EHA EUROPEAN HEMATOLOGY ASSOCIATION

P732

IMerge

# Analysis of Patient-Reported Fatigue in IMerge Ph3 Trial of Imetelstat vs Placebo in Heavily Transfused Non-Del(5q) Lower-Risk Myelodysplastic Syndromes R/R to Erythropoiesis Stimulating Agents

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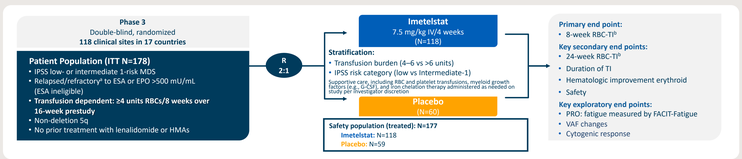
## INTRODUCTION

- Imetelstat is a first-in-class direct and competitive inhibitor of telomerase activity that specifically targets malignant clones with abnormally high telomerase activity, enabling recovery of effective hematopoiesis[1–4]
- A key goal of MDS treatment is to manage anemia with fewer transfusions (thereby improving patient's fatigue and reducing the associated risks) to improve the quality of life of patients, most of whom are elderly and frail
- A recent report showed that patients with MDS had clinically meaningful worse fatigue than the general population and fatigue worsened with increasing IPSS-R risk even for patients with very low, low, and intermediate risk[5]
- Hence, fatigue was selected as the main patient-reported outcome (PRO) concept of interest for the phase 3 part of the IMerge study as measured by the FACIT-Fatigue score, which is a reliable and valid measure of fatigue[6]
- In the phase 3 part of the IMerge study, imetelstat demonstrated clinically meaningful efficacy compared with placebo in patients with heavily transfusion-dependent low-risk myelodysplastic syndromes (LR-MDS), including higher rates of 8-, 16-, 24-week and 1-year RBC-TI, longer RBC-TI duration, higher rate of hematologic improvement, and fewer RBC transfusion units over time[7]
- This poster presents the analyses conducted to support the main PRO objective related to deterioration and improvement in fatigue as measured by the FACIT-Fatigue in the phase 3 part of IMerge **(Fig. 1)**

### Figure 1. IMerge Phase 3 Trial Design (MDS3001; NCT02598661)




[a]Received ≥8 weeks of ESA treatment (epoetin alfa ≥40,000 units, epoetin beta ≥30,000 units or darbepoetin alfa 150 µg or equivalent per week) without Hgb rise ≥1.5 g/dL or decreased RBC transfusion requirement ≥4 units/8 weeks or transfusion dependence or reduction in Hgb by ≥1.5 g/dL after hematologic improvement from ≥8 weeks of ESA treatment. [b]Proportion of patients without any RBC transfusion for ≥8 consecutive weeks since entry to the trial (8-week TI); proportion of patients without any RBC transfusion for ≥24 consecutive weeks since entry to the trial (24-week TI)

## OBJECTIVE

**Primary patient-reported outcome objective**

- To explore the hypothesis that, while on treatment, patients with LR-MDS who were treated with imetelstat are not more likely to experience meaningful deterioration in fatigue, as measured by the FACIT-Fatigue score, than those treated with placebo, regardless of RBC transfusion status

## METHODS

**Patient-reported outcome**

- Previous research, including a literature review of qualitative research on the experience of patients with LR-MDS and input from expert clinicians in LR-MDS, led to the identification of a set of PRO concepts relevant to patients with LR-MDS
- The PRO items collected in IMerge were scrutinized to identify sets of items that would capture these concepts
- Psychometric analyses were conducted using blinded interim IMerge phase 3 data to document the measurement properties of these item sets and define the scores that would be used to specify exploratory PRO endpoints in the study

**FACIT-Fatigue Scale**

- A 13–item questionnaire measured during daily activity (**Table 1**)

**Analyses**

- Proportion of patients in each treatment group reporting any episode of sustained meaningful deterioration or improvement in fatigue (**Fig. 2**)[8,9]
- Sensitivity analyses were performed in alternate populations and with alternate definitions of meaningful deterioration and improvement
- Association of the proportion of patients reporting an episode of sustained meaningful improvement with RBC-TI clinical endpoints

### Table 1. PRO Items for FACIT-Fatigue

| Derived Score | Source Instrument | Scoring Method | Items | |
|---|---|---|---|---|
| Fatigue | FACIT-Fatigue | Sum of item scores, multiplied by 13, divided by the number of items answered | HI7 | I feel fatigued |
| | | | HI12 | I feel weak all over |
| | | | An1 | I feel listless ("washed out") |
| | | | An2 | I feel tired |
| | | | An3 | I have trouble starting things because I am tired |
| | | Score range 0–52 | An4 | I have trouble finishing things because I am tired |
| | | | An5 | I have energy |
| | | Higher score = better | An7 | I am able to do my usual activities |
| | | | An8 | I need to sleep during the day |
| | | | An12 | I am too tired to eat |
| | | | An14 | I need help to do my usual activities |
| | | | An15 | I am frustrated by being too tired to do the things I want to do |
| | | | An16 | Have to limit my social activity because I am tired |

### Figure 2. End Point: PRO Fatigue


## RESULTS

### Demographics and Disease Characteristics

- The PRO population, which included all patients in the ITT population who had FACIT-Fatigue data at baseline, comprised 118 patients in the imetelstat arm and 57 patients in the placebo arm, for a total of 175 patients (**Table 2**)
- Most patients were males and had an ECOG PS of 1 (restricted in strenuous activity but ambulatory)

### Table 2. PRO Population Demographics

| | Imetelstat (N=118) | Placebo (N=57) |
|---|---|---|
| **Median age, years (range)** | 72 (44–87) | 73 (39–85) |
| **Gender, n (%)** | | |
| Male | 71 (60) | 38 (67) |
| Female | 47 (40) | 19 (33) |
| **Region, n (%)** | | |
| Europe | 80 (68) | 38 (67) |
| North America | 13 (11) | 9 (16) |
| Other | 25 (21) | 10 (18) |
| **ECOG PS, n (%)** | | |
| 0-Fully active | 42 (36) | 21 (37) |
| 1-Restricted in strenuous activity, but ambulatory | 70 (59) | 36 (63) |
| 2-Ambulatory, but unable to work | 6 (5) | 0 |

### Patient-Reported Outcome Completion Rate (ITT Population)[10]

- Percent of patients with PRO data for whom data were expected
- Completion rates were good throughout the study, >85% at most cycles

### Sustained Meaningful Deterioration in FACIT-Fatigue Score

- Imetelstat group had a numerically lower percentage of patients who experienced any episode of sustained meaningful deterioration than the placebo group (43.2% vs 45.6%)
- Patients receiving imetelstat were slower than those receiving placebo to report sustained meaningful deterioration in fatigue; median 66.3 vs 43.1 weeks (HR, 0.91 [95% CI, 0.56–1.47])

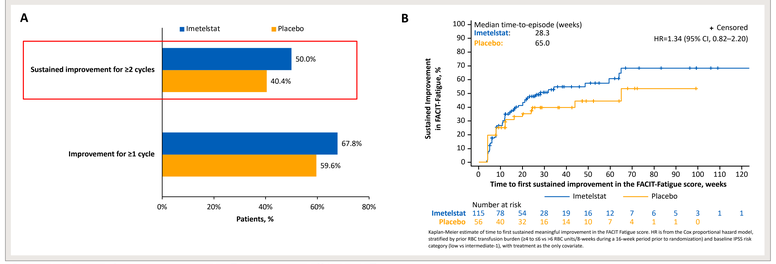
### Sensitivity Analyses

- In the ITT population, the sensitivity analysis showed that 43% of patients in either group experienced any episode of meaningful deterioration in fatigue for ≥2 consecutive cycles
- In the PRO population, 67% of patients in either group reported any episode of meaningful deterioration in fatigue for ≥1 cycle
- Meaningful deterioration in fatigue using a threshold of 4-, 5-, and 6-point decreases in score occurred in a smaller proportion of patients receiving imetelstat vs placebo (36.4% vs 42.1%, 30.5% vs 38.6%, and 28.0% vs 29.8%, respectively)

### Sustained Meaningful Improvement in FACIT-Fatigue Score

- In the imetelstat group, there was a numerically higher percentage of patients reporting any episode of sustained meaningful improvement in fatigue than in the placebo group (**Fig. 3A**)
- Patients treated with imetelstat were quicker to report sustained meaningful improvement in fatigue than those receiving placebo **(Fig. 3B)**
- Compared with placebo, imetelstat treatment resulted in more frequent reports of improvement in fatigue after Week 12 (**Fig. 3B**)

### Figure 3. Meaningful Improvement in FACIT-Fatigue Score

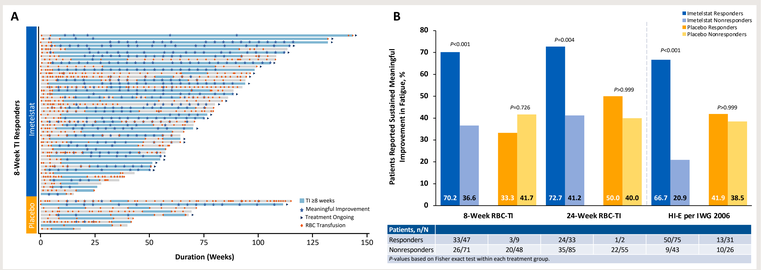



Kaplan-Meier estimate of time to first sustained meaningful improvement in the FACIT-Fatigue score. HR is from the Cox proportional hazard model, stratified by prior RBC transfusion burden (≥4 to ≤6 vs >6 RBC units/8 weeks during a 16-week period prior to randomization) and baseline IPSS risk category (low vs intermediate-1), with treatment as the only covariate.

### Association of Improvement in Fatigue and Clinical Responses

- Majority of the 8-week RBC-TI responders in the imetelstat group consistently had sustained meaningful improvement in FACIT-Fatigue scores through the durable TI intervals (**Fig. 4A**)
- Among patients treated with imetelstat, a higher proportion of patients with 8-week RBC-TI, 24-week RBC-TI, and HI-E response (per IWG 2006) reported sustained meaningful improvement in fatigue vs nonresponders; such association was not observed in patients receiving placebo (**Fig. 4B**)

### Figure 4. RBC-TI and HI-E Response by Meaningful Improvement in Fatigue Score




| Patients, n/N | | | | | | |
|---|---|---|---|---|---|---|
| Responders | 33/47 | 3/9 | 24/33 | 1/2 | 50/75 | 13/31 |
| Nonresponders | 26/71 | 20/48 | 35/85 | 22/55 | 9/43 | 10/26 |

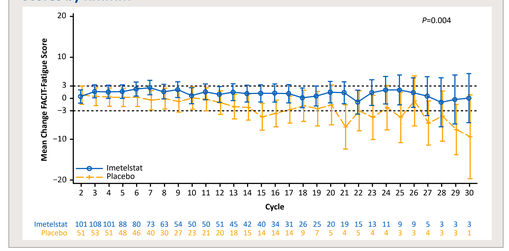
P-values based on Fisher exact test within each treatment group.

## RESULTS (CONT.)

### Supplementary Analyses

- A repeated measurement mixed model (RMMM) analysis showed an overall change in FACIT-Fatigue score from baseline of 1.08 (by LS mean with 95% CI, −0.36 to 2.53) with imetelstat vs −2.48 (by LS mean with 95% CI, −4.48 to −0.5) with placebo, with a significant difference between the treatment groups (LSM difference 3.57 [1.16, 5.97], *P*=0.004) **(Fig. 5)**
- Additional analysis showed that patients experiencing grade 3 or 4 neutropenia or thrombocytopenia had the same rates of sustained meaningful improvement in fatigue (52.5% and 53.4%, respectively) as the total imetelstat population (50%)

### Figure 5. Model-Based Mean Change From Baseline in FACIT-Fatigue Scores by RMMM




*Changes of −3 and +3 in FACIT-Fatigue score from baseline represent meaningful deterioration and improvement, respectively. The plotted least squares mean (LSM) estimates for change from baseline in FACIT-Fatigue score and the P-value between treatment arms are based on a RMMM with the change in FACIT-Fatigue score as the explained variable and baseline score, time, treatment, time and treatment interaction, and study stratification factors (RBC transfusion burden status and IPSS risk group) as covariates (fixed effects) as explanatory variables. The model included a random effect for individuals to account for the within-individual correlation in the longitudinal assessments. The number of patients at the bottom represent the number of patients with valid FACIT-Fatigue data at each visit.*

## CONCLUSIONS

- The IMerge phase 3 trial is the first randomized global trial of patients with LR-MDS who had a transfusion burden of ≥4 units / 8 weeks that showed sustained meaningful improvement in patient-reported fatigue when treated with imetelstat (50.0%) vs placebo (40.4%)
- Patients treated with imetelstat reported a lower rate than placebo of sustained meaningful deterioration in fatigue at (43.2% vs 45.6%), while also receiving fewer RBC transfusion units over time
- In the imetelstat group, there was a numerically higher percentage of patients reporting any episode of sustained meaningful improvement in fatigue and patients receiving imetelstat experienced a shorter median time to first sustained clinically meaningful improvement in fatigue vs placebo (28.3 vs 65.0 weeks)
- After 12 weeks, greater sustained and meaningful improvement in FACIT-Fatigue Scale was reported with imetelstat compared with placebo
- In the imetelstat group, there were significant associations between sustained meaningful improvement in fatigue and 8- and 24-week RBC-TI and HI-E response rates; this association was not seen in the placebo group
- The improvement in fatigue observed in patients who achieved TI indicates that imetelstat is targeting multiple core symptoms of LR-MDS simultaneously, bringing greater clinical benefit than current treatment options

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## ABBREVIATIONS

ECOG PS, Eastern Cooperative Oncology Group performance status; EPO, erythropoietin; ESA, Erythropoiesis stimulating agents; FACIT, Functional Assessment of Chronic Illness Therapy; G-CSF, granulocyte-colony stimulating factor; Hgb, hemoglobin; HI-E, hematologic improvement-erythroid; HMA, hypomethylating agent; HR, hazard ratio; IPSS, International Prognostic Scoring System; IPSS-R, International Prognostic Scoring System-Revised; ITT, intent-to-treat; IV, intravenous; IWG, International Working Group; LR-MDS, lower risk myelodysplastic syndromes; LS, least squares; LSM, least-squares means; R, randomization; R/R, relapsed/refractory; RBC, red blood cell; RMMM; repeated measurement mixed model; TI, transfusion independence; VAF, variant allele frequency.

## DISCLOSURES

Mikkael Sekeres reports advisory board fees from BMS, Geron, Kurome, and Novartis

## CONTACT INFORMATION

IMerge (MDS3001): https://www.geron.com/patients/imerge-study
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