RWD58

Real-World Utilization of Talazoparib Plus Enzalutamide in Metastatic Castration-Resistant Prostate Cancer in the United States

Suvina Amin[1]; Shel Liang[1], Melissa Kirker[1]; Neo Su[1]; Samuel Wagner[2]; Onur Baser[2,3]; Katarzyna Rodchenko[2]; Shuangrui Chen[2]; Precious Nchekwube[2]; Lixuan Wu[2]; Sarah Hanson[1]

[1]Pfizer Inc., New York, NY; [2]Columbia Data Analytics, New York, NY, USA; [3]Graduate School of Public Health, City University of New York (CUNY), New York, NY, USA

Objective

To describe patient characteristics, prior treatment exposure, prescribing patterns, and utilization among patients initiating tala+enza in routine US clinical practice.

Conclusions

- This early claims-based analysis provides evidence on the real-world adoption and treatment patterns of tala+enza among men with mPC, using treatment initiation as a proxy for the mCRPC setting.
- The majority of patients had prior exposure to commonly used mPC therapies, particularly androgen receptor pathway inhibitors, before tala+enza initiation.
- Most patients started talazoparib at the full dose of 0.5 mg; dose reductions were less common than reported in TALAPRO-2.
- Treatment was primarily managed by oncology specialists in community-based settings.
- These findings provide early insights into the real-world uptake and implementation of tala+enza in routine oncology practice.

Presenting author:
Dr. Neo Su

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Background

- Talazoparib plus enzalutamide (tala+enza) was approved in the United States in June 2023 for homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC), defined in the PCWG4 recommendations[1] as metastatic androgen pathway modulation-resistant (mAPMR) prostate cancer.[2]
- Approximately 25% of mCRPC patients harbor HRR gene mutations, which compromise DNA repair mechanisms, making the disease more aggressive and presenting both challenges and opportunities for targeted therapy.[3-6]
- Claim-based evidence describing early uptake and treatment patterns of tala+enza remains limited.

Materials and Methods

STUDY DESIGN

- Retrospective observational cohort study of men initiating talazoparib plus enzalutamide (tala+enza) between June 20, 2023, and August 31, 2025 (**Figure 1**).
- Combination therapy was defined as initiation of the second agent within 90 days of the first.
- The index date was the initiation date of the second agent, establishing combination therapy.

DATA SOURCE

- Data were obtained from de-identified US administrative claims in the Kythera Labs database.

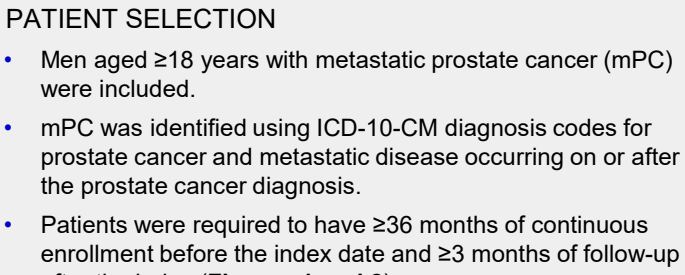
PATIENT SELECTION

- Men aged ≥18 years with metastatic prostate cancer (mPC) were included.
- mPC was identified using ICD-10-CM diagnosis codes for prostate cancer and metastatic disease occurring on or after the prostate cancer diagnosis.
- Patients were required to have ≥36 months of continuous enrollment before the index date and ≥3 months of follow-up after the index (**Figures 1 and 2**).
- Because castration resistance cannot be directly confirmed in claims, tala+enza initiation was used as a claims-based proxy for treatment in the mCRPC setting.

VARIABLE DEFINITIONS AND ANALYSIS

- Demographics, comorbidities, and socioeconomic status (SES) were assessed during the 12-month baseline period, while prior therapies were assessed during the 12, 24, and 36 months before the index date.
- Combination-level treatment-utilization measures were assessed from the index date, whereas agent-specific measures, including talazoparib treatment duration, discontinuation, and dose modification, were assessed from the first observed claim for the respective agent. Treatment setting and prescriber specialty were assessed during follow-up.
- Outcomes were summarized descriptively using counts, percentages, means, SDs, and medians, as appropriate.

Figure 1. Study Design



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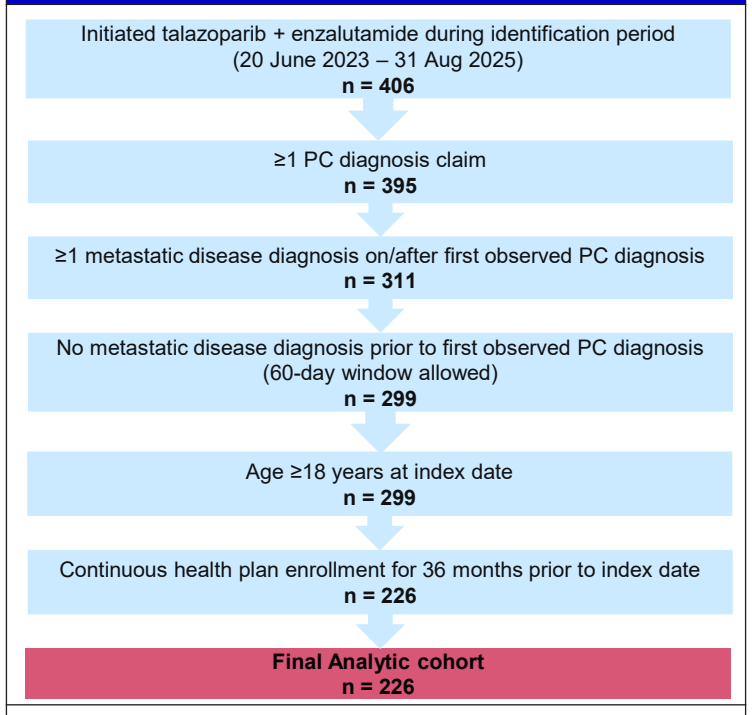
References: 1. Armstrong AJ, et al. *J Clin Oncol.* 2026;44(13):1249-1265. **2.** Heiss BL, et al. *J Clin Oncol*. 2024;42(15):1851-1860. **3.** Kim IE, Jr., et al. *BMC Urol.* 2019;19(1):33. **4.** Chung JH, et al. *JCO Precis Oncol.* 2019;3. **5.** Lang SH, et al. *Int J Oncol.* 2019;55(3):597-616. **6.** Moore C, et al. *Oncologist.* 2024;29(8):716-720.

Acknowledgments:
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Results

Figure 2. Study attrition



NCI, National Cancer Institute; PC, prostate cancer; SD, standard deviation

PATIENT CHARACTERISTICS

- Overall, 226 men met the eligibility criteria; mean age was 74.0 years (median: 74 years).
- Nearly half of patients resided in the South US region (49.6%).
- Patients were distributed relatively evenly across SES tertiles: high, 33.2%; low, 32.3%; and middle, 31.9%.
- The mean Charlson Comorbidity Index score was 2.5.
- Common comorbidities included hypertension (48.2%) and diabetes (22.6%) (**Table 1**).

Table 1. Demographic and clinical characteristics

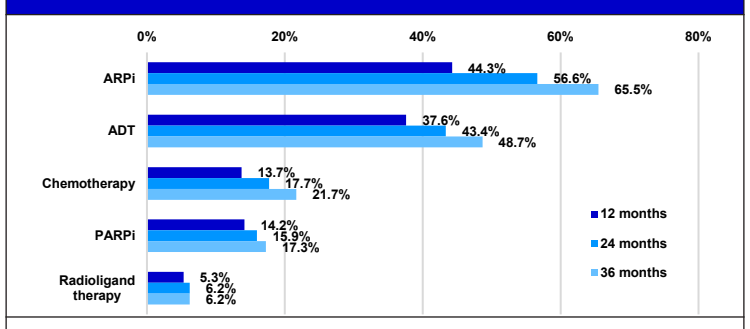
Characteristic	Overall (n=226)
Age	
Age, years, mean (SD)	74.0 (8.9)
<55 years, n (%)	3 (1.3)
55–<70 years, n (%)	67 (29.6)
≥70 years, n (%)	156 (69.0)
US geographic region, n (%)	
Northeast	25 (11.1)
Midwest	44 (19.5)
South	112 (49.6)
West	43 (19.0)
Unknown	2 (0.9)
Socioeconomic status tertile, n (%)	
Low	73 (32.3)
Middle	72 (31.9)
High	75 (33.2)
Unknown	6 (2.7)
Comorbidity indices, mean (SD)	
Charlson Comorbidity Index	2.5 (2.2)
Chronic Disease Score	4.0 (3.7)
NCI Comorbidity Index	1.6 (2.9)
Elixhauser Comorbidity Index	4.2 (4.2)
Baseline systemic comorbidities, n (%)	
Hypertension	109 (48.2)
Diabetes	51 (22.6)
Chronic obstructive pulmonary disease	24 (10.6)
Obesity	24 (10.6)
Cardiovascular disease	23 (10.2)
Depression	22 (9.7)
Chronic kidney disease	17 (7.5)

NCI, National Cancer Institute; SD, standard deviation

PRE-INDEX TREATMENT HISTORY

- During the 36-month pre-index lookback period, 65.5% of patients received an androgen receptor pathway inhibitor, 48.7% received androgen deprivation therapy, and 21.7% received chemotherapy (**Figure 3**).

Figure 3. Treatment history during the 12-, 24-, and 36-month periods before tala+enza initiation



Note: The figure compares the proportion of patients with at least 1 claim for each treatment across the 12-, 24-, and 36-month lookback periods before the index date (tala+enza initiation).

ADT, androgen deprivation therapy; ARPi, androgen receptor pathway inhibitor; PARPi, poly (adenosine diphosphate-ribose) polymerase inhibitor; tala+enza, talazoparib plus enzalutamide.

PRESCRIBER SPECIALTY & TREATMENT SETTING

- Treatment was primarily prescribed by hematology-oncology (67.3%) and medical oncology (23.5%) specialists; urologists accounted for 6.7% of prescribing providers.
- Most treatment was observed in community-based settings (80.5%), consistent with the composition of the Kythera provider network.

TREATMENT UTILIZATION

- The median observed follow-up duration was 366 days.
- Most patients initiated both agents on the same date (70.4%), while 15.5%, 5.8%, and 8.4% initiated the second medication within 1–30, 31–60, and 61–90 days, respectively; enzalutamide was more commonly initiated first.
- Talazoparib was most commonly initiated at a dose 0.50 mg (79.6%).
- The mean observed duration of tala+enza treatment was 178.8 days.
- The median time from the initial metastasis diagnosis to tala+enza initiation was 728.5 days (**Table 2**).

Table 2. Treatment utilization patterns

Measure	Overall (n=226)
Treatment timing and duration	
Observed follow-up duration, median, days	366
Time from initial metastatic diagnosis to tala+enza initiation, median, days	**728.5**
Combination-treatment duration among all patients, mean (SD), days	178.8 (212.4)
Combination-treatment duration among patients who discontinued tala+enza combination (n=123), mean (SD), days	67.3 (50.0)
Duration of treatment for talazoparib among all patients, mean (SD), days	172.2 (206.9)
Duration of treatment for talazoparib among patients who discontinued talazoparib (n=126), mean (SD), days	62.5 (47.2)
Treatment discontinuation, n (%)	
Discontinued tala+enza combination	123 (54.4)
Discontinued talazoparib	126 (55.8)
≥1 talazoparib dose reduction before discontinuation (among patients who discontinued [n=123])	21 (17.1)
Talazoparib starting dose, n (%)	
0.50 mg	180 (79.6)
0.35 mg	19 (8.4)
0.25 mg	24 (10.6)
0.10 mg	3 (1.3)
Talazoparib dose reductions, n (%)	
Patients with 1 dose reduction	27 (11.9)
Patients with 2 dose reductions	3 (1.3)

SD, standard deviation; tala+enza, talazoparib plus enzalutamide.

LIMITATIONS

- Castration resistance could not be directly confirmed in the claims; therefore, tala+enza initiation was used as a proxy for treatment in the mCRPC setting.
- HRR gene mutation status was unavailable and could not be assessed. However, because tala+enza is approved in the United States specifically for patients with HRR gene-mutated mCRPC, most patients initiating the combination were expected to have HRR gene mutations and mCRPC, consistent with the approved indication.
- The setting and line of prior treatment could not be determined, limiting interpretation of treatment duration relative to TALAPRO-2.
- Prescription claims indicate that a medication was dispensed but do not confirm that it was taken as prescribed.
- The geographic distribution and community-based treatment patterns should be interpreted in the context of the US claims dataset and the Kythera provider network and may not represent national prescribing or treatment-setting patterns.

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