Clinically Relevant Anti-Vaccine and Virus Antibodies in Patients With Sjögren's Disease Treated With Nipocalimab: Post-Hoc Analysis of the DAHLIAS Study

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Background

- Nipocalimab is a fully human, high affinity, aglycosylated, effectorless, immunoselective immunoglobulin (Ig) G1 monoclonal antibody that blocks the neonatal fragment crystallizable receptor (FcRn), thereby lowering serum IgG levels[1–4]
- In the DAHLIAS study (NCT04968912), significant clinical improvement over placebo in ClinESSDAI (Clinical European League Against Rheumatism Sjögren's Syndrome Disease Activity Index) scores at 24 weeks were observed with nipocalimab 15 mg/kg intravenous (IV) biweekly treatment, which was well tolerated in participants with moderate-to-severe Sjögren's Disease (SjD)[5]
- Results from a randomized, open-label vaccine study in healthy volunteers suggest that nipocalimab does not impact the development of IgG responses to T-cell–dependent or –independent vaccines[6]

Objective

- **To assess the impact of nipocalimab on pre-existing anti-vaccine antibodies to tetanus toxoid (TT) and varicella zoster virus (VZV), and the humoral responses to Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2) infection and vaccination in a post-hoc analysis of participants enrolled in the DAHLIAS study**

Methods

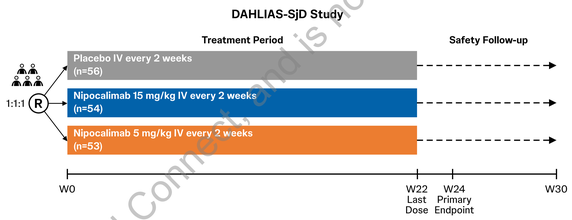
Study Design

- In the Phase 2 DAHLIAS study (NCT04968912), participants with moderate-to-severe SjD received an IV injection of nipocalimab 5 mg/kg, 15 mg/kg, or placebo every 2 weeks for 22 weeks (**Figure 1**)
- Serum IgG antibody levels against TT and VZV were measured in baseline and post-treatment samples from a subset of participants who received 15 mg/kg nipocalimab
- In participants with documented SARS-CoV-2 vaccination or infection during the study, antibodies against different epitopes of SARS-CoV-2 were measured
- Participants in the placebo and the 15 mg/kg nipocalimab groups with available samples were included in the analysis

FIGURE 1: Study design

Key Eligibility Criteria

- ✓ Adults 18-75 years
- ✓ Anti-SSA positive, moderate-to-severe SjD
- ✓ Total ClinESSDAI score ≥6



Anti-SSA=anti-Sjögren's syndrome–related antigen, ClinESSDAI=Clinical European League Against Rheumatism Sjögren's Syndrome Disease Activity Index, IV=intravenous, R=randomization, SjD=Sjögren's Disease, W=week.

Key Takeaways

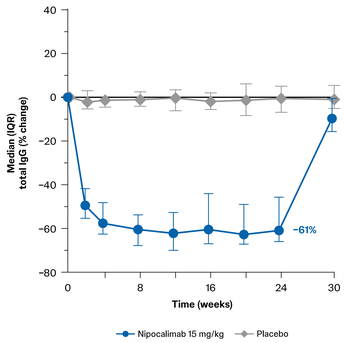
- **Nipocalimab-treated participants with Sjögren's Disease elicited IgG responses to SARS-CoV-2 vaccination and/or infection**
- **Nipocalimab reduced pre-existing anti-vaccine antibodies to a similar extent as total IgG, consistent with the mechanism of action of nipocalimab; most nipocalimab-treated participants who were immune to TT and VZV at baseline maintained protective IgG levels during and after treatment**
- **Total and vaccine-specific IgG returned to baseline levels after treatment cessation**
- **Results suggest that nipocalimab-treated participants with Sjögren's Disease can:**
  - **Often maintain protective IgG levels to clinically relevant pathogens**
  - **Mount IgG responses to infection and vaccination**
  - **Follow recommended vaccination schedules**

Results

Nipocalimab treatment significantly and reversibly reduced total IgG levels in participants with Sjögren's Disease

- Nipocalimab 15 mg/kg produced a minimum reduction in total IgG of 61%, which was consistent with its mechanism of action (**Figure 2**)

FIGURE 2: Observed pre-dose (minimal) reduction in total IgG in participants with Sjögren's Disease

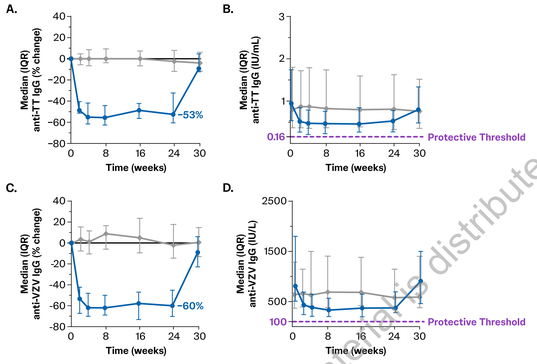


IgG=immunoglobulin G, IQR=interquartile range.

Most participants remained protected during the study, despite reductions in pre-existing anti-TT IgG and anti-VZV IgG due to nipocalimab

- Nipocalimab reduced pre-existing anti-TT and anti-VZV consistent with the mechanism of action of nipocalimab in the DAHLIAS study (**Figure 3**)
- Nipocalimab reduced anti-TT IgG (**Figure 3A**) and anti-VZV IgG (**Figure 3C**) levels to a similar extent as total IgG levels; the majority of participants were able to maintain anti-TT IgG (**Figure 3B**) and anti-VZV IgG (**Figure 3D**) levels above the protective threshold
- Anti-TT IgG and anti-VZV IgG levels returned to baseline after treatment cessation (**Figures 3B and 3D**)

FIGURE 3: Levels of pre-existing anti-TT IgG (A and B) and anti-VZV (C and D) IgG during nipocalimab treatment



Treatment	Participants with anti-TT IgG levels above protective threshold (0.16 IU/mL), n/N (%)			
	BL/W0	W24	W30	All timepoints
Nipocalimab 15 mg/kg (n=41)	38	28/31 (90%)	30/31 (97%)	32/38 (84%)
Placebo (n=49)	44	38/39 (97%)	35/36 (97%)	42/44 (95%)

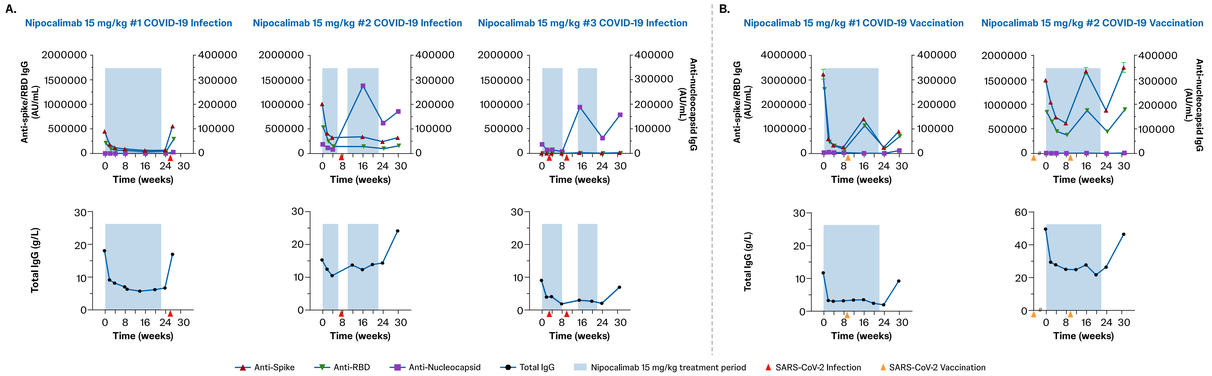
Treatment	Participants with anti-VZV IgG levels above protective threshold (100 IU/L), n/N (%)			
	BL/W0	W24	W30	All timepoints
Nipocalimab 15 mg/kg (n=50)	46	36/40 (90%)	39/39 (100%)	40/46 (87%)
Placebo (n=55)	53	46/46 (100%)	44/44 (100%)	53/53 (100%)

BL=baseline, IgG=immunoglobulin G, IQR=interquartile range, TT=tetanus toxoid, VZV=varicella zoster virus, W=week.

Nipocalimab-treated participants mounted IgG responses to SARS-CoV-2 antigens during acute infection and upon vaccination

- Participants with SARS-CoV-2 acute infection in the nipocalimab 15 mg/kg (n=3; 2 mild, 1 moderate) had increased levels of anti-spike and anti-nucleocapsid antibodies; all infections resolved without complications (**Figure 4A**)
- All participants receiving SARS-CoV-2 vaccination mounted a humoral response as shown by increases in anti-spike antibodies; no humoral responses were observed against nucleocapsid, since nucleocapsid is not part of the vaccine (**Figure 4B**)

FIGURE 4: Levels of anti-spike/S1 RBD/nucleocapsid IgG and total IgG during nipocalimab treatment following COVID-19 infection (A) and COVID-19 vaccination (B)



AU=arbitrary unit, COVID-19=coronavirus disease 2019, IgG=immunoglobulin G, RBD=receptor-binding domain, SARS-CoV-2=Severe acute respiratory syndrome coronavirus-2.

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PRESENTED BY: Brittany Durgin at Congress of Clinical Rheumatology – East 2026 (CCR – East); April 30–May 3, 2026; Destin, FL. **REFERENCES: 1.** Ling LE, et al. *Clin Pharmacol Ther.* 2019;105(4):1031–1039. **2.** Roy S, et al. *Am J Obstet Gynecol.* 2019;220(5):498e1–498.e9. **3.** Moise KJ Jr, et al. *N Engl J Med.* 2024;391(6):526–537. **4.** Antozzi C, et al. *Neurology.* 2024;102(2):e207937. **5.** Cossu M, et al. *Hum. Vaccin. Immunother.* 2025;21(1):2491269. **6.** Gottenberg J, et al. *Arthritis Rheumatol.* 2024; 76(suppl 9). **ACKNOWLEDGMENTS:** Medical writing support was provided by Jennifer L Venzie, PhD (SystemOne) under the direction of the authors in accordance with Good Publication Practice guidelines (*Ann Intern Med.* 2022;175:1298–1304). Layout design and formatting for this presentation were provided by Amit Kavle of SIRO Medical Writing Pvt Ltd, India (funded by Johnson & Johnson). This study was sponsored by Johnson & Johnson. **DISCLOSURES: FY, EM, JJH, KC, MJL, DD, CC,** and **SG** are employees of and may hold stock in Johnson & Johnson. **Previously presented at:** American College of Rheumatology (ACR) Convergence 2025; October 24–29, 2025; Chicago, IL, USA.