Clinician’s Guide to ABECMA®
CAR T Cell Therapy Process

Information on patient eligibility, leukapheresis, the ABECMA manufacturing process, dosing and administration, and adverse event monitoring following infusion.

CAR=chimeric antigen receptor.

INDICATION

ABECMA (idecabtagene vilocileucel) is a B-cell maturation antigen (BCMA)-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory multiple myeloma after four or more prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody.

IMPORTANT SAFETY INFORMATION

WARNING: CYTOKINE RELEASE SYNDROME, NEUROLOGIC TOXICITIES, HLH/MAS, AND PROLONGED CYTOPENIA

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

• Neurologic Toxicities, which may be severe or life-threatening, occurred following treatment with ABECMA, including concurrently with CRS, after CRS resolution, or in the absence of CRS. Monitor for neurologic events after treatment with ABECMA. Provide supportive care and/or corticosteroids as needed.

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

• Prolonged Cytopenia with bleeding and infection, including fatal outcomes following stem cell transplantation for hematopoietic recovery, occurred following treatment with ABECMA.

• ABECMA is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ABECMA REMS.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Is the First CAR T Cell Therapy for RRMM¹

A personalized immune cell therapy that targets BCMA with a one-time infusion¹*

ABECMA consists of T cells transduced with a CAR lentiviral vector.

The CAR construct includes an extracellular scFv-targeting domain that binds specifically to BCMA, a cell-surface antigen expressed at significantly higher levels on malignant plasma cells of MM.¹,³

TARGETING BCMA

BCMA expression is largely restricted to plasma cells and is uniquely overexpressed on myeloma cells, making BCMA a promising target antigen.¹,³

Following ABECMA infusion, the CAR-positive cells proliferate and undergo rapid multi-log expansion followed by a bi-exponential decline. ABECMA can persist in peripheral blood for up to 1 year post infusion.¹

IMPORTANT SAFETY INFORMATION (cont’d)

Cytokine Release Syndrome (CRS): CRS, including fatal or life-threatening reactions, occurred following treatment with ABECMA in 85% (108/127) of patients. Grade 3 or higher CRS occurred in 9% (12/127) of patients, with Grade 5 CRS reported in one (0.8%) patient. The median time to onset of CRS, any grade, was 1 day (range: 1 - 23 days) and the median duration of CRS was 7 days (range: 1 - 63 days). The most common manifestations included pyrexia, hypotension, tachycardia, chills, hypoxia, fatigue, and headache. Grade 3 or higher events that may be associated with CRS include hypotension, hypoxia, hyperbilirubinemia, hypofibrinogenemia, acute respiratory distress syndrome (ARDS), atrial fibrillation, hepatocellular injury, metabolic acidosis, pulmonary edema, multiple organ dysfunction syndrome, and HLH/MAS.

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ABECMA® REMS

Due to the risk of CRS and NT, ABECMA is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ABECMA REMS.

The required components of the ABECMA REMS are:

- Healthcare facilities that dispense and administer ABECMA must be enrolled and comply with the REMS requirements
- Certified healthcare facilities must have on-site, immediate access to tocilizumab
- Ensure that a minimum of 2 doses of tocilizumab are available for each patient for infusion within 2 hours after ABECMA infusion, if needed for treatment of CRS
- Certified healthcare facilities must ensure that healthcare providers who prescribe, dispense, or administer ABECMA are trained on the management of CRS and NT
- Further information is available at www.AbecmaREMS.com, or contact Bristol Myers Squibb at 1-888-423-5436

CRS=cytokine release syndrome; NT=neurologic toxicity.

IMPORTANT SAFETY INFORMATION (cont’d)

Cytokine Release Syndrome (CRS) (cont’d): Identify CRS based on clinical presentation. Evaluate for and treat other causes of fever, hypoxia, and hypotension. CRS has been reported to be associated with findings of HLH/MAS, and the physiology of the syndromes may overlap. In patients with progressive symptoms of CRS or refractory CRS despite treatment, evaluate for evidence of HLH/MAS.

Fifty four percent (68/127) of patients received tocilizumab (single dose: 35%; more than 1 dose: 18%). Overall, 15% (19/127) of patients received at least 1 dose of corticosteroids for treatment of CRS. All patients that received corticosteroids for CRS received tocilizumab. Ensure that a minimum of 2 doses of tocilizumab are available prior to infusion of ABECMA.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
The ABECMA® Process

An overview of the ABECMA process¹

Pre-infusion
- Patient eligibility and initiation
- Leukapheresis
- Manufacturing
- Shipping and receipt
- Storage
- Lymphodepleting chemotherapy

Infusion process
- Premedication
- Thawing
- Infusion

Post infusion
- Short-term monitoring
- Long-term monitoring

At any point during the ABECMA process, you can visit the Scheduling and Apheresis Portal at www.CT360.com for appointment and product status information.

IMPORTANT SAFETY INFORMATION (cont’d)

Cytokine Release Syndrome (CRS) (cont’d): Monitor patients at least daily for 7 days following ABECMA infusion at the REMS-certified healthcare facility for signs or symptoms of CRS and monitor patients for signs or symptoms of CRS for at least 4 weeks after ABECMA infusion. At the first sign of CRS, institute treatment with supportive care, tocilizumab and/or corticosteroids as indicated. Counsel patients to seek immediate medical attention should signs or symptoms of CRS occur at any time.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Patient Eligibility and Initiation

Determining eligibility for ABECMA®1,2

Eligible adult patients include those who are:

- **Triple-class exposed** (patients who have received an IMiD® agent, a PI, and an anti-CD38 monoclonal antibody) and who have received at least 4 prior lines of therapy
- **Clinically fit** (e.g., good performance status and adequate organ function)

Pivotal trial population1

KarMMa was an open-label, single-arm, multicenter trial that evaluated the efficacy and safety of ABECMA in adult patients with RRMM who had received at least 3 prior antimyeloma therapies, including an IMiD® agent, a PI, and an anti-CD38 monoclonal antibody.

ABECMA was studied in patients of varying ages and risk profiles:

- 33 to 78 years of age (median age: 62 years)
- 37% had high-risk cytogenetics*
- 36% had extramedullary plasmacytoma
- Data are from patients who received 300-460 x 10⁶ CAR-positive T cells (N=100)

PI=proteasome inhibitor.
*Presence of t(4:14), t(14:16), and 17p13 del.

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Neurologic Toxicities:** Neurologic toxicities, which may be severe or life-threatening, occurred following treatment with ABECMA in 28% (36/127) of patients receiving ABECMA, including Grade 3 in 4% (5/127) of patients. One patient had ongoing Grade 2 neurotoxicity at the time of death. Two patients had ongoing Grade 1 tremor at the time of data cutoff. The median time to onset of neurotoxicity was 2 days (range: 1 - 42 days). CAR T cell-associated neurotoxicity resolved in 92% (33/36) of patients with a median time to resolution of 5 days (range: 1 - 61 days). The median duration of neurotoxicity was 6 days (range: 1 - 578) in all patients including 3 patients with ongoing neurotoxicity. Thirty-four patients with neurotoxicity had CRS with onset in 3 patients before, 29 patients during, and 2 patients after CRS. The most frequently reported manifestations of CAR T cell-associated neurotoxicity include encephalopathy, tremor, aphasia, and delirium. Grade 4 neurotoxicity and cerebral edema in 1 patient, Grade 3 myelitis, and Grade 3 parkinsonism have been reported with ABECMA in another study in multiple myeloma.

Monitor patients at least daily for 7 days following ABECMA infusion at the REMS-certified healthcare facility for signs or symptoms of neurologic toxicities and monitor patients for signs or symptoms of neurologic toxicities for at least 4 weeks after ABECMA infusion and treat promptly. Rule out other causes of neurologic symptoms. Neurologic toxicity should be managed with supportive care and/or corticosteroids as needed.

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

Please see additional Important Safety Information on the following pages and [click here for full Prescribing Information](#), including Boxed WARNINGS and Medication Guide.
Leukapheresis

Collecting your patient’s T cells through leukapheresis is the first step in the ABECMA® treatment process¹,²

Before leukapheresis begins:

• Perform screening for CMV, HBV, HCV, and HIV in accordance with clinical guidelines before collection of cells for manufacturing
• Confirm that your patient has been given adequate time after their last anticancer treatment

Washout periods before leukapheresis in the KarMMa pivotal trial²

<table>
<thead>
<tr>
<th>Systemic MM therapy, including experimental agents</th>
<th>Stopped ≥14 days prior to leukapheresis</th>
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</thead>
<tbody>
<tr>
<td>Corticosteroids (&gt;20 mg/day prednisone or equivalent)*</td>
<td>Stopped ≥14 days prior to leukapheresis</td>
</tr>
</tbody>
</table>

Following leukapheresis, your patient’s T cells are sent to a manufacturing site.¹

Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS): HLH/MAS occurred in 4% (5/127) of patients receiving ABECMA. One patient developed fatal multi-organ HLH/MAS with CRS and another patient developed fatal bronchopulmonary aspergillosis with contributory HLH/MAS. Three cases of Grade 2 HLH/MAS resolved. All events of HLH/MAS had onset within 10 days of receiving ABECMA with a median onset of 7 days (range: 4 - 9 days) and occurred in the setting of ongoing or worsening CRS. Two patients with HLH/MAS had overlapping neurotoxicity. The manifestations of HLH/MAS include hypotension, hypoxia, multiple organ dysfunction, renal dysfunction, and cytopenia. HLH/MAS is a potentially life-threatening condition with a high mortality rate if not recognized early and treated. Treatment of HLH/MAS should be administered per institutional guidelines.

CMV=cytomegalovirus; HBV=hepatitis B virus; HCV=hepatitis C virus; HIV=human immunodeficiency virus.
*Physiologic replacement, topical, intranasal, and inhaled steroids were permitted in the KarMMa trial.

IMPORTANT SAFETY INFORMATION (cont’d)

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Manufacturing

At the manufacturing site

- The patient’s T cells are transduced with a CAR lentiviral vector targeting BCMA
- The transduced T cells are expanded, formulated into a suspension, and cryopreserved

Bridging therapy during manufacturing

Bridging therapy can be used in some patients at the physician’s discretion for disease control during the manufacturing process.

- 87% of patients received bridging therapy in the pivotal trial

ABECMA® is provided as a single dose for infusion containing a suspension of CAR-positive T cells in 1 or more infusion bags

- The recommended dose range is 300 to 460 \( \times 10^6 \) CAR-positive T cells
- ABECMA is an autologous product

>98% manufacturing success rate in the KarMMa pivotal trial

- Of 135 patients who underwent leukapheresis, there was 1 manufacturing failure and 1 non-conforming product

The median time from leukapheresis to product availability was 33 days in the pivotal study (range: 26-49 days)

*The manufacturing success rate is defined as the ability to manufacture the product. The risk that manufacturing was unsuccessful was 1.5% (2/135) in the pivotal trial.

†Manufacturing turnaround times may vary.

IMPORTANT SAFETY INFORMATION (cont’d)

**ABECMA REMS:** Due to the risk of CRS and neurologic toxicities, ABECMA is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ABECMA REMS. Further information is available at www.AbecmaREMS.com or 1-888-423-5436.

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

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Chain of Identity

To ensure patient safety, Bristol Myers Squibb requires chain of identity (COI) at 4 key points in the treatment process.1,4

1. When you receive the liquid nitrogen (LN₂) dry vapor shipper
   - Shipper contains Release for Infusion (RFI) certificate and frozen product in LN₂ container. Verify patient identifiers on product RFI certificate match across patient medical records.

2. After transferring ABECMA® to on-site storage *
   - If on-site vapor phase LN₂ storage is qualified, transfer product container to on-site storage. Verify patient identifiers, including JOIN, match on product RFI certificate and on product labels.

3. Prior to thawing ABECMA
   - Verify product containers match product RFI certificate. Verify patient identifiers across all product labels, including JOIN.

4. Prior to ABECMA administration
   - Prior to administration, verify patient identifiers match product RFI certificate and patient medical records. Verbally confirm patient identification with patient.

*Applies to institutions that have demonstrated capacity and have been prequalified for on-site storage.
†The JOIN is a unique identification code that is assigned to the patient’s specific cellular material and is the link between the patient and their cells throughout the manufacturing process.

IMPORTANT SAFETY INFORMATION (cont’d)

Infections: ABECMA should not be administered to patients with active infections or inflammatory disorders. Severe, life-threatening, or fatal infections occurred in patients after ABECMA infusion. Infections (all grades) occurred in 70% of patients. Grade 3 or 4 infections occurred in 23% of patients. Overall, 4 patients had Grade 5 infections (3%); 2 patients (1.6%) had Grade 5 events of pneumonia, 1 patient (0.8%) had Grade 5 bronchopulmonary aspergillosis, and 1 patient (0.8%) had cytomegalovirus (CMV) pneumonia associated with Pneumocystis jiroveci. Monitor patients for signs and symptoms of infection before and after ABECMA infusion and treat appropriately. Administer prophylactic, pre-emptive, and/or therapeutic antimicrobials according to standard institutional guidelines.

Febrile neutropenia was observed in 16% (20/127) of patients after ABECMA infusion and may be concurrent with CRS. In the event of febrile neutropenia, evaluate for infection and manage with broad-spectrum antibiotics, fluids, and other supportive care.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Receiving the ABECMA® Shipment

Cryopreserved ABECMA is shipped to your site in a LN₂ dry vapor shipper

- ABECMA will be shipped on the scheduled date directly to the infusion site’s assigned address and/or department, as specified on the Cell Therapy 360® Scheduling Portal

1. When you receive the LN₂ dry vapor shipper

STOP AND CONFIRM PATIENT ID

Two site staff are required to verify the patient information listed on the RFI certificate matches the information listed on the treatment center’s patient medical records:

- Patient’s first and last name
- Patient’s date of birth
- JOIN*

In case of any questions or concerns with the RFI certificate, contact Bristol Myers Squibb at 1-888-805-4555.

- Confirm the LN₂ dry vapor shipper is free of damage and the tamper-evident tag is intact
  - If the tamper-evident tag is cut or the tag numbers do not match those listed on the RFI certificate, contact Bristol Myers Squibb at 1-888-805-4555

Note the shipper expiration date and time on label inside shipper, and ensure expiration is after the planned date of ABECMA infusion or transfer to on-site storage.

Unless preapproved for on-site storage, do not open the inner container until ready to prepare ABECMA on the day of infusion.

*The JOIN is a unique identification code that is assigned to the patient’s specific cellular material and is the link between the patient and their cells throughout the manufacturing process.

IMPORTANT SAFETY INFORMATION (cont’d)

Infections (cont’d): Viral Reactivation: CMV infection resulting in pneumonia and death has occurred following ABECMA administration. Monitor and treat for CMV reactivation in accordance with clinical guidelines. 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 plasma cells. Perform screening for CMV, HBV, hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in accordance with clinical guidelines before collection of cells for manufacturing.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
General Guidelines for Safe Handling

Before handling ABECMA®, ensure the appropriate safety measures are taken and that personnel have been trained according to institutional practices.

Wear the following personal protective equipment (PPE):

- Cryogenic protective gloves
- Safety glasses with side shields
- Lab coat

IMPORTANT SAFETY INFORMATION (cont’d)

Prolonged Cytopenias: In the clinical study, 41% of patients (52/127) experienced prolonged Grade 3 or 4 neutropenia and 49% (62/127) experienced prolonged Grade 3 or 4 thrombocytopenia that had not resolved by Month 1 following ABECMA infusion. In 83% (43/52) of patients who recovered from Grade 3 or 4 neutropenia after Month 1, the median time to recovery from ABECMA infusion was 1.9 months. In 65% (40/62) of patients who recovered from Grade 3 or 4 thrombocytopenia, the median time to recovery was 2.1 months.

Three patients underwent stem cell therapy for hematopoietic reconstitution due to prolonged cytopenia. Two of the three patients died from complications of prolonged cytopenia. Monitor blood counts prior to and after ABECMA infusion. Manage cytopenia with myeloid growth factor and blood product transfusion support.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
General Guidelines for Safe Handling (cont’d)

Before handling ABECMA®, ensure the appropriate safety measures are taken and that personnel have been trained according to institutional practices

Always work in a well-ventilated area

Always keep the outer container and LN2 dry vapor shipper in an upright position

ABECMA must be handled according to institutional procedures for cellular products, which may contain infectious materials

- ABECMA contains human blood cells that are genetically modified with replication incompetent, self-inactivating lentiviral vector
- Follow universal precautions and local biosafety guidelines for handling and disposal to avoid potential transmission of infectious diseases

IMPORTANT SAFETY INFORMATION (cont’d)

Hypogammaglobulinemia: Hypogammaglobulinemia was reported as an adverse event in 21% (27/127) of patients; laboratory IgG levels fell below 500 mg/dl after infusion in 25% (32/127) of patients treated with ABECMA.

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

The safety of immunization with live viral vaccines during or after ABECMA 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 ABECMA treatment, and until immune recovery following treatment with ABECMA.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
LN₂ Dry Vapor Shipper Contents

ABECMA® is stored within a temperature-controlled LN₂ dry vapor shipper that is placed inside an outer container⁴

Affixed to the outside of the outer container are:

• The waybill and shipper receipt documentation
• FedEx® return label
• A label containing the shipper expiry and anonymized patient identifiers, including JOIN*⁵
• Warning labels

Attached to the inside lid of the outer container are:

• The RFI certificate
• ABECMA Prescribing Information and Medication Guide
• A temperature control monitor lies within the outer shipper container and remotely tracks the internal temperature of the LN₂ dry vapor shipper until removal of the drug product

*The JOIN is a unique identification code that is assigned to the patient’s specific cellular material and is the link between the patient and their cells throughout the manufacturing process.

IMPORTANT SAFETY INFORMATION (cont’d)

Secondary Malignancies: Patients treated with ABECMA may develop secondary malignancies. Monitor life-long for secondary malignancies. If a secondary malignancy occurs, contact Bristol Myers Squibb at 1-888-805-4555 to obtain instructions on patient samples to collect for testing of secondary malignancy of T cell origin.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
LN₂ Dry Vapor Shipper Contents (cont’d)

Inside the LN₂ dry vapor shipper is¹,⁴:

- The ABECMA® drug product, which will be packaged in 1 or more infusion bags containing a total of 300 to 460 x 1₀⁶ CAR-positive T cells
  - Each infusion bag is contained within a metal cassette, which is stored in a rack within the LN₂ dry vapor shipper

ABECMA components¹,⁴

- The ABECMA formulation contains Plasma-Lyte A and CryoStor® CS10, resulting in a final DMSO concentration of 5%
- ABECMA is cryopreserved and supplied in 1 or more infusion bag(s). The full contents of each infusion bag supplied should be administered
- Each infusion bag of ABECMA is individually packed in a metal cassette. ABECMA is stored in the vapor phase of LN₂ and supplied in a LN₂ dry vapor shipper

The LN₂ dry vapor shipper will be monitored remotely by Bristol Myers Squibb for temperature deviations until the product is received at the site.

In the event that the temperature goes above -130 °C, DO NOT initiate ABECMA infusion, and call Bristol Myers Squibb at 1-888-805-4555 to determine next steps.

IMPORTANT SAFETY INFORMATION (cont’d)

Effects on Ability to Drive and Operate Machinery: Due to the potential for neurologic events, patients receiving ABECMA are at risk for altered or decreased consciousness or coordination in the 8 weeks following ABECMA 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.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Storage

The method of storage will depend on individual site capabilities\(^1,4\)

There are 2 delivery/storage options for ABECMA:

Method 1: Just-in-time delivery

ABECMA arrives on or near the date of infusion and remains in the LN\(_2\) dry vapor shipper until the product is thawed for patient administration.

**NOTE:** The LN\(_2\) dry vapor shipper will arrive the day of intended infusion or earlier pending delivery logistics and agreement with the infusion site.

- The LN\(_2\) dry vapor shipper should be stored upright in a LOCKED, WELL-VENTILATED room upon arrival at the site and until time of infusion of ABECMA
- If ABECMA is received earlier than the intended infusion day, it can be kept temporarily in the LN\(_2\) dry vapor shipper until the time of infusion, as long as it does not exceed the maximum allowable LN\(_2\) dry vapor shipper storage duration
- Storage of the LN\(_2\) dry vapor shipper should not exceed the shipper expiration date; planned date of administration should be before this expiration date for just-in-time delivery
- If the patient is not expected to be ready for same-day administration before the shipper expires and the infusion site is not qualified for on-site storage, contact Bristol Myers Squibb at 1-888-805-4555 to arrange for return shipment

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Adverse Reactions:** The most common nonlaboratory adverse reactions include CRS, infections – pathogen unspecified, fatigue, musculoskeletal pain, hypogammaglobulinemia, diarrhea, upper respiratory tract infection, nausea, viral infections, encephalopathy, edema, pyrexia, cough, headache, and decreased appetite.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Storage (cont’d)

Method 2: On-site storage (by preapproval process)

ABECMA is transferred to on-site vapor-phase LN₂ storage.

- **Preparation for transfer**
  - The transfer should be completed by 2 qualified site staff who can ensure it is done in less than 2 minutes
  - Prepare for the upcoming COI checks by locating the RFI certificate and identifying the location of the data points required for COI check #2
- **On-site institutional temperature monitoring:** Store ABECMA frozen in the vapor phase of LN₂ (-130 °C or colder)
  - In the event that the temperature goes above -130 °C, **DO NOT** initiate ABECMA infusion, and call Bristol Myers Squibb at 1-888-805-4555
- **Upon arrival, ABECMA should be transferred to on-site vapor-phase LN₂ storage.** Complete the transfer to on-site storage within 2 minutes
  - Remove the metal cassettes within the LN₂ dry vapor shipper
  - Transfer the metal cassettes to your site’s storage rack immediately
  - During transfer, keep the metal cassette over the vapor phase of the shipper to prevent thawing
  - Complete COI check #2 outlined in the purple box below

### 2. After transferring ABECMA to on-site storage

**STOP AND CONFIRM PATIENT ID**

Two site staff are required to verify the patient information listed on the product RFI certificate matches the information listed on the cassette labels:

- Patient’s first and last name
- Patient’s date of birth
- **JOIN**

**NOTE:** This COI check only occurs if storing ABECMA in on-site vapor-phase LN₂ storage.

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*Applies to institutions that have demonstrated capacity and have been prequalified for on-site storage.

†ABECMA infusion bags will arrive in a labeled cassette.

‡The JOIN is a unique identification code that is assigned to the patient’s specific cellular material and is the link between the patient and their cells throughout the manufacturing process.

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Cytokine Release Syndrome (CRS):** CRS, including fatal or life-threatening reactions, occurred following treatment with ABECMA in 85% (108/127) of patients. Grade 3 or higher CRS occurred in 9% (12/127) of patients, with Grade 5 CRS reported in one (0.8%) patient. The median time to onset of CRS, any grade, was 1 day (range: 1 - 23 days) and the median duration of CRS was 7 days (range: 1 - 63 days). The most common manifestations included pyrexia, hypotension, tachycardia, chills, hypoxia, fatigue, and headache. Grade 3 or higher events that may be associated with CRS include hypotension, hypoxia, hyperbilirubinemia, hypofibrinogenemia, acute respiratory distress syndrome (ARDS), atrial fibrillation, hepatocellular injury, metabolic acidosis, pulmonary edema, multiple organ dysfunction syndrome, and HLH/MAS.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Lymphodepleting Chemotherapy

Begin administration of low-dose lymphodepleting chemotherapy 5 days before ABECMA® infusion\(^1,5\)

- Confirm the availability of ABECMA before starting the lymphodepleting chemotherapy regimen
- Administer lymphodepleting chemotherapy regimen: fludarabine 30 mg/m\(^2\)/day IV and cyclophosphamide 300 mg/m\(^2\)/day IV for 3 days\(^*\)
- Administer ABECMA 2 days after completion of lymphodepleting chemotherapy

Delay the infusion of ABECMA up to 7 days if a patient has any of the following conditions:

- Unresolved serious adverse events (especially pulmonary events, cardiac events, or hypotension), including those after preceding chemotherapies
- Active infections or inflammatory disorders

\(^{IV=intravenously.}\)

\(^{*}\)See the prescribing information of cyclophosphamide and fludarabine for information on dose adjustment in renal impairment.

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Cytokine Release Syndrome (CRS) (cont’d):** Identify CRS based on clinical presentation. Evaluate for and treat other causes of fever, hypoxia, and hypotension. CRS has been reported to be associated with findings of HLH/MAS, and the physiology of the syndromes may overlap. In patients with progressive symptoms of CRS or refractory CRS despite treatment, evaluate for evidence of HLH/MAS.

Fifty four percent (68/127) of patients received tocilizumab (single dose: 35%; more than 1 dose: 18%). Overall, 15% (19/127) of patients received at least 1 dose of corticosteroids for treatment of CRS. All patients that received corticosteroids for CRS received tocilizumab. Ensure that a minimum of 2 doses of tocilizumab are available prior to infusion of ABECMA.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Considerations Before Lymphodepleting Chemotherapy

Washout periods before lymphodepleting chemotherapy in the KarMMa pivotal trial²

<table>
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<tr>
<th>MM bridging therapies (following leukapheresis)</th>
<th>Stopped ≥14 days prior to lymphodepleting chemotherapy</th>
</tr>
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</table>

MM bridging therapies included:

- Corticosteroids, alkylating agents, IMiD® agents, proteasome inhibitors, and/or anti-CD38 monoclonal antibodies as single agents or in combination
- Bridging therapy for disease control was limited to agents the patient had previously been exposed to. Experimental agents were not used as bridging therapy in the KarMMa trial. In patients who received bridging MM therapy, baseline disease staging assessments were repeated following completion of bridging therapy and prior to starting lymphodepleting chemotherapy

IMPORTANT SAFETY INFORMATION (cont’d)

Cytokine Release Syndrome (CRS) (cont’d): Monitor patients at least daily for 7 days following ABECMA infusion at the REMS-certified healthcare facility for signs or symptoms of CRS and monitor patients for signs or symptoms of CRS for at least 4 weeks after ABECMA infusion. At the first sign of CRS, institute treatment with supportive care, tocilizumab and/or corticosteroids as indicated. Counsel patients to seek immediate medical attention should signs or symptoms of CRS occur at any time.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Preparing for the Infusion

Before beginning treatment with ABECMA®

- Ensure that a minimum of 2 doses of tocilizumab per patient and emergency equipment are available prior to infusion and during the recovery period
- Monitor patients for signs and symptoms of infection before and after ABECMA infusion and treat appropriately. ABECMA should not be administered to patients with active infections or inflammatory disorders
- Monitor complete blood counts prior to and after ABECMA infusion

ABECMA may cause a false-positive HIV test result by some commercial tests.

Premedication on infusion day

30-60 minutes before ABECMA infusion

- Administer acetaminophen (650 mg orally) and diphenhydramine (12.5 mg IV or 25 to 50 mg orally, or another H₁-antihistamine)

Avoid prophylactic use of dexamethasone or other systemic corticosteroids, as they may interfere with the activity of ABECMA.

IMPORTANT SAFETY INFORMATION (cont’d)

Neurologic Toxicities: Neurologic toxicities, which may be severe or life-threatening, occurred following treatment with ABECMA in 28% (36/127) of patients receiving ABECMA, including Grade 3 in 4% (5/127) of patients. One patient had ongoing Grade 2 neurotoxicity at the time of death. Two patients had ongoing Grade 1 tremor at the time of data cutoff. The median time to onset of neurotoxicity was 2 days (range: 1 - 42 days). CAR T cell-associated neurotoxicity resolved in 92% (33/36) of patients with a median time to resolution of 5 days (range: 1 - 61 days). The median duration of neurotoxicity was 6 days (range: 1 - 578) in all patients including 3 patients with ongoing neurotoxicity. Thirty-four patients with neurotoxicity had CRS with onset in 3 patients before, 29 patients during, and 2 patients after CRS. The most frequently reported manifestations of CAR T cell-associated neurotoxicity include encephalopathy, tremor, aphasia, and delirium. Grade 4 neurotoxicity and cerebral edema in 1 patient, Grade 3 myelitis, and Grade 3 parkinsonism have been reported with ABECMA in another study in multiple myeloma.

Monitor patients at least daily for 7 days following ABECMA infusion at the REMS-certified healthcare facility for signs or symptoms of neurologic toxicities and monitor patients for signs or symptoms of neurologic toxicities for at least 4 weeks after ABECMA infusion and treat promptly. Rule out other causes of neurologic symptoms. Neurologic toxicity should be managed with supportive care and/or corticosteroids as needed.

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

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Preparing for the Infusion (cont’d)

Setup

A Y-type administration set is recommended to accommodate the infusion bag on one arm and a bag of normal saline on the second arm.

- ABECMA® can be administered via peripheral or central venous access. Central venous access is encouraged in patients with poor peripheral access.

IMPORTANT SAFETY INFORMATION (cont’d)

Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS): HLH/MAS occurred in 4% (5/127) of patients receiving ABECMA. One patient developed fatal multi-organ HLH/MAS with CRS and another patient developed fatal bronchopulmonary aspergillosis with contributory HLH/MAS. Three cases of Grade 2 HLH/MAS resolved. All events of HLH/MAS had onset within 10 days of receiving ABECMA with a median onset of 7 days (range: 4 - 9 days) and occurred in the setting of ongoing or worsening CRS. Two patients with HLH/MAS had overlapping neurotoxicity. The manifestations of HLH/MAS include hypotension, hypoxia, multiple organ dysfunction, renal dysfunction, and cytopenia. HLH/MAS is a potentially life-threatening condition with a high mortality rate if not recognized early and treated. Treatment of HLH/MAS should be administered per institutional guidelines.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Preparing to Thaw ABECMA®

Ensure that the following steps are completed prior to thawing ABECMA¹,⁴:

When removing ABECMA from vapor-phase LN₂ storage, proper PPE should be worn. Ensure that personnel are trained on the handling of LN₂ according to institutional practices.

- Have the RFI certificate ready
- Confirm with site staff that the patient is ready for infusion and has been appropriately premedicated
- Preheat approved thaw device or water bath to 37 °C
- Confirm the infusion start time in advance and adjust the start time of the thaw so that ABECMA is available for infusion when the patient is ready
- Verify that the number of infusion bags and label information match the ABECMA RFI certificate

3. Prior to thawing ABECMA¹,⁴

STOP AND CONFIRM PATIENT ID

Two site staff are required to verify the patient information on the ABECMA RFI certificate matches the cassette labels and bag labels:

- Patient’s first and last name
- Patient’s date of birth
- JOIN*

NOTE: Do not remove the ABECMA infusion bag from the cassette if the information on the patient-specific label does not match the intended patient. Contact Bristol Myers Squibb at 1-888-805-4555 if there are any discrepancies between the labels and the patient identifiers.

*The JOIN is a unique identification code that is assigned to the patient’s specific cellular material and is the link between the patient and their cells throughout the manufacturing process.

IMPORTANT SAFETY INFORMATION (cont’d)

ABECMA REMS: Due to the risk of CRS and neurologic toxicities, ABECMA is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ABECMA REMS. Further information is available at www.AbecmaREMS.com or 1-888-423-5436.

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

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
IMPORTANT SAFETY INFORMATION (cont’d)

Infections: ABECMA should not be administered to patients with active infections or inflammatory disorders. Severe, life-threatening, or fatal infections occurred in patients after ABECMA infusion. Infections (all grades) occurred in 70% of patients. Grade 3 or 4 infections occurred in 23% of patients. Overall, 4 patients had Grade 5 infections (3%); 2 patients (1.6%) had Grade 5 events of pneumonia, 1 patient (0.8%) had Grade 5 bronchopulmonary aspergillosis, and 1 patient (0.8%) had cytomegalovirus (CMV) pneumonia associated with Pneumocystis jiroveci. Monitor patients for signs and symptoms of infection before and after ABECMA infusion and treat appropriately. Administer prophylactic, pre-emptive, and/or therapeutic antimicrobials according to standard institutional guidelines.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
**Directions for Thawing the Cassette**

**Front of Cassette**

- Hold open cassette in one hand
- With the opposite hand, use one finger to gently push bag from the back of the cassette to prop up the bag
- Additionally, while not recommended for retrieving materials from within the LN₂ dry vapor shipper or extended exposure to cryogenic temperatures, rubber-coated cryogenic gloves may provide better dexterity for removing the bag from the cassette.

**Back of Cassette**

1. **NOTE:** Cassette appearance may differ depending on infusion bag size (50 mL, 250 mL, or 500 mL).

**ABECMA® Thawing (cont’d)**

**Viral Reactivation**

CMV infection resulting in pneumonia and death has occurred following ABECMA administration. Monitor and treat for CMV reactivation in accordance with clinical guidelines. 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 plasma cells. Perform screening for CMV, HBV, hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in accordance with clinical guidelines before collection of cells for manufacturing.

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Infections (cont’d):** Febrile neutropenia was observed in 16% (20/127) of patients after ABECMA infusion and may be concurrent with CRS. In the event of febrile neutropenia, evaluate for infection and manage with broad-spectrum antibiotics, fluids, and other supportive care.

**Viral Reactivation:** CMV infection resulting in pneumonia and death has occurred following ABECMA administration. Monitor and treat for CMV reactivation in accordance with clinical guidelines. 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 plasma cells. Perform screening for CMV, HBV, hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in accordance with clinical guidelines before collection of cells for manufacturing.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Thawing$^{1,4}$ (cont’d)

**Step 2**
Thaw ABECMA at approximately 37 °C using an approved thaw device or water bath until there is no visible ice in the infusion bag.

- Gently mix the contents of the bag to disperse clumps of cellular material. If visible cell clumps remain, continue to gently mix the contents of the bag. Small clumps of cellular material should disperse with gentle manual mixing.

- If the clumps of cellular material do not disperse, do not administer, and contact Bristol Myers Squibb at 1-888-805-4555

- **DO NOT** walk away from the thawing product

- **DO NOT** wash, spin down, and/or resuspend ABECMA in new media prior to infusion

If more than 1 infusion bag has been received for treatment, thaw each infusion bag 1 at a time.

**Step 3**
If thawing in a cell therapy lab, transport ABECMA to bedside in an insulated room temperature carrier. Note, thaw begins at time ABECMA is removed from frozen storage.

Provide the RFI certificate to the staff performing product administration.

**Repeat**
Follow the same procedure for all subsequent infusion bags for the identified patient.

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Prolonged Cytopenias:** In the clinical study, 41% of patients (52/127) experienced prolonged Grade 3 or 4 neutropenia and 49% (62/127) experienced prolonged Grade 3 or 4 thrombocytopenia that had not resolved by Month 1 following ABECMA infusion. In 83% (43/52) of patients who recovered from Grade 3 or 4 neutropenia after Month 1, the median time to recovery from ABECMA infusion was 1.9 months. In 65% (40/62) of patients who recovered from Grade 3 or 4 thrombocytopenia, the median time to recovery was 2.1 months.

Three patients underwent stem cell therapy for hematopoietic reconstitution due to prolonged cytopenia. Two of the three patients died from complications of prolonged cytopenia. Monitor blood counts prior to and after ABECMA infusion. Manage cytopenia with myeloid growth factor and blood product transfusion support.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Infusion Process

After obtaining the RFI certificate, ensure that the following steps are completed immediately before administering ABECMA1,2,4:

- Conduct a general nursing assessment
- Check for fever or infection, monitor complete blood counts, and confirm the patient can appropriately receive ABECMA
- Confirm that the patient has been appropriately premedicated
- Determine peripheral or central venous access
- Confirm 1 hour after thaw has not passed
- Tubing of the infusion set has been primed with normal saline
- Gently massage the thawed infusion bag and attach it to the administration set

NOTE: The ABECMA infusion bags should be administered in series. If more than 1 infusion bag is required for administration, keep the remaining bag(s) in LN₂ storage until prior bag has been infused and patient is ready; proceed to the subsequent infusion bag based on clinical judgment. Each infusion bag should be infused within 1 hour of the start of its thaw.*

*ABECMA is stable for 2 hours at room temperature once thawed.

IMPORTANT SAFETY INFORMATION (cont’d)

Prolonged Cytopenias (cont’d): Three patients underwent stem cell therapy for hematopoietic reconstitution due to prolonged cytopenia. Two of the three patients died from complications of prolonged cytopenia. Monitor blood counts prior to and after ABECMA infusion. Manage cytopenia with myeloid growth factor and blood product transfusion support.

Hypogammaglobulinemia: Hypogammaglobulinemia was reported as an adverse event in 21% (27/127) of patients; laboratory IgG levels fell below 500 mg/dl after infusion in 25% (32/127) of patients treated with ABECMA. Monitor immunoglobulin levels after treatment with ABECMA and administer IVIG for IgG <400 mg/dl. Manage appropriately per local institutional guidelines, including infection precautions and antibiotic or antiviral prophylaxis.

The safety of immunization with live viral vaccines during or after ABECMA 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 ABECMA treatment, and until immune recovery following treatment with ABECMA.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Infusion Process (cont’d)

4. Prior to ABECMA administration

STOP AND CONFIRM PATIENT ID

Two site staff are required to verify the patient information on the ABECMA RFI certificate matches the cassette labels and bag labels:
• Patient’s first and last name
• Patient’s date of birth
• JOIN*

Site staff must verify patient information on product labels against the patient’s medical records, as well as verbally with the patient prior to infusion.

Each infusion bag should be infused within 1 hour from start of thaw1,4

Step 1
Infuse the contents of the infusion bag by gravity flow

Step 2
After the entire contents of the infusion bag have been infused, flush the tubing with 30 to 60 mL of normal saline at the same infusion rate to ensure all of the cells are delivered

Step 3
If more than 1 infusion bag is being administered, repeat the procedure (thawing through saline flush) to administer subsequent infusion bags of ABECMA in series

*The JOIN is a unique identification code that is assigned to the patient’s specific cellular material and is the link between the patient and their cells throughout the manufacturing process.

IMPORTANT SAFETY INFORMATION (cont’d)

Secondary Malignancies: Patients treated with ABECMA may develop secondary malignancies. Monitor life-long for secondary malignancies. If a secondary malignancy occurs, contact Bristol Myers Squibb at 1-888-805-4555 to obtain instructions on patient samples to collect for testing of secondary malignancy of T cell origin.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Cytokine Release Syndrome

During administration and at least daily for the first 7 days following ABECMA® infusion, monitor your patients at the certified healthcare facility for adverse reactions1

These reactions can include CRS and NT:
- Refer to the CRS and NT tables on pages 28-29 and 32 for grading and management
- Accurate grading is imperative for appropriate management

CRS in the KarMMa pivotal trial1,6*

CRS rates

<table>
<thead>
<tr>
<th>CAR-positive T cells (N=127)</th>
<th>Grade ≥3 (n=12)</th>
<th>All grades (n=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>150-450 x 10^6</td>
<td>9%</td>
<td>85%</td>
</tr>
</tbody>
</table>

46% Grade 1 (n=58)
30% Grade 2 (n=38)
Grade 5 CRS was reported in one (0.8%) patient.

Median time to onset

- 150-450 x 10^6 CAR-positive T cells (N=127)
- 1 DAY
- Range: 1-23 days

Median duration

- 7 DAYS
- Range: 1-63 days

CRS, including fatal or life-threatening reactions, occurred following treatment with ABECMA.

*Lee criteria for grading CRS (Lee et al, 2014).

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Cytokine Release Syndrome (cont’d)

Monitoring and management of CRS

- **Counsel** patients and caregivers to seek immediate medical attention should signs or symptoms of CRS occur at any time
  - Symptoms of CRS include fever, difficulty breathing, dizziness or light-headedness, nausea, headache, fast heartbeat, low blood pressure, or fatigue
- **Instruct** patients to remain within proximity of the certified healthcare facility for at least 4 weeks following infusion
- **Monitor** patients for signs and symptoms of CRS
  - At least daily for 7 days at the certified healthcare facility following ABECMA® infusion
  - For at least 4 weeks after ABECMA infusion
- **Treat** at the first sign of CRS with supportive care, tocilizumab, and/or corticosteroids as needed based on the grading and management guidelines
  - If concurrent CRS is suspected during an NT event, manage CRS according to the recommendations in the full Prescribing Information
- **Ensure** that a minimum of 2 doses of tocilizumab per patient are available prior to infusion of ABECMA

Identify CRS based on clinical presentation. Evaluate for and treat other causes of fever, hypoxia, and hypotension.

- CRS has been reported to be associated with findings of HLH/MAS, and the physiology of the syndromes may overlap
  - In patients with progressive symptoms of CRS or refractory CRS despite treatment, evaluate for evidence of HLH/MAS
  - HLH/MAS is a potentially life-threatening condition, and patients should be closely monitored for evidence of HLH/MAS. Treatment of HLH/MAS should be administered per institutional standards

Patients who experience CRS should be closely monitored for cardiac and organ function until resolution of symptoms.

- For severe or life-threatening CRS, consider intensive care unit level monitoring and supportive therapy

If CRS is suspected, manage according to the recommendations in the tables on pages 28-29.

HLH/MAS=hemophagocytic lymphohistiocytosis/macrophage activation syndrome.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Cytokine Release Syndrome (cont’d)

CRS grading from the ABECMA® Prescribing Information

<table>
<thead>
<tr>
<th>Grade 1</th>
<th>Symptoms require symptomatic treatment only (eg, fever, nausea, fatigue, headache, myalgia, malaise).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 2</td>
<td>Symptoms require and respond to moderate intervention. Oxygen requirement &lt;40% FiO₂ or hypotension responsive to fluids, or low dose of 1 vasopressor, or Grade 2 organ toxicity.</td>
</tr>
<tr>
<td>Grade 3</td>
<td>Symptoms require and respond to aggressive intervention. Fever, oxygen requirement ≥40% FiO₂ or hypotension requiring high-dose or multiple vasopressors, or Grade 3 organ toxicity or Grade 4 transaminitis.</td>
</tr>
<tr>
<td>Grade 4</td>
<td>Life-threatening symptoms. Requirements for ventillator support, continuous veno-venous hemodialysis (CVVHD), or Grade 4 organ toxicity (excluding transaminitis).</td>
</tr>
</tbody>
</table>

The ASTCT Consensus Grading system is another guideline for evaluating cell therapy-associated CRS. Please refer to these guidelines for additional information.

ASTCT=American Society for Transplantation and Cellular Therapy.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
## Cytokine Release Syndrome (cont’d)

### CRS management guidance from the ABECMA® Prescribing Information

<table>
<thead>
<tr>
<th>Tocilizumab†</th>
<th>Corticosteroids‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grade 1</strong></td>
<td></td>
</tr>
<tr>
<td>If onset ≥72 hours after infusion, treat symptomatically. If onset &lt;72 hours after infusion, consider tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg).</td>
<td>Consider dexamethasone 10 mg IV every 24 hours.</td>
</tr>
<tr>
<td><strong>Grade 2</strong></td>
<td></td>
</tr>
<tr>
<td>Administer tocilizumab 8 mg/kg IV over 1 hour (not to exceed 800 mg). Repeat tocilizumab every 8 hours as needed if not responsive to intravenous fluids or increasing supplemental oxygen. Limit to a maximum of 3 doses in a 24-hour period; maximum total of 4 doses.</td>
<td>Consider dexamethasone 10 mg IV every 12-24 hours.</td>
</tr>
<tr>
<td>If no improvement within 24 hours or rapid progression, repeat tocilizumab and escalate dose and frequency of dexamethasone (20 mg IV every 6 to 12 hours). If no improvement within 24 hours or continued rapid progression, switch to methylprednisolone 2 mg/kg followed by 2 mg/kg divided 4 times per day. After 2 doses of tocilizumab, consider alternative anticytokine agents. Do not exceed 3 doses of tocilizumab in 24 hours, or 4 doses in total.</td>
<td></td>
</tr>
<tr>
<td><strong>Grade 3</strong></td>
<td></td>
</tr>
<tr>
<td>Per Grade 2.</td>
<td>Administer dexamethasone 10 mg IV every 12 hours.</td>
</tr>
<tr>
<td>If no improvement within 24 hours or rapid progression, repeat tocilizumab and escalate dose and frequency of dexamethasone (20 mg IV every 6 to 12 hours). If no improvement within 24 hours or continued rapid progression, switch to methylprednisolone 2 mg/kg followed by 2 mg/kg divided 4 times per day. After 2 doses of tocilizumab, consider alternative anticytokine agents. Do not exceed 3 doses of tocilizumab in 24 hours, or 4 doses in total.</td>
<td></td>
</tr>
<tr>
<td><strong>Grade 4</strong></td>
<td></td>
</tr>
<tr>
<td>Per Grade 2.</td>
<td>Administer dexamethasone 20 mg IV every 6 hours.</td>
</tr>
<tr>
<td>After 2 doses of tocilizumab, consider alternative anticytokine agents. Do not exceed 3 doses of tocilizumab in 24 hours, or 4 doses in total. If no improvement within 24 hours, consider methylprednisolone (1-2 g, repeat every 24 hours if needed; taper as clinically indicated) or other anti-T cell therapies.</td>
<td></td>
</tr>
</tbody>
</table>

*Lee criteria for grading CRS (Lee et al, 2014).
†Refer to tocilizumab Prescribing Information for details.
‡If corticosteroids are initiated, continue corticosteroids for at least 3 doses, and taper over a maximum of 7 days.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Neurologic Toxicity

NT in the KarMMa pivotal trial1,6

NT rates

<table>
<thead>
<tr>
<th>CAR-positive T cells (N=127)</th>
<th>Grade 3 (n=5)</th>
<th>All grades (n=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>150-450 x 10⁶</td>
<td>4%</td>
<td>28%</td>
</tr>
</tbody>
</table>

17% Grade 1 (n=21)
8% Grade 2 (n=10)
There were no grade 4 or 5 NT events in KarMMa.

Median time to onset

- 150-450 x 10⁶ CAR-positive T cells (N=127)
- 2 DAYS
- Range: 1-42 days

Median duration*

- 150-450 x 10⁶ CAR-positive T cells (N=127)
- 5 DAYS
- Range: 1-61 days

In 33 of 36 patients who had resolved NT

Neurologic toxicities, which may be severe or life-threatening, occurred following treatment with ABECMA®, including concurrently with CRS (n=34), with onset during CRS (n=29), before CRS (n=3), after CRS resolution (n=2), or in the absence of CRS.

In KarMMa, all NT events were ICANS events and no grade 3 or higher Parkinsonian, neurosensory, or motor symptoms were observed.1,2†

*For patients who experienced NT, including 3 patients with ongoing NT, the median duration of CAR T cell-associated NT was 6 days (range: 1 to 578 days).
†ICANS is a pathologic process involving the central nervous system after immune therapy that activates or engages endogenous or infused T cells and/or other immune effector cells. Signs and symptoms may include aphasia, altered level of consciousness, impairment of cognitive skills, motor weakness, seizures, and cerebral edema and may be progressive.7

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Neurologic Toxicity (cont’d)

Monitoring and management of NT1

- **Counsel** patients and caregivers to seek immediate medical attention should signs or symptoms of NT occur at any time
  - Symptoms of NT include headache, confusion, dizziness, or anxiety
- **Instruct** patients to remain within proximity of the certified healthcare facility for at least 4 weeks following infusion
- **Monitor** patients for signs and symptoms of NT
  - At least daily for 7 days at the certified healthcare facility following ABECMA® infusion
  - For at least 4 weeks after ABECMA infusion
- **Exclude** other causes of neurologic signs or symptoms
- **Treat** promptly with supportive care and/or corticosteroids as needed based on the grading and management guidelines

If NT is suspected, manage according to the recommendations in the table on page 32.

If concurrent NT is suspected during CRS, or if concurrent CRS is suspected during the NT event, administer1:

- Corticosteroids according to the more aggressive intervention based on the CRS and NT grades
- Tocilizumab according to the CRS grade
- Antiseizure medication according to the NT grade

Management recommendations from the Prescribing Information for each grade of CRS and NT are outlined in the tables on pages 28-29 and 32, respectively.
## Neurologic Toxicity (cont’d)

### NT management guidance from the ABECMA® Prescribing Information

<table>
<thead>
<tr>
<th>NT grade*</th>
<th>Corticosteroids and antiseizure medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grade 1</strong></td>
<td>Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis. If ≥72 hours after infusion, observe patient. If &lt;72 hours after infusion, consider dexamethasone 10 mg IV every 12 to 24 hours for 2 to 3 days.</td>
</tr>
<tr>
<td><strong>Grade 2</strong></td>
<td>Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis. Start dexamethasone 10 mg IV every 12 hours for 2 to 3 days, or longer for persistent symptoms. Consider taper for a total steroid exposure of &gt;3 days. Steroids are not recommended for isolated Grade 2 headaches. If no improvement after 24 hours or worsening of NT, increase the dose and/or frequency of dexamethasone up to a maximum of 20 mg IV every 6 hours.</td>
</tr>
<tr>
<td><strong>Grade 3</strong></td>
<td>Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis. Start dexamethasone 10 to 20 mg IV every 6 to 12 hours. Steroids are not recommended for isolated Grade 3 headaches. If no improvement after 24 hours or worsening of NT, escalate to methylprednisolone (2 mg/kg loading dose, followed by 2 mg/kg divided into 4 times a day; taper within 7 days). If cerebral edema is suspected, consider hyperventilation and hyperosmolar therapy. Give high-dose methylprednisolone (1 to 2 g, repeat every 24 hours if needed; taper as clinically indicated) and cyclophosphamide 1.5 g/m².</td>
</tr>
<tr>
<td><strong>Grade 4</strong></td>
<td>Start non-sedating, antiseizure medicines (eg, levetiracetam) for seizure prophylaxis. Start dexamethasone 20 mg IV every 6 hours. If no improvement after 24 hours or worsening of NT, escalate to high-dose methylprednisolone (1 to 2 g, repeated every 24 hours if needed; taper as clinically indicated). If cerebral edema is suspected, consider hyperventilation and hyperosmolar therapy. Give high-dose methylprednisolone (1 to 2 g, repeat every 24 hours if needed; taper as clinically indicated), and cyclophosphamide 1.5 g/m².</td>
</tr>
</tbody>
</table>

*National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE) criteria for grading neurologic toxicities.

The ASTCT ICANS Consensus Grading system is another guideline for evaluating cell therapy-associated NT. Please refer to these guidelines for additional information.

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Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Hemophagocytic Lymphohistiocytosis/ Macrophage Activation Syndrome

HLH/MAS in the KarMMa pivotal trial\textsuperscript{1}

150-450 x 10\textsuperscript{6} CAR-positive T cells (N=127)

- HLH/MAS rates: 4% all grades (n=5)

- One grade 5 HLH/MAS was observed. In another patient with fatal bronchopulmonary aspergillosis, HLH/MAS was contributory to the fatal outcome

- Median time to onset: 7 days (range: 4-9 days)

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

Prolonged cytopenias in the KarMMa pivotal trial\(^1\)*

150-450 x 10\(^6\) CAR-positive T cells (N=127)

- Prolonged neutropenia rates: 41% grade ≥3 (n=52)
  - Median time to recovery was 1.9 months in 83% (n=43/52) of patients who recovered from grade 3 or 4 neutropenia after month 1

- Prolonged thrombocytopenia rates: 49% grade ≥3 (n=62)
  - Median time to recovery was 2.1 months in 65% (n=40/62) of patients who recovered from grade 3 or 4 thrombocytopenia

- 2 of 3 patients who underwent hematopoietic reconstitution due to prolonged cytopenia died

- Monitor blood counts prior to and after ABECMA\(^\text{®}\) infusion. Manage cytopenia with myeloid growth factor and blood product transfusion support according to local institutional guidelines

*Not resolved by month 1 following ABECMA infusion.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Safety Profile

Adverse reactions\(^1\)

- The most common nonlaboratory adverse reactions (incidence ≥20%) included CRS, infections—pathogen unspecified, fatigue, musculoskeletal pain, hypogammaglobulinemia, diarrhea, upper respiratory tract infection, nausea, viral infections, encephalopathy, edema, pyrexia, cough, headache, and decreased appetite.

- Serious adverse reactions occurred in 67% of patients. The most common nonlaboratory (≥5%) serious adverse reactions included CRS (18%), general physical health deterioration (10%), pneumonia (12%), infections—pathogen unspecified (19%), viral infections (9%), sepsis (7%), and febrile neutropenia (6%). Fatal adverse reactions occurred in 6%.

- The most common (≥10%) grade 3 or 4 nonlaboratory adverse reactions were febrile neutropenia (16%) and infections—pathogen unspecified (15%).
### ABECMA® Safety Profile (cont’d)

Summary of adverse reactions observed in at least 10% of patients treated with ABECMA in the KarMMa study

<table>
<thead>
<tr>
<th>Any Grade, %</th>
<th>Grade 3 or Higher, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>150-450 x 10^6 (N=127)</td>
<td>150-450 x 10^6 (N=127)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>BLOOD AND LYMPHATIC SYSTEM DISORDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Febrile neutropenia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CARDIAC DISORDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tachycardia*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>GASTROINTESTINAL DISORDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Nausea</td>
</tr>
<tr>
<td>Constipation</td>
</tr>
<tr>
<td>Vomiting</td>
</tr>
<tr>
<td>Oral pain†</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue‡</td>
</tr>
<tr>
<td>Pyrexia</td>
</tr>
<tr>
<td>General physical health deterioration</td>
</tr>
<tr>
<td>Edema§</td>
</tr>
<tr>
<td>Chills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>IMMUNE SYSTEM DISORDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytokine release syndrome</td>
</tr>
<tr>
<td>Hypogammaglobulinemia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>INFECTIONS AND INFESTATIONS¶</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections – Pathogen unspecified</td>
</tr>
<tr>
<td>Viral infections</td>
</tr>
<tr>
<td>Bacterial infections</td>
</tr>
<tr>
<td>Pneumonia*</td>
</tr>
<tr>
<td>Upper respiratory tract infection**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>INVESTIGATIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight decreased</td>
</tr>
</tbody>
</table>

*Tachycardia includes sinus tachycardia, tachycardia.
†Oral pain includes oral pain, oropharyngeal pain, toothache.
‡Fatigue includes asthenia, fatigue, malaise.
§Edema includes edema, face edema, fluid overload, fluid retention, generalized edema, peripheral edema, peripheral swelling, scrotal swelling, swelling.
|| Hypogammaglobulinemia includes patients with adverse events (21%) of blood immunoglobulin G decreased, hypogammaglobulinemia, hypoglobulinemia; and/or patients with laboratory IgG levels below 500 mg/dL following ABECMA infusion (25%).
¶Infections and infestations System Organ Class Adverse Events are grouped by pathogen type and selected clinical syndromes.
#Pneumonia includes bronchopulmonary aspergillosis, lung infection, pneumonia, pneumonia aspiration, pneumonia cytomegaloviral, pneumonia pneumococcal, pneumonia pseudomonal. Pneumonias may also be included under pathogen categories.
**Upper respiratory tract infection includes laryngitis, nasopharyngitis, pharyngeal erythema, pharyngitis, respiratory tract congestion, respiratory tract infection, rhinitis, rhinovirus infection, sinusitis, upper respiratory tract infection, upper respiratory tract infection bacterial. Upper respiratory tract infections may also be included under pathogen categories.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
# ABECMA® Safety Profile (cont’d)

## Summary of adverse reactions observed in at least 10% of patients treated with ABECMA in the KarMMa study¹ (cont’d)

<table>
<thead>
<tr>
<th>Reaction / System</th>
<th>Any Grade, %</th>
<th>Grade 3 or Higher, %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>METABOLISM AND NUTRITION DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased appetite*</td>
<td>22</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal pain†</td>
<td>45</td>
<td>3.1</td>
</tr>
<tr>
<td>Motor dysfunction‡</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td><strong>NERVOUS SYSTEM DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalopathy§</td>
<td>26</td>
<td>6</td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td>††</td>
</tr>
<tr>
<td>Dizziness¶</td>
<td>17</td>
<td>0.8</td>
</tr>
<tr>
<td>Neuropathy peripheral#</td>
<td>17</td>
<td>0.8</td>
</tr>
<tr>
<td>Tremor**</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td><strong>PSYCHIATRIC DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia††</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Anxiety‡‡</td>
<td>12</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>RENAL AND URINARY DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal failure§§</td>
<td>10</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>RESPIRATORY, THORACIC AND MEDIASTINAL DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td>¶</td>
</tr>
<tr>
<td>Dyspnea**</td>
<td>13</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>SKIN AND SUBCUTANEOUS TISSUE DISORDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash***</td>
<td>14</td>
<td>0.8</td>
</tr>
<tr>
<td>Xerosis†††</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td><strong>VASCULAR DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypotension†††</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Hypertension</td>
<td>11</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*Decreased appetite includes decreased appetite, hypophagia.
†Musculoskeletal pain includes arthralgia, back pain, bone pain, musculoskeletal chest pain, musculoskeletal discomfort, musculoskeletal pain, musculoskeletal stiffness, myalgia, neck pain, spinal pain.
‡Motor dysfunction includes asthenia, bradynxia, cognitive disorder, confusional state, depressed level of consciousness, disturbance in attention, dyscalculia, dysgraphia, encephalopathy, lethargy, memory impairment, mental status changes, metabolic encephalopathy, somnolence, toxic encephalopathy.
§Encephalopathy includes amnesia, bradyphrenia, cognitive disorder, confusional state, depressed level of consciousness, disturbance in attention, dyscalculia, dysgraphia, encephalopathy, lethargy, memory impairment, mental status changes, metabolic encephalopathy, somnolence, toxic encephalopathy.
||Headache includes headache, head discomfort, sinus headache.
¶Dizziness includes dizziness, presyncope, syncope, vertigo.
#Neuropathy peripheral includes carpal tunnel syndrome, hypohesia, hypoesthesia, neurological, neuropathy peripheral, paresthesia, peripheral sensorimotor neuropathy, peripheral sensory neuropathy, sciatica.
**Tremor includes asterixis, tremor.
††Insomnia includes insomnia, sleep deficit, sleep disorder.
‡‡Anxiety includes anxiety, feeling jittery, nervousness.
§§Renal failure includes acute kidney injury, blood creatinine increased, chronic kidney disease, renal failure, renal impairment.
¶¶Cough includes cough, productive cough, upper-airway cough syndrome.
**Dyspnea includes acute respiratory failure, dyspnea, dyspnea exertional, respiratory failure.
***Rash includes acne, dermatitis, dermatitis bullous, erythema, rash, rash macular, rash papular, urticaria.
†††Xerosis includes dry eye, dry mouth, dry skin, dry lip, xerosis.
‡‡‡Hypotension includes hypotension, orthostatic hypotension.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
ABECMA® Safety Profile (cont’d)

Grade 3 or 4 laboratory abnormalities worsening from baseline in at least 10% of patients treated with ABECMA in the KarMMa study¹

<table>
<thead>
<tr>
<th>Laboratory Abnormality</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutropenia</td>
<td>96</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>96</td>
</tr>
<tr>
<td>Lymphopenia</td>
<td>92</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>63</td>
</tr>
<tr>
<td>Anemia</td>
<td>63</td>
</tr>
<tr>
<td>Hypophosphatemia</td>
<td>45</td>
</tr>
<tr>
<td>Hyponatremia</td>
<td>10</td>
</tr>
<tr>
<td>aPTT Increased (seconds)</td>
<td>10</td>
</tr>
</tbody>
</table>

aPTT=activated partial thromboplastin time.
Laboratory tests were graded according to NCI CTCAE Version 4.03. Laboratory abnormalities are sorted by decreasing frequency in the 150 to 450 x 10⁶ column.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Returning the LN₂ Dry Vapor Shipper⁴

1. Load the cassette rack into the inner chamber of the outer container and replace the inner chamber lid

2. Remove shipping pouch from the pocket inside the outer container. The shipping pouch contains the FedEx® return label and an “EMPTY” label

3. Remove the “EMPTY” label from the shipping pouch and place “EMPTY” label on one of the metal plates on the outer container

4. Seal the shipping pouch containing the FedEx® return label, remove sticker backing, and place FedEx® return label on the other metal plate on the outer container

5. Close the outer container lid and lock the latch by turning the key to the right

6. Place LN₂ dry vapor shipper in scheduled pickup location or contact Bristol Myers Squibb at 1-888-805-4555 to schedule a pickup

NOTE: Cassettes should be disposed of on site after administration of ABECMA®.

IMPORTANT SAFETY INFORMATION (cont’d)

Effects on Ability to Drive and Operate Machinery: Due to the potential for neurologic events, patients receiving ABECMA are at risk for altered or decreased consciousness or coordination in the 8 weeks following ABECMA 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.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
Transition Back to Primary Oncologist

Considerations\textsuperscript{1,8}

After at least 4 weeks of monitoring by the certified healthcare facility, the patient may return to the primary oncologist for continued monitoring and routine care appointments. Consider the following before returning your patients to home care:

• **Before transitioning care**, regularly meet with your patients to discuss the treatment they received, side effects, medications, infection prevention, and immunization recommendations
• **Provide** updated medical records and confirm home care is appropriate
• **Transition care** back to the primary oncologist or hematologist within 7 days

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Adverse Reactions:** The most common nonlaboratory adverse reactions include CRS, infections – pathogen unspecified, fatigue, musculoskeletal pain, hypogammaglobulinemia, diarrhea, upper respiratory tract infection, nausea, viral infections, encephalopathy, edema, pyrexia, cough, headache, and decreased appetite.

Please see additional Important Safety Information on the following pages and [click here for full Prescribing Information](#), including Boxed WARNINGS and Medication Guide.
Long-term Monitoring

Warnings and precautions include:\footnote{1}

- **CRS:** CRS, including fatal or life-threatening reactions, occurred in patients following treatment with ABECMA®. Do not administer ABECMA to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids.

- **NT:** NT, which may be severe or life-threatening, occurred following treatment with ABECMA, including concurrently with CRS, after CRS resolution, or in the absence of CRS. Monitor for neurologic events after treatment with ABECMA. Provide supportive care and/or corticosteroids as needed.

- **HLH/MAS:** HLH/MAS, including fatal and life-threatening reactions, occurred in patients following treatment with ABECMA. HLH/MAS can occur with CRS or NT.

- **Prolonged cytopenias:** Prolonged cytopenia with bleeding and infection, including fatal outcomes following stem cell transplantation for hematopoietic recovery, occurred following treatment with ABECMA. Patients may exhibit Grade 3 or higher cytopenias for several weeks following pretreatment and ABECMA infusion. Monitor complete blood counts prior to and after ABECMA infusion.

- **Hypersensitivity reactions:** Monitor for hypersensitivity reactions during infusion.

- **Infections:** Monitor patients for signs and symptoms of infection; treat appropriately.

- **Hypogammaglobulinemia:** Monitor immunoglobulin levels after treatment. Manage using infection precautions, antibiotic or antiviral prophylaxis, and immunoglobulin replacement.

- **Use of live vaccines:** Not recommended for at least 6 weeks prior to lymphodepleting chemotherapy, during treatment with ABECMA, and until immune recovery following treatment.

- **Secondary malignancies:** Monitor life-long. In the event that a secondary malignancy occurs, contact Bristol Myers Squibb at 1-888-805-4555 to obtain instructions on patient samples to collect for testing of secondary malignancy of T cell origin.

- **Effects on ability to drive and use machines:** Advise patients to refrain from driving or operating heavy or potentially dangerous machines for at least 8 weeks after ABECMA administration.

Please see additional Important Safety Information on the following pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.
INDICATION
ABECMA® (idecabtagene vicleucel) is a B-cell maturation antigen (BCMA)-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory multiple myeloma after four or more prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody.

IMPORTANT SAFETY INFORMATION

WARNING: CYTOKINE RELEASE SYNDROME, NEUROLOGIC TOXICITIES, HLH/MAS, AND PROLONGED CYTOPENIA

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

- Neurologic Toxicities, which may be severe or life-threatening, occurred following treatment with ABECMA, including concurrently with CRS, after CRS resolution, or in the absence of CRS. Monitor for neurologic events after treatment with ABECMA. Provide supportive care and/or corticosteroids as needed.

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

- Prolonged Cytopenia with bleeding and infection, including fatal outcomes following stem cell transplantation for hematopoietic recovery, occurred following treatment with ABECMA.

- ABECMA is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ABECMA REMS.

Please see additional Important Safety Information on the previous pages and click here for full Prescribing Information, including Boxed WARNINGS and Medication Guide.