THE FACES OF **NINLARO**® (ixazomib)

BRUCE* IS EXPERIENCING AN **INDOLENT FIRST RELAPSE** OF MULTIPLE MYELOMA

AT THE FIRST MULTIPLE MYELOMA RELAPSE, OFFER DURABLE STRENGTH WITH THE NINLARO REGIMEN†[1]

Learn about patients who could benefit from NINLARO at **NINLAROhcp.com**

*Hypothetical patient.
†The NINLARO regimen includes NINLARO+lenalidomide+dexamethasone.[1]

INDICATION AND USAGE

Indication: NINLARO is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.

Limitations of Use: NINLARO is not recommended for use in the maintenance setting or in newly diagnosed multiple myeloma in combination with lenalidomide and dexamethasone outside of controlled clinical trials.

IMPORTANT SAFETY INFORMATION

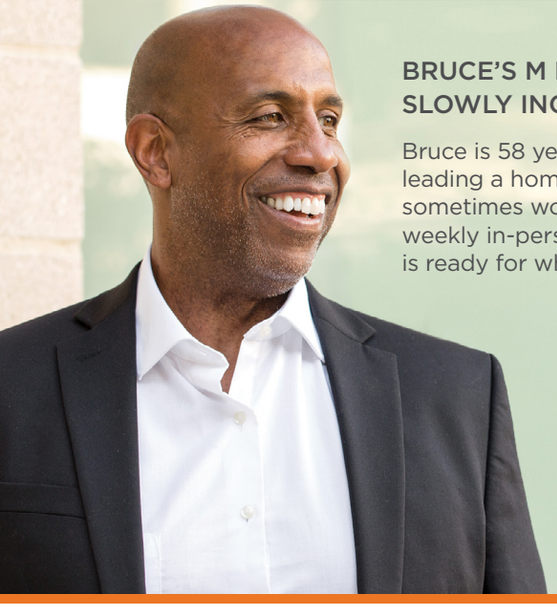
WARNINGS AND PRECAUTIONS

- **Thrombocytopenia** has been reported with NINLARO. Platelet nadirs typically occurred between Days 14-21 of each 28-day cycle and recovered to baseline by the start of the next cycle. Grade 3 thrombocytopenia was reported in 17% of patients in the NINLARO regimen and Grade 4 thrombocytopenia was reported in 13% in the NINLARO regimen. During treatment, monitor platelet counts at least monthly, and consider more frequent monitoring during the first three cycles. Manage thrombocytopenia with dose modifications and platelet transfusions as per standard medical guidelines.

Please see additional Important Safety Information for NINLARO throughout and accompanying NINLARO (ixazomib) full Prescribing Information.

NINLARO® (ixazomib) capsules
4mg | 3mg | 2.3mg

MEET **BRUCE**, A PATIENT EXPERIENCING AN **INDOLENT FIRST RELAPSE**



Hypothetical patient

BRUCE'S M PROTEIN LEVELS HAVE BEEN SLOWLY INCREASING OVER THE PAST 4 MONTHS

Bruce is 58 years old and has spent the past 15 years leading a homeowners' insurance sales team. While Bruce sometimes works from home, he's still required to make weekly in-person office visits. He's nearing retirement and is ready for what's next.

- Bruce has been living with multiple myeloma (MM)
- His first line of therapy was a PI-based regimen along with an immunomodulator and a steroid. This was followed by an autologous stem cell transplant (ASCT)
- Bruce achieved a very good partial response (VGPR) and then received immunomodulator therapy for 2 years at a suboptimal dosage
  - Bruce is not lenalidomide refractory
- A follow-up appointment showed that his M protein levels had slowly increased, confirming his relapse
- Bruce is experiencing an indolent first relapse—his situation is not unique
- 1 in 3 (33%) first MM relapses are indolent—almost 7,000 patients in the US annually[2]

Despite lacking clinical symptoms, Bruce may benefit from a treatment option that may help delay his cancer from progressing.

"Now that I've relapsed, it's really important for me to receive a treatment option that can delay the progression of my disease."

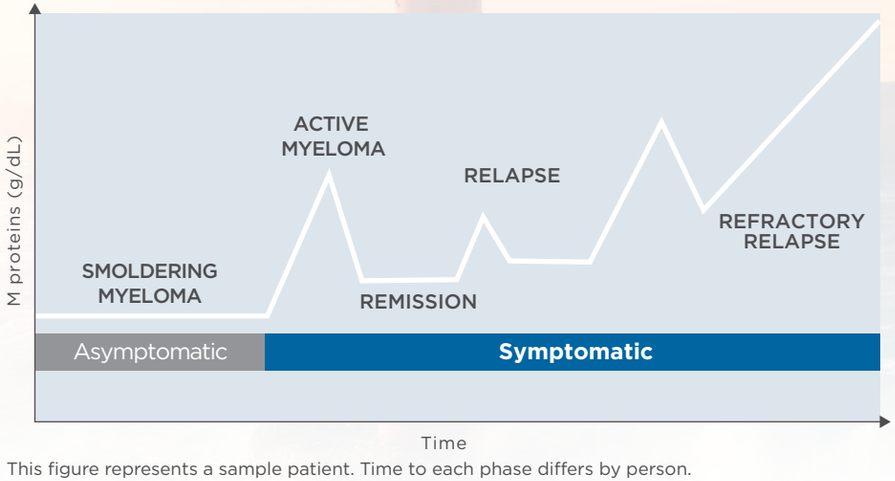
—A real patient similar to Bruce

ASCT=autologous stem cell transplant; PI=proteasome inhibitor; VGPR=very good partial response.

Please see additional Important Safety Information for NINLARO throughout and accompanying NINLARO (ixazomib) full Prescribing Information.

AS OUTCOMES MAY WORSEN WITH INCREASING LINES OF THERAPY, THE FIRST RELAPSE IS A CRITICAL JUNCTURE IN THE MM TREATMENT JOURNEY[3,4]

DISEASE PHASES IN MM[5]



This figure represents a sample patient. Time to each phase differs by person.

BRUCE'S GOALS

- Bruce wanted to keep doing the things that matter to him
- He wanted a treatment option that could help delay his disease progression
- Bruce's oncologist recommended an option that could deliver **extended efficacy, manageable tolerability, and convenient dosing**[1]

After shared decision-making with his oncologist, **Bruce chose the NINLARO® (ixazomib) regimen**.*†

WHAT ARE YOUR TREATMENT GOALS FOR A PATIENT EXPERIENCING AN INDOLENT FIRST RELAPSE?

*The NINLARO regimen includes NINLARO+lenalidomide+dexamethasone.[1]
†**Please see pages 6–9 to review efficacy, safety, and dosing information for NINLARO.**
MM=multiple myeloma.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

- **Gastrointestinal Toxicities,** including diarrhea, constipation, nausea and vomiting were reported with NINLARO and may occasionally require the use of antidiarrheal and antiemetic medications, and supportive care. Diarrhea resulted in the discontinuation of one or more of the three drugs in 3% of patients in the NINLARO regimen and 2% of patients in the placebo regimen. Adjust dosing for Grade 3 or 4 symptoms.

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NEXT TIME YOU SEE A PATIENT LIKE BRUCE, CONSIDER THE NINLARO® (ixazomib) REGIMEN*

ABOUT BRUCE

Reason for clinic visit
- Follow-up visit (quarterly)
- No clinical symptoms were present

Diagnosis
- Diagnosed with multiple myeloma 3.5 years ago; R-ISS stage I

Treatment history
- First line of therapy was PI+immunomodulator+steroid, followed by ASCT
- Patient achieved a VGPR
- Bruce received immunomodulator therapy for 2 years at a suboptimal dosage
- He is not lenalidomide refractory

Laboratory results
- **ECOG PS:** 0
- **Hemoglobin:** 11.7 g/dL
- **Serum creatinine:** 0.9 mg/dL
- **Serum calcium:** 10.3 mg/dL
- **Serum M protein:**
  - June: 1.1 g/dL
  - July: 1.3 g/dL
  - August: 1.6 g/dL
- **Skeletal imaging:** no new lytic lesions detected
- **Cytogenetics/FISH:** no adverse cytogenetics

*The NINLARO regimen includes NINLARO+lenalidomide+dexamethasone.[1]

ASCT=autologous stem cell transplant; ECOG PS=Eastern Cooperative Oncology Group performance status; FISH=fluorescence in situ hybridization; PI=proteasome inhibitor; R-ISS=revised International Staging System; VGPR=very good partial response.

Please see additional Important Safety Information for NINLARO throughout and accompanying NINLARO (ixazomib) full Prescribing Information.

BRUCE'S TREATMENT JOURNEY

Time

Bruce was diagnosed with multiple myeloma
R-ISS stage I

Began first-line regimen
Treated with an injectable PI+immunomodulator+steroid regimen, followed by an ASCT

Responded to therapy
Achieved a VGPR

Received maintenance therapy
Continued treatment with immunomodulator as maintenance therapy at a suboptimal dosage

Relapse confirmed
Discussed second-line treatment goals with oncologist

Now receives the NINLARO regimen*†

"I'm very lucky that I can take my medication wherever I am, and then continue to go about my day. I feel empowered."

—A real patient similar to Bruce

*The NINLARO regimen includes NINLARO+lenalidomide+dexamethasone.[1]

†**Please see pages 6-9 to review efficacy, safety, and dosing information for NINLARO.**

ASCT=autologous stem cell transplant; PI=proteasome inhibitor; R-ISS=revised International Staging System; VGPR=very good partial response.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

- **Peripheral Neuropathy** was reported with NINLARO. The most commonly reported reaction was peripheral sensory neuropathy (24% and 17% in the NINLARO and placebo regimens, respectively). Peripheral motor neuropathy was not commonly reported in either regimen (<1%). Peripheral neuropathy resulted in discontinuation of one or more of the three drugs in 4% of patients in the NINLARO regimen and <1% of patients in the placebo regimen. During treatment, monitor patients for symptoms of neuropathy and consider adjusting dosing for new or worsening peripheral neuropathy.

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In TOURMALINE-MM1

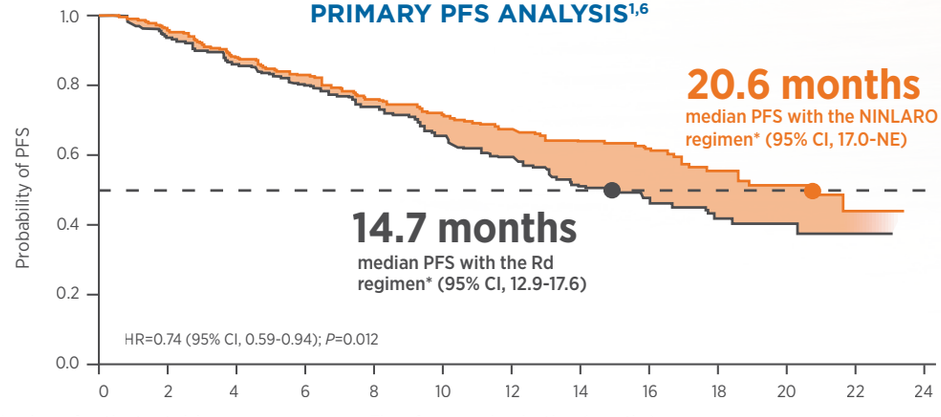
THE NINLARO® (ixazomib) REGIMEN PROLONGED PROGRESSION-FREE SURVIVAL VS THE Rd REGIMEN

STUDY DESIGN

TOURMALINE-MM1 was a global, phase 3, randomized (1:1), double-blind, placebo-controlled study that evaluated the safety and efficacy of the NINLARO regimen* vs the Rd regimen* in 722 patients with relapsed and/or refractory multiple myeloma who received 1-3 prior therapies.[1,6,7]

- The primary endpoint of PFS, according to 2011 IMWG criteria, was assessed every 4 weeks until disease progression by a blinded IRC and was based on central laboratory results[1]
- Key secondary endpoints included OS and OS in del(17p)[6]
- Other select secondary endpoints included ORR, PFS in patients with high-risk cytogenetics,† and safety[6]
- Patients who were refractory to lenalidomide or PIs were excluded from the study[1]

PRIMARY PFS ANALYSIS[1,6]



Number of patients at risk

NINLARO regimen	360	332	298	270	233	206	145	111	72	44	26	9	0
Rd regimen	362	325	288	254	218	188	130	85	58	31	15	3	0

FINAL OS ANALYSIS[1]

- With a median follow-up of ~85 months, median OS in the ITT population was 53.6 months for patients receiving the NINLARO regimen* and 51.6 months for patients receiving the Rd regimen* (HR=0.94 [95% CI, 0.78-1.13])

*The NINLARO regimen included NINLARO+lenalidomide+dexamethasone. The Rd regimen included placebo+lenalidomide+dexamethasone.[1]

†Defined as patients with del(17p), t(4;14), and/or t(14;16).[6]

CI=confidence interval; HR=hazard ratio; IMWG=International Myeloma Working Group; IRC=independent review committee; ITT=intent-to-treat; NE=not evaluable; ORR=overall response rate; OS=overall survival; PFS=progression-free survival; PI=proteasome inhibitor.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

- **Peripheral Edema** was reported with NINLARO. Evaluate for underlying causes and provide supportive care, as necessary. Adjust dosing of NINLARO for Grade 3 or 4 symptoms or dexamethasone per its prescribing information.

Please see additional Important Safety Information for NINLARO throughout and accompanying NINLARO (ixazomib) full Prescribing Information.

THE NINLARO REGIMEN* DEMONSTRATED A SAFETY PROFILE COMPARABLE TO THE Rd REGIMEN*[1]

NONHEMATOLOGIC ARs OCCURRING IN ≥5% OF PATIENTS WITH A ≥5% DIFFERENCE BETWEEN NINLARO+Rd AND Rd IN TOURMALINE-MM1[1]

AR	NINLARO+Rd* (n=361)			Rd* (n=359)		
	All grades	Grade 3	Grade 4	All grades	Grade 3	Grade 4
Diarrhea	52%	10%	0	43%	3%	0
Constipation	35%	<1%	0	28%	<1%	0
Peripheral neuropathies†	32%	2%	0	24%	2%	0
Nausea	32%	2%	0	23%	0	0
Peripheral edema	27%	2%	0	21%	1%	0
Back pain‡	27%	<1%	0	24%	3%	0
Rash†	27%	3%	0	16%	2%	0
Upper respiratory tract infection‡	27%	1%	0	23%	1%	0
Vomiting	26%	1%	0	13%	<1%	0
Bronchitis	22%	2%	0	17%	2%	<1%

- Incidence of thrombocytopenia in patients in the NINLARO and Rd regimens,* respectively: any grade, 85% vs 67%; grades 3-4, 30% vs 14%[1]
- Incidence of neutropenia in the NINLARO and Rd regimens,* respectively: any grade, 74% vs 70%; grades 3-4, 34% vs 37%[1]

Safety in high-risk§ patient population

- The overall safety profiles in the high-risk and standard-risk cytogenetics patients in each group are consistent with data reported for the overall population[8]
- As seen in the overall population, in both high-risk and standard-risk cytogenetics patients, common adverse events were primarily of grade 1 or 2 severity and included diarrhea, constipation, neutropenia, and anemia[8]

*The NINLARO regimen included NINLARO+lenalidomide+dexamethasone. The Rd regimen included placebo+lenalidomide+dexamethasone.[1]

†Represents a pooling of preferred terms.[1]

‡At the time of the final analysis, these adverse reactions no longer met the criterion for a ≥5% difference between the NINLARO regimen and the placebo regimen.[1]

§Defined as patients with del(17p), t(4;14), and/or t(14;16).[6]

AR=adverse reaction.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

- **Cutaneous Reactions,** including a fatal case of Stevens-Johnson syndrome, were reported with NINLARO. If Stevens-Johnson syndrome occurs, discontinue NINLARO and manage as clinically indicated. Rash, most commonly maculo-papular and macular rash, was reported with NINLARO. Rash resulted in discontinuation of one or more of the three drugs in <1% of patients in both regimens. Manage rash with supportive care or with dose modification if Grade 2 or higher.

NINLARO® (ixazomib) capsules
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THE NINLARO® (ixazomib) TRIPLET REGIMEN* DEMONSTRATED A SAFETY PROFILE APPROPRIATE FOR LONG-TERM† TREATMENT

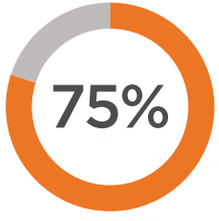
IN TOURMALINE-MM1, DISCONTINUATION RATES DUE TO ARs WERE SIMILAR ACROSS REGIMENS[2]

13% vs 11%

with the NINLARO and Rd regimens,* respectively

- Permanent discontinuation of NINLARO due to ARs occurred in 10% of patients[1]

THE MAJORITY OF PATIENTS CONTINUED AT THE STARTING DOSE OF NINLARO WITHOUT DOSE REDUCTION[2]



of patients receiving the NINLARO regimen* in TOURMALINE-MM1 continued on their starting NINLARO dose

- The median dose intensity for NINLARO and placebo was high and similar in the NINLARO and Rd regimens*: 97.8% and 100%, respectively[2]
- Relative dose intensity was calculated as 100 x (total amount of dose taken/total planned dose over treated cycles)[2]
- Serious ARs reported in ≥2% of patients in the NINLARO regimen included diarrhea (3%), thrombocytopenia (2%), and bronchitis (2%)[1]

THE NINLARO TRIPLET REGIMEN MAY OFFER PATIENTS LIKE BRUCE EXTENDED EFFICACY WITH SAFETY THAT IS SIMILAR TO A DOUBLET*[1,6]

*The NINLARO regimen included NINLARO+lenalidomide+dexamethasone. The Rd regimen included placebo+lenalidomide+dexamethasone.[1]
†Used herein to refer to treatment to disease progression or unacceptable toxicity.[1]
AR=adverse reaction.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

- **Thrombotic Microangiopathy** has been reported with NINLARO. Fatal cases of thrombotic microangiopathy, including thrombotic thrombocytopenic purpura/hemolytic uremic syndrome (TTP/HUS), have been reported in patients who received NINLARO. Monitor for signs and symptoms of TTP/HUS. If the diagnosis is suspected, stop NINLARO and evaluate. If the diagnosis of TTP/HUS is excluded, consider restarting NINLARO. The safety of reinitiating NINLARO therapy in patients previously experiencing TTP/HUS is not known.

Please see additional Important Safety Information for NINLARO throughout and accompanying NINLARO (ixazomib) full Prescribing Information.

DOSING: CONSIDER AN ALL-ORAL PI-BASED REGIMEN YOUR PATIENTS CAN TAKE AT HOME[1,9,10]

DOSING SCHEDULE[1]

WEEK 1	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
WEEK 2	DAY 8	DAY 9	DAY 10	DAY 11	DAY 12	DAY 13	DAY 14
WEEK 3	DAY 15	DAY 16	DAY 17	DAY 18	DAY 19	DAY 20	DAY 21
WEEK 4	DAY 22	DAY 23 NO DOSE	DAY 24 NO DOSE	DAY 25 NO DOSE	DAY 26 NO DOSE	DAY 27 NO DOSE	DAY 28 NO DOSE

NINLARO (4 mg, 3 mg, 2.3 mg) · Lenalidomide (25 mg) · Dexamethasone (40 mg)

As the graphic shows,
NINLARO is administered orally on days 1, 8, and 15 of a 28-day cycle.[1]
Lenalidomide is administered orally on days 1-21 of a 28-day cycle.[9]
Dexamethasone is administered orally on days 1, 8, 15, and 22 of a 28-day cycle.[1,10]
Please note that there is **NO DOSING** on days 23-28.

- Advise patients to take NINLARO once a week on the same day and at approximately the same time for the first 3 weeks of a 4-week cycle. The importance of carefully following all dosage instructions should be discussed with patients starting treatment. Instruct patients to take the recommended dosage as directed because overdosage has led to deaths[1]
- The recommended starting dose of NINLARO is 4 mg (one capsule) in combination with lenalidomide and dexamethasone[1]
- A 3-mg starting dose is recommended for patients with moderate or severe hepatic impairment and patients with severe renal impairment or end-stage renal disease requiring dialysis. A 2.3-mg dose is also available for subsequent dose reductions due to ARs[1]

AR=adverse reaction; PI=proteasome inhibitor.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

- **Hepatotoxicity** has been reported with NINLARO. Drug-induced liver injury, hepatocellular injury, hepatic steatosis, hepatitis cholestatic and hepatotoxicity have each been reported in <1% of patients treated with NINLARO. Hepatotoxicity has been reported (10% in the NINLARO regimen and 9% in the placebo regimen). Monitor hepatic enzymes regularly and adjust dosing for Grade 3 or 4 symptoms.

NINLARO® (ixazomib) capsules
4mg | 3mg | 2.3mg

INDICATION AND USAGE

Indication: NINLARO® (ixazomib) is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.

Limitations of Use: NINLARO is not recommended for use in the maintenance setting or in newly diagnosed multiple myeloma in combination with lenalidomide and dexamethasone outside of controlled clinical trials.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

- **Thrombocytopenia** has been reported with NINLARO. Platelet nadirs typically occurred between Days 14-21 of each 28-day cycle and recovered to baseline by the start of the next cycle. Grade 3 thrombocytopenia was reported in 17% of patients in the NINLARO regimen and Grade 4 thrombocytopenia was reported in 13% in the NINLARO regimen. During treatment, monitor platelet counts at least monthly, and consider more frequent monitoring during the first three cycles. Manage thrombocytopenia with dose modifications and platelet transfusions as per standard medical guidelines.
- **Gastrointestinal Toxicities,** including diarrhea, constipation, nausea and vomiting were reported with NINLARO and may occasionally require the use of antidiarrheal and antiemetic medications, and supportive care. Diarrhea resulted in the discontinuation of one or more of the three drugs in 3% of patients in the NINLARO regimen and 2% of patients in the placebo regimen. Adjust dosing for Grade 3 or 4 symptoms.
- **Peripheral Neuropathy** was reported with NINLARO. The most commonly reported reaction was peripheral sensory neuropathy (24% and 17% in the NINLARO and placebo regimens, respectively). Peripheral motor neuropathy was not commonly reported in either regimen (<1%). Peripheral neuropathy resulted in discontinuation of one or more of the three drugs in 4% of patients in the NINLARO regimen and <1% of patients in the placebo regimen. During treatment, monitor patients for symptoms of neuropathy and consider adjusting dosing for new or worsening peripheral neuropathy.
- **Peripheral Edema** was reported with NINLARO. Evaluate for underlying causes and provide supportive care, as necessary. Adjust dosing of NINLARO for Grade 3 or 4 symptoms or dexamethasone per its prescribing information.
- **Cutaneous Reactions,** including a fatal case of Stevens-Johnson syndrome, were reported with NINLARO. If Stevens-Johnson syndrome occurs, discontinue NINLARO and manage as clinically indicated. Rash, most commonly maculo-papular and macular rash, was reported with NINLARO. Rash resulted in discontinuation of one or more of the three drugs in <1% of patients in both regimens. Manage rash with supportive care or with dose modification if Grade 2 or higher.
- **Thrombotic Microangiopathy** has been reported with NINLARO. Fatal cases of thrombotic microangiopathy, including thrombotic thrombocytopenic purpura/hemolytic uremic syndrome (TTP/HUS), have been reported in patients who received NINLARO. Monitor for signs and symptoms of TTP/HUS. If the diagnosis is suspected, stop NINLARO and evaluate. If the diagnosis of TTP/HUS is excluded, consider restarting NINLARO. The safety of reinitiating NINLARO therapy in patients previously experiencing TTP/HUS is not known.

Please see additional Important Safety Information for NINLARO throughout and accompanying NINLARO (ixazomib) full Prescribing Information.

IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

- **Hepatotoxicity** has been reported with NINLARO. Drug-induced liver injury, hepatocellular injury, hepatic steatosis, hepatitis cholestatic and hepatotoxicity have each been reported in <1% of patients treated with NINLARO. Hepatotoxicity has been reported (10% in the NINLARO regimen and 9% in the placebo regimen). Monitor hepatic enzymes regularly and adjust dosing for Grade 3 or 4 symptoms.
- **Embryo-fetal Toxicity:** NINLARO can cause fetal harm. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective non-hormonal contraception during treatment with NINLARO and for 90 days following the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with NINLARO and for 90 days following the last dose.
- **Increased Mortality in Patients Treated with NINLARO in the Maintenance Setting:** In two prospective randomized clinical trials in multiple myeloma in the maintenance setting, treatment with NINLARO resulted in increased deaths. Treatment of patients with NINLARO for multiple myeloma in the maintenance setting is not recommended outside of controlled trials.

ADVERSE REACTIONS

The most common adverse reactions (≥ 20%) in the NINLARO regimen compared to placebo in combination with lenalidomide plus dexamethasone, respectively were thrombocytopenia (85%, 67%; pooled from adverse event and laboratory data), neutropenia (74%, 70%; pooled from adverse event and laboratory data), diarrhea (52%, 43%), constipation (35%, 28%), peripheral neuropathy (32%, 24%), nausea (32%, 23%), edema peripheral (27%, 21%), rash (27%, 16%), vomiting (26%, 13%), and bronchitis (22%, 17%). Serious adverse reactions reported in ≥ 2% of patients in the NINLARO regimen included diarrhea (3%), thrombocytopenia (2%), and bronchitis (2%).

DRUG INTERACTIONS: Avoid concomitant administration of NINLARO with strong CYP3A inducers.

USE IN SPECIFIC POPULATIONS

- **Lactation:** Advise women not to breastfeed during treatment with NINLARO and for 90 days after the last dose.
- **Hepatic Impairment:** Reduce the NINLARO starting dose to 3 mg in patients with moderate or severe hepatic impairment.
- **Renal Impairment:** Reduce the NINLARO starting dose to 3 mg in patients with severe renal impairment or end-stage renal disease requiring dialysis. NINLARO is not dialyzable.

To report SUSPECTED ADVERSE REACTIONS, contact Takeda Pharmaceuticals at 1-844-617-6468 or the FDA at 1-800-FDA-1088 or **www.fda.gov/medwatch**.

Please see accompanying NINLARO (ixazomib) full Prescribing Information.

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THE NINLARO® (ixazomib) REGIMEN* OFFERS LONG-TERM† PROTEASOME INHIBITION UNTIL PROGRESSION[1,6]

EFFICACY

In TOURMALINE-MM1, mPFS was extended by ~6 months (20.6 months with the NINLARO triplet regimen* compared with 14.7 months with the Rd regimen*).[1]

TOLERABILITY

- In TOURMALINE-MM1, the discontinuation rate due to ARs with the NINLARO regimen* was similar to that of the Rd regimen* (13% vs 11%, respectively)[2]
- 75% of patients receiving the NINLARO regimen* in TOURMALINE-MM1 continued on their starting dose of NINLARO[2]
- Serious ARs reported in ≥2% of patients included diarrhea (3%), thrombocytopenia (2%), and bronchitis (2%)[1]

CONVENIENT DOSING

The NINLARO triplet regimen* is the first and only PI-based therapy with the convenience of all-oral administration.[1,9,10]

OFFER THE NINLARO REGIMEN TO YOUR PATIENT EXPERIENCING AN INDOLENT FIRST RELAPSE

*The NINLARO regimen includes NINLARO+lenalidomide+dexamethasone.[1]
†Used herein to refer to treatment to disease progression or unacceptable toxicity.[1]
AR=adverse reaction; mPFS=median progression-free survival; PI=proteasome inhibitor.

IMPORTANT SAFETY INFORMATION

SUMMARY OF WARNINGS AND PRECAUTIONS

- Warnings and Precautions for NINLARO include thrombocytopenia, gastrointestinal toxicities, peripheral neuropathy, peripheral edema, cutaneous reactions including fatal cases of Stevens-Johnson syndrome, thrombotic microangiopathy including fatal cases, hepatotoxicity, embryo-fetal toxicity, and increased mortality in patients treated with NINLARO in the maintenance setting

ADVERSE REACTIONS

The most common adverse reactions (≥ 20%) in the NINLARO regimen compared to placebo in combination with lenalidomide plus dexamethasone, respectively were thrombocytopenia (85%, 67%; pooled from adverse event and laboratory data), neutropenia (74%, 70%; pooled from adverse event and laboratory data), diarrhea (52%, 43%), constipation (35%, 28%), peripheral neuropathy (32%, 24%), nausea (32%, 23%), edema peripheral (27%, 21%), rash (27%, 16%), vomiting (26%, 13%), and bronchitis (22%, 17%). Serious adverse reactions reported in ≥2% of patients in the NINLARO regimen included diarrhea (3%), thrombocytopenia (2%), and bronchitis (2%).

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Please see additional Important Safety Information for NINLARO throughout and accompanying NINLARO (ixazomib) full Prescribing Information.

References: 1. NINLARO. Prescribing information. Takeda Pharmaceuticals America, Inc.; 05/2022. **2.** Data on File. Takeda Pharmaceuticals U.S.A., Inc.; 2022. **3.** Borrello I. Can we change the disease biology of multiple myeloma? *Leuk Res.* 2012;36 Suppl 1(0 1):S3-S12. **4.** Sonneveld P. Management of multiple myeloma in the relapsed/refractory patient. *Hematology Am Soc Hematol Educ Program.* 2017;2017(1):508-517. **5.** Durie BGM. *Concise Review of the Disease and Treatment Options: Multiple Myeloma: Cancer of the Bone Marrow.* 2011/2012 ed. International Myeloma Foundation; 2011. **6.** Moreau P, Masszi T, Grzasko N, et al; for TOURMALINE-MM1 Study Group. Oral ixazomib, lenalidomide, and dexamethasone for multiple myeloma. *N Engl J Med.* 2016;374(17):1621-1634. **7.** Moreau P, Masszi T, Grzasko N, et al; for TOURMALINE-MM1 Study Group. Oral ixazomib, lenalidomide, and dexamethasone for multiple myeloma. *N Engl J Med.* 2016;374(17):1621-1634 [supplemental appendix]. **8.** Avet-Loiseau H, Bahlis NJ, Chng W-J, et al. Ixazomib significantly prolongs progression-free survival in high-risk relapsed/refractory myeloma patients. *Blood.* 2017;130(24):2610-2618. **9.** Revlimid. Prescribing information. Celgene Corporation; 08/2021. **10.** Hemady. Prescribing information. Acrotech Biopharma LLC; 06/2021.

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