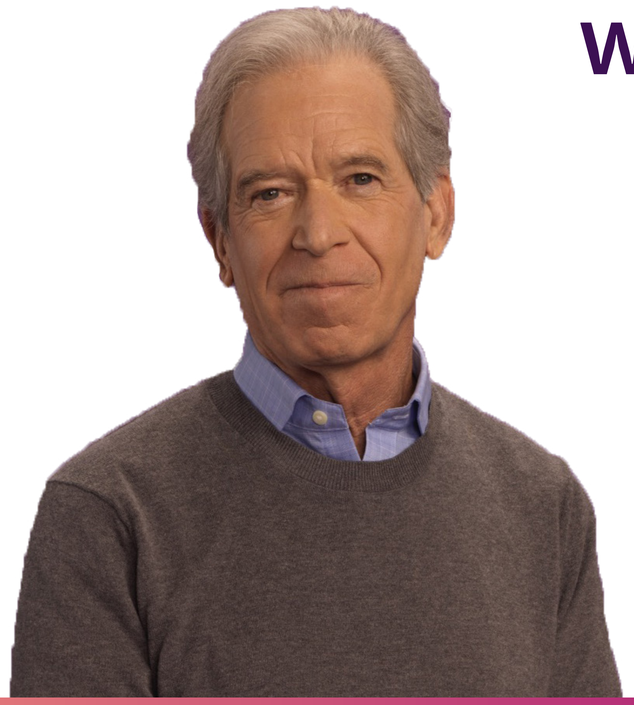
YESCARTA®
(axicabtagene ciloleucel) Suspension for IV infusion



Which of your patients may be appropriate for YESCARTA?

MICHAEL, 73* « EARLY RELAPSED

MARY, 60* PRIMARY REFRACTORY† »

Learn more about relapsed or refractory LBCL patients who may benefit from therapy with YESCARTA

*Not actual patients; profiles do not encompass all characteristics for YESCARTA eligibility.
†In ZUMA-7, refractory disease was defined as no CR to 1L therapy.[1]
1L=first line; 2L=second line; CR=complete remission; LBCL=large B-cell lymphoma.

INDICATION

YESCARTA® is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of:

- Adult patients with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy.

Limitations of Use: YESCARTA is not indicated for the treatment of patients with primary central nervous system lymphoma.

IMPORTANT SAFETY INFORMATION

BOXED WARNING: CYTOKINE RELEASE SYNDROME and NEUROLOGIC TOXICITIES

- **Cytokine Release Syndrome (CRS), including fatal or life-threatening reactions, occurred in patients receiving YESCARTA. Do not administer YESCARTA to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids.**
- **Neurologic toxicities, including fatal or life-threatening reactions, occurred in patients receiving YESCARTA, including concurrently with CRS or after CRS resolution. Monitor for neurologic toxicities after treatment with YESCARTA. Provide supportive care and/or corticosteroids as needed.**
- **YESCARTA is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the YESCARTA and TECARTUS REMS Program.**

Please see additional Important Safety Information throughout, and full Prescribing Information, including **BOXED WARNING** and Medication Guide.

YESCARTA®
(axicabtagene ciloleucel) Suspension for IV infusion

This profile is not an actual patient. Profile does not encompass all characteristics for YESCARTA eligibility.

MICHAEL, 73 YEARS OLD: EARLY RELAPSED

Progressed 8 months after 1L treatment

Clinical considerations

- ECOG PS: 0
- Low LDH*
- Low tumor burden: 1500 mm^2
- FDG-PET positive disease
- Normal cardiac function—EF above 50%
- Normal liver function†
- Normal renal function‡
- Normal blood values§

Current status

- Stage III DLBCL
- Relapsed after 1L chemoimmunotherapy

Prior therapy

- Achieved CR with 6 cycles of R-CHOP and relapsed at 8 months

- Willing to travel 2 hours for treatment, and has a wife who can help with care
- Restaurant owner used to working 5 days a week
- Wants to see the anniversary of the opening of his restaurant

MARY'S PROFILE »

*Based on LDH <300 U/L.
†Based on AST: 25 U/L, ALT: 45 U/L.
‡Based on CrCl: 110 mL/min.
§Leukocytes: 8.0×10^9/L; ANC: 4800 cells/mm^3; Hb: 14.3 g/dL; Plt: 250×10^9/L.
1L=first line; 2L=second line; ALT=alanine aminotransferase; ANC=absolute neutrophil count; AST=aspartate aminotransferase; CR=complete remission; CrCl=creatinine clearance; DLBCL=diffuse large B-cell lymphoma; ECOG PS=Eastern Cooperative Oncology Group performance status; EF=ejection fraction; FDG-PET=fluorodeoxyglucose-positron emission tomography; g/dL=grams per deciliter; Hb=hemoglobin; LDH=lactate dehydrogenase; Plt=platelet; R-CHOP=rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone; U/L=units per liter.

IMPORTANT SAFETY INFORMATION

CYTOKINE RELEASE SYNDROME (CRS)

CRS, including fatal or life-threatening reactions, occurred. CRS occurred in 90% (379/422) of patients with non-Hodgkin lymphoma (NHL), including ≥ Grade 3 in 9%. CRS occurred in 93% (256/276) of patients with large B-cell lymphoma (LBCL), including ≥ Grade 3 in 9%. Among patients with LBCL who died after receiving YESCARTA, 4 had ongoing CRS events at the time of death. For patients with LBCL in ZUMA-1, the median time to onset of CRS was 2 days following infusion (range: 1-12 days) and the median duration was 7 days (range: 2-58 days). For patients with LBCL in ZUMA-7, the median time to onset of CRS was 3 days following infusion (range: 1-10 days) and the median duration was 7 days (range: 2-43 days). CRS occurred in 84% (123/146) of patients with indolent non-Hodgkin lymphoma (iNHL) in ZUMA-5, including ≥ Grade 3 in 8%. Among patients with iNHL who died after receiving YESCARTA, 1 patient had an ongoing CRS event at the time of death. The median time to onset of CRS was 4 days (range: 1-20 days) and median duration was 6 days (range: 1-27 days) for patients with iNHL.

Please see additional Important Safety Information throughout.

YESCARTA® (axicabtagene ciloleucel) Suspension for IV infusion

This profile is not an actual patient. Profile does not encompass all characteristics for YESCARTA eligibility.

MARY, 60 YEARS OLD: PRIMARY REFRACTORY*

Achieved partial remission with 1L therapy

Clinical considerations

- ECOG PS: 1
- High LDH†
- High tumor burden: 5600 mm^2
- FDG-PET positive disease
- Normal cardiac function
- Normal liver function‡
- Moderate renal function§
- Slightly anemic with normal leukocytes‖

Current status

- Stage III DLBCL
- Refractory to 1L chemoimmunotherapy

Prior therapy

- Achieved PR as best response with 6 cycles of R-CHOP

- Full-time English professor
- Has a husband who can help with her care
- Is excited to celebrate her wedding anniversary and attend the party her family has planned

MICHAEL'S PROFILE »

*In ZUMA-7, refractory disease was defined as no CR to 1L therapy.[1]
†Based on LDH: 650 U/L.
‡Based on AST: 25 U/L, ALT: 45 U/L.
§Based on CrCl: ≥60 mL/min.
‖Leukocytes: 6.0×10^9/L; ANC: 3400 cells/mm^3; Hb: 9.1 g/dL; Plt: 300×10^9/L.
1L=first line; 2L=second line; ALT=alanine aminotransferase; ANC=absolute neutrophil count; AST=aspartate aminotransferase; CR=complete remission; CrCl=creatinine clearance; DLBCL=diffuse large B-cell lymphoma; ECOG PS=Eastern Cooperative Oncology Group performance status; FDG-PET=fluorodeoxyglucose-positron emission tomography; g/dL=grams per deciliter; Hb=hemoglobin; LDH=lactate dehydrogenase; Plt=platelet; PR=partial remission; R-CHOP=rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone; U/L=units per liter.

IMPORTANT SAFETY INFORMATION

CYTOKINE RELEASE SYNDROME (CRS) (continued)

Key manifestations of CRS (≥ 10%) in all patients combined included fever (85%), hypotension (40%), tachycardia (32%), chills (22%), hypoxia (20%), headache (15%), and fatigue (12%). Serious events that may be associated with CRS include cardiac arrhythmias (including atrial fibrillation and ventricular tachycardia), renal insufficiency, cardiac failure, respiratory failure, cardiac arrest, capillary leak syndrome, multi-organ failure, and hemophagocytic lymphohistiocytosis/macrophage activation syndrome.

The impact of tocilizumab and/or corticosteroids on the incidence and severity of CRS was assessed in 2 subsequent cohorts of LBCL patients in ZUMA-1. Among patients who received tocilizumab and/or corticosteroids for ongoing Grade 1 events, CRS occurred in 93% (38/41), including 2% (1/41) with Grade 3 CRS; no patients experienced a Grade 4 or 5 event. The median time to onset of CRS was 2 days (range: 1-8 days) and the median duration of CRS was 7 days (range: 2-16 days). Prophylactic treatment with corticosteroids was administered to a cohort of 39 patients for 3 days beginning on the day of infusion of YESCARTA.

Please see additional Important Safety Information throughout.

YESCARTA® (axicabtagene ciloleucel) Suspension for IV infusion

ZUMA-7: The largest phase 3 CAR T 2L LBCL trial with the longest follow-up[1-3]

ZUMA-7 study design[1-4]

- A phase 3, randomized, open-label, multicenter study of YESCARTA single-infusion therapy vs salvage chemotherapy +/- HDT+ASCT, a current standard therapy,* in 359 adult patients with R/R LBCL. Patients were randomized 1:1 to YESCARTA (N=180) and standard therapy (N=179) and stratified by response to 1L therapy and 2L age-adjusted IPI. Two recipients of nonconformal product are included in the YESCARTA arm for the efficacy analysis
- Patients were required to have primary refractory disease or relapse within 12 months following completion of 1L therapy
- The primary endpoint was event-free survival (EFS)
  - The median follow-up time for the primary analysis was 19.2 months
  - EFS is defined as the time from randomization to the earliest date of disease progression or relapse, best response of stable disease up to and including the day 150 assessment, commencement of new lymphoma therapy, or death from any cause. Response was assessed by an independent review committee, per the International Working Group Lugano classification (Cheson 2014)
- Select secondary endpoints included ORR, DOR, OS, PFS, PROs, and safety

Key inclusion criteria: histologically proven LBCL; R/R disease after 1L chemoimmunotherapy (anti-CD20 monoclonal antibody and anthracycline-containing regimen); intent to proceed to HDT+ASCT; radiographically documented disease; no CNS involvement by lymphoma; ≥2 weeks (or 5 half-lives) since prior systemic cancer therapy; ≥18 years of age; ECOG PS of 0 or 1; adequate bone marrow, renal, hepatic, pulmonary, and cardiac function; and negative pregnancy test, if applicable.[5]

Key exclusion criteria: PMBCL; any history of CNS lymphoma; need for urgent therapy due to tumor mass effect; active or serious infections; and ECOG PS of ≥2.[2]

*Standard-care chemotherapy could include 2 to 3 cycles of R-ICE, R-GDP, R-ESHAP, R-DHAP, or R-DHAX followed by high-dose chemotherapy and autologous stem cell transplant in patients with disease response.[1]

1L=first line; 2L=second line; ASCT=autologous stem cell transplant; CAR T=chimeric antigen receptor T cell; CD20=cluster of differentiation 20; CNS=central nervous system; DOR=duration of response; ECOG PS=Eastern Cooperative Oncology Group performance status; HDT=high-dose therapy; IPI=International Prognostic Index; LBCL=large B-cell lymphoma; ORR=objective response rate; OS=overall survival; PFS=progression-free survival; PMBCL=primary mediastinal large B-cell lymphoma; PRO=patient-reported outcome; R-DHAP=rituximab, dexamethasone, high-dose cytarabine, cisplatin; R-DHAX=rituximab, high-dose dexamethasone, cytarabine, oxaliplatin; R-ESHAP=rituximab, etoposide, methylprednisolone, high-dose cytarabine, cisplatin; R-GDP=rituximab, gemcitabine, dexamethasone, cisplatin; R-ICE=rituximab, ifosfamide, carboplatin, etoposide; R/R=relapsed/refractory.

IMPORTANT SAFETY INFORMATION

CYTOKINE RELEASE SYNDROME (CRS) (continued)

Thirty-one of the 39 patients (79%) developed CRS and were managed with tocilizumab and/or therapeutic doses of corticosteroids with no patients developing ≥ Grade 3 CRS. The median time to onset of CRS was 5 days (range: 1-15 days) and the median duration of CRS was 4 days (range: 1-10 days). Although there is no known mechanistic explanation, consider the risk and benefits of prophylactic corticosteroids in the context of pre-existing comorbidities for the individual patient and the potential for the risk of Grade 4 and prolonged neurologic toxicities.

Ensure that 2 doses of tocilizumab are available prior to YESCARTA infusion. Monitor patients for signs and symptoms of CRS at least daily for 7 days at the certified healthcare facility, and for 4 weeks thereafter. Counsel patients to seek immediate medical attention should signs or symptoms of CRS occur at any time. At the first sign of CRS, institute treatment with supportive care, tocilizumab, or tocilizumab and corticosteroids as indicated.

NEUROLOGIC TOXICITIES

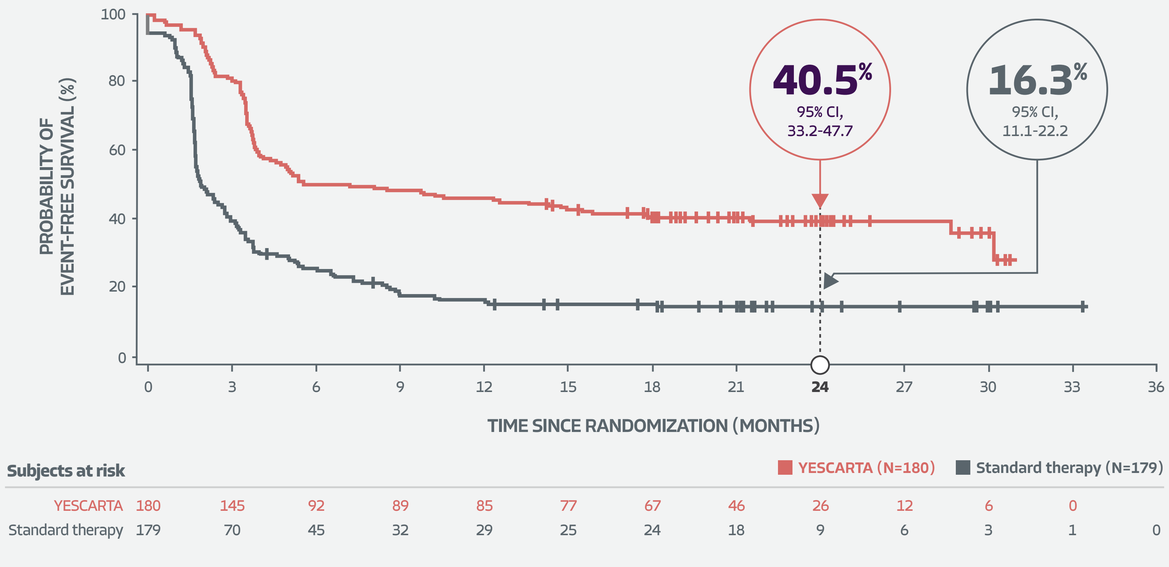
Neurologic toxicities (including immune effector cell-associated neurotoxicity syndrome) that were fatal or life-threatening occurred. Neurologic toxicities occurred in 78% (330/422) of patients with NHL receiving YESCARTA, including ≥ Grade 3 in 25%. Neurologic toxicities occurred in 87% (94/108) of patients with LBCL in ZUMA-1, including ≥ Grade 3 in 31% and in 74% (124/168) of patients in ZUMA-7 including ≥ Grade 3 in 25%. The median time to onset was 4 days (range: 1-43 days) and the median duration was 17 days for patients with LBCL in ZUMA-1. The median time to onset for neurologic toxicity was 5 days (range: 1-133 days) and median duration was 15 days in patients with LBCL in ZUMA-7.

Please see additional Important Safety Information throughout.

YESCARTA® (axicabtagene ciloleucel) Suspension for IV infusion

YESCARTA demonstrated significant improvement in EFS* vs salvage chemotherapy +/- HDT+ASCT, a current standard therapy (N=359)[1,2]

More than double the number of patients treated with YESCARTA remain event free at 2 years compared with standard therapy[1,2,6†]



PRIMARY ANALYSIS

60%

REDUCTION IN RISK OF EFS EVENTS[6]

HR: 0.398

(95% CI, 0.31-0.51)
(*P*<0.0001)

The tick marks represent censored patients. Patients who did not meet the event criteria had their data censored; disease progression events and censoring times were determined on the basis of blinded central review.[1] At 24 months, 48 patients in the YESCARTA arm and 26 patients in the standard therapy arm were censored.[7]

- **The estimated 18-month EFS rate was 41.5% (95% CI, 34.2-48.6) in the YESCARTA arm and 17.0% (95% CI, 11.8-23.0) in the standard therapy arm[2]**

QUADRUPLED mEFS WITH YESCARTA vs STANDARD THERAPY

(8.3 MONTHS [95% CI, 4.5-15.8] vs 2 MONTHS [95% CI, 1.6-2.8])[2‡]

*EFS is defined as the time from randomization to the earliest date of disease progression or relapse, best response of stable disease up to and including the day 150 assessment, commencement of new lymphoma therapy, or death from any cause. Response was assessed by an independent review committee, per the International Working Group Lugano classification (Cheson 2014).[2]

†EFS rate at 2 years is a KM estimate and should be carefully interpreted due to the number of censored patients. Data are not included in the YESCARTA Prescribing Information.[1]

‡KM estimate.[2]

2L=second line; ASCT=autologous stem cell transplant; CI=confidence interval; EFS=event-free survival; HDT=high-dose therapy; HR=hazard ratio; KM=Kaplan-Meier; mEFS=median event-free survival.

IMPORTANT SAFETY INFORMATION

NEUROLOGIC TOXICITIES (continued)

Neurologic toxicities occurred in 77% (112/146) of patients with iNHL, including ≥ Grade 3 in 21%. The median time to onset was 6 days (range: 1-79 days) and the median duration was 16 days. Ninety-eight percent of all neurologic toxicities in patients with LBCL and 99% of all neurologic toxicities in patients with iNHL occurred within the first 8 weeks of YESCARTA infusion. Neurologic toxicities occurred within the first 7 days of infusion for 87% of affected patients with LBCL and 74% of affected patients with iNHL.

Please see additional Important Safety Information throughout.

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In ZUMA-7, YESCARTA demonstrated a well-characterized safety profile; AEs were managed per established guidance[2]

- In the ZUMA-7 trial, safety was evaluated in 168 patients with primary refractory or first relapse of LBCL treated with YESCARTA[2]
- ZUMA-7 safety data were consistent with previous YESCARTA ≥3L LBCL clinical trial data and real-world experience[1,8-10]
  - No new safety signals were identified

Cytokine release syndrome (CRS) (N=168)[2]

Grade ≥3 incidence	Overall incidence	Median time to onset	Median duration
7%	92%	3 DAYS (range: 1 to 10 days)	7 DAYS (range: 2 to 43 days)

Neurologic toxicities (N=168)[2]

Grade ≥3 incidence	Overall incidence	Median time to onset	Median duration
25%	74%	5 DAYS (range: 1 to 133 days)	15 DAYS

No Grade 5 CRS or neurologic toxicities[1]

2L=second line; 3L=third line; AE=adverse event; LBCL=large B-cell lymphoma.

Adverse reactions[2]

The most common non-laboratory adverse reactions to YESCARTA (incidence ≥20%) included fever, CRS, fatigue, hypotension, encephalopathy, tachycardia, diarrhea, headache, musculoskeletal pain, nausea, febrile neutropenia, chills, cough, infection with unspecified pathogen, dizziness, tremor, decreased appetite, edema, hypoxia, abdominal pain, aphasia, constipation, and vomiting. Serious adverse reactions occurred in 50% of patients. The most common serious adverse reactions (>5%) included CRS, fever, encephalopathy, hypotension, infection with unspecified pathogen, and pneumonia. Fatal adverse reactions occurred in 2% of patients.

The most common (≥10%) Grade 3 or higher non-laboratory adverse reactions included febrile neutropenia, encephalopathy, and hypotension.

This is not a complete list of adverse events associated with YESCARTA. For additional information, please see Important Safety Information throughout.

Please see additional Important Safety Information throughout.

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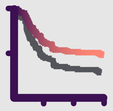
In the ZUMA-7 study, YESCARTA demonstrated significant improvement in EFS* vs salvage chemotherapy +/- HDT+ASCT, the current standard therapy (N=359)[2]

More than double the patients remain event free at 2 years[1,2,6†]



- 40.5% with YESCARTA (95% CI, 33.2-47.7) vs 16.3% with standard therapy (95% CI, 11.1-22.2)
- Primary analysis: 60% reduction in risk of EFS events (HR: 0.398); *P*<0.0001
- The estimated 18-month EFS was 41.5% (95% CI, 34.2-48.6) in the YESCARTA arm and 17.0% (95% CI, 11.8-23.0) in the standard therapy arm
- Quadrupled mEFS with YESCARTA (8.3 months) vs standard therapy (2 months)[‡]

Deep and durable remissions[2,5]

- Significant improvement in ORR (*P*<0.0001) with YESCARTA vs standard therapy (83% [95% CI, 77-88] vs 50% [95% CI, 43-58])[§]
- Doubled CR rate with YESCARTA vs standard therapy (65% [95% CI, 58-72] vs 32% [95% CI, 26-40])
- The median DOR was 26.9 months (95% CI, 13.6-NE) in patients treated with YESCARTA (number of responders=150)[||]

Well-characterized safety profile[2]

- AEs were managed per established guidance
- ZUMA-7 safety data were consistent with previous YESCARTA ≥3L LBCL clinical trial data and real-world experience[1,8-10]
  - No new safety signals were identified

Supported by NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)[11]

Axicabtagene ciloleucel (YESCARTA) is the **ONLY** CAR T with a Category 1 recommendation from NCCN Guidelines® for treatment of 2L DLBCL patients with primary refractory or relapsed disease within 12 months

NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

*EFS is defined as the time from randomization to the earliest date of disease progression or relapse, best response of stable disease up to and including the day 150 assessment, commencement of new lymphoma therapy, or death from any cause. Response was assessed by an independent review committee, per the International Working Group Lugano classification (Cheson 2014).[2]
†EFS rate at 2 years is a KM estimate and should be carefully interpreted due to the number of censored patients. Data are not included in the YESCARTA Prescribing Information.[1]
‡KM estimate.[2]
§Assessed per Cochran-Mantel-Haenszel method for best objective response rate. For all stratified analyses, stratification was based on response to 1L therapy (primary refractory vs relapse within 6 months of 1L therapy vs relapse within >6 but ≤12 months) and 2L age-adjusted IPI.[2]
||The estimated median DOR was 28.4 months (95% CI, 26.9-NE) in patients who achieved CR and 1.6 months (95% CI, 1.4-1.9) in patients who achieved a best response of PR.[2]

1L=first line; 2L=second line; 3L=third line; AE=adverse event; ASCT=autologous stem cell transplant; CAR T=chimeric antigen receptor T cell; CI=confidence interval; CR=complete remission; DLBCL=diffuse large B-cell lymphoma; DOR=duration of response; EFS=event-free survival; HDT=high-dose therapy; HR=hazard ratio; IPI=International Prognostic Index; KM=Kaplan-Meier; LBCL=large B-cell lymphoma; mEFS=median event-free survival; NE=not estimable; ORR=objective response rate; PR=partial remission.

IMPORTANT SAFETY INFORMATION

NEUROLOGIC TOXICITIES (continued)

The most common neurologic toxicities (≥ 10%) in all patients combined included encephalopathy (50%), headache (43%), tremor (29%), dizziness (21%), aphasia (17%), delirium (15%), and insomnia (10%). Prolonged encephalopathy lasting up to 173 days was noted. Serious events, including aphasia, leukoencephalopathy, dysarthria, lethargy, and seizures occurred. Fatal and serious cases of cerebral edema and encephalopathy, including late-onset encephalopathy, have occurred.

Please see additional Important Safety Information throughout.

IMPORTANT SAFETY INFORMATION

NEUROLOGIC TOXICITIES (continued)

The impact of tocilizumab and/or corticosteroids on the incidence and severity of neurologic toxicities was assessed in 2 subsequent cohorts of LBCL patients in ZUMA-1. Among patients who received corticosteroids at the onset of Grade 1 toxicities, neurologic toxicities occurred in 78% (32/41) and 20% (8/41) had Grade 3 neurologic toxicities; no patients experienced a Grade 4 or 5 event. The median time to onset of neurologic toxicities was 6 days (range: 1-93 days) with a median duration of 8 days (range: 1-144 days). Prophylactic treatment with corticosteroids was administered to a cohort of 39 patients for 3 days beginning on the day of infusion of YESCARTA. Of those patients, 85% (33/39) developed neurologic toxicities; 8% (3/39) developed Grade 3, and 5% (2/39) developed Grade 4 neurologic toxicities. The median time to onset of neurologic toxicities was 6 days (range: 1-274 days) with a median duration of 12 days (range: 1-107 days). Prophylactic corticosteroids for management of CRS and neurologic toxicities may result in higher grade of neurologic toxicities or prolongation of neurologic toxicities, delay the onset and decrease the duration of CRS.

Monitor patients for signs and symptoms of neurologic toxicities at least daily for 7 days at the certified healthcare facility, and for 4 weeks thereafter, and treat promptly.

REMS

Because of the risk of CRS and neurologic toxicities, YESCARTA is available only through a restricted program called the YESCARTA and TECARTUS REMS Program which requires that: Healthcare facilities that dispense and administer YESCARTA must be enrolled and comply with the REMS requirements and must have on-site, immediate access to a minimum of 2 doses of tocilizumab for each patient for infusion within 2 hours after YESCARTA infusion, if needed for treatment of CRS. Certified healthcare facilities must ensure that healthcare providers who prescribe, dispense, or administer YESCARTA are trained about the management of CRS and neurologic toxicities. Further information is available at www.YescartaTecartusREMS.com or 1-844-454-KITE (5483).

HYPERSENSITIVITY REACTIONS

Allergic reactions, including serious hypersensitivity reactions or anaphylaxis, may occur with the infusion of YESCARTA.

SERIOUS INFECTIONS

Severe or life-threatening infections occurred. Infections (all grades) occurred in 45% of patients with NHL. ≥ Grade 3 infections occurred in 17% of patients, including ≥ Grade 3 infections with an unspecified pathogen in 12%, bacterial infections in 5%, viral infections in 3%, and fungal infections in 1%. YESCARTA should not be administered to patients with clinically significant active systemic infections. Monitor patients for signs and symptoms of infection before and after infusion and treat appropriately. Administer prophylactic antimicrobials according to local guidelines.

Febrile neutropenia was observed in 36% of patients with NHL 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.

In immunosuppressed patients, including those who have received YESCARTA, life-threatening and fatal opportunistic infections including disseminated fungal infections (e.g., candida sepsis and aspergillus infections) and viral reactivation (e.g., human herpes virus-6 [HHV-6] encephalitis and JC virus progressive multifocal leukoencephalopathy [PML]) have been reported. The possibility of HHV-6 encephalitis and PML should be considered in immunosuppressed patients with neurologic events and appropriate diagnostic evaluations should be performed.

Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, has occurred in patients treated with drugs directed against B cells, including YESCARTA. Perform screening for HBV, HCV, and HIV and management in accordance with clinical guidelines before collection of cells for manufacturing.

PROLONGED CYTOPENIAS

Patients may exhibit cytopenias for several weeks following lymphodepleting chemotherapy and YESCARTA infusion. ≥ Grade 3 cytopenias not resolved by Day 30 following YESCARTA infusion occurred in 39% of all patients with NHL and included neutropenia (33%), thrombocytopenia (13%), and anemia (8%). Monitor blood counts after infusion.

Please see additional Important Safety Information throughout.

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IMPORTANT SAFETY INFORMATION

HYPOGAMMAGLOBULINEMIA

B-cell aplasia and hypogammaglobulinemia can occur. Hypogammaglobulinemia was reported as an adverse reaction in 14% of all patients with NHL. Monitor immunoglobulin levels after treatment and manage using infection precautions, antibiotic prophylaxis, and immunoglobulin replacement. The safety of immunization with live viral vaccines during or following YESCARTA 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 YESCARTA treatment, and until immune recovery following treatment.

SECONDARY MALIGNANCIES

Secondary malignancies may develop. Monitor life-long for secondary malignancies. In the event that one occurs, contact Kite at 1-844-454-KITE (5483) to obtain instructions on patient samples to collect for testing.

EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Due to the potential for neurologic events, including altered mental status or seizures, patients are at risk for altered or decreased consciousness or coordination in the 8 weeks following YESCARTA infusion. Advise patients to refrain from driving and engaging in hazardous occupations or activities, such as operating heavy or potentially dangerous machinery, during this initial period.

ADVERSE REACTIONS

The most common non-laboratory adverse reactions (incidence ≥ 20%) in patients with LBCL in ZUMA-7 included fever, CRS, fatigue, hypotension, encephalopathy, tachycardia, diarrhea, headache, musculoskeletal pain, nausea, febrile neutropenia, chills, cough, infection with unspecified pathogen, dizziness, tremor, decreased appetite, edema, hypoxia, abdominal pain, aphasia, constipation, and vomiting.

References

1. Locke FL, Miklos DB, Jacobson CA, et al. Axicabtagene ciloleucel as second-line therapy for large B-cell lymphoma. *N Engl J Med*. 2022;386(7):640-654. **2.** YESCARTA® (axicabtagene ciloleucel). Prescribing information. Kite Pharma, Inc; 2022. **3.** Data on file [1]. Kite Pharma, Inc; 2021. **4.** Data on file [2]. Kite Pharma, Inc; 2021. **5.** Locke FL, Miklos DB, Jacobson CA, et al. Axicabtagene ciloleucel as second-line therapy for large B-cell lymphoma. *N Engl J Med.* 2022;386(7):640-654 (suppl). doi:10.1056/NEJMoa2116133 **6.** Data on file [3]. Kite Pharma, Inc; 2021. **7.** Data on file. Kite Pharma, Inc; 2022. **8.** Locke FL, Ghobadi A, Jacobson CA, et al. Long-term safety and activity of axicabtagene ciloleucel in refractory large B-cell lymphoma (ZUMA-1): a single-arm, multicentre, phase 1–2 trial. *Lancet Oncol*. 2019;20(1):31-42. **9.** Nastoupil LJ, Jain MD, Feng L, et al. Standard-of-care axicabtagene ciloleucel for relapsed or refractory large B-cell lymphoma: results from the US Lymphoma CAR T Consortium. *J Clin Oncol*. 2020;38(27):3119-3128. **10.** Sanderson R, Benjamin R, Patten P, et al. Axi-cel for large B-cell lymphoma: real-world outcomes from a prospective UK cohort. Poster presented at: European Society for Blood and Marrow Transplantation (EBMT) 46th Annual Meeting; August 29-September 1, 2020; Virtual. **11.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for B-Cell Lymphomas V.2.2022. © National Comprehensive Cancer Network, Inc. 2022. All rights reserved. Accessed March 21, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org.

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Please see additional Important Safety Information throughout, and full Prescribing Information, including **BOXED WARNING** and Medication Guide.