5 Minute JournalClub

POST-ASH Issue 6, 2015

Phase I Trial of SAR650984 and Phase I/II Trial of Daratumumab for Patients with Relapsed/Refractory MM

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CME INFORMATION

OVERVIEW OF ACTIVITY

Each year, thousands of clinicians, basic scientists and other industry professionals sojourn to major international oncology conferences, like the American Society of Hematology (ASH) annual meeting, to hone their skills, network with colleagues and learn about recent advances altering state-of-the-art management in hematologic oncology. As such, these events have become global stages where exciting science, cutting-edge concepts and practice-changing data emerge on a truly grand scale. This massive outpouring of information has enormous benefits for the hematologic oncology community, but the truth is it also creates a major challenge for practicing oncologists and hematologists.

Although original data are consistently being presented and published, the flood of information unveiled during a major academic conference is unprecedented and leaves in its wake an enormous volume of new knowledge that practicing oncologists must try to sift through, evaluate and consider applying. Unfortunately and quite commonly, time constraints and an inability to access these data sets leave many oncologists struggling to ensure that they're aware of crucial practice-altering findings. This creates an almost insurmountable obstacle for clinicians in community practice because they are not only confronted almost overnight with thousands of new presentations and data sets to consider but they are also severely restricted in their ability to review and interrogate the raw findings.

To bridge the gap between research and patient care, this CME activity will deliver a serial review of the most important emerging data sets on novel agents and salvage therapeutic options for the treatment of relapsed or refractory multiple myeloma (MM) and Waldenström macroglobulinemia (WM), high-risk smoldering MM (SMM) and the front-line management of AL amyloidosis from the latest ASH meeting, including expert perspectives on how these new evidence-based concepts may be applied to routine clinical care. This activity will assist medical oncologists, hematologists, hematology-oncology fellows and other healthcare professionals in the formulation of optimal clinical management strategies and the timely application of new research findings to best-practice patient care.

LEARNING OBJECTIVES

- Evaluate the final efficacy and safety results from the Phase I/II 1703 study of elotuzumab in combination with lenalidomide and dexamethasone for patients with relapsed/refractory MM.
- Appraise recent clinical research findings on the effectiveness of the monoclonal anti-CD38 antibodies SAR650984 and daratumumab in combination with lenalidomide and dexamethasone in relapsed/refractory MM.
- Investigate the efficacy and safety of ibrutinib as a single agent or in combination with dexamethasone in relapsed or relapsed/refractory MM.
- Compare and contrast the benefits and risks of lenalidomide and low-dose dexamethasone with or without carfilzomib for patients with high-risk SMM.
- Analyze the role of front-line cyclophosphamide in combination with bortezomib and dexamethasone (CyBorD) in AL amyloidosis.
- Assess the safety and efficacy of the proteasome inhibitor oprozomib as a single agent in the treatment of WM.

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FACULTY — The following faculty (and their spouses/partners) reported real or apparent conflicts of interest, which have been resolved through a conflict of interest resolution process:

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Contracted Research: Celgene Corporation, Onyx Pharmaceuticals, an Amgen subsidiary.

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Hardware/Software Requirements:
A high-speed Internet connection
A monitor set to 1280 x 1024 pixels or more
Internet Explorer 7 or later, Firefox 3.0 or later, Chrome, Safari 3.0 or later
Adobe Flash Player 10.2 plug-in or later
Adobe Acrobat Reader
(Optional) Sound card and speakers for audio

Last review date: May 2015
Expiration date: May 2016

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POST-ASH Issue 6, 2015

To go directly to slides and commentary for this issue, **click here**.

Sagar Lonial, MD

One of my favorite days of the year occurs every April when the American Society of Clinical Oncology (ASCO) releases their iPlanner for the upcoming annual meeting that provides a first glimpse at the titles of all the oral abstracts that will be presented during the conference. This year my review quickly established that in the world of solid tumors there would be many highlights, including the long-awaited MARIANNE report evaluating pertuzumab and T-DM1 in HER2-positive breast cancer and a ton of impressive checkpoint inhibitor papers in lung cancer (squamous and nonsquamous), melanoma and a number of other diseases.

In terms of hematologic cancers, ASCO is always good for a few headline grabbers, and in reviewing the papers, my attention was immediately drawn to the first abstract in the multiple myeloma (MM) oral session — the Phase III ELOQUENT-2 trial in relapsed/refractory (RR) disease. The study, one of the most anticipated in MM in many years, randomized patients to lenalidomide (len)/dexamethasone (dex) alone or combined with the novel monoclonal antibody elotuzumab (elo).

This was definitely not the first time I became aware ahead of time that an important new data set was about to be presented, and as usual I was desperately curious to find out the results. About a week later I had my chance when the principal investigator, Dr Sagar Lonial, participated in a symposium we were doing as part of our always rewarding annual visit to the Oncology Nursing Society Congress. However, as usual my hopes were crushed by a strict embargo, and Sagar was a complete stone-wall Buddha sphinx, rebuffing all my attempts to squeeze the information out of him and leaving me totally clueless whether the study proved what earlier smaller trials suggested, namely that a special synergy exists between this antibody, which has no single-agent activity, and len.

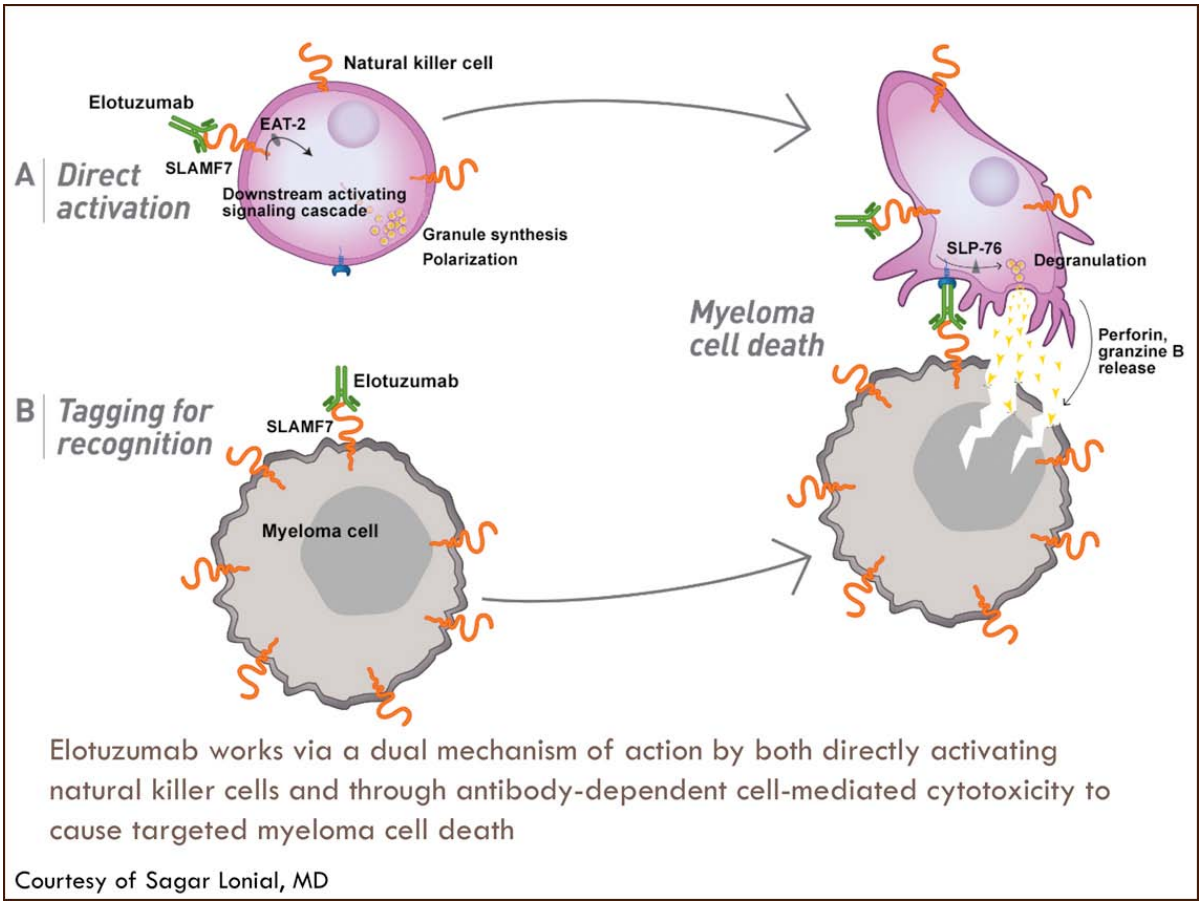
Fast forward to a week ago, when ASCO released online all but the late-breaking abstracts. My first click was to ELOQUENT-2, and to my delight, elo/len/dex resulted in a 30% reduction in the risk of disease progression and also a mortality benefit. While we most definitely need to see the data and hear Sagar and the rest of the myeloma community's take, if first impressions are any indication it could be that finally a cancer of cells that produce antibodies is soon going to have one as part of its treatment.

However, until the fun begins in Chicago, there is still much work to be done, and this issue of our American Society of Hematology (ASH) review series highlights a number of new directions in the treatment of MM, including antibodies, and several other related (at least in terms of who manages them) diseases, including Waldenström macroglobulinemia and AL amyloidosis.

Monoclonal antibodies in MM

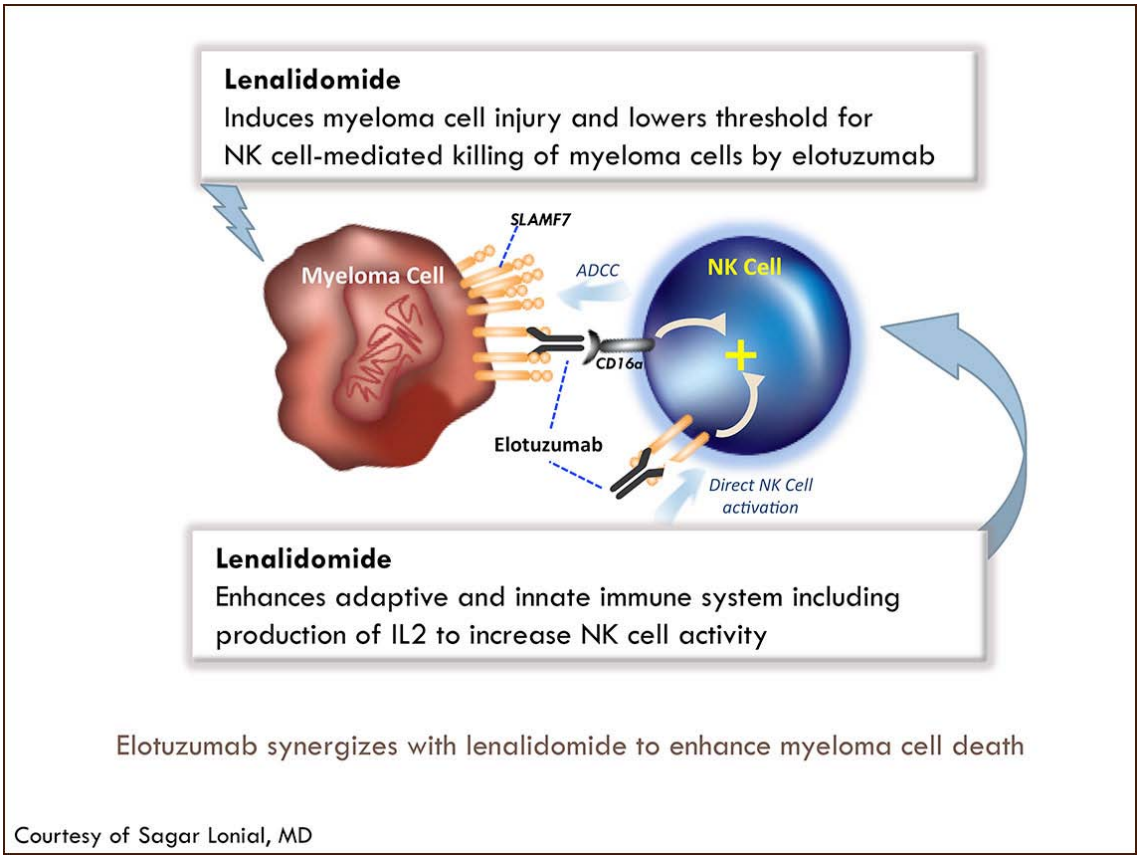
• Elo/len/dex

After years of asking investigators to explain how immunomodulating drugs work (and still not completely understanding the answer), I suspect that elo may be even more of a challenge. Signaling lymphocytic activation molecule F7 (SLAMF7) is a glycoprotein that is highly expressed on MM and natural killer (NK) cells but not on normal tissue. As a monoclonal antibody targeted against SLAMF7, elo is thought to directly activate and engage NK cells and selectively target SLAMF7-expressing MM cells for destruction.



Elotuzumab works via a dual mechanism of action by both directly activating natural killer cells and through antibody-dependent cell-mediated cytotoxicity to cause targeted myeloma cell death

Courtesy of Sagar Lonial, MD



Elotuzumab synergizes with lenalidomide to enhance myeloma cell death

Courtesy of Sagar Lonial, MD

As we learn more about the biologic basis of the apparently important synergy of len and elo, ongoing trials are evaluating this approach clinically. At ASH we saw Paul Richardson's **report of 73 patients** with RR MM who were treated with this regimen in the Phase II portion of the 1703 study, revealing similar encouraging outcomes as a prior single-arm study (response rate: 84%) with good tolerability. The bottom line now is that on Tuesday, June 2nd at 9:45 AM in the McCormick Place Convention Center, we will find out just how much it helps patients.

- **Anti-CD38 antibodies with len/dex**

While elo may be first with Phase III data, among MM investigators there is perhaps even more excitement about anti-CD38 agents, particularly daratumumab (dara) and the as yet nameless SAR650984 (sar). For quite some time now on our CME programs we have been hearing about the single-agent activity of these compounds, and I can recall a number of cases with impressive responses after disease progression on multiple therapies. However, the future of MM treatment seems to be combinations, which are firmly entrenched in the induction setting and gaining traction in RR disease. Thus it is no surprise to see strategies like **the 2 featured here** of combining these antibodies with len/dex and producing very good outcomes (77% very good partial response or greater with dara/len/dex; 64.5% overall response rate with sar/len/dex).

Many investigators, including Dr Lonial, believe that depth of response is critical in MM, and the hope has been that bringing in new classes of effective agents might push the disease into a more prolonged remission, also raising the possibility of cure as a treatment goal. Much more to come.

Ibrutinib in MM

Ibrutinib has been a revelation in terms of efficacy and activity across many variants of non-Hodgkin lymphoma, and when laboratory evidence emerged regarding the activation of Bruton tyrosine kinase in MM cells, there was optimism that this drug might play an important role in the management of this disease. Unfortunately, at ASH we saw data from **a Phase II trial** evaluating ibrutinib as a single agent or in combination with dex for patients with RR MM that demonstrated modest, somewhat underwhelming activity (clinical benefit rate of 8% with single-agent ibrutinib and 25% with the combination of ibrutinib/dex). Although further research is ongoing, few are optimistic that ibrutinib in MM will be anything close to what it is in chronic lymphocytic leukemia and mantle-cell lymphoma.

High-risk smoldering MM (SMM)

Although the standard therapy for these patients continues to be observation, a variety of predictive factors identify a subgroup with at least a 75% risk of disease progression at 5 years. As such, there continues to be significant interest in whether early intervention could help improve outcomes for these patients. In this regard, in San Francisco we saw more follow-up from the **landmark Spanish Phase III QUIREDEX trial** that had previously demonstrated an important benefit with the use of len/low-dose dex. With a median follow-up of 64 months, these findings continue to be positive, revealing that progression to symptomatic disease occurred in 25% of patients who received treatment versus 85% in the control group (overall survival rate at 7 years: 94% versus 64% with a hazard ratio of 4.6 and $p = 0.001$).

The NCI group formerly led by Ola Landgren, MD, PhD decided to take things even further and evaluate a triplet regimen, in this case carfilzomib/len/dex, followed by len maintenance in patients with high-risk SMM. Among the 12 patients who received treatment in this manner, 10 became MRD-negative after 8 cycles as determined by next-generation sequencing, which, by way of indirect comparison, appears to be an even greater benefit than the approach taken by the Spanish.

Importantly, a number of ongoing studies are pursuing these encouraging leads, including a major ECOG trial chaired by Dr Lonial in an attempt to confirm the Spanish len/dex data, and it could very well be that one day soon treating high-risk SMM will become part of practice.

Cyclophosphamide/bortezomib/dex (CyBorD) in AL amyloidosis (ALA)

Based on the results from a number of smaller trials, CyBorD has become one of the most commonly used up-front regimens for the treatment of this disease. To further confirm the benefits of this approach, 2 major ALA centers in London, England and Pavia, Italy prospectively collected findings from 230 cases of patients with newly diagnosed disease who received this regimen. The result is the **largest data set ever reported** with up-front CyBorD in the disease, from which a number of important observations can be made. Notably, of 30 patients with Stage I ALA (no cardiac

involvement), 80% responded (56% complete response/very good partial response) and there were no deaths with a median of 25 months of follow-up. Median survival of all patients was 72 months.

However, it appears that cardiac stage was the main determinant of survival, and patients with advanced heart disease (defined as those with N-terminal pronatriuretic peptide type B >8,500 ng/L) had poor outcomes, although 37% did achieve a response and seemed to fare better overall. The key takeaway from this data set is that due to the high clonal response and excellent outcome in early-stage ALA, CyBorD remains a preferred induction option and further research is needed to determine whether autologous stem cell transplant should be initiated as part of up-front treatment.

Novel agents in Waldenström macroglobulinemia (WM)

On January 29, 2015, ibrutinib became the first ever agent approved by the FDA for the management of WM. This significant milestone, along with emerging data indicating the activity of a number of other established and novel therapeutics, has breathed new life and interest into the treatment of this rare disease. At ASH we saw several examples of work attempting to move the field forward, including a Phase I/II trial evaluating **single-agent len** in 17 patients with RR WM. Thirty-six percent of these individuals responded to therapy, and with a median follow-up of 36 months, 35% of patients had a progression-free survival greater than 24 months.

Similarly, we also saw data from a Phase Ib/II trial evaluating the oral proteasome inhibitor oprozomib, which, like its intravenous cousin carfilzomib, appears to have significant efficacy in this disease. Notably, responses were observed in 5 of 7 patients refractory to bortezomib, and treatment was reasonably well tolerated, although some of the gastrointestinal toxicity that has plagued this agent was observed. To potentially eliminate this troubling side effect there is great interest in evaluating an extended-release formulation of the agent in both MM and WM.

Next, on the final issue of our ASH series, we check out papers on non-Hodgkin lymphoma, including the evaluation of anti-CD20 maintenance treatment in mantle-cell lymphoma.

Neil Love, MD
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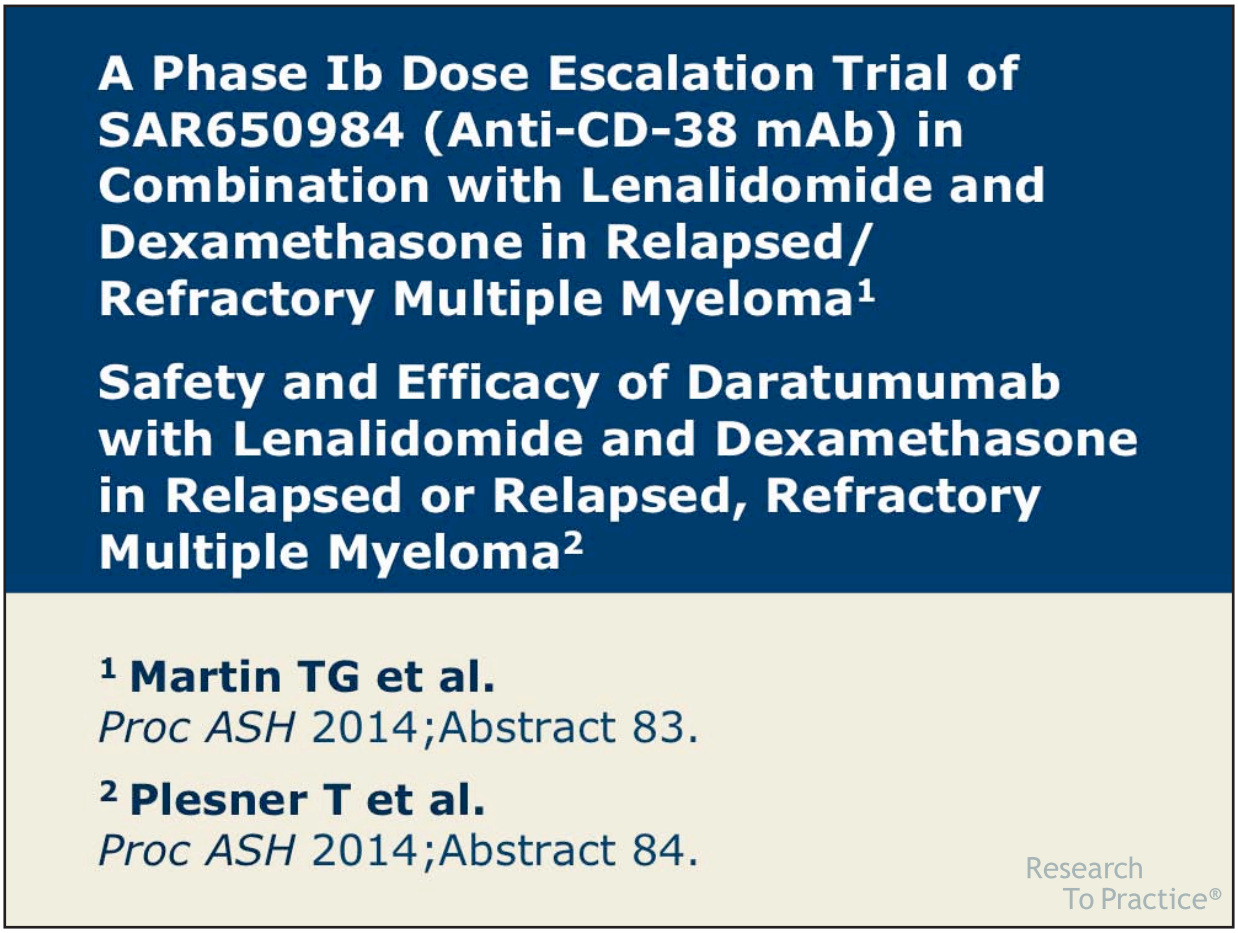
Phase I Trial of SAR650984 and Phase I/II Trial of Daratumumab for Patients with Relapsed/Refractory MM

Presentations discussed in this issue

Martin TG et al. **A Phase Ib dose escalation trial of SAR650984 (anti-CD-38 mAb) in combination with lenalidomide and dexamethasone in relapsed/refractory multiple myeloma.** *Proc ASH* 2014;**Abstract 83**.

Plesner T et al. **Safety and efficacy of daratumumab with lenalidomide and dexamethasone in relapsed or relapsed, refractory multiple myeloma.** *Proc ASH* 2014;**Abstract 84**.

Slides from presentations at ASH 2014 and transcribed comments from a recent interview with Ola Landgren, MD, PhD (2/9/15)



A Phase Ib Dose Escalation Trial of SAR650984 (Anti-CD-38 mAb) in Combination with Lenalidomide and Dexamethasone in Relapsed/ Refractory Multiple Myeloma

Martin TG et al.

Proc ASH 2014;Abstract 83.

Background

- SAR650984 (SAR) is a humanized IgG1 monoclonal antibody that binds selectively to a unique epitope on the human CD38 receptor.
- SAR may induce antitumor effects via antibody-dependent cellular-mediated cytotoxicity, complement-dependent cytotoxicity, direct apoptosis induction without secondary crosslinking and/or allosteric inhibition on CD38 enzymatic activity.
- Preclinical and xenograft data support the clinical use of SAR in combination with lenalidomide (LEN) (*Clin Cancer Res* 2014;20(17):4574; ASH 2014;Abstract 653).
- **Study objective:** To report preliminary efficacy and safety of SAR in combination with LEN and dexamethasone (Dex) for patients with relapsed/refractory (R/R) multiple myeloma (MM).

Ongoing Phase Ib Trial Design (NCT01749969)

Eligibility (Target: n = 60)

Diagnosis of R/R MM
≥2 prior therapies
Prior bone marrow transplant is allowed

→

SAR + LEN + Dex
SAR: 3, 5 or 10 mg/kg d1, 15
→ dose escalation (3 + 3 design)
LEN: 25 mg d1-21*
Dex: 40 mg d1, 8, 15, 22
(28-day cycles)

↓

Expansion cohort (n = 18)
Maximum tolerated dose (MTD) or the highest dose tested (10 mg/kg)

* Adjusted to 10 mg if baseline creatinine clearance is ≤60 mL/min

- **Primary endpoint:** Safety
- **Secondary endpoints** include overall response rate (ORR), progression-free survival (PFS) and the assessment of pharmacokinetic parameters

Martin TG et al. *Proc ASH* 2014;Abstract 83.

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Patient Characteristics

Characteristic	n = 31*
Median time from initial MM diagnosis to first dose of SAR (range)	4.5 years (1.1-11.7)
Median number of prior treatment regimens (range)	6 (2-12)
Patients who received prior IMiD therapy, including lenalidomide and pomalidomide	>95%
R/R to ≥1 prior IMiD-based therapy	>85%
Received prior bortezomib	>90%
Received prior carfilzomib	48%

* Total number of patients receiving treatment to date, including 24 patients (6 + 18) at the 10-mg/kg dose limit because the MTD was not reached

- Cutoff date: June 7, 2014

Martin TG et al. *Proc ASH* 2014;Abstract 83 (Abstract only).

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Response

All patients	n = 31
ORR	20 (64.5%)
Stringent complete response (sCR)	2 (6.5%)
Very good partial response (VGPR)	8 (25.8%)
Partial response (PR)	10 (32.3%)
With MM R/R to last LEN-containing regimen	**n = 24**
ORR	15 (62.5%)
VGPR	8 (33.3%)
PR	7 (29.2%)
Minimal response	2 (8.3%)

- Median follow-up: 6 months
- Clinical benefit rate:
  - All patients: 71%; R/R to last LEN-containing regimen: 70.8%

Martin TG et al. *Proc ASH* 2014;Abstract 83 (Abstract only).

Response (continued)

With MM R/R to both IMiD and PIs*	n = 21
ORR	11 (52.4%)
VGPR	4 (19.1%)
PR	7 (33.3%)
Minimal response (MR)	2 (9.5%)

PIs = proteasome inhibitors

* Clinical benefit rate: 61.9%

Martin TG et al. *Proc ASH* 2014;Abstract 83 (Abstract only).

Treatment Outcomes

- Median time to first response among all patients was 4.2 weeks (4.0-10.1).
- Median time to best response was 8.5 weeks (4.0-32.6).
- Patients with improvement of response after a median of 16.1 weeks (8.1-32.6) of therapy (n = 9):
  - PR → sCR (n = 1)
  - VGPR → sCR (n = 1)
  - PR → VGPR (n = 5)
  - MR → PR (n = 2)
- Median time on treatment was 26.4 weeks (2.0-61.0).
- Patients who remained on treatment at the cutoff date: n = 14.
- Median duration of response was 23.1 weeks (0.1-54.7).

Martin TG et al. *Proc ASH* 2014;Abstract 83 (Abstract only).

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Survival Outcomes

- Overall, 15 (48.4%) patients had PFS events:
  - Death unrelated to treatment (n = 1)
  - Disease progression (n = 14)
- The median PFS was 6.2 months.
- Patients who previously received LEN, bortezomib and at least 1 of the newer agents (carfilzomib and/or pomalidomide and/or elotuzumab): n = 17
  - Median PFS was 4.8 months

Martin TG et al. *Proc ASH* 2014;Abstract 83 (Abstract only).

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Author Conclusions

- With a median follow-up of 6 months, the treatment with SAR/LEN/Dex for patients with heavily pretreated R/R MM appears effective:
  - ORR of 64.5%
  - Clinical benefit response rate of 71%
  - PFS of 6.2 months
- Responses were seen after the first cycle of therapy and deepened with continued treatment.
- The ORR was 62.5% for patients with MM R/R to their last regimen containing LEN.
- SAR in combination with LEN/Dex was well tolerated, produced impressive durable responses and warrants further evaluation.

Martin TG et al. *Proc ASH* 2014;Abstract 83 (Abstract only).

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Safety and Efficacy of Daratumumab with Lenalidomide and Dexamethasone in Relapsed or Relapsed, Refractory Multiple Myeloma

Plesner T et al.

Proc ASH 2014;Abstract 84.

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Background

- Daratumumab (DARA) is a human monoclonal antibody that targets CD38-expressing tumor cells.
- In the first-in-human dose-escalation Phase I/II study of DARA (≥4 mg/kg) for patients with heavily pretreated relapsed or relapsed, refractory (RR) multiple myeloma (MM) (*Proc ASCO* 2013;Abstract 8512):
  - Patients who achieved partial response (PR) = 42%
  - Patients who achieved minimal response (MR) = 25%
- Previously, DARA in combination with lenalidomide (LEN) and dexamethasone (Dex) was shown to be well tolerated in patients with heavily pretreated relapsed or RR MM (*Proc ASCO* 2014;Abstract 8533).
- **Study objective:** To report updated efficacy and safety data with DARA in combination with LEN/Dex for patients with relapsed or RR MM.

Plesner T et al. *Proc ASH* 2014;Abstract 84.

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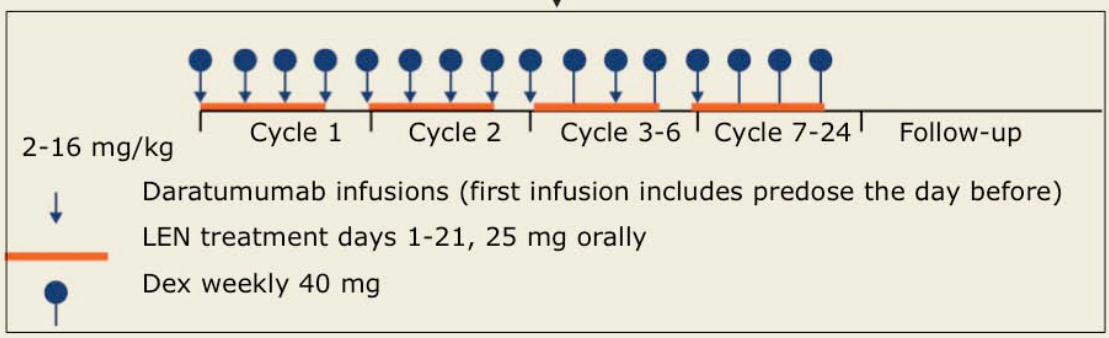
Phase I/II Trial Design

Eligibility (n = 45)

Part 1: Relapsed or RR MM after 2-4 lines of therapy (n = 13)
Part 2: Relapsed or RR MM after ≥1 prior line of therapy (n = 32)
Measurable disease by M protein and serum light chain
No LEN-refractory or intolerant MM



- **Primary endpoint:** Safety

Plesner T et al. *Proc ASH* 2014;Abstract 84.

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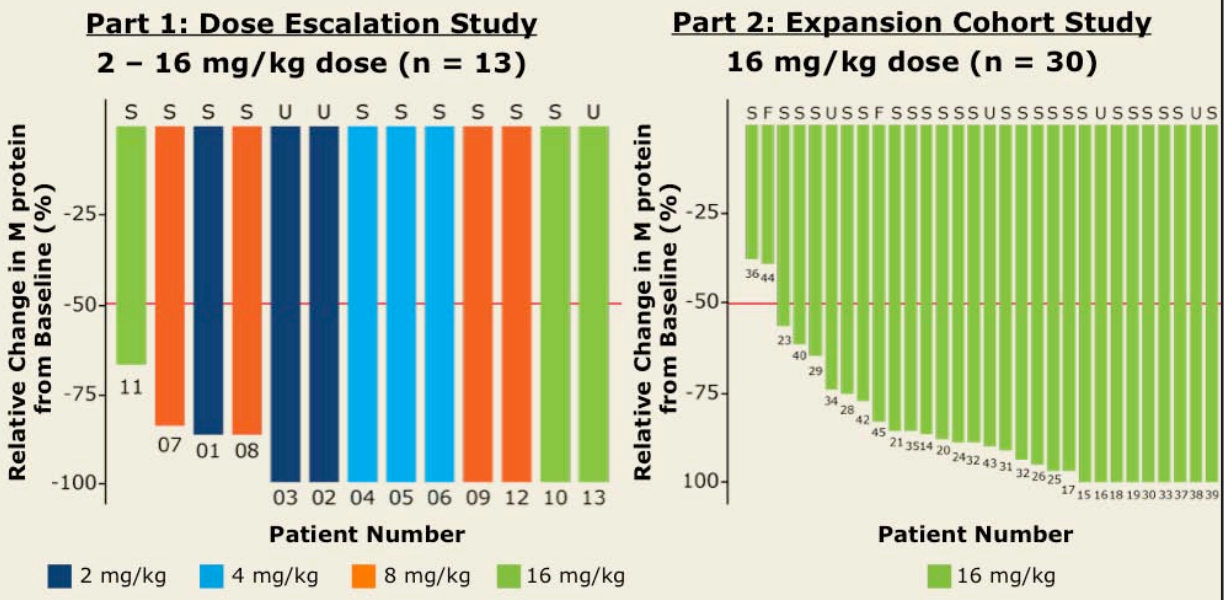
Maximum Percentage Change in M Protein from Baseline



- Majority of patients had >50% reduction in M protein levels

With permission from Plesner T et al. *Proc ASH* 2014;Abstract 84.

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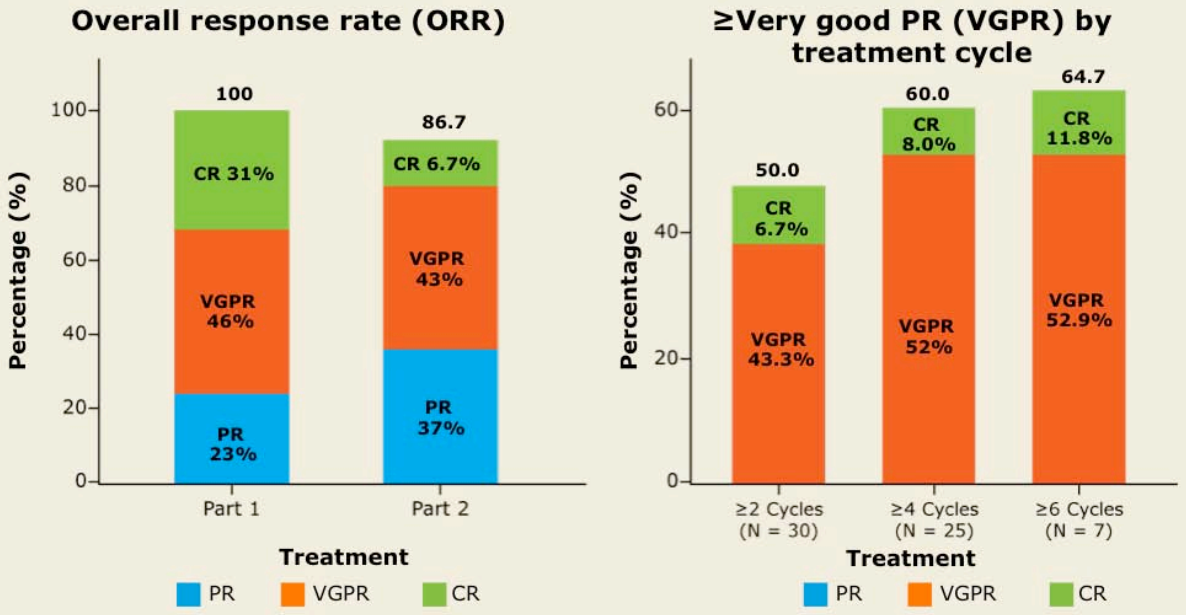
Best Response



- Mean duration of follow-up: 12.9 mo (Part 1) and 5.6 mo (Part 2)

With permission from Plesner T et al. *Proc ASH* 2014;Abstract 84.

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Response Characteristics

- VGPR or better was achieved by 75% of patients who received treatment for at least 6 months.
- Part 2 (16 mg/kg):
  - Median time to response was 1 month.
  - Median time to complete response was 4.9 months.
- As observed with other monoclonal antibodies, DARA may interfere with the serum immunofixation electrophoresis (IFE) test used to determine response to treatment.
  - The interference assay is yet to be validated.

Plesner T et al. *Proc ASH* 2014;Abstract 84.

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Safety (N = 45)

- No dose-limiting toxicities were reported.
- In Part 1, patients who discontinued treatment (n = 4)
  - Due to disease progression (n = 3):
    - 1 each in 2-, 8- and 16-mg/kg dose cohorts
  - Due to adverse events (n = 1):
    - Cardiac disorder in the 2-mg/kg cohort, due to recurrence of low-grade QT prolongation unrelated to DARA
  - Serious adverse events (n = 7):
    - All unrelated to DARA
- In Part 2, one patient discontinued treatment due to infusion-related reaction (laryngeal edema)
- Serious adverse events (n = 8) in Part 2:
  - DARA related (n = 4)

Plesner T et al. *Proc ASH* 2014;Abstract 84.

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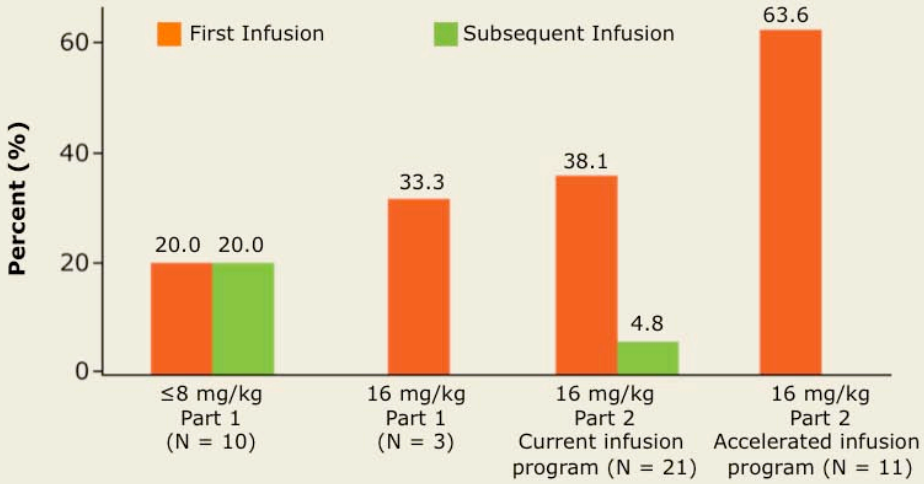
Infusion-Related Reactions (IRRs)



- Majority of IRRs were of Grade 1 and 2
- Patients who reported IRRs: 19 of 45 (42%)
- Most IRRs occurred during first infusion
- 18 of 19 (95%) patients with IRRs recovered and were able to continue with treatment

With permission from Plesner T et al. *Proc ASH* 2014;Abstract 84.

Select Adverse Events Occurring in >10% of Patients

Event	Part 1 (n = 13)	Part 2 (n = 32)	Total (n = 45)
Neutropenia	62%	65%	64%
Muscle spasms	62%	38%	44%
Nasopharyngitis	62%	3%	20%
Fatigue	62%	16%	29%
Diarrhea	54%	18%	31%
Constipation	54%	13%	27%
Nausea	38%	19%	24%
Anemia	31%	19%	11%
Dyspnea	23%	6%	11%

DARA-related serious adverse events included pneumonia, neutropenia, diarrhea and laryngeal edema.

Plesner T et al. *Proc ASH* 2014;Abstract 84.

Author Conclusions

- The ORR was 100% in Part 1 and 87% in Part 2 of the study.
  - ≥VGPR in patients who received treatment for at least 6 months: 75%
- Data from Part 1 are mature and demonstrate impressive complete response rates.
- Early results from Part 2 are consistent with Part 1 results:
  - Median follow-up <6 months with depth of response expected to further improve
- Accelerated infusion was tolerable but associated with a higher incidence of Grade 1 and 2 adverse events:
  - Accelerated infusion requires further investigation
- DARA/LEN/Dex demonstrated a favorable safety profile and manageable toxicities in relapsed and RR MM.
- Phase III trials of DARA/LEN/Dex are ongoing:
  - MMY3003-POLLUX trial for patients with relapsed or refractory MM
  - MMY3008-MAIA trial in the MM front-line setting

Plesner T et al. *Proc ASH* 2014;Abstract 84.

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Investigator Commentary: Efficacy and Safety Results from the Phase Ib Trial of SAR/LEN/Dex and the Phase I/II Trial of DARA/LEN/Dex for Patients with Relapsed and/or Refractory MM

In the ongoing Phase Ib trial of SAR/LEN/Dex for patients with relapsed or refractory MM after a median follow-up of 6 months, the investigators demonstrated an ORR of about 65% for all patients. The study showed that the addition of SAR, a CD38 monoclonal antibody, improves on the outcomes we have observed with LEN and low-dose Dex only.

In the Phase I/II trial of DARA/LEN/Dex, 75% of patients achieved VGPR or better, whereas with LEN/Dex alone only about 15% of patients usually achieve a complete response. The addition of DARA to LEN/Dex is tolerable and produces good response rates. However, I would argue that the administration of a proteasome inhibitor in this setting could result in about 75% of patients achieving a complete response. This begs the question of what would happen if an anti-CD38 monoclonal antibody were also added. Of course, several aspects of that approach have to be considered, including the cost of therapy, as it would be expensive, and the requirement for intravenous infusions, which would affect the patient's quality of life.

Interview with Ola Landgren, MD, PhD, February 9, 2015

continued

Investigator Commentary: Efficacy and Safety Results from the Phase Ib Trial of SAR/LEN/Dex and the Phase I/II Trial of DARA/LEN/Dex for Patients with Relapsed and/or Refractory MM (continued)

I believe that for patients with newly diagnosed disease, it may be worthwhile to use a strategy capable of producing deep responses in order to maintain long-term benefit from treatment.

In my opinion, the findings from these 2 studies are similar and support the idea that the addition of a monoclonal antibody to backbone therapy will probably become the standard therapy in this setting.

Interview with Ola Landgren, MD, PhD, February 9, 2015

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