Avatrombopag in TPO-RA–naive adults in acute, persistent, and chronic phases of ITP: Results from the REAL-AVA 3.0 retrospective study

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CONCLUSIONS

- In the real-world setting, treatment with avatrombopag (AVA) yielded a high rate of sustained platelet response in TPO-RA–naive adult patients with chronic or early (acute/persistent) ITP
- Response rates and durability of response were high and similar across patients with chronic ITP and patients with early ITP

INTRODUCTION

- Immune thrombocytopenia (ITP) is an autoimmune disorder characterized by low platelet counts (PCs) due to impaired platelet production and increased platelet destruction[1,2]
- ITP can significantly affect quality of life through the risk of bleeding, activity restrictions, anxiety, and fatigue[3]
- Avatrombopag (AVA) is an orally administered thrombopoietin receptor agonist (TPO-RA) approved for the treatment of chronic ITP in adult patients who have had an insufficient response to a previous treatment[4] or who are refractory to other treatments[5]
- AVA was first approved in the United States in 2018, 10 years later than other available TPO-RAs[4]; therefore, currently available real-world data largely reflect patients who switched to AVA from other TPO-RAs[6-11]
- There is a need for real-world evidence on the use of AVA in patients with TPO-RA–naive ITP

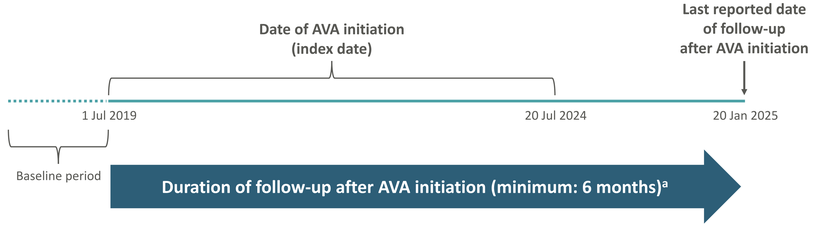
OBJECTIVES

- Here, we present results of the REAL-AVA 3.0 study, a retrospective study describing real-world treatment patterns and clinical outcomes in TPO-RA–naive patients with ITP receiving AVA in the United States, by duration of ITP

METHODS

- **Data source:** Cardinal Health Oncology Provider Extended Network (OPEN), retrospective chart review
- **Study population:** TPO-RA–naive adults (≥18 years of age) with primary ITP who initiated AVA on or after 1 Jul 2019, with ≥6 months of follow-up after AVA initiation[a]; patients with secondary ITP or AVA/eltrombopag/romiplostim use for another condition or in a clinical trial were excluded
  - Chronic ITP was defined as ITP with a duration of ≥12 months from diagnosis to AVA initiation, and early (acute/persistent) ITP was defined as ITP with a duration of <12 months from diagnosis to AVA initiation
- **Follow-up period:** Time from AVA initiation (ie, index date) to the earliest of the following: last contact, death, or study end (20 Jan 2025)
- **Outcomes and definitions:**
  - **Response on AVA:** Achieving a meaningful PC (response thresholds: ≥30×10^9/L, ≥50×10^9/L, and ≥100×10^9/L) at least once in the absence of rescue therapy
  - **Durability of response on AVA:** The percentage of time on AVA with a PC above the prespecified response threshold in the absence of rescue therapy

Study period

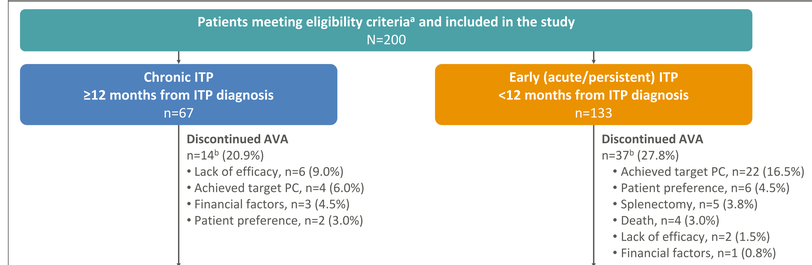


[a]Patients were required to have a minimum of 6 months of follow-up, except for patients who died prior to 6 months; follow-up was defined as the management of patients by the provider completing the chart abstraction, and patients were not required to have been on AVA for the full 6 months. AVA, avatrombopag.

RESULTS

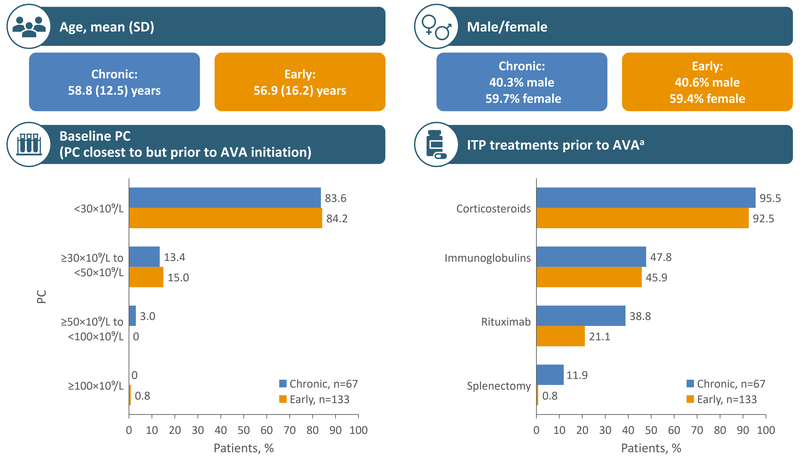
- A total of 200 patients with ITP were treated with AVA, including 67 (33.5%) with chronic ITP and 133 (66.5%) with early ITP (acute, n=61; persistent, n=72) (**Figure 1**)
- Mean (standard deviation) age at AVA initiation was 57.5 (15.0) years in the total population, and a majority of patients were female (59.5%); demographics and baseline PCs were similar between patients with chronic ITP and those with early ITP, and nearly all patients had received corticosteroids before starting AVA treatment (**Figure 2**)
- At last follow-up (median of 9.6 months for chronic ITP; 8.2 months for early ITP), median duration of treatment after AVA initiation was 9.1 months for patients with chronic ITP and 7.7 months for patients with early ITP (**Figure 3**); a total of 149 patients (chronic, n=53 [79.1%]; early, n=96 [72.2%]) remained on AVA (**Figure 1**)
  - The most common reasons for discontinuation were achieving target PC (chronic, n=4 [6.0%]; early, n=22 [16.5%]), lack of efficacy (chronic, n=6 [9.0%]; early, n=2 [1.5%]), and patient preference (chronic, n=2 [3.0%]; early, n=6 [4.5%])
  - Among the 51 patients who discontinued AVA, 10 (19.6%) initiated subsequent ITP treatment (8/14 [57.1%] with chronic ITP; 2/37 [5.4%] with early ITP)

Figure 1: Patient disposition



[a]Eligibility criteria: TPO-RA–naive adults (≥18 years of age) with primary ITP who initiated AVA on or after 1 Jul 2019, with ≥6 months of follow-up after AVA initiation; patients with secondary ITP or AVA/ELT/ROMI use for another condition or in a clinical trial were excluded. [b]Patients may have had ≥1 reason for discontinuation; reasons reported by >2 patients in either group are shown for both groups.
AVA, avatrombopag; ELT, eltrombopag; ITP, immune thrombocytopenia; PC, platelet count; ROMI, romiplostim; TPO-RA, thrombopoietin receptor agonist.

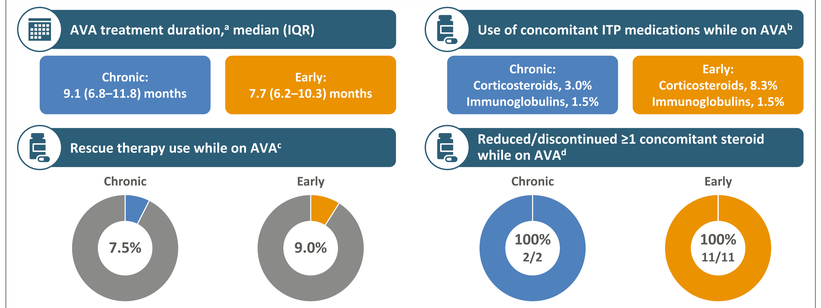
Figure 2: Patient characteristics at AVA initiation and prior ITP treatments in patients with chronic ITP (n=67) or early ITP (n=133)



[a]Treatments in ≥10% of patients in either group are shown for both groups.
AVA, avatrombopag; ITP, immune thrombocytopenia; PC, platelet count; SD, standard deviation.

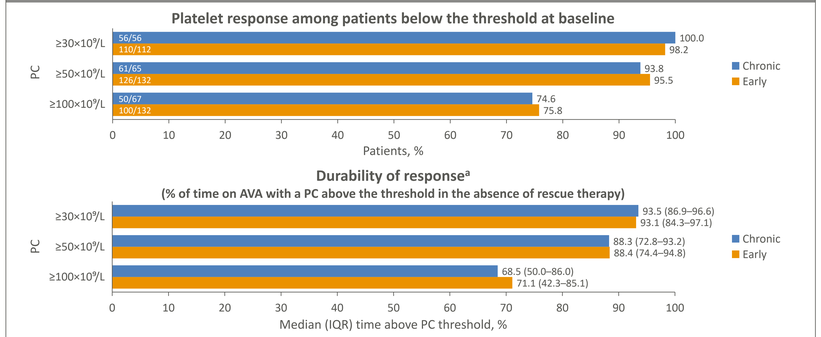
- During AVA treatment, few patients required concomitant ITP therapy (corticosteroids: chronic, n=2 [3.0%]; early, n=11 [8.3%]; immunoglobulins: chronic, n=1 [1.5%]; early, n=2 [1.5%]) or rescue therapy (chronic, n=5 [7.5%]; early, n=12 [9.0%]); among patients who received concomitant steroids, all reduced or discontinued use of ≥1 of these concomitant medications (**Figure 3**)
- Response rates and durability of response were high across groups (**Figure 4**)
  - Among patients whose baseline PC was <30×10^9/L (chronic, n=56; early, n=112), 100% of those with chronic ITP and 98.2% of those with early ITP reached levels ≥30×10^9/L; median durability of response with PC ≥30×10^9/L (% of time on AVA above threshold) was ≥93% for chronic and early ITP
  - Among patients whose baseline PC was <50×10^9/L (chronic, n=65; early, n=132), 93.8% of those with chronic ITP and 95.5% of those with early ITP reached levels ≥50×10^9/L; median durability of response with PC ≥50×10^9/L (% of time on AVA above threshold) was ≥88% for chronic and early ITP

Figure 3: Treatment patterns in patients with chronic ITP (n=67) or early ITP (n=133)



[a]Time from AVA initiation to discontinuation of AVA or, if still on therapy, last day of follow-up. [b]Concomitant ITP medications administered in >1 patient in either group are shown for both groups. [c]Concomitant ITP-related medication given during AVA treatment to manage acute worsening of thrombocytopenia or bleeding. [d]Among patients who received ≥1 concomitant steroid during AVA treatment; 2 patients with chronic ITP and 11 patients with early ITP received ≥1 concomitant steroid during AVA treatment.
AVA, avatrombopag; IQR, interquartile range; ITP, immune thrombocytopenia.

Figure 4: Clinical outcomes (platelet response and durability of response) in patients with chronic ITP (n=67) or early ITP (n=133)



[a]Among patients with any baseline PC and ≥1 PC above threshold.
AVA, avatrombopag; IQR, interquartile range; ITP, immune thrombocytopenia; PC, platelet count.

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Disclosures

SP: Consultancy/honoraria: Novartis, Recordati, Sanofi, and Sobi. **AO, FS,** and **MV:** Current employment: Sobi. **SL** and **EB:** Current employment: Cardinal Health. **PP:** Former employment: Cardinal Health. **BF:** Current employment/stock ownership: Cardinal Health. **DJ:** Consultancy/honoraria: Sobi.

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