Preclinical Development

FcRL5 as a Target of Antibody–Drug Conjugates for the Treatment of Multiple Myeloma

Kristi Elkins1, Bing Zheng1, MaryAnn Go1, Dionysos Slaga1, Changchun Du1, Suzie J. Scales1, Shang-Fan Yu1, Jacqueline McBride1, Ruth de Tute2,3, Andy Rawstron2,3, Andrew S. Jack3, Allen Ebens1, and Andrew G. Polson1

Abstract

Fc receptor-like 5 (FcRL5/FcRH5/IRTA2/CD307) is a surface protein expressed selectively on B cells and plasma cells. We found that FcRL5 was expressed at elevated levels on the surface of plasma cells from the bone marrow of patients diagnosed with multiple myeloma. This prevalence in multiple myeloma and narrow pattern of normal expression indicate that FcRL5 could be a target for antibody-based therapies for multiple myeloma, particularly antibody–drug conjugates (ADC), potent cytotoxic drugs linked to antibodies via specialized chemical linkers, where limited expression on normal tissues is a key component to their safety. We found that FcRL5 is internalized upon antibody binding, indicating that ADCs to FcRL5 could be effective. Indeed, we found that FcRL5 ADCs were efficacious in vitro and in vivo but the unconjugated antibody was not. The two most effective consisted of our anti-FcRL5 antibody conjugated through cysteines to monomethylauristatin E (MMAE) by a maleimidocaproyl-valine-citrulline-p-aminobenzyloxycarbonyl (MC-vcPAB) linker (anti-FcRL5-MC-vcPAB-MMAE) or conjugated via lysines to the maytansinoid DM4 through a disulfide linker (anti-FcRL5-SPDB-DM4). These two ADCs were highly effective in vitro in combination with bortezomib or lenalidomide, drugs in use for the treatment of multiple myeloma. These data show that the FcRL5 ADCs described herein show promise as an effective treatment for multiple myeloma. Mol Cancer Ther; 11(10); 2222–32. ©2012 AACR.

Introduction

Multiple myeloma is a malignancy of plasma cells characterized by skeletal lesions, renal failure, anemia, and hypercalcemia. It is essentially incurable by current therapies. Current drug treatments for multiple myeloma include combinations of the proteosome inhibitor bortezomib (Velcade), the immunomodulator lenalidomide (Revlimid), and the steroid dexamethasone. We have been searching for surface targets that could be used to develop antibody-based therapies for multiple myeloma. Unfortunately, unmodified antibodies to most surface targets have little, if any, efficacy. Therefore, in addition to the identification of potential targets, an appropriate technology to enhance the antibody antitumor efficacy needs to be identified as well. One approach to making effective antibody therapies is to conjugate the antibodies to cytotoxic drugs via specialized chemical linkers creating antibody–drug conjugates (ADC). ADCs provide a means to target cytotoxic drugs to neoplastic cells, reducing the nonspecific systemic effects of the cytotoxic drug while retaining any efficacy of the antibody (1, 2), and this technology has been applied to multiple myeloma (reviewed in ref. 3). One of the major obstacles to the development of ADCs for the treatment of multiple myeloma is the selection of a suitable surface antigen. Expression of the target antigen on normal tissues can result in dose-limiting toxicities; thus, tumor specificity of the ADC target is desirable. Such tumor-specific targets are rare in practice, limiting choices to those with highly selective expression in tumor tissues and/or normal tissue expression either at low levels on nonvital normal tissues, or, at a minimum, expression on tissues that are not susceptible to the drug. Clinical experiences with ADCs and naked antibody therapies to B-cell lineage restricted targets (e.g., CD20 and CD22) that deplete normal B-cells that have proven safe and effective (3). In principle, a target that is expressed on normal B cells and plasma cells as well as multiple myeloma cells could provide an appropriate target because the normal cell types can be regenerated and, in the case of targeted chemotherapies, the normal tissue would be less sensitive to the toxin. The well-characterized B-cell-specific antigens are lost when B cells mature into plasma...
cells. Surface markers associated with multiple myeloma such as CD38, CD138, and CD56 have relatively broad expression patterns including normal tissues that may cause target-dependent toxicity (3). However, several ADCs to some of these targets for the treatment of multiple myeloma are in clinical development (see discussion).

The Fc receptor-like 5 (FcRL5, also known as FcRH5 and IRTA2) belongs to a family of 6 recently identified genes of the immunoglobulin superfamily (IgSF). This family of genes is closely related to the Fc receptors with the conserved genomic structure, extracellular Ig domain composition and the ITIM- and ITAM-like signaling motifs (4). The ligand(s) for FcRL5 are unknown, but FcRL5 has been implicated in enhanced proliferation and downstream isotype expression during the development of antigen-primed B cells (5). The FcR genes are clustered together in the midst of the classical FcR genes, FcγRI, FcγRII, FcγRIII, and FcεRI, in the 1q21–23 region of chromosome 1. This region contains 1 of the most frequent secondary chromosomal abnormalities associated with malignant phenotype in hematopoietic tumors, especially in multiple myeloma (6). FcRL5 is expressed only in the B-cell lineage, starting as early as pre-B cells, but does not attain full expression until the mature B-cell stage. Unlike all other B–cell-specific surface proteins (e.g., CD20, CD19, and CD22), FcRL5 continues to be expressed in plasma cells whereas other B–cell-specific markers are downregulated (7). In addition, FcRL5 mRNA is overexpressed in multiple myeloma cell lines with 1q21 abnormalities as detected by oligonucleotide arrays (8). The expression pattern indicates that FcRL5 could be a target for antibody-based therapies for the treatment of multiple myeloma. In this study, we showed that FcRL5 has a high prevalence on the surface of multiple myeloma, validated it as a target for the use of ADCs, characterized 2 ADCs that have the potential to be used in humans, and showed that these anti-FcRL5 ADCs increase the effectiveness of current multiple myeloma therapies in xenograft preclinical models.

Materials and Methods

Antibodies

Antibodies to FcRL5 were generated and characterized as previously described (7). Antibody cross-reactivity to Cynomolgus monkey (cyto) FcRL5 was tested by flow cytometry using a stably transfected cell line expressing cyto FcRL5 (the clone a kind gift from Sothy Yi). Both anti-FcRL5(13G9) and anti-FcRL5(10A8) cross-reacted to cyto FcRL5 and were humanized as previously described (9).

Cell lines

Because cultured multiple myeloma cell lines down-regulate FcRL5, transgenic stable cell lines expressing human and cyto FcRL5 were established. The EJM and OPM2 multiple myeloma cell lines (no authentication was done by the authors) were transfected with human FcRL5 using the Amaxa Nucleofector system. After puromycin selection, the EJM pool was sorted for human FcRL5 expression by flow cytometry (Epics Elite; Beckman Coulter) resulting in the EJM-CMV.PD.FcRL5.LSP.2 (EJM-FcRL5) cell line, and the OPM2 pool was sorted for human FcRL5 expression using the MACS Separation System (Miltenyi Biotec) resulting in the OPM2-CMV.PD.FcRL5. SP2 (OPM2-FcRL5) cell line. The SVT2 cell line was transfected with cyto FcRL5 using Lipofectamine 2000 (Invitrogen). After G418 selection, the SVT2 pool was sorted for cyto FcRL5 by flow cytometry resulting in the SVT2.MSCV.gD.cyFcRL5.SP.2 cell line.

Cell viability assay

The in vitro efficacy of anti-FcRL5(13G9) ADCs was determined using an ADC dosing titration on OPM2-FcRL5. Before ADC addition, cells were plated in quadruplicate at 75 × 10^5 per well in 384-well plates in RPMI containing 10% FBS and allowed to attach overnight. Anti-FcRL5(13G9) ADCs or the control anti-GP120 ADCs were added to experimental wells to final concentration of 10, 3.3, 1.1, 0.37, 0.12, 0.041, 0.014, or 0.0046 μg/mL, with "non-drug conjugate" control wells receiving medium alone. After 72-hour incubation at 37 °C, cell viability was measured using the CellTiter-Glo Luminescent Cell Viability Assay (Promega Corp). The concentration of anti-FcRL5(13G9) ADCs resulting in the 50% inhibition of cell viability was calculated from a 4-variable curve analysis.

Scatchard analysis

To determine binding affinity (Kd), 0.5 nmol/L 125I labeled Hu Anti-FcRL5(10A8) was competed against unlabeled Hu Anti-FcRL5(10A8), respectively, ranging from 50 to 0.02 nmol/L (12 step 1:2 serial dilution) in the presence of OPM2-FcRL5 or SVT2.MSCV.gD.cyFcRL5. SP.2 cells. After incubation at 4 °C for 4 hours, cells were washed, and cell pellet counts were read by a gamma counter (1470 WIZARD Automatic Gamma Counter; Perkin Elmer). All points were carried out in triplicate and counted for 10 minutes. The average CPM were used for Kd calculation using the New Ligand (Genentech) program. Binding affinity for Hu Anti-FcRL5(13G9) was determined using the same protocol.

Flow cytometry

Bone marrow aspirates were collected from patients during their initial presentation for diagnosis of a suspected plasma cell disorder or follow-up assessment. FcRL5 expression levels were determined on plasma cells within bone marrow aspirates from patients diagnosed as having multiple myeloma (n = 16) or monoclonal gammopathy of uncertain significance (MGUS; n = 11). Additional data were collected from 7 subjects that were ultimately diagnosed as having no evidence of bone marrow lymphoma (normal controls). Leukocytes from bone marrow aspirates were prepared via ammonium chloride lysis of erythrocytes. In summary, a volume of the sample (between 0.5 and 1.5 mL) was
incubated with a 10-fold excess of ammonium chloride (8.6 g/L in distilled H2O; Vickers Laboratories) for 5 minutes at 37°C. The leukocytes were then washed twice in buffer (FACSFlow; Becton Dickinson Biosciences) containing 0.3% bovine serum albumin (BSA; Sigma). Leukocytes were stained with cocktails of Abs for 20 minutes at 4°C and washed twice in buffer before acquisition on a Canto II instrument (Becton Dickinson Biosciences). A minimum of 100,000 events were collected per sample. Fluorescently conjugated antibodies were used in combinations against the following markers: CD45 Pacific Orange (HI30; Invitrogen), CD20 Pacific Blue (B9E9; Beckman Coulter), CD19 PE-Cy7(3-119; Beckman Coulter), CD38 APC-AF750 (LS198-4-3; Beckman Coulter), CD138 APC (B-B4; Miltenyi), FcRL5 PE (10A8, mouse anti-human FcRL5; Genentech Inc), and CD56 PE (MY31; Becton Dickinson Biosciences).

Data analysis was carried out using FACSDiva software. Plasma cells were defined by strong CD138 and CD38 expression, CD45 Lo with light scatter characteristics of large mononuclear cells. Pan B cells were identified as CD19+CD138-, CD45 Hi with lymphoid light scatter characteristics. The median fluorescence intensity (MFI) for each antibody was derived for both cell populations: total plasma cells and pan B cells. MFIs for FcRL5 were normalized by subtraction of the MFI of the appropriate conjugated isotype antibody (CD34PE) in Tube 2 within the same gated population. The isotype antibodies used in the panel were specific to non-B-cell markers.

**Internalization studies**

OPM2 wild type or OPM2-FcRL5 were incubated on ice for 1 hour in complete carbonate-independent medium ( Gibco) or at 37°C in growth media containing 3 µg/mL murine or humanized anti-FcRL5(10A8) or isotype controls (murine anti-gD tag or trastuzumab hlgG1, respectively) and lysosomal protease inhibitors (10 µg/mL leupeptin and 5 µmol/L pepstatin; Roche). Cells were then washed twice, fixed with 3% paraformaldehyde (Electron Microscopy Sciences), quenched with 50 mmol/L NH4Cl (Sigma), permeabilized with 0.4% saponin/2% FBS/1% Triton X-100, and added to the protein solution in ratios of 6 to 8 moles of SPDB to 1 mole of antibody to achieve a final drug:antibody ratio of 3–4:1. The linker conjugation reaction was carried out at room temperature for 90 minutes followed by the addition of 1.7-fold excess DM4 over SPDB and an overnight reaction. The conjugates were purified using gel filtration, ion exchange chromatography, or dialysis.

**Animal studies**

All animal studies were carried out in compliance with National Institutes of Health guidelines for the care and use of laboratory animals and were approved by the Institutional Animal Care and Use Committee at Genentech, Inc.

To establish subcutaneous xenograft models, the tumor cells (2 × 10^7 cells in 0.2 mL Hank’s Balanced Salt Solution; HyClone) were inoculated subcutaneously into the flanks of female CB17 ICR SCID mice (7 to 16 weeks of age from Charles Rivers Laboratories). When mean tumor size reached the desired volume, the mice were divided into groups of 7 to 10 mice with the same mean tumor size and dosed intravenously (i.v.) via the tail vein with ADCs or antibodies.

Bortezomib (Velcade) was obtained from Millennium Pharmaceuticals, Inc., and dissolved in 0.9% sodium chloride at the appropriate concentration before drug injection. Mice were dosed by intravenous injection at 1 mg/kg twice weekly for 2 weeks.

Lenalidomide (Revlimid) was supplied by the ECA International Corporation and dissolved in dimethyl sulfoxide (DMSO). Immediately before use, lenalidomide was further diluted in 0.5% methylcellulose and 0.2% Tween 80, and administered intraperitoneally into mice at 50 mg/kg once a day for 13 days.

The SCID-rab model was carried out as previously described (12). To establish SCID-rabbit bone model, the tibia, humerus, ulna, and radius were harvested from New Zealand White rabbits (3 to 4 weeks of age from Myrtle Rabbitry), and fractioned into fragments (1 to 2 cm^3 size). The bone fragments were then surgically engrafted into the flanks of female CB17 ICR SCID mice (6 to 8 weeks of age from Harlan Sprague Dawley). At 6 to 8 weeks post bone engraftment, the LD cells (1 × 10^6 cells in 50 µL PBS; ref. 13) were injected directly into the engrafted bone. The LD line was maintained by serial passage because of poor in vitro growth. Blood samples were taken periodically to assess tumor burden by measuring the amount of human lambda light chain in serum. When the amount of human lambda light chain reached the desired serum level, mice were randomized into groups of 8 to 10 with the same mean serum concentration and received weekly intravenous injections of ADCs for 2 weeks.

**Antibody conjugation**

MCC-DM1 (Immunogen, Inc), MC-MMAF (Seattle Genetics, Inc) ADCs were prepared as previously described (10, 11). N-succinimidyl-3-O-pyridylidithio-butyrate-DM4 (SPDB-DM4; Immunogen, Inc) conjugates were prepared using purified antibody in 50 mmol/L potassium phosphate at pH 7.5 containing 50 mmol/L NaCl and 2 mmol/L EDTA. SPDB was dissolved in 100% ethanol and added to the protein solution in ratios of 6 to 8 moles of SPDB to 1 mole of antibody to achieve a final drug:antibody ratio of 3–4:1. The linker conjugation reaction was carried out at room temperature for 90 minutes followed by the addition of 1.7-fold excess DM4 over SPDB and an overnight reaction. The conjugates were purified using gel filtration, ion exchange chromatography, or dialysis.
Results

Expression of FcRL5 in multiple myeloma

FcRL5 expression levels were assessed on B cells and plasma cells within bone marrow aspirate samples from patients diagnosed with either multiple myeloma \((n = 16)\) or MGUS \((n = 11)\) and compared with plasma cells \((n = 7)\) from normal control cases. FcRL5 expression was present on all plasma cells, however expression levels differed among groups. As shown in Fig. 1A, the expression levels of FcRL5 appeared to be quite variable and elevated on bone marrow plasma cells derived from both multiple myeloma and MGUS patients, with MFIs ranging from 191 to 10654 and 490 to 6477, respectively, compared with 289 to 897 on normal plasma cells from control cases. The differences between multiple myeloma or MGUS patients and normal

![Image of Figure 1](https://example.com/figure1.png)

**Figure 1.** FcRL5 expression on plasma cells. A, FcRL5 is expressed on the surface of bone marrow resident plasma cells of multiple myeloma (MM) or MGUS patients and normal subjects. FcRL5 expression levels were assessed by flow cytometry on plasma cells from bone marrow aspirates of MM \((n = 16)\) or MGUS cases \((n = 11)\) and controls \((n = 7)\). All MFIs were normalized by subtraction of the isotype control MFIs. The horizontal line indicates the sample median and the box and lines represent the 25th and 75th quartiles, respectively. B, FcRL5 can be used to identify plasma cells. FcRL5 expression was measured by flow cytometry using a conjugated murine anti-human FcRL5 monoclonal antibody. Plasma cell populations were gated using FSc/SSc and CD38, CD138, CD45, CD19 markers. Combinations of FcRL5 with CD138 or CD38 are shown as compared with the CD38/CD138 combination. The percentages of CD45<sup>Lo</sup> plasma cells are shown in each combination from both a representative patient with MM and a normal control subject (Normal).
controls were statistically significant, with the prob > chi-squared values being 0.0092 and 0.0164, respectively, as determined using the Wilcoxin (Kruskal–Wallis) test. Within the same subjects, we found that CD19⁺ B lymphocytes had either low or barely detectable FcRL5 expression across all subjects tested (data not shown). Furthermore, it appears that FcRL5 staining in combination with CD38 staining can identify plasma cells or multiple myeloma cells as effectively as the CD38/CD138 combination, currently used. The percentages of cells found in the CD138/CD38 gate were replicated with the CD38/FcRL5 and the CD138/FcRL5 combinations (Fig. 1B). Moreover, in samples that are CD138Hi CD38Hi, 100% of the cells from the FcRL5/CD38⁺⁺ population were also CD138 Hi, indicating that the FcRL5/CD38 marker combination does not pick up non-plasma cells (Fig. 1B). These observations indicate that the addition of FcRL5 to the current CD138 and CD38 plasma cells markers could only improve the diagnostic sensitivity and accuracy of multiple myeloma cell detection, especially with aberrant immunophenotypes or should technical difficulties interfere with their detection.

One of the major obstacles of immunotherapy for multiple myeloma, especially with ADCs, is the selection of a suitable surface antigen. The fact that FcRL5 is elevated in multiple myeloma or MGUS compared with normal plasma cells, and that its levels are low on pan B cells, render FcRL5 an excellent target for immunotherapy.

**Validation of FcRL5 as an ADC target for the treatment of multiple myeloma**

The expression pattern of FcRL5 indicated that it would be a good target for the use of antibody or ADC therapy for the treatment of multiple myeloma. To validate this hypothesis, we sought to identify cell lines where we could test potential anti-FcRL5 therapies. We identified 10 cell lines that expressed FcRL5 RNA but found none that expressed significant amounts of surface FcRL5. We have observed a similar downregulation of other FcRL family proteins on cultured cells compared with the primary tissue expression levels (data not shown). To circumvent this problem, we developed 2 transgenic multiple myeloma cell lines, OPM2-FcRL5 and EJM-FcRL5, which stably express surface FcRL5 (see methods). During growth, in both in vitro and as xenograft models, OPM2-FcRL5 and EJM-FcRL5 cells express levels of surface FcRL5 that are equivalent to the higher end and the
mean levels of expression found in multiple myeloma patient cells, respectively (data not shown).

Internalization upon antibody binding can be a key feature that determines whether a target will be more suited to a naked antibody approach that uses antibody-dependent cell cytotoxicity (ADCC) and requires an extended duration of antibody binding on the cell surface, as compared with an ADC therapy where internalization to facilitate drug delivery is desirable. Anti-FcRL5 antibody bound specifically to OPM2-FcRL5 cells versus controls (Fig. 2A) and was internalized within 2 hours (Fig. 2B). By 13 hours, anti-FcRL5 was almost completely delivered to lysosomes, as detected by colocalization with LAMP1 (Fig. 2C–E). Uptake was specific, because an isotype control antibody gave no signal (Fig. 2C–E insets) and no anti-FcRL5 signal was seen in OPM2 cells lacking FcRL5 (insets in A, B; data not shown). These data show that anti-FcRL5 is well internalized upon binding and, thus, has properties that would make it an appropriate target for ADCs.

We sought to further test our hypothesis that FcRL5 would make a good target for ADCs by testing the effectiveness of 4 ADC formats, all of which use potent inhibitors of microtubule polymerization as the active drug. We tested maytansinoid conjugates linked to the antibody through the ε-amino group of lysine with an uncleavable thioester linker (MCC-DM1) or a hindered disulfide reducible linker (SPDB-DM4). In addition, we tested the monomethylauristatins linked to antibody cysteines with an uncleavable maleimidocaproyl (MC) linker (MC-MMAF) and a protease cleavable linker (MC-vc-PAB-MMAE; see ref. 14 and Fig. 3 for detailed descriptions of these linker drugs).

The anti-FcRL5-MC-vc-PAB-MMAE, anti-FcRL5-MC-MMAF, and anti-FcRL5-SPDB-DM4 ADCs had similar efficacy in vitro, whereas anti-FcRL5-MCC-DM1 appeared less potent in comparison (Fig. 4A). In vivo, only the cleavable linker ADCs, namely anti-FcRL5-MC-vc-PAB-MMAE and anti-FcRL5-SPDB-DM4, showed strong antitumor efficacy (Fig. 4B); however, all the FcRH5 conjugates showed significant activity compared with vehicle and its corresponding control conjugates. In addition, the activity of the FcRH5 conjugates is significantly different from each other (Supplementary Fig. S1). Unconjugated anti-FcRL5 antibodies did not have any efficacy in vitro or in vivo (Fig. 5A and data not shown), consistent with their rapid internalization and lack of ADCC induction. These data indicate that FcRL5 is a potential target for the treatment of multiple myeloma with ADCs containing cleavable linkers.

Figure 3. Structures of key small molecules. A and B, structure of MC-vc-PAB-MMAE attached to an interchain disulfide bond (A) and SPDB-DM4 attached to antibody lysine (B). The drug-to-antibody ratio for the ADCs was 3.4. Only 1 linker drug is shown for clarity. C, structure of bortezomib (Velcade). D, structure of lenalidomide (Revlimid).
Generation of anti-FcRL5 ADCs suitable for treatment of humans

To generate ADCs suitable for the treatment of humans, we tested our anti-FcRL5 antibodies for cross-reactivity to cynomolgus monkeys with the goal of having FcRL5 ADCs that would be suitable for target-dependent safety studies in non-human primates (NHP). We found that both anti-FcRL5(13G9) and anti-FcRL5(10A8) cross-reacted with cynomolgus monkey FcRL5 with high affinity (data not shown). Anti-FcRL5(13G9) and anti-FcRL5(10A8) were humanized using previously described methods to generate anti-FcRL5(hu13G9) and anti-FcRL5(hu10A8) (9). These humanized antibodies that cross-react to cynomolgus monkey could serve as a basis for anti-FcRL5 antibody therapies to be tested in NHP for safety and subsequently used in humans in the clinic.

Next, we conjugated anti-FcRL5(hu10A8) to SPDB-DM4 and MC-vc-PAB-MMAE and tested the 2 resultant ADCs at several dose levels in our 2 xenograft models. In the OPM2-FcRL5 model, a single dose of anti-FcRL5(13G9) and anti-FcRL5(10A8) cross-reacted with cynomolgus monkey FcRL5 with high affinity (data not shown). Anti-FcRL5(13G9) and anti-FcRL5(10A8) were humanized using previously described methods to generate anti-FcRL5(hu13G9) and anti-FcRL5(hu10A8) (9). These humanized antibodies that cross-react to cynomolgus monkey could serve as a basis for anti-FcRL5 antibody therapies to be tested in NHP for safety and subsequently used in humans in the clinic.

Next, we conjugated anti-FcRL5(hu10A8) to SPDB-DM4 and MC-vc-PAB-MMAE and tested the 2 resultant ADCs at several dose levels in our 2 xenograft models. In the OPM2-FcRL5 model, a single dose of anti-FcRL5(hu10A8)-MC-vc-PAB-MMAE or anti-FcRL5(hu10A8)-SPDB-DM4 resulted in complete tumor remission (Fig. 5A and B). Substantial responses included complete remissions with anti-FcRL5(hu10A8)-MC-vc-PAB-MMAE in the EJM-FcRL5 model (Fig. 5C and D). In contrast, the unconjugated anti-FcRL5(hu10A8) or the negative control trastuzumab ADCs had very little, if any, effect on tumor growth, which indicates that the activity seen with the anti-FcRL5 ADCs was due to the target-specific delivery of cytotoxic drugs to the tumors, rather than ADCC. Interestingly, the EJM-FcRL5 model responded better than OPM2-FcRL5 to the FcRL ADCs despite having a lower expression level of FcRL5. In addition, anti-FcRL5-SPDB-DM4 was more effective than anti-FcRL5-MC-vc-PAB-MMAE in the OPM2-FcRL5 model, whereas their efficacy was switched in the EJM-FcRL5 model. These data show that anti-FcRL5 ADCs have excellent preclinical efficacy in xenograft models of multiple myeloma and that, even in cases where one anti-FcRL5 ADC is not effective, another one can be.

To further explore the effectiveness of our anti-FcRL5 ADCs we tested anti-FcRL5-SPDB-DM4 in a xenograft model that better recapitulates the biology of multiple myeloma cells, such as the stromal–multiple myeloma cell interactions and naturally expressed FcRL5. We used a SCID-rab model in which bone grafts were established subcutaneously in SCID mice and subsequently injected with human LD tumor cells (12, 13). LD cells express FcRL5 and are dependent on stromal cells for survival. When co-cultured in vitro with stromal cells, LD cells could be maintained, but lost their FcRL5 expression, which led us to maintain them by serial passage in the in vivo SCID-rab bone multiple myeloma model. Because the cells secrete IgA1, we monitored tumor growth by using ELISA for human lambda light chain (hulg). When the average serum hulg concentration reached...
594 ng/mL, the mice were grouped out and treated. Mice treated with vehicle and control ADC continued to have an increase in serum huIg, whereas the anti-FcRL5-SPDB-DM4–treated mice showed a reduction in the serum human Ig that later increased after treatment had stopped (Fig. 6). These data show that, even in a higher bar in vivo model of multiple myeloma, supported by host stromal interactions, anti-FcRL5 ADCs can be effective.

Combining ADC with current drug treatments of multiple myeloma

Multiple myeloma is a difficult disease to treat; it is incurable and no single new treatment is likely to cure patients. Thus, it is important to establish whether anti-FcRL5 ADCs could combine with current therapies to improve treatment outcomes. We tested our 2 anti-FcRL5 ADCs in combination with bortezomib in the OPM-2-FcRL5 xenograft model. Biweekly doses of 1 mg/kg bortezomib (the maximum tolerated dose in this model) had similar efficacy as a single dose of 4 mg/kg of the anti-FcRL5-SPDB-DM4 or anti-FcRL5-MC-vc-PAB-MMAE, which slowed tumor growth without substantially regressing the tumors. However, the combination of anti-FcRL5-SPDB-DM4 and bortezomib resulted in 8 of 9 complete tumor remissions (Fig. 7A). Bortezomib plus anti-FcRL5-SPDB-DM4 showed significant activity compared with bortezomib alone (P < 0.0001; Supplementary Fig. S2), whereas bortezomib plus control-SPDB-DM4 did not (P = 0.081). Anti-FcRL5-MC-vc-PAB-MMAE plus bortezomib resulted in 3 of 9 complete tumor remissions (Fig. 7B). Anti-FcRL5-MC-vc-PAB-MMAE alone showed the same activity as bortezomib alone (P = 0.7383). The combination was significantly more efficacious than either single agent alone (P < 0.0001; Supplementary Fig. S3). In addition, we tested the combination of anti-FcRL5-MC-vc-PAB-MMAE and lenalidomide in the OPM2-FcRL5 xenograft model. Thirteen daily doses of 50 mg/kg lenalidomide (the maximum tolerated dose in this model) had...
similar efficacy as a single dose of 6 mg/kg anti-FcRL5-MC-vc-PAB-MMAE (Fig. 7C); in both cases tumor growth slowed but there was no substantially regression of the tumors. The combination at the same doses caused regression of the tumors resulting in 8 of 8 tumors having partial remission. Anti-FcRL5-MC-vc-PAB-MMAE alone showed the same activity as lenalidomide alone ($P = 0.5453$) and the combination was more effective than either single agent alone ($P < 0.0001$; Supplementary Fig. S4).

Mice receiving single-agent anti-FcRL5 ADCs continued gaining weight over time, when tracked along with the vehicle group. In contrast, mice receiving bortezomib or lenalidomide had between 5% and 10% weight loss. In addition, the combination groups had 5% to 10% weight loss, indicating that anti-FcRL5 ADCs combined well with bortezomib or lenalidomide, and did not appear to exacerbate the weight loss caused by bortezomib or lenalidomide.

These data show that anti-FcRL5 ADCs, when used in combination with current treatments, can lead to substantially improved therapeutic outcomes.

Discussion

In this work, we examined FcRL5 as a target for antibody-based therapies. Our data characterizing FcRL5 as a marker indicate that the addition of FcRL5 to the current CD138 and CD38 plasma cell markers can further improve the diagnostic sensitivity and accuracy of multiple myeloma cell detection, especially in cases with aberrant immunophenotypes or when technical difficulties interfere with detection.

We detected FcRL5 expression on plasma cells from the vast majority of patients with multiple myeloma, which, combined with its restricted expression pattern and prevalence, led us to the conclusion that FcRL5 could be a target for antibody-based therapies for multiple myeloma.

One aspect of FcRL5 biology that could slightly complicate the use of anti-FcRL5 antibody therapies is that there is a soluble form of FcRL5 in circulation that is elevated in patients with multiple myeloma (15). This circulating form of FcRL5 could interfere with antibody-based therapies at low doses of antibody therapy or in the first few treatments.

Our results indicate that, while unmodified anti-FcRL5 antibodies are not effective therapeutically, anti-FcRL5 ADCs show promising antitumor efficacy in multiple preclinical models. We report on 2 anti-FcRL5 ADCs suitable for further testing in NHPs and use in humans. The linker drugs we have used, MC-vc-PAB-MMAE and SPDB-DM4, show promise in the context of other ADCs in early clinical trials. Brentuximab vedotin (SGN-35, anti-CD30-MC-vc-PAB-MMAE) is currently under development for the treatment of Hodgkin lymphoma (16) and CDX-011 (Anti-GPNMB MC-vc-PAB-MMAE) for the treatment of breast cancer and melanoma. In both cases, the maximum tolerated dose is $1.8$ mg/kg every 3 weeks with the primary dose-limiting toxicities being diarrhea and leukopenia and, in the case of CR011, target-mediated skin toxicities (17). nBT062 (anti-CD138-SPDB-DM4) is being tested for the treatment of multiple myeloma. CD138 is found on the basolateral surface of epithelial cells, vascular smooth muscle cells, and the endothelium (ref. 18 and references therein). nBT062 has shown promising preclinical activity in xenograft models of multiple myeloma (19, 20) and, on the basis of these data, a phase 1 clinical trial was started where patients were treated every 3 weeks at 7 dose levels ranging from 10 to 200 mg/m$^2$. The skin, eye, and gastrointestinal tract are the target organs for toxicity at high doses (21). The ocular toxicity is probably not target dependent as this has been observed with other ADCs containing the SPDB-DM4 linker drug.
However, the skin and GI toxicity could be due to target expression in these tissues. In the 20 evaluable patients, 7 showed clinical benefit and 2 showed an objective response. In addition to nBT062, an ADC targeting CD56, IMGN901 (huN901-DM1), is in phase 1 clinical trials. IMGN901 (huN901-DM1) is a humanized anti-CD56 antibody with a linker cleavable by disulfide reduction (SPP) attached to the maytansinoid DM1. CD56 is expressed in NK cells, a subpopulation of T lymphocytes, neural tissue, and muscle. Although CD56 is not found in normal plasma cells, it is expressed in 70% of multiple myeloma (23). In the current phase 1 trial, patients with CD56+ relapsed or refractory multiple myeloma received a single intravenous infusion of IMGN901 on 2 consecutive weeks every 3 weeks at doses ranging from 40 to 140 mg/m². Headache, fatigue, and neuropathy were the major adverse events and 1 of the 25 patients showed a partial response. That patient had been on treatment for more than a year (24).

FcRL5 offers advantages over other ADC targets for the treatment of multiple myeloma because the normal tissue expression of FcRL5 is limited to B cells and plasma cells and it is found on most, if not all, multiple myeloma. A broader expression pattern can lead to damage of normal tissues and more rapid clearance of the ADC due to the antigen acting as a sink, limiting the therapeutic potential of the ADC. FcRL5-ADCs can overcome these problems and deliver the therapeutic agent selectively to the tumor, thus increasing the therapeutic index. The promising

Figure 7. Anti-FcRL5 ADCs showed greater activity when combined with standard of care therapeutics. OPM2-FcRL5 cell line (2 × 10⁴) was injected into mice, and the resulting tumors were treated with: A, a single dose of 4 mg anti-FcRL5-SPDB-DM4/kg mouse or twice weekly doses as indicated (arrows) of 1 mg bortezomib/kg mouse as single-agent or in combination. Average starting volume was 306 mm³ for the groups of 9 mice. B, a single dose of 4 mg anti-FcRL5-MC-vc-PAB-MMAE/kg mouse or twice weekly doses as indicated (arrows) of 1 mg bortezomib/kg mouse as single-agent or in combination. Average starting volume was 331 mm³ for the groups of 9 mice. C, a single dose of 6 mg anti-FcRL5-MC-vc-PAB-MMAE/kg mouse and daily doses as indicated (line) of 50 mg lenalidomide/kg mouse as single-agent or in combination. Average starting volume was 446 mm³ for the groups of 8 mice. Error bars represent SEM.
clinical data with other ADCs using MC-vc-PAB-MMAE and SPDB-DM4, combined with our preclinical efficacy data in several multiple myeloma preclinical models, clearly show that both anti-FcRL5-MC-vc-PAB-MMAE and anti-FcRL5-SPDB-DM4 are potentially effective ADCs for the treatment of multiple myeloma, both as single agents and especially in combination with currently approved multiple myeloma therapeutics.

Disclosure of Potential Conflicts of Interest
A. Rawstron has honoraria from Speakers Bureau of Roche and GlaxoSmithKline and is a consultant/advisory board member for Celgene, Biogen Idec, and BD Biosciences. No potential conflicts of interest were disclosed by the other authors.

Authors' Contributions
Writing, review, and/or revision of the manuscript: K. Elkins, B. Zheng, M. A. Go, S.-F. Yu, J. McBride, A. Rawstron, A. Eben, A. G. Polson
Administrative, technical, or material support: K. Elkins, M. A. Go, J. McBride
Study supervision: S.-F. Yu

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Kristi Elkins, Bing Zheng, MaryAnn Go, et al.


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