Lumanity perspectives

EHA 2026 Congress

June 11–14, 2026 | Stockholm, Sweden

Exploring the role of bispecific antibody-based strategies across the multiple myeloma treatment continuum



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Elranatamab (Elrexfio, Pfizer)
in Phase 2 ERASMM trial for patients with high-risk smoldering multiple myeloma (HR-SMM) (S205)[1]
Teclistamab (Tecvayli, J&J)
in Phase 2 ImmunoPRISM trial in patients with high-risk smoldering multiple myeloma (HR-SMM) (LB5008)[2]
Talquetamab (J&J) +
daratumumab +/- pomalidomide in Phase 3 MonumenTAL-3 as first in class redirecting bispecific antibody targeted GPRC5D and CD3 for RR MM (2503)[3]

One clear message from EHA 2026 was that bispecific antibody-based strategies (BsAbs) are no longer confined to late-line, heavily pre-treated patients - data presented across the congress points to an expanding role from high-risk smoldering disease through to relapsed/ refractory settings. With this shift to earlier lines, a new set of questions for the field arises around sequencing, access and what comes next for patients across a longer treatment journey.

The phase 2 **ERASMM** trial speaks to bringing BsAbs earlier in the disease journey – treating patients before active myeloma develops, in the high-risk smoldering setting. At a median follow-up of 14 months, **single-agent elranatamab** achieved an ORR of 92%, including a CR rate of 72%, with MRD negativity in 90% of evaluable patients with suspected CR. PFS was 96% and no patients progressed to active myeloma.[1]

The Phase 2 **ImmunoPRISM** trial complements **ERASMM** data, with **teclistamab** shown to outperform lenalidomide plus dexamethasone in high-risk SMM — 75.6% of patients achieved a CR vs. none in the combination chemotherapy arm, and 82% of evaluable patients became MRD-negative with teclistamab.[2]

ERASMM and **ImmunoPRISM** make a compelling early case that if confirmed in larger studies could be a paradigm shift of BsAbs intercepting disease before it becomes active myeloma.

In RRMM, the phase 3 **MonumenTAL-3** trial showed that talquetamab plus daratumumab (Dara) +/- pomalidomide (Pom) showed significantly improved PFS (HR: Tal-DP, 0.28; Tal-D, 0.33). This has resulted in clinically meaningful improvements in OS, as well as a consistent safety profile with individual agents.[3]

MonumenTAL-3 is the first Phase 3 study of a **GPRC5D-targeted therapy** in RRMM and validates GPRC5D as a clinically proven target in earlier-line relapsed disease — opening the door to a true two-target BsAb landscape in MM (BCMA + GPRC5D), with meaningful sequencing and combination possibilities.

Another key highlight from EHA moves beyond trial results and focuses on the increasing number of patients that will be receiving BsAbs, exploring how to make it simpler, smoother and more tolerable for patients. Efforts are now going in the direction of overcoming operational and access challenges of moving BsAbs beyond academic centres to outpatient and community settings.[4]

Innovation is only transformative if patients can actually receive them. Current infrastructure requirements of in-patient step-up dosing (SUD) is a real barrier, more so for those in remote or underserved areas. The BOSS programme (outpatient step-up dosing with **elranatamab**) showed significantly lower rates of CRS and ICANs vs in-patient step-up dosing, with 87% of patients avoiding hospitalization.[5] There is also a strong patient preference for remote patient monitoring over hospital stays. However, there is a need for defined minimum infrastructure, that harmonizes frameworks, and education on safe outpatient step-up protocols to ensure community-setting readiness.

The data from EHA 2026 signals a meaningful shift in how BsAbs are being used — but moving these therapies earlier raises as many questions as it answers. The emerging BsAb story in MM is not just about efficacy — it is about building a treatment ecosystem that is sequencable, deliverable, and equitable.

As BsAbs move earlier the challenge shifts from efficacy to strategy: not just which BsAb, but in what order, after what, and for how long. Resolving the sequencing complexity that earlier use creates and building the community infrastructure to ensure patients can access these therapies.

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Shout-outs: Additional advances

What is going to define the next decade of hematology?

The hematology space is shifting from treating the disease to more dynamically managing the disease. Updates in MRD monitoring, optimal sequencing with greater combination therapy use and more personalized treatment approaches is just the beginning.

Additional congress highlights are summarized here.

Contact@lumanity.com for a more detailed discussion around these advances.

01

The growing role of MRD

Not only a prognostic tool but now a guide for treatment[6]

- New qualitative MRD response categories: optimal, warning, high risk of treatment failure
- Lower MRD cutoffs introduced for NPM1, with specific distinctions between peripheral blood and bone marrow
- FLT3-ITD UHS-NGS testing recommended after 2 cycles of chemo and prior to AlloSCT
- ELN-DAVID launched as an open platform for advancing MRD standardization in AML

02

Role of Menin inhibitors in Acute Myeloid Leukemia (AML)[7]

- The most prominent emerging class — relevant in **40–50% of AML cases**
- Combinations being explored: Menin/7+3 (KOMET-017), Menin/VenAza (Beat AML substudy, KOMET-07)
- Resistance remains a challenge — ~40% of patients on prolonged menin inhibitor therapy (>2 months) develop acquired MEN1 mutations
- Post-AlloSCT maintenance with revumenib is under investigation

03

RISE UP Phase 3 Trial:

potential of mitapivat as a novel treatment option for patients with sickle cell disease[8]

- Demonstrated significant improvement in hemoglobin response with new analyses showing patients in the mitapivat arm having clinically meaningful reduction in transfusion burden compared with placebo
- Mitapivat was well-tolerated, with the safety profile remaining consistent with previous trials in sickle cell disease with mitapivat

1. ERASMM (EMN34) study: Broijl A. et al. Presented at EHA 2026 Annual Meeting. Stockholm. Abstract: EHA-3326 Short: S205
2. ImmunoPRISM study: Nadeem O. et al. Presented at EHA 2026 Annual Meeting. Stockholm. Abstract: EHA-7181 Short: LB5008
3. MonumenTAL-3: Voorhees P. Et al. Presented EHA 2026 Annual Meeting. Stockholm. Abstract: EHA-2503 Short: S100
4. M. Mateos, E. Zamagni, M. Gentile, et al. "European Recommendations for Transitioning the Care of Patients With Multiple Myeloma Treated With B-Cell Maturation Antigen Bispecific Antibodies From Academic Hospitals to Community-Based Centers and for Outpatient Step-Up Dosing." *eJHaem7*, no. 3 (2026): e70290.
5. D. Cirstea, E. Bridget Kim, S O'Neill et al. "Implementing the bispecific outpatient safe step-up (BOSS program) for elranatamab in ambulatory treatment of multiple myeloma." *J Clin Oncol* **43** (2025):e19507
6. Heuser H. Presented at EHA 2026 Annual Meeting. Stockholm. Presentation ID p250-1
7. Zneider J. JCO 2025 Roboz G ASH 2025 Abstract: 766
8. Andemariam et al. Presented at EHA 2026 Annual Meeting. Stockholm. Abstract: EHA-2778 Short (S102)

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