

Vidaza Significantly Extends Overall Survival by 74% in Phase 3 Trial in Myelodysplastic Syndromes (MDS)

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- Two year survival rate of 50.8 percent for Vidaza vs 26.2 for conventional care regimens
- 9.4 months median survival benefit for patients on Vidaza compared to conventional care regimens
- Only agent to demonstrate survival benefit in MDS compared to conventional care regimens
- Only epigenetic modifier to show survival benefit in cancer
- Stratified log-rank p-value = 0.0001, Hazard ratio = 0.58
- Largest study ever conducted in higher-risk MDS

BOULDER, Colo., Aug. 2 /PRNewswire-FirstCall/ -- Pharmion Corporation (Nasdaq: PHRM) today announced topline results from the multi-institutional, international, randomized, Phase 3 controlled trial of Vidaza(R) (azacitidine for injection) versus conventional care regimens (CCR) in the treatment of patients with higher-risk myelodysplastic syndromes (MDS).

In the primary endpoint analysis, Vidaza treatment was associated with a median survival of 24.4 months versus 15 months for those receiving CCR treatment, an improvement of 9.4 months with a stratified log-rank p-value of 0.0001.

The hazard ratio describing this treatment effect was 0.58 (95 percent confidence interval of 0.43 to 0.77). Two-year survival rates were 50.8 percent versus 26.2 percent for patients receiving Vidaza versus CCR (p < 0.0001). The survival benefits of Vidaza were consistent regardless of the CCR treatment option (best supportive care (BSC) alone, low-dose cytarabine plus BSC or standard chemotherapy plus BSC) utilized in the control arm.

"These landmark results, showing a significant improvement in survival in the most advanced MDS patients, validate the benefit Vidaza can provide patients with this extremely difficult to treat disease," said Dr. Lewis R. Silverman, Associate Professor of Medicine, Division of Hematology and Medical Oncology, Mount Sinai School of Medicine.

"Building on the established data from our earlier clinical studies, which showed that Vidaza offers transfusion independence to many patients with MDS, we now see that Vidaza not only improves a patient's life, but extends it as well."

"With these very exciting results for Vidaza, survival should now be the standard by

which we evaluate treatment options for higher-risk MDS," said Dr. Alan F. List, Chief, Malignant Hematology Division and Deputy Physician in Chief, H. Lee Moffitt Cancer Center and Research Institute.

"Importantly, as the first and only epigenetic therapy to have demonstrated a survival benefit in any cancer, these findings should accelerate exploration of Vidaza in other malignancies where hypermethylation is believed to play a key role in tumor development and progression."

"We are extremely gratified with the results from the Vidaza Survival Study, which for the first time bring the hope of prolonged survival for patients with higher-risk MDS," said Patrick J. Mahaffy, Pharmion's chief executive officer and president. "As the only therapy to have ever demonstrated a survival advantage in MDS, and especially to have demonstrated an improvement of this magnitude, Vidaza is unique in the treatment for this disease."

Pharmion expects to present full study results at an upcoming medical meeting. Based on these results, Pharmion intends to file a Marketing Authorization Application (MAA) in the European Union (EU) for Vidaza for the treatment of higher-risk MDS before the end of this year and will shortly thereafter submit additional international regulatory submissions.

The Company will also file a supplemental New Drug Application (NDA) with the U.S. Food and Drug Administration (FDA) to include these data in the prescribing information in the U.S.

About the Trial Design

This was the largest randomized study ever conducted in higher-risk MDS. The study was a multi-center, randomized, open-label, parallel-group, Phase 3 trial of subcutaneous (SC) Vidaza (administered at 75/mg/m²/day SC for seven consecutive days every 28 days) plus best supportive care versus CCR plus best supportive care for the treatment of MDS.

CCR consisted of one of three physician selected regimens: best supportive care alone, low-dose cytarabine plus best supportive care or standard chemotherapy plus best supportive care. EPO and prophylactic G-CSF use was not permitted. The CCR represented standard of care within the territories where the trial was conducted.

The study evaluated 358 higher-risk MDS patients at sites in the U.S. , Europe and Australia . Patients were randomized on a 1:1 ratio to either Vidaza of the CCR with stratification by FAB subtypes (RAEB or RAEB-T) and IPSS subgroups (INT-2 or HIGH). Investigators selected the CCR option for each individual patient prior to randomization.

The primary objective of the trial was to demonstrate superiority in survival of Vidaza plus best supportive care versus CCR plus best supportive care in higher-risk MDS patients.

Secondary objectives of the trial included transfusion independence, hematologic status, hematologic response and hematologic improvement, episodes of infections requiring intravenous antibiotics, time to relapse after complete response (CR) or partial response (PR), time to disease progression, time to transformation to AML, time to transformation or death from any cause, safety and toxicity and pharmacoeconomics.

About Vidaza **Important Safety Information**

Vidaza is contraindicated in patients with a known hypersensitivity to Vidaza or mannitol and in patients with advanced malignant hepatic tumors.

In clinical studies, the most commonly occurring adverse reactions by SC route were nausea (70.5%), anemia (69.5%), thrombocytopenia (65.5%), vomiting (54.1%), pyrexia (51.8%), leukopenia (48.2%), diarrhea (36.4%), fatigue (35.9%), injection site erythema (35.0%), constipation (33.6%), neutropenia (32.3%) and ecchymosis (30.5%). Other adverse reactions included dizziness (18.6%), chest pain (16.4%), febrile neutropenia (16.4%), myalgia (15.9%), injection site reaction (13.6%), aggravated fatigue (12.7%) and malaise (10.9%).

The most common adverse reactions by IV route also included petechiae (45.8%), rigors (35.4%), weakness (35.4%) and hypokalemia (31.3%).

Because treatment with Vidaza is associated with neutropenia and thrombocytopenia, complete blood counts should be performed as needed to monitor response and toxicity, but at a minimum, prior to each dosing cycle.

Because Vidaza is potentially hepatotoxic in patients with severe pre-existing hepatic impairment, caution is needed in patients with liver disease. In addition, Vidaza and its metabolites are substantially excreted by the kidneys and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, it may be useful to monitor renal function.

Vidaza may cause fetal harm. While receiving treatment with Vidaza, women of childbearing potential should avoid becoming pregnant, and men should avoid fathering a child. In addition, women treated with Vidaza should not nurse.

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