P-401

Real-world Experience With Talquetamab Clinical Management in Relapsed Refractory Multiple Myeloma (RRMM): A Qualitative Study of US Healthcare Providers

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Key Takeaways

Talquetamab SUD was administered in various clinical settings, including inpatient, outpatient, and hybrid models

The 0.8 mg/kg Q2W dosing schedule was most common; however, changing to Q4W (0.8 mg/kg for all but one center, which used 0.4 mg/kg) was reported as a real-world strategy for symptom management among patients who responded to therapy

HCPs adopted a variety of strategies to manage oral, skin, and nail symptoms; prophylactic use of dexamethasone and nystatin mouthwash or zinc and vitamin B complex may be effective strategies to alleviate oral symptoms

Conclusions

Current clinical practices indicated that there is variation in the SUD care setting for talquetamab treatment (half as inpatient and half as outpatient/hybrid models)

Most HCPs used a 0.8 mg/kg Q2W dosing schedule in SUD and treatment phases; for some patients with response to therapy, switching to a Q4W schedule (0.8 mg/kg for all but one center, which used 0.4 mg/kg) is a real-world adverse event management strategy

HCPs recommended symptom management and prophylactic strategies, such as reducing dosing frequency. This is supported by two recent post hoc analyses of MonumenTAL-1 that indicated dose modification may help manage GPRC5D-related symptoms after patients achieve response[4,6]; however, there remain limited real-world data and further evidence is needed to inform the optimal dosing schedule of talquetamab and long-term efficacy and safety

While HCPs provided valuable insights into real-world practices with talquetamab, the small sample size of HCPs and the limited generalizability of qualitative assessments are key limitations of this study

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Poster

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https://www.congresshub.com/Oncology/IMS2024/Talquetamab/Schinke-Real-World

Acknowledgments

This study was sponsored and funded by Johnson & Johnson Innovative Medicine. Medical writing and editorial support were provided by Jessica A Weaver, PhD, of Lumanity Communications Inc. These results have been published previously in *Current Medical Research and Opinion* by Schinke et al in August 2024 (doi:10.1080/03007995.2024.2387183).

Disclosures

CS received consulting fees from Janssen and Arcellx; and received payment or honoraria for lectures/presentations/speakers bureaus/manuscript writing/educational events from Janssen, Arcellx, Pfizer, and MJH Life Sciences. **HHL**, **SP**, **JB**, **KH**, and **XZ** are employees of Johnson & Johnson Innovative Medicine and hold stock options. **BD** received payment or honoraria for lectures/presentations/speakers bureaus/manuscript writing/educational events from Karyopharm, Janssen, and Bristol Myers Squibb; and participated in a data safety monitoring board or advisory board for Bristol Myers Squibb, Kite Pharma, Genentech, Pfizer, Arcellx, and Janssen. **SM** received consulting fees from Janssen; and has patents planned, issued, or pending from Janssen. **SS** received consulting fees from Janssen; received payment or honoraria for lectures/presentations/speakers bureaus/manuscript writing/educational events from Janssen; and participated in a data safety monitoring board or advisory board for Janssen. **SAS** received consulting fees from Pfizer; participated in a data safety monitoring board or advisory board for Janssen Scientific Affairs, LLC, and Genzyme Corporation (Sanofi); had a leadership or fiduciary role in another board, society, committee, or advocacy group (paid or unpaid) for a HOPA mentorship subcommittee; and received ASTCT Pharmacy SIG communications and membership recognition. **TR** received consulting fees from Johnson & Johnson and Bristol Myers Squibb. **AD**, **PO**, and **RM** are employees of Avalere Health (payment by study sponsor to Avalere Health to conduct this research study) and received consulting fees from Johnson & Johnson Innovative Medicine. **CR** received consulting fees from Janssen, Sanofi, AbbVie, Bristol Myers Squibb, and Takeda; and has participated in a data safety monitoring board or advisory board for CAEL, AbbVie, and Janssen.

Introduction

- Talquetamab is a first-in-class, G protein–coupled receptor family C group 5 member D (GPRC5D) × CD3 bispecific monoclonal antibody that showed strong clinical efficacy in heavily pretreated patients with relapsed/refractory multiple myeloma (RRMM) in the phase 1/2 MonumenTAL-1 study (ClinicalTrials.gov Identifier: NCT03399799)[1,2]
- Based on the MonumenTAL-1 clinical study data, talquetamab was approved in 2023 in the United States at 2 dosing schedules for patients with RRMM who received ≥4 prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody: (1) a weekly (QW) dosing schedule that includes 3 step-up doses followed by 0.4 mg/kg QW thereafter; and (2) a biweekly (Q2W) dosing schedule that includes 4 step-up doses followed by 0.8 mg/kg Q2W thereafter[3]
- Because GPRC5D is a novel target, GPRC5D-related, on-target, off-tumor side effects may be unfamiliar to physicians and patients[1,4,5]
- Given talquetamab's unique target and recent approval, there are limited real-world data on talquetamab and an unmet need for information on real-world dosing and symptom management

Objective

- To capture real-world practices of US healthcare providers (HCPs) regarding talquetamab clinical utilization patterns, step-up dosing (SUD), treatment dosing schedules, dose modifications, and symptom (oral, skin, and nail) management

Methods

Study design and population

- This study was conducted between February and March of 2024 and employed a protocol-driven, mixed-methods qualitative design with 2 unblinded phases
  - Phase 1: in-depth interviews (IDIs) with HCPs who had early experience administering talquetamab
  - Phase 2: an expert panel of HCPs with similar qualifications to those in the IDIs, with the majority being the same HCPs
- A pool of US healthcare institutions was identified with early experience using talquetamab through preapproval access programs or clinical trials
- From these institutions, 55 HCPs with board certification or specialization in oncology/hematology were selected who had treated patients with RRMM and who had treated patients with talquetamab (via clinical trial or preapproval patient access program)
  - Among these, 21 HCPs from 11 states were contacted via email to participate in 1-hour individual IDIs
  - Convenience sampling was employed to select HCPs who were subsequently recruited based on their interest in participation, and efforts were made to ensure geographic diversity

Data collection

- IDIs were conducted virtually using a standardized discussion guide with open-ended questions about HCPs' experiences treating triple-class–exposed RRMM with talquetamab, alongside a pre-IDI survey for baseline data; recordings were transcribed and analyzed by 2 independent reviewers to identify recurring themes and insights
- After the IDIs, HCPs joined a 2.5-hour virtual expert panel to discuss talquetamab clinical management, using a summary of the insights gained from the IDIs to guide and deepen the conversation

Results

Patient characteristics

- Of the 21 invited HCPs, 11 participated in the study, representing healthcare centers across 9 states (**Table 1**)
- 10 HCPs took part in the IDIs, and the subsequent expert panel included 6 HCPs (5 from the IDIs and 1 additional expert who was unavailable for participation in the IDIs; **Table 1**)
  - On average, participants had 10.5 years of experience, collectively treating an average of 100 patients with RRMM per month

Table 1: Interviewee and panelist demographics

Characteristic	Interviewees, n (%) (N=10)	Panelists, n (%) (N=6)
Principal practice setting		
University/academic medical center	10 (100)	6 (100)
HCP role		
Oncologist/hematologist	5 (50)	3 (50)
Nurse practitioner	2 (20)	2 (33)
Clinical oncology pharmacist	2 (20)	1 (17)
Myeloma program director	1 (10)	0
Number of patients treated for RRMM each month		
1-10	0	0
11-50	3 (30)	1 (17)
51-100	3 (30)	3 (50)
101-200	3 (30)	1 (17)
>200	1 (10)	1 (17)
Years of experience		
0-5	3 (30)	2 (33)
6-10	1 (10)	1 (17)
11-15	3 (30)	1 (17)
16-20	3 (30)	2 (33)
Practice's census region		
South	3 (30)	2 (33)
Midwest	3 (30)	2 (33)
West	3 (30)	1 (17)
Northeast	1 (10)	1 (17)

HCP, healthcare provider; RRMM, relapsed/refractory multiple myeloma.

Clinical utility and sequencing

- IDI participants considered various patient factors, such as age, caregiver support, comorbidities, performance status, and disease history, when initiating talquetamab
- Most HCPs (n=7) explicitly stated that they mainly used B-cell maturation antigen (BCMA)–targeted therapies first, followed by talquetamab, but 2 of these HCPs also reported using talquetamab earlier to reserve the BCMA target for chimeric antigen receptor T-cell (CAR-T) therapy
- Most interviewed HCPs (n=8) used talquetamab as a bridging therapy while awaiting CAR-T therapy manufacture, especially for very sick or frail patients or those with aggressive disease; panelists indicated that talquetamab was given for 1 or 2 cycles after cell collection or apheresis and stopped 2 weeks before CAR-T therapy
  - Panelists also reported they would consider giving talquetamab again after CAR-T therapy if patients had previously used talquetamab as bridging therapy to CAR-T therapy
- Talquetamab combined with pomalidomide was noted as a potential option for some patients (especially for those not achieving the expected response of very good partial response); however, there is not yet a uniform practice on this and additional data are needed to inform this treatment approach

Initiation setting and SUD

- HCPs from the IDIs reported a variety of settings for SUD, including inpatient (n=5), outpatient (n=3), and hybrid models (n=2; **Table 2**), with a trend toward shorter inpatient stays to reduce healthcare resource utilization
- Most IDI participants (n=7) used a Q2W SUD schedule (4 step-up doses followed by 0.8 mg/kg Q2W thereafter; **Table 2**)
  - The SUD schedule varied, with most participants administering Q2W step-up doses on days 1-3-5-7 or 1-3-5-8
- Half of panel participants (n=3) reported an average of 7 days (range: 6-10 days) for length of stay during SUD

Treatment dose schedule and dose modification

- Most HCPs (n=8 IDI participants; n=5 panelists) preferred the 0.8 mg/kg Q2W dosing schedule over the 0.4 mg/kg QW schedule for treatment, citing patient convenience, observed treatment responses, and institutional alignment with other RRMM treatments to simplify logistics and maintain consistency (**Table 2**)
- 6 IDI participants and all panelists reported exploring less frequent dosing (0.8 mg/kg every 4 weeks [Q4W] for all but 1 center, which used 0.4 mg/kg Q4W) for patients responding well to talquetamab to manage GPRC5D-related symptoms
  - Panelists typically switched to a Q4W (0.8 mg/kg Q4W or 0.4 mg/kg Q4W) schedule after 3 cycles (range: 2-6 months), though the timing varied based on patient response and toxicities

GPRC5D-related symptoms: impact and management

- HCPs noted that most patients who received talquetamab experienced varying degrees of oral, skin, and/or nail symptoms and that educating and setting expectations with patients before therapy were important
  - These symptoms may have led to delayed doses/schedule modifications, but most were not seen as dose-limiting and none resulted in treatment discontinuation
- Symptom management approaches are summarized (**Table 3**; **Figure 1**)
- Interviewed HCPs indicated that oral toxicities, mainly dysgeusia (alterations in taste), were the most prevalent and fastest-to-develop symptoms; talquetamab-associated changes to the skin and nails typically occurred later, fluctuated over time, and had less of an impact on quality of life compared with oral symptoms
  - GPRC5D-related symptoms were not perceived to discourage HCPs from choosing talquetamab; skin and nail symptoms improved with adequate management and usually resolved after treatment stopped, and oral symptoms seemed to persist in varying degrees, even after treatment cessation, but did ultimately go away with time
- 5 panelists noted that their institutions were developing talquetamab "tool kits" and symptom management protocols

Table 2: Summary of SUD setting and dosing practices among IDI participants

Dosing practices[a]	Interviewees, n (%) (N=10)
SUD site of care	
Inpatient	5 (50)
Outpatient	3 (30)
Hybrid	2 (20)
SUD schedule	
Q2W	7 (70)
QW	3 (30)
SUD day schedule	
1-3-5-7	4 (40)
1-4-7	2 (20)
1-3-5-7/8	2 (20)
1-3-5	1 (10)
1-4-7-10/11	1 (10)
Treatment dosing schedule	
Q2W[b]	8 (80)
QW[c] → Q2W[b]	1 (10)
Use of both QW[c] and Q2W[b]	1 (10)
Modifications for patients responding well to treatment	
Has used a Q4W[d] schedule	6 (60)
Has not used a Q4W[d] schedule	4 (40)

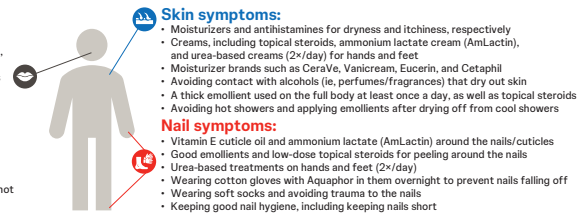
HCP, healthcare provider; IDI, in-depth interview; Q2W, once every 2 weeks (biweekly); Q4W, once every 4 weeks; QW, once per week (weekly); SUD, step-up dosing.
[a]These values represent the number of HCPs who mentioned a given practice during their IDI. More HCPs may have made use of a strategy in practice but did not mention it during the IDI.
[b]Q2W dosing at 0.8 mg/kg.
[c]QW dosing at 0.4 mg/kg.
[d]Q4W dosing at 0.8 mg/kg for all but 1 center, which used 0.4 mg/kg.

Table 3: Summary of GPRC5D-related symptom management among IDI participants

Symptom management strategies[a]	Interviewees, n (%) (N=10)
Oral symptom management	
Dietitian	5 (50)
Consider Q4W[b]	5 (50)
Steroid (eg, dexamethasone) mouth rinse	4 (40)
Dietary changes	4 (40)
Biotène	3 (30)
Saliva substitutes	3 (30)
Nystatin (for those with oral thrush from steroid)	1 (10)
Ice packs	1 (10)
Salt solution	1 (10)
Gum/lozenges	1 (10)
AE protocol	1 (10)
Skin symptom management	
Creams (including urea-based creams, moisturizers, and ammonium lactate cream [AmLactin])	8 (80)
Topical steroids	7 (70)
Hydration	3 (30)
Abrasion to help healing	2 (20)
Consider Q4W[b]	2 (20)
Dermatologist referral	1 (10)
Nail symptom management	
No plan	4 (40)
Cosmetics	3 (30)
Nail polish	1 (10)
Gloves	1 (10)
Dermatologist referral	1 (10)

AE, adverse event; GPRC5D, G protein–coupled receptor family C group 5 member D; HCP, healthcare provider; IDI, in-depth interview; Q4W, once every 4 weeks.
[a]These values represent the number of HCPs who mentioned a given strategy for symptom management during their IDI. There may be additional HCPs who made use of a strategy in practice but did not mention it during the IDI.
[b]Q4W dosing at 0.8 mg/kg for all but 1 center, which used 0.4 mg/kg.

Figure 1: Management strategies for symptoms (oral, skin, and nail) from the expert panel



SUD, step-up dosing; Q2W, once every 2 weeks (biweekly); Q4W, once every 4 weeks.
[a]Q4W dosing at 0.8 mg/kg for all but 1 center, which used 0.4 mg/kg.

References

1. Chari A, et al. *N Engl J Med*. 2022;387(24):2232-2244. 2. Rasche L, et al. Poster presented at: Annual Meeting of the European Hematology Association (EHA); June 13-16, 2024; Madrid, Spain. 3. TALVEY™ (talquetamab-tgvs) [package insert]. Janssen Biotech, Inc.; 2023. 4. Chari A, et al. *Clin Lymphoma Myeloma Leuk*. 2024. Online ahead of print. doi:10.1016/j.clml.2024.05.003. 5. Rodriguez-Otero P, et al. *Lancet Oncol*. 2024;25(5):e205-e216. 6. Chari A, et al. *Blood*. 2023;142(supp 1):1010.

Multiple Myeloma

Presented by S Patel at the 21st International Myeloma Society (IMS) Annual Meeting; September 25-28, 2024; Rio de Janeiro, Brazil