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DARZALEX FASPRO
(daratumumab and hyaluronidase)
for the Treatment of High-Risk Smoldering Multiple Myeloma

May 20, 2025

Oncologic Drugs Advisory Committee

Johnson & Johnson

Introduction

Sen Zhuang, MD, PhD

Vice President, Oncology Research & Development

Johnson & Johnson

Daratumumab is Well-Established Standard of Care Treatment for Multiple Myeloma (MM)

- Initial approval in 2015
  - > 500,000 patients treated worldwide
- 10 FDA approved indications, the most of any MM therapy
  - From frontline through relapsed refractory MM
  - Approved as monotherapy and in combinations
- Recommended in MM guidelines, including NCCN

Daratumumab Consistently Demonstrates Positive Benefit-Risk in Multiple Myeloma

- Consistent and compelling PFS benefit across approved indications
  - HR ranging from 0.37 to 0.63
- Improvements in OS demonstrated
  - HR ranging from 0.56 to 0.82
- Well-established favorable safety profile, including in combinations

AQUILA Study Designed to Address Limitations of Prior Studies in SMM

- Study design based on
  - Learnings from prior studies in SMM
  - Collaboration with myeloma experts
  - Agreement from global health authorities
- Enrollment criteria, endpoints, and use of advanced imaging addressed many of the limitations from prior studies
- AQUILA provides a robust assessment of a finite daratumumab treatment in high-risk SMM

AQUILA Supports Daratumumab Positive Benefit-Risk for Patients with High-Risk SMM

Unmet Need

- Half of patients with high-risk SMM likely develop active MM within 2-3 years
- Patients need safe/effective treatment that delays progression to MM
- Current standard of care is observation

Efficacy

- Statistically significant improvement in time to progression to active myeloma or death (PFS)
- Evidence of positive OS trend
- Supported by all secondary endpoints
- Comparable HRQoL over time

Safety

- Well-established safety profile
- Clinicians familiar in monitoring and managing AEs
- Most AEs reported align with labeling and were low grade

36-month daratumumab monotherapy significantly delays progression to active MM that requires continuous combination therapy with associated toxicities

Proposed Indication

DARZALEX FASPRO[1] as monotherapy for the treatment of adult patients with high risk smoldering multiple myeloma

1. daratumumab and hyaluronidase-fihj injection

Agenda

Introduction	**Sen Zhuang, MD, PhD** Vice President, Oncology Research & Development Johnson & Johnson
Unmet Medical Need	**Sagar Lonial, MD** Chair and Professor, Dept of Hematology and Medical Oncology Emory University School of Medicine
Efficacy	**Robin Carson, MD** Vice President, Oncology Research & Development Clinical Leader, Daratumumab Johnson & Johnson
Safety	**Robyn Dennis, MD** Senior Medical Director, Oncology Research & Development Johnson & Johnson
Clinical Perspective	**Vincent Rajkumar, MD** Edward W. and Betty Knight Scripps Professor of Medicine Mayo Clinic

Additional Experts

Peter Voorhees, MD	**Professor of Medicine,** Atrium Heath Levine Cancer Institute, Wake Forest University School of Medicine
Johnson & Johnson	
Katharine Gries, PharmD, PhD	**Senior Director, Patient Reported Outcomes**
Ivo Nnane, PhD	**Distinguished Scientist II, Clinical Pharmacology**
Ke Zhang, PhD	**Senior Director, Biostatistics**

No external experts received compensation for their time

Background and Unmet Need

Sagar Lonial, MD

Chair and Professor

Department of Hematology and Medical Oncology

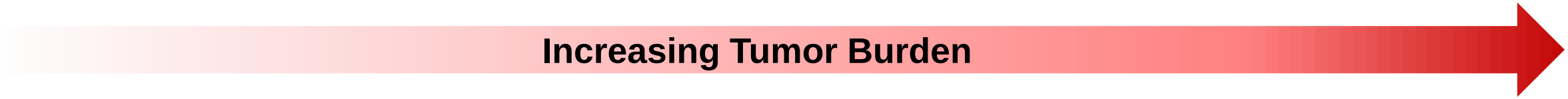
Anne and Bernard Gray Family Chair in Cancer

Chief Medical Officer

Winship Cancer Institute

Emory University School of Medicine

SMM as Part of Multiple Myeloma Disease Continuum

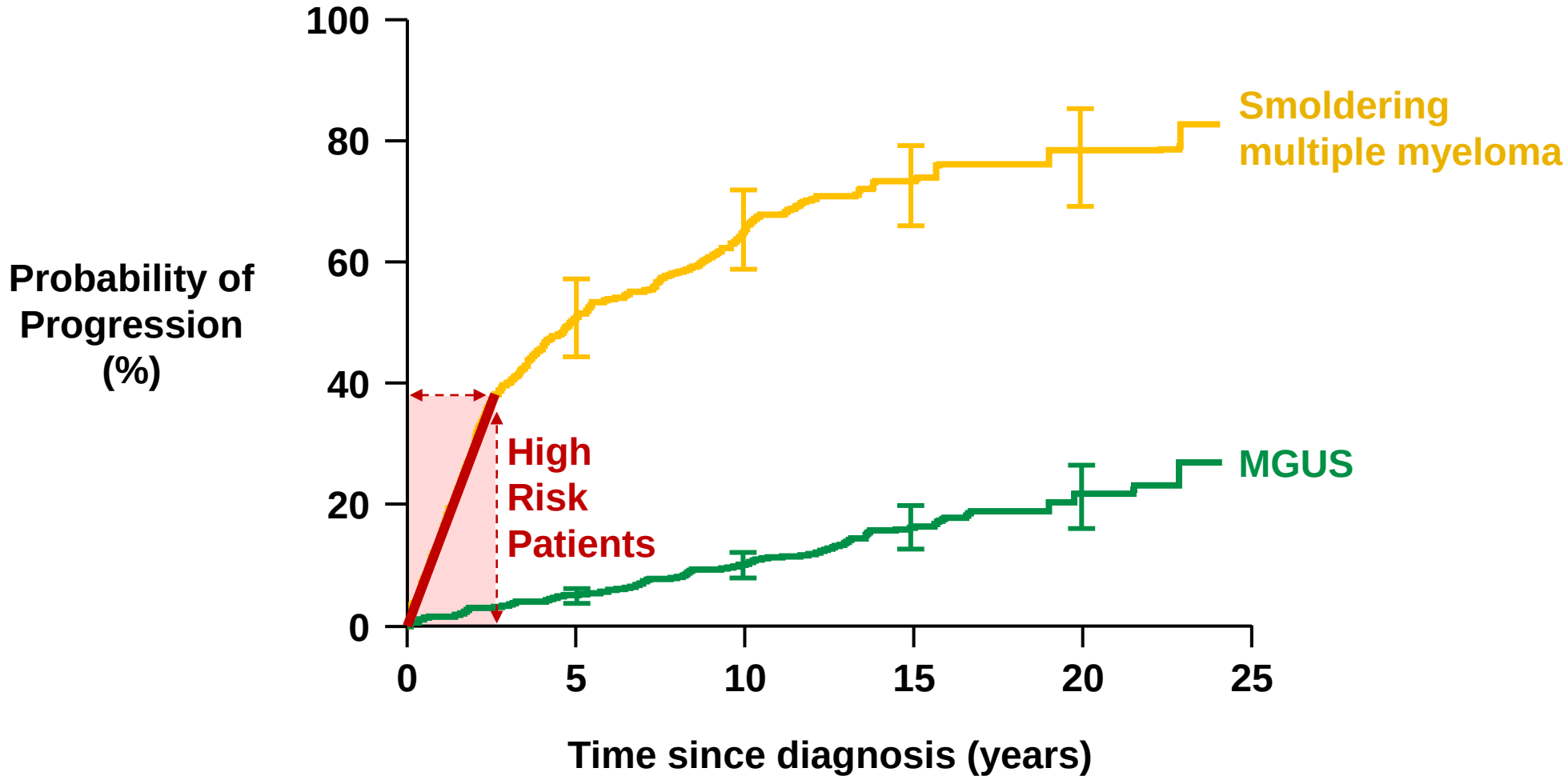


MGUS	SMM	Active Multiple Myeloma
Pre-malignant phase 1% / year risk of progression	Asymptomatic, predominantly malignant disease diagnosed based on biomarkers	MM as defined by IMWG that requires treatment (existing or imminent organ damage)

Low Risk | High Risk

MGUS: monoclonal gammopathy of undetermined significance

Natural History of Patients with SMM to MM



Bladé J et al. JCO 2010

Clinical Relevance of Definition of Myeloma Based on IMWG Criteria (Requiring Intensive Therapy)

SLiM / CRAB Criteria Signalling Progression to Myeloma	Clinical Relevance
≥ 60% BMPCs	**Cytopenias, infections, bleeding**
FLC ratio ≥ 100	**Renal failure**
> 1 focal lesions on MRI	**Bone disease and fracture**
Serum calcium > 1 mg/dL higher than ULN	**Fracture and renal failure**
Creatinine clearance < 40 mL/min or serum creatinine > 2 mg/dL	**Renal failure**
Hemoglobin > 2.0 g/dL below the limit of normal or < 10.0 g/dL (anemia)	**Fatigue, cytopenias, infections, bleeding**
≥ 1 osteolytic lesions on skeletal radiography, CT, or PET-CT	**Fracture**

Rajkumar SV, et al. *Lancet Oncol*. 2014.

Key Thresholds Used to Determine High Risk for Progression from SMM to Active MM

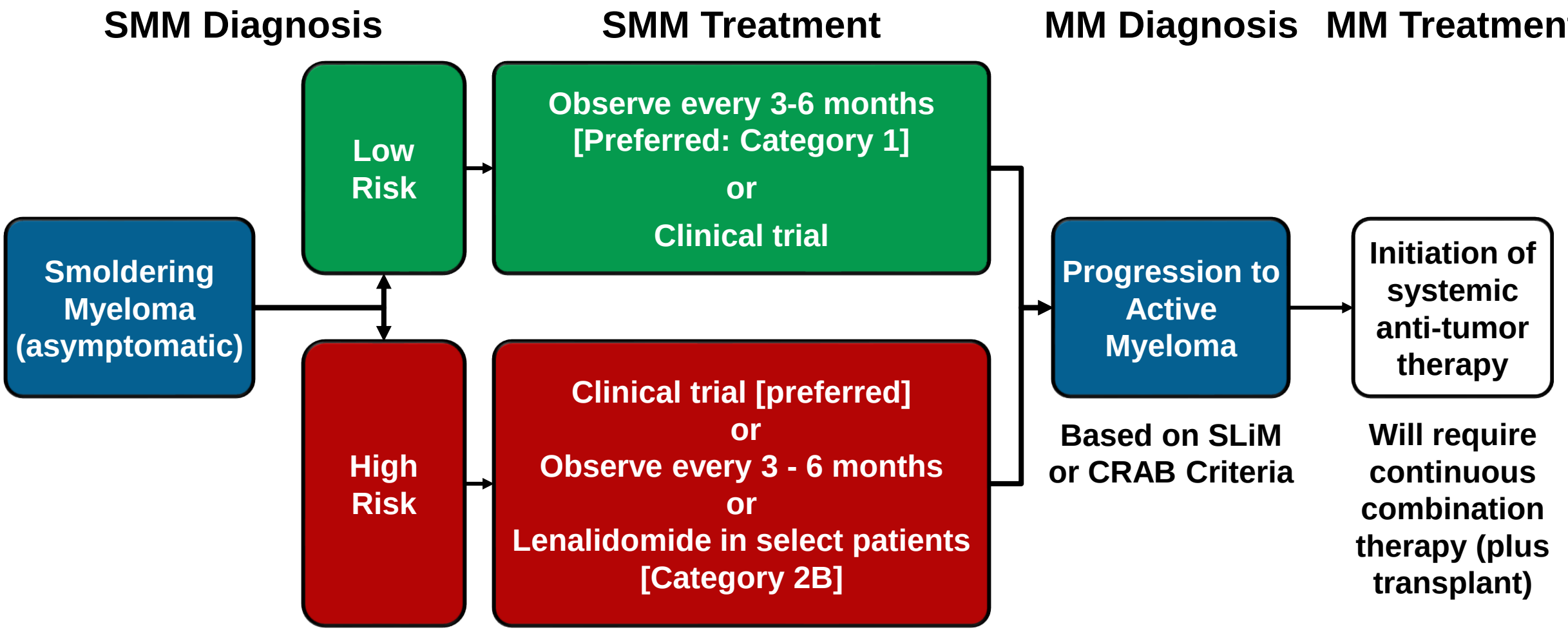
Markers Used to Determine High-Risk SMM	PETHEMA (2007)[1]	Mayo (2008)[2]	Rajkumar Consensus paper (2015)[3]	Mayo 2018 20/2/20
Serum M-Protein		✓	✓	✓
Abnormal FLC ratio		✓	✓	✓
IgA SMM			✓	
Immunoparesis	✓		✓	
Clonal BMPC			✓	✓
2-year risk of progression in high-risk	50%	52%	50%	47%

AQUILA (2017)

BMPC: clonal bone marrow plasma cells; FLC: free light chain ratio

1. Perez-Persona, 2007; 2. Dispenzieri, 2008; 3. Rajkumar, 2015

SMM Standard of Care (NCCN)



Adapted from NCCN Guidelines Version 1.2025 Multiple Myeloma

Preliminary Data Support Early Treatment Delays Progression in MM Continuum

Study	N	Response	OS (HR, 95% CI)	3-Year Progression to MM
QuiRedex[1,2] (Rd vs observation)	**119**	**ORR: 90%**	**0.57 (0.34, 0.95)**	**77%**
ECOG[3] (R vs observation)	**182**	**PR or better: 50%**	**-**	**91%**

Study limitations

- No advanced imaging to exclude active MM at baseline (QuiRedex)
- Toxicity of lenalidomide (ECOG)
  - 40% of patients discontinued due to an AE
  - Median duration of treatment only 2 years

Rd = lenalidomide, dexamethasone; R = lenalidomide

1. Mateos 2016; 2. Mateos 2022; 3. Lonial 2019

Patients with High-Risk SMM Likely to Progress to MM

- Observation is current standard of care for SMM
  - Risk of therapeutic intervention being initiated only after detection of end-organ damage
- Patients and providers want option of proactive treatment for high-risk SMM rather than watching and waiting for disease progression
- Treatment decision to be made between patient and provider

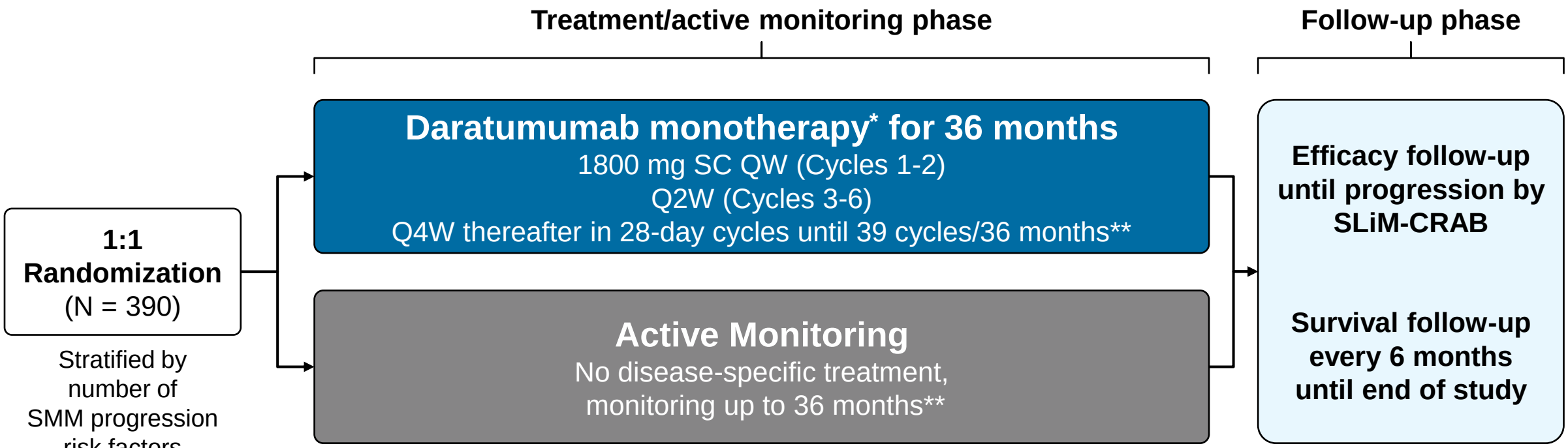
Clinical Efficacy

Robin Carson, MD

Vice President, Oncology Research & Development
Clinical Leader, Daratumumab

Johnson & Johnson

Phase 3 AQUILA (Study SMM3001): Study Design



Disease evaluation schedule

- **Laboratory efficacy** – Every 12 weeks by central lab until disease progression
- **Imaging (CT/PET-CT, MRI)** – Yearly (central review)
- **Bone marrow** – At least every 2 years

*** Same dose as recommended to treat active MM**

**** Or confirmed disease progression (whichever occurred first)**

AQUILA: Enrollment Criteria

- High-risk SMM based on predefined criteria
- Confirmed SMM diagnosis (per IMWG criteria) for ≤ 5 years
- ≥ 18 years of age
- ECOG PS score of 0 or 1
- Absence active myeloma defined by SLiM-CRAB criteria or amyloidosis
  - Confirmed by CT/PET-CT and MRI imaging during screening to exclude bone disease

AQUILA: Thresholds Used to Define High-Risk SMM

- BMPC ≥ 10% AND

  ≥ 1 of the following
  - Serum M-Protein ≥ 3 g/dL
  - Abnormal FLC ratio ≥ 8 and < 100 (serum involved: uninvolved)
  - Immunoparesis (reduction of 2 uninvolved immunoglobulin isotypes below normal reference range)
  - IgA SMM
  - Clonal BMPCs > 50% to < 60%

Rajkumar, Blood, 2015

Primary Endpoint - PFS: Progression to Active Myeloma Assessed by IRC per IMWG Criteria, or Death

SLiM criteria	**Clonal BMPCs**	≥ 60% BMPCs
	Modified serum FLC	Involved:uninvolved serum FLC ratio ≥ 100, involved light chain ≥ 100 mg/L, and difference of involved − uninvolved light chain ≥ 25% from lowest value (nadir)
	Focal lesions	> 1 focal lesions on MRI studies
CRAB criteria	**Calcium elevation**	Serum calcium > 0.25 mmol/L (> 1 mg/dL) higher than the upper limit of normal of > 2.75 mmol/L (> 11 mg/dL)
	Renal insufficiency	Creatinine clearance < 40 mL/min or serum creatinine > 177 µmol/L (> 2 mg/dL)
	Anemia	Hemoglobin > 2.0 g/dL below the limit of normal or < 10.0 g/dL
	Bone disease	≥ 1 osteolytic lesions on skeletal radiography, CT, or PET-CT

Rajkumar SV, et al. *Lancet Oncol*. 2014.

Key Secondary Endpoints

- Type 1 error- controlled secondary endpoints
  - Overall response rate (ORR)
  - Progression-free survival on first-line multiple myeloma treatment (PFS2)
  - Overall survival (OS)
- Other secondary endpoints
  - Time to first subsequent treatment for MM
  - Health-related quality of life measures

Baseline Demographics Balanced Between Arms

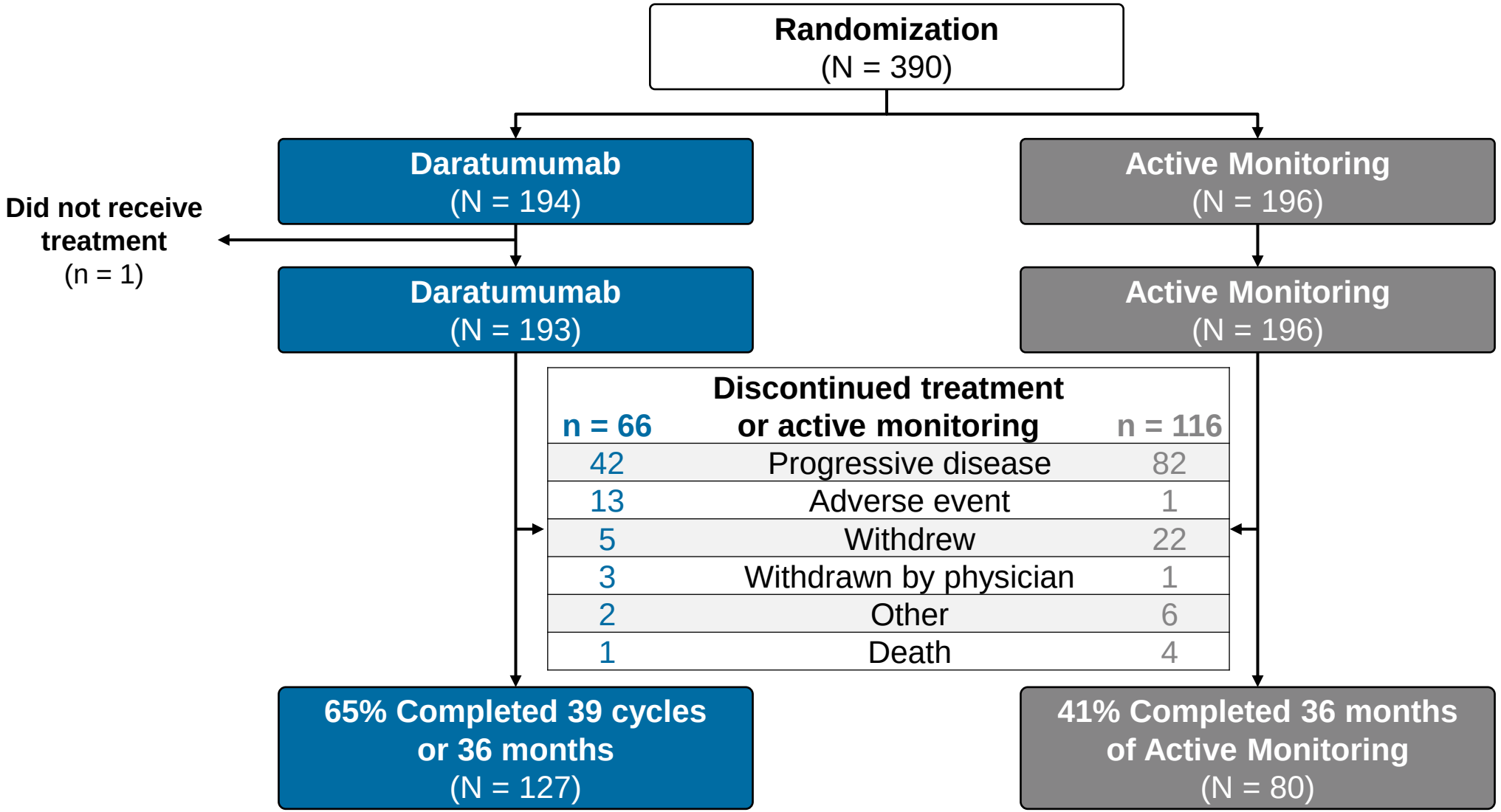
		Daratumumab (N = 194)	Active Monitoring (N = 196)
Age (years)	**Median** (range)	**63.0** (31, 86)	**64.5** (36, 83)
	18 to < 65, %	**55%**	**50%**
	65 to < 75, %	**35%**	**38%**
	≥ 75 years, %	**11%**	**12%**
Sex, %	**Female**	**51%**	**53%**
Race	**White**	**83%**	**83%**
	Black	**2%**	**4%**
	Asian	**9%**	**7%**
	Other / NR	**6%**	**7%**
ECOG PS score, %	**0**	**85%**	**82%**
	1	**15%**	**18%**

Disease Characteristics Balanced and Representative of Patients with High-Risk SMM

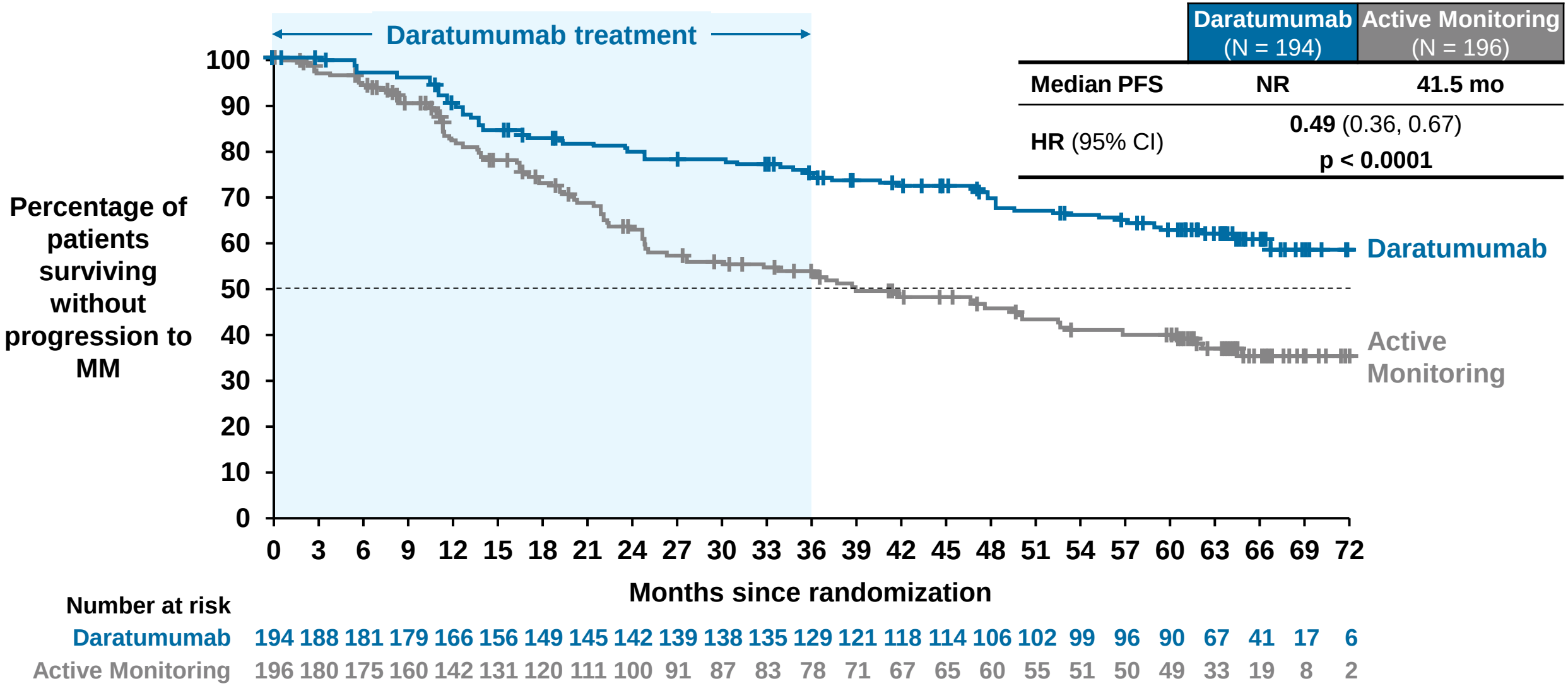
		Daratumumab (N = 194)	Active Monitoring (N = 196)
Median time from SMM diagnosis to randomization (range)		**0.80 years** (0, 4.7)	**0.67 years** (0, 5.0)
Time from diagnosis < 2 years		77%	76%
Median BMPCs (range)		**20%** (8, 60)	**20%** (10, 55)
Risk Factors for High-Risk SMM			
Serum M Protein ≥ 3 g/L		**18%**	**20%**
Serum Involved: uninvolved FLC Ratio ≥ 8 and < 100		**70%**	**75%**
Immunoparesis with reduction of ≥ 2 uninvolved immunoglobulin isotypes		**60%**	**59%**
IgA SMM		**28%**	**21%**
Clonal BMPCs > 50% to < 60%		**3%**	**2%**
Number of risk factors for progression	**< 3***	**81%**	**82%**
	≥ 3	**19%**	**18%**
Cytogenetic risk profile		**n = 167**	**n = 170**
≥ 1 of del(17p), t(4;14), and/or t(14;16)		**17%**	**13%**

*Median number of risk factors was 2

Disposition: More Patients Completed Study Treatment in Daratumumab Arm



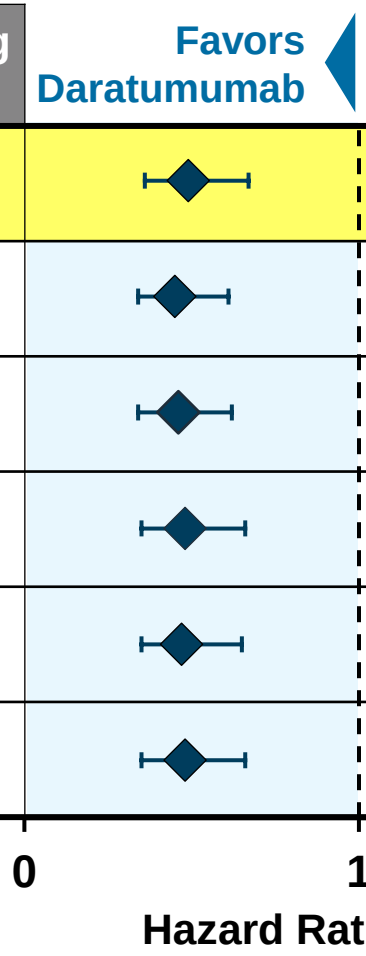
Primary Endpoint of PFS Met, Daratumumab Significantly Reduced Risk of Progression to MM



	Daratumumab (N = 194)	Active Monitoring (N = 196)
Median PFS	**NR**	**41.5 mo**
HR (95% CI)	**0.49** (0.36, 0.67)	
	p < 0.0001	

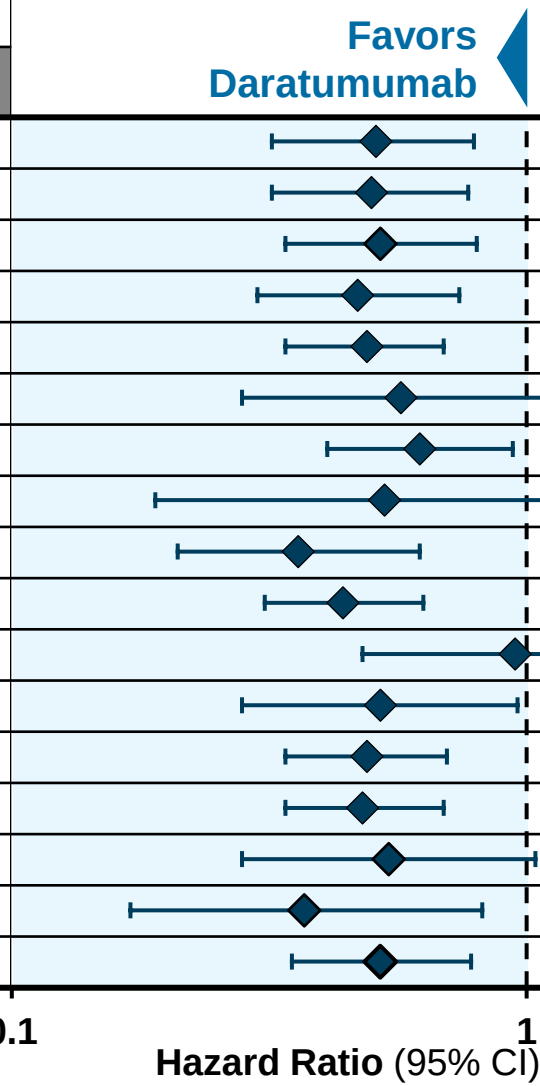
Sensitivity / Supplementary Analyses Strongly Support the Robustness of Primary PFS Results

Endpoint, % (n)	Daratumumab N = 193	Active Monitoring N = 196	HR (95% CI)
PFS per IRC assessment	**35%** (67)	**51%** (99)	**0.49** (0.36, 0.67)
PFS per Investigator assessment	**38%** (73)	**60%** (117)	**0.45** (0.34, 0.61)
PFS per computerized algorithm	**35%** (67)	**54%** (105)	**0.46** (0.34, 0.62)
Not censored patients with subsequent therapy	**35%** (68)	**53%** (104)	**0.48** (0.35, 0.66)
Censored patients who died due to COVID-19	**34%** (65)	**51%** (99)	**0.47** (0.35, 0.65)
Censored patients with ≥ 2 missing consecutive DEs	**34%** (65)	**50%** (98)	**0.48** (0.35, 0.66)

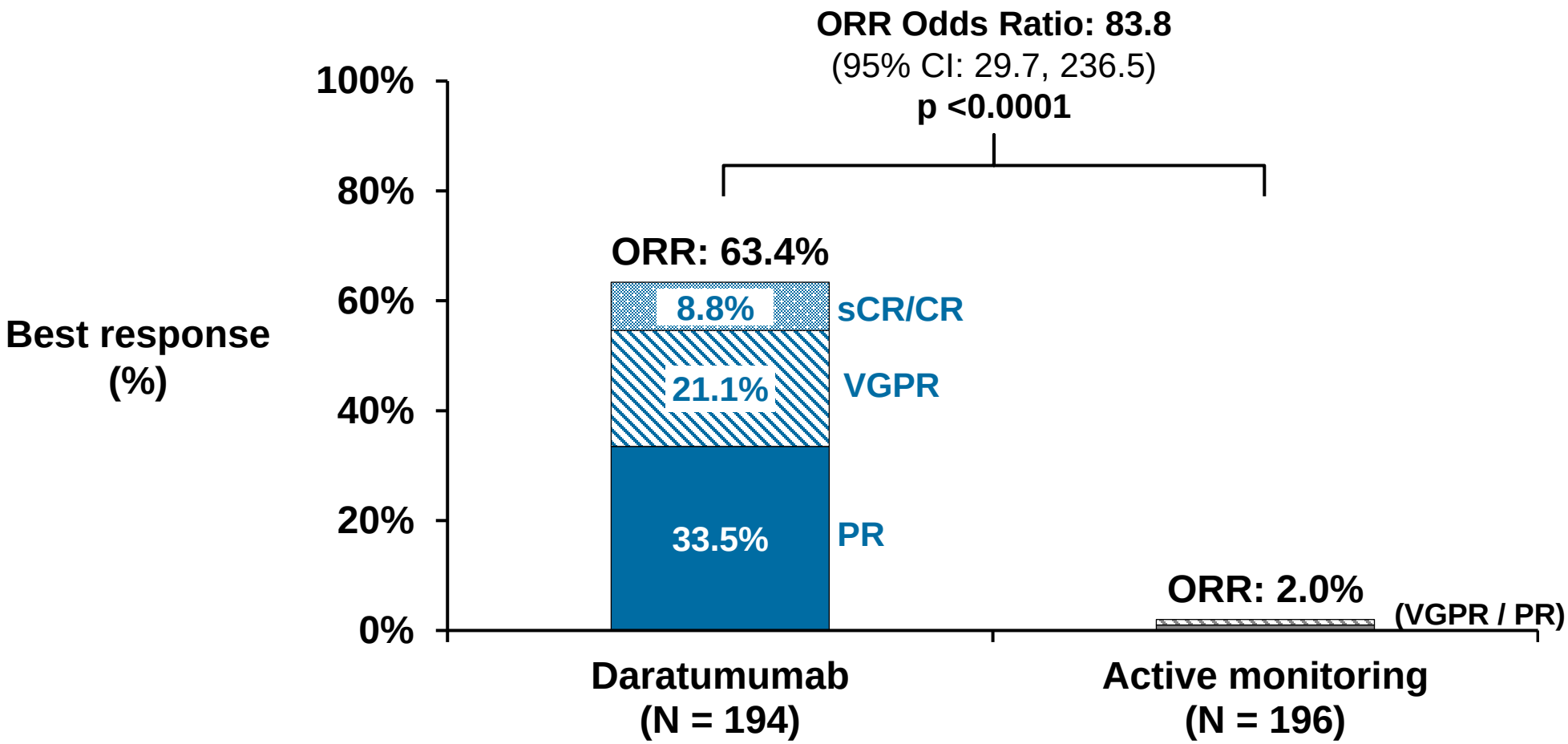


PFS Benefit Consistent Across Preplanned Subgroups

Subgroup		Disease progression or death, events / patients: Daratumumab	Disease progression or death, events / patients: Active Monitoring	HR (95% CI)
Age	< 65 years	34/106	45/98	**0.51** (0.32, 0.79)
	≥ 65 years	33/88	54/98	**0.50** (0.32, 0.77)
Sex	Male	37/95	48/93	**0.52** (0.34, 0.80)
	Female	30/99	51/103	**0.47** (0.30, 0.74)
Race	White	53/161	79/162	**0.49** (0.34, 0.69)
	Non-White	14/33	20/34	**0.57** (0.28, 1.12)
Region	EU	39/97	50/95	**0.62** (0.41, 0.94)
	North America	7/32	9/33	**0.53** (0.19, 1.42)
	Other	21/64	40/68	**0.36** (0.21, 0.62)
Baseline ECOG PS score	0	53/165	80/160	**0.44** (0.31, 0.63)
	1	14/29	19/36	**0.95** (0.48, 1.91)
Baseline renal function	Normal	17/54	27/58	**0.52** (0.28, 0.96)
	Abnormal	50/140	72/138	**0.49** (0.34, 0.70)
Risk factors	< 3	51/157	78/161	**0.48** (0.34, 0.69)
	≥ 3	16/37	21/35	**0.54** (0.28, 1.04)
Cytogenetic risk at study entry	Yes	13/29	14/22	**0.37** (0.17, 0.82)
	No	39/116	59/118	**0.52** (0.35, 0.78)

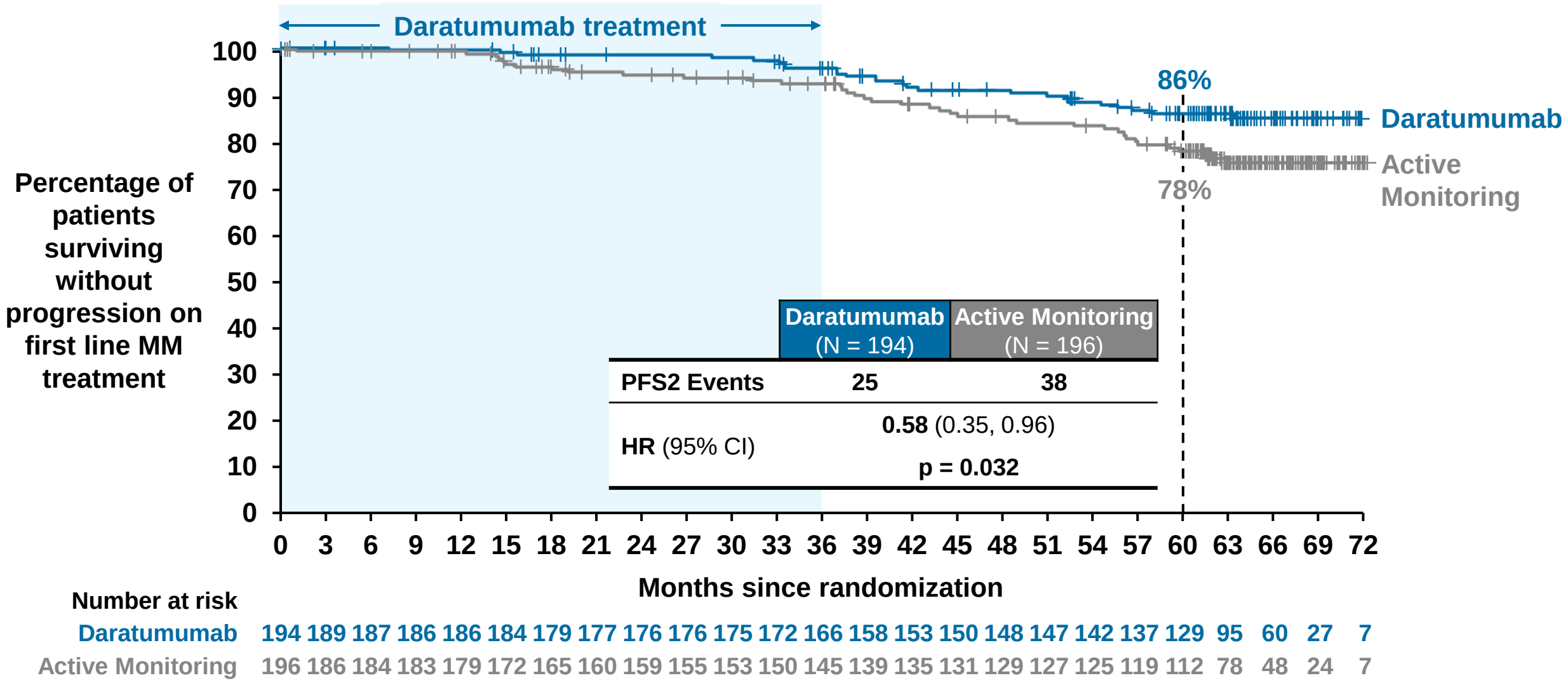


Secondary Endpoint: ORR Shows Statistically Significant and Clinically Meaningful Daratumumab Response

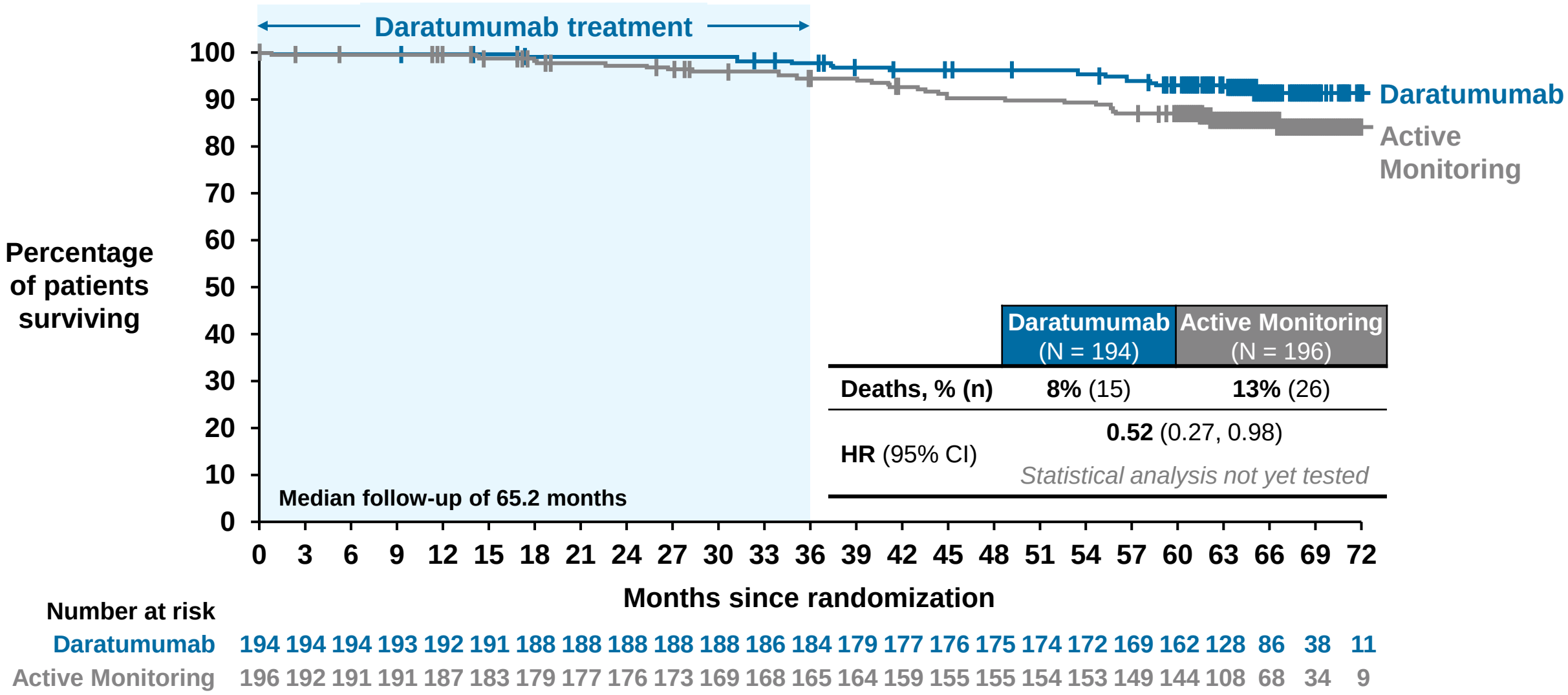


sCR: stringent complete response, CR: complete response, VGPR: Very good partial response, PR: Partial response

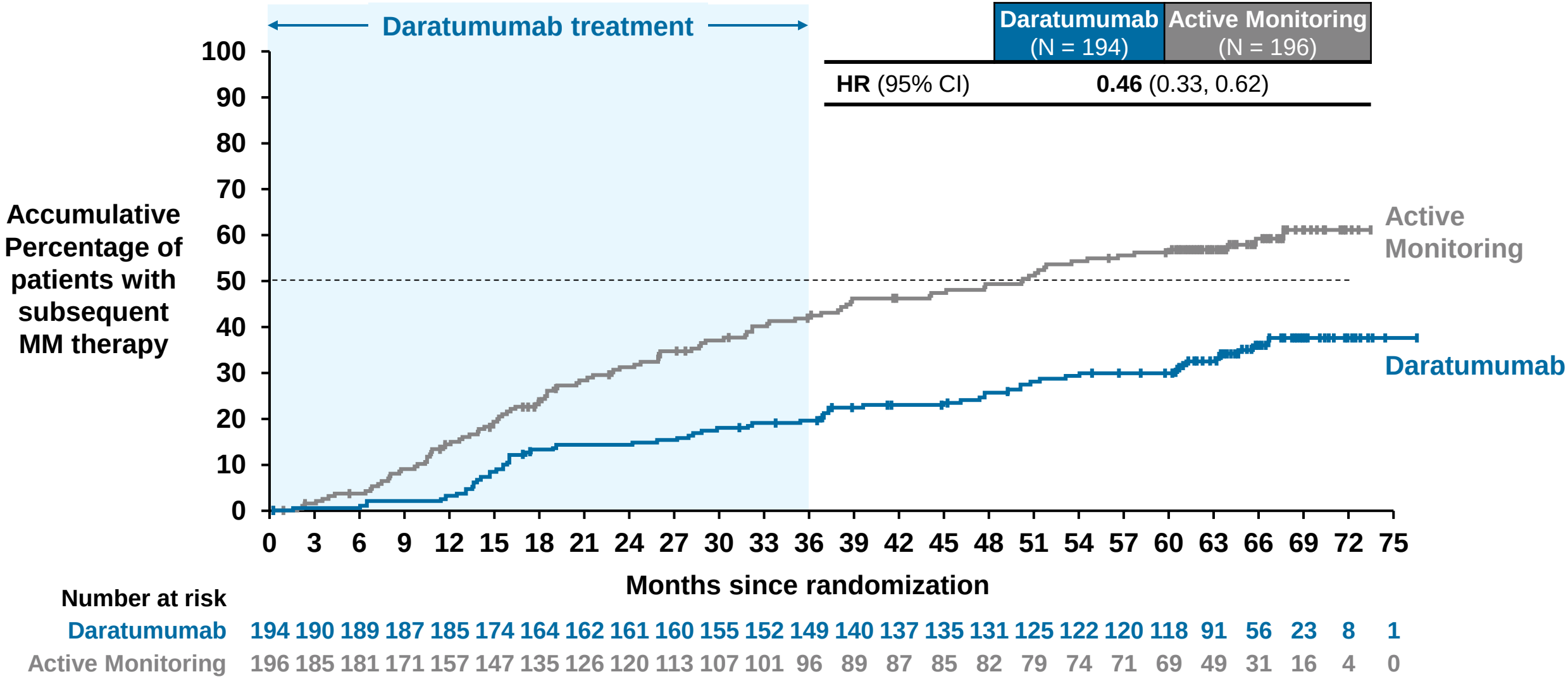
Secondary Endpoint: PFS2 (From Randomization to Progression After First-Line Treatment for Active MM or Death)



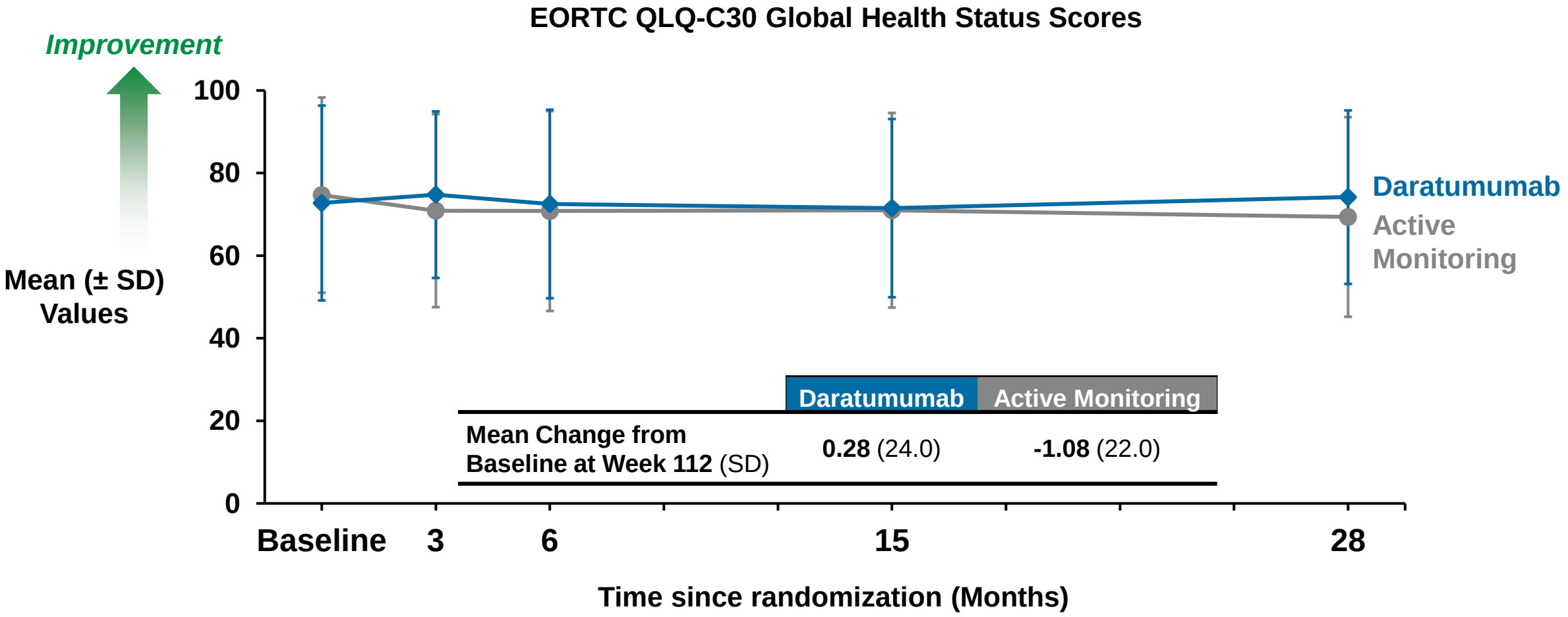
Secondary Endpoint: Evidence of Positive Overall Survival Trend



Secondary Endpoint: Daratumumab Delayed Time to First Treatment for Multiple Myeloma



Secondary Endpoint: Health Related QoL Comparable Between Arms Over Course of the Study



Number of patients					
Daratumumab	185	178	168	153	121
Active Monitoring	153	177	155	135	83

AQUILA Strongly Favored Early Intervention with Daratumumab in Patients with High-risk SMM

- Statistically significant and clinically meaningful improvements in PFS
- Benefit observed across secondary endpoints, including early evidence of positive OS
- Health-related quality of life for daratumumab-treated patients comparable to active monitoring
- Daratumumab offers an opportunity to delay disease progression

Clinical Safety

Robyn Dennis, MD

Senior Medical Director Oncology Research & Development

Johnson & Johnson

Exposure to Daratumumab

	Daratumumab (N = 193)	Active Monitoring (N = 196)
Median duration of treatment or monitoring (range)**, months**	**35.0** (0.03, 36.1)	**25.9** (0.1, 36.0)
Median number of treatment cycles (range)	**38** (1, 39)	n/a

Daratumumab 1800 mg SC Dosing Schedule and Predose Medications

QW (Cycles 1-2)	Q2W (Cycles 3 - 6)	Q4W (Cycles 7 - 39)
Months		
1	3 6	9 12 15 18 21 24 27 30 33 36
********	********	* *
		Doses

- Medications given 1 – 3 hours prior to each daratumumab dose
  - Antipyretic
  - Antihistamine
  - Corticosteroid
- Leukotriene inhibitor recommended on Cycle 1 Day 1

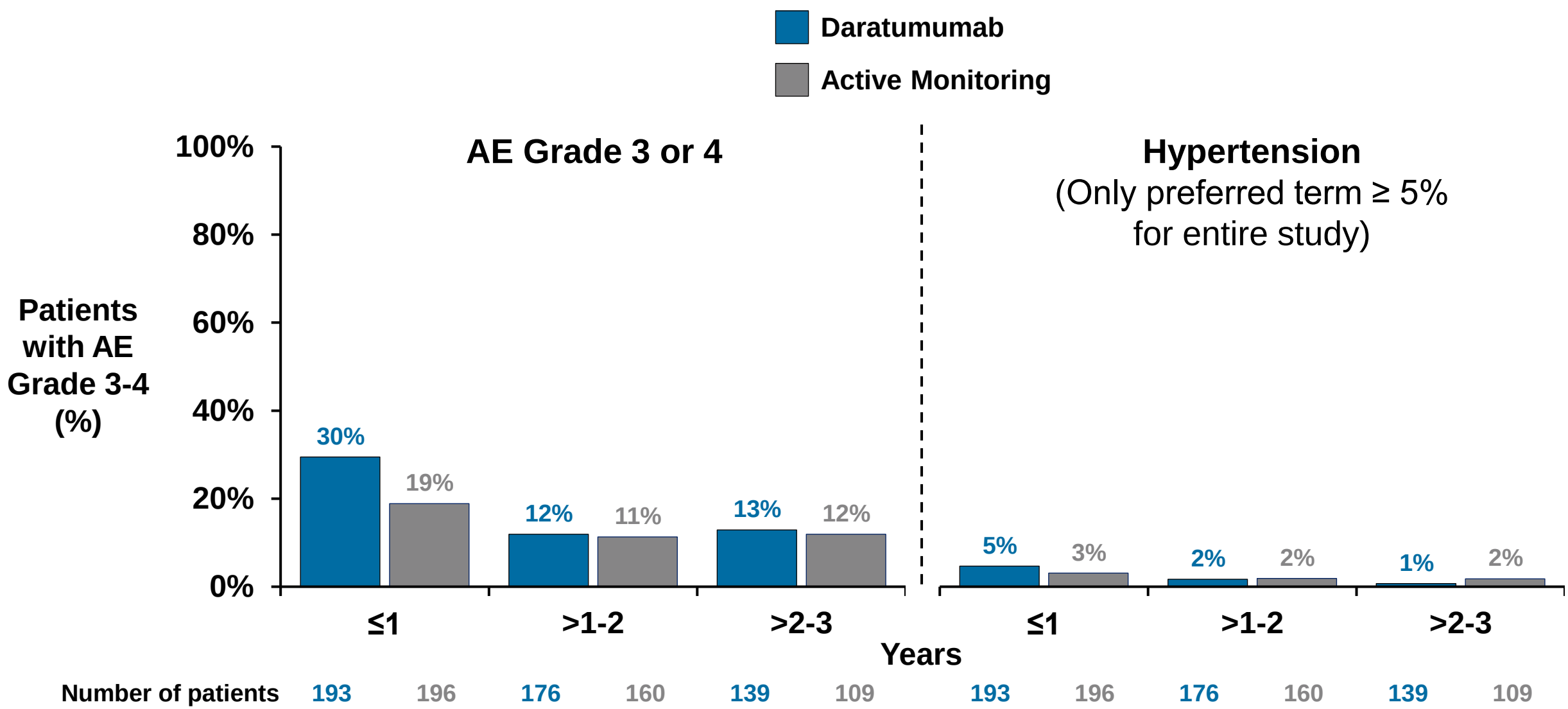
AQUILA: Most Adverse Events were Low Grade

	Daratumumab (N = 193)	Active Monitoring (N = 196)
Any AE	**97%**	**83%**
Grade 3 or 4	**40%**	**30%**
Any SAE	**29%**	**19%**
AEs leading to discontinuation, % (n)	**6%** (11)	n/a
AEs with outcome of death, % (n)	**1%** (2)	**2%** (4)

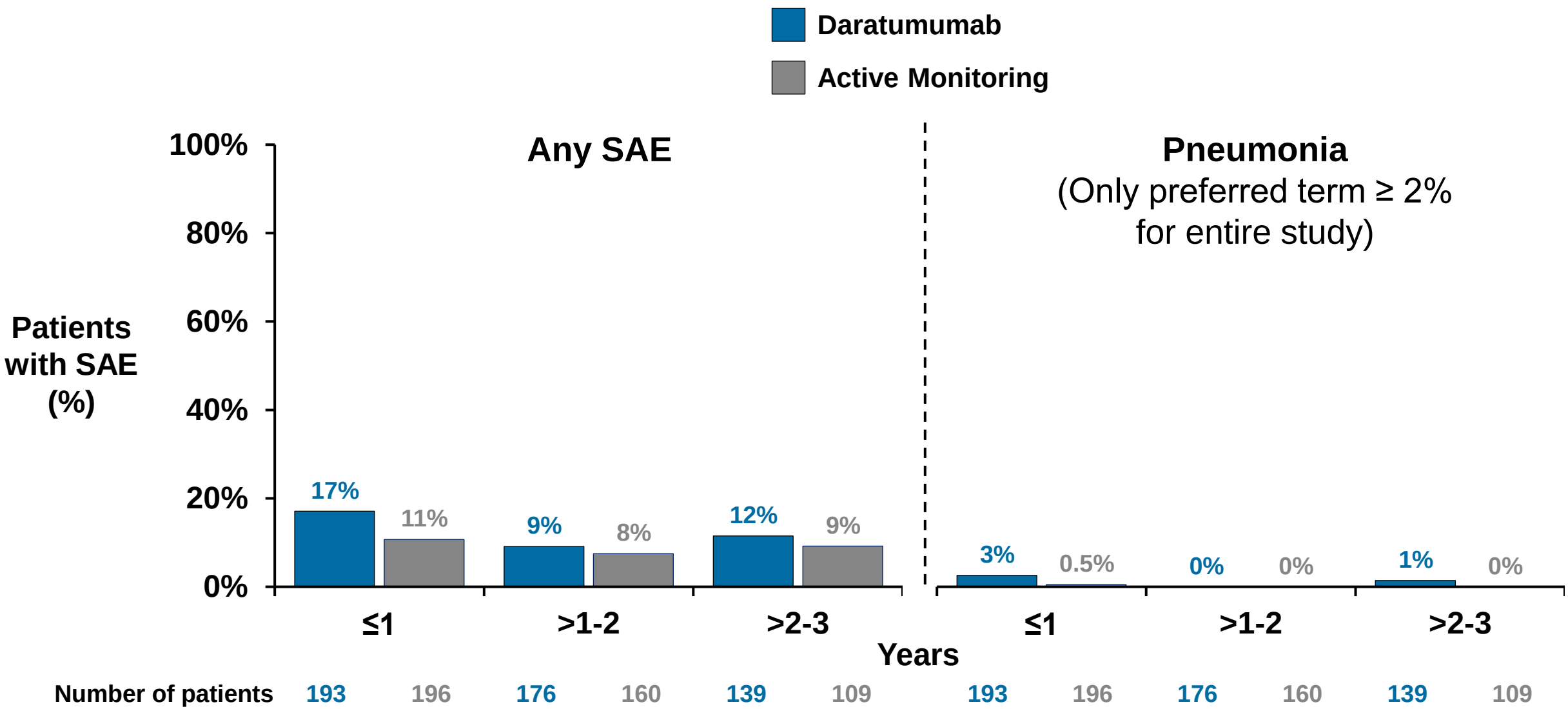
AQUILA: Common AEs (≥ 10% in Either Arm) Align with Current Daratumumab Label

	Daratumumab (N = 193)	Active Monitoring (N = 196)
Any AE, %	97%	83%
Fatigue	34%	13%
Upper respiratory tract infection	30%	8%
Diarrhea	28%	5%
Arthralgia	27%	18%
Nasopharyngitis	25%	12%
Back pain	24%	19%
Insomnia	22%	3%
Nausea	19%	5%
Headache	18%	7%
Cough	17%	6%
Pyrexia	17%	3%
Injection site erythema	16%	0
Pain in extremity	15%	8%
Dyspnea	15%	5%
Pneumonia	11%	5%
Hypertension	10%	10%
Myalgia	10%	5%
Edema Peripheral	10%	2%

AQUILA: Incidence of Grade 3 or 4 AEs was Highest within the First Year



AQUILA: Incidence of Serious Adverse Events



AQUILA: Dose Delay Recommended As Primary Method For Managing Toxicities

	Daratumumab (N = 193)
AEs leading to dose modification, %	47%
Cycle delays	38%
Dose skips	18%
Dose delay within cycle	4%
By preferred term (≥ 5%)	
Upper respiratory tract infection	7%
Pneumonia	6%
COVID-19	5%

AQUILA: AEs Leading to Discontinuation ≥ 1% Patients

	Daratumumab (N = 193)	
	Any Grade	Grade 3 or 4
Treatment discontinuation due to AEs % (n)	**6%** (11)	**3%** (5)
By Preferred Term ≥ 1%		
Fatigue	**1%** (2)	**0.5%** (1)
Anxiety	**1%** (2)	**0.5%** (1)
Dyspnea	**1%** (2)	**0.5%** (1)

AQUILA: Deaths

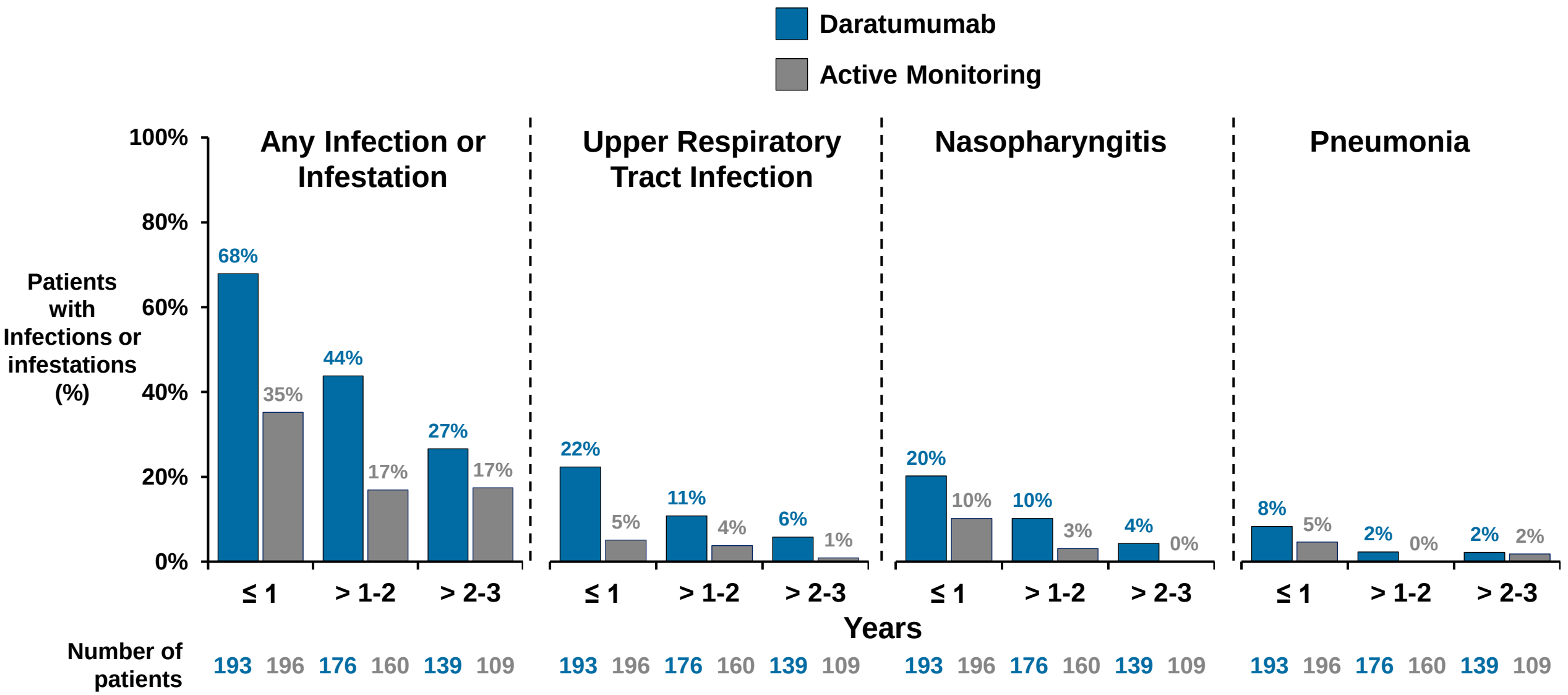
	Daratumumab (N = 193)	Active Monitoring (N = 196)
Deaths, % (n)	**8%** (15)	**13%** (26)
Progressive disease	**2%** (3)	**5%** (9)
Adverse event	**1%** (2)	**2%** (4)
COVID-19	**1%** (2)	**0**
Pulmonary	**0**	**1%** (2)
Cardiac	**0**	**1%** (2)
Other*	**5%** (10)	**7%** (13)
Unknown, n	**5**	**5**
Cardiac events, n	**3**	**3**
Infection, n	**1**	**3**
Respiratory failure, n	**1**	**1**
General deterioration, n	**0**	**1**

*Events that occurred >30 days after discontinuation of daratumumab or active monitoring, or after the start of subsequent therapy

AQUILA: Median Duration of Infections/Infestations was Comparable Between Arms

	Daratumumab (N = 193)		Active Monitoring (N = 196)	
	Any Grade	Grade 3 or 4	Any Grade	Grade 3 or 4
Patients with Infections and infestations, %	**80%**	**16%**	**45%**	**5%**
Duration of infections				
Median, days (Q1, Q3)	**14** (7, 28)	**5** (4, 15)	**14** (8, 31)	**9** (6, 12)

AQUILA: Infections/Infestations Risk Over Time (with Preferred Terms ≥ 10%)



Daratumumab Well-tolerated in Patients with High-Risk SMM, with Clinically Manageable Side Effects

- AEs observed were expected for daratumumab
- Majority AEs were low grade
- Highest incidence of AEs primarily occurred within the first year
- Treatment discontinuations low (6%)
- Most infections were low grade and 98% of infections resolved with a median duration of 14 days

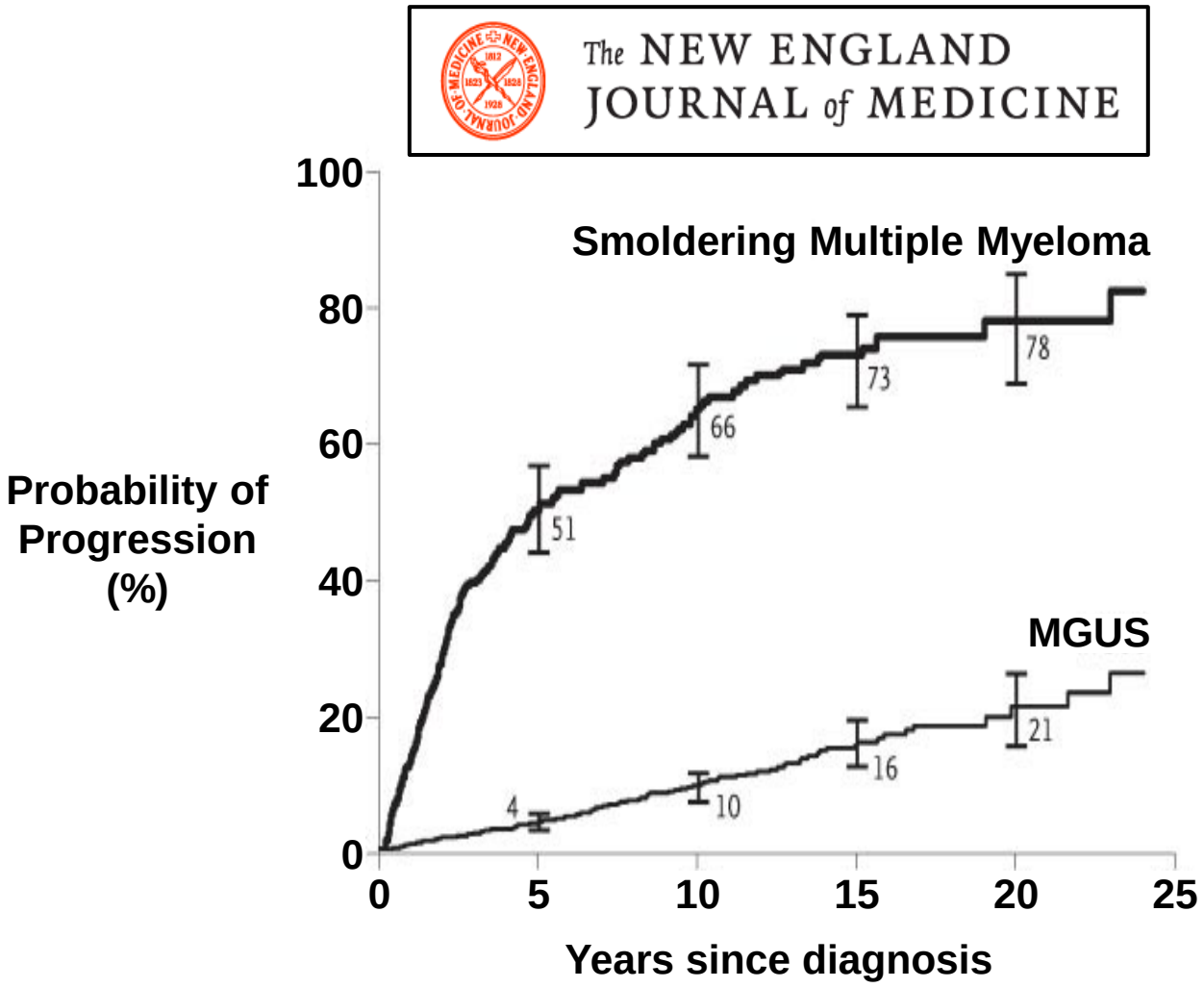
Clinical Perspective

S. Vincent Rajkumar, MD

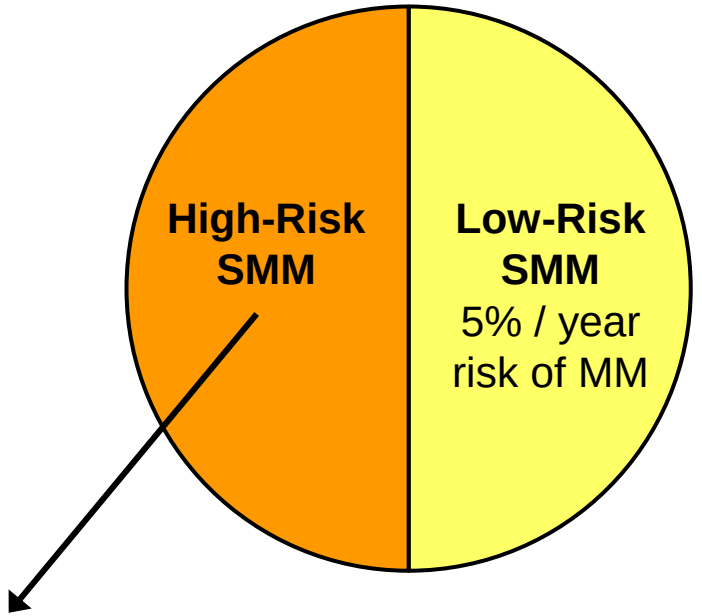
Edward W. and Betty Knight Scripps Professor of Medicine

Mayo Clinic

High-Risk SMM is Appropriate Group for Early Intervention; NOT a Premalignancy (MGUS)



Kyle RA…Rajkumar SV. N Engl J Med 2007



≥10% Plasma Cells plus:

- M protein ≥3 g/dL
- Immunoparesis
- Abnormal FLC ratio 8-100
- IgA type

Rajkumar SV, Landgren O, Mateos MV. Blood 2015

Challenges with Active Monitoring

- Don’t want to treat too early but risk treating too late
- Close observation as done in AQUILA is likely not feasible in real world settings
- Observation in reputed academic settings has not been able to intervene in a timely manner
- Intervention should be considered in the right patient population

Early Intervention for High-Risk SMM Acknowledged by Myeloma Experts

- MM studies have already moved beyond observation as standard of care
- Observation is not a control arm in any current or ongoing phase III trials for high-risk patients
- MM clinicians acknowledge need for treatment of high-risk disease, defining that patient population has shifted over time

While Definition of High-Risk Continues to Evolve, Patients Today Deserve an Effective and Safe Option

- Key considerations from FDA
  - Suggested heterogeneity of study population
  - PFS as an appropriate endpoint in SMM
  - Safety in an asymptomatic patient population
  - Potential impact on QoL

AQUILA Enrolled Well-Defined High-Risk Population

- AQUILA has the best characterized high-risk group
  - 50% of active monitoring patients progressed by 3 years
  - Included same biomarkers as used in current Mayo 2018 criteria with different risk thresholds
  - AQUILA showed benefit regardless of subgroup
- Patients with SMM will progress to MM at variable rates

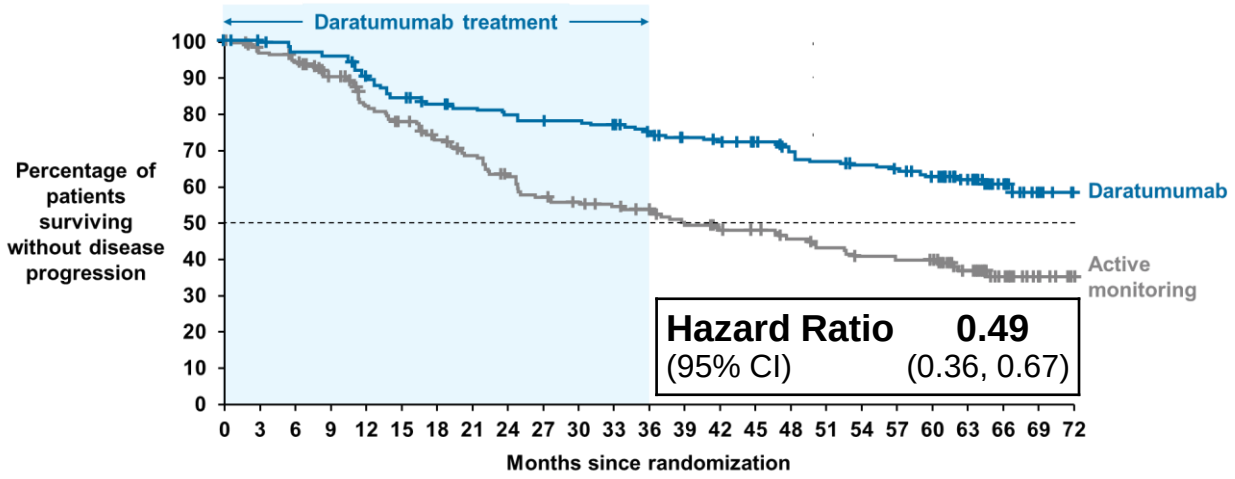
PFS, as Defined in AQUILA, is an Appropriate Endpoint to Assess Benefit in SMM

- PFS in SMM is progression to MM or death
  - Stringent requirement for IMWG definition
- With progression comes life changing consequences
  - Life-long multi-drug regimens
  - Higher risk of morbidity and mortality
  - Worsening QoL
- Daratumumab monotherapy has low toxicity

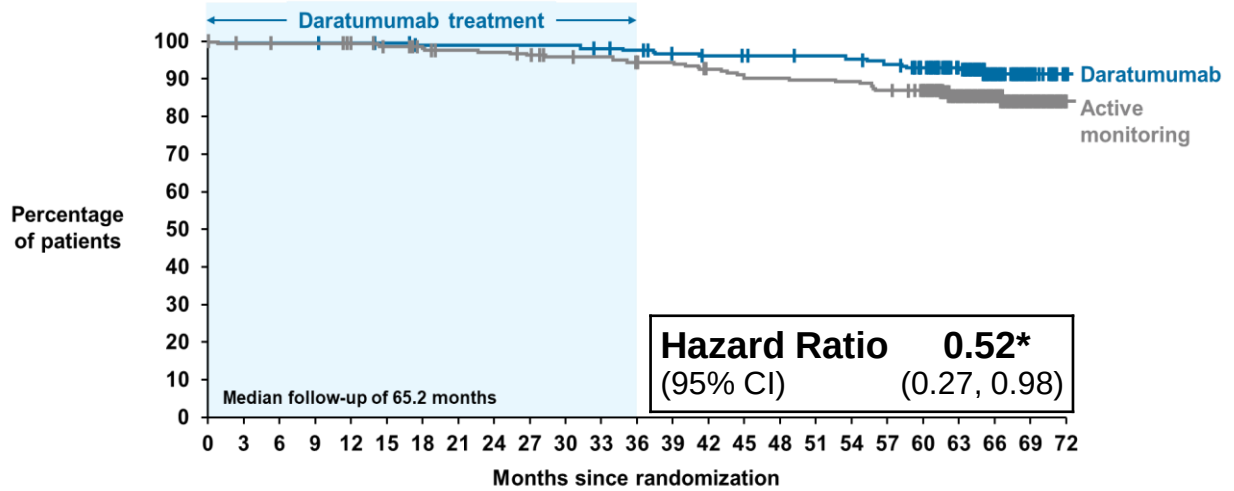
Delaying time to progression of MM is a meaningful endpoint for high-risk SMM

AQUILA Provides Compelling Efficacy Data

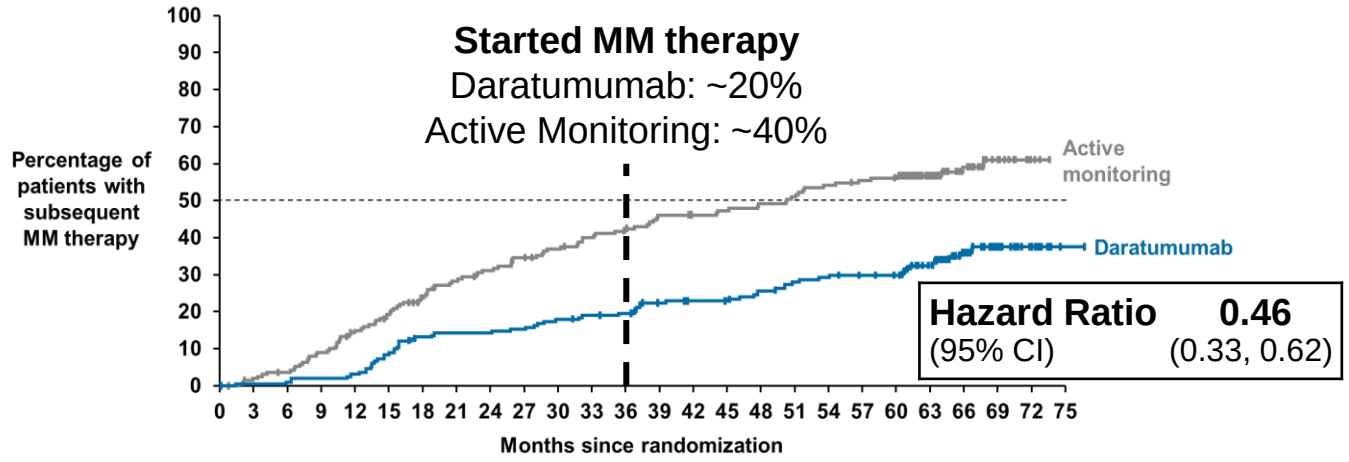
PFS



OS



Time to subsequent therapy



*** Statistical analysis not yet tested**

AQUILA Shows Treatment with Single Agent Daratumumab for 36 Months is Safe

- Physicians diagnosing SMM familiar with daratumumab risks
- AEs mostly mild and occur early in treatment
  - Few discontinuations due to AEs
  - Mostly monitoring for infection risk
- QoL maintained in asymptomatic patients
- Daratumumab provides opportunity to delay more severe AEs associated with multi-drug myeloma therapy

Daratumumab Offers Patients with High-Risk SMM an Early Intervention

- Meaningfully delay in progression to MM
- No negative impact to quality of life
- Manageable and well-understood adverse events
  - Daratumumab as standard of care for MM for >10 years
- Patients want ability to choose proactive treatments
  - With informed consent, in shared decision making, can determine their best treatment path
- Daratumumab can fundamentally change treatment landscape
  - Offering patients a choice that could extend their life

DARZALEX FASPRO (daratumumab and hyaluronidase) for the Treatment of High-Risk Smoldering Multiple Myeloma

May 20, 2025

Oncologic Drugs Advisory Committee

Johnson & Johnson

Backup Slides Shown

FDA Table 10: First Line Subsequent Therapies for MM

	Dara SC N = 194 n (%)	ACTM N = 196 n (%)	Overall N = 390 n (%)
Participants with first line therapy	65 (34)	105 (54)	170 (44)
VRd	19 (10)	29 (15)	48 (12)
VCd	6 (3)	14 (7)	20 (5)
VTd	9 (5)	8 (4)	17 (4)
DVRd	4 (2)	10 (5)	14 (4)
DRd	3 (2)	10 (5)	13 (3)
Rd	5 (3)	7 (4)	12 (3)
DVMP	1 (0.5)	5 (3)	6 (2)
KRd	3 (2)	3 (2)	6 (2)
DVTd	2 (1)	2 (1)	4 (1)
Isa-VRd	1 (0.5)	3 (2)	4 (1)
Vd	2 (1)	1 (0.5)	3 (1)
Daratumumab	2 (1)	0 (0)	2 (0.5)
IRd	0 (0)	2 (1)	2 (0.5)
R	1 (0.5)	1 (0.5)	2 (0.5)
RCd	1 (0.5)	1 (0.5)	2 (0.5)
VMP	1 (0.5)	1 (0.5)	2 (0.5)
VMP-DRd	0 (0)	2 (1)	2 (0.5)
D-VTCd	0 (0)	1 (0.5)	1 (0.3)
Dara-Iber-d	1 (0.5)	0 (0)	1 (0.3)
DKRd	1 (0.5)	0 (0)	1 (0.3)
DVd	0 (0)	1 (0.5)	1 (0.3)
Elo-KRd	0 (0)	1 (0.5)	1 (0.3)
Isa	0 (0)	1 (0.5)	1 (0.3)
KCd	0 (0)	1 (0.5)	1 (0.3)
Venetoclax+VTd	0 (0)	1 (0.5)	1 (0.3)
VTCd	1 (0.5)	0 (0)	1 (0.3)
VRd, Isa-Kd, transplant	1 (0.5)	0 (0)	1 (0.3)
VRTd + melphalan, transplant	1 (0.5)	0 (0)	1 (0.3)
Any Daratumumab-containing regimen	14 (7)	31 (16)	45 (12)