HKSOM
HONG KONG SOCIETY OF MYELOMA
香港骨髓瘤學會

Hong Kong Society of Myeloma

Annual Scientific Meeting 2023

Date:
28 October 2023 (Sat)

Time:
14:00 - 20:00

Venue:
Grand Ballroom,
Conrad Hong Kong

Program Book

IN THE TREATMENT OF **RELAPSED REFRACTORY MULTIPLE MYELOMA**

SARCLISA (isatuximab)

ACHIEVE **GREATER OUTCOMES** FOR **YOUR PATIENTS**

IKEMA[2,4]**:** SARCLISA + Kd vs Kd (N=302)

mPFS 35.7 mo*
vs 19.2 mo with Kd alone

HR=0.58
(95.4% CI: 0.42-0.79)

Superior PFS[1]

ICARIA[3]**:** SARCLISA + Pd vs Pd (N=307)

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[1,2]

IKEMA (EFC15246) 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. Patients received either SARCLISA 10 mg/kg administered as an IV infusion in combination with Kd (n=179) or Kd alone (n=123), administered in 28-day cycles until disease progression or unacceptable toxicity. PFS was the primary endpoint; secondary endpoints included ORR, CR, ≥VGPR, MRD-, and OS. Median follow-up for the first interim analysis was 20.7 months.

ICARIA trial: SARCLISA + Pd[1,3]

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, including lenalidomide and a PI. Patients received either SARCLISA 10 mg/kg administered as an IV infusion in combination with Pd (n=154) or Pd alone (n=153), administered in 28-day cycles until disease progression or unacceptable toxicity. PFS was the primary endpoint; ORR was one of the secondary endpoints. Median follow-up for the first interim analysis was 11.6 months.

Most common adverse reactions[1,2,4]

- In ICARIA, the most frequent adverse reactions (≥20%) were neutropenia (47%), infusion reactions (38%), pneumonia (31%), upper respiratory tract infection (28%), diarrhoea (26%), and bronchitis (24%)
- In IKEMA, the most frequent adverse reactions (≥20%) were infusion reactions (46%), hypertension (37%), diarrhoea (36%), upper respiratory tract infection (36%), pneumonia (29%), fatigue (28%), dyspnoea (28%), insomnia (24%), bronchitis (23%), and back pain (22%).

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 masked independent response committee (IRC)

References: 1. Sarclisa Hong Kong prescribing information based on EU SmPC 29 July 2021. 2. Moreau P, et al. Lancet 2021; 397: 2361–71. 3. Attal M, et al. Lancet. 2019;394(10214):2096-2107. 4. Moreau P, et al. Presented at ESMO Virtual Plenaries, 2022 and 8th COMy World Congress. 20th May, 2022.

Presentation: SARCLISA 20 mg/mL concentrate for solution for infusion. One ml of concentrate for solution for infusion contains 20 mg of isatuximab. Each vial contains 100 mg of isatuximab in 5 mL of concentrate (100 mg/5mL). Each vial contains 500 mg of isatuximab in 25 mL of concentrate (500 mg/25mL). Indications: I. 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. II. In combination with carfilzomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy. Dosage & Administration: Intravenous infusion. Each treatment cycle consists of a 28-day period. Treatment is repeated until disease progression or unacceptable toxicity.

Cydes	Dosing schedule
Cycle 1	Days 1, 8, 15, and 22 (weekly)
Cycle 2 and beyond	Days 1, 15 (every 2 weeks)

Premedication should be used prior to SARCLISA infusion with the following medicinal products: I. a. Dexamethasone 40 mg oral or intravenous (or 20 mg oral or intravenous for patients≥75 years of age); when administered in combination with isatuximab and pomalidomide. b. Dexamethasone 20 mg (intravenous on the days of isatuximab and/or Carfilzomib infusions, and oral on the other days); when administered in combination with isatuximab and carfilzomib. II. Acetaminophen 650 mg to 1000 mg oral (or equivalent). III. Diphenhydramine 25 mg to 50 mg intravenous or oral (or equivalent [e.g., cetirizine, promethazine, dexchlorpheniramine]). The intravenous route is preferred for at least the first 4 infusions. The above recommended dose of dexamethasone corresponds to the total dose to be administered only once before the infusion. The recommended premedication agents should be administered 15–60 minutes prior to starting a SARCLISA infusion. Contraindications: Hypersensitivity to the active substance or to any of its excipients. Precautions: Vital signs should be frequently monitored during the entire SARCLISA infusion. When required, interrupt SARCLISA infusion and provide appropriate medical and supportive measures. In case symptoms do not improve to grade≤1 after interruption of SARCLISA infusion, persist or worsen despite appropriate medicinal products, require hospitalization or are life-threatening, permanently discontinue SARCLISA and institute appropriate management. Complete blood cell counts should be monitored periodically during treatment. Patients with neutropenia should be monitored for signs of infection. No dose reductions of SARCLISA are recommended. SARCLISA dose delays and the use of colony-stimulating factors (e.g. G-CSF) should be considered to mitigate the risk of neutropenia. Patients receiving SARCLISA should be closely monitored for signs of infection and appropriate standard therapy instituted. Antibiotics and antiviral prophylaxis can be considered during treatment. Physicians should carefully evaluate patients before and during treatment as per IMWG guidelines for occurrence of SPM and initiate treatment as indicated. To avoid potential problems with RBC transfusion, patients being treated with SARCLISA should have blood type and screen tests performed prior to the first infusion. Phenotyping may be considered prior to starting SARCLISA treatment as per local practice. If treatment with SARCLISA has already started, the blood bank should be informed. Patients should be monitored for theoretical risk of haemolysis. If an emergency transfusion is required, non-cross-matched ABO/Rh-compatible RBCs can be given as per local blood bank practices. Drug Interactions: Isatuximab has no impact on the pharmacokinetics of pomalidomide or carfilzomib, or vice versa. Pregnancy and lactation: There are no available data on isatuximab use in pregnant women. Animal reproduction toxicity studies have not been conducted with isatuximab. Immunoglobulin G1 monoclonal antibodies are known to cross the placenta after the first trimester of pregnancy. The use of isatuximab in pregnant women is not recommended. It is unknown whether isatuximab is excreted in human milk. Human IgGs are known to be excreted in breast milk during the first few days after birth, which is decreasing to low concentrations soon afterwards; however, a risk to the breast-fed child cannot be excluded during this short period just after birth. For this specific period, a decision must be made whether to discontinue breast-feeding or to discontinue/abstain from isatuximab therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. Afterwards, isatuximab could be used during breast-feeding if clinically needed. Undesirable effects: isatuximab in combination with pomalidomide and dexamethasone: Most common adverse reactions reported- pneumonia, upper respiratory tract infection, bronchitis, neutropenia, febrile neutropenia, dyspnoea, diarrhoea, nausea, vomiting, infusion reaction. isatuximab in combination with carfilzomib and dexamethasone: Most common adverse reaction reported- pneumonia, upper respiratory tract infection, bronchitis, hypertension, dyspnoea, cough, diarrhoea, vomiting, fatigue, infusion reaction. For other undesirable effects, please refer to the full prescribing information. Preparation: The preparation of the infusion solution must be done under aseptic conditions. Legal Classification: Part 1, First & Third Schedules Poison Full prescribing information is available upon request.

API-HK-SAR-22.01

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MAT-HK-2200190-1.0-06/2022 4IC_2269

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REDUCES TREATMENT TIME TO 3–5 MINUTES[1]

Say goodbye to long infusions.
Say hello to DARZALEX® SC

From the first dose, DARZALEX® SC transforms treatment time from a long infusion to just a 3–5-minute injection.[1]

You can now deliver equal efficacy with fewer and less severe IRRs in a fraction of the time.[2,3]

References: 1. DARZALEX® SC Hong Kong Prescribing Information P01. **2.** Mateos MV, et al. *Lancet Haematol.* 2020;7(5):e370-80. **3.** Usmani SZ, et al. *Haematologica.* 2022;107(10):2408-17.

Watch DARZALEX® SC MOA video online

DARZALEX SOLUTION FOR SUBCUTANEOUS INJECTION 1800MG/15ML
ABBREVIATED PRESCRIBING INFORMATION
ACTIVE INGREDIENT(S): Daratumumab **INDICATION(S):** Multiple myeloma: 1) DARZALEX is indicated 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, thalidomide 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) in combination with pomalidomide and dexamethasone for the treatment of adult patients with multiple myeloma who have received one prior therapy containing a proteasome inhibitor and lenalidomide and were lenalidomide-refractory, or who have received at least two prior therapies that included lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or after the last therapy; 5) 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. Light chain (AL) amyloidosis: DARZALEX is indicated in combination with cyclophosphamide, bortezomib and dexamethasone for the treatment of adult patients with newly diagnosed systemic AL amyloidosis. **DOSAGE & ADMINISTRATION:** 1800 mg administered subcutaneously over approximately 3-5 minute according to the dosing schedule in package insert. Refer to package insert for dose and schedule of other medicinal products in combination and recommended concomitant medicinal products. **CONTRAINDICATIONS:** Hypersensitivity to the active substance or to any of the excipients. **SPECIAL WARNINGS & PRECAUTIONS:** Infusion-related reactions: patients should be pre-medicated with antihistamines, antipyretics, and corticosteroids as well as monitored and counselled regarding IRRs; Neutropenia/thrombocytopenia: complete blood cell counts should be monitored periodically during treatment; Interference with indirect antiglobulin test (indirect Coombs test): Interference with determination of complete response; Hepatitis B virus (HBV) reactivation: HBV screening should be performed in all patients before initiation of treatment. **SIDE EFFECTS:** Infusion-related reactions, fatigue, nausea, diarrhoea, constipation, pyrexia, cough, neutropenia, thrombocytopenia, anaemia, oedema peripheral, peripheral sensory neuropathy and upper respiratory tract infection. Refer to the full prescribing information for other side effects. **PREGNANCY & LACTATION:** DARZALEX is not recommended during pregnancy and in women of childbearing potential not using contraception. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from DARZALEX therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. **INTERACTIONS:** No interaction studies have been performed. PLEASE REFER TO FULL PRESCRIBING INFORMATION BEFORE PRESCRIBING.
API version to be quoted on promotional material: Darzalex SC aPI ver.1.0

Janssen, a division of Johnson & Johnson (HK) Ltd
13/F Tower 1, Grand Century Place, 193 Prince Edward Road West, Mongkok, Hong Kong
Tel: 2736 1711 Fax: 2736 1926

CP-355585 NOV 2022

DARZALEX® SC
daratumumab subcutaneous

Welcome Message

Prof. James CS Chim
Founding & Current Chairman,
Hong Kong Society of Myeloma

Dear friends & colleagues,

Time flies! It's been a year since our last Annual Scientific Meeting (ASM). The ASM of the Hong Kong Society of Myeloma (HKSOM) is around the corner, and you are cordially invited to the **13th ASM of HKSOM**. The treatment of multiple myeloma is complex and rapidly evolving because of groundbreaking advances in recent years, particularly in the post COVID-19 pandemic era.

In this meeting, we are delighted to have internationally renowned myeloma experts to talk about the advances in the management of multiple myeloma, spanning from anti-CD38, IMiD to anti-BCMA. Moreover, it is also the prime time to have brainstorming on the need of re-defining "high-risk" myeloma, and hence a possible risk-stratified approach.

Therefore, on behalf of the Society, I would like to extend to you our warmest welcome, and am sure that you will enjoy these inspiring presentations. Moreover, it is time to catch up with one another after these years of separation.

Looking forward to seeing you soon!

Sincerely yours,

Prof. James CS Chim

GSK

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.[1] 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

BLENREP Prescribing Information:

HK67213-Blenrep powder for concentrate for solution for insfusion 100mcg

BLENREP
belantamab mafodotin

Made for This Moment

Reference: 1. BLENREP (belantamab mafodotin) Summary of Product Characteristics.

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

PM-HK-BLM-ADVT-210001 (09/2025)
Date of preparation : 10/2023

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WE FORM THE

Backbone of Regimens in Multiple Myeloma[1,2]

Revlimid® (lenalidomide)

Pomalyst® (pomalidomide)

Recommended by **NCCN & EHA-ESMO Guidelines** as preferred regimens[1,2]

REVLIMID© is indicated:

- As monotherapy for the maintenance treatment of adult patients newly diagnosed MM who have undergone autologous stem cell transplantation.
- As combination therapy for the treatment of adult patients with previously untreated MM who are not eligible for 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 BORT 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 BORT, 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.

References:

1. National Comprehensive Cancer Network. NCCN Guidelines: Multiple Myeloma, Version 7.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf (accessed on 6 May 2021).
2. Dimopoulos MA, et al. Ann Oncol. 2021;32:309-322.

Abbreviated Prescribing Information: Revlimid® 5 mg, 10 mg, 15 mg, 25 mg hard capsules.
Refer to the full Prescribing Information (PI) before prescribing. Full PI is available on request.
Name of medicine: Revlimid® 5 mg, 10 mg, 15 mg, 25 mg hard capsules. Active ingredient: Lenalidomide. Available dosage forms: Hard capsules containing lenalidomide 5 mg, 10 mg, 15 mg or 25 mg. Indications: Revlimid® as monotherapy is indicated for the maintenance treatment of adult patients with newly diagnosed multiple myeloma who have undergone autologous stem cell transplantation. Revlimid® as combination therapy is indicated for the treatment of adult patients with previously untreated multiple myeloma who are not eligible for transplant. Revlimid® in combination with dexamethasone is indicated for the treatment of multiple myeloma in adult patients who have received at least one prior therapy. Posology and method of administration: For all indications described below: Dose is modified based upon clinical and laboratory findings. Dose adjustments, during treatment and restart of treatment, are recommended to manage grade 3 or 4 thrombocytopenia, neutropenia, or other grade 3 or 4 toxicity judged to be related to lenalidomide. In case of neutropenia, the use of growth factors in patient management should be considered. If less than 12 hours has elapsed since missing a dose, the patient can take the dose. If more than 12 hours has elapsed since missing a dose at the normal time, the patient should not take the dose, but take the next dose at the normal time on the following day. Newly diagnosed multiple myeloma (Lenalidomide maintenance in patients who have undergone autologous stem cell transplantation (ASCT)): Lenalidomide maintenance should be initiated after adequate haematologic recovery following ASCT in patients without evidence of progression. Lenalidomide must not be started if the Absolute Neutrophil Count (ANC) is < 1.0 x 10⁹/L, and/or platelet counts are < 75 x 10⁹/L. The recommended starting dose is lenalidomide 10 mg orally once daily continuously (on days 1 to 28 of repeated 28-day cycles) given until disease progression or intolerance. After 3 cycles of lenalidomide maintenance, the dose can be increased to 15 mg orally once daily if tolerated. Newly diagnosed multiple myeloma (Lenalidomide in combination with dexamethasone until disease progression in patients who are not eligible for transplant): Lenalidomide treatment must not be started if the ANC is < 1.0 x 10⁹/L, and/or platelet counts are < 50 x 10⁹/L. The recommended starting dose of lenalidomide is 25 mg orally once daily on days 1 to 21 of repeated 28-day cycles. The recommended dose of dexamethasone is 40 mg orally once daily on days 1, 8, 15 and 22 of repeated 28-day cycles. Patients may continue lenalidomide and dexamethasone therapy until disease progression or intolerance. For hematologic toxicity the dose of lenalidomide may be re-introduced to the next higher dose level (up to the starting dose) upon improvement in bone marrow function (no hematologic toxicity for at least 2 consecutive cycles: ANC ≥ 1.5 x 10⁹/L with a platelet count ≥ 100 x 10⁹/L at the beginning of a new cycle). Newly diagnosed multiple myeloma (Lenalidomide in combination with melphalan and prednisone followed by lenalidomide maintenance in patients who are not eligible for transplant): Lenalidomide treatment must not be started if the ANC is < 1.5 x 10⁹/L, and/or platelet counts are < 75 x 10⁹/L. The recommended starting dose is lenalidomide 10 mg orally once daily on days 1 to 21 of repeated 28-day cycles for up to 9 cycles, melphalan 0.18 mg/kg orally on days 1 to 4 of repeated 28-day cycles, prednisone 2 mg/kg orally on days 1 to 4 of repeated 28-day cycles. Patients who complete 9 cycles or who are unable to complete the combination therapy due to intolerance are treated with lenalidomide monotherapy as follows:10 mg orally once daily on days 1 to 21 of repeated 28-day cycles given until disease progression. Multiple myeloma with at least one prior therapy: Lenalidomide treatment must not be started if the ANC < 1.0 x 10⁹/L, and/or platelet counts < 75 x 10⁹/L or, dependent on bone marrow infiltration by plasma cells, platelet counts < 30 x 10⁹/L. The recommended starting dose of lenalidomide is 25 mg orally once daily on days 1 to 21 of repeated 28-day cycles. The recommended dose of dexamethasone is 40 mg orally once daily on days 1 to 4, 9 to 12 and 17 to 20 of each 28-day cycle for the first 4 cycles of therapy and then 40 mg once daily on days 1 to 4 every 28 days. Prescribing physicians should carefully evaluate each dose of dexamethasone to use, taking into account the condition and disease status of the patient. All indications: For other grade 3 or 4 toxicities judged to be related to lenalidomide, treatment should be stopped and only restarted at next lower dose level when toxicity has resolved to ≤ grade 2 depending on the physician's discretion. Lenalidomide interruption or discontinuation should be considered for grade 2 or 3 skin rash. Lenalidomide must be discontinued for angioedema, anaphylactic reaction, grade 4 rash, exfoliative or bullous rash, or if Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) is suspected, and should not be resumed following discontinuation from these reactions. Special populations (refer to section 4.2 of the PI for full details): Paediatric population, elderly, patients with renal impairment, patients with hepatic impairment. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Women who are pregnant. Women of childbearing potential unless all of the conditions of the Pregnancy Prevention Programme (PPP) are met. Warnings (refer to section 4.4 of the PI for full details): Pregnancy warning: If lenalidomide is taken during pregnancy, a teratogenic effect in humans is expected. The conditions of the PPP must be fulfilled for all patients unless there is reliable evidence that the patient does not have childbearing potential. Counselling: For women of childbearing potential, lenalidomide is contraindicated unless all of the following are met: She understands the expected teratogenic risk to the unborn child and the need for effective contraception without interruption, at least 4 weeks before starting treatment, throughout the entire duration of treatment, and at least 4 weeks after the end of treatment. She should be capable of complying with effective contraceptive measures and understand the need to rapidly consult if there is a risk of pregnancy. Male patients must understand the expected teratogenic risk if engaged in sexual activity with a pregnant woman or a woman of childbearing potential and understand the need for the use of a condom if engaged in sexual activity with a pregnant woman or a woman of childbearing potential not using effective contraception (even if the man has had a vasectomy), during treatment and for at least 4 weeks after dose interruptions and/or cessation of treatment. Contraception: Women of childbearing potential must use at least one effective method of contraception for at least 4 weeks before therapy, during therapy, and until at least 4 weeks after lenalidomide therapy and even in case of dose interruption unless the patient commits to absolute and continuous abstinence confirmed on a monthly basis. Because of the increased risk of venous thromboembolism in patients with multiple myeloma taking lenalidomide in combination therapy, and to a lesser extent in patients with multiple myeloma taking lenalidomide monotherapy, combined oral contraceptive pills are not recommended. Refer to section 4.4 of the PI for full details. Pregnancy testing: According to local practice, medically supervised pregnancy tests with a minimum sensitivity of 25 mIU/mL must be performed for women of childbearing potential. Additional precautions: Patients should be instructed never to give this medicinal product to another person and to return any unused capsules to their pharmacist at the end of treatment. Patients should not donate blood during therapy or for at least 4 weeks following discontinuation of lenalidomide. Other special warnings and precautions (refer to section 4.4 of the PI for full details): Myocardial infarction, venous and arterial thromboembolic events, pulmonary hypertension, neutropenia and thrombocytopenia, thyroid disorders, peripheral neuropathy, tumour flare reaction and tumour lysis syndrome, allergic reactions and severe skin reactions (SJS, TEN and DRESS have been reported), lactose intolerance, second primary malignancies, hepatic disorders, infections, progressive multifocal leukoencephalopathy, cataract. Clinically significant interactions: Erythropoietic agents, or other agents that may increase the risk of thrombosis, such as hormone replacement therapy, should be used with caution in multiple myeloma patients receiving lenalidomide with dexamethasone. Refer to section 4.5 of the PI for full details. Reported side effects: Very common side effects include a fall in the number of red blood cells which may cause anemia leading to tiredness and weakness, rashes, itching, muscle cramps, muscle weakness, muscle pain, muscle aches, bone pain, joint pain, back pain, pain in the extremities, generalised swelling including swelling of your arms and legs, weakness, tiredness, fever and flu like symptoms including fever, muscle ache, headache, earache, cough and chills, numbness, tingling or burning sensation to the skin, pains in hands or feet, dizziness, tremor, decreased appetitie, changes in the way things taste, stomach pain, tumour size or redness around the tumour, weight loss, constipation, diarrhoea, nausea, vomiting, stomach pain, heartburn, low levels of potassium or calcium and/or sodium in the blood, thyroid functioning less than it should be, leg pain (which could be a symptom of thrombosis), chest pain or shortness of breath (which may be a symptom of blood clots in the lungs, called pulmonary embolism), infections of all types, including infection of the sinuses that surround the nose, infection of the lung and the upper respiratory tract, shortness of breath, blurred vision, clouding of your eye (cataract), problems which include kidney not working properly or not being able to maintain normal function, abnormal liver test results, increase in liver test results, changes to a protein in the blood that can cause swelling of the arteries (vasculitis), increases in your blood sugar levels (diabetes), decreases in your blood sugar levels, headache, nosebleed, dry skin, depression, mood change, difficulty sleeping, cough, a fall in blood pressure, a vague feeling of discomfort, feeling bad, sore inflamed mouth, dry mouth, dehydration. Please refer to section 4.8 of the PI for other side effects seen on treatment with lenalidomide. Date of revision of prescribing information: 14 May 2021.

Abbreviated Prescribing Information: Pomalyst® 1 mg, 2 mg, 3 mg, 4 mg hard capsules.
Refer to the full Prescribing Information (PI) before prescribing. Full PI is available on request.
Name of medicine: Pomalyst® 1 mg, 2 mg, 3 mg, 4 mg hard capsules. Active ingredient: Pomalidomide. Available dosage form: Hard capsules containing pomalidomide 1 mg, 2 mg, 3 mg or 4 mg. Authorised indications: Pomalyst® in combination with bortezomib and dexamethasone is indicated in the treatment of adult patients with multiple myeloma who have received at least one prior treatment regimen including lenalidomide. Pomalyst® in combination with dexamethasone is indicated in the treatment of adult patients with relapsed and refractory multiple myeloma who have received at least two prior treatment regimens, including both lenalidomide and bortezomib, and have demonstrated disease progression on the last therapy. Posology and method of administration: Dosing is continued or modified based upon clinical and laboratory findings. Pomalidomide in combination with bortezomib and dexamethasone: The recommended starting dose of Pomalyst® is 4 mg orally once daily on Days 1 to 14 of repeated 21-day cycles. Pomalidomide is administered in combination with bortezomib and dexamethasone, as shown in Table 1 of the full PI. Please refer to section 4.2 of the PI for the recommended dosing scheme for Pomalyst® in combination with bortezomib and dexamethasone. Pomalidomide in combination with dexamethasone: The recommended starting dose of Pomalyst® is 4 mg once daily taken orally on Days 1 to 21 of repeated 28-day cycles. The recommended dose of dexamethasone is 40 mg orally once daily on Days 1, 8, 15 and 22 of each 28-day treatment cycle. Treatment with pomalidomide combined with dexamethasone should be given until disease progression or until unacceptable toxicity occurs. Pomalidomide must be discontinued for exfoliative or bullous rash, or if Stevens-Johnson syndrome (SJS), Toxic Epidermal Necrolysis (TEN) or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) is suspected, and should not be resumed following discontinuation from these reactions. Pomalidomide interruption or discontinuation should be considered for Grade 2-3 skin rash. Pomalidomide must be discontinued permanently for angioedema and anaphylactic reaction. Special populations: Elderly: Please refer to section 4.2 of the full PI for details. Paediatric population: There is no relevant use in the paediatric population aged 0-17 years for the indication of multiple myeloma. Renal impairment. No dose adjustment of pomalidomide is required for patients with renal impairment. On haemodialysis days, patients should take their pomalidomide dose following hemodialysis. Hepatic impairment: Patients with mild (total bilirubin > 1.5 x ULN (upper limit of normal range) were excluded from clinical studies. Hepatic impairment has a modest effect on the pharmacokinetics of pomalidomide. No adjustment of the starting dose of pomalidomide is required for patients with hepatic impairment as defined by the Child-Pugh criteria. However, patients with hepatic impairment should be carefully monitored for adverse reactions and dose reduction or interruption of pomalidomide should be used as needed. Contraindications: Pregnancy. Women of childbearing potential, unless all the conditions of the pregnancy prevention programme are met. Male patients unable to follow or comply with the required contraceptive measures. Hypersensitivity to the active substance or to any of the excipients. Warnings: Pregnancy warning. Pomalidomide must not be taken during pregnancy, since a teratogenic effect is expected. The conditions of the Pregnancy Prevention Programme must be fulfilled for all patients unless there is reliable evidence that the patient does not have childbearing potential. Refer to Section 4.4 of the PI for a full list of the criteria for women of non-childbearing potential. Breastfeeding. It is not known if pomalidomide is excreted in human milk. Pomalidomide was detected in milk in the lactating animal. Contraception: For women of childbearing potential, pomalidomide is contraindicated unless all of the following are met: She understands the expected teratogenic risk to the unborn child. She understands the need for effective contraception, without interruption, at least 4 weeks before starting treatment, throughout the entire duration of treatment, and at least 4 weeks after the end of treatment. She should be capable of complying with effective contraceptive measures, and understands the need to undergo medically supervised pregnancy tests. For male patients taking pomalidomide, he understands the expected teratogenic risk if engaged in sexual activity with a pregnant woman or a woman of childbearing potential and he understands the need for the use of a condom during treatment duration, during dose interruption and for 4 weeks after dose interruptions and/ or cessation of treatment. Contraception. Women of childbearing potential must use at least one effective method of contraception for at least 4 weeks before therapy, during therapy, and until at least 4 weeks after pomalidomide therapy and even in case of dose interruption unless the patient commits to absolute and continuous abstinence confirmed on a monthly basis. Please refer to section 4.4 of the PI for examples of suitable methods of contraception. Because of the increased risk of venous thromboembolism in patients with multiple myeloma taking pomalidomide and dexamethasone, combined oral contraceptive pills are not recommended. If a patient is currently using combined oral contraception the patient should switch to one of the effective methods listed in Section 4.4 of the PI. Pregnancy testing. According to local practice, medically supervised pregnancy tests with a minimum sensitivity of 25 mIU/mL must be performed for women of childbearing potential. Please refer to Section 4.4 of the PI for full details of pregnancy testing. Additional precautions. Patients should be instructed never to give this medicinal product to another person and to return any unused capsules to their pharmacist at the end of treatment. Patients should not donate blood, semen or sperm during treatment (including during dose interruptions) and for 4 weeks following discontinuation of pomalidomide. Healthcare professionals and caregivers should wear disposable gloves when handling the blister or capsule. Women who are pregnant or suspect they may be pregnant should not handle the blister or capsule. Other special warnings and precautions (refer to section 4.4 of the PI for full details): Haematological events, thromboembolic events, thyroid disorders, peripheral neuropathy, significant cardiac dysfunction, tumour lysis syndrome, second primary malignancies, allergic reactions and severe skin reactions, dizziness and confusion, interstitial lung disease, hepatic disorders, infections, progressive multifocal leukoencephalopathy. Clinically significant interactions: Pomalidomide is not anticipated to cause clinically relevant pharmacokinetic drug-drug interactions due to P450 isoenzyme inhibition or induction or transporter inhibition when co-administered with substrates of these enzymes or transporters. Refer to section 4.5 of the PI for full details. Reported side effects: Anaemia, neutropenia, thrombocytopenia, fatigue, pyrexia, oedema peripheral, pneumonia, peripheral sensory neuropathy. Prescribers should consult the full Prescribing Information in relation to other side-effects. Date of revision of abbreviated prescribing information: 18/12/2020.

Bristol Myers Squibb™

Bristol-Myers Squibb Pharma (HK) Ltd.
Room 3001-3002, 30/F, Windsor House,
311 Gloucester Road, Causeway Bay, Hong Kong
Tel: (852) 2510 6188 Fax: (852) 2510 6199

2204-HK-2200007 Oct 2022

Agenda

14:00 - 14:20	Registration
14:20 - 14:30	Opening Ceremony *Prof. James CS CHIM*
14:30 - 15:05	**Session I :** The Role of IMiDs in the Treatment of Multiple Myeloma in the 21st Century *Q&A - 5 mins* *Prof. Joaquin MARTINEZ-LOPEZ (Spain)*
15:05 - 15:40	**Session II:** Anti-CD38 Antibody Therapy Sequencing in rrMM Management *Q&A - 5 mins* *Prof. Kwee YONG (UK)*
15:40 - 16:15	Tea Break
16:15 - 16:50	**Session III:** Incorporating the BCMA-Targeted Therapies Throughout the MM Disease Course *Q&A - 5 mins* *Dr. Suzanne TRUDEL (Canada)*
16:50 - 17:25	**Session IV:** The Era of T-cell Redirecting Bispecific Antibodies in Multiple Myeloma *Q&A - 5 mins* *Prof. Gareth MORGAN (US)*
17:25 - 17:45	Break
17:45 - 18:20	**Session V:** Induction for Non-transplant Candidates of Multiple Myeloma & Case Presentation *Q&A - 5 mins* *Prof. James CS CHIM & Dr. Justin KS LI*
18:20 - 20:00	Dinner | Closing Ceremony Certificate of Appreciation Presentation *Dr. Harold LEE*

IN THE TREATMENT OF RELAPSED/REFRACTORY MULTIPLE MYELOMA, NINLARO® BRINGS[1]

^Tourmaline MM1 study (n=722)
Aim: Compare efficacy and tolerability IRd vs placebo-Rd in rrMM patients; Key Primary Endpoint: PFS (IRd vs placebo-Rd=20.6 months vs 14.7 months); Key Secondary Endpoint: ORR (IRd vs placebo-Rd=78.3% vs 71.5%)
I: Ixazomib; R: Lenalidomide; d: Dexamethasone; rrMM: 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® ixazomib capsules 恩萊瑞®

Ninlaro 2.3mg, 3mg 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, 15, and 22 of a 28-day treatment cycle. Treatment should be continued until disease progression or unacceptable toxicity. Ninlaro 3mg and 2.3mg 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 nadirs typically occurring between Days 14-21 of each 28-day cycle and recovery to baseline by the start of the next cycle. Diarrhoea, constipation, nausea and vomiting have been reported with NINLARO, occasionally requiring use of antiemetic and antidiarrhoeal 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, diarrhoea, nausea, vomiting, constipation, rash, peripheral oedema.
For details, please refer to full prescribing information.

Takeda ONCOLOGY

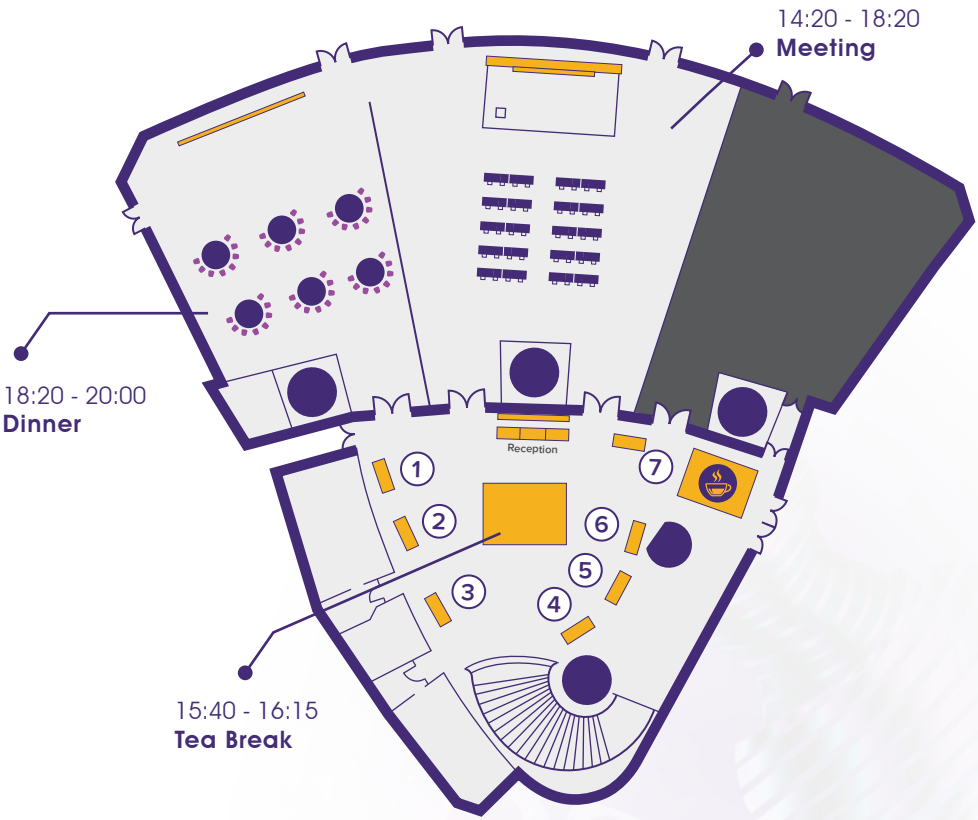
Takeda Pharmaceuticals (HK) Ltd
23/F & 24/F East Exchange Tower,
38 Leighton Road, Causeway Bay, Hong Kong
Tel : 2133 9800 Fax : 2856 2728

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.HongKong@takeda.com
For asking medical information and other inquiries for Takeda products at medinfohk@takeda.com

C-APROM/HK/NINL/0018(08/2022)

Floor Plan

Conrad Hong Kong
Grand Ballroom



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Kyprolis® (carfilzomib) for injection

WHEN MULTIPLE MYELOMA RELPASES,

RESPOND WITH THE EFFICACY OF KYPROLIS®[1,2]

Around 4 in 10 patients with MM who start second-line therapy never start a third.[3]
Your treatment choice at first relapse matters for your patients with relapsed MM.[4]

	ASPIRE (KRd)	ENDEAVOR (Kd)
IMPROVED MEDIAN OS	**Median OS of 48.3 months** with KRd in relapsed MM patients compared to 40.4 months with Rd; (HR=0.794; 95% CI: 0.667-0.945; *p*-value (2-sided)=0.0091)[1,5] (OS was a secondary endpoint in ASPIRE)	**Median OS of 47.6 months** with Kd in relapsed or refractory MM patients compared to 40.0 months with Vd; (HR=0.791; 95% CI: 0.648-0.964; $p=0.010$)[1,6] (OS was a secondary endpoint in ENDEAVOR)
SUSTAINABLE EFFICACY	**Median PFS of 26.3 months** with KRd in relapsed patients compared to 17.6 months with Rd; (HR=0.69; 95% CI: 0.57-0.83; $p<0.0001$)[2]	**KYPROLIS® doubled the median PFS** compared to bortezomib; (**18.7 months** vs. 9.4 months; HR=0.533; 95% CI: 0.44-0.65; $p<0.0001$)[1,7]
DEEP RESPONSE	With KRd, **almost 1 out of 3 patients reached complete response** or better (31.8%)[2]	**KYPROLIS® doubled the rate of complete response** or better compared to bortezomib; (12.5% vs. 6.2%; $p=0.0005$)[1]

KYPROLIS® is now available in ONCE-WEEKLY and TWICE-WEEKLY dosing, so you can choose the treatment regimen that best suits your patients.[1]

Abbreviations: CI, confidence interval; **HR**, hazard ratio; **Kd**, carfilzomib and dexamethasone; **KRd**, carfilzomib, lenalidomide and dexamethasone; **MM**, multiple myeloma; **OS**, overall survival; **PFS**, progression-free survival; **Rd**, lenalidomide and dexamethasone; **Vd**, bortezomib and dexamethasone

References: 1. KYPROLIS® Hong Kong Prescribing Information. December 2020. **2.** Stewart AK, et al. *N Engl J Med.* 2015;372(2):142-152. **3.** Yong K, et al. *Br J Haematol.* 2016;175(2):252-264. **4.** Durie BG. *Cancer Treat Rev.* 2010;36 Suppl 2:S18-S23. **5.** Siegel DS, et al. *J Clin Oncol.* 2018;36(8):728-734. **6.** Dimopoulos MA, et al. *Lancet Oncol.* 2017;18(10):1327-1337. **7.** Dimopoulos MA, et al. *Lancet Oncol.* 2016;17(1):27-38.

Kyprolis® (Carfilzomib) Abbreviated Prescribing Information

Indications: Kyprolis is indicated in combination with dexamethasone or with lenalidomide plus dexamethasone for the treatment of patients with relapsed or refractory multiple myeloma who have received one to three lines of therapy. **Dosage & Administration:** Administration Precautions: Dose based on BSA to max 2.2 m²; dose adjust for weight changes >20%. See full PI for dosing & administration information. Ensure adequate hydration before Cycle 1, Day 1 with oral fluids (30 mL per kg) and prior to each dose in Cycle 1 with IV fluids (250-500 mL). Administer after hemodialysis procedure for patients on hemodialysis. In combination with dexamethasone: Each 28 day period is considered one treatment cycle. Administer dexamethasone 30 mins to 4 hrs before Kyprolis. Treatment may be continued until disease progression or unacceptable toxicity occurs. *Once weekly:* Kyprolis is administered as a 30 min IV infusion once weekly for 3 weeks followed by a 13 day rest period. Administer Kyprolis at a starting dose of 20 mg/m² on Cycle 1 on Day 1. If tolerated, escalate the dose to 70 mg/m² on Day 8 of Cycle 1. Dexamethasone 40 mg is taken PO or IV on Days 1, 8, and 15 of all cycles and on Day 22 of Cycles 1 to 9. *Twice weekly:* Kyprolis is administered as a 30 minute IV infusion on two consecutive days, each week for 3 weeks followed by a 12 day rest period. Administer Kyprolis at a starting dose of 20 mg/m² in Cycle 1 on Days 1 and 2. If tolerated, escalate the dose to 56 mg/m² on Day 8 of Cycle 1. Dexamethasone 20 mg is taken PO or IV on Days 1, 2, 8, 9, 15, 16, 22, and 23 of each 28 day cycle. In combination with lenalidomide and dexamethasone: Administer Kyprolis as a 10 min IV infusion on two consecutive days, each week for 3 weeks followed by a 12 day rest period. Each 28 day period is considered one treatment cycle. The recommended starting dose of Kyprolis is 20 mg/m² in Cycle 1 on Days 1 and 2. If tolerated, escalate the dose to 27 mg/m² on Day 8 of Cycle 1. From Cycle 13, omit the Day 8 and 9 doses of Kyprolis. Lenalidomide 25 mg is taken PO on Days 1–21 and dexamethasone 40 mg PO or IV on Days 1, 8, 15, and 22 of the 28 day cycles. Continue treatment until disease progression or unacceptable toxicity occurs. Treatment for longer than 18 cycles should be based on individual benefit/risk assessment. **Contraindications:** None. **Warnings & Precautions:** Recommend: Control hypertension prior to starting Kyprolis, thromboprophylaxis (venous thrombosis). Consider: Uric acid-lowering drugs in patients at risk for tumor lysis syndrome, prophylaxis with antivirals for patients who are hepatitis B virus (HBV) carriers. Monitor: Clinical signs or symptoms of cardiac failure or cardiac ischemia (cardiac toxicities), blood loss (hemorrhage), thrombotic thrombocytopenic purpura/hemolytic uremic syndrome (TTP/HUS) (thrombotic microangiopathy); renal function with regular measurement of the serum creatinine and/or estimated clearance; platelet counts (thrombocytopenia), liver enzymes (hepatic toxicity and failure), serum potassium levels. Discontinue Kyprolis: In the event of drug-induced pulmonary toxicity, if Posterior Reversible Encephalopathy Syndrome (PRES) is suspected or if Progressive Multifocal Leukoencephalopathy (PML) diagnosis is confirmed. Others: Evaluate promptly if cardiac toxicity is suspected. Withhold Kyprolis for Grade 3/4 cardiac adverse reactions until recovery. Withhold for pulmonary hypertension until resolved or returned to baseline. Stop Kyprolis for Grade 3/4 dyspnea until resolved or returned to baseline. Infusion-related reactions up to 24 hrs after administration of Kyprolis. HBV reactivation. Kyprolis in combination with melphalan and prednisone is not indicated for transplant-ineligible patients with newly diagnosed multiple myeloma. **Pregnancy:** Kyprolis can cause fetal harm when administered to a pregnant woman. Use effective contraception during & after treatment (females: 6 mo; males 3 mo); consider alternate to oral or hormonal contraceptives. Do not administer to breastfeeding women. **Adverse Reactions:** Common: Anemia, neutropenia, thrombocytopenia, diarrhea, constipation, nausea, vomiting; fatigue, pyrexia, edema peripheral, asthenia, upper respiratory tract infection, bronchitis, viral upper respiratory tract infection, respiratory tract infection, pneumonia, hypokalemia, hypocalcemia, hyperglycemia, muscle spasms, back pain, peripheral neuropathies, headache, insomnia; cough, dyspnea, rash, embolic and thrombotic events, hypertension. **Please read full prescribing information prior to administration (available upon request).** Kyprolis® is a registered trademark owned or licensed by Amgen Inc., its subsidiaries, or affiliates. Version: HKKYPP104

For medical inquiries or to report adverse events/product complaint, please contact 800 961 142 or email medinfo.JAPAC@amgen.com

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HK-09219-KYP-2022-OCT

IN THE MAZE OF MULTIPLE MYELOMA,

BCMA-DIRECTED BsAbs MAY PROVIDE A NEW WAY FORWARD[1,2]

B-cell maturation antigen **(BCMA) is overexpressed on multiple myeloma (MM) cells**[1,3]

Bispecific antibodies (BsAbs) designed to target BCMA have the potential to function as **tumor-recognizing immune enhancers** and may offer a new way forward for MM patients[1-6]

References: 1. Caraccio C, Krishna S, Phillips DJ, Schürch CM. Bispecific antibodies for multiple myeloma: a review of targets, drugs, clinical trials, and future directions. *Front Immunol.* 2020;11:501. doi:10.3389/fimmu.2020.00501 **2.** Nadeem O, Tai YT, Anderson KC. Immunotherapeutic and targeted approaches in multiple myeloma. *Immunotargets Ther.* 2020;9:201-215. doi:10.2147/ITT.S240886 **3.** Shah N, Chari A, Scott E, Mezzi K, Usmani SZ. B-cell maturation antigen (BCMA) in multiple myeloma: rationale for targeting and current therapeutic approaches. *Leukemia.* 2020;34:985-1005. doi.org/10.1038/s41375-020-0734-z **4.** Zhou X, Einsele H, Danhof S. Bispecific antibodies: a new era of treatment for multiple myeloma. *J Clin Med.* 2020;9:1-14. doi:10.3390/jcm9072166 **5.** Swann JB, Smyth MJ. Immune surveillance of tumors. *J Clin Invest.* 2007;117:1137-1146. doi:10.1172/JCI31405 **6.** Pratt G, Goodyear O, Moss P. Immunodeficiency and immunotherapy in multiple myeloma. *Br J Haematol.* 2007;138:563-579. doi:10.1111/j.1365-2141.2007.06705.x

Pfizer Oncology

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The Role of IMiDs in the Treatment of Multiple Myeloma in the 21st Century

Prof. Joaquin MARTINEZ-LOPEZ
Complutense University of Madrid, Spain

Since 1999, when the NEJM published a study showing thalidomide's efficacy in multiple myeloma (MM), thalidomide and its derivatives have been used increasingly and have had a positive impact on MM treatment. We now know that thalidomide derivatives act through cereblon, which is responsible for both their primary antimyeloma effects and their main adverse events. Cereblon E3 ligase modulators are immunomodulatory medications. Cereblon is a protein that plays a role in the degradation of other proteins. IMiDs bind to cereblon and alter its activity, which can lead to the degradation of proteins involved in cancer cell growth and survival. In MM, IMiDs specifically target two proteins for degradation: Ikaros and Aiolos. These proteins are transcription factors that play a role in the development and survival of myeloma cells. By degrading Ikaros and Aiolos, IMiDs can kill myeloma cells. New IMiDs are more specifics to degrade Ikaros and Aiolos; this reduces their adverse events because reduce their effect over other proteins degradation that produce some adverse events. IMiDs have also a immune-stimulatory effect. This means that it can help to activate the immune system to fight cancer cells. IMiDs does this by upregulating the expression of cell adhesion molecules on myeloma cells. This makes it easier for T-cells to bind to and kill the myeloma cells. These increase also the cytotoxity activity of immune effectors cells against MM cells.

Now we have 5 IMiDs within the clinic: thalidomide, lenalidomide and pomalidomide approved and 2 in the last steps of clinical development. The success of IMiDs is due to their high oral antimyeloma activity, safety with low long-term adverse events, and synergy with other key antimyeloma drugs. Although thalidomide is approved in MM and can now be used in combination with daratumumab and bortezomib in patients eligible for transplant, it is avoided because it frequently causes irreversible neuropathy.

Lenalidomide plays a pivotal role in the initial treatment of multiple myeloma, both during induction therapy and as part of a maintenance regimen, often in conjunction with proteasome inhibitors, monoclonal antibodies, and corticoids. Meanwhile, pomalidomide finds application in combination with other antimyeloma medications in second and third-line treatments, demonstrating efficacy especially in patients who have become refractory to or have been exposed to lenalidomide.

Importantly, all these drugs share a similar safety profile. The predominant adverse events involve hematological toxicity, including neutropenia, anemia, and thrombocytopenia. While they do elevate the risk of thrombosis, this risk can be mitigated through the use of antiplatelet agents or anticoagulants. Moreover, the likelihood of significant neuropathy is substantially reduced to approximately 5%.

New IMiDs show preliminary results from early-phase clinical trials suggested that may be effective, particularly in combination with other myeloma therapies. It has shown promise in treating patients who have become resistant to other treatments, including lenalidomide and pomalidomide, even in some cases where patients had relapsed after CAR-T cell therapies. But now its development is focus on newly diagnosis patients. These are also well-tolerated by most patients. The most common side effects are like to pomalidomide and lenalidomide.

Furthermore, these are currently under investigation in combination with other anti-myeloma drugs in various phase II and phase III clinical trials for the treatment of multiple myeloma in early and late phases of the disease.

In conclusion, the new class of drugs known as IMiDs, has shown a highly favorable safety profile along with promising clinical efficacy in the treatment of multiple myeloma. These findings offer hope for improved treatment options for patients with this challenging disease.

Anti-CD38 Antibody Therapy Sequencing in rrMM Management

Prof. Kwee YONG
University College London, United Kingdom

CD38 is a type II transmembrane glycoprotein that functions as both membrane receptor inducing leukocyte proliferation, and ectoenzyme regulating calcium signalling. Its elevated expression in multiple myeloma cells render it differential target for anti-tumor therapy. Currently approved anti-CD38 antibodies, including isatuximab and daratumumab, exhibited diverse mechanisms of action. For instance, they may directly inhibit CD38 cyclase activity, trigger receptor removal or even apoptosis. In addition, Fc-mediated responses such as antibody-dependent cell-mediated cytoxicity (ADCC), cellular phagocytosis (ADCP), immunomodulation or complement-dependent cytoxicity (CDC) are also involved.

With such mechanistic differences, it was proposed that various anti-CD38 medications might be used in sequence to treat relapsed/refractory multiple myeloma (rrMM). Whether isatuximab should be administered before or after daratumumab remain disputed. In this session, evidence-based anti-CD38 drug sequencing strategies would be discussed.

Incorporating the BCMA-Targeted Therapies Throughout the MM Disease Course

Dr. Suzanne TRUDEL
University of Toronto, Canada

B-cell maturation antigen (BCMA) is a type III transmembrane glycoprotein receptor of tumor necrosis family. Its expression is elevated in neoplasm such as multiple myeloma, correlating with disease burden. Thus, BCMA-targeted therapies are widely-anticipated to be efficacious.

One pharmacological direction is chimeric antigen receptor T-cell (CAR-T) therapy. By engineering patient T-cell to express CAR specific to tumor-associated antigen (TAA) such as BCMA, cell-mediated immune response could be directed towards tumor cytotoxicity via granzyme B/ perforin pathway.

Another direction is use of T-cell engaging bispecific antibodies (BsAbs). By immediately linking BCMA to T-cell surface marker such as CD3, cell-mediated immune response could also be engaged. Both strategies have demonstrated clinical efficacy, and are subjected to similar side effect such as cytokine release syndrome and immune effector cell-associated neurotixicity syndrome (ICANS). In this session, different BCMA-targeted therapies would be compared throughout disease course of multiple myeloma.

The Era of T-cell Redirecting Bispecific Antibodies in Multiple Myeloma

Prof. Gareth MORGAN
New York University, United States

T-cell engaging bispecific antibodies (BsAbs) is a novel treatment option for multiple myeloma patients refractory to multiple drug classes, including immunomodulatory imide drug (IMiD), proteasomal inhibitors (PI) and anti-CD38 monoclonal antibodies (mAb). By linking tumor-associated antigen (TAA) to T-cell surface marker such as CD3, cell-mediated immune response could be directed towards tumor cytotoxicity via granzyme B/ perforin pathway.

Yet, BsAbs are often inducive of cytokine release syndrome, necessitating addition of IL-6 receptor-blocking antibodies to manage side effects. As BsAbs continued to show promising efficacy, therapy combinations are being developed to improve clinical outcomes.

In addition, structural design of BsAbs has direct pharmacological implication. Antibodies that omit Fc fragments [such as bispecific T-cell engager (BiTe)] prevent non-specific T-cell activation, yet reduced half-life to the extent that continuous intravenous administration might be required. Optimising BsAbs for clinical use remain challenging. In this session, the landscape of BsAbs in clinical practice would be surveyed.

Induction for Non-transplant Candidates of Multiple Myeloma & Case Presentation

Prof. James CS CHIM
University of Hong Kong, Hong Kong SAR

Dr. Justin KS LI
Tuen Mun Hospital, Hong Kong SAR

To transplant-ineligible multiple myeloma patients, conventional induction therapies were poor. For more than 40 years, combination of melphalan and prednisone (MP) was the standard approach, yielding progression-free survival (PFS) of about 18 months and overall survival (OS) of 3 years at best. Treatment goal was limited to achieving partial response and preventing organ damage.

With advent in combination therapies, three-drug regimens were reported with higher efficacy and safety for newly diagnosed patients. They commonly comprised of one proteasome inhibitor, one steroid, and one immunomodulatory imide drug (IMiDs) or DNA alkylator. For instance, both the National Comprehensive Cancer Network (NCCN) and European Society of Medical Oncology (ESMO) have recommended bortezomib/lenalidomide/dexamethasone (VRd) as primary therapy for non-transplant candidates. Daratumumab, an anti-CD38 antibody, also served as replacement for bortezomib (DaraRd) or augmenting the combination into four-drug regimen (DaraVMP). In addition, second-generation novel agents such as carfilzomib and elotuzumab were being investigated. In this session, the variations in induction therapy for non-transplant multiple myeloma patients would be discussed in depth and exemplified by case studies.

Romiplate®
Romiplostim

Patients achieved early platelet Boost with Romiplate®[1]*

Fast onset of action

- Median time to platelet response was 2.1 weeks[1]
- 88% of patients achieved a platelet response[2#]

Sustained Response

- 61% of patients sustained platelet counts ≥ 50 x 10^9/L for ≥ 11 months during the treatment period[1]

Abbreviated Package Insert of ROMIPLATE Power for Solution for Injection 250mcg

Composition: Romiplostim. **Indications:** Treatment of primary immune thrombocytopenia (ITP) in adult patients who are refractory to other treatments (e.g. corticosteroids & immunoglobulins); **Dosage and Administration:** SC inj Initially 1 mcg/kg (ABW) q1w, may be increased by increments of 1 mcg/kg until achieving a PLC ≥ 50 x 10^9 /L. Max: 10 mcg/kg q1w. **Contraindications:** Hypersensitivity to romiplostim or any of the excipients or E. coli-derived proteins. **Precautions:** Recurrence of thrombocytopenia & bleeding after discontinuation. Increased bone marrow reticulin. Thrombotic/thromboembolic complications. Progression of existing myelodysplastic syndrome (MDS). Immunogenicity. Alterations in RBC & WBC. Renal & hepatic impairment. May impair ability to drive or operate machinery. Pregnancy & lactation. Child <18 yr. **Common adverse reactions:** Upper respiratory tract infection, hypersensitivity, headache. **Serious adverse reactions:** reoccurrence of thrombocytopenia and bleeding after cessation of treatment, increased bone marrow reticulin, thrombotic/thromboembolic complications, progression of existing MDS to AML. **P/P:** Powd for soln for inj (vial) 250 mcg x 1's.

Approved version of package insert: Jan 2023.
Please refer to the full prescribing information before prescribing. Further information is available upon request.
*Platelet response was defined as a platelet count ≥50 x 10^9/L # Based on Overall Platelet Response in non-splenectomized patient

Reference: 1. Newland A, Godeau VP, Priego V, et al. Remission and platelet responses with romiplostim in primary immune thrombocytopenia: final results from a phase 2 study. *Br J Haematol*. 2016;172(2):262-273. **2.** Vishnu P, Aboulafia DM. Long-term safety and efficacy of romiplostim for treatment of immune thrombocytopenia. *J Blood Med*. 2016;7:99-106. **3.** Hong Kong Prescribing Information, Sep 2019.

THIS MATERIAL IS MEANT FOR HEALTHCARE PROFESSIONALS ONLY

KYOWA KIRIN

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HK-RPT-23-00001 AUG 2023

XPOVIO®
(selinexor)

THE X FACTOR

XPOVIO® (selinexor) is the first clinically proven XPO1 inhibitor[1]

HELPS RESTORE TUMOUR SUPPRESSOR PATHWAYS TO FIGHT MULTIPLE MYELOMA (MM)[2,3]

XPOVIO® + dexamethasone (Xd)

for the treatment of

penta-refractory multiple myeloma[1,4]

References:

1. XPOVIO® (selinexor) [prescribing information], Antengene (Hong Kong) Ltd, July 2023.
2. Benkova K, Mihalyova J, Hajek R, Jelinek T. Selinexor, selective inhibitor of nuclear export: unselective bullet for blood cancers. Blood Rev. 2021;46:100758.
3. Azmi AS, Uddin MH, Mohammad RM. The nuclear export protein XPO1 - from biology to targeted therapy. Nat Rev Clin Oncol. 2021;18(3):152-169.
4. Chari A, et al., Oral Selinexor–Dexamethasone for Triple Class Refractory Multiple Myeloma. N Engl J Med 2019;381:727-38.

Hong Kong Approved Indication:

• XPOVIO® in combination with dexamethasone is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior therapies and whose disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody.

XPOVIO® (selinexor) Tablets 20mg Minimum Product information. Indication: XPOVIO is indicated in combination with dexamethasone (Xd) 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 two proteasome inhibitors, two immunomodulatory agents and an anti-CD38 monoclonal antibody, and who have demonstrated disease progression on the last therapy. **Dosage & administration: Xd -** XPOVIO® (Selinexor) 80mg PO on Days 1 & 3 of each week in combination with dexamethasone 20mg PO on Days 1 & 3 of each week until disease progression or unacceptable toxicity. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients (listed in section 6.1 of product information). **Warnings & Precautions:** Assess complete blood counts (CBC) at baseline, during treatment and as clinically indicated. Monitor more frequently during the first two months of treatment. **Thrombocytopenia:** Monitor for signs and symptoms of bleeding. Manage with dose interruptions, modifications, platelet transfusions, and/or other treatments as clinically indicated or permanently discontinue based on severity. **Neutropenia:** Monitor for signs of infection. Neutropenia can be managed with dose interruptions, modifications, and colony-stimulating factors as per medical guidelines. **Gastrointestinal Toxicity:** Prophylaxis with 5HT3 antagonists and/or other anti-nausea agents prior to and during treatment. Administer fluids with electrolytes to prevent dehydration. Manage nausea/vomiting with dose interruptions, modifications and/or initiation of other antiemetics. Manage Diarrhoea with dose interruptions, modifications and/or anti-diarrhoeals. **Weight Loss and anorexia:** body weight and nutritional status should be monitored throughout treatment. Monitor more frequently during the first two months of treatment. Dose modifications, appetite stimulants and nutritional consultations may be required. **Hyponatremia:** Monitor sodium levels throughout treatment. Monitor more frequently in the first two months. Manage with intravenous sodium chloride solution and/or salt tablets. Dose interruptions and/or modifications may be required. **Embryo-Fetal Toxicity:** Advise females of reproductive potential and males with a female partner of reproductive potential, of avoid becoming pregnancy or abstain from sexual intercourse while treated with XPOVIO and for at least 1 week following the last dose. **Recommended concomitant treatments** Patients should be advised to maintain adequate fluid and caloric intake throughout treatment. Intravenous hydration should be considered for patients at risk of dehydration. **Interactions:** Concomitant use of strong CYP3A4 inducer might lead to lower exposure of XPOVIO. **Adverse Events: The most common adverse reactions (≥30%) in patients with multiple myeloma who received Xd** were nausea (75%), thrombocytopenia (75%), fatigue (66%), anemia (60%), decreased appetite (56%), decreased weight (49%), diarrhea (47%), vomiting (43%), hyponatremia (40%), neutropenia (36%) and leukopenia (30%). **Use In Specific Populations:** Lactation: Breast feeding should be discontinued during treatment with XPOVIO and for 1 week after last dose.

Healthcare providers are encouraged to report adverse events in patients taking XPOVIO to Antengene Ltd (Hong Kong) at ae@antengene.com
Should you have questions or require information on the safety and appropriate use of XPOVIO®, please email to medinfo.hk@antengene.com

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