

A photograph of the Tampa General Hospital building, a large, modern, multi-story structure with a curved facade and many windows. The building is yellow and orange. In the background, there are other skyscrapers and a body of water with palm trees in the foreground.

First Relapse MM

Ciltacabtagne Autoleucel

Ankit Kansagra MD

Hematology, Transplant and Cellular Therapy



The Question on the Table

For a patient at first relapse with access to both – which do you choose first ?

Six Battle Lines



Decision Factor 1: Efficacy

Metric	CARTITUDE-4 (cilta-cel)	MajesTEC-3 (tec-dara)
Design / n	1–3 prior lines · ITT n=419	1–3 prior lines · n=587
PFS	30-mo 59.4% HR 0.26 weighted / ~0.40 unweighted	36-mo 83.4% vs 29.7% HR 0.17
Overall survival	30-mo OS 76.4%	36-mo OS 83.3% vs 65.0%
ORR / ≥CR	>99% of 176 infused	89.0% vs 75.3% · ≥CR 81.8%
MRD–	72% of infused	58.4% vs 17.1% (10^{-5})
CD38-refractory	24.0%	0% — excluded by design

Which trial is reflective of patients seen in our clinic today ?

CARTITUDE-4

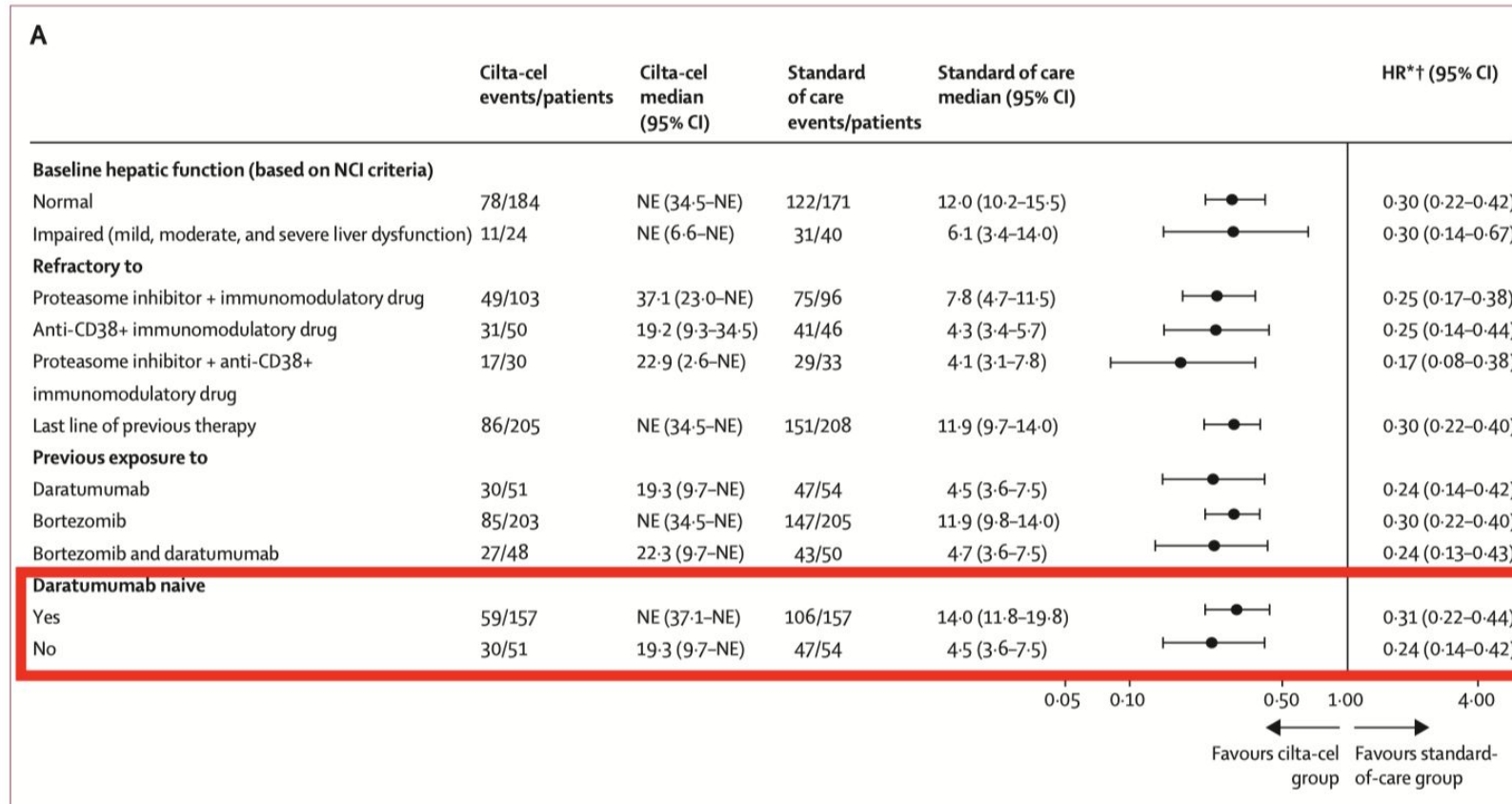


CD38-refrac
included

026–2030

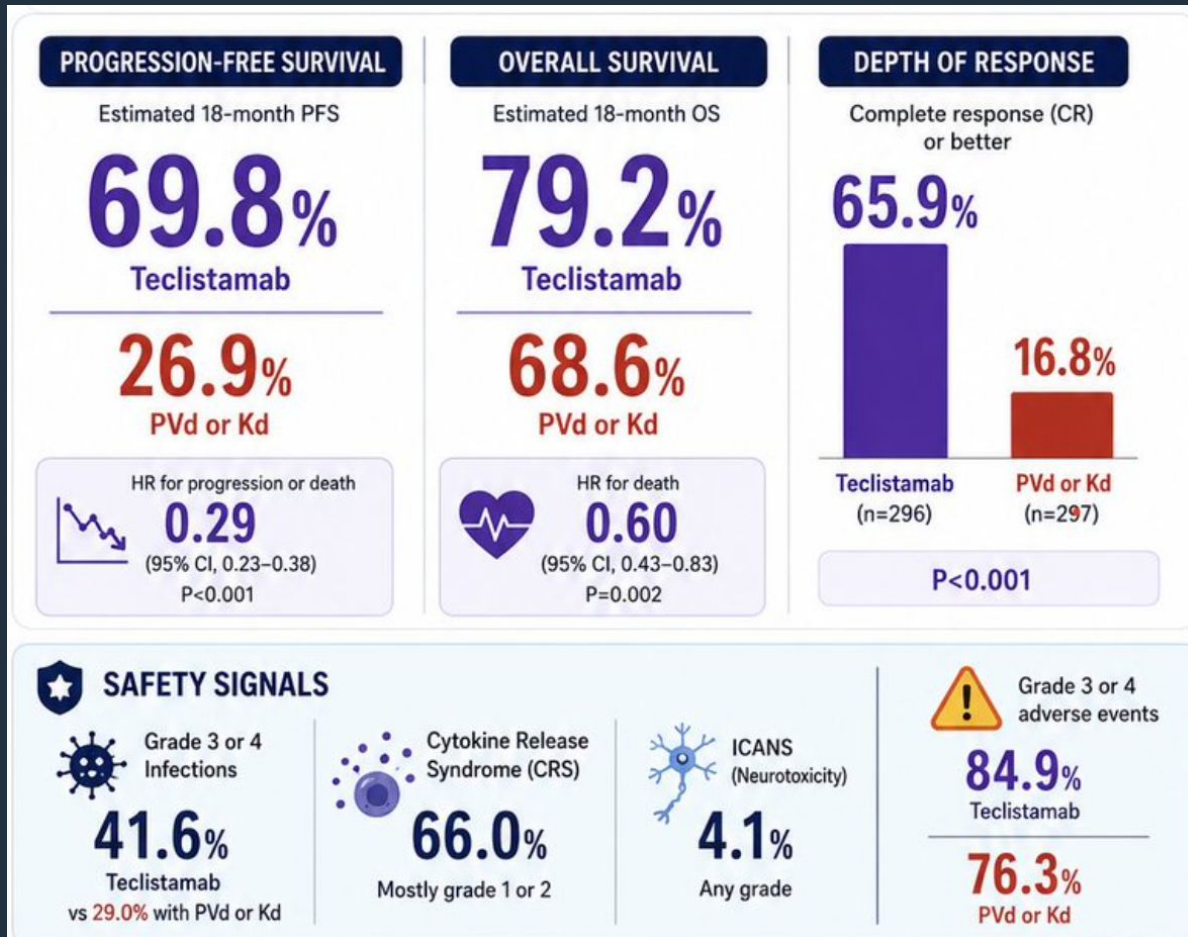


18-exposed
rejection



MajesTEC-9: Teclistamab vs PVd/Kd

Pop: 1-3 Prior Lines, Anti-CD38 and Lenalidomide Exp



Why it does not change my answer:

1. Follow up: SHORT for MajesTEC-9 (17.3 months)
2. Indefinite Therapy
3. Infection Risk
4. HR 0.29 in CD38 Exposed disease – and CARTITUDE-4 –HR 0.26

Decision Factor 2: Treatment Free Survival

1 infusion
cilta-cel — no maintenance, no consolidation

weekly → q2w → q4w
tec-dara — indefinitely, plus ongoing IVIG

~68 vs 1
treatment encounters over 3 years

One infusion vs. therapy forever

Each marker = a treatment encounter over 36 months

cilta-cel



tec-dara



Decision Factor 3: Quality of Life

NR vs 34.3 mo

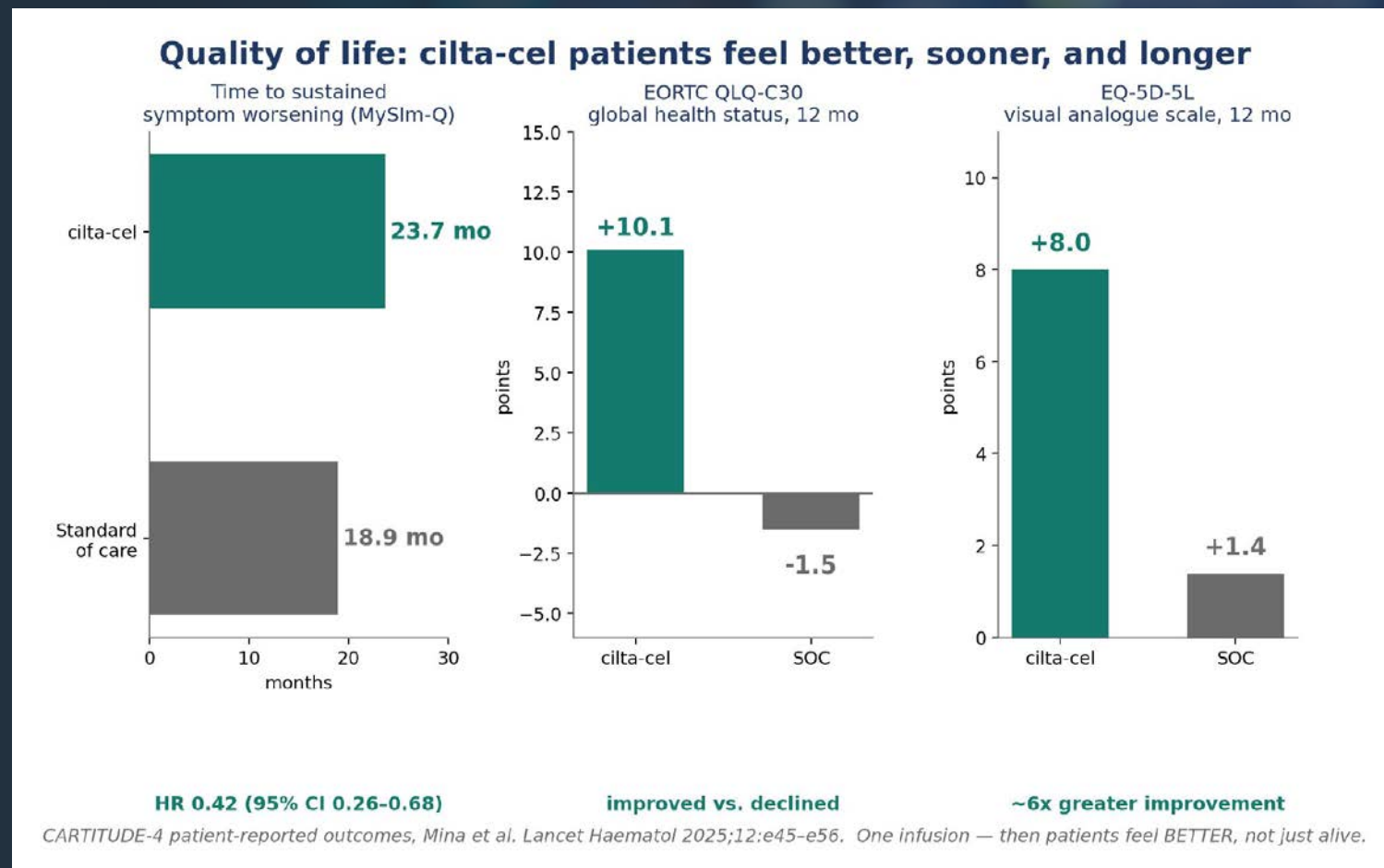
Time to sustained symptom worsening · HR 0.38

+10.1 vs -1.5

EORTC global health status at 12 months

+8.0 vs +1.4

EQ-5D-5L VAS at 12 months



Comparator is the CARTITUDE-4 SOC arm (DPd/PVd) — not tec-dara. No head-to-head PRO data exist.

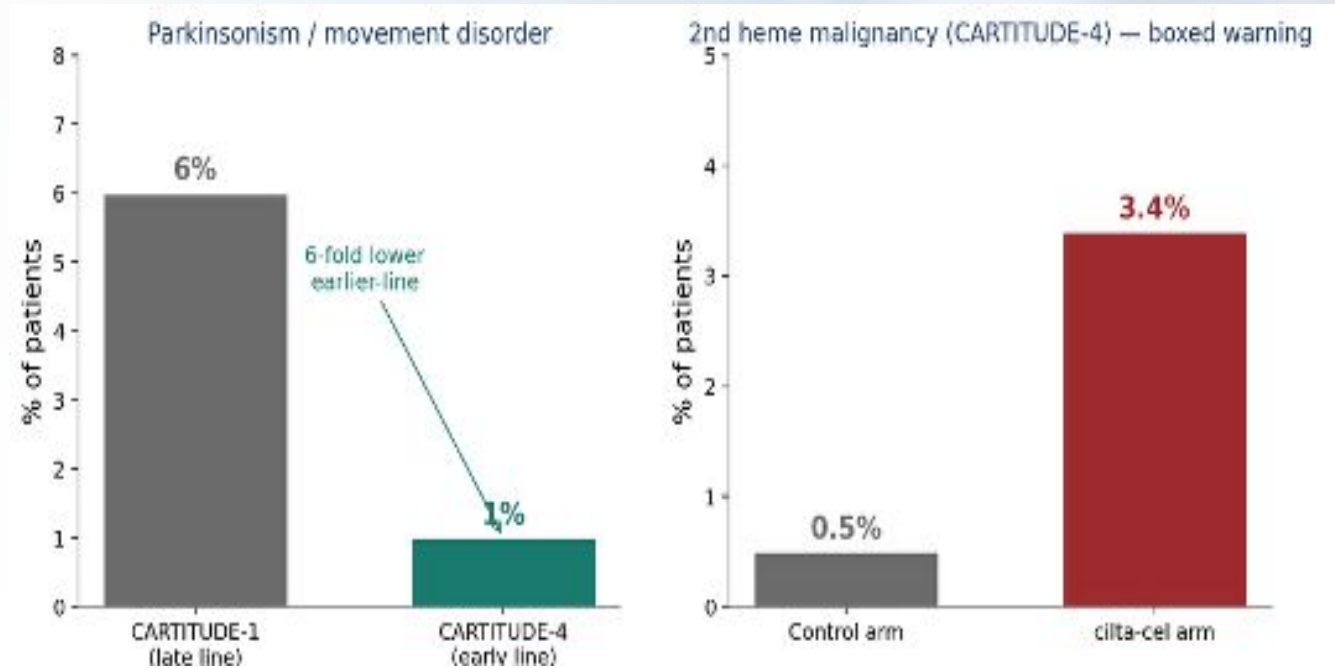
Decision Factor 4: Safety: Cilta-cell Toxicities are real

Delayed / atypical neurotoxicity — parkinsonism, cranial nerve palsy, peripheral neuropathy

Enterocolitis — **boxed warning**

Second malignancies incl. vector-related T-cell lymphoma — **boxed warning**; 3.4% vs 0.5%

Cranial nerve palsy ~9% in CARTITUDE-4 vs ~3% in CARTITUDE-1



Parkinsonism: 6% in CARTITUDE-1 (late line) → ~1% in CARTITUDE-4 (early line).

MajesTEC-3: Safety Concerns

7.1%

death from adverse event (vs 5.9%)

70.7%

serious adverse events (vs 62.4%)

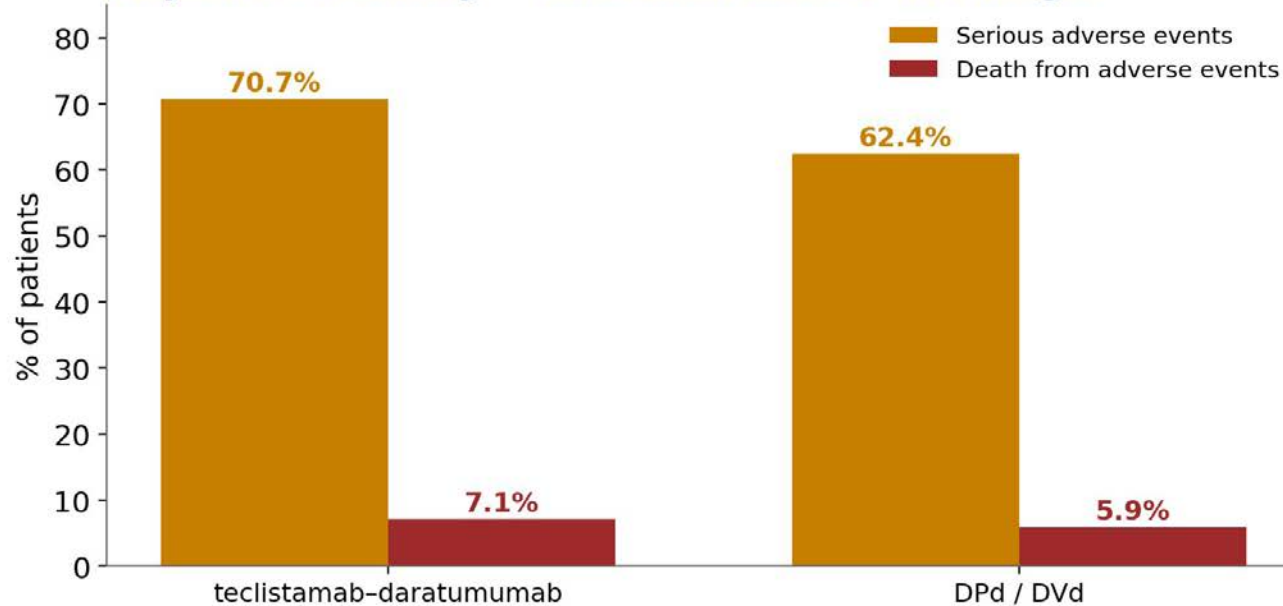
54.1%

grade 3/4 infection (vs 43.4%)

IVIg added mid-trial

as an urgent safety measure

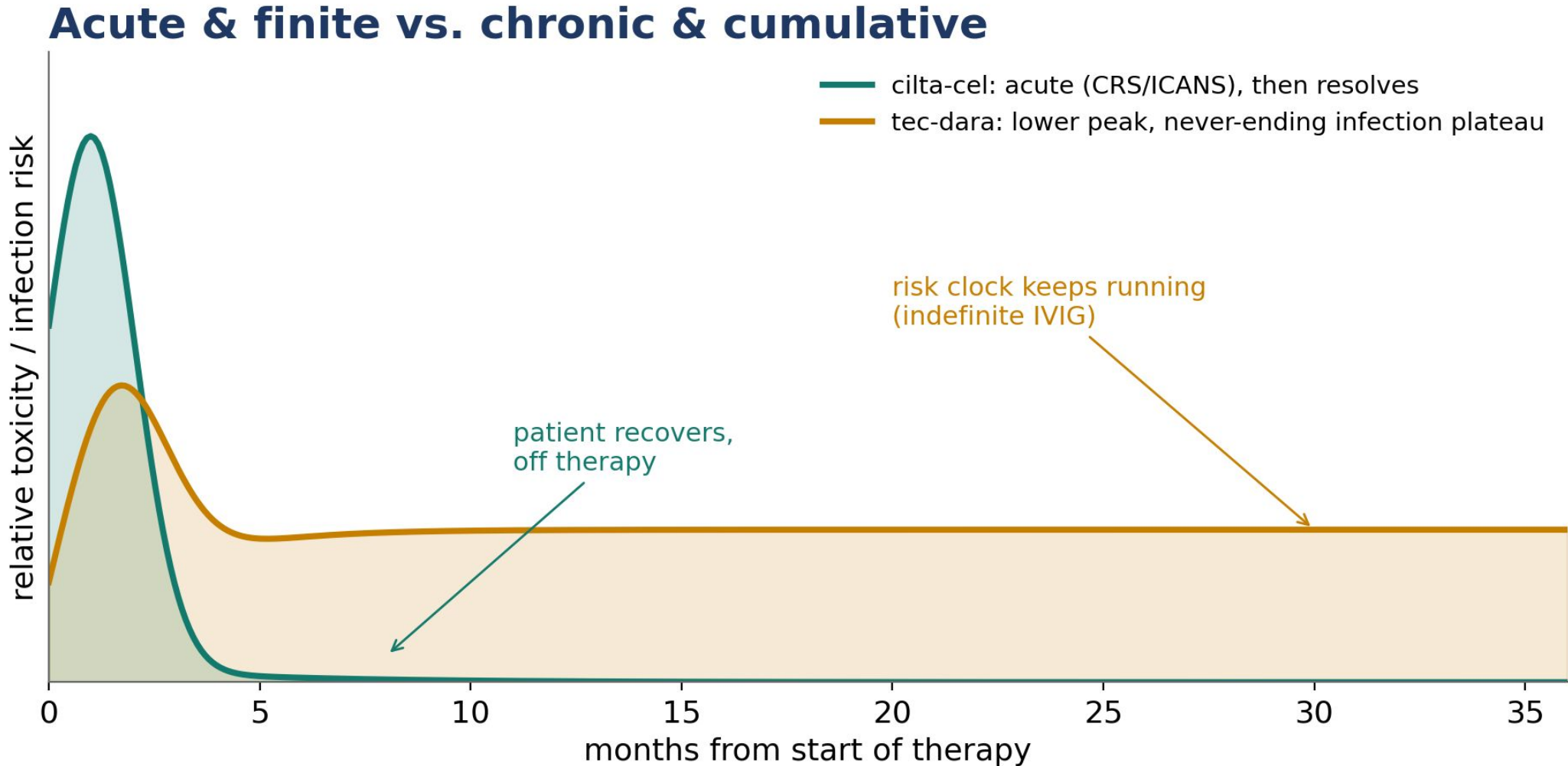
MajesTEC-3 safety — the other side of the ledger



7.1% of patients on tec-dara died of an adverse event — continuous therapy carries a continuous price.

Costa LJ et al. N Engl J Med 2025;394:739–752.

Acute and Finite vs Chronic and Cumulative



Halftime: where we stand

1 Efficacy	Cross-trial HR ranking isn't valid	TIE
2 Treatment-free	1 infusion vs ~68 encounters over 3 yrs	CAR-T
3 Quality of life	Symptoms improve vs. decline	CAR-T
4 Safety	Acute & finite vs. chronic & cumulative	CAR-T
5 Access	<i>still to come</i>	
6 Cost	<i>still to come</i>	

3 wins, 1 tie — and we haven't talked about access or cost yet.

Decision Factor 5 Access:

Used to be the argument against CART – its changing rapidly

THE HONEST HISTORICAL CASE FOR BISPECIFICS

Off the shelf. No apheresis. No manufacturing wait. Give it anywhere.

For many patients this was decisive — and for some it still is.

WHAT CHANGED

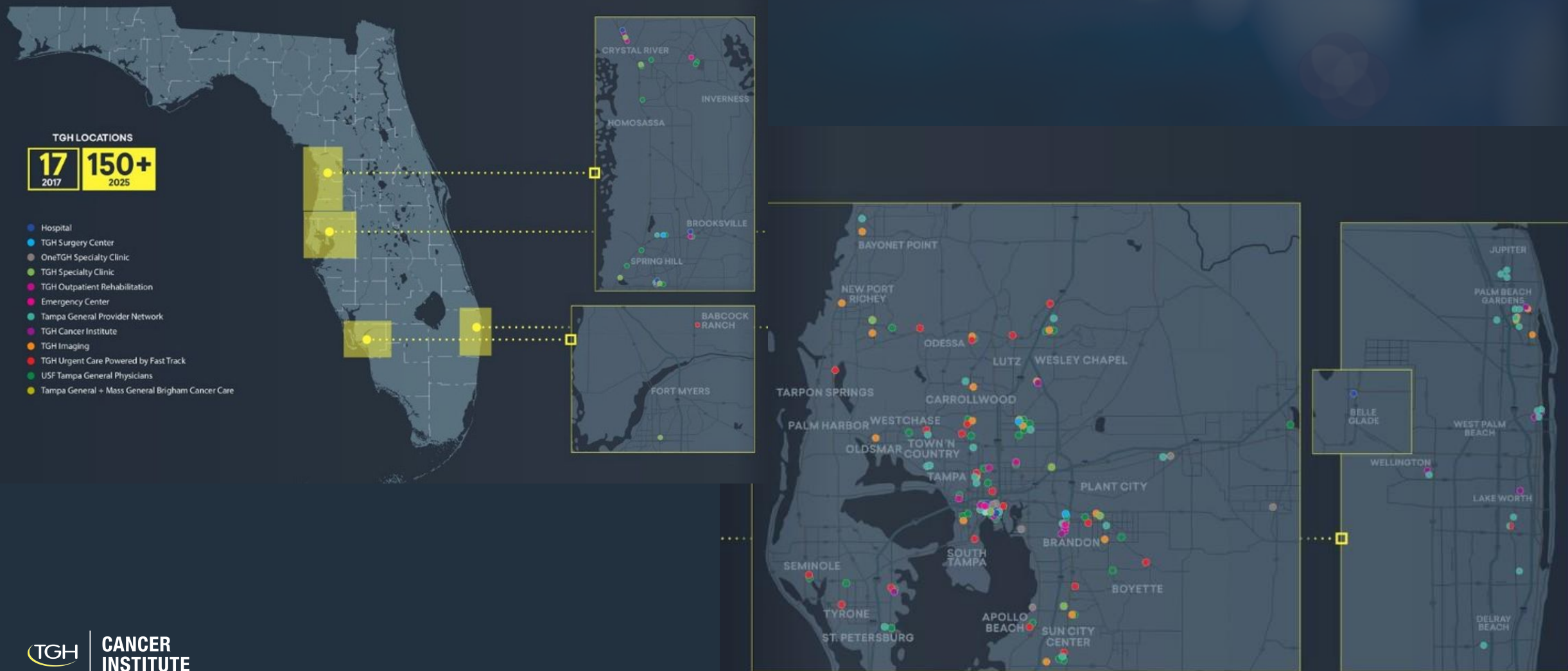
Outpatient CAR-T administration

Community cell-therapy networks

Hub-and-spoke referral and shared care

Tampa General Hospital Network

THE ACADEMIC HEALTH CARE FOOTPRINT



Decision Factor 6: Cost: The One-Time Therapy is Not the Expensive One

\$792K vs \$815K

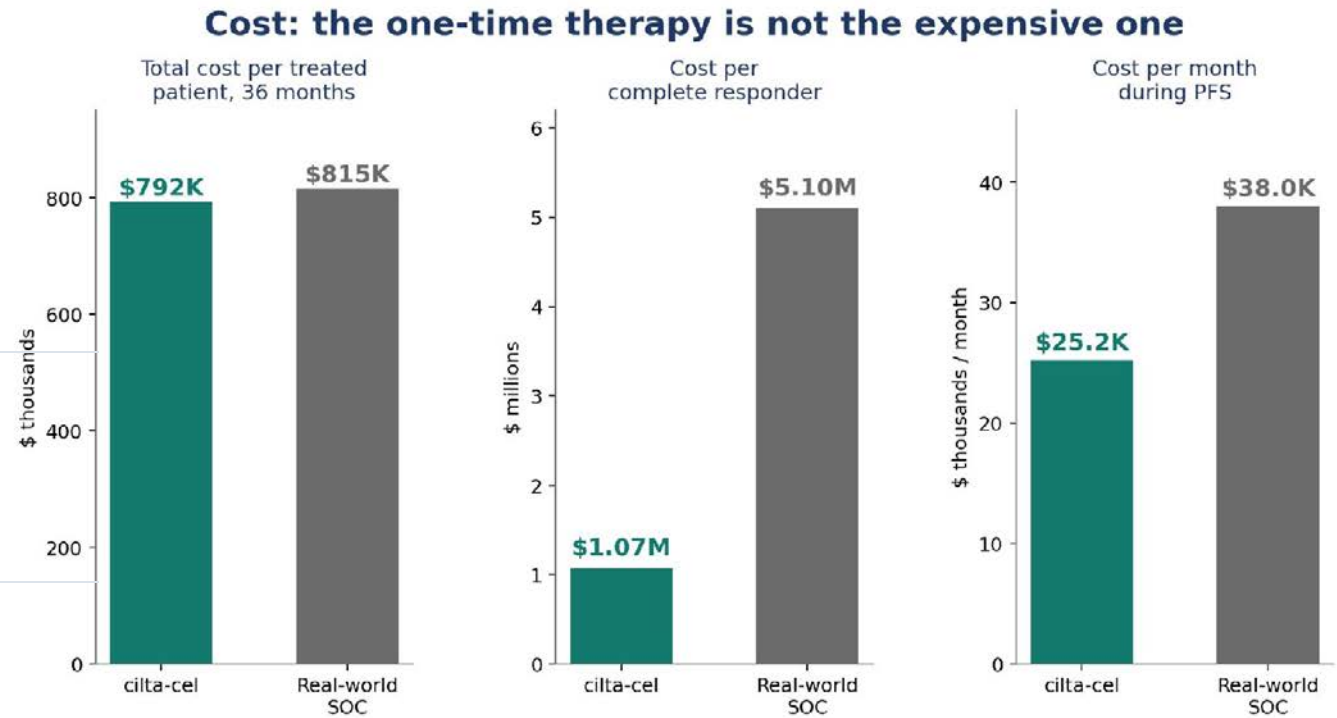
Total cost per treated patient, 36 months

\$1.07M vs \$5.10M

Cost per complete responder

\$25.2K vs \$38.0K

Cost per month alive and progression-free



CAR-T costs LESS over 3 years

~4.8x cheaper per CR

1/3 lower per month alive & progression-free

Cost-per-responder model, Hansen DK et al. Expert Rev Pharmacoecon Outcomes Res 2026;26:369-378. Industry-funded — disclose. Sticker price ≠ total cost of care.

Sticker price ≠ total cost of care.

Verdict on the decision factors !

1 Efficacy	Tie on matched early-line data; HR ranking invalid	TIE
2 Treatment-free	One infusion vs. years of dosing; QOL proven	CAR-T
3 Safety	Acute & finite vs. chronic & cumulative	CAR-T
4 Sequencing	CAR-T-first preserves optionality	CAR-T
5 Access	Gap closing fast; community + outpatient	CAR-T
6 Cure	Only modality pairing MRD– with off-therapy	CAR-T

5 wins, 1 tie → if efficacy is a tie, every tie-breaker picks CAR-T.

THE MULTIPLE MYELOMA FIST: POWER THROUGH UNIFICATION



ALL DIAMONDS ARE CRUCIAL. IF ONE IS MISSING, THE POWER WANES. DEFEAT MYELOMA.

The Question on the Table

For a patient at first relapse with access to both – which do you choose first ?

Six Decision Factors



What if we use non-CAR-T options before CAR-T ?

Study / Agent	N (prior BCMA)	ORR (prior BCMA)	ORR (BCMA-naive)	mPFS (prior)	mPFS (naive)
Cilta-cel CARTITUDE-2 (ADC)	13	62%	~98%	9.5 months	34.9 months
Cilta-cel CARTITUDE-2 (BsAb)	7	57%	~98%	5.3 months	34.9 months
Cilta-cel Real World	AVOID using BCMA directed therapy before BCMA CAR-T				
Ide-cel Real World (Ferreri)	50 / 153	74%	88%	3.2 months	9.0 months
Ide-cel CIBMTR (Sidana)	121 / 821	Lower ORR	Higher ORR	5.3 months	9.7 months

BCMA-free interval >6 months before CAR-T infusion associated with significantly superior outcomes
1-year OS: 52% vs 70% with/without prior BCMA therapy (CIBMTR)

What if we flip that sequence

Given CAR-T first and then BCMA Bispecific

BCMA-Targeting Bispecific Ab After BCMA CAR-T				GPC5D-Targeting (Target Switch) — PREFERRED			
Study / Agent	N	ORR	Median PFS	Study / Agent	N	ORR	PFS/DOR
Teclistamab (MajesTEC-1)	15	53%	4.4 months	Talquetamab (MonumenTAL-1)	57	72%	mDOR 12.3 mo
Elranatamab (MagnetisMM pool)	36	53%	10.0 months	Talquetamab + Dara (TRIMM-2)	11	82%	N/A
Teclistamab RW (Riedhammer)	21	33%	1.8 months	Talq + Dara + Pom (TRIMM-2)	24	83%	74% at 12 mo.

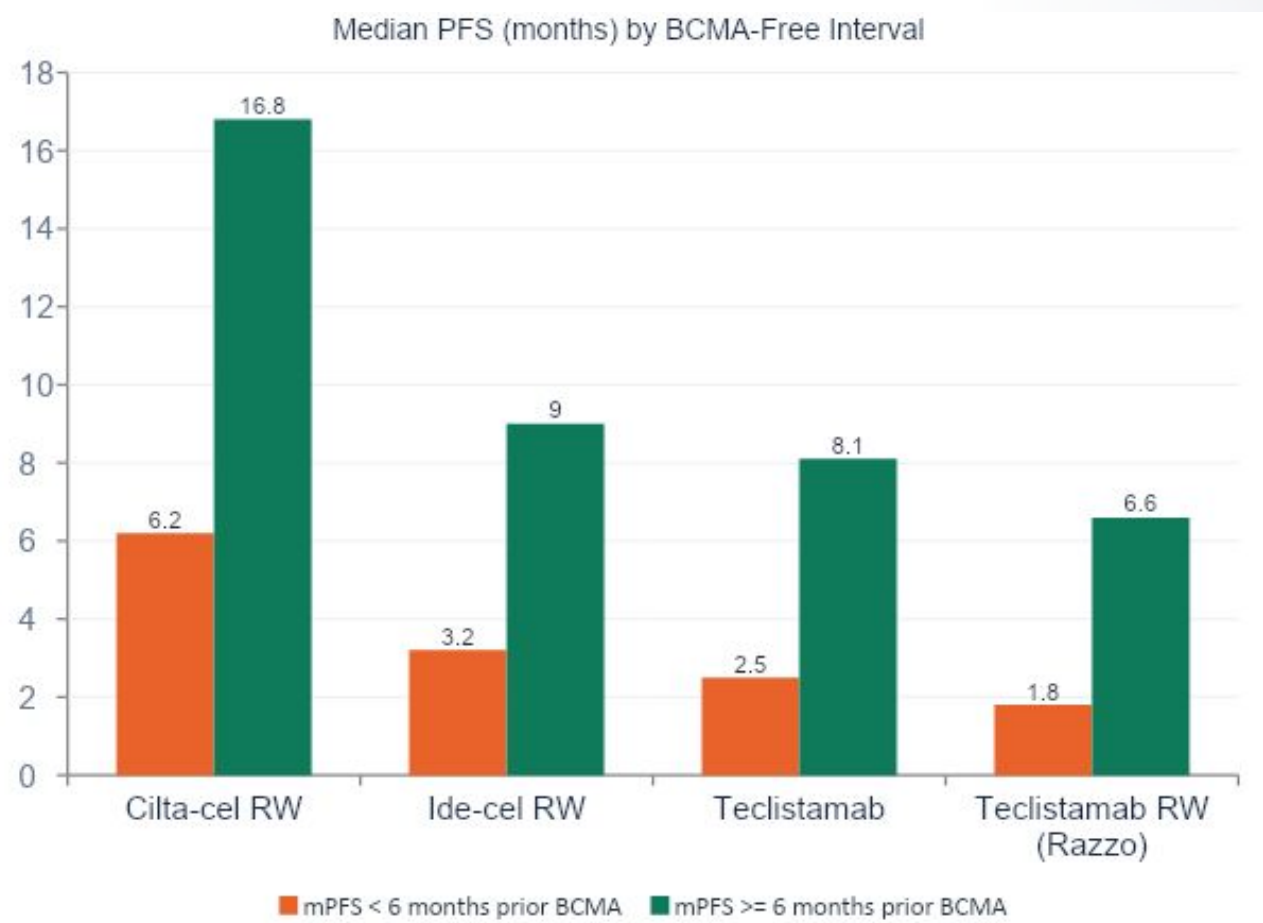
*Note: BCMA-free interval >6–9 months = significantly better PFS
>9 months: mPFS 8.1 vs 2.5 months*

GPC5D-targeting NOT impaired by prior BCMA CAR-T.
RW German analysis confirmed: no negative impact on ORR or PFS

Ideally change target, if same target wait atleast 6-9 months



The BCMA-Free Interval: A Critical Modifying Factor



< 6 months

Significantly impaired PFS with subsequent BCMA CAR-T or BiTE. Common denominator across all studies.

6–9 months

'Sweet spot' threshold. Emerging data suggest threshold may be 9 months for optimal BiTE responses.

> 9 months

Superior PFS with second BsAb (8.2 vs 4.6 mo, Dima et al.). T-cell fitness and BCMA re-expression recover.

It was never either /

or *One myeloma journey. Both therapies. The order is the strategy.*



For a patient with myeloma the question is not **WHICH** therapy.
It is **HOW** to use both — and the order decides how much of each you get.

A photograph of the Tampa General Hospital building, a large, multi-story structure with a curved facade and many windows. The building is yellow and orange. In the background, there are other skyscrapers and a body of water with palm trees in the foreground.

In the pursuit of a cure, our
therapies are rivals only in
excellence, but absolute
allies in purpose

Ankit Kansagra MD

X: @kansagramd



CANCER
INSTITUTE

A photograph of the Tampa skyline featuring several skyscrapers and the Tampa General Hospital (TGH) in the foreground. The hospital is a large, multi-story building with a curved facade and many windows. The text "THANK YOU" is overlaid in large white letters, and a thick yellow horizontal line is positioned below it. The background includes a river and palm trees.

THANK YOU

TGH Tampa General Hospital

EMERGENCY