La rivoluzione terapeutica nel **linfoma** e nel **mieloma**

Napoli, Hotel Royal Continental • 14–15 Maggio 2026

Come cambia la seconda linea di trattamento

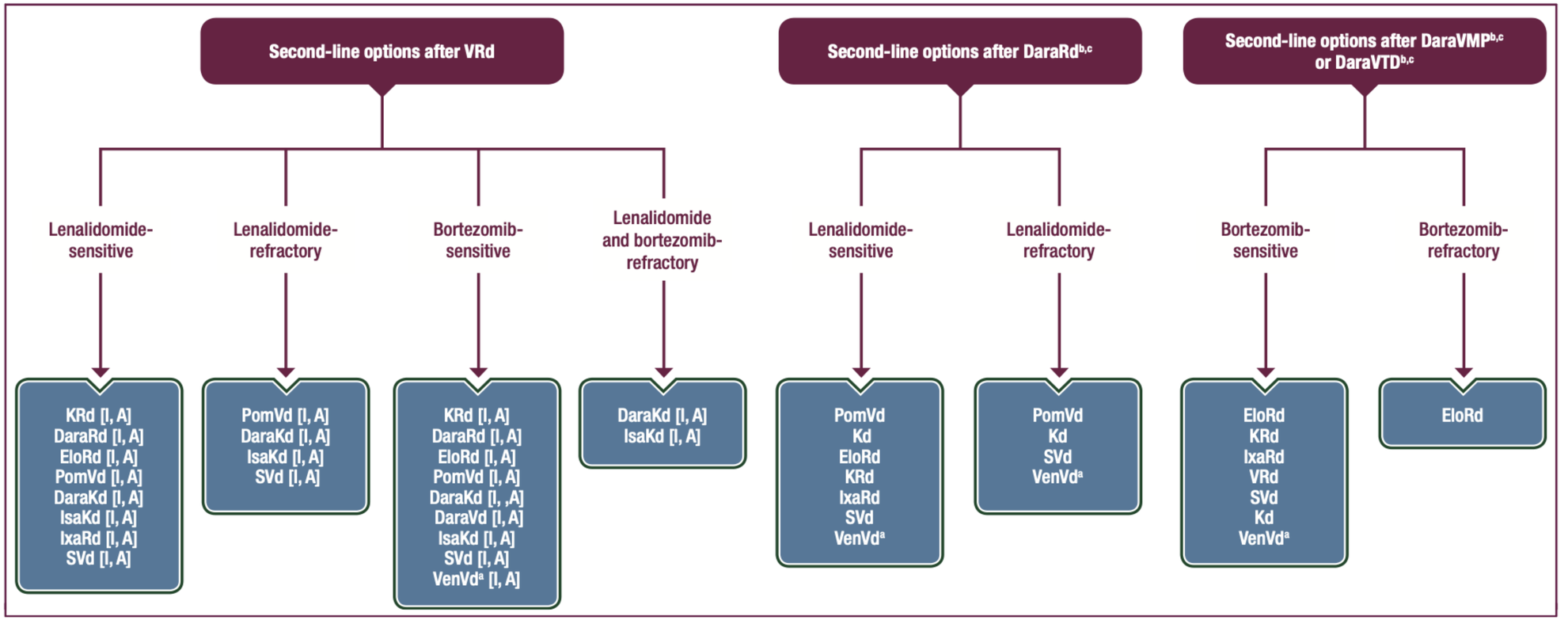
Danilo De Novellis, AOU Ruggi D'Aragona

Salerno

Disclosures of Danilo De Novellis

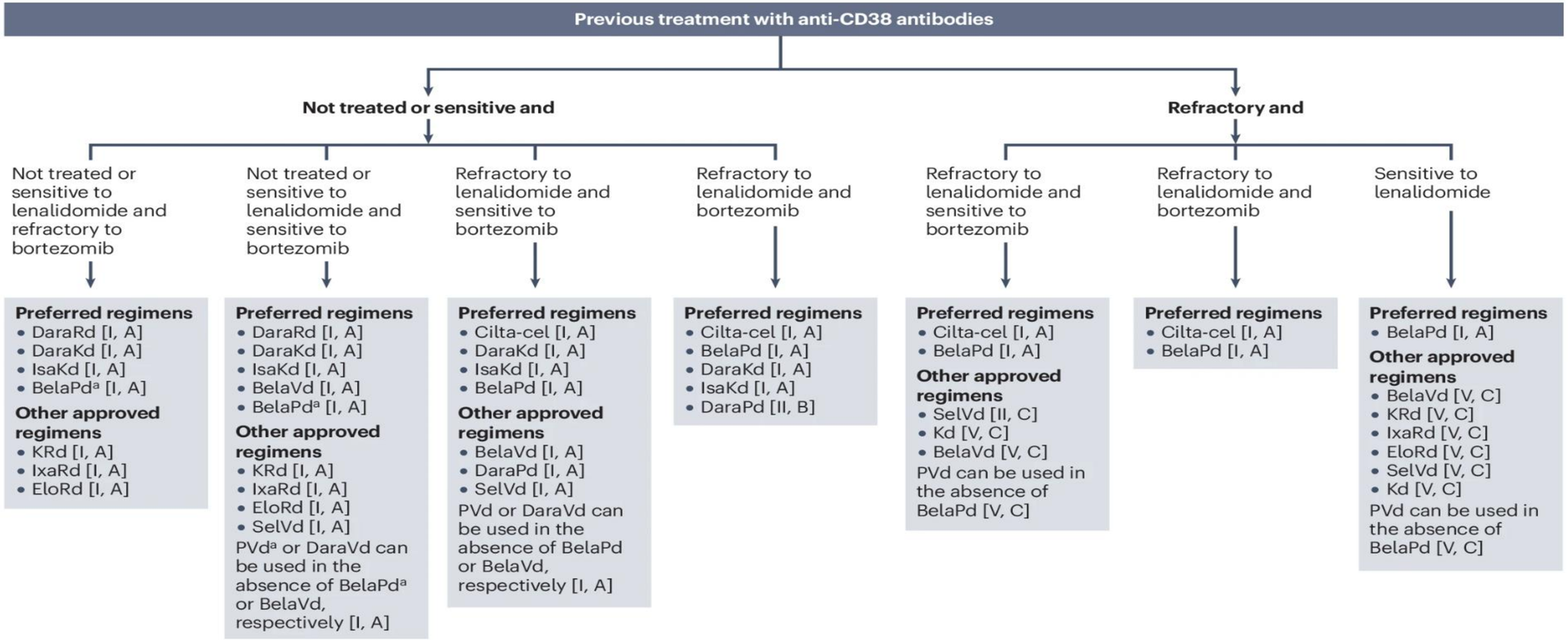
Company name	Research support	Employee	Consultant	Stockholder	Speakers bureau	Advisory board	Other
Sanofi			x			X	
Amgen			x				
Johnson&Johnson			x				
GSK						X	
Pfizer						X	

La II linea è già cambiata



Annals of Oncology

Linee guida 2021

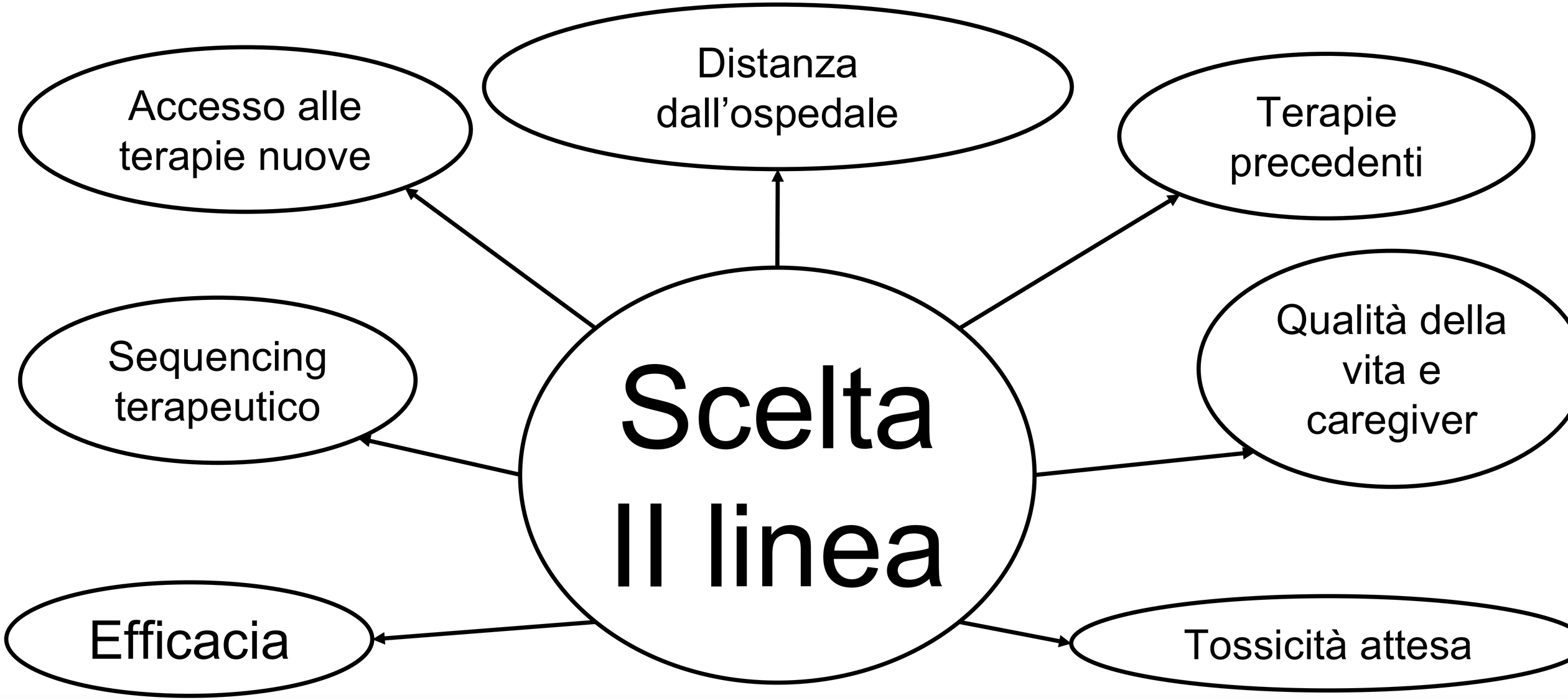


Linee guida 2025

- Rispetto al passato, il paziente che recidiva oggi è virtualmente refrattario a lenalidomide

- Il cardine delle nuove linee guida è la valutazione della refrattarietà/esposizione ad anti-CD38 mAbs

Approccio alla seconda linea nel mieloma oggi

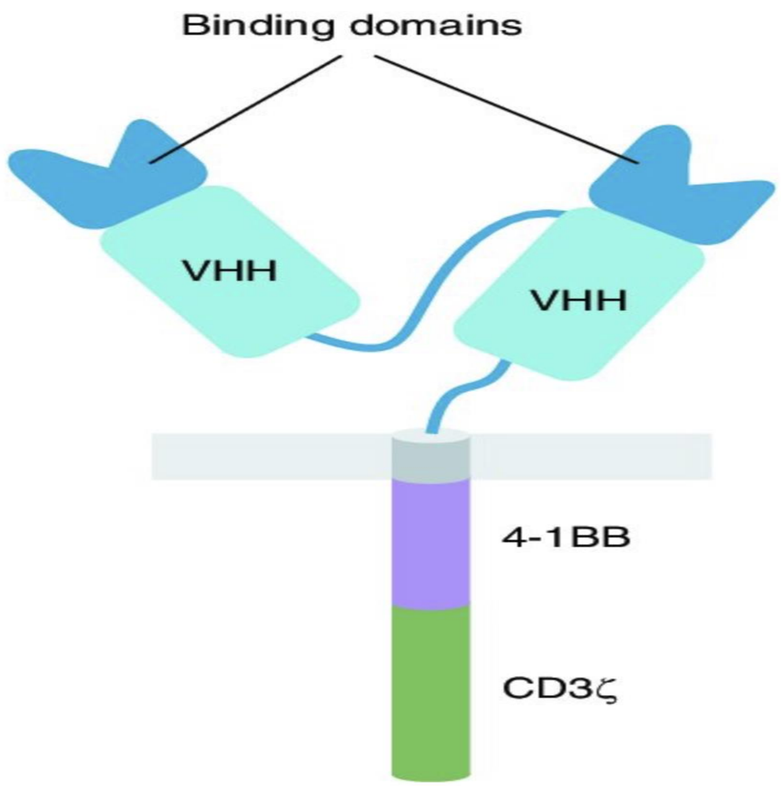


Approccio alla seconda linea nel mieloma oggi

La domanda è…

Il paziente, considerato tutti i fattori decisionali, è candidato da subito o lo sarà in linee successive a terapia CAR-T con target BCMA (cilta-cel)?

Costrutto CAR cilta-cel



Target = BCMA

Due anticorpi a singolo dominio per potenziare l'avidità di legame

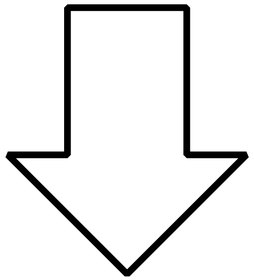
Cilta-cel, a BCMA-targeting CAR-T therapy for heavily pretreated patients with relapsed/refractory multiple myeloma Thomas G Martin, Deepu Madduri, Lida Pacaud & Saad Z Usmani

Criteri eleggibilità a cilta-cel

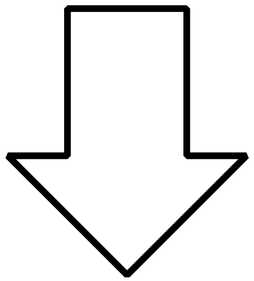
- Età
- Fitness e comorbidità (ECOG 0-1)
- No Disfunzione renale (clearance creatinina > 40 ml/min)
- Trattamenti precedenti (almeno 1 PI, IMiD, anti-CD38→ de facto si)
- No precente terapia anti-BCMA
- Aggressività e velocità della recidiva (biochimica, clinica EMD, etc)
- Logistica breve di accesso al prodotto

Scenario 1

Paziente triplo esposto o triplo refrattario

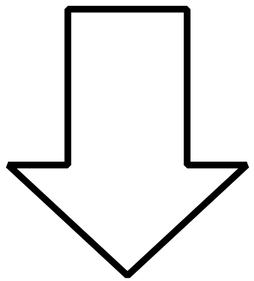


Se soddisfatte condizioni di eleggibilità a CAR-T



Allora cilta-cel

Ma… perché proprio cilta-cel?



Campionato a parte

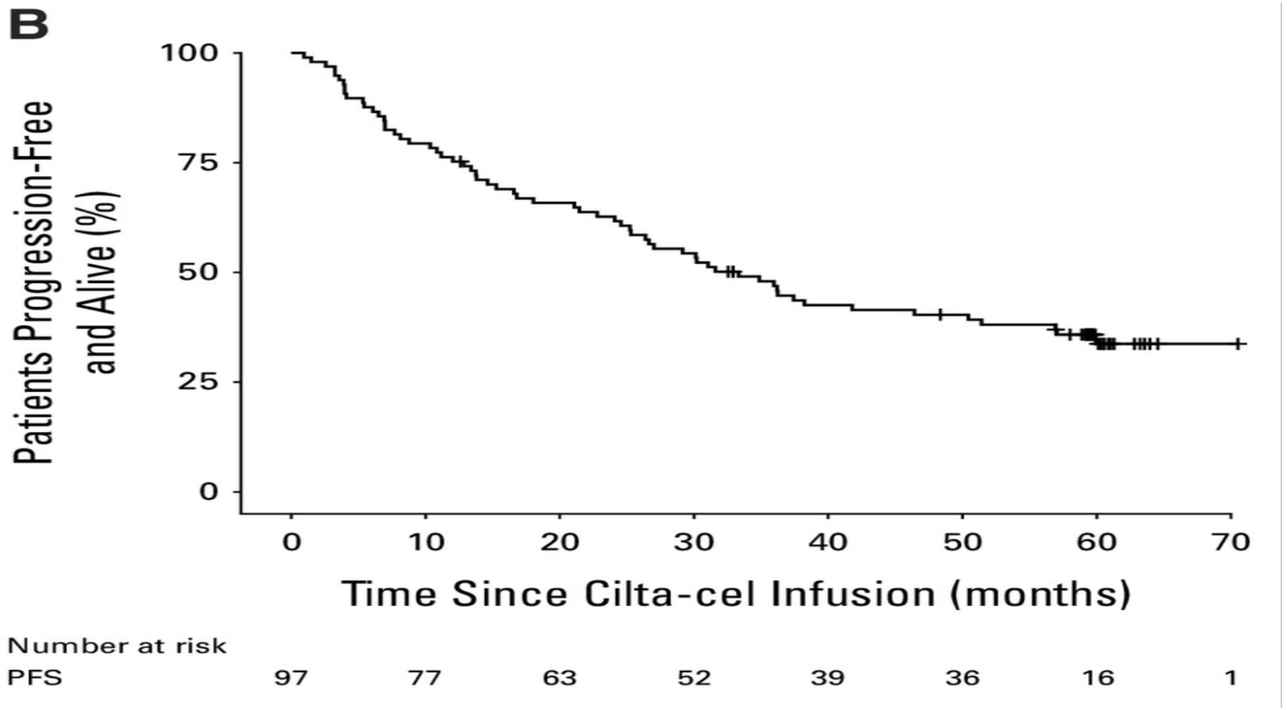
Sia nel plurirecidivato...

Studio Cartitude-1

Mediana linee precedenti 6 (3-18)

87% triple class refrattari

42% penta class refrattari



PFS mediana 34.9 mesi

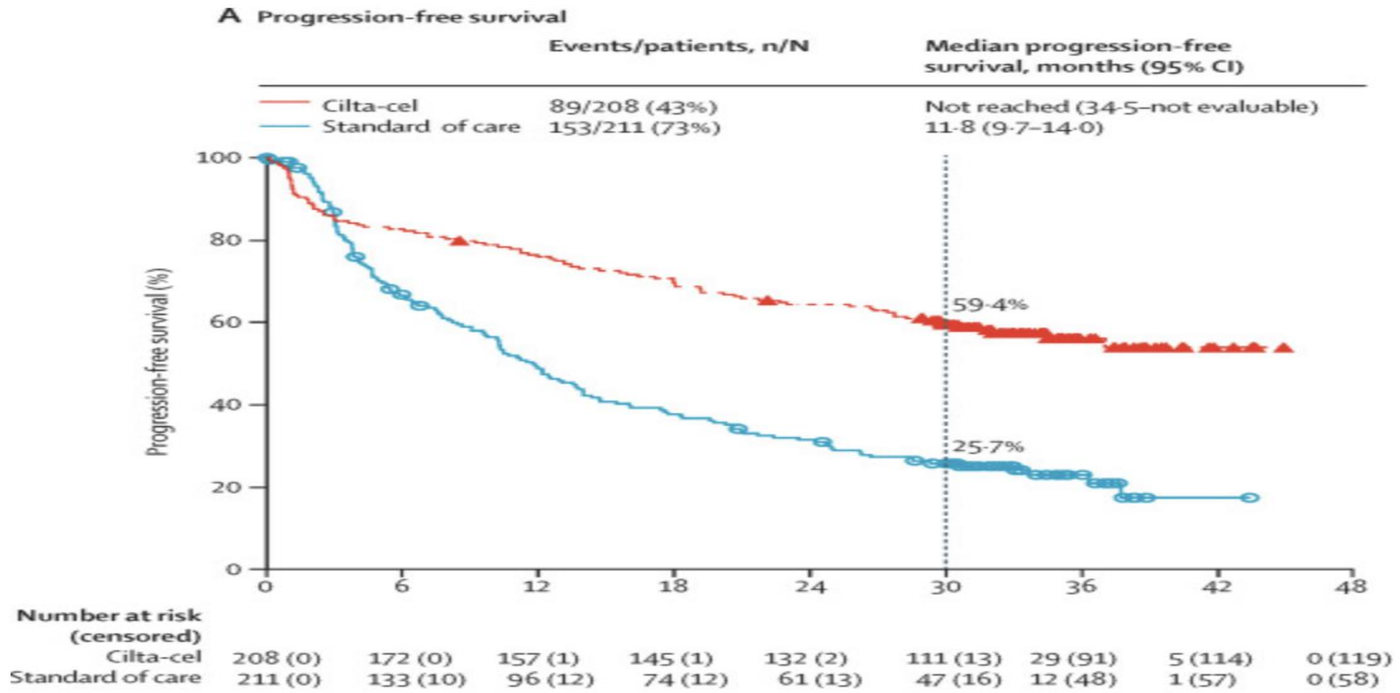
...che in linee più precoci

Studio Cartitude-4

Linee precedenti: 1 (32.7%), 2 (39.9%), 3 (27.4%)

25% triple class esposti

6.7% penta class exposure



PFS mediana non raggiunta vs 11.9 mesi

Efficace nei vari sottogruppi

Multiple Myeloma

MM-567 Ciltacabtagene Autoleucel vs Standard of Care in Lenalidomide-Refractory Multiple Myeloma: Phase 3 CARTITUDE-4 Subgroup Analysis by Cytogenetic Risk

Roberto Mina MD [1], Binod Dhakal MD [2], Jesus San-Miguel MD, PhD [3], Mi Kwon MD [4, 5], Duncan Purtill MD [6], Hila Magen MD [7, 8], Magdalena Dutka PhD [9], Michel Delforge MD [10], Ravi Vij MD, MBA [11], Stina Wichert N/A [12], Sung-Soo Yoon MD [13], Monique C. Minnema MD, PhD [14], Nikoletta Lendvai MD [15], Carolina Lonardi N/A [16], Ana Slaughter N/A [17], Martin Vogel MD, PhD [18], Katherine Li N/A [19], Diana Chen MS [20], Man Zhao PhD [21], Tzu-min Yeh MS [15]...
Joaquin Martinez-Lopez MD, PhD [27]

Multiple Myeloma

MM-549 Ciltacabtagene Autoleucel vs Standard of Care in Patients With Functional High-Risk Multiple Myeloma: CARTITUDE-4 Subgroup Analysis

Luciano Costa MD [1], Katja Weisel MD [2], Niels WCJ van de Donk MD, PhD [3], Surbhi Sidana MD [4], Yaël Cohen MD [5], Duncan Purtill MD [6], Cyrille Touzeau MD, PhD [7], Carlos Fernández de Larrea MD, PhD [8], Joaquin Martinez-Lopez MD [9], Nikoletta Lendvai MD [10], Ana Slaughter [11], Carolina Lonardi N/A [12], Man Zhao [13], Katherine Li [14], Martin Vogel MD, PhD [15], Mythili Koneru MD, PhD [16], Nitin Patel [16], Erika Florendo MD [16], Octavio Costa Filho MD [16], Maria-Victoria Victoria MD, PhD [17]

EMN: POSTERS

P48 | LONG-TERM PROGRESSION-FREE SURVIVAL BENEFIT WITH CILTACABTAGENE AUTOLEUCEL IN STANDARD-RISK RELAPSED/REFRACTORY MULTIPLE MYELOMA

D. Dytfeld [1], L.J. Costa [2], A. Oriol [3], S. Manier [4|5], P.M. Voorhees [6], Y. Lin [7], M. Htut [8], W. Roeloffzen [9], P. J. Ho [10|11], U. Shah [12|13], M. Zhao [14], Q. Li [15], A. Balogh [15], K. Li [15], A. Slaughter [15], N. Benachour [15], C. Lonardi [15], A. Ghosh [15], H. Sun [15], N. Lendvai [15], T. Lengil [15], N. Patel [16], M. Koneru [16], E. Florendo [16], O. Costa Filho [16], V. Mahajan [16], P. Rodríguez-Otero [17], C. Strouse [18], A.K. Stewart [19|20], S. Sidana [21]
Affiliations +

Vol. 111 No. s2 (2026): Abstract Book of the 7th European Myeloma Network Meeting, Prague, 16–18 April 2026
https://doi.org/10.3324/haematol.2026.s2.14061

Tossicità neurologica
Rara ma distintiva

Tossicità neurologica tardiva Non -ICANS

blood® advances

Available online 30 March 2026

In Press, Journal Pre-proof ? What's this?

Systematic Review

Non-ICANS Neurologic Toxicity after BCMA CAR T: A systematic review and meta-analysis of 4630 multiple myeloma patients *, †,

Herman van Besien [*1], Gwynne Ozkan [*1], Neela Easton [1], Tobias Tix [2], Mohammad Alhomoud [1 3], Roni Shouval [1 3], Kai Rejeski [† 2 3], Samuel Yamshon [† 1 4]

N= 4630 pts

Paralisi nervi cranici: 32.3%

Disturbi cognitivi e del movimento: 12%

Neuropatie periferiche: 7.5%

Parkinsonismo

5/60 pazienti trattati a Chicago

Tempo mediano di insorgenza: 26 giorni

Spesso associata a linfocitosi CAR nel liquor

Refrattarietà a steroide e levo dopa

MTX intratecale o ciclofosfamide ad alte dosi

Kaitlin Kelly, Jennifer H. Cooperrider, Michael R. Bishop, Satyajit Kosuri, Andrzej Jakubowiak, Benjamin A. Derman; Intrathecal chemotherapy for ciltacabtagene autoleucel–associated movement and neurocognitive toxicity. *Blood Adv* 2025; 9 (14): 3613–3616. doi: https://doi.org/10.1182/bloodadvances.2024015721

Fattori di rischio e strategia di mitigazione

1. Alto burden di malattia all'infusione
2. CRS ≥ 2
3. ICANS
4. Picco di espansione CAR-T > 1000 cellule a giorno 14
5. Persistenza CART > 300 cellule al gg +56

1. Bridging therapy efficace
2. Trattamento intensivo di CRS ed ICANS
3. Riconoscimento precoce
4. Monitoraggio stretto

Paula Rodríguez-Otero, Non-ICANS Neurologic Events in Patients With Relapsed/Refractory Multiple Myeloma Treated With Ciltacabtagene Autoleucel: Clinical Presentation and Management in CARTITUDE Studies,Clinical Lymphoma Myeloma and Leukemia,

Scenario 2

Paziente

- Non candidato a cilta-cel nell'immediato ma che potrebbe esserlo in futuro
- Non ancora triplo esposto/refrattario (post dara-RD)
- Tempi logistici lunghi per l'accesso al prodotto (holding therapy)

Meeting Abstract: 2025 ASCO Annual Meeting I

FREE ACCESS | Hematologic Malignancies—Plasma Cell Dyscrasia | May 28, 2025 | Latest version

Disease response at apheresis and association with long-term outcomes following CAR-T cells for relapsed/refractory multiple myeloma (RRMM).

Authors: Thomas Luo, Luca Paruzzo, Sandra P. Susanibar Adaniya, Alfred L. Garfall, Matthew Ho, Shivani Kapur, Marco Ruella, Edward Allen Stadtmauer, Federico Stella, Dan T. Vogl, Adam J. Waxman, and Adam D. Cohen | AUTHORS INFO & AFFILIATIONS

N=149

Follow up mediano: 14 mesi

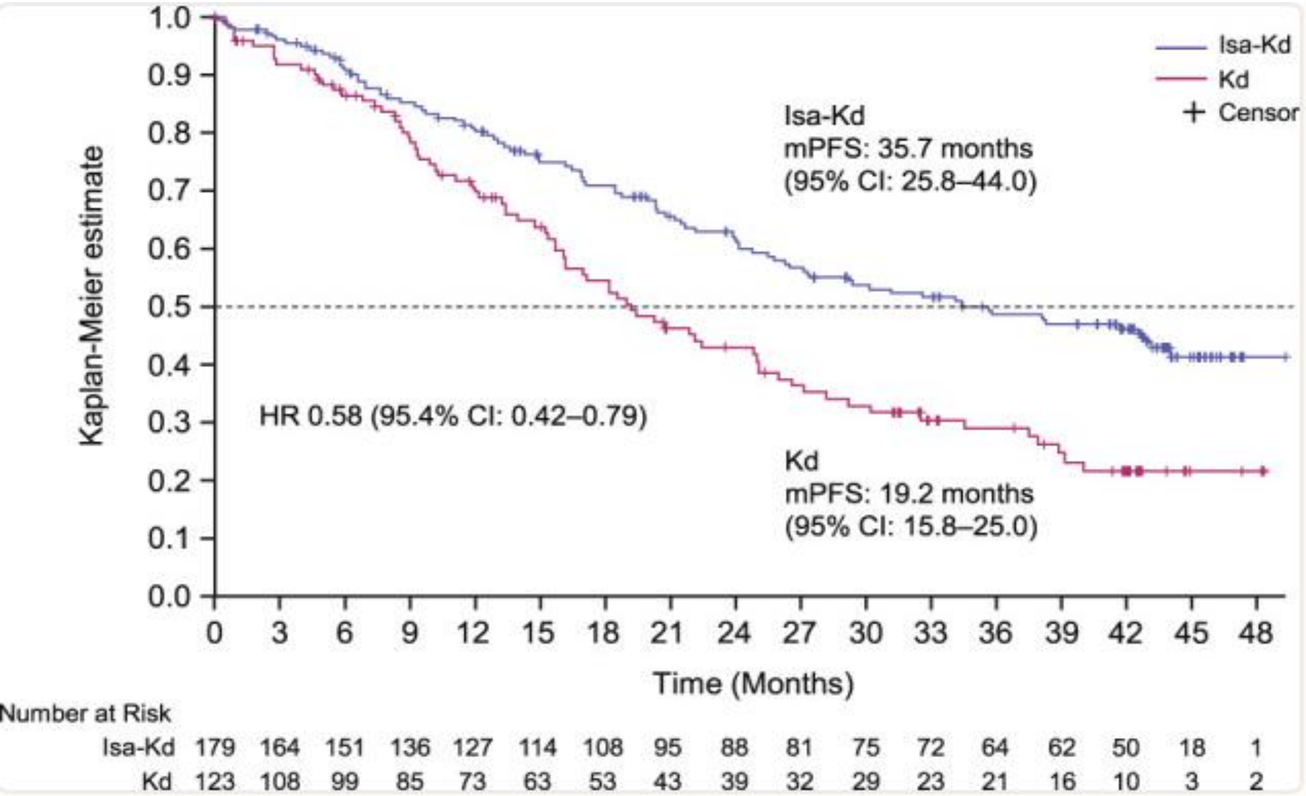
CAR-T come consolidamento vs. CAR-T alla progressione

Nel gruppo CAR-T di consolidamento gli outcomes sono stati migliori (≥VGPR, 86% vs. 66%; PFS mediana non raggiunta vs. 10 mesi)

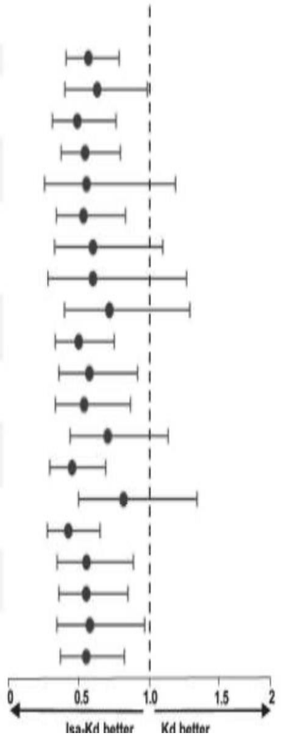
Evitare altre terapie anti-BCMA→ no regimi a base belantamab

Valutazione status verso anti-CD38:
- Se esposto→ ISA-KD
- Se refrattario→ SVD o KD56

Studio IKEMA



Subgroup		Isa-Kd Events/total	Kd Events/total	Hazard ratio (95% CI)
All patients		86/179	77/123	0.576 (0.418–0.792)
Age	<65 years	43/88	38/66	0.637 (0.410–0.990)
	≥65 years	43/91	39/57	0.497 (0.321–0.771)
Baseline eGFR (MDRD)	≥60 mL/min/1.73 m²	55/122	60/93	0.553 (0.382–0.801)
	<60 mL/min/1.73 m²	23/43	10/18	0.562 (0.266–1.189)
ISS staging at study entry	I	39/89	43/71	0.541 (0.350–0.837)
	II	34/63	17/31	0.608 (0.336–1.099)
	III	13/26	16/20	0.607 (0.290–1.268)
High-risk cytogenetic status	Yes	26/42	21/31	0.724 (0.406–1.290)
	No	50/114	48/77	0.508 (0.341–0.758)
1q21+	Yes	39/75	35/52	0.582 (0.368–0.923)
	No	39/84	33/55	0.546 (0.342–0.873)
Number of prior lines of therapy (IRT)	1	41/80	31/55	0.712 (0.445–1.138)
	>1	45/99	46/68	0.460 (0.302–0.698)
Prior PI treatment*	Yes	43/81	26/47	0.824 (0.506–1.343)
	No	43/98	51/76	0.434 (0.286–0.657)
Prior IMiD treatment*	Yes	37/81	37/62	0.562 (0.355–0.892)
	No	49/98	40/61	0.560 (0.367–0.854)
Refractory to lenalidomide	Yes	31/57	30/42	0.586 (0.353–0.972)
	No	55/122	47/81	0.560 (0.378–0.829)



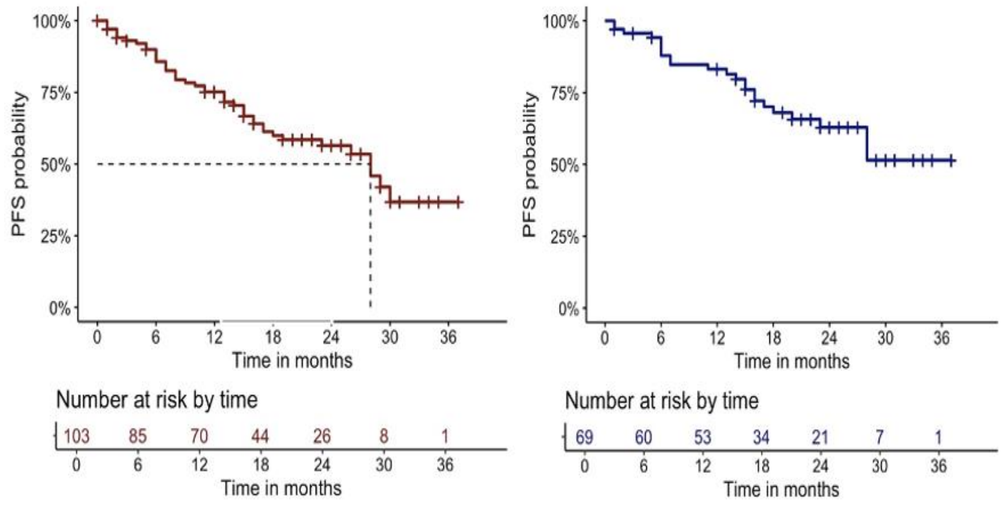
Scarsa rappresentazione pazienti refrattari a lenalidomide (32%)

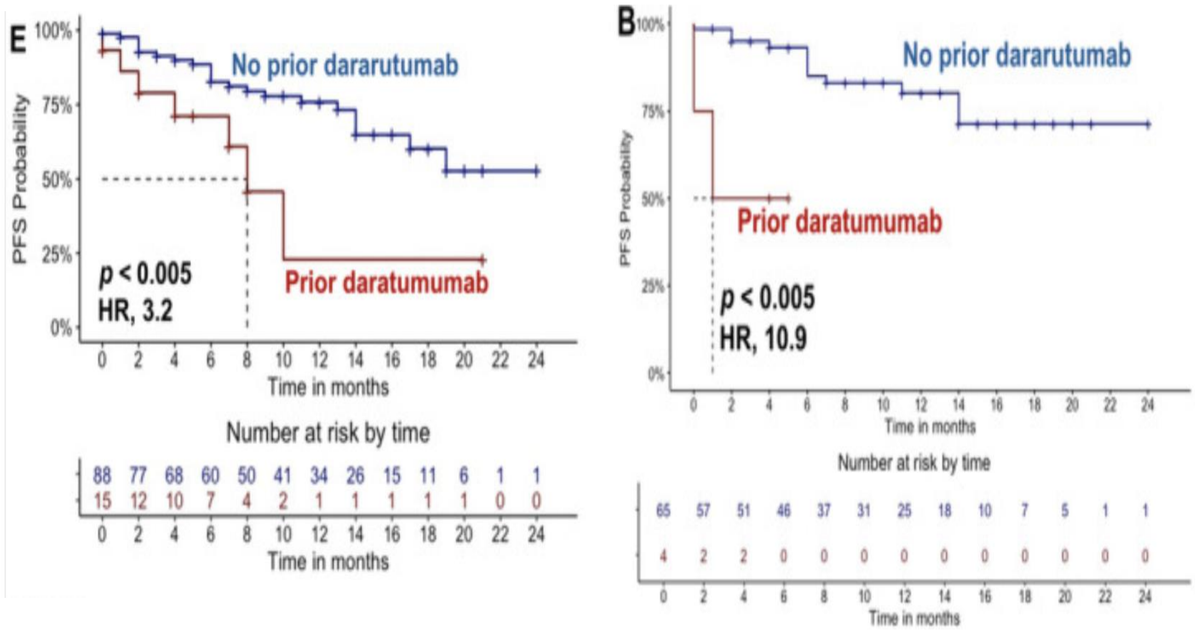
No pazienti anti-CD38 esposti/refrattari

Real-life per colmare il gap dei trials clinici

Eur J Haematol. 2024 Oct 6;114(1):105–114. doi: 10.1111/ejh.14314

Clinical Efficacy of Isatuximab Plus Carfilzomib and Dexamethasone in Relapsed/Refractory Multiple Myeloma Patients



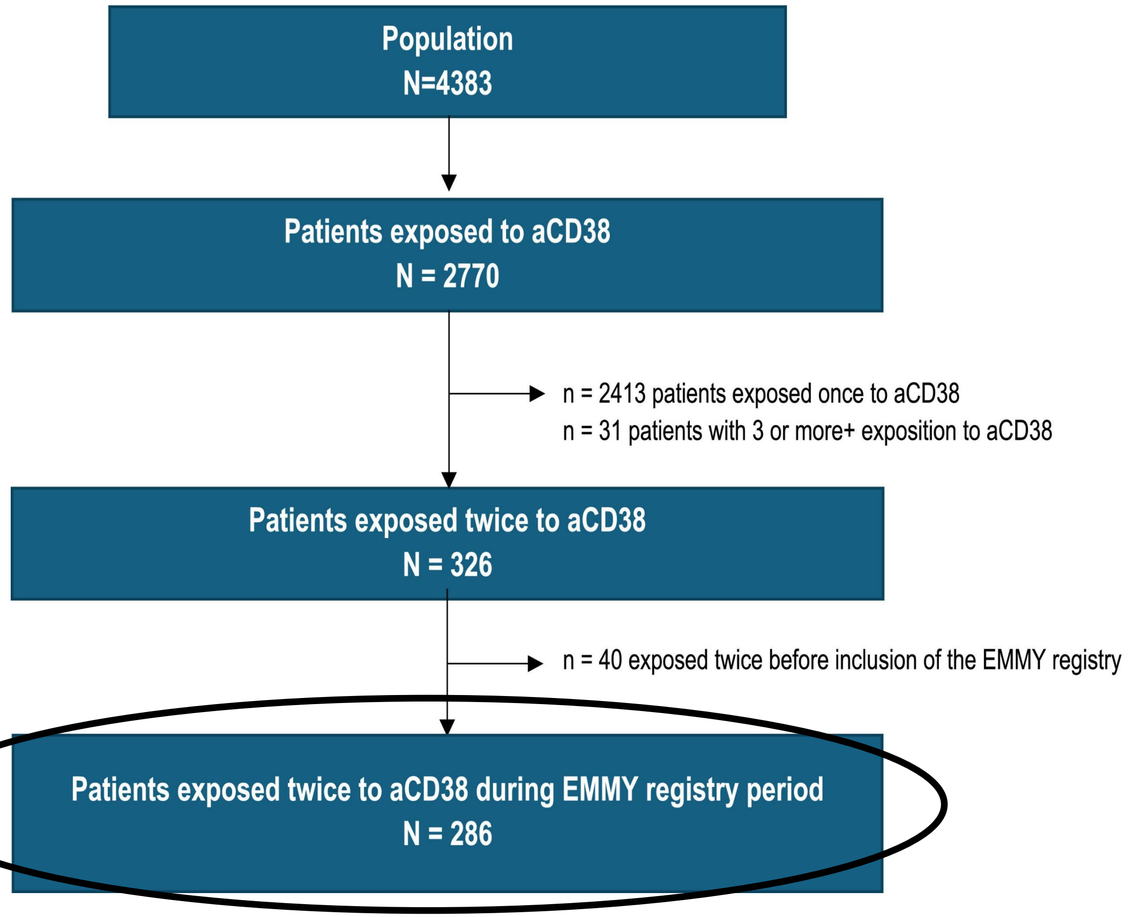


Mediana linee precedenti 1 (1-3)

Lenalidomide esposti/refrattari 19%-71%

Ritrattamento con anti-CD38

Studio EMMY



Exposure to aCD38	Yes	286 (100.0)
aCD38	Daratumumab	267 (93.4)
	Isatuximab	19 (6.6)
Refractory to aCD38	Yes	209 (73.1)
	No	76 (26.6)

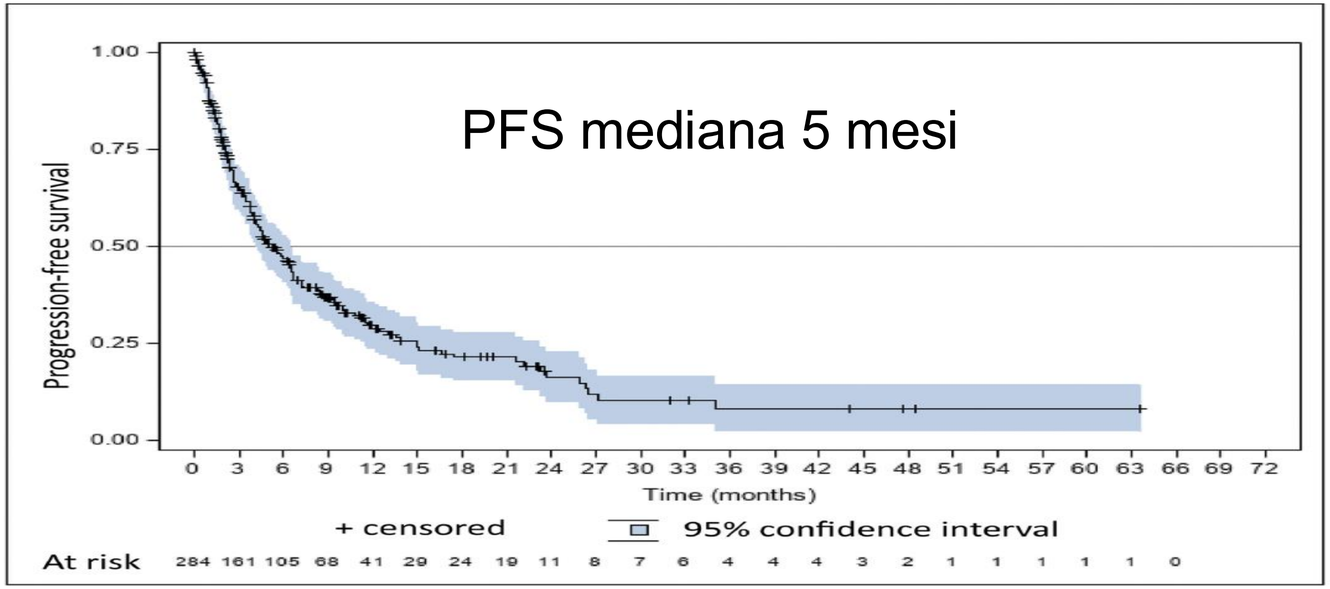
Talbot A, Hulin C, Perrot A**Retreatment With Anti-CD38-Based Combinations in Multiple Myeloma in Real-Life: Results From the Emmy Cohort Study** Clinical Lymphoma, Myeloma and Leukemia,2025; 25, 863-872

Ritrattamento con anti-CD38

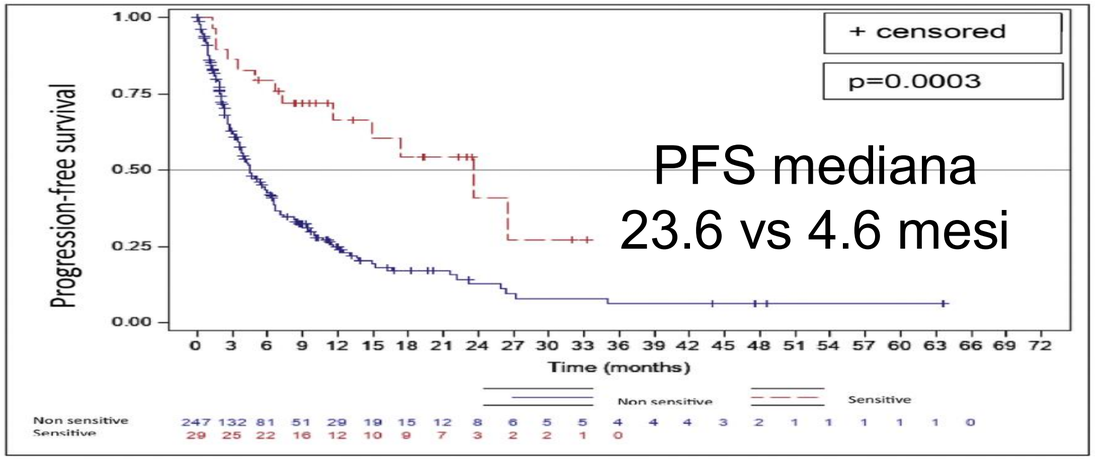
Refrattarietà < 90 giorni

Non refrattarietà e no sensibilità: tra 90 giorni e 11 mesi

Sensibilità > 12 mesi



A

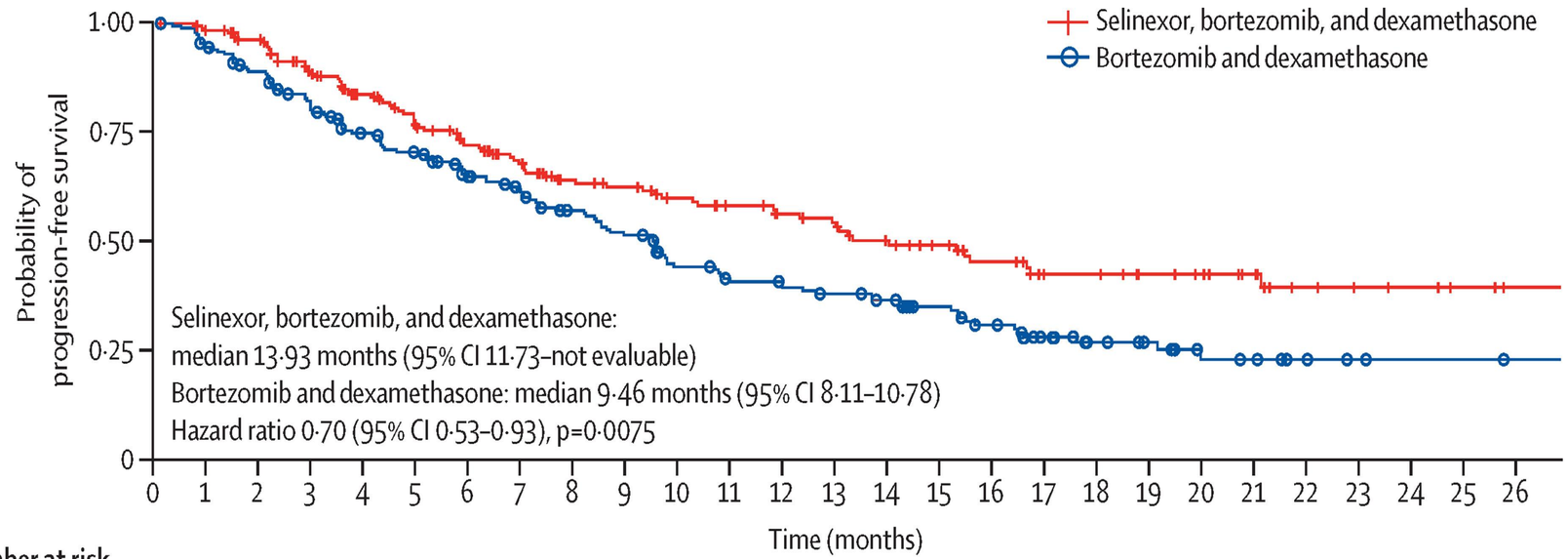


Ritrattamento con anti-CD38

Complessivamente pochi dati disponibili, provenienti da studi perlopiù osservazionali

Ritrattare con anti-CD 38 come holding therapy permette di controllare la malattia per un periodo anche breve, sufficiente per avere accesso a cilta-cel

Studio Boston

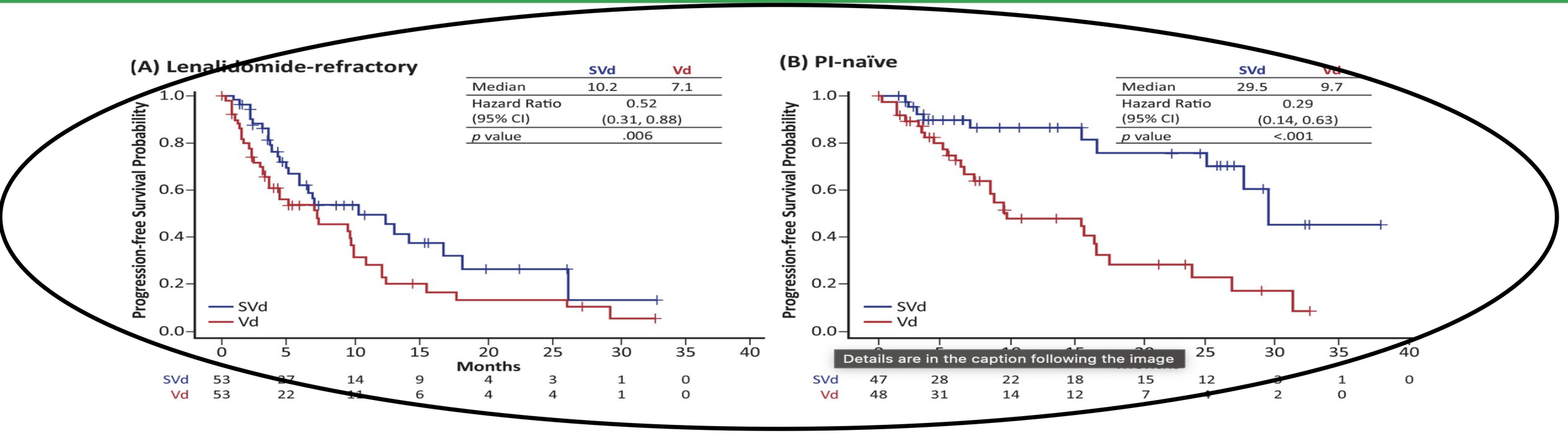


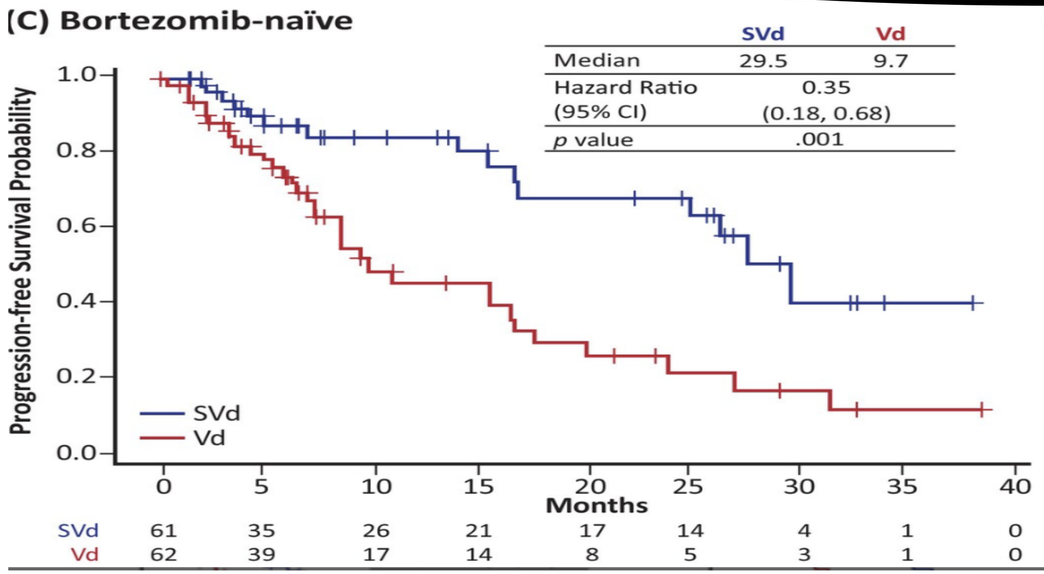
Number at risk (number censored)

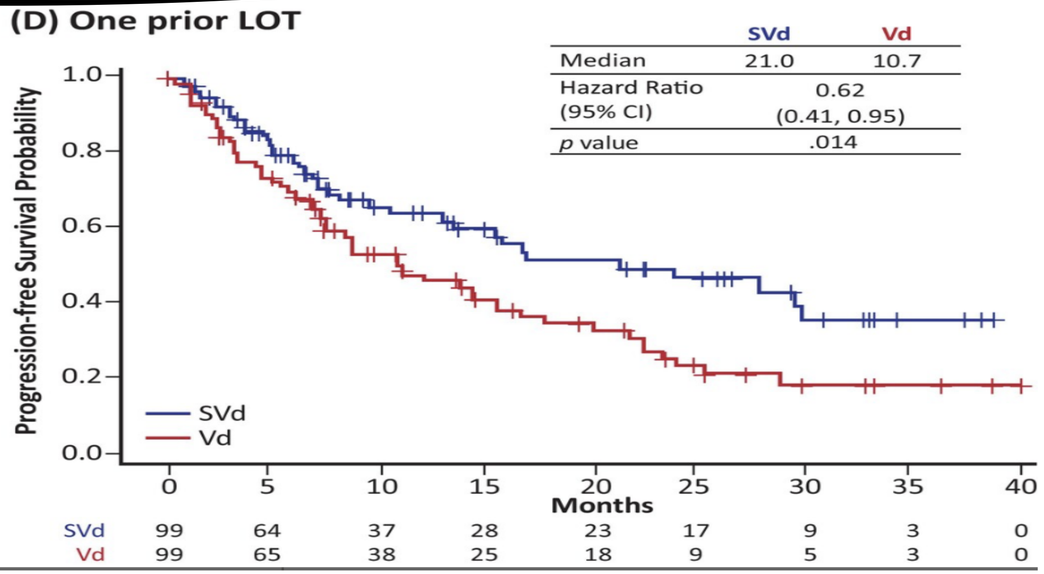
Selinexor, bortezomib, and dexamethasone	195 (0)	187 (5)	175 (12)	152 (21)	135 (31)	117 (37)	106 (42)	89 (50)	79 (57)	76 (59)	69 (63)	64 (66)	57 (71)	51 (73)	45 (76)	41 (80)	35 (83)	27 (89)	26 (90)	22 (94)	19 (97)	14 (102)	9 (106)	7 (108)	6 (109)	4 (111)	2 (113)
Bortezomib and dexamethasone	207 (0)	187 (8)	175 (10)	152 (15)	138 (20)	127 (22)	111 (29)	100 (32)	90 (37)	81 (37)	66 (41)	59 (43)	56 (44)	53 (45)	49 (47)	42 (52)	35 (55)	26 (60)	20 (65)	16 (69)	10 (73)	8 (75)	5 (78)	4 (79)	3 (80)	3 (80)	2 (81)

PFS mediana 13.93 mesi

Mateos, M. V., Engelhardt, M., Leleu, X., Mesa, M. G., Cavo, M., Dimopoulos, M., Bianco, M., Merlo, G. M., Porte, C., Richardson, P. G., & Moreau, P. (2024). Impact of prior treatment on selinexor, bortezomib, dexamethasone outcomes in patients with relapsed/refractory multiple myeloma: Extended follow-up subgroup analysis of the BOSTON trial. *European journal of haematology*, *113*(2), 242–252. https://doi.org/10.1111/ejh.14223


(A) Lenalidomide-refractory
SVd Vd
Median 10.2 7.1
Hazard Ratio (95% CI) 0.52 (0.31, 0.88)
p value .006
Progression-free Survival Probability
SVd
Vd
Months
SVd 53 27 14 9 4 3 1 0
Vd 53 22 11 6 4 4 1 0
(B) PI-naïve
SVd Vd
Median 29.5 9.7
Hazard Ratio (95% CI) 0.29 (0.14, 0.63)
p value <.001
Progression-free Survival Probability
SVd
Vd
Details are in the caption following the image
SVd 47 28 22 18 15 12 3 1 0
Vd 48 31 14 12 7 4 2 0


(C) Bortezomib-naïve
SVd Vd
Median 29.5 9.7
Hazard Ratio (95% CI) 0.35 (0.18, 0.68)
p value .001
Progression-free Survival Probability
SVd
Vd
Months
SVd 61 35 26 21 17 14 4 1 0
Vd 62 39 17 14 8 5 3 1 0


(D) One prior LOT
SVd Vd
Median 21.0 10.7
Hazard Ratio (95% CI) 0.62 (0.41, 0.95)
p value .014
Progression-free Survival Probability
SVd
Vd
Months
SVd 99 64 37 28 23 17 9 3 0
Vd 99 65 38 25 18 9 5 3 0

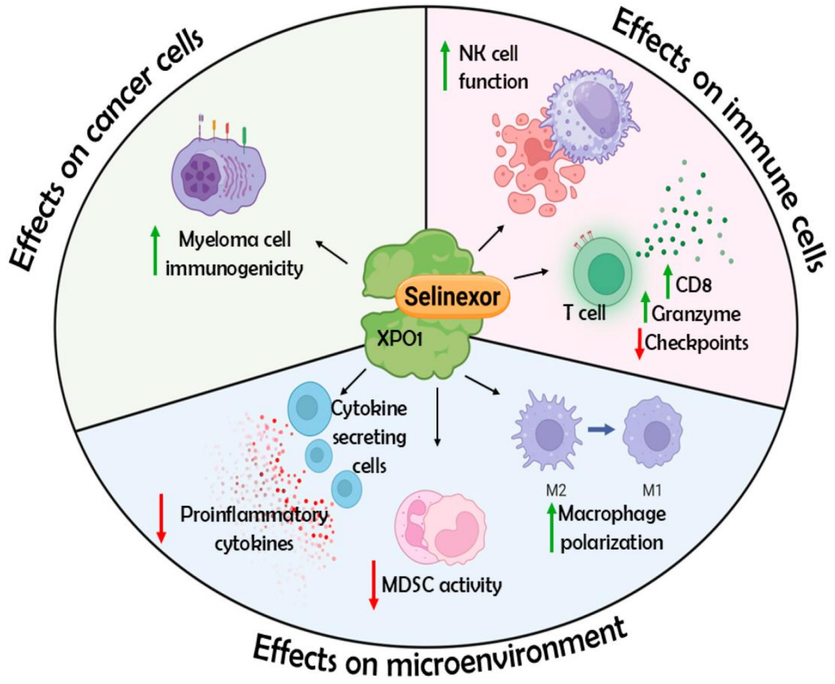
Selinexor ed immunoterapia

Focusing on Selinexor for Holding and Bridging Prior to CAR-T in Relapsed/Refractory Multiple Myeloma

by Jack Khouri [1], Douglas Sborov [2], Adriana Rossi [3], Thomas Martin [4], Trinayan Kashyap [5], Tomer Mark [5] and Muhamed Baljevic [6,*]

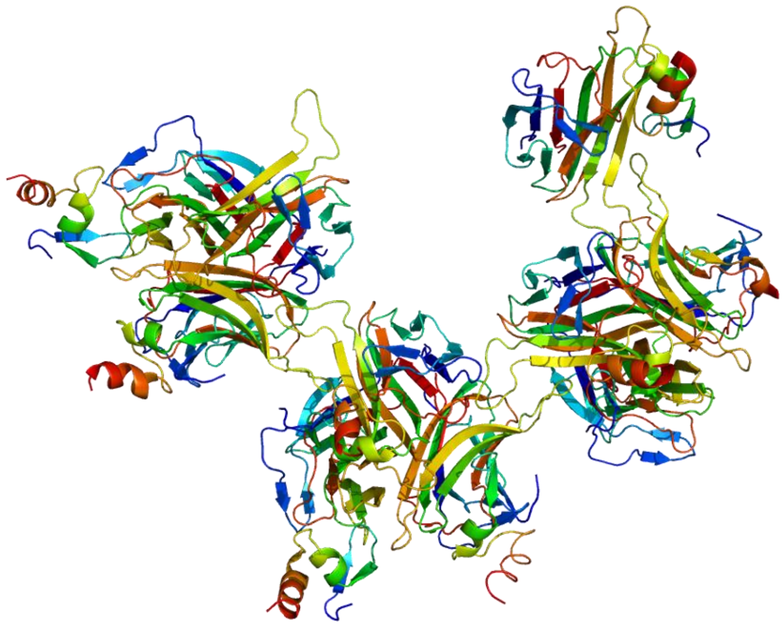
- Effetto immunomodulante e di promozione dell'espressione di BCMA

- Selinexor non solo opzione terapeutica per MMRR ma anche potenziale strumento per gestire il paziente pre-CAR-T (terapia holding/bridging)



Scenario 3

Paziente non candidato a cilta-cel



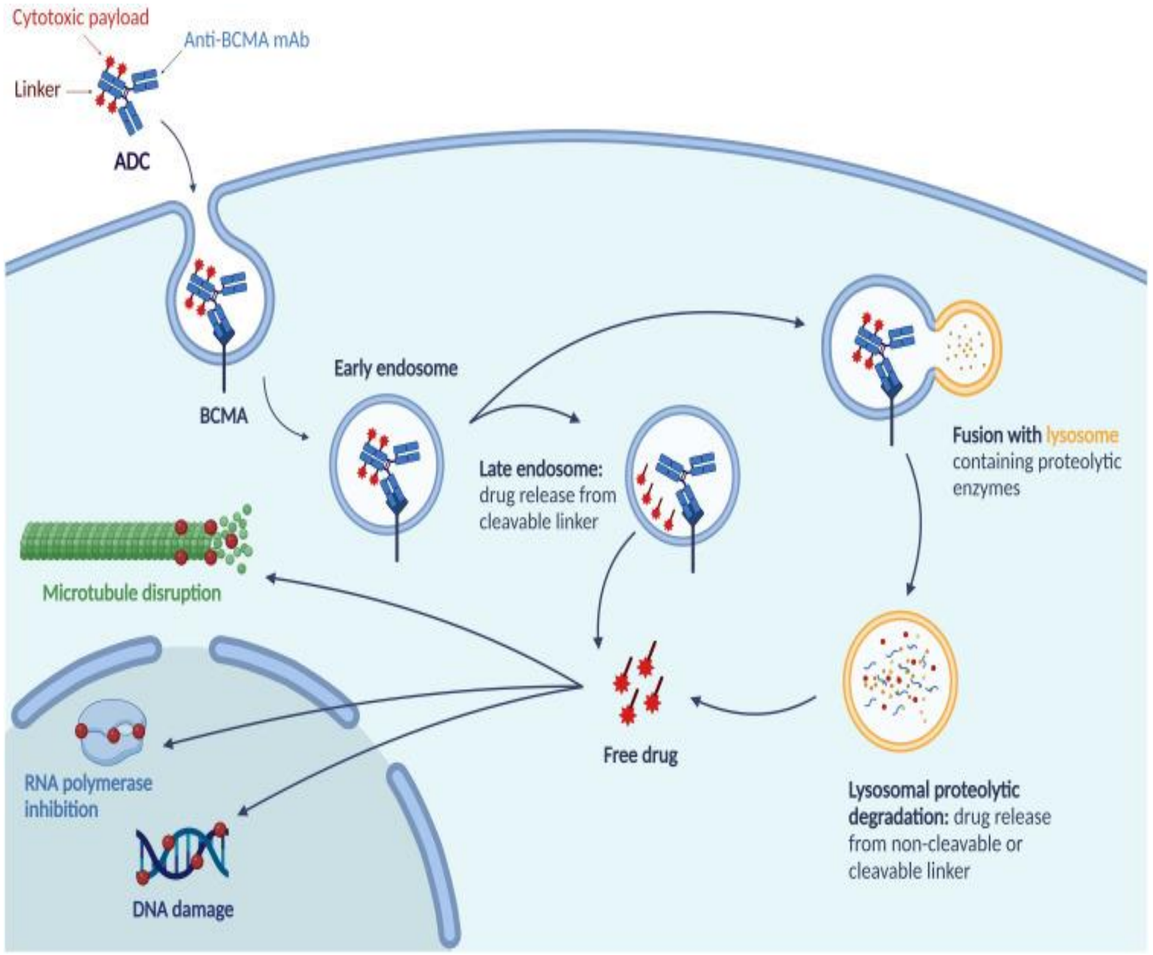
All’assalto del BCMA

Belantamab mafodotin

Anticorpo coniugato al composto citotossico monomethyl auristatina F (MMAF)

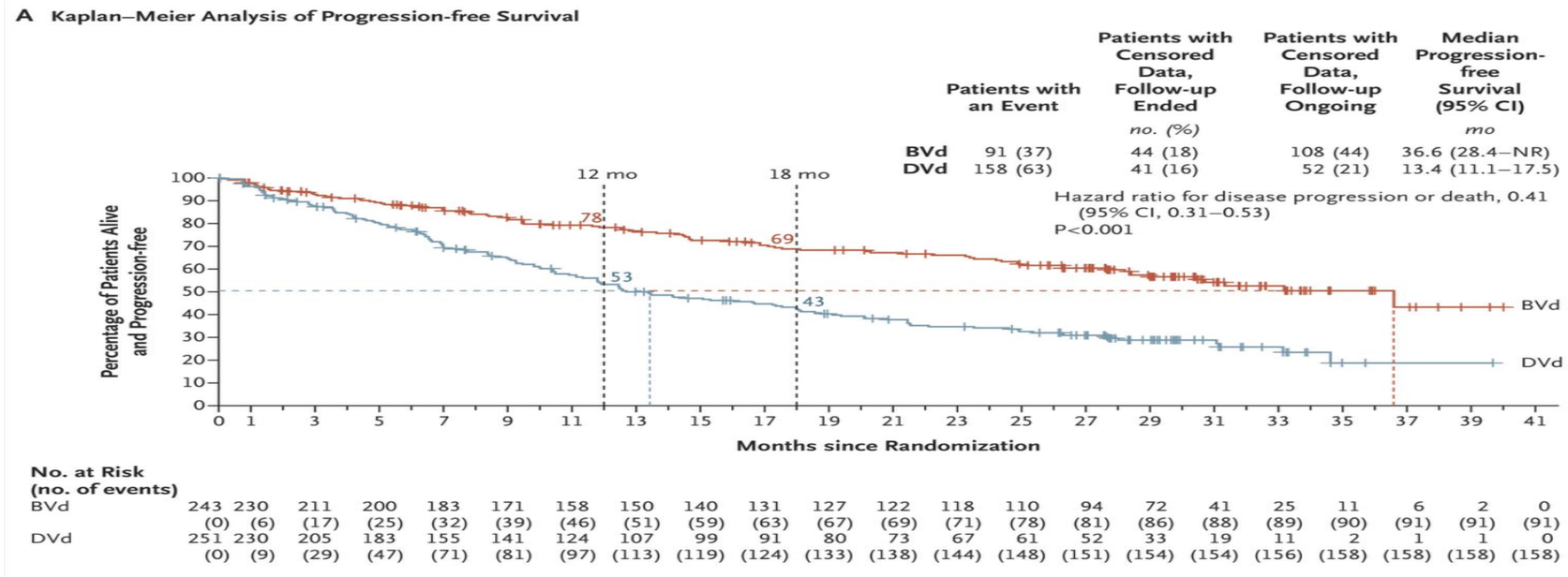
Una volta legato al BCMA sulle cellule MM, l'ADC viene internalizzato attraverso un processo di endocitosi mediata da recettore e trasportato ai lisosomi

Nell'ambiente acido dei lisosomi, viene rilasciato MMAF che si lega alla tubulina, interrompendo la formazione dei microtubuli, con arresto del ciclo cellulare ed innesco dell' apoptosi



Almodovar Diaz, A. A., Alouch, S. S., Chawla, Y., & Gonsalves, W. I. (2024). The Antibody Drug Conjugate, Belantamab-Mafodotin, in the Treatment of Multiple Myeloma: A Comprehensive Review. Blood and lymphatic cancer : targets and therapy, 14, 71–87. https://doi.org/10.2147/BLCTT.S490021

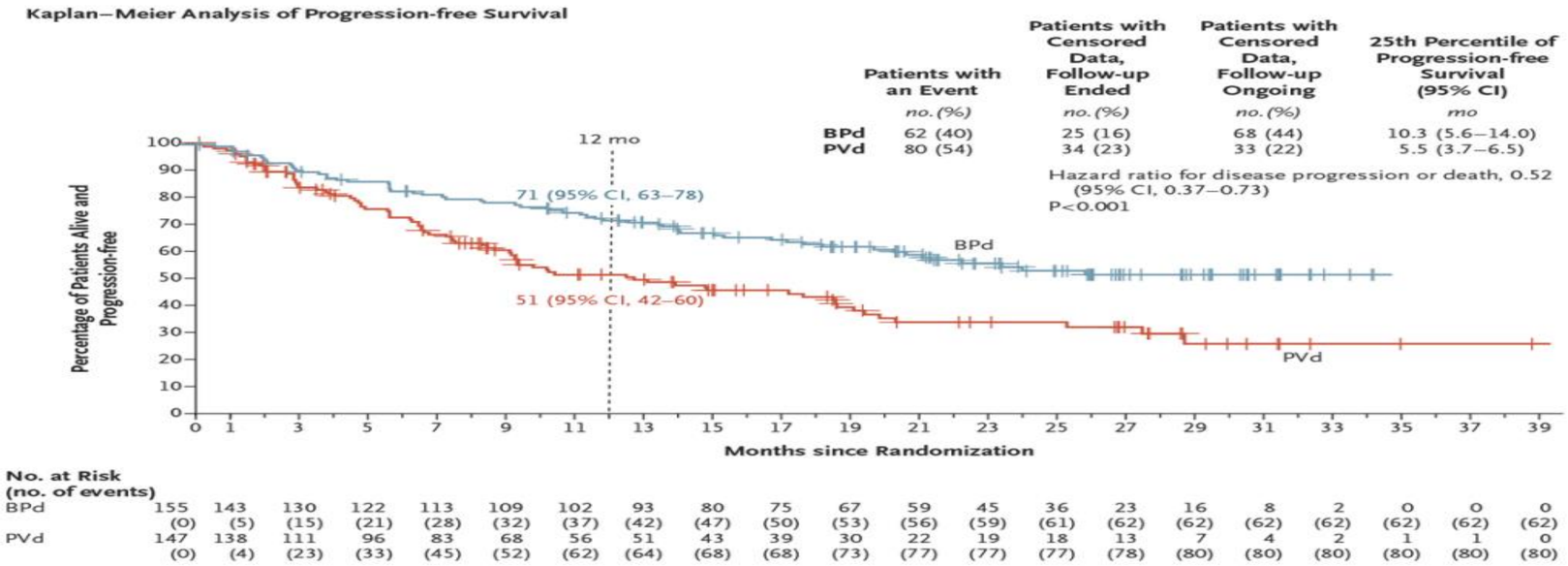
Studio DREAMM-7



PFS mediana 36.6 mesi

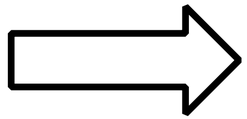
Coorte anti-CD38 naive a causa del braccio di controllo

Studio DREAMM-8

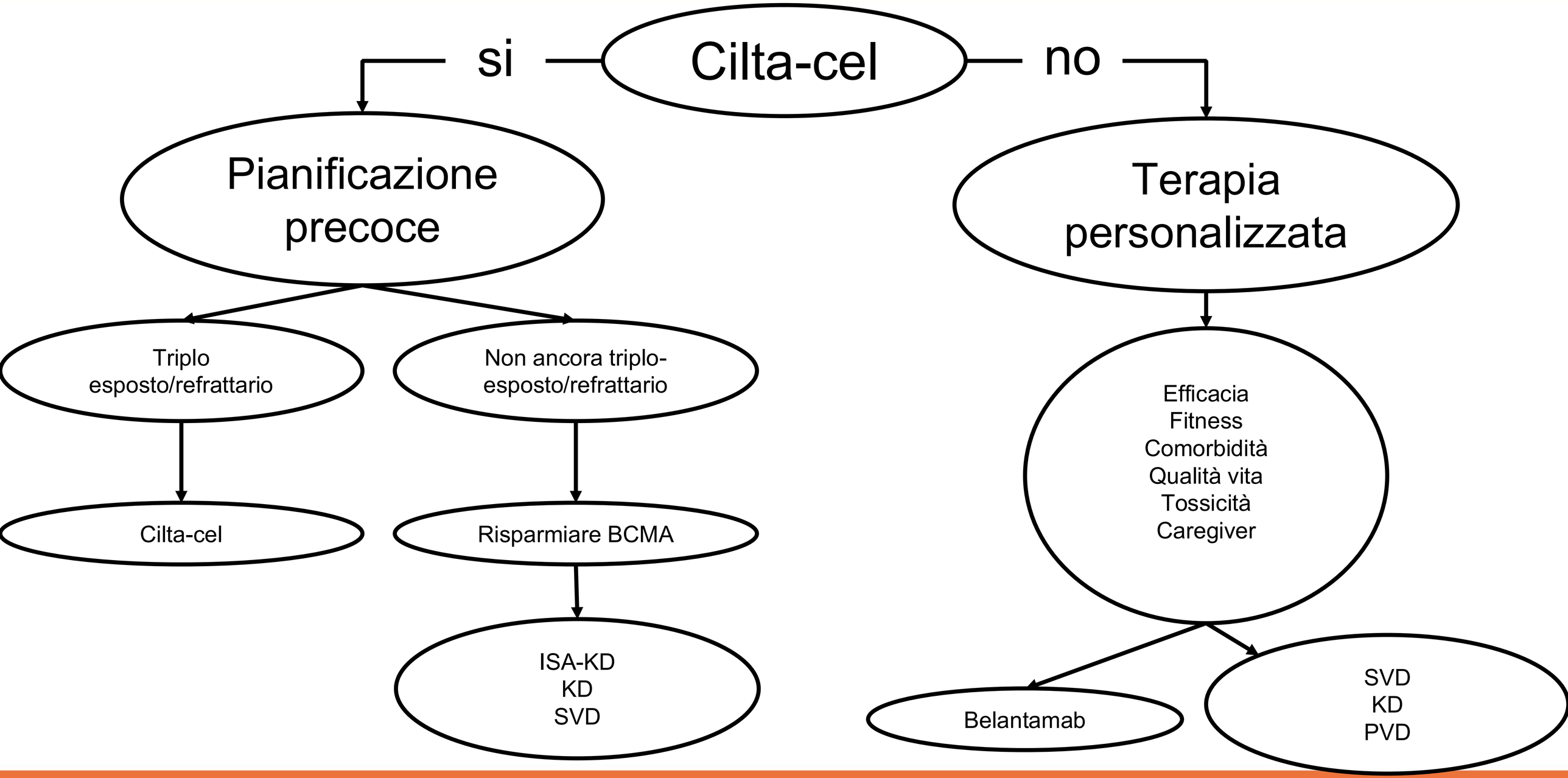


PFS mediana 32.6 mesi

25% and 29% dei pazienti con pregresso trattamento anti-CD 38



Più rappresentativa dei pz provenienti da dara-RD


Cilta-cel
si
no
Pianificazione precoce
Terapia personalizzata
Triplo esposto/refrattario
Non ancora triplo-esposto/refrattario
Cilta-cel
Risparmiare BCMA
ISA-KD
KD
SVD
Efficacia
Fitness
Comorbidità
Qualità vita
Tossicità
Caregiver
Belantamab
SVD
KD
PVD

Take home messages

La seconda linea è un momento cardine in cui si decide il futuro del paziente (attrition rate)

Oggi tutti i pazienti sono virtualmente refrattari a lenalidomide e la maggior parte esposti/refrattari ad anti-CD38

Valutare eleggibilità a CAR-T è essenziale nella scelta terapeutica

Se CAR-T ⟶ richiesta pianificazione anticipata con preservazione del target BCMA

Se non CAR-T ⟶ scelta terapeutica personalizzata

«Come cambierà la seconda linea di trattamento»

MajesTEC-3: Phase 3 Study Design

Key inclusion criteria
- RRMM
- 1-3 prior LOTs including PI and lenalidomide
  - Patients with only 1 prior LOT must have been lenalidomide refractory per IMWG criteria
- ECOG PS score of 0-2

Key exclusion criteria
- Prior BCMA-directed therapy
- Refractory to anti-CD38 mAbs[a]

1:1 randomization N=587
22 Oct 2021 to 29 Sept 2023[b]

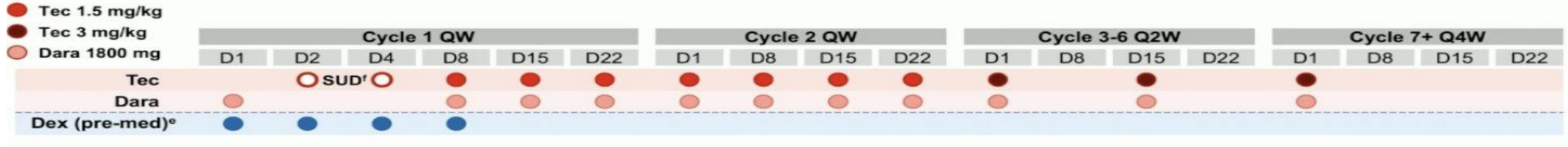
Tec-Dara
N=291
SC dosing following Dara schedule

DPd/DVd
N=296 (91% DPd)
by investigator's choice[c]

Primary endpoint
- PFS per IRC

Key secondary endpoints
- ≥CR[d] and ORR[d]
- MRD negativity (10^{-5})
- OS
- MySIm-Q Total Symptom score

Other secondary endpoints
- Safety
- PK and immunogenicity



SC dosing aligned with Dara schedule, with monthly dosing after 6 cycles; steroid sparing after Cycle 1 Day 8

[a]Prior exposure to anti-CD38 mAbs was permitted. [b]During the COVID-19 pandemic. [c]DPd/DVd were administered per the approved schedules. [d]Response and disease progression were assessed by a blinded IRC per IMWG criteria. [e]Dexamethasone, acetaminophen, and diphenhydramine pre-medication was required for the first 2 weeks; subsequent dexamethasone was not required thereafter. [f]Patients received SUD of 0.06 mg/kg and 0.3 mg/kg on Days 2 and 4, respectively.
CR, complete response; D, day; Dex, dexamethasone; DPd, daratumumab, pomalidomide, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; IMWG, International Myeloma Working Group; IRC, independent review committee; MRD, minimal residual disease; MySIm-Q, Multiple Myeloma Symptom and Impact Questionnaire; ORR, overall response rate; PFS, progression-free survival; PI, proteasome inhibitor; PK, pharmacokinetics; pre-med, pre-medication; QW, weekly; Q2W, every 2 weeks; Q4W, every 4 weeks; SC, subcutaneous; SUD, step-up dosing.

Presented by M-V Mateos at the 67th American Society of Hematology (ASH) Annual Meeting and Exposition; December 6-9, 2025; Orlando, FL, USA.

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Caratteristiche PZs

Characteristic	Tec-Dara (n = 291)	DPd/DVd (n = 296)
Age		
Median, years (range)	64 (36-88)	63 (25-84)
≥75 years, n (%)	31 (10.7)	25 (8.4)
Sex, n (%)		
Male	156 (53.6)	169 (57.1)
Female	135 (46.4)	127 (42.9)
Race, n (%)		
White	190 (65.3)	194 (65.5)
Asian	68 (23.4)	63 (21.3)
Black or African American	13 (4.5)	20 (6.8)
Other[a]	20 (6.9)	19 (6.4)

Characteristic	Tec-Dara (n = 291)	DPd/DVd (n = 296)
Baseline ECOG PS score, n (%)		
0	167 (57.4)	160 (54.1)
1	108 (37.1)	127 (42.9)
2	16 (5.5)	9 (3.0)
ISS stage, n/N (%)		
I	182 (62.5)	185 (62.5)
II	85 (29.2)	88 (29.7)
III	24 (8.2)	23 (7.8)
BMPCs ≥60%[b] n/N (%)	28/286 (9.8)	24/293 (8.2)
Presence of soft-tissue plasmacytomas, n (%)	41 (14.1)	41 (13.9)
Extramedullary plasmacytomas	14 (4.8)	17 (5.7)
High-risk cytogenetics,[c] n/N (%)	104/285 (36.5)	104/294 (35.4)

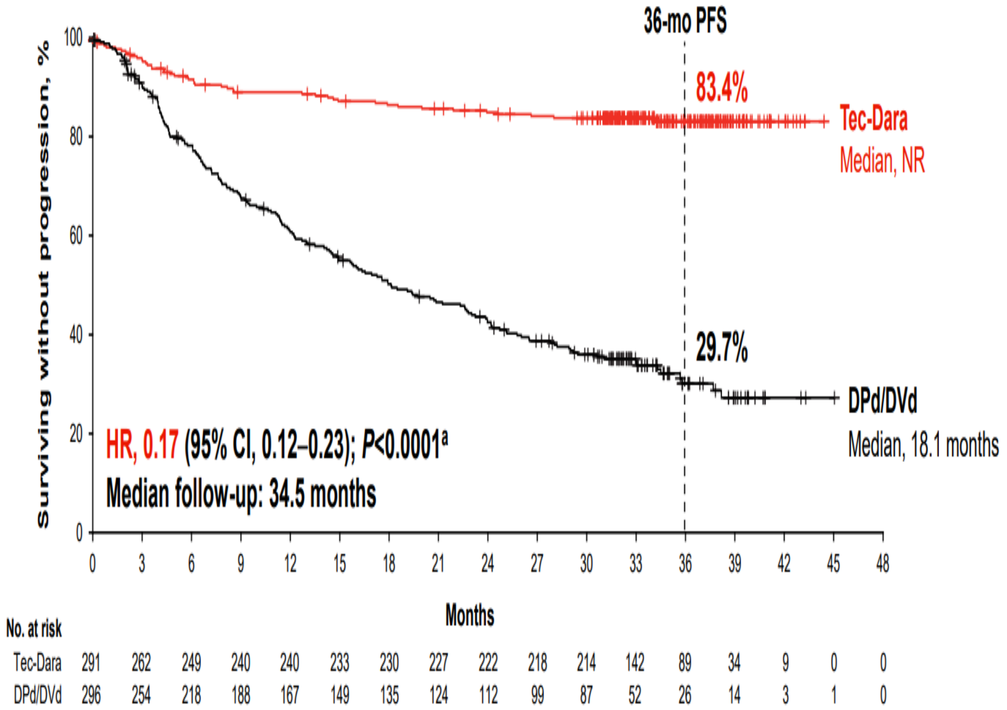
Characteristic	Tec-Dara (n = 291)	DPd/DVd (n = 296)
Prior LOT		
Median, n (range)	2 (1–3)	2 (1–3)
1 prior LOT	108 (37.1)	114 (38.5)
2 prior LOT	134 (46.0)	134 (45.3)
3 prior LOT	49 (16.8)	48 (16.2)
Prior transplantation, n (%)	210 (72.2)	226 (76.4)

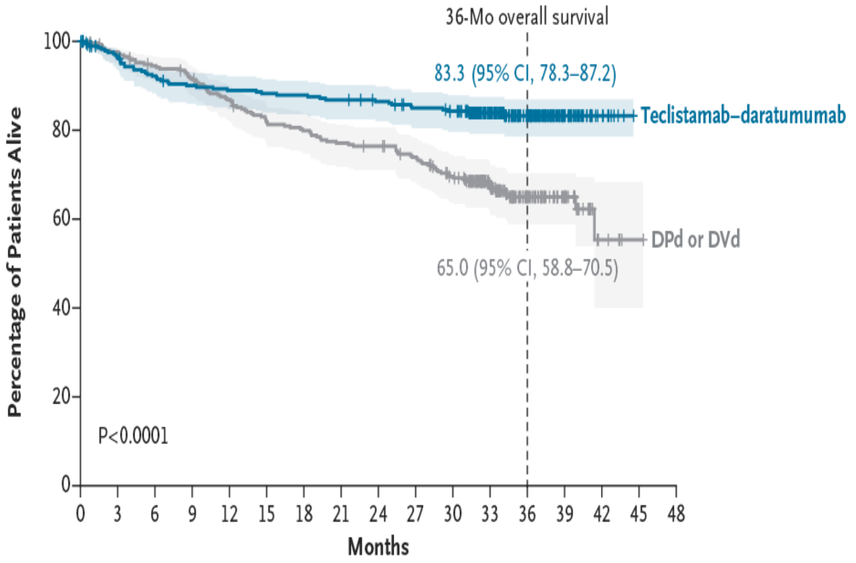
- Median prior LOT was 2
- The number of patients with prior anti-CD38 exposure was low
- >80% of patients were lenalidomide-refractory

Characteristic	Tec-Dara (n = 291)	DPd/DVd (n = 296)
Prior therapy exposure, n (%)		
PI	290 (99.7)	296 (100)
IMiD	291 (100)	296 (100)
Anti-CD38	15 (5.2)	16 (5.4)
Refractory status, n (%)		
To last line of prior therapy	250 (85.9)	251 (84.8)
Any PI	117 (40.2)	104 (35.1)
Any IMiD	247 (84.9)	253 (85.5)
Lenalidomide	240 (82.5)	251 (84.8)
Double (PI and IMiD)	99 (34.0)	88 (29.7)

Costa, L. J., Bahlis, N. J., Perrot, A., Nooka, A. K., Lu, J., Pawlyn, C., Mina, R., Caeiro, G., Kentos, A., Hungria, V., Reece, D., Niu, T., Mylin, A. K., Hansen, C. T., Teipel, R., Besemer, B., Dimopoulos, M. A., Zamagni, E., Yoshihara, S., Kim, K., … MajesTEC-3 Trial Investigators (2026). Teclistamab plus Daratumumab in Relapsed or Refractory Multiple Myeloma. *The New England journal of medicine*, *394*(8), 739–752. https://doi.org/10.1056/NEJMoa2514663

PFS&OS


36-mo PFS
83.4%
Tec-Dara
Median, NR
29.7%
DPd/DVd
Median, 18.1 months
HR, 0.17 (95% CI, 0.12–0.23); P<0.0001[a]
Median follow-up: 34.5 months
Surviving without progression, %
Months
No. at risk
Tec-Dara 291 262 249 240 240 233 230 227 222 218 214 142 89 34 9 0 0
DPd/DVd 296 254 218 188 167 149 135 124 112 99 87 52 26 14 3 1 0


36-Mo overall survival
83.3 (95% CI, 78.3–87.2)
Teclistamab–daratumumab
DPd or DVd
65.0 (95% CI, 58.8–70.5)
P<0.0001
Percentage of Patients Alive
Months
No. at Risk
Teclistamab–daratumumab 291 272 259 252 249 247 246 243 239 232 227 160 100 40 9 0 0
DPd or DVd 296 285 274 265 250 235 229 221 218 208 190 127 66 33 5 1 0

Pfizer's ELREXFIO Significantly Improves Progression-Free Survival for Double-Class Exposed Patients with Relapsed or Refractory Multiple Myeloma

Wednesday, April 29, 2026 - 06:45am | 12 min read

- *Primary endpoint met at the interim analysis in MagnetisMM-5 trial demonstrating a statistically significant and clinically meaningful improvement in progression-free survival*
- *Safety was consistent with the known ELREXFIO profile, with no new safety signals identified*
- *Trial remains ongoing to assess overall survival, a key secondary endpoint*
- *Interim efficacy results further strengthen confidence in development strategy for ELREXFIO as monotherapy and in combination, across multiple lines of therapy*

NEW YORK--(BUSINESS WIRE)-- Pfizer Inc. (NYSE: PFE) today announced positive topline results from the Phase 3 MagnetisMM-5 study evaluating ELREXFIO® (elranatamab) as monotherapy in adults with relapsed or refractory multiple myeloma (RRMM) who received at least one prior line of treatment. The study demonstrated a statistically significant and clinically meaningful improvement in the primary endpoint of progression-free survival (PFS), as assessed by blinded independent central review (BICR), versus standard-of-care daratumumab plus pomalidomide and dexamethasone (DPd). The safety and tolerability of ELREXFIO was consistent with its known safety profile.

La seconda linea verso il futuro

Ruolo sempre più crescente
dell'immunoterapia

↓

Cilta-cel
Bispecifici in associazione
Bispecifici in monoterapia

↓

Quali criteri useremo per scegliere?
Quale terapia a chi?

CaMMpania
IL GRUPPO MIELOMA CAMPANO

Grazie per l'attenzione!