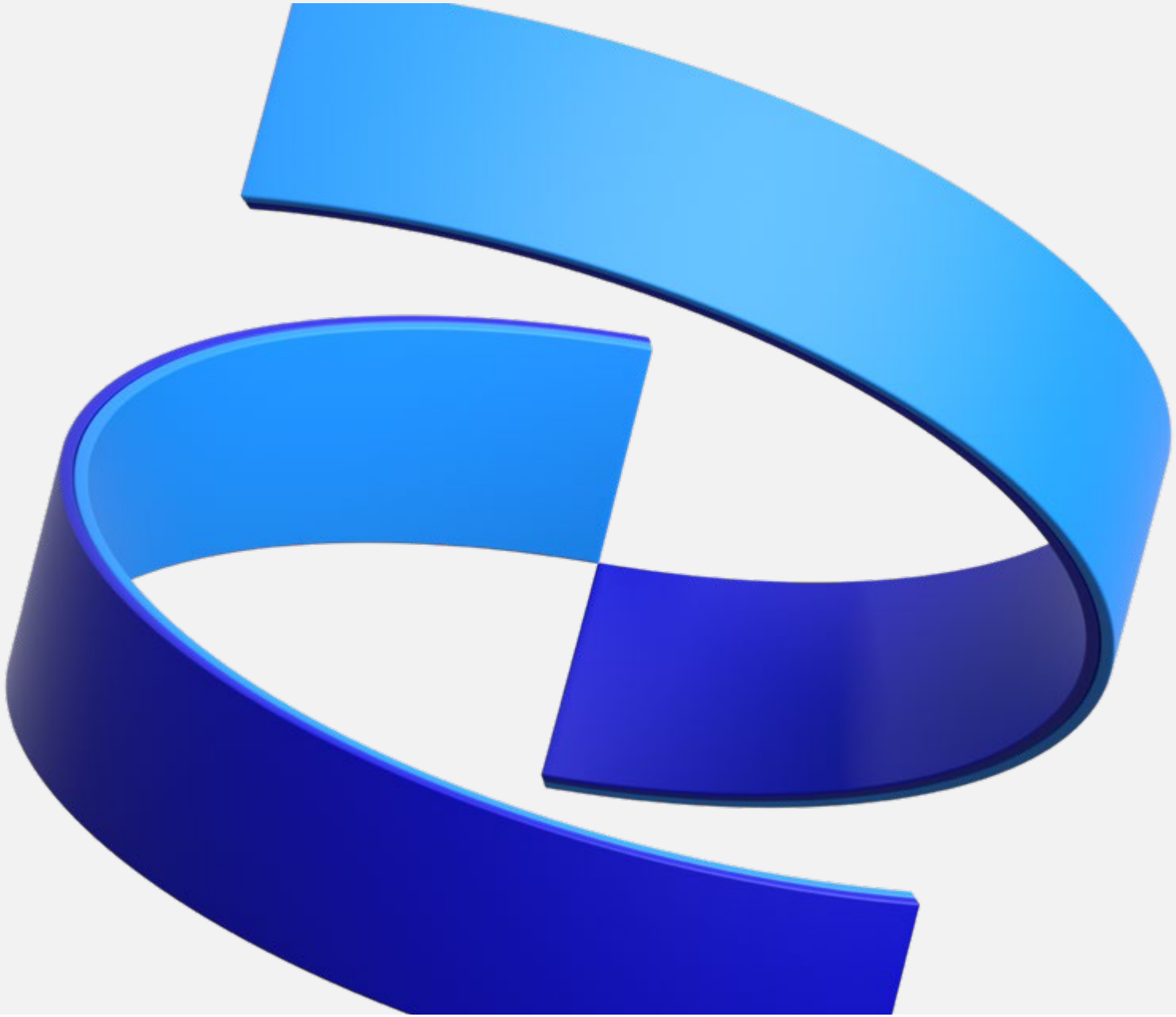
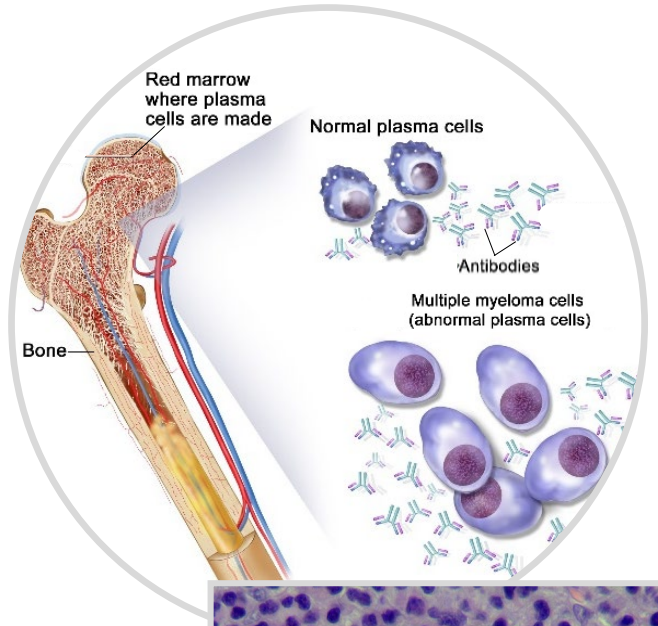
Administration of Elranatamab

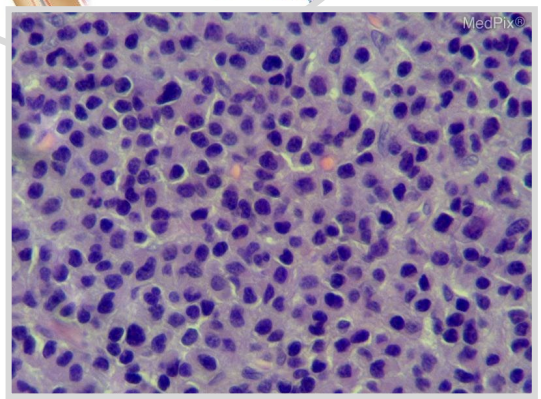


ICD-10-PCS Coordination & Maintenance Committee Meeting – March 7, 2023

Multiple Myeloma Is A Plasma Cell Malignancy[1]

- MM is the **second most common** hematologic malignancy in adults[1]
- The disease is characterized by the **buildup of malignant plasma cells,** or myeloma cells, **in the bone marrow**[1]
  - The exact etiology of MM is **unknown**[2]
- Myeloma cells produce an **excess of monoclonal immunoglobulins**, also known as M proteins[1,3]
  - Excess monoclonal immunoglobulins in the blood can cause **hyperviscosity, platelet dysfunction, and renal tubular damage**[2]
- **Clinical features** of symptomatic MM include hyper**c**alcemia, **r**enal failure, **a**nemia, and **b**one disease (**CRAB**)[4]
  - Infection is also common in MM patients[2]





Top image is open access from National Cancer Institute Visuals Online; bottom image is open access from MedPix® (synpic37150.jpg).1. Caraccio C, et al. Front Immunol. 2020;11:501. 2. Albagoush SA, et al. Multiple myeloma. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK534764/. Accessed February 24, 2022. 3. Cho SF, et al. Front Immunol. 2018;9:1821. 4. Nakaya A, et al. Hematol Rep. 2017;9:6887.

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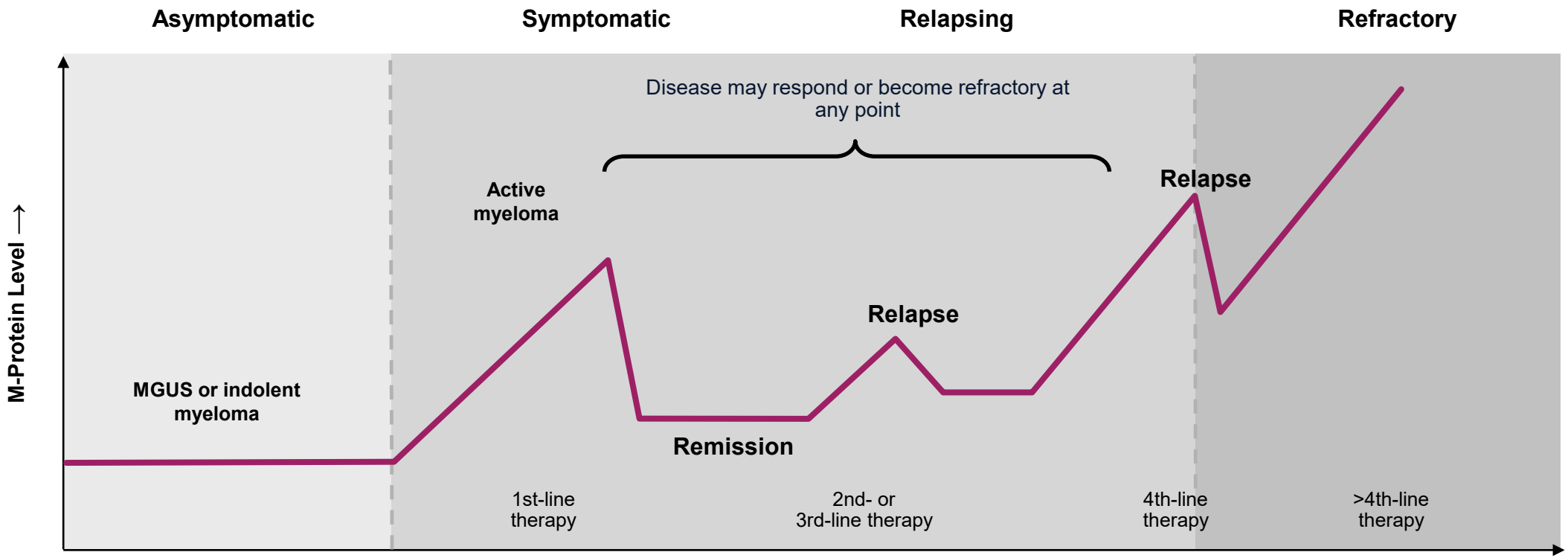
Patients with Relapsed and Refractory Multiple Myeloma Need New Treatment Options

MM is an incurable malignancy, and patients generally experience multiple lines of therapy before eventually succumbing to their disease

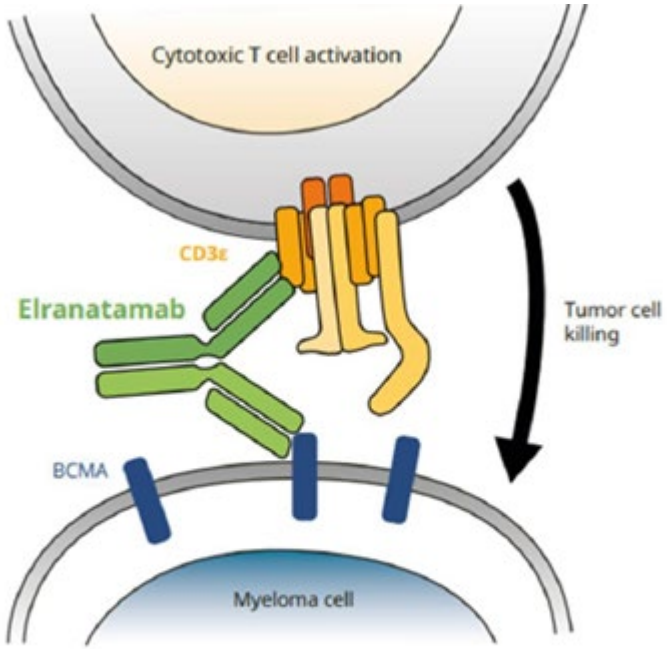


Elranatamab Is A Bispecific Antibody Targeted For The Treatment Of Patients Relapsed And Refractory Multiple Myeloma

Overview of Elranatamab

- Elranatamab is a humanized bispecific antibody targeting BMCA on myeloma cells and CD3 on T cells
- Bispecific antibodies offer an emerging immunotherapeutic approach that activates and directs T cells to induce selective immunogenic myeloma cell death
- Elranatamab is proposed to act through direct bridging of the BCMA cell-surface antigen and the extracellular CD3 subunit expressed on T cells
- If FDA-approved, elranatamab will potentially be used for the treatment of adult patients with relapsed or refractory multiple myeloma (R/R MM) who have received at least three prior therapies, including a proteasome inhibitor (Pis), an immunomodulatory agent (IMiD), and an anti-CD38 monoclonal antibody
- Elranatamab is not yet FDA-approved
- Pfizer applied for NTAP consideration for FY24

Elranatamab mechanism of action



T-cells release cytokines that result in the killing of the close-proximity MM cell

Overview of Elranatamab Treatment

Dosing and Administration

- Patients receive a step-up priming regimen during the first 4 days of Cycle 1* (Dose 1 is 12 mg and dose 2 is 32 mg). Patient receive a fixed dose of 76 mg weekly thereafter. Reduced dose frequency to once every two weeks (Q2W) may be considered after confirmed response. All doses are by subcutaneous injection
- Premedication with dexamethasone, diphenhydramine, and acetaminophen is recommended prior to priming doses and the first full dose
- Elranatamab should be administered by a healthcare provider with adequate medical personnel and appropriate medical equipment to manage severe reactions, including CRS and neurologic toxicity, including ICANS. In clinical trials, CRS and ICANS occurred predominantly during the first 3 doses, suggesting that administration of these doses may occur in the hospital setting upon FDA approval
- The administration of elranatamab would most often be found in the medication administration section of the medical record

Setting of Care

- It is anticipated that patients could receive elranatamab in a mix of treatment settings

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* NOTE: 1 Cycle = 4 weeks

MagnetisMM-3 Trial: Safety Profile

TEAEs in ≥20% of patients, n (%)	Cohort A (N=123)	
	Any grade	Grade 3/4
Hematologic		
Anemia	59 (48.0)	45 (36.6)
Neutropenia	59 (48.0)	59 (48.0)
Thrombocytopenia	37 (30.1)	27 (22.0)
Lymphopenia	32 (26.0)	30 (24.4)
Non-hematologic		
CRS	71 (57.7)	0
Diarrhea	48 (39.0)	2 (1.6)
Fatigue	42 (34.1)	4 (3.3)
Decreased appetite	40 (32.5)	1 (0.8)
Injection site reaction	32 (26.0)	0
Nausea	32 (26.0)	0
COVID-19 related[a]	31 (25.2)	14 (11.4)
Hypokalemia	29 (23.6)	12 (9.8)
Pyrexia	29 (23.6)	4 (3.3)
Cough	27 (22.0)	0
Headache	27 (22.0)	0

- The most common Grade 3/4 Treatment Emergent Adverse Events (TEAE) were hematologic
- Non-hematologic TEAEs were predominantly Grade 1/2
- Infections were reported in 66.7% (Grade 3/4, 35.0%) of patients
- TEAEs led to permanent elranatamab discontinuation in 19 (15.4%) patients
- TEAEs led to death in 21 patients;
  - 2 of these events were judged treatment-related per investigator[b]
    - 1 grade 5 pseudomonal pneumonia and 1 grade 5 failure to thrive

a Includes preferred terms in COVID-19 (narrow) standardized MedDRA queries; b Other grade 5 TEAEs (n=19) were not treatment-related per investigator and included TEAEs at the MedDRA level of system organ class: disease progression or neoplasms benign, malignant and unspecified (n=11), infections (n=5), cardiac disorders (n=2), and respiratory disorders (n=1); AEs were graded by Common Terminology Criteria for Adverse Events v5.0, except for CRS and ICANS which were graded by American Society for Transplant and Cellular Therapy criteria (Lee DW, et al. Biol Blood Marrow Trans 2019;25:62). TEAEs were defined as any new event that occurred from the start of elranatamab treatment through 90 days or the last dose or start of new anticancer therapy, whichever occurs first

CRS=cytokine release syndrome; MedDRA PT=Medical Dictionary for Regulatory Activities Terminology preferred term

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Source: Bahlis et al, ASH 2022