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Released: 03/24/2026
Valid until: 03/24/2027
Time needed to complete: 1h 04m

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Escalate With Intention: Stepwise, Target-Anchored Moves

Dr. Wolfe:
In this episode, we're looking at what happens after FcRn therapy starts. How do you know when to adjust the plan, whether that's repeating a cycle, changing timing, or switching agents?

This is CE on ReachMD, and I'm Dr. Gil Wolfe. Here with me today is Dr. Christyn Edmundson.

Dr. Edmundson, when you're facing a patient who isn't meeting their treatment goals, what's your approach to escalation?

Dr. Edmundson:
So that's a great question. So, if I'm treating a patient with FcRn inhibitors, any 1 of the 3 that's available, and they're not meeting their targets, there are a couple of different things that I'm going to look at. The first is going to be looking at cycle frequency, particularly in the case of efgartigimod and rozanolixizumab, both of which are used as cyclical therapy. In the case of efgartigimod, 4 weekly doses followed by 4 weeks off therapy. In rozanolixizumab, 6 weekly doses followed by 4 weeks off therapy.

So, one thing that I sometimes see is that folks will wait to use another cycle of therapy until patients are becoming symptomatic again, and when that happens, sometimes you're actually a little bit behind the 8 ball already. So, I oftentimes, when I'm starting these agents, will start a patient on the maximum allowed frequency of treatment and then if they're doing well, I'll wean from there. So, starting by either increasing or maximizing cycle frequency.

Specifically, in the case of efgartigimod, which is labeled for 4 weeks on, 4 weeks off cyclical therapy, there has been a study looking at alternate dosing, looking at every other week dosing of efgartigimod versus 4 weeks on, 4 weeks off, which is the same amount of drug used, but just spread out over time. That showed sort of a non-inferior response and no new safety signals. So, in certain cases, in my own clinical practice, I will occasionally consider sort of an off-label cadence of treatment.

Then you might also want to consider switching within classes. So, for example, if a patient is on efgartigimod or rozanolixizumab, and they're consistently wearing off between cycles, you might consider switching over to nipocalimab, which is labeled for continuous every other week IV infusion. So really, switching to something that's meant to be given more continuously to minimize those fluctuations.

And then of course, if ultimately a patient is just not responding adequately to the FcRn inhibitor that they're taking, you may want to consider switching drug classes. So, for instance, stopping the FcRn inhibitor and switching over to a complement inhibitor.

Dr. Wolfe, I'm curious about what your thoughts are on this subject.

Dr. Wolfe:
My thoughts align with yours really quite precisely. In fact, I can just think of a patient that I switched to a regular dosing in the FcRn

blocking space just 2 months ago because we were having a little bit too much off and on type responses. And she has done very, very well. So, those are the same types of thought processes I go through. Obviously, if you've tried a few times, maybe with a couple of the agents in this mechanism of action and it just hasn't worked adequately, yeah, thinking about another agent, if they are receptor antibody positive, such as a C5 cleavage inhibitor, I think is very appropriate as well.

Another thing I might bring up in this discussion is our juvenile/pediatric population. We do have a couple of agents that have been approved for children. Most recently, nipocalimab has been approved for 12-year-old and older children, teenagers, for treatment with an FcRn blocker.

And eculizumab, which is in the C5 cleavage space, has been approved down to age 6. These studies are generally based on open-label investigations in the kids. They have worked quite well, though, and the adverse events have not shown any kind of new information in the pediatric population compared to what we see on the adult side.

That's all for now. Thanks for joining us for this quick clinical deep dive.