

Long-Term Safety, Tolerability, and Efficacy of Efgartigimod in Participants With Generalized Myasthenia Gravis: Concluding Analyses From ADAPT+



M266

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SUMMARY

- Efgartigimod was well tolerated throughout the course of ADAPT+, with no increase in TEAEs, serious TEAEs, or infections observed with long-term treatment
- In AChR-Ab+ participants, efgartigimod treatment resulted in consistent and repeatable improvements in MG-ADL and QMG scores
- In AChR-Ab+ participants, efgartigimod treatment resulted in consistent and repeatable CMI in MG-ADL and QMG scores across increasing MG-ADL and QMG thresholds over multiple cycles in ADAPT+
- AChR-Ab+ participants with >350 days of follow-up across ADAPT/ADAPT+ showed varying intertreatment periods, which supports an individualized treatment approach
- These analyses suggest that long-term efgartigimod treatment is well tolerated and efficacious in participants with gMG

RESULTS

Table 1. ADAPT+ Baseline Demographics and Disease Characteristics
Overall Population

Characteristics	Efgartigimod (n=145)
Age, y (SD)	47.0 (14.8)
Sex, n (%)	
Female	103 (71)
Male	42 (29)
Race, n (%)	
Asian	11 (7.6)
Black/African American	5 (3.4)
White	126 (86.9)
Time since gMG diagnosis, y (SD)	9.7 (8.2)
MGFA class at screening, n (%)	
II	55 (37.9)
III	86 (59.3)
IV	4 (2.8)
AChR-Ab+, n (%)	111 (76.6)
Total MG-ADL score, mean (SD)	9.8 (3.2)
Total QMG score, mean (SD)	15.4 (5.7)
Standard of care, n (%)	
NSIST	89 (61.4)
No NSIST	56 (38.6)
Steroid	111 (76.6)
No steroid	34 (23.4)

Table 2. Summary of TEAEs
Overall Population

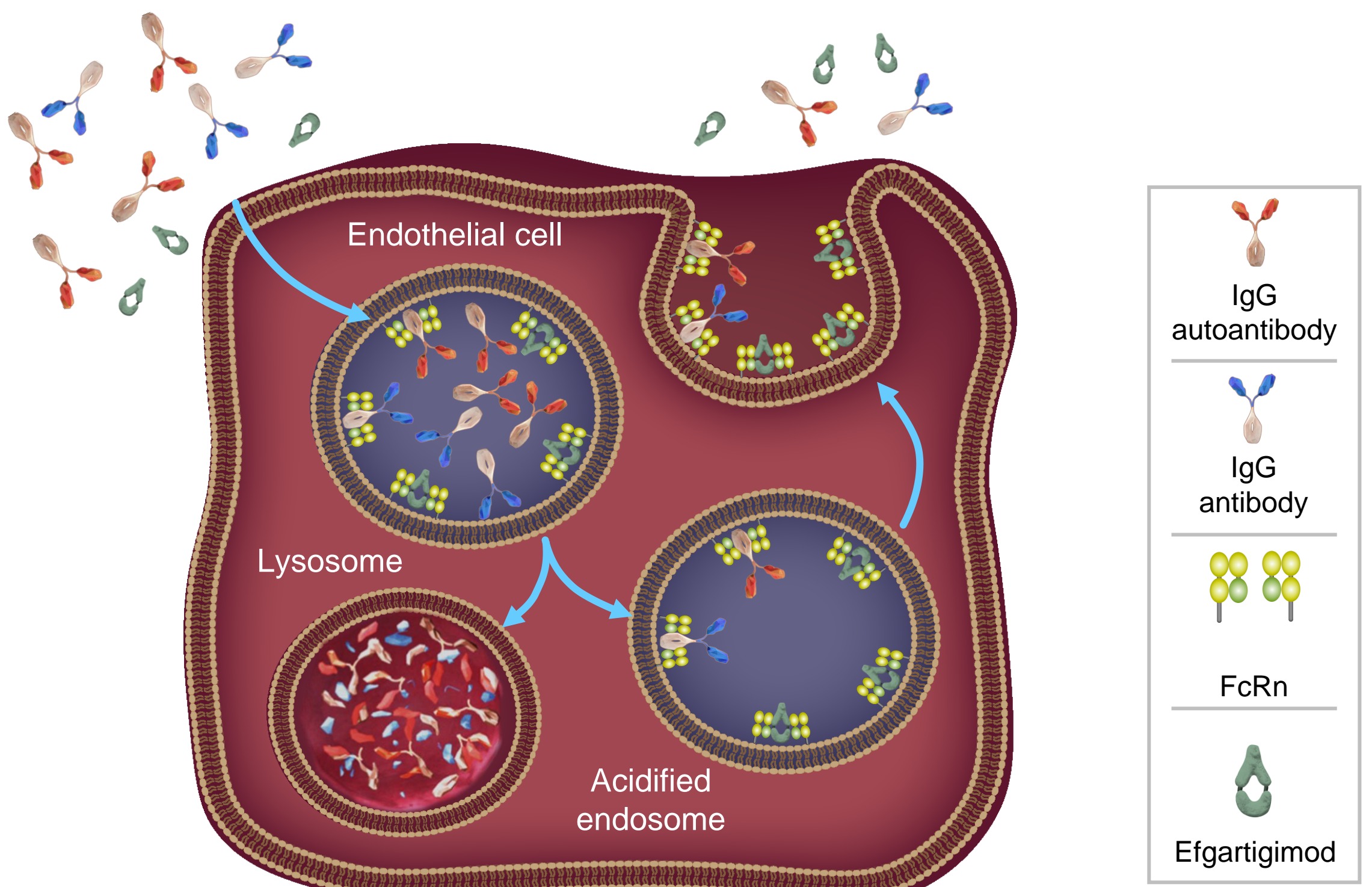
	ADAPT		ADAPT+	
	Placebo (n=83) [34.5 PY]	Efgartigimod (n=84) [34.9 PY]	Efgartigimod (n=145) [229.0 PY]	Efgartigimod (n=145) [229.0 PY]
TEAEs ^b	7.83	7.23	3.53	124 (86)
SAEs	0.29	0.11	0.24	36 (25) ^c
≥1 Infusion-related reaction event	0.26	0.09	0.09	15 (10)
Infection TEAEs	1.22	1.61	0.73	80 (55)
Discontinued due to TEAEs	0.09	0.20	0.06	12 (8)
Severe TEAEs (grade ≥3)	0.35	0.29	0.33	40 (28)
Death ^d	-	0 (0)	0.02	5 (3)
Most frequent TEAEs				
Nasopharyngitis	0.49	0.34	0.10	20 (14)
Upper respiratory tract infection	0.14	0.32	0.03	6 (4)
Urinary tract infection	0.12	0.26	0.08	13 (9)
Headache	1.13	1.15	0.45	36 (25)
Nausea	0.43	0.20	0.06	9 (6)
Diarrhea	0.41	0.17	0.08	14 (10)
COVID-19 ^e	-	0 (0)	0.10	23 (16) ^f

^aER was calculated as number of events per total PY of follow-up. ^bTEAEs were predominantly mild or moderate. ^cOnly 1 SAE was considered treatment related per investigator. ^dNone of the deaths in ADAPT+ were related to efgartigimod administration per the principal investigator. ^eIncludes all preferred terms of COVID-19, COVID-19 pneumonia, coronavirus infection, exposure to SARS-CoV-2, and SARS-CoV-2 test positive. ^fAmong participants reporting COVID-19 during ADAPT+, 83% had not received prior COVID-19 vaccination.

- In ADAPT+, 145 participants received ≥1 cycle over a median study duration of 651 days (minimum-maximum, 50-1074)
 - Participants in ADAPT+ received ≤19 treatment cycles
- Total follow-up since first treatment in study was 229 PY
- No new safety signals were observed in ADAPT+, with the safety profile over time consistent with that in ADAPT
- TEAE ERs were similar between efgartigimod and placebo in ADAPT, and ERs of most TEAEs did not increase with long-term treatment in ADAPT+
- No reductions in albumin levels or increases in LDL levels were observed with efgartigimod in ADAPT or ADAPT+

INTRODUCTION

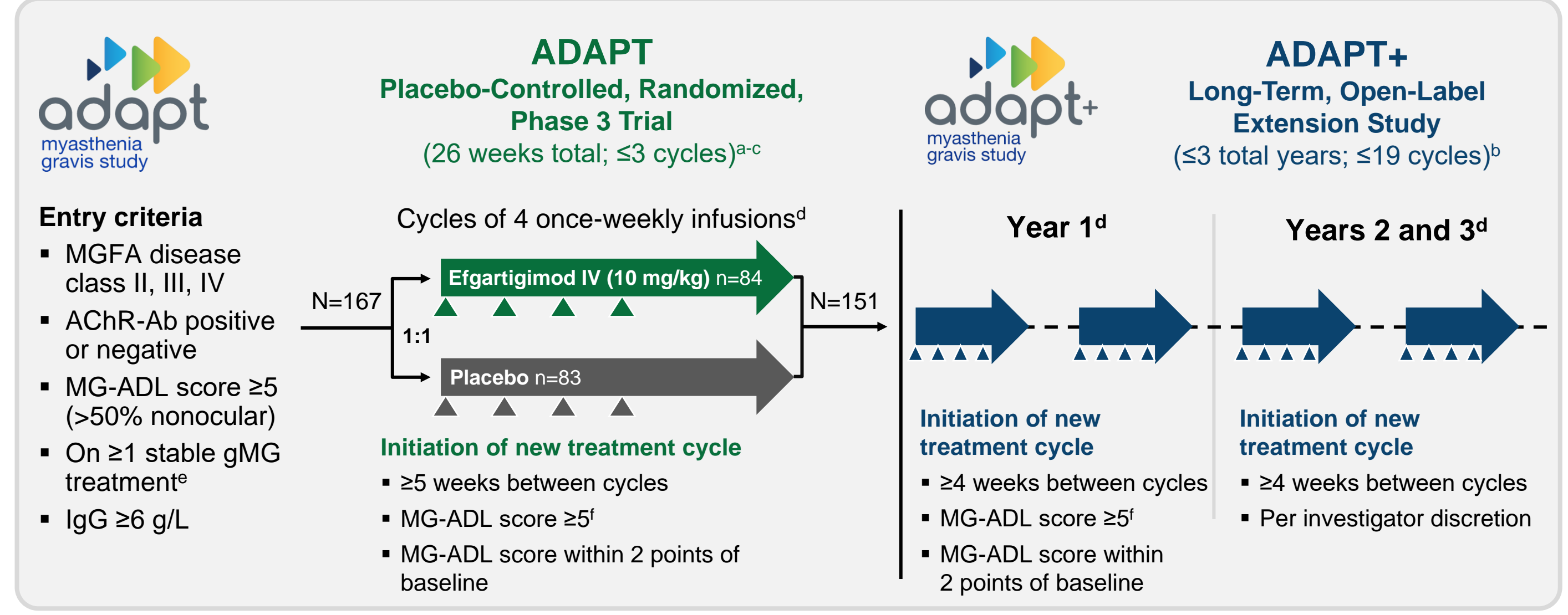
Efgartigimod Mechanism of Action: Blocking FcRn



- FcRn recycles IgG to extend its half-life and maintain its high serum concentration¹
- Efgartigimod is a human IgG1 Fc fragment, a natural ligand of FcRn, engineered to have increased affinity for FcRn and outcompete endogenous IgG^{2,3}
- Efgartigimod binding to FcRn prevents IgG recycling and promotes its lysosomal degradation, thus reducing IgG levels without directly impacting IgG production²⁻⁵
 - Targeted reduction of all IgG subtypes^{2,4}
 - No impact on levels of IgM, IgA, IgE, or IgD^{2,5}
 - No reduction in albumin or increase in cholesterol levels⁴⁻⁶

METHODS

ADAPT was a 26-week, global, multicenter, randomized, double-blind, placebo-controlled, phase 3 trial evaluating efgartigimod in participants with gMG. Participants who completed ADAPT were eligible to be rolled over to ADAPT+.⁴



^aParticipants who required subsequent treatment cycles but were unable to complete a treatment cycle within the time frame of ADAPT were also eligible to be rolled over to ADAPT+.
^bParticipants requiring rescue therapy in ADAPT and ADAPT+ Year 1 discontinued the study if they required rescue therapy; however, participants in ADAPT+ Years 2 and 3 did not.
^c33 cycles dosed at 26 weeks after initial cycle. ^dArrows indicate efgartigimod administration. ^eAChEi, steroid +/- NSIST. Participants could not change concomitant therapies in ADAPT. Physicians could change concomitant therapies between doses in Year 1 and at any time in Years 2 and 3 of ADAPT+. ^fWith >50% from nonocular items.

ABBREVIATIONS
AChEi, acetylcholinesterase inhibitor; AChR-Ab, acetylcholine receptor antibody; CMI, clinically meaningful improvement; ER, event rate; Fc, fragment crystallizable region; FcRn, neonatal Fc receptor; gMG, generalized myasthenia gravis; IgA, immunoglobulin A; IgD, immunoglobulin D; IgE, immunoglobulin E; IgG, immunoglobulin G; IgM, immunoglobulin M; IV, intravenously; LDL, low-density lipoprotein; LLN, lower limit of normal; MG-ADL, Myasthenia Gravis Activities of Daily Living; MGFA, Myasthenia Gravis Foundation of America; NSIST, nonsteroidal immunosuppressive therapy; PY, participant-years; QMG, Quantitative Myasthenia Gravis; SAE, serious adverse event; TEAE, treatment-emergent adverse event.

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Figure 1. TEAEs by Cycle
Overall Population

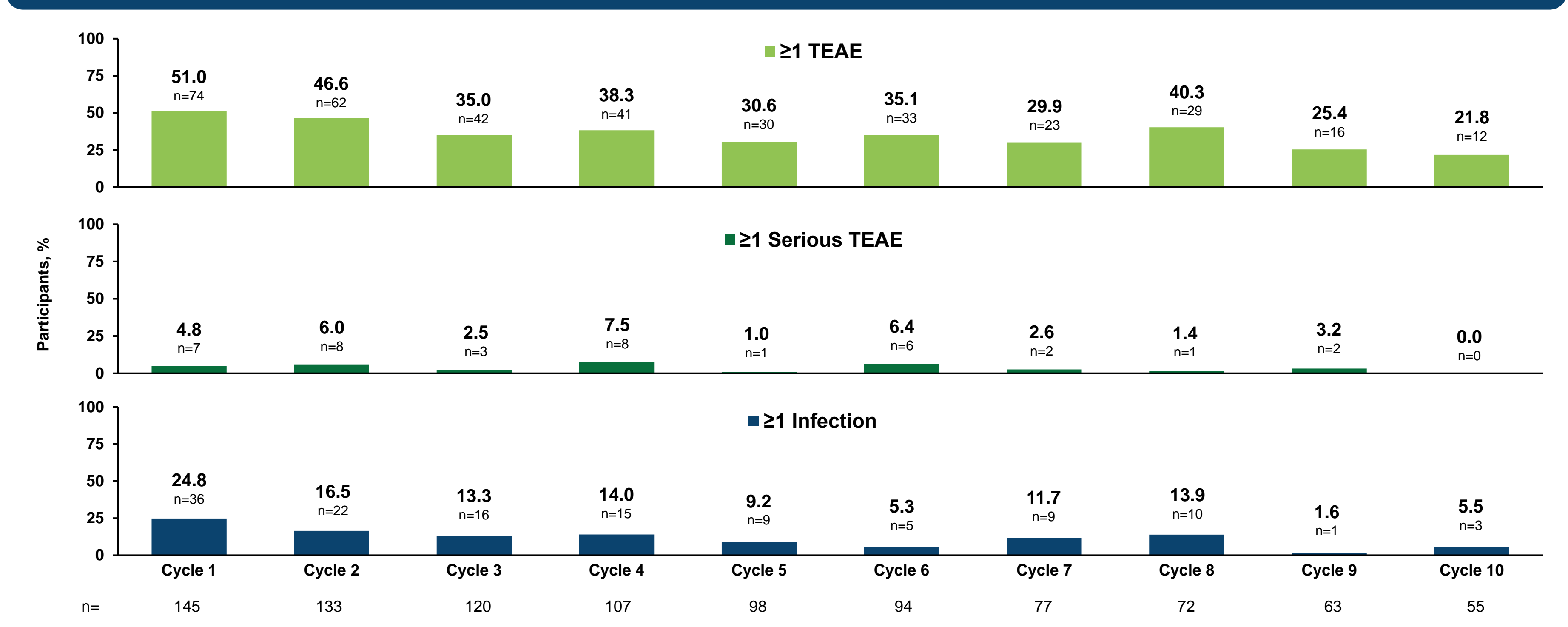


Figure 2. Proportion of Participants With Increasing MG-ADL or QMG Thresholds
AChR-Ab+ Population

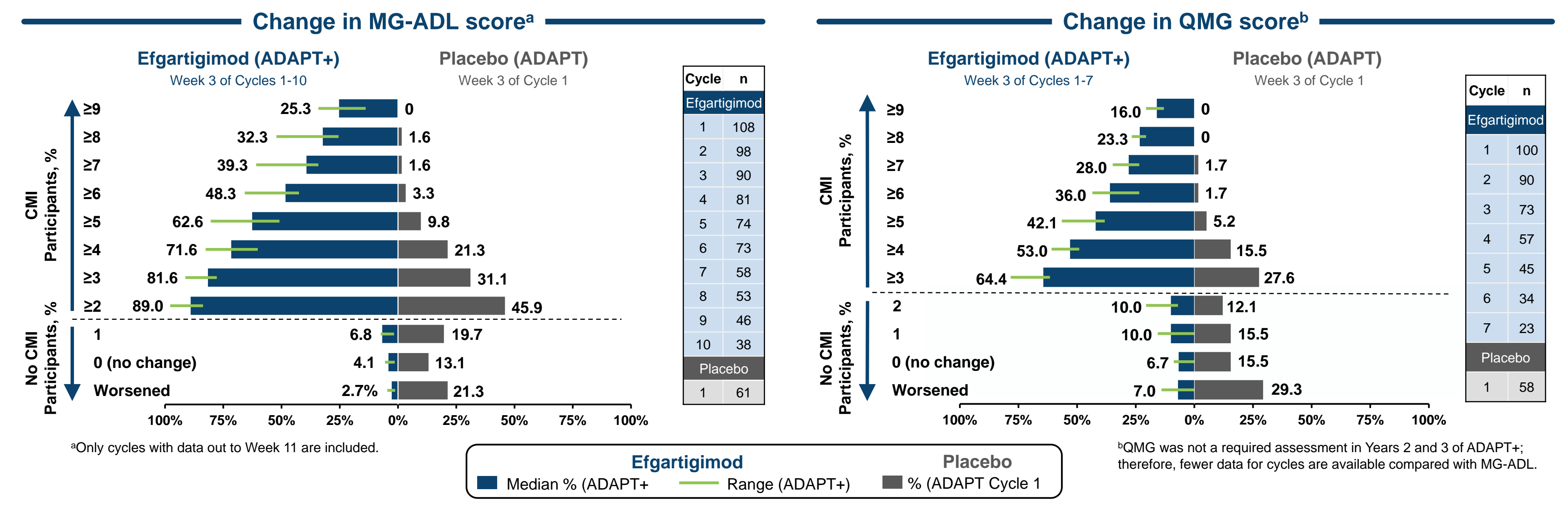
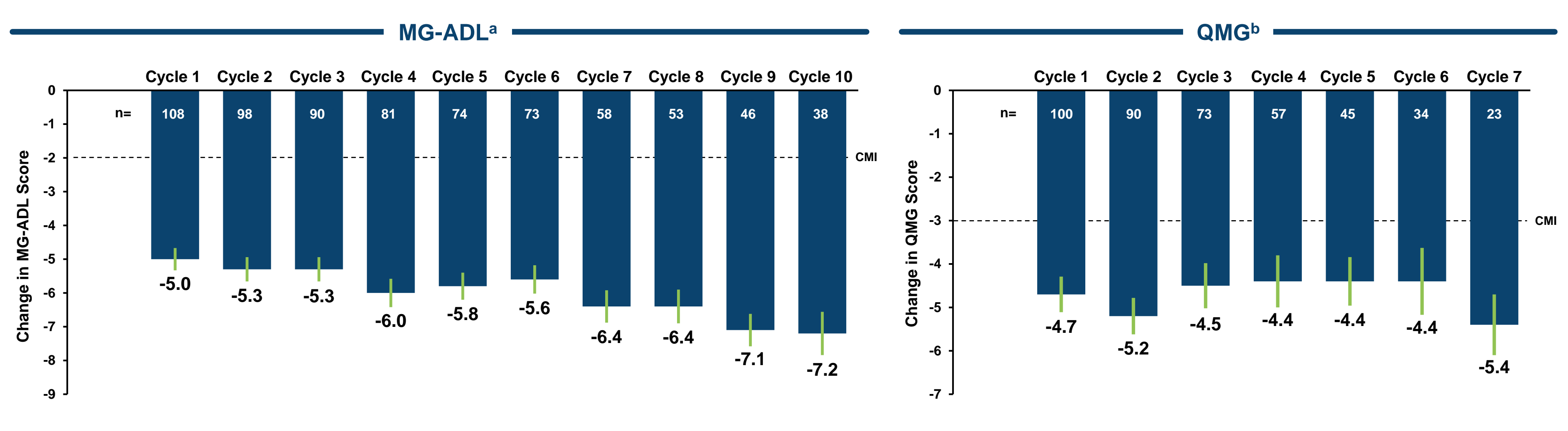
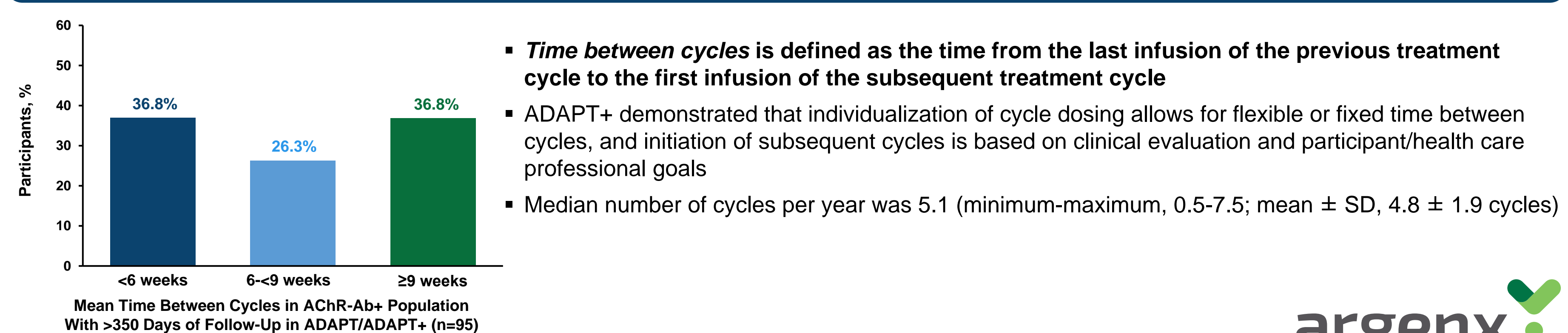


Figure 3. Mean Change in MG-ADL and QMG Scores From Cycle Baseline at Week 3
AChR-Ab+ Population



- Efgartigimod demonstrated consistent and repeatable improvement in both MG-ADL and QMG scores over multiple cycles in ADAPT+

Figure 4. Distribution of Time Between Cycles
AChR-Ab+ Population With >350 Days of Follow-Up in ADAPT/ADAPT+



- Time between cycles is defined as the time from the last infusion of the previous treatment cycle to the first infusion of the subsequent treatment cycle
- ADAPT+ demonstrated that individualization of cycle dosing allows for flexible or fixed time between cycles, and initiation of subsequent cycles is based on clinical evaluation and participant/health care professional goals
- Median number of cycles per year was 5.1 (minimum-maximum, 0.5-7.5; mean ± SD, 4.8 ± 1.9 cycles)

