First analysis from Phase 3 CheckMate -227 Part 1b in first-line non-small cell lung cancer, assessing Opdivo plus chemotherapy and Opdivo plus Yervoy versus chemotherapy in patients with PD-L1 <1%

Updated data from Phase 3 CheckMate -238 study of Opdivo as adjuvant treatment in Stage III/IV melanoma will further explore potential durability of recurrence-free survival

Seven BMS compounds to be featured in presentations spanning more than 20 types of cancer

PRINCETON, N.J.--(BUSINESS WIRE)---Bristol-Myers Squibb Company (NYSE:BMY) today announced that data from over 70 Company-sponsored studies and collaborations evaluating its oncology compounds across more than 20 types of cancer will be featured at the American Society of Clinical Oncology (ASCO) Annual Meeting 2018 in Chicago from June 1-5. Presentations will report data from clinical trials highlighting the potential role of Immuno-Oncology (I-O)-based combinations, including translational research to help identify patient populations that may have the potential to benefit from I-O therapy. Additional findings include patient-reported outcomes and real-world data.

Key data from Company-sponsored studies and supported research include:

Bristol-Myers Squibb Oral Abstracts

- Nivolumab plus platinum-doublet chemotherapy vs chemo as first-line treatment for advanced non-small cell lung cancer with <1% tumor PD-L1 expression: results from CheckMate -227
  Author: H. Borghaei
  Abstract #9001
  Oral Abstract Session: Lung Cancer—Non-Small Cell Metastatic
  Monday, June 4, 3:12-3:24 PM CDT, Hall B1

- NKTR-214 (CD122-biased agonist) plus nivolumab in patients with advanced solid tumors: Preliminary Phase 1/2 results of PIVOT
  Author: A. Diab
  Abstract #3006
  Oral Abstract Session: Developmental Therapeutics—Immunotherapy
  Saturday, June 2, 5-5:12 PM CDT, Hall B1

- Adjuvant therapy with nivolumab vs ipilimumab after complete resection of stage III/IV melanoma: Updated results from a Phase 3 trial (CheckMate -238)
  Author: J. Weber
  Abstract #9502
  Oral Abstract Session: Melanoma/Skin Cancers
  Monday, June 4, 8:24-8:36 AM CDT, Arie Crown Theater
Nivolumab as neoadjuvant therapy in patients with resectable Merkel cell carcinoma in CheckMate-358
Author: S. Topalian
Abstract #9505
Oral Abstract Session: Melanoma/Skin Cancers
Monday, June 4, 9:48-10 AM CDT, Arie Crown Theater

Adaptive Phase 2 randomized trial of nivolumab after induction treatment in triple negative breast cancer (TOMIC Trial): Final response data stage I and first translational data
Author: M. Kok
Abstract #1012
Clinical Science Symposium Session: Breast Cancer Immunotherapy: Can we Crack the Code?
Monday June 4, 3:48-4 PM CDT, Hall D2

New / Early Assets and Translational Medicine

BMS-986205, an indoleamine 2,3-dioxygenase 1 inhibitor (IDO1i), in combination with nivolumab: Updated safety across all tumor cohorts and efficacy in patients with advanced bladder cancer
Author: J. Tabernero
Abstract #4512
Poster Discussion Session: Genitourinary (Nonprostate) Cancer
Saturday, June 2, 8-11:30 AM CDT, Hall A, Poster Board #338
Discussed at the Poster Discussion Session on Saturday, June 2, 1:15-2:30 PM CDT, Hall D2

Phase 1 trial of BMS-986253, an anti-IL-8 monoclonal antibody in patients with metastatic or unresectable solid tumors
Author: J. Collins
Abstract #3091
Poster Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #305

Serum interleukin 8 (IL-8) may serve as a biomarker of response to Immuno-Oncology therapy
Author: M. Carleton
Abstract #3025
Poster Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #239

Phase 1, open-label, adaptive biomarker trial that informs the evolution of combination Immuno-Oncology therapies (ADVISE), a precision I-O approach to personalized medicine
Author: J. Luke
Abstract #TPS3101
Poster Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #319a

Phase 1b/2 study of nivolumab in combination with an anti-IL-8 monoclonal antibody, BMS-986253, in a biomarker-enriched population of patients with advanced cancer
Author: I. Melero
Abstract #TPS3109
Poster Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #319a

Pharmacodynamics and genomic profiling of patients treated with cabiralizumab plus nivolumab provide evidence of on-target tumor immune modulations and support future clinical applications
Author: M. Carleton
Abstract #3020
Poster Discussion Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #234
Discussed at the Poster Discussion Session on Monday, June 4, 11:30 AM-12:45 PM CDT, Hall B1

Head and Neck

Nivolumab vs investigator’s choice in patients with recurrent or metastatic squamous cell carcinoma of the head and neck: Analysis of CheckMate -141 by age
Author: N. Saba
Abstract #6028
Poster Session: Head and Neck Cancer
Saturday, June 2, 1:15-4:45 PM CDT, Hall A, Poster Board #16

Hematology

Extended 5-y follow-up of Phase 3 ELOQUENT-2 study of elotuzumab plus lenalidomide/dexamethasone (ELd) vs Ld in relapsed/refractory multiple myeloma
Author: S. Lonial
Abstract #8040
Poster Session: Hematologic Malignancies—Plasma Cell Dyscrasia
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #49

Genitourinary
A Phase 3, randomized, open-label study of nivolumab combined with cabozantinib vs sunitinib in patients with previously untreated advanced or metastatic renal cell carcinoma (CheckMate -9ER)
Author: T. Choueiri
Abstract #TPS4598
Poster Session: Genitourinary (Nonprostate) Cancer
Saturday, June 2, 8-11:30 AM CDT, Hall A, Poster Board #41a

A Phase 3, open-label, randomized study of nivolumab plus ipilimumab or standard of care vs SoC alone in patients with previously untreated unresectable or metastatic urothelial carcinoma (CheckMate -901)
Author: M. Galsky
Abstract #TPS4588
Poster Session: Genitourinary (Nonprostate) Cancer
Saturday, June 2, 8-11:30 AM CDT, Hall A, Poster Board #413a

Quality of life in patients with advanced renal cell carcinoma in the randomized, open-label CheckMate -214 trial
Author: D. Cella
Abstract #3073
Poster Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #287

An open-label, Phase 2 study of nivolumab in combination with either rucaparib, docetaxel, or enzalutamide in men with castration-resistant metastatic prostate cancer (CheckMate -9KD)
Author: K. Fizazi
Abstract #TPS3126
Poster Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #327b

Efficacy and safety of nivolumab in patients with advanced or recurrent uterine cervical or corpus cancers
Author: K. Hasegawa
Abstract #5594
Poster Session: Gynecologic Cancer
Monday, June 4, 1:15-4:45 PM CDT, Hall A, Poster Board #321

Lung Cancer

Nivolumab plus ipilimumab vs platinum-doublet chemotherapy as first-line treatment for advanced non-small cell lung cancer: Safety analysis and patient-reported outcomes from CheckMate -227
Author: M. Reck
Abstract #9020
Poster Discussion Session: Lung Cancer—Non-Small Cell Metastatic
Sunday, June 3, 8-11:30 AM CDT, Hall A, Poster Board #343
Discussed at the Poster Discussion Session on Sunday, June 3, 11:30 AM-12:45 PM CDT, Arie Crown Theater

Immuno-oncology biomarker study in a large cohort of LC-SCRUM-Japan: Assessment of PD-L1 expression and tumor mutation burden in non-small cell lung cancer patients treated with immune checkpoint inhibitors
Author: K. Yoh
Abstract #9070
Poster Session: Lung Cancer—Non-Small Cell Metastatic
Sunday, June 3, 8-11:30 AM CDT, Hall A, Poster Board #393

Phase 1b trial of nivolumab combined with metformin for refractory/recurrent solid tumors
Author: T. Kubo
Abstract #TPS3119
Poster Session: Developmental Therapeutics—Immunotherapy
Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #324a

Melanoma

Treatment-free survival, a novel outcome applied to Immuno-Oncology agents in advanced melanoma
Author: M. Regan
Abstract #9531
Poster Session: Melanoma/Skin Cancers
Monday, June 4, 1:15-4:15 PM CDT, Hall A, Poster Board #358

Clinical and economic outcomes associated with sequential treatment in BRAF mutant advanced melanoma patients
Author: A. Tarhini
Abstract #9538
Poster Session: Melanoma/Skin Cancers
Monday, June 4, 1:15-4:15 PM CDT, Hall A, Poster Board #365

Indirect treatment comparison of nivolumab vs placebo as an adjuvant therapy for resected melanoma
Author: A. Shoushtari
Abstract #9593
Poster Session: Melanoma/Skin Cancers
Monday, June 4, 1:15-4:15 PM CDT, Hall A, Poster Board #420

- **Assessing the value of nivolumab vs placebo and ipilimumab as adjuvant therapy for resected melanoma**
  Author: M. Freeman
  Abstract #9594
  Poster Session: Melanoma/Skin Cancers
  Monday, June 4, 1:15-4:15 PM CDT, Hall A, Poster Board #421

**Clinical Collaborations**

- **Anti-CD27 Agonist antibody varilumab with nivolumab for colorectal and ovarian cancer: Phase 1/2 clinical trial results**
  Author: R. Sanborn
  Abstract #3001
  Oral Abstract Session: Developmental Therapeutics—Immunotherapy
  Saturday, June 2, 3:12-3:24 PM CDT, Hall B1

- **Correlation of degree of tumor immune infiltration and insertion-and-deletion burden with outcome on PD-1 therapy in advanced renal cell cancer**
  Author: M. Voss
  Abstract #4518
  Poster Discussion Session: Genitourinary (Nonprostate) Cancer
  Saturday, June 2, 1:15-2:30 PM CDT, Hall D2
  Discussed at the Poster Discussion Session on Saturday, June 2, 1:15-2:30 PM CDT, Hall D2

- **Profiling the immune checkpoint pathway in acute myeloid leukemia**
  Author: P. Dama
  Abstract #7015
  Poster Session: Hematologic Malignancies—Leukemia, Myelodysplastic Syndromes, and Allotransplant
  Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #75
  Discussed at the Poster Discussion Session on Monday, June 4, 11:30 AM-12:45 PM CDT, E450

- **Initial results from first-in-human study of IPI-549, a tumor macrophage targeting agent, combined with nivolumab in advanced solid tumors**
  Author: R. Sullivan
  Abstract #3013
  Poster Session: Developmental Therapeutics—Immunotherapy
  Monday, June 4, 8-11:30 AM CDT, Hall A
  Discussed at the Poster Discussion Session on Monday, June 4, 11:30 AM-12:45 PM CDT, Hall B1

- **Veliparib in combination with nivolumab and platinum doublet chemotherapy in metastatic/advanced NSCLC**
  Author: J. Clarke
  Abstract #3061
  Poster Session: Developmental Therapeutics—Immunotherapy
  Monday, June 4, 8-11:30 AM CDT, Hall A, Poster Board #275

- **Epacadostat plus nivolumab for advanced melanoma: Updated phase 2 results of the ECHO-204 study**
  Author: A. Daud
  Abstract #9511
  Poster Session: Melanoma/Skin Cancers
  Monday, June 4, 1:15-4:15 PM CDT, Hall A, Poster Board #338
  Discussed at the Poster Discussion Session on Monday, June 4, 2018, 4:45-6 PM CDT, E451

- **A Phase 1 study of concomitant galinpepimut-s in combination with nivolumab in patients with WT1+ ovarian cancer in second or third remission**
  Author: R. O'Cearbhan
  Abstract #5553
  Poster Session: Gynecologic Cancer
  Monday, June 4, 1:15-4:45 PM CDT, Hall A, Poster Board #280

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

At Bristol-Myers Squibb, patients are at the center of everything we do. Our vision for the future of cancer care is focused on researching and developing transformational medicines, including Immuno-Oncology (I-O) therapeutic approaches, for hard-to-treat cancers that could potentially improve outcomes for these patients.

We are leading the integrated scientific understanding of both tumor cell and immune system pathways, through our extensive portfolio of investigational compounds and approved agents. Our differentiated clinical development program is studying broad patient populations across more than 50 types of cancers with 24 clinical-stage molecules designed to target different immune system pathways. Our deep expertise and innovative clinical trial designs position us to advance the I-O, I-O/chemotherapy, I-O/targeted therapies and I-O radiation therapies across multiple tumors and potentially deliver the next wave of therapies with a sense of urgency. We also continue to pioneer research that will help facilitate a deeper understanding of the role of immune biomarkers and how a patient’s tumor biology can be used as a guide for treatment decisions throughout their journey.
We understand making the promise of transformational medicines like I-O therapies a reality for the many patients who may benefit from these therapies requires not only innovation on our part but also close collaboration with leading experts in the field. Our partnerships with academia, government, advocacy and biotech companies support our collective goal of providing new treatment options to advance the standards of clinical practice.

**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 enrolled more than 25,000 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 60 countries, including the United States, the European Union and Japan. 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.

**INDICATIONS**

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 the confirmatory trials.

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

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 the 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 anti-angiogenic therapy.

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

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

OPDIVO® (nivolumab) is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. This indication is approved under accelerated approval based on tumor 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) is indicated for the treatment of adult and pediatric (12 years and older) patients with microsatellite instability high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (CRC) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

OPDIVO® (nivolumab) 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 tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

OPDIVO® (nivolumab) is indicated for the adjuvant treatment of patients with melanoma with involvement of lymph nodes or metastatic disease who have undergone complete resection.

OPDIVO® (10 mg/mL) is an injection for intravenous (IV) use.

**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 patients receiving **OPDIVO** 1 mg/kg with **YERVOY** 3 mg/kg, immune-mediated pneumonitis occurred in 6% (25/407) of patients. In patients receiving **OPDIVO** 3 mg/kg with **YERVOY** 1 mg/kg, immune-mediated pneumonitis occurred in 4.4% (24/547) of patients.

In Checkmate 205 and 039, pneumonitis, including interstitial lung disease, occurred in 6.0% (162/266) of patients receiving **OPDIVO**. Immune-mediated pneumonitis occurred in 4.9% (13/266) of patients receiving **OPDIVO**: Grade 3 (n=1) and Grade 2 (n=12).

**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% (58/2073) of patients. In 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 patients receiving **OPDIVO** 3 mg/kg with **YERVOY** 1 mg/kg, immune-mediated colitis occurred in 10% (52/547) 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**

**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 5 times ULN at baseline and increases to >B and up to 10 times the ULN. 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 patients receiving **OPDIVO** 1 mg/kg with **YERVOY** 3 mg/kg, immune-mediated hepatitis occurred in 13% (51/407) of patients. In patients receiving **OPDIVO** 3 mg/kg with **YERVOY** 1 mg/kg, immune-mediated hepatitis occurred in 7% (38/547) of patients.

In Checkmate 040, immune-mediated hepatitis requiring systemic corticosteroids occurred in 5% (8/154) of patients receiving **OPDIVO**.

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 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**

**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 patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, hypophysitis occurred in 9% (36/407) of patients. In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, hypophysitis occurred in 4.6% (25/547) of patients. In patients receiving OPDIVO monotherapy, adrenal insufficiency occurred in 1% (20/1994) of patients. In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, adrenal insufficiency occurred in 5% (21/407) of patients. In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, adrenal insufficiency occurred in 7% (41/547) 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 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 patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, hypothyroidism or thyroiditis occurred in 1% (20/1994) of patients receiving OPDIVO monotherapy. In patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, diabetes occurred in 2% (119/547) of patients. Hyperthyroidism occurred in 12% (66/547) of patients receiving this dose of OPDIVO with YERVOY. In patients receiving OPDIVO monotherapy, diabetes occurred in 0.9% (17/1994) of patients. In patients receiving OPDIVO 1 mg/kg with YERVOY 1 mg/kg, diabetes occurred in 1.5% (6/407) of patients. In 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 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

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% (22/1994) of patients. In 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 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.

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 Grade 3 or 4 rash. Withhold OPDIVO for Grade 3 and permanently discontinue for Grade 4 rash. For symptoms or signs of SJS or TEN, 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 patients receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg, immune-mediated rash occurred in 22.6% (92/407) of patients. In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, immune-mediated rash occurred in 16.6% (91/547) of patients.

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 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 in one patient receiving OPDIVO 1 mg/kg with YERVOY 3 mg/kg (0.2%) after approximately 4 months of exposure. Encephalitis occurred in one patient receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg (0.2%) after approximately 4 months 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, polymyositis and myositis, autoimmune neuropathy, Guillain-Barré syndrome, hypophysitis, 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 Reactions

OPDIVO can cause severe infusion reactions, which have been reported in <1.0% of patients in clinical trials. 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 patients receiving OPDIVO monotherapy as a 60-minute infusion, infusion-related reactions occurred in 6.4% (127/1994) of patients. In a separate study 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 patients receiving OPDIVO 1 mg/kg with ipilimumab 3
mg/kg every 3 weeks, infusion-related reactions occurred in 2.5% (10/407) of patients. In patients receiving OPDIVO 3 mg/kg with YERVOY 1 mg/kg, infusion-related reactions occurred in 5.1% (28/547) of patients.

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 HSCT 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 breastfeeding during treatment with YERVOY and for 3 months following the final dose.

Serious Adverse Reactions

In Checkmate 037, serious adverse reactions occurred in 41% of patients receiving OPDIVO (n=268). Grade 3 and 4 adverse reactions occurred in 42% of patients receiving OPDIVO . The most frequent Grade 3 and 4 adverse drug reactions reported in 2% to <5% of patients receiving OPDIVO were abdominal pain, hyponatremia, increased aspartate aminotransferase, and increased lipase. In Checkmate 066, serious adverse reactions occurred in 36% of patients receiving OPDIVO (n=206). Grade 3 and 4 adverse reactions occurred in 41% of patients receiving OPDIVO. The most frequent Grade 3 and 4 adverse reactions reported in ≥2% of patients receiving OPDIVO were gamma-glutamyltransferase increase (3.9%) and diarhoea (3.4%). 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 (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 diarhoea (13% and 2.6%), colitis (10% and 1.6%), and pyrexia (10% and 0.6%). In Checkmate 017 and 057, serious adverse reactions occurred in 46% of patients receiving OPDIVO (n=418). The most frequent serious adverse reactions reported in at least 2% of patients receiving OPDIVO were pneumonia, pulmonary embolism, dyspnea, pyrexia, pleural effusion, pneumonitis, and respiratory failure. In Checkmate 025, serious adverse reactions occurred in 47% of patients receiving OPDIVO (n=416). The most frequent serious adverse reactions reported in at least 2% of patients receiving OPDIVO were pneumonia, pulmonary embolism, dyspnea, pyrexia, pleural effusion, pneumonitis, and respiratory failure. In Checkmate 141, serious adverse reactions occurred in 49% of patients receiving OPDIVO (n=236). The most frequent serious adverse reactions reported in at least 2% of patients receiving OPDIVO were pneumonia, dyspnea, respiratory failure, urinary tract infection, and sepsis. In Checkmate 275, serious adverse reactions occurred in 54% of patients receiving OPDIVO (n=270). The most frequent serious adverse reactions reported in at least 2% of patients receiving OPDIVO were pneumonia, dyspnea, respiratory failure, urinary tract infection, and sepsis.

Complications of Allogeneic HSCT after OPDIVO

In Checkmate 037, the most common serious adverse reaction (≥20%) reported with OPDIVO (n=268) was rash (21%). In Checkmate 066, the most common adverse reaction (≥20%) reported with OPDIVO (n=206) vs dacarbazine (n=205) were fatigue (49% vs 39%), musculoskeletal pain (32% vs 25%), rash (28% vs 12%), and pruritus (23% vs 12%). In Checkmate 067, the most
common (≥20%) adverse reactions in the OPDIVO plus YERVOY arm (n=313) 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 (n=313) arm were fatigue (53%), rash (40%), diarrhea (31%), and nausea (28%). In Checkmate 017 and 057, the most common adverse reactions (≥20%) in patients receiving OPDIVO (n=418) were fatigue, musculoskeletal pain, cough, dyspnea, and decreased appetite. In Checkmate 025, the most common adverse reactions (≥20%) reported in patients receiving OPDIVO (n=406) vs everolimus (n=397) were fatigue (56% vs 57%), cough (34% vs 38%), nausea (28% vs 29%), rash (28% vs 36%), dyspnea (27% vs 31%), diarrhea (25% vs 32%), constipation (23% vs 18%), decreased appetite (23% vs 30%), back pain (21% vs 16%), and arthralgia (20% vs 14%). In Checkmate 214, the most common adverse reactions (≥20%) reported in patients treated with OPDIVO plus YERVOY (n=547) vs sunitinib (n=535) were fatigue (58% vs 69%), rash (39% vs 25%), diarrhea (38% vs 56%), musculoskeletal pain (37% vs 40%), pruritus (33% vs 11%), nausea (30% vs 43%), cough (28% vs 25%), pyrexia (25% vs 17%), arthralgia (23% vs 16%), and decreased appetite (21% vs 29%). In Checkmate 205 and 039, the most common adverse reactions (≥20%) reported in patients receiving OPDIVO (n=266) were upper respiratory tract infection (44%), fatigue (39%), cough (36%), diarrhea (33%), pyrexia (29%), musculoskeletal pain (26%), rash (24%), nausea (20%) and pruritus (20%). In Checkmate 141, the most common adverse reactions (≥10%) in patients receiving OPDIVO (n=236) were cough and dyspnea at a higher incidence than investigator’s choice. In Checkmate 275, the most common adverse reactions (≥20%) reported in patients receiving OPDIVO (n=270) were fatigue (46%), musculoskeletal pain (30%), nausea (22%), and decreased appetite (22%). In Checkmate 040, the most common adverse reactions (≥20%) in patients receiving OPDIVO (n=154) were fatigue (38%), musculoskeletal pain (36%), abdominal pain (34%), pruritus (27%), diarrhea (27%), rash (26%), cough (23%), and decreased appetite (22%). In Checkmate 238, the most common adverse reactions (≥20%) reported in OPDIVO-treated patients (n=452) vs ipilimumab-treated patients (n=453) were fatigue (57% vs 55%), diarrhea (37% vs 55%), rash (35% vs 47%), musculoskeletal pain (32% vs 27%), pruritus (28% vs 37%), headache (23% vs 31%), nausea (23% vs 28%), upper respiratory tract infection (22% vs 15%), and abdominal pain (21% vs 23%). The most common immune-mediated adverse reactions were rash (16%), diarrhea/collitis (6%), and hepatitis (3%). The most common adverse reactions (≥20%) in patients who received OPDIVO as a single agent were fatigue, rash, musculoskeletal pain, pruritus, diarrhea, nausea, asthenia, cough, dyspnea, constipation, decreased appetite, back pain, arthralgia, upper respiratory tract infection, pyrexia, headache, and abdominal pain.

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 067–advanced melanoma alone or in combination with YERVOY® (ipilimumab); Checkmate 037 and 066–advanced melanoma; Checkmate 017–squamous non-small cell lung cancer (NSCLC); Checkmate 057–non-squamous NSCLC; Checkmate 025–renal cell carcinoma; Checkmate 205/039–classical Hodgkin lymphoma; Checkmate 141–squamous cell carcinoma of the head and neck; Checkmate 214–renal cell carcinoma; Checkmate 275–urothelial carcinoma; Checkmate 040–hepatocellular carcinoma, Checkmate 238–adjuvant treatment of melanoma.

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

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 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.

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

U.S. FDA-APPROVED INDICATION FOR EMPPLICITI

EMLUCITI™ (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.
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 drug use in pregnancy. Refer to the lenalidomide full prescribing information for requirements regarding contraception and the prohibitions against drug use in pregnancy.

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 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. Among other risks, there can be no guarantee that Opdivo, Yervoy or any of the oncology compounds mentioned in this release will receive regulatory approval for the indication described herein. 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, 2017 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.
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