MULTIPLE MYELOMA — QUICK-REF CARD

MHA-MYELOMA-2026-v0.4.1-GOVERNANCE-POLISH (DRAFT) — BSH/UKMS, NICE, IMWG synthesis

Educational quick-reference only. Not a prescribing protocol. Confirm indication, line of therapy, Blueteq eligibility, local formulary, renal/hepatic function, infection status, pregnancy/contraception requirements and current SmPC before treatment.

Dose examples in this card are educational only — they must not override local e-prescribing protocols, SmPC, renal/hepatic adjustment, frailty modification, pharmacy verification or consultant decision-making.

Diagnosis — IMWG 2014 (active myeloma)

Clonal BMPC ≥10% (or biopsy-proven plasmacytoma) PLUS any of: **S** BMPC ≥60% · **Li** SFLC ratio >100 · **M** >1 MRI focal lesion >5mm · **C** Ca >2.75 mmol/L · **R** Cr >177 µmol/L · **A** Hb <100 g/L · **B** ≥1 lytic lesion ≥5mm on imaging.

NDMM — UK pathway at a glance

Group	First-line	Maintenance / next step
TE — standard risk	TA763 — D-VTd induction/consolidation for newly diagnosed transplant-eligible myeloma, within NICE criteria → ASCT	Lenalidomide maintenance until progression (TA680)
TE — high risk (2+ HRCA, SKY92, PCL)	OPTIMUM / CONCEPT / IFM 2018-04 / EMN12 strategies where access permits; otherwise NHS standard induction	Tandem ASCT considered; len maintenance (TA680); trial referral
Transplant-ineligible	Rd continuous (TA587); Isa-VRd (TA1098, Sept 2025) per NICE recommendation. D-Rd / D-VMP: verify current NICE TA, Blueteq and local formulary status before use.	Continue until progression; reduce dex in age 75+ / frailty
Horizon scanning (transplant-unsuitable)	D-VRd (PERSEUS): horizon/evidence only; NICE GID-TA10726 / ID3843 currently relates to transplant-unsuitable NDMM. Verify live NICE indication before pathway placement.	Not a transplant-eligible NICE in-development option; awaiting final NICE guidance.

R/R Myeloma — line-by-line options

Line	Options (class-switch principle)	NICE TA chips
1st relapse (post-Vel)	KRd; Dara-Rd; Isa-Pd	TA695 (KRd) · TA427 (Pd)
1st relapse (post-Len) — Len-intolerant / Len-refractory	Belantamab + Pd (BPd, DREAMM-8) — option after 1 prior Len-containing line if Len-intolerant or Len-refractory. Mandatory pre-dose ophthalmology. Also: Dara-Vd; Isa-Kd; PVd; Pd.	TA1133 (belantamab + Pd) · TA427 (Pd) · TA586 (Rd after Vel)
2nd–3rd relapse	2nd ASCT (if fit, ≥PR), retreatment after long TFI, dara mono	TA510 (dara mono)
Triple-class refractory (≥3 lines)	Teclistamab (verified). Talquetamab (verified, GPRC5D). Elranatamab (managed access). CAR-T: status evolving.	TA1015 (teclistamab) · TA1114 (talquetamab) · TA1023 (elranatamab, managed access)
Penta-refractory / late-line (≥4 lines)	Selinexor + dex. Venetoclax t(11;14) off-label/biomarker-restricted only.	TA970 (selinexor)
Terminated / not commissioned	Cilta-cel TA889 — Janssen withdrew submission. Cilta-cel earlier line (1–3 prior): GID-TA10905 / ID4012 in development; status evolving.	TA889 terminated

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MGUS & SMM — risk stratification

Model	Factors	Action
Mayo 2005 (MGUS)	≥1: M-protein >15 g/L · abnormal κ/λ ratio (<0.26 or >1.65) · non-IgG	0–1 factors: no BM, no imaging. 2–3 factors: BM + WB imaging.
Mayo 20-2-20 (SMM)	BMPC >20% · M-protein >20 g/L · SFLC ratio >20	0: 6–12 monthly. 1: 3-monthly. ≥2: trial referral.
IMWG 2020 (SMM)	20-2-20 + HRCA: t(4;14), t(14;16), gain(1q), monosomy 13/del(13q)	High risk: 3-monthly × 5 years; trial.

NICE technology appraisals — selected entries checked May 2026

Live NICE verification required before prescribing. ★ = recently appraised / commonly pathway-relevant where NICE criteria and local access are met.

TA	Regimen	Status / use
TA129	Bortezomib monotherapy R/R	Older TA — first relapse
TA228	V-Thal first-line	Older first-line TE/TI
TA311	Bortezomib induction pre-ASCT	Bortezomib-based induction
TA380	Panobinostat + Vd	Reserved option
TA427	Pomalidomide + dex	R/R, established UK comparator
TA510	Daratumumab monotherapy	R/R
TA586	Lenalidomide + dex after one bortezomib line	R/R post-Vel
TA587	Lenalidomide + dex untreated	NDMM transplant-ineligible
TA657	Carfilzomib for previously treated MM	Partially replaced by TA695
TA680	Lenalidomide maintenance post-ASCT	UK standard
TA695	KRd previously treated	R/R
TA763 ★	D-VTd induction/consolidation for newly diagnosed transplant-eligible myeloma, within NICE criteria	NDMM transplant-eligible
TA970	Selinexor + dex (≥4 prior treatments)	Penta-refractory / late-line
TA1015 ★	Teclistamab (≥3 prior treatments)	Replaces TA869, Nov 2024
TA1023	Elranatamab (≥3 prior treatments)	Managed access, Dec 2024
TA1098 ★	Isa-VRd untreated when ASCT unsuitable	Sept 2025 — anti-CD38 quadruplet for TI-NDMM
TA1114 ★	Talquetamab (≥3 prior treatments)	Dec 2025, routine NHS option (GPRC5D)
TA1133 ★	Belantamab + Pd after 1 prior Len-containing line if Len-intolerant or Len-refractory	Feb 2026 — pre-dose ophthalmology mandatory

NICE horizon scanning / evolving therapies — verify live status before use

D-VRd (daratumumab + bortezomib + lenalidomide + dexamethasone): NICE **in development**, GID-TA10726 / ID3843, for untreated myeloma when stem cell transplant is unsuitable. **Horizon / evidence only**; cited NICE in-development entry currently relates to transplant-unsuitable NDMM. Do not place as a transplant-eligible NICE in-development option. Verify live NICE indication before pathway placement.

Isa-VRd TA1098 published Sept 2025 for untreated myeloma when transplant is unsuitable. Verify final recommendation restrictions and local access.

Isatuximab maintenance post-ASCT GID-TA11846 / ID6639 **awaiting development**. Horizon scanning only.

Ixazomib maintenance post-ASCT GID-TA10843 / ID1517 **discontinued February 2026**. Do not list as active in-development.

Cilta-cel TA889 **terminated**. Separate **in-development** appraisal GID-TA10905 / ID4012 for relapsed, lenalidomide-refractory myeloma after 1 to 3 therapies. Approved-centre access only if final NICE guidance supports use.

Elranatamab TA1023, **managed access** after ≥3 prior lines including IMiD, PI and anti-CD38 exposure.

Talquetamab TA1114, **routine NHS option** after ≥3 prior lines including IMiD, PI and anti-CD38 exposure, where disease progressed on last treatment.

Belantamab + Pd TA1133: **option after 1 prior lenalidomide-containing line if lenalidomide is not tolerated or disease is lenalidomide-refractory**. Not a generic penta-refractory option. Verify ocular monitoring, commercial arrangement, Blueteq and local pathway.

Venetoclax t(11;14) not NICE-commissioned for myeloma. Off-label, biomarker-restricted.

Imaging — modality by scenario

Scenario	Imaging
High-IR / high-risk MGUS	WB-MRI, PET-CT or low-dose WB-CT
SMM at diagnosis	WB-MRI, PET-CT or low-dose WB-CT per local protocol
NDMM at diagnosis	WB-MRI preferred; PET-CT or low-dose WB-CT acceptable; skeletal X-ray inadequate alone
Biochemical / symptomatic relapse	WB-MRI or PET-CT — especially for EMD or oligo-secretory
Suspected MSCC	Same-day MRI of symptomatic region (do not wait for WB-MRI capacity)

Key safety / supportive principles

Domain	Standard
VTE prophylaxis (with IMiDs)	Aspirin low-risk; LMWH or apixaban higher-risk per VTE risk assessment
Antiviral (with PIs)	Aciclovir or valaciclovir during and ≥6 weeks after PI-based treatment
Bisphosphonates	Zoledronic acid or pamidronate for all treated NDMM; restart at frank relapse; dental assessment before initiation
Vaccines	Annual flu, COVID-19, PCV13 + PPV23 (5-yearly), Shingrix (recombinant); no live attenuated vaccines
IVIg replacement	Consider if recurrent infection + hypogammaglobulinaemia; standard with bispecifics / CAR-T
Bispecific / CAR-T pre-workup	Baseline Ig, HBV/HCV/HIV screen, cardiac assessment, bridging plan, approved-centre referral

Pattern recognition & common pitfalls

• **SLiM features alone define active myeloma.** Do not wait for CRAB if BMPC ≥60% or SFLC ratio >100 or >1 MRI focal lesion.

• **Stable M-protein does not exclude MGRS.** Falling eGFR and rising ACR justify biopsy and treatment of the clone.

• **Class-switch at relapse.** Switch the backbone class from the most recent regimen unless TFI was long.

• **Repeat FISH and TP53 at relapse.** Clonal evolution alters treatment in ≥20% of patients.

• **Urine dipstick is insensitive to light chains.** Send urine ACR (not PCR) where AL amyloid or MGRS is in differential.