

This is a reprint from ECTRIMS 2021 virtual congress, which was originally published in Switzerland; the references to “Merck” or “Merck KGaA” within refer to (1) Merck KGaA, Darmstadt, Germany; (2) an affiliate of Merck KGaA, Darmstadt, Germany; or (3) one of the businesses of Merck KGaA, Darmstadt, Germany, which operate as EMD Serono in the healthcare, MilliporeSigma in the life science and EMD Electronics in the electronics business in the U.S. and Canada.

There are two different, unaffiliated companies that use the name “Merck”. Merck KGaA, Darmstadt, Germany, which is providing this content, uses the firm name “Merck KGaA, Darmstadt, Germany” and the business names EMD Serono in the healthcare, MilliporeSigma in the life science and EMD Electronics in the electronics business in the U.S. and Canada. The other company, Merck & Co., Inc. holds the rights in the trademark “Merck” in the U.S. and Canada. Merck & Co., Inc. is not affiliated with or related to Merck KGaA, Darmstadt, Germany, which owns the “Merck” trademark in all other countries of the world.

Disease-Modifying Treatment Patterns of Patients With Multiple Sclerosis and Newly Treated With Cladribine Tablets or Fingolimod: An Interim Analysis of the CLARION Study

H. Butzkueven¹, J. Hillert², J. Sönaajalg³, M. Soilu-Hänninen⁴, A. Aydemir⁵, T. Ziemssen⁶, J. Kuhle⁷, M. Magyari⁸, S. Wergeland⁹, I. Bezemer¹⁰, M. Sabidó¹¹

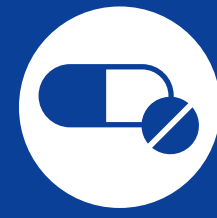
¹Monash University, Melbourne, VIC, Australia; ²Department of Clinical Neuroscience, Karolinska Institute, Stockholm, Sweden; ³Global Database Studies, IQVIA, Tartu, Estonia; ⁴Turku University Hospital Neurocenter and Department of Neurology, University of Turku, Turku, Finland; ⁵EMD Serono Research and Development Institute, Inc., Billerica, MA, USA, an affiliate of Merck KGaA; ⁶Center of Clinical Neuroscience, Neurological University Clinic Carl Gustav Carus, University of Technology, Dresden, Germany; ⁷Neurology Clinic and Policlinic, MS Center and Research Center for Clinical Neuroimmunology and Neuroscience Basel (RC2NB), University Hospital of Basel, Basel, Switzerland; ⁸Department of Neurology, Danish Multiple Sclerosis Center and The Danish Multiple Sclerosis Registry, Copenhagen University Hospital, Rigshospitalet, Copenhagen, Denmark; ⁹Department of Neurology, Haukeland University Hospital, Bergen, Norway; ¹⁰Global Epidemiology and Outcomes Research, IQVIA, Amsterdam, The Netherlands; ¹¹Merck Healthcare KGaA, Darmstadt, Germany



GET POSTER PDF
Copies of this poster obtained through QR (Quick Response) code are for personal use only and may not be reproduced without written permission of the authors

CONCLUSIONS

In this interim analysis of the real-world CLARION study, about one third and one fifth of patients initiated cladribine tablets and fingolimod as first-line treatment, respectively.



Dimethyl fumarate and interferon beta-1a were the most commonly used DMT prior to initiation of cladribine tablets and fingolimod cohort, respectively. Teriflunomide was the most common last DMT prior to initiation of cladribine tablets or fingolimod.

Within the available study follow-up, fingolimod patients switched to another DMT more often than cladribine tablets patients.

INTRODUCTION

Patients with multiple sclerosis (MS) may require life-long therapy, and some new disease-modifying therapies (DMTs) have a prolonged duration of effect; as such, it is important to understand their long-term safety in routine clinical practice.^[1-3]

CLARION is a long-term study (EUPAS24484) designed to characterize the real-world safety profile of cladribine tablets and describe the sequence of DMT use in MS patients.



METHODS

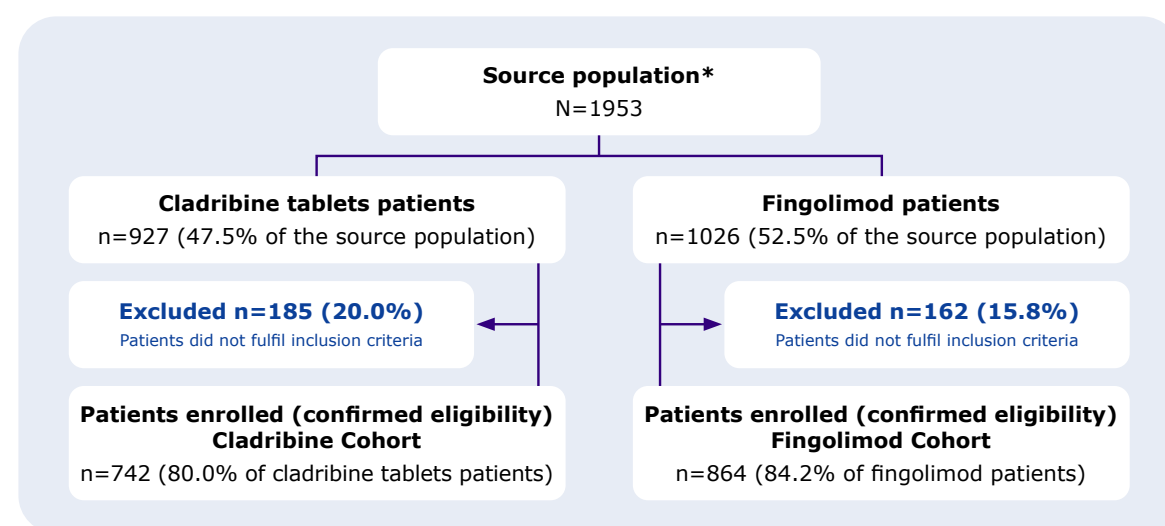
- MS patients newly initiating cladribine tablets or fingolimod after the country-specific launch date for cladribine tablets and without prior fingolimod use were identified (interim analysis cut-off date, 1 April 2020).
- Prior and subsequent DMT use was described by cohort and type. Danish MS Registry (DMSR) is reported separately due to small observations handling with no intention to directly compare it to "all registries".
- Results are presented for DMTs with at least 10% of the DMT use in cladribine or fingolimod cohort (all MS registries except DMSR).
- Data are available from 7 registries:
 - Danish MS Registry; Multiple Sclerosis database [MSBase]; Multiple Sclerosis Management System 3D and NeuroTransData database; Norwegian Multiple Sclerosis Register; Finnish MS Registry; Swiss Multiple Sclerosis Cohort; and Swedish Multiple Sclerosis Register.
 - In Denmark, number and percentages were sometimes provided as ranges due to data protection restrictions of reporting small observations. Because of this, Danish results are presented as a stand-alone registry.

OBJECTIVES

To describe prior and subsequent DMT use in MS patients newly initiating cladribine tablets or fingolimod for MS and included in the first interim analysis of CLARION.

RESULTS

Figure 1. Patient Disposition



*Source population: Patients with fingolimod or cladribine tablets between cladribine tablets launch date (country-specific) and date of data cut-off (1 April 2020).

- In DMSR, 525 patients (136 of 185 cladribine tablets users and 389 of 443 fingolimod users) were included. The main reason for non-inclusion was prior use of fingolimod (49 cladribine tablets users and 54 fingolimod users).

Table 1. Data Sources & Follow-up

	Cladribine cohort N=742	Fingolimod cohort N=864
Data source, n (%)		
Danish Multiple Sclerosis Registry	136 (18.3)	389 (45.0)
MSBase	132 (17.8)	49 (5.7)
MSDS3D (and NTD)	130 (17.5)	104 (12.0)
Norwegian MS Registry	183 (24.7)	136 (15.7)
Finnish MS Registry	73 (9.8)	123 (14.2)
Swedish MS Registry	80 (10.8)	50 (5.8)
Swiss MS Cohort	8 (1.1)	13 (1.5)
Mean (SD) duration of follow-up at the time of data cut-off (years)	0.9 (0.5)	1.4 (0.7)

MS, multiple sclerosis; MSBase, Multiple Sclerosis database; MSDS3D, Multiple Sclerosis Management System 3D; N, total number of patients; n, number of occurrences; NTD, NeuroTransData database; SD, standard deviation

Table 2. Any Prior DMT for MS before Initiation of Study Treatment

Number (%) of patients with prior DMT use	All MS Registries except DMSR		DMSR	
	Cladribine cohort N=606	Fingolimod cohort N=475	Cladribine cohort N=136	Fingolimod cohort N=389
Any prior DMT use	494 (63.2)	345 (72.6)	111 (81.6)	334 (85.9)
Dimethyl fumarate*	135 (35.2)	116 (33.6)	36 (32.4)	56 (16.8)
Interferon beta-1a*	130 (33.9)	152 (44.1)	50 (45.0)	168 (50.3)
Glatiramer acetate*	128 (33.4)	112 (32.5)	32 (28.8)	49 (14.7)
Teriflunomide*	110 (28.7)	106 (30.7)	47 (42.3)	172 (51.5)
Natalizumab*	79 (20.6)	48 (13.9)	47 (42.3)	94 (28.1)
Interferon beta-1b*	50 (13.1)	54 (15.7)	5 (4.5)	16 (4.8)

*Among patients with prior DMT use. DMSR, Danish MS Registry; DMT, disease-modifying therapy; MS, multiple sclerosis; N, total number of patients; n, number of occurrences

Table 3. Last Prior DMT for MS before Initiation of Study Treatment

Number (%) of patients with prior DMT use	All MS Registries except DMSR		DMSR	
	Cladribine cohort N=606	Fingolimod cohort N=475	Cladribine cohort N=136	Fingolimod cohort N=389
Any last prior DMT use	494 (63.2)	345 (72.6)	111 (81.6)	334 (85.9)
Teriflunomide*	92 (24.0)	83 (24.1)	28 (25.2)	143 (42.8)
Dimethyl fumarate*	90 (23.5)	78 (22.6)	15 (13.5)	36 (10.8)
Glatiramer acetate*	64 (16.7)	51 (14.8)	13 (11.7)	17 (5.1)
Natalizumab*	52 (13.6)	40 (11.6)	39 (35.1)	88 (26.3)
Interferon beta-1a*	31 (8.1)	70 (20.3)	1 - 4 (0.9 - 3.6) [†]	44 (13.2)

*Among patients with prior DMT use. †Numbers and percentages were sometimes provided as ranges due to restrictions of reporting small observations in Danish MS Registry. DMSR, Danish MS Registry; DMT, disease-modifying therapy; MS, multiple sclerosis; N, total number of patients; n, number of occurrences

Table 4. Any Subsequent DMT after Initiation of Study Treatment

Number (%) of patients with subsequent DMT use	All MS Registries except DMSR		DMSR	
	Cladribine cohort N=606	Fingolimod cohort N=475	Cladribine cohort N=136	Fingolimod cohort N=389
Any subsequent DMT use	15 (2.5)	96 (20.2)	1 - 4 (0.7 - 2.9)[†]	98 (25.2)
Natalizumab*	7 (46.7)	11 (11.5)	1 - 4 (25.0 - 100.0) [†]	13 (13.3)
Rituximab*	5 (33.3)	34 (35.4)	0 (0.0 - 0.0)	2 - 8 (2.0% - 8.2%) [†]
Ocrelizumab*	2 (13.3)	15 (15.6)	0 (0.0 - 0.0)	54 (55.1)
Cladribine tablets*	0 (0.0)	18 (18.8)	0 (0.0 - 0.0)	6 - 9 (6.1% - 9.2%) [†]

*Among patients with subsequent DMT use. †Numbers and percentages were sometimes provided as ranges due to restrictions of reporting small observations in Danish MS Registry. DMSR, Danish MS Registry; DMT, disease-modifying therapy; MS, multiple sclerosis; N, total number of patients; n, number of occurrences

REFERENCE
1. Chisari CG et al. Expert Opin Drug Saf. 2019 Oct;18(10):925-948. 2. Dirks P et al. BMC Neurol. 2020 Mar 14;20(1):95. 3. Butzkueven H et al. J Neurol Neurosurg Psychiatry. 2020 Jun;91(6):660-668.

Disclosures: HB's Institution (Monash University) received compensation for consulting, talks, and advisory/steering board activities from Alfred Health, Biogen, Genzyme, Merck, and Novartis; research support from Biogen, Merck, MS Research Australia, National Health and Medical Research (Australia), Novartis, the Oxford Health Policy Forum, and Roche. Personal compensation for steering group activities from Merck and Oxford Health Policy Forum. JH has received honoraria for serving on advisory boards for Biogen, Bristol-Myers-Squibb, Merck, Novartis, Sandoz and Sanofi-Genzyme, and speaker's fees from Bayer, Biogen, Merck, Novartis, Sanofi-Genzyme, and Teva. He has served as P.I. for projects, or received unrestricted research support from Bayer, Biogen, Merck, Novartis, Sanofi-Genzyme, and Teva. His MS research is funded by the Swedish Research Council and the Swedish Brain Foundation. AS and TB are employees of IQVIA, a contract research organization that performs commissioned pharmacoepidemiological studies for several pharmaceutical companies. MS-H has served on scientific advisory boards for Biogen, Celgene (BMS), Merck, Sanofi, and Roche, and has received honoraria for lecturing from Biogen, Merck, Sanofi, and Teva, and has received research support and support for congress participation from Biogen, Merck, Novartis, and Roche. AA is an employee of EMD Serono Research and Development Institute, Inc., Billerica, MA, USA (an affiliate of Merck KGaA). TZ has received grants and personal fees from Almirall, Bayer, Biogen, Celgene (BMS), Merck, Novartis, Roche, Sanofi, and Teva. JK has received speaker fees, research support, travel support, and/or served on advisory boards by Swiss MS Society, Swiss National Research Foundation (320030_189140/1), University of Basel, Progressive MS Alliance, Bayer, Biogen, Celgene (BMS), Merck, Novartis, Roche, and Sanofi. MM has served on scientific advisory boards and served as consultant for, received support for congress participation or received speaker honoraria from AbbVie, Alexion (Janssen/J&J), Biogen, Merck, Roche, and Sanofi. SW has received honoraria for serving on advisory boards for Biogen and Sanofi-Genzyme, speaker fees from Biogen and Novartis, and research support from Biogen and Novartis. MS is an employee of Merck Healthcare KGaA, Darmstadt, Germany.

Medical writing assistance was provided by Joseph Ward of InScience Communications, Springer Healthcare Ltd, UK, and was funded by Merck Healthcare KGaA, Darmstadt, Germany. CLARION study: EU PAS Register No. EUPAS24484.