Switching to Zanubrutinib in Patients Diagnosed With Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma and Previously Treated With Another Bruton Tyrosine Kinase Inhibitor in a US Community Oncology Setting

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CONCLUSIONS

- Among patients diagnosed with CLL/SLL and initiated on zanubrutinib after previous treatment with another BTKi, the most common reason for discontinuation of the previous BTKi was physician reported AEs
- While the majority of patients discontinued zanubrutinib by the end of the study period, there was a meaningful duration of therapy and many remained on treatment
- These results suggest that an "in-class" switch to zanubrutinib can be an effective clinical option for physicians who prefer to treat CLL/SLL with a BTKi
- Future work will continue to follow patients treated with zanubrutinib with a focus on time on treatment and reason for discontinuation

INTRODUCTION

- Examining treatment patterns and switching in cancer care is common in health economic research, both in randomized controlled trials[1,2] and real-world studies[3,4]
- Examining treatment switching in patients diagnosed with chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) has been of particular interest lately because of advances in novel therapies for B-cell cancer[5]
- The Bruton tyrosine kinase inhibitors (BTKis) revolutionized the treatment of CLL/SLL since they were introduced in 2013[5]
- Following the introduction of the second-generation BTKis, acalabrutinib and zanubrutinib, "in-class" switching became common
- Common reasons for treatment switching in CLL/SLL include disease progression, adverse events (AEs), and physician or patient preference[6]

OBJECTIVE

- To examine outcomes associated with BTKi treatment in patients diagnosed with CLL/SLL, previously treated with another covalent BTKi, and then switched to zanubrutinib

METHODS

- This was a retrospective chart review study of patients from the US Oncology Network
- Structured and unstructured fields were examined from the iKnowMed electronic health record (EHR)
- Patients were included if they were diagnosed with CLL/SLL, switched to zanubrutinib from another BTKi, in any line of treatment and without intervening therapy, between 1/1/2022 and 9/30/2023 (**Figure 1**). The index date was the date of zanubrutinib initiation
- Patients were followed until zanubrutinib treatment discontinuation, new treatment initiation, death, or end of the study period on 8/30/2024
- In addition to demographic and clinical characteristics, outcomes included time to discontinuation (TTD) of previous covalent BTKi, physician-reported reasons for discontinuation, and following initiation of zanubrutinib, time to new treatment (TTNT) and TTD

Figure 1. Study Design

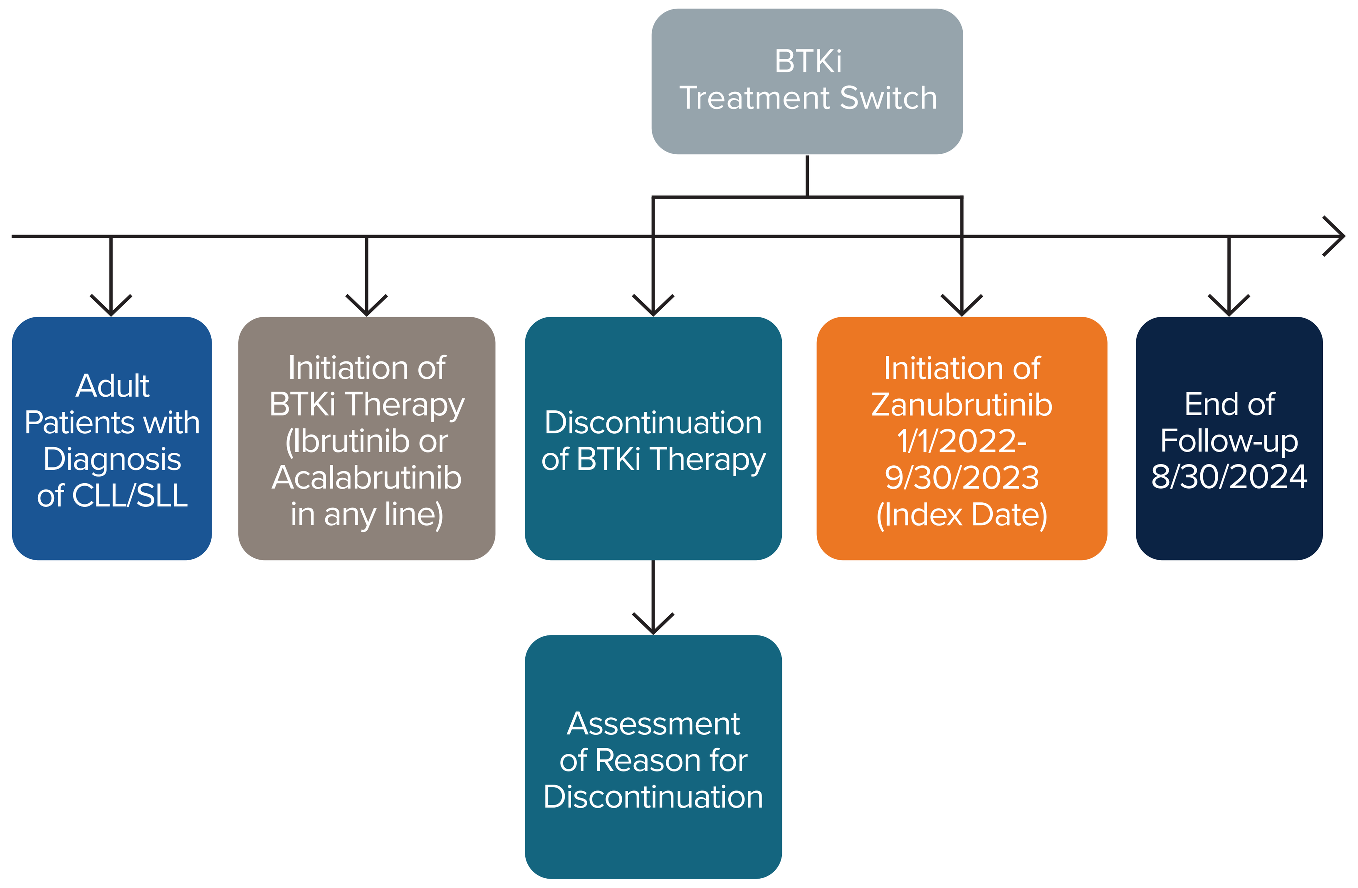
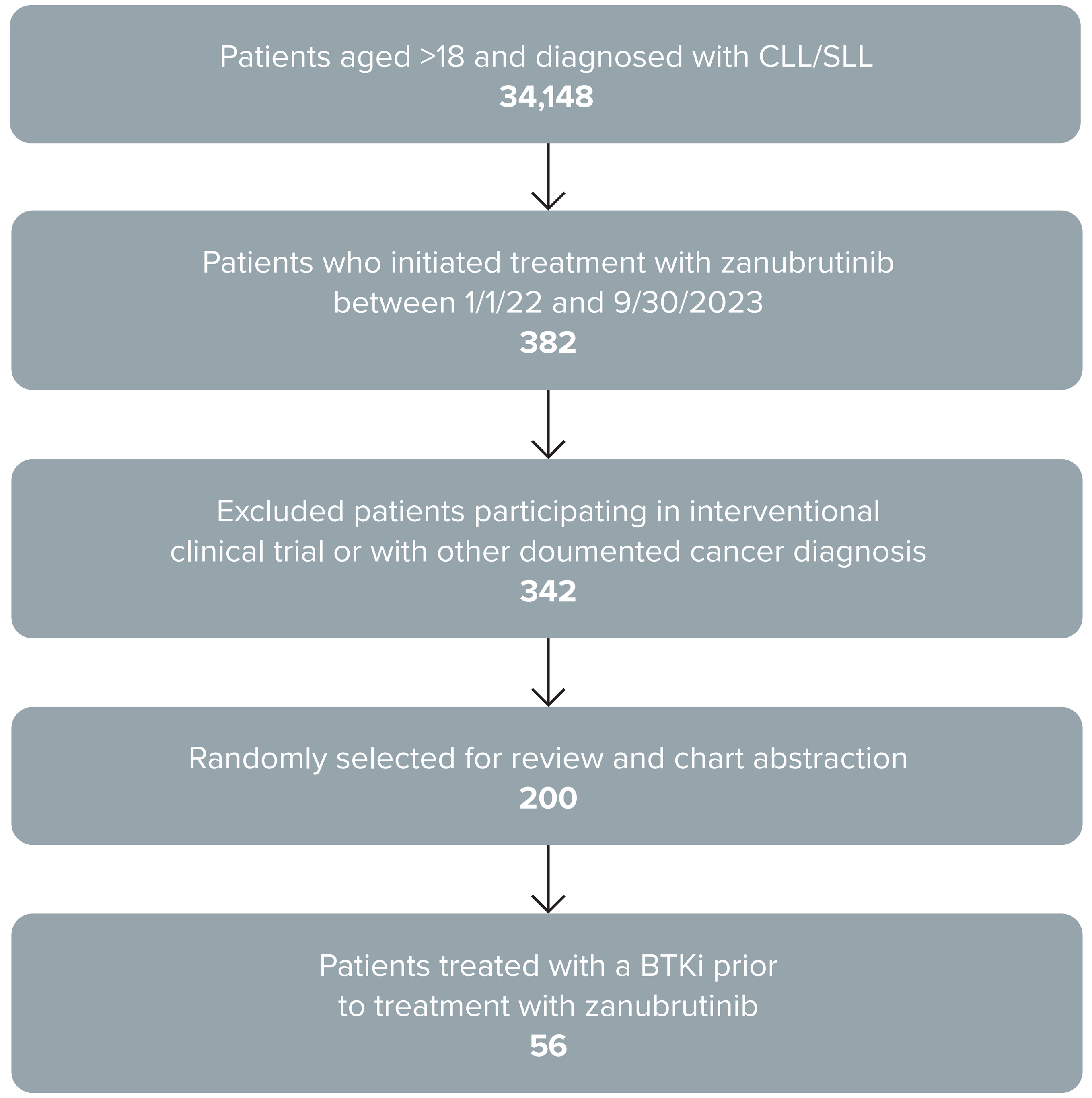


Figure 2. Patient Identification and Selection



RESULTS

- A total of 200 charts were randomly selected for review. The majority of patients prescribed zanubrutinib were treatment-naïve (n=103, 51.5%). Others were treated with something other than a covalent BTKi (n=26, 13.0%) or had intervening therapy (n=15, 7.5%). The 56 patients (28%) who switched directly to zanubrutinib from another BTKi were included in the analysis (**Figure 2**)
- Median age at time of zanubrutinib initiation was 75 years, and 71.4% of patients were male (**Table 1**)
- Median time from CLL/SLL diagnosis to initiation of zanubrutinib was 84.6 months (**Figure 3**)
- A total of 33 (58.9%) patients switched from ibrutinib to zanubrutinib and 23 (41.1%) switched from acalabrutinib to zanubrutinib
- Median TTNT for ibrutinib was 39.9 months and TTNT for acalabrutinib was 4.6 months (**Figure 3**)
- Reasons for discontinuing the previous covalent BTKi were physician-reported AEs (62.5%), patient or physician choice (17.9%), or physician-reported disease progression (17.9%). One case (1.8%) was undocumented (**Figure 4**)
- After zanubrutinib initiation, median follow-up was 15.7 months (IQR: 12.9-17.9) (**Table 2**)
- During the follow-up, 35 (62.5%) patients discontinued zanubrutinib, with a median TTD of 11.4 months (95% CI:6.9-15.6)
- Among patients who discontinued zanubrutinib, 19 (33.9%) initiated new treatment. The median TTNT was not reached

Figure 3. Treatment Timeline

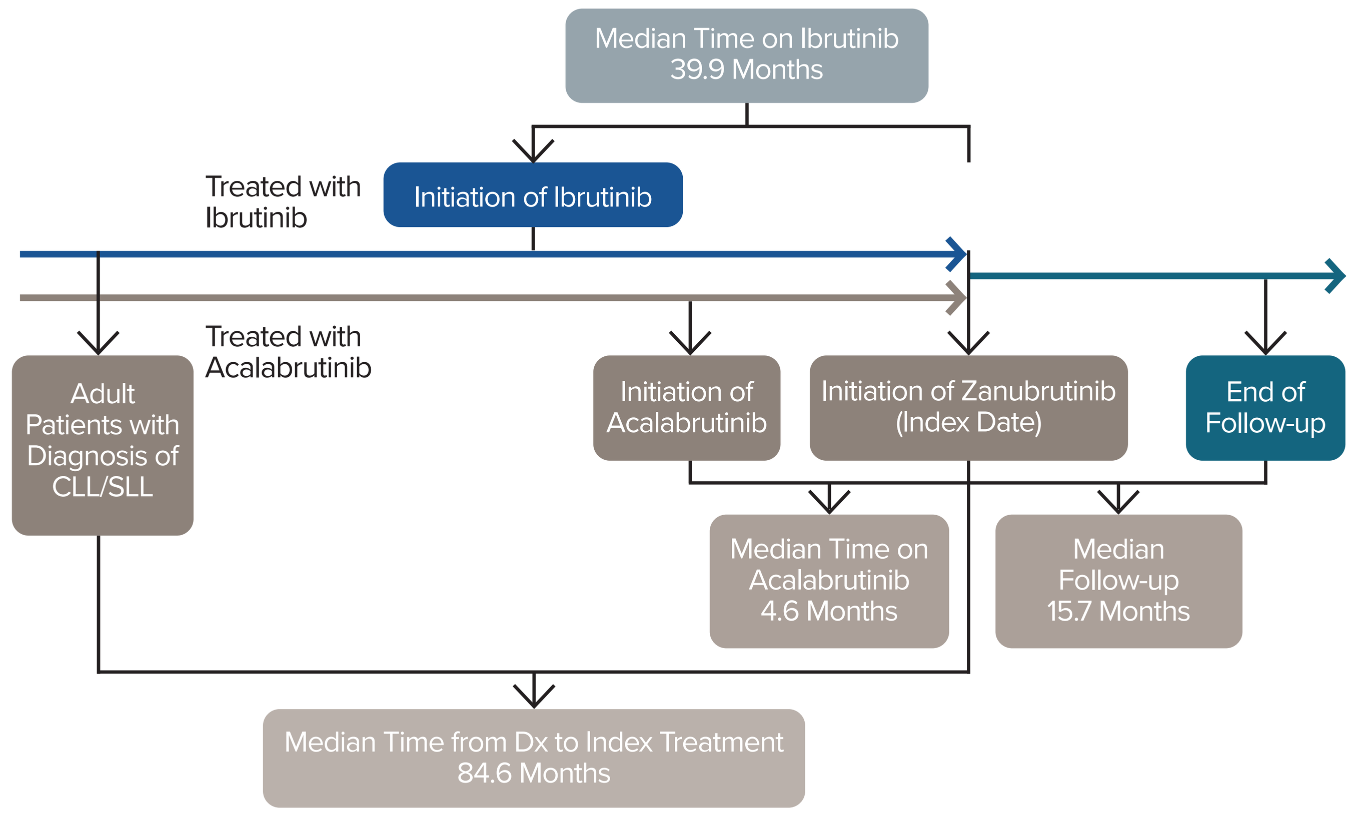


Table 1. Demographic Characteristics

Characteristic	Value
Patient Count (N)	56
Age (Years), Median (Min, Max)	75 (56, 90+)
Gender (%)	
Male	71.4%
Female	28.6%
Disease Type (%)	
CLL	85.7%
SLL	14.3%

Characteristic	Value
Time since CLL/SLL Diagnosis (Months) Median (Min, Max)	84.6 (11.9, 451.9)
ECOG	
0	14.3%
1+	23.2%
Unknown	62.5%

Figure 4. Reason for Discontinuation of Previous BTKi

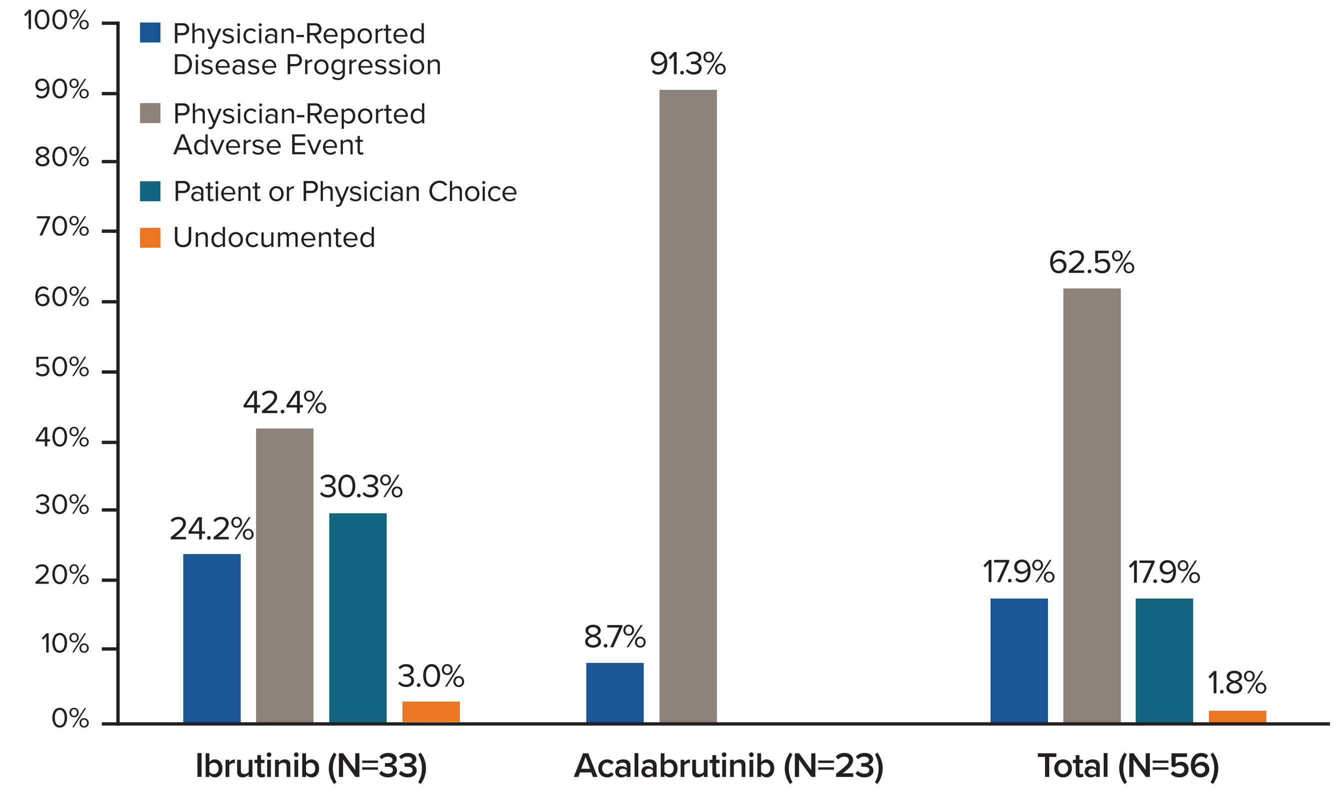


Table 2. Zanubrutinib Time on Treatment and Time to Discontinuation

Characteristic	Value
Patient Count (N)	56
Follow-up Duration (Months)	
Mean (SD)	15.1 (5.0)
Median (IQR)	15.7 (12.9, 17.9)

Characteristic	Value
Time to Discontinuation (Months)	
Patient Count (%)	35 (62.5%)
Median (95% CI)	11.4 (6.9, 15.6)
Time to Next Treatment (Months)	
Patient Count (%)	19 (33.9%)
Median (95% CI)	NR (15.2, NR)

DISCUSSION

- The primary reason patients discontinued the previous covalent BTKi was AEs
- After the switch to zanubrutinib, median TTD for zanubrutinib was over 10 months and more than one third of patients were still on treatment at the end of the study period
- Median TTD on zanubrutinib in the follow-up was approximately 2.5 times longer than the time on acalabrutinib prior to switching
- Limitations include reliance on a real-world chart-abstraction design, which could be affected by abstractor bias, and a study population that was heterogeneous regarding the characteristics of the switch such as time between treatments

REFERENCES

1. Henshall C, et al. Int J Technol Assess Health Care. 2016 Jan;32(3):167-74.
2. Latimer NR, et al. Int J Technol Assess Health Care. 2016 Jan;32(3):160-66.
3. Latimer NR, et al. BMC Med Res Methodol. 2024 Jan 22;24(1):17.
4. Moria FA, et al. Curr Oncol. 2024 Jan 25;31(2):704-722.
5. Tasso B, et al. 2021 Dec 6;26(23):7411.
6. Mato AR, et al. Blood. 2016 Nov 3;128(18):2199-2205.

There are no head-to-head trials between zanubrutinib and acalabrutinib. This study is hypothesis-generating and does not establish comparable efficacy, safety, or product interchangeability

DISCLOSURES

DA: Consultancy for Novartis, research funding from Abbvie, AstraZeneca, Epizyme, Novartis, Ipsen. **ES**: Employment at BeOne, equity holder in BeOne, Roche. **GM**: Employment at BeOne, receipt of travel support and other services from, and consultancy for BeOne, CRISPR Therapeutics, equity holder in BeOne, Amgen, Gilead, CRISPR Therapeutics. **RC, MB**: Employment and equity holder in BeOne. **CW**: Employment at BeOne. **IZ**: Employment at McKesson, funding from BeOne. **YW**: Equity holder in McKesson

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