Bispecific Therapies for Mature Lymphoid Malignancies

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Disclosures

- I have no relevant disclosures or conflicts of interest.
- My spouse has an ongoing consultancy with Kyra Oncology.

Introduction

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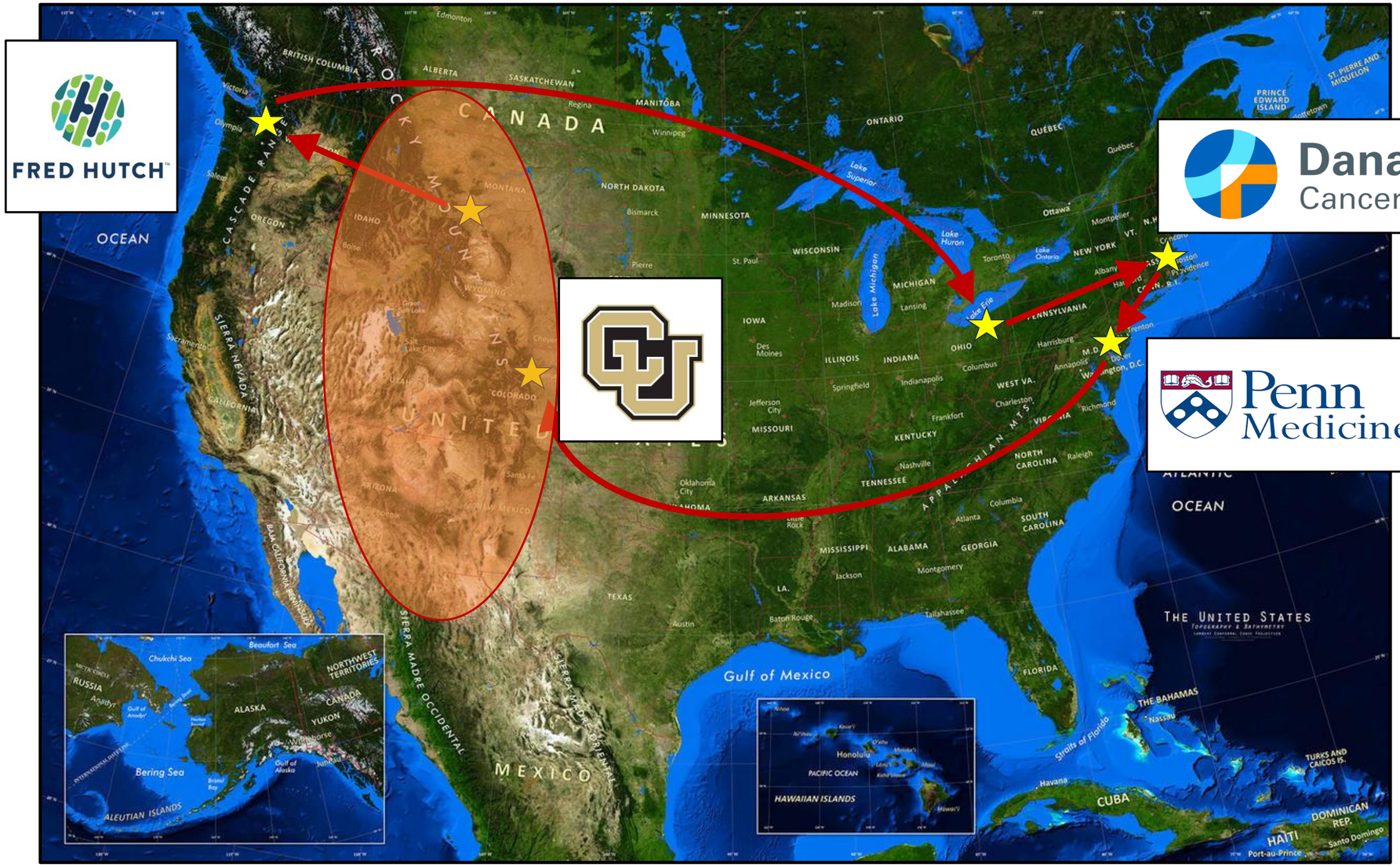
Introduction



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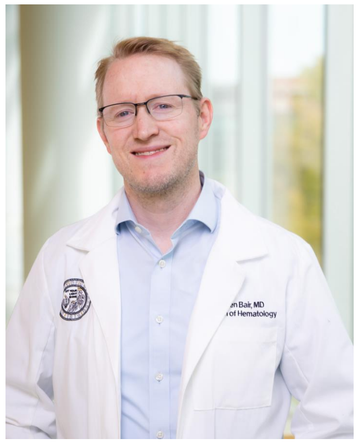

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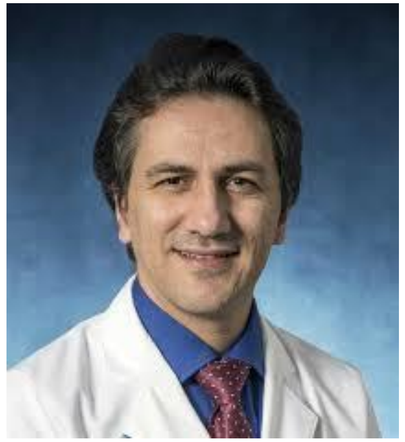

Jagar Jasem

Ajay Major

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Outline

- Overview of bispecific antibody (BsAb) structure and function
- BsAb therapy in aggressive lymphomas (LBCL)
- BsAb therapy in indolent lymphomas (FL)
- Toxicity management
- Biomarkers to predict response and resistance
- Challenging questions regarding BsAb in lymphoma
- Where is the field going?
- Summary

Structure and Function of Bispecific Antibody Therapies

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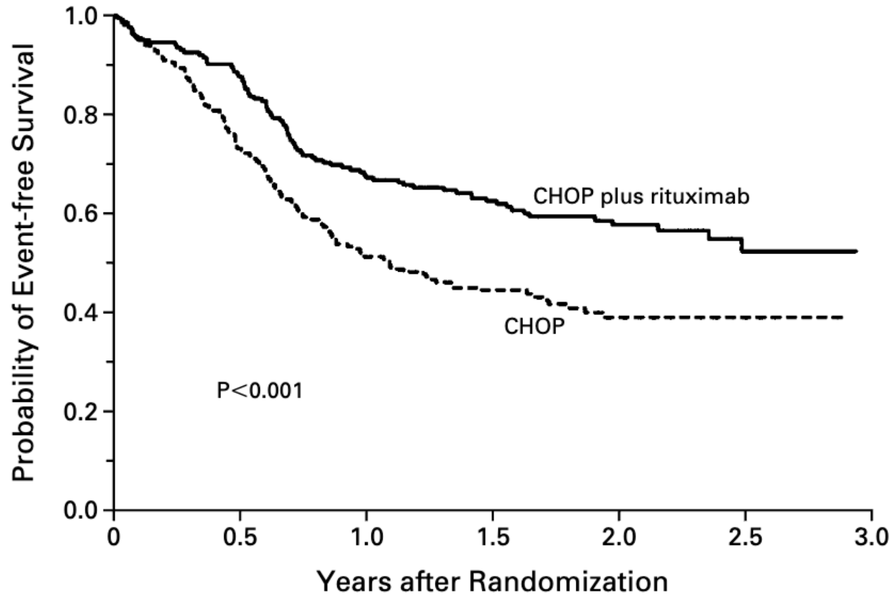
CHOP CHEMOTHERAPY PLUS RITUXIMAB COMPARED WITH CHOP ALONE IN ELDERLY PATIENTS WITH DIFFUSE LARGE-B-CELL LYMPHOMA

BERTRAND COIFFIER, M.D., ERIC LEPAGE, M.D., PH.D., JOSETTE BRIÈRE, M.D., RAOUL HERBRECHT, M.D., HERVÉ TILLY, M.D., REDA BOUABDALLAH, M.D., PIERRE MOREL, M.D., ERIC VAN DEN NESTE, M.D., GILLES SALLES, M.D., PH.D., PHILIPPE GAULARD, M.D., FELIX REYES, M.D., AND CHRISTIAN GISSELBRECHT, M.D.



No. at Risk						
CHOP plus rituximab	202	177	137	108	63	19
CHOP	197	144	101	72	42	17

Rituximab improves efficacy through FcγR-mediated mobilization of cytotoxic and phagocytic host immune cells

Coiffier et al, *NEJM*, 2002; Maloney et al, *NEJM, 2012*

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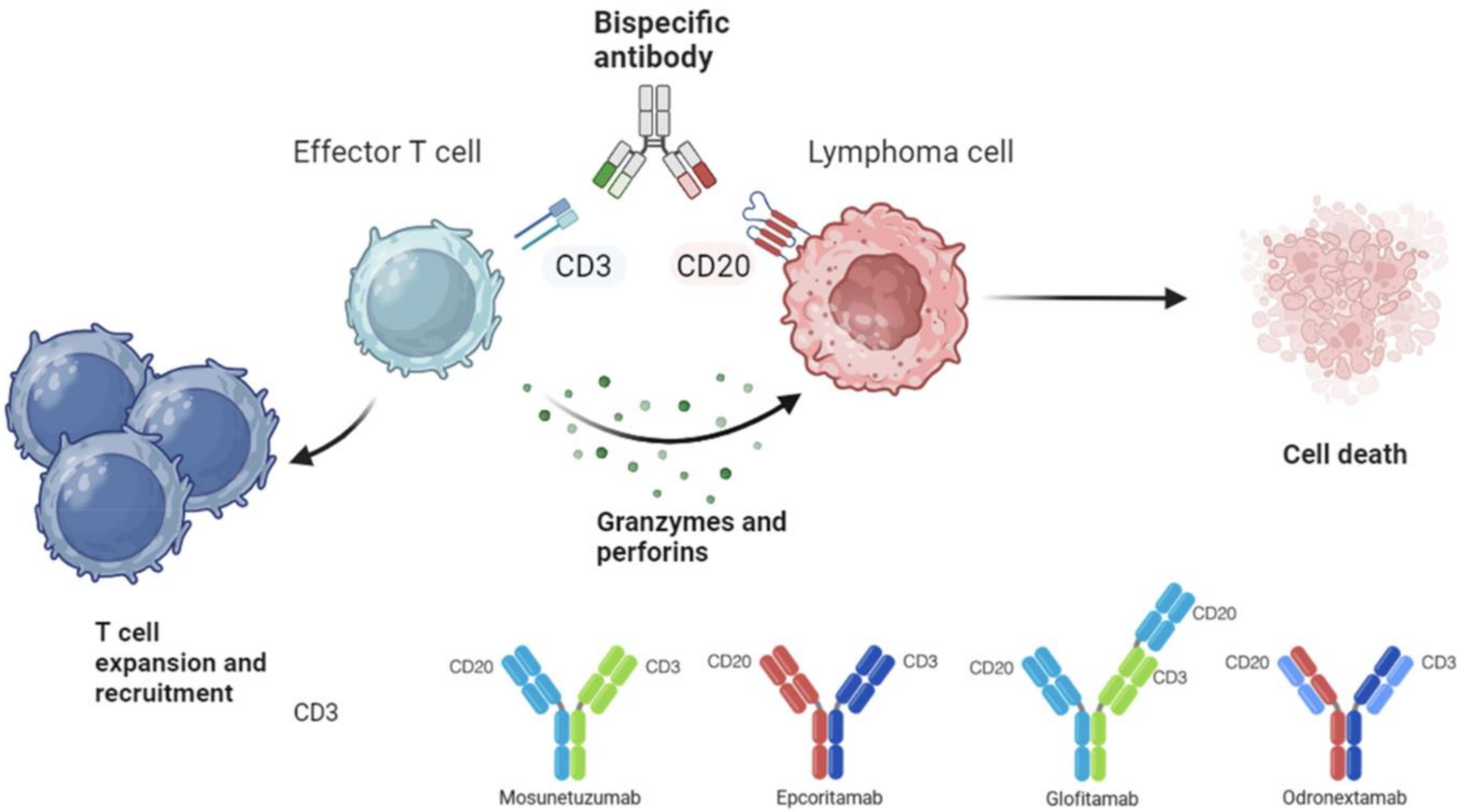
Basic BsAb Structure and Function



Cassanello et al, *Oncoimmunol*, 2024

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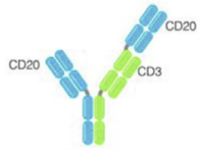
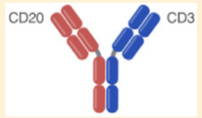
Differences in BsAb structure

Product name	Schematic depiction	Format	Technology	CD20:CD3 ratio	CD3 clone	CD20 clone	Fc silencing mutations*
Mosunetuzumab[18]		IgG1	Knobs-into-holes (different Fabs)	1:1	UCHT1v9 (CD3δε)	2H7 (type 1 epitope, identical to rituximab)	N297G (no FcγR binding)
Glofitamab[15]		IgG1	Head-to-tail fusion	2:1	SP34-der.(CD3ε)	By-L1 (type 2 epitope, identical to obinutuzumab)	IgG1-P329G-LALA (no FcγR binding)
Epcoritamab[16]		IgG1	Controlled Fab-arm exchange	1:1	huCACAO (SP34-der.)(CD3ε)	7D8 (type 1 epitope, shared by ofatumomab)	L234F,L235E,D265A (no FcγR,C1q binding)
Odronexamab[17]		IgG4	Heavy chains with different affinity	1:1	REG1250 (CD3δε)	3B9-10 (type 1 epitope, shared by ofatumomab)	Modified IgG4 (no FcγRIII binding)

Falchi et al, *Blood*, 2023

Bispecific Antibody Therapy for Aggressive B-Cell Lymphoma

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Bispecific antibody therapies for aggressive B-cell lymphomas

Epcoritamab

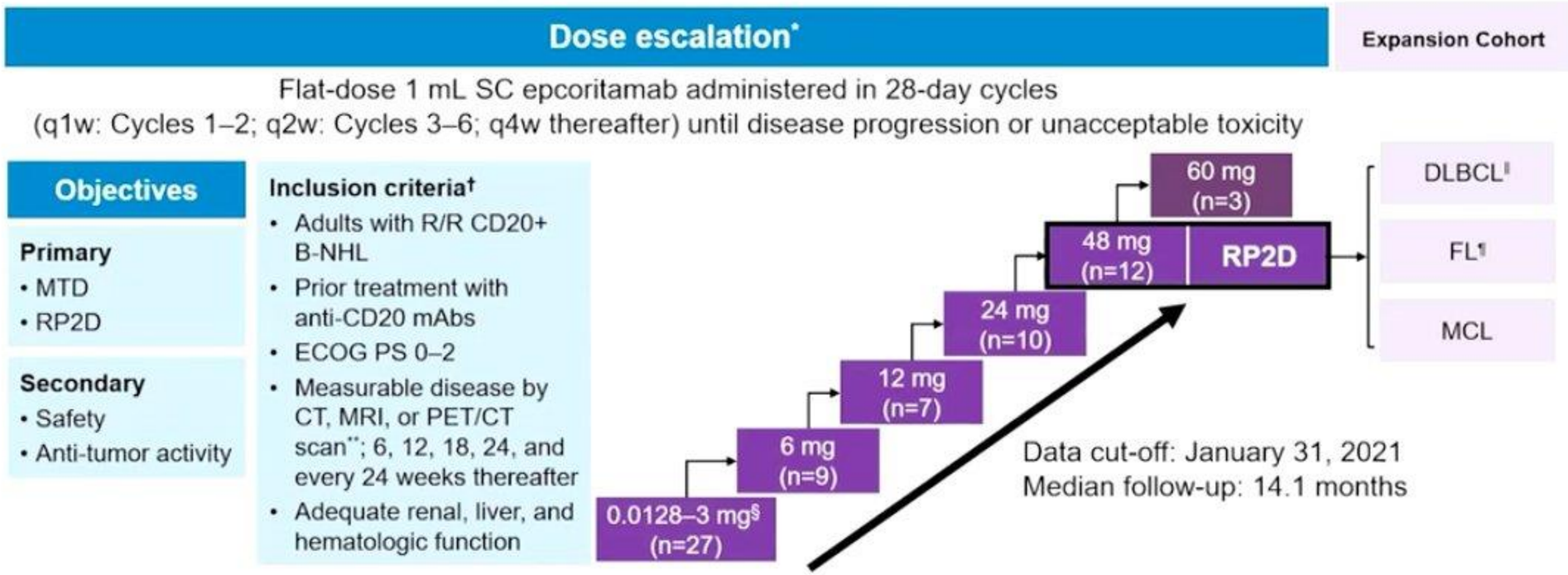
- Subcutaneous
- Continuous
- Approved May 19, 2023 (≥3L)

Glofitamab

- Intravenous
- Time-limited
- Approved June 15, 2023 (≥3L)

Epcoritamab (SC) in R/R aggressive B-cell lymphoma

EPCORE NHL-1 Study Design

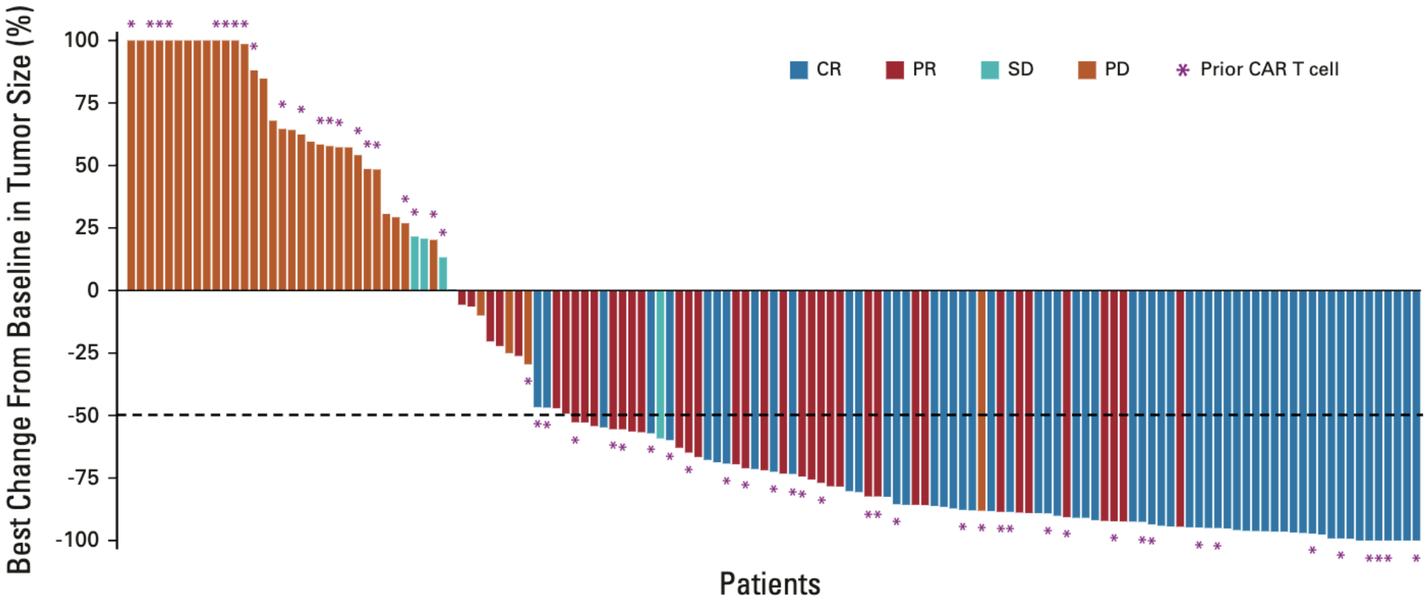


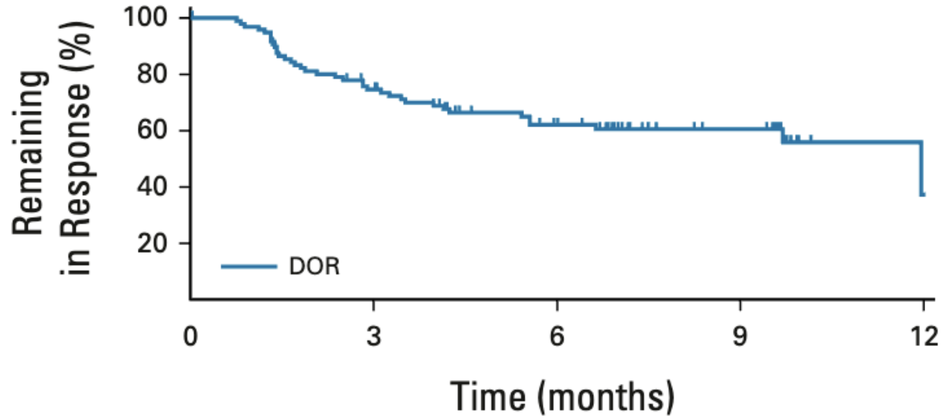
To minimize the occurrence and severity of CRS, a priming dose (160 µg, Cycle 1 Day 1) and an intermediate dose (800 µg, Cycle 1 Day 8) of epcoritamab prior to the full dose (beginning on Cycle 1 Day 15), and premedication with corticosteroids, antihistamines, and antipyretics were used (during Cycle 1; as needed in Cycle 2)

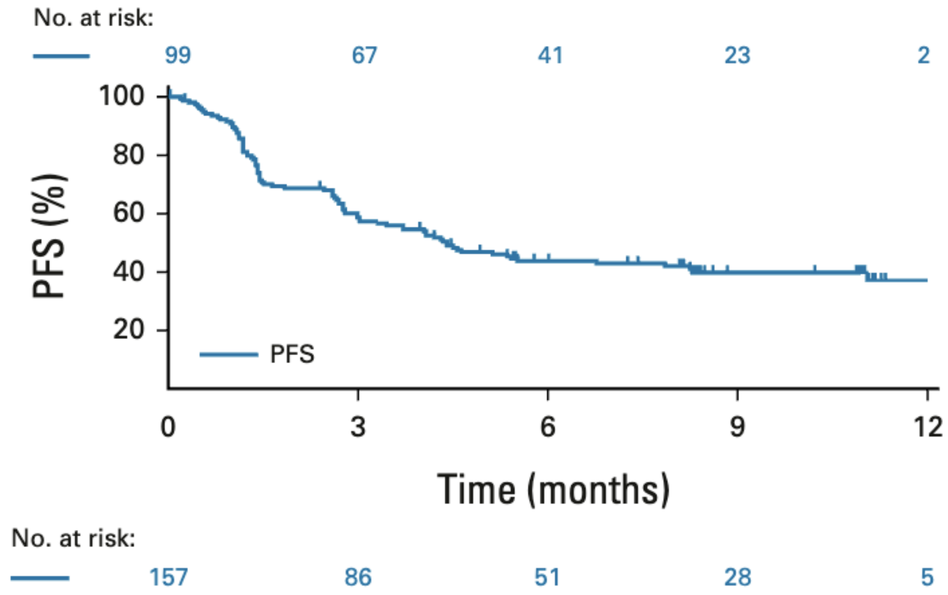
*Modified Bayesian optimal interval design consisting of accelerated and standard titration. Accelerated titration includes single-patient cohorts; up to 2 patients may be added (at the currently investigated dose) to obtain additional PK/PD biomarker data. †Patients previously treated with CAR-T cell therapy were allowed (protocol amended after study start). **CT or MRI scans: Weeks 6, 12, 18, 24, and every 12 weeks thereafter. PET scans not required in all patients. §Includes the following priming/final dose levels (mg): 0.004/0.0128, 0.0128/0.04, 0.04/0.12, 0.12/0.38, 0.04/0.76, 0.04/0.25/1.5, 0.04/0.5/3. ‖Includes patients with DLBCL or other aggressive histologies. ¶Includes FL or other indolent histologies

Hutchings, *ICML*, 2021

Epcoritamab (SC) in R/R aggressive B-cell lymphoma







Thieblemont, *JCO*, 2023

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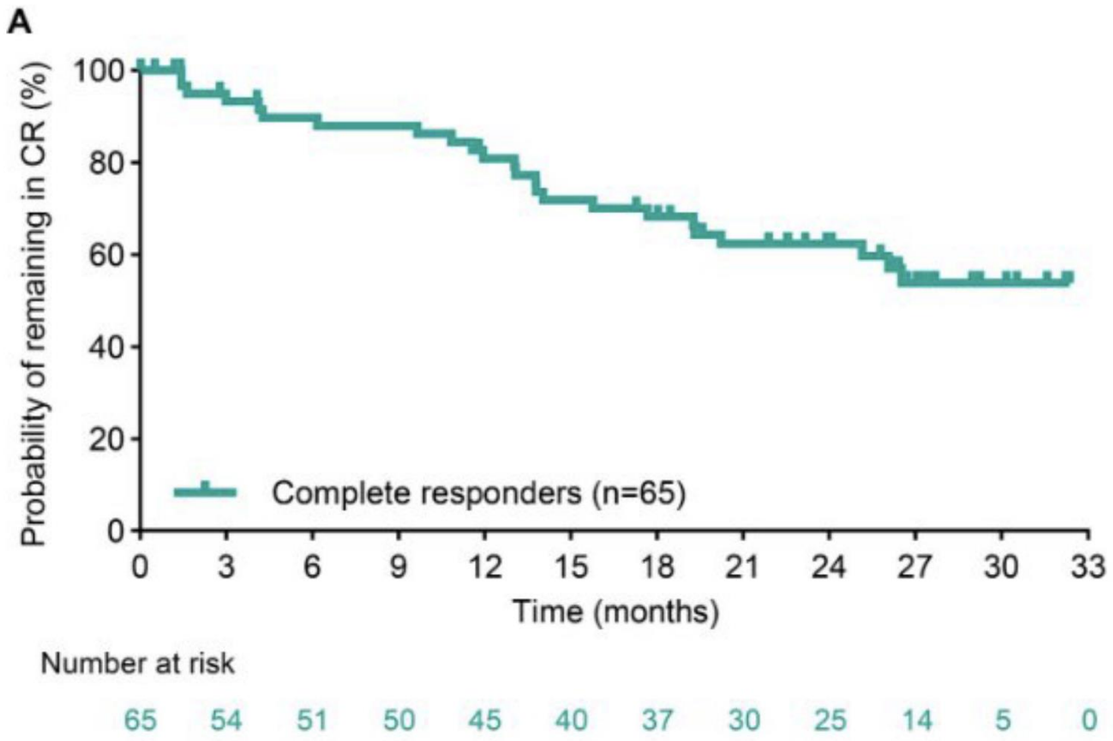
Epcoritamab (SC) in R/R aggressive B-cell lymphoma



Timepoint estimate, % (95% CI)	Pts in CR	Progression-free survival	Overall survival	Pts who have not initiated next line of therapy
24 mo	62 (48–74)	65 (52–76)	76 (64–85)	82 (69–90)
30 mo	54 (39–67)	55 (39–68)	71 (58–81)	78 (64–87)
33 mo	NA	55 (39–68)	71 (58–81)	78 (64–87)

Data cutoff: October 16, 2023. Kaplan–Meier estimates. NA, not assessed.

<u>36 months (ASH 2024):</u>

ORR: 59%, CR: 41%

Median DoCR: 36.1 months

mPFS: 4.2 mos (37.3 mos in CR)

mOS: 18.5 mos (NR in CR)

Thieblemont, et al, *EHA*, 2024; Vose, *ASH*, 2024

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Glofitamab (IV) in R/R aggressive B-cell lymphoma

Figure 1. Study overview.

Key inclusion criteria

- DLBCL NOS, HGBCL, trFL, or PMBCL
- ECOG PS 0–1
- ≥2 prior therapies, including:
  - Anti-CD20 antibody
  - Anthracycline

Endpoints

- Primary: CR rate (as BOR) by IRC*
- Key secondary: ORR†, DoR, DoCR†, PFS, and OS

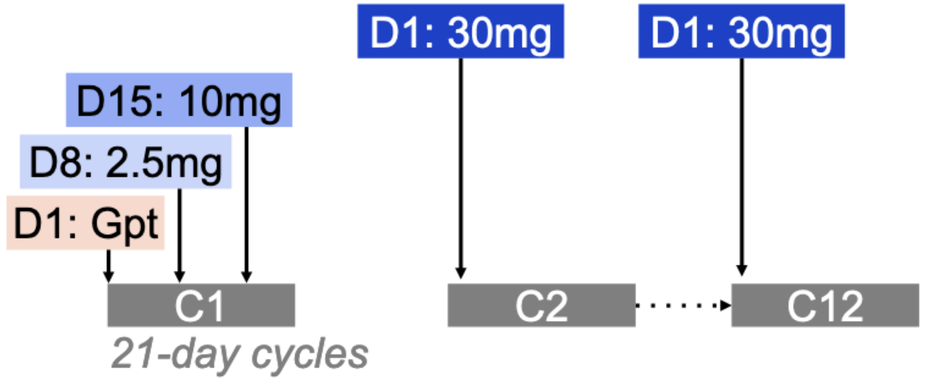
Glofitamab IV administration

Fixed-duration treatment

- Maximum 12 cycles

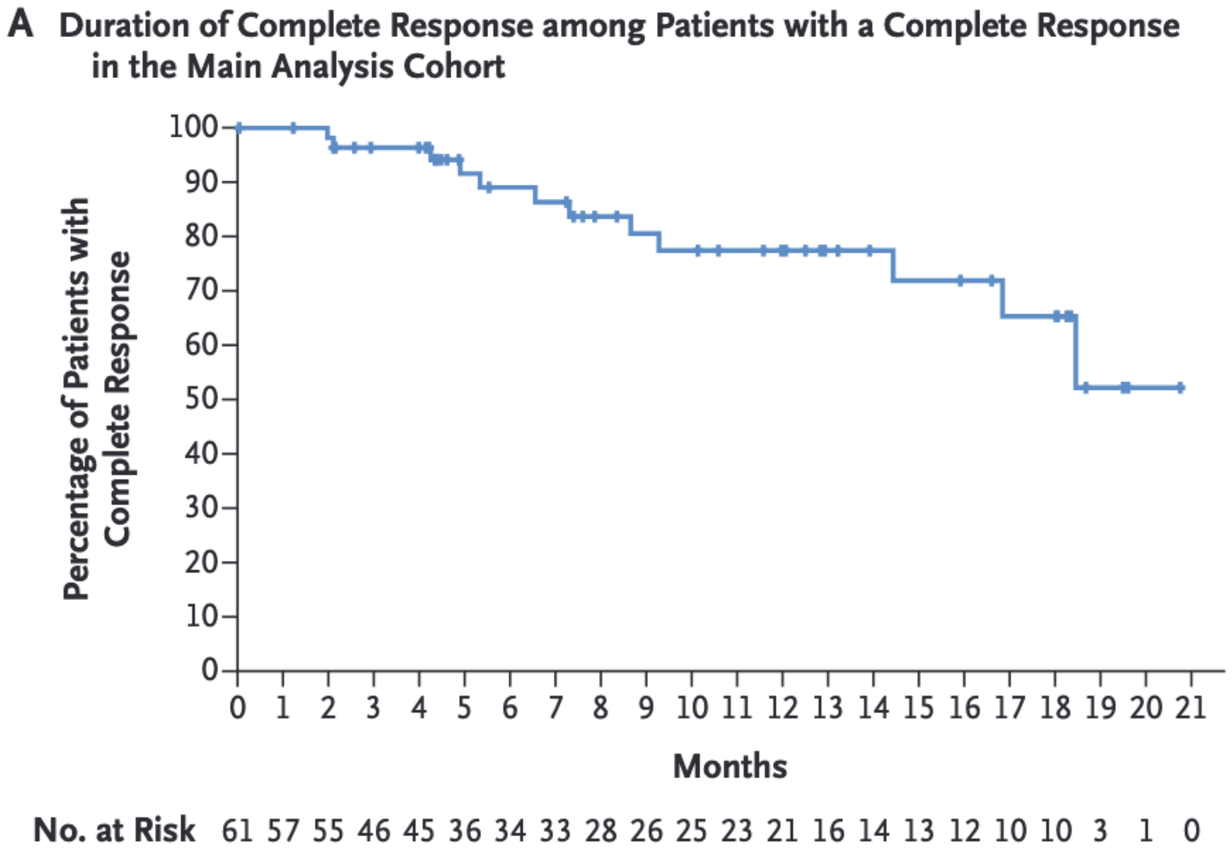
CRS‡ mitigation:

- Obinutuzumab pretreatment (1 x 1000mg)
- C1 step-up dosing
- Monitoring after first dose (2.5mg)



Falchi et al, *ASCO*, 2023

Glofitamab (IV) in R/R aggressive B-cell lymphoma

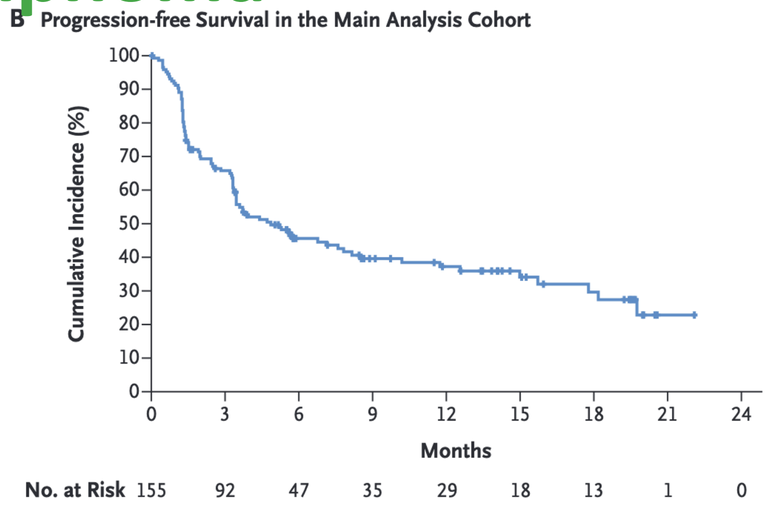


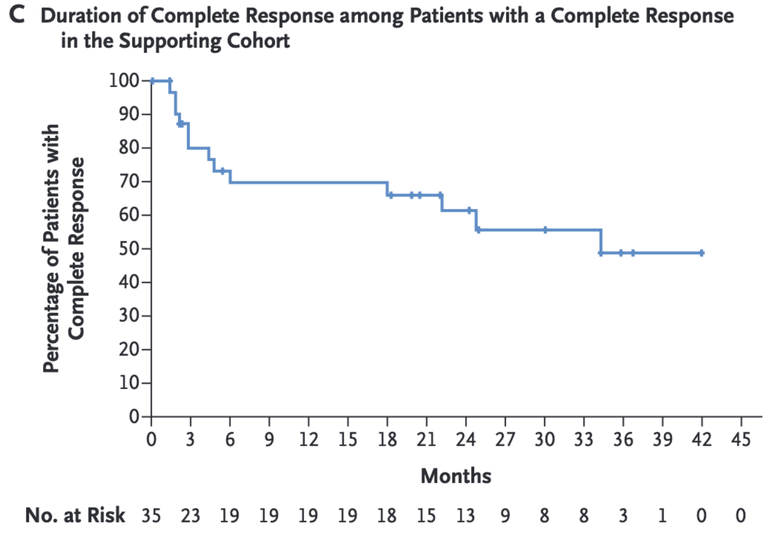
Overall
ORR: 52%
CR: 40%

mDoCR: 29.8

EOT CR:
2y PFS: 57%
2y OS: 77%

ASH 2024





Dickinson et al, *NEJM*, 2022; Dickinson et al, *ASH, 2024*

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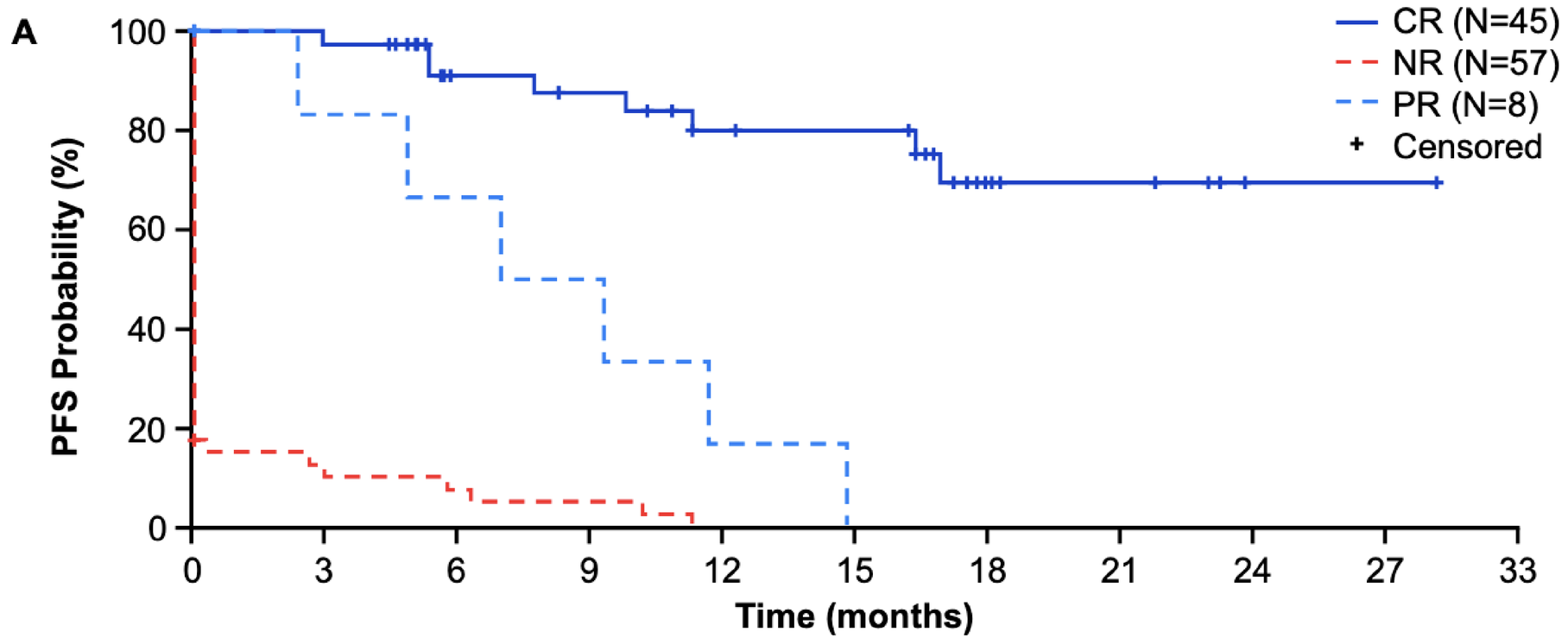
Glofitamab (IV) in R/R aggressive B-cell lymphoma

Figure 5. PFS (A) and OS (B) landmark analysis by response at EOT.



CR (N=45)	45	37	26	24	19	18	7	5	1	1	NE
NR (N=57)	57	4	3	2	NE	NE	NE	NE	NE	NE	NE
PR (N=8)	8	5	4	3	1	NE	NE	NE	NE	NE	NE

Falchi et al, *ASCO*, 2023

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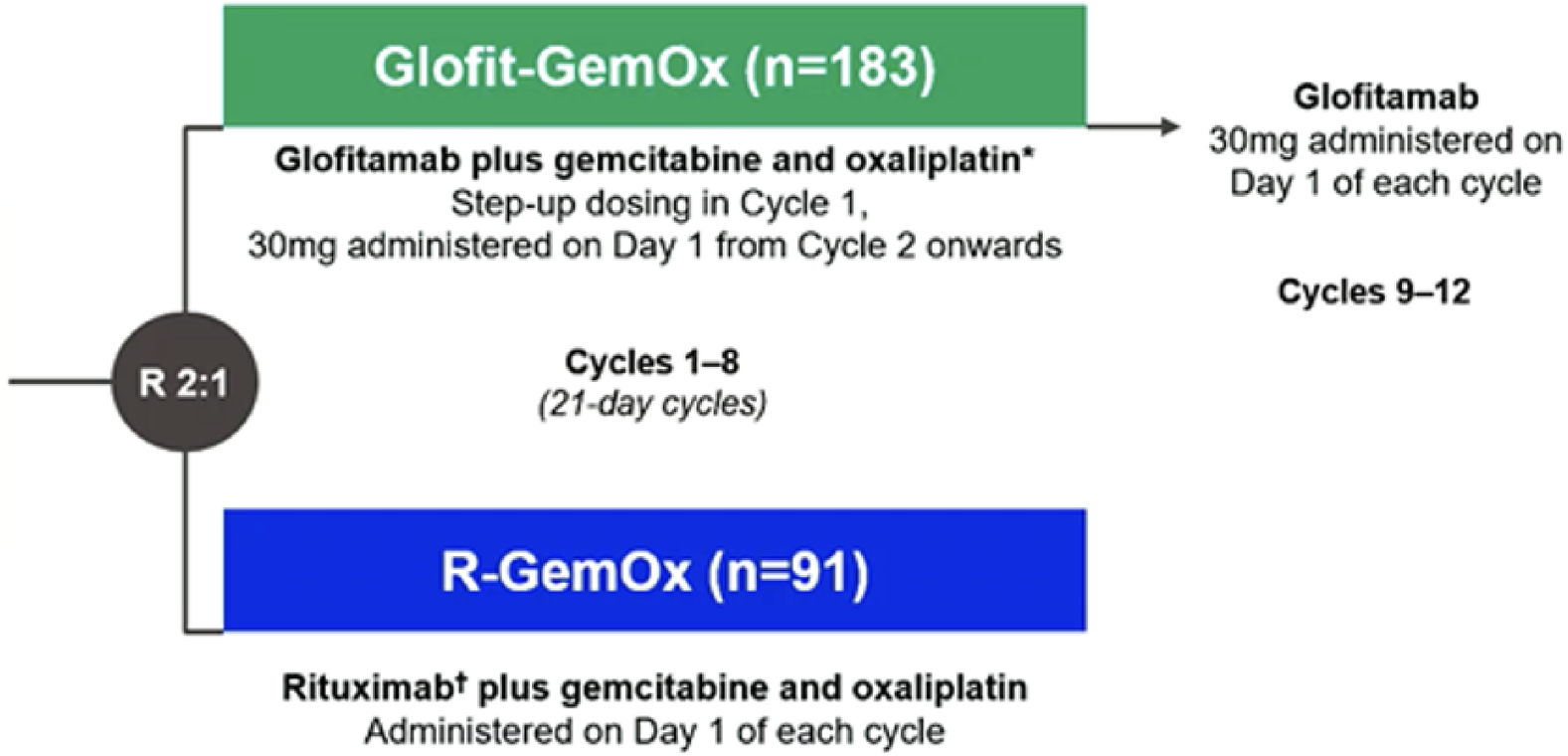
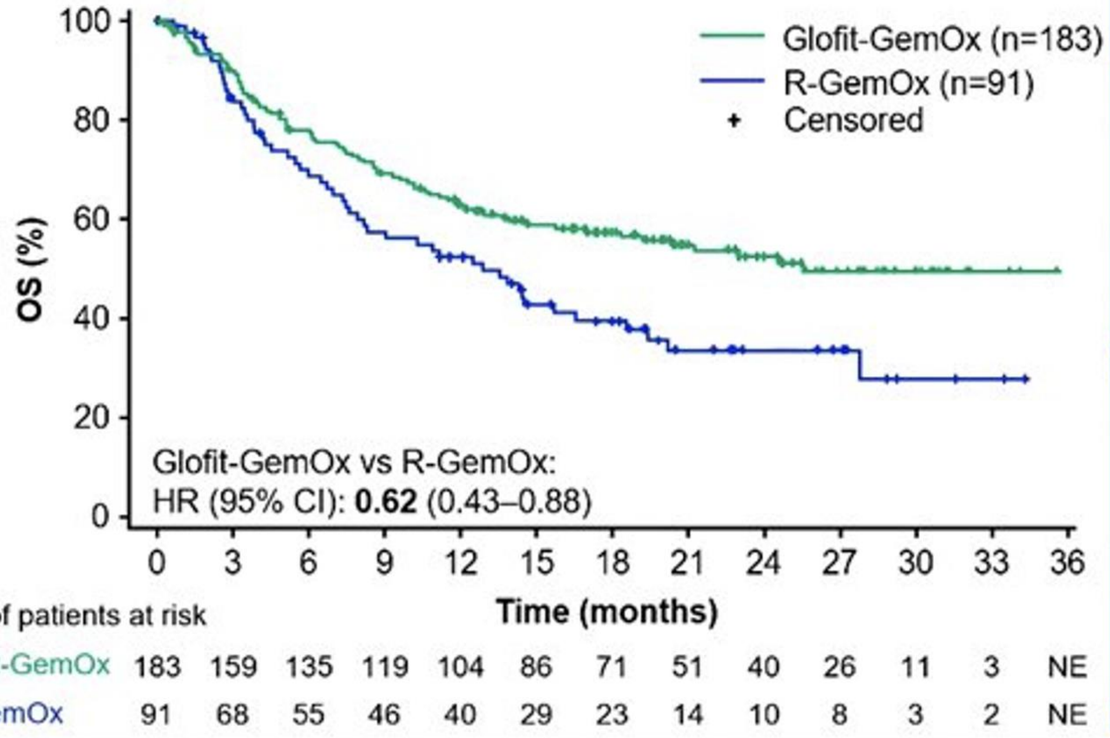
Combination regimens with BsAb in LBCL: STARGLO



Abramson et al, *EHA*, 2024

Combination regimens with BsAb in LBCL: STARGLO

Updated analysis



	R-GemOx (n=91)	Glofit-GemOx (n=183)
Primary analysis (median follow-up: 11.3 months)		
OS, median (95% CI); months	9 (7.3–14.4)	NE (13.8–NE)
HR (95% CI)	**0.59** (0.40–0.89)	
p-value*	0.011	
Updated analysis (median follow-up: 20.7 months)		
OS, median (95% CI); months	12.9 (7.9–18.5)	25.5 (18.3–NE)
HR (95% CI)	**0.62** (0.43–0.88)	
p-value*	0.006	
24-month OS (95% CI)	33.5% (22.2–44.9)	52.8% (44.8–60.7)

Statistically significant and clinically meaningful **OS benefit for Glofit-GemOx** vs R-GemOx

Abramson et al, *EHA*, 2024

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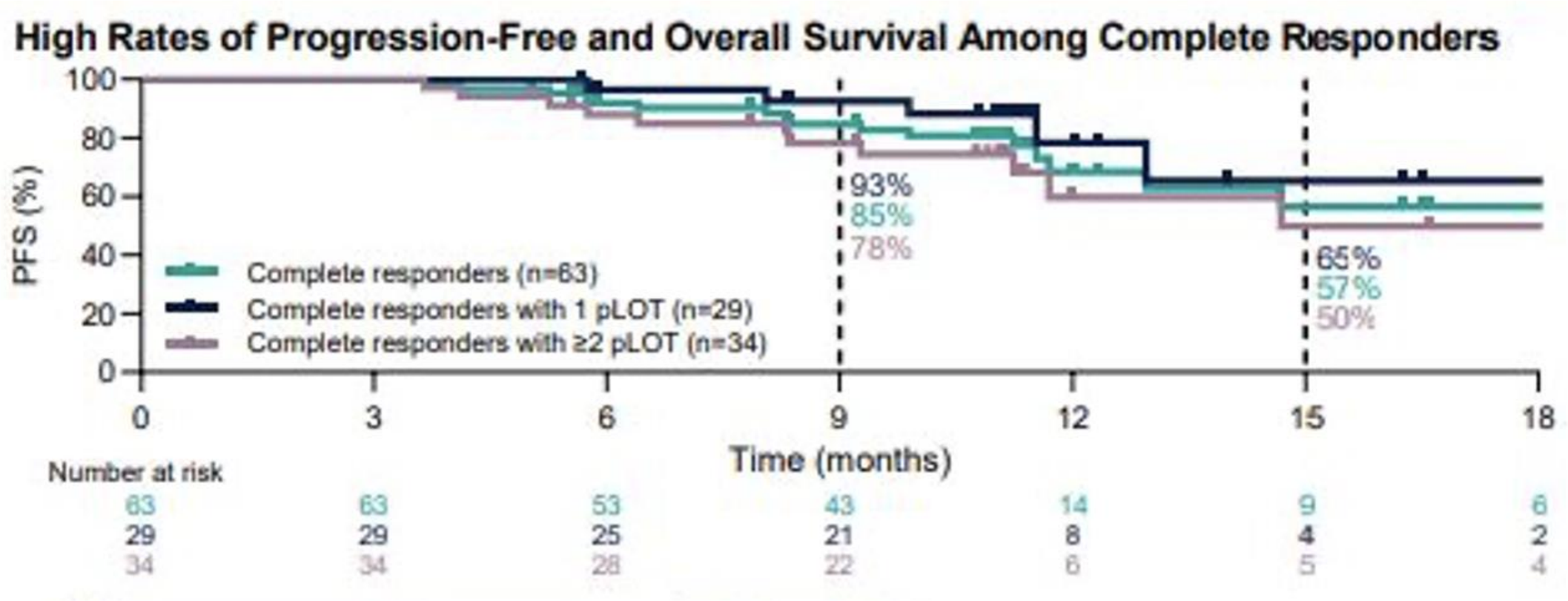
Combination regimens with BsAb in LBCL: STARGLO

n (%), unless otherwise stated	R-GemOx (n=88)	Glofit-GemOx (n=180)
Number of cycles,* median (range)	4 (1–8)	11 (1–13)
Any grade AEs	84 (95.5)	180 (100)
Rituximab/glofitamab related	58 (65.9)	149 (82.8)
Serious AEs	15 (17.0)	98 (54.4)
Rituximab/glofitamab related	7 (8.0)	62 (34.4)
Grade 3–5 AEs	36 (40.9)	140 (77.8)
Rituximab/glofitamab related	20 (22.7)	85 (47.2)
Grade 5 (fatal) AEs	4 (4.5)	15 (8.3)
Rituximab/glofitamab related	1 (1.1)	5 (2.8)
AE leading to any treatment discontinuation	11 (12.5)	48 (26.7)

The safety profile of Glofit-GemOx is **consistent with the known risk of the individual study drugs**

Abramson et al, *EHA*, 2024

Combination regimens with BsAb in LBCL: EPCORE-NHL 2



Cordoba et al, *SOHO*, 2024

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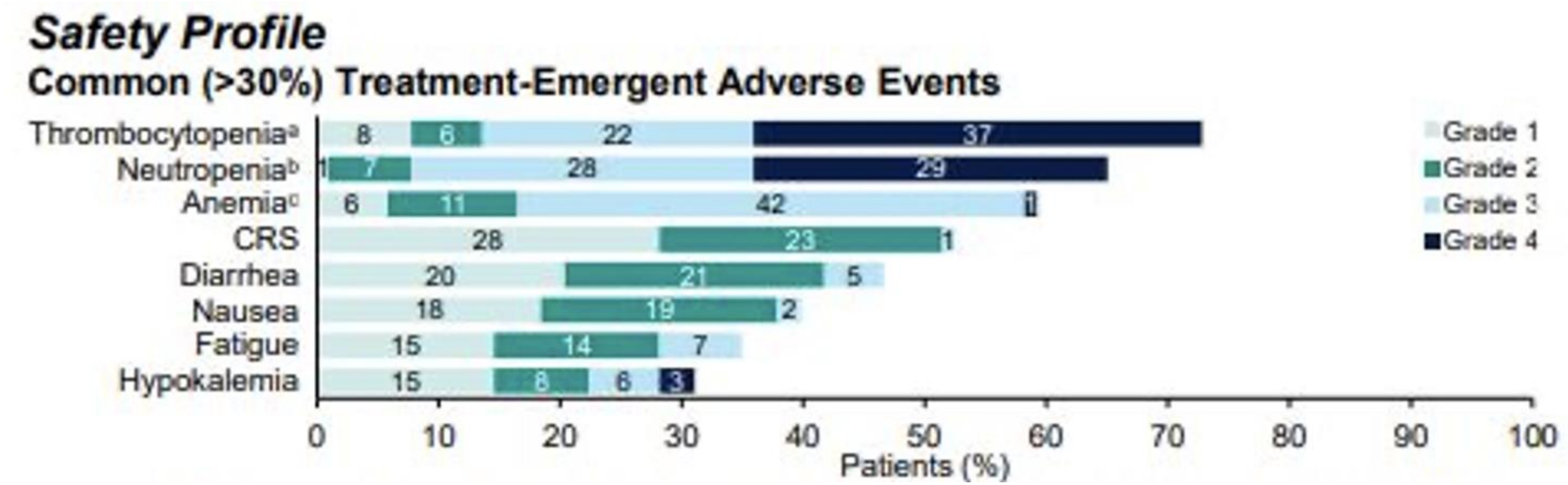
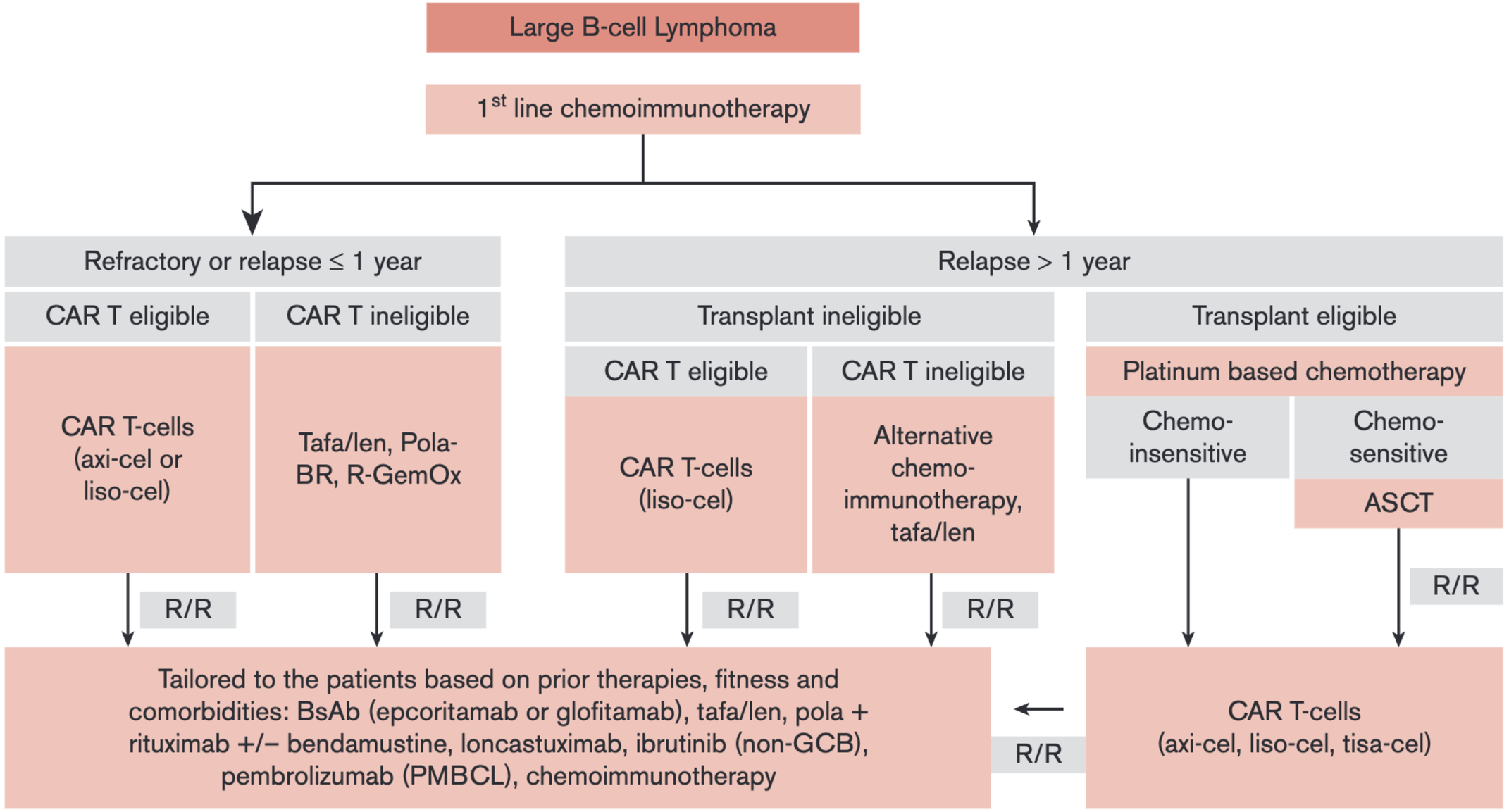
Combination regimens with BsAb in LBCL: EPCORE-NHL 2



Cordoba et al, *SOHO*, 2024



Haydu et al, *Blood Adv*, 2024

Bispecific Antibody Therapy for Indolent B-Cell Lymphoma

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Bispecific antibody therapies for indolent B-cell lymphomas

Mosunetuzumab

- Intravenous
- Time-limited (8 or 17 cycles)
- Approved December 22, 2022 (≥3L)

Epcoritamab

- Subcutaneous
- Continuous
- Approved June 26, 2024 (≥3L)

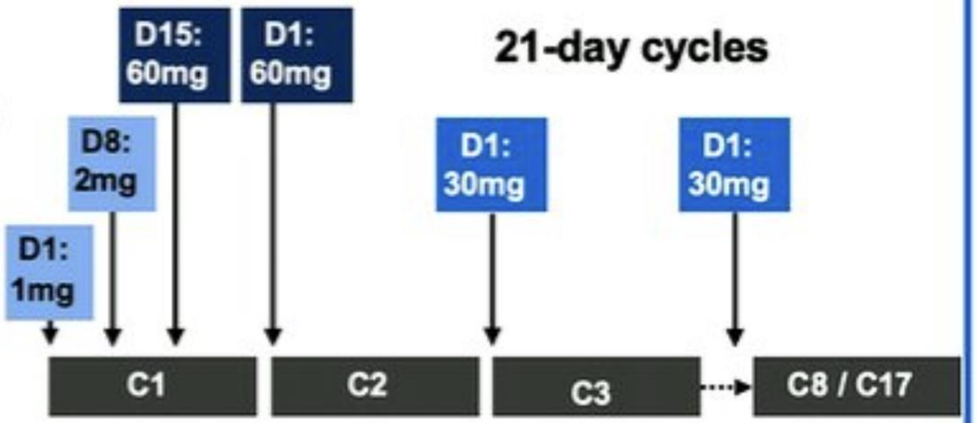
Mosunetuzumab (IV) in R/R follicular lymphoma

Key inclusion criteria

- FL (Grade 1–3a)
- ECOG PS 0–1
- ≥2 prior regimens, including
  - ≥1 anti-CD20 Ab
  - ≥1 alkylating agent

Mosunetuzumab administration

- Q3W intravenous administration
- C1 step-up dosing (CRS mitigation)
- **Fixed-duration treatment**
  - 8 cycles if CR after C8
  - 17 cycles if PR/SD after C8
- **No mandatory hospitalization**

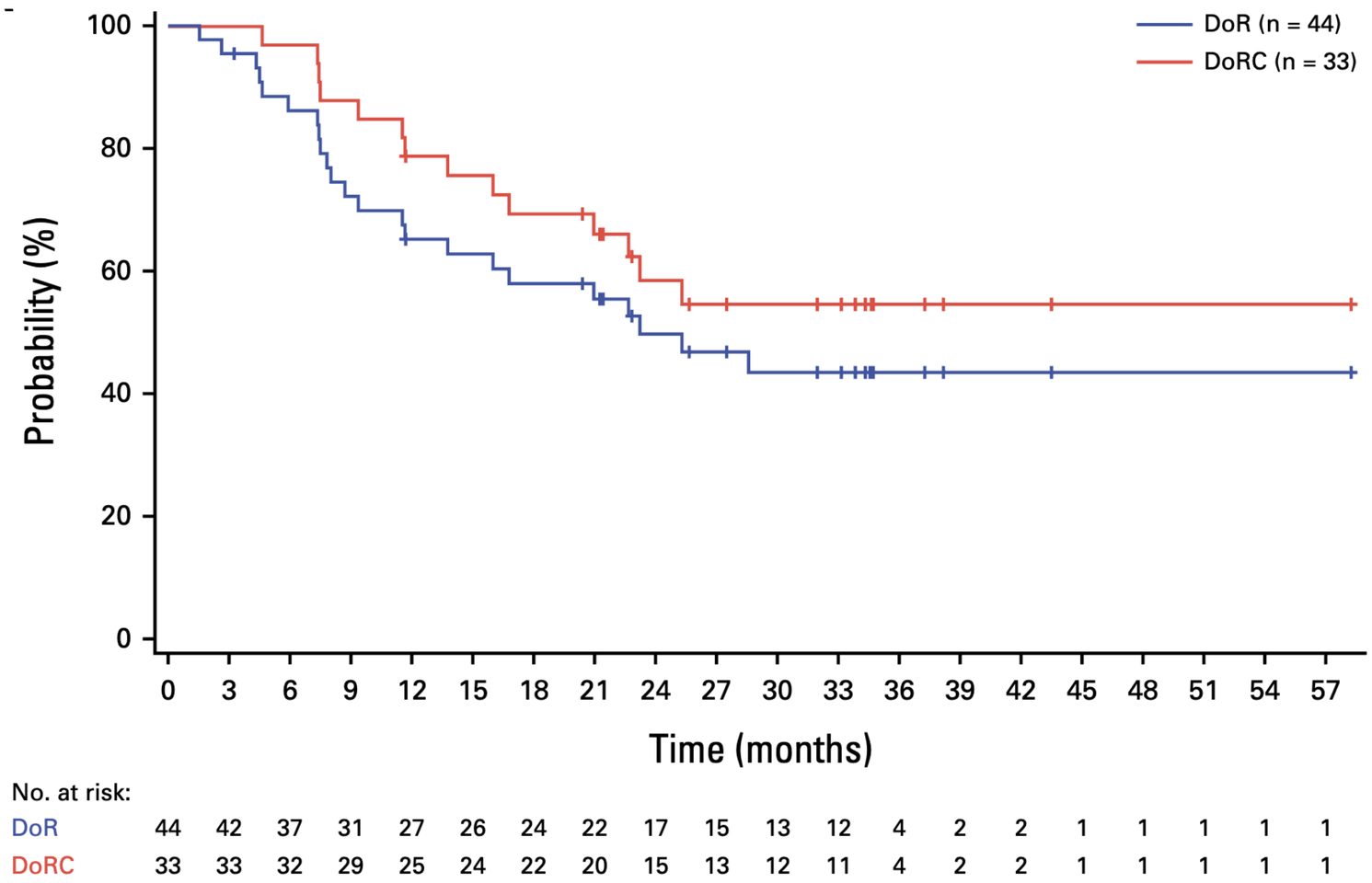


Endpoints

- Primary: CR (best response) rate by IRF* – assessed vs 14% historical control CR rate[1]
- Secondary: ORR, DoR, PFS, safety and tolerability

Nastoupil et al, SOHO, 2022

Mosunetuzumab (IV) in R/R follicular lymphoma



Budde et al, *JCO*, 2024

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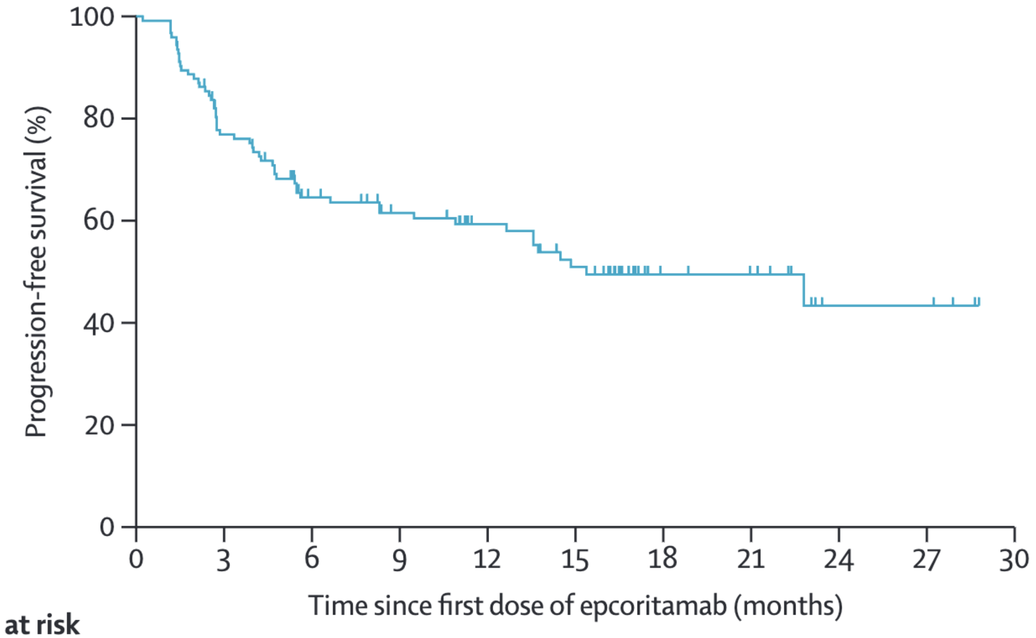
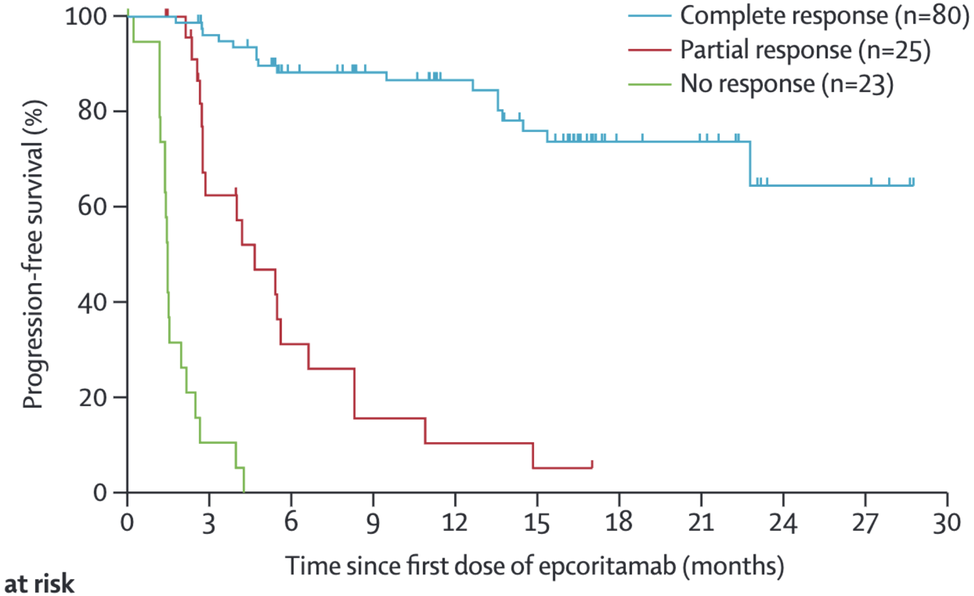
Epcoritamab (SC) in R/R follicular lymphoma



Number at risk (number censored)											
Pivotal cohort	128 (0)	90 (10)	67 (19)	57 (26)	43 (38)	35 (40)	14 (60)	12 (62)	4 (69)	4 (69)	0 (73)



Number at risk (number censored)											
Complete response	80 (0)	75 (2)	61 (10)	54 (17)	41 (29)	34 (31)	14 (50)	12 (52)	4 (59)	4 (59)	0 (63)
Partial response	25 (0)	13 (4)	6 (5)	3 (5)	2 (5)	1 (5)	0 (6)	0 (6)	0 (6)	0 (6)	0 (6)
No response	23 (0)	2 (4)	0 (4)	0 (4)	0 (4)	0 (4)	0 (4)	0 (4)	0 (4)	0 (4)	0 (4)

Linton et al, *Lancet Oncol, 2024*

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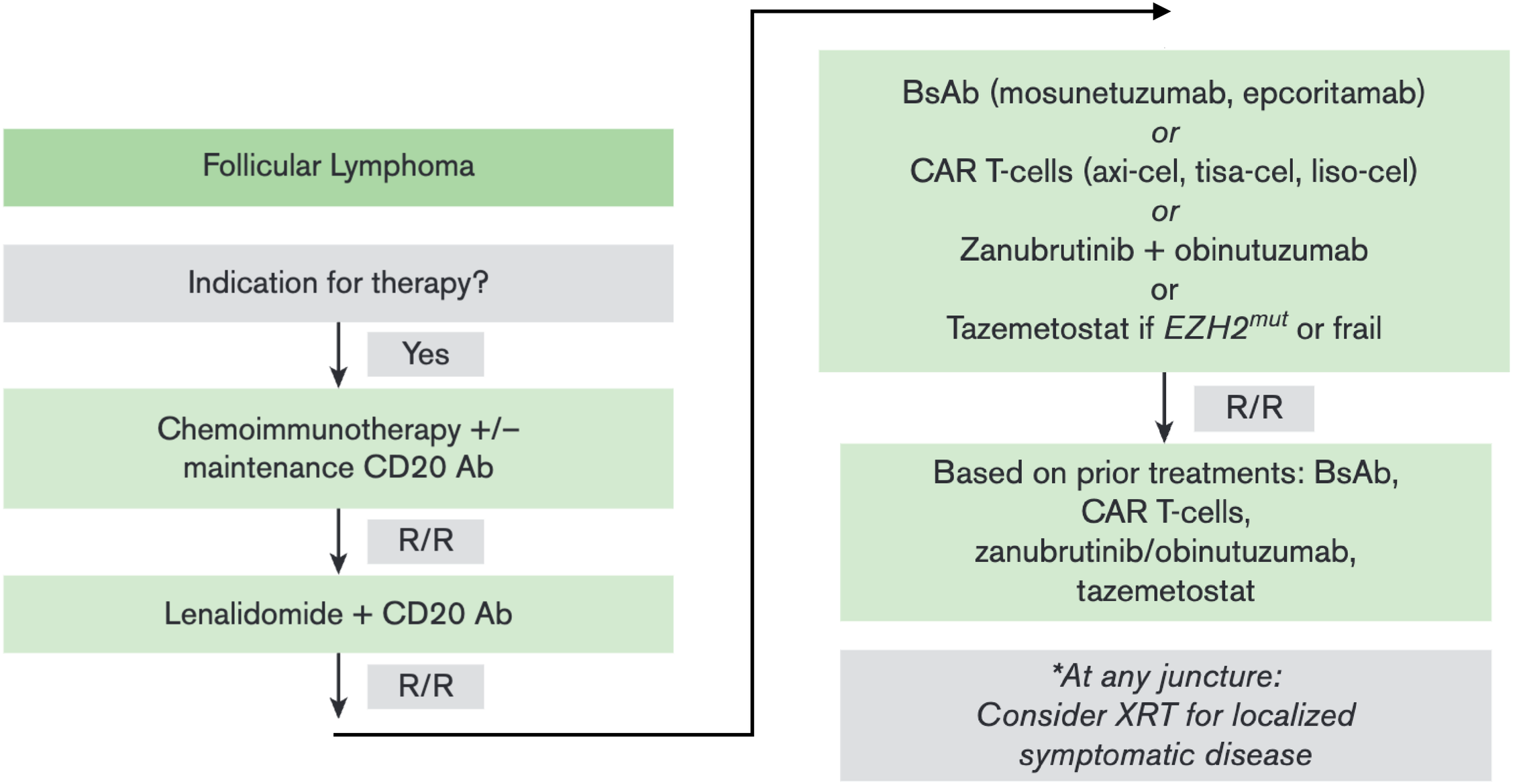

Haydu et al, *Blood Adv*, 2024

Bispecific Antibody Therapy Toxicity Management

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Common Toxicities of BsAb Therapies

- Cytokine release syndrome (CRS)
- Immune-effector cell mediated neurotoxicity syndrome (ICANS)
- Prolonged cytopenias
- Tumor flare reaction
- Infectious complications

Administration of various BsAb

	Mosunetuzumab	Epcoritamab	Glofitamab
Administration	IV, time-limited	SC, indefinite	IV, time-limited
Dosing schedule	C1: days 1, 8, 15 C2+: day 1, every 21 d, for up to 8 cycles in CR or up to 17 cycles for PR or SD	C1-3: days 1, 8 ,15, 22 C4-9: days 1 and 15 C10+: day 1, every 28 d until PD	C1: obin, day 1; glofit, days 8 and 15 C2-12: d1, every 21d
Risk mitigation strategy	Step-up dosing	Step-up dosing	Obinutuzumab Step-up dosing
Hospitalization	Optional	C1D15 for 24h	C1D8 for 24h

Cytokine Release Syndrome (CRS) in BsAb Therapy

	Mosunetuzumab					Epcoritamab					Glofitamab				
CRS Grade	G1	G2	G3	G4	G5	G1	G2	G3	G4	G5	G1	G2	G3	G4	G5
CRS Incidence	26%	17%	1%	1%	0%	34%	15%	3%	0%	0%	47%	12%	3%	1%	0%
Time to onset:	C1D1	23.3%	(5h)	C1D1	5.8%	(24h)	C1D1								
	C1D8	5.6%	(20h)	C1D8	11.8%	(24h)	C1D8	42.8%	13.5h						
	C1D15	36.4%	(27h)	C1D15	42.3%	(20h)	C1D15	25.2%	(6-52)						
	C2D1	10.3%	(38h)	C1D22	4.9%	(24h)	C2D1	26%							
	C3D1+	2.4%	(na)	C2D1+	3%	(na)	C3D1+	0.9%							
Median duration of CRS	3d (1-29d)					2d (1-27d)					2.5d (1-34d)				

Crombie et al, *Blood*, 2024

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Management of Cytokine Release Syndrome

Grade and definition	Management
Grade 1: Fever* of ≥100.4°F with/without constitutional symptoms requiring symptomatic treatment, no hypotension or hypoxia	Home: • A/P 650-1000 mg orally, can repeat, if recurrent fever, ≥6-8 h later if clinically stable • Recommend aggressive oral hydration • Continue to check temperature every 1-2 h and other vitals if able. Patients should recontact the clinic urgently or present to ED if BP goes <10 mm Hg below baseline AND <90 mm Hg systolic, new orthostatic symptoms, weakness, confusion, dizziness, or new hypoxia (<90%). Home vs outpatient/ED evaluation: • If refractory or recurrent fever (<6-8 h) consider dexamethasone 10 mg once. Home management may be appropriate if vital signs remain stable and no other concerning symptoms. Otherwise, patients should be evaluated in a health care facility. • Consider earlier administration of steroids and immediate in-person evaluation for patients with multiple disease risk factors or comorbidities (see text) • Consider daily dexamethasone with persistent symptoms Additional management: • Consider anticytokine therapy (eg, tocilizumab) in cases of protracted fever (eg, >48 h despite corticosteroids) • Early tocilizumab after trial of dexamethasone should be considered for patients with multiple medical risk factors (eg, comorbidities)

Crombie et al, *Blood*, 2024

Management of Cytokine Release Syndrome

Grade 2: Fever of ≥100.4°F with either hypotension not requiring pressors and/or hypoxia managed with low-flow nasal canula or blow-by.	• All patients should be urgently evaluated in person. Recommend inpatient management for most cases of grade 2 CRS unless qualified outpatient day hospital/infusion center and no hypoxia. • If after hours without access to appropriate outpatient treatment area or if clinical scenario dictates, recommend ED evaluation • A/P 650-1000 mg as needed, up to 3-4 times daily • Dexamethasone 10 mg every 12 h • Administer IV fluids/supplemental oxygen as appropriate • Administer tocilizumab† if symptoms persist despite IV fluids and dexamethasone (~4-6 h after dosing) or if clinically unstable. Consider alternative agent (eg, anakinra or siltuximab) if persistent symptoms despite maximal dosing.

Crombie et al, *Blood*, 2024

Management of Cytokine Release Syndrome

Grade 3: Fever of ≥100.4°F with either hypotension (BP <90/60 or <10 mmHg below, not responsive to fluids and/or hypoxia requiring high-flow nasal canula, face mask, or venturi mask)	• Emergent inpatient admission (floor or ICU) for hemodynamic monitoring, IV fluids, oxygen therapy, and vasopressors • A/P 1000 mg IV as needed up to 3-4 times daily when safe • Dexamethasone (eg, 10 mg IV Q 6 h), until resolution to grade ≤1, followed by dexamethasone taper • Evaluate for sepsis and consider empiric antibiotics • Administer tocilizumab† and consider alternative agent (eg, anakinra or siltuximab) if persistent grade 3 CRS despite maximal dosing • If refractory hypotension/hypoxia, admit to ICU
Grade 4: Fever of ≥100.4°F with any of the following: Life-threatening consequences, urgent intervention required; requiring multiple pressors and/or positive pressure respiratory support or mechanical intubation.	• Inpatient admission to ICU for hemodynamic monitoring, IV fluids, oxygen therapy, and vasopressors • A/P 1000 mg IV as needed up to 3-4 times daily when safe • Dexamethasone (eg, 20 mg IV every 6 h), until resolution to grade ≤1, followed by dexamethasone taper • Administer tocilizumab and if repeated doses of tocilizumab have been used, consider alternative agent (eg, anakinra or siltuximab) if persistent grade 4 CRS despite maximal dosing of first agent

Crombie et al, *Blood*, 2024

Immune Effector Cell Associated Neurotoxicity Syndrome (ICANS) in BsAb Therapy

	Mosunetuzumab				Epcoritamab					Glofitamab		
ICANS Grade	G1-2	G3	G4	G5	G1	G2	G3	G4	G5	G1-2	G3-4	G5
ICANS Incidence	3%	0%	0%	0%	4.5%	1.3%	3%	0%	0.6%	5%	3%	0%

Crombie et al, *Blood*, 2024

ASTCT Neurotoxicity – ICE Score Consensus Grading for Adults

ICE
Orientation: orientation to year, month, city, hospital: 4 points Naming: ability to name 3 objects (eg, point to clock, pen, button): 3 points Following commands: ability to follow simple commands (eg, "Show me 2 fingers" or "Close your eyes and stick out your tongue"): 1 point Writing: ability to write a standard sentence (eg, "Our national bird is the bald eagle"): 1 point Attention: ability to count backwards from 100 by 10: 1 point
Scoring: 10, no impairment; 7-9, grade 1 ICANS; 3-6, grade 2 ICANS; 0-2, grade 3 ICANS; 0 due to patient unarousable and unable to perform ICE assessment, grade 4 ICANS.

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Management of ICANS

ICANS grading	Management
Grade 1: ICE 7-9 or depressed level of consciousness but awakens spontaneously	• Pending clinical scenario and social situation, can consider observation or close monitoring in outpatient setting. Can consider dexamethasone 10 mg × 1
Grade 2: ICE 3-6 or depressed level of consciousness but awakens to voice	• Admit patient to hospital for monitoring • Dexamethasone 10 mg IV every 12 h, followed by taper once grade ≥1
Grade 3: ICE 0-2 or depressed level of consciousness but awakens to tactile stimulus or any clinical seizure that resolves rapidly or focal/local edema on neuroimaging	• Monitor in ICU setting • Neurology consult • Dexamethasone 10 mg IV every 6 h, followed by taper once grade ≥1 • Use antiepileptics for seizure management as needed • Consider adding anakinra 100 mg every 12 h if symptoms persist beyond 24 h, continue until resolution
Grade 4: ICE is 0 or patient is unarousable or requires vigorous or repetitive tactile stimuli, or life-threatening prolonged seizure (>5 min) or repetitive seizures without return to baseline or deep focal motor weakness or diffuse cerebral edema on neuroimaging	• Monitor in ICU setting • Neurology consult • Dexamethasone 10 mg IV every 6 h, followed by taper once grade ≥1 • Use antiepileptics for seizure management as needed • Consider adding anakinra 100 mg every 12 h if symptoms persist beyond 24 h, continue until resolution

Crombie et al, *Blood*, 2024

Tumor Flare Reaction

- Characterized by short-term volumetric increase in tumor burden, erythema, pain, and fever
- Typically occurs after first dose of BsAb
- Incidence 4-7%
- May cause organ compression or compromise
- Have risk mitigation plan in place when tumor flare could result in urgent scenario
  - Steroids / analgesics
  - Radiation
  - Surgical consultation

Cytopenias and Infections

- Cytopenias are common following BsAb in B-cell NHL
  - Neutropenia: 20-40% (Avoid GCSF during SUD and active CRS)
  - Anemia: 15-45%
  - Thrombocytopenia: 10-25%
- Infectious risk is significant in clinical trial patients, probably higher in real world cohorts (robust data lacking here)

Table 1. Summary of included clinical trials by malignant target and bispecific product

Malignant target	BsAb	No. of trials	Lymphoma subtype (no. of trials)	No. of patients	All-grade infection, % (95% CI)	Median length of follow-up, mo (IQR)
CD20	Epcoritamab	7	Aggressive (5), indolent (1), and B-cell NHL NOS (1)	470	39 (29-47)	11.4 (6.1-17.1)
	Glofitamab	7	Aggressive (6) and B-cell NHL NOS (1)	618	42 (30-53)	10.6 (6-15)
	Mosunetuzumab	6	Aggressive (3), indolent (2), and B-cell NHL NOS (1)	599	43 (47-50)	12.5 (8-28.5)
	Odronextamab	3	Aggressive (1), indolent (1), and B-cell NHL NOS (1)	414	59 (48-69)	21 (NR)

NR, not reported; NHL, non-Hodgkin lymphoma; NOS, not otherwise specified.

Reynolds et al, *Blood Adv*, 2024

Infectious Prevention Strategies

Strategy	Specification	Action Taken
Vaccination	VZV Pneumococcal spp. Influenza COVID-19	If possible, should vaccinate prior to initiating BsAb therapy
Viral testing (prior to therapy initiation)	HBV HCV HIV EBV CMV	Entecavir (or other hepatitis prophylaxis) if indicated Pre-emptive treatment of CMV reactivation
Pretreatment level assessment	IgG	IVIG if IgG <400 mg/dL
Prophylaxis	Antiviral PJP Antibacterial Antifungal	Strongly recommended Strongly recommended Institutional guidelines Institutional guidelines

Braun et al, *ASCO Educ*, 2024

Future Directions and Challenges in Bispecific Therapy

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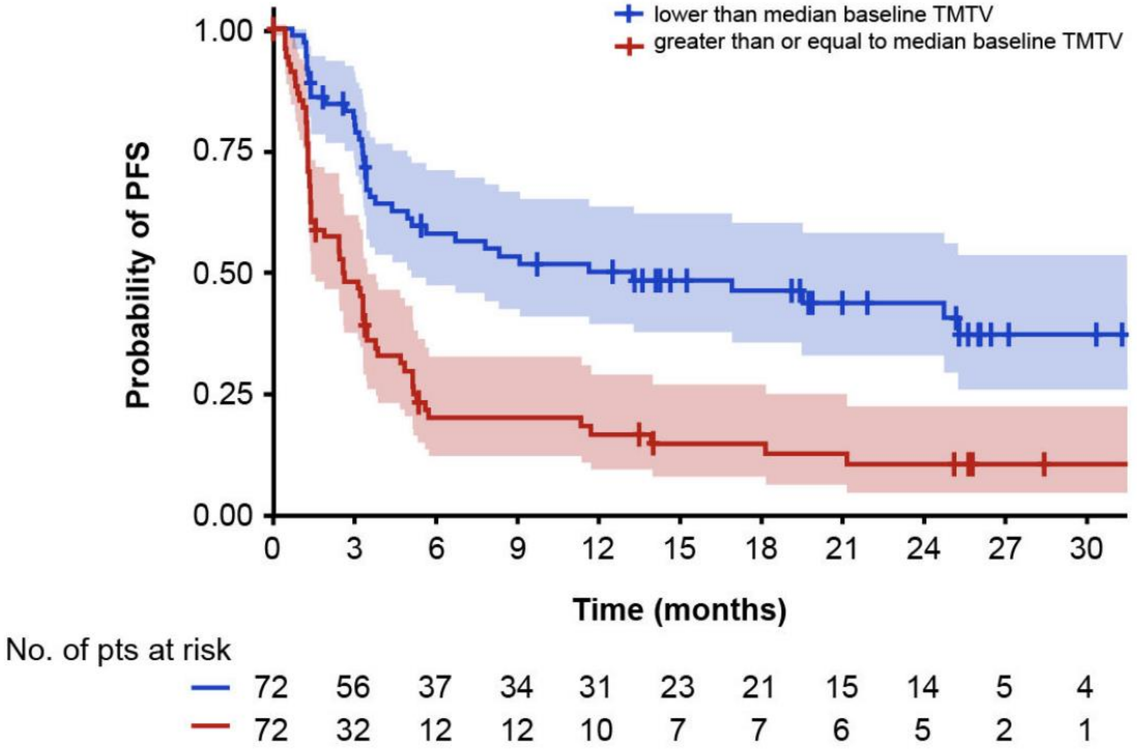
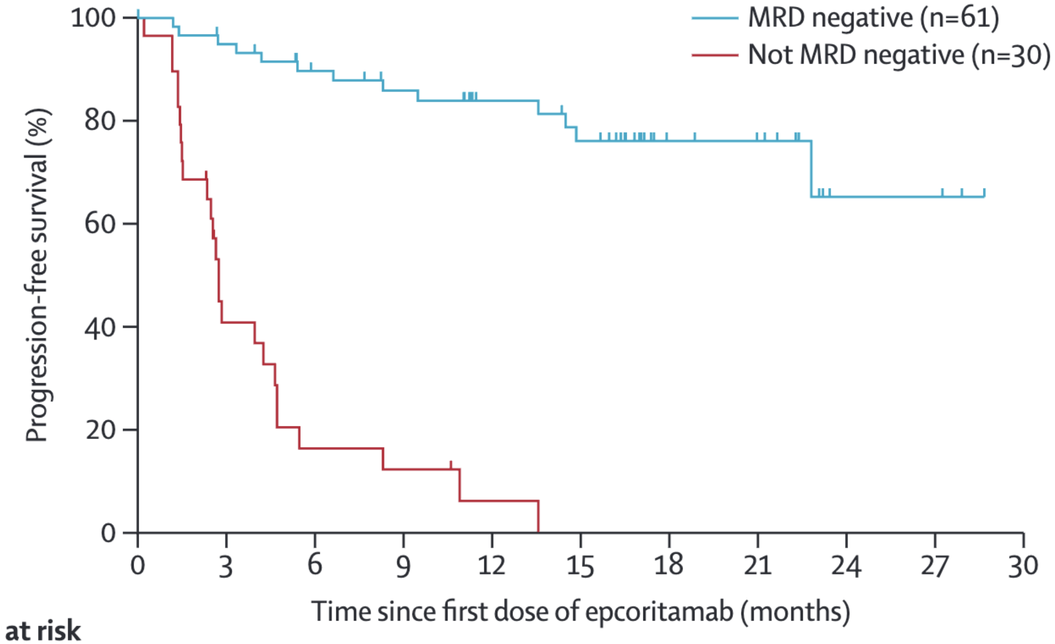
Forthcoming Studies

- ASH 2024 (selected)
  - Abstract 987: Glofi-R-ICE in transplant or CAR T-eligible R/R LBCL
  - Abstract 988: Glofi + pola in R/R LBCL
  - Abstract 3100: BsAb outcomes in real world UK cohort
  - Abstract 111: BsAb outcomes in real world US cohort
  - Abstract 582: Glofi+ R-CHOP/pola-R-CHP in high risk DLBCL
  - Abstract 1627: FD Epco+BR in 1st line FL
  - Abstract 867: FD Epco mono in 1L, anthracycline-ineligible LBCL
  - Abstract 3110: FD Epco + lenalidomide in R/R LBCL
  - Abstract 581: FD Epco + R-CHOP in 1st line LBCL

MRD as a prognostic marker in BsAb therapy



Glofitamab in LBCL



Number at risk (number censored)											
MRD negative	61	56	48	43	33	29	13	11	3	3	0
	(0)	(2)	(7)	(10)	(19)	(20)	(36)	(38)	(45)	(45)	(48)
Not MRD negative	30	10	4	3	1	0	0	0	0	0	0
	(0)	(4)	(4)	(4)	(5)	(5)	(5)	(5)	(5)	(5)	(5)

Epcoritamab in FL

Hutchings et al, *Blood*, 2023; Linton et al, *Lancet Oncol, 2024*

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CAR T-cell therapy OR Bispecific Antibody Therapy??

CAR T-cells	Bispecific Antibodies
Excellent efficacy	Excellent efficacy
Manufacturing process (3-4 weeks)	Available off-the-shelf
Usually inpatient, followed by period of time proximal to administering center for monitoring	Usually outpatient, initially with weekly visits that ultimately space out depending on product
"One and done"	Months (fixed duration) or continuous treatment
Requires lymphodepleting chemotherapy +/– bridging	No lymphodepleting chemotherapy or bridging
Higher risk of, and less predictable, CRS and NT	Less risk of, and more predictable, CRS and NT
Infections and cytopenias are common; likely higher rates and more prolonged	Infections and cytopenias are common; potentially lower rates but more follow up needed
Durable responses with years of follow up	Longer follow up needed for response durability

Haydu et al, *Blood Adv*, 2024

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Summary Points

- BsAb therapy has shown remarkable efficacy in a subset of patients with NHL, in particular among those who achieve CR
- Longer follow-up is needed and we cannot yet make assumptions about curative potential of these therapies
- There are 3 FDA approved BsAb therapies for indolent and aggressive NHL
- Toxicity can be significant
  - CRS, common but low grade
  - ICANS is rare
  - Infections and prolonged cytopenias common and preventive strategies should be clearly defined
- BsAb actively being explored in combination regimens in 1st line and R/R

Thank you!

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