

Abstract Title : Primary results from VAYHIT2, a randomized, double-blind, phase 3 trial of ivalumab plus eltrombopag versus placebo plus eltrombopag in patients with primary immune thrombocytopenia (ITP) who failed first-line corticosteroid treatment

Category: 300s - Hemostasis, Thrombosis and Vascular Wall Biology

Review Category: 311. Disorders of Platelet Number or Function: Clinical and Epidemiological

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Abstract Body

Introduction: B cells and the B-cell activating factor (BAFF) pathway are key in immune thrombocytopenia (ITP) pathophysiology. Ivalumab is a novel, first-in-class monoclonal antibody which binds to and blocks BAFF receptor, causing enhanced depletion of B cells via antibody-dependent cellular cytotoxicity and inhibition of B-cell activation, maturation, proliferation, and survival. We hypothesize that early intervention with ivalumab may provide a disease-modifying effect, such that the typical natural history

of ITP is ameliorated in a significant proportion of patients (pts).

Methods: VAYHIT2 (NCT05653219) is a randomized, double-blind, placebo-controlled, Phase 3 study of ianalumab in adults with primary ITP. Pts had insufficient response to/relapse after first-line corticosteroid therapy ($\pm$ intravenous [IV] immunoglobulin), platelet (PLT) count $<30 \times 10^9/L$, and were naive to and had indication for second-line ITP treatment. Pts were randomized (1:1:1) to receive eltrombopag plus either ianalumab 9mg/kg or 3mg/kg or placebo. Ianalumab or placebo was administered as four once-monthly IV infusions, simultaneously with daily eltrombopag for 16 weeks then an 8-week eltrombopag tapering period. The primary endpoint was time to treatment failure (TTF), defined as time from randomization until PLT count $<30 \times 10^9/L$ or start of rescue therapy 8 weeks after randomization, start of a new ITP therapy at any time, inability to taper or discontinue eltrombopag by week 24, or death. The key secondary endpoint was stable response at 6 months (SR6), defined as having $\geq 75\%$ of PLT counts between weeks 19 and 25 being $\geq 50 \times 10^9/L$ without rescue or new ITP treatment. On-treatment safety outcomes were assessed from first study drug infusion to 28 days following the last infusion; adverse events (AEs) associated with B-cell depletion were assessed until end of study.

Results: Of 152 pts enrolled, 50 were randomized to ianalumab 9mg/kg, 51 to ianalumab 3mg/kg, and 51 to placebo. Pt characteristics were generally balanced between arms. Median (interquartile range) follow-up: 12.9 (8.6–18.0), 13.6 (8.4–18.1), and 11.6 (8.1–18.2) months in the ianalumab 9mg/kg, 3mg/kg, and placebo arms, respectively. TTF was significantly longer with ianalumab 9mg/kg (HR 0.55, 95% CI 0.32–0.92; log-rank $p=0.021$) and ianalumab 3mg/kg (HR 0.58, 95% CI 0.34–0.98; log-rank $p=0.023$), vs placebo; median (95% CI) TTF was 13.0 (5.1–not estimable [NE]), NE (3.7–NE), and 4.7 (3.9–5.6) months, respectively.

Significantly more pts achieved SR6 with ianalumab 9mg/kg (31 [62.0%]) vs placebo (20 [39.2%]), Cochran-Mantel-Haentzel (CMH) $p=0.023$; and ianalumab 3mg/kg (29 [56.9%]), not reaching statistical significance compared with placebo, CMH $p=0.035$. At 6 months, response (PLT $\geq 50 \times 10^9/L$) and complete response (PLT $\geq 100 \times 10^9/L$) rates were 73.5% and 55.1%, respectively with ianalumab 9mg/kg and 48.0% and 26.0%, respectively with placebo.

At the end of the eltrombopag tapering period, PROMIS short-form v1.0 fatigue 13a showed reduction of fatigue (mean [SD] change in T-score from baseline) of -7.7 [8.9], and -3.6 [7.0] with ianalumab 9 mg/kg and placebo, respectively.

All-grade AE rates were similar between arms (84.0%–94.0%). Grade ≥ 3 AEs occurred in 12 (24.0%), 10 (20.0%), and 2 (3.9%) pts in the ianalumab 9mg/kg, ianalumab 3mg/kg and placebo arms, respectively. All SAEs as assessed by investigator were unrelated to study drug except for 1 event (Grade 1 palpitations) in the ianalumab 3mg/kg arm. Frequency and severity of infections (including Grade ≥ 3) were similar across arms. In the ianalumab 9mg/kg, ianalumab 3mg/kg, and placebo arms, respectively: infusion-related reactions (14.0%, 8.0%, and 7.8%, all Grade 1/2), neutropenia (14.0%, 10.0%, and 2.0%) and allergic hypersensitivity reactions (0%, 0% and 2.0%) occurred. Grade ≥ 3 neutropenia occurred in 5 (10.0%) and 2 (4.0%) pts in the ianalumab 9mg/kg and 3mg/kg arms, respectively. There were no on-treatment AEs leading to ianalumab discontinuations; 1 reported in post-treatment period (started >28 days post-treatment).

Conclusions: Ianalumab in combination with eltrombopag prolonged TTF, improved SR6, reduced fatigue, facilitated tapering off eltrombopag, and delayed need for subsequent therapy in pts with primary ITP previously treated with corticosteroids. Ianalumab was well tolerated, with no observed increase in infection risk relative to placebo. Ianalumab may be disease-modifying when used early in the course of ITP.

Keywords: Young Adult, Bleeding and Clotting, Research, Adult, Human, Treatment Considerations, Non-Biological Therapies, Combination Therapy, Clinical Trials, Clinical Research, Diseases, Thrombocytopenias, Immune Disorders, Monoclonal Antibody Therapy, Immune Mechanism, Biological

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