Burden of Administration: Belamaf-Based Combinations (BVd, BPd) Versus Carfilzomib-Based Combinations (IsaKd, DKd, Kd)

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Over 2 years of treatment, the belamaf-containing regimens, BVd and BPd, required fewer administrations and associated costs, and less administration and monitoring time, compared to standards of care IsaKd, DKd, and Kd in patients with RRMM

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Background

- Belantamab mafodotin (belamaf) is being investigated at first relapse or later in phase 3 RRMM studies
  - The DREAMM-7 study (NCT04246047) evaluated belamaf with bortezomib and dexamethasone (BVd) and showed significant PFS and OS benefits versus daratumumab with bortezomib and dexamethasone[1,2]
  - The DREAMM-8 study (NCT04484623) evaluated belamaf with pomalidomide and dexamethasone (BPd) in lenalidomide-exposed patients and showed significant PFS versus pomalidomide with bortezomib and dexamethasone and a trend for OS favoring BPd, with follow-up ongoing[3]
- Administration burden can be important for patients when considering treatment options.[4] Most patients in DREAMM-7 (88%) and DREAMM-8 (90%) experienced extended belamaf dosing intervals, resulting in reduced administration burden

Aim

- To evaluate the administration burden of BVd and BPd in patients on treatment compared to IV-administered second-line-or-later standards of care (carfilzomib and dexamethasone alone [Kd] or with isatuximab [IsaKd] or daratumumab [DKd])

Methods

- A model estimating administration burden per patient receiving BVd/BPd/IsaKd/DKd/Kd for the first 2 years of treatment was developed
- Dosing regimens were obtained using weekly individual patient-level dosing data from DREAMM-7 (BVd) and DREAMM-8 (BPd), and from published protocols for IsaKd, DKd, and Kd[5–10]
- Administration burden inputs (administration number, clinic visits, and administration/monitoring [including ocular exam for BVd/BPd] durations) for the IV and SC agents were sourced from published protocols/clinician input[5–10]
- Oral pomalidomide/dexamethasone were assumed to not require administration visits. Reported results are means per patient on treatment

Results

Figure 1: **Across years 1 and 2, BVd and BPd had lower mean numbers of administrations per patient compared to the IV and SC components of IsaKd, DKd, and Kd**

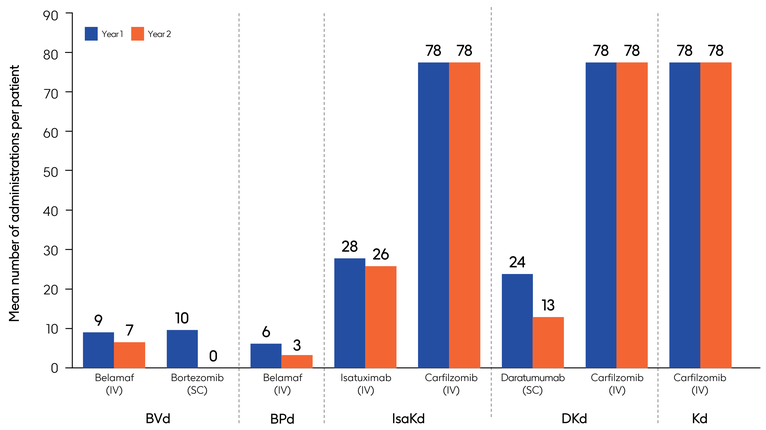
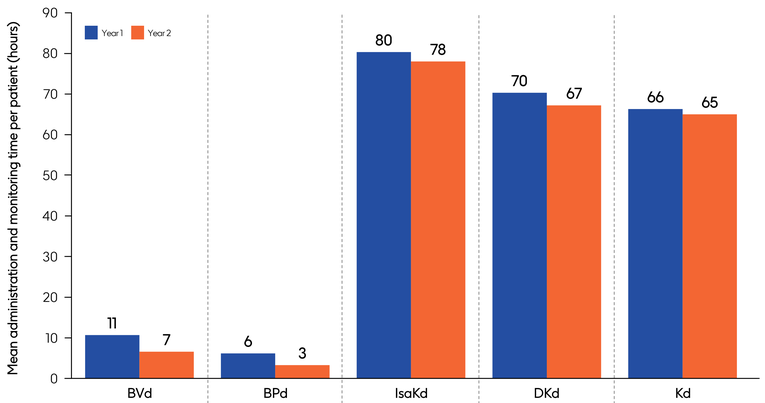
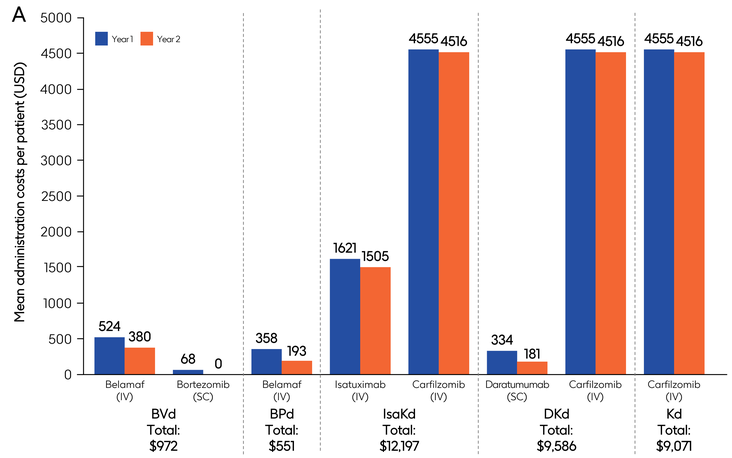


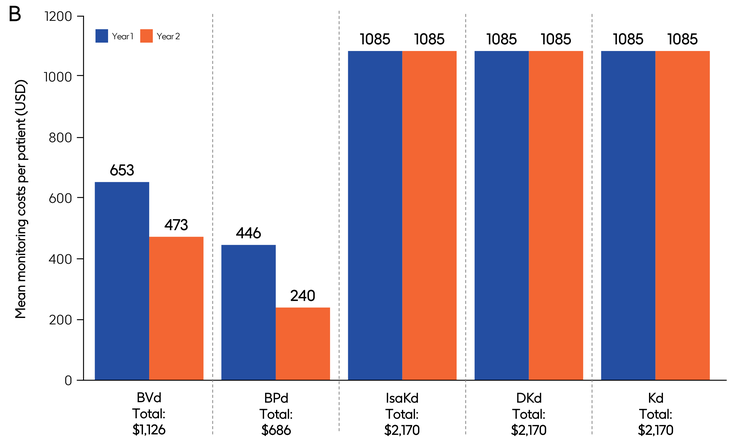
Figure 2: **Mean administration and monitoring times per patient in years 1 and 2 were shorter for BVd and BPd compared to IsaKd, DKd, and Kd**



	BVd		BPd		IsaKd		DKd		Kd	
Administration	6.1	3.3	3.1	1.7	54.3	52.0	44.3	41.2	40.3	39.0
Monitoring	4.5	3.3	3.1	1.7	26.0	26.0	26.0	26.0	26.0	26.0

Figure 3: **Mean costs of administration (A) and monitoring (B) per patient were lower for BVd and BPd in years 1 and 2**





- Sensitivity analyses were consistent with primary analyses. Alternative administration times were also explored

Conclusions

BVd and BPd demonstrated substantially lower administration burden versus IsaKd, DKd, and Kd in the treatment of RRMM

Total costs of administration and monitoring were markedly lower compared to IsaKd, DKd, and Kd

BVd and BPd represent potential RRMM treatment options with high clinical efficacy[1–3] that are accessible to patients who require lower administration burden and/or fewer associated costs

Abbreviations

Belamaf, belantamab mafodotin; BPd, belantamab mafodotin, pomalidomide, and dexamethasone; BVd, belantamab mafodotin, bortezomib, and dexamethasone; DKd, daratumumab, carfilzomib, and dexamethasone; IsaKd, isatuximab, carfilzomib, and dexamethasone; IV, intravenous; Kd, carfilzomib and dexamethasone; OS, overall survival; PFS, progression-free survival; RRMM, relapsed/refractory multiple myeloma; SC, subcutaneous; USD, United States dollar

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Acknowledgements

Funding: Study was funded by GSK. Writing, editorial support, and formatting assistance for this poster were provided by Alexus Rivas-John, PharmD, of Fishawack Indicia Ltd, part of Avalere Health, funded by GSK.

Disclosures

AS reports a consulting/advisory board role with GSK, Janssen Oncology, BMS, and Karyopharm, received a research grant from BMS (Inst), Genentech (Inst), GSK (Inst), Janssen Oncology (Inst), and Regeneron (Inst), and reports patents, royalties, or other intellectual property for a novel bone anabolic agent in the treatment of cancer bone metastasis (Inst). KB, ED, and PM are employees of FIECON. NB, MP, SM, SS, and YS are employees of and hold financial equities in GSK.

ISPOR 2025 | May 13–16, 2025 | Montreal, QC, Canada

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