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## Exelixis Announces U.S. Food and Drug Administration (FDA) Accepted the Supplemental New Drug Application for Cabozantinib for Patients with Advanced Neuroendocrine Tumors

August 6, 2024

– The FDA assigned a Prescription Drug User Fee Act target action date of April 3, 2025 –

– Application is based on results from the phase 3 CABINET pivotal trial, in which cabozantinib provided a statistically significant and clinically meaningful improvement in progression-free survival versus placebo –

ALAMEDA, Calif.--(BUSINESS WIRE)--Aug. 6, 2024-- [Exelixis, Inc.](#) (Nasdaq: EXEL) today announced that its supplemental New Drug Application (sNDA) for cabozantinib (CABOMETYX<sup>®</sup>) has been accepted in the U.S. for: 1) the treatment of adults with previously treated, locally advanced/unresectable or metastatic, well- or moderately differentiated pancreatic neuroendocrine tumors (pNET), and 2) the treatment of adults with previously treated, locally advanced/unresectable or metastatic, well- or moderately differentiated extra-pancreatic NET (epNET). The U.S. Food and Drug Administration (FDA) also granted orphan drug designation to cabozantinib for the treatment of pNET. The FDA assigned a standard review with a Prescription Drug User Fee Act target action date of April 3, 2025.

"The FDA's acceptance of this application marks another important milestone in our commitment to bringing cabozantinib to patients living with difficult-to-treat cancers and who have limited treatment options," said Amy Peterson, M.D., Executive Vice President, Product Development & Medical Affairs, and Chief Medical Officer, Exelixis. "We appreciate the opportunity to work with the FDA in the coming months as they review our application, with the goal to bring this new, effective treatment option to patients with advanced neuroendocrine tumors as quickly as possible."

The sNDA is based on the final results of the phase 3 CABINET pivotal trial evaluating cabozantinib compared with placebo in two cohorts of patients with previously treated NET: advanced pNET and advanced epNET. As previously [announced](#), CABINET was stopped early for compelling activity; all patients were unblinded and those on placebo were given the option to cross over to active treatment with cabozantinib. This early stopping was due to a dramatic improvement in progression-free survival (PFS) observed at an interim analysis in both cohorts. The study demonstrated a statistically significant and clinically meaningful improvement in PFS with cabozantinib versus placebo, based on results of both local review and available independent blinded central radiology review. Initial results were [presented](#) at the 2023 European Society of Medical Oncology (ESMO) Congress; final results will be presented at the 2024 ESMO Congress on September 16<sup>th</sup> in Barcelona, Spain.

### About CABINET (Alliance A021602)

CABINET (Randomized, Double-Blinded Phase III Study of CABozantinib versus Placebo In Patients with Advanced NEuroendocrine Tumors After Progression on Prior Therapy) is sponsored by the National Cancer Institute (NCI), part of the National Institutes of Health, and is being led and conducted by the NCI-funded Alliance for Clinical Trials in Oncology with participation from the NCI-funded National Clinical Trials Network as part of Exelixis' collaboration through a Cooperative Research and Development Agreement with the NCI's Cancer Therapy Evaluation Program.

CABINET is a multicenter, randomized, double-blinded, placebo-controlled phase 3 pivotal trial that had enrolled a total of 290 patients in the U.S. at the time of the interim analysis. Patients were randomized 2:1 to cabozantinib or placebo in two separate cohorts (pNET, n=93; epNET, n=197). The epNET cohort included patients with the following primary tumor sites: gastrointestinal (GI) tract, lung and other. Each cohort was randomized separately and had its own statistical analysis plan. Patients must have had measurable disease per RECIST 1.1 criteria and must have experienced disease progression or intolerance after at least one U.S. FDA-approved line of prior therapy other than somatostatin analogs. The primary endpoint in each cohort was PFS per RECIST 1.1 by retrospective blinded independent central review. Upon disease progression, patients were unblinded, and those receiving placebo were permitted to cross over to open-label therapy with cabozantinib. Secondary endpoints included overall survival, radiographic response rate and safety. More information about this trial is available at [ClinicalTrials.gov](#).

### About Neuroendocrine Tumors (NET)

Neuroendocrine tumors (NET) are cancers that begin in the specialized cells of the body's neuroendocrine system.<sup>1</sup> These cells have traits of both hormone-producing endocrine cells and nerve cells.<sup>1</sup> In the U.S., it is estimated that 161,000 to 192,000 people are living with unresectable, locally advanced or metastatic NET.<sup>2</sup> The number of people diagnosed with NET has been increasing in recent decades.<sup>3</sup> Functional NET release peptide hormones that can cause debilitating symptoms, like diarrhea, hypertension and flushing, which may require focused treatment, while symptoms of non-functional NET are related primarily to tumor growth.<sup>4,5</sup> Most NET take years to develop and grow slowly, but eventually, all patients with advanced or metastatic NET will develop refractory and progressing disease.<sup>6,7</sup>

NET can develop in any part of the body but most commonly start in the gastrointestinal (GI) tract or in the lungs, where they have historically been referred to as carcinoid tumors and are more recently called epNET.<sup>1</sup> The five-year survival rates for advanced GI and lung NET are 68% and 55%, respectively.<sup>8,9</sup> NET can also start in the pancreas, where they tend to be more aggressive, with a five-year survival rate of only 23% for advanced disease.<sup>1,10</sup> For advanced NET patients, treatment options include somatostatin analogs, chemotherapy, targeted therapy and peptide-receptor radionuclide therapy.<sup>11</sup>

### About CABOMETYX<sup>®</sup> (cabozantinib)

In the U.S., CABOMETYX tablets are approved as monotherapy for the treatment of patients with advanced renal cell carcinoma (RCC) and in combination with nivolumab as a first-line treatment for patients with advanced RCC; for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib; 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 Pharmaceutical Company Limited 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 is not indicated as a treatment for NET.

### 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 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](https://twitter.com/ExelixisInc) on X (Twitter), like [Exelixis, Inc.](https://www.facebook.com/Exelixis) on Facebook and follow [Exelixis](https://www.linkedin.com/company/exelixis) on LinkedIn.

### Forward-Looking Statements

This press release contains forward-looking statements, including, without limitation, statements related to: the therapeutic potential of cabozantinib as a treatment for patients with previously treated, locally advanced/unresectable or metastatic, well- or moderately differentiated pNET and epNET; the regulatory review process, including the PDUFA target action date assigned by the FDA, and Exelixis' plans to work with the FDA while the application is reviewed; and Exelixis' scientific pursuit to create transformational treatments that give patients more 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, which include, without limitation: complexities and the unpredictability of the regulatory review and approval processes in the U.S. and elsewhere, including the risk that the FDA may not approve cabozantinib as a treatment for pNET or epNET in a timely fashion, if at all; unexpected concerns that may arise as a result of the occurrence of adverse safety events or additional data analyses of clinical trials evaluating cabozantinib; Exelixis' ability to protect its 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 the ability of Exelixis to obtain regulatory approval for cabozantinib in new indications 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.

*Exelixis, the Exelixis logo and CABOMETYX are registered U.S. trademarks of Exelixis.*

<sup>1</sup> Neuroendocrine Tumors. Cleveland Clinic website. Available at: <https://my.clevelandclinic.org/health/diseases/22006-neuroendocrine-tumors-net>. Accessed August 2024.

<sup>2</sup> Population Estimate: Unresectable, Locally Advanced or Metastatic Extra-Pancreatic NET. June 2024 (internal data on file).

<sup>3</sup> Pathak S, Starr JS, Halfdanarson T, et al. Understanding the increasing incidence of neuroendocrine tumors. *Expert Rev Endocrinol Metab.* September 2023;18(5):377-385.

<sup>4</sup> Pancreatic Neuroendocrine Tumors (Islet Cell Tumors) Treatment (PDQ<sup>®</sup>)—Patient Version. NCI website. Available at: <https://www.cancer.gov/types/pancreatic/patient/pnet-treatment-pdq>. Accessed August 2024.

<sup>5</sup> What Is a Pancreatic Neuroendocrine Tumor? ACS website. Available at: <https://www.cancer.org/cancer/types/pancreatic-neuroendocrine-tumor/about/what-is-pnet.html>. Accessed August 2024.

<sup>6</sup> McClellan K, Chen EY, Kardosh A, et al. Therapy Resistant Gastroenteropancreatic Neuroendocrine Tumors. *Cancers.* 2022, 14(19), 4769.

<sup>7</sup> What is a Gastrointestinal Carcinoid Tumor? ACS website. Available at: <https://www.cancer.org/cancer/types/gastrointestinal-carcinoid-tumor/about/what-is-gastrointestinal-carcinoid.html>. Accessed August 2024.

<sup>8</sup> Survival Rates for Gastrointestinal Carcinoid Tumors. ACS website. Available at: <https://www.cancer.org/cancer/types/gastrointestinal-carcinoid-tumor/detection-diagnosis-staging/survival-rates.html>. Accessed August 2024.

<sup>9</sup> Survival Rates for Lung Carcinoid Tumors. ACS website. Available at: <https://www.cancer.org/cancer/types/lung-carcinoid-tumor/detection-diagnosis-staging/survival-rates.html>. Accessed August 2024.

<sup>10</sup> Survival Rates for Pancreatic Neuroendocrine Tumor. ACS website. Available at: <https://www.cancer.org/cancer/types/pancreatic-neuroendocrine-tumor/detection-diagnosis-staging/survival-rates.html>. Accessed August 2024.

<sup>11</sup> Neuroendocrine Tumor (NET). NCI website. Available at: <https://www.cancer.gov/pediatric-adult-rare-tumor/rare-tumors/rare-endocrine-tumor/carcinoid-tumor>. Accessed August 2024.

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