Welcome & Introductions

Dr. Anderson's slides are available for download at

www.LLS.org/programs

Emerging Therapies for Multiple Myeloma

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Emerging Therapies for Multiple Myeloma

Larry D. Anderson, Jr, MD, PhD
Associate Professor of Internal Medicine
Director of Myeloma, Waldenström's, and Amyloidosis Program
Attending, Hematologic Malignancies/Blood and Marrow Transplantation Program
UT Southwestern Medical Center
Simmons Comprehensive Cancer Center
Dallas, TX

Emerging Therapies for Multiple Myeloma

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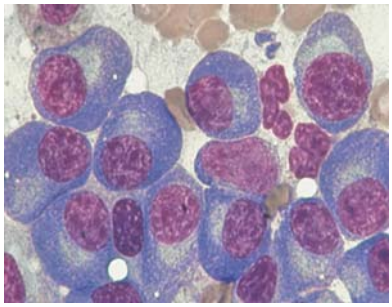
Disclosures

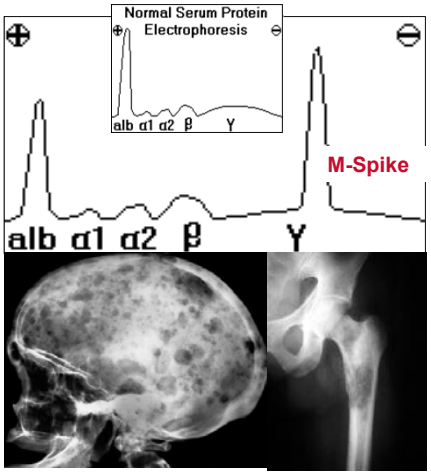
Speaker Bureau for Celgene, Amgen, and Takeda

Will discuss off-label use of therapies

Multiple Myeloma Classic Triad



>10% Clonal Plasma Cells
In Bone Marrow



Lytic Bone Lesions

Multiple Myeloma Facts

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- 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.)

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- 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

AND

NO CRAB

Symptomatic MM

≥10% PC
+/- M-spike

AND

≥ 1 CRAB:
Calcium elevation,
Renal dysfunction
Anemia (Hgb <10)
Bone lesions

Ultra High Risk SMM = Active Myeloma

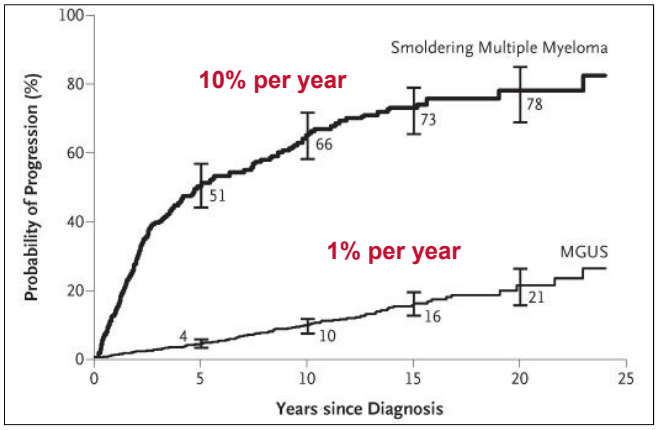
CRAB is now SLiM CRAB

- **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

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



These patients DO NOT require treatment!!
(unless on a Clinical Trial).
Many NEVER require treatment!

Kyle RA et al. N Engl J Med 2007;356:2582-2590

REVISED INTERNATIONAL STAGING SYSTEM (R-ISS)

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Table 1. Standard Risk Factors for MM and the R-ISS

Prognostic Factor	Criteria
ISS stage	
I	Serum β_2-microglobulin < 3.5 mg/L, serum albumin ≥ 3.5 g/dL
II	Not ISS stage I or III
III	Serum β_2-microglobulin ≥ 5.5 mg/L
CA by iFISH	
High risk	Presence of del(17p) and/or translocation t(4;14) and/or translocation t(14;16)
Standard risk	No high-risk CA
LDH	
Normal	Serum LDH < the upper limit of normal
High	Serum LDH > the upper limit of normal
A new model for risk stratification for MM	
R-ISS stage	
I	ISS stage I and standard-risk CA by iFISH and normal LDH
II	Not R-ISS stage I or III
III	ISS stage III and either high-risk CA by iFISH or high LDH

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)

MAYO CLINIC

mSMART 3.0: Classification of Active MM

High-Risk

- FISH[a,b]
  - Del 17p
  - t(4;14)
  - 1q gain
  - t(14;16)
  - t(14;20)
- RISS Stage 3
- High Plasma Cell S-phase[c]
- GEP: High risk signature

Standard-Risk[a]

All others including:

- Trisomies
- t(11;14)[d]
- t(6;14)

As of 5/2018 NO more "Intermediate Risk" Group

[a]Trisomies may ameliorate

Polling Question #1

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How many of you are the following:

A. Myeloma patient on or after treatment

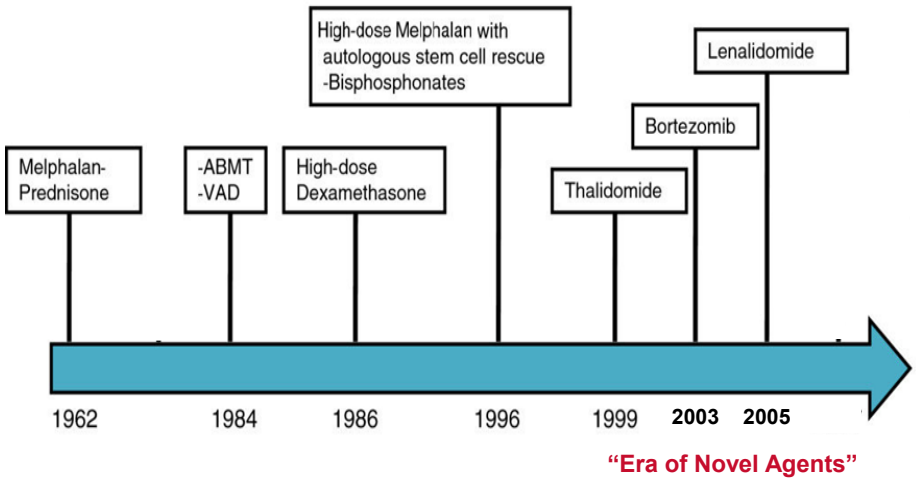
B. MGUS or Smoldering Myeloma patients not needing treatment yet

C. Caregiver or Family of Myeloma patient

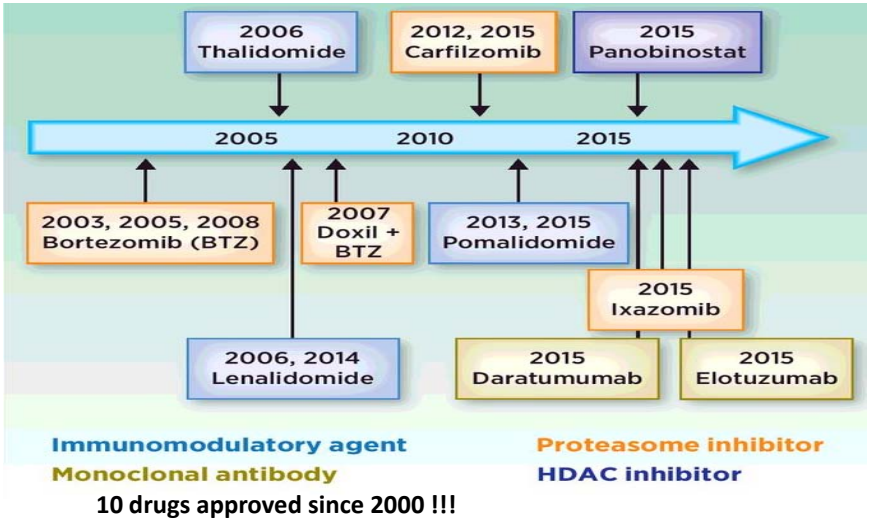
D. Healthcare worker (RN, MD, RD, etc)

E. Just interested in Health topics

Major Milestones in Myeloma Therapy

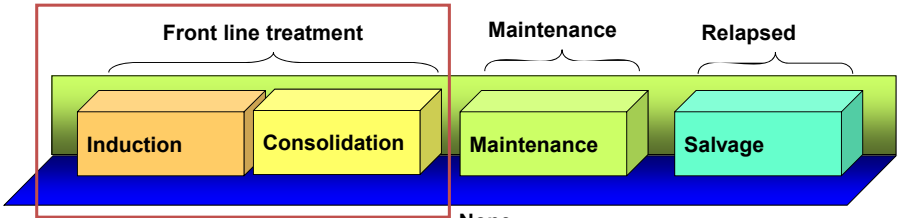


FDA approvals in Multiple Myeloma



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



Rev/Dex,
RVD, VCD
CTD, VTD, VDD,
MPT, MPV, MPR

Auto-SCT

None
Rev
Thalidomide
Prednisone
Velcade
Clinical Trial

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)

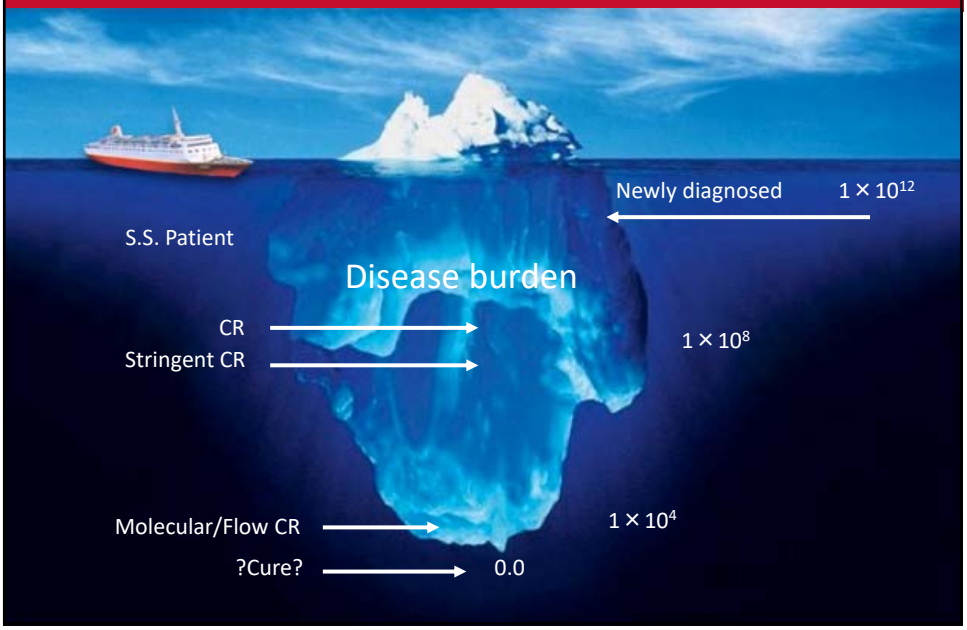
Stringent CR: CR + Normalization of free light chain ratio, absence of aberrant cells on flow cytometry)

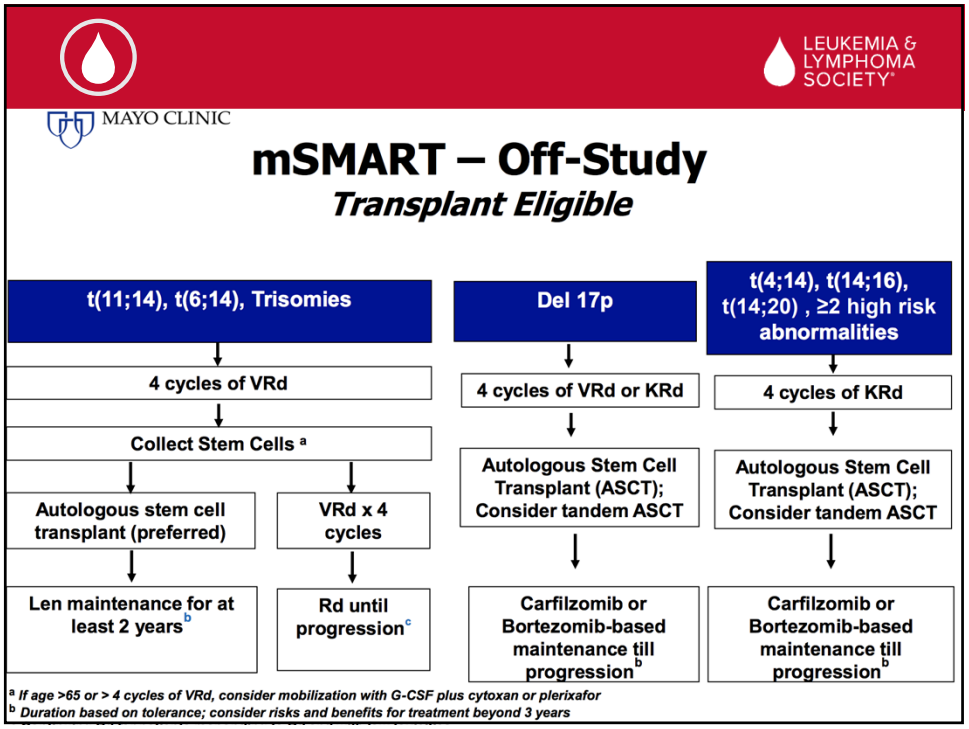
MRD Negative (Molecular Remission): Using either PCR or high throughput multicolor flow cytometry to find MM in 1 in 1x10^6 marrow cells

Anything VGPR or better considered a "Deep Remission"

Durie BGM, et al. Leukemia. 2006;20:1467-1473.

Getting to Minimal Residual Disease (MRD)





Novel Therapies

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- 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

Novel Induction Regimens

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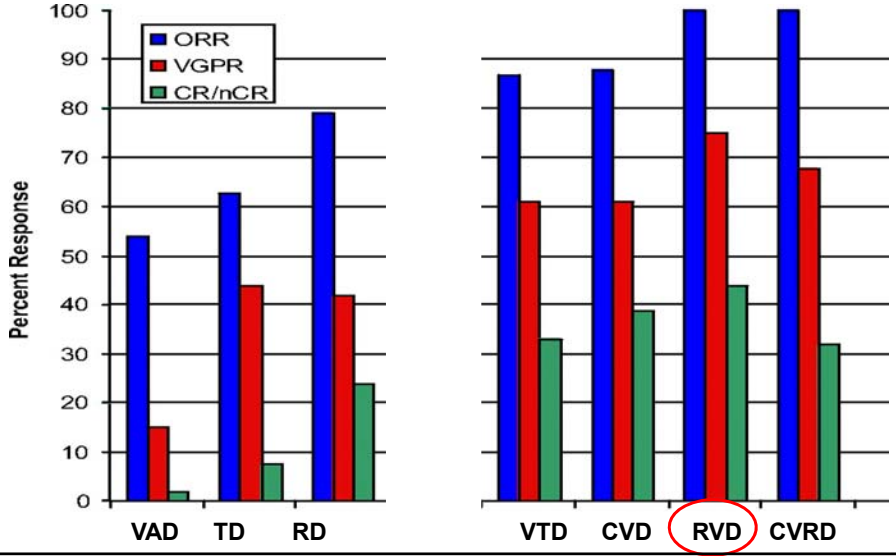
Continuous Improvement of Responses

Stewart et al, Blood 2009



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

Eligibility (N = 525)

- Previously untreated NDMM
- Immediate ASCT not intended

R

RVd
8 cycles of 21 days each

Rd
6 cycles of 28 days each

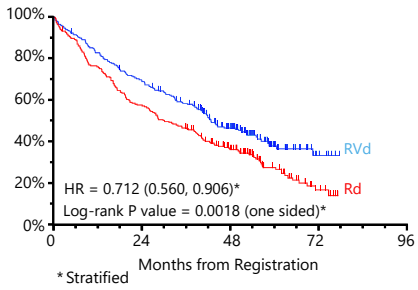
Rd maintenance until toxicity or withdrawal

Primary endpoint: Progression-free survival

Durie B et al. *Proc ASH* 2015;Abstract 25.

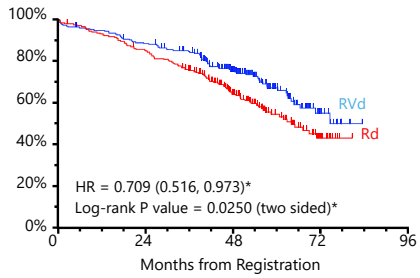
Survival Analyses

PFS



* Stratified

OS



	RVd (n = 242)	Rd (n = 229)	HR	One-sided *p*-value
Median PFS	43 mo	30 mo	0.712	0.0018

	RVd (n = 242)	Rd (n = 229)	HR	Two-sided *p*-value
Median OS	75 mo	64 mo	0.709	0.025

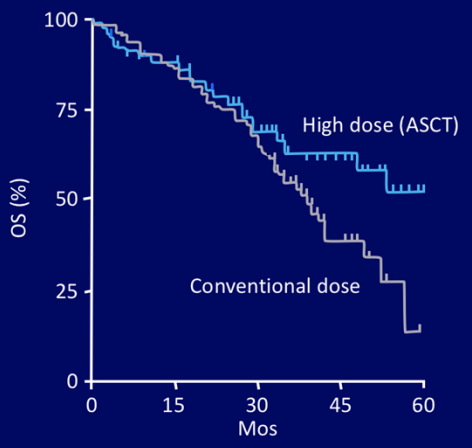
Durie B et al. *Proc ASH* 2015;Abstract 25.

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

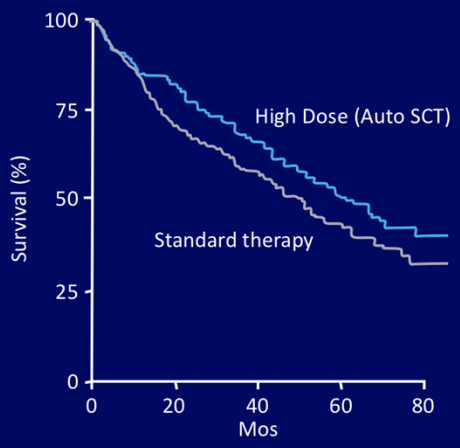
- **Autologous peripheral blood stem cells collected by apheresis, frozen, later used as a "rescue" from marrow ablative effect of high dose chemo**
- **Introduced in the 1980's, several randomized trials in the 1990's and early 2000's using high dose melphalan and ASCT showed improved PFS and Overall Survival**
- **Generally see 1-2 year survival increase compared to conventional chemotherapy**
- **SOC since the 1990's and remains today (up to age 75)**

Attal M, et al. N Engl J Med 1996;335:91-7. Child JA, et al. N Engl J Med 2003:1875-83.

ASCT vs Conventional Chemotherapy

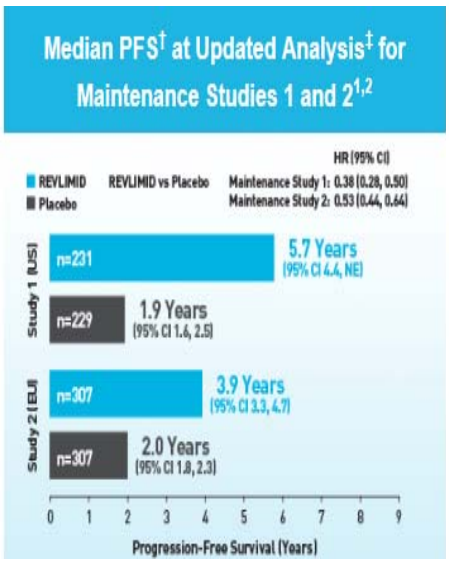


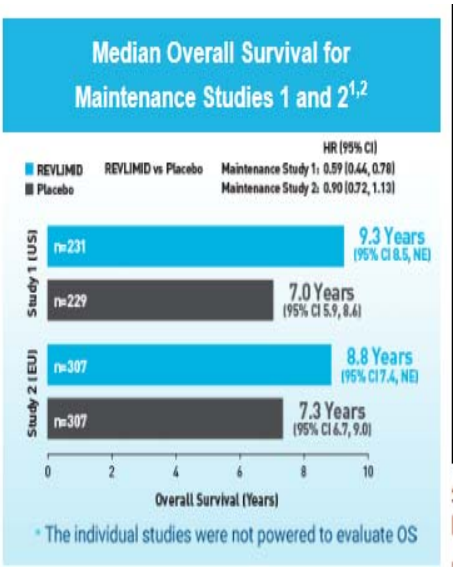
Attal M, et al. N Engl J Med. 1996;335:91-97.



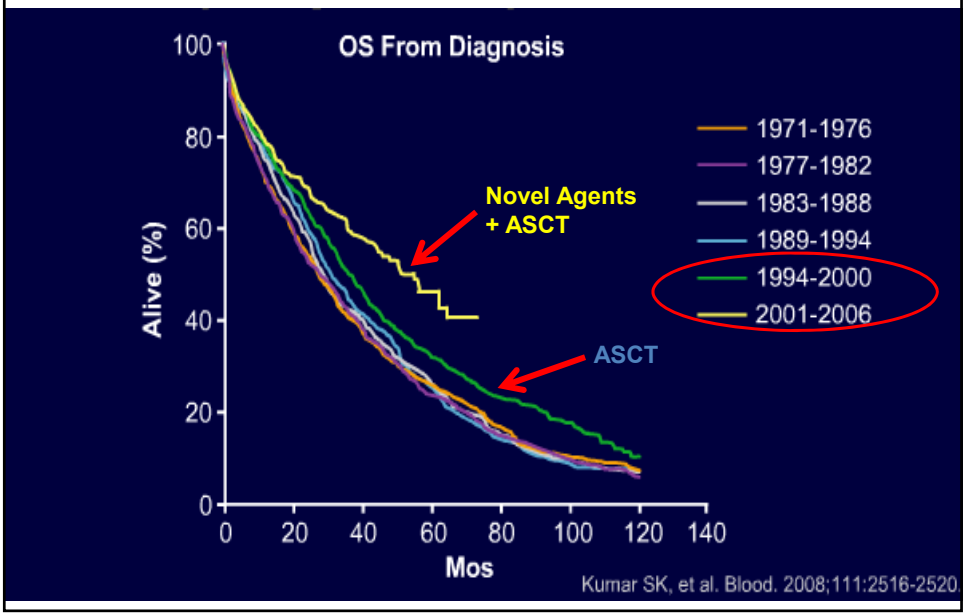
Child JA, et al. N Engl J Med. 2003;348:1875-1883.

Lenalidomide Maintenance after Auto SCT, Effect on PFS/OS





Effect of Novel Agents on Survival in Newly Diagnosed MM



MM Survival is Improving With Novel Agents

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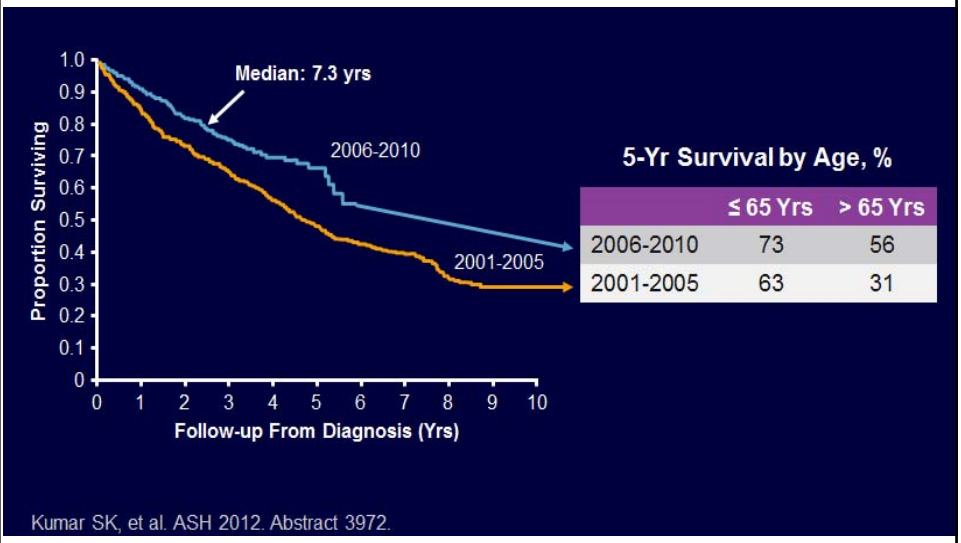

5-Yr Survival by Age, %

	≤ 65 Yrs	> 65 Yrs
2006-2010	73	56
2001-2005	63	31

Kumar SK, et al. ASH 2012. Abstract 3972.

Projected Survival in MM

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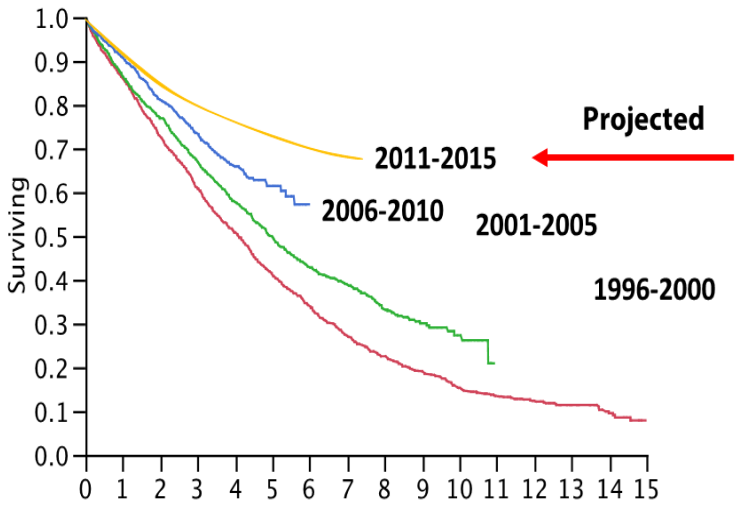

International Myeloma Foundation

Kumar S. Blood 2008;111: 2516 – 2520; Kumar S. Leukemia (2014) 28, 1122–1128.

If 1 Works Well, Why Not 2 Tandem Transplants?

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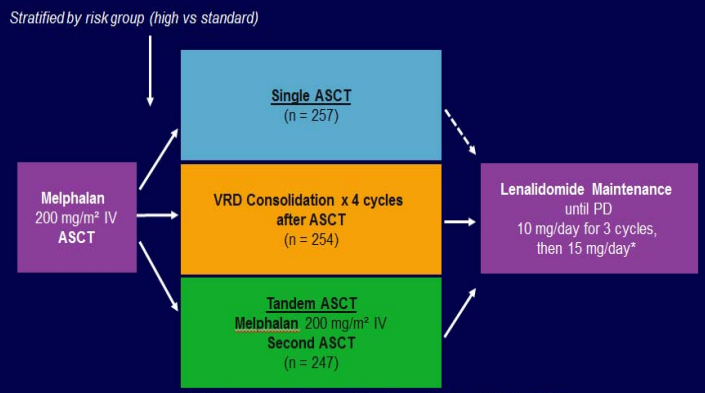
STaMINA: Phase III Study Design



*Originally given for 3 yrs only, but amended to until PD in 2014.

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

Stadtmauer EA, et al. ASH 2016. Abstract LBA-1

If 1 Works Well, Why Not 2 Tandem Transplants?

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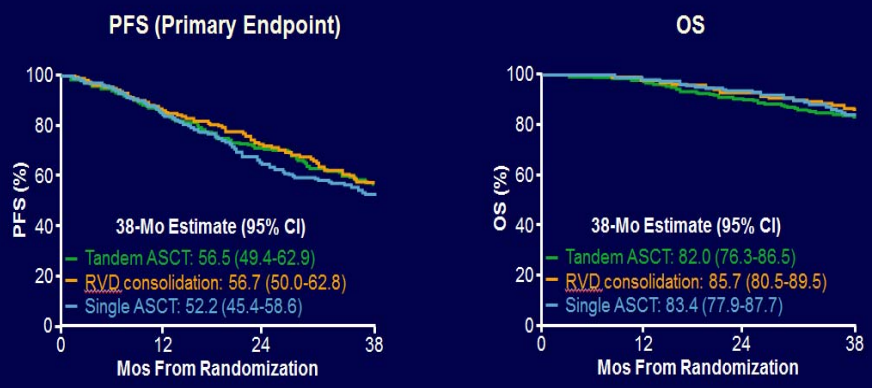
STaMINA: PFS and OS for Overall Population



Stadtmauer EA, et al. ASH 2016. Abstract LBA-1.

If 1 Works Well, Why Not 2 Tandem Transplants?

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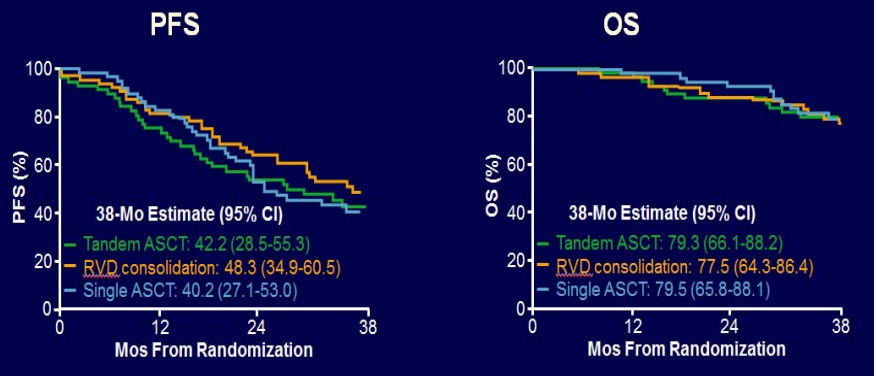
STaMINA: PFS and OS for Pts With High Risk



Stadtmauer EA, et al. ASH 2016. Abstract LBA-1.

Early vs Delayed Auto SCT

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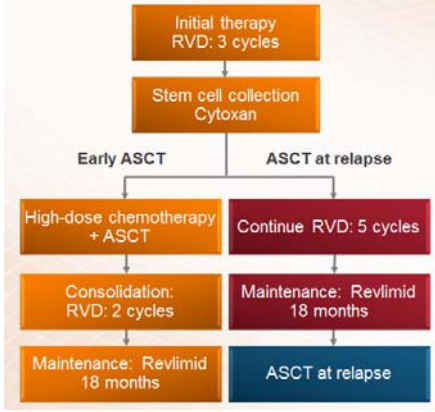
Should I get a transplant after induction therapy or should I wait until after I relapse?
Ongoing Clinical Trial (IFM/DFCI)



- 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*

RVD, Revlimid, Velcade, dexamethasone; Cytoxan, cyclophosphamide
Attal M et al. *Blood*. 2015;126: Abstract 391.
Avet-Loiseau H et al. *Blood*. 2015;126: Abstract 191.

Early vs Delayed Auto SCT?

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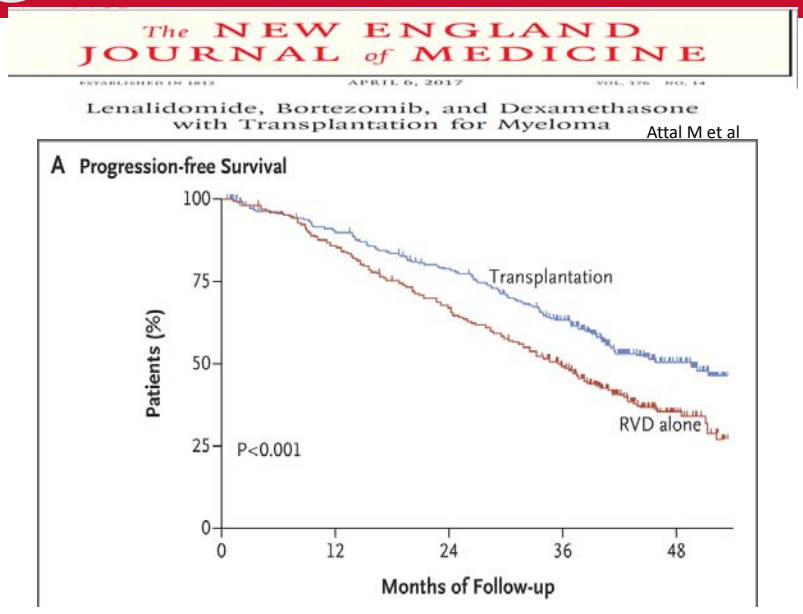
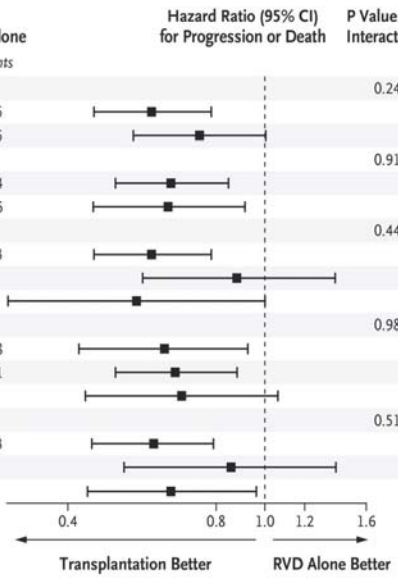


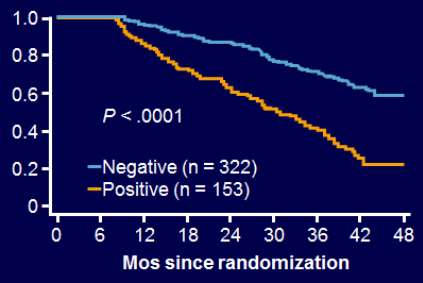
Is there a Subgroup that Benefits more from early SCT?

Subgroup	Transplantation (no. of events/no. of patients)	RVD Alone (no. of events/no. of patients)	P Value for Interaction
Age			0.24
18–59 yr	126/196	85/185	
60–65 yr	85/154	72/165	
Sex			0.91
Male	129/208	102/214	
Female	82/142	55/136	
Type of multiple myeloma			0.44
IgG	133/209	96/223	
IgA	38/71	39/73	
Light chain	31/57	17/46	
International Staging System disease stage			0.98
I	60/115	44/118	
II	107/170	81/171	
III	44/65	32/61	
Cytogenetic risk at screening			0.51
Standard risk	122/212	83/213	
High risk	32/44	31/46	
Test failure	57/94	43/91	

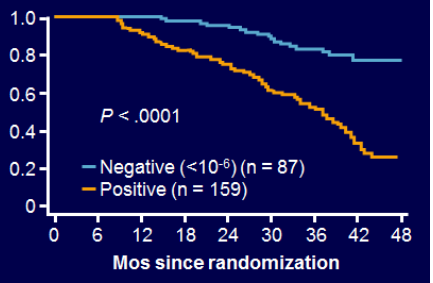


IFM-DFCI 2009: PFS by MRD Before Maintenance Therapy

- MRD by FCM (10^{-4})



- MRD by NGS (10^{-6})

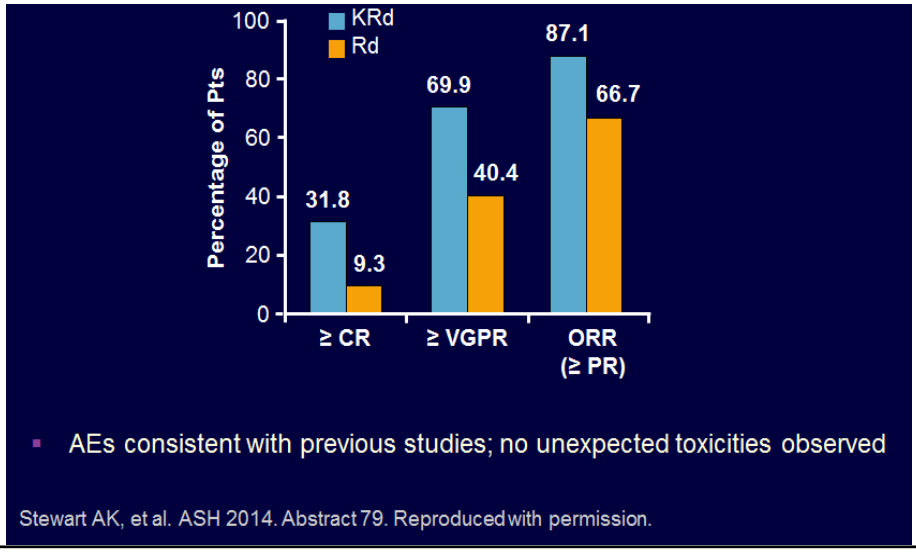


- 51% of pts MRD negative by FCM were MRD positive by NGS, with similar trends in PFS by NGS MRD status
- 13 of 26 pts with t(4;14) achieved MRD negativity; none with del(17p)

Avet-Loiseau H, et al. ASH 2015. Abstract 191.

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

Stewart AK, et al. ASH 2014. Abstract 79. Reproduced with permission.

4 Recently Approved Therapies

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- 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

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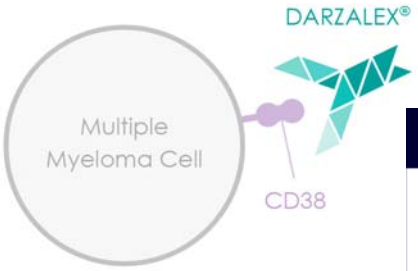
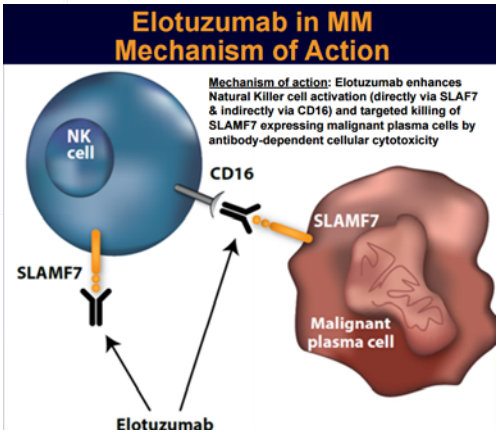
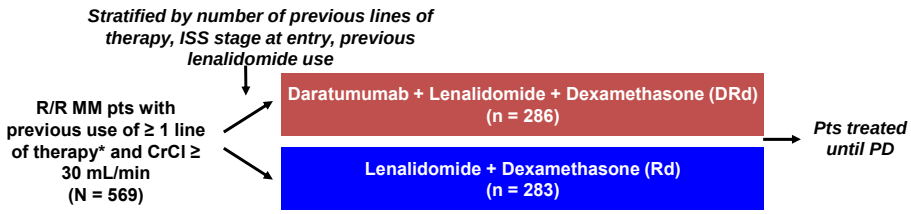


Monoclonal Antibody therapy for relapsed Myeloma Combinations can induce deep molecular remissions



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

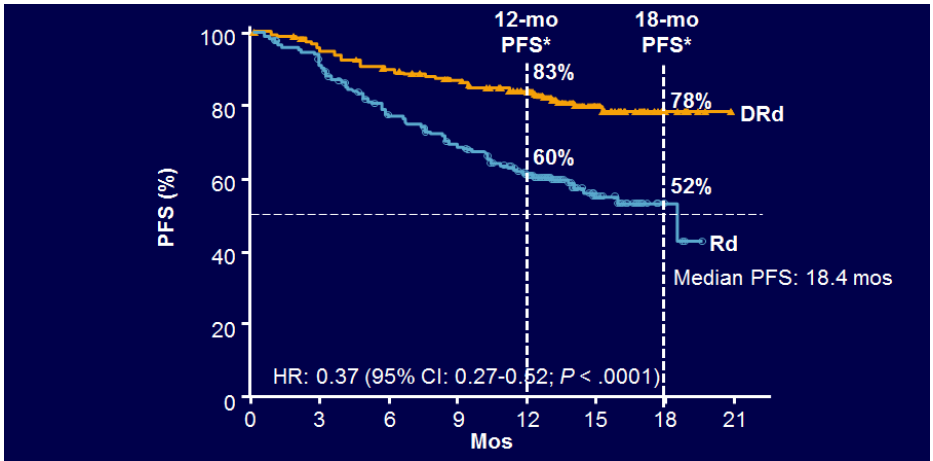
- Multicenter, open-label, randomized phase III trial



*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.

Dimopoulos MA, et al. ASH 2017. Abstract 739.

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

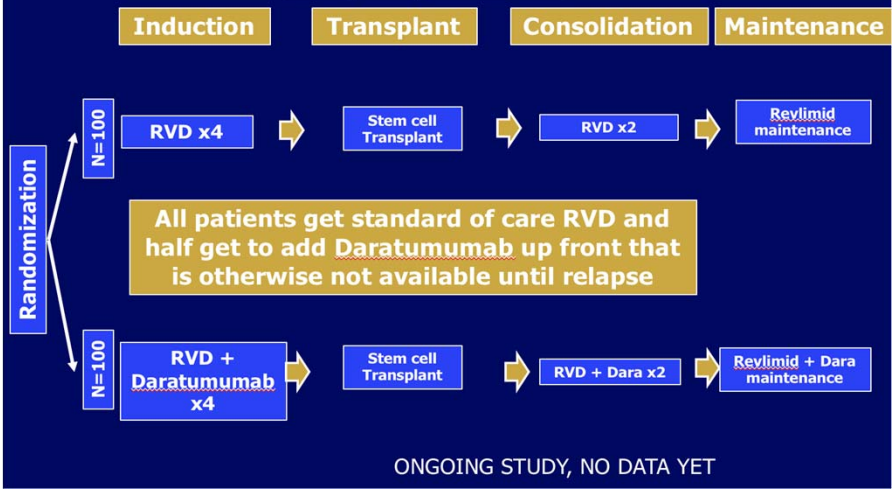


63% reduction in the risk of disease progression or death for DRd vs Rd

Dimopoulos M, et al. EHA 2016. Abstract LB238.

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



Dara/MPV vs MPV Frontline in Spain

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ALCYONE: Open-Label, Phase III Study Design

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

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

- **Daratumumab** 16 mg/kg IV QW in cycle 1 then Q3W in cycles 2-9 **VMP*** x 9 cycles (n = 350) → **Daratumumab** 16 mg/kg IV Q4W until PD
- **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

Mateos MV, et al. ASH 2017. Abstract LBA-4.

Dara/MPV vs MPV Responses and MRD

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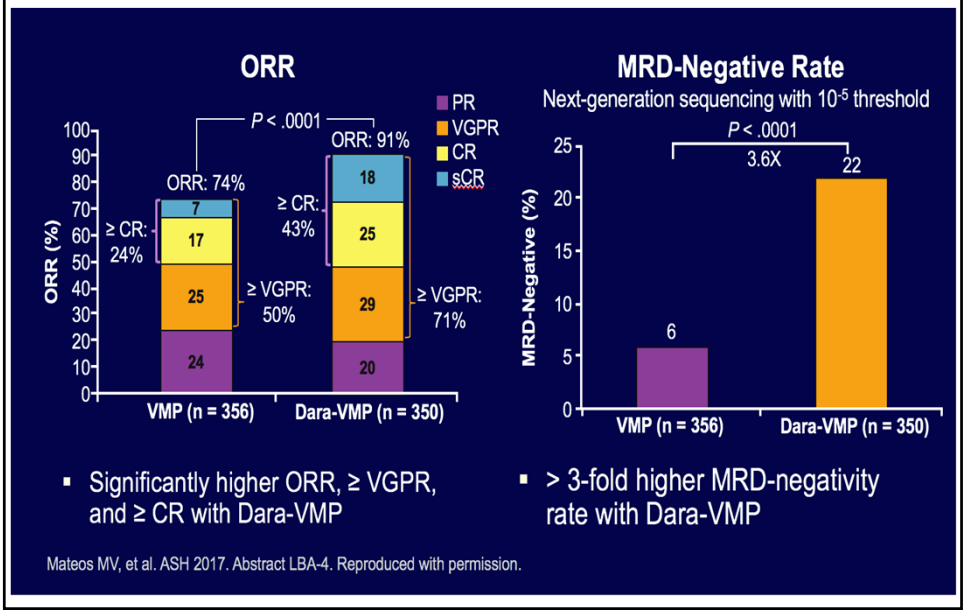

- Significantly higher ORR, ≥ VGPR, and ≥ CR with Dara-VMP
- > 3-fold higher MRD-negativity rate with Dara-VMP

Mateos MV, et al. ASH 2017. Abstract LBA-4. Reproduced with permission.

Dara/MPV vs MPV
Progression Free Survival

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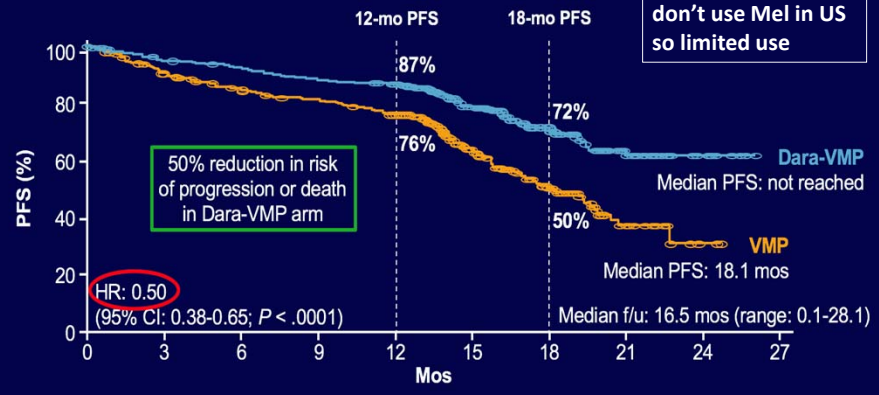
ALCYONE: PFS



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

- Consistent PFS benefit across subgroups

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

Mateos MV, et al. ASH 2017. Abstract LBA-4. Reproduced with permission.

FDA Approved CAR-T Therapies
A New Era of Immunotherapy

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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

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Chimeric — Chimera – Greek Mythology = Monster with Lion's head Part Antibody, Part T Cell Receptor Signaling domains

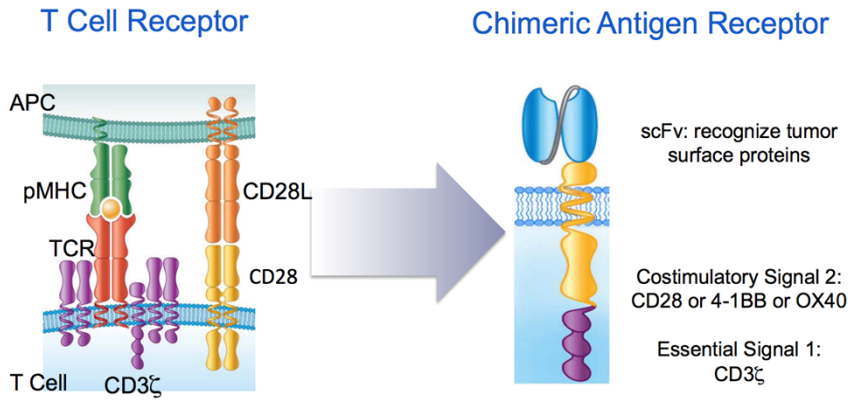
Antigen — Protein target on cancer cells that T cells are engineered to recognize

Receptor — CAR – Engineered Receptor Added to surface of T cells Recognizes specific target antigen on cancer cells

T-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

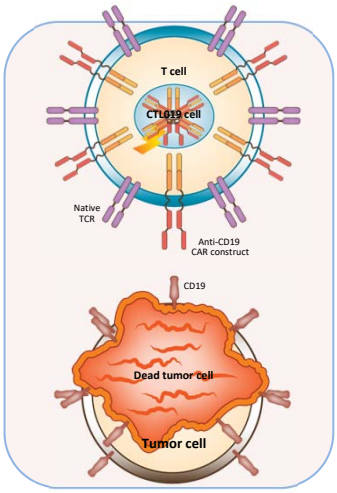
CAR T cells are genetically altered to express CAR on the cell surface.



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**



1. Milone MC, et al. *Mol Ther.* 2009;17:1453-1464.
2. Hollyman D, et al. *J Immunother.* 2009;32:169-180.
3. Kalos M, et al. *Sci Transl Med.* 2011;3:95ra73.

Overview of CAR T-Cell Process

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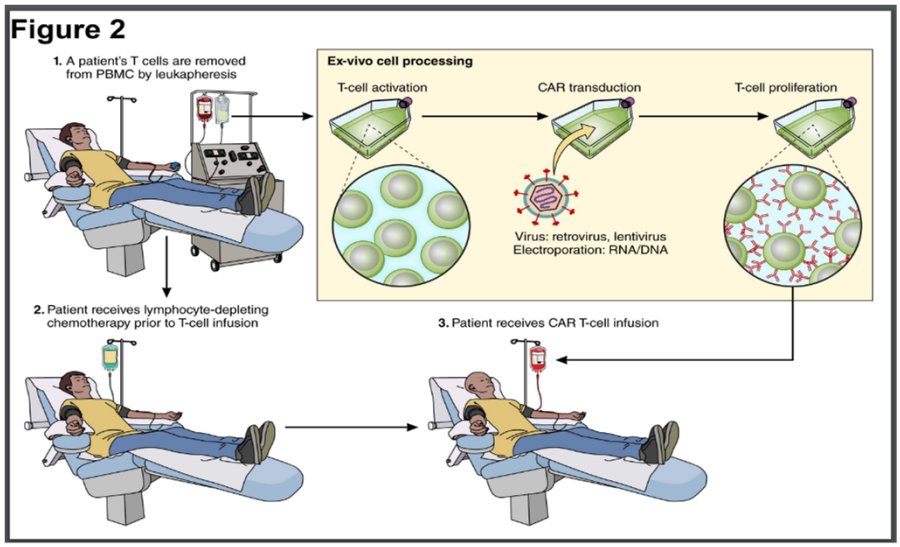
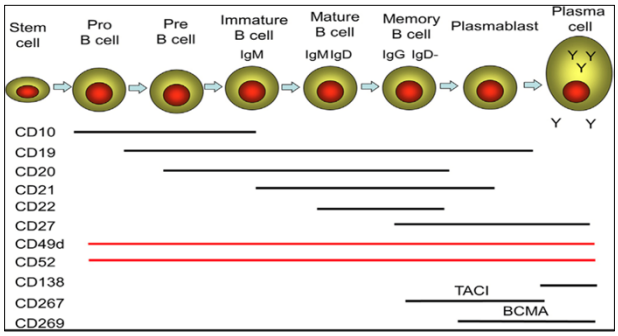


BCMA as a Target for Myeloma CAR T-Cell Therapy

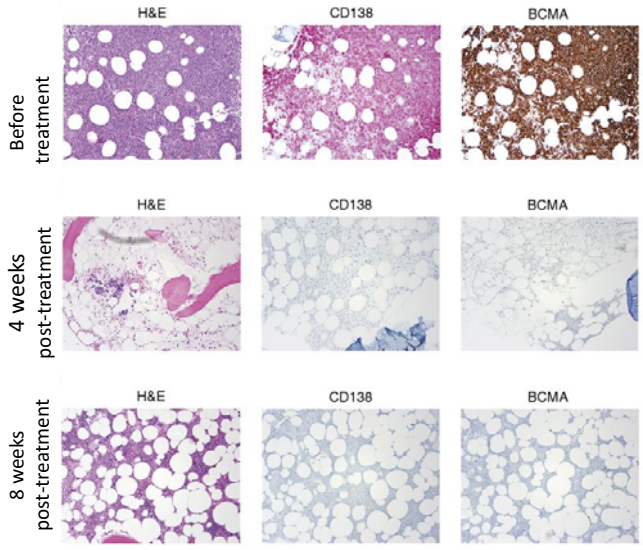
- **BCMA:** B Cell Maturation Antigen
- Receptor expressed on Myeloma tumor cells, nonmalignant plasma cells, and some late stage mature B-cells
- Cell lineage specific so avoids off target toxicity



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



Syed Abbas Ali et al. Blood 2016;128:1688-1700

Phase 1 BB2121 BlueBird Bio/Celgene CRB-401

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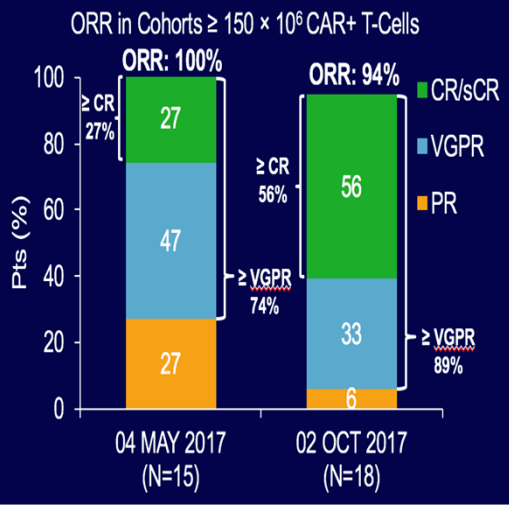
Depth of Response to BB2121

- 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)

Berdeja JG et al. ASH 2017. Abstract 740.



Responses in BB2121 Phase 1

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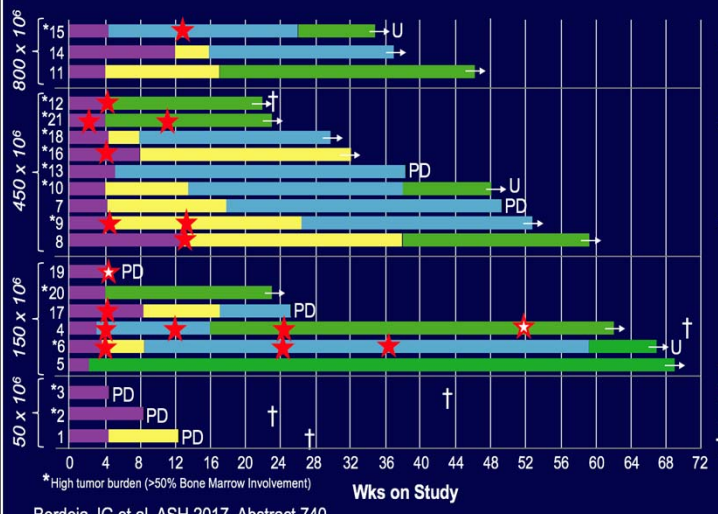
CRB-401: Tumor Response to bb2121



- 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)

CR/sCR VGPR PR
Stable Disease MRD- MRD+
† Deceased U Unconfirmed response PD Progressive disease

Berdeja JG et al. ASH 2017. Abstract 740.

BB2121 Phase 1 Conclusions

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- 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)

Berdeja JG et al. ASH 2017. Abstract 740.

CAR T Future Directions

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- 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/m^2 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]

1. Costa LJ, et al. ASCO 2018. Abstract 8004. 2. Berenson JR, et al. Blood. 2016;127:3360-3368. 3. Moreau P, et al. Blood. 2017;130:2392-2400.

Conclusions

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- **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

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I find that these Webinars are:

A. Helpful to stay up to date on Emerging Treatment Options

B. Too complicated to be useful

Questions?

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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

Emerging Therapies for Multiple Myeloma

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Q&A Session

Ask a question by phone:

- Press star (*) then the number 1 on your keypad.

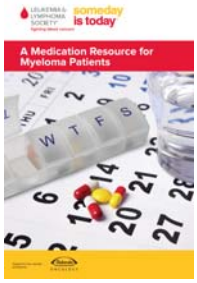
Ask a question by web:

- 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



The Leukemia & Lymphoma Society Offers:

- **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/whattoask
- **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
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