Treatment characteristics and healthcare resource utilization among patients with generalized myasthenia gravis initiating rozanolixizumab in the United States

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Introduction

- Rozanolixizumab is a neonatal fragment crystallizable receptor blocker approved for the treatment of adults with gMG who are anti-AChR or anti-MuSK Ab+[1]
- Following an initial 6-week treatment cycle, subsequent cycles are administered based on clinical evaluation[1]
- This retrospective, observational cohort study evaluated MG treatment patterns, including rozanolixizumab utilization and HCRU, in individuals with MG who initiated rozanolixizumab in the United States, including those who switched from efgartigimod treatment to rozanolixizumab

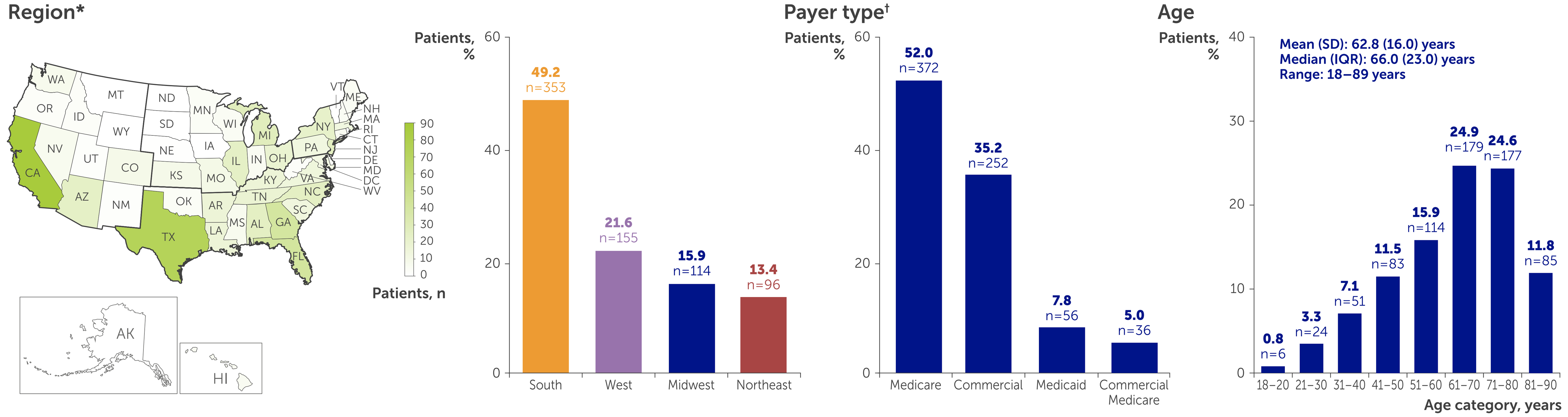
Methods

- Patients were selected from de-identified claims data from the Komodo Healthcare Map® database, which includes more than 330 million patients across the United States
- Enrolled patients were aged ≥18 years and had an MG diagnosis, in addition to ≥1 rozanolixizumab medical/pharmacy claim and continuous enrollment or plan coverage for 12 months prior to first rozanolixizumab treatment initiation
- The patient selection period was July 1, 2023 to March 31, 2025, and the study period was July 1, 2022 to March 31, 2025
- The index date was defined as the first recorded treatment date with rozanolixizumab in either pharmacy or medical claims
- The baseline period comprised the 12 months prior to the index date, and the follow-up period was from the day after the index date until the last date of recorded enrollment
- Sociodemographics during the baseline period, HCRU and treatments for MG during baseline and follow-up, and utilization of rozanolixizumab during follow-up, were described
- A second study using the Komodo Healthcare Map® database (July 2022 to June 2025) assessed patients who started rozanolixizumab after previous efgartigimod treatment
  - Patients had continuous plan coverage for 12 months before and after the index date (first rozanolixizumab treatment) and received ≥1 efgartigimod treatment ≤12 months prior to the index date

Results

- 719 patients met the eligibility criteria and were included in the main study; sociodemographic characteristics are displayed in **Figure 1**
  - Approximately half of the patients (n=373; 51.9%) were female
- Mean (SD) length of the follow-up period was 315.2 (149.2) days (range: 0–642 days)
  - Patients may or may not have continued rozanolixizumab during follow-up
- During the baseline period, the most common comorbidities were hypertension (n=386; 53.7%), dyslipidemia (n=337; 46.9%) and infections (n=311; 43.3%)

Figure 1 Sociodemographic characteristics during the baseline period

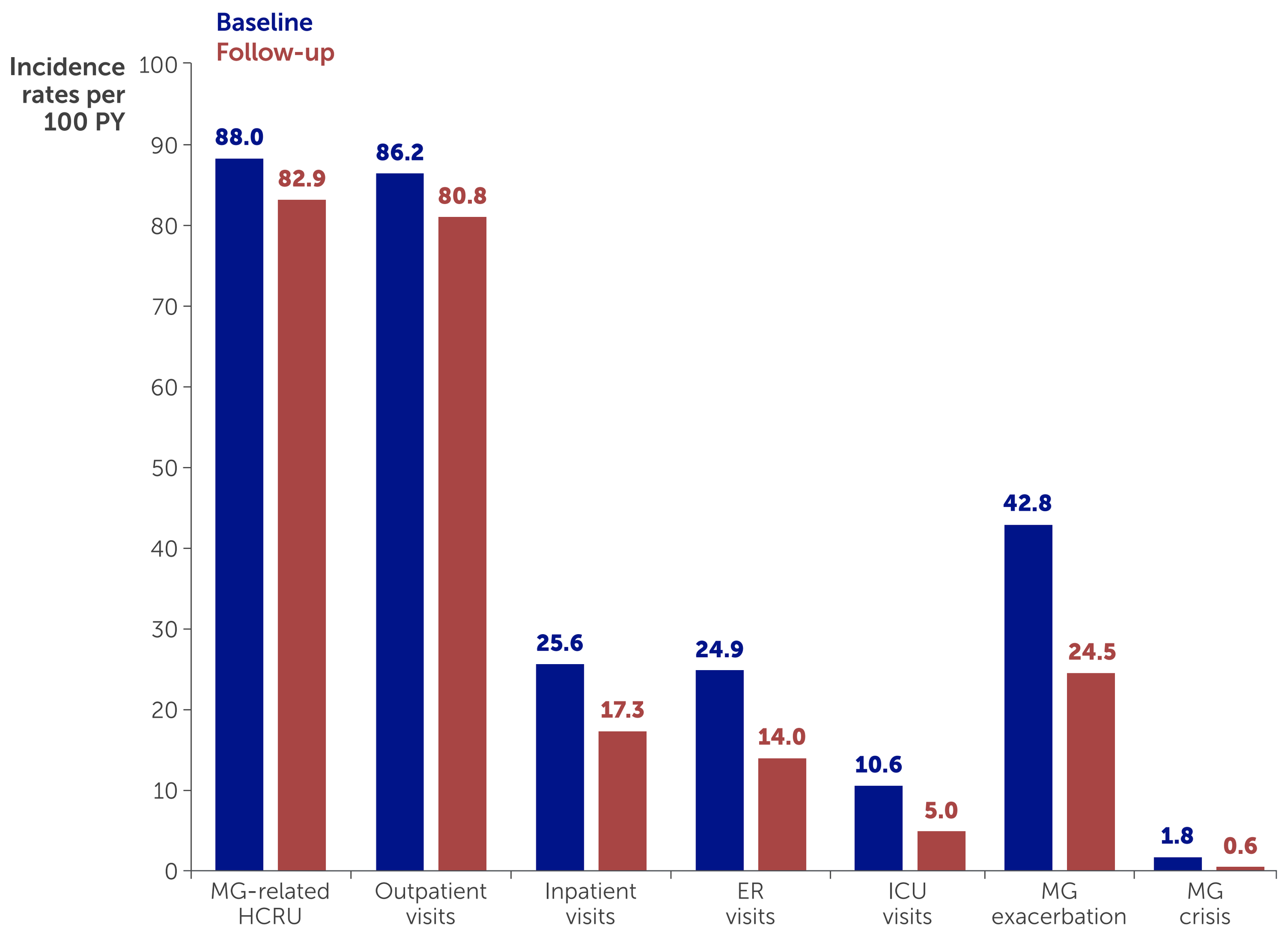


N=719 unless otherwise specified. *N=718; **Midwest region:** Indiana, Illinois, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; **Northeast region:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York, Pennsylvania; **South region:** Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, Texas; **West region:** Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada, Wyoming, Alaska, California, Hawaii, Oregon, Washington. †N=716; type of insurance nearest to index date.

Healthcare resource utilization

- MG-related HCRU was slightly reduced after rozanolixizumab initiation (**Figure 2**)
- There were lower incidence rates across all categories of MG-related HCRU after rozanolixizumab initiation

Figure 2 MG-related HCRU during the baseline and follow-up periods

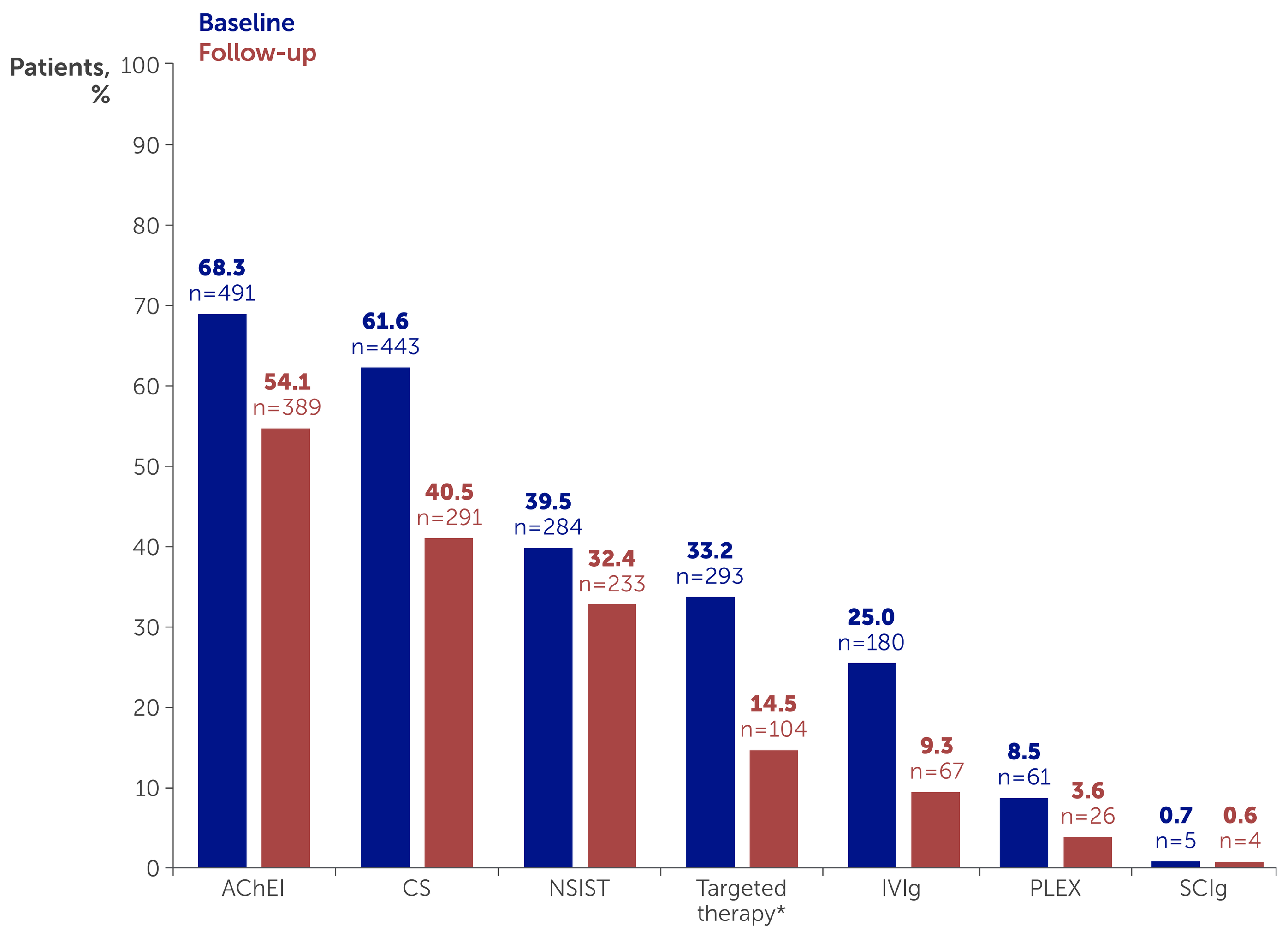


Total person-years were 719.0 during the baseline period and 620.4 during the follow-up period. Categories of HCRU were not mutually exclusive.

MG treatments

- Mean (SD) number of treatment classes prescribed during the baseline and follow-up periods, excluding rozanolixizumab, was 2.4 (1.4) and 1.7 (1.3), respectively
  - During the baseline period, the most common treatment classes for MG were AChEI, CS and NSIST (**Figure 3**)
  - During the follow-up period, after rozanolixizumab initiation, use of all treatment classes (including rescue therapies) was reduced

Figure 3 Treatment classes for MG during the baseline and follow-up periods

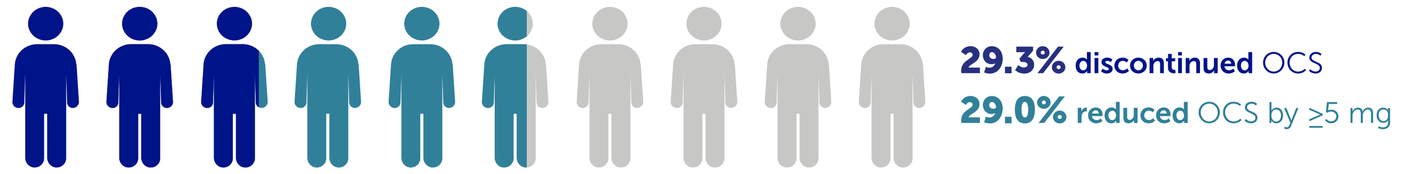


*Targeted therapy included efgartigimod (IV or SC), eculizumab, ravulizumab, anti-CD20 monoclonal antibodies (including rituximab) and zilucoplan.

Rozanolixizumab and OCS utilization

- For patients with ≥365 days since rozanolixizumab initiation (n=287), a mean (SD) of 2.9 (1.8) cycles were started in Year 1
  - This was lower than the first-year mean observed in Phase 3 clinical studies, which was 4.1 for patients who were in the studies for at least 1 year[2]
- A total of 386 patients had prior use of OCS during the baseline period and ≥3 months of follow-up
  - Across the entire follow-up period, nearly two-thirds of these patients were able to reduce their OCS dose by ≥5 mg or discontinue completely (**Figure 4**)
  - The remaining patients either maintained (<5 mg change) or increased their OCS dose

Figure 4 Reductions in dose and discontinuations of OCS after rozanolixizumab initiation



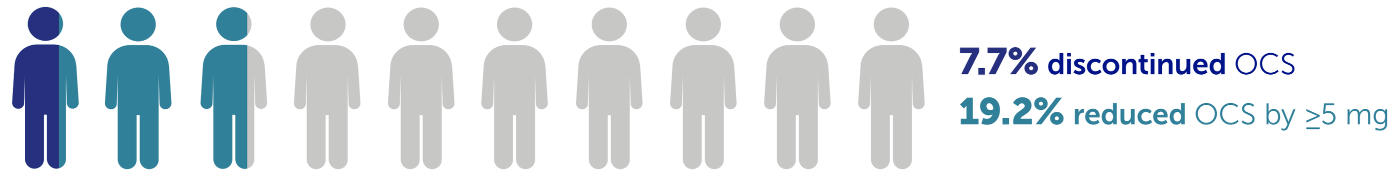
Summary and conclusions

- This large, real-world study evaluated a broad population of patients who initiated rozanolixizumab treatment in the United States
- Compared with the baseline period, MG-related HCRU was reduced in the follow-up period
- There were reductions from baseline to follow-up in the use of rescue therapies, and in the incidence of MG exacerbations and MG crises
- Following rozanolixizumab initiation, reductions and discontinuations in corticosteroid use were observed during the follow-up period compared with the baseline period; reductions were also observed in patients who switched from efgartigimod to rozanolixizumab
- Patients started a mean of 2.9 rozanolixizumab cycles in Year 1, which was lower than the mean of 4.1 cycles observed in Phase 3 studies[2]

Switching from efgartigimod to rozanolixizumab

- 26 patients met the eligibility criteria and were included in this second study
  - 15 (57.7%) patients were female; mean (SD) age at rozanolixizumab initiation was 61.0 (16.9) years
- Patients initiated a mean (SD) of 3.5 (1.9) cycles of efgartigimod during the 12-month baseline period and 2.3 (1.3) cycles of rozanolixizumab during the 12-month follow-up period
- During the follow-up period, the proportion of patients with ≥1 MG-related hospitalization reduced from 50.0% (n=13) at baseline to 23.0% (n=6); the proportion of patients with ≥1 MG exacerbation also decreased, from 69.2% (n=18) during baseline to 38.5% (n=10) during follow-up
- Mean (SD) OCS doses were 8.1 (6.5) mg and 7.9 (12.9) mg during the baseline and follow-up periods, respectively
  - Over the 12-month follow-up period, nearly 30% of patients were either able to reduce their OCS dose by ≥5 mg or discontinue completely (**Figure 5**)
  - The remaining patients maintained a consistent dose (<5 mg change)

Figure 5 Reductions in dose and discontinuations of OCS after switching from efgartigimod to rozanolixizumab



Abbreviations: Ab+, antibody positive; AChEI, acetylcholinesterase inhibitor; AChR, acetylcholine receptor; CD, cluster of differentiation; ER, emergency room; (g)MG, (generalized) myasthenia gravis; HCRU, healthcare resource utilization; ICU, intensive care unit; IQR, interquartile range; IV, intravenous; IVIg, intravenous immunoglobulin; MuSK, muscle-specific tyrosine kinase; NSIST, nonsteroidal immunosuppressant therapy; (O)CS, (oral) corticosteroids; PLEX, plasma exchange; PY, person-years; SC, subcutaneous; SCIg, subcutaneous immunoglobulin; SD, standard deviation.

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These data have been accepted for publication in Neurol Ther: Kumar M, et al. Treatment characteristics and healthcare resource utilization among patients with myasthenia gravis initiating rozanolixizumab: a US claims database analysis. Neurol Ther. [In press]. The switching data were previously presented at the MDA Annual Meeting; Orlando, FL, USA; March 8–11, 2026.