Navigating the treatment of RRMM with BCMA-directed therapies: Updates from COMy, ASCO and EHA 2025

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Recorded following **COMy** (15–18 May 2025, Paris, France), **ASCO** (30 May–3 June 2025, Chicago, IL, USA) and **EHA** (12–15 June 2025, Milan, Italy)

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How should we interpret the latest clinical evidence for approved BCMA-directed therapeutic approaches to managing RRMM?

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Recorded following **COMy** (15–18 May 2025, Paris, France),
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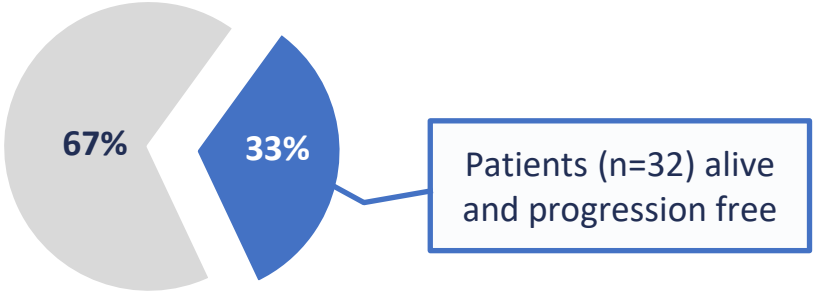
7507: Long-term (≥5 year) remission and survival after treatment with cilta-cel in CARTITUDE-1 patients with RRMM

Voorhees P, et al.

Survival outcomes ≥5 years post cilta-cel infusion

- ≥3 LoT, including a PI, IMiD and an anti-CD38 mAb
- Double refractory to PI and IMiD

N=97



Follow-up: 61.3 months
mOS: 60.7 months (95% CI 41.9–NE)

BL characteristics according to progression status

	PD (<5 years) n=46	PF (≥5 years) n=32
Median age, years (range)	61.5 (47–77)	60.0 (43–78)
Extramedullary disease, %	13	13
High-risk cytogenetics, %	27	23
Prior LoT, median (range)	5 (3–18)	6.5 (3–14)
Refractory to prior therapy, %		
Triple-class	85	91
Penta-class	33	47
High BL tumour burden, %	17	6

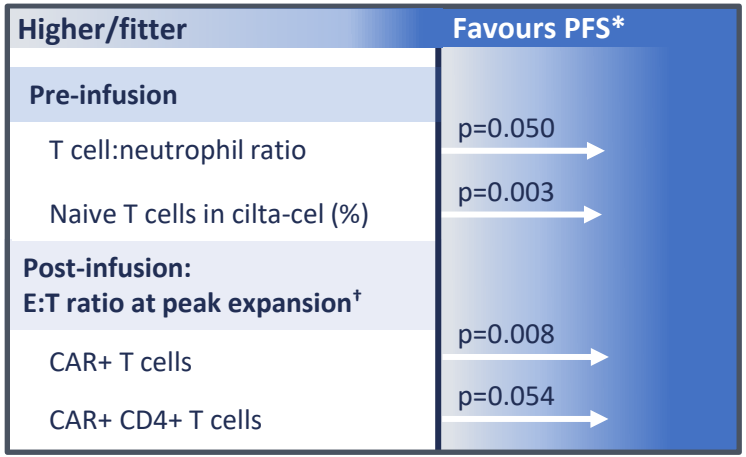
Apart from tumour burden (6% vs 17%), BL characteristics of patients who were PF at ≥5 years were comparable to those with PD in <5 years*

*Serial MRD and PET/CT assessments for 12 patients in complete remission from a single centre had MRD-negativity ≥10^{-5}.
BL, baseline; CI, confidence interval; cilta-cel, ciltacabtagene autoleucel; IMiD, immunomodulatory drug; LoT, line of therapy; m, median; mAb, monoclonal antibody; MRD, minimal residual disease; NE, not estimable; OS, overall survival; PD, progressive disease; PET/CT, positron emission tomography/computerized tomography; PF, progression free; PI, protease inhibitor; RRMM, relapsed/refractory multiple myeloma.
Voorhees P, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7507.

7507: Long-term (≥5 year) remission and survival after treatment with cilta-cel in CARTITUDE-1 patients with RRMM

Voorhees P, et al.

Biomarkers associated with PFS at ≥5 years



Safety in patients without PD at ≥5 years

At 61.3 months follow-up:

- Second primary malignancy: 2 cases
  - Lung adenocarcinoma
  - Anal squamous cell carcinoma
- Parkinsonian or CNP: 0 cases
- Grade 3 infections: 4 cases (not related to cilta-cel)

These data provide the first evidence that cilta-cel is potentially curative in patients with RRMM

*Statistical testing provided for descriptive purposed only: two-sided nominal p-values unadjusted for multiple testing.
†E:T ratio was defined as CAR-positive T cells normalized by pre-infusion serum BCMA levels.
BCMA, B-cell maturation antigen; CAR, chimeric antigen receptor; cilta-cel, ciltacabtagene autoleucel; CNP, cranial nerve palsy; E:T, effector-to-target; PD, progressive disease; PFS, progression free; RRMM, relapsed/refractory multiple myeloma.
Voorhees P, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025, Abstr. 7507.

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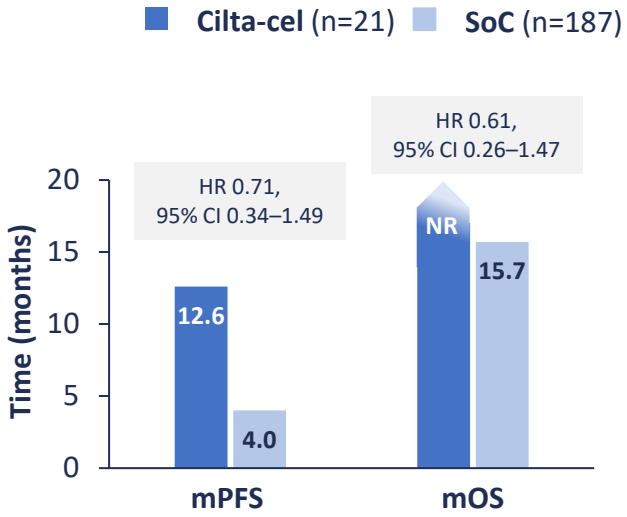
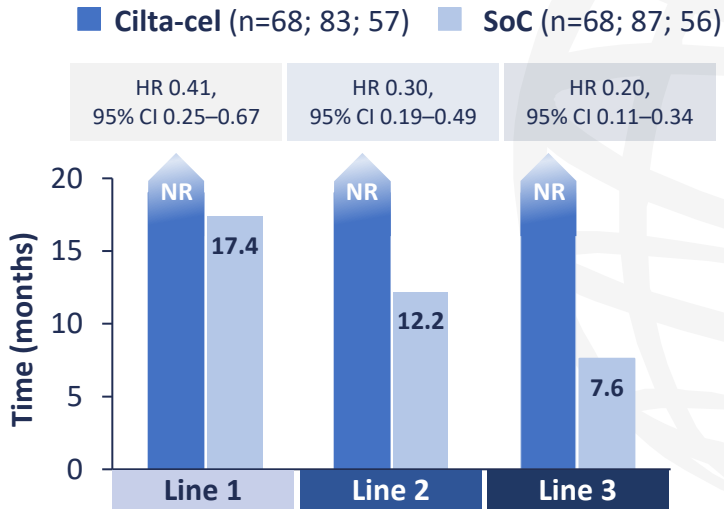
7539: Cilta-cel vs SoC in patients with RRMM: CARTITUDE-4 survival subgroup analyses

Sidana S, et al.

EMD (median follow-up: 33.6 months)



Prior LoT: mPFS (median follow-up: 33.6 months)



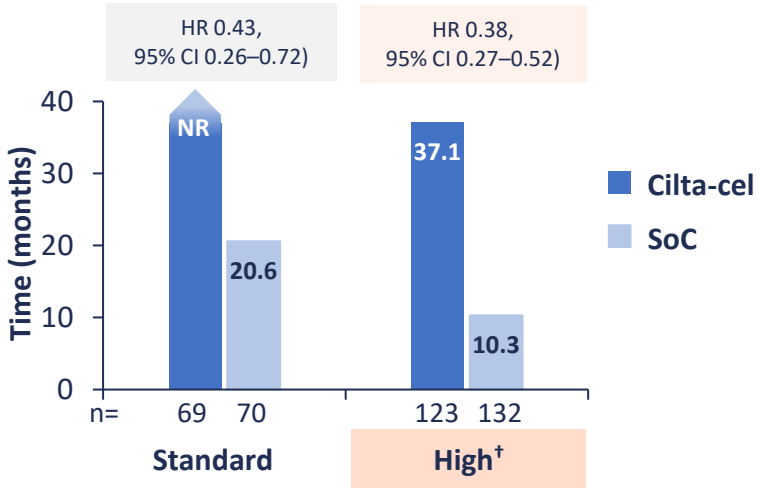
CI, confidence interval; cilta-cel, ciltacabtagene autoleucel; EMD, extramedullary disease; HR, hazard ratio; LoT, lines of therapy; m, median; NR, not reached; OS, overall survival; PFS, progression-free survival; RRMM, relapsed/refractory MM; SoC, standard of care.

Sidana S, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7539.

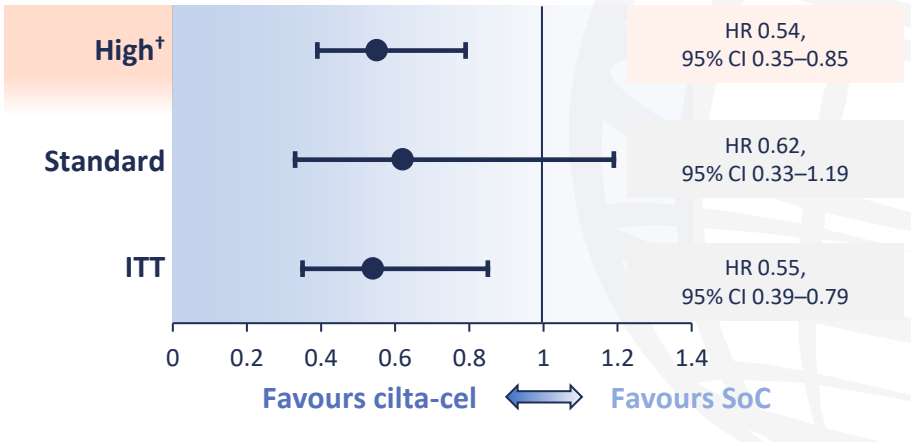
7539: Cilta-cel vs SoC in patients with RRMM: CARTITUDE-4 survival subgroup analyses

Sidana S, et al.

Cytogenetic risk: mPFS*



Cytogenetic risk: mOS*



Cilta-cel offers a positive benefit:risk ratio vs SoC for patients with lenalidomide-refractory MM as early as after the first relapse. It may overcome the poor prognosis associated with high-risk cytogenetics.

*Median follow-up: 33.6 months. †High risk was defined as, del(17p), t(4;14), t(14;16), or gain/amp(1q).
CI, confidence interval; cilta-cel, ciltacabtagene autoleucel; HR, hazard ratio; ITT, intent-to-treat; m, median; MM, multiple myeloma; NR, not reached; OS, overall survival; PFS, progression-free survival; RRMM, relapsed/refractory MM; SoC, standard of care.

Sidana S, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7539.

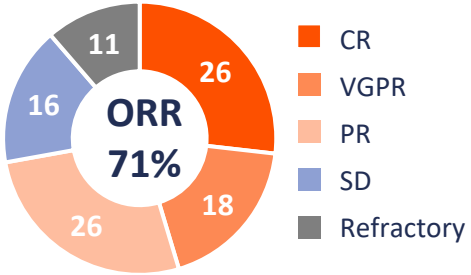
PF796: Single-agent elranatamab for RRMM: Multicentre real-world outcomes from five United Kingdom sites

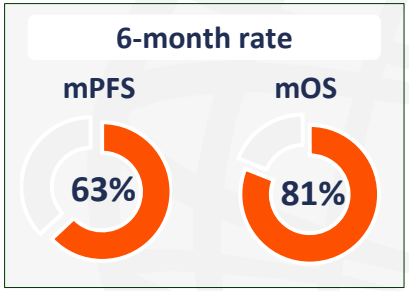
Tomkins O, et al.

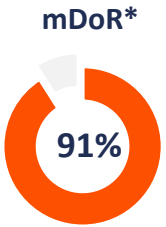
Baseline characteristics

Refractory to ≥1 PI, ≥1 IMiD, and ≥1 anti-CD38 mAb	N=43
Median age, years (range)	63.5 (45–80)
ECOG PS (0/1/2), %	23 / 60 / 16
Extra/paramedullary disease, %	26
High-risk cytogenetics, %	47
Prior LoT, median (range)	**4 (2–7)**
Therapy class (exposure/refractory), %	
Triple-class	100/79
Penta-class	44/23
Prior anti-BCMA, %	9

Efficacy (median follow-up: 8.5 months)







PFS was unaffected by:

- Prior anti-BCMA exposure
- Extra/paramedullary disease
- High-risk cytogenetic abnormalities

*Remaining in response at 9 months.

BCMA, B-cell maturation antigen receptor; CR, complete response; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group Performance Status; IMiD, immunomodulatory drug; LoT, lines of therapy; m, median; mAb, monoclonal antibody; ORR, objective response rate; OS, overall survival; PFS, progression-free disease; PI, protease inhibitor; PR, partial response; RRMM, relapsed/refractory multiple myeloma; SD, stable disease; VGPR, very good PR.

Tomkins O, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PF796.

PF796: Single-agent elranatamab for RRMM: Multicentre real-world outcomes from five United Kingdom sites

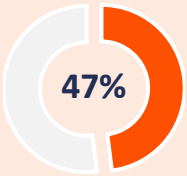
Tomkins O, et al.[1]

Safety (median follow-up: 8.5 months)

TEAEs, %	Any grade	Grade ≥3
CRS	63	0
ICANS	5	0
Bacterial infections*	47	37
Viral infections	48	16
Anaemia	67	16
Neutropenia	53	44
Thrombocytopenia	48	16

- Ig replacement 67%†
- Dry skin 30%
- GI TEAEs 26%

Discontinuations



Primary reasons, %

- Progression: 50
- Death: 30
- Toxicities: 15

The UK cohort was frailer, with a larger proportion of patients with high-risk disease vs the patients in the phase II MagnetisMM-3 study;[2] nonetheless, the real-world data are comparable to the trial data

*Confirmed or suspected. †Median time into treatment: 3 months (0.0–6.6 months).
CRS, cytokine release syndrome; GI, gastrointestinal; ICANS, immune effector cell-associated neurotoxicity syndrome; Ig, immunoglobulin; RRMM, relapsed/refractory multiple myeloma; TEAE, treatment-emergent adverse event.

1. Tomkins O, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PF796; 2. Lesokhin AM, et al. *Nat Med*. 2023;29:2259–67.

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7531: Indirect comparison of linvoseltamab vs elranatamab for triple-class exposed RRMM

Jagannath S, et al.

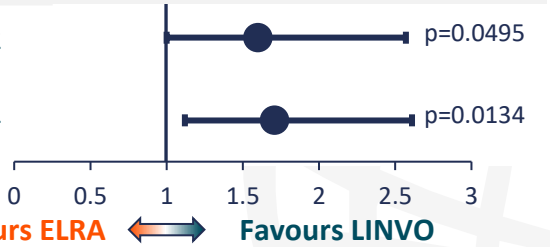
Baseline characteristics (unadjusted)

	ELRA (N=123)	LINVO (N=107)
≥75 years, %	20	24
ECOG PS ≥1, %	63	72
R-ISS III, %	15	12
EMD/EMP,* %	32	29
High-risk cytogenetics, %	25	38
Refractory status, %		
Triple-class only	55	54
Penta class	41	30

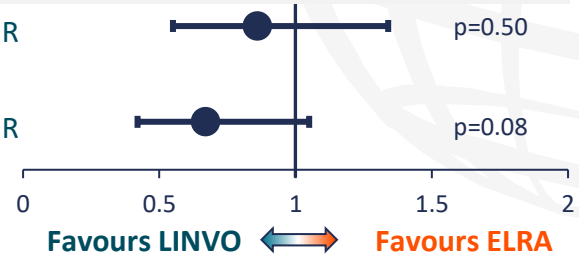
Linvoseltamab may be associated with higher efficacy vs elranatamab in triple-class exposed RRMM

Outcomes (ELRA vs LINVO [adjusted])

	ELRA†	LINVO‡
ORR, %	61	72
≥CR, %	37	51



mPFS, months	17.6	NR
mOS, months	24.6	NR



*Paramedullary disease or EMD/EMP. †Median follow-up: 33.9 months. ‡Median follow-up: 21.3 months.
CI, confidence interval; CR, complete response; ECOG PS, Eastern Cooperative Oncology Group performance status; ELRA, elranatamab; EMD/EMP, extramedullary disease/extramedullary plasmacytoma; HR, hazard ratio; LINVO, linvoseltamab; m, median; NR, not reached; OR, odds ratio; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; R-ISS, Revised-International Staging System; RRMM, relapsed/refractory multiple myeloma.

Jagannath S, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7531.

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What do emerging data tell us about the practical application, such as sequencing, of BCMA-directed therapies in RRMM?

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Recorded following **COMy** (15–18 May 2025, Paris, France),
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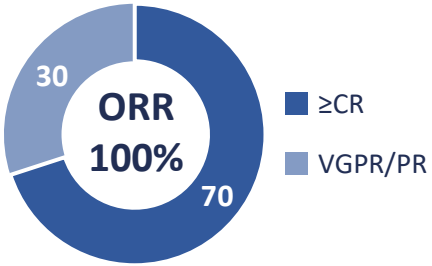
PF758: Sequential BCMA CAR T-cell therapy in refractory MM

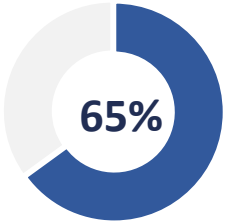
Richardson T, et al.

Efficacy and safety (N=10, median follow-up: 8.8 months)

- **Median interval between CAR T-cell therapies**: 1.9 years
- **Bridging therapy included**: belantamab mafodotin (n=1) and talquetamab (n=3)



6-month PFS rate



- No new safety signals or grade ≥3 CRS/ICANS
- Trochlear palsy was observed in one patient; there were no other NTs

Patients with **<12 months PFS after ide-cel** had significantly poorer outcomes (p=0.0024) following **retreatment with cilta-cel**

This study provides the largest real-world analysis supporting the feasibility and efficacy of sequential BCMA-directed CAR-T therapy (ide-cel → cilta-cel). The findings may help inform clinical decisions in the management of post-CAR T-cell therapy relapse in RRMM.

BCMA, B-cell maturation antigen; CAR, chimeric antigen receptor; cilta-cel, ciltacabtagene autoleucel; CR, complete response; CRS, cytokine release syndrome; ICANS, immune cell-associated neurotoxicity syndrome; ide-cel, idecabtagene vicleucel; MM, multiple myeloma; NT, neurotoxicity; ORR, objective response rate; PFS, progression-free survival; PR, partial response; RRMM, relapsed/refractory MM; VGPR, very good PR.

Richardson T, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PF758.

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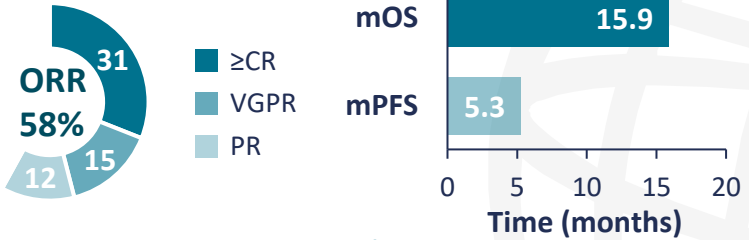
PS1721: BCMA-targeting T-cell redirecting BsAb therapy post-GPRC5D-directed BsAb in RRMM (IFM 2024-13 BCMA post-GPRC5D)

Hulin C, et al.

Baseline characteristics

	N=26
Median age, years (range)	72 (53–80)
Teclistamab:elranatamab, %	77:23
IgG subtype, %	50
Extramedullary disease, %	31
High-risk cytogenetics, %	31
Prior LoT, median (range)	7 (3–15)
Triple-class refractory, %	81
Prior talquetamab:forimtamig, %	58:42
Prior BCMA-directed therapy,* %	38

Efficacy and safety (median follow-up: 20.0 months)



CRS, gr <3 **50%**

Infections, gr ≥3 **38%**

Toxicity-related discontinuations **15%**

Dose spacing **46%**

BCMA-targeting BsAbs following progression on GPRC5D-targeting BsAbs is feasible in heavily pretreated MM. No additional toxicities were observed. Sequencing BsAbs appears to be a viable strategy in MM treatment.

*4 CAR T-cell therapy and 6 belantamab mafodotin. BCMA, B cell maturation antigen; BsAb, bispecific antibody; CAR, chimeric antigen receptor; CR, complete response; CRS, cytokine release syndrome; GPRC5D, G protein–coupled receptor, family C, group 5, member D; gr, grade; Ig, immunoglobulin; LoT, lines of therapy; m, median; MM, multiple myeloma; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PR, partial response; RRMM, relapsed/refractory MM; VGPR, very good PR.

Hulin C, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PS1721.

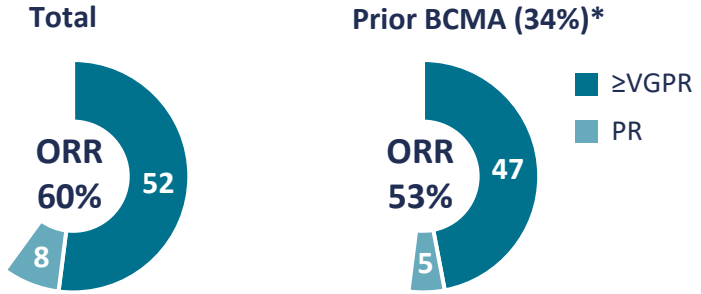
PF770: REALiTEC subgroup analysis: A multi-country observational retrospective study of teclistamab in patients with RRMM outside of clinical trials

Popat R, et al.[1]

Baseline characteristics

Preapproval access (n=100) Commercial teclistamab (n=13)	N=113
Median age, years (range)	66 (43–86)
ECOG PS ≥1, %	55
Extramedullary plasmacytoma, %	15
Prior LoT, median (range)	6 (2–12)
High-risk cytogenetics, %	52
Prior therapy (exposed/refractory), % Triple-class Penta-class	 100/79 88/44
Prior anti-BCMA therapy, %	34

Efficacy (median follow-up: 20.7 months)



Patients meeting MajesTEC-1 eligibility criteria[2]
had significantly better outcomes vs those who did not:
PFS, p=0.004; OS, p=0.015; DoR, p=0.024

REALiTEC demonstrates comparable outcomes to MajesTEC-1 in patients treated outside of clinical trials, with no significant differences in effectiveness considering subgroups with historically poorer outcomes

*32 ADCs and 10 CAR T. ADC, antibody–drug conjugate; BCMA, B-cell maturation antigen; CAR, chimeric antigen receptor; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group Performance Status; LoT, lines of therapy; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PR, partial response; RRMM, relapsed/refractory multiple myeloma; VGPR, very good PR.

1. Popat R, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PF770; 2. Moreau P, et al. *N Engl J Med*. 2022;387:495–505.

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55: Safety results from REALiTEC: A multi-country observational retrospective study of teclistamab in RRMM outside of clinical trials

Perrot A, et al.

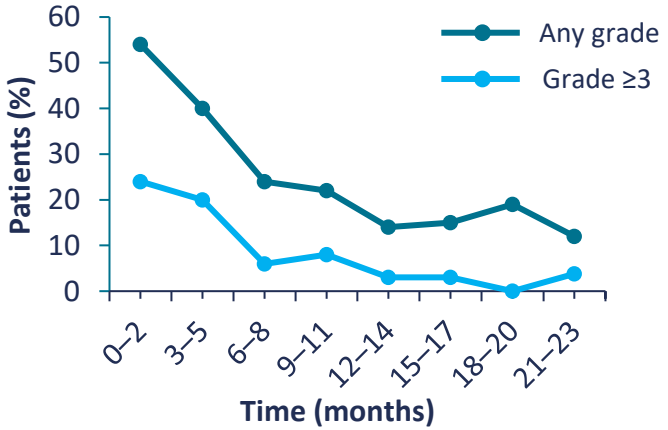
Safety profile (median follow-up: 20.7 months)

TEAEs, %	Any grade	Grade ≥3
CRS	56	2
ICANS	4	0
Infections	71	39
Haematological		
Anaemia	26	17
Neutropenia	35	33
Thrombocytopenia	19	15

Discontinuations

16%

Infections over time



Up to 60% of patients were treated with IVIg, highlighting the role of supportive care in optimizing outcomes

Teclistamab demonstrated deep and durable responses with a similar safety profile as that shown in the MajesTEC-1 study in patients treated outside of clinical trials

CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; IVIg, intravenous immunoglobulin; RRMM, relapsed/refractory multiple myeloma; TEAE, treatment-emergent adverse event.

Perrot A, et al. Presented at: 11th World Congress on COMy, Paris, France. 15–18 May 2025. Abstr. 55.

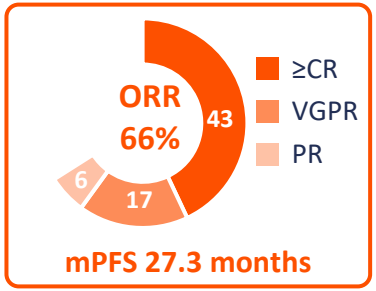
7549: Efficacy and safety of less frequent dosing with elranatamab in patients with RRMM: A US subgroup analysis from MagnetisMM-3

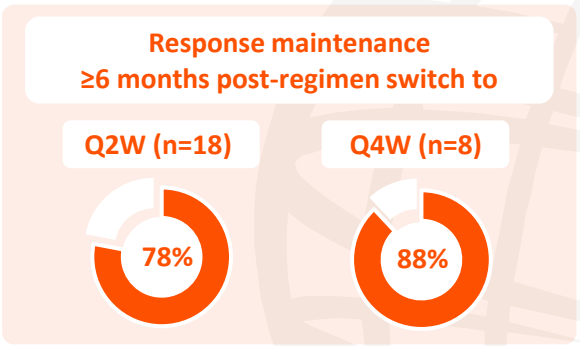
Nooka A, et al.

Baseline characteristics

BCMA-naive; refractory to ≥1 PI, ≥1 IMiD, and ≥1 anti-CD38 mAb	N=47
Median age, years (range)	68 (36–89)
Extramedullary disease, %	32
High-risk cytogenetics, %	28
R-ISS III, %	15
Prior stem cell transplant, %	74
Prior LoT, median (range)	5 (2–22)
Therapy, exposed/refractory, %	
Triple-class	100/94
Penta-class	79/47
Refractory to last line of therapy, %	98

Efficacy and safety (median follow-up: 39.6 months*)





CRS 62%

ICANS 9%

Infections, gr ≥3† 43%

Deaths 11%

Efficacy and safety in the US population were consistent with the overall Cohort A study population in the MagnetisMM-3 study

*By reverse Kaplan–Meier. †Infection prophylaxis, including Ig replacement therapy is recommended.
BCMA, B-cell maturation antigen; CR, complete response; CRS, cytokine release syndrome; gr, grade; ICANS, immune effector cell-associated neurotoxicity syndrome; Ig, immunoglobulin; IMiD, immunomodulatory drug; LoT, line of therapy; mAb, monoclonal antibody; mPFS, median progression-free survival; ORR, objective response rate; PI, protease inhibitor; PR, partial response; Q2W, once every 2 weeks; Q4W, once every 4 weeks; R-ISS, Revised-International Staging System; RRMM, relapsed/refractory multiple myeloma; VGPR, very good PR. Nooka A, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7549.

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PS1752: Clinical management of belantamab mafodotin-associated OEs: Practical guidance from the Belamaf Expert Experience Program

Terpos E, et al.

Overview of recommendations from the Belamaf Expert Experience Program

11
Recommendations

01 Screening, identifying and monitoring BL OCs and classifying belamaf-OEs

- Specialist eye evaluation is recommended before each of the first four cycles

02 Dose adjustments

- Dosing should be based on the KVA scale
- Tailor dosing to mitigate risk of MM relapse

03 Effective MDT working

- Shared learning is important due to varying experience with belamaf within the MDT

04 Patient-centric approaches in managing OEs

- Communicate the benefits and risks of belamaf
- Support SDM

A key resource for clinicians has been developed, offering evidence-based recommendations for the effective use of belamaf in clinical practice. The guidance will maximize treatment effectiveness, while minimizing OEs.

1L, first line; belamaf, belantamab mafodotin; BL, baseline; KVA, Keratopathy Visual Acuity Scale; MDT, multidisciplinary team; MM, multiple myeloma; OC, ocular conditions; OE, ocular events; SDM shared decision-making.

Terpos E, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PS1752.

What do the latest clinical data on emerging BCMA-directed therapies and combinations tell us about the future of treating RRMM?

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ASCO (30 May–3 June 2025, Chicago, IL, USA) and **EHA** (12–15 June 2025, Milan, Italy)

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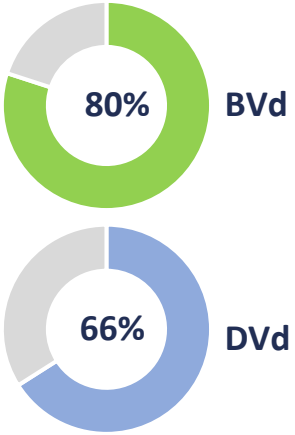
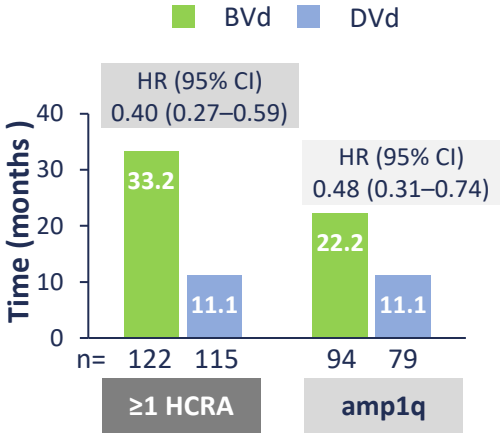
7546: DREAMM-7: A high-risk cytogenetic subgroup analysis Mateos V, et al.[1]
PS1734: DREAMM-7: Efficacy in patients by subsequent therapy Hungria V, et al.[2]

High-risk cytogenetic subgroup analysis[1*]

18-month OS (≥1 HRCA)

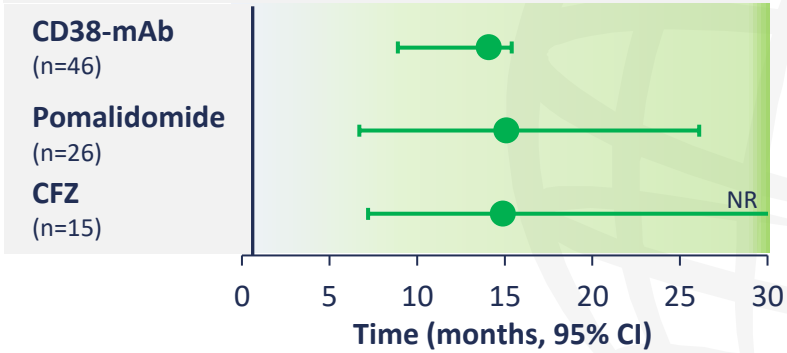


mPFS



Efficacy by subsequent therapy[2]

mPFS for the therapy following BVd, until progression or death



Outcomes in patients with RRMM and HRCA are suboptimal; the data support BVd as a potential SoC

Subsequent therapy with common classes of agents was effective post-BVd treatment

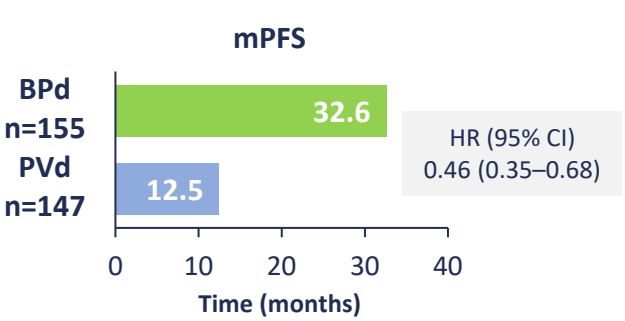
*Median follow up: primary PFS analysis, 28.2 months; OS analysis, 39.4 months.
BVd, belantamab mafodotin, bortezomib and dexamethasone; CFZ, carfilzomib; CI, confidence interval; DVd, daratumumab, bortezomib and dexamethasone; HR, hazard ratio; HRCA, high-risk cytogenetic abnormalities; m, median; mAb, monoclonal antibody; NR, not reached; OS, overall survival; PFS, progression-free survival; RRMM, relapsed/refractory multiple myeloma; SoC, standard of care.

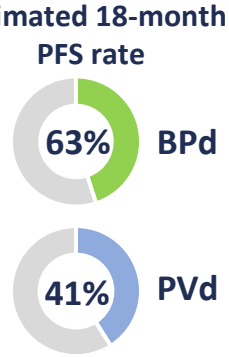
1. Mateos V, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7546;
2. Hungria V, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PF1734.

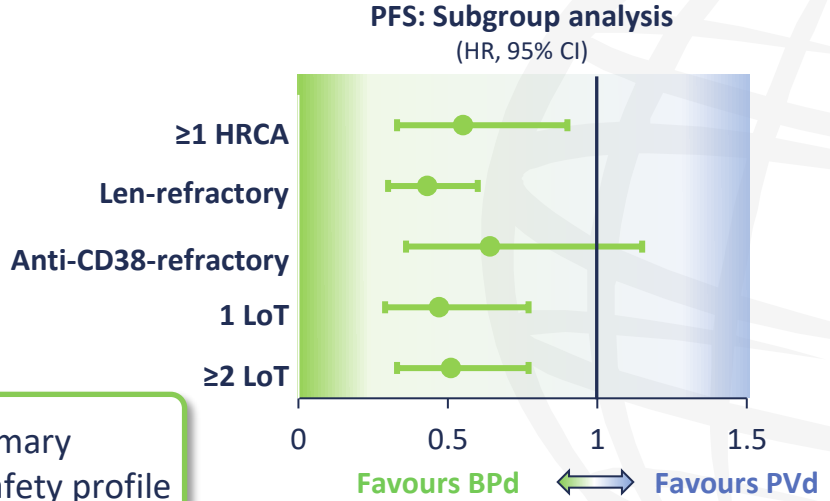
PF728: DREAMM-8: Updated efficacy and safety

Dimopoulos E, et al.

Efficacy and safety (median follow-up: 28.0 months)







The updated safety results were consistent with the primary analysis and did not change BPd's previously reported safety profile

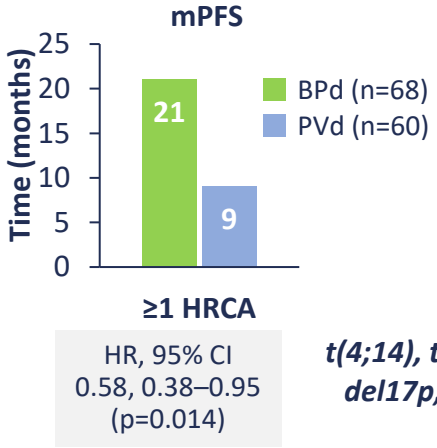
BPd continued to demonstrate a clinically meaningful PFS benefit vs PVd with no new safety signals

BPd, belantamab mafodotin, pomalidomide and dexamethasone; CI, confidence interval; HR, hazard ratio; HRCA, high-risk cytogenetics; Len, lenalidomide; LoT, line of therapy; m, median; PFS, progression-free survival; PVd, pomalidomide, bortezomib and dexamethasone.

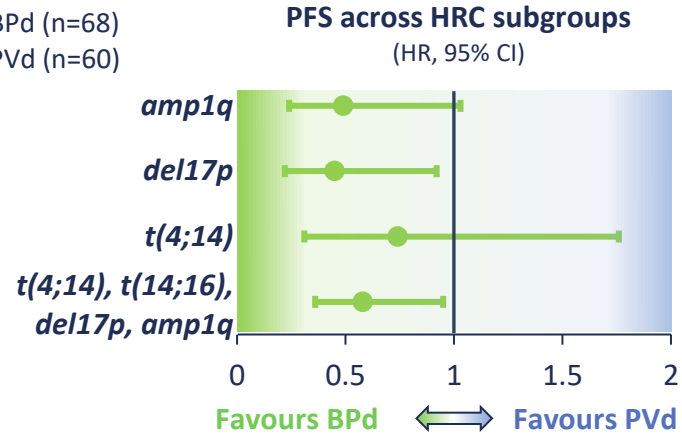
Dimopoulos E, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr. PF728.

7533: DREAMM-8: Efficacy by high-risk cytogenetics. Trudel S, et al.
7515: DREAMM-8: Efficacy by MRD-negativity status. Trudel S, et al.

HRCAs (subgroup analysis)[1]

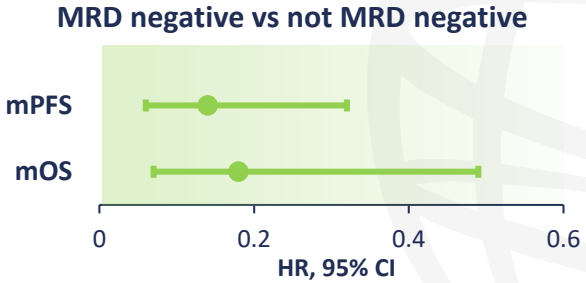


HR, 95% CI
0.58, 0.38–0.95
(p=0.014)



Efficacy by MRD-negativity status[2]

Achievement of CR-based MRD negativity:
5 to 7 times higher in BPd vs PVd



CR-based MRD negativity not achieved:
clinically meaningful PFS benefit in BPd vs PVd

The PFS benefit of BPd vs PVd is maintained across HRCAs. Depth of response is associated with outcomes with evidence for additional benefits from BPd vs PVd.

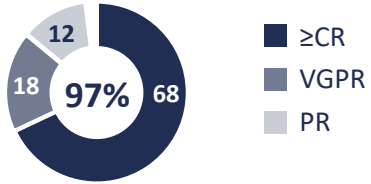
BPd, belantamab mafodotin, pomalidomide and dexamethasone; CI, confidence interval; CR, complete response; HR, hazard ratio; HRC, high-risk cytogenetic; HRCA, HRC abnormalities; m, median; MRD, minimal residual disease; OS, overall survival; PFS, progression-free survival; PVd, pomalidomide, bortezomib and dexamethasone.

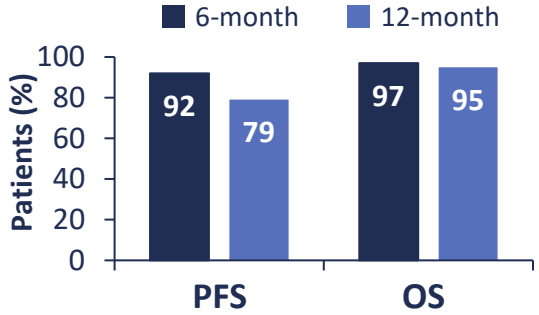
1. Trudel S, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7533;
2. Trudel S, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7515.

S201: Phase II registrational study of anito-cel for RRMM: Updated results from iMMagine-1

Kaur G, et al.

Efficacy (n=117; median follow-up: 12.6 months)





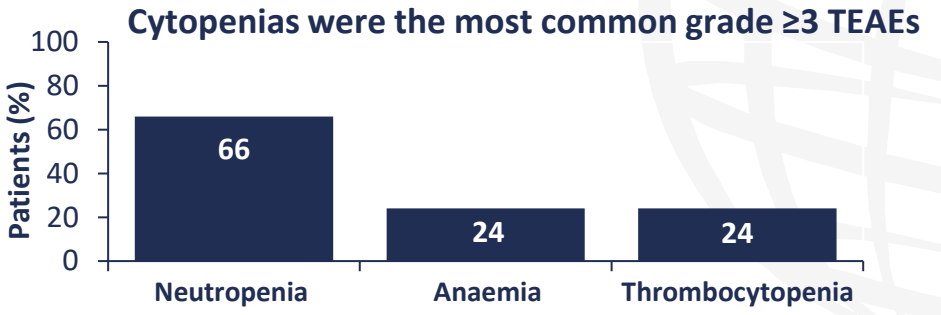
Safety (n=117)

CRS, gr 1–5 85%

97% resolved in ≤10 days

ICANS, gr ≤3 8%

No delayed or non-ICANS NTs



Interim results from phase II iMMagine-1 trial demonstrate deep and durable efficacy and manageable safety for anito-cel in a high-risk 4L+ RRMM population. Global, phase III iMMagine-3 study (NCT06413498) now enrolling.

4L, fourth line; anito-cel, anitocabtagene autoleucel; CR, complete response; CRS, cytokine release syndrome; gr, grade; ICANS, immune effector cell-associated neurotoxicity syndrome; NT, neurotoxicity; OS, overall survival; PFS, progression-free survival; PR, partial response; RRMM, relapsed/refractory multiple myeloma; TEAE, treatment-emergent adverse event; VGPR, very good PR.

Kaur G, et al. Presented at: EHA 2025, Milan, Italy. 12–15 June 2025. Abstr S201.

7513: Linvoseltamab + carfilzomib in patients with RRMM: Initial results from the LINKER-MM2 trial[1]

Manier S, et al.

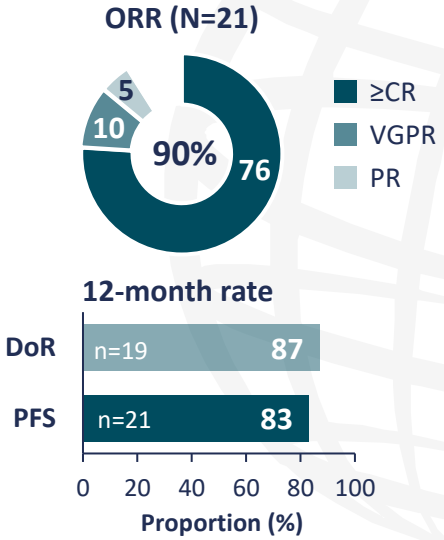
DLTs and safety (median follow-up: 14.8 months)

DLT evaluable (n=17): 10 (100 mg), 3 (150 mg), 4 (200 mg)

- DLT: 1 patient (100 mg dose), grade 4 thrombocytopenia
  - Fully resolved and treatment resumed

	100 mg + CFZ (n=12)	150 mg + CFZ (n=6)	200 mg + CFZ (n=5)
Median exposure LINVO, wks (range)	92 (5–130)	57 (8–65)	25 (10–34)
Median exposure CFZ, wks (range)	35.9 (6–99)	49.7 (3–61)	15.0 (6–30)
Any TEAE, %	**100**	**100**	**100**
Serious	92	50	100
Discontinuation of LINVO	0	17	20
Discontinuation of CFZ	25	17	40
Death	17	0	0

Efficacy



LINVO + CFZ shows potential as a suitable combination therapy for patients with RRMM; Similar results were reported for LINVO + BTZ.[2] Further investigation of both combinations is warranted.

BTZ, bortezomib; CFZ, carfilzomib; CR, complete response; DLT, dose-limiting toxicity; DoR, duration of response; LINVO, linvoseltamab; ORR, objective response rate; PFS, progression-free survival; PR, partial response; RRMM, relapsed/refractory multiple myeloma; TEAE, treatment-emergent adverse event; VGPR, very good PR; wks, weeks.

Manier S, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7513.

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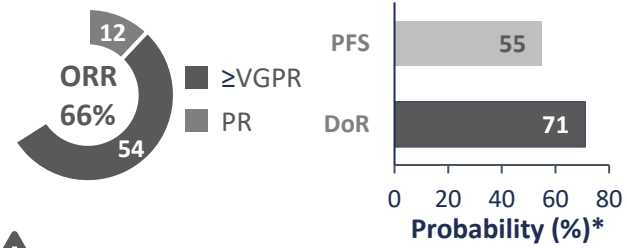
7527: Long-term efficacy and safety of etentamig (ABBV-383), a BCMA bispecific antibody in patients with RRMM

Baljević M, et al.

Baseline characteristics

	N=146
Median age, years (range)	68 (40–87)
R-ISS III, %	20
Extramedullary disease, %	22
High-risk cytogenetics, %	26
Prior LoT, median (range)	4 (3–23)
Refractory to prior therapy, %	
Triple-class	77
Penta-class	33

Efficacy and safety (median follow-up: 13.0 months)



- mPFS and mDoR were NR
- ORR, mPFS and mDoR were comparable across all subgroups analysed†

- TEAEs, grade ≥3: 79%
  - Haematological AEs were the most common
- Infections, grade ≥3: 22%
- TEAE-related discontinuations: 9%
- TEAEs leading to death: 13 (9%)
  - 10/13 were not related to etentamig

CRS, gr <3 30%‡

ICANS, gr <3 13%

The data support further exploration in the ongoing phase III CERVINO study (NCT06158841)

*Estimated using Kaplan–Meier curves at 12 months. †Groups analysed: ≥75 years; Black; high-risk cytogenetics; 3 or ≥4 LoT. ‡Rate for patients treated with 60 mg QW4.
AE, adverse event; BCMA, B-cell maturation antigen; CRS, cytokine release syndrome; DoR, duration of response; gr, grade; ICANS, immune effector cell-associated neurotoxicity syndrome; LoT, lines of therapy; m, median; NR, not reached; ORR, objective response rate; PFS, progression-free survival; PR, partial response; Q4W, every 4 weeks; R-ISS, Revised-International Staging System; RRMM, relapsed/refractory multiple myeloma; TEAE, treatment-emergent AE; VGPR, very good PR.
Baljević M, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7527.

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7505: First-in-human study of JNJ-79635322 (JNJ-5322) van de Donk NWCJ et al.[1]
7514: Phase I, first-in-human study of ISB 2001 Lichtman EI, et al.[2]

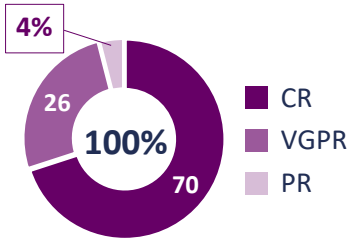
JNJ-79635322 (median follow-up: 12.2 months)

- Improved or similar safety profile compared with BsAbs targeting BCMA/GPRC5D
- Infections, grade ≥3: 29%
- Improved oral TEAEs with minimal/no weight loss
- Low-grade CRS events (69%), no grade ≥3 events

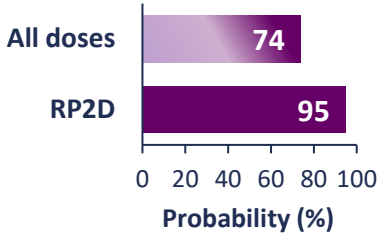
ISB 2001 (N=35; ≥1 month follow-up) Dose-escalation phase (median follow-up: 6.3 months)

- **No dose-limiting toxicities across the full dose escalation**
  - Grade ≥3 haematological AEs, 60%; 49% treatment related
  - Grade ≥3 infections, 29%; 11% treatment related
  - Grade <3 CRS events, 69%; all treatment related

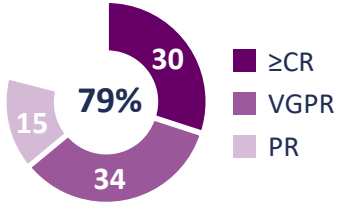
ORR (RP2D: n=27)



12-month PFS rate



ORR (DL3–9, n=33)



Effective, regardless of:

- Therapy history (ORR: 71–84%)
- Presence of EMD (ORR: 82%)
- Presence of HRCAs (ORR: 78%)

Trispecific antibodies are novel therapeutic agents that potentially offer greater efficacy with fewer serious off-target effects

AE, adverse event; BCMA, B-cell maturation antigen; BsAb, bispecific antibody; CR, complete response; CRS, cytokine release syndrome; DL, dose level; EMD, etxamedullary disease; GPRC5D, G protein-coupled receptor, class C, group 5, member D; HRCA, high-risk cytogenetic abnormality; ORR, objective response rate; PFS, progression-free survival; PR, partial response; RP2D, recommended phase 2 dose; TEAE, treatment-emergent AE; VGPR, very good PR.

1. van de Donk NWCJ, et al. Presented at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7505.
2. Lichtman EI, et al. Presented by Quach H at: ASCO 2025, Chicago, IL, USA. 30 May–3 June 2025. Abstr. 7514.

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