

IN PURSUIT OF *YOUR CURE*.®

Integrating Bispecific Antibodies in My Clinical Practice

Immunotherapy in Multiple Myeloma

C. Ola Landgren, M.D., Ph.D.

Professor of Medicine

Chief, Division of Myeloma, Department of Medicine

Director, Sylvester Myeloma Institute

Co-Leader, Translational and Clinical Oncology Program

Paul J. DiMare Endowed Chair in Immunotherapy

Sylvester Comprehensive Cancer Center

University of Miami

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**MYELOMA
INSTITUTE**



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Disclosures

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- Honoraria/ad boards: AbbVie, Adaptive, Amgen, Binding Site, BMS, Celgene, GSK, Janssen, Pfizer, Sanofi
- Chairman for “Medscape Myeloma”: 2014-2025
- Chairman for “Myeloma Rounds in the US” (CME): 2023-ongoing
- Independent Data Monitoring Committee (IDMC): Merck, Janssen, Novartis, Arcellx

Outline

- Case: 57-year-old patient with multiple myeloma
- Updated clinical trials and real-world evidence focusing on elranatamab
- Treatment sequencing in multiple myeloma: bispecifics, ADC, and CAR T

Case: Newly Diagnosed Multiple Myeloma

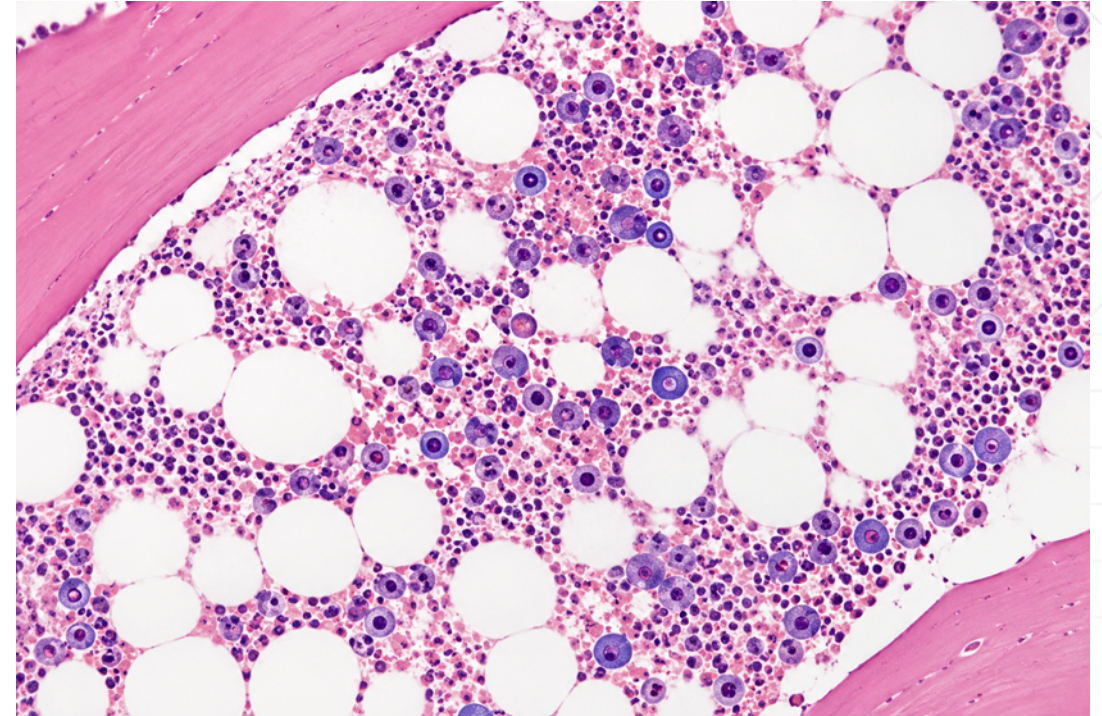
- 57-year-old male. Diagnosed with multiple myeloma in Feb 2010. Back pain and fatigue. Hgb 9.8 g/dL. No M spike, kappa sFLC 51 mg/dL, lambda sFLC 0.25 mg/dL, all other labs WNL, PET/CT showing lytic lesions in L2 and L3 and SUVs 4.2 and 5.1. Bone marrow biopsy: 60-70% kappa restricted plasma cells, FISH found t(11;14) and 13q-

- **Initial therapy:** Bortezomib/lenalidomide/dexamethasone x 4 cycles followed by autologous stem cell transplant, obtained VGPR as best response. Started on lenalidomide maintenance (10 mg)



Case: Now Relapsed/Refractory Multiple Myeloma (2nd Line)

- Rising sFLC kappa in Jan 2017; sFLC kappa 25 mg/dL, all other labs WNL. Bone marrow biopsy show 25% kappa restricted plasma cells, FISH negative. PET/CT: no new lesions
- **Second line:** Started on pomalidomide/daratumumab/dexamethasone. Best response: VGPR



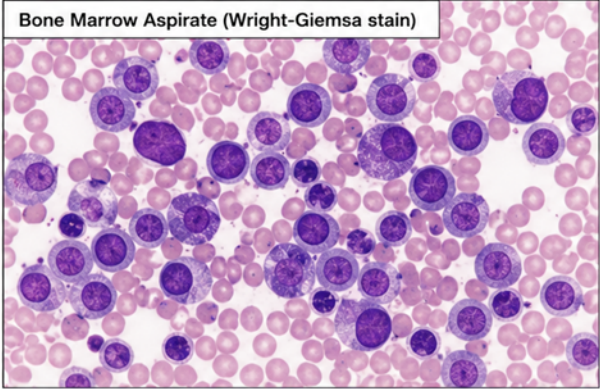
Case: Now Relapsed/Refractory Multiple Myeloma (3rd Line)

- In Feb 2020, rising sFLC kappa levels; eventually, 30 mg/dL, all other labs WNL. Bone marrow biopsy show 40% kappa restricted plasma cells, FISH found t(11;14) and PET/CT no new lesions

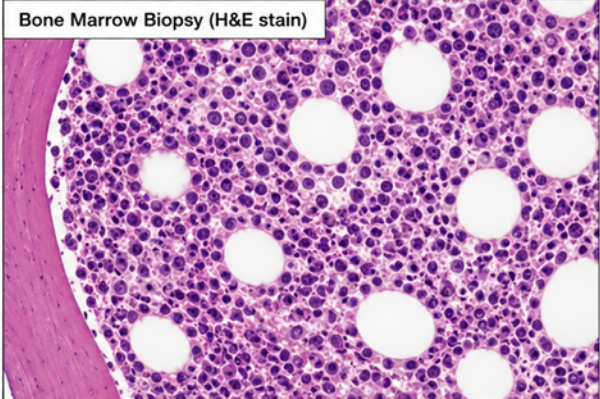
Third line: Started bortezomib/venetoclax/dexamethasone x 6 cycles, then single drug venetoclax 400 mg daily. Best response: (u)CR

Plasma cells: ~40% infiltration

Bone Marrow Aspirate (Wright-Giemsa stain)

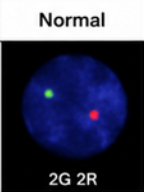
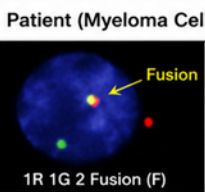
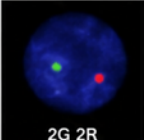
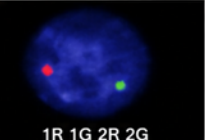
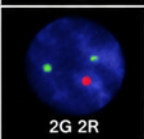
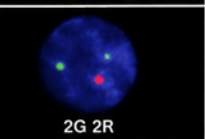
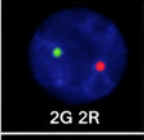
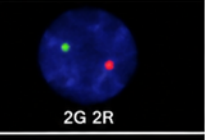
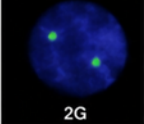
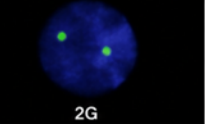


Bone Marrow Biopsy (H&E stain)



Plasma cell infiltration: ~40%

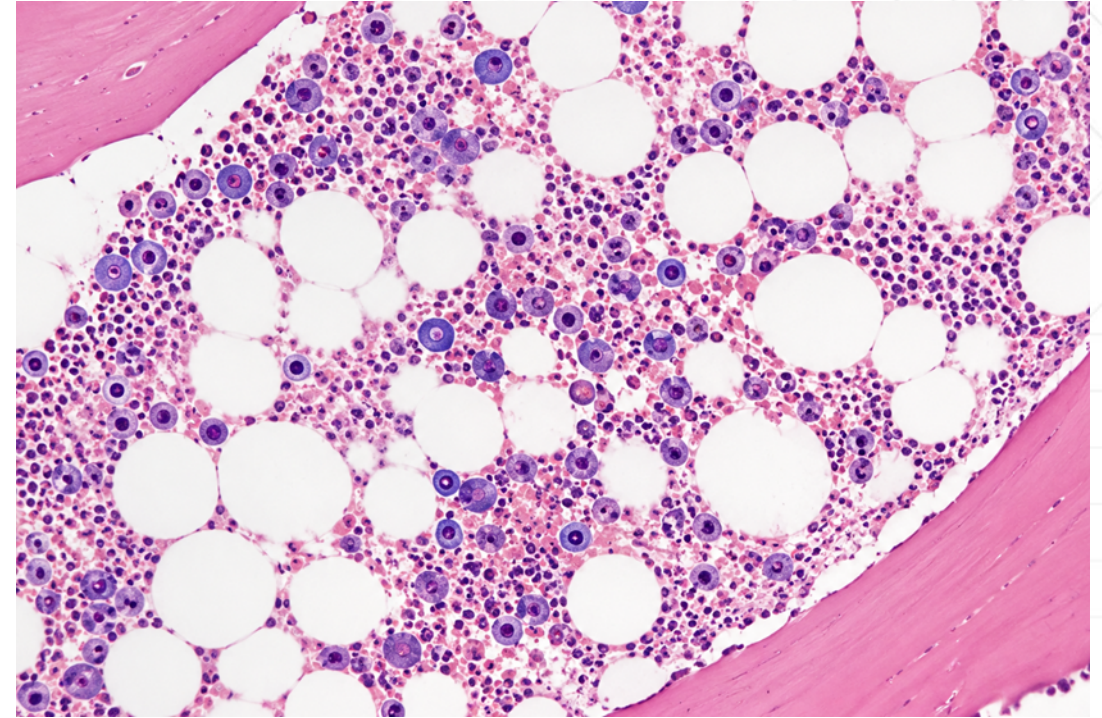
FISH: t(11;14)(q13;q32) POSITIVE

FISH Analysis (Plasma Cells)			
Probe	Normal	Patient (Myeloma Cells)	
CCND1/IGH t(11;14)			POSITIVE t(11;14)(q13;q32) (CCND1-IGH fusion)
FGFR3/IGH t(4;14)			NEGATIVE
IGH/MAF t(14;16)			NEGATIVE
IGH/MAFB t(14;20)			NEGATIVE
CEP 11 (Control)			NORMAL

Interpretation: t(11;14)(q13;q32) POSITIVE
(CCND1-IGH fusion detected in plasma cells)

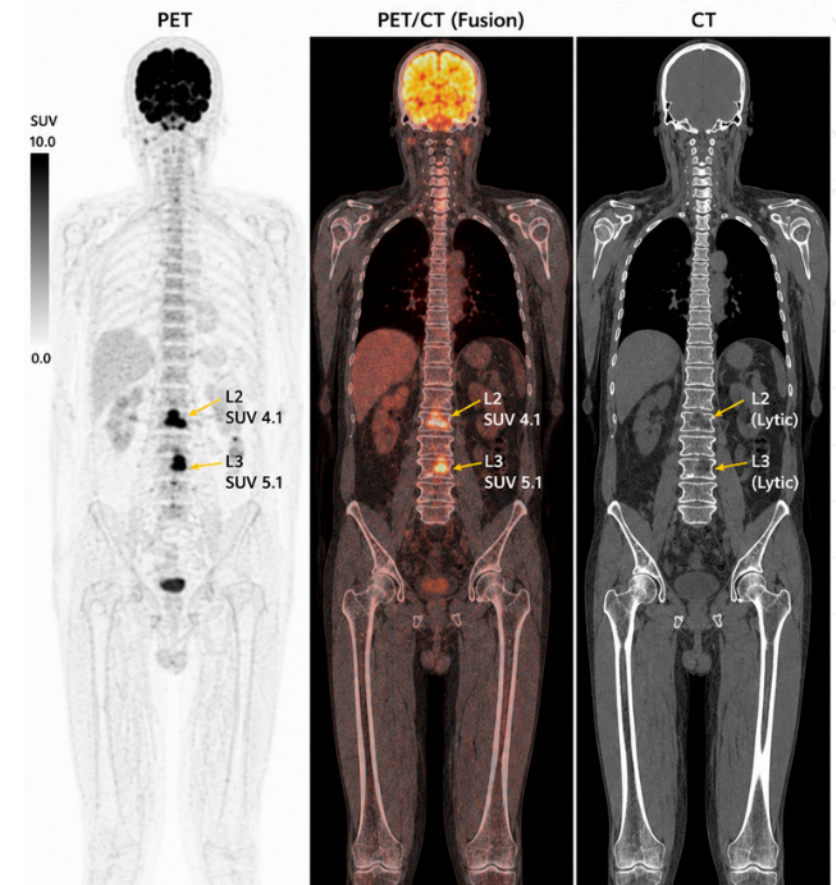
Case: Now Relapsed/Refractory Multiple Myeloma (4th Line)

- In Jan 2024, slowly rising sFLC kappa levels; when 20 mg/dL, a new bone marrow biopsy show 20-25% kappa restricted plasma cells, FISH negative. All other labs WNL
- **Forth line:** Switched to carfilzomib/cyclophosphamide/dexamethasone x 6 cycles, then carfilzomib/dexamethasone every 14 days



Case: Now Relapsed/Refractory Multiple Myeloma (5th Line)

- Patient is 73-year-old in Aug 2025 when sFLC kappa levels are rising again. At this time, sFLC kappa levels are 30 mg/dL, all other labs WNL. Bone marrow biopsy show 35% kappa restricted plasma cells, FISH t(11;14) and 13q-. PET/CT show uptake in initial L2 (SUV 4.1) and L3 (5.1) lesions
- **What to do next? What treatment may be reasonable?**
- **Fifth line:** Started on elranatamab 76 mg, weekly dosing x 4 cycles. Then planned restaging, depending on labs



Case: Now Relapsed/Refractory Multiple Myeloma (5th Line)

- After elranatamab 76 mg weekly dosing x 4 cycles, peripheral labs show: sFLC kappa and lambda <LLN, no M spike, normal CBC, normal chem panel
- Therefore, move forward with restaging as planned:
 - **PET/CT:** no increased SUV in L2 and L3 lesions, no new lesions
 - **Bone marrow biopsy and aspirate:** shows <5% plasma cells by IHC; flow cytometry negative for abnormal PCs. For the first time ever, the patient is MRD-negative 10⁻⁶ and is feeling great
- **What to do next? Adjust dosing schedule?**

Case: Now Relapsed/Refractory Multiple Myeloma (5th Line)

- Elranatamab dosing is switched to every other week elranatamab 76 mg x 6 cycles, then new assessment/decision on dosing schedule
- **What to do next? Adjust dosing schedule?**

Case: Now Relapsed/Refractory Multiple Myeloma (5th Line)

- **Treatment plan:** monthly dosing with elranatamab 76 mg
- **Monitoring plan:**
 - Myeloma labs every 3 months
 - Offer patient re-checking PET/CT and bone marrow biopsy (including MRD testing) in ~1 year

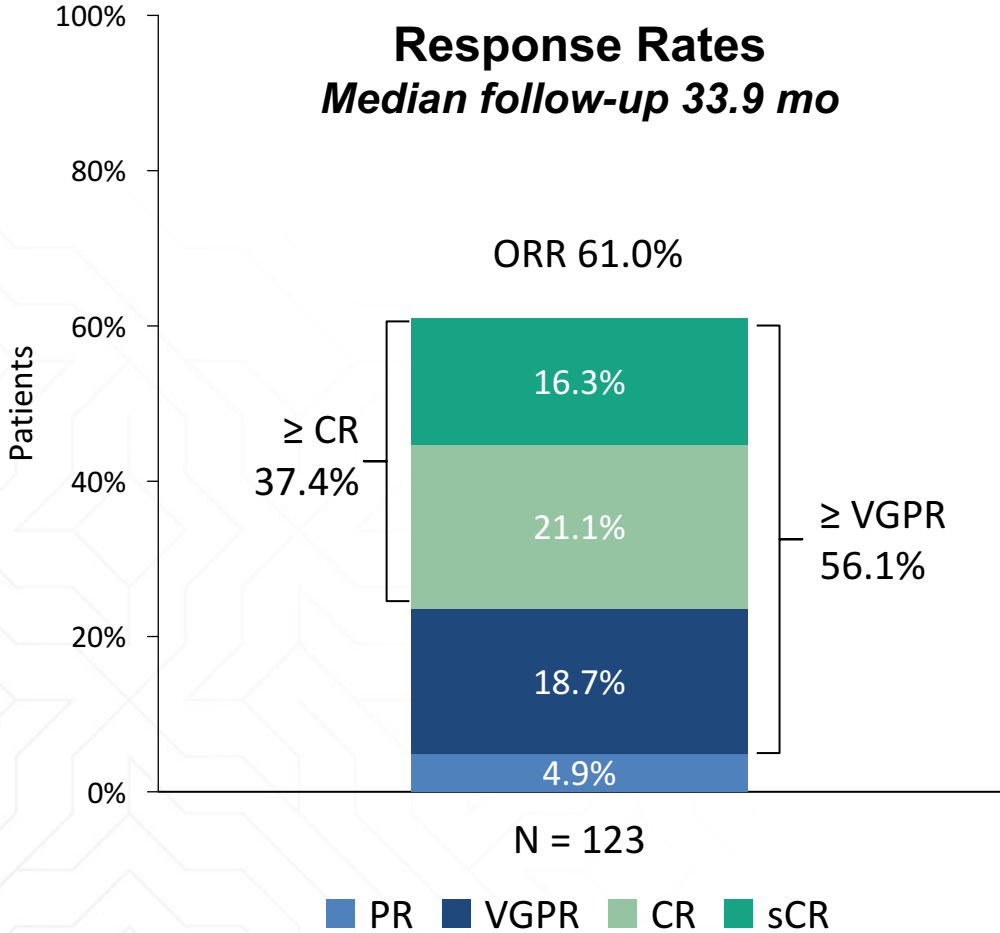
Medical differentiating factors for BCMAxCD3 MoAbs

- Efficacy
- Safety
- Response/resistance mechanisms
- Step-up-dosing schedule
- Long-term dosing schedule
- Route of administration
- Combinations
- Other factors

Outline

- Case 1: 57-year-old patient with multiple myeloma
- Updated clinical trials and real-world evidence focusing on elranatamab
- Treatment sequencing in multiple myeloma: bispecifics, ADC, and CAR T

MagnetisMM-3: Phase 2 study of elranatamab in RRMM



61%
ORR
Primary endpoint



37%
≥CR rate



Median DOR
not yet reached

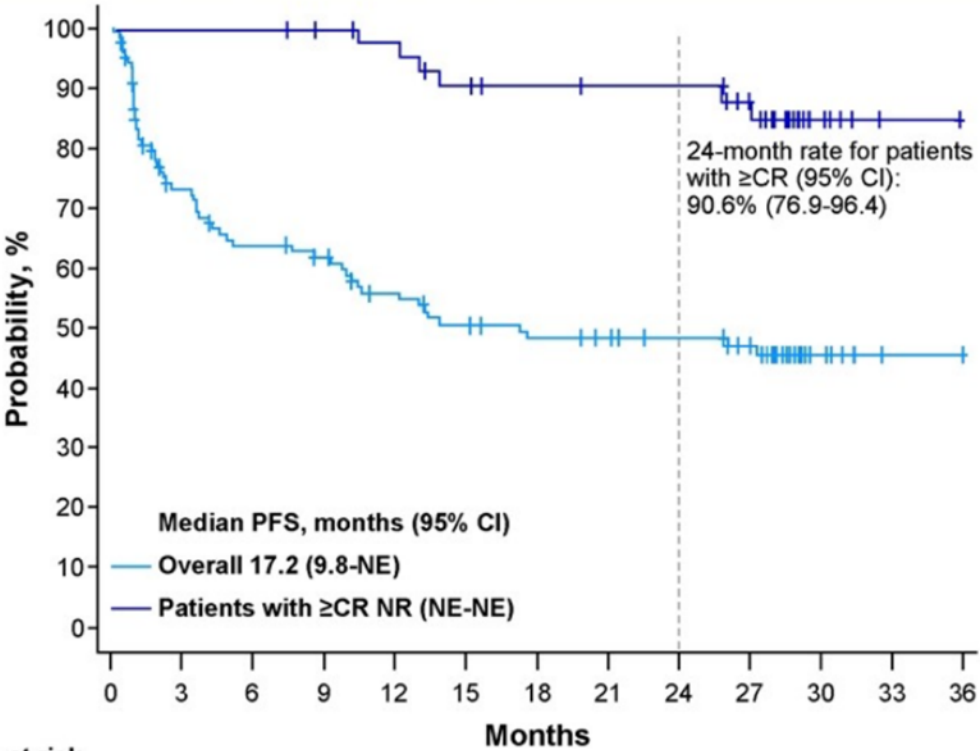
Safety

- Overall safe drug
- Most common AEs included infections, CRS, and cytopenias
- CRS (58%, mostly grade 1), median onset 2 days, median duration 2 days
- ICANS occurred in 3.4% of patients, all grade 1/2

Lesokhin AM et al. *Nat Med.* 2023;29:2259-2267; 2. Prince M et al. Poster presented at ASH 2024 (Abstract 4738). Nooka A et al. Poster presented at IMS 2025 (Abstract PA-046).

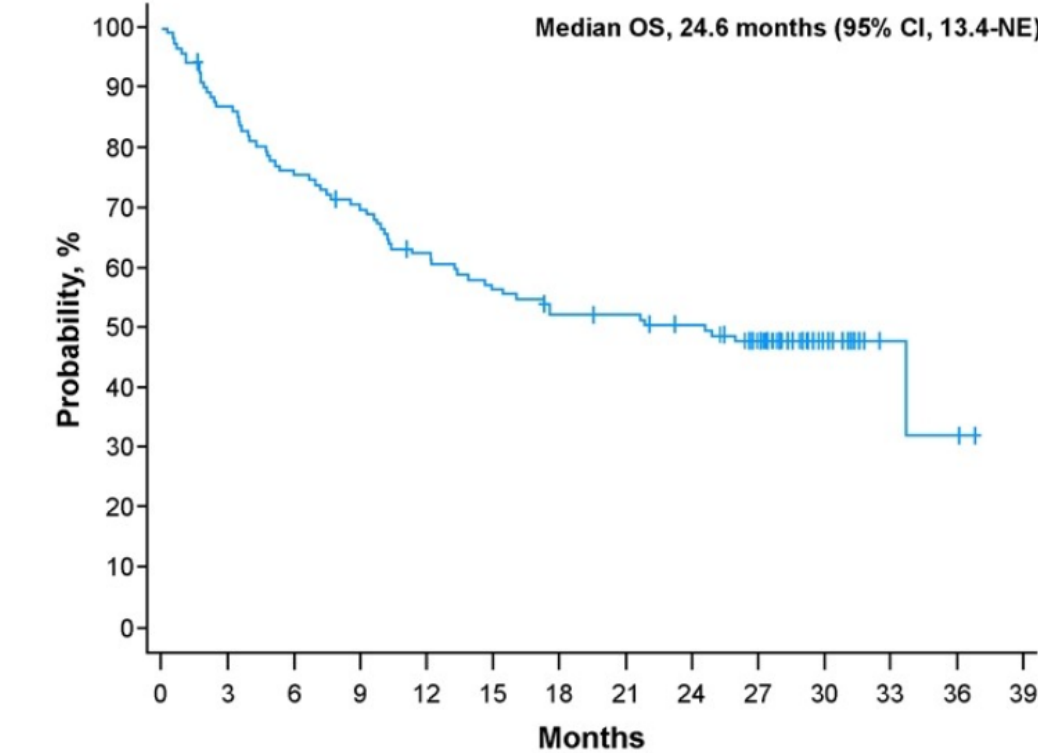
MagnetisMM-3: Long-Term Follow-up

PFS



No. at risk	0	3	6	9	12	15	18	21	24	27	30	33	36
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

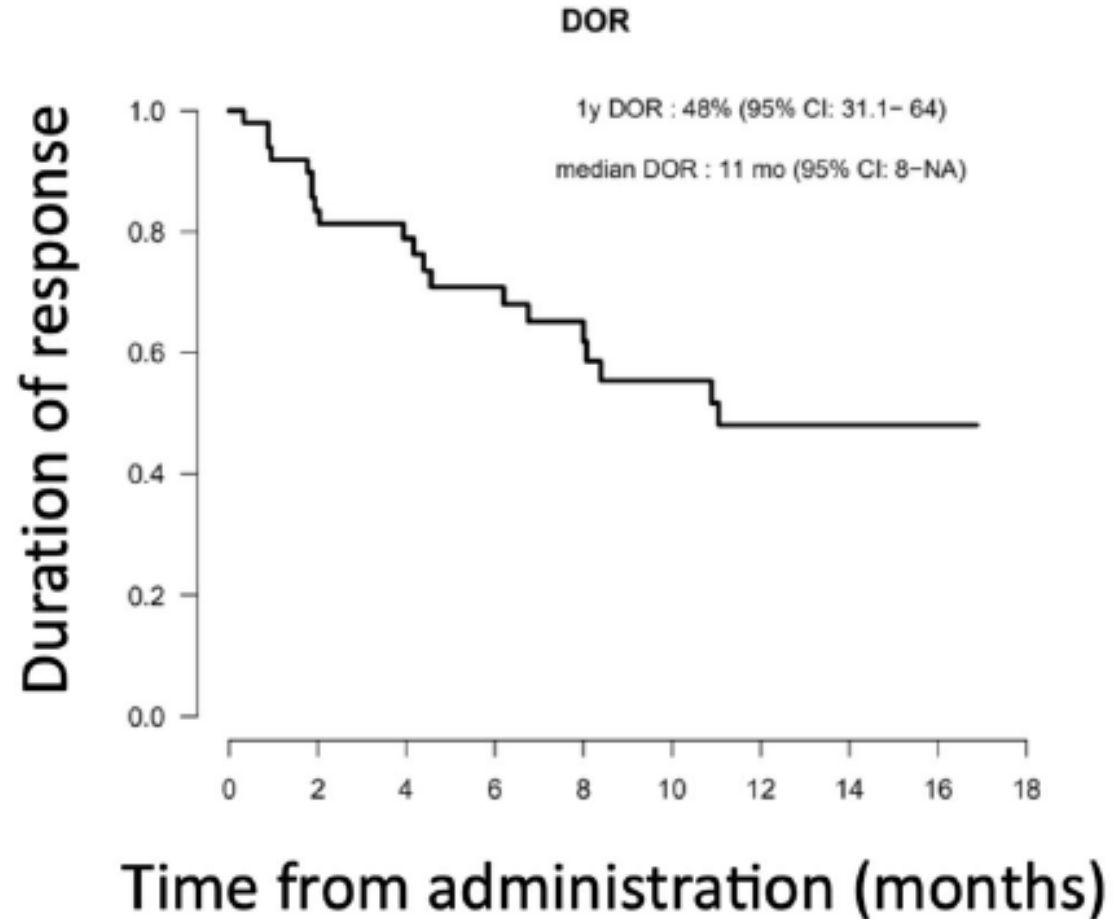
OS



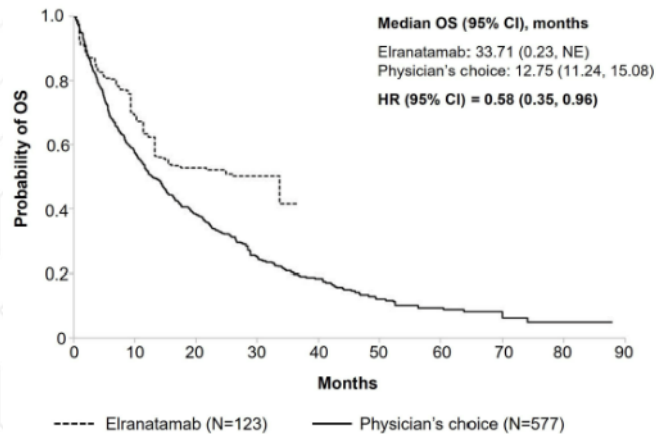
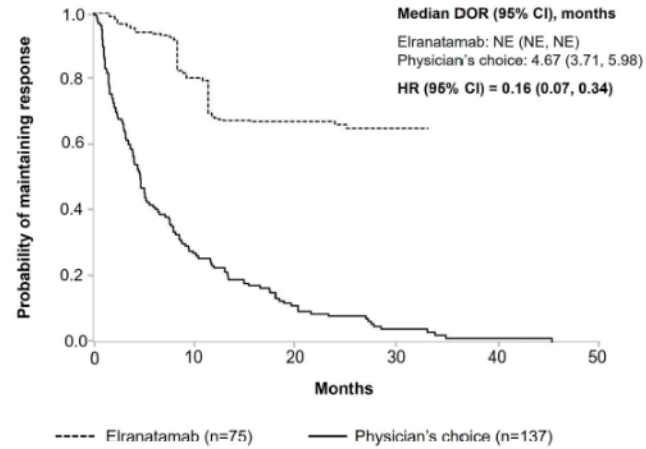
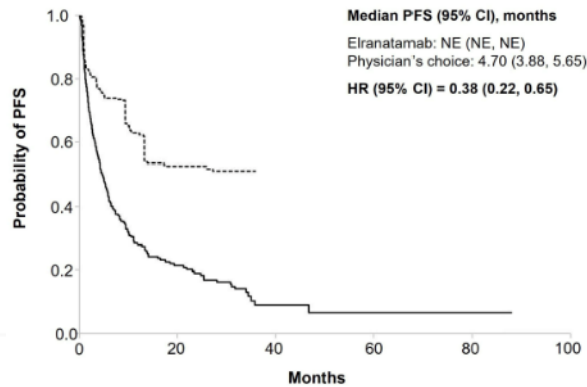
No. at risk	0	3	6	9	12	15	18	21	24	27	30	33	36	39
	123	106	92	84	74	67	61	60	56	47	13	3	2	0

Elranatamab real world evidence (RWE) data: Malard *et al.* 2024

- N = 101
- Median 5 (1-17) prior LOT
- 97% TCE, 53% TCR
- 17% prior BCMA-directed therapy
- **ORR=52%, \geq VGPR=42%.**
- 1-year PFS=34%, OS=42%
- 1-year DOR= 48%
- No New safety findings



Elranatamab real world evidence (RWE) data: Costa *et al.* 2025



- Retrospective study designed to indirectly compare the efficacy observed in the elranatamab arm of MagnetisMM-3 Cohort A (BCMA-naïve; N=123) with COTA, a US-based oncology electronic health record database, as an external control
- MagnetisMM-3 inclusion and exclusion criteria were applied to obtain comparable patient populations across sources
- Compared with physician's choice (i.e., real-world data serving as an external control), elranatamab significantly improved PFS (HR = 0.38, $p < 0.05$), OS (HR = 0.58, $p < 0.05$), and DOR (HR = 0.16, $p < 0.05$)

Elranatamab real world evidence (RWE) data: ASH 2025

Elranatamab for relapsed/refractory multiple myeloma – multi-centre real-world outcomes from the United Kingdom

- N= 195 (15 United Kingdom sites)
- Median 4 prior LOT
- 75% TCR - Penta-class refractory: 31%
- 15% prior BCMA-directed therapy
- ECOG 2=25%
- HR cytogenetics = 36%
- ISS III = 22% - Extramedullary: 19%

- **ORR=71%, CR ≥ 27, ≥VGPR=28%.**
- Median PFS 11.8 , Median OS 18.3
- DOR= NR
- No New safety findings

Real world efficacy and safety of elranatamab, a BCMA bispecific antibody for patients with relapsed and refractory multiple myeloma: An international myeloma working group immunotherapy database analysis

- N= 79 (7 countries: UK, USA, Canada, Greece, Spain, Czech Republic and Singapore)
- Median 5 (1-11) prior LOT
- 35% prior BCMA-directed therapy
- ECOG 1/2=55%, EMD=13%
- HR cytogenetics = 45%
- 48% would not have been eligible for the MM-3 trial

- ORR=54%, CR ≥ 9, VGPR=33%
- **ORR BCMA naïve=67% vs 32% BCMA exposed**
- 1-year PFS=52%, OS 1-year=58%
- Infections=42% all grades

MagnetisMM-3: less frequent dosing sub-analysis (IMS2025)

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3

Nooka A et al. (IMS Poster Presentation)

Background

- The ongoing Phase 2 MagnetisMM-3 (NCT04649359) study demonstrated the efficacy and safety of elranatamab monotherapy in patients with RRMM and no prior BCMA-directed therapy (Cohort A)¹
 - As of the September 10, 2024 data cutoff (median follow-up in Cohort A: 33.9 months), the ORR was 61.0%, median PFS was 17.2 months, and median OS was 24.6 months²

Objective

To report long-term efficacy and safety results of elranatamab ~38 months after the last patient's first dose in the subgroup of BCMA-naïve patients enrolled in the US

Methods

- Eligible patients had RRMM with disease refractory to ≥ 1 IMiD, ≥ 1 PI, and ≥ 1 anti-CD38 antibody
- Patients received elranatamab as step-up priming doses, followed by 76 mg QW for 6 cycles, then if achieving \geq PR for ≥ 2 months switched to Q2W for 6 cycles, then Q4W (after ≥ 6 cycles of Q2W)
- The primary endpoint was ORR by BICR per IMWG; secondary endpoints included DOR and PFS by BICR, OS, and safety
- Outcomes in patients who switched to Q4W dosing were assessed in a post hoc analysis
- The data cutoff was March 10, 2025, ~38 months after the last patient's first dose
 - Median follow-up by reverse Kaplan-Meier was 39.6 (95% CI 38.7–41.5) months

MagnetisMM-3: less frequent dosing sub-analysis (IMS2025)

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Nooka A et al. (IMS Poster Presentation)

Results: Patients and Treatment

- Among the 123 BCMA-naïve patients in Cohort A, 47 were enrolled in the US (Table)
- 22 (47%) patients switched from QW to Q2W; the median duration of Q2W dosing was 11.1 (range 0.03–25.9) months
- Of the 17 patients who completed ≥6 cycles of Q2W dosing, 8 (17%) patients switched to Q4W dosing; the median duration of Q4W dosing was 15.0 (range 6.5–20.7) months
 - Among the 9 patients who did not switch to Q4W dosing, 5 had ended therapy or had their last dose before the date of the Q4W amendment, 3 were on hold at the time of the Q4W amendment and did not resume dosing, and for 1 patient the reason was unknown
- At data cutoff, 5 (10.6%) patients were still receiving treatment

Footnotes and abbreviations included in Notes page.
Nooka A et al. Poster presented at IMS 2025 (Abstract PA-046).

Table. Demographics and Baseline Characteristics

	N=47
Age, median (range), years	68.0 (36.0–89.0)
Male, n (%)	24 (51.1)
Race, n (%)	
African American or Black	8 (17.0)
Asian	3 (6.4)
White	34 (72.3)
Unknown	1 (2.1)
Not reported	1 (2.1)
ECOG PS, n (%)	
0	15 (31.9)
1	28 (59.6)
2	4 (8.5)
R-ISS disease stage, n (%)	
I	14 (29.8)
II	24 (51.1)
III	7 (14.9)
Unknown	2 (4.3)

Table. Demographics and Baseline Characteristics (cont.)

	N=47
Cytogenetic risk, n (%)	
Standard	32 (68.1)
High*	13 (27.7)
Missing	2 (4.3)
EMD by BICR, n (%) [†]	
Yes	15 (31.9)
No	32 (68.1)
≥1 poor prognosis feature [‡]	32 (68.1)
Prior LOTs, median (range)	5.0 (2.0–22.0)
Prior SCT, n (%)	35 (74.5)
Exposure status, n (%)	
Triple-class [§]	47 (100)
Penta-drug [¶]	37 (78.7)
Refractory status, n (%)	
Triple-class [§]	44 (93.6)
Penta-drug [¶]	22 (46.8)
Refractory to last LOT, n (%)	46 (97.9)

MagnetisMM-3: less frequent dosing sub-analysis (IMS2025)

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3

Nooka A et al. (IMS Poster Presentation)

Results: Efficacy

- ORR by BICR was 66.0% (95% CI 50.7–79.1)
 - sCR (27.7%); CR (14.9%); VGPR (17.0%); PR (6.4%)
 - Median TTR was 1.1 (range 1.0–7.4) months
 - Median time to CR or better was 4.76 (range 1.2–12.8) months
- Median DOR was 40.8 (95% CI 24.0–NE) months (**Figure 1**)
- Median PFS was 27.3 (95% CI 4.3–NE) months (**Figure 2**)
- Median OS was 43.6 (95% CI 14.9–NE) months (**Figure 3**)
- Among 18 responders who switched to Q2W, 14 (77.8%) maintained or improved their response ≥ 6 months after the switch
- Among 8 responders who switched to Q4W, 7 (87.5%) maintained their response ≥ 6 months after the switch

Results: Safety

- Safety is consistent with that in the overall study population; no new safety signals were observed with longer follow-up

Figure 1. Duration of Response

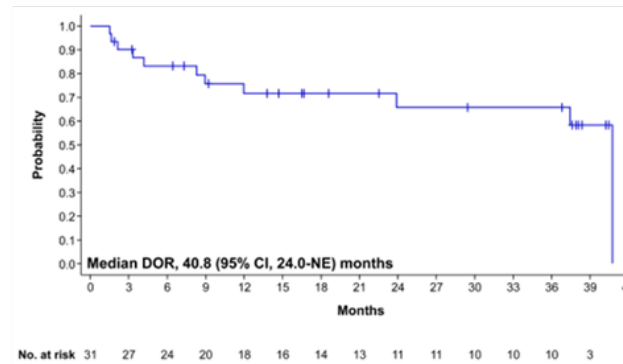


Figure 2. Progression-Free Survival

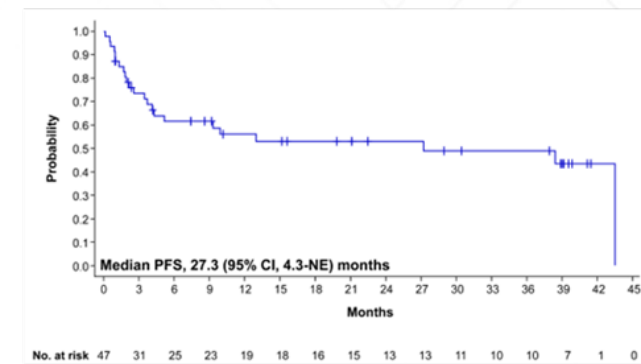
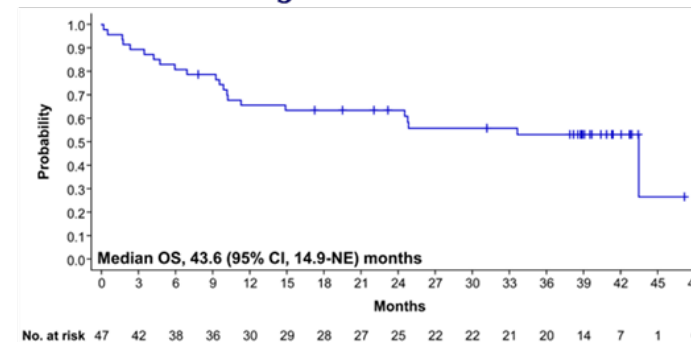


Figure 3. Overall Survival



MagnetisMM-3: less frequent dosing sub-analysis (IMS2025)

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3

Nooka A et al. (IMS Poster Presentation)

Authors' Conclusions

- Consistent with overall Cohort A data, elranatamab was associated with deep, durable responses in the heavily pretreated US subgroup
- With a median follow-up of 39.6 months:
 - ORR was 66.0%
 - Median DOR was 40.8 months, but data may not yet be mature
 - Median PFS was 27.3 months
 - Median OS was 43.6 months, but data may not yet be mature
- Overall, the safety profile, including infections, was consistent with that of the overall study population
 - CRS and ICANS were grade 1 or 2 only
 - Infection prophylaxis, including immunoglobulin replacement, are recommended

Please note: The conclusions above represent the authors' conclusions only.

CRS = cytokine release syndrome; DOR = duration of response; ICANS = immune effector cell-associated neurotoxicity syndrome; ORR = overall response rate; OS = overall survival; PFS = progression-free survival.

Nooka A et al. Poster presented at IMS 2025 (Abstract PA-046).

MagnetisMM-3: fixed dosing sub-analysis (IMS2025)

Elranatamab Fixed Dosing: The Optimal Dosing Strategy for Safety, Efficacy, and Convenience Across Body Weights

Background

Evaluation of dosing strategies including utilization of body weight-based vs fixed dosing is essential to ensure optimal therapeutic outcomes for bispecific antibodies such as elranatamab¹

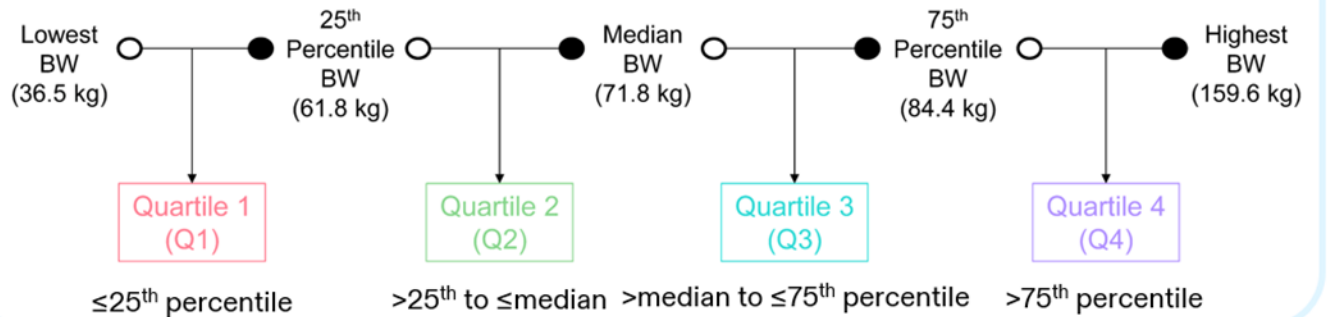
Objective

To evaluate the impact of body weight on the PK, safety, and efficacy of fixed dosing of elranatamab in patients with RRMM

Methods

- Data sources: Phase 2 MagnetisMM-3 trial (NCT04649359)²
 - Cohort A (n=123): BCMA-naïve patients
 - Cohort B (n=64): BCMA-exposed patients
- Patients were classified into quartiles according to their baseline body weight (Figure)
- All patients received a 76 mg fixed dose of SC elranatamab after a 2-step priming dose regimen (12 mg on Day 1; 32 mg of Day 4)
- Blood samples were collected from MagnetisMM-3 trial patients for PK analysis

Figure. Overview of BW Quartiles Based on Baseline Body Weight*



*Open circles represent greater than or less than, while closed circles represent greater than or equal to or less than or equal to.
BCMA = B-cell maturation antigen; BW = body weight; PK = pharmacokinetics; Q = quartile; RRMM = relapsed/refractory multiple myeloma; SC = subcutaneous; TCE = T-cell engagers.
1. Klein C et al. Nat Rev Drug Discov. 2024;23:301-319; 2. Lesokhin AM et al. Nat Med. 2023;29:2259-2267.

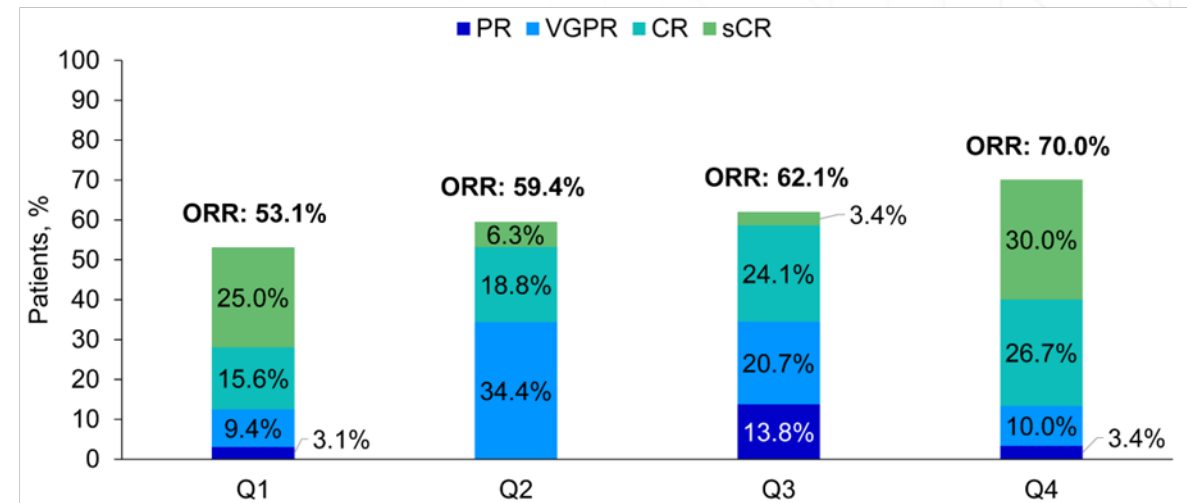
MagnetisMM-3: fixed dosing sub-analysis (IMS2025)

Elranatamab Fixed Dosing: The Optimal Dosing Strategy for Safety, Efficacy, and Convenience Across Body Weights

Results: Efficacy

- For Cohort A (n=123), overall response and complete response rates were comparable across body weight quartiles (**Figure 1**)
- Consistent with the primary efficacy analysis for Cohort A,¹ a clinically meaningful ORR benefit with overlapping CIs was observed across quartiles (**Figure 2**)
- No trend was identified between body weight and PFS and the DOR

Figure 1. Responses by BICR by Body Weight Quartile (Cohort A)*



*Stacked bar graph illustrating the rate of sCR, CR, VGPR, and PR in 123 patients who were treated with elranatamab. Responses assessed by BICR.

BICR = blinded independent central review; CI = confidence interval; CR = complete response; DOR = duration of response; NE = not estimable; ORR = objective response rate; PFS = progression-free survival; PR = partial response; Q = quartile; sCR = stringent complete response; VGPR = very good partial response.

1. Lesokhin AM et al. Nat Med. 2023;29:2259-2267

MagnetisMM-3: fixed dosing sub-analysis (IMS2025)

Elranatamab Fixed Dosing: The Optimal Dosing Strategy for Safety, Efficacy, and Convenience Across Body Weights

Results: Safety

- There were no clinically relevant differences in the safety profiles across body weight quartiles (n=183) (Table)
- Incidence of TEAEs was 100% in all quartiles
- For body weight quartiles Q1, Q2, Q3, and Q4:
 - Incidence of grade 3/4 TEAEs was 63.8%, 68.8%, 60.5%, and 84.4%
 - Incidence of serious TEAEs was 72.3%, 77.1%, 81.4%, and 71.1%
 - Discontinuations due to TEAEs occurred in 27.7%, 16.7%, 37.2%, and 28.9%

Table. TEAEs by Body Weight Quartile

Preferred term*	Any Grade				Grade 3 or 4			
	Q1 (n=47)	Q2 (n=48)	Q3 (n=43)	Q4 (n=45)	Q1 (n=47)	Q2 (n=48)	Q3 (n=43)	Q4 (n=45)
CRS	27 (57.4)	30 (62.5)	22 (51.2)	27 (60.0)	0	1 (2.1)	0	0
Anemia	25 (53.2)	27 (56.3)	27 (62.8)	20 (44.4)	19 (40.4)	23 (47.9)	21 (48.8)	15 (33.3)
Neutropenia	22 (46.8)	17 (35.4)	22 (51.2)	23 (51.1)	22 (46.8)	15 (31.3)	21 (48.8)	25 (51.1)
Thrombocytopenia	19 (40.4)	16 (33.3)	19 (44.2)	13 (28.9)	13 (27.7)	11 (22.9)	15 (34.9)	9 (20.0)
Hypokalemia	15 (31.9)	9 (18.8)	14 (32.6)	5 (11.1)	6 (12.8)	4 (8.3)	5 (11.6)	2 (4.4)
Pyrexia	15 (31.9)	16 (33.3)	10 (23.3)	12 (26.7)	1 (2.1)	1 (2.1)	2 (4.7)	2 (4.4)
Diarrhea	14 (29.8)	18 (37.5)	24 (55.8)	21 (46.7)	0	1 (2.1)	2 (4.7)	2 (4.4)
Asthenia	12 (25.5)	11 (22.9)	4 (9.3)	7 (15.6)	1 (2.1)	3 (6.3)	2 (4.7)	2 (4.4)
Lymphopenia	12 (25.5)	16 (33.3)	18 (41.9)	9 (20.0)	10 (21.3)	16 (33.3)	17 (39.5)	8 (17.8)
Decreased appetite	12 (25.5)	11 (22.9)	13 (30.2)	14 (31.1)	0	1 (2.1)	0	1 (2.2)
Cough	10 (21.3)	11 (22.9)	13 (30.2)	12 (26.7)	0	0	0	1 (2.2)
Nausea	9 (19.1)	11 (22.9)	9 (20.9)	11 (24.4)	0	0	0	0
Fatigue	9 (19.1)	14 (29.2)	17 (39.5)	13 (28.9)	0	1 (2.1)	2 (4.7)	1 (2.2)
Leukopenia	8 (17.0)	8 (16.7)	13 (30.2)	5 (11.1)	4 (8.5)	6 (12.5)	11 (25.6)	3 (6.7)
Headache	6 (12.8)	11 (22.9)	9 (20.9)	10 (22.2)	0	0	0	0
SARS-CoV-2 test positive	6 (12.8)	11 (22.9)	11 (25.6)	12 (26.7)	1 (2.1)	5 (10.4)	2 (4.7)	1 (2.2)

Outline

- Case 1: 57-year-old patient with multiple myeloma
- Updated clinical trials and real-world evidence focusing on elranatamab
- Treatment sequencing in multiple myeloma: bispecifics, ADC, and CAR T

Treatment sequencing of CAR T, ADC, & BsAbs: current status

**No randomized
data available**

**Only consensus
guidelines**



Treatment sequencing of CAR T, ADC, & BsAbs: consensus

IMWG

REVIEW ARTICLE OPEN

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MULTIPLE MYELOMA, GAMMOPATHIES

International myeloma working group immunotherapy committee recommendation on sequencing immunotherapy for treatment of multiple myeloma

Luciano J. Costa^{1,6*}, Rahul Banerjee², Hira Mian³, Katja Weisel⁴, Susan Bal¹, Benjamin A. Derman⁵, Maung M. Htut⁶, Chandramouli Nagarajan⁷, Cesar Rodriguez⁸, Joshua Richter⁹, Matthew J. Frigault⁹, Jing C. Ye¹⁰, Niels W. C. J. van de Donk¹¹, Peter M. Voorhees¹², Benjamin Puliafito⁹, Nizar Bahlis¹³, Rakesh Popat¹⁴, Wee Joo Chng¹⁵, P. Joy Ho¹⁶, Gurbakhash Kaur⁸, Prashant Kapoor¹⁷, Juan Du¹⁸, Fredrik Schjesvold¹⁹, Jesus Berdeja²⁰, Hermann Einsele²¹, Adam D. Cohen²², Joseph Mikhael^{23,24}, Yelak Biru²⁴, S. Vincent Rajkumar¹⁷, Yi Lin¹⁷, Thomas G. Martin²⁵ and Ajai Chari²⁵

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“Assuming equal access, in patients who are reasonable candidates to both BCMA-targeted ADC and BCMA-targeted TCRT, we recommend pursuing TCRT first given its higher activity and lower efficacy of TCRT after prior BCMA-targeted ADC”

EMN

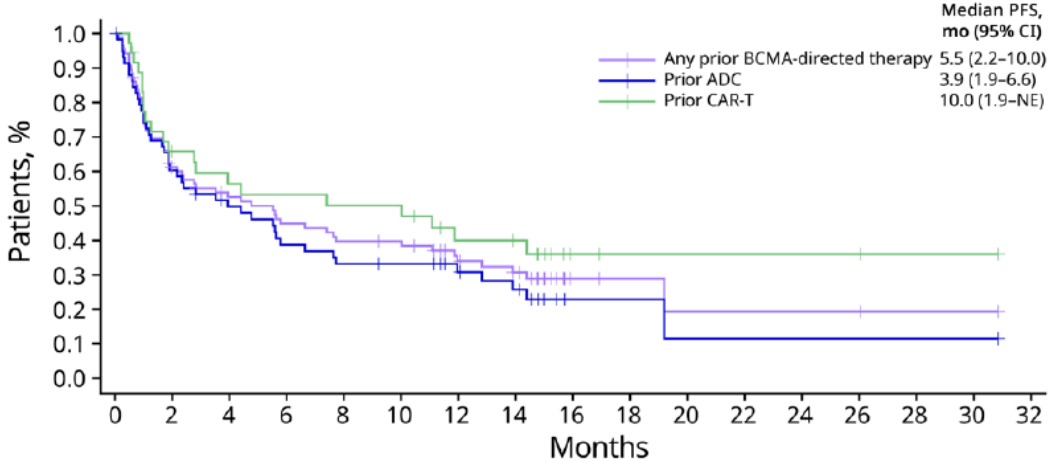
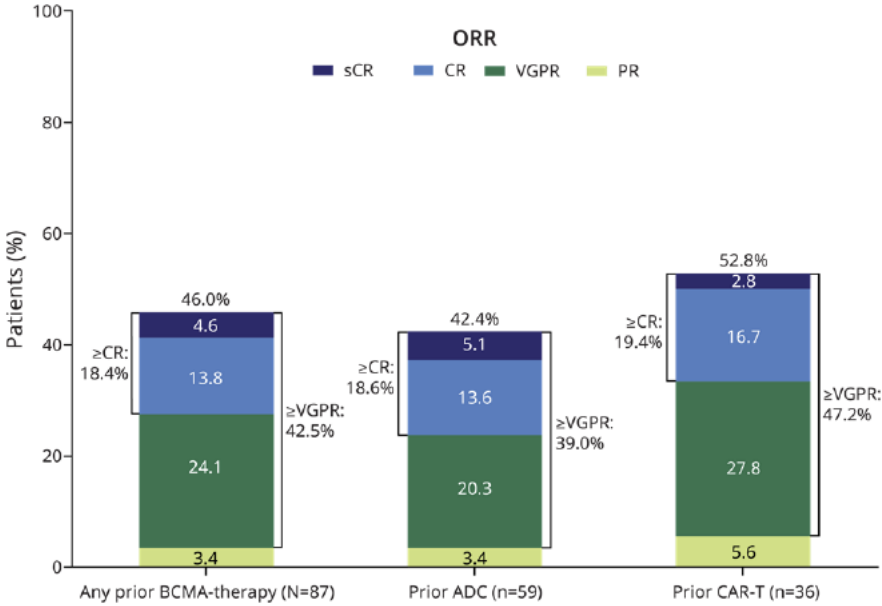
Optimising T-cell immunotherapy in patients with multiple myeloma: practical considerations from the European Myeloma Network



Niels W C J van de Donk, Philippe Moreau, Jesús F San-Miguel, Maria-Victoria Mateos, Meletios A Dimopoulos, Sonja Zweegman, Francesca Gay, Monika Engelhardt, Roberto Mina, Elena Zamagni, Michel Delforge, Meral Beksac, Andrew Spencer, Fredrik Schjesvold, Christoph Driessen, Martin Kaiser, Aurore Perrot, Ralph Wäsch, Charlotte LBM Korst, Annemiek Broijl, Cyrille Touzeau, Salomon Manier, Roman Hajek, Heinz Ludwig, Carlos Fernandez de Larrea, Rakesh Popat, Pellegrino Musto, Paula Rodriguez-Otero, Kwee Yong, Leo Rasche, Evangelos Terpos, Marc S Raab, Mario Boccadoro, Pieter Sonneveld, Hermann Einsele, on behalf of the EMN Guidelines Committee

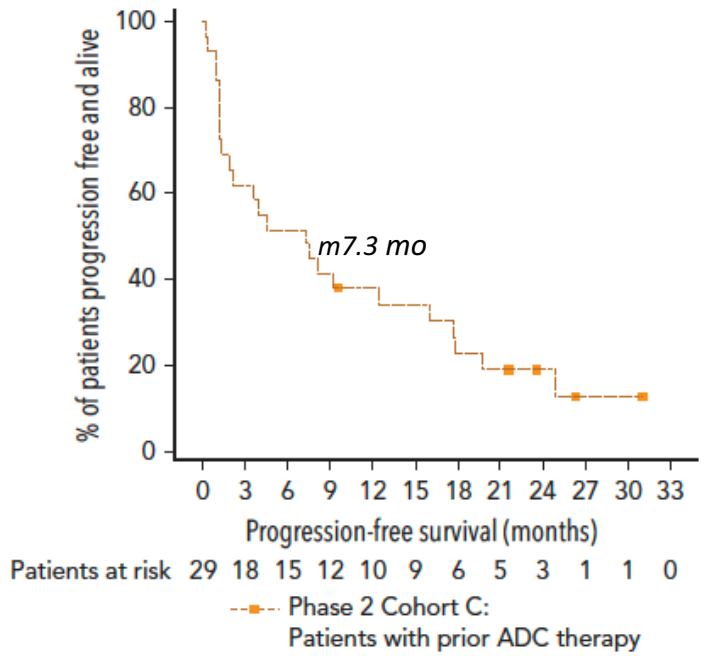
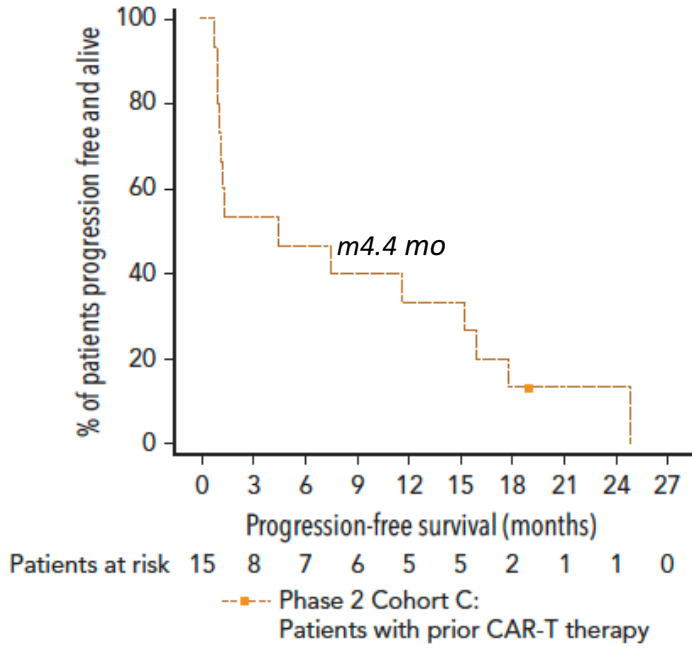
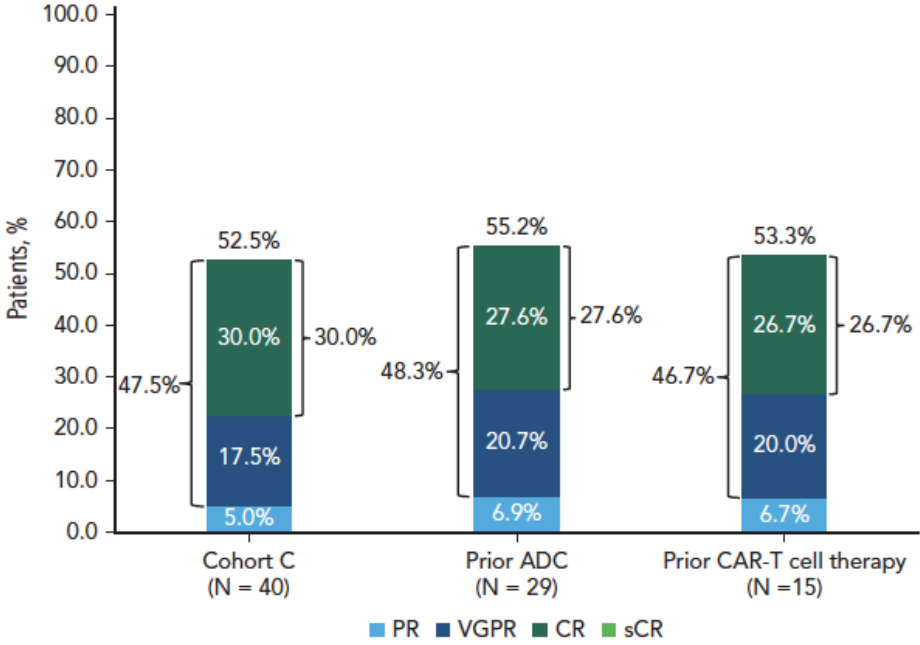
“Assuming equal access, in patients who are reasonable candidates to both BCMA CAR T-cell and TCE we recommend pursuing CAR T-cell therapy. This recommendation considers more robust data supporting activity of TCEs upon progression after CAR T-cell therapy and also the extended treatment-free interval post-CAR-T that is typically associated with more salvage options at the time of progression”

Elranatamab in patients with prior anti-BCMA therapy

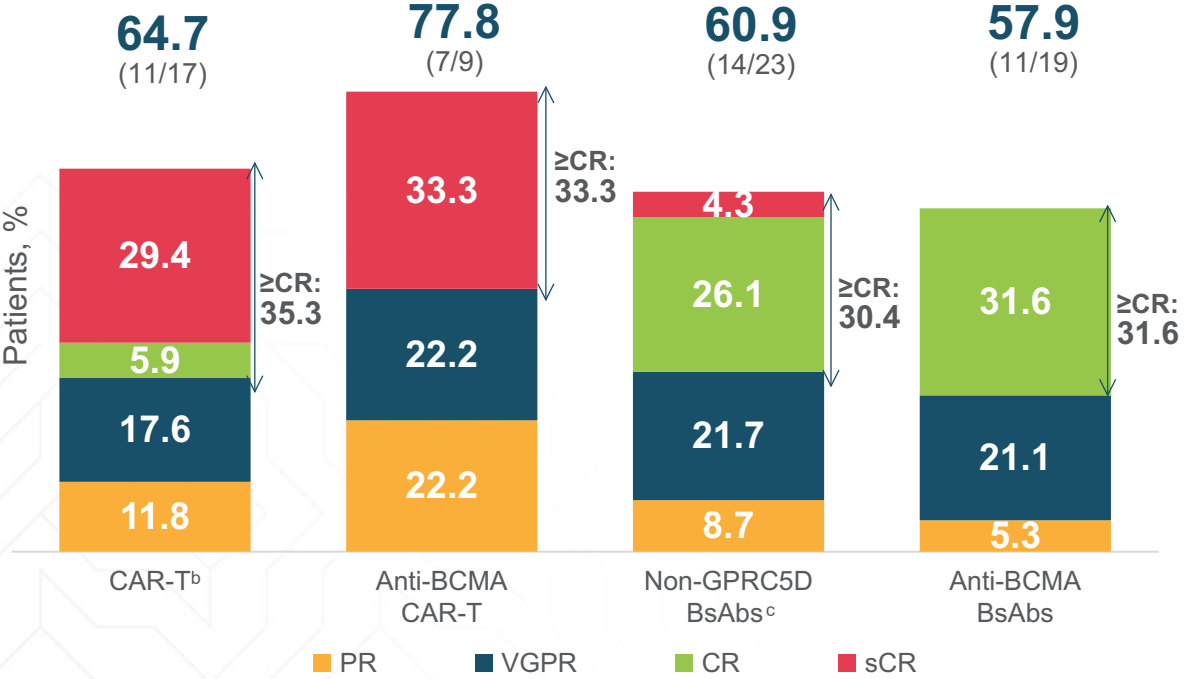


	No. at risk	0	2	4	6	8	10	12	14	16	18	20	22	24	26	28	30	32
Any prior BCMA-directed therapy:	87	50	41	35	31	30	22	18	4	3	2	2	2	2	1	1	0	
Prior ADC:	59	35	27	27	18	17	13	10	2	2	1	1	1	1	1	1	0	
Prior CAR-T:	36	21	18	17	16	16	11	10	3	2	2	2	2	2	1	1	0	

Teclistamab in patients with prior anti-BCMA therapy



Talquetamab in patients with prior anti-BCMA therapy



MonumentAL-1 Single agent	Prior CAR T-cell N=56	Prior Bispecific N=26
ORR	71%	58%
mPFS	12.3 mo	4.1 mo

Adaptado de Sanchez L, et al 2023.1 | 1. Sanchez L et al., ASH 2023. Clinical Outcomes of Subsequent Therapies in Patients With Relapsed/Refractory Multiple Myeloma Following Talquetamab Treatment: Analyses From the Phase 1/2 MonumentAL-1 Study
 1. Sanchez L et al., ASH 2023. Clinical Outcomes of Subsequent Therapies in patients with Relapsed/Refractory Multiple Myeloma Following Talquetamab Treatment: Analyses From the Phase 1/2 MonumentAL-1 Study.

After a BCMA-directed CAR T

	Study	N	ORR	CRR	PFS	DOR	Particularities/unique toxicities
BCMA-targeted CAR T-cells							
Cilta-cel	Martin, 2022 ⁷⁷	3	0%	0%	n.a	n.a	On trial, second administration of product
BCMA-targeted TCE							
Teclistamab	Touzeau, 2024 ⁷⁹	15	53%	27%	mPFS 4.4 mo.	n.a	Dedicated MajesTEC-1 cohort
Elranatamab	Nooka, 2023 ⁸⁰	36	53%	20%	mPFS 10 mo.	n.a	Pool from clinical trials
Teclistamab	Dima, 2024 ⁷⁴	43	63%	28%	n/a	n.a	RWE, 38/42 prior CAR T-cells were ide-cel
GPRC5D-targeted TCE							
Talquetamab	Rasche, 2024 ¹⁹	56	71%	n.a.	n.a.	mDOR 12.3mo.	Subset of MonumenTAL-1 trial

(a) relates to the 39 patients with prior BCMA-targeted therapy, of which 30 received prior BCMA-targeted CAR T-cells. (b) For all 43 patients with prior BCMA-targeted therapy; ORR= overall response rate; CRR= complete response rate; PFS= progression-free survival; DOR= duration of response; n.a.= not available; n.r.= median not reached.

Tabela adaptada conforme Regulação Brasileira

After a BCMA-directed bispecific antibodies

	Study	N	ORR	CRR	PFS	DOR	Particularities/unique toxicities
BCMA-targeted CAR T-cells							
Cilta-cel	Cohen, 2023	7	57%	14%	mPFS 5.3mo.	mDOR 8.2 mo.	Dedicated CARTITUDE-2 cohort, 2 deaths due to infection
BCMA-targeted TCE							
None reported							
GPRC5D-targeted CAR T-cells							
None reported							
GPRC5D-targeted TCE							
Talquetamab	Rasche, 2024	26	58%	n.a.	mPFS 4.1mo.	n.a.	Subset of MonumentAL-1 trial

ORR= overall response rate; CRR= complete response rate; PFS= progression-free survival; DOR= duration of response; n.a.= not available; n.r.= median not reached.

Tabela adaptada conforme Regulação Brasileira

After a BCMA-directed ADC

	Study	N	ORR	CRR	PFS	DOR	Particularities/unique toxicities
BCMA-targeted CAR T-cells							
Cilta-cel	Cohen, 2023	13	62%	38%	mPFS 9.5mo	mDOR 11.5mo	Dedicated CARTITUDE-2 cohort
BCMA-targeted TCE							
Teclistamab	Touzeau, 2024	29	55%	28%	mPFS 7.3 mo.	n.a.	Dedicated MajesTEC-1 cohort
Elranatamab	Nooka, 2023	59	42%	19%	mPFS 3.9 mo.	n.a.	Pool from clinical trials
Teclistamab	Riedhammer, 2024	23	74%	22%	n.a.	n.a.	RWE
Teclistamab	Dima, 2024	23	61%	26%	n.a.	n.a.	
GPRC5D-targeted CAR T-cells							
None reported							
GPRC5D-targeted TCE							
Talquetamab	Jakubowiak, 2023	8	75%	n.a.	n.a.	n.a.	Subset of MonumentAL-1 trial

(a) For all 43 patients with prior BCMA-targeted therapy. ORR= overall response rate; CRR= complete response rate; PFS= progression-free survival; DOR= duration of response; n.a.= not available; n.r.= median not reached.

Myeloma Program at Sylvester Comprehensive Cancer Center, University of Miami

Myeloma Program

Benjamin Diamond, MD
David Coffey, MD
James Hoffman, MD
Dickran Kazandjian, MD
Abhi Pandey, MD
Gil Hevroni, MD
Rafat Abonour, MD
Ola Landgren, MD, PhD
and team

Blood & Marrow Transplantation and Cell Therapy Program

Jay Spiegel, MD
Lazaros Lekakis, MD
Denise Pereira, MD
Damian Green, MD
and team

Hematopathology Program

Katie Thoren, PhD
Kaz Murata, PhD
Yi Zhou, MD, PhD
Jennifer Chapman, MD
Merce Jorda, MD, PhD
and team

Myeloma Genomic & Translational Lab

Benjamin Diamond, MD
David Coffey, MD
Gil Hevroni, MD
Rafat Abonour, MD
Arjun Rajanna, MS
Marios Papadimitriou, MD
Abdessamad Alaoui, PhD
Ava Amidei, PhD stud
Chrissy Baker PhD stud
Alexander Pentakalos, BS
Bahar Bahrani, MD
Shaivi Shah, MD
Abhi Pandey, MD
Michael Durante, MD, PhD
Enzie Liu, PhD
Brian Walker, PhD
Ola Landgren, MD, PhD
and team

Molecular Imaging Program

Russ Kuker, MD
Ty Subhawong, MD
Michael Georgiou, MD
and team



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Thank you for your attention!

C. Ola Landgren, M.D., Ph.D.

Professor of Medicine

Chief, Division of Myeloma

Director, Sylvester Myeloma Institute

Co-Leader, Translational and Clinical Oncology Program

Paul J. DiMare Endowed Chair in Immunotherapy

Sylvester Comprehensive Cancer Center

University of Miami

LinkedIn: [C. Ola Landgren, M.D., Ph.D.](#) | X: [@DrOlaLandgren](#)

