Bristol Myers Squibb Announces Acceptance of U.S. and EU Regulatory Filings for Opdivo (nivolumab) Plus Yervoy (ipilimumab) Combined with Limited Chemotherapy in First-Line Lung Cancer

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Dateline City:
PRINCETON, N.J.

FDA application granted Priority Review designation with PDUFA date of August 6, 2020

Submissions based on results from Phase 3 CheckMate -9LA trial

PRINCETON, N.J.--(BUSINESS WIRE)--Bristol Myers Squibb (NYSE:BMY) today announced that the U.S. Food and Drug Administration (FDA) has accepted its supplemental Biologics License Application (sBLA) for Opdivo (nivolumab) plus Yervoy (ipilimumab), administered concomitantly with a limited course of chemotherapy, for the first-line treatment of patients with metastatic or recurrent non-small cell lung cancer (NSCLC) with no EGFR or ALK genomic tumor aberrations. The FDA granted this application Priority Review with a Prescription Drug User Fee Act (PDUFA) goal date of August 6, 2020, in addition to granting Fast Track designation.

Additionally, the European Medicines Agency (EMA) validated a type II variation application for Opdivo plus Yervoy, combined with limited chemotherapy, for the same indication. Validation of the application confirms the submission is complete and begins the EMA’s centralized review process. This follows an announcement on March 26, 2020 that Ono Pharmaceutical Co., in partnership with Bristol Myers Squibb, submitted a supplemental application for Opdivo plus Yervoy combined with limited chemotherapy for consideration of manufacturing and marketing approval in Japan.

The applications were based on results from the Phase 3 CheckMate -9LA trial. In October 2019, the company announced the trial met its primary endpoint of superior overall survival (OS) at a pre-specified interim analysis.

“Despite treatment advances, there remains a serious unmet need for additional innovative treatment options for lung cancer patients globally,” said Sabine Maier, M.D., development lead, thoracic cancers, Bristol Myers Squibb. “The FDA’s acceptance and EMA’s validation of our applications represent important milestones for patients with lung cancer, and we look forward to working with regulatory authorities to bring the first and only dual immunotherapy plus limited chemotherapy regimen to patients as soon as possible.”

About CheckMate -9LA
CheckMate -9LA is an open-label, multi-center, randomized Phase 3 trial evaluating Opdivo (360 mg Q3W) plus Yervoy (1 mg/kg Q6W) combined with chemotherapy (two cycles) compared to chemotherapy alone (up to four cycles followed by optional pemetrexed maintenance therapy if eligible) as a first-line treatment in patients with metastatic non-small cell lung cancer (NSCLC) regardless of PD-L1 expression and histology. Patients in the experimental arm were treated for up to two years or until disease progression or unacceptable toxicity. Patients in the control arm were treated with up to four cycles of chemotherapy and optional pemetrexed maintenance (if eligible) until disease progression or toxicity. The primary endpoint of the trial was overall survival (OS) in the intent-to-treat population. Secondary endpoints included progression-free survival (PFS), overall response rate (ORR) and efficacy measures according to biomarkers.

About Lung Cancer
Lung cancer is the leading cause of cancer deaths globally. The two main types of lung cancer are non-small cell and small cell. Non-small cell lung cancer (NSCLC) is one of the most common types of lung cancer and accounts for up to 84% of diagnoses. Survival rates vary depending on the stage and type of the cancer when diagnosed. For patients diagnosed with metastatic lung cancer, the five-year survival rate is approximately 5%.

Bristol Myers Squibb: Advancing Cancer Research
At Bristol Myers Squibb, patients are at the center of everything we do. The goal of our cancer research is to increase
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 October 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.

About **Yervoy**

**Yervoy** is a recombinant, human monoclonal antibody that binds to the cytotoxic T-lymphocyte-associated antigen-4 (CTLA-4). CTLA-4 is a negative regulator of T-cell activity. **Yervoy** binds to CTLA-4 and blocks the interaction of CTLA-4 with its ligands, CD80/CD86. Blockade of CTLA-4 has been shown to augment T-cell activation and proliferation, including the activation and proliferation of tumor infiltrating T-effector cells. Inhibition of CTLA-4 signaling can also reduce T-regulatory cell function, which may contribute to a general increase in T-cell responsiveness, including the anti-tumor immune response. On March 25, 2011, the U.S. Food and Drug Administration (FDA) approved **Yervoy** 3 mg/kg monotherapy for patients with unresectable or metastatic melanoma. **Yervoy** is approved for unresectable or metastatic melanoma in more than 50 countries. There is a broad, ongoing development program in place for **Yervoy** spanning multiple tumor types.

**Indications**

**OPDVO**® (nivolumab), in combination with **YERVOY**® (ipilimumab), is indicated for the treatment of patients with unresectable or metastatic melanoma.

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

**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 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.

**IMPORTANT SAFETY INFORMATION**

**WARNING: IMMUNE-MEDIATED ADVERSE REACTIONS**

**YERVOY** can result in severe and fatal immune-mediated adverse reactions. These immune-mediated reactions may involve any organ system; however, the most common severe immune-mediated adverse reactions are enterocolitis, hepatitis, dermatitis (including toxic epidermal necrolysis), neuropathy, and endocrinopathy. The majority of these immune-mediated reactions initially manifested during treatment; however, a minority occurred weeks to months after discontinuation of **YERVOY**.

Assess patients for signs and symptoms of enterocolitis, dermatitis, neuropathy, and endocrinopathy, and evaluate clinical chemistries including liver function tests (LFTs), adrenocorticotropic hormone (ACTH) level, and thyroid function tests, at baseline and before each dose.

Permanently discontinue **YERVOY** and initiate systemic high-dose corticosteroid therapy for severe immune-mediated reactions.
Immune-Mediated Pneumonitis

OPDIVO can cause immune-mediated pneumonitis. Fatal cases have been reported. Monitor patients for signs with radiographic imaging and for symptoms of pneumonitis. Administer corticosteroids for Grade 2 or more severe pneumonitis. Permanently discontinue for Grade 3 or 4 and withhold until resolution for Grade 2. In patients receiving OPDIVO monotherapy, fatal cases of immune-mediated pneumonitis have occurred. Immune-mediated pneumonitis occurred in 3.1% (61/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated pneumonitis occurred in 6% (25/407) of patients. In HCC patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated pneumonitis occurred in 10% (5/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated pneumonitis occurred in 4.4% (24/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated pneumonitis occurred in 1.7% (2/119) of patients.

Immune-Mediated Colitis

OPDIVO can cause immune-mediated colitis. Monitor patients for signs and symptoms of colitis. Administer corticosteroids for Grade 2 (of more than 5 days duration), 3, or 4 colitis. Withhold OPDIVO monotherapy for Grade 2 or 3 and permanently discontinue for Grade 4 or recurrent colitis upon re-initiation of OPDIVO. When administered with YERVOY, withhold OPDIVO and YERVOY for Grade 2 and permanently discontinue for Grade 3 or 4 or recurrent colitis. In patients receiving OPDIVO monotherapy, immune-mediated colitis occurred in 2.9% (58/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated colitis occurred in 26% (107/407) of patients including three fatal cases. In HCC patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated colitis occurred in 10% (5/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated colitis occurred in 10% (52/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated colitis occurred in 7% (8/119) of patients.

In a separate Phase 3 trial of YERVOY 3 mg/kg, severe, life-threatening, or fatal (diarrhea of ≥7 stools above baseline, fever, ileus, peritoneal signs; Grade 3-5) immune-mediated enterocolitis occurred in 34 (7%) patients. Across all YERVOY-treated patients in that trial (n=511), 5 (1%) developed intestinal perforation, 4 (0.8%) died as a result of complications, and 26 (5%) were hospitalized for severe enterocolitis.

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. Addition of an alternative immunosuppressive agent to the corticosteroid therapy, or replacement of the corticosteroid therapy, should be considered in corticosteroid-refractory immune-mediated colitis if other causes are excluded.

Immune-Mediated Hepatitis

OPDIVO can cause immune-mediated hepatitis. Monitor patients for abnormal liver tests prior to and periodically during treatment. Administer corticosteroids for Grade 2 or greater transaminase elevations. For patients without HCC, withhold OPDIVO for Grade 2 and permanently discontinue OPDIVO for Grade 3 or 4. For patients with HCC, withhold OPDIVO and administer corticosteroids if AST/ALT is within normal limits at baseline and increases to >3 and up to 5 times the upper limit of normal (ULN), if AST/ALT is >1 and up to 3 times ULN at baseline and increases to >5 and up to 10 times the ULN, and if AST/ALT is >3 and up to 10 times ULN in patients with HCC. Permanently discontinue OPDIVO and administer corticosteroids if AST or ALT increases to >10 times the ULN or total bilirubin increases >3 times the ULN. In patients receiving OPDIVO monotherapy, immune-mediated hepatitis occurred in 1.8% (35/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated hepatitis occurred in 13% (51/407) of patients. In HCC patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated hepatitis occurred in 20% (10/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated hepatitis occurred in 7% (38/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated hepatitis occurred in 8% (10/119) of patients.

In a separate Phase 3 trial of YERVOY 3 mg/kg, severe, life-threatening, or fatal hepatotoxicity (AST or ALT elevations >5x the ULN or total bilirubin elevations >3x the ULN; Grade 3-5) occurred in 8 (2%) patients, with fatal hepatic failure in 0.2% and hospitalization in 0.4%.

Immune-Mediated Neuropathies

In a separate Phase 3 trial of YERVOY 3 mg/kg, 1 case of fatal Guillain-Barré syndrome and 1 case of severe (Grade 3) peripheral motor neuropathy were reported.

Immune-Mediated Endocrinopathies

OPDIVO can cause immune-mediated hypophysitis, immune-mediated adrenal insufficiency, autoimmune thyroid disorders, and Type 1 diabetes mellitus. Monitor patients for signs and symptoms of hypophysitis, signs and symptoms of adrenal insufficiency, thyroid function prior to and periodically during treatment, and hyperglycemia. Administer hormone replacement as clinically indicated and corticosteroids for Grade 2 or greater hypophysitis. Withhold for Grade 2 or 3 and permanently discontinue for Grade 4 hypophysitis. Administer corticosteroids for Grade 3 or 4 adrenal insufficiency. Withhold for Grade 2 and permanently discontinue for Grade 3 or 4 adrenal insufficiency. Administer hormone-replacement therapy for hypothyroidism. Initiate medical management for control of hyperthyroidism. Withhold OPDIVO for Grade 3 and permanently discontinue for Grade 4 hyperglycemia.

In patients receiving OPDIVO monotherapy, hypophysitis occurred in 0.6% (12/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, hypophysitis occurred in 9% (36/407) of patients. In HCC patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, hypophysitis occurred in 4% (2/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, hypophysitis occurred in 4.6% (25/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated hypophysitis occurred in 3.4% (4/119) of patients. In patients receiving OPDIVO monotherapy, adrenal insufficiency occurred in 1% (20/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, adrenal insufficiency occurred in 5% (21/407) of patients. In HCC patients receiving OPDIVO monotherapy, adrenal insufficiency occurred in 6% (25/407) of patients.
OPDIVO 1 mg/kg with YERVOY 3 mg/kg, adrenal insufficiency occurred in 18% (9/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, adrenal insufficiency occurred in 7% (41/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, adrenal insufficiency occurred in 5.9% (7/119) of patients. In patients receiving OPDIVO monotherapy, hypothyroidism or thyroiditis resulting in hypothyroidism occurred in 9% (171/1994) of patients. Hyperthyroidism occurred in 2.7% (54/1994) of patients receiving OPDIVO monotherapy. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, hypothyroidism or thyroiditis resulting in hypothyroidism occurred in 22% (89/407) of patients. Hyperthyroidism occurred in 8% (34/407) of patients receiving this dose of OPDIVO with YERVOY. In RCC patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, hypothyroidism or thyroiditis resulting in hypothyroidism occurred in 22% (119/547) of patients. Hyperthyroidism occurred in 10% (5/49) of patients receiving this dose of OPDIVO with YERVOY. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, hypothyroidism or thyroiditis resulting in hypothyroidism occurred in 12% (66/547) of patients receiving this dose of OPDIVO with YERVOY. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, hypothyroidism or thyroiditis resulting in hypothyroidism occurred in 15% (18/119) of patients. Hyperthyroidism occurred in 12% (14/119) of patients. In patients receiving OPDIVO monotherapy, diabetes occurred in 0.9% (17/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, diabetes occurred in 1.5% (6/407) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, diabetes occurred in 2.7% (15/547) of patients.

In a separate Phase 3 trial of YERVOY 3 mg/kg, severe, life-threatening immune-mediated endocrinopathies (requiring hospitalization, urgent medical intervention, or interfering with activities of daily living; Grade 3-4) occurred in 9 (1.8%) patients. All 9 patients had hypopituitarism, and some had additional concomitant endocrinopathies such as adrenal insufficiency, hypogonadism, and hypothyroidism. Six of the 9 patients were hospitalized for severe endocrinopathies.

Immune-Mediated Nephritis and Renal Dysfunction

OPDIVO can cause immune-mediated nephritis. Monitor patients for elevated serum creatinine prior to and periodically during treatment. Administer corticosteroids for Grades 2-4 increased serum creatinine. Withhold OPDIVO for Grade 2 or 3 and permanently discontinue for Grade 4 increased serum creatinine. In patients receiving OPDIVO monotherapy, immune-mediated nephritis and renal dysfunction occurred in 1.2% (23/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated nephritis and renal dysfunction occurred in 2.2% (9/407) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated nephritis and renal dysfunction occurred in 4.6% (25/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated nephritis and renal dysfunction occurred in 1.7% (2/119) of patients.

Immune-Mediated Skin Adverse Reactions and Dermatitis

OPDIVO can cause immune-mediated rash, including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN), some cases with fatal outcome. Administer corticosteroids for Grades 3 or 4 rash. Withhold OPDIVO and refer the patient for specialized care for assessment and treatment; if confirmed, permanently discontinue. In patients receiving OPDIVO monotherapy, immune-mediated rash occurred in 9% (171/1994) of patients. In melanoma patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated rash occurred in 22.6% (92/407) of patients. In RCC patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated rash occurred in 35% (17/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated rash occurred in 16% (90/547) of patients. In MSI-H/dMMR mCRC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated rash occurred in 14% (17/119) of patients.

In a separate Phase 3 trial of YERVOY 3 mg/kg, severe, life-threatening, or fatal immune-mediated dermatitis (e.g., Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full thickness dermal ulceration, or necrotic, bullous, or hemorrhagic manifestations; Grade 3-5) occurred in 13 (2.5%) patients. 1 (0.2%) patient died as a result of toxic epidermal necrolysis. 1 additional patient required hospitalization for severe dermatitis.

Immune-Mediated Encephalitis

OPDIVO can cause immune-mediated encephalitis. Evaluation of patients with neurologic symptoms may include, but not be limited to, consultation with a neurologist, brain MRI, and lumbar puncture. Withhold OPDIVO in patients with new-onset moderate to severe neurologic signs or symptoms and evaluate to rule out other causes. If other etiologies are ruled out, administer corticosteroids and permanently discontinue OPDIVO for immune-mediated encephalitis. In patients receiving OPDIVO monotherapy, encephalitis occurred in 0.2% (3/1994) of patients. Fatal limbic encephalitis occurred in one patient after 7.2 months of exposure despite discontinuation of OPDIVO and administration of corticosteroids. Encephalitis occurred one RCC patient receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg (0.2%) after 1.7 months of exposure. Encephalitis occurred in one melanoma patient receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg (0.2%) after approximately 4 months of exposure. Encephalitis occurred in one MSI-H/dMMR mCRC patient (0.8%) receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg after 15 days of exposure.

Other Immune-Mediated Adverse Reactions

Based on the severity of the adverse reaction, permanently discontinue or withhold OPDIVO, administer high-dose corticosteroids, and, if appropriate, initiate hormone-replacement therapy. Across clinical trials of OPDIVO monotherapy or in combination with YERVOY, the following clinically significant immune-mediated adverse reactions, some with fatal outcome, occurred in <1.0% of patients receiving OPDIVO: myocarditis, rhabdomyolysis, myositis, uveitis, iritis, pancreatitis, facial and abducens nerve paresis, demyelination, polymyalgia rheumatica, autoimmune neuropathy, Guillain-Barré syndrome, hypopituitarism, systemic inflammatory response syndrome, gastritis, duodenitis, sarcoidosis, histiocytic necrotizing lymphadenitis (Kikuchi lymphadenitis), motor dysfunction, vasculitis, aplastic anemia, pericarditis, and myasthenic syndrome.

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 may require treatment with systemic steroids to reduce the risk of permanent vision loss.

Infusion-Related Reactions
OPDIVO can cause severe infusion-related reactions, which have been reported in ≤1.0% of patients in clinical trials. Discontinue OPDIVO in patients with Grade 3 or 4 infusion-related reactions. Interrupt or slow the rate of infusion in patients with Grade 1 or 2. 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, infusion-related reactions occurred in 8% (4/49) of patients. In RCC patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, 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, infusion-related reactions occurred in 4.2% (5/119) of patients.

Embryo-Fetal Toxicity

Based on mechanism of action, OPDIVO and YERVOY can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with OPDIVO or 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 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

It is not known whether OPDIVO or YERVOY is present in human milk. Because many drugs, including antibodies, are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from OPDIVO or YERVOY, advise women not to breastfeed during treatment and for at least 5 months after the last dose.

Serious Adverse Reactions

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 214, serious adverse reactions occurred in 59% of patients receiving OPDIVO plus YERVOY. 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 142 in MSI-H/dMMR mCRC patients receiving OPDIVO with YERVOY, serious adverse reactions occurred in 47% of patients. The most frequent serious adverse reactions reported in ≥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 ≥4% of patients were pyrexia, diarrhea, anemia, increased AST, adrenal insufficiency, ascites, esophageal varices hemorrhage, hyponatremia, increased blood bilirubin, and pneumonitis.

Common Adverse Reactions

In Checkmate 067, the most common (≥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%), arthrosis (18%), increased transaminases (25%). In Checkmate 067, the most common (≥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 214, the most common adverse reactions (≥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 142 in MSI-H/dMMR mCRC patients receiving OPDIVO with YERVOY, the most common adverse reactions (≥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 (≥20%) in patients receiving OPDIVO with YERVOY (n=49), were rash (53%), pruritus (53%), musculoskeletal pain (41%), diarrhea (39%), cough (37%), decreased appetite (35%), fatue (27%), pyrexia (27%), abdominal pain (22%), headache (22%), nausea (20%), dizziness (20%), hypothyroidism (20%), and weight decreased (20%).

In a separate Phase 3 trial of YERVOY 3 mg/kg, the most common adverse reactions (≥5%) in patients who received YERVOY at 3 mg/kg were fatigue (41%), diarrhea (32%), pruritus (31%), rash (29%), and colitis (8%).

Please see U.S. Full Prescribing Information for OPDIVO and YERVOY, including Boxed WARNING regarding immune-mediated adverse reactions for YERVOY.

Checkmate Trials and Patient Populations

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 non-squamous non-small cell lung cancer; Checkmate 057- second-line treatment of metastatic squamous non-small cell lung cancer; Checkmate 032- small cell lung cancer; Checkmate 025- previously treated renal cell carcinoma; Checkmate 214- previously untreated renal cell carcinoma, in...
combination with YERVOY; Checkmate 205/039-classical Hodgkin lymphoma; Checkmate 141-recurrent or metastatic squamous cell carcinoma of the head and neck; Checkmate 275-urothelial carcinoma; Checkmate 142-MSI-H or dMMR metastatic colorectal cancer, as a single agent or in combination with YERVOY; Checkmate 040-hepatocellular carcinoma; Checkmate 238-adjunct treatment of melanoma.

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 or follow us on LinkedIn, Twitter, YouTube, Facebook and Instagram.

Celgene and Juno Therapeutics are wholly owned subsidiaries of Bristol-Myers Squibb Company. In certain countries outside the U.S., due to local laws, Celgene and Juno Therapeutics are referred to as, Celgene, a Bristol-Myers Squibb Company and Juno Therapeutics, a Bristol-Myers Squibb Company.

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 historical performance and 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 Opdivo plus Yervoy may not receive regulatory approval for the additional indications described in this release in the currently anticipated timeline or at all and, if approved, whether such combination treatment for such additional indications described in this release will be commercially successful. 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, 2019, 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.

Language:

English

Contact:

Bristol Myers Squibb
Media Inquiries:
media@bms.com
609-252-3345

Investors:
Tim Power
609-252-7509
timothy.power@bms.com

Ticker Slug:
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