RRMM: New Drugs and Combinations

ASH UPDATES 2024

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Lisaftoclax (APG-2575) Combined with Novel Therapeutic Regimens in Patients (Pts) with Relapsed or Refractory Multiple Myeloma (R/RMM) or Immunoglobulin Light-Chain (AL) Amyloidosis

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Study Design

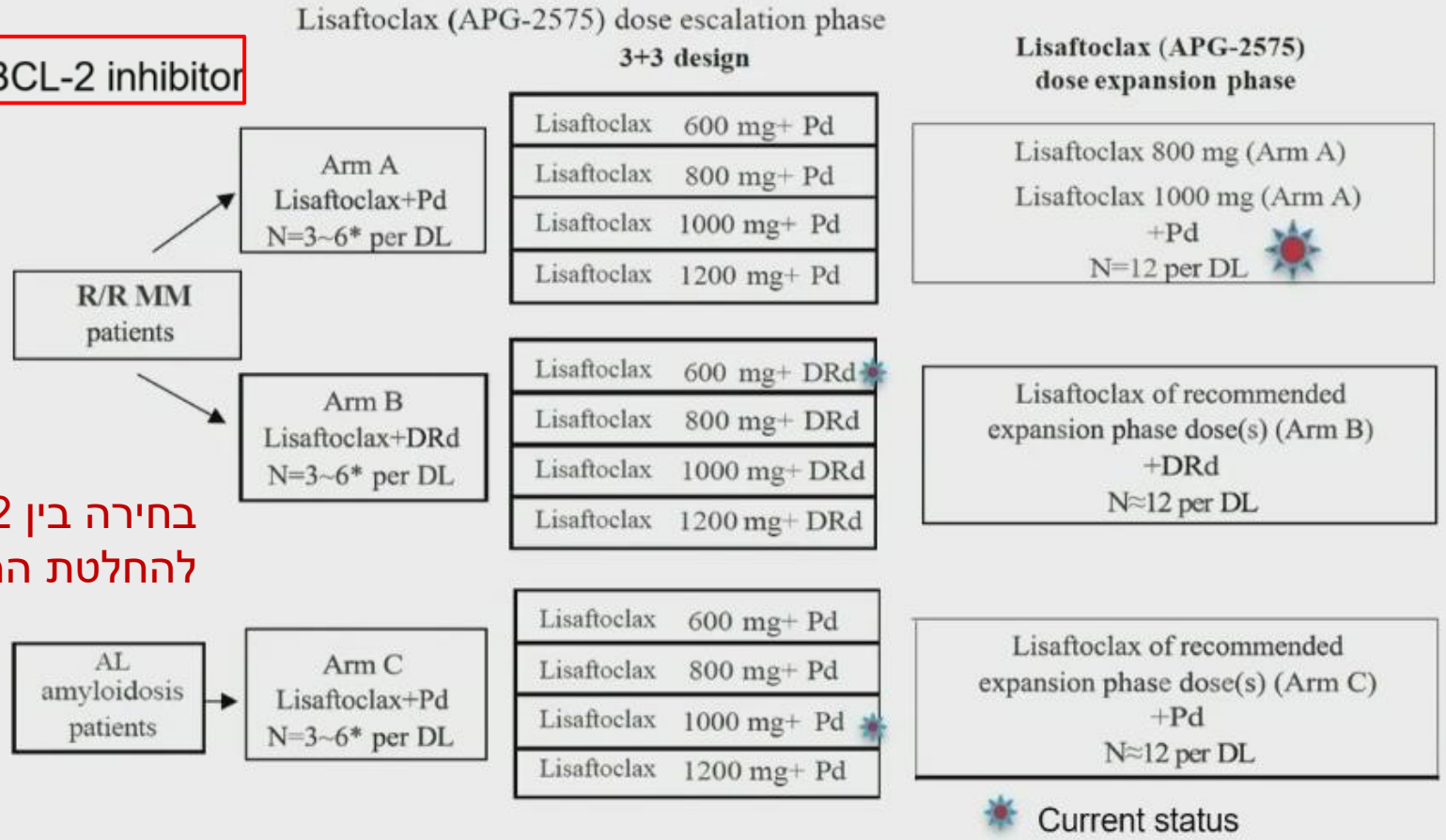
נכללו במחקר גם מטופלים ללא t(11,14)

Phase 1/2 clinical trial of lisaftoclax in R/RMM and R/R AL amyloidosis

Lisaftoclax, a novel, investigational BCL-2 inhibitor

28 days/cycle

Lisaftoclax orally once daily



בחירה בין 2 הזרועות לא רנדומלית- להחלטת הרופא המטפל

מטרות המחקר- בטיחות ויעילות

- DRd, daratumumab, lenalidomide, and dexamethasone; Pd, pomalidomide and dexamethasone; DL, dose level.
- Dexamethasone: 40 mg for patients aged ≤ 75 years and 20 mg for patients > 75 years on Days 1, 8, 15, and 22
- Pomalidomide, daratumumab, and lenalidomide were administered according to manufacturer labelling.

Data cutoff date: November 5, 2024

מאפייני החולים

	R/R MM (n = 48)		R/R AL amyloidosis (n = 10)
	Lisaftoclax + Pd	Lisaftoclax + DRd	Lisaftoclax + Pd
Population	41	7	10
No. of prior systemic therapies			
Mean (SD)	4.5 (3.38)	4.4 (3.78)	2.0 (0.47)
Median (range)	3.0 (1-19)	3.0 (1-12)	2.0 (1-3)

רוב המטופלים בזרוע A קיבלו PI (100%), IMIDs (95%), ant-CD38 (85%) לפני

Efficacy: Responses in 36 R/RMM Patients Treated with Lisaftoclax+Pd

40% קיבלו פומלידומיד בעבר, אין כאן מידע על הבדל בתגובה, מאמינים שיש אפקט סינרגיסטי לשילוב

רק 4/36 היו עם t(11,14) –מנסים להעשיר כמות חולים אלו

t(11;14) MM

	Dose, mg	Best response	Cycle
1201-002	400	VGPR	37
1201-004	400	SD	7 (withdrawn)
1201-020	800	PR	15
1201-034	1000	PR	4
ORR (PR or better): 75%			

Hematologic responses	Lisaftoclax dose combined with Pd					
	400 mg (n = 3)	600 mg (n = 4)	800 mg (n = 14)	1,000 mg (n = 9)	1,200 mg (n = 6)	Total (N = 36)
Best overall response, n (%)						
CR	0 (0.0)	0 (0.0)	1 (7.1)	1 (11.1)	1 (16.7)	3 (8.3)
VGPR	1 (33.3)	1 (25.0)	2 (14.3)	2 (22.2)	2 (33.3)	8 (22.2)
PR	0 (0.0)	2 (50.0)	5 (35.7)	5 (55.6)	0 (0.0)	12 (33.3)
MR	0 (0.0)	0 (0.0)	3 (21.4)	0 (0.0)	0 (0.0)	3 (8.3)
SD	2 (66.7)	1 (25.0)	2 (14.3)	1 (11.1)	3 (50.0)	9 (25.0)
PD	0 (0.0)	0 (0.0)	1 (7.1)	0 (0.0)	0 (0.0)	1 (2.8)
VGPR or better	1 (33.3)	1 (25.0)	3 (21.4)	3 (33.3)	3 (50.0)	11 (30.6)
95% CI	(0.8-90.6)	(0.6-80.6)	(4.7-50.8)	(7.5-70.1)	(11.8-88.2)	(16.3-48.1)
ORR (PR or better)	**1 (33.3)**	**3 (75.0)**	**8 (57.1)**	**8 (88.9)**	**3 (50.0)**	**23 (63.9)**
95% CI	(0.8-90.6)	(19.4-99.4)	(28.9-82.3)	(51.8-99.7)	(11.8-88.2)	(46.2-79.2)

Presenting author: Dr. Ailawadhi

Efficacy: PFS in 36 R/RMM Patients Treated with Lisaftoclax+Pd*

	Lisaftoclax dose combined with Pd, mg					
	400 (n = 3)	600 (n = 4)	800 (n = 14)	1,000 (n = 9)	1,200 (n = 6)	Total (N = 36)
No. of patients with an event, n (%)	0 (0.0)	4 (100.0)	11 (78.6)	4 (44.4)	4 (66.7)	23 (63.9)
No. of patients censored, n (%)	3 (100.0)	0 (0.0)	3 (21.4)	5 (55.6)	2 (33.3)	13 (36.1)
PFS, mo.						
25th percentile (95% CI)	NE (NE-NE)	3.7 (2.2-7.7)	3.7 (1.4-7.4)	2.8 (1.2-15.2)	2.6 (2.5-10.2)	3.7 (2.2-6.7)
Median (95% CI)	**NE (NE-NE)**	**6.5 (2.2-17.4)**	**7.4 (3.0-12.9)**	**11.1 (1.2-15.2)**	**7.0 (2.5-NE)**	**9.7 (4.7-12.9)**
75th percentile (95% CI)	NE (NE-NE)	12.5 (2.2-17.4)	12.9 (7.4-13.7)	15.2 (11.1-15.2)	NE (2.6-NE)	13.7 (10.2-NE)

*Median follow-up: 9.2 months. Abbreviations: CI, confidence interval; mo, months; no., number.

Efficacy: Responses in 32 R/RMM Patients Pretreated with anti-CD38 MoAb

Hematologic responses	Lisaftoclax dose combined with Pd, mg					
	400 (n = 3)	600 (n = 3)	800 (n = 14)	1,000 (n = 8)	1,200 (n = 4)	Total (N = 32)
Best overall response, n (%)						
CR	0 (0.0)	0 (0.0)	1 (7.1)	1 (12.5)	0 (0.0)	2 (6.3)
VGPR	1 (33.3)	1 (33.3)	2 (14.3)	2 (25.0)	2 (50.0)	8 (25.0)
PR	0 (0.0)	1 (33.3)	5 (35.7)	4 (50.0)	0 (0.0)	10 (31.3)
MR	0 (0.0)	0 (0.0)	3 (21.4)	0 (0.0)	0 (0.0)	3 (9.4)
SD	2 (66.7)	1 (33.3)	2 (14.3)	1 (12.5)	2 (50.0)	8 (25.0)
PD	0 (0.0)	0 (0.0)	1 (7.1)	0 (0.0)	0 (0.0)	1 (3.1)
VGPR or better	1 (33.3)	1 (33.3)	3 (21.4)	3 (37.5)	2 (50.0)	10 (31.3)
95% CI	(0.8-90.6)	(0.8-90.6)	(4.7-50.8)	(8.5-75.5)	(6.8-93.2)	(16.1-50.0)
ORR (PR or better)	**1 (33.3)**	**2 (66.7)**	**8 (57.1)**	**7 (87.5)**	**2 (50.0)**	**20 (62.5)**
95% CI	(0.8-90.6)	(9.4-99.2)	(28.9-82.3)	(47.3-99.7)	(6.8-93.2)	(43.7-78.9)

Abbreviations: CI, confidence interval; CR, complete response; MR, minimal response; ORR, overall response rate; PD, progressive disease; SD, stable disease; VGPR, very good partial response.

Efficacy: Responses in 32 R/RMM Patients Pretreated with anti-CD38 MoAb

	Lisaftoclax dose combined with Pd, mg					
	400 (n = 3)	600 (n = 3)	800 (n = 14)	1,000 (n = 8)	1,200 (n = 4)	Total (N = 32)
No. of patients with an event, n (%)	0 (0.0)	3 (100.0)	11 (78.6)	4 (50.0)	3 (75.0)	21 (65.6)
No. of patients censored, n (%)	3 (100.0)	0 (0.0)	3 (21.4)	4 (50.0)	1 (25.0)	11 (34.4)
PFS, mo.						
25th percentile (95% CI)	NE (NE-NE)	2.2 (2.2-17.4)	3.7 (1.4-7.4)	2.8 (1.2-15.2)	3.2 (2.5-10.2)	3.7 (1.9-7.4)
Median (95% CI)	**NE (NE-NE)**	**7.7 (2.2-17.4)**	**7.4 (3.0-12.9)**	**11.1 (1.2-15.2)**	**7.0 (2.5-10.2)**	**9.7 (4.7-12.9)**
75th percentile (95% CI)	NE (NE-NE)	17.4 (2.2-17.4)	12.9 (7.4-13.7)	15.2 (11.1-15.2)	10.2 (2.5-10.2)	13.7 (10.2-NE)

Efficacy: Responses in Cohort C R/R Amyloidosis

Hematologic responses	Lisaftoclax dose combined with Pd, mg				
	400 (n = 1)	600 (n = 4)	800 (n = 2)	1,000 (n = 2)	Overall (N = 9)
Best overall response, n (%)					
sCR	0 (0.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (11.1)
Unconfirmed sCR	0 (0.0)	1 (25.0)	0 (0.0)	0 (0.0)	1 (11.1)
VGPR	0 (0.0)	2 (50.0)	2 (100.0)	2 (100.0)	6 (66.7)
SD	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (11.1)
VGPR or better	0 (0.0)	4 (100.0)	2 (100.0)	2 (100.0)	8 (88.9)
95% CI	(0.0-97.5)	(39.8-100.0)	(15.8-100.0)	(15.8-100.0)	(51.8-99.7)
ORR (PR or better)	**0 (0.0)**	**4 (100.0)**	**2 (100.0)**	**2 (100.0)**	**8 (88.9)**
95% CI	(0.0-97.5)	(39.8-100.0)	(15.8-100.0)	(15.8-100.0)	(51.8-99.7)

CI, confidence interval; ORR, overall response rate; Pd, pomalidomide and dexamethasone; PR, partial response; R/R, relapsed or refractory; sCR, stringent complete response; SD, stable disease; VGPR, very good partial response

זמן לתגובה פחות מחודש, טרם מידע על organ response אבל יודעים שהיו organ response

- Because AL amyloidosis incidence is low, the current lisaftoclax dose of 1,000 mg was determined at the dose-escalation stage

Conclusions

- Lisaftoclax+Pd has demonstrated an impressive safety profile, even at a relatively high dose to promote longer treatment duration.
- In heavily treated R/RMM, lisaftoclax in combination with Pd has shown improved ORR and extended DoR, noted despite refractoriness to anti-CD38 monoclonal antibodies.
- For R/R AL amyloidosis, lisaftoclax could accelerate the time to hematologic responses.
- Enrollment is ongoing to confirm the efficacy and safety of lisaftoclax in combination with Pd, to explore an optimal dosage for R/RMM (**ClinicalTrials.gov identifier: NCT04942067**).

מינון שימשיכו איתו- נראה 800-1000 מכ

- היסטורית -שילוב ונטוקלקס-פומלידמויד- דקס- רק 8 מקרים דווחו- מינונים גבוהים גרמו רעילות
- לא הייתה בעיית רעילות במינונים גבוהים
- גם ב-10 חולים ם עמילואיד פרופיל בטיחות טוב

Tolerability and Clinical Activity of Novel First-In-Class Oral Agent, inobrodib (CCS1477), in Combination With Pomalidomide and Dexamethasone in Relapsed/Refractory Multiple Myeloma

Emma Searle[1,2], Victoria Campbell[3], Charlotte Pawlyn[4,5], Ceri Bygrave[6], Sarah Gooding[7], James Cavet[1], Matthew W. Jenner[8], Vivek Radhakrishnan[9], Steve Knapper[10], Dima el-Sharkawi[5], Jenny O'Nions[11], Tomasz Knurowski[12], Karen Clegg, PhD[12], Will Henry West[12], Debbie Haynes[12], Kris Frese[12] and Tim Somervaille[1,2]

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Abstract 1023
Presented by E Searle at ASH 2024; December 7–10, 2024; San Diego

Background

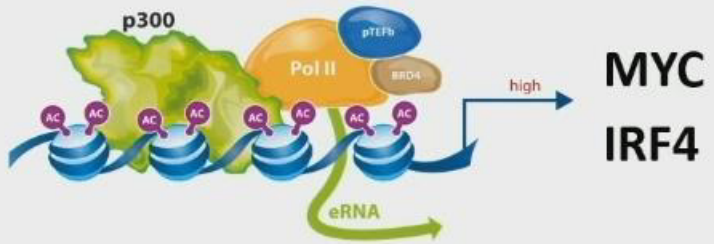
Inobrodib: First-in-class, oral, potent and specific bromodomain inhibitor of p300/CBP, two transcriptional coactivators with key roles in hematological cancers

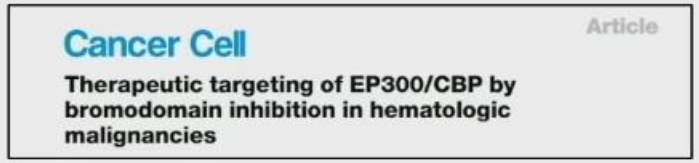
Strong scientific rationale for targeting p300/CBP in myeloma

- selective displacement of p300/CBP from 10% of binding sites[1]
- inhibition of key oncogenic drivers IRF4 and MYC
- exquisite synergy with IMiDs[2]

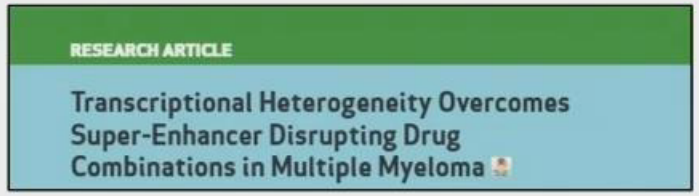
Clinical activity has been observed in patients with relapsed and refractory myeloma when given as a monotherapy (ORR 25%)[3]

We report on the combination of inobrodib (INO), pomalidomide (POM) and dexamethasone (DEX) in the ongoing Phase I/IIa trial (NCT04068597).




Cancer Cell
Article
Therapeutic targeting of EP300/CBP by bromodomain inhibition in hematologic malignancies

[1]*Nicosia et al, Cancer Cell 2023*


RESEARCH ARTICLE
Transcriptional Heterogeneity Overcomes Super-Enhancer Disrupting Drug Combinations in Multiple Myeloma

[2]*Welsh et al, Blood Cancer Discovery 2024*

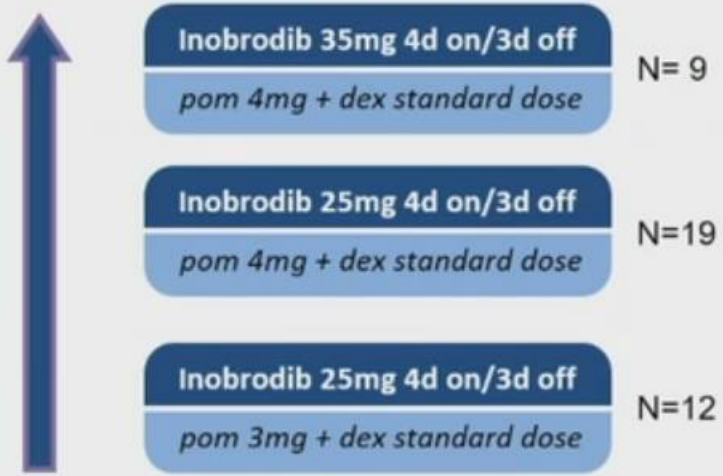
[3]Searle E et al presented at ASH 2023

Searle E, et al. ASH 2024 [Abstract #1023]

Study design

PI/IIa of Inobrodib in patients with advanced haematologic malignancies

Myeloma combination cohorts N =40



Three dose escalation cohorts

Inobrodib 4 day on 3 days off, 28-day cycles

Pomalidomide Days 1-21 of each 28-day cycle

Dexamethasone 20mg/ 40mg weekly

Primary objective

Establish safety profile and select doses for expansion cohorts

Secondary objectives

Characterise inobrodib pharmacokinetics

Assess anti-myeloma efficacy (IMWG criteria)

Exploratory objectives

Explore PD biomarker profiling (e.g. IRF4,MYC) in paired BM and serial PBMC samples

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Prior therapies and refractory status

Prior therapy n=40	Total n (%)
Prior lines; median (range)	5 (2-9)
Prior stem cell transplantation 1 2	 18 (45%) inc. 1 allo SCT 9 (22.5%)
Triple-class exposed	40 (100%)
Refractory	
Lenalidomide *	31/38 (82%)
Pomalidomide *	28/40 (70%)
Triple-class *	28/37 (76%)
Penta-drug *	8/39 (20.5%)
aBCMA/TCE	12/40 (30%)
To last line	40 (100%)

Most patients were heavily pre-treated & triple class refractory, 30% had received an anti-BCMA and/or T cell engagers

Data cut 04 Nov 2024

*Percentage of evaluable patients/data missing

Searle E, et al. ASH 2024 [Abstract #1023]

Safety profile of InoPd: TEAEs irrespective of causality

TEAEs	All Grades n (%)	Grade ≥3
Thrombocytopenia	18 (45)	13 (32.5)
Bleeding	5 (12.5)	1 (2.5)
Anaemia	16 (40)	7 (17.5)
Neutropenia	15 (37.5)	14 (35)
Febrile neutropenia	2 (5)	2 (5)
Fatigue	25 (62.5)	
Diarrhoea	18 (45)	1 (2.5)
Pyrexia	15 (37.5)	1 (2.5)
Constipation	12 (30)	
Pneumonia	12 (30)	8 (20)
UTI	12 (30)	3 (7.5)
Muscle spasms	12 (30)	
Myocardial ischaemia*	1 (2.5)	1 (2.5)
Discontinued due to TEAE	5 (12.5%)	

Key Observations

InoPomDex combination had a tolerable safety profile

- Most common TEAEs were cytopenias & fatigue
- Most TEAEs were mild/moderate and did not impact compliance
- No differences between cohorts

Thrombocytopenia, the main anticipated overlapping toxicity was manageable

- Limited (mostly G1) bleeding events

Low treatment discontinuation due to AEs

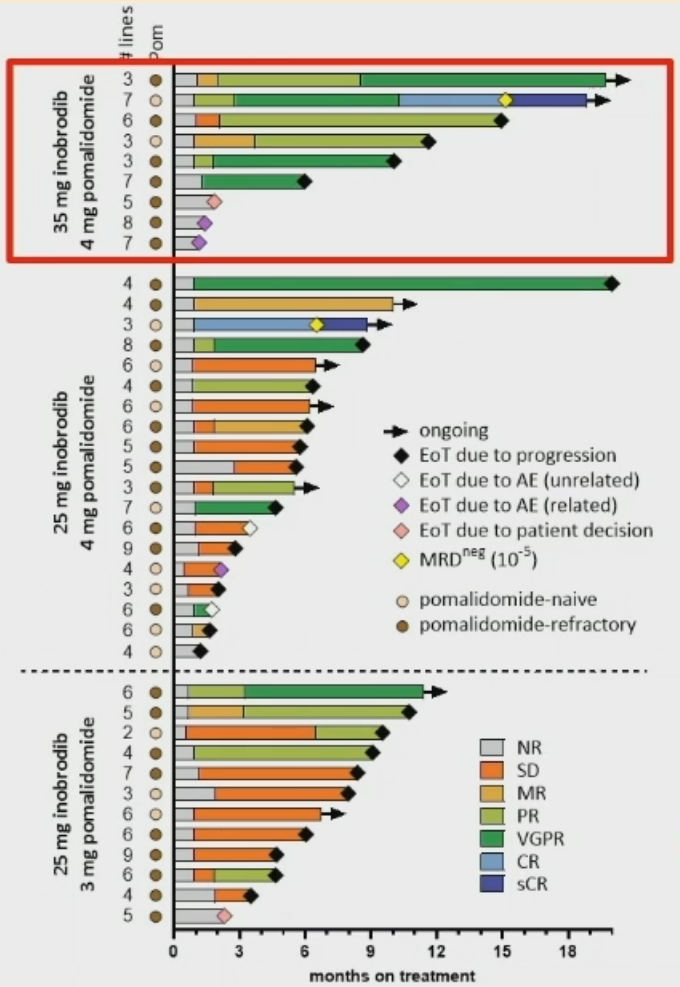
No new safety signals identified

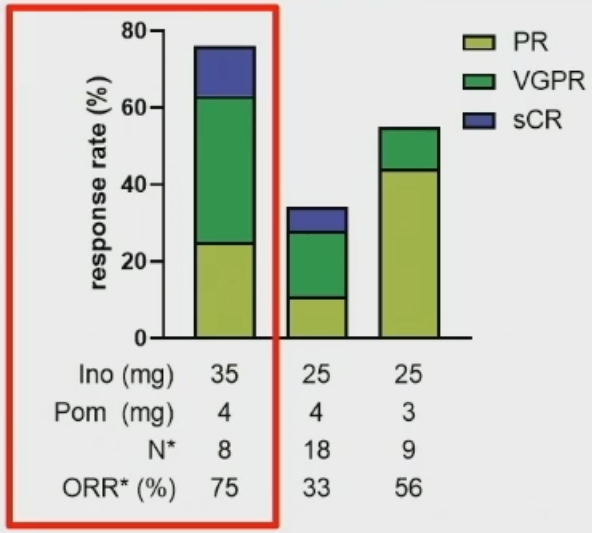
Most frequent ≥25% (TEAEs) plus *1 patient with Grade 5 event (MI: not related to inobrodib)

Data cut 04 Nov 2024

Searle E, et al. ASH 2024 [Abstract #1023]

InoPd efficacy in relapsed refractory multiple myeloma





Ino (mg)	35	25	25
Pom (mg)	4	4	3
N*	8	18	9
ORR* (%)	75	33	56

Across all cohorts: 49% ORR, mDOR 6.3 months , 63% of pts ≥ 6 mo.

Highest dose cohort: 75% ORR, mDOR 9.7 months

Pom-refractory patients (last line): 4/8 pts responded ≥PR, + 1 MR

* Among evaluable patients

Searle E, et al. ASH 2024 [Abstract #1023]

Conclusions

- Inobrodib in combination with pomalidomide and dexamethasone (**InoPd**) shows a manageable safety profile, favorable pharmacokinetics and promising efficacy in heavily pre-treated RRMM
- The highest efficacy was seen at doses of 35mg BD (4 days on/3 days off) with 4mg pomalidomide (21 days) and dexamethasone **with a 75% ORR** and activity seen across all dosing levels
  - Two pomalidomide-naïve patients achieved an MRD negative sCR
  - Efficacy was observed in pomalidomide refractory and BCMA-TCE refractory patients
- **No new safety signals were identified across the 3 dosing cohorts**
  - Thrombocytopenia was the most frequent grade 3 /4 TEAE overall which was manageable, and bleeding events were infrequent
  - Neutropenia was the second most common TEAE, but febrile neutropenia was rare
- **A randomized expansion evaluating three doses of Inobrodib with pom/dex is currently recruiting (NCT04068597)**

Searle E, et al. ASH 2024 [Abstract #1023]

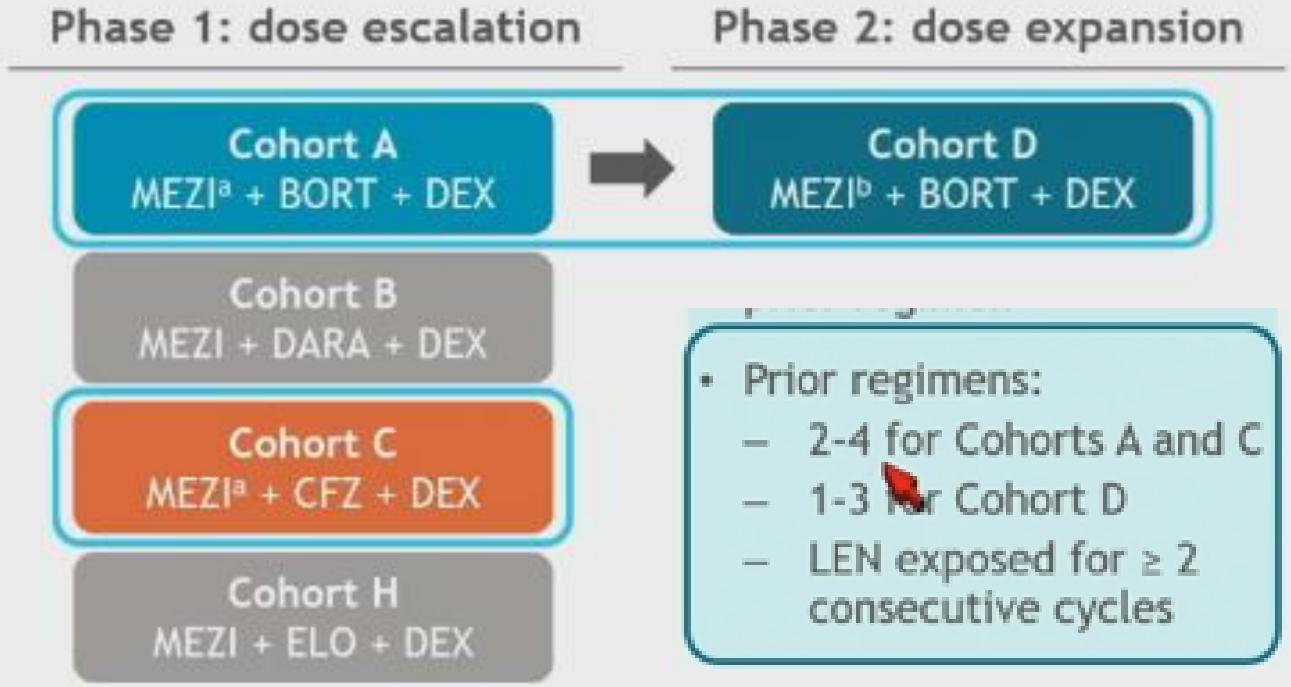
Mezigdomide plus dexamethasone and bortezomib or carfilzomib in patients with relapsed/refractory multiple myeloma: updated results from the CC-92480-MM-002 trial

Irwindeep Sandhu,[1] Paul G. Richardson,[2] Albert Oriol,[3] Darrell White,[4] Richard LeBlanc,[5] Noopur Raje,[6] Enrique M. Ocio,[7] Aurore Perrot,[8] Thierry Facon,[9] Cesar Rodriguez,[10] Ralph Wäsch,[11] Meletios A. Dimopoulos,[12] Tracy T. Chow,[13] Allison Gaudy,[13] Jing Gong,[13] Zehua Zhou,[13] Tiziana Civardi,[14] Joseph T. Hadala,[13] Yue Zhu,[15] Jessica Katz,[13] Marc S. Raab[16]

ASH 2024, Presentation 1025

CC-92480-MM-002 study design

Open-label, multicenter, phase 1/2 dose-finding and dose-expansion clinical trial evaluating MEZI + DEX in combination with different treatments in patients with MM[1,2]

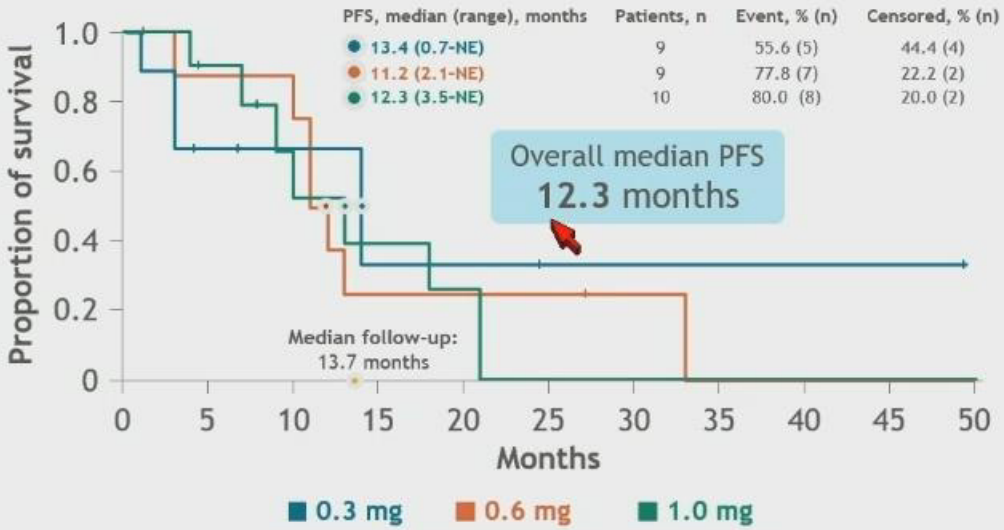


This study reports updated results with longer follow-up from the phase 1/2 CC-92480-MM-002 trial (NCT03989414)[6-8] from the MEZI + DEX + BORT (MeziVd) and MEZI + DEX + CFZ (MeziKd) dose-escalation cohorts (A and C) and the MeziVd dose-expansion cohort (D)

PFS in dose-escalation Cohort A and dose-expansion Cohort D (MeziVd)

PFS[a] - Cohort A

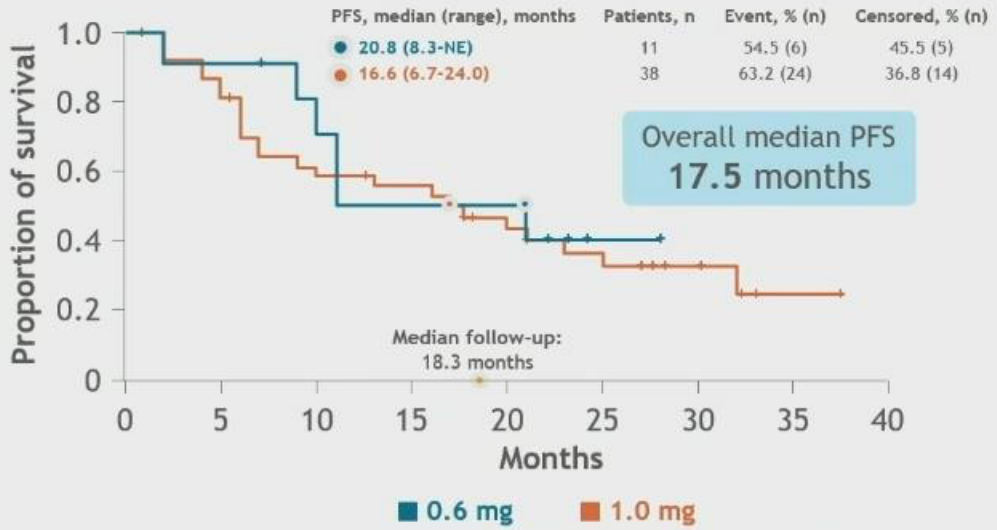
Median number of prior therapies = 3



	All doses	1.0 mg
ORR,[b] % (95% CI)	75.0 (55.1-89.3)	60.0 (55.1-89.3)
DOR, median (95% CI), months	10.9 (8.8-18.7)	11.6 (5.3-NA)

PFS[a] - Cohort D

Median number of prior therapies = 1



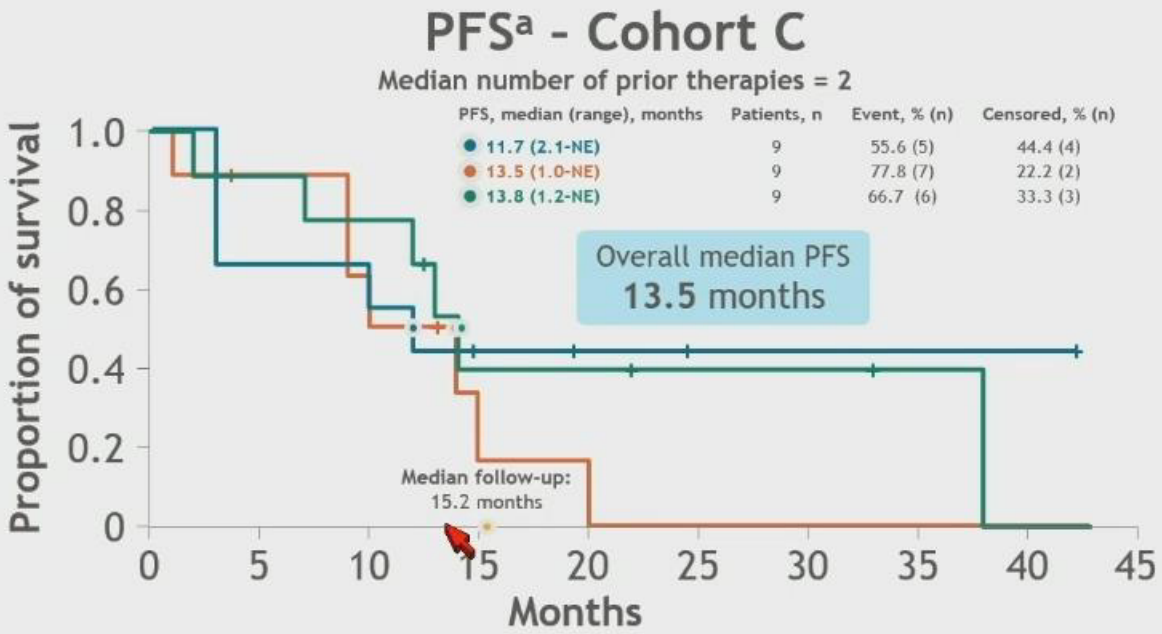
	All doses	1.0 mg
ORR,[b] % (95% CI)	85.7 (72.8-94.1)	84.2 (68.7-94.0)
DOR, median (95% CI), months	19.4 (9.7-NA)	19.4 (7.0-NA)

MeziVd showed durable efficacy at all dose levels tested with an overall median PFS > 1 year (17.5 months in Cohort D)

[a]Data cutoff: June 28, 2024; [b]ORR refractory to LEN and anti-CD38 mAbs (data cutoff: May 9, 2024): Cohort A = 69.2%, Cohort D = 75.0%.
CI, confidence interval; DOR, duration of response; NA, not applicable; PFS, progression-free survival.

Sandhu I, et al. ASH 2024 [Abstract #1025]

PFS in dose-escalation Cohort C (MeziKd)



	All doses	1.0 mg
ORR,[b] % (95% CI)	85.2 (66.3-95.8)	77.8 (40.0-97.2)
DOR, median (95% CI), months	11.9 (6.4-35.9)	11.9 (0.2-NA)

MeziKd showed efficacy at all dose levels tested with an overall median PFS of 13.5 months

[a]Data cutoff: June 28, 2024; [b]ORR refractory to LEN and anti-CD38 mAbs (data cutoff: May 9, 2024): Cohort C = 82.4%.

Sandhu I, et al. ASH 2024 [Abstract #1025]

Conclusions and future directions

- MEZI is a novel, oral CELMoD agent that induces rapid, potent, and deep degradation of Ikaros and Aiolos, resulting in enhanced cytotoxic effects in myeloma cells and direct T-cell and NK-cell immune-stimulatory activities[1]
- Proteasome inhibition does not abrogate the substrate degradation induced by MEZI
- MEZI demonstrated dose-dependent linear pharmacokinetics, with no difference in exposure between Cohorts A, D, or C[2]
- MeziVd and MeziKd in RRMM confirmed promising efficacy at all dose levels tested, including at the 1.0-mg dose, in patients with RRMM previously exposed to IMiD agents, PI, and anti-CD38 mAbs
  - Responses were deep and durable (ORR Cohort A: 75.0%; Cohort D: 85.7%; Cohort C: 85.2%), with median PFS of ≥ 1 year in all cohorts (Cohort A: 12.3 months; Cohort D: 17.5 months; Cohort C: 13.5 months)
  - PFS was longer in the MeziVd dose-expansion cohort (Cohort D) with 1 median prior line of therapy than in the dose-escalation cohort (Cohort A) with 3 median prior lines of therapy
- Among all cohorts, MEZI demonstrated a manageable safety profile with no cumulative toxicity
  - Neutropenia was the most common grade 3/4 TEAE, occurred infrequently with grade 3/4 infections, and was manageable with G-CSF and dose interruption/reduction
  - Non-hematologic grade 3/4 TEAEs were uncommon

These results support the investigation of MEZI in the phase 3 trials SUCCESSOR-1[a] (MeziVd vs PVd) and SUCCESSOR-2[b] (MeziKd vs Kd) in RRMM

Kd, CFZ + DEX; PVd, POM + BORT + DEX. [a]NCT05519085; eligible patients had MM and measurable disease, received 1-3 antimyeloma regimens, and achieved ≥ MR to ≥ 1 therapy. [b]NCT05552976; eligible patients had MM and measurable disease with documented disease progression after the last myeloma regimen, received ≥ 1 prior anti-myeloma therapy, received prior LEN treatment and ≥ 2 cycles of an anti-CD38 mAb, and achieved ≥ MR to ≥ 1 therapy. 1. Richardson PG, et al. *N Engl J Med* 2023;389:1009-1022; 2. BMS. Data on file.