THURSDAY, SEPTEMBER 10, 2026 VOLUME 2 OF 4

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Insider DAILY EDITION

Daily news from the SOHO 2026 Annual Meeting

Cooperation and compassion: a story of partnerships that improved CML outcomes in low- and middle-income countries

By Jerald Radich, MD

These are strange times to be in the health science field. We have our government leadership openly advocating for moving grants away from academia, particularly for institutions and investigators that do not toe the party line. We have prediction markets now wagering on the outcomes of clinical trials. We have public displays of disgracing scientists and public health officials. Where does this end? Where does it lead?

SEE *CML OUTCOMES* ON PAGE 18

CELMoDs in multiple myeloma: a decade of progress

By Ajay Nooka, MD, MPH

The first- and second-generation immunomodulatory drugs (IMiDs) have fundamentally transformed the treatment landscape of multiple myeloma (MM) over the past two decades. Lenalidomide combinations became an integral component of frontline regimens,[1,2] maintenance,[3] and relapsed disease therapy.[4,5] Owing to the extensive use of lenalidomide

SEE *CELMoDs* ON PAGE 14

The SOHO Ambassador Program connects a global community

By Phillip Scheinberg, MD, PhD

Since its early days, the Ambassador Program has been a cornerstone of the Society of Hematologic Oncology's global growth. From the beginning, it was clear that for SOHO to become a truly representative international society, strong outreach and meaningful regional engagement would be essential.

The Ambassador Program was established to advance SOHO's mission, increase awareness, and connect hematologists across diverse healthcare settings.

As one of the founding members of SOHO

SEE *AMBASSADOR PROGRAM* ON PAGE 10

AWARD SPOTLIGHT

Dr. O'Brien takes stage today for Keating award plenary lecture

By Leah Sherwood

Susan O'Brien, MD

During today's plenary session, **Susan O'Brien, MD,** will receive the Michael J. Keating Outstanding Achievement Award, an honor bestowed by her peers on the SOHO Board of Directors and the society's Steering Committee.

"I am thrilled and honored to receive this award from SOHO," Dr. O'Brien wrote in an

SEE *PLENARY SESSION* ON PAGE 7

SOHO abstract winners
PAGE 16

Meet Melinda White
PAGE 33

SOHO ANNUAL MEETING 2026

RECRUITING

A Study to Assess the Tolerability of Ianalumab (VAY736) With Investigator's Choice Thrombopoietin Receptor Agonist (IC TPO-RA) in Patients With Primary Immune Thrombocytopenia (ITP) (VAY2EXPLORE)

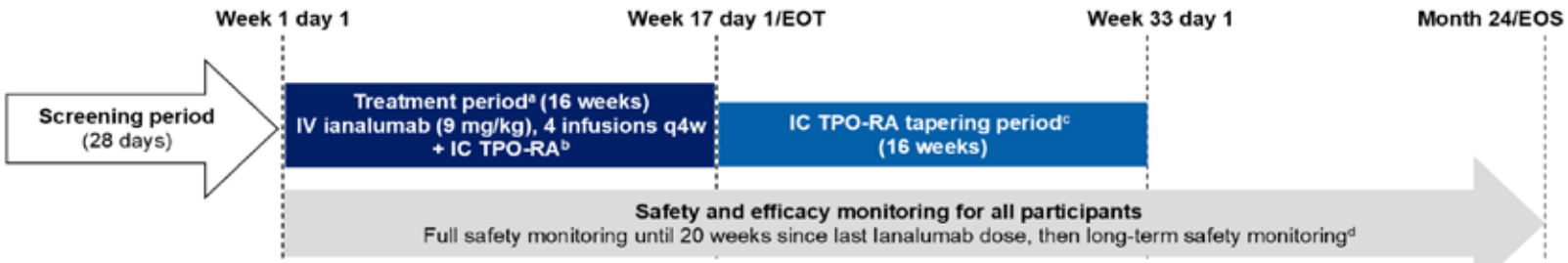
NCT07421167

The purpose of this study is to investigate the tolerability of ianalumab (9 mg/kg) with investigator's choice thrombopoietin receptor agonist (IC TPO-RA) in participants diagnosed with primary immune thrombocytopenia (ITP) who have been treated with at least one but no more than four prior treatments, and with no change in IC TPO-RA dose in at least the last 14 days prior to the start of ianalumab.

Key Inclusion Criteria[1]:

- Participants aged ≥18 years who provided signed informed consent
- Participants may be receiving or initiating a TPO-RA at screening, but should be on a stable dose of TPO-RA for at least 14 days before first dose of ianalumab
- ITP cohort only:
  - Participants with confirmed diagnosis of primary ITP with a prior response to corticosteroids or IVIG that was not sustained (response was defined as platelet count ≥50 G/L)
  - Participants who received at least 1 prior treatment for ITP
  - Participants with a platelet count <100 G/L who are receiving a TPO-RA
- ES cohort only:
  - Participants with primary ES with active thrombocytopenia (platelet count <100 G/L) and wAIHA, confirmed by current or past positive direct antiglobulin test (IgG+, with or without C3+) with evidence of hemolysis, and for whom TPO-RA treatment was considered appropriate by the investigator
  - Participants with i nadequate response to or relapse after treatment with corticosteroid therapy
  - Participants receiving supportive care treatment for wAIHA must be stable for at least 4 weeks before enrollment

Study Design[1,2]: N ≈ 164



[a]The study will include a main cohort of patients with primary ITP and an exploratory cohort of patients with primary ES. [b]Includes eltrombopag, avatrombopag, and romiplostim. [c]IC TPO-RA tapering should start at the end of the combination treatment period, if platelet count has been ≥100 G/L for at least 4 weeks with all platelet counts assessments during these 4 weeks ≥100 G/L. Dose reduction of the IC TPO-RA is allowed prior to the tapering period if clinically indicated. Tapering should be completed by week 33 day 1. However, if the IC TPO-RA cannot be tapered off by the week 33 day 1 visit, the participant will continue to be monitored in the study. [d]Long-term safety monitoring: collection of AEs/SAEs potentially related to B-cell depletion and bleeding events regardless of causality, SAEs assessed by the Investigator as related to ianalumab. If B-cell depleting therapy starts, only SAEs assessed by Investigator as related to ianalumab will be collected.

Primary Endpoints[1]

- Main cohort: The proportion of participants who tolerate ianalumab (9 mg/kg) defined as those who do not experience any of the following events during the combination treatment period:
  - Discontinuation due to an AE unrelated to efficacy
  - AEs leading to dose reduction or dose rate reduction
  - AEs resulting in study drug interruption

Secondary Endpoints[1]

Main cohort:

- Incidence rate of AEs
- Percentage of participants with platelet count ≥30 G/L, ≥50 G/L, ≥100 G/L
- Change from baseline in platelet count for prespecified subgroups (<30 G/L, 30 to 50 G/L, 50 to <100 G/L)
- Percentage of participants with successful IC TPO-RA tapering

For More Information About the Study Design or Enrollment

- See the Novartis medical representative at this booth
- US residents may call our clinical trials hotline at 1-888-NOW-NOVA (1-888-669-6682)
- For countries outside the United States, please contact your local Novartis medical representative
- Visit www.clinicaltrials.gov for eligibility criteria

Acronyms:

AE, adverse event; C3, complement protein; EOS, end of study; EOT, end of treatment; ES, Evans syndrome; IgG, immunoglobulin G; IV, intravenous; IVIG, IV immunoglobulin; q4w, once every 4 weeks; SAE, serious AE; wAIHA, warm autoimmune hemolytic anemia.

REFERENCES: 1. ClinicalTrials.gov. NCT07421167. Accessed March 4, 2026. https://clinicaltrials.gov/study/NCT07421167 **2.** Data on file. Clinical Trial Protocol CVAY736Q1US01. Novartis Pharmaceuticals Corp; December 11, 2025

Compound(s) are either investigational or being studied for (a) new use(s). Efficacy and safety have not been established and there is no guarantee that they will become commercially available for the use(s) under investigation.

NOVARTIS

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Thursday, September 10, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
INDUSTRY EXPERT SESSION II: BREAKFAST SESSION (Non-Accredited)			**GRAND BALLROOM B, THEATER 2**
6:45 AM	Reignite the Spark: Clinical Conversations About Jaypirca® (pirtobrutinib) ***This activity is sponsored by Lilly USA, LLC.***	M. Yair Levy, MD	Charles A. Sammons Cancer Center Dallas, Texas, USA
INDEPENDENT SATELLITE SYMPOSIA: BREAKFAST SESSION			**GRAND BALLROOM C, THEATER 3**
6:45 AM	**Expert Exchanges on the Evolving Treatment Landscape of Acute Lymphoblastic Leukemia** Elias Jabbour, MD | MD Anderson Cancer Center | Houston, Texas, USA Bijal D. Shah, MD, MS | H. Lee Moffitt Cancer Center | Tampa, Florida, 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 program is supported by independent medical education grants from Jazz Pharmaceuticals and Autolus Therapeutics.*		
7:45 AM	**BREAK**		
SESSION IV: MYELOPROLIFERATIVE NEOPLASMS **Session Chairs: John O. Mascarenhas, MD and Laura C. Michaelis, MD**			**LEVEL 3, GENERAL ASSEMBLY**
8:15 AM	ET/PV State of the Art Treatment	Gabriela Hobbs, MD	Massachusetts General Hospital Boston, Massachusetts, USA
8:30 AM	Q&A		
8:33 AM	Targeting Anemia in MF	John O. Mascarenhas, MD	Mount Sinai Medical Center New York, New York, USA
8:48 AM	Q&A		
8:51 AM	Mutant CALR Directed Therapies in Development	Anthony Hunter, MD	Emory University, Winship Cancer Institute Atlanta, Georgia, USA
9:06 AM	Q&A		
9:09 AM	JAK Inhibitor Selection/Sequence Is Nuanced in MF	Andrew Kuykendall, MD	H. Lee Moffitt Cancer Center Tampa, Florida, USA
9:24 AM	Q&A		
9:27 AM	Cellular Therapies for MPNs	Roni Tamari, MD	Memorial Sloan Kettering Cancer Center New York, New York, USA
9:42 AM	Q&A		
9:45 AM	**Oral Abstract | MPN-120:** RALLY-MF: Initial Efficacy of a Phase 2 Study of DISC-0974, an Anti-Hemojuvelin Antibody, to Treat Anemia in Myelofibrosis	Naseema Gangat, MBBS	Mayo Clinic Rochester Rochester, Minnesota, USA
9:55 AM	**Oral Abstract | MPN-099:** Restore-PV: A Phase 2 Open-Label Study Evaluating the Safety and Efficacy of the Anti-TMPRSS6 Monoclonal Antibody DISC-3405 in Participants with Polycythemia Vera	Naseema Gangat, MBBS	Mayo Clinic Rochester Rochester, Minnesota, USA
10:05 AM	**BREAK**		
SESSION V: CHRONIC MYELOID LEUKEMIA **Session Chairs: Michael Deininger, MD, PhD and Jorge E. Cortés, MD**			**LEVEL 3, GENERAL ASSEMBLY**
10:35 AM	STAMP: Advantages and Pitfalls	Andreas Hochhaus, MD	Jena University Hospital Jena, Germany
10:50 AM	Q&A		
10:53 AM	Good Response but Not DMR: What to Do	Ehab L. Atallah, MD	Medical College of Wisconsin Milwaukee, Wisconsin, USA
11:08 AM	Q&A		
11:11 AM	AGA in CML: Potential Role and Therapeutic Strategies	Vivian Oehler, MD	Fred Hutchinson Cancer Research Center Seattle, Washington, USA
11:26 AM	Q&A		
11:29 AM	Is There Still a Role for Allogeneic Transplant in CML?	Hugues de Lavallade, MD, PhD	Guy's & St Thomas' NHS Foundation Trust London, United Kingdom
11:44 AM	Q&A		
11:47 AM	**Oral Abstract | CML-652:** ENABLE: A Phase 1 Study of ELVN-001, a Novel, Selective ATP-Competitive Inhibitor of BCR::ABL1, in Patients With Previously Treated CP-CML	Fadi Haddad, MD	MD Anderson Cancer Center Houston, Texas, USA
11:57 AM	**BREAK**		

Thursday, September 10, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
INDUSTRY EXPERT SESSION III: LUNCH (Non-Accredited)			**GRAND BALLROOM A, THEATER 1**
12:27 PM	Unlocking the Potential for a Bispecific Antibody in 3L+ DLBCL and 2L+ FL ***This activity is sponsored by Genmab/AbbVie***	Jonathan Abbas, MD	Tennessee Oncology Nashville, Tennessee, USA
INDUSTRY EXPERT SESSION IV: LUNCH (Non-Accredited)			**GRAND BALLROOM B, THEATER 2**
12:27 PM	The Only BTKi Approved in 1L CLL/SLL and 1L MCL ***This activity is sponsored by AstraZeneca***	M. Yair Levy, MD	Charles A. Sammons Cancer Center Dallas, Texas, USA
INDUSTRY EXPERT SESSION V: LUNCH (Non-Accredited)			**GRAND BALLROOM C, THEATER 3**
12:27 PM	Evaluating Practice Patterns in PV and MF: A Case-Based Discussion on Optimizing Treatment Goals ***This activity is sponsored by Incyte***	Sagar Patel, MD Firas El Chaer, MD	Huntsman Cancer Institute Salt Lake City, Utah, USA Baptist Health Miami Cancer Institute Miami, Florida, USA
POSTER WALK II			**LEVEL 3, POSTER HALL B3**
12:27 PM	***POSTER WALK - MM, MPN, CML, CLL***		
1:27 PM	**BREAK**		
PLENARY SESSION II			**LEVEL 3, GENERAL ASSEMBLY**
Session Chair: Hagop Kantarjian, MD			
1:57 PM	CLL	Susan O'Brien, MD	University of California Irvine, California, USA
	Recipient of the Michael J. Keating Outstanding Achievement Award		
SESSION VI: MULTIPLE MYELOMA **Session Chairs: Thomas G. Martin, MD and Noopur Raje, MD**			**LEVEL 3, GENERAL ASSEMBLY**
2:17 PM	Frontline Therapy: TE – Current and Future – Where Should We Be Headed?	Luciano J. Costa, MD, PhD	University of Alabama Birmingham, Alabama, USA
2:32 PM	Q&A		
2:35 PM	Frailty Defines Frontline and Which IT at Relapse	Hira Mian, MD, MSc	McMaster University Hamilton, Ontario, Canada
2:50 PM	Q&A		
2:53 PM	Sequencing Based on Mutations/Surface Expression?	Paola Neri, MD, PhD	University of Calgary Calgary, Canada
3:08 PM	Q&A		
3:11 PM	**Debate:** CAR Should Be Used First in RR MM	Noopur Raje, MD	Massachusetts General Hospital Boston, Massachusetts, USA
3:20 PM	**Debate:** Bispecifics Should Be Used First in RR MM	Saad Z. Usmani, MD, MBA, FACP, FRCP, FASCO	Memorial Sloan Kettering Cancer Center New York, New York, USA
3:29 PM	Q&A		
3:32 PM	Updates - Amyloidosis and WM	Meletios A. Dimopoulos, MD	National and Kapodistrian University of Athens Athens, Greece
3:47 PM	Q&A		
3:50 PM	ADCs and Non-BCMA Immuno Therapeutics	Robert Orlowski, MD, PhD	MD Anderson Cancer Center Houston, Texas, USA
4:05 PM	Q&A		
4:08 PM	Next Generation: Degraders, Targeted Therapy – Where Do They Fit Best?	Ajay K. Nooka, MD, MPH, FACP	Emory University, Winship Cancer Institute Atlanta, Georgia, USA
4:23 PM	Q&A		
4:26 PM	**Oral Abstract | MM-218:** Phase 3 Randomized Trial of Anselamimab Demonstrates Improvement in All-Cause Mortality in χ Light-Chain Amyloidosis	Giada Bianchi, MD	Dana-Farber Cancer Institute Boston, Massachusetts, USA
4:36 PM	**BREAK**		
SESSION VII: CHRONIC LYMPHOCYTIC LEUKEMIA **Session Chairs: Alessandra Ferrajoli, MD and Kerry A. Rogers, MD**			**LEVEL 3, GENERAL ASSEMBLY**
5:06 PM	Bringing Order to the Alphabet Soup (IV, BO, IVO, AV, AVO, ZVO etc.)	Mary Ann Anderson, MBBS, FRACP, FRCPA, PhD	The University of Melbourne Victoria, Australia
5:21 PM	Q&A		
5:24 PM	How Do We Define Refractory CLL?	Paolo Ghia, MD, PhD	Università Vita-Salute San Raffaele Milano, Italy
5:39 PM	Q&A		

Thursday, September 10, 2026

TIME	TOPIC/SESSION	SPEAKER	AFFILIATION/ROOM
5:42 PM	**Debate:** Relapse After FD: Repeat Ven-Based - PRO	Catherine C. Coombs, MD	UCI Health Orange, California, USA
5:57 PM	**Debate:** Relapse After FD: Change to BTKi - CON	John N. Allan, MD	Weill Cornell Medicine New York, New York, USA
6:12 PM	Q&A		
6:18 PM	Immunotherapy (CAR T, Bispecifics, etc.) in CLL	Jordan Gauthier, MD, MSc	Fred Hutchinson Cancer Research Center Seattle, Washington, USA
6:33 PM	Q&A		
6:36 PM	Update on Richters	Mahesh Swaminathan, MD	MD Anderson Cancer Center Houston, Texas, USA
6:51 PM	Q&A		
6:54 PM	**Oral Abstract | CLL-1265:** Pirtobrutinib, Venetoclax, and Obinutuzumab Treatment in First-Line CLL (PIVOT-CLL)	Nitin Jain, MD	MD Anderson Cancer Center Houston, Texas, USA
7:04 PM	**BREAK**		
INDEPENDENT SATELLITE SYMPOSIA IV: DINNER SESSION			**GRAND BALLROOM A, THEATER 1**
7:14 PM	**Transforming Lymphoma Management: Practical Integration of CAR T Cell Therapies for Improved Outcomes** Caron Jacobson, MD, MMSc | Dana-Farber Cancer Institute | Boston, Massachusetts, USA Krish Patel, MD | Sarah Cannon Research Institute | Nashville, Tennessee, USA Jason R. Westin, MD, MS, FACP, FASCO | MD Anderson Cancer Center | Houston, Texas, USA *In support of improving patient care, Clinical Care Options, LLC dba Decera Clinical Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. This activity is supported by an educational grant from Bristol Myers Squibb.*		
INDEPENDENT SATELLITE SYMPOSIA V: DINNER SESSION			**GRAND BALLROOM C, THEATER 3**
7:14 PM	**Redefining Supportive Care in Myelofibrosis: Improving Outcomes in Myelofibrosis Through Effective Anemia Management** Prithviraj Bose, MD | MD Anderson Cancer Center | Houston, Texas, USA Pankit Vachhani, MD | University of Alabama at Birmingham | Birmingham, Alabama, USA *In support of improving patient care, Med Learning Group is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. This activity is supported by an independent medical education grant from GSK.*		
8:14 PM	**BREAK**		
INDEPENDENT SATELLITE SYMPOSIA VI: DESSERT SESSION			**GRAND BALLROOM A, THEATER 1**
8:24 PM	**Navigating the Evolving Landscape of Acute Lymphoblastic Leukemia** Hagop Kantarjian, MD | MD Anderson Cancer Center | Houston, Texas, USA Elias Jabbour, MD | MD Anderson Cancer Center | Houston, Texas, USA Aaron C. Logan, MD, PhD, MPhil | University of California | San Francisco, California, USA *Physicians' Education Resource®, LLC, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Physicians' Education Resource®, LLC, designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Physicians' Education Resource®, LLC, is approved by the California Board of Registered Nursing, Provider #16669, for 1.0 Contact Hour. This activity is supported by educational grants from AstraZeneca Pharmaceuticals, Amgen Inc., and Autolus, Inc.*		
INDEPENDENT SATELLITE SYMPOSIA VII: DESSERT SESSION			**GRAND BALLROOM C, THEATER 3**
8:24 PM	Medical Crossfire®: Where CAR-T and Bispecific Antibodies Fit in Lymphoid Malignancies Today…and Tomorrow Krina K. Patel, MD, MSc | MD Anderson Cancer Center | Houston, Texas, USA Christopher R. Flowers, MD, MS, FASCO | MD Anderson Cancer Center | Houston, Texas, USA Juan Alderuccio, MD | Sylvester Comprehensive Cancer Center | Miami, Florida, USA Matthew Lunning, DO, FACP | University of Nebraska Medical Center | Omaha, Nebraska, USA *Physicians' Education Resource®, LLC, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Physicians' Education Resource®, LLC, designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Physicians' Education Resource®, LLC, is approved by the California Board of Registered Nursing, Provider #16669, for 1.0 Contact Hour. This activity is supported by an educational grant from AstraZeneca Pharmaceuticals.*		

Today's can't-miss session:

1:57 PM | GENERAL ASSEMBLY

Dr. Susan O'Brien receives the Michael J. Keating Outstanding Achievement Award

PLENARY SESSION FROM PAGE 1

email. "It is particularly apt that this award is named after Dr. Michael Keating. He was one of my first mentors and helped me develop my career in CLL, which, over the years, has been so interesting and rewarding."

Dr. O'Brien, a founding member of the society, has contributed far beyond her scientific expertise. Known for her dedication and commitment to the field, she has supported SOHO's growth and mission since the society's earliest days.

"Dr. O'Brien has consistently gone above and beyond whenever we've asked for her help," SOHO Executive Director **Janet M. Cesak, MBA, BS,** said. "She believes deeply in SOHO's mission and in what we're trying to accomplish, and she's always been willing to pitch in and support the organization."

The current chair of the International Workshop on Chronic Lymphocytic Leukemia (iwCLL), Dr. O'Brien is internationally recognized for her contributions to advancing the treatment of chronic lymphocytic leukemia (CLL), guiding the field from an era dominated by chemotherapy to one defined by targeted therapies that have dramatically improved outcomes for patients.

Guillermo Garcia-Manero, MD

"Dr. O'Brien has been an outstanding leader in leukemia research and has transformed the care of patients with CLL worldwide," said **Guillermo Garcia-Manero, MD,** a member of the SOHO Board of Directors and incoming editor-in-chief of SOHO Insider.

The iwCLL describes Dr. O'Brien as "a leading leukemia expert worldwide" and ranks her among the top 1% of the world's most highly cited and influential researchers. She has authored more than 900 peer-reviewed publications and has played a central role in developing therapies that changed clinical practice.

A role model for women in hematology

When Dr. O'Brien started her career, treatment options for patients with CLL were limited, and women were uncommon in leadership positions in academic hematology.

Catherine Coombs, MD

"She came into the field at a time when there really weren't that many women," said **Catherine Coombs, MD,** a hematologist-oncologist at the University of California, Irvine.

Although women have made significant strides in hematology and oncology over the past several decades, leadership positions remain disproportionately held by men. A 2020 report published in the Journal of Clinical Oncology found that women comprised fewer than 40% of academic faculty in hematology and oncology and only about one-fifth of full professorships.[1]

"I think she's a role model for many women in the field, where sometimes it's hard to speak up," Dr. Coombs said.

Speaking of Dr. O'Brien's candid and straightforward communication style, Dr. Coombs said that Dr. O'Brien's expertise and scientific rigor allowed her to command respect in rooms that were dominated by men.

"Susan's a role model because she knows what she's talking about and has that expertise," Dr. Coombs said. "A lot of the work she's done for so many years of being in a minority has paved the way for women like me and many others in CLL to have that seat at the table."

A reputation built on scientific rigor

William Wierda, MD, PhD

By the time **William Wierda, MD, PhD,** became a fellow at the University of Texas MD Anderson Cancer Center, where he currently serves as a professor of medicine and CLL section chief, Dr. O'Brien had already established herself as one of the leading investigators in leukemia research.

He said he first knew of Dr. O'Brien through her research and publications before he joined the institution in 2001.

"Susan has been one of my mentors from early on in my career," Dr. Wierda said. "She mentored me in clinical trials and in reporting clinical research, and I have always admired her clinical insights and expertise."

Dr. Wierda recalled that Dr. O'Brien first helped advance chemoimmunotherapy, including early work with rituximab-based chemoimmunotherapy regimens, before becoming a leader in the clinical development of targeted therapies.

She was instrumental in enrolling the first patient in the first clinical trial of the Bruton's tyrosine kinase (BTK) inhibitor ibrutinib, a clinical trial that she helped design. Ibrutinib would go onto become a game-changing and life-changing therapy for patients with CLL.

"It was a remarkable time," Dr. Wierda said of the early ibrutinib studies. "To see patients with very refractory disease, who really had no further treatment options, respond to ibrutinib was extraordinary. It wasn't curative, but it fundamentally changed how we managed the disease."

Although she was part of advancing ibrutinib, Dr. Wierda said he most closely associates Dr. O'Brien with the early clinical development of ibrutinib's successor acalabrutinib, where she designed and led clinical trials of the therapy.

"I would associate her even more strongly with the development of acalabrutinib," Dr. Wierda said. "She certainly was very important in those early studies."

Acalabrutinib, a more selective BTK inhibitor than ibrutinib, expanded treatment options for patients while reducing some treatment-related side effects associated with ibrutinib.

Dr. O'Brien also contributed to the understanding of the benefits and limitations of the PI3K inhibitor idelalisib, one of the first targeted therapies that could be used to treat patients without chemotherapy.

SESSION HIGHLIGHT

SESSION NAME:
Plenary Session II

WHEN:
September 10 at 1:57 PM

WHERE:
Level 3, General Assembly

1. See Riaz IB, Siddiqi R, Zahid U, et al. Gender differences in faculty rank and leadership positions among hematologists and oncologists in the United States. JCO Oncol Pract. 2020;16(6):e507-e516. doi:10.1200/OP.19.00255

However, the drug's safety prevented it from becoming a blockbuster therapy.

"She was very important in terms of the challenges we had with idelalisib development," Dr. Wierda said. "It had activity, but there was a lot of toxicity with it. She was helpful in reporting that and bringing that to light with that drug."

When Dr. Coombs completed her fellowship in 2016, targeted therapies were replacing chemotherapy as the standard approach for many patients with CLL.

"The use of novel agents has largely been routine practice for my entire medical career," Dr. Coombs said. "Dr. O'Brien is one of the people who really helped make that transition through all the trials she has done."

Beyond science

Beyond her scientific accomplishments, colleagues consistently describe Dr. O'Brien as a trusted mentor and a direct communicator.

"You always know where you stand with her," Dr. Wierda said. "She will always share her frank opinion with you. That's something I've always valued."

Elias Jabbour, MD

Elias Jabbour, MD, of the MD Anderson Cancer Center, who has known Dr. O'Brien for more than 25 years, describes a colleague who can be blunt and tough, but whose directness is matched by courage and a strong sense of justice.

"She is one of the kindest and most generous people I know," Dr. Jabbour said. "She is smart, inventive, and fearless, never afraid to support an underdog or an unpopular opinion if she believes it is the right thing to do. Her sense of justice and ability to cut through to the crux of an issue have made her an invaluable resource to her patients, colleagues, and many friends."

Despite her international reputation as a clinical investigator, colleagues say Dr. O'Brien has never lost sight of the individual patient.

The 2023 nonfiction book by Nathan Vardi, For Blood and Money: Billionaires, Biotech, and the Quest for a Blockbuster Drug, recounts how Dr. O'Brien personally monitored the first patient treated with ibrutinib for weeks, carefully following every aspect of the patient's care.[2]

In a more recent example, while caring for another patient who had transferred into her practice, Dr. Coombs later learned that Dr. O'Brien had spent hours working directly with a pharmaceutical company to ensure that the patient maintained access to a therapy after a clinical trial was closing.

"I remember she spent hours advocating for this patient," Dr. Coombs said. "I'll never forget that. This is a patient whose care I had largely taken over because he could only go to one site, and it wasn't the site where she practiced. It really showed me that she's in it for the patient."

Dr. O'Brien never sought recognition for her efforts. "She was just looking to do the right thing," Dr. Coombs said.

Dr. Wierda described Dr. O'Brien in much the same way: "She's always been a very staunch patient advocate and patient supporter. She's very well-liked by her patients."

Leah Sherwood is the editorial director of SOHO Insider.

2. Nathan Vardi, For Blood and Money: Billionaires, Biotech, and the Quest for a Blockbuster Drug (New York: W.W. Norton & Company, 2023).

save the date

AUGUST

25-28

SOHO ANNUAL MEETING

2027

AMBASSADOR PROGRAM FROM PAGE 1

in 2012, I became closely involved in the Ambassador Program early on, representing Brazil. I have seen firsthand the impact this initiative can have. Over the years, it has been particularly rewarding to watch how ambassadors have helped build stronger connections between local communities and the broader SOHO network.

In recent discussions with ambassadors, this exchange of ideas has become even more evident. The structure and organization of regional meetings have also matured, reflecting a steady increase in engagement. Participation from physicians across different regions has grown significantly—both at regional meetings and at the society's flagship annual meeting in Houston.

A program is born and quickly grows

In its early stages, the program included only a handful of ambassadors. As SOHO expanded, so did the program. Today, ambassadors from across multiple regions reflect the society's growing international presence. These individuals serve as important connectors, linking SOHO's mission with local hematologists, institutions, and scientific communities.

Ambassadors play a key role in bridging global initiatives with local impact. They bring education and cutting-edge scientific knowledge to their regions, while also identifying and engaging colleagues who share a commitment to collaboration, leadership, and the dissemination of knowledge. Through this network, SOHO has built a truly international community dedicated to advancing hematologic oncology.

Global representation remains at the heart of the Ambassador Program. This diversity strengthens the society by enriching discussions, highlighting differences in access to care, and helping shape more inclusive and globally relevant approaches to research and treatment.

Ambassadors act as liaisons between the society and their home institutions or regions. They help disseminate educational content, promote SOHO activities, and encourage participation in scientific meetings and collaborative initiatives. Through these efforts, they help ensure that high-quality, evidence-based education is accessible across the globe.

Importantly, this is a two-way exchange. Ambassadors also bring valuable insights from their regions, creating a continuous flow of knowledge that strengthens the society. This exchange allows SOHO to better understand regional challenges and opportunities and to continuously refine its global strategy.

Worldwide collaboration that is mutually beneficial

One of the most visible outcomes of the Ambassador Program has been the development of regional SOHO meetings. This initiative began in 2018 in Brazil—an early milestone in extending SOHO's reach beyond its flagship activities—and has since expanded to multiple countries across Asia, Europe, the Middle East and Africa, and Latin America. These regional meetings have grown steadily and continue to expand, with new initiatives being proposed almost every year.

I still remember the uncertainty surrounding the first regional SOHO meeting. During the planning stages in 2016 and 2017, SOHO was still a relatively young society, and there was understandable uncertainty about what this collaboration and partnership would ultimately look like.

At the time, however, we strongly believed there was a need for a more interactive and internationally connected educational experience in hematologic oncology—one that closely followed the model of the flagship SOHO meeting in Houston: a focused program dedicated exclusively to hematologic malignancies, a single-room format without competing sessions, disease-oriented blocks, cutting-edge topics, and leading international experts discussing the most relevant and rapidly evolving areas of the field.

What became immediately clear during that first meeting was the tremendous enthusiasm from the Brazilian hematology community and how well the model was received. This

was evident not only among physicians, but also among nurses, trainees, and allied health professionals. The engagement was so strong that it naturally led to the creation of a parallel multidisciplinary program, which quickly became equally successful.

More importantly, the regional meeting helped expand awareness of SOHO and its mission while also strengthening interest in the society itself. Many participants who first engaged with SOHO through the Brazilian regional meeting later became interested in attending the annual meeting in Houston, further reinforcing the connection between local initiatives and the broader international hematology community.

Strengthening the community of hematologic oncologists

A highlight of the annual meeting in Houston is the ambassador meeting session, which brings together ambassadors from around the world to share updates on regional initiatives, exchange ideas, and learn from each other's experiences. It provides a space for ambassadors to showcase their work, reflect on its impact, and identify new opportunities for collaboration. This interaction reinforces the sense of community within the program and helps align regional activities with SOHO's broader mission.

For many early-career hematologists, involvement in the Ambassador Program can be a transformative experience. It opens doors to mentorship, collaboration, and exposure to leading experts and institutions. Many individuals who first engaged with SOHO through the program have gone on to take active roles within the society, with some becoming part of its leadership. This progression highlights one of the program's greatest strengths: its ability to help develop future leaders in hematologic oncology.

The growth of the Ambassador Program has also contributed to the expansion of SOHO itself. Today, the society has more than 13,000 members worldwide, with representation continuing to grow across different regions. This reflects both the increasing relevance of SOHO and the success of the Ambassador Program in building a connected and engaged global community.

Ultimately, the Ambassador Program represents a strategic investment in the future of hematologic oncology. What began as an educational outreach initiative has evolved into a platform for leadership development, collaboration, and global engagement.

Through the dedication and energy of its ambassadors, SOHO continues to strengthen its impact—ensuring that knowledge is shared, connections are built, and the next generation of hematologists is not only empowered to lead but equipped to shape the future of the field.

Phillip Scheinberg, MD, PhD, is the chief of hematology at the Hospital A Beneficência Portuguesa de São Paulo in Brazil. He is the immediate past-president of SOHO and has served as the SOHO Ambassador to Brazil since 2014.

INSIDE THE MIND OF DR. SCHEINBERG

You've suddenly found yourself in Doctor Strange's Multiverse of Madness and come face-to-face with a version of yourself from another universe. What bizarre situation do the two of you find yourselves in?

We're trapped in a car dealership with 47 nearly identical cars, and the only way out is for the two of us to agree on which one to buy.

In the Odyssey, characters are given epithets that are repeated throughout: Odysseus is "the man of many ways,"Athena is "bright-eyed Athena," and Penelope is "wise Penelope." If you were a character in an ancient Greek epic, what would your epithet be?

Phillip of the restless mind

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?

Werewolves

What SOHO Ambassadors are saying

Prof. Charles Craddock, CBE SOHO UK

"We've had unbelievable interest and support from the UK hemato-oncology community... [and] we've now got a compelling program, which is not only going to cover the length and breadth of hemato-oncology, but it's going to explore really important new areas such as the role of registries and translational medicine. We want SOHO UK to stand alongside the Houston meeting, but also offer something different that speaks to the next generation. We are keen to encourage trainees to advance their own ideas about key areas in hematology."

Gabriela Hobbs, MD

"I think SOHO Asia is a wonderful way for clinicians to interact with colleagues from around the world. Overall, the presentations give clinicians from many parts of the world an opportunity to attend a SOHO meeting where it may have been more challenging to attend the US SOHO meeting, so I think its wonderful to have more opportunities for global exchange as is offered by a meeting like this!"

Vania Hungria, MD

"It was a great pleasure to participate in the joint SOHO–HEMO 2025 sessions in Brazil. The collaboration brought together Brazilian and international experts for an excellent scientific exchange and a wonderful opportunity to share knowledge, experiences, and different perspectives in hematology. It was especially rewarding to see SOHO and HEMO joining forces and strengthening the connection between our hematology communities. I was delighted to be part of it and very much look forward to another exciting joint session at HEMO 2026!"

William Wierda, MD, PhD

"I've participated in several SOHO activities and events, particularly overseas. I think those are a great opportunity to talk about our data, share our data, and educate our colleagues on diseases and new therapeutics. Most of the new developments and access to new drugs happens in the US. What we see, what we develop, and what we work on impacts us initially, but ultimately most of these treatments and drugs will become available to patients and physicians in other countries. It's a nice opportunity to interact with others, educate them on our work, and talk to them about advances that we're making in treatment."

Caron Jacobson, MD

"I was delighted and honored to be included in the first SOHO Asia in Taipei. The meeting was well run and highly educational, and the chance to meet and collaborate with colleagues from all around Asia, in person, was a terrific and unique opportunity. I was so glad I was able to attend!"

Dr. Jacobson spoke on "Progress and Strategy on Treating Primary Central Nervous System Lymphoma" at the first SOHO Asia in January of this year.

Bor-Sheng Ko, MD SOHO Asia

"For young staff, it is very hard to get support to attend meetings like ASH or SOHO. We felt this meeting could be more educational and more practical for physicians in this region."

POSTERS NOT TO MISS: MPN edition
as reported by Gabriela Hobbs, MD

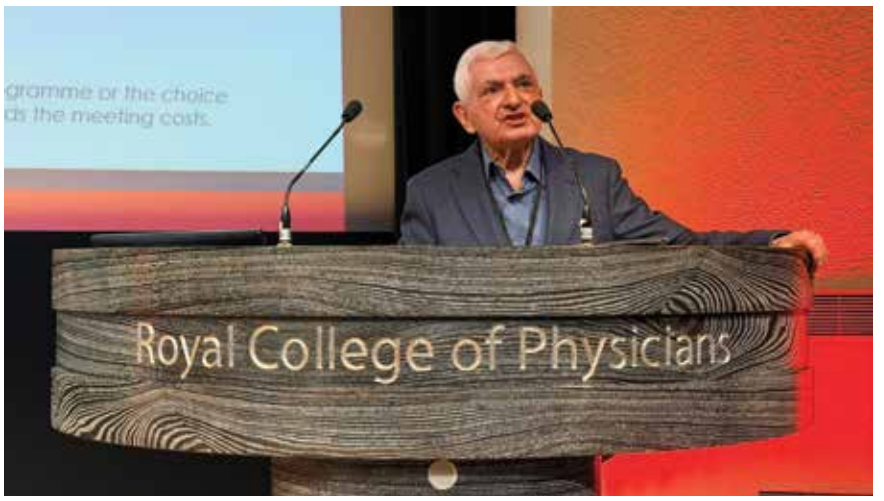
MPN-556: Mutant Calreticulin-Specific Monoclonal Antibody INCA033989 Produces Molecular Responses That Correlate With Clinical Responses in Patients With Myelofibrosis

MPN-425: Baseline Predictors of Survival and Spleen Response in Ruxolitinib-Treated Myelofibrosis: Development of the Ruxolitinib Prognostic Scoring System in a Real-World Cohort

MPN-985: Effect of Rusfertide on Cytoreductive Therapy Use in Patients With Phlebotomy-Dependent Polycythemia Vera: Post Hoc Analysis From the Randomized Controlled Phase 3 VERIFY Study

MPN-1022: Artificial Intelligence vs Conventional Prognostic Models for Survival Prediction in Myelofibrosis: A Systematic Review and Meta-Analysis and External Validation Cohort

MPN-1090: Real-World Patient Characteristics, Treatment Patterns, and Blood Counts of Patients With Essential Thrombocythemia Treated With Ropeginterferon Alfa-2b in the US Community Oncology Setting


Royal College of Physicians


Caron A. Jacobson


FREE*
Insider
UK DAILY EDITION
SOHO UK mirrors traditional
SOHO meeting with UK twist

... CELMoDs FROM PAGE 1

as induction and maintenance therapy, a proportion of myeloma patients are "lenalidomide-refractory" at first relapse. In this patient population, pomalidomide multidrug regimens (with bortezomib,[6] CD38 monoclonal antibodies[7,8]) had proven efficacy in relapsed and refractory disease, but ultimately most patients relapse. This therapeutic evolution has exposed an important unmet need: a viable oral option with proven mechanistic advantage to overcome mechanisms of IMiD resistance.

CELMoDs represent the next generation of cereblon-binding agents specifically designed to address this challenge. Iberdomide and mezigdomide have demonstrated encouraging activity in heavily pretreated and IMiD-refractory MM that led to their evaluation in the maintenance and frontline settings.

Similar to IMiDs, CELMoDs pursue CRBN as their molecular target.[9,10] Both iberdomide and mezigdomide bind CRBN with greater affinity compared with lenalidomide or pomalidomide and induce a conformational change from open to closed conformation, that promotes more efficient recruitment of the transcription factors IKZF1 and IKZF3 to the CRBN-E3 ubiquitin ligase complex.[11,12] This results in accelerated ubiquitination and proteasomal degradation of these critical transcription factors, leading to suppression of IRF4 and MYC signaling, apoptosis of malignant plasma cells by direct tumoricidal effects (a differentiating feature from IMiDs), and enhanced immune cell activation through increased IL-2 production and T- and NK-cell stimulation.[13,14] Compared with currently approved IMiDs, CELMoDs induce more rapid, deeper, and sustained degradation of IKZF1 and IKZF3, translating into superior antitumor activity in preclinical models and retained efficacy in models resistant to lenalidomide and pomalidomide.

Importantly, the enhanced immunologic effects of CELMoDs may have further implications in the current era of immunotherapy in myeloma. By restoring T-cell fitness, reducing immune exhaustion, and augmenting cytokine production, both iberdomide and mezigdomide may provide an ideal orally available partner for immune-based therapies such as bispecific antibodies and as priming prior to CAR T-cell therapies or as maintenance after.[15]

Clinical development of iberdomide

The initial first-in-human phase 2/3 CC-220-MM-001 trial as a single agent (cohorts A and C) and in combination with dexamethasone (cohorts B, D, and I) demonstrated clinically meaningful responses despite a heavily refractory patient population.[16] Responses were observed among patients whose disease was refractory to both lenalidomide and pomalidomide, confirming clinically that CELMoDs have the potential to overcome IMiD resistance. These encouraging findings prompted evaluation of iberdomide in multidrug combinations such as iberdomide combined with daratumumab and dexamethasone (cohort E),[17] which exploits complementary immune mechanisms of myeloma apoptosis. While daratumumab induces antibody-dependent cellular cytotoxicity and immune-mediated plasma cell killing, iberdomide simultaneously enhances T- and NK-cell function, potentially enhancing antitumor activity.[18] This provided the clinical rationale and identified the optimal dose for the phase 3 study EXCALIBER-RRMM among patients who had early relapse (one to two lines of therapy) for the primary endpoint of progression-free survival (PFS).[19] The study evaluated iberdomide at doses of 1.0, 1.3, and 1.6 mg in stage 1, given orally on days one to 21 every 28 days; in stage two, the dose of iberdomide at 1.0 mg was recommended as the phase 3 dose in combination with standard daratumumab and dexamethasone. The control arm is daratumumab, bortezomib, and dexamethasone. The study completed enrollment, and a press release confirmed a statistically significant improvement in measurable residual disease (MRD) negativity rates, compared with the control arm, in a planned interim analysis of the MRD endpoint.[20]

Two other phase 3 studies, EXCALIBER-maintenance[21] and GMMG-HD9/DSMM XVIII[22], evaluated the benefit of iberdomide in the maintenance setting post-transplant. The control arm for EXCALIBER-maintenance was lenalidomide for the primary endpoint of PFS. The study completed enrollment and results are awaited. For GMMG-HD9/DSMM XVIII, the control arm was iberdomide and isatuximab, and the primary endpoint is MRD negativity at two years. Ongoing and recently completed phase 3 trials of iberdomide are summarized in **Table 1**. A cohort of 75 transplant-ineligible newly diagnosed MM patients were evaluated with iberdomide at doses of 1.0, 1.3, and 1.6 mg (25 patients at each dose level) combined with daratumumab and dexamethasone, showing an overall response rate (ORR) of 100%. MRD negativity (threshold 10^{-5}) among patients who have achieved very good partial response (VGPR) or better was close to 60% in both the 1.0 and 1.3 mg cohorts.[23] Clinical development increasingly emphasizes that iberdomide is likely to provide its greatest benefit as an immune-enhancing backbone supporting other active anti-myeloma agents across multiple phases of the myeloma treatment continuum.

SESSION HIGHLIGHT

SESSION NAME:
Next Generation: Degraders, Targeted Therapy – Where Do They Fit Best

WHEN:
September 10 at 4:08 PM

WHERE:
Level 3, General Assembly

Clinical development of mezigdomide

Mezigdomide has emerged as the second-generation CELMoD, akin to pomalidomide as a second-generation IMiD. The first-in-human phase 1/2 CC-92480-MM-001 trial evaluated mezigdomide plus dexamethasone in heavily pretreated patients with relapsed or refractory MM who received a median of six prior lines of therapy. Among this population, median PFS of 4.4 months and median duration of response (DOR) of 7.6 months was reported. In patients with prior anti-BCMA therapy, a median DOR of 6.9 months and median PFS of 5.4 months suggested clinically meaningful responses.[24]

Encouraging early-phase results rapidly led to the evaluation of mezigdomide in combination regimens. Notably, in the CC-92480-MM-001 trial, 40% of patients had extramedullary disease, and mezigdomide plus dexamethasone had shown activity in this population.[25] Mezigdomide in combination with proteasome inhibitors was found to be safe, tolerable, and had clinical activity.[26,27] The combination of mezigdomide, carfilzomib, and dexamethasone (MezKd) demonstrated particularly impressive efficacy,

suggesting synergistic cereblon-mediated protein degradation and proteasome inhibition, ultimately providing the foundation for the randomized phase 3 SUCCESSOR clinical program as outlined in **Table 1**.

The SUCCESSOR-2 trial represents the first randomized phase 3 study to demonstrate a significant clinical benefit for a CELMoD in MM.[28] Patients with relapsed or refractory MM were enrolled who had received at least one prior line of therapy and were exposed to both anti-CD38 monoclonal antibodies and lenalidomide. Median prior lines of therapy were two, more than three-quarters were lenalidomide refractory, and over 85% were refractory to anti-CD38 therapy. The trial compared MeziKd (with weekly carfilzomib) to standard carfilzomib and dexamethasone (Kd; twice weekly dosing) for the primary endpoint of PFS. After a median follow-up of 10.6 months, the median PFS for MeziKd versus Kd was 18.0 and 8.3 months (HR, 0.48; *P*<0.0001). MeziKd substantially deepened treatment responses. Rates of VGPR or better and ORR with MeziKd were doubled and tripled, respectively, compared with Kd alone. A particularly noteworthy finding was the consistency of benefit across patients with high-risk cytogenetics, anti-CD38-refractory disease, and older adults.[28] The FDA accepted the new drug application for mezigdomide in patients with relapsed or refractory MM on July 13, 2026, based on results from SUCCESSOR-2 trial. The FDA has assigned a target action date of May 13, 2027, which likely will be the first CELMoD approval in the US.[29]

Safety

The toxicity profiles of CELMoDs differ in several important respects from those of lenalidomide and pomalidomide. Higher grades of neutropenia were typical of both iberdomide and mezigdomide, which has resulted in multiple dose exploratory studies in both the CC-220-MM-001 and CC-92480-MM-001[24] trials. Grade 3/4 neutropenia exceeded 60% with mezigdomide-containing

●●● CONTINUED ON PAGE 36

Table 1. Ongoing and Completed Phase 3 Studies of Iberdomide and Mezigdomide

Study	Patient Criteria	Number of Patients	Study Intervention	Control Arm	Primary Endpoint	Primary Completion
EXCALIBER-Maintenance (NCT05827016)[21,34]	Post-AHCT maintenance; received 3-6 PI + IMiD-based induction cycles; achieved ≥PR after AHCT	Dose-finding phase: 120 patients (1:1:1:1 randomization to 3 iberdomide dose levels or lenalidomide) Phase 3: 1096 patients (1:1 randomization)	Iberdomide maintenance (optimal dose selected after lead-in)	Lenalidomide maintenance	PFS	**March 2029** (estimated)
EXCALIBER-RRMM (NCT04975997)[19]	Early relapse (1-2 prior lines of therapy)	Dose-finding phase: 200 patients (1:1:1:1 randomization to 3 iberdomide dose levels or Dara-Vd) Phase 3: patients (1:1 randomization)	Iberdomide + daratumumab + dexamethasone	Daratumumab + bortezomib + dexamethasone	PFS	**March 2026**
GMMG-HD9/ DSMM XVIII (NCT06216158)[22]	Post-AHCT maintenance; previously treated in GMMG-HD8/DSMM XIX; achieved ≥PR after AHCT	411 patients; 1:1 randomization	Iberdomide + isatuximab maintenance	Iberdomide maintenance	MRD-negative status at 2 years	**December 2028** (estimated)
GEM21menos65 (NCT05558319)[35]	Transplant-eligible NDMM patients; age ≤65 years; ECOG PS ≤2	480 patients; 1:1:1 randomization	**Experimental arm:** Iberdomide + isatuximab + Vd induction → AHCT → Iberdomide + isatuximab + Vd consolidation → Iberdomide + isatuximab maintenance	**Control arms:** RVd induction → AHCT → RVd → Rd with early rescue intervention (Isa-Iber-dexamethasone) Isatuximab + RVd induction → AHCT → Isatuximab + RVd consolidation → Isatuximab + lenalidomide maintenance	MRD-negative rate	**April 2027** (estimated)
MIDAS/IFM 2020-02 (NCT04934475)[36]	Transplant-eligible NDMM patients; age ≤65 years; ECOG PS ≤2	791 patients; all receive 6 cycles of Isa-KRd induction, then stratified by MRD status	**MRD-positive cohort:** randomization to AHCT + 2 cycles Isa-KRd → Isa-Iber maintenance for 3 years vs double AHCT → Isa-Iber maintenance for 3 years	***MRD-negative cohort:** randomization to AHCT + 2 cycles Isa-KRd → Lenalidomide maintenance for 3 years vs 6 additional cycles Isa-KRd → Lenalidomide maintenance for 3 years	MRD-negative rate	**September 2024**
SUCCESSOR-1 (NCT05519085)[37]	Early relapse (1-3 prior lines of therapy)	Dose-finding phase: Mezi+Vd Phase 3: 1096 patients (1:1 randomization)	Mezigdomide + bortezomib + dexamethasone	Pomalidomide + bortezomib + dexamethasone	PFS	**November 2025**
SUCCESSOR-2 (NCT05552976)[28]	Early relapse (≥1 prior line of therapy)	Dose-finding phase: Mezi+Kd Phase 3: 1096 patients (1:1 randomization)	Mezigdomide + carfilzomib + dexamethasone	Carfilzomib + dexamethasone	PFS	**February 2026**

AHCT: autologous hematopoietic cell transplant; PI: proteasome inhibitor; IMiD: immunomodulatory drug; PR: partial response; PFS: progression-free survival; MRD: measurable residual disease; NDMM: newly diagnosed multiple myeloma; ECOG PS: Eastern Cooperative Oncology Group performance status; RVd: lenalidomide, bortezomib, dexamethasone; Isa: isatuximab; KRD: carfilzomib, lenalidomide, dexamethasone; Iber: iberdomide; Mezi: mezigdomide; Dara: daratumumab; Vd; bortezomib and dexamethasone; Kd; carfilzomib and dexamethasone
*Not a control arm

Dr. Jingliao Zhang takes top honors in SOHO 2026 abstract awards

Seven additional abstract presentations from this year's annual meeting were also recognized by the society.

On Wednesday evening, **Jingliao Zhang, MD,** was awarded first place for the SOHO 2026 abstract awards for the presentation, "Safety and Preliminary Efficacy of Olverembatinib (HQP1351) Combined With Lisaftoclax (APG-2575) in Children and Adolescents With Relapsed/Refractory Philadelphia-Positive Acute Lymphoblastic Leukemia: Results of a Phase 1b Study."

Dr. Zhang is medical researcher and hematologist at the Institute of Hematology and Blood Diseases Hospital of the Chinese Academy of Medical Sciences and Peking Union Medical College in Tianjin, China.


Colton Jones, MD

Second place was awarded to **Colton Jones, MD,** of the University of Texas Health, San Antonio, for the poster MM-626, "GLP-1 Receptor Agonist Exposure and Survival Outcomes in Newly Diagnosed Multiple Myeloma Treated With Daratumumab-Based Quadruplet Therapy: A Target Trial Emulation."

In his own words

In Dr. Jones' target-trial emulation of more than 1000 patients with newly diagnosed multiple myeloma (MM) and metabolic comorbidities (type 2 diabetes or obesity) starting frontline D-VRd, GLP-1 receptor agonist exposure was associated with an overall survival (OS) benefit (HR, 0.30; 95% CI, 0.19-0.47) and higher rates of complete response or better (HR, 1.20), with no significant difference in relapse. An E-value of 6.1 indicates the survival association is relatively robust to unmeasured confounding.

Three practical points to walk away with:

1. **A metabolic-immune interaction may matter in the quadruplet era.** Obesity, insulin resistance, and IL-6-driven inflammation are established drivers of inferior MM outcomes, and the anti-inflammatory/immunomodulatory effects of GLP-1 RAs offer a biologically plausible mechanism for synergy with anti-CD38 therapy.
2. **This extends a converging literature from prevention to treatment.** Prior data tie GLP-1 RAs to lower MM incidence and reduced MGUS-to-MM progression; this is among the first analyses to examine survival and response depth in a uniformly D-VRd-treated population.
3. **Interpret with appropriate caution.** The magnitude of the OS benefit, which is disproportionate to the modest response gain and null relapse effect, suggests contributions from reduced competing/non-myeloma events (infection, cardiometabolic death) and healthy-adherer bias, alongside residual confounding and EHR-based response ascertainment.

Bottom line: These hypothesis-generating data support metabolic optimization as a modifiable target and justify prospective evaluation of GLP-1 RAs as an adjunct in metabolically comorbid newly diagnosed MM, but do not yet support initiating them for anti-myeloma benefit.


Pranati Shah, MD

Third place was awarded to **Pranati Shah, MD,** of Loma Linda University Medical Center in California, for the poster, "Safety, Tolerability and Clinical Activity of Anito-Cel in RRMM."

In her own words

Here are the key takeaways from Dr. Shah's abstract regarding the safety, tolerability, and clinical activity of anitocabtagene autoleucel (anito-cel) in patients with relapsed/refractory multiple myeloma (MM) across the phase 1 and 2 portions of the iMMagine-1 trial.

- **Exceptional and deep efficacy.** Anito-cel demonstrated high overall response rates across both cohorts—100% in phase 1 and 95% in phase 2—with complete/stringent complete response rates of 79% and 62%, respectively.
- **High rates of measurable residual disease (MRD) negativity.** MRD-negativity was achieved by ~90% of evaluable patients in both phase 1 (89%) and phase 2 (92%), driving durable responses even in heavily pretreated and refractory populations.
- **Durable progression-free survival (PFS) and OS.** At a median follow-up of 34 months in phase 1, the 27-month PFS and OS rates were 52% and 78%, respectively. In phase 2 (median follow-up, 10.3 months), the six-month PFS and OS rates were 90% and 95%, respectively.
- **Manageable safety profile with low severe neurotoxicity.** Cytokine release syndrome was frequent but manageable (84% to 95%), while immune effector cell-associated neurotoxicity syndrome (ICANS) was primarily low-grade, with grade ≥3 ICANS remaining low across both phases (5% in phase 1; 2% in phase 2).

Honorable distinctions

Four additional presenters received honorable distinctions:

Tautvilė Smalinskaitė, MD
Vilnius University Hospital Santaros Klinikos
AML-1299 - "Actinomycin D in Combination with Low-dose Cytarabine and Venetoclax in Relapsed or Refractory NPM1-mutated Acute Myeloid Leukemia"

Ashlyn Oleary, MD
University of Texas Southwestern Medical Center
AML-1113 - "Treatment Intensity Rather Than Isoform Is Associated With Improved Outcomes in IDH Mutated AML: A Single-Center Cohort Study"

Akriti Jain, MD
Cleveland Clinic
CML-929 - "Validation of a Prognostic Score in Blast Phase CML: A Cure CML Consortium Analysis"

Abigail Huetteman, MD
Moffitt Cancer Center
ALL-1317 - "Outcomes After TKI Discontinuation in Patients with Ph+ ALL Treated With Blinatumomab and Ponatinib"

Congratulations to our SOHO 2026 corporate partner and industry award recipients

Corporate Partner Award:

NOVARTIS

Industry Award recipients:

AstraZeneca

Bristol Myers Squibb

Lilly
A MEDICINE COMPANY

Genmab

GSK

Incyte

Johnson&Johnson

NOVARTIS

sobi

••• CML OUTCOMES FROM PAGE 1

Franz Kafka spoke to the power of narration: "A book must be the axe for the frozen sea inside us." Well, right about now we need a BIG axe. We need a great story.

I've got one.

The theme of SOHO 2026 is "Advancing Care Through Collaborative Science." There are obviously many challenges in collaborations. There are egos. There are issues of priorities (often pitting shareholder values against human values). There are cultural pressures, given that the prevailing currency seems to emphasize greed and testosterone ("Cooperation is for suckers!"). And while many of us intuit the power and wisdom of the "it takes a village" approach, the reality is that one village idiot can break anything of value to smithereens.

"The impossible attracts me, because everything has been done and the world didn't change." —Sun Ra

The elevator pitch of our lab's work is that we study the luck of biology: why some patients respond to therapy, while others don't. This is an important part of the concept of "precision medicine," where specific drugs are used according to an individual's biologic characteristic (in principle, this includes tumor characteristics as well as non-tumor biology, such as the immune system and microbiome).

The "poster child" of precision medicine is chronic myeloid leukemia (CML), where the unique BCR::ABL1 fusion gene provides the target for therapeutic intervention (tyrosine kinase inhibitors [TKIs]) as well as a direct measure of drug activity and disease burden (measurement of the BCR::ABL1 mRNA transcript). Before TKIs, the average lifespan of a CML patient (without allogeneic transplant) was roughly seven years. Now, patients receiving TKI therapy live a normal lifespan. The amazing promise of targeted therapy shown in CML has spawned enormous enthusiasm in the academic, pharmaceutical, and biotech sectors, and sparked the development of the National Cancer Institute precision medicine initiative in acute myeloid leukemia and myelodysplastic syndromes (myeloMATCH).

Sadly, the biggest component of luck that drives cancer outcomes isn't genetic or immunologic—it's where you were born, as your geography determines access to healthcare. Should we accept this? Should the amazing advances in cancer therapy just be the sole property of those of us lucky enough to be born in wealthy countries (or, indeed, better zip codes)? How do we get "precision medicine" to the millions worldwide who desperately need it? The magic of precision medicine relies on costly medications and complicated diagnostics. How do patients in low-resource areas gain access? Is this daunting challenge impossible to overcome?

"Start by doing what is necessary, then do what is possible, and suddenly you are doing the impossible." —Saint Francis of Assisi

The story that follows is a remarkable tale of loss, hope, dogged perseverance, hard work, creativity, coincidences, and—well—luck. It involves (in order of appearance) The Max Foundation, the giant pharmaceutical company Novartis, Fred Hutch, and the diagnostic biotech company Cepheid.

The Max Foundation was created in the late 1990s by Pat Garcia-Gonzalez after the loss of her stepson Maximiliano (Max) to CML in 1991. Two important notes: first, this was before the advent of TKIs, and second, prior to this, Pat had no experience in the healthcare industry. At first, The Max Foundation was a support and education group for low-resource areas around the world. Think of a shop powered by paper and fax machines. This all changed with the approval of imatinib. Pat reached out to Novartis and came up with a miraculous deal: if she could identify patients with CML who had no access to imatinib, Novartis would provide the drug for free, for life. Thus came the establishment of one of the most successful global medicine access programs: the Glivec International Patient Assistance Program (GIPAP) in 2001.

My guess is that Novartis did this as an idle gesture of goodwill, figuring that Pat could never get this done. If so, it was a dreadfully bad bet. GIPAP supported tens of thousands of CML patients across the globe, and in 2017, this program evolved into Max Access Solutions, partnering with multiple other pharmaceutical companies to offer access to five other TKIs, including second- and third-generation therapies. The Max partnership network now works in over 75 low- and middle-income countries, currently helping over 28,000 CML patients. Max has established the supply network, physician and patient relationships, drug toxicity reporting, and support for diagnostics and monitoring and works on patient-centered activities, including educational and travel support. By the way, this is done with a total global staff of around 100. The efficiency of the operation is utterly remarkable.

Our lab's role in this story stemmed from pure coincidence (luck) and fortune. When The Max Foundation was starting, Pat was having trouble confirming the diagnosis of CML in patients (as I recall, the initial cohort was in El Salvador). A volunteer at Max suggested she give us a call, as he knew we did molecular diagnostics in CML. He happened to know this arcane fact because I had transplanted him for his CML a number of years earlier!

Soon, The Max Foundation was sending us peripheral blood from Salvadoran patients, and after, from patients around the world.

The model of our lab doing all the world's CML molecular diagnostics was clearly not realistic. Some early attempts to send our home-brew assay to other labs fizzled; it was too technical and too complicated to export to the hospitals serving these patients. Again, fate (luck) intervened.

Cepheid, a company that made simple, cartridge PCR assays for infectious disease (especially bioterrorism agents—much of the mail centers across the land have anthrax testing performed by the Cepheid platform) approached us about developing an automated BCR::ABL1 assay. In an additional piece of luck, one of their lead technicians had to move to Seattle and had no job. Cepheid was willing to embed him into our lab. With him at the helm, we quickly worked with Cepheid to develop the assay.

In the last link of the luck chain, the World Health Organization was putting the Cepheid platform into low-resource areas around the globe to use for TB and HIV testing around the same time. Cepheid offered terrific reagent support to Max, and soon, BCR::ABL1 testing was available widely, allowing for a dramatic increase in patients eligible for the Max program. After the launch of the Cepheid assay, we remained active in the cause, starting the Spot on CML program, which offers dried blood spot testing through Max for BCR::ABL1, ABL resistance mutations, and myeloid panel mutations.

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

—Margaret Mead

So how effective overall is this unique nonprofit/big pharma/biotech/academia partnership? Some fun facts, circa 2025:

- CML patients supported with treatment in 2025: **31,857** in 76 countries
- Pills provided (dispensed) to CML patients in 2025: **432,856,006**
- Treatment-free remission patients being supported in 2025: **125**
- Nearly half of all CML patients have been on treatment for 10 years or more
- Overall survival for patients on the program is similar to those of high-income countries!

Take a second to reflect on the last *mind-blowing* bullet. Being diagnosed in with CML in Uganda can be the same as the US—if access to the tools of diagnostics and medicines are possible. The CML success story has driven an expansion of Max's work, now involving multiple corporate partnerships, and expanding to over a dozen different diseases.

This is a great story that teaches that enormous obstacles in logistics, politics, and health systems can be overcome. It shows the power of dreaming and doing. It proves that human values can supplant shareholder values. The story goes up, unfolding in tens of thousands of lives every year touched by this program.

An axe has smashed the frozen sea. I urge you all to take up this spirit of driven compassion and get swimming.

"It is great to be great, but it is greater to be human."

—Will Rogers

Jerald Radich, MD, is an editor at SOHO Insider and a professor in the Clinical Research Division at Fred Hutch Cancer Center in Seattle.

Dr. Radich spoke on Improving Care in LMIC Through Collaborations during an earlier MTP session.

Did you miss this talk?

Find it in the attendee hub located in the SOHO365 mobile app.

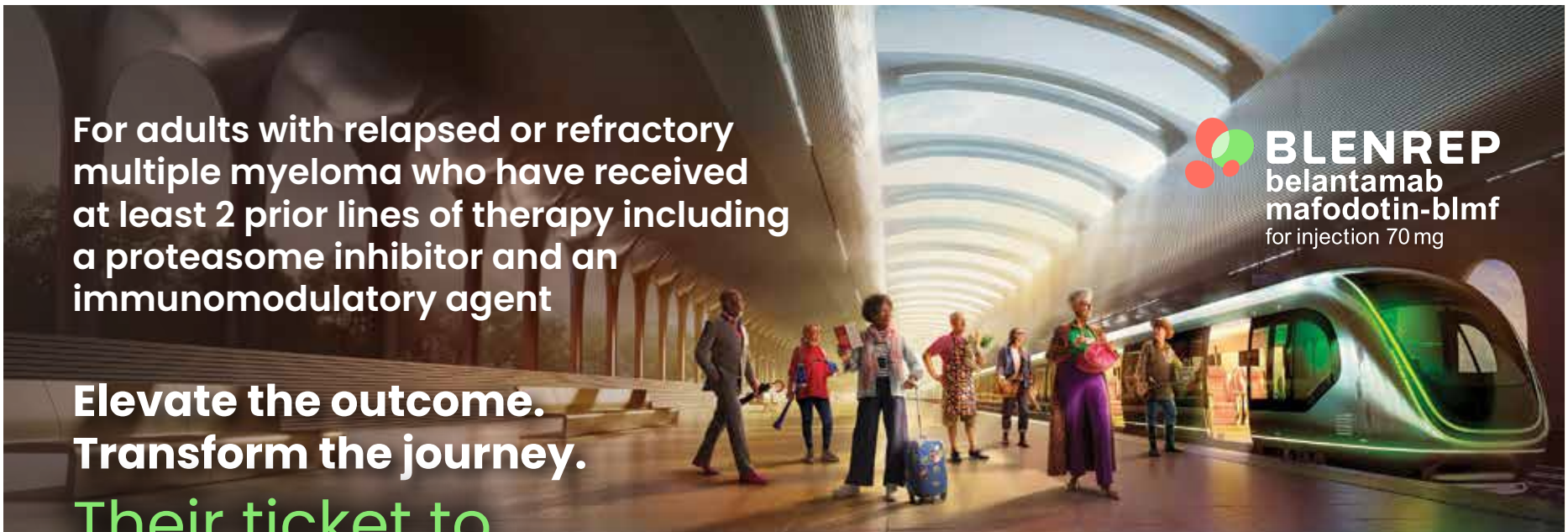
INSIDE THE MIND OF DR. RADICH

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?

Vampires. Long ago I did a stint of field research on bats. I once had vampire bats regurgitate blood on my head and shoulders (long story). I've seen and survived their best shot. Plus, I'm guessing vampires smell a lot better than werewolves.

In the Odyssey, characters are given epithets that are repeated throughout: Odysseus is "the man of many ways," Athena is "bright-eyed Athena," and Penelope is "wise Penelope." If you were a character in an ancient Greek epic, what would your epithet be?

Nerd of the North



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

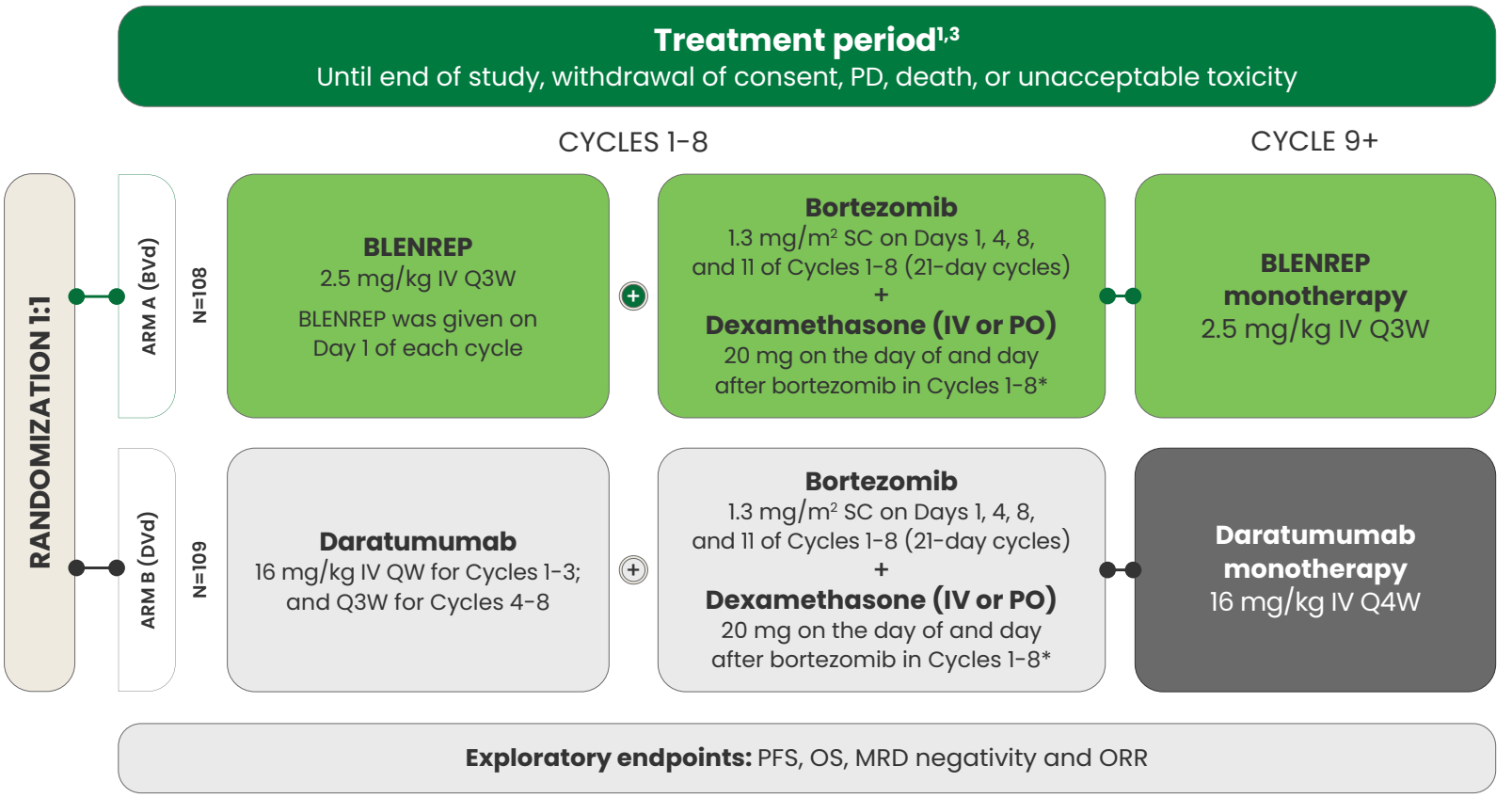
WARNING: OCULAR TOXICITY

- **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).

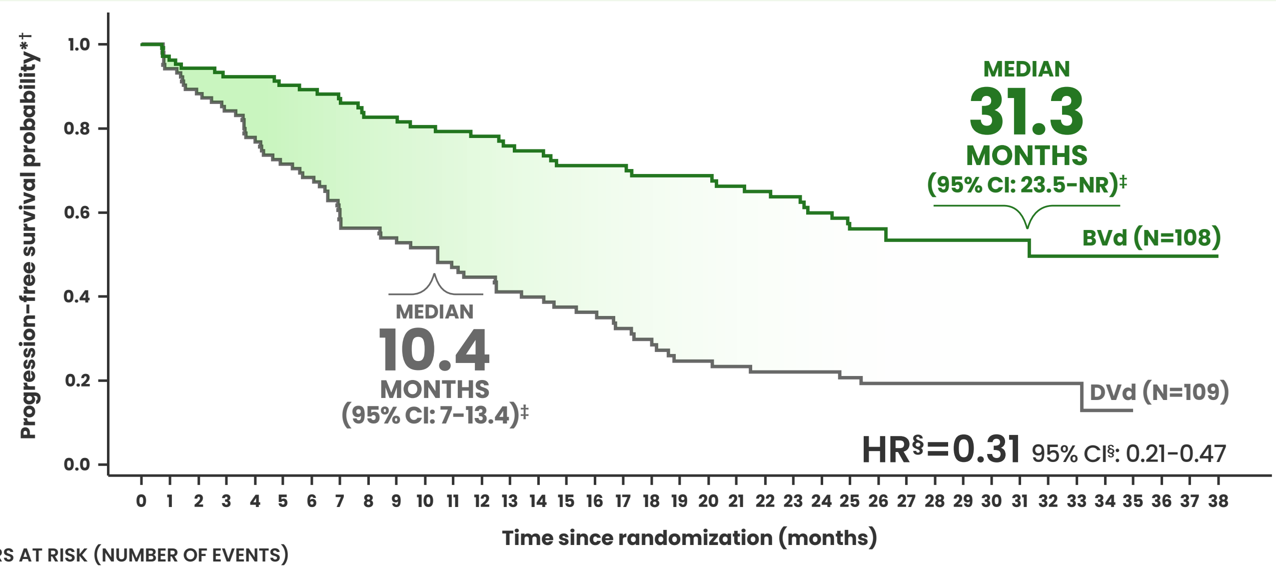
FDA approval was based on a post hoc exploratory subgroup analysis of patients with at least 2 prior lines of therapy, including a proteasome inhibitor and immunomodulatory agent.

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)

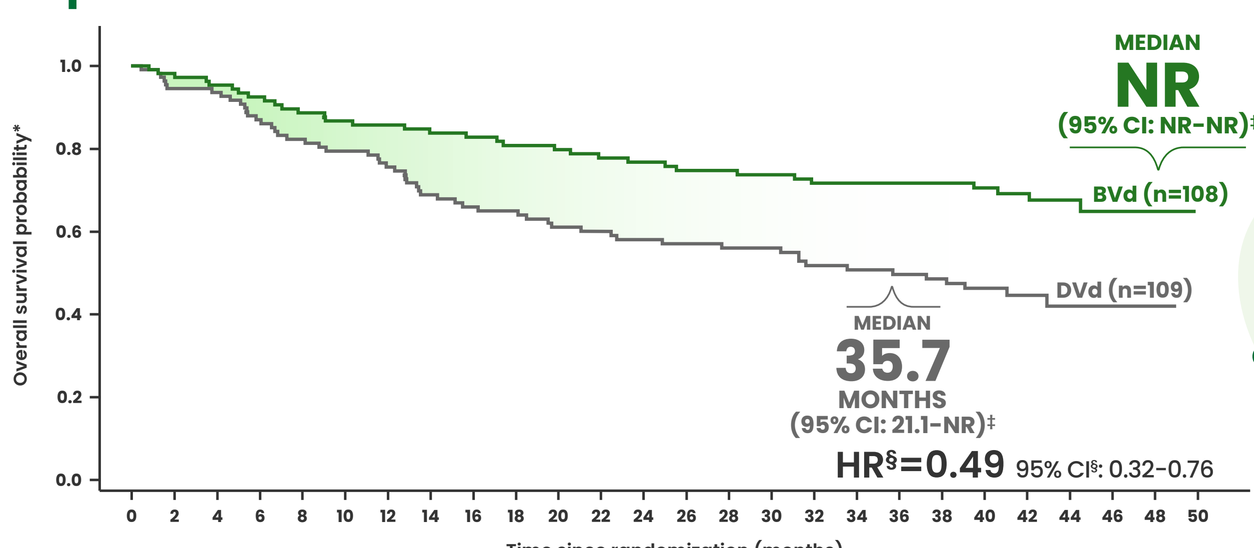
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
BLENREP + bortezomib/dexamethasone	108 (0)	101 (4)	96 (6)	91 (8)	90 (8)	88 (10)	85 (11)	81 (13)	74 (17)	74 (17)	71 (19)	69 (20)	68 (21)	65 (23)	64 (24)	61 (27)	61 (27)	59 (27)	57 (29)	57 (29)
Daratumumab + bortezomib/dexamethasone	109 (0)	96 (6)	87 (12)	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	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
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)
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)

	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
BLENREP + bortezomib/dexamethasone	82 (18)	80 (20)	80 (20)	79 (21)	78 (22)	77 (23)	77 (23)	76 (24)	76 (24)	74 (26)	74 (26)	74 (26)	73 (27)	72 (27)	72 (27)	70 (29)	70 (29)
Daratumumab + bortezomib/dexamethasone	67 (37)	66 (37)	64 (39)	62 (41)	61 (41)	60 (42)	58 (44)	58 (44)	57 (45)	56 (45)	55 (45)	54 (46)	54 (46)	53 (46)	52 (47)	49 (50)	49 (50)

	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
BLENREP + bortezomib/dexamethasone	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	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.

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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.

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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]*.

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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]*.

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Meet the woman behind the curtain of SOHO

As managing director of SOHO, **Melinda White** leads the small but mighty team that makes the society function and the annual meeting go off smoothly. Often called the face of SOHO by Executive Director **Janet M. Cesak, MBA, BS,** SOHO Insider interviewed Melinda to learn more about her critical role at the society.

To start, could you describe your day-to-day role?

My day-to-day is pretty much operational and involves a little bit of everything. When I first started with SOHO 15 years ago, we all wore so many different hats; nobody did just one thing. We all helped with the speakers and various other tasks. Now, I oversee all those different parts, including coordinating the annual meeting and managing exhibitor logistics.

I also work with the speakers and the different programs, including the main SOHO program and the virtual SOHO Breakthroughs in Blood Cancers (SBBC) program. I also make sure that the membership database is accurate and current, with help from Ashlie Koester. Additionally, I work closely with Janet Cesak on all committees. For example, every year I put together the meetings for the education committees. I receive all their session materials and put everything in a template, so we have a full program. Once we have that, I invite the speakers and coordinate logistics.

What is your favorite part of the job?

I love working with the doctors. They're so nice, and it always amazes me that they're running these huge cancer institutions but still make time for SOHO and find that it's an important mission. When I first started, we had around 600 members. Seeing the growth of the society, where we are today—at over 13,000 members—and the support that we've received from doctors from all around the world, I just love seeing the progress.

What has been the biggest change since you started?

I didn't realize SOHO would take off quite like it has. The society was so small when we started. Even our committees were small. We might have had eight people on a committee and now we have 70 people on one committee and 80 people on the scientific committee. The abstracts have seen the same kind of growth. We went from maybe 100 abstracts to over 1400 last year. Seeing that growth is very exciting.

When you work with young investigators, is there a common sentiment they share when they receive their scholarships?

They're so thankful and appreciative, and I love it because they're so excited that somebody would give them a travel scholarship to come to a meeting to show their work. They're very appreciative, especially those from countries where they don't have the funds to come to the United States. They personally will come up to me and say, "Thank you, Ms. White." But it's not me; it's the society's funding.

How has the Ambassador Program evolved over the years?

In the beginning, the Ambassador Program was more about getting as many ambassadors as possible from different parts of the world to participate in SOHO, so they could get the message out in their respective countries. Now, we're starting to form satellite meetings and other initiatives, including authoring articles for SOHO Insider.

It has been nice to see the Ambassador Program grow; we are still working on the progress. It is satisfying to see it being refined.

As a long-time Texas resident, what should first-time visitors know about Houston?

The Space Center is a huge thing to see when you're in Texas. Also, the food here is delicious. If you're coming to Texas, you have to eat Texas barbecue because it is the best. I also love all the people. I'm probably biased because I've lived here for so long. I feel like everyone is friendly, nice, and polite. The men will say, "Thank you, ma'am." They will open doors for you. Sometimes I'll go other places, and it's not as friendly. I guess I do like that Southern hospitality.

Get in touch with Melinda at mwhite@sohoonline.org.

> "I love working with the doctors. They're so nice, and it always amazes me that they're running these huge cancer institutions but still make time for SOHO and find that it's an important mission."

Ready, set, SOHO!


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The best patient care,
or patient service,
is clinical research.

••• CELMoDs FROM PAGE 15

regimens, and the increased incidence of neutropenia is accompanied by a higher frequency of serious infections in the SUCCESSOR-2 trial.[28] Grade ≥3 infections occurred in approximately one-third of patients receiving MeziKd compared with 16% in the Kd arm. Appropriate antimicrobial usage when there is a suspicion for a infectious process and growth-factor support are highly encouraged.

Gastrointestinal toxicities such as diarrhea seem to be less common with CELMoDs compared with IMiDs. Early clinical experience has not identified unexpected toxicities such as secondary primary malignancies despite prolonged administration, although long-term surveillance remains necessary. The VTE risk appears comparable to that of existing IMiDs, reinforcing the continued need for thromboprophylaxis based on established myeloma guidelines.[30] The risk of fetal abnormalities among patients receiving CELMoDs remains the same as IMiDs, likely stemming from pursuing the molecular target CRBN, and in future, one would expect dispensing through a REMS program.[31]
The optimal balance between hematologic toxicity and clinical efficacy is likely to be acceptable for patients with relapsed or refractory MM, particularly for those who are BCMA-refractory, and a potential active oral agent is promising. Although many patients achieve deep responses after CAR T-cell therapy, relapse remains common because of antigen escape, limited CAR persistence, and progressive immune dysfunction. CELMoDs may provide an effective immune-restorative strategy capable of prolonging remission after cellular therapy.[15]

Conclusions and future directions

CELMoDs induce direct tumor cytotoxicity and simultaneously enhance immune-mediated myeloma cell kill makes them attractive partners across virtually every stage of the disease continuum.[12] Perhaps the most exciting future application is combination therapy with bispecific antibodies. Current BCMA- and GPRC5D-directed bispecific antibodies produce remarkable response rates but remain limited by T-cell exhaustion and diminishing immune function during prolonged treatment. Iberdomide and mezigdomide in combination with elranatamab have shown impressive activity in preliminary trials and can improve the durability of bispecific antibody responses.[32,33] An equally promising application involves priming prior to CAR-T collection and as maintenance after CAR T-cell therapy.

CELMoDs could potentially maintain immune activation after CAR T-cell infusion, improve persistence of a subset of functional cytotoxic lymphocytes that potentially can offer ongoing myeloma control, and delay disease recurrence.[15] Their oral administration makes them attractive as long-term maintenance therapy following cellular therapy similar to IMiDS. As safety experience accumulates, CELMoDs are likely to move progressively into frontline treatment. Replacing conventional IMiDs with CELMoDs during quadruplet induction therapies or consolidation may produce deeper responses, higher MRD-negativity rates, and more durable remissions. Similarly, CELMoDs also represent a logical evolution of maintenance therapy.[34] Their greater potency and early clinical evidence raise the possibility of deeper MRD negativity rates.

Looking ahead, CELMoDs likely are ideal partners with other anti-myeloma agents in the newly diagnosed setting, as agents to attain MRD negativity in the maintenance setting, in combinations with bispecific antibodies, as priming agents for T cells prior to CAR T-cell therapy or as maintenance, and in the future with other immune-based combinations. Their integration into rational combination strategies has an extensive potential not only to extend survival but for "cure" in myeloma.

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Let's get social! Tag #SOHO2026

Society of Hematologic Oncology (SOHO)
@SocietyofHemOnc

The public and private sectors must work together moving forward. We cannot rely solely on the NIH. #SOHO2026

SOHO President John DiPersio this morning at the opening remarks.

Francesco Maura
@FrancescoMaura4

Happy to be in Houston and attend for the first time #SOHO2026! Looking forward to connect with friends and colleagues and present tomorrow our data on myeloma precursor conditions MGUS and SMM. @MSKCancerCenter #mmsm

Kamira Maharaj, PhD · 3rd+
Medical Science Liaison
1d ·

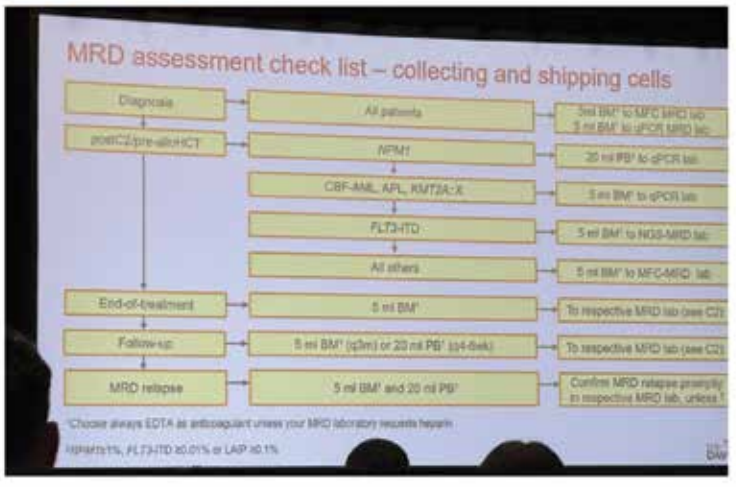
I'm excited to attend SOHO 2026 for the first time this week in sunny Houston, TX! 😎 I always enjoy getting together with the heme community, catching up with colleagues and hearing the latest scientific findings and clinical updates. #SOHO2026 #hematology #oncology

drsairahahmed
@drsairahahmed

Fantastic meet-the-professor session in Cell Therapy with Dr Doris Hansen, @MeeraMohanMD @niravshahmd @SocietyofHemOnc #SOHO2026

Sujay Rainchwar @SujayRainchwar

Terrific AML Talk by Michael Heuser at #soho2026 elucidating ELN DAVID and detailed overview on sample collection and handling for effective testing and diagnosis of MRD which is an very important tool to guide best treatment strategy for AML patients.
@SocietyofHemOnc



Lisa Palacios
@Lisa_Palacios

How should we monitor Ph-positive #ALL in the modern treatment era? Join @NicholasShortMD at #SOHO2026 as he shares insights on the best tools for disease monitoring during the Meet-the-Professor ALL Case Studies session. #CancerResearch @UTMDAnderson soho.click/2026

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†*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.

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