Overview

Useful For
Detection and quantification of antibodies directed against adalimumab in serum

Trough level quantitation for evaluation of patients with loss of response to adalimumab

Highlights
Adalimumab (tradename Humira, manufactured by AbbVie) is a fully human therapeutic monoclonal antibody targeting tumor necrosis factor alpha (TNF), a proinflammatory cytokine that is upregulated in several autoimmune inflammatory states.

Adalimumab is FDA-approved for treatment of rheumatoid arthritis, juvenile idiopathic arthritis, psoriatic arthritis; ankylosing spondylitis, pediatric and adult Crohn disease, ulcerative colitis, plaque psoriasis, hidradenitis suppurativa and uveitis. Adalimumab is a subcutaneous injection, usually self-administered every other week at a fixed dose of 40 mg in adults, although dosing can vary.

Testing for adalimumab concentration and presence of anti-adalimumab antibodies is helpful to adjust therapeutic strategies for patients starting therapy (proactive monitoring), and to adjust dosing when partial response or loss of response to therapy is observed, manifested as recurrence of symptoms.

Reflex Tests

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<th>Test ID</th>
<th>Reporting Name</th>
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<tbody>
<tr>
<td>ADLAB</td>
<td>Adalimumab Ab, S</td>
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</tbody>
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Testing Algorithm
If the result is 8.0 mcg/mL or less, then adalimumab antibody test will be performed at an additional charge.

Method Name
ADALX, ADLAB: Enzyme-Linked Immunosorbent Assay (ELISA)

NY State Available
Yes

Specimen

Specimen Type
Serum

Specimen Required
Container/Tube:
Preferred: Serum gel
Acceptable: Red top
Specimen Volume: 0.5 mL

Forms
If not ordering electronically, complete, print, and send a Gastroenterology and Hepatology Client Test Request (T728) with the specimen.

Specimen Minimum Volume
0.35 mL

Reject Due To

<table>
<thead>
<tr>
<th>Gross hemolysis</th>
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<tbody>
<tr>
<td>Gross lipemia</td>
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Specimen Stability Information

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Clinical and Interpretive

Clinical Information
Adalimumab, sold under the trade name Humira, is a medication used to treat rheumatoid arthritis, psoriatic arthritis, Crohn disease, ulcerative colitis, chronic psoriasis, amongst others. Adalimumab is a tumor necrosis factor (TNF)-inhibiting, anti-inflammatory, biologic medication. It binds to TNF-alpha, which normally binds to TNF-alpha receptors, leading to the inflammatory response of autoimmune diseases. By binding to TNF-alpha, adalimumab reduces inflammatory response. Because TNF-alpha is also part of the immune system that protects the body from infection, treatment with adalimumab may increase the risk of infections. Treatment with adalimumab is effective in reducing disease activity, offers significant benefits in quality of life, and may have the potential to change the progression of the disease when given early. However, over 30% of patients fail to respond to anti-TNF-alpha therapy, and approximately 60% of patients who responded initially lose the response over time and require either drug dose-escalation or switch to an alternative agent in order to maintain response. Antidrug antibody formation may increase drug clearance in treated patients and/or neutralize the drug effect, thereby potentially contributing to the loss of response. Antidrug antibodies could also cause adverse events such as serum sickness and hypersensitivity reactions. Currently, adalimumab quantitation is commonly performed in conjunction with immunogenicity assessment for antibodies to adalimumab (ATA). Most often, this testing is ordered in patients on therapy who are experiencing loss of response.

Results from drug concentration measurement combined to ATA testing play an important role in patient management. When measured at trough, for patients who have undetectable or low concentrations of drug but no detectable ATA, the physician may choose to increase the dose of adalimumab in an attempt to increase the amount of the drug in circulation. If the patient has low adalimumab in the presence of an ATA, in many cases, the physician may switch the patient to another TNF inhibitor. In contrast, for patients with increased trough concentrations of adalimumab, whether or not an ATA is present, it may be necessary to switch the patient to a therapy with a different mechanism of action.

For patients on biologics, assessing response to therapy is critical, since therapies are expensive and adverse
events include greater risk for infections, such as reactivation of latent TB or hepatitis B, infusion or injection site
reactions, cutaneous reactions, and reports of hepatotoxicity, demyelinating disease, and higher incidence of mortality
and hospitalization in heart failure patients have been documented. Despite their therapeutic efficacy, more than one-
third of patients on TNF inhibitors show no response to induction therapy (primary nonresponders) and in up to 50%
of the responders, therapy becomes ineffective over time (secondary nonresponders). Reasons for primary loss of
response are not well understood, but may include disease processes mediated by proinflammatory molecules other
than TNF. Secondary loss of response, on the other hand, is associated with low albumin, high body-mass index, the
degree of systemic inflammation and immune response to therapy, or immunogenicity. Laboratory testing of patients
for quantitation of adalimumab and assessment of immunogenicity (development of autoantibodies against
adalimumab) can help optimize therapy when partial response or loss of response to therapy are observed.

Reference Values

ADALIMUMAB QUANTITATIVE WITH REFLEX TO ANTIBODY

Limit of quantitation is 0.8 mcg/mL. Optimal therapeutic ranges are disease specific.

ADALIMUMAB ANTIBODY

<14.0 AU/mL

Interpretation

Currently, adalimumab quantitation is one of the most commonly tested monoclonal antibodies in routine practice;
this testing is generally performed in conjunction with immunogenicity assessment for antibodies to adalimumab
(ATA). Most often, this testing is ordered for patients with inflammatory bowel disease (IBD) who are on adalimumab
therapy and who are experiencing loss of response, but the testing may be ordered for anyone on adalimumab.
Results from adalimumab and ATA testing play an important role in patient management. When measured at trough,
for patients who have undetectable or low concentrations of adalimumab, but no detectable ATA, the physician may
choose to increase the dose of adalimumab in an attempt to increase the amount of the drug in circulation. If the
patient has low adalimumab in the presence of an ATA, in many cases the physician may switch the patient to
another tumor necrosis factor (TNF) inhibitor. In contrast, for patients with increased trough concentrations of
adalimumab, whether or not an ATA is present, it may be necessary to switch the patient to a therapy with a different
mechanism of action, such as the anti-alpha4-beta-7-integrin antibody vedolizumab or the IL12/IL23 antibody
ustekinumab, in the setting of IBD.

Adalimumab quantitation will be interpreted in 2 different ways. When measured at trough, individuals may be
considered to have adequate trough levels when drug concentrations are above 8 mcg/mL, and faster clearance of
the drug, which may warrant a dosing adjustment or additional action if adalimumab trough concentration is below or
equal to 8 mcg/mL. Adalimumab quantitation may influence patient management decisions as to whether therapy
should continue as is, dose escalation is necessary, or a switch to a new therapeutic regimen is needed.

Low trough concentrations may be correlated with loss of response to adalimumab. For adalimumab trough
concentrations of 8.0 mcg/mL or less, testing for an ATA is suggested.

For adalimumab trough concentrations above 8.0 mcg/mL, the presence of ATA is unlikely; patients experiencing
loss of response to adalimumab may benefit from an increased dose or more frequent dosing.

Adalimumab concentration results above 35 mcg/mL are suggestive of a blood draw at a time-point in treatment
other than trough.

Cautions

Laboratory testing of patients for quantitation of adalimumab and assessment of immunogenicity (development of
autoantibodies against adalimumab) can help optimize therapy when partial response or loss of response to therapy
is observed. As a side note, tumor necrosis factor (TNF) measurement is not the analyte of choice for monitoring therapy with TNF inhibitors (such as adalimumab or infliximab), since it would not distinguish between free TNF and TNF bound to the monoclonal antibody, either in the extracellular or membrane-bound form of the cytokine.

Toxicity effects other than acute hypersensitivity infusion reactions have not been described nor correlated with adalimumab concentrations.

Optimal therapeutic concentrations of adalimumab may vary according to the disease (eg, Crohn disease verses ulcerative colitis verses rheumatoid arthritis).

**Clinical Reference**


**Performance**

**Method Description**

**ADALX:**

The adalimumab enzyme-linked immunosorbent assay (ELISA) is designed to determine the quantity of free adalimumab (therapeutic antibody against tumor necrosis factor-alpha: TNF-alpha) in EDTA plasma or serum samples. In a first incubation step, the free adalimumab from the sample is bound to the specific monoclonal anti-adalimumab antibody coated on the plate. To remove all unbound substances, a washing step is carried out. In a further incubation step, peroxidase-labeled antibody is added. Tetramethylbenzidine (TMB) is used as a substrate for peroxidase. Finally, an acidic stop solution is added to terminate the reaction. The color changes from blue to yellow. The intensity of the yellow color is directly proportional to the concentration of free adalimumab in the sample. A dose response curve of the absorbance unit (optical density, OD) verses concentration is generated, using the values obtained from standard. The concentrations of free adalimumab in the samples are determined directly from this curve. (Package insert: Adalimumab Drug Level ELISA reagent; Immun Diagnostik KR9657, ver 2019-07-12)

**ADLAB:**

This enzyme-linked immunosorbent assay (ELISA) serves for the determination of antibodies against tumor necrosis factor-alpha (TNF-alpha) blocker adalimumab (Humira). During sample preparation, the antibodies-to-adalimumab (ATA) are separated from the therapeutic antibody adalimumab using an acid dissociation in order to acquire free ATA. By adding the peroxidase conjugate (POD-therapeutic antibody adalimumab) and the tracer (biotinylated therapeutic antibody adalimumab), the unlabeled therapeutic antibodies are replaced and the labeled antibodies can form a complex with the ATA. This complex binds via biotin to the streptavidin-coated microtiter plate. It is detected via the peroxidase conjugate with the peroxidase converting the substrate tetramethylbenzidine (TMB) to a blue product. The enzymatic reaction is stopped by adding an acidic solution. The samples convert from blue to yellow. The color change should be measured in a photometer at 450 nm. The interpretation is made using the cut-off control. (Package insert: Adalimumab Total ADA ELISA reagent; Immun Diagnostik KR9651, ver 2019-02-14)

**PDF Report**
Test Definition: ADALX
Adalimumab QN with Reflex to Ab, S

No

Day(s) and Time(s) Test Performed
Tuesday, Friday; 9 a.m.

Analytic Time
1 day

Maximum Laboratory Time
4 days

Specimen Retention Time
14 days

Performing Laboratory Location
Rochester

Fees and Codes

Fees
- Authorized users can sign in to Test Prices for detailed fee information.
- Clients without access to Test Prices can contact Customer Service 24 hours a day, seven days a week.
- Prospective clients should contact their Regional Manager. For assistance, contact Customer Service.

Test Classification
This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

CPT Code Information
80145
83520 (if appropriate)

LOINC® Information

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