First on the dance floor.

First-line for prolonged survival.[1–5]

Use DARZALEX® first-line to transform outcomes for your patients with newly-diagnosed multiple myeloma[1–5]

Prescribing information appears on the back cover

Janssen Oncology

PHARMACEUTICAL COMPANIES OF Johnson & Johnson

DARZALEX® SC

daratumumab subcutaneous

Your first choice can transform their future[6–8]

There's a growing case for early use of effective treatment in first-line multiple myeloma (MM)[6–10]

- **With each subsequent line of therapy, a patient's chance of receiving treatment declines[9]**

  Attrition rates are 43–57% for non-transplant patients and 21–37% for transplant patients[9]

- **Relapses further restrict treatment continuation[6–8,10]**

  With each relapse, the frequency and burden of comorbidities and disease-related complications increase, leading up to 40% of patients to stop treatment[6–8,10]

- **Early, effective treatment can improve patients' long-term prospects[6,8]**

  Early use of effective combinations may prolong remission and increase the chances of a positive long-term outcome[6,8]

- **Updated EHA-ESMO guidelines recommend DARZALEX® first-line[11]**

  DARZALEX® + Rd and DARZALEX® + VMP are both recommended as first options for TIE NDMM patients[11]

  DARZALEX® + VTd is recommended as first option for TE NDMM patients[11]

EHA, European Hematology Association; ESMO, European Society for Medical Oncology; MM, multiple myeloma; NDMM, newly-diagnosed multiple myeloma; Rd, lenalidomide + dexamethasone; TE, transplant-eligible; TIE, transplant-ineligible; VMP, bortezomib + melphalan + prednisone; VTd, bortezomib + thalidomide + dexamethasone.

DARZALEX® + Rd: Your first choice for transplant-ineligible newly-diagnosed multiple myeloma

- **DARZALEX® + Rd significantly prolongs PFS and OS** vs. Rd alone[12,13]
  - Data modelling suggests DARZALEX® + Rd first improves median OS vs. VRd first*[14]
- **DARZALEX® + Rd provides 3x the rate of MRD-negativity** vs. Rd alone[1]
- **DARZALEX® + Rd significantly delays decline in HRQoL** vs. Rd alone[15]
- **No new safety signals reported** after >4.5 years' median follow-up[3]

HRQoL, health-related quality of life; MRD, minimal residual disease; PFS, progression-free survival; OS, overall survival; Rd, lenalidomide + dexamethasone; VRd, bortezomib + lenalidomide + dexamethasone.
*Data from a modelling simulation comprising the MAIA and PEGASUS studies and the Flatiron Health database. Initial therapy considered in the simulation included DRd (n=368) vs. Rd (n=369) and VRd (n=235) vs. Rd (n=225). Simulated pathways (based on published treatment guidelines) included DRd then a pomalidomide- or carfilzomib-based regimen; VRd then a DARZALEX®-based regimen; and Rd then a DARZALEX®-based regimen. The simulation used 3 health states representing different stages on the patient treatment journey: 1L (on/off treatment), 2L (on/off treatment) and death. Median OS rates were evaluated at 5, 10 and 15 years.[14]

DARZALEX® + Rd delays progression[1,3]

Frontline DARZALEX® + Rd delivered years more progression-free survival vs. Rd alone for patients with TIE NDMM[1,12]

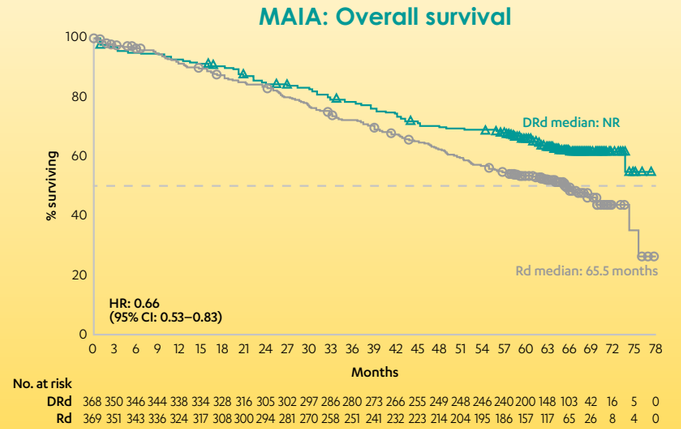
Median PFS with DARZALEX® + Rd (ITT population) was **significantly longer** vs. Rd alone at 64.5 months' median follow-up.[12]

61.9 months	vs.	34.4 months
DARZALEX® + Rd		Rd alone

HR: 0.55 (95% CI: 0.45–0.67)

CI, confidence interval; DRd, DARZALEX® + lenalidomide + dexamethasone; HR, hazard ratio; TT, intention-to-treat; NR, not reached; mOS, median overall survival; NDMM, newly-diagnosed multiple myeloma; OS, overall survival; PFS, progression-free survival; Rd, lenalidomide + dexamethasone; TIE, transplant-eligible.

Frontline DARZALEX® + Rd prolonged overall survival vs. Rd alone[1,13]



Adapted from DARZALEX® Summary of Product Characteristics. Median follow-up: 64 months.[1]

Median OS was significantly longer with DARZALEX® + Rd vs. Rd alone after 56 months' median follow-up (p=0.0013)*[3]

66.6%*

of DARZALEX® + Rd patients were still alive at 60 months vs. 53.6% for Rd alone[13]

Extended follow-up confirms a long-term OS advantage over Rd alone

At 73.6 months' median follow-up, median OS was significantly longer with DARZALEX® + Rd vs. Rd alone – mOS not reached vs. 64.1 months respectively (HR: 0.65)†[13]

CI, confidence interval; DRd, DARZALEX® + lenalidomide + dexamethasone; HR, hazard ratio; NR, not reached; mOS, median overall survival; OS, overall survival; Rd, lenalidomide + dexamethasone.
*Median OS was not reached in either treatment arm. Estimated 60-month OS rates: DRd: 66.3% (95% CI: 60.8–71.3); Rd: 53.1% (95% CI: 47.2–58.6).[3]
†At a median follow-up of 64.5 months, median OS was NR with DRd vs. 65.5 months with Rd alone; HR: 0.66 (95% CI: 0.53–0.83; p=0.0003), and the estimated 60-month OS rate was 66.6% with DRd and 53.6% with Rd alone.[13]

Prolonged survival outcomes stem from deep responses[6,16–18]

MRD is proven to be a strong prognostic factor in MM, with MRD-negativity reliably correlating to significantly improved outcomes[19,20]

Increased MRD-negativity rate

3 times the rate of MRD-negativity* with DRd vs. Rd alone[1]

24.2% vs. 7.3% (p<0.0001)†‡

≥VGPR with DRd

Higher rate of ≥VGPR and faster ≥VGPR achievement with DRd vs. Rd alone[†1,21]

≥VGPR rate: 79.3% vs. 53.1%[1]
Median time to ≥VGPR: 3.8 months vs. 9.4 months[21]

MRD-negativity improved OS

OS was improved for DRd patients who were MRD-negative vs. MRD-positive[13]

60-month OS rates: 88.9% vs. 55.9%[13]

Improved OS vs. VRd

Data modelling suggests choosing DRd first improved median OS by 2.5 years vs. choosing VRd first[§14]

7.6 years' median OS with DRd first vs. 5.1 years with VRd first[†14]

≥CR with DRd

Higher rate of ≥CR with DRd vs. Rd alone[1]

47.6% vs. 24.9%[1]

CR, complete response; DRd, DARZALEX® + lenalidomide + dexamethasone; MM, multiple myeloma; MRD, minimal residual disease; OS, overall survival; Rd, lenalidomide + dexamethasone; VGPR, very good partial response; VRd, bortezomib + lenalidomide + dexamethasone.
*At 10^{-5} threshold (24.2% vs. 7.3%; p<0.0001)[1]. †Median follow-up of 64 months.[1] ‡p-value from Fisher's exact test.[1] §Data from a modelling simulation comprising the MAIA and PEGASUS studies and the Flatiron Health database. Initial therapy considered in the simulation included DRd (n=368) vs. Rd (n=369) and VRd (n=235) vs. Rd (n=225). Simulated pathways (based on published treatment guidelines) included DRd then a pomalidomide- or carfilzomib-based regimen; VRd then a DARZALEX®-based regimen; and Rd then a DARZALEX®-based regimen. The simulation used 3 health states representing different stages on the patient treatment journey: 1L (on/off treatment), 2L (on/off treatment) and death. Median OS rates were evaluated at 5, 10 and 15 years.[14]

DARZALEX® + Rd helped patients maintain their quality of life for longer vs. Rd alone*[15]

At ~5 years of follow-up, DRd significantly delayed decline in HRQoL vs. Rd alone†[15]

Significantly longer median time to worsening:[15]

Physical functioning	Pain	Dyspnoea
HR: 0.77; 95% CI: 0.62–0.96	HR: 0.69; 95% CI: 0.55–0.86	HR: 0.78; 95% CI: 0.63–0.96

DRd provided an additional ~21 months without worsening pain vs. Rd alone[21]

CI, confidence interval; DRd, DARZALEX® + lenalidomide + dexamethasone; HR, hazard ratio; HRQoL, health-related quality of life; Rd, lenalidomide + dexamethasone.
*HRQoL assessed using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core 30-item (EORTC QLQ-C30).[21]
†Median follow-up 56.2 months.[21]

DARZALEX® + VTd: Your first choice for patients with transplant-eligible newly-diagnosed multiple myeloma

- **DARZALEX® + VTd significantly prolongs PFS** vs. VTd alone[1,2]
- **DARZALEX® + VTd provides significantly higher MRD-negativity rates** vs. VTd alone (post-induction and post-consolidation)[5]
- **Responses to DARZALEX® + VTd deepen over time[2]**
- **DARZALEX® + VTd has minimal additional toxicity** vs. VTd alone with no increase in discontinuation rates[2]

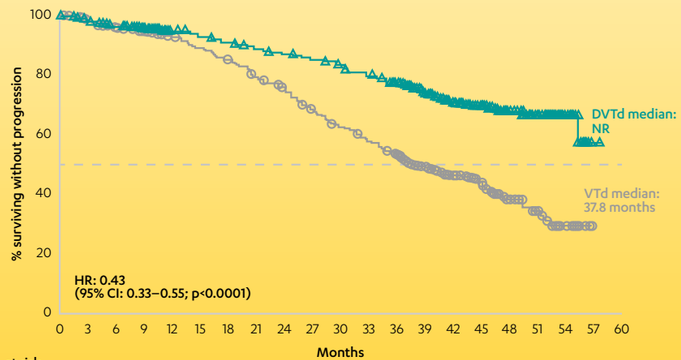
MRD, minimal residual disease; PFS, progression-free survival; VTd, bortezomib + thalidomide + dexamethasone.

DARZALEX® + VTd offered transplant-eligible patients more time free from progression vs. VTd alone[1,2]

Median PFS not reached vs. 37.8 months for VTd alone*[1]

With DARZALEX® + VTd, MRD-negative patients have even more time free from progression vs. MRD-positive patients*[5]

CASSIOPEIA: Progression-free survival*[1]



Adapted from DARZALEX® Summary of Product Characteristics.[1]

57%
reduction in the risk of disease progression or death at a median of 44.5 months*[1]

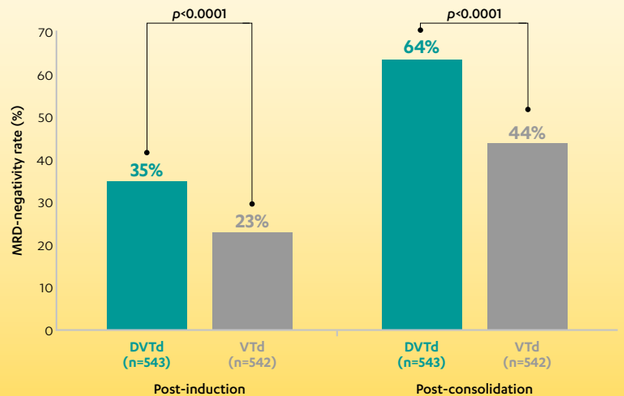
69%
reduction in the risk of disease progression or death with MRD-negativity post-consolidation (HR: 0.31; p<0.0001)†‡[5]

CI, confidence interval; DVTd, DARZALEX® + bortezomib + thalidomide + dexamethasone; HR, hazard ratio; MRD, minimal residual disease; PFS, progression-free survival; VTd, bortezomib + thalidomide + dexamethasone.
*Results of an updated PFS analysis with a median follow-up of 44.5 months, censoring patients who were randomised to DARZALEX® maintenance in the second randomisation. HR=0.43; 95% CI: 0.33–0.55; p<0.0001.[1] †MRD-negative vs. MRD-positive in the DVTd arm[5]. ‡PFS by MRD status following two post-transplant cycles using a multivariate analysis and excluding patients who had a PFS event or were censored before 9 months (median time to Day 100).[5]

More patients free from detectable residual disease vs. VTd alone[5]

Significantly more patients achieved MRD-negativity with DARZALEX® + VTd vs. VTd alone*[5]

MRD-negativity*[5]



Adapted from Avet-Loiseau *et al*, 2019.[5]

DVTd, DARZALEX® + bortezomib + thalidomide + dexamethasone; MRD, minimal residual disease; VTd, bortezomib + thalidomide + dexamethasone.
*Threshold for MRD was defined as 1 tumour cell per 10^5 white cells. MRD-negativity was assessed using Euroflow MFC assays performed on a FACSCanto II™ (BD Biosciences, San Jose, CA) analyser.[5]

CASSIOPEIA

With DARZALEX® + VTd, responses deepen over time[2]

For TE NDMM patients, the depth and duration of response after ASCT is generally acknowledged to be an important factor associated with prolonged PFS and OS[8,22,23]

60%

increase in likelihood of achieving sCR (primary endpoint) with DVTd vs. VTd alone by clinical cut-off*[2]

53.8%

of patients achieved **≥CR as best response** with DVTd vs. 38.5% for VTd alone†[2]

ASCT, autologous stem cell transplant; CR, complete response; DVTd, DARZALEX® + bortezomib + thalidomide + dexamethasone; MRD, minimal residual disease; OS, overall survival; PFS, progression-free survival; sCR, stringent complete response; VTd, bortezomib + thalidomide + dexamethasone.
*sCR rates: 29% DVTd vs. 20% VTd. Odds ratio: 1.60 (95% CI: 1.21–2.12; p=0.0010). †At clinical cut-off (June 19, 2018) for the primary analysis of part 1 and regardless of second randomisation (*post-hoc* analysis).[2]

Dependable long-term tolerability for your first-line patients[1,3,24]

TIE patients

- The long-term safety profile of DARZALEX® + Rd in frontline therapy for TIE patients was consistent with the known tolerability of regimen components[1,3,25,26]
- No new safety signals reported at a median of 56.2 months of follow-up, despite a large proportion (43%) of the population being ≥75 years of age[3]
- The safety profile of DARZALEX® + Rd in frailty subgroups was generally consistent with that for the overall population of MAIA*[24]
- Higher rates of neutropenia and pneumonia were observed with DARZALEX® + Rd in the frail subgroup; however, these events were clinically manageable[24]

Rd, lenalidomide + dexamethasone; TIE, transplant-ineligible.
*Median follow-up of 36.4 months.[24]

TE patients

- DARZALEX® + VTd showed a consistent safety profile vs. the known tolerability of regimen components, with minimal additional toxicity and no increase in discontinuation rates due to TEAEs vs. VTd alone†[2]
- Rates of serious AEs were similar between DARZALEX® + VTd and VTd alone, and infections were manageable†[2]

AE, adverse event; VTd, bortezomib + thalidomide + dexamethasone; TE, transplant-eligible; TEAE, treatment-emergent adverse event.
†Discontinuation rates were 7% for DVTd and 8% for VTd alone. Rates of serious AEs were 47% for DVTd and 47% VTd alone. 1% of DVTd patients discontinued treatment due to infections. Grade ≥3 pneumonia occurred in 4% of DVTd patients and 2% of VTd patients.[2]

First on the dance floor. First-line for prolonged survival.[1–5]

DARZALEX® combinations offer frontline MM patients:

- Prolonged PFS and OS*[1–3,5]
- Deep responses*[2,5,27]
- Sustained quality of life*[15,28,29]
- A tolerability profile that allows flexibility to treat a variety of patients[2,3,5,30]
- A convenient, 3- to 5-minute subcutaneous injection[1]
- Experience from 15 years of clinical trials and >300,000 patients treated[31,32]

*in approved treatment combinations vs. the same combinations minus DARZALEX®

MM, multiple myeloma; OS, overall survival; PFS, progression-free survival.

DARZALEX 1800 mg SOLUTION FOR INJECTION ABBREVIATED PRESCRIBING INFORMATION BASED ON THE EU SUMMARY OF PRODUCT CHARACTERISTICS

ACTIVE INGREDIENT: Daratumumab

Please refer to Summary of Product Characteristics (SmPC) before prescribing.

INDICATION(S):

Multiple myeloma - DARZALEX is indicated:

- in combination with lenalidomide and dexamethasone or with bortezomib, melphalan and prednisone for the treatment of adult patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant.
- in combination with bortezomib, thalidomide and dexamethasone for the treatment of adult patients with newly diagnosed multiple myeloma who are eligible for autologous stem cell transplant.
- in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.
- as monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy.

DOSAGE & ADMINISTRATION: DARZALEX subcutaneous formulation is not intended for intravenous administration and should be given by subcutaneous injection only. DARZALEX should be administered by a healthcare professional, and the first dose should be administered in an environment where resuscitation facilities are available. For patients currently receiving daratumumab intravenous formulation, DARZALEX solution for subcutaneous injection may be used as an alternative to the intravenous daratumumab formulation starting at the next scheduled dose. Administer pre- and post-injection medicinal products to reduce the risk of IRRs and delayed IRRs (please refer to the full SmPC). *Adults:* Recommended dose: Inject 1800 mg of DARZALEX solution for subcutaneous injection administered into the subcutaneous tissue of the abdomen approximately 7.5 cm to the right or left of the navel over approximately 3-5 minutes. **Multiple myeloma:** *Dosing schedule in combination with lenalidomide and dexamethasone or pomalidomide and dexamethasone (4-week cycle regimen) and for monotherapy*, is weekly from week 1 to 8, every two weeks from week 9 to 24, followed by every four weeks from week 25 until disease progression. Dexamethasone should be administered at 40 mg/week (or a reduced dose of 20 mg/week for patients >75 years). *Dosing schedule in combination with bortezomib, melphalan and prednisone (6-week cycle regimen)*, is weekly from week 1 to 6, every three weeks from week 7 to 54, followed by every four weeks from week 55 until disease progression. Bortezomib is given twice weekly at weeks 1, 2, 4 and 5 for the first 6-week cycle, followed by **once** weekly at weeks 1, 2, 4 and 5 for eight more 6-week cycles. *Dosing schedule in combination with bortezomib, thalidomide and dexamethasone (4-week cycle regimens) for treatment of newly diagnosed patients eligible for autologous stem cell transplant (ASCT):* Induction phase: is weekly from week 1 to 8, every two weeks from week 9 to 16. The dosing schedule is stopped for high dose chemotherapy and ASCT. *Consolidation phase:* The dosing schedule is every two weeks from week 1 to 8 upon re-initiation of treatment following ASCT. Dexamethasone should be administered at 40 mg on days 1, 2, 8, 9, 15, 16, 22 and 23 of cycles 1 and 2, and at 40 mg on days 1-2 and 20 mg on subsequent dosing days (days 8, 9, 15, 16) of cycles 3-4. Dexamethasone 20 mg should be administered on days 1, 2, 8, 9, 15, 16 in cycles 5 and 6. *Dosing schedule in combination with bortezomib and dexamethasone (3 week cycle regimen)* is weekly from week 1 to 9, every three weeks from week 10 to 24, followed by every four weeks from week 25 until disease progression. Dexamethasone should be administered at 20 mg on days 1, 2, 4, 5, 8, 9, 11 and 12 of the first 8 bortezomib treatment cycles or a reduced dose of 20 mg/week for patients >75 years, underweight (BMI <18.5), poorly controlled diabetes mellitus or prior intolerance to steroid therapy. **AL Amyloidosis:** *Dosing schedule in combination with bortezomib, cyclophosphamide and dexamethasone (4 week cycle regimens))* is weekly from week 1 to 8, every two weeks from week 9 to 24, followed by every four weeks from week 25 until disease progression. *Prevention of herpes zoster virus reactivation:* Consider anti-viral prophylaxis. *Children (≤18 years):* Safety/efficacy not established. No data available. *Elderly patients:* No dose adjustment. *Renal impairment:* No dose adjustment. *Hepatic impairment:* No dose adjustment. *Body weight (>120 kg):* Limited number of patients with body weight >120 kg have been studied using flat-dose (1800 mg) DARZALEX solution for subcutaneous injection and efficacy in these patients has not been established. No dose adjustment based on body weight can currently be recommended. **CONTRAINDICATIONS:** Hypersensitivity to the active substance(s) or any of the excipients. **SPECIAL WARNINGS & PRECAUTIONS:** *Traceability:* In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. *Infusion-related reactions (IRRs):* DARZALEX solution for subcutaneous injection can cause severe and/or serious IRRs, including anaphylactic reactions. In clinical studies, approximately 9% of patients experienced an IRR. Most IRRs occurred following the first injection and were grade 1 2. The median time to onset of IRRs following DARZALEX injection was 3.2 hours. Delayed IRRs have occurred in 1% of patients. Signs and symptoms of IRRs may include respiratory symptoms, such as nasal congestion, cough, throat irritation, allergic rhinitis, wheezing as well as pyrexia, chest pain, pruritis, chills, vomiting, nausea, and hypotension. Severe reactions have occurred, including bronchospasm, hypoxia, dyspnoea, hypertension and tachycardia. Patients should be pre-medicated with antihistamines, antipyretics, and corticosteroids as well as monitored and counselled regarding IRRs, especially during and following the first and second injections. If an anaphylactic reaction or life-threatening (grade 4) reactions occur, appropriate emergency care should be initiated immediately. DARZALEX therapy should be discontinued immediately and permanently. To reduce the risk of delayed IRRs, oral corticosteroids should be administered to all patients following DARZALEX injection. Patients with a history of chronic obstructive pulmonary disease may require additional post injection medicinal products to manage respiratory complications. The use of post injection medicinal products (e.g. short- and long-acting bronchodilators and inhaled corticosteroids) should be considered for patients with chronic obstructive pulmonary disease. *Neutropenia/Thrombocytopenia:* DARZALEX may increase neutropenia and thrombocytopenia induced by background therapy. Complete blood cell counts should be monitored periodically during treatment according to manufacturer's prescribing information for background therapies. Patients with neutropenia should be monitored for signs of infection. DARZALEX delay may be required to allow recovery of blood cell counts. In lower body weight patients receiving DARZALEX subcutaneous formulation, higher rates of neutropenia were observed; however, this was not associated with higher rates of serious infections. No dose reduction of DARZALEX is recommended. Consider supportive care with transfusions or growth factors. *Interference with indirect antiglobulin test (Indirect Coombs test):* Daratumumab binds to CD38 found at low levels on red blood cells (RBCs) and may result in a positive indirect Coombs test. Daratumumab-mediated positive indirect Coombs test may persist for up to 6 months after the last DARZALEX administration. Type and screen patient prior to treatment with DARZALEX. Consider phenotyping prior to starting DARZALEX treatment per local practice. Red blood cell genotyping is not impacted by DARZALEX and may be performed at any time. Notify centres of this interference with indirect antiglobulin tests in the event of a planned blood transfusion. Give non-cross-matched ABO/RhD-compatible RBCs per local blood bank practices if an emergency transfusion is required. *Interference with determination of complete response:* Daratumumab can be detected on both the serum protein electrophoresis (SPE) and immunofixation (IFE) assays used for the clinical monitoring of endogenous M-protein. This interference can impact the determination of complete response and of disease progression in some patients with IgG kappa myeloma protein. *Hepatitis B virus (HBV) reactivation:* HBV reactivation, in some cases fatal, has been reported in patients treated with DARZALEX. Before initiating treatment with DARZALEX, HBV screening should be performed in all patients. Patients with evidence of positive HBV serology should be monitored for clinical and laboratory signs of HBV reactivation during, and for at least six months post treatment with DARZALEX. Current clinical guidelines are to be followed for managing patients. Consider consulting a hepatitis disease expert as clinically indicated. Suspend treatment with DARZALEX and institute appropriate treatment, in patients who develop reactivation of HBV while on DARZALEX. Resumption of DARZALEX treatment in patients whose HBV reactivation is adequately controlled should be discussed with physicians with expertise in managing HBV. *Body weight (>120 kg):* There is a potential for reduced efficacy with DARZALEX solution for subcutaneous injection in patients with body weight >120 kg. *Excipients:* Contains sorbitol (E420)- Patients with hereditary fructose intolerance (HFI) should not be given this medicinal product. Contains less than 1 mmol (23 mg) sodium per dose, that is to say essentially 'sodium free'. **SIDE EFFECTS:** The most frequent adverse reactions of any grade (≥ 20% patients) with daratumumab (either intravenous or subcutaneous formulations) when administered either as monotherapy or in combination were IRRs, fatigue, nausea, diarrhoea, constipation, pyrexia, cough, neutropenia, thrombocytopenia, anaemia, oedema peripheral, peripheral sensory neuropathy and upper respiratory tract infection. Serious adverse reactions were sepsis, pneumonia, bronchitis, upper respiratory tract infection, pulmonary oedema, influenza, pyrexia, dehydration, diarrhoea, atrial fibrillation and syncope. Rare occasions of anaphylactic reactions were reported from post marketing data of the IV formulation. The incidence of serious adverse reactions was higher in older than in younger patients, most commonly pneumonia and sepsis. Please refer to the SmPC for further details and information on other side effects. **PREGNANCY:** Women of child-bearing potential should use effective contraception during, and for 3 months after cessation of DARZALEX treatment. There are no or limited amount of data from the use of daratumumab in pregnant women. Animal studies are insufficient with respect to reproductive toxicity. DARZALEX is not recommended during pregnancy and in women of childbearing potential not using contraception. **LACTATION:** A risk to newborns/infants cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from DARZALEX therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. **INTERACTIONS:** *Interference with indirect antiglobulin test (indirect Coombs test):* Daratumumab binds to CD38 on RBCs and interferes with compatibility testing, including antibody screening and cross matching. Interference mitigation methods include treating reagent RBCs with dithiothreitol (DTT) to disrupt DARZALEX binding or other locally validated methods. Kell-negative units should be supplied after ruling out or identifying alloantibodies using DTT-treated RBCs. *Interference with serum protein electrophoresis and immunofixation tests:* In patients with persistent very good partial response, where daratumumab interference is suspected, consider using a validated daratumumab-specific IFE assay to distinguish daratumumab from any remaining endogenous M protein in the patient's serum, to facilitate determination of a complete response. See SPECIAL WARNINGS & PRECAUTIONS. Clinical pharmacokinetic assessments with daratumumab intravenous or subcutaneous formulations and lenalidomide, pomalidomide, thalidomide, bortezomib, melphalan, prednisone, carfilzomib, cyclophosphamide and dexamethasone indicated no clinically-relevant drug-drug interaction between daratumumab and these small molecule medicinal products.

LEGAL CLASSIFICATION: Prescription Only Medicine

MARKETING AUTHORISATION NUMBER(S): EU/1/16/1101/004 (15 mL vial).

MARKETING AUTHORISATION HOLDER: Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium.

PACKS & PRICE: *country specific*

Prescribing Information may vary per country. Health Care Providers must refer to their country prescribing information. Prescribing information based on Jan 2022 EU Summary of Product Characteristics available at: www.ema.europa.eu/en/documents/product-information/darzalexepar-product-information_en.pdf

References: 1. Darzalex Summary of product characteristics. Available at https://www.ema.europa.eu/en/documents/product-information/darzalex-epar-product-information_en.pdf Last Accessed April 2023. **2.** Moreau P, *et al. Lancet.* 2019;394(10192):29–38. **3.** Facon T, *et al. Lancet Oncol.* 2021;22:1582–1596. **4.** Mateos MV, *et al. Lancet.* 2020;395(10218):132–141. **5.** Avet-Loiseau H, *et al.* Poster presented at: the American Society of Clinical Oncology (ASCO) Annual Meeting. May 31–June 4, 2019. #8017. **6.** Landgren O, Iskander, K. J Intern Med. 2017;281:365–382. **7.** Dimopoulos MA, *et al. Nat Rev Clin Oncol.* 2015;12:42–54. **8.** Cejalvo MJ, de la Rubia J. *Expert Rev Hematol.* 2017;10:383–392. **9.** Fonseca R, *et al. BMC Cancer.* 2020;20(1):1087. **10.** Yong K, *et al. Br J Haematol.* 2016;175(2):252–264. **11.** Dimopoulos MA, *et al. Ann Oncol.* 2021;32(3):309–322. **12.** Moreau P, *et al.* Poster presented at the 64th American Society of Hematology (ASH) Annual Meeting & Exposition; December 10-13, 2022; New Orleans, LA, USA. #3245. **13.** Kumar SK, *et al.* Poster presented at the 64th American Society of Hematology (ASH) Annual Meeting & Exposition; December 10–13, 2022; New Orleans, LA, USA. #4559. **14.** Fonseca R, *et al.* Abstract presented at: the 63rd American Society of Hematology (ASH) Annual Meeting & Exposition; December 11–14, 2021. #118. **15.** Perrot A, *et al.* Poster presented at: the 63rd American Society of Hematology (ASH) Annual Meeting & Exposition; December 11–14, 2021. #1655. **16.** Paiva B, et al. Blood. 2015;125:3059–3068. **17.** Lahuerta J-J, *et al. J Clin Oncol.* 2017;35:2900-2910. **18.** Rodriguez-Otero P, *et al.* Poster presented at: the 62nd American Society of Hematology (ASH) Annual Meeting. December 5–8, 2020. #3238. **19.** Fulciniti M, *et al. Biomed Res Int.* 2015;832049. **20.** Kostopoulos IV, *et al. Front Oncol.* 2020;10:860. **21.** Facon T, *et al.* Poster presented at: American Society of Clinical Oncology (ASCO) Annual Meeting. June 3–7, 2022. #8044. **22.** Moreau P, *et al. Ann Oncol.* 2017; 28(suppl_4):iv52–iv61–38. **23.** Lehners N, *et al. Cancer Medicine.* 2018; 7(2):307–316. **24.** Facon T, *et al. Leukemia.* 2022;36(4):1066–1077. **25.** Revlimid® (lenalidomide) Summary of Product Characteristics. Bristol-Myers Squibb Pharma EEIG, Dublin, Ireland, January 2022. **26.** Neofordex® (dexamethasone) Summary of Product Characteristics. Laboratoires CTRS, France, February 2021. **27.** Avet-Loiseau H, *et al. J Clin Oncol.* 2021;39(10):1139–1149. **28.** Roussel M, *et al. Lancet Haematol.* 2020;7(12):e874–e883. **29.** Knop S, *et al. BMC Cancer.* 2021;21(1):659. **30.** Mateos MV, *et al. Clin Lymphoma Myeloma Leuk.* 2020;20(8):509–518. **31.** Plesner T, Krejcik J. *Front Immunol.* 2018;9:1228. **32.** Mateos MV, *et al.* Presented at the 19th International Myeloma Society (IMS) Annual Meeting; August 25-27, 2022; Los Angeles, CA, USA. #1276144.

CP-385059
Date of Preparation: April 2023

Janssen Oncology
PHARMACEUTICAL COMPANIES OF Johnson & Johnson

DARZALEX® SC
daratumumab subcutaneous