Durable Disease Control with Obexelimab in IgG4-Related Disease: Phase 3 INDIGO Open-Label Extension

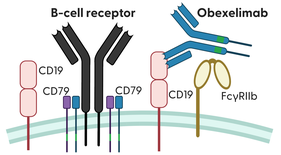
John H. Stone[1], Matthew C. Baker[2], Emanuel Della-Torre[3], Wen Zhang[4], Guy Katz[1], Luke Y.C. Chen[5], Mollie Carruthers[6], Thomas J. Greene[7], Audrey Wells[7], Admasu Mamuye[7], Emma L. Culver[8]

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[1]Division of Rheumatology, Inflammation, and Immunity, Mass General Brigham, Boston, MA, USA; [2]Division of Immunology and Rheumatology, Department of Medicine, Stanford University, Palo Alto, CA, USA; [3]Unit of Immunology, Rheumatology, Allergy, and Rare Diseases, IRCCS San Raffaele Scientific Institute; Università Vita-Salute San Raffaele, Milan, Italy; [4]Department of Rheumatology and Clinical Immunology, Peking Union Medical College Hospital, Chinese Academy of Medical Sciences and Peking Union Medical College, Beijing, China; [5]Dalhousie Medical School, Halifax, NS, Canada; [6]Arthritis Research Canada, Vancouver, BC, Canada; [7]Zenas BioPharma, Waltham, MA, USA; [8]Translational Gastroenterology and Liver Unit, John Radcliffe Hospital, and NIHR Biomedical Research Centre Oxford, Nuffield Department of Medicine, University of Oxford, Oxford, UK

Background

- Obexelimab is a humanized, bifunctional, monoclonal antibody
- It is designed to inhibit B-cell activity through co-engagement of CD19 and the inhibitory receptor FcγRIIb.
- This approach is intended to mimic natural inhibitory signaling pathways that regulate B-cell activation.[1,2]
- Obexelimab does not induce antibody-dependent cellular cytotoxicity or complement-dependent cytotoxicity, and does not result in cytotoxic B-cell depletion, unlike B cell depleting therapies.[3,4]

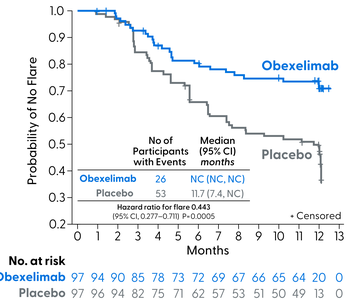


INDIGO RCP Showed Significant Reduction in Disease Flares Compared to Placebo



INDIGO was a global, double-blind, randomized, placebo-controlled Phase 3 trial in IgG4-RD[5]

- 52-week randomized controlled period (RCP) of the Phase 3 INDIGO study
- Obexelimab:
  - » Significantly reduced the risk of IgG4-RD flare
  - » 73.2% of patients receiving Obexelimab remained flare-free



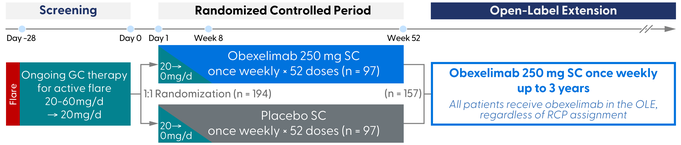
INDIGO RCP Showed Significant Reduction in Annualized Flare Rate and GC Use in RCP Compared to Placebo[5]



Rate ratio 0.48 (95% CI 0.32–0.74) **P=0.0008** **–600 mg difference** **P=0.0042**

*GC exposure shown reflects rescue treatment for flare management; obexelimab was not administered with routine GC prophylaxis for hypersensitivity.

INDIGO OLE Evaluates Longer-Term Disease Control With Obexelimab



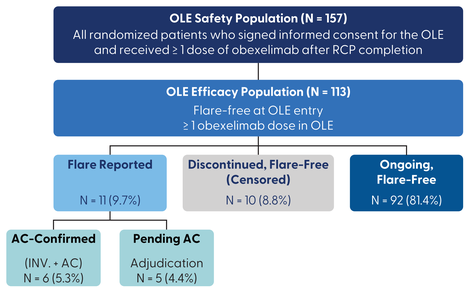
Objectives

- Evaluate the durability of disease control with continued obexelimab treatment
- Assess longer-term glucocorticoid requirements during continued obexelimab treatment
- Evaluate the longer-term safety of obexelimab

Efficacy Endpoints

- Time to first investigator- and adjudication committee (AC)-determined flare requiring rescue therapy
- Time to first investigator-determined flare requiring rescue therapy
- Annualized flare rates based on:
  - » Investigator- and AC-determined flares
  - » Investigator-determined flares
- Cumulative glucocorticoid rescue dose

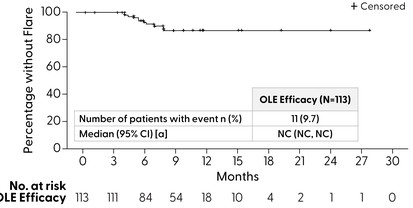
Safety and Efficacy Population Flow



Data cut: 15-May-2026. flare= investigator determined flare. Discontinued= discontinued from treatment. Percentages for OLE Efficacy Population subgroups are of N = 113. "AC-Confirmed" = flares meeting the primary OLE efficacy endpoint definition (investigator- and AC-adjudicated). "Pending AC Adjudication" reflects the expected lag between investigator-reported flares and independent AC review inherent to an interim analysis of an ongoing study; these are not yet counted as events under the primary endpoint. 11 + 10 + 92 = 113 (OLE Efficacy Population). 113 + 44 = 157 (OLE Safety Population).

Results

90.3% Did not have Investigator-Determined Flares



- 94.7% did not have AC confirmed flare
- 11/113 (9.7%) experienced investigator-determined flare, 6 of which were positively adjudicated at the time of data cut
- 92 patients remained in the OLE without an investigator-determined flare
- 12-month flare-free probability: 0.87 (95% CI, 0.77–0.93)
- No flares observed past 8.34 months

Annualized Flare Rate

- At the data cutoff, 97.1 patient-years of Obexelimab exposure had accumulated in the OLE.
- No subject experienced more than one flare during the OLE

	Number of Flares	Annualized Flare Rate
Investigator Determined Flare	11	0.11 flares/year
Investigator and AC Confirmed Flare	6*	0.06 flares/year

*5 additional investigator-determined flares were pending adjudication at the data cutoff

Disease Control Was Maintained With Limited Glucocorticoid Rescue

- 104/113 (92%) required no glucocorticoid rescue during OLE
- Mean unadjusted Annualized Dose of GC Rescue Therapy: 118.15mg/year
- Median cumulative GC Rescue dose was 0.0 mg (Q1, Q3: 0, 0) in all arms

Cumulative Dose of Rescue Therapy during the OLE (mg)	
n	113
Mean (SD)	104.7 (473.6)
Median	0.0
Q1, Q3	0, 0
Min, Max	0, 3040
Total Follow-Up (yr)	100.1

The OLE Safety Profile Was Consistent With the RCP

- Obexelimab was generally well tolerated, with no new safety signals identified

	RCP Obexelimab (N = 97), n (%)	RCP Placebo (n = 97), n (%)	OLE (N = 157), n (%)
Patients with ≥ 1 AE	95 (97.9)	93 (95.9)	135 (86.0)
Patients with ≥ 1 SAE	10 (10.3)	18 (18.6)	11 (7.0)
Patients with ≥1 Grade ≥3 AE	11 (11.3)	23 (23.7)	18 (11.5)
Patients with AE leading to discontinuation of treatment	9 (9.3)	3 (3.1)	5 (3.2)
Selected Treatment-emergent AEs (≥ 10 in either)			
Arthralgia	19 (19.6)	11 (11.3)	14 (8.9)
Nasopharyngitis	18 (18.6)	14 (14.4)	19 (12.1)
Upper respiratory infection	15 (15.6)	22 (22.7)	24 (15.3)
Adverse events of Special Interest			
Hypersensitivity (≥ Grade 2)	16 (16.5)	11 (11.3)	13 (8.3)
Infections (≥ Grade 3)	2 (2.1)	4 (4.1)	2 (1.3)
Malignancy*	3 (3.1)	0	4 (2.5)
Injection site reaction (≥ Grade 2)	2 (2.1)	1 (1.0)	0 (0.0)

*7 patients reported malignancies (3 RCP; 4 OLE); all were assessed as not treatment related. 2 had a history of the same malignancy; RCC was evident on baseline imaging, prostate cancer was preceded by PSA >3× ULN, and SCC was diagnosed 8 months after obexelimab discontinuation. An OLE nasal neoplasm was confirmed as a benign polyp and excluded.

Conclusions

- These OLE findings demonstrated sustained clinical activity of Obexelimab, with low flare rates and limited GC rescue during continued treatment.
- The safety profile remained consistent with the RCP, with no new safety signals identified.
- Together, these findings support the potential for long-term disease control with continued Obexelimab treatment in IgG4-RD.

Obexelimab is an investigational drug and has not been approved by the US Food and Drug Administration or any regulatory body worldwide.

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Abbreviations: AE = adverse event; BAU = binding antibody unit; HA = hemagglutinin; HAI = hemagglutination inhibition; IgG4-RD = IgG4-related disease; MNT = microneutralization; OLE = open-label extension; RCP = randomized controlled period; SARS-CoV-2 = severe acute respiratory syndrome coronavirus 2; VSS = vaccine sub-study.

References: 1) Chu SY, et al. Mol Immunol. 2008;45:3926–3933. **2)** Horton HM, et al. J Immunol. 2011;186:4223–4233. **3)** Perugino CA, et al. Lancet Rheumatol. 2023;5:e442–e450. **4)** Wang X, et al. Clin Pharmacol Drug Dev. 2025;14:656–668. **5)** Della-Torre E, et al. N Engl J Med. 2026.

Disclosures: Emma L. Culver: Amgen, Gilead, Ipsen, GSK, Mirum, Falk, Zenas BioPharma, Sanofi, Acepodia, Janssen, Matthew C. Baker: Amgen, Eli Lilly, Gilead, BeOne Medicines, Zenas BioPharma, Sanofi, argenx, Neurocrine, AnaptysBio, Xencor, Jade Biosciences, Arcus Biosciences; Emanuel Della Torre: Amgen, Zenas BioPharma, Sanofi. Wen Zhang: Amgen, Zenas BioPharma, Sanofi. Guy Katz: Zenas, Amgen, Acepodia. Luke Y.C. Chen: Recordati, Amgen. Mollie Carruthers: Amgen, AbbVie, UCB, Janssen, Sanofi, Roche, Pfizer, Acepedia, Zenas BioPharma. Thomas J. Greene: Owns stock and stock options in Zenas BioPharma; employee of Zenas BioPharma. Audrey Wells: Owns stock and stock options in Zenas BioPharma; employee of Zenas BioPharma. Admasu Mamuye: Owns stock and stock options in Zenas BioPharma; employee of Zenas BioPharma. John H. Stone: Amgen, Zenas BioPharma, Sanofi, AcepodiaBio, Novartis, HingeBio, ZipBio, Argenx, Q32Bio.