METHODS FOR INCREASING FORCED EXPIRATORY VOLUME IN ASTHMATICS USING BENRALIZUMAB

Reference to Sequence Listing

[0001] The instant application contains a Sequence Listing which has been submitted electronically in ASCII format and is hereby incorporated by reference in its entirety. Said ASCII copy, created on July 16, 2014, is named IL5R-604WO1_SL.txt and is 15,971 bytes in size.

BACKGROUND

[0002] More than 300 million people around the world have asthma. Despite the use of long-acting bronchodilators and inhaled corticosteroids, asthma continues to be a major source of morbidity worldwide. (Masoli M, *et al. Allergy 59*: 469-78(2004)).

[0003] Relapse following acute asthma exacerbation has been reported to range from 41 to 52% at 12 weeks despite the use of systemic steroids upon discharge (Lederle F, *et al. Arch Int Med 147*:2201-03 (1987)). Management of these patients has proved problematic due either to severe refractory disease or inability and/or unwillingness to comply with medical treatment. In one study of patients admitted to the hospital, some with near fatal asthma, 50% were non-compliant with systemic corticosteroids at 7 days following discharge (Krishnan J, *et al. AJRCCM 170*: 1281-85 (2004)). Many factors may contribute to non-compliance including poor access to routine quality healthcare (particularly in the inner city), lack of education or understanding of their disease, unwillingness to accept the chronic nature of their disease, or inability to obtain medications.

[0004] Many lines of evidence implicate eosinophils as one of the main causative cells of asthmatic airway inflammation (James A. *Curr Opin Pulm Med 11*(1):1-6 (2005)). Peripheral blood (PB) eosinophilia is a risk factor for relapse of acute asthma (Janson C and Herala M. *Resp Med 86*(2):101-104 (1992)). In subjects with peripheral blood eosinophilia, the risk of dying from asthma was 7.4 (confidence interval, 2.8-19.7) times greater than in those without eosinophilia (Ulrik C and Fredericksen J. *Chest 108*:10-15 (1995)). Necropsy results have identified 2 distinct pathogenic inflammatory mechanisms of fatal asthma (Restrepo R and Peters J. *Curr Opin Pulm Med 14*: 13-23 (2008)). A neutrophilic infiltrate is more prominent in those dying suddenly (approximately within 2 hours on onset of symptoms), while an eosinophilic infiltrate is

more common in those dying from more protracted asthma crises. Sputum and blood eosinophils can also be increased in patients presenting to the ED with rapid onset of asthma symptoms (Bellido-Casado J, *et al. Arch Bronconeumol 46*(11): 587-93 (2010)). Therapies that target eosinophils lead to a reduction in the number and severity of asthma exacerbations as compared to the use of clinical guidelines (Green R, *et al. Lancet 360*:1715-21 (2002); Haldar P, *et al. NEJM 360*:973-84 (2009)).

[0005] Benralizumab (MEDI-563) is a humanized monoclonal antibody (mAb) that binds to the alpha chain of the interleukin-5 receptor alpha (IL-5Rα), which is expressed on eosinophils and basophils. It induces apoptosis of these cells via antibody-dependent cell cytotoxicity. A single intravenous (IV) dose of benralizumab administered to adults with mild asthma provoked prolonged PB eosinopenia likely due to the effects on eosinophil/basophil bone marrow progenitors that express the target (Busse W, *et al. JACI 125*: 1237-1244 e2 (2010)). In addition, a single dose of benralizumab significantly reduced the blood eosinophil count in subjects who presented to the emergency department with a severe asthma exacerbation, but did not impact pulmonary function (WO 2013/066780).

[0006] Thus, given the high unmet need of increasing lung function, e.g., as measured by forced expiratory volume in one second (FEV_1), in patents with asthma and that some patients with asthma have an eosinophilic component, the effect of benralizumab on the forced expiratory volume in one second (FEV_1) in adult subjects were examined.

BRIEF SUMMARY

[0007] Methods of increasing forced expiratory volume in one second (FEV_1) in an asthma patient are provided herein. In certain aspects, a method of increasing forced expiratory volume in one second (FEV_1) in an asthma patient, comprises administering to the patient an effective amount of benralizumab or an antigen-binding fragment thereof.

[0008] Methods of treating asthma are also provided herein. In certain aspects, a method of treating asthma comprises administering to an asthma patient an effective amount of benralizumab or an antigen-binding fragment thereof, wherein the patient has a blood eosinophil count of at least 300 cells/μl prior to the administration.

[0009] In certain aspects, a method of treating asthma comprises administering to an asthma patient an effective amount of benralizumab or an antigen-binding fragment

thereof, wherein the patient has a forced expiratory volume in one second (FEV_1) of at least 75% predicted value prior to the administration.

[0010] In certain aspects, a method of treating asthma comprises administering at least two doses of benralizumab or an antigen-binding fragment thereof to an asthma patient.

[0011] In certain aspects of the methods provided herein, the administration increases the patient's FEV_1. In certain aspects, the administration increases the patient's FEV_1 within 4 weeks of the first administration. In certain aspects, the $FEV_1$is increased by at least 0.1 L. In certain aspects, the $FEV_1$is increased by at least 0.13 L. In certain aspects, the $FEV_1$is increased by at least 0.2 L. In certain aspects, the FEV_1 is increased by at least 0.25 L. In certain aspects the FEV_1 is increased by at least 0.50 L.

[0012] In certain aspects of the methods provided herein, the asthma is eosinophilic asthma. In certain aspects, the patient has a blood eosinophil count of at least 300 cells/μl.

[0013] In certain aspects of the methods provided herein, the patient has a forced expiratory volume in one second (FEV_1) of at least 75% predicted value prior to the administration. In certain aspects, the patient has an asthma control questionnaire score of at least 1.5 prior to the administration. In certain aspects, the patient uses high-dose inhaled corticosteroids (ICS). In certain aspects, the patient uses long-acting β2 agonists (LABA). In certain aspects, the patient has a history of exacerbations. In certain aspects, the history of exacerbations comprises at least two exacerbations in the year prior to the administration of benralizumab or an antigen-binding fragment thereof. In certain aspects, the history of exacerbations comprises no more than six exacerbations in the year prior to the administration of benralizumab or an antigen-binding fragment thereof.

[0014] In certain aspects of the methods provided herein, at least two doses of benralizumab or an antigen-binding fragment thereof are administered to the patient.

[0015] In certain aspects of the methods provided herein, benralizumab or an antigen-binding fragment thereof is administered at about 2 mg to about 100 mg per dose. In certain aspects, benralizumab or an antigen-binding fragment thereof is administered at about 20 mg per dose. In certain aspects, benralizumab or an antigen-binding fragment thereof is administered at about 30 mg per dose. In certain aspects, benralizumab or an antigen-binding fragment thereof is administered at about 100 mg per dose.

[0016] In certain aspects of the methods provided herein, benralizumab or an antigen-binding fragment thereof is administered once every four weeks to once every twelve weeks. In certain aspects, benralizumab or an antigen-binding fragment thereof is administered once every four weeks. In certain aspects, benralizumab or an antigen-binding fragment thereof is administered once every eight weeks. In certain aspects, benralizumab or an antigen-binding fragment thereof is administered once every four weeks for twelve weeks and then once every eight weeks.

[0017] In certain aspects of the methods provided herein, benralizumab or an antigen-binding fragment thereof is administered parenterally. In certain aspects, benralizumab or an antigen-binding fragment thereof is administered subcutaneously.

[0018] In certain aspects of the methods provided herein, benralizumab or an antigen-binding fragment thereof is administered in addition to corticosteroid therapy.

[0019] In certain aspects, a method of increasing forced expiratory volume in one second (FEV_1) in an asthma patient comprises administering to the patient 20-100 mg of benralizumab or an antigen-binding fragment thereof, wherein the patient has an blood eosinophil count of at least 300 cells/μl prior to the administration. In certain aspects, the method comprises administering 20 mg of benralizumab or an antigen-binding fragment thereof. In certain aspects, the 20 mg of benralizumab is administered once every four weeks for twelve weeks and then once every eight weeks. In certain aspects, the method comprises administering 30 mg of benralizumab or an antigen-binding fragment thereof. In certain aspects, the 30 mg of benralizumab is administered once every four weeks for eight weeks and then once every eight weeks. In certain aspects, the 30 mg of benralizumab is administered once every four weeks. In certain aspects, the method comprises administering 100 mg of benralizumab or an antigen-binding fragment thereof. . In certain aspects, the 100 mg of benralizumab is administered once every four weeks for twelve weeks and then once every eight weeks.

[0020] In certain aspects, a method of treating asthma in an asthma patient comprises administering to the patient a dose of at least 2 and less than 100 mg of benralizumab or an antigen-binding fragment thereof. In certain aspects, the method comprises administering 20 mg of benralizumab or an antigen-binding fragment thereof. In certain aspects, the method comprises administering 30 mg of benralizumab or an antigen-binding fragment thereof. In certain aspects, the method comprises administering a dose

of at least 20 and less than 100 mg of benralizumab or an antigen-binding fragment thereof. In certain aspects, the method comprises administering a dose of at least 30 and less than 100 mg of benralizumab or an antigen-binding fragment thereof. In certain aspects, the method decreases exacerbation rates of asthma. In certain aspects, the method decreases annual exacerbation rates of asthma. In certain aspects, the administration is subcutaneous.

[0021] In certain aspects of the provided methods, administration of benralizumab or an antigen-binding fragment thereof results in the increase in forced expiratory volume in one second (FEV_1) as shown in Figures 2-9.

[0022] In certain aspects of the provided methods, administration of benralizumab or an antigen-binding fragment thereof results in the increase in forced expiratory volume in one second (FEV_1) as shown in Examples 1-2.

BRIEF DESCRIPTION OF THE DRAWINGS/FIGURES

[0023] **Figure 1** shows the study flow diagram.

[0024] **Figure 2** shows the change in forced expiratory volume in one second (FEV_1) at 24-weeks after treatment with placebo, 2 mg benralizumab, 20 mg benralizumab, or 100 mg benralizumab in patients with fewer than 300 eosinophils/μl and patients with at least 300 eosinophils/μl.

[0025] **Figure 3** shows the interim (24 weeks) and Stage I (52 weeks) change in FEV_1 after treatment with placebo, 2 mg benralizumab, 20 mg benralizumab, or 100 mg benralizumab in patients with fewer than 300 eosinophils/μl and patients with at least 300 eosinophils/μl

[0026] **Figure 4** shows the interim (24 weeks) and Stage I (52 weeks) change in FEV_1 after treatment with placebo, 2 mg benralizumab, 20 mg benralizumab, or 100 mg benralizumab in patients with medium or high use of inhaled corticosteroids (ICS).

[0027] **Figure 5** shows the interim (24 weeks) and Stage I (52 weeks) change in FEV_1 after treatment with placebo, 2 mg benralizumab, 20 mg benralizumab, or 100 mg benralizumab in patients with fewer than 300 eosinophils/μl and (i) medium use of ICS or (ii) high use of ICS.

[0028] **Figure 6** shows the interim (24 weeks) and Stage I (52 weeks) change in FEV_1 after treatment with placebo, 2 mg benralizumab, 20 mg benralizumab, or 100 mg

benralizumab in patients with at least 300 eosinophils/μl and (i) medium use of ICS or (ii) high use of ICS.

[0029] **Figures 7A and 7B** show the changes in FEV_1 in patients with various eosinophil counts.

[0030] **Figure 8** shows the time course of mean FEV_1 in patients with at least 300 eosinophils/μl.

[0031] **Figure 9** shows the time course of mean FEV_1 in patients with less than 300 eosinophils/μl.

DETAILED DESCRIPTION

[0032] It is to be noted that the term "a" or "an" entity refers to one or more of that entity; for example, "an anti-IL-5α antibody" is understood to represent one or more anti-IL-5α antibodies. As such, the terms "a" (or "an"), "one or more," and "at least one" can be used interchangeably herein.

[0033] Provided herein are methods for increasing the forced expiratory volume in one second (FEV_1) in patients with asthma. The methods provided include administering an effective amount of benralizumab or an antigen-binding fragment thereof.

[0034] Information regarding benralizumab (or fragments thereof) for use in the methods provided herein can be found in U.S. Patent Application Publication No. US 2010/0291073 A1, the disclosure of which is incorporated herein by reference in its entirety. Benralizumab and antigen-binding fragments thereof for use in the methods provided herein comprise a heavy chain and a light chain or a heavy chain variable region and a light chain variable region. In a further aspect, benralizumab or an antigen-binding fragment thereof for use in the methods provided herein includes any one of the amino acid sequences of SEQ ID NOs: 1-4. In a specific aspect, benralizumab or an antigen-binding fragment thereof for use in the methods provided herein comprises a light chain variable region comprising the amino acid sequence of SEQ ID NO:1 and a heavy chain variable region comprising the amino acid sequence of SEQ ID NO:3. In a specific aspect, benralizumab or an antigen-binding fragment thereof for use in the methods provided herein comprises a light chain comprising the amino acid sequence of SEQ ID NO: 2 and heavy chain comprising the amino acid sequence of SEQ ID NO:4. In a specific aspect, benralizumab or an antigen-binding fragment thereof for use in the

methods provided herein comprises a heavy chain variable region and a light chain variable region, wherein the heavy chain variable region comprises the Kabat-defined CDR1, CDR2, and CDR3 sequences of SEQ ID NOs: 7-9, and wherein the light chain variable region comprises the Kabat-defined CDR1, CDR2, and CDR3 sequences of SEQ ID NOs: 10-12. Those of ordinary skill in the art would easily be able to identify Chothia-defined, Abm-defined or other CDRs. In a specific aspect, benralizumab or an antigen-binding fragment thereof for use in the methods provided herein comprises the variable heavy chain and variable light chain CDR sequences of the KM1259 antibody as disclosed in U.S. 6,018,032, which is herein incorporated by reference in its entirety.

[0035] In certain aspects, a patient presenting at a physician's office or ED with asthma is administered benralizumab or an antigen-binding fragment thereof. Given the ability of benralizumab to reduce or deplete eosinophil counts for up to 12 weeks or more (*see* US 2010/0291073), benralizumab or an antigen-binding fragment thereof can be administered only once or infrequently while still providing benefit to the patient in increasing the forced expiratory volume in one second (FEV_1). In further aspects the patient is administered additional follow-on doses. Follow-on doses can be administered at various time intervals depending on the patient's age, weight, ability to comply with physician instructions, clinical assessment, eosinophil count (blood or sputum eosinophils), Eosinophilic Cationic Protein (ECP) measurement, Eosinophil-derived neurotoxin measurement (EDN), Major Basic Protein (MBP) measurement and other factors, including the judgment of the attending physician. The intervals between doses can be every four weeks, every five weeks, every 6 weeks, every 8 weeks, every 10 weeks, every 12 weeks, or longer intervals. In certain aspects the intervals between doses can be every 4 weeks, every 8 weeks or every 12 weeks. In certain aspects, the single dose or first dose is administered to the asthma patient shortly after the patient presents with an acute exacerbation, *e.g.*, a mild, moderate or severe exacerbation. For example, the single or first dose of benralizumab or an antigen-binding fragment thereof can be administered during the presenting clinic or hospital visit, or in the case of very severe exacerbations, within 1, 2, 3, 4, 5, 6, 7, or more days, *e.g.*, 7 days of the acute exacerbation, allowing the patient's symptoms to stabilize prior to administration of benralizumab.

[0036] In some embodiments, at least two doses of benralizumab or antigen-binding fragment thereof are administered to the patient. In some embodiments, at least three

doses, at least four doses, at least five doses, at least six doses, or at least seven doses are administered to the patient. In some embodiments, benralizumab or an antigen-binding fragment thereof is administered over the course of four weeks, over the course of eight weeks, over the course of twelve weeks, over the course of twenty-four weeks, or over the course of a year.

[0037] The amount of benralizumab or an antigen-binding fragment thereof to be administered to the patient will depend on various parameters such as the patient's age, weight, clinical assessment, eosinophil count (blood or sputum eosinophils), Eosinophilic Cationic Protein (ECP) measurement, Eosinophil-derived neurotoxin measurement (EDN), Major Basic Protein (MBP) measurement and other factors, including the judgment of the attending physician. In certain aspects, the dosage or dosage interval is not dependent on the sputum eosinophil level.

[0038] In certain aspects the patient is administered one or more doses of benralizumab or an antigen-binding fragment thereof wherein the dose is about 2 mg to about 100 mg, for example about 20 mg to about 100 mg, or about 30 mg to about 100 mg. In certain specific aspects, the patient is administered one or more doses of benralizumab or an antigen-binding fragment thereof where the dose is about 20 mg, about 30 mg, about 40 mg, about 50 mg, about 60 mg, about 70 mg, about 80 mg, about 90 mg, or about 100 mg. In some embodiments, the dose is about 20 mg. In some embodiments the dose is about 30 mg. In some embodiments, the dose is about 100 mg.

[0039] In certain aspects, administration of benralizumab or an antigen-binding fragment thereof according to the methods provided herein is through parenteral administration. For example, benralizumab or an antigen-binding fragment thereof can be administered by intravenous infusion or by subcutaneous injection.

[0040] In certain aspects, benralizumab or an antigen-binding fragment thereof is administered according to the methods provided herein in combination or in conjunction with additional asthma therapies. Such therapies include, without limitation, inhaled corticosteroid therapy, long- or short-term bronchodilator treatment, oxygen supplementation, or other standard therapies as described, *e.g.*, in the NAEPP Guidelines. In certain aspects, use of the methods provided herein, *i.e.*, administration of benralizumab or an antigen-binding fragment thereof to an asthma patient with a history

of acute exacerbations serves as adjunct therapy in situations of poor compliance with standard forms of asthma management.

[0041] The methods provided herein can significantly increase forced expiratory volume in one second (FEV_1) in asthmatics. An increase can be measured based on the expected FEV_1 based on a large patient population, on the FEV_1 measured in a control population, or on the individual patient's FEV_1 prior to administration. In certain aspects, the patient population is those patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year. In certain aspects, the patient population is those patients who had ≥2 exacerbations requiring systemic corticosteroid bursts in the past year and ≤6 exacerbations requiring systemic corticosteroid bursts in the past year. In certain aspects, the patient population is patients having an eosinophil count of at least 300 cells/μl.

[0042] In certain aspects, use of the methods provided herein, *i.e.*, administration of benralizumab or an antigen-binding fragment thereof increases the forced expiratory volume in one second (FEV_1) over a 24-week period following administration of benralizumab or an antigen-binding fragment thereof, as compared to the patient's baseline FEV_1. In certain aspects, the patient can receive follow on doses of benralizumab or an antigen-binding fragment thereof at periodic intervals, *e.g.*, every 4 weeks, every 5 weeks, every 6 weeks, every 8 weeks, every 12 weeks, or as scheduled based on patient's age, weight, ability to comply with physician instructions, clinical assessment, eosinophil count (blood or sputum eosinophils), Eosinophilic Cationic Protein (ECP) measurement, Eosinophil-derived neurotoxin measurement (EDN), Major Basic Protein (MBP) measurement and other factors, including the judgment of the attending physician. Use of the methods provided herein can increase FEV_1 by at least 0.05 L, at least 0.1 L, at least 0.13 L, at least 0.15 L, at least 0.20 L, at least 0.21 L, at least 0.22 L, at least 0.23 L, at least 0.24 L, or at least 0.25 L, at least 0.30 L, at least 0.35 L, at least 0.40 L, at least 0.45 L, or at least 0.50 L over the 24-week period.

[0043] In other aspects, use of the methods provided herein, *i.e.*, administration of benralizumab or an antigen-binding fragment thereof to an asthma patient, increases the forced expiratory volume in one second (FEV_1) of patient over a 52-week period following administration of the benralizumab or antigen-binding fragment thereof. In certain aspects, the patient can receive follow on doses of benralizumab or an antigen-binding fragment thereof at periodic intervals, *e.g.*, every 4 weeks, every 5 weeks, every 6

weeks, every 8 weeks, every 12 weeks, or as scheduled based on patient's age, weight, ability to comply with physician instructions, clinical assessment, eosinophil count (blood or sputum eosinophils), Eosinophilic Cationic Protein (ECP) measurement, Eosinophil-derived neurotoxin measurement (EDN), Major Basic Protein (MBP) measurement and other factors, including the judgment of the attending physician. In certain aspects, the interval is every 4 weeks, every 8 weeks or every 12 weeks. Use of the methods provided herein can increases the forced expiratory volume in one second (FEV_1) by at least 0.05 L, at least 0.1 L, at least 0.13 L, at least 0.15 L, at least 0.20 L, at least 0.21 L, at least 0.22 L, at least 0.23 L, at least 0.24 L, or at least 0.25 L, at least 0.30 L, at least 0.35 L, at least 0.40 L, at least 0.45 L, or at least 0.50 L over the 24-week period.

[0044] In certain aspects, use of the methods provided herein, *i.e.*, administration of benralizumab or an antigen-binding fragment thereof increases the forced expiratory volume in one second (FEV_1) within 4 weeks, within 8 weeks, within 12 weeks, within 16 weeks, within 20 weeks, within 24 weeks, within 28 weeks, within 32 weeks, within 36 weeks, within 40 weeks, within 44 weeks, within 48 weeks, or within 52 weeks.

[0045] In certain aspects, use of the methods provided herein, i.e., administration of benralizumab or antigen-binding fragment thereof to an asthma patient, increases forced expiratory volume in one second (FEV_1), reduces the annual exacerbation rate, and/or improves an asthma questionnaire score (e.g., the asthma control questionnaire (ACQ)).

[0046] In certain aspects, the patient is "eosinophilic positive" meaning the patient is one whose asthma is likely to be eosinophilic.

[0047] In certain aspects, the asthma patient has a particular blood eosinophil count, e.g., prior to the administration of benralizumab or an antigen-binding fragment thereof. Blood eosinophil counts can be measured, for example, using a complete blood count (CBC) with cell differential.

[0048] In certain aspects, the asthma patient has a blood eosinophil count of at least 300 cells/µl prior to the administration of benralizumab or an antigen-binding fragment thereof. In certain aspects, the asthma patient has a blood eosinophil count of at least 350 cells/µl, at least 400 cells/µl, at least 450 cells/µl, or at least 500 cells/µl prior to the administration of benralizumab or an antigen-binding fragment thereof.

[0049] In certain aspects, the asthma patient has a blood eosinophil count of less than 300 cells/µl prior to the administration of benralizumab or an antigen-binding fragment

thereof. In certain aspects, the asthma patient has a blood eosinophil count of at least 100 cells/μl, at least 150 cells/μl, at least 180 cells/μl, at least 200 cells/μl, or at least 250 cells/μl prior to the administration of benralizumab or an antigen-binding fragment thereof.

[0050] In certain aspects, the asthma patient was prescribed or has been using a medium-dose of inhaled corticosteroids (ICS) use prior to the administration of benralizumab or an antigen-binding fragment thereof. A medium-dose of ICS can be a dose of at least 600 μg to 1,200 μg budesonide daily or an equivalent dose of another ICS.

[0051] In certain aspects, the asthma patient was prescribed or had been using a high-dose of ICS use prior to the administration of benralizumab or an antigen-binding fragment thereof. A high-dose of ICS can be a dose of at least 1,200 μg budesonide daily or an equivalent dose of another ICS. A high dose of ICS can also be a dose of greater than 1,200 μg to 2000 μg budesonide daily or an equivalent dose of another ICS.

[0052] In certain aspects, the asthma patient was prescribed or has been using oral corticosteroids prior to the administration of benralizumab or an antigen-binding fragment thereof. In certain aspects, administration of benralizumab or an antigen-binding fragment thereof decreases the use of oral corticosteroids in an asthma patient. In certain aspects, the administration decreases the use of oral corticosteroids in an asthma patient by at least 50%.

[0053] In certain aspects, the asthma patient was prescribed or had been using a long-acting beta agonist (LABA) prior to the administration of benralizumab or an antigen-binding fragment thereof.

[0054] In certain aspects, the asthma patient was prescribed or had been using both ICS and LABA prior to the administration of benralizumab or an antigen-binding fragment thereof.

[0055] In certain aspects, the asthma patient has a blood eosinophil count of at least 300 cells/μl and high ICS use prior to the administration of benralizumab or an antigen-binding fragment thereof.

[0056] In certain aspects, the asthma patient has a forced expiratory volume in 1 second (FEV_1) of at least 40% and less than 90% predicted value prior to the administration of benralizumab or an antigen-binding fragment thereof. In some embodiments, the FEV_1 is greater than 70% predicted value prior to the administration of benralizumab or an

antigen-binding fragment thereof. In some embodiments, the FEV_1 is greater than 70% and less than 90% predicted value prior to the administration of benralizumab or an antigen-binding fragment thereof. In some embodiments, the FEV_1 is at least 75% predicted value prior to the administration of benralizumab or an antigen-binding fragment thereof. In some embodiments, the FEV_1 is at least 75% and less than 90% prior predicted value to the administration of benralizumab or an antigen-binding fragment thereof. In some embodiments, the FEV_1 is at least 80% predicted value prior to the administration of benralizumab or an antigen-binding fragment thereof. In some embodiments, the FEV_1 is at least 80% and less than 90% predicted value prior to the administration of benralizumab or an antigen-binding fragment thereof.

Examples

EXAMPLE 1: Patients and Methods

(a) SUBJECTS

[0057] Subjects in this study were required to be 18 to 75 years of age with a weight of greater than 45 kg and less than or equal to 150 kg (greater than 100 pounds, but less than or equal to 330 pounds). They also must have had a physician diagnosis of asthma for a minimum of 12 months prior to screening as well as physician prescribed daily use of medium-dose or high-dose inhaled corticosteroids (ICS) plus long-acting beta agonist (LABA) or any combination of sequential dosing of either medium-dose or high-dose ICS/LABA for at least 12 months prior to screening. Medium and high-doses of ICS as defined in this study are shown in Table 1 below.

Table 1: Estimated Comparative Daily Dosages for Inhaled Corticosteroids

Drug	Medium Daily Dose (Adult)	High Daily Dose (Adult)
Beclamethazone HFA/MDI 40 or 80 µg/puff	> 240-480 µg	> 480 µg
Budesonide DPI 90, 180, or 200 µg/inhalation	> 600-1,200 µg	> 1,200 µg
Ciclesonide HFA/MDI 80 or 160 µg/inhalation	> 160-320 µg	> 320-1280 µg
Flunisolide CFC/MDI 250 µg/puff	> 1,000-2,000 µg	> 2,000 µg
Flunisolide HFA/MDI 80 µg/puff	> 320-640 µg	> 640 µg
Fluticasone HFA/MDI: 44, 110, or 220 µg/puff DPI: 50, 100, or 250 µg/puff	> 264-440 µg > 300-500 µg	> 440 µg > 500 µg
Mometasone DPI 200 µg/inhalation	400 µg	> 400 µg
Triamcinolone acetonide CFC/MDI 75 µg/puff	> 750-1,500 µg	> 1,500 µg

CFC = chlorofluorocarbon; DPI = dry powder inhaler; HFA = hydrofluoroalkane; MDI = metered dose inhaler.

[0058] The dose of other asthma controller medications must have been stable in the subjects for at least 30 days prior to screening. Subjects must also have had at least 2, but no more than 6, documented asthma exacerbations in the 12 months prior to screening that required the use of a systemic corticosteroid burst. Subjects must also have had a morning pre-bronchodilator forced expiratory volume in 1 second (FEV_1) of at least 40% and less than 90% predicted during the screening/run-in period (described below). Subjects must also have fulfilled one of the following criteria:

a) Proof of post-bronchodilator reversibility of airflow obstruction ≥ 12% and ≥ 200 mL documented within 36 months prior to randomization or proof of a positive response [PC20 ≤ 8 mg/mL] to a methacholine challenge documented within 36 months prior to randomization; OR

b) A post-bronchodilator increase in FEV_1 ≥ 12% and ≥ 200 mL at Week -3 screening visit; OR

c) If a) and b) were not met and all other inclusion/exclusion criteria were met, subjects with a FEV_1 of ≥ 1.5 L and ≥ 60% predicted on the Week -2 screening visit were eligible to undergo a methacholine challenge at the Week-2 screening visit at sites

where methacholine testing was available. If the subject achieved a positive response, (PC20 ≤ 8 mg/mL), then this inclusion criterion was met.

[0059] Subjects must also have had an Asthma Control Questionnaire (ACQ) score of at least 1.5 at least twice during the screening/run-in period.

[0060] Subjects were not able to participate if they had a cigarette exposure of 10 pack-years or more or had been smoking within 12 months prior to screening or had any condition (e.g., any eosinophilic lower respiratory disease other than asthma, chronic obstructive pulmonary disease (COPD), or cystic fibrosis) that, in the opinion of the investigator or medical monitor, would interfere with the evaluation. Subjects were also not able to participate if they had received an oral corticosteroid burst or short-acting systemic corticosteroid within 30 days prior to screening or during the screening/run-in period.

(b) DESIGN OF THE STUDY

[0061] The study was a phase 2b randomized, double-blind, placebo-controlled, dose-ranging, multicenter study (ClinicalTrials.gov number: NCT01238861) in which multiple doses of benralizumab were administered subcutaneously to asthma patients. Benralizumab was administered at 2, 20, or 100 mg doses, and patients were followed for 1 year. The study flow diagram is shown in Figure 1.

[0062] A 3-week screening/run-in period preceded administration of benralizumab or placebo. During the 3-week period, subjects continued to use the same medium-dose or high-dose ICS/LABA combination product as prior to the participation in the study (doses of ICS/LABA were required to be stable for 30 days prior to the 3-week screening/run-in period). Subjects remained on the same dose of ICS/LABA throughout the study.

[0063] The administered benralizumab composition contained benralizumab (50 mg/mL), 10 mM histidine, 10 mM histidine HCl monohydrate, 9% (w/v) trehalose dihydrate, and 0.004% (w/v) polysorbate-20, pH 6. The administered placebo composition contained 10 mM histidine, 10 mM histidine hydrochloride monohydrate, 9% (w/v) trehalose dihydrate, and 0.02% (w/v) polysorbate-20, pH 6.

[0064] Subjects received two subcutaneous (SC) injections of 1 ml of benralizumab or placebo every four weeks for the first 3 doses on Weeks 1 (Day 1), 4, and 8 and then every 8 weeks thereafter for the last 4 doses on Weeks 16, 24, 32, and 40. After Week 40, subjects were followed for an additional 12 weeks (through Week 52) for

assessment of acute exacerbations. The day of receipt of the first dose of benralizumab or placebo was considered Day 1.

[0065] Pulmonary function as measured by changes of airflow obstruction (FEV_1 and forced vital capacity (FVC) at the site and peak expiratory flow (PEF) and FEV_1 at home) during the study was assessed. The measurements, along with change from baseline at various time points were summarized using descriptive statistics. ANCOVA with treatment arm and baseline value as possible covariates were used to compare the changes from baseline in FEV_1 and PEF between the individual benralizumab group and the placebo group, respectively.

[0066] Home peak flow testing for FEV_1 and PEF were performed twice daily in the morning upon awakening and in the evening prior to bedtime from the first screening visit through the Week 52 visit using an ePRO device. Subject adherence was checked at each visit through the Week 52 visit. Subjects were asked to perform peak flow testing every morning while sitting or standing, but in the same position at every testing. Peak flow meters for home and instructions for data recording were provided to each enrolled subject at screening.

[0067] In addition, spirometry was performed by the investigator or qualified designee on equipment provided by a central vendor according to ATS/European Respiratory Society (ERS) guidelines (Miller *et al, Eur Respir J 26*:153-61 (2005)). Spirometry was performed at weeks -3, -2, -1, 1 (Day 1), 4, 16, 24, 32, 40, and 52 in the morning between 6:00 AM and 11:00 AM. On treatment days, spirometry testing was performed before administration of investigational product. All post-screening morning spirometry testing was required to be completed between 6 and 11 AM and within ± 1 hour of the time the screening spirometry was completed. For example, if the screening spirometry was at 8:00 AM, then all subsequent spirometry testing needed to be completed between 7:00 AM and 9:00 AM.

[0068] Multiple forced expiratory efforts (at least 3 but no more than 8) were performed for each office spirometry session, and the 2 best efforts that meet the American Thoracic Society/European Respiratory Society (ATS/ERS) acceptability and reproducibility criteria were recorded. The best efforts were based on the highest FEV_1. The maximum FEV_1 of the 2 best efforts was used for the analysis. The absolute measurement (for FEV_1 and forced vital capacity (FVC)), and the percentage of predicted normal value

(Hankinson *et al., Am J Respir Crit Care Med 159*:179-87 (1999)) was recorded. The highest FVC was also reported regardless of the effort in which it occurred (even if the effort did not result in the highest FEV_1). The preferred standard for predicted normal ranges is the National Health and Nutrition Examination Survey III (NHANES III). Indirect measurement of air trapping was assessed using data obtained from routine spirometry. The spirometry data will be input into the formula developed by Sorkness *et al.* (*J Appl Physiol 104*:394-403 (2008)).

[0069] Reversibility of FEV_1 with albuterol/salbutamol was measured at weeks -3, 1 (Day 1), 16, 24, 32, 40, and 52 after the subject has performed pre-bronchodilator (pre-BD) spirometry. Maximal bronchodilation were induced using albuterol/salbutamol MDI with an Aeorchamber for a maximum of 8 total puffs or 720 µg (Sorkness *et al., J Appl Physiol 104*:394-403 (2008)).

[0070] Following pre-BD spirometry, 4 puffs of albuterol/salbutamol MDI was administered in single puffs 30 seconds apart and post-bronchodilator (post-BD) spirometry was performed 15-20 minutes later. Afterwards, an additional 2 puffs of albuterol/salmeterol was administered in single puffs 30 seconds apart and a second post-BD spirometry was performed 15-20 minutes later. Finally, if the incremental change in FEV_1 after 6 puffs of albuterol/salbutamol was $\leq$ 5% the FEV_1 value after 4 puffs of albuterol/salbutamol, then last 2 puffs of albuterol/salmeterol were not administered. On the other hand, if the change is > 5% then 2 puffs of albuterol/salmeterol was administered in single puffs 30 seconds apart and a third post-BD spirometry was performed 15-20 minutes later.

[0071] The % difference comparing FEV_1 after 6 puffs to the FEV_1 after 4 puffs was calculated as follows:

$$\% \text{ Difference} = (FEV_1 \text{ (6 puffs)} - FEV_1 \text{ (4 puffs)}/FEV_1 \text{ (4 puffs)} \times 100$$

[0072] The highest pre- and post-BD FEV_1 were used to determine reversibility, which was calculated as follows:

$$\% \text{ Reversibility} = \frac{(\text{post-BD FEV1- pre-BD } FEV_1) \times 100}{\text{pre-BD } FEV_1}$$

[0073] The methacholine inhalation challenge was completed in the morning ± 1 hour at each assessment, if applicable. Direct challenges using methacholine cause airflow obstruction by acting directly on airway smooth muscle to reduce FEV_1. Methacholine inhalation challenge testing was performed using either of 2 ATS guideline recommended

methodologies: the 2-minute tidal breathing method or the 5 breath dosimeter method (American Thoracic Society, *Am J Respir Crit Care Med. 161*:309-329 (2000)). The same method was used on individual subjects. At each stage the maximum FEV_1 determined the best effort; the highest FVC and peak flow were also recorded even if they were obtained in different efforts from the maximum FEV_1. Only 2 efforts were required at each stage if these efforts were considered by the investigator or qualified designee to be representative of the subject's ability to perform spirometry at that stage. In general, no more than 3 efforts were performed at each stage in order to conserve the subject's ability to perform spirometry for the duration of the test.

[0074] Contraindications for methacholine challenge testing included: pregnancy, breast feeding, FEV_1 < 1.5 L or < 60% of predicted, heart attack or stroke in the previous 3 months, known aortic aneurysm, uncontrolled hypertension (systolic > 200 mm Hg or diastolic > 100 mm Hg), current use of anticholinesterase medication for myasthenia gravis, respiratory infection in the previous 6 weeks, acute asthma attack on day of study, oral corticosteroid burst in the previous 30 days, or certain prohibited medication or food.

[0075] The fall in FEV_1 was calculated as a percentage of the best FEV_1 determined at the saline stage. Subjects with a positive test or who were symptomatic received 2-4 puffs of albuterol/salbutamol and were observed until their FEV_1 returned to at least 90% of the baseline (Week -2 screening visit) value. Subjects who had a decrease in FEV_1 of > 50% were rescued with albuterol and followed closely. If the FEV_1 did not return to at least 90% of baseline (pre-diluent) value, the subject was not be discharged from the clinic without the approval of the investigator or qualified designee.

(c) SAFETY ASSESSMENTS

[0076] Adverse events were monitored following administration of placebo or benralizumab. Other assessments included physical examination, vital sign monitoring, and laboratory measurements.

EXAMPLE 2: Results

(a) ENROLLMENT AND BASELINE CHARACTERISTICS

[0077] The baseline characteristics of all randomized subjects who received any dose of investigational product are provided in Table 2 below. The mean population ICS dose

was 1100 budesonide equivalents overall, 700 budesonide equivalents in the medium dose stratum, and 1600 budesonide equivalents in the high dose stratum.

Table 2: Demographics for Baseline Eosinophils (EOS)

POPULATION	PLACEBO EOS < 300	BENRALIZUMAB EOS < 300	PLACEBO EOS >= 300	BENRALIZUMAB EOS >= 300
N	139	151	83	232
Mean Age (yrs)	50.3	51.2	45.2	46.3
Gender Female (%)	71	70	66	68
Race White (%)	76	80	64	65
BMI (mean)	29.6	29.2	28.8	28.5
EOS mean cells / µl	149	156	542	548-615
Chronic OCS (%)	2.2%	7.9%	4.8%	4.3%
FEV_1 (L) % pred	70.0	54-69	65	64-67
Reversibility (%)	12.5	13-18	15.5	17-19
Historical Exacerbations	2.2	2.3-2.5	2.2	2.3-2.5
ACQ at Baseline	2.5	2.5-2.8	2.6	2.4-2.7
Childhood Asthma YES	32%	33-38%	40%	37-41%
History Nasal Polyps YES	10.8%	11.9%	14.5%	19.3%
FE_{NO} mean ppb	22.1	21-39	34.8	34-42

OCS = oral corticosteroids; FEV_1 = forced expiratory volume in 1 second; ACQ = asthma control questionnaire; and FENO = fraction of exhaled nitric oxide.

[0078] The baseline characteristics of randomized subjects who received any dose of investigational product and had a baseline eosinophil count of at least 300 cells/µl are shown in Table 3 below.

Table 3: Demographics for ICS with Baseline EOS at Least 300 Cells/µl

POPULATION	PLACEBO MED ICS	BENRALIZUMAB MED ICS	PLACEBO HIGH ICS	BENRALIZUMAB HIGH ICS
N	43	121	40	111
Mean Age (yrs)	45	46-47	45	45-47
Gender Female (%)	65	63	68	70-79
Race White (%)	56	66	73	63

BMI (mean)	27.3	27.6-28.3	30.3	27.8-30.0
EOS mean cells / µl	480	462-625	608	605-656
Chronic OCS (%)	0	0	10%	9%
FEV_1 (L) % pred	68.8	64-70	60	63-65
Reversibility (%)	16%	17-23%	15%	14-21%
Historical Exacerbations	2.2	2.1-2.5	2.3	2.4-2.5
ACQ at Baseline	2.6	2.3-2.6	2.7	2.6-2.8
Childhood Asthma YES	42%	36%	38%	27-53%
History Nasal Polyps YES	14%	11%	15%	23-37%
FE_{NO} mean ppb	38.3	35-45	31.0	33-39

OCS = oral corticosteroids; FEV_1 = forced expiratory volume in 1 second; ACQ = asthma control questionnaire; and FENO = fraction of exhaled nitric oxide.

(b) EFFICACY

[0079] The effects of administration of benralizumab on FEV_1 are shown in Figures 2-9. For example, the data in Figure 2 demonstrate that by week 24, patients with a blood eosinophil count of at least 300 cells/µl who received 2, 20, or 100 mg of benralizumab showed increases in FEV_1. Similar results were also observed at week 52 (Figure 3). The data in Figure 4 demonstrate that FEV_1 was improved in patients receiving either medium or high dose ICS, but the improvement was greater in patients receiving high dose ICS. The data in Figure 5 compare the changes in FEV_1 in patients with a blood eosinophil count of less than 300 cells/µl who were receiving medium dose ICS with those receiving high dose ICS, and the data in Figure 6 compare the changes in FEV_1 in patients with a blood eosinophil count of at least 300 cells/µl who were receiving medium dose ICS with those receiving high dose ICS. In patients with a blood eosinophil count of at least 300 cells/µl, a greater improvement in FEV_1 was observed in those receiving a high dose of ICS (Figure 6). A more detailed breakdown by eosinophil number is provided in Figure 7. As shown in Figures 8 and 9, a difference in FEV_1 between patients receiving benralizumab and placebo was observable as early as week 4. However, this difference was much greater in patients with a blood eosinophil count of at least 300 cells/µl.

(c) SAFETY

[0080] Treatment emergent adverse events (TEAEs) occurred at an approximate 10 percentage point higher frequency in patients treated with benralizumab compared with those treated with placebo. Treatment emergent severe adverse events (TE-SAEs) occurred at similar frequencies in patients treated with benralizumab and placebo. TEAEs and TE-SAEs were not dose dependent in patients treated with benralizumab.

(d) ANTI-DRUG ANTIBODIES

[0081] The development of anti-drug antibodies (ADA) to benralizumab was inversely related to dose, with the highest proportion of ADA-positive subjects at the 2 mg dose (see Table 4 below). The incidence of high titer ADA ($\geq$ 400) was 12% and 9% in the 20 and 100 mg dose groups, respectively. High titer ADAs were associated with reduced benralizumab concentration and varying degrees of eosinophil recovery when present. The pharmacokinetic/pharmacodynamic (PK/PD) impact of high titer ADA was reduced at higher drug exposures. No pattern was observed between TEAEs and ADA.

Table 4: Anti-Drug Antibodies at Week 24

Treatment Group	Total Number of Subjects	% Subjects with Positive ADA Titres	% Subjects with ADA Titres $\geq$ 400
Placebo	222	8.1% (n = 18)	3% (n = 6)
Benralizumab 2 mg	81	34.6% (n = 28)	23% (n = 19)
Benralizumab 20 mg	81	18.5% (n = 15)	12% (n = 10)
Benralizumab 100 mg	222	21.2% (n = 47)	9% (n = 20)

[0082] Based on both PK and immunological considerations, additional patients will receive dosing of 30 mg benralizumab. In some patients, the 30 mg benralizumab dose will be administered every four weeks. In some patients, the 30 mg benralizumab dose will be administered once every four weeks for three doses and then once every eight weeks thereafter.

(e) DISCUSSION

[0083] This study demonstrates that benralizumab improves lung function. Improvements were observed at all doses, but a greater magnitude of benefit was evident

in the 20 and 100 mg doses relative to the 2 mg dose. In addition, FEV_1 appeared to improve more in those on high-dose ICS/LABA than those on medium-dose ICS/LABA.

EXAMPLE 3: Additional Dose Evaluation

[0084] Dose-efficacy modeling was performed to identify additional doses of benralizumab that reduce annual exacerbation rates and are safe and well tolerated. The modeling indicated that a dose of about 30 mg is the minimum effective dose to produce 90% maximum treatment effect. Therefore patients with uncontrolled asthma receive subcutaneous injections of 30 mg of benralizumab or placebo. The 30 mg doses are administered (i) every four weeks or (ii) every four weeks for eight weeks (3 doses) and then every eight weeks (i.e., every 8 weeks including an additional dose at week 4). The number of exacerbations in patients receiving 30 mg benralizumab is compared to the number of exacerbations in patients receiving placebo in order to demonstrate that 30 mg doses of benralizumab decrease annual exacerbation rates. In addition, the number of exacerbations in patients with baseline blood eosinophil count of at least 300 cells/μl is analyzed in order to demonstrate that 30 mg doses of benralizumab can be effective in decrease annual exacerbation rates in such patients.

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[0085] Those skilled in the art will recognize, or be able to ascertain using no more than routine experimentation, many equivalents to the specific aspects of the disclosure described herein. Such equivalents are intended to be encompassed by the following claims.

[0086] Various publications are cited herein, the disclosures of which are incorporated by reference in their entireties.

[0087] Although the foregoing invention has been described in some detail by way of illustration and example for purposes of clarity of understanding, it will be obvious that certain changes and modifications can be practiced within the scope of the appended claims.

SEQUENCE LISTING

SEQ ID NO:1

>US20100291073_1 Sequence 1 from Patent US 20100291073 Organism: Homo sapiens

DIQMTQSPSSLSASVGDRVTITCGTSEDIINYLNWYQQKPGKAPKLLIYHTSRLQSGVPSR
FSGSGSGTDFTLTISSLQP
EDFATYYCQQGYTLPYTFGQGTKVEIK

SEQ ID NO:2

>US20100291073_2 Sequence 2 from Patent US 20100291073 Organism: Homo sapiens

DIQMTQSPSSLSASVGDRVTITCGTSEDIINYLNWYQQKPGKAPKLLIYHTSRLQSGVPSR
FSGSGSGTDFTLTISSLQP
EDFATYYCQQGYTLPYTFGQGTKVEIKRTVAAPSVFIFPPSDEQLKSGTASVVCLLNNFY
PREAKVQWKVDNALQSGNSQ
ESVTEQDSKDSTYSLSSTLTLSKADYEKHKVYACEVTHQGLSSPVTKSFNRGEC

SEQ ID NO:3

>US20100291073_3 Sequence 3 from Patent US 20100291073 Organism: Homo sapiens

EVQLVQSGAEVKKPGASVKVSCKASGYTFTSYVIHWVRQRPGQGLAWMGYINPYNDG
TKYNERFKGKVTITSDRSTSTVY
MELSSLRSEDTAVYLCGREGIRYYGLLGDYWGQGTLVTVSS

SEQ ID NO:4

>US20100291073_4 Sequence 4 from Patent US 20100291073 Organism: Homo sapiens

EVQLVQSGAEVKKPGASVKVSCKASGYTFTSYVIHWVRQRPGQGLAWMGYINPYNDG
TKYNERFKGKVTITSDRSTSTVY
MELSSLRSEDTAVYLCGREGIRYYGLLGDYWGQGTLVTVSSASTKGPSVFPLAPSSKSTS
GGTAALGCLVKDYFPEPVTV
SWNSGALTSGVHTFPAVLQSSGLYSLSSVVTVPSSSLGTQTYICNVNHKPSNTKVDKKVE
PKSCDKTHTCPPCPAPELLG
GPSVFLFPPKPKDTLMISRTPEVTCVVVDVSHEDPEVKFNWYVDGVEVHNAKTKPREEQ
YNSTYRVVSVLTVLHQDWLNG

KEYKCKVSNKALPAPIEKTISKAKGQPREPQVYTLPPSRDELTKNQVSLTCLVKGFYPSDI
AVEWESNGQPENNYKTTPP
VLDSDGSFFLYSKLTVDKSRWQQGNVFSCSVMHEALHNHYTQKSLSLSPGK

SEQ ID NO:5
>US20100291073_5 Sequence 5 from Patent US 20100291073 Organism: Homo sapiens
DLLPDEKISLLPPVNFTIKVTGLAQVLLQWKPNPDQEQRNVNLEYQVKINAPKEDDYET
RITESKCVTILHKGFSASVRT
ILQNDHSLLASSWASAELHAPPGSPGTSIVNLTCTTNTTEDNYSRLRSYQVSLHCTWLVG
TDAPEDTQYFLYYRYGSWTE
ECQEYSKDTLGRNIACWFPRTFILSKGRDWLAVLVNGSSKHSAIRPFDQLFALHAIDQINP
PLNVTAEIEGTRLSIQWEK
PVSAFPIHCFDYEVKIHNTRNGYLQIEKLMTNAFISIIDDLSKYDVQVRAAVSSMCREAGL
WSEWSQPIYVGNDEHKPLR
EWFVIVIMATICFILLILSLICKICHLWIKLFPPIPAPKSNIKDLFVTTNYEKAGSSETEIEVIC
YIEKPGVETLEDSVF

SEQ ID NO:6
>US20100291073_6 Sequence 6 from Patent US 20100291073 Organism: Mus musculus
DLLNHKKFLLLPPVNFTIKATGLAQVLLHWDPNPDQEQRHVDLEYHVKINAPQEDEYDT
RKTESKCVTPLHEGFAASVRT
ILKSSHTTLASSWVSAELKAPPGSPGTSVTNLTCTTHTVVSSHTHLRPYQVSLRCTWLVG
KDAPEDTQYFLYYRFGVLTE
KCQEYSRDALNRNTACWFPRTFINSKGFEQLAVHINGSSKRAAIKPFDQLFSPLAIDQVN
PPRNVTVEIESNSLYIQWEK
PLSAFPDHCFNYELKIYNTKNGHIQKEKLIANKFISKIDDVSTYSIQVRAAVSSPCRMPGR
WGEWSQPIYVGKERKSLVE
WHLIVLPTAACFVLLIFSLICRVCHLWTRLFPPVPAPKSNIKDLPVVTEYEKPSNETKIEVV
HCVEEVGFEVMGNSTF

SEQ ID NO:7 - VH CDR1

SYVIH

SEQ ID NO:8 – VH CDR2

YINPYNDGTKYNERFKG

SEQ ID NO:9 – VH CDR3

EGIRYYGLLGDY

SEQ ID NO:10 – VL CDR1

GTSEDIINYLN

SEQ ID NO:11 – VL CDR2

HTSRLQS

SEQ ID NO:12 – VL CDR3

QQGYTLPYT

WHAT IS CLAIMED IS:

1. A method of increasing forced expiratory volume in one second (FEV_1) in an asthma patient, comprising administering to the patient an effective amount of benralizumab or an antigen-binding fragment thereof, wherein the administration increases the patient's FEV_1.

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2. A method of treating asthma, comprising administering to an asthma patient an effective amount of benralizumab or an antigen-binding fragment thereof, wherein the patient has a blood eosinophil count of at least 300 cells/μl prior to the administration.

3. A method of treating asthma, comprising administering to an asthma patient an effective amount of benralizumab or an antigen-binding fragment thereof, wherein the patient has a forced expiratory volume in one second (FEV_1) of at least 75% predicted value prior to the administration.

4. A method of treating asthma, comprising administering at least two doses of benralizumab or an antigen-binding fragment thereof to an asthma patient.

5. The method of any one of claims 2-4, wherein the administration increases the patient's FEV_1.

6. The method of claim 5, wherein the administration increases the patient's FEV_1 within 4 weeks of the first administration.

7. The method of any one of claims 1 or 3-6, wherein the asthma is eosinophilic asthma.

8. The method of any one of claims 1 or 3-7, wherein the patient has a blood eosinophil count of at least 300 cells/μl.

9. The method of any one of claims 1, 2, or 4-8, wherein, the patient has a forced expiratory volume in one second (FEV_1) of at least 75% predicted value prior to the administration.

10. The method of any one of claims 1-9, wherein the patient has an asthma control questionnaire score of at least 1.5 prior to the administration.

11. The method of any one of claims 1-3 or 5-10, wherein at least two doses of the benralizumab or antigen-binding fragment thereof are administered to the patient.

12. The method of any one of claims 1 or 6-11, which increases the patient's FEV_1 following administration of the benralizumab or antigen-binding fragment thereof.

13. The method of any one of claims 1 or 6-12, wherein the $FEV_1$is increased by at least 0.1 L.

14. The method of claim 13, wherein the $FEV_1$is increased by at least 0.13 L.

15. The method of claim 14, wherein the $FEV_1$is increased by at least 0.2 L.

16. The method of claim 15, wherein the $FEV_1$is increased by at least 0.25 L.

17. The method of claim 16, wherein the $FEV_1$is increased by at least 0.5 L

18. The method of any one of claims 1-17, wherein the patient uses high-dose inhaled corticosteroids (ICS).

19. The method of any one of claims 1-18, wherein the patient uses long-acting β2 agonists (LABA).

20. The method of any one of claims 1-19, wherein the patient has a history of exacerbations.

21. The method of claim 20, wherein the history of exacerbations comprises at least two exacerbations in the year prior to the administration of the benralizumab or antigen-binding fragment thereof.

22. The method of claim 20 or 21, wherein the history of exacerbations comprises no more than six exacerbations in the year prior to the administration of the benralizumab or antigen-binding fragment thereof.

23. The method of any one of claims 1-22, wherein the benralizumab or antigen-binding fragment thereof is administered at about 2 mg to about 100 mg per dose.

24. The method of claim 23, wherein the benralizumab or antigen-binding fragment thereof is administered at about 20 mg per dose.

25. The method of claim 23, wherein the benralizumab or antigen-binding fragment thereof is administered at about 30 mg per dose.

26. The method of claim 23, wherein the benralizumab or antigen-binding fragment thereof is administered at about 100 mg per dose.

27. The method of any one of claims 1-26, wherein the benralizumab or antigen-binding fragment thereof is administered once every four weeks to once every twelve weeks.

28. The method of claim 27, wherein the benralizumab or antigen-binding fragment thereof is administered once every four weeks.

29. The method of claim 27, wherein the benralizumab or antigen-binding fragment thereof is administered once every eight weeks.

30. The method of claim 27, wherein the benralizumab or antigen-binding fragment thereof is administered once every four weeks for twelve weeks and then once every eight weeks.

31. The method of any one of claims 1 to 30, wherein the benralizumab or antigen-binding fragment thereof is administered parenterally.

32. The method of claim 31, wherein the benralizumab or antigen-binding fragment thereof is administered subcutaneously.

33. The method of any one of claims 1 to 32, wherein the benralizumab or antigen-binding fragment thereof is administered in addition to corticosteroid therapy.

34. A method of increasing forced expiratory volume in one second (FEV_1) in an asthma patient, comprising administering to the patient 20-100 mg of benralizumab or an antigen-binding fragment thereof, wherein the patient has an blood eosinophil count of at least 300 cells/μl prior to the administration.

35. The method of claim 34, comprising administering 20 mg of benralizumab or an antigen-binding fragment thereof.

36. The method of claim 35, wherein the benralizumab or antigen-binding fragment thereof is administered once every four weeks for twelve weeks and then once every eight weeks.

37. The method of claim 34, comprising administering 30 mg of benralizumab or an antigen-binding fragment thereof.

38. The method of claim 37, wherein the benralizumab or antigen-binding fragment thereof is administered once every four weeks for eight weeks and then once every eight weeks.

39. The method of claim 37, wherein the benralizumab or antigen-binding fragment thereof is administered once every four weeks.

40. The method of claim 34, comprising administering 100 mg of benralizumab or an antigen-binding fragment thereof.

41. The method of claim 40, wherein the benralizumab or antigen-binding fragment thereof is administered once every four weeks for twelve weeks and then once every eight weeks

42. A method of treating asthma in an asthma patient, comprising administering to the patient a dose of at least 2 and less than 100 mg of benralizumab or an antigen-binding fragment thereof.

43. The method of claim 42, wherein 20 mg of the benralizumab or antigen-binding fragment is administered.

44. The method of claim 42, wherein 30 mg of the benralizumab or antigen-binding fragment is administered.

45. The method of claim 42, wherein a dose of at least 20 and less than 100 mg of the benralizumab or antigen-binding fragment is administered.

46. The method of claim 42, wherein a dose of at least 30 and less than 100 mg of the benralizumab or antigen-binding fragment is administered.

47. The method of any one of claims 42-46, wherein administration of the benralizumab or antigen-binding fragment increases the FEV_1 in the asthma patient.

48. The method of any one of claims 42-47, wherein administration of the benralizumab or antigen-binding fragment increases the FEV_1 in the asthma patient within four weeks of the first administration.

49. The method of any one of claims 42-48, wherein the administration is subcutaneous.