**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/medical-industry-feature/real-world-patient-cases-in-rms-care-part-3-discussions-around-selecting-an-appropriate-therapy/13208/

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Real-World Patient Cases in RMS Care, Part 3: Discussions Around Selecting An Appropriate Therapy

**Announcer:**
Welcome to ReachMD.

This medical industry feature, titled “Real World Patient Cases in MS Care Part 3: Discussions Around Selecting The Right Therapy” is sponsored by Novartis Pharmaceuticals Corporation and the presenters have been compensated for their time.

**Dr. Bloch**
You’re listening to ReachMD.

This medical industry feature, entitled KESIMPTA: Call for Cases Podcast, is sponsored by Novartis Pharmaceuticals Corporation. This program is intended for US health care professionals. The Important Safety Information for KESIMPTA®, also known as ofatumumab, will be available at all times underneath the player of the audio presentation. A link to the full Prescribing Information, including the Medication Guide, is available at the bottom of the presentation.

The speakers have been compensated by Novartis Pharmaceuticals Corporation (NPC) to conduct this presentation.

Welcome back, everyone, to the KESIMPTA: Call for Cases series on ReachMD.

My name is Dr Melissa Bloch, and I am a MS neurologist at Renown Neurology in Reno, Nevada, and I’ve been in practice here for 22 years.

This is the third in a series of 3 podcasts, each discussing a real-world patient who was a candidate for treatment with KESIMPTA. We will share our own clinical perspectives on each case and discuss what we will consider when deciding on an appropriate therapy. Finally, we’ll discuss why we feel that KESIMPTA is a good treatment option for these patients.

Let’s introduce our panel. Dr Pardo, let’s start with you.

**Dr. Pardo**
Hello, everyone! My name is Dr Gabriel Pardo, and I am a neurologist and the Director of the Oklahoma Medical Research Foundation Multiple Sclerosis Center of Excellence. I have been dedicated to the treatment and research of multiple sclerosis for over two decades.

**Dr. Bloch**
Thank you, Dr Pardo. John, can you introduce yourself?

**Mr. Kramer**
Hello! My name is John Kramer, and I am a practicing physician assistant at St. Thomas Medical Partners’ Neurology Department here in Nashville, Tennessee. I have worked in the field of MS now for the past 21 years.

**Dr. Bloch**
Thank you, John! I just wanted to take a moment to let our listeners know the indication for KESIMPTA. KESIMPTA is indicated for the treatment of relapsing forms of multiple sclerosis in adults. This includes clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.

KESIMPTA is contraindicated in patients with active HBV infection.

After the initial dosing period, KESIMPTA is a monthly, self-administered, subcutaneous injection and is available as a single-dose,

prefilled Sensoready® Pen.

In this episode, we'll be focusing on one of my patients, Maria. Maria is a 39-year-old Latina who's worked in food preparation at a hospital for years. Before her relapsing multiple sclerosis diagnosis, she had a 20-year history of intermittent numbness and tingling in her hands and in her left leg, and first she saw a doctor about 10 years ago. She always just thought it was from too much work and heavy lifting. A general neurologist made a diagnosis of relapsing multiple sclerosis 3 years ago and placed Maria on an oral medication. However, Maria experienced breakthrough disease activity despite treatment and her insurance coverage changed, so one of her friends recommended seeing me.

**Mr. Kramer**
Did Maria ever talk to a doctor about these symptoms?

**Dr. Bloch**
She didn't for many years, and actually may have developed new symptoms beyond the intermittent numbness and tingling in her limbs. For example, Maria says that she had more trouble when she gets overheated. She has headaches that are worse in the heat. She feels dehydrated easily, but she needs to be careful about her water intake because she doesn't want to have to use the bathroom during her commute to work. She also noticed urinary urgency and frequency at times, but she thought that was because all 3 of her children were vaginal deliveries. Her daily oral medication may have fit her lifestyle at time of diagnosis, but as Maria has gotten busier, she occasionally misses treatment on some days.

**Dr. Pardo**
I think this highlights an aspect of how patients sometimes present. They ascribe the reasons for many of their symptoms to other things, not realizing that these symptoms are actual, direct manifestations of their relapsing multiple sclerosis. Has Maria experienced any other recent disease activity?

**Dr. Bloch**
Her MRI that was sent to me showed 5 periventricular white matter lesions and 1 in the corpus callosum. I ordered a new MRI of the spinal cord, which showed a previous lesion in the cervical cord at C3 to C4 and a new enlarging lesion with mild enhancement in the upper thoracic spine at T4 to T5. These spinal cord lesions were concerning. This means that Maria has relapsing multiple sclerosis that has been progressing.

So, Dr Kramer and Dr Pardo, what are your initial thoughts on Maria's case? Do you think it would be appropriate to switch her therapy? Dr Pardo, let’s start with you.

**Dr. Pardo**
In my clinical experience, the presence of enhancing lesions in the spinal cord may warrant a treatment change to a high efficacy therapy with a different mechanism of action.

**Mr. Kramer**
I agree. From my experience, it may be worthwhile to consider a switch in therapies. I consider switching patients when patients show signs of clinical progression while on a DMT. Because Maria expressed worsening symptoms, Maria could benefit from switching to a different DMT.

**Dr. Bloch**
Maria had relapses on her oral therapy, so switching to a high efficacy therapy seemed justified. So, switching to a different therapy may reduce the risk of disability progression.

I thought a good choice might be a high efficacy disease-modifying therapy, perhaps one that targets B cells. B cells are thought to play an important role in relapsing multiple sclerosis pathogenesis. They produce pro- inflammatory cytokines, release autoreactive antibodies, and activate pathogenic T cells.

One of the high efficacy therapies I presented to Maria as an option was KESIMPTA. This was because, we wanted to slow disability progression, and there were also new lesions on her MRI.

**Dr. Pardo**
Dr Bloch, Maria’s MRI shows gadolinium-enhancing lesions, which indicate ongoing disease activity that we want to reduce.

**Dr. Bloch**
Yes, reducing the likelihood of developing new lesions was actually one of my treatment goals for Maria. In that regard, KESIMPTA showed reduction in gad-enhancing T1 lesions and fewer T2 lesions compared to teriflunomide in both Phase 3 trials. I explained to

Maria the importance of reducing the number of lesions on her brain, and that KESIMPTA could help with this.

**Mr. Kramer**
It seems like Maria would also be concerned about disability progression. Maria could benefit from a switch to reduce the risk of disability progression.

**Dr. Bloch**
Yes, she would. I explained to her that physical disability can get worse over the long term and one way that could help reduce the risk of disability progression is to switch to a therapy that works for her. As you said, she does a lot of heavy lifting, so maintaining physical function is a priority. She's been able to see for herself how things don't always go back to normal, since she was unfortunately left untreated for a long time. KESIMPTA significantly reduced the risk of 3-month and 6-month confirmed disability progression compared to teriflunomide in the pooled Phase 3 trial population.

**Mr. Kramer**
When you were considering KESIMPTA, did you have teriflunomide on your mind?

**Dr. Bloch**
Yes, I presented KESIMPTA as an option because it significantly reduced the annualized relapse rate in patients with relapsing MS relative to teriflunomide. This was the primary end point of both Phase 3 studies. However, it's important to note here that teriflunomide was also shown to reduce annualized relapse rates in MS patients.

**Mr. Kramer**
There are several high efficacy treatment options out there. What made you and Maria decide KESIMPTA was the most appropriate one?

**Dr. Bloch**
Maria preferred to take her disease-modifying therapy at home because she has a busy lifestyle and job. She doesn't have a day to go to an infusion center to do infusion therapies. With KESIMPTA, after initial dosing, it's a once-a-month treatment that she can do at home and on her own time. When she's ready to administer, it takes less than a minute to do.

**Dr. Pardo**
How did Maria feel about the possibility of injections?

**Dr. Bloch**
Well, Maria was not comfortable with needles, but I explained that she needs to use KESIMPTA once per month after the initial doses at 0, 1, and 2 weeks. She thought that would be okay or that maybe her sister could perform the injection for her.

**Mr. Kramer**
For patients with significant concerns, I bring them back to the clinic for their first dose to show how to use the Sensoready® Pen.

**Dr. Pardo**
It is very important to discuss the fact that adherence and compliance have significant impact on the control of the disease. Patients who are not adhering to the schedule of their medication administration are risking new disease activity.

Dosing for KESIMPTA is only once a month.

I directly ask the patient to what extent they have been able to adhere to the schedule of administration. I also ask them how they remind themselves of that schedule. And we can indirectly get information on when the medication is not filled on time, which can be a red flag to bring up with the patient and make sure we're all on the same page

Some of my patients also have concerns about the safety of injecting themselves. Did Maria have those concerns? If so, how did you address them?

**Dr. Bloch**
Yes, safety was an important consideration for Maria, too. I explained that 21% and 11% of patients treated with KESIMPTA in the Phase 3 clinical trials had systemic and local injection-site reactions, respectively. By comparison, 15% and 6% of patients treated with teriflunomide had systemic and local injection-site reactions. It was also important for Maria to know that the incidence of systemic injection-related reactions diminishes over time with each injection. The incidence was highest with the first injection, 14.4% of patients, but that decreased to 4.4% of patients after the second injection, and to less than 3% after the third injection.

**Dr. Pardo**

Some of my patients become concerned about depleting B-cell counts. How did you explain this risk to her and other patients?

**Dr. Bloch**
That's a good point. I explain that there are long-term extension trial data looking at igG and igM levels in patients treated with KESIMPTA for up to 3.5 years. I mention that we regularly monitor IgG and IgM levels before, during, and after KESIMPTA treatment until B-cell counts come back.

**Mr. Kramer**
Do your patients ask about IgG and IgM levels?

**Dr. Bloch**
Yes, they sometimes do. I tell them the mean serum levels of IgG, the main antibody that protects from infection, remained stable with KESIMPTA for up to 3.5 years. Serum IgM, which is the antibody mainly produced during the primary immune response, declined over time but remained above the lower limit of normal. There was no association observed between decreased IgG or IgM levels and the risk of serious infections at 3.5 years in patients treated with KESIMPTA.

**Mr. Kramer**
When we have patients who are hesitant to use injectable therapies, we also have to be concerned about them staying on treatment. Is this a concern you have? How do you discuss this with your patients?

**Dr. Pardo**
Yes, this is something I think about in my practice. In my opinion, I think it's important to note KESIMPTA trial completion rates of the ASCLEPIOS I and II trials. In ASCLEPIOS I, 90% of the KESIMPTA group remained on KESIMPTA treatment until trial completion versus 81% of patients on teriflunomide. In ASCLEPIOS II, 83% of KESIMPTA patients remained on treatment until trial completion versus 82% of patients on teriflunomide.

**Mr. Kramer**
Are there resources you provide your patients?

**Dr. Bloch**
I think the Alongside™ KESIMPTA program offers comprehensive ongoing support for my patients, which aligns with my treatment plan. That support includes monthly phone calls, periodic emails, or text messages based on the patient's preferences.

To sum up, KESIMPTA was an important consideration for Maria, since she was hesitant to self-inject. The efficacy of KESIMPTA was also critical to slow disability progression. Finally, Maria liked that KESIMPTA has a safety profile similar to teriflunomide.

This episode concludes our 3-episode podcast on KESIMPTA. If you'd like to learn about additional patient examples, feel free to explore the previous 2 podcasts on ReachMD, which cover a newly diagnosed patient and a patient considering. Thank you for listening!

## INDICATION AND IMPORTANT SAFETY INFORMATION

KESIMPTA (ofatumumab) is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

## IMPORTANT SAFETY INFORMATION

**Contraindication**: KESIMPTA is contraindicated in patients with active hepatitis B virus infection.

## WARNINGS AND PRECAUTIONS

### Indication

KESIMPTA is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

### Contraindication

KESIMPTA is contraindicated in patients with active hepatitis B virus infection.

### Infections

An increased risk of infections has been observed with other anti-CD20 B-cell depleting therapies. KESIMPTA has the potential for an increased risk of infections including serious bacterial, fungal, and new or reactivated viral infections; some have been fatal in patients

treated with other anti-CD20 antibodies. The overall rate of infections and serious infections in KESIMPTA-treated patients was similar to teriflunomide-treated patients (51.6% vs 52.7%, and 2.5% vs 1.8%, respectively). The most common infections reported by KESIMPTA-treated patients in relapsing MS (RMS) trials included upper respiratory tract infection (39%) and urinary tract infection (10%). Delay KESIMPTA administration in patients with an active infection until resolved.

Consider the potential increased immunosuppressive effects when initiating KESIMPTA after an immunosuppressive therapy or initiating an immunosuppressive therapy after KESIMPTA.

**Hepatitis B Virus**

*Reactivation*: No reports of hepatitis B virus (HBV) reactivation in patients with MS treated with KESIMPTA. However, HBV reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, has occurred in patients treated with ofatumumab at higher intravenous doses for chronic lymphocytic leukemia (CLL) than the recommended dose in MS and in patients treated with other anti-CD20 antibodies.

*Infection*: KESIMPTA is contraindicated in patients with active hepatitis B disease. Fatal infections caused by HBV in patients who have not been previously infected have occurred in patients treated with ofatumumab at higher intravenous doses for CLL than the recommended dose in MS. Perform HBV screening in all patients before initiation of KESIMPTA. Patients who are negative for HBsAg and positive for HB core antibody [HBcAb+] or are carriers of HBV [HBsAg+], should consult liver disease experts before starting and during KESIMPTA treatment.

**Progressive Multifocal Leukoencephalopathy**

No cases of progressive multifocal leukoencephalopathy (PML) have been reported for KESIMPTA in RMS clinical studies; however, PML resulting in death has occurred in patients being treated with ofatumumab at higher intravenous doses for CLL than the recommended dose in MS. In addition, JC virus infection resulting in PML has also been observed in patients treated with other anti-CD20 antibodies and other MS therapies. If PML is suspected, withhold KESIMPTA and perform an appropriate diagnostic evaluation. If PML is confirmed, KESIMPTA should be discontinued.

**Vaccinations**

Administer all immunizations according to immunization guidelines: for live or live-attenuated vaccines at least 4 weeks and, whenever possible at least 2 weeks prior to starting KESIMPTA for inactivated vaccines. The safety of immunization with live or live-attenuated vaccines following KESIMPTA therapy has not been studied. Vaccination with live or live-attenuated vaccines is not recommended during treatment and after discontinuation until B-cell repletion.

*Vaccination of Infants Born to Mothers Treated with KESIMPTA During Pregnancy*

For infants whose mother was treated with KESIMPTA during pregnancy, assess B-cell counts prior to administration of live or live-attenuated vaccines. If the B-cell count has not recovered in the infant, do not administer the vaccine as having depleted B-cells may pose an increased risk in these infants.

**Injection-Related Reactions**

Injection-related reactions with systemic symptoms occurred most commonly within 24 hours of the first injection, but were also observed with later injections. There were no life-threatening injection reactions in RMS clinical studies.

The first injection of KESIMPTA should be performed under the guidance of an appropriately trained health care professional. If injection-related reactions occur, symptomatic treatment is recommended.

**Reduction in Immunoglobulins**

As expected with any B-cell depleting therapy, decreased immunoglobulin levels were observed. Monitor the levels of quantitative serum immunoglobulins during treatment, especially in patients with opportunistic or recurrent infections and after discontinuation of therapy until B-cell repletion. Consider discontinuing KESIMPTA therapy if a patient with low immunoglobulins develops a serious opportunistic infection or recurrent infections, or if prolonged hypogammaglobulinemia requires treatment with intravenous immunoglobulins.

**Fetal Risk**

Based on animal data, KESIMPTA can cause fetal harm due to B-cell lymphopenia and reduce antibody response in offspring exposed to KESIMPTA in utero. Transient peripheral B-cell depletion and lymphocytopenia have been reported in infants born to mothers

exposed to other anti-CD20 B-cell depleting antibodies during pregnancy. Advise females of reproductive potential to use effective contraception while receiving KESIMPTA and for at least 6 months after the last dose.

**Most common adverse reactions**

(>10%) are upper respiratory tract infection, headache, injection-related reactions, and local injection-site reactions.

**Announcer:**

This program was sponsored by Novartis Pharmaceuticals Corporation. If you missed any part of this discussion, visit reach-m-d-dot-com-industryfeature. This is ReachMD. Be Part of the Knowledge.

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