Multidisciplinary Approaches to Cancer Symposium

Harnessing the Immune System to Fight Relapsed/Refractory Multiple Myeloma

Focus: Bispecific Antibodies

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Bispecific Antibodies in Myeloma

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Division of Myeloma

Disclosures

- Consultant/Advisor Bristol Myers Squibb, Janssen, & Legend Biotech
- Grant/Research Support from Bristol Myers Squibb, Janssen, & Fate Therapeutics

This presentation and/or comments will be free of any bias toward or promotion of the above referenced companies or their product(s) and/or other business interests.

This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.

This presentation has been peer-reviewed and no conflicts were noted.

Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

STATE LAW:

The California legislature has passed Assembly Bill (AB) 1195, which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed AB 241, which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.

EXEMPTION:

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

The following CLC & IB components will be addressed in this presentation:

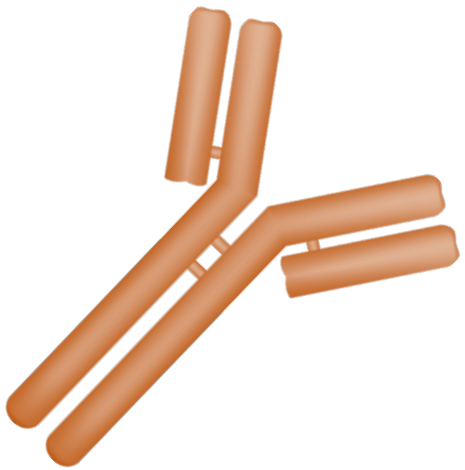
- *Address differences among individuals based on social determinants of health.*

THERAPY FOR PREVIOUSLY TREATED MULTIPLE MYELOMA[a-d,l-o] Relapsed/Refractory Disease After 3 Prior Lines of Therapy
Preferred Regimens[q]
▸ ***CAR T-cell Therapy:*** ◊ Ciltacabtagene autoleucel ◊ Idecabtagene vicleucel ***After at least four prior therapies, including an anti-CD38 monoclonal antibody, a PI, and an IMiD*** ▸ *Bispecific Antibodies:* ◊ Elranatamab-bcmm ◊ Talquetamab-tgvs ◊ Teclistamab-cqyv
Other Recommended Regimens
• Bendamustine • Bendamustine/bortezomib/dexamethasone • Bendamustine/carfilzomib/dexamethasone • Bendamustine/lenalidomide/dexamethasone • High-dose or fractionated cyclophosphamide ***After at least four prior therapies and whose disease is refractory to at least two PIs, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody*** • Selinexor/dexamethasone
Useful in Certain Circumstances[q]
After at least four prior therapies, including an anti-CD38 monoclonal antibody, a PI, and an IMiD • Belantamab mafodotin-blmf (if available through compassionate use program)

[a] Selected, but not inclusive of all regimens. The regimens under each preference category

Types of Antibodies

Naked



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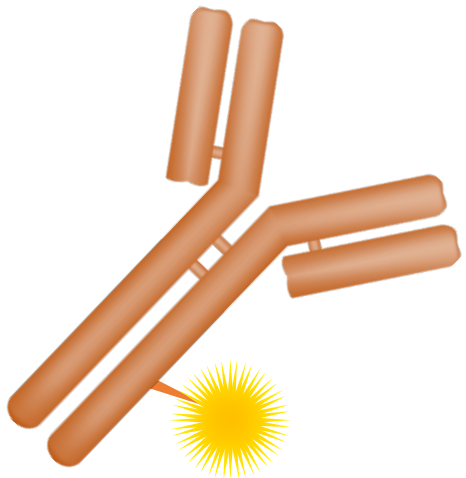
Antibody–Drug Conjugates (ADC)



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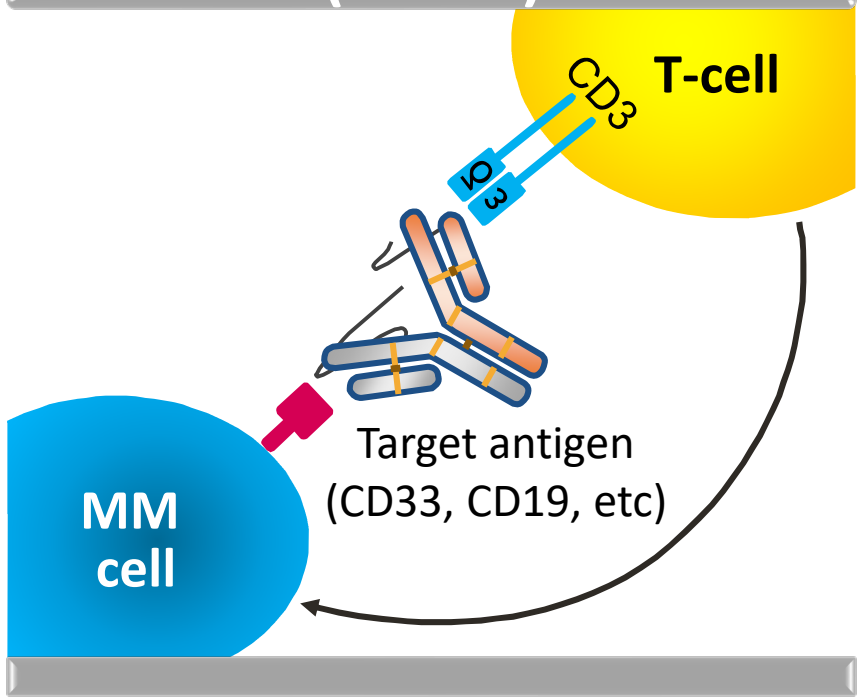
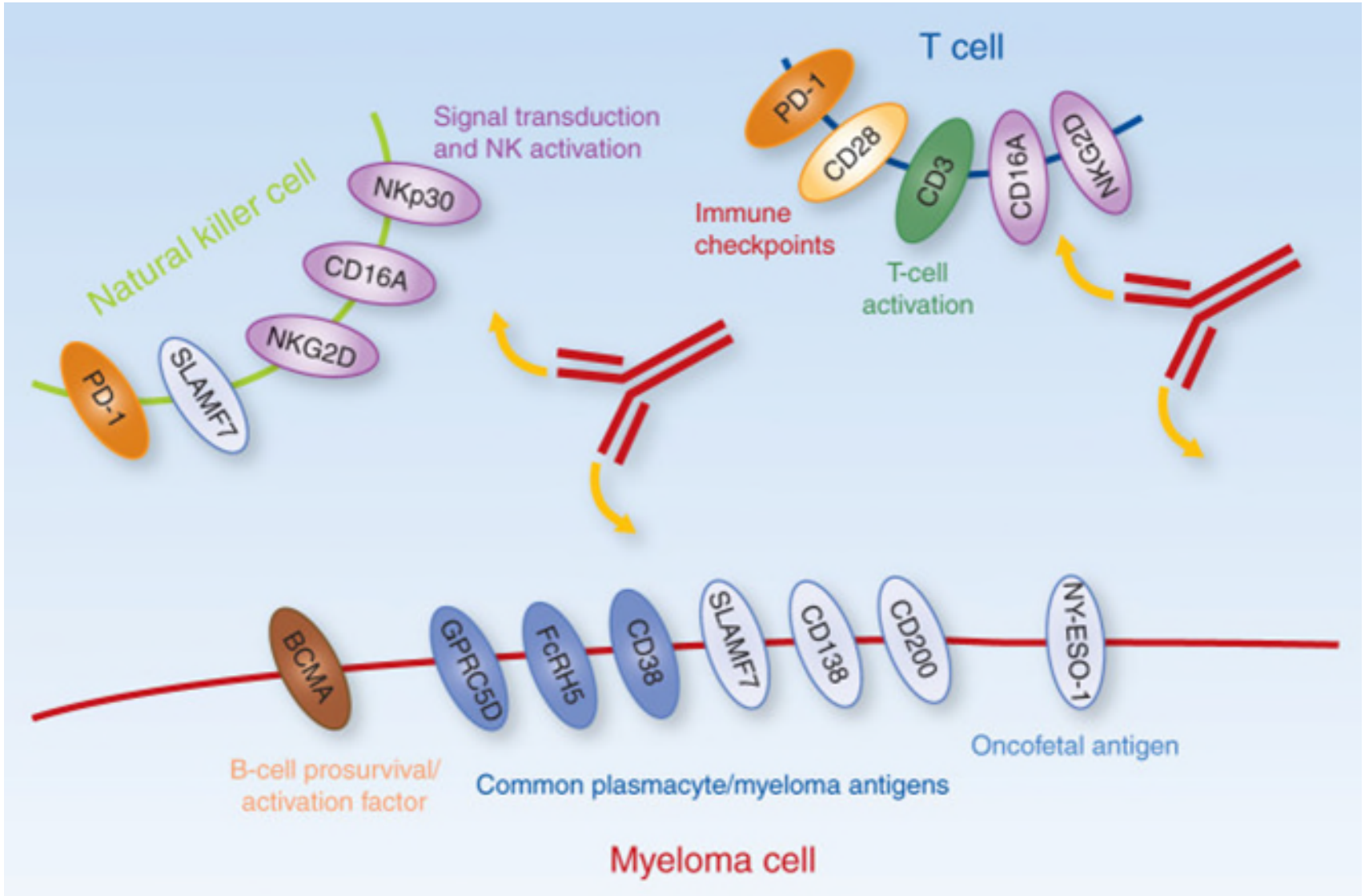
Bispecific Antibodies (BsAbs)



Engineered so that one end binds to MM cell, the other end binds to T-cell

Barila. Pharmaceuticals (Basel). 2021;14:40.

Slide credit: clinicaloptions.com



Lancman G, Sastow DL, Cho HJ, et al. Bispecific Antibodies in Multiple Myeloma: Present and Future. Blood Cancer Discovery. 2021 Sep;2(5):423-433. DOI: 10.1158/2643-3230.bcd-21-0028. PMID: 34661161; PMCID: PMC8510808.

Long-Term Follow-Up From the Phase 1/2 MajesTEC-1 Trial of Teclistamab in Patients With Relapsed/Refractory Multiple Myeloma

Alfred L Garfall[1], Ajay K Nooka[2], Niels WCJ van de Donk[3], Philippe Moreau[4], Manisha Bhutani[5], Albert Oriol[6], Thomas G Martin[7], Laura Rosiñol[8], María-Victoria Mateos[9], Nizar J Bahlis[10], Rakesh Popat[11], Britta Besemer[12], Joaquin Martinez-Lopez[13], Amrita Y Krishnan[14], Michel Delforge[15], Lin Huang[16],
Deeksha Vishwamitra[16], Tara Stephenson[16], Katherine Chastain[17], Surbhi Sidana[18]

[1]Abramson Cancer Center, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, USA; [2]Winship Cancer Institute, Emory University, Atlanta, GA, USA; [3]Amsterdam University Medical Center, Vrije Universiteit Amsterdam, Amsterdam, Netherlands; [4]University Hospital Hôtel-Dieu, Nantes, France; [5]Levine Cancer Institute/Atrium Health, Charlotte, NC, USA; [6]Institut Català d'Oncologia and Institut Josep Carreras, Hospital Germans Trias i Pujol, Badalona, Barcelona, Spain; [7]University of California, San Francisco, San Francisco, CA, USA; [8]Hospital Clínic de Barcelona, IDIBAPS, Barcelona, Spain; [9]Hospital Universitario de Salamanca, Instituto de Investigación Biomédica de Salamanca (IBSAL), Centro de Investigación del Cáncer (IBMCC-USAL,CSIC), Salamanca, Spain; [10]Arnie Charbonneau Cancer Institute, University of Calgary, Calgary, AB, Canada; [11]University College London Hospitals, NHS Foundation Trust, London, UK; [12]University of Tübingen, Tübingen, Germany; [13]Hematological Malignancies Clinical Research Unit, Hospital 12 de Octubre Universidad Complutense, Centro Nacional de Investigaciones Oncológicas CIBERONC, Madrid, Spain; [14]City of Hope Comprehensive Cancer Center, Duarte, CA, USA; [15]University of Leuven, Leuven, Belgium; [16]Janssen Research & Development, Spring House, PA, USA; [17]Janssen Research
& Development, Raritan, NJ, USA; [18]Stanford University School of Medicine, Stanford, CA, USA

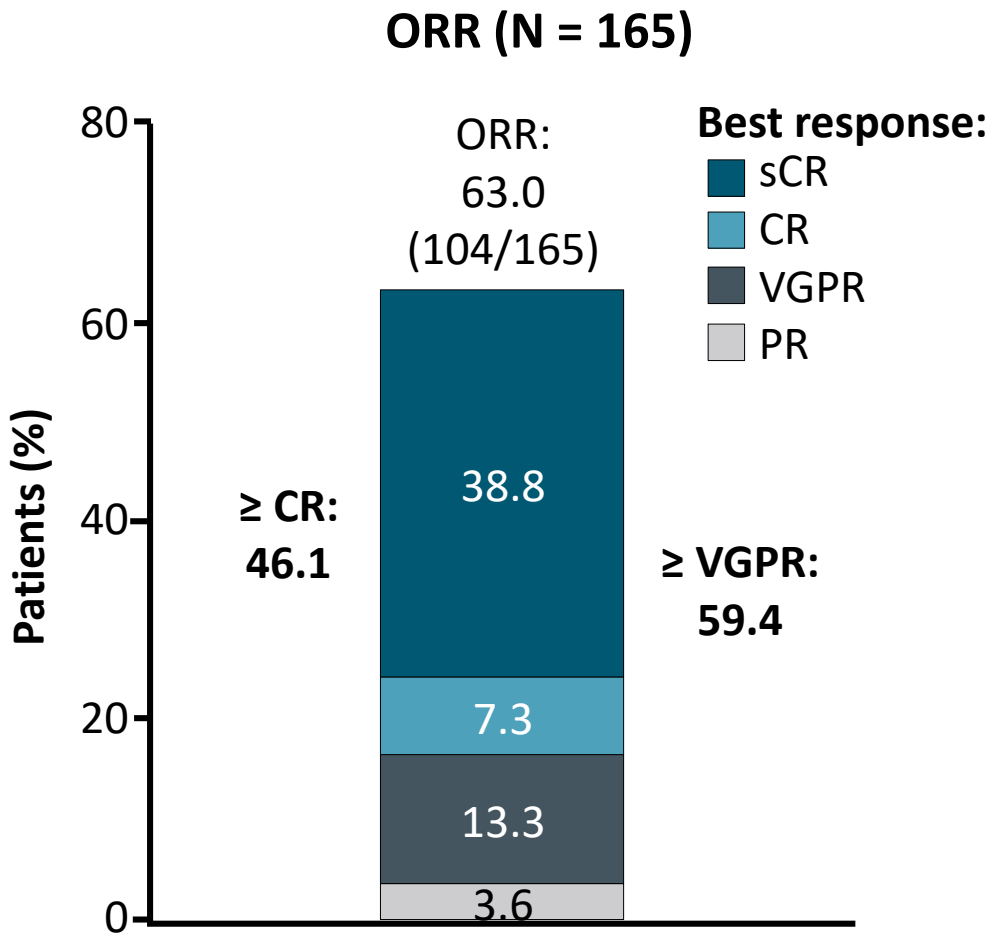
Presented by AL Garfall at the 2024 American Society of Clinical Oncology (ASCO) Annual Meeting; May 31–June 4, 2024; Chicago, IL, USA & Virtual

Garfall AL, et al. ASCO 2024. Abstract 7540.

Phase I/II MajesTEC-1: Teclistamab in R/R MM

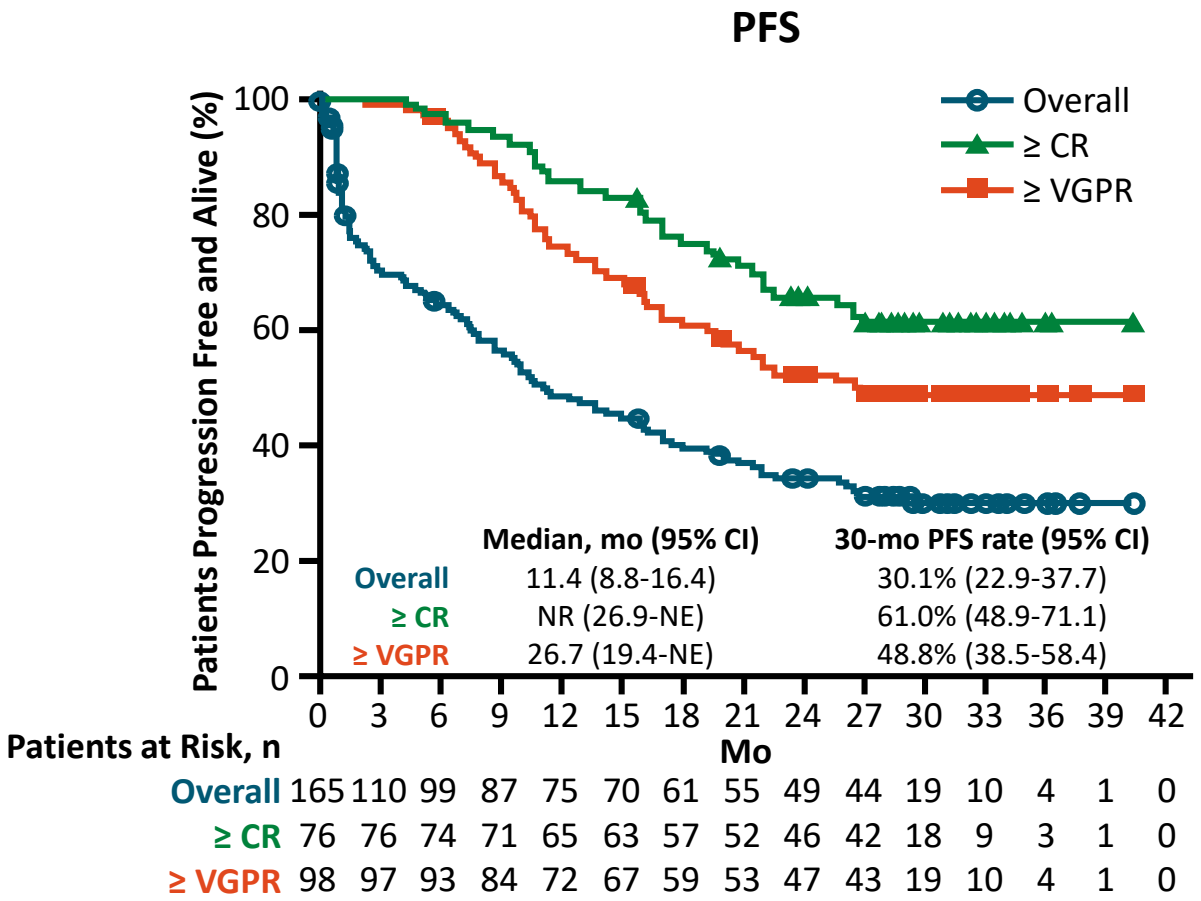
- R/R MM after ≥3 lines of therapy, including an IMiD, PI, and anti-CD38 mAb
  - 26% high-risk cytogenetics
  - Median 5 prior lines of therapy (range: 2-14)
  - 78% triple-class refractory; 30% penta refractory
  - 90% refractory to last therapy line
- **Teclistamab**: 1.5 mg/kg SC weekly, after step-up

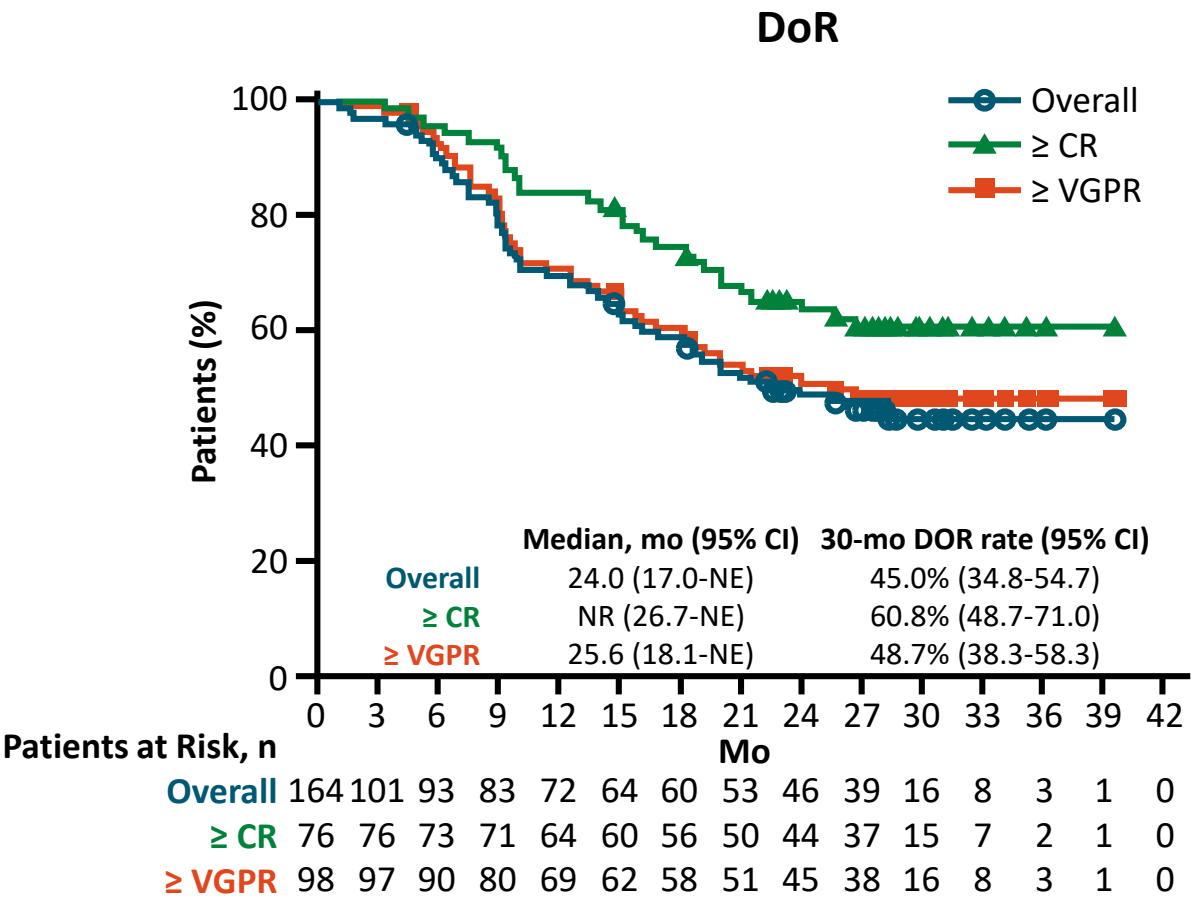
Outcomes, Mo (95% CI)	All Patients (N = 165)
Median DoR	24.0 (17.0-NE)
Median PFS	11.4 (8.8-16.4)
Median OS	21.9 (16-NE)



Moreau. NEJM. 2022;387:495. van de Donk. ASCO 2023. Abstr 8011. Garfall. ASCO 2024. Abstr 7540.

MajesTEC-1: PFS and DoR With Teclistamab in R/R MM



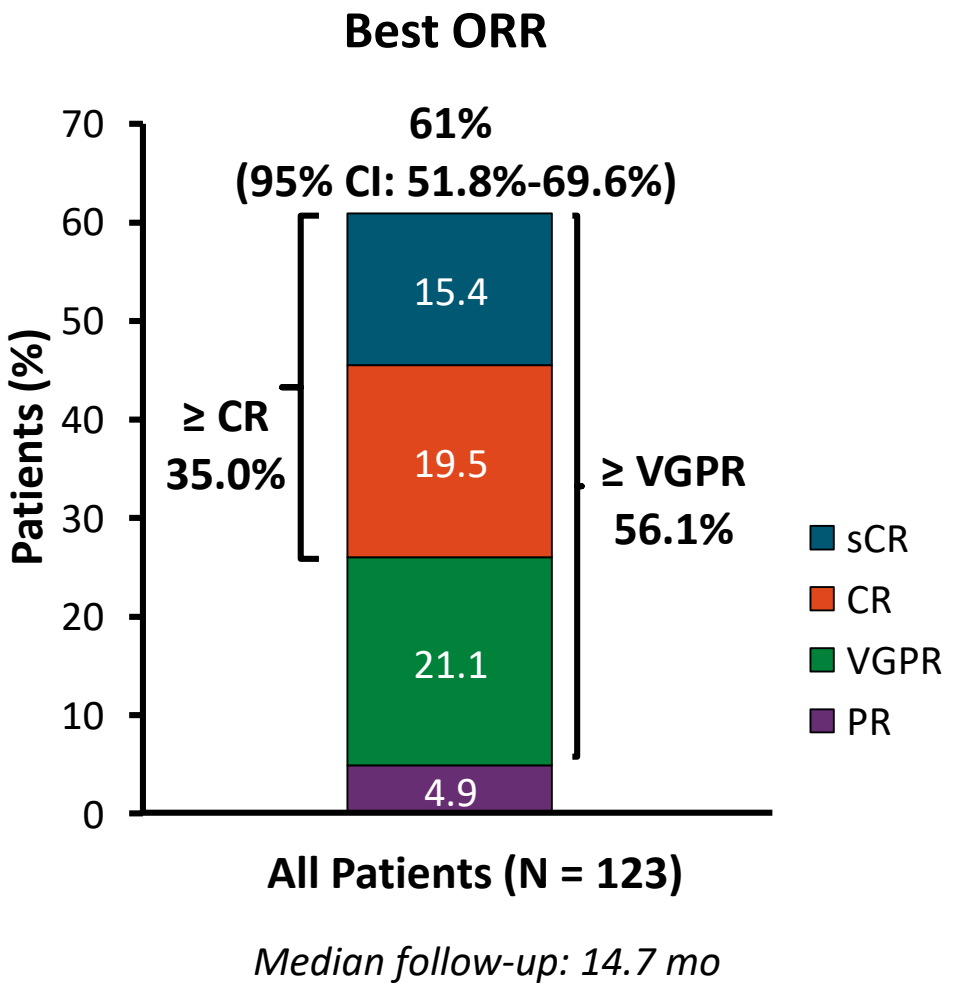


Garfall. ASCO 2024. Abstr 7540.

Slide credit: clinicaloptions.com

Phase II MagnetisMM-3: Elranatamab for BCMA-Directed Therapy-Naive R/R MM (Cohort A)

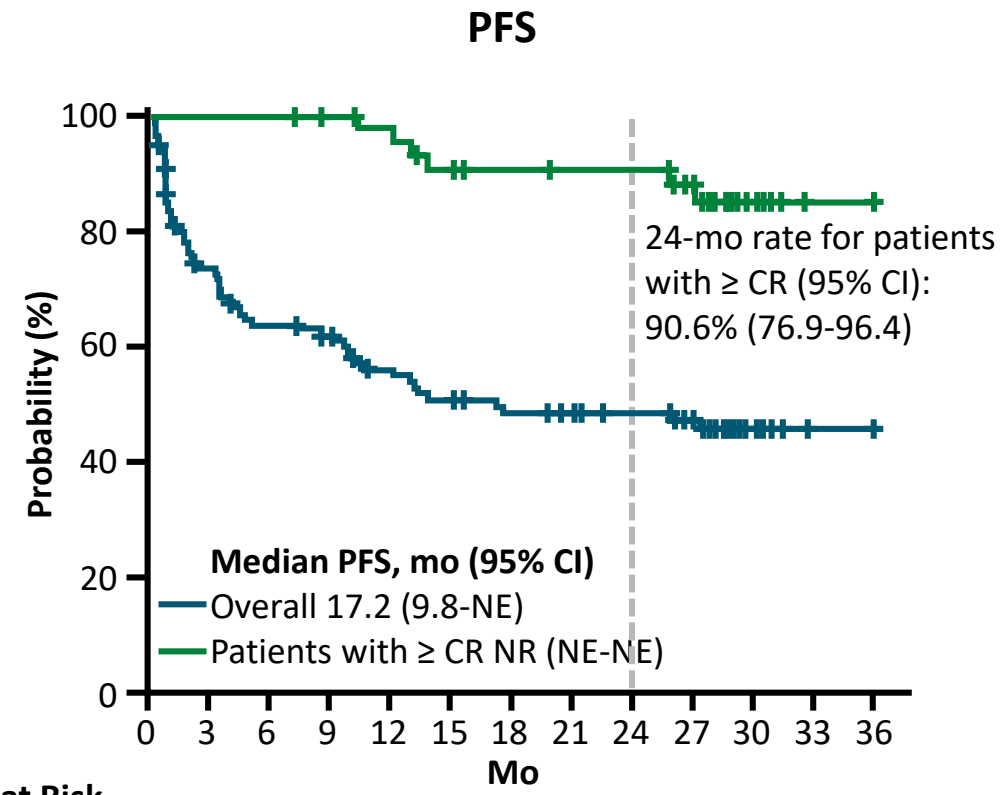
- Patients with MM refractory to ≥1, including an IMiD, PI, and anti-CD38 mAb
  - 97% triple-class refractory
  - Median 5 prior lines of therapy (range: 2-22)
  - 25% with high-risk cytogenetics
  - 32% with extramedullary disease
- **Elranatamab**: 76 mg SC weekly with priming and/or premedication to reduce CRS
  - If weekly dosing given for ≥6 cycles with achievement of ≥ PR for ≥2 mo, then dosing interval changed to every 2 wk
- **Primary endpoint:** ORR
- **Secondary endpoint:** DoR, OS, PFS, safety



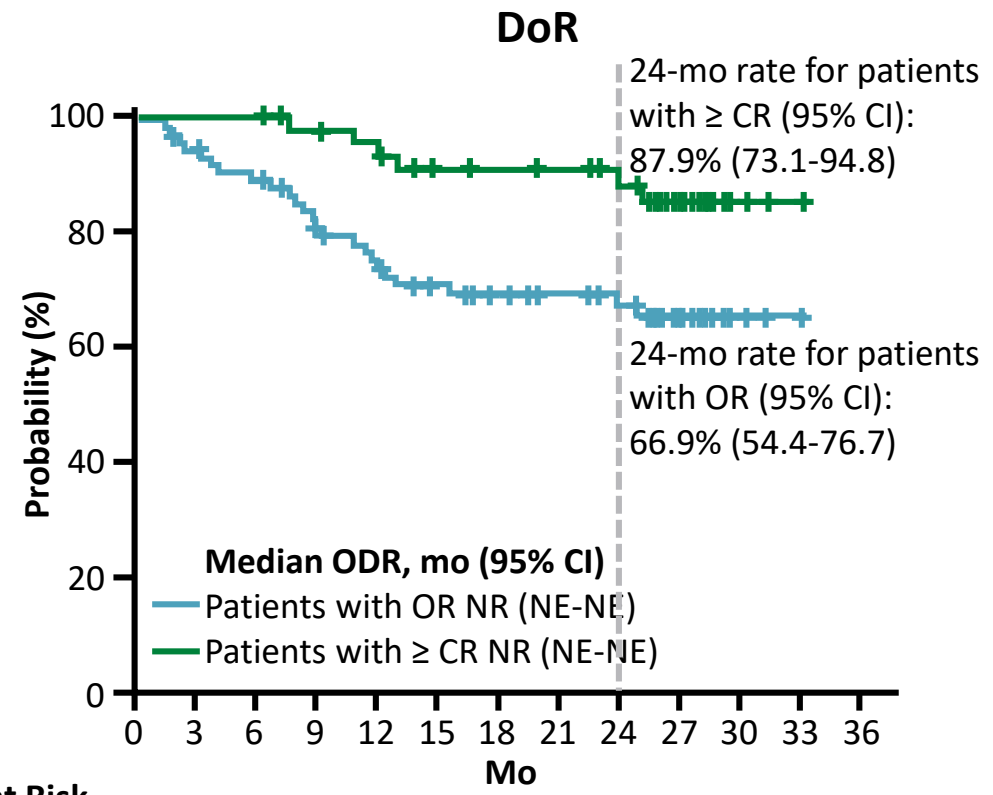
Median follow-up: 14.7 mo

Lesokhin. Nat Med. 2023;29:2259. Mohty. EHA 2024. P932.

MagnetisMM-3: PFS and DoR



No. at Risk													
Overall	123	78	67	63	54	48	44	42	39	32	7	1	0
Patients with ≥ CR	46	46	46	44	42	38	36	35	35	28	7	1	0



No. at Risk													
Patients with OR	75	70	65	57	50	45	41	38	35	18	3	1	0
Patients with ≥ CR	46	46	46	43	40	36	35	34	31	18	3	1	0

Mohty. EHA 2024. P932.

Slide credit: clinicaloptions.com

BCMA x CD3 Bispecific Antibodies: Summary

Therapy	Characteristics	N	Population	Safety	Response	DoR/PFS/OS, Mo
Teclistamab[1]	▪ RP2D: 1.5 mg/kg SC once weekly	165	▪ Median of 5 prior lines of tx ▪ 78% triple refractory ▪ 30% penta refractory	▪ CRS 72% (0.6% G3/4) ▪ Neurotox 14% (0.6% G3/4) ▪ ICANS 3% ▪ Infections 76%	ORR: 63% sCR/CR: 39% ≥VGPR: 59%	mDoR: 18.4 mPFS: 11.3 mOS: 18.3
Elranatamab[2,3]	▪ 215-1000 µg/kg SQ weekly or every 2 wk ▪ RP2D: 1000 µg/kg	55	▪ Median of 6 prior lines of tx ▪ 91% triple refractory ▪ 24% prior BCMA-based tx	▪ CRS 87%, no G3-4 (67% with priming and premeds) ▪ ICANS 20% ▪ ISR 56%	ORR: 64% sCR/CR: 35% ≥VGPR: 58.2%	No mature data at 10.6 mo follow-up
Linvoseltamab (REGN5458)[4,5]	▪ IV weekly, then every other wk after Wk 16 ▪ 3-800 mg dose escalation	73	▪ Median of 5 prior lines of tx ▪ 89% triple refractory ▪ 38% penta refractory	▪ CRS 38%, no G3/4 ▪ ICANS 4%	ORR (all doses): 51% ORR (200-800 mg): 75% ≥VGPR (200-800 mg): 58%	mDoR: NR at median 3 mo follow-up
ABBV-383 (TNB-383B)[6]	▪ IV fixed doses, once every 3 wk with no step dosing ▪ 0.025-120 mg dose escalation	124	▪ Median of 5 prior lines of tx ▪ 82% triple refractory ▪ 35% penta refractory	▪ CRS 57%, G3/4: 2% ▪ ICANS 2% ▪ Infections 41%	ORR (all doses): 57% ORR (60 mg exp): 59% ≥VGPR (60 mg exp): 39%	mDoR: NR mPFS: 10.4
Pavurutamab (AMG 701)[7]	▪ IV weekly ▪ 0.005-18 mg dose escalation	85	▪ Median of 6 prior lines of tx ▪ 62% triple refractory	▪ CRS 65% (9% G3) ▪ No ICANS reported ▪ 17% infection SAE	ORR (all doses): 26% ORR (3-18 mg): 36% ORR (most recent cohort): 83%	No mature data at 6.5 mo follow-up

1. Moreau. NEJM. 2022;387:495. 2. Jakubowiak. ASCO 2022. Abstr 8014. 3. Dalovisio. EHA 2022. Abstr P897. 4. Zonder. ASH 2021. Abstr 160. 5. Zonder. IMS 2022. Abstr OAB-056. 6. D'Souza. JCO. 2022;[Epub]. 7. Harrison. ASH 2020. Abstr 181.

Toxicity ?

Table 3. Literature summary of infection data from BsAb clinical trials in MM patients.

Drug	Target	Study	Phase	Safety cohort *N*	No. of patients receiving RP2D *n*	Duration of treatment (range)	Infection AEs *n* (%)	Treatment-related infection AEs *n* (%)	Serious infection TEAEs *n* (%)	Infection AEs leading to discontinuation *n* (%)	Infection AEs resulting in death *n* (%)	Neutropenia *n* (%)	Lymphopenia *n* (%)	Leukopenia *n* (%)
Teclistamab		MajesTEC-1 [24]	I/II	165[a]	165	8.5 months (0.2–24.4)	Any grade: (76.4)	Any grade: -	-	2 (1.21)[b†]	16 (8.48%)[c]	Any grade: 117[d] (70.9)	Any grade: 57 (34.5%)	Any grade: 29 (17.6)
							Grade 3/4: (44.8)	Grade 3/4: -			Considered related: 4 (2.4)	Grade 3/4: 106 (64.2)	Grade 3/4: 54 (32.7)	Grade 3/4: 12 (7.3)
	BCMA x CD3	MajesTEC-2 [40] (+daratumumab +lenalidomide)	Ib	32[e]	19	-	Any grade: 29 (90.6)	-	-	2 (6.3)[f]	2 (6.3)[g]	Any grade: 27 (84.4)	Any grade: 4 (12.5)	-
							Grade 3/4: 12 (37.5)					Grade 3/4: 25 (78.1)	Grade 3/4: 4 (12.5)	
Elranatamab	BCMA x CD3	MagnetisMM-1 [46–48]	I	55[h]	-	-	-	-	-	-	1	Any grade: 41 (74.5)[h]	Any grade: 29 (52.7)[h]	Any grade: 19 (34.5)[i]
							Grade 3/4: 15 (27.3)					Grade 3/4: 39 (71.0)[h]	Grade 3/4: 28 (51.0)[h]	Grade 3/4: 13 (23.7)[i]
		MagnetisMM-3 [32]	II	123[j]	123	5.6 months (0.03–19.8)	Any grade: (66.7)	-	-	8 (6.5)	2 (1.6)	Any grade: 59 (48.0)	Any grade: 32 (26.0)	-
							Grade 3/4: (35.0)					Grade 3/4: 59 (48.0)	Grade 3/4: 30 (24.4%)	

Monitoring, prophylaxis, and treatment of infections in patients with MM receiving bispecific antibody therapy: consensus recommendations from an expert panel

Noopur Raje, Kenneth Anderson, Hermann Einsele, Yvonne Efebera, Francesca Gay, Sarah P. Hammond, Alexander M. Lesokhin, Sagar Lonial, Heinz Ludwig, Philippe Moreau, Krina Patel, Karthik Ramasamy & Maria-Victoria Mateos

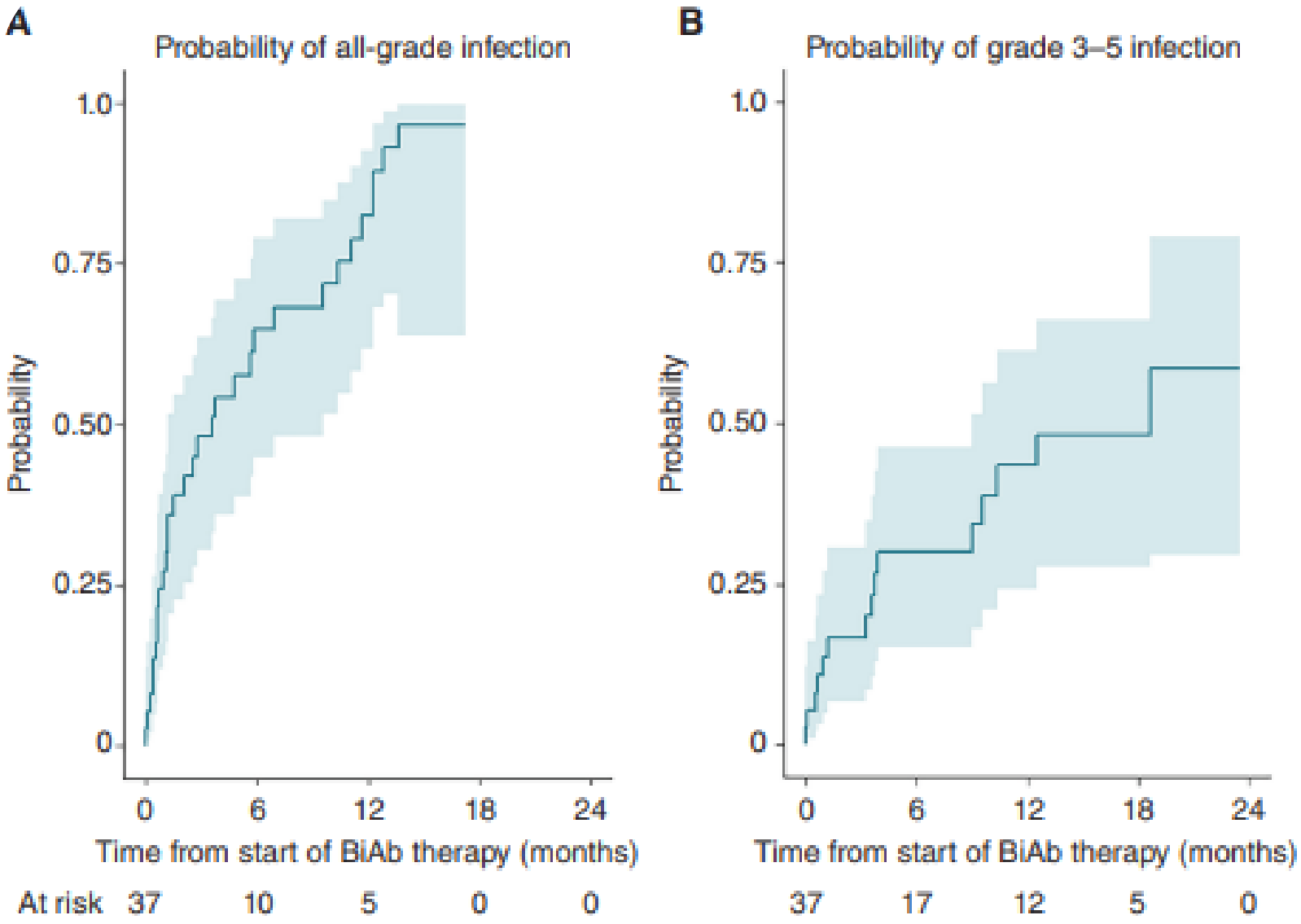
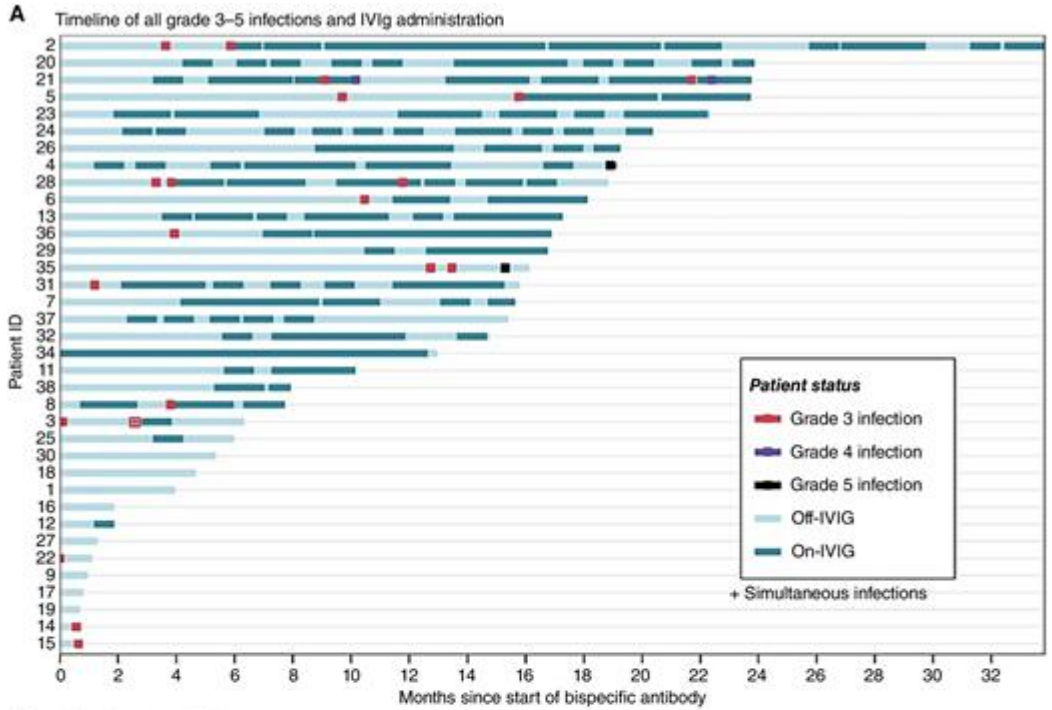


Figure 2. Time-to-event cumulative probability of developing any-grade infection (**A**) and grade 3–5 infection (**B**) from the start of bispecific antibody therapy, as calculated by the Kaplan–Meier method with shaded 95% confidence intervals.

RESEARCH ARTICLES | NOVEMBER 01 2023

IVIg Use Associated with Ten-Fold Reduction of Serious Infections in Multiple Myeloma Patients Treated with Anti BCMA Bispecific Antibodies FREE

Guido Lancman ; Kian Parsa ; Krzysztof Kotlarz ; Lisa Avery ; Alaina Lurie ; Alex Lieberman-Cribbin ; Hearn Jay Cho ; Samir S. Parekh ; Shambavi Richard ; Joshua Richter ; Cesar Rodriguez ; Adriana Rossi ; Larysa J. Sanchez ; Santiago Thibaud ; Sundar Jagannath ; Ajai Chari



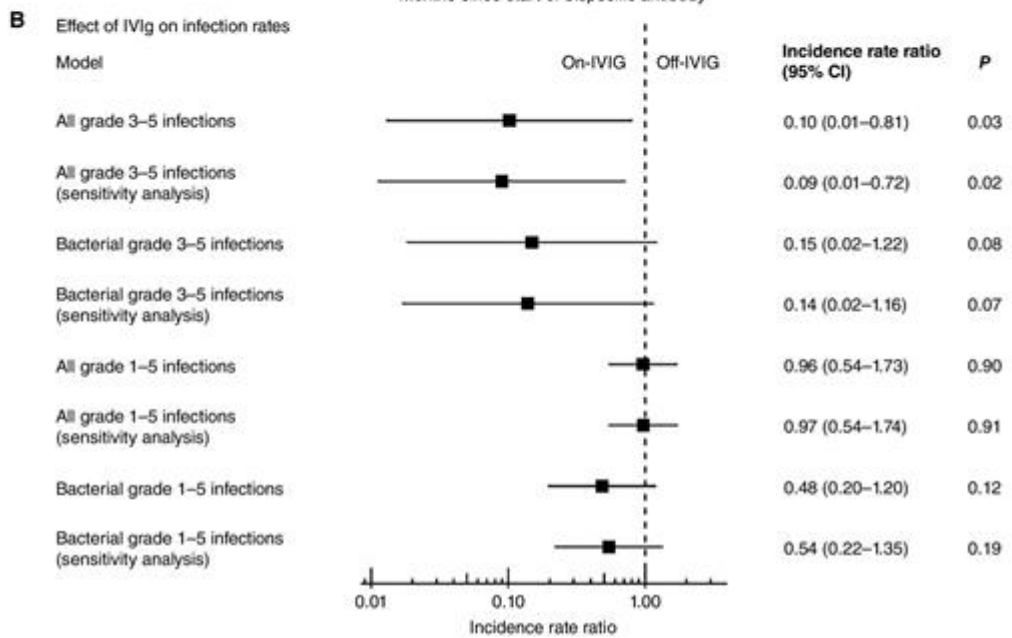


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Table 3. Recommendations for prevention and management of infections for patients on BiAbs.

	Infection prevention before BCMA bispecific	Infection prevention during BCMA bispecific	Treatment of infection during BCMA bispecific[a]
Bacterial	Vaccinate if appropriate	IVIg q4 weeks	Based on sensitivities
Viral			
Zoster	Vaccinate if appropriate	VZV prophylaxis	Anti VZV therapeutic dosing
Influenza	Vaccinate if due	Hygiene	Antiviral
Hepatitis	Vaccinate if appropriate	Prophylaxis if evidence of Hep B exposure	Per ID input
CMV	N/A	Monitor CMV PCR q monthly	Treat if rising significantly or symptomatic
RSV	N/A	Hygiene	Consider inhaled ribavirin
COVID-19	Vaccinate/Boost	? Preventative monoclonal antibodies based on viral patterns Hygiene Consider monitoring Ab response and continue boosting	Oral or parenteral agents
Fungal	N/A	N/A	As indicated
PCP	N/A	PCP prophylaxis	Per ID Input

Abbreviations: ID, infectious disease; N/A, not applicable; RSV, respiratory syncytial virus; VZV, varicella zoster virus.

[a]Educate patients/caregivers about monitoring for signs and symptoms of infection. In setting of active infection, hold BCMA bispecific until recovery. Consider cytokine release syndrome, hemophagocytic lymphohistiocytosis, Epstein–Barr virus, *Clostridium difficile*, and unusual organisms in differential diagnosis; collaborate closely with ID team.

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ORIGINAL ARTICLE

Talquetamab, a T-Cell–Redirecting GPRC5D Bispecific Antibody for Multiple Myeloma

Ajai Chari, M.D., Monique C. Minnema, M.D., Jesus G. Berdeja, M.D., Albert Oriol, M.D., Ph.D., Niels W.C.J. van de Donk, M.D., Ph.D., Paula Rodríguez-Otero, M.D., Ph.D., Elham Askari, M.D., María-Victoria Mateos, M.D., Ph.D., Luciano J. Costa, M.D., Ph.D., Jo Caers, M.D., Ph.D., Raluca Verona, Ph.D., Suzette Girgis, Ph.D., Shiyi Yang, Ph.D., Rachel B. Goldsmith, Ph.D., Xiang Yao, Ph.D., Kodandaram Pillarisetti, M.Sc., Brandi W. Hilder, Ph.D., Jeffery Russell, M.D., Ph.D., Jenna D. Goldberg, M.D., and Amrita Krishnan, M.D.

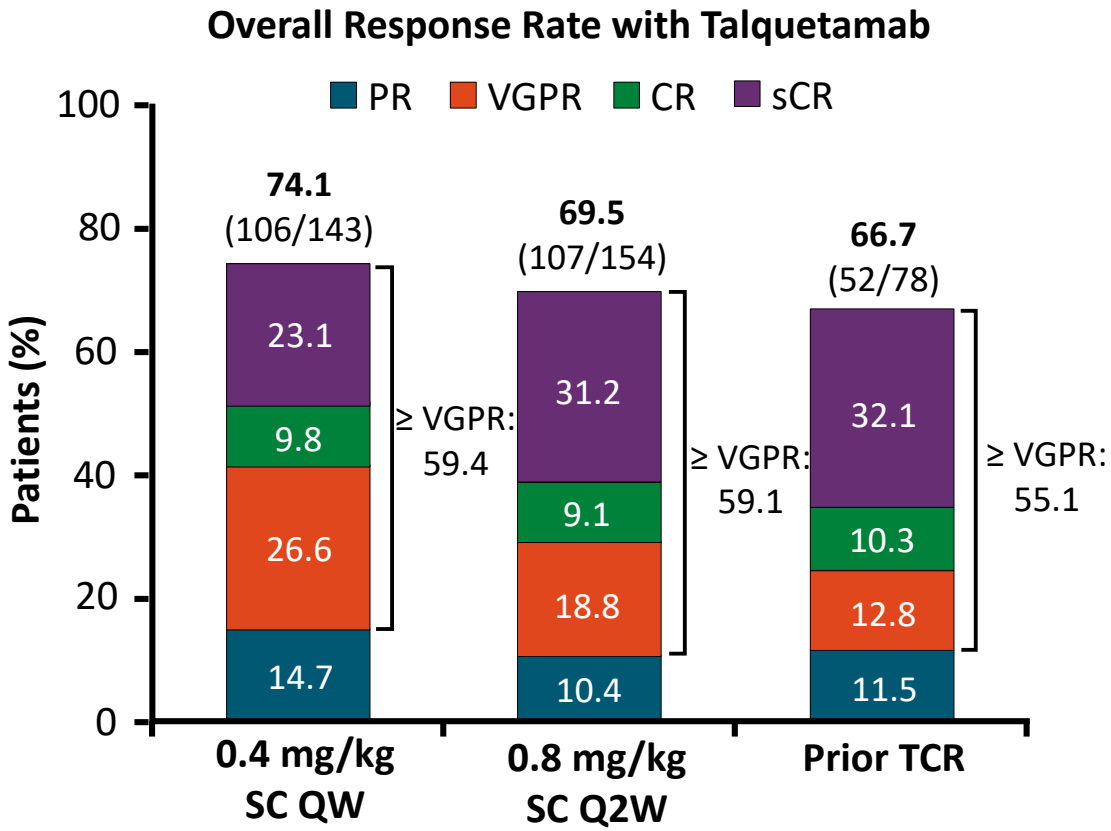
Long-Term Efficacy and Safety Results From the Phase 1/2 MonumenTAL-1 Study of Talquetamab, a GPRC5D×CD3 Bispecific Antibody, in Patients With Relapsed/Refractory Multiple Myeloma

Leo Rasche[1], Carolina Schinke[2], Cyrille Touzeau[3], Monique C Minnema[4], Niels WCJ van de Donk[5], Paula Rodríguez-Otero[6], María-Victoria Mateos[7], Jing Christine Ye[8], Deeksha Vishwamitra[9], Indrajeet Singh[9], Xiang Qin[9], Michela Campagna[10], Tara Masterson[9], Brandi W Hilder[9], Jaszianne Tolbert[9], Thomas Renaud[11], Christoph Heuck[9], Colleen Kane[9], Ajai Chari[12]

[1]University Hospital of Würzburg, Würzburg, Germany; [2]Myeloma Center, University of Arkansas for Medical Sciences, Little Rock, AR, USA; [3]Centre Hospitalier Universitaire de Nantes, Nantes, France; [4]University Medical Center Utrecht, Utrecht, Netherlands; [5]Amsterdam University Medical Center, Vrije Universiteit Amsterdam, Amsterdam, Netherlands; [6]Clínica Universidad de Navarra, CIMA, CIBERONC, IDISNA, Pamplona, Spain; [7]University Hospital of Salamanca/IBSAL/CIC/CIBERONC, Salamanca, Spain; [8]MD Anderson Cancer Center, University of Texas, Houston, TX, USA; [9]Janssen Research & Development, Spring House, PA, USA; [10]Janssen Research & Development, Madrid, Spain; [11]Janssen Research & Development, Raritan, NJ, USA; [12]Mount Sinai School of Medicine, New York, NY, USA, at the time that the work was performed.

Phase II MonumenTAL-1: Talquetamab in R/R MM

- Patients with R/R MM after ≥3 lines of therapy, including an IMiD, PI, anti-CD38 mAb
  - 69%-84% triple-class refractory
  - Median 5-6 prior lines of therapy across all cohorts
  - 27.1% with high-risk cytogenetics; 24.3% with EMD
- **Talquetamab**: 0.4 mg/kg SC QW or 0.8 mg/kg SC Q2W with 2-3 step-up doses and/or premedication to reduce CRS
- **Primary endpoint:** DLTs
- **Key secondary endpoint:** ORR

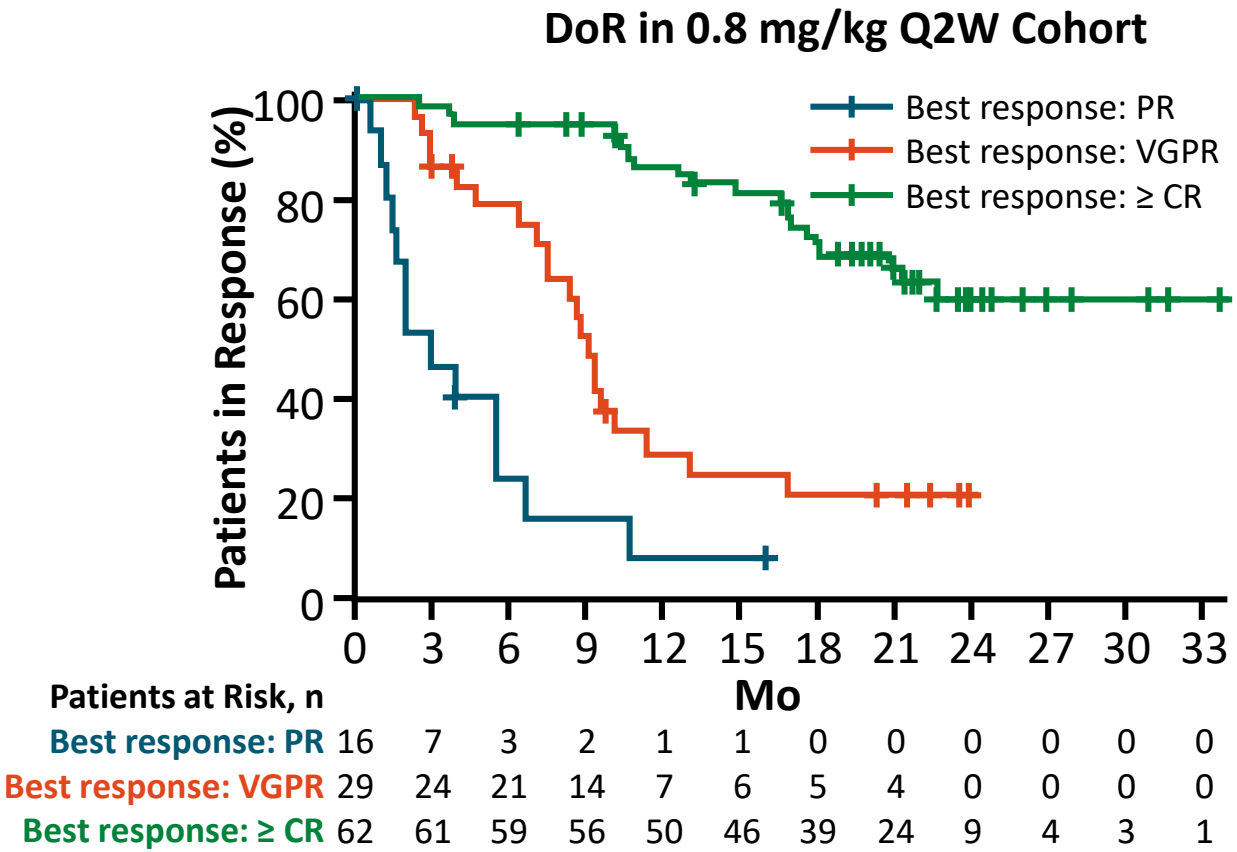


The phase III MonumenTAL-3 (NCT05455320) and MonumenTAL-6 (NCT05455320) trials are actively recruiting.

Chari. NEJM. 2022;387:2232. Schinke. ASCO 2023. Abstr 8036. Rasche. EHA 2024. Abstr P915.

Slide credit: clinicaloptions.com

MonumenTAL-1: DoR and PFS Outcomes

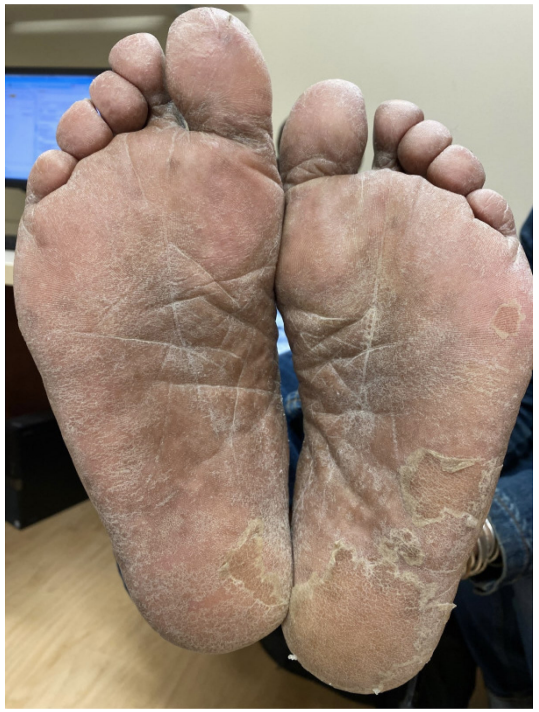


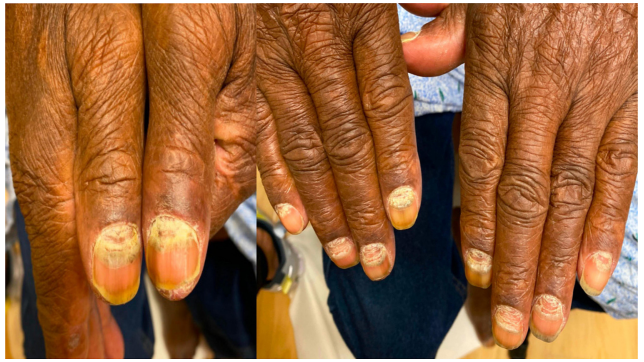
Outcome	0.4 mg/kg QW (n = 143)	0.8 mg/kg Q2W (n = 154)	Prior T-Cell Redirection Tx (n = 78)
Median f/u	29.8	23.4	20.5
Median DoR, mo (95% CI)	9.5 (6.7-13.4)	17.5 (12.5-NE)	N/A
Median PFS, mo (95% CI)	7.5 (5.7-9.4)	11.2 (8.4-14.6)	7.7 (4.1-14.5)
24-Mo OS, %	60.6	67.1	57.3

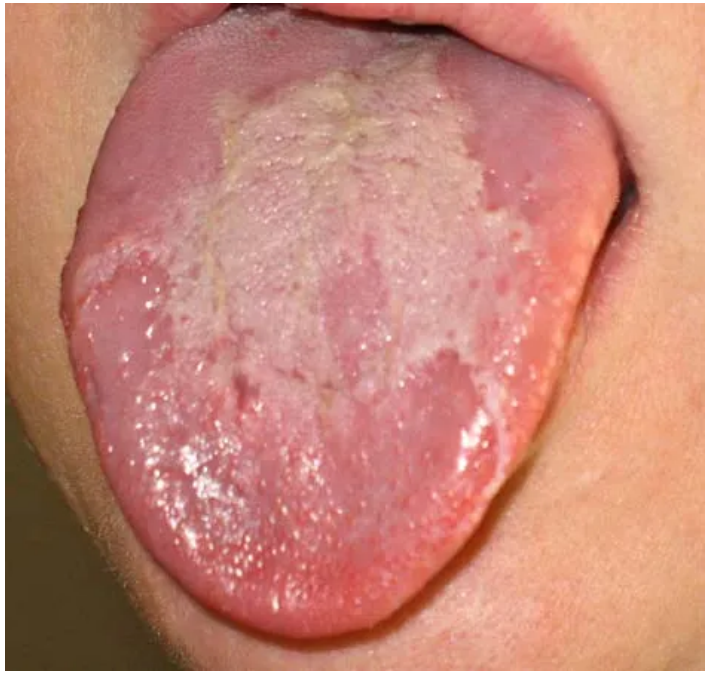
Rasche. EHA 2024. Abstr P915.

Slide credit: clinicaloptions.com

Toxicity ?



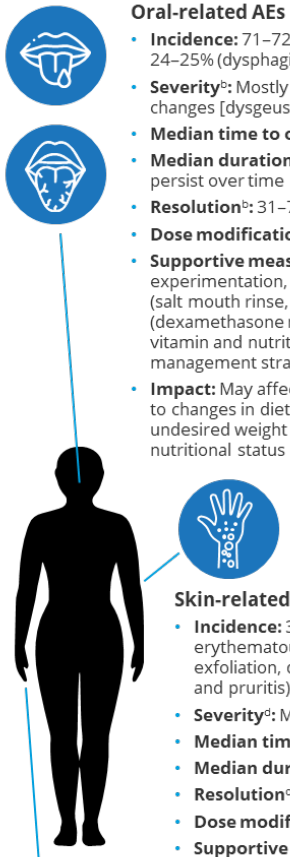




Onychomadesis and palmoplantar keratoderma associated with talquetamab therapy for relapsed and refractory multiple myeloma

Neha Narayan BA , Benjamin Williams MD , Brea Lipe MD , Anna De Benedetto MD

Dermatologists, dentists, and nutritionists can be consulted to provide additional guidance on managing AEs and confirming that AEs are treatment associated



Oral-related AEs

- **Incidence:** 71–72% (taste changes [dysgeusia[a]]); 27–40% (dry mouth); 24–25% (dysphagia)
- **Severity[b]:** Mostly grade 1 or 2 (maximum CTCAE grade 2 for taste changes [dysgeusia])
- **Median time to onset[b,c]:** 15–29 days for most patients
- **Median duration[b]:** 57–109 days for most patients; oral toxicity may persist over time
- **Resolution[b]:** 31–73% of events resolve
- **Dose modification/discontinuation[b]:** <9% (mostly taste changes)/<2%
- **Supportive measures/management:** Food texture and flavor experimentation, increased hydration, salivary substitutes (salt mouth rinse, artificial saliva spray), local corticosteroids (dexamethasone mouth wash for dry mouth), anti-infection agents, and vitamin and nutritional support; dose modification may be an effective management strategy
- **Impact:** May affect ability to experience food taste and texture, leading to changes in diet or food interest; patients should be monitored for undesired weight loss, which may affect concurrent medications and nutritional status

Skin-related AEs

- **Incidence:** 30–73%; rash related (rash, maculopapular rash, erythematous rash, and erythema) and non–rash related (skin exfoliation, dry skin, palmar-plantar erythrodysesthesia syndrome, and pruritis)
- **Severity[d]:** Mostly grade 1 or 2
- **Median time to onset[c,d]:** 20–30 days for most patients
- **Median duration[d]:** 26–39 days for most patients
- **Resolution[d]:** 57–88% of events resolve
- **Dose modification/discontinuation[d]:** <9%/<2%
- **Supportive measures/management:** Heavy moisturizers and hydration, while topical corticosteroids can be used to control inflammation, irritation and redness; oral corticosteroids may be considered for severe events
- **Impact:** Mostly benign, not painful, and self-limiting

Nail-related AEs

- **Incidence:** 54–55%; onycholysis, onychomadesis, onychoclasis, discoloration, disorder, dystrophy, toxicity, and ridging
- **Severity:** Mostly grade 1 or 2
- **Median time to onset[c]:** 68–69 days for most patients
- **Median duration:** 74–89 days for most patients
- **Resolution:** 26–33% of events resolve
- **Dose modification/discontinuation:** <1%/0%
- **Supportive measures/management:** Education to avoid irritants, use of comfortable shoes, good hygiene, soft shoes/socks, and treatment with moisturizers and/or topical corticosteroids
- **Impact:** Relatively benign, although some patients reported concerns with changes in nail appearance and nail loss

[a]Includes ageusia, dysgeusia, hypogeusia, and taste disorder. [b]Data reported for taste changes (dysgeusia), dysphagia, and dry mouth. [c]Relative to first treatment dose. [d]Data reported for rash-related and nonrash–related AEs. CTCAE, Common Terminology Criteria for Adverse Events.

MonumenTAL-1 Phase 1/2: Management of Skin-related Events at a Single Center[6]

AE	Management
Dry Skin	Heavy moisturizers
Hand and/or Foot Peeling	Ammonium lactate 12% lotion to soles and palms BID.
Pruritis	Loratadine 10 mg PO daily for 3–5 days post-TALVEY dose. Triamcinolone 0.1% cream BID.
Body rash/drug rash	Loratadine 10 mg PO daily for 3–5 days post-TALVEY dose. Triamcinolone 0.1% cream BID. Methylprednisolone taper. Betamethasone 0.05% cream BID.

Abbreviations: AE, adverse event; BID, twice daily; PO, oral.

Practical Management of Patients With Relapsed/Refractory Multiple Myeloma Receiving Talquetamab, a GPRC5D×CD3 Bispecific Antibody: Experience in MonumenTAL-1

Donna Catamero[1], Kiah Purcell[1],
Chloe Ray[1], Leora Giacoia[1], Sheryl Leahey[2], Patricia Born[3], Sandy Kruyswijk[4]

How to choose – Simple- Best is whichever has the best access for the patient

	Antibody–Drug Conjugate	Bispecific Antibody	CAR T-Cell
Approved product	Belantamab mafodotin (August 2020)	Teclistamab, Talquetamab, Elrantamab	Ide-cel (March 2021) Cilta-cel (February 2022)
Efficacy	++ (as single agent; higher in combinations)	+++	++++
How given	IV, every 3 wk, until progression	IV or SC, weekly or Q2W until PD	One time dosing
Where given	Community	Community /Academic medical centers	Academic medical centers
Notable adverse events	Ocular (corneal)	CRS and neurotoxicity, Infections, Skin/taste	CRS and neurotoxicity
CRS	Not seen	++	+++
Neurotoxicity	Not seen	+	++
Availability	Off-the-shelf; after ophthalmology evaluation	Off-the-shelf	Wait time for manufacturing

Questions