U.S. Phase I First-in-human Study of Taletrectinib (DS-6051b/AB-106), a ROS1/TRK Inhibitor, in Patients with Advanced Solid Tumors

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Purpose: Taletrectinib (DS-6051b/AB-106) is an oral, tyrosine kinase inhibitor of ROS1 and NTRK with potent preclinical activity against ROS1 G2032R solvent-front mutation among others. We report the first-in-human U.S. phase I results of taletrectinib.

Patients and Methods: Patients ≥18 years old with neuroendocrine tumors, with tumor-induced pain, or tumors harboring ROS1/NTRK rearrangements were eligible. Accelerated titration followed by modified continuous reassessment method and escalation with overdose control was used (50–1,200 mg once daily or 400 mg twice daily). Primary objectives were safety/tolerability, and MTD determination. Secondary objectives were food-effect pharmacokinetics and antitumor activity.

Results: A total of 46 patients were enrolled. Steady-state peak concentration (Cmax) and exposure (AUC0–24) increased dose dependently from 50-mg to 800-mg once-daily doses. The ratio of the geometric mean of AUC0–24 between low-fat-diet-fed/fasted state was 123% (90% confidence interval, 104%–149%). Dose-limiting toxicities (grade 3 transaminases increase) occurred in two patients (1,200-mg once-daily dose). MTD was 800 mg once daily. Most common treatment-related adverse events were nausea (47.8%), diarrhea (43.5%), and vomiting (32.6%). Pain score reductions were observed in the 800-mg once-daily dose cohort. Confirmed objective response rate was 33.3% among the six patients with RECIST-evaluable crizotinib-refractory ROS1+ NSCLC. One patient with TPM3-NTRK1 differentiated thyroid cancer achieving a confirmed partial response of 27 months at data cutoff. We identified a cabozantinib-sensitive ROS1 L2086F as an acquired taletrectinib-resistance mutation.

Conclusions: Taletrectinib has manageable toxicities at the MTD of 800 mg daily. Preliminary efficacy was observed in patients with crizotinib-refractory ROS1+ NSCLC.

Introduction

Receptor tyrosine kinase fusions are actionable driver alterations in solid malignancies (1). Tyrosine kinase inhibitors (TKIs) targeting these fusions such as crizotinib and entrectinib for ROS1 fusion–positive non–small cell lung cancer (NSCLC) and larotrectinib and entrectinib for TRK fusion–positive malignancies have been approved for clinical use (2–5). Resistance to these TKIs invariably develops and usually involves second site mutations such as gatekeeper mutation, xDFG motif mutations, and solvent-front mutation (1). Development of next-generation TKIs that can inhibit these acquired mutations is needed.

Furthermore, TrkB (NTRK2) signaling pathway is considered to be involved in the proliferation, tumorigenesis, and invasive nature of neuroendocrine tumors (NETs; ref. 6). In addition, ligand to the TRK receptors kinase such as nerve growth factor (NGF) which is a ligand to TrkA is involved in pain sensation and strategy to block NTRK pathway has been investigated for pain control TrkA (7). Taletrectinib (DS6051b/AB-106) is a highly selective type I ROS1/NTRK inhibitor. Taletrectinib demonstrates an enzymatic inhibition concentration at 50% (IC50) against ROS1, NTRK1, NTRK2, and NTRK3 of 0.207 nmol/L, 0.622 nmol/L, 2.28 nmol/L, and 0.980 nmol/L, respectively (8). In addition, it has potent growth inhibitory activity against both ROS1 L2026M gatekeeper mutation and ROS1 G2032R solvent-front mutation (growth inhibition at 50% GI50 = 4 nmol/L against ETV6-ROS1 wild-type (WT); GI50 = 14 nmol/L against ETV6-ROS1 L2026M; GI50 = 64 nmol/L against ETV6-ROS1 G2032R; refs. 8, 9). In silico docking study indicated while taletrectinib...
Translational Relevance
Receptor tyrosine kinase ROS1 fusion is an actionable driver mutation in solid malignancy. Crizotinib and entrectinib are two ROS1 tyrosine kinase inhibitors approved by the FDA to treat ROS1 fusion–positive non–small cell lung cancer. Resistance to ROS1 TKI invariably occurs and is the most common on-target resistance mechanism is the emergence of an acquired solvent-front mutation, ROS1 G2032R. Taletrectinib is a next-generation ROS1/NTRK1–3 inhibitor that can inhibit ROS1 G2032R potently in vitro. In this U.S. phase I study, taletrectinib was well tolerated and the MTD was 800 mg once daily. Preliminary activity of taletrectinib in crizotinib-resistant/refractory ROS1+ NSCLC and TRK TKI-naïve NTRK1 fusion–positive malignancy was observed. We identified a novel acquired resistance ROS1 mutation, ROS1 L2086F, as an on-target resistance mechanism to taletrectinib that can be inhibited by cabozantinib, a type II ROS1 TKI in vitro. A CD74-ROS1 L2086F NSCLC patient-derived durable clinical benefit with cabozantinib immediately post-taletrectinib.

Patients and Methods
This was a U.S. multicenter, nonrandomized, open-label, multipledose, first-in-human study of taletrectinib in patients with metastatic and/or unresectable solid tumors. The trial consisted of three portions: dose escalation, food effect, and an exploratory portion that enrolled patients with ROS1/NRTK1 alterations (determined by the tests performed at the investigators’ local institutions or commercial sequencing companies) at the MTD. The study was conducted under the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice. Written informed consent was obtained from all patients by the investigators and institutional review board of each investigational site approved the study.

The primary objectives for the dose-escalation portion were to assess the safety and tolerability of taletrectinib and to determine the dose-limiting toxicities (DLTs) and the MTD. The primary objective for the food effect portion of the study was to determine the effect of food on the pharmacokinetics (PK) of taletrectinib. Main secondary objective for both portions of the trial was to assess the preliminary objective response rate (ORR). The primary objective of the exploratory cohort was to investigate the preliminary clinical activity of taletrectinib against ROS1/NTRK1-3 rearranged tumors. Tumor assessments were every three cycles by RECIST 1.1. for the dose escalation and food-effect cohorts and every two cycles for the dose expansion cohort.

Patients with advanced NET were eligible as TrkB (+) with ≥ grade 2 AE. Definitions of hematologic and liver enzymes elevations DLT are listed in Supplementary Table S1. On the basis of 4 weeks of daily repeated-dose toxicity studies, the severely toxic dose in 10% of rats (STD10 = 100 mg/kg/day or 600 mg/m²/day) and the highest nonseverely toxic dose (HNSTD = 100 mg/kg/day or 1,200 mg/m²/day) in monkeys were determined. At this dose level, taletrectinib was generally tolerated and any findings were mainly resolved after a 4-week recovery period. Seventeen of STD10 is 60 mg/m² while 1/6 of HNSTD 200 mg/m². The 1/10 of STD10 in rats (60 mg/m²) is not considered a toxic dose in monkeys; therefore, the rat is considered the more sensitive species. The estimated maximum starting dose for this phase I clinical study would be 60 mg/m² (1.62 mg/kg) which is equivalent to a flat dose of 97.2 mg for a 60-kg person or approximately 100 mg. However, as a conservative approach, the starting dose of 50 mg/day is selected for this study based on nonclinical pharmacology study this starting dose still has the potential to demonstrate pharmacologic activity in humans (8).

Taletrectinib was dosed once daily in 21-day cycles. The dose escalation cohorts were 50, 100, 200, 400, 800, and 1,200 mg once daily. A 400-mg twice-daily cohort was added after 800 mg once daily was determined to be MTD. Dose reductions are 400 mg decrements. Standard PK parameters (Cmax, Tmax, and AUC) were determined using a noncompartmental analysis approach. The food effect schema is shown in Supplementary Fig. S2. Patients were assigned to receive a single dose of taletrectinib 400 mg under fasted or fed (low-fat meal) conditions on days -7 and -1, and then received taletrectinib 800 mg once daily (MTD) for a 21-day cycle. Low-fat meal consisted of 400–500 kcal per meal (100–125 kcal from fat, 11–14 grams of fat, and 25% fat composition). For food-effect evaluation, the ANOVA was determined using a log-transformed Cmax and AUC values.
In the dose-escalation cohort, 11 patients in the food-effect cohort had tumor stable disease (SD) on those days, pain intensity was measured using a visual analogue scale (0: least possible, 100: worst possible) on the Memorial Pain Assessment Card (12).

AEs were tabulated by event, relationship, and CTCAE grade. Summary statistics were calculated for safety parameters and efficacy parameters. ORR was calculated as the proportion of subjects demonstrating the best overall response of complete response (CR) or partial response (PR). Disease control rate (DCR) was calculated as the proportion of subjects demonstrating the best overall response of CR, PR, or stable disease (SD). Ninety-five percent confidence intervals (95%CI) were calculated on the basis of Wilson method (13).

\[ \text{Dose escalation and expansion} \ (N = 35) \]

<table>
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<tr>
<th>Dose escalation and expansion (N = 35)</th>
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Abbreviation: NOS, not otherwise specified.

*Others: One of each: appendiceal (food effect), breast, desmoid tumor, high-grade serous carcinoma of the fallopian tube, inflammatory myofibroblastic tumor, osteosarcoma, small-bowel carcinoma.

bIncluded mutations and fusions.

Table 1. Patient demographics and baseline characteristics (N = 46).

In vitro inhibition of ROS1 L2086F

cDNA encoding WT or L2086F-mutated CD74–ROS1 were cloned into P lent 6.3 (Invitrogen) using LR clonase. Each plasmid was transfected into 293FT cells by Fugene HD (Promega). Twenty-one hours after transfection, 300 nmol/L of ROS1 inhibitors (crizotinib, taletrectinib, lorlatinib, or cabozantinib) were treated for 3 hours. Then, the cell lysates were prepared using 1 × SDS lysis buffer [1% SDS and 10% glycerol in 100 mmol/L Tris-HCl (pH 7.5)]. Equal amount of proteins was electrophoresed and were immunoblotted with antibodies against phospho–ROS1 (Tyr2274, catalog no. 3078, Cell Signaling Technology), ROS1 (69D6, catalog no. 3266, Cell Signaling Technology), and β-actin (Sigma-Aldrich). All the primary antibody was used with 1:1,000 dilution for immunoblot analysis. Taletrectinib, crizotinib, and lorlatinib were synthesized at DaiichiSankyo Co. Ltd. Cabozantinib was purchased from ShangHai Biochempartner. Each compound was dissolved in DMSO for the cell culture experiments.

Statistical calculations

Duration of response (DOR) was calculated as the time from the first observation of response to the date of the first documentation of progressive disease (PD) according to RECIST 1.1 or death due to any cause, whichever occurred first. Time to progression (TTP) was defined as the time from the start of taletrectinib treatment to the date of the first documentation of PD according to RECIST 1.1. Progression-free survival (PFS) time was defined as the time from the start of taletrectinib treatment to the date of the first documentation of PD according to RECIST 1.1 or death due to any cause (whichever occurs first). PFS and TTP were summarized descriptively using the Kaplan–Meier method. Statistical analysis was performed using SAS (version 9.4).

Results

The trial began on September 24, 2014 and the data cutoff date was March 11, 2019. A total of 46 patients were enrolled (35 patients in the dose-escalation cohort, 11 patients in the food-effect cohort, and eight patients in the dose-expansion ROS1/NTRK cohort; Table 1; Supplementary Fig. S3). The majority of the patients were heavily pretreated with 82.6% of the patients having received ≥3 prior treatments. Three patients remained on treatment at the time of data cutoff. There were no patients with RECIST-defined measurable CNS metastasis enrolled.

PK

The plasma concentration of taletrectinib increased in a dose-dependent manner by visual inspection on cycle 1 day 1 (Fig. 1A).
Food effect

A total of 14 patients were enrolled into the food effect. Eight patients were randomly assigned to the fasted then fed sequence (fasted/fed) while six patients were randomly assigned to the fed then fasted (fed/fasted) sequence. Three patients (one fasted/fed and two fed/fasted) were found to be ineligible. Thus, 11 patients completed the 21-day food effect study [fed/fasted (N = 4); fasted/fed (N = 7)]. The geometric mean AUC_0-24 for the fasted state was 1,810 ng.hour/mL and the ratio of the geometric mean of AUC_0-24 between fed/fasted state was 123% (90% CI, 104%–149%) resulting in a 23% increase from fasted to fed state. The maximum concentration, C_max was 123.2 ng/mL (fasted) and 178.9 ng/mL (fed). The ratio of the geometric mean of C_max between low-fat-diet-fed/fasted was 145% (90% CI, 120%–175%) resulting in a 45% increase from fasted to fed state. The median T_max in the fed state was 5.0 hours compared with 3.92 hours in the fasted state (Fig. 1D).

DLTs

MTD was determined to be 800 mg once daily after two of three patients at 1,200 mg once daily developed DLTs. One patient at 1,200 mg once daily developed grade 3 ALT elevations and discontinued treatment after 6 days. In addition, one patient at the 800-mg once-daily dose expansion cohort developed grade 3 hyponatremia that resolved with dose interruptions for 4 days and resumed treatment at 400 mg once daily. Another patient at 400 mg twice daily dose who received prior nivolumab developed grade 3 rash that resolved after dose interruption with dose resumption at 200 mg once daily without further recurrence (see below).

Treatment-emergent adverse events/treatment-related adverse events

Treatment-emergent adverse events (TEAEs) occurred in all 46 (100.0%) patients. The three most common TEAEs were diarrhea (65.2%), nausea (57.1%), and vomiting (37.0%; Table 2). TEAEs most commonly associated with TRK (primarily TrkB) inhibition such as dysgeusia, dizziness, and dysesthesia occurred at a total incidence of 26.1%, 17.4%, and 15.2%, respectively with no grade 3 severity among these three AEs (Table 2).

Treatment-related AEs (TRAEs) occurred in 40 of 46 (87.0%) patients. The three most common TRAEs were nausea (47.8%), diarrhea (43.5%), and vomiting (32.6%). Grade 3 TRAEs were AST elevation (6.5%), diarrhea (2.2%), and fatigue (2.2%; Table 2). Of note, TRAEs related to specific TRK inhibition such as dysgeusia, numbness, and dysesthesia occurred in 23.9%, 15.2%, and 8.7%, respectively, with

Figure 1.
A, Single-dose PK curves with increasing dose of taletrectinib on cycle 1 day 1 (C1D1). B, Steady-state PK curves with increasing dose of taletrectinib on cycle 1 day 15 (C1D15 for 50 mg and 100 mg once daily). C, Projected free drug level of taletrectinib required to achieve IC50 and IC90 of ROS1 WT and IC50 and IC90 of ROS1 G2032R superimposed on the steady-state free drug levels of taletrectinib at various dosing concentration. D, Food effect PK curves with taletrectinib.
no grade 3 severity. Of the 46 patients treated, eight (17.4%) required ≥1 dose reduction with all dose reductions due to AEs. No patient had weight gain of >5% due to taletrectinib.

Seven patients received immune checkpoint inhibitors (ICIs) prior to taletrectinib (range, 129 to 50 days). Only one of the seven patients who received single-agent nivolumab developed grade 3 rash which resolved after stopping taletrectinib. The patient received nivolumab for 100 days and stopped 50 days prior to starting taletrectinib. While the rash was attributed to taletrectinib, it is unknown whether it was precipitated by prior ICI use. No other patients developed rash or other common potential immune-related AEs such as interstitial lung disease, pneumonitis colitis, or nephritis were not observed.

**Pain assessment**

Pain score assessment was collected every week during the dose-escalation cohorts. There was an increase in the mean pain intensity score in patients on 50 mg (N = 1) and 100 mg once daily (N = 1; Supplementary Fig. S4A and S4B), but then a decrease in the mean pain intensity score among patients who were on the 400 mg once daily (N = 3), 800 mg once daily (N = 9), and 400 mg twice daily (N = 6) cohorts (Supplementary Fig. 4D–F). There was no change in the mean pain intensity score for patients on the 200 mg once daily (N = 3) and 1,200 mg once daily (N = 2; Supplementary Fig. 4C and 4G).

**Efficacy**

Forty-one (89%) of 46 patients were evaluable for response (Fig. 2A; Supplementary Fig. S5A and S5B; Supplementary Table S3) including 12 patients with NET (Fig. 2B, Supplementary Table S5). There were four patients who achieved confirmed PRs (two patients with CD74-ROS1+ NSCLC, one patient with TPM3-NTRK1+ thyroid cancer, and one patient with small-bowel NET). The ORR of the 12 patients with NET was 8.3% (95% CI, 1.5–38.4) with one patient with small-bowel NET achieving confirmed PR with a median PFS of 10.2 months (95% CI, 1.2–not reached; Supplementary Fig. SSC and SSD). This patient initially presented with a 1-cm poorly differentiated nonfunctional, octreotide-scan positive small-bowel NET and multifocal hepatic metastases with the largest metastasis at 15 cm in 2003. The patient subsequently received radiofrequency ablation, primary resection, and partial liver resection, drugs targeting PI3/AKT/mTOR, MAPK, and WNT pathways, sandostatin and combination chemotherapy with SD as the best response (Supplementary Fig. S6A).

Genomic profiling of the small-bowel NET was unsuccessful due to insufficient available tumor tissue given the long storage time of the archival tumor tissue (diagnosed in 2003 and enrolled onto the current trial in 2014).

Among the six patients with RECIST-eligible ROS1+ NSCLC all of whom had progressed on crizotinib and were treated with either 800 mg once daily, 1,200 mg once daily, or 400 mg twice daily, the confirmed ORR is 33% (95% CI, 9.7–70.0) and median PFS is 4.1 months (95% CI, 0.5–14.2; Fig. 2C; Supplementary Fig. S4E and S4F; Supplementary Table S3). One of these two patients had crizotinib– and ceritinib-refractory ROS1+ NSCLC who received 1,200 mg once daily of taletrectinib and achieved a confirmed PR of 8 months prior to progression (Fig. 3A and B). The initial diagnosis of ROS1 rearrangement is by FISH. Next-generation sequencing using FoundationOne CDx (Foundation Medicine Inc) performed on the biopsy of a progressing liver metastasis while on taletrectinib revealed CD74-ROS1 and a ROS1 L2086F mutation both at an estimated mean allele frequency (MAF) of approximately 32% (Fig. 3C; ROC L2086F is analogous to ALK L1256F (Fig. 3D) which is susceptible to inhibition by a TKI without an extended L-ring. This patient was subsequently treated with cabozantinib, a type II ROS TKI, with a PR of 13 months (Fig. 3B and E; ref. 14). Treatment history of the other ROS1+ NSCLC patient achieved a confirmed PR in an IVEK fusion and a confirmed PR of 8 months after receiving cabozantinib, a type II ROS TKI (Fig. 3C).

Only one patient (metastatic TPM3-NTRK1+ papillary thyroid cancer) with an NTRK fusion enrolled to the study, who achieved a DOR of 33.4 months at the time of last tumor assessment (September 2019; Fig. 4). The treatment history of this TPM3-NTRK1 patient prior to taletrectinib included thyroidectomy, chemoradiation, radioactive I-131, sorafenib, phase I trials of targeted and/or ICIs but no prior
Efficacy of taletrectinib among all 41 evaluable patients
Spider plot of change of sum of diameter from baseline over time

Efficacy of AB-106 among NET patients
Spider plot of change of sum of diameter from baseline over time

Efficacy of AB-106 among confirmed crizotinib-refractory ROS1+ fusion patients
Spider plot of change of sum of diameter from baseline over time

Discussion

The MTD of taletrectinib was determined to be 800 mg once daily in this U.S. phase I study. In addition, the food-effect study indicates that a low-fat diet increased the taletrectinib level by 23%. The ratio of geometric mean of AUC_{0-24} between low-fat-diet-fed/fasted state was 123% (90% CI, 104%–149%) which is outside the range of the 90% CI of 80%–125% considered by the FDA for bioequivalence. Thus, taletrectinib is given without food in the current phase II trial of taletrectinib in patients with ROS1+ NSCLC in China (Clinical-Trials.gov Identifier: NCT04395677). The projected free plasma taletrectinib at 400 mg once daily is consistently at the IC_{90} necessary to inhibitor ROS1 G2032R. However, we do note that projected free plasma drug level does not necessary equate to similar intratumoral concentration. The current phase II clinical trial in China will enroll both patients who are TKI-naïve and those with TKI-refractory ROS1+ NSCLC.

Side effects of taletrectinib are primarily gastrointestinal in nature (diarrhea, nausea, vomiting) with DLTs being grade 3 liver enzymes elevation at 1,200 mg once daily. Grade 3 TRAEs from taletrectinib are uncommon (<5%) including TRAE-related TrkB inhibition (dysgeusia, dizziness, peripheral neuropathy/numbness; ref. 9). This may be related to the property of taletectinib where it is least potent against TrkB (8). Preliminary clinical efficacy was observed in patients with crizotinib-refractory ROS1+ NSCLC with a confirmed ORR of 33% among six evaluable patients. The resistance mechanisms to crizotinib-refractory ROS1+ NSCLC were not systematically captured prior to treatment with taletrectinib in this phase I trial. Thus, it is unknown if any of these six patients harbored the ROS1 G2032R solvent front mutation, the most common acquired resistance mutation to crizotinib (15, 16). In addition, one patient with TKI-naïve TPM3-NTRK fusion–positive thyroid cancer achieving an ongoing PFS of 33 months at the time of last follow-up (September 2019, Fig. 4).

A smaller phase I study in Japan that enrolled 15 patients with ROS1+ NSCLC concluded that the MTD and recommended phase II dose for taletrectinib was 600 mg once daily (17). Two grade 3 ALT elevations were observed at the 800-mg once-daily dose and were considered as DLTs. The steady level of taletrectinib when adjusted by weight is about 32% higher in Japanese patients than in U.S. patients. Diarrhea (53.3%), nausea (46.7%), constipation (33.3%), and creatinine elevation (33.3%) were the most common AEs observed. Among the total of 15 patients with ROS1+ NSCLC enrolled, ORR was 66.7% for the nine evaluable patients who were crizotinib-naïve and 33.3% for the three patients with evaluable crizotinib-refractory ROS1+. Activity against CNS metastasis was also observed (17). There was no patient with NTRK fusion–positive tumors or NET enrolled in the Japanese phase I trial (17).

The elimination half-life of taletrectinib could not be calculated on the basis of this study alone with conventional noncompartmental PK analysis due to insufficient sampling time duration postdose (only 24 hours post the first dose and 8 hours postdose on day 8/15). However, population PK analysis using pooled data from this study and Japan

NTRK TKIs. The NTRK fusion was detected by Foundation One CDx (Foundation Medicine Inc). Of the two neuroendocrine patients still on treatment at the time data cutoff, one patient has received taletrectinib treatment at 400 mg once daily for 47.2 months and the other patient has been on treatment at 800 mg once daily for 41.4 months (Fig. 2B).
phase I data (frequent and sparse PK sampling) indicates the elimination half-life at steady state is about 37.5 hours (geometric mean).

NGF is a ligand to TrkA is involved in pain sensation and strategy to block NTRK pathway has been investigated for pain control (17). Taletrectinib has been shown to be a NTRK inhibitor based on preclinical data and the one patient with NTRK1 fusion–positive thyroid cancer with durable response to taletrectinib. An exploratory analysis in this study revealed stabilization of or modest decrease in the pain intensity score at higher doses of taletrectinib (≥400 mg daily dose). Whether this pain decrease represents pain relief from tumor response or intrinsic pain relief by inhibition of the NTRK pathway remains to be determined.

This is the first report to identify ROS1 L2086F as a likely on-target resistance mutation to a ROS1 inhibitor. Although we did not perform any comprehensive genomic profiling prior to patient progressing on crizotinib and/or enrollment onto treatment with taletrectinib, several lines of indirect evidence indicate ROS1 L2086F is an acquired on-target resistance to taletrectinib. First, the MAF of ROS1 L2086F is relatively high at 32% and at almost identical to the MAF of the CD74-ROS1 fusion variant indicating ROS1 L2086F was not a minor clone. Second, ROS1 L2086F is analogous to the ALK L1256F mutation (Fig. 3D). ALK L1256F as a single or as compound mutation has been demonstrated to confer resistance to crizotinib or lorlatinib but sensitive to alectinib.

Figure 3.
A, Treatment timeline schema of the ROS1 NSCLC patient who progressed on chemotherapy, crizotinib, ceritinib and achieved a confirmed PR on taletrectinib. NGS on liver biopsy on progression on taletrectinib revealed a ROS1 L2086F. Patient achieved a confirmed PR on cabozantinib. B, Response images of the CD74-ROS1 NSCLC patient to taletrectinib. C, Integrated Genome Viewer (IGV) of the ROS1 L2086F mutation. MAF of the ROS1 L2086F is estimated be 32%. Hybrid-capture DNA sequencing indicated CD74-ROS1 variant at a MAF approximately 32%. D, ROS1 L2086F is analogous to ALK L1256F. E, Cabozantinib is a type II ROS1 inhibitor which has a large residue passing through the gatekeeper position and extending to the pack pocket and not interfering with F2086. F, Cabozantinib and taletrectinib inhibited the phosphorylation of ROS1 G2032R solvent-front mutation but not crizotinib or lorlatinib. Only cabozantinib inhibited phosphorylation of ROS1 L2086F mutation but not crizotinib, taletrectinib, or lorlatinib.
which lacks an L-shape structure (18, 19). Similarly, cabozantinib is a type II ROS1 inhibitor that also lacks an L-shape structure and extends to the pack pocket without steric interference from a phenylalanine at position 2086 (Fig. 3E). Third, in vitro experiments demonstrated that cabozantinib but not crizotinib, taletrecinib, or lorlatinib inhibited the phosphorylation of ROS1 L2086F (Fig. 3F). Fourth, given our patient achieved a confirmed PR to taletrecinib after progressing on crizotinib and ceritinib, the ROS1 L2086F mutation detected very likely emerged during treatment with taletrecinib. Consistent with our preclinical data, our patient responded to cabozantinib for >13 months indicating a ROS1-dependent resistance mechanism was responsible for the progression on taletrecinib given cabozantinib’s documented clinical activity against crizotinib-refractory ROS1+ NSCLC (14, 20). Finally, ROS1 L2086F has recently been shown to be an acquired resistance mutation to lorlatinib (21). Taken all the evidence to date, ROSI L2086F is likely on-target resistance mutation to taletrecinib. Our patient case also points to potential sequential use of ROS1 TKI, if and when solvent-front mutation such as L2086F emerges as resistance to type I ROS1 TKI, then cabozantinib can be potential considered albeit as off-label use for now.

Currently, crizotinib and entrectinib are the only two ROS1 TKIs approved in the United States for treatment of patients with TKI-naïve ROS1+ NSCLC (2, 3). Solvent-front mutation ROS1 G2032R mutation has been well documented as a resistance mechanism to crizotinib (15, 16). In addition, entrectinib is unlikely to overcome the acquired resistance ROS1 mutations including the most common solvent ROS1 G2032R solvent-front mutation based on preclinical data (22). In silico simulation suggested that docking pose of taletrecinib in ROS1 Gly2032 was almost the same as that in ROS1 WT (Supplementary Fig. S6A and S6B), while crizotinib showed a different docking pose in ROS1 Arg2032 from the binding mode in ROS1 WT (Supplementary Fig. S6C and S6D). Ceritinib, an approved ALK TKI, has demonstrated clinical activity in patients with TKI-naïve ROS1+ NSCLC but no clinical activity in those with crizotinib-refractory ROS1+ NSCLC (23). Lorlatinib, another ALK/ROS1 TKI, has demonstrated clinical activity in patients with crizotinib-refractory ROS1+ NSCLC with an ORR of 35% and median PFS of 8.5 months (24). However, of the six patients with ROS1 G2032R solvent-front mutation (two de novo and four acquired) in the lorlatinib study, the ORR to lorlatinib was 0% consistent with limited preclinical activity (cellular IC50 = 203 nmol/L) of lorlatinib against ROS1 G2032R mutation (24, 25). Furthermore, in the two patients who developed acquired ROS1 L2026M gatekeeper mutation, the ORR to lorlatinib was also 0% (23). Brigitinib, an ALK TKI, has reported clinical activity in one patient with ceritinib-refractory ROS1+ NSCLC (26). Repotrectinib, a next-generation ROS1/NTRK inhibitor, has demonstrated preliminary clinical activity against patients with crizotinib-refractory ROS1+ NSCLC (22, 27).

In this phase I study, taletrectinib has demonstrated good safety profile with long-term tolerability as some of the responding patients have been on taletrecinib for a prolonged period (Fig. 2A–C), once-a-day dosing convenience, and preliminary confirmed clinical activity in patients with crizotinib-refractory ROS1+ NSCLC for whom there is currently no approved next-generation ROSI TKI (Fig. 2C). Currently, one large-scale phase II clinical trials investigating the clinical efficacy of taletrecinib in patients with TKI-naïve and TKI-refractory ROS1+ NSCLC is ongoing in China (ClinicalTrials.gov Identifier: NCT04395677). In addition, a phase II trial will commence in Japan soon.

Disclosure of Potential Conflicts of Interest
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