MM - 1051

Clinical investigators' (CIs') selection of induction and maintenance therapy for patients with newly diagnosed multiple myeloma (MM) eligible and ineligible for transplant

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INTRODUCTION:

Numerous clinical trials have demonstrated that the addition of an anti-CD38 antibody to standard induction regimens is beneficial for patients with newly diagnosed MM. However, it remains unclear how clinicians are interpreting these findings and incorporating these agents into the care of both younger and older patients with newly diagnosed MM.

METHODS:

In June 2025, 20 US-based and international CIs completed a case-based survey designed to document their choices of induction and maintenance therapy for previously untreated MM.

RESULTS:

For a 65-year-old patient with standard-risk disease who is eligible for transplant, all 20 investigators opt for a 4-drug combination, with 17 of 20 turning to daratumumab (D) in combination with lenalidomide (R), bortezomib (V) and dexamethasone (d), D-RVd (**Figure 1**). For an 80-year-old patient with standard-risk disease who was not eligible for transplant, only 6 of the CIs would use D-RVd, with 13 favoring D-Rd (**Figure 2**). Interestingly, for an 80-year-old with high-risk disease, only 3 CIs would offer D-Rd, with most (15) now favoring a 4-drug regimen (**Figure 3**).

In terms of maintenance therapy, more than half of CIs continue it indefinitely even for standard-risk disease and regardless of patient age (**Figures 5-7**). For a 65-year-old patient with standard risk and measurable residual disease (MRD) negativity, 9 of 20 CIs recommend DR maintenance (**Figure 4**). Similarly, for an 80-year-old patient with standard-risk disease who was not eligible for transplant, 14 of 20 CIs would recommend DR maintenance (**Figure 6**).

Although almost all CIs currently use daratumumab, all consider isatuximab to have equivalent efficacy (**Figure 8**). Prior to the FDA approval, when asked about preferences if a subcutaneous formulation of isatuximab were available, 12 CIs would have no preference between agents, 4 would prefer isatuximab and the others were mixed in their responses (**Figure 9**).

CONCLUSIONS:

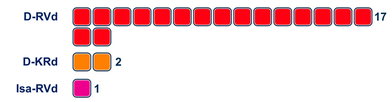
Among the anti-CD38 antibodies, daratumumab is used almost exclusively, likely because of its subcutaneous administration, but since subcutaneous isatuximab is now available, treatment selection may become more diversified. Maintenance therapy is employed for all situations — often indefinitely — and many are continuing anti-CD38 antibodies in this setting. However, CIs' approaches to maintenance may be swayed by MRD assessment and risk status. Ongoing trials are likely to resolve questions about the role of these factors in up-front management.

SURVEY RESPONDENTS

Larry D Anderson Jr, MD, PhD	Xavier Leleu, MD, PhD
Jesús G Berdeja, MD	Thomas Martin, MD
Natalie S Callander, MD	María-Victoria Mateos, MD, PhD
Rafael Fonseca, MD	Joseph Mikhael, MD, MEd
Morie A Gertz, MD, MACP	Professor Philippe Moreau, MD
Carol Ann Huff, MD	Ajay K Nooka, MD, MPH
Amrita Krishnan, MD	S Vincent Rajkumar, MD
Shaji K Kumar, MD	Alexander K Stewart, MD
C Ola Landgren, MD, PhD	Sascha A Tuchman, MD, MHS
Hans Lee, MD	Peter Voorhees, MD

1 INDUCTION THERAPY FOR 65-YEAR-OLD WITH TRANSPLANT-ELIGIBLE, STANDARD-RISK MM

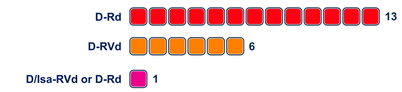
Regulatory and reimbursement issues aside, what is your preferred induction regimen for a 65-year-old transplant-eligible patient with standard-risk multiple myeloma (MM)?



K = carfilzomib; Isa = isatuximab

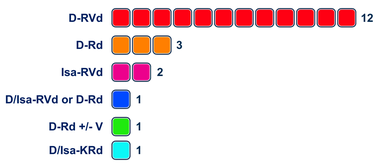
2 INDUCTION THERAPY FOR 80-YEAR-OLD WITH TRANSPLANT-INELIGIBLE, STANDARD-RISK MM

Regulatory and reimbursement issues aside, what is your preferred initial regimen for an 80-year-old patient with standard-risk MM who is not eligible for transplant?



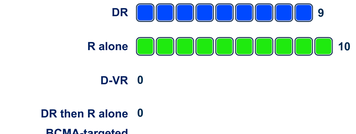
3 INDUCTION THERAPY FOR 80-YEAR-OLD WITH TRANSPLANT-INELIGIBLE, HIGH-RISK MM

Regulatory and reimbursement issues aside, what would be your preferred initial regimen for an 80-year-old patient with high-risk (eg, del[17p]) MM who was not eligible for transplant?



4 SELECTION OF MAINTENANCE THERAPY FOR 65-YEAR-OLD WITH TRANSPLANT-ELIGIBLE, STANDARD-RISK MM

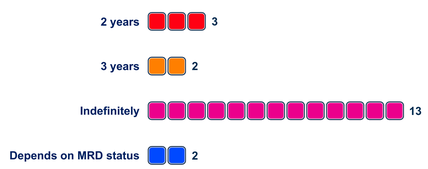
What maintenance therapy would you recommend for a 65-year-old transplant-eligible patient with standard-risk MM if the post-transplant measurable residual disease (MRD) status was negative?



*Bispecific antibody or CAR T-cell therapy

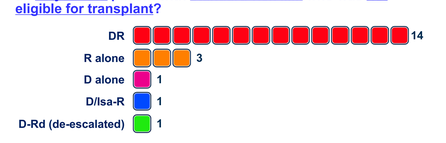
5 DURATION OF MAINTENANCE THERAPY FOR 65-YEAR-OLD WITH TRANSPLANT-ELIGIBLE, STANDARD-RISK MM

How long would you continue maintenance therapy for a 65-year-old transplant-eligible patient with standard-risk MM?

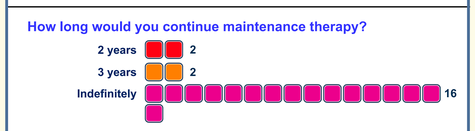


6 MAINTENANCE THERAPY FOR 80-YEAR-OLD WITH TRANSPLANT-INELIGIBLE, STANDARD-RISK MM

What maintenance therapy, if any, would you recommend for an 80-year-old patient with standard-risk MM who was not eligible for transplant?

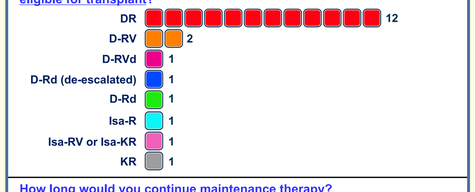


How long would you continue maintenance therapy?



7 MAINTENANCE THERAPY FOR 80-YEAR-OLD WITH TRANSPLANT-INELIGIBLE, HIGH-RISK MM

What maintenance therapy, if any, would you recommend for an 80-year-old patient with high-risk (eg, del[17p]) MM who was not eligible for transplant?



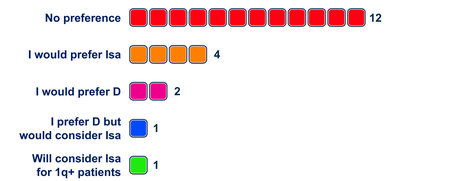
How long would you continue maintenance therapy?

8 COMPARATIVE EFFICACY OF ANTI-CD38 ANTIBODIES

According to current clinical trial data and your personal experience, in which clinical situations, if any, does a difference in efficacy exist between daratumumab and isatuximab?

9 SUBCUTANEOUS FORMULATIONS OF ANTI-CD38 ANTIBODIES

Assuming subcutaneous formulations of isatuximab and daratumumab were both FDA approved and available and the efficacy and tolerability were equal, would you prefer one over the other for your patients with MM?



*Question was asked prior to FDA approval of subcutaneous isatuximab

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