WEDNESDAY, SEPTEMBER 9, 2026 VOLUME 1 OF 4

soho

Insider DAILY EDITION

Daily news from the SOHO 2026 Annual Meeting

PRESIDENT'S LETTER

Advancing care means protecting the environment that makes discovery possible

"The future of discovery depends on both good ideas and on the systems that allow those ideas to reach patients. We cannot lose sight of that responsibility," Dr. DiPersio writes in this year's welcome address.

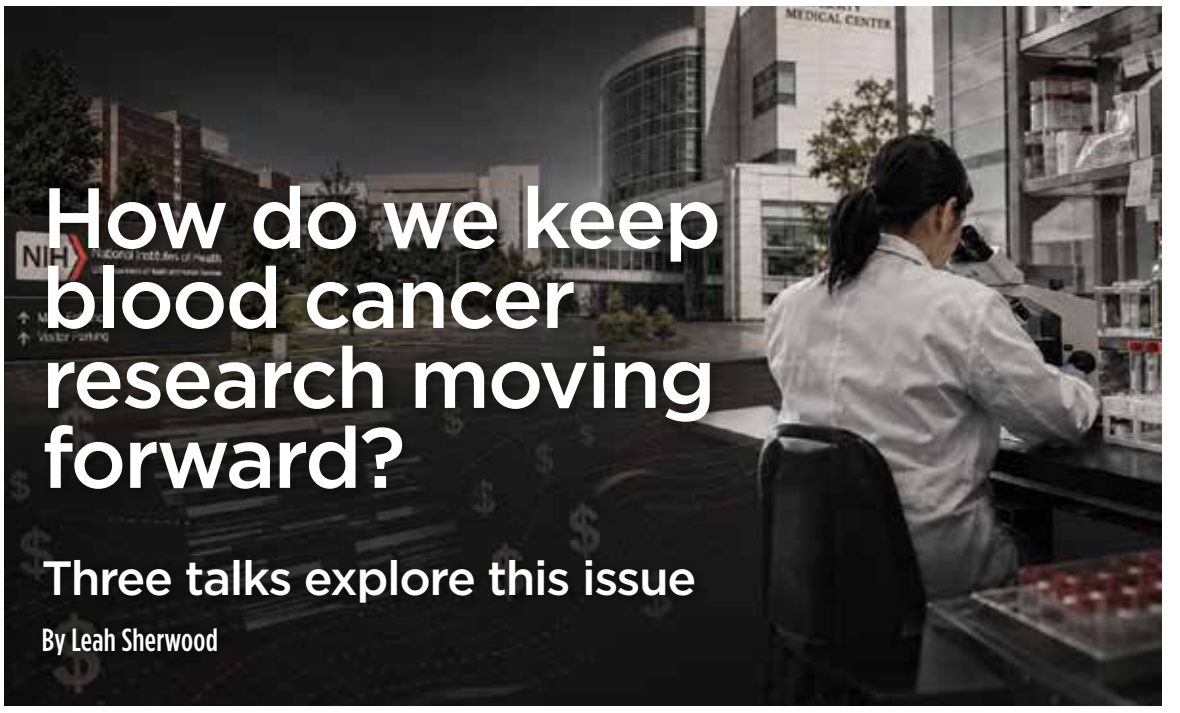
By John F. DiPersio, MD, PhD

It has been my privilege to serve as SOHO president for the 2025–2026 term. Despite the many challenges we face as clinicians and as a society, we can still take encouragement from the remarkable progress made in recent years to bring more effective therapies to patients with blood cancers.

In recent years, we have witnessed the emergence of entirely new classes of therapies, including next-generation immune engagers, CRISPR-engineered T cell and stem cell products, menin inhibitors, and CELMoDs. We are moving beyond chemotherapy-alone approaches toward more rational, combination-based strategies. For the first time, clinicians are beginning to speak more seriously about the possibility of cure in diseases such as multiple myeloma in select patient populations, an idea that would have seemed out of reach not long ago.

These advances are translating into

SEE *WELCOME ADDRESS* ON PAGE 15



How do we keep blood cancer research moving forward?

Three talks explore this issue

By Leah Sherwood

When it comes to funding scientific research, Washington appears to be speaking with two voices.

The Trump administration has repeatedly proposed steep reductions in federal research spending, while Congress has pushed back against many of those cuts and continued to fund biomedical research. For fiscal year 2026, the administration sought to reduce National Institutes of

SEE *RESEARCH* ON PAGE 12

AWARD SPOTLIGHT

Alan List, MD, to receive SOHO Freireich Pioneer Award, deliver Wednesday plenary on lower-risk MDS

By Rami Komrokji, MD

Alan List, MD

As the recipient of this year's Emil J. Freireich Distinguished Pioneer Award, **Alan List, MD,** will present the Wednesday plenary session, "The emerging promise of biologically rational therapies for lower risk MDS."

Dr. List, of Stelexis BioSciences, is widely regarded as one of the clinicians who helped reshape the understanding and treatment of lower-risk myelodysplastic syndromes (MDS). Dr. List has played a central role in many of the discoveries that have transformed the field.

The past decade has brought significant advances in our understanding of MDS pathogenesis through the study of clonal evolution, precursor states, inflammatory signaling, and immune dysregulation. These discoveries have translated into meaningful therapeutic progress, including the US Food and Drug Administration approvals of luspatercept and imetelstat, both of which

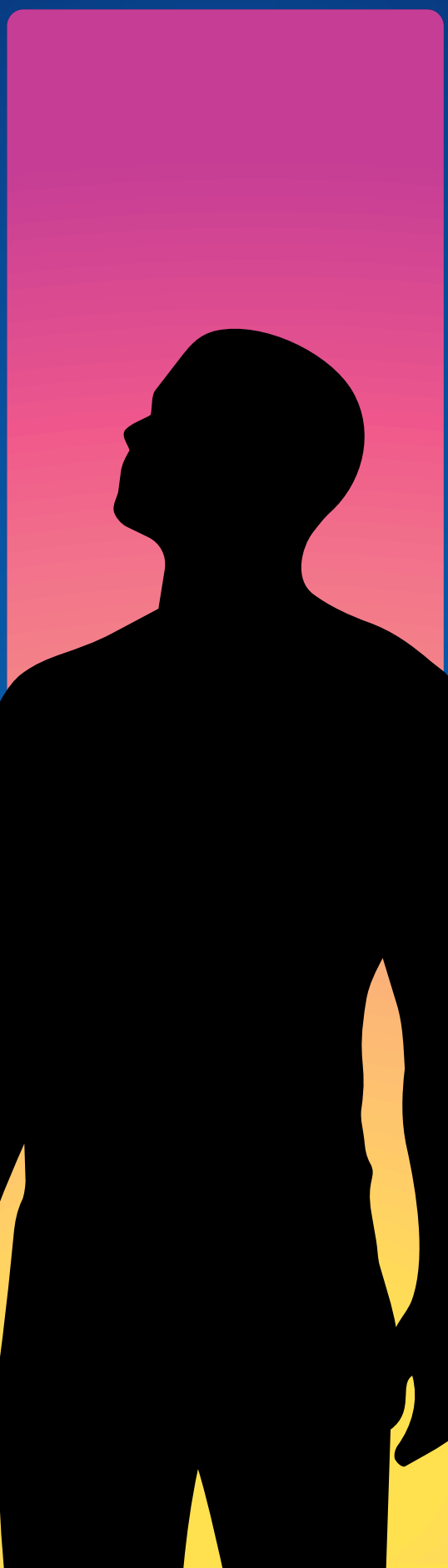
SEE *FREIREICH AWARD* ON PAGE 10

SOHO ANNUAL MEETING 2026

Introducing a new era

with Mimrylo™ rusfertide for injection

Discover the difference



soho
Insider
VOLUME 1 OF 4
DAILY EDITION

TABLE OF CONTENTS

Wednesday, September 9, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
MEET-THE-PROFESSOR SESSION I (Non-Accredited)			
7:00 AM	**MTP Session I: AML - Menin Inhibition**		**Level 3, Room 361 BCEF**
	Session Chair: Ghayas C. Issa, MD		
	Overview of Menin Inhibitors in KMT2Ar, NPM1m and Other HOX Expressing Leukemias	Ghayas C. Issa, MD	MD Anderson Cancer Center Houston, Texas, USA
	Menin Inhibitors – Mechanisms of Resistance	Jolanta Grembecka, PhD	University of Michigan Ann Arbor, Michigan, USA
	Menin Inhibitor Combinations – Ongoing Trials	Joshua Zeidner, MD	University of North Carolina Chapel Hill, North Carolina, USA
7:00 AM	**MTP Session II: ALL - Case Studies**		**Level 3, Room 351 BE**
	Session Chair: Kristen O'Dwyer, MD		
	CAR T in T-ALL	Armin Ghobadi, MD	Washington University St. Louis, Missouri, USA
	Monitoring Ph-Positive ALL: Best Tool	Nicholas J. Short, MD	MD Anderson Cancer Center Houston, Texas, USA
	Bench to Bedside Research in ABL-Class ALL	Monique den Boer, PhD	Princess Máxima Center for Pediatric Oncology Utrecht, Netherlands
7:00 AM	**MTP Session III: Lymphoma 1**		**Level 3, Room 370 BE**
	Session Chair: Jonathon B. Cohen, MD, MS		
	Chemotherapy-Free Approaches in MCL	Jonathon B. Cohen, MD, MS	Emory University, Winship Cancer Institute Atlanta, Georgia, USA
	Sequencing CD19 and CD20 Targeted Therapies in Lymphoma: The Truth About Antigen Loss	Stephen J. Schuster, MD	University of Pennsylvania Philadelphia, Pennsylvania, USA
	Understanding PTLD and How to Manage It	Jennifer E. Amengual, MD	Columbia University New York, New York, USA
7:00 AM	**MTP Session IV: Lymphoma 2**		**Level 3, Room 370 CF**
	Session Chair: Jasmine M. Zain, MD		
	Understanding the Risk of Second Malignancies After CAR T Therapies	Jasmine M. Zain, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
	Approaching Management of Rare T Cell Lymphomas With Focus on Biology	Stefan K. Barta, MD, MS	University of Pennsylvania Philadelphia, Pennsylvania, USA
	Digestive T Cell Lymphomas (EATL, MEITL)	Olivier Hermine, MD, PhD	Imagine Institute Paris, France
7:00 AM	**MTP Session V: CML - RW Data and LMIC Collaboration**		**Level 3, Room 360 CF**
	Session Chair: Douglas Tremblay, MD		
	Improving Care in LMIC Through Collaborations	Jerald Radich, MD	Fred Hutchinson Cancer Research Center Seattle, Washington, USA
	Tolerability: Possible Strategies	Fadi Haddad, MD	MD Anderson Cancer Center Houston, Texas, USA
	RW Data in Registries and National Agencies	Massimo Breccia, MD	Sapienza University Rome, Italy
7:00 AM	**MTP Session VI: MPN**		**Level 3, Room 370 AD**
	Session Chair: Lucia Masarova, MD		
	Optimizing Therapy Across the Mast Cell Disease Spectrum	Lindsay A.M. Rein, MD	Duke University Durham, North Carolina, USA
	Recognizing and Managing MDS/MPN Overlaps	Mrinal S. Patnaik, MD	Mayo Clinic Rochester Rochester, Minnesota, USA
	Novel Approaches to Addressing Cytopenias in MPNs	Aaron T. Gerds, MD, MS	Cleveland Clinic Cleveland, Ohio, USA
7:00 AM	**MTP Session VII: MDS**		**Level 3, Room 351 AD**
	Session Chair: Amer Zeidan, MBBS, MHS		
	Progress in CHIP/CCUS	Zhuoer Xie, MD, MS	H. Lee Moffitt Cancer Center Tampa, Florida, USA
	Progress in Lower Risk MDS	Sangeetha Venugopal, MD, MS	Sylvester Comprehensive Cancer Center Miami, Florida, USA
	Progress in Higher Risk MDS	Amer Zeidan, MBBS, MHS	Yale Cancer Center New Haven, Connecticut, USA

Wednesday, September 9, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
7:00 AM	**MTP Session VIII: MM - IT Delivery And Managing Toxicity**		**Level 3, Room 371 BE**
	Session Chair: Krina K. Patel, MD, MSc		
	Outpatient IT – Blueprint for Success!!	Hans Lee, MD	Sarah Cannon Research Institute Nashville, Tennessee, USA
	Neurotoxicity Following IT	Anupama Kumar, MD	University of California San Francisco, California, USA
	HLH, Second Malignancies and GI Toxicity From IT: Diagnosis and Treatment	Krina K. Patel, MD, MSc	MD Anderson Cancer Center Houston, Texas, USA
7:00 AM	**MTP Session IX: CLL - Clinical Management of Early CLL**		**Level 3, Room 361 AD**
	Session Chair: Mary Ann Anderson, MBBS, FRACP, FRCPA, PhD		
	When to Start Therapy in CLL	Petra Langerbeins, MD	University of Cologne Cologne, Germany
	How I Choose Therapy in CLL	Jacob Soumerai, MD	Massachusetts General Hospital Boston, Massachusetts, USA
	Supportive Care in CLL Before, During and After Therapy	Kerry A. Rogers, MD	Ohio State University Columbus, Ohio, USA
7:00 AM	**MTP Session X: CT - What Has the Clinical Trials Network Taught Us?**		**Level 3, Room 371 AD**
	Session Chair: Sergio Giralt, MD		
	CTN Myeloma Trials – What Have We Learned?	Sergio Giralt, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
	CTN Lymphoma Trials – What Have We Learned?	Timothy S. Fenske, MD, MS	Sarah Cannon Cancer Institute San Antonio, Texas, USA
	CTN AML Trials – What Have We Learned?	Iskra Pusic, MD, MSCI	Washington University St. Louis, Missouri, USA
7:45 AM	**BREAK**		
MEET-THE-PROFESSOR SESSION II (Non-Accredited)			
8:00 AM	**MTP Session XI: AML - MRD in AML**		**Level 3, Room 361 BCEF**
	Session Chair: Michael Heuser, MD		
	Update From ELN	Michael Heuser, MD	Martin-Luther-University Halle-Wittenberg Halle, Germany
	Molecular MRD Assays, NPM1, FLT3, KMT2Ar and Others	Richard Dillon, MD, PhD	King's College London, United Kingdom
	Should We Eradicate Persistent MRD in AML?	Farhad Ravandi, MD	MD Anderson Cancer Center Houston, Texas, USA
8:00 AM	**MTP Session XII: ALL - Advances In ALL**		**Level 3, Room 351 BE**
	Session Chair: Ibrahim Aldoss, MD		
	ALL With Myeloid Mutations	Caner Saygin, MD	University of Chicago Medicine Chicago, Illinois, USA
	When to Transplant in 2026	Nicolas Boissel, MD, PhD	Hôpital Saint-Louis, Université Paris Paris, France
	Menin Inhibitors in ALL	Cristina Papayannidis, MD, PhD	University of Bologna Bologna, Italy
8:00 AM	**MTP Session XIII: Lymphoma 1**		**Level 3, Room 370 BE**
	Session Chair: Mark J. Roschewski, MD		
	CAR T-Cell Therapy and Bispecifics in LBCL - Does Sequencing Matter?	Jeremy S. Abramson, MD, MMSc	Massachusetts General Hospital Boston, Massachusetts, USA
	MRD in DLBCL and MCL: If, When and How to Use It	Mark J. Roschewski, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
	When and How to Use Radiation Therapy in Hodgkin Lymphoma	David Hodgson, MD, MPH, FRCPC	Princess Margaret Cancer Centre Toronto, Canada
8:00 AM	**MTP Session XIV: Lymphoma 2**		**Level 3, Room 370 CF**
	Session Chair: Jorge J. Castillo, MD		
	NK/T Cell Lymphoma	Won Seog Kim, MD, PhD	Samsung Medical Center Seoul, South Korea
	How Good Are Bispecifics in Marginal Zone Lymphoma?	Narendranath Epperla, MD, MS, FACP	Huntsman Cancer Institute Salt Lake City, Utah, USA
	BTK Inhibitors in LPL and MZL: What Does the Data Tell Us?	Jorge J. Castillo, MD	Dana-Farber Cancer Institute Boston, Massachusetts, USA

Wednesday, September 9, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
8:00 AM	**MTP Session XV: CML - Biological Aspects**		**Level 3, Room 360 CF**
	Session Chair: Vivian Oehler, MD		
	CML With Atypical Transcripts	Delphine Rea, MD, PhD	Saint-Louis University Hospital Paris, France
	From Single Cells to Standard Care: Protein Biomarkers to Predict Blast Crisis and Durable TFR in CML	Tiong Ong, MA, MBBCh, MRCP (UK)	Duke-NUS Medical School Singapore
	Monitoring Standards and New Approaches	Simona Soverini, PhD	University of Bologna Bologna, Italy
8:00 AM	**MTP Session XVI: MPN**		**Level 3, Room 370 AD**
	Session Chair: Naveen Pemmaraju, MD		
	Opportunities to Integrate Interferon in the Treatment of MPN	Anthony Hunter, MD	Emory University, Winship Cancer Institute Atlanta, Georgia, USA
	Individualizing Treatment Selection for MF	Naveen Pemmaraju, MD	MD Anderson Cancer Center Houston, Texas, USA
	Who and When to Transplant in MF	Vikas Gupta, MD, FRCP, FRCPath	Princess Margaret Cancer Centre Toronto, Canada
8:00 AM	**MTP Session XVII: MDS**		**Level 3, Room 351 AD**
	Session Chair: Simona Colla, PhD		
	MDS at the Single Cell Level	Simona Colla, PhD	MD Anderson Cancer Center Houston, Texas, USA
	Innate Immune Alterations in MDS	Daniel T. Starczynowski, PhD	Cincinnati Children's Hospital Cincinnati, Ohio, USA
	MDS Hematopoiesis During Stem Cell Transplantation	Pavan Bachireddy, MD	MD Anderson Cancer Center Houston, Texas, USA
8:00 AM	**MTP Session XVIII: MM**		**Level 3, Room 371 BE**
	Session Chair: Natalie Callander, MD		
	Should We Be Screening for MGUS?	Nisha Joseph, MD	Emory University, Winship Cancer Institute Atlanta, Georgia, USA
	Genetics Defines SMM/MM	Francesco Maura, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
	Should We Treat High Risk SMM With/Without Genetics?	Natalie Callander, MD	University of Wisconsin Madison, Wisconsin, USA
8:00 AM	**MTP Session XIX: CLL – MRD: Present and Future**		**Level 3, Room 361 AD**
	Session Chair: Paolo Ghia, MD, PhD		
	Advantages/Disadvantages of Various MRD Techniques	Andy C. Rawstron, PhD	Leeds Teaching Hospitals NHS Trust Leeds, United Kingdom
	Rational Decision Making Based on the Molecular Landscape	William Wierda, MD, PhD	MD Anderson Cancer Center Houston, Texas, USA
	MRD Relapse, Time to Treat?	Carsten Niemann, MD, PhD	Copenhagen University Hospital Copenhagen, Denmark
8:00 AM	**MTP Session XX: CT - How Advocacy Groups and Pharma Can Drive Research Agendas**		**Level 3, Room 371 AD**
	Session Chair: Sairah Ahmed, MD		
	Immunotherapy Trials	Doris K. Hansen, MD	H. Lee Moffitt Cancer Center Tampa, Florida, USA
	Pharma Trials in Myeloma	Meera Mohan, MD, MS, FACP	MD Anderson Cancer Center Houston, Texas, USA
	Pharma Trials in Lymphoma	Nirav N. Shah, MD	Medical College of Wisconsin Milwaukee, Wisconsin, USA
8:45 AM	**BREAK**		
SESSION I: ACUTE LYMPHOBLASTIC LEUKEMIA **Session Chairs: Selina Luger, MD, FRCPC and Ching-Hon Pui, MD**			**LEVEL 3, GENERAL ASSEMBLY**
9:15 AM	Welcome and Opening Remarks	John DiPersio, MD, PhD	President Society of Hematologic Oncology
9:25 AM	Risk Stratification in ALL in Light of the Advances in Immunotherapy	Charles G. Mullighan, MBBS (Hons), MSc, MD	St. Jude Children's Research Hospital Memphis, Tennessee, USA
9:40 AM	Q&A		
9:43 AM	Optimal Management of CNS Relapses	LaQuisa Hill, MD	Baylor College of Medicine Houston, Texas, USA
9:58 AM	Q&A		
10:01 AM	Optimal Management of Philadelphia-Positive ALL and New Horizons	Josep-Maria Ribera, MD, PhD	Catalan Institute of Oncology Barcelona, Spain

Wednesday, September 9, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
10:16 AM	Q&A		
10:19 AM	CAR T-Cell Therapy: A Consolidation Approach or a Bridge to Allogeneic Stem Transplantation	Jae Park, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
10:34 AM	Q&A		
10:37 AM	Management of Resistant B-ALL: Novel Agents	Aaron C. Logan, MD, PhD, MPhil	University of California San Francisco, California, USA
10:52 AM	Q&A		
10:55 AM	**Debate:** It Is Time to Move Into Less Chemotherapy and Chemotherapy-Free Regimens in Frontline ALL - PRO	Hagop Kantarjian, MD	MD Anderson Cancer Center Houston, Texas, USA
11:10 AM	**Debate:** It Is Time to Move Into Less Chemotherapy and Chemotherapy-Free Regimens in Frontline ALL - CON	Rob Pieters, MD, MSc, PhD	Princess Máxima Center for Pediatric Oncology Utrecht, Netherlands
11:25 AM	Q&A		
11:31 AM	**Oral Abstract | ALL-1317:** Outcomes After TKI Discontinuation in Patients with Ph+ ALL Treated With Blinatumomab and Ponatinib	Abigail Huetteman, MD	H. Lee Moffitt Cancer Center Tampa, Florida, USA
11:41 AM	**BREAK**		
INDEPENDENT SATELLITE SYMPOSIA I: LUNCH SESSION			**GRAND BALLROOM A, THEATER 1**
11:56 AM	**C³ – Changing Conversations on CLL: Evidence and Emerging Consensus on Targeted Agents Across Lines of Therapy** Chair | William Wierda, MD, PhD | MD Anderson Cancer Center | Houston, Texas, USA Presenter | Nicole Lamanna, MD | Herbert Irving Comprehensive Cancer Center | New York, New York, USA Presenter | Jacob Soumerai, MD | Massachusetts General Hospital | Boston, Massachusetts, USA *This live educational symposium is provided by PVI, PeerView Institute for Medical Education, and is certified for 1.0 CME/MOC/NCPD/CPE/AAPA/IPCE credit/contact hour. This activity is supported by independent educational grants from AstraZeneca, BeOne Medicines, and Lilly.*		
INDEPENDENT SATELLITE SYMPOSIA II: LUNCH SESSION			**GRAND BALLROOM B, THEATER 2**
11:56 AM	**Data & Perspectives: Investigators Discuss the Optimal Management of Patients with Relapsed/Refractory Multiple Myeloma** Moderator: Robert Orlowski, MD, PhD | MD Anderson Cancer Center | Houston, Texas, USA Noopur Raje, MD | Massachusetts General Hospital | Boston, Massachusetts, USA Meletios A. Dimopoulos, MD | National and Kapodistrian University of Athens | Athens, Greece *Research To Practice is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Research To Practice designates this live activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This activity is supported by educational grants from Bristol Myers Squibb, Genentech, a member of the Roche Group, and GSK.*		
INDEPENDENT SATELLITE SYMPOSIA III: LUNCH SESSION			**GRAND BALLROOM C, THEATER 3**
11:56 AM	**Advancing Care in Myeloproliferative Neoplasms: From Established Standards to Future Treatment Paradigms** Aaron T. Gerds, MD, MS | Cleveland Clinic | Cleveland, Ohio, USA John O. Mascarenhas, MD | Mount Sinai Medical Center | New York, New York, USA *This live educational symposium is certified by Medical Learning Institute, Inc. (MLI),., an independent, nonprofit educational provider that is Jointly Accredited with Commendation, will certify this initiative for 1.0 credit/contact hour/EBAH CME-CPE for the multidisciplinary, interprofessional team, including hematologists/oncologists and their teams. This activity is supported by educational grants from Bristol Myers Squibb, Karyopharm Therapeutics, and PharmaEssentia USA Corporation.*		
POSTER WALK I			**LEVEL 3, POSTER HALL B3**
11:56 AM	***POSTER WALK - ALL, MDS, AML***		
12:56 PM	**BREAK**		
PLENARY SESSION I (Non-Accredited)			**LEVEL 3, GENERAL ASSEMBLY**
Session Chair: Guillermo Garcia-Manero, MD			
1:11 PM	The Emerging Promise of Biologically Rational Therapies for Lower Risk MDS	Alan List, MD	Stelexis BioSciences Waltham, Massachusetts, USA
	Recipient of the Emil J Freireich Distinguished Pioneer Award		
1:31 PM	**BREAK**		
SESSION II: MYELODYSPLASTIC SYNDROMES **Session Chairs: Valeria Santini, MD and Guillermo Garcia-Manero, MD**			**LEVEL 3, GENERAL ASSEMBLY**
2:01 PM	CHIP/CCUS	Kelly S. Chien, MD	MD Anderson Cancer Center Houston, Texas, USA
2:16 PM	Q&A		
2:19 PM	Chronic Myelomonocytic Leukemia (CMML)	Eric Padron, MD	H. Lee Moffitt Cancer Center Tampa, Florida, USA
2:34 PM	Q&A		
2:37 PM	Progress in Lower Risk MDS	Valeria Santini, MD	University of Florence Florence, Italy
2:52 PM	Q&A		

Wednesday, September 9, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
2:55 PM	What Is Going On in HR MDS?	Rami S. Komrokji, MD	H. Lee Moffitt Cancer Center Tampa, Florida, USA
3:10 PM	Q&A		
3:13 PM	What Can Research Funding Entities Do to Help Progress in MDS?	Timothy Graubert, MD	Massachusetts General Hospital Boston, Massachusetts, USA
3:28 PM	Q&A		
3:31 PM	**Oral Abstract | MDS-812:** Ofirnoflast (HT-6184), a First-in-Class Allosteric NEK7 Inhibitor, Achieves Durable Transfusion Independence (TI) and Hematological Improvement-Erythroid (HI-E) in ESA-Refractory Lower-Risk Myelodysplastic Syndrome (LR-MDS): Phase 2 Final Results	David A. Sallman, MD	H. Lee Moffitt Cancer Center Tampa, Florida, USA
3:41 PM	**BREAK**		
SESSION III: ACUTE MYELOID LEUKEMIA **Session Chairs: Tapan Kadia, MD and Amir Fathi, MD**			**LEVEL 3, GENERAL ASSEMBLY**
3:56 PM	Evolution of Venetoclax Based Combinations	Courtney D. DiNardo, MD, MSCE	MD Anderson Cancer Center Houston, Texas, USA
4:11 PM	Q&A		
4:14 PM	Menin Inhibitors – How Do They Compare?	Eunice Wang, MD	Roswell Park Cancer Center Buffalo, New York, USA
4:29 PM	Q&A		
4:32 PM	FLT3 Combinations in Frontline and Relapse	Jessica K. Altman, MD	Northwestern University Chicago, Illinois, USA
4:47 PM	Q&A		
4:50 PM	**Debate:** Is Low Intensity Therapy Appropriate for Younger Patients With AML - PRO	Amir Fathi, MD	Massachusetts General Hospital Boston, Massachusetts, USA
5:05 PM	**Debate:** Is Low Intensity Therapy Appropriate for Younger Patients With AML - CON	Christian Recher, MD, PhD	University of Toulouse Toulouse, France
5:20 PM	Q&A		
5:26 PM	Older AML: Better Regimens Than HMA-Venetoclax Including HMA-Venetoclax Triplets and Triple-Nucleosides-Venetoclax	Tapan Kadia, MD	MD Anderson Cancer Center Houston, Texas, USA
5:41 PM	Q&A		
5:44 PM	Transplant Decisions for AML Based on MRD	Michael Heuser, MD	Martin-Luther-University Halle-Wittenberg Halle, Germany
5:59 PM	Q&A		
6:02 PM	Advancing AML Treatment Through Collaborative Science	Charles Craddock, CBE, FRCP, FRCPath, DPhil, FMedSci	University of Warwick Coventry, United Kingdom
6:17 PM	Q&A		
6:20 PM	**Oral Abstract | AML-1299:** Actinomycin D in Combination With Low-Dose Cytarabine and Venetoclax in Relapsed or Refractory NPM1-Mutated Acute Myeloid Leukemia	Tautvilė Smalinskaitė, MD	Vilnius University Hospital Santaros Klinikos Vilnius, Lithuania
6:30 PM	**ADJOURN**		
POSTER SESSION, WELCOME & AWARDS (Non-Accredited)			**LEVEL 3, HALL B3**
6:30 PM	**POSTER AWARDS**		
6:45 PM	**INDUSTRY AWARDS**		
6:55 PM	**POSTER SESSION/WELCOME RECEPTION**		
INDUSTRY EXPERT SESSION I: DINNER SESSION (Non-Accredited)			**GRAND BALLROOM B, THEATER 2**
7:55 PM	A New Therapeutic Option for ET *This activity is sponsored by PharmaEssentia*	Zohra Nooruddin, MD	The University of Texas Health Science Center San Antonio, Texas, USA

This evening features important award presentations and a reception.

Beginning at 6:30, meet in Hall B3 on Level 3 for:

POSTER AWARDS ..... **6:30-6:45 PM**

INDUSTRY AWARDS ..... **6:45-6:55 PM**

POSTER SESSION AND WELCOME RECEPTION ..... **6:55-7:55 PM**

Menin inhibitors are making an impact in acute leukemia

Ghayas C. Issa, MD, of the University of Texas MD Anderson Cancer Center in Houston, talks about the role of menin inhibitors in acute myeloid leukemia, which he will cover in today's Meet-the-Professor session.

SESSION HIGHLIGHT
MEET-THE-PROFESSOR

SESSION NAME:
Overview of menin inhibitors in KMT2Ar, NPM1m and other HOX expressing leukemias

WHEN:
September 9 at 7 AM

WHERE:
Level 3, Room 361 BCEF

Which menin inhibitors have been approved?
Menin inhibitors are new targeted therapies for acute myeloid leukemia (AML). We now have two menin inhibitors that are approved: revumenib and ziftomenib. Revumenib was approved for KMT2A-rearranged leukemias about two years ago and then later approved for NPM1-mutant AML. Ziftomenib is approved for relapsed or refractory NPM1-mutant AML.

How has the science evolved over the years in this area?
Like many things in science, it took a lot of incremental knowledge from many people to understand the biology of leukemia and its subtypes. The major breakthroughs involved understanding of the function and structure of menin, then designing medicines that could fit the binding site pocket within menin. That was the genesis of menin inhibitors. Since that discovery, multiple companies have launched their versions of menin inhibitors, and the success of multiple inhibitors shows the robustness of the data.

What science do you think will most advance this area of AML treatment?
This is just the start. Menin inhibitors are epigenetic therapies, and with this type of therapy, we are showing that targeting key transcriptional regulators can reverse the leukemia back into a normal state. This gives us hope that many other epigenetic regulators can be targeted, especially in leukemias resistant to chemotherapy.

If we understand the biology well, we can reverse this epigenetic imprinting. Regarding menin inhibitors specifically, we are now understanding how to better utilize these medicines. The fun part is including all these medicines into combinations. Instead of using them as a last resort for patients, we're trying to combine them with standard chemotherapy or other exciting new drugs to improve the chance of a cure for patients.

What do you hope people who attend the Meet-the-Professor session can take away as you dig deeper into the topic?
I hope they learn about the journey that led to the discovery of menin inhibitors and how to design studies specifically for menin inhibitors or similar therapies that would lead to success. I will also discuss how to use these menin inhibitors in clinical practice, including how to monitor response and address the side effects.

••• FREIREICH AWARD FROM PAGE 1

have significantly altered the treatment landscape for patients with lower-risk MDS.

Practice-changing advances

Few investigators have contributed more to that evolution than Dr. List. An internationally recognized expert in MDS, he was a pioneer in elucidating the underlying biology of the disease, particularly the role of inflammation in disease pathogenesis. His laboratory has been instrumental in advancing our understanding of inflammasome activation and its contribution to ineffective erythropoiesis.

Dr. List and colleagues demonstrated that chronic inflammation and pyroptotic cell death are key drivers of ineffective hematopoiesis in lower-risk MDS. This work provided the strong biological rationale for targeting innate immune pathways and suppressing the inflammatory cascade that underlies bone marrow failure.

His clinical research established lenalidomide as the standard of care for patients with del(5q) MDS and contributed to the development and approval of luspatercept for the treatment of anemia in lower-risk MDS. His team has led numerous clinical trials inspired by insights from his translational research program.

Dr. List has authored more than 425 peer-reviewed publications and book chapters. He previously served as president of the Society of Hematologic Oncology and as a member of the MDS Foundation Board of Directors. He is a Charter Fellow of the National Academy of Inventors, an inductee into the Florida Inventors Hall of Fame, and holds 18 US patents with more than 45 additional patent applications filed. His previous honors include the 2016 Celgene Career Achievement Award for Clinical Research in Hematology, the General Motors Cancer Research Foundation Merit Award, the J.P. McCarthy Foundation International Prize, recognition from the Joshua Lederberg Society, and the Aplastic Anemia & MDS International Foundation Leadership in Science Award.

Biologic insights drive therapeutic development

Increasingly, biologic insights are driving therapeutic development. Early-intervention studies in clonal cytopenia of undetermined significance (CCUS) are exploring whether anti-inflammatory and molecularly targeted therapies can prevent or delay progression to overt MDS. Future drug development is expected to focus on biologically rational approaches that target the specific mechanisms driving disease.

Targeted therapies are also being investigated earlier in the disease course. For example, the Spanish SintraREV study demonstrated that earlier use of lower-dose, fixed-duration lenalidomide prolonged the time to red blood cell transfusion dependence in patients with del(5q) MDS. Similarly, early studies evaluating IDH inhibitors in CCUS have shown encouraging activity, and the use of these agents as frontline therapy in select patients with higher-risk MDS could potentially challenge the longstanding hypomethylating agent standard of care for molecularly defined patient subsets.

> “The future of MDS therapy will increasingly depend on accurately defining the biology of each disease subtype and matching patients with biologically rational, mechanism-based treatments.”

Several strategies aimed at suppressing inflammatory signaling in MDS have been evaluated, including Toll-like receptor blockade, anti-interleukin therapies, anti-CD33 approaches to reduce myeloid-derived suppressor cells, IRAK inhibitors, and NLRP3 inflammasome inhibitors. Recently, an oral NEK7 inhibitor that prevents assembly of the NLRP3 inflammasome reported promising early clinical results, highlighting the continued potential of targeting innate immune pathways.

The development of immunotherapy in MDS has proven challenging, largely due to a lack of ideal target antigens and the well-described T-cell dysfunction and exhaustion observed in these patients. Future efforts may increasingly focus on allogeneic immune-based approaches and novel strategies to restore T-cell function. Indeed, allogeneic hematopoietic cell transplantation remains the only curative therapy for MDS and provides proof of principle for the potential effectiveness of immune-mediated disease eradication.

Targeting apoptosis pathways remains another area of active investigation. While BCL-2 inhibitors have become a cornerstone of treatment in acute myeloid leukemia (AML), their role in higher-risk MDS remains uncertain. The phase 3 VERONA trial did not meet its primary endpoint of overall survival; however, many investigators continue to believe that BCL-2 inhibition has therapeutic potential in higher-risk disease, and several studies evaluating next-generation BCL-2 inhibitors are ongoing. Additional approaches targeting MDS and leukemia stem cells, including selective PI3Kγ inhibitors, are also advancing in clinical development. Restoring normal TP53 function or overcoming TP53-associated therapeutic resistance remains one of the greatest unmet needs in the field.

MDS represents a highly heterogeneous group of hematologic malignancies that share the clinical manifestations of bone marrow failure and a propensity to progress to AML. As our understanding of the molecular, inflammatory, and immunologic drivers of disease continues to deepen, the future of MDS therapy will increasingly depend on accurately defining the biology of each disease subtype and matching patients with biologically rational, mechanism-based treatments. Such an approach offers the greatest promise for improving outcomes and changing the natural history of MDS.

SESSION HIGHLIGHT PLENARY

SESSION NAME:
The emerging promise of biologically rational therapies for lower risk MDS

WHEN:
September 9 at 1:11 PM

WHERE:
Level 3, General Assembly

Rami Komrokji, MD, is an editor at SOHO Insider and the Vice Chair of the Malignant Hematology Department at the Moffitt Cancer Center in Tampa, Florida.

Session sparks debate on whether chemotherapy is needed in ALL care

By Elias Jabbour, MD

Drs. Hagop Kantarjian and Rob Pieters will debate whether ALL is ready to move away from chemotherapy. SOHO Insider editor, Elias Jabbour, MD, explores what the evidence shows in this preview.

PRO

Hagop Kantarjian, MD

CON

Rob Pieters, MD, MSc, PhD

The debate over whether chemotherapy is still needed for patients with acute lymphoblastic leukemia (ALL) reflects one of the most important questions facing the field today. While immunotherapy has transformed treatment and made less chemotherapy-intensive approaches increasingly feasible, questions remain about which patients can safely avoid chemotherapy altogether. I believe the field is moving in that direction, but additional evidence is needed before chemotherapy-free regimens can be broadly adopted.

> **I believe there is a path toward moving away from chemotherapy and more toward immunotherapy, although additional trials are still needed to confirm this direction.**

It is a very exciting time in ALL; the advances are immense. The next question is, do we still need chemotherapy? Historically, patients have required three years of treatment, though that requires adherence to optimize outcomes.

We have had immunotherapy available since 2014, and the results to date show better outcomes than chemotherapy alone. The question we are now facing is whether we can safely replace chemotherapy with immunotherapy and move away from the intensity and duration of treatment.

The randomized E1910 trial showed that adding blinatumomab to consolidation chemotherapy improves outcomes, though this regimen still includes chemotherapy. At MD Anderson, we conducted a trial using less chemotherapy by substituting immunotherapy, and we have shown that this approach is safe, effective, and improves outcomes.

I believe there is a path toward moving away from chemotherapy and more toward immunotherapy, although additional trials are still needed to confirm this direction.

In Philadelphia chromosome-positive ALL, we have shown that treatment with blinatumomab and ponatinib can eliminate the need for chemotherapy while improving outcomes.

That said, I still believe there is a role for chemotherapy and chimeric antigen receptor (CAR) T-cell therapy in certain patients, such as those with high white blood cell counts at high risk of central nervous system (CNS) disease, where chemotherapy is needed for CNS penetration.

Can we mitigate this issue with CAR T-cell therapy? It is very possible. Frontline CAR T-cell therapy trials are ongoing to address this risk and further improve outcomes. We have launched a trial evaluating mini-hyper-CVD plus inotuzumab ozogamicin followed by CAR T-cell therapy, with the goal of delivering seven to eight months of treatment and curing ALL.

Will that become a reality? Not today, but confirmatory trials are needed to prove this point. I believe there is a way to move away from chemotherapy, and ongoing trials will determine whether this approach can become the new standard.

Elias Jabbour, MD, is an editor at SOHO Insider and a professor in the Department of Leukemia in the Division of Cancer Medicine at the University of Texas MD Anderson Cancer Center.

SESSION HIGHLIGHT DEBATE

SESSION NAME:
It is time to move into less chemotherapy and chemotherapy-free regimens in frontline ALL

WHEN:
September 9 at 10:55 AM

WHERE:
Level 3, General Assembly

Who won?

Tell us your thoughts about the debate.

Tag us on X @SocietyofHemOnc

... RESEARCH FROM PAGE 1

Health (NIH) funding by about 40%, but Congress ultimately provided NIH with $47.5 billion in program-level funding, a 1% increase over the previous year. The final appropriation included increased funding for cancer research.

Anthony Letai, MD, PhD, director of the National Cancer Institute, addressed the mixed signals from Washington during a fireside chat at the American Association for Cancer Research Annual Meeting, stressing that Congress controls appropriations and remains strongly supportive of cancer research.

"I want to remind you, the only budget that really counts is the budget that is approved by Congress and signed by the president," he said at the time.

Still, the competing messages have contributed to uncertainty among scientists about what support will be available and where it will come from. With the administration again proposing reductions to NIH funding for fiscal year 2027, questions about how to sustain scientific progress are unlikely to disappear.

Due to these tensions in the system, SOHO President **John DiPersio, MD, PhD,** chose the theme, "Advancing care through collaborative science," to encourage discussion about funding and to explore alternative approaches to sustain progress in cancer discovery and research.

"SOHO 2026 will explore how public-private partnerships can sustain discovery, preserve basic research, and ensure access to innovation for patients around the world," he said.

Several sessions will look at funding from a different perspective, examining how foundations, advocacy organizations, and partnerships with industry can support research and help move promising science forward.

Timothy Graubert, MD

Timothy Graubert, MD, brings the perspective of a clinician-scientist who has spent his career on both sides of the grant-making process. After approximately three decades in academic medicine as a physician-scientist, he became president of the Edward P. Evans Foundation in January 2025. The foundation is a private philanthropic organization focused on medical research in myelodysplastic syndromes (MDS) and acute myeloid leukemia.

SESSION NAME:
What can research funding entities do to help progress in MDS?

WHEN:
September 9 at 3:13 PM

WHERE:
Level 3, General Assembly

WHO:
Timothy Graubert, MD
President, Edward P. Evans Foundation
Massachusetts General Hospital

"I've seen it from both sides, both as a funded investigator doing research, applying for grants, and now as the president of this foundation," Dr. Graubert said in an interview with SOHO Insider.

The transition has changed the scale at which he can think about advancing MDS research. Rather than concentrating on projects within his own laboratory, Dr. Graubert now considers where a private foundation can strategically invest its resources.

"I'm still engaged in the research effort in MDS by making strategic decisions at the foundation about how we might deploy our resources to best advance the field," he said.

Historically, the Edward P. Evans Foundation has directed much of its support toward academic laboratories investigating the biology of MDS and identifying potential vulnerabilities in preclinical research. The foundation has also funded clinical investigators and their research, although Dr. Graubert said that represents a smaller portion of its funding.

Dr. Graubert plans to begin his SOHO presentation with some of the obstacles that continue to make MDS difficult to study despite advances in understanding its biology and the arrival of new treatments.

"We have made a tremendous amount of progress in the MDS field. We understand the biology much better. We have some new drugs approved, but there are some significant obstacles that remain," he said.

He will then turn to what the Edward P. Evans Foundation has done, what it is doing now, and what new initiatives it is considering to address those obstacles.

SESSION NAME:
MTP Session: How advocacy groups and pharma can drive research agendas

WHEN:
September 9 at 8 AM

WHERE:
Level 3, Room 371 AD

WHO:
Sairah Ahmed, MD
MD Anderson Cancer Center

See page 14 for more information

Sairah Ahmed, MD

Sairah Ahmed, MD, will chair a Meet-the-Professor session that aims to examine another source of support that can sometimes be overlooked in discussions about research funding: patient advocacy organizations.

"What is often not well understood is how advocacy groups and industry play roles together in advancing research," Dr. Ahmed told SOHO Insider.

Organizations such as the Lymphoma Research Foundation and Blood Cancer United combine patient advocacy with direct investment in research, Dr. Ahmed said. They provide millions of dollars in grants to early-career investigators and can support projects that may struggle to find funding through more traditional mechanisms.

That can include high-risk, high-reward projects as well as research involving rare diseases and relatively small patient populations.

These projects "fill in critical gaps in knowledge but are overlooked by traditional funding mechanisms," Dr. Ahmed said.

The role of advocacy organizations also extends beyond providing research grants. Because of their relationship with patients, the groups can bring patient priorities into decisions about which scientific questions receive attention.

"When industry alone is driving research, the priorities they put forth may not be the same priorities that are important to patients," she said.

Advocacy organizations can push for research into underserved subtypes and rare diseases, as well as quality-of-life outcomes and long-term survivorship.

Those areas are "not really commercially attractive to industry, but they matter to patients."

Advocacy organizations can also help connect patients with clinical trials. She pointed to the Lymphoma Research Foundation and what she informally described as a "trial concierge." The organization can identify a study that appears appropriate for a patient and contact the participating center to ask whether the patient might be eligible before making the referral.

The process can take away some of the overwhelming sense that patients need to do everything themselves when they are first diagnosed or experience a relapse and are trying to determine what comes next. Connecting appropriate patients with studies can also help accelerate enrollment.

The organizations can contribute in other ways as well. She pointed to registries and research infrastructure that allow investigators at multiple institutions to pool data and resources that would be difficult for a single center to assemble, citing the Lymphoma Epidemiology of Outcomes Consortium, a large multicenter prospective cohort studying non-Hodgkin lymphoma, as one example.

SESSION NAME:
Advancing AML treatment through collaborative science

WHEN:
September 9 at 6:02 PM

WHERE:
Level 3, General Assembly

WHO:
Prof. Charles Craddock, CBE
University of Warwick Coventry, United Kingdom

Prof. Charles Craddock, CBE

Prof. Charles Craddock, CBE, approaches the funding question from the clinical trial side. He is examining whether academic clinical trial organizations can partner creatively with industry while creating a source of funding that can be reinvested in research.

One problem with the existing global contract research organizations (CROs), Prof. Craddock noted, is that pharmaceutical companies "often have to contract with a number of distinct CROs to deliver a complex trial," whereas academic CROs can offer a "one-stop shop."

"One of the other attractions of developing an academic CRO model is that this is a model that generates financial surplus," Prof. Craddock added.

Rather than allowing that money to leave the academic research environment, he explained, the model provides a way for it to support the people and infrastructure needed to conduct additional studies.

The "financial surplus generated by the academic CRO [can] be reinvested back into research nurses, back into clinical trials, therefore creating a sustainable model."

One example of how the approach can work is the UK organization Accelerating Clinical Trials Limited, which operates as a company limited by guarantee, generating revenue from clinical research and reinvesting its profit in trials.

In its first four years, Prof. Craddock said, the initiative attracted more than £45 million (approximately $60 million) from global pharmaceutical companies. The funding helped establish two national clinical trial networks, employ nearly 30 research nurses, and support a central staff.

The approach is also intended to preserve a role for academic investigators in the design and conduct of industry-supported studies. Academic CROs can generate "registration-standard data" while maintaining "some academic control and input," Prof. Craddock explained.

Leah Sherwood is the editorial director of SOHO Insider.

Can't-miss presentation: Meet-the-Professor session on immunotherapy trials

Doris K. Hansen, MD, an associate member in the Department of Blood and Marrow Transplant and Cellular Immunotherapy at Moffitt Cancer Center, will lead an MTP session on immunotherapy trials today, September 9, at 8 AM.

SESSION HIGHLIGHT
MEET-THE-PROFESSOR

SESSION NAME:
Immunotherapy Trials

WHEN:
September 9 at 8 AM

WHERE:
Level 3, Room 371 AD

What will your MTP session focus on?
My session will focus on the rapidly evolving immunotherapy landscape in multiple myeloma, as well as how we determine the next important questions to answer. I will highlight key advances with chimeric antigen receptor (CAR) T-cell therapies and bispecific antibodies, as well as emerging approaches, including dual-targeted, allogeneic, and in vivo CAR T-cell therapies and trispecific antibodies.

Importantly, we will also discuss how partnerships among investigators, patient advocacy groups, and industry can help shape research priorities and move the field forward. Clinical trials provide the foundation for new therapies, but real-world studies are increasingly important for understanding how these treatments perform in broader patient populations and for answering questions that may not be addressed in registration trials.

Ultimately, the session will highlight how clinical trials and real-world evidence can complement one another and how collaboration can help identify and address the questions that matter most to patients.

How does an MTP session compare with a general session at the meeting?
This will be my first time leading an MTP session at SOHO, and I am really looking forward to the format. Rather than a formal presentation, it will be more interactive and discussion-based. Because it's a smaller group, there is more opportunity for questions, open discussion, and personalized interaction. I think it provides a great setting not only to review the latest data, but also to discuss where the field is going and what questions we should be asking next.

INSIDE THE MIND OF DR. HANSEN

What is one thing that makes your clinical day better?
Giving good news to my patients. There is nothing better than being able to say, "The CAR-T worked," or hearing a patient say, "Sometimes I forget I even have multiple myeloma." Those moments are incredibly rewarding. I also love working alongside the wonderful nurses, APPs, research staff, and colleagues who take care of our patients with me. They make the busy clinical days so much better. Before I even get to work, getting some extra love from my five- and three-year-olds always starts my day right. My son currently thinks mama is his hero, and I am enjoying that for as long as it lasts!

You've been kidnapped for your hematology expertise. Your captors give you a choice: become the personal hematologist for a colony of vampires or a pack of werewolves. Who are you treating?
Definitely the vampires. As a hematologist, I feel like I have been training for this my entire career! Although I suspect "transfusion independence" would not be one of our treatment goals.

What is the last great book you have read or movie you have watched?
One book that has stayed with me is "When Breath Becomes Air." It is a beautifully written reflection on medicine, mortality, and what gives life meaning, and it resonated with me personally because I lost my mother to lung cancer far too young. I first read it several years ago, but it remains one of the most memorable books I have read.

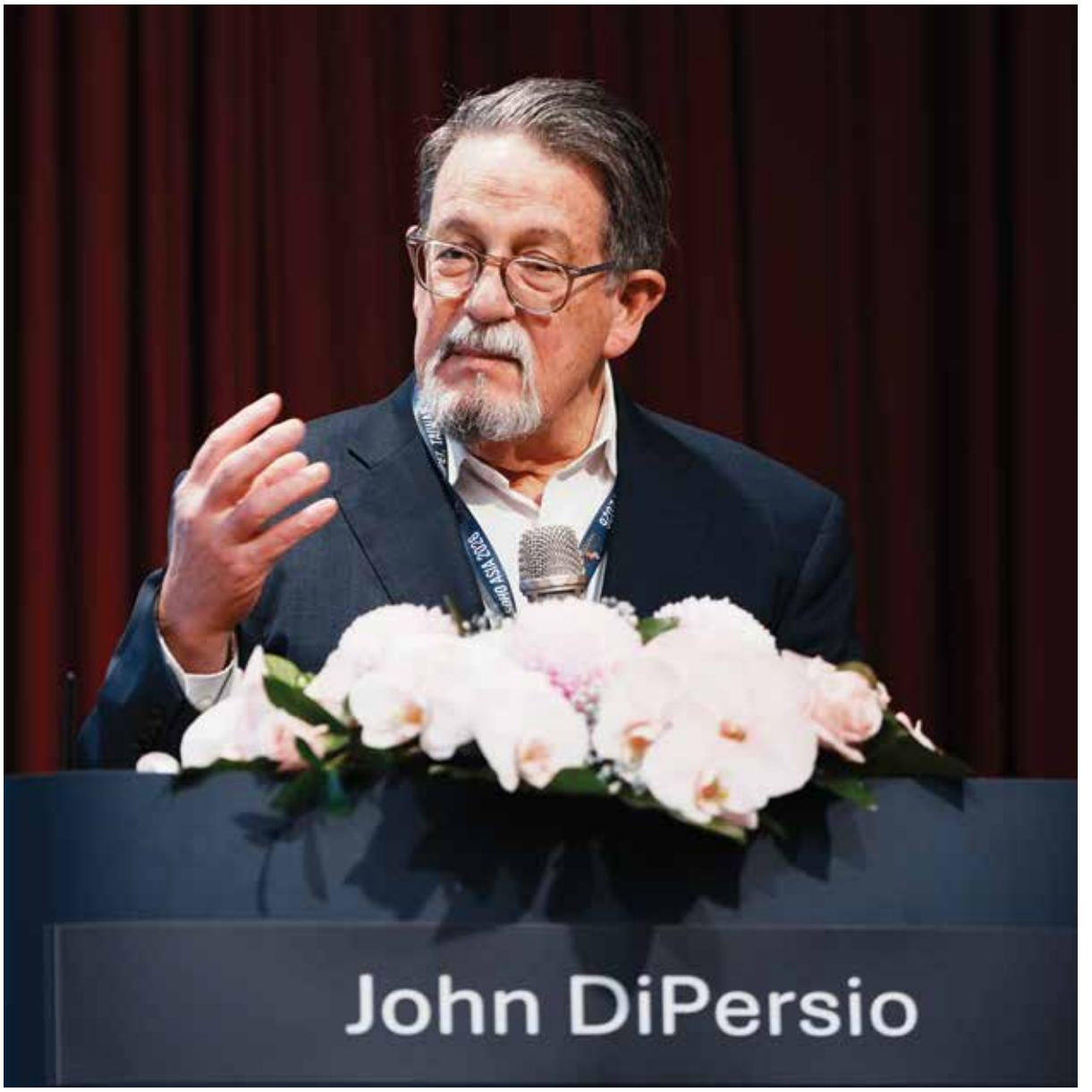
... WELCOME ADDRESS FROM PAGE 1

meaningful improvements in outcomes, with many of our patients living longer and most importantly with a better quality of life.

However, scientific progress is only one part of improving patient outcomes. We do not operate in a vacuum, and broader societal and structural pressures, from funding instability to barriers in clinical trial access, can significantly hinder biomedical advancement in the United States.

These past two years have been plagued with instability, whether perceived or real, as well as a lack of transparency. The current environment cannot be ignored by the field in which we practice. Turnover and turmoil within the institutions we rely on to advance science have had a significant effect on US global competitiveness due to brain drain and acute anxiety among international and early-career investigators. We cannot forget our mandate to drive the science internationally and not follow the lead of others.

Clinical research is facing a moment of real pressure. Across institutions, investigators continue to see trials become more expensive and entangled in bureaucracy, causing slower patient enrollment. Sponsored studies are often weighed down by regulatory demands and contract research organization-driven processes that consume valuable time and resources. At the same time, investigator-initiated trials are increasingly difficult to launch, even when there is a strong scientific rationale, an available drug, and a well-developed protocol. Finally, the reduced enthusiasm of biotech and big pharma to support institutional investigator-initiated trials coupled with decreased investment from the private sector for the support of startups from academic labs has created a very challenging environment for continued progress.



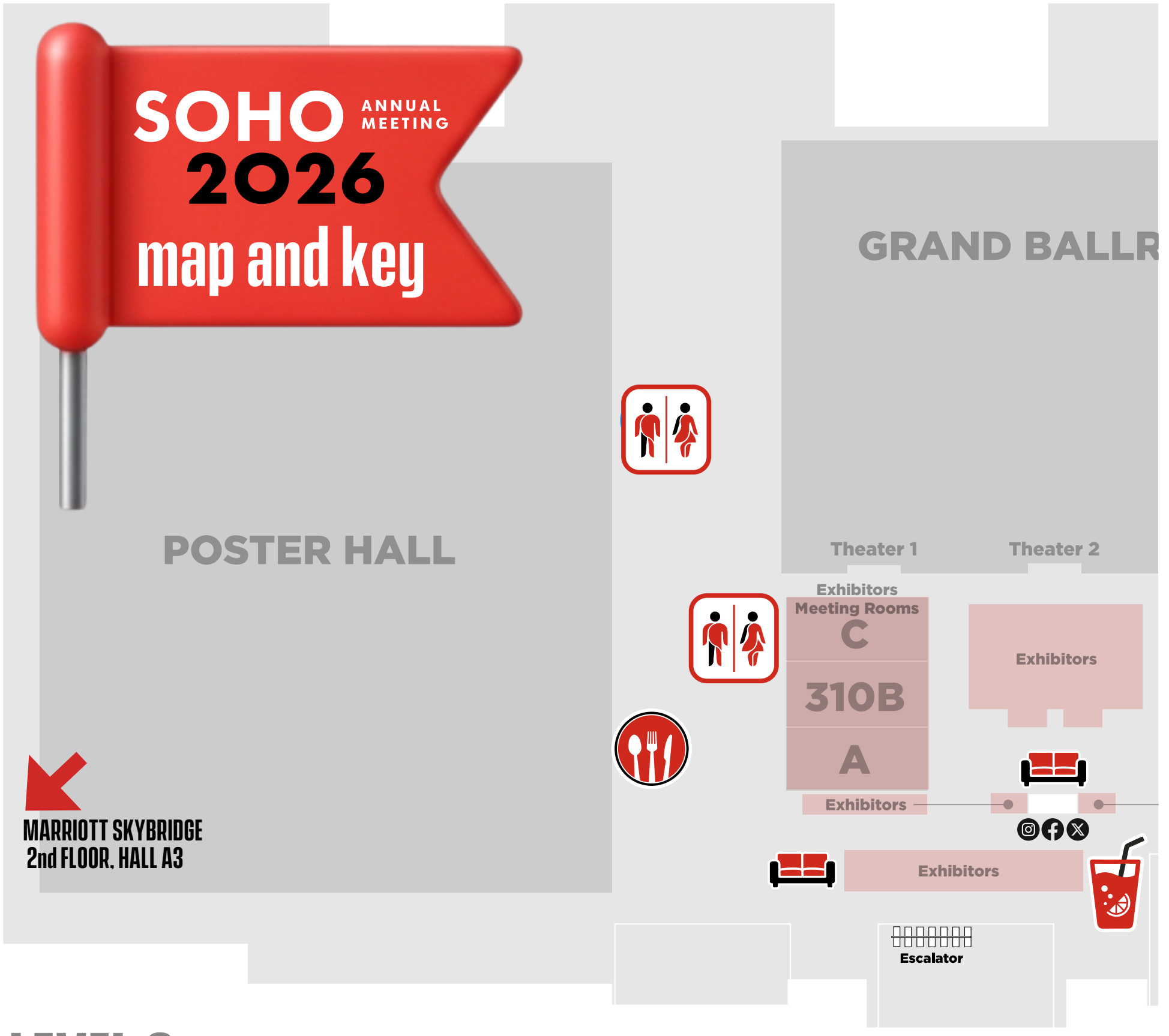
These challenges directly affect patients. When studies are delayed, underfunded, or unable to open or when ideas cannot be supported or translated into the clinic, patients lose access to potential therapies, and the field loses opportunities to answer important questions. Public funding constraints, private-sector uncertainty, and institutional cost pressures are converging in ways that make discovery harder, not easier.

As a biomedical community, we also need a stronger, more unified voice. Clinicians and scientists understand these problems because they live them every day, but we have not always communicated them clearly to stakeholders and policymakers. If we want collaborative science to move forward, we must be willing to explain why efficient, adequately supported clinical research and productive public-private collaborations matter.

The future of discovery depends on both good ideas and the systems that allow those ideas to reach patients. We cannot lose sight of that responsibility.

> **"If we want collaborative science to move forward, we must be willing to explain why efficient, adequately supported clinical research and productive public-private collaborations matter."**

John F. DiPersio, MD, PhD, is the President of the Society of Hematologic Oncology and chief of the Division of Oncology at Washington University School of Medicine in St. Louis, Missouri.



LEVEL 3

Restrooms

Concessions

Infused Water Station

Lounge Areas

@socofhemonc @SocietyofHemOnc

Social Media Wall

Live feed with **#SOHO2026 #SOHO26** pics and comments

SOHO 2026 Photobooth
Snap SOHO Annual Meeting memories! Upload, share, and tag **#SOHO2026 #SOHO26**

Coffee Bar

FREIREICH Quote Wall

SOHO Boutique
Grab your SOHO swag! All proceeds support critical society programs.

SOHO 2026 Registration Booth

SOHO Selfie Station

Do the data support a departure from intensive treatment in younger patients with AML?

Today, Drs. Amir Fathi and Christain Recher face off on the debate stage to discuss the appropriate treatment for younger fit patients with acute myeloid leukemia (AML). Read on for a preview of their positions and catch the pair live during their session this afternoon.

SESSION HIGHLIGHT DEBATE

SESSION NAME:
Is low intensity therapy appropriate for younger patients with AML?

WHEN:
September 9 at 4:50 PM

WHERE:
Level 3, General Assembly

PRO

Amir Fathi, MD
Massachusetts General Hospital

The upfront treatment for many functionally fit adults with AML may be evolving toward the use of lower-intensity, better-tolerated regimens. For more than five decades, intensive induction chemotherapy (IC) has been the established upfront approach for the fit AML patient. However, long-term outcomes remain poor for most, and the associated toxicity and morbidity with IC are substantial.

The success of combinations using hypomethylating agents and venetoclax (HMA-Ven) among older patients has highlighted the possibility of effective therapy for AML, while minimizing associated toxicity. In recent years, multiple retrospective studies have compared the use of traditional IC regimens with HMA-Ven among them, although these have been impacted by the natural limitations and biases of retrospective designs.

More recently, prospective trials, including randomized comparative studies such as PARADIGM, have demonstrated that HMA-Ven can be a more effective and better-tolerated upfront therapeutic approach and bridge to transplant compared with IC among select fit patients with AML. However, it is important to note that certain patient populations were excluded by eligibility from PARADIGM, such as younger patients with favorable-risk disease or those with FLT3 mutations. For these patients, future trials that incorporate relevant targeted therapies into HMA-Ven regimens are required to support the use of gentler, more targeted upfront approaches.

CON

Christian Recher, MD, PhD
University of Toulouse, France

For over 40 years, IC—the "7+3" combination of cytarabine and an anthracycline as induction, followed by intermediate- to high-dose cytarabine consolidation and, when indicated, allogeneic transplantation—has remained the backbone of curative treatment for younger fit patients with AML. Despite criticism of its toxicity, IC still cures a substantial proportion of patients within a fixed treatment duration, with or without transplant in first complete remission (CR).

Far from becoming obsolete, IC is now entering its most promising era. Recent research has focused not on abandoning the chemotherapy backbone but on enriching it: the RATIFY and QUANTUM-First trials established midostaurin and quizartinib as standards of care for FLT3-mutated AML, each demonstrating a clear overall survival benefit when added to IC.

This is only the beginning. Pivotal trials combining IC with IDH1, IDH2, menin-KMT2A, or BCL-2 inhibitors are due to report shortly, and early phase 1 data with ivosidenib, enasidenib, venetoclax, and menin inhibitors already show excellent feasibility, safety, high CR rates, and rapid measurable residual disease clearance. In other words, rather than being replaced, standard IC is set to diversify into a family of molecularly tailored standards—one backbone, multiple targeted combinations—leaving only a handful of very-high-risk subgroups, such as TP53-mutated or MECOM-rearranged AML, without a truly effective option. Against this backdrop, the case for low-intensity therapy in younger adults remains, at best, premature. The available data are simply not mature or robust enough to justify a departure from intensive treatment in this population today.

Who won?

Tell us your thoughts about the debate.

Tag us on X **@SocietyofHemOnc**

SOHO Boutique is open Wednesday to Friday during the annual meeting

Attendees at the annual meeting have the opportunity to directly support SOHO's mission of advancing education and treatment progress in blood cancers worldwide when they make a purchase at the SOHO Boutique located next to the Coffee Bar. Make a donation and receive any of the following gifts:

- **Umbrella: $20**
- **T-shirt: $25**
- **Shawl: $25**
- **Stanley Tumbler: $50**
- **Jacket (XS, S, M, L, XL): $75**

Fund vital programs

Your contributions fund vital programs that accelerate progress in hematologic malignancies.

Your generosity funds SOHO educational programs, scholarship programs for young investigators, and our global community of SOHO Ambassadors. Below are people who were directly helped through the contributions to these programs.

Maha Hameed, MD
2025 SOHO Young Investigator awardee

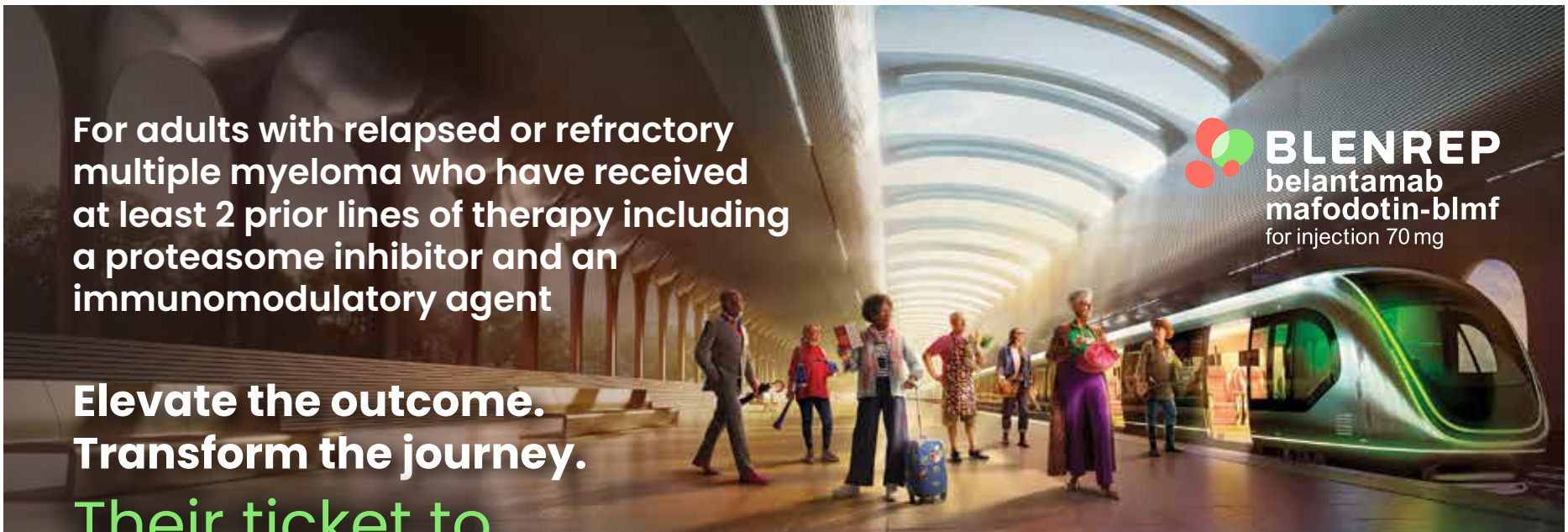
Hsin-An Hou, MD
SOHO Ambassador, Asia

SOHO is a 501(c)(3) nonprofit organization; all contributions are 100% tax-deductible.

Show your support on social media

Show your support for SOHO's mission to advance hematologic care and research. When you contribute, help spread the word by tagging us and using the hashtag **#supportSOHO** on Instagram, X, Bluesky, and LinkedIn to share why this initiative matters to you.

Visit **soho.click/donate** to join the initiative.



For adults with relapsed or refractory multiple myeloma who have received at least 2 prior lines of therapy including a proteasome inhibitor and an immunomodulatory agent

BLENREP
belantamab mafodotin-blmf
for injection 70 mg

Elevate the outcome.
Transform the journey.

Their ticket to
3x mPFS vs a daratumumab-based triplet
is within reach

PFS (HR=0.31 [95% CI: 0.21-0.47]); mPFS was 31.3 months (95% CI: 23.5-NR) for BVd (N=108) vs 10.4 months (95% CI: 7-13.4) for DVd (N=109).[1]

The data presented are based on a post hoc exploratory subgroup analysis (N=217) and not adjusted for multiplicity nor powered to detect a statistical difference.

Please scan for full Prescribing Information, including Boxed Warning, for BLENREP.

BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); CI, confidence interval; DVd, daratumumab (D) + bortezomib (V) + dexamethasone (d); HR, hazard ratio; mPFS, median progression-free survival; NR, not reached.

INDICATION

BLENREP is indicated in combination with bortezomib and dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least 2 prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

IMPORTANT SAFETY INFORMATION

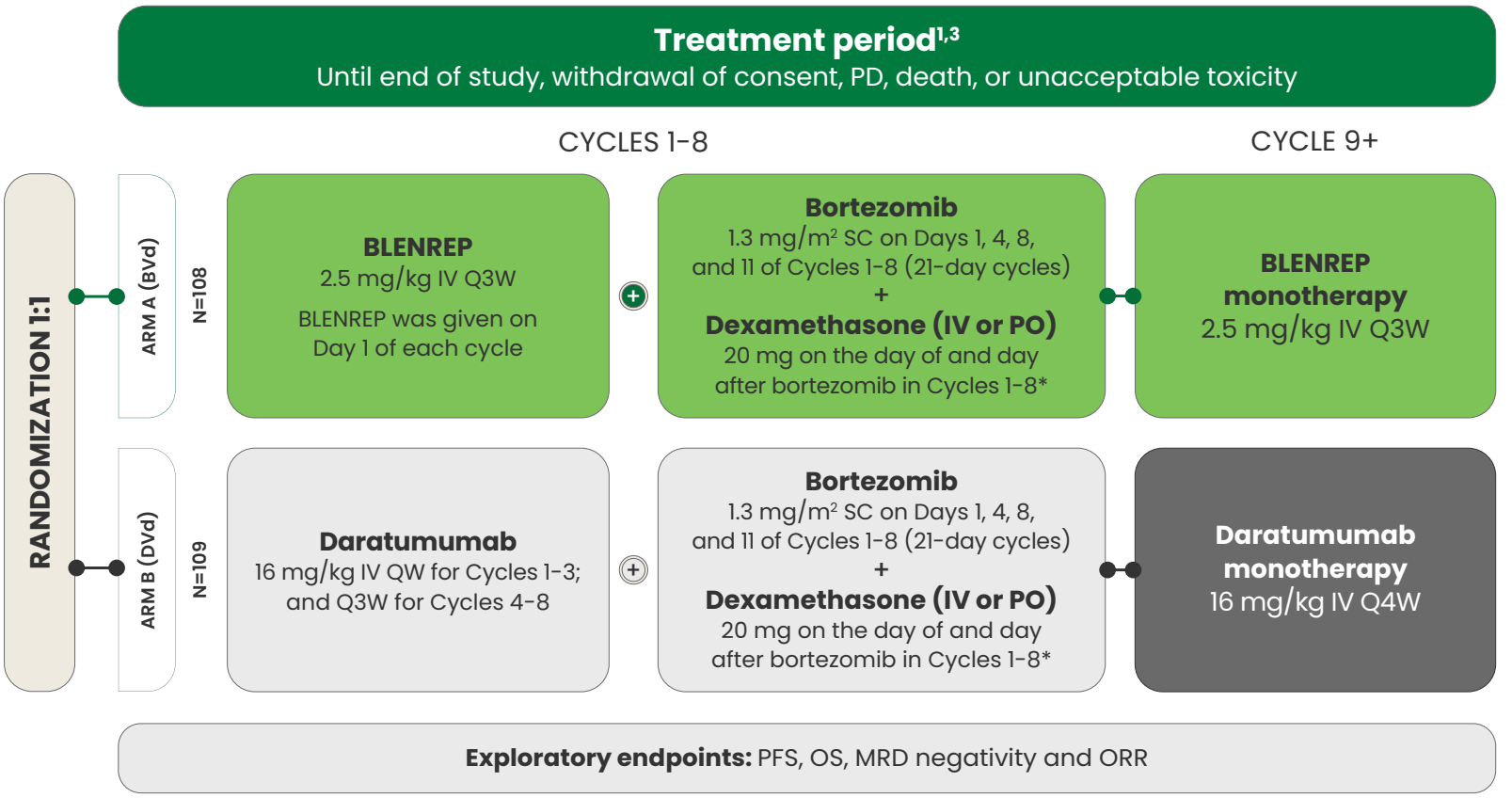
WARNING: OCULAR TOXICITY

- **BLENREP causes changes in the corneal epithelium resulting in changes in vision, including severe visual impairment, and symptoms such as blurred vision and dry eyes. In the clinical study, corneal ulcers, including cases with infection, also occurred.**
- **Conduct ophthalmic exams at baseline, before each dose, promptly for new or worsening symptoms, and as clinically indicated. In the clinical study, 83% of patients required a dosage modification due to ocular toxicity. Withhold BLENREP until improvement and resume or permanently discontinue, based on severity.**
- **Because of the risk of ocular toxicity, BLENREP is available only through a restricted program called the BLENREP Risk Evaluation and Mitigation Strategy (REMS).**

Please see additional Important Safety Information, including Boxed Warning, and the Brief Summary of Prescribing Information for BLENREP on the following pages.

DREAMM-7 was a pivotal Phase 3 trial designed to study a triplet combination vs a daratumumab-based triplet[1,2]

- FDA approval was based on a post hoc exploratory subgroup analysis of patients with at least 2 prior lines of therapy, including a proteasome inhibitor and immunomodulatory agent
- DREAMM-7 was an open-label, randomized (1:1), multicenter study in adult patients with multiple myeloma who received at least 1 prior line of therapy[1]



- **Follow-up period:** PFS Q3W.† Disease assessment Q3W. Follow-up for OS Q12W[3,‡]

Select eligibility criteria for efficacy population[1,3]

Inclusion criteria:

- Adults with RRMM
- 2 prior lines of MM therapy including a proteasome inhibitor and immunomodulatory agent
- Progressive disease during or after most recent therapy

Exclusion criteria:

- Prior treatment with anti-BCMA therapy
- Refractory to or intolerant of daratumumab or bortezomib
- Current corneal epithelial disease§

Patients were stratified by prior lines of treatment (1 vs 2 or 3 vs ≥4), R-ISS stage (I vs II/III), and prior bortezomib (yes vs no)[3]

***The dose of dexamethasone in each arm was reduced by half in patients aged ≥75 years.[1] †For patients who discontinue due to reasons other than PD.[3] ‡For patients who discontinue due to PD or other reasons.[3] §Patients with current corneal disease, except for mild punctate keratopathy, were excluded.[1]**

BCMA, B-cell maturation agent; BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); DVd, daratumumab (D) + bortezomib (V) + dexamethasone (d); FDA, US Food and Drug Administration; IV, intravenous; MM, multiple myeloma; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PO, by mouth; QW, every week; Q3W, every 3 weeks; Q4W, every 4 weeks; Q12W, every 12 weeks; R-ISS, Revised International Staging System; RRMM, relapsed or refractory multiple myeloma; SC, subcutaneous; Vd, bortezomib (V) + dexamethasone (d).

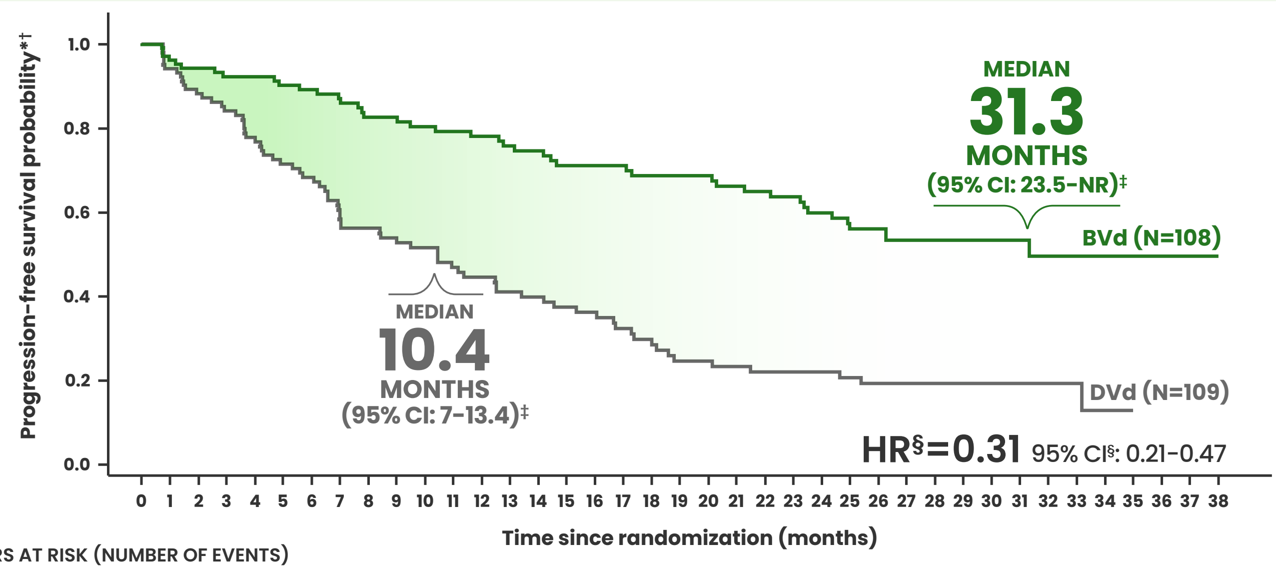
FDA approval was based on a post hoc exploratory subgroup analysis of patients with at least 2 prior lines of therapy, including a proteasome inhibitor and immunomodulatory agent.

The data presented are based on a post hoc exploratory subgroup analysis (N=217) and not adjusted for multiplicity nor powered to detect a statistical difference.

BLENREP
belantamab mafodotin-blmf
for injection 70 mg

BLENREP triplet combination (BVd) delivered 3x mPFS vs a daratumumab-based triplet (DVd)[1]

BVd is the first and only triplet that improved median PFS vs a daratumumab-based triplet, with durable benefit observed[1]



NUMBERS AT RISK (NUMBER OF EVENTS)

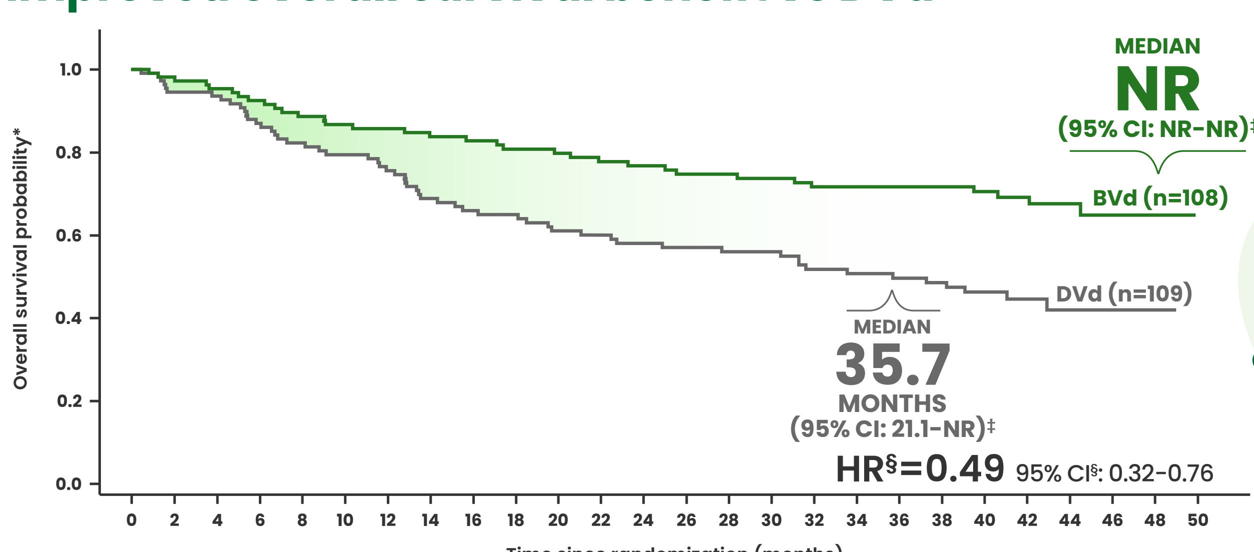
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
BLENREP + bortezomib/dexamethasone	108 (0)	101 (4)	96 (6)	91 (8)	90 (8)	88 (10)	85 (11)	81 (13)	74 (17)	74 (17)	71 (19)	69 (20)	68 (21)	65 (23)	64 (24)	61 (27)	61 (27)	59 (27)	57 (29)	57 (29)
Daratumumab + bortezomib/dexamethasone	109 (0)	96 (6)	87 (12)	81 (16)	73 (23)	67 (28)	64 (31)	50 (42)	49 (42)	45 (45)	44 (46)	40 (50)	38 (52)	35 (55)	33 (56)	31 (58)	28 (59)	25 (62)	22 (65)	19 (68)

	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
BLENREP + bortezomib/dexamethasone	56 (29)	53 (31)	52 (32)	50 (33)	47 (36)	45 (38)	42 (39)	38 (41)	31 (41)	29 (41)	26 (41)	18 (41)	13 (42)	10 (42)	7 (42)	5 (42)	3 (42)	3 (42)	0 (42)
Daratumumab + bortezomib/dexamethasone	19 (68)	18 (69)	17 (70)	17 (70)	16 (70)	15 (71)	14 (72)	12 (72)	8 (72)	7 (72)	6 (72)	5 (72)	3 (72)	3 (72)	1 (73)	0 (73)	0 (73)	0 (73)	0 (73)

Response was based on Independent Review Committee per International Myeloma Working Group criteria.[1]

- PFS data had a median follow-up of 27.9 months[1]

BVd improved overall survival benefit vs DVd[1]



51% reduction in risk of death with BVd vs a daratumumab-based triplet[1]

NUMBERS AT RISK (NUMBER OF EVENTS)

	0		2		4		6		8		10		12		14		16		18		20		22		24	
BLENREP + bortezomib/dexamethasone	108 (0)	107 (1)	106 (2)	103 (3)	101 (5)	98 (7)	97 (8)	95 (10)	91 (12)	91 (12)	89 (14)	88 (15)	88 (15)	87 (16)	85 (17)	85 (17)	84 (18)	82 (18)	80 (20)	80 (20)	79 (21)	78 (22)	77 (23)	77 (23)	76 (24)	76 (24)
Daratumumab + bortezomib/dexamethasone	109 (0)	108 (1)	103 (6)	103 (6)	101 (7)	97 (9)	92 (14)	88 (18)	87 (19)	84 (21)	83 (22)	83 (22)	79 (26)	75 (30)	71 (33)	70 (34)	68 (36)	67 (37)	66 (37)	64 (39)	62 (41)	61 (41)	60 (42)	58 (44)	58 (44)	57 (45)

	26		28		30		32		34		36		38		40		42		44		46		48		50
BLENREP + bortezomib/dexamethasone	74 (26)	74 (26)	74 (26)	73 (27)	72 (27)	72 (27)	70 (29)	70 (29)	70 (29)	70 (29)	69 (29)	69 (29)	67 (29)	67 (29)	55 (30)	48 (31)	44 (31)	35 (32)	27 (32)	22 (33)	16 (33)	13 (33)	9 (33)	4 (33)	0 (33)
Daratumumab + bortezomib/dexamethasone	56 (45)	55 (45)	54 (46)	54 (46)	53 (46)	52 (47)	49 (50)	49 (50)	48 (51)	48 (51)	46 (52)	46 (52)	44 (53)	41 (54)	36 (55)	27 (55)	20 (56)	16 (57)	14 (57)	12 (57)	9 (57)	9 (57)	5 (57)	1 (57)	0 (57)

- mOS for BVd was not reached. At the time of the interim analysis data cutoff, fewer patients on BVd (33; 31%) had an event vs DVd (57; 52%)[1]
- OS data had a median follow-up of 38.7 months[1]

*Based on all randomized patients who had received at least 2 prior lines of therapy including a proteasome inhibitor and immunomodulatory agent.[1] †Median follow-up of 27.9 months.[1] ‡By Brookmeyer and Crowley method.[1] §Based on stratified Cox regression model.[1]

BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); CI, confidence interval; DVd, daratumumab (D) + bortezomib (V) + dexamethasone (d); HR, hazard ratio; mOS, median OS; mPFS, median progression-free survival; NR, not reached; OS, overall survival.

BLENREP has a well-characterized safety profile[1]

In DREAMM-7, the safety of BLENREP with bortezomib and dexamethasone (n=242) compared to daratumumab with bortezomib and dexamethasone (n=246) was assessed in patients who received at least 1 prior line of therapy. Safety of BLENREP in combination with bortezomib and dexamethasone in patients who have received only 1 prior line of therapy (n=125) has not been established.

Adverse reactions (≥20%) in patients with relapsed or refractory multiple myeloma who received BLENREP in DREAMM-7[1]

Adverse Reaction*	BLENREP + Vd N=242		Daratumumab + Vd N=246	
	All Grades (%)	Grades 3+4 (%)	All Grades (%)	Grades 3+4 (%)
Eye Disorders				
Reduction in BCVA†	89	57	44	9
Corneal exam findings†	86	72	19	3
Blurred vision	66	22	11	0.8
Dry eye‡	51	7	7	0
Photophobia	47	2	2	0
Foreign body sensation in eyes‡	44	3	4	0
Eye irritation	43	5	5	0
Eye pain‡	33	0.8	4	0.4
Cataract‡	24	8	14	3
Gastrointestinal Disorders				
Diarrhea	32	4	31	4
Infections				
Upper respiratory tract infection‡,§	38	2	36	2
Pneumonia‡,§	26	16	17	5
COVID-19§	24	5	20	2
Hepatobiliary Disorders				
Hepatotoxicity‡	33	14	16	2
General Disorders and Administration Site Conditions				
Fatigue‡	26	6	27	4

- **Serious adverse reactions** occurred in 50% of patients who received BVd. Serious adverse reactions in ≥2% of patients included pneumonia (18%), pyrexia (5%), thrombocytopenia (5%), COVID-19 (5%), upper respiratory tract infection (4%), sepsis (4%), second primary malignancy (3%), and anemia (2%)[1]
- **Fatal adverse reactions** occurred in 10% of patients who received BVd. Fatal adverse reactions which occurred in >1 patient included pneumonia (4%), sepsis (2%), COVID-19 (1%), respiratory failure (<1%), and intracranial hemorrhage (<1%)[1]
- **Permanent discontinuation** of BLENREP due to an adverse reaction occurred in 17% of patients. Adverse reactions which resulted in permanent discontinuation of BLENREP in ≥3% of patients included ocular toxicity (9%) and pneumonia (4%)[1]

*Adverse reactions, except ophthalmic exam findings, were graded according to CTCAE v5.0.[1] †Based on ophthalmic exam findings.[1] ‡Grouped term includes other related terms.[1] §Includes the following fatal adverse reactions: BVd: pneumonia (n=10), COVID-19 (n=3), upper respiratory tract infection (n=1); DVd: pneumonia (n=7), COVID-19 (n=5), pyrexia (n=1).[1]

BCVA, Best-Corrected Visual Acuity; BVd, BLENREP (B) + bortezomib (V) + dexamethasone (d); CTCAE, Common Terminology Criteria for Adverse Events; Vd, bortezomib (V) + dexamethasone (d).

Please see additional Important Safety Information, including Boxed Warning, and the Brief Summary of Prescribing Information for BLENREP on the following pages.

IMPORTANT SAFETY INFORMATION (cont'd)

BLENREP
belantamab
mafodotin-blmf
for injection 70 mg

WARNINGS AND PRECAUTIONS

Ocular Toxicity

BLENREP causes ocular toxicity, defined as changes in the corneal epithelium and changes in BCVA based on ophthalmic exam (including slit lamp exam), or other ocular adverse reactions as defined by the CTCAE.

In DREAMM-7, ocular toxicity occurred in 92% of patients, including Grade 3 or 4 in 77% of patients. The most common ocular toxicities (>25%) were reduction in BCVA (89%) and corneal exam findings (86%) based on ophthalmic exam findings, blurred vision (66%), dry eye (51%), photophobia (47%), foreign body sensation in eyes (44%), eye irritation (43%), and eye pain (33%).

Ocular toxicity based on ophthalmic exam findings was reported as Grade 2 in 9% of patients, Grade 3 in 56% of patients, and Grade 4 in 21% of patients. The median time to onset of the first Grade 2 to 4 ophthalmic exam findings was 43 days (range: 15 to 611 days). The median duration of all Grade 2 to 4 ophthalmic exam findings was 85 days (range: 5 to 813 days). Patients experienced a median of 3 episodes (range: 1 to 11 episodes) of ocular toxicity based on ophthalmic exam findings. Of the patients with Grade 2 to 4 ophthalmic exam findings, 42% had improvement of the last event to Grade 1 or better; 22% had resolution of the last event based on return to baseline or normal ophthalmic exam findings.

The most commonly reported corneal exam findings included superficial punctate keratopathy, microcyst-like deposits, epithelial changes, and haze. Cases of corneal ulcer, including cases with infection, have been reported and should be managed promptly by an eye care professional.

A reduction in BCVA to 20/50 or worse in at least one eye occurred in 69% of patients, including 29% who experienced a change in BCVA to 20/100 or worse, and 12% who experienced a change in BCVA to 20/200 or worse. Of the patients with reduced BCVA to 20/50 or worse in at least one eye, 61% had resolution of the last event to baseline or better. Of the patients with reduced BCVA to 20/100 or worse, 57% had resolution of the last event. Of the patients with reduced BCVA to 20/200 or worse, 48% had resolution of the last event.

Ophthalmic exams (including slit lamp exam and BCVA assessment) should be conducted by an eye care professional, such as an ophthalmologist or optometrist, at baseline, before each dose of BLENREP, promptly for new or worsening symptoms, and as clinically indicated. Perform baseline exam within 4 weeks prior to the first dose. Perform each follow-up exam within 10 days prior to the next planned dose. All effort should be made to schedule the exam as close to BLENREP dosing as possible. Withhold BLENREP until improvement in both corneal exam findings and change in BCVA to Grade 1 or less and resume at same or reduced dose or permanently discontinue based on severity.

Counsel patients to promptly inform their healthcare provider of any ocular symptoms. Counsel patients to use preservative-free artificial tears at least 4 times a day starting with the first infusion and continuing until the end of treatment, and to avoid wearing contact lenses for the duration of therapy. Bandage contact lenses may be used under the direction of an eye care professional.

Changes in visual acuity may be associated with difficulty for driving and reading. Counsel patients to use caution when driving or operating machinery.

BLENREP Risk Evaluation and Mitigation Strategy (REMS)

BLENREP is available only through a restricted program called the BLENREP REMS because of the risk of ocular toxicity.

Further information is available at www.BLENREPREMS.com and 1-855-690-9572.

IMPORTANT SAFETY INFORMATION (cont'd)

Thrombocytopenia

Thrombocytopenia of any grade occurred in 100% of patients in DREAMM-7.

Grade 2 thrombocytopenia occurred in 10% of patients, Grade 3 in 29% of patients, and Grade 4 in 45% of patients. Clinically significant bleeding (Grade ≥2) occurred in 7% of patients with concomitant low platelet levels (Grade 3 or 4).

Monitor complete blood cell counts at baseline and periodically during treatment as clinically indicated. Withhold or reduce the dose of BLENREP based on severity.

Embryo-fetal Toxicity

Based on its mechanism of action, BLENREP can cause fetal harm when administered to a pregnant woman because it contains a genotoxic compound (the microtubule inhibitor, monomethyl auristatin F [MMAF]) and it targets actively dividing cells.

Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with BLENREP and for 4 months after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with BLENREP and for 6 months after the last dose.

ADVERSE REACTIONS

The most common adverse reactions (≥20%) with BLENREP in combination with bortezomib and dexamethasone are reduction in BCVA, corneal exam findings, blurred vision, dry eye, photophobia, foreign body sensation in eyes, eye irritation, upper respiratory tract infection, hepatotoxicity, eye pain, diarrhea, fatigue, pneumonia, cataract and COVID-19.

The most common Grade 3 or 4 (≥10%) laboratory abnormalities are decreased platelets, decreased lymphocytes, decreased neutrophils, increased gamma-glutamyl transferase, decreased white blood cells, and decreased hemoglobin.

Please see accompanying full Prescribing Information, including BOXED WARNING, for BLENREP. For more information, please visit www.BLENREPhcp.com

Please see Brief Summary of Prescribing Information for BLENREP on the following pages.

References:

1. BLENREP. Prescribing information. GSK; 2025.
2. Hungria V, et al. *N Engl J Med*. 2024;391(5):393-407.
3. Hungria V, et al. *N Engl J Med*. 2024;391(5)(suppl):1-31.

PMUS-BLMJRNA260006 July 2026
Produced in USA.

Please see additional Important Safety Information, including Boxed Warning, on this spread and the Brief Summary of Prescribing Information for BLENREP on the following pages.

BLENREP
belantamab
mafodotin-blmf
for injection 70 mg

BRIEF SUMMARY

BLENREP (belantamab mafodotin-blmf) for injection, for intravenous use

The following is a brief summary; see full Prescribing Information for additional product information

WARNING: OCULAR TOXICITY

- **BLENREP causes changes in the corneal epithelium resulting in changes in vision, including severe visual impairment, and symptoms such as blurred vision and dry eyes. In the clinical study, corneal ulcers, including cases with infection, also occurred *[see Warnings and Precautions (5.1)]*.**
- **Conduct ophthalmic exams at baseline, before each dose, promptly for new or worsening symptoms, and as clinically indicated. In the clinical study, 83% of patients required a dosage modification due to ocular toxicity. Withhold BLENREP until improvement and resume or permanently discontinue, based on severity *[see Dosage and Administration (2.3), Warnings and Precautions (5.1)]*.**
- **Because of the risk of ocular toxicity, BLENREP is available only through a restricted program called the BLENREP Risk Evaluation and Mitigation Strategy (REMS) *[see Warnings and Precautions (5.2)]*.**

1 INDICATIONS AND USAGE

BLENREP is indicated in combination with bortezomib and dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Ocular Toxicity

BLENREP causes ocular toxicity, defined as changes in the corneal epithelium and changes in BCVA based on ophthalmic exam (including slit lamp exam), or other ocular adverse reactions as defined by the CTCAE *[see Adverse Reactions (6.1)]*.

In DREAMM-7, ocular toxicity occurred in 92% of patients, including Grade 3 or 4 in 77% of patients. The most common ocular toxicities (>25%) were reduction in BCVA (89%) and corneal exam findings (86%) based on ophthalmic exam findings, blurred vision (66%), dry eye (51%), photophobia (47%), foreign body sensation in eyes (44%), eye irritation (43%), and eye pain (33%) *[see Adverse Reactions (6.1)]*.

Ocular toxicity based on ophthalmic exam findings was reported as Grade 2 in 9% of patients, Grade 3 in 56% of patients, and Grade 4 in 21% of patients. The median time to onset of the first Grade 2 to 4 ophthalmic exam findings was 43 days (range: 15 to 611 days). The median duration of all Grade 2 to 4 ophthalmic exam findings was 85 days (range: 5 to 813 days). Patients experienced a median of 3 episodes (range: 1 to 11 episodes) of ocular toxicity based on ophthalmic exam findings. Of the patients with Grade 2 to 4 ophthalmic exam findings, 42% had improvement of the last event to Grade 1 or better; 22% had resolution of the last event based on return to baseline or normal ophthalmic exam findings.

The most commonly reported corneal exam findings included superficial punctate keratopathy, microcyst-like deposits, epithelial changes, and haze. Cases of corneal ulcer, including cases with infection, have been reported and should be managed promptly by an eye care professional *[see Adverse Reactions (6.1)]*.

(continued on next page)

5.1 Ocular Toxicity (cont'd)

A reduction in BCVA to 20/50 or worse in at least one eye occurred in 69% of patients, including 29% who experienced a change in BCVA to 20/100 or worse, and 12% who experienced a change in BCVA to 20/200 or worse. Of the patients with reduced BCVA to 20/50 or worse in at least one eye, 61% had resolution of the last event to baseline or better. Of the patients with reduced BCVA to 20/100 or worse, 57% had resolution of the last event. Of the patients with reduced BCVA to 20/200 or worse, 48% had resolution of the last event.

Ophthalmic exams (including slit lamp exam and BCVA assessment) should be conducted by an eye care professional, such as an ophthalmologist or optometrist, at baseline, before each dose of BLENREP, promptly for new or worsening symptoms, and as clinically indicated. Perform baseline exam within 4 weeks prior to the first dose. Perform each follow-up exam within 10 days prior to the next planned dose. All effort should be made to schedule the exam as close to BLENREP dosing as possible. Withhold BLENREP until improvement in both corneal exam findings and change in BCVA to Grade 1 or less and resume at same or reduced dose or permanently discontinue based on severity *[see Dosage and Administration (2.1, 2.3) of the full Prescribing Information]*.

Counsel patients to inform their healthcare provider of any ocular symptoms. Counsel patients to use preservative-free artificial tears at least 4 times a day starting with the first infusion and continuing until the end of treatment, and to avoid wearing contact lenses for the duration of therapy. Bandage contact lenses may be used under the direction of an eye care professional *[see Dosage and Administration (2.1) of the full Prescribing Information]*.

Changes in visual acuity may be associated with difficulty for driving and reading. Counsel patients to use caution when driving or operating machinery.

5.2 BLENREP Risk Evaluation and Mitigation Strategy (REMS)

BLENREP is available only through a restricted program called the BLENREP REMS because of the risk of ocular toxicity *[see Warnings and Precautions (5.1)]*. Notable requirements of the BLENREP REMS include the following:

- Prescribers must be certified in the BLENREP REMS by enrolling and completing training.
- Prescribers must counsel patients receiving BLENREP on the risk of ocular toxicity, the need for monitoring via ophthalmic exams before each dose, and provide patients with the BLENREP REMS Patient Guide.
- Patients must be enrolled in the BLENREP REMS and adhere to monitoring.
- Healthcare settings that dispense BLENREP must be certified in the BLENREP REMS by enrolling and must obtain authorization prior to dispensing.
- Wholesalers and distributors must distribute BLENREP only to certified healthcare settings.

Further information is available at www.BLENREPREMS.com and 1-855-690-9572.

5.3 Thrombocytopenia

Thrombocytopenia of any grade occurred in 100% of patients in DREAMM-7 *[see Adverse Reactions (6.1)]*.

Grade 2 thrombocytopenia occurred in 10% of patients, Grade 3 in 29% of patients, and Grade 4 in 45% of patients. Clinically significant bleeding (Grade ≥2) occurred in 7% of patients with concomitant low platelet levels (Grade 3 or 4).

Monitor complete blood cell counts at baseline and periodically during treatment as clinically indicated. Withhold or reduce the dose of BLENREP based on severity *[see Dosage and Administration (2.3) of the full Prescribing Information]*.

5.4 Embryo-fetal Toxicity

Based on its mechanism of action, BLENREP can cause fetal harm when administered to a pregnant woman because it contains a genotoxic compound (the microtubule inhibitor, monomethyl auristatin F [MMAF]) and it targets actively dividing cells.

(continued on next page)

5.4 Embryo-fetal Toxicity (cont'd)

Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with BLENREP and for 4 months after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with BLENREP and for 6 months after the last dose *[see Use in Specific Populations (8.1, 8.3)]*.

6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:

- Ocular Toxicity *[see Warnings and Precautions (5.1)]*
- Thrombocytopenia *[see Warnings and Precautions (5.3)]*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Relapsed or Refractory Multiple Myeloma in Combination with Bortezomib and Dexamethasone

The safety of BLENREP with bortezomib and dexamethasone (n = 242) compared with daratumumab with bortezomib and dexamethasone (n = 246) was evaluated in DREAMM-7 in patients with relapsed or refractory multiple myeloma who received at least one prior line of therapy *[see Clinical Studies (14) of the full Prescribing Information]*. Patients received BLENREP 2.5 mg/kg of actual body weight once every 3 weeks in combination with bortezomib and dexamethasone (BVd) for the first 8 cycles, followed by BLENREP as a single agent or daratumumab in combination with bortezomib and dexamethasone (DVd) for the first 8 cycles, followed by daratumumab as a single agent. Among patients who received BLENREP, 69% were exposed for 6 months or longer and 55% were exposed for greater than one year. The safety of BLENREP in combination with bortezomib and dexamethasone in patients who received only one prior line of therapy (n = 125) has not been established.

Serious adverse reactions occurred in 50% of patients who received BVd. Serious adverse reactions in ≥2% of patients included pneumonia (18%), pyrexia (5%), thrombocytopenia (5%), COVID-19 (5%), upper respiratory tract infection (4%), sepsis (4%), second primary malignancy (3%), and anemia (2%). Fatal adverse reactions occurred in 10% of patients who received BVd. Fatal adverse reactions which occurred in >1 patient included pneumonia (4%), sepsis (2%), COVID-19 (1%), respiratory failure (<1%), and intracranial hemorrhage (<1%).

Permanent discontinuation of BLENREP due to an adverse reaction occurred in 17% of patients. Adverse reactions which resulted in permanent discontinuation of BLENREP in ≥3% of patients included ocular toxicity (9%) and pneumonia (4%).

Dosage interruptions of BLENREP due to an adverse reaction occurred in 78% of patients. Adverse reactions which required dosage interruption of BLENREP in ≥3% of patients included ocular toxicity based on ophthalmic exam findings (74%), blurred vision (32%), upper respiratory tract infection (20%), dry eye (14%), photophobia (14%), pneumonia (14%), eye irritation (13%), COVID-19 (12%), foreign body sensation in eyes (12%), eye pain (10%), thrombocytopenia (9%), visual impairment (7%), cataract (5%), diarrhea (4%), and neutropenia (4%).

Dosage reductions of BLENREP due to an adverse reaction occurred in 36% of patients. Adverse reactions which required dosage reductions for BLENREP in ≥3% of patients included ocular toxicity based on ophthalmic exam findings (30%), thrombocytopenia (14%), and blurred vision (10%).

The most common adverse reactions (≥20%) were reduction in BCVA, corneal exam findings, blurred vision, dry eye, photophobia, foreign body sensation in eyes, eye irritation, upper respiratory tract infection, hepatotoxicity, eye pain, diarrhea, fatigue, pneumonia, cataract, and COVID-19. The most common Grade 3 or 4 laboratory abnormalities (≥10%) were decreased platelets, decreased lymphocytes, decreased neutrophils, increased gamma glutamyltransferase, decreased white blood cells, and decreased hemoglobin.

Table 4 summarizes the adverse reactions in DREAMM-7.

(continued on next page)

6.1 Clinical Trials Experience (cont'd)

Table 4. Adverse Reactions (≥10%) in Patients with Relapsed or Refractory Multiple Myeloma Who Received BLENREP in DREAMM-7

Adverse Reactiona	BLENREP + Bortezomib and Dexamethasone N = 242		Daratumumab + Bortezomib and Dexamethasone N = 246	
	All Grades (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Eye disorders				
Reduction in BCVA[b]	89	57	44	9
Corneal exam findings[b]	86	72	19	3
Blurred vision	66	22	11	0.8
Dry eye[c]	51	7	7	0
Photophobia	47	2	2	0
Foreign body sensation in eyes[c]	44	3	4	0
Eye irritation	43	5	5	0
Eye pain[c]	33	0.8	4	0.4
Cataract[c]	24	8	14	3
Visual impairment	11	5	2	0.4
Gastrointestinal disorders				
Diarrhea	32	4	31	4
Nausea	16	0.8	12	0
Infections				
Upper respiratory tract infection[c,d]	38	2	36	2
Pneumonia[c,d]	26	16	17	5
COVID-19[d]	24	5	20	2
Hepatobiliary disorders				
Hepatotoxicity[c]	33	14	16	2
General disorders and administration site conditions				
Fatigue[c]	26	6	27	4
Pyrexia[c,d]	19	0.4	11	2

BCVA = best-corrected visual acuity; BVd = BLENREP + bortezomib and dexamethasone; DVd = daratumumab + bortezomib and dexamethasone.

[a] Adverse reactions, except ophthalmic exam findings, were graded according to Common Terminology Criteria for Adverse Events v5.0.

[b] Based on ophthalmic exam findings.

[c] Grouped term includes other related terms.

[d] Includes the following fatal adverse reactions: BVd: pneumonia (n = 10), COVID-19 (n = 3), upper respiratory tract infection (n = 1); DVd: pneumonia (n = 7), COVID-19 (n = 5), pyrexia (n = 1).

Clinically relevant adverse reactions in <10% of patients who received BVd included: increased lacrimation, vomiting, diplopia, albuminuria, sepsis, eye pruritus, infusion-related reactions, corneal ulcer (including cases with infection), and pneumonitis.

(continued on next page)

6.1 Clinical Trials Experience (cont'd)

Table 5 summarizes the laboratory abnormalities in DREAMM-7.

Table 5. Select Laboratory Abnormalities (>10%) That Worsened from Baseline in Patients with Relapsed or Refractory Multiple Myeloma Who Received BLENREP in DREAMM-7

Laboratory Abnormality	BLENREP + Bortezomib and Dexamethasone[a]		Daratumumab + Bortezomib and Dexamethasone[a]	
	All Grades (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Hematology				
Platelets decreased	100	74	88	48
Lymphocytes decreased	90	53	92	56
Leukocytes decreased	59	11	67	17
Neutrophils decreased	52	17	53	13
Hemoglobin decreased	51	10	60	12
Chemistry				
Aspartate aminotransferase increased	88	5	40	0
Gamma glutamyltransferase increased	73	15	44	3
Alanine aminotransferase increased	71	5	54	1
Creatinine increased	51	2	53	<1
Creatine phosphokinase increased	48	3	31	3

BVd = BLENREP + bortezomib and dexamethasone; DVd = daratumumab + bortezomib and dexamethasone.

[a] The denominator used to calculate the rate varied from 238 to 241 (BVd) and 243 to 246 (DVd) based on the number of patients with a baseline value and at least one post-treatment value.

Patient-reported ocular symptoms were assessed using the Patient-Reported Outcomes Common Terminology Criteria for Adverse Events (PRO-CTCAE) and Ocular Surface Disease Index (OSDI).

PRO-CTCAE assessments were collected at baseline and then every 3 weeks until treatment discontinuation. Completion rates in both arms were ≥90% at baseline and ≥81% at subsequent timepoints where >50% of patients remained on treatment. OSDI assessments were collected every 3 weeks until Dose 6 and then every 6 weeks thereafter until treatment discontinuation for BVd and every 3 weeks until Cycle 6 and then every 12 weeks thereafter until treatment discontinuation for DVd. Completion rates in both arms were ≥90% at baseline and ≥52% at subsequent timepoints where >50% of patients remained on treatment.

Table 6 summarizes the patient-reported symptom of blurred vision as assessed by PRO-CTCAE.

Table 6. Patient-Reported Symptom of Blurred Vision Assessed by PRO-CTCAE in Patients with Relapsed or Refractory Multiple Myeloma in DREAMM-7

Symptom (Attribute)[a]	Any Symptom Before Treatment[b]		Score 3 or 4 Before Treatment[c]		Any Symptom on Treatment[d,e]		Score 3 or 4 on Treatment[d,f]	
	BVd (%) n = 232	DVd (%) n = 227	BVd (%) n = 232	DVd (%) n = 227	BVd (%) n = 238	DVd (%) n = 239	BVd (%) n = 238	DVd (%) n = 239
Blurred vision (severity)	28	24	<1	2	93	74	55	15

BVd = BLENREP + bortezomib and dexamethasone; DVd = daratumumab + bortezomib and dexamethasone; PRO-CTCAE = patient-reported outcomes common terminology criteria for adverse events.

(continued on next page)

6.1 Clinical Trials Experience (cont'd)

[a] Symptom attribute scoring defined as severity with a score of 0 = 'none'; 1 = 'mild'; 2 = 'moderate'; 3 = 'severe'; 4 = 'very severe'.

[b] Percentage of patients whose symptom score before treatment was 1 to 4.

[c] Percentage of patients whose symptom score before treatment was 3 or 4.

[d] Number of patients who provided at least one on-treatment score.

[e] Percentage of patients whose maximum post-baseline score was 1 to 4 on treatment.

[f] Percentage of patients whose maximum post-baseline score was 3 or 4 on treatment.

Driving at night was assessed using the OSDI. At baseline, the proportion of patients who reported limitations with driving at night "all of the time" or "most of the time" during the last week was 9% in the BVd arm and 4% in the DVd arm. The proportion of patients who reported limitations with driving at night "all of the time" or "most of the time" during the last week was highest in the BVd arm at 47% at Week 13 and in the DVd arm at 12% at Week 76.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Based on its mechanism of action, BLENREP can cause fetal harm when administered to a pregnant woman, because it contains a genotoxic compound (the microtubule inhibitor, MMAF) and it targets actively dividing cells *[see Clinical Pharmacology (12.1), Nonclinical Toxicology (13.1) of the full Prescribing Information]*. Human immunoglobulin G (IgG) is known to cross the placenta; therefore, belantamab mafodotin-blmf has the potential to be transmitted from the mother to the developing fetus. There are no available data on the use of BLENREP in pregnant women to evaluate for drug-associated risk. No animal reproduction studies were conducted with BLENREP. Advise pregnant women of the potential risk to a fetus.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

8.2 Lactation

Risk Summary

There are no data on the presence of belantamab mafodotin-blmf in human milk or the effects on the breastfed child or milk production. Because of the potential for serious adverse reactions in the breastfed child, advise women not to breastfeed during treatment with BLENREP and for 3 months after the last dose.

8.3 Females and Males of Reproductive Potential

BLENREP can cause fetal harm when administered to pregnant women *[see Use in Specific Populations (8.1)]*.

Pregnancy Testing

Verify the pregnancy status of females of reproductive potential prior to initiating BLENREP.

Contraception

Females: Advise females of reproductive potential to use effective contraception during BLENREP treatment and for 4 months after the last dose.

Males: Because of the potential for genotoxicity, advise males with female partners of reproductive potential to use effective contraception during treatment with BLENREP and for 6 months after the last dose *[see Nonclinical Toxicology (13.1) of the full Prescribing Information]*.

(continued on next page)

8.3 Females and Males of Reproductive Potential (cont'd)

Infertility

Based on findings in animal studies, BLENREP may impair fertility in females and males. The effects were not reversible in male rats but were reversible in female rats *[see Nonclinical Toxicology (13.1) of the full Prescribing Information]*.

8.5 Geriatric Use

Of 242 patients who received BLENREP in DREAMM-7, 121 patients (50%) were aged 65 years or older and 37 patients (15%) were 75 years or older. No overall differences in the safety of BLENREP were observed between patients 65 years of age and older and younger adult patients.

Of the 108 patients who received BLENREP and were evaluated for efficacy in the DREAMM-7 study, there was an insufficient number of older adult patients to determine if the effectiveness in patients 65 years of age and older is different than in younger adult patients.

8.6 Hepatic Impairment

No dose adjustment is recommended for patients with mild hepatic impairment (total bilirubin > upper limit of normal [ULN] to ≤1.5 × ULN and any aspartate aminotransferase [AST] or total bilirubin ≤ULN with AST >ULN).

The recommended dose of BLENREP has not been established in patients with moderate or severe hepatic impairment *[see Clinical Pharmacology (12.3) of the full Prescribing Information]*.

Manufactured by:

GlaxoSmithKline LLC

Philadelphia PA, 19104

U.S. License No. 1727

For:

GlaxoSmithKline

Durham, NC 27701

BLP:1BRS

Approved: 10/2025

PMUS-BLMJRNA260006 July 2026
Produced in USA.

save the date

AUGUST

25-28

SOHO ANNUAL MEETING

2027

HEM-ONC WORD SEARCH

J	E	M	N	U	F	Z	G	R	N	Z	W	L	U	F	O	V	A
O	M	F	F	C	B	E	N	C	A	R	T	S	S	K	E	L	A
O	B	M	W	O	C	B	I	S	P	E	C	I	F	I	C	G	L
R	S	B	B	N	O	K	B	E	H	O	I	H	S	S	Y	M	Y
H	W	L	U	D	N	C	S	P	F	E	Y	C	S	L	N	D	M
Q	O	B	C	I	S	D	S	A	C	Q	A	U	O	M	V	M	P
E	X	D	L	T	O	I	M	R	Z	G	P	F	M	Y	L	G	H
R	M	D	S	I	L	L	B	P	E	F	H	V	G	E	H	C	O
R	V	H	N	O	I	E	E	V	N	F	E	Z	F	L	N	U	M
Y	A	J	M	N	D	U	K	P	Z	V	R	X	U	O	A	I	A
Y	A	K	T	I	A	K	W	I	H	M	E	A	R	M	X	O	N
C	A	L	T	N	T	E	K	A	L	T	S	N	C	A	V	N	E
R	U	R	H	G	I	M	O	E	F	S	I	B	Q	T	D	A	V
V	B	R	M	T	O	I	Y	H	Y	B	S	X	L	P	O	N	P
G	H	X	E	R	N	A	Y	F	M	X	F	A	Y	M	F	R	O
F	J	Y	C	Y	T	O	P	E	N	I	A	D	Z	X	D	F	Y
S	Z	D	G	I	M	M	U	N	O	T	H	E	R	A	P	Y	W
J	Z	S	S	N	F	O	S	O	G	F	B	N	M	V	X	P	N

APHERESIS

BISPECIFIC

CART

CONDITIONING

CONSOLIDATION

CURE

CYTOPENIA

IMMUNOTHERAPY

LEUKEMIA

LYMPHOMA

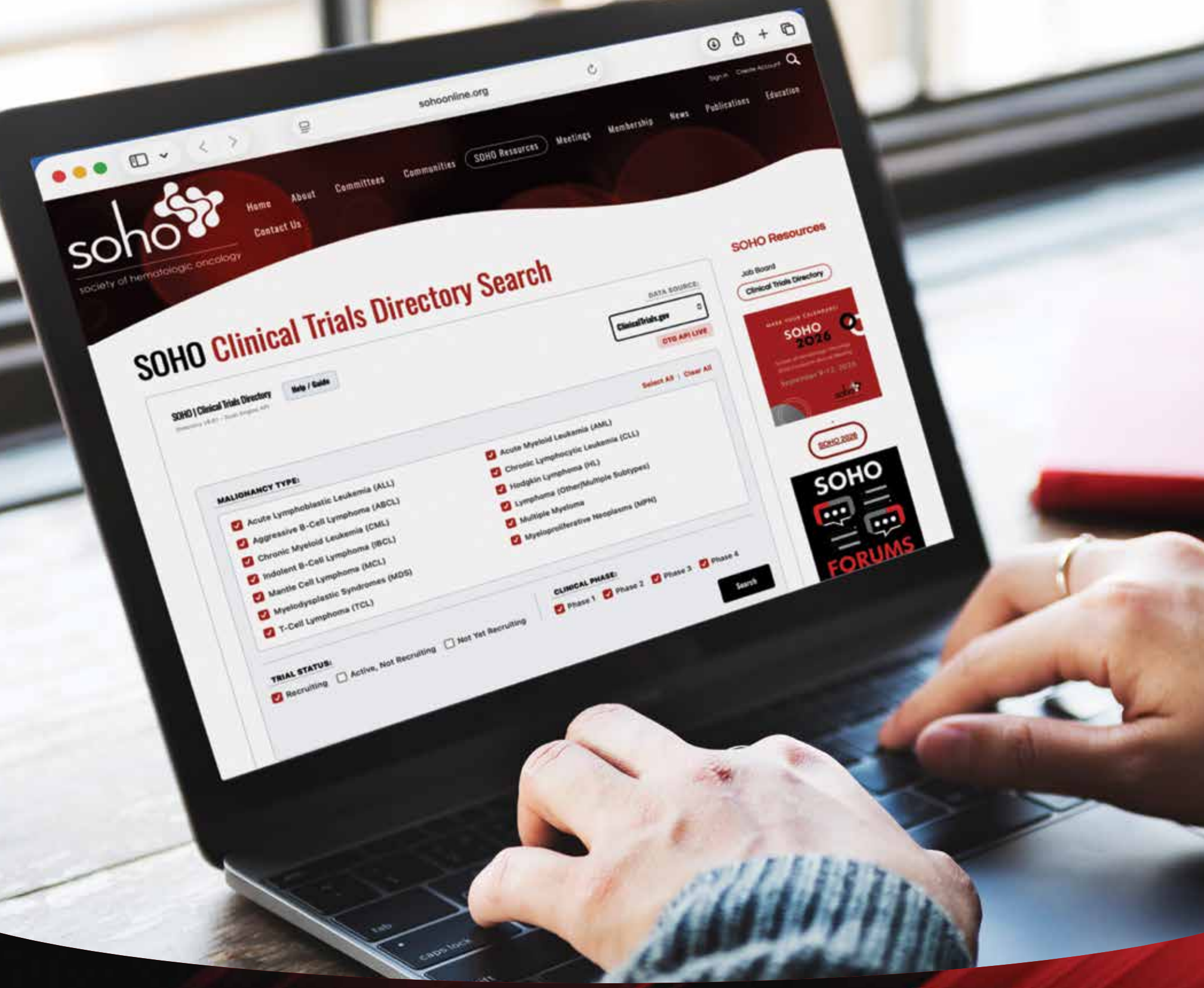
MDS

MENIN

MPN

MYELOMA

REFRACTORY



New Clinical Trials Directory

SOHO has released a new clinical trials directory to help hematologic oncologists identify active blood cancer clinical trials. The resource is designed to make it easier to search for studies and connect patients with potential treatment opportunities.

Scan the QR code or visit
https://soho.click/clinicaltrials

soho
society of hematologic oncology

EXPLORE HOUSTON

beyond the convention center walls

Danny Ye - stock.adobe.com

Welcome to Houston, Texas, and the George R. Brown (GRB) Convention Center (1001 Avenida De Las Americas), your host to the Fourteenth Annual Meeting of the Society of Hematologic Oncology (SOHO).

Houston has so much to offer, from diverse cuisine to the famous Space Center. Make sure you bookmark some time to see the sights of the fourth largest US city. Read on for dining, shopping, and entertainment recommendations, as well as some events happening during your time at the meeting, September 9–12.

Transportation

Traveling from the George Bush Intercontinental Airport to the GRB? Catch the 500 IAH Downtown Direct shuttle from the ground transportation area at Terminal E, Level 2, exit door E201. Traveling one-way costs $4.50, and the route operates seven days a week, from 5:30 AM to 8 PM, with buses departing every 30 minutes.

Shopping

There are several shopping areas near the GRB. **The Highlight at Houston Center** (1200 McKinney St., 5-minute walk from GRB) is a downtown hub perfect for quick stops. For a larger shopping adventure, **The Galleria** (5085 Westheimer Rd., 20-minute drive from GRB) hosts a variety of stores offering everything from designer to everyday labels. For personal care items, a **CVS** is located about a mile from the GRB at both 300 Milam St. and 4210 Polk St.

A Local Gem

Houston is known for many things, most notably, the **Space Center**. Located about 30 minutes from the GRB at 1601 NASA Pkwy, it's a can't-miss for space enthusiasts and excited tourists alike. With rotating and permanent exhibits, the museum features over 400 space artifacts and captivating experiences that celebrate the history and exciting future of America's space exploration. Tickets range from $30 to $45 for adults. This is a great place for both families and individuals looking to learn more about this unique landmark in Houston.

Events

The Journey to End Cancer

1–3 PM; SEPTEMBER 9–12

The Journey to End Cancer: From Cause to Cure is an interactive exhibition held at **The Health Museum**. Located at 1515 Hermann Dr, the exhibit offers a comprehensive look at the history and future of oncology. General admission is priced at $15 for adults and $12 for children and seniors. Visitors can explore medical progress from the discovery of cancer causes to modern life-saving treatments. The exhibition is presented by The University of Texas MD Anderson Cancer Center.

John Akomfrah: The Hour Of The Dog

11 AM TO 7 PM; SEPTEMBER 9–12

The Menil Collection presents the exhibition "John Akomfrah: The Hour Of The Dog." This program takes place in the main building at 1533 Sul Ross St. Admission to the Menil Collection and this specific exhibition is free and open to the public. The showcase features the work of the renowned filmmaker and artist, focusing on themes of memory and post-colonialism.

Nevine Mahmoud: Second Nature

10 AM TO 5 PM; SEPTEMBER 9–12

The Asia Society Texas Center hosts the "Nevine Mahmoud: Second Nature." The exhibition is located at 1370 Southmore Blvd in the Museum District. Entry to the gallery for this event is $15 per person. This presentation highlights the artist's sculptures that explore the intersection of natural forms and synthetic materials.

River Oaks Mercantile

4–8 PM; SEPTEMBER 9

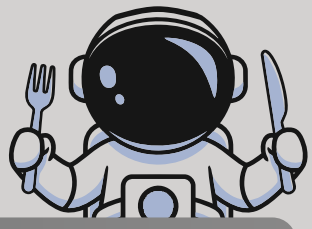
This local pop-up market takes place at 4200 Westheimer Rd. This community event is free for the public to attend and features a curated mix of artisan goods, gourmet foods, and boutique fashion from local small businesses. The family-friendly market serves as a hub for supporting Houston's talented entrepreneurs and connecting with the community.

The Viral Comedy Show

9–11 PM; SEPTEMBER 9

The Viral Comedy Show is held every at Drift Bar, located at 1207 W 20th St in the heart of the Heights. This event is free and includes stand-up comedy and karaoke. The show features regional and national comics providing hilarious commentary on viral video clips from social media.

Places to eat in Houston



As recommended by Naval Daver, MD, to SOHO Insider.

STEAK 48

This fine-dining restaurant offers prime cuts of steak, including the highest-grade Wagyu, as well as seafood and seasonal offerings. Known for its intimate setting and top-tier service, this is a great place to unwind with colleagues and friends after a day of sessions.

www.steak48.com/steakhouses/houston

4444 Westheimer Rd
Houston, TX 77027

About 9 miles from the convention center

KIRAN'S

A fine dining Indian restaurant located in the heart of Houston, chef Kiran Verma brings world-class cuisine. The "Godmother of Indian fine dining" is a self-taught chef who was a guest judge on season 19 of Top Chef and a James Beard semi-finalist best chef of Texas in 2023. Kiran bends a combination of cultures, philosophies, and cooking techniques and sources food from local purveyors and the Gulf waters. The food is inspired by the Awadhi style of cooking over a slow fire with spices and herbs that create memorable flavors.

https://kiranshouston.com

2925 Richmond Ave
Houston, TX 77098

About 5 miles from the convention center

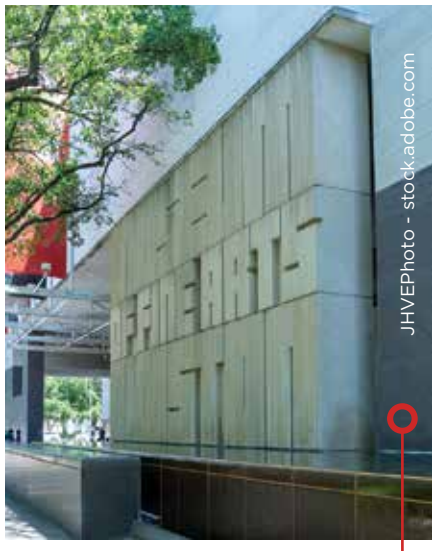
CARACOL

Caracol means snail in Spanish and was chosen as the restaurant's moniker thanks to Chef Hugo's fond memories of making ceviche de caracol in Playa del Carmen with his brother. This Mexican restaurant has an ocean-inspired setting and specializes in fresh seafood and wood-grilled items. Don't overlook its agave-focused cocktail menu and a four-course Yucatán tasting menu. The award-winning restaurant is helmed by Chef Hugo Ortega and restaurateur Tracy Vaught.

www.caracol.net

2200 Post Oak Blvd
Houston, TX 77056

About 9 miles from the convention center



Happy Hour Fridays

5–8 PM; SEPTEMBER 11

Happy Hour Fridays at the Museum of Fine Arts, Houston at 1001 Bissonnet St. feature music and drinks. General museum admission is $13 for adults. This weekly gathering offers a social atmosphere where visitors can enjoy cocktails while exploring the museum's vast art collections, providing a unique opportunity to experience the museum's galleries in a more relaxed evening setting.

Tea d'Alba

12–2 PM; SEPTEMBER 11–12

Located at Hotel Granduca Houston, Tea d'Alba service is available on Friday and Saturday, located at 1080 Uptown Park Blvd. The cost for this afternoon tea experience starts at $79 per guest. Experience a selection of fine teas paired with tiered trays of savory bites and traditional sweets.

Houston on Foot Tour at Hermann Park

8:30 AM; SEPTEMBER 12

The Houston on Foot Tour at Hermann Park, located at 1700 Herman Dr, is a two-hour guided walking tour that is free to both locals and visitors. Led by Will Blasingame, the walk explores iconic neighborhoods, including the Museum District and Rice University. Participants will learn about the area's 20th-century architecture and the historic stories of the individuals who built it.

Tag us on 𝕏 @SocietyofHemOnc with pictures and comments of how you're spending your time in the "Space City."

Download the

SOHO365

mobile app

for the best

annual meeting

experience

Scan the QR code

Download on the App Store

GET IT ON Google Play

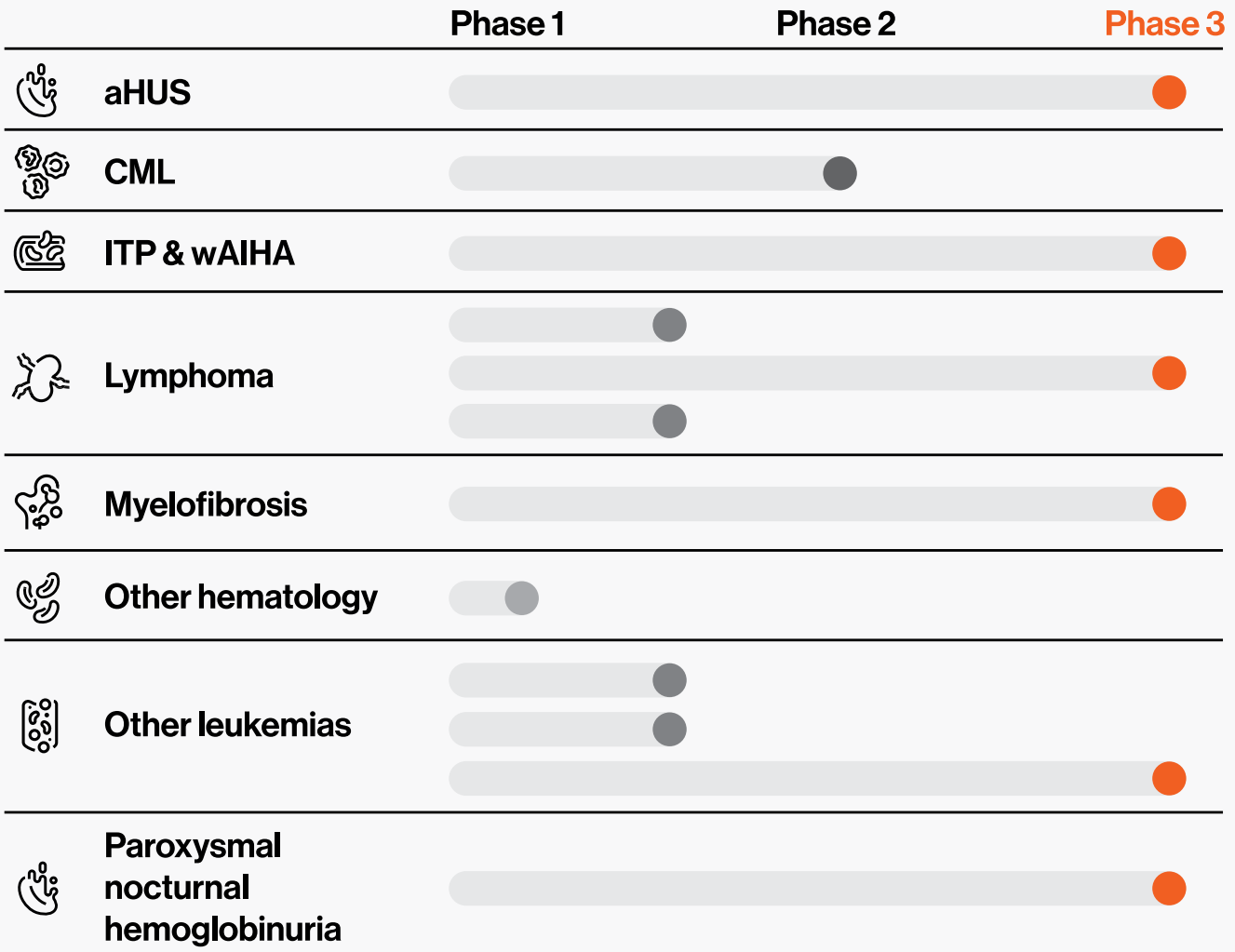
NOVARTIS

Building on a history of innovation in hematology

Novartis is committed in our pursuit to transform the future of care for patients with blood cancers and blood disorders worldwide

7
Investigational compounds

17
Ongoing clinical trials



aHUS, atypical hemolytic uremic syndrome; CML, chronic myeloid leukemia; ITP, immune thrombocytopenia; wAIHA, warm autoimmune hemolytic anemia.

Scan to visit the pipeline navigator or speak to a medical representative to learn more at **#SOHO booth #175**

pipelinenavigator.com/pipeline/

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

FA-11758894

Genmab

Patient Support at Your *Fingertips*

MyNavCare®
PATIENT SUPPORT BY GENMAB

Arm your patients with support and resources as they navigate treatment with a Genmab medication

MyNavCare Patient Support by Genmab® offers services to assist your patients on their treatment journey.

Visit us at Booth 176

To enroll patients, visit **MyNavCare.com**

For more information, call 1-866-NAV-CAR1 (1-866-628-2271).

*Based on eligibility requirements and Terms and Conditions.

†*MyNavCare* Patient Engagement Liaisons are part of the *MyNavCare Patient Support by Genmab* Program and do not provide medical advice or work under the direction of the prescribing healthcare providers. They are trained to direct patients to speak with their HCP about any treatment-related questions.

06/26 COM-US-UNB-0001063