Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/project-oncology/evaluating-axatilimab-in-chronic-gvhd-how-prior-therapies-impact-outcomes/36315/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Evaluating Axatilimab in Chronic GVHD: How Prior Therapies Impact Outcomes

Announcer:
You're listening to *Project Oncology* on ReachMD. And now, here's Dr. Hallie Blevins.

Dr. Hallie Blevins:
Welcome to *Project Oncology* on ReachMD. I'm Dr. Hallie Blevins, and today, we'll be reviewing a poster titled *"The Effects of Prior Lines of Therapy on Clinical Outcomes for Patients With Chronic Graft-Versus-Host Disease Receiving Axatilimab: A Post Hoc Analysis of AGAVE-201."* This research, led by Dr. Carrie Kitko and colleagues, was presented at the European Hematology Association 2025 Congress, which was held in Milan, Italy from June 12th to 15th.

But before we dive into the poster, let's start with some background. Chronic graft-versus-host disease, or chronic GVHD, is a progressive condition marked by inflammatory and fibrotic pathology that can affect multiple organs with varying severity and lead to significant impairment.

Patients with chronic GVHD often receive three or more lines of therapy, which can include FDA-approved agents such as ruxolitinib, belumosudil, or ibrutinib. Axatilimab, an anti-colony-stimulating factor 1 receptor, or CSF-1R, monoclonal antibody, targets monocytes and macrophages that are critical to chronic GVHD pathogenesis.

In the pivotal AGAVE-201 trial, the FDA-approved the axatilimab dose of 0.3 mg/kg once every two weeks, or Q2W for short. Axatilimab had robust clinical activity and was generally well tolerated in patients with chronic GVHD, with treatment-related adverse events that were mostly low grade and transient.

However, the potential impact of prior FDA-approved agents on axatilimab's efficacy hadn't been fully characterized, raising important questions around treatment sequencing in chronic GVHD.

As a result, the objective of this post hoc analysis was to evaluate the effects of prior lines of therapy on clinical outcomes among patients treated with axatilimab for chronic GVHD in AGAVE-201.

In terms of methods, the trial enrolled patients aged two years or older with active chronic GVHD who had received at least two prior lines of systemic therapy. Patients were randomized 1:1:1 to receive intravenous axatilimab at one of three doses: 0.3 mg/kg Q2W, one mg/kg Q2W, or three mg/kg every four weeks, or Q4W for short. Each group included approximately 80 patients.

Key endpoints included overall response rate, time to first response, sustained response rate—defined as a response lasting at least 20 weeks—and organ-specific responses based on NIH 2014 consensus criteria. For this analysis, outcomes were stratified based on number of prior lines of therapy and the last agent received, categorized as ruxolitinib, belumosudil, or other therapies. All treatment histories were clinically adjudicated.

With that in mind, let's take a look at the results. Patients enrolled in the study had received a range of prior therapies for chronic GVHD, most commonly prednisone at 77 percent, extracorporeal photopheresis at 56 percent, and ruxolitinib or ruxolitinib phosphate at 55 percent and 20 percent, along with other systemic agents.

Overall response rates with axatilimab were consistent across dosing groups, and did not appear to be influenced by response to the most recent prior therapy. There was also a trend toward slightly higher overall response rates in patients who had received a greater number of prior lines of therapy.

Among the 68 patients who had received ruxolitinib as their last therapy, the overall response rate with axatilimab was 62 percent. The median time to response was approximately two months, and the sustained response rate was 43 percent. For the 34 patients whose last treatment was belumosudil, the overall response rate was 50 percent, with a similar time to response of just under two months and a sustained response rate of 26 percent.

Now, organ-specific responses were assessed across all dose levels due to the small number of patients in the 0.3 mg/kg Q2W group. Response rates were generally similar between patients who had received ruxolitinib versus other therapies.

However, responses tended to be higher among those previously treated with ruxolitinib compared to belumosudil, particularly in the joints and fascia, mouth, lungs, and skin. Responses in the eyes were similar between groups. However, it's important to keep in mind that these exploratory analyses were not powered to assess statistical differences.

From a safety standpoint, treatment-emergent adverse events were common across the study population, with nearly all patients experiencing at least one event. In the 0.3 mg/kg Q2W group, about 96 percent of patients reported treatment-emergent adverse events, and 49 percent had events that were grade 3 or higher. Across all dose levels, these rates were slightly higher, about 98 percent for any-grade treatment-emergent adverse events and 60 percent for grade 3 or above.

Notably, no opportunistic infections were reported in the 0.3 mg/kg Q2W group, while about four percent of patients across all doses experienced infections such as cytomegalovirus, Epstein-Barr virus, or invasive fungal infections. Treatment-emergent adverse events leading to discontinuation occurred in six percent of patients in the 0.3 mg/kg Q2W group, compared to 16 percent across all doses.

All in all, axatilimab achieved consistent overall response rates in AGAVE-201 regardless of how many prior lines of therapy had been received, but responses were more sustained with ruxolitinib as last prior therapy. Patients who received axatilimab immediately following a regimen that included ruxolitinib demonstrated rapid and durable clinical responses.

Additionally, organ-specific responses to axatilimab were seen across all prior therapies, with a trend toward higher response rates in certain organs—like joints and fascia, mouth, lungs, and skin—among patients whose last treatment was ruxolitinib compared with belumosudil.

These findings warrant further investigation and may be attributable to the novel mechanism of action of axatilimab or the influence of prior lines of therapy. However, it should be noted that small patient numbers and heterogeneity in treatment regimens may limit interpretation.

But overall, these data demonstrate the efficacy of axatilimab in patients with steroid-refractory chronic GVHD after two lines of therapy, including those previously treated with ruxolitinib as their last line of therapy. This study highlights axatilimab's viability as a later-line option in a landscape where durable responses remain difficult to achieve.

Announcer:
You've been listening to *Project Oncology* on ReachMD. To access this and other episodes in our series, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.

Reference:
Kitko, C, Mehta, R, Popradi, G, et al. The Effects of Prior Lines of Therapy on Clinical Outcomes for Patients With Chronic Graft-Versus-Host Disease Receiving Axatilimab: A Post Hoc Analysis of AGAVE-201. Poster presented at: European Hematology Association (EHA) 2025 Congress; June 12-15, 2025; Milan, Italy.