



## **Opdivo® (nivolumab) in Combination with CABOMETYX® (cabozantinib) Demonstrates Long-Term Survival Benefits After Four Years of Follow-Up in the CheckMate -9ER Trial in First-Line Advanced Renal Cell Carcinoma**

January 22, 2024

***Opdivo in combination with CABOMETYX reduced the risk of death by 23% in the first-line treatment of advanced renal cell carcinoma vs. sunitinib***

***Four-year results demonstrating continued benefits with immunotherapy-tyrosine kinase inhibitor combination to be shared in an oral presentation at ASCO GU 2024***

PRINCETON, N.J. & ALAMEDA, Calif.--([BUSINESS WIRE](#))--[Bristol Myers Squibb](#) (NYSE: BMY) and [Exelixis, Inc.](#) (NASDAQ: EXEL) today announced four-year follow-up results from the CheckMate -9ER trial evaluating *Opdivo*® (nivolumab) in combination with CABOMETYX® (cabozantinib) vs. sunitinib in patients with previously untreated advanced or metastatic renal cell carcinoma (RCC). Results continued to show superior progression-free survival (PFS) and objective response rates (ORR) in patients treated with *Opdivo* plus CABOMETYX over sunitinib, regardless of risk classification based on International Metastatic Renal Cell Carcinoma Database Consortium (IMDC) scores. Superior overall survival (OS) was also observed in patients treated with the combination. These updated results, including data showing health-related quality-of-life benefits with *Opdivo* in combination with CABOMETYX vs. sunitinib, will be featured in an oral presentation (Abstract #362) at the American Society of Clinical Oncology (ASCO) 2024 Genitourinary Cancers Symposium from January 25-27, 2024.

“Renal cell carcinoma can be very challenging to treat and patients who are diagnosed with advanced disease or develop metastasis often face poor outcomes,” said Maria Teresa Bourlon, Urologic Oncology Clinic, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Mexico. “These updated results from the CheckMate -9ER trial continue to support the role of nivolumab in combination with cabozantinib as an important first-line treatment option for this devastating disease, demonstrating durable efficacy across its multiple study endpoints, including a 23% reduction in the risk of death.”

At a median follow-up of 55.6 months (48.1 months minimum), all patients randomized to the *Opdivo* plus CABOMETYX treatment arm (n=323) continued to experience benefits over those who received sunitinib (n=328) across efficacy endpoints:

- PFS (primary endpoint): PFS continued to favor *Opdivo* plus CABOMETYX, with median PFS nearly doubled with the combination regimen at 16.4 months vs. 8.4 months with sunitinib (Hazard Ratio [HR] 0.58; 95% Confidence Interval [CI]: 0.49 to 0.70).
- OS (secondary endpoint): Treatment with *Opdivo* in combination with CABOMETYX elicited durable survival benefit over sunitinib, with a median OS of 46.5 months compared to 36.0 months with sunitinib (HR 0.77; 95% CI: 0.63 to 0.95).
- ORR (secondary endpoint): The combination regimen showed durable response improvements, doubling the ORR compared to sunitinib (55.7% vs. 27.7%, respectively).
- Complete response (CR): Patients who received *Opdivo* plus CABOMETYX continued to show CR benefit, with triple the number of patients achieving CR vs. sunitinib (13.6% vs. 4.6%).
- Duration of response (DOR): *Opdivo* plus CABOMETYX was associated with a longer median DOR of 22.0 months vs. 15.2 months in the sunitinib group.
- Safety: No new safety concerns were identified in this follow-up analysis. Among all treated patients, any-grade treatment-related adverse events (TRAEs) occurred in 97.5% in the *Opdivo* plus CABOMETYX group compared to 93.1% in the sunitinib group. Grade ≥3 TRAEs occurred in 67.5% of *Opdivo* plus CABOMETYX-treated patients vs. 55.3% in sunitinib-treated patients.

Additionally, in exploratory analyses, durable and clinically meaningful benefits were observed in patient subgroups across risk groups, including within the favorable-risk and intermediate- and poor-risk groups:

- OS: Among patients with intermediate-/poor-risk, median OS was 43.9 months for those treated with *Opdivo* plus CABOMETYX vs. 29.3 months with sunitinib (HR 0.73; 95% CI: 0.58 to 0.91). In patients with favorable risk, median OS was similar across treatment arms at 52.9 months with the combination regimen and 58.9 months with sunitinib (HR 1.10; 95% CI: 0.69 to 1.75).
- PFS: PFS was improved with the combination regimen in patients with intermediate-/poor-risk with a median PFS of 15.4 months compared to 7.1 months with sunitinib (HR 0.56; 95% CI: 0.45 to 0.68), as well as in those with favorable risk at 21.4 months vs. 12.8 months (HR 0.69; 95% CI: 0.48 to 1.00).
- ORR: In patients with intermediate-/poor-risk, ORR was more than doubled at 52.6% with *Opdivo* and CABOMETYX vs. 23.0% with sunitinib. In those with favorable risk, ORR was 66.2% vs. 44.4%, respectively.
- CR: Among those with intermediate-/poor-risk profiles, the number of patients who achieved CR more than tripled (12.9% vs. 3.5%) with the combination regimen compared to sunitinib. In those with favorable risk profiles, the number of patients

who achieved CR was doubled (16.2% vs. 8.3%) with the combination regimen.

- DOR: Median DOR was also improved with *Opdivo* and CABOMETYX across both groups. Among the intermediate- and poor-risk group, those treated with the combination regimen had a median DOR of 23.1 months vs. 13.8 months with sunitinib. Among the favorable risk group, median DOR was 18.7 months vs. 17.8 months, respectively.

"There has been an ongoing need for therapeutic options that can provide patients with previously untreated advanced or metastatic renal cell carcinoma with the potential for disease control and extended survival. By combining the power of these two unique modalities, we established a new standard of care with *Opdivo* and CABOMETYX, building on our commitment to improving outcomes for patients with advanced cancers, including but not limited to genitourinary cancers," said Dana Walker, M.D., M.S.C.E., vice president, global program lead, gastrointestinal and genitourinary cancers, Bristol Myers Squibb. "Now, after more than four years of follow up, the data continue to underscore the value of *Opdivo*-based combinations in the GU cancer treatment paradigm with the potential to help patients diagnosed with advanced RCC live longer, regardless of risk classification."

"These results from CheckMate -9ER provide hope that patients with previously untreated advanced kidney cancer may experience a long-term survival benefit. We are pleased to see that the combination of CABOMETYX and *Opdivo* continues to demonstrate durable and clinically meaningful efficacy after four years of follow-up in this patient population across risk groups, reinforcing the value of this regimen as a standard of care in this setting," said Amy Peterson, M.D., executive vice president, product development & medical affairs, and chief medical officer, Exelixis. "It is also encouraging that CABOMETYX in combination with *Opdivo* demonstrated superior PFS and OS benefits in patients who had disease burdens in often challenging-to-treat areas, including bone, liver and lung metastases. The totality of these encouraging findings, achieved in partnership with Bristol Myers Squibb, underscore our commitment to collaborating with the scientific community to advance treatment regimens for patients with advanced cancers."

Bristol Myers Squibb and Exelixis thank the patients and investigators involved in the CheckMate -9ER clinical trial.

### **About CheckMate -9ER**

CheckMate -9ER is an open-label, randomized, multi-national Phase 3 trial evaluating patients with previously untreated advanced or metastatic renal cell carcinoma (RCC). A total of 651 patients (23% favorable risk, 58% intermediate risk, 20% poor risk; 25% PD-L1 $\geq$ 1%) were randomized to receive *Opdivo* plus CABOMETYX (n=323) vs. sunitinib (n=328). The primary endpoint is progression-free survival (PFS). Secondary endpoints include overall survival (OS) and objective response rate (ORR). The primary efficacy analysis is comparing the doublet combination vs. sunitinib in all randomized patients. The trial is sponsored by Bristol Myers Squibb and Ono Pharmaceutical Co. and co-funded by Exelixis, Inc., Ipsen Pharma SAS and Takeda Pharmaceutical Company Limited.

### **About Renal Cell Carcinoma**

Renal cell carcinoma (RCC) is the most common type of kidney cancer in adults, accounting for more than 431,000 new cases and 179,000 deaths worldwide each year. RCC is approximately twice as common in men as in women, with the highest rates of the disease in North America and Europe. At diagnosis, up to 30% of patients present with advanced or metastatic RCC.

### **Bristol Myers Squibb: Creating a Better Future for People with Cancer**

Bristol Myers Squibb is inspired by a single vision — transforming patients' lives through science. The goal of the company's cancer research is to deliver medicines that offer each patient a better, healthier life and to make cure a possibility. Building on a legacy across a broad range of cancers that have changed survival expectations for many, Bristol Myers Squibb researchers are exploring new frontiers in personalized medicine and, through innovative digital platforms, are turning data into insights that sharpen their focus. Deep understanding of causal human biology, cutting-edge capabilities and differentiated research platforms uniquely position the company to approach cancer from every angle.

Cancer can have a relentless grasp on many parts of a patient's life, and Bristol Myers Squibb is committed to taking actions to address all aspects of care, from diagnosis to survivorship. As a leader in cancer care, Bristol Myers Squibb is working to empower all people with cancer to have a better future.

### **About Opdivo**

*Opdivo* is a programmed death-1 (PD-1) immune checkpoint inhibitor that is designed to uniquely harness the body's own immune system to help restore anti-tumor immune response. By harnessing the body's own immune system to fight cancer, *Opdivo* has become an important treatment option across multiple cancers.

*Opdivo*'s leading global development program is based on Bristol Myers Squibb's scientific expertise in the field of Immuno-Oncology and includes a broad range of clinical trials across all phases, including Phase 3, in a variety of tumor types. To date, the *Opdivo* clinical development program has treated more than 35,000 patients. The *Opdivo* trials have contributed to gaining a deeper understanding of the potential role of biomarkers in patient care, particularly regarding how patients may benefit from *Opdivo* across the continuum of PD-L1 expression.

In July 2014, *Opdivo* was the first PD-1 immune checkpoint inhibitor to receive regulatory approval anywhere in the world. *Opdivo* is currently approved in more than 65 countries, including the United States, the European Union, Japan and China. In September 2015, the Company's *Opdivo* and *Yervoy* combination regimen was the first Immuno-Oncology combination to receive regulatory approval for the treatment of metastatic melanoma and is currently approved in more than 50 countries, including the United States and the European Union.

### **INDICATIONS**

OPDIVO® (nivolumab), as a single agent, is indicated for the treatment of adult and pediatric patients 12 years of age and older with unresectable or metastatic melanoma.

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the treatment of adult and pediatric patients 12 years of age and older with unresectable or metastatic melanoma.

OPDIVO® is indicated for the adjuvant treatment of adult and pediatric patients 12 years and older with completely resected Stage IIB, Stage IIC,

Stage III, or Stage IV melanoma.

OPDIVO® (nivolumab), in combination with platinum-doublet chemotherapy, is indicated as neoadjuvant treatment of adult patients with resectable (tumors  $\geq 4$  cm or node positive) non-small cell lung cancer (NSCLC).

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the first-line treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors express PD-L1 ( $\geq 1\%$ ) as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations.

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab) and 2 cycles of platinum-doublet chemotherapy, is indicated for the first-line treatment of adult patients with metastatic or recurrent non-small cell lung cancer (NSCLC), with no EGFR or ALK genomic tumor aberrations.

OPDIVO® (nivolumab) is indicated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving OPDIVO.

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the first-line treatment of adult patients with unresectable malignant pleural mesothelioma (MPM).

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the first-line treatment of adult patients with intermediate or poor risk advanced renal cell carcinoma (RCC).

OPDIVO® (nivolumab), in combination with cabozantinib, is indicated for the first-line treatment of adult patients with advanced renal cell carcinoma (RCC).

OPDIVO® (nivolumab) is indicated for the treatment of adult patients with advanced renal cell carcinoma (RCC) who have received prior anti-angiogenic therapy.

OPDIVO® (nivolumab) is indicated for the treatment of adult patients with classical Hodgkin lymphoma (cHL) that has relapsed or progressed after autologous hematopoietic stem cell transplantation (HSCT) and brentuximab vedotin or after 3 or more lines of systemic therapy that includes autologous HSCT. This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

OPDIVO® (nivolumab) is indicated for the treatment of adult patients with recurrent or metastatic squamous cell carcinoma of the head and neck (SCCHN) with disease progression on or after platinum-based therapy.

OPDIVO® (nivolumab) is indicated for the treatment of adult patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

OPDIVO® (nivolumab), as a single agent, is indicated for the adjuvant treatment of adult patients with urothelial carcinoma (UC) who are at high risk of recurrence after undergoing radical resection of UC.

OPDIVO® (nivolumab), as a single agent, is indicated for the treatment of adult and pediatric (12 years and older) patients with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (CRC) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the treatment of adults and pediatric patients 12 years and older with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (CRC) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the treatment of adult patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

OPDIVO® (nivolumab) is indicated for the treatment of adult patients with unresectable advanced, recurrent or metastatic esophageal squamous cell carcinoma (ESCC) after prior fluoropyrimidine- and platinum-based chemotherapy.

OPDIVO® (nivolumab) is indicated for the adjuvant treatment of completely resected esophageal or gastroesophageal junction cancer with residual pathologic disease in adult patients who have received neoadjuvant chemoradiotherapy (CRT).

OPDIVO® (nivolumab), in combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the first-line treatment of adult patients with unresectable advanced or metastatic esophageal squamous cell carcinoma (ESCC).

OPDIVO® (nivolumab), in combination with YERVOY® (ipilimumab), is indicated for the first-line treatment of adult patients with unresectable advanced or metastatic esophageal squamous cell carcinoma (ESCC).

OPDIVO® (nivolumab), in combination with fluoropyrimidine- and platinum-containing chemotherapy, is indicated for the treatment of adult patients with advanced or metastatic gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma.

## **IMPORTANT SAFETY INFORMATION**

### **Severe and Fatal Immune-Mediated Adverse Reactions**

Immune-mediated adverse reactions listed herein may not include all possible severe and fatal immune-mediated adverse reactions.

Immune-mediated adverse reactions, which may be severe or fatal, can occur in any organ system or tissue. While immune-mediated adverse reactions usually manifest during treatment, they can also occur after discontinuation of OPDIVO or YERVOY. Early identification and management are essential to ensure safe use of OPDIVO and YERVOY. Monitor for signs and symptoms that may be clinical manifestations of underlying immune-mediated adverse reactions. Evaluate clinical chemistries including liver enzymes, creatinine, adrenocorticotropic hormone (ACTH) level, and thyroid function at baseline and periodically during treatment with OPDIVO and before each dose of YERVOY. In cases of suspected immune-mediated adverse reactions, initiate appropriate workup to exclude alternative etiologies, including infection. Institute medical management promptly, including specialty consultation as appropriate.

Withhold or permanently discontinue OPDIVO and YERVOY depending on severity (please see section 2 Dosage and Administration in the accompanying Full Prescribing Information). In general, if OPDIVO or YERVOY interruption or discontinuation is required, administer systemic corticosteroid therapy (1 to 2 mg/kg/day prednisone or equivalent) until improvement to Grade 1 or less. Upon improvement to Grade 1 or less, initiate corticosteroid taper and continue to taper over at least 1 month. Consider administration of other systemic immunosuppressants in patients whose immune-mediated adverse reactions are not controlled with corticosteroid therapy. Toxicity management guidelines for adverse reactions that do not necessarily require systemic steroids (e.g., endocrinopathies and dermatologic reactions) are discussed below.

#### Immune-Mediated Pneumonitis

OPDIVO and YERVOY can cause immune-mediated pneumonitis. The incidence of pneumonitis is higher in patients who have received prior thoracic radiation. In patients receiving OPDIVO monotherapy, immune-mediated pneumonitis occurred in 3.1% (61/1994) of patients, including Grade 4 (<0.1%), Grade 3 (0.9%), and Grade 2 (2.1%). In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, immune-mediated pneumonitis occurred in 7% (31/456) of patients, including Grade 4 (0.2%), Grade 3 (2.0%), and Grade 2 (4.4%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, immune-mediated pneumonitis occurred in 3.9% (26/666) of patients, including Grade 3 (1.4%) and Grade 2 (2.6%). In NSCLC patients receiving OPDIVO 3 mg/kg every 2 weeks with YERVOY 1 mg/kg every 6 weeks, immune-mediated pneumonitis occurred in 9% (50/576) of patients, including Grade 4 (0.5%), Grade 3 (3.5%), and Grade 2 (4.0%). Four patients (0.7%) died due to pneumonitis.

In Checkmate 205 and 039, pneumonitis, including interstitial lung disease, occurred in 6.0% (16/266) of patients receiving OPDIVO. Immune-mediated pneumonitis occurred in 4.9% (13/266) of patients receiving OPDIVO, including Grade 3 (n=1) and Grade 2 (n=12).

#### Immune-Mediated Colitis

OPDIVO and YERVOY can cause immune-mediated colitis, which may be fatal. A common symptom included in the definition of colitis was diarrhea. Cytomegalovirus (CMV) infection/reactivation has been reported in patients with corticosteroid-refractory immune-mediated colitis. In cases of corticosteroid-refractory colitis, consider repeating infectious workup to exclude alternative etiologies. In patients receiving OPDIVO monotherapy, immune-mediated colitis occurred in 2.9% (58/1994) of patients, including Grade 3 (1.7%) and Grade 2 (1%).

In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, immune-mediated colitis occurred in 25% (115/456) of patients, including Grade 4 (0.4%), Grade 3 (14%) and Grade 2 (8%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, immune-mediated colitis occurred in 9% (60/666) of patients, including Grade 3 (4.4%) and Grade 2 (3.7%).

#### Immune-Mediated Hepatitis and Hepatotoxicity

OPDIVO and YERVOY can cause immune-mediated hepatitis. In patients receiving OPDIVO monotherapy, immune-mediated hepatitis occurred in 1.8% (35/1994) of patients, including Grade 4 (0.2%), Grade 3 (1.3%), and Grade 2 (0.4%).

In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, immune-mediated hepatitis occurred in 15% (70/456) of patients, including Grade 4 (2.4%), Grade 3 (11%), and Grade 2 (1.8%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, immune-mediated hepatitis occurred in 7% (48/666) of patients, including Grade 4 (1.2%), Grade 3 (4.9%), and Grade 2 (0.4%).

OPDIVO in combination with cabozantinib can cause hepatic toxicity with higher frequencies of Grade 3 and 4 ALT and AST elevations compared to OPDIVO alone. Consider more frequent monitoring of liver enzymes as compared to when the drugs are administered as single agents. In patients receiving OPDIVO and cabozantinib, Grades 3 and 4 increased ALT or AST were seen in 11% of patients.

#### Immune-Mediated Endocrinopathies

OPDIVO and YERVOY can cause primary or secondary adrenal insufficiency, immune-mediated hypophysitis, immune-mediated thyroid disorders, and Type 1 diabetes mellitus, which can present with diabetic ketoacidosis. Withhold OPDIVO and YERVOY depending on severity (please see section 2 Dosage and Administration in the accompanying Full Prescribing Information). For Grade 2 or higher adrenal insufficiency, initiate symptomatic treatment, including hormone replacement as clinically indicated. Hypophysitis can present with acute symptoms associated with mass effect such as headache, photophobia, or visual field defects. Hypophysitis can cause hypopituitarism; initiate hormone replacement as clinically indicated. Thyroiditis can present with or without endocrinopathy. Hypothyroidism can follow hyperthyroidism; initiate hormone replacement or medical management as clinically indicated. Monitor patients for hyperglycemia or other signs and symptoms of diabetes; initiate treatment with insulin as clinically indicated.

In patients receiving OPDIVO monotherapy, adrenal insufficiency occurred in 1% (20/1994), including Grade 3 (0.4%) and Grade 2 (0.6%). In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, adrenal insufficiency occurred in 8% (35/456), including Grade 4 (0.2%), Grade 3 (2.4%), and Grade 2 (4.2%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, adrenal insufficiency occurred in 7% (48/666) of patients, including Grade 4 (0.3%), Grade 3 (2.5%), and Grade 2 (4.1%). In patients receiving OPDIVO and cabozantinib, adrenal insufficiency occurred in 4.7% (15/320) of patients, including Grade 3 (2.2%) and Grade 2 (1.9%).

In patients receiving OPDIVO monotherapy, hypophysitis occurred in 0.6% (12/1994) of patients, including Grade 3 (0.2%) and Grade 2 (0.3%).

In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, hypophysitis occurred in 9% (42/456), including Grade 3 (2.4%) and Grade 2 (6%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, hypophysitis occurred in 4.4% (29/666) of patients, including Grade 4 (0.3%), Grade 3 (2.4%), and Grade 2 (0.9%).

In patients receiving OPDIVO monotherapy, thyroiditis occurred in 0.6% (12/1994) of patients, including Grade 2 (0.2%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, thyroiditis occurred in 2.7% (22/666) of patients, including Grade 3 (4.5%) and Grade 2 (2.2%).

In patients receiving OPDIVO monotherapy, hyperthyroidism occurred in 2.7% (54/1994) of patients, including Grade 3 (<0.1%) and Grade 2 (1.2%). In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, hyperthyroidism occurred in 9% (42/456) of patients, including Grade 3 (0.9%) and Grade 2 (4.2%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, hyperthyroidism occurred in 12% (80/666) of patients, including Grade 3 (0.6%) and Grade 2 (4.5%).

In patients receiving OPDIVO monotherapy, hypothyroidism occurred in 8% (163/1994) of patients, including Grade 3 (0.2%) and Grade 2 (4.8%). In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, hypothyroidism occurred in 20% (91/456) of patients, including Grade 3 (0.4%) and Grade 2 (11%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, hypothyroidism occurred in 18% (122/666) of patients, including Grade 3 (0.6%) and Grade 2 (11%).

In patients receiving OPDIVO monotherapy, diabetes occurred in 0.9% (17/1994) of patients, including Grade 3 (0.4%) and Grade 2 (0.3%), and 2 cases of diabetic ketoacidosis. In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, diabetes occurred in 2.7% (15/666) of patients, including Grade 4 (0.6%), Grade 3 (0.3%), and Grade 2 (0.9%).

#### Immune-Mediated Nephritis with Renal Dysfunction

OPDIVO and YERVOY can cause immune-mediated nephritis. In patients receiving OPDIVO monotherapy, immune-mediated nephritis and renal dysfunction occurred in 1.2% (23/1994) of patients, including Grade 4 (<0.1%), Grade 3 (0.5%), and Grade 2 (0.6%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, immune-mediated nephritis with renal dysfunction occurred in 4.1% (27/666) of patients, including Grade 4 (0.6%), Grade 3 (1.1%), and Grade 2 (2.2%).

#### Immune-Mediated Dermatologic Adverse Reactions

OPDIVO can cause immune-mediated rash or dermatitis. Exfoliative dermatitis, including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug rash with eosinophilia and systemic symptoms (DRESS) has occurred with PD-1/PD-L1 blocking antibodies. Topical emollients and/or topical corticosteroids may be adequate to treat mild to moderate nonexfoliative rashes.

YERVOY can cause immune-mediated rash or dermatitis, including bullous and exfoliative dermatitis, SJS, TEN, and DRESS. Topical emollients and/or topical corticosteroids may be adequate to treat mild to moderate non-bullous/exfoliative rashes.

Withhold or permanently discontinue OPDIVO and YERVOY depending on severity (please see section 2 Dosage and Administration in the accompanying Full Prescribing Information).

In patients receiving OPDIVO monotherapy, immune-mediated rash occurred in 9% (171/1994) of patients, including Grade 3 (1.1%) and Grade 2 (2.2%). In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, immune-mediated rash occurred in 28% (127/456) of patients, including Grade 3 (4.8%) and Grade 2 (10%). In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, immune-mediated rash occurred in 16% (108/666) of patients, including Grade 3 (3.5%) and Grade 2 (4.2%).

#### Other Immune-Mediated Adverse Reactions

The following clinically significant immune-mediated adverse reactions occurred at an incidence of <1% (unless otherwise noted) in patients who received OPDIVO monotherapy or OPDIVO in combination with YERVOY or were reported with the use of other PD-1/PD-L1 blocking antibodies. Severe or fatal cases have been reported for some of these adverse reactions: cardiac/vascular: myocarditis, pericarditis, vasculitis; nervous system: meningitis, encephalitis, myelitis and demyelination, myasthenic syndrome/myasthenia gravis (including exacerbation), Guillain-Barré syndrome, nerve paresis, autoimmune neuropathy; ocular: uveitis, iritis, and other ocular inflammatory toxicities can occur; gastrointestinal: pancreatitis to include increases in serum amylase and lipase levels, gastritis, duodenitis; musculoskeletal and connective tissue: myositis/polymyositis, rhabdomyolysis, and associated sequelae including renal failure, arthritis, polymyalgia rheumatica; endocrine: hypoparathyroidism; other (hematologic/immune): hemolytic anemia, aplastic anemia, hemophagocytic lymphohistiocytosis (HLH), systemic inflammatory response syndrome, histiocytic necrotizing lymphadenitis (Kikuchi lymphadenitis), sarcoidosis, immune thrombocytopenic purpura, solid organ transplant rejection.

In addition to the immune-mediated adverse reactions listed above, across clinical trials of YERVOY monotherapy or in combination with OPDIVO, the following clinically significant immune-mediated adverse reactions, some with fatal outcome, occurred in <1% of patients unless otherwise specified: nervous system: autoimmune neuropathy (2%), myasthenic syndrome/myasthenia gravis, motor dysfunction; cardiovascular: angiopathy, temporal arteritis; ocular: blepharitis, episcleritis, orbital myositis, scleritis; gastrointestinal: pancreatitis (1.3%); other (hematologic/immune): conjunctivitis, cytopenias (2.5%), eosinophilia (2.1%), erythema multiforme, hypersensitivity vasculitis, neurosensory hypoacusis, psoriasis.

Some ocular IMAR cases can be associated with retinal detachment. Various grades of visual impairment, including blindness, can occur. If uveitis occurs in combination with other immune-mediated adverse reactions, consider a Vogt-Koyanagi-Harada-like syndrome, which has been observed in patients receiving OPDIVO and YERVOY, as this may require treatment with systemic corticosteroids to reduce the risk of permanent vision loss.

#### **Infusion-Related Reactions**

OPDIVO and YERVOY can cause severe infusion-related reactions. Discontinue OPDIVO and YERVOY in patients with severe (Grade 3) or life-threatening (Grade 4) infusion-related reactions. Interrupt or slow the rate of infusion in patients with mild (Grade 1) or moderate (Grade 2) infusion-related reactions. In patients receiving OPDIVO monotherapy as a 60-minute infusion, infusion-related reactions occurred in 6.4% (127/1994) of patients. In a separate trial in which patients received OPDIVO monotherapy as a 60-minute infusion or a 30-minute infusion, infusion-related reactions occurred in 2.2% (8/368) and 2.7% (10/369) of patients, respectively. Additionally, 0.5% (2/368) and 1.4% (5/369) of patients, respectively, experienced adverse reactions within 48 hours of infusion that led to dose delay, permanent discontinuation or withholding of OPDIVO. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, infusion-related reactions occurred in 2.5% (10/407) of patients. In HCC patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg every 3 weeks, infusion-related reactions occurred in 8% (4/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, infusion-related reactions occurred in 5.1% (28/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg every 3 weeks, infusion-related reactions occurred in 4.2% (5/119) of patients. In MPM patients receiving OPDIVO 3 mg/kg every 2 weeks with YERVOY 1 mg/kg every 6 weeks, infusion-related reactions occurred in 12%

(37/300) of patients.

### **Complications of Allogeneic Hematopoietic Stem Cell Transplantation**

Fatal and other serious complications can occur in patients who receive allogeneic hematopoietic stem cell transplantation (HSCT) before or after being treated with OPDIVO or YERVOY. Transplant-related complications include hyperacute graft-versus-host-disease (GVHD), acute GVHD, chronic GVHD, hepatic veno-occlusive disease (VOD) after reduced intensity conditioning, and steroid-requiring febrile syndrome (without an identified infectious cause). These complications may occur despite intervening therapy between OPDIVO or YERVOY and allogeneic HSCT.

Follow patients closely for evidence of transplant-related complications and intervene promptly. Consider the benefit versus risks of treatment with OPDIVO and YERVOY prior to or after an allogeneic HSCT.

### **Embryo-Fetal Toxicity**

Based on its mechanism of action and findings from animal studies, OPDIVO and YERVOY can cause fetal harm when administered to a pregnant woman. The effects of YERVOY are likely to be greater during the second and third trimesters of pregnancy. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with OPDIVO and YERVOY and for at least 5 months after the last dose.

### **Increased Mortality in Patients with Multiple Myeloma when OPDIVO is Added to a Thalidomide Analogue and Dexamethasone**

In randomized clinical trials in patients with multiple myeloma, the addition of OPDIVO to a thalidomide analogue plus dexamethasone resulted in increased mortality. Treatment of patients with multiple myeloma with a PD-1 or PD-L1 blocking antibody in combination with a thalidomide analogue plus dexamethasone is not recommended outside of controlled clinical trials.

### **Lactation**

There are no data on the presence of OPDIVO or YERVOY in human milk, the effects on the breastfed child, or the effects on milk production. Because of the potential for serious adverse reactions in breastfed children, advise women not to breastfeed during treatment and for 5 months after the last dose.

### **Serious Adverse Reactions**

In Checkmate 037, serious adverse reactions occurred in 41% of patients receiving OPDIVO (n=268). Grade 3 and 4 adverse reactions occurred in 42% of patients receiving OPDIVO. The most frequent Grade 3 and 4 adverse drug reactions reported in 2% to <5% of patients receiving OPDIVO were abdominal pain, hyponatremia, increased aspartate aminotransferase, and increased lipase. In Checkmate 066, serious adverse reactions occurred in 36% of patients receiving OPDIVO (n=206). Grade 3 and 4 adverse reactions occurred in 41% of patients receiving OPDIVO. The most frequent Grade 3 and 4 adverse reactions reported in ≥2% of patients receiving OPDIVO were gamma-glutamyltransferase increase (3.9%) and diarrhea (3.4%). In Checkmate 067, serious adverse reactions (74% and 44%), adverse reactions leading to permanent discontinuation (47% and 18%) or to dosing delays (58% and 36%), and Grade 3 or 4 adverse reactions (72% and 51%) all occurred more frequently in the OPDIVO plus YERVOY arm (n=313) relative to the OPDIVO arm (n=313). The most frequent (≥10%) serious adverse reactions in the OPDIVO plus YERVOY arm and the OPDIVO arm, respectively, were diarrhea (13% and 2.2%), colitis (10% and 1.9%), and pyrexia (10% and 1.0%). In Checkmate 238, serious adverse reactions occurred in 18% of patients receiving OPDIVO (n=452). Grade 3 or 4 adverse reactions occurred in 25% of OPDIVO-treated patients (n=452). The most frequent Grade 3 and 4 adverse reactions reported in ≥2% of OPDIVO-treated patients were diarrhea and increased lipase and amylase. In Checkmate 816, serious adverse reactions occurred in 30% of patients (n=176) who were treated with OPDIVO in combination with platinum-doublet chemotherapy. Serious adverse reactions in >2% included pneumonia and vomiting. No fatal adverse reactions occurred in patients who received OPDIVO in combination with platinum-doublet chemotherapy. In Checkmate 227, serious adverse reactions occurred in 58% of patients (n=576). The most frequent (≥2%) serious adverse reactions were pneumonia, diarrhea/colitis, pneumonitis, hepatitis, pulmonary embolism, adrenal insufficiency, and hypophysitis. Fatal adverse reactions occurred in 1.7% of patients; these included events of pneumonitis (4 patients), myocarditis, acute kidney injury, shock, hyperglycemia, multi-system organ failure, and renal failure. In Checkmate 9LA, serious adverse reactions occurred in 57% of patients (n=358). The most frequent (>2%) serious adverse reactions were pneumonia, diarrhea, febrile neutropenia, anemia, acute kidney injury, musculoskeletal pain, dyspnea, pneumonitis, and respiratory failure. Fatal adverse reactions occurred in 7 (2%) patients, and included hepatic toxicity, acute renal failure, sepsis, pneumonitis, diarrhea with hypokalemia, and massive hemoptysis in the setting of thrombocytopenia. In Checkmate 017 and 057, serious adverse reactions occurred in 46% of patients receiving OPDIVO (n=418). The most frequent serious adverse reactions reported in ≥2% of patients receiving OPDIVO were pneumonia, pulmonary embolism, dyspnea, pyrexia, pleural effusion, pneumonitis, and respiratory failure. In Checkmate 057, fatal adverse reactions occurred; these included events of infection (7 patients, including one case of *Pneumocystis jirovecii* pneumonia), pulmonary embolism (4 patients), and limbic encephalitis (1 patient). In Checkmate 743, serious adverse reactions occurred in 54% of patients receiving OPDIVO plus YERVOY. The most frequent serious adverse reactions reported in ≥2% of patients were pneumonia, pyrexia, diarrhea, pneumonitis, pleural effusion, dyspnea, acute kidney injury, infusion-related reaction, musculoskeletal pain, and pulmonary embolism. Fatal adverse reactions occurred in 4 (1.3%) patients and included pneumonitis, acute heart failure, sepsis, and encephalitis. In Checkmate 214, serious adverse reactions occurred in 59% of patients receiving OPDIVO plus YERVOY (n=547). The most frequent serious adverse reactions reported in ≥2% of patients were diarrhea, pyrexia, pneumonia, pneumonitis, hypophysitis, acute kidney injury, dyspnea, adrenal insufficiency, and colitis. In Checkmate 9ER, serious adverse reactions occurred in 48% of patients receiving OPDIVO and cabozantinib (n=320). The most frequent serious adverse reactions reported in ≥2% of patients were diarrhea, pneumonia, pneumonitis, pulmonary embolism, urinary tract infection, and hyponatremia. Fatal intestinal perforations occurred in 3 (0.9%) patients. In Checkmate 025, serious adverse reactions occurred in 47% of patients receiving OPDIVO (n=406). The most frequent serious adverse reactions reported in ≥2% of patients were acute kidney injury, pleural effusion, pneumonia, diarrhea, and hypercalcemia. In Checkmate 205 and 039, adverse reactions leading to discontinuation occurred in 7% and dose delays due to adverse reactions occurred in 34% of patients (n=266). Serious adverse reactions occurred in 26% of patients. The most frequent serious adverse reactions reported in ≥1% of patients were pneumonia, infusion-related reaction, pyrexia, colitis or diarrhea, pleural effusion, pneumonitis, and rash. Eleven patients died from causes other than disease progression: 3 from adverse reactions within 30 days of the last OPDIVO dose, 2 from infection 8 to 9 months after completing OPDIVO, and 6 from complications of allogeneic HSCT. In Checkmate 141, serious adverse reactions occurred in 49% of patients receiving OPDIVO (n=236). The most frequent serious adverse reactions reported in ≥2% of patients receiving OPDIVO were pneumonia, dyspnea, respiratory failure, respiratory tract infection, and sepsis. In Checkmate 275, serious adverse reactions occurred in 54% of patients receiving OPDIVO (n=270). The most frequent serious adverse reactions reported in ≥2% of patients receiving OPDIVO were urinary tract infection, sepsis, diarrhea,

small intestine obstruction, and general physical health deterioration. In Checkmate 274, serious adverse reactions occurred in 30% of patients receiving OPDIVO (n=351). The most frequent serious adverse reaction reported in  $\geq 2\%$  of patients receiving OPDIVO was urinary tract infection. Fatal adverse reactions occurred in 1% of patients; these included events of pneumonitis (0.6%). In Checkmate 142 in MSI-H/dMMR mCRC patients receiving OPDIVO with YERVOY (n=119), serious adverse reactions occurred in 47% of patients. The most frequent serious adverse reactions reported in  $\geq 2\%$  of patients were colitis/diarrhea, hepatic events, abdominal pain, acute kidney injury, pyrexia, and dehydration. In Checkmate 040, serious adverse reactions occurred in 59% of patients receiving OPDIVO with YERVOY (n=49). Serious adverse reactions reported in  $\geq 4\%$  of patients were pyrexia, diarrhea, anemia, increased AST, adrenal insufficiency, ascites, esophageal varices hemorrhage, hyponatremia, increased blood bilirubin, and pneumonitis. In Attraction-3, serious adverse reactions occurred in 38% of patients receiving OPDIVO (n=209). Serious adverse reactions reported in  $\geq 2\%$  of patients who received OPDIVO were pneumonia, esophageal fistula, interstitial lung disease, and pyrexia. The following fatal adverse reactions occurred in patients who received OPDIVO: interstitial lung disease or pneumonitis (1.4%), pneumonia (1.0%), septic shock (0.5%), esophageal fistula (0.5%), gastrointestinal hemorrhage (0.5%), pulmonary embolism (0.5%), and sudden death (0.5%). In Checkmate 577, serious adverse reactions occurred in 33% of patients receiving OPDIVO (n=532). A serious adverse reaction reported in  $\geq 2\%$  of patients who received OPDIVO was pneumonitis. A fatal reaction of myocardial infarction occurred in one patient who received OPDIVO. In Checkmate 648, serious adverse reactions occurred in 62% of patients receiving OPDIVO in combination with chemotherapy (n=310). The most frequent serious adverse reactions reported in  $\geq 2\%$  of patients who received OPDIVO with chemotherapy were pneumonia (11%), dysphagia (7%), esophageal stenosis (2.9%), acute kidney injury (2.9%), and pyrexia (2.3%). Fatal adverse reactions occurred in 5 (1.6%) patients who received OPDIVO in combination with chemotherapy; these included pneumonitis, pneumatosis intestinalis, pneumonia, and acute kidney injury. In Checkmate 648, serious adverse reactions occurred in 69% of patients receiving OPDIVO in combination with YERVOY (n=322). The most frequent serious adverse reactions reported in  $\geq 2\%$  who received OPDIVO in combination with YERVOY were pneumonia (10%), pyrexia (4.3%), pneumonitis (4.0%), aspiration pneumonia (3.7%), dysphagia (3.7%), hepatic function abnormal (2.8%), decreased appetite (2.8%), adrenal insufficiency (2.5%), and dehydration (2.5%). Fatal adverse reactions occurred in 5 (1.6%) patients who received OPDIVO in combination with YERVOY; these included pneumonitis, interstitial lung disease, pulmonary embolism, and acute respiratory distress syndrome. In Checkmate 649, serious adverse reactions occurred in 52% of patients treated with OPDIVO in combination with chemotherapy (n=782). The most frequent serious adverse reactions reported in  $\geq 2\%$  of patients treated with OPDIVO in combination with chemotherapy were vomiting (3.7%), pneumonia (3.6%), anemia (3.6%), pyrexia (2.8%), diarrhea (2.7%), febrile neutropenia (2.6%), and pneumonitis (2.4%). Fatal adverse reactions occurred in 16 (2.0%) patients who were treated with OPDIVO in combination with chemotherapy; these included pneumonitis (4 patients), febrile neutropenia (2 patients), stroke (2 patients), gastrointestinal toxicity, intestinal mucositis, septic shock, pneumonia, infection, gastrointestinal bleeding, mesenteric vessel thrombosis, and disseminated intravascular coagulation. In Checkmate 76K, serious adverse reactions occurred in 18% of patients receiving OPDIVO (n=524). Adverse reactions which resulted in permanent discontinuation of OPDIVO in  $>1\%$  of patients included arthralgia (1.7%), rash (1.7%), and diarrhea (1.1%). A fatal adverse reaction occurred in 1 (0.2%) patient (heart failure and acute kidney injury). The most frequent Grade 3-4 lab abnormalities reported in  $\geq 1\%$  of OPDIVO-treated patients were increased lipase (2.9%), increased AST (2.2%), increased ALT (2.1%), lymphopenia (1.1%), and decreased potassium (1.0%).

### Common Adverse Reactions

In Checkmate 037, the most common adverse reaction ( $\geq 20\%$ ) reported with OPDIVO (n=268) was rash (21%). In Checkmate 066, the most common adverse reactions ( $\geq 20\%$ ) reported with OPDIVO (n=206) vs dacarbazine (n=205) were fatigue (49% vs 39%), musculoskeletal pain (32% vs 25%), rash (28% vs 12%), and pruritus (23% vs 12%). In Checkmate 067, the most common ( $\geq 20\%$ ) adverse reactions in the OPDIVO plus YERVOY arm (n=313) were fatigue (62%), diarrhea (54%), rash (53%), nausea (44%), pyrexia (40%), pruritus (39%), musculoskeletal pain (32%), vomiting (31%), decreased appetite (29%), cough (27%), headache (26%), dyspnea (24%), upper respiratory tract infection (23%), arthralgia (21%), and increased transaminases (25%). In Checkmate 067, the most common ( $\geq 20\%$ ) adverse reactions in the OPDIVO arm (n=313) were fatigue (59%), rash (40%), musculoskeletal pain (42%), diarrhea (36%), nausea (30%), cough (28%), pruritus (27%), upper respiratory tract infection (22%), decreased appetite (22%), headache (22%), constipation (21%), arthralgia (21%), and vomiting (20%). In Checkmate 238, the most common adverse reactions ( $\geq 20\%$ ) reported in OPDIVO-treated patients (n=452) vs ipilimumab-treated patients (n=453) were fatigue (57% vs 55%), diarrhea (37% vs 55%), rash (35% vs 47%), musculoskeletal pain (32% vs 27%), pruritus (28% vs 37%), headache (23% vs 31%), nausea (23% vs 28%), upper respiratory infection (22% vs 15%), and abdominal pain (21% vs 23%). The most common immune-mediated adverse reactions were rash (16%), diarrhea/colitis (6%), and hepatitis (3%). In Checkmate 816, the most common ( $>20\%$ ) adverse reactions in the OPDIVO plus chemotherapy arm (n=176) were nausea (38%), constipation (34%), fatigue (26%), decreased appetite (20%), and rash (20%). In Checkmate 227, the most common ( $\geq 20\%$ ) adverse reactions were fatigue (44%), rash (34%), decreased appetite (31%), musculoskeletal pain (27%), diarrhea/colitis (26%), dyspnea (26%), cough (23%), hepatitis (21%), nausea (21%), and pruritus (21%). In Checkmate 9LA, the most common ( $>20\%$ ) adverse reactions were fatigue (49%), musculoskeletal pain (39%), nausea (32%), diarrhea (31%), rash (30%), decreased appetite (28%), constipation (21%), and pruritus (21%). In Checkmate 017 and 057, the most common adverse reactions ( $\geq 20\%$ ) in patients receiving OPDIVO (n=418) were fatigue, musculoskeletal pain, cough, dyspnea, and decreased appetite. In Checkmate 743, the most common adverse reactions ( $\geq 20\%$ ) in patients receiving OPDIVO plus YERVOY were fatigue (43%), musculoskeletal pain (38%), rash (34%), diarrhea (32%), dyspnea (27%), nausea (24%), decreased appetite (24%), cough (23%), and pruritus (21%). In Checkmate 214, the most common adverse reactions ( $\geq 20\%$ ) reported in patients treated with OPDIVO plus YERVOY (n=547) were fatigue (58%), rash (39%), diarrhea (38%), musculoskeletal pain (37%), pruritus (33%), nausea (30%), cough (28%), pyrexia (25%), arthralgia (23%), decreased appetite (21%), dyspnea (20%), and vomiting (20%). In Checkmate 9ER, the most common adverse reactions ( $\geq 20\%$ ) in patients receiving OPDIVO and cabozantinib (n=320) were diarrhea (64%), fatigue (51%), hepatotoxicity (44%), palmar-plantar erythrodysesthesia syndrome (40%), stomatitis (37%), rash (36%), hypertension (36%), hypothyroidism (34%), musculoskeletal pain (33%), decreased appetite (28%), nausea (27%), dysgeusia (24%), abdominal pain (22%), cough (20%) and upper respiratory tract infection (20%). In Checkmate 025, the most common adverse reactions ( $\geq 20\%$ ) reported in patients receiving OPDIVO (n=406) vs everolimus (n=397) were fatigue (56% vs 57%), cough (34% vs 38%), nausea (28% vs 29%), rash (28% vs 36%), dyspnea (27% vs 31%), diarrhea (25% vs 32%), constipation (23% vs 18%), decreased appetite (23% vs 30%), back pain (21% vs 16%), and arthralgia (20% vs 14%). In Checkmate 205 and 039, the most common adverse reactions ( $\geq 20\%$ ) reported in patients receiving OPDIVO (n=266) were upper respiratory tract infection (44%), fatigue (39%), cough (36%), diarrhea (33%), pyrexia (29%), musculoskeletal pain (26%), rash (24%), nausea (20%) and pruritus (20%). In Checkmate 141, the most common adverse reactions ( $\geq 10\%$ ) in patients receiving OPDIVO (n=236) were cough (14%) and dyspnea (14%) at a higher incidence than investigator's choice. In Checkmate 275, the most common adverse reactions ( $\geq 20\%$ ) reported in patients receiving OPDIVO (n=270) were fatigue (46%), musculoskeletal pain (30%), nausea (22%), and decreased appetite (22%). In Checkmate 274, the most common adverse reactions ( $\geq 20\%$ ) reported in patients receiving OPDIVO (n=351) were rash (36%), fatigue (36%), diarrhea (30%), pruritus (30%), musculoskeletal pain (28%), and urinary tract infection (22%). In Checkmate 142 in MSI-H/dMMR mCRC patients receiving OPDIVO as a single agent (n=74), the most common adverse reactions ( $\geq 20\%$ ) were fatigue (54%), diarrhea (43%), abdominal pain (34%), nausea (34%), vomiting (28%), musculoskeletal pain (28%), cough (26%), pyrexia (24%), rash (23%), constipation (20%), and upper respiratory tract infection (20%). In Checkmate 142 in MSI-H/dMMR mCRC patients receiving OPDIVO with YERVOY (n=119), the most

common adverse reactions ( $\geq 20\%$ ) were fatigue (49%), diarrhea (45%), pyrexia (36%), musculoskeletal pain (36%), abdominal pain (30%), pruritus (28%), nausea (26%), rash (25%), decreased appetite (20%), and vomiting (20%). In Checkmate 040, the most common adverse reactions ( $\geq 20\%$ ) in patients receiving OPDIVO with YERVOY (n=49), were rash (53%), pruritus (53%), musculoskeletal pain (41%), diarrhea (39%), cough (37%), decreased appetite (35%), fatigue (27%), pyrexia (27%), abdominal pain (22%), headache (22%), nausea (20%), dizziness (20%), hypothyroidism (20%), and weight decreased (20%). In Attraction-3, the most common adverse reactions ( $\geq 20\%$ ) in OPDIVO-treated patients (n=209) were rash (22%) and decreased appetite (21%). In Checkmate 577, the most common adverse reactions ( $\geq 20\%$ ) in patients receiving OPDIVO (n=532) were fatigue (34%), diarrhea (29%), nausea (23%), rash (21%), musculoskeletal pain (21%), and cough (20%). In Checkmate 648, the most common adverse reactions ( $\geq 20\%$ ) in patients treated with OPDIVO in combination with chemotherapy (n=310) were nausea (65%), decreased appetite (51%), fatigue (47%), constipation (44%), stomatitis (44%), diarrhea (29%), and vomiting (23%). In Checkmate 648, the most common adverse reactions reported in  $\geq 20\%$  of patients treated with OPDIVO in combination with YERVOY were rash (31%), fatigue (28%), pyrexia (23%), nausea (22%), diarrhea (22%), and constipation (20%). In Checkmate 649, the most common adverse reactions ( $\geq 20\%$ ) in patients treated with OPDIVO in combination with chemotherapy (n=782) were peripheral neuropathy (53%), nausea (48%), fatigue (44%), diarrhea (39%), vomiting (31%), decreased appetite (29%), abdominal pain (27%), constipation (25%), and musculoskeletal pain (20%). In Checkmate 76K, the most common adverse reactions ( $\geq 20\%$ ) reported with OPDIVO (n=524) were fatigue (36%), musculoskeletal pain (30%), rash (28%), diarrhea (23%) and pruritus (20%).

Please see US Full Prescribing Information for [OPDIVO](#) and [YERVOY](#).

## Clinical Trials and Patient Populations

Checkmate 227—previously untreated metastatic non-small cell lung cancer, in combination with YERVOY; Checkmate 9LA—previously untreated recurrent or metastatic non-small cell lung cancer in combination with YERVOY and 2 cycles of platinum-doublet chemotherapy by histology; Checkmate 649—previously untreated advanced or metastatic gastric cancer, gastroesophageal junction and esophageal adenocarcinoma; Checkmate 577—adjuvant treatment of esophageal or gastroesophageal junction cancer; Checkmate 238—adjuvant treatment of patients with completely resected Stage III or Stage IV melanoma; Checkmate 76K—adjuvant treatment of patients 12 years of age and older with completely resected Stage IIB or Stage IIC melanoma; Checkmate 274—adjuvant treatment of urothelial carcinoma; Checkmate 275—previously treated advanced or metastatic urothelial carcinoma; Checkmate 142—MSI-H or dMMR metastatic colorectal cancer, as a single agent or in combination with YERVOY; Checkmate 142—MSI-H or dMMR metastatic colorectal cancer, as a single agent or in combination with YERVOY; Attraction-3—esophageal squamous cell carcinoma; Checkmate 648—previously untreated, unresectable advanced recurrent or metastatic esophageal squamous cell carcinoma; Checkmate 648—previously untreated, unresectable advanced recurrent or metastatic esophageal squamous cell carcinoma; Checkmate 040—hepatocellular carcinoma, in combination with YERVOY; Checkmate 743—previously untreated unresectable malignant pleural mesothelioma, in combination with YERVOY; Checkmate 037—previously treated metastatic melanoma; Checkmate 066—previously untreated metastatic melanoma; Checkmate 067—previously untreated metastatic melanoma, as a single agent or in combination with YERVOY; Checkmate 017—second-line treatment of metastatic squamous non-small cell lung cancer; Checkmate 057—second-line treatment of metastatic non-squamous non-small cell lung cancer; Checkmate 816—neoadjuvant non-small cell lung cancer, in combination with platinum-doublet chemotherapy; Checkmate 141—recurrent or metastatic squamous cell carcinoma of the head and neck; Checkmate 025—previously treated renal cell carcinoma; Checkmate 214—previously untreated renal cell carcinoma, in combination with YERVOY; Checkmate 9ER—previously untreated renal cell carcinoma, in combination with cabozantinib; Checkmate 205/039—classical Hodgkin lymphoma.

## About CABOMETYX® (cabozantinib)

In the U.S., CABOMETYX tablets are approved for the treatment of patients with advanced RCC; for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib; for patients with advanced RCC as a first-line treatment in combination with nivolumab; and for adult and pediatric patients 12 years of age and older with locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible. CABOMETYX tablets have also received regulatory approvals in the European Union and additional countries and regions worldwide. In 2016, Exelixis granted Ipsen Pharma SAS exclusive rights for the commercialization and further clinical development of cabozantinib outside of the U.S. and Japan. In 2017, Exelixis granted exclusive rights to Takeda for the commercialization and further clinical development of cabozantinib for all future indications in Japan. Exelixis holds the exclusive rights to develop and commercialize cabozantinib in the U.S.

## CABOMETYX IMPORTANT SAFETY INFORMATION

### WARNINGS AND PRECAUTIONS

**Hemorrhage:** Severe and fatal hemorrhages occurred with CABOMETYX. The incidence of Grade 3 to 5 hemorrhagic events was 5% in CABOMETYX patients in RCC, HCC, and DTC studies. Discontinue CABOMETYX for Grade 3 or 4 hemorrhage and prior to surgery as recommended. Do not administer CABOMETYX to patients who have a recent history of hemorrhage, including hemoptysis, hematemesis, or melena.

**Perforations and Fistulas:** Fistulas, including fatal cases, occurred in 1% of CABOMETYX patients. Gastrointestinal (GI) perforations, including fatal cases, occurred in 1% of CABOMETYX patients. Monitor patients for signs and symptoms of fistulas and perforations, including abscess and sepsis. Discontinue CABOMETYX in patients who experience a Grade 4 fistula or a GI perforation.

**Thrombotic Events:** CABOMETYX increased the risk of thrombotic events. Venous thromboembolism occurred in 7% (including 4% pulmonary embolism) and arterial thromboembolism in 2% of CABOMETYX patients. Fatal thrombotic events occurred in CABOMETYX patients. Discontinue CABOMETYX in patients who develop an acute myocardial infarction or serious arterial or venous thromboembolic events that require medical intervention.

**Hypertension and Hypertensive Crisis:** CABOMETYX can cause hypertension, including hypertensive crisis. Hypertension was reported in 37% (16% Grade 3 and <1% Grade 4) of CABOMETYX patients. Do not initiate CABOMETYX in patients with uncontrolled hypertension. Monitor blood pressure regularly during CABOMETYX treatment. Withhold CABOMETYX for hypertension that is not adequately controlled with medical management; when controlled, resume at a reduced dose. Permanently discontinue CABOMETYX for severe hypertension that cannot be controlled with anti-hypertensive therapy or for hypertensive crisis.

**Diarrhea:** Diarrhea occurred in 62% of CABOMETYX patients. Grade 3 diarrhea occurred in 10% of CABOMETYX patients. Monitor and manage patients using antidiarrheals as indicated. Withhold CABOMETYX until improvement to  $\leq$  Grade 1, resume at a reduced dose.

**Palmar-Plantar Erythrodysesthesia (PPE):** PPE occurred in 45% of CABOMETYX patients. Grade 3 PPE occurred in 13% of CABOMETYX patients. Withhold CABOMETYX until improvement to Grade 1 and resume at a reduced dose for intolerable Grade 2 PPE or Grade 3 PPE.

**Hepatotoxicity:** CABOMETYX in combination with nivolumab can cause hepatic toxicity with higher frequencies of Grades 3 and 4 ALT and AST elevations compared to CABOMETYX alone.

Monitor liver enzymes before initiation of and periodically throughout treatment. Consider more frequent monitoring of liver enzymes than when the drugs are administered as single agents. For elevated liver enzymes, interrupt CABOMETYX and nivolumab and consider administering corticosteroids.

With the combination of CABOMETYX and nivolumab, Grades 3 and 4 increased ALT or AST were seen in 11% of patients. ALT or AST >3 times ULN (Grade  $\geq 2$ ) was reported in 83 patients, of whom 23 (28%) received systemic corticosteroids; ALT or AST resolved to Grades 0-1 in 74 (89%). Among the 44 patients with Grade  $\geq 2$  increased ALT or AST who were rechallenged with either CABOMETYX (n=9) or nivolumab (n=11) as a single agent or with both (n=24), recurrence of Grade  $\geq 2$  increased ALT or AST was observed in 2 patients receiving CABOMETYX, 2 patients receiving nivolumab, and 7 patients receiving both CABOMETYX and nivolumab. Withhold and resume at a reduced dose based on severity.

**Adrenal Insufficiency:** CABOMETYX in combination with nivolumab can cause primary or secondary adrenal insufficiency. For Grade 2 or higher adrenal insufficiency, initiate symptomatic treatment, including hormone replacement as clinically indicated. Withhold CABOMETYX and/or nivolumab and resume CABOMETYX at a reduced dose depending on severity.

Adrenal insufficiency occurred in 4.7% (15/320) of patients with RCC who received CABOMETYX with nivolumab, including Grade 3 (2.2%), and Grade 2 (1.9%) adverse reactions. Adrenal insufficiency led to permanent discontinuation of CABOMETYX and nivolumab in 0.9% and withholding of CABOMETYX and nivolumab in 2.8% of patients with RCC.

Approximately 80% (12/15) of patients with adrenal insufficiency received hormone replacement therapy, including systemic corticosteroids. Adrenal insufficiency resolved in 27% (n=4) of the 15 patients. Of the 9 patients in whom CABOMETYX with nivolumab was withheld for adrenal insufficiency, 6 reinstated treatment after symptom improvement; of these, all (n=6) received hormone replacement therapy and 2 had recurrence of adrenal insufficiency.

**Proteinuria:** Proteinuria was observed in 8% of CABOMETYX patients. Monitor urine protein regularly during CABOMETYX treatment. For Grade 2 or 3 proteinuria, withhold CABOMETYX until improvement to  $\leq$  Grade 1 proteinuria; resume CABOMETYX at a reduced dose. Discontinue CABOMETYX in patients who develop nephrotic syndrome.

**Osteonecrosis of the Jaw (ONJ):** ONJ occurred in <1% of CABOMETYX patients. ONJ can manifest as jaw pain, osteomyelitis, osteitis, bone erosion, tooth or periodontal infection, toothache, gingival ulceration or erosion, persistent jaw pain, or slow healing of the mouth or jaw after dental surgery. Perform an oral examination prior to CABOMETYX initiation and periodically during treatment. Advise patients regarding good oral hygiene practices. Withhold CABOMETYX for at least 3 weeks prior to scheduled dental surgery or invasive dental procedures, if possible. Withhold CABOMETYX for development of ONJ until complete resolution, resume at a reduced dose.

**Impaired Wound Healing:** Wound complications occurred with CABOMETYX. Withhold CABOMETYX for at least 3 weeks prior to elective surgery. Do not administer CABOMETYX for at least 2 weeks after major surgery and until adequate wound healing. The safety of resumption of CABOMETYX after resolution of wound healing complications has not been established.

**Reversible Posterior Leukoencephalopathy Syndrome (RPLS):** RPLS, a syndrome of subcortical vasogenic edema diagnosed by characteristic findings on MRI, can occur with CABOMETYX. Evaluate for RPLS in patients presenting with seizures, headache, visual disturbances, confusion, or altered mental function. Discontinue CABOMETYX in patients who develop RPLS.

**Thyroid Dysfunction:** Thyroid dysfunction, primarily hypothyroidism, has been observed with CABOMETYX. Based on the safety population, thyroid dysfunction occurred in 19% of patients treated with CABOMETYX, including Grade 3 in 0.4% of patients.

Patients should be assessed for signs of thyroid dysfunction prior to the initiation of CABOMETYX and monitored for signs and symptoms of thyroid dysfunction during CABOMETYX treatment. Thyroid function testing and management of dysfunction should be performed as clinically indicated.

**Hypocalcemia:** CABOMETYX can cause hypocalcemia. Based on the safety population, hypocalcemia occurred in 13% of patients treated with CABOMETYX, including Grade 3 in 2% and Grade 4 in 1% of patients. Laboratory abnormality data were not collected in CABOSUN.

In COSMIC-311, hypocalcemia occurred in 36% of patients treated with CABOMETYX, including Grade 3 in 6% and Grade 4 in 3% of patients.

Monitor blood calcium levels and replace calcium as necessary during treatment. Withhold and resume at reduced dose upon recovery or permanently discontinue CABOMETYX depending on severity.

**Embryo-Fetal Toxicity:** CABOMETYX can cause fetal harm. Advise pregnant women and females of reproductive potential of the potential risk to a fetus. Verify the pregnancy status of females of reproductive potential prior to initiating CABOMETYX and advise them to use effective contraception during treatment and for 4 months after the last dose.

## ADVERSE REACTIONS

The most common ( $\geq 20\%$ ) adverse reactions are:

CABOMETYX as a single agent: diarrhea, fatigue, PPE, decreased appetite, hypertension, nausea, vomiting, weight decreased, and constipation.

CABOMETYX in combination with nivolumab: diarrhea, fatigue, hepatotoxicity, PPE, stomatitis, rash, hypertension, hypothyroidism, musculoskeletal pain, decreased appetite, nausea, dysgeusia, abdominal pain, cough, and upper respiratory tract infection.

## DRUG INTERACTIONS

**Strong CYP3A4 Inhibitors:** If coadministration with strong CYP3A4 inhibitors cannot be avoided, reduce the CABOMETYX dosage. Avoid grapefruit

or grapefruit juice.

**Strong CYP3A4 Inducers:** If coadministration with strong CYP3A4 inducers cannot be avoided, increase the CABOMETYX dosage. Avoid St. John's wort.

## USE IN SPECIFIC POPULATIONS

**Lactation:** Advise women not to breastfeed during CABOMETYX treatment and for 4 months after the final dose.

**Hepatic Impairment:** In patients with moderate hepatic impairment, reduce the CABOMETYX dosage. Avoid CABOMETYX in patients with severe hepatic impairment.

Please see accompanying full Prescribing Information

<https://www.cabometryx.com/downloads/CABOMETYXUSPI.pdf>.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.FDA.gov/medwatch](http://www.FDA.gov/medwatch) or call 1-800-FDA-1088.

## **About the Bristol Myers Squibb and Ono Pharmaceutical Collaboration**

In 2011, through a collaboration agreement with Ono Pharmaceutical Co., Bristol Myers Squibb expanded its territorial rights to develop and commercialize Opdivo globally, except in Japan, South Korea and Taiwan, where Ono had retained all rights to the compound at the time. On July 23, 2014, Ono and Bristol Myers Squibb further expanded the companies' strategic collaboration agreement to jointly develop and commercialize multiple immunotherapies – as single agents and combination regimens – for patients with cancer in Japan, South Korea and Taiwan.

## **About Bristol Myers Squibb**

Bristol Myers Squibb is a global biopharmaceutical company whose mission is to discover, develop and deliver innovative medicines that help patients prevail over serious diseases. For more information about Bristol Myers Squibb, visit us at [BMS.com](http://BMS.com) or follow us on [LinkedIn](#), [Twitter](#), [YouTube](#), [Facebook](#) and [Instagram](#).

## **About Exelixis**

Exelixis is a globally ambitious oncology company innovating next-generation medicines and regimens at the forefront of cancer care. Powered by drug discovery and development excellence, we are rapidly evolving our product portfolio to target an expanding range of tumor types and indications with our clinically differentiated pipeline of small molecules, antibody-drug conjugates and other biotherapeutics. This comprehensive approach harnesses decades of robust investment in our science and partnerships to advance our investigational programs and extend the impact of our flagship commercial product, CABOMETYX<sup>®</sup> (cabozantinib). Exelixis is driven by a bold scientific pursuit to create transformational treatments that give more patients hope for the future. For information about the company and its mission to help cancer patients recover stronger and live longer, visit [www.exelixis.com](http://www.exelixis.com), follow [@ExelixisInc](#) on X (Twitter), like [Exelixis, Inc.](#) on Facebook and follow [Exelixis](#) on LinkedIn.

## **Bristol Myers Squibb Cautionary Statement Regarding Forward-Looking Statements**

*This press release contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995 regarding, among other things, the research, development and commercialization of pharmaceutical products. All statements that are not statements of historical facts are, or may be deemed to be, forward-looking statements. Such forward-looking statements are based on current expectations and projections about our future financial results, goals, plans and objectives and involve inherent risks, assumptions and uncertainties, including internal or external factors that could delay, divert or change any of them in the next several years, that are difficult to predict, may be beyond our control and could cause our future financial results, goals, plans and objectives to differ materially from those expressed in, or implied by, the statements. These risks, assumptions, uncertainties and other factors include, among others, that future study results may not be consistent with the results to date, that Opdivo<sup>®</sup> (nivolumab) in combination with CABOMETYX<sup>®</sup> (cabozantinib) for the indication described in this release will be commercially successful, that any marketing approvals, if granted, may have significant limitations on their use, and, that continued approval of such combination treatment for such indication described in this release may be contingent upon verification and description of clinical benefit in additional confirmatory trials. No forward-looking statement can be guaranteed. Forward-looking statements in this press release should be evaluated together with the many risks and uncertainties that affect Bristol Myers Squibb's business and market, particularly those identified in the cautionary statement and risk factors discussion in Bristol Myers Squibb's Annual Report on Form 10-K for the year ended December 31, 2022, as updated by our subsequent Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and other filings with the Securities and Exchange Commission. The forward-looking statements included in this document are made only as of the date of this document and except as otherwise required by applicable law, Bristol Myers Squibb undertakes no obligation to publicly update or revise any forward-looking statement, whether as a result of new information, future events, changed circumstances or otherwise.*

## **Exelixis Forward-Looking Statements**

*This press release contains forward-looking statements, including, without limitation, statements related to: the presentation of updated results from the CheckMate -9ER trial at ASCO GU 2024; the therapeutic potential of cabozantinib in combination with nivolumab and Exelixis' belief that the regimen may provide a long-term survival benefit for patients with previously untreated advanced kidney cancer, regardless of risk classification; Exelixis' commitment to collaborating with the scientific community to advance treatment regimens for patients with advanced cancers; and Exelixis' scientific pursuit to create transformational treatments that give more patients hope for the future. Any statements that refer to expectations, projections or other characterizations of future events or circumstances are forward-looking statements and are based upon Exelixis' current plans, assumptions, beliefs, expectations, estimates and projections. Forward-looking statements involve risks and uncertainties. Actual results and the timing of events could differ materially from those anticipated in the forward-looking statements as a result of these risks and uncertainties, which include, without limitation: the availability of data at the referenced times; complexities and the unpredictability of the regulatory review and approval processes in the U.S. and elsewhere; Exelixis' and Bristol Myers Squibb's continuing compliance with applicable legal and regulatory requirements; the potential failure of cabozantinib in combination with nivolumab to demonstrate safety and/or efficacy in future clinical testing; unexpected concerns that may arise as a result of the occurrence of adverse safety events or additional data analyses of clinical trials evaluating cabozantinib; the costs of conducting clinical trials; Exelixis' dependence on third-party vendors for the development, manufacture and supply of cabozantinib; Exelixis' and*

*Bristol Myers Squibb's ability to protect their respective intellectual property rights; market competition, including the potential for competitors to obtain approval for generic versions of CABOMETYX; changes in economic and business conditions; and other factors affecting Exelixis and its development programs detailed from time to time under the caption "Risk Factors" in Exelixis' most recent Annual Report on Form 10-K and subsequent Quarterly Reports on Form 10-Q, and in Exelixis' future filings with the Securities and Exchange Commission. All forward-looking statements in this press release are based on information available to Exelixis as of the date of this press release, and Exelixis undertakes no obligation to update or revise any forward-looking statements contained herein, except as required by law.*

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