UniteMM

Linking Insights for Multiple Myeloma Patient Care

For the latest information on the Unite for MM survey findings, please visit our website at:

www.UniteMM.com

Pfizer Oncology

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CAR, chimeric antigen receptor; HCP, health care professional; MM, multiple myeloma.

The Unite for MM INITIATIVE

With the recent approvals of innovative therapies to treat relapsed refractory multiple myeloma (RRMM), such as bispecific antibodies and chimeric antigen receptor (CAR) T-cell therapies, patients and health care professionals (HCPs) now have more treatment options than ever before.[1-3] However, this increasingly complex treatment landscape can be challenging to navigate.[1]

Together with Pfizer, a multinational Steering Committee composed of members from across the multiple myeloma (MM) community developed a global survey to understand unmet needs in the care of patients with RRMM and key barriers to adoption of recently approved immunotherapies. The survey asked patients and HCPs about their treatment priorities, the challenges they face, and awareness and use of bispecific antibodies and CAR T-cell therapies.[1]

This booklet reviews the initial survey findings, and proposes actions that may help improve patient care and access to therapy

The Unite for MM Steering Committee

The Steering Committee included MM experts, care team members, patients, and patient advocacy group representatives, providing varying perspectives of the myeloma community.

The Steering Committee provided insights and feedback during survey and protocol development, tested the surveys, and helped interpret and publish the results.

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The organization names are to show Steering Committee member affiliations and do not imply endorsement by the respective organizations. Members of the Steering Committee have been compensated by Pfizer Inc.

HCP, health care professional; MM, multiple myeloma; NHS, National Health Service; VCU, Virginia Commonwealth University.

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The organization names are to show Steering Committee member affiliations and do not imply endorsement by the respective organizations. Members of the Steering Committee have been compensated by Pfizer Inc.

HCP, health care professional; MM, multiple myeloma.

Survey Population[1]

The survey population consisted of patients with RRMM and HCPs from 7 countries

1301 PATIENTS

983 HCPS

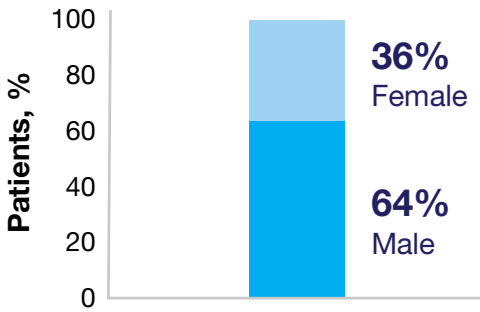
HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

PATIENT FEATURES[1]

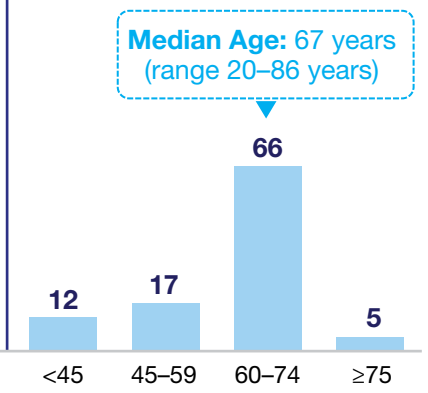
The survey included adult patients with RRMM who had relapsed at least once

The majority of patients were male, lived in cities, and had university or advanced education degrees

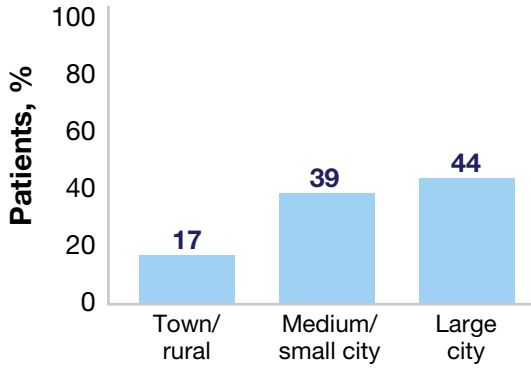
GENDER



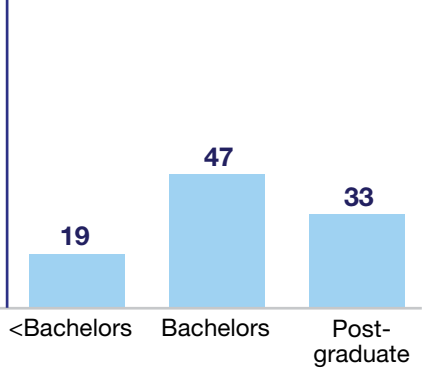
PATIENT AGE (YEARS)



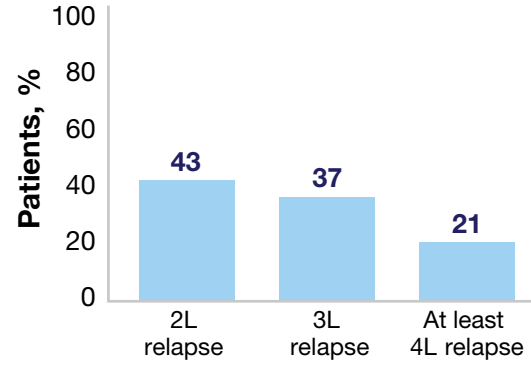
LOCATION



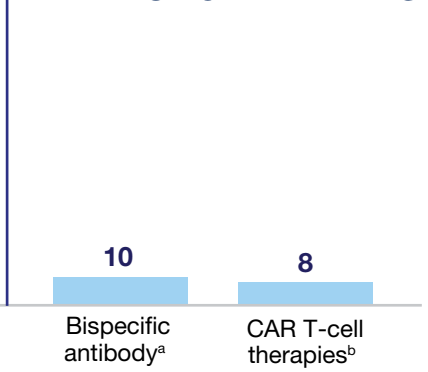
HIGHEST EDUCATION LEVEL



MOST RECENT LINE OF THERAPY



RECEIVED RECENTLY APPROVED IMMUNOTHERAPIES



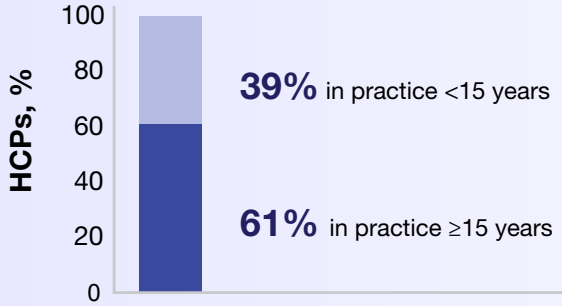
[a]Bispecific antibody percentages do not include respondents from Spain, the UK, or Japan. [b]Percentages for CAR T-cell therapies do not include respondents from Spain or the UK.[1]

2L, second line; 3L, third line; 4L, fourth line; CAR, chimeric antigen receptor; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

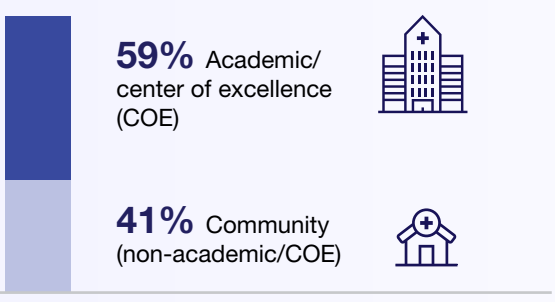
HCP FEATURES[1]

The survey also included oncologists and/or hematologists who spent more than half their time treating patients, had seen or treated at least 3 patients with RRMM in the past year, and had been practicing medicine for 4 to 35 years

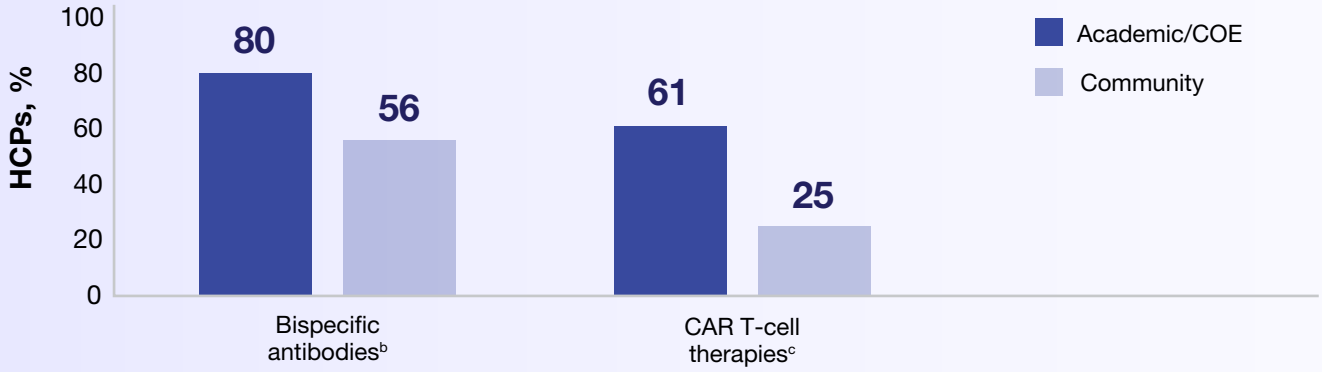
YEARS IN PRACTICE



PRACTICE SETTING[a]



HCPS WHO CAN ADMINISTER BISPECIFIC ANTIBODIES OR CAR T-CELL THERAPIES WITHIN THEIR PRACTICE



HCPs in community settings were less likely to have the capacity to administer bispecific antibodies or CAR T-cell therapies within their own practice than HCPs in academic/COE settings

[a]In the US, HCPs were defined as academic/COE if 50% or more of their practice was based in a hospital with academic affiliation and/or a specialized cancer center. In other countries, HCPs were defined as academic/COE if 50% or more of their practice was based in a COE or teaching hospital, or a cancer center if in France.[4] [b]Bispecific antibody percentages do not include respondents from Spain, the UK, or Japan. [c]Percentages for CAR T-cell therapies do not include respondents from Spain or the UK.[1]
CAR, chimeric antigen receptor; COE, center of excellence; HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

Barriers to Care and CALLS TO ACTION

This section presents the current barriers to care that were identified by the Unite for MM survey. These barriers are presented alongside Calls To Action, which were developed with input from the Unite for MM Steering Committee in response to the survey results.

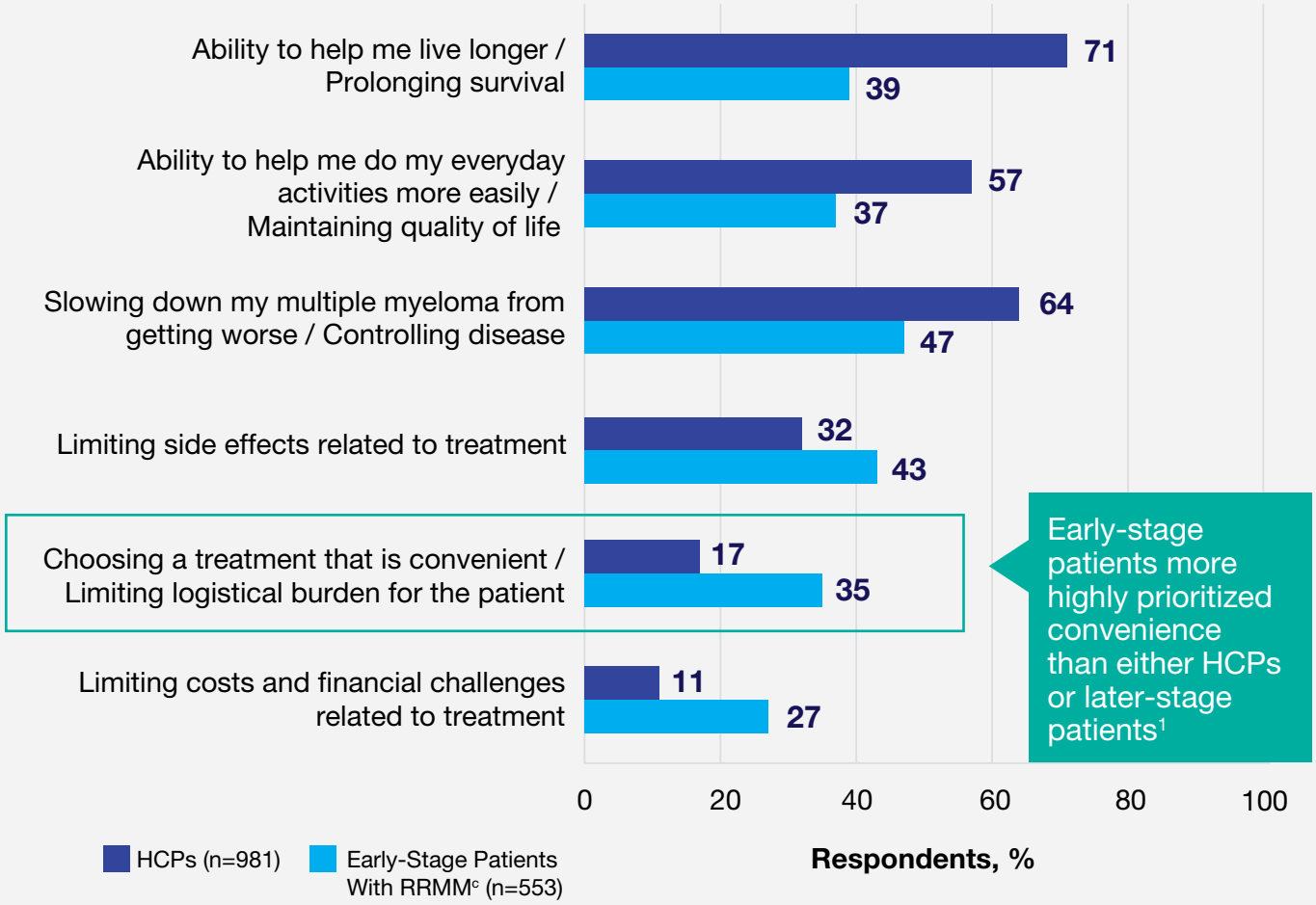
The Calls To Action are positive steps that the MM community can take to reduce these barriers and improve patient care. Each Call to Action is paired with the members of the community who may be best positioned to make these changes a reality.

MM, multiple myeloma.

01 Patients and HCPs prioritized treatment goals differently[1]

- To assess RRMM treatment goals, the survey asked patients and HCPs to select their top 3 priorities when starting a new treatment[1,5]
- Patients with early-stage RRMM more highly prioritized convenience than either patients with later-stage RRMM or HCPs[1,a]

TOP PATIENT AND HCP TREATMENT PRIORITIES[5,a,b] (EARLY-STAGE RRMM)[c]

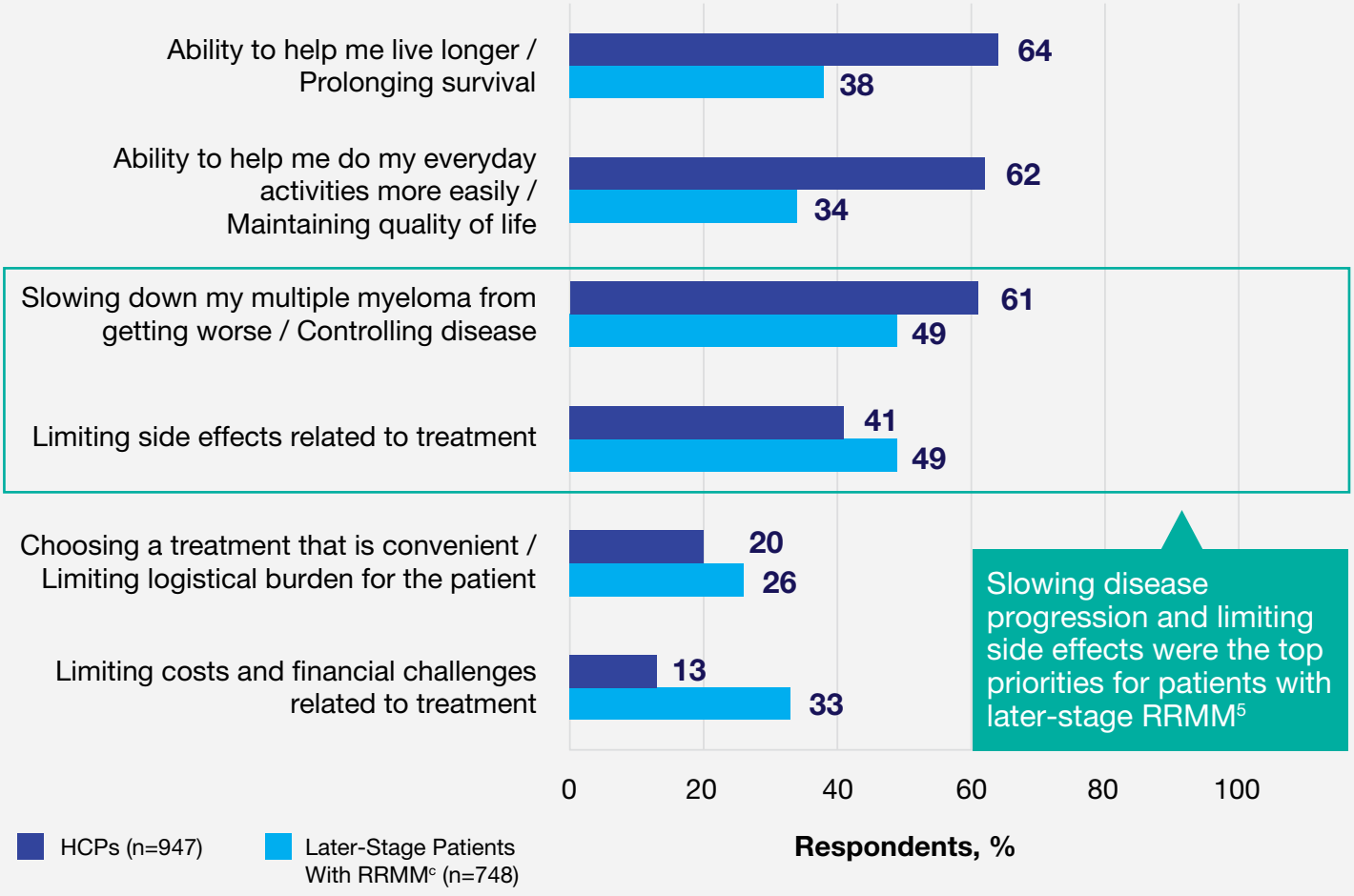


[a]Graph shows the percentage of patients with early-stage RRMM and HCPs who selected these responses among their top 3 priorities.[5] [b]Language is simplified from the survey prompt.[1] [c]Early-stage RRMM defined as 2 prior lines of therapy. Later-stage RRMM defined as 2 or more prior lines of therapy.
HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

01 Patients and HCPs prioritized treatment goals differently *(cont'd)*[1]

- For later stage patients, HCPs generally prioritized efficacy and quality of life over minimizing side effects related to treatment, while patients prioritized them equally[1,a]
- At all disease stages, patients placed higher priority on cost considerations than did HCPs[1]

TOP PATIENT AND HCP TREATMENT PRIORITIES[5,a,b] (LATER-STAGE RRMM)[c]



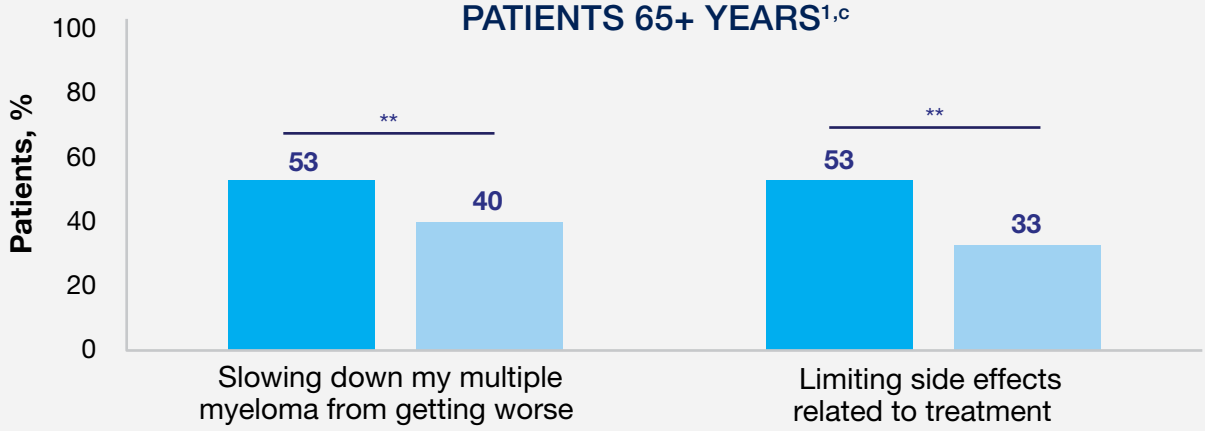
[a]Graph shows the percentage of patients with later-stage RRMM and HCPs who selected these responses among their top 3 priorities.[5] [b]Language is simplified from the survey prompt.[1] [c]Early-stage RRMM defined as 2 prior lines of therapy. Later-stage RRMM defined as 2 or more prior lines of therapy.

HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

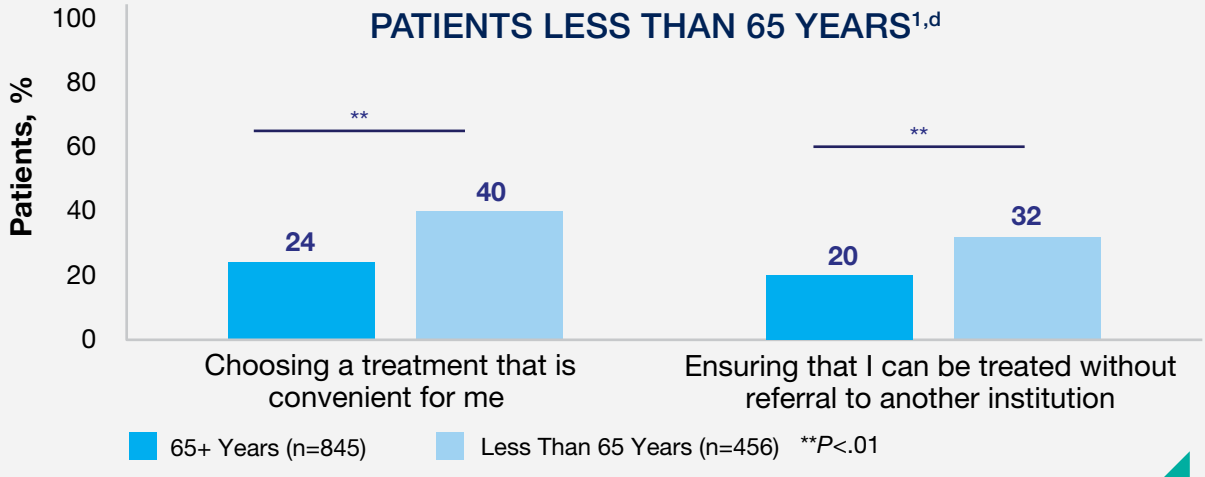
In patients with RRMM, age impacted treatment priorities and satisfaction[1]

- Older patients (aged 65+ years) were significantly more concerned about limiting disease progression and side effects than younger patients (*P*<.01)[1]
- Younger patients (aged less than 65 years) prioritized convenient treatment administration[a] and avoiding referrals compared to their older counterparts (*P*<.01)[1,b]

TREATMENT GOALS MORE HIGHLY PRIORITIZED BY PATIENTS 65+ YEARS[1,c]



TREATMENT GOALS MORE HIGHLY PRIORITIZED BY PATIENTS LESS THAN 65 YEARS[1,d]



Patients with comorbidities were also more concerned about limiting side effects related to treatment than their counterparts (52% vs 32%, *P*=.055)[1]

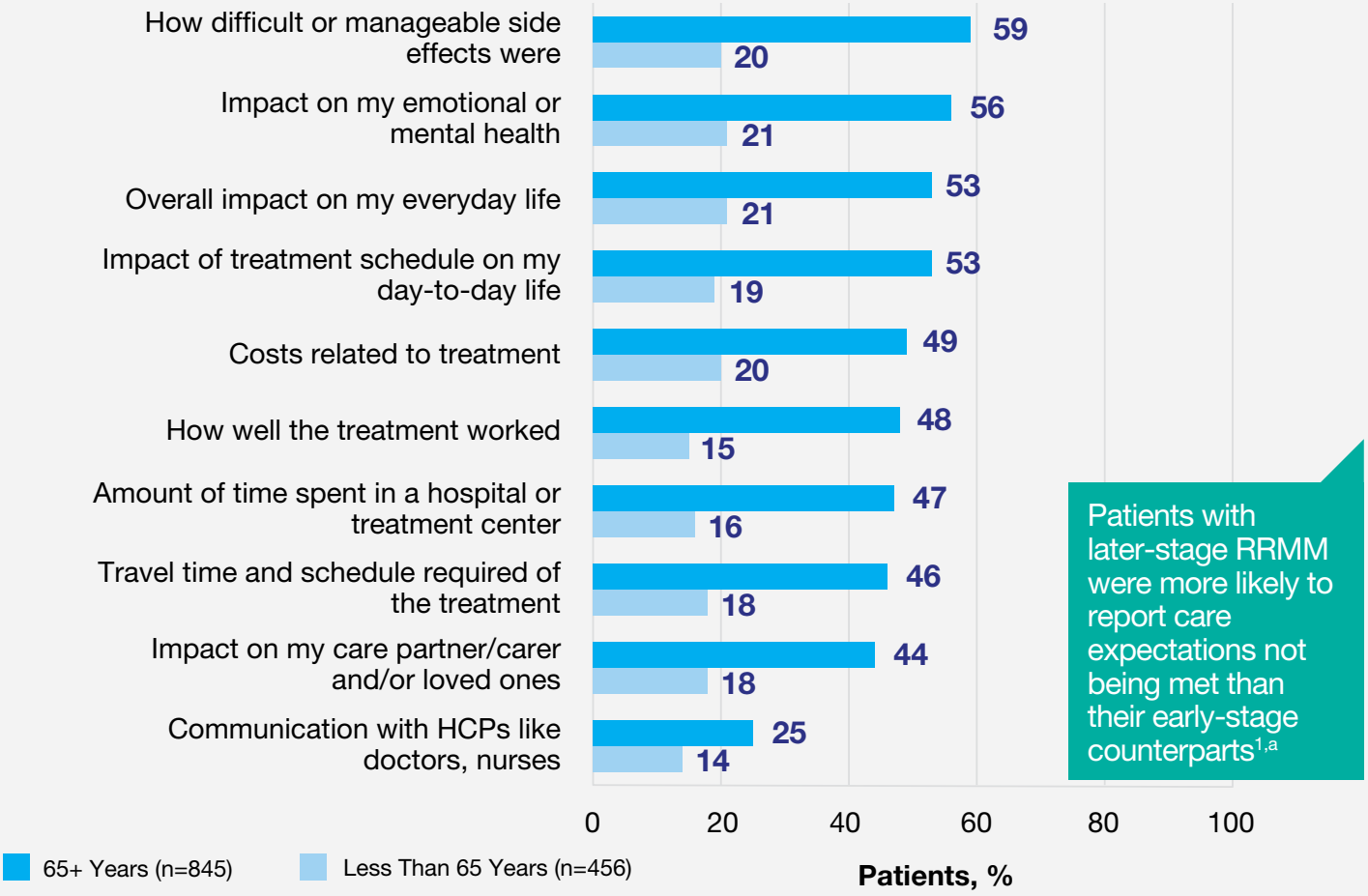
[a]Refers to how patients take their treatments or the timing required for them (including travel, time receiving treatment, and any follow-up visits). [b]Such as prioritizing treatments readily available in their HCP's practice. [c]Defined as treatment goals chosen as a top 3 treatment priority by more patients 65+ years old than their younger counterparts, with a difference of at least 10% between the groups.[1] [d]Defined as treatment goals chosen as a top 3 treatment priority by more patients less than 65 years old compared with their older counterparts, with a difference of at least 10% between the groups.[1]

HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

In patients with RRMM, age impacted treatment priorities and satisfaction *(cont'd)*[1]

- In addition to their treatment priorities, patients were asked about how their MM treatment and care compared with their expectations[1]
- Compared with their younger counterparts, older patients were more likely to find aspects of their treatment "worse" or "slightly worse" than expected[1,a]

PATIENTS FINDING ASPECTS OF MM TREATMENT "WORSE" OR "SLIGHTLY WORSE" THAN EXPECTATIONS[1,a]



[a]*P*-values were not reported.[1]
HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

CALL TO ACTION

Collaborate to Relieve Treatment-Related Burdens and Identify Patient Treatment Goals

Support increased access to support services, such as social workers, counselors, gerontologists, and patient navigators; and identify opportunities to **reduce treatment-related financial burdens**

Who Can Take Action?

Patient advocacy groups, payers, policymakers, industry

Rationale

This survey found that patients experience a variety of treatment-related burdens, including side effects, psychological impacts, logistical difficulties, and financial challenges.[1]

Increasing access to support services may help alleviate many of these treatment-related burdens. For instance, counselors can help navigate the impact of care on mental health, while gerontologists can help provide care that addresses the specific needs of elderly patients.[6] Non-clinical support staff, such as patient navigators and social workers, may help patients access resources that address logistic and cost considerations.[7] Increasing the financial resources for patients, and better communicating the available resources, may also help ease treatment-related financial burdens.[7-9]

MM, multiple myeloma.

CALL TO ACTION

Support studies to **investigate if dosing regimens can be made more convenient for patients** without compromising efficacy

Who Can Take Action?

Researchers, industry, HCPs

Rationale

Changes to dosing regimens, such as reducing how often treatments need to be taken and including breaks from treatment in responding patients, can increase convenience for patients.[10,11] These changes may also reduce side effects and financial challenges, easing many patient burdens.[11,12]

Develop discussion tools in partnership with patient advocacy groups to help **foster a more cohesive dialogue between patients and HCPs**

Who Can Take Action?

Researchers, patient advocacy groups, HCPs, patients

Rationale

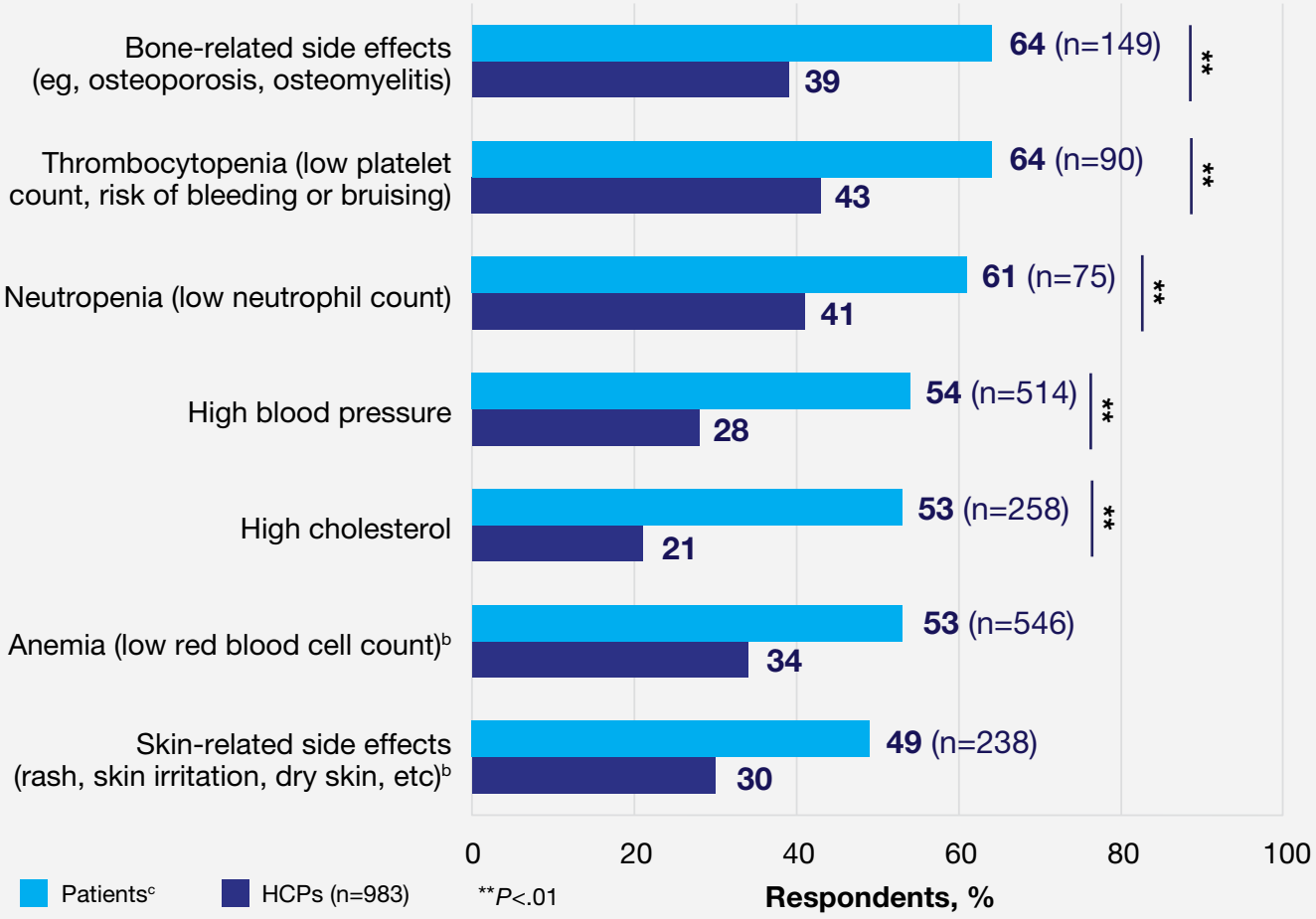
Survey findings indicate treatment goals differ between patients and HCPs.[1] Additionally, treatment goals and patient perceptions are impacted by many factors, including age, the presence of comorbidities, and the number of times the patient has relapsed.[1] Developing and using shared decision-making tools may help ensure patients are receiving the care that best aligns with their unique treatment goals.[13-15]

HCP, health care professional; MM, multiple myeloma.

02 Patients and HCPs considered different side effects to be challenging to manage

- The ability to manage side effects can impact the treatment experience for both patients and HCPs[1]
- To evaluate how side effects affect HCPs and patients with RRMM, respondents were asked how challenging certain side effects that they had experienced were to manage[1]
- The survey found that more patients than HCPs considered side effects—such as those related to bone, thrombocytopenia, neutropenia, high blood pressure, high cholesterol, anemia, and those related to skin—as "extremely challenging"[1,5]

SIDE EFFECTS CONSIDERED "EXTREMELY CHALLENGING" BY MORE PATIENTS THAN HCPS[1,4,5,a]



The survey findings suggest a gap in managing side effects that are potentially addressed by non-hematologists/oncologists[1,16]

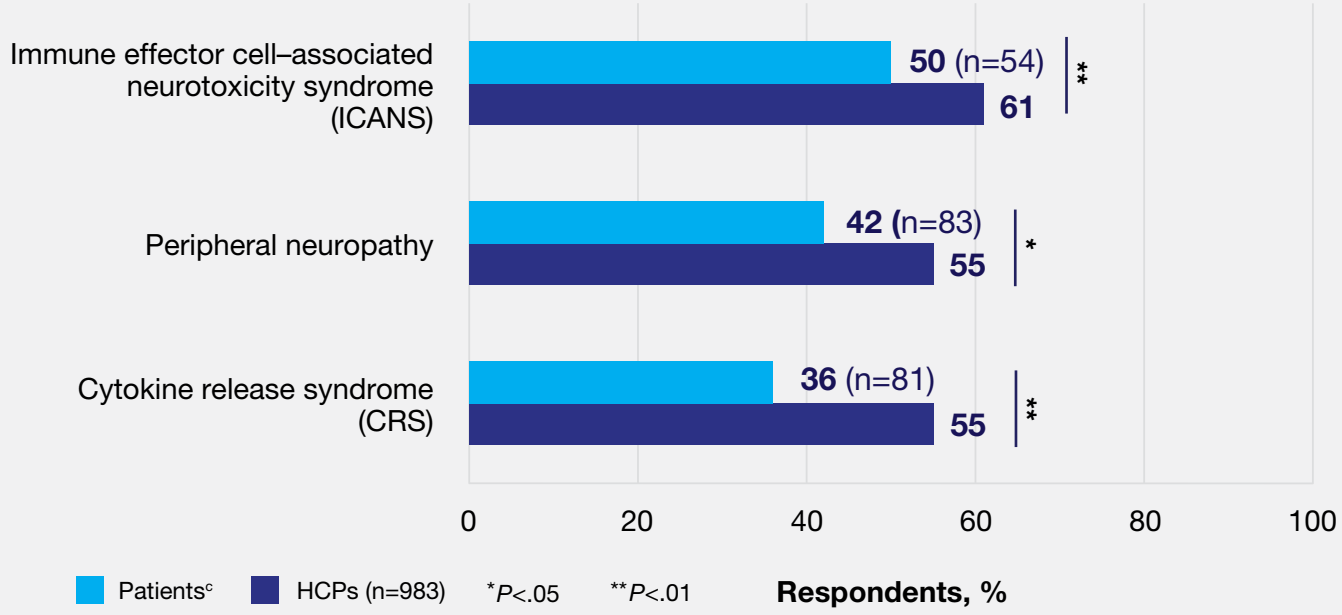
[a]Graph shows side effects considered "extremely challenging" by at least 10% more patients than HCPs. [b]*P*-values for anemia and skin-related side effects were not reported. [c]Only patients who had experienced a specific side effect were asked how challenging it is to manage.

HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

02 Patients and HCPs considered different side effects to be challenging to manage *(cont'd)*

The few side effects that more HCPs than patients viewed as "extremely challenging" were those associated with newly approved immunotherapies (eg, CRS and ICANS)[1-3,a,b]

SIDE EFFECTS CONSIDERED "EXTREMELY CHALLENGING" BY MORE HCPS THAN PATIENTS[1,5,a]

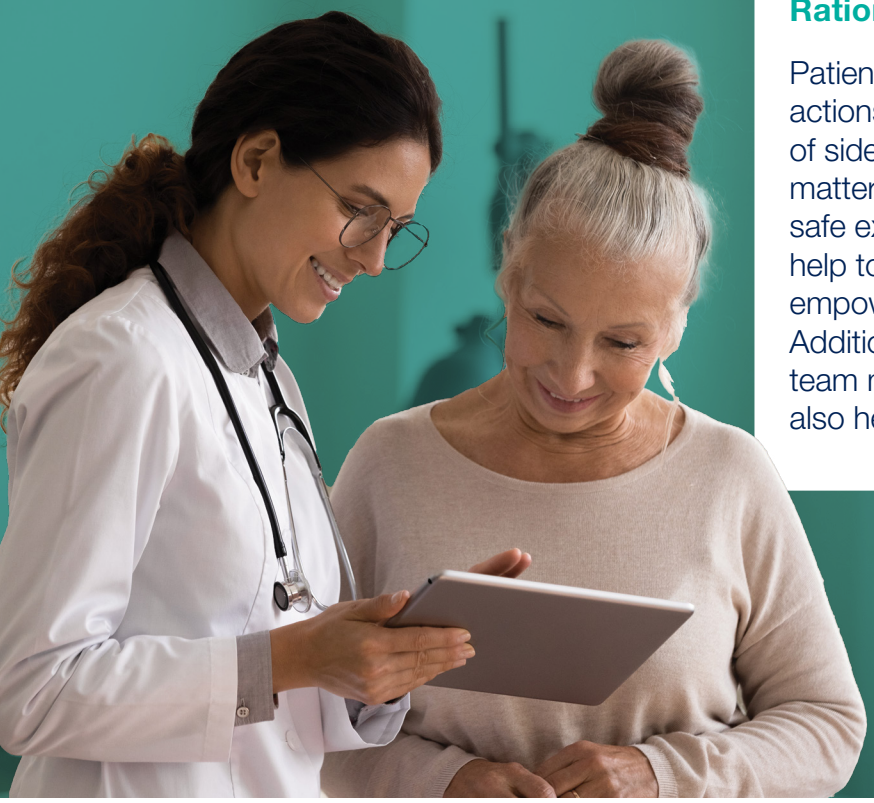


HCPs may be less familiar with managing the side effects associated with recently approved immunotherapies (eg, bispecific antibodies and CAR T-cell therapies)[1,2,17,18]

[a]Includes side effects considered "extremely challenging" by at least 10% more HCPs than patients. [b]Side effects considered "extremely challenging" by both HCPs and patients included leukemia and serious infections (data not shown).[1]
[c]Only patients who had experienced a specific side effect were asked how challenging it is to manage.
CAR, chimeric antigen receptor; CRS, cytokine release syndrome; HCP, health care professional; ICANS, immune effector cell-associated neurotoxicity syndrome; MM, multiple myeloma.

CALL TO ACTION

Reduce Treatment Burden by Using a Comprehensive Approach to Manage Side Effects



Support a **proactive approach to patient and care partner education** to help manage side effects

Who Can Take Action?

HCPs, care partners, patients

Rationale

Patients and care partners may not be fully aware of actions they can take to prevent or lessen the impact of side effects. Providing education on practical matters ranging from fall prevention measures, safe exercises, and use of moisturizers can all help to reduce the risk of certain side effects and empower patients to take control of their health.[19-21] Additionally, educating patients to notify their care team members of health events as they occur may also help to manage side effects more effectively.[15]

HCP, health care professional.

CALL TO ACTION

Support HCP **education and coordination of care** for optimal management of side effects

Who Can Take Action?

Clinical experts, HCPs

Rationale

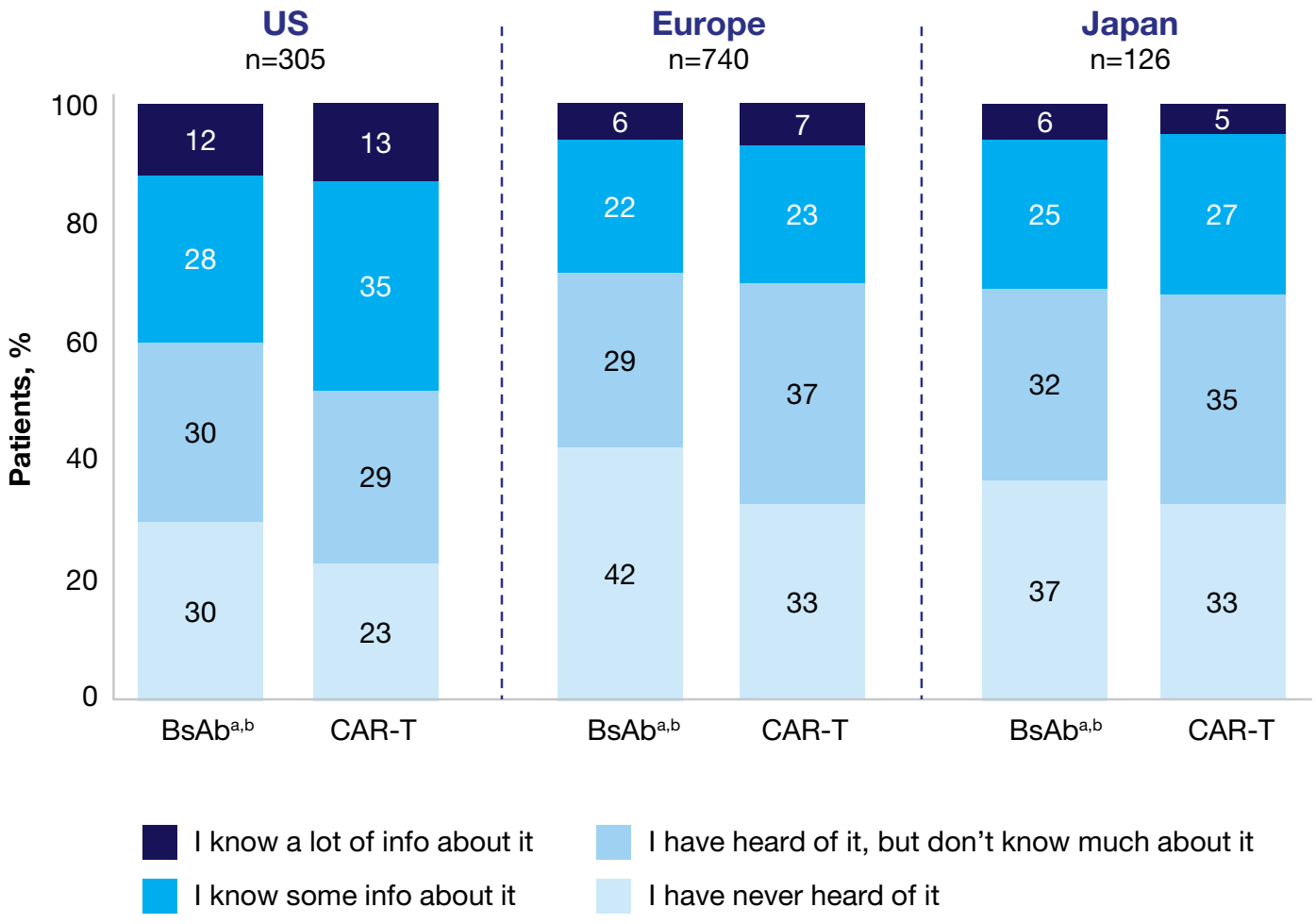
The survey findings indicate patients may need additional support to manage side effects.[1] Recommended supportive or prophylactic medications may be underutilized in patients with MM;[22] and care may be fragmented between oncologists and other providers such as PCPs, particularly for patients with comorbidities.[16,23] Peer-to-peer education and sharing of best practices may help improve these areas to potentially provide better supportive care. These efforts should include all members of the care team, as nurses and pharmacists communicate extensively with patients, and therefore are well-positioned to identify potential side effects or issues with following the treatment plan.[24,25]

HCP, health care professional; MM, multiple myeloma; PCP, primary care provider.

03 Patient awareness of bispecific antibodies and CAR T-cell therapies is limited[1]

- At the time of this survey, 2 types of immunotherapies, bispecific antibodies[a] and CAR T-cell therapies, had been recently approved to treat patients with RRMM[1,26]
- When asked about these therapies, 30%–42% of patients surveyed had never heard of bispecific antibodies, and 23%–33% had never heard of CAR T-cell therapies[1]
- Patient awareness was highest in the US and lowest in Europe and Japan[1]

PATIENT AWARENESS OF RECENTLY APPROVED IMMUNOTHERAPIES[1,b]



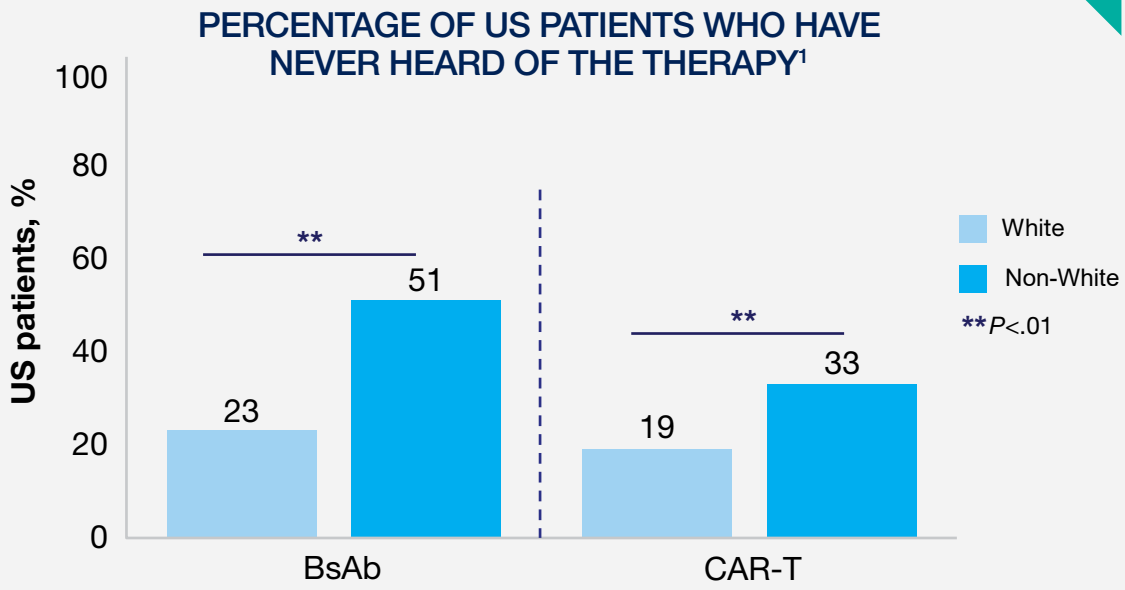
[a]Includes bispecific antibodies targeted toward BCMA and GPRC5D.[1,26] [b]At the time of the survey (March-June 2024), CAR T-cell therapies were not available in the UK and bispecific antibodies were not available in Japan.[1]

BsAb, bispecific antibody; CAR, chimeric antigen receptor; CAR-T, CAR T-cell therapy; GPRC5D, G protein–coupled receptor class C group 5 member D; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma; UK, United Kingdom; US, United States.

03 Patient awareness of bispecific antibodies and CAR T-cell therapies is limited *(cont'd)*[1]

- The survey did not capture treatment eligibility. However, only a small proportion of patients recalled their doctor offering these immunotherapies as options (bispecific antibodies, 13%; CAR T-cell therapies, 17%)[1]
  - This suggests that for the 28%–48% of patients who know at least some information about these therapies, awareness may be driven by their own research rather than conversations with the care team
- In the US (the only country for which racial data were available), non-White patients were significantly less likely to have heard of bispecific antibodies or CAR T-cell therapies (*P*<.01)[1]
  - Non-White patients were also less likely to report being treated by a doctor who only specializes in MM[1]

Awareness of bispecific antibodies and CAR T-cell therapies was lower in non-White populations[1]



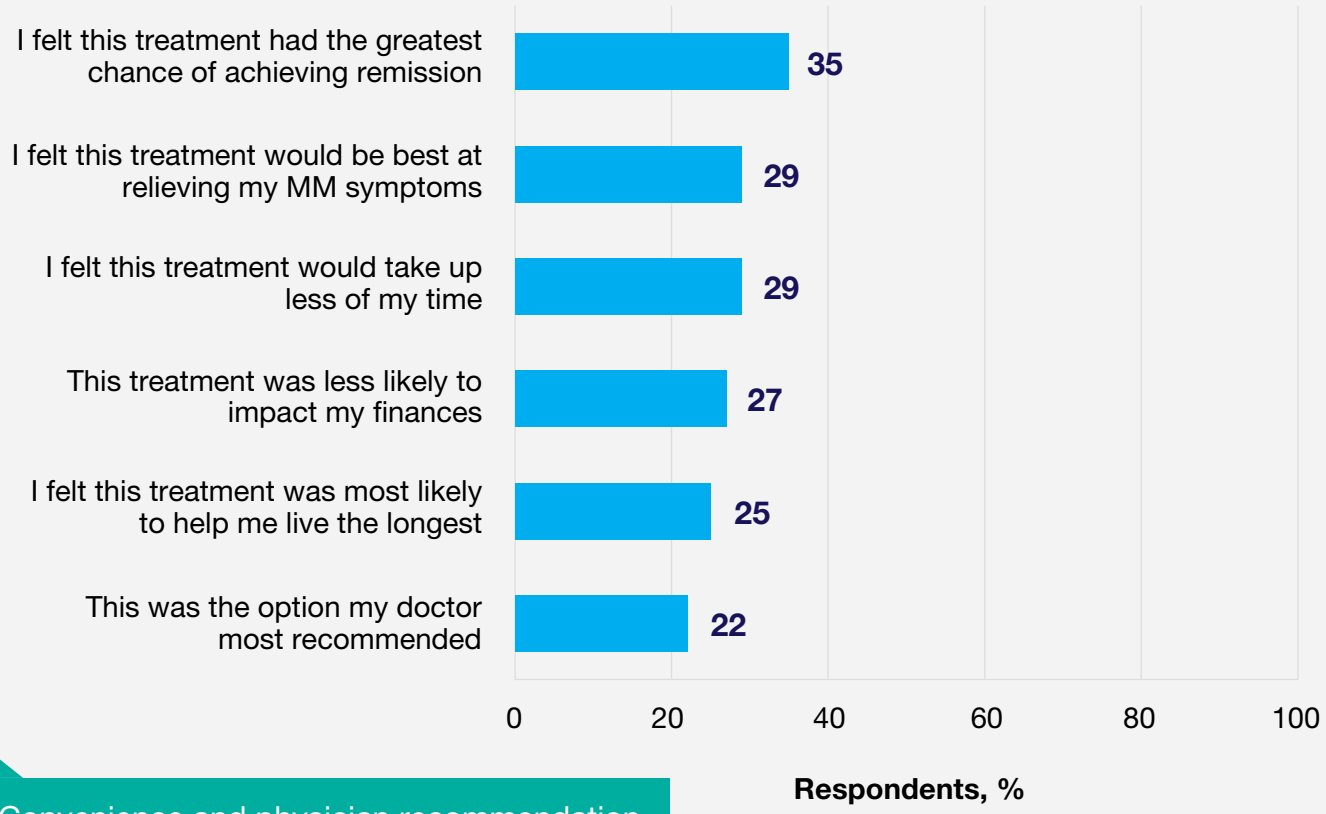
To learn more about how bispecific antibodies and CAR T-cell therapies work, go to page 37

CAR, chimeric antigen receptor; CAR-T, CAR T-cell therapy; MM, multiple myeloma; US, United States.

Efficacy was the most important consideration for patients who chose bispecific antibodies or CAR T-cell therapies[1]

- Patients who were offered bispecific antibodies or CAR T-cell therapies were asked if they received the therapy, and if so, what were their top reasons for selecting that treatment[1]
- Of patients who were offered bispecific antibodies, 57% (n=51) chose to receive treatment, while 76% (n=103) of patients who were offered CAR T-cell therapies received treatment[1,4]

TOP REASONS FOR PATIENTS CHOOSING BISPECIFIC ANTIBODIES (n=51)[1,a]



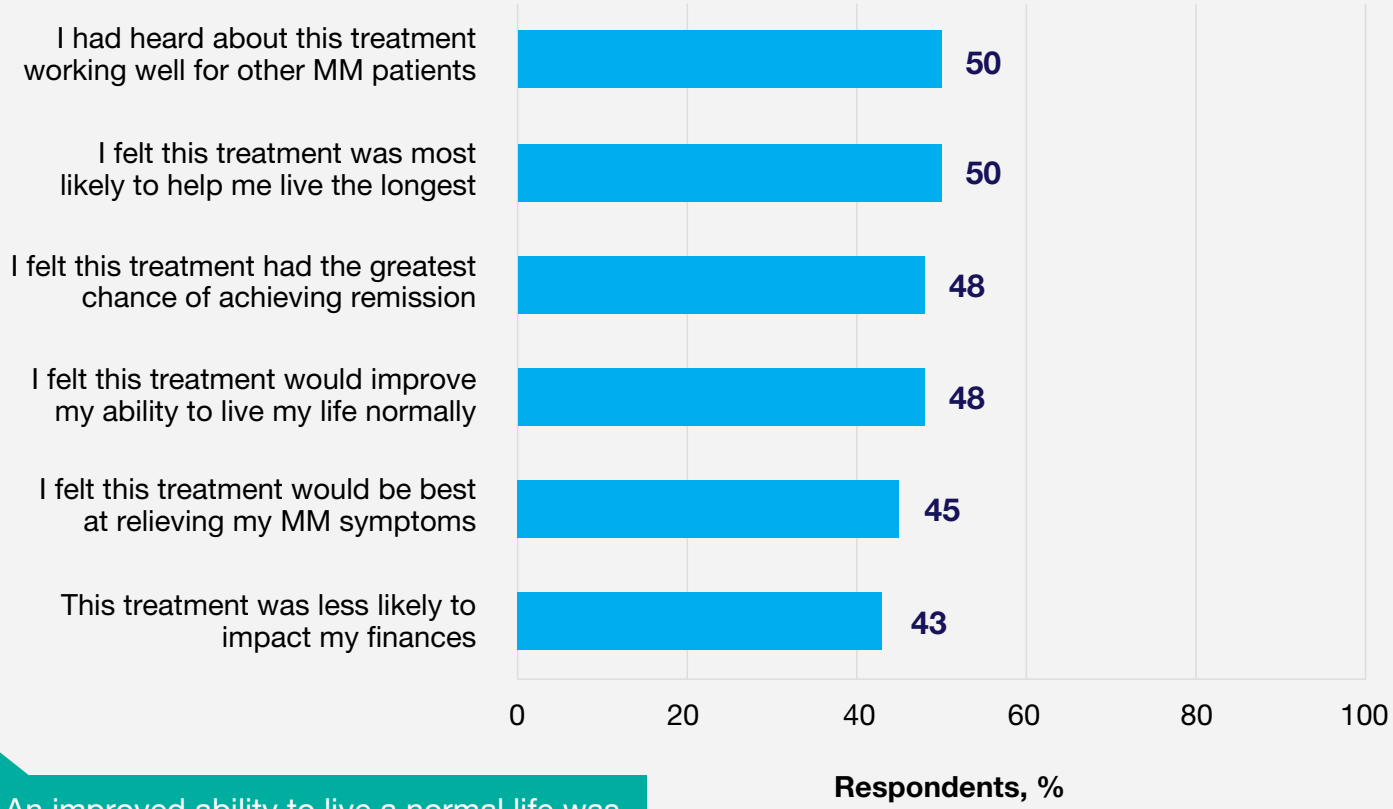
Convenience and physician recommendation were also among the top reasons patients chose treatment with bispecific antibodies[1]

[a]Survey respondents could select up to 5 responses from a choice of 15.[4]
CAR, chimeric antigen receptor; MM, multiple myeloma.

Efficacy was the most important consideration for patients who chose bispecific antibodies or CAR T-cell therapies *(cont'd)*[1]

- In addition to efficacy, hearing the treatment worked well for other patients was another top response, suggesting demand for CAR T-cell therapy may be influenced by other patients' experiences[1]
- For both therapies, financial considerations also influenced patient's choice of treatment[1]

TOP REASONS FOR PATIENTS CHOOSING CAR T-CELL THERAPIES (n=103)[1,a]



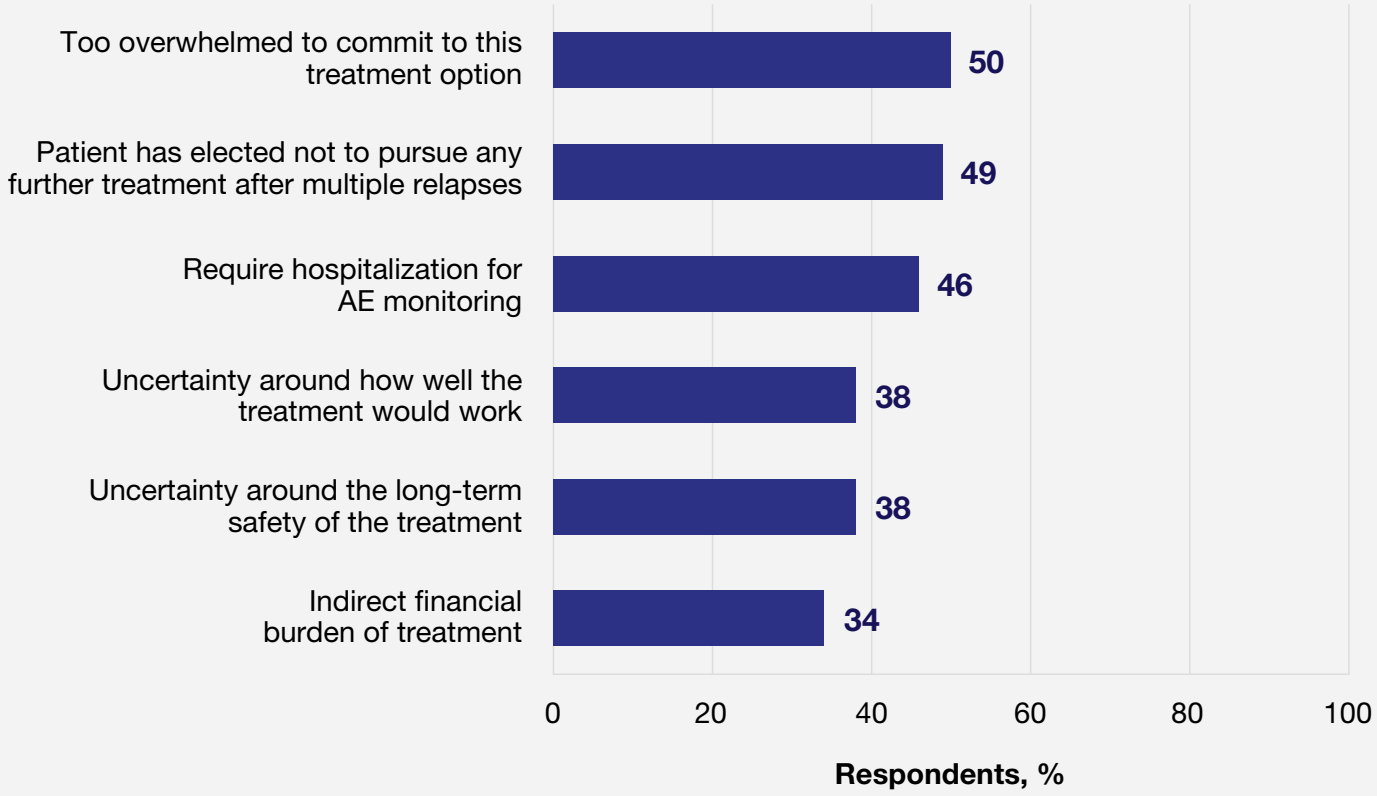
An improved ability to live a normal life was one of the top reasons patients chose treatment with CAR T-cell therapy[1]

[a]Survey respondents could select up to 5 responses from a choice of 13.[4]
CAR, chimeric antigen receptor; MM, multiple myeloma.

The top reason patients declined bispecific antibodies or CAR T-cell therapies was due to feeling overwhelmed[1]

Reasons for declining treatment were generally similar, although uncertainty around treatment efficacy was one of the top reasons for declining BsAbs but not CAR T-cell therapies[1,a]

TOP REASONS PATIENTS DECLINE BISPECIFIC ANTIBODIES ACCORDING TO HCPS (n=391)[1,b]



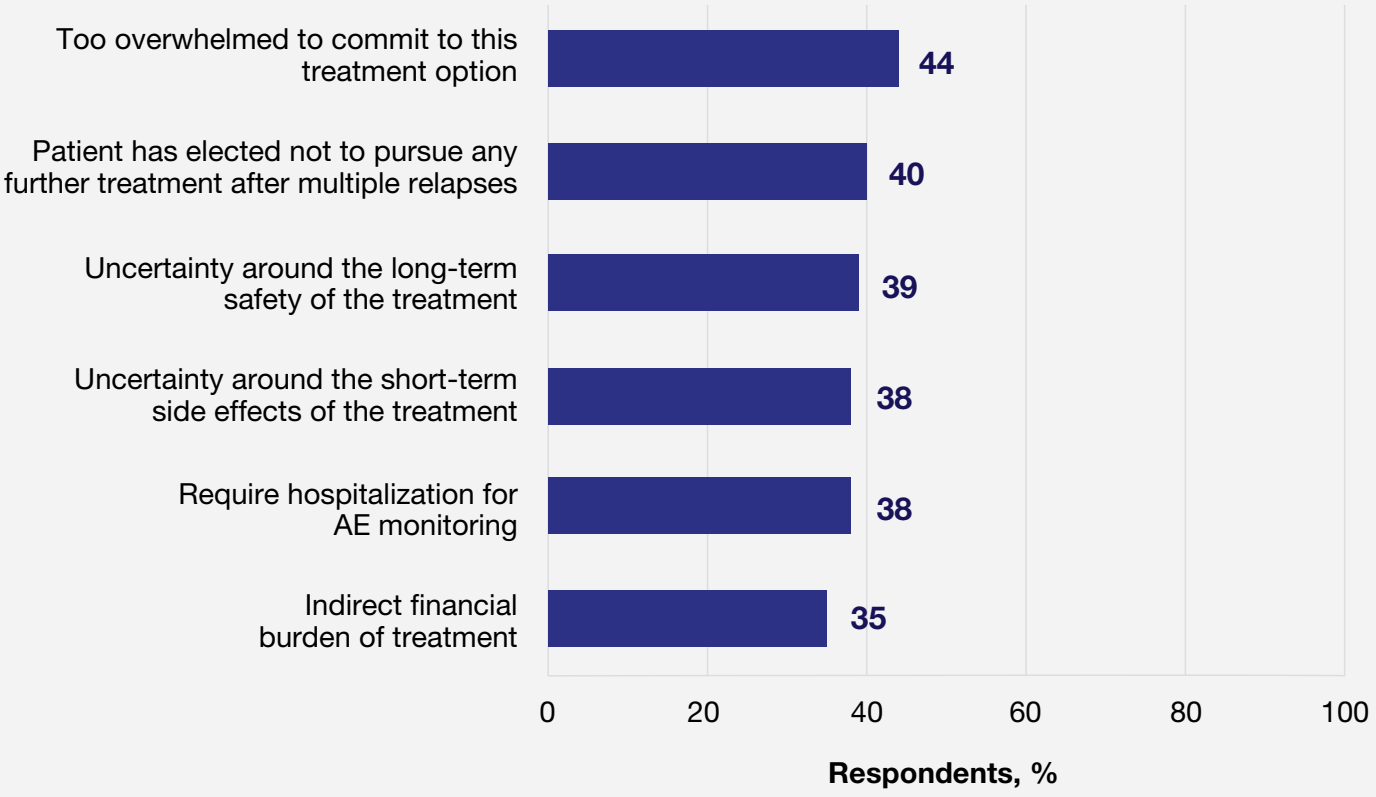
[a]If applicable, patients were also asked their reasons for declining these therapies; however, this data was not included due to the small number of patients (11 each for bispecific antibodies and CAR T-cell therapies).[1] [b]HCPs were asked to choose the top 5 reasons their patients declined each type of therapy from a selection of 15.[1,4]

AE, adverse event; BsAb, bispecific antibody; CAR, chimeric antigen receptor; HCP, health care professional; MM, multiple myeloma.

The top reason patients declined bispecific antibodies or CAR T-cell therapies was due to feeling overwhelmed *(cont'd)*[1]

Short-term safety concerns were among the top reasons for declining CAR T-cell therapies but not bispecific antibodies[1]

TOP REASONS PATIENTS DECLINE CAR T-CELL THERAPIES ACCORDING TO HCPS (n=442)[1,a]



[a]HCPs were asked to choose the top 5 reasons their patients declined each type of therapy from a selection of 15.[1,4]
AE, adverse event; CAR, chimeric antigen receptor; HCP, health care professional; MM, multiple myeloma.

CALL TO ACTION

Improve Patient Familiarity With Recently Approved Immunotherapies

Partner with patient advocacy groups to increase awareness of bispecific antibodies and CAR T-cell therapies, particularly among patients in non-White populations

Who Can Take Action?

Industry, patient advocacy groups, HCPs, patients

Rationale

The limited awareness among patients with RRMM (up to 42% of patients had never heard of bispecific antibodies, and up to 33% had never heard of CAR T-cell therapies) indicates a need for broad patient education.[1] Awareness was lowest in the EU and Japan and among non-White patients in the US, suggesting educational efforts may be particularly needed for these groups.[1] Patient advocacy groups and other organizations can be important sources of patient information and improve awareness through educational outreach, helping to ensure patients are fully informed when making treatment decisions.[27] In addition, survey results suggest that including platforms for patient-to-patient communication may be particularly impactful.[1]

Support creation and distribution of information to make patients and care partners more comfortable using these types of immunotherapies

Who Can Take Action?

Clinical experts, HCPs, patient advocacy groups

Rationale

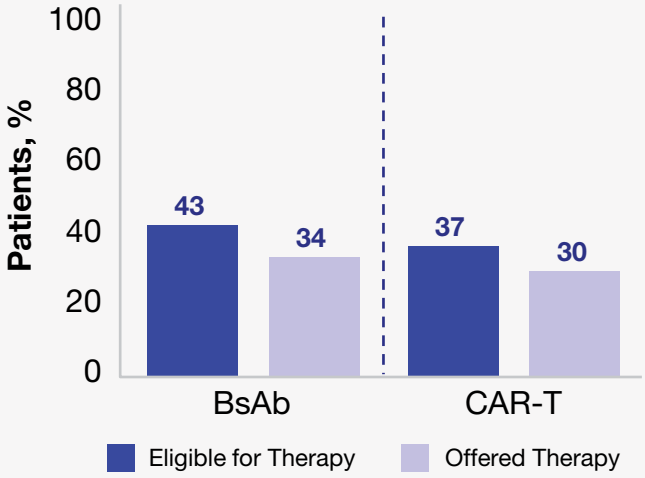
For both bispecific antibodies and CAR T-cell therapies, feeling overwhelmed was the top reason patients declined treatment.[1] Providing practical advice through multiple methods of communication (verbal, written, and video content, patient mentors, etc) may help reduce complexity for patients.

CAR-T, CAR T-cell therapy; EU, European Union; HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma; US, United States.

04 Recently approved immunotherapies may not be offered to all eligible patients[1]

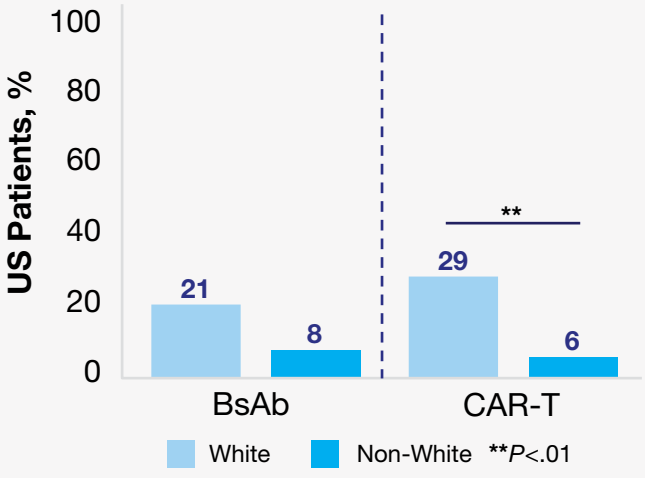
- HCPs did not offer bispecific antibodies or CAR T-cell therapies to all of the patients they thought were eligible[1]
  - HCPs considered 43% of their patients with RRMM to be eligible for bispecific antibodies, but only offered the therapy to 34% of patients
  - For CAR T-cell therapies, HCPs considered 37% of patients with RRMM to be eligible, but only offered the therapy to 30% of patients

PATIENTS ELIGIBLE FOR AND OFFERED RECENTLY APPROVED IMMUNOTHERAPIES[1]



- Awareness of bispecific antibodies or CAR T-cell therapies is lower in non-White populations in the US[1,a]
  - In the US (the only country for which racial data were available), over 20% of White patients recalled their doctor offering these treatments, whereas less than 10% of non-White patients recalled being offered these treatments

PATIENT RECOLLECTION OF BEING OFFERED TREATMENT[1]

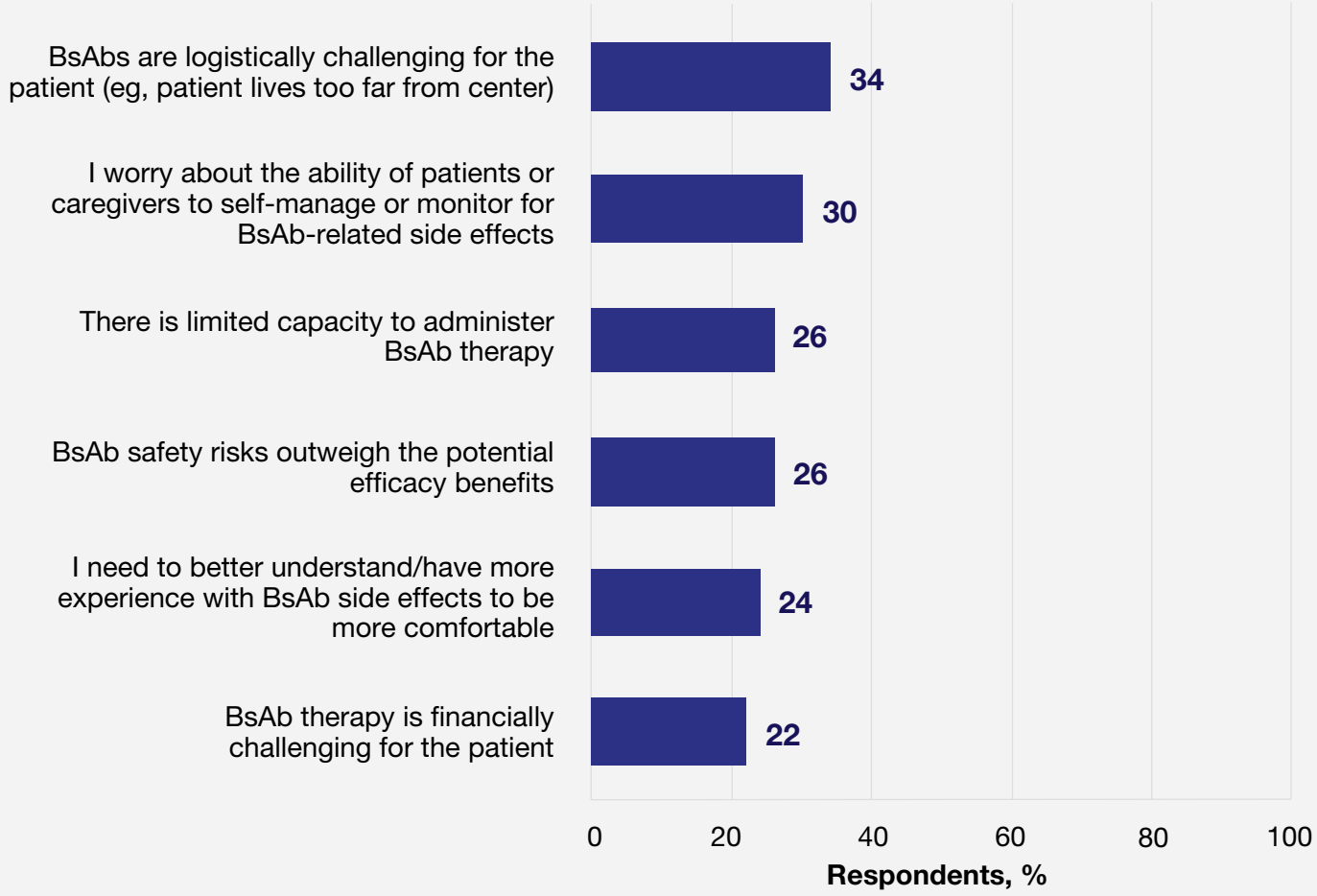


[a]The data represent all patient respondents from the US regardless of eligibility for bispecific antibodies or CAR T-cell therapies. Individual patient eligibility for bispecific antibodies or CAR T-cell therapy was not determined on the survey.[1]
BsAb, bispecific antibody; CAR, chimeric antigen receptor; CAR-T, CAR T-cell therapy; HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma.

Logistical challenges were the top reasons given by HCPs for not offering these immunotherapies to all eligible patients[1]

- In addition to logistical challenges, limited administration capacity was another top reason for not offering both bispecific antibodies and CAR T-cell therapies to patients[1]
  - For both bispecific antibodies and CAR T-cell therapies, patient financial challenges were more of a concern in the US than in other regions[a]
- For bispecific antibodies, there were concerns about patients being able to monitor side effects, a perception that safety risks outweighed the benefits, and the need to better understand and have more experience with these therapies[1]

TOP REASONS WHY HCPS DO NOT OFFER BISPECIFIC ANTIBODIES TO ALL ELIGIBLE PATIENTS (n=357)[1,b]



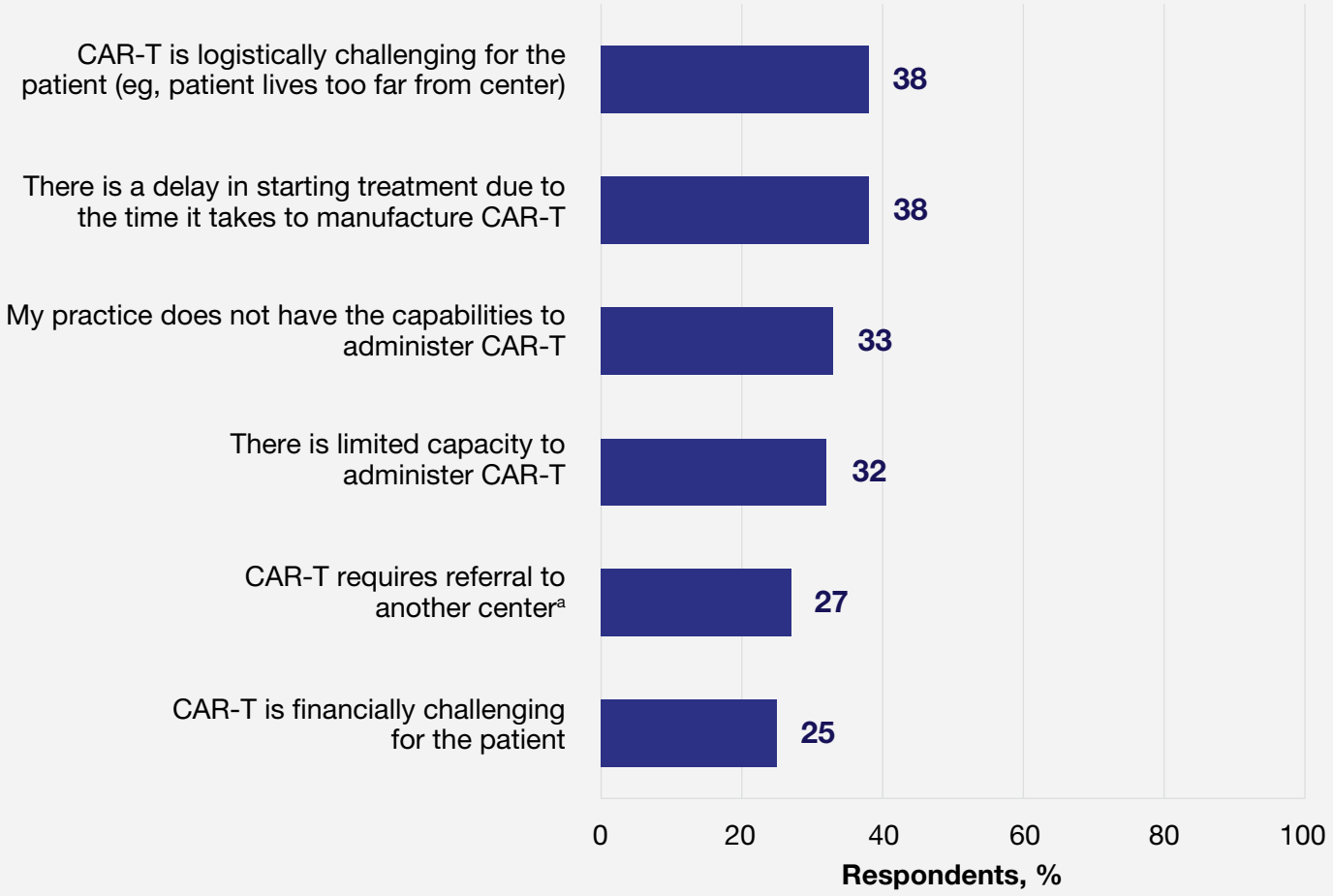
[a]For bispecific antibodies, 36% of US HCPs cited patient financial concerns as a reason to not offer therapy, compared to 14% of EU HCPs. For CAR T-cell therapies, 42% of US HCPs cited financial concerns, compared to 18% of EU and 21% of Japanese HCPs.1 bSample consisted of HCPs from the US and EU but not Japan.[1]

BsAb, bispecific antibody; CAR, chimeric antigen receptor; EU, European Union; HCP, health care professional; MM, multiple myeloma; US, United States.

Logistical challenges were the top reasons given by HCPs for not offering these immunotherapies to all eligible patients *(cont'd)*[1]

- CAR T-cell therapy–specific reasons included the delay in starting treatment, a lack of administration capabilities in their practice, and having to refer patients to another center[1]

TOP REASONS WHY HCPS DO NOT OFFER CAR T-CELL THERAPIES TO ALL ELIGIBLE PATIENTS (n=485)[1]

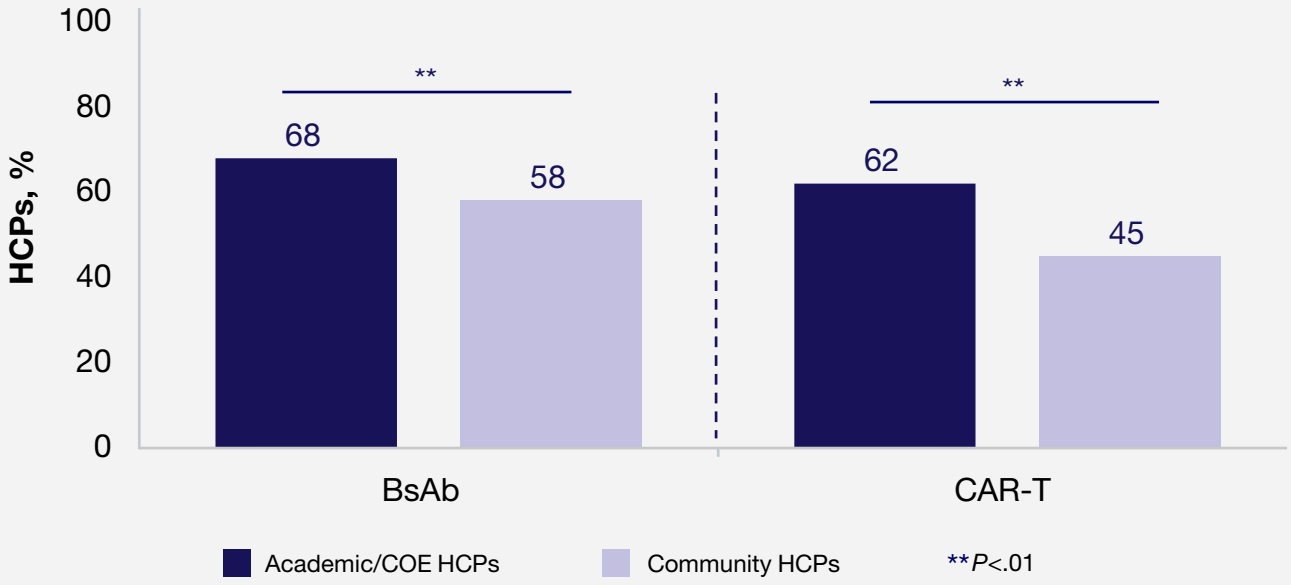


[a]Simplified from survey language.[1]
CAR, chimeric antigen receptor; CAR-T, CAR T-cell therapy; HCP, health care professional; MM, multiple myeloma.

There is an opportunity to improve physican confidence in identifying eligible patients for bispecific antibodies and CAR T-cell therapies[1]

- HCPs in academic/COE settings were significantly more confident determining patient eligibility for recently approved immunotherapies than their peers at community institutions (bispecific antibodies: 68% vs 58%, *P*<.01; CAR T-cell therapies: 62% vs 45%, *P*<.01)[1]
- At both types of institutions, HCPs were more confident in their ability to identify patients eligible for bispecific antibodies than CAR T-cell therapy[1]

HCP CONFIDENCE IN DETERMINING PATIENT ELIGIBILITY FOR RECENTLY APPROVED IMMUNOTHERAPIES[1]



BsAb, bispecific antibody; CAR, chimeric antigen receptor; CAR-T, CAR T-cell therapy; COE, center of excellence; HCP, health care professional; MM, multiple myeloma.

CALL TO ACTION

Increase HCP Familiarity With Recently Approved Immunotherapies

Support physician-led programs providing **peer-to-peer education** and collection of **real-world evidence around immunotherapies** while **promoting collaboration between oncologists at academic centers/COEs and those in community clinics/non-COE**

Who Can Take Action?

Clinical experts, HCPs, industry

Rationale

HCPs in community clinics reported feeling less confident in their ability to identify eligible patients for recently approved immunotherapies than their counterparts at academic/COE institutions, suggesting a knowledge gap between these groups.[1] Without confidence in identifying eligible patients, HCPs may be hesitant to adopt these therapies into their routine clinical practice. Programs that connect clinical experts with community HCPs to share best practices may improve physician confidence in identifying eligible patients and using these therapies.[18] Additionally, real-world data around patient outcomes, particularly in patients who might not have qualified for clinical trials, may bolster clinical evidence and address the safety concerns of HCPs regarding these therapies.[18]

COE, center of excellence; HCP, health care professional; MM, multiple myeloma.

CALL TO ACTION

Reduce Barriers to the Adoption of Recently Approved Immunotherapies

Explore opportunities to **help reduce the challenges associated with administration of recently approved immunotherapies**

Who Can Take Action?

Clinical experts, industry

Rationale

Logistical challenges and hospitalization for side effect monitoring were among the top reasons that HCPs did not offer immunotherapies and patients declined them, respectively.[1] To address these issues, real-world studies have begun to investigate the feasibility and safety of initiating these therapies in an outpatient setting,[28,29] which may improve accessibility of these treatments for both patients and HCPs.[2,18] Additionally, reducing the time patients spend in a hospital may help relieve capacity and resource limitations, addressing a concern of HCPs regarding these therapies.[28]

Explore reasons for **differences in patient access to recently approved immunotherapies and potential solutions** to address those gaps

Who Can Take Action?

Clinical experts, patient advocacy groups, policymakers

Rationale

Non-White patients were less likely to recall being offered recently approved immunotherapies than their White counterparts.[1] This echoes findings from other studies, which have found disparities in access to MM treatments and outcomes among patients of different races and socioeconomic status (SES).[2,27] Non-White patients were also less likely to be treated by MM specialists.[1] Such outcomes support continued research into why racial and SES factors affect access to MM treatment, including recently approved immunotherapies.

HCP, health care professional; MM, multiple myeloma.

Linking It ALL TOGETHER

- The Unite for MM initiative was developed by a Steering Committee that included representatives from across the MM community, and surveyed over 2000 patients and HCPs about their challenges with RRMM[1]
  - Patients and HCPs have different priorities when it comes to RRMM treatments, and these treatments can place a heavy toll on patients
  - Many patients, particularly non-White patients in the US,[a] have a lower awareness of recently approved immunotherapies, or have not been offered these treatments
- By encouraging conversations between patients and HCPs, increasing education, decreasing logistic burdens, gathering data, and strengthening links between members of the MM community, Pfizer hopes to optimize care and improve patient outcomes
- Pfizer would like to thank the Steering Committee and survey participants for their contributions to this valuable initiative

[a]Racial data available only for patients in the US.[1]
HCP, health care professional; MM, multiple myeloma; RRMM, relapsed refractory multiple myeloma; US, United States.

Summary of CALLS TO ACTION

Steering Committee Recommendations on Positive Steps for the MM Community

01 Collaborate to Relieve Treatment-Related Burdens and Identify Patient Treatment Goals

- Support increased access to support services, such as social workers, counselors, gerontologists, and patient navigators; and identify opportunities to reduce treatment-related financial burdens
- Support studies to investigate if dosing regimens can be made more convenient for patients without compromising efficacy
- Develop discussion tools in partnership with patient advocacy groups to help foster a more cohesive dialogue between patients and HCPs

02 Reduce Treatment Burdens by Using a Comprehensive Approach to Manage Side Effects

- Support a proactive approach to patient and care partner education to help manage side effects
- Support HCP education around and coordination of care for optimal management of side effects

HCP, health care professional; MM, multiple myeloma.

03 Improve Patient Familiarity With Recently Approved Immunotherapies

- Partner with patient advocacy groups to increase awareness of bispecific antibodies and CAR T-cell therapies, particularly among patients in non-White populations
- Support creation and distribution of information to make patients and care partners more comfortable using these types of immunotherapies

04 Increase HCP Familiarity With Recently Approved Immunotherapies

- Support physician-led programs providing peer-to-peer education and collection of real-world evidence around immunotherapies while promoting collaboration between oncologists at academic centers/COEs and those in community clinics/non-COEs

Reduce Barriers to the Adoption of Recently Approved Immunotherapies

- Explore opportunities to help reduce the challenges associated with administration of recently approved immunotherapies
- Explore reasons for differences in patient access to recently approved immunotherapies and potential solutions to address those gaps

CAR, chimeric antigen receptor; COE, center of excellence; HCP, health care professional.

Appendix

An Introduction to Bispecific Antibodies

Antibodies are Y-shaped proteins and are normally produced by the immune system. Antibodies recognize and bind to harmful substances such as bacteria and viruses.[32]

Bispecific antibodies are modified so that one arm of the Y binds to myeloma cells, while the other arm binds to T cells. T cells are a type of immune cell that are capable of killing infected or cancerous cells.[33]

When T cells and myeloma cells are bound by the bispecific antibody, the T cell is activated, causing it to release chemicals to destroy the myeloma cell.[33]

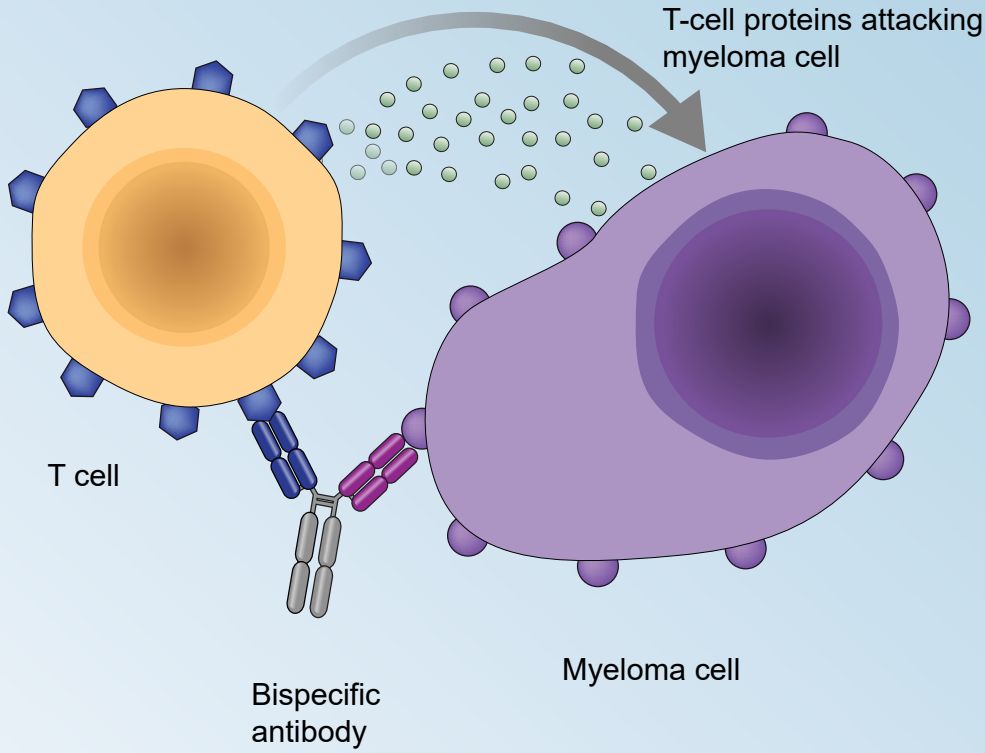


Figure adapted from: https://healthtree.org/myeloma/guides/bispecific-antibodies/bispecific-antibodies-myeloma-guide-understanding-bsab.[34]

MM, multiple myeloma.

An Introduction to CAR T-cell Therapies

CAR T-cell therapies use T cells collected from the patient and modified to make proteins called chimeric antigen receptors, or CAR proteins, that can bind to myeloma cells.[35]

These cells, now called CAR T cells, are then reintroduced to the patient.[35]

In the body, CAR T cells recognize and bind to myeloma cells, leading to myeloma cell death.[35]

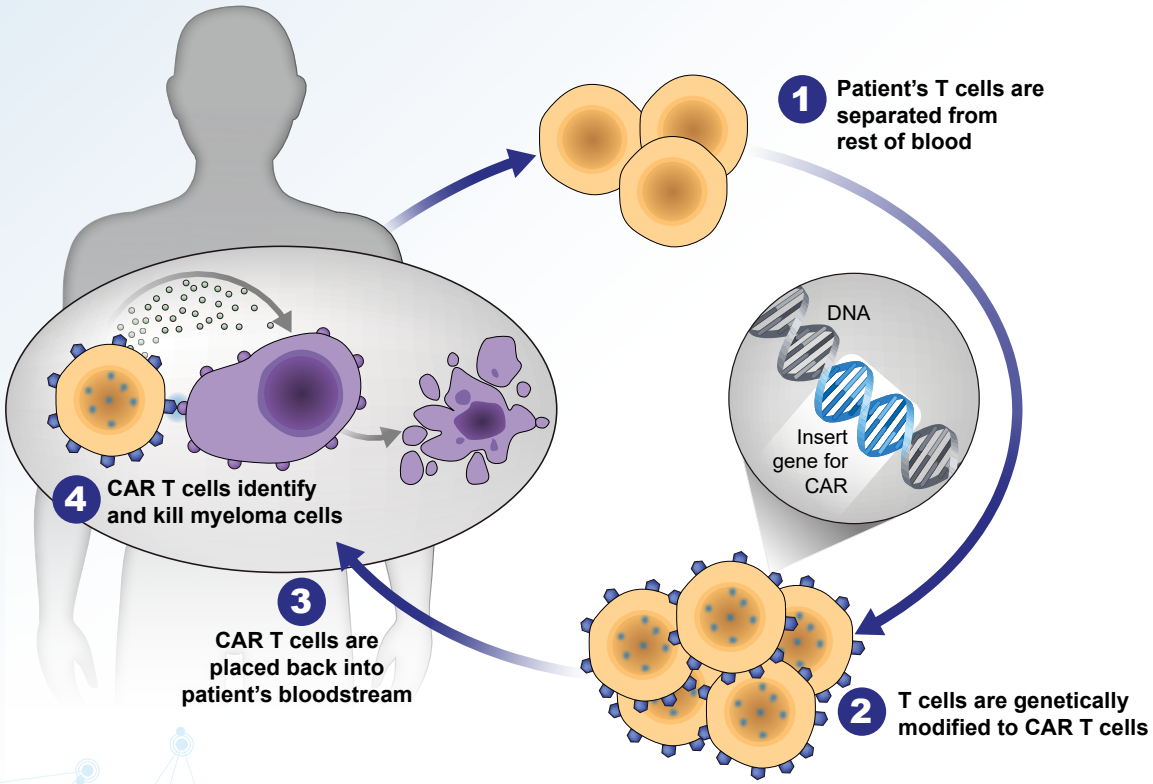


Figure adapted from: Luo J, Zhang X. Challenges and innovation in CAR-T cell therapy: a comprehensive analysis. *Front Oncol*. 2024;14:1399544[36]

CAR, chimeric antigen receptor; MM, multiple myeloma.

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