For patients with R/R MULTIPLE MYELOMA

CHALLENGE EXPECTATIONS

Rapid, deep, and durable responses with a one-time infusion of ABECMA®1-3*

ABECMA reached its primary endpoint (≥PR as assessed by an IRC) with an ORR of 72% (n=72/100). Rapid (1 month median TTR; range: 15 to 88 days; n=72/100), deep (29% ≥CR; n=29/100), and durable (11.1 months mPFS; range: 6.1 to 12.2 months; N=100) responses were achieved.† See study design on page 5.

CAR=chimeric antigen receptor; CR=complete response; IRC=Independent Response committee; mPFS=median progression-free survival; ORR=overall response rate; PR=partial response; R/R=relapsed/refractory; TTR=time to response.

* Treatment process includes leukapheresis, manufacturing, administration, and adverse event monitoring. A single dose of ABECMA contains a cell suspension of 300 to 460 x 10⁶ CAR-positive T cells in one or more infusion bags.
† Efficacy data based on long-term follow-up analysis (median time from ABECMA infusion to data cutoff 27.3 months [range: 24.1 to 33.1]; N=100). Data were generally consistent with the primary analysis. See ORR at primary analysis on page 8.

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 following pages and accompanying full Prescribing Information, including Boxed WARNINGS.
Outcomes Are Poor for Triple Class–Exposed* RRMM Patients⁴,⁵

Although advancements in the treatment of RRMM have transformed outcomes, deep and durable responses remain difficult to achieve after patients have received an IMiD® agent, a PI, and an anti-CD38 monoclonal antibody.⁴,⁶

When patients relapse, their disease becomes increasingly nonresponsive to the 3 main classes of treatments,⁴,⁷ resulting in:

• Shorter remissions between treatments⁵,⁶
• Rising burden of continuous administrations⁵,⁷
• Decreased quality of life⁷,¹⁰

Although treatment of RRMM is evolving, an unmet need remains—especially for triple class–exposed* patients.⁴-⁶

No standard of care exists for triple class–exposed* RRMM, and several studies have demonstrated poor outcomes in these patients⁷

<table>
<thead>
<tr>
<th>ORR¹⁵,¹²,¹³</th>
<th>≥CR¹²,¹³</th>
<th>mPFS⁴,¹²,¹⁶</th>
</tr>
</thead>
<tbody>
<tr>
<td>26%-32%</td>
<td>2%-3%</td>
<td>3-5 months</td>
</tr>
</tbody>
</table>

Table shows the outcomes for patients with triple class–exposed* RRMM.

Novel Mechanisms of Action Are Needed in the Management of RRMM⁴

After receiving multiple lines of therapy, patients’ T cell populations can become compromised, with fewer healthy T cells present. This can lead to¹⁵-¹⁷:

• Continued immune dysfunction
• Uncontrolled residual disease

Triple class–exposed* patients are in need of a novel treatment that:

• Can deliver deep responses with long durations of response³
• Alleviates the need for repeated administration¹⁸,¹⁹
• Increases quality of life⁹,¹⁰

Harnessing the power of the immune system early, while the immune cells are healthy, represents an important window of opportunity¹⁵

Although treatment of RRMM is evolving, an unmet need remains—especially for triple class–exposed* patients.⁴,⁶

*Received an IMiD® agent, a PI, and an anti-CD38 monoclonal antibody.
**ABECMA® Is the First CAR T Cell Therapy for RRMM**

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

**TARGETING BCMA**

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

Antigen-specific activation of ABECMA results in CAR-positive T cell proliferation, cytokine secretion, and subsequent cytolytic killing of BCMA-expressing cells.

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

**Warnings and Precautions:**

**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 3 or higher CRS in 9% (12/127) of patients. 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, hypophysitis, pneumonia, acute respiratory distress syndrome (ARDS), atrial fibrillation, hepatic cell injury, metabolic acidosis, pulmonary edema, multiple organ dysfunction syndrome, and HLH/MAS.

**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.

Please see additional Important Safety Information on the following pages and accompanying full prescribing information, including Boxed WARNINGS.

**The Largest Pivotal Study and Longest Follow-up of a CAR T Cell Therapy in MM**

KarMMa was an open-label, single-arm, multicenter trial

- **PRIMARY ENDPOINT:** ORR (PR or better as assessed by an IRC)
- **SELECT SECONDARY ENDPOINTS:** CR, DoR, HRQoL, MRD, OS, PFS, TTR, and safety

**Dose:** Of the 135 patients who underwent leukapheresis, the efficacy-evaluable population included 106 (74%) patients who received ABECMA in the dose range of 300 to 460 x 10⁶ CAR-positive T cells.

**Trial Design**

- **ABECMA MANUFACTURING**
  - 3 days of fludarabine (30 mg/m²)
  - 3 days of cyclophosphamide (300 mg/m²)
- **LEUKAPHERESIS**
- **ABECMA INFUSION**
- Days -5, -4, -3, -0

**Inclusion criteria**

- ≥3 prior treatment regimens
- Received prior IMiD® agent, PI, and anti-CD38 monoclonal antibody
- Clinical fitness (eg, ECOG PS 0 or 1 and adequate organ function

**Exclusion criteria**

- Creatinine clearance of ≤60 mL/minute
- Alanine aminotransferase >2.5 times upper limit of normal
- Left ventricular ejection fraction <50%
- Absolute neutrophil count <1000 cells/mm³ and platelet count <50,000/mm³

**ABECMA is the first CAR T cell therapy in RRMM, with the longest real-world experience.**
ABECMA® Was Studied in a Broad Patient Population, Including Patients With a Poor Prognosis1,2,5

Patients of varying ages and risk profiles were included (N=100)

- 33 to 78 years of age (median age: 62)
- 37% had high-risk cytogenetics* (n=37)
- 36% had extramedullary plasmacytoma (n=36)

Select patient characteristics

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<th>ECOG PERFORMANCE STATUS, n (%)</th>
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<tr>
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<tr>
<td>REvised ISS STAGE AT BASELINE (DERIVED), n (%)</td>
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<td>Median number of prior-anti-MM regimens (range)</td>
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<td>10 (10)</td>
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<tr>
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<tr>
<td></td>
<td>≥80</td>
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</table>

Select patient characteristics

*Presence of t(4:14), t(14:16), or 17p13 del.

§ Induction with or without hematopoietic SCT and with or without maintenance therapy was considered a single regimen.2

‡Revised ISS was derived using baseline ISS stage, cytogenetic abnormality, and serum lactate dehydrogenase.

† Three patients had ECOG scores of <2 at screening for eligibility but subsequently deteriorated to ECOG scores of 2 at baseline prior to start of LDC.

A broad range of ages1

- Range: 33-78 years (median 62 years)

Patients who did or did not receive an SCT1

- 92% (n=92) received a prior SCT

LDC prior to ABECMA infusion1

- 3 days of low-dose LDC (thalidomide [300 mg/m² IV infusion] and cyclophosphamide [300 mg/m² IV infusion])

No BCMA testing required

Patients do not need BCMA testing to receive ABECMA1

Eligible adult patients include those who are1:

- 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 (eg, good performance status and adequate organ function)

Eligibility requirements differ for ABECMA and SCT1,2,5

The ABECMA pivotal trial included:

- A broad range of ages1
- Patients who did or did not receive an SCT1
- LDC prior to ABECMA infusion1

IMPORTANT SAFETY INFORMATION (cont’d)

Cytokine Release Syndrome (CRS) (cont’d): 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.

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 accompanying full Prescribing Information, including Boxed WARNINGS.
Rapid, Deep, and Durable Responses After a One-time Infusion\(^1,3\)\(^*\)

A majority of patients responded to ABECMA\(^6\), with more than half achieving ≥VGPR\(^1,3,25\).

![Graph showing ORR and sCR](Image)

Deep responses were achieved in MRD-evaluable patients with ≥VGPR\(^3\):
- In KarMMa, 54 patients had ≥VGPR
- Of those patients, 42 were evaluable for MRD
- 93% of evaluable ≥VGPR patients were MRD negative (39/42 patients)

Rapid and durable responses with ABECMA\(^1,3\):
- Median TTR: 1 month
  (n=72; range: 0.5-2.9 months)
- mDoR\(^†\): 11.3 months
  (95% CI, 10.3-15.3; n=72)
- mDoR with ≥CR: 21.6 months
  (95% CI, 13.5-NE; n=29)

**Survival at 24-month Follow-up Analysis\(^3\)**

OS was a secondary endpoint of KarMMa and was not statistically tested in the setting of a single-arm trial. \(^*\) OS data are not in the USPI and should be interpreted with caution in a single-arm trial. The statistical significance of OS is not known. Median follow-up of 19.9 months (range 0.2-31.5): 50 events and 50 deaths occurred prior to data cutoff December 2020.

**Median OS by best response**

![Survival graph](Image)

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

Neurologic Toxicities (cont'd): 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 accompanying full Prescribing Information, including Boxed WARNINGS.
**Explanatory Subgroup Analysis of ORR Was Generally Consistent With the Overall Treated Population**

**Analysis limitations:** These analyses are exploratory in nature and definitive conclusions should not be drawn.

<table>
<thead>
<tr>
<th>N</th>
<th>ORR %</th>
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<th>UCL</th>
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</table>

**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.

**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.

**Please see additional Important Safety Information on the following pages and accompanying full Prescribing Information, including Boxed WARNINGS.**

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**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.
In the event of febrile neutropenia, evaluate for infection and manage with broad-spectrum antibiotics, fluids, and other supportive care.

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.

Hypogammaglobulinemia: Hypogammaglobulinemia was reported as an adverse event in 21% (27/127) of patients; treatment 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.

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.

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.

In the event of febrile neutropenia, evaluate for infection and manage with broad-spectrum antibiotics, fluids, and other supportive care.

Viral Reactivation

[Boxed WARNINGS]

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 accompanying full Prescribing Information, including Boxed WARNINGS.
CRS and NT Were Generally Predictable: Most Were Low Grade, With Early Onset and Resolution.1,25*

**CRS rates**
- Grade ≥3: 9% (n=12)
- All grades: 85% (n=108)

**NT rates**
- Grade 3: 4% (n=5)
- All grades: 28% (n=36)

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

**Median time to onset**
- Grade ≥3: 1 DAY
- All grades: 1-23 days

**Median duration**
- Grade ≥3: 7 DAYS
- All grades: 1-63 days

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

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

**Median time to onset**
- Grade 3: 2 DAYS
- All grades: 1-42 days

**Median duration**
- Grade 3: 5 DAYS
- All grades: 1-61 days

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

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), after CRS resolution (n=2), or in the absence of CRS.

**HLH/MAS**
- 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 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 infusion. Manage cytopenia with myeloid growth factor and blood product transfusion support according to local institutional guidelines

**Most common adverse reactions**
- 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%)
A seamless initiation process for ABECMA

Once a patient is referred to a certified treatment center, the center will evaluate patient eligibility and begin initial stages of the treatment process, if appropriate.

Find a certified treatment center at AbecmaFinder.com

The ABECMA process

Step 1: Leukapheresis1

- T cells are collected via leukapheresis

Step 2: Manufacturing1

- The patient’s cells are sent to the manufacturing site for engineering and expansion to the recommended dose
- ABECMA is an autologous product: the manufactured dose at the physician’s discretion for individual patients may vary
- The patient’s dose will be 300 to 460 x 10⁶ CAR-positive T cells
- Bridging therapy can be used in some patients at the physician’s discretion for disease control during the manufacturing process

>98%1 Manufacturing success rate in the pivotal study

33 DAYS Median time from leukapheresis to product availability (range: 26 to 49 days)1

Step 3: Infusion1,30

- ABECMA is to be administered 2 days after completion of lymphodepletion (low-dose fludarabine [30 mg/m² IV infusion] and cyclophosphamide [300 mg/m² IV infusion] daily for 3 days)
- Physician is notified of estimated ABECMA delivery date. Product availability should be confirmed prior to starting lymphodepletion

Step 4: Monitoring1

- Patients are to be monitored at least daily for 7 days at the REMS-certified healthcare facility following ABECMA infusion for signs and symptoms of CRS and NT
- Patients should remain within proximity of the certified healthcare facility for at least 4 weeks following ABECMA infusion for monitoring
- A support network is important for patients throughout their experience with ABECMA

Follow-up—Providing Long-term Care1

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

Monitor CBC. Watch for signs and symptoms of serious infections, febrile neutropenia, cytopenias, and hypogammaglobulinemia

Monitor life-long for secondary malignancies. 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

A support network is important for patients throughout their experience with ABECMA

Bristol Myers Squibb has multiple FDA-approved CAR T cell therapies that utilize one centralized platform and one dedicated team with CAR T cell therapy expertise.

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.

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 accompanying full Prescribing Information, including Boxed WARNINGS.
Post-infusion monitoring support

Patients can receive a disposable wearable technology during the initial post-infusion monitoring period to help track their temperature in real time through their smartphone when outside the treatment center. Patients are instructed to call their healthcare provider or go to the hospital if their temperature goes above 100.4 °F (38.0 °C).

Cell Therapy 360 enrollment

Patients may enroll in support programs offered through Cell Therapy 360 after a certified CAR T cell therapy treatment center determines that ABECMA® is the right treatment for them.

IMPORTANT SAFETY INFORMATION (cont’d)

Adverse Reactions: The most common nonlaboratory adverse reactions include CRS, infections – pathogen unspecified, fatigue, musculoskeletal pain, hypophosphatemia, febrile neutropenia, nausea, viral infections, encephalopathy, edema, pyrexia, cough, headache, and decreased appetite.

References


Please see additional Important Safety Information on the following page and accompanying full Prescribing Information, including Boxed WARNINGS.
Have confidence when treating RRMM with ABECMA®

- Longest real-world experience
- Rapid, deep, and durable responses
- One-time infusion*
- Early CRS and NT onset and resolution

ABECMA is the first CAR T cell therapy in RRMM, with the longest real-world experience. ABECMA reached its primary endpoint (≥PR as assessed by an IRC) with an ORR of 72% (n=72/100). Rapid (1 month median TTR; range: 15 to 88 days; n=72/100), deep (29% ≥CR; n=29/100), and durable (11.1 months mPFS; range: 6.1 to 12.2 months; N=100) responses were achieved.† See study design on page 5. Median time to onset for CRS was 1 day (range: 1 to 23 days) and resolved within a median of 7 days post infusion (range: 1 to 63 days). Median time to onset for NT was 2 days (range: 1 to 42 days) and resolved within a median of 5 days (range: 1 to 61 days) in 33 of 36 patients who had a resolved NT.‡

Visit AbecmaHCP.com to learn more and find a certified treatment center near you

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) recommend idecabtagene vicleucel (ABECMA) as a category 2A Other Recommended therapy for previously treated multiple myeloma in patients who have received at least four prior therapies, including an anti-CD38 monoclonal antibody, a proteasome inhibitor, and an immunomodulatory agent.³¹

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 accompanying full Prescribing Information, including Boxed WARNINGS.

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