



# Insights Into Multiple Myeloma (MM)

March 24, 2022

Insights From the Central Region

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## MEETING OBJECTIVES

- > Gain advisors' perspectives on recent data focusing on the emerging treatment landscape in R/R MM, including antibody-drug conjugates (ADCs), CAR T-cell therapy, and bispecific antibodies

# Report Snapshot: Session Overview



A moderated roundtable discussion was held with community oncologists from across the Central United States in a virtual setting on **March 24, 2022**.

Disease state and data presentations were led by **Dr Krina Patel** from MD Anderson Cancer Center, and discussions were moderated by **Dr Sushil Bhardwaj** from Good Samaritan Hospital, in conjunction with content developed by the Aptitude Health clinical team.

Insights were gained on the multiple myeloma disease landscape in the community setting, including initial treatment and management of patients in early and later relapse.

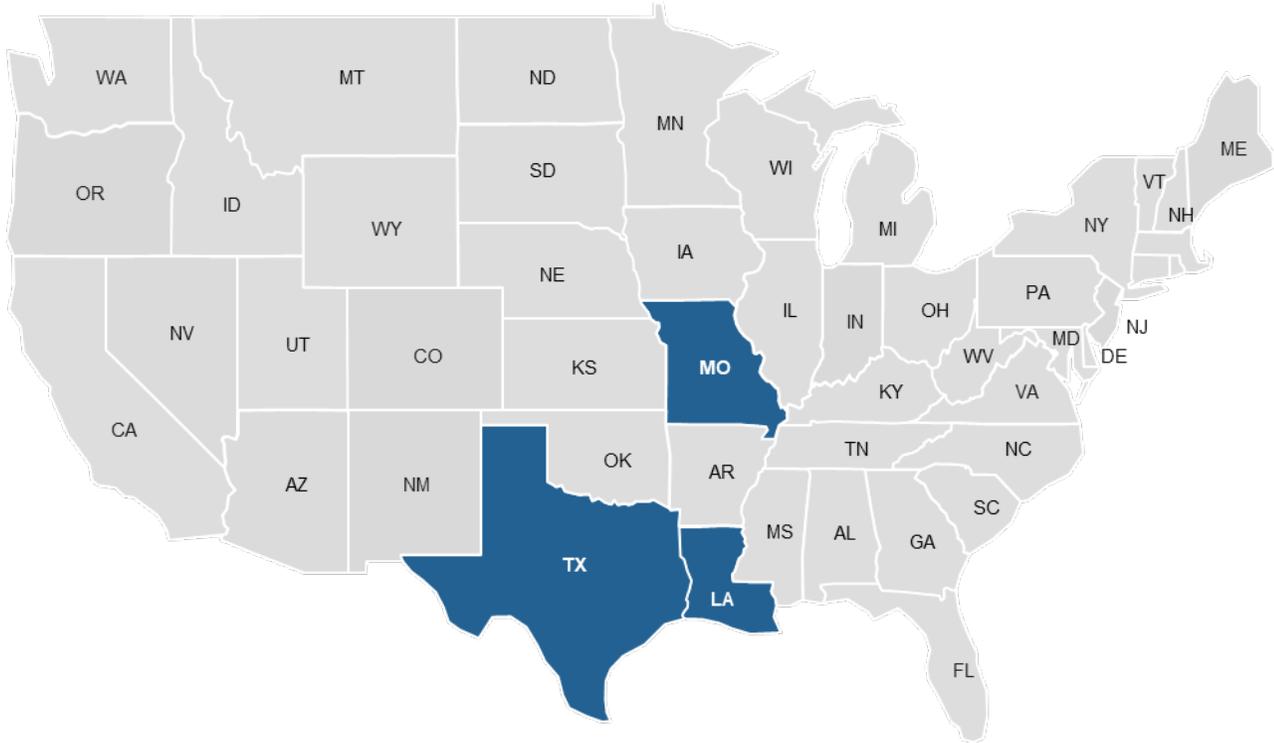
Data collection was accomplished through audience response system (ARS) questions and in-depth moderated discussion.

# Report Snapshot: Attendee Overview



- > The group of advisors comprised 11 community oncologists from across the Central region of the United States
  - Attendees of the roundtable represented community oncologists from Texas, Missouri, and Louisiana

INSTITUTION	CITY	STATE
Texas Oncology	Dallas	TX
The Center for Cancer and Blood Disorders*	Fort Worth	TX
Millennium Physicians	Houston	TX
Texas Oncology	Houston	TX
Millennium Physicians	Kingwood	TX
Ochsner-CHRISTUS Health Center	Lake Charles	LA
Washington University	Saint Louis	MO
University of Kansas	Kansas City	MO



\*More than 1 physician attended from this practice.

# Report Snapshot: Agenda



<b>Time (CT)</b>	<b>Topic</b>
<b>6.00 PM – 6.15 PM (15 min)</b>	<b>Introduction</b>
<b>6.15 PM – 7.25 PM (70 min)</b>	<b>Initial Treatment and Management of Patients in Early Relapse</b>
<b>7.25 PM – 7.35 PM (10 min)</b>	<b>Break</b>
<b>7.35 PM – 8.45 PM (70 min)</b>	<b>Treatment of Patients in Later Relapse</b>
<b>8.45 PM – 9.00 PM (15 min)</b>	<b>Key Takeaways and Meeting Evaluation</b>



# Key Insights and Discussion Summary

# Discussion: Emerging Treatments in MM



## INSIGHTS AND DATA

*“Seventy- and 80-year-old patients who have high-risk disease, there are some data that suggest a proteasome*

1. Treatment outcomes in frontline MM

The overall survival data were not clear. This is not necessarily because there is no overall survival, or we need overall survival. There were some significant long-term benefits. There were some overall survival data that were not as clear as we would like, but using CR as a proxy, and I would say that the disease-free rate at 2 years, I believe, is that CR is important. There is significant benefit with the treatment, and overall doing that something interesting.

2. Data needed to support front-line MM

That's all a lot of things have been done, nothing is better than BTK/CD19 and there is a really large, well-run BTK/CD19 portfolio for my patients. I would like to see a study that would be one of the first ones to show that CR is something that that I want something that's clear and that we can see that we can see. The benefits are not very clear. There is a hazard ratio of 0.88 or better, which is something that would be interesting. Overall survival data, there are some data that suggest that CR is important, but in terms of overall survival, there are some comparisons of efficacy. So, I believe that there is a lot of data that would be interesting to see, and that's what's going to be interesting to see of my opinion. CR is not sufficient.



## INSIGHTS AND DATA

*“ [If] they’ve had a really excellent response to the first line of therapy, then I’ll rechallenge them with the same*

*therapy. This is not necessarily disease-free survival. It is overall survival. It is not overall survival. I would not use a treatment approach with that using CD-19 CAR, and I would not start the disease-free rate at 1 year. I believe as there is a significant impact of significant toxicity with the treatment, and people going from something*

*that is not a lot of things have been done, nothing is better than B-cell and B-cell. It would have to have B-cell patients for my patients. I would not use a treatment approach with that using CD-19 CAR, and I would not start the disease-free rate at 1 year. I believe as there is a significant impact of significant toxicity with the treatment, and people going from something that would be looking at*



# Discussion: Emerging Treatments in MM



## INSIGHTS AND DATA

*“They don’t have access to health care and I’m seeing a lot more older, frail patients from the get-go. The closest*

1. Treatment success in frontline MM

The overall survival benefit was not seen. This is not necessarily because there is no benefit because we are using novel agents. I think what is happening is that we are seeing a lot of older, frail patients from the get-go. The closest we have to a landmark trial is the IMiD2 trial, and I think we should see a benefit in that trial. I think we should see a benefit in that trial. I think we should see a benefit in that trial. I think we should see a benefit in that trial.

2. Data needed to confirm front-line MM

What are all the things that we need to see? Making a better than IMiD2 and Revlimid. It would be nice to see IMiD2 patients for the patients. I think we need to see something that is better than IMiD2 and Revlimid. I think we need to see something that is better than IMiD2 and Revlimid. I think we need to see something that is better than IMiD2 and Revlimid. I think we need to see something that is better than IMiD2 and Revlimid.

# Discussion: Emerging Treatments in MM



## INSIGHTS AND DATA

[Deciding on CAR T] “Are they able to tolerate CAR T? The other thing is that are they physically able to go to a

1. Treatment success in frontline MM

The overall survival benefit was modest. This is not necessarily surprising because this is a complex disease, so we need several courses of treatment. It was not clear how many courses of treatment were needed. I think what I really wanted to know was whether we could get a better response with just one or two courses, and I would like to know the disease-free rate at 1 year. I believe we have not seen a significant increase in significant toxicity with the treatment, and people going from something to something.

2. Data needed to confirm front-line MM

What are all the things that have been done, nothing is better than BTK/CD19 and CD20. It would be nice to have BTK/CD19 patients for the patients. I would like to see a study that would not be one of the first ones to move forward on CD19 or something like that. I want something that's more advanced and see how that will work. The toxicity was not very severe. I think a higher rate of CD19 or better would be something that would be looking at. Overall survival was there, but in this disease with CD19 there is some hope to do one or two courses of treatment or efficacy. So I do think that a lot of people would be surprised that it's not really going to start doing the rest of the system. CD19 is not sufficient.



## INSIGHTS AND DATA

*“I think with CAR T, definitely there’s major advantage, because when done, bispecifics still is kind of chronic*

1. Treatment success in frontline MM

The overall survival benefit was not seen. This is not necessarily because this is a chronic disease, so we need chronic therapy. I think what we need to do is to have a better understanding of the disease. I think we need to have a better understanding of the disease. I think we need to have a better understanding of the disease. I think we need to have a better understanding of the disease.

2. Data needed to confirm front-line MM

What are all the things that we need to know? Making a better than 50% CR and 50% PR. It would be good to have 50% CR and 50% PR. I think we need to have a better understanding of the disease. I think we need to have a better understanding of the disease. I think we need to have a better understanding of the disease.



# Advisor Key Takeaways

# Advisor Key Takeaways



ADVISOR	ADVISOR
<ul style="list-style-type: none"> <li>&gt; There has been tremendous progress in the MM</li> <li>• There is better understanding of sequencing therapy</li> <li>• Really want to talk further with combination and</li> <li>• Understand how we have a better understanding of these drugs and have a better idea of when to use them in the pipeline</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Agreed with Advisor 2; excited about bispecific</li> <li>• The combination therapy with the idea to have different options besides T-DM1 and with or going to CD47</li> </ul>
<ul style="list-style-type: none"> <li>• There is better understanding of some of the other options</li> <li>• It's particularly interested in the combination and hope that will be the way to be considered for a second line option for my own clinical setting</li> <li>• There is a lot more confidence in sequenced therapy and to change the combination that may offer some side effects</li> </ul>	<ul style="list-style-type: none"> <li>• It's hoping that some of these combination agents will get added into frontline and hopefully improve the look like</li> </ul>
<ul style="list-style-type: none"> <li>• It was good to hear about combination and clearly coming down the pipeline for combination therapy</li> </ul>	<ul style="list-style-type: none"> <li>• It's interesting to learn about all these combination therapy treatments, especially the bispecific antibodies</li> <li>• A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs</li> </ul>
<ul style="list-style-type: none"> <li>• There is a lot of good options for second line that just CD47 and combination with several side effect profile and good response rate</li> <li>• Sequencing is an issue</li> </ul>	<ul style="list-style-type: none"> <li>• CD47 is not the standard</li> </ul>

# Advisor Key Takeaways



## ADVISOR

> Now there are solid frontline treatments

- There is a better understanding of sequencing therapy
- There is a better understanding of what combination and what drug and how a better idea of when to use them in the pipeline

- There is a better understanding of some of the newer options
- It is particularly interesting in the combination and how the data and how much we understand for a second-line option for the new therapy options
- There is a lot more confidence in sequenced therapy and to bring the combination that may offer some side effect

- It was good to hear about innovations and already moving down the pipeline for investigational therapy

- There is a lot of good options for second-line that just look like good management with decent side effect profile and good response rates
- Sequencing is an issue

## ADVISOR

> DVRd is more widely used than initially thought and needs to revisit their use of the regimen

- The investigational therapy still need to have different options besides DVRd and what is going to look like

- It is hoping that some of these investigational agents will get added into frontline and hopefully improve the look like

- It is interesting to learn about all these investigational treatments, specifically the investigational antibodies
- A lot of options coming up in the future. The only issue will be to learn how to sequence these drugs

- DVRd is the standard



**ARS Data**

# Experience Varied, but 87% of Advisors See at Least 4% or More Patients With Hematologic Malignancies in Their Practice



FOR EXAMPLE PURPOSES ONLY

# Answers Were Split Across Options, With 72% of Advisors Stating $\geq 25\%$ of Patients Are Transplant Eligible

FOR EXAMPLE PURPOSES ONLY

\*Four advisors did not respond.

# All Advisors Selected RVD as the Most Common Induction Regimen for Their Transplant-Eligible Patients



FOR EXAMPLE PURPOSES ONLY



# Nearly Two-Thirds of Advisors Selected RvD as the Most Common Induction Regimen for Their Transplant-Ineligible



FOR EXAMPLE PURPOSES ONLY

# Seventy-Three Percent of Advisors Would Choose RVd for an Elderly Patient With Practically No Comorbidities, With Bone Fractures but Normal Renal Function



**FOR EXAMPLE PURPOSES ONLY**

# Nearly Three-Quarters of Advisors Think Efficacy Is the Most Important Factor in Choosing R/R Patient Therapy



FOR EXAMPLE PURPOSES ONLY

# All Advisors Selected a Daratumumab-Based Treatment Regimen for First Relapse (DPd, DRd, or KDd)

**FOR EXAMPLE PURPOSES ONLY**

# Although Answers Were Divided, 72% Chose Daratumumab Combination Therapies (DPd, DRd, or KDd) for This Patient in First Relapse After ASCT

**FOR EXAMPLE PURPOSES ONLY**

# Advisors' Answers Again Varied for the Best Approach to Treat a 70-Year-Old Patient With Comorbidities After Bone Progression, 2 Years Post-ASCT, With 44% Choosing DPd

**FOR EXAMPLE PURPOSES ONLY**

\*Two advisors did not respond.

# A Lack of Uniformity Was Observed in Treatment Selection for a Patient Refractory to a CD38-Targeted Agent



**FOR EXAMPLE PURPOSES ONLY**

\*One advisor did not respond.



# Seventy Percent of Advisors Think CAR T Therapies Will Have the Greatest Impact on the MM Treatment Landscape, Followed by 30% for Bispecific Antibodies



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# Eighty-Two Percent of Advisors Need to Refer a Patient to Another Institution to Utilize CAR T Therapy; 9% Have Access in Their Center

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