THE CARVYKTI® (ciltacabtagene autoleucel) PATIENT JOURNEY

Treating Terry's Multiple Myeloma

INDICATIONS AND USAGE

CARVYKTI® (ciltacabtagene autoleucel) is a B-cell maturation antigen (BCMA)-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory multiple myeloma, who have received at least 1 prior line of therapy, including a proteasome inhibitor and an immunomodulatory agent, and are refractory to lenalidomide.

IMPORTANT SAFETY INFORMATION

WARNING: CYTOKINE RELEASE SYNDROME, NEUROLOGIC TOXICITIES, HLH/MAS, PROLONGED and RECURRENT CYTOPENIA, and SECONDARY HEMATOLOGICAL MALIGNANCIES

Cytokine Release Syndrome (CRS), including fatal or life-threatening reactions, occurred in patients following treatment with CARVYKTI®. Do not administer CARVYKTI® to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids.

Immune Effector Cell-associated Neurotoxicity Syndrome (ICANS), which may be fatal or life-threatening, occurred following treatment with CARVYKTI®, including before CRS onset, concurrently with CRS, after CRS resolution, or in the absence of CRS. Monitor for neurologic events after treatment with CARVYKTI®. Provide supportive care and/or corticosteroids as needed.

Parkinsonism and Guillain-Barré syndrome (GBS) and their associated complications resulting in fatal or life-threatening reactions have occurred following treatment with CARVYKTI®.

Hemophagocytic Lymphohistiocytosis/Macrophage Activation Syndrome (HLH/MAS), including fatal and life-threatening reactions, occurred in patients following treatment with CARVYKTI®. HLH/MAS can occur with CRS or neurologic toxicities.

Prolonged and/or recurrent cytopenias with bleeding and infection and requirement for stem cell transplantation for hematopoietic recovery occurred following treatment with CARVYKTI®.

Immune Effector Cell-associated Enterocolitis (IEC-EC), including fatal or life-threatening reactions, occurred following treatment with CARVYKTI®.

Secondary hematological malignancies, including myelodysplastic syndrome and acute myeloid leukemia, have occurred in patients following treatment with CARVYKTI®. T-cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19-directed genetically modified autologous T-cell immunotherapies, including CARVYKTI®.

Patient and healthcare provider images are actor portrayals.

Please click here to read full Important Safety Information.

Please read full Prescribing Information, including Boxed Warning, for CARVYKTI®.

CARVYKTI®
(ciltacabtagene autoleucel) Suspension for IV Infusion

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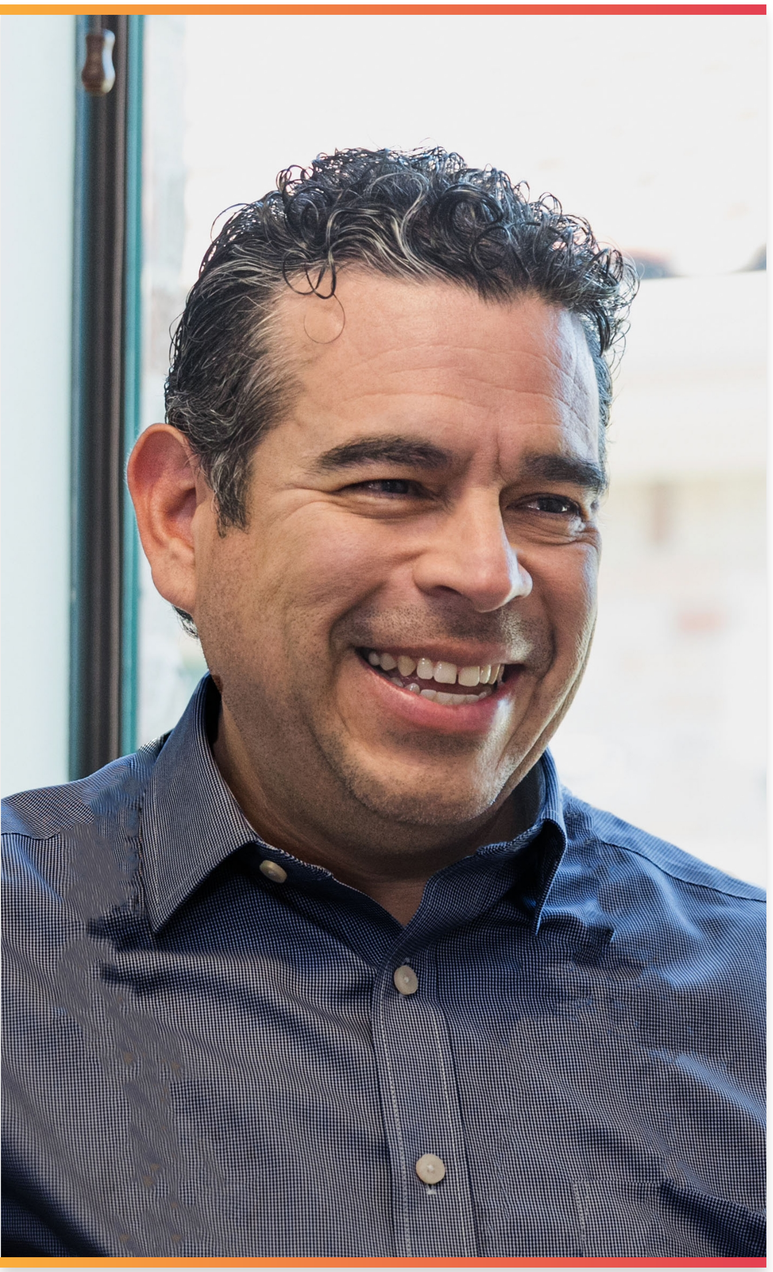
INTRODUCTION



Patient and healthcare provider images are actor portrayals.

MEET TERRY,

A 57-year-old diagnosed with multiple myeloma (MM) 3 years ago, who has recently relapsed following 1 line of therapy. He's the owner of a property management company, a backyard gardener, and his support system includes his wife Becca and son Rob.

What is multiple myeloma? ›

For illustration purposes, this brochure will walk through the CARVYKTI® process with a fictional MM patient.

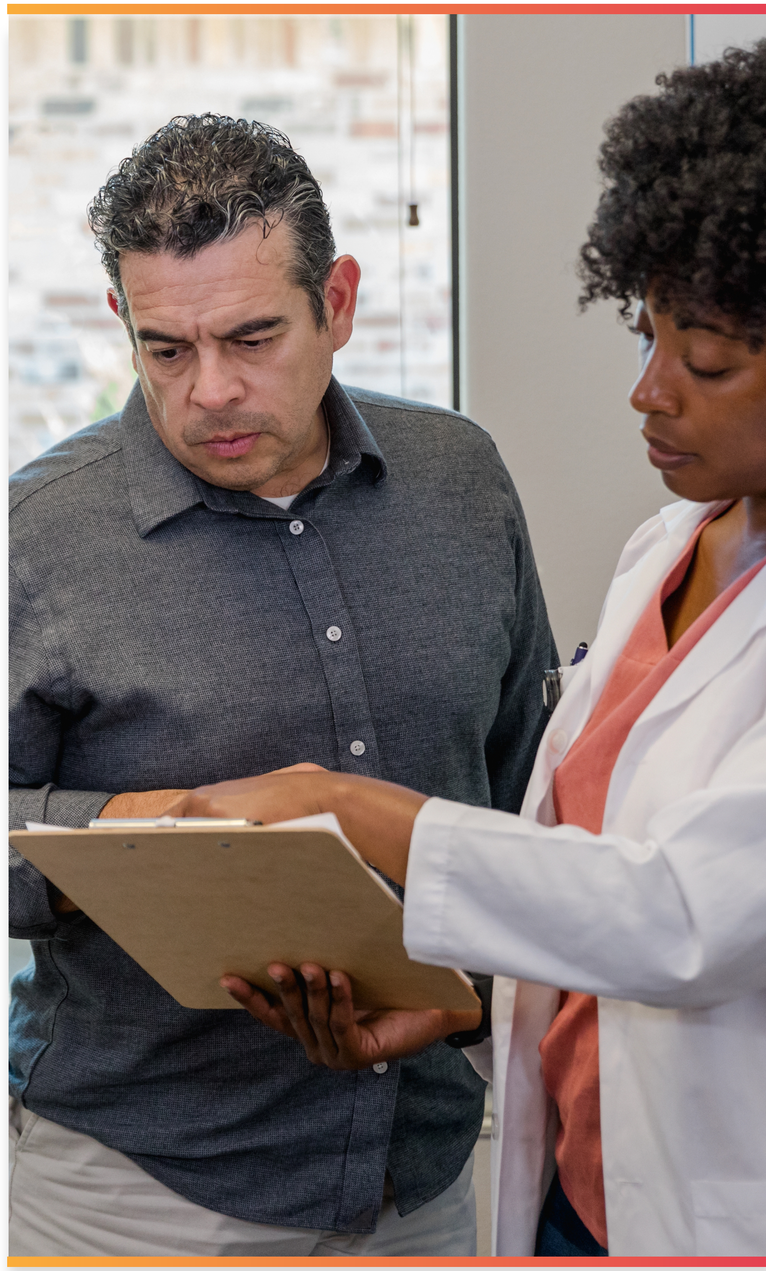
PATIENT DIAGNOSIS

After a blood test came back with abnormal results, Terry's primary care physician referred him to an oncologist who then ordered a full myeloma workup. After the results came back from his myeloma labs, Terry's oncologist diagnosed him with MM.[4]

Early in MM, a patient may be asymptomatic, but when signs and symptoms do occur, they may include but are not limited to[4]:

- Fatigue
- Bone pain
- Constipation
- Unexplained weight loss
- Nausea
- Loss of appetite
- Mental fogginess or confusion
- Infections
- Weakness
- Thirst
- Urination changes

How is MM diagnosed? ›



Patient and healthcare provider images are actor portrayals.

MM=multiple myeloma.

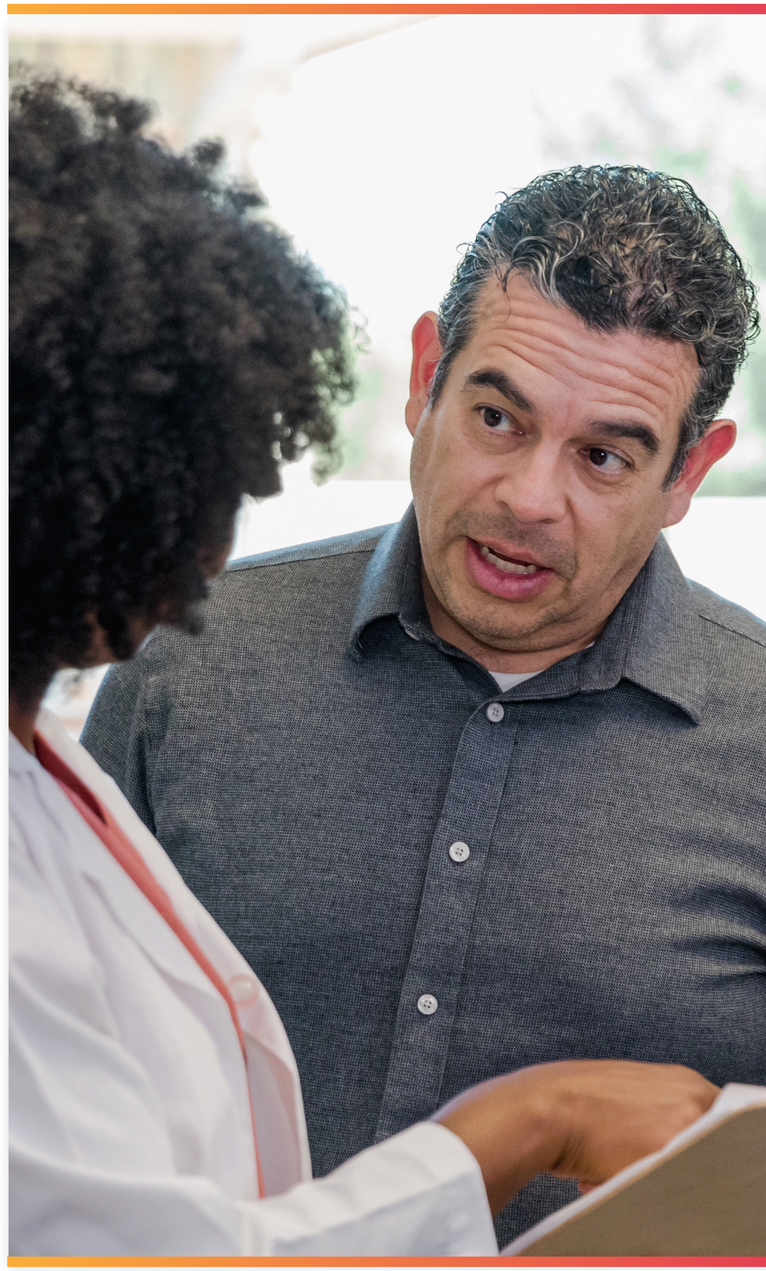
CLINICAL CONSIDERATIONS[5]

Terry's oncologist started him on his first line of therapy with lenalidomide, bortezomib, and dexamethasone (RVd) for a total of 8 cycles with lenalidomide maintenance. Terry achieved a remission and continued to visit his primary oncologist for follow-up visits and routine labs.

It's been about 3 years since the start of Terry's treatment and repeat lab work shows a spike in his M protein levels and that he's no longer responding to lenalidomide. His primary oncologist lets him know it's time to begin thinking about his next treatment option.

Terry and his wife Becca have been worried about when his first relapse would come, so they had already began researching treatment options. In their search, Terry and Becca came across CARVYKTI®, which they thought may be a potential option, so they asked Terry's primary oncologist about it.

What is CARVYKTI®? >



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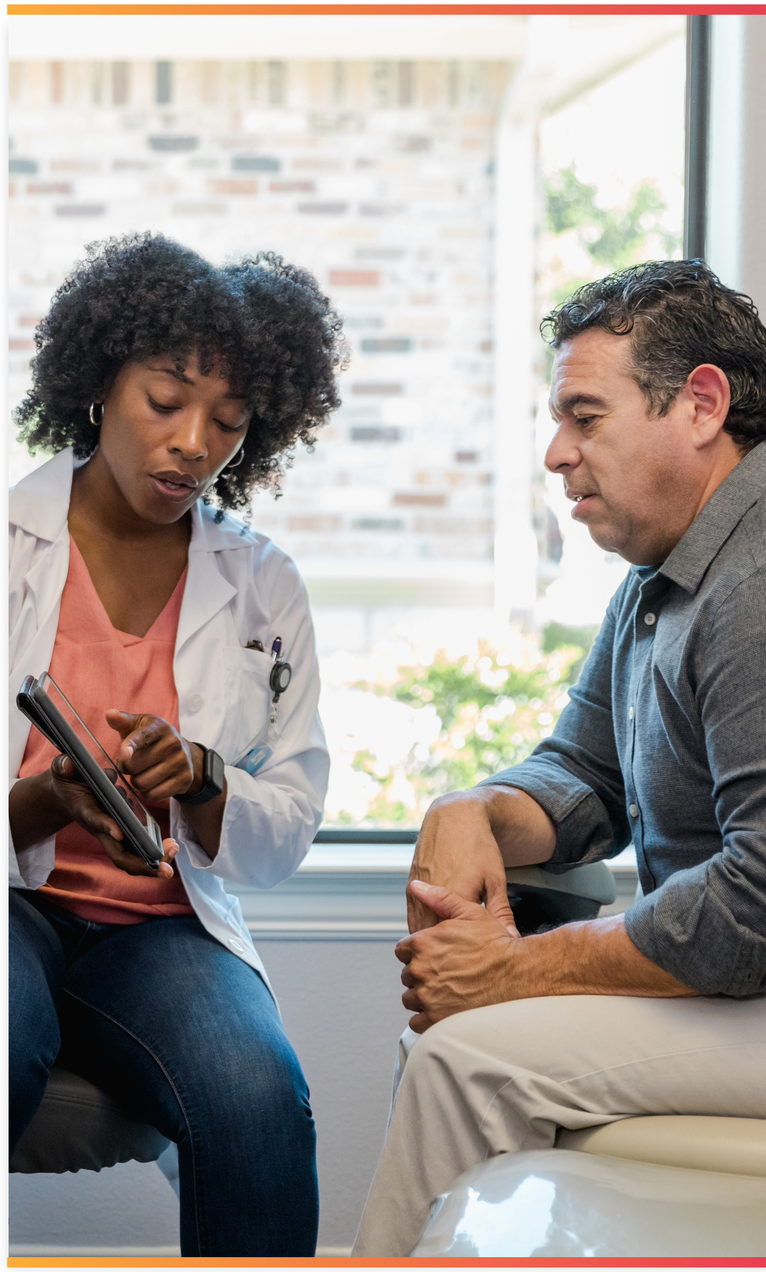
REFERRAL TO A CARVYKTI® ACTIVATED TREATMENT CENTER

Terry's oncologist discussed the risks and benefits of CARVYKTI® with him and his wife and agreed that it could be an option as he meets the baseline eligibility and has a supportive care partner. He was told he will need to be referred to a CARVYKTI® Activated Treatment Center (ATC) for a consultation with a treating physician who will confirm his eligibility and prescribe CARVYKTI®.

Terry's community oncology team used the **CARVYKTI® Activated Treatment Center locator on CARVYKTI.com** to show him which treatment centers he can be referred to for his consultation. Because Terry was located in a city, he had a few different options. Terry decided on a treatment center that was in closest proximity to his home, and Terry's oncologist began the process for his referral.

Terry was eager to begin treatment but wanted to learn more about patient assistance and if there were transportation options available to him as neither he nor his wife drive.

What logistical support is available? ›



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CARVYKTI® (ciltacabtagene autoleucel) Suspension for IV Infusion

AT THE CARVYKTI® ACTIVATED TREATMENT CENTER

When Terry met with the treating oncologist at the CARVYKTI® Activated Treatment Center, it was confirmed he met the criteria and was a candidate for CARVYKTI® treatment. Terry and his oncologist reviewed the risks and benefits of CARVYKTI®, including the risk of early mortality.

While CARVYKTI® treatment is a 6-step process, Terry was excited that it was a one-time infusion.[5,8]

1

LEUKAPHERESIS
(~3-6 hours)*

Terry's white blood cells were extracted over the course of approximately 3 to 6 hours.

2

BRIDGING THERAPY†

Terry was given an additional therapy for disease control before his treatment with CARVYKTI®.

3

MANUFACTURING
(~4-5 weeks)

Terry's T cells were genetically modified into personalized CAR-T cells.

4

LYMPHODEPLETION

Terry was lymphodepleted with cyclophosphamide + fludarabine daily for 3 days (completed 2 to 4 days prior to infusion of CARVYKTI®).

5

INFUSION
(~30-60 minutes)

Terry received his one-time CARVYKTI® infusion.

6

MONITORING

Terry was monitored for 7 days at the CARVYKTI® Activated Treatment Center Patients should plan to stay close to the CARVYKTI® Activated Treatment Center for monitoring for at least 2 weeks following the CARVYKTI® infusion.

Increased Early Mortality ›

CAR-T=chimeric antigen receptor-T cell.
*Time ranges are estimates based on the average CARVYKTI® treatment.
†Bridging therapy may vary per patient. Not all patients receive bridging therapy as it is prescribed at the discretion of the healthcare teams.

Please see Important Safety Information on pages 9-17 and full Prescribing Information, including Boxed Warning, for CARVYKTI®.

POST-INFUSION MONITORING WITH CARVYKTI®[5]

After CARVYKTI® infusion, the patient is monitored:

- For 2 hours after infusion for signs and symptoms of severe reaction
- Daily for at least 7 days at the Activated Treatment Center
- Periodically for at least 2 weeks
- Long-term with a qualified oncologist

Terry was instructed to stay close to his Activated Treatment Center for at least 2 weeks. During this time, Terry, his care partner, and his treatment team will watch closely and contact his healthcare provider if they observe signs and symptoms of potential side effects including but not limited to:

- Cytokine release syndrome
- Neurologic toxicity, including immune effector cell-associated neurotoxicity syndrome
- Parkinsonism
- Guillain-Barré Syndrome
- Immune mediated myelitis
- Peripheral neuropathy
- Cranial nerve palsies
- Hemophagocytic Lymphohistiocytosis/Macrophage Activation Syndrome
- Prolonged and/or recurrent cytopenias
- Serious infections including febrile neutropenia
- Hypogammaglobulinemia
- Immune Effector Cell-associated Enterocolitis (IEC-EC)
- Secondary malignancies

For at least 2 weeks after receiving CARVYKTI®, patients should not drive, operate heavy machinery, or do other activities that could be dangerous if they are not mentally alert. This is because the treatment can cause memory and coordination problems, sleepiness, confusion, dizziness, seizures, or other neurologic side effects as discussed by their healthcare provider.

After his 2-week monitoring period, Terry transitioned back to his primary oncologist back home. They made a long-term monitoring plan with regular follow-up visits.

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IMPORTANT SAFETY INFORMATION (CONT'D)

WARNINGS AND PRECAUTIONS

Increased early mortality. In CARTITUDE-4, a (1:1) randomized controlled trial, there was a numerically higher percentage of early deaths in patients randomized to the CARVYKTI® treatment arm compared to the control arm. Among patients with deaths occurring within the first 10 months from randomization, a greater proportion (29/208; 14%) occurred in the CARVYKTI® arm compared to (25/211; 12%) in the control arm. Of the 29 deaths that occurred in the CARVYKTI® arm within the first 10 months of randomization, 10 deaths occurred prior to CARVYKTI® infusion, and 19 deaths occurred after CARVYKTI® infusion. Of the 10 deaths that occurred prior to CARVYKTI® infusion, all occurred due to disease progression, and none occurred due to adverse events. Of the 19 deaths that occurred after CARVYKTI® infusion, 3 occurred due to disease progression, and 16 occurred due to adverse events. The most common adverse events were due to infection (n=12).

Cytokine release syndrome (CRS), including fatal or life-threatening reactions, occurred following treatment with CARVYKTI®. Among patients receiving CARVYKTI® for RRMM in the CARTITUDE-1 & -4 studies (N=285), CRS occurred in 84% (238/285), including ≥ Grade 3 CRS (ASTCT 2019) in 4% (11/285) of patients. Median time to onset of CRS, any grade, was 7 days (range: 1 to 23 days). CRS resolved in 82% with a median duration of 4 days (range: 1 to 97 days). The most common manifestations of CRS in all patients combined (≥10%) included fever (84%), hypotension (29%) and aspartate aminotransferase increased (11%). Serious events that may be associated with CRS include pyrexia, hemophagocytic lymphohistiocytosis, respiratory failure, disseminated intravascular coagulation, capillary leak syndrome, and supraventricular and ventricular tachycardia. CRS occurred in 78% of patients in CARTITUDE-4 (3% Grade 3 to 4) and in 95% of patients in CARTITUDE-1 (4% Grade 3 to 4).

Identify CRS based on clinical presentation. Evaluate for and treat other causes of fever, hypoxia, and hypotension. CRS has been reported to be associated with findings of HLH/MAS, and the physiology of the syndromes may overlap. HLH/MAS is a potentially life-threatening condition. In patients with progressive symptoms of CRS or refractory CRS despite treatment, evaluate for evidence of HLH/MAS.

Confirm that a minimum of 2 doses of tocilizumab are available prior to infusion of CARVYKTI®.

Of the 285 patients who received CARVYKTI® in clinical trials, 53% (150/285) patients received tocilizumab; 35% (100/285) received a single dose, while 18% (50/285) received more than 1 dose of tocilizumab. Overall, 14% (39/285) of patients received at least 1 dose of corticosteroids for treatment of CRS.

IMPORTANT SAFETY INFORMATION (CONT'D)

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IMPORTANT SAFETY INFORMATION (CONT'D)

Monitor patients at least daily for 7 days following CARVYKTI® infusion for signs and symptoms of CRS. Monitor patients for signs or symptoms of CRS for at least 2 weeks after infusion. At the first sign of CRS, immediately institute treatment with supportive care, tocilizumab, or tocilizumab and corticosteroids.

Counsel patients to seek immediate medical attention should signs or symptoms of CRS occur at any time.

Neurologic toxicities, which may be severe, life-threatening, or fatal, occurred following treatment with CARVYKTI®. Neurologic toxicities included ICANS, neurologic toxicity with signs and symptoms of Parkinsonism, GBS, immune mediated myelitis, peripheral neuropathies, and cranial nerve palsies. Counsel patients on the signs and symptoms of these neurologic toxicities, and on the delayed nature of onset of some of these toxicities. Instruct patients to seek immediate medical attention for further assessment and management if signs or symptoms of any of these neurologic toxicities occur at any time.

Among patients receiving CARVYKTI® in the CARTITUDE-1 & 4 studies for RRMM, one or more neurologic toxicities occurred in 24% (69/285), including ≥ Grade 3 cases in 7% (19/285) of patients. Median time to onset was 10 days (range: 1 to 101) with 63/69 (91%) of cases developing by 30 days. Neurologic toxicities resolved in 72% (50/69) of patients with a median duration to resolution of 23 days (range: 1 to 544). Of patients developing neurotoxicity, 96% (66/69) also developed CRS. Subtypes of neurologic toxicities included ICANS in 13%, peripheral neuropathy in 7%, cranial nerve palsy in 7%, parkinsonism in 3%, and immune mediated myelitis in 0.4% of the patients.

Immune Effector Cell-associated Neurotoxicity Syndrome (ICANS): Patients receiving CARVYKTI® may experience fatal or life-threatening ICANS following treatment with CARVYKTI®, including before CRS onset, concurrently with CRS, after CRS resolution, or in the absence of CRS.

Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, ICANS occurred in 13% (36/285), including Grade ≥3 in 2% (6/285) of the patients. Median time to onset of ICANS was 8 days (range: 1 to 28 days). ICANS resolved in 30 of 36 (83%) of patients, with a median time to resolution of 3 days (range: 1 to 143 days). Median duration of ICANS was 6 days (range: 1 to 1229 days) in all patients, including those with ongoing neurologic events at the time of death or data cutoff. Of patients with ICANS, 97% (35/36) had CRS. The onset of ICANS occurred during CRS in 69% of patients, before and after the onset of CRS in 14% of patients, respectively.

IMPORTANT SAFETY INFORMATION (CONT'D)

Immune Effector Cell-associated Neurotoxicity Syndrome occurred in 7% of patients in CARTITUDE-4 (0.5% Grade 3) and in 23% of patients in CARTITUDE-1 (3% Grade 3). The most frequent (≥2%) manifestations of ICANS included encephalopathy (12%), aphasia (4%), headache (3%), motor dysfunction (3%), ataxia (2%), and sleep disorder (2%).

Monitor patients at least daily for 7 days following CARVYKTI® infusion for signs and symptoms of ICANS. Rule out other causes of ICANS symptoms. Monitor patients for signs or symptoms of ICANS for at least 2 weeks after infusion and treat promptly. Neurologic toxicity should be managed with supportive care and/or corticosteroids as needed. Advise patients to avoid driving for at least 2 weeks following infusion.

Parkinsonism: Neurologic toxicity with parkinsonism has been reported in clinical trials of CARVYKTI®. Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, parkinsonism occurred in 3% (8/285), including Grade ≥3 in 2% (5/285) of the patients. Median time to onset of parkinsonism was 56 days (range: 14 to 914 days). Parkinsonism resolved in 1 of 8 (13%) of patients with a median time to resolution of 523 days. Median duration of parkinsonism was 243.5 days (range: 62 to 720 days) in all patients, including those with ongoing neurologic events at the time of death or data cutoff. The onset of parkinsonism occurred after CRS for all patients and after ICANS for 6 patients.

Parkinsonism occurred in 1% of patients in CARTITUDE-4 (no Grade 3 to 4) and in 6% of patients in CARTITUDE-1 (4% Grade 3 to 4).

Manifestations of parkinsonism included movement disorders, cognitive impairment, and personality changes. Monitor patients for signs and symptoms of parkinsonism that may be delayed in onset and managed with supportive care measures. There is limited efficacy information with medications used for the treatment of Parkinson's disease for the improvement or resolution of parkinsonism symptoms following CARVYKTI® treatment.

Guillain-Barré syndrome: A fatal outcome following GBS occurred following treatment with CARVYKTI® despite treatment with intravenous immunoglobulins. Symptoms reported include those consistent with Miller-Fisher variant of GBS, encephalopathy, motor weakness, speech disturbances, and polyradiculoneuritis.

Monitor for GBS. Evaluate patients presenting with peripheral neuropathy for GBS. Consider treatment of GBS with supportive care measures and in conjunction with immunoglobulins and plasma exchange, depending on severity of GBS.

IMPORTANT SAFETY INFORMATION (CONT'D)

Immune mediated myelitis: Grade 3 myelitis occurred 25 days following treatment with CARVYKTI® in CARTITUDE-4 in a patient who received CARVYKTI® as subsequent therapy. Symptoms reported included hypoesthesia of the lower extremities and the lower abdomen with impaired sphincter control. Symptoms improved with the use of corticosteroids and intravenous immune globulin. Myelitis was ongoing at the time of death from other cause.

Peripheral neuropathy occurred following treatment with CARVYKTI®. Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, peripheral neuropathy occurred in 7% (21/285), including Grade ≥3 in 1% (3/285) of the patients. Median time to onset of peripheral neuropathy was 57 days (range: 1 to 914 days). Peripheral neuropathy resolved in 11 of 21 (52%) of patients with a median time to resolution of 58 days (range: 1 to 215 days). Median duration of peripheral neuropathy was 149.5 days (range: 1 to 692 days) in all patients including those with ongoing neurologic events at the time of death or data cutoff.

Peripheral neuropathies occurred in 7% of patients in CARTITUDE-4 (0.5% Grade 3 to 4) and in 7% of patients in CARTITUDE-1 (2% Grade 3 to 4). Monitor patients for signs and symptoms of peripheral neuropathies. Patients who experience peripheral neuropathy may also experience cranial nerve palsies or GBS.

Cranial nerve palsies occurred following treatment with CARVYKTI®. Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, cranial nerve palsies occurred in 7% (19/285), including Grade ≥3 in 1% (1/285) of the patients. Median time to onset of cranial nerve palsies was 21 days (range: 17 to 101 days). Cranial nerve palsies resolved in 17 of 19 (89%) of patients with a median time to resolution of 66 days (range: 1 to 209 days). Median duration of cranial nerve palsies was 70 days (range: 1 to 262 days) in all patients, including those with ongoing neurologic events at the time of death or data cutoff. Cranial nerve palsies occurred in 9% of patients in CARTITUDE-4 (1% Grade 3 to 4) and in 3% of patients in CARTITUDE-1 (1% Grade 3 to 4).

The most frequent cranial nerve affected was the 7th cranial nerve. Additionally, cranial nerves III, V, and VI have been reported to be affected.

Monitor patients for signs and symptoms of cranial nerve palsies. Consider management with systemic corticosteroids, depending on the severity and progression of signs and symptoms.

IMPORTANT SAFETY INFORMATION (CONT'D)

Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS): Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, HLH/MAS occurred in 1% (3/285) of patients. All events of HLH/MAS had onset within 99 days of receiving CARVYKTI®, with a median onset of 10 days (range: 8 to 99 days), and all occurred in the setting of ongoing or worsening CRS. The manifestations of HLH/MAS included hyperferritinemia, hypotension, hypoxia with diffuse alveolar damage, coagulopathy and hemorrhage, cytopenia, and multi-organ dysfunction, including renal dysfunction and respiratory failure.

Patients who develop HLH/MAS have an increased risk of severe bleeding. Monitor hematologic parameters in patients with HLH/MAS and transfuse per institutional guidelines. Fatal cases of HLH/MAS occurred following treatment with CARVYKTI®.

HLH is a life-threatening condition with a high mortality rate if not recognized and treated early. Treatment of HLH/MAS should be administered per institutional standards.

Prolonged and Recurrent Cytopenias: Patients may exhibit prolonged and recurrent cytopenias following lymphodepleting chemotherapy and CARVYKTI® infusion.

Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, Grade 3 or higher cytopenias not resolved by Day 30 following CARVYKTI® infusion occurred in 62% (176/285) of the patients and included thrombocytopenia 33% (94/285), neutropenia 27% (76/285), lymphopenia 24% (67/285), and anemia 2% (6/285). After Day 60 following CARVYKTI® infusion, 22%, 20%, 5%, and 6% of patients had a recurrence of Grade 3 or 4 lymphopenia, neutropenia, thrombocytopenia, and anemia, respectively, after initial recovery of their Grade 3 or 4 cytopenia. Seventy-seven percent (219/285) of patients had one, two, or three or more recurrences of Grade 3 or 4 cytopenias after initial recovery of Grade 3 or 4 cytopenia. Sixteen and 25 patients had Grade 3 or 4 neutropenia and thrombocytopenia, respectively, at the time of death.

Monitor blood counts prior to and after CARVYKTI® infusion. Manage cytopenias with growth factors and blood product transfusion support according to local institutional guidelines.

IMPORTANT SAFETY INFORMATION (CONT'D)

Infections: CARVYKTI® should not be administered to patients with active infection or inflammatory disorders. Severe, life-threatening, or fatal infections occurred in patients after CARVYKTI® infusion.

Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, infections occurred in 57% (163/285), including Grade ≥3 in 24% (69/285) of patients. Grade 3 or 4 infections with an unspecified pathogen occurred in 12%, viral infections in 6%, bacterial infections in 5%, and fungal infections in 1% of patients. Overall, 5% (13/285) of patients had Grade 5 infections, 2.5% of which were due to COVID-19. Patients treated with CARVYKTI® had an increased rate of fatal COVID-19 infections compared to the standard therapy arm.

Monitor patients for signs and symptoms of infection before and after CARVYKTI® infusion and treat patients appropriately. Administer prophylactic, pre-emptive, and/or therapeutic antimicrobials according to the standard institutional guidelines. Febrile neutropenia was observed in 5% of patients after CARVYKTI® infusion and may be concurrent with CRS. In the event of febrile neutropenia, evaluate for infection and manage with broad-spectrum antibiotics, fluids, and other supportive care, as medically indicated. Counsel patients on the importance of prevention measures. Follow institutional guidelines for the vaccination and management of immunocompromised patients with COVID-19.

Viral Reactivation: Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, can occur in patients with hypogammaglobulinemia. Perform screening for Cytomegalovirus (CMV), HBV, hepatitis C virus (HCV), and human immunodeficiency virus (HIV) or any other infectious agents if clinically indicated in accordance with clinical guidelines before collection of cells for manufacturing. Consider antiviral therapy to prevent viral reactivation per local institutional guidelines/clinical practice.

Reactivation of John Cunningham (JC) virus, leading to progressive multifocal leukoencephalopathy (PML), including cases with fatal outcomes, have been reported following treatment. Perform appropriate diagnostic evaluations in patients with neurological adverse events.

Hypogammaglobulinemia: can occur in patients receiving treatment with CARVYKTI®. Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, hypogammaglobulinemia adverse event was reported in 36% (102/285) of patients; laboratory IgG levels fell below 500 mg/dL after infusion in 93% (265/285) of patients. Hypogammaglobulinemia either as an adverse reaction or laboratory IgG level below 500 mg/dL after infusion occurred in 94% (267/285) of patients treated. Fifty-six percent (161/285) of patients received intravenous immunoglobulin (IVIG) post CARVYKTI® for either an adverse reaction or prophylaxis.

Monitor immunoglobulin levels after treatment with CARVYKTI® and administer IVIG for IgG <400 mg/dL. Manage per local institutional guidelines, including infection precautions and antibiotic or antiviral prophylaxis.

IMPORTANT SAFETY INFORMATION (CONT'D)

Use of Live Vaccines: The safety of immunization with live viral vaccines during or following CARVYKTI® treatment has not been studied. Vaccination with live virus vaccines is not recommended for at least 6 weeks prior to the start of lymphodepleting chemotherapy, during CARVYKTI® treatment, and until immune recovery following treatment with CARVYKTI®.

Hypersensitivity Reactions occurred following treatment with CARVYKTI®. Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, hypersensitivity reactions occurred in 5% (13/285), all of which were ≤2 Grade. Manifestations of hypersensitivity reactions included flushing, chest discomfort, tachycardia, wheezing, tremor, burning sensation, non-cardiac chest pain, and pyrexia.

Serious hypersensitivity reactions, including anaphylaxis, may be due to the dimethyl sulfoxide (DMSO) in CARVYKTI®. Patients should be carefully monitored for 2 hours after infusion for signs and symptoms of severe reaction. Treat promptly and manage patients appropriately according to the severity of the hypersensitivity reaction.

Immune effector cell-associated enterocolitis (IEC-EC) has occurred in patients treated with CARVYKTI®. Manifestations include severe or prolonged diarrhea, abdominal pain, and weight loss requiring parenteral nutrition. IEC-EC has been associated with fatal outcome from perforation or sepsis. Manage according to institutional guidelines, including referral to gastroenterology and infectious disease specialists.

In cases of refractory IEC-EC, consider additional workup to exclude alternative etiologies, including T-cell lymphoma of the GI tract, which has been reported in the post marketing setting.

Secondary Malignancies: Patients treated with CARVYKTI® may develop secondary malignancies. Among patients receiving CARVYKTI® in the CARTITUDE-1 & -4 studies, myeloid neoplasms occurred in 5% (13/285) of patients (9 cases of myelodysplastic syndrome, 3 cases of acute myeloid leukemia, and 1 case of myelodysplastic syndrome followed by acute myeloid leukemia). The median time to onset of myeloid neoplasms was 447 days (range: 56 to 870 days) after treatment with CARVYKTI®. Ten of these 13 patients died following the development of myeloid neoplasms; 2 of the 13 cases of myeloid neoplasm occurred after initiation of subsequent antimyeloma therapy. Cases of myelodysplastic syndrome and acute myeloid leukemia have also been reported in the post marketing setting. T-cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19-directed genetically modified autologous T-cell immunotherapies, including CARVYKTI®. Mature T-cell malignancies, including CAR-positive tumors, may present as soon as weeks following infusions, and may include fatal outcomes.

Monitor lifelong for secondary malignancies. In the event that a secondary malignancy occurs, contact Janssen Biotech, Inc., at 1-800-526-7736 for reporting and to obtain instructions on collection of patient samples.

IMPORTANT SAFETY INFORMATION (CONT'D)

ADVERSE REACTIONS

The most common nonlaboratory adverse reactions (incidence greater than 20%) are pyrexia, cytokine release syndrome, hypogammaglobulinemia, hypotension, musculoskeletal pain, fatigue, infections-pathogen unspecified, cough, chills, diarrhea, nausea, encephalopathy, decreased appetite, upper respiratory tract infection, headache, tachycardia, dizziness, dyspnea, edema, viral infections, coagulopathy, constipation, and vomiting. The most common Grade 3 or 4 laboratory adverse reactions (incidence greater than or equal to 50%) include lymphopenia, neutropenia, white blood cell decreased, thrombocytopenia, and anemia.

Please read full Prescribing Information, including Boxed Warning, for CARVYKTI®.

cp-258862v11

References: 1. Rajkumar SV. Multiple myeloma: 2022 update on diagnosis, risk stratification, and management. *Am J Hematol*. 2022;97(8):1086-1107. doi:10.1002/ajh.26590 **2.** Swamydas M, Murphy EV, Ignatz-Hoover JJ, et al. Deciphering mechanisms of immune escape to inform immunotherapeutic strategies in multiple myeloma. *J Hematol Oncol*. 2022;15(1):17. doi:10.1186/s13045-022-01234-2 **3.** Barwick BG, Gupta VA, Vertino PM, et al. Cell of origin and genetic alterations in the pathogenesis of multiple myeloma. *Front Immunol*. 2019;10:1121. doi:10.3389/fimmu.2019.01121 **4.** Symptoms and causes - Mayo Clinic. www.mayoclinic.org. https://www.mayoclinic.org/diseases-conditions/multiple-myeloma/symptoms-causes/syc-20353378?p=1 **5.** CARVYKTI® [Prescribing Information]. Horsham, PA: Janssen Biotech, Inc. **6.** San-Miguel J, Dhakal B, Yong K, et al. Cilta-cel or standard care in lenalidomide-refractory multiple myeloma. *N Engl J Med*. 2023;389(4):335-347. doi:10.1056/NEJMoa2303379 **7.** Source: Managed Markets Insight and Technology, LLC™, a trademark of MMIT, as of November 2023. **8.** Beaupierre A, Lundberg R, Marrero L, et al. Management across settings: an ambulatory and community perspective for patients undergoing CAR T-cell therapy in multiple care settings. *Clin J Oncol Nurs*. 2019;23(2):27-34. doi:10.1188/19.CJON.S1.27-34

Johnson&Johnson

LEGEND BIOTECH

CARVYKTI® (ciltacabtagene autoleucel) Suspension for IV Infusion

SUMMARY

DO YOU HAVE PATIENTS WITH A STORY SIMILAR TO TERRY'S?

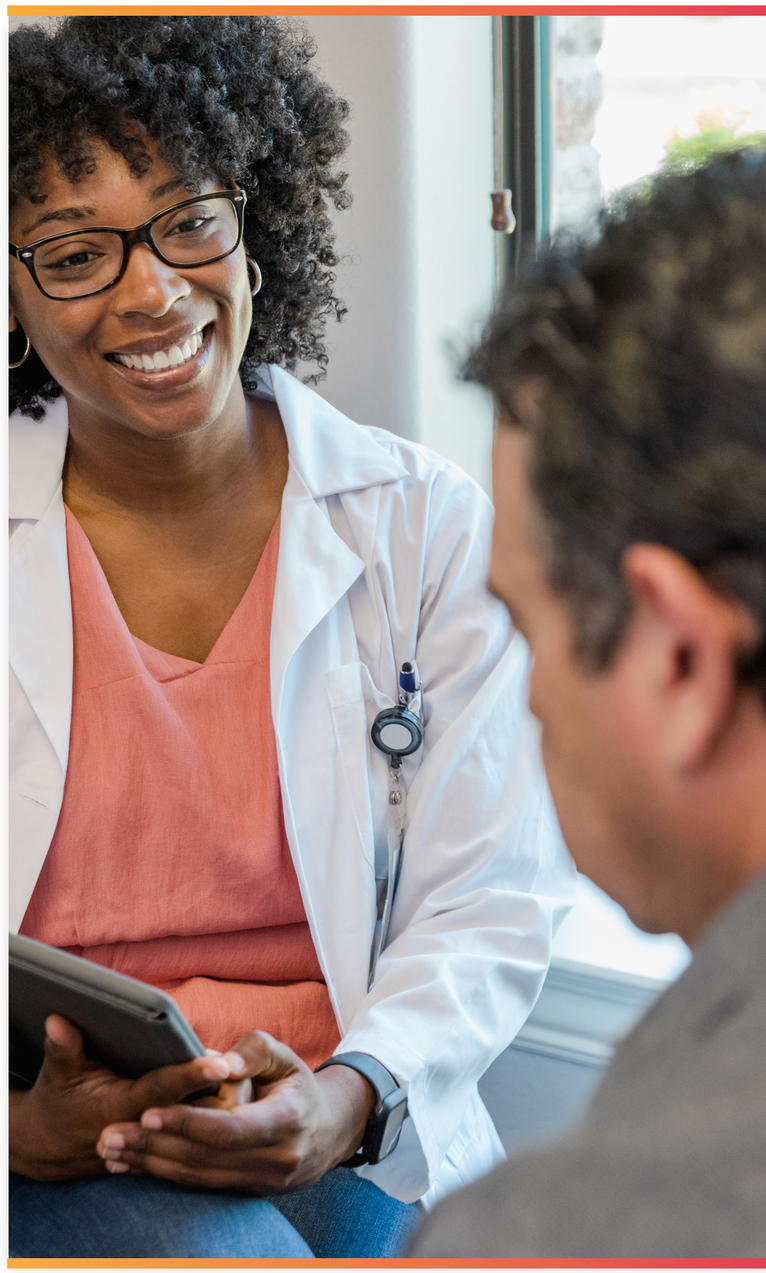
In the CARTITUDE-4 study, eligibility criteria included:

KEY INCLUSION CRITERIA

- ✔ Adult patients with RRMM
- ✔ Received 1-3 prior LoT including a PI and an immunomodulatory agent
- ✔ Refractory to lenalidomide
- ✔ ECOG PS 0-1

KEY EXCLUSION CRITERIA

- ✔ Prior CAR-T or BCMA-targeting therapy
- ✔ Known active or prior history of central nervous system involvement
- ✔ Exhibit clinical signs of meningeal involvement of multiple myeloma
- ✔ History of Parkinson's disease or other neurodegenerative disorder



Patient and healthcare provider images are actor portrayals.

Could CARVYKTI® be an option for your patients?

For more information about CARVYKTI® and to find a CARVYKTI® Activated Treatment Center, visit CARVYKTIHCP.com

BCMA=B-cell maturation antigen; CAR-T=chimeric antigen receptor-T cell; ECOG PS=Eastern Cooperative Oncology Group performance status; LoT=line(s) of therapy; PI=proteasome inhibitor; RRMM=relapsed or refractory multiple myeloma.

CARVYKTI® (ciltacabtagene autoleucel) Suspension for IV Infusion

Multiple myeloma is a rare, incurable blood cancer that affects plasma cells within bone marrow[1,2]

- Multiple myeloma develops from genetic abnormalities that occur as the B cell differentiates into an antibody-producing plasma cell[3]

- B cells develop from hematopoietic stem cells and undergo several rounds of differentiation in the bone marrow[3]

- People with multiple myeloma have an impaired immune response[2]

- Multiple myeloma is associated with several well-known mechanisms of tumor escape[2]

IMWG Diagnostic Criteria for Multiple Myeloma[1]

BOTH CRITERIA MUST BE MET:

- Clonal bone marrow plasma cells ≥10% or biopsy-proven bony or extramedullary plasmacytoma

  AND

- Any 1 or more of the following myeloma-defining events:
  - Evidence of end-organ damage meeting CRAB criteria (refer to table)
  - Clonal bone marrow plasma cell percentage ≥60%
  - Involved: uninvolved serum FLC ratio ≥100 (involved FLC level must be ≥100 mg/L)
  - >1 focal lesion on MRI (≥5 mm in size)

CRAB criteria

C	Hypercalcemia	Serum calcium level >0.25 mmol/L (>1 mg/dL) higher than the upper limit of normal or >2.75 mmol/L (>11 mg/dL)
R	Renal impairment	Creatinine clearance <40mL/min or serum creatinine level >177 µmol/L (>2 mg/dL)
A	Anemia	Hemoglobin value of >2 g/dL below the lower limit of normal or <10 g/dL
B	Bone lesions	One or more osteolytic lesions on skeletal radiography, CT, or PET-CT scan

CT=computed tomography; FLC=free light chain; IMWG=International Myeloma Working Group; MRI=magnetic resonance imaging; PET-CT=positron emission tomography-computed tomography.

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What is CARVYKTI®?[5]

CARVYKTI® (ciltacabtagene autoleucel) is a BCMA-directed genetically modified autologous T-cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory multiple myeloma, who have received at least 1 prior line of therapy, including a proteasome inhibitor and an immunomodulatory agent, and are refractory to lenalidomide.

With CARVYKTI®, a patient's T cells are genetically modified to encode a CAR to find and destroy BCMA-expressing cells.

What type of patients are eligible for CARVYKTI®? ›

BCMA=B-cell maturation antigen; CAR=chimeric antigen receptor.

Please see Important Safety Information on pages 9-17 and full Prescribing Information, including Boxed Warning, for CARVYKTI®.

What type of patients were eligible for CARVYKTI® as early as second line in the clinical trials?[5,6]

ELIGIBILITY CRITERIA

Key Inclusion Criteria

- Adult patients with RRMM
- Received 1-3 prior LoT including a PI and an immunomodulatory agent
- Refractory to lenalidomide
- ECOG PS 0-1

Key Exclusion Criteria

- Prior CAR-T or BCMA-targeting therapy
- Known active or prior history of central nervous system involvement
- Exhibit clinical signs of meningeal involvement of multiple myeloma
- History of Parkinson's disease or other neurodegenerative disorder

BCMA=B-cell maturation antigen; CAR-T=chimeric antigen receptor-T cell; ECOG PS=Eastern Cooperative Oncology Group performance status; LoT=line(s) of therapy; PI=proteasome inhibitor; RRMM=relapsed or refractory multiple myeloma.

Please see Important Safety Information on pages 9-17 and full Prescribing Information, including Boxed Warning, for CARVYKTI®.

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What support is available for patients who receive CARVYKTI® (ciltacabtagene autoleucel) treatment?

The **MyCARVYKTI® Patient Support Program**, sponsored by Janssen Biotech, Inc., and Legend Biotech, is designed to help eligible patients prescribed CARVYKTI® and their care partners with support during treatment.

Patients who meet financial and other eligibility requirements, and their caregivers, may receive:

Assistance with transportation, lodging, and out-of-pocket costs for meals and other travel expenses related to treatment at the CARVYKTI® Activated Treatment Center

Support from MyCARVYKTI® Patient Support Specialists, who are available to help guide your patients through the enrollment process and assist with program benefits

Patients who are prescribed CARVYKTI® can contact a MyCARVYKTI® Patient Support Specialist at:

1-800-559-7875

Monday to Friday, 8:00 AM to 8:00 PM ET

How is coverage determined for patients who receive CARVYKTI®? ›

How is coverage determined for patients who receive CARVYKTI® (ciltacabtagene autoleucel) treatment?[7]

The healthcare team at the CARVYKTI® Activated Treatment Center will work with the patient and insurance provider to secure treatment coverage during the consultation phase prior to beginning the CARVYKTI® treatment process.

For academic treatment centers, CARVYKTI® may be covered for its approved FDA Indication by third-party payers including:

- Commercial insurers
- Medicare
- Medicaid

However, the Centers for Medicare and Medicaid Services (CMS) has issued a national coverage determination (NCD) for CAR-T cell therapy (NCD 110.24).

More information about access is available at CARVYKTIHCP.com

CAR-T=chimeric antigen receptor-T cell; FDA=U.S. Food and Drug Administration.

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Increased Early Mortality

In a study comparing CARVYKTI® to standard therapy, there was a higher rate of death in the first 10 months in the CARVYKTI® arm (14%) compared to the standard therapy arm (12%). The increased rate of deaths occurred before receiving CARVYKTI® and after treatment with CARVYKTI®. The reasons for death were progression of multiple myeloma and side effects of the treatment.