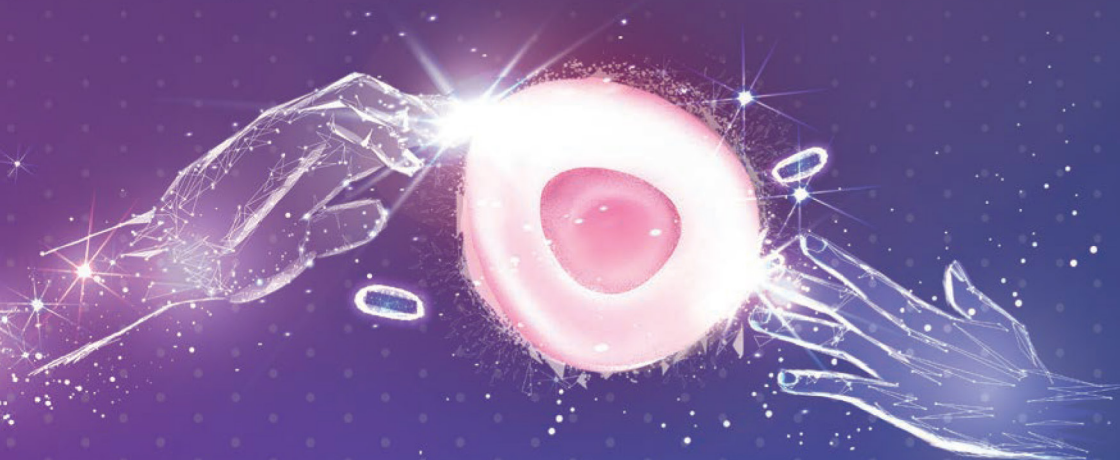


Hong Kong Society of Myeloma

# Annual Scientific Meeting 2022

## Program Book



**DATE** 5 Nov 2022 (Sat)  
**TIME** 14:00 – 20:30  
**VENUE** Grand Ballroom, Conrad Hong Kong





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For appropriate patients faced with relapsed/refractory multiple myeloma

## FORGE AHEAD WITH A BOLD APPROACH

### Target BCMA for RRMM

BLENREP is the first and only BCMA-targeted antibody-drug conjugate (ADC) monotherapy.<sup>1</sup> So you can offer your RRMM patients a clear option.

**INDICATION**  
BLENREP is indicated as monotherapy for the treatment of multiple myeloma in adult patients, who have received at least four prior therapies and whose disease is refractory to at least one proteasome inhibitor, one immunomodulatory agent, and an anti-CD38 monoclonal antibody and who have demonstrated disease progression on the last therapy.

#### Important Safety Information for Blenrep (belantamab mafodotin)

- The most commonly reported adverse reactions were keratopathy including microcyst-like epithelial changes in corneal epithelium with or without changes in visual acuity, blurred vision, and dry eye.
- Patients should be advised to use caution when driving or operating machinery as Blenrep may affect their vision.
- Patients should have an ophthalmic examination performed by an eye care professional at baseline, before the subsequent 3 treatment cycles, and as clinically indicated whilst on Blenrep treatment.
- Physicians should advise patients to administer preservative-free artificial tears at least 4 times a day beginning on the first day of infusion and continuing until completion of treatment.

#### Abbreviated Prescribing Information

Adverse Reaction	Category	Recommended dose modification
Thrombocytopenia	Grade 3: Platelet count <25000 cells/mm <sup>3</sup> or <250 x 10 <sup>9</sup> /L Grade 4: Platelet count <10000 cells/mm <sup>3</sup> or <100 x 10 <sup>9</sup> /L	Consider interrupting Blenrep and/or reducing the dose of Blenrep to 3 mg/kg.
Infusion-related reactions	Grade 1 (moderate)	Interrupt Blenrep until patient count improves to Grade 0 or better. Consider rearing on a reduced dose of Blenrep.
	Grade 2 (severe)	Interrupt Blenrep and provide supportive treatment. Once symptoms resolve, resume at lowest infusion rate (reduced by at least 50%). If asymptomatic or the reaction is mild, resume at the same infusion rate in the next cycle.
	Grade 3 or 4 (severe)	Interrupt Blenrep and provide supportive treatment. Once symptoms resolve, resume at lowest infusion rate (reduced by at least 50%). If asymptomatic or the reaction is mild, resume at the same infusion rate in the next cycle.
Other Adverse Reactions	Grade 3 Grade 4	Interrupt Blenrep until patient count improves to Grade 0 or better. Consider rearing on a reduced dose of Blenrep. Consider permanent discontinuation of Blenrep. If continuing treatment with Blenrep is not recommended to Grade 0 or better and severe side effects.

**Reference 1:** BLENREP (belantamab mafodotin) Summary of Product Characteristics. The material is for the reference and use by healthcare professionals only. For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong). Full Prescribing Information is available upon request. Please read the full prescribing information prior to administration, available from GlaxoSmithKline Limited. Trade marks are owned by or licensed to the GSK group of companies. ©2021 GSK group of companies or its licensee.

GlaxoSmithKline Limited  
23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong  
Tel: (852) 3189 8989 Fax: (852) 3189 8931

PH-HK-ELM-ADVT-210001 (09/2022)  
Date of preparation: 10/10/2021

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Acknowledgment



# Treating Patients Beyond Borders

Developing Innovative medicines to Improve  
the lives of cancer patients around the world

## Welcome Message



**Prof. James CS Chim**

Founding & Current Chairman,  
Hong Kong Society of Myeloma

We would like to welcome you to the 12<sup>th</sup> Annual Scientific Meeting of the Hong Kong Society of Myeloma. In recent years, the field of myeloma is rapidly evolving. Despite the ongoing COVID epidemic, research in myeloma has not ceased, and new data is being generated and continue to refine the way forward in myeloma treatment.

Recent advances in myeloma has resulted in remarkable improvement in outcomes and quality of life. The advent of CART cell, therapeutic antibodies, Exportin-1 inhibitor and next generation novel agents have reshaped the treatment landscape of myeloma with ground-breaking success. Moreover, whether high-risk myeloma should be treated differently from standard-risk has remained controversial.

In this meeting, we are delighted to have internationally renowned myeloma experts to talk about the cutting edge advances in the management of high-risk myeloma, management of triple-class refractory advanced myeloma relapse, and the sequencing of novel agents for relapsed & refractory myeloma will be discussed.

Therefore, on behalf of the Society, I would like to extend to you our warmest welcome, and hope that you will enjoy these inspiring presentations.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'James Chim', written in a cursive style.

James Chim





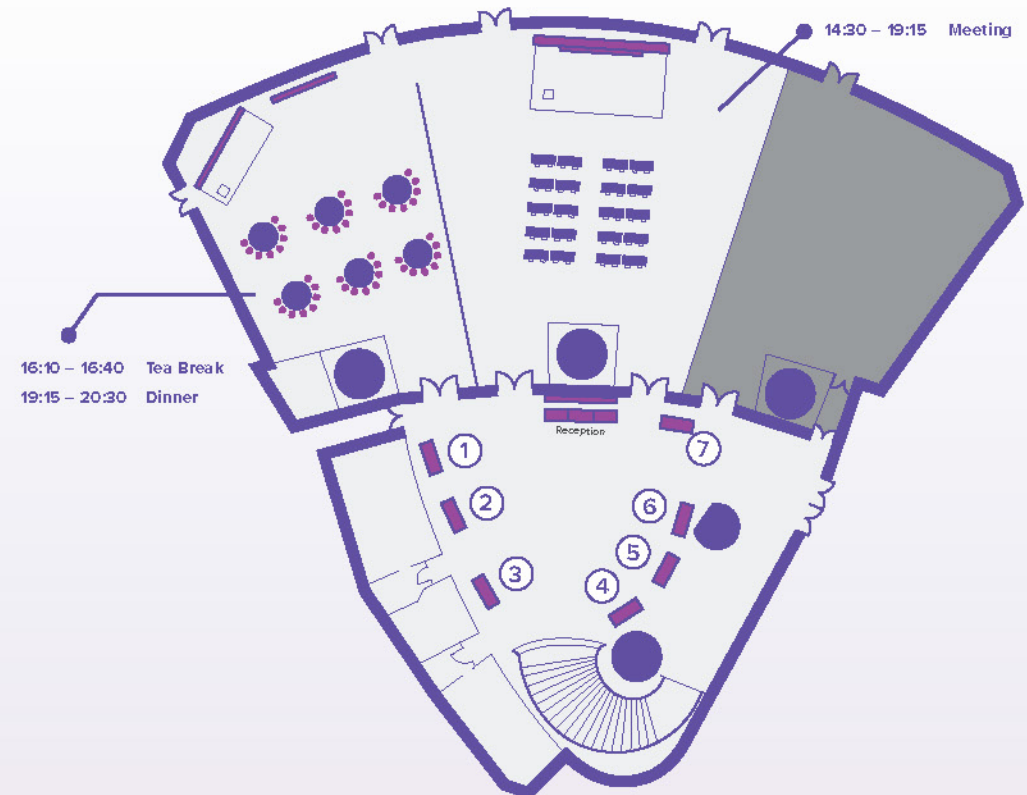


# Agenda

Time	Program
14:00 – 14:30	Registration
14:30 – 14:40	Opening Ceremony <i>Prof. James CS Chim</i>
14:40 – 15:25	Lecture 1 High-risk diseases in multiple myeloma: R2-ISS and beyond <i>Prof. Thomas G. Martin (CA, USA)</i>
15:25 – 16:10	Lecture 2 The evolving role of IMiD-based strategy for RRMM <i>Prof. Katja Weisel (Hamburg, Germany)</i>
16:10 – 16:40	Tea Break
16:40 – 17:25	Lecture 3 Contemporary treatment paradigm of triple-class refractory multiple myeloma <i>Dr. Elena Zamagni (Bologna, Italy)</i>
17:25 – 18:10	Lecture 4 Optimizing treatment selection and sequencing for patients with RRMM <i>Dr. Rafael Fonseca (AZ, USA)</i>
18:10 – 18:30	Break
18:30 – 19:15	Lecture 5 Targeting XPO1 in relapsed/refractory multiple myeloma <i>Dr. Shambavi Richard (NY, USA)</i>
19:15 – 20:30	Dinner Closing Ceremony Certificate of Appreciation Presentation <i>Dr. Harold Lee</i>

# Floor Plan

## Conrad Hong Kong Grand Ballroom



- 1 Antengene Corporation Limited
- 2 Bristol-Myers Squibb Pharma (HK) Limited
- 3 GlaxoSmithKline PLC
- 4 Takeda Pharmaceutical (Hong Kong) Ltd
- 5 Amgen Hong Kong Limited
- 6 Janssen, Johnson & Johnson (HK) Limited
- 7 Sanofi Hong Kong Limited



# Lecture 1

## High-risk diseases in multiple myeloma: R2-ISS and beyond

### Prof. Thomas G. Martin

University of California San Francisco, USA

Patients with multiple myeloma show heterogeneous outcomes. Approximately 60% of newly diagnosed myeloma patients are at intermediate-risk according to the Revised International Staging system (R-ISS), the standard-of-care risk stratification model. Moreover, chromosome 1q gain/amplification (+1q) recently proved to be a poor prognostic factor. The R2-ISS published by the ASCO group in May this year have introduced a weighted scoring system, with the inclusion of +1q in the risk stratification for myeloma.

This presentation will begin with a brief introduction of the R2-ISS as well as other relevant international guidelines or scoring updates. It will highlight the current evidence and clinical advancement on high-risk diseases, including del 17p, t(4,14), +1q. Insightful discussion will also focus beyond R2-ISS to other high-risk group and the latest scientific development regarding the cytogenetics of multiple myeloma, as well as case sharing on the latest available monoclonal antibodies regarding high-risk group.

# Lecture 2

## The evolving role of IMiD-based strategy for RRMM

### Prof. Katja Weisel

University Medical Center Hamburg-Eppendorf, Germany

Immunomodulatory drug (IMiD) is a class of treatment which is well-proven in providing long-term improvement in survival and quality of life for relapsed/refractory multiple myeloma (RRMM) patients. It has been used as one of the treatment foundations for RRMM patients in Hong Kong and across other countries. However, with different choices of treatment combinations as well as practical constraints, optimising the use of IMiD could be difficult in clinical practice.

In this lecture, Prof. Katja Weisel would lead us through the journey of the past, present and future development of RRMM treatments and IMiD-based combinations. She would share her valuable clinical perspectives in managing IMiD-based treatment, particularly in the sequential use of treatment, safety management and treatment individualization. Looking forward, Prof. Weisel would highlight the innovation on the next-generation IMiD.

We are incredibly honored to invite Prof. Katja Weisel from Hamburg, Germany to speak for this lecture. Prof. Katja Weisel is the Deputy Director and associate professor of Hematology/Oncology in the Department of Oncology, Hematology and Bone Marrow Transplantation with Department of Pneumology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany. Prof. Weisel's myeloma research interests focus on treatment optimisation for high-risk myeloma, renally-impaired myeloma patients, refractory myeloma patients and radiographic methods for disease monitoring of myeloma. She is a member of the German Speaking Myeloma Multicentre Group (GMMG) steering committee. Professor Weisel is co-investigator in all GMMG trials and is the lead investigator of three GMMG trials. Furthermore, she was the principal investigator in several national and international phase I-III clinical trials. She has contributed to more than 100 publications on multiple myeloma treatment and biology.

### Contemporary treatment paradigm of triple-class refractory multiple myeloma

#### Dr. Elena Zamagni

University of Bologna, Italy

The traditional approaches to the treatment of triple-class refractory multiple myeloma are limited and they include conventional chemotherapy and recycling use of previous regimens.

Based on a recent MAMMOTH study, patients with relapsed or refractory myeloma have a poorer OS in their outcome. Patients who are triple and quad refractory have a median OS of 9.2 months, and patients who are penta-refractory have a median OS of 5.6 months. The unmet need for triple refractory myeloma patients is huge.

With different novel agents launched in recent years, more options are available for relapsed refractory multiple myeloma patients. In the presentation, Dr. Zamagni will share the current available treatment options for triple-class refractory myeloma and their clinical data. Dr. Zamagni will share the role of anti-BCMA therapy which will be likely to be a core pillar in myeloma and cover the topic of anti-BCMA treatment sequencing.

### Optimizing treatment selection and sequencing for patients with RRMM

#### Dr. Rafael Fonseca

Mayo Clinic, USA

The use of anti-CD38 antibody daratumumab has become increasingly prominent in the treatment of relapsed/refractory myeloma in recent years. Longer follow-up updates of pivotal trials, e.g. Castor and Pollux, have demonstrated consistent and substantial clinical and survival benefits to patients, including prolonged PFS and deepened responses. Importantly, increased rates of sustained MRD-negativity have been observed with the use of daratumumab combinations.

In the real-world setting, attrition, in which patients fail to receive the next line of treatment, has been observed in each line of therapy. As such, with each increasing line of therapy, there is a decreasing number of available patients. This points to the significance of treatment sequencing that produces the longest progression-free survival duration while allowing the overall maximum number of patients to enjoy the benefit.

In this presentation, we will focus on the application of clinical data into real-world setting by exploring the impact of treatment attrition and the importance of treatment sequencing on patient management.

## Targeting XPO1 in relapsed/refractory multiple myeloma

**Dr. Shambavi Richard**

Icahn School of Medicine at Mount Sinai, USA

Despite recent advances, there remains an unmet need for novel therapies to improve outcomes in patients with relapsed or refractory multiple myeloma (RRMM).

Exportin 1 (XPO1), an oncoprotein overexpressed in various hematologic and solid tumor malignancies, transports certain proteins and RNAs from the nucleus to the cytoplasm. In addition to correlating with more aggressive MM, elevated levels of XPO1 have been shown to correlate with resistance to proteasome inhibitors and to immunomodulatory drugs. In cancer cells, overexpression of XPO1 leads to the nuclear export of tumor suppressor proteins and the glucocorticoid receptor, culminating in their functional inactivation. High XPO1 also facilitates the nuclear export and translation of several oncoprotein mRNAs (e.g., cyclin D1, c-myc) leading to elevated oncoprotein levels.

Selinexor is a first-in-class, orally administered, selective inhibitor of nuclear export (SINE) compound with an innovative mechanism of action that triggers apoptosis in malignant cells by inducing nuclear retention of oncogene messenger RNAs and reactivation of tumor suppressor proteins. In RRMM clinical studies, selinexor has demonstrated both promising efficacy and manageable safety profile.

We are honored to have Dr. Shambavi Richard to provide an overview of selinexor and shed light on the latest emerging data. With appropriate combination drug choice and supportive care measures, patients now have multiple potential regimens to control their disease.

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# Acknowledgment

## DIAMOND SPONSOR



## PLATINUM SPONSOR



# IN THE TREATMENT OF RELAPSED/REFRACTORY MULTIPLE MYELOMA, NINLARO® BRINGS<sup>1</sup>

## SUSTAINED

## EFFICACY<sup>^</sup>



<sup>1</sup>Tourmaline MM1 study (n=722)  
Aim: Compare efficacy and tolerability IRd vs placebo-IRd in rMM patients; Key Primary Endpoint: PFS (IRd vs placebo-IRd=20.6 months vs 14.7 months); Key Secondary Endpoint: ORR (IRd vs placebo-IRd=78.5% vs 71.5%)  
R: lenalidomide; IR: Lenalidomide; d: Decamethasone; rMM: Relapsed/Refractory Multiple Myeloma; PFS: Progression Free Survival; OS: Overall Survival; ORR: Overall Response Rate. The rates of serious adverse events were similar in both study groups.

### Abbreviated Prescribing Information (EU APR21-HK JUN21) Ninlaro 2.5mg, 5mg and 4mg Capsules

Active ingredient: ixazomib citrate. Indication: NINLARO in combination with lenalidomide and dexamethasone is indicated for the treatment of adult patients with multiple myeloma who have received at least one prior therapy. Dose & Administration: The recommended starting dose of NINLARO is 4 mg administered orally once a week on Days 1, 8, and 15 of a 28-day treatment cycle. The recommended starting dose of lenalidomide is 25 mg administered daily on Days 1 to 21 of a 28-day treatment cycle. The recommended starting dose of dexamethasone is 40 mg administered on Days 1, 8, 16, and 22 of a 28-day treatment cycle. Treatment should be continued until disease progression or unacceptable toxicity. Ninlaro 5mg and 2.5mg are available for dose modification according to the dose modifications guidelines. NINLARO is for oral use. NINLARO should be taken at approximately the same time on days 1, 8, and 15 of each treatment cycle at least 1 hour before or at least 2 hours after food. The capsule should be swallowed whole with water. It should not be crushed, chewed, or opened. Contraindications: Hypersensitivity to ixazomib citrate. Special precautions: Thrombocytopenia has been reported with NINLARO with platelet counts typically occurring between Days 14-21 of each 28-day cycle and recovery to baseline by the start of the next cycle. Diarrhea, constipation, nausea and vomiting have been reported with NINLARO, occasionally requiring use of antiemetic and antidiarrheal medicinal products and supportive care. The dose should be adjusted for severe (Grade 3-4) symptoms. In case of severe gastrointestinal events, monitoring of serum potassium level is recommended. Patients experiencing new or worsening peripheral neuropathy may require dose modification. Rash should be managed with supportive care or with dose modification if Grade 2 or higher. Cases of thrombotic microangiopathy, including thrombotic thrombocytopenic purpura, have been reported in patients who received NINLARO, some of these events have been fatal, signs and symptoms of thrombotic microangiopathy should be monitored. Women should avoid becoming pregnant while being treated with NINLARO. Women of childbearing potential must use highly effective contraception while taking NINLARO and for 90 days after stopping treatment. Women using hormonal contraceptives should additionally use a barrier method of contraception. Adverse Reactions: upper respiratory tract infection, thrombocytopenia, neutropenia, peripheral neuropathy, diarrhea, nausea, vomiting, constipation, rash, peripheral edema. For details, please refer to full prescribing information.



Reference: 1. Moreau P et al. N Engl J Med. 2016 Apr 28;374(17):1621-1634.  
For reporting suspected side effects for Takeda products at AE: Hong Kong: [takeda.com](mailto:takeda.com)  
For sending medical information and other inquiries for Takeda products at [readinfo@takeda.com](mailto:readinfo@takeda.com)  
C-APROMA#NINL001(09/2022)



# OPEN A NEW DIMENSION IN MULTIPLE MYELOMA

**DARZALEX®**, The first human monoclonal IgG1κ antibody targeting CD38 antigen which induces myeloma cell death through direct on-tumour and immunomodulatory actions<sup>1-5</sup>

## Direct ON-TUMOUR Actions

### Complement-dependent Cytotoxicity

### Antibody-dependent Cell-mediated Cytotoxicity

### Antibody-dependent Cellular Phagocytosis

### Apoptosis via Crosslinking

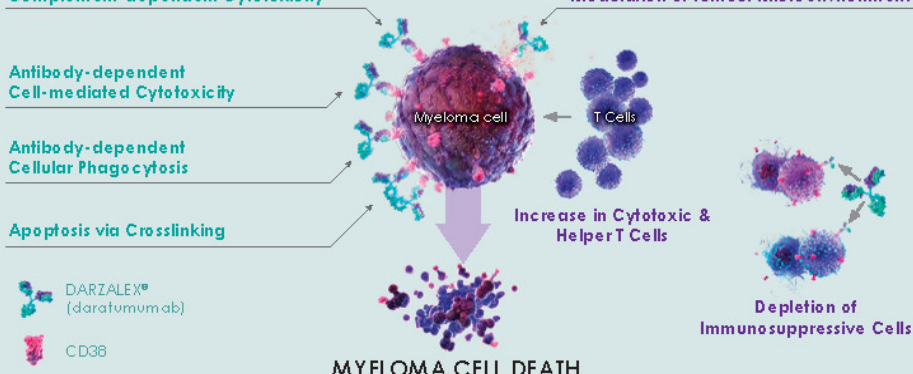
## IMMUNOMODULATORY Actions

### Modulation of Tumour Micro environment

### Increase in Cytotoxic & Helper T Cells

### Depletion of Immunosuppressive Cells

## MYELOMA CELL DEATH



### DARZALEX® (daratumumab) is indicated<sup>1</sup>:

- in combination with lenalidomide and dexamethasone or with bortezomib, melphalan and prednisone for the treatment of adult patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant.
- in combination with bortezomib, melphalan and dexamethasone for the treatment of adult patients with newly diagnosed multiple myeloma who are eligible for autologous stem cell transplant.
- in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.
- as monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy.

See **DARZALEX®** prescribing information for full indication, including its use as a monotherapy<sup>2</sup>.

### References:

- Sanchez L, Wang Y, Siegel DS, and Wang WL. Daratumumab: a first-in-class CD38 monoclonal antibody for the treatment of multiple myeloma. *J Hematol Oncol*. 2016;9:31.
- DARZALEX® Hong Kong prescribing information. Rev. 4. de 2020. Janssen (HK) Ltd, 133 Prince Edward Road West, Mong Kok, Hong Kong.
- Ovaidi KM, Velgodes S, Bögels M, et al. Antibody-mediated phagocytosis contributes to the anti-tumour activity of the therapeutic antibody daratumumab in lymphoma and multiple myeloma. *MBio*. 2014;7:311-321.
- Rejklev J, Casneuf F, et al. Daratumumab depletes CD38+ immune regulatory cells, promotes T-cell expansion, and skewes T-cell repertoire in multiple myeloma. *Blood*. 2014;123:484-494.

**DARZALEX® (daratumumab) is indicated<sup>1</sup>:**

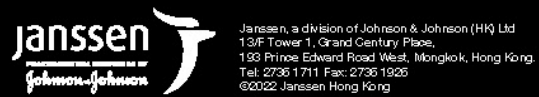
1. In combination with lenalidomide and dexamethasone or with bortezomib, melphalan and prednisone for the treatment of adult patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant. 2. In combination with bortezomib, melphalan and dexamethasone for the treatment of adult patients with newly diagnosed multiple myeloma who are eligible for autologous stem cell transplant. 3. In combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy. 4. As monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy.

**See DARZALEX® prescribing information for full indication, including its use as a monotherapy<sup>2</sup>.**

**References:**

- Sanchez L, Wang Y, Siegel DS, and Wang WL. Daratumumab: a first-in-class CD38 monoclonal antibody for the treatment of multiple myeloma. *J Hematol Oncol*. 2016;9:31.
- DARZALEX® Hong Kong prescribing information. Rev. 4. de 2020. Janssen (HK) Ltd, 133 Prince Edward Road West, Mong Kok, Hong Kong.
- Ovaidi KM, Velgodes S, Bögels M, et al. Antibody-mediated phagocytosis contributes to the anti-tumour activity of the therapeutic antibody daratumumab in lymphoma and multiple myeloma. *MBio*. 2014;7:311-321.
- Rejklev J, Casneuf F, et al. Daratumumab depletes CD38+ immune regulatory cells, promotes T-cell expansion, and skewes T-cell repertoire in multiple myeloma. *Blood*. 2014;123:484-494.

**Rev. 4. de 2020. Janssen (HK) Ltd, 133 Prince Edward Road West, Mong Kok, Hong Kong.**



# WE FORM THE Backbone of Regimens in Multiple Myeloma<sup>1,2</sup>



Recommended by NCCN & EHA-ESMO Guidelines as preferred regimens<sup>1,2</sup>

- REVLIMID® is indicated:**
- As monotherapy for the maintenance treatment of adult patients newly diagnosed MM who have undergone a 0 to 2 cycles of anti-plasma cell transplant.
  - As combination therapy for the treatment of adult patients with previously untreated MM who are not eligible for a transplant.
  - In combination with DEX for the treatment of MM in adult patients who have received at least one prior therapy.
- POMALYST is indicated:**
- In combination with BORtd and DEX for the treatment of adult patients with MM who have received at least one prior treatment regimen including REVLIMID®.
  - In combination with DEX for the treatment of adult patients with RRMM who have received at least two prior treatment regimens, including both REVLIMID® and BORtd, and have demonstrated disease progression on the last therapy.

**BORt:** bortezomib. **DEX:** dexamethasone. **EHA:** European Hematology Association. **ESMO:** European Society for Medical Oncology. **MM:** multiple myeloma. **NCCN:** National Comprehensive Cancer Network. **RRMM:** relapsed and refractory multiple myeloma.

**Reference:**

- National Comprehensive Cancer Network. NCCN Guidelines for Multiple Myeloma, Version 7.2021. Available at: [https://www.nccn.org/professionall/physician\\_glg/pdf/multiple\\_myeloma.pdf](https://www.nccn.org/professionall/physician_glg/pdf/multiple_myeloma.pdf) (accessed on 6 May 2021).
- Dimitrakopoul SA, et al. *Ann Oncol*. 2021;32:309-322.

**Revlimid® (lenalidomide) is indicated:**

1. As monotherapy for the maintenance treatment of adult patients newly diagnosed MM who have undergone a 0 to 2 cycles of anti-plasma cell transplant. 2. As combination therapy for the treatment of adult patients with previously untreated MM who are not eligible for a transplant. 3. In combination with DEX for the treatment of MM in adult patients who have received at least one prior therapy.

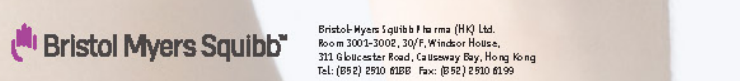
**Pomalyst (pomalidomide) is indicated:**

1. In combination with BORtd and DEX for the treatment of adult patients with MM who have received at least one prior treatment regimen including REVLIMID®. 2. In combination with DEX for the treatment of adult patients with RRMM who have received at least two prior treatment regimens, including both REVLIMID® and BORtd, and have demonstrated disease progression on the last therapy.

**BORt:** bortezomib. **DEX:** dexamethasone. **EHA:** European Hematology Association. **ESMO:** European Society for Medical Oncology. **MM:** multiple myeloma. **NCCN:** National Comprehensive Cancer Network. **RRMM:** relapsed and refractory multiple myeloma.

**Reference:**

- National Comprehensive Cancer Network. NCCN Guidelines for Multiple Myeloma, Version 7.2021. Available at: [https://www.nccn.org/professionall/physician\\_glg/pdf/multiple\\_myeloma.pdf](https://www.nccn.org/professionall/physician_glg/pdf/multiple_myeloma.pdf) (accessed on 6 May 2021).
- Dimitrakopoul SA, et al. *Ann Oncol*. 2021;32:309-322.



CS-1815-000003

2020-000100014-14 June 2021



IN THE TREATMENT OF RELAPSED REFRACTORY MULTIPLE MYELOMA



ACHIEVE GREATER OUTCOMES FOR YOUR PATIENTS



IKEMA<sup>2A</sup>: SARCLISA + Kd vs Kd (N=302)



ICARIA<sup>2</sup>: SARCLISA + Pd vs Pd (N=307)

mPFS 35.7 mo\* vs 19.2 mo with Kd alone HR=0.58 (95.4% CI: 0.42-0.79)

Superior PFS<sup>1</sup>

mPFS 11.53 mo vs 6.47 mo with Pd alone HR=0.596 (95% CI: 0.44-0.81; P=0.001)

IKEMA trial: SARCLISA + Kd<sup>2</sup>

IKEMA (EFC15244) was a multicentre, multinational, randomised, open-label, 2-arm, phase 3 study that evaluated the efficacy and safety of SARCLISA in 302 patients with relapsed and/or refractory multiple myeloma who had received 1 to 3 prior lines of therapy...

ICARIA trial: SARCLISA + Pd<sup>2</sup>

ICARIA (EFC14335) was a multicentre, multinational, randomised, open-label, 2-arm, phase 3 study that evaluated the efficacy and safety of SARCLISA in 307 patients with relapsed and refractory multiple myeloma who had received at least 2 prior lines of therapy...

Most common adverse reactions<sup>1,2,4</sup>

- In ICARIA, the most frequent adverse reactions (≥20%) were neutropenia (4.7%), infusion reactions (3.8%), pneumonia (3.1%), upper respiratory tract infection (2.8%), diarrhoea (2.6%), and bronchitis (2.4%)
- In IKEMA, the most frequent adverse reactions (≥20%) were infusion reactions (4.6%), hypertension (3.7%), diarrhoea (3.6%), upper respiratory tract infection (3.6%), pneumonia (2.9%), fatigue (2.8%), dyspnoea (2.8%), insomnia (2.4%), bronchitis (2.3%), and back pain (2.2%).

SARCLISA is indicated:

- In combination with pomalidomide and dexamethasone, for the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on the last therapy
- In combination with carfilzomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy

\*Assessment by modified independent response criteria (mIRC)

References: 1. Sandoz Hong Kong. Product Information for Sarplisa 300 mg IV infusion. 2. Mooney P, et al. Lancet 2019; 393:2447-53. 3. Ardal M, et al. Lancet 2019; 393:4010-4019. 4. Mooney P, et al. Presented at ESMO Virtual Congress, 2022 and 9th CMH World Congress, 20th May, 2022.

Preparation: SARCLISA 300 mg/30 mL concentrate for infusion. Each mL of concentrate for infusion contains 30 mg of isatuximab. Each mL contains 100 mg of isatuximab in 0.9% of sodium chloride (NaCl) injection. Each mL contains 100 mg of isatuximab in 0.9% of sodium chloride (NaCl) injection. Each mL contains 100 mg of isatuximab in 0.9% of sodium chloride (NaCl) injection...

Table with 2 columns: Cycle, Dosing schedule. Row 1: Cycle 1, Days 1, 8, 15, and 22 (weekly). Row 2: Cycle 2 and beyond, Days 1, 15 (every 2 weeks).

Precautions should be used prior to SARCLISA infusion with the following medical conditions: 1. a. Diarrhoea/colitis: At the start of the infusion (for 20 mg and 100 mg), or before (for 300 mg) or after (for 300 mg) of the infusion. Patients should be closely monitored for signs and symptoms of diarrhoea/colitis during treatment. Patients should be closely monitored for signs and symptoms of diarrhoea/colitis during treatment. Patients should be closely monitored for signs and symptoms of diarrhoea/colitis during treatment...

AP-16-004-22/1



MKT-16-0250183-10-05-2022 4C-2289