METHODS FOR TREATING PROGRESSIVE MULTIPLE SCLEROSIS

CROSS-REFERENCE TO RELATED APPLICATIONS

[0001] This application claims priority benefit to United States Provisional Application Ser. No. 61/097,464, filed September 16, 2008, the entirety of which is hereby incorporated by reference.

FIELD OF THE INVENTION

[0002] The present invention concerns methods for treating progressive multiple sclerosis (MS) in a patient, and an article of manufacture with instructions for such use.

BACKGROUND OF THE INVENTION

Multiple Sclerosis

[0003] Multiple Sclerosis (MS) is an inflammatory and demyelinating degenerative disease of the human central nervous system (CNS). It is a worldwide disease that affects approximately 300,000 persons in the United States; it is a disease of young adults, with 70%–80% having onset between 20 and 40 years old (Anderson *et al. Ann Neurology* 31(3):333–6 (1992); Noonan *et al. Neurology* 58:136–8 (2002)). MS is a heterogeneous disorder based on clinical course, magnetic resonance imaging (MRI) scan assessment, and pathology analysis of biopsy and autopsy material (Lucchinetti *et al. Ann Neurol* 47:707–17 (2000)). The disease manifests itself in a large number of possible combinations of deficits, including spinal cord, brainstem, cranial nerve, cerebellar, cerebral, and cognitive syndromes. Progressive disability is the fate of most patients with MS, especially when a 25-year perspective is included. Half of MS patients require a cane to walk within 15 years of disease onset. MS is a major cause of neurologic disability in young and middle-aged adults and, until the past decade, has had no known beneficial treatments. MS is difficult to diagnose because of the non-specific clinical findings, which led to the development of highly structured diagnostic criteria that include several technological advances, consisting of MRI scans, evoked potentials, and cerebrospinal fluid (CSF) studies. All diagnostic criteria rely upon the general principles of scattered lesions in the central white matter occurring at different times and not explained by other etiologies such as infection, vascular disorder, or autoimmune disorder (McDonald *et al. Ann Neurol* 50:121–7 (2001)). MS has four patterns of disease: relapsing-remitting MS (RRMS; 80%–85% of cases at onset), primary progressive MS (PPMS; 10%–15% at onset), progressive relapsing MS (PRMS; 5% at onset); and secondary progressive MS (SPMS) (Kremenchutzky *et al. Brain* 122 (Pt 10):1941–50 (1999); Confavreux *et al. N Engl J Med* 343(20):1430–8 (2000)). An estimated 50% of patients with RRMS will develop SPMS in

10 years, and up to 90% of RRMS patients will eventually develop SPMS (Weinshenker *et al. Brain* 112(Pt 1):133–46 (1989)).

[0004] Currently, six drugs in four classes are approved in the United States for the treatment of RRMS, whereas no drugs have been approved for PPMS. The RRMS treatments include the following: interferon class, IFN-beta-1a (REBIF® and AVONEX®) and IFN-beta-1b (BETASERON®); glatiramer acetate (COPAXONE®), a polypeptide; natalizumab (TYSABRI®); and mitoxantrone (NOVANTRONE®), a cytotoxic agent. Other drugs have been used with varying degrees of success, including corticosteroids, methotrexate, cyclophosphamide, azathioprine, and intravenous (IV) immunoglobulin. The benefits of currently approved treatments are relatively modest (~30%) for relapse rate and prevention of disability in RRMS as suggested by two meta-analyses (Filippini *et al. Lancet* 361:545–52 (2003)).

[0005] Other clinical studies evaluated other immunomodulatory agents in MS, including tumor necrosis factor–α inhibitors and altered peptide ligands, which aggravated rather than improved MS (Lenercept Multiple Sclerosis Study Group and the University of British Columbia MS/MRI *Neurology* 53:457–65 (1999); Bielekova *et al. Nat Med* 2000; 6:1167–75 (2000), erratum appears in *Nat Med* 6:1412 (2000)).

[0006] The predominant view of MS pathophysiology has held that inflammation is principally mediated by $CD4^+$ Th1 T cells. Therapeutic approaches based on this theory such as IFN-beta and glatiramer acetate decrease, but do not fully prevent, occurrence of exacerbations or accumulation of disability.

[0007] The existence of a humoral component in human MS has been implicitly recognized for decades, as evidenced by inclusion of CSF oligoclonal bands and increased intrathecal IgG synthesis in diagnostic criteria for MS (Siden A. *J Neurol* 221:39–51(1979); McDonald *et al. Ann Neurol* 50:121–7 (2001); Andersson *et al. Eur J Neurol* 9:243–51 (2002); O'Connor, P. *Neurology* 59:S1–33 (2002)). The presence of oligoclonal bands, increased free light chains, and increased intrathecal IgM synthesis correlates with MS disease activity and may be a predictor of more severe outcomes (Rudick *et al. Mult Scler* 1:150–5 (1995); Zeman *et al. Acta Cytol* 45:51–9 (2001); Izquierdo *et al. Acta Neurol Scand* 105:158–63 (2002); Wolinsky J. *J Neurol Sci* 206:145–52 (2003); Villar *et al. Ann Neurol* 53:222–6 (2003)).

[0008] Anti-myelin antibodies (myelin basic protein (MBP) and myelin oligodendrocyte glycoprotein (MOG)) have been detected in the serum of patients with progressive and relapsing forms of MS (Reindl *et al. Brain* 122:2047–56 (1999); Egg *et al. Mult Scler* 7(5):285–9 (2001)). Anti-myelin antibodies have also been detected in the CSF of MS patients (Reindl *et al. Brain*

122:2047–56 (1999); Egg *et al. Mult Scler* 7(5):285–9 (2001); Andersson *et al. Eur J Neurol* 9:243–51 (2002)). Additional types of antibodies such as anti-ganglioside antibodies or anti-neurofilament antibodies have been observed in patients with MS (Mata *et al. Mult Scler* 5:379–88 (1999); Sadatipour *et al. Ann Neurol* 44:980–3 (1998)). A report indicated that the presence of serum anti-MOG and anti-MBP antibodies was a strong predictor of progression from a clinically isolated demyelinating event to definite RRMS (Berger *et al. N Engl J Med* 349:139–45 (2003)). The adjusted hazard ratio for experiencing an exacerbation was 76.5 for patients who were seropositive for both antibodies and 31.6 for patients who were seropositive only for anti-MOG.

[0009] An international pathology consortium found that antibodies bound to myelin are present in the majority of patients with MS, with plasma cells and B cells also found in MS lesions, providing additional evidence for a humoral role in MS (Prineas and Wright, *Lab Invest* 38:409–21 (1978); Esiri M. *Neuropathol Appl Neurobiol* 6:9–21 (1980); Genain *et al. Nat Med* 5:170–5 (1999); Lucchinetti *et al. Ann Neurol* 47:707–17 (2000); Wingerchuk *et al. Lab Invest* 81:263–81 (2001)). B cells are detectable in the CSF of patients with MS, and the presence of a relatively high proportion of B cells may be predictive of more severe disability progression (Cepok *et al. Brain* 124(Pt 11):2169–76 (2001)).

[0010] In patients with RRMS or opsoclonus-myoclonus syndrome, Rituximab reportedly depleted peripheral B-cells in all patients and decreased the number of CSF B cells in some patients (Pranzatelli *et al. Neurology* 60(Suppl1) PO5.128:A395 (2003); Cross *et al.* "Preliminary Results from a Phase II Trial of Rituximab in MS" (abstract) *Eighth Annual Meeting of the Americas Committees for Research and Treatment in Multiple Sclerosis ACTRIMS* 20–1 (October, 2003); Cross *et al. J. Neuroimmunol.* 180:63-70 (2006)). *See also* Cree *et al.* "Tolerability and Effects of Rituximab "Anti-CD20 Antibody" in Neuromyelitis Optica and Rapidly Worsening Multiple Sclerosis" *Meeting of the Am. Acad. Neurol.* (April, 2004); Cree *et al. Neurology* 64:1270-2 (2005).

CD20 Antibodies and Therapy Therewith

[0011] Lymphocytes are one of many types of white blood cells produced in the bone marrow during the process of hematopoiesis. There are two major populations of lymphocytes: B lymphocytes (B cells) and T lymphocytes (T cells). The lymphocytes of particular interest herein are B cells.

[0012] B cells mature within the bone marrow and leave the marrow expressing an antigen-binding antibody on their cell surface. When a naive B cell first encounters the antigen for which

its membrane-bound antibody is specific, the cell begins to divide rapidly and its progeny differentiate into memory B cells and effector cells called "plasma cells". Memory B cells have a longer life span and continue to express membrane-bound antibody with the same specificity as the original parent cell. Plasma cells do not produce membrane-bound antibody but instead produce the antibody in a form that can be secreted. Secreted antibodies are the major effector molecule of humoral immunity.

[0013] The CD20 antigen (also called human B-lymphocyte-restricted differentiation antigen, Bp35) is a hydrophobic transmembrane protein with a molecular weight of approximately 35 kD located on pre-B and mature B lymphocytes (Valentine *et al. J. Biol. Chem.* 264(19):11282-11287 (1989); and Einfeld *et al. EMBO J.* 7(3):711-717 (1988)). The antigen is also expressed on greater than 90% of B-cell non-Hodgkin's lymphomas (NHL) (Anderson *et al. Blood* 63(6):1424-1433 (1984)), but is not found on hematopoietic stem cells, pro-B cells, normal plasma cells or other normal tissues (Tedder *et al. J. Immunol.* 135(2):973-979 (1985)). CD20 regulates an early step(s) in the activation process for cell cycle initiation and differentiation (Tedder *et al., supra*) and possibly functions as a calcium ion channel (Tedder *et al. J. Cell. Biochem.* 14D:195 (1990)).

[0014] Given the expression of CD20 in B-cell lymphomas, this antigen can serve as a candidate for "targeting" of such lymphomas. In essence, such targeting can be generalized as follows: antibodies specific to the CD20 surface antigen of B cells are administered to a patient. These anti-CD20 antibodies specifically bind to the CD20 antigen of (ostensibly) both normal and malignant B cells; the antibody bound to the CD20 surface antigen may lead to the destruction and depletion of neoplastic B cells. Additionally, chemical agents or radioactive labels having the potential to destroy the tumor can be conjugated to the anti-CD20 antibody such that the agent is specifically "delivered" to the neoplastic B cells. Irrespective of the approach, a primary goal is to destroy the tumor; the specific approach can be determined by the particular anti-CD20 antibody that is utilized and, thus, the available approaches to targeting the CD20 antigen can vary considerably.

[0015] The Rituximab (RITUXAN®) antibody is a genetically engineered chimeric murine/human monoclonal antibody directed against the CD20 antigen. Rituximab is the antibody called "C2B8" in US Patent No. 5,736,137 issued April 7, 1998 (Anderson *et al.*). RITUXAN® is indicated for the treatment of patients with relapsed or refractory low-grade or follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. *In vitro* mechanism of action studies have demonstrated that RITUXAN® binds human complement and lyses lymphoid B-cell lines through complement-dependent cytotoxicity (CDC) (Reff *et al. Blood* 83(2):435-445 (1994)). Additionally, it has significant activity in assays for antibody-dependent cellular cytotoxicity

(ADCC). More recently, RITUXAN® has been shown to have anti-proliferative effects in tritiated thymidine incorporation assays and to induce apoptosis directly, while other anti-CD19 and CD20 antibodies do not (Maloney *et al. Blood* 88(10):637a (1996)). Synergy between RITUXAN® and chemotherapies and toxins has also been observed experimentally. In particular, RITUXAN® sensitizes drug-resistant human B-cell lymphoma cell lines to the cytotoxic effects of doxorubicin, CDDP, VP-16, diphtheria toxin and ricin (Demidem *et al. Cancer Chemotherapy & Radiopharmaceuticals* 12(3):177-186 (1997)). *In vivo* preclinical studies have shown that RITUXAN® depletes B cells from the peripheral blood, lymph nodes, and bone marrow of cynomolgus monkeys, presumably through complement and cell-mediated processes (Reff *et al. Blood* 83(2):435-445 (1994)).

[0016] Rituximab was approved in the United States in November 1997 for the treatment of patients with relapsed or refractory low-grade or follicular $CD20^+$ B-cell non-Hodgkin's lymphoma (NHL) at a dose of 375 mg/m^2 weekly for four doses. In April 2001, the Food and Drug Administration (FDA) approved additional claims for the treatment of low-grade NHL: retreatment (weekly for four doses) and an additional dosing regimen (weekly for eight doses). There have been more than 300,000 patient exposures to Rituximab either as monotherapy or in combination with immunosuppressant or chemotherapeutic drugs. Patients have also been treated with Rituximab as maintenance therapy for up to 2 years (Hainsworth *et al. J Clin Oncol* 21:1746–51 (2003); Hainsworth *et al. J Clin Oncol* 20:4261–7 (2002)).

[0017] Rituximab has also been studied in a variety of non-malignant autoimmune disorders, in which B cells and autoantibodies appear to play a role in disease pathophysiology (Edwards *et al. Biochem Soc Trans* 30:824–8 (2002)). Rituximab has been reported to potentially relieve signs and symptoms of rheumatoid arthritis (RA) (Leandro *et al. Ann Rheum Dis.* 61:883–8 (2002); Emery *et al. Arthritis Rheum* 48(9):S439 (2003)), lupus (Eisenberg R. *Arthritis Res Ther* 5:157–9 (2003); Leandro *et al. Arthritis Rheum* 46:2673–7 (2002)), immune thrombocytopenia (D'Arena *et al. Leuk Lymphoma* 44:561–2 (2003)), autoimmune anemia (Zaja *et al. Haematologica* 87:189–95 (2002) (erratum appears in *Haematologica* 87:336 (2002)), autoimmune neuropathy (Pestronk *et al. J Neurol Neurosurg Psychiatry* 74:485–9 (2003)), paraneoplastic opsoclonus-myoclonus syndrome (Pranzatelli *et al. Neurology* 60(Suppl1) PO5.128:A395 (2003)), and relapsing-remitting multiple sclerosis (RRMS) (Cross *et al.* (abstract) Eighth Annual Meeting of the Americas Committees for Research and Treatment in Multiple Sclerosis 20–1 (2003)).

[0018] A Phase II study (WA16291) has been conducted in patients with rheumatoid arthritis (RA), providing 48-week follow-up data on safety and efficacy of Rituximab (Emery *et al.*

Arthritis Rheum 48(9):S439 (2003); Szczepanski *et al. Arthritis Rheum* 48(9):S121 (2003)). A total of 161 patients were evenly randomized to four treatment arms: methotrexate, Rituximab alone, Rituximab plus methotrexate, Rituximab plus cyclophosphamide (CTX). The treatment regimen of Rituximab was 1 g administered intravenously on Days 1 and 15. Infusions of Rituximab in most patients with RA were well tolerated by most patients, with 36% of patients experiencing at least one adverse event during their first infusion (compared with 30% of patients receiving placebo). Overall, the majority of adverse events were considered to be mild to moderate in severity and were well balanced across all treatment groups. There were a total of 19 serious adverse events across the four arms over the 48 weeks, which were slightly more frequent in the Rituximab/CTX group. The incidence of infections was well balanced across all groups. The mean rate of serious infection in this RA patient population was 4.6 6 per 100 patient-years, which is lower than the rate of infections requiring hospital admission in RA patients (9.57 per 100 patient-years) reported in a community-based epidemiologic study (Doran *et al. Arthritis Rheum* 46:2287–93 (2002)).

[0019] The reported safety profile of Rituximab in a small number of patients with neurologic disorders, including autoimmune neuropathy (Pestronk *et al. J Neurol Neurosurg Psychiatry* 74:485–9 (2003)), opsoclonus/myoclonus syndrome (Pranzatelli *et al. Neurology* 60(Suppl1) PO5.128:A395 (2003)), and RRMS (Cross *et al.* Preliminary results from a phase II trial of Rituximab in MS (abstract) Eighth Annual Meeting of the Americas Committees for Research and Treatment in Multiple Sclerosis 20–1 (2003)), was reported. In an ongoing investigator-sponsored trial (IST) of Rituximab in combination with interferon-beta (IFN-beta) or glatiramer acetate in subjects with RRMS (Cross *et al., supra*), 1 of 10 treated subjects was admitted to the hospital for overnight observation after experiencing moderate fever and rigors following the first infusion of Rituximab, while the other 9 subjects completed the four-infusion regimen without any reported adverse events.

[0020] Patents and patent publications concerning CD20 antibodies, CD20-binding molecules, and self-antigen vaccines include U.S. 5,776,456, 5,736,137, 5,843,439, 6,399,061, and 6,682,734, as well as US 2002/0197255, US 2003/0021781, US 2003/0082172, US 2003/0095963, US 2003/0147885, US 2005/0186205, and WO 1994/11026 (Anderson *et al.*); U.S. 6,455,043, US 2003/0026804, US 2003/0206903, and WO 2000/09160 (Grillo-Lopez, A.); WO 2000/27428 (Grillo-Lopez and White); US 2004/0213784 and WO 2000/27433 (Grillo-Lopez and Leonard); WO 2000/44788 (Braslawsky *et al.*); WO 2001/10462 (Rastetter, W.); WO 2001/10461 (Rastetter and White); WO 2001/10460 (White and Grillo-Lopez); US 2001/0018041, US 2003/0180292, US 2002/0028178, WO 2001/34194, and WO 2002/22212

(Hanna and Hariharan); US 2002/0006404 and WO 2002/04021 (Hanna and Hariharan); US 2002/0012665, US 2005/0180975, WO 2001/74388, and U.S. 6,896,885 (Hanna, N.); US 2002/0058029 (Hanna, N.); US 2003/0103971 (Hariharan and Hanna); US 2005/0123540 (Hanna *et al.*); US 2002/0009444 and WO 2001/80884 (Grillo-Lopez, A.); WO 2001/97858; US 2005/0112060, US 2002/0039557, and U.S. 6,846,476 (White, C.); US 2002/0128448 and WO 2002/34790 (Reff, M.); WO 2002/060955 (Braslawsky *et al.*);WO 2002/096948 (Braslawsky *et al.*);WO 2002/079255 (Reff and Davies); U.S. 6,171,586 and 6,991,790, and WO 1998/56418 (Lam *et al.*); US 2004/0191256 and WO 1998/58964 (Raju, S.); WO 1999/22764 (Raju, S.); WO 1999/51642, U.S. 6,194,551, U.S. 6,242,195, 6,528,624 and 6,538,124 (Idusogie *et al.*); U.S. 7,122,637, US 2005/0118174, US 2005/0233382, US 2006/0194291, US 2006/0194290, US 2006/0194957, and WO 2000/42072 (Presta, L.); WO 2000/67796 (Curd *et al.*); WO 2001/03734 (Grillo-Lopez *et al.*); US 2002/0004587, US 2006/0025576, and WO 2001/77342 (Miller and Presta); US 2002/0197256 and WO 2002/078766 (Grewal, I.); US 2003/0157108 and WO 2003/035835 (Presta, L.); U.S. 5,648,267, 5,733,779, 6,017,733, and 6,159,730, and WO 1994/11523 (Reff *et al.* on expression technology); U.S. 6,565,827, 6,090,365, 6,287,537, 6,015,542, 5,843,398, and 5,595,721 (Kaminski *et al.*); U.S. 5,500,362, 5,677,180, 5,721,108, 6,120,767, 6,652,852, and 6,893,625 as well as WO 1988/04936 (Robinson *et al.*); U.S. 6,410,391 (Zelsacher); U.S. 6,224,866 and WO 2000/20864 (Barbera-Guillem, E.); WO 2001/13945 (Barbera-Guillem, E.); WO 2000/67795 (Goldenberg); U.S. 7,074,403 (Goldenberg and Hansen); U.S. 7,151,164 (Hansen *et al.*); US 2003/0133930; WO 2000/74718 and US 2005/0191300A1 (Goldenberg and Hansen); US 2003/0219433 and WO 2003/68821 (Hansen *et al.*); WO 2004/058298 (Goldenberg and Hansen); WO 2000/76542 (Golay *et al.*);WO 2001/72333 (Wolin and Rosenblatt); U.S. 6,368,596 (Ghetie *et al.*); U.S. 6,306,393 and US 2002/0041847 (Goldenberg, D.); US 2003/0026801 (Weiner and Hartmann); WO 2002/102312 (Engleman, E.); US 2003/0068664 (Albitar *et al.*); WO 2003/002607 (Leung, S.); WO 2003/049694, US 2002/0009427, and US 2003/0185796 (Wolin *et al.*); WO 2003/061694 (Sing and Siegall); US 2003/0219818 (Bohen *et al.*); US 2003/0219433 and WO 2003/068821 (Hansen *et al.*); US 2003/0219818 (Bohen *et al.*); US 2002/0136719 (Shenoy *et al.*); WO 2004/032828 and US 2005/0180972 (Wahl *et al.*); and WO 2002/56910 (Hayden-Ledbetter). See also U.S. 5,849,898 and EP 330,191 (Seed *et al.*); EP332,865A2 (Meyer and Weiss); U.S. 4,861,579 (Meyer *et al.*); US 2001/0056066 (Bugelski *et al.*); WO 1995/03770 (Bhat *et al.*); US 2003/0219433 A1 (Hansen *et al.)*; WO 2004/035607 and US 2004/167319 (Teeling *et al.*); WO 2005/103081 (Teeling *et al.*); US 2006/0034835, US 2006/0024300, and WO 2004/056312 (Lowman *et al.*); US 2004/0093621 (Shitara *et al.*); WO 2004/103404 (Watkins *et al.*); WO 2005/000901 (Tedder *et al.*); US 2005/0025764 (Watkins *et al.*); US 2006/0251652 (Watkins *et*

al.); WO 2005/016969 (Carr *et al.*); US 2005/0069545 (Carr *et al.*); WO 2005/014618 (Chang *et al.*); US 2005/0079174 (Barbera-Guillem and Nelson); US 2005/0106108 (Leung and Hansen); US 2005/0123546 (Umana *et al.*); US 2004/0072290 (Umana *et al.*) ; US 2003/0175884 (Umana *et al.*); and WO 2005/044859 (Umana *et al.*); WO 2005/070963 (Allan *et al.*); US 2005/0186216 (Ledbetter and Hayden-Ledbetter); US 2005/0202534 (Hayden-Ledbetter and Ledbetter); US 2005/136049 (Ledbetter *et al.*); US 2003/118592 (Ledbetter *et al.*); US 2003/133939 (Ledbetter and Hayden-Ledbetter); US 2005/0202012 (Ledbetter and Hayden-Ledbetter); US 2005/0175614 (Ledbetter and Hayden-Ledbetter); US 2005/0180970 (Ledbetter and Hayden-Ledbetter); US 2005/0202028 (Hayden-Ledbetter and Ledbetter); US 2005/0202023 (Hayden-Ledbetter and Ledbetter); WO 2005/017148 (Ledbetter *et al.*); WO 2005/037989 (Ledbetter *et al.*); U.S. 6,183,744 (Goldenberg); U.S. 6,897,044 (Braslawski *et al.*); WO 2006/005477 (Krause *et al.*); US 2006/0029543 (Krause *et al.*); US 2006/0018900 (McCormick *et al.*); US 2006/0051349 (Goldenberg and Hansen); WO 2006/042240 (Iyer and Dunussi-Joannopoulos); US 2006/0121032 (Dahiyat *et al.*); WO 2006/064121 (Teillaud *et al.*); US 2006/0153838 (Watkins), CN 1718587 (Chen *et al.*); WO 2006/084264 (Adams *et al.*); US 2006/0188495 (Barron *et al.*); US 2004/0202658 and WO 2004/091657 (Benynes, K.); US 2005/0095243, US 2005/0163775, WO 2005/00351, and WO 2006/068867 (Chan, A.); US 2006/0135430 and WO 2005/005462 (Chan *et al.*); US 2005/0032130 and WO 2005/017529 (Beresini *et al.*); US 2005/0053602 and WO 2005/023302 (Brunetta, P.); US 2006/0179501 and WO 2004/060052 (Chan *et al.*); WO 2004/060053 (Chan *et al.*); US 2005/0186206 and WO 2005/060999 (Brunetta, P.); US 2005/0191297 and WO 2005/061542 (Brunetta, P.); US 2006/0002930 and WO 2005/115453 (Brunetta *et al.*); US 2006/0099662 and WO 2005/108989 (Chuntharapai *et al.*); CN 1420129A (Zhongxin Guojian Pharmaceutical); US 2005/0276803 and WO 2005/113003 (Chan *et al.*); US 2005/0271658 and WO 2005/117972 (Brunetta *et al.*); US 2005/0255527 and WO 2005/11428 (Yang, J.); US 2006/0024295 and WO 2005/120437 (Brunetta, P.); US 2006/0051345 and WO 2005/117978 (Frohna, P.); US 2006/0062787 and WO 2006/012508 (Hitraya, E.); US 2006/0067930 and WO 2006/31370 (Lowman *et al.*); WO 2006/29224 (Ashkenazi, A.); US 2006/0110387 and WO 2006/41680 (Brunetta, P.); US 2006/0134111 and WO 2006/066086 (Agarwal, S.); WO 2006/069403 (Ernst and Yansura); US 2006/0188495 and WO 2006/076651 (Dummer, W.); WO 2006/084264 (Lowman, H.); WO 2006/093923 (Quan and Sewell); WO 2006/106959 (Numazaki *et al.*); WO 2006/126069 (Morawala); WO 2006/130458 (Gazit-Bornstein *et al.*); US 2006/0275284 (Hanna, G.); US 2007/0014785 (Golay *et al.*); US 2007/0014720 (Gazit-Bornstein *et al.*); and US 2007/0020259 (Hansen *et al.*); US 2007/0020265 (Goldenberg and Hansen); US 2007/0014797 (Hitraya); US 2007/0224189 (Lazar *et al.*); WO

2007/014238 (Bruge and Bruger); and WO 2008/003319 (Parren and Baadsgaard). Certain of these include, *inter alia*, treatment of multiple sclerosis.

[0021] Publications concerning therapy with Rituximab include: Perotta and Abuel "Response of chronic relapsing ITP of 10 years duration to Rituximab" Abstract # 3360 *Blood* 10(1)(part 1-2): p. 88B (1998); Stashi *et al.* "Rituximab chimeric anti-CD20 monoclonal antibody treatment for adults with chronic idopathic thrombocytopenic purpura" *Blood* 98(4):952-957 (2001); Matthews, R. "Medical Heretics" *New Scientist* (7 April, 2001); Leandro *et al.* "Clinical outcome in 22 patients with rheumatoid arthritis treated with B lymphocyte depletion" *Ann Rheum Dis* 61:833-888 (2002); Leandro *et al.* "Lymphocyte depletion in rheumatoid arthritis: early evidence for safety, efficacy and dose response. *Arthritis and Rheumatism* 44(9): S370 (2001); Leandro *et al.* "An open study of B lymphocyte depletion in systemic lupus erythematosus", *Arthritis & Rheumatism* 46(1):2673-2677 (2002); Edwards and Cambridge "Sustained improvement in rheumatoid arthritis following a protocol designed to deplete B lymphocytes" *Rhematology* 40:205-211 (2001); Edwards *et al.* "B-lymphocyte depletion therapy in rheumatoid arthritis and other autoimmune disorders" *Biochem. Soc. Trans.* 30(4):824-828 (2002); Edwards *et al.* "Efficacy and safety of Rituximab, a B-cell targeted chimeric monoclonal antibody: A randomized, placebo controlled trial in patients with rheumatoid arthritis. *Arthritis and Rheumatism* 46(9): S197 (2002); Levine and Pestronk "IgM antibody-related polyneuropathies: B-cell depletion chemotherapy using Rituximab" *Neurology* 52: 1701-1704 (1999); DeVita *et al.* "Efficacy of selective B cell blockade in the treatment of rheumatoid arthritis" *Arthritis & Rheum* 46:2029-2033 (2002); Hidashida *et al.* "Treatment of DMARD-Refractory rheumatoid arthritis with Rituximab." Presented at the *Annual Scientific Meeting of the American College of Rheumatology*; Oct 24-29; New Orleans, LA 2002; Tuscano, J. "Successful treatment of Infliximab-refractory rheumatoid arthritis with Rituximab" Presented at the *Annual Scientific Meeting of the American College of Rheumatology*; Oct 24-29; New Orleans, LA 2002; Specks *et al.* "Response of Wegener's granulomatosis to anti-CD20 chimeric monoclonal antibody therapy" *Arthritis & Rheumatism* 44(12):2836-2840 (2001); Anolik *et al.*,"B lympocyte Depletion in the Treatment of Systemic Lupus (SLE): Phase I/II Trial of Rituximab (RITUXAN®) in SLE" *Arthritis And Rheumatism*, 46(9), S289-S289 Abstract 717 (October, 2002), and Albert *et al.*, "A Phase I Trial of Rituximab (Anti-CD20) for Treatment of Systemic Lupus Erythematosus" *Arthritis And Rheumatism*, 48(12): 3659-3659, Abstract LB9 (December, 2003); Martin and Chan "Pathogenic Roles of B cells in Human Autoimmunity: Insights from the Clinic" *Immunity* 20:517-527 (2004); Cree *et al.* "An open label study of the effects of rituximab in neuromyelitis optica." *Neurology* 64(7):1270-2 (2005); Cross *et al.* "Rituximab reduces B cells and T cells in

cerebrospinal fluid of multiple sclerosis patients." J *Neuroimmunol*, 180(1-2):63-70 (2006); Bar-Or A. *et al.*, "Safety, pharmacodynamics, and activity of Rituximab in patients with relapsing-remitting multiple sclerosis: a phase I, multicentre, open-label clinical trial." *Ann Neurol* 63(3):395-400 (2008); Hauser S. *et al.*, "B-cell depletion with Rituximab in relapsing-remitting multiple sclerosis." *NEJM*, 358(7):676-88, (2008); Hawker K *et al.*, "Efficacy and Safety of rituximab in patients with primary progressive multiple sclerosis: results of a randomized, double-blind, placebo-controlled, multicenter trial." *Multiple Sclerosis* 14(1):S299 (2008), Abstract; Hawker K *et al.*, "Efficacy and Safety of rituximab in patients with primary progressive multiple sclerosis: results of a randomized, double-blind, placebo-controlled, multicenter trial." *Neurology* 72(S3):A254 (2009), Abstract.

BRIEF SUMMARY OF THE INVENTION

[0022] The present invention provides methods of treating progressive multiple sclerosis in a patient comprising administering to the patient an effective amount of an anti-CD20 antibody, wherein treatment is based upon the patient having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0023] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0024] In some embodiments, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0025] In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to

starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0026] In some embodiments, the age of the patient is less than about 51.

[0027] In some embodiments, the treatment reduces the time to confirmed disease progression. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twelve weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

[0028] In some embodiments, the effective amount of the anti-CD20 antibody is administered to the patient to provide an initial anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams followed by a second anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams. In some embodiments, the initial anti-CD20 antibody exposure and/or the second anti-CD20 antibody exposure is between about 0.3 to about 1.5 grams. In some embodiments, the second exposure not being provided until from about 16 to 60 weeks from the initial exposure. In some embodiments, each of the anti-CD20 antibody exposures is provided to the patient as one or two doses of anti-CD20 antibody.

[0029] In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0030] The present invention provides methods of treating progressive multiple sclerosis in a patient provided that the patient has been found to have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, the treatment comprising administering to the patient an effective amount of an anti-CD20 antibody.

[0031] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is

progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0032] In some embodiments, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0033] In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0034] In some embodiments, the age of the patient is less than about 51.

[0035] In some embodiments, the treatment reduces the time to confirmed disease progression. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twelve weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

[0036] In some embodiments, the effective amount of the anti-CD20 antibody is administered to the patient to provide an initial anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams followed by a second anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams. In some embodiments, the initial anti-CD20 antibody exposure and/or the second anti-CD20 antibody exposure is between about 0.3 to about 1.5 grams. In some embodiments, the second exposure not being provided until from about 16 to 60 weeks from the initial exposure. In some embodiments, each of the anti-CD20 antibody exposures is provided to the patient as one or two doses of anti-CD20 antibody.

[0037] In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some

embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0038] The present invention provides methods of treating progressive multiple sclerosis, comprising: (a) selecting a patient having progressive multiple sclerosis, wherein said patient has one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and (b) administering to the patient thus selected an effective amount of an anti-CD20 antibody.

[0039] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0040] In some embodiments, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0041] In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0042] In some embodiments, the age of the patient is less than about 51.

[0043] In some embodiments, the treatment reduces the time to confirmed disease progression. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twelve weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

[0044] In some embodiments, the effective amount of the anti-CD20 antibody is administered to the patient to provide an initial anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams followed by a second anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams. In some embodiments, the initial anti-CD20 antibody exposure and/or the second anti-CD20 antibody exposure is between about 0.3 to about 1.5 grams. In some embodiments, the second exposure not being provided until from about 16 to 60 weeks from the initial exposure. In some embodiments, each of the anti-CD20 antibody exposures is provided to the patient as one or two doses of anti-CD20 antibody.

[0045] In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0046] The present invention also provides methods of assessing whether a patient with progressive multiple sclerosis will respond to treatment with an anti-CD20 antibody comprising assessing one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, wherein one or more of the characteristics in the patient indicates the patient will be responsive to the treatment.

[0047] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0048] In some embodiments, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0049] In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to

about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0050] In some embodiments, the age of the patient is less than about 51.

[0051] In some embodiments, the method further comprises advising a patient.

[0052] In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0053] The present invention also provides methods of identifying a patient with progressive multiple sclerosis likely to respond to anti-CD20 antibody treatment comprising: (a) assessing one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and (b) identifying the patient having one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (i) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting the anti-CD20 treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0054] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0055] In some embodiments, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the

evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0056] In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0057] In some embodiments, the age of the patient is less than about 51.

[0058] In some embodiments, the method further comprises advising a patient.

[0059] In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0060] The present invention further provides methods for marketing an anti-CD20 antibody or a pharmaceutically acceptable composition thereof for use in a progressive multiple sclerosis patient subpopulation, the methods comprising informing a target audience about the use of the anti-CD20 antibody for treating the patient subpopulation characterized by the patients of such subpopulation having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0061] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient subpopulation is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0062] In some embodiments, the patient subpopulation further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0063] In some embodiments, the patient subpopulation had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient subpopulation had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient subpopulation further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0064] In some embodiments, the age of the patient subpopulation is less than about 51.

[0065] In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0066] The present invention provides articles of manufacture comprising, packaged together, a pharmaceutical composition comprising an anti-CD20 antibody and a pharmaceutically acceptable carrier and a label denoting (*i.e.*, indicating) that the anti-CD20 antibody or pharmaceutical composition is indicated for treating patients with multiple sclerosis having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting the treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0067] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary

progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0068] In some embodiments, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0069] In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0070] In some embodiments, the age of the patient is less than about 51.

[0071] In some embodiments, the pharmaceutical composition comprising the anti-CD20 antibody and the pharmaceutically acceptable carrier is in a container. In some embodiments, the container comprises between about 0.3 to about 4.0 grams of the anti-CD20 antibody. In some embodiments, the container comprises between about 0.3 to about 1.5 grams of the anti-CD20 antibody.

[0072] In some embodiments, the label provides instructions, wherein the instructions indicate that an effective amount of the anti-CD20 antibody is administered to the patient to provide an initial anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams followed by a second anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams. In some embodiments, the initial anti-CD20 antibody exposure and/or the second anti-CD20 antibody exposure is between about 0.3 to about 1.5 grams. In some embodiments, the second exposure not being provided until from about 16 to 60 weeks from the initial exposure. In some embodiments, each of the anti-CD20 antibody exposures is provided to the patient as one or two doses of anti-CD20 antibody.

[0073] In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain

variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0074] The present invention also provides methods for predicting whether a subject with progressive multiple sclerosis will respond to a treatment with a drug used to treat multiple sclerosis, the methods comprising assessing one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, whereby the age, the gadolinium staining lesions, the increase in EDDS over two years prior to starting the treatment, the MSSS, or a combination thereof indicates that the subject will respond to the treatment.

[0075] In some embodiments, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the subject is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0076] In some embodiments, the subject further has had evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0077] In some embodiments, the subject has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the subject had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the at least about a 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the subject further had two or more relapses within two years prior to starting treatment. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5.

[0078] In some embodiments, the age of the subject is less than about 51.

[0079] In some embodiments of any of the methods or articles of manufacture described herein, the patients have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment.

[0080] The invention further provides methods of treating multiple sclerosis in a patient comprising administering an effective amount of ocrelizumab to the patient to provide an initial ocrelizumab exposure of between about 0.3 to about 0.6 grams followed by a second ocrelizumab exposure of between about 0.3 to about 0.6 grams, the second exposure not being provided until from about 16 to 60 weeks from the initial exposure, and each of the ocrelizumab exposures is provided to the patient as one or two doses of ocrelizumab.

[0081] In some embodiments, the initial ocrelizumab exposure is about 0.6 grams. In some embodiments, the second ocrelizumab exposure is about 0.6 grams. In some embodiments, the second exposure is administered from about 24 weeks from the initial exposure. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as one dose of ocrelizumab. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as two doses of ocrelizumab. In some embodiments, the initial ocrelizumab exposure comprises a first dose and a second dose of ocrelizumab, wherein the first dose and second dose of ocrelizumab is about 0.3 grams. In some embodiments, the second ocrelizumab exposure comprises a single dose of ocrelizumab, wherein the single dose of ocrelizumab is 0.6 grams. In some embodiments, the methods further comprising providing a third ocrelizumab exposure. In some embodiments, the methods further comprising providing a fourth ocrelizumab exposure. In some embodiments, the methods further comprising providing a fifth ocrelizumab exposure. In some embodiments of any of the methods, the methods further comprising providing between about one to about three subsequent ocrelizumab exposures.

[0082] The invention also provides articles of manufacture comprising: (a) a container comprising ocrelizumab; and (b) a package insert with instructions for treating multiple sclerosis in a patient, wherein the instructions denote that an amount of ocrelizumab is administered to the patient that is effective to provide an initial ocrelizumab exposure of between about 0.3 to about 0.6 grams followed by a second ocrelizumab exposure of between about 0.3 to about 0.6 grams, the second exposure not being administered until from about 16 to 60 weeks from the initial exposure, and each of the ocrelizumab exposures is provided to the patient as one or two doses of ocrelizumab.

[0083] In some embodiments, the initial ocrelizumab exposure is about 0.6 grams. In some embodiments, the second ocrelizumab exposure is about 0.6 grams. In some embodiments, the second exposure is administered from about 24 weeks from the initial exposure. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as one dose of ocrelizumab. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as two doses of ocrelizumab. In some embodiments, the initial ocrelizumab exposure comprises a first dose and a second dose of ocrelizumab, wherein the first dose and second dose of ocrelizumab is about 0.3 grams. In some embodiments, the instructions further comprising providing a third ocrelizumab exposure. In some embodiments, the instructions further comprising providing a fourth ocrelizumab exposure. In some embodiments, the instructions further comprising providing a fifth ocrelizumab exposure. In some embodiments of any of the methods, the instructions further comprising providing between about one to about three subsequent ocrelizumab exposures.

BRIEF DESCRIPTION OF THE DRAWINGS

[0084] Figure 1A is a sequence alignment comparing the amino acid sequences of the light chain variable domain (V_L) of each of murine 2H7 (SEQ ID NO:1), humanized 2H7.v16 variant (SEQ ID NO:2), and the human kappa light chain subgroup I (SEQ ID NO:3). The CDRs of V_L of 2H7 and hu2H7.v16 are as follows: CDR1 (SEQ ID NO:4), CDR2 (SEQ ID NO:5), and CDR3 (SEQ ID NO:6).

[0085] Figure 1B is a sequence alignment comparing the amino acid sequences of the heavy chain variable domain (V_H) of each of murine 2H7 (SEQ ID NO:7), humanized 2H7.v16 variant (SEQ ID NO:8), and the human consensus sequence of the heavy chain subgroup III (SEQ ID NO:9). The CDRs of V_H of 2H7 and hu2H7.v16 are as follows: CDR1 (SEQ ID NO:10), CDR2 (SEQ ID NO:11), and CDR3 (SEQ ID NO:12).

[0086] In Figure 1A and Figure 1B, the CDR1, CDR2 and CDR3 in each chain are enclosed within brackets, flanked by the framework regions, FR1-FR4, as indicated. 2H7 refers to the murine 2H7 antibody. The asterisks in between two rows of sequences indicate the positions that are different between the two sequences. Residue numbering is according to Kabat *et al.* *Sequences of Immunological Interest*, 5th Ed. Public Health Service, National Institutes of Health, Bethesda, Md. (1991), with insertions shown as a, b, c, d, and e.

[0087] Figure 2 shows the amino acid sequence of the mature 2H7.v16 light chain (SEQ ID NO:13)

[0088] Figure 3 shows the amino acid sequence of the mature 2H7.v16 heavy chain (SEQ ID NO:14).

[0089] Figure 4 shows the amino acid sequence of the mature 2H7.v31 heavy chain (SEQ ID NO:15). The L chain of 2H7.v31 is the same as for 2H7.v16.

[0090] Figure 5 shows an alignment of the mature 2H7.v16 and 2H7.v511 light chains (SEQ ID NOS. 13 and 16, respectively), with Kabat variable domain residue numbering and Eu constant domain residue numbering.

[0091] Figure 6 shows an alignment of the mature 2H7.v16 and 2H7.v511 heavy chains (SEQ ID NOS. 14 and 17, respectively), with Kabat variable domain residue numbering and Eu constant domain residue numbering.

[0092] Figure 7 shows an overview of the study design for treating relapsing-remitting multiple sclerosis using ocrelizumab.

[0093] Figure 8 shows Kaplan Meier plots of the time to confirmed disease progression for subjects in the placebo and rituximab groups.

[0094] Figure 9 shows the median change in T2 lesion volume from baseline to week 96. The Y-axis shows the T2 Lesion Volume mm^3.

[0095] Figure 10 shows a summary of baseline characteristics and hazard ratio of subjects in the placebo and rituximab groups.

[0096] Figure 11 shows multivariate analysis of additive predictive effects of age and gadolinium (Gd) lesion at baseline for the treatment effect in the placebo and rituximab groups. Figure 11A shows multivariate analysis of age < 51 and Gd lesions at baseline = 0. Figure 11B shows multivariate analysis of age = 51 and Gd lesions at baseline = 0. Figure 11C shows multivariate analysis of age < 51 and Gd lesions at baseline = 1. Figure 11D shows multivariate analysis of age = 51 and Gd lesions at baseline = 1.

[0097] Figure 12 shows multivariate analysis of additive predictive effects of age and Multiple Sclerosis Severity Score (MSSS) for the treatment effect in the placebo and rituximab groups. Figure 12A shows multivariate analysis of age = 55 and MSSS < 5. Figure 12B shows multivariate analysis of age > 55 and MSSS < 5. Figure 12C shows multivariate analysis of age = 55 and MSSS = 5. Figure 12D shows multivariate analysis of age > 55 and MSSS = 5.

[0098] Figure 13 shows Kaplan Meier plots for the time to confirmed disease progression of subjects in the placebo and rituximab groups with the following characteristics: age = 55; 3 =

baseline EDSS = 6.5; excluding patients with disease duration > 10 years if their baseline EDSS < 5 or disease duration > 15 if their baseline EDSS =5.

DETAILED DESCRIPTION OF THE INVENTION

I. Definitions

[0099] A "B-cell" is a lymphocyte that matures within the bone marrow, and includes a naive B cell, memory B cell, or effector B cell (plasma cells). The B-cell herein may be a normal or non-malignant B cell.

[0100] A "B-cell surface marker" or "B-cell surface antigen" herein is an antigen expressed on the surface of a B cell that can be targeted with an antibody that binds thereto. Exemplary B-cell surface markers include the CD10, CD19, CD20, CD21, CD22, CD23, CD24, CD37, CD40, CD53, CD72, CD73, CD74, CDw75, CDw76, CD77, CDw78, CD79a, CD79b, CD80, CD81, CD82, CD83, CDw84, CD85 and CD86 leukocyte surface markers (for descriptions, *see* The Leukocyte Antigen Facts Book, 2nd Edition. 1997, ed. Barclay *et al.* Academic Press, Harcourt Brace & Co., New York). Other B-cell surface markers include RP105, FcRH2, B-cell CR2, CCR6, P2X5, HLA-DOB, CXCR5, FCER2, BR3, Btig, NAG14, SLGC16270, FcRH1, IRTA2, ATWD578, FcRH3, IRTA1, FcRH6, BCMA, and 239287. The B-cell surface marker of particular interest herein is preferentially expressed on B cells compared to other non-B-cell tissues of a mammal and may be expressed on both precursor B cells and mature B cells. The preferred B-cell surface marker herein is CD20.

[0101] The "CD20" antigen, or "CD20," is an about 35-kDa, non-glycosylated phosphoprotein found on the surface of greater than 90% of B cells from peripheral blood or lymphoid organs. CD20 is present on both normal B cells as well as malignant B cells, but is not expressed on stem cells. Other names for CD20 in the literature include "B-lymphocyte-restricted antigen" and "Bp35". The CD20 antigen is described in Clark *et al. Proc. Natl. Acad. Sci.* (USA) 82:1766 (1985), for example.

[0102] An "antibody antagonist" herein is a antibody that, upon binding to a B cell surface marker on B cells, destroys or depletes B cells in a mammal and/or interferes with one or more B-cell functions, *e.g.* by reducing or preventing a humoral response elicited by the B cell. The antibody antagonist preferably is able to deplete B cells (*i.e.* reduce circulating B-cell levels) in a mammal treated therewith. Such depletion may be achieved via various mechanisms such antibody-dependent cell-mediated cytotoxicity (ADCC) and/or complement dependent

cytotoxicity (CDC), inhibition of B-cell proliferation and/or induction of B-cell death *(e.g.* via apoptosis).

[0103] "Antibody-dependent cell-mediated cytotoxicity" and "ADCC" refer to a cell-mediated reaction in which nonspecific cytotoxic cells that express Fc receptors (FcRs) *(e.g.* Natural Killer (NK) cells, neutrophils, and macrophages) recognize bound antibody on a target cell and subsequently cause lysis of the target cell. The primary cells for mediating ADCC, NK cells, express FcγRIII only, whereas monocytes express FcγRI, FcγRII and FcγRIII. FcR expression on hematopoietic cells in summarized is Table 3 on page 464 of Ravetch and Kinet, *Annu. Rev. Immunol* 9:457-92 (1991). To assess ADCC activity of a molecule of interest, an *in vitro* ADCC assay, such as that described in US Patent No. 5,500,362 or 5,821,337 may be performed. Useful effector cells for such assays include peripheral blood mononuclear cells (PBMC) and Natural Killer (NK) cells. Alternatively, or additionally, ADCC activity of the molecule of interest may be assessed *in vivo*, *e.g.*, in a animal model such as that disclosed in Clynes *et al. PNAS (USA)* 95:652-656 (1998).

[0104] "Human effector cells" are leukocytes that express one or more FcRs and perform effector functions. In some embodiments, the cells express at least FcγRIII and carry out ADCC effector function. Examples of human leukocytes that mediate ADCC include peripheral blood mononuclear cells (PBMC), natural killer (NK) cells, monocytes, cytotoxic T cells and neutrophils; with PBMCs and NK cells being preferred.

[0105] The terms "Fc receptor" or "FcR" are used to describe a receptor that binds to the Fc region of an antibody. In some embodiments, the FcR is a native sequence human FcR. Moreover, a preferred FcR is one that binds an IgG antibody (a gamma receptor) and includes receptors of the FcγRI, FcγRII, and Fcγ RIII subclasses, including allelic variants and alternatively spliced forms of these receptors. FcγRII receptors include FcγRIIA (an "activating receptor") and FcγRIIB (an "inhibiting receptor"), which have similar amino acid sequences that differ primarily in the cytoplasmic domains thereof. Activating receptor FcγRIIA contains an immunoreceptor tyrosine-based activation motif (ITAM) in its cytoplasmic domain. Inhibiting receptor FcγRIIB contains an immunoreceptor tyrosine-based inhibition motif (ITIM) in its cytoplasmic domain. (*see* Daëron, *Annu. Rev. Immunol.* 15:203-234 (1997)). FcRs are reviewed in Ravetch and Kinet, *Annu. Rev. Immunol* 9:457-92 (1991); Capel *et al., Immunomethods* 4:25-34 (1994); and de Haas *et al., J. Lab. Clin. Med.* 126:330-41 (1995). Other FcRs, including those to be identified in the future, are encompassed by the term "FcR" herein. The term also includes the neonatal receptor, FcRn, which is responsible for the transfer of maternal IgGs to the fetus (Guyer *et al., J. Immunol.* 117:587 (1976) and Kim *et al., J. Immunol.* 24:249 (1994)).

[0106] "Complement dependent cytotoxicity" or "CDC" refer to the ability of a molecule to lyse a target in the presence of complement. The complement activation pathway is initiated by the binding of the first component of the complement system (C1q) to a molecule *(e.g.* an antibody) complexed with a cognate antigen. To assess complement activation, a CDC assay, *e.g.* as described in Gazzano-Santoro *et al., J. Immunol. Methods* 202:163 (1996), may be performed.

[0107] "Growth inhibitory" antibodies are those that prevent or reduce proliferation of a cell expressing an antigen to which the antibody binds. For example, the antibody may prevent or reduce proliferation of B cells *in vitro* and/or *in vivo*.

[0108] Antibodies that "induce apoptosis" are those that induce programmed cell death, *e.g.* of a B cell, as determined by standard apoptosis assays, such as binding of annexin V, fragmentation of DNA, cell shrinkage, dilation of endoplasmic reticulum, cell fragmentation, and/or formation of membrane vesicles (called apoptotic bodies).

[0109] The term "antibody" herein is used in the broadest sense and specifically covers monoclonal antibodies, polyclonal antibodies, multispecific antibodies *(e.g.* bispecific antibodies) formed from at least two intact antibodies, and antibody fragments so long as they exhibit the desired biological activity.

[0110] "Antibody fragments" comprise a portion of an intact antibody, preferably comprising the antigen binding region thereof. Examples of antibody fragments include Fab, Fab', $F(ab')_2$, and Fv fragments; diabodies; linear antibodies; single-chain antibody molecules; and multispecific antibodies formed from antibody fragments.

[0111] For the purposes herein, an "intact antibody" is one comprising heavy and light variable domains as well as an Fc region.

[0112] "Native antibodies" are usually heterotetrameric glycoproteins of about 150,000 daltons, composed of two identical light (L) chains and two identical heavy (H) chains. Each light chain is linked to a heavy chain by one covalent disulfide bond, while the number of disulfide linkages varies among the heavy chains of different immunoglobulin isotypes. Each heavy and light chain also has regularly spaced intrachain disulfide bridges. Each heavy chain has at one end a variable domain (V_H) followed by a number of constant domains. Each light chain has a variable domain at one end (V_L) and a constant domain at its other end; the constant domain of the light chain is aligned with the first constant domain of the heavy chain, and the light chain variable domain is aligned with the variable domain of the heavy chain. Particular amino acid residues are believed to form an interface between the light chain and heavy chain variable domains.

[0113] The term "variable" refers to the fact that certain portions of the variable domains differ extensively in sequence among antibodies and are used in the binding and specificity of each particular antibody for its particular antigen. However, the variability is not evenly distributed throughout the variable domains of antibodies. It is concentrated in three segments called hypervariable regions both in the light chain and the heavy chain variable domains. The more highly conserved portions of variable domains are called the framework regions (FRs). The variable domains of native heavy and light chains each comprise four FRs, largely adopting a ß-sheet configuration, connected by three hypervariable regions, which form loops connecting, and in some cases forming part of, the ß-sheet structure. The hypervariable regions in each chain are held together in close proximity by the FRs and, with the hypervariable regions from the other chain, contribute to the formation of the antigen-binding site of antibodies (*see* Kabat *et al., Sequences of Proteins of Immunological Interest*, 5th Ed. Public Health Service, National Institutes of Health, Bethesda, MD. (1991)). The constant domains are not involved directly in binding an antibody to an antigen, but exhibit various effector functions, such as participation of the antibody in antibody dependent cellular cytotoxicity (ADCC).

[0114] Papain digestion of antibodies produces two identical antigen-binding fragments, called "Fab" fragments, each with a single antigen-binding site, and a residual "Fc" fragment, whose name reflects its ability to crystallize readily. Pepsin treatment yields an $F(ab')_2$ fragment that has two antigen-binding sites and is still capable of cross-linking antigen.

[0115] "Fv" is the minimum antibody fragment that contains a complete antigen-recognition and antigen-binding site. This region consists of a dimer of one heavy chain and one light chain variable domain in tight, non-covalent association. It is in this configuration that the three hypervariable regions of each variable domain interact to define an antigen-binding site on the surface of the V_H-V_L dimer. Collectively, the six hypervariable regions confer antigen-binding specificity to the antibody. However, even a single variable domain (or half of an Fv comprising only three hypervariable regions specific for an antigen) has the ability to recognize and bind antigen, although at a lower affinity than the entire binding site.

[0116] The Fab fragment also contains the constant domain of the light chain and the first constant domain (CH1) of the heavy chain. Fab' fragments differ from Fab fragments by the addition of a few residues at the carboxy terminus of the heavy chain CH1 domain including one or more cysteines from the antibody hinge region. Fab'-SH is the designation herein for Fab' in which the cysteine residue(s) of the constant domains bear at least one free thiol group. $F(ab')_2$ antibody fragments originally were produced as pairs of Fab' fragments that have hinge cysteines between them. Other chemical couplings of antibody fragments are also known.

[0117] The "light chains" of antibodies (immunoglobulins) from any vertebrate species can be assigned to one of two clearly distinct types, called kappa (κ) and lambda (λ), based on the amino acid sequences of their constant domains.

[0118] Depending on the amino acid sequence of the constant domain of their heavy chains, antibodies can be assigned to different classes. There are five major classes of intact antibodies: IgA, IgD, IgE, IgG, and IgM, and several of these may be further divided into subclasses (isotypes), *e.g.,* IgG1, IgG2, IgG3, IgG4, IgA, and IgA2. The heavy chain constant domains that correspond to the different classes of antibodies are called a, d, e, γ, and μ, respectively. The subunit structures and three-dimensional configurations of different classes of immunoglobulins are well known.

[0119] "Single-chain Fv" or "scFv" antibody fragments comprise the V_H and V_L domains of antibody, wherein these domains are present in a single polypeptide chain. In some embodiments, the Fv polypeptide further comprises a polypeptide linker between the V_H and V_L domains that enables the scFv to form the desired structure for antigen binding. For a review of scFv see Plückthun in *The Pharmacology of Monoclonal Antibodies*, vol. 113, Rosenburg and Moore eds., Springer-Verlag, New York, pp. 269-315 (1994).

[0120] The term "diabodies" refers to small antibody fragments with two antigen-binding sites, which fragments comprise a heavy chain variable domain (V_H) connected to a light chain variable domain (V_L) in the same polypeptide chain (V_H - V_L). By using a linker that is too short to allow pairing between the two domains on the same chain, the domains are forced to pair with the complementary domains of another chain and create two antigen-binding sites. Diabodies are described more fully in, for example, EP 404,097; WO 93/11161; and Hollinger *et al., Proc. Natl. Acad. Sci. USA*, 90:6444-6448 (1993).

[0121] The term "monoclonal antibody" as used herein refers to an antibody obtained from a population of substantially homogeneous antibodies, *i.e.*, the individual antibodies comprising the population are identical and/or bind the same epitope, except for possible variants that may arise during production of the monoclonal antibody, such variants generally being present in minor amounts. In contrast to polyclonal antibody preparations that typically include different antibodies directed against different determinants (epitopes), each monoclonal antibody is directed against a single determinant on the antigen. In addition to their specificity, the monoclonal antibodies are advantageous in that they are uncontaminated by other immunoglobulins. The modifier "monoclonal" indicates the character of the antibody as being obtained from a substantially homogeneous population of antibodies, and is not to be construed as

requiring production of the antibody by any particular method. For example, the monoclonal antibodies to be used in accordance with the present invention may be made by the hybridoma method first described by Kohler *et al., Nature*, 256:495 (1975), or may be made by recombinant DNA methods (*see*, *e.g.*, U.S. Patent No. 4,816,567). The "monoclonal antibodies" may also be isolated from phage antibody libraries using the techniques described in Clackson *et al., Nature,* 352:624-628 (1991) and Marks *et al., J. Mol. Biol.*, 222:581-597 (1991), for example.

[0122] The monoclonal antibodies herein specifically include "chimeric" antibodies (immunoglobulins) in which a portion of the heavy and/or light chain is identical with or homologous to corresponding sequences in antibodies derived from a particular species or belonging to a particular antibody class or subclass, while the remainder of the chain(s) is identical with or homologous to corresponding sequences in antibodies derived from another species or belonging to another antibody class or subclass, as well as fragments of such antibodies, so long as they exhibit the desired biological activity (U.S. Patent No. 4,816,567; Morrison *et al., Proc. Natl. Acad. Sci. USA*, 81:6851-6855 (1984)). Chimeric antibodies of interest herein include "primatized" antibodies comprising variable domain antigen-binding sequences derived from a non-human primate *(e.g.* Old World Monkey, such as baboon, rhesus or cynomolgus monkey) and human constant region sequences (US Pat No. 5,693,780).

[0123] "Humanized" forms of non-human *(e.g.,* murine) antibodies are chimeric antibodies that contain minimal sequence derived from non-human immunoglobulin. For the most part, humanized antibodies are human immunoglobulins (recipient antibody) in which residues from a hypervariable region of the recipient are replaced by residues from a hypervariable region of a non-human species (donor antibody) such as mouse, rat, rabbit or nonhuman primate having the desired specificity, affinity, and capacity. In some instances, framework region (FR) residues of the human immunoglobulin are replaced by corresponding non-human residues. Furthermore, humanized antibodies may comprise residues that are not found in the recipient antibody or in the donor antibody. These modifications are made to further refine antibody performance. In general, the humanized antibody will comprise substantially all of at least one, and typically two, variable domains, in which all or substantially all of the hypervariable loops correspond to those of a non-human immunoglobulin and all or substantially all of the FRs are those of a human immunoglobulin sequence, except for FR substitution(s) as noted above. The humanized antibody optionally also will comprise at least a portion of an immunoglobulin constant region, typically that of a human immunoglobulin. For further details, see Jones *et al., Nature* 321:522-525 (1986); Riechmann *et al., Nature* 332:323-329 (1988); and Presta, *Curr. Op. Struct. Biol.* 2:593-596 (1992).

[0124] The term "hypervariable region" when used herein refers to the amino acid residues of an antibody that are responsible for antigen binding. The hypervariable region comprises amino acid residues from a "complementarity determining region" or "CDR" *(e.g.* residues 24-34 (L1), 50-56 (L2) and 89-97 (L3) in the light chain variable domain and 31-35 (H1), 50-65 (H2) and 95-102 (H3) in the heavy chain variable domain; Kabat *et al., Sequences of Proteins of Immunological Interest*, 5th Ed. Public Health Service, National Institutes of Health, Bethesda, MD. (1991)) and/or those residues from a "hypervariable loop" *(e.g.* residues 26-32 (L1), 50-52 (L2) and 91-96 (L3) in the light chain variable domain and 26-32 (H1), 53-55 (H2) and 96-101 (H3) in the heavy chain variable domain; Chothia and Lesk *J. Mol. Biol.* 196:901-917 (1987)). "Framework" or "FR" residues are those variable domain residues other than the hypervariable region residues as herein defined.

[0125] A "naked antibody" is an antibody (as herein defined) that is not conjugated to a heterologous molecule, such as a cytotoxic moiety or radiolabel.

[0126] Examples of Examples of anti-CD20 antibodies include: "C2B8," which is now called "rituximab" ("RITUXAN®/MABTHERA®") (U.S. 5,736,137); the yttrium-[90]-labelled 2B8 murine antibody designated "Y2B8" or "Ibritumomab Tiuxetan" (ZEVALIN®) commercially available from Biogen Idec, Inc. (*e.g.,* U.S. 5,736,137; 2B8 deposited with ATCC under accession no. HB11388 on June 22, 1993); murine IgG2a "B1," also called "Tositumomab," optionally labelled with ^{131}I to generate the "131I-B1" or "iodine I131 tositumomab" antibody (BEXXAR™) commercially available from Corixa (*see, also, e.g.,* U.S. 5,595,721); murine monoclonal antibody "1F5" (*e.g.,* Press *et al. Blood* 69(2):584-591 (1987) and variants thereof including "framework patched" or humanized 1F5 (*e.g.,* WO 2003/002607, Leung, S.; ATCC deposit HB-96450); murine 2H7 and chimeric 2H7 antibody (*e.g.,* U.S. 5,677,180); a 2H7 antibody (*e.g.,* WO 2004/056312 (Lowman *et al.*) and as set forth below); HUMAX-CD20™ (ofatumumab) fully human, high-affinity antibody targeted at the CD20 molecule in the cell membrane of B-cells (Genmab, Denmark; see, for example, Glennie and van de Winkel, *Drug Discovery Today* 8: 503-510 (2003) and Cragg *et al., Blood* 101: 1045-1052 (2003)); the human monoclonal antibodies set forth in WO 2004/035607 and WO 2005/103081 (Teeling *et al.,* GenMab/Medarex); the antibodies having complex N-glycoside-linked sugar chains bound to the Fc region described in US 2004/0093621 (Shitara *et al.*); a chimerized or humanized monoclonal antibody having a high binding affinity to an extracellular epitope of a CD20 antigen described in WO 2006/106959 (Numazaki *et al.*, Biomedics Inc.); monoclonal antibodies and antigen-binding fragments binding to CD20 (*e.g.,* WO 2005/000901, Tedder *et al.*) such as HB20-3, HB20-4, HB20-25, and MB20-11; single-chain proteins binding to CD20 including, but not limited to,

TRU-015 (*e.g.*, US 2005/0186216 (Ledbetter and Hayden-Ledbetter); US 2005/0202534 (Hayden-Ledbetter and Ledbetter); US 2005/0202028 (Hayden-Ledbetter and Ledbetter); US 2005/136049 (Ledbetter *et al.*); US 2005/0202023 (Hayden-Ledbetter and Ledbetter) – Trubion Pharm Inc.); CD20-binding molecules such as the AME series of antibodies, *e.g.*, AME-133™ antibodies as set forth, for example, in WO 2004/103404; US 2005/0025764; and US 2006/0251652 (Watkins *et al.*, Applied Molecular Evolution, Inc.) and the anti-CD20 antibodies with Fc mutations as set forth, for example, in WO 2005/070963 (Allan *et al.*, Applied Molecular Evolution, Inc.); CD20-binding molecules such as those described in WO 2005/016969 and US 2005/0069545 (Carr *et al.*); bispecific antibodies as set forth, for example, in WO 2005/014618 (Chang *et al.*); humanized LL2 monoclonal antibodies and other anti-CD20 antibodies as described, for example, in U.S. 7,151,164 (Hansen *et al.*, Immunomedics; US 2005/0106108 (Leung and Hansen; Immunomedics); fully human antibodies against CD20 as described, *e.g.*, in WO 2006/130458; Gazit *et al.*, Amgen/AstraZeneca); antibodies against CD20 as described, for example, in WO 2006/126069 (Morawala, Avestha Gengraine Technologies Pvt Ltd.); chimeric or humanized B-Ly1 antibodies to CD20 (*e.g.*, GA-101) as described, for example, in WO 2005/044859; US 2005/0123546; US 2004/0072290; and US 2003/0175884 (Umana *et al.*; GlycArt Biotechnology AG); A20 antibody or variants thereof such as chimeric or humanized A20 antibody (cA20, hA20, respectively) and IMMUN-106 (*e.g.*, US 2003/0219433, Immunomedics); and monoclonal antibodies L27, G28-2, 93-1B3, B-C1 or NU-B2 available from the International Leukocyte Typing Workshop (*e.g.*, Valentine *et al.*, In: *Leukocyte Typing* III (McMichael, Ed., p. 440, Oxford University Press (1987)). In some embodiments,the anti-CD20 antibodies herein are chimeric, humanized, or human anti-CD20 antibodies, more preferably rituximab, a 2H7 antibody, chimeric or humanized A20 antibody (Immunomedics), and HUMAX-CD20™ human anti-CD20 antibody (Genmab).

[0127] The terms "Rituximab" or "RITUXAN®" herein refer to the genetically engineered chimeric murine/human monoclonal antibody directed against the CD20 antigen and designated "C2B8" in US Patent No. 5,736,137, including fragments thereof that retain the ability to bind CD20. Rituximab is commercially available from Genentech.

[0128] Purely for the purposes herein and unless indicated otherwise, "humanized 2H7" refers to a humanized antibody that binds human CD20, or an antigen-binding fragment thereof, wherein the antibody is effective to deplete primate B cells *in vivo*, the antibody comprising in the H chain variable region (V_H) thereof at least a CDR H3 sequence of SEQ ID NO:12 (Fig. 1B) from an anti-human CD20 antibody and substantially the human consensus framework (FR) residues of the human heavy- chain subgroup III (V_HIII). In some embodiments, this antibody

further comprises the H chain CDR H1 sequence of SEQ ID NO:10 and CDR H2 sequence of SEQ ID NO:11, and, in some embodiments, further comprises the L chain CDR L1 sequence of SEQ ID NO:4, CDR L2 sequence of SEQ ID NO:5, CDR L3 sequence of SEQ ID NO:6 and substantially the human consensus framework (FR) residues of the human light chain subgroup I (VI), wherein the V_H region may be joined to a human IgG chain constant region, wherein the region may be, for example, IgG1 or IgG3. In some embodiments, such antibody comprises the V_H sequence of SEQ ID NO:8 (v16, as shown in Fig. 1B), optionally also comprising the V_L sequence of SEQ ID NO:2 (v16, as shown in Fig. 1A), which may have the amino acid substitutions of D56A and N100A in the H chain and S92A in the L chain (v96). In some embodiments, the antibody is an intact antibody comprising the light and heavy chain amino acid sequences of SEQ ID NOS:13 and 14, respectively, as shown in Figs. 2 and 3. In some embodiments, the antibody is 2H7.v31 comprising the light and heavy chain amino acid sequences of SEQ ID NOS:13 and 15, respectively, as shown in Figs. 2 and 4. The antibody herein may further comprise at least one amino acid substitution in the Fc region that improves ADCC and/or CDC activity, such as one wherein the amino acid substitutions are S298A/E333A/K334A, and in some embodiments, the 2H7.v31 having the heavy chain amino acid sequence of SEQ ID NO:15 (as shown in Fig. 4). Any of these antibodies may further comprise at least one amino acid substitution in the Fc region that decreases CDC activity, for example, comprising at least the substitution K322A. *See* U.S. Patent No. 6,528,624B1 (Idusogie *et al.).*

[0129] The term "Ocrelizumab" herein refers to the genetically engineered humanized monoclonal antibody directed against the CD20 antigen and comprising (a) a light chain comprising the amino acid sequence of SEQ ID NO: 13 and (b) a heavy chain comprising the amino acid sequence of SEQ ID NO:14, including fragments thereof that retain the ability to bind CD20. Ocrelizumab is available from Genentech.

[0130] An "isolated" antibody is one that has been identified and separated and/or recovered from a component of its natural environment. Contaminant components of its natural environment are materials that would interfere with diagnostic or therapeutic uses for the antibody, and may include enzymes, hormones, and other proteinaceous or non-proteinaceous solutes. In some embodiments, the antibody will be purified (1) to greater than 95% by weight of antibody as determined by the Lowry method, and in some embodiments, more than 99% by weight, (2) to a degree sufficient to obtain at least 15 residues of N-terminal or internal amino acid sequence by use of a spinning cup sequenator, or (3) to homogeneity by SDS-PAGE under reducing or nonreducing conditions using Coomassie blue or, in some embodiments, silver stain.

Isolated antibody includes the antibody *in situ* within recombinant cells since at least one component of the antibody's natural environment will not be present. Ordinarily, however, isolated antibody will be prepared by at least one purification step.

[0131] A "subject" or "patient" herein is a human subject or patient. Generally, the subject or patient is eligible for treatment for multiple sclerosis. For the purposes herein, such eligible subject or patient is one who is experiencing, has experienced, or is likely to experience, one or more signs, symptoms or other indicators of multiple sclerosis; has been diagnosed with multiple sclerosis, whether, for example, newly diagnosed (with "new onset" MS), previously diagnosed with a new relapse or exacerbation, previously diagnosed and in remission, etc; and/or is at risk for developing multiple sclerosis. One suffering from or at risk for suffering from multiple sclerosis may optionally be identified as one who has been screened for elevated levels of CD20-positive B cells in serum, cerebrospinal fluid (CSF) and/or MS lesion(s) and/or is screened for using an assay to detect autoantibodies, assessed qualitatively, and preferably quantitatively. Exemplary such autoantibodies associated with multiple sclerosis include anti-myelin basic protein (MBP), anti-myelin oligodendrocytic glycoprotein (MOG), anti-ganglioside and/or anti-neurofilament antibodies. Such autoantibodies may be detected in the subject's serum, cerebrospinal fluid (CSF) and/or MS lesion. By "elevated" autoantibody or B cell level(s) herein is meant level(s) of such autoantibodies or B cells which significantly exceed the level(s) in an individual without MS.

[0132] As used herein, "treatment" or "treating" is an approach for obtaining beneficial or desired results including clinical results. For purposes of this invention, beneficial or desired clinical results include, but are not limited to, one or more of the following: decreasing one or more symptoms resulting from the disease, diminishing the extent of the disease, stabilizing the disease (*e.g.*, preventing or delaying the worsening of the disease), delay or slowing the progression of the disease, ameliorating the disease state, decreasing the dose of one or more other medications required to treat the disease, and/or increasing the quality of life.

[0133] As used herein, "delaying" the progression of multiple sclerosis means to defer, hinder, slow, retard, stabilize, and/or postpone development of the disease. This delay can be of varying lengths of time, depending on the history of the disease and/or individual being treated.

[0134] As used herein, "at the time of starting treatment" refers to the time period at or prior to the first exposure to a multiple sclerosis drug, such as an anti-CD20 antibody. In some embodiments, "at the time of starting treatment" is about any of one year, nine months, six months, three months, second months, or one month prior to a multiple sclerosis drug, such as an

anti-CD20 antibody. In some embodiments, “at the time of starting treatment” is immediately prior to coincidental with the first exposure to a multiple sclerosis drug, such as an anti-CD20 antibody.

[0135] As used herein, "based upon" includes (1) assessing, determining, or measuring the patient characteristics as described herein (and preferably selecting a patient suitable for receiving treatment; and (2) administering the treatment(s) as described herein.

[0136] A “symptom” of MS is any morbid phenomenon or departure from the normal in structure, function, or sensation, experienced by the subject and indicative of MS.

[0137] “Multiple sclerosis” refers to the chronic and often disabling disease of the central nervous system characterized by the progressive destruction of the myelin. There are four internationally recognized forms of MS, namely, primary progressive multiple sclerosis (PPMS), relapsing-remitting multiple sclerosis (RRMS), secondary progressive multiple sclerosis (SPMS), and progressive relapsing multiple sclerosis (PRMS).

[0138] “Progressive multiple sclerosis” as used herein refers to primary progressive multiple sclerosis (PPMS), secondary progressive multiple sclerosis (SPMS), and progressive relapsing multiple sclerosis (PRMS). In some embodiments, progressive multiple sclerosis is characterized by documented, irreversible loss of neurological function persisting for = 6 months that cannot be attributed to clinical relapse.

[0139] “Primary progressive multiple sclerosis” or “PPMS” is characterized by a gradual progression of the disease from its onset with no superimposed relapses and remissions at all. There may be periods of a leveling off of disease activity and there may be good and bad days or weeks. PPMS differs from RRMS and SPMS in that onset is typically in the late thirties or early forties, men are as likely women to develop it, and initial disease activity is often in the spinal cord and not in the brain. PPMS often migrates into the brain, but is less likely to damage brain areas than RRMS or SPMS. For example, people with PPMS are less likely to develop cognitive problems than those with RRMS or SPMS. PPMS is the sub-type of MS that is least likely to show inflammatory (gadolinium enhancing) lesions on MRI scans. The Primary Progressive form of the disease affects between 10 and 15% of all people with multiple sclerosis. PPMS may be defined according to the criteria in McDonald *et al. Ann Neurol* 50:121–7 (2001). The subject with PPMS treated herein is usually one with probable or definitive diagnosis of PPMS.

[0140] “Relapsing-remitting multiple sclerosis” or “RRMS” is characterized by relapses (also known as exacerbations) during which time new symptoms can appear and old ones resurface or worsen. The relapses are followed by periods of remission, during which time the person fully or

partially recovers from the deficits acquired during the relapse. Relapses can last for days, weeks or months and recovery can be slow and gradual or almost instantaneous. The vast majority of people presenting with MS are first diagnosed with RRMS. This is typically when they are in their twenties or thirties, though diagnoses much earlier or later are known. Twice as many women as men present with this sub-type of MS. During relapses, myelin, a protective insulating sheath around the nerve fibers (neurons) in the white matter regions of the central nervous system (CNS), may be damaged in an inflammatory response by the body's own immune system. This causes a wide variety of neurological symptoms that vary considerably depending on which areas of the CNS are damaged. Immediately after a relapse, the inflammatory response dies down and a special type of glial cell in the CNS (called an oligodendrocyte) sponsors remyelination - a process whereby the myelin sheath around the axon may be repaired. It is this remyelination that may be responsible for the remission. Approximately 50% of patients with RRMS convert to SPMS within 10 years of disease onset. After 30 years, this figure rises to 90%. At any one time, the relapsing-remitting form of the disease accounts around 55% of all people with MS.

[0141] "Secondary progressive multiple sclerosis" or "SPMS" is characterized by a steady progression of clinical neurological damage with or without superimposed relapses and minor remissions and plateaux. People who develop SPMS will have previously experienced a period of RRMS which may have lasted anything from two to forty years or more. Any superimposed relapses and remissions there are, tend to tail off over time. From the onset of the secondary progressive phase of the disease, disability starts advancing much quicker than it did during RRMS though the progress can still be quite slow in some individuals. After 10 years, 50% of people with RRMS will have developed SPMS. By 25 to 30 years, that figure will have risen to 90%. SPMS tends to be associated with lower levels of inflammatory lesion formation than in RRMS but the total burden of disease continues to progress. At any one time, SPMS accounts around 30% of all people with multiple sclerosis.

[0142] "Progressive relapsing multiple sclerosis" refers to "PRMS" is characterized by a steady progression of clinical neurological damage with superimposed relapses and remissions. There is significant recovery immediately following a relapse but between relapses there is a gradual worsening of symptoms. PRMS affects around 5% of all people with multiple sclerosis. Some neurologists believe PRMS is a variant of PPMS.

[0143] The expression "effective amount" refers to an amount of the antibody (or other drug) that is effective for ameliorating or treating the multiple sclerosis. Such an effective amount will generally result in an improvement in the signs, symptoms or other indicators of MS, such as reducing relapse rate, preventing disability, reducing number and/or volume of brain MRI lesions,

improving timed 25-foot walk, slow or delay the progression of the disease such as extending the time to disease progression *(e.g.* using Expanded Disability Status Scale, EDSS), etc.

[0144] "Antibody exposure" refers to contact with or exposure to the antibody herein in one or more doses administered over a period of time of about 1-20 days. The doses may be given at one time or at fixed or irregular time intervals over this period of exposure. Initial and later *(e.g.* second or third) antibody exposures are separated in time from each other as described in detail herein.

[0145] The term "immunosuppressive agent" as used herein for adjunct therapy refers to substances that act to suppress or mask the immune system of the mammal being treated herein. This would include substances that suppress cytokine production, down-regulate or suppress self-antigen expression, or mask the MHC antigens. Examples of such agents include 2-amino-6-aryl-5-substituted pyrimidines (*see* U.S. Pat. No. 4,665,077); nonsteroidal anti-inflammatory drugs (NSAIDs); ganciclovir, tacrolimus, glucocorticoids such as cortisol or aldosterone, anti-inflammatory agents such as a cyclooxygenase inhibitor, a 5-lipoxygenase inhibitor, or a leukotriene receptor antagonist; purine antagonists such as azathioprine or mycophenolate mofetil (MMF); alkylating agents such as cyclophosphamide; bromocryptine; danazol; dapsone; glutaraldehyde (which masks the MHC antigens, as described in U.S. Pat. No. 4,120,649); anti-idiotypic antibodies for MHC antigens and MHC fragments; cyclosporin A; steroids such as corticosteroids or glucocorticosteroids or glucocorticoid analogs, *e.g.*, prednisone, methylprednisolone, and dexamethasone; dihydrofolate reductase inhibitors such as methotrexate (oral or subcutaneous); hydroxycloroquine; sulfasalazine; leflunomide; cytokine or cytokine receptor antagonists including anti-interferon-alpha, -beta, or -gamma antibodies, anti-tumor necrosis factor-alpha antibodies (infliximab or adalimumab), anti-TNF-alpha immunoahesin (etanercept), anti-tumor necrosis factor-beta antibodies, anti-interleukin-2 antibodies and anti-IL-2 receptor antibodies; anti-LFA-1 antibodies, including anti-CD11a and anti-CD18 antibodies; anti-L3T4 antibodies; heterologous anti-lymphocyte globulin; pan-T antibodies, preferably anti-CD3 or anti-CD4/CD4a antibodies; soluble peptide containing a LFA-3 binding domain (WO 90/08187 published 7/26/90); streptokinase; TGF-beta; streptodornase; RNA or DNA from the host; FK506; RS-61443; deoxyspergualin; rapamycin; T-cell receptor (Cohen *et al.*, U.S. Pat. No. 5,114,721); T-cell receptor fragments (Offner *et al.*, *Science*, 251: 430-432 (1991); WO 90/11294; Ianeway, *Nature*, 341: 482 (1989); and WO 91/01133); and T cell receptor antibodies (EP 340,109) such as T10B9.

[0146] The term "cytotoxic agent" as used herein refers to a substance that inhibits or prevents the function of cells and/or causes destruction of cells. The term is intended to include radioactive

isotopes (*e.g.* At^{211}, I^{131}, I^{125}, Y^{90}, Re^{186}, Re^{188}, Sm^{153}, Bi^{212}, P^{32} and radioactive isotopes of Lu), chemotherapeutic agents, and toxins such as small molecule toxins or enzymatically active toxins of bacterial, fungal, plant or animal origin, or fragments thereof.

[0147] A "chemotherapeutic agent" is a chemical compound useful in the treatment of cancer. Examples of chemotherapeutic agents include alkylating agents such as thiotepa and CYTOXAN® cyclosphosphamide; alkyl sulfonates such as busulfan, improsulfan and piposulfan; aziridines such as benzodopa, carboquone, meturedopa, and uredopa; ethylenimines and methylamelamines including altretamine, triethylenemelamine, trietylenephosphoramide, triethiylenethiophosphoramide and trimethylolomelamine; acetogenins (especially bullatacin and bullatacinone); a camptothecin (including the synthetic analogue topotecan); bryostatin; callystatin; CC-1065 (including its adozelesin, carzelesin and bizelesin synthetic analogues); cryptophycins (particularly cryptophycin 1 and cryptophycin 8); dolastatin; duocarmycin (including the synthetic analogues, KW-2189 and CB1-TM1); eleutherobin; pancratistatin; a sarcodictyin; spongistatin; nitrogen mustards such as chlorambucil, chlornaphazine, cholophosphamide, estramustine, ifosfamide, mechlorethamine, mechlorethamine oxide hydrochloride, melphalan, novembichin, phenesterine, prednimustine, trofosfamide, uracil mustard; nitrosureas such as carmustine, chlorozotocin, fotemustine, lomustine, nimustine, and ranimnustine; antibiotics such as the enediyne antibiotics (*e. g.*, calicheamicin, especially calicheamicin gamma1I and calicheamicin omegaI1 (*see*, *e.g.*, Agnew, *Chem Intl. Ed. Engl.*, 33: 183-186 (1994)); dynemicin, including dynemicin A; bisphosphonates, such as clodronate; an esperamicin; as well as neocarzinostatin chromophore and related chromoprotein enediyne antiobiotic chromophores), aclacinomysins, actinomycin, authramycin, azaserine, bleomycins, cactinomycin, carabicin, carminomycin, carzinophilin, chromomycinis, dactinomycin, daunorubicin, detorubicin, 6-diazo-5-oxo-L-norleucine, ADRIAMYCIN® doxorubicin (including morpholino-doxorubicin, cyanomorpholino-doxorubicin, 2-pyrrolino-doxorubicin and deoxydoxorubicin), epirubicin, esorubicin, idarubicin, marcellomycin, mitomycins such as mitomycin C, mycophenolic acid, nogalamycin, olivomycins, peplomycin, potfiromycin, puromycin, quelamycin, rodorubicin, streptonigrin, streptozocin, tubercidin, ubenimex, zinostatin, zorubicin; anti-metabolites such as methotrexate and 5-fluorouracil (5-FU); folic acid analogues such as denopterin, methotrexate, pteropterin, trimetrexate; purine analogs such as fludarabine, 6-mercaptopurine, thiamiprine, thioguanine; pyrimidine analogs such as ancitabine, azacitidine, 6-azauridine, carmofur, cytarabine, dideoxyuridine, doxifluridine, enocitabine, floxuridine; androgens such as calusterone, dromostanolone propionate, epitiostanol, mepitiostane, testolactone; anti- adrenals such as aminoglutethimide, mitotane, trilostane; folic

acid replenisher such as frolinic acid; aceglatone; aldophosphamide glycoside; aminolevulinic acid; eniluracil; amsacrine; bestrabucil; bisantrene; edatraxate; defofamine; demecolcine; diaziquone; elfornithine; elliptinium acetate; an epothilone; etoglucid; gallium nitrate; hydroxyurea; lentinan; lonidainine; maytansinoids such as maytansine and ansamitocins; mitoguazone; mitoxantrone; mopidanmol; nitraerine; pentostatin; phenamet; pirarubicin; losoxantrone; podophyllinic acid; 2- ethylhydrazide; procarbazine; PSK® polysaccharide complex (JHS Natural Products, Eugene, OR); razoxane; rhizoxin; sizofiran; spirogermanium; tenuazonic acid; triaziquone; 2,2',2"-trichlorotriethylamine; trichothecenes (especially T-2 toxin, verracurin A, roridin A and anguidine); urethan; vindesine; dacarbazine; mannomustine; mitobronitol; mitolactol; pipobroman; gacytosine; arabinoside ("Ara-C"); cyclophosphamide; thiotepa; taxoids, *e.g.*, TAXOL® paclitaxel (Bristol- Myers Squibb Oncology, Princeton, N.J.), ABRAXANE™ Cremophor-free, albumin-engineered nanoparticle formulation of paclitaxel (American Pharmaceutical Partners, Schaumberg, Illinois), and TAXOTERE® doxetaxel (Rhône- Poulenc Rorer, Antony, France); chloranbucil; GEMZAR® gemcitabine; 6-thioguanine; mercaptopurine; methotrexate; platinum analogs such as cisplatin and carboplatin; vinblastine; platinum; etoposide (VP-16); ifosfamide; mitoxantrone; vincristine; NAVELBINE® vinorelbine; novantrone; teniposide; edatrexate; daunomycin; aminopterin; xeloda; ibandronate; CPT-11; topoisomerase inhibitor RFS 2000; difluorometlhylornithine (DMFO); retinoids such as retinoic acid; capecitabine; and pharmaceutically acceptable salts, acids or derivatives of any of the above.

[0148] Also included in this definition are anti-hormonal agents that act to regulate or inhibit hormone action on tumors such as anti-estrogens and selective estrogen receptor modulators (SERMs), including, for example, tamoxifen (including NOLVADEX® tamoxifen), raloxifene, droloxifene, 4-hydroxytamoxifen, trioxifene, keoxifene, LY117018, onapristone, and FARESTON toremifene; aromatase inhibitors that inhibit the enzyme aromatase, which regulates estrogen production in the adrenal glands, such as, for example, 4(5)-imidazoles, aminoglutethimide, MEGASE® megestrol acetate, AROMASIN® exemestane, formestanie, fadrozole, RIVISOR® vorozole, FEMARA® letrozole, and ARIMIDEX® anastrozole; and anti-androgens such as flutamide, nilutamide, bicalutamide, leuprolide, and goserelin; as well as troxacitabine (a 1,3-dioxolane nucleoside cytosine analog); antisense oligonucleotides, particularly those that inhibit expression of genes in signaling pathways implicated in abherant cell proliferation, such as, for example, PKC-alpha, Ralf and H-Ras; vaccines such as gene therapy vaccines, for example, ALLOVECTIN® vaccine, LEUVECTIN® vaccine, and VAXID®

vaccine; PROLEUKIN® rIL-2; LURTOTECAN® topoisomerase 1 inhibitor; ABARELIX® rmRH; and pharmaceutically acceptable salts, acids or derivatives of any of the above.

[0149] The term "cytokine" is a generic term for proteins released by one cell population that act on another cell as intercellular mediators. Examples of such cytokines are lymphokines, monokines; interleukins (ILs) such as IL-1, IL-1a, IL-2, IL-3, IL-4, IL-5, IL-6, IL-7, IL-8, IL-9, IL-11, IL-12, IL-15; a tumor necrosis factor such as TNF-a or TNF-ß; and other polypeptide factors including LIF and kit ligand (KL). As used herein, the term cytokine includes proteins from natural sources or from recombinant cell culture and biologically active equivalents of the native sequence cytokines, including synthetically produced small-molecule entities and pharmaceutically acceptable derivatives and salts thereof.

[0150] The term "hormone" refers to polypeptide hormones, which are generally secreted by glandular organs with ducts. Included among the hormones are, for example, growth hormone such as human growth hormone, N-methionyl human growth hormone, and bovine growth hormone; parathyroid hormone; thyroxine; insulin; proinsulin; relaxin; prorelaxin; glycoprotein hormones such as follicle stimulating hormone (FSH), thyroid stimulating hormone (TSH), and luteinizing hormone (LH); prolactin, placental lactogen, mouse gonadotropin-associated peptide, inhibin; activin; mullerian-inhibiting substance; and thrombopoietin. As used herein, the term hormone includes proteins from natural sources or from recombinant cell culture and biologically active equivalents of the native sequence hormone, including synthetically produced small-molecule entities and pharmaceutically acceptable derivatives and salts thereof.

[0151] The term "growth factor" refers to proteins that promote growth, and include, for example, hepatic growth factor; fibroblast growth factor; vascular endothelial growth factor; nerve growth factors such as NGF-ß; platelet-derived growth factor; transforming growth factors (TGFs) such as TGF-a and TGF-ß; insulin-like growth factor-I and -II; erythropoietin (EPO); osteoinductive factors; interferons such as interferon-a, -ß, and -γ; and colony stimulating factors (CSFs) such as macrophage-CSF (M-CSF); granulocyte-macrophage-CSF (GM-CSF); and granulocyte-CSF (G-CSF). As used herein, the term growth factor includes proteins from natural sources or from recombinant cell culture and biologically active equivalents of the native sequence growth factor, including synthetically produced small-molecule entities and pharmaceutically acceptable derivatives and salts thereof.

[0152] The term "integrin" refers to a receptor protein that allows cells both to bind to and to respond to the extracellular matrix and is involved in a variety of cellular functions such as wound healing, cell differentiation, homing of tumor cells and apoptosis. They are part of a large

family of cell adhesion receptors that are involved in cell-extracellular matrix and cell-cell interactions. Functional integrins consist of two transmembrane glycoprotein subunits, called alpha and beta that are non-covalently bound. The alpha subunits all share some homology to each other, as do the beta subunits. The receptors always contain one alpha chain and one beta chain. Examples include Alpha6beta1, Alpha3beta1, Alpha7beta1, LFA-1, alpha 4 integrin etc. As used herein, the term integrin includes proteins from natural sources or from recombinant cell culture and biologically active equivalents of the native sequence integrin, including synthetically produced small-molecule entities and pharmaceutically acceptable derivatives and salts thereof.

[0153] Examples of "integrin antagonists or antibodies" herein include an LFA-1 antibody such as Efalizumab (RAPTIVA®) commercially available from Genentech; an alpha 4 integrin antibody such as natalizumab (TYSABRI®) available from Biogen Idec/Elan Pharmaceuticals, Inc.; diazacyclic phenylalanine derivatives (WO 2003/89410); phenylalanine derivatives (WO 2003/70709, WO 2002/28830, WO 2002/16329 and WO 2003/53926); phenylpropionic acid derivatives (WO 2003/10135); enamine derivatives (WO 2001/79173); propanoic acid derivatives (WO 2000/37444); alkanoic acid derivatives (WO 2000/32575); substituted phenyl derivatives (US Pat. Nos. 6,677,339 and 6,348,463); aromatic amine derivatives (US Pat. No. 6,369,229); and ADAM disintegrin domain polypeptide (US2002/0042368), antibodies to alphavbeta3 integrin (EP 633945); aza-bridged bicyclic amino acid derivatives (WO 2002/02556) etc.

[0154] For the purposes herein, "tumor necrosis factor alpha (TNF-alpha)" refers to a human TNF-alpha molecule comprising the amino acid sequence as described in Pennica *et al., Nature,* 312:721 (1984) or Aggarwal *et al., JBC*, 260:2345 (1985).

[0155] A "TNF-alpha inhibitor" herein is an agent that inhibits, to some extent, a biological function of TNF-alpha, generally through binding to TNF-alpha and neutralizing its activity. Examples of TNF inhibitors specifically contemplated herein are Etanercept (ENBREL®), Infliximab (REMICADE®) and Adalimumab (HUMIRA™).

[0156] Examples of "disease-modifying anti-rheumatic drugs" or "DMARDs" include hydroxycloroquine, sulfasalazine, methotrexate, leflunomide, etanercept, infliximab (plus oral and subcutaneous methrotrexate), azathioprine, D-penicillamine, Gold (oral), Gold (intramuscular), minocycline, cyclosporine, Staphylococcal protein A immunoadsorption, including salts and derivatives thereof, etc.

[0157] Examples of "nonsteroidal anti-inflammatory drugs" or "NSAIDs" are acetylsalicylic acid, ibuprofen, naproxen, indomethacin, sulindac, tolmetin, including salts and derivatives thereof, etc.

[0158] "Corticosteroid" refers to any one of several synthetic or naturally occurring substances with the general chemical structure of steroids that mimic or augment the effects of the naturally occurring corticosteroids. Examples of synthetic corticosteroids include prednisone, prednisolone (including methylprednisolone), dexamethasone, glucocorticoid and betamethasone.

[0159] A "package insert" is used to refer to instructions customarily included in commercial packages of therapeutic products, that contain information about the indications, usage, dosage, administration, contraindications, other therapeutic products to be combined with the packaged product, and/or warnings concerning the use of such therapeutic products, etc.

[0160] A "label" is used herein to refer to information customarily included with commercial packages of pharmaceutical formulations including containers such as vials and package inserts, as well as other types of packaging.

[0161] Reference to "about" a value or parameter herein includes (and describes) variations that are directed to that value or parameter per se. For example, description referring to "about X" includes description of "X".'

[0162] As used herein and in the appended claims, the singular forms "a," "or," and "the" include plural referents unless the context clearly dictates otherwise. It is understood that aspects and variations of the invention described herein include "consisting" and/or "consisting essentially of" aspects and variations.

II. Methods of Treatment

[0163] The present invention provides methods of treating progressive multiple sclerosis in a patient comprising administering to the patient an effective amount of an anti-CD20 antibody.

[0164] In some embodiments, the invention provides methods of treating progressive multiple sclerosis in a patient comprising administering to the patient an effective amount of an anti-CD20 antibody, wherein treatment is based upon the patient having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0165] In some embodiments, the invention provides methods of treating progressive multiple sclerosis in a patient provided that the patient has been found to have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status

Scale (EDSS) over two years prior to starting the treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, the treatment comprising administering to the patient an effective amount of an anti-CD20 antibody.

[0166] In some embodiments, the invention provides methods of treating progressive multiple sclerosis in a patient comprising administering to the patient an effective amount of an anti-CD20 antibody, wherein the patient has at the time of starting treatment one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, whereby evidence of the age, the gadolinium staining lesions, the increase in EDDS over two years prior to starting the treatment, MSSS, or a combination thereof indicates that the patient will respond to treatment with the anti-CD20 antibody.

[0167] In some embodiments, the invention provides methods of treating progressive multiple sclerosis, comprising: (a) selecting a patient has one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and (b) administering to the patient thus selected an effective amount of an anti-CD20 antibody.

[0168] In some embodiments, the invention provides methods of treating progressive multiple sclerosis in a patient, comprising administering to the patient an effective amount of an anti-CD20 antibody, and wherein one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.is used as a basis for selecting the patient to receive the treatment, and wherein said treatment comprises administering an effective amount of the anti-CD20 antibody to the patient.

[0169] The invention further provides methods of treating multiple sclerosis in a patient comprising administering an effective amount of ocrelizumab to the patient to provide an initial ocrelizumab exposure of between about 0.3 to about 0.6 grams followed by a second ocrelizumab exposure of between about 0.3 to about 0.6 grams, the second exposure not being provided until from about 16 to 60 weeks from the initial exposure, and each of the ocrelizumab exposures is

provided to the patient as one or two doses of ocrelizumab. In some embodiments, the initial ocrelizumab exposure is about 0.6 grams. In some embodiments, the second ocrelizumab exposure is about 0.6 grams. In some embodiments, the second exposure is administered from about 24 weeks from the initial exposure. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as one dose of ocrelizumab. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as two doses of ocrelizumab. In some embodiments, the two doses of ocrelizumab comprise about 0.3 grams of ocrelizumab.

[0170] The present invention also provides methods of assessing and/or predicting responsiveness of a patient with progressive multiple sclerosis to an anti-CD20 antibody treatment.

[0171] In some embodiments, the invention provides methods of assessing whether a patient with progressive multiple sclerosis will respond to treatment with an anti-CD20 antibody comprising assessing one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, wherein one or more of the characteristics in the patient indicates the patient will be responsive to the treatment.

[0172] In some embodiments, the invention provides methods of assessing whether a patient with progressive multiple sclerosis will respond to treatment with an anti-CD20 antibody comprising: (a) assessing one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; (b) implementing an algorithm to determine that the patient is responsive to said treatment; and (c) recording a result specific to the patient being tested.

[0173] In some embodiments, the invention provides methods of treating progressive multiple sclerosis in a patient comprising: (a) assessing one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (i) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, wherein the patient is selected for treatment based on the patient having one or more characteristics selected from the group consisting of (i) an age less than about 55 years,

(ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and (b) treating said selected patient by administering to said selected patient an effective amount of an anti-CD20 antibody.

[0174] In some embodiments, the invention provides methods for selecting a therapy for a patient and/or a patient population with progressive multiple sclerosis comprising: (a) assessing one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and (b) selecting an anti-CD20 antibody for treatment if the patient or patient population has one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting the anti-CD20 treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0175] In some embodiments, the invention provides methods for predicting whether a patient with progressive multiple sclerosis will respond to an anti-CD20 antibody, the methods comprising assessing one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, whereby the age, the gadolinium staining lesions, the increase in EDDS over two years prior to starting treatment, MSSS, or a combination thereof indicates that the patient will respond to the anti-CD20 antibody.

[0176] In some embodiments, the invention provides methods of identifying a patient with progressive multiple sclerosis likely to respond to anti-CD20 antibody treatment comprising: (a) assessing one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and (b) identifying the patient having one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0177] In some embodiments of any of the methods of treating, assessing, and/or predicting responsiveness described herein, the patients have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment.

[0178] In some embodiments of any of the methods of assessing and/or predicting responsiveness described herein, the methods further comprise advising a patient.

[0179] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the patient has more than one characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the patient has two characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments, the patient has three characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in EDSS over two years prior to starting treatment. In some embodiments, the patient has (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0180] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient and/or patient population is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0181] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the patient and/or patient population further has evidence of inflammation in a sample. Evidence of inflammation is indicated by assessing one or more indicia

of inflammation. The sample can be any suitable sample to assess inflammation. In some embodiments, the sample is tissue or fluid. In some embodiments, the fluid sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing. In some embodiments, the evidence of inflammation is detected by MRI. In some embodiments, the evidence of inflammation is detected by the presence of Gd-enhancing lesions or T2 lesions. Other methods of assessing evidence of inflammation are known in the art.

[0182] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the patient and/or patient population is characterized by a change in EDSS over a period of time. In some embodiments, the patient and/or patient population is characterized by at least about any of 1 point, 1.25 point, 1.5 point, 1.75 point, 2 point, 2.25 point, 2.5 point, 2.75 point, or 3 point increase in EDSS over two years prior to starting the anti-CD20 antibody treatment. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient and/or patient population is characterized by having had an EDSS of greater than about 5.0 for less than about any of 5 years, 6 years, 7 years, 8 years, 9 years, 10 years, 11 years, 12 years, 13 years, 14 years, 15 years, 16 years, 17 years, 18 years, 19 years, or 20 years. In some embodiments, the patient and/or patient population is characterized by having had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient and/or patient population is characterized by having had an EDSS less than or equal to about 5.0 for less than about any of 5 years, 6 years, 7 years, 8 years, 9 years, 10 years, 11 years, 12 years, 13 years, 14 years, or 15 years. In some embodiments, the patient and/or patient population is characterized by having had an EDSS less than or equal to about 5.0 for less than about 10 years.

[0183] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the patient and/or patient population is characterized by having an EDSS of between about any of 1.5 points to 7 points, 1.5 points to 6.5 points, 2 points to 6.5 points, or 3 points to 6.5 points. In some embodiments, the patient and/or patient population is characterized by having an EDSS when starting treatment is between about 3.0 and about 6.5.

[0184] In some embodiments of any of the methods of treating, assessing and/or predicting responsiveness described herein, the patient and/or patient population is characterized by having an MSSS of greater than about any of 6, 7, 8, or 9. In some embodiments of any of the methods

of treating and assessing and/or predicting responsiveness described herein, the patient and/or patient population is characterized by having an MSSS of greater than about 9.

[0185] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the patient and/or patient population is further characterized by having two or more relapses within two years prior to starting treatment. In some embodiments, the patient and/or patient population is further characterized by having any of 2 relapses, 3 relapses, 4 relapses, or 5 relapses within two years prior to starting treatment.

[0186] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the patient and/or patient population is characterized by an age. In some embodiments, the patient and/or patient population is characterized by having an age less than about any of 55 years, 54 years, 53 years, 52 years, 51 years, or 50 years. In some embodiments, the patient and/or patient population is characterized by having an age of less than about 51 years.

[0187] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the treatment reduces time to confirmed disease progression. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for about any of 4 weeks, 8 weeks, 12 weeks, 16 weeks, 20 weeks, 24 weeks, 28 weeks, or 32 weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twelve weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

[0188] In some embodiments of any of the methods of treating and assessing and/or predicting responsiveness described herein, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments of any of the methods described herein, the anti-CD20 antibody is ocrelizumab. In some embodiments of any of the methods described herein, the anti-CD20 antibody is rituximab. In some embodiments of any of the methods described herein, the anti-CD20 antibody is ofatumumab. In some embodiments of any of the methods described herein, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments of any of the methods described herein, the anti-CD20 antibody is GA101. In some embodiments of any of the methods described herein, the anti-CD20 antibody is hA20.

[0189] The methods described herein may encompass any combination of the embodiments described herein. For example, the methods include methods of treatment and assessing and/or

predicting wherein the patient has (a) an age less than about 55 years and (b) one or more gadolinium staining lesions.

III. Dosages

[0190] According to some embodiments of any of the methods or articles of manufacture described herein, the method or instructions comprises administering an effective amount of an anti-CD20 antibody to the multiple sclerosis patient to provide an initial antibody exposure of about 0.3 to about 4 grams (preferably about 0.3 to about 1.5 grams, such as about 0.6 grams or about 1.0 grams) followed by a second antibody exposure of about 0.3 to about 4 grams (preferably about 0.3 to about 1.5 grams, such as about 0.6 grams or about 1.0 grams), the second antibody exposure not being provided until from about 16 to about 60 weeks from the initial antibody exposure. For purposes of this invention, the second antibody exposure is the next time the patient is treated with the anti-CD20 antibody after the initial antibody exposure, there being no intervening anti-CD20 antibody treatment or exposure between the initial and second exposures. In some embodiments, the initial antibody exposure and/or the second antibody exposure is about any of 0.3 grams, 0.4 grams, 0.5 grams, 0.6 grams, 0.7 grams, 0.8 grams, 0.9 grams, or 1.0 grams.

[0191] The interval between the initial and second or subsequent antibody exposures can be measured from either the first or second dose of the initial antibody exposure, but in some embodiments, from the first dose of the initial antibody exposure.

[0192] In some embodiments, the antibody exposures are approximately 24 weeks or 6 months apart; or approximately 48 weeks or 12 months apart.

[0193] In one embodiment, the second antibody exposure is not provided until about 20 to about 30 weeks from the initial exposure, optionally followed by a third antibody exposure of about 0.3 to about 4 grams (preferably about 0.3 to about 1.5 grams), the third exposure not being administered until from about 46 to 60 weeks (preferably from about 46 to 54 weeks) from the initial exposure, and then, in some embodiments, no further antibody exposure is provided until at least about 70-75 weeks from the initial exposure. In some embodiments, the third antibody exposure is about any of 0.3 grams, 0.4 grams, 0.5 grams, 0.6 grams, 0.7 grams, 0.8 grams, 0.9 grams, or 1.0 grams.

[0194] In an alternative embodiment, the second antibody exposure is not provided until about 46 to 60 weeks from the initial exposure, and subsequent antibody exposures, if any, are not provided until about 46 to 60 weeks from the previous antibody exposure.

[0195] Any one or more of the antibody exposures herein may be provided to the patient as a single dose of antibody, or as two separate doses of the antibody (*i.e.*, constituting a first and second dose). The particular number of doses (whether one or two) employed for each antibody exposure is dependent, for example, on the type of MS treated, the type of antibody employed, whether and what type of second medicament is employed, and the method and frequency of administration. Where two separate doses are administered, the second dose is preferably administered from about 3 to 17 days, more preferably from about 6 to 16 days, and most preferably from about 13 to 16 days from the time the first dose was administered. In some embodiments, where two separate doses are administered, the second dose is about 14 days. Where two separate doses are administered, the first and second dose of the antibody is preferably about 0.3 to 1.5 grams, more preferably about 0.3 to about 1.0 grams. In some embodiments, where two separate doses are administered, the first and second dose of the antibody is about any of 0.3 grams, 0.4 grams, 0.5 grams, or 0.6 grams. In some embodiments, the initial ocrelizumab exposure comprises a first dose and a second dose of ocrelizumab, wherein the first dose and second dose of ocrelizumab is about 0.3 grams. In some embodiments, the second ocrelizumab exposure comprises a single dose of ocrelizumab, wherein the single dose of ocrelizumab is 0.6 grams.

[0196] In one embodiment, the patient is provided at least about three, at least about four, or at least about five exposures of the antibody, for example, from about 3 to 60 exposures, and more particularly about 3 to 40 exposures, most particularly, about 3 to 20 exposures. In some embodiments of any of the methods, the methods further comprising providing between about one to about three subsequent ocrelizumab exposures. In some embodiments, such exposures are administered at intervals each of approximately 24 weeks or 6 months, or 48 weeks or 12 months. In one embodiment, each antibody exposure is provided as a single dose of the antibody. In an alternative embodiment, each antibody exposure is provided as two separate doses of the antibody. However, not every antibody exposure need be provided as a single dose or as two separate doses.

[0197] The antibody may be a naked antibody or may be conjugated with another molecule such as a cytotoxic agent such as a radioactive compound. In some embodiments, the antibody is Rituximab, humanized 2H7 (*e.g.* comprising the variable domain sequences in SEQ ID NOS. 2 and 8) or humanized 2H7 comprising the variable domain sequences in SEQ ID NOS. 23 and 24, or huMax-CD20 (Genmab). In some embodiments, the antibody is ocrelizumab (*e.g.*, comprising (a) a light chain comprising the amino acid sequence of SEQ ID NO: 13 and (b) a heavy chain comprising the amino acid sequence of SEQ ID NO:14).

[0198] In one embodiment, the patient has never been previously treated with drug(s), such as immunosuppressive agent(s), to treat the multiple sclerosis and/or has never been previously treated with an antibody to a B-cell surface marker *(e.g.* never previously treated with a CD20 antibody).

[0199] The antibody is administered by any suitable means, including parenteral, topical, subcutaneous, intraperitoneal, intrapulmonary, intranasal, and/or intralesional administration. Parenteral infusions include intramuscular, intravenous, intraarterial, intraperitoneal, or subcutaneous administration. Intrathecal administration is also contemplated (*see, e.g.*, US Patent Appln No. 2002/0009444, Grillo-Lopez, A concerning intrathecal delivery of a CD20 antibody). In addition, the antibody may suitably be administered by pulse infusion, *e.g.*, with declining doses of the antibody. In some embodiments, the dosing is given intravenously, subcutaneously or intrathecally. In some embodiments, the dosing is given by intravenous infusion(s).

[0200] While the CD20 antibody may be the only drug administered to the patient to treat the multiple sclerosis, one may optionally administer a second medicament, such as a cytotoxic agent, chemotherapeutic agent, immunosuppressive agent, cytokine, cytokine antagonist or antibody, growth factor, hormone, integrin, integrin antagonist or antibody *(e.g.* an LFA-1 antibody such as efalizumab (RAPTIVA®) commercially available from Genentech, or an alpha 4 integrin antibody such as natalizumab (TYSABRI®) available from Biogen Idec/Elan Pharmaceuticals, Inc) etc, with the antibody that binds a B cell surface marker *(e.g.* with the CD20 antibody).

[0201] In some embodiments of combination therapy, the antibody is combined with an interferon class drug such as IFN-beta-1a (REBIF® and AVONEX®) or IFN-beta-1b (BETASERON®); an oligopeptide such a glatiramer acetate (COPAXONE®); a cytotoxic agent such as mitoxantrone (NOVANTRONE®), methotrexate, cyclophosphamide, chlorambucil, azathioprine; intravenous immunoglobulin (gamma globulin); lymphocyte-depleting therapy *(e.g.*, mitoxantrone, cyclophosphamide, Campath, anti-CD4, cladribine, total body irradiation, bone marrow transplantation); corticosteroid *(e.g.* methylprednisolone, prednisone, dexamethasone, or glucorticoid), including systemic corticosteroid therapy; non–lymphocyte-depleting immunosuppressive therapy *(e.g.*, mycophenolate mofetil (MMF) or cyclosporine); cholesterol-lowering drug of the "statin" class, which includes cerivastatin (BAYCOL®), fluvastatin (LESCOL®), atorvastatin (LIPITOR®), lovastatin (MEVACOR®), pravastatin (PRAVACHOL®), Simvastatin (ZOCOR®); estradiol; testosterone (optionally at elevated dosages; Stuve *et al. Neurology* 8:290–301 (2002)); hormone replacement therapy; treatment for symptoms secondary or related to MS *(e.g.,* spasticity, incontinence, pain, fatigue);

a TNF inhibitor; disease-modifying anti-rheumatic drug (DMARD); non-steroidal anti-inflammatory drug (NSAID); plasmapheresis; levothyroxine; cyclosporin A; somatastatin analogue; cytokine or cytokine receptor antagonist; anti-metabolite; immunosuppressive agent; rehabilitative surgery; radioiodine; thyroidectomy; another B-cell surface antagonist/antibody; etc.

[0202] The second medicament is administered with the initial exposure and/or later exposures of the CD20 antibody, such combined administration includes co-administration, using separate formulations or a single pharmaceutical formulation, and consecutive administration in either order, wherein preferably there is a time period while both (or all) active agents simultaneously exert their biological activities.

[0203] Aside from administration of antibodies to the patient, the present application contemplates administration of antibodies by gene therapy. Such administration of nucleic acid encoding the antibody is encompassed by the expression administering an "effective amount" of an antibody. *See*, for example, WO96/07321 published March 14, 1996 concerning the use of gene therapy to generate intracellular antibodies.

[0204] There are two major approaches to getting the nucleic acid (optionally contained in a vector) into the patient's cells; *in vivo* and *ex vivo*. For *in vivo* delivery the nucleic acid is injected directly into the patient, usually at the site where the antibody is required. For *ex vivo* treatment, the patient's cells are removed, the nucleic acid is introduced into these isolated cells and the modified cells are administered to the patient either directly or, for example, encapsulated within porous membranes that are implanted into the patient (*see*, *e.g.* U.S. Patent Nos. 4,892,538 and 5,283,187). There are a variety of techniques available for introducing nucleic acids into viable cells. The techniques vary depending upon whether the nucleic acid is transferred into cultured cells *in vitro*, or *in vivo* in the cells of the intended host. Techniques suitable for the transfer of nucleic acid into mammalian cells *in vitro* include the use of liposomes, electroporation, microinjection, cell fusion, DEAE-dextran, the calcium phosphate precipitation method, etc. A commonly used vector for *ex vivo* delivery of the gene is a retrovirus.

[0205] In some embodiments, the *in vivo* nucleic acid transfer techniques include transfection with viral vectors (such as adenovirus, Herpes simplex I virus, or adeno-associated virus) and lipid-based systems (useful lipids for lipid-mediated transfer of the gene are DOTMA, DOPE and DC-Chol, for example). In some situations it is desirable to provide the nucleic acid source with an agent that targets the target cells, such as an antibody specific for a cell surface membrane protein or the target cell, a ligand for a receptor on the target cell, etc. Where liposomes are

employed, proteins that bind to a cell surface membrane protein associated with endocytosis may be used for targeting and/or to facilitate uptake, *e.g.* capsid proteins or fragments thereof tropic for a particular cell type, antibodies for proteins that undergo internalization in cycling, and proteins that target intracellular localization and enhance intracellular half-life. The technique of receptor-mediated endocytosis is described, for example, by Wu *et al.*, *J. Biol. Chem.* 262:4429-4432 (1987); and Wagner *et al.*, *Proc. Natl. Acad. Sci. USA* 87:3410-3414 (1990). For review of the currently known gene marking and gene therapy protocols *see* Anderson *et al.*, *Science* 256:808-813 (1992). *See also* WO 93/25673 and the references cited therein.

IV. Antibodies and their Production

[0206] The methods and articles of manufacture of the present invention use, or incorporate, an antibody that binds to a B-cell surface marker, especially one that binds to CD20. Accordingly, methods for generating such antibodies will be described here.

[0207] The B cell surface marker to be used for production of, or screening for, antibodies may be, *e.g.*, a soluble form of the marker or a portion thereof, containing the desired epitope. Alternatively, or additionally, cells expressing the marker at their cell surface can be used to generate, or screen for, antibodies. Other forms of the B cell surface marker useful for generating antibodies will be apparent to those skilled in the art.

[0208] A description follows as to exemplary techniques for the production of the antibodies used in accordance with the present invention.

(i) Polyclonal antibodies

[0209] Polyclonal antibodies are preferably raised in animals by multiple subcutaneous (sc) or intraperitoneal (ip) injections of the relevant antigen and an adjuvant. It may be useful to conjugate the relevant antigen to a protein that is immunogenic in the species to be immunized, *e.g.*, keyhole limpet hemocyanin, serum albumin, bovine thyroglobulin, or soybean trypsin inhibitor using a bifunctional or derivatizing agent, for example, maleimidobenzoyl sulfosuccinimide ester (conjugation through cysteine residues), N-hydroxysuccinimide (through lysine residues), glutaraldehyde, succinic anhydride, $SOCl_2$, or $R^1N=C=NR$, where R and R^1 are different alkyl groups.

[0210] Animals are immunized against the antigen, immunogenic conjugates, or derivatives by combining, *e.g.*, 100 µg or 5 µg of the protein or conjugate (for rabbits or mice, respectively) with 3 volumes of Freund's complete adjuvant and injecting the solution intradermally at multiple sites. One month later the animals are boosted with 1/5 to 1/10 the original amount of peptide or conjugate in Freund's complete adjuvant by subcutaneous injection at multiple sites. Seven to 14

days later the animals are bled and the serum is assayed for antibody titer. Animals are boosted until the titer plateaus. In some embodiments, the animal is boosted with the conjugate of the same antigen, but conjugated to a different protein and/or through a different cross-linking reagent. Conjugates also can be made in recombinant cell culture as protein fusions. Also, aggregating agents such as alum are suitably used to enhance the immune response.

(ii) Monoclonal antibodies

Monoclonal antibodies are obtained from a population of substantially homogeneous antibodies, *i.e.*, the individual antibodies comprising the population are identical and/or bind the same epitope except for possible variants that arise during production of the monoclonal antibody, such variants generally being present in minor amounts. Thus, the modifier "monoclonal" indicates the character of the antibody as not being a mixture of discrete or polyclonal antibodies.

[0211] For example, the monoclonal antibodies may be made using the hybridoma method first described by Kohler *et al., Nature,* 256:495 (1975), or may be made by recombinant DNA methods (U.S. Patent No. 4,816,567).

[0212] In the hybridoma method, a mouse or other appropriate host animal, such as a hamster, is immunized as herein described to elicit lymphocytes that produce or are capable of producing antibodies that will specifically bind to the protein used for immunization. Alternatively, lymphocytes may be immunized *in vitro*. Lymphocytes then are fused with myeloma cells using a suitable fusing agent, such as polyethylene glycol, to form a hybridoma cell (Goding, *Monoclonal Antibodies: Principles and Practice*, pp.59-103 (Academic Press, 1986)).

[0213] The hybridoma cells thus prepared are seeded and grown in a suitable culture medium that preferably contains one or more substances that inhibit the growth or survival of the unfused, parental myeloma cells. For example, if the parental myeloma cells lack the enzyme hypoxanthine guanine phosphoribosyl transferase (HGPRT or HPRT), the culture medium for the hybridomas typically will include hypoxanthine, aminopterin, and thymidine (HAT medium), which substances prevent the growth of HGPRT-deficient cells.

[0214] In some embodiments, the myeloma cells are those that fuse efficiently, support stable high-level production of antibody by the selected antibody-producing cells, and are sensitive to a medium such as HAT medium. Among these, in some embodiments, the myeloma cell lines are murine myeloma lines, such as those derived from MOPC-21 and MPC-11 mouse tumors available from the Salk Institute Cell Distribution Center, San Diego, California USA, and SP-2 or X63-Ag8-653 cells available from the American Type Culture Collection, Rockville, Maryland

USA. Human myeloma and mouse-human heteromyeloma cell lines also have been described for the production of human monoclonal antibodies (Kozbor, *J. Immunol.*, 133:3001 (1984); Brodeur *et al., Monoclonal Antibody Production Techniques and Applications*, pp. 51-63 (Marcel Dekker, Inc., New York, 1987)).

[0215] Culture medium in which hybridoma cells are growing is assayed for production of monoclonal antibodies directed against the antigen. In some embodiments, the binding specificity of monoclonal antibodies produced by hybridoma cells is determined by immunoprecipitation or by an *in vitro* binding assay, such as radioimmunoassay (RIA) or enzyme-linked immunoabsorbent assay (ELISA).

[0216] The binding affinity of the monoclonal antibody can, for example, be determined by the Scatchard analysis of Munson *et al., Anal. Biochem.*, 107:220 (1980).

[0217] After hybridoma cells are identified that produce antibodies of the desired specificity, affinity, and/or activity, the clones may be subcloned by limiting dilution procedures and grown by standard methods (Goding, *Monoclonal Antibodies: Principles and Practice*, pp.59-103 (Academic Press, 1986)). Suitable culture media for this purpose include, for example, D-MEM or RPMI-1640 medium. In addition, the hybridoma cells may be grown *in vivo* as ascites tumors in an animal.

[0218] The monoclonal antibodies secreted by the subclones are suitably separated from the culture medium, ascites fluid, or serum by conventional immunoglobulin purification procedures such as, for example, protein A-Sepharose, hydroxylapatite chromatography, gel electrophoresis, dialysis, or affinity chromatography.

[0219] DNA encoding the monoclonal antibodies is readily isolated and sequenced using conventional procedures *(e.g.*, by using oligonucleotide probes that are capable of binding specifically to genes encoding the heavy and light chains of murine antibodies). In some embodiments, the hybridoma cells serve as a source of such DNA. Once isolated, the DNA may be placed into expression vectors, which are then transfected into host cells such as *E. coli* cells, simian COS cells, Chinese Hamster Ovary (CHO) cells, or myeloma cells that do not otherwise produce immunoglobulin protein, to obtain the synthesis of monoclonal antibodies in the recombinant host cells. Review articles on recombinant expression in bacteria of DNA encoding the antibody include Skerra *et al., Curr. Opinion in Immunol.*, 5:256-262 (1993) and Plückthun, *Immunol. Revs.*, 130:151-188 (1992).

[0220] In a further embodiment, antibodies or antibody fragments can be isolated from antibody phage libraries generated using the techniques described in McCafferty *et al., Nature*,

348:552-554 (1990). Clackson *et al., Nature*, 352:624-628 (1991) and Marks *et al., J. Mol. Biol.*, 222:581-597 (1991) describe the isolation of murine and human antibodies, respectively, using phage libraries. Subsequent publications describe the production of high affinity (nM range) human antibodies by chain shuffling (Marks *et al., Bio/Technology*, 10:779-783 (1992)), as well as combinatorial infection and *in vivo* recombination as a strategy for constructing very large phage libraries (Waterhouse *et al., Nuc. Acids. Res.*, 21:2265-2266 (1993)). Thus, these techniques are viable alternatives to traditional monoclonal antibody hybridoma techniques for isolation of monoclonal antibodies.

[0221] The DNA also may be modified, for example, by substituting the coding sequence for human heavy- and light chain constant domains in place of the homologous murine sequences (U.S. Patent No. 4,816,567; Morrison, *et al., Proc. Natl Acad. Sci. USA*, 81:6851 (1984)), or by covalently joining to the immunoglobulin coding sequence all or part of the coding sequence for a non-immunoglobulin polypeptide.

[0222] Typically such non-immunoglobulin polypeptides are substituted for the constant domains of an antibody, or they are substituted for the variable domains of one antigen-combining site of an antibody to create a chimeric bivalent antibody comprising one antigen-combining site having specificity for an antigen and another antigen-combining site having specificity for a different antigen.

(iii) Humanized antibodies

[0223] Methods for humanizing non-human antibodies have been described in the art. In some embodiments, a humanized antibody has one or more amino acid residues introduced into it from a source that is non-human. These non-human amino acid residues are often referred to as "import" residues, which are typically taken from an "import" variable domain. Humanization can be essentially performed following the method of Winter and co-workers (Jones *et al., Nature*, 321:522-525 (1986); Riechmann *et al., Nature*, 332:323-327 (1988); Verhoeyen *et al., Science*, 239:1534-1536 (1988)), by substituting hypervariable region sequences for the corresponding sequences of a human antibody. Accordingly, such "humanized" antibodies are chimeric antibodies (U.S. Patent No. 4,816,567) wherein substantially less than an intact human variable domain has been substituted by the corresponding sequence from a non-human species. In practice, humanized antibodies are typically human antibodies in which some hypervariable region residues and possibly some FR residues are substituted by residues from analogous sites in rodent antibodies.

[0224] The choice of human variable domains, both light and heavy, to be used in making the humanized antibodies is very important to reduce antigenicity. According to the so-called "best-fit" method, the sequence of the variable domain of a rodent antibody is screened against the entire library of known human variable-domain sequences. The human sequence that is closest to that of the rodent is then accepted as the human framework region (FR) for the humanized antibody (Sims *et al., J. Immunol.*, 151:2296 (1993); Chothia *et al., J. Mol. Biol.*, 196:901 (1987)). Another method uses a particular framework region derived from the consensus sequence of all human antibodies of a particular subgroup of light or heavy chain variable regions. The same framework may be used for several different humanized antibodies (Carter *et al., Proc. Natl. Acad. Sci. USA*, 89:4285 (1992); Presta *et al., J. Immunol.*, 151:2623 (1993)).

[0225] It is further important that antibodies be humanized with retention of high affinity for the antigen and other favorable biological properties. To achieve this goal, in some embodiments of the methods, humanized antibodies are prepared by a process of analysis of the parental sequences and various conceptual humanized products using three-dimensional models of the parental and humanized sequences. Three-dimensional immunoglobulin models are commonly available and are familiar to those skilled in the art. Computer programs are available that illustrate and display probable three-dimensional conformational structures of selected candidate immunoglobulin sequences. Inspection of these displays permits analysis of the likely role of the residues in the functioning of the candidate immunoglobulin sequence, *i.e.*, the analysis of residues that influence the ability of the candidate immunoglobulin to bind its antigen. In this way, FR residues can be selected and combined from the recipient and import sequences so that the desired antibody characteristic, such as increased affinity for the target antigen(s), is achieved. In general, the hypervariable region residues are directly and most substantially involved in influencing antigen binding.

[0226] In some embodiments, the humanized anti-CD20 antibody is a humanized 2H7 antibody. In some embodiments, the humanized 2H7 antibody preferably comprises one, two, three, four, five or six of the following CDR sequences:

CDR L1 sequence RASSSVSYXH wherein X is M or L (SEQ ID NO. 18), for example SEQ ID NO:4 (Fig. 1A),

CDR L2 sequence of SEQ ID NO:5 (Fig. 1A),

CDR L3 sequence QQWXFNPPT wherein X is S or A (SEQ ID NO. 19), for example SEQ ID NO:6 (Fig. 1A),

CDR H1 sequence of SEQ ID NO:10 (Fig. 1B),

CDR H2 sequence of AIYPGNGXTSYNQKFKG wherein X is D or A (SEQ ID NO. 20), for example SEQ ID NO:11 (Fig. 1B), and

CDR H3 sequence of VVYYSXXYWYFDV wherein the X at position 6 is N, A, Y, W or D, and the X as position 7 is S or R (SEQ ID NO. 21), for example SEQ ID NO:12 (Fig. 1B).

[0227] The CDR sequences above are generally present within human variable light and variable heavy framework sequences, such as substantially the human consensus FR residues of human light chain kappa subgroup I (V_L6I), and substantially the human consensus FR residues of human heavy chain subgroup III (V_HIII). *See also* WO 2004/056312 (Lowman *et al.*).

[0228] In some embodiments, the variable heavy region may be joined to a human IgG chain constant region, wherein the region may be, for example, IgG1 or IgG3, including native sequence and variant constant regions.

[0229] In some embodiments, such antibody comprises the variable heavy domain sequence of SEQ ID NO:8 (v16, as shown in Fig. 1B), optionally also comprising the variable light domain sequence of SEQ ID NO:2 (v16, as shown in Fig. 1A), which optionally comprises one or more amino acid substitution(s) at positions 56, 100, and/or 100a, *e.g.* D56A, N100A or N100Y, and/or S100aR in the variable heavy domain and one or more amino acid substitution(s) at positions 32 and/or 92, *e.g.* M32L and/or S92A, in the variable light domain. In some embodiments, the antibody is an intact antibody comprising the light chain amino acid sequences of SEQ ID NOs. 13 or 16, and heavy chain amino acid sequences of SEQ ID NO. 14, 15, 17, 22 or 25. In some embodiments, the humanized 2H7 antibody is ocrelizumab (Genentech).

[0230] In the embodiments, the humanized 2H7 is an intact antibody or antibody fragment comprising the variable light chain sequence:

DIQMTQSPSSLSASVGDRVTITCRASSSVSYMHWYQQKPGKAPKPLIYAPSNLAS GVPSRFSGSGSGTDFTLTISSLQPEDFATYYCQQWSFNPPTFGQGTKVEIKR (SEQ ID NO:2);

and the variable heavy chain sequence:
EVQLVESGGGLVQPGGSLRLSCAASGYTFTSYNMHWVRQAPGKGLEWVGAIYP GNGDTSYNQKFKGRFTISVDKSKNTLYLQMNSLRAEDTAVYYCARVVYYSNSY WYFDVWGQGTLVTVSS (SEQ ID NO:8).

[0231] In some embodiments, the humanized 2H7 antibody is an intact antibody, in some embodiments, it comprises the light chain amino acid sequence:

DIQMTQSPSSLSASVGDRVTITCRASSSVSYMHWYQQKPGKAPKPLIYAPSNLAS
GVPSRFSGSGSGTDFTLTISSLQPEDFATYYCQQWSFNPPTFGQGTKVEIKRTVAA
PSVFIFPPSDEQLKSGTASVVCLLNNFYPREAKVQWKVDNALQSGNSQESVTEQD
SKDSTYSLSSTLTLSKADYEKHKVYACEVTHQGLSSPVTKSFNRGEC (SEQ ID
NO:13);

and the heavy chain amino acid sequence:
EVQLVESGGGLVQPGGSLRLSCAASGYTFTSYNMHWVRQAPGKGLEWVGAIYP
GNGDTSYNQKFKGRFTISVDKSKNTLYLQMNSLRAEDTAVYYCARVVYYSNSY
WYFDVWGQGTLVTVSSASTKGPSVFPLAPSSKSTSGGTAALGCLVKDYFPEPVT
VSWNSGALTSGVHTFPAVLQSSGLYSLSSVVTVPSSSLGTQTYICNVNHKPSNTK
VDKKVEPKSCDKTHTCPPCPAPELLGGPSVFLFPPKPKDTLMISRTPEVTCVVVDV
SHEDPEVKFNWYVDGVEVHNAKTKPREEQYNSTYRVVSVLTVLHQDWLNGKE
YKCKVSNKALPAPIEKTISKAKGQPREPQVYTLPPSREEMTKNQVSLTCLVKGFY
PSDIAVEWESNGQPENNYKTTPPVLDSDGSFFLYSKLTVDKSRWQQGNVFSCSV
MHEALHNHYTQKSLSLSPGK (SEQ ID NO:14)

or the heavy chain amino acid sequence:

EVQLVESGGGLVQPGGSLRLSCAASGYTFTSYNMHWVRQAPGKGLEWVGAIYP
GNGDTSYNQKFKGRFTISVDKSKNTLYLQMNSLRAEDTAVYYCARVVYYSNSY
WYFDVWGQGTLVTVSSASTKGPSVFPLAPSSKSTSGGTAALGCLVKDYFPEPVT
VSWNSGALTSGVHTFPAVLQSSGLYSLSSVVTVPSSSLGTQTYICNVNHKPSNTK
VDKKVEPKSCDKTHTCPPCPAPELLGGPSVFLFPPKPKDTLMISRTPEVTCVVVDV
SHEDPEVKFNWYVDGVEVHNAKTKPREEQYNATYRVVSVLTVLHQDWLNGKE
YKCKVSNKALPAPIAATISKAKGQPREPQVYTLPPSREEMTKNQVSLTCLVKGFY
PSDIAVEWESNGQPENNYKTTPPVLDSDGSFFLYSKLTVDKSRWQQGNVFSCSV
MHEALHNHYTQKSLSLSPGK (SEQ ID NO:15).

[0232] In some embodiments, the humanized 2H7 antibody comprises 2H7.v511 variable light domain sequence:

DIQMTQSPSSLSASVGDRVTITCRASSSVSYLHWYQQKPGKAPKPLIYAPSNLASG
VPSRFSGSGSGTDFTLTISSLQPEDFATYYCQQWAFNPPTFGQGTKVEIKR (SEQ
ID NO:23)

and 2H7.v511 variable heavy domain sequence:

EVQLVESGGGLVQPGGSLRLSCAASGYTFTSYNMHWVRQAPGKGLEWVGAIYP
GNGATSYNQKFKGRFTISVDKSKNTLYLQMNSLRAEDTAVYYCARVVYYSYRY
WYFDVWGQGTLVTVSS (SEQ ID NO. 24).

[0233] In some embodiments, the humanized 2H7.v511 antibody is an intact antibody, it may comprise the light chain amino acid sequence:

DIQMTQSPSSLSASVGDRVTITCRASSSVSYLHWYQQKPGKAPKPLIYAPSNLASG
VPSRFSGSGSGTDFTLTISSLQPEDFATYYCQQWAFNPPTFGQGTKVEIKRTVAAP
SVFIFPPSDEQLKSGTASVVCLLNNFYPREAKVQWKVDNALQSGNSQESVTEQDS
KDSTYSLSSTLTLSKADYEKHKVYACEVTHQGLSSPVTKSFNRGEC (SEQ ID
NO:16)

and the heavy chain amino acid sequence of SEQ ID NO. 17 or:

EVQLVESGGGLVQPGGSLRLSCAASGYTFTSYNMHWVRQAPGKGLEWVGAIYP
GNGATSYNQKFKGRFTISVDKSKNTLYLQMNSLRAEDTAVYYCARVVYYSYRY
WYFDVWGQGTLVTVSSASTKGPSVFPLAPSSKSTSGGTAALGCLVKDYFPEPVT
VSWNSGALTSGVHTFPAVLQSSGLYSLSSVVTVPSSSLGTQTYICNVNHKPSNTK
VDKKVEPKSCDKTHTCPPCPAPELLGGPSVFLFPPKPKDTLMISRTPEVTCVVVDV
SHEDPEVKFNWYVDGVEVHNAKTKPREEQYNATYRVVSVLTVLHQDWLNGKE
YKCKVSNAALPAPIAATISKAKGQPREPQVYTLPPSREEMTKNQVSLTCLVKGFY
PSDIAVEWESNGQPENNYKTTPPVLDSDGSFFLYSKLTVDKSRWQQGNVFSCSV
MHEALHNHYTQKSLSLSPG (SEQ ID NO. 25).

[0234] In some embodiments, the antibody herein may further comprise at least one amino acid substitution in the Fc region that improves ADCC activity, such as one wherein the amino acid substitutions are at positions 298, 333, and 334, preferably S298A, E333A, and K334A, using Eu numbering of heavy chain residues. *See also* US Patent No. 6,737,056B1, Presta. Any of these antibodies may comprise at least one substitution in the Fc region that improves FcRn binding or serum half-life, for example a substitution at heavy chain position 434, such as N434W. *See also* US Patent No. 6,737,056B1, Presta. Any of these antibodies may further comprise at least one amino acid substitution in the Fc region that increases CDC activity, for example, comprising at least a substitution at position 326, preferably K326A or K326W. *See also* US Patent No. 6,528,624B1 (Idusogie *et al.*).

[0235] In some embodiments, the humanized 2H7 variants are those comprising the variable light domain of SEQ ID NO:2 and the variable heavy domain of SEQ ID NO:8, including those with or without substitutions in an Fc region (if present), and those comprising a variable heavy

domain with alteration N100A; or D56A and N100A; or D56A, N100Y, and S100aR; in SEQ ID NO:8 and a variable light domain with alteration M32L; or S92A; or M32L and S92A; in SEQ ID NO:2. M34 in the variable heavy domain of 2H7.v16 has been identified as a potential source of antibody stability and is another potential candidate for substitution.

[0236] In some embodiments of the invention, the variable region of variants based on 2H7.v16 comprise the amino acid sequences of v16 except at the positions of amino acid substitutions that are indicated in the table below. Unless otherwise indicated, the 2H7 variants will have the same light chain as that of v16.

Table 1: Exemplary Humanized 2H7 Antibody Variants

2H7 Version	**Heavy chain (V_H) changes**	**Light chain (V_L) changes**	**Fc changes**
16 for reference			-
31	-	-	S298A, E333A, K334A
73	N100A	M32L	
75	N100A	M32L	S298A, E333A, K334A
96	D56A, N100A	S92A	
114	D56A, N100A	M32L, S92A	S298A, E333A, K334A
115	D56A, N100A	M32L, S92A	S298A, E333A, K334A, E356D, M358L
116	D56A, N100A	M32L, S92A	S298A, K334A, K322A
138	D56A, N100A	M32L, S92A	S298A, E333A, K334A, K326A
477	D56A, N100A	M32L, S92A	S298A, E333A, K334A, K326A, N434W
375	-	-	K334L
588	-	-	S298A, E333A, K334A, K326A
511	D56A, N100Y, S100aR	M32L, S92A	S298A, E333A, K334A, K326A

(iv) Human antibodies

[0237] As an alternative to humanization, human antibodies can be generated. For example, it is now possible to produce transgenic animals *(e.g.*, mice) that are capable, upon immunization, of producing a full repertoire of human antibodies in the absence of endogenous immunoglobulin production. For example, it has been described that the homozygous deletion of the antibody heavy chain joining region (J_H) gene in chimeric and germ-line mutant mice results in complete

inhibition of endogenous antibody production. Transfer of the human germ-line immunoglobulin gene array in such germ-line mutant mice will result in the production of human antibodies upon antigen challenge. *See, e.g.*, Jakobovits *et al., Proc. Natl. Acad. Sci. USA*, 90:2551 (1993); Jakobovits *et al., Nature*, 362:255-258 (1993); Bruggermann *et al., Year in Immuno.*, 7:33 (1993); and US Patent Nos. 5,591,669, 5,589,369 and 5,545,807.

[0238] Alternatively, phage display technology (McCafferty *et al.*, *Nature* 348:552-553 (1990)) can be used to produce human antibodies and antibody fragments *in vitro*, from immunoglobulin variable (V) domain gene repertoires from unimmunized donors. According to this technique, antibody V domain genes are cloned in-frame into either a major or minor coat protein gene of a filamentous bacteriophage, such as M13 or fd, and displayed as functional antibody fragments on the surface of the phage particle. Because the filamentous particle contains a single-stranded DNA copy of the phage genome, selections based on the functional properties of the antibody also result in selection of the gene encoding the antibody exhibiting those properties. Thus, the phage mimics some of the properties of the B cell. Phage display can be performed in a variety of formats; for their review *see, e.g.*, Johnson, Kevin S. and Chiswell, David J., *Current Opinion in Structural Biology* 3:564-571 (1993). Several sources of V-gene segments can be used for phage display. Clackson *et al.*, *Nature*, 352:624-628 (1991) isolated a diverse array of anti-oxazolone antibodies from a small random combinatorial library of V genes derived from the spleens of immunized mice. A repertoire of V genes from unimmunized human donors can be constructed and antibodies to a diverse array of antigens (including self-antigens) can be isolated essentially following the techniques described by Marks *et al.*, *J. Mol. Biol.* 222:581-597 (1991), or Griffith *et al.*, *EMBO J.* 12:725-734 (1993). *See also*, US Patent Nos. 5,565,332 and 5,573,905.

[0239] Human antibodies may also be generated by *in vitro* activated B cells (*see* US Patents 5,567,610 and 5,229,275).

(v) Antibody fragments

[0240] Various techniques have been developed for the production of antibody fragments. Traditionally, these fragments were derived via proteolytic digestion of intact antibodies (*see, e.g.*, Morimoto *et al.*, *Journal of Biochemical and Biophysical Methods* 24:107-117 (1992) and Brennan *et al., Science*, 229:81 (1985)). However, these fragments can now be produced directly by recombinant host cells. For example, the antibody fragments can be isolated from the antibody phage libraries discussed above. Alternatively, Fab'-SH fragments can be directly recovered from *E. coli* and chemically coupled to form $F(ab')_2$ fragments (Carter *et al.*, Bio/Technology 10:163-

167 (1992)). According to another approach, $F(ab')_2$ fragments can be isolated directly from recombinant host cell culture. Other techniques for the production of antibody fragments will be apparent to the skilled practitioner. In other embodiments, the antibody of choice is a single chain Fv fragment (scFv). *See* WO 93/16185; US Patent No. 5,571,894; and US Patent No. 5,587,458. The antibody fragment may also be a "linear antibody", *e.g.*, as described in US Patent 5,641,870 for example. Such linear antibody fragments may be monospecific or bispecific.

(vi) Bispecific antibodies

[0241] Bispecific antibodies are antibodies that have binding specificities for at least two different epitopes. Exemplary bispecific antibodies may bind to two different epitopes of the B cell surface marker. Other such antibodies may bind the B cell surface marker and further bind a second different B-cell surface marker. Alternatively, an anti-B cell surface marker binding arm may be combined with an arm that binds to a triggering molecule on a leukocyte such as a T-cell receptor molecule *(e.g.* CD2 or CD3), or Fc receptors for IgG (FcγR), such as FcγRI (CD64), FcγRII (CD32) and FcγRIII (CD16) so as to focus cellular defense mechanisms to the B cell. Bispecific antibodies may also be used to localize cytotoxic agents to the B cell. These antibodies possess a B cell surface marker-binding arm and an arm that binds the cytotoxic agent *(e.g.* saporin, anti-interferon-a, vinca alkaloid, ricin A chain, methotrexate or radioactive isotope hapten). Bispecific antibodies can be prepared as full length antibodies or antibody fragments *(e.g.* $F(ab')_2$ bispecific antibodies).

[0242] Methods for making bispecific antibodies are known in the art. Traditional production of full length bispecific antibodies is based on the coexpression of two immunoglobulin heavy chain-light chain pairs, where the two chains have different specificities (Millstein *et al., Nature*, 305:537-539 (1983)). Because of the random assortment of immunoglobulin heavy and light chains, these hybridomas (quadromas) produce a potential mixture of 10 different antibody molecules, of which only one has the correct bispecific structure. Purification of the correct molecule, which is usually done by affinity chromatography steps, is rather cumbersome, and the product yields are low. Similar procedures are disclosed in WO 93/08829, and in Traunecker *et al., EMBO J.*, 10:3655-3659 (1991).

[0243] According to a different approach, antibody variable domains with the desired binding specificities (antibody-antigen combining sites) are fused to immunoglobulin constant domain sequences. In some embodiments, the fusion is with an immunoglobulin heavy chain constant domain, comprising at least part of the hinge, CH2, and CH3 regions. In some embodiments, the first heavy chain constant region (CH1) containing the site necessary for light chain binding, present in at least one of the fusions. DNAs encoding the immunoglobulin heavy chain fusions

and, if desired, the immunoglobulin light chain, are inserted into separate expression vectors, and are co-transfected into a suitable host organism. This provides for great flexibility in adjusting the mutual proportions of the three polypeptide fragments in embodiments when unequal ratios of the three polypeptide chains used in the construction provide the optimum yields. It is, however, possible to insert the coding sequences for two or all three polypeptide chains in one expression vector when the expression of at least two polypeptide chains in equal ratios results in high yields or when the ratios are of no particular significance.

[0244] In some embodiments of this approach, the bispecific antibodies are composed of a hybrid immunoglobulin heavy chain with a first binding specificity in one arm, and a hybrid immunoglobulin heavy chain-light chain pair (providing a second binding specificity) in the other arm. It was found that this asymmetric structure facilitates the separation of the desired bispecific compound from unwanted immunoglobulin chain combinations, as the presence of an immunoglobulin light chain in only one half of the bispecific molecule provides for a facile way of separation. This approach is disclosed in WO 94/04690. For further details of generating bispecific antibodies see, for example, Suresh *et al., Methods in Enzymology*, 121:210 (1986).

[0245] According to another approach described in US Patent No. 5,731,168, the interface between a pair of antibody molecules can be engineered to maximize the percentage of heterodimers that are recovered from recombinant cell culture. In some embodiments, the interface comprises at least a part of the C_H3 domain of an antibody constant domain. In this method, one or more small amino acid side chains from the interface of the first antibody molecule are replaced with larger side chains *(e.g.* tyrosine or tryptophan). Compensatory "cavities" of identical or similar size to the large side chain(s) are created on the interface of the second antibody molecule by replacing large amino acid side chains with smaller ones *(e.g.* alanine or threonine). This provides a mechanism for increasing the yield of the heterodimer over other unwanted end-products such as homodimers.

[0246] Bispecific antibodies include cross-linked or "heteroconjugate" antibodies. For example, one of the antibodies in the heteroconjugate can be coupled to avidin, the other to biotin. Such antibodies have, for example, been proposed to target immune system cells to unwanted cells (US Patent No. 4,676,980), and for treatment of HIV infection (WO 91/00360, WO 92/200373, and EP 03089). Heteroconjugate antibodies may be made using any convenient cross-linking methods. Suitable cross-linking agents are well known in the art, and are disclosed in US Patent No. 4,676,980, along with a number of cross-linking techniques.

[0247] Techniques for generating bispecific antibodies from antibody fragments have also been described in the literature. For example, bispecific antibodies can be prepared using chemical linkage. Brennan *et al., Science*, 229: 81 (1985) describe a procedure wherein intact antibodies are proteolytically cleaved to generate $F(ab')_2$ fragments. These fragments are reduced in the presence of the dithiol complexing agent sodium arsenite to stabilize vicinal dithiols and prevent intermolecular disulfide formation. The Fab' fragments generated are then converted to thionitrobenzoate (TNB) derivatives. One of the Fab'-TNB derivatives is then reconverted to the Fab'-thiol by reduction with mercaptoethylamine and is mixed with an equimolar amount of the other Fab'-TNB derivative to form the bispecific antibody. The bispecific antibodies produced can be used as agents for the selective immobilization of enzymes.

[0248] Various techniques for making and isolating bispecific antibody fragments directly from recombinant cell culture have also been described. For example, bispecific antibodies have been produced using leucine zippers. Kostelny *et al.*, *J. Immunol.*, 148(5):1547-1553 (1992). The leucine zipper peptides from the Fos and Jun proteins were linked to the Fab' portions of two different antibodies by gene fusion. The antibody homodimers were reduced at the hinge region to form monomers and then re-oxidized to form the antibody heterodimers. This method can also be utilized for the production of antibody homodimers. The "diabody" technology described by Hollinger *et al., Proc. Natl. Acad. Sci. USA*, 90:6444-6448 (1993) has provided an alternative mechanism for making bispecific antibody fragments. The fragments comprise a heavy chain variable domain (V_H) connected to a light chain variable domain (V_L) by a linker that is too short to allow pairing between the two domains on the same chain. Accordingly, the V_H and V_L domains of one fragment are forced to pair with the complementary V_L and V_H domains of another fragment, thereby forming two antigen-binding sites. Another strategy for making bispecific antibody fragments by the use of single-chain Fv (sFv) dimers has also been reported. *See* Gruber *et al., J. Immunol.*, 152:5368 (1994).

[0249] Antibodies with more than two valencies are contemplated. For example, trispecific antibodies can be prepared. Tutt *et al. J. Immunol.* 147: 60 (1991).

V. Conjugates and Other Modifications of the Antibody

[0250] The antibody used in the methods or included in the articles of manufacture herein is optionally conjugated to a cytotoxic agent. For instance, the antibody may be conjugated to a drug as described in WO2004/032828.

[0251] Chemotherapeutic agents useful in the generation of such antibody-cytotoxic agent conjugates have been described above.

[0252] Conjugates of an antibody and one or more small molecule toxins, such as a calicheamicin, a maytansine (US Patent No. 5,208,020), a trichothene, and CC1065 are also contemplated herein. In one embodiment of the invention, the antibody is conjugated to one or more maytansine molecules *(e.g.* about 1 to about 10 maytansine molecules per antibody molecule). Maytansine may, for example, be converted to May-SS-Me, which may be reduced to May-SH3 and reacted with modified antibody (Chari *et al. Cancer Research* 52: 127-131 (1992)) to generate a maytansinoid-antibody conjugate.

[0253] Alternatively, the antibody is conjugated to one or more calicheamicin molecules. The calicheamicin family of antibiotics is capable of producing double-stranded DNA breaks at sub-picomolar concentrations. Structural analogues of calicheamicin that may be used include, but are not limited to, γ_1^I, a_2^I, a_3^I, N-acetyl-γ_1^I, PSAG and θ^I_1 (Hinman *et al. Cancer Research* 53: 3336-3342 (1993) and Lode *et al. Cancer Research* 58: 2925-2928 (1998)).

[0254] Enzymatically active toxins and fragments thereof that can be used include diphtheria A chain, nonbinding active fragments of diphtheria toxin, exotoxin A chain (from *Pseudomonas aeruginosa*), ricin A chain, abrin A chain, modeccin A chain, alpha-sarcin, *Aleurites fordii* proteins, dianthin proteins, *Phytolaca americana* proteins (PAPI, PAPII, and PAP-S), momordica charantia inhibitor, curcin, crotin, sapaonaria officinalis inhibitor, gelonin, mitogellin, restrictocin, phenomycin, enomycin and the tricothecenes. *See*, for example, WO 93/21232 published October 28, 1993.

[0255] The present invention further contemplates antibody conjugated with a compound with nucleolytic activity *(e.g.* a ribonuclease or a DNA endonuclease such as a deoxyribonuclease; DNase).

[0256] A variety of radioactive isotopes are available for the production of radioconjugated antibodies. Examples include At^{211}, I^{131}, I^{125}, Y^{90}, Re^{186}, Re^{188}, Sm^{153}, Bi^{212}, P^{32} and radioactive isotopes of Lu.

[0257] Conjugates of the antibody and cytotoxic agent may be made using a variety of bifunctional protein coupling agents such as N-succinimidyl-3-(2-pyridyldithiol) propionate (SPDP), succinimidyl-4-(N-maleimidomethyl) cyclohexane-1-carboxylate, iminothiolane (IT), bifunctional derivatives of imidoesters (such as dimethyl adipimidate HCL), active esters (such as disuccinimidyl suberate), aldehydes (such as glutareldehyde), bis-azido compounds (such as bis (p-azidobenzoyl) hexanediamine), bis-diazonium derivatives (such as bis-(p-diazoniumbenzoyl)-ethylenediamine), diisocyanates (such as tolyene 2,6-diisocyanate), and bis-active fluorine compounds (such as 1,5-difluoro-2,4-dinitrobenzene). For example, a ricin immunotoxin can be

prepared as described in Vitetta *et al. Science* 238: 1098 (1987). Carbon-14-labeled 1-isothiocyanatobenzyl-3-methyldiethylene triaminepentaacetic acid (MX-DTPA) is an exemplary chelating agent for conjugation of radionucleotide to the antibody. *See* WO94/11026. The linker may be a "cleavable linker" facilitating release of the cytotoxic drug in the cell. For example, an acid-labile linker, peptidase-sensitive linker, dimethyl linker or disulfide-containing linker (Chari *et al. Cancer Research* 52: 127-131 (1992)) may be used.

[0258] Alternatively, a fusion protein comprising the antibody and cytotoxic agent may be made, *e.g.* by recombinant techniques or peptide synthesis.

[0259] In yet another embodiment, the antibody may be conjugated to a "receptor" (such streptavidin) for utilization in tumor pretargeting wherein the antibody-receptor conjugate is administered to the patient, followed by removal of unbound conjugate from the circulation using a clearing agent and then administration of a "ligand" *(e.g.* avidin) that is conjugated to a cytotoxic agent *(e.g.* a radionucleotide).

[0260] The antibodies of the present invention may also be conjugated with a prodrug-activating enzyme that converts a prodrug (*e.g.* a peptidyl chemotherapeutic agent, *see* WO81/01145) to an active anti-cancer drug. *See*, for example, WO 88/07378 and U.S. Patent No. 4,975,278.

[0261] The enzyme component of such conjugates includes any enzyme capable of acting on a prodrug in such a way so as to covert it into its more active, cytotoxic form.

[0262] Enzymes that are useful in the method of this invention include, but are not limited to, alkaline phosphatase useful for converting phosphate-containing prodrugs into free drugs; arylsulfatase useful for converting sulfate-containing prodrugs into free drugs; cytosine deaminase useful for converting non-toxic 5-fluorocytosine into the anti-cancer drug, 5-fluorouracil; proteases, such as serratia protease, thermolysin, subtilisin, carboxypeptidases and cathepsins (such as cathepsins B and L), that are useful for converting peptide-containing prodrugs into free drugs; D-alanylcarboxypeptidases, useful for converting prodrugs that contain D-amino acid substituents; carbohydrate-cleaving enzymes such as ß-galactosidase and neuraminidase useful for converting glycosylated prodrugs into free drugs; ß-lactamase useful for converting drugs derivatized with ß-lactams into free drugs; and penicillin amidases, such as penicillin V amidase or penicillin G amidase, useful for converting drugs derivatized at their amine nitrogens with phenoxyacetyl or phenylacetyl groups, respectively, into free drugs. Alternatively, antibodies with enzymatic activity, also known in the art as "abzymes", can be used to convert the prodrugs of the invention into free active drugs (*see*, *e.g.*, Massey, *Nature* 328:

457-458 (1987)). Antibody-abzyme conjugates can be prepared as described herein for delivery of the abzyme to a tumor cell population.

[0263] The enzymes of this invention can be covalently bound to the antibody by techniques well known in the art such as the use of the heterobifunctional crosslinking reagents discussed above. Alternatively, fusion proteins comprising at least the antigen binding region of an antibody of the invention linked to at least a functionally active portion of an enzyme of the invention can be constructed using recombinant DNA techniques well known in the art (*see, e.g.*, Neuberger *et al.*, *Nature*, 312: 604-608 (1984)).

[0264] Other modifications of the antibody are contemplated herein. For example, the antibody may be linked to one of a variety of nonproteinaceous polymers, *e.g.*, polyethylene glycol (PEG), polypropylene glycol, polyoxyalkylenes, or copolymers of polyethylene glycol and polypropylene glycol. In some embodiments, the antibody fragments, such as Fab', are linked to one or more PEG molecules.

[0265] The antibodies disclosed herein may also be formulated as liposomes. Liposomes containing the antibody are prepared by methods known in the art, such as described in Epstein *et al., Proc. Natl. Acad. Sci. USA*, 82:3688 (1985); Hwang *et al., Proc. Natl. Acad. Sci. USA*, 77:4030 (1980); U.S. Pat. Nos. 4,485,045 and 4,544,545; and WO97/38731 published October 23, 1997. Liposomes with enhanced circulation time are disclosed in U.S. Patent No. 5,013,556.

[0266] Particularly useful liposomes can be generated by the reverse phase evaporation method with a lipid composition comprising phosphatidylcholine, cholesterol and PEG-derivatized phosphatidylethanolamine (PEG-PE). Liposomes are extruded through filters of defined pore size to yield liposomes with the desired diameter. Fab' fragments of an antibody of the present invention can be conjugated to the liposomes as described in Martin *et al. J. Biol. Chem.* 257: 286-288 (1982) via a disulfide interchange reaction. A chemotherapeutic agent is optionally contained within the liposome. *See* Gabizon *et al. J. National Cancer Inst.* 81(19)1484 (1989).

[0267] Amino acid sequence modification(s) of the antibody are contemplated. For example, it may be desirable to improve the binding affinity and/or other biological properties of the antibody. Amino acid sequence variants of the antibody are prepared by introducing appropriate nucleotide changes into the antibody nucleic acid, or by peptide synthesis. Such modifications include, for example, deletions from, and/or insertions into and/or substitutions of, residues within the amino acid sequences of the antibody. Any combination of deletion, insertion, and substitution is made to arrive at the final construct, provided that the final construct possesses the

desired characteristics. The amino acid changes also may alter post-translational processes of the antibody, such as changing the number or position of glycosylation sites.

[0268] A useful method for identification of certain residues or regions of the antibody that are preferred locations for mutagenesis is called "alanine scanning mutagenesis" as described by Cunningham and Wells *Science*, 244:1081-1085 (1989). Here, a residue or group of target residues are identified *(e.g.*, charged residues such as arg, asp, his, lys, and glu) and replaced by a neutral or negatively charged amino acid (most preferably alanine or polyalanine) to affect the interaction of the amino acids with antigen. Those amino acid locations demonstrating functional sensitivity to the substitutions then are refined by introducing further or other variants at, or for, the sites of substitution. Thus, while the site for introducing an amino acid sequence variation is predetermined, the nature of the mutation *per se* need not be predetermined. For example, to analyze the performance of a mutation at a given site, ala scanning or random mutagenesis is conducted at the target codon or region and the expressed antibody variants are screened for the desired activity.

[0269] Amino acid sequence insertions include amino- and/or carboxyl-terminal fusions ranging in length from one residue to polypeptides containing a hundred or more residues, as well as intrasequence insertions of single or multiple amino acid residues. Examples of terminal insertions include an antibody with an N-terminal methionyl residue or the antibody fused to a cytotoxic polypeptide. Other insertional variants of the antibody molecule include the fusion to the N- or C-terminus of the antibody of an enzyme, or a polypeptide that increases the serum half-life of the antibody.

[0270] Another type of variant is an amino acid substitution variant. These variants have at least one amino acid residue in the antibody molecule replaced by different residue. The sites of greatest interest for substitutional mutagenesis of antibody antibodies include the hypervariable regions, but FR alterations are also contemplated. Conservative substitutions are shown in Table 2 under the heading of "preferred substitutions". If such substitutions result in a change in biological activity, then more substantial changes, denominated "exemplary substitutions" in Table 2, may be introduced and the products screened.

Table 2.

Original Residue	Exemplary Substitutions	Preferred Substitutions
Ala (A)	Val; Leu; Ile	Val
Arg (R)	Lys; Gln; Asn	Lys
Asn (N)	Gln; His; Asp, Lys; Arg	Gln
Asp (D)	Glu; Asn	Glu
Cys (C)	Ser; Ala	Ser
Gln (Q)	Asn; Glu	Asn
Glu (E)	Asp; Gln	Asp
Gly (G)	Ala	Ala
His (H)	Asn; Gln; Lys; Arg	Arg
Ile (I)	Leu; Val; Met; Ala; Phe; Norleucine	Leu
Leu (L)	Norleucine; Ile; Val; Met; Ala; Phe	Ile
Lys (K)	Arg; Gln; Asn	Arg
Met (M)	Leu; Phe; Ile	Leu
Phe (F)	Trp; Leu; Val; Ile; Ala; Tyr	Tyr
Pro (P)	Ala	Ala
Ser (S)	Thr	Thr
Thr (T)	Val; Ser	Ser
Trp (W)	Tyr; Phe	Tyr
Tyr (Y)	Trp; Phe; Thr; Ser	Phe
Val (V)	Ile; Leu; Met; Phe; Ala; Norleucine	Leu

[0271] Substantial modifications in the biological properties of the antibody are accomplished by selecting substitutions that differ significantly in their effect on maintaining (a) the structure of the polypeptide backbone in the area of the substitution, for example, as a sheet or helical conformation, (b) the charge or hydrophobicity of the molecule at the target site, or (c) the bulk of the side chain. Amino acids may be grouped according to similarities in the properties of their side chains (in A. L. Lehninger, in *Biochemistry*, second ed., pp. 73-75, Worth Publishers, New York (1975)):

(1) non-polar: Ala (A), Val (V), Leu (L), Ile (I), Pro (P), Phe (F), Trp (W), Met (M)

(2) uncharged polar: Gly (G), Ser (S), Thr (T), Cys (C), Tyr (Y), Asn (N), Gln (Q)

(3) acidic: Asp (D), Glu (E)

(4) basic: Lys (K), Arg (R), His(H)

[0272] Alternatively, naturally occurring residues may be divided into groups based on common side-chain properties:

(1) hydrophobic: Norleucine, Met, Ala, Val, Leu, Ile;

(2) neutral hydrophilic: Cys, Ser, Thr, Asn, Gln;

(3) acidic: Asp, Glu;

(4) basic: His, Lys, Arg;

(5) residues that influence chain orientation: Gly, Pro;

(6) aromatic: Trp, Tyr, Phe.

[0273] Non-conservative substitutions will entail exchanging a member of one of these classes for another class.

[0274] Any cysteine residue not involved in maintaining the proper conformation of the antibody also may be substituted, generally with serine, to improve the oxidative stability of the molecule and prevent aberrant crosslinking. Conversely, cysteine bond(s) may be added to the antibody to improve its stability (particularly where the antibody is an antibody fragment such as an Fv fragment).

[0275] A particularly preferred type of substitutional variant involves substituting one or more hypervariable region residues of a parent antibody. Generally, the resulting variant(s) selected for further development will have improved biological properties relative to the parent antibody from which they are generated. A convenient way for generating such substitutional variants is affinity maturation using phage display. Briefly, several hypervariable region sites *(e.g.* 6-7 sites) are mutated to generate all possible amino substitutions at each site. The antibody variants thus generated are displayed in a monovalent fashion from filamentous phage particles as fusions to the gene III product of M13 packaged within each particle. The phage-displayed variants are then screened for their biological activity *(e.g.* binding affinity) as herein disclosed. In order to identify candidate hypervariable region sites for modification, alanine scanning mutagenesis can be performed to identify hypervariable region residues contributing significantly to antigen binding. Alternatively, or in additionally, it may be beneficial to analyze a crystal structure of the antigen-

antibody complex to identify contact points between the antibody and antigen. Such contact residues and neighboring residues are candidates for substitution according to the techniques elaborated herein. Once such variants are generated, the panel of variants is patiented to screening as described herein and antibodies with superior properties in one or more relevant assays may be selected for further development.

[0276] Another type of amino acid variant of the antibody alters the original glycosylation pattern of the antibody. Such altering includes deleting one or more carbohydrate moieties found in the antibody, and/or adding one or more glycosylation sites that are not present in the antibody.

[0277] Glycosylation of polypeptides is typically either N-linked or O-linked. N-linked refers to the attachment of the carbohydrate moiety to the side chain of an asparagine residue. The tripeptide sequences asparagine-X-serine and asparagine-X-threonine, where X is any amino acid except proline, are the recognition sequences for enzymatic attachment of the carbohydrate moiety to the asparagine side chain. Thus, the presence of either of these tripeptide sequences in a polypeptide creates a potential glycosylation site. O-linked glycosylation refers to the attachment of one of the sugars N-aceylgalactosamine, galactose, or xylose to a hydroxyamino acid, most commonly serine or threonine, although 5-hydroxyproline or 5-hydroxylysine may also be used.

[0278] Addition of glycosylation sites to the antibody is conveniently accomplished by altering the amino acid sequence such that it contains one or more of the above-described tripeptide sequences (for N-linked glycosylation sites). The alteration may also be made by the addition of, or substitution by, one or more serine or threonine residues to the sequence of the original antibody (for O-linked glycosylation sites).

[0279] Where the antibody comprises an Fc region, the carbohydrate attached thereto may be altered. For example, antibodies with a mature carbohydrate structure that lacks fucose attached to an Fc region of the antibody are described in US Pat Appl No US 2003/0157108 A1 (Presta, L.); *see also* US 2004/0093621 A1 (Kyowa Hakko Kogyo Co., Ltd) concerning a CD20 antibody composition. Antibodies with a bisecting N-acetylglucosamine (GlcNAc) in the carbohydrate attached to an Fc region of the antibody are referenced in WO03/011878, Jean-Mairet *et al.* and US Patent No. 6,602,684, Umana *et al.* Antibodies with at least one galactose residue in the oligosaccharide attached to an Fc region of the antibody are reported in WO97/30087 (Patel *et al.*); *see also* WO98/58964 (Raju, S.) and WO99/22764 (Raju, S.) concerning antibodies with altered carbohydrate attached to the Fc region thereof.

[0280] In some embodiments, the glycosylation variant herein comprises an Fc region, wherein a carbohydrate structure attached to the Fc region lacks fucose. Such variants have improved

ADCC function. Optionally, the Fc region further comprises one or more amino acid substitutions therein which further improve ADCC, for example, substitutions at positions 298, 333, and/or 334 of the Fc region (Eu numbering of residues). Examples of publications related to "defucosylated" or "fucose-deficient" antibodies include: US Pat. Appl. No. US 2003/0157108 A1, Presta, L; WO 00/61739A1; WO01/29246A1; US2003/0115614A1; US2002/0164328A1; US2004/0093621A1; US2004/0132140A1; US2004/0110704A1; US2004/0110282A1; US2004/0109865A1; WO03/085119A1; WO03/084570A1; WO2005/035778; WO2005/035586 (describing RNA inhibition (RNAi) of fucosylation); Okazaki *et al. J. Mol. Biol.* 336:1239-1249 (2004); Yamane-Ohnuki *et al. Biotech. Bioeng.* 87: 614 (2004). Examples of cell lines producing defucosylated antibodies include Lec13 CHO cells deficient in protein fucosylation (Ripka *et al. Arch. Biochem. Biophys.* 249:533-545 (1986); US Pat Appl No US 2003/0157108 A1, Presta, L; and WO 2004/056312 A1, Adams *et al.*, especially at Example 11), and knockout cell lines, such as alpha-1,6-fucosyltransferase gene, *FUT8*,knockout CHO cells (Yamane-Ohnuki *et al. Biotech. Bioeng.* 87: 614 (2004)).

[0281] Nucleic acid molecules encoding amino acid sequence variants of the antibody are prepared by a variety of methods known in the art. These methods include, but are not limited to, isolation from a natural source (in the case of naturally occurring amino acid sequence variants) or preparation by oligonucleotide-mediated (or site-directed) mutagenesis, PCR mutagenesis, and cassette mutagenesis of an earlier prepared variant or a non-variant version of the antibody.

[0282] It may be desirable to modify the antibody of the invention with respect to effector function, *e.g.* so as to enhance antigen-dependent cell-mediated cytotoxicity (ADCC) and/or complement dependent cytotoxicity (CDC) of the antibody. This may be achieved by introducing one or more amino acid substitutions in an Fc region of an antibody. Alternatively or additionally, cysteine residue(s) may be introduced in the Fc region, thereby allowing interchain disulfide bond formation in this region. The homodimeric antibody thus generated may have improved internalization capability and/or increased complement-mediated cell killing and antibody-dependent cellular cytotoxicity (ADCC). *See* Caron *et al., J. Exp Med.* 176:1191-1195 (1992) and Shopes, B. *J. Immunol.* 148:2918-2922 (1992). Homodimeric antibodies with enhanced anti-tumor activity may also be prepared using heterobifunctional cross-linkers as described in Wolff *et al. Cancer Research* 53:2560-2565 (1993). Alternatively, an antibody can be engineered that has dual Fc regions and may thereby have enhanced complement lysis and ADCC capabilities. *See* Stevenson *et al. Anti-Cancer Drug Design* 3:219-230 (1989).

[0283] WO00/42072 (Presta, L.) describes antibodies with improved ADCC function in the presence of human effector cells, where the antibodies comprise amino acid substitutions in the

Fc region thereof. In some embodiments, the antibody with improved ADCC comprises substitutions at positions 298, 333, and/or 334 of the Fc region. In some embodiments, the altered Fc region is a human IgG1 Fc region comprising or consisting of substitutions at one, two or three of these positions.

[0284] Antibodies with altered C1q binding and/or complement dependent cytotoxicity (CDC) are described in WO99/51642, US Patent No. 6,194,551B1, US Patent No. 6,242,195B1, US Patent No. 6,528,624B1 and US Patent No. 6,538,124 (Idusogie *et al.*). The antibodies comprise an amino acid substitution at one or more of amino acid positions 270, 322, 326, 327, 329, 313, 333 and/or 334 of the Fc region thereof.

[0285] To increase the serum half life of the antibody, one may incorporate a salvage receptor binding epitope into the antibody (especially an antibody fragment) as described in US Patent 5,739,277, for example. As used herein, the term "salvage receptor binding epitope" refers to an epitope of the Fc region of an IgG molecule *(e.g.,* IgG_1, IgG_2, IgG_3, or IgG_4) that is responsible for increasing the *in vivo* serum half-life of the IgG molecule. Antibodies with substitutions in an Fc region thereof and increased serum half-lives are also described in WO00/42072 (Presta, L.).

[0286] Engineered antibodies with three or more (preferably four) functional antigen binding sites are also contemplated (US Appln No. US2002/0004587 A1, Miller *et al.*).

VI. Pharmaceutical Formulations

[0287] Therapeutic formulations of the antibodies used in accordance with the present invention are prepared for storage by mixing an antibody having the desired degree of purity with optional pharmaceutically acceptable carriers, excipients or stabilizers (*Remington's Pharmaceutical Sciences* 16th edition, Osol, A. Ed. (1980)), in the form of lyophilized formulations or aqueous solutions. Acceptable carriers, excipients, or stabilizers are nontoxic to recipients at the dosages and concentrations employed, and include buffers such as phosphate, citrate, and other organic acids; antioxidants including ascorbic acid and methionine; preservatives (such as octadecyldimethylbenzyl ammonium chloride; hexamethonium chloride; benzalkonium chloride, benzethonium chloride; phenol, butyl or benzyl alcohol; alkyl parabens such as methyl or propyl paraben; catechol; resorcinol; cyclohexanol; 3-pentanol; and m-cresol); low molecular weight (less than about 10 residues) polypeptides; proteins, such as serum albumin, gelatin, or immunoglobulins; hydrophilic polymers such as polyvinylpyrrolidone; amino acids such as glycine, glutamine, asparagine, histidine, arginine, or lysine; monosaccharides, disaccharides, and other carbohydrates including glucose, mannose, or dextrins; chelating agents such as EDTA; sugars such as sucrose, mannitol, trehalose or sorbitol; salt-forming counter-ions

such as sodium; metal complexes *(e.g.* Zn-protein complexes); and/or non-ionic surfactants such as TWEEN™, PLURONICS™ or polyethylene glycol (PEG).

[0288] Exemplary anti-CD20 antibody formulations are described in WO98/56418. This publication describes a liquid multidose formulation comprising 40 mg/mL Rituximab, 25 mM acetate, 150 mM trehalose, 0.9% benzyl alcohol, 0.02% polysorbate 20 at pH 5.0 that has a minimum shelf life of two years storage at 2-8BC. Another anti-CD20 formulation of interest comprises 10mg/mL Rituximab in 9.0 mg/mL sodium chloride, 7.35 mg/mL sodium citrate dihydrate, 0.7mg/mL polysorbate 80, and Sterile Water for Injection, pH 6.5.

[0289] Lyophilized formulations adapted for subcutaneous administration are described in US Pat No. 6,267,958 (Andya *et al.*). Such lyophilized formulations may be reconstituted with a suitable diluent to a high protein concentration and the reconstituted formulation may be administered subcutaneously to the mammal to be treated herein.

[0290] Crystalized forms of the antibody or antibody are also contemplated. *See*, for example, US 2002/0136719A1 (Shenoy *et al.).*

[0291] The formulation herein may also contain more than one active compound as necessary for the particular indication being treated, in some embodiments, those with complementary activities that do not adversely affect each other. For example, it may be desirable to further provide a cytotoxic agent; chemotherapeutic agent; immunosuppressive agent; cytokine; cytokine antagonist or antibody; growth factor; hormone; integrin; integrin antagonist or antibody *(e.g.* an LFA-1 antibody such as efalizumab/RAPTIVA commercially available from Genentech, or an alpha 4 integrin antibody such as natalizumab/TYSABRI®) available from Biogen Idec/Elan Pharmaceuticals, Inc.); interferon class drug such as IFN-beta-1a (REBIF® and AVONEX®) or IFN-beta-1b (BETASERON®); an oligopeptide such a glatiramer acetate (COPAXONE®); a cytotoxic agent such as mitoxantrone (NOVANTRONE®), methotrexate, cyclophosphamide, chlorambucil, or azathioprine; intravenous immunoglobulin (gamma globulin); lymphocyte-depleting drug *(e.g.*, mitoxantrone, cyclophosphamide, Campath, anti-CD4, or cladribine); non–lymphocyte-depleting immunosuppressive drug *(e.g.*, mycophenolate mofetil (MMF) or cyclosporine); cholesterol-lowering drug of the "statin" class; estradiol; testosterone; hormone replacement therapy; drug that treats symptoms secondary or related to MS *(e.g.,* spasticity, incontinence, pain, fatigue); a TNF inhibitor; disease-modifying anti-rheumatic drug (DMARD); non-steroidal anti-inflammatory drug (NSAID); corticosteroid *(e.g.* methylprednisolone, prednisone, dexamethasone, or glucorticoid); levothyroxine; cyclosporin A; somatastatin analogue; cytokine antagonist; anti-metabolite; immunosuppressive agent; integrin antagonist or

antibody *(e.g.* an LFA-1 antibody, such as efalizumab or an alpha 4 integrin antibody such as natalizumab); or another B-cell surface antagonist/antibody; etc in the formulation. The type and effective amounts of such other agents depend, for example, on the amount of antibody present in the formulation, the type of multiple sclerosis being treated, and clinical parameters of the patients. These are generally used in the same dosages and with administration routes as used hereinbefore or about from 1 to 99% of the heretofore employed dosages.

[0292] The active ingredients may also be entrapped in microcapsules prepared, for example, by coacervation techniques or by interfacial polymerization, for example, hydroxymethylcellulose or gelatin-microcapsules and poly-(methylmethacylate) microcapsules, respectively, in colloidal drug delivery systems (for example, liposomes, albumin microspheres, microemulsions, nano-particles and nanocapsules) or in macroemulsions. Such techniques are disclosed in *Remington's Pharmaceutical Sciences* 16th edition, Osol, A. Ed. (1980).

[0293] Sustained-release preparations may be prepared. Suitable examples of sustained-release preparations include semipermeable matrices of solid hydrophobic polymers containing the antibody, which matrices are in the form of shaped articles, *e.g.* films, or microcapsules. Examples of sustained-release matrices include polyesters, hydrogels (for example, poly(2-hydroxyethyl-methacrylate), or poly(vinylalcohol)), polylactides (U.S. Pat. No. 3,773,919), copolymers of L-glutamic acid and γ ethyl-L-glutamate, non-degradable ethylene-vinyl acetate, degradable lactic acid-glycolic acid copolymers such as the LUPRON DEPOT™ (injectable microspheres composed of lactic acid-glycolic acid copolymer and leuprolide acetate), and poly-D-(-)-3-hydroxybutyric acid.

[0294] The formulations to be used for *in vivo* administration must be sterile. This is readily accomplished by filtration through sterile filtration membranes.

[0295] In some embodiments, the formulation comprises one or more of the group consisting of a histidine buffer, trehalose, sucrose, and polysorbate 20. In some embodiments, the histidine buffer is a histidine-acetate buffer, pH 6.0. Examples of formulations suitable for the administration of the anti-CD20 antibody are found in Andya et al., US2006/0088523, which is incorporated by reference in its entirety with respect to formulations.

[0296] Exemplary anti-CD20 antibody formulations are described in Andya et al., US2006/0088523 and WO98/56418, which are incorporated by reference in its entirety. In some embodiments, formulation is a liquid multidose formulation comprising the anti-CD20 antibody at 40 mg/mL, 25 mM acetate, 150 mM trehalose, 0.9% benzyl alcohol, 0.02% polysorbate 20 at pH 5.0 that has a minimum shelf life of two years storage at 2-8°C. In some embodiments, anti-

CD20 formulation of interest comprises 10mg/mL antibody in 9.0 mg/mL sodium chloride, 7.35 mg/mL sodium citrate dihydrate, 0.7mg/mL polysorbate 80, and Sterile Water for Injection, pH 6.5. In some embodiments, the anti-CD20 antibody is in an aqueous pharmaceutical formulation comprising 10-30 mM sodium acetate from about pH 4.8 to about pH 5.5, preferably at pH5.5, polysorbate as a surfactant in a an amount of about 0.01-0.1% v/v, trehalose at an amount of about 2-10% w/v, and benzyl alcohol as a preservative (U.S. 6,171,586, which is incorporated by reference in its entirety). Lyophilized formulations adapted for subcutaneous administration are described in WO97/04801, which is incorporated by reference in its entirety. Such lyophilized formulations may be reconstituted with a suitable diluent to a high protein concentration and the reconstituted formulation may be administered subcutaneously to the mammal to be treated herein.

[0297] In some embodiments, the humanized 2H7 variants formulation is antibody at 12-14 mg/mL in 10 mM histidine, 6% sucrose, 0.02% polysorbate 20, pH 5.8. In a specific embodiment, 2H7 variants and in particular 2H7.v16 is formulated at 20mg/mL antibody in 10mM histidine sulfate, 60mg/ml sucrose., 0.2 mg/ml polysorbate 20, and Sterile Water for Injection, at pH5.8. In a specific embodiment, one IV formulation of humanized 2H7 v16 is: 30mg/ml antibody in 20mM sodium acetate, 4% trehalose dihydrate, 0.02% polysorbate 20 (Tween 20™), pH 5.3. In some embodiments, the humanized 2H7.v511 variant formulation is 15-30mg/ml antibody, preferably 20mg/mL antibody, in 10mM histidine sulfate, 60mg/ml sucrose (6%), 0.2 mg/ml polysorbate 20 (0.02%), and Sterile Water for Injection, at pH5.8. In yet another embodiment, the formulation for 2H7 variants and in particular 2H7.v511 is 20 mg/ml 2H7, 20 mM sodium acetate, 4% trehalose dihydrate, 0.02% polysorbate 20, pH 5.5, for intravenous administration. In some embodiments, 2H7.v 114 formulation is antibody at 15-25 mg/ml, preferably 20mg/ml, in 20mM Sodium Acetate, 240mM (8%) trehalose dihydrate, 0.02% Polysorbate 20, pH 5.3.

VII. Articles of Manufacture and Methods of Manufacture

[0298] The invention provides articles of manufacture comprising: (a) a container comprising ocrelizumab; and (b) a package insert with instructions for treating multiple sclerosis in a patient, wherein the instructions denote (*i.e.*, indicate) that an amount of ocrelizumab is administered to the patient that is effective to provide an initial ocrelizumab exposure of between about 0.3 to about 0.6 grams followed by a second ocrelizumab exposure of between about 0.3 to about 0.6 grams, the second exposure not being administered until from about 16 to 60 weeks from the initial exposure, and each of the ocrelizumab exposures is provided to the patient as one or two doses of ocrelizumab. In some embodiments, the initial ocrelizumab exposure is about 0.6 grams.

In some embodiments, the second ocrelizumab exposure is about 0.6 grams. In some embodiments, the second exposure is administered from about 24 weeks from the initial exposure. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as one dose of ocrelizumab. In some embodiments, one or more of the ocrelizumab exposures are provided to the patient as two doses of ocrelizumab. In some embodiments, the two doses of ocrelizumab comprise about 0.3 grams of ocrelizumab.

[0299] The invention further provides articles of manufacture containing materials useful for the treatment of progressive multiple sclerosis described herein. In some embodiments, the article of manufacture comprising, packaged together, a pharmaceutical composition comprising an anti-CD20 antibody and a pharmaceutically acceptable carrier and a label denoting that the anti-CD20 antibody or pharmaceutical composition is indicated for treating patients with multiple sclerosis having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting the treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0300] In some embodiments, the article of manufacture comprising, packaged together, a pharmaceutical composition comprising an anti-CD20 antibody and a pharmaceutically acceptable carrier and a label denoting that administration of the anti-CD20 antibody or pharmaceutical composition is based upon the patient having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0301] In some embodiments, the article of manufacture comprising, packaged together, a pharmaceutical composition comprising an anti-CD20 antibody and a pharmaceutically acceptable carrier and a label denoting that the pharmaceutical composition is administered to a selected patient, wherein the selected patient has one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0302] In some embodiments of any of the articles of manufacture described herein, the patients have one or more characteristics selected from the group consisting of (a) an age less

than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment.

[0303] In some embodiments of any of the articles of manufacture described herein, the patient has more than one characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments of any of the articles of manufacture described herein, the patient has two characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in EDSS over two years prior to starting treatment. In some embodiments, the patient has three characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments, the patient has (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0304] In some embodiments of any of the articles of manufacture, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0305] In some embodiments of any of the articles of manufacture, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0306] In some embodiments of any of the articles of manufacture, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10

years. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment.

[0307] In some embodiments of any of the articles of manufacture described herein, the patient and/or patient population is characterized by having an MSSS of greater than about any of 6, 7, 8, or 9. In some embodiments of any of the articles of manufacture, the patient and/or patient population is characterized by having an MSSS of greater than about 9.

[0308] In some embodiments of any of the articles of manufacture, the age of the patient is less than about 51.

[0309] In some embodiments of any of the articles of manufacture, the treatment reduces the time to confirmed disease progression. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twelve weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

[0310] In some embodiments of any of the articles of manufacture, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0311] The article of manufacture comprises a container and a label or package insert on or associated with the container. Suitable containers include, for example, bottles, vials, syringes, etc. The containers may be formed from a variety of materials such as glass or plastic. The container holds or contains a composition that is effective for treating the multiple sclerosis and may have a sterile access port (for example the container may be an intravenous solution bag or a vial having a stopper pierceable by a hypodermic injection needle). At least one active agent in the composition is the antibody. In some embodiments, the container comprises between about 0.3 to about 4.0 grams of the anti-CD20 antibody. In some embodiments, the container comprises between about 0.3 to about 1.5 grams of the anti-CD20 antibody.

[0312] The label or package insert indicates that the composition is used for treating multiple sclerosis in a patient suffering therefrom with specific guidance regarding dosing amounts and intervals of antibody and any other drug being provided. The article of manufacture may further comprise a second container comprising a pharmaceutically acceptable diluent buffer, such as bacteriostatic water for injection (BWFI), phosphate-buffered saline, Ringer's solution and dextrose solution. The article of manufacture may further include other materials desirable from a commercial and user standpoint, including other buffers, diluents, filters, needles, and syringes.

[0313] Optionally, the article of manufacture herein further comprises a container comprising an agent other than the antibody for treatment and further comprising instructions on treating the patient with such agent, such agent preferably being a chemotherapeutic agent or immunosuppressive agent, interferon class drug such as IFN-beta-1a (REBIF® and AVONEX®) or IFN-beta-1b (BETASERON®); an oligopeptide such a glatiramer acetate (COPAXONE®); a cytotoxic agent such as mitoxantrone (NOVANTRONE®), methotrexate, cyclophosphamide, chlorambucil, or azathioprine; intravenous immunoglobulin (gamma globulin); lymphocyte-depleting drug *(e.g.*, mitoxantrone, cyclophosphamide, Campath, anti-CD4, or cladribine); non–lymphocyte-depleting immunosuppressive drug *(e.g.*, mycophenolate mofetil (MMF) or cyclosporine); cholesterol-lowering drug of the "statin" class; estradiol; hormone replacement therapy; drug that treats symptoms secondary or related to MS *(e.g.*, spasticity, incontinence, pain, fatigue); a TNF inhibitor; disease-modifying anti-rheumatic drug (DMARD); non-steroidal anti-inflammatory drug (NSAID); corticosteroid *(e.g.* methylprednisolone, prednisone, dexamethasone, or glucorticoid); levothyroxine; cyclosporin A; somatastatin analogue; cytokine or cytokine receptor antagonist; anti-metabolite; immunosuppressive agent; integrin antagonist or antibody *(e.g.* an LFA-1 antibody, such as efalizumab or an alpha 4 integrin antibody such as natalizumab); and another B-cell surface marker antibody; etc.

[0314] In some embodiments, the label may further denote any of the embodiments described herein. For example, the label may denote that the patient has (a) an age less than about 55 years and (b) one or more gadolinium staining lesions.

[0315] In another embodiment of the invention, a method for manufacturing containing materials useful for the treatment of progressive multiple sclerosis described herein is provided. In some embodiments, the method for manufacturing an anti-CD20 antibody or a pharmaceutical composition thereof comprising combining in a package the anti-CD20 antibody or pharmaceutical composition and a label denoting that the anti-CD20 antibody or pharmaceutical composition is indicated for treating patients with progressive multiple sclerosis, wherein the patients have one or more characteristics selected from the group consisting of (a) an age less

than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0316] In some embodiments of any of the methods of manufacturing described herein, the patients have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment.

VIII. Methods of Advertising and Marketing

[0317] The present invention also provides methods for advertising an anti-CD20 antibody or a pharmaceutically acceptable composition thereof comprising promoting, to a target audience, the use of the anti-CD20 antibody or pharmaceutical composition thereof for treating a patient or patient population with progressive multiple sclerosis, wherein the patient or patient population has one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0318] Provided herein are also methods for marketing an anti-CD20 antibody or a pharmaceutically acceptable composition thereof for use in a progressive multiple sclerosis patient subpopulation, the method comprising informing a target audience about the use of the anti-CD20 antibody for treating the patient subpopulation characterized by the patients of such subpopulation having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0319] In addition, the invention provides methods of specifying an anti-CD20 antibody for use in a progressive multiple sclerosis patient subpopulation, the method comprising providing instruction to administer the anti-CD20 antibody or a pharmaceutically acceptable composition thereof to the patient subpopulation characterized by the subpopulation has one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0320] The invention further provides methods of providing a treatment option for patients with progressive multiple sclerosis comprising packaging an anti-CD20 antibody in a vial with a package insert containing instructions to treat patients with progressive multiple sclerosis, wherein the patients have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0321] In some embodiments of any of the methods, the patients have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment.

[0322] In some embodiments of any of the methods, the patient has two characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments, the patient has three characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments, the patient has (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0323] In some embodiments of any of the methods, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0324] In some embodiments of any of the methods, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0325] In some embodiments of any of the methods, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment.

[0326] In some embodiments of any of the methods, the age of the patient is less than about 51.

[0327] In some embodiments of any of the methods, the treatment reduces the time to confirmed disease progression. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twelve weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

[0328] In some embodiments of any of the methods, the anti-CD20 antibody is ocrelizumab. In some embodiments of any of the methods, the anti-CD20 antibody is rituximab. In some embodiments of any of the methods, the anti-CD20 antibody is ofatumumab. In some embodiments of any of the methods, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments of any of the methods, the anti-CD20 antibody is GA101. In some embodiments of any of the methods, the anti-CD20 antibody is hA20.

[0329] The methods described herein may encompass any combination of the embodiments described herein. For example, the methods include methods, wherein the patient (a) an age less than about 55 years and (b) one or more gadolinium staining lesions.

IX. Systems and Methods for Predicting Responsiveness to Multiple Sclerosis Treatment

[0330] The invention also provides systems and methods for analyzing whether a subject and/or patient with progressive multiple sclerosis will respond to a treatment with a drug used to treat multiple sclerosis. The invention provides systems for analyzing responsiveness of a patient with progressive multiple sclerosis to treatment with a drug used to treat multiple sclerosis comprising: (a) assessing one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; (b)

hardware to perform the assessment of (a); and (c) computational means to perform an algorithm to determine if the patient is susceptible or responsive to said treatment.

[0331] The invention further provides methods for predicting whether a subject with progressive multiple sclerosis will respond to a treatment with a drug used to treat multiple sclerosis, the methods comprising assessing one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, whereby the age, the gadolinium staining lesions, the increase in EDDS over two years prior to starting the treatment, MSSS, or a combination thereof indicates that the subject will respond to the treatment.

[0332] In some embodiments of any of the systems and/or methods, the patient has more than one characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, and (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment.

[0333] In some embodiments of any of the systems and/or methods described herein, the patient has more than one characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments of any of the systems and/or methods, the patient has two characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments, the patient has three characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points. In some embodiments, the patient has (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

[0334] In some embodiments of any of the systems and/or methods, the progressive multiple sclerosis is primary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is secondary progressive multiple sclerosis. In some embodiments, the progressive multiple sclerosis is progressive relapsing multiple sclerosis. In some embodiments, the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

[0335] In some embodiments of any of the systems or methods, the patient further has evidence of inflammation in a sample. In some embodiments, the sample is a cerebrospinal fluid sample. In some embodiments, the evidence of inflammation is indicated by an elevated IgG index. In some embodiments, the evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

[0336] In some embodiments of any of the systems and/or methods, the increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient has had an EDSS of greater than about 5.0 for less than about 15 years. In some embodiments, the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years. In some embodiments, the EDSS when starting treatment is between about 3.0 and about 6.5. In some embodiments, the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment. In some embodiments, the 1.5 point increase in EDSS over two years prior to starting treatment is not attributable to relapse. In some embodiments, the patient further had two or more relapses within two years prior to starting treatment.

[0337] In some embodiments of any of the systems and/or methods, the age of the patient is less than about 51.

[0338] In some embodiments of any of the systems and/or methods, the systems or methods further comprises advising the patient.

[0339] In some embodiments of any of the systems and/or methods, the treatment reduces the time to confirmed disease progression. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twelve weeks. In some embodiments, the confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

[0340] In some embodiments of any of the systems and/or methods, the drug is a Interferon beta-1b (*e.g.*, Betaseron®), Interferon beta-1a (*e.g.*, Avonex® or Rebif®), Glatiramer (*e.g.*, Copaxone®), Mitoxantrone (*e.g.*, Novantrone), corticosteroids (*e.g.*, ethylprednisolone, prednisone, dexamethasone), 3-4 diaminopyridine, ABT-874, Alemtuzumab, Albuterol (Proventil®), ATL1102, Atorvastatin (Lipitor®), Azathioprine, BG00012 (dimethyl fumarate), BHT-3009, Botulinum toxin A (Botox®), C-105, cannador, dronabinol, tetrahydrocannabinol,

cannabidiol, CDP323, Cladribine, CNTO 1275, Cyclophosphamide, Daclizumab, Dextromethorphan/quinidine (AVP-923, ZenviaTM), Donepezil (Aricept®), Doxycycline, Estradiol, Estriol, Estroprogestins, Fampridine-SR (4-aminopyridine, sustained release), Fingolimod (FTY720), Interferon tau, Lamotrigine (Lamictal®), Laquinimod, Lidocaine + prilocaine (EMLA), MBP8298 (synthetic myelin basic protein peptide), Memantine (Namenda®), Methylprednisolone, MN-166, Modafinil (Provigil®), Mycophenolate mofetil (Cellcept®), naltrexone, Natalizumab (Tysabri®), Paroxetine (Paxil®), PI-2301 (co-polymer), Pioglitazone (Actos®), Pixantrone (BBR 2778), Pravastatin (Pravachol®), Pregabalin (Lyrica®), Progesterone, RG2077, Riluzole (Rilutek®), Rolipram (phosphodiesterase-4 inhibitor), RTL1000, SB-683699, Simvastatin (Zocor®), T cell receptor peptide vaccine (NeuroVaxTM), Teriflunomide, Testosterone gel (Androgel®), or Trimethoprim.

[0341] In some embodiments of any of the systems and/or methods, the drug used to treat multiple sclerosis is an anti-CD20 antibody. In some embodiments, the anti-CD20 antibody comprises: a) a heavy chain variable region comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6. In some embodiments, the anti-CD20 antibody is ocrelizumab. In some embodiments, the anti-CD20 antibody is rituximab. In some embodiments, the anti-CD20 antibody is ofatumumab. In some embodiments, the anti-CD20 antibody is TRU-015 or SBI-087. In some embodiments, the anti-CD20 antibody is GA101. In some embodiments, the anti-CD20 antibody is hA20.

[0342] The systems and/or methods described herein may encompass any combination of the embodiments described herein. For example, the methods include methods, wherein the patient (a) an age less than about 55 years and (b) one or more gadolinium staining lesions.

[0343] Further details of the invention are illustrated by the following non-limiting Examples. The disclosures of all citations in the specification are expressly incorporated herein by reference.

EXAMPLES

[0344] The examples, which are intended to be purely exemplary of the invention and should therefore not be considered to limit the invention in any way, also describe and detail aspects and embodiments of the invention discussed above. The foregoing examples and detailed description are offered by way of illustration and not by way of limitation.

Example 1: A Phase II Study of Ocrelizumab in Relapsing-Remitting Multiple Sclerosis (RRMS)

[0345] A phase II, multicenter, randomized, parallel-group, partially blinded, placebo and Avonex controlled dose finding study to evaluate the efficacy as measured by brain Magnetic Resonance Imaging (MRI) lesions, and safety of two dose regimens of ocrelizumab in patients with Relapsing-Remitting Multiple Sclerosis (RRMS) is performed.

[0346] The two ocrelizumab dose regimens under investigation are as follows: 1) ocrelizumab 1000 mg dose regimen: consisting of a dual infusion of 1000 mg for the first treatment cycle followed by single infusions of 1000 mg for the subsequent treatment cycles and 2) ocrelizumab 600 mg dose regimen: consisting of a dual infusion of 300 mg for the first treatment cycle followed by single infusions of 600 mg for the subsequent treatment cycles.

[0347] Eligible patients are randomized (1:1:1:1) into one of four treatment groups A, B, C or D as described in Figure 7. The overview of the study design is illustrated in Figure 7.

[0348] Group A (ocrelizumab 1000 mg): Two intravenous (i.v.) infusions of ocrelizumab each of 1000 mg separated by 14 days for the 1st treatment cycle. Patients then receive the maintenance dose regimen, *i.e.*, a single infusion of 1000 mg for every subsequent 24-week treatment cycle. Subsequently, in order to maintain the study double-blind during the 2nd treatment cycle, patients receive two infusions separated by 14 days, the first infusion is ocrelizumab 1000 mg and the second infusion placebo. In the 3rd and 4th treatment cycles, patients are treated with a single 1000 mg infusion, without a second placebo infusion, in a double-blind manner until a preferred dose is chosen on the basis of the primary analysis.

[0349] Group B (ocrelizumab 600 mg): Two i.v. infusions of ocrelizumab each of 300 mg separated by 14 days for the 1st treatment cycle. Patients then receive the maintenance dose regimen, *i.e.*, a single infusion of 600 mg for every subsequent 24-week treatment cycle. Subsequently, in order to maintain the study double-blind during the 2nd treatment cycle, patients receive two infusions separated by 14 days, the first infusion is ocrelizumab 600 mg and the second infusion placebo. In the 3rd and 4th treatment cycles, patients are treated with a single 600 mg infusion, without a second placebo infusion in a double-blind manner until a preferred dose is chosen on the basis of the primary analysis.

[0350] Group C (placebo): Two i.v. infusions of placebo separated by 14 days for the 1st treatment cycle. Thereafter, patients are placed on the 600 mg dose regimen of ocrelizumab starting with two double-blind i.v. infusions of ocrelizumab 300 mg separated by 14 days at the start of the 2nd treatment cycle. Patients then receive the maintenance dose regimen, *i.e.*, a single

infusion of 600 mg administered in a double-blind manner for the 3rd and 4th treatment cycles, until a preferred dose is chosen on the basis of the primary analysis.

[0351] Group D (Avonex): Avonex 30 µg intra-muscular (i.m.) weekly for the 1st treatment cycle. Thereafter, patients are offered, on a voluntary and open label basis, the 600 mg dose regimen of ocrelizumab starting with two i.v. infusions of ocrelizumab 300 mg separated by 14 days at the start of the 2nd treatment cycle. Patients in the 3rd and 4th treatment cycles are treated with a single 600 mg infusion until a preferred dose is chosen on the basis of the primary analysis.

[0352] For all groups, after investigators and ethics committees are informed of the preferred dose, patients receive the preferred dose (600 mg or 1000 mg) as a single infusion at their next successive treatment cycle(s).

[0353] The first administration of study medication whether an i.v. infusion (ocrelizumab or placebo) or the first i.m. injection of Avonex will define the start of the Treatment Period (Day 1). All patients also receive an i.v. infusion of methylprednisolone 100 mg on study day 1 and with each subsequent ocrelizumab or placebo infusion or, for patients receiving Avonex (Group D) according to the time points required for the ocrelizumab infusions.

[0354] There are four treatment cycles, *i.e.* cycle 1 = Baseline to Week 24; cycle 2 = Week 24 to Week 48; cycle 3 = Week 48 to Week 72; cycle 4 = Week 72 to Week 96. After the 1st cycle infusion visits (Visits 2 and 3, Day 1 and Week 2, respectively), visits occur at Week 4 and every 4 weeks thereafter for the first 24 weeks. After the 2nd cycle infusion visits (Visits 9 and 10, Week 24 and 26, respectively), visits occur at Week 36 and every 12 weeks thereafter through the end of the Treatment and Follow-up Periods. All effort should be made to schedule the visits within the provided windows. Additional unscheduled visits for the assessment of potential relapses, new neurological symptoms or safety events may occur at any time.

Study Population and Selection Criteria

[0355] Men and women from 18 to 55 years of age inclusive, who are diagnosed with relapsing-remitting multiple sclerosis (RRMS) in accordance with the revised McDonald criteria (2005) and who meet the inclusion/exclusion criteria provided below are eligible for enrollment into the study.

Inclusion Criteria:

[0356] Patients must meet the following criteria to be eligible for study entry:

1. RRMS in accordance with the revised McDonald criteria (2005);

2. Ages 18-55 years inclusive;
3. At least two documented relapses within the last 3 years prior to screening, at least one of which occurred within the last year prior to screening;
4. Expanded Disability Status Scale (EDSS) at baseline from 1.0 to 6.0 points;
5. Evidence of Multiple Sclerosis (MS) disease burden as defined below:
    a. At least six T2 lesions on an MRI scan done in the year prior to screening, based on local reading. Should an MRI scan be unavailable within the last year or showing less than six T2 lesions, a screening MRI scan with at least six T2 lesions is required for the patient to be eligible, OR
    b. Patient had 2 documented relapses within the year prior to screening.

Exclusion Criteria

[0357] Patients who meet the following criteria will be excluded from study entry:

1. Secondary or primary progressive multiple sclerosis at screening (Visit 1);
2. Disease duration of more than 15 years in patients with an EDSS = 2.0.

Efficacy Analysis

[0358] The primary objective in this study is to investigate the effect of ocrelizumab given as two dose regimens of 600 or 1000 mg intravenously (*see* Figure 7) on the total number of gadolinium-enhancing T1 lesions observed on MRI scans of the brain at weeks 12, 16, 20 and 24 as compared with placebo.

[0359] The secondary objectives of this study are to evaluate the efficacy and safety of ocrelizumab compared with placebo, as reflected by the following: the annualized protocol defined relapse rate by Week 24; proportion of patients who remain relapse-free by Week 24 (protocol defined relapses); the total number of gadolinium-enhancing T1 lesions observed on MRI scans of the brain at Weeks 4, 8, 12, 16, 20 and 24; the total number of new and/or persisting gadolinium-enhancing T1 lesions on MRI scans of the brain at Weeks 4, 8, 12, 16, 20 and 24; change in total volume of T2 lesions on MRI scans of the brain from baseline to Week 24, to evaluate the safety and tolerability of two dose regimens of ocrelizumab in patients with RRMS as compared with placebo and Avonex at Week 24 and the overall safety of ocrelizumab administered for up to 96 weeks, and to investigate the pharmacokinetics and other pharmacodynamic study endpoints of ocrelizumab.

[0360] In this Example, a relapse is defined as the occurrence of new or worsening neurological symptoms attributable to MS and immediately preceded by a relatively stable or improving neurological state of least 30 days. Symptoms must persist for >24 hours and should not be attributable to confounding clinical factors (*e.g.*, fever, infection, injury, adverse reactions to concomitant medications). The new or worsening neurological symptoms must be accompanied by objective neurological worsening consistent with an increase of at least half a step on the EDSS, or 2 points on one of the appropriate Functional System Scores (FSS), or 1 point on two or more of the appropriate FSS. The change must affect the selected FSS (*i.e.*, pyramidal, gait, cerebellar, brainstem, sensory, or visual). Sensory changes, episodic spasms, fatigue, mood change or bladder or bowel urgency or incontinence do not suffice to establish a relapse. The examining investigator confirms those relapses that adhere to the above criteria.

[0361] The exploratory objectives in this study will include, but may not be limited to: change in brain volume on MRI scans of the brain from the baseline scan to Week 12; change in brain volume on MRI scans of the brain from Week 12 to Week 96 in a subgroup of patients receiving ocrelizumab; the total number of new and/or enlarging T2 lesions observed on MRI scans of the brain at Weeks 4, 8, 12, 16, 20 and 24; the proportion of patients who remain free of new gadolinium-enhancing T1 lesions by Week 24; time to first new gadolinium-enhancing T1 lesions developing over 24 weeks; to evaluate the treatment withdrawal effect by means of the total number of gadolinium-enhancing T1 lesions 48 weeks after receiving up to 4 treatment cycles of ocrelizumab in a subgroup of patients; proportion of patients who remain free from relapses (clinical and protocol-defined relapses) during each treatment cycle and at Weeks 48 and 96; proportion of patients requiring systemic methylprednisolone treatment for an MS relapse during each treatment cycle and at Weeks 48 and 96; annualized clinical and protocol-defined relapse rate during each treatment cycle and at Weeks 48 and 96; time to first protocol-defined relapse by Week 24; time to first protocol-defined relapse by Week 96; time to onset of sustained disability progression as defined by the sustained worsening in EDSS of 1.0 point or more for 12 weeks through Week 96; time to onset of sustained disability progression as defined by the sustained worsening in EDSS of 1.0 point or more for 24 weeks through Week 96; to explore the effects of ocrelizumab on the primary and secondary study endpoints vs. Avonex; to explore the correlation of polymorphic variants in genes associated with RRMS susceptibility and ocrelizumab activity and therapeutic response to ocrelizumab in RRMS patients; to explore the relationship between circulating biomarkers associated with RRMS susceptibility and ocrelizumab activity and therapeutic response to ocrelizumab treatment in RRMS patients; change in the Modified Fatigue Impact Scale (MFIS) from baseline to Weeks 24 and 48; change in the Fatigue Scale for Motor

and Cognitive Functions (FSMC) from baseline to Weeks 24 and 48; change in the proportion of patients who moved from "severe" to "moderate" and from "moderate" to "mild" fatigue on the FSMC, comparing baseline to Weeks 24 and 48; change in the Center for Epidemiological Studies-Depression Scale (CES-D) from baseline to Weeks 24 and 48; and change in the proportion of patients who moved from a state of greater depressive symptomatology to a state of less depressive symptomatology on the CES-D, comparing baseline to Weeks 24 and 48.

Brain MRI

[0362] MRI is a useful tool for monitoring central nervous system (CNS) lesions in MS. Brain MRI scans are only obtained at screening in some patients (*see* Secondary Endpoints) and in all patients at baseline and at four-week intervals between baseline and week 24. In addition, in a sub-group of patients (Groups A and B), a brain MRI scan is performed at weeks 96 (Visit 16) and 48 weeks later, *i.e.*, week 144.

[0363] The MRI includes the acquisition of the following scans at each time point: T2-weighted MRI scan, T1-weighted MRI scan (without gadolinium-enhancement), and T1-weighted MRI scan (with gadolinium-enhancement).

Assessment of Disability

[0364] Disability progression as measured by EDSS is assessed in all patients by the independent examining investigator at screening and every 12 weeks throughout the study until the Observation Period at which time disability progression is assessed after 24 weeks.

[0365] Disability progression is defined as an increase of = 1.0 point from the baseline EDSS score that is not attributable to another etiology (e.g. fever, concurrent illness, or concomitant medication) when the baseline score is 5.0 or less, and = 0.5 when the baseline score is 5.5 or more. Disease progression is considered sustained when the increase in the EDSS is confirmed at a regularly scheduled visit at least 12 weeks after the initial documentation of the progression. An alternative definition of sustained disability progression requires that the increase in EDSS be confirmed at least 24 weeks after the initial documentation of the progression.

[0366] The EDSS is based on a standard neurological examination; the seven categories of the EDSS representing functional systems (pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, and cerebral and/or mental, plus "other") are rated and scored (collectively, functional system scores or FSS). Each score of the FSS is an ordinal clinical rating scale ranging from 0 to 5 or 6. These ratings are then used in conjunction with observations and information concerning ambulation and use of assistive devices to determine the EDSS score. The EDSS is a disability scale that ranges in 0.5-point steps from 0 (normal) to 10 (death).

Example 2: A Phase II/III Study of Rituximab in Primary Progressive Multiple Sclerosis (PPMS)

[0367] A randomized, double-blind, parallel group, placebo controlled, multicenter Phase II/III study (U2786g) to evaluate the safety and efficacy of rituximab in adults with Primary Progressive Multiple Sclerosis (PPMS) as defined by McDonald *et al* (Ann Neurol 50:121-7(2001)) was performed.

[0368] Subjects were randomized in a 2:1 ratio to receive either rituximab or placebo. Rituximab, commercially available from Genentech, was formulated for i.v. administration as a sterile product in 9.0 mg/ml sodium chloride, 0.7 mg/ml polysorbate 80, 7.35 mg/ml sodium citrate dehydrate, and sterile water for injection (pH 6.5). Each course of study drug consisted of two i.v. infusions (separated by 14 days) of 1000 mg rituximab or placebo. Subjects received the first course of treatment at Days 1 and 15 and received additional courses at Weeks 24, 48, and 72. Subjects received acetaminophen (1 g) and diphenhydramine HCl (50 mg), or equivalent, by mouth 30-60 min prior to start of each infusion. Glucocorticoids were not administered prior to infusion. In 96 weeks of trial duration, subjects were seen at regularly scheduled visits for physical examinations, neurologic and MRI assessments, to collect adverse events and vital signs, and to complete routine hematology, serum chemistries, and urinalysis lab tests.

[0369] Baseline demographics of Intent-To-Treat (ITT) subjects are presented in Table 3.

Table 3: Demographic and Baseline Characteristics: Intent-to-Treat Subjects.

Characteristic	Placebo (n = 147)	Rituximab (n = 292)	All Subjects (n = 439)
Age (yr)			
n	147	292	439
Mean (SD)	49.6 (8.69)	50.1 (9.02)	49.9 (8.90)
Median	51.0	51.0	51.0
Minimum to maximum	20 - 66	18 - 66	18 - 66
18–<40	20 (13.6%)	40 (13.7%)	60 (13.7%)
40–<55	80 (54.4%)	145 (49.7%)	225 (51.3%)
≥ 55	47(32.0%)	107 (36.6%)	154 (35.1%)

[0370] MS disease duration was similar in both treatment groups. Baseline MRI results are summarized in Table 4. The baseline MRI characteristics were similar in placebo and rituximab groups.

Table 4: Baseline MRI Results: Intent-to-Treat Subjects.

MRI Endpoint	Placebo (N=147)	Rituximab (N=292)	All Subjects (N=439)
Total gadolinium-enhancing lesion count	2		
N	147	290	437
Mean (SD)	0.5 (1.26)	0.7 (2.96)	0.7 (2.52)
Median	0.0	0.0	0.0
Minimum to maximum	0 - 8	0 - 32	0 - 32
0	110 (74.8%)	220 (75.9%)	330 (75.5%)
1	23 (15.6%)	44 (15.2%)	67 (15.3%)
2	5 (3.4%)	10 (3.4%)	15 (3.4%)
3	5 (3.4%)	5 (1.7%)	10 (2.3%)
≥ 4	4 (2.7%)	11 (3.8%)	15 (3.4%)
Total gadolinium-enhancing lesion volume (mm^3)			
N	147	290	437
Mean (SD)	27.56 (81.86)	49.50 (220.32)	42.12 (185.82)
Median	0.00	0.00	0.00
Minimum to maximum	0.00 - 556.40	0.00 - 2660.00	0.00 - 2660.00
T2 lesion volume (mm^3)			
N	147	290	437
Mean (SD)	8850.86 (11808.95)	9336.66 (13744.94)	9173.25 (13113.98)
Median	5199.50	5240.50	5220.70
Minimum to maximum	73.83 - 74534.0	174.00 - 155303.0	73.83 - 155303.0
Brain volume (cc)			
N	130	237	367
Mean (SD)	1210.91 (128.89)	1202.92 (120.23)	1205.75 (123.25)
Median	1209.5	1204.0	1207.0
Minimum to maximum	642.0 - 1522.0	712.60 - 1508.0	642.0- 1522.0

MRI = magnetic resonance imaging.

[0371] Randomization was stratified according to study site; baseline disease severity defined by EDSS (≤ 4.0, > 4.0). Baseline EDSS is summarized in Table 5. As a result of the dynamic randomization, the percentage of subjects in each treatment group was similar at all levels of the stratification factors.

Table 5: Baseline Stratification Factors, Disease Severity Intent-to-Treat Subjects.

Stratification Factor	Placebo (n = 147)	Rituximab (n = 292)	All Subjects (n =439)
EDSS			
N	147	292	439
2	6 (4.1%)	8 (2.7%)	14 (3.2%)
2.5	5 (3.4%)	11 (3.8%)	16 (3.6%)
3	11 (7.5%)	22 (7.5%)	33 (7.5%)
3.5	21 (14.3%)	36 (12.3%)	57 (13.0%)
4	25 (17.0%)	47 (16.1%)	72 (16.4%)
4.5	8 (5.4%)	19 (6.5%)	27 (6.2%)
5	6 (4.1%)	10 (3.4%)	16 (3.6%)
5.5	10 (6.8%)	10 (3.4%)	20 (4.6%)
6	28 (19.0%)	81 (27.7%)	109 (24.8%)
6.5	27 (18.4%)	48 (16.4%)	75 (17.1%)
Mean (SD)	4.73 (1.395)	4.84 (1.369)	4.80 (1.377)
Median	4.50	5.00	5.00
Minimum to maximum	2.0 - 6.5	2.0 - 6.5	2.0 - 6.5

EDSS = Expanded Disability Status Scale.

[0372] Additionally, the two treatment groups were similar in other baseline disease severity measures: EDSS, Kurtzke Functional System Scores, the Multiple Sclerosis Functional Composite Scale (MSFCS) score and the MSFCS components (Timed 25-Foot Walk, 9-Hole Peg Test, and PASAT-3).

Efficacy Results

[0373] The primary efficacy analysis for this trial compared the time to confirmed disease progression, during the 96 week treatment period, between rituximab and placebo. Disease progression is defined as an increase of = 1.0 point from baseline EDSS (Kurtzke *J. Neurology*

33(11):1444-52 (1983)), if the baseline EDSS is between 2.0 and 5.5 points (inclusive), or an increase of = 0.5 point if the baseline EDSS is > 5.5 points, for which change is not attributable to another etiology (*e.g.*, fever, concurrent illness, MS relapse or exacerbation, or concomitant medication).

[0374] Stratified analysis showed that rituximab did not significantly delay the confirmed disease progression compared with placebo (p=0.1442, stratified log-rank). The percentage of patients progressing by 96 weeks was estimated to be 38.5% and 30.2% for the placebo and rituximab groups, respectively (Table 6). Kaplan-Meier plots for the time to confirmed disease progression are shown in the Figure 8.

Table 6: The Time to Confirmed Disease Progression during Treatment Period Intent-to-Treat Subjects.

	Placebo (n=147)	Rituximab (n=292)
No. of subjects who had CDP (%)	53 (36.1%)	83 (28.4%)
No. of subjects who censored (%)	94 (63.9%)	209 (71.6%)
Stratified p-value		
Log-rank test		0.1442
Stratified hazard ratio (rel to placebo)		0.773
95% CI for		(0.546 - 1.093)
Proportion of subjects with CDP		
at week 24	6.9%	9.1%
at week 48	19.3%	20.2%
at week 72	30.3%	28.0%
at week 96	38.5%	30.2%

[0375] Secondary efficacy endpoints included change from baseline to Week 96 in the total volume of T2 lesions and change from baseline to Week 96 in the brain volume. A Hochberg-Bonferroni procedure was used to control the type I error rate in testing these two secondary endpoints. The change from baseline to Week 96 in the brain volume was not significantly different in the two treatment groups (p=0.6237). *See* Table 7.

Table 7: Change in Brain Volume from Baseline to Week 96.

	Placebo (N=130)	**Rituximab (N=237)**	**P-value**
Volume at baseline (cm3)			
mean (SD)	1211 (129)	1203 (120)	
median	1209.5	1204.0	
Volume change from baseline to week 96 (LOCF)			
mean (SD)	-9.9 (37.0)	-10.8 (40.3)	0.62
median	-14.0	-13.1	

[0376] A significant difference was observed between the two treatments for the change in T2 lesion volume from baseline to week 96 (p=0.0008). The median increase in volume of the T2 lesion was 809.50 mm^3 and 301.95 mm^3 in the placebo and rituximab groups, respectively. (*See* Table 8 and Figure 9).

Table 8: Change from Baseline to Week 96 in the Total Volume of T2 Lesions on Brain MRI Scans Intent-to-Treat Subjects

	Placebo (n=147)	**Rituximab (n=292)**	**p-Value**
Total volume of T2 lesions on brain MRI scan (mm3)			
Baseline			
N	147	290	
Mean(SD)	8850.86 (11808.95)	9336.66 (13744.94)	
Median	5199.50	5240.50	
Range	73.83 - 74534.00	174.00 - 155303.0	
SE	973.99	807.13	
95% CI	(6925.93 - 10775.79)	(7748.06 - 10925.26)	
Week 96			
N	147	290	
Mean(SD)	11055.55 (14536.29)	10843.80 (15827.44)	
Median	5526.60	5569.35	
Range	94.92 - 86232.00	179.30 - 170464.0	
SE	1198.93	929.42	

	Placebo (n=147)	Rituximab (n=292)	p-Value
95% CI	(8686.04 - 13425.05)	(9014.51 - 12673.09)	
Change from baseline to week 96			
N	147	290	
Mean(SD)	2204.69 (4306.24)	1507.14 (3739.45)	
Median	809.50	301.95	
Range	-8557.00 - 26367.00	-4031.00 - 24076.00	
SE	355.17	219.59	
95% CI	(1502.74 - 2906.63)	(1074.94 - 1939.33)	
Treatment difference in LS means(vs. placebo)		-718.24	
95% CI of the difference in LS means		(-1504.48,68.00)	
ANOVA t-test (stratified)			0.0733
Friedman ranked ANOVA test			0.0008
ANOVA t-test (stratified) on percent change from baseline to week 96			0.0006
Friedman ranked ANOVA test on percent change from baseline to week 96			0.0005

[0377] Analyses of all exploratory endpoints except the change in T2 lesion volume, enlarging T2 lesion and new T2 lesion showed statistically non-significant differences between placebo and rituximab arms. Compared to placebo, the rituximab group experienced significantly less increase in T2 lesion volume at Week 48 and 122 (p= 0.0051 and 0.0222, respectively); had less new T2 lesion at week 48 and 96 (p<0.001); had less enlarging T2 lesion count at week 48 and 96 (p=0.008 and 0.072, respectively).

Subgroup Analysis

[0378] Subgroup analysis for the primary endpoints included time to confirmed disease progression according to the following demographic and baseline disease characteristics: sites, age, gender, race, prior MS therapies, baseline EDSS, duration since MS symptom onset and baseline gadolinium (Gd) lesion, and baseline Multiple Sclerosis Severity Score (MSSS) (an index of how fast the patient progressed; *see* Roxburgh *et al. Neurology* 64; 1144-1151 (2005)).

[0379] The subgroup analysis results suggest a potential treatment effect in patients who are younger, progressed more rapidly (higher MSSS) or with Gd lesions at baseline (Figure 10). Moreover, additive predictive effects of age, Gd lesion at baseline and MSSS for the treatment effect have been verified using multivariate analysis method (Figure 11 and Figure 12). *See also* Table 9. Based on these findings with MSSS, a subgroup of the study population excluding older patients with longstanding disease and slow progression was selected using modified inclusion/exclusion criteria (age ≤ 55, 3 ≤ baseline EDSS ≤ 6.5, excluding patients with disease duration > 10 if their baseline EDSS <5 or disease duration > 15 if their baseline EDSS ≥ 5). A significant treatment effect was also shown for this subgroup (stratified log-rank test P-value=0.01; Figure 13).

Table 9: Time to Confirmed Disease Progression Subgroup Result Summary.

Subgroups	Total N	CDP@wk 96 Placebo	CDP@wk96 Rituximab	HR	HR 95% CI	P-value (Log-rank)
All patients (Primary analysis)	439	38.5%	30.2%	n/a	n/a	0.1442
Age <51	215	44.9%	27.5%	0.52	(0.32, 0.86)	0.0101
Gd+	107	52.8%	27.4%	0.41	(0.21, 0.80)	0.0069
Gd+ and age <51	72	51.6%	24.6%	0.33	(0.14, 0.79)	0.0088
Gd+ and age <55	93	49.5%	29.1%	0.40	(0.19, 0.84)	0.0126
MSSS >= 5 and age < 55	251	46.8%	29.6%	0.59	(0.38, 0.91)	.0163

[0380] Subgroup analyses suggest that PPMS patients with evidence of active disease show significant clinical signs of treatment related benefit as measured by time to confirmed disease progression, as well as change from baseline in EDSS, MSFC, and T2 lesions on brain MRI (data not shown). Independent factors that appeared prognostic of disease progression in the placebo group and potentially predictive of treatment response in the rituximab group included the following: younger age, particularly age less than 51; presence of contrast enhancing lesions at baseline on brain MRI; and higher MS severity score. These observations serve a hypothesis generating role supporting a potential therapeutic benefit of B-cell depletion on confirmed disease progression in appropriately selected progressive onset MS patients.

[0381] While this study failed to demonstrate primary efficacy in the overall PPMS population, subgroup efficacy analyses indicated that patients with contrast enhancing brain MRI lesions at baseline potentially responded to treatment with rituximab, with a 57% relative reduction in the

hazard (1-HR) of confirmed disease progression in the treated group versus placebo, which is largely but not entirely driven by a very high placebo Confirmed Disease Progression (CDP) rate of 52.8% at 96 weeks (Figure 10). PPMS patients aged less than 51 may also have benefited, with a 43% relative reduction in the hazard of confirmed disease progression and a placebo progression rate of 44.9%. While the presence of contrast enhancing lesions and age < 51 were correlated, a post-hoc analysis of the 72 patients exhibiting both characteristics revealed a more pronounced apparent effect, with a 77% relative reduction in the hazard of confirmed disease progression (Table 9). In this subgroup the placebo progression rate of 51.6% was not higher than the rate for all patients with enhancing MRI lesions at baseline, but a lower rate of progression in the rituximab group (24.6%) accounts for the potentially greater risk reduction with treatment. These OLYMPUS placebo data corroborate natural history observations on the clinical and MRI heterogeneity of PPMS patients (Sastre-Garriga et al. *Neurology* 65(4):633-5 (2005), Ingle et al. *Brain* 126(Pt 11):2528-36 (2003), Tremlett et al. *Mult Scler.* 14(3):314-24 (2008), Tremlett et al. *Neurology* 65(12):1919-23 (2005), Kremenchutzky et al. *Brain* 129(Pt 3):584-94. (2006)). Furthermore, the MAGNIMS clinical and MRI cohort study described a subset of PPMS patients with more inflammatory MRI activity early in the disease course and a worse prognosis for disability progression (Ingle et al. *J. Neurol Neurosurg Psychiatry* 76(9):1255-8 (2005)); the OLYMPUS placebo data appear to confirm these observations for the first time.

Example 3: A Phase III Study of Ocrelizumab in Progressive Multiple Sclerosis

[0382] A Phase III, randomized, double-blind, parallel-group, multicenter study to evaluate the safety and efficacy of 600 mg of ocrelizumab as compared with placebo in adults with progressive MS is performed.

[0383] A total of 630 progressive MS patients (315 with progressive onset and 315 with relapsing onset MS) are enrolled and assigned (2:1 randomization) to either ocrelizumab arm or placebo arm stratified by site and type of multiple sclerosis. This study consists of the following three periods that apply to all patients: a screening period, a treatment period and a treatment free follow up period. In the first course of study drug treatment (300 mg ocrelizumab or placebo infusion × 2) are administered on Days 1 and 15. In subsequent treatment courses, patients are dosed (600 mg ocrelizumab single infusion) every 24 weeks until the last patient enrolled receives his/her last course of treatment to be administered at Week 96.

[0384] Prior to each study drug infusion, patients receive treatment with an analgesic/antipyretic such as acetaminophen/paracetamol (1 grams) and an i.v. or oral antihistamine (such as diphenhydramine 50 mg), and 100mg methylprednisolone intravenously, or equivalents, to reduce the incidence of potential infusion reactions. In patients with Common

Terminology for Adverse Events (CTCAE) Grade 3 or higher (severe) infusion reactions with associated respiratory symptoms (stridor, wheeze or bronchospasm), additional treatment with bronchodilators may be indicated.

[0385] Routine laboratory studies are obtained throughout the study, with additional tests following courses of study drug treatment. Immune panel, serum human anti-human antibody (HAHA), and thyroid tests are also conducted. Serum samples of all patients are collected for pharmacokinetic analysis and blood samples are collected for B-cell count determination. B-cell counts are followed as a pharmacodynamic marker of ocrelizumab.

Patient Population and Selection Criteria

[0386] The target population for this study includes patients with progressive MS with or without a history of superimposed relapses. Patients with progressive MS eligible for this study are characterized by a diagnosis in accordance with the revised McDonald criteria (2005) and a period of 6 months or greater of documented irreversible loss of neurological function in the absence of relapses. Patients are selected with evidence of active disease and higher risk for more rapid disability progression, using criteria identified as potential risk factors in previous clinical trials with progressive MS patients. These factors include younger age, evidence of inflammation in the cerebrospinal fluid (CSF) (oligoclonal bands or elevated IgG index), contrast enhancing lesions on brain MRI, high relapse activity superimposed on non-relapse related progression, and more rapid historical accumulation of disability.

[0387] All patients volunteering and eligible for participation in the study are screened for conformance with the following inclusion and exclusion criteria:

Inclusion Criteria include:

1. Diagnosis of Multiple Sclerosis in accordance with the revised McDonald criteria (2005).

2. Progressive MS, characterized by documented, irreversible loss of neurological function persisting for = 6 months that cannot be attributed to clinical relapse.

3. Ages 18-55 years inclusive.

4. EDSS at screening from 3.0 to 6.5 points.

5. Score of = 2.0 on the Functional Systems (FS) scale for the pyramidal system or gait that is due to lower extremity findings.

6. Presence of at least one of the following laboratory findings in a CSF specimen obtained during the screening period or documented within the previous 6 months as indicated by, for example, elevated IgG index and/or IgG oligoclonal bands detected by isoelectric focusing.

7. Presence of at least one of the following criteria:

- Age <50
- Gd+ lesions on brain MRI at screening or within 6 months of screening
- At least 1.5 point increase in EDSS over past 2 yrs not attributable to relapse
- Two relapses in past two years

Exclusion criteria include:

1. Relapsing remitting multiple sclerosis at screening (Visit 1)

2. Disease duration from the onset of MS symptoms: more than 15 years in patients with an EDSS at screening > 5.0 or more than 10 years in patients with an EDSS at screening = 5.0.

Efficacy Analysis

[0388] The primary efficacy endpoint is the time to confirmed disease progression. Disease progression is defined as an increase of = 1.0 point from baseline EDSS, if the baseline EDSS is between 2.0 and 5.5 points (inclusive), or an increase of = 0.5 points, if the baseline EDSS is > 5.5 points, for which change is not attributable to another etiology (*e.g.*, fever, concurrent illness, MS relapse or exacerbation, or concomitant medication).

[0389] The EDSS is based on a standard neurological examination; the seven categories of the EDSS representing functional systems (pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, and cerebral and/or mental, plus "other") are rated and scored (collectively, functional system scores or FSS). Each score of the FSS is an ordinal clinical rating scale ranging from 0 to 5 or 6. These ratings are then used in conjunction with observations and information concerning ambulation and use of assistive devices to determine the EDSS score. The EDSS is a disability scale that ranges in 0.5-point steps from 0 (normal) to 10 (death).

[0390] The secondary efficacy endpoints in support of the primary efficacy endpoint include: change from baseline to Week 120 in the total volume of T2 lesions on brain MRI scan, change from baseline to Week 120 in the 25-foot timed walk, time to confirmed disease progression, with confirmation occurring at least 24 weeks (= 168 days) after initial disease progression.

Assessment of Relapse

[0391] Patients are evaluated for relapses by the treating investigator at each visit throughout the study and, if necessary, at unscheduled visits to confirm relapses occurring between the visits. To meet the criteria for a protocol-defined relapse, the relapse is defined as the occurrence of new or worsening neurological symptoms attributable to MS and immediately preceded by a relatively stable or improving neurological state of least 30 days. Symptoms must persist for >24 hours and should not be attributable to confounding clinical factors (*e.g.*, fever, infection, injury, adverse reactions to concomitant medications). The new or worsening neurological symptoms must be accompanied by objective neurological worsening consistent with an increase of at least half a step on the EDSS, or 2 points on one of the appropriate FSS, or 1 point on two or more of the appropriate FSS. The change must affect the selected FSS (*i.e.*, pyramidal, ambulation, cerebellar, brainstem, sensory, or visual). Episodic spasms, sexual dysfunction, fatigue, mood change or bladder or bowel urgency or incontinence do not suffice to establish a relapse.

Brain MRI Imaging

[0392] Magnetic resonance imaging of the brain and cervical spinal cord are obtained at multiple time points during this study, including at baseline. The brain MRI includes the acquisition of the following scans at each time point: T2-weighted MRI scan and T1-weighted MRI scan (without gadolinium-enhancement).

[0393] Change from baseline to Week 120 in the total volume of T2 lesions and timed 25 foot walk are compared between ocrelizumab and placebo using ranked analysis of variance. The model includes the two stratification factors noted in the primary analysis.

Example 4: A Phase III Study of Ocrelizumab in Primary Progressive Multiple Sclerosis

[0394] A Phase III, randomized, double-blind, parallel-group, multicenter study to evaluate the safety and efficacy of one of two dose regimens of ocrelizumab as compared with placebo in adults with primary progressive MS is performed.

The two ocrelizumab dose regimens under investigation are as follows: 1) ocrelizumab 1000 mg dose regimen: consisting of a dual infusion of 1000 mg for the first treatment cycle followed by single infusions of 1000 mg for the subsequent treatment cycles and 2) ocrelizumab 600 mg dose regimen: consisting of a dual infusion of 300 mg for the first treatment cycle followed by single infusions of 600 mg for the subsequent treatment cycles.

[0395] A total of 630 primary progressive MS patients are enrolled and assigned (2:1 randomization) to either ocrelizumab arm or placebo arm stratified by site and type of multiple sclerosis. This study consists of the following three periods that apply to all patients: a screening

period, a treatment period and a safety follow up period. In the first course of study drug treatment (ocrelizumab or placebo infusion × 2) are administered on Days 1 and 15. In subsequent treatment courses, patients are dosed (ocrelizumab or placebo single infusion) every 24 weeks until the last patient enrolled receives his/her last course of treatment to be administered at Week 96.

[0396] Prior to each study drug infusion, patients receive treatment with an analgesic/antipyretic such as acetaminophen/paracetamol (1 grams) and an i.v. or oral antihistamine (such as diphenhydramine 50 mg), and 100mg methylprednisolone intravenously, or equivalents, to reduce the incidence of potential infusion reactions. In patients with Common Terminology for Adverse Events (CTCAE) Grade 3 or higher (severe) infusion reactions with associated respiratory symptoms (stridor, wheeze or bronchospasm), additional treatment with bronchodilators may be indicated.

[0397] Routine laboratory studies are obtained throughout the study, with additional tests following courses of study drug treatment. Immune panel, serum human anti-human antibody (HAHA), and thyroid tests are also conducted. Serum samples of all patients are collected for pharmacokinetic analysis and blood samples are collected for B-cell count determination. B-cell counts are followed as a pharmacodynamic marker of ocrelizumab.

Patient Population and Selection Criteria

[0398] The target population for this study includes patients with primary progressive MS. Patients with primary progressive MS eligible for this study are characterized by a diagnosis in accordance with the revised McDonald criteria (2005). Patients are selected with evidence of active disease and higher risk for more rapid disability progression, using criteria identified as potential risk factors in previous clinical trials with progressive MS patients. These factors include younger age, evidence of inflammation in the cerebrospinal fluid (CSF) (oligoclonal bands or elevated IgG index), and more rapid historical accumulation of disability.

[0399] All patients volunteering and eligible for participation in the study are screened for conformance with the following inclusion and exclusion criteria:

Inclusion Criteria include:

1. Diagnosis of Primary Progressive Multiple Sclerosis in accordance with the revised McDonald criteria (2005).
2. Ages 18-55 years inclusive.
3. EDSS at screening from 3.0 to 6.5 points.

4. Score of = 2.0 on the Functional Systems (FS) scale for the pyramidal system that is due to lower extremity findings.

5. Documented history or presence at screening of at least one of the following laboratory findings in a CSF specimen as indicated by, elevated IgG index and/or IgG oligoclonal bands detected by isoelectric focusing.

6. Disease duration from the onset of MS symptoms: less than 15 years in patients with an EDSS at screening > 5.0 or less than 10 years in patients with an EDSS at screening = 5.0.

Exclusion criteria include:

1. History of relapsing remitting, secondary progressive, or progressive relapsing multiple sclerosis at screening (Visit 1).

Efficacy Analysis

[0400] The primary efficacy endpoint is the time to confirmed disease progression. Disease progression is defined as an increase of = 1.0 point from baseline EDSS, if the baseline EDSS is between 2.0 and 5.5 points (inclusive), or an increase of = 0.5 points, if the baseline EDSS is > 5.5 points, for which change is not attributable to another etiology (*e.g.*, fever, concurrent illness, MS relapse or exacerbation, or concomitant medication).

[0401] The EDSS is based on a standard neurological examination; the seven categories of the EDSS representing functional systems (pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, and cerebral and/or mental, plus "other") are rated and scored (collectively, functional system scores or FSS). Each score of the FSS is an ordinal clinical rating scale ranging from 0 to 5 or 6. These ratings are then used in conjunction with observations and information concerning ambulation and use of assistive devices to determine the EDSS score. The EDSS is a disability scale that ranges in 0.5-point steps from 0 (normal) to 10 (death).

[0402] The secondary efficacy endpoints in support of the primary efficacy endpoint include: change from baseline to Week 120 in the total volume of T2 lesions on brain MRI scan, change from baseline to Week 120 in the 25-foot timed walk, time to confirmed disease progression, with confirmation occurring at least 24 weeks (= 168 days) after initial disease progression.

Assessment of Relapse

[0403] Patients are evaluated for relapses by the treating investigator at each visit throughout the study and, if necessary, at unscheduled visits to confirm relapses occurring between the visits. To meet the criteria for a protocol-defined relapse, the relapse is defined as the occurrence of new or worsening neurological symptoms attributable to MS and immediately preceded by a relatively stable or improving neurological state of least 30 days. Symptoms must persist for >24 hours and

should not be attributable to confounding clinical factors (*e.g.*, fever, infection, injury, adverse reactions to concomitant medications). The new or worsening neurological symptoms must be accompanied by objective neurological worsening consistent with an increase of at least half a step on the EDSS, or 2 points on one of the appropriate FSS, or 1 point on two or more of the appropriate FSS. The change must affect the selected FSS (*i.e.*, pyramidal, ambulation, cerebellar, brainstem, sensory, or visual). Episodic spasms, sexual dysfunction, fatigue, mood change or bladder or bowel urgency or incontinence do not suffice to establish a relapse.

Brain MRI Imaging

[0404] Magnetic resonance imaging of the brain and cervical spinal cord are obtained at multiple time points during this study, including at baseline. The brain MRI includes the acquisition of the following scans at each time point: T2-weighted MRI scan and T1-weighted MRI scan (without gadolinium-enhancement).

[0405] Change from baseline to Week 120 in the total volume of T2 lesions and timed 25 foot walk are compared between ocrelizumab and placebo using ranked analysis of variance. The model includes the two stratification factors noted in the primary analysis.

CLAIMS

What is claimed is:

1. A method of treating progressive multiple sclerosis in a patient comprising administering to the patient an effective amount of an anti-CD20 antibody, wherein treatment is based upon the patient having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

2. The method of claim 1, wherein the progressive multiple sclerosis is primary progressive multiple sclerosis.

3. The method of claim 1, wherein the progressive multiple sclerosis is secondary progressive multiple sclerosis.

4. The method of claim 1, wherein the progressive multiple sclerosis is progressive relapsing multiple sclerosis.

5. The method of claim 1, wherein the patient is not diagnosed with relapsing remitting multiple sclerosis when starting treatment.

6. The method of claim 1, wherein the patient further has evidence of inflammation in a sample.

7. The method of claim 6, wherein the sample is a cerebrospinal fluid sample.

8. The method of claim 7, wherein evidence of inflammation is indicated by an elevated IgG index.

9. The method of claim 7, wherein evidence of inflammation is indicated by IgG oligoclonal bands detected by isoelectric focusing.

10. The method of claim 1, wherein the patient has had an EDSS of greater than about 5.0 for less than about 15 years.

11. The method of claim 1, wherein the patient has had an EDSS less than or equal to about 5.0 for less than about 10 years.

12. The method of claim 1, wherein the increase in EDSS over two years prior to starting treatment is not attributable to relapse.

13. The method of claim 1, wherein the increase in EDSS is at least about a 1.5 point increase in EDSS over two years prior to starting treatment.

14. The method of claim 13, wherein the increase in EDSS over two years prior to starting treatment is not attributable to relapse.

15. The method of claim 1, wherein the age of the patient is less than about 51.

16. The method of claim 1, wherein the patient further had two or more relapses within two years prior to starting treatment.

17. The method of claim 1, wherein the EDSS when starting treatment is between about 3.0 and about 6.5.

18. The method of claim 1, wherein the treatment reduces the time to confirmed disease progression.

19. The method of claim 18, wherein confirmed disease progression is an increase in EDSS that is sustained for twelve weeks.

20. The method of claim 18, wherein confirmed disease progression is an increase in EDSS that is sustained for twenty-four weeks.

21. The method of claim 1, wherein the anti-CD20 antibody comprises: a) a heavy chain variable region comprising three CDR regions comprising SEQ ID NO:10, SEQ ID NO:11, and SEQ ID NO:12, and b) a light chain variable region comprising three CDR regions comprising SEQ ID NO:4, SEQ ID NO:5, and SEQ ID NO:6.

22. The method of claim 1, wherein the anti-CD20 antibody is ocrelizumab.

23. The method of claim 1, wherein the anti-CD20 antibody is rituximab.

24. The method of claim 1, wherein the anti-CD20 antibody is ofatumumab.

25. The method of claim 1, wherein the anti-CD20 antibody is TRU-015 or SBI-087.

26. The method of claim 1, wherein the anti-CD20 antibody is GA101.

27. The method of claim 1, wherein the anti-CD20 antibody is hA20.

28. The method of claim 1, wherein the effective amount of the anti-CD20 antibody is administered to the patient to provide an initial anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams followed by a second anti-CD20 antibody exposure of between about 0.3 to about 4.0 grams.

29. The method of claim 28, wherein the initial anti-CD20 antibody exposure and/or the second anti-CD20 antibody exposure is between about 0.3 to about 1.5 grams.

30. The method of claim 29, wherein the second exposure not being provided until from about 16 to 60 weeks from the initial exposure.

31. The method of claim 30, wherein each of the anti-CD20 antibody exposures is provided to the patient as one or two doses of anti-CD20 antibody.

32. A method of treating progressive multiple sclerosis in a patient provided that the patient has been found to have one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, the treatment comprising administering to the patient an effective amount of an anti-CD20 antibody.

33. A method of treating progressive multiple sclerosis, comprising:

(a) selecting a patient having progressive multiple sclerosis, wherein said patient has one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and

(b) administering to the patient thus selected an effective amount of an anti-CD20 antibody.

34. A method of assessing whether a patient with progressive multiple sclerosis will respond to treatment with an anti-CD20 antibody comprising assessing one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, wherein one or more of the characteristics in the patient indicates the patient will be responsive to the treatment.

35. A method of identifying a patient with progressive multiple sclerosis likely to respond to anti-CD20 antibody treatment comprising:

(a) assessing one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (ii) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points; and

(b) identifying the patient having one or more characteristics selected from the group consisting of (i) an age less than about 55 years, (i) one or more gadolinium staining lesions, (iii) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting the anti-CD20 treatment, and (iv) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

36. A method for marketing an anti-CD20 antibody or a pharmaceutically acceptable composition thereof for use in a progressive multiple sclerosis patient subpopulation, the method comprising informing a target audience about the use of the anti-CD20 antibody for treating the patient subpopulation characterized by the patients of such subpopulation having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

37. An article of manufacture comprising, packaged together, a pharmaceutical composition comprising an anti-CD20 antibody and a pharmaceutically acceptable carrier and a label denoting that the anti-CD20 antibody or pharmaceutical composition is indicated for treating patients with multiple sclerosis having one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points.

38. A method for predicting whether a subject with progressive multiple sclerosis will respond to a treatment with a drug used to treat multiple sclerosis, the method comprising assessing one or more characteristics selected from the group consisting of (a) an age less than about 55 years, (b) one or more gadolinium staining lesions, (c) at least about a one point increase in Expanded Disability Status Scale (EDSS) over two years prior to starting treatment, and (d) a Multiple Sclerosis Severity Score (MSSS) greater than about 5 points, whereby the age, the gadolinium staining lesions, the increase in EDDS over two years prior to starting the treatment, or a combination thereof indicates that the subject will respond to the treatment.

39. A method of treating multiple sclerosis in a patient comprising administering an effective amount of ocrelizumab to the patient to provide an initial ocrelizumab exposure of between about 0.3 to about 0.6 grams followed by a second ocrelizumab exposure of between about 0.3 to about 0.6 grams, the second exposure not being provided until from about 16 to 60 weeks from the

initial exposure, and each of the ocrelizumab exposures is provided to the patient as one or two doses of ocrelizumab.

40. The method of claim 39, wherein the initial ocrelizumab exposure comprises a first dose and a second dose of ocrelizumab, wherein the first dose and second dose of ocrelizumab is about 0.3 grams.

41. The method of claim 40, wherein the second ocrelizumab exposure comprises a single dose of ocrelizumab, wherein the single dose of ocrelizumab is 0.6 grams.

42. The method of claim 41, wherein the second ocrelizumab exposure is provided approximately 24 weeks after the initial ocrelizumab exposure.

43. The method of claim 42, further comprising providing a third ocrelizumab exposure.

44. The method of claim 43, further comprising providing a fourth ocrelizumab exposure.

45. The method of claim 44, further comprising providing a fifth ocrelizumab exposure.

46. The method of claim 42, further comprising providing between about one to about three subsequent ocrelizumab exposures.

47. An article of manufacture comprising:

(a) a container comprising ocrelizumab; and

(b) a package insert with instructions for treating multiple sclerosis in a patient, wherein the instructions indicate that an amount of ocrelizumab is administered to the patient that is effective to provide an initial ocrelizumab exposure of between about 0.3 to about 0.6 grams followed by a second ocrelizumab exposure of between about 0.3 to about 0.6 grams, the second exposure not being administered until from about 16 to 60 weeks from the initial exposure, and each of the ocrelizumab exposures is provided to the patient as one or two doses of ocrelizumab.