The Case for Abdakibart After the AVTX Selloff

Why the AVTX selloff may underweight molecular differences and the consistency of LOTUS

Richard Doxtator, CFA, MBA I October 26, 2026 I AVTX I Effective price: $6.93

I believe abdakibart has a more attractive profile on paper than AbbVie's lutikizumab for hidradenitis suppurativa (HS). Its reported binding affinity and half-life favor sustained IL-1β inhibition, and its Phase 2 results provide a clear basis for advancing a monthly regimen. The central investment question is how much credit those differences deserve after AbbVie's lutikizumab Phase 3 readout.

Avalo shares fell from $12.26 on October 21 to $6.93 on October 23, a decline of 43.5%, following the release of lutikizumab's INTREPID results. That is a substantial repricing of a company whose own Phase 2 evidence remains intact. [1,2]

AbbVie's results warrant a more cautious view of the opportunity. But a common pathway does not make two molecules interchangeable. My concern is that the selloff gives too little weight to the specific reasons abdakibart could perform differently: the quality of its IL-1β blockade, the uncertain contribution of IL-1α inhibition, and the concordance between its two active treatment arms in the Phase 2 LOTUS trial.

What INTREPID actually changes

Lutikizumab met its Phase 3 primary endpoint. At week 16, 31.4% of treated patients achieved HiSCR75 versus 23.4% on placebo, an 8.0 percentage point difference. HiSCR75 requires at least a 75% reduction in abscess and inflammatory nodule count, without an increase in abscess or draining fistula counts. AbbVie also reported success on eight ranked secondary endpoints, including measures of pain and flares, with no new safety concerns. [2]

These findings support clinical activity from IL-1 inhibition in HS, while tempering expectations for the size of lutikizumab's benefit. They should lower confidence in simply extrapolating an impressive Phase 2 result into Phase 3. They do not identify why the effect was smaller, isolate the contribution of either cytokine, or establish an efficacy ceiling for a selective IL-1β antibody.

That distinction matters for Avalo. A competitor's result is relevant evidence, and investors should update their expectations. The size of that update should depend on how closely the molecules, treatment regimens and clinical datasets resemble one another.

Selective inhibition has a credible rationale

Abdakibart selectively binds IL-1β. Lutikizumab binds both IL-1α and IL-1β. Broader blockade would be an advantage if inhibiting IL-1α added meaningful benefit at otherwise comparable IL-1β inhibition. That incremental benefit has not been established in HS. [2,3]

Bermekimab gives reason to question it if IL-1α does convey any benefit. The Phase 2 LYRA trial, which specifically tested selective IL-1α blockade, was stopped after meeting prespecified futility criteria. In the reported interim analysis, with 35 patients per group, HiSCR75 was 25.7% with bermekimab and 25.7% with placebo.[4]

LYRA weakens the assumption that adding IL-1α inhibition necessarily improves an HS therapy. It does not establish that IL-1α is irrelevant in every patient, or that blocking it reduces the benefit of IL-1β inhibition. A combination can behave differently from either component alone, but the available evidence suggests IL-1α inhibition by itself does not translate into better outcomes in HS.

Gout, another disease driven by chronic inflammation, offers a further comparison. Canakinumab blocks only IL-1β, like abdakibart. Rilonacept blocks both, like lutikizumab.

In randomized gout trials, canakinumab outperformed a steroid injection for acute pain relief. Rilonacept failed to outperform indomethacin, a standard anti-inflammatory treatment, and provided no additional pain relief when added to it. A broader analysis of 30 randomized trials also ranked canakinumab highest for pain reduction at the time points evaluated. These were separate studies with different comparators, but the selective drug's strong performance gives investors a concrete reason to question whether broader blockade deserves a premium. [5,6,7]

For Avalo, that makes IL-1β selectivity a credible strength. Combined with the failure of IL-1α blockade in LYRA and the positive LOTUS results, the evidence supports taking seriously the possibility that abdakibart's more focused approach could deliver the better HS treatment.

Binding and half-life strengthen the molecular case

The reported affinity difference favors abdakibart. Avalo's January 2026 presentation compares an affinity below 3 picomolar with 21 picomolar for lutikizumab. A lower dissociation constant indicates tighter binding. [3]

This is a plausible pharmacological advantage. At comparable free antibody concentrations, tighter binding can favor target engagement. Whether that produces additional efficacy depends on exposure in diseased tissue and how fully each regimen already neutralizes IL-1β.

The duration of exposure also looks favorable. Avalo reports an approximately 19-day half-life for abdakibart. Published human studies of lutikizumab report approximately 10 to 14 days. These estimates come from different studies and populations, but they support the rationale for testing abdakibart at longer intervals. LOTUS tested dosing every four weeks and produced a response closely matching dosing every two weeks. [3,8,9]

The consistency of LOTUS deserves weight

LOTUS enrolled 253 patients. Both active regimens met the week 16 HiSCR75 primary endpoint: 42.2% for 150 mg every two weeks and 42.9% for 300 mg every four weeks, versus 25.6% for placebo. Reported p values were 0.018 and 0.015, respectively. The observed treatment effects were almost identical. [9]

The comparison with lutikizumab's Phase 2 study is informative because it shows the pattern behind the headline result.

Phase 2 regimen	Active n	HiSCR75	Placebo	Raw gap
Abdakibart 150 mg every 2 weeks	83	42.2%	25.6%	+16.6 pp
Abdakibart 300 mg every 4 weeks	84	42.9%	25.6%	+17.3 pp
Lutikizumab 100 mg every 2 weeks	37	16.2%	17.5%	−1.3 pp
Lutikizumab 300 mg every 2 weeks	37	45.9%	17.5%	+28.4 pp
Lutikizumab 300 mg every week	39	38.5%	17.5%	+21.0 pp

Week 16 results from separate trials. Placebo n was 86 in LOTUS and 40 in AbbVie's study. Gaps are simple subtraction of rounded response rates, not adjusted trial estimates. HiSCR75 was primary in LOTUS and an additional endpoint in AbbVie's study, whose primary endpoint was HiSCR50. pp means percentage points. Sources 9–12.

LOTUS offers evidence of benefit across both schedules, without relying on selecting one standout arm. Each active group was also more than twice the size of an active group in AbbVie's study. That makes the agreement worth taking seriously. I would give this pattern more weight than a comparison based only on each drug's best response rate. The two LOTUS regimens deliver the same maintenance amount over four weeks, after different loading doses. Their agreement supports flexibility in dosing interval.

Lutikizumab's two higher-dose arms both showed benefit on HiSCR75, although the weekly arm was numerically weaker than the every-other-week arm. The published investigators noted that responses differed even during the initial period when those groups received identical dosing. They suggested baseline differences could help explain the pattern. It would therefore be unjustified to conclude that weekly dosing or dual blockade caused the weaker result. [11]

There are substantial population differences as well. AbbVie enrolled patients after anti-TNF failure, and 70.6% had Hurley stage III disease. In LOTUS, 36.4% had prior biologic exposure and 42.3% had stage III disease. These studies cannot establish a relative efficacy ranking. The favorable conclusion for Avalo is that its own data give a coherent basis for dose selection and further development. [10,12]

LOTUS also reported similar overall treatment-emergent adverse-event rates across active treatment and placebo. That supports continued development, while the size and duration of the trial leave uncommon or longer-term risks unresolved. The consistency argument is strongest when it refers to the observed efficacy pattern, rather than implying that abdakibart has already demonstrated superior safety. [12]

The selloff should be assessed against the whole investment case

At $6.93, Avalo's equity is worth approximately $434 million using the June 30 common share count plus the common equivalents of its convertible preferred shares and pre-funded warrants, approximately 62.68 million shares in total. This illustrative calculation excludes other options and warrants and is not an updated fully diluted valuation. Avalo reported $472.2 million in cash, cash equivalents and investments at June 30, with expected runway into 2029. [1,13,14]

© 2026 Helix Data Analytics, HelixDataAnalytics.com

The clinical case must also survive a competitive test. Approved TNF and IL-17 therapies already serve HS, and a new mechanism alone does not guarantee uptake. Abdakibart will need a persuasive combination of durable efficacy, tolerability and practical use.

I believe the evidence supports a serious case that abdakibart could be the better HS drug. The selectivity hypothesis remains unresolved, but the affinity and half-life observations provide a rational basis for differentiation, and LOTUS supplies clinical support for a practical dosing schedule. Judging by the selloff, investors appear to have dismissed the idea that abdakibart should be measured on its own data, and there are reasons to think its results could come in stronger than lutikizumab's.

Disclosure

As of October 26, 2026, the author holds Avalo Therapeutics stock. This article expresses the author's research views and is not personalized investment advice.

© 2026 Helix Data Analytics. All rights reserved. This article may not be reproduced, republished or distributed, in whole or in part, without the author's written permission, except for brief quotations with attribution and a link to the original. Third-party data, trademarks and product names belong to their respective owners.

Sources

1. AVTX historical closing prices through October 23, 2026. Stock Analysis, S&P Global Market Intelligence data. Read source
2. AbbVie. INTREPID Phase 3 topline results. October 22, 2026. Read source
3. Avalo. Corporate overview, January 2026, particularly slides 11–12. Company-reported molecular comparison. Read source
4. Janssen. LYRA results, EudraCT 2020-002607-19, NCT04988308. Futility and interim efficacy results. Read source
5. Schlesinger N et al. Canakinumab for acute gouty arthritis in patients with limited treatment options. Ann Rheum Dis. 2012;71:1839–1848. Read source
6. Terkeltaub RA et al. Rilonacept in the treatment of acute gouty arthritis. Arthritis Res Ther. 2013;15:R25. Read source
7. Zeng L et al. Efficacy and safety of pharmacologic interventions in patients experiencing a gout flare. Systematic review and network meta-analysis. Arthritis Care Res. 2021. doi:10.1002/acr.24402. Read source
8. Kosloski MP et al. Pharmacokinetics and tolerability of ABT-981 in healthy subjects and patients with knee osteoarthritis. J Clin Pharmacol. 2016. doi:10.1002/jcph.764. Read source
9. Avalo. Positive Phase 2 LOTUS topline results. May 5, 2026. Read source
10. AbbVie. Lutikizumab Phase 2 results. January 8, 2024. Includes all three active arms and nominal p values. Read source
11. Kimball AB et al. Lutikizumab after anti-TNF therapy failure. JAMA Dermatol. 2026;162:469–477. doi:10.1001/jamadermatol.2026.0155. Read source
12. Avalo. LOTUS topline results presentation, May 5, 2026, slides 6–10 and 18. Trial design, population, response analysis and safety. Read source
13. Avalo. Second quarter 2026 financial results and business updates. August 6, 2026. Read source
14. Avalo. Form 10-Q for the quarter ended June 30, 2026. Balance sheet and Notes 3 and 8. Share calculation: 52,900,692 common + 4,085,000 Series C equivalents + 4,295,000 Series C-1 equivalents + 1,400,000 pre-funded warrants = 62,680,692. Read source