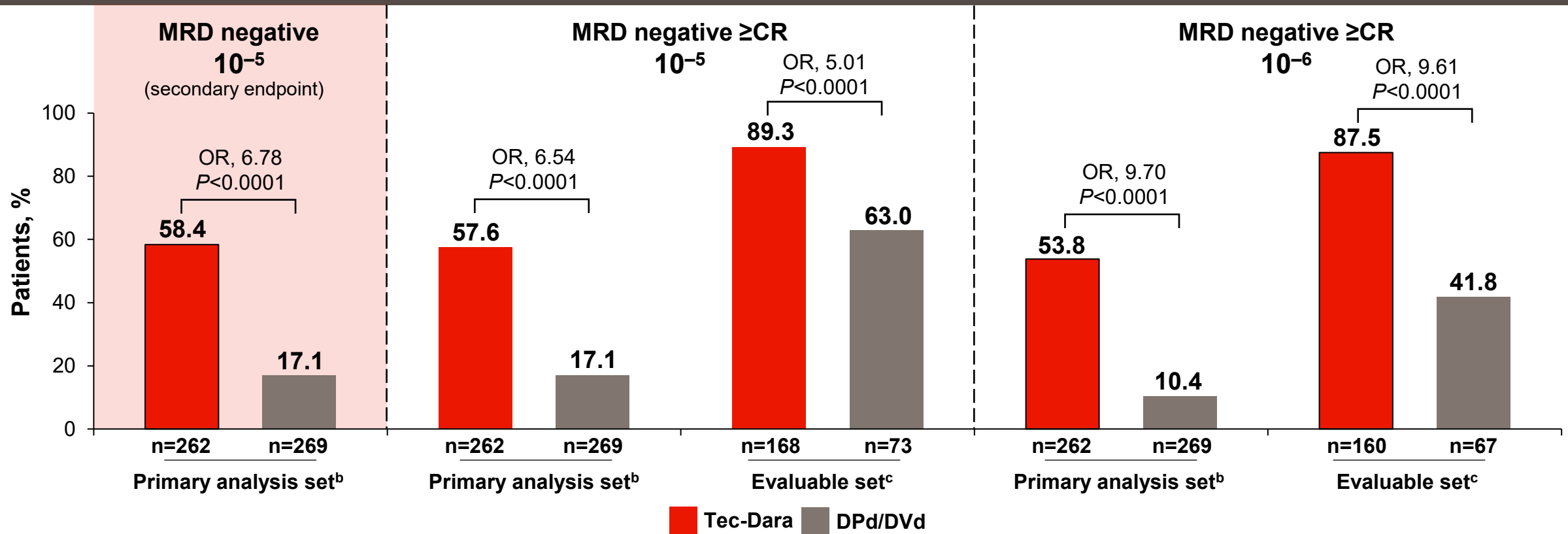


Superior PFS with Tec-Dara was consistent across all subgroups^b

^aBaseline soft-tissue plasmacytomas contain both extramedullary and paraspinal plasmacytomas. ^bNot all clinically meaningful and prespecified subgroups that were assessed are shown; however, PFS was improved versus DPd/DVd across all subgroups.



MajesTEC-3: MRD Negativity^a



~90% MRD negativity with Tec-Dara in MRD evaluable patients

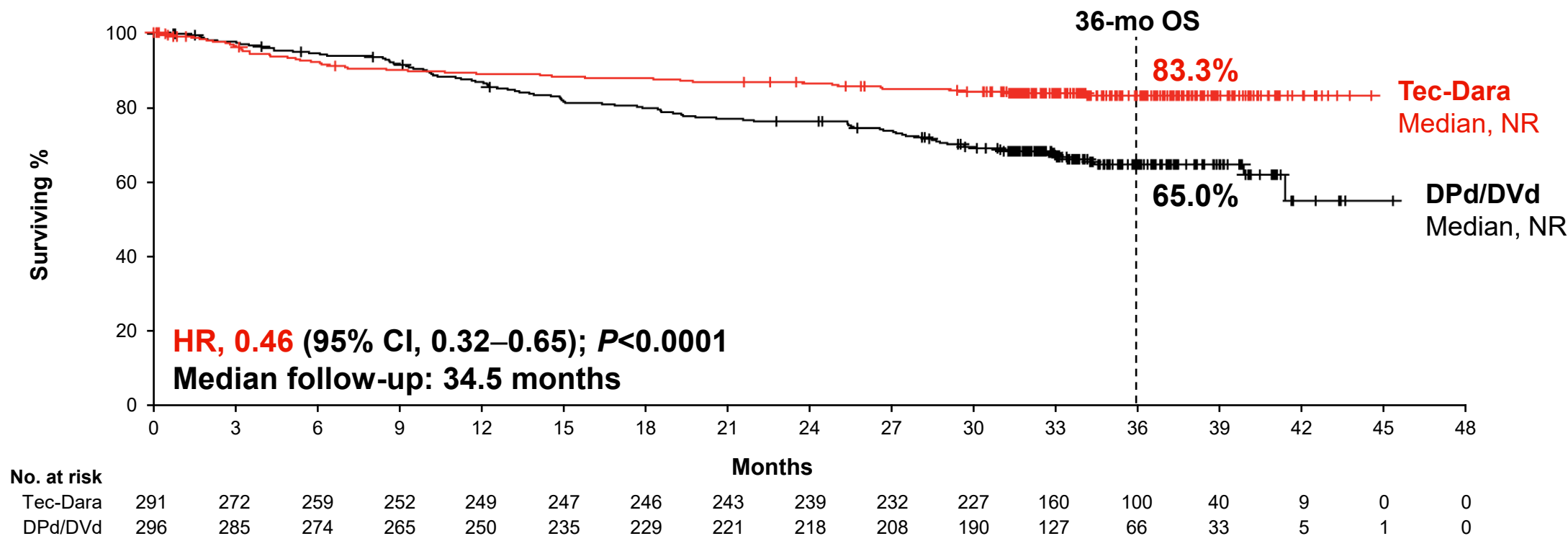
Median follow-up: 34.5 months.

^aMRD was assessed in the bone marrow by NGS in accordance with International Myeloma Working Group guidelines. ^bThe MRD NGS primary analysis set was defined as all randomized patients in the study except those recruited in China (due to China instead utilizing NGF for MRD assessment). ^cThe MRD NGS evaluable set was defined as patients who achieved $\geq CR$, had a successful baseline calibration, and had ≥ 1 post-baseline MRD sample with a positive or negative result (per NGS) at the indicated threshold.

NGF, next-generation flow; NGS, next-generation sequencing.

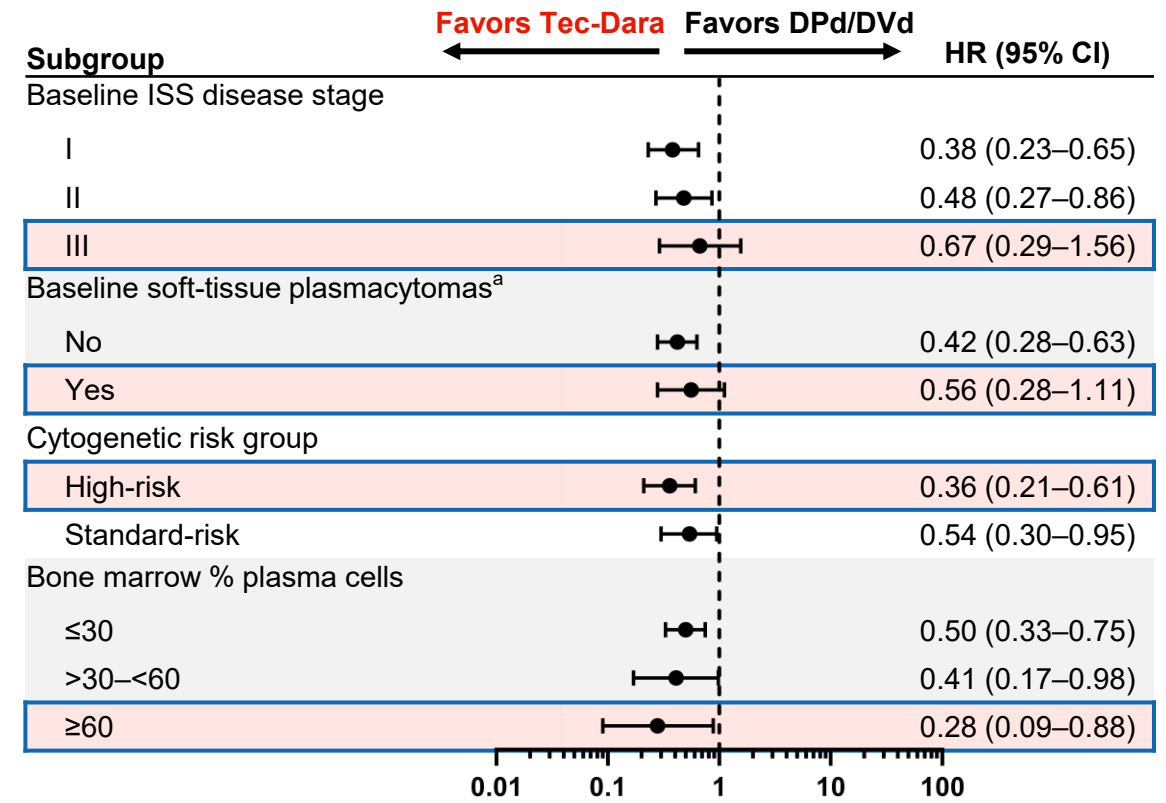
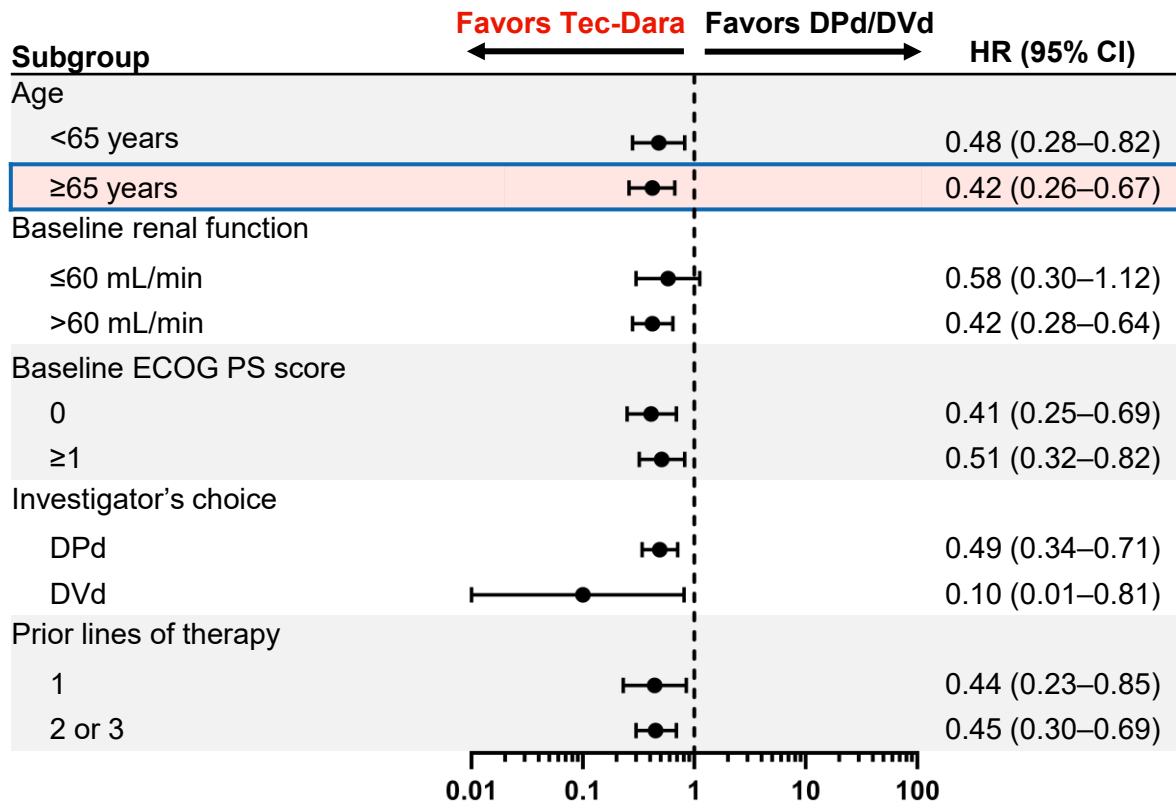


MajesTEC-3: OS



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

MajesTEC-3: OS Subgroup Analysis



Superior OS with Tec-Dara across prespecified subgroups^b

^aBaseline soft-tissue plasmacytomas contain both extramedullary and paraspinal plasmacytomas. ^bNot all prespecified subgroups that were assessed are shown; however, OS favored Tec-Dara versus DPd/DVd across all subgroups.



Patients at first relapse, len exp/ref

BCMA BispAbs

Majestec-3
(Len ref + PI exp)

(R)

Tec dara

DPd or DVd

1 – 3 prior line; PFS primary end-point

Magnetismm-5
(Len exp +
PI exp)

(R)

Elra

Elra Dara

DPd

> 1 prior line; PFS primary end-point

MajesTEC-9: Prior LOTs

Characteristic	Tec (n=296)	PVd/Kd (n=297)
Prior LOTs, n (%)		
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 (%)		
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	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)

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

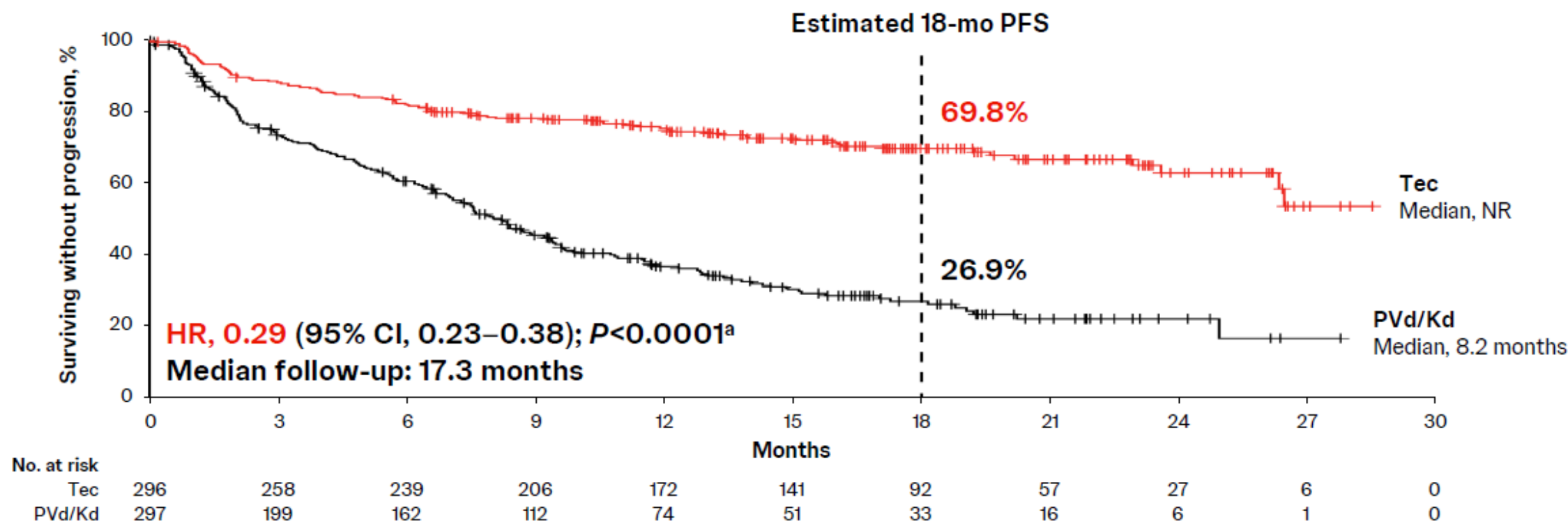
IMiD, immunomodulatory drug; PI, proteasome inhibitor.

From The New England Journal of Medicine, Touzeau C, et al., Teclistamab in Multiple Myeloma with 1–3 Prior Lines of Therapy.

Copyright © 2026 Massachusetts Medical Society. Adapted with permission from Massachusetts Medical Society.



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



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

^aThe P value crossed the prespecified stopping boundary for superiority for the first interim analysis ($P=0.0197$).

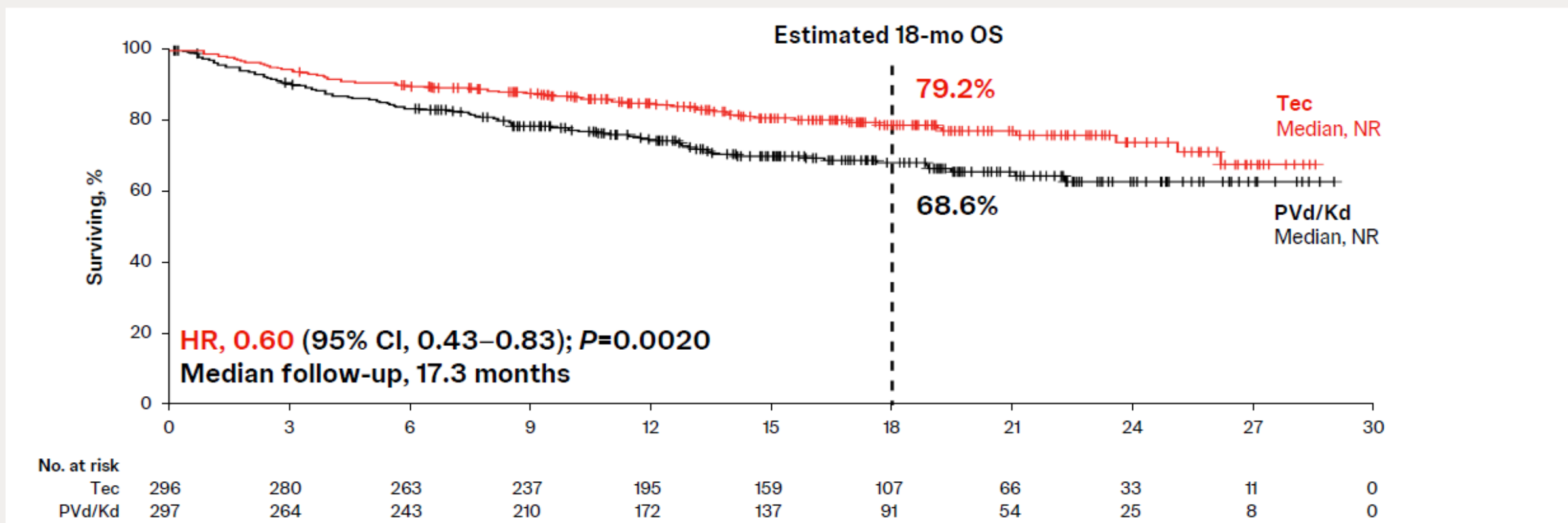
CI, confidence interval; NR, not reached.

From The New England Journal of Medicine, Touzeau C, et al., Teclistamab in Multiple Myeloma with One to Three Previous Lines of Therapy.

Copyright © 2026 Massachusetts Medical Society. Adapted with permission from Massachusetts Medical Society.



MajesTEC-9: Tec Significantly Improved OS



Tec significantly improved OS vs PVd/Kd, despite over two-thirds of PVd/Kd patients who initiated subsequent therapy receiving a BsAb or CAR-T



MONUMENTAL-3

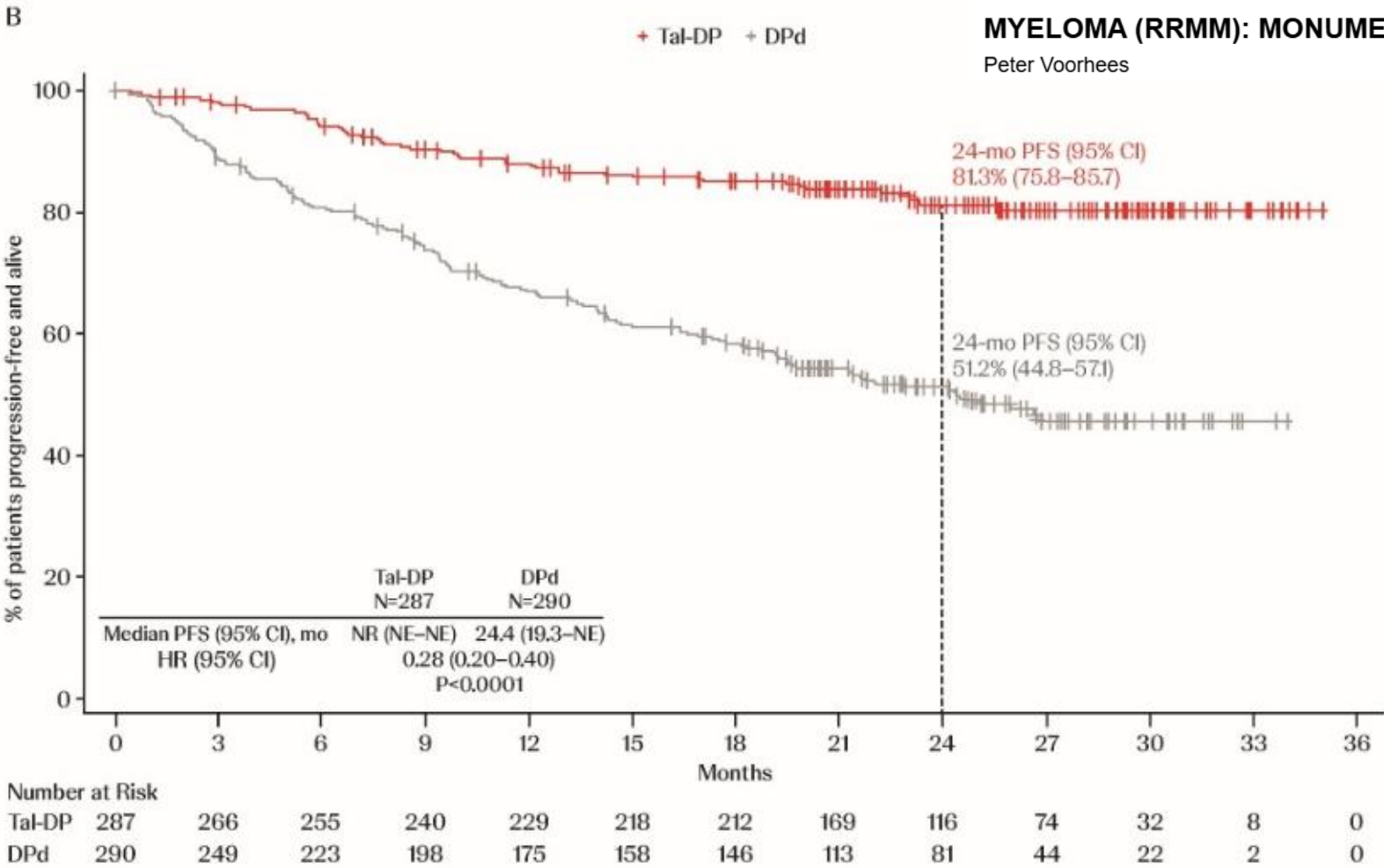
PHASE 3, RANDOMIZED STUDY OF
TALQUETAMAB (TAL) PLUS DARATUMUMAB
(DARA) ± POMALIDOMIDE (POM) VS DARA
PLUS POM AND DEXAMETHASONE (DPD) IN
RELAPSED/REFRACTORY MULTIPLE
MYELOMA (RRMM): MONUMENTAL-3
Peter Voorhees

- A**
- Tal-DP**

 - Tal 0.8 mg/kg SC Q2W from C1 through C4–6 then Q4W^a
 - Dara 1800 mg SC QW for C1–2, Q2W C3–6, then Q4W
 - Pom 2 mg daily for 21 days per C from C2^b
- Tal-D**

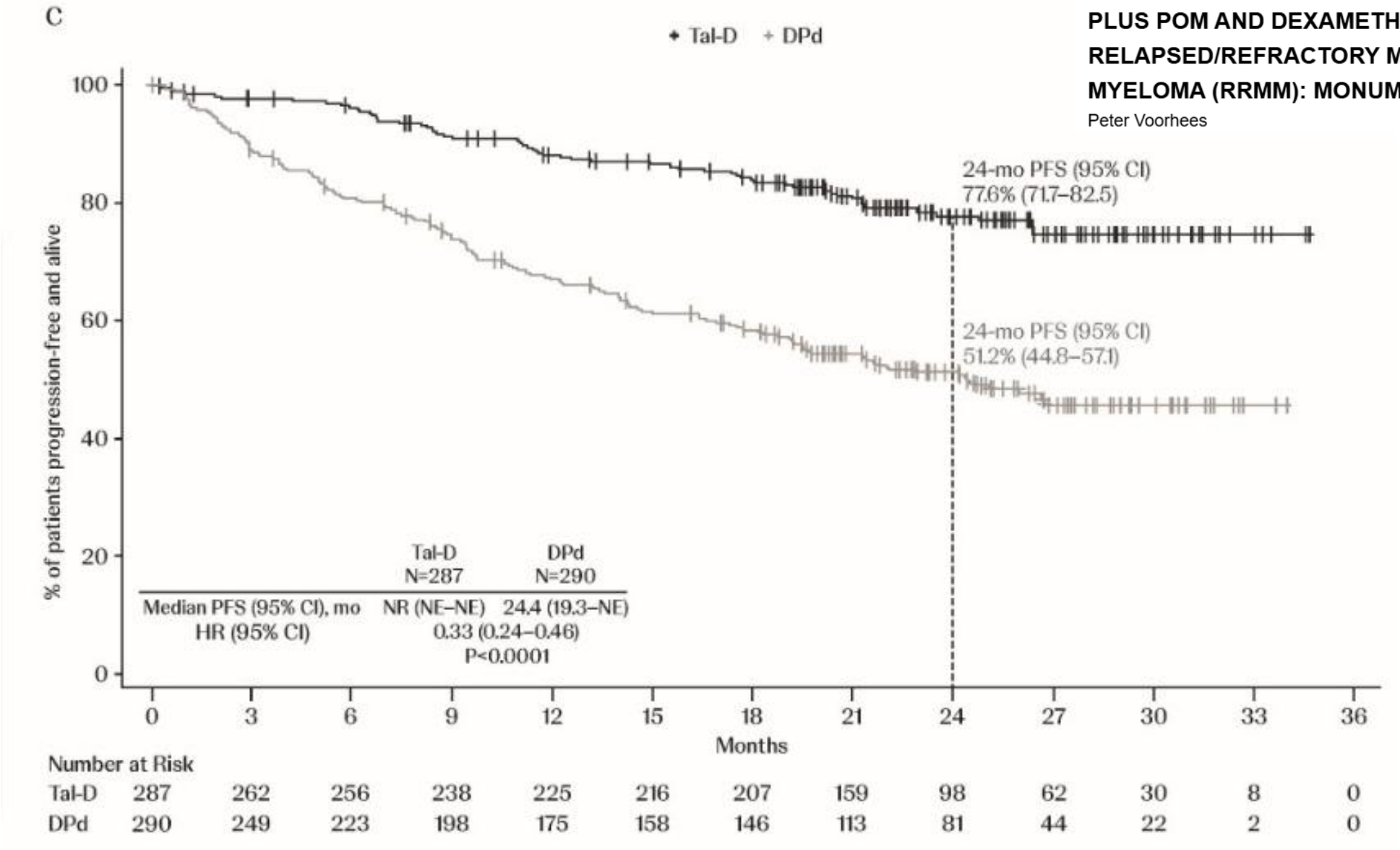
 - Tal 0.8 mg/kg SC Q2W from C1 through C4–6 then Q4W^a
 - Dara 1800 mg SC QW for C1–2, Q2W C3–6, then Q4W
- DPd**

 - Dara 1800 mg SC QW for C1–2, Q2W C3–6, then Q4W
 - Pom 4 mg daily for 21 days per C from C1
 - Dex 40 mg (age <75) or 20 mg (BMI ≤18.5 or age ≥75) QW



MONUMENTAL-3

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
Peter Voorhees



Results from the randomized phase 3 DREAMM-8 study of belantamab mafodotin plus pomalidomide and dexamethasone vs pomalidomide plus bortezomib and dexamethasone in relapsed/refractory multiple myeloma

Suzanne Trudel,¹ Meral Beksac,² Luděk Pour,³ Sosana Delimpasi,⁴ Hang Quach,⁵ Vladimir I. Vorobyev,⁶ Michele Cavo,⁷ Kazuhito Suzuki,⁸ Pawel Robak,⁹ Kristin Morris,¹⁰ Amy Phillips-Jones,¹¹ Xiaou L. Zhou,¹² Giulia Fulci,¹² Neal Sule,¹³ Brandon E. Kremer,¹³ Joanna Opalinska,¹³ Maria-Victoria Mateos Manteca,¹⁴ Meletios A. Dimopoulos¹⁵

¹Department of Medical Oncology and Hematology, Princess Margaret Cancer Centre, Toronto, ON, Canada; ²Department of Hematology, Ankara Liv Hospital, Istinye University, Ankara, Turkey; ³Department of Internal Medicine, Hematology and Oncology, University Hospital Brno, Brno, Czech Republic; ⁴General Hospital Evangelismos, Athens, Greece; ⁵University of Melbourne, St. Vincent's Hospital, Melbourne, VIC, Australia; ⁶Leningrad Regional Clinical Hospital, St Petersburg, Russian Federation; ⁷IRCCS Azienda Ospedaliero-Universitaria di Bologna, Seragnoli Institute of Hematology, and Department of Medical and Surgical Sciences, University of Bologna, Bologna, Italy; ⁸Division of Clinical Oncology/Hematology, Department of Internal Medicine, The Jikei University School of Medicine, Tokyo, Japan; ⁹Medical University of Lodz, Lodz, Poland; ¹⁰GSK, Raleigh-Durham, NC, USA; ¹¹GSK, Stevenage, UK; ¹²GSK, Waltham, MA, USA; ¹³GSK, Collegeville, PA, USA; ¹⁴Hematology Department, University Hospital of Salamanca/IBSAL/Cancer Research Center-IBMCC (USAL-CSIC), Salamanca, Spain; ¹⁵Department of Clinical Therapeutics, School of Medicine, National and Kapodistrian University of Athens, Athens, Greece.

Study Design

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)

PVd (Q3W)

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

Bortezomib

1.3 mg/m² 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 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, belantamab, 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 received 20 mg 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).

Baseline Demographics and Clinical Characteristics Were Balanced

Baseline characteristics	ITT population	
	BPd (N=155)	PVd (N=147)
Age, median (range), years	67 (40-82)	68 (34-86)
<65, n (%)	64 (41)	53 (36)
65 to <75, n (%)	72 (46)	59 (40)
≥75, n (%)	19 (12)	35 (24)
Male/female, n (%)	99 (64)/56 (36)	82 (56)/65 (44)
White/Black/Asian/Mixed race, n (%)^a	133 (86)/0/20 (13)/1 (<1)	127 (87)/0/17 (12)/0
ECOG PS ≤1, n (%)^b	146 (97)	140 (97)
ISS stage at screening, n (%)		
I	93 (60)	85 (58)
II	39 (25)	40 (27)
III	22 (14)	22 (15)
Unknown	1 (<1)	0
Years since diagnosis, median (range)	4.04 (0.4-16.7)	3.43 (0.4-17.7)
Cytogenetic abnormalities, n (%)		
Standard risk ^c	72 (46)	75 (51)
High risk^d	52 (34)	47 (32)
Missing or nonevaluable ^e	31 (20)	25 (17)
Time to relapse after initiation of 1L treatment		
≤12 months	22 (14)	20 (14)
>12 months	133 (86)	127 (86)
Extramedullary disease, n (%)	20 (13)	11 (7)

BPd, belamaf, pomalidomide, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; ISS, International Staging System; ITT, intent to treat; PVd, pomalidomide, bortezomib, and dexamethasone.

^a Mixed race included a patient who was Native Hawaiian or Other Pacific Islander and White. ^b Evaluated in the safety population (BPd, N=150; PVd, N=145). ^c Standard-risk cytogenetics were defined as having negative results for all high-risk abnormalities: t(4;14), t(14;16), or del(17p13). ^d High-risk cytogenetics were defined as the presence of ≥1 of the following: t(4;14), t(14;16), or del(17p13). ^e Patients with considered missing or nonevaluable may not be high or standard risk.

Prior Treatments Were Generally Balanced

Prior treatments, n (%)	ITT population			
	BPd (N=155)		PVd (N=147)	
Prior LOT				
1	82 (53)		77 (52)	
2 or 3	54 (35)		48 (33)	
≥4	19 (12)		22 (15)	
Prior ASCT	99 (64)		82 (56)	
Prior treatment	Exposed	Refractory	Exposed	Refractory
Prior proteasome inhibitor	140 (90)	40 (26)	136 (93)	35 (24)
Bortezomib	134 (86)	16 (10)	130 (88)	8 (5)
Carfilzomib	34 (22)	18 (12)	37 (25)	23 (16)
Ixazomib	11 (7)	8 (5)	15 (10)	11 (7)
Prior immunomodulatory drug ^a	155 (100)	127 (82)	147 (100)	111 (76)
Lenalidomide	155 (100)	125 (81)	147 (100)	111 (76)
Thalidomide	49 (32)	9 (6)	48 (33)	6 (4)
Prior anti-CD38 monoclonal antibody ^b	38 (25)	35 (23)	42 (29)	36 (24)
Daratumumab	36 (23)	33 (21)	39 (27)	34 (23)
Isatuximab	2 (1)	2 (1)	3 (2)	2 (1)

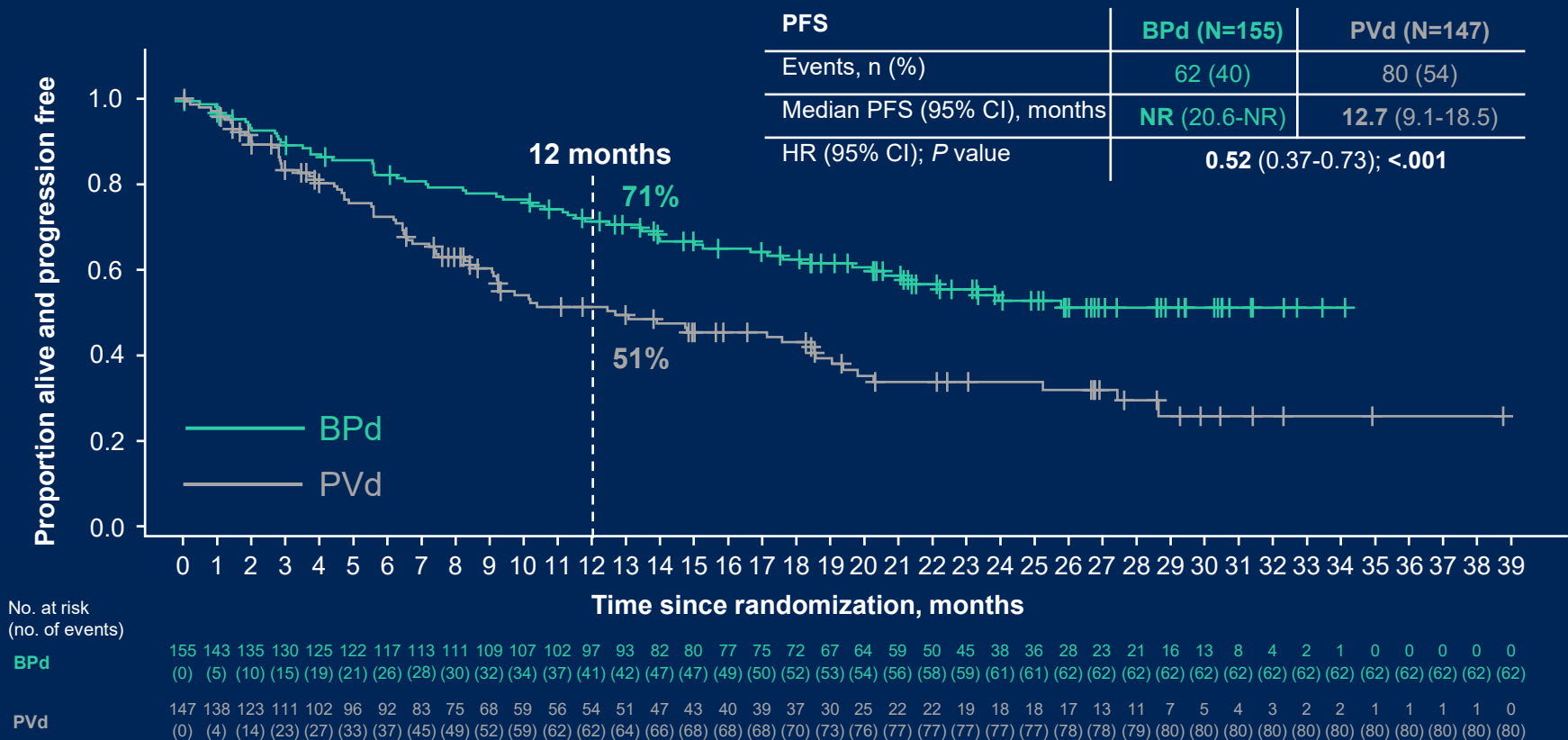
In the BPd group:

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

ASCT, autologous stem cell transplant; BPd, belamaf, pomalidomide, and dexamethasone; CD, cluster of differentiation; ITT, intent to treat; LOT, line of therapy; PI, proteasome inhibitor; PVd, pomalidomide, bortezomib, and dexamethasone.

^a One patient in the PVd arm and no patients in the BPd arm received prior pomalidomide. ^b One patient in the PVd arm and no patients in the BPd arm received prior anti-CD38 inhibitors.

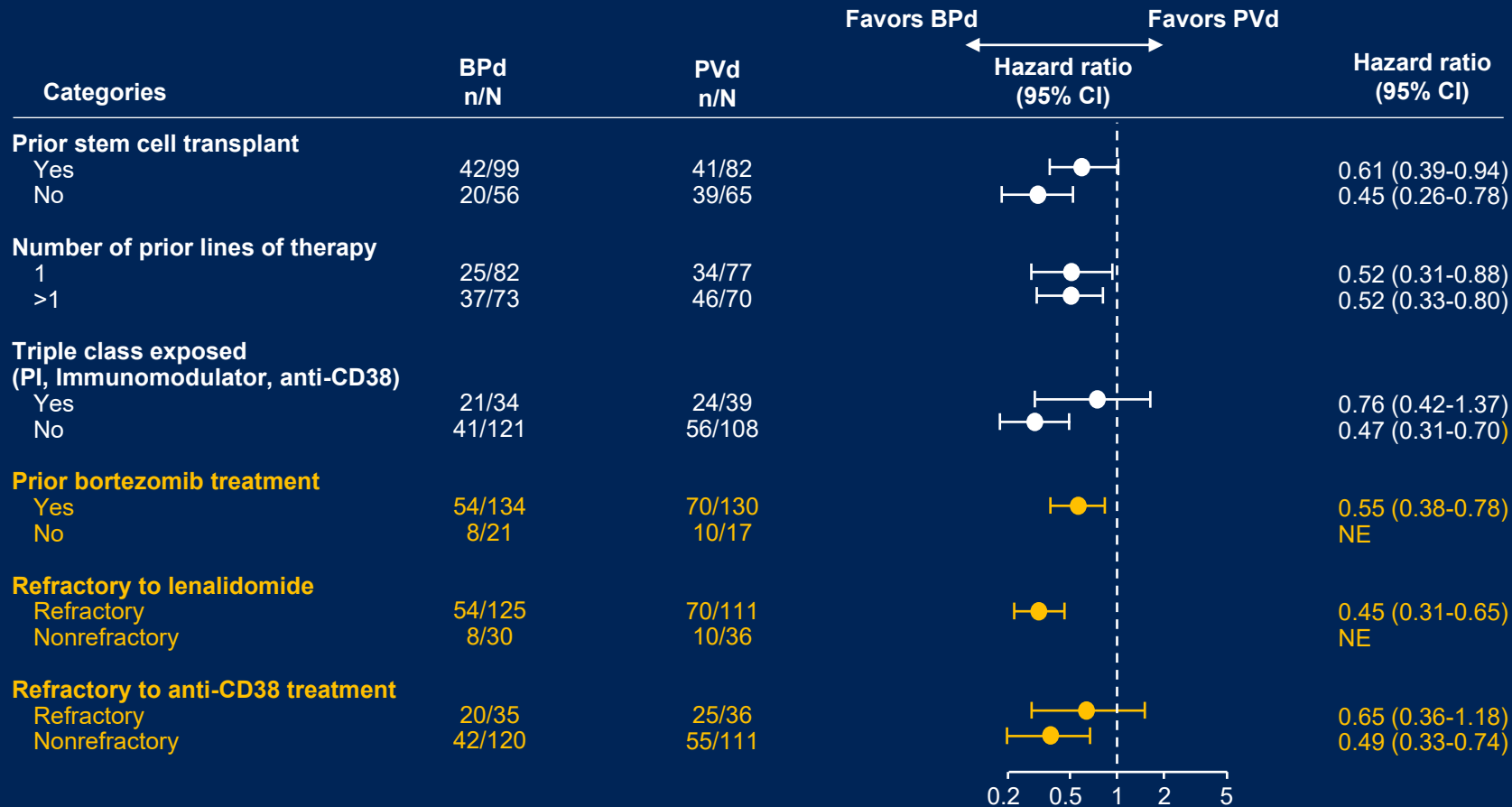
BPd Led to a Significant PFS Benefit vs PVd



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.

PFS Benefit Was Seen Consistently Across All Prespecified Subgroups

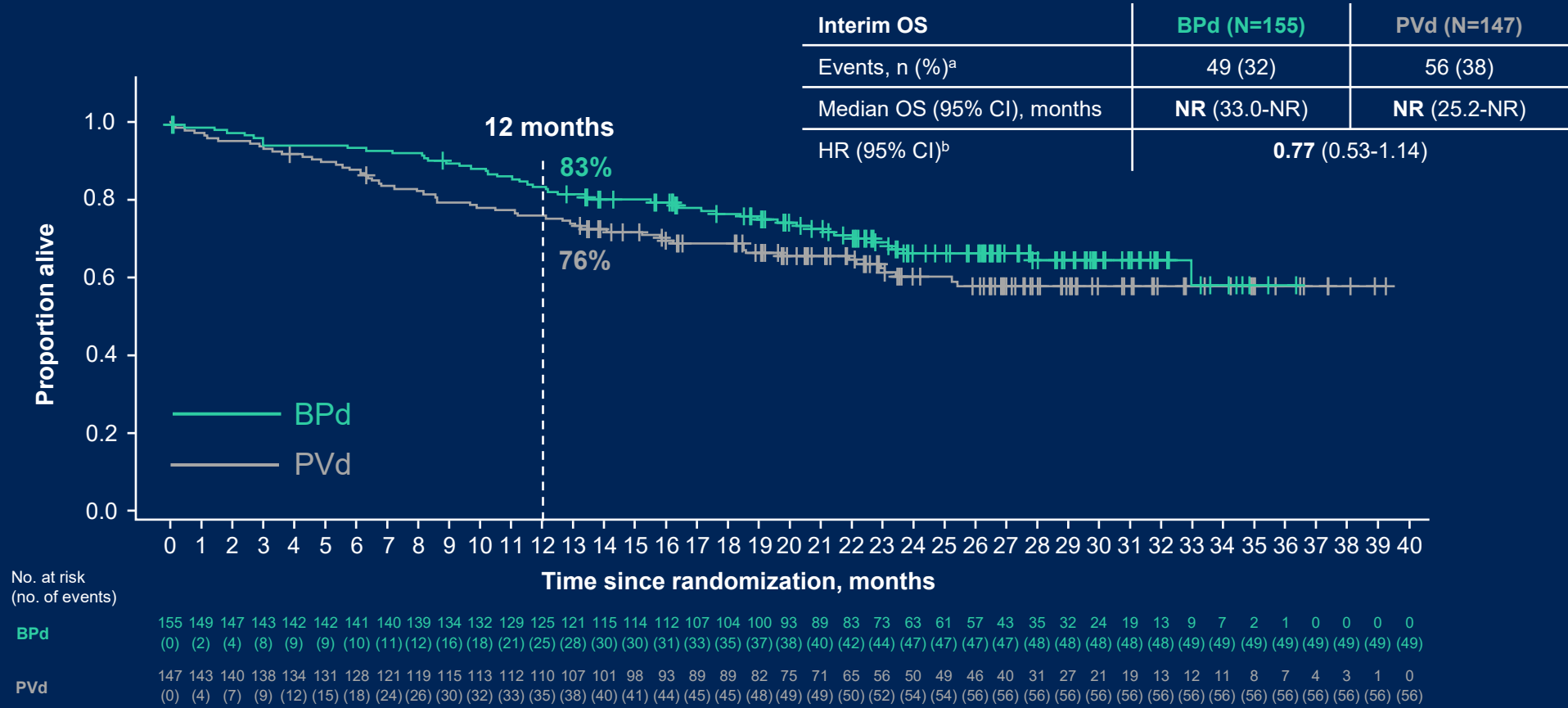


PFS HR <1 was observed in difficult-to-treat subgroups

HRs for subgroups were only plotted if the number of events was ≥ 20 in total across both treatments and were estimated using Cox proportional hazards models, without adjustments for stratification variables. All patients were stratified by the number of prior LOT (1 vs 2 or 3 vs ≥ 4) and prior bortezomib (yes or no) according to an interactive voice response system stratum with a covariate of treatment. A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13) and considered standard risk if they had negative results for all high-risk cytogenetics listed above.

BPd, belantamab, pomalidomide, and dexamethasone; CD, cluster of differentiation; HR, hazard ratio; LOT, line of therapy; NE, not evaluable; PI, proteasome inhibitor; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.

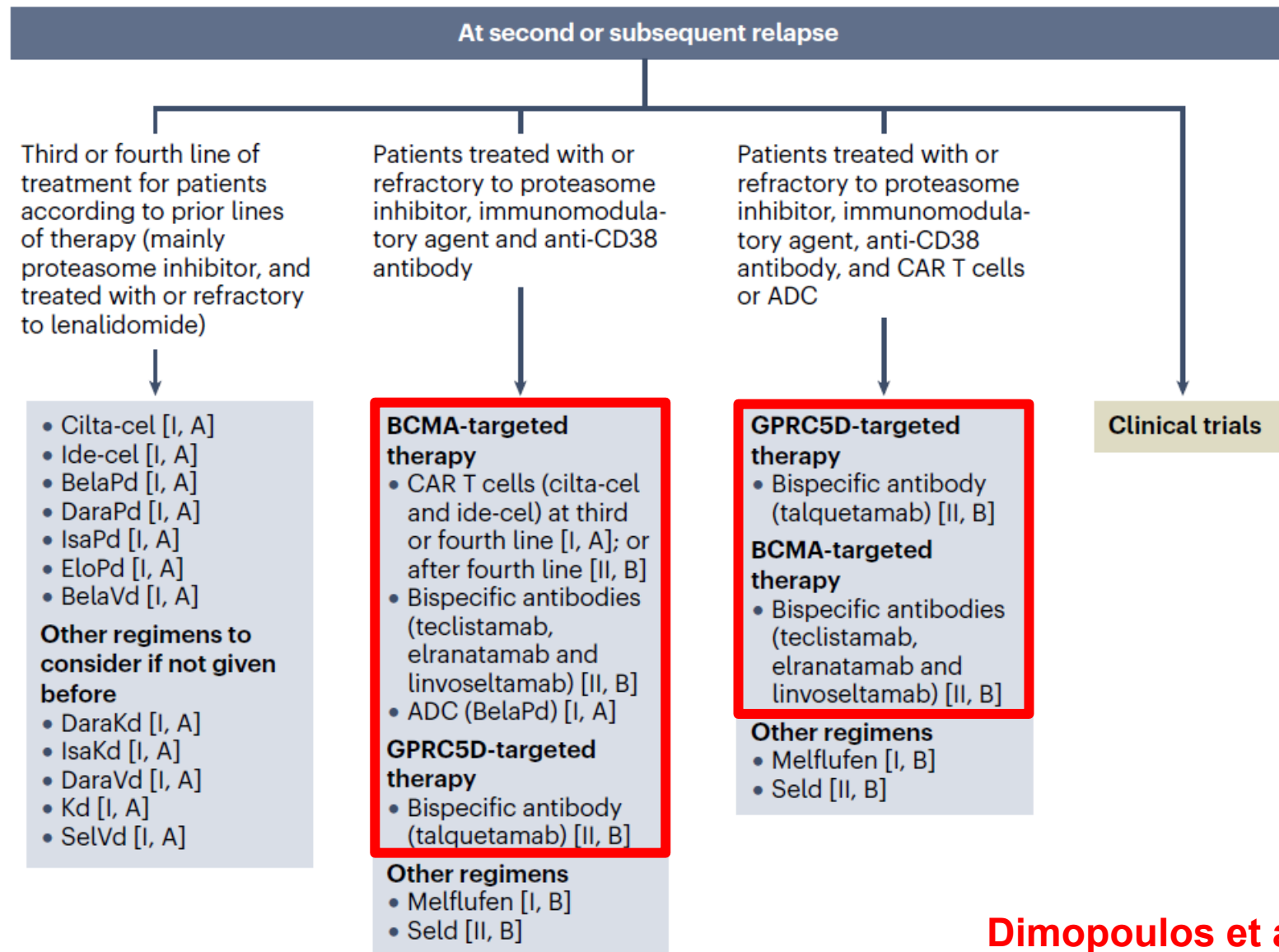
Positive OS Trend Favoring BPd vs PVd



Positive OS trend favoring BPd was seen despite the use of effective anti-MM therapies after progression with PVd; additional OS follow-up for future pre-specified analyses is ongoing

Median follow-up, 21.8 months (range, 0.03-39.23 months). Minimum ongoing follow-up, 12.8 months.
BPd, belamaf, pomalidomide, and dexamethasone; HR, hazard ratio; MM, multiple myeloma; NR, not reached; OS, overall survival; PVd, pomalidomide, bortezomib, and dexamethasone.
^aIncludes patients who died after study withdrawal when permitted per local laws. ^bThe treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use.

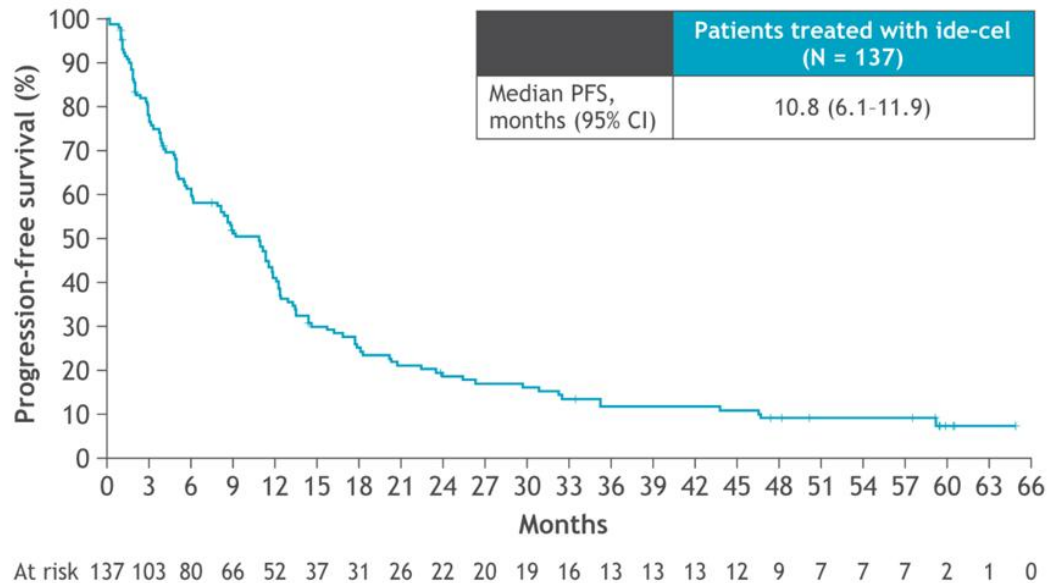
EHA – EMN GUIDELINES



KarMMa – ide-cel:

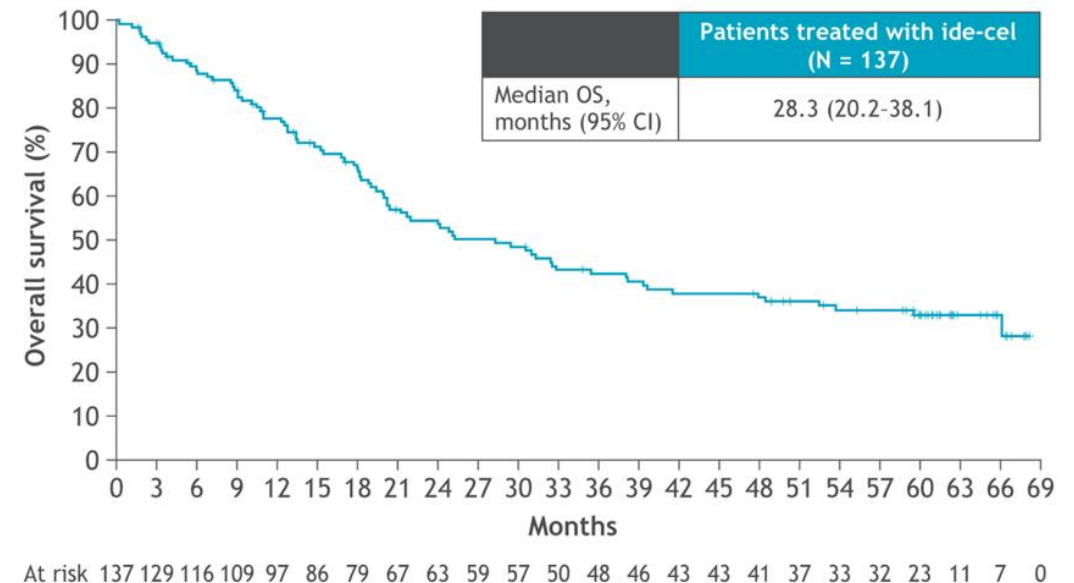
PFS and OS with 5-years median follow-up¹

PFS¹



Median PFS: 10.8 months in all ide-cel-treated patients¹

OS¹



Median OS: 28.3 months in all ide-cel-treated patients¹

- **Ide-cel is approved by FDA and EMA^{2,3}**
- The safety profile of ide-cel was consistent with previous reports across all groups¹

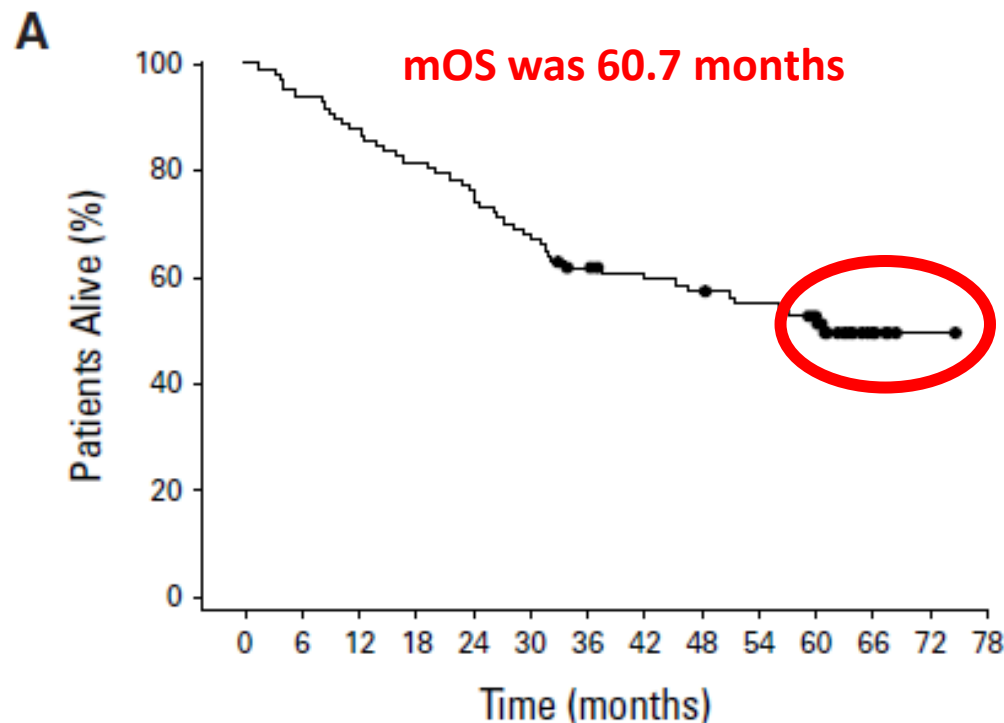
Data cut-off date: 20 December 2023.

CI, confidence interval; OS, overall survival; PFS, progression-free survival.

1. Anderson LD, et al. IMS 2024 (Abstract No. P-069 – poster presentation). FDA Available at: <https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-idecabtagene-vicleucel-multiple-myeloma> (last accessed April 2025). 3. EMA. Available at: <https://www.ema.europa.eu/en/medicines/human/EPAR/abecma> (last accessed May 2025).

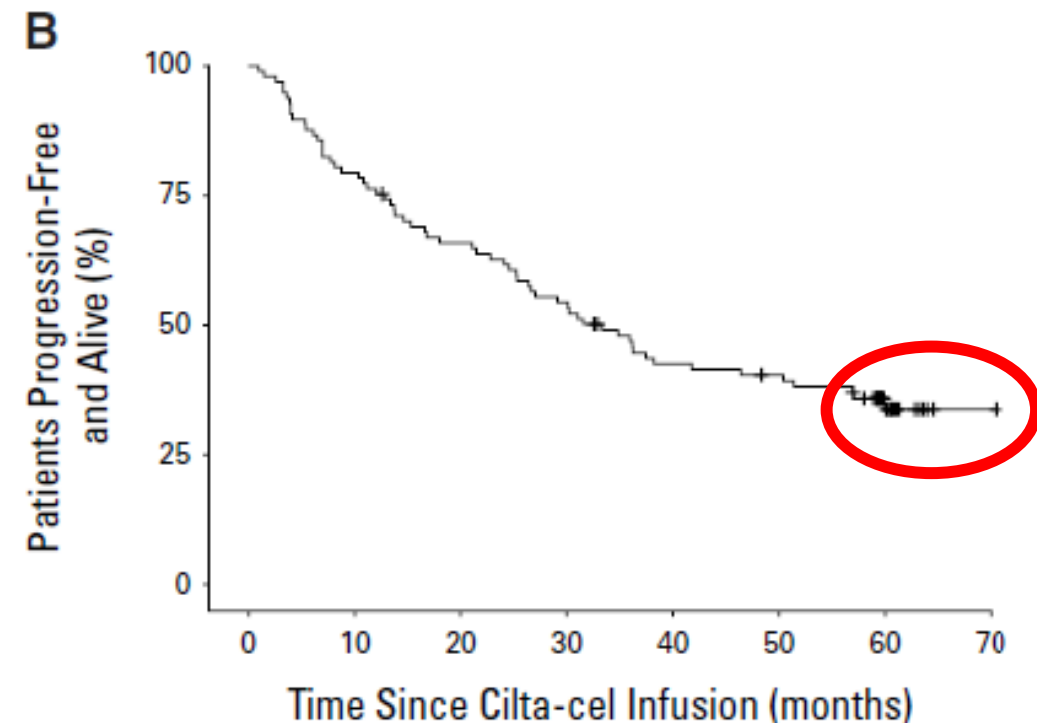
③ Long-Term (≥ 5 -Year) Remission and Survival After Treatment With Ciltacabtagene Autoleucel in CARTITUDE-1 Patients With Relapsed/Refractory Multiple Myeloma

Sundar Jagannath, MD, FASCO¹ ; Thomas G. Martin, MD²; Yi Lin, MD, PhD³ ; Adam D. Cohen, MD⁴ ; Noopur Raje, MD⁵ ; Myo Htut, MD⁶; Abhinav Deol, MD⁷ ; Mounzer Agha, MD⁸ ; Jesus G. Berdeja, MD⁹ ; Alexander M. Lesokhin, MD¹⁰; Jessica J. Liegel, MD¹¹ ; Adriana Rossi, MD¹ ; Alex Lieberman-Cribbin, MPH, CCRP¹ ; Saad Z. Usmani, MD, MBA, FACP, FASCO¹⁰ ; Binod Dhakal, MD¹² ; Samir Parekh, MD¹ ; Hui Li, PhD¹³; Feng Wang, PhD¹³; Rocio Montes de Oca, PhD¹⁴ ; Vicki Plaks, PhD, LLB¹⁴; Huabin Sun, MD¹⁵; Arnob Banerjee, MD, PhD¹⁴; Jordan M. Schecter, MD¹⁵; Nikolett Lendvai, MD, PhD¹⁵; Deepu Madduri, MD¹⁵; Tamar Lengil, PhD¹⁵; Jieqing Zhu, PhD¹⁶; Mythili Koneru, MD, PhD¹⁶; Muhammad Akram, MD¹⁶; Nitin Patel, BM BCh¹⁶; Octavio Costa Filho, MD¹⁶; Andrzej J. Jakubowiak, MD, PhD¹⁷ ; and Peter M. Voorhees, MD¹⁸ 



Number at risk
OS

Time (months)	0	6	12	18	24	30	36	42	48	54	60	66	72	78
OS	97	91	85	79	74	66	58	53	51	48	36	5	1	0



Number at risk
PFS

Time (months)	0	10	20	30	40	50	60	70
PFS	97	77	63	52	39	36	16	1

Bispecific antibodies approved by EMA in 2025

BCMA bispecific antibodies :

- Teclistamab : Majestec-1 (Moreau et al. N Engl J Med 2022)
- Elranatamab : MagnetisMM-3 (Lesokhin et al. Nature Med 2023)
- Linvoseltamab : LinkerMM-1 (Bumma et al. J Clin Oncol 2024)

GPRC5D bispecific antibody :

- Talquetamab : MonumenTAL-1 (Chari et al. N Engl J Med 2022)

BCMA BISPECIFIC ANTIBODIES APPROVED by EMA

Baseline characteristics

	TECLISTAMAB Majestec-1	ELRANATAMAB MagnetisMM-3	LINVOSELTAMAB Linker-MM1
N	165	123	117
Dose	(0.06 – 0.03) 1.5 mg/kg	(12 – 32) 76 mg	(5 – 25) 200 mg
Route of adm	SC	SC	IV
Schedule	Weekly 6mos → Every 2 w	Weekly 6 mos → Every 2 w	Weekly → E2W → monthly
Median age	64 (34-84)	68 (36-89)	70 (37-91)
Triple-class Exposed %	100	100	100
Triple-class Refractory %	77.6	96.7	82.1
Penta-refractory %	30.3	42.3	28.2
Nb prior lines	5 (2-14)	5 (2-22)	5 (2-16)
ISS3 %	12.3	15.4	17.9
High-risk cytogen %	25.9	25.2	39.3
EMD %	17	31.7	16.2

BCMA BISPECIFIC ANTIBODIES APPROVED by EMA

Efficacy

	TECLISTAMAB Majestec-1	ELRANATAMAB MagnetisMM-3	LINVOSELTAMAB Linker-MM1
Overall response rate %	63	61	70.9
≥ CR %	39.4	27.6	49.6
≥ VGPR %	58.8	55.3	63.2
Med time to 1st resp (mos)	1.2 (0.2-5.5)	1.2 (0.9-7.4)	1 (0.5-6.3)
Median PFS (mos)	11.4	17.2	12 mo : 70%
Median OS (mos)	21.9	24.6	31.4
Median DOR (mos)	24	30-month : 61%	29.4

BCMA BISPECIFIC ANTIBODIES APPROVED by EMA

Safety

	TECLISTAMAB Majestec-1	ELRANATAMAB MagnetisMM-3	LINVOSELTAMAB Linker-MM1
CRS any grade %	72.1	57.7	46.2
CRS grade 3 %	0.6	0	0.9
ICANS any grade %	3	3.4	7.7
ICAN grade 3 %	0	0	0 grade 4
Infections any grade %	76.4	69.9	NA
Infections grade 3-4 %	44.8	39.8	34

Safety and activity of talquetamab in patients with relapsed or refractory multiple myeloma (MonumenTAL-1): a multicentre, open-label, phase 1–2 study

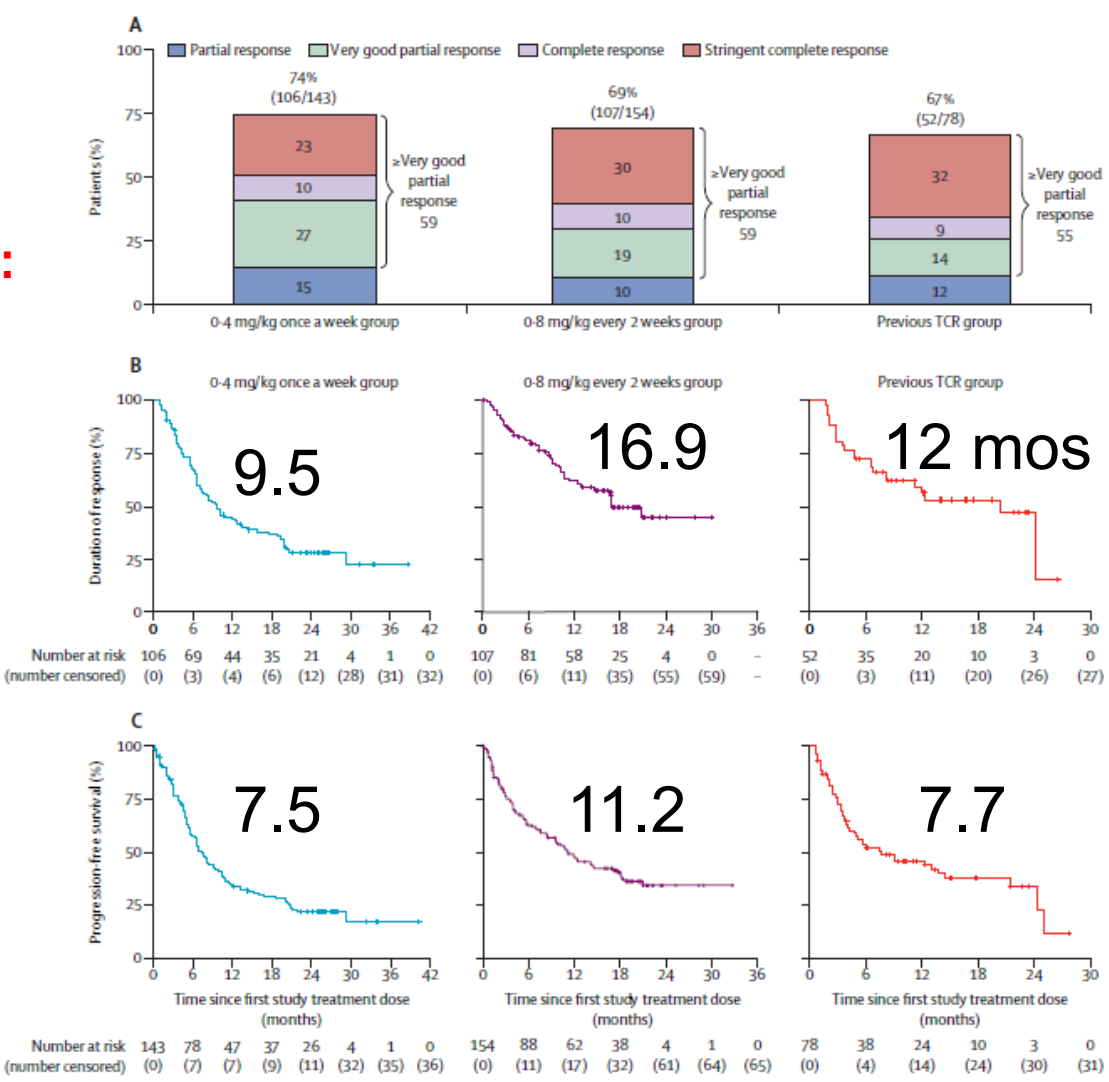
Lancet Haematol 2025

Published Online

March 13, 2025

Ajai Chari, Cyrille Touzeau, Carolina Schinke, Monique C Minnema, Jesus G Berdeja, Albert Oriol, Niels W C J van de Donk, Paula Rodríguez-Otero, Daniel Morillo, Carmen Martínez-Chamorro, María-Victoria Mateos, Luciano J Costa, Jo Caers, Leo Rasche, Amrita Krishnan, Jing Christine Ye, Lionel Karlin, Brea LiPe, Deeksha Vishwamitra, Sheri Skerget, Raluca Verona, Xuewen Ma, Xiang Qin, Hein Ludlage, Michela Campagna, Tara Masterson, Brandi Hilder, Jaszianna Tolbert, Thomas Renaud, Jenna D Goldberg, Colleen Kane, Christoph Heuck, Jesus San-Miguel, Philippe Moreau

Median time to first response :
1.2 months



56%

Advantages of bispecific antibodies

- Off the shelf, large access
- Community hospitals
- Outpatient setting : prophylactic tocilizumab...
- Guidelines / recommendations for optimal management
- Feasible in « frail » patients, elderly, renal impairment and hemodialysis
- Real life data to confirm results of pivotal trials

Some ongoing issues

- Optimal sequence : CAR-T → bispecific antibodies, BCMA / GPRC5D
- Understanding primary resistance
- Understanding acquired resistance (loss of target, T-cell exhaustion...)
- Optimize the schedule
- Reduce toxicity
- Work of fixed duration
- Reduce cost → Access
- Combinations of bispecific antibodies
- Future use at earlier lines

CONCLUSIONS

Immunotherapies are game changers

- Cartitude 4 : ciltacel**
- BCMA bispecific based therapy : TEC3, TEC9, magnetism-5**
- GPRC5D bispe : monumental-3**

Thank you