Index (HAQ-DI) at W12 was analysed by a mixed-effects model for repeated measures. Analyses were exploratory and not adjusted for multiplicity.

Results: Despite high PBO response rates in Eastern Europe and South and Central America, greater proportions of pts receiving FIL200 or FIL100 vs PBO achieved ACR20 at W12 ($P < 0.05$) in all regions, except Other (with lowest sample size, $n = 69$), where both FIL doses were numerically greater than PBO (Table 1). At W12, least-squares mean CFB in HAQ-DI improved for pts receiving FIL200 or FIL100 vs PBO ($P < 0.05$) in all regions, except SE Asia, where improvement was numeric (Table 1).

Table 1. Proportion of pts achieving ACR20 and LSM change from baseline HAQ-DI at week 1

	ACR20			HAQ-DI		
	FIL200	FIL100	PBO	FIL200	FIL100	PBO
North America	64.8 [†]	58.3 [†]	33.8	-0.63 [†]	-0.58 [†]	-0.34
n = 455	(56.7, 72.9)	(50.3, 66.4)	(26.0, 41.6)	(-0.70, -0.56)	(-0.65, -0.51)	(-0.41, -0.27)
South and Central America	77.2	77.3	57.4	-0.77 [†]	-0.67 [†]	-0.43
n = 283	(68.1, 86.3) [†]	(65.8, 86.2) [†]	(46.9, 68.0)	(-0.85, -0.68)	(-0.75, -0.59)	(-0.52, -0.35)
Western Europe	69.4 [†]	68.3 [†]	24.4	-0.69 [†]	-0.61 [†]	-0.28
n = 135	(55.5, 83.3)	(52.8, 83.8)	(10.8, 38.1)	(-0.80, -0.58)	(-0.73, -0.49)	(-0.40, -0.17)
Eastern Europe	77.1 [†]	69.1 [†]	54.6	-0.62 [†]	-0.51 [†]	-0.34
n = 822	(71.9, 82.3)	(63.5, 74.7)	(48.5, 60.7)	(-0.68, -0.56)	(-0.57, -0.45)	(-0.40, -0.28)
Asia	81.0 [†]	60.0 [†]	37.7	-0.83 [†]	-0.61 [†]	-0.42
n = 236	(71.7, 90.3)	(48.6, 71.4)	(26.2, 49.1)	(-0.92, -0.73)	(-0.70, -0.52)	(-0.52, -0.33)
South East Asia	70.2 [†]	71.1 [†]	39.5	-0.61 [†]	-0.57 [†]	-0.45
n = 135	(56.1, 84.4)	(56.8, 85.5)	(23.8, 55.3)	(-0.73, -0.49)	(-0.69, -0.45)	(-0.58, -0.33)
Other	60.0	52.4	39.1	-0.56 [†]	-0.60 [†]	-0.33
n = 69	(38.8, 81.2)	(28.6, 76.1)	(17.0, 61.2)	(-0.72, -0.41)	(-0.76, -0.43)	(-0.49, -0.17)
Overall	73.4 [†]	66.4 [†]	45.3	-0.71 [†]	-0.61 [†]	-0.40
N = 2135	(70.1, 76.8)	(62.9, 70.0)	(41.5, 49.0)	(-0.76, -0.66)	(-0.66, -0.56)	(-0.45, -0.35)

Includes only patients initially randomised to the treatment groups in each study for the comparison of interest. ACR20 presented as percentage (95% CI); 95% CI was based on normal approximation method with a continuity correction; P values calculated from the logistic regression. HAQ-DI presented as LSM (95% CI); LSM, 95% CI, and P value calculated from a mixed-effects model for repeated measures. * $P < 0.001$, † $P < 0.01$, ‡ $P < 0.05$; not adjusted for multiplicity.

ACR20, American College of Rheumatology 20% improvement; CI, confidence interval; FIL, filgotinib; HAQ-DI, Health Assessment Questionnaire-Disability Index; LSM, least square mean; PBO, placebo.

At W24, DAS28(CRP) < 2.6 and ≤ 3.2 response rates were higher for both doses of FIL vs PBO ($P < 0.05$) in all regions, with the exception of Other, where PBO was higher than FIL100 for DAS28(CRP) < 2.6 (Figure 1).

Conclusion: In exploratory analyses, ACR20, DAS28(CRP) < 2.6 and ≤ 3.2 response rates and HAQ-DI scores varied between regions; however, no stable trend was shown in any particular region. Small pt numbers in some subgroups may confound statistical analysis.

REFERENCES:

- Genovese et al. *JAMA*. 2019;322:315–25.
- Westhovens et al. *Ann Rheum Dis*. 2021; online first.
- Combe et al. *Ann Rheum Dis*. 2021; online first.

Disclosure of Interests: Maya H Buch Speakers bureau: AbbVie; Eli Lilly and Company; Gilead Sciences, Inc.; Merck-Serono; Pfizer; Roche; Sandoz; Sanofi; and UCB, Consultant of: AbbVie; Eli Lilly and Company; Gilead Sciences, Inc.; Merck-Serono; Pfizer; Roche; Sandoz; Sanofi; and UCB., Grant/research support from: AbbVie; Eli Lilly and Company; Gilead Sciences, Inc.; Merck-Serono; Pfizer; Roche; Sandoz; Sanofi; and UCB., Tsukasa Matsubara Speakers bureau: Pfizer Japan, Nichi-Iko, Astellas, Meiji Seika, Bristol-Myers Squibb, AbbVie GK, Janssen, Chugai, Eisai, AYUMI, Bernard Combe Speakers bureau: BMS; Eli Lilly & Co.; Gilead Sciences, Inc.; MSD; Pfizer; Roche-Chugai; and UCB, Consultant of: AbbVie; Eli Lilly & Co.; Gilead Sciences, Inc.; Janssen; Pfizer; Roche-Chugai; and Sanofi, Grant/research support from: Novartis, Pfizer, and Roche-Chugai, Alena Pechonkina Shareholder of: Gilead Sciences, Inc., Employee of: Gilead Sciences, Inc., Yingmei Tan Shareholder of: Gilead Sciences, Inc., Employee of: Gilead Sciences, Inc., Zhaoyu Yin Shareholder of: Gilead Sciences, Inc., Employee of: Gilead Sciences, Inc., Jaehyung Hong Shareholder of: Gilead Sciences, Inc., Employee of: Gilead Sciences, Inc., Robin Besuyen Shareholder of: Galapagos, BV, Employee of: Galapagos, BV, Antonio Gomez-Centeno Speakers bureau: AbbVie, Bristol-Myers Squibb, Eli Lilly & Co., Gebro, Janssen, Menarini, Merck Sharp & Dohme, Pfizer, Roche, Rubio, Sanofi, and UCB, Consultant of: AbbVie, Biogen, Bristol-Myers Squibb, Celgene, Eli Lilly & Co., Gebro, Gilead Sciences, Inc., Hospira, Merck Sharp & Dohme, Pfizer, Roche, Rubio, Sandoz, Sanofi, Grant/research support from: Boehringer Ingelheim, Celltrion, Eli Lilly & Co., Galapagos NV, Gilead Sciences, Inc., Novartis, Pfizer, Roche, Sanofi, UCB, YL Biologics

DOI: 10.1136/annrheumdis-2021-eular.648

POS0659 REAL WORD EXPERIENCE WITH TOFACITINIB IN PATIENTS WITH RHEUMATOID ARTHRITIS: AN INTERIM ANALYSIS FROM A FRENCH PROSPECTIVE OBSERVATIONAL STUDY DeFacTo

C. Gaujoux-Viala¹, A. Basch², S. Lassoued³, F. Coury-Lucas⁴, M. Kessouri⁵, N. Mammari⁶, T. Lequerre⁶, C. Salliot⁷. ¹University Hospital Carêmeau, Rheumatology, NIMES, France; ²Infirmerie Protestante de Lyon, Rheumatology, Caluire et Cuire, France; ³Cahors Hospital Center, Rheumatology, Cahors, France; ⁴Lyon Sud Hospital, Rheumatology, Pierre-Bénite, France; ⁵Pfizer, Immunologie & Inflammation, Paris, France; ⁶Rouen University Hospital & Inserm U905, Rheumatology, Rouen, France; ⁷Orléans Regional Hospital Center, Rheumatology, Orléans, France

Background: Tofacitinib is an oral JAK inhibitor indicated for moderate to severe active rheumatoid arthritis (RA).

Objectives: To present baseline patients characteristics and effectiveness data at 6 months of DeFacTo real life study ("Identification of Factors predictive of Tofacitinib's survival").

Methods: DeFacTo is an observational, open-label, prospective, multi-center, national study designed to evaluate the predictive factors of tofacitinib's survival in patients with moderate-to-severe active rheumatoid arthritis according to the SmPC^[1]. Here we present the 1st interim results involving a descriptive analysis of the 221 patients included between January 2019 and March 2020 (POP1). Effectiveness results at 6 months of 145 patients having ≥ 6 months follow-up (POP2) are also described.

Results: The baseline characteristics of the POP1 patients ($n = 221$) were: 78.3% women with a mean age ($\pm$ SD) of 60.4 ± 11.1 years, disease duration of 12.0 ± 9.8 years, TJC: 7.3 ± 5.7 and SJC: 5.1 ± 4.7 ; 44.0% of patients had erosions, 79.5% were RF+ and 75.9% were ACPA+. The mean CRP was 15.3 ± 21.8 mg/l, the ESR at one hour was 28.7 ± 23.6 mm, DAS28-4 CRP was 4.6 ± 1.0 , DAS28-4 ESR was 4.9 ± 1.1 and the FACIT-Fatigue score was 27.6 ± 11.3 . A total of 97.3% of patients had been previously treated by ≥ 1 csDMARD (mean number 1.9 ± 1.0) and 66.1% by b/tsDMARDs (mean number 2.9 ± 2.5), tofacitinib was prescribed as monotherapy (without csDMARD) in 49.3% of patients. The characteristics of the POP2 patients were similar to those of POP1. At 6 months in POP2, 29 patients have discontinued their treatment with tofacitinib. The results showed a decrease from baseline in inflammatory markers (CRP from 14.2 ± 17.1 to 4.7 ± 4.2 mg/l), pain (Pain VAS from 58.3 ± 23.4 to 27.6 ± 22.1) and DAS28 activity scores with 23% of patients in DAS28-CRP remission and 36% of patients in DAS28-CRP LDA (figure 1). This interim analysis didn't identify any new safety findings (Table 1).

Conclusion: Preliminary results from this prospective observational study on the use of tofacitinib in patients suffering with RA in France indicate that its effectiveness and safety are similar to those found in the clinical studies^[1-3]. In this study, tofacitinib was prescribed as monotherapy (without csDMARD) in more than 49% of cases.

REFERENCES:

- European Medicines Agency, Tofacitinibi SmPc (summary of product characteristics).
- Burmester G et al. *Lancet*. 2013; 381: 451-460.

- [3] Fleischman R et al. *Lancet* 2017; 390: 457-6.
 [4] Wollenhaupt et al. *Arthritis Research & Therapy* (2019) 21:89

Figure 1. Patients with LDA or remission at baseline and 6 months

Table 1. Safety data

Tolerability, n patients (%)	<65 years, n = 132	≥ 65 years, n = 86	Total n = 218
AE	56 (42.4)	33 (38.4)	89 (40.8)
Serious AE	8 (6.1)	5 (5.8)	13 (6.0)
Herpes Zoster	4 (3.0)	2 (2.3)	6 (2.8)
Infection	27 (20.5)	15 (17.4)	42 (19.3)
Severe infection	2 (1.5)	2 (2.3)	4 (1.8)

Acknowledgements: To all investigators involved in this study.

Disclosure of Interests: Cécile Gaujoux-Viala Speakers bureau: AbbVie; Amgen; Bristol-Myers Squibb; Celgene; Eli Lilly; Galapagos; Gilead Sciences, Inc.; Janssen; Medac; Merck-Serono; Mylan; Nordic Pharma; Novartis; Pfizer; Roche; Sandoz; Sanofi; and UCB, Consultant of: AbbVie; Amgen; Bristol-Myers Squibb; Celgene; Eli Lilly; Galapagos; Gilead Sciences, Inc.; Janssen; Medac; Merck-Serono; Mylan; Nordic Pharma; Novartis; Pfizer; Roche; Sandoz; Sanofi; and UCB, Andre BASCH Speakers bureau: Janssen, Novartis, Amgen, BMS, Abbvie, Lilly, Pfizer, MSD, UCB, Consultant of: Janssen, Novartis, Amgen, BMS, Abbvie, Lilly, Pfizer, MSD, UCB, Slim Lassoued: None declared, Fabienne COURRY-LUCAS Consultant of: AbbVie, Bristol-Myers Squibb, Janssen, Lilly, MSD, Novartis and Pfizer, Grant/research support from: AbbVie, Biogen, Roche Chugai, Pfizer, and UCB, Meriem Kessouri Shareholder of: Pfizer, Employee of: Pfizer, Nadir Mammar Shareholder of: Pfizer, Employee of: Pfizer, Thierry Lequerre Consultant of: Abbvie, BMS, Boehringer, Lilly, Medac, MSD, Nordic Pharma, Novartis, Pfizer, Roche – Chugai, Sanofi, UCB, Carine Salliot Consultant of: Biogen, Lilly, Novartis, Roche Chugai, Pfizer

DOI: 10.1136/annrheumdis-2021-eular.870

POS0660

CONCOMITANT USE OF STATINS IN FILGOTINIB-TREATED PATIENTS WITH RHEUMATOID ARTHRITIS

P.C. Taylor¹, C. Charles-Schoeman², M. Alani^{3,4}, M. Trivedi³, V. Castellano⁵, I. Tamiyu³, D. Jiang⁶, L. Ye⁶, S. Strengtholt⁷, M. Nurmohamed⁸, G. R. Burmester⁹. ¹University of Oxford, Botnar Research Center, Oxford, United Kingdom; ²UCLA Medical Center, Department of Medicine, Los Angeles, United States of America; ³Gilead Sciences, Inc., Clinical Research, Foster City, United States of America; ⁴University of Washington, Department of Rheumatology, Seattle, United States of America; ⁵Gilead Sciences, Inc., Rheumatology Therapeutic Area, Foster City, United States of America; ⁶Gilead Sciences, Inc., Biostatistics, Foster City, United States of America; ⁷Galapagos BV, Department of Rheumatology, Leiden, Netherlands; ⁸Amsterdam Rheumatology & Immunology Center, Department of Rheumatology, Amsterdam, Netherlands; ⁹Charité – Universitätsmedizin Berlin, Department of Rheumatology and Clinical Immunology, Berlin, Germany

Background: The Janus kinase-1 preferential inhibitor filgotinib (FIL) improved rheumatoid arthritis (RA) signs and symptoms in phase (P)3 trials.^{1–3} RA elevates cardiovascular disease risk; statins are used to reduce risk.

Objectives: To assess safety of statin and filgotinib coadministration across the clinical program.

Methods: Patients (pts) meeting 2010 ACR/EULAR RA criteria in P2 DARWIN 1–2 (D1–2; NCT01888874, NCT01894516), P3 FINCH 1–3 (F1–3; NCT02889796, NCT02873936, NCT02886728), and long-term extensions DARWIN 3 and FINCH 4 (D3, F4; NCT02065700, NCT03025308) receiving FIL 100mg (FIL100) QD, FIL 200mg QD (FIL200), adalimumab (ADA), methotrexate (MTX), or placebo (PBO) were included. Events related to statin use were analysed as exposed by treatment received. N and % were provided.

Week (W)12 PBO-controlled safety analysis included pts receiving FIL100, FIL200, or PBO for ≤12W (D1–2, F1–2); as-treated safety analysis included pts

receiving long-term FIL100 QD (n=1647), FIL200 QD (n=2267), ADA (n=325), MTX (n=416), or PBO (n=781) (D1–3, F1–4); P3 as-randomised analysis included data up to W52 (F1–3) per assigned treatment.

Results: In each arm, similar proportions of pts took statins at baseline (9.4%–11.9%); initiation during study was low (1.2%–6.8%). Through W12 in PBO-controlled analysis, mean creatine phosphokinase (CPK; Figure 1), alanine aminotransferase (ALT), and aspartate aminotransferase (AST) levels were similar regardless of statin use and remained within normal levels across all arms.

Figure: CPK levels through W12 in PBO-controlled analysis*

*FINCH 1–2. CPK, creatine phosphokinase; csDMARD, conventional synthetic disease-modifying antirheumatic drug; PBO, placebo; QD, once daily; W, week.

Mean baseline ALT and AST levels were 20–23 and 20–22 U/L, respectively; at W12, ALT and AST ranged from 22–24 and 20–25 U/L, respectively. Graded CPK, ALT, and AST elevations are in Table 1.

Table 1. Graded laboratory abnormalities at week 12 by baseline statin use in PBO-controlled analysis

	Concomitant			None		
	FIL200 (n=68)	FIL100 (n=95)	PBO (n=93)	FIL200 (n=709)	FIL100 (n=693)	PBO (n=688)
CPK increased*	59	82	81	562	549	537
G1 (≤2.5xULN)	10 (16.9)	13 (15.9)	6 (7.4)	71 (12.6)	47 (8.6)	18 (3.4)
G2 (>2.5 to 5xULN)	3 (5.1)	0	0	6 (1.1)	2 (0.4)	3 (0.6)
G3 (>5 to 10xULN)	0	0	0	1 (0.2)	0	3 (0.6)
G4 (>10xULN)	0	0	0	1 (0.2)	2 (0.4)	0
AST increased**	68	94	92	708	692	684
G1 (≤3.0xULN)	9 (13.2)	11 (11.7)	7 (7.6)	97 (13.7)	79 (11.4)	60 (8.8)
G2 (>3.0 to 5.0xULN)	0	0	0	3 (0.4)	2 (0.3)	3 (0.4)
G3 (>5.0 to 20.0xULN)	0	1 (1.1)	0	2 (0.3)	0	0
G4 (>20.0xULN)	0	0	0	0	0	0
ALT increased**	68	94	92	708	692	684
G1 (≤3.0xULN)	13 (19.1)	14 (14.9)	13 (14.1)	98 (13.8)	92 (13.3)	72 (10.5)
G2 (>3.0 to 5.0xULN)	0	2 (2.1)	0	10 (1.4)	5 (0.7)	6 (0.9)
G3 (>5.0 to 20.0xULN)	0	0	0	1 (0.1)	0	1 (0.1)
G4 (>20.0xULN)	0	0	0	0	0	0

Data are n (%). Grading per Common Terminology Criteria for Adverse Events v4.03

*FINCH 1–2**DARWIN 1–2, FINCH 1–2ALT, alanine aminotransferase; AST, aspartate aminotransferase; CPK, creatine phosphokinase; csDMARD, conventional synthetic disease-modifying antirheumatic drug; FIL200/100, filgotinib 200/100 mg + csDMARDs; Grade, G; PBO, placebo; ULN, upper limit of normal.

In the long-term as-treated analysis, 1 (0.5%)/6 (3.2%)/0/0/0 treatment-emergent adverse events (AE) of myalgia occurred in pts on statins at baseline receiving FIL200/FIL100/ADA/MTX/PBO and in 12 (0.6%)/8 (0.5%)/3 (1.0%)/2 (0.5%)/1 (0.1%) pts not on statins. Muscle spasms occurred in 2 (0.9%)/3 (1.6%)/1 (3.2%)/0/1 (1.1%) pts on statins at baseline receiving FIL200/FIL100/ADA/MTX/PBO and 21 (1.0%)/8 (0.5%)/0/3 (0.8%)/1 (0.1%) pts not on statins at baseline. One patient not on statins receiving FIL200 reported rhabdomyolysis. For all treatment arms in P3 as-randomised analysis, mean LDL and HDL increased similarly from baseline (108–110 and 56–59 mg/dL, respectively) to W52 (119–130 and 59–71 mg/dL, respectively).

Conclusion: No increases in statin-induced AEs such as muscle or liver toxicities occurred with statins and filgotinib coadministration; results are supported by a drug-drug interaction study.⁴ Mean LDL and HDL increased at W52 in all treatment arms.

REFERENCES:

- Genovese et al. *JAMA*. 2019;322:315–25.
- Westhovens et al. *Ann Rheum Dis*. 2021; online first.
- Combe et al. *Ann Rheum Dis*. 2021; online first.
- Anderson et al. *EULAR* 2021 abstract.

Disclosure of Interests: Peter C. Taylor Consultant of: AbbVie, Biogen, Eli Lilly, Fresenius, Galapagos, Gilead, GlaxoSmithKline, Janssen, Nordic Pharma, Pfizer, Roche, BMS, Sanofi, Celltrion, and UCB, Grant/research support from: Celgene, Eli Lilly, Galapagos, and Gilead, Christina Charles-Schoeman