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Released: 03/24/2026
Valid until: 03/24/2027
Time needed to complete: 1h 04m

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FcRn: Same Class, Different Paths—Spot Agent Differentiators

Dr. Edmundson:
This is CE on ReachMD, and I'm Dr. Christyn Edmundson. Here with me today is Dr. Gil Wolfe.

Today, we're taking a look at FcRn therapies. While these agents share a mechanism, they offer different paths in terms of how they're delivered, how often they're given, and how patients tolerate them.

Dr. Wolfe, from a practical standpoint, how do you differentiate between the FcRn agents when deciding which one might be the best fit for any particular patient?

Dr. Wolfe:
Well, some of the factors that come in, Dr. Edmundson, when making that decision include the route and the setting. Efgartigimod, for instance, can be given either intravenously or subcutaneously, whereas rozanolixizumab is a subcutaneous infusion, and nipocalimab is just an intravenous delivery at a steady dosing of every 2 weeks. So, it kind of depends on where the patient lives, how comfortable they might be, even with self-administration, such as for efgartigimod. Those kinds of questions come into the decision-making.

The dosing frequency can matter as well. There are some patients, and we saw these in the clinical trials, that can have a sustained response even after a cycle is over, say, of efgartigimod or rozanolixizumab.

And so, if patients want a longer infusion-free interval, say, because they have to travel for work or travel for fun, and so forth, that might play a role also if they can time it properly.

Venous access can be important. Some patients are older who have myasthenia gravis and they just may not have as good veins, and so that becomes a struggle. Because one thing I really don't want to have to do with MG patients is putting in a central line just because of infection risk or even a PICC line and so forth. So, that can come into play as well.

The patient populations were somewhat different as well, leading to different approvals for these different agents. So, if the patient is MuSK antibody positive, you're going to be sticking with rozanolixizumab and nipocalimab because those agents were approved in that population. They had enough data from the trials in order to lead to that FDA approval.

And then finally, we mentioned briefly before, the juvenile population, the only agent that we have in this class for anyone who's not an adult, and this is age 12 and beyond, would be for nipocalimab.

The last thing that I might mention, when a patient perhaps doesn't respond to an individual FcRn therapy, you might consider switching to a different drug in its class. Perhaps you would get more of a bump out of it. You may not. But one thought that I had with that is, if patients aren't responding well on the cyclical fashion, you may want to go to nipocalimab, which has a more regular administration,

again, every 2 weeks, to get as much benefit as you might out of that class of agents.

Dr. Edmundson, are there any other factors that help you select one FcRn blocking agent versus another?

Dr. Edmundson:
Yeah, it's a great question. I think you did a great job of kind of outlining the factors. I think so much of it comes down to individual patient desire, right?

Some people might have an injection site reaction with a subcutaneous agent and really prefer IV, getting an IV placed and having IV infusions. Other patients might really like the flexibility that an FcRn inhibitor that's self-injected in a subcutaneous fashion offers. So, so much of it comes down to individual patient experience.

I will say that if a patient isn't tolerating an FcRn inhibitor, it depends a little bit on what they're not tolerating that will help drive my response to that. So, for instance, in the case of a subcutaneous injection or infusion, if they're not tolerating that subcutaneous injection or infusion because of a site reaction, I might switch over to nipocalimab, which is available IV, or over to the IV form of efgartigimod. Versus if someone is having an adverse reaction that's pretty similar or present across the different drugs, for instance, if they're having frequent infections, if they're having headaches, if they're having a lot of GI side effects, that might push me towards abandoning the FcRn class and switching the class of drugs entirely.

And I think, overall, the take-home is that these decisions are really made on an individualized basis with patients and that what one patient may be looking for in a therapy is really different than what another may be looking for in terms of frequency and administration route.

With that, we'll wrap up this episode and thanks so much for listening.