THE FUTURE OF Breyanzi® is now

New FDA changes* bring hope for a **cure**† to more patients with Breyanzi[1-3]

*These changes are a result of a June 2025 FDA label update. †Cure in LBCL can be defined as when the therapy has been stopped and (1) the survival curve plateaus and (2) 3-year OS data and/or at least 2-year EFS data have been collected.[4-6]

At least 2-week close monitoring, reduced from 1 month[1]

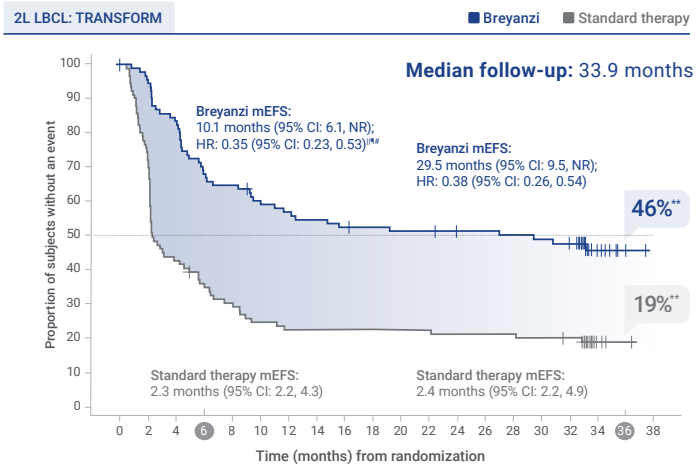
Early onset and rapid resolution of primarily low-grade CRS and NT events‡ with a lower incidence within 2 weeks post infusion reinforce the trusted safety profile of Breyanzi[1,7,8§]

At least 2-week driving restriction, reduced from 2 months[1]

At least 2 weeks after receiving Breyanzi, your patients may be able to return to driving[1]

Elimination of the REMS program

Breyanzi can now be administered without the burden of stringent REMS requirements



TRANSFORM (ASCT eligible; N=184) was a randomized, open-label, multicenter study in adults aged ≤75 years with primary refractory LBCL or relapse within 1 year of first-line chemoimmunotherapy who were treated with Breyanzi (n=89) or standard therapy (n=91). The primary endpoint was EFS.[1]

Identify appropriate patients for Breyanzi **today**, and **deliver more cures**† **to more patients** vs standard therapy than ever before[1-3]

EFS is defined as the time from randomization to death from any cause, progressive disease, failure to achieve CR or PR by 9 weeks post randomization, or the start of new lymphoma therapy due to efficacy concerns, whichever occurs first.[1]

‡In 2L LBCL clinical trials of Breyanzi (N=150), 45% of patients experienced Any Grade CRS and 1% of patients experienced Grade 3 CRS. 27% experienced NT and 7% of patients experienced Grade 3 NT. Median time to onset of CRS was 4 days (range: 1-63); median duration was 4 days (range: 1-16). Median time to onset for NT was 8 days (range: 1-63); median duration was 6 days (range: 1-119).[7] §In clinical trials of Breyanzi (N=702), 98% of CRS and 88% of NT events occurred ≤2 weeks post infusion. Median time to onset of CRS was 5 days (range: 1-63); median duration was 5 days (range: 1-37). Median time to onset for NT was 8 days (range: 1-63); median duration was 7 days (range: 1-119).[1,8] ‖Based on a stratified Cox proportional hazards model.[2] ¶*P*<0.0001; *P*-value is compared with 0.012 of the allocated alpha for this prespecified interim analysis (median follow-up: 6.2 months).[1,2] #Per the Lugano criteria, as assessed by an IRC.[2] **Rates at 3 years (36 months).[3]

2L, second-line; ASCT, autologous stem cell transplantation; CI, confidence interval; CR, complete response; CRS, cytokine release syndrome; EFS, event-free survival; HR, hazard ratio; IRC, Independent Review Committee; LBCL, large B-cell lymphoma; NT, neurologic toxicity; NR, not reached; mEFS, median event-free survival; OS, overall survival; PR, partial response; REMS, Risk Evaluation and Mitigation Strategy; R/R, relapsed or refractory.

Indications

BREYANZI is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of R/R LBCL.

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

Please see full indications on the following page.

Important Safety Information

WARNING: CYTOKINE RELEASE SYNDROME, NEUROLOGIC TOXICITIES, AND SECONDARY HEMATOLOGICAL MALIGNANCIES

- **Cytokine Release Syndrome (CRS), including fatal or life-threatening reactions, occurred in patients receiving BREYANZI. Do not administer BREYANZI to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab with or without corticosteroids.**
- **Neurologic toxicities, including fatal or life-threatening reactions, occurred in patients receiving BREYANZI, including concurrently with CRS, after CRS resolution, or in the absence of CRS. Monitor for neurologic events after treatment with BREYANZI. Provide supportive care and/or corticosteroids as needed.**
- **T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19-directed genetically modified autologous T cell immunotherapies, including BREYANZI.**

See Important Safety Information throughout and click for full Prescribing Information, including Boxed WARNINGS and Medication Guide.

Breyanzi™ (lisocabtagene maraleucel) SUSPENSION FOR IV INFUSION

Indications

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

- adult patients with large B-cell lymphoma (LBCL), including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B, who have:
  - refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy; or
  - refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age; or
  - relapsed or refractory disease after two or more lines of systemic therapy.

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

Important Safety Information

Cytokine Release Syndrome: Cytokine release syndrome (CRS), including fatal or life-threatening reactions, occurred following treatment with BREYANZI. In clinical trials of BREYANZI, which enrolled a total of 702 patients with non-Hodgkin lymphoma (NHL), CRS occurred in 54% of patients, including ≥ Grade 3 CRS in 3.2% of patients. The median time to onset was 5 days (range: 1 to 63 days). CRS resolved in 98% of patients with a median duration of 5 days (range: 1 to 37 days). One patient had fatal CRS and 5 patients had ongoing CRS at the time of death. The most common manifestations of CRS (≥10%) were fever, hypotension, tachycardia, chills, hypoxia, and headache.

Serious events that may be associated with CRS include cardiac arrhythmias (including atrial fibrillation and ventricular tachycardia), cardiac arrest, cardiac failure, diffuse alveolar damage, renal insufficiency, capillary leak syndrome, hypotension, hypoxia, and hemophagocytic lymphohistiocytosis/macrophage activation syndrome (HLH/MAS).

Ensure that 2 doses of tocilizumab are available prior to infusion of BREYANZI.

Neurologic Toxicities: Neurologic toxicities that were fatal or life-threatening, including immune effector cell-associated neurotoxicity syndrome (ICANS), occurred following treatment with BREYANZI. Serious events including cerebral edema and seizures occurred with BREYANZI. Fatal and serious cases of leukoencephalopathy, some attributable to fludarabine, also occurred.

In clinical trials of BREYANZI, CAR T cell-associated neurologic toxicities occurred in 31% of patients, including ≥ Grade 3 cases in 10% of patients. The median time to onset of neurotoxicity was 8 days (range: 1 to 63 days). Neurologic toxicities resolved in 88% of patients with a median duration of 7 days (range: 1 to 119 days). Of patients developing neurotoxicity, 82% also developed CRS.

The most common neurologic toxicities (≥5%) included encephalopathy, tremor, aphasia, headache, dizziness, and delirium.

CRS and Neurologic Toxicities Monitoring: Monitor patients daily for at least 7 days following BREYANZI infusion for signs and symptoms of CRS and neurologic toxicities and assess for other causes of neurological symptoms. Continue to monitor patients for signs and symptoms of CRS and neurologic toxicities for at least 2 weeks after infusion and treat promptly. At the first sign of CRS, institute treatment with supportive care, tocilizumab, or tocilizumab and corticosteroids as indicated. Manage neurologic toxicity with supportive care and/or corticosteroid as needed. Advise patients to avoid driving for at least 2 weeks following infusion. Counsel patients to seek immediate medical attention should signs or symptoms of CRS or neurologic toxicity occur at any time.

Hypersensitivity Reactions: Allergic reactions may occur with the infusion of BREYANZI. Serious hypersensitivity reactions, including anaphylaxis, may be due to dimethyl sulfoxide (DMSO).

Serious Infections: Severe infections, including life-threatening or fatal infections, have occurred in patients after BREYANZI infusion. In clinical trials of BREYANZI, infections of any grade occurred in 34% of patients, with Grade 3 or higher infections occurring in 12% of all patients. Grade 3 or higher infections with an unspecified pathogen occurred in 7%, bacterial infections in 3.7%, viral infections in 2%, and fungal infections in 0.7% of patients. One patient who received 4 prior lines of therapy developed a fatal case of John Cunningham (JC) virus progressive multifocal leukoencephalopathy 4 months after treatment with BREYANZI. One patient who received 3 prior lines of therapy developed a fatal case of cryptococcal meningoencephalitis 35 days after treatment with BREYANZI.

Febrile neutropenia developed after BREYANZI infusion in 8% of patients. Febrile neutropenia 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.

Monitor patients for signs and symptoms of infection before and after BREYANZI administration and treat appropriately. Administer prophylactic antimicrobials according to standard institutional guidelines. Avoid administration of BREYANZI in patients with clinically significant, active systemic infections.

Viral reactivation: Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, can occur in patients treated with drugs directed against B cells. In clinical trials of BREYANZI, 35 of 38 patients with a prior history of HBV were treated with concurrent antiviral suppressive therapy. Perform screening for HBV, HCV, and HIV in accordance with clinical guidelines before collection of cells for manufacturing. In patients with prior history of HBV, consider concurrent antiviral suppressive therapy to prevent HBV reactivation per standard guidelines.

Important Safety Information (cont'd)

Prolonged Cytopenias: Patients may exhibit cytopenias not resolved for several weeks following lymphodepleting chemotherapy and BREYANZI infusion. In clinical trials of BREYANZI, Grade 3 or higher cytopenias persisted at Day 29 following BREYANZI infusion in 35% of patients, and included thrombocytopenia in 25%, neutropenia in 22%, and anemia in 6% of patients. Monitor complete blood counts prior to and after BREYANZI administration.

Hypogammaglobulinemia: B-cell aplasia and hypogammaglobulinemia can occur in patients receiving BREYANZI. In clinical trials of BREYANZI, hypogammaglobulinemia was reported as an adverse reaction in 10% of patients. Hypogammaglobulinemia, either as an adverse reaction or laboratory IgG level below 500 mg/dL after infusion, was reported in 30% of patients. Monitor immunoglobulin levels after treatment with BREYANZI and manage using infection precautions, antibiotic prophylaxis, and immunoglobulin replacement as clinically indicated.

Live vaccines: The safety of immunization with live viral vaccines during or following BREYANZI 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 BREYANZI treatment, and until immune recovery following treatment with BREYANZI.

Secondary Malignancies: Patients treated with BREYANZI may develop secondary malignancies. T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19-directed genetically modified autologous T cell immunotherapies, including BREYANZI. Mature T cell malignancies, including CAR-positive tumors, may present as soon as weeks following infusion, and may include fatal outcomes. Monitor lifelong for secondary malignancies. In the event that a secondary malignancy occurs, contact Bristol-Myers Squibb at 1-888-805-4555 for reporting and to obtain instructions on collection of patient samples for testing.

Immune Effector Cell-Associated Hemophagocytic Lymphohistiocytosis-Like Syndrome (IEC-HS): Immune Effector Cell-Associated Hemophagocytic Lymphohistiocytosis-Like Syndrome (IEC-HS), including fatal or life-threatening reactions, occurred following treatment with BREYANZI. IEC-HS is a life-threatening condition with a high mortality rate if not recognized and treated early. Treatment of IEC-HS should be administered per current practice guidelines.

Adverse Reactions: The most common adverse reaction(s) (incidence ≥30%) in:

- LBCL are fever, cytokine release syndrome, fatigue, musculoskeletal pain, and nausea. The most common Grade 3-4 laboratory abnormalities include lymphocyte count decrease, neutrophil count decrease, platelet count decrease, and hemoglobin decrease.

References: 1. Breyanzi [package insert]. Summit, NJ: Bristol-Myers Squibb Company; 2025. **2.** Kamdar M, Solomon S, Arnason J, et al. Lisocabtagene maraleucel versus standard of care with salvage chemotherapy followed by autologous stem cell transplantation as second-line treatment in patients with relapsed or refractory large B-cell lymphoma (TRANSFORM): results from an interim analysis of an open-label, randomised, phase 3 trial. *Lancet.* 2022;399(10343):2294-2308. **3.** Kamdar M, Solomon SR, Arnason J, et al. Lisocabtagene maraleucel versus standard of care for second-line relapsed/refractory large B-cell lymphoma: 3-year follow-up from the randomized, phase III TRANSFORM study. *J Clin Oncol.* Published online July 7, 2025. doi:10.1200/JCO-25-00399 **4.** Ravi P, Kumar SK, Cerhan JR, et al. Defining cure in multiple myeloma: a comparative study of outcomes of young individuals with myeloma and curable hematologic malignancies. *Blood Cancer J.* 2018;8(3):26. doi:10.1038/s41408-018-0065-8 **5.** Howlader N, Mariotto AB, Besson C, et al. Cancer-specific mortality, cure fraction, and noncancer causes of death among diffuse large B-cell lymphoma patients in the immunochemotherapy era. *Cancer.* 2017;123(17):3326-3334. **6.** Maurer MJ, Ghesquières H, Jais JP, et al. Event-free survival at 24 months in a robust end point for disease-related outcome in diffuse large B-cell lymphoma treated with immunochemotherapy. *J Clin Oncol.* 2014;32(10):1066-1073. **7.** Data on file. BMS-REF-LIS-0052. Princeton, NJ: Bristol-Myers Squibb Company; 2024. **8.** Kamdar M, Shadman M, Ahmed S, et al. Optimizing post–chimeric antigen receptor T cell monitoring: evidence across lisocabtagene maraleucel pivotal clinical trials and real-world experience. Presented at: American Society of Clinical Oncology Annual Meeting; May 30-June 3, 2025; Chicago, IL. Poster 7026.

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Bristol Myers Squibb®

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