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

February 17, 2023

Tech Support

1-719-234-7952
Resources

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

Submit your questions throughout the program!
MMRF Research Initiatives

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Speakers

Suzanne Lentzsch, MD, PhD  
Columbia University Medical Center  
New York, New York

Cesar Rodriguez, MD  
Tisch Cancer Institute  
The Icahn School of Medicine at Mount Sinai  
New York, New York
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
Clinical Director for Multiple Myeloma
Tisch Cancer Institute
New York, New York

Overview of Treatment Approach for Active Multiple Myeloma

Is the patient a candidate for autologous stem cell transplantation?

Yes
• 3–4 cycles of induction therapy
  – 3- to 4-drug regimen generally preferred
  • Clinical trial

Stem cell collection and storage
High-dose melphalan + stem cell transplant
Consolidation and or continuous/maintenance therapy
Supportive care

No
• Any of the regimens used for transplant candidates*
  • Clinical trial
  *2-drug regimen may be considered for frail patients
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

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

- Stem cell mobilization
  - Neupogen, Neulasta, Leukine, Cytoxan, Mozobil
- Melphalan
  - Alkeran, Evolena

~4–6 cycles
-2 to -3 weeks*
Day 0
Days +1 to +100†

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

- Early ASCT (RVd + ASCT)
- Late ASCT (RVd alone)

Median PFS: 50 months
Median PFS: 36 months

P = 0.001

Overall Survival (OS)

- Early ASCT (RVd + ASCT)
- Late ASCT (RVd alone)

4-year OS rate: 82%
4-year OS rate: 81%

P = 0.87

ASCT, autologous stem cell transplantation

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

- Early ASCT (RVd + ASCT)
- Late ASCT (RVd alone)

P = 0.751

Overall Survival

8 y-OS 62.2% (Early ASCT [RVd + ASCT])
8 y-OS 60.2% (Late ASCT [RVd alone])

P = 0.815

Early vs Delayed Transplant Pros and Cons

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early ASCT</strong></td>
<td>20% of patients still relapse within 2 years</td>
</tr>
<tr>
<td>Youngest you are going to be</td>
<td>1% risk of serious life-threatening complications</td>
</tr>
<tr>
<td>Healthiest you are going to be</td>
<td>3 months of full clinical recovery</td>
</tr>
<tr>
<td>Allows for fewer cycles of initial treatment</td>
<td>No proven impact on overall survival</td>
</tr>
<tr>
<td>Deeper and more durable response</td>
<td><strong>Delayed ASCT</strong></td>
</tr>
<tr>
<td><strong>Delayed ASCT</strong></td>
<td>60%–70% of patients will relapse and may need it as salvage</td>
</tr>
<tr>
<td>Conserve quality of life in the early part of disease journey</td>
<td>Not all patients relapsing are unable to undergo salvage HCT</td>
</tr>
<tr>
<td>Minimize disruption to lifestyle</td>
<td>May need longer duration of chemotherapy to replace its effects</td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

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.
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.

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
Revlimid Maintenance Therapy: Improves Depth of Response

Disease Response

Number of Patients

Before Maintenance | During/After Maintenance
---|---
MRD negative | 11 | 14
CR | 34 | 49
VGPR | 57 | 72
≤PR | 37 | 14


At maximal response during or after maintenance treatment with Revlimid

Cumulative Survival

PFS (Months)

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

STAMINA Trial (BMT-CTN0702)

ASCT MEL 200 mg/m²

Consolidation | Maintenance
---|---
MEL 200 mg/m² | REV × 3 yrs
Auto/Auto group
RVD × 4 | REV × 3 yrs
Auto/RVD group
No consolidation | REV × 3 yrs
Auto/Rev group

MEL, melphalan; RVD, Revlimid-Velcade-dex; REV, Revlimid

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Revlimid Maintenance: Cumulative Incidence of Second Primary Malignancies

- **Hematologic**
  - **Lenalidomide**
  - **Control**
  - HR (95% CI): 2.03 (1.14–3.61)
  - \( P = 0.015 \)

- **Solid Tumor**
  - **Lenalidomide**
  - **Control**
  - HR (95% CI): 1.71 (1.04–2.79)
  - \( P = 0.032 \)


Continuous or Maintenance Therapy Options

<table>
<thead>
<tr>
<th>Transplant eligible</th>
<th>Preferred</th>
<th>Recommended</th>
<th>Certain circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revlimid*</td>
<td>Ninlaro*</td>
<td>Velcade-Revlidim ± dex</td>
</tr>
<tr>
<td>Transplant ineligible</td>
<td>Revlimid*</td>
<td>Ninlaro*</td>
<td>Velcade-Revlidim</td>
</tr>
</tbody>
</table>

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.
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.

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**Minimal Residual Disease Negativity as a Multiple Myeloma Treatment Goal**

**Suzanne Lentzsch, MD, PhD**

Professor of Medicine
Director of the Multiple Myeloma and Amyloidosis Program
Columbia University Medical Center
New York, New York
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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

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

Measuring Response to Therapy

- Stable disease
- Minor response
- Partial response
- Very good partial response
- Complete response (CR)
- Stringent CR
- Minimal residual disease negative

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

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.
How is MRD measured?

- **Diagnostic Tumor burden**
- **Flow cytometry**
- **Next-generation DNA sequencing**

Key Terms for MRD

- **MRD positive or MRD positivity (MRD+)**
  - Myeloma cells are still detected

- **MRD negative or MRD negativity (MRD-)**
  - 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).
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.

Why is it important to achieve MRD negativity?

- **Initial therapy RVD: 3 cycles**
  - Stem cell collection
  - Cytoxan
- **High-dose chemotherapy + ASCT**
- **Consolidation: RVD: 2 cycles**
- **Maintenance: Revlimid 12 months**
- **Continue RVD: 5 cycles**
- **Maintenance: Revlimid 12 months**

RVD, Revlimid, Velcade, dexamethasone; Cytoxan, cyclophosphamide

**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.

![Graph showing comparison between MRD negative and MRD positive patients over time](Image)


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**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.

*M5 trials included stem cell transplantation/10 studies included maintenance*

MRD Is Important for Clinical Care and New Drug Registration

- Currently assessed by BM-based technologies: Flow cytometry and next-generation sequencing.
- A surrogate for patient outcome in clinical trials.
- Progress being made with blood-based technologies: MS and cell-free DNA.
- Many clinical trials are using MRD-driven strategies.

MRD Response-Adapted Consolidation and Treatment Cessation

**MASTER Trial**

- Newly diagnosed myeloma patients

**Induction**

- Darzalex + Kyprolis + Revlimid + dex (Dara-KRd)
- MRD

**ASCT**

- 2nd MRD- (<10^-5)

**Consolidation**

- Dara-KRd
- MRD

**Consolidation**

- Dara-KRd
- MRD

**Maintenance**

- Revlimid
- MRD

- Treatment-free observation and MRD surveillance*

- 80% of patients achieved MRD negativity (at <1 \times 10^{-5}) and 66% achieved MRD negativity at <1 \times 10^{-6}.
- 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)


BM, bone marrow; MS, mass spectrometry

**Potential Blood-Based MRD Testing: Mass Spectrometry**

**Induction**
- Kyprolis + Revlimid + Cytoxan + dex
- *MRD post induction* (100 days post ASCT and before randomization to maintenance)

**Maintenance**
- Observation
- Revlimid

**MS positivity**
- 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.**

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.

*By flow cytometry at a sensitivity of 4 × 10⁻⁵

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**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
Recent Updates

What has changed recently?

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

Using MRD Negativity to Guide Discontinuation of Maintenance Therapy

MRD2STOP Study

Complete response × 2 years and/or MRD negative (≤ 10^-5), PET-negative, 1+ years maintenance

MRD and PET/CT positive

Discontinue maintenance

MRD and PET/CT negative N=38

Continue maintenance

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)

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

**Transplant-eligible patients**

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**

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


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

<table>
<thead>
<tr>
<th>Frailty Status</th>
<th>Non-frail</th>
<th>Prefrail</th>
<th>Mildly frail</th>
<th>Moderately frail</th>
<th>Severely frail</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>25%</td>
<td>32%</td>
<td>23%</td>
<td>16%</td>
<td></td>
</tr>
</tbody>
</table>

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-measurement.

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Dexamethasone-Sparing Regimen for Frail Patients

**IFM2017-03 Trial**

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

- **200 patients**
- **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.


High-Risk Disease Definitions

**Revised International Staging System (R-ISS)**

**R-ISS Stage I**
- ISS2 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**
- ISS3 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)**

**High risk**
- Genetic abnormalities*
  - t(4;14) 
  - t(14;16) 
  - p53 mutation 
  - t(14;20) 
  - 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

Treatment Regimens for High-Risk Disease Features

**Kyprolis-Revlimid-dex (KRd) vs Revlimid-Velcade-dex (RVd) Retrospective Chart Review**

- 154 consecutive high-risk* newly diagnosed myeloma patients treated with KRd (n=87) and RVd (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**

- Study to evaluate the efficacy of Darzalex-cyclophosphamide-Velcade-Revlimd-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.

Sarclisa Combinations in Newly Diagnosed Patients With High-Risk Disease

**GMMG-CONCEPT Study**

- 127 transplant eligible (≤70 yrs)
- 26 transplant ineligible (>70 yrs)
- **Best Response (through consolidation), %**
- **Transplant Eligible (n=99)**
  - Overall response rate 94.9
  - sCR/CR 72.7
  - VGPR 18.2
  - PR 4.0
  - SD 0
- **Transplant Ineligible (n=26)**
  - Overall response rate 88.5
  - sCR/CR 57.7
  - VGPR 30.8
  - PR 0
  - SD 0
- MRD negative (1 × 10⁻⁵) in evaluable patients:
  - Transplant Eligible (n=97) 67.7
  - Transplant Ineligible (n=25) 54.2

**Adverse Events, % Grade ≥3**

<table>
<thead>
<tr>
<th>Hematologic</th>
<th>Transplant Eligible (n=97)</th>
<th>Transplant Ineligible (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutropenia</td>
<td>39.2</td>
<td>28</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>24.7</td>
<td>4</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>26.8</td>
<td>16</td>
</tr>
<tr>
<td>Anemia</td>
<td>14.4</td>
<td>12</td>
</tr>
</tbody>
</table>

**Non-hematologic**

<table>
<thead>
<tr>
<th>Infection</th>
<th>Transplant Eligible (n=97)</th>
<th>Transplant Ineligible (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.8</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

**Maintenance Duration**

**Myeloma XI Study**

Newly diagnosed myeloma patients

- Induction:
  - CTD/CRD
  - KCRD
- Consolidation:
  - CVD
  - No CVD
- Maintenance:
  - Revlimid
  - Observation

**Median PFS (mos)**

<table>
<thead>
<tr>
<th>At Time of Randomization to Maintenance Therapy (median follow up 44.7 mos)</th>
<th>All Patients*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revlimid</td>
<td>64</td>
</tr>
<tr>
<td>Observation</td>
<td>32</td>
</tr>
<tr>
<td>Hazard Ratio</td>
<td>0.52</td>
</tr>
<tr>
<td>P Value</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

*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.

**Second Primary Malignancies With Revlimid**

**Myeloma XI Study**

Transplant eligible:

- 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:

- 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.

Questions & Answers
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.
### Upcoming Patient Education Events

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

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