ASCO/EHA 2025 Multiple Myeloma Overview

American Society of Clinical Oncology
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Pfizer
Medical Affairs

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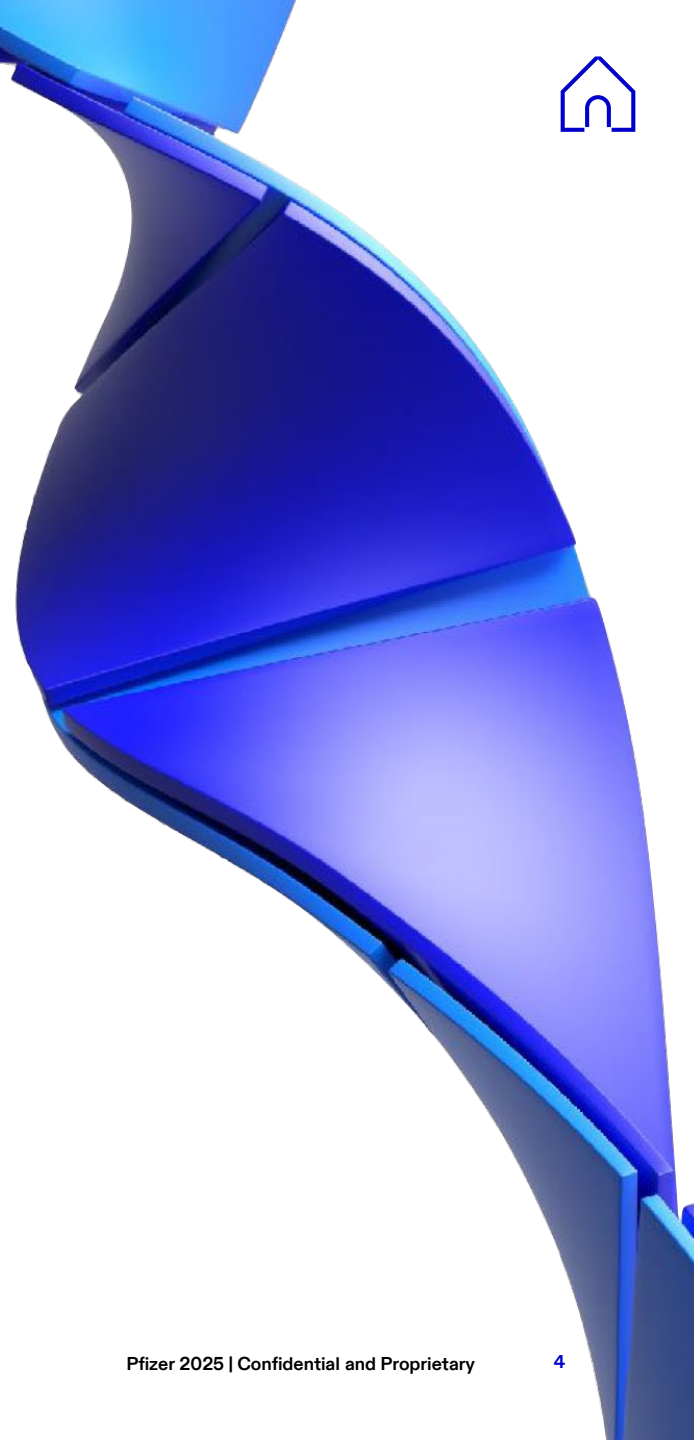
Indication

- Elranatamab is a BCMA-directed CD3 T-cell engager indicated as monotherapy for the treatment of adult patients with relapsed or refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor and an anti-CD38 monoclonal antibody, and have demonstrated disease progression on the last therapy.
- This medicinal product has been authorised under a so-called ‘conditional approval’ scheme. This means that further evidence on this medicinal product is awaited. The European Medicines Agency will review new information on this medicinal product at least every year and this SmPC will be updated as necessary.
- Special warnings and precautions for use include traceability, CRS, neurologic toxicities, including ICANS, infections, neutropenia, hypogammaglobulinaemia, concomitant use of live viral vaccines, and excipients.

Please see Elranatamab Fachinformation for additional details.

BCMA = B-cell maturation antigen; CD = cluster of differentiation; CRS = cytokine release syndrome; ICANS = immune effector cell-associated neurotoxicity syndrome; SmPC = Summary of Product Characteristics.
Elranatamab Fachinformation, aktueller Stand.

Clinical



Clinical – *Presentations*

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CD = cluster of differentiation; EPd = elotuzumab-pomalidomide-dexamethasone; Kd = carfilzomib-dexamethasone; PVd = pomalidomide-bortezomib-dexamethasone.

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3

Nooka A et al.

ASCO 2025 Poster Presentation (Abstract 7549);

Raje N et al.

EHA 2025 Poster Presentation (Abstract PF771)

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Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3 (1/5)

Nooka A et al. (ASCO Poster Presentation) / Raje N et al. (EHA Poster Presentation)

Background

In the ongoing Phase 2 MagnetisMM-3 (NCT04649359) study, as of the September 10, 2024 data cutoff (median follow-up of 33.9 months in Cohort A of BCMA-naïve patients), ORR was 61.0%, median PFS was 17.2 months, and median OS was 24.6 months[1,2]

Objective

To report long-term efficacy and safety results of elranatamab approximately 38 months after the last patient's first dose in a subgroup of BCMA-naïve patients enrolled in the US

Methods

- Patients with RRMM received elranatamab as step-up priming doses, followed by 76 mg QW for 6 cycles, then Q2W for 6 cycles (QW for ≥6 cycles and achieving ≥PR for ≥2 months), then Q4W (after ≥6 cycles of Q2W)
- The primary endpoint was ORR by BICR per IMWG; secondary endpoints included DOR and PFS by BICR, OS, and safety
- Outcomes in patients who switched to Q4W dosing were assessed in a post hoc analysis
- The data cutoff date was March 10, 2025, approximately 38 months after the last patient's first dose
  - Median follow-up (by reverse Kaplan–Meier) was 39.6 (95% CI 38.7–41.5) months

BCMA = B-cell maturation antigen; BICR = blinded independent central review; CI = confidence interval; DOR = duration of response; IMWG = International Myeloma Working Group; ORR = overall response rate; OS = overall survival; PFS = progression-free survival; PR = partial response; QW = once weekly; Q2W = once every 2 weeks; Q4W = once every 4 weeks; RRMM = relapsed or refractory multiple myeloma.

1. Lesokhin AM et al. *Nat Med.* 2023;29:2259-2267; 2. Prince M et al. Poster presented at ASH 2024 (Abstract 4738).
Nooka A et al. Poster presented at ASCO 2025 (Abstract 7549)/Raje N et al. Poster presented at EHA 2025 (Abstract PF771).

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3 (2/5)

Nooka A et al. (ASCO Poster Presentation) / Raje N et al. (EHA Poster Presentation)

Results: Patients and Treatment

- 47/123 BCMA-naïve patients from Cohort A were enrolled in the US (**Table**)
- 22 (47%) patients switched from QW to Q2W; the median duration of Q2W dosing was 11.1 (range 0.03–25.9) months
- Of the 17 patients who completed ≥6 cycles of Q2W dosing, 8 (17%) patients switched to Q4W dosing; the median duration of Q4W dosing was 15.0 (range 6.5–20.7) months
  - Among the 9 patients who did not switch to Q4W dosing, 5 had ended therapy or had their last dose before the date of Q4W amendment, 3 were on hold at the time of the Q4W amendment and did not resume dosing, and for 1 patient the reason was unknown
- At data cutoff, 5 (10.6%) patients were still receiving treatment

Table. Demographics and Baseline Characteristics

	N=47
Age, median (range), years	68.0 (36.0–89.0)
Male, n (%)	24 (51.1)
Race, n (%)	
African American or Black	8 (17.0)
Asian	3 (6.4)
White	34 (72.3)
Unknown	1 (2.1)
Not reported	1 (2.1)
ECOG PS, n (%)	
0	15 (31.9)
1	28 (59.6)
2	4 (8.5)
R-ISS disease stage, n (%)	
I	14 (29.8)
II	24 (51.1)
III	7 (14.9)
Unknown	2 (4.3)

Table. Demographics and Baseline Characteristics (cont.)

Cytogenetic risk, n (%)	
Standard	32 (68.1)
High*	13 (27.7)
Missing	2 (4.3)
Extramedullary disease by BICR,† n (%)	
Yes	15 (31.9)
No	32 (68.1)
Patients with ≥1 poor prognosis feature,‡ n (%)	32 (68.1)
Prior lines of therapy, median (range)	5.0 (2.0–22.0)
Prior stem cell transplant, n (%)	35 (74.5)
Exposure status, n (%)	
Triple-class§	47 (100)
Penta-drug¶	37 (78.7)
Refractory status, n (%)	
Triple-class§	44 (93.6)
Penta-drug¶	22 (46.8)
Refractory to last line of therapy, n (%)	46 (97.9)

*Includes t(4;14), t(14;16), del(17p) chromosomal abnormalities. †Extramedullary disease was defined as any plasmacytoma (extramedullary and/or paramedullary with a soft-tissue component). ‡Poor prognosis feature refers to at least one of the following: ECOG PS of 2, R-ISS stage III, EMD at baseline by BICR, high cytogenetic risk, BMPCs ≥50%, or penta-drug refractory disease. §Triple-class refers to ≥1 proteasome inhibitor, ≥1 immunomodulatory drug, and ≥1 anti-CD38 antibody. ¶Penta-drug refers to ≥2 proteasome inhibitors, ≥2 immunomodulatory drugs, and ≥1 anti-CD38 antibody. BCMA = B-cell maturation antigen; BICR = blinded independent central review; BMPC = bone marrow plasma cell; CD = cluster of differentiation; ECOG PS = Eastern Cooperative Oncology Group performance status; EMD = extramedullary disease; R-ISS = Revised Multiple Myeloma International Staging System; QW = once weekly; Q2W = once every 2 weeks; Q4W = once every 4 weeks. Nooka A et al. Poster presented at ASCO 2025 (Abstract 7549)/Raje N et al. Poster presented at EHA 2025 (Abstract PF771).

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3 (3/5)

Nooka A et al. (ASCO Poster Presentation) / Raje N et al. (EHA Poster Presentation)

Results: Efficacy

- ORR by BICR was 66.0% (95% CI 50.7–79.1)
  - sCR, 27.7%; CR, 14.9%; VGPR, 17.0%; PR, 6.4%
  - Median time to response was 1.1 (range 1.0–7.4) months
  - Median time to ≥CR was 4.76 (range 1.2–12.8) months
- Median DOR was 40.8 (95% CI 24.0–NE) months but may not yet be mature* (**Figure 1**)
- Median PFS was 27.3 (95% CI 4.3–NE) months (**Figure 2**)
- Median OS was 43.6 (95% CI 14.9–NE) months but may not yet be mature* (**Figure 3**)
- Among 18 responders who switched to Q2W, 14 (77.8%) maintained or improved their response ≥6 months after the switch
- Among 8 responders who switched to Q4W, 7 (87.5%) maintained their response ≥6 months after the switch

Figure 1. Duration of Response

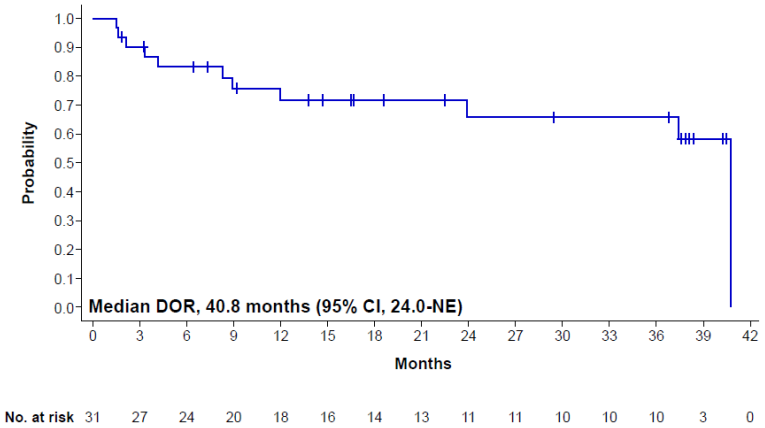


Figure 2. Progression-Free Survival

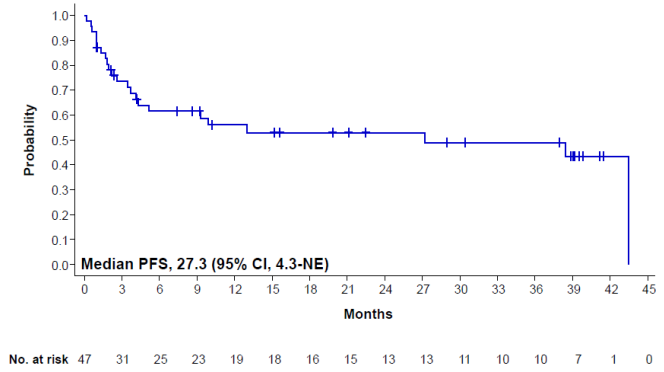
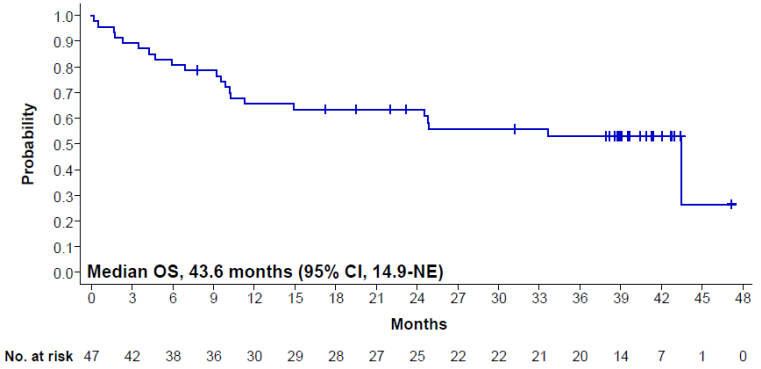


Figure 3. Overall Survival



*Data may not be mature as the median values are longer than the 38-month duration from the last patient's first dose to data cutoff.
BICR = blinded independent central review; CI = confidence interval; CR = complete response; DOR = duration of response; NE = not estimable; ORR = overall response rate; OS = overall survival; PFS = progression-free survival; PR = partial response; Q2W = once every 2 weeks; Q4W = once every 4 weeks; sCR = stringent complete response; VGPR = very good partial response.
Nooka A et al. Poster presented at ASCO 2025 (Abstract 7549)/Raje N et al. Poster presented at EHA 2025 (Abstract PF771).

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3 (4/5)

Nooka A et al. (ASCO Poster Presentation) / Raje N et al. (EHA Poster Presentation)

Results: Safety

- Safety was consistent with the overall study population; no new safety signals were observed with longer follow-up (**Table**)
  - CRS was reported in 61.7% of patients (all grade 1 [34.0%] or grade 2 [27.7%])
  - ICANS was reported in 8.5% of patients (grade 1 [4.3%] or grade 2 [4.3%])
  - Infections were reported in 70.2% of patients, consistent with that observed in the overall population
- Overall, 5 patients (10.6%) died due to TEAEs
  - 3 patients (6.4%) died due to disease progression
  - 2 patients (4.3%) died due to a TEAE other than disease progression, none due to infections

Table. Most Common (≥25%) TEAEs (N=47)

TEAE, n (%)*	Any grade	Grade 3/4
Any	47 (100)	37 (78.7)
Hematologic		
Anemia	21 (44.7)	16 (34.0)
Neutropenia	20 (42.6)	20 (42.6)
Non-hematologic		
Infections†,‡	33 (70.2)	20 (42.6)
Fatigue	29 (61.7)	4 (8.5)
Cytokine release syndrome	29 (61.7)	0
Diarrhea	27 (57.4)	3 (6.4)
Decreased appetite	27 (57.4)	1 (2.1)
Injection site reaction	18 (38.3)	0
Headache	18 (38.3)	0
Nausea	16 (34.0)	0
Dry skin	16 (34.0)	0
Pyrexia	15 (31.9)	2 (4.3)
Hypokalemia	14 (29.8)	7 (14.9)
Aspartate aminotransferase increased	13 (27.7)	2 (4.3)
Nasal congestion	13 (27.7)	0
SARS-CoV-2 test positive	12 (25.5)	3 (6.4)
Arthralgia	12 (25.5)	1 (2.1)
Insomnia	12 (25.5)	0

*TEAEs according to the Medical Dictionary of Regulatory Activities v27.0 and Common Criteria for Adverse Events v5. Any-grade TEAEs reported in ≥25% of patients; severity of CRS assessed according to the American Society for Transplantation and Cellular Therapy criteria. †Infections include preferred terms in the system organ class of infections and infestations. ‡No grade 5 infections were reported.
CRS = cytokine release syndrome; ICANS = immune effector cell-associated neurotoxicity syndrome;
TEAE = treatment-emergent adverse event.
Nooka A et al. Poster presented at ASCO 2025 (Abstract 7549)/Raje N et al. Poster presented at EHA 2025 (Abstract PF771).

Efficacy and Safety of Less Frequent Dosing With Elranatamab in Patients With Relapsed or Refractory Multiple Myeloma: A US Subgroup Analysis From MagnetisMM-3 (5/5)

Nooka A et al. (ASCO Poster Presentation) / Raje N et al. (EHA Poster Presentation)

Authors' Conclusions

- Consistent with overall Cohort A data, elranatamab was associated with deep, durable responses in the heavily pretreated US subgroup
- With a median follow-up of 39.6 months
  - Median ORR was 66.0%
  - Median DOR was 40.8 months but may not yet be mature
  - Median PFS was 27.3 months
  - Median OS was 43.6 months but may not yet be mature
- Overall, the safety profile and infections were consistent with the total study population
  - CRS and ICANS were grade 1 or grade 2 only
  - Infection prophylaxis including Ig replacement were recommended

CRS = cytokine release syndrome; DOR = duration of response; ICANS = immune effector cell-associated neurotoxicity syndrome; Ig = immunoglobulin; ORR = overall response rate; OS = overall survival; PFS = progression-free survival.
Nooka A et al. Poster presented at ASCO 2025 (Abstract 7549)/Raje N et al. Poster presented at EHA 2025 (Abstract PF771).

The Effect of Switching to Less Frequent Dosing on Patient-Reported Outcomes Among Patients With Relapsed/Refractory Multiple Myeloma Treated with Elranatamab

Bahlis N et al.

EHA 2025 Poster Presentation (Abstract PF788)

Pfizer-Sponsored Study

The Effect of Switching to Less Frequent Dosing on Patient-Reported Outcomes Among Patients With Relapsed/Refractory Multiple Myeloma Treated With Elranatamab (1/5)

Bahlis N et al. (EHA Poster Presentation)

Background

- Reduced dosing frequency of BsAb therapies could potentially improve tolerability and safety in patients with MM[1,2]
- In the Phase 2 MagnetisMM-3 trial (NCT04649359), patients (Cohort A: BCMA-naïve; Cohort B: BCMA-exposed) receiving QW ELRA reported notable reductions in pain and disease symptoms[3,4]
  - When switched from QW to Q2W, 80.0% of BCMA-naïve patients maintained or improved their response, while the incidence of some grade 3/4 AEs decreased by >10%

Objective

To explore the effect of switching from QW to Q2W dosing of ELRA on PROs among BCMA-naïve and BCMA-exposed patients with RRMM enrolled in the MagnetisMM-3 study

Methods

- Patients with RRMM received ELRA in 28-day cycles with step-up priming doses, followed by 76 mg QW; patients receiving ELRA QW for ≥6 cycles and achieving ≥PR per IMWG criteria for ≥2 months switched to Q2W dosing, and then to Q4W after ≥6 Q2W cycles
- PRO measures included the EORTC QLQ-C30, EORTC QLQ-MY20, and EQ-5D-5L administered on D1 and D15 of C1–3, D1 of C4–12, and D1 of every subsequent third cycle
- Analyses focused on patients who switched from QW to Q2W dosing
  - BL was redefined as when the patient switched to Q2W dosing (Q2W BL); PRO changes from this point were reported using repeated measures longitudinal models

AE = adverse event; BCMA = B-cell maturation antigen; BL = baseline; BsAb = bispecific antibody; C = cycle; D = day; ELRA = elranatamab; EORTC = European Organisation for Research and Treatment of Cancer; EQ-5D-5L = EuroQol 5-dimension 5-level Questionnaire; IMWG = International Myeloma Working Group; MM = multiple myeloma; ≥PR = partial response or better; PRO = patient-reported outcome; Q2W = once every 2 weeks; Q4W = once every 4 weeks; QLQ-C30 = Quality of Life Questionnaire – Core 30; QLQ-MY20 = Quality of Life Multiple Myeloma Module; QW = once weekly; RRMM = relapsed/refractory multiple myeloma.

1. Tacchetti P et al. *Cancers.* 2024;16:2337; 2. van de Donk NWCJ et al. *Blood Cancer Discov.* 2024;5:388-399; 3. Lesokhin A et al. *Nat Med.* 2023;29:2259-2267; 4. Mohty M et al. *Br J Haematol.* 2024;204:1801-1810.
Bahlis et al. Poster presented at EHA 2025 (Abstract PF788).

The Effect of Switching to Less Frequent Dosing on Patient-Reported Outcomes Among Patients With Relapsed/Refractory Multiple Myeloma Treated With Elranatamab (2/5)

Bahlis N et al. (EHA Poster Presentation)

Results: Patients and Treatment

- The data cutoff was March 26, 2024; median follow-up was approximately 28 months for the overall population
- Of the 61 BCMA-naïve and 22 BCMA-exposed patients treated with ELRA through at least C7, 58 (95%) and 19 patients (86%), respectively, transitioned from QW to Q2W dosing
- Demographic and clinical characteristics were generally similar between the two cohorts (**Table**)

Table. Demographics and Baseline Characteristics

	BCMA-Naïve n=58	BCMA-Exposed n=19
Age, median (IQR), years	67.5 (63.0–71.0)	67.0 (61.0–69.5)
Male, n (%)	26 (44.8)	9 (47.4)
Race, n (%)		
African American or Black	5 (8.6)	1 (5.3)
Asian	8 (13.8)	0
White	35 (60.3)	12 (63.2)
Not reported	10 (17.2)	6 (31.6)
ECOG PS, n (%)		
0	19 (32.8)	9 (47.4)
1	36 (62.1)	8 (42.1)
2	3 (5.2)	2 (10.5)
R-ISS disease stage, n (%)		
I	17 (29.3)	4 (21.1)
II	33 (56.9)	11 (57.9)
III	4 (6.9)	3 (15.8)
Unknown	4 (6.9)	1 (5.3)
Cytogenetic risk, n (%)		
Standard	42 (72.4)	14 (73.9)
High*	13 (22.4)	3 (15.8)
Missing	3 (5.2)	2 (10.5)
Extramedullary disease, n (%)	14 (24.1)	6 (31.6)
Prior lines of therapy, median (IQR)	5.0 (3.0–6.0)	7.0 (5.5–8.0)

*Includes t(4;14), t(14:16) and del(17p) chromosomal abnormalities.
BCMA = B-cell maturation antigen; BICR = blinded independent central review; C = cycle; ECOG PS = Eastern Cooperative Oncology Group performance status; ELRA = elranatamab; IQR = interquartile range; Q2W = once every 2 weeks; QW = once weekly; R-ISS = Revised International Staging System.
Bahlis et al. Poster presented at EHA 2025 (Abstract PF788).

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The Effect of Switching to Less Frequent Dosing on Patient-Reported Outcomes Among Patients With Relapsed/Refractory Multiple Myeloma Treated With Elranatamab (3/5)

Bahlis N et al. (EHA Poster Presentation)

Results: QLQ-C30 and EQ-5D-5L

- **Global Health Status (Figure 1A)**
  - **BCMA-naïve patients**: Scores were maintained from Q2W BL through month 13, with a non-significant improvement at month 16 and a non-significant worsening at month 18
  - **BCMA-exposed patients**: Scores improved relative to Q2W BL after month 6, with a numerically larger improvement at month 18*
- **Fatigue (Figure 1B)**
  - Scores for **both** cohorts were maintained from Q2W BL through month 16, with **both** cohorts showing a non-significant worsening at month 18*
- **Pain (Figure 1C)**
  - **BCMA-naïve patients**: Scores remained near Q2W BL through month 7, with numerically larger worsening at months 10, 16, and 18*
  - **BCMA-exposed patients**: Transient improvement was observed relative to Q2W BL at month 6 before returning to near Q2W BL at month 7 and maintained through month 18
- **Overall QoL (Figure 2)**
  - **BCMA-naïve patients**: Scores maintained from Q2W BL through month 18
  - **BCMA-exposed patients**: Scores worsened from Q2W BL to month 18*

*May be due to small sample size, n<10. †Dotted line represents Q2W BL value. Error bars indicate 95% CI.
BCMA = B-cell maturation antigen; BL = baseline; CI = confidence interval; EQ-5D-5L = EuroQol 5-dimension 5-level Questionnaire; M = month; Q2W = once every 2 weeks; QLQ-C30 = Quality of Life Questionnaire – Core 30; QoL = quality of life.
Bahlis et al. Poster presented at EHA 2025 (Abstract PF788).

Figure 1. Change From Baseline in QLQ-C30 Score by Visit†

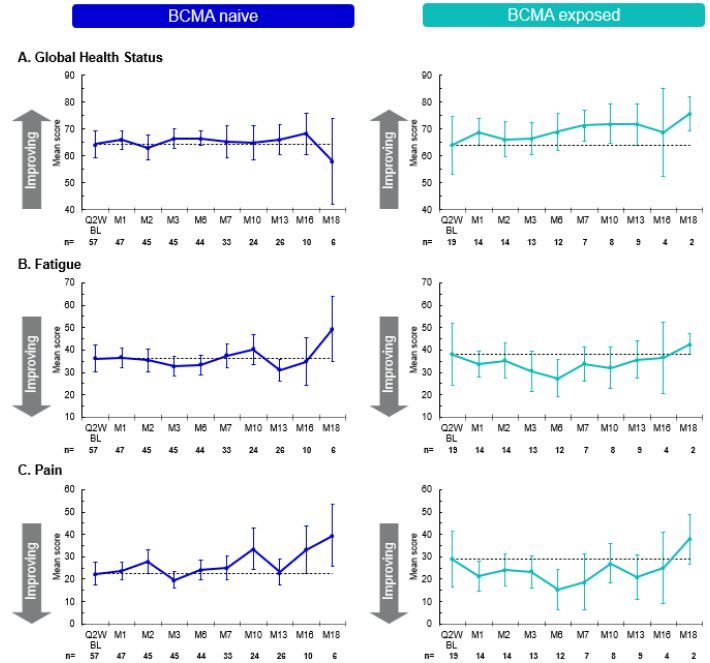
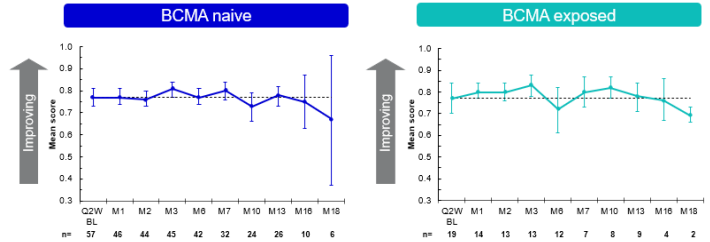


Figure 2. Change From Baseline in EQ-5D-5L Score by Visit†



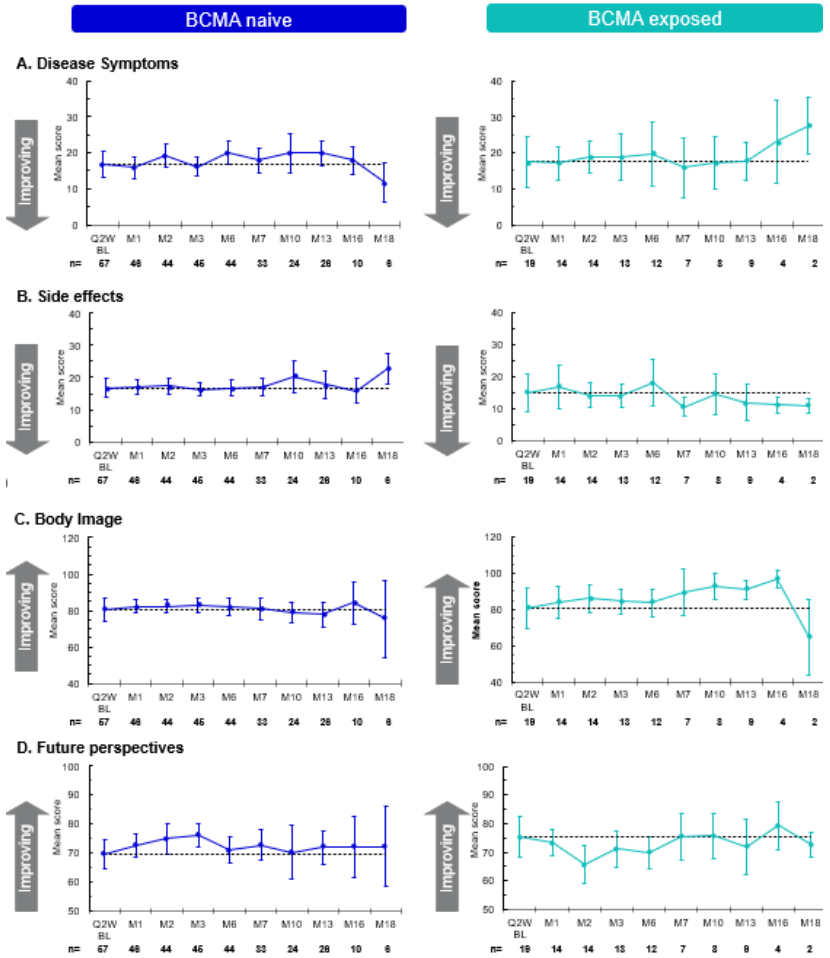
The Effect of Switching to Less Frequent Dosing on Patient-Reported Outcomes Among Patients With Relapsed/Refractory Multiple Myeloma Treated With Elranatamab (4/5)

Bahlis N et al. (EHA Poster Presentation)

Results: QLQ-MY20

- **Disease symptoms** (**Figure A**)
  - **BCMA-naïve patients**: Scores were maintained at or near Q2W BL through month 16, with a numerically larger improvement at month 18*
  - **BCMA-exposed patients**: Scores remained at or near Q2W BL through month 16, with a numerically larger worsening at month 18*
- **Side effects** (**Figure B**)
  - **BCMA-naïve patients**: Little change was observed from Q2W BL through month 16, with a worsening at month 18*
  - **BCMA-exposed patients**: Numerically greater improvements were observed from Q2W BL at months 7, 16, and 18
- **Body image** (**Figure C**)
  - **BCMA-naïve patients**: Little change was observed from Q2W BL through month 18
  - **BCMA-exposed patients**: Numerically greater improvements were observed from Q2W BL at months 10, 13, and 16, with a non-significant worsening at month 18*
- **Future perspectives** (**Figure D**)
  - **Both** cohort's scores were consistent with Q2W BL through month 18

Figure. Change From Baseline in QLQ-MY20 Score by Visit†



*May be due to small sample size, n<10. †Dotted line represents Q2W BL value. Error bars indicate 95% CI.
BCMA = B-cell maturation antigen; BL = baseline; CI = confidence interval; M = month; Q2W = once every 2 weeks; QLQ-MY20 = Quality of Life Multiple Myeloma Module.
Bahlis et al. Poster presented at EHA 2025 (Abstract PF788).

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The Effect of Switching to Less Frequent Dosing on Patient-Reported Outcomes Among Patients With Relapsed/Refractory Multiple Myeloma Treated With Elranatamab (5/5)

Bahlis N et al. (EHA Poster Presentation)

Authors' Conclusions

- For patients who met the criteria to switch to Q2W dosing of ELRA in the MagnetisMM-3 trial, QoL and symptoms remained stable up to well over a year, regardless of whether patients were naïve or exposed to prior BCMA-directed therapy
  - These data complement previous findings that the clinical benefit and safety of ELRA monotherapy were maintained with less frequent dosing

Please note: The conclusions above represent the authors' conclusions only.
BCMA = B-cell maturation antigen; ELRA = elranatamab; QoL = quality of life; Q2W = once every 2 weeks.
Bahlis et al. Poster presented at EHA 2025 (Abstract PF788).

Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results from MagnetisMM-6 Part 1

Quach H et al.

ASCO 2025 Oral Presentation (Abstract 7504);

Dimopoulos M-A et al.

EHA 2026 Oral Presentation (Abstract S206)

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Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results From MagnetisMM-6 Part 1 (1/7)

Quach H et al. (ASCO Oral Presentation) / Dimopoulos M-A et al. (EHA Oral Presentation)

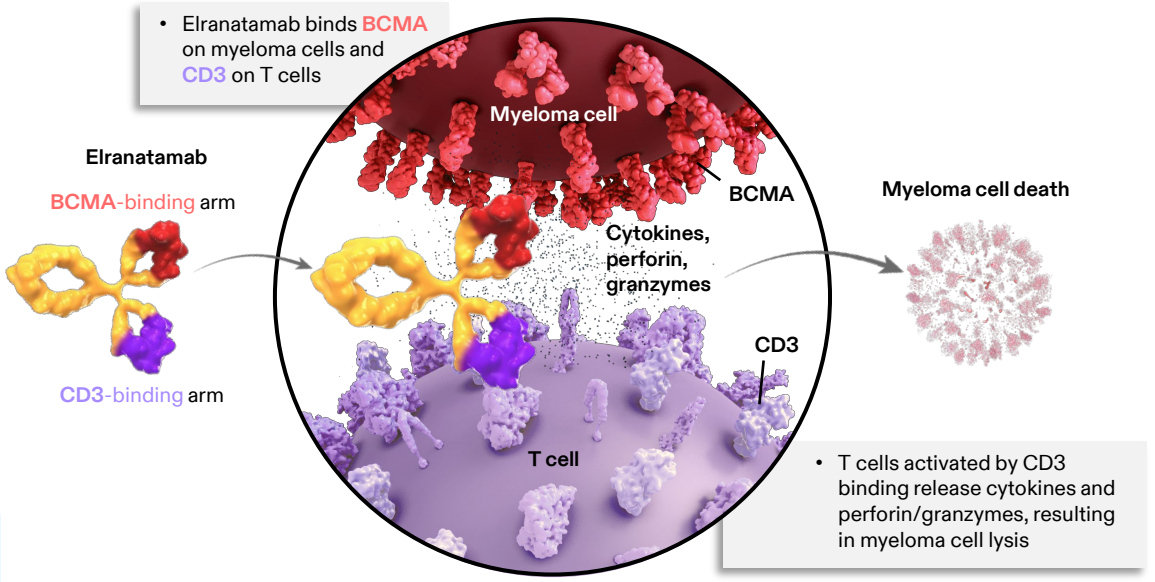
Background

- **Elranatamab** is a BCMA-CD3 bispecific antibody that demonstrated an ORR of 61.0%, mPFS of 17.2 months, and mOS 24.6 months in MagnetisMM-3 (NCT04649359) (median follow-up of 33.9 months in BCMA-naïve RRMM patients)[1,2]
- **Lenalidomide** stimulates the activation of CD4+ and CD8+ T cells and NK cells, while **daratumumab** exerts immunomodulatory effects and multiple actions (i.e., ADCC, CDC, and ADCP) against CD38-expressing myeloma. Thus, combining elranatamab with lenalidomide and daratumumab may enhance immune cell-mediated myeloma cell death[3-5]

Objective

MagnetisMM-6 is designed to:

- Evaluate the efficacy and safety of elranatamab + lenalidomide ± daratumumab (EDR or ER) vs daratumumab + lenalidomide + dexamethasone (DRd) in patients with transplant-ineligible NDMM
- Part 1 of the study evaluates the optimal dose of EDR or ER in patients with RRMM or NDMM to determine the recommended Phase 3 dose for part 2



Lenalidomide and daratumumab
- Enhance T-cell activation
- Deplete immune-suppressive cells

\+

Elranatamab
Promotes T-cell–mediated tumor lysis

→

Combination proposed to enhance the activation of immune cell–mediated myeloma cell death

ADCC = antibody-dependent cell-mediated cytotoxicity; ADCP = antibody-dependent cellular phagocytosis; BCMA = B-cell maturation antigen; CD = cluster of differentiation; CDC = complement-dependent cytotoxicity; mOS = median overall survival; mPFS = median progression-free survival; NDMM = newly diagnosed multiple myeloma; NK = natural killer; ORR = objective response rate; RRMM = relapsed or refractory multiple myeloma. 1. Lesokhin AM et al. Nat Med. 2023;29:2259-2267; 2. Tomasson MH et al. Hemasphere. 2024;8:e136; 3. Gandhi AK et al. Br J Haematol. 2014;164:811-821; 4. Krejcik J et al. Blood. 2016;128:384-394; 5. Sanchez L et al. J Hematol Oncol. 2016;9:51. Quach H et al. Oral presentation at ASCO 2025 (Abstract 7504)/Dimopoulos M-A et al. Oral Presentation at EHA 2025 (Abstract S206).

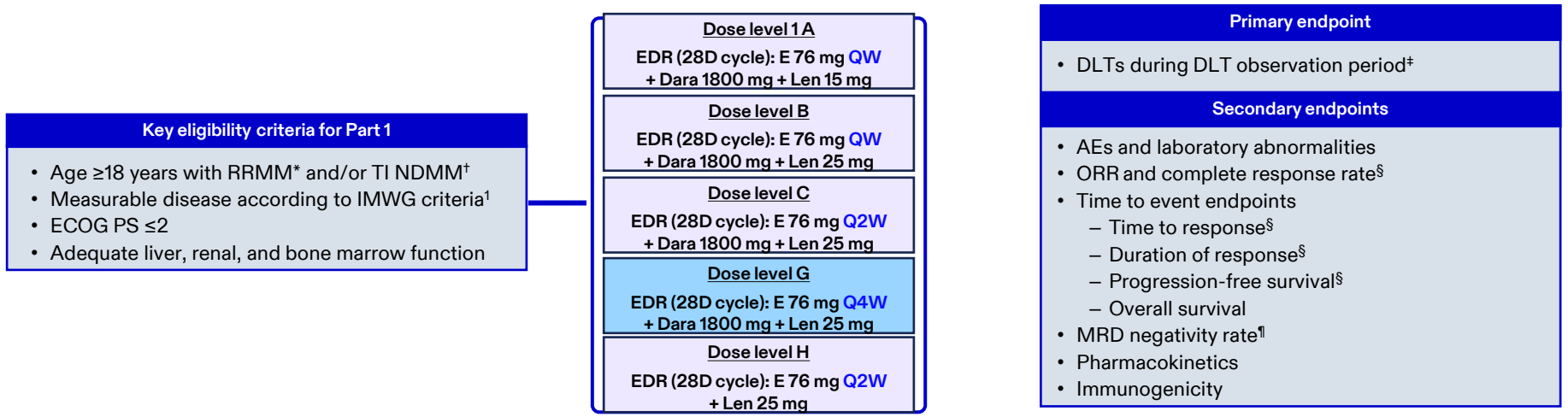
Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results From MagnetisMM-6 Part 1 (2/7)

Quach H et al. (ASCO Oral Presentation) / Dimopoulos M-A et al. (EHA Oral Presentation)

Methods: Study Design

- MagnetisMM-6 Part 1 **dose level G** is evaluating the combination of **elranatamab 76 mg SC Q4W**, **daratumumab 1800 mg SC**, and **lenalidomide 25 mg PO** in patients with transplant-ineligible NDMM (Data cutoff: April 1, 2025) (**Figure**)

Figure. MagnetisMM-6 Part 1 Study Design



*Must have received 1–2 prior lines of MM therapy including at least 1 IMiD and 1 PI. †Defined as age ≥65 years or <65 years with comorbidities impacting the possibility of transplant. ‡DLTs will not be assessed in any DL that represents a lower dose than an already cleared DL, or where the initial DLT period is the same as an already cleared DL. §Per IMWG response criteria. ¶Per IMWG sequencing criteria. AE = adverse event; BCMA = B-cell maturation antigen; D = day; Dara = daratumumab; DL = dose level; DLT = dose-limiting toxicity; E = elranatamab; ELRA = elranatamab; ECOG PS = Eastern Cooperative Oncology Group performance status; EDR = elranatamab + daratumumab + lenalidomide; ER = elranatamab + lenalidomide; GBS = Guillain-Barré syndrome; GvHD = graft vs host disease; IMiD = immunomodulatory drug; IMWG = International Myeloma Working Group; IV = intravenous; Len = lenalidomide; MRD = minimal residual disease; NDMM = newly diagnosed MM; ORR = objective response rate; PI = proteasome inhibitor; PMN = peripheral motor neuropathy; PMP = peripheral motor polyneuropathy; PO = orally; PSN = peripheral sensory neuropathy; QD = once daily; QW = once every week; Q2W = once every 2 weeks; Q4W = once every 4 weeks; RRMM = relapsed or refractory MM; SC = subcutaneous; SCT = stem cell transplant; TI = transplant-ineligible.

1. Kumar S et al. Lancet Oncol. 2016;17:e328-e346. Quach H et al. Oral presentation at ASCO 2025 (Abstract 7504)/Dimopoulos M-A et al. Oral Presentation at EHA 2025 (Abstract S206).

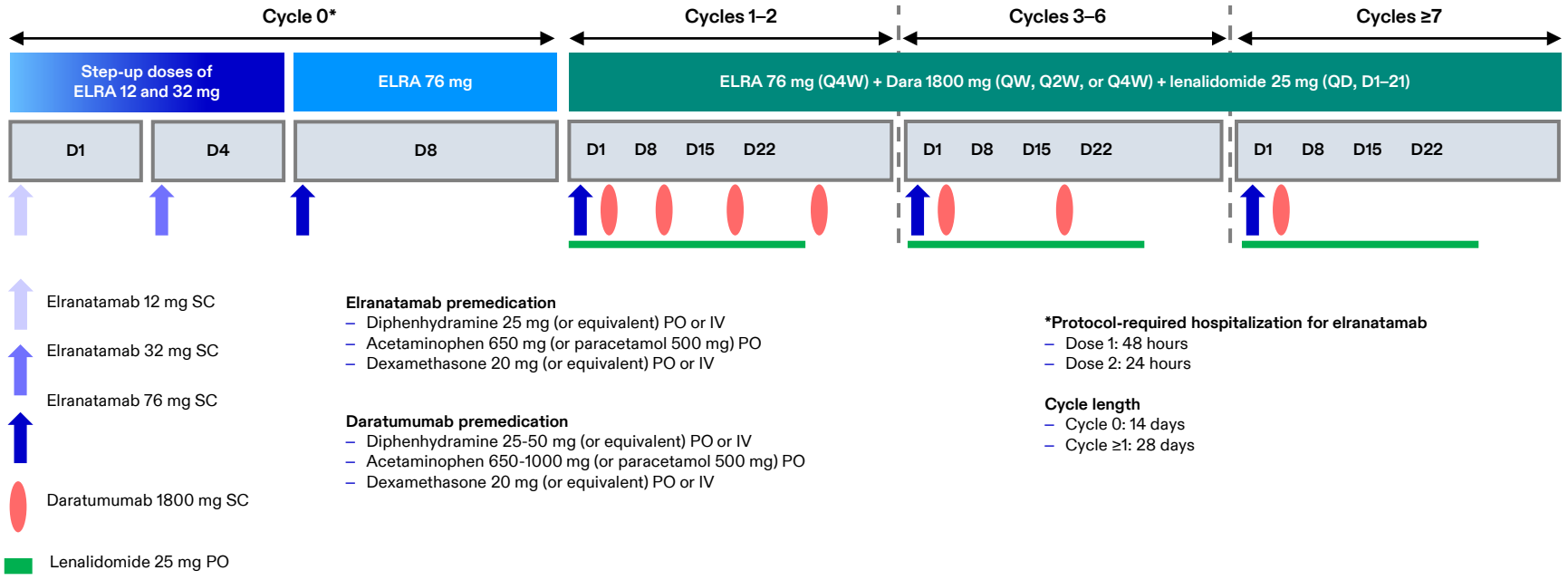
Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results From MagnetisMM-6 Part 1 (3/7)

Quach H et al. (ASCO Oral Presentation) / Dimopoulos M-A et al. (EHA Oral Presentation)

Methods: Study Design

- Part 1 dose level G dosing schedule is shown in the **Figure**

Figure. Part 1 Dose Level G Dosing Schedule



D = day; Dara = daratumumab; ELRA = elranatamab; IV = intravenous; PO = orally; QD = once daily; QW = once every week; Q2W = once every 2 weeks; Q4W = once every 4 weeks; SC = subcutaneous.
Quach H et al. Oral presentation at ASCO 2025 (Abstract 7504)/Dimopoulos M-A et al. Oral Presentation at EHA 2025 (Abstract S206).

Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results From MagnetisMM-6 Part 1 (4/7)

Quach H et al. (ASCO Oral Presentation) / Dimopoulos M-A et al. (EHA Oral Presentation)

Results

- 37 patients with TI NDMM were enrolled and received at least one dose of elranatamab **(Table)**
  - 34 patients received the EDR regimen

Table. Demographics and Baseline Characteristics

	N=37
Age, median (range), years	75.0 (67-83)
Female, n (%)	23 (62.2)
Race, n (%)	
Asian	5 (13.5)
White	32 (86.5)
ECOG PS, n (%)	
0	22 (59.5)
1	14 (37.8)
2	1 (2.7)
R-ISS disease stage, n (%)	
I	9 (24.3)
II	20 (54.1)
III	5 (13.5)
Unknown	3 (8.1)

Table. Demographics and Baseline Characteristics

	N=37
Extramedullary disease by investigator, n (%)	
Yes	0
No	37 (100)
Baseline bone marrow plasma cells, n (%)	
<50%	28 (75.7)
≥50%	9 (24.3)
Frail status,* n (%)	
Yes	9 (24.3)
No	28 (75.7)

*According to the simplified IMWG scale using scores for ECOG PS, Charlson Comorbidity Index, and age.
AE = adverse event; CI = confidence interval; CR = complete response; ECOG PS = Eastern Cooperative Oncology Group performance status; EDR = elranatamab + daratumumab + lenalidomide; IMWG = International Myeloma Working Group; ORR = objective response rate; PR = partial response; sCR = stringent complete response; TI NDMM = transplant-ineligible newly diagnosed multiple myeloma; VGPR = very good partial response.
Quach H et al. Oral presentation at ASCO 2025 (Abstract 7504)/Dimopoulos M-A et al. Oral Presentation at EHA 2025 (Abstract S206).

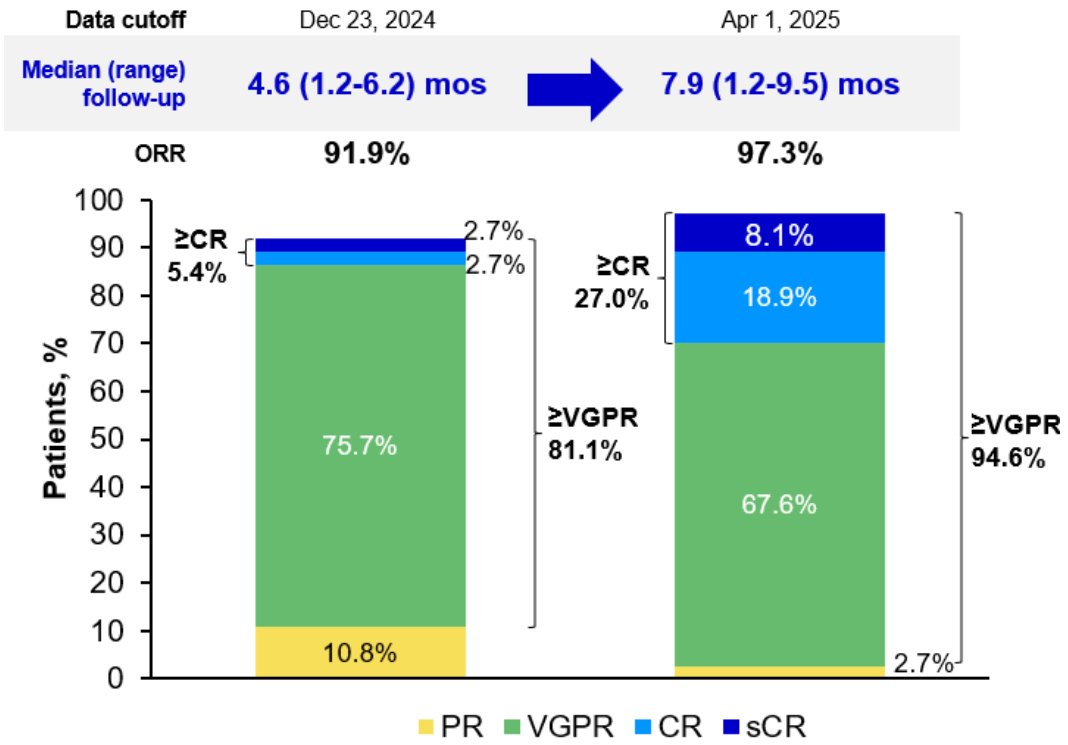
Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results From MagnetisMM-6 Part 1 (5/7)

Quach H et al. (ASCO Oral Presentation) / Dimopoulos M-A et al. (EHA Oral Presentation)

Results

- As of the data cutoff (Apr 1, 2025), median follow-up was 7.9 (range 1.2–9.5) months
  - 32 (86.5%) patients were still on treatment
  - Among the 5 patients that discontinued with treatment, 3 discontinued the last drug because of AE, 1 due to death, and 1 refused further treatment
- The confirmed ORR by investigator was 97.3% (95% CI 85.8–99.9) (**Figure**)
  - 94.6% had ≥VGPR
  - 27.0% had ≥CR
- Responses occurred early with a median time to response of 1.5 (range 0.3–4.2) months

Figure. ORR



AE = adverse event; CI = confidence interval; CR = complete response; ECOG PS = Eastern Cooperative Oncology Group performance status; EDR = elranatamab + daratumumab + lenalidomide; IMWG = International Myeloma Working Group; ORR = objective response rate; PR = partial response; sCR = stringent complete response; TI NDMM = transplant-ineligible newly diagnosed multiple myeloma; VGPR = very good partial response.

Quach H et al. Oral presentation at ASCO 2025 (Abstract 7504)/Dimopoulos M-A et al. Oral Presentation at EHA 2025 (Abstract S206).

Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results From MagnetisMM-6 Part 1 (6/7)

Quach H et al. (ASCO Oral Presentation) / Dimopoulos M-A et al. (EHA Oral Presentation)

Results: Safety

- Most frequent (≥50%) TEAEs were hematologic (83.3%; grade 3/4 78.4%), infections (70.3%; grade 3/4 18.9%) and CRS (62.2%, grade 3/4 0%) (**Table 1**)
  - All CRS events were grade ≤2
  - One grade 2 ICANS event was reported
- Any grade infections were reported in 70.3% of patients (grade 3/4 18.9%) (**Table 2**)
  - One case (2.7%) of grade 5 Candida pneumonia was reported
- Frequent (any grade >10%) infections included upper respiratory tract infection and *Escherichia* urinary tract infection
- Anti-infective prophylaxis was given and 34 patients (91.9%) received immunoglobulin replacement therapy

Table 2. Infections ≥5% (N=37)

TEAE, n (%)*	Any grade	Grade 3/4
Infections¶	26 (70.3)	7 (18.9)
Upper respiratory tract infection	8 (21.6)	0
Escherichia urinary tract infection	4 (10.8)	1 (2.7)
Bronchitis	3 (8.1)	0
Cytomegalovirus infection reactivation#	4 (10.8)	1 (2.7)
Rhinitis	3 (8.1)	0
Viral upper respiratory tract infection	3 (8.1)	0
Pneumonia	2 (5.4)	1 (2.7)
Urinary tract infection	2 (5.4)	0

Table 1. TEAEs ≥15% (N=37)

TEAE, n (%)*	Any grade	Grade 3/4
Any	37 (100)	35 (94.6)
Hematologic		
Neutropenia†	28 (75.7)	27 (73.0)
Anemia‡	13 (35.1)	7 (18.9)
Thrombocytopenia§	6 (16.2)	4 (10.8)
Nonhematologic		
CRS	23 (62.2)	0
Pyrexia	14 (37.8)	0
Cough	11 (29.7)	0
Injection site reaction	11 (29.7)	0
Nausea	11 (29.7)	0
Rash	11 (29.7)	3 (8.1)
Diarrhea	9 (24.3)	1 (2.7)
Hypogammaglobulinemia	9 (24.3)	1 (2.7)
Constipation	8 (21.6)	0
Decreased appetite	8 (21.6)	2 (5.4)
Fatigue	7 (18.9)	0
Peripheral sensory neuropathy	7 (18.9)	0
Asthenia	6 (16.2)	4 (10.8)
Cytomegalovirus test positive	6 (16.2)	0
Edema peripheral	6 (16.2)	0

*TEAEs according to the Medical Dictionary for Regulatory Activities v27.1 and Common Terminology Criteria for Adverse Events v5; severity of CRS and ICANS was assessed according to the American Society for Transplantation and Cellular Therapy criteria1. †Includes neutrophil count decreased. ‡Includes hemoglobin decreased. §Includes platelet count decreased. ¶Infections include preferred terms in the system organ class of infections and infestations. #3 patients with cytomegalovirus infection reactivation, 1 patient with cytomegalovirus viremia and pneumonia cytomegaloviral (grade 3). CRS = cytokine release syndrome; ICANS = immune effector cell-associated neurotoxicity syndrome; TEAE = treatment-emergent adverse event. 1. Lee DW et al. Biol Blood Marrow Transplant. 2019;25:625-638. Quach H et al. Oral presentation at ASCO 2025 (Abstract 7504)/Dimopoulos M-A et al. Oral Presentation at EHA 2025 (Abstract S206).

Elranatamab in Combination With Daratumumab and Lenalidomide in Patients With Newly Diagnosed Multiple Myeloma Not Eligible for Transplant: Initial Results From MagnetisMM-6 Part 1 (7/7)

Quach H et al. (ASCO Oral Presentation) / Dimopoulos M-A et al. (EHA Oral Presentation)

Authors' Conclusions

- Initial data from MagnetisMM-6 Part 1, dose level G demonstrated that the combination of **elranatamab with daratumumab and lenalidomide is effective and manageable** in transplant-ineligible patients with NDMM
  - **The safety profile was consistent with the known toxicities of the components**
    - The most frequent TEAEs were hematologic AEs, infections, and CRS
    - All CRS and ICANS events were grade ≤2
  - **Early and promising efficacy**
    - Responses are expected to deepen further with longer follow-up
- **Phase 3 MagnetisMM-6 Part 2** (opening soon) will evaluate **EDR (elranatamab 76 mg SC Q4W + daratumumab + lenalidomide) vs DRd (daratumumab + lenalidomide + dexamethasone)** in transplant-ineligible and transplant-deferred patients with NDMM
  - Study design is patient centric with respect to dosing frequency and de-escalation

Please note: The conclusions above represent the authors' conclusions only.
AE = adverse event; CRS = cytokine release syndrome; ER = elranatamab + lenalidomide; ICANS = immune effector cell-associated neurotoxicity syndrome; NDMM = newly diagnosed multiple myeloma; ORR = objective response rate; RP3D = recommended Phase 3 dose; TEAE = treatment-emergent adverse event; VGPR = very good partial response.
Quach H et al. Oral presentation at ASCO 2025 (Abstract 7504)/Dimopoulos M-A et al. Oral Presentation at EHA 2025 (Abstract S206).

MagnetisMM-30: A Phase 1b, Open-Label Study of Elranatamab in Combination With Iberdomide in Patients With Relapsed or Refractory Multiple Myeloma

Lesokhin A et al.

ASCO 2025 Poster Presentation (Abstract TPS7566);

EHA 2025 Poster Presentation (Abstract PF784)

Pfizer-Sponsored Study

Pfizer Medical Affairs

MagnetisMM-30: A Phase 1b, Open-Label Study of Elranatamab in Combination With Iberdomide in Patients With Relapsed or Refractory Multiple Myeloma (1/3)

Lesokhin A et al. (ASCO / EHA Poster Presentation)

Background

- The Phase 2 MagnetisMM-3 trial (NCT04649359) demonstrated that elranatamab monotherapy in patients with RRMM induced deep and durable responses with a manageable safety profile[1]
- Iberdomide, a novel CELMoD™, in combination with elranatamab may provide additional benefit to patients with RRMM based on their complementary MOAs (**Figure**)

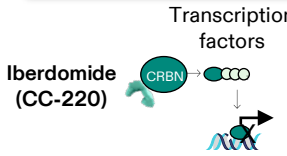
Objective

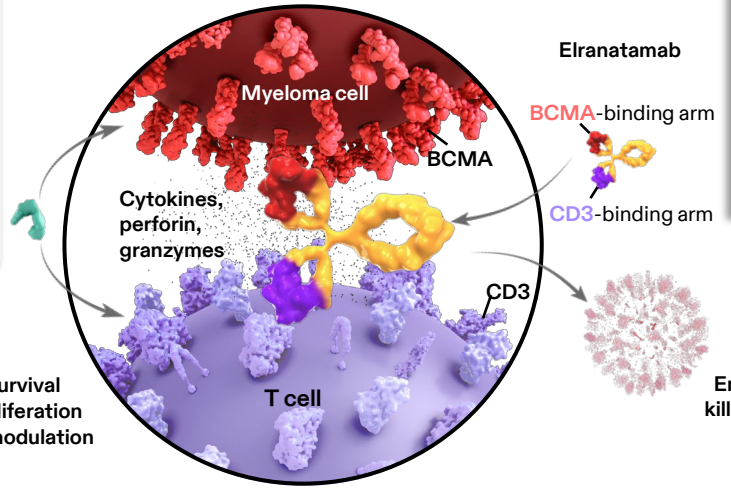
To evaluate the safety, efficacy, and PK of elranatamab in combination with iberdomide in patients with RRMM

Figure. Elranatamab and Iberdomide MOAs

Iberdomide[2-4]

- Novel cereblon E3 ligase modulator (CELMoD™)
- Exhibits antiproliferative and proapoptotic activity in myeloma cells and immunomodulatory activity
- Enhances T-cell engager function in vitro and in vivo





Elranatamab[1,5,6]

- Bispecific antibody that binds BCMA on myeloma cells and CD3 on T cells
- T cells activated by CD3 binding release cytokines and perforin/granzymes, resulting in myeloma cell lysis

BCMA = B-cell maturation antigen; CD = cluster of differentiation; CELMoD™ = cereblon E3 ligase modulatory drug; CRBN = cereblon; MM = multiple myeloma; MOA = mechanism of action; PK = pharmacokinetics; RRMM = relapsed or refractory multiple myeloma.

1. Lesokhin AM et al. *Nat Med.* 2023;29:2259-2267; 2. Lonial S et al. *Lancet Haematol.* 2022;9:e822-e832; 3. Bjorklund CC et al. *Leukemia.* 2020;34:1197-1201; 4. Paiva B et al. *Hemasphere.* 2023;7(suppl 3):P799; 5. Elranatamab Fachinformation, aktueller Stand; 6. Elranatamab Fachinformation, aktueller Stand.

Lesokhin A et al. Poster presented at ASCO 2025 (Abstract TPS7566)/poster presented at EHA 2025 (Abstract PF784).

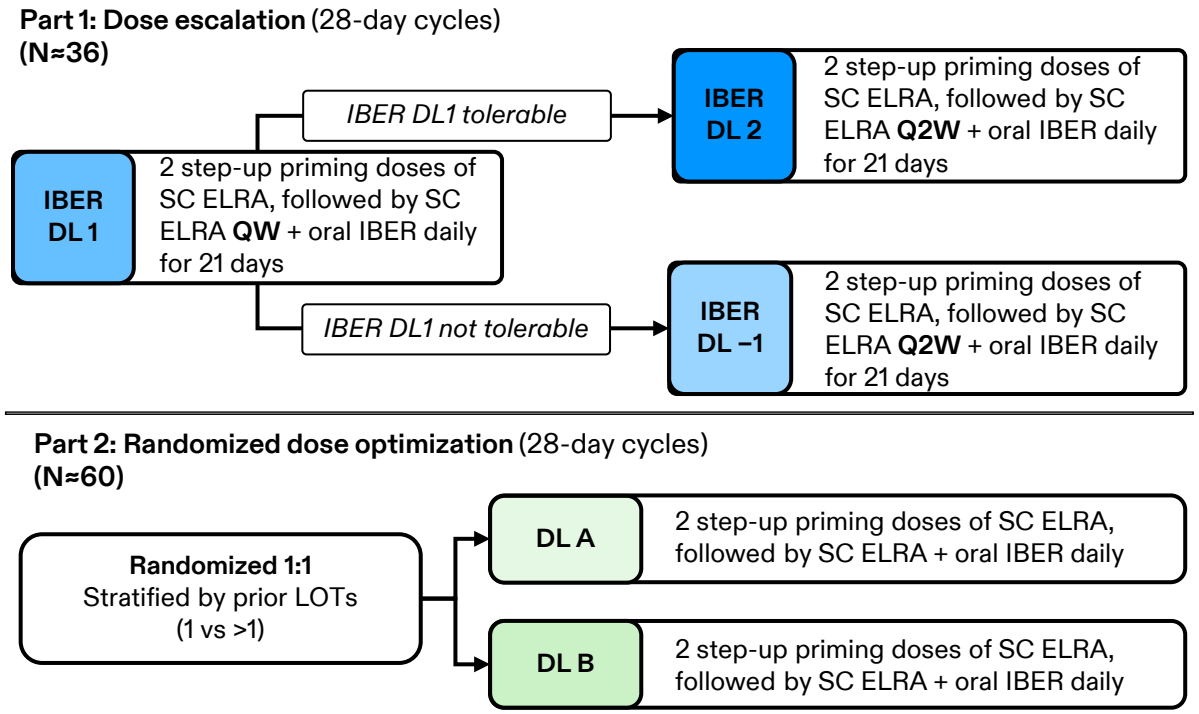
MagnetisMM-30: A Phase 1b, Open-Label Study of Elranatamab in Combination With Iberdomide in Patients With Relapsed or Refractory Multiple Myeloma (2/3)

Lesokhin A et al. (ASCO / EHA Poster Presentation)

Methods: Study Design

- MagnetisMM-30 (NCT06215118), a Phase 1b, open-label, prospective study, is divided into 2 parts (**Figure**):
  - Part 1: Dose escalation
  - Part 2: Randomized dose optimization
- Two combination dose levels (DL A and DL B) will be selected from Part 1 as the recommended doses in Part 2
  - Patients in Part 2 will be randomized 1:1 to DL A and DL B stratified by prior LOTs (1 vs >1)

Figure. MagnetisMM-30 Study Design



ELRA = elranatamab; DL = dose level; IBER = iberdomide; LOT = line of therapy; QW = once weekly; Q2W = once every 2 weeks; SC = subcutaneous.
Lesokhin A et al. Poster presented at ASCO 2025 (Abstract TPS7566)/poster presented at EHA 2025 (Abstract PF784).

MagnetisMM-30: A Phase 1b, Open-Label Study of Elranatamab in Combination With Iberdomide in Patients With Relapsed or Refractory Multiple Myeloma (3/3)

Lesokhin A et al. (ASCO / EHA Poster Presentation)

Methods

- Key inclusion and exclusion criteria are shown in **Table 1**
- Primary and key secondary endpoints are shown in **Table 2**

Table 1. Key Inclusion and Exclusion Criteria

Key inclusion criteria	Key exclusion criteria
• Age ≥18 years • MM per IMWG criteria • ECOG PS 0–1 • **Part 1**: 2–4 prior LOTs, including ≥1 IMiD and ≥1 PI* • **Part 2**: 1–3 prior LOTs, including ≥1 IMiD and ≥1 PI* • Relapsed or refractory to last LOT • Adequate bone marrow and organ function	• SCT ≤12 weeks prior to enrollment or active GVHD • Active, uncontrolled infection • Ongoing grade ≥2 peripheral sensory or motor neuropathy; history of grade ≥3 peripheral motor polyneuropathy • Prior BCMA-directed or CD3-redirecting therapy or prior IBER or mezigdomide

*All patients must have received ≥2 consecutive cycles of an IMiD-containing regimen and ≥2 consecutive cycles of a PI or PI-containing regimen. †Per IMWG criteria.
AE = adverse event; BCMA = B-cell maturation antigen; CRR = complete response rate; ECOG PS = Eastern Cooperative Oncology Group performance status; GVHD = graft vs host disease; IBER = iberdomide; IMiD = immunomodulatory drug; IMWG = International Myeloma Working Group; LOT = line of therapy; MM = multiple myeloma; MRD = minimal residual disease; ORR = objective response rate; PI = proteasome inhibitor; PK = pharmacokinetics; SCT = stem cell transplant.
Lesokhin A et al. Poster presented at ASCO 2025 (Abstract TPS7566)/poster presented at EHA 2025 (Abstract PF784).

Table 2. Study Endpoints

Primary endpoints	
Part 1 • Dose-limiting toxicities during the first cycle of treatment	**Part 2** • AEs, laboratory abnormalities
Key secondary endpoints	
Part 1 • AEs, laboratory abnormalities • ORR† • CRR† • Time-to-event outcomes† • PK • MRD negativity rate† • Immunogenicity	**Part 2** • ORR† • CRR† • Time-to-event outcomes† • PK • MRD negativity rate† • Immunogenicity

Study Status

- The study is ongoing and plans to enroll ≈36 and ≈60 patients in Part 1 and Part 2, respectively
- As of April 15, 2025, the study is open in 13 sites across 3 countries

MagnetisMM-32: A Phase 3 Randomized Study of Elranatamab vs EPd, PVd, or Kd in Patients With Relapsed or Refractory Multiple Myeloma and Prior Anti-CD38-Directed Therapy

Schuster S et al.

ASCO 2025 Poster Presentation (Abstract TPS7568);

Chalopin T et al.

EHA 2025 Poster Presentation (Abstract PB2926)

Pfizer-Sponsored Study

Pfizer Medical Affairs

MagnetisMM-32: A Phase 3 Randomized Study of Elranatamab vs EPd, PVd, or Kd in Patients With Relapsed or Refractory Multiple Myeloma and Prior Anti-CD38–Directed Therapy (1/3)

Schuster S et al. (ASCO Poster Presentation) / Chalopin T et al. (EHA Poster Presentation)

Background

- The Phase 2 MagnetisMM-3 trial (NCT04649359) demonstrated that elranatamab monotherapy in patients with RRMM induced deep and durable responses with a manageable safety profile[1]
- The MOA of elranatamab may benefit patients already exposed to PIs, IMiDs, and anti-CD38 mAbs in early LOTs (**Figure**)

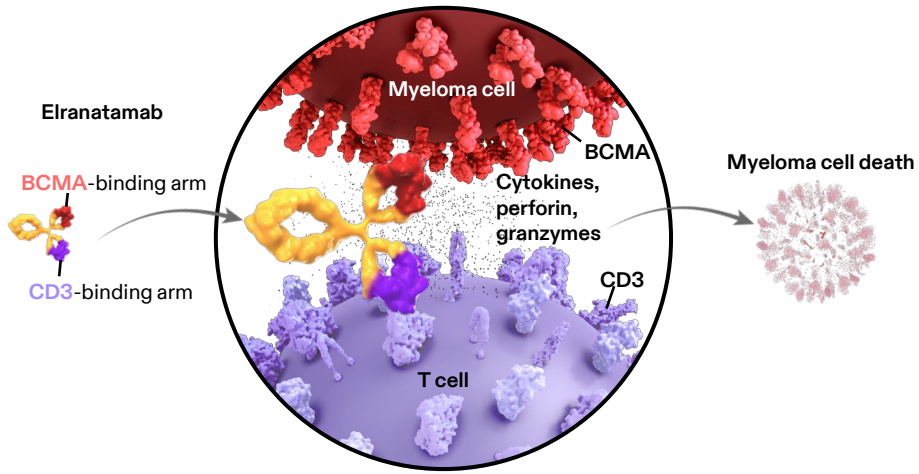
Objective

To evaluate whether elranatamab can provide superior clinical benefit over EPd, PVd, or Kd in patients with RRMM

Elranatamab[1,2]

- Bispecific antibody that binds BCMA on myeloma cells and CD3 on T cells
- T cells activated by CD3 binding release cytokines and perforin/granzymes, resulting in myeloma cell lysis

Figure. Elranatamab MOA



BCMA = B-cell maturation antigen; CD = cluster of differentiation; EPd = elotuzumab-pomalidomide-dexamethasone; IMiD = immunomodulatory agent; LOT = line of therapy; Kd = carfilzomib-dexamethasone; mAb = monoclonal antibody; MOA = mechanism of action; PI = proteasome inhibitor; PVd = pomalidomide-bortezomib-dexamethasone; RRMM = relapsed or refractory multiple myeloma. 1. Lesokhin AM et al. Nat Med. 2023;29:2259-2267; 2. Elranatamab Fachinformation, aktueller Stand. Schuster S et al. Poster presented at ASCO 2025 (Abstract TPS7568)/Chalopin T et al. Poster presented at EHA 2025 (Abstract PB2926).

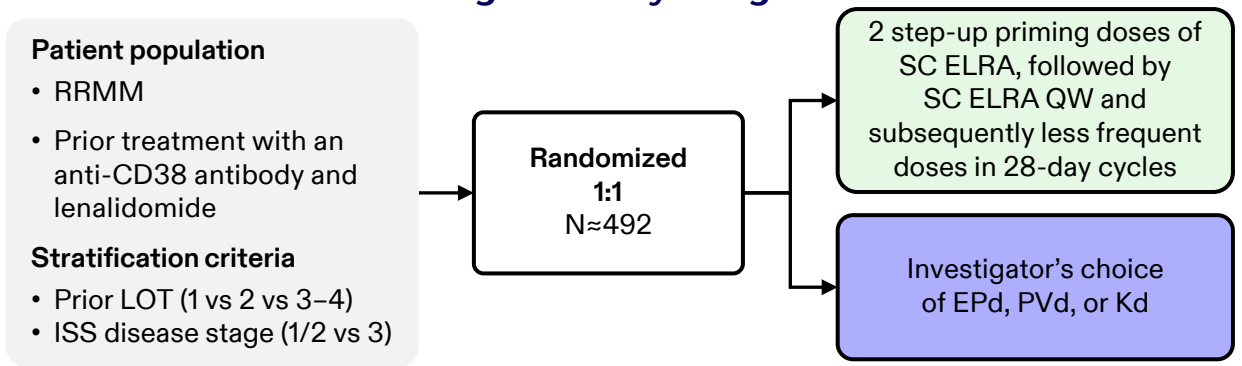
MagnetisMM-32: A Phase 3 Randomized Study of Elranatamab vs EPd, PVd, or Kd in Patients With Relapsed or Refractory Multiple Myeloma and Prior Anti-CD38–Directed Therapy (2/3)

Schuster S et al. (ASCO Poster Presentation) / Chalopin T et al. (EHA Poster Presentation)

Methods: Study Design

- MagnetisMM-32 (NCT06152575) is a Phase 3, open-label, multicenter, randomized study
- Eligible patients will receive SC elranatamab or investigator's choice of EPd, PVd, or Kd until disease progression, unacceptable toxicity, withdrawal of consent, loss to follow-up, or study termination (**Figure**)
- Key inclusion and exclusion criteria are shown in the **Table**

Figure. Study Design



*Patients with 4 prior LOTs will be restricted to a maximum of 10%.
BCMA = B-cell maturation antigen; CD = cluster of differentiation; ECOG PS = Eastern Cooperative Oncology Group performance status; ELRA = elranatamab; EPd = elotuzumab-pomalidomide-dexamethasone; GVHD = graft versus host disease; IMWG = International Myeloma Working Group; ISS = International Staging System; Kd = carfilzomib-dexamethasone; LOT = line of therapy; MM = multiple myeloma; PR = partial response; PVd = pomalidomide-bortezomib-dexamethasone; QW = once weekly; RRMM = relapsed or refractory multiple myeloma; SC = subcutaneous; SCT = stem cell transplant.
Schuster S et al. Poster presented at ASCO 2025 (Abstract TPS7568)/Chalopin T et al. Poster presented at EHA 2025 (Abstract PB2926).

Table. Key Inclusion and Exclusion Criteria

Key inclusion criteria	Key exclusion criteria
• Age ≥18 years • MM per IMWG criteria • ECOG PS ≤2 • 1–4 prior LOTs* • Received ≥2 consecutive cycles of an anti-CD38 antibody-containing regimen in any prior line and ≥2 consecutive cycles of a lenalidomide-containing regimen in any prior line • Progressive disease or refractory to last LOT per IMWG criteria • Adequate bone marrow function	• SCT ≤12 weeks prior to enrollment, or active GVHD • Active, uncontrolled infection • Ongoing grade ≥3 peripheral sensory or motor neuropathy; history of any grade ≥3 peripheral motor polyneuropathy • Prior BCMA-directed or CD3-redirecting therapy • Individuals who have never achieved ≥PR with any treatment during the disease course • Unable to receive any of the Arm B regimens (EPd, PVd, or Kd) • Any other active malignancy <3 years prior to enrollment

MagnetisMM-32: A Phase 3 Randomized Study of Elranatamab vs EPd, PVd, or Kd in Patients With Relapsed or Refractory Multiple Myeloma and Prior Anti-CD38–Directed Therapy (3/3)

Schuster S et al. (ASCO Poster Presentation) / Chalopin T et al. (EHA Poster Presentation)

Methods

- Primary and key secondary endpoints are shown in **Table**

Study status

- The study is ongoing and plans to enroll ≈492 patients
- As of April 14, 2025, the study is open in 18 countries (**Figure**)

Table. Study Endpoints

Primary endpoints

- PFS by BICR per IMWG criteria

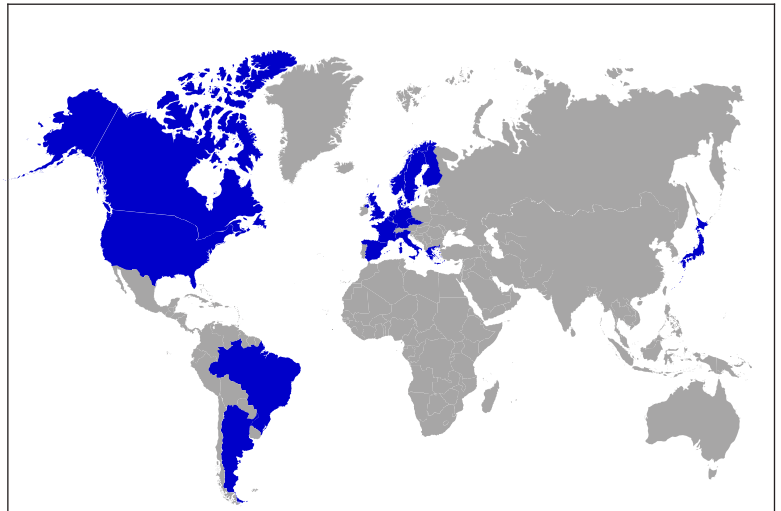
Key secondary endpoint

- OS

Other secondary endpoints

- *By investigator per IMWG criteria*
  - PFS
  - PFS on next LOT
- *By BICR per IMWG criteria*
  - Complete response rate
  - Duration of response
  - Duration of complete response
  - Objective response rate
  - Time to response
  - Very good partial response rate
- MRD negativity rate (including sustained for ≥12 months) and duration (*per IMWG)*
- Safety
- Pharmacokinetics
- Immunogenicity
- Health-related QOL outcomes

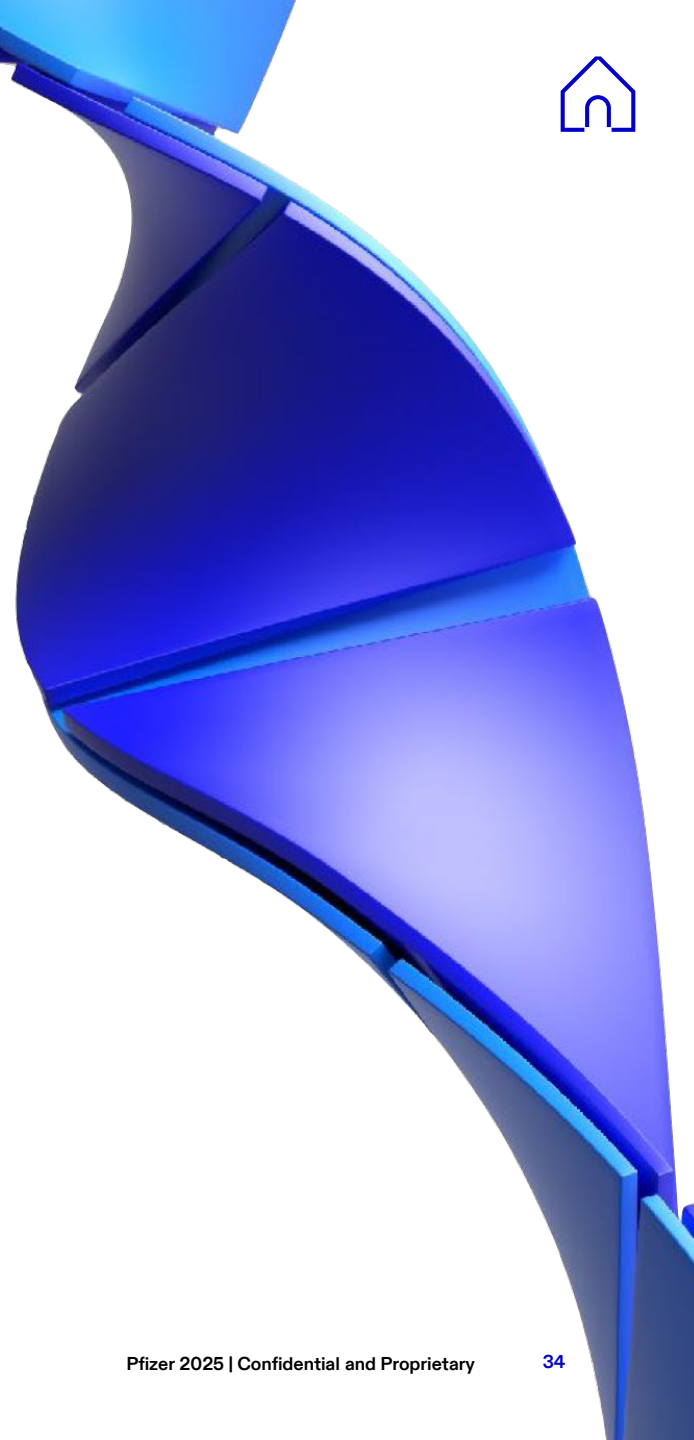
Figure. MagnetisMM-32 Study Sites



Argentina, Belgium, Brazil, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Italy, Japan, Netherlands, Norway, Spain, Sweden, UK, and US

BICR = blinded independent central review; CD = cluster of differentiation; EPd = elotuzumab-pomalidomide-dexamethasone; IMWG = International Myeloma Working Group; Kd = carfilzomib-dexamethasone; LOT = line of therapy; MRD = minimal residual disease; OS = overall survival; PFS = progression-free survival; PVd = pomalidomide-bortezomib-dexamethasone; QOL = quality of life.
Schuster S et al. Poster presented at ASCO 2025 (Abstract TPS7568)/Chalopin T et al. Poster presented at EHA 2025 (Abstract PB2926).

Real-World Evidence



Real-World Evidence – *Presentations*

ASCO/EHA Presentation Summaries	First Author	Abstract #	Slide: Title	Slide: Authors' Conclusions
ALTITUDE-1: Real-World Treatment Patterns Associated With Elranatamab Among Patients With Multiple Myeloma	Banerjee R	PF798	36	41
Treatment Patterns and Effectiveness in an Anti-CD38 and Lenalidomide Pretreated RRMM Population: Data From Two Real-World Datasets	Mohan M	PF774	42	47
An Indirect Comparison of Elranatamab's Patient-Reported Outcomes From MagnetisMM-3 vs Real-World External Control Arms in Triple-Class Refractory Multiple Myeloma	Hebraud B	PB2918	48	53
The Efficacy of Elranatamab in MagnetisMM-3 Compared With a Real-World Control Arm Simulating a Colombian Triple-Class Refractory Multiple Myeloma Population	Reyes JM	PB2968	54	57

CD = cluster of differentiation; RRMM = relapsed or refractory multiple myeloma.

ALTITUDE-1: Real-World Treatment Patterns Associated With Elranatamab Among Patients With Multiple Myeloma

Banerjee R et al.

EHA 2025 Poster Presentation (Abstract PF798)

Pfizer-Sponsored Study

ALTITUDE-1: Real-World Treatment Patterns Associated With Elranatamab Among Patients With Multiple Myeloma (1/5)

Banerjee R et al. (EHA Poster Presentation)

Background

- The Phase 2 MagnetisMM-3 (NCT04649359) trial established ELRA's efficacy and safety[1]
- Real-world data on patient usage (including patients ineligible for MagnetisMM-3 due to comorbidities) are lacking

Objective

To understand the treatment and dosing patterns of ELRA in a real-world setting

Methods

- ALTITUDE-1 is an ongoing, non-interventional database study to capture real-world ELRA use among patients with MM from Komodo Health's Healthcare Map™*
- The study included adult patients with MM with ≥1 claim for ELRA and ≥180 days of continuous closed claims enrollment prior to their first ELRA claim (index date), and excluded patients with a prior claim for a BCMA BsAb
- This interim analysis (data cutoff January 2025; median days on therapy: 65 [IQR 17–127]) reports on treatment patterns for:
  - Index to Day 8 (step-up dosing [SUD] period)
  - Day 9 to Day 168 (maintenance period 1 [MP1] with ELRA QW)
  - Day 169+ (maintenance period 2 [MP2] with ELRA Q2W†)

*Integrates both open- and closed-claims databases from ≥150 public and private payers/insurers as well as clearinghouses across the United States. †Depending on individual patient response.
BCMA = B-cell maturation antigen; BsAb = bispecific antibody; ELRA = elranatamab; IQR = interquartile range; MM = multiple myeloma; QW = once every week; Q2W = once every 2 weeks; SUD = step-up dosing.
1. Lesokhin A et al. *Nat Med.* 2023;29:2259-2267.
Banerjee R et al. Poster presented at EHA 2025 (Abstract PF798).

ALTITUDE-1: Real-World Treatment Patterns Associated With Elranatamab Among Patients With Multiple Myeloma (2/5)

Banerjee R et al. (EHA Poster Presentation)

Results: Patients and Treatment

- 69 patients were included, with a median age of 70.0 (IQR 63.0–78.0) years (**Table**)
  - 46.4% were male
  - 56.5% were White and 21.7% were Black or African American
  - 46.4% were penta-drug exposed
    - 29.0% had a prior BCMA-directed therapy
    - 15.9% had a prior BCMA-directed CAR T-cell therapy

*Assessed from any time prior to index date to index date. †Assessed from the initial MM diagnosis date to 1 day prior to index date. ‡Exposed to 2 unique proteasome inhibitors, 2 unique immunomodulatory agents, and CD38 monoclonal antibodies. §Assessed from 14 days prior to index date to index date. ¶Assessed from 180 days prior to index date to index date.
BCMA = B-cell maturation antigen; CAR = chimeric antigen receptor; CCI = Charlson Comorbidity Index; CD = cluster of differentiation; IQR = interquartile range; IV = intravenous; MM = multiple myeloma; SD = standard deviation.
Banerjee R et al. Poster presented at EHA 2025 (Abstract PF798).

Table. Baseline and Treatment Characteristics

	N=69
Age on index date, median (IQR), years	70.0 (63.0–78.0)
Sex, n (%)	
Male	32 (46.4)
Female	31 (44.9)
Unknown/Missing	6 (8.7)
Race/ethnicity, n (%)	
Asian or Pacific Islander	1 (1.4)
Black or African American	15 (21.7)
Hispanic or Latino	5 (7.2)
White	39 (56.5)
Other	3 (4.3)
Unknown or missing	6 (8.7)
Region on index date*, n (%)	
South	25 (36.2)
Northeast	22 (31.9)
West	16 (23.2)
Midwest	6 (8.7)
Care setting on index date, n (%)	
Inpatient	38 (55.1)
Outpatient	13 (18.8)
Pharmacy	0 (0.0)
Unknown/Missing	18 (26.1)
Time from initial MM diagnosis to index date, median (IQR), months	74.8 (48.4–97.5)
Prior treatment history†, n (%)	
Penta-drug exposed‡	32 (46.4)
BCMA-directed therapy	20 (29.0)
CAR-T	11 (15.9)
Talquetamab	5 (7.2)

Table. Baseline and Treatment Characteristics (cont.)

	N=69
Relevant disease history†, n (%)	
Any infection	62 (89.9)
Hypertension	61 (88.4)
Peripheral neuropathy	56 (81.2)
Neutropenia	45 (65.2)
Use of IV anti-infective§	44 (63.8)
Hypercalcemia	23 (33.3)
Extramedullary disease	11 (15.9)
Amyloidosis	9 (13.0)
CCI score¶, mean (SD)	3.6 (3.4)
Categorical CCI scored¶, n (%)	
0 (no comorbidities)	14 (20.3)
1 to 2 (mild)	20 (29.0)
3 to 4 (moderate)	11 (15.9)
≥5 (severe)	24 (34.8)
CCI comorbidities (≥5%)¶, n (%)	
Metastatic solid tumor	21 (30.4)
Renal disease	20 (29.0)
Congestive heart failure	20 (29.0)
Chronic pulmonary disease	16 (23.2)
Diabetes	14 (20.3)
Cerebrovascular disease	10 (14.5)
Perivascular disease	10 (14.5)
Myocardial infarction	6 (8.7)

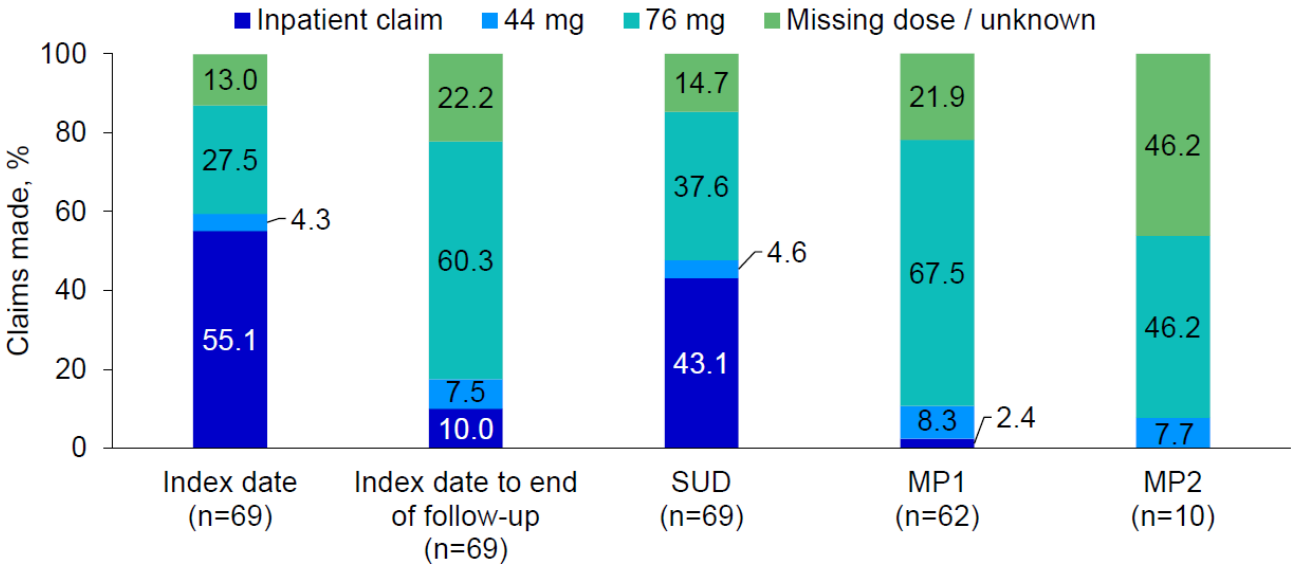
ALTITUDE-1: Real-World Treatment Patterns Associated With Elranatamab Among Patients With Multiple Myeloma (3/5)

Banerjee R et al. (EHA Poster Presentation)

Results: Treatment Patterns

- The proportions of claims made per vial size reported as the percentage of total ELRA claims are shown in the **Figure**
  - SUD period (index date to Day 8)
    - 69 patients contributed 109 claims of ELRA (1.6 per patient)
  - MP1 (Day 9 to 168)
    - 62 patients contributed 424 claims of ELRA
  - MP2 (Day 169+)
    - 10 patients contributed 39 claims of ELRA
- Among the post-SUD administrations with non-missing dose information (342 claims), the 44 mg vial was used in 10.8% of these claims

Figure. Proportions of Claims by Vial Size*,†,‡



Patients were followed from their index ELRA claim and censored at the earliest of death, next treatment, the end of observability, or the end of data.
*Reported as numbers of claims for specific vial size and percentage of total ELRA claims during the time period of interest. †For 44 mg and 76 mg, the reported dose is based on the dose associated with the NDC in the non-inpatient and pharmacy setting. If the NDC is not available, the quantity of dosing is used. ‡Missing/unknown dose is defined as an ELRA claim with a missing dose or a recorded dose that is not 44 mg/1.1 mL or 76 mg/1.9 mL.
ELRA = elranatamab; MP = maintenance period; NDC = National Drug Code; SUD = step-up dosing.
Banerjee R et al. Poster presented at EHA 2025 (Abstract PF798).

ALTITUDE-1: Real-World Treatment Patterns Associated With Elranatamab Among Patients With Multiple Myeloma (4/5)

Banerjee R et al. (EHA Poster Presentation)

Results: Treatment Patterns (cont.)

- Mean (SD) and median (IQR) number of days between administrations are shown in the **Figure**
  - SUD period (index date to Day 8)
    - Mean (SD): 5.7 (1.8) days
    - Median (IQR): 7 (4–7) days
  - MP1 (Day 9 to 168)
    - Mean (SD): 10.7 (8.2) days
    - Median (IQR): 7 (7–14) days
    - Nearly a quarter of administrations occurred on a Q2W cadence
  - MP2 (Day 169+)
    - Mean (SD): 26.0 (22.3) days
    - Median (IQR): 27 (14–28) days
    - Suggests a monthly (Q4W) cadence in a quarter of administrations
- At any point during the post-index period, 76.8% of patients received antivirals, 56.5% received antibiotics, 27.5% received antifungals, and 40.6% received intravenous immunoglobulin (**Table**)

Patients were followed from their index ELRA claim and censored at the earliest of death, next treatment, the end of observability, or the end of data.
*Assessed in patients with at least 2 administrations for ELRA during the time period of interest.
CD38=cyclic ADP ribose hydrolase; ELRA = elranatamab; HSCT=Hematopoietic stem cell transplantation; IMiDs=immunomodulatory drugs; IQR = interquartile range; IVIG=Intravenous immunoglobulin; mAbs=monoclonal antibodies; MP = maintenance period; PI=proteasome inhibitors; Q2W = once every 2 weeks; Q4W = once every 4 weeks; SD = standard deviation; SUD = step-up dosing.
Banerjee R et al. Poster presented at EHA 2025 (Abstract PF798).

Figure. Number of Days Between Administration*

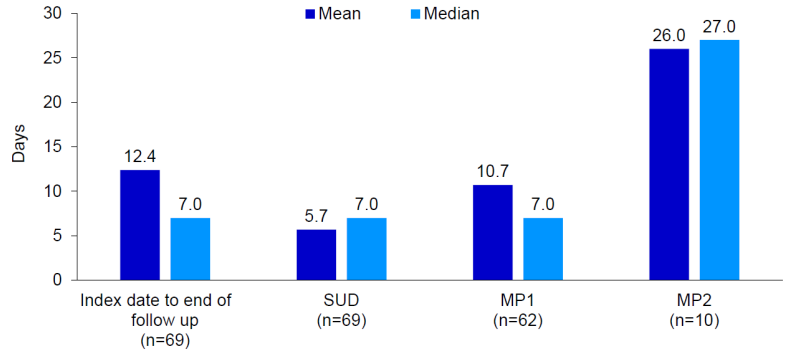


Table. Therapies Received in Follow-up (N=69)

Anti-myeloma therapies, n (%)	
HSCT	6 (8.7)
Proteasome inhibitors	5 (7.2)
Chemotherapies	3 (4.3)
IMiDs	3 (4.3)
CD38 mAbs	2 (2.9)
Nuclear export inhibitor	2 (2.9)
Talquetamab	2 (2.9)
Supportive care therapies, n (%)	
Antivirals	53 (76.8)
Antibiotics	39 (56.5)
Antifungals	19 (27.5)
Intravenous immunoglobulin	28 (40.6)

ALTITUDE-1: Real-World Treatment Patterns Associated With Elranatamab Among Patients With Multiple Myeloma (5/5)

Banerjee R et al. (EHA Poster Presentation)

Authors' Conclusions

- This was the first real-world analysis of ELRA using claims data of patients with heavily pretreated MM, with nearly a third previously treated with a BCMA-directed therapy
- ELRA was administered less frequently than per the FDA label, with earlier Q2W and even Q4W dosing schedules observed
- Continued analyses with larger sample sizes and longer follow-up are ongoing

Please note: The conclusions above represent the authors' conclusions only.
BCMA = B-cell maturation antigen; ELRA = elranatamab; FDA = Food and Drug Administration; MM = multiple myeloma; Q2W = once every 2 weeks; Q4W = once every 4 weeks.
Banerjee R et al. Poster presented at EHA 2025 (Abstract PF798).

Treatment Patterns and Effectiveness in an Anti-CD38 and Lenalidomide Pretreated RRMM Population: Data From Two Real-World Datasets

Mohan M et al.

EHA 2025 Poster Presentation (Abstract PF774)

Pfizer-Sponsored Study

Treatment Patterns and Effectiveness in an Anti-CD38 and Lenalidomide Pretreated RRMM Population: Data From Two Real-World Datasets (1/5)

Mohan M et al. (EHA Poster Presentation)

Background

- There is no clear SOC for patients with RRMM following treatment with lenalidomide and an anti-CD38 mAb,[1,2] creating an unmet need to understand real-world treatment patterns and clinical outcomes to optimize treatment strategies in this patient population

Objective

To explore real-world characteristics and clinical outcomes in patients with RRMM previously treated with lenalidomide and an anti-CD38 mAb from large datasets in the US and Germany

Methods

- Data were analyzed from the TM MM database (Germany)[3] and the COTA EHR database (US)[4]
- Patients were included if they received prior lenalidomide and an anti-CD38 therapy within 1–4 prior LOTs and initiated their next therapy (index therapy) between May 2016 and December 2023 (TM MM) or November 2015 and August 2023 (COTA)
  - Patients with ECOG PS >2 were excluded
- Patient characteristics, number of prior LOTs, and treatment regimens were analyzed
- Kaplan-Meier curves were calculated for PFS and OS
  - In the TM MM dataset, biochemical progression was not available, so PFS was defined as time from index to death or start of a new LOT

CD = cluster of differentiation; ECOG PS = Eastern Cooperative Oncology Group performance status; EHR = electronic health record; LOT = line of therapy; mAb = monoclonal antibody; OS = overall survival; PFS = progression-free survival; RRMM = relapsed/refractory multiple myeloma; SOC = standard of care; TM MM = Therapy Monitor Multiple Myeloma.

1. Ramasamy K et al. *Clin Lymphoma Myeloma Leuk.* 2025;25:337-348.e2; 2. Tan CJ et al. *Cancer Med.* 2025;14:e70585; 3. Therapy Monitor Multiple Myeloma German database. Available at: https://catalogues.ema.europa.eu/node/1073/administrative-details. Accessed June 2025; 4. COTA US database. Cota Healthcare. 2025. Available at: https://cotahealthcare.com/. Accessed June 2025.
Mohan M et al. Poster presented at EHA 2025 (Abstract PF774).

Treatment Patterns and Effectiveness in an Anti-CD38 and Lenalidomide Pretreated RRMM Population: Data From Two Real-World Datasets (2/5)

Mohan M et al. (EHA Poster Presentation)

Results: Patients and Prior Treatment (Table)

- Median age was higher in the TM MM database compared with the COTA database (74 vs 68 years)
- Patients in the COTA dataset were heavily pretreated (median of 3 prior LOTs vs 2 prior LOTs in TM MM)
- In both datasets, more than half of patients were double refractory

Table. Demographics and Baseline Characteristics

	TM MM* N=1246	COTA N=190
Median age (min–max), years	74 (25–95)	68 (37–92)
Median prior LOT (min–max)	2 (1–4)	3 (1–4)
Prior LOT, n (%)		
1	92 (7.4)	5 (2.6)
2	600 (48.2)	52 (27.4)
3	389 (31.2)	83 (43.7)
4	165 (13.2)	50 (26.3)
Prior therapy, n (%)		
Lenalidomide	1246 (100)	190 (100)
Anti-CD38 mAb	1246 (100)	190 (100)
Protease inhibitor	1129 (90.6)	185 (97.4)
Selinexor	0	0
Exposure status, n (%)		
Double-class†	1246 (100)	190 (100)
Triple-class‡	1129 (90.6)	185 (97.4)
Quad-class§	387 (31.1)	119 (62.6)
Penta-drug¶	29 (2.3)	30 (15.8)

Table. Demographics and Baseline Characteristics (cont.)

	TM MM* N=1246	COTA N=190
Refractory status, n (%)		
Lenalidomide	758 (60.8)	109 (57.4)
Anti-CD38 mAb	790 (63.4)	101 (53.2)
Protease inhibitor	523 (42.0)	116 (61.1)
Double-class†	827 (66.4)	139 (73.2)
Triple-class‡	332 (26.7)	42 (22.1)
Penta-drug¶	11 (0.9)	2 (1.1)
Cytogenetic risk, n (%)		
Standard	189 (15.2)	125 (65.8)
High#	122 (9.8)	48 (25.3)
Unknown	935 (75.0)	17 (8.9)
ECOG PS, n (%)		
0	139 (11.2)	84 (44.2)
1	682 (54.7)	92 (48.4)
2	425 (34.1)	14 (7.4)
ISS/R-ISS, n (%)		
I	39 (3.1)	53 (27.9)
II	697 (55.9)	60 (31.6)
III	381 (30.6)	50 (26.3)
Unknown	129 (10.4)	27 (14.2)

*In TM MM, refractoriness is based on documentation of relapsed/refractory status of entire line if patient has progressed to the next. †Double-class refers to ≥2 of the following classes: proteasome inhibitor, immunomodulatory drug, and anti-CD38 antibody. ‡Triple-class refers to ≥1 proteasome inhibitor, ≥1 immunomodulatory drug, and ≥1 anti-CD38 antibody. §Quad-class refers to ≥2 proteasome inhibitor, ≥1 immunomodulatory drug, and ≥1 anti-CD38 antibody, or ≥1 proteasome inhibitor, ≥2 immunomodulatory drugs, and ≥1 anti-CD38 antibody. ¶Penta-drug refers to ≥2 proteasome inhibitors (bortezomib and carfilzomib in COTA), ≥2 immunomodulatory drugs (lenalidomide and pomalidomide in COTA), and ≥1 anti-CD38 antibody (daratumumab in COTA). #Includes t(4;14), t(14;16), and del(17p) chromosomal abnormalities. CD = cluster of differentiation; ECOG PS = Eastern Cooperative Oncology Group performance status; ISS = International Staging System; LOT = line of therapy; mAb = monoclonal antibody; R-ISS = Revised ISS; RRMM = relapsed/refractory multiple myeloma; TM MM = Therapy Monitor Multiple Myeloma. Mohan M et al. Poster presented at EHA 2025 (Abstract PF774).

Treatment Patterns and Effectiveness in an Anti-CD38 and Lenalidomide Pretreated RRMM Population: Data From Two Real-World Datasets (3/5)

Mohan M et al. (EHA Poster Presentation)

Results: Treatments

- Index treatment regimens (first treatment after patient exposed to lenalidomide and anti-CD38 within 1–4 lines) were heterogenous (**Table**)
- The most common regimen in each dataset was used by <20% of patients
  - TM MM: pomalidomide + dexamethasone (16.2%)
  - COTA: pomalidomide + carfilzomib + dexamethasone (9.5%)
- The 3 most common regimens were collectively used by <40% of patients

Table. Index Treatment Regimens

	TM MM N=1246	COTA N=190
Top 5 most-used regimens at index, n (%)		
1	Pd 202 (16.2)	PKd 18 (9.5)
2	EPd 165 (13.2)	DPd 16 (8.4)
3	Kd 139 (11.1)	EPd 13 (6.8)
4	IRd 111 (8.9)	DVd 12 (6.3)
5	ERd 108 (8.7)	DKd 11 (5.8)
Top 5 most-used regimens after index (subsequent therapy), n (%)		
	TM MM N=628	**COTA N=124**
1	IsaKd 105 (16.7)	Kd 11 (8.9)
2	Pd 65 (10.4)	Kcd 7 (5.7)
3	EPd 56 (8.9)	DKd 6 (4.8)
4	IsaPd 46 (7.3)	EPd 6 (4.8)
5	Kd 45 (7.2)	PKd 5 (4.0)

DKd = daratumumab, carfilzomib, dexamethasone; DPd = daratumumab, pomalidomide, dexamethasone; DVd = daratumumab, bortezomib, dexamethasone; EPd = elotuzumab, pomalidomide, dexamethasone; ERd = elotuzumab, lenalidomide, dexamethasone; IRd = ixazomib, lenalidomide, dexamethasone; IsaKd = isatuximab, carfilzomib, dexamethasone; IsaPd = isatuximab, pomalidomide, dexamethasone; Kcd = carfilzomib, cyclophosphamide, dexamethasone; Kd = carfilzomib, dexamethasone; Pd = pomalidomide, dexamethasone; PKd = pomalidomide, carfilzomib, dexamethasone; RRMM = relapsed/refractory multiple myeloma; TM MM = Therapy Monitor Multiple Myeloma.
Mohan M et al. Poster presented at EHA 2025 (Abstract PF774).

Treatment Patterns and Effectiveness in an Anti-CD38 and Lenalidomide Pretreated RRMM Population: Data From Two Real-World Datasets (4/5)

Mohan M et al. (EHA Poster Presentation)

Results: Efficacy

- Both datasets showed consistent efficacy results
  - Median PFS (95% CI, months): 12.1 (12.0–12.7) in TM MM and 11.8 (8.5–15.1) in COTA
  - Median OS (95% CI, months): 33.5 (29.7–38.7) in TM MM and 28.9 (24.8–34.2) in COTA
- Patients treated in Germany experience worse PFS, but not OS, compared to those treated in the US, suggested by the shape of the Kaplan-Meier curves (**Figures 1 and 2**)
  - Mean PFS (months): 14.4 in TM MM and 23.3 in COTA
  - Mean OS (months): 38.7 in TM MM and 35.9 in COTA

Figure 1. PFS in TM MM and COTA datasets

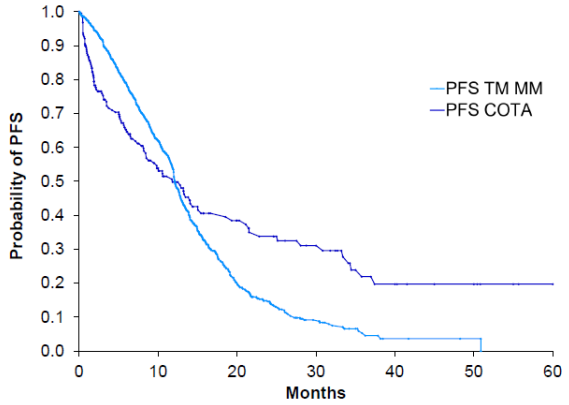
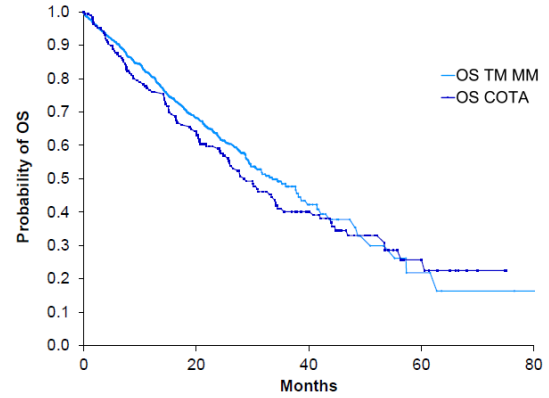


Figure 2. OS in TM MM and COTA datasets



OS = overall survival; PFS = progression-free survival; RRMM = relapsed/refractory multiple myeloma; TM MM = Therapy Monitor Multiple Myeloma.
Mohan M et al. Poster presented at EHA 2025 (Abstract PF774).

Treatment Patterns and Effectiveness in an Anti-CD38 and Lenalidomide Pretreated RRMM Population: Data From Two Real-World Datasets (5/5)

Mohan M et al. (EHA Poster Presentation)

Authors' Conclusions

- This study supports the findings from prior research on the outcomes of lenalidomide and anti-CD38 mAb-exposed patients,[1] while focusing on an earlier-line population (1–4 prior LOTs) and including a larger European population
- There is no clear SOC for patients post-lenalidomide and anti-CD38 mAb-exposed. While some differences in patient characteristics and availability of and access to therapies were observed in patients from the datasets, which may influence treatment outcomes, the consistency of median PFS and OS across the two sources underscores the reliability of these findings
- The median PFS was approximately 1 year, underscoring the poor outcomes and the unmet need for more effective therapies in this patient population. It should be noted that there is a risk that PFS in the TM MM dataset is overestimated due to the missing progression data
- Further research is needed to explore these differences and optimize treatment strategies for this patient population

Please note: The conclusions above represent the authors' conclusions only.
CD = cluster of differentiation; LOT = line of therapy; mAb = monoconal antibody; OS = overall survival; PFS = progression-free survival; RRMM = relapsed/refractory multiple myeloma; SOC = standard of care; TM MM = Therapy Monitor Multiple Myeloma.

1. Ramasamy K et al. *Clin Lymphoma Myeloma Leuk.* 2025;25:337-348.e2.
Mohan M et al. Poster presented at EHA 2025 (Abstract PF774).

An Indirect Comparison of Elranatamab's Patient-Reported Outcomes From MagnetisMM-3 vs Real-World External Control Arms in Triple-Class Refractory Multiple Myeloma

Hebraud B et al.

EHA 2025 Publication Only (Abstract PB2918)

Pfizer-Sponsored Study

An Indirect Comparison of Elranatamab's Patient-Reported Outcomes From MagnetisMM-3 vs Real-World External Control Arms in Triple-Class Refractory Multiple Myeloma (1/5)

Hebraud B et al. (EHA Publication Only Abstract)

Background

- Elranatamab is a BCMA/CD3 BsAb approved for the treatment of RRMM
- The efficacy of elranatamab in the MagnetisMM-3 trial was previously contextualized with real-world external control arms in prior publications[1-4]

Objective

To compare PROs between elranatamab and real-world external control arms as an extension of prior publications

Methods

- The study indirectly compared the changes in PROs observed in MM-3 from the March 26, 2024 data cut with two ongoing, prospective, observational studies (MM-13 and MM-14)
- MM-3 inclusion and exclusion criteria were used in both real-world studies to identify similar patients as in MM-3
  - Both real-world studies used PCT
- In MM-13 and MM-14, PRO assessments occurred at baseline and monthly through Month 6
- PRO measures included EORTC QLQ-C30, EORTC QLQ-MY20, EQ-5D, PGIS, and PGIC
- A single PCT cohort was created by combining non-CAR T-cell patients who had a baseline PRO value from MM-13 and MM-14 using May 2024 data cuts
- Mixed models were conducted to compare PRO measures over time between the elaranatamab and PCT cohorts

BCMA = B-cell maturation antigen; BsAb = bispecific antibody; CAR = chimeric antigen receptor; CD = cluster of differentiation; EORTC = European Organisation for Research and Treatment of Cancer; EQ-5D = EuroQol 5-dimension Questionnaire; PCT = physician's choice of therapy; PGIC = Patient Global Impression of Change; PGIS = Patient Global Impression of Severity; PRO = patient-reported outcome; QLQ-C30 = Quality of Life Questionnaire – Core 30; QLQ-MY20 = Quality of Life Multiple Myeloma Module; RRMM = relapsed/refractory multiple myeloma.

1. Costa LJ et al. *Future Oncol.* 2024;20:1175-1189; 2. Mol I et al. *Curr Med Res Opin.* 2024;40:199-207; 3. Mol I et al. *Leuk Lymphoma.* 2024;65:660-668; 4.Costa LJ et al. Poster presentation at ASH 2024 (Abstract 2401).
Hebraud B et al. Abstract publication at EHA 2025 (Abstract PB2918).

An Indirect Comparison of Elranatamab's Patient-Reported Outcomes From MagnetisMM-3 vs Real-World External Control Arms in Triple-Class Refractory Multiple Myeloma (2/5)

Hebraud B et al. (EHA Publication Only Abstract)

Results: Baseline Characteristics

- Most baseline characteristics were similar across cohorts between MM-3 (N=184) and MM-13/14 (N=84) (**Table**)
- The MM-3 cohort had been diagnosed earlier (7.2 vs 6.0 years) and had a higher number of prior LOTs (mean = 6.1 vs 4.0)

Table. Baseline Characteristics

	MM-3 N=184	MM-13/14 N=84
Age, years	66.5	69.3
Sex, male (%)	51.6	57.1
ECOG PS 1, %	34.8	34.5
ISS stage III, %	23.4	29.8
High-risk cytogenetics, %	23.9	27.4
Time since diagnosis, years	7.2	6.0
Mean number of prior LOTs	6.1	4.0

ECOG PS = Eastern Cooperative Oncology Group performance status; ISS = International Staging System; LOT = line of therapy.
Hebraud B et al. Abstract publication at EHA 2025 (Abstract PB2918).

An Indirect Comparison of Elranatamab's Patient-Reported Outcomes From MagnetisMM-3 vs Real-World External Control Arms in Triple-Class Refractory Multiple Myeloma (3/5)

Hebraud B et al. (EHA Publication Only Abstract)

Results: Least-Square Mean Differences

- Numerical trends favored elranatamab over PCT for PROs across most measures and visits (**Table**)
- Significantly greater improvements for patients treated with elranatamab vs PCT
  - At Visit 5 (LSMD = 8.53 [95% CI 1.26 to 15.81]) for QLQ-C30 General Health Status score
  - At Visit 3 (-11.22 [95% CI -19.48 to -2.90]) for QLQ-C30 Pain score
- No significant differences were observed for the Side Effects or Body Image domains in the QLQ-MY20

Table. Least-Square Mean Differences Between Patients

		Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
QLQ-C30							
Global health status	LSMD 95% CI	-1.64 -6.78 to 3.5	4.39 -1.65 to 10.42	5.12 -0.96 to 11.2	5.87 -0.87 to 12.61	**8.53*** 1.26 to 15.81	3.30 -3.5 to 10.1
Pain	LSMD 95% CI	-2.01 -9.53 to 5.51	-3.33 -10.91 to 4.26	**-11.22*** -19.48 to -2.96	-6.93 -15.33 to 1.48	-7.74 -17.57 to 2.1	-4.26 -13.55 to 5.04
QLQ-MY20							
Disease symptoms	LSMD 95% CI	**-5.36*** -10.56 to -0.15	-3.51 -8.17 to 1.15	-3.57 -9.01 to 1.87	**-7.70*** -13.38 to -2.03	-7.08 -14.3 to 0.14	-4.96 -11.63 to 1.71
Side effects	LSMD 95% CI	1.67 -1.94 to 5.28	1.28 -2.3 to 4.86	-0.26 -3.94 to 3.42	1.10 -3.15 to 5.35	-1.75 -6.12 to 2.63	-2.08 -6.58 to 2.42
Future perspectives	LSMD 95% CI	3.23 -2.58 to 9.04	5.53 -0.13 to 11.19	**10.08*** 4.42 to 15.74	**7.65*** 1.32 to 13.98	**6.21*** 0.29 to 12.13	5.02 -1.96 to 12.01
Body image	LSMD 95% CI	0.56 -6.88 to 8.01	-0.56 -7.84 to 6.72	-1.85 -9.78 to 6.08	0.58 -8.45 to 9.62	0.31 -7.5 to 8.13	0.09 -7.95 to 8.14

*P<0.05. Note: negative mean differences in QLQ-C30 Pain, QLQ-MY20 Disease symptoms, QLQ-MY20 Side effects, and PGIS indicate results that favor elranatamab over PCT; positive mean differences in all other PRO measures indicate results favoring elranatamab over PCT.
CI = confidence interval; LSMD = least-square mean difference; PCT = physician's choice of therapy; PGIS = Patient Global Impression of Severity; PRO = patient-reported outcome; QLQ-C30 = Quality of Life Questionnaire – Core 30; QLQ-MY20 = Quality of Life Multiple Myeloma Module.
Hebraud B et al. Abstract publication at EHA 2025 (Abstract PB2918).

An Indirect Comparison of Elranatamab's Patient-Reported Outcomes From MagnetisMM-3 vs Real-World External Control Arms in Triple-Class Refractory Multiple Myeloma (4/5)

Hebraud B et al. (EHA Publication Only Abstract)

Results: Least-Square Mean Differences

- Patients treated with elranatamab reported significantly greater improvements (P<0.05) in generic QoL (**Table**)
  - Assessed by EQ-5D index (Visits 3, 5, and 6), EQ-5D visual analog scale (Visits 2 and 5), and global assessments of PGIS (Visits 2, 3, 4, and 5) and PGIC (Visits 2, 3, 4, 5, and 6)

Table. Least-Square Mean Differences Between Patients (cont.)

		Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
EQ-5D							
Index	LSMD 95% CI	-0.01 -0.06 to 0.05	0.05 -0.01 to 0.1	**0.08*** 0.02 to 0.14	0.04 -0.02 to 0.1	**0.08*** 0.01 to 0.16	**0.12*** 0.03 to 0.21
Visual analog scale	LSMD 95% CI	-1.85 -6.95 to 3.25	**5.43*** 0.45 to 10.41	4.21 -1.47 to 9.88	4.15 -1.76 to 10.06	**11.00*** 4.38 to 17.61	7.13 -0.12 to 14.37
Patient Global Impression							
PGIS	LSMD 95% CI	-0.21 -0.47 to 0.04	**-0.37*** -0.63 to -0.11	**-0.33*** -0.59 to -0.06	**-0.42*** -0.7 to -0.13	**-0.60*** -0.89 to -0.30	-0.26 -0.55 to 0.03
PGIC	LSMD 95% CI	0.22 -0.15 to 0.59	**0.75*** 0.38 to 1.13	**0.93*** 0.53 to 1.33	**1.08*** 0.71 to 1.44	**0.79*** 0.34 to 1.24	**1.04*** 0.6 to 1.49

*P<0.05. Note: negative mean differences in QLQ-C30 Pain, QLQ-MY20 Disease symptoms, QLQ-MY20 Side effects, and PGIS indicate results that favor elranatamab over PCT; positive mean differences in all other PRO measures indicate results favoring elranatamab over PCT.
CI = confidence interval; EQ-5D = EuroQol 5-dimension Questionnaire; LSMD = least-square mean difference; PCT = physician's choice of therapy; PGIC = Patient Global Impression of Change; PGIS = Patient Global Impression of Severity; PRO = patient-reported outcome; QoL = quality of life.
Hebraud B et al. Abstract publication at EHA 2025 (Abstract PB2918).

An Indirect Comparison of Elranatamab's Patient-Reported Outcomes From MagnetisMM-3 vs Real-World External Control Arms in Triple-Class Refractory Multiple Myeloma (5/5)

Hebraud B et al. (EHA Publication Only Abstract)

Authors' Conclusions

- Although caution should be applied when comparing clinical trial data with real-world data, it was found that patients treated with elranatamab in the MM-3 trial showed comparable, if not superior, symptom and QoL experiences compared with similar patients treated with PCT in real-world clinical practice
- These results were consistent with previously published clinical efficacy comparisons between MM-3 and real-world data sources

Please note: The conclusions above represent the authors' conclusions only.
PCT = physician's choice of therapy; QoL = quality of life.
Hebraud B et al. Abstract publication at EHA 2025 (Abstract PB2918).

The Efficacy of Elranatamab in MagnetisMM-3 Compared With a Real-World Control Arm Simulating a Colombian Triple-Class Refractory Multiple Myeloma Population

Reyes JM et al.

EHA 2025 Publication Only (Abstract PB2968)

Pfizer-Sponsored Study

The Efficacy of Elranatamab in MagnetisMM-3 Compared With a Real-World Control Arm Simulating a Colombian Triple-Class Refractory Multiple Myeloma Population (1/3)

Reyes JM et al. (EHA Publication Only Abstract)

Background

- Elranatamab is a BCMA/CD3 BsAb approved for the treatment of RRMM

Objective

To compare the PFS, DOR, and OS of elranatamab from the Phase 2 MagnetisMM-3 trial (NCT04649359) vs a real-world external control arm simulating Colombian patients with TCRMM

Methods

- This retrospective cohort study indirectly compared the efficacy observed in Cohort A (BCMA-naïve) of MagnetisMM-3 with a real-world external control arm from COTA, a US-based oncology EHR database
- Additionally, a Health Management Organization database in Colombia was analyzed to determine the treatment regimens available locally in TCRMM; only patients using these regimens in COTA were included in the final real-world cohort, which simulated the Colombian population
- The index date was defined as the date of initiation of elranatamab in MagnetisMM-3 or PCT regimen in the COTA database after documented TCRMM
- PFS was defined as the time from the index date until progression confirmed through IMWG criteria or death due to any cause, whichever came first
- OS was defined as the time from the index date until death due to any cause

BCMA = B-cell maturation antigen; BsAb = bispecific antibody; CD = cluster of differentiation; DOR = duration of response; EHR = electronic health record; IMWG = International Myeloma Working Group; OS = overall survival; PCT = physician's choice of therapy; PFS = progression-free survival; RRMM = relapsed/refractory multiple myeloma; TCRMM = triple-class refractory multiple myeloma.
Reyes JM et al. Abstract publication at EHA 2025 (Abstract PB2968).

The Efficacy of Elranatamab in MagnetisMM-3 Compared With a Real-World Control Arm Simulating a Colombian Triple-Class Refractory Multiple Myeloma Population (2/3)

Reyes JM et al. (EHA Publication Only Abstract)

Results: Outcomes

- Outcomes in the MagnetisMM-3 elranatamab cohort (N=213) was compared with the Real-World cohort (N=240)
- The main treatment regimens used in the real-world cohort were:
  - Daratumumab, pomalidomide, and dexamethasone (17.5%)
  - Carfilzomib, dexamethasone, and cyclophosphamide (11.7%)
  - Carfilzomib and dexamethasone (11.7%)
  - Carfilzomib, pomalidomide, and dexamethasone (11.7%)
- Demographic and clinical variables were relatively similar between groups after IPT weighting
- Elranatamab was associated with significantly longer PFS (AF=0.50 [95% CI 0.33–0.77]) and DOR (HR=0.15 [95% CI 0.07–0.31]) vs the real-world cohort (**Table**)
- Median PFS and DOR in the real-world cohort were 5.9 (95% CI 4.4–9.2) and 4.70 (95% CI 4.44–9.46), respectively
  - Median PFS and DOR were not reached in the elranatamab cohort (95% CI NE)
- The median OS was 33.7 (95% CI 13.3–NE) vs 15.2 months (95% CI 12.2–19.6) for the elranatamab and real-world cohorts, respectively

Table. Outcomes in the Elranatamab Cohort vs the Simulated Colombia Real-World Cohort

	Unweighted Analysis		IPT Weighted Analysis	
	Median time (95% CI), months	HR (95% CI)	Median time (95% CI), months	HR (95% CI)*
PFS				
MagnetisMM-3 Cohort A (n=123)	17.25 (9.76–NE)	0.36 (0.22–0.58)	NE	0.50 (0.33–0.77)
Real-world cohort (n=240)	5.85 (4.63–9.23)		5.85 (4.44–9.23)	
DOR				
MagnetisMM-3 Cohort A (n=123)	NE	0.20 (0.12–0.33)	NE	0.15 (0.07–0.31)
Real-world cohort (n=240)	7.75 (4.63–10.41)		7.75 (4.63–10.41)	
OS				
MagnetisMM-3 Cohort A (n=123)	24.61 (13.37–NE)	0.82 (0.59–1.15)	33.71 (13.27–NE)	0.72 (0.50–1.04)
Real-world cohort (n=240)	16.33 (12.75–19.65)		15.18 (12.19–19.65)	

*In the case of PFS, this figure represents an acceleration factor, not a hazard ratio due to the violation of the proportional hazard's assumption.
AF = acceleration factor; CI = confidence interval; DOR = duration of response; HR = hazard ratio; IPT = inverse probability of treatment; NE = not estimable; OS = overall survival; PFS = progression-free survival.
Reyes JM et al. Abstract publication at EHA 2025 (Abstract PB2968).

The Efficacy of Elranatamab in MagnetisMM-3 Compared With a Real-World Control Arm Simulating a Colombian Triple-Class Refractory Multiple Myeloma Population (3/3)

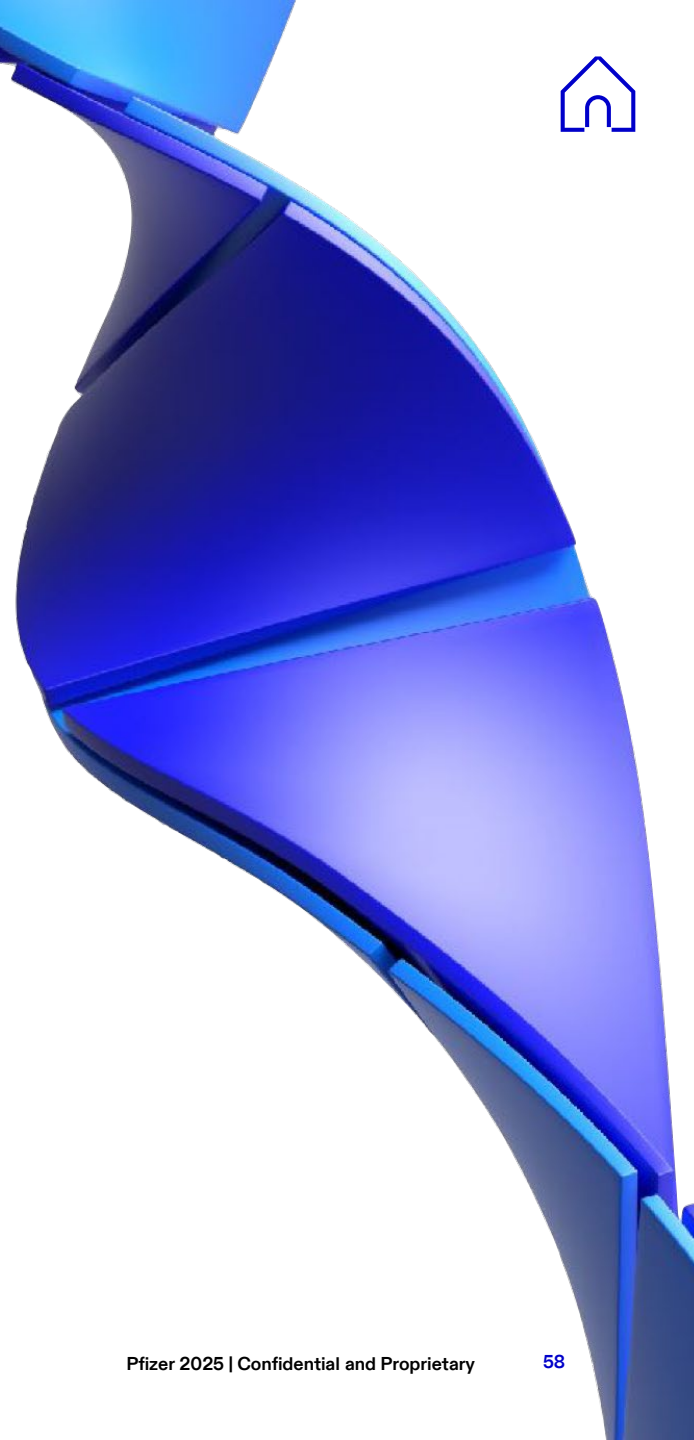
Reyes JM et al. (EHA Publication Only Abstract)

Authors' Conclusions

- Elranatamab was associated with significantly longer PFS and DOR vs patients treated with standard regimens available in Colombia
- The OS rate was numerically favorable for elranatamab but not statistically significant

Please note: The conclusions above represent the authors' conclusions only.
DOR = duration of response; OS = overall survival; PFS = progression-free survival.
Reyes JM et al. Abstract publication at EHA 2025 (Abstract PB2968).

Health Economics and Outcomes Research



Health Economics and Outcomes Research – *Presentations*

ASCO/EHA Presentation Summaries	First Author	Abstract #	Slide: Title	Slide: Authors' Conclusions
Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma	Zamagni E	PS1751	60	66
Healthcare Resource Utilization and Costs Following the Initiation of Various Lines of Therapy Among Patients With Relapsed/Refractory Multiple Myeloma	Estrin A	PS2298	67	72

CAR-T = chimeric antigen receptor T-cell.

Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma

Zamagni E et al.

EHA 2025 Poster Presentation (Abstract PS1751)

Pfizer-Sponsored Study

Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma (1/6)

Zamagni E et al. (EHA Poster Presentation)

Background

- CAR T-cell and BsAb therapies have improved outcomes in patients with MM[1]; however, experience with, and access to, these therapies varies by country[2]

Objective

To investigate the differences in HCP confidence in CAR T-cell and BsAb therapies across countries and explore barriers to offering these therapies to eligible patients

Methods

- 30-minute web-based quantitative surveys were conducted from March 2024 to June 2024
- Participants included HCPs* (N=983) and patients with RRMM (N=1301) across 7 countries (US, UK, France, Germany, Italy, Spain, and Japan)
- Due to commercial unavailability during the study, the question about barriers to BsAb was not asked in Italy or Japan, and the question about barriers to CAR T-cell therapy was not asked in the UK
- Only HCP data are reported here, analyzed using descriptive statistics and χ^2 tests

*Includes specialists in medical oncology, hematology/oncology, hematology (US only), transplant surgery or internal medicine practicing full time and managing ≥3 patients with MM receiving second-line or later treatment in the past 12 months.
BsAb = bispecific antibody; CAR = chimeric antigen receptor; HCP = healthcare professional; MM = multiple myeloma; RRMM = relapsed/refractory multiple myeloma.
1. Holstein SA et al. *J Clin Oncol.* 2023;41:4416-29; 2. Ailawadhi S et al. *Patient Prefer Adherence.* 2025;19:1089-1104.
Zamagni E et al. Poster presented at EHA 2025 (Abstract PS1751).

Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma (2/6)

Zamagni E et al. (EHA Poster Presentation)

Results: HCP Characteristics and CAR T-cell and BsAb Administration

- HCP characteristics were similar, with BsAb and CAR T-cell administration in practice shown in the **Table**

Table: HCP Characteristics and CAR T-cell and BsAb Administration in Practice*

n (%)	Total N=983	US n=251	JP n=152	FR n=150	DE n=65	IT n=150	ES n=143	UK n=72	Ex-US n=732	EU5 n=580	Academic n=582	Community n=401
Years in practice												
≤10	234 (24)	80 (32)§	27 (18)	32 (21)	9 (14)	33 (22)	34 (24)	19 (26)	154 (21)‖	127 (22)	155 (27)¶	79 (20)
11–20	438 (45)	101 (40)	55 (36)	78 (52)	38 (58)	59 (39)	68 (48)	39 (54)	337 (46)	282 (49)	272 (47)	166 (41)
>20	311 (32)	70 (28)	70 (46)‡	40 (27)	18 (28)	58 (39)	41 (29)	14 (19)	241 (33)	171 (29)	155 (27)	156 (39)#
Practice setting												
Academic†	582 (59)	117 (47)‡	91 (60)	92 (61)	40 (62)	98 (65)	96 (67)	48 (67)	465 (64)‡	374 (64)	-	-
Community	401 (41)	134 (53)‡	61 (40)	58 (39)	25 (38)	52 (35)	47 (33)	24 (33)	267 (36)‡	206 (36)‡	-	-
Administration in practice												
BsAb	586 (71)	153 (61)‡	NA	119 (79)	45 (69)	120 (80)	105 (73)	44 (61)	433 (75)‡	433 (75)‡	394/491 (80)	192/340 (56)
CAR T-cell	420 (46)	146 (58)‡	42 (28)	69 (46)	29 (45)	76 (51)	58 (41)	NA	274 (42)‡	232 (46)	326/534 (61)	94/377 (25)

*Versus requiring referral. †Academic setting was defined as a "hospital associated with a university" or a "stand-alone cancer center with multiple doctors". ‡P<0.01 compared with total. §P=0.030 compared with total. ‖P=0.018 compared with total. ¶P<0.01 compared with community. #P=0.012 compared with academic.
BsAb = bispecific antibody; CAR = chimeric antigen receptor; DE = Germany; ES = Spain; EU5 = France, Germany, Italy, Spain, and UK; FR = France; HCP = healthcare professional; IT = Italy; JP = Japan; NA = not asked.
Zamagni E et al. Poster presented at EHA 2025 (Abstract PS1751).

Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma (3/6)

Zamagni E et al. (EHA Poster Presentation)

Results: Patient Eligibility (Figure 1)

- Perceived patient eligibility for CAR T-cell therapy varied more than for BsAbs
- HCPs considered 37% of patients eligible for CAR T-cell therapy; the US reported the highest proportion (44%, P<0.001) and Japan the lowest (25%, P<0.001)
- HCPs considered 43% of patients eligible for BsAbs; Spain reported the highest (50%, P=0.015) and the UK the lowest (36%)
- Perceived patient eligibility was higher in academic vs community settings for both CAR T-cell (P<0.001) and BsAb (P=0.014) therapies

Results: HCP Confidence (Figure 2)

- Confidence determining patient eligibility for CAR T-cell therapy was highest in Spain (72%, P<0.01) and France (67%, P=0.025), and lowest in Japan (28%; P<0.01)
- Confidence in determining patient eligibility for BsAbs was also highest in France (80%; P<0.01) and Spain (77%, P=0.011), and lowest in the UK (44%, P<0.01)
- HCP confidence in determining patient eligibility for both CAR T-cell therapy and BsAbs was higher in academic vs community settings (both P<0.01)

Figure 1. Perceived Patient Eligibility

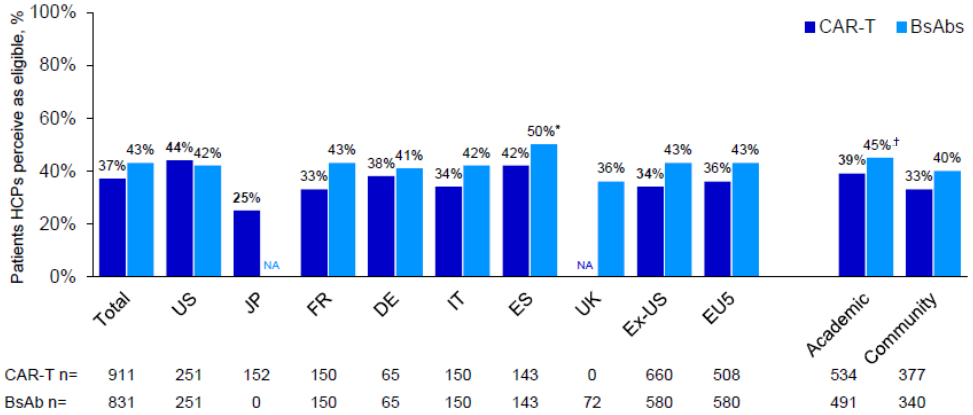
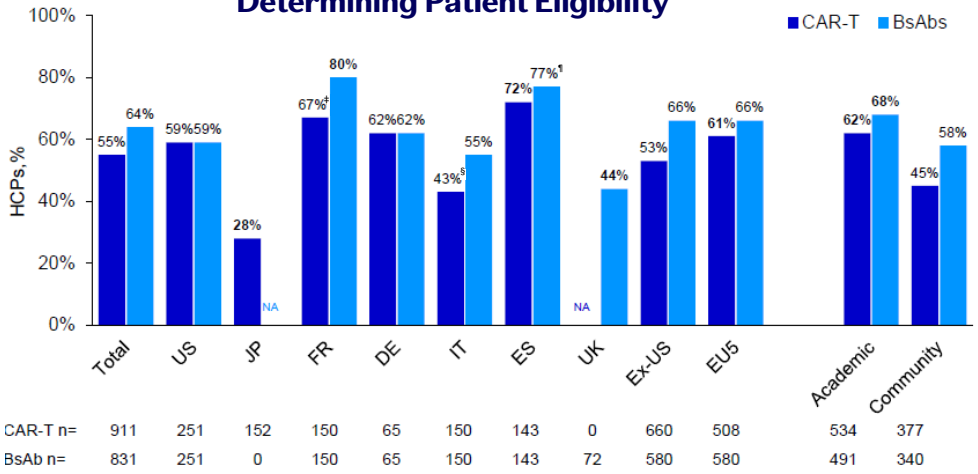


Figure 2. HCPs Who Were Very/Extremely Confident in Determining Patient Eligibility



Bold text in figures denotes P<0.01 for country vs total or academic vs community. Figure 1: *P=0.015 compared with total, †P=0.014 compared with community. Figure 2: ‡P=0.025 compared with total, §P=0.042 compared with total, ¶P=0.011 compared with total. Abbreviations included in Notes page. BsAb = bispecific antibody; CAR-T cell = chimeric antigen receptor T-cell; DE = Germany; ES = Spain; EU5 = France, Germany, Italy, Spain and UK; FR = France; HCP = healthcare provider; IT = Italy; JP = Japan; NA = not asked; UK = United Kingdom. Zamagni E et al. Poster presented at EHA 2025 (Abstract PS1751).

Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma (4/6)

Zamagni E et al. (EHA Poster Presentation)

Results: Top Barriers for CAR T-cell Therapy

HCPs

- Overall: Delays in manufacturing time (15%) and limited capacity to administer CAR T-cell therapy (14%)
- US: Limited CAR T-cell therapy capabilities (15%) and logistical challenges (14%)
- EU5: Manufacturing time (20% vs 15% total) and limited capacity to administer CAR T-cell therapy (17%)
- DE: Limited capacity to administer CAR T-cell therapy (29%)

Academic setting

- Delays in manufacturing time (18%) and limited capacity to administer CAR T-cell therapy (15%)

Community setting

- Limited CAR T-cell therapy capabilities in practice (18% vs 11% academic; P=0.040) and logistical challenges (15% vs 9% academic; P=0.029)

Figure. Primary Reason Provided by HCPs Why CAR T-cell Therapy is Not Offered to Eligible Patients*

	Total N=485	US n=130	JP n=47	FR n=88	DE n=35	IT n=99	ES n=86	Ex-US n=355	EU5 n=308	Academic n=291	Community n=194
Delay in starting Tx due to CAR-T manufacturing time	15%	7%†	11%	19%	20%	20%	20%	19%	20%†	18%	12%
Limited capacity to administer CAR-T, so not brought up as option	14%	6%‡	17%	16%	29%	15%	16%	17%	17%	15%	12%
Practice does not have the capabilities to administer CAR-T therapy	14%	15%	13%	15%	14%	13%	12%	13%	13%	11%	18%§
CAR-T therapy too logistically challenging for patient	11%	14%	6%	15%	9%	10%	8%	10%	11%	9%	15%¶
CAR-T requires referral to another center, would prefer Tx in practice	9%	11%	15%	5%	6%	8%	8%	8%	7%	8%	10%
CAR-T safety risks outweigh the potential efficacy benefits	8%	9%	9%	11%	0%	8%	6%	8%	7%	9%	6%
CAR-T is financially challenging for the patient	7%	12%	9%	2%	6%	5%	6%	5%	5%	8%	5%
Ability of patients or caregivers to self-manage or monitor for CAR-T AEs	5%	6%	4%	3%	0%	6%	8%	5%	5%	7%#	3%
Need to better understand/more experience with CAR-T AEs	4%	5%	6%	2%	3%	4%	5%	4%	4%	4%	5%
Not clear which patients will benefit most from CAR-T therapy	4%	2%	2%	3%	9%	5%	7%	5%	6%	4%	4%
CAR-T requires referral to another center, not clear where patient would prefer to be treated	4%	6%	2%	2%	3%	3%	2%	3%	3%	2%	6%‖
Worry about the staff ability/capacity of staff to learn processes required for CAR-T	3%	6%	2%	2%	3%	2%	2%	2%	2%	4%	2%
Not comfortable with managing the potential CAR-T AEs	1%	2%	4%	3%	0%	0%	0%	1%	1%	1%	3%

*Not asked in the UK. †P=0.033. ‡P=0.041 vs total. §P=0.040 vs academic. ¶P=0.029 vs academic. #P=0.026 vs community. ‖P=0.034 vs academic.
AE = adverse event; CAR = chimeric antigen receptor; DE = Germany; ES = Spain; EU5 = France, Germany, Italy, Spain and UK; FR = France; HCP = healthcare professional; IT = Italy; JP = Japan; Tx = treatment.
Zamagni E et al. Poster presented at EHA 2025 (Abstract PS1751).

Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma (5/6)

Zamagni E et al. (EHA Poster Presentation)

Results: Top Barriers for BsAb Therapy

HCPs

- Overall: Logistical challenges (13%) and safety risks outweighing potential efficacy benefits (12%)
- US: Financial (20% vs 11% total; P<0.01) and logistical (13%) challenges
- FR: Safety risks outweighing potential efficacy benefits (29% vs 12% total; P<0.01) and uncertainty around which patients will benefit (15% vs 9% total)
- DE: Uncertainty around which patients will benefit (19% vs 9% total) and knowledge of AEs (19% vs 11% total)
- UK: logistical challenges (22% vs 13% total), with safety risks outweighing the potential efficacy benefits ranking the lowest (2% vs 12% total)

Academic setting

- Logistics (14%), safety risks outweighing potential efficacy benefits (12%), and patient management/monitoring of AEs (12%)

Community setting

- Financial (13%) and logistical (12%) challenges, and knowledge of AEs (12%)

Figure. Primary Reason Provided by HCPs Why BsAb Therapy is Not Offered to Eligible Patients*

	Total N=357	US n=126	FR n=65	DE n=32	ES n=79	UK n=55	EU5 n=231	Academic n=203	Community n=154
BsAb therapy is too logistically challenging for the patient	13%	13%	6%	13%	14%	22%	13%	14%	12%
BsAb safety risks outweigh the potential efficacy benefits	12%	6%	29% †	9%	15%	2%	15%	12%	11%
Need to better understand/more experience with BsAb AEs	11%	9%	9%	19%	9%	15%	12%	10%	12%
BsAb is financially challenging for the patient	11%	20% †	5%	0%	8%	7%	6% †	9%	13%
Limited capacity to administer BsAb, so not brought up as option	10%	9%	6%	6%	18%	5%	10%	10%	8%
Ability of patients or caregivers to self-manage or monitor for BsAb AEs	9%	7%	11%	13%	9%	11%	10%	12%	6%
Not clear which patients will benefit most from BsAb therapy	9%	3%	15%	19%	8%	9%	12%	11%	6%
Practice does not have the capacity to administer BsAb	8%	12%	6%	3%	5%	9%	6%	7%	9%
Practice does not have the capabilities to administer BsAb therapy	7%	8%	3%	13%	5%	11%	7%	4%	11% ‡
BsAb requires referral to another center, would prefer treatment in practice	5%	7%	3%	0%	8%	2%	4%	4%	6%
Worry about the staff ability/capacity of staff to oversee BsAb	3%	3%	3%	6%	3%	0%	3%	3%	3%
Not comfortable with managing the potential BsAb AEs	2%	2%	2%	0%	0%	4%	1%	1%	3%
BsAb requires referral to another center, unclear where to refer my patient would prefer to be treated	1%	1%	2%	0%	0%	4%	1%	1%	1%

*Not asked in Italy or Japan. †P<0.01 vs total. ‡P=0.017 vs academic.
AE = adverse event; BsAb = bispecific antibody; DE = Germany; ES = Spain; EU5 = France, Germany, Italy, Spain and UK; FR = France; HCP = healthcare professional.
Zamagni E et al. Poster presented at EHA 2025 (Abstract PS1751).

Differences Across Countries in Healthcare Provider Confidence With CAR-T and Bispecific Antibody Therapies for Relapsed/Refractory Multiple Myeloma (6/6)

Zamagni E et al. (EHA Poster Presentation)

Authors' Conclusions

- Our results identify various country-specific barriers to CAR T-cell and BsAb usage which need to be addressed
- A more tailored strategy for addressing BsAb barriers may be needed, as they varied more by country than CAR T-cell barriers
  - Overcoming barriers is important, as BsAbs have potential for broad use and have demonstrated efficacy in clinical trials and real-world settings[1,2]
- Enhancing HCP confidence through additional training and clearer eligibility criteria could help make CAR T-cell and BsAb therapies more available to appropriate patients
- Responses could have been influenced by commercial availability at the time of the study, and as access increases, addressing barriers could support a more consistent and equitable approach to providing these therapies

Please note: The conclusions above represent the authors' conclusions only.
BsAb = bispecific antibody; CAR = chimeric antigen receptor; HCP = healthcare professional.
1. Malard F et al. *Blood Cancer J.* 2024;14:219; 2. Wang X et al. *Front Immunol.* 2024;15:1348955.
Zamagni E et al. Poster presented at EHA 2025 (Abstract PS1751).

Healthcare Resource Utilization and Costs Following the Initiation of Various Lines of Therapy Among Patients With Relapsed/Refractory Multiple Myeloma

Estrin A et al.

EHA 2025 Poster Presentation (Abstract PS2298)

Pfizer-Sponsored Study

Healthcare Resource Utilization and Costs Following the Initiation of Various Lines of Therapy Among Patients With Relapsed/Refractory Multiple Myeloma (1/5)

Estrin A et al. (EHA Poster Presentation)

Background

- Many patients with RRMM require new lines of treatments,[1,2] incurring significant HCRU and costs, particularly considering the recent availability of CAR T-cell therapy and BsAbs[3-5]

Objective

To provide current estimates of the HCRU and costs associated with initiating various lines of therapy for patients with RRMM

Methods

- Claims data were analyzed from the Komodo Healthcare US claims and COTA EHR databases
- Adult patients with MM who were TCE and initiated their 2L+ treatment between January 1, 2019 and May 2, 2024 (index date), with closed-claims enrollment 180 days prior to the index date (pre-index period) and ≥30 days of closed-claims enrollment and EHR observability after the index date (follow-up period) were included
- HCRU and costs were reported on a PPPM basis
- Two additional *a priori* cohorts were identified: patients initiating their 4L+ treatment and patients initiating a CAR T-cell therapy
- Changes in HCRU and costs from pre-index to follow-up were analyzed

2L+ = second line or later; 4L+ = fourth line or later; BsAb = bispecific antibody; CAR = chimeric antigen receptor; EHR = electronic health record; HCRU = healthcare resource utilization; MM = multiple myeloma; PPPM = per-patient-per-month; RRMM = relapsed/refractory multiple myeloma; TCE = triple-class exposed.

1. Chim CS et al. *Leukemia.* 2018;32:252-262; 2. Gahvari ZJ et al. *Oncology.* 2023;37:164-174; 3. Kocaata Z et al. *Pharmacoecon Open.* 2022;6:619-628; 4. Martínez-Lopez J et al. *Future Oncol.* 2023;19:2103-2121; 5. Myers GD et al. *J Immunother Cancer.* 2020;9:e002056.
Estrin A et al. Poster presented at EHA 2025 (Abstract PS2298).

Healthcare Resource Utilization and Costs Following the Initiation of Various Lines of Therapy Among Patients With Relapsed/Refractory Multiple Myeloma (2/5)

Estrin A et al. (EHA Poster Presentation)

Results: Patients and Treatments

- 143 patients with 2L+ RRMM were included in this analysis (**Table**)
- At the index date, 2.8%, 40.6%, 28.7%, and 28.0% of patients were initiating their 2L, 3L, 4L, or 5L+ regimens, respectively
- Median follow-up was 4.5 (range 0.2–46.8) months

Table. Baseline and Treatment Characteristics

	N=143
Age on index date, mean (SD), years	63.6 (11.0)
Sex, n (%)	
Female	85 (59.4)
Male	58 (40.6)
Race / ethnicity, n (%)	
Asian or Pacific Islander	3 (2.1)
Black or African American	18 (12.6)
Hispanic or Latino	0 (0.0)
White	93 (65.0)
Other	8 (5.6)
Unknown or missing	21 (14.7)
Region on index date, n (%)	
South	103 (72.0)
Northeast	39 (27.3)
West	1 (0.7)
Midwest	0 (0.0)

Table. Baseline and Treatment Characteristics (cont.)

	N=143
Index LOT, n (%)	
2L	4 (2.8)
3L	58 (40.6)
4L	41 (28.7)
5L+	40 (28.0)
Time from initial MM diagnosis to index date, median (IQR), months	34.2 (18.5–53.6)
Modified CCI score,* mean (SD)	0.08 (0.29)
Medical insurance type, n (%)	
Commercial	74 (51.7)
Medicare	59 (41.3)
Medicaid	10 (7.0)
Pharmacy insurance type, n (%)	
Commercial	74 (51.7)
Medicare	57 (39.9)
Medicaid	8 (5.6)
Missing	4 (2.8)

*Assessed from 180 days prior to the index date to 1 day prior to the index date.
2L = second line; 2L+ = second line or later; 3L = third line; 4L = fourth line; 5L+ = fifth line or later; CCI = Charlson Comorbidity Index; IQR = interquartile range; LOT = line of therapy; MM = multiple myeloma; RRMM = relapsed/refractory multiple myeloma; SD = standard deviation.
Estrin A et al. Poster presented at EHA 2025 (Abstract PS2298).

Healthcare Resource Utilization and Costs Following the Initiation of Various Lines of Therapy Among Patients With Relapsed/Refractory Multiple Myeloma (3/5)

Estrin A et al. (EHA Poster Presentation)

Results: All-Cause Inpatient and Outpatient Visits (Table)

Patients with TCE MM receiving 2L+ treatment (N=143)

- Mean number of all-cause inpatient and outpatient visits increased (pre-index: 0.08 PPPM and 3.79 PPPM, respectively; follow-up period: 0.23 PPPM and 4.79 PPPM)
- Median number of all-cause inpatient and outpatient visits increased

Patients with TCE MM receiving 4L+ treatment (n=107)

- Mean number of all-cause inpatient and outpatient visits increased (pre-index: 0.09 PPPM and 3.74 PPPM, respectively; follow-up period: 0.21 PPPM and 4.53 PPPM)
- Median number of inpatient visits was zero for both periods

Patients initiating CAR T-cell therapy (n=11)

- Mean number of inpatient visits increased (0.21 to 0.24 PPPM) and the median number of inpatient visits remained similar (0.17 to 0.16 PPPM)
- Median number of outpatient visits increased from the pre-index to the follow-up period (2.67 to 3.46 PPPM) and mean number of outpatient visits decreased from pre-index to follow-up period (3.61 to 3.39 PPPM)

Table. All-Cause Inpatient and Outpatient Visits PPPM by Relapsed/Refractory Subgroup

	2L+ TCE* N=143		4L+ TCE* n=107		CAR T-cell Therapy n=11	
	Pre-index	Post-index	Pre-index	Post-index	Pre-index	Post-index
All-cause inpatient visits PPPM						
Mean (SD)	0.08 (0.15)	0.23 (0.59)	0.09 (0.17)	0.21 (0.52)	0.21 (0.25)	0.24 (0.30)
Median (IQR)	0.00 (0.00–0.17)	0.00 (0.00–0.25)	0.00 (0.00–0.17)	0.00 (0.00–0.25)	0.17 (0.00–0.42)	0.16 (0.00–0.27)
All-cause outpatient visits PPPM						
Mean (SD)	3.79 (3.55)	4.79 (3.95)	3.74 (2.91)	4.53 (3.83)	3.61 (2.45)	3.39 (2.19)
Median (IQR)	3.00 (1.83–4.92)	3.80 (2.43–6.03)	3.00 (1.92–4.50)	3.57 (1.96–5.70)	2.67 (1.92 –4.67)	3.46 (1.84–4.45)

*TCE is defined as having prior exposure to at least one anti-CD38, immunomodulatory drug, and PI treatment.
2L+ = second line or later; 4L+ = fourth line or later; CAR = chimeric antigen receptor; CD = cluster of differentiation; IQR = interquartile range; MM = multiple myeloma; PI = proteasome inhibitor; PPPM = per-patient-per-month; SD = standard deviation; TCE = triple-class exposed.
Estrin A et al. Poster presented at EHA 2025 (Abstract PS2298).

Healthcare Resource Utilization and Costs Following the Initiation of Various Lines of Therapy Among Patients With Relapsed/Refractory Multiple Myeloma (4/5)

Estrin A et al. (EHA Poster Presentation)

Results: Mean and Median All-Cause Patient Costs (Figure)

Patients with TCE MM receiving 2L+ treatment (N=143)

- The total mean and median all-cause medical and pharmacy costs PPPM increased
  - Pre-index: $23,143 and $19,137
  - Follow-up period: $31,583 and $25,343

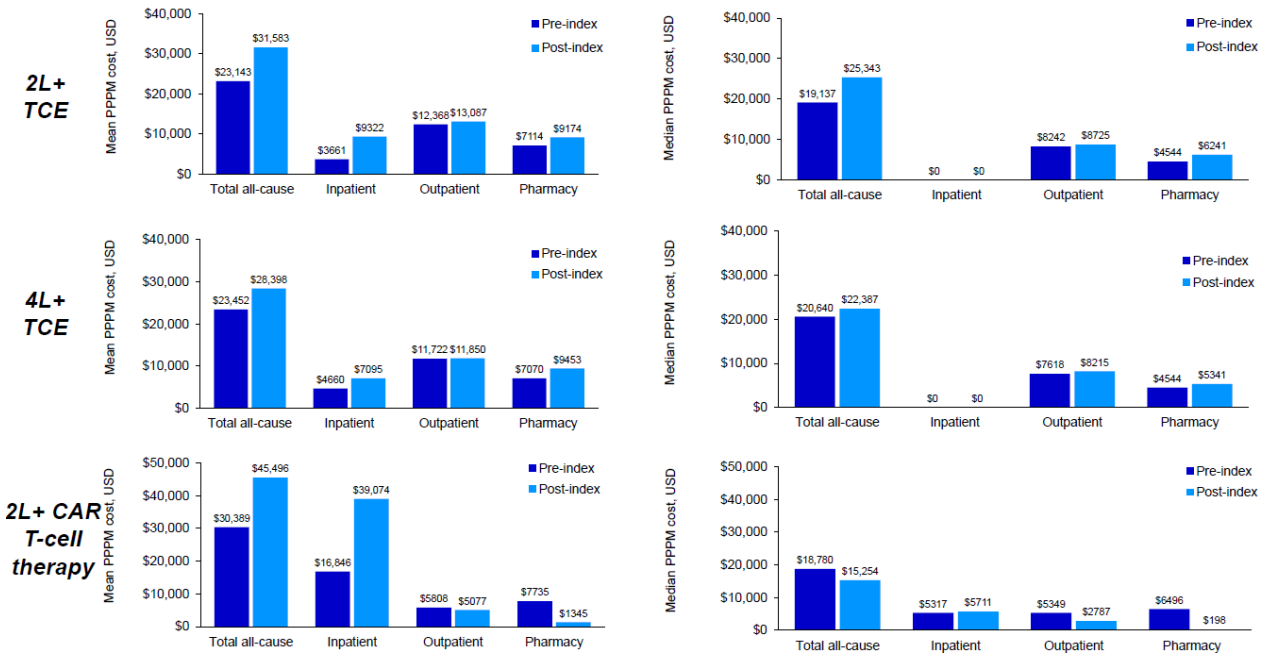
Patients with TCE MM receiving 4L+ treatment (n=107)

- Mean and median PPPM costs increased from pre-index to the follow-up period ($23,452 to $28,398 and $20,640 to $22,387, respectively

Patients initiating 2L+ CAR T-cell therapy (n=11)

- Mean total costs increased from pre-index ($30,389 PPPM) to the follow-up period ($45,496)
- Median total cost decreased from pre-index to the follow-up period ($18,780 to $15,254)

Figure. Mean and Median All-Cause Patient Costs (PPPM) Pre- and Post-Index Date*,†,‡,§



*Inpatient represents any observations in the inpatient table or observations in the non-inpatient table with an inpatient place of service linked through the visit identifier. †Outpatient represents any observation in the non-inpatient table with an outpatient place of service without a linked visit identifier in the inpatient table. ‡Total HCRU assessed as the total number of pharmacy claims, inpatient visits, and outpatient visits during the assessment period. §Follow-up period was assessed from the index line of therapy date and censored on next treatment, death, end of study period (June 1, 2024), or end of continuous enrollment/observability.

2L+ = second line or later; 4L+ = fourth line or later; CAR = chimeric antigen receptor; HCRU = healthcare resource utilization; MM = multiple myeloma; PPPM = per-patient-per-month; TCE = triple-class exposed.

Estrin A et al. Poster presented at EHA 2025 (Abstract PS2298).

Healthcare Resource Utilization and Costs Following the Initiation of Various Lines of Therapy Among Patients With Relapsed/Refractory Multiple Myeloma (5/5)

Estrin A et al. (EHA Poster Presentation)

Authors' Conclusions

- The results suggest significant HCRU and costs for patients with 2L+ RRMM, which often increases after initiating a new therapy
- The small sample sizes of patients initiating a CAR T-cell therapy prevented a meaningful interpretation, as a discordance between the changes in mean and median levels of HCRU and costs was observed

Please note: The conclusions above represent the authors' conclusions only.
2L+ = second line or later; CAR = chimeric antigen receptor; HCRU = healthcare resource utilization; RRMM = relapsed/refractory multiple myeloma.
Estrin A et al. Poster presented at EHA 2025 (Abstract PS2298).