LEUKEMIA & LYMPHOMA SOCIETY®

ADVANCES IN MULTIPLE MYELOMA

Angela Dispenzieri, MD
Professor of Medicine
Research Chair, Division of Hematology
Mayo Clinic
Rochester, MN

Slide credits to Dr. Rahma Warsame

1

WELCOMING REMARKS
ADVANCES IN MULTIPLE MYELOMA

Lizette Figueroa-Rivera, MA
Sr. Director, Education & Support
The Leukemia & Lymphoma Society
Rye Brook, NY

2

LEUKEMIA & LYMPHOMA SOCIETY®

2

WELCOMING REMARKS
ADVANCES IN MULTIPLE MYELOMA

This program is supported by

Bristol Myers Squibb™ | gsk | LEGEND BIOTECH

Genentech A Member of the Roche Group | Biogen | oncopeptides | janssen Oncology

PHARMACEUTICAL COMPANIES OF Johnson & Johnson

LEUKEMIA & LYMPHOMA SOCIETY®

WELCOMING REMARKS
ADVANCES IN MULTIPLE MYELOMA

Angela Dispenzieri, MD
Professor of Medicine
Research Chair, Division of Hematology
Mayo Clinic
Rochester, MN

LEUKEMIA & LYMPHOMA SOCIETY®

DISCLOSURES

Companies	Role
Janssen	Advisory board and independent review committee
Oncopeptides, Sorrento	Data monitoring safety committee
Alynlam, Pfizer, Takeda, BMS	Research dollars

The presentation includes off-label information on treatment regimens

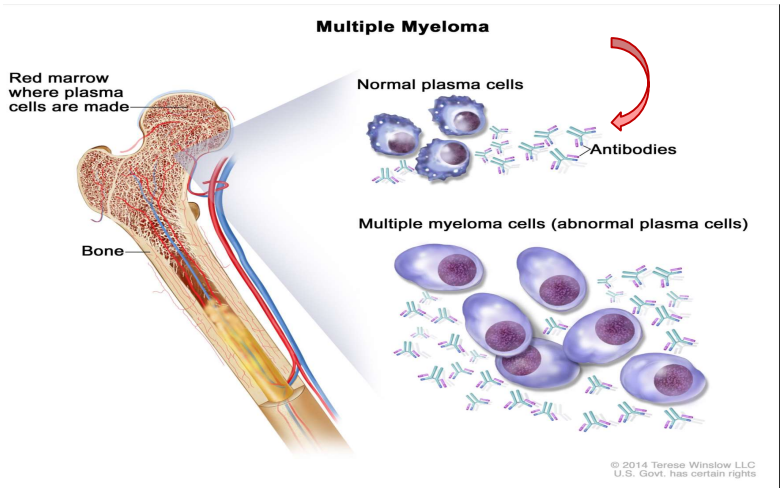
5

KEY POINTS

- Understand diagnosis and staging of multiple myeloma
- Review treatment paradigm
- Immunotherapy for multiple myeloma
  - Naked antibodies
  - Antibody drug conjugates
  - Bispecific antibodies
  - Chimeric antigen receptor T-cell therapy (CART)
- Future directions

6

1. WHAT IS MULTIPLE MYELOMA?



S sixty percent plasma cells
L light chains l/U>100
I
M MRI with >1 focal lesion

C calcium high
R renal impairment
A anemia
B bone damage

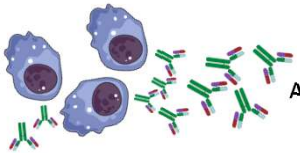
Kyle RA. *Mayo Clinic Proceedings*. 2003.
Rajkumar SV. *Lancet Oncol*. 2014

7

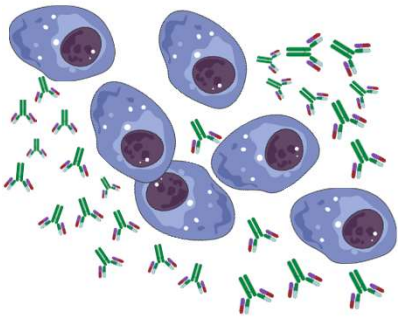
2. MULTIPLE MYELOMA – EPIDEMIOLOGY

- Cancer of plasma cells in the bone marrow that produce monoclonal immunoglobulins/proteins
- Approximately 1-2% of all cancers
- Cancer of older adults
  - Median age at diagnosis 65-74
  - 10% are <50
- More common in African American individuals

Normal plasma cells



Multiple myeloma cells (abnormal plasma cells)



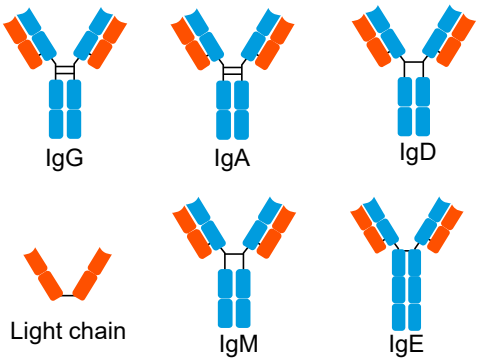
Siegel RL. *Cancer Statistics*. 2021
Kyle RA. *Mayo Clinic Proceedings*. 2003.
Waxman AJ. *Blood*. 2010

8

3. PLASMA CELL – BASICS

Plasma cell: terminally differentiated B-cell that secretes Immunoglobulins (Ig factory)

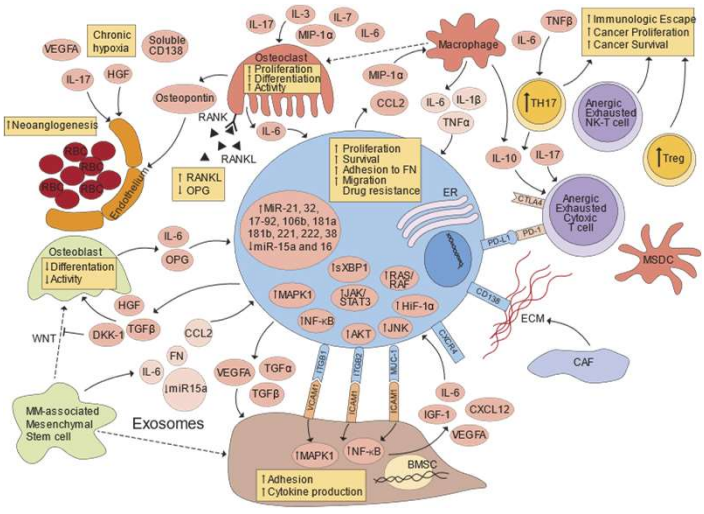
- Immunoglobulins
  - Heavy chain
    - IgM, IgG, IgA, IgD, IgE
  - Light chain
    - Kappa and lambda



Handy-dandy tumor maker that can be followed in blood and/or urine

MYELOMA BONE MARROW MILIEU

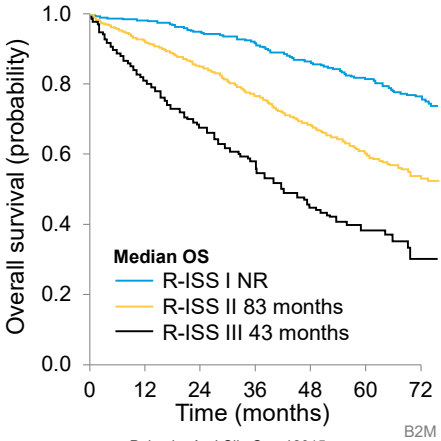
Bone marrow microenvironment of MM patients differs in cellular and non-cellular composition from healthy individuals



Redrawn from: Bianchi et al: Blood 2015; (125): 3049-3058

4. MULTIPLE MYELOMA – RISK STRATIFICATION

Overall Survival International Staging System (R-ISS) in Multiple Myeloma



Palumbo A. *J Clin Oncol* 2015.

Revised International Staging System

Stage I	Stage II	Stage III
All of the following: • B2M <3.5 mg/L • Serum albumin ≥3.5 g/dL • Normal LDH • No del(17p), t(4;14), or t(14;16) by FISH	Neither Stage I or III	• B2M ≥5.5 mg/L and • elevated LDH -and/or- • del(17p), t(4;14), or t(14;16) by FISH

B2M = beta 2 microglobulin, LDH = Lactate dehydrogenase, FISH = fluorescence in situ hybridization

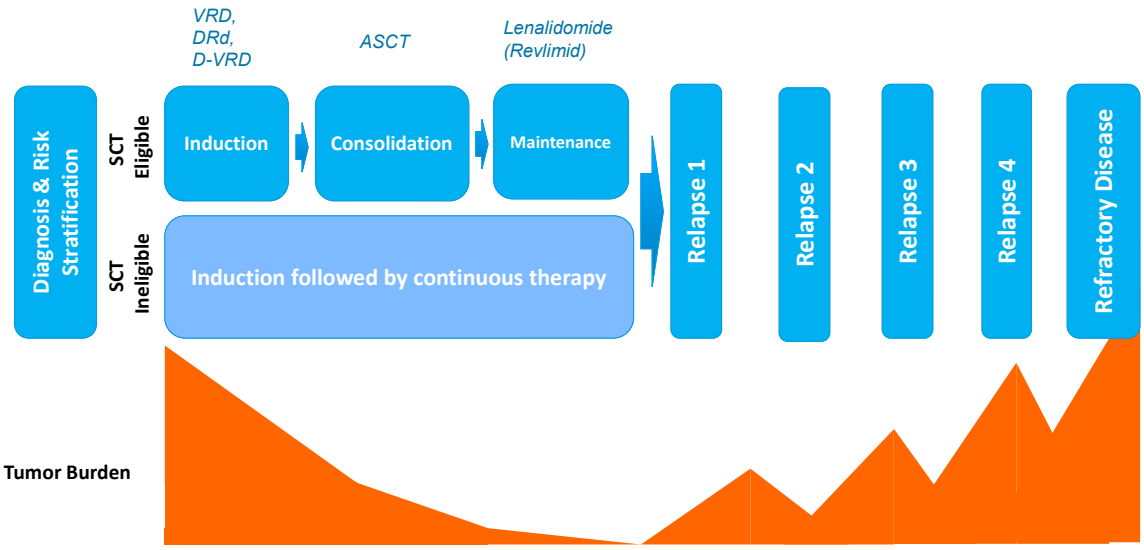
MM RISK STRATIFICATION - FISH

- High Risk genetic abnormalities
  - t(4;14)
  - t(14;16)
  - t(14;20)
  - Del 17p or p53 mutation
  - Gain 1q (amplification or duplication)
- R-ISS stage 3
- High risk plasma cell S-phase

- Standard Risk
  - All others including:
  - Trisomies
  - t(11;14)
  - t(6;14)

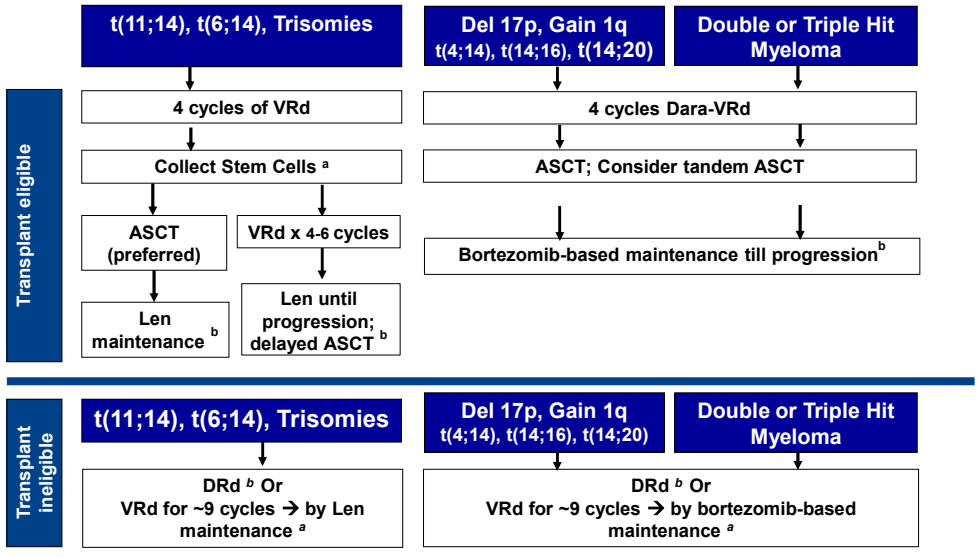
https://www.msmart.org/

5. MYELOMA TREATMENT PARADIGM



13

Msmart, non-trial recommendations



a If age >65 or > 4 cycles of VRd, consider mobilization with G-CSF plus cytoxan or plerixafor; b Duration usually until progression based on tolerance

VRd, Bortezomib, lenalidomide, dexamethasone; Dara, daratumumab

Dispenzieri et al. Mayo Clin Proc 2007;82:323-341; Kumar et al. Mayo Clin Proc 2009 84:1095-1110; Mikhael et al. Mayo Clin Proc 2013;88:360-376. v19 //last reviewed Feb 2021

14

Considerations for Treatment Selection for Relapsed MM

Patient Factors

- ✓ Age: second ASCT? Frail?
- ✓ Comorbidities:
  - ✓ Cardiac/Renal impairment?
  - ✓ Neuropathy?

Disease Biology

- ✓ Biochemical recurrence only or clinical relapse?
- ✓ Maintained or unmaintained?
- ✓ High risk ?

Treatment Factors

- ✓ Choice of 1st line of therapy; prior ASCT?
- ✓ Duration/depth of prior response
- ✓ Trial availability?

15

Pillars of Myeloma therapy

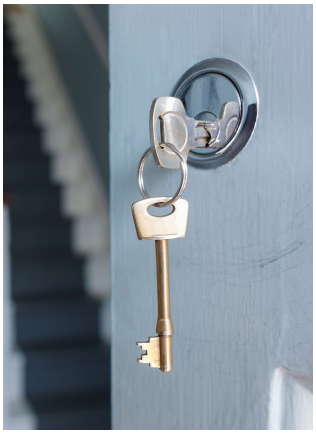
Alkylators/Cytotoxics	Proteasome Inhibitors	IMiDs	Antibodies	Targeted therapies/ Novel MOAs
Melphalan	Bortezomib	Lenalidomide	Daratumumab	Venetoclax
Cyclophosphamide	Carfilzomib	Pomalidomide	Isatuximab	Panobinostat
Bendamustine	Ixazomib	Thalidomide	Elotuzumab	Selinexor
Anthracyclines		Iberdomide	Belantamab mafadotin	Immune Cell Therapy

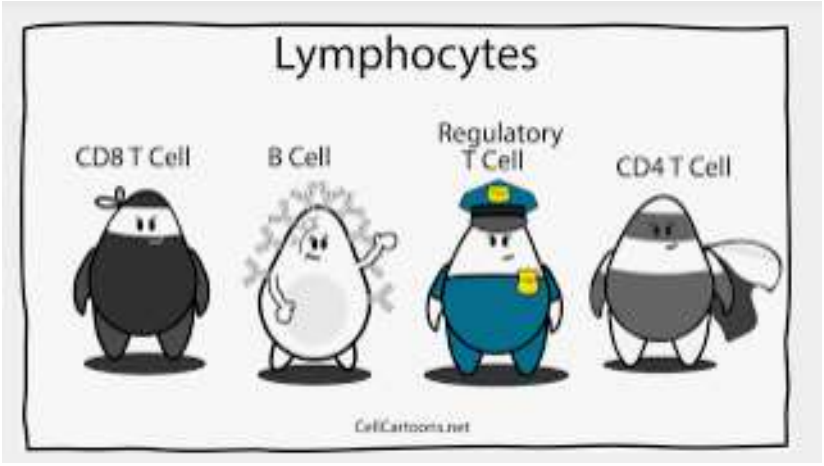
Steroids (Dexamethasone, Prednisone)

Therapy upon relapse will be impacted by changes in frontline therapy:

16

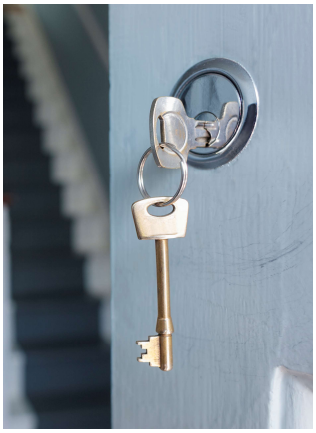
6. RETRAIN THE IMMUNE SYSTEM TO KILL MM

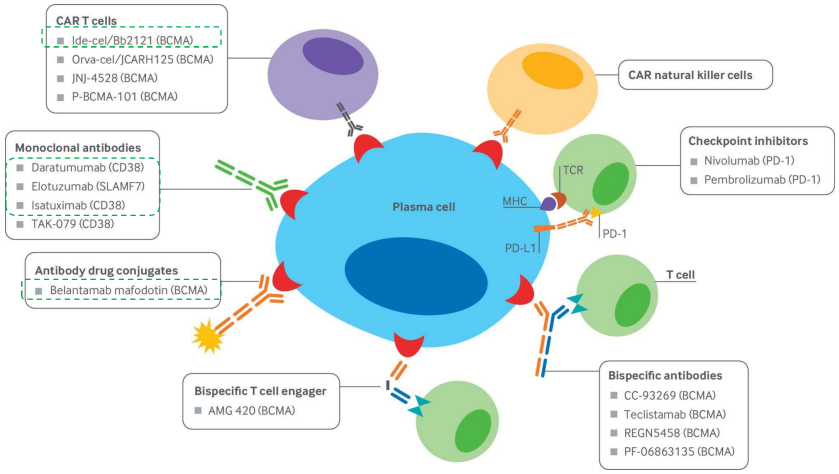




17

EMERGING IMMUNOTHERAPIES IN MULTIPLE MYELOMA

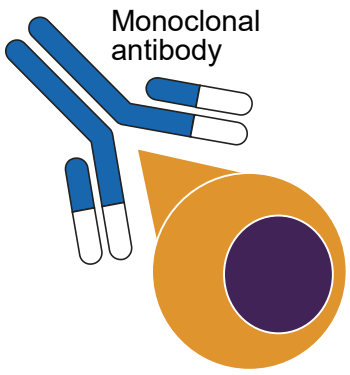




Shah A, Mailankody S. *BMJ* 2020; 370

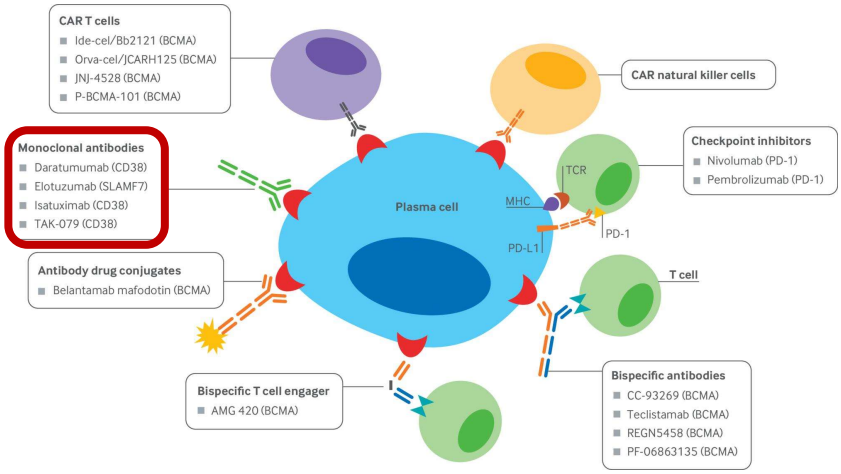
18

NAKED ANTIBODIES



19

EMERGING IMMUNOTHERAPIES IN MULTIPLE MYELOMA



Shah A, Mailankody S. *BMJ* 2020; 370

20

MAYO CLINIC

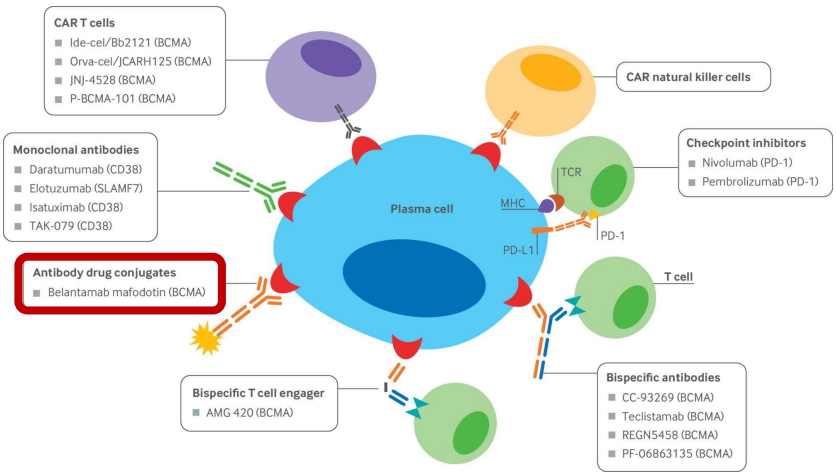
CD38 T-MABS ARE EVERYWHERE!

T-mAb	Newly diagnosed MM	RRMM
Daratumumab	D-VTd	D-Pd
	D-VMP	D-Kd
	D-Rd	D-Vd
	Master: KRd ± Dara	D-Rd
	Perseus: VRd ± Dara	
Isatuximab	Isa-Kia (KRd ± Isa)	Isa-Pd
	(VRd ± Isa)	Isa-Kd
	(VCd ± Isa)	

Randomized trials on-going in MM maintenance, MGUS, and SMM spaces

21

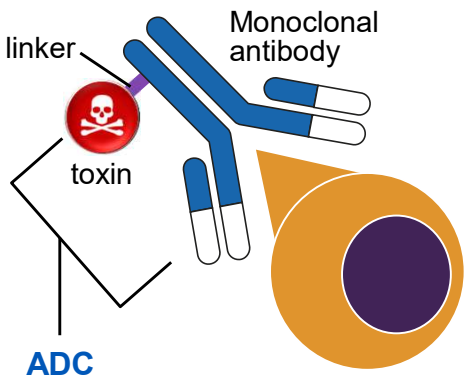
EMERGING IMMUNOTHERAPIES IN MULTIPLE MYELOMA



Shah A, Mailankody S. *BMJ* 2020; 370

22

ANTIBODY DRUG CONJUGATE



23

ANTIBODY DRUG CONJUGATE (ADC)

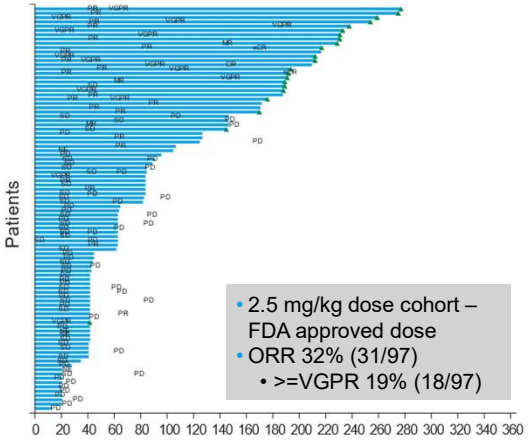
Benefits	Risk
• Targeted release of chemotherapy/ immunotoxin/ immunotherapy • Attracts immune cells that clear cancer even if the treatment does not • Dead cancer cells attract even more immune effector cells enhancing its potential response	• Still not 100% specific for myeloma cells and can cause tissue specific toxicity

24

BELANTAMAB

- BCMA ADC
  - Humanized IgG1 anti-BCMA monoclonal antibody & monomyethyl auristatin F (toxin)
  - IV infusion over 3 minutes every 3 weeks
- Progression free survival 2.8 months
- Continued response can be seen in patients with ADC on hold

Time to Best Response

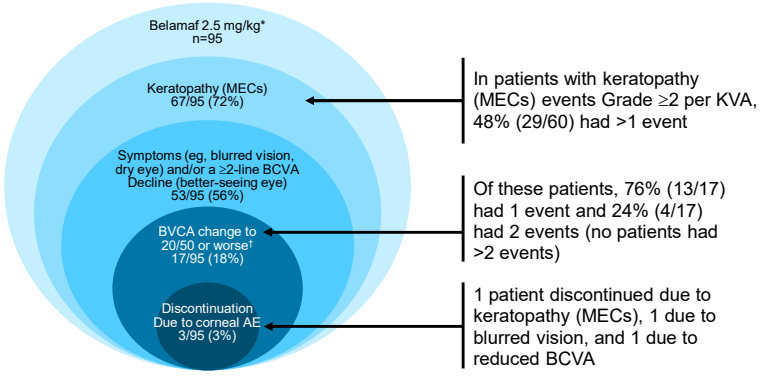


- 2.5 mg/kg dose cohort – FDA approved dose
- ORR 32% (31/97)
  - >=VGPR 19% (18/97)

Redrawn from: Lonial et al. Lancet Oncol 2020; 21: 207

25

BELANTAMAB OCULAR TOXICITY



26

BELANTAMAB + POM/DEX (ALGONQUIN STUDY, NCT03715478

Eligibility criteria
≥1 prior line, Len refractory, PI exposed or refractory, Mild/moderate renal impairment allowed

Most frequent AE's
Keratopathy 96.9%, blurred vision 87.5%, fatigue 59.4%, neutropenia (62.5%), thrombocytopenia (50%), fever (46.9%), diarrhea (34.4%), constipation (34.4%), and dry eye (28.1%)

Table 1; Summary of corneal events, ocular symptoms and efficacy data by cohort

Cohort	Median number for treatment cycles (range)	≥G3 Keratopathy (%)	≥G3 blurred vision n (%)	AEs leading to dose holds	AEs leading to dose reductions	≥VGPR n/N (%)	ORR n/N (%)	6-month PFS (%)
1.92 SINGLE n=12	13.5 (2-23)	5 (41.7%)	4 (33.3%)	7 (58.3%)	0 (0%)	7/11 (63.6%)	9/11 (81.8%)	80%
2.5 SINGLE n=7	27 (13-29)	7 (100%)	4 (57.1%)	7 (100%)	7 (100%)	7/77 (100%)	7/7 (100%)	100%
2.5 LOADING N=5	9 (5-17)	4 (80%)	0 (0%)	5 (100%)	5 (100%)	4/5 (80%)	5/5 (100%)	80%
2.5 BIMONTHLY (N=12)	6 (4-10)	10 (83.3%)	2 (16.7%)	7 (58.3%)	5 (41.7%)	9/12 (75%)	11/12 (91.7%)	100%
2.5 TRIMONTHLY N=11	6 (1-10)	8 (72.7%)	2 (18.2%)	4 (36.4%)	5 (45.5%)	4/7 (57.1%)	5/7 (71.4%)	75%
2.5 SPLIT	12.5 (3-22)	7 (87.5%)	4 (50%)	8 (100%)	6 (75%)	6/8 (75%)	7/8 (87.5%)	85.7%
3.4 SPLIT N=5	7.5 (1-21)	3 (60%)	2 (40%)	3 (60%)	1 (20%)	3/4 (75%)	4/4 (100%)	75%
All cohorts N=60	8 (1-29)	44 (73.3%)	18 (30%)	41 (68.3%)	29 (48.3%)	40/54 (74.1%)	48/54 (88.9%)	86.5%

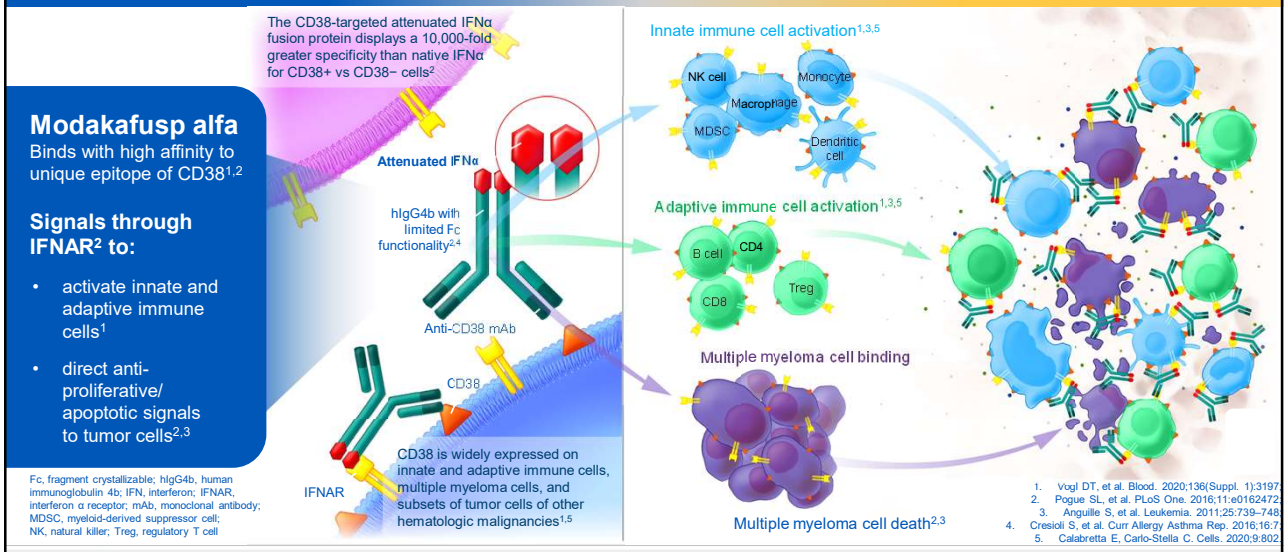
27

MODAKAFUSP ALFA IS A NOVEL, FIRST-IN-CLASS IMMUNOCYTOKINE DESIGNED TO DELIVER IFNA2B TO CD38+ CELLS

Modakafusp alfa
Binds with high affinity to unique epitope of CD38[1,2]

Signals through IFNAR[2] to:

- activate innate and adaptive immune cells[1]
- direct anti-proliferative/ apoptotic signals to tumor cells[2,3]



Fc, fragment crystallizable; hIgG4b, human immunoglobulin 4b; IFN, interferon; IFNAR, interferon α receptor; mAb, monoclonal antibody; MDSC, myeloid-derived suppressor cell; NK, natural killer; Treg, regulatory T cell

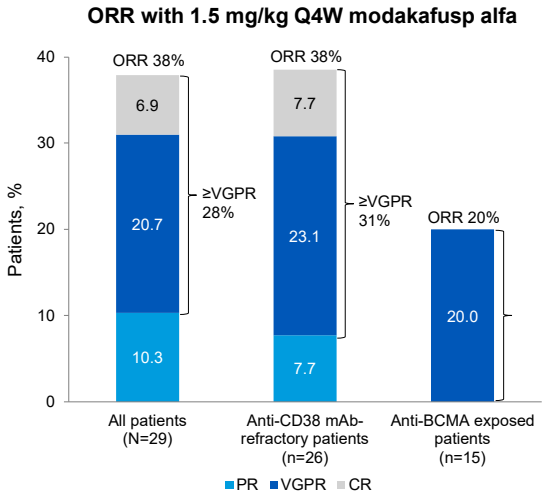
1. Vogl DT, et al. Blood. 2020;136(Suppl. 1):3197
2. Pogue SL, et al. PLoS One. 2016;11:e0162472
3. Anguille S, et al. Leukemia. 2011;25:739–748
4. Cresioli S, et al. Curr Allergy Asthma Rep. 2016;16:7
5. Calabretta E, Carlo-Stella C. Cells. 2020;9:802

American Society of Hematology

Vogl DT, et al. Blood 2021;138(Suppl.1):898

28

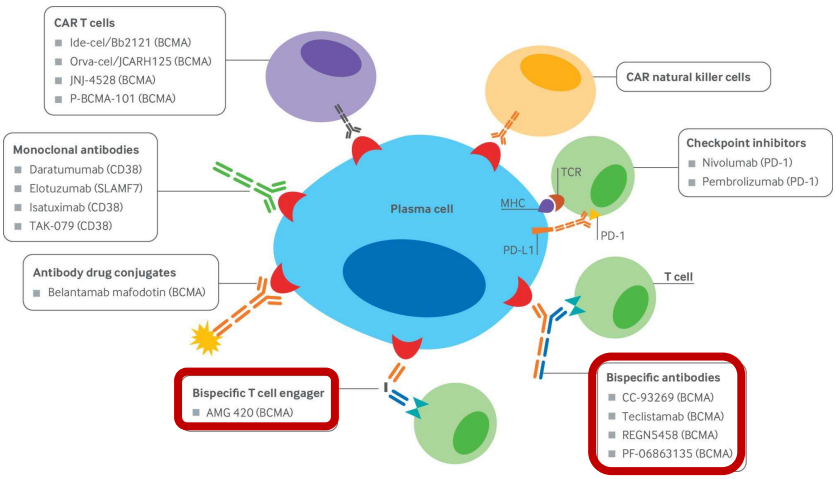
TAK-573: NOVEL ANTI-CD38 AND IFNα (modakafusp-alfa)



- Humanized CD38 that recognize different epitope from daratumumab and isatuximab
- IgG4 with no Fc function
- Attenuated IFNα molecules
  - Induce innate immune response
  - Induce adaptive immune response
- Key eligibility criteria
  - RRMM, ≥3 prior lines of therapy
  - Refractory to at least 1 PI an 1 IMiD
  - Daratumumab washout of 90 days for patients > 5 months of therapy in escalation
  - No daratumumab washout for expansion phase

29

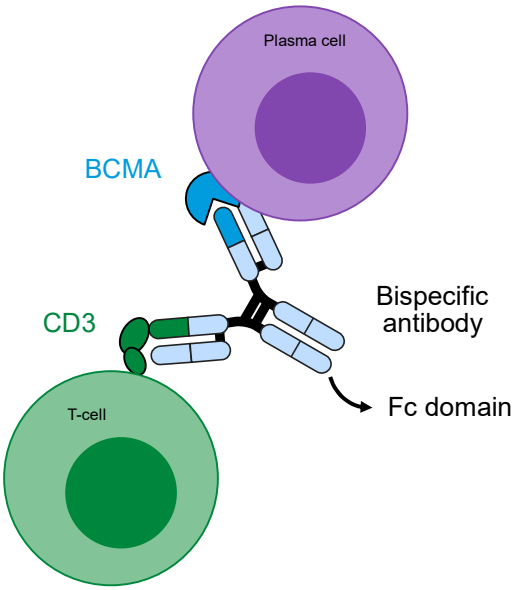
EMERGING IMMUNOTHERAPIES IN MULTIPLE MYELOMA



Shah A, Mailankody S. *BMJ* 2020; 370

30

BISPECIFIC ANTIBODY



31

BISPECIFIC ANTIBODIES

- Novel immune therapy approach designed to bind antigens on MM cells and cytotoxic T cells
- Early phase clinical trials targeting BCMA, GPRC5D, and FcRH5 have shown favorable safety profiles
- Most are IV or subcutaneous injections weekly or every other week
- Therapy is ongoing until progression
- Unknown sequence of therapy if benefit after CAR T

32

THERAPEUTIC BISPECIFIC T-CELL ENGAGERS FOR MM

BCMA / CD3

Drug	Prior lines	ORR (%) @ therapeutic dose	≥ VGPR (%)	G3+ CRS (%)
AMG-701	6	83	50	9
TNB-33B	6	80	73	0
REGN5458	5	62	NR	0
Teclistamab (JNJ-64007957)	5	65	58	0
Elranatamab (PF-06863135)	8	83	66	0
CC-93269	5	89	33	3
Talquetamab (GPRC5D/CD3)	6	70	60	2
Cevostamab (FcRH5/CD3)	6	53 Not RP2D	32	2

Harison ASH 2020, abs 181; Rodriguez ASH 2020, abs 293; Madduri ASH 2020, abs 291; Krishnan ASCO 2021; Bahlis ASCO 2021; Costa ASH 2019, abs 142; Berdeja ASCO 2021, abs 8008; Cohen ASH 2020

33

CEVOSTAMAB: FCRH5 BISPECIFIC ANTIBODY PHASE I STUDY

- FcRH5: Fc receptor homolog 5
- 100% expression on MM cells
- Humanized IgG
- Prior CART, bispecific ab, and ADC allowed
- IV q3 weeks, for 17 cycles
- Cycle 1 step wise dosing

N (%) unless stated	N=53
Any CRS event*	**40 (76)**
Grade 1	18 (34)
Grade 2	21 (40)
Grade 3	1 (2)†
Median time to onset, hours (range)	6–12 (0–6, >48)‡
Any neurological event	**15 (28)**
Grade 1	10 (19)
Grade 2	5 (9)
Median time to onset, hours (range)	12–24 (0–6, >48)‡

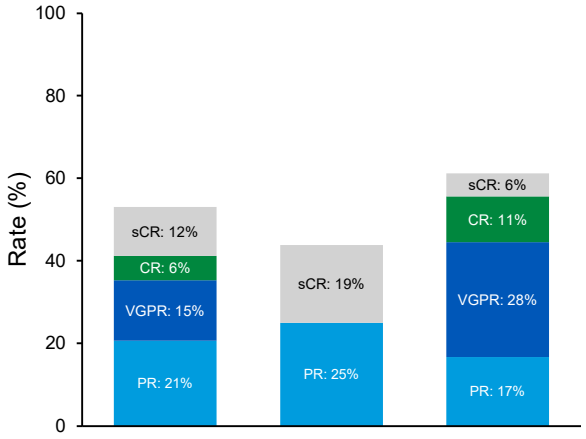
All CRS events resolved with standard of care, tocilizumab (13 pts, 25%) or steroids (9 pts, 17%)

34

CEVOSTAMAB: FCRH5 BISPECIFIC ANTIBODY PHASE I STUDY

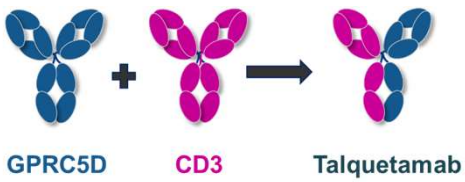
- 51/53 pts efficacy evaluable; no response in ≤3.6/10.8mg cohorts
- ORR* in ≥3.6mg/20mg cohorts
  - 53% (18/34) in all pts
  - 41% (7/17) in penta-drug refractory pts
  - 63% (5/8) in pts with prior anti-BCMA
- Median time to first response/best response: 29.5 days (range: 21–105)/57.5 days (range: 21–272)
- Response irrespective of target expression level in patients assessed to date
- MRD negativity by NGS ($<10^{-5}$) detected in 6/7 evaluable pts with ≥VGPR

Response Rate (%) in ≥3.6/20 mg cohorts



35

TALQUETAMAB: G PROTEIN-COUPLED RECEPTOR CLASS C GROUP 5 MEMBER D (GPRC5D) BISPECIFIC ANTIBODY PHASE I STUDY



- GPRC5D – function unknown
- High expression in MM cells and limited expression in normal human tissue
- Expr in MM cells associated with poor prognosis
- Given subcutaneously

- Eligible patient's intolerant to standard therapies, prior BCMA directed treatments allowed
- Data as of July 2021 – 95 patients received SC talquetamab
- Two doses studied 405 µg/kg weekly, and 800 µg/kg biweekly
- No discontinuations due to AE's at either dose

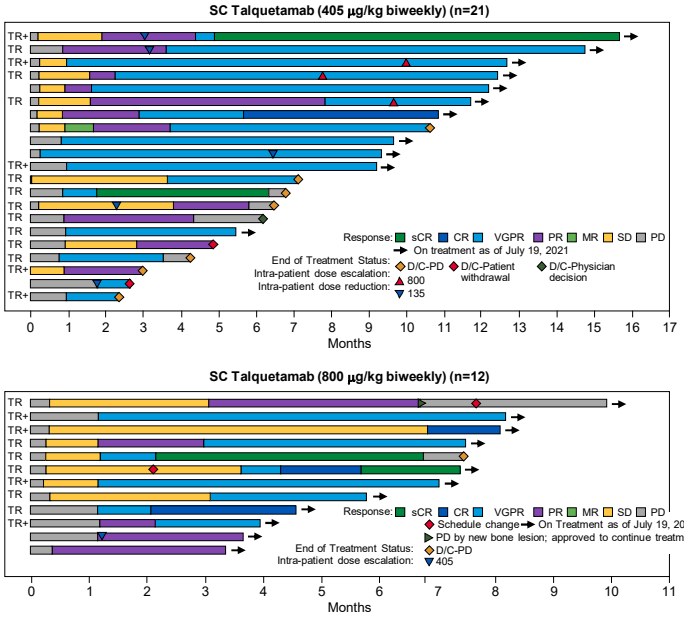
- Common AE's at 405 µg/kg weekly
  - CRS 73%, neutropenia 67%, Dysgeusia 60%, skin changes 77% and infections in 37%
- Common AE's at 800 µg/kg biweekly
  - CRS 78%, dry mouth 44%, neutropenia 44%, skin changes 65% and 17% infections

Redrawn from: Krishnan A et.al. ASH 2021 abstract 158

36

TALQUETAMAB

- 30 evaluable patients at 405 mg/kg weekly dose ORR was 70% (≥VGPR 57%)
- 17 evaluable patients at 800mg/kg biweekly, ORR 71% (≥VGPR 53%)

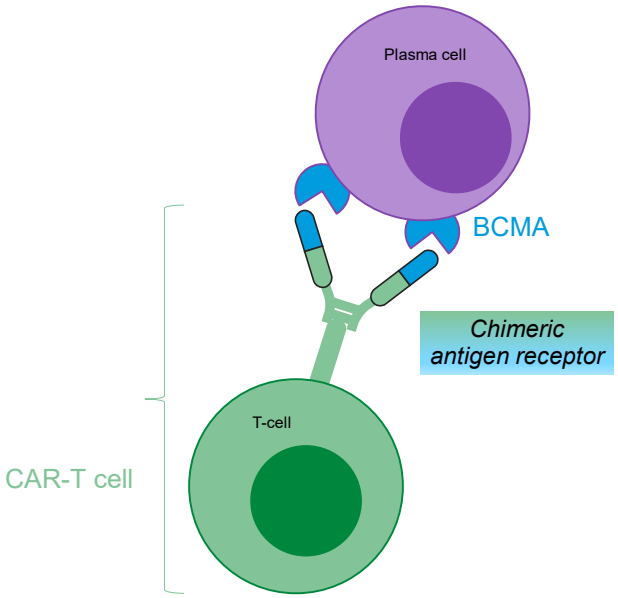


+, penta-drug refractory; CR, complete response; D/C, discontinued: MR, minimal response; PD, progressive disease: PR, partial response; SC, subcutaneous; sCR, stringent complete response; SD, stable disease; TR, triple-class refractory; VGPR, very good partial response

OVERVIEW OF BISPECIFIC ANTIBODIES

- Several targeting BCMA in clinical trials
- Non-BCMA directed antibodies are encouraging
- CRS and neurotoxicity less grade 3, than CAR T cells
- Maximum response and duration of response yet to be determined
- More likely to be an option to combine with other agents

CAR-T CELLS

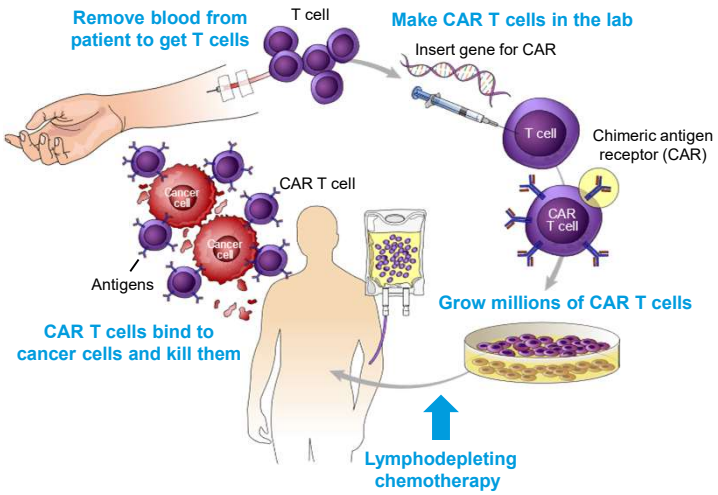


39

CAR T-CELL THERAPY

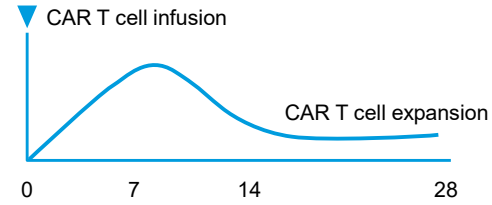
Benefits

- High response rates (~ 75% of patients)
- No maintenance
- No steroids
- Effective even in heavily pretreated or previously refractory patients



40

CAR T CELLS – RISKS



CRS

Neurologic events

May occur within minutes or hours but generally appears within days or weeks

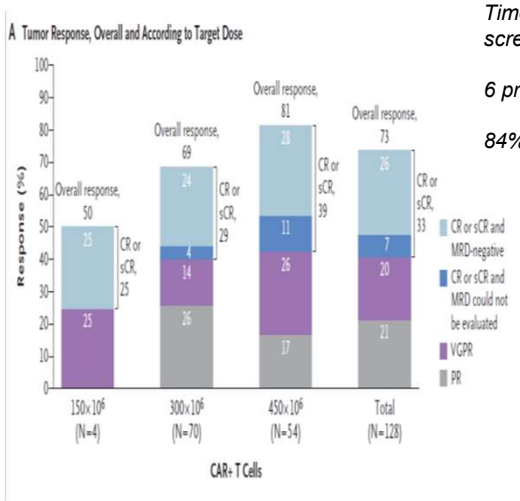
Coincides with maximal T-cell expansion

May need hospital/ICU care

- Cytokine release syndrome (CRS)
  - Fevers, chills
  - Low blood pressure
  - Low oxygen levels
  - Multi-system organ damage
- Neurotoxicity
  - Delirium
  - Loss of ability to speak
  - Inability to write
  - Decreased alertness (obtundation)
  - seizures
- Prolonged cytopenias

41

IDE-CEL REGISTRATION STUDY (KARMMA-1) RESULTS

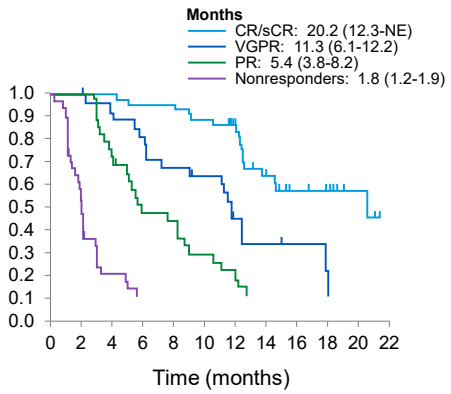


Time from Dx to CART screen: 6 yr (1-17)

6 prior lines of therapy

84% triple refractory

PFS by Response



- Single dose CAR-T with no maintenance therapy
- ORR of 73% and CRR of 33%
- mOS 19.4 mo (95% CI 18.2 – NE)

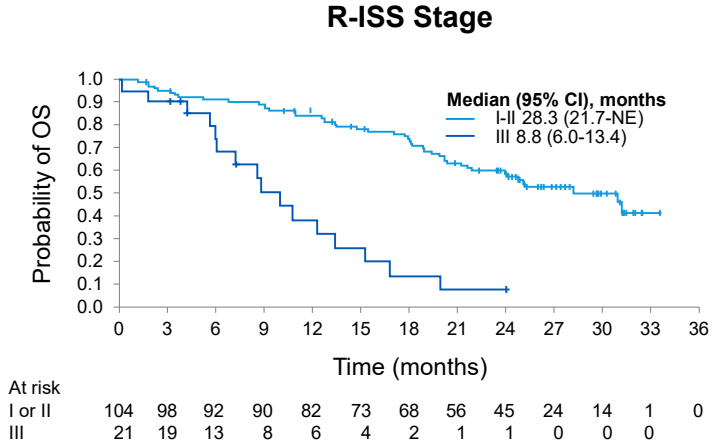
Redrawn from: Munshi NC et al: N Engl J Med 2021;384:705-716.

42

KARMMA-1 STUDY (IDE-CEL) LONG TERM FOLLOW UP

- Overall survival (OS) is not decreased with age, extramedullary disease or triple refractory disease
- OS is decreased by R-ISS stage

FDA approved March 26, 2021

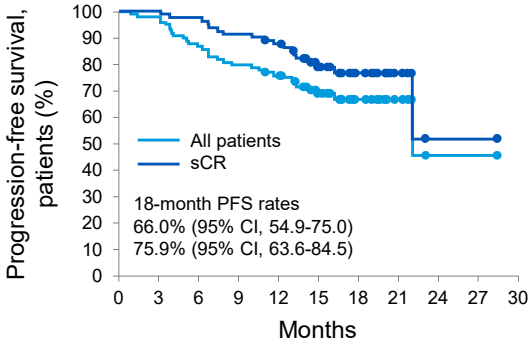


Redrawn from: Anderson L et al. ASCO 2021. Abstr 8016

43

CILTA-CEL (Ciltacabtagene autoleucel; Carvykti) REGISTRATION STUDY CERTITUDE-1

- 3 or more prior lines of therapy
- Triple class exposed
- Median # lines of therapy 6 (4-8)
- Median Follow up 12.4 months
- ORR: 97%; sCR: 67%, MRD sCR: 34%
- 18-month PFS 66%
- 18-month OS 81%



Number at risk

All patients	97	95	85	77	73	55	26	9	1	1	0
Responders with sCR	78	78	76	71	68	51	26	9	1	1	0

Median duration of follow-up: 18 months (range, 1.5-30.5)

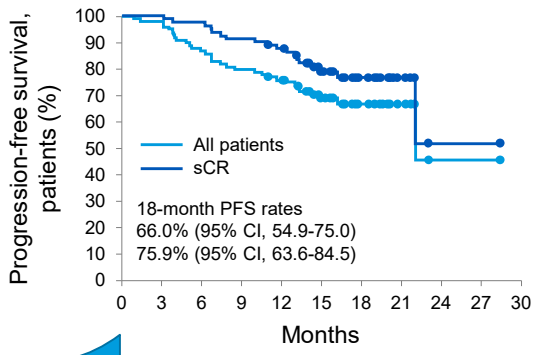
Berdeja, JG. *Lancet.* July 2021

44

CILTA-CEL (Ciltacabtagene autoleucel; Carvykti) REGISTRATION STUDY CERTITUDE-1

- 3 or more prior lines of therapy
- Triple class exposed
- Median # lines of therapy 6 (4-8)
- Median Follow up 12.4 months
- ORR: 97%; sCR: 67%, MRD sCR: 34%
- 18-month PFS 66%
- 18-month OS 81%

FDA Approved Feb. 28, 2022



7 95 85 77 73 55 26 9 1 1 0
8 78 76 71 68 51 26 9 1 1 0

llow-up: 18 months (range, 1.5-30.5)

Berdeja, JG. *Lancet.* July 2021

45

CAR T-CELL THERAPY DATA

	Ide-cel KarMMa-1[1] (N = 128)	Cilta-cel CARTITUDE -1[2] (N = 97)	P-BCMA-101 PRIME[3] (N = 55)	Bb21217 CRB-402[4] (N = 69)	CT053 LUMMICAR-2[5] (N = 20)	Allo-715 UNIVERSAL[6] (N = 31)
ORR	73%	97%	67%	73%	94%	60-67%
CR/sCR	33%	67%		29%	29%	
Durability	mPFS 8.8 mo	12 mo PFS 76%	NA	mDOR 17 mo	NA	NA

1. Munshi NC et al. N Engl J Med 2021;384:705-716. 2. Usmani et al. ASCO 2021, abstr 8005. 3. Costello et al ASH 2020, abstr 134. 4. Alsina et al ASH 2020, abstr 130. 5. Kumar et al. ASH 2020, abstr 133. 6. Mailankody et al. ASH 2020, abstr 129

46

WHY DOES CAR T NOT ALWAYS WORK ?

MM is too aggressive (progresses before infusion)

Patient T cells are less effective

Do not persist long enough

Loss of target by MM cell

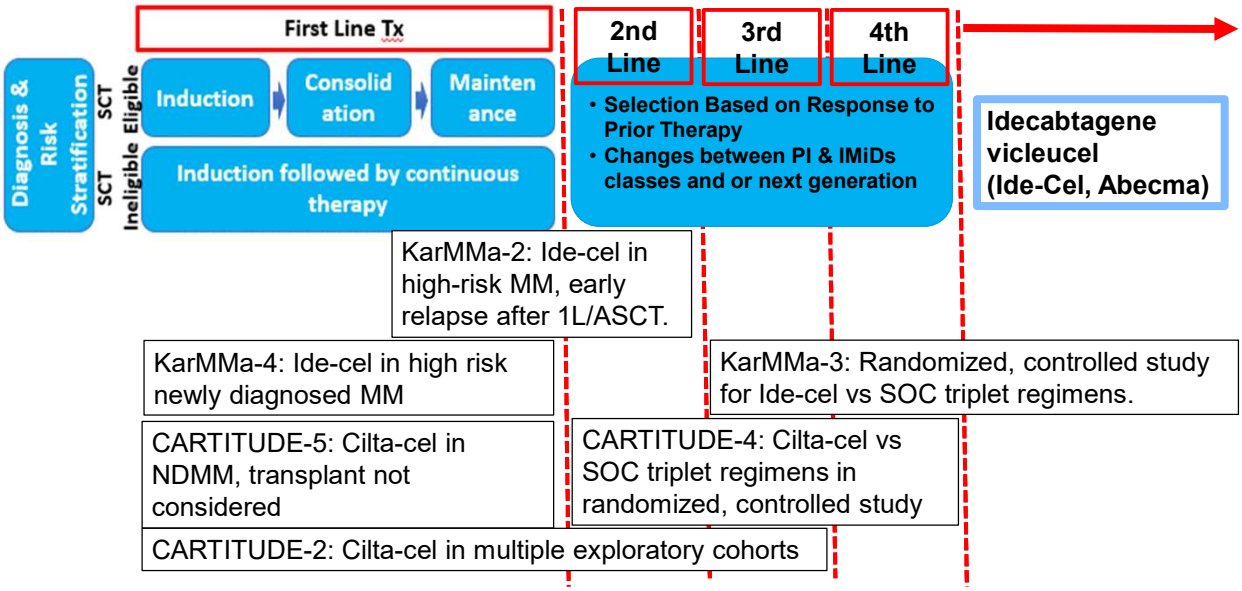
47

FUTURE OF CAR T-CELL THERAPY

- Obtaining T cells earlier in the disease
- Obtain T cells from healthy donors
- Use other targets other than BCMA
- Manufacturing differences, optimize to expedite manufacturing

48

CAR-T INVESTIGATIONS IN EARLIER LINES OF THERAPY



49

7. FUTURE IS BRIGHT

https://www.dreamstime.com/stock-photos-golden-path-bright-future-eps-image5580023

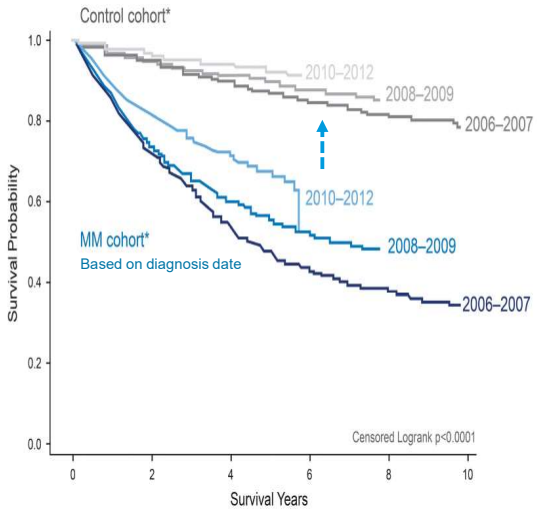
As of today, the FDA has approved for MM 3 naked t-mAb, 1 cargo loaded t-mAb, and 2 CAR-T

Within next year or two, more coming including bi-specific T-cell engagers

Many more novel therapies on the horizon

50

MULTIPLE MYELOMA



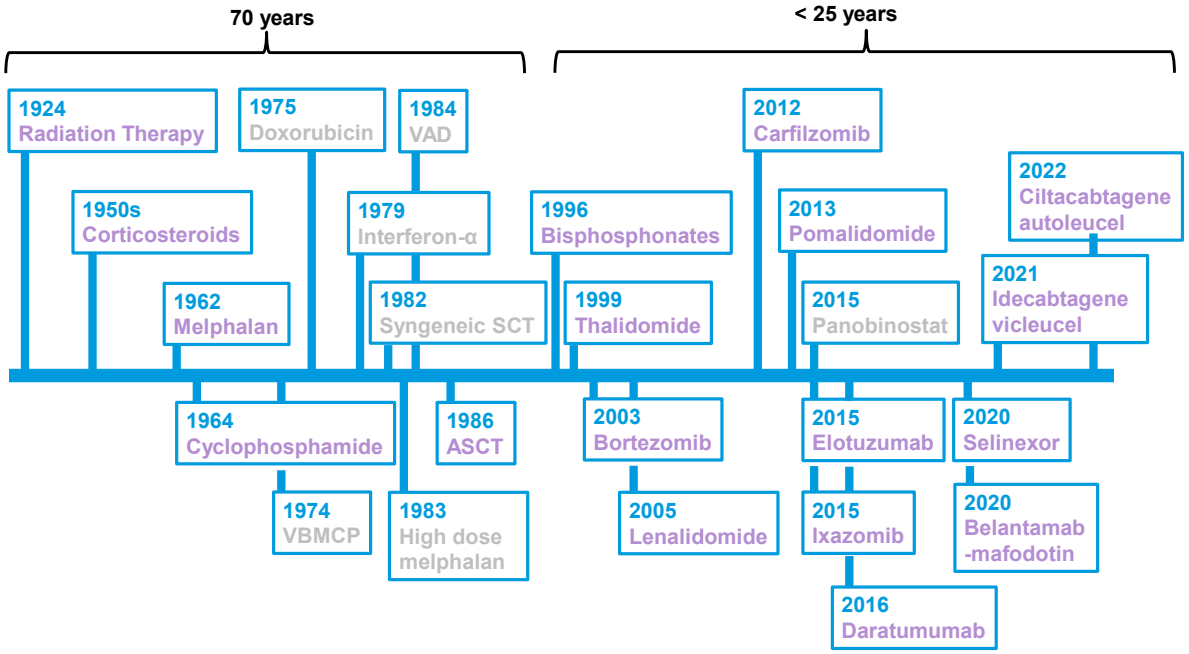
With each passing year, the **difference** between age and gender based expected survival

and survival for patients with multiple myeloma

SHRINKS

Fonseca et al. Leukemia (2017) 1915 – 1921

51



Landmark therapeutic innovations. ASCT, autologous stem cell transplant; VAD, vincristine, doxorubicin, and dexamethasone; VBMCP, vincristine

52

ACKNOWLEDGEMENTS

- Patients
- Multiple Myeloma Awareness®
- The Leukemia & Lymphoma Society®

warsame.rahma@mayo.edu
@RahmaWarsameMD

dispenzieri.angela@mayo.edu

QUESTIONS & ANSWERS

ASK A QUESTION
ADVANCES IN MULTIPLE MYELOMA

Ask a question by phone:

Press star (*) zero (0) on your keypad to ask a question
To remove your question press star (*) 2 on your keypad

Ask a question by web:

Click “Ask a question”
Type your question
Click “Submit”

Due to time constraints, we can only take one question per person.
Once you’ve asked your question, the operator will transfer you back into the audience line.

55

LEUKEMIA & LYMPHOMA SOCIETY®

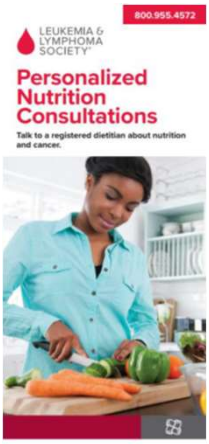
LLS EDUCATION & SUPPORT RESOURCES

HOW TO CONTACT US:

To contact an **Information Specialist** about disease, treatment and support information, resources and clinical trials:

Call: (800) 955-4572
Monday to Friday, 9 a.m. to 9 p.m. ET
Chat live online: www.LLS.org/InformationSpecialists
Monday to Friday, 10 a.m. to 7 p.m. ET
Email: www.LLS.org/ContactUs
All email messages are answered within one business day.

CLINICAL TRIAL SUPPORT CENTER
Work one-on-one with an LLS Clinical Trial Nurse Navigator who will help you find clinical trials and personally assist you throughout the entire clinical-trial process.
www.LLS.org/Navigation



NUTRITION CONSULTATIONS
Our registered dietitian has expertise in oncology nutrition and provides free one-on-one consultations by phone or email.
www.LLS.org/Consult.

LEUKEMIA & LYMPHOMA SOCIETY®

LLS EDUCATION & SUPPORT RESOURCES

Online Chats

Online Chats are free, live sessions, moderated by oncology social workers. To register for one of the chats below, or for more information, please visit **www.LLS.org/Chat**.

Education Videos

View our free education videos on disease, treatment, and survivorship. To view all patient videos, please visit **www.LLS.org/EducationVideos**.

Patient Podcast

The Bloodline with LLS is here to remind you that after a diagnosis comes hope. To listen to an episode, please visit **www.TheBloodline.org**.

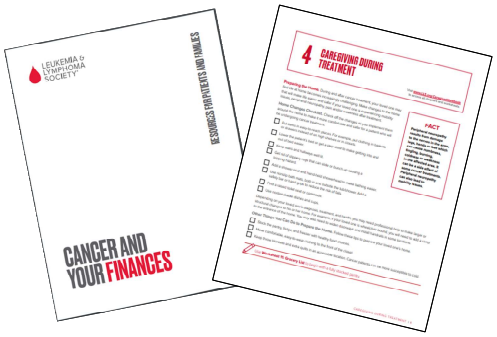
LEUKEMIA & LYMPHOMA SOCIETY

57

57

LLS EDUCATION & SUPPORT RESOURCES

The Leukemia & Lymphoma Society (LLS) offers the following financial assistance programs to help individuals with blood cancers: www.LLS.org/Finances



To order free materials: **www.LLS.org/Booklets**

LEUKEMIA & LYMPHOMA SOCIETY

58

58


THANK YOU
This program is supported by
Bristol Myers Squibb
gsk
LEGEND BIOTECH
Genentech
A Member of the Roche Group
Biogen
oncopeptides
Janssen Oncology
LEUKEMIA & LYMPHOMA SOCIETY
We have one goal: A world without blood cancers