Bristol-Myers Squibb to Present New Data Demonstrating Continued Research Expansion and Immuno-Oncology Advancements Across Multiple Blood Cancers at the 21st Congress of the European Hematology Association

Release Date:
Thursday, June 9, 2016 6:59 am EDT

Terms:
#BloodCancer #BMSatEHA #DYK #EHA16 #HCP #ImmunoOncology #leukemia #Lymphoma #MEDIA #MMAware #MultipleMyeloma #blood #BMS #BristolMyers #Cancer #caregiver #CheckMate #clinicaltrial #CML #dasatinib #data #doctor #EHA #EHA16 #elotuzumab #Empliciti #hematology #Hodgkin #ImmunoOncology #leukemia #lymphoma #myeloid #myeloma #nivolumab #nurse #nursing #Oncology #Opdivo #patient #R&D #Research #sprycel #Squibb #therapy #treatment

Dateline City:
PRINCETON, N.J.

Presentation of Opdivo CheckMate -205 registrational trial reports on objective response rates and ongoing responses in patients with classical Hodgkin lymphoma who had relapsed or progressed after auto-HSCT and post-transplantation brentuximab vedotin

New analysis evaluating impact of time from diagnosis and prior lines of therapy in progression-free survival from Empliciti ELOQUENT-2 trial in relapsed or refractory multiple myeloma also to be presented

Subgroup analyses of long-term outcomes in newly diagnosed adults with chronic phase Philadelphia chromosome-positive chronic myeloid leukemia to be presented from Sprycel DASISION trial

PRINCETON, N.J.--(BUSINESS WIRE)--Bristol-Myers Squibb Company (NYSE:BMY) announced today clinical data featuring two of its Immuno-Oncology agents, Opdivo (nivolumab) and Empliciti (elotuzumab), will be presented at the 21st Congress of the European Hematology Association (EHA) in Copenhagen, Denmark from June 9 – 12. Data will be presented from the Phase 2 CheckMate -205 trial evaluating Opdivo in patients with classical Hodgkin lymphoma (cHL) who had relapsed or progressed after autologous hematopoietic stem cell transplantation (auto-HSCT) and post-transplantation brentuximab vedotin, as well as from the Phase 3 ELOQUENT-2 trial evaluating Empliciti in combination with Revlimid (lenalidomide) and dexamethasone in patients with multiple myeloma who had received one to three prior therapies. In addition, subgroup analyses of long-term outcomes from the Phase 3 DASISION trial in newly diagnosed adults with chronic phase Philadelphia chromosome-positive chronic myeloid leukemia (CML) with Sprycel (dasatinib), the company’s first blood cancer agent, will be presented.

“The research being presented at EHA demonstrates our commitment to hematologic malignancies with high unmet need, including multiple myeloma, classical Hodgkin lymphoma and chronic myeloid leukemia,” said Jean Viallet, M.D., Global Clinical Research Lead, Oncology, Bristol-Myers Squibb. “These data for Opdivo and Empliciti provide additional understanding of how our therapies work and show the potential for Immuno-Oncology treatment options in patients with hematologic malignancies.”

Data to be presented during oral presentations include:

- **CheckMate -205**: Additional results from a Phase 2 study of Opdivo in patients with cHL following auto-HSCT and brentuximab vedotin (Abstract #S793) will be presented as an oral presentation during the “Relapsed Hodgkin Lymphoma & Primary Mediastinal Large B-Cell Lymphoma (PM-DLBCL)” session on Sunday, June 12, 8:00 – 8:15 a.m. CEST.

- **SMM 011**: First presentation of results from a study of Empliciti monotherapy in patients with high-risk smoldering
multiple myeloma (Abstract #S815) will be presented as an oral presentation during the “Experimental Approaches for Plasma Disorders” session on Sunday, June 12, 8:30 – 8:45 a.m. CEST.

- **Preclinical I-O:** Results from a study showing PD-1 blockade enhances the efficacy of elotuzumab in mouse models (Abstract #S450) will be presented as an oral presentation during the “New Biological Markers in MM” session on Saturday, June 11, 12:15 – 12:30 p.m. CEST.

The full set of data to be presented by Bristol-Myers Squibb includes:

**Hodgkin Lymphoma**

- **Checkmate 205: a phase 2 study of nivolumab in patients with classical Hodgkin lymphoma following autologous stem cell transplantation and brentuximab vedotin**
  Author: A. Engert
  Abstract #S793
  Oral Presentation, Relapsed Hodgkin Lymphoma & Primary Mediastinal Large B-Cell Lymphoma (PM-DLBCL) Session
  Sunday, June 12, 8:00 – 8:15 a.m. CEST, Hall A2, The Bella Center

**Multiple Myeloma**

- **Elotuzumab + lenalidomide/dexamethasone in patients with relapsed/refractory multiple myeloma: ELOQUENT-2 post-hoc analysis of PFS and tumor regrowth by time from diagnosis and prior lines of therapy**
  Author: M. Dimopoulos
  Abstract #P280
  Poster Presentation, Innovative Therapies for MM 2
  Friday, June 10, 5:15 – 6:45 p.m. CEST, Hall H, The Bella Center

- **PD-1 blockade enhances the efficacy of elotuzumab in mouse tumor models**
  Author: N. Bezman
  Abstract #S450
  Oral Presentation, New Biological Markers in MM
  Saturday, June 11, 12:15 – 12:30 p.m. CEST, Auditorium 2, The Bella Center

- **A phase 2, open-label, multicenter study of elotuzumab monotherapy in patients with high-risk smoldering multiple myeloma**
  Author: P. Richardson
  Abstract #S815
  Oral Presentation, Experimental Approaches for Plasma Disorders Session
  Sunday, June 12, 8:30 – 8:45 a.m. CEST, Hall C14, The Bella Center

- **Differential effects of elotuzumab (anti-SLAMF7) and anti-CD38 monoclonal antibodies in preclinical models**
  Author: N. Bezman
  Abstract #P646
  Poster Presentation, Novel Targets for MM
  Saturday, June 11, 5:30 – 7:00 p.m. CEST, Hall H, The Bella Center

- **An ongoing multinational observational study in multiple myeloma (PREAMBLE): preliminary report on progression-free survival**
  Author: D. Kuter
  Abstract #E1261
  E-Poster, Myeloma and Other Monoclonal Gammopathies – Clinical
  Friday, June 10, 9:30 a.m. CEST – Saturday, June 11, 7:00 p.m. CEST

- **Fc-gamma receptor polymorphisms and progression-free survival: analysis of three clinical trials of elotuzumab in multiple myeloma**
  Author: V. Poupart
  Abstract #E1281
  E-Poster, Myeloma and Other Monoclonal Gammopathies – Clinical
  Friday, June 10, 9:30 a.m. CEST – Saturday, June 11, 7:00 p.m. CEST

- **Clinical characteristics, treatment patterns and healthcare resource utilization among Italian patients with relapsed refractory multiple myeloma: results from a prospective observational study**
  Author: A. Palumbo
  Abstract #E1438
  E-Poster, Quality of Life, Palliative Care, Ethics and Health Economics
  Friday, June 10, 9:30 a.m. CEST – Saturday, June 11, 7:00 p.m. CEST

- **Real-world characteristics, treatment pathways and healthcare resource use in patients treated for relapsed refractory multiple myeloma in Spain: preliminary results from the PREMIERE study**
  Author: J. Martínez-López
  Abstract #PB2097
  Publication Only, Quality of Life, Palliative Care, Ethics and Health Economics

**Chronic Myeloid Leukemia**

- **The impact of early molecular response on long-term outcomes in patients with chronic myeloid**
leukemia in chronic phase (CML-CP) treated with dasatinib or imatinib from the DASISION trial

Author: F. Stegelmann
Abstract #P617
Poster Presentation, Chronic Myeloid Leukemia - Clinical 2
Saturday, June 11, 5:30 – 7:00 p.m. CEST, Hall H, The Bella Center

Bristol-Myers Squibb & Immuno-Oncology: Advancing Oncology Research

At Bristol-Myers Squibb, we have a vision for the future of cancer care that is focused on Immuno-Oncology, now considered a major treatment choice alongside surgery, radiation, chemotherapy and targeted therapies for certain types of cancer.

We have a comprehensive clinical portfolio of investigational and approved Immuno-Oncology agents, many of which were discovered and developed by our scientists. Our ongoing Immuno-Oncology clinical program is looking at broad patient populations, across multiple solid tumors and hematologic malignancies, and lines of therapy and histologies, with the intent of powering our trials for overall survival and other important measures like durability of response. We pioneered the research leading to the first regulatory approval for the combination of two Immuno-Oncology agents and continue to study the role of combinations in cancer.

We are also investigating other immune system pathways in the treatment of cancer including CTLA-4, CD-137, KIR, SLAMF7, PD-1, GITR, CSF1R, IDO and LAG-3. These pathways may lead to potential new treatment options – in combination or monotherapy – to help patients fight different types of cancers.

Our collaboration with academia, as well as small and large biotech companies, to research the potential of Immuno-Oncology and non-Immuno-Oncology combinations, helps achieve our goal of providing new treatment options in clinical practice.

At Bristol-Myers Squibb, we are committed to changing survival expectations in hard-to-treat cancers and the way patients live with cancer.

About Opdivo

Cancer cells may exploit “regulatory” pathways, such as checkpoint pathways, to hide from the immune system and shield the tumor from immune attack. Opdivo is a PD-1 immune checkpoint inhibitor that binds to the checkpoint receptor PD-1 expressed on activated T-cells, and blocks the binding of PD-L1 and PD-L2, preventing the PD-1 pathway’s suppressive signaling on the immune system, including the interference with an anti-tumor immune response.

Opdivo’s broad global development program is based on Bristol-Myers Squibb’s understanding of the biology behind Immuno-Oncology. Our company is at the forefront of researching the potential of Immuno-Oncology to extend survival in hard-to-treat cancers. This scientific expertise serves as the basis for the Opdivo development program, which includes a broad range of Phase 3 clinical trials evaluating overall survival as the primary endpoint across a variety of tumor types. The Opdivo trials have also contributed toward the clinical and scientific understanding of the role of biomarkers and how patients may benefit from Opdivo across the continuum of PD-L1 expression. To date, the Opdivo clinical development program has enrolled more than 18,000 patients.

Opdivo was the first PD-1 immune checkpoint inhibitor to receive regulatory approval anywhere in the world in July 2014 and currently has regulatory approval in 51 countries including the United States, Japan and in the European Union.

OPDIVO U.S. INDICATIONS & IMPORTANT SAFETY INFORMATION

INDICATIONS

OPDIVO® (nivolumab) as a single agent is indicated for the treatment of patients with BRAF V600 wild-type unresectable or metastatic melanoma.

OPDIVO® (nivolumab) as a single agent is indicated for the treatment of patients with BRAF V600 mutation-positive unresectable or metastatic melanoma. This indication is approved under accelerated approval based on progression-free survival. 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 unresectable or metastatic melanoma. This indication is approved under accelerated approval based on progression-free survival. 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 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) is indicated for the treatment of patients with advanced renal cell carcinoma (RCC) who have received prior antiangiogenic therapy.

OPDIVO® (nivolumab) is indicated for the treatment of patients with classical Hodgkin lymphoma (cHL) that has relapsed or progressed after autologous hematopoietic stem cell transplantation (HSCT) and post-transplantation brentuximab vedotin. 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.

Please refer to the end of the Important Safety Information for a brief description of the patient populations studied in the CheckMate 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

Immune-mediated pneumonitis, including fatal cases, occurred with OPDIVO treatment. Across the clinical trial experience with solid tumors, fatal immune-mediated pneumonitis occurred with OPDIVO. In addition, in Checkmate 069, there were six patients who died without resolution of abnormal respiratory findings. Monitor patients for signs with radiographic imaging and symptoms of pneumonitis. Administer corticosteroids for Grade 2 or greater pneumonitis. Permanently discontinue for Grade 3 or 4 and withhold until resolution for Grade 2. In Checkmate 069 and 067, immune-mediated pneumonitis occurred in 6% (25/407) of patients receiving OPDIVO with YERVOY: Fatal (n=1), Grade 3 (n=6), Grade 2 (n=17), and Grade 1 (n=1). In Checkmate 037, 066, and 067, immune-mediated pneumonitis occurred in 1.8% (14/787) of patients receiving OPDIVO: Grade 3 (n=2) and Grade 2 (n=12). In Checkmate 057, immune-mediated pneumonitis, including interstitial lung disease, occurred in 3.4% (10/287) of patients: Grade 3 (n=5), Grade 2 (n=2), and Grade 1 (n=3). In Checkmate 025, pneumonitis, including interstitial lung disease, occurred in 5% (21/406) of patients receiving OPDIVO and 18% (73/397) of patients receiving everolimus. Immune-mediated pneumonitis occurred in 4.4% (18/406) of patients receiving OPDIVO: Grade 4 (n=1), Grade 3 (n=4), Grade 2 (n=12), and Grade 1 (n=1). In Checkmate 205 and 039, pneumonitis, including interstitial lung disease, occurred in 4.9% (13/263) of patients receiving OPDIVO. Immune-mediated pneumonitis occurred in 3.4% (9/263) of patients receiving OPDIVO: Grade 3 (n=1) and Grade 2 (n=8).

Immune-Mediated Colitis

Immune-mediated colitis can occur with OPDIVO treatment. Monitor patients for signs and symptoms of colitis. Administer corticosteroids for Grade 2 (of more than 5 days duration), 3, or 4 colitis. As a single agent, withhold OPDIVO for Grade 2 or 3 and permanently discontinue for Grade 4 or recurrent colitis upon restarting OPDIVO. When administered with YERVOY, withhold OPDIVO for Grade 2 and permanently discontinue for Grade 3 or 4 or recurrent colitis upon restarting OPDIVO. In Checkmate 069 and 067, diarrhea or colitis occurred in 56% (228/407) of patients receiving OPDIVO with YERVOY. Immune-mediated colitis occurred in 26% (107/407) of patients: Grade 4 (n=2), Grade 3 (n=60), Grade 2 (n=32), and Grade 1 (n=13). In Checkmate 037, 066, and 067, diarrhea or colitis occurred in 31% (242/787) of patients receiving OPDIVO. Immune-mediated colitis occurred in 4.1% (32/787) of patients: Grade 3 (n=20), Grade 2 (n=10), and Grade 1 (n=2). In Checkmate 057, diarrhea or colitis occurred in 17% (50/287) of patients receiving OPDIVO. Immune-mediated colitis occurred in 2.4% (7/287) of patients: Grade 3 (n=3), Grade 2 (n=2), and Grade 1 (n=2). In Checkmate 025, diarrhea or colitis occurred in 25% (100/406) of patients receiving OPDIVO and 32% (126/397) of patients receiving everolimus. Immune-mediated diarrhea or colitis occurred in 3.2% (13/406) of patients receiving OPDIVO: Grade 3 (n=5), Grade 2 (n=7), and Grade 1 (n=1). In Checkmate 205 and 039, diarrhea or colitis occurred in 30% (80/263) of patients receiving OPDIVO. Immune-mediated diarrhea (Grade 3) occurred in 1.1% (3/263) of patients.

In a separate Phase 3 study 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 study (n=511), 5 (1%) developed intestinal perforation, 4 (0.8%) died as a result of complications, and 26 (5%) were hospitalized for severe enterocolitis.

Immune-Mediated Hepatitis

Immune-mediated hepatitis can occur with OPDIVO treatment. Monitor patients for abnormal liver tests prior to and periodically during treatment. Administer corticosteroids for Grade 2 or greater transaminase elevations. Withhold for Grade 2 and permanently discontinue for Grade 3 or 4 immune-mediated hepatitis. In Checkmate 069 and 067, immune-mediated hepatitis occurred in 13% (51/407) of patients receiving OPDIVO with YERVOY: Grade 4 (n=8), Grade 3 (n=37), Grade 2 (n=5), and Grade 1 (n=1). In Checkmate 037, 066, and 067, immune-mediated hepatitis occurred in 2.3% (18/787) of patients receiving OPDIVO: Grade 4 (n=3), Grade 3 (n=11), and Grade 2 (n=4). In Checkmate 057, one patient (0.3%) developed immune-mediated hepatitis. In Checkmate 025, there was an increased incidence of liver test abnormalities compared to baseline in AST (33% vs 39%), alkaline phosphatase (32% vs 32%), ALT (22% vs 31%), and total bilirubin (9% vs 3.5%) in the OPDIVO and everolimus arms, respectively. Immune-mediated hepatitis requiring systemic immunosuppression occurred in 1.5% (6/406) of patients receiving OPDIVO: Grade 3 (n=5) and Grade 2 (n=1). In Checkmate 205 and 039, hepatitis occurred in 11% (30/263) of patients receiving OPDIVO. Immune-mediated hepatitis occurred in 3.4% (9/263): Grade 3 (n=7) and Grade 2 (n=2).

In a separate Phase 3 study 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 Dermatitis

In a separate Phase 3 study of YERVOY 3 mg/kg, severe, life-threatening, or fatal immune-mediated dermatitis (eg, 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 Neuropathies

In a separate Phase 3 study 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

Hyphophysitis, adrenal insufficiency, thyroid disorders, and type 1 diabetes mellitus can occur with OPDIVO treatment. Monitor patients for signs and symptoms of hyphophysitis, signs and symptoms of adrenal insufficiency during and after treatment, thyroid function prior to and periodically during treatment, and hyperglycemia. Administer corticosteroids for Grade 2 or greater hyphophysitis. Withhold for Grade 2 or permanently discontinue for Grade 4 hyphophysitis. 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. Administer insulin for type 1 diabetes. Withhold OPDIVO for Grade 3 and permanently discontinue for Grade 4 hyperglycemia.

In Checkmate 069 and 067, hyphophysitis occurred in 9% (36/407) of patients receiving OPDIVO with YERVOY: Grade 3 (n=8), Grade 2 (n=25), and Grade 1 (n=3). In Checkmate 307, 066, and 067, hyphophysitis occurred in 0.9% (7/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=3), and Grade 1 (n=2). In Checkmate 025, hyphophysitis occurred in 0.5% (2/406) of patients receiving OPDIVO: Grade 3 (n=1) and Grade 1 (n=1). In Checkmate 069 and 067, adrenal insufficiency occurred in 5% (21/407) of patients receiving OPDIVO with YERVOY: Grade 4 (n=1), Grade 3 (n=7), Grade 2 (n=11), and Grade 1 (n=2). In Checkmate 037, 066, and 067, adrenal insufficiency occurred in 1% (8/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=5), and Grade 1 (n=1). In Checkmate 057, 0.3% (1/287) of OPDIVO-treated patients developed adrenal insufficiency. In Checkmate 025, adrenal insufficiency occurred in 2.0% (8/406) of patients receiving OPDIVO: Grade 3 (n=3), Grade 2 (n=4), and Grade 1 (n=1). In Checkmate 205 and 039, adrenal insufficiency (Grade 2) occurred in 0.4% (1/263) of patients receiving OPDIVO. In Checkmate 069 and 067, hypothyroidism or thyroiditis occurred in 22% (89/407) of patients receiving OPDIVO with YERVOY: Grade 3 (n=6), Grade 2 (n=47), and Grade 1 (n=36). Hyperthyroidism occurred in 8% (34/407) of patients: Grade 3 (n=4), Grade 2 (n=17), and Grade 1 (n=13). In Checkmate 037, 066, and 067, hypothyroidism or thyroiditis occurred in 9% (73/787) of patients receiving OPDIVO: Grade 3 (n=1), Grade 2 (n=37), Grade 1 (n=35). Hyphophysitis occurred in 4.4% (35/787) of patients receiving OPDIVO: Grade 3 (n=1), Grade 2 (n=12), and Grade 1 (n=22). In Checkmate 057, Grade 1 or 2 hyphophysitis, including thyroiditis, occurred in 7% (20/287) and elevated thyroid stimulating hormone occurred in 17% of patients receiving OPDIVO. Grade 1 or 2 hyperthyroidism occurred in 1.4% (4/287) of patients. In Checkmate 025, thyroid disease occurred in 11% (43/406) of patients receiving OPDIVO, including one Grade 3 event, and in 3.0% (12/397) of patients receiving everolimus. Hyperthyroidism/thyroiditis occurred in 8% (33/406) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=17), and Grade 1 (n=14). Hyperthyroidism occurred in 2.5% (10/406) of patients receiving OPDIVO: Grade 2 (n=5) and Grade 1 (n=5). In Checkmate 205 and 039, hypothyroidism/thyroiditis occurred in 12% (32/263) of patients receiving OPDIVO: Grade 2 (n=18) and Grade 1 (n=14). Hyperthyroidism occurred in 1.5% (4/263) of patients receiving OPDIVO: Grade 2: (n=3) and Grade 1 (n=1). In Checkmate 069 and 067, diabetes mellitus or diabetic ketoacidosis occurred in 1.5% (6/407) of patients: Grade 4 (n=3), Grade 3 (n=1), Grade 2 (n=1), and Grade 1 (n=1). In Checkmate 037, 066, and 067, diabetes mellitus or diabetic ketoacidosis occurred in 0.8% (6/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=3), and Grade 1 (n=1). In Checkmate 025, hyperglycemic adverse events occurred in 9% (37/406) patients. Diabetes mellitus or diabetic ketoacidosis occurred in 1.5% (6/406) of patients receiving OPDIVO: Grade 3 (n=3), Grade 2 (n=2), and Grade 1 (n=1). In Checkmate 205 and 039, diabetes mellitus occurred in 8% (2/263) of patients receiving OPDIVO: Grade 3 (n=1) and Grade 1 (n=1).

In a separate Phase 3 study of YERVOY 3 mg/kg, severe to 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. 6 of the 9 patients were hospitalized for severe endocrinopathies.

Immune-Mediated Nephritis and Renal Dysfunction

Immune-mediated nephritis can occur with OPDIVO treatment. Monitor patients for elevated serum creatinine prior to and periodically during treatment. For Grade 2 or 3 increased serum creatinine, withhold and administer corticosteroids; if worsening or no improvement occurs, permanently discontinue. Administer corticosteroids for Grade 4 serum creatinine elevation and permanently discontinue. In Checkmate 069 and 067, immune-mediated nephritis and renal dysfunction occurred in 2.2% (9/407) of patients: Grade 4 (n=4), Grade 3 (n=3), and Grade 2 (n=2). In Checkmate 037, 066, and 067, nephritis and renal dysfunction of any grade occurred in 5% (40/787) of patients receiving OPDIVO. Immune-mediated nephritis and renal dysfunction occurred in 0.8% (6/787) of patients: Grade 3 (n=4) and Grade 2 (n=2). In Checkmate 057, Grade 2 immune-mediated renal dysfunction occurred in 0.3% (1/287) of patients receiving OPDIVO. In Checkmate 025, renal injury occurred in 7% (27/406) of patients receiving OPDIVO and 3.0% (12/397) of patients receiving everolimus. Immune-mediated nephritis and renal dysfunction occurred in 3.2% (13/406) of patients receiving OPDIVO: Grade 5 (n=1), Grade 4 (n=1), Grade 3 (n=5), and Grade 2 (n=6). In Checkmate 205 and 039, nephritis and renal dysfunction occurred in 4.9% (13/263) of patients treated with OPDIVO. This included one reported case (0.3%) of Grade 3 autoimmune nephritis.

Immune-Mediated Rash

Immune-mediated rash can occur with OPDIVO treatment. Severe rash (including rare cases of fatal toxic epidermal necrolysis) occurred in the clinical program of OPDIVO. Monitor patients for rash. Administer corticosteroids for Grade 3 or 4 rash. Withhold for Grade 3 and permanently discontinue for Grade 4. In Checkmate 069 and 067, immune-mediated rash occurred in 22.6% (92/407) of patients receiving OPDIVO with YERVOY: Grade 3 (n=15), Grade 2 (n=31), and Grade 1 (n=46). In Checkmate 037, 066, and 067, immune-mediated rash occurred in 9% (72/787) of patients receiving OPDIVO: Grade 3 (n=7), Grade 2 (n=15), and Grade 1 (n=50). In Checkmate 057, immune-mediated rash occurred in 6% (17/287) of patients receiving OPDIVO including four Grade 3 cases. In Checkmate 025, rash occurred in 28% (112/406) of patients receiving OPDIVO and 33.6% (143/430) of patients receiving OPDIVO plus 5 mg/kg of patients receiving everolimus. Immune-mediated rash, defined as a rash treated with systemic or topical corticosteroids, occurred in 7% (30/406) of patients receiving OPDIVO: Grade 3 (n=4), Grade 2 (n=7), and Grade 1 (n=19). In Checkmate 205 and 039, rash occurred in 22% (58/263) of patients receiving OPDIVO. Immune-mediated rash occurred in 7% (18/263) of patients on OPDIVO: Grade 3 (n=4), Grade 2 (n=3), and Grade 1 (n=11).
Immune-Mediated Encephalitis

Immune-mediated encephalitis can occur with OPDIVO treatment. 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 Checkmate 067, encephalitis was identified in one patient (0.2%) receiving OPDIVO with YERVOY. In Checkmate 057, fatal limbic encephalitis occurred in one patient (0.3%) receiving OPDIVO. In Checkmate 205 and 039, encephalitis occurred in 0.8% (2/263) of patients after allogeneic HSCT after OPDIVO.

Other Immune-Mediated Adverse Reactions

Based on the severity of adverse reaction, permanently discontinue or withhold treatment, administer high-dose corticosteroids, and, if appropriate, initiate hormone-replacement therapy. In < 1.0% of patients receiving OPDIVO, the following clinically significant, immune-mediated adverse reactions occurred: uveitis, iritis, pancreatitis, facial and abducens nerve paresis, demyelination, polymyalgia rheumatica, autoimmune neuropathy, Guillain-Barré syndrome, hypopituitarism, systemic inflammatory response syndrome, gastritis, duodenitis, and sarcoidosis. Across clinical trials of OPDIVO as a single agent administered at doses of 3 mg/kg and 10 mg/kg, additional clinically significant, immune-mediated adverse reactions were identified: motor dysfunction, vasculitis, and myasthenic syndrome.

Infusion Reactions

Severe infusion reactions have been reported in < 1.0% of patients in clinical trials of OPDIVO. Discontinue OPDIVO in patients with Grade 3 or 4 infusion reactions. Interrupt or slow the rate of infusion in patients with Grade 1 or 2. In Checkmate 069 and 067, infusion-related reactions occurred in 2.5% (10/407) of patients receiving OPDIVO with YERVOY: Grade 2 (n=6) and Grade 1 (n=4). In Checkmate 037, 066, and 067, Grade 2 infusion related reactions occurred in 2.7% (21/787) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=8), and Grade 1 (n=11). In Checkmate 057, Grade 2 infusion reactions requiring corticosteroids occurred in 1.0% (3/287) of patients receiving OPDIVO. In Checkmate 025, hypersensitivity/infusion-related reactions occurred in 6% (25/406) of patients receiving OPDIVO and 1.0% (4/397) of patients receiving everolimus. In Checkmate 205 and 039, hypersensitivity/infusion-related reactions occurred in 16% (42/263) of patients receiving OPDIVO: Grade 3 (n=2), Grade 2 (n=24), and Grade 1 (n=16).

Complications of Allogeneic HSCT after OPDIVO

Complications, including fatal events, occurred in patients who received allogeneic HSCT after OPDIVO. Outcomes were evaluated in 17 patients from Checkmate 205 and 039, who underwent allogeneic HSCT after discontinuing OPDIVO (15 with reduced-intensity conditioning, 2 with myeloablative conditioning). Thirty-five percent (6/17) of patients died from complications of allogeneic HSCT after OPDIVO. Five deaths occurred in the setting of severe or refractory GVHD. Grade 3 or higher acute GVHD was reported in 29% (5/17) of patients. Hyperacute GVHD was reported in 20% (n=2) of patients. A steroid-requiring febrile syndrome, without an identified infectious cause, was reported in 35% (n=6) of patients. Two cases of encephalitis were reported: Grade 3 (n=1) lymphocytic encephalitis without an identified infectious cause, and Grade 3 (n=1) suspected viral encephalitis. Hepatic veno-occlusive disease (VOD) occurred in one patient, who received reduced-intensity conditioned allogeneic SCT and died of GVHD and multi-organ failure. Other cases of hepatic VOD after reduced-intensity conditioned allogeneic HSCT have also been reported in patients with lymphoma who received a PD-1 receptor blocking antibody before transplantation. Cases of fatal hyperacute GVHD have also been reported. These complications may occur despite intervening therapy between PD-1 blockade and allogeneic HSCT.

Follow patients closely for early evidence of transplant-related complications such as hyperacute GVHD, severe (Grade 3 to 4) acute GVHD, steroid-requiring febrile syndrome, hepatic VOD, and other immune-mediated adverse reactions, and intervene promptly.

Embryo-fetal Toxicity

Based on their mechanisms 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 an OPDIVO- or YERVOY-containing regimen and for at least 5 months after the last dose of OPDIVO.

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 an OPDIVO-containing regimen, advise women to discontinue breastfeeding during treatment. Advise women to discontinue nursing during treatment with YERVOY and for 3 months following the final dose.

Serious Adverse Reactions

In Checkmate 067, serious adverse reactions (73% and 37%), adverse reactions leading to permanent discontinuation (43% and 14%) or to dosing delays (55% and 28%), and Grade 3 or 4 adverse reactions (72% and 44%) all occurred more frequently in the OPDIVO plus YERVOY arm relative to the OPDIVO arm. The most frequent (≥10%) serious adverse reactions in the OPDIVO plus YERVOY arm and the OPDIVO arm, respectively, were diarrhea (13% and 2.6%), colitis (10% and 1.6%), and pyrexia (10% and 0.6%). In Checkmate 037, serious adverse reactions occurred in 41% of patients receiving OPDIVO. 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. 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 057, serious adverse reactions occurred in 47% of patients receiving OPDIVO. The most frequent serious adverse reactions reported in ≥2% of patients were pneumonia, pulmonary embolism, dyspnea, pleural effusion, and respiratory failure. In Checkmate 025, serious adverse reactions occurred in 47% of patients receiving OPDIVO.
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, among all patients (safety population [n=263]), adverse reactions leading to discontinuation (4.2%) or to dosing delays (23%) occurred. The most frequent serious adverse reactions reported in ≥1% of patients were infusion-related reaction, pneumonia, pleural effusion, pyrexia, rash and pneumonitis. Ten patients died from causes other than disease progression, including 6 who died from complications of allogeneic HSCT. Serious adverse reactions occurred in 21% of patients in the safety population (n=263) and 27% of patients in the subset of patients evaluated for efficacy (efficacy population [n=95]).

Common Adverse Reactions

In Checkmate 067, the most common (≥20%) adverse reactions in the OPDIVO plus YERVOY arm were fatigue (59%), rash (53%), diarrhea (52%), nausea (40%), pyrexia (37%), vomiting (28%), and dyspnea (20%). The most common (≥20%) adverse reactions in the OPDIVO arm were fatigue (53%), rash (40%), diarrhea (31%), and nausea (28%). In Checkmate 037, the most common adverse reaction (≥20%) reported with OPDIVO was rash (21%). In Checkmate 066, the most common adverse reactions (≥20%) reported with OPDIVO vs dacarbazine were fatigue (49% vs 39%), musculoskeletal pain (32% vs 25%), rash (28% vs 12%), and pruritus (23% vs 12%). In Checkmate 057, the most common adverse reactions (≥20%) reported with OPDIVO were fatigue (49%), musculoskeletal pain (36%), cough (30%), decreased appetite (29%), and constipation (23%). In Checkmate 025, the most common adverse reactions (≥20%) reported in patients receiving OPDIVO vs everolimus were asthenic conditions (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, among all patients (safety population [n=263]) and the subset of patients in the efficacy population (n=95), respectively, the most common adverse reactions (reported in at least 20%) were fatigue (32% and 43%), upper respiratory tract infection (28% and 48%), pyrexia (24% and 35%), diarrhea (23% and 30%), and cough (22% and 35%). In the subset of patients in the efficacy population (n=95), the most common adverse reactions also included rash (31%), musculoskeletal pain (27%), pruritus (25%), nausea (23%), arthralgia (21%), and peripheral neuropathy (21%).

In a separate Phase 3 study 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%).

Checkmate Trials and Patient Populations

Checkmate 069 and 067 – advanced melanoma alone or in combination with YERVOY; Checkmate 037 and 066 – advanced melanoma; Checkmate 057 – non-squamous non-small cell carcinoma (NSCLC); Checkmate 025 – renal cell carcinoma; Checkmate 205/039 – classical Hodgkin lymphoma.

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

Please see U.S. Full Prescribing Information for OPDIVO.

About Empliciti

Empliciti is an immunostimulatory antibody that specifically targets Signaling Lymphocyte Activation Molecule Family member 7 (SLAMF7), a cell-surface glycoprotein. SLAMF7 is expressed on myeloma cells independent of cytogenetic abnormalities. SLAMF7 also is expressed on Natural Killer cells, plasma cells and at lower levels on specific immune cell subsets of differentiated cells within the hematopoietic lineage.

Empliciti has a dual mechanism-of-action. It directly activates the immune system through Natural Killer cells via the SLAMF7 pathway. Empliciti also targets SLAMF7 on myeloma cells, tagging these malignant cells for Natural Killer cell-mediated destruction via antibody-dependent cellular toxicity.

On November 30, 2015, the U.S. Food and Drug Administration (FDA) approved Empliciti in combination with lenalidomide and dexamethasone in patients with multiple myeloma who have received one to three prior therapies. On May 11, 2016, the European Commission approved Empliciti in combination with lenalidomide and dexamethasone in patients with multiple myeloma who have received at least one prior therapy. The safety and efficacy of Empliciti is being evaluated by other health authorities.

Bristol-Myers Squibb and AbbVie are co-developing Empliciti; with Bristol-Myers Squibb solely responsible for commercial activities.

EMPLICITI U.S. INDICATION & IMPORTANT SAFETY INFORMATION

INDICATION

EMPLICITI™ (elotuzumab) is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received one to three prior therapies.

IMPORTANT SAFETY INFORMATION

Infusion Reactions

- EMPLICITI can cause infusion reactions. Common symptoms include fever, chills, and hypertension. Bradycardia and hypotension also developed during infusions. In the trial, 5% of patients required interruption of the administration of EMPLICITI for a median of 25 minutes due to infusion reactions, and 1% of patients discontinued due to infusion reactions. Of the patients who experienced an infusion reaction, 70% (23/33) had them during the first dose. If a Grade 2 or higher infusion reaction occurs, interrupt the EMPLICITI infusion and institute appropriate medical and supportive measures. If the infusion reaction recurs, stop the EMPLICITI infusion and do not restart it on that day. Severe infusion reactions may require permanent discontinuation of EMPLICITI therapy and emergency treatment.
• Premedicate with dexamethasone, H1 Blocker, H2 Blocker, and acetaminophen prior to infusing with EMPLICITI.

Infections

• In a clinical trial of patients with multiple myeloma (N=635), infections were reported in 81.4% of patients in the EMPLICITI with lenalidomide/dexamethasone arm (ERd) and 74.4% in the lenalidomide/dexamethasone arm (Rd). Grade 3-4 infections were 28% (ERd) and 24.3% (Rd). Opportunistic infections were reported in 22% (ERd) and 12.9% (Rd). Fungal infections were 9.7% (ERd) and 5.4% (Rd). Herpes zoster was 13.5% (ERd) and 6.9% (Rd). Discontinuations due to infections were 3.5% (ERd) and 4.1% (Rd). Fatal infections were 2.5% (ERd) and 2.2% (Rd). Monitor patients for development of infections and treat promptly.

Second Primary Malignancies

• In a clinical trial of patients with multiple myeloma (N=635), invasive second primary malignancies (SPM) were 9.1% (ERd) and 5.7% (Rd). The rate of hematologic malignancies were the same between ERd and Rd treatment arms (1.6%). Solid tumors were reported in 3.5% (ERd) and 2.2% (Rd). Skin cancer was reported in 4.4% (ERd) and 2.8% (Rd). Monitor patients for the development of SPMs.

Hepatotoxicity

• Elevations in liver enzymes (AST/ALT greater than 3 times the upper limit, total bilirubin greater than 2 times the upper limit, and alkaline phosphatase less than 2 times the upper limit) consistent with hepatotoxicity were 2.5% (ERd) and 0.6% (Rd). Two patients experiencing hepatotoxicity discontinued treatment; however, 6 out of 8 patients had resolution and continued treatment. Monitor liver enzymes periodically. Stop EMPLICITI upon Grade 3 or higher elevation of liver enzymes. After return to baseline values, continuation of treatment may be considered.

Interference with Determination of Complete Response

• EMPLICITI is a humanized IgG kappa monoclonal antibody that can be detected on both the serum protein electrophoresis and immunofixation assays used for the clinical monitoring of endogenous M-protein. This interference can impact the determination of complete response and possibly relapse from complete response in patients with IgG kappa myeloma protein.

Pregnancy/Females and Males of Reproductive Potential

• There are no studies with EMPLICITI with pregnant women to inform any drug associated risks.

• There is a risk of fetal harm, including severe life-threatening human birth defects associated with lenalidomide and it is contraindicated for use in pregnancy. Refer to the lenalidomide full prescribing information for requirements regarding contraception and the prohibitions against blood and/or sperm donation due to presence and transmission in blood and/or semen and for additional information.

Adverse Reactions

• Infusion reactions were reported in approximately 10% of patients treated with EMPLICITI with lenalidomide and dexamethasone. All reports of infusion reaction were Grade 3 or lower. Grade 3 infusion reactions occurred in 1% of patients.

• Serious adverse reactions were 65.4% (ERd) and 56.5% (Rd). The most frequent serious adverse reactions in the ERd arm compared to the Rd arm were: pneumonia (15.4%, 11%), pyrexia (6.9%, 4.7%), respiratory tract infection (3.1%, 1.3%), anemia (2.8%, 1.9%), pulmonary embolism (3.1%, 2.5%), and acute renal failure (2.5%, 1.9%).

• The most common adverse reactions in ERd and Rd, respectively (>20%) were fatigue (61.6%, 51.7%), diarrhea (46.9%, 36.0%), pyrexia (37.4%, 24.6%), constipation (35.5%, 27.1%), cough (34.3%, 18.9%), peripheral neuropathy (26.7%, 20.8%), nasopharyngitis (24.5%, 19.2%), upper respiratory tract infection (22.6%, 17.4%), decreased appetite (20.8%, 12.6%), and pneumonia (20.1%, 14.2%).

Please see the full Prescribing Information for Empliciti.

About Sprycel

Sprycel was first approved by the FDA in 2006 for the treatment of adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase (CP) who are resistant or intolerant to prior therapy including imatinib. At that time, Sprycel was also approved for adults with Ph+ acute lymphoblastic leukemia (ALL) who are resistant or intolerant to prior therapy. It is the first and only BCR-ABL kinase inhibitor with survival data in its label for CP Ph+ CML patients who are resistant or intolerant to Gleevec (imatinib mesylate). Sprycel is approved and marketed worldwide for these indications in more than 60 countries.

Sprycel is also an FDA-approved treatment for adults with newly diagnosed CP Ph+ CML (since October 2010). Sprycel received accelerated FDA approval for this indication. Additional country approvals for this indication total more than 50.

SPRYCEL U.S. INDICATIONS & IMPORTANT SAFETY INFORMATION

INDICATIONS

SPRYCEL® (dasatinib) is indicated for the treatment of adults with:

• Newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase.

• Chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib.
Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy.

**IMPORTANT SAFETY INFORMATION**

**Myelosuppression:**
Treatment with SPRYCEL is associated with severe (NCI CTC Grade 3/4) thrombocytopenia, neutropenia, and anemia, which occur earlier and more frequently in patients with advanced phase CML or Ph+ ALL than in patients with chronic phase CML. Myelosuppression was reported in patients with normal baseline laboratory values as well as in patients with pre-existing laboratory abnormalities.

- In patients with chronic phase CML, perform complete blood counts (CBCs) every 2 weeks for 12 weeks, then every 3 months thereafter, or as clinically indicated
- In patients with advanced phase CML or Ph+ ALL, perform CBCs weekly for the first 2 months and then monthly thereafter, or as clinically indicated
- Myelosuppression is generally reversible and usually managed by withholding SPRYCEL temporarily and/or dose reduction
  - In clinical studies, myelosuppression may have also been managed by discontinuation of study therapy
  - Hematopoietic growth factor has been used in patients with resistant myelosuppression

**Bleeding-Related Events:**
SPRYCEL caused thrombocytopenia in human subjects. In addition, dasatinib caused platelet dysfunction in vitro. In all CML or Ph+ ALL clinical studies, ≥grade 3 central nervous system (CNS) hemorrhages, including fatalities, occurred in <1% of patients receiving SPRYCEL. Grade 3 or greater gastrointestinal hemorrhage, including fatalities, occurred in 4% of patients and generally required treatment interruptions and transfusions. Other cases of ≥grade 3 hemorrhage occurred in 2% of patients.

- Most bleeding events in clinical studies were associated with severe thrombocytopenia
- Concomitant medications that inhibit platelet function or anticoagulants may increase the risk of hemorrhage

**Fluid Retention:**
SPRYCEL may cause fluid retention. After 5 years of follow-up in the randomized newly diagnosed chronic phase CML study (n=258), grade 3/4 fluid retention was reported in 5% of patients, including 3% of patients with grade 3/4 pleural effusion. In patients with newly diagnosed or imatinib resistant or intolerant chronic phase CML, grade 3/4 fluid retention occurred in 6% of patients treated with SPRYCEL at the recommended dose (n=548). In patients with advanced phase CML or Ph+ ALL treated with SPRYCEL at the recommended dose (n=304), grade 3/4 fluid retention was reported in 8% of patients, including grade 3/4 pleural effusion reported in 7% of patients.

- Patients who develop symptoms of pleural effusion or other fluid retention, such as new or worsened dyspnea on exertion or at rest, pleuritic chest pain, or dry cough should be evaluated promptly with a chest x-ray or additional diagnostic imaging as appropriate
- Fluid retention events were typically managed by supportive care measures that may include diuretics or short courses of steroids
- Severe pleural effusion may require thoracentesis and oxygen therapy
- Consider dose reduction or treatment interruption

**Cardiovascular Events:**
After 5 years of follow-up in the randomized newly diagnosed chronic phase CML trial (n=258), the following cardiac adverse events occurred:

- Cardiac ischemic events (3.9% dasatinib vs 1.6% imatinib), cardiac related fluid retention (8.5% dasatinib vs 3.9% imatinib), and conduction system abnormalities, most commonly arrhythmia and palpitations (7.0% dasatinib vs 5.0% imatinib). Two cases (0.8%) of peripheral arterial occlusive disease occurred with imatinib and 2 (0.8%) transient ischemic attacks occurred with dasatinib

Monitor patients for signs or symptoms consistent with cardiac dysfunction and treat appropriately.

**Pulmonary Arterial Hypertension (PAH):**
SPRYCEL may increase the risk of developing PAH, which may occur any time after initiation, including after more than 1 year of treatment. Manifestations include dyspnea, fatigue, hypoxia, and fluid retention. PAH may be reversible on discontinuation of SPRYCEL.

- Evaluate patients for signs and symptoms of underlying cardiopulmonary disease prior to initiating SPRYCEL and during treatment. If PAH is confirmed, SPRYCEL should be permanently discontinued

**QT Prolongation:**
*In vitro* data suggest that dasatinib has the potential to prolong cardiac ventricular repolarization (QT interval).

- In clinical trials of patients treated with SPRYCEL at all doses (n=2440), 16 patients (<1%) had QTc prolongation
Twenty-two patients (1%) experienced a QTcF >500 ms in 865 patients with leukemia treated with SPRYCEL in five Phase 2 single-arm studies, the maximum mean changes in QTcF (90% upper bound CI) from baseline ranged from 7.0 to 13.4 ms. SPRYCEL may increase the risk of prolongation of QTc in patients including those with hypokalemia or hypomagnesemia, patients with congenital long QT syndrome, patients taking antiarrhythmic medicines or other medicinal products that lead to QT prolongation, and cumulative high-dose anthracycline therapy. Correct hypokalemia or hypomagnesemia prior to and during SPRYCEL administration.

Severe Dermatologic Reactions:
Cases of severe mucocutaneous dermatologic reactions, including Stevens-Johnson syndrome and erythema multiforme, have been reported in patients treated with SPRYCEL.

Tumor Lysis Syndrome (TLS):
TLS has been reported in patients with resistance to prior imatinib therapy, primarily in advanced phase disease.

Embryo-Fetal Toxicity:
Based on limited human data, SPRYCEL can cause fetal harm when administered to a pregnant woman. Hydrops fetalis, fetal leukopenia and fetal thrombocytopenia have been reported with maternal exposure to SPRYCEL. Transplacental transfer of dasatinib has been measured in fetal plasma and amniotic fluid at concentrations comparable to those in maternal plasma. Advise females of reproductive potential to avoid pregnancy, which may include the use of effective contraception, during treatment with SPRYCEL and for 30 days after the final dose.

Lactation:
No data are available regarding the presence of dasatinib in human milk, the effects of the drug on the breastfed infant or the effects of the drug on milk production. However, dasatinib is present in the milk of lactating rats. Because of the potential for serious adverse reactions in nursing infants from SPRYCEL, breastfeeding is not recommended during treatment with SPRYCEL and for 2 weeks after the final dose.

Drug Interactions:
SPRYCEL is a CYP3A4 substrate and a weak time-dependent inhibitor of CYP3A4.

- **CYP3A4 inhibitors:** Concomitant use of SPRYCEL and drugs that inhibit CYP3A4 should be avoided. If administration of a potent CYP3A4 inhibitor cannot be avoided, close monitoring for toxicity and a SPRYCEL dose reduction should be considered.

- **Strong CYP3A4 inhibitors** (eg, ketoconazole, itraconazole, clarithromycin, atazanavir, indinavir, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, voriconazole). If SPRYCEL must be administered with a strong CYP3A4 inhibitor, a dose decrease or temporary discontinuation should be considered.

- **Grapefruit juice** may also increase plasma concentrations of SPRYCEL and should be avoided.

- **CYP3A4 inducers:** If SPRYCEL must be administered with a CYP3A4 inducer, a dose increase in SPRYCEL should be considered.

- **Strong CYP3A4 inducers** (eg, dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, phenobarbital) should be avoided. Alternative agents with less enzyme induction potential should be considered. If the dose of SPRYCEL is increased, the patient should be monitored carefully for toxicity.

- **St John’s Wort** may decrease SPRYCEL plasma concentrations unpredictably and should be avoided.

- **Antacids** may decrease SPRYCEL drug levels. Simultaneous administration of SPRYCEL and antacids should be avoided. If antacid therapy is needed, the antacid dose should be administered at least 2 hours prior to or 2 hours after the dose of SPRYCEL.

- **H2 antagonists/proton pump inhibitors** (eg, famotidine and omeprazole): Long-term suppression of gastric acid secretion by use of H2 antagonists or proton pump inhibitors is likely to reduce SPRYCEL exposure. Therefore, concomitant use of H2 antagonists or proton pump inhibitors with SPRYCEL is not recommended.

- **Drugs that may have their plasma concentration altered by SPRYCEL are:**
CYP3A4 substrates (e.g., simvastatin) with a narrow therapeutic index should be administered with caution in patients receiving SPRYCEL.

**Adverse Reactions:**

The safety data reflects exposure to SPRYCEL at all doses tested in clinical studies including 324 patients with newly diagnosed chronic phase CML and 2388 patients with imatinib resistant or intolerant chronic or advanced phase CML or Ph+ ALL.

The median duration of therapy in all 2712 SPRYCEL-treated patients was 19.2 months (range 0–93.2 months). Median duration of therapy in:

- 1618 patients with chronic phase CML was 29 months (range 0–92.9 months)
- 1094 patients with advanced phase CML or Ph+ ALL was 6.2 months (range 0–93.2 months)

In the newly diagnosed chronic phase CML trial, after a minimum of 60 months of follow-up, the cumulative discontinuation rate for 258 patients was 39%.

In the overall population of 2712 SPRYCEL-treated patients, 88% of patients experienced adverse reactions at some time and 19% experienced adverse reactions leading to treatment discontinuation.

Among the 1618 SPRYCEL-treated patients with chronic phase CML, drug-related adverse events leading to discontinuation were reported in 329 (20.3%) patients.

- In the newly diagnosed chronic phase CML trial, drug was discontinued for adverse reactions in 16% of SPRYCEL-treated patients with a minimum of 60 months of follow-up.

Among the 1094 SPRYCEL-treated patients with advanced phase CML or Ph+ ALL, drug-related adverse events leading to discontinuation were reported in 191 (17.5%) patients.

Patients ≥65 years are more likely to experience the commonly reported adverse reactions of fatigue, pleural effusion, diarrhea, dyspnea, cough, lower gastrointestinal hemorrhage, and appetite disturbance, and more likely to experience the less frequently reported adverse reactions of abdominal distention, dizziness, pericardial effusion, congestive heart failure, hypertension, pulmonary edema and weight decrease, and should be monitored closely.

- In newly diagnosed chronic phase CML patients:
  - Drug-related serious adverse events (SAEs) were reported for 16.7% of SPRYCEL-treated patients. Serious adverse reactions reported in ≥5% of patients included pleural effusion (5%) and myelosuppression, fluid retention, and diarrhea.
  - Grade 3/4 laboratory abnormalities included neutropenia (29%), thrombocytopenia (22%), anemia (13%), hypophosphatemia (7%), hypocalcemia (4%), elevated bilirubin (1%), and elevated creatinine (1%).

- In patients resistant or intolerant to prior imatinib therapy:
  - Drug-related SAEs were reported for 26.1% of SPRYCEL-treated patients treated at the recommended dose of 100 mg once daily in the randomized dose-optimization trial of patients with chronic phase CML resistant or intolerant to prior imatinib therapy. Serious adverse reactions reported in ≥5% of patients included pleural effusion (10%).
  - The most common adverse reactions (≥15%) included myelosuppression, fluid retention events, diarrhea, headache, fatigue, dyspnea, skin rash, nausea, hemorrhage and musculoskeletal pain.
  - Grade 3/4 hematologic laboratory abnormalities in chronic phase CML patients resistant or intolerant to prior imatinib therapy who received SPRYCEL 100 mg once daily with a minimum follow up of 60 months included: neutropenia (36%), thrombocytopenia (24%), and anemia (13%). Other grade 3/4 laboratory abnormalities included: hypophosphatemia (10%), and hypokalemia (2%).
  - Among chronic phase CML patients with resistance or intolerance to prior imatinib therapy, cumulative grade 3/4 cytopenias were similar at 2 and 5 years including: neutropenia (36% vs 36%), thrombocytopenia (23% vs 24%), and anemia (13% vs 13%).
  - Grade 3/4 elevations of transaminases or bilirubin and Grade 3/4 hypocalcemia, hypokalemia, and hypophosphatemia were reported in patients with all phases of CML.
  - Elevations in transaminases or bilirubin were usually managed with dose reduction or interruption.
  - Patients developing Grade 3/4 hypocalcemia during the course of SPRYCEL therapy often had recovery with oral calcium supplementation.

Please see the full Prescribing Information [here](#).

**About the Bristol-Myers Squibb and Ono Pharmaceutical Co., Ltd. Collaboration**

In 2011, through a collaboration agreement with Ono Pharmaceutical Co., Ltd (Ono), 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, Bristol-Myers Squibb and Ono 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 and Facebook.

Bristol-Myers Squibb Forward-Looking Statement

This press release contains “forward-looking statements” as that term is defined in the Private Securities Litigation Reform Act of 1995 regarding the research, development and commercialization of pharmaceutical products. Such forward-looking statements are based on current expectations and involve inherent risks and uncertainties, including factors that could delay, divert or change any of them, and could cause actual outcomes and results to differ materially from current expectations. No forward-looking statement can be guaranteed. Forward-looking statements in this press release should be evaluated together with the many uncertainties that affect Bristol-Myers Squibb’s business, particularly those identified in the cautionary factors discussion in Bristol-Myers Squibb’s Annual Report on Form 10-K for the year ended December 31, 2015 in our Quarterly Reports on Form 10-Q and our Current Reports on Form 8-K. Bristol-Myers Squibb undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise.

Language:
English

Contact:
Bristol-Myers Squibb
Media Inquiries:
Kirby Hosea, 609-419-5071
kirby.hosea@bms.com
or
Investors:
Ranya Dajani, 609-252-5330
ranya.dajani@bms.com
or
Bill Szablewski, 609-252-5894
william.szablewski@bms.com

Ticker Slug:
Ticker: BMY
Exchange: NYSE
@bmsnews

Bristol-Myers Squibb presents data across multiple blood cancers at #EHA16