Indication	For 2nd line treatment of relapsed or refractory myeloma in patients who have previously received 1 and only 1 prior line of systemic therapy for myeloma which contained lenalidomide that has had to be discontinued due to disease progression whilst on treatment or intolerance of lenalidomide. Patients with amyloidosis or POEMS syndrome are not eligible for Belantamab mafodotin. NB lenalidomide treatment to have been given either as commissioned by NHS England or is part of a 1st line treatment regimen in a NIHRbadged clinical trial.
Treatment Intent	Disease Modification
Frequency and number of cycles	Repeat every 28 days Continue until disease progression, unacceptable toxicity or patient choice to discontinue. NB this indication is exempt from NHS England's treatment break policy due to the potentially necessary frequency and duration of treatment breaks during treatment. If there is disease progression during a treatment break, treatment with belantamab mafodotin must be discontinued.
Monitoring Parameters	• **Virology screening:** All new patients referred for systemic anti-cancer treatment should be screened for hepatitis B and C and the result reviewed prior to the start of treatment. Patients not previously tested who are starting a new line of treatment, should also be screened for hepatitis B and C. Further virology screening will be performed following individual risk assessment and clinician discretion. • Consider flu and pneumococcal vaccination pre-therapy. • **Ophthalmology assessment:** o An ophthalmic examination including visual acuity and slit lamp examination must be performed by an eye care professional prior to each of cycles 1, 2, 3 and 4 and then during treatment as indicated. o Arrangements must be in place for eye care professionals to categorize both the degree of any corneal damage and the best corrected visual acuity in the most severely affected eye and for these results to be communicated to the myeloma team. o Patients should avoid using contact lenses until the end of belantamab mafodotin treatment unless bandage contact lenses are used under the direction of an ophthalmologist. o Dose modification may be required. After a dose reduction is made for ocular adverse reactions do not re-escalate the dose (see table 2). • **Haematological monitoring and parameters:** o Monitor FBC, U&Es and LFTs at baseline and at each cycle. o If NEUTS >/= 1 and PLTS >/= 50 continue treatment. If parameters not met see table 1 for belantamab mafodotin guidance and for pomalidomide see table 3 • Cases of hypothyroidism have been reported with pomalidomide, baseline and ongoing monitoring of thyroid function is recommended. • **BP** baseline and as clinically indicated. • **Hepatic impairment:** o **Belantamab mafodotin:** No dose modification recommended in mild impairment. Limited data in moderate impairment, treat with caution and monitor closely. No data in severe impairment. o **Pomalidomide:** No recommended dose adjustment. Increased monitoring required in hepatic impairment and dose reduction or interruption may be required due to adverse reactions. • **Renal impairment:** o **Belantamab mafodotin:** No dose modification recommended. o **Pomalidomide:** No dose adjustment required. On haemodialysis days, patients should take their pomalidomide dose following haemodialysis.

- **Infusion-related reactions:**
  Belantamab mafodotin: Patients experiencing IRR may require a dose modification (delay and/or reduction) or treatment discontinuation (see table 1).
- **Management of adverse reactions and dose adjustments:**
- **Dexamethasone:** Consider dose reduction to 20mg in patients who are >/=75 years.
- **Belantamab mafodotin:**
- If a dose reduction is required dose at 1.9mg/kg but extend the administration to every 8 weeks, if this dose is not tolerated dose reduce to 1.4mg/kg every 8 weeks, if this dose is not tolerated treatment should be stopped. See table 1 and table 2 for dose modification guidance.
- **Pomalidomide:**
  - If a dose reduction is required the first reduction should be 3mg OD, second reduction 2mg OD and the final dose reduction 1mg OD. If this does cannot be tolerated pomalidomide should be discontinued.
  - **Thromboembolic events:**
  - Patients with known risk factors for thromboembolism – including prior thrombosis – should be closely monitored and VTE prophylaxis considered. Patients should be instructed to report any new symptoms such as shortness of breath, chest pain, arm or leg swelling.
  - **Tumour Lysis Syndrome: (TLS)**
  - Monitor for signs and symptoms of TLS. Appropriate measures (hydration, allopurinol, rasburicase) must be taken to prevent hyperuricemia as clinically indicated.
  - **Severe Cutaneous Adverse Reactions (SCARs)**
  - Pomalidomide can induce severe skin reactions such as Stevens-Johnson syndrome. Patients should be informed of the possibility of severe skin reactions such as Stevens-Johnson syndrome and informed to seek urgent medical advice should any symptoms of a severe skin reaction occur.
  - **Interstitial lung disease (ILD)**
  - Patients should report any new respiratory symptoms. Pomalidomide should be interrupted pending investigation of these symptoms and if ILD is confirmed, appropriate treatment should be initiated. Pomalidomide should only be resumed after a thorough evaluation of the benefits and the risks.
  - **Progressive multifocal leukoencephalopathy (PML)**
  - PML has been reported in patients receiving pomalidomide. Patients should be monitored for new or worsening neurological, cognitive or behavioural changes. All treatment should be held if PML is suspected and permanently discontinued if PML is confirmed.
- **Common drug interactions (for comprehensive list refer to BNF/SPC):**
- **Belantamab mafodotin:** no formal drug interaction studies have been performed.
- **Pomalidomide:** If strong inhibitors of CYP1A2 (e.g. ciprofloxacin and fluvoxamine) are co-administered with pomalidomide, reduce the dose of pomalidomide by 50%.
- **Missed dose:**
- If a planned dose of pomalidomide is missed, the dose should be omitted and the patient should take the normal prescribed dose as scheduled on the next day.
- **Pregnancy and contraception:**
- Ensure Pomalidomide pregnancy prevention programme forms are completed with each prescription. The PAF must be submitted to Celgene for every dispensing event.
- Women of childbearing potential must use at least one effective method of contraception for at least 4 weeks before pomalidomide therapy, during therapy with belantamab and pomalidomide, and until at least 4 weeks after pomalidomide therapy (even in case of dose interruption) and for 4 months after cessation of belantamab mafodotin.
- Male patients with partners of childbearing potential should use effective contraception during treatment with pomalidomide and belantamab, during any dose interruption and for 7 days after cessation of pomalidomide treatment and for 6 months following completion of belantamab mafodotin treatment.

	• **Driving and machinery:** Belantamab mafodotin can have significant effects on a patient's ability to drive and operate machinery and dizziness and fatigue are reported side effects of pomalidomide; patients should be advised to use caution when driving or operating machinery. • **For oral self-administration:** refer to local Trust policy on oral anti-cancer medicines and supply Patient Information Leaflet and Macmillan information sheet.
References	SPC accessed online belantamab mafodotin, pomalidomide and dexamethasone 03.02.2026 CDF list V1.385 accessed online 03.02.2026

NB For funding information, refer to CDF and NICE Drugs Funding List

Table 1 Recommended dose modifications for belantamab mafodotin for other adverse reactions[a]

Adverse Reaction	Severity	Recommended dose modifications
Thrombocytopenia	Grade 3	No bleeding: • For patients on 2.5 mg/kg, reduce to 1.9 mg/kg. For patients on 1.9 mg/kg or lower continue at same dose With bleeding: • Withhold until improvement to Grade 2 or better. For patients previously on 2.5 mg/kg, resume at 1.9 mg/kg. For patients on 1.9 mg/kg or lower resume at same dose. Consider additional supportive treatment (e.g., transfusion), as clinically indicated and per local practice.
	Grade 4	Withhold the dose. Consider restarting if recovered to Grade 3 or better, and only if there is no active bleeding at time of treatment restart. For patients previously on 2.5 mg/kg, resume at 1.9 mg/kg. For patients on 1.9 mg/kg or lower resume at same dose. If thrombocytopenia is considered disease-related, is not accompanied by bleeding, and recovers with transfusion to >25 $x10^9$/L, continuing treatment at the same dose may be considered.
Infusion-related reactions	Grade 2	Interrupt infusion and provide supportive treatment. Once symptoms resolve to Grade 1 or better, resume at a decreased infusion rate by at least 50% and may consider premedication.
	Grade 3	Interrupt infusion and provide supportive treatment. Once symptoms resolve to Grade 1 or better, resume with premedication and at lower infusion rate extended to 2 to 4 hours. Any future infusion requires premedication.
	Grade 4	Permanently discontinue. If anaphylactic or life-threatening infusion reaction, permanently discontinue the infusion and institute appropriate emergency care.
Other adverse reactions	Grade 3	Withhold until improvement to Grade 1 or better. For patients previously on 2.5 mg/kg, resume at 1.9 mg/kg. For patients on 1.9 mg/kg or lower resume at same dose.
	Grade 4	Consider permanent discontinuation. If continuing treatment, withhold until improvement to Grade 1 or better. For patients previously on 2.5 mg/kg, resume at 1.9 mg/kg. For patients on 1.9 mg/kg or lower resume at same dose.

[a] Other adverse reactions were graded according to the National Cancer Institute Common Terminology Criteria for Adverse Events (CTCAE).

Table 2: Recommended dose modifications for belantamab mafodotin for ocular adverse reactions

Severity[a]	**Recommended dose modifications**
Grade 1 *Corneal examination finding(s)* Mild superficial punctate keratopathy with worsening from baseline, with or without symptoms. *Change in BCVA* Decline from baseline of 1 line on Snellen Equivalent Visual Acuity.	Continue treatment at current dose.
Grade 2 *Corneal examination finding(s)* Moderate superficial punctate keratopathy, patchy microcyst-like deposits, peripheral sub-epithelial haze, or a new peripheral stromal opacity. *Change in BCVA* Decline from baseline of 2 lines (and Snellen Equivalent Visual Acuity not worse than 20/200). Or Grade 3 *Corneal examination finding(s)* Severe superficial punctate keratopathy, diffuse microcyst-like deposits involving the central cornea, central sub-epithelial haze, or a new central stromal opacity. *Change in BCVA* Decline from baseline of 3 or more lines (and Snellen Equivalent Visual Acuity not worse than 20/200).	Withhold treatment until improvement in both corneal examination findings and BCVA to Grade 1 or better. Resume treatment at reduced dose level 1[b].
Grade 4 *Corneal examination finding(s)* Corneal epithelial defect.[c] Or *Change in BCVA* Decline to Snellen Equivalent Visual Acuity of worse than 20/200.	Withhold until improvement in both corneal examination findings and BCVA to Grade 1 or better. Resume treatment at reduced dose level 2 For worsening symptoms that are unresponsive to dose reductions or withholding of treatment, consid*er permanent discontinuation*.

BCVA = best corrected visual acuity; BPd = Belantamab mafodotin with pomalidomide and dexamethasone

[a] Ocular adverse reaction severity is defined by the most severely affected eye as both eyes may not be affected to the same degree.

[b] If toxicity is identified prior to dosing Cycle 2 for Belantamab mafodotin with pomalidomide and dexamethasone, dose at 1.9 mg/kg every 4 weeks

[c] A corneal defect may lead to corneal ulcers. These should be managed promptly and as clinically indicated by an eye care professional.

Table 3. Pomalidomide dose modification instructions∞

Toxicity	**Dose modification**
Neutropenia* ANC** < 0.5 x 10^9/l or febrile neutropenia (fever ≥38.5°C and ANC <1 x 10^9/l)	Interrupt pomalidomide treatment for remainder of cycle. Follow CBC*** weekly.
ANC return to ≥ 1 x 10^9/l	Resume pomalidomide treatment at one dose level lower than previous dose.
For each subsequent drop < 0.5 x 10^9/l	Interrupt pomalidomide treatment.
ANC return to ≥ 1 x 10^9/l	Resume pomalidomide treatment at one dose level lower than the previous dose.
Thrombocytopenia Platelet count < 25 x 10^9/l	Interrupt pomalidomide treatment for remainder of cycle. Follow CBC*** weekly.
Platelet count return to ≥ 50 x 10^9/l	Resume pomalidomide treatment at one dose level lower than previous dose.
For each subsequent drop < 25 x 10^9/l	Interrupt pomalidomide treatment.
Platelet count return to ≥ 50 x 10^9/l	Resume pomalidomide treatment at one dose level lower than the previous dose.
Rash Rash = Grade 2-3	Consider dose interruption or discontinuation of pomalidomide treatment.
Rash = Grade 4 or blistering (including angioedema, anaphylactic reaction, exfoliative or bullous rash or if Stevens-Johnson syndrome (SJS), Toxic Epidermal Necrolysis (TEN) or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) is suspected)	Permanently discontinue treatment
Other Other ≥ Grade 3 pomalidomide-related adverse events	Interrupt pomalidomide treatment for remainder of cycle. Resume at one dose level lower than previous dose at next cycle (adverse event must be resolved or improved to ≤ Grade 2 before restarting dosing).

∞ Dose modification instructions in this table are applicable to pomalidomide in combination with bortezomib and dexamethasone and to pomalidomide in combination with dexamethasone.

*In case of neutropenia, the physician should consider the use of growth factors. **ANC – Absolute Neutrophil Count;

***CBC – Complete Blood Count.

Cycle 1 only: 28 day cycle

Day	Drug	Dose	Route	Infusion Duration	Administration
1	**BELANTAMAB MAFODOTIN**	**2.5mg/kg**	IV	30minutes	In 250ml sodium chloride 0.9%
TTO	Drug	Dose	Route	Directions	
Day 1	**POMALIDOMIDE**	**4mg**	PO	OD on days 1 to 21 only, take at the same time each day. Swallow whole with a whole glass of water. Do not crush or open the capsules. Complete prescription authorisation form. Capsules available in 1mg, 2mg 3mg and 4mg	
	DEXAMETHASONE	**40mg***	PO	OM on days 1, 8, 15 and 22 Take with or after food. When taken on d1 take prior to belantamab mafodotin.	
	Hypromellose Preservative free	0.3%	Eye drops	1 drop both eyes QDS for the duration of treatment.	
	Loperamide	2mg	PO	Take two capsules (4mg) after first loose stool, then one capsule (2mg) after each loose stool when required. (Maximum 16mg per day). Dispense on Cycle 1 only, then prescribe as required.	
	Metoclopramide	10mg	PO	Take 10mg up to TDS when required Do not take for more than 5 days continuously.	
	Aciclovir	400mg	PO	TWICE daily.	
	Co-trimoxazole	480mg	PO	TWICE daily on Mondays, Wednesdays and Fridays.	
	Allopurinol	300mg	PO	OD Cycle 1 only, then prescribed only if required	
	Consider anti-fungals and prophylactic anticoagulation				

* If >/=75years consider reducing to 20mg

Cycle 2 onwards: repeat every 28 days.

Day	Drug	Dose	Route	Infusion Duration	Administration
1	**BELANTAMAB MAFODOTIN**	**1.9mg/kg**	IV	30minutes	In 250ml sodium chloride 0.9%
TTO	Drug	Dose	Route	Directions	
Day 1	**POMALIDOMIDE**	**4mg**	PO	OD on days 1 to 21 only, take at the same time each day. Swallow whole with a whole glass of water. Do not crush or open the capsules. Complete prescription authorisation form. Capsules available in 1mg, 2mg 3mg and 4mg	
	DEXAMETHASONE	**40mg***	PO	OM on days 1, 8, 15 and 22 Take with or after food. When taken on Day 1 take prior to belantamab mafodotin.	
	Hypromellose Preservative free	0.3%	Eye drops	1 drop both eyes QDS for the duration of treatment.	
	Loperamide	2mg	PO	Take two capsules (4mg) after first loose stool, then one capsule (2mg) after each loose stool when required. (Maximum 16mg per day). Dispense on Cycle 1 only, then prescribe as required.	
	Metoclopramide	10mg	PO	Take 10mg up to TDS when required. Do not take for more than 5 days continuously.	
	Aciclovir	400mg	PO	TWICE daily.	
	Co-trimoxazole	480mg	PO	TWICE daily on Mondays, Wednesdays and Fridays.	
	Consider anti-fungals and prophylactic anticoagulation				

* If >/=75years consider reducing to 20mg