A Complement and B-Cell Modifying Pipeline to Address Unmet Needs in IgA Nephropathy (IgAN)

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Introduction and Objectives:

Therapeutic developments for IgA nephropathy (IgAN) are at the forefront of innovation, supported by the accelerated approval of two products and a robust pipeline with various mechanisms of action. In upcoming years, new products will likely be available that will further help physicians address IgAN at the pathogenic level.

Materials and Methods:

Data from 454 audited patient charts were collected in partnership with 142 US nephrologists in January 2024 and in partnership with an additional 105 US nephrologists in February 2024 via online surveys.

Acknowledgements:

Thank you to Spherix Global Insights' network of nephrologists and their patients.

Disclosures:

Justin Snyder and Meghan Weiss are employees of Spherix Global Insights, an independent market intelligence firm and have received no industry funding to conduct and report on this study.

Figure 1

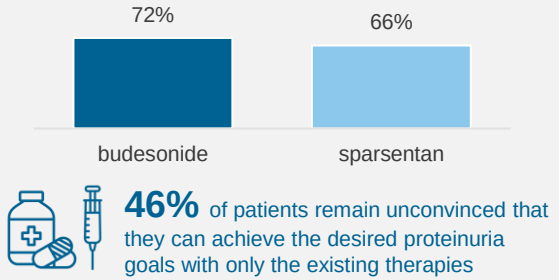
Statement Agreement: IgAN Treatment Opinions

% of respondents

Figure 2

Ideal IgAN Step Therapy Approach

% of respondents using 3rd line or later

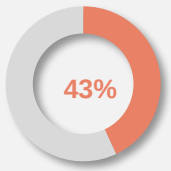


46% of patients remain unconvinced that they can achieve the desired proteinuria goals with only the existing therapies

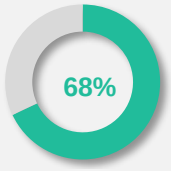
Figure 3

Statement Agreements

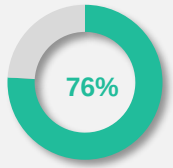
% of respondents



Unconvinced that targeting the Peyer's patch is an important goal in treatment



Agree that IgAN is a B-cell mediated disease, where the root cause of Gd-IgA1 production comes from over-stimulated B-cells and plasma cells

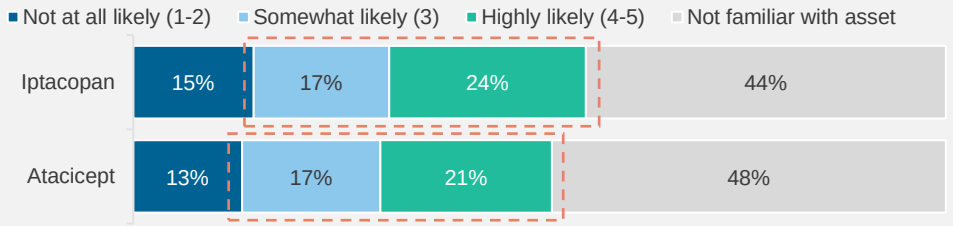


Agree that the complement system has an active role in the pathogenesis of IgAN and its treatment

Figure 4

Likelihood to Prescribe Pipeline IgA Nephropathy Products

% of patients



Results:

With the approvals of delayed-release oral budesonide and sparsentan in IgAN, most nephrologists (80%) indicate that they feel better equipped to treat their IgAN patients (Fig. 1).

Currently, 72% and 66% of nephrologists are using budesonide or sparsentan, respectively, positioned as third-line or later treatments after RAASi and SGLT2 inhibitors. However, nearly half (46%) remain unconvinced that they can achieve the desired proteinuria goals with only the existing therapies (Fig. 2).

It is theorized that the Peyer's patches are the main source of the galactose-deficient (Gd) IgA1 antibodies that cause damage and inflammation to the kidneys, yet almost one-half (43%) of nephrologists are unconvinced that targeting the Peyer's patch is an important goal in treatment. However, 68% of nephrologists agree that IgAN is a B-cell mediated disease, where the root cause of Gd-IgA1 production comes from overstimulated B-cells and plasma cells. Additionally, 76% believe that the complement system plays an active role in the pathogenicity of IgAN (Fig. 3).

There are several IgAN pipeline agents that potentially target B-cell and plasma factors. Two products that are in Phase 3 trials include iptacopan, which is a complement factor B inhibitor, and atacicept, which is a B lymphocyte stimulator (BlyS) inhibitor and a proliferation-inducing ligand (APRIL) inhibitor that targets B cells and plasma cells. If approved, nephrologists indicate that they would be at least somewhat likely to prescribe iptacopan or atacicept to approximately one-third of the IgAN patients included in the study (Fig. 4).

Conclusions:

Nephrologists continue to see an unmet need in the IgAN space, leaving room for new market entrants to effectively treat the root cause of the disease and further enable physicians to individualize treatments.

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