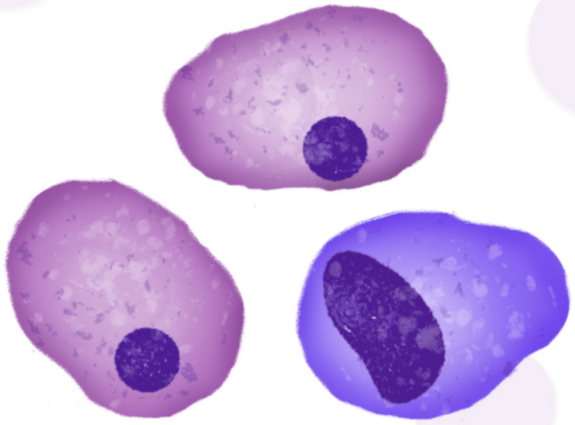
Multiple Myeloma Research and Treatment



A Series by REALWORLDHEALTHCARE.org

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Multiple myeloma is a type of blood cancer that affects the plasma cells found in bone marrow. It is the second most common blood cancer and is considered incurable. It is a treatable disease, however, thanks to recent advances in cancer research which are improving the life expectancy of multiple myeloma patients.

Multiple Myeloma Research and Treatment is a recently published series of articles that shines a spotlight on the individuals and organizations driving research on new multiple myeloma therapies, including monoclonal antibodies, CAR-T cell therapy, checkpoint inhibitors and other immunotherapies. Please accept this complimentary copy as our way of thanking you for your commitment to advancing medicine and improving patients' lives.

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The Multiple Myeloma Landscape

By Emily Burke, PhD, Director of Curriculum Development, BiotechPrimer.com

Editor's Note: This article originally appeared in Biotech Primer Weekly. For more of the science behind the headlines, please subscribe.

Multiple myeloma is a cancer formed by a type of white blood cell called a plasma cell. These cells are the antibody-producing cells of our immune system and play a critical role in our defense against infections. If they begin to grow and divide in an uncontrolled manner, however, they form a plasmacytoma – a mass of cells within the bone marrow that no longer function in our defense but instead simply take up space and interfere with the functions of healthy cells. Instead of producing normal disease-fighting antibodies, plasmacytoma cells produce abnormal antibodies called M proteins, which don't provide any benefit to the body and crowd out normally functioning antibodies.

Easily Confused: Plasma Cells vs Blood Plasma

Plasma cells are specialized white blood cells that produce infection-fighting antibody proteins. Most plasma cells are found in the bone marrow. Blood plasma is the straw-colored liquid component of blood that holds blood cells in suspension, made up of water (95%), proteins, glucose, clotting factors, electrolytes, hormones, carbon dioxide, and oxygen.

Picking Apart Plasmacytoma

Plasmacytoma formation can lead to a host of problems with recognizable clinical symptoms. Because all blood cells are formed in the bone marrow, over-production of plasma cells can essentially "crowd out" normal blood-forming cells. This can lead to anemia, caused by a shortage of oxygen-carrying red blood cells; increased bruising and bleeding due to a reduction in clot-promoting platelets; and an increased risk of infections due to lower levels of healthy infection-fighting white blood cells.

Although multiple myeloma is classified as a blood cancer, it has a significant impact on bone health. As the plasmacytoma grows, bone-forming cells called osteoblasts are suppressed. At the same time, production of a substance that activates bone-reabsorbing cells, osteoclasts, is increased. The resultant damage to the bone structure results in soft spots or lesions which may extend from the inner bone marrow to the outside surface of the bone. Bone lesions result in significant pain and increase the risk of fracture. Bone destruction also releases excessive calcium into the bloodstream,

which leads to a range of symptoms including changes in urination, restlessness, confusion, increased thirst, nausea, and loss of appetite. Excess blood calcium, combined with high levels of M protein, also contributes to the impaired kidney function seen in multiple myeloma patients.

Unmasking Multiple Myeloma

There is no one diagnostic test for multiple myeloma. Blood and urine tests to detect some of the symptoms listed above such as low blood cell counts, elevated blood calcium levels, and impaired kidney function may suggest multiple myeloma. These tests can be followed by a bone marrow biopsy for confirmation.

Most cases of multiple myeloma have no known cause, although some research suggests that regular exposure to herbicides, insecticides, petroleum products, heavy metals, and asbestos increases the risk of developing the disease. And although there is not a specific gene yet associated with multiple myeloma, abnormalities in chromosome structure or number are associated with the disease.

Multiple Myeloma Treatments

Once considered incurable, there are now a number of effective treatments for multiple myeloma, and several more are in the pipeline.

Currently, there are two FDA-approved monoclonal antibody therapeutics approved to treat multiple myeloma. They work by recognizing and binding to proteins on the surface of multiple myeloma cells, activating the patient's immune system to destroy those cells.

Another type of approved therapy for multiple myeloma is a small molecule proteasome inhibitor therapy. A proteasome is a specialized compartment within the cell that gets rid of damaged proteins by digesting them. If the proteasome is inhibited, damaged proteins build up within the cell. This triggers a process called apoptosis – essentially, cell suicide. In other words, the cancer cell kills itself.

Small molecule histone deacetylase (HDAC) inhibitors have also been shown to be safe and effective in treating multiple myeloma. HDACs are enzymes that modify chromosomes (strands of DNA that contain our genes) and influence how often specific genes are activated. Some cases of multiple myeloma are associated with changes in gene activation. By inhibiting HDACs, this faulty gene expression can be corrected.

In the Pipeline

Two novel drugs in the multiple myeloma pipeline are Mivebresib and Selinexor.

Mivebresib influences the activation of specific genes by inhibiting a group of proteins called Bromodomain and Extra Terminal motif (BET) proteins. In some types of cancer, genes are activated

or deactivated inappropriately due to BET activity. By inhibiting BET, normal gene activity may be restored to these cells.

Selinexor helps to increase the number of tumor suppressor proteins present in the nucleus of cancer cells. These proteins help to protect against cancer by detecting DNA damage and promoting apoptosis in those cells that have high levels of DNA damage. In many types of cancer cells, tumor suppressor proteins are transported out of the nucleus, where they can no longer do their job of detecting DNA damage. Selinexor blocks this transport and enables tumor suppressor proteins to do their job of triggering apoptosis in cancer cells.

A number of CAR-T therapies are also in development for multiple myeloma, with several early stage clinical trials ongoing.

Multiple myeloma is a complex type of cancer. In recent years, a better understanding of the disease has led to the approval of several new therapeutics. In the coming years, we can look forward to additional approvals as novel therapeutics move through the pipeline.

Read this article at Real World Health Care.

Multiple Myeloma: Promising New Therapies, But Challenges Remain

This week, our series on multiple myeloma continues as we talk about immunotherapies and other promising new treatments with Shaji Kumar, MD. Dr. Kumar is a professor of medicine in the division of hematology at Mayo Clinic, where he chairs the myeloma group across all three Mayo sites. Dr. Kumar conducts National Institutes of Health-funded research on resistance mechanisms to common myeloma drugs and epidemiology of disease progression. He also receives funding from the Multiple Myeloma Research Foundation to study the relationship between molecular profiles, treatment regimens for patients with multiple myeloma and outcomes.

Inspirations

Real World Health Care: How did you become interested in the field of multiple myeloma?

Shaji Kumar: I did my fellowship training at Mayo Clinic. Mayo is one of the most renowned institutions in the field of plasma cell disorders. Training at Mayo, and having the fortune of working with people like Professor Robert Kyle, was very inspiring and led to my interest in this group of disorders. The patients I see keep me inspired. While we have made some progress in this area, much work needs to be done and we need to develop a cure for this disease. The progress so far convinces me that we can reach this goal if we keep at it.

High-Risk Multiple Myeloma Patients

RWHC: What is the significance of your research work to the multiple myeloma patient community?

SK: I am involved in several aspects of myeloma research. In the laboratory, we try to understand how the myeloma cell survives, especially how the other cells in the body help them grow, and try to develop new drug combinations that can lead to better treatments. I try to translate these findings to the clinic in the form of early clinical trials, which if successful, can lead to larger phase 3 trials. I am the principal investigator of several phase 1, 2 and 3 clinical trials. Another area of great interest to me is risk stratification and identification of high risk myeloma. What we have seen is that patients with high risk myeloma continue to do badly despite all the new therapies. Moreover, there are still significant issues with the current systems for identifying high risk patients. We are trying to develop new approaches for risk stratification in myeloma and develop new treatment approaches for these patients.

Monoclonal Antibodies and Immunotherapy

RWHC: What promise do monoclonal antibodies and chimeric antigen receptor (CAR T-cell) therapies hold for the treatment of multiple myeloma? Could a cure be around the corner?

SK: Immunotherapy is the next frontier for myeloma. The results so far have been spectacular. The monoclonal antibodies have opened up a new class of drugs, and daratumumab especially has led to high response rates and deep responses in patients with myeloma. The next step is to combine the current classes of drugs to develop the most effective regimens. Other immunotherapy approaches, especially CAR T-cells, while early in the testing phase, has shown significant benefit among patients with very few options left. Other approaches to enhancing the T-cell immunity such as BiTE platforms as well as vaccination approaches are in clinical trials. All in all, this is an exciting time for myeloma and I am convinced that a cure is around the corner. What needs to be determined is if this will come from treating myeloma with these approaches or whether we need to intervene at the smoldering phase.

What Triggers Multiple Myeloma?

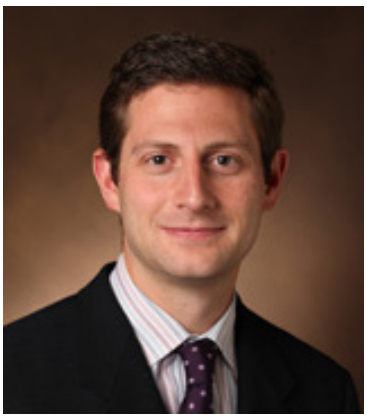
RWHC: What are some of the biggest challenges facing researchers studying multiple myeloma?

SJ: There are many challenges facing researchers. These include the lack of understanding the triggers for development of the disease, and the ability to identify patients who progress to myeloma in a specific fashion. Lack of good models for testing the myeloma cells outside of the patient, both for its behavior and responses to treatment, remains a problem. In the clinical trial arena, the ability to do clinical trials fast and also have faster readouts using surrogate endpoints remain a challenge.

Read this article at Real World Health Care.

Multiple Myeloma & Cardiac Risk

Real World Health Care continues our series on multiple myeloma with a discussion about the cardiac effects of cancer treatment with Dr. Robert Frank Cornell. Dr. Cornell is the clinical director of the plasma cell disorder program and the director of the plasma cell/lymphoma clinical trial research program at Vanderbilt University Medical Center.



Dr. Cornell's research focuses on translational and early phase clinical trials for the treatment of multiple myeloma. He also conducts research and clinical trials for relapsed/refractory multiple myeloma and other plasma cell disorders. He also researches cardio-oncology to better understand the effects of chemotherapy on the heart and vascular system.

Effective Treatments Carry Risks

Real World Health Care: What initially intrigued you about the cardiac effects of cancer treatments?

Robert Frank Cornell: I was initially drawn to study cardio-oncology due to some cardiac toxicities observed with a drug used to treat myeloma called carfilzomib. While this drug was found to be very effective in treating myeloma, it had a small but definitive increased risk of cardiac toxicities including heart failure, arrhythmia, hypertension, coronary syndrome and rarely sudden cardiac death.

I continue to be inspired by researching cardiac toxicities because it is through our research efforts we have determined means to both predict patients at risk for cardiac toxicity and mitigate the severity of the effects in order for patients to continue to receive this effective therapy. As more drugs are developed, such as CAR T-cell therapies, there will be ongoing need to understand any potential cardiac risk associated with treatments with the goal of improved patient outcomes and quality of life.

Many Myeloma Patients Already at Risk

RWHC: Can you describe some of the common cardiac complications involved in multiple myeloma treatment?

RFC: Since the average age of diagnosis for myeloma is around 68 years, many patients already have risk factors for cardiac toxicities such as hypertension, hyperlipidemia, diabetes mellitus, obesity and kidney dysfunction. The addition of chemotherapy in this patient population increases the risk of possible cardiac complications.

One of the most common drugs used to treat myeloma is dexamethasone. This drug is a corticosteroid and can result in fluid retention and high blood pressure. Another treatment commonly used for myeloma is high dose melphalan followed by autologous hematopoietic cell transplantation (stem cell transplant). During the course of the transplantation process, patients are monitored for development of cardiac toxicities. It is not uncommon for patients to develop atrial fibrillation (a fib) or have an exacerbation of preexisting a fib during the course of transplant due to the added stress on the heart.

Carfilzomib, as mentioned above, also increases the risk as cardiac complications. The drug class of immunomodulatory/cereblon-binding agents including lenalidomide and pomalidomide increases the risk for thromboembolic events including deep vein thrombosis (clot in the deep veins of the leg) or pulmonary embolus (clot in the artery of the lung). While this is not a traditional cardiac complication, many cardiologists monitor for this since it is thought that the blood vascular system may play a role in the development of these.

The majority of other FDA approved treatments for myeloma have very low risk for cardiac toxicity such as the drug class of reversible proteasome inhibitors including bortezomib and Ixazomib (though there are case reports of cardiac problems with bortezomib) and monoclonal antibodies including elotuzumab and daratumumab.

Collaborative Care

RWHC: What sort of challenges do clinicians face when treating multiple myeloma patients in terms of minimizing cardiac complications?

RFC: The biggest challenge I see is how best to manage a patient considered to be at very high risk for cardiac complications during the course of treatment. This patient is identified according the medical history as already having a known history of cardiac difficulties. The best strategy to overcome this is with a collaborative cardiac and oncology effort to optimize the patient's cardiac status prior to and during the course of treatment. This includes optimization of a patient's blood pressure, cholesterol, diabetes, heart failure, rhythm control and volume status. Should cardiac problems arise during the course of treatment, then prompt evaluation by a cardiologist should be considered, particularly in high-risk patients.

Underlying Causes of Cardiac Complications

RWHC: How can researchers overcome the challenges they face when studying cardiac complications of cancer therapies?

RFC: One of the biggest challenging for the research of cardiac complications is the determination of the underlying cause for the cardiac complication. Since patients with myeloma already often have risk factors for cardiac events, it can be challenging determining if the cardiac event occurred

from the treatment itself, from supportive care as part of the treatment such as intravenous fluids, or simply occurred by chance since the patient was at higher risk for cardiac complications regardless of treatment. The cardiac event may have also occurred due to a combination of these factors. To overcome this challenge, ongoing research and collaboration between hematology and cardiology are needed to better understand the cardiac complications, develop strategies to prevent or mitigate the events and optimize patients care and outcomes to both improve survival and quality of life.

Read this article at Real World Health Care.

Multiple Myeloma: A Rare and Complex Cancer

We continue our series on multiple myeloma with an interview with Gareth J. Morgan, MD, FRCP, FRCPath, PhD, professor of hematology and director of the Myeloma Institute at the University of Arkansas for Medical Sciences (UAMS). Dr. Morgan also serves as deputy director of the Winthrop P. Rockefeller Cancer Institute at UAMS.

Dr. Morgan is responsible for all clinical, research, and administrative operations at the Myeloma Institute, which is one of the largest programs in the world focused on the research and treatment of multiple myeloma and related diseases. Clinically, he directly oversees 8 physician specialists, 14 mid-level providers, and 7 hospitalists, all experts in the management of myeloma and related plasma cell diseases. He also manages 8 research teams, which represent an integrated program of the genetics and biology of myeloma.

Mechanisms of Malignant Transformation

Real World Health Care: What got you interested in the field of multiple myeloma and what keeps you inspired?

Gareth Morgan: Scientifically, I saw the opportunity to exploit the transition of MGUS (monoclonal gammopathy of undetermined significance) to smoldering myeloma to multiple myeloma as a model to understand the mechanism that drives malignant transformation. I reasoned that if we understood these, we should be able to manipulate them therapeutically.

I continue to be inspired by the ability to translate the biology and genetics of myeloma into clinical practice, where better and less toxic treatments can and are being developed to help patients achieve better outcomes and increased survival. Patients are the true source of inspiration.

Myeloma Genome Project

RWHC: Tell us about your recent research work and its significance to the multiple myeloma patient community.

GM: This is an exciting time for the field of myeloma, and our research investigations have led to some exciting discoveries in the biology of myeloma based on the genetic variations within the

human genome. With our colleagues in Europe, have identified eight new genetic variations that could be linked to an increased risk of developing myeloma.

We are also focused on developing a molecular classification of myeloma based on patient subgroups with distinct pathogenesis and clinical behavior. We have partnered with Celgene and the Dana–Farber Cancer Institute in establishing a global collaboration called the Myeloma Genome Project. The goal of this project is to compile and analyze the largest set of genomic and clinical data to design a molecular classification system to improve the diagnosis, prognosis and treatment of myeloma. Up to this point, we have collated the data that we already have, and now we are bringing other national and international investigators in to really form a global consortium. This data will help us identify patients who have distinct clinical outcomes, and allow us to take a stratified-risk approach to designing treatment strategies. This initiative could really lead the way in developing specific clinical trials for targeted treatments for patients in the future.

Personalized Medicine: The Future of Cancer Care

RWHC: What are the most promising new treatments for multiple myeloma? Are there any on the horizon that hold the possibility for a cure?

GM: I believe that stem cell transplantation remains the backbone of treatment for many patients, and we don't want to move away from a strategy we know to be successful for many. So, we are now incorporating new treatments to increase cure rates and to give more patients higher and better responses overall. This involves moving away from the one-size-fits-all approach to a more directed, personalized one which includes the use of novel agents, immunotherapy, and targeted-based treatments.

Immunotherapy is one of the more exciting developments for patients with relapsed/refractory disease, and we are now looking at incorporating these agents into the newly diagnosed setting. Using different combinations of antibodies that address the different components of the immune system is going to be a really important way forward. In addition, the increased understanding of cancer genomics has given us a wealth of information about the biological processes involved in the initiation and development of myeloma cells, which has really powered the concept of developing targeted therapies directed at specific mutations at the molecular level. This approach, also known as personalized or precision medicine, clearly represents the future of cancer care.

Underlying Causes of Myeloma

RWHC: What are some of the biggest challenges facing multiple myeloma researchers?

GM: Some challenges myeloma researchers face include gaining a better understanding of the underlying causes of myeloma and designing prevention and early intervention strategies, as well as developing strategies to prevent precursor states of myeloma—MGUS (monoclonal gammopathy of

undetermined significance) and smoldering myeloma—from developing into active multiple myeloma. Of course, funding remains one of the biggest challenges faced by researchers, and it probably always will be.

Increasing collaborations with university and industry partners provides an opportunity to gain access to much larger datasets and to develop clinical trials to help answer some of these important questions.

Overcoming Resistance to Multiple Myeloma Treatment

RWHC: What are some of the biggest challenges facing clinicians treating multiple myeloma patients?

GM: Over the last decade, we've seen an unprecedented improvement in multiple myeloma as novel agents and treatment combinations expand. Despite the vast improvement, there remains a proportion of patients who relapse and are more likely to have aggressive disease that is refractory to therapy. I think one of the challenges in myeloma is how do we treat and design strategies that can overcome treatment resistance for these high-risk patients to improve their long-term outcomes.

This challenge requires a change that focuses on the use of genetic analyses to segment myeloma at the molecular level to enhance risk segmentation to develop biologically-stratified treatment approaches. We are also exploring the use of imaging studies to recognize high-risk and DNA-based features. Collecting the sequencing and imaging data and analyzing it consistently provides a resource for the myeloma community that can continue to grow into the future.

Another important challenge facing clinicians is patient access to a myeloma specialist. Myeloma is a rare and complex cancer, so oncologists can't use concepts developed for more common cancers, such as breast or colon, in myeloma. The key is having a focused strategy that is directed by a myeloma expert. Unfortunately, some patients don't have access to a specialist because of location, insurance, or other financial restrictions. At the Myeloma Institute we incorporate a team approach, whereby our team of myeloma experts direct the treatment strategy and for practical purposes, patients can receive much of their treatment locally. So, if myeloma experts can partner with local oncologists who can then deliver some of the treatment, then it's an ideal setting for patients, because they receive the benefit of a myeloma-specific strategy and risk stratification upfront, and in the long-term, they have the comfort and security of being close to home.

Read this article at Real World Health Care.

Multiple Myeloma Treatment: Too Many Choices?

Real World Health Care continues our multiple myeloma series with an interview with Edward A. Faber Jr., DO, MS, associate director of the Blood and Marrow Transplant Program managed by Oncology Hematology Care, Inc. in conjunction with the Mercy Health and The Jewish Hospital in Cincinnati. He also serves as principal investigator for OHC's multiple myeloma clinical trials. Dr. Faber is a member of OHC's board of directors and the Dayton Clinical Oncology Program and serves on the board of trustees for the Leukemia and Lymphoma Society. We discussed his clinical trial work and his views on promising new treatments for multiple myeloma.

Early Work in Multiple Myeloma

Real World Health Care: What attracted you to the field of multiple myeloma and what keeps you inspired?

Edward Faber: I initially sought a career in bone marrow transplantation. During my training and fellowship, I decided to pursue a career in academic medicine, at a time when multiple myeloma was almost in its infancy. There have been so many advances over the past decade, not only with new individual medications but also with new combination therapies.

The inspiration comes from the patients, as quality of life and survival have improved over the past 10-15 years. This is a testament to the collaborative effort between academia, cooperative groups and pharmaceutical companies.

Clinical Trials

RWHC: What is the significance of your recent clinical trials?

EF: Over the past five to six years, we have been involved with clinical trials involving carfilzomib, pomalidomide, panobinostat, and daratumumab. We're also comparing combination therapies between carfilzomib (KRd) versus bortezomib (RVd). These trials have demonstrated the efficacy of the combination of carfilzomib and panobinostat. For example, daratumumab, a potent choice for our patients with multiple myeloma, may offer benefits towards patients with smoldering myeloma.

Bone marrow transplant is an accepted treatment option, and the large Eastern Cooperative Oncology Group (ECOG) trial comparing KRd and RVd with lenalidomide maintenance may prove to offer a

viable strategy outside of transplant. Quite simply, the research that we have been participating in has led to improvements in combination therapies with the newer medications for patients in the current community.

Research Collaboration

RWHC: What are some of the biggest challenges facing multiple myeloma researchers?

EF: The challenges facing multiple myeloma researchers are not unlike those facing all researchers, from the standpoint of availability of clinical trials, and making clinical trials available to large portions of the population.

Funding is always an issue for basic science researchers, bench top researchers, and clinical scientists.

Staying up-to-date with the current large cooperative groups, as well as the national scientific groups such as the American Society of Hematology and American Society of Clinical Oncology, is more important than ever, in order to learn and understand which available therapies offer more promise and move those therapies forward so that they eventually can lead to FDA indications.

Sequencing Therapies

RWHC: How are clinicians overcoming treatment challenges in multiple myeloma?

EF: The availability of a large number of drugs to treat multiple myeloma patients is both positive and a challenge for clinicians because there can be just too many choices.

The most important step begins at initial diagnosis and knowing how to sequence available therapies — especially combination therapies — over time to maximize benefit. These combinations must be interpreted in the context of the patient's other medical issues. Certain side effects, such as cardiac toxicities, need to be avoided in certain patients. Patients should be encouraged to develop a good relationship with a physician who has focused interest in multiple myeloma. If that physician is aligned with a large academic center, he or she will be in a better position to help translate recent research and trial successes to hospital exam rooms, where the majority of myeloma patients are treated.

Read this article at Real World Health Care.

Helping Others Get the Help They Need

Editor's Note: We conclude our series on Multiple Myeloma with a profile of a patient who was struggling to afford her treatments until she received a grant from our sponsor, the HealthWell Foundation.

The searing back pain was the first indication to Marilyn Gould that something wasn't quite right. The 67-year-old retired architect from Baltimore started to feel the pain at age 62 and began visiting a variety of doctors and specialists to find out what was wrong.

Blood work indicated high protein levels — a potential marker for multiple myeloma. Imaging did not reveal any tumors. Eventually, her L5 vertebra cracked and she had to have surgery. It was during this surgery that a tumor was discovered inside her vertebra. Two surgeries were needed to remove the tumor and replaced it with a titanium cage.

"At that point, there was no question: I had multiple myeloma," said Marilyn.

Relief, Followed by Concern

"Getting the formal diagnosis was almost like a relief, because I knew I was a candidate for the disease and tried to educate myself about what was going to happen," she said. "But nobody told me exactly what to do."

Marilyn's hematologist suggested that she consult with a multiple myeloma specialist, who started her on a course of treatment that involves an oral chemotherapy medication, steroids, an antibiotic and four 30-minute bone infusions a year — a regimen she has followed for the last 5 years.

As can happen with many chronic and life-altering diseases, multiple myeloma and its related treatments have had an impact on Marilyn's lifestyle, though she says she still remains fairly active.

"I don't run anymore and can no longer play golf," she said. "But I do a lot of walking, and some bike riding. I also practice yoga, which has helped tremendously with my stability and balance, which have been compromised after two back surgeries."

The disease and its treatments have also had an impact on Marilyn's financial security.

"My Medicare Part D coverage still leaves me with a significant copay for the oral chemotherapy drug that I need to take for three weeks every month," she said. "It's a $10,000 copay every year — a difficult amount to afford on a fixed income, or just about any income. I originally received financial assistance from another copay assistance foundation, but when they couldn't renew my grant, I turned to the HealthWell Foundation."

Reaching Out

Marilyn said that financial assistance for treatment copays is a common topic when she speaks with other multiple myeloma patients as part of her volunteer outreach work with the Leukemia & Lymphoma Society.

"Just about everyone I speak with has financial concerns," she said. "I let them know about the existence of copay assistance foundations like HealthWell, as well as other help that is available, like the Maryland-based MobilityLink program, which provides transportation to and from treatments for people who can't drive or don't have access to other transportation."

While Marilyn is quick to point out that she is not a medical professional and can't give medical advice, she does have words of wisdom to share with other multiple myeloma patients.

"Don't be afraid to seek a second opinion, especially if a bone marrow transplant has been suggested," she said. "And because multiple myeloma tends to hit people over 50 more than younger people, I tell everyone of that age to stay current with their blood work."

Supporting Multiple Myeloma Patients

The HealthWell Foundation, sponsor of Real World Health Care, is proud to have supported the multiple myeloma patient community in recent years with copayment and premium assistance. We have helped more than 9,000 multiple myeloma patients afford their treatments since 2015 — thanks to the generous support of our donors. Due to high patient volume, our multiple myeloma fund is temporarily closed until we receive additional funding. We invite corporations and individuals to help us meet this demand by contributing to our Multiple Myeloma Medicare Access Fund, so no one goes without essential medications because they cannot afford them.

Read this article on Real World Health Care.