(NCT02886728) and with placebo (PBO) or adalimumab (ADA) in FINCH 1 (NCT02889796).

Objectives: 50% clinical improvement from baseline at W12 is a key checkpoint for RA treatment.[1] These post hoc analyses evaluated FIL treatment effect on improvement in ACR components at W12 and remission at W24 in FINCH 3 and FINCH 1.

Methods: FINCH 3 and FINCH 1 were global, phase 3, double-blind studies in patients (pts) with active RA. In FINCH 3, MTX-naïve pts were randomised 2:1:1:2 to once-daily (QD) oral FIL 200 mg + weekly MTX, FIL 100 mg + MTX, FIL 200 mg mono + PBO, or PBO + MTX mono up to W52. In FINCH 1, pts with inadequate response to MTX (MTX-IR) on a background of stable MTX were randomised (3:3:2:3) to oral FIL 200 or 100 mg QD, subcutaneous ADA 40 mg Q2W, or PBO up to W52. Post hoc analyses evaluated proportions of pts with 50% improvement from baseline in each ACR component and in all 7 ACR components (ACR50c) at W12, and proportions of pts with ACR50c at W12 achieving clinical remission at W24. Comparisons between treatments were not adjusted for multiplicity; subgroup comparisons are descriptive.

Results: Analyses included 1249 pts in FINCH 3 and 1755 pts in FINCH 1. Greater proportions of pts receiving FIL 200 mg + MTX, FIL 100 mg + MTX, or FIL mono (FINCH 3) vs MTX mono (FINCH 3) or PBO + MTX (FINCH 1)—and numerically higher proportions of pts receiving FIL 200 mg + MTX vs FIL 100 mg + MTX (both studies) or ADA + MTX (FINCH 1)—achieved ACR50c and individual components at W12 (**Table**). Proportions of pts achieving CDAI ≤2.8 (Figure 1) or Boolean remission (Figure 2) at W24 were higher for pts with vs without ACR50c at W12 (Figures 1–2).

Table. Proportions of patients with 50% improvement in each ACR component and ACR50c at week 12

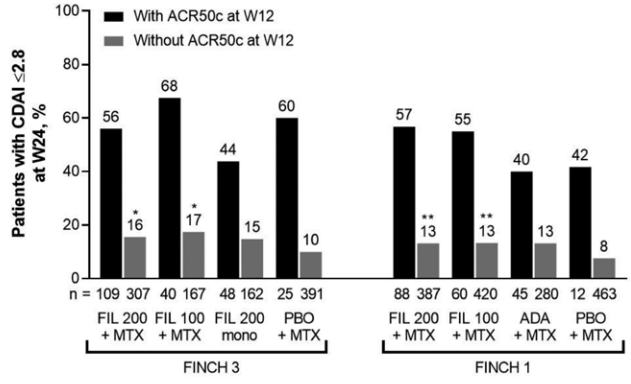
	ACR component							
	SJC66	TJC68	Pain	PGA	SGA	HAQ-DI	hsCRP	ACR50c
FINCH 3								
FIL 200 mg + MTX	82.2***	76.9***	59.2***	72.8***	56.5***	54.9***	59.1***	26.2***
FIL 100 mg + MTX	81.2***	74.4***	48.5*	68.1*	46.9**	49.5***	58.5***	19.3***
FIL 200 mg mono	82.9***	75.7***	47.6*	66.2*	47.1**	47.3**	59.5***	22.9***
MTX mono	67.1	59.6	39.2	58.4	35.6	35.6	33.7	6.0
FINCH 1								
FIL 200 mg + MTX	83.2$^{***,+}$	77.9$^{***,+}$	50.1$^{***,+}$	67.4***	48.2***	42.1$^{***,+}$	67.2$^{***,+++}$	18.5***
FIL 100 mg + MTX	77.9***	72.3***	45.1***	62.9***	43.2***	35.2***	55.0***	12.5***
ADA + MTX[a]	76.9	70.5	41.5	61.5	42.0	34.4	55.7	13.8
PBO + MTX	66.7	59.2	28.0	50.9	28.0	23.1	25.9	2.5

[a]Not formally compared vs PBO + MTX.

*, p <0.05; **, p <0.01; ***, p <0.001 vs MTX mono (FINCH 3) or PBO + MTX (FINCH 1); $^{+}$, p <0.05; $^{+++}$, p <0.001 vs ADA + MTX (FINCH 1); not adjusted for multiplicity.

ACR50c, 50% improvement from baseline in all ACR components; ADA, adalimumab; FIL, filgotinib; MTX, methotrexate; mono, monotherapy; PBO, placebo.

Figure 1. Proportions of patients with and without 50% improvement in all ACR components at week 12 who achieved CDAI remission at week 24

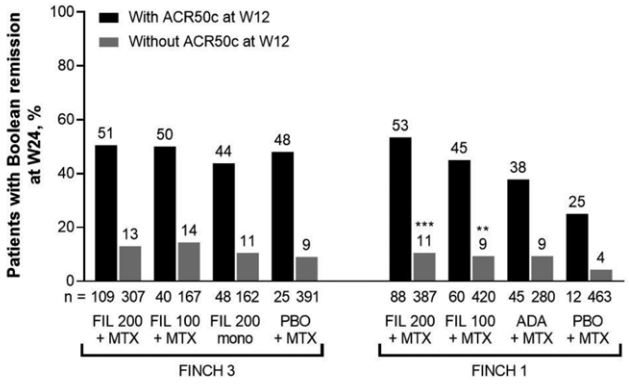


*, p <0.05; **, p <0.01 vs PBO + MTX; not adjusted for multiplicity.

ACR50c, 50% improvement from baseline in all ACR components; ADA, adalimumab; CDAI, Clinical Disease Activity Index; FIL, filgotinib; mono, monotherapy; MTX, methotrexate; PBO, placebo; W, week.

Conclusion: In MTX-naïve and MTX-IR pts with RA, FIL treatment was more effective vs MTX (FINCH 3) or PBO (FINCH 1) for achieving ACR50c at W12—a potential predictor of remission at W24. Proportions of pts achieving ACR50c at W12 were numerically higher for pts receiving FIL 200 mg + MTX vs FIL 100 mg + MTX (both studies) or ADA + MTX (FINCH 1).

Figure 2. Proportions of patients with and without 50% improvement in all ACR components at week 12 who achieved Boolean remission at week 24



*, p <0.05; **, p <0.01 vs PBO + MTX; not adjusted for multiplicity.

ACR50c, 50% improvement from baseline in all ACR components; ADA, adalimumab; FIL, filgotinib; mono, monotherapy; MTX, methotrexate; PBO, placebo; W, week.

References:

[1] Smolen JS, et al. *Ann Rheum Dis*. 2017;76:960–77.

Disclosure of Interests: Gerd Rüdiger Burmester Consultant of: AbbVie Inc, Eli Lilly, Gilead, Janssen, Merck, Roche, Pfizer, and UCB Pharma, Speakers bureau: AbbVie Inc, Eli Lilly, Gilead, Janssen, Merck, Roche, Pfizer, and UCB Pharma, Daniel Aletaha Grant/research support from: AbbVie, Novartis, Roche, Consultant of: AbbVie, Amgen, Celgene, Lilly, Medac, Merck, Novartis, Pfizer, Roche, Sandoz, Sanofi Genzyme, Speakers bureau: AbbVie, Celgene, Lilly, Merck, Novartis, Pfizer, Sanofi Genzyme, UCB, Janet Pope Grant/research support from: AbbVie, Bristol-Myers Squibb, Eli Lilly & Company, Merck, Roche, Seattle Genetics, UCB, Consultant of: AbbVie, Actelion, Amgen, Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, Eicos Sciences, Eli Lilly & Company, Emerald, Gilead Sciences, Inc., Janssen, Merck, Novartis, Pfizer, Roche, Sandoz, Sanofi, UCB, Speakers bureau: UCB, Yoshiya Tanaka Grant/research support from: Asahi-kasei, Astellas, Mitsubishi-Tanabe, Chugai, Takeda, Sanofi, Bristol-Myers, UCB, Daiichi-Sankyo, Eisai, Pfizer, and Ono, Consultant of: Abbvie, Astellas, Bristol-Myers Squibb, Eli Lilly, Pfizer, Speakers bureau: Daiichi-Sankyo, Astellas, Chugai, Eli Lilly, Pfizer, AbbVie, YL Biologics, Bristol-Myers, Takeda, Mitsubishi-Tanabe, Novartis, Eisai, Janssen, Sanofi, UCB, and Teijin, Patrick Durez Speakers bureau: AbbVie, Bristol-Myers Squibb, Celltrion, Eli Lilly, Pfizer, Sanofi, Antonio Gomez-Centeno: None declared, Alena Pechonkina Shareholder of: Gilead Sciences, Inc., Employee of: Gilead Sciences, Inc., Beatrix Bartok Shareholder of: Gilead Sciences Inc., Employee of: Gilead Sciences Inc., Franziska Matzkies Shareholder of: Gilead Sciences, Inc., Employee of: Gilead Sciences, Inc., Lei Ye Shareholder of: Gilead Sciences Inc., Employee of: Gilead Sciences Inc., Zhaoyu Yin Shareholder of: Gilead Sciences, Inc., Employee of: Gilead Sciences, Inc., Robin Besuyen Shareholder of: Galapagos, Employee of: Galapagos, William Rigby Grant/research support from: Bristol-Myers Squibb, Consultant of: AbbVie, Bristol-Myers Squibb, Genentech, Pfizer, Bernard Combe Grant/research support from: Novartis, Pfizer, Roche-Chugai, Consultant of: AbbVie; Gilead Sciences, Inc.; Janssen; Eli Lilly and Company; Pfizer; Roche-Chugai; Sanofi, Speakers bureau: Bristol-Myers Squibb; Gilead Sciences, Inc.; Eli Lilly and Company; Merck Sharp & Dohme; Pfizer; Roche-Chugai; UCB

DOI: 10.1136/annrheumdis-2020-eular.2236

THU0195

INCIDENCE AND RISK OF VENOUS THROMBOEMBOLIC EVENTS AMONG PATIENTS WITH RHEUMATOID ARTHRITIS ENROLLED IN THE UPADACITINIB SELECT CLINICAL TRIAL PROGRAM

E. Choy[1], I. Mcinnes[2], J. Cush[3], J. Aelion[4], W. Rigby[5], Y. Song[6], S. Meerwein[6], J. Liu[6], N. Khan[6], J. Subotickí[6], A. Cohen[7]. *[1]CREATE Centre, Cardiff University, Cardiff, United Kingdom*; *[2]University of Glasgow, Glasgow, United Kingdom*; *[3]University of Texas Southwestern Medical School, Dallas, United States of America*; *[4]Arthritis Clinic PLLC, Jackson, United States of America*; *[5]Dartmouth-Hitchcock Medical Center, Lebanon, United States of America*; *[6]AbbVie, North Chicago, United States of America*; *[7]Guy's and St Thomas' NHS FT Hospitals, King's College, London, United Kingdom*

Background: Patients (pts) with rheumatoid arthritis (RA) are at an increased risk for the development of venous thromboembolism (VTE, including pulmonary embolism [PE] and deep vein thrombosis [DVT]) vs the general population

(~2-fold increase).[1] Beyond RA, additional risk factors have been described, with prior history of VTE and obesity posing particular risk. VTE events have been observed in pts receiving JAK inhibitors, including upadacitinib (UPA).

Objectives: To describe the incidence of VTE in pts with RA receiving UPA relative to active comparators in the phase 3 clinical trial program and to evaluate potential risk factors.

Methods: Adjudicated events of treatment-emergent VTE were determined in pts receiving UPA in an integrated analysis (data cut-off, 30 Jun 2019) of five randomized phase 3 trials (SELECT-EARLY, SELECT-MONOTHERAPY, SELECT-NEXT, SELECT-COMPARE, and SELECT-BEYOND), of which 4 evaluated both the UPA 15 mg and 30 mg QD doses and 1 (SELECT-COMPARE) evaluated only UPA 15. Incidence of VTE was also determined in pts receiving adalimumab (ADA) + methotrexate (MTX) in SELECT-COMPARE and MTX monotherapy in SELECT-EARLY. Events are attributed to treatment received at time of event and are summarized per events/100 patient yrs. VTE risk factors were assessed using univariate Cox regression models.

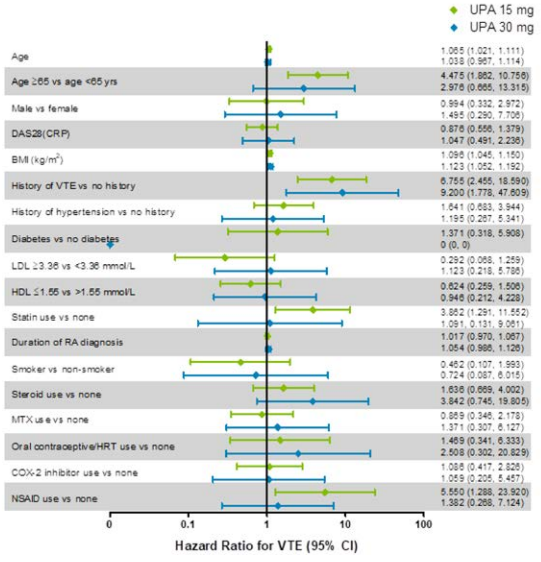
Results: A total of 35 VTE events were observed across treatment groups. The exposure-adjusted treatment-emergent event rates (E/100 PYs, 95% CI) of VTE were 0.5 (0.3, 0.7) for UPA 15, 0.3 (0.1, 0.7) for UPA 30, 0.5 (0.1, 1.3) for ADA + MTX, and 0.4 (0.1, 1.6) for MTX, with no pattern to event onset across treatments. Events of PE, DVT, or both PE and DVT were reported across treatment groups (**Table**). Pts who experienced VTE, across all treatment groups, on average, were older than pts who did not (62/59/58/61 yrs vs 54/55/54/53 yrs for UPA 15, UPA 30, ADA + MTX, and MTX, respectively). The mean body mass index (BMI) of pts with VTE tended to be higher (34–40 for pts with VTE vs 28-29 kg/m^2 for those without). Across UPA treatment groups, 135/2629 (UPA 15) and 62/1204 (UPA 30) pts had a prior history of VTE; of these pts, 5 (3.7%) and 2 (3.2%) experienced VTE on UPA 15 and UPA 30, respectively. Univariate Cox regression models identified BMI and prior history of VTE as factors associated with VTE in the UPA 15 and 30 mg groups (**Figure**). Age and NSAID use were shown to be associated with VTE risk among pts in the UPA 15 but not 30 mg group.

Table. Events of VTE Observed Across Treatment Groups

	UPA 15 mg QD[a] N=2629 (4565.8 PYs)	UPA 30 mg QD[b] N=1204 (2309.7 PYs)	ADA + MTX[c] N=579 (768.6 PYs)	MTX Monotherapy[d] N=314 (456.0 PYs)
Events, n	21	8	4	2
Patients, n	20	7	4	2
PE only	11	1	3	1
DVT only	5	2	1	0
PE + DVT	4	4	0	1

[a]From SELECT-EARLY, -MONOTHERAPY, -NEXT, -COMPARE, and -BEYOND.
[b]From SELECT-EARLY, -MONOTHERAPY, -NEXT, and -BEYOND.
[c]From SELECT-COMPARE.
[d]From SELECT-EARLY.
VTE, venous thromboembolism; PE, pulmonary embolism; DVT, deep vein thrombosis.

Figure: VTE Risk Factors in Patients Receiving UPA 15 or 30 mg QD Through Univariate Cox Regression



Conclusion: VTE event rates appeared balanced across UPA doses and active comparator groups in pts with RA. Risk factors for VTE events identified through univariate analyses in pts who received UPA included prior history of VTE and BMI, two factors previously known to be associated with VTE risk. One limitation is the small sample size, limiting the analysis to univariate. Continued follow-up of pts receiving UPA is ongoing to further contextualize the risk of VTE in the clinical trial program.

References:

[1] Kim SC, et al. *Arthritis Care Res* 2013;65:1600-7.

Disclosure of Interests: Ernest Choy Grant/research support from: Amgen, Bio-Cancer, Chugai Pharma, Ferring Pharmaceuticals, Novimmune, Pfizer, Roche, UCB, Consultant of: AbbVie, Amgen, AstraZeneca, Biogen, Boehringer Ingelheim, Bristol-Myers Squibb, Celgene, Chelsea Therapeutics, Chugai Pharma, Daiichi Sankyo, Eli Lilly, Ferring Pharmaceuticals, GlaxoSmithKline, Hospita, Ionis, Janssen, Jazz Pharmaceuticals, MedImmune, Merck Sharp & Dohme, Merrimack Pharmaceutical, Napp, Novartis, Novimmune, ObsEva, Pfizer, R-Pharm, Regeneron Pharmaceuticals, Inc., Roche, SynAct Pharma, Sanofi Genzyme, Tonix, UCB, Speakers bureau: Amgen, Boehringer Ingelheim, Bristol-Myers Squibb, Chugai Pharma, Eli Lilly, Hospira, Merck Sharp & Dohme, Novartis, Pfizer, Regeneron Pharmaceuticals, Inc., Roche, Sanofi-Aventis, UCB, Iain McInnes Grant/research support from: Bristol-Myers Squibb, Celgene, Eli Lilly and Company, Janssen, and UCB, Consultant of: AbbVie, Bristol-Myers Squibb, Celgene, Eli Lilly and Company, Gilead, Janssen, Novartis, Pfizer, and UCB, John Cush Grant/research support from: AbbVie, Astra Zeneca, Aurinia, Bristol-Myers Squibb, Genentech, Novartis, Pfizer, Consultant of: AbbVie, Amgen, Bristol-Myers Squibb, Boehringer-Ingelheim, Genentech, Gilead, Eli Lilly, Novartis and UCB, Jacob Aelion Grant/research support from: AbbVie, Ardea Biosciences, AstraZeneca, Boehringer Ingelheim, Bristol-Myers Squibb, Celgene, Galapagos, GlaxoSmithKline, Janssen, Eli Lilly, Merck, Mesoblast, Novartis, Novo Nordisk, Pfizer, Roche, Sanofi-Aventis, Takeda, and UCB Pharma, Consultant of: AbbVie, Boehringer Ingelheim, Celgene, and Eli Lilly, William Rigby Grant/research support from: Bristol-Myers Squibb, Consultant of: AbbVie, Bristol-Myers Squibb, Genentech, Pfizer, Yanna Song Shareholder of: AbbVie Inc., Employee of: AbbVie Inc., Sebastian Meerwein Shareholder of: AbbVie Inc., Employee of: AbbVie Inc., Jianzhong Liu Shareholder of: AbbVie Inc., Employee of: AbbVie Inc., Nasser Khan Shareholder of: AbbVie Inc., Employee of: AbbVie Inc., Jessica Suboticki Shareholder of: AbbVie Inc., Employee of: AbbVie Inc., Alexander Cohen Consultant of: AbbVie, Apalgon, Aspen, BMS, Pfizer, Bayer, Daiichi Sankyo, Boehringer Ingelheim, Boston Scientific, Janssen, Portola

DOI: 10.1136/annrheumdis-2020-eular.2897

THU0196 TOFACITINIB IN PATIENTS WITH RHEUMATOID ARTHRITIS AND INDICATIVE OF DEPRESSION AND/OR ANXIETY: A POST HOC ANALYSIS OF PHASE 3 AND PHASE 3B/4 CLINICAL TRIALS

G. Citera[1], R. Jain[2], F. Irazoque-Palazuelos[3], R. Guzman[4], H. Madariaga[5], D. C. Gruben[6], L. Wang7, L. Stockert[8], M. A. Hsu7, K. Santana[9], A. Ebrahim10, D. Ponce de Leon[11]. *[1]Instituto de Rehabilitación Psicofísica, Buenos Aires, Argentina; [2]Texas Tech University School of Medicine, El Paso, United States of America; [3]Hospital Angeles Mocel, San Miguel, Mexico; [4]Fundación Universitaria Juan N. Corpas e IDEARG, Bogotá, Colombia; [5]Clínica del Sur, Arequipa, Peru; [6]Pfizer Inc, Groton, United States of America; [6]Pfizer Inc, Groton, United States of America; [8]Pfizer Inc, Collegeville, United States of America; [9]Pfizer Inc, Ciudad de México, Mexico; [8]Pfizer Inc, Collegeville, United States of America; [11]Pfizer Inc, Lima, Peru*

Background: Depression/anxiety are common in RA pts. SF-36 MCS ≤38 can identify probable major depressive disorder and/or probable generalised anxiety disorder (pMDD/pGAD) in RA pts. Tofacitinib is an oral JAK inhibitor for the treatment of RA.

Objectives: To assess pMDD/pGAD prevalence in the tofacitinib RA program and efficacy by baseline (BL) pMDD/pGAD status.

Methods: Data from pts receiving tofacitinib, ADA, or PBO were pooled from 5 Phase (P)3 and 1 P3b/4 trials. Demographics/BL characteristics were reported by BL pMDD/pGAD (SF-36 MCS ≤38, presence; >38, absence). Month (M)3/6/9/12 SF-36 MCS change from BL (Δ) was estimated, and % with pMDD/pGAD reported. M3/6/12 efficacy outcomes compared tofacitinib-treated pts by BL pMDD/pGAD.

Results: BL pMDD/pGAD was seen in 44.5% (tofacitinib 5 mg BID), 39.8% (tofacitinib 10 mg BID), 45.4% (ADA 40 mg Q2W) and 39.1% (PBO) of pts. pMDD/pGAD pts had higher BL CRP and worse disability, fatigue, pain and sleep vs pts without. SF-36 MCS increases were greater for tofacitinib vs PBO/ADA (Fig 1a). The % of pts with BL pMDD/pGAD who continued to have pMDD/pGAD reduced over time, and was generally lower for tofacitinib vs PBO/ADA (Fig 1b). Regardless of BL pMDD/pGAD, efficacy was generally similar for tofacitinib 5 mg BID (Table) and 10 mg BID.