SOHO ANNUAL MEETING 2024

DARATUMUMAB VERSUS ISATUXIMAB: PERCEPTIONS OF ANTI-CLUSTER OF DIFFERENTIATION 38 MONOCLONAL ANTIBODY USE IN TRANSPLANT-ELIGIBLE PATIENTS WITH NEWLY DIAGNOSED MULTIPLE MYELOMA

Nicholas Moffett, PharmD[1], Robert N. Bone, PhD[1], Yolaine Jeune-Smith, PhD[1], Muhamad Baljevic, MD[2], Bruce Feinberg, DO[1]

[1]Cardinal Health, Dublin, Ohio, USA; [2]Vanderbilt University Medical Center, Nashville, Tennessee, USA

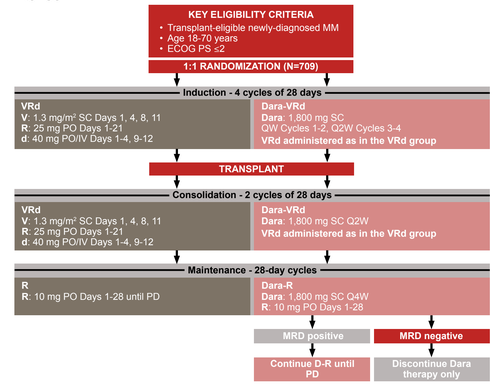
Abstract # MM-500

CardinalHealth™

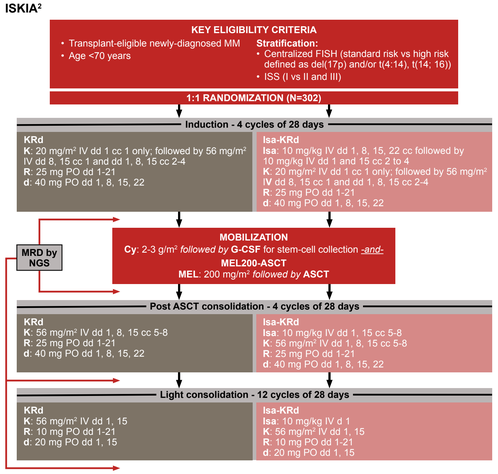
BACKGROUND

- Utilization of anti-CD38 monoclonal antibodies within quadruplet therapies for the management of transplant-eligible, newly diagnosed multiple myeloma (MM) is currently considered optimal standard of care.
- Little is known about which of the available anti-CD38 monoclonal antibodies, daratumumab (Dara) or isatuximab (Isa), are preferred by providers and the rationale behind the selection.
- The phase III PERSEUS trial (NCT03710603) and the phase III IsKia trial (NCT04483739) are evaluating anti-CD38 monoclonal antibody-based quadruplet regimens in patients with transplant-eligible, newly diagnosed MM.

PERSEUS[1]



ISKIA[2]



OBJECTIVE

- Evaluate trends in self-reported treatment patterns and perceptions surrounding utilization of anti-CD38 mAb therapies during induction for transplant-eligible, newly diagnosed MM.

METHODS

- US-licensed oncologists/hematologists convened at one of three live meetings from February to April 2024 to review clinical updates presented at the 2023 ASH Annual Meeting.
- Respondent characteristics and demographics were collected via an online survey ahead of the meeting.
- During the meeting, participants responded to queries about their treatment preferences in newly diagnosed MM before and after reviewing the efficacy/safety data from the phase III PERSEUS and IsKia trials presented at the 2023 ASH Annual Meeting.
- Responses were captured via audience response system technology; not all participants answered every question.
- Pooled data were summarized using descriptive statistics.

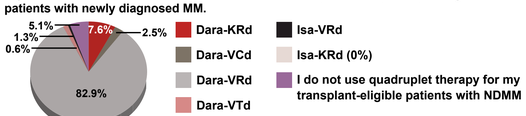
RESULTS

- A total of 194 unique participants attended the live meetings, of which 164 treat patients with MM.
- Of the 164 MM-treating respondents, 114 (71.1%) identified as community-based physicians. These respondents average 17.3 years (1–42 years) of clinical experience, spend approximately 82% of their working time in direct patient care, and see approximately 17 patients/day (**Table 1**).

Table 1: Participant Demographics

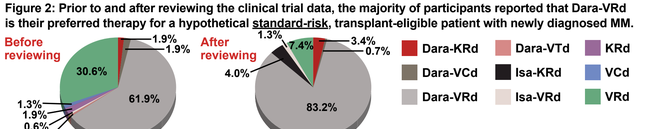
	N=164
US region of practice[a], n (%)	
Midwest	41 (25.0)
Northeast	32 (19.5)
South	46 (28.1)
West	45 (27.4)
Practice setting, n (%)	
Community	114 (71.1)
Academic	50 (28.9)
Years in practice	
Average (min-max)	17.3 (1–42)
Patients seen per clinic day	
Average (min-max)	17.4 (3–60)
Allocation of time, %	
Direct patient care	81.7
Research	10.6
Other	7.7

Figure 1: Most participants reported Dara-VRd as their preferred quadruplet regimen for their transplant-eligible patients with newly diagnosed MM.



***Question**: When selecting quadruplet therapy for a transplant-eligible patient with newly diagnosed MM, which regimen do you prefer? (n=158)*

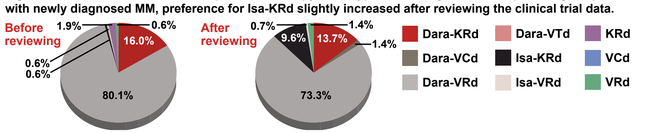
Figure 2: Prior to and after reviewing the clinical trial data, the majority of participants reported that Dara-VRd is their preferred therapy for a hypothetical standard-risk, transplant-eligible patient with newly diagnosed MM.



***Question**: What is your treatment approach for a transplant-eligible, standard-risk patient with newly diagnosed MM? (n=160)*
After reviewing data from the IsKia and PERSEUS trials, what would your treatment approach be for a transplant-eligible, standard-risk patient with newly diagnosed MM? (n=149)

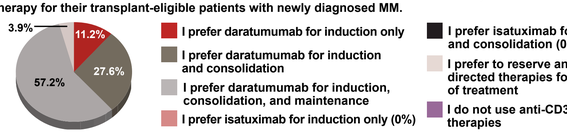
RESULTS

Figure 3: While Dara-VRd is still the preferred therapy for a hypothetical high-risk, transplant-eligible patient with newly diagnosed MM, preference for Isa-KRd slightly increased after reviewing the clinical trial data.



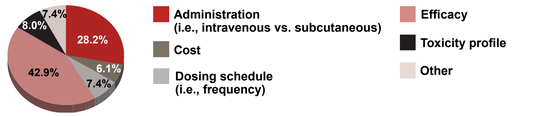
***Question**: What would your treatment approach be for a transplant-eligible, high-risk (i.e., del[17p]) patient with newly diagnosed MM? (n=156)*
After reviewing data from the IsKia and PERSEUS trials, what would your treatment approach be for a transplant-eligible, high-risk (i.e., del[17p]) patient with newly diagnosed MM? (n=146)

Figure 4: The majority of respondents use daratumumab in induction, consolidation, and maintenance therapy for their transplant-eligible patients with newly diagnosed MM.



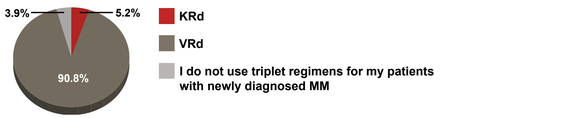
***Question**: Which of the following statements most accurately reflects your use of an anti-CD38 monoclonal antibody for your transplant-eligible patients with newly diagnosed MM? (n=152)*

Figure 5: Respondents identified efficacy and administration as their primary reasons for selecting their preferred anti-CD38 monoclonal antibody.



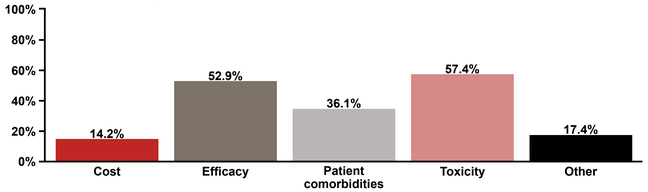
***Question**: Which of the following best reflects your reasons for selecting your preferred anti-CD38 monoclonal antibody for patients with newly diagnosed MM?[a] (n=163)*
[a]Note: Multiple select question, data analyzed reflects the first option selected by participants.

Figure 6: Most respondents prefer VRd as their triplet backbone therapy for their patients with newly diagnosed MM.



***Question**: Which of the following triplet regimens do you prefer as your backbone for your patients with newly diagnosed MM? (n=153)*

Figure 7: Respondents reported toxicity and efficacy as the factors that most influence their preferred triplet regimen backbone therapy.



***Question**: Which of the following factors most influences your selection of KRd or VRd for patients with newly diagnosed MM? Please select up to 2. (n=155)*

CONCLUSIONS

- **Our data showed that daratumumab is the preferred anti-CD38 monoclonal antibody among this cohort of physicians for management of transplant-eligible, newly diagnosed MM.**
- **Before reviewing the PERSEUS and IsKia trials, preference for daratumumab-based regimens was high for management of transplant-eligible, newly diagnosed MM regardless of risk status. After reviewing the trial data, preference for daratumumab-based regimens remained. However, daratumumab-based regimen preference increased numerically for standard-risk MM and decreased numerically for high-risk MM. Preference for isatuximab-based regimens slightly increased as well, particularly for high-risk MM.**
- **Preference for the triplet backbone aligned with the trial designs, VRd for daratumumab and KRd for the isatuximab.**
- **Given the overall preference for VRd over KRd as triplet backbone, it is unknown how much of an impact the preference of triplet regimens have on anti-CD38 monoclonal antibody preference. More research is needed to determine if the PERSEUS regimen (i.e., Dara-VRd) dominates due to preference for the VRd backbone. Additionally, it is unknown if the providers would consider combining isatuximab as the anti-CD38 mAb with the VRd backbone regimen for transplant-eligible, newly diagnosed MM.**

ACKNOWLEDGEMENTS

- The authors thank the Insights & Engagement team at Cardinal Health who made the oncology summits possible. The authors also thank Ryan Laughlin for graphic design support of this poster and Bhawna Gupta, PhD for her support of the research.

CORRESPONDING AUTHOR

Corresponding author: Nicholas Moffett, PharmD; nicholas.moffett@cardinalhealth.com

REFERENCES

1. Sonneveld P et al. Abstract LBA-1. ASH 2023.
2. Gay F et al. Abstract 4. ASH 2023.

[a]**Midwest**, IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI; **Northeast**, CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT; **South**, AL, AR, DC, FL, GA, KY, LA, MS, NC, OK, SC, TN, TX, VA, WV; **West**, AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY.

Abbreviations: **ASCT**, autologous stem cell transplantation; **CD38**, cluster of differentiation 38; **Cy**, cyclophosphamide; **d**, dexamethasone; **Dara**, daratumumab; **dd**, daily dose; **del(17p)**, deletion of chromosome 17p; **ECOG**, Eastern Cooperative Oncology Group; **G-CSF**, granulocyte colony stimulating factor; **Isa**, isatuximab; **ISS**, International Staging System; **IV**, intravenous; **K**, carfilzomib; **mAb**, monoclonal antibody; **MEL**, melphalan; **MM**, multiple myeloma; **MRD**, minimal residual disease; **NGS**, next generation sequencing; **PD**, progressive disease; **PFS**, progression-free survival; **PO**, by mouth; **PS**, performance status; **QW**, every week; **Q2W**, every other week; **R**, lenalidomide; **SC**, subcutaneously; **V**, bortezomib.

Presented at:

Society of Hematologic Oncology 2024 (SOHO 2024) Annual Meeting

September 4-7, 2024
Houston, Texas