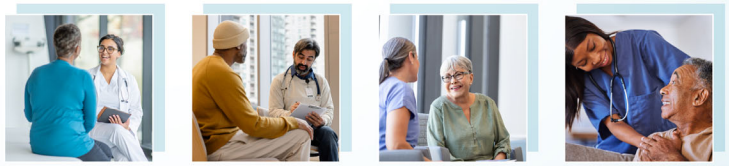
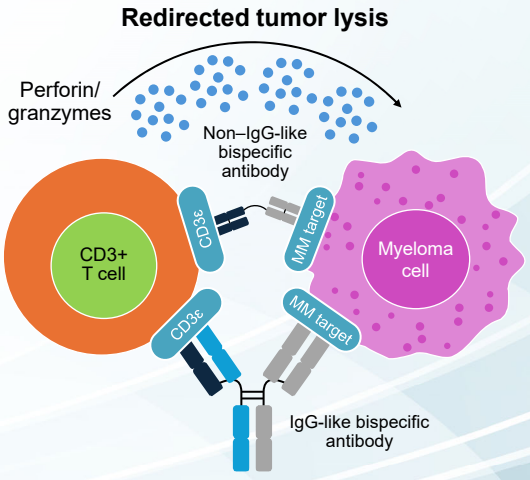


# *Prevention and Management of Bispecific Antibody–Associated Adverse Events in Multiple Myeloma*

1

## Bispecific Antibodies

- Bispecific antibodies are also referred to as *dual-specific antibodies, bifunctional antibodies,* or *T cell–engaging antibodies.*
- Bispecific antibodies can target two cell surface molecules at the same time (one on the myeloma cell and one on a T cell).
- Many different bispecific antibodies are in clinical development; three are approved for use in myeloma!
- Availability is off-the-shelf, allowing for immediate treatment.




2

# Myeloma Cell Targets for Bispecific Antibodies

## BCMA

- Highly expressed only on the surface of plasma cells
- Myeloma patients have significantly higher serum BCMA levels than healthy individuals
- **2 BCMA-targeted bispecific approved**
  - **Teclistamab**
  - **Elranatamab**

## GPRC5D

- High expression on myeloma cells in the bone marrow
- Low expression on hair follicles but not on other healthy cells
- Expression on myeloma cells is independent of BCMA
- **1 GPRC5D-targeted bispecific approved**
  - **Talquetamab**

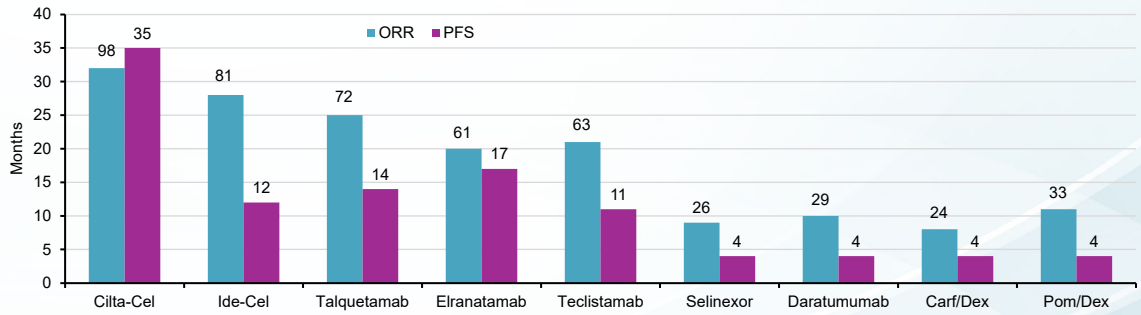
## FcRH5

- Selectively expressed on B cells and plasma cells

BCMA, B-cell maturation antigen; GPRC5D, G protein-coupled receptor family C group 5 member D; FcRH5, Fc receptor homolog 5

3

# Overall Response Rate and Progression-Free Survival of Recently Approved Therapies in RRMM*




*This is not a head-to-head comparison; cross-trial comparisons should not be inferred from these data. Data represent two populations: PFS includes all patients; ORR includes responding patients only.

RRMM, relapsed/refractory multiple myeloma; ORR, overall response rate; PFS, progression-free survival

Usmani S et al. *J Clin Oncol*. 2022;40(suppl 16):8028. Anderson L et al. ASCO 2021; Abstract 8016. Touzeau et al. EHA 2023. Nooka A et al ASCO 2022; Abstract 8007. Lesohkin et al. *Nat Med*. 2023. Chari A et al. *N Eng J Med*. 2019;381:727. Lonial S et al. *Lancet*. 2016;387:1551. Siegel DS et al. *Blood*. 2012;120(14):2817. Richardson P et al. *Blood*. 2014;123(12):1826.

4

| Bispecific antibody | Teclistamab[1] | Elranatamab[2] |
|---|---|---|
| **Structure/function** | Humanized antibody | Humanized antibody |
| **Treatment** | Weekly SC | Weekly SC |
| **Patients** | n=165 | n=123 |
| **Median prior lines** | 5 | 5 |
| **Triple-class refr. (TCR)** | 78% | 100% |
| **ORR at RP2D**<br>RP2D<br>(n) | 63%<br>1.5 mg/kg SC<br>(n=165) | 61%<br>76 mg SC<br>(n=123) |
| **PFS** | 12.5 mos (8.8–17.2) | 17.2 mos (9.8–NE) |
| **OS** | 21.9 mo (16.0–NE) | |
| **DOR** | 24 mos (16.2–NE) | 69% @ 18 mos |

**1.** Moreau P et al. *N Engl J Med*. 2022;387:495. **2.** Lesokhin A et al. *Nat Med*. 2023;29:2259.

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| Bispecific antibody | Teclistamab[1] | Elranatamab[2] |
|---|---|---|
| **Median follow-up** | 22 mos | 17.6 mos |
| **AEs, all (Gr 3+)** | | |
| **CRS** | 72% (1%) | 58% (0%) |
| **Infections** | 80% (55%) | 70% (40%) |
| **Neutropenia** | 72% (66%) | 49% (49%) |
| **Anemia** | 54% (38%) | 49% (37%) |
| **Thrombocytopenia** | 42% (22%) | 31% (24%) |
| **Neurotoxicity** | 15% (1%) | 4% (0%) |
| **# Deaths** | 68 (41 due to PD) | 25 (11 due to PD) |
| **Hypogamma/IVIG** | 75%/39% | 75%/40% |

**1.** Moreau P et al. *N Engl J Med*. 2022;387:495. **2.** Lesokhin A et al. *Nat Med*. 2023;29:2259.

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| Bispecific antibody | Talquetamab phase 1/2 MonumenTAL-1 study GPRC5D × CD3 | | |
|---|---|---|---|
| **Treatment** | 0.4 mg/kg SC QW | 0.8 mg/kg SC Q2W | Either dose |
| **Patients** | n=143 | n=145 | n=51 |
| **Median prior lines** | 5 | 5 | 6 (Prior CAR T therapy 75%; prior bispecific therapy 44%) |
| **Triple-class refractory** | 74% | 69% | |
| **ORR at RP2D** | 74% | 72% | 65% |
| **PFS** | 7.5 mos | 14.2 mos | 5.1 mos |
| **DOR** | 9.5 mos | NR | 11.3 mos |

Schinke CD et al. *J Clin Oncol*. 2023;41. Abstract 8036.

7

| Bispecific antibody | Talquetamab phase 1/2 MonumenTAL-1 study GPRC5D × CD3 | | |
|---|---|---|---|
| **Treatment** | 0.4 mg/kg SC QW | 0.8 mg/kg SC Q2W | Either dose |
| **Median follow-up** | 18.8 mos | 12.7 mos | 14.8 mos |
| **AEs, all (Gr 3+)** | | | |
| **CRS** | 79% (2%) | 75% (0.7%) | 77% (2.0%) |
| **Infections** | 59% (20%) | 66% (15%) | 73% (28%) |
| **Neutropenia** | 35% (31%) | 28% (22%) | 55% (53%) |
| **Anemia** | 45% (32%) | 39% (25%) | 39% (25%) |
| **Thrombocytopenia** | 27% (20%) | 30% (19%) | 37% (29%) |
| **ICANS** | 11% (1.6%) | 10% (1.8%) | 10% (1.8%) |
| **# Deaths** | 0 due to AEs | 0 due to AEs | 0 due to AEs |
| **Hypogamma/IVIG** | NR/13% | NR/10% | NR/10% |
| | Dysgeusia 72% (N/A)<br>Skin 56% (0%)<br>Nail 55% (0%) | Dysgeusia 71% (N/A)<br>Skin 73% (1%)<br>Nail 54% (0%) | Dysgeusia 77% (N/A)<br>Skin 69% (0%)<br>Nail 63% (0%) |

Schinke CD et al. *J Clin Oncol*. 2023;41. Abstract 8036.

8

| Bispecific antibody | Talquetamab phase 1/2 MonumenTAL-1 study[1] GPRC5D × CD3 | | |
|---|---|---|---|
| **Treatment** | 0.4 mg/kg SC QW | 0.8 mg/kg SC Q2W | Either dose |
| **Median follow-up** | 18.8 mos | 12.7 mos | 14.8 mos |
| **AEs, all (Gr 3+)** | Dysgeusia 72% (N/A)<br>Skin 56% (0%)<br>Nail 55% (0%) | Dysgeusia 71% (N/A)<br>Skin 73% (1%)<br>Nail 54% (0%) | Dysgeusia 77% (N/A)<br>Skin 69% (0%)<br>Nail 63% (0%) |

**Patients who have ≥1 GPRC5D-related oral, skin, or nail AE in the first 90 days of treatment had a 20% higher likelihood of having a response.[2]**

**1.** Schinke CD et al. *J Clin Oncol*. 2023;41.Abstract 8036. **2.** Chari A et al. *Blood*. 2023;142(suppl 1):1010.

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# Key Points

- Approved bispecific antibodies offer “off-the-shelf” treatment
- Bispecific antibodies are very active even in heavily pretreated patients
- AEs such as CRS, neurotoxicity, infections, and cytopenias are common and can be managed
  - Dysgeusia and skin/nail toxicity observed with talquetamab
- Differentiating factors between bispecifics include
  - Target (BCMA or GPCR5D)
  - Step-up dosing schedule, dosing frequency

10

# Case Discussion

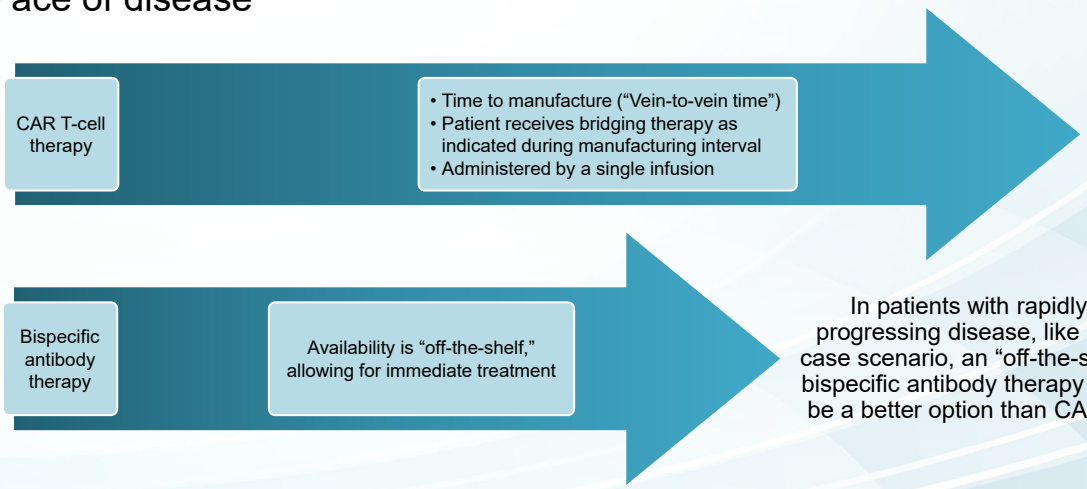
**70-yr-old with rapidly progressive MM after 4 lines of prior therapy**

- PS of 2 at most recent progression
- Standard risk cytogenetics
- Treatment history
  - Daratumumab, lenalidomide, bortezomib, dexamethasone, then ASCT; lenalidomide maintenance
  - Elotuzumab, pomalidomide, dexamethasone
  - Carfilzomib, dexamethasone (Kd)
  - Isatuximab added to Kd

11

# Considerations for Selecting CAR T or Bispecific Antibody Therapy

- Pace of disease




12

## Considerations for Selecting CAR T or Bispecific Antibody Therapy

- Pace of disease
- AE profile
  - Can pause or reduce dose of bispecific antibody therapy to manage challenging AEs
- Very limited data in certain patient populations
  - Frail and elderly patients
  - Patients with comorbidities such as
    - Renal failure
    - Central nervous system disorders
    - Heart failure
- Health status, not age alone, should determine CAR T eligibility
  - Refer eligible patients to a CAR T treatment center

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## Determinants of the Use of Bispecific Antibody Therapy

- Efficacy and safety
- Convenience
  - REMS program requirements
    - Step-up dosing schedule
    - Inpatient hospitalization vs outpatient monitoring for CRS
  - Access to tocilizumab (off label for bispecific), IVIG
  - Need for and number of priming doses
  - Route of administration: SQ vs IV
  - Frequency of administration
  - Treatment to progression vs fixed duration
- Targets and sequencing within bispecifics and relative to other agents: CAR Ts, etc
- Time to market

14

# Early T Cell Redirection May Have Downstream Sequelae: PFS2 and OS Impact Unknown

| | Ide-cel KarMMa[1] | Ide-cel Real World[2] | | Cilta-cel CARTITUDE-1[3,4] | Cilta-cel CARTIUDE-2[5] | Teclistamab[6] | MajesTEC-1 Cohort C[7] | |
|---|---|---|---|---|---|---|---|---|
| **N** | 128 | 50 | | 97 | 20 | 165 | 40 | |
| **Age, (range)** | 61 (33–78) | 66 (43–79) | | 61 (56–68) | 63 (44–81) | 64 (33–84) | 64 (32–82) | |
| **# of lines** | 6 | 9 | | 6 | 8 | 5 | 6 | |
| **HR cytog, %** | 35 | 36 | | 24 | 15 | 26 | 33 | |
| **EMD, %** | 39 | 50 | | 13 | 25 | 17 | 30 | |
| **Triple refractory, %** | 84 | 90 | | 88 | 90 | 78 | 85 | |
| **BCMA refractory, %** | n/a | | | n/a | 80 | n/a | | |
| **Prior BCMA** | | CAR T | Bispecific | | Bispecific | | CAR T | ADC |
| **n** | | 5 | 7 | | 7 | | 15 | 29 |
| **ORR, %** | 81 | 100 | 86 | 98 | 57 | 63 | 53 | 55 |
| **CR/sCR, %** | 39 | 60 | 43 | 82 | 14 | 39 | 27 | 24 |
| **PFS, months** | 12.2 | NR | 2.8 | 34.9 | 5.3 | 11.3 | | |

**Elranatamab: 54% ORR (7/13) with prior BCMA[8]**

**1.** Anderson L et al. 2021 ASCO. Abstract 8016. **2.** Ferreri CJ et al. 2021 ASH. Abstract 766. **3.** Berdeja J et al. *Lancet*. 2021;398;314. **4.** Lin Y et al. 2022 EHA. Abstract P961. **5.** Cohen AD et al. *Blood*. 2023;141:219-230. **6.** Moreau P et al. *N Engl J Med*. 2022;387(6):495. **7.** Touzeau C et al. 2022 ASCO. Abstract 8013. **8.** Bahlis NJ et al. *Nat Med*. 2023;29(10):2570-2576.

15

# Case Discussion

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- PS of 2 at most recent progression
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- Treatment history
  - Daratumumab, lenalidomide, bortezomib, dexamethasone, then ASCT; lenalidomide maintenance
  - Elotuzumab, pomalidomide, dexamethasone
  - Carfilzomib, dexamethasone (Kd)
  - Isatuximab added to Kd

- Patient is candidate for either bispecific antibody or CAR T-cell therapy
- Consider a bispecific antibody given patient's progressive disease
- Could consider non–BCMA-targeted bispecific antibody

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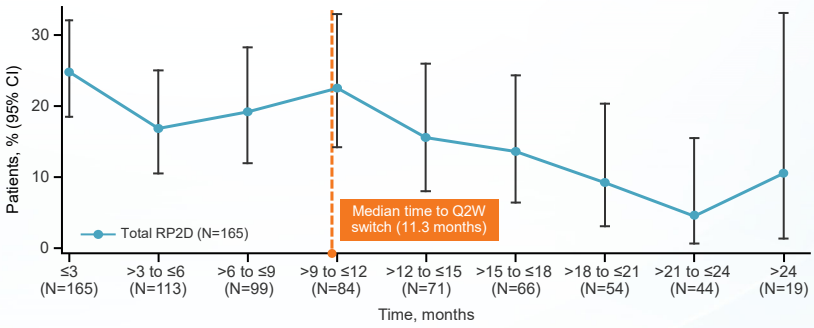
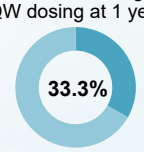
# New-Onset Grade ≥3 Infections Decreased Over Time in MajesTEC-1, With Fewer Infections in Patients Switching to Q2W

**New-onset grade ≥3 infections over time**

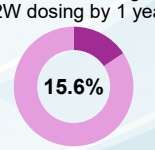



**New-onset grade ≥3 infections at 1–1.5 years**

Patients remaining on QW dosing at 1 year




Patients switching to Q2W dosing by 1 year




**Responders could receive less frequent teclistamab at the same dose.**

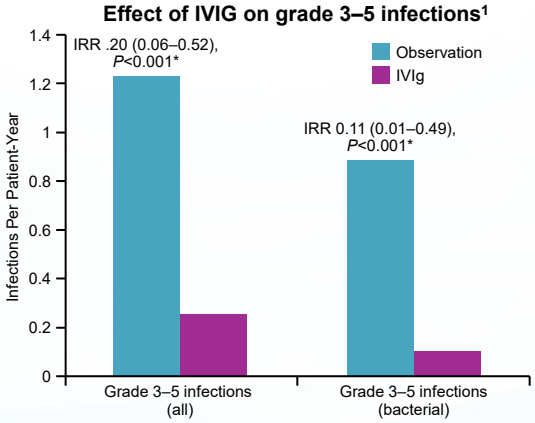
Weekly 1.5 mg/kg doses after step-up → Switch to every 2 weeks if: ≥PR after ≥4 cycles (phase 1) ≥CR after ≥6 months (phase 2) → Switch to every 4 weeks if response maintained on biweekly schedule

Usmani SZ et al. *J Clin Oncol.* 2023;41(suppl 16):8034.

17

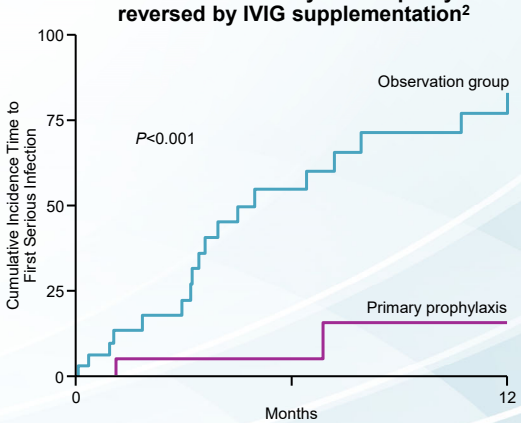
# Impact of IVIG in MM Patients on BCMA Bispecific Antibody Treatment

**Effect of IVIG on grade 3–5 infections[1]**




IgG levels censored at time of IVIG use; for IgG myeloma, the M spike was subtracted from the total IgG.

**The negative impact of teclistamab on humoral immunity can be partly reversed by IVIG supplementation[2]**

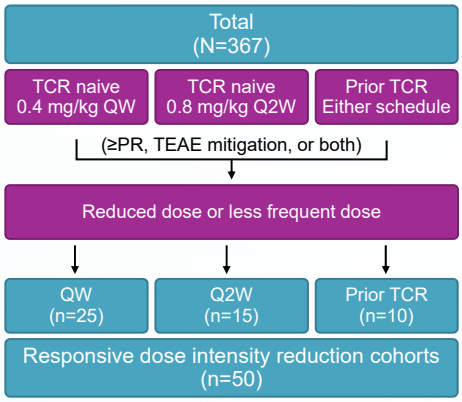


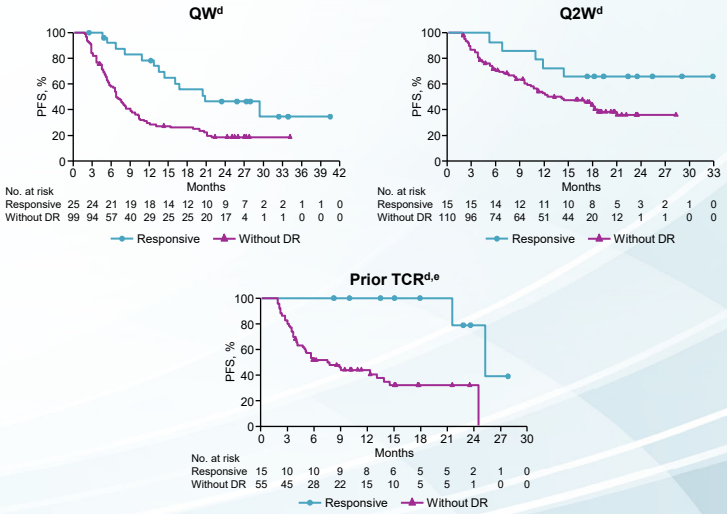

Impact of IVIG supplementation on risk of serious infections

**1.** Lancman G et al. *Blood.* 2022;140(Suppl 1):10073. **2.** Reprinted from *Blood Adv.* 2024;8(1), Frerichs KA, et al. Teclistamab impairs humoral immunity in patients with heavily pretreated myeloma: importance of immunoglobulin supplementation, 194-206. Copyright 2024, with permission from The American Society of Hematology.

18

# MonumenTAL-1 Responsive Dose Intensity Reduction Cohorts: Disease Response Maintained Even With Dose Reduction



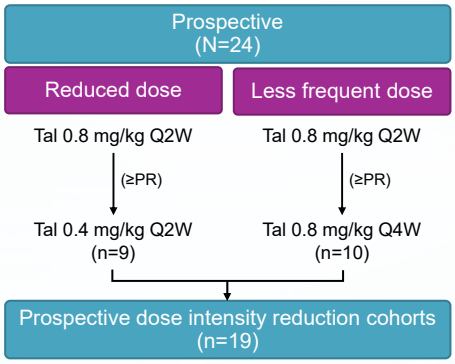



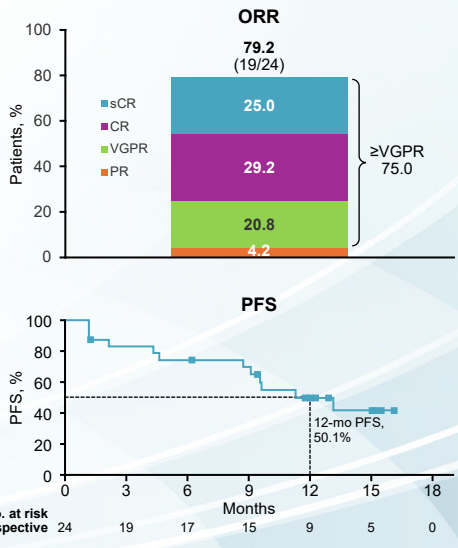

Chari A et al. *Blood*. 2023;142(Suppl 1):1010.

19

# MonumenTAL-1 Prospective Dose Intensity Reduction Cohorts: Disease Response Maintained Even With Dose Reduction

- Patients with dose reductions had to be in response (n=19); dose reduction occurred at a median of 3.1 mo (range, 2.3–4.2) relative to treatment start




PR, partial response; Q2W, every other week; Q4W, every 4 weeks; QW, weekly; TCR, T-cell redirection therapy; TEAE, treatment-emergent adverse event

Chari A et al. *Blood*. 2023;142(Suppl 1):1010.

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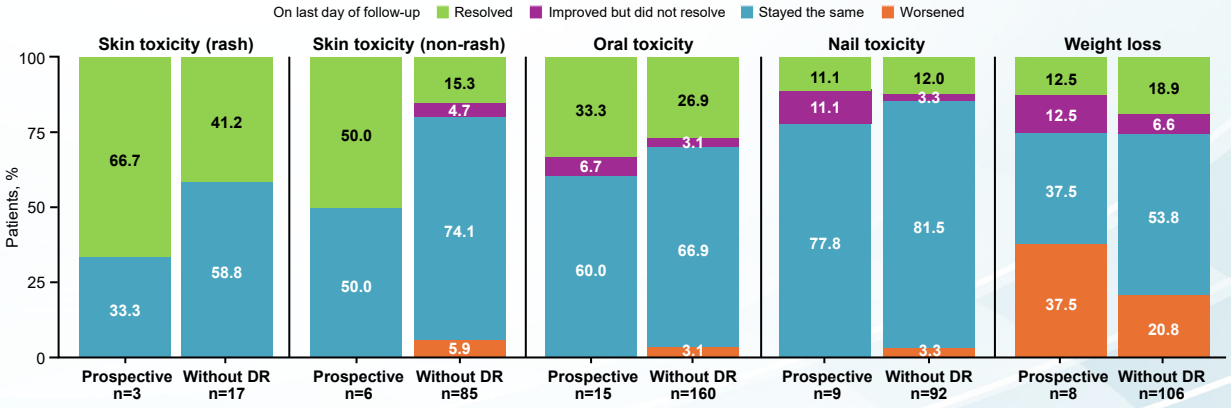
# MonumenTAL-1 Prospective Dose Intensity Reduction Cohorts: Resolution of GPRC5D-Related AEs vs Matched Cohort

**Prospective cohorts with change in AE status after switch vs matched cohort without dose reduction[a]**




**Trend toward improved resolution of GPRC5D-related AEs, except weight loss**

[a]Patients included had ≥PR before day 200 from the prospective dose modification cohort (n=18) and from the MonumenTAL-1 cohort who did not dose reduce (n=206). Each category shows only patients who had a respective AE on day 100. Color signifies how that respective AE grade changed from day 100 to last day of follow-up (within 30 days of last treatment; capped at 500 days); DR, dose reduction.

Chari A et al. *Blood*. 2023;142(Suppl 1):1010.

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# Key Points

- With bispecific antibodies, CRS and ICANS are likely to be low grade and managed in the short-term
- The clinician assuming care later on must be aware of
  - Infectious complications (including atypical infections like PJP, HSV, and CMV reactivation)
  - Management of off-tumor, on-target effects of talquetamab
  - Prolonged cytopenias
- Prophylactic antibiotics and antivirals are a must during the entire time of treatment
- IVIG replacement is strongly encouraged for all patients
- Optimally sequencing T cell-directed therapies is critical; however, best available therapy should be offered considering logistics, access, and availability

CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; PJP, *Pneumocystis jirovecii* pneumonia; HSV, herpes simplex virus; CMV, cytomegalovirus

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## Role of the Advanced Practice Provider

- Patient education
  - Discuss potential side effects
  - Provide guidance on the treatment process
- Patient assessment and monitoring
  - Assess for treatment-related side effects or complications
  - Monitor patient response to bispecific antibody therapy, including evaluating laboratory results, imaging studies, and clinical symptoms to track disease progression or treatment efficacy
- Treatment planning and coordination
  - Collaborate with physicians and other health care team members to develop individualized treatment plans

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## Role of the Advanced Practice Provider

- Patient counseling
  - Discuss treatment goals and potential side effects
  - Address patient questions, concerns, and emotional needs
- Symptom management and supportive care
  - Assess and address pain, fatigue, nausea, neuropathy, and other treatment-related side effects
  - Employ pharmacologic and nonpharmacologic interventions as appropriate
  - Coordinate with other health care providers, such as oncology nurses, social workers, and palliative care specialists
  - Provide comprehensive supportive care services aimed at optimizing patient quality of life and well-being

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# Patient Experience

**Lines of therapy**

1. VRd
2. KRd →ASCT → maintenance with KRd → Rd (during COVID)
3. Dara-Pd
4. Cilta-cel
5. Teclistamab (did not fit enrollment criteria at the time for talquetamab clinical trial)
6. Selinexor + Kd
7. Talquetamab

ASCT, autologous stem cell transplant; cilta-cel, ciltacabtagene autoleucel; d, dexamethasone; Dara, daratumumab; K, carfilzomib; P, pomalidomide; R, lenalidomide; V, bortezomib

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# Infection Prevention

| | | | |
|---|---|---|---|
| Avoid crowds | Ensure handwashing, hygiene | Growth factors | IVIG for hypo-gammaglobulinemia |
| Immunizations (no live vaccines) | COVID-19 prevention | Zoster and PJP prophylaxis | Monitor CD4 count |

IVIG, Intravenous immunoglobulin; PJP, *Pneumocystis jirovecii* pneumonia

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# GPRC5D-Associated Side Effects

| Affected area | Symptoms and effects | Management |
|---|---|---|
| Skin | Rash, skin peeling | Relatively benign, not painful, self-limiting, and manageable with emollients |
| Nails | Nail thinning and loss | Mostly aesthetic but takes time to resolve |
| Oral | Difficulty swallowing, dry mouth, taste changes | Can lead to weight loss; have longer duration and can affect quality of life. Most successfully managed with dose modification. Supportive measures may be used (eg, NaCl mouth rinse, artificial saliva spray, diet modification) |

***Myeloma patients respond well to treatment, and GPRC5D-associated side effects improve over time, becoming more tolerable; notable reduction in side effects is seen with dose modification.***

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# Bispecific and Trispecific Engagers

**T-cell engagers**

| Drug name | HPN217 | Alnuctamab | Forimtamig | Abbv-383 | EMB-06 | JNJ-79635322 |
|---|---|---|---|---|---|---|
| Specificity | BCMA | BCMA | GPRC | BCMA | BCMA | BCMA/GPRC |
| Format | Albumin half-life extender | 2:1 tumor: CD3 binding domain | | Low CD3 affinity | Tetravalent | Trispecific |

**NK-cell engagers**

| Drug name | IPH6401/SAR445514 | CC-92328/DF3001 |
|---|---|---|
| Format | ANKET | TriNKET |
| Specificity | BCMA/CD16/NKp46 | BCMA/CD16/NKG2D |

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# Emerging BCMA-Targeted Bispecific Antibodies

| Bispecific antibody | Linvoseltamab[1] | ABBV-383[2] | Alnuctamab[3] | HPN217[4] |
|---|---|---|---|---|
| **Structure/function** | *Veloci-Bi*® platform fully human antibody | Low CD3 affinity fully human antibody | Humanize antibody 2 BCMA + 1 CD3 | Trispecific 50kDa (albumin) |
| **Treatment** | Weekly IV | IV Q3wk | Qwk → Q4wk SC | Q2wk IV |
| **Patients** | n=252 | n=220 | n=68 | n=97 |
| **Median prior lines** | 5 | 5 | 4 | 6 |
| **Triple-class refractory** | 74% | 80% | 63% | 78% |
| **ORR at RP2D**<br>RP2D<br>(n) | 71%<br>200 mg IV<br>(n=117) | 60%<br>60 mg IV<br>(n=61) | 65%<br>30 mg SQ<br>(n=26) | 63%<br>12 mg IV<br>(n=19) |
| **Median follow-up** | 11 mos | | 4.6 mos | |
| **AEs, All (Gr 3+)** | | | | |
| **CRS** | 46% (1%) | 70% (2%) | 53% (0%) | 16% (0%) |
| **Infections** | 73% (34%) | 24% (16%) | 34% (9%) | 59% (25%) |
| **Neutropenia** | 32% (31%) | 43% (34%) | 37% (32%) | 47% (47%) |
| **Anemia** | | 38% (13%) | 38% (25%) | 47% (32%) |
| **Thrombocytopenia** | | 26% (13%) | 24% (9%) | 32% (21%) |
| **Neurotoxicity** | 8% (3%) | 5% (0%) | 0% (0%) | 0% (0%) |

ORR, overall response rate; AE, adverse event; CRS, cytokine release syndrome

**1.** Jagannath S et al. *Blood.* 2023;142(Suppl 1):4746. **2.** Vij R et al. *Blood.* 2023;142(Suppl 1):3378. **3.** Wong S et al. *Blood.* 2022;140(Suppl 1):400–402. **4.** Madan S et al. *Blood.* 2023;142(Suppl 1):1012.

29

# Emerging Treatment Combinations With BCMA-Targeted Bispecific Antibodies

| Bispecific antibody | Teclistamab + daratumumab (MajesTEC-3)[1] | Teclistamab + dara + lenalidomide (MajesTEC-2)[2] | Elranatamab + daratumumab (MagnetisMM-5)[3,4] |
|---|---|---|---|
| **Treatment** | Dara SC 1,800 mg<br>Tec SC 1.5–3 mg/kg Qwk or Q2wk | Dara + Len 25 + dex 40 + Tec 0.72 or 1.5 Qwk to 3 mg/kg Q2wk C3+ | Dara SC 1,800 mg + Elra44 or 76 mg Qwk SC → Q2wk C7+ |
| **Patients** | n=65 | n=32 | n=34 |
| **Median prior lines** | 5 | 2 | 4 |
| **Triple-class refractory** | 59% | N/A | 18% |
| **Median follow-up** | 8.6 mos | 8.4 mos | |
| **AEs, All (Gr 3+)** | | | |
| **CRS** | 78% (0%) | 81% (0%) | 41% (0%) |
| **Infections** | 63% (22%) | 91% (38%) | |
| **Neutropenia** | 49% (41%) | 84% (74% incl 13% FN) | 47% (47%) |
| **Anemia** | 52% (28%) | 22% (13%) | 29% (27%) |
| **Thrombocytopenia** | 32% (25%) | 25% (16%) | 21% (15%) |
| **Neurotoxicity** | 2% (0%) | 0% (0%) | 0% (0%) |
| **# Deaths** | 4 | 2 | 15 (6 COVID) |

AE, adverse event; CRS, cytokine release syndrome

**1.** Mateos MV et al. *J Clin Onc.* 2022;40(Suppl 16):TPS8072. **2.** Searle E et al. *Blood.* 2022.140(Suppl 1):394. **3.** Grosicki S et al. *Blood.* 2022.140(Suppl 1):4407. **4.** Grosicki S et al. ASH 2022.

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# Emerging Non-BCMA Targeted *CD3 Bispecific Antibodies

| Bispecific antibody | Forimtamig[1] Phase 1 GPRC5D X CD3 (2:1) | Cevostamab[2] Phase 1 FcRH5 X CD3 |
|---|---|---|
| **Treatment** | SC q 2wk *12 mos | IV q3w *12 mos |
| **Patients** | n=57 | n=161 |
| **Median prior lines** | 5 | 6 |
| **Triple-class refractory** | 63% | 85% |
| **ORR at RP2D** | **64%** | **57%** |
| **AEs, All (Gr 3+)** | | **+/- Prophylactic tocilizumab[3]** |
| **CRS** | 79% (2%) | 80% (2%) → **36% (2%)/90% (3.6%)** |
| **Infections** | 46% (26%) | 43% (19%) |
| **Neutropenia** | 18% (16%) | 18% (16%) → **Gr3+ 64% vs 39%** |
| **Anemia** | 49% (39%) | 32% (22%) |
| **Thrombocytopenia** | 26% (19%) | |
| **ICANS** | 2% (2%) | 6% (4%) |
| **# Deaths** | 2 (1 due to AEs) | |
| **Other** | Mucosal 77% (5%)<br>Skin 86% (23%)<br>Hair/nail 28% (0%) | Diarrhea 26% (1%) |

ORR, overall response rate; AE, adverse event; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome

**1.** Carlo-Stella C et al. *Blood*. 2022;140(Suppl 1):397. **2.** Trudel S et al. *Blood*. 2021;138(Suppl 1):157. **3.** Mateos MV et al. *Hemasphere*. 2023;7(Suppl):e75458a8.

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# Talquetamab Combinations

| Bispecific antibody | Talquetamab + daratumumab Phase 1b TRIMM 2[1] | Talquetamab + teclistamab Phase 1 RedriectTT-1[2] | Talquetamab + pomalidomide MonumenTAL-2[3] |
|---|---|---|---|
| **Treatment** | Dara + Tal 0.4 or 0.8 mg/kg | RP2D<br>Tec 3 mg/kg, Tal 0.8 | Tal 0.4 or 0.8 mg/kg<br>+ pom 2 mg *cycle 2* |
| **Patients** | n=14, n= 51 | n=93, n=34 | n=16, n=19 |
| **Median lines of therapy** | 5 | 4 | 3 vs 3 |
| **TCRefr** | 61% (53% prior BCMA exp) | 80% | 25 vs 21% |
| **PFS** | 19.4 mos | 20.9 mos | NR |
| **Median follow-up** | 15 mos | 13.4 mos | 15 vs 11 mos |
| **AEs, All (Gr 3+)** | | | |
| **CRS** | 78% (0%) | 76% (3%) | 74% (2%) |
| **Infections** | 63% (22%) | 84% (53%) | 71% (23%) |
| **Neutropenia** | 38% (26%) | 66% (61%) | 60% (49%) |
| **Anemia** | 52% (26%) | 51% (34%) | (26%) |
| **Thrombocytopenia** | 37% (20%) | 43% (29%) | (20%) |
| **ICANS** | 5% (0%) | 3% (1%) | 6% (0%) |
| **# Deaths** | 1 due to AE | NR | 1 |
| **Other** | Oral 90% (4%)<br>Skin 84%(8%)<br>Nail 67% (2%) | 61% (N/A)<br>54% (0%)<br>46% (0%) | Dysgeusia 86%<br>Skin 74% (6%)<br>Nail 69% |

AE, adverse event; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome

**1.** Dholaria BR et al. *J Clin Onc*. 2023;41(Suppl 16):8003. **2.** Cohen YC et al. *J Clin Onc*. 2023;41(Suppl 16):8002. **3.** Matous J et al. *Blood*. 2023;142(Suppl 1):1014.

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# Pending Phase 3 Studies

| Disease state | Study Design | Title | NCT Number |
|---|---|---|---|
| NDMM, TIE | Elranatamb + DR vs DRd in non SCT | MagnetisMM-6 | NCT05623020 |
| NDMM, TIE | Teclistamab + DR vs talquetamab-DR vs DRd in non SCT | MajestTEC-7 | NCT05552222 |
| Post SCT | Teclistamab + R vs teclistamab vs R | MajesTEC-4 | NCT05243797 |
| Post SCT | Elranatamb vs R | MagnetisMM-7 | NCT05317416 |
| RRMM | Linvoseltamab vs elotuzumab + Pd | LINKER-MM3 | NCT05730036 |
| RRMM | Elranatamab vs elranatamab + D vs DPd | MagnetisMM-5 | NCT05020236 |
| RRMM | Teclistamab + D vs DPd vs DVd | MajesTEC-3 | NCT05083169 |
| RRMM | Teclistamab vs PVd vs Kd<br>in 1-3 LOT CD38- and R-exposed | MajesTEC-9 | NCT05572515 |
| RRMM | Talquetamab-DP vs talquetamab-D vs DPd in<br>>1 (R refractory) or >2 & non-CD38 refractory | MonumenTAL-3 | NCT05455320 |

NDMM, newly diagnosed multiple myeloma; SCT, stem cell transplant; RRMM, relapsed/refractory multiple myeloma; TIE, transplant ineligible

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# Thank you for joining us!

Please complete the evaluation
and share your feedback

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