


3. RELAPSED/REFRACTORY MULTIPLE MYELOMA

# PROLONGED ELRANATAMAB TREATMENT INTERRUPTION IN PATIENTS WITH RELAPSED/REFRACTORY MULTIPLE MYELOMA: A MAGNETISMM-3 RETROSPECTIVE ANALYSIS

**E. Searle[1|2], A. Lesokhin[3], R. Niesvizky[4], B. Arnulf[5], S. Larson[6], Ch. Strouse[7], C. Fernandez De Larrea[8], D. Vesole[9], Y. Nagai[10], S.T. Sullivan[11], E. Leip[11], Nizar Bahlis[12]**

*[1]The Christie NHS Foundation Trust, Manchester, UK; [2]University of Manchester, UK; [3]Memorial Sloan Kettering Cancer Center, New York, USA; [4]Weill Cornell Medicine/New York Presbyterian Hospital, USA; [5]Hôpital Saint-Louis, APHP, Université Paris, France; [6]UCLA Medical Center, Santa Monica, USA; [7]Carver College of Medicine,Iowa City, USA; [8]Hospital Clínic, Barcelona, Spain; [9]John Theurer Cancer Center, Hackensack, USA; [10]Kobe City Medical Center General Hospital, Japan; [11]Pfizer Inc, Cambridge, USA; [12]Arnie Charbonneau Cancer Institute, Calgary, Canada*

Elranatamab (ELRA), a B-cell maturation antigen (BCMA)-CD3 bispecific antibody, induced deep and durable responses in BCMA-naïve patients in the registrational MagnetisMM-3 (NCT04649359) study. Here, we report a post-hoc analysis in patients who experienced prolonged treatment interruption or who permanently discontinued ELRA and maintained response >6 months. MagnetisMM-3 evaluated ELRA monotherapy in patients with RRMM refractory to ≥1 IMiD, ≥1 PI, and ≥1 anti-CD38 antibody. Following step-up dosing, subcutaneous ELRA was given QW for 6 cycles then Q2W if ≥PR for ≥2 months, then Q4W after ≥6 cycles of Q2W. Primary endpoint was ORR by BICR per IMWG. Patients with treatment interruption/discontinuation >6 consecutive months and under efficacy assessment were included. Data cut-off was 10-Mar-2025. Of 187 patients enrolled in MagnetisMM-3, 28 met the analysis criteria. Included patients (46.4% female; 67.9% White) had median age 69.0 years (range, 52-84); median 5 (range, 2-14) prior treatment lines; 100% triple-class and 35.7% penta-drug refractory disease. Most common treatment-emergent adverse events (AEs) (≥10%) leading to prolonged treatment interruption/discontinuation were infections (28.6%), hematologic AEs (17.9%), fatigue (10.7%), and exacerbation of pre-existing peripheral sensory neuropathy (10.7%). Median treatment duration before interruption/discontinuation was 12.1 months (range, 1.2-35.1); median treatment-free period was 15.5 months (range, 6.5-35.4). At interruption/discontinuation, 10.7% had SD, 3.6% MR, 17.9% PR, 21.4% VGPR and 46.4% ≥CR; best overall response (any time) was PR in 7.1%, VGPR in 25.0%, and ≥CR in 67.9%. At data cutoff, median global follow-up was 39.4 months (range, 9.9-43.5); follow-up after interruption/discontinuation was 19.9 months (range, 7.3-40.6). Median PFS and OS were not reached; probability of PFS and OS at 36 months was 79.4% (95% CI, 57.0-90.9) and 84.2% (95% CI, 63.0-93.8), respectively. Six patients (21.4%) had an event (3 had PD and permanently discontinued ELRA; 3 died), 22 (78.6%) were censored. Among the 3 PD events: n=2 achieved ≥CR and had PD ≈2 and ≈3 years after the last dose; n=1 achieved PR and had PD ≈1 year after the last dose. Two patients restarted ELRA after ≈12 and ≈14 month interruptions and are continuing treatment; both maintained ≥CR as of data cut-off. Early signs of relapse resolved after treatment resumption in one patient. Most patients maintained clinical response despite prolonged treatment interruptions. These data support the feasibility of dose interruptions/treatment breaks to manage AEs without compromising ELRA's efficacy. Studies evaluating ELRA re-initiation upon early disease progression are warranted.