IBCL - 740

Anchored Matching-Adjusted Indirect Comparison of Epcoritamab, Lenalidomide, and Rituximab vs Tafasitamab, Lenalidomide, and Rituximab in Relapsed/Refractory Follicular Lymphoma: EPCORE FL-1 vs inMIND

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Objective

- In the absence of head-to-head clinical trials, we conducted an anchored matching-adjusted indirect comparison (MAIC) to estimate the comparative efficacy of epcoritamab + R^2 vs tafasitamab + R^2 to treat relapsed or refractory FL

Conclusions

- Findings from this anchored MAIC showed that epcoritamab + R^2 was associated with significantly higher ORR and CR and improved PFS and TTNT compared with tafasitamab + R^2 in patients with R/R FL
- These findings position epcoritamab + R^2 as the new chemotherapy-free standard of care in R/R FL

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Disclosures

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References

1. Danilov AV, et al. *Blood Adv*. 2025;9(15):3754-3765.
2. Kaseb H, et al. In: *StatPearls*. StatPearls Publishing; 2026.
3. Sehn LH, et al. *Lancet*. 2026;407(10524):133-146.
4. Falchi L, et al. *Lancet*. 2026;407(10524):161-173.
5. Falchi L, et al. *Blood*. 2025;146(22):2629-2640.

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Introduction

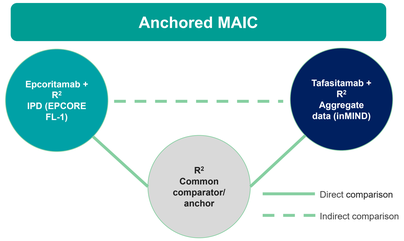
- Follicular lymphoma (FL), the most common indolent non-Hodgkin lymphoma, accounts for approximately 20%–25% of all cases and is characterized by a relapsing disease pattern, with increasing lines of therapy (LOTs)[1-3]
- The ongoing phase 3 EPCORE FL-1 trial (NCT05409066) compared 12-cycle fixed-duration epcoritamab + rituximab and lenalidomide (R^2) vs R^2 in relapsed/refractory (R/R) FL after ≥1 prior LOT[4]
- Epcoritamab + R^2, an off-the-shelf, subcutaneous, fixed-duration bispecific, resulted in a 79% reduction in risk of progression or death and a higher rate of complete responses (CRs) vs R^2 alone, with a manageable safety profile, leading to regulatory approval in R/R FL[4,5]
- The efficacy and safety of tafasitamab, a humanized CD19-directed monoclonal antibody, + R^2 after ≥1 LOT in patients with R/R FL have been assessed in the phase 3 inMIND trial (NCT04680052), supporting its regulatory approval[3]
- Head-to-head clinical evidence comparing epcoritamab + R^2 and tafasitamab + R^2 in second-line or later R/R FL is currently lacking, resulting in limited evidence guiding treatment decisions in this population

Methods

Study Design

Data sources
- Epcoritamab + R^2 IPD: obtained from EPCORE FL-1 (data cutoff: May 2025[4]; median follow-up: 14.8 months)
- Tafasitamab + R^2 aggregate data: obtained from inMIND (data cutoff: February 2024[3]; median follow-up: 14.1 months)

Matching variables (effect modifiers)
- Age ≥65 years
- Ethnicity
- FLIPI score of 3–5
- Refractory to last treatment
- Prior treatment with R^2



Statistical analysis
- An anchored MAIC was conducted using R^2 as the common comparator arm
- Propensity score weights were applied based on key baseline characteristics to create balanced cohorts
- Weighted regression models estimated anchored ORs and 95% CIs for response outcomes
- Weighted stratified Cox proportional-hazard models estimated anchored HRs and 95% CIs for time-to-event outcomes

Efficacy outcomes
- Response outcomes: ORR and CR rate
- Time-to-event outcomes: PFS and TTNT

CI, confidence interval; CR, complete response; FLIPI, Follicular Lymphoma International Prognostic Index; HR, hazard ratio; IPD, individual patient data; IRC, independent review committee; MAIC, matching-adjusted indirect comparison; OR, odds ratio; ORR, overall response rate; PFS, progression-free survival; R^2, rituximab and lenalidomide; TTNT, time to next treatment.

Results

- Prior to match-adjustment, compared with patients from inMIND (N=548), patients in the epcoritamab + R^2 cohort (N=243) were younger (aged ≥65 years: 36.2% vs 49.7%), had a shorter median time since initial diagnosis (4.5 vs 5.3 years), had a lower proportion of high-risk Follicular Lymphoma International Prognostic Index (FLIPI) scores (3–5: 41.2% vs 52.4%), had a higher proportion meeting Groupe d'Etude des Lymphomes Folliculaires (GELF) criteria (100.0% vs 82.8%), and had a comparable proportion refractory to prior anti-CD20 (42.8% vs 42.5%) (**Table 1**)
- After match-adjustment (effective sample size: 208 for epcoritamab + R^2; 225 for R^2 from the EPCORE FL-1 trial), the intent-to-treat populations were well balanced (**Table 1**)

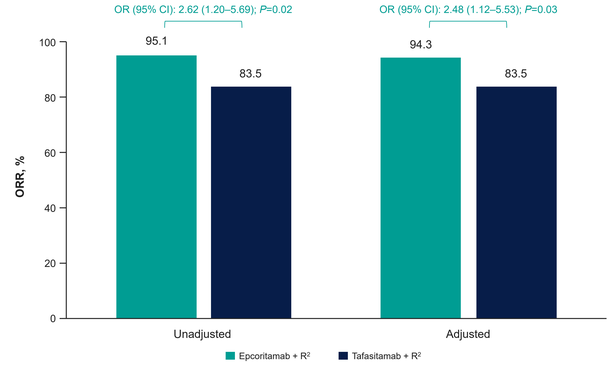
Table 1. Baseline characteristics between epcoritamab + R^2 and tafasitamab + R^2 (unadjusted and adjusted)

Variable		Epcoritamab + R^2 (EPCORE FL-1)		R^2 (EPCORE FL-1)		Tafasitamab + R^2 and R^2 (inMIND) (N=548)
		Unadjusted (N=243)	Adjusted (ESS = 208)	Unadjusted (N=245)	Adjusted (ESS = 225)	
Age group	≥65 years	36.2	49.6	43.3	49.6	49.7
Gender	Male	57.2	58.1	56.3	55.6	54.6
Ethnicity	Hispanic/Latino	11.9	10.0	11.4	10.1	10.1
	Not Hispanic/Latino	86.0	87.0	87.8	88.8	82.9
Median time since initial diagnosis, years		4.5	4.5	5.3	4.8	5.3
ECOG PS score	0	68.3	66.3	69.4	69.1	68.1
	1-2	31.7	33.7	30.6	30.9	31.9
Ann Arbor stage	I-II	15.2	12.4	18.0	17.3	18.6
	III-IV	84.8	87.6	82.0	82.7	81.4
	IV	54.3	54.6	54.3	54.4	57.0
FL grade	1-2	77.0	77.0	66.5	65.1	74.1
	3A	21.4	20.9	30.6	31.6	25.2
FLIPI score	0 or 1	25.9	18.4	22.9	20.2	20.8
	2	32.5	28.7	31.0	27.4	26.6
	3-5	41.2	52.4	46.1	52.4	52.4
Median number of prior LOTs		1	1	1	1	1
≤2 years since last anti-lymphoma treatment		53.5	55.9	55.5	57.6	55.5
POD24 since diagnosis		31.7	32.6	30.6	32.3	31.6
Refractory to last therapy		34.6	38.1	33.5	38.1	38.1
Refractory to prior anti-CD20		42.8	45.9	42.0	46.4	42.5
Prior R^2 therapies		3.3	0.0	3.7	0.0	0.0

Values are percentages unless otherwise specified.
ECOG PS, Eastern Cooperative Oncology Group performance status; ESS, effective sample size; FL, follicular lymphoma; FLIPI, Follicular Lymphoma International Prognostic Index; LOT, line of therapy; POD24, progression of disease within 24 months of the initial diagnosis; R^2, rituximab and lenalidomide.

- Epcoritamab + R^2 demonstrated a significantly higher likelihood of achieving overall response rate (ORR; 94.3% vs 83.5%; odds ratio [OR]: 2.48 [95% confidence interval (CI): 1.12–5.53]; P=0.03) vs tafasitamab + R^2 (**Figure 1**)

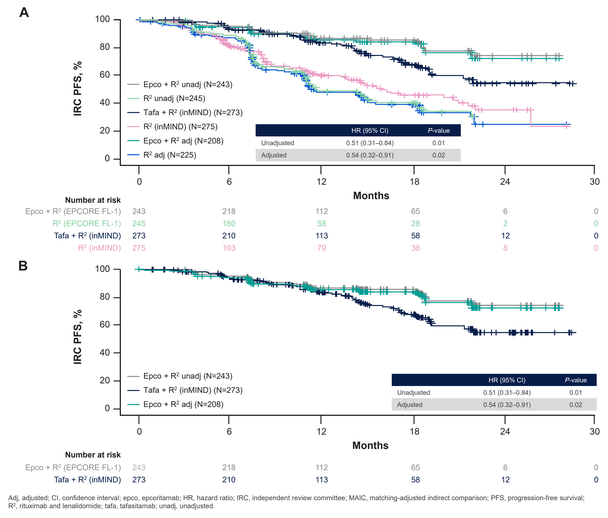
Figure 1. Unadjusted and adjusted ORR (95% CI).



CI, confidence interval; OR, odds ratio; ORR, overall response rate; R^2, rituximab and lenalidomide.

- Epcoritamab + R^2 was associated with a 46% reduction in the risk of progression or death vs tafasitamab + R^2 (hazard ratio [HR]: 0.54 [95% CI: 0.32–0.91]; P=0.02) (**Figure 3**)
  - The 24-month progression-free survival (PFS) was 72.2% with epcoritamab + R^2 and 54.4% with tafasitamab + R^2

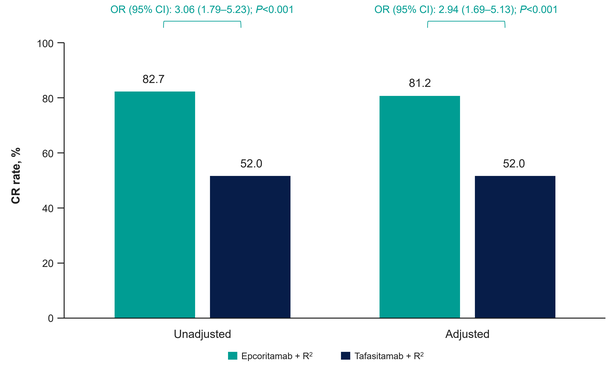
Figure 3. MAIC of IRC-assessed PFS in epcoritamab + R^2 vs tafasitamab + R^2: (A) full analysis and (B) treatment arms, with R^2 comparator curves not shown.



Adj, adjusted; CI, confidence interval; epco, epcoritamab; HR, hazard ratio; IRC, independent review committee; MAIC, matching-adjusted indirect comparison; PFS, progression-free survival; R^2, rituximab and lenalidomide; tafa, tafasitamab; unadj, unadjusted.

- Epcoritamab + R^2 demonstrated a significantly higher likelihood of achieving complete response (CR) (81.2% vs 52.0%; OR: 2.94 [95% CI: 1.69–5.13]; P<0.001) vs tafasitamab + R^2 (**Figure 2**)

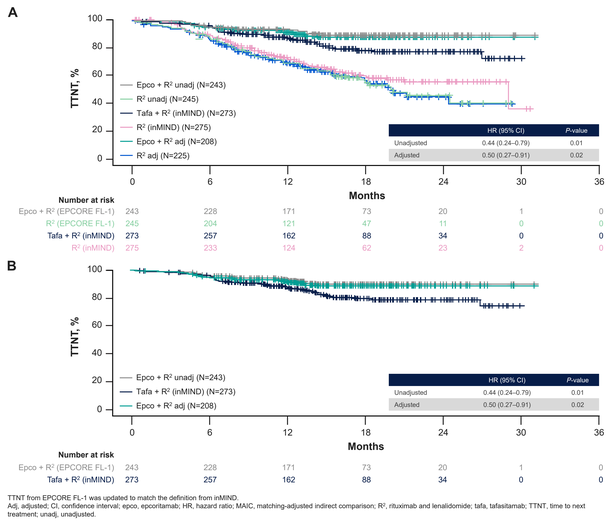
Figure 2. Unadjusted and adjusted CR rates (95% CI).



CI, confidence interval; CR, complete response; OR, odds ratio; R^2, rituximab and lenalidomide.

- Epcoritamab + R^2 also demonstrated a significant improvement in time to next treatment (TTNT; HR: 0.50 [95% CI: 0.27–0.91]; P=0.02) (**Figure 4**)
  - The 24-month TTNT rates were 88.1% with epcoritamab + R^2 and 78.0% with tafasitamab + R^2

Figure 4. MAIC of TTNT in epcoritamab + R^2 vs tafasitamab + R^2: (A) full analysis and (B) treatment arms, with R^2 comparator curves not shown.



TTNT from EPCORE FL-1 was updated to match the definition from inMIND.
Adj, adjusted; CI, confidence interval; epco, epcoritamab; HR, hazard ratio; MAIC, matching-adjusted indirect comparison; R^2, rituximab and lenalidomide; tafa, tafasitamab; TTNT, time to next treatment; unadj, unadjusted.

Limitations

- These results should be interpreted within the context of the safety data from the respective trials
- Although the anchored MAIC adjusted for observed baseline differences between studies, residual confounding may remain