



## **News Release**

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## **Janssen Aims to Define New Standards of Care in the Treatment of Solid Tumor Cancers with Transformative Data Planned for Presentation at ESMO**

*Three Phase 3 RYBREVANT® (amivantamab-vmjw) studies (MARIPOSA, MARIPOSA-2 and PAPILLON) in EGFR-mutated lung cancer achieved statistically significant and clinically meaningful progression-free survival endpoints and will be presented in Presidential Symposium sessions*

*New results for investigational TAR-200 and TAR-210 novel intravesical delivery system highlight potential for transformational outcomes in the treatment of bladder cancer*

**RARITAN, N.J., October 16, 2023** — The Janssen Pharmaceutical Companies of Johnson & Johnson announced today that nine oral presentations from the Company's robust solid tumor portfolio and pipeline, with three highlighted in Presidential Symposium sessions, will be featured at the European Society for Medical Oncology (ESMO) 2023 Congress. In total, 19 studies (17 company-sponsored abstracts and two investigator-initiated studies), including seven late-breaking abstracts, will feature new data and updates in lung cancer, bladder cancer, and prostate cancer, highlighting Janssen's pioneering efforts to transform the treatment of solid tumors.

"The data and results premiering at this year's ESMO represent our determination to advance oncology science and set new innovation standards in the treatment of solid tumor malignancies," said Peter Lebowitz, M.D., PhD, Global Therapeutic Area Head, Oncology, Janssen Research & Development, LLC. "We are uniquely positioned to build upon our legacy of innovation in oncology as we aim to improve patients' lives by transforming the treatment of non-small cell lung cancer and genitourinary cancers where massive unmet needs persist."

"This year marks Janssen's largest number of clinical presentations ever at the leading global oncology conference in Europe, highlighting our progress and commitment in bringing forward novel therapies and precision medicines," said Martin Vogel, EMEA Therapeutic Area Lead Oncology, Janssen-Cilag GmbH. "The evolution of targeted therapeutics in oncology presents a promising path forward to bring the very latest innovations to patients. We are proud to be at the forefront of advancing and delivering novel therapies as we continue our efforts to ultimately eliminate cancer."

### **Key ESMO Presentations**

Groundbreaking research in **lung cancer** at ESMO reinforces Janssen's ambition to transform the trajectory of disease, including in epidermal growth factor receptor (*EGFR*)-mutated non-small cell lung cancer (NSCLC).

Highlights include:

- A Presidential Symposium presentation from the Phase 3 MARIPOSA study, the largest study conducted to date in *EGFR*-mutated NSCLC, evaluating RYBREVANT® in combination with lazertinib versus osimertinib as a first-line treatment for patients with locally advanced or metastatic *EGFR*-mutated NSCLC (Abstract #LBA14).
- A Presidential Symposium presentation from the Phase 3 MARIPOSA-2 study evaluating RYBREVANT® plus chemotherapy, given with or without lazertinib, versus chemotherapy alone in patients with locally advanced or metastatic *EGFR*-mutated NSCLC with disease progression after treatment with osimertinib (Abstract #LBA15).
- A Presidential Symposium presentation from the Phase 3 PAPILLON study evaluating RYBREVANT® in combination with chemotherapy as a first-line treatment for patients with locally advanced or metastatic NSCLC with *EGFR* exon 20 insertion mutations (Abstract #LBA5).

Data in **bladder cancer** underscore Janssen's ambition to advance new therapies and approaches to address unmet treatment needs.

Key presentations include:

- An oral presentation from the Phase 2b SunRISe-1 study evaluating TAR-200 monotherapy in patients with Bacillus Calmette-Guerin (BCG)-unresponsive high-risk non-muscle invasive bladder cancer (NMIBC) (Abstract #LBA105).
- An oral presentation of the first safety and efficacy results from the Phase 1 TAR-210 (erdafitinib intravesical delivery system) study investigating patients with NMIBC with select fibroblast growth factor receptor (FGFR) alterations (Abstract #LBA104).
- An oral presentation from the Phase 2 THOR-2 study evaluating BALVERSA® versus intravesical chemotherapy in patients with high-risk NMIBC with select FGFR alterations who received prior BCG treatment (Abstract #LBA102).
- Two oral presentations highlighting data from Cohort 1 and Cohort 2 of the Phase 3 THOR study. Cohort 1 includes results investigating subgroup analyses of erdafitinib versus chemotherapy in patients with prior therapy including a checkpoint inhibitor with advanced or metastatic urothelial cancer (mUC) with select FGFR alterations (Abstract #2362MO). Cohort 2 includes findings evaluating erdafitinib versus pembrolizumab in pretreated patients with mUC and select FGFR alterations (Abstract #2359O).

Building on a legacy in the treatment of **prostate cancer**, data at ESMO highlight precision-driven and patient-centric strategies across the disease continuum.

Key highlights include:

- An oral presentation from the final analysis of the Phase 3 MAGNITUDE study evaluating niraparib with abiraterone acetate plus prednisone in the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) and homologous recombination repair (HRR) gene alterations, especially BRCA alterations (Abstract # LBA85).
- A poster presentation on the efficacy of niraparib with abiraterone acetate plus prednisone in HRR+ mCRPC by tissue and/or plasma assays in the Phase 3 MAGNITUDE trial (Abstract #1806P).

- A poster presentation on results from the Phase 3 TITAN study evaluating the prognostic importance of prostate-specific antigen decline ( $\leq 0.2$  ng/mL) in patients with metastatic castration-sensitive prostate cancer (mCSPC) who received apalutamide plus androgen deprivation therapy (Abstract #1786P).

All Janssen-sponsored abstracts to be presented are listed below:

<b>Lung Cancer</b>	
<b>RYBREVANT® (amivantamab-vmjw)</b>	
<b>Presidential Sessions</b>	
Abstract # <b>LBA5</b>	Amivantamab plus carboplatin/pemetrexed vs carboplatin/pemetrexed as first line treatment in EGFR exon 20 insertion-mutated advanced NSCLC: primary results from PAPILLON, a randomized Phase 3 global study
Abstract # <b>LBA15</b>	Amivantamab plus chemotherapy (with or without lazertinib) vs chemotherapy alone in EGFR-mutated, advanced NSCLC after progression on osimertinib: MARIPOSA-2, a Phase 3, global, randomized, controlled trial
Abstract # <b>LBA14</b>	Amivantamab plus lazertinib vs osimertinib as first-line treatment in patients with EGFR-mutated, advanced NSCLC: primary results from MARIPOSA, a Phase 3, global, randomized, controlled trial
<b>Poster Session</b>	
Abstract # <b>1506TiP</b>	A single-arm, phase 2 study of amivantamab, lazertinib and pemetrexed for first-line treatment of recurrent/metastatic NSCLCs with EGFR mutations: AMIGO-1 (LACOG0821)
<b>Bladder Cancer</b>	
<b>BALVERSA® (erdafitinib)</b>	
<b>Mini Oral</b>	
Abstract # <b>2362MO</b>	Erdafitinib (erda) vs chemotherapy (chemo) in patients with advanced or metastatic urothelial cancer with select FGFR alterations (FGFRalt): subgroups from the Phase 3 THOR study
<b>Proffered Paper</b>	
Abstract # <b>2359O</b>	Phase 3 THOR study: results of erdafitinib (erda) vs pembrolizumab (pembro) in pretreated patients with advanced or metastatic urothelial cancer with select FGFRalt
Abstract # <b>LBA102</b>	THOR-2 cohort 1: results of erdafitinib (ERDA) vs intravesical chemotherapy (chemo) in patients with high-risk (HR) NMIBC with select FGFRalt who received prior BCG treatment
<b>Poster Session</b>	
Abstract # <b>192P</b>	Impact of oncogenic FGFR alterations in patients with advanced solid tumors in a real-world setting

Abstract # <b>230P</b>	FGFR co-alteration (co-alt) landscape and its impact on erdafitinib (erda) response in the Phase 2 open-label, single-arm RAGNAR trial
Abstract # <b>1621P</b>	Efficacy and safety of erdafitinib in adults with pancreatic cancer and prespecified FGFRalt in the Phase 2 open-label, single-arm RAGNAR trial
<b>TAR-200</b>	
<b>Mini Oral</b>	
Abstract # <b>LBA105</b>	Results from SunRISe-1 in patients with BCG unresponsive high-risk NMIBC receiving TAR-200 monotherapy
<b>Poster Session</b>	
Abstract # <b>2407TiP</b>	SunRISe-3: TAR-200 plus cetrelimab (CET) or TAR-200 versus intravesical BCG in patients with BCG-naïve HR NMIBC
<b>TAR-210</b>	
<b>Mini Oral</b>	
Abstract # <b>LBA104</b>	First safety and efficacy results of the TAR-210 erdafitinib (erda) intravesical delivery system in pts with NMIBC with select FGFRalt
<b>Prostate Cancer</b>	
<b>AKEEGA™ (niraparib)</b>	
<b>Mini Oral</b>	
Abstract # <b>LBA85</b>	Niraparib (NIRA) with abiraterone acetate and prednisone (AAP) as first-line therapy in patients (pts) with mCRPC and HRR gene alterations: final analysis of MAGNITUDE
<b>Poster Session</b>	
Abstract # <b>1806P</b>	MAGNITUDE efficacy by assay: efficacy of niraparib and abiraterone acetate plus prednisone (NIRA+AAP) in HRR gene-altered mCRPC by tissue and/or plasma assays in the MAGNITUDE trial
Abstract # <b>1835P</b>	A prospective study to determine the prevalence of DNA repair defects in patients with advanced prostate cancer
<b>ERLEADA® (apalutamide)</b>	
<b>Poster Session</b>	
Abstract # <b>1786P</b>	Effect of rapid ultra-low prostate-specific antigen decline (UL PSA) in TITAN patients with mCSPC who received apalutamide (APA) plus androgen deprivation therapy (ADT)

### About RYBREVANT®

RYBREVANT® (amivantamab-vmjw), a fully-human bispecific antibody targeting EGFR and MET with immune cell-driven activity, received accelerated approval by the U.S. Food and Drug Administration (FDA) in May 2021 for the treatment of adult patients with locally advanced or metastatic NSCLC with *EGFR* exon 20 insertion mutations, as detected by an FDA-approved test, whose disease has progressed on or after platinum-based chemotherapy.<sup>1</sup> This indication is approved under accelerated approval based on overall

response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials. RYBREVANT® has also received approval from health authorities in Europe, as well as other markets around the world.

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Non-Small Cell Lung Cancer\* prefer NGS-based strategies over PCR-based approaches for the detection of *EGFR* exon 20 insertion variants and include amivantamab-vmjw (RYBREVANT®) as a subsequent therapy option with a Category 2A recommendation for patients that have progressed on or after platinum-based chemotherapy with or without immunotherapy and have *EGFR* exon 20 insertion mutation-positive advanced NSCLC.<sup>2,1††</sup>

RYBREVANT® is being studied in multiple clinical trials in NSCLC, including:

- The Phase 3 MARIPOSA ([NCT04487080](#)) study assessing RYBREVANT® in combination with lazertinib, a novel third generation EGFR TKI, versus osimertinib and versus lazertinib alone in the first-line treatment of patients with locally advanced or metastatic NSCLC with *EGFR* ex19del or L858R substitution mutations. Topline data for this randomized Phase 3 study [showed](#) statistically significant and clinically meaningful improvement in PFS in patients receiving RYBREVANT® plus lazertinib versus osimertinib.<sup>3</sup>
- The Phase 3 MARIPOSA-2 ([NCT04988295](#)) study assessing the efficacy of RYBREVANT® (with or without lazertinib) and carboplatin-pemetrexed versus carboplatin-pemetrexed in patients with locally advanced or metastatic *EGFR* ex19del or L858R substitution NSCLC after disease progression on or after osimertinib. Topline data for this randomized Phase 3 study [showed](#) statistically significant and clinically meaningful improvement in PFS in these patients receiving RYBREVANT® plus chemotherapy with and without lazertinib versus chemotherapy.<sup>4</sup>
- The Phase 3 PAPILLON ([NCT04538664](#)) study assessing RYBREVANT® in combination with carboplatin-pemetrexed versus carboplatin-pemetrexed in the first-line treatment of patients with advanced or metastatic NSCLC with *EGFR* exon 20 insertion mutations. Topline data for this randomized Phase 3 study [showed](#) statistically significant and clinically meaningful improvement in PFS in patients receiving RYBREVANT® versus chemotherapy.<sup>5</sup>
- The Phase 1 CHRYSALIS ([NCT02609776](#)) study evaluating RYBREVANT® in participants with advanced NSCLC.<sup>6</sup>
- The Phase 1/1b CHRYSALIS-2 ([NCT04077463](#)) study evaluating RYBREVANT® in combination with lazertinib and lazertinib as a monotherapy in patients with

advanced NSCLC with *EGFR* mutations.<sup>7</sup>

- The Phase 1 PALOMA ([NCT04606381](https://clinicaltrials.gov/ct2/show/study/NCT04606381)) study assessing the feasibility of subcutaneous (SC) administration of amivantamab based on safety and pharmacokinetics and to determine a dose, dose regimen, and formulation for amivantamab SC delivery.<sup>8</sup>
- The Phase 2 PALOMA-2 ([NCT05498428](https://clinicaltrials.gov/ct2/show/study/NCT05498428)) study assessing subcutaneous amivantamab in participants with advanced or metastatic solid tumors including *EGFR*-mutated NSCLC.<sup>9</sup>
- The Phase 3 PALOMA-3 ([NCT05388669](https://clinicaltrials.gov/ct2/show/study/NCT05388669)) study assessing lazertinib with subcutaneous amivantamab compared to intravenous amivantamab in participants with *EGFR*-mutated advanced or metastatic NSCLC.<sup>10</sup>
- The Phase 1/2 METalmark ([NCT05488314](https://clinicaltrials.gov/ct2/show/study/NCT05488314)) study assessing amivantamab and capmatinib combination therapy in locally advanced or metastatic NSCLC.<sup>11</sup>
- The Phase 1/2 PolyDamas ([NCT05908734](https://clinicaltrials.gov/ct2/show/study/NCT05908734)) study assessing amivantamab and cetrelimab combination therapy in locally advanced or metastatic NSCLC.<sup>12</sup>
- The Phase 2 SKIPPirr study ([NCT05663866](https://clinicaltrials.gov/ct2/show/study/NCT05663866)) exploring how to decrease the incidence and/or severity of first-dose infusion-related reactions with RYBREVANT® in combination with lazertinib in relapsed or refractory *EGFR*-mutated advanced or metastatic NSCLC.<sup>13</sup>

For more information, visit: <https://www.RYBREVANT.com>.

### **About Lazertinib**

Lazertinib is an oral, third-generation, brain-penetrant *EGFR* tyrosine kinase inhibitor (TKI) that targets both the T790M mutation and activating *EGFR* mutations while sparing wild type-*EGFR*. An analysis of the efficacy and safety of lazertinib from the Phase 3 study was published in [\*The Journal of Clinical Oncology\*](#) in 2023.<sup>14</sup> In 2018, Janssen Biotech, Inc., entered into a license and collaboration agreement with Yuhan Corporation for the development of lazertinib.

### **About BALVERSA®**

BALVERSA® (erdafitinib) is a once-daily, oral FGFR kinase inhibitor that is approved by the U.S. FDA for the treatment of adults with locally advanced or mUC that has susceptible FGFR3 or FGFR2 genetic alterations and has progressed during or following at least one line of platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy. Patients are selected for therapy based on an FDA-approved companion diagnostic for BALVERSA®. Information on FDA-approved tests for the detection of FGFR genetic alterations in urothelial cancer is available at: <http://www.fda.gov/CompanionDiagnostics>. This indication is approved under accelerated

approval based on tumor response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

In 2008, Janssen entered into an exclusive worldwide license and collaboration agreement with Astex Pharmaceuticals to develop and commercialize BALVERSA®.

For more information, visit [www.BALVERSA.com](http://www.BALVERSA.com).

### **About TAR-200**

TAR-200 is an investigational intravesical drug delivery system designed to provide continuous release of gemcitabine into the bladder. The safety and efficacy of TAR-200 are being evaluated in Phase 2 and Phase 3 studies in patients with muscle-invasive bladder cancer (MIBC) in [SunRISe-2](#) and [SunRISe-4](#) and NMIBC in [SunRISe-1](#) and [SunRISe-3](#).

### **About TAR-210**

TAR-210 is an investigational intravesical drug delivery system designed to provide local, continuous release of erdafitinib into the bladder. The safety and efficacy of TAR-210 is being evaluated in a Phase 1 study in patients with MIBC and NMIBC ([NCT05316155](#)).

### **About Cetrelimab**

Cetrelimab is an investigational anti-programmed cell death receptor-1 (PD-1) monoclonal antibody being studied to treat bladder cancer, prostate cancer, melanoma, and multiple myeloma as part of a combination treatment. Cetrelimab is also being evaluated in multiple other combination regimens across the Johnson & Johnson portfolio.

### **About AKEEGA™**

AKEEGA™ is a combination, in the form of a dual-action tablet (DAT), of niraparib, a highly selective poly (ADP-ribose) polymerase (PARP) inhibitor, and abiraterone acetate, a CYP17 inhibitor. AKEEGA™ together with prednisone or prednisolone was approved in April 2023 by the European Medicines Agency, and in August 2023 by the U.S. FDA, for the treatment of adult patients with deleterious or suspected deleterious *BRCA*-mutated (*BRCAm*) metastatic castration-resistant prostate cancer (mCRPC). Additional marketing authorization applications are under review across a number of countries globally.

Additional ongoing studies include the Phase 3 AMPLITUDE study, evaluating the combination of AKEEGA™ and prednisone in a biomarker-selected patient population with metastatic castration-sensitive prostate cancer (mCSPC).



In April 2016, Janssen Biotech, Inc., entered into a worldwide (except Japan) collaboration and license agreement with TESARO, Inc. (acquired by GlaxoSmithKline [GSK] in 2019) for exclusive rights to niraparib in prostate cancer. GSK holds rights to all other indications for niraparib.

### **About ERLEADA®**

ERLEADA® (apalutamide) is an androgen receptor signaling inhibitor indicated for the treatment of patients with non-metastatic castration-resistant prostate cancer (nmCRPC) and for the treatment of patients with mCSPC.<sup>15</sup> ERLEADA® received U.S. FDA approval for nmCRPC in February 2018, and received U.S. FDA approval for mCSPC in September 2019.<sup>15</sup> To date, more than 150,000 patients worldwide have been treated with ERLEADA®.

For more information, visit [www.ERLEADA.com](http://www.ERLEADA.com).

## **RYBREVANT® IMPORTANT SAFETY INFORMATION**

### **WARNINGS AND PRECAUTIONS**

#### **Infusion-Related Reactions**

RYBREVANT® can cause infusion-related reactions (IRR); signs and symptoms of IRR include dyspnea, flushing, fever, chills, nausea, chest discomfort, hypotension, and vomiting.

Based on the safety population, IRR occurred in 66% of patients treated with RYBREVANT®. Among patients receiving treatment on Week 1 Day 1, 65% experienced an IRR, while the incidence of IRR was 3.4% with the Day 2 infusion, 0.4% with the Week 2 infusion, and cumulatively 1.1% with subsequent infusions. Of the reported IRRs, 97% were Grade 1-2, 2.2% were Grade 3, and 0.4% were Grade 4. The median time to onset was 1 hour (range 0.1 to 18 hours) after start of infusion. The incidence of infusion modifications due to IRR was 62% and 1.3% of patients permanently discontinued RYBREVANT® due to IRR.

Premedicate with antihistamines, antipyretics, and glucocorticoids and infuse RYBREVANT® as recommended. Administer RYBREVANT® via a peripheral line on Week 1 and Week 2. Monitor patients for any signs and symptoms of infusion reactions during RYBREVANT® infusion in a setting where cardiopulmonary resuscitation medication and

equipment are available. Interrupt infusion if IRR is suspected. Reduce the infusion rate or permanently discontinue RYBREVANT® based on severity.

### **Interstitial Lung Disease/Pneumonitis**

RYBREVANT® can cause interstitial lung disease (ILD)/pneumonitis. Based on the safety population, ILD/pneumonitis occurred in 3.3% of patients treated with RYBREVANT®, with 0.7% of patients experiencing Grade 3 ILD/pneumonitis. Three patients (1%) discontinued RYBREVANT® due to ILD/pneumonitis.

Monitor patients for new or worsening symptoms indicative of ILD/pneumonitis (e.g., dyspnea, cough, fever). Immediately withhold RYBREVANT® in patients with suspected ILD/pneumonitis and permanently discontinue if ILD/pneumonitis is confirmed.

### **Dermatologic Adverse Reactions**

RYBREVANT® can cause rash (including dermatitis acneiform), pruritus and dry skin. Based on the safety population, rash occurred in 74% of patients treated with RYBREVANT®, including Grade 3 rash in 3.3% of patients. The median time to onset of rash was 14 days (range: 1 to 276 days). Rash leading to dose reduction occurred in 5% of patients, and RYBREVANT® was permanently discontinued due to rash in 0.7% of patients.

Toxic epidermal necrolysis occurred in one patient (0.3%) treated with RYBREVANT®.

Instruct patients to limit sun exposure during and for 2 months after treatment with RYBREVANT®. Advise patients to wear protective clothing and use broad spectrum UVA/UVB sunscreen. Alcohol-free emollient cream is recommended for dry skin.

If skin reactions develop, start topical corticosteroids and topical and/or oral antibiotics. For Grade 3 reactions, add oral steroids and consider dermatologic consultation. Promptly refer patients presenting with severe rash, atypical appearance or distribution, or lack of improvement within 2 weeks to a dermatologist. Withhold, dose reduce or permanently discontinue RYBREVANT® based on severity.

### **Ocular Toxicity**

RYBREVANT® can cause ocular toxicity including keratitis, dry eye symptoms, conjunctival redness, blurred vision, visual impairment, ocular itching, and uveitis. Based on the safety population, keratitis occurred in 0.7% and uveitis occurred in 0.3% of patients treated with RYBREVANT®. All events were Grade 1-2. Promptly refer patients presenting with eye

symptoms to an ophthalmologist. Withhold, dose reduce or permanently discontinue RYBREVANT® based on severity.

### **Embryo-Fetal Toxicity**

Based on its mechanism of action and findings from animal models, RYBREVANT® can cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential of the potential risk to the fetus. Advise female patients of reproductive potential to use effective contraception during treatment and for 3 months after the final dose of RYBREVANT®.

### **Adverse Reactions**

The most common adverse reactions ( $\geq 20\%$ ) were rash (84%), IRR (64%), paronychia (50%), musculoskeletal pain (47%), dyspnea (37%), nausea (36%), fatigue (33%), edema (27%), stomatitis (26%), cough (25%), constipation (23%), and vomiting (22%). The most common Grade 3 to 4 laboratory abnormalities ( $\geq 2\%$ ) were decreased lymphocytes (8%), decreased albumin (8%), decreased phosphate (8%), decreased potassium (6%), increased alkaline phosphatase (4.8%), increased glucose (4%), increased gamma-glutamyl transferase (4%), and decreased sodium (4%).

**Please read the full [Prescribing Information](#) for RYBREVANT®.**

## **BALVERSA® Important Safety Information**

### **Warnings and Precautions**

**Ocular Disorders** – BALVERSA® can cause ocular disorders, including central serous retinopathy/retinal pigment epithelial detachment (CSR/RPED) resulting in visual field defect.

CSR/RPED was reported in 25% of patients treated with BALVERSA®, with a median time to first onset of 50 days. Grade 3 CSR/RPED, involving central field of vision, was reported in 3% of patients. CSR/RPED resolved in 13% of patients and was ongoing in 13% of patients at the study cutoff. CSR/RPED led to dose interruptions and reductions in 9% and 14% of patients, respectively, and 3% of patients discontinued BALVERSA®. Dry eye symptoms occurred in 28% of patients during treatment with BALVERSA® and were Grade 3 in 6% of patients. All patients should receive dry eye prophylaxis with ocular demulcents as needed.

Perform monthly ophthalmological examinations during the first 4 months of treatment and every 3 months afterwards, and urgently at any time for visual symptoms. Ophthalmological examination should include assessment of visual acuity, slit lamp examination, fundoscopy, and optical coherence tomography. Withhold BALVERSA® when CSR occurs and permanently discontinue if it does not resolve within 4 weeks or if Grade 4 in severity. For ocular adverse reactions, follow the dose modification guidelines [see *Dosage and Administration (2.3)*].

**Hyperphosphatemia and Soft Tissue Mineralization** – BALVERSA® can cause hyperphosphatemia leading to soft tissue mineralization, cutaneous calcinosis, non-uremic calciphylaxis and vascular calcification. Increases in phosphate levels are a pharmacodynamic effect of BALVERSA® [see *Pharmacodynamics (12.2)*]. Hyperphosphatemia was reported as an adverse reaction in 76% of patients treated with BALVERSA®. The median onset time for any grade event of hyperphosphatemia was 20 days (range: 8–116) after initiating BALVERSA®. Thirty-two percent of patients received phosphate binders during treatment with BALVERSA®. Cutaneous calcinosis, non-uremic calciphylaxis and vascular calcification have been observed in 0.3% of patients treated with BALVERSA®.

Monitor for hyperphosphatemia throughout treatment. In all patients, restrict phosphate intake to 600-800 mg daily. If serum phosphate is above 7.0 mg/dL, consider adding an oral phosphate binder until serum phosphate level returns to <5.5 mg/dL. Withhold, dose reduce, or permanently discontinue BALVERSA® based on duration and severity of hyperphosphatemia [see *Dosage and Administration (2.3)*, *Table 2: Dose Modifications for Adverse Reactions*].

**Embryo-Fetal Toxicity** – Based on the mechanism of action and findings in animal reproduction studies, BALVERSA® can cause fetal harm when administered to a pregnant woman. In a rat embryo-fetal toxicity study, erdafitinib was embryotoxic and teratogenic at exposures less than the human exposures at all doses studied. Advise pregnant women of the potential risk to the fetus. Advise female patients of reproductive potential to use effective contraception during treatment with BALVERSA® and for one month after the last dose. Advise male patients with female partners of reproductive potential to use effective contraception during treatment with BALVERSA® and for one month after the last dose [see *Use in Specific Populations (8.1, 8.3)* and *Clinical Pharmacology (12.1)*].

**Most common adverse reactions including laboratory abnormalities ≥20%:**

Phosphate increased (76%), stomatitis (56%), fatigue (54%), creatinine increased (52%), diarrhea (47%), dry mouth (45%), nail disorder (45%), alanine aminotransferase increased (41%), alkaline phosphatase increased (41%), sodium decreased (40%), decreased appetite (38%), albumin decreased (37%), dysgeusia (37%), hemoglobin decreased (35%), dry skin (34%), aspartate aminotransferase increased (30%), magnesium decreased (30%), dry eye (28%), alopecia (26%), palmar-plantar erythrodysesthesia syndrome (26%), constipation (28%), phosphate decreased (24%), abdominal pain (23%), calcium increased (22%), nausea (21%), and musculoskeletal pain (20%). The most common Grade 3 or greater adverse reactions (>1%) were stomatitis (9%), nail dystrophy<sup>§</sup>, palmar-plantar erythrodysesthesia syndrome (6%), paronychia (3%), nail disorder (10%), keratitis<sup>||</sup>, and hyperphosphatemia (1%).

<sup>§</sup>Included within nail disorder. <sup>||</sup>Included within dry eye.

- An adverse reaction with a fatal outcome in 1% of patients was acute myocardial infarction.
- Serious adverse reactions occurred in 41% of patients, including eye disorders (10%).
- Permanent discontinuation due to an adverse reaction occurred in 13% of patients. The most frequent reasons for permanent discontinuation included eye disorders (6%).
- Dosage interruptions occurred in 68% of patients. The most frequent adverse reactions requiring dosage interruption included hyperphosphatemia (24%), stomatitis (17%), eye disorders (17%), and palmar-plantar erythrodysesthesia syndrome (8%).
- Dose reductions occurred in 53% of patients. The most frequent adverse reactions for dose reductions included eye disorders (23%), stomatitis (15%), hyperphosphatemia (7%), palmar-plantar erythrodysesthesia syndrome (7%), paronychia (7%), and nail dystrophy (6%).

### **Drug Interactions**

- Moderate CYP2C9 or strong CYP3A4 Inhibitors: Consider alternative agents or monitor closely for adverse reactions. (7.1)
- Strong CYP2C9 or CYP3A4 inducers: Avoid concomitant use with BALVERSA<sup>®</sup>. (7.1)
- Moderate CYP2C9 or CYP3A4 inducers: Increase BALVERSA<sup>®</sup> dose up to 9 mg. (7.1)

- Serum phosphate level-altering agents: Avoid concomitant use with agents that can alter serum phosphate levels before the initial dose modification period. (2.3, 7.1)
- CYP3A4 substrates: Avoid concomitant use with sensitive CYP3A4 substrates with narrow therapeutic indices. (7.2)
- OCT2 substrates: Consider alternative agents or consider reducing the dose of OCT2 substrates based on tolerability. (7.2)
- P-gp substrates: Separate BALVERSA® administration by at least 6 hours before or after administration of P-gp substrates with narrow therapeutic indices. (7.2)

### **Use in Specific Populations**

**Lactation** – Because of the potential for serious adverse reactions from erdafitinib in a breastfed child, advise lactating women not to breastfeed during treatment with BALVERSA® and for one month following the last dose.

Please [click here](#) to see full BALVERSA® Prescribing Information.

## **AKEEGA™ IMPORTANT SAFETY INFORMATION**

### **WARNINGS AND PRECAUTIONS**

The safety population described in the WARNINGS and PRECAUTIONS reflect exposure to AKEEGA™ in combination with prednisone in *BRCAm* patients in Cohort 1 (N=113) of MAGNITUDE.

#### **Myelodysplastic Syndrome/Acute Myeloid Leukemia**

AKEEGA™ may cause myelodysplastic syndrome/acute myeloid leukemia (MDS/AML).

MDS/AML, including cases with fatal outcome, has been observed in patients treated with niraparib, a component of AKEEGA™.

All patients treated with niraparib who developed secondary MDS/cancer-therapy-related AML had received previous chemotherapy with platinum agents and/or other DNA-damaging agents, including radiotherapy.

For suspected MDS/AML or prolonged hematological toxicities, refer the patient to a hematologist for further evaluation. Discontinue AKEEGA™ if MDS/AML is confirmed.

#### **Myelosuppression**

AKEEGA™ may cause myelosuppression (anemia, thrombocytopenia, or neutropenia).

In MAGNITUDE Cohort 1, Grade 3-4 anemia, thrombocytopenia, and neutropenia were reported, respectively in 28%, 8%, and 7% of patients receiving AKEEGA™. Overall, 27% of patients required a red blood cell transfusion, including 11% who required multiple transfusions. Discontinuation due to anemia occurred in 3% of patients.

Monitor complete blood counts weekly during the first month of AKEEGA™ treatment, every two weeks for the next two months, monthly for the remainder of the first year and then every other month, and as clinically indicated. Do not start AKEEGA™ until patients have adequately recovered from hematologic toxicity caused by previous therapy. If hematologic toxicities do not resolve within 28 days following interruption, discontinue AKEEGA™ and refer the patient to a hematologist for further investigations, including bone marrow analysis and blood sample for cytogenetics.

### **Hypokalemia, Fluid Retention, and Cardiovascular Adverse Reactions**

AKEEGA™ may cause hypokalemia and fluid retention as a consequence of increased mineralocorticoid levels resulting from CYP17 inhibition. In post-marketing experience, QT prolongation and Torsades de Pointes have been observed in patients who develop hypokalemia while taking abiraterone acetate, a component of AKEEGA™. Hypertension and hypertensive crisis have also been reported in patients treated with niraparib, a component of AKEEGA™.

In MAGNITUDE Cohort 1, which used prednisone 10 mg daily in combination with AKEEGA™, Grades 3-4 hypokalemia was detected in 2.7% of patients on the AKEEGA™ arm and Grades 3-4 hypertension were observed in 14% of patients on the AKEEGA™ arm.

The safety of AKEEGA™ in patients with New York Heart Association (NYHA) Class II to IV heart failure has not been established because these patients were excluded from MAGNITUDE.

Monitor patients for hypertension, hypokalemia, and fluid retention at least weekly for the first two months, then once a month. Closely monitor patients whose underlying medical conditions might be compromised by increases in blood pressure, hypokalemia, or fluid retention, such as those with heart failure, recent myocardial infarction, cardiovascular disease, or ventricular arrhythmia. Control hypertension and correct hypokalemia before and during treatment with AKEEGA™.

Discontinue AKEEGA™ in patients who develop hypertensive crisis or other severe cardiovascular adverse reactions.

### **Hepatotoxicity**

AKEEGA™ may cause hepatotoxicity.

Hepatotoxicity in patients receiving abiraterone acetate, a component of AKEEGA™, has been reported in clinical trials. In post-marketing experience, there have been abiraterone acetate-associated severe hepatic toxicity, including fulminant hepatitis, acute liver failure, and deaths.

In MAGNITUDE Cohort 1, Grade 3-4 ALT or AST increases (at least 5 x ULN) were reported in 1.8% of patients. The safety of AKEEGA™ in patients with moderate or severe hepatic impairment has not been established as these patients were excluded from MAGNITUDE.

Measure serum transaminases (ALT and AST) and bilirubin levels prior to starting treatment with AKEEGA™, every two weeks for the first three months of treatment and monthly thereafter. Promptly measure serum total bilirubin, AST, and ALT if clinical symptoms or signs suggestive of hepatotoxicity develop. Elevations of AST, ALT, or bilirubin from the patient's baseline should prompt more frequent monitoring and may require dosage modifications.

Permanently discontinue AKEEGA™ for patients who develop a concurrent elevation of ALT greater than 3 x ULN and total bilirubin greater than 2 x ULN in the absence of biliary obstruction or other causes responsible for the concurrent elevation, or in patients who develop ALT or AST  $\geq 20$  x ULN at any time after receiving AKEEGA™.

### **Adrenocortical Insufficiency**

AKEEGA™ may cause adrenal insufficiency.

Adrenocortical insufficiency has been reported in clinical trials in patients receiving abiraterone acetate, a component of AKEEGA™, in combination with prednisone, following interruption of daily steroids and/or with concurrent infection or stress. Monitor patients for symptoms and signs of adrenocortical insufficiency, particularly if patients are withdrawn from prednisone, have prednisone dose reductions, or experience unusual stress. Symptoms and signs of adrenocortical insufficiency may be masked by adverse reactions associated with mineralocorticoid excess seen in patients treated with abiraterone acetate. If clinically indicated, perform appropriate tests to confirm the diagnosis of adrenocortical insufficiency. Increased doses of corticosteroids may be indicated before, during, and after stressful situations.



## **Hypoglycemia**

AKEEGA™ may cause hypoglycemia in patients being treated with other medications for diabetes.

Severe hypoglycemia has been reported when abiraterone acetate, a component of AKEEGA™, was administered to patients receiving medications containing thiazolidinediones (including pioglitazone) or repaglinide.

Monitor blood glucose in patients with diabetes during and after discontinuation of treatment with AKEEGA™. Assess if antidiabetic drug dosage needs to be adjusted to minimize the risk of hypoglycemia.

## **Increased Fractures and Mortality in Combination with Radium 223 Dichloride**

AKEEGA™ with prednisone is not recommended for use in combination with Ra-223 dichloride outside of clinical trials.

The clinical efficacy and safety of concurrent initiation of abiraterone acetate plus prednisone/prednisolone and radium Ra 223 dichloride was assessed in a randomized, placebo-controlled multicenter study (ERA-223 trial) in 806 patients with asymptomatic or mildly symptomatic castration-resistant prostate cancer with bone metastases. The study was unblinded early based on an Independent Data Monitoring Committee recommendation.

At the primary analysis, increased incidences of fractures (29% vs 11%) and deaths (39% vs 36%) have been observed in patients who received abiraterone acetate plus prednisone/prednisolone in combination with radium Ra 223 dichloride compared to patients who received placebo in combination with abiraterone acetate plus prednisone.

It is recommended that subsequent treatment with Ra-223 not be initiated for at least five days after the last administration of AKEEGA™, in combination with prednisone.

## **Posterior Reversible Encephalopathy Syndrome**

AKEEGA™ may cause Posterior Reversible Encephalopathy Syndrome (PRES).

PRES has been observed in patients treated with niraparib as a single agent at higher than the recommended dose of niraparib included in AKEEGA™.

Monitor all patients treated with AKEEGA™ for signs and symptoms of PRES. If PRES is suspected, promptly discontinue AKEEGA™ and administer appropriate treatment. The safety of reinitiating AKEEGA™ in patients previously experiencing PRES is not known.

### **Embryo-Fetal Toxicity**

The safety and efficacy of AKEEGA™ have not been established in females. Based on animal reproductive studies and mechanism of action, AKEEGA™ can cause fetal harm and loss of pregnancy when administered to a pregnant female.

Niraparib has the potential to cause teratogenicity and/or embryo-fetal death since niraparib is genotoxic and targets actively dividing cells in animals and patients (e.g., bone marrow).

In animal reproduction studies, oral administration of abiraterone acetate to pregnant rats during organogenesis caused adverse developmental effects at maternal exposures approximately  $\geq 0.03$  times the human exposure (AUC) at the recommended dose.

Advise males with female partners of reproductive potential to use effective contraception during treatment and for 4 months after the last dose of AKEEGA™. Females who are or may become pregnant should handle AKEEGA™ with protection, e.g., gloves.

Based on animal studies, AKEEGA™ may impair fertility in males of reproductive potential.

### **ADVERSE REACTIONS**

The safety of AKEEGA™ in patients with *BRCAm* mCRPC was evaluated in Cohort 1 of MAGNITUDE.

The most common adverse reactions ( $\geq 10\%$ ), including laboratory abnormalities, are decreased hemoglobin, decreased lymphocytes, decreased white blood cells, musculoskeletal pain, fatigue, decreased platelets, increased alkaline phosphatase, constipation, hypertension, nausea, decreased neutrophils, increased creatinine, increased potassium, decreased potassium, increased AST, increased ALT, edema, dyspnea, decreased appetite, vomiting, dizziness, COVID-19, headache, abdominal pain, hemorrhage, urinary tract infection, cough, insomnia, increased bilirubin, weight decreased, arrhythmia, fall, and pyrexia.

Serious adverse reactions reported in  $>2\%$  of patients included COVID-19 (7%), anemia (4.4%), pneumonia (3.5%), and hemorrhage (3.5%). Fatal adverse reactions occurred in 9% of patients who received AKEEGA™, including COVID-19 (5%), cardiopulmonary arrest (1%), dyspnea (1%), pneumonia (1%), and septic shock (1%).

### **DRUG INTERACTIONS**

#### **Effect of Other Drugs on AKEEGA™**

Avoid coadministration with strong CYP3A4 inducers.

Abiraterone is a substrate of CYP3A4. Strong CYP3A4 inducers may decrease abiraterone concentrations, which may reduce the effectiveness of abiraterone.

### **Effects of AKEEGA™ on Other Drugs**

Avoid coadministration unless otherwise recommended in the Prescribing Information for CYP2D6 substrates for which minimal changes in concentration may lead to serious toxicities. If alternative treatments cannot be used, consider a dose reduction of the concomitant CYP2D6 substrate drug.

Abiraterone is a CYP2D6 moderate inhibitor. AKEEGA™ increases the concentration of CYP2D6 substrates, which may increase the risk of adverse reactions related to these substrates.

Monitor patients for signs of toxicity related to a CYP2C8 substrate for which a minimal change in plasma concentration may lead to serious or life-threatening adverse reactions.

Abiraterone is a CYP2C8 inhibitor. AKEEGA™ increases the concentration of CYP2C8 substrates, which may increase the risk of adverse reactions related to these substrates.

**Please see the full [Prescribing Information](#) for AKEEGA™.**

## **ERLEADA® IMPORTANT SAFETY INFORMATION**

### **WARNINGS AND PRECAUTIONS**

**Cerebrovascular and Ischemic Cardiovascular Events** — In a randomized study (SPARTAN) of patients with nmCRPC, ischemic cardiovascular events occurred in 3.7% of patients treated with ERLEADA® and 2% of patients treated with placebo. In a randomized study (TITAN) in patients with mCSPC, ischemic cardiovascular events occurred in 4.4% of patients treated with ERLEADA® and 1.5% of patients treated with placebo. Across the SPARTAN and TITAN studies, 4 patients (0.3%) treated with ERLEADA® and 2 patients (0.2%) treated with placebo died from an ischemic cardiovascular event. Patients with history of unstable angina, myocardial infarction, congestive heart failure, stroke, or transient ischemic attack within 6 months of randomization were excluded from the SPARTAN and TITAN studies.

In the SPARTAN study, cerebrovascular events occurred in 2.5% of patients treated with ERLEADA® and 1% of patients treated with placebo. In the TITAN study, cerebrovascular events occurred in 1.9% of patients treated with ERLEADA® and 2.1% of patients treated with placebo. Across the SPARTAN and TITAN studies, 3 patients (0.2%) treated with ERLEADA®, and 2 patients (0.2%) treated with placebo died from a cerebrovascular event.

Cerebrovascular and ischemic cardiovascular events, including events leading to death, occurred in patients receiving ERLEADA®. Monitor for signs and symptoms of ischemic heart disease and cerebrovascular disorders. Optimize management of cardiovascular risk factors, such as hypertension, diabetes, or dyslipidemia. Consider discontinuation of ERLEADA® for Grade 3 and 4 events.

**Fractures** — In a randomized study (SPARTAN) of patients with nmCRPC, fractures occurred in 12% of patients treated with ERLEADA® and in 7% of patients treated with placebo. In a randomized study (TITAN) of patients with mCSPC, fractures occurred in 9% of patients treated with ERLEADA® and in 6% of patients treated with placebo. Evaluate patients for fracture risk. Monitor and manage patients at risk for fractures according to established treatment guidelines and consider use of bone-targeted agents.

**Falls** — In a randomized study (SPARTAN), falls occurred in 16% of patients treated with ERLEADA® compared with 9% of patients treated with placebo. Falls were not associated with loss of consciousness or seizure. Falls occurred in patients receiving ERLEADA® with increased frequency in the elderly. Evaluate patients for fall risk.

**Seizure** — In two randomized studies (SPARTAN and TITAN), 5 patients (0.4%) treated with ERLEADA® and 1 patient treated with placebo (0.1%) experienced a seizure. Permanently discontinue ERLEADA® in patients who develop a seizure during treatment. It is unknown whether anti-epileptic medications will prevent seizures with ERLEADA®. Advise patients of the risk of developing a seizure while receiving ERLEADA® and of engaging in any activity where sudden loss of consciousness could cause harm to themselves or others.

**Severe Cutaneous Adverse Reactions** — Fatal and life-threatening cases of severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome/toxic epidermal necrolysis (SJS/TEN), and drug reaction with eosinophilia and systemic symptoms (DRESS) occurred in patients receiving ERLEADA®.

Monitor patients for the development of SCARs. Advise patients of the signs and symptoms of SCARs (eg, a prodrome of fever, flu-like symptoms, mucosal lesions, progressive skin rash, or lymphadenopathy). If a SCAR is suspected, interrupt ERLEADA<sup>®</sup> until the etiology of the reaction has been determined. Consultation with a dermatologist is recommended. If a SCAR is confirmed, or for other Grade 4 skin reactions, permanently discontinue ERLEADA<sup>®</sup> [see *Dosage and Administration (2.2)*].

**Embryo-Fetal Toxicity** — The safety and efficacy of ERLEADA<sup>®</sup> have not been established in females. Based on findings from animals and its mechanism of action, ERLEADA<sup>®</sup> can cause fetal harm and loss of pregnancy when administered to a pregnant female. Advise males with female partners of reproductive potential to use effective contraception during treatment and for 3 months after the last dose of ERLEADA<sup>®</sup> [see *Use in Specific Populations (8.1, 8.3)*].

## ADVERSE REACTIONS

The most common adverse reactions ( $\geq 10\%$ ) that occurred more frequently in the ERLEADA<sup>®</sup>-treated patients ( $\geq 2\%$  over placebo) from the randomized placebo-controlled clinical trials (TITAN and SPARTAN) were fatigue, arthralgia, rash, decreased appetite, fall, weight decreased, hypertension, hot flush, diarrhea, and fracture.

### Laboratory Abnormalities — All Grades (Grade 3-4)

- **Hematology** — In the TITAN study: white blood cell decreased ERLEADA<sup>®</sup> 27% (0.4%), placebo 19% (0.6%). In the SPARTAN study: anemia ERLEADA<sup>®</sup> 70% (0.4%), placebo 64% (0.5%); leukopenia ERLEADA<sup>®</sup> 47% (0.3%), placebo 29% (0%); lymphopenia ERLEADA<sup>®</sup> 41% (1.8%), placebo 21% (1.6%)
- **Chemistry** — In the TITAN study: hypertriglyceridemia ERLEADA<sup>®</sup> 17% (2.5%), placebo 12% (2.3%). In the SPARTAN study: hypercholesterolemia ERLEADA<sup>®</sup> 76% (0.1%), placebo 46% (0%); hyperglycemia ERLEADA<sup>®</sup> 70% (2%), placebo 59% (1.0%); hypertriglyceridemia ERLEADA<sup>®</sup> 67% (1.6%), placebo 49% (0.8%); hyperkalemia ERLEADA<sup>®</sup> 32% (1.9%), placebo 22% (0.5%)

**Rash** — In 2 randomized studies (SPARTAN and TITAN), rash was most commonly described as macular or maculopapular. Adverse reactions of rash were 26% with ERLEADA<sup>®</sup> vs 8% with placebo. Grade 3 rashes (defined as covering  $>30\%$  body surface area [BSA]) were reported with ERLEADA<sup>®</sup> treatment (6%) vs placebo (0.5%).

The onset of rash occurred at a median of 83 days. Rash resolved in 78% of patients within a median of 78 days from onset of rash. Rash was commonly managed with oral antihistamines, topical corticosteroids, and 19% of patients received systemic corticosteroids. Dose reduction or dose interruption occurred in 14% and 28% of patients, respectively. Of the patients who had dose interruption, 59% experienced recurrence of rash upon reintroduction of ERLEADA®.

**Hypothyroidism** — In 2 randomized studies (SPARTAN and TITAN), hypothyroidism was reported for 8% of patients treated with ERLEADA® and 1.5% of patients treated with placebo based on assessments of thyroid-stimulating hormone (TSH) every 4 months. Elevated TSH occurred in 25% of patients treated with ERLEADA® and 7% of patients treated with placebo. The median onset was at the first scheduled assessment. There were no Grade 3 or 4 adverse reactions. Thyroid replacement therapy, when clinically indicated, should be initiated or dose adjusted.

## **DRUG INTERACTIONS**

**Effect of Other Drugs on ERLEADA®** — Co-administration of a strong CYP2C8 or CYP3A4 inhibitor is predicted to increase the steady-state exposure of the active moieties. No initial dose adjustment is necessary; however, reduce the ERLEADA® dose based on tolerability [*see Dosage and Administration (2.2)*].

### **Effect of ERLEADA® on Other Drugs**

**CYP3A4, CYP2C9, CYP2C19, and UGT Substrates** — ERLEADA® is a strong inducer of CYP3A4 and CYP2C19, and a weak inducer of CYP2C9 in humans. Concomitant use of ERLEADA® with medications that are primarily metabolized by CYP3A4, CYP2C19, or CYP2C9 can result in lower exposure to these medications. Substitution for these medications is recommended when possible or evaluate for loss of activity if medication is continued. Concomitant administration of ERLEADA® with medications that are substrates of UDP-glucuronosyl transferase (UGT) can result in decreased exposure. Use caution if substrates of UGT must be co-administered with ERLEADA® and evaluate for loss of activity.

**P-gp, BCRP, or OATP1B1 Substrates** — Apalutamide is a weak inducer of P-glycoprotein (P-gp), breast cancer resistance protein (BCRP), and organic anion transporting polypeptide 1B1 (OATP1B1) clinically. Concomitant use of ERLEADA® with medications that are substrates of P-gp, BCRP, or OATP1B1 can result in lower exposure

of these medications. Use caution if substrates of P-gp, BCRP, or OATP1B1 must be co-administered with ERLEADA<sup>®</sup> and evaluate for loss of activity if medication is continued.

**Please see the full Prescribing Information for ERLEADA<sup>®</sup>.**

### **About the Janssen Pharmaceutical Companies of Johnson & Johnson**

At Janssen, we're creating a future where disease is a thing of the past. We're the Pharmaceutical Companies of Johnson & Johnson, working tirelessly to make that future a reality for patients everywhere by fighting sickness with science, improving access with ingenuity, and healing hopelessness with heart. We focus on areas of medicine where we can make the biggest difference: Cardiovascular, Metabolism & Retina; Immunology; Infectious Diseases & Vaccines; Neuroscience; Oncology; and Pulmonary Hypertension.

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### **Cautions Concerning Forward-Looking Statements**

*This press release contains "forward-looking statements" as defined in the Private Securities Litigation Reform Act of 1995 regarding product development and the potential benefits and treatment impact of RYBREVANT<sup>®</sup> (amivantamab-vmjw), BALVERSA<sup>®</sup> (erdafitinib), ERLEADA<sup>®</sup> (apalutamide), AKEEGA<sup>™</sup> (niraparib and abiraterone acetate), TAR-200 and TAR-210. The reader is cautioned not to rely on these forward-looking statements. These statements are based on current expectations of future events. If underlying assumptions prove inaccurate or known or unknown risks or uncertainties materialize, actual results could vary materially from the expectations and projections of Janssen Research & Development, LLC, Janssen Biotech, Inc., Janssen-Cilag GmbH, and/or Johnson & Johnson. Risks and uncertainties include, but are not limited to: challenges and uncertainties inherent in product research and development, including the uncertainty of clinical success and of obtaining regulatory approvals; uncertainty of commercial success; manufacturing difficulties and delays; competition, including technological advances, new products and patents attained by competitors; challenges to patents; product efficacy or safety concerns resulting in product recalls or regulatory action; changes in behavior and spending patterns of purchasers of health care products and services; changes to applicable laws and regulations, including global health care reforms; and trends toward health care cost containment. A further list and descriptions of these risks, uncertainties and other factors can be found in Johnson & Johnson's Annual Report on Form 10-K for the fiscal year ended January 1, 2023, including in the sections*

*captioned "Cautionary Note Regarding Forward-Looking Statements" and "Item 1A. Risk Factors," and in Johnson & Johnson's subsequent Quarterly Reports on Form 10-Q and other filings with the Securities and Exchange Commission. Copies of these filings are available online at [www.sec.gov](http://www.sec.gov), [www.jnj.com](http://www.jnj.com) or on request from Johnson & Johnson. None of Janssen Research & Development, LLC, Janssen Biotech, Inc., Janssen-Cilag GmbH, nor Johnson & Johnson undertake to update any forward-looking statement as a result of new information or future events or developments.*

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†See the NCCN Guidelines for detailed recommendations, including other treatment options.

‡The NCCN Guidelines for NSCLC provide recommendations for certain individual biomarkers that should be tested and recommend testing techniques but do not endorse any specific commercially available biomarker assays or commercial laboratories.

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<sup>1</sup> RYBREVANT® (amivantamab-vmjw) [Prescribing Information]. Horsham, PA: Janssen Biotech, Inc.

<sup>2</sup> Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Non-Small Cell Lung Cancer V.3.2022. © National Comprehensive Cancer Network, Inc. 2022. All rights reserved. Accessed March 22, 2023. To view the most recent and complete version of the guideline, go online to [NCCN.org](http://NCCN.org).

<sup>3</sup> ClinicalTrials.gov. A Study of Amivantamab and Lazertinib Combination Therapy Versus Osimertinib in Locally Advanced or Metastatic Non-Small Cell Lung Cancer (MARIPOSA). Available at: <https://clinicaltrials.gov/ct2/show/NCT04487080>. Accessed August 2023.

<sup>4</sup> ClinicalTrials.gov. A Study of Amivantamab and Lazertinib in Combination With Platinum-Based Chemotherapy Compared With Platinum-Based Chemotherapy in Patients With Epidermal Growth Factor Receptor (EGFR)-Mutated Locally Advanced or Metastatic Non-Small Cell Lung Cancer After Osimertinib Failure (MARIPOSA-2). Available at: <https://clinicaltrials.gov/ct2/show/NCT04988295>. Accessed August 2023.

<sup>5</sup> ClinicalTrials.gov. A Study of Combination Amivantamab and Carboplatin-Pemetrexed Therapy, Compared With Carboplatin-Pemetrexed, in Participants With Advanced or Metastatic Non-Small Cell Lung Cancer Characterized by Epidermal Growth Factor Receptor (EGFR) Exon 20 Insertions (PAPILLON). Available at: <https://clinicaltrials.gov/ct2/show/NCT04538664>. Accessed August 2023.

<sup>6</sup> ClinicalTrials.gov. A Study of Amivantamab, a Human Bispecific EGFR and cMet Antibody, in Participants With Advanced Non-Small Cell Lung Cancer (CHRYSALIS). Available at: <https://clinicaltrials.gov/ct2/show/NCT02609776>. Accessed October 2023.

<sup>7</sup> ClinicalTrials.gov. A Study of Lazertinib as Monotherapy or in Combination With Amivantamab in Participants With Advanced Non-small Cell Lung Cancer (CHRYSALIS-2). Available at: <https://clinicaltrials.gov/ct2/show/NCT04077463>. Accessed October 2023.

<sup>8</sup> ClinicalTrials.gov. A Study of Amivantamab Subcutaneous (SC) Administration for the Treatment of Advanced Solid Malignancies (PALOMA). Available at: <https://clinicaltrials.gov/ct2/show/NCT04606381>. Accessed August 2023.

<sup>9</sup> ClinicalTrials.gov. A Study of Amivantamab in Participants With Advanced or Metastatic Solid Tumors Including Epidermal Growth Factor Receptor (EGFR)-Mutated Non-Small Cell Lung Cancer (PALOMA-2). Available at: <https://clinicaltrials.gov/ct2/show/NCT05498428>. Accessed August 2023.



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<sup>10</sup> ClinicalTrials.gov. A Study of Lazertinib With Subcutaneous Amivantamab Compared With Intravenous Amivantamab in Participants With Epidermal Growth Factor Receptor (*EGFR*)-Mutated Advanced or Metastatic Non-small Cell Lung Cancer (PALOMA-3). Available at: <https://clinicaltrials.gov/ct2/show/NCT05388669>. Accessed August 2023.

<sup>11</sup> ClinicalTrials.gov. A Study of Amivantamab and Capmatinib Combination Therapy in Unresectable Metastatic Non-small Cell Lung Cancer (METalmark). Available at: <https://clinicaltrials.gov/ct2/show/NCT05488314>. Accessed August 2023.

<sup>12</sup> ClinicalTrials.gov. A Study of Combination Therapy With Amivantamab and Cetrelimab in Participants With Metastatic Non-small Cell Lung Cancer (PolyDamas). Available at: <https://www.clinicaltrials.gov/study/NCT05908734?term=polydamas&rank=1>. Accessed August 2023.

<sup>13</sup> ClinicalTrials.gov. Premedication to Reduce Amivantamab Associated Infusion Related Reactions (SKIPPirr). Available at: <https://classic.clinicaltrials.gov/ct2/show/NCT05663866>. Accessed August 2023.

<sup>14</sup> Cho BC, et al. (2023). Lazertinib versus gefitinib as first-line treatment in patients with *EGFR*-mutated advanced non-small cell lung cancer: Results From LASER301. *J. Clin Oncol*. JCO2300515. Advance online publication. <https://doi.org/10.1200/JCO.23.00515>.

<sup>15</sup> ERLEADA® (apalutamide) US [Prescribing Information]. Horsham, PA: Janssen Biotech, Inc.