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Faculty Information

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PTce ONCOLOGY

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This activity is supported by an educational grant from Bristol Myers Squibb.

PTce ONCOLOGY

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The CELMoD Initiative: Advancing Community Oncology Readiness in Relapsed/Refractory Multiple Myeloma

Sara A. Scott, PharmD, BCOP

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Educational Objectives

After completion of this activity, participants will be able to:

- Differentiate cereblon E3 ligase modulators (CELMoDs) from immunomodulatory drugs (IMiDs) and other targeted agents in relapsed/refractory multiple myeloma (RRMM) based on their mechanisms of action, resistance pathways, and pharmacologic properties to support evidence-based clinical decision-making
- Explore pharmacist-led strategies to anticipate, monitor, and manage hematologic toxicities associated with CELMoD-based regimens, including evidence-based interventions for neutropenia prevention and dose optimization in community oncology practice
- Apply emerging clinical evidence to determine where CELMoDs fit within the RRMM treatment continuum, including sequencing with T-cell–directed and other novel therapies, and address practical considerations for integration into community-based care

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Targeted Protein Degradation and the CELMoD Distinction

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Multiple Myeloma

- Incurable hematologic malignancy defined by clonal proliferation of immunoglobin (Ig)-secreting malignant plasma cells
  - Secretion of M-protein into serum or urine
  - Results in end-organ damage
- US prevalence in 2025
  - 14th most common malignancy
  - Estimated 36,110 new cases and 12,030 deaths
- Median age at diagnosis: 69 years

Siegel RL. *CA Cancer J Clin.* 2025;75(1):10-45; NIH. Accessed March 16, 2026. https://seer.cancer.gov/statfacts/html/mulmy.html; American Cancer Society. Accessed March 16 2026. https://www.cancer.org/cancer/types/multiple-myeloma.html

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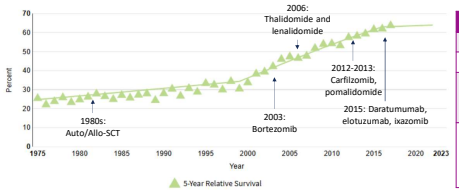
Multiple Myeloma Drug Development Timeline



Approvals since 2015
Oral SINE: selinexor
mAb: isatuximab
CAR T cell: idecabtagene vicleucel, ciltacabtagene autoleucel
BsAb: teclistamab, elranatamab, talquetamab, linvoseltamab
ADC: belantamab mafodotin

SEER 8 5-Year Relative Survival Percent from 1975–2017, All Races, Both Sexes.

ADC, autobody drug conjugate; Auto/Allo-SCT, autologous/allogenic stem cell transplantation; BsAb, bispecific antibody; CAR, chimeric antigen receptor; mAb, monoclonal antibody; SINE, selective inhibitor of nuclear export.

Figure adapted from NIH. Accessed March 16, 2026. https://seer.cancer.gov/statfacts/html/mulmy.html; International Myeloma Foundation. Updated November 7, 2025. Accessed March 16, 2026. https://www.myeloma.org/multiple-myeloma-drugs

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General Principles for Selecting Treatment in RRMM

Patient	Disease	Treatment	Regimen
▪ Age/frailty ▪ Performance status ▪ Lifestyle ▪ Patient preference ▪ Caregiver support ▪ Comorbidities – Renal status – Neuropathy – Cardiac – Diabetes – Cytopenias	▪ Disease burden: ISS – Rate of progression – Marrow burden – CRAB symptoms – Extramedullary disease ▪ Biology – LDH – Cytogenetics: • del(17p) or *TP53* mutation • t(4;14) • t(14;16) • t(14;20) • amp(1q) • Del(1p32) • t(11;14)	▪ AEs – Myelosuppression – Infections – Neuropathy – Secondary cancers ▪ Access and cost ▪ Administration route ▪ Relapsed vs refractory ▪ Depth/duration of response to prior treatment	▪ Triplet is preferred over doublet ▪ Include ≥1 agent from a new or nonrefractory class ▪ Previously used agents may be effective in different combinations ▪ Treat to maximum response ▪ Maintain on ≥1 agent until progression or intolerability

AE, adverse effect; CRAB, calcium elevation, renal failure, anemia, bone disease; ISS, international staging system; LDH, lactate dehydrogenase; RRMM, relapsed/refractory multiple myeloma.

NCCN. Clinical Practice Guidelines in Oncology. Multiple myeloma, version 5.2026. Accessed March 16, 2026. https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf; Sanchez L et al. *Expert Rev Hematol.* 2020;13(9):943-958; Sonneveld P, Broijl A. *Haematologica.* 2016;101(4):396-406; MaplesKT et al. *Clin Adv Hematol Oncol.* 2023;21(5):247-256; Avet-Loiseau H et al. *J Clin Oncol.* 2025;43(24):2739-2751.

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Unmet Need in Patients With MM

ADDITIONAL ACTIVE TREATMENTS IN RELAPSED SETTING

- Patients receive triplet or quadruplet regimens within their first and second-line treatments—this may result in fewer existing treatment options for later lines of therapy.
- As CAR T-cell therapies and BsAbs are used earlier in the treatment algorithm, there is an emerging need for treatment options with activity in the post-T-cell redirection therapy setting.

SUBOPTIMAL OUTCOMES IN SPECIFIC POPULATIONS

- Elderly/frail patients: poor tolerance to intensive regimens
- High-risk cytogenetics: poor response across treatment settings
  - Current therapies insufficient to overcome high-risk biology
- Penta-exposed/refractory patients
- Post-T-cell redirecting therapy setting in the context of immune exhaustion

PATIENT-CENTERED CARE GAPS

- Oncology patients prefer oral chemotherapy over IV
- Oral therapies improve convenience, reduce clinic visits
- Adherence is still a challenge: 38% reported nonadherence
- Access/availability of CAR T-cell therapy

IV, intravenous.

Ramasamy K et al. *Clin Lymphoma Myeloma Leuk.* 2025;25(5):337-348.e2; Rajkumar SV. *Am J Hematol.* 2022;97(8):1086-1107; Stalker ME, Mark TM. *Curr Oncol.* 2022;29(7):4464-4477; Eek D et al. *Patient Prefer Adherence.* 2016;10:1609-1621; Mian H et al. *Clin Lymphoma Myeloma Leuk.* 2019;20(2):98-104.e1.

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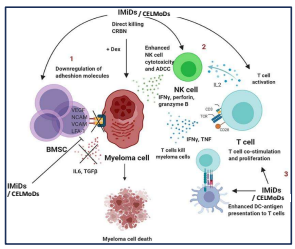
CELMoD: Mechanism of Action

- Highly selective molecular degraders that reprogram the cereblon ubiquitin ligase complex
- Leads to degradation of Ikaros and Aiolos and suppression of c-Myc and IRF4 signaling, induction of apoptosis, and immunostimulatory effect to enhance NK and T-cell activity



CELMoDs, cereblon E3 ligase modulators; IMiDs, immunomodulatory drugs.

Patel TH et al. *Clin Lymphoma Myeloma Leuk.* 2024;24(11):762-769; Ioannou N et al. *Int J Mol Sci.* 2021;22(16):8572; Costacurta M et al. *J Pers Med.* 2021;11(11):1185; Republished from D'Souza C et al. *Front Immunol.* 2021;12:632399, under the terms of the under the terms of the Creative Commons Attribution License (CC BY).

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CELMoDs vs IMiDs

Compound	Molecular structure	CRBN binding affinity (IC_{50})	CRBN closed confirmation	Half-life (hours)	Renal dosing	Liver metabolism
Lenalidomide		≈1.5 uM	--	3-5	Adjustments for CrCl <60 mL/min	Minimal
Pomalidomide		≈1.2 uM	20%	7.5-9.5	Adjustments for severe renal impairment requiring dialysis	Partially metabolized by CYP1A2, CYP3A4, substrate for p-glycoprotein CYP2C19, CYP2D6, CYP3A4
Iberdomide		≈0.06 uM	50%	9-13	NA	Primarily metabolized by CYP3A
Mezigdomide		≈0.03 uM	100%	16-19	NA	Primarily liver metabolized

CrCl, creatinine clearance.

Patel TH et al. *Clin Lymphoma Myeloma Leuk.* 2024;24(11):762-769; Costacurta M et al. *J Pers Med.* 2021;11(11):1185; Hartley-Brown MA et al. *Cancers (Basel).* 2024;16(6):1166; van de Donk NWCJ et al. *Onco Targets Ther.* 2025;18:921-933; Lee H et al. *Hematol Oncol Clin North Am.* 2024;38(2):305-319; Watson ER et al. *Science.* 2022;378(6619):549-553.

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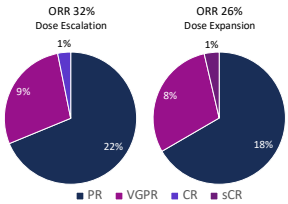
CC-220-MM-001: Phase 1/2 Study of Iberdomide + Dexamethasone

Dose escalation (n = 90)

- Median 5 prior LOT
- 59% triple-class refractory
- 16% high-risk cytogenetics
- 18% extramedullary disease

Dose expansion (n = 107)

- Median 6 prior LOT
- 97% triple-class refractory
- 30% high-risk cytogenetics
- 25% extramedullary disease



CR; complete response; LOT, lines of therapy; ORR, overall response rate; PR, partial response; VGPR, very good partial response; sCR, stringent complete response.

Lonial S et al. *Lancet Haematol.* 2022;9(11):e822-e832.

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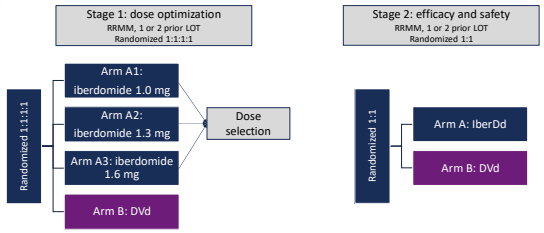
CC-220-MM-002



DVd, daratumumab + bortezomib + dexamethasone; IberDd, iberdomide + daratumumab.

Republished from Lonial S et al. *Future Oncol.* 2025;21(14):1761-1769, under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License; Press release. Bristol Myers Squibb. September 23, 2025. Accessed March 16, 2026. https://news.bms.com/news/corporate-financial/2025/Bristol-Myers-Squibb-Announces-Phase-3-EXCALIBER-RRMM-Study-Evaluating-Iberdomide-in-Combination-with-Standard-Therapies-Demonstrated-a-Significant-Improvement-in-Minimal-Residual-Disease-Negativity-Rates-in-Relapsed-or-Refractory-Multiple-Myeloma/default.aspx

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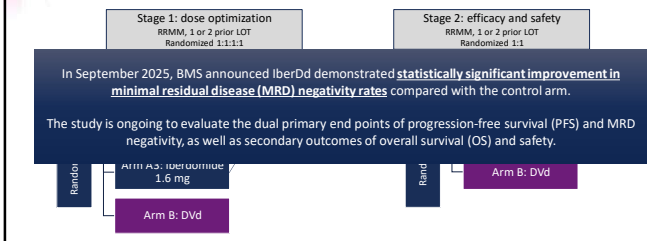
CC-220-MM-002



Republished from Lonial S et al. *Future Oncol.* 2025;21(14):1761-1769, under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License; Press release. Bristol Myers Squibb. September 23, 2025. Accessed March 16, 2026. https://news.bms.com/news/corporate-financial/2025/Bristol-Myers-Squibb-Announces-Phase-3-EXCALIBER-RRMM-Study-Evaluating-Iberdomide-in-Combination-with-Standard-Therapies-Demonstrated-a-Significant-Improvement-in-Minimal-Residual-Disease-Negativity-Rates-in-Relapsed-or-Refractory-Multiple-Myeloma/default.aspx

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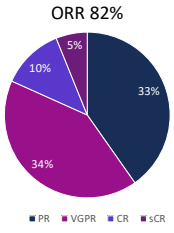
ICON: Iberdomide + Cyclophosphamide + Dexamethasone

Study design and population

- Single-arm, phase 2 study
- RRMM with 2-4 prior LOT (median 3)
- 85% triple-class exposed
- 44% triple-class refractory

Results

- Median PFS: 17.6 months
- Neutropenia: 61% (grade 3-4: 56%)
- Infection: 74% (grade 3-5: 35%)
- VTE: 7% (grade 3-4: 2%)
- Secondary primary malignancy: 6%



VTE, venous thromboembolism.

Korst CLBM et al. *Lancet Haematol.*2026;13(1):e30-40.

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CC-92480-MM-001: Mezigdomide + Dexamethasone

Phase 1/2, multicenter trial

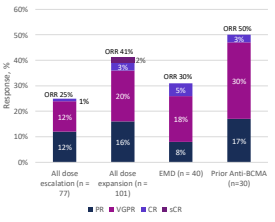
- Median 6 prior LOT

Dose escalation (n = 77)

- 30% high-risk cytogenetics, 35% EMD
- 56% triple-class refractory

Dose expansion at recommended phase 2 dose (n = 101)

- 37% high-risk cytogenetics, 40% EMD
- 100% triple-class refractory
- Median DOR: 7.6 months
- Median PFS: 4.4 months
- Prior anti-BCMA therapy
  - Median DOR: 6.9 months, median PFS: 5.4 months



EMD, extramedullary disease; DOR, duration of response.

Richardson RG et al; CC-92480-MM-001 Study Investigators. *N Engl J Med.* 2023;389(11):1009-1022.

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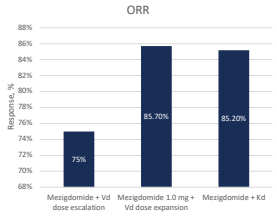
CC-92480-MM-002: Mezigdomide + PI + Dexamethasone

Mezigdomide + Vd (n = 28)
- Dose escalation cohort
- Median 3 prior LOT
- 85.7% IMiD refractory
- 50% PI refractory

Mezigdomide + Vd 1.0 mg/0.6 mg (n = 49)
- Median 1 prior LOT
- 63.3% IMiD refractory
- 16.3% PI refractory

Mezigdomide + Kd (n = 27)
- Median 2 prior LOT
- 88.9% IMiD refractory
- 51.9% PI refractory



Kd, carfilzomib and dexamethasone; PI, proteasome inhibitor; Vd, bortezomib and dexamethasone.

Sandhu I et al. *Blood*. 2024;144(Supplement 1):1025.

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SUCCESSOR Trials: Phase 3 Mezigdomide Combinations

SUCCESSOR-1: MeziVd vs PVd
- RRMM with 1-3 prior LOT, including lenalidomide
- Stage 1 dose optimization followed by stage 2 efficacy and safety analysis
  - Primary end point: PFS
  - Key secondary end points: ORR, CRR, OS, safety, MRD negativity, HRQOL

SUCCESSOR-2: MeziKd vs Kd
- RRMM with ≥1 prior LOT, including lenalidomide and an anti-CD38 mAb
- Stage 1 dose optimization followed by stage 2 efficacy and safety analysis
  - Primary end point: PFS
  - Key secondary end points: ORR, CRR, OS, safety, MRD negativity, HRQOL

CRR, complete response rate; HRQOL, health-related quality of life; PVd, pomalidomide, bortezomib, and dexamethasone.

Dimopoulos M et al. 21st International Myeloma Society Annual Meeting. Abstract P-389.

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SUCCESSOR Trials: Phase 3 Mezigdomide Combinations

SUCCESSOR-1:
- RRMM with 1-3 prior LOT, including lenalidomide
- Stage 1 dose optimization followed by stage 2 efficacy and safety analysis

March 9, 2026: BMS announced MeziKD demonstrated **statistically significant and clinically meaningful improvement in PFS** compared with Kd at the interim analysis of SUCCESSOR-2.

The study is ongoing to evaluate survival and safety.

MeziKd vs Kd
- Stage 1 dose optimization followed by stage 2 efficacy and safety analysis
- Primary end point: PFS
- Key secondary end points: ORR, CRR, OS, safety, MRD negativity, HRQOL

Dimopoulos M et al. 21st International Myeloma Society Annual Meeting. Abstract P-389. Press release. Bristol Myers Squibb. March 9, 2026. Accessed March 10, 2026. https://news.bms.com/news/corporate-financial/2026/Bristol-Myers-Squibb-Announces-Positive-Phase-3-Results-from-the-SUCCESSOR-2-Study-of-Oral-Mezigdomide-in-Relapsed-or-Refractory-Multiple-Myeloma/default.aspx

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CELMoD Toxicity

ADE, % (grade 3-4)	Iberdomide	Mezigdomide		
	CC-220-MM-001: iberdomide + dexamethasone (N = 107)	CC-92480-MM-001 mezigdomide + dexamethasone (N = 101)	CC-92480-MM-002: MeziKd (N = 27)	CC-92480-MM-002: MeziVd (N = 49)
Neutropenia	60 (45)	77 (76)	Grade 3-4: 44.4	Grade 3-4: 63.3
Anemia	41 (28)	52 (36)	Grade 3-4: 14.8	Grade 3-4: 7.9
Thrombocytopenia	36 (22)	43 (28)	Grade 3-4: 14.8	Grade 3-4: 26.5
Infection	58 (27)	65 (35)	70.4 (33.3)	79.6 (32.7)
Fatigue	24 (3)	36 (5)	NR	NR
Diarrhea	23 (1)	31 (3)	0 (0)	NR
Rash	20 (3)	NR	0 (0)	NR
VTE	0 (0)	3 (1)	NR	NR

ADE, adverse drug effect.

Lonial S et al. *Lancet Haematol*. 2022;9(11):e822-e832; Richardson RG et al; CC-92480-MM-001 Study Investigators. *N Engl J Med*. 2023;389(11):1009-1022; Sandhu I et al. *Blood*. 2024;144(Supplement 1):1025.

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Lonial S et al. *Lancet Haematol*. 2022;9(11):e822-e832; Richardson RG et al; CC-92480-MM-001 Study Investigators. *N Engl J Med*. 2023;389(11):1009-1022; Sandhu I et al. *Blood*. 2024;144(Supplement 1):1025.

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Role in RRMM Therapy

IMiD-refractory patients
- Iberdomide for early relapse
  - PDUFA date 8/17/2026 for iberdomide + daratumumab + dexamethasone in RRMM
- Mezigdomide for later relapse and post-BCMA therapy

Combination with T-cell–redirecting agents
- Enhanced T-cell activation with increased tumor infiltration
- Potential cytokine release mitigation with CELMoD pretreatment
- Rejuvenate CAR T-cell function and reverse T-cell exhaustion

PDUFA, Prescription Drug User Fee Act.

Hartley-Brown MA et al. *Cancers (Basel)*. 2024;16(6):1166; Liu Y et al. *Expert Rev Hematol*. 2024;17(8):445-465; Aleman A et al. EHA 2025. Abstract PF685.

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Future Directions

- Iberdomide in earlier lines
  - Smoldering myeloma
  - Post-transplant maintenance
  - Newly diagnosed myeloma for both transplant-eligible and ineligible patients
- Mezigdomide combinations
- Combinations with T-cell–redirecting therapies
  - MagnetisMM-30: iberdomide + elranatamab
- Therapy sequencing

Joseph NS et al. *Blood*. 2024;144(Supplement 1):1983; Puig N et al. EHA 2025. Abstract PS1784; Amatangelo M et al. *Blood*. 2024;144(Supplement 1):1973; White et al. ASCO. Abstract 7532; Dimopoulos M et al. 21st International Myeloma Society Annual Meeting. Abstract P-389; Tuchman S et al. *Blood*. 2025;146(Supplement 1):2289; Suvannasankha A et al. *Blood*. 2025;146(Supplement 1):100; Byun JM et al. *Blood*. 2025;146(Supplement 1):5835; Bar N et al. *Blood*. 2025;146(Supplement 1):8246.

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The Role of the Pharmacist

EHR, electronic health record.

Segal EM et al. *J Oncol Pharm Pract*. 2019;25(8):1945-1967.

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Case 1: Management of Treatment-Related Neutropenia

CG is a 68-year-old woman with a history of IgG lambda MM diagnosed in 2013. She recently started iberdomide + dexamethasone and presents to the clinic for initiation of cycle 2.

- **Myeloma markers**
  - Free lambda light chains: 35.6 mg/L
  - Free kappa light chains: 0.07 mg/L
  - Serum M-protein: 1.4 g/L
  - Bone marrow biopsy: 15% monoclonal plasma cells
- **Other pertinent lab results**
  - Serum creatinine: 0.8 mg/dL
  - Hemoglobin: 9.4 g/dL
  - White blood cells (WBCs): 0.6 x 10^9/L
  - Absolute neutrophil count (ANC): 425 cells/µL
  - Platelet: 130,000 cells/µL

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Audience Response Question

What interventions may be recommended for the management of CG's grade 4 neutropenia? (select all that apply)

A. Hold iberdomide and dexamethasone until ANC ≥1000 cells/µL and resume at the same dose.
B. Continue therapy and assess complete blood count (CBC) in 1 week.
C. Initiate filgrastim 5 mcg/kg subcutaneous injection 3x weekly to maintain ANC >1000 cells/µL.
D. Initiate levofloxacin 500 mg daily until ANC ≥500 cells/µL.

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Real-World Neutropenia Management

Emory Winship Cancer Institute	American Oncology Network	Fred Hutchinson Cancer Center
• Goal: Optimize efficacy by maintaining the patient on therapy. • Initiate filgrastim 2-3x weekly to maintain ANC ≥1000 cells/µL. • If neutropenia anticipated >7 days: initiate levofloxacin 500 mg daily (or equivalent). • Consider a therapeutic hold based on disease status. • Consider dose reduction if ANC is not improved with G-CSF.	• Hold therapy for ANC ≤1000 cells/µL, resume at the same dose when resolved, or lower dose if persistent (>7 days), recurrent, or grade 4. • Consider G-CSF 2-3x weekly for ANC ≤1000 cells/µL without other significant toxicities. • Consider antibacterial and antifungal prophylaxis for ANC ≤100 cells/µL anticipated >7 days.	• Start filgrastim 2-3x weekly to maintain ANC ≥500-1000 cells/µL. • If persistent neutropenia, consider temporarily holding treatment for 7 days. • If persistent neutropenia or recurrence after a temporary hold (with filgrastim), consider a dose reduction. • Start prophylaxis with levofloxacin if ANC <500 cells/µL.

G-CSF, granulocyte colony-stimulating factor.

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Neutropenia and Management

NCCN hematopoietic growth factors
- Consider G-CSF based on patient-specific factors, but no direct guidance for intermittent G-CSF use
- No direct guidance

ASCO recommendations for the use of WBC growth factors
- "Primary prophylaxis is recommended for the prevention of febrile neutropenia in patients who are at high risk on the basis of age, medical history, disease characteristics, and myelotoxicity of the chemotherapy regimen"

Clinical trial guidance
- Grade 4 neutropenia or febrile neutropenia:
  - Hold therapy for remainder of cycle and initiate G-CSF
  - Follow CBC at least weekly
  - Maintain CELMoD dose if neutropenia was the only therapy-related toxicity, or decrease by 1 dose level
  - Resume when ANC ≥1000 cells/µL
- Initiate antibacterial prophylaxis during periods of susceptibility to infection

ASCO, American Society of Clinical Oncology; NCCN, National Comprehensive Cancer Network.

NCCN. Clinical Practice Guidelines in Oncology. Hematopoietic growth factors, version 3.2026. Accessed March 16, 2026. https://www.nccn.org/professionals/physician_gls/pdf/growthfactors.pdf; Smith TJ et al; American Society of Clinical Oncology. *J Clin Oncol*. 2015;33(28):3199-3212; Lonial S et al. *Lancet Haematol*. 2022;9(11):e822-e832; Lonial S et al. *Future Oncol*. 2025;21(14):1761-1769; Richardson RG et al; CC-92480-MM-001 Study Investigators. *N Engl J Med*. 2023;389(11):1009-1022; Sandhu I et al. *Blood*. 2024;144(Supplement 1):1025.

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The Role of the Pharmacist

- Toxicity management protocols
- Dose adjustment protocols
- Infection prevention
- Interprofessional education
- Patient education

Segal EM et al. *J Oncol Pharm Pract*. 2019;25(8):1945-1967.

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Case 2: Bringing CELMoDs Into the Real World

Picture this…the first CELMoD agent has just been FDA approved for RRMM.

- Iberdomide in combination with daratumumab and dexamethasone
- Approved for RRMM after 1 prior LOT
- Not yet included in NCCN guidelines

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Case 2: Bringing CELMoDs Into the Real World

ESTABLISHING EMR ORDERS

Components of the treatment plan
- Iberdomide (dose, schedule, administration instructions)
- Concurrent therapy (daratumumab, dexamethasone)
- Supportive medications (aspirin, antiemetic, daratumumab premedications per institution protocol)
- Laboratory monitoring (CBC with differential, comprehensive metabolic panel, thyroid-stimulating hormone, myeloma markers)
- REMS reminders

REMS PREPAREDNESS

Providers
- Complete prescriber enrollment.
- Obtain monthly REMS authorization number.
- Include authorization number and patient risk category on each prescription.

Pharmacies
- Complete pharmacy enrollment and individual staff training/certification.
- Confirm provider steps completed, authorization number still valid, and prescription for 28-day supply or less.
- Obtain confirmation number and dispense within 24 hours.
- Certified counselor counsels and completes the checklist with the patient.

COMMUNICATION WORKFLOWS

Clinic and pharmacy
- Designate responsibilities
  - Initial REMS enrollment
  - Monthly authorization
  - Patient counseling/ checklist completion
  - Reporting ADEs
- Communicating ADEs, dose reductions, treatment holds

Clinic/pharmacy and patient
- Recognizing importance of responsiveness to phone calls
- Reporting ADEs
- Taking appropriate concomitant medications

EMR, electronic medical record; REMS, Risk Evaluation and Mitigation Strategy.

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Audience Response Question

When choosing between 2 treatment options with similar efficacy, what is the most important factor pharmacists should consider if all options are appropriate?

A. AE profile and patient tolerability
B. Cost and insurance coverage
C. Patient preference and convenience
D. Potential drug interactions and contraindications

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Case 2

The case continues…3 months following the approval of iberdomide, mezigdomide receives FDA approval in combination with carfilzomib and dexamethasone after ≥1 prior LOT.

Education and formulary
- Provider and staff education
- Patient education materials
- Considerations for formulary addition

Comparing iberdomide and mezigdomide
- Efficacy/relapse profiles
- Safety/toxicity profiles
- Selection based on patient/disease characteristics?

CELMoDs in the treatment continuum
- Sequencing with IMiDs, BCMA
- Sequencing with T-cell–directed therapy

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Conclusion

- CELMoDs including iberdomide (CC-220) and mezigdomide (CC-92480) are high selective molecular degraders that reprogram the cereblon ubiquitin ligase complex.
- CELMoDs have increased binding affinity for cereblon, enhanced degradation of Ikaros and Aiolos, and greater immunostimulatory effects than IMiDs.
- These novel agents will help to address a therapeutic need for IMiD-refractory patients and may enhance the therapeutic activity of T-cell–redirecting therapies.
- Pharmacists will play a key role in the therapeutic management of CELMoDs, including formulary decision-making, development of toxicity management protocols, and education for interdisciplinary teams and patients.

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Additional Resources

	Resources
International Myeloma Foundation	www.myeloma.org
mSMART Stratification for Myeloma & Risk-Adapted Therapy	www.msmart.org/mm-treatment-guidelines
Multiple Myeloma Research Foundation	themmrf.org

Hicks LK et al. Treatment of multiple myeloma: ASCO-Ontario Health (Cancer Care Ontario) living guideline. *J Clin Oncol*. 2026:JCO2502587.

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