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Advancing Care in Chronic GVHD: Evolving Therapeutic Insights

Announcer:
You're listening to *Project Oncology* on ReachMD. This medical industry feature, titled "Advancing Care in Chronic GVHD: Evolving Therapeutic Insights," is sponsored by Incyte. Here's your host, Dr. Brian McDonough.

Dr. McDonough:
This is *Project Oncology* on ReachMD, and I'm Dr. Brian McDonough. Joining me today to discuss our evolving treatment approach for patients with chronic graft-versus-host disease, or cGVHD, is Dr. Brooke Adams. She's a clinical pharmacy specialist specializing in blood and marrow transplantation and cellular therapy in Orlando, Florida and has been taking care of chronic GVHD patients for over a decade. Dr. Adams, welcome to the program.

Dr. Adams:
Thank you for the introduction, I'm honored to be here today discussing a disease that is very near and dear to my heart.

Dr. McDonough:
So, Dr. Adams, can you start by explaining the clinical landscape for patients who require additional systemic therapy for GVHD and the challenges we're facing in this setting?

Dr. Adams:
Absolutely. That's an important question because chronic GVHD really is a dynamic disease, and in my experience, it's not always obvious when we're seeing residual damage versus ongoing activity—and that's complicated when we're thinking about additional systemic therapy.

Fortunately, we do have treatment options. For patients who are steroid refractory, Jakafi, or ruxolitinib, is typically used as the second-line therapy as indicated for treatment of chronic GVHD after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older.[1] But the reality is that this disease often becomes more challenging once patients move past the second line and reach later lines of therapy.[2,3]

In fact, more than 60 percent of patients who reach the third line of therapy will unfortunately progress to require a fourth line or more. And what's particularly concerning is that once patients reach that third-line setting, they tend to progress more rapidly through each successive line of therapy.[3] These patients often have a high disease burden with multi-organ involvement, so selecting the best therapy in third line is critical for our patients.[4,5]

In my clinic, I've had patients who limited their time in public because of the impact of visible symptoms, in other patients whose mobility was affected by joint and fascial tightness, which made even short walking distances more difficult. I've also cared for a patient who needed dietary modifications, like pureed foods, because of esophageal involvement that made swallowing challenging. And these are just a few examples of the challenges patients with chronic GVHD may face.

Dr. McDonough:
That really highlights the need for effective treatment strategies in this setting, and Niktimvo™ (axatilimab) is the latest addition to the FDA-approved therapies.[6] Can you walk us through how Niktimvo addresses chronic GVHD's complex pathophysiology?

Dr. Adams:
Absolutely! Niktimvo is the first and only monoclonal antibody approved for chronic GVHD that targets CSF-1R—or colony-stimulating factor-one-receptor—on macrophages and monocytes, which are key drivers of inflammation and fibrosis.[6–8] And it was designed to

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target both of these pathways: depleting nonclassical monocytes from circulation and inhibiting the transforming growth factor-beta mediated fibrotic development by macrophages.[6,8]

Now, when we look at the other currently approved therapies for chronic GVHD therapies—like ruxolitinib, ibrutinib, and belumosudil—they actually share several important mechanistic similarities. If we map out their mechanisms of action side-by-side, we see a lot of overlapping downstream effects, primarily focusing on decreasing cell proliferation and cytokine production.[7,9–11]

In contrast, Niktimvo, or axatilimab, offers a non-overlapping pathway. By specifically targeting the monocyte and macrophage axis, it reduces pro-inflammatory signaling and directly disrupts the pro-fibrotic factors driving the disease.[6–8,12,13] Because it operates through this distinct mechanism, Niktimvo may provide a unique approach for patients who have had a suboptimal response to a second-line therapy.

Dr. McDonough:
That mechanistic differentiation is really helpful. Now, let's look at the clinical data from the AGAVE-201 trial, which supported Niktimvo's approval. How was the study designed, and what patients were included?

Dr. Adams:
The AGAVE-201 study was a randomized, open-label, international, phase two trial that enrolled 241 patients with refractory or recurrent chronic GVHD. Patients were randomized to one of three dosing groups, with 0.3 milligrams per kilo by IV every two weeks ultimately being selected as the recommended therapeutic dose.[6,14]

The primary endpoint was overall response rate, or ORR, by cycle seven, day one of treatment, which was defined by the 2014 NIH consensus criteria.[6] The study also looked at important secondary and exploratory endpoints, including symptom improvement through the modified Lee Symptom Scale, or mLSS, duration of response, or DOR, and failure-free survival, or FFS.[14–16] Overall, this was a trial in a heavily pretreated population, with a focus on response, durability, and patient-reported outcomes.[6]

This heavily pretreated population is evident in the patient demographics. 72 percent of patients included in the study had prior exposure to ruxolitinib, 34 percent had prior exposure to ibrutinib, and 20 percent had prior exposure to belumosudil with a median number of prior lines of therapy being four, ranging from two to 12. In fact, almost half of patients had received five or more prior treatments. These patients had been suffering from chronic GVHD for an average of 47 months, or 3.9 years, progressing through multiple lines of therapy.[6]

It's also important to note the patients' disease burden at baseline; over half had involvement of four or more organs, and a high percentage had inflammation and fibrosis in organs such as the skin, joints and fascia, and lungs.[14,17]

Dr. McDonough:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Brian McDonough and today I'm speaking with Dr. Brooke Adams about clinical trial data on a treatment option for chronic GVHD.

So, Dr. Adams, could you walk us through the response rates for Niktimvo?

Dr. Adams:
Absolutely. Niktimvo demonstrated a 75 percent overall response rate with a 95 percent confidence interval of 64 to 84 by cycle seven, day one in a heavily pretreated population. The median time to first response being 1.5 months. That's after just the third dose! Making this therapy highly efficacious.[6]

Niktimvo also showed activity across multiple organ systems such as the lower and upper GI tract, esophagus, joints and fascia, lungs, liver, eyes, and skin.[14] At baseline, many patients actually had deep sclerotic skin involvement, and we saw that 44 percent experienced reductions in body surface area affected by sclerosis, while 66 percent had improvements in skin and joint tightening.[14]

Dr. McDonough:
And what should we know about the secondary and exploratory endpoints?

Dr. Adams:
For secondary endpoints, among patients who responded, 60 percent maintained their response for at least one year, with a 95 percent confidence interval of 43 to 74.[6,14,15] The median duration of response was around 1.9 months with a 95 percent confidence interval of 1.6 to 3.5 when defined strictly from first response to progression, death, or a new systemic therapy.[6]

Additionally, patient-reported outcomes were collected with the modified Lee Symptom Scale, or mLSS, which measures symptom burden in chronic GVHD. In this exploratory analysis, 56 percent of patients reported a seven-point improvement with a median time to that level of improvement of around 1.5 months.[6,18]

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These results support the overall response rate because we're also seeing meaningful reductions in symptom burden from the patient's perspective, which is an important part of evaluating treatment impact in chronic GVHD. Patients, in my experience, are not going to stay on a therapy without it making them feel better.

Dr. McDonough:
So, considering the efficacy data, how do you see Niktimvo fitting into the treatment paradigm for chronic GVHD?

Dr. Adams:
Great question, the key here is the mechanism of action! Because Niktimvo targets the monocyte-macrophage axis, which distinguishes it from other available therapies, it provides a non-overlapping approach to target both the inflammation and the fibrosis that drive the disease.[6,8–11]

For patients who have progressed on prior systemic therapies, like ruxolitinib, Niktimvo offers a mechanism-informed option that addresses the underlying pathophysiology in a different way, allowing for a nonoverlapping sequential approach.[2,3,6–8,12,13]

And I can attest – I've seen this in clinical practice. For those organ systems that are very sclerotic in nature, Niktimvo makes sense, and my patients' responses on this therapy have validated my theory. I've had all my patients get off of extracorporeal photopheresis, or ECP, after starting Niktimvo. Observations across multiple organs in patients in my practice have been consistent with the findings in the AGAVE-201 study.

Dr. McDonough:
Thank you for that summary, Dr. Adams. With that efficacy and durability data in mind, what should we know about Niktimvo's safety?

Dr. Adams:
The most common adverse reactions in the AGAVE-201, which occurred in 15 percent or more of patients, included infection of an unspecified pathogen in 57 percent, viral infections in 43 percent, musculoskeletal pain in 35 percent, fatigue in 32 percent, nausea in 23 percent, headache in 20 percent, cough or diarrhea in 18 percent, and bacterial infection, pyrexia, or dyspnea in 15 percent. The most common serious adverse reactions were due to infections.[6]

Lab abnormalities included decreases in phosphate in 51 percent and hemoglobin in 48 percent as well as increases in AST in 61 percent, ALT in 51 percent, GGT in 39 percent, lipase in 34 percent, amylase in 32 percent, and calcium in 31 percent.[6] These transient elevations in serum enzyme levels are consistent with Niktimvo's mechanism of action on macrophage clearance.[15] Permanent discontinuation due to an adverse event occurred in 10 percent of patients, with dose reductions in 8 percent.[6]

Dr. McDonough:
And as we wrap up, Dr. Adams, what key takeaway would you like to leave with our audience today?

Dr. Adams:
I want to emphasize that we have an available therapy that targets some of the root causes of chronic GVHD progression.[6–8,12,13] With Niktimvo, we're seeing high response rates in heavily pretreated patients and we saw changes in overall symptom burden as seen in mLSS.[6,14,15,18] The therapeutic landscape is expanding to help us better care for patients struggling with this chronic and debilitating disease.

It is truly an exciting time for our patients and the treatment of chronic GVHD! A little over a decade ago, we had yet to receive the first FDA approval for chronic GVHD and now we have four FDA approved therapies for our patients. Niktimvo provides us with another "tool" in our "toolbox" for our patients.

Dr. McDonough:
That is a great way to round out our discussion. I want to thank my guest, Dr. Brooke Adams, for sharing insights on this potential treatment approach for patients with chronic GVHD. Dr. Adams, it was great speaking with you today.

Dr. Adams:
Thank you so much for having me!

Dr. McDonough:
For ReachMD, I'm Dr. Brian McDonough.

Please stay tuned to hear some Important Safety Information.

Announcer:

Select Safety Information for JAKAFI®/JAKAFI XR™ (ruxolitinib)

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Select warnings and precautions for JAKAFI®/JAKAFI XR™ include thrombocytopenia, anemia, neutropenia, and risk of infection. JAKAFI® (ruxolitinib) is available as 5 mg, 10 mg, 15 mg, 20 mg, and 25 mg tablets. JAKAFI XR™ (ruxolitinib) is available as 11 mg, 22 mg, 33 mg, 44 mg, and 55 mg extended-release tablets.

Indication for JAKAFI® (ruxolitinib).

JAKAFI®/JAKAFI XR™ (ruxolitinib) is for treatment of chronic graft-versus-host disease (cGVHD) after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older.

Please see Important Safety Information and Full Prescribing Information.

Indications and Usage for Niktimvo™
Niktimvo™ (axatilimab-csfr) is a colony stimulating factor-1 receptor (CSF-1R)-blocking antibody indicated for the treatment of chronic graft-versus-host disease (cGVHD) after failure of at least two prior lines of systemic therapy in adult and pediatric patients weighing at least 40 kg.

WARNINGS AND PRECAUTIONS
Infusion-Related Reactions
Niktimvo™ (axatilimab-csfr) can cause infusion-related reactions. Infusion-related reactions, including hypersensitivity reactions, occurred in 18% of patients who received Niktimvo in the clinical trial (AGAVE-201), with Grade 3 or 4 reactions in 1.3%.

Premedicate with an antihistamine and an antipyretic for patients who have previously experienced an infusion-related reaction to Niktimvo. Monitor patients for signs and symptoms of infusion-related reactions, including fever, chills, rash, flushing, dyspnea, and hypertension. Interrupt or slow the rate of infusion or permanently discontinue Niktimvo based on severity of the reaction.

Embryo-Fetal Toxicity
Based on its mechanism of action, Niktimvo may cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to the fetus. Advise females of reproductive potential to use effective contraception during treatment with Niktimvo and for 30 days after the last dose.

ADVERSE REACTIONS
Serious adverse reactions occurred in 44% of patients who received Niktimvo (N=79). Serious adverse reactions in > 2 patients included infection (pathogen unspecified) (14%), viral infection (14%), and respiratory failure (5.1%). Permanent discontinuation of Niktimvo due to an adverse reaction occurred in 10% of patients and dose reduction due to adverse reaction occurred in 8% of patients. Dose interruptions due to an adverse reaction occurred in 44% of patients. The adverse reactions leading to dose interruption in > 2 patients were viral infection, infection (pathogen unspecified), bacterial infection, musculoskeletal pain, and pyrexia.

The most common (≥ 15%) adverse reactions, including laboratory abnormalities, were increased aspartate aminotransferase (AST), infection (pathogen unspecified), increased alanine aminotransferase (ALT), decreased phosphate, decreased hemoglobin, viral infection, increased gamma glutamyl transferase (GGT), musculoskeletal pain, increased lipase, fatigue, increased amylase, increased calcium, increased creatine phosphokinase (CPK), increased alkaline phosphatase (ALP), nausea, headache, diarrhea, cough, bacterial infection, pyrexia, and dyspnea.

Clinically relevant adverse reactions in < 10% of patients who received Niktimvo included:

- *Eye disorders*: periorbital edema
- *Skin and subcutaneous skin disorders*: pruritus
- *Vascular disorders*: hypertension

Immunogenicity: Anti-Drug Antibody–Associated Adverse Reactions
Across treatment arms in patients with cGVHD who received Niktimvo in clinical trials, among the patients who developed anti-drug antibodies (ADAs), hypersensitivity reactions occurred in 26% (13/50) of patients with neutralizing antibodies (NAb) and in 4% (2/45) of those without NAb.

USE IN SPECIFIC POPULATIONS
Lactation
Because of the potential for serious adverse reactions in a breastfed child, advise women not to breastfeed during treatment and for 30 days after the last dose of Niktimvo.

Females and Males of Reproductive Potential

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Pregnancy Testing
Verify pregnancy status in females of reproductive potential prior to initiating Niktimvo.

Contraception
Females
Advise females of reproductive potential to use effective contraception during treatment with Niktimvo and for 30 days after the last dose of Niktimvo.

DOSAGE AND ADMINISTRATION
Dosage Modifications for Adverse Reactions
Monitor aspartate aminotransferase (AST), alanine aminotransferase (ALT), alkaline phosphatase (ALP), creatine phosphokinase (CPK), amylase, and lipase prior to the start of Niktimvo therapy, every 2 weeks for the first month, and every 1 to 2 months thereafter until abnormalities are resolved. See Table 1 in the Prescribing Information for more recommendations.

Please see the Full Prescribing Information, which includes a more complete discussion of the risks associated with Niktimvo.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

You may also report side effects to Incyte Medical Information at 1-855-463-3463.

This medical industry feature was sponsored by Incyte. If you missed any part of this discussion or to find others in this series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge.

References:

1. Zeiser R, Russo D, Ram R, et al. Ruxolitinib in Patients With Corticosteroid-Refractory or Corticosteroid-Dependent Chronic Graft-Versus-Host Disease: 3-Year Final Analysis of the Phase III REACH3 Study. *J Clin Oncol*. 2025;43(23):2566–2571. doi:10.1200/JCO-24-02477
2. Lee SJ, Nguyen TD, Onstad L, et al. Success of Immunosuppressive Treatments in Patients with Chronic Graft-versus-Host Disease. *Biol Blood Marrow Transplant*. 2018;24(3):555–562. doi:10.1016/j.bbmt.2017.10.042
3. Bachier CR, Aggarwal SK, Hennegan K, et al. Epidemiology and Treatment of Chronic Graft-versus-Host Disease Post-Allogeneic Hematopoietic Cell Transplantation: A US Claims Analysis. *Transplant Cell Ther*. 2021;27(6):504 e1–504 e6. doi:10.1016/j.jtct.2020.12.027
4. Zeiser R, Blazar BR. Acute Graft-versus-Host Disease - Biologic Process, Prevention, and Therapy. *N Engl J Med*. 2017;377(22):2167–2179. doi:10.1056/NEJMra1609337
5. Flowers ME, Martin PJ. How we treat chronic graft-versus-host disease. *Blood*. 2015;125(4):606–15. doi:10.1182/blood-2014-08-551994
6. Niktimvo Prescribing Information. Wilmington, DE: Incyte Corporation.
7. Lee SJ, Zeiser R. FDA-approved therapies for chronic GVHD. *Blood*. 2025;145(8):795–800. doi:10.1182/blood.2024026633
8. Kitko CL, Arora M, DeFilipp Z, et al. Axatilimab for Chronic Graft-Versus-Host Disease After Failure of at Least Two Prior Systemic Therapies: Results of a Phase I/II Study. *J Clin Oncol*. 2023;41(10):1864–1875. doi:10.1200/JCO.22.00958
9. Jakafi Prescribing Information. Wilmington, DE: Incyte Corporation.
10. Imbruvica Prescribing Information. Horsham, PA: Janssen Biotech.
11. Belumosudil Prescribing Information. Morristown, NJ: Kadmon Pharmaceuticals. A Sanofi Company.
12. Cersosimo F, Lonardi S, Ulivieri C, et al. CSF-1R in Cancer: More than a Myeloid Cell Receptor. *Cancers (Basel)*. 2024;16(2)doi:10.3390/cancers16020282
13. Bajpai A, Solomon L, Volkova A, et al. Axatilimab Abrogates Inflammatory Cytokines and Chemokines and Interrupts the Differentiation of Monocytes to Macrophages, a Pathogenic Driver of Inflammation and Fibrosis in cGVHD. Poster presented at: ASH Annual Meeting and Exposition; December 7-10, 2024; San Diego, CA. Poster #1147.
14. Wolff D, Cutler C, Lee SJ, et al. Axatilimab in Recurrent or Refractory Chronic Graft-versus-Host Disease. *N Engl J Med*. 2024;391(11):1002–1014. doi:10.1056/NEJMoa2401537
15. Data on file. Incyte Corporation. Wilmington, DE.
16. Wolff D, Cutler C, Lee SJ, et al. Axatilimab in Recurrent or Refractory Chronic Graft-versus-Host Disease [supplementary appendix]. *N Engl J Med*. 2024;391(11):1002–1014.
17. Lee SJ, Flowers ME. Recognizing and managing chronic graft-versus-host disease. *Hematology Am Soc Hematol Educ Program*. 2008:134–41. doi:10.1182/asheducation-2008.1.134

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18. Wolff D, Cutler C, Lee SJ, et al. Safety and Efficacy of Axatilimab at 3 Different Doses in Patients with Chronic Graft-Versus-Host Disease (AGAVE-201). Plenary session presented at: ASH Annual Meeting; December 10, 2023; San Diego, CA.

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