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<https://doi.org/10.1016/j.annonc.2024.08.2268>

**LBA30 ATHENA-COMBO, a phase III, randomized trial comparing rucaparib (RUCA) + nivolumab (NIVO) combination therapy vs RUCA monotherapy as maintenance treatment in patients (pts) with newly diagnosed ovarian cancer (OC)**

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**Background:** ATHENA (NCT03522246) consists of 2 studies, MONO and COMBO. In MONO, RUCA monotherapy provided a sustained investigator-assessed progression-free survival (PFS) vs placebo (PBO), median [mdn] 20.2 vs 9.2 months [mo], data

cutoff 23 Mar 2022) in pts with newly diagnosed, advanced high-grade OC (AHGOC) after first-line (1L) treatment. COMBO was designed to evaluate if the addition of NIVO to RUCA could further delay time to progression. RUCA + NIVO (COMBO) was compared with RUCA + PBO (MONO) with an additional 2 years (y) of follow up (cutoff 17 May 2024). We report primary efficacy and safety results from COMBO.

**Methods:** Pts with FIGO stage III–IV AHGOC with response to 1L platinum-based chemotherapy were randomized 1:1 to RUCA 600 mg PO BID + NIVO 480 mg IV Q4W or RUCA + PBO. The primary endpoint was PFS in the intent-to-treat (ITT) population. PFS in homologous recombination deficiency (HRD) subgroups and programmed death-ligand 1 (PD-L1) subgroups were exploratory.

**Results:** Between 7 Aug 2018 and 26 Oct 2020, 863 pts were randomized. After a mdn follow-up of 48 mo, COMBO was associated with numerically shorter mdn PFS vs MONO in the ITT (15.0 vs 20.2 mo; HR, 1.3; 95% CI, 1.1–1.5), HRD subgroups, and in pts with PD-L1  $\geq 1\%$  and  $\geq 5\%$  (table). PFS benefit of 2.2 mo with RUCA MONO was maintained with the additional 2 y follow-up. COMBO had shorter mdn exposure to treatment vs MONO (PO 8.4 vs 14.7 mo, IV 4.6 vs 11.1 mo). Common grade  $\geq 3$  treatment-related AEs in COMBO vs MONO were anemia/hemoglobin decreased (27.1% vs 28.6%), neutropenia/neutrophil count decreased (25.4% vs 15.4%), and ALT/AST increased (21.2% vs 10.0%).

**Table: LBA30**

	COMBO vs MONO Data cutoff 17 May 2024			
	RUCA + NIVO (COMBO), n	RUCA + PBO (MONO), n	Median investigator-assessed PFS, mo	HR (95% CI)
ITT	436	427	15.0 vs 20.2	1.3 (1.1–1.5)
HRD	193	185	28.9 vs 31.4	1.1 (0.9–1.5)
BRCA mutation	94	91	48.0 vs NR	1.1 (0.7–1.7)
BRCA wt/LOH <sup>high</sup>	99	94	17.3 vs 22.3	1.1 (0.7–1.5)
BRCA wt/LOH <sup>low</sup>	188	189	11.0 vs 12.1	1.3 (1.0–1.7)
BRCA wt/LOH <sup>indeterminate</sup>	55	53	9.2 vs 17.5	1.6 (1.0–2.5)
PD-L1 $\geq 5\%$	69	72	22.8 vs 52.2	1.5 (0.9–2.4)
PD-L1 $\geq 1\%$	199	197	18.3 vs 25.8	1.3 (1.0–1.7)

LOH, loss of heterozygosity; NR, not reached; wt, wild-type.

**Conclusions:** NIVO in combination with RUCA did not add to the PFS benefit of RUCA observed in MONO. The safety profile of RUCA in combination with NIVO was consistent with previously reported studies and their individually known safety profiles.

**Clinical trial identification:** NCT03522246.

**Editorial acknowledgement:** Medical writing and editorial support, funded by pharma&, were provided by Gautam Bijur, PhD, and Celia Nelson of Ashfield MedComms, an Inizio company.

**Legal entity responsible for the study:** pharma&.

**Funding:** pharma&.

**Disclosure:** B.J. Monk: Financial Interests, Personal, Other, Consultant: Aegus, Elevar, GOG Foundation, Genmab/Seattle Genetics, Gradalis, Immunogen, Karyopharm, Mersana, Novocure, Pfizer, Acrivon, Alkermes, Amgen, Bayer, BioNtech, Concept, Duality, EMD Merck, Genelux, Laekna, Novartis, OncoC4, Panavance, Profound Bio, Sarah Cannon Research Institute, Tubulis; Financial Interests, Personal, Other, Consultant/Speaker: AstraZeneca, Clovis, Eisai, Merck, Myriad, Roche/Genentech, TESARO/GSK; Financial Interests, Personal, Other, Honorarium Consultant: Regeneron, Verastem, Zentaris; Financial Interests, Personal, Invited Speaker: Aadi; Financial Interests, Personal, Other, Speaker/Consultant: AdaptImmune. A. Oaknin: Financial Interests, Personal, Advisory Board: Aegus, AstraZeneca, Clovis Oncology, Concept Therapeutics, Deciphera Pharmaceuticals, Eisai, F. Hoffmann-La Roche, GSK, Genmab, Immunogen, Itheos, MSD, Mersana Therapeutics, Novocure, OncoXerna Therapeutics, Inc, PharmaMar, Regeneron, Sotatcklabs, Seagen/Pfizer, Sutro Biopharma, Exelixis, Daiichi Sankyo, Debiopharm International, Myriad Genetics, Zentaris, TORL Therapeutics, Zymeworks; Financial Interests, Personal, Other, Travel and accommodation: AstraZeneca, PharmaMar, Roche; Financial Interests, Institutional, Funding: Amgen, AbbVie Deutschland, Advaxis Inc., Aeterna Zentaris, Aprea Therapeutics AB, Regeneron Pharmaceuticals, Clovis Oncology Inc, Eisai Limited LTD, F. Hoffmann – La Roche LTD, Immunogen Inc, Merck, Sharp & Dohme de España SA, Millennium Pharmaceuticals Inc, PharmaMar SA, Tesaro Inc., Bristol Myers Squibb; Non-Financial Interests, Leadership Role, on behalf of GEICO: GCIG; Non-Financial Interests, Officer, Chair of Gynaecological Track ESMO 2019. Scientific Track Member Gynaecological Cancers ESMO 2018, ESMO 2020, ESMO 2022. Member of Gynaecological Cancers Faculty and Subject Editor Gyn ESMO Guidelines: ESMO; Non-Financial Interests, Leadership Role, ESMO GYN Co-Chair 2023 – 2025: ESMO; Non-Financial Interests, Leadership Role, Chair of Cervix Committee. 2022–2024: GCIG; Non-Financial Interests, Member: ESMO, ASCO, GCIG, SEOM, GOG. D.M. O'Malley: Financial Interests, Personal, Advisory Role: AdaptImmune, Aegus, Arcus Biosciences, AstraZeneca, Atossa Therapeutics, BBI Healthcare, Celsion, Clovis Oncology, Concept Therapeutics, DualityBio, Eisai, Elevar Therapeutics, Genelux, Genentech/Roche, GSK, GOG Foundation, Immunogen, Imvax, InxMed, Jazz Pharmaceuticals, Laekna, Merck, Mersana, Novartis, Novocure, OncoC4, Onconova Therapeutics, Regeneron, Roche, Seagen, Sutro Biopharma, Takeda, Toray Industries, Umoja Biopharma, VBL Therapeutics, Verastem Oncology, Vincex Pharma; Financial Interests, Personal, Research Funding: AbbVie, AbbVie/Stemcentrx, Actera Pharma, Advaxis, Ajinomoto, Amgen, Arcus Biosciences, Array BioPharma, AstraZeneca, BBI Healthcare, BeiGene, Bristol Myers Squibb, Cerulean Pharma, Clovis Oncology, Deciphera, Eisai, EMD Serono, Ergomed, Exelixis, Genentech/Roche, Genmab, GSK, Immunogen, Incyte, Iovance Biotherapeutics, Janssen Research & Development, Karyopharm Therapeutics, Leap Therapeutics, Ludwig Institute for Cancer Research, Merck, Mersana, Novartis, NovoCure, OncoQuest, Pfizer,

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No personal compensation received: AstraZeneca, Genmab, Concept; Non-Financial Interests, Principal Investigator, PI of clinical trial. No personal compensation received: Clovis Oncology, Immunogen, Incyte, Roche; Non-Financial Interests, Principal Investigator, PI of several trials, no compensation received: GSK; Non-Financial Interests, Principal Investigator, PI in several trials. No personal compensation received: MSD; Non-Financial Interests, Principal Investigator, PI of several trials, no personal compensation received: Novartis; Non-Financial Interests, Principal Investigator, PI of clinical trials, no personal compensation received: PharmaMar; Non-Financial Interests, Principal Investigator, PI of clinical trial, no personal compensation received: Seagen; Non-Financial Interests, Member, Board of Directors: GCG; Non-Financial Interests, Member, President Elect: MITO; Non-Financial Interests, Member, Coordinating: ENGOT; Other, Grants for traveling: AstraZeneca, Menarini, Clovis Oncology, GSK. S. 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All other authors have declared no conflicts of interest.

<https://doi.org/10.1016/j.annonc.2024.08.2269>

## LBA32

### A randomized, phase II, dose optimization of gotistobart, a pH-sensitive anti-CTLA-4, in combination with standard dose pembrolizumab in platinum-resistant recurrent ovarian cancer: Safety, efficacy and dose optimization (PRESERVE-004/GOG-3081)

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**Background:** Gotistobart (ONC-392/BNT316) is a humanized anti-CTLA-4 mAb that preserves CTLA-4 immune checkpoint activity by avoiding lysosomal degradation. The safety and clinical activity of gotistobart monotherapy in ovarian cancer was previously reported [<https://doi.org/10.1136/jitc-2022-SITC2022.0564>]. We report safety and efficacy results of gotistobart + pembrolizumab in a randomized, open-label, multicenter phase 2 trial in patients with PROC.

**Methods:** Patients with platinum-resistant high-grade serous OC, tubal or peritoneal cancer who previously received 1 line of platinum-based therapy and progressed between 3-6 months, or received  $\geq 1$  line and progressed within 6 months of last dose, were randomized 1:1 to receive different doses of gotistobart + pembrolizumab 200 mg, Q3W. Primary endpoints are ORR (RECIST 1.1) and safety. Secondary endpoints include PFS and OS.

**Results:** As of May 24, 2024, 83 patients had received  $\geq 1$  dose of gotistobart + pembrolizumab with 33 and 29 patients in 1 mg/kg and 2 mg/kg gotistobart + pembrolizumab groups, respectively. At the safety and efficacy cutoff date of May 10, 2024, with a median follow-up of 2.1 months (range 0.1-9.2), grade  $\geq 3$  treatment-related adverse events (TRAEs) were observed in 35.7% and 31.0% patients in 1 mg/kg or 2 mg/kg groups, respectively. No grade 5 TRAEs were observed. Common grade 3 TRAEs from combined groups were increased ALT and AST (both 7.0%), and diarrhea (5.3%). Unconfirmed ORR was 31.8% (7/22; 95% CI 13.9-54.9) and 36.4% (8/22; 95% CI 17.2-59.3) in 1 mg/kg and 2 mg/kg groups, respectively.

Table: LBA32

Gotistobart + 200 mg Pembrolizumab Q3W Cutoff date: 10 May 2024	1 mg/kg n=28	2 mg/kg n=29
<b>Safety</b>		
Treatment cycles, Mean (Range)	3.6 (1-9)	3.4 (1-9)
Treatment duration in months, Mean (Range)	2.71 (0.1-7.6)	2.55 (0.3-7.1)
Any TEAEs, N (%)	25 (89.3)	26 (89.7)
TRAEs: All grades, N (%)	21 (75.0)	20 (69.0)
TRAEs: Grade $\geq 3$ , N (%)	10 (35.7)	9 (31.0)
irAE All grades, N (%)	11 (39.3)	13 (44.8)
irAE: Grade $\geq 3$ , N (%)	5 (17.9)	8 (27.6)
TRAE leading to study drug discontinuation	4 (14.3)	3 (10.3)
<b>Efficacy</b>		
Efficacy-evaluable population	22	22
Unconfirmed ORR, N (%)	7 (31.8)	8 (36.4)
CR	1 (4.5)	1 (4.5)
PR	6 (27.3)	7 (31.8)
SD	6 (27.3)	2 (9.0)
PD*	9 (40.9)	12 (54.5)

\*PD included those without post baseline disease assessment