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Under the Skin: Revolutionizing Oncology Drug Delivery

Announcer:
Welcome to CE on ReachMD. This activity is provided by Medcon International. This episode is part of our MinuteCE curriculum.

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Dr. Cho:
This is a CME on ReachMD, and I'm Dr. Cho. Here with me today is Dr. Leighl and Dr. Kerr.

Dr. Leighl, can you talk about difference in administration of therapy for EGFR-mutated NSCLC and how we implement subcutaneous administration of amivantamab?

Dr. Leighl:
So of course EGFR-driven therapy has been so great because we only had oral, but now that we've got these great new combination regimens, we need to add that IV component, whether it's chemotherapy or amivantamab. It's really important to optimize that patient journey, right, and make it as simple as possible.

Amivantamab has been a great addition to the EGFR-targeted space, but it's got a busy schedule. And so it can take several hours, up to about 5 hours with each administration.

And so of course, how do you make that better for patients? We were really thrilled to be part of the PALOMA program, where we looked at subcutaneous administration really aimed at improving patient outcomes, side effects, and that patient journey and treatment burden.

So in PALOMA-3, we actually randomized patients with prior osimertinib and platinum chemotherapy. They either got IV amivantamab and lazertinib or subcutaneous amivantamab and lazertinib, and we showed that not only were the pharmacokinetics just as good with subq amivantamab, we showed the clinical outcomes were just as good—whether it was response rate, duration of response a little longer, PFS a little bit longer or trending to that, and even overall survival a bit longer—all with subq.

The other thing that we showed was that patients had a marked reduction in the rate of IRR, so from 66% down to 13%—a 5-fold reduction. Also fewer venous thrombotic events, although rash and other things were similar in terms of toxicity.

The other thing, of course, is time. Whereas the IV administration initially took about 5 hours and you could get it down to 2 hours, this only takes 5 minutes. And you know there's really very, very little risk of local reaction, and patients really loved it. Patients preferred it. They had greater satisfaction. And even by the end of treatment, patients still preferred subcutaneous amivantamab over IV. And so I think this really is a step forward.

In PALOMA-2, this was a single-arm, multi-cohort study, but we looked at combining subcutaneous amivantamab with different partners. So amivantamab and lazertinib first line, we saw the same outcomes in terms of response as we did in MARIPOSA. Also chemotherapy plus subq amivantamab in pretreated patients—same outcomes as we saw in MARIPOSA-2.

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So I think this has really been very exciting and has led to the approval by the European Medicines Agency in April of 2025. And the FDA approval has been slightly delayed—we're looking forward to getting that soon, just because of some review of manufacturing issues.

So when you think about giving subq ami, there are a number of drugs that we give subq now. We have noticed that marked reduction in the risk of IRR, so of course that makes it so much easier in the treatment delivery suite.

What's nice about ami subq is we do give it as a push, so we don't need all of the fancy pumps that are always beeping and getting clogged. It takes only about 5 minutes. The vast majority of patients, it's just one syringe administered subq.

So we're really looking forward to using subq very broadly and really replacing IV amivantamab across indications, really making the journey better.

Dr. Kerr:
Yeah, this sounds like very good news for our patients. One of the things that we hear repeatedly in our MDT discussions is around what our patients actually want in terms of their therapy. And it's not uncommon for patients to be very uncomfortable about having IV and particularly chemotherapy.

Dr. Cho:
So I think because EGFR mutation is really prevalent in this region, and we have a lot of experience with first-gen EGFR TKI and second-gen EGFR TKI, skin rash with amivantamab is not a matter, in particularly Asian physicians, because we have a lot of experience in managing these kind of dermatology toxicity.

So I think I really enjoyed Dr. Leighl's presentation last year at ASCO on PALOMA-3, and then subq amivantamab significantly reduced infusion-related reaction.

So I think it is really good news for both physicians and doctors, and I really love subq amivantamab into our clinical practice as quickly as possible.

Super. That is all the time we have today. Thank you for listening.

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