MULTIPLE MYELOMA Research Foundation

Focus on Treatments, Monitoring, and Maintenance for Newly Diagnosed Multiple Myeloma Patients, With Updates

February 17, 2023

1

Tech Support

1-719-234-7952

2

3

Resources

- Resource tab includes
  - Speaker bios
  - Copy of the slide presentation
  - Exhibit Hall

Submit your questions throughout the program!

4

MMRF Research Initiatives

MULTIPLE MYELOMA Research Consortium

CoMMpass Study℠

MMRF CureCloud™

For more information, please visit themmrf.org

5

Speakers

Suzanne Lentzsch, MD, PhD
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Tisch Cancer Institute
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New York, New York

6

Autologous Stem Cell Transplantation and Continuous or Maintenance Therapy

Cesar Rodriguez, MD
Associate Professor of Medicine
The Icahn School of Medicine at Mount Sinai Hospital
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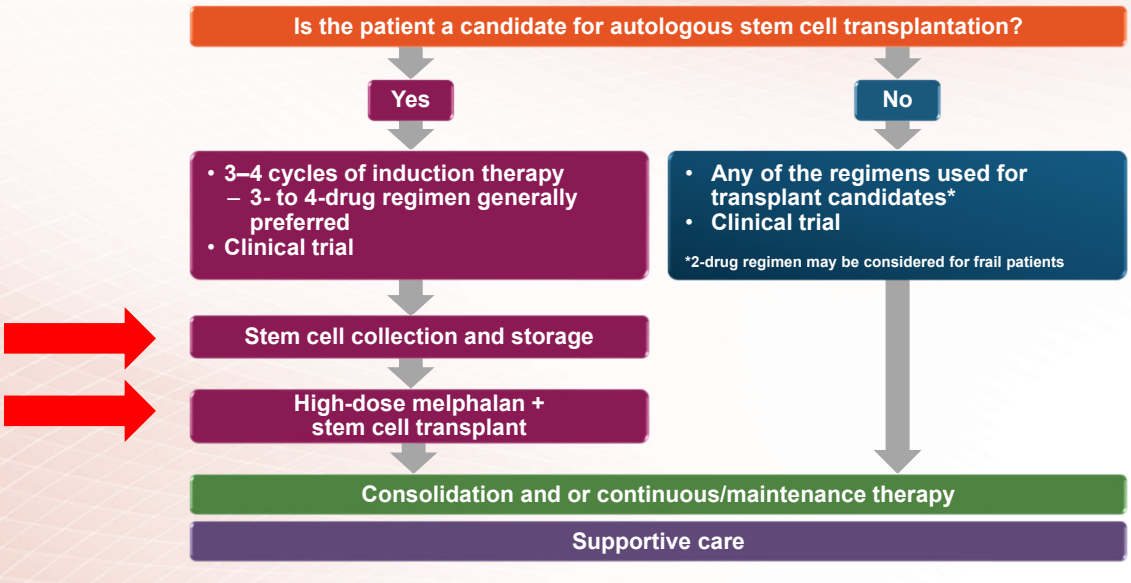
7

Overview of Treatment Approach for Active Multiple Myeloma



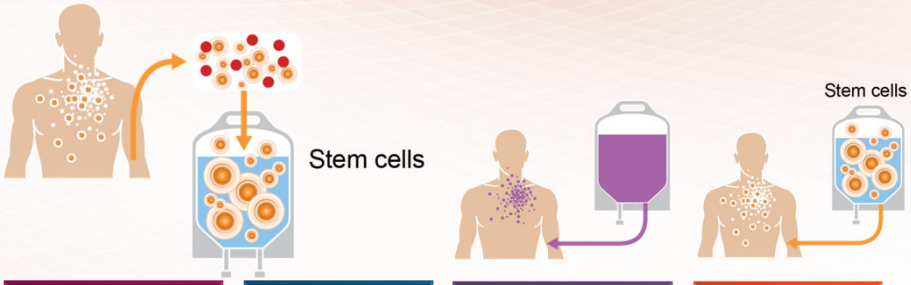
8

High-Dose Chemotherapy and Stem Cell Transplantation

- Offers durable remission based on current data
- Can be done as part of frontline therapy or at relapse (or both)
- More patients considered candidates than in the past, age is not a limiting factor

9

The Transplant Process



1. Induction therapy
2. Collection of stem cells from the bloodstream
3. Freezing of stem cells
4. High-dose chemotherapy
5. Thawing and infusion of stem cells
6. Recovery

-2 to -3 weeks*

~4–6 cycles

Stem cell mobilization
- Neupogen, Neulasta, Leukine, Cytoxan, Mozobil

Melphalan
- Alkeran, Evomela

Day 0

Days +1 to +100†

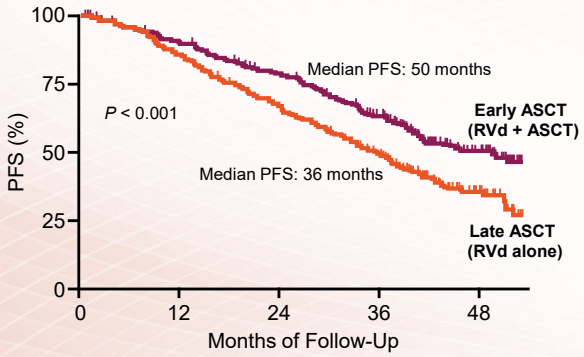
*The weeks leading up to the transplant; †The days after the transplant.

10

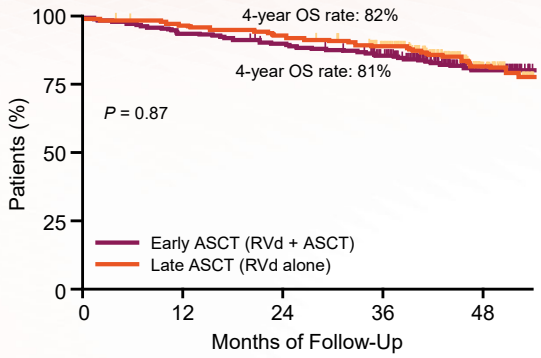
Should I get a transplant after induction therapy or should I wait until after I relapse? *Ongoing Clinical Trial*

Lenalidomide, Bortezomib, and Dexamethasone (RVd) With Transplantation for Myeloma (IFM 2009 Study): First Report

Progression-Free Survival (PFS)



Overall Survival (OS)



ASCT, autologous stem cell transplantation

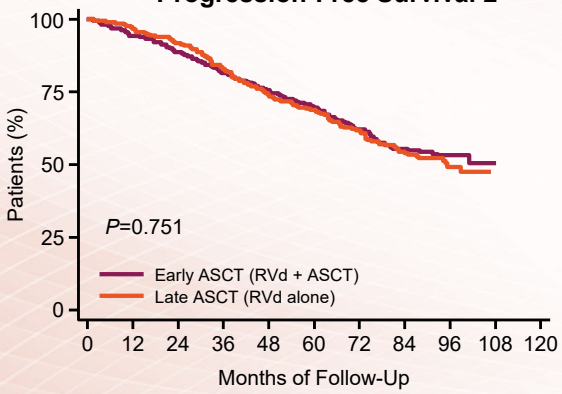
Attal M et al. *N Engl J Med*. 2017;376:1311.
Perrot A et al. *Blood* 2020;136: Abstract 143.

11

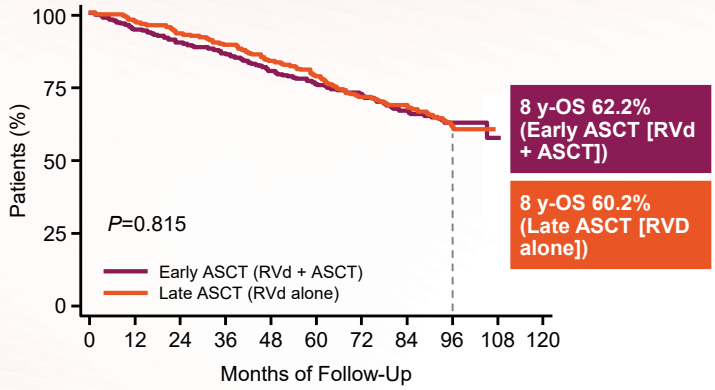
Should I get a transplant after induction therapy or should I wait until after I relapse? *Ongoing Clinical Trial*

Lenalidomide, Bortezomib, and Dexamethasone (RVd) With Transplantation for Myeloma (IFM 2009 Study): Updated (Long-Term) Report

Progression-Free Survival 2



Overall Survival



Attal M et al. *N Engl J Med*. 2017;376:1311.
Perrot A et al. *Blood* 2020;136: Abstract 143.

12

Early vs Delayed Transplant Pros and Cons

Pros

Early ASCT
- Youngest you are going to be
- Healthiest you are going to be
- Allows for fewer cycles of initial treatment
- Deeper and more durable response

Delayed ASCT
- Conserve quality of life in the early part of disease journey
- Minimize disruption to lifestyle
- If there is residual disease after completed combination therapy, PFS may be shorter with delayed (vs early) hematopoietic cell transplantation (HCT), but OS is the same

Cons

Early ASCT
- 20% of patients still relapse within 2 years
- 1% risk of serious life-threatening complications
- 3 months of full clinical recovery
- No proven impact on overall survival

Delayed ASCT
- 60%–70% of patients will relapse and may need it as salvage
- Not all patients relapsing are unable to undergo salvage HCT
- May need longer duration of chemotherapy to replace its effects

13

Autologous Stem Cell Transplantation
Summary

Autologous stem cell transplantation (ASCT) remains the standard of care for frontline myeloma therapy for patients who are eligible; its safety has been established and it induces long remissions.

14

What is maintenance therapy?

- A prolonged, and often low-dose, treatment given to myeloma patients after achieving a desired response to initial therapy
- To prevent disease progression for as long as possible while maintaining favorable quality of life
- To deepen responses by reducing minimal residual disease (MRD) or maintaining the response achieved, reduce the risk of relapse, and prolong survival

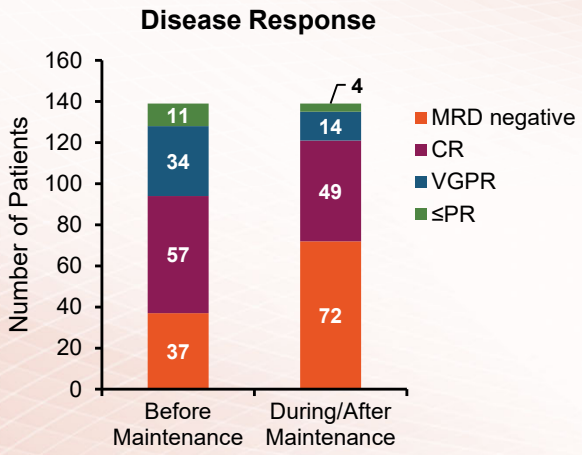
15

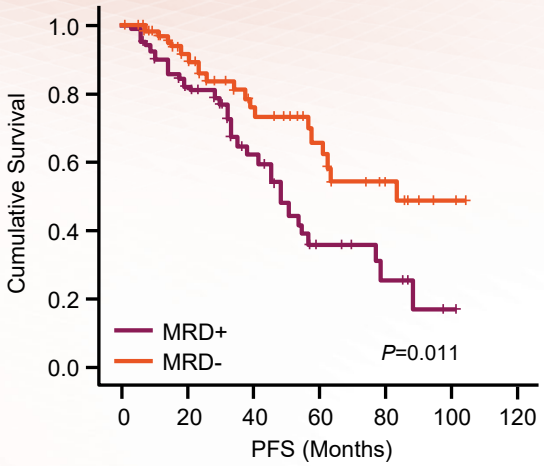
Successful Maintenance Therapy Must...

1. Be convenient
2. Be safe and well tolerated long term
3. Not interfere with the use of other future treatments

16

Revlimid Maintenance Therapy: Improves Depth of Response





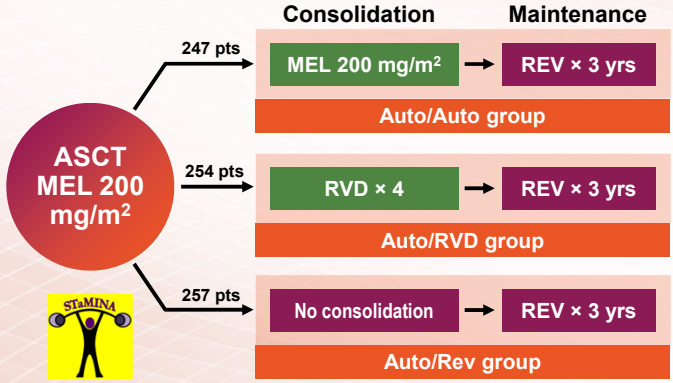
At maximal response during or after maintenance treatment with Revlimid

Alonso R et al. *Blood Adv*. 2020;4:2163.

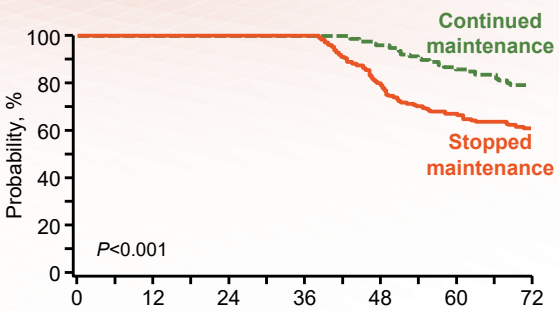
17

Revlimid Maintenance Duration

STAMINA Trial (BMT-CTN0702)



There was no difference in PFS or OS between the 3 groups



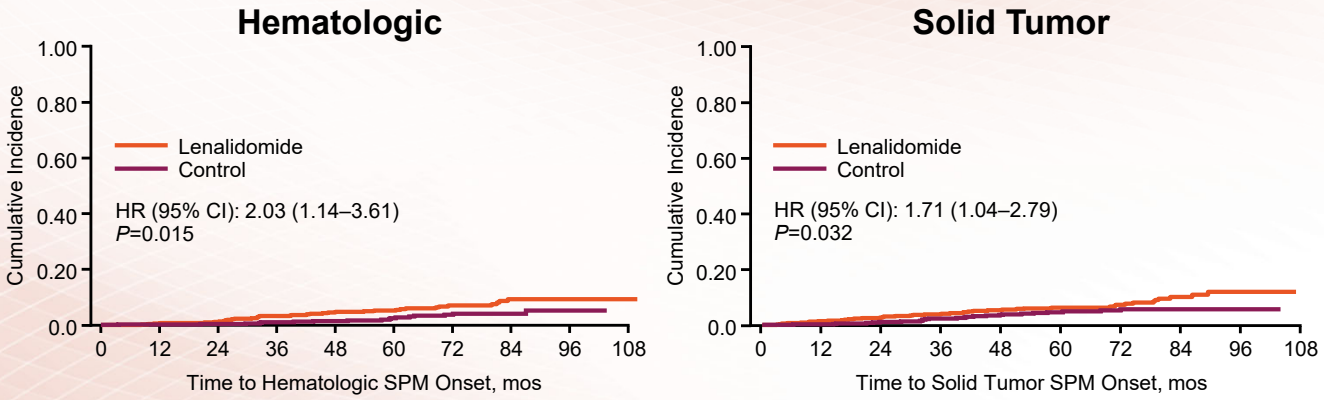
Discontinuation of Revlimid @ 3 years did not impact overall second primary malignancies (SPM) rates @ 6 years

Discontinuation of Revlimid maintenance at 3 years is not recommended because of the increased risk of disease progression

MEL, melphalan; RVD, Revlimid-Velcade-dex; REV, Revlimid
STAMINA Trial. Stadtmauer EA et al. *J Clin Oncol*. 2019;37:589; Hari P et al. *J Clin Oncol*. 2020;38: Abstract 8506.

18

Revlimid Maintenance: Cumulative Incidence of Second Primary Malignancies



McCarthy PL et al. *J Clin Oncol*. 2017;35:3279.

19

Continuous or Maintenance Therapy Options

	Preferred	Recommended	Certain circumstances
Transplant eligible	• Revlimid*	• Ninlaro* • Velcade	• Velcade-Revlimid ± dex
Transplant ineligible	• Revlimid*	• Ninlaro* • Velcade	• Velcade-Revlimid

Additional agents under investigation (alone or in combination with Revlimid): Darzalex, Kyprolis

*Category 1 recommendation. Based on high-level evidence, there is uniform National Comprehensive Cancer Network (NCCN) consensus that the intervention is appropriate.

National Comprehensive Cancer Network Guidelines Version 1.2022. Multiple Myeloma.

20

Maintenance Therapy
Summary

- **The body of evidence from phase 3 trials indicates that maintenance therapy improves PFS and likely OS and should be given until progression.**
- **Most patients should receive maintenance with some agent if able to tolerate the side effects.**
- **Minimizing side effects and maximizing quality of life are essential to the success of maintenance therapy.**
- **For patients who are unable to tolerate Revlimid, there are other agents such as Pomalyst, Ninlaro, Kyprolis, Velcade, and Darzalex that are effective, but they are not yet FDA-approved for use as maintenance. Several clinical trials are under way.**

21

Minimal Residual Disease Negativity as a Multiple Myeloma Treatment Goal

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Professor of Medicine
Director of the Multiple Myeloma and Amyloidosis Program
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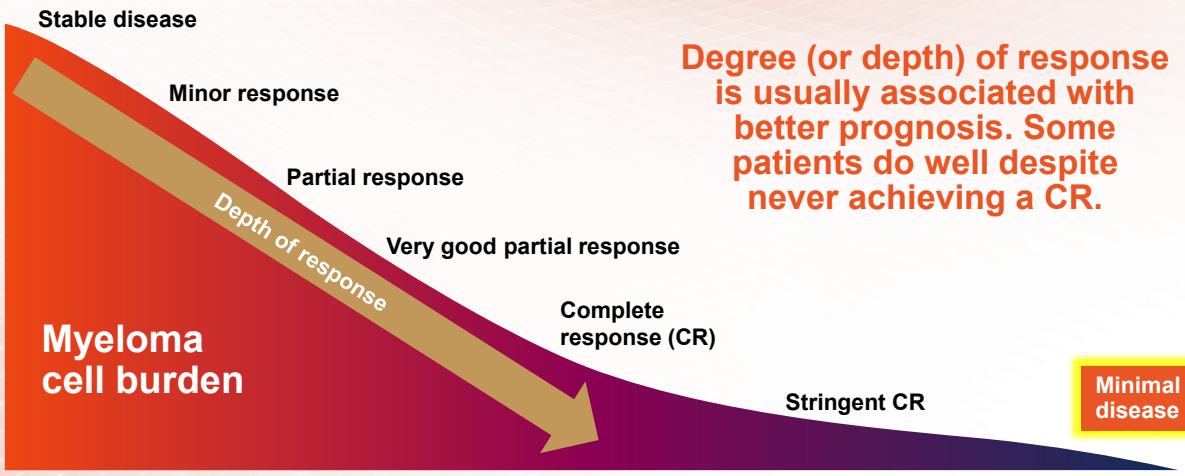
22

Goals of Multiple Myeloma Therapy

- Reduce the amount of M protein (as measured by serum protein electrophoresis) or light chains (as measured via the free light chain test) to the lowest level possible
- Eliminate myeloma cells from the bone marrow (as measured via minimal residual disease [MRD] testing)
- Improve quality of life with as few treatment side effects as possible
- Provide the longest possible period of response before first relapse
- Prolong overall survival

23

Measuring Response to Therapy



Degree (or depth) of response is usually associated with better prognosis. Some patients do well despite never achieving a CR.

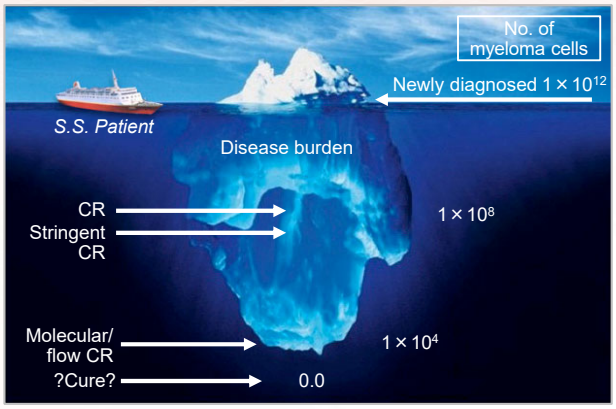
ClonoSEQ is an FDA-approved next-generation sequencing (NGS) test to measure MRD in MM patients

Palumbo A et al. *J Clin Oncol.* 2014;32:587.
Kumar S et al. *Lancet Oncol.* 2016;17:e328.

24

Why do we need to MRD?

- With new and more effective treatments, more patients achieve CR
- However, achieving a CR does not necessarily mean that all myeloma cells are gone
- Routine blood tests are not sensitive enough to detect these remaining cells



25

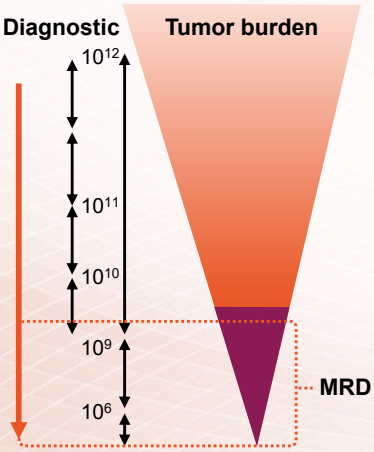
What is MRD?

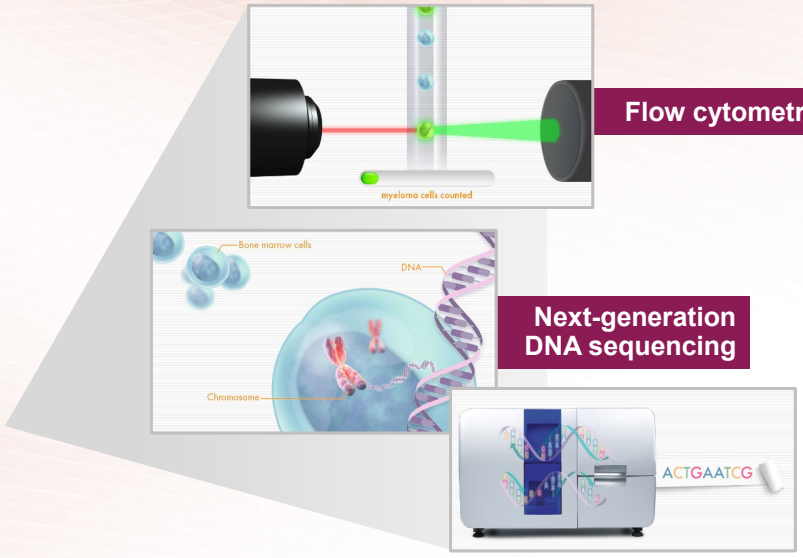
The presence of small amounts of myeloma cells left in the bone marrow following the achievement of a CR after treatment

MRD tests can detect at least 1 cell in 100,000 or better. Ideally, we want to use more sensitive assays that can find 1 cell in a million

26

How is MRD measured?





27

Key Terms for MRD

MRD positive or MRD positivity (MRD+)	MRD negative or MRD negativity (MRD-)
• Myeloma cells are still detected	• Myeloma cells are not detected

Level of sensitivity can be different depending on methodology used: next-generation sequencing (NGS) or next-generation flow cytometry (NGF).

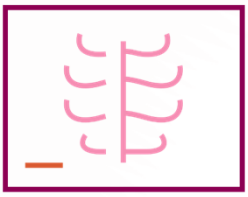
28

Comprehensive Response Assessment

Right now, measurement of MRD depends on counting cells in bone marrow samples

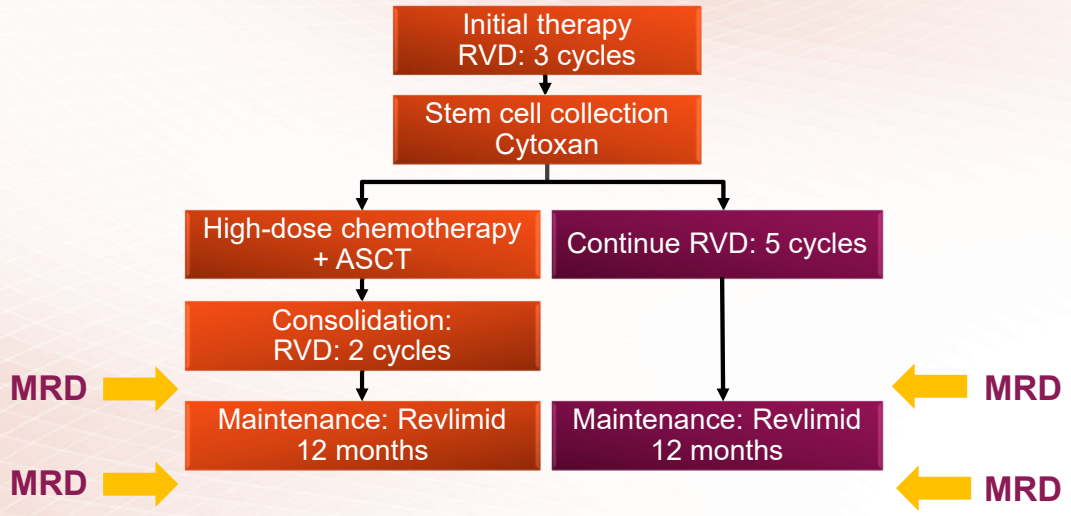
What about other areas of the body?

Imaging (with PET/CT scan) is also required to detect residual disease outside of the bone marrow



29

Why is it important to achieve MRD negativity?



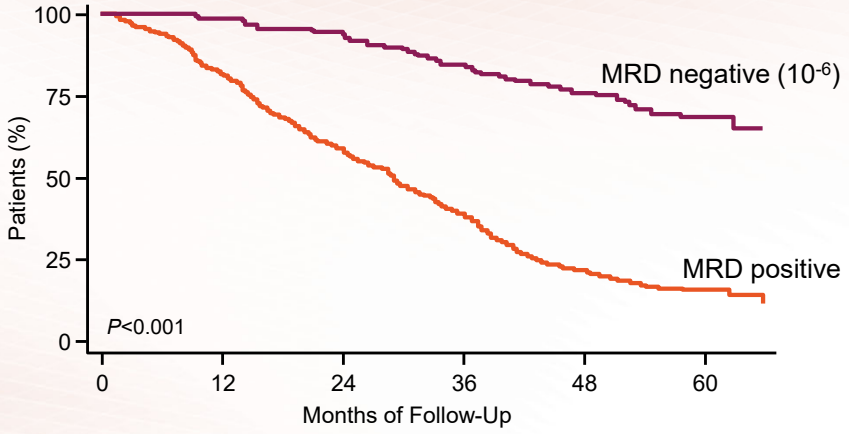
RVD, Revlimid, Velcade, dexamethasone; Cytoxan, cyclophosphamide

Determination Trial (IFM 2009). Avet-Loiseau H et al. *Blood*. 2017;130: Abstract 435.

30

Why is it important to achieve MRD negativity?

Patients who achieve MRD negativity following treatment experience longer remission than those who are still MRD positive after treatment.



Perrot A et al. *Blood*. 2018;132:2456.

31

Patients Who Achieve MRD Negativity Following Treatment Live Longer Than Those Who Are MRD Positive

Key points from 14 studies analyzed*

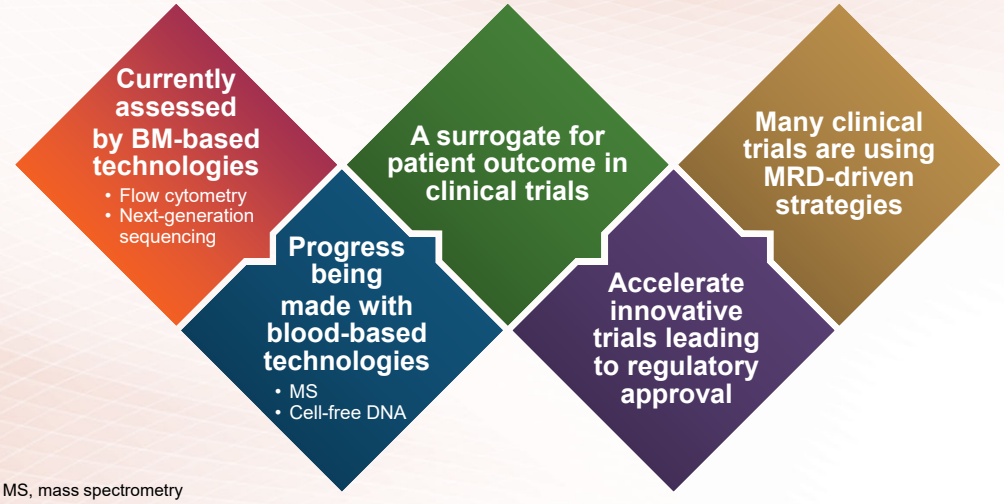
- Being MRD negative is correlated with longer progression-free and overall survival.
- MRD negativity may not (?) carry the same weight in patients with standard-risk vs high-risk disease.

*5 trials included stem cell transplantation/10 studies included maintenance

Munshi NC et al. *JAMA Oncol*. 2017;3:28.

32

MRD Is Important for Clinical Care and New Drug Registration

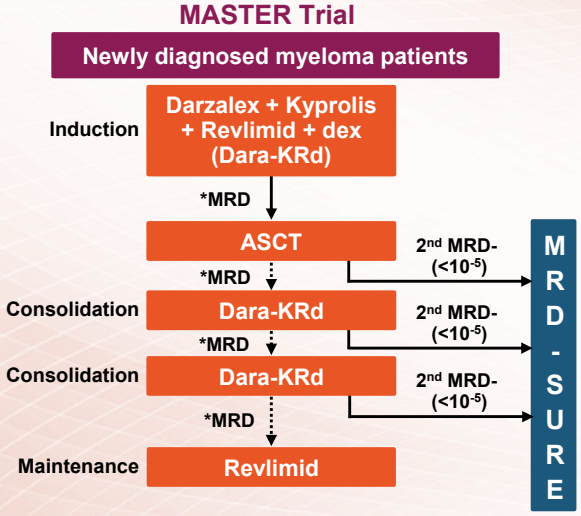


BM, bone marrow; MS, mass spectrometry

Anderson KC et al. *Clin Cancer Res*. 2021;27:5195.
Costa LJ et al. *Leukemia*. 2021;35:18.

33

MRD Response-Adapted Consolidation and Treatment Cessation



- 80% of patients achieved MRD negativity (at <1 × 10^{-5}) and 66% achieved MRD negativity at <1 × 10^{-6}.
- 86% of patients achieved a CR or better.
- Responses deepened with each phase of treatment—and were similar in patients with zero, one, or two or more high-risk genetic abnormalities.
- ASCT increased the rates of MRD negativity following induction therapy, benefitting patients with highest-risk disease features.

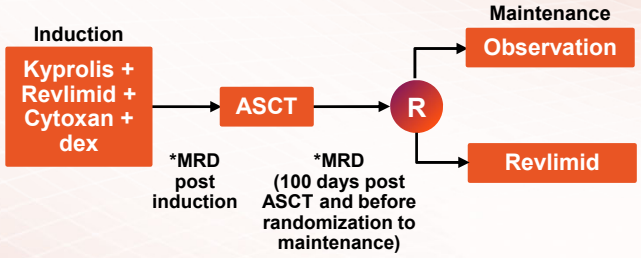
Nearly all patients with no or only one high-risk genetic abnormality and confirmed MRD negativity had no disease progression or MRD resurgence since stopping treatment.

*24 and 72 weeks after completion of therapy (by next-generation sequencing)

Costa LJ et al. *Blood*. 2021;138. Abstract 481; Costa LJ et al. *J Clin Oncol*. 2021; Dec 13 [epub ahead of print].

34

Potential Blood-Based MRD Testing: Mass Spectrometry



MRD is currently measured using a bone marrow sample; myeloma cells are detected using one of two methodologies: (1) flow cytometry or (2) next-generation sequencing.

Mass spectrometry (MS) is being evaluated as a method to detect free light chains (FLCs) in the blood as a potentially more sensitive test to detect MRD in patients after therapy.

MS positivity was associated with patients having a shorter time until disease progression compared to being MS negative.

In patients who achieved a CR or sCR, 16% to 34% were MS positive following induction, ASCT, or prior to maintenance; these patients also had a shorter time until disease progression compared to being MS negative and in CR/sCR.

Some patients who were MRD negative* and also MS positive also had a shorter time until disease progression compared to being MRD negative and MS negative.

MS may provide a useful alternative to bone marrow testing to detect MRD in patients and may even help to identify patients at increased risk of early relapse if they are MRD negative but MS positive during maintenance therapy.

*By flow cytometry at a sensitivity of 4×10^{-5}

Giles HV et al. *Blood*. 2021;138. Abstract 820.

35

Minimal Residual Disease *Summary*

- **MRD is the deepest response after myeloma treatment, including bone marrow MRD and imaging MRD. NGF and NGS are the two most commonly used marrow MRD tests. Blood-based MRD is in exploration.**
- **MRD has been associated with longer progression-free and overall survival to predict lower risk of progression. Modern combination therapies show increasingly higher MRD negativity rate.**
- **MRD response–directed therapy has been applied in more and more clinical trials to explore how to guide treatment decisions in myeloma.**
- **MRD is also useful as an end point in clinical trials helping to expedite new drug approval in myeloma.**

MRD, minimal residual disease; NGF, next-generation flow cytometry; NGS, next-generation sequencing

36

Recent Updates

37

What has changed recently?

- Tecvayli approval granted (October 2022)
- Blenrep approval withdrawn (November 2022)

38

Minimal Residual Disease Detection and Monitoring in the Blood by Mass Spectrometry

MRD is currently measured using a bone marrow sample; myeloma cells are detected using one of two methodologies: (1) flow cytometry or (2) next-generation sequencing.

Mass spectrometry (MS) is being evaluated as a method to assess MRD or M protein in the blood as a potentially more sensitive test to detect MRD in patients after therapy.

The phase 3 trials GEM2014MAIN and GMMG-MM5 are providing critical information on the use of this new technology compared to results from bone marrow biopsy samples.[1-3]

Sustained MRD negativity as determined by MS is prognostic for improved outcome, whereas MRD positivity is associated with worse outcome and is a potential marker for earlier treatment intervention.[4]

MS is more sensitive than measuring the M-spike (SPEP and IFE)

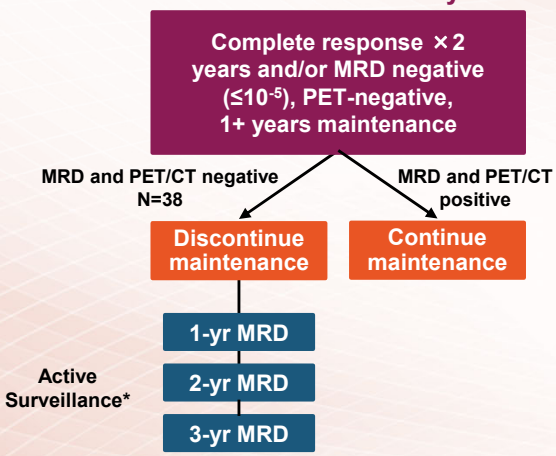
MS has a high concordance with bone marrow based MRD methods and can guide the need for bone marrow biopsies

1. Puig N et al. *Blood*. 2022;140. Abstract 866.
2. Notarfranchi L et al. *Blood*. 2022;140. Abstract 865.
3. Mai EK et al. *Blood*. 2022;140. Abstract 968
4. Claveau JS et al. *Blood*. 2022;140. Abstract 970.

39

Using MRD Negativity to Guide Discontinuation of Maintenance Therapy

MRD2STOP Study



89% remain on study (5% with PD, 6% withdrew).

MRD resurgence occurred in 13% of patients (2 patients had resurgence of M-protein and disease progression).

MRD negativity (at 10^{-6} and 10^{-7}) is sustained even after discontinuation of maintenance therapy.

MRD-guided discontinuation of maintenance may carry significant cost savings.

*MRD assessment performed with PET, flow cytometry (10^{-5}), next-generation sequencing (10^{-6}), and CD138-selected next-generation sequencing (10^{-7})

Derman BA et al. *Blood*. 2022;140. Abstract 870.

40

Health-Related Quality of Life for Patients With Newly Diagnosed Multiple Myeloma

Transplant-eligible patients[1]

Phase 2 GRIFFIN trial comparing daratumumab, lenalidomide, bortezomib, and dexamethasone (Dara-RVd) with RVd

- Both groups of patients had meaningful reduction in pain symptoms
- Large reductions in pain symptoms favored Dara-RVd (post-consolidation and throughout maintenance)
- Greater reduction in fatigue symptoms at maintenance for patients treated with Dara-RVd than RVd

Frail, transplant-ineligible patients[2]

Phase 3 MAIA trial comparing daratumumab, lenalidomide, and dexamethasone (Dara-Rd) with Rd

- Patients treated with Dara-Rd showed large reductions in pain from baseline, and pain symptoms improved compared with Rd
- Fatigue moderately improved in both treatment groups, but Dara-Rd did not increase fatigue
- Global health status improvements were consistent over time for patients in both treatment groups
- Emotional and social functioning improvements observed in both groups
- Physical functioning improved from baseline in patients treated with Dara-Rd
- No meaningful changes observed for nausea and vomiting in either group

1. Silbermann R et al. *Blood.* 2022;140. Abstract 473.
2. Perrot A et al. *Blood.* 2022;140. Abstract 472.

41

Frailty Status Changes Over Time

SEER-Medicare–linked database

Newly diagnosed myeloma patients ≥65 years receiving novel drugs between 2007–2014

4,617 patients identified

Non-frail	Prefrail	Mildly frail	Moderately frail	Severely frail
5%	25%	32%	23%	16%

Frailty status followed for 3 years

Frailty categorization changed in 93% of patients (78% improved, 72% deteriorated)

Current frailty status was a better predictor of overall survival than frailty at diagnosis.

Frailty categorization changes during myeloma disease course, necessitating the need for re-measurment.

Mian HS et al. *Blood.* 2022;140. Abstract 171.

42

Dexamethasone-Sparing Regimen for Frail Patients

IFM2017-03 Trial

Newly diagnosed myeloma patients (≥65 years old) with IFM frailty score ≥2

200 patients — **R** — **95 patients**

- **Revlimid + Darzalex (RD)**
- **Revlimid + dex (Rd)**

No dexamethasone!

- Deeper responses observed with RD vs Rd at 4, 8, and 12 months (≥VGPR rates 41% vs 26%; 68% vs 48%; 71% vs 55%, respectively).
- Favorable safety profile without increased infection or pneumonia with RD vs Rd

Encouraging results for a dexamethasone-sparing strategy for frail MM patients.

Manier S et al. *Blood*. 2022;140. Abstract 569.

43

High-Risk Disease Definitions

Revised International Staging System (R-ISS)[1]

R-ISS Stage I
- ISS[2] stage I
  - Serum β2M level <3.5 mg/L
  - Serum albumin level ≥3.5 g/dL
- No high-risk CA*
- Normal LDH level

R-ISS Stage II
- All other possible combinations

R-ISS Stage III
- ISS[2] stage III
  - Serum β2M level ≥5.5 mg/L
- High-risk CA* or high LDH level

*Deletion 17p and/or t(4;14) and/or t(14;16)

Mayo Clinic Stratification for Myeloma & Risk-Adapted Therapy (mSMART)[3]

High risk
- Genetic abnormalities*
  - t(4;14)
  - t(14;16)
  - t(14;20)
  - del 17p
  - p53 mutation
  - Gain 1q
- R-ISS Stage 3
- High plasma cell S-phase
- GEP: high-risk signature
- *Double-hit myeloma*: any two high-risk genetic abnormalities
- *Triple-hit myeloma*: three or more high-risk genetic abnormalities

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

*By FISH or equivalent

Additional Features
- **Disease features**
  - Other cytogenetic and genetic abnormalities
  - Plasma cell leukemia
  - Extramedullary disease
  - Renal failure
- **Patient features**
  - Comorbidities
  - Frailty
- **Response features**
  - Lack of response to therapy
  - Short first PFS

1. Palumbo A et al. *J Clin Oncol*. 2015;33:2863. **2.** Griepp PR et al. *J Clin Oncol*. 2005;23:3412. **3.** Mikhael J et al. *Mayo Clin Proc*. 2013;88:360.

44

Treatment Regimens for High-Risk Disease Features

Kyprolis-Revlimid-dex (KRd) vs Revlimid-Velcade-dex (RVd) Retrospective Chart Review[1]

- 154 consecutive high-risk* newly diagnosed myeloma patients treated with KRd (n=87) and VRd (n=67) at Memorial Sloan Kettering Cancer Center from 2015 to 2019
- Patients receiving KRd vs RVd had:
  - Greater depth of response
  - Significant improvement in PFS (especially those who received early ASCT)
- R-ISS stage II and III (compared to stage I) were significant predictors for progression or death
- More than 6 cycles of treatment was associated with longer PFS and OS

*High risk cytogenetic abnormalities defined as 1q+ (gain or amp), t(4;14), t(14;16), t(14;20), and/or del(17p) or monosomy 17.

OPTIMUM Study[2]

- Study to evaluate the efficacy of Darzalex-cyclophosphamide-Velcade-Revlimid-dex (Dara-CyVRd) induction followed by ASCT and 2 rounds of consolidation with Dara-VR (with or without dex) in 107 ultra high-risk† patients with multiple myeloma and plasma cell leukemia (PCL)
- By end of second consolidation, 46.7% of patients were MRD negative (10^{-5}); 84% of patients who were MRD negative after ASCT sustained their MRD negativity at the end of second consolidation
- 86% of patients were alive and 77% were progression free at 30 months

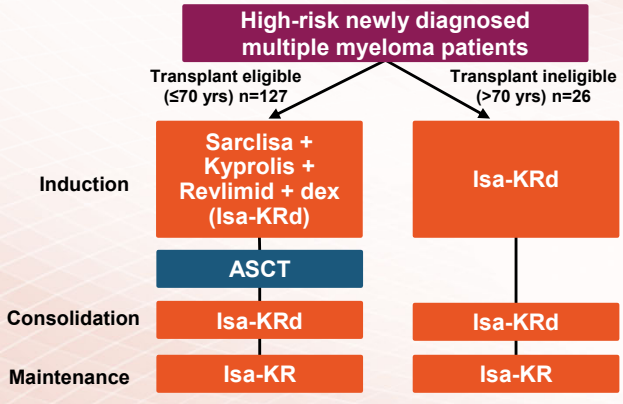
†≥2 high risk lesions: t(4;14), t(14;16), t(14;20), gain(1q), del(1p), del(17p), or SKY92 risk signature.

1. Tan C et al. *Blood.* 2022;140. Abstract 752.
2. Kaiser MF et al. *Blood.* 2022;140. Abstract 758.

45

Sarclisa Combinations in Newly Diagnosed Patients With High-Risk Disease

GMMG-CONCEPT Study



Total population cytogenetic abnormalities: 44% del(17p); 38.4% t(4;14); 15.2% t(14;16); 36% >3 copies of 1q21; 30.4% ≥2 high-risk cytogenetic abnormalities

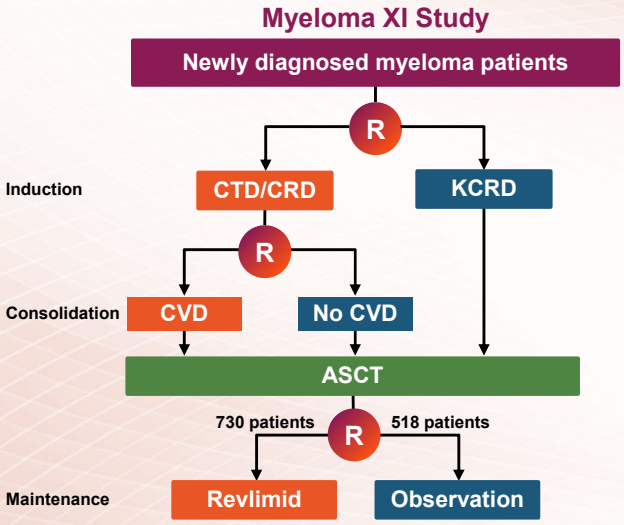
Best Response (through consolidation), %	Transplant Eligible (n=99)	Transplant Ineligible (n=26)
Overall response rate	**94.9**	**88.5**
sCR/CR	72.7	57.7
VGPR	18.2	30.8
PR	4.0	0
SD	0	0
MRD negative (1×10^{-5}) in evaluable patients	67.7	54.2

Adverse Events, % Grade ≥3	Transplant Eligible (n=97)	Transplant Ineligible (n=25)
Hematologic		
Neutropenia	39.2	28
Leukopenia	24.7	4
Thrombocytopenia	26.8	16
Anemia	14.4	12
Non-hematologic		
Infection	27.8	28
Cardiac	2.1	20

Weisel KC et al. *Blood.* 2022;140. Abstract 759.

46

Maintenance Duration



Median PFS (mos)	At Time of Randomization to Maintenance Therapy (median follow up 44.7 mos)
	All Patients*
Revlimid	64
Observation	32
Hazard Ratio	0.52
P Value	<0.001

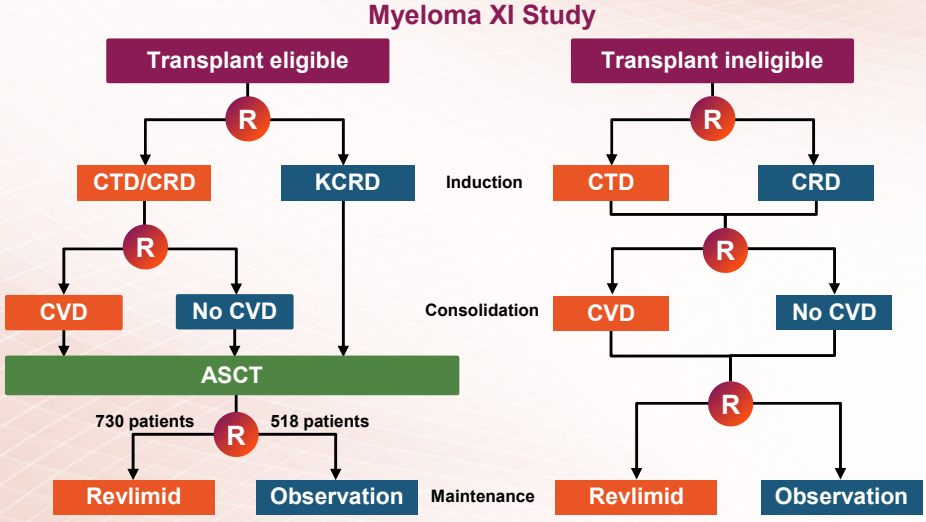
*PFS benefit across all patient subgroups on Revlimid maintenance therapy: standard risk; molecular high risk which included the presence of del(17p), gain(1q), t(4;14), t(14;16), or t(14;20); MRD positive; and MRD negative.

More evidence for the benefit of longer duration of Revlimid maintenance in patients who are MRD positive than MRD negative. And evidence of ongoing benefit beyond 2–3 years for patients with both standard- and high-risk disease.

Pawlyn C et al. *Blood*. 2022;140. Abstract 570.

47

Second Primary Malignancies With Revlimid



Transplant eligible:
- 5.5% developed an SPM overall
- SPM incidence was 12.2% at 7 years in lenalidomide maintenance arm compared to 5.8% in the observation arm

Transplant ineligible:
- 9.9% developed an SPM overall
- SPM incidence was 17.1% at 5 years in lenalidomide maintenance arm compared to 10% in the observation arm

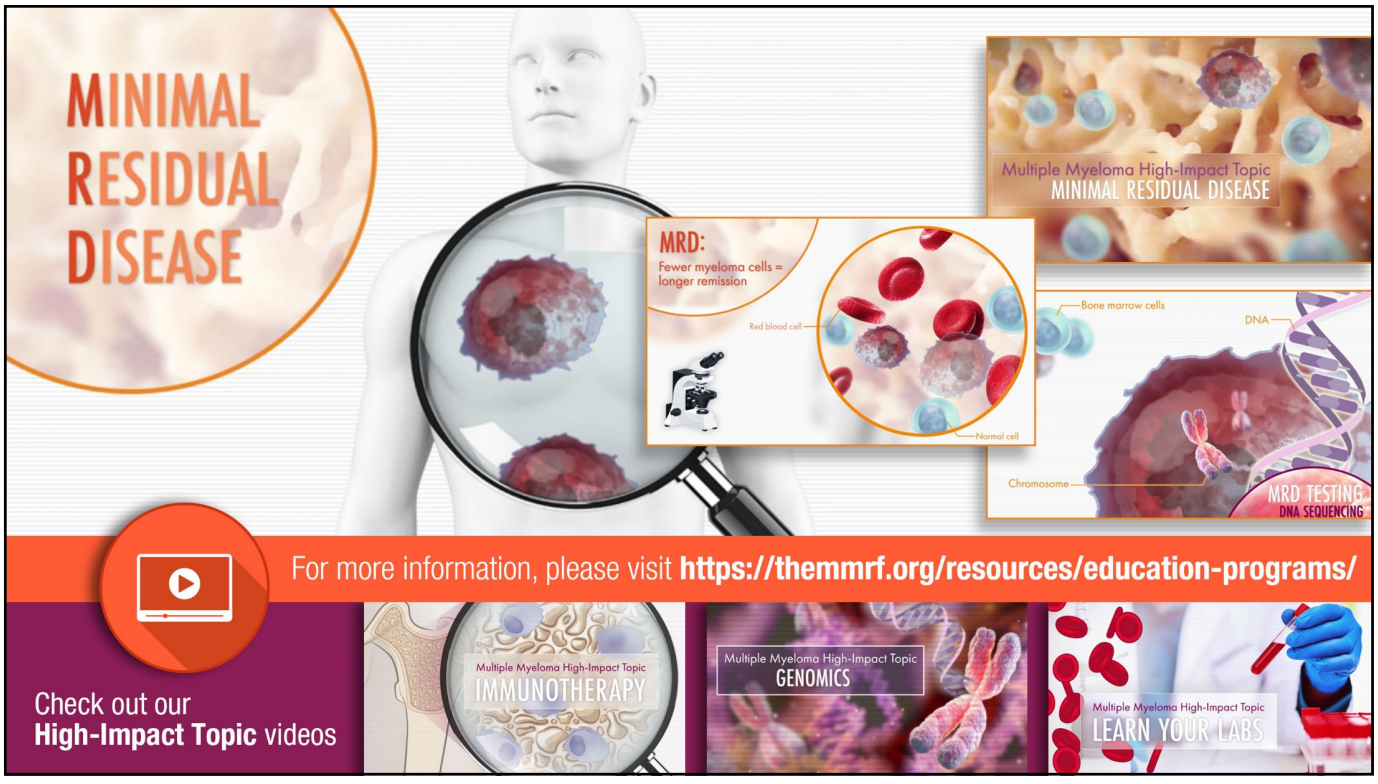
Double-exposure to lenalidomide (induction and maintenance) is associated with higher incidence of SPM and is more marked in transplant-ineligible patients.

Jones JR et al. *Blood*. 2022;140. Abstract 754.

48

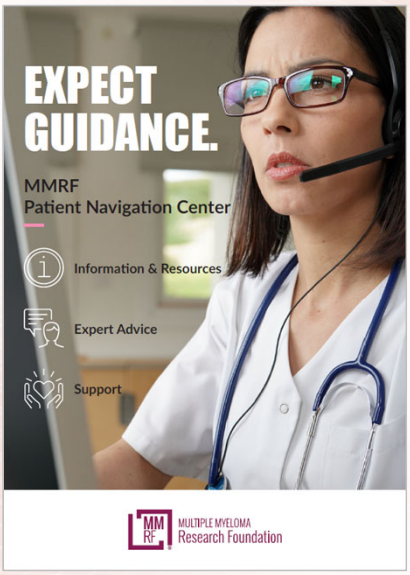
Questions & Answers

49



50

MMRF Patient Resources



MMRF Patient Navigation Center

You and your care team will have many decisions to make along your treatment journey. The Patient Navigation Center is a space for multiple myeloma patients and their caregivers to connect with patient navigators — who are professionals specializing in oncology — for guidance, information, and support. You can connect with a patient navigator via phone, or email. Whatever questions you may have, our patient navigators are here to help.

MMRF Patient Navigators include:
- Grace Allison, RN, BSN, OCN, RN-BC
- Brittany Hartmann, RN-BSN
- Erin Mensching, RN-BSN, OCN

THE RIGHT TRACK

Get on the right track for you

The MMRF's Right Track program puts you on the path to the best results for you.

Right Team
Access experts and centers that have extensive experience treating multiple myeloma.

Right Tests
Get the information, tests, and precise diagnoses to make the right treatment decisions.

Right Treatment
Work with your team to consider the best treatment plan and identify clinical trials that are right for you.

Contact the Patient Navigation Center Today

Looking for guidance? We're here to help.

Monday – Friday | 9:00AM – 7:00PM ET

Phone: 1-888-841-MMRF (6673) Online: TheMMRF.org/PatientNavigationCenter

Email: patientnavigator@themmrf.org

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51

Myeloma Mentors®

Myeloma Mentors® allows patients and caregivers the opportunity to connect with trained mentors. This is a phone-based program offering an opportunity for a patient and/or caregiver to connect one-on-one with a trained patient and/or caregiver mentor to share his or her patient journeys and experiences.

No matter what your disease state—smoldering, newly diagnosed, or relapsed/refractory—our mentors have insights and information that can be beneficial to both patients and their caregivers.

Contact the Patient Navigation Center at 888-841-6673 to be connected to a Myeloma Mentor or to learn more.

52

53

Upcoming Patient Education Events

Save the Date

Topic	Date and Time (ET)	Speakers
Webinar (rebroadcast): *Management of Patients Who Have Relapsed After One to Three Prior Lines of Therapy*	Wednesday, March 8 1:00 to 2:00 PM ET	Larry Anderson, Jr, MD, PhD Faith Davies, MBBCh, MD
Patient Summit Hackensack, NJ	Saturday, March 11 9:00 AM to 2:00 PM ET	David Vesole, MD, PhD
Patient Summit Scottsdale, AZ	Saturday, March 25 9:00 AM to 2:00 PM MT	*In collaboration with Arizona Myeloma Network*
Webinar (rebroadcast): *Multiple Myeloma Precursor Conditions*	Wednesday, April 5 2:30 to 3:30 PM ET	Sagar Lonial, MD Omar Nadeem, MD

For more information or to register, visit
themmrf.org/resources/education-program

54


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Thank you!
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56