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# Expert Discussion: Building Unique Networks and Partnerships to Bring Novel Therapies to Remote Patients

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# About the Experts

## Arleigh Robertson McCurdy, MHA, MD, FRCPC

Dr. Arleigh Robertson McCurdy is an Associate Professor in the Faculty of Medicine at the University of Ottawa, Lead of the Multiple Myeloma Program at The Ottawa Hospital, and a Clinician Investigator at The Ottawa Hospital Research Institute. Her clinical research is focused on multiple myeloma and related disorders. She is a member of the Canadian Cancer Trials Group Myeloma Committee, the International Myeloma Working Group, and she is currently the Treasurer on the Canadian Myeloma Research Group Board of Directors.

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## Nicole Laferriere, MD, Ph.D, FRCPC

Dr. Laferriere completed an HBSc degree in Medical Laboratory Science at Lakehead University and a PhD in Cell Biology at the University of Ottawa. She completed her undergraduate medical degree at McMaster University, then attended the University of Ottawa for Internal Medicine and Hematology Residency. She has been a full time Hematologist in the Regional Cancer Program since 2005. From 2015–2023 she held the appointment of Chief of Oncology. She is the Medical Director and Systemic Therapy Regional Quality Lead for Cancer Care Northwest. She is an Associate Professor at NOSM and Past President of the Canadian Hematology Society. She is the recipient of the College of Physicians and Surgeons of Ontario (CPSO) 2020 Council award.

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# Expert Discussion: Building Unique Networks and Partnerships to Bring Novel Therapies to Remote Patients

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*Novel, highly effective therapies for multiple myeloma are raising hopes, while also adding complexity to treatment decisions and care management. Recently, Canadian Hematology Today sat down with two Canadian experts and discussed what the availability of novel therapies means for patients, and how clinical leaders are coordinating care to improve access for patients in Northern Ontario.*

**The newest approved therapy for multiple myeloma patients is belantamab mafodotin. How will this treatment impact your practice?**

**Arleigh McCurdy:** Blenrep, or belantamab mafodotin, targets B-cell maturation antigen (BCMA) – the same target of the bispecific antibodies and CAR T-cell therapies that are entering the myeloma space. What's unique about belantamab mafodotin is that it's an antibody drug conjugate. Belantamab is the BCMA-targeting antibody and mafodotin is the active chemotherapeutic part of the drug.

Belantamab mafodotin is typically given intravenously every 2 to 4 months, depending on the patient. While it's very well tolerated, it is linked to ocular toxicity. When implementing this very effective and very convenient therapy, we need to have our ducks in a row, so to speak, to manage the ocular toxicity.

**Nicole Laferriere:** I work in Thunder Bay, in a remote part of Ontario. Our central core value is to be able to provide treatment close to home as much as possible. Belantamab mafodotin is an ideal therapy for second- and third-line myeloma patients who want care close to home. We are currently working in partnership with The Ottawa Hospital so that we can safely deliver belantamab mafodotin and monitor patients for these toxicities across our region.

**Is this new therapy filling an unmet need for your myeloma patients?**

**A.M.:** Belantamab mafodotin is the first off-the-shelf, BCMA-targeted therapy to be available as early as the second line. In the second- and third-line settings, both belantamab mafodotin, pomalidomide, and dexamethasone (BPd) and belantamab mafodotin, bortezomib and dexamethasone (BVd) have demonstrated very strong response rates and durable remissions, even when compared to highly effective daratumumab combinations.

The ideal patient for belantamab mafodotin therapy is the second- or third-line patient who is lenalidomide-refractory. Patients may have had daratumumab in front line. The infrequent dosing has broad appeal for all patients, particularly patients who live far from treatment centers. Belantamab may also be a consideration for patients with very high infectious risk, which becomes higher with the BCMA bispecific antibodies and necessitates immunoglobulin replacement monthly. The response rates and the durability of response in both BPd and BVd are similar to other BCMA-targeting agents, which aren't expected to be available in the second-line setting for at least a couple of years.

**N.L.:** Our catchment area is larger than the size of France. The catchment area includes about 270,000 people and 11 regional chemotherapy centers. A significant proportion of our patients may choose not to travel to Southern Ontario to receive treatments such as CAR T-cell therapy. Belantamab mafodotin is the best treatment for patients who want to access therapy here in the north, because of work or family obligations or because their support network is here, for instance.

**How do you coordinate care for myeloma patients between Ottawa and Thunder Bay?**

**A.M.:** We're fortunate in myeloma that we have options. If we decide that CAR T-cell therapy is the best option for a patient, and the patient agrees, we'll work to make that happen. If we decide belantamab mafodotin or bispecific therapy is the best option, we'll make that happen.

We are working on bispecific antibody delivery in Thunder Bay. Currently we coordinate the return of patients after ramp-up dosing in Ottawa. We then transfer the patients back after the acute cytokine release syndrome (CRS) risk window. With belantamab mafodotin, the care can be administered close to home, and our support in Ottawa is more in developing a network and protocols for ocular care monitoring.

**N.L.:** The coordinated care we provide is an exemplary model of patient-centred care.

There is an incredible ease of communication to make sure that patients' treatment histories, comorbidities, and preferences are seamlessly shared.

We also have patient rounds every two weeks as a multidisciplinary team. This team includes physicians from Ottawa and our center in Thunder Bay, as well as nurses in the complex malignant hematology program. We discuss every patient to make sure that everything is in place for the next step in their care, whether that be a prescription renewal or referral.

**A.M.:** Indeed, the communication piece is what drives the success of our coordinated care model. Treaters at both sites can contact each other, get timely answers to their questions, and share ideas. We have a symposium every year where the stakeholders and clinicians from both the Northern and Ottawa sites get together and talk about what's working, what isn't working, and how we can improve the flow of information.

Communication is so key, because making treatment decisions in myeloma is already challenging, and it's getting harder as new therapies emerge. Even amongst myeloma treaters, there are different approaches, so it's vital we keep communication pathways open and have ways to share resources and discuss cases.

**What role does access and funding play into the success of a coordinated model like yours?**

**N.L.:** Our province has been exceptional in creating a complex malignant hematology program, which involves numerous committees with physician input. This means the voices of physicians are heard at that very high level, which is vital for patient access.

**A.M.:** Myeloma patients take time off work to travel to Ottawa or Thunder Bay and they may have accommodation and transportation costs. The eye exams are not always covered by public and provincial plans. Combined funding from industry and the province has been essential to make travel and monitoring possible for patients. Some Patient Support Programs (PSPs) will even book transportation and hotel stays for patients. We don't want patients to turn down care because of costs, so it's really important to remove those roadblocks for patients.

**N.L.:** To travel to Ottawa for some of these therapies, it's essential for patients to have a caregiver with them. If they don't have that support person, they are more likely to require hospitalization. Both The Ottawa Hospital and many of our industry partners understand this, and they facilitate travel for caregivers as well.

**On top of inequities in access to therapies, there are also geographical inequities in accessing clinical trials. Are these barriers being addressed as well?**

**N.L.:** The Northern Health Travel Grant Program, which provides financial assistance for Northern Ontario residents who need to travel for health care, does not support the travel of patients to participate in a clinical trial. In Thunder Bay we do conduct clinical trials, however due to our smaller size we are limited in the number of trials that can be opened. We are working with Ottawa to expand access to clinical trials in more remote communities. Until we're able to include people from all parts of Canada in our clinical trials, studies will have an ongoing bias.

**A.M.:** Some patients have occasionally moved to Toronto or Montreal to access a clinical trial. But those are rare patients, with exceptional resources. Several national advocacy and research groups are working to support medium-sized sites to engage in clinical trials. Ideally, urban centres can partner with remote sites, similar to how we partner with the Thunder Bay site. We assist with enrolling and monitoring patients in the north and have successfully negotiated travel costs for clinical trial patients when needed. But the progress we're making is still relatively small, compared to the need. The contracting process with industry is unfortunately getting more complicated, rather than less complicated.

**We briefly discussed ocular toxicity, but novel therapies for myeloma are also associated with infections and other adverse events. How do patients in remote areas access advanced monitoring for novel adverse events?**

**A.M.:** Centres need to ensure they have defined pathways in place for managing adverse events, in accordance with best practice guidelines. For example, with bispecific antibodies, they need to outline whether they will use subcutaneous or IV Ig and how patients will be monitored for cytomegalovirus infection.

Treatment centres also need to clearly explain adverse event management to patients when they start the therapy. They should explain that they may need to travel back and forth to the center for subcutaneous or IV Ig, and detail any out-of-pocket costs for these additional therapies. This needs to be part of the informed consent discussion.

Belantamab mafodotin requires baseline ocular exams and ongoing assessments and that needs to be explicitly discussed with the patients at the consent stage. We're currently identifying ophthalmology and optometry partners who can perform timely slit lamp exams and communicate those results seamlessly so that the hematologist can adjust the dosing schedule of belantamab mafodotin, if needed.

We're also hoping to initiate bedside ocular assessments, based on visual acuity and symptoms, to minimize the number of slit lamp examinations.

**Do you involve ophthalmology upfront, when patients are being initiated on belantamab mafodotin?**

**A.M.:** We're fortunate in Ottawa because the Eye Institute is in our building. All our patients have baseline ocular assessments prior to starting belantamab mafodotin. During the belantamab mafodotin trials, we identified two ophthalmologists who were interested in participating in research, and they developed a skillset in this area. We also have about five optometrists in the community who have expressed interest in partnering with us. The optometrists will follow our patients, and they'll be able to contact the two ophthalmologists here at the Eye Institute, if they have any questions or need to refer complex cases.

**Dr. Laferriere, how do you manage toxicities associated with novel treatments in Thunder Bay?**

**N.L.:** We almost exclusively use subcutaneous Ig to avoid travel barriers, and this has worked out well. GSK is also helping us create a network of ophthalmologists to support our patients. In some of the communities we serve, there are no optometry services. People have to travel to Thunder Bay in order to access an optometrist. In the future, we hope to be able to administer eye chart assessments via telehealth.

**In addition to telehealth and networks of optometrists and ophthalmologists, are there any innovations that help with managing patients on novel therapies?**

**A.M.:** For ocular toxicity, a sub-study of the ALGONQUIN trial is assessing whether blocking contacts can reduce ocular toxicity. Drops haven't been successful, but we're hopeful that contacts will be able to block monomethyl auristatin F (MMAF) in the cornea.

Research shows that spacing out dosing of belantamab mafodotin mitigates ocular toxicity, without impacting efficacy. Even if physicians adjust the dose down from every 2 months to every 4 months, the outcomes appear to be almost the same. With this adjusted dosing schedule, there is no long-term vision impairment, and the symptoms resolve completely.

In other words, the right thing to do is hold the therapy, rather than press through the ocular toxicity or reduce the dose but keep the dosing frequency the same.

**N.L.:** Sometimes, simple improvements can make a big difference. For example, we're making sure that we're asking every patient standard questions at every assessment, to ensure we're comprehensively monitoring for unique toxicities. Physician education, support for patients and providers in underserved areas, and standardized protocols are all key ensuring patients can safely be treated with this highly effective therapy.

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