Welcome & Introductions

Dr. Anderson’s slides are available for download at www.LLS.org/programs
Disclosures

Speaker Bureau for Celgene, Amgen, and Takeda

Will discuss off-label use of therapies

Multiple Myeloma Classic Triad

>10% Clonal Plasma Cells
In Bone Marrow

Lytic Bone Lesions
Multiple Myeloma Facts

- 2nd most common Hematologic Malignancy
- ~30,280 people Dx with MM in 2017 in US
- 103,463 people in the US living with MM
- 12,650 MM patients die each year in US
- Median age at Dx ~67 years (only 4% <45)
- Incidence twice as high in African Americans

Multiple Myeloma Facts (cont.)

- More frequent in men (1.3:1)
- bone/back pain, fatigue/anemia or infections
- This disease remains incurable in most patients
- Median survival with older therapies 3yrs, with transplant 5-7 years, and with novel therapies + transplant probably 8-10 years (still improving)
- M protein seen in 99% of cases in serum and/or urine, IgG > 50%, IgA 20-25%, IgE/IgD 1-3%, IgM 1%, light chain only 5-10%, Nonsecretory 1%
Criteria for Diagnosis of Myeloma

**MGUS**
- <3 g/dL M spike
- <10% PC

**Smoldering MM**
- ≥3 g M spike
- OR ≥10% PC

**Symptomatic MM**
- ≥10% PC
- +/- M-spike
- AND
- ≥1 CRAB:
  - Calcium elevation
  - Renal dysfunction
  - Anemia (Hgb <10)
  - Bone lesions

NO CRAB

Ultra High Risk SMM = Active Myeloma

CRAB is now SLiM CRAB

- **S** (60% PCs)
- **Li** (Light chains I/U Ratio >100)
- **M** (MRI >1 focal lesion)
- **C** (calcium elevation)
- **R** (renal insufficiency)
- **A** (anemia)
- **B** (bone disease)

MDE: Myeloma Defining Event

Lancet Oncology 11/2014
These patients DO NOT require treatment!!
(unless on a Clinical Trial).
Many NEVER require treatment!

**Probability of Progression to Active/Symptomatic MM in pts with Smoldering MM or MGUS**

1% per year

10% per year

**REVISED INTERNATIONAL STAGING SYSTEM (R-ISS)**

<table>
<thead>
<tr>
<th>Table 1: Standard Risk Factors for MM and the R-ISS</th>
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<tbody>
<tr>
<td><strong>Prognostic Factor</strong></td>
</tr>
<tr>
<td>ISS stage</td>
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<tr>
<td>II</td>
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<td>III</td>
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<tr>
<td>CA by iFISH</td>
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<td>High risk</td>
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<td>LDH</td>
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<td>Normal</td>
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<td>High</td>
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<td>A new model for risk stratification for MM R-ISS stage</td>
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<td>I</td>
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<td>II</td>
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<td>III</td>
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Abbreviations: CA, chromosomal abnormalities; iFISH, interphase fluorescent in situ hybridization; ISS, International Staging System; LDH, lactate dehydrogenase; MM, multiple myeloma; R-ISS, revised International Staging System.
Management of Active/Symptomatic MM

- Those patients with SLIM-CRAB (Stage II or III Disease) need treatment
- Even Active MM outcomes can vary widely, and there are many treatment options
  - Need to stratify prognosis based on risk factors and whether or not the pt is a stem cell transplant candidate
  - mSmart System

Mayo Stratification of Myeloma and Risk-Adapted Therapy (mSMART.org)

mSMART 3.0: Classification of Active MM

<table>
<thead>
<tr>
<th>High-Risk</th>
<th>Standard-Risk*</th>
</tr>
</thead>
</table>
| FISH<sup>a,b</sup>  
  - Del 17p  
  - t(4;14)  
  - 1q gain  
  - t(14;16)  
  - t(14;20)  
  - RISS Stage 3  
  - High Plasma Cell S-phase<sup>c</sup>  
  - GEP: High risk signature | All others including:  
  - Trisomies  
  - t(11;14)<sup>d</sup>  
  - t(6;14)  
  
As of 5/2018 NO more “Intermediate Risk” Group

*Trisomies may ameliorate
Polling Question #1

How many of you are the following:

A. Myeloma patient on or after treatment
B. MGUS or Smoldering Myeloma patients not needing treatment yet
C. Caregiver or Family of Myeloma patient
D. Healthcare worker (RN, MD, RD, etc)
E. Just interested in Health topics

Major Milestones in Myeloma Therapy

Melphalan-Prednisone  1962
-ABMT  1984
VAD  1986
High-dose Melphalan with autologous stem cell rescue  1996
-Bisphosphonates
High-dose Dexamethasone  1999
Thalidomide  2003
Bortezomib  2005
Lenalidomide

“Era of Novel Agents”
**FDA approvals in Multiple Myeloma**

2005 - 2015

- 2006: Thalidomide
- 2012, 2015: Carfilzomib
- 2015: Panobinostat
- 2007: Doxil + BTZ
- 2013, 2015: Pomalidomide
- 2015: Ixazomib
- 2015: Daratumumab
- 2015: Elotuzumab

10 drugs approved since 2000 !!!
compared to only oral and iv Melphalan from 1960s to 2000

**Therapeutic Algorithms for Newly Diagnosed Patients with Plasma Cell Myeloma**

- **Front line treatment**
  - Induction
  - Consolidation
  - Revi/Dex, RVD, VCD, CTD, VTD, VDD, MPT, MPV, MPR
  - Auto-SCT

- **Maintenance**
  - None
  - Rev: Thalidomide
  - Prednisone
  - Velcade
  - Clinical Trial

- **Relapsed**
  - Whatever worked before or haven’t tried
International Myeloma Working Group
Uniform Response Criteria

**PR:** ≥ 50% reduction in serum M-protein

**VGPR:** > 90% reduction in M-protein

**Near CR:** Negative SPEP/UPEP but POSITIVE Immunofixation
(Faint monoclonal band but too small to quantitate)

**CR:** Negative SPEP AND Negative Immunofixation (serum and urine)

**Stringent CR:** CR + Normalization of free light chain ratio,
abscence of aberrant cells on flow cytometry

**MRD Negative (Molecular Remission):** Using either PCR or
high throughput multicolor flow cytometry to find MM in 1 in
1x10^6 marrow cells

Anything VGPR or better considered a “Deep Remission”


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Getting to Minimal Residual Disease (MRD)

Disease burden

- S.S. Patient
- CR
- Stringent CR
- Molecular/Flow CR
- ?Cure?

Newly diagnosed 1 × 10^{12}

1 × 10^{6}

1 × 10^{4}

0.0
Anti-cancer therapy but NOT traditional chemotherapy (which kills both cancer and healthy cells by attacking cell division)

These drugs target the cancer cells by attacking other pathways besides cell division and are more cancer specific, often less toxic
**Continuous Improvement of Responses**

Stewart et al, Blood 2009

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**Novel Induction Regimens**

SWOG S0777: Phase III Trial of RVd versus Rd in New Dx MM

Primary endpoint: Progression-free survival

Survival Analyses

**PFS**

- Median PFS (RVd vs. Rd)
  - RVd: 43 mo
  - Rd: 30 mo
  - HR: 0.712
  - One-sided p-value: 0.0018

**OS**

- Median OS (RVd vs. Rd)
  - RVd: 75 mo
  - Rd: 64 mo
  - HR: 0.709
  - Two-sided p-value: 0.025

Log-rank P value = 0.0018 (one sided)*

HR = 0.712 (0.560, 0.906)*

Log-rank P value = 0.0250 (two sided)*

* Stratified

High-Dose Chemotherapy With Autologous Stem Cell Transplantation (ASCT)

- Autologous peripheral blood stem cells collected by apheresis, frozen, later used as a “rescue” from marrow ablative effect of high dose chemo

- Introduced in the 1980’s, several randomized trials in the 1990’s and early 2000’s using high dose melphalan and ASCT showed improved PFS and Overall Survival

- Generally see 1-2 year survival increase compared to conventional chemotherapy

- SOC since the 1990’s and remains today (up to age 75)

ASCT vs Conventional Chemotherapy

Lenalidomide Maintenance after Auto SCT, Effect on PFS/OS

Median PFS\(^2\) at Updated Analysis\(^2\) for Maintenance Studies 1 and 2\(^{1,2}\)

**Median Overall Survival for Maintenance Studies 1 and 2\(^{1,2}\)**

- **Median PFS\(^2\) at Updated Analysis\(^2\) for Maintenance Studies 1 and 2\(^{1,2}\)**
  - **REVLIMID vs Placebo**
    - Study 1: 5.7 Years (95% CI 4.4, NE)
    - Study 2: 3.9 Years (95% CI 3.1, NE)
    - Study 3: 2.0 Years (95% CI 1.8, 2.3)

- **Median Overall Survival for Maintenance Studies 1 and 2\(^{1,2}\)**
  - **REVLIMID vs Placebo**
    - Study 1: 9.3 Years (95% CI 8.4, NE)
    - Study 2: 8.8 Years (95% CI 7.4, NE)

*The individual studies were not powered to evaluate OS*
Effect of Novel Agents on Survival in Newly Diagnosed MM

MM Survival is Improving With Novel Agents
Projected Survival in MM

If 1 Works Well, Why Not 2 Tandem Transplants?

STaMINA: Phase III Study Design

- Primary endpoint: PFS at 38 mos
- Secondary endpoints: OS, ORR, CR conversion rate, safety, infections, tx-related mortality, QoL

Staudtman E, et al. ASH 2016. Abstract LBA-1
If 1 Works Well, Why Not 2 Tandem Transplants?

STaMINA: PFS and OS for Overall Population

**PFS (Primary Endpoint)**
- **38-Mo Estimate (95% CI)**
  - Tandem ASCT: 58.5 (69.4-62.6)
  - RVD consolidation: 56.7 (50.0-62.8)
  - Single ASCT: 52.2 (45.4-58.6)

**OS**
- **38-Mo Estimate (95% CI)**
  - Tandem ASCT: 82.0 (78.5-86.5)
  - RVD consolidation: 85.7 (80.5-89.5)
  - Single ASCT: 83.4 (77.9-87.7)


If 1 Works Well, Why Not 2 Tandem Transplants?

STaMINA: PFS and OS for Pts With High Risk

**PFS**
- **38-Mo Estimate (95% CI)**
  - Tandem ASCT: 42.2 (28.5-55.3)
  - RVD consolidation: 49.3 (34.9-60.5)
  - Single ASCT: 40.2 (27.1-53.0)

**OS**
- **38-Mo Estimate (95% CI)**
  - Tandem ASCT: 79.3 (66.1-88.2)
  - RVD consolidation: 77.5 (64.3-86.4)
  - Single ASCT: 79.5 (65.8-88.1)

Early vs Delayed Auto SCT

Should I get a transplant after induction therapy or should I wait until after I relapse? Ongoing Clinical Trial (IFM/DFCI)

- Better/deeper response rates with early transplant
- Longer remissions when transplant done early (43 months vs 34 months)
- Overall survival at 4 years was not significantly different so delaying doesn’t compromise long-term outcome
- Continuous therapy with maintenance until progression to be addressed by US study

Early vs Delayed Auto SCT?

The NEW ENGLAND JOURNAL of MEDICINE

Lenalidomide, Bortezomib, and Dexamethasone with Transplantation for Myeloma
Attal M et al

A Progression-free Survival

Transplantation

RVD alone

Patients [%]

0 25 50 75 100

0 12 24 36 48 Months of Follow-up

P<0.001
Is there a Subgroup that Benefits more from early SCT?

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Transplantation</th>
<th>RVD Alone</th>
<th>Hazard Ratio (95% CI) for Progression or Death</th>
<th>P Value for Interaction</th>
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<tbody>
<tr>
<td>Age</td>
<td></td>
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<tr>
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<td>55/136</td>
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<td>Light chain</td>
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<td>60/115</td>
<td>44/118</td>
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<td>II</td>
<td>107/170</td>
<td>81/171</td>
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<td>III</td>
<td>44/65</td>
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<td>Cytogenetic risk at screening</td>
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<tr>
<td>Standard risk</td>
<td>122/212</td>
<td>83/213</td>
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<td></td>
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<tr>
<td>High risk</td>
<td>32/44</td>
<td>31/46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test failure</td>
<td>57/94</td>
<td>43/91</td>
<td></td>
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</tbody>
</table>

IFM-DFCI 2009: PFS by MRD Before Maintenance Therapy

- **MRD by FCM (10^-4)**
  - 51% of pts MRD negative by FCM were MRD positive by NGS, with similar trends in PFS by NGS MRD status
  - 13 of 26 pts with t(4;14) achieved MRD negativity; none with del(17p)

- **MRD by NGS (10^-6)**
  - P < .0001

Triplet Carfilzomib/Len/Dex (KRd) vs Len/Dex (Rd) at Relapse

Improved ORR, CR, PFS, and Overall Survival with KRd vs Rd

- AEs consistent with previous studies; no unexpected toxicities observed


4 Recently Approved Therapies

- New Proteasome Inhibitors (ORAL)
  - Ixazomib (Ninlaro) – weekly pill combined with Rev/Dex in relapsed pts (Triple Oral Therapy with less PN!!)
- New IMIDs (Oral, More potent, less toxic)
  - Pomalidomide - 30% Response in Rev and Vel-Refractory pts (FDA approved 2/2013)
- Monoclonal Antibodies targeting PCs
  - Daratumumab (mAb targeting CD38), single agent responses 29%, combined with Imid OR Velcade 83-93% (initially 4th line but now 2nd line therapy as triple Rx!)
  - Elotuzumab (Anti-CS1/SLAMF7) ~ 80% Response in Relapsed pts combined with Rev/dex but not alone (activates NK cells)
Monoclonal Antibodies for MM

Monoclonal Antibody therapy for relapsed Myeloma
Combinations can induce deep molecular remissions

Elotuzumab in MM
Mechanism of Action

Mechanisms of action: Elotuzumab enhances Natural Killer cell activation (directly) via SLAMF7
indirectly via CD16) and targeted killing of SLAMF7-expressing malignant plasma cells by
antibody-dependent cellular cytotoxicity.

POLLUX Extended Follow-up: Study Design. (DRd vs Rd at Relapse)

- Multicenter, open-label, randomized phase III trial

Stratified by number of previous lines of therapy, ISS stage at entry, previous lenalidomide use

R/R MM pts with previous use of ≥ 1 line of therapy* and CrCl ≥ 30 mL/min
(N = 569)

Daratumumab + Lenalidomide + Dexamethasone (DRd)
(n = 286)

Lenalidomide + Dexamethasone (Rd)
(n = 283)

Pts treated until PD

*Pts eligible if lenalidomide experienced but not lenalidomide refractory.
Dosing (28-day cycles): daratumumab 16 mg/kg IV QW in cycles 1-2, Q2W in cycles 3-6, and then every 4 wks;
lenalidomide 25 mg PO on Days 1-21; dexamethasone 40 mg PO QW.

Dara/Rev/dex vs Rev/dex (Pollux) Progression Free Survival

- 12-mo PFS*: 83%
- 18-mo PFS*: 78%
- DRd line
- Rd line
- Median PFS: 16.4 mos

HR: 0.37 (95% CI: 0.27-0.52; P < .0001)

63% reduction in the risk of disease progression or death for DRd vs Rd


Can We Move Dara to Frontline Therapy?

MMY2004. A randomized, phase II study of Revlimid, Velcade, and dexamethasone (RVD) with or without Daratumumab in Newly Diagnosed MM

- Induction
- Transplant
- Consolidation
- Maintenance

Randomization
- N=300
- RVD x4
- Stem cell Transplant
- RVD x2
- Revlimid maintenance

- N=100
- RVD + Daratumumab x4
- Stem cell Transplant
- RVD + Dara x2
- Revlimid + Dara maintenance

All patients get standard of care RVD and half get to add Daratumumab up front that is otherwise not available until relapse

ONGOING STUDY, NO DATA YET
**ALCYONE: Open-Label, Phase III Study Design**

**Dara/MPV vs MPV**

- **Frontline in Spain**

**Stratified by ISS (I vs II vs III), region (EU vs other), age (<75 yrs vs ≥ 75 yrs)**

- **Transplant-eligible pts with NDMM, ECOG PS ≤ 2, CrCl ≥ 40 mL/min, no PN grade ≥ 2** (N = 706)

- **Dara/MPV**
  - Daratumumab 16 mg/kg IV QW in cycle 1 then Q3W in cycles 2-9
  - VMP* x 9 cycles (n = 350)

- **MPV**
  - VMP x 9 cycles (n = 356)

- **Follow-up for PD and survival**

*VMP: bortezomib 1.3 mg/m² SC twice weekly in cycle 1, QW in cycles 2-9; melphalan 9 mg/m² PO Days 1-4; prednisone 60 mg/m² PO Days 1-4.

Cycles 1-9; 6 wk cycles


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**Dara/MPV vs MPV**

**Responses and MRD**

**ORR**

- ORR: 74% (VMP n = 356), 91% (Dara-VMP n = 350)

- \( P < .0001 \)

- ≥ CR: 24% (VMP), 43% (Dara-VMP)

- ≥ VGPR: 50% (VMP), 71% (Dara-VMP)

**MRD-Negative Rate**

- Next-generation sequencing with 10^4 threshold

- 3.6X 22

- \( P < .0001 \)

- Significantly higher ORR, ≥ VGPR, and ≥ CR with Dara-VMP

- > 3-fold higher MRD-negativity rate with Dara-VMP

June 13, 2018

Dara/MPV vs MPV Progression Free Survival

**ALCYONE: PFS**

- Consistent PFS benefit across subgroups

More Infections in Dara/MPV (23% vs 14%) but only 1.4% stopped due to infections

Now FDA Approved Frontline but we don’t use Mel in US so limited use

FDA Approved CAR-T Therapies

A New Era of Immunotherapy

Tisagenlecleucel (Kymriah; Novartis)
- Acute Lymphoblastic Leukemia (< 25 yrs of age)
- Price: $475,000

Axicabagene ciloleucel (Yescarta; Kite Pharma)
- Non-Hodgkins Lymphoma
- Price: $373,000
What are CAR T Cells?
Chimeric Antigen Receptor T Cells

- **Chimera** – Greek Mythology = Monster with Lion’s head Part Antibody, Part T Cell Receptor Signaling domains
- **Antigen**
- **Receptor**
  - CAR – Engineered Receptor Added to surface of T cells Recognizes specific target antigen on cancer cells
  - Re-engineered T cells are forced to recognize the cancer cells and kill them

CAR Design: Critical Elements of T-Cell Activation and Function in a Single Molecule

CAR T cells are genetically altered to express CAR on the cell surface.

**T Cell Receptor**
- APC
- pMHC
- TCR
- CD3ζ

**Chimeric Antigen Receptor**
- scFv: recognize tumor surface proteins
- Costimulatory Signal 2: CD28 or 4-1BB or OX40
- Essential Signal 1: CD3ζ

Activation independent of MHC Limited to cell surface proteins
Redirecting T-Cell Specificity with Chimeric Antigen Receptor (CAR) T-Cell Therapy

- Gene transfer technology stably expresses CARs on T cells\(^1,2\)
- Takes advantage of the cytotoxic potential of T cells, killing tumor cells in an antigen-dependent manner\(^1,3\)
- Persistent CAR T cells consist of both effector (cytotoxic) and central memory T cells\(^3\)
- T cells are non-cross resistant to chemotherapy

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BCMA as a Target for Myeloma CAR T-Cell Therapy

- **BCMA**: B Cell Maturation Antigen
- Receptor expressed on Myeloma tumor cells, nonmalignant plasma cells, and some late stage mature B-cells
- Cell lineage specific so avoids off target toxicity

CAR T-Cell BCMA Phase 1 Studies in Myeloma

- 4 Phase 1 Studies presented: NIH, U Penn, Chinese, and Bluebird Bio
- LBA3001 ASCO 2017, Fan et al: 100% ORR, 33/35 patients in remission at 2 mo
- U Penn also promising with high ORR, Cohen et al, ASH ’16 6 out of 9 responses in U Penn
  My pt WW is pt #1, in CR at 29 months
- NCI CART-BCMA, Ali et al, Blood 2016, 3 out of 6 at higher dose levels had either VGPR or CR
- BlueBird Bio (Celgene) BB2121 ASH ’17, Berdeja et al 94% ORR, 56% CR. (out of 12 pts with over 150x10^6)
- FDA Breakthrough Designation for BlueBird Bio CAR T on 11/17/17
- UTSW participating in Phase 2 KarMMa Study (1 out of 9 sites in US and only site in Tx, 1st infusion 3/19/18, 7 infused and 9 enrolled already)
NCI Anti-BCMA CAR T Therapy Pt


Phase 1 BB2121
BlueBird Bio/Celgene CRB-401

Depth of Response to BB2121

- Responses continued to deepen in pts receiving 150-800 x 10^6 CAR T-cells
- over median follow-up of 40 wks
- Progression independent of tumor burden, bb2121 dose, CRS, bb2121 persistence (N = 4)

Responses in BB2121 Phase 1

CRB-401: Tumor Response to bb2121

- ORR: 94% (CR: 56%)
- MRD neg: 9 of 10 evaluable pts
- 5 patients with ongoing responses > 1 yr
- Responses continue to improve as late as Month 15 (VGPR to CR)

BB2121 Phase 1 Conclusions

- Investigators conclude that bb2121 confers deep, durable responses at active doses (150-800 x 10^6 CAR T cells) in heavily pretreated pts with R/R MM
  - ORR: 94%, ≥ VGPR: 89%, CR: 56%
  - 90% of evaluable pts MRD negative at 40 wks of follow-up
- Safety profile of bb2121 manageable up to 800 x 10^6 CAR T-cell dose
  - 2 cases of grade 3 CRS during dose escalation; resolved within 24 hours
  - 1 case of delayed, reversible grade 4 neurotoxicity during dose expansion associated with TLS and CRS in patient with highest tumor burden
- Global phase II KarMMA trial evaluating bb2121 at doses of 150-300 x 10^6 CAR T-cells open for enrollment (NCT03361748)

CAR T Future Directions

• This is a new Era of exciting treatment options for Hematologic Malignancies. Some diseases that never had an option for a cure may now have that option (Myeloma, FL, Chemo-refractory ALL/DLBCL)
• Solid Tumor CARs are on the horizon (prostate, etc)
• Antigen Escape:
  • Infusion of 2 different CAR T products (CD19 and CD22, etc)
  • Tandem CAR that recognizes 2 different targets from same CAR
• Lack of persistence of CAR T-Cells:
  • Reinfusion after loss
  • Isolation of Central Memory T-Cells with self renewal capacity
• Lack of Efficacy:
  • TRUCKs (T-cells redirected for universal cytokine-mediated killing) (IL-12)
  • Earlier therapy (after induction, after SCT, ? Instead of SCT)
• Cost and Availability: Off the shelf CAR T-Cells
• Insertional mutagenesis: Working on CRISPR instead of viral gene insertion
• Toxicity of CRS: Pre-emptive anti-IL-6 mAb infusion with rise of CRP or ferritin?

Venetoclax/Carfilzomib/Dex in R/R MM

A Phase II Trial of Venetoclax, Carfilzomib, and Dexamethasone for Relapsed/Refractory Myeloma

• VenKd associated with no new safety signals in patients with R/R MM[1]
• Investigators selected carfilzomib at 70 mg/m² once weekly for combo
• Preliminary data suggest VenKd active in R/R MM (ORR: 83%)[1]
  • Highest ORR observed in subgroup with t(11;14)
  • ORR similar for patients with high-risk vs standard-risk cytogenetics
• Investigators concluded that interim results suggest VenKd well tolerated and with promising efficacy, justifying ongoing study in R/R MM[1]

Conclusions

- No new MM drugs approved for 4 decades from the 60’s until 2000s but 10 approved since then
- Survival is Improving in Myeloma with combinations of Novel Agents (triple therapy), Auto SCT, and maintenance therapy over the past decade
- Adding Antibodies may allow deeper responses up front without much added toxicity of 4 drug regimens
- Although we have effective therapies, all MM pts relapse and become refractory to all therapies, so we need more
- Combinations of these new drugs can often make Myeloma a controllable chronic disease but ongoing studies using immunotherapy (Up front Darzalex and CAR-T) may be approaching a cure

Polling question #2

I find that these Webinars are:

A. Helpful to stay up to date on Emerging Treatment Options
B. Too complicated to be useful
We have seen many changes in therapy of Myeloma over the past few years and many more are expected to come!

#WeightWatchers, Walking, and jogging
#73 pounds down so far

Q&A Session

**Ask a question by phone:**
- Press star (*) then the number 1 on your keypad.

**Ask a question by web:**
- Click green “Q&A” box in lower left corner
- 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.
The Leukemia & Lymphoma Society Offers:

• Information Specialists: Master’s level oncology professionals available to help cancer survivors navigate the best route from diagnosis through treatment, clinical trials and survivorship.
  ➢ TOLL-FREE PHONE: 1-800-955-4572
  ➢ EMAIL: infocenter@LLS.org

• Free Education Booklets:
  ➢ www.LLS.org/booklets

• Free Telephone/Web Programs:
  ➢ www.LLS.org/programs

• Live, weekly Online Chats:
  ➢ www.LLS.org/chat

• LLS Podcast, The Bloodline with LLS: Listen in as experts and patients guide listeners in understanding diagnosis, treatment, and resources available to blood cancer patients: www.LLS.org/thebloodline

• Education Video: Free education videos about survivorship, treatment, disease updates and other topics: www.LLS.org/educationvideos

• Information on myeloma: For information about myeloma, visit www.LLS.org/myeloma

• Patti Robinson Kaufmann First Connection Program: Peer-to-peer program that matches newly diagnosed patients and their families: www.LLS.org/firstconnection

• Free Nutrition Consults: Telephone and email consultations with a Registered Dietitian: www.LLS.org/nutrition

• What to ask: Questions to ask your treatment team: www.LLS.org/whatask

• Support Resources: LLS Community, blogs, support groups, financial assistance and more: www.LLS.org/support
THANK YOU FOR PARTICIPATING!

We have one goal: A world without blood cancers