#1 PRESCRIBED IN FIRST-LINE

treatment of locally advanced or metastatic BTCs

Data are based on total US patients treated with IMFINZI vs non-IMFINZI in 1L from September 2022 to January 2024.
Reference: Data on File, US-88164, AstraZeneca Pharmaceuticals LP; 2024.

NOW WITH 3-YEAR DATA

REACH BEYOND

with IMFINZI + gem-cis

BTCs

LOCALLY ADVANCED OR METASTATIC

Standard of care in the 1L treatment of advanced biliary tract cancers (BTCs), including cholangiocarcinoma and gallbladder cancer[1-3]

OVERALL SURVIVAL (primary endpoint)[1,2]

20% REDUCTION IN THE RISK OF DEATH
with IMFINZI + gem-cis vs gem-cis
HR=0.80 (95% CI, 0.66-0.97); *P*=0.021*

12.8-month mOS (95% CI, 11.1-14.0) vs 11.5-month mOS (95% CI, 10.1-12.5)

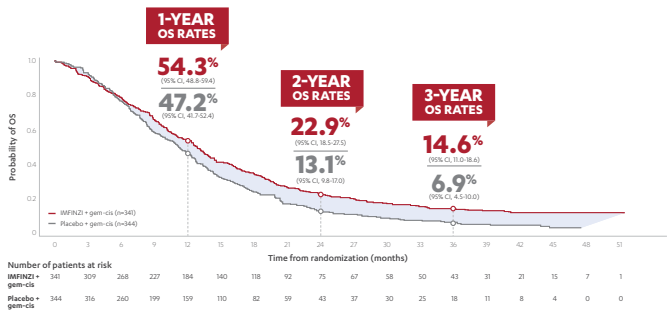
PROGRESSION-FREE SURVIVAL (secondary endpoint)[1,2]

25% REDUCTION IN THE RISK OF DISEASE PROGRESSION OR DEATH
with IMFINZI + gem-cis vs gem-cis
HR=0.75 (95% CI, 0.63-0.89); *P*=0.001*

7.2-month mPFS (95% CI, 6.7-7.4) vs 5.7-month mPFS (95% CI, 5.6-6.7)

Data cutoff was August 11, 2021. Because superior OS was demonstrated at the prespecified interim analysis, PFS was formally evaluated at this time. Median duration of follow-up was 16.8 months (95% CI, 14.8-17.7) with IMFINZI + gem-cis and 15.9 months (95% CI, 14.9-16.9) with gem-cis.[1,2]
*HR based on Cox proportional hazards model stratified by disease status and primary tumor location. 2-sided *P* value based on a stratified log-rank test compared with alpha boundary of 0.030 for OS and 0.048 for PFS.[1]

OVERALL SURVIVAL AT 3 YEARS (post-hoc analysis)[4]



26% REDUCTION IN THE RISK OF DEATH
with IMFINZI + gem-cis vs gem-cis
HR=0.74 (95% CI, 0.63-0.87)

12.9-month mOS (95% CI, 11.6-14.1)

11.3-month mOS (95% CI, 10.1-12.5)

The 3-year OS analysis was conducted post hoc and not powered for statistical significance

Data cutoff was October 23, 2023. Median duration of follow-up: 42.9 months (95% CI, 39.8-44.3) with IMFINZI + gem-cis and 41.8 months (95% CI, 36.7-46.2) with gem-cis.

IMFINZI + gem-cis is the ONLY FDA-approved 1L regimen to set the 3-year benchmark for OS analyses in advanced BTCs[3,4]

1L=first line; CI=confidence interval; gem-cis=gemcitabine-cisplatin; HR=hazard ratio; mOS=median overall survival; mPFS=median progression-free survival; OS=overall survival; PFS=progression-free survival.

Indication:

IMFINZI, in combination with gemcitabine and cisplatin, is indicated for the treatment of adult patients with locally advanced or metastatic biliary tract cancer (BTC).

IMPORTANT SAFETY INFORMATION

There are no contraindications for IMFINZI® (durvalumab).

Immune-Mediated Adverse Reactions
Important immune-mediated adverse reactions listed under Warnings and Precautions may not include all possible severe and fatal immune-mediated reactions. Immune-mediated adverse reactions, which may be severe or fatal, can occur in any organ system or tissue. Immune-mediated adverse reactions can occur at any time after starting treatment or after discontinuation. Monitor patients closely for symptoms and signs that may be clinical manifestations of underlying immune-mediated adverse reactions.

Please see additional Important Safety Information throughout and Full Prescribing Information including Medication Guide for IMFINZI.

IMFINZI®
durvalumab
Injection for Intravenous Use 50 mg/mL

IMPORTANT SAFETY INFORMATION (continued)

Immune-Mediated Adverse Reactions (continued)

Evaluate liver enzymes, creatinine, and thyroid function at baseline and periodically during treatment. In cases of suspected immune-mediated adverse reactions, initiate appropriate workup to exclude alternative etiologies, including infection. Institute medical management promptly, including specialty consultation as appropriate. Withhold or permanently discontinue IMFINZI depending on severity. See USPI Dosing and Administration for specific details. In general, if IMFINZI requires interruption or discontinuation, administer systemic corticosteroid therapy (1 mg to 2 mg/kg/day prednisone or equivalent) until improvement to Grade 1 or less. Upon improvement to Grade 1 or less, initiate corticosteroid taper and continue to taper over at least 1 month. Consider administration of other systemic immunosuppressants in patients whose immune-mediated adverse reactions are not controlled with corticosteroid therapy.

Immune-Mediated Pneumonitis

IMFINZI can cause immune-mediated pneumonitis. The incidence of pneumonitis is higher in patients who have received prior thoracic radiation. In patients who did not receive recent prior radiation, the incidence of immune-mediated pneumonitis was 2.4% (34/1414), including fatal (<0.1%), and Grade 3-4 (0.4%) adverse reactions. In patients who received recent prior radiation, the incidence of pneumonitis (including radiation pneumonitis) in patients with unresectable Stage III NSCLC following definitive chemoradiation within 42 days prior to initiation of IMFINZI in PACIFIC was 18.3% (87/475) in patients receiving IMFINZI and 12.8% (30/234) in patients receiving placebo. Of the patients who received IMFINZI (475), 1.1% were fatal and 2.7% were Grade 3 adverse reactions. The frequency and severity of immune-mediated pneumonitis in patients who did not receive definitive chemoradiation prior to IMFINZI were similar in patients who received IMFINZI as a single agent or with ES-SCLC or BTC when given in combination with chemotherapy.

Immune-Mediated Colitis

IMFINZI can cause immune-mediated colitis that is frequently associated with diarrhea. Cytomegalovirus (CMV) infection/reactivation has been reported in patients with corticosteroid-refractory immune-mediated colitis. In cases of corticosteroid-refractory colitis, consider repeating infectious workup to exclude alternative etiologies. Immune-mediated colitis occurred in 2% (37/1889) of patients receiving IMFINZI, including Grade 4 (<0.1%) and Grade 3 (0.4%) adverse reactions.

Immune-Mediated Hepatitis

IMFINZI can cause immune-mediated hepatitis. Immune-mediated hepatitis occurred in 2.8% (52/1889) of patients receiving IMFINZI, including fatal (0.2%), Grade 4 (0.3%) and Grade 3 (1.4%) adverse reactions.

Immune-Mediated Endocrinopathies

- ***Adrenal Insufficiency***: IMFINZI can cause primary or secondary adrenal insufficiency. For Grade 2 or higher adrenal insufficiency, initiate symptomatic treatment, including hormone replacement as clinically indicated. Immune-mediated adrenal insufficiency occurred in 0.5% (9/1889) of patients receiving IMFINZI, including Grade 3 (<0.1%) adverse reactions.
- ***Hypophysitis***: IMFINZI can cause immune-mediated hypophysitis. Hypophysitis can present with acute symptoms associated with mass effect such as headache, photophobia, or visual field cuts. Hypophysitis can cause hypopituitarism. Initiate symptomatic treatment including hormone replacement as clinically indicated. Grade 3 hypophysitis/hypopituitarism occurred in <0.1% (1/1889) of patients who received IMFINZI.
- ***Thyroid Disorders***: IMFINZI can cause immune-mediated thyroid disorders. Thyroiditis can present with or without endocrinopathy. Hypothyroidism can follow hyperthyroidism. Initiate hormone replacement therapy for hypothyroidism or institute medical management of hyperthyroidism as clinically indicated.
- ***Thyroiditis***: Immune-mediated thyroiditis occurred in 0.5% (9/1889) of patients receiving IMFINZI, including Grade 3 (<0.1%) adverse reactions.
- ***Hyperthyroidism***: Immune-mediated hyperthyroidism occurred in 2.1% (39/1889) of patients receiving IMFINZI.
- ***Hypothyroidism***: Immune-mediated hypothyroidism occurred in 8.3% (156/1889) of patients receiving IMFINZI, including Grade 3 (<0.1%) adverse reactions.
- ***Type 1 Diabetes Mellitus, which can present with diabetic ketoacidosis***: Monitor patients for hyperglycemia or other signs and symptoms of diabetes. Initiate treatment with insulin as clinically indicated. Grade 3 immune-mediated Type 1 diabetes mellitus occurred in <0.1% (1/1889) of patients receiving IMFINZI.

Immune-Mediated Nephritis with Renal Dysfunction

IMFINZI can cause immune-mediated nephritis. Immune-mediated nephritis occurred in 0.5% (10/1889) of patients receiving IMFINZI, including Grade 3 (<0.1%) adverse reactions.

Immune-Mediated Dermatology Reactions

IMFINZI can cause immune-mediated rash or dermatitis. Exfoliative dermatitis, including Stevens-Johnson Syndrome (SJS), drug rash with eosinophilia and systemic symptoms (DRESS), and toxic epidermal necrolysis (TEN), has occurred with PD-1/L-1 blocking antibodies. Topical emollients and/or topical corticosteroids may be adequate to treat mild to moderate non-exfoliative rashes. Immune-mediated rash or dermatitis occurred in 1.8% (34/1889) of patients receiving IMFINZI, including Grade 3 (0.4%) adverse reactions.

Other Immune-Mediated Adverse Reactions

The following clinically significant, immune-mediated adverse reactions occurred at an incidence of less than 1% each in patients who received IMFINZI or were reported with the use of other PD-1/PD-L1 blocking antibodies.

- ***Cardiac/vascular***: Myocarditis, pericarditis, vasculitis.
- ***Nervous system***: Meningitis, encephalitis, myelitis and demyelination, myasthenic syndrome/myasthenia gravis (including exacerbation), Guillain-Barré syndrome, nerve paresis, autoimmune neuropathy.
- ***Ocular***: Uveitis, iritis, and other ocular inflammatory toxicities can occur. Some cases can be associated with retinal detachment. Various grades of visual impairment to include blindness can occur. If uveitis occurs in combination with other immune-mediated adverse reactions, consider a Vogt-Koyanagi-Harada-like syndrome, as this may require treatment with systemic steroids to reduce the risk of permanent vision loss.

- ***Gastrointestinal***: Pancreatitis including increases in serum amylase and lipase levels, gastritis, duodenitis.
- ***Musculoskeletal and connective tissue disorders***: Myositis/polymyositis, rhabdomyolysis and associated sequelae including renal failure, arthritis, polymyalgia rheumatic.
- ***Endocrine***: Hypoparathyroidism.
- ***Other (hematologic/immune)***: Hemolytic anemia, aplastic anemia, hemophagocytic lymphohistiocytosis, systemic inflammatory response syndrome, histiocytic necrotizing lymphadenitis (Kikuchi lymphadenitis), sarcoidosis, immune thrombocytopenia, solid organ transplant rejection.

Infusion-Related Reactions

IMFINZI can cause severe or life-threatening infusion-related reactions. Monitor for signs and symptoms of infusion-related reactions. Interrupt, slow the rate of, or permanently discontinue IMFINZI based on the severity. See USPI Dosing and Administration for specific details. For Grade 1 or 2 infusion-related reactions, consider using pre-medications with subsequent doses. Infusion-related reactions occurred in 2.2% (42/1889) of patients receiving IMFINZI, including Grade 3 (0.3%) adverse reactions.

Complications of Allogeneic HSCT after IMFINZI

Fatal and other serious complications can occur in patients who receive allogeneic hematopoietic stem cell transplantation (HSCT) before or after being treated with a PD-1/L-1 blocking antibody. Transplant-related complications include hyperacute graft-versus-host-disease (GVHD), acute GVHD, chronic GVHD, hepatic veno-occlusive disease (VOD) after reduced intensity conditioning, and steroid-requiring febrile syndrome (without an identified infectious cause). These complications may occur despite intervening therapy between PD-1/L-1 blockade and allogeneic HSCT. Follow patients closely for evidence of transplant-related complications and intervene promptly. Consider the benefit versus risks of treatment with a PD-1/L-1 blocking antibody prior to or after an allogeneic HSCT.

Embryo-Fetal Toxicity

Based on its mechanism of action and data from animal studies, IMFINZI can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. In females of reproductive potential, verify pregnancy status prior to initiating IMFINZI and advise them to use effective contraception during treatment with IMFINZI and for 3 months after the last dose of IMFINZI.

Lactation

There is no information regarding the presence of IMFINZI in human milk; however, because of the potential for adverse reactions in breastfed infants from IMFINZI, advise women not to breastfeed during treatment and for 3 months after the last dose.

Adverse Reactions

- In patients with locally advanced or metastatic BTC in the TOPAZ-1 study receiving IMFINZI (n=338), the most common adverse reactions (occurring in ≥20% of patients) were fatigue (42%), nausea (40%), constipation (32%), decreased appetite (26%), abdominal pain (24%), rash (23%), and pyrexia (20%).
- In patients with locally advanced or metastatic BTC in the TOPAZ-1 study receiving IMFINZI (n=338), discontinuation due to adverse reactions occurred in 6% of the patients receiving IMFINZI plus chemotherapy. Serious adverse reactions occurred in 47% of patients receiving IMFINZI plus chemotherapy. The most frequent serious adverse reactions reported in at least 2% of patients were cholangitis (7%), pyrexia (3.8%), anemia (3.6%), sepsis (3.3%) and acute kidney injury (2.4%). Fatal adverse reactions occurred in 3.6% of patients receiving IMFINZI plus chemotherapy. These include ischemic or hemorrhagic stroke (4 patients), sepsis (2 patients), and upper gastrointestinal hemorrhage (2 patients).

The safety and effectiveness of IMFINZI have not been established in pediatric patients.

Please see additional Important Safety Information throughout and Full Prescribing Information including Medication Guide for IMFINZI.

You may *report side effects related to AstraZeneca products.*

References: 1. IMFINZI® (durvalumab) [Prescribing Information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2023. **2.** Oh DY, He AR, Qin S, et al. Durvalumab plus gemcitabine and cisplatin in advanced biliary tract cancer. *NEJM Evid*. 2022;1(8). doi:10.1056/EVIDoa2200015. **3.** Oncology (cancer)/hematologic malignancies approval notifications. US Food and Drug Administration. Updated January 19, 2024. Accessed February 9, 2024. https://www.fda.gov/drugs/resources-information-approved-drugs/oncology-cancer-hematologic-malignancies-approval-notifications **4.** Oh DY, He AR, Qin S, et al. Three-year survival and safety update from the phase 3 TOPAZ-1 study of durvalumab plus chemotherapy in biliary tract cancer. Poster presented at: 2024 CCF Conference; April 17-19, 2024; Salt Lake City, UT. **5.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Biliary Tract Cancers V.3.2023. ©National Comprehensive Cancer Network, Inc. 2023. All rights reserved. Accessed March 1, 2024. To view the most recent and complete version of the guideline, go online to NCCN.org.

IMFINZI®
durvalumab
Injection for Intravenous Use 50 mg/mL

BTCs

LOCALLY ADVANCED OR METASTATIC

Choose IMFINZI + gem-cis: Standard of care in the 1L treatment of locally advanced or metastatic biliary tract cancers (BTCs)[1-3]

#1 PRESCRIBED IN FIRST LINE
with >10,000 patients treated to date

Data are based on total US patients treated with IMFINZI vs non-IMFINZI in 1L from September 2022 to January 2024.
Reference: Data on File, US-88164, AstraZeneca Pharmaceuticals LP; 2024.

OS/PFS

ONLY APPROVED THERAPY WITH SUPERIOR OS/PFS[1,2]

- Median OS was 12.8 months with IMFINZI + gem-cis vs 11.5 months with gem-cis: HR=0.80 (95% CI, 0.66-0.97); *P*=0.021[1,2]
- Median PFS was 7.2 months with IMFINZI + gem-cis vs 5.7 months with gem-cis: HR=0.75 (95% CI, 0.63-0.89); *P*=0.001[1,2]

3-YEAR OS

ONLY APPROVED THERAPY WITH A 3-YEAR OS ANALYSIS

No other FDA-approved therapy for advanced BTCs has 3 years of OS follow-up (post-hoc analysis; median duration of follow-up: 42.9 months) in a Phase III study.[3,4] Not powered for statistical significance.[4]

Start with IMFINZI + gem-cis Q3W **CONTINUE WITH IMFINZI ALONE Q4W[1]**

In patients ≥30 kg, IMFINZI 1500 mg is administered every 3 weeks (21 days) for up to 8 cycles, followed by IMFINZI 1500 mg as a single agent every 4 weeks until disease progression or unacceptable toxicity.[1]*

*Patients with a body weight of <30 kg: 20 mg/kg in combination with gemcitabine and cisplatin every 3 weeks (21 days) for up to 8 cycles, followed by 20 mg/kg every 4 weeks as a single agent.[1]

NCCN CATEGORY 1, PREFERRED

National Comprehensive Cancer Network® (NCCN®)—Category 1, Preferred
Durvalumab (IMFINZI®) + gemcitabine and cisplatin is an **NCCN Category 1, preferred** primary systemic therapy option for unresectable or metastatic biliary tract cancers[5†‡§]

†NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way. To view the most recent and complete version of the guideline, go online to NCCN.org.

‡See the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for detailed recommendations, including other treatment options.[5]

§Biliary tract cancers: Gallbladder cancer, intrahepatic cholangiocarcinoma, and extrahepatic cholangiocarcinoma.[5]

Explore how IMFINZI + gem-cis has delivered firsts in the 1L treatment of advanced BTCs, at IMFINZIhcp.com/BTCs

Study design: TOPAZ-1 was a randomized, double-blind, placebo-controlled, multicenter, Phase III study in patients with previously untreated locally advanced or metastatic intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, or gallbladder cancer. Patients who developed recurrent disease >6 months after surgery and/or completion of adjuvant therapy were eligible. Patients were randomized 1:1 to receive IMFINZI 1500 mg (n=341) or placebo (n=344) on Day 1 + gem-cis on Days 1 and 8 Q3W for up to 8 cycles followed by IMFINZI 1500 mg or placebo Q4W until disease progression or unacceptable toxicity.[1,2]

NCCN=National Comprehensive Cancer Network® (NCCN®); Q3W=every 3 weeks; Q4W=every 4 weeks.

IMPORTANT SAFETY INFORMATION

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