











### 1.10 Cervical Cancer

KEYTRUDA is indicated for the treatment of patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy whose tumors express PD-L1 (CPS  $\geq$ 1) as determined by an FDA-approved test [see *Dosage and Administration* (2.1)].

This indication is approved under accelerated approval based on tumor response rate and durability of response [see *Clinical Studies* (14.10)]. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

### 1.11 Hepatocellular Carcinoma

KEYTRUDA is indicated for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib.

This indication is approved under accelerated approval based on tumor response rate and durability of response [see *Clinical Studies* (14.11)]. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

### 1.12 Merkel Cell Carcinoma

KEYTRUDA is indicated for the treatment of adult and pediatric patients with recurrent locally advanced or metastatic Merkel cell carcinoma (MCC).

This indication is approved under accelerated approval based on tumor response rate and durability of response [see *Clinical Studies* (14.12)]. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

### 1.13 Renal Cell Carcinoma

KEYTRUDA, in combination with axitinib, is indicated for the first-line treatment of patients with advanced renal cell carcinoma (RCC).

## 2 DOSAGE AND ADMINISTRATION

### 2.1 Patient Selection for NSCLC, HNSCC, Urothelial Carcinoma, Gastric Cancer, or Cervical Cancer

Select patients for treatment with KEYTRUDA as a single agent based on the presence of positive PD-L1 expression in:

- stage III NSCLC who are not candidates for surgical resection or definitive chemoradiation [see *Clinical Studies* (14.2)].
- metastatic NSCLC [see *Clinical Studies* (14.2)].
- first-line treatment of metastatic or unresectable, recurrent HNSCC [see *Clinical Studies* (14.4)].
- metastatic urothelial carcinoma [see *Clinical Studies* (14.7)].
- metastatic gastric cancer [see *Clinical Studies* (14.9)]. If PD-L1 expression is not detected in an archival gastric cancer specimen, evaluate the feasibility of obtaining a tumor biopsy for PD-L1 testing.
- recurrent or metastatic cervical cancer [see *Clinical Studies* (14.10)].

Information on FDA-approved tests for the detection of PD-L1 expression for these indications is available at: <http://www.fda.gov/CompanionDiagnostics>.

### 2.2 Recommended Dosage for Melanoma

The recommended dose of KEYTRUDA in patients with unresectable or metastatic melanoma is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity.

The recommended dose of KEYTRUDA for the adjuvant treatment of adult patients with melanoma is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease recurrence, unacceptable toxicity, or for up to 12 months in patients without disease recurrence.





























**Table 5: Selected\* Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Melanoma Patients Receiving KEYTRUDA in KEYNOTE-002**

Laboratory Test†	KEYTRUDA 2 mg/kg or 10 mg/kg every 3 weeks		Chemotherapy	
	All Grades‡ %	Grades 3-4 %	All Grades %	Grades 3-4 %
<b>Chemistry</b>				
Hyperglycemia	49	6	44	6
Hypoalbuminemia	37	1.9	33	0.6
Hyponatremia	37	7	24	3.8
Hypertriglyceridemia	33	0	32	0.9
Increased alkaline phosphatase	26	3.1	18	1.9
Increased AST	24	2.2	16	0.6
Decreased bicarbonate	22	0.4	13	0
Hypocalcemia	21	0.3	18	1.9
Increased ALT	21	1.8	16	0.6

\* Laboratory abnormalities occurring at same or higher incidence than in chemotherapy arm.

† Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 320 to 325 patients) and chemotherapy (range: 154 to 161 patients); hypertriglyceridemia: KEYTRUDA n=247 and chemotherapy n=116; decreased bicarbonate: KEYTRUDA n=263 and chemotherapy n=123.

‡ Graded per NCI CTCAE v4.0

Other laboratory abnormalities occurring in ≥20% of patients receiving KEYTRUDA were anemia (44% all Grades; 10% Grades 3-4) and lymphopenia (40% all Grades; 9% Grades 3-4).

#### *Adjuvant Treatment of Resected Melanoma*

The safety of KEYTRUDA as a single agent was investigated in KEYNOTE-054, a randomized (1:1) double-blind trial in which 1019 patients with completely resected stage IIIA (>1 mm lymph node metastasis), IIIB or IIIC melanoma received 200 mg of KEYTRUDA by intravenous infusion every 3 weeks (n=509) or placebo (n=502) for up to one year [see *Clinical Studies (14.1)*]. Patients with active autoimmune disease or a medical condition that required immunosuppression or mucosal or ocular melanoma were ineligible. Seventy-six percent of patients received KEYTRUDA for 6 months or longer.

The study population characteristics were: median age of 54 years (range: 19 to 88), 25% age 65 or older; 62% male; and 94% ECOG PS of 0 and 6% ECOG PS of 1. Sixteen percent had stage IIIA, 46% had stage IIIB, 18% had stage IIIC (1-3 positive lymph nodes), and 20% had stage IIIC (≥4 positive lymph nodes).

Two patients treated with KEYTRUDA died from causes other than disease progression; causes of death were drug reaction with eosinophilia and systemic symptoms and autoimmune myositis with respiratory failure. Serious adverse reactions occurred in 25% of patients receiving KEYTRUDA. Adverse reactions leading to permanent discontinuation occurred in 14% of patients receiving KEYTRUDA; the most common (≥1%) were pneumonitis (1.4%), colitis (1.2%), and diarrhea (1%). Adverse reactions leading to interruption of KEYTRUDA occurred in 19% of patients; the most common (≥1%) were diarrhea (2.4%), pneumonitis (2%), increased ALT (1.4%), arthralgia (1.4%), increased AST (1.4%), dyspnea (1%), and fatigue (1%). Tables 6 and 7 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-054.

**Table 6: Selected\* Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-054**

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks n=509		Placebo n=502	
	All Grades <sup>†</sup> (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
<b>Gastrointestinal</b>				
Diarrhea	28	1.2	26	1.2
Nausea	17	0.2	15	0
<b>Skin and Subcutaneous Tissue</b>				
Pruritus	19	0	12	0
Rash	13	0.2	9	0
<b>Musculoskeletal and Connective Tissue</b>				
Arthralgia	16	1.2	14	0
<b>Endocrine</b>				
Hypothyroidism	15	0	2.8	0
Hyperthyroidism	10	0.2	1.2	0
<b>Respiratory, Thoracic and Mediastinal</b>				
Cough	14	0	11	0
<b>General</b>				
Asthenia	11	0.2	8	0
Influenza like illness	11	0	8	0
<b>Investigations</b>				
Weight loss	11	0	8	0

\* Adverse reactions occurring at same or higher incidence than in placebo arm

† Graded per NCI CTCAE v4.03

**Table 7: Selected\* Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Melanoma Patients Receiving KEYTRUDA in KEYNOTE-054**

Laboratory Test <sup>†</sup>	KEYTRUDA 200 mg every 3 weeks		Placebo	
	All Grades <sup>‡</sup> %	Grades 3-4 %	All Grades %	Grades 3-4 %
<b>Chemistry</b>				
Increased ALT	27	2.4	16	0.2
Increased AST	24	1.8	15	0.4
<b>Hematology</b>				
Lymphopenia	24	1	16	1.2

\* Laboratory abnormalities occurring at same or higher incidence than placebo.

† Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range:503 to 507 patients) and placebo (range: 492 to 498 patients).

‡ Graded per NCI CTCAE v4.03

## NSCLC

### *First-line treatment of metastatic nonsquamous NSCLC with pemetrexed and platinum chemotherapy*

The safety of KEYTRUDA in combination with pemetrexed and investigator's choice of platinum (either carboplatin or cisplatin) was investigated in KEYNOTE-189, a multicenter, double-blind, randomized (2:1), active-controlled trial in patients with previously untreated, metastatic nonsquamous NSCLC with no EGFR or ALK genomic tumor aberrations [see *Clinical Studies (14.2)*]. A total of 607 patients received KEYTRUDA 200 mg, pemetrexed and platinum every 3 weeks for 4 cycles followed by KEYTRUDA and pemetrexed (n=405) or placebo, pemetrexed, and platinum every 3 weeks for 4 cycles followed by placebo and pemetrexed (n=202). Patients with autoimmune disease that required systemic therapy within 2 years of treatment; a medical condition that required immunosuppression; or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible.

The median duration of exposure to KEYTRUDA 200 mg every 3 weeks was 7.2 months (range: 1 day to 20.1 months). Sixty percent of patients in the KEYTRUDA arm were exposed to KEYTRUDA for ≥6 months. Seventy-two percent of patients received carboplatin.

The study population characteristics were: median age of 64 years (range: 34 to 84), 49% age 65 or older; 59% male; 94% White and 3% Asian; and 18% with history of brain metastases at baseline.

KEYTRUDA was discontinued for adverse reactions in 20% of patients. The most common adverse reactions resulting in permanent discontinuation of KEYTRUDA were pneumonitis (3%) and acute kidney injury (2%). Adverse reactions leading to the interruption of KEYTRUDA occurred in 53% of patients; the most common adverse reactions or laboratory abnormalities leading to interruption of KEYTRUDA ( $\geq 2\%$ ) were neutropenia (13%), asthenia/fatigue (7%), anemia (7%), thrombocytopenia (5%), diarrhea (4%), pneumonia (4%), increased blood creatinine (3%), dyspnea (2%), febrile neutropenia (2%), upper respiratory tract infection (2%), increased ALT (2%), and pyrexia (2%). Tables 8 and 9 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-189.

**Table 8: Adverse Reactions Occurring in  $\geq 20\%$  of Patients in KEYNOTE-189**

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks Pemetrexed Platinum Chemotherapy n=405		Placebo Pemetrexed Platinum Chemotherapy n=202	
	All Grades* (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
<b>Gastrointestinal</b>				
Nausea	56	3.5	52	3.5
Constipation	35	1.0	32	0.5
Diarrhea	31	5	21	3.0
Vomiting	24	3.7	23	3.0
<b>General</b>				
Fatigue <sup>†</sup>	56	12	58	6
Pyrexia	20	0.2	15	0
<b>Metabolism and Nutrition</b>				
Decreased appetite	28	1.5	30	0.5
<b>Skin and Subcutaneous Tissue</b>				
Rash <sup>‡</sup>	25	2.0	17	2.5
<b>Respiratory, Thoracic and Mediastinal</b>				
Cough	21	0	28	0
Dyspnea	21	3.7	26	5

\* Graded per NCI CTCAE v4.03

<sup>†</sup> Includes asthenia and fatigue

<sup>‡</sup> Includes genital rash, rash, rash generalized, rash macular, rash maculo-papular, rash papular, rash pruritic, and rash pustular.

**Table 9: Laboratory Abnormalities Worsened from Baseline Occurring in  $\geq 20\%$  of Patients in KEYNOTE-189**

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks Pemetrexed Platinum Chemotherapy		Placebo Pemetrexed Platinum Chemotherapy	
	All Grades <sup>†</sup> %	Grades 3-4 %	All Grades %	Grades 3-4 %
	<b>Hematology</b>			
Anemia	85	17	81	18
Lymphopenia	64	22	64	25
Neutropenia	48	20	41	19
Thrombocytopenia	30	12	29	8
<b>Chemistry</b>				
Hyperglycemia	63	9	60	7
Increased ALT	47	3.8	42	2.6
Increased AST	47	2.8	40	1.0
Hypoalbuminemia	39	2.8	39	1.1
Increased creatinine	37	4.2	25	1.0
Hyponatremia	32	7	23	6
Hypophosphatemia	30	10	28	14
Increased alkaline phosphatase	26	1.8	29	2.1
Hypocalcemia	24	2.8	17	0.5
Hyperkalemia	24	2.8	19	3.1
Hypokalemia	21	5	20	5

\* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA/pemetrexed/platinum chemotherapy (range: 381 to 401 patients) and placebo/pemetrexed/platinum chemotherapy (range: 184 to 197 patients).

† Graded per NCI CTCAE v4.03

*First-line treatment of metastatic squamous NSCLC with carboplatin and either paclitaxel or paclitaxel protein-bound chemotherapy*

The safety of KEYTRUDA in combination with carboplatin and investigator's choice of either paclitaxel or paclitaxel protein-bound was investigated in KEYNOTE-407, a multicenter, double-blind, randomized (1:1), placebo-controlled trial in 558 patients with previously untreated, metastatic squamous NSCLC [see *Clinical Studies (14.2)*]. Safety data are available for the first 203 patients who received KEYTRUDA and chemotherapy (n=101) or placebo and chemotherapy (n=102). Patients with autoimmune disease that required systemic therapy within 2 years of treatment; a medical condition that required immunosuppression; or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible.

The median duration of exposure to KEYTRUDA was 7 months (range: 1 day to 12 months). Sixty-one percent of patients in the KEYTRUDA arm were exposed to KEYTRUDA for  $\geq 6$  months. A total of 139 of 203 patients (68%) received paclitaxel and 64 patients (32%) received paclitaxel protein-bound in combination with carboplatin.

The study population characteristics were: median age of 65 years (range: 40 to 83), 52% age 65 or older; 78% male; 83% White; and 9% with history of brain metastases.

KEYTRUDA was discontinued for adverse reactions in 15% of patients, with no single type of adverse reaction accounting for the majority. Adverse reactions leading to interruption of KEYTRUDA occurred in 43% of patients; the most common ( $\geq 2\%$ ) were thrombocytopenia (20%), neutropenia (11%), anemia (6%), asthenia (2%), and diarrhea (2%). The most frequent ( $\geq 2\%$ ) serious adverse reactions were febrile neutropenia (6%), pneumonia (6%), and urinary tract infection (3%).

The adverse reactions observed in KEYNOTE-407 were similar to those observed in KEYNOTE-189 with the exception that increased incidences of alopecia (47% vs. 36%) and peripheral neuropathy (31% vs. 25%) were observed in the KEYTRUDA and chemotherapy arm compared to the placebo and chemotherapy arm in KEYNOTE-407.

### Previously Untreated NSCLC

The safety of KEYTRUDA was investigated in KEYNOTE-042, a multicenter, open-label, randomized (1:1), active-controlled trial in 1251 patients with PD-L1 expressing, previously untreated stage III NSCLC who were not candidates for surgical resection or definitive chemoradiation or metastatic NSCLC [see *Clinical Studies* (14.2)]. Patients received KEYTRUDA 200 mg every 3 weeks (n=636) or investigator's choice of chemotherapy (n=615), consisting of pemetrexed and carboplatin followed by optional pemetrexed (n=312) or paclitaxel and carboplatin followed by optional pemetrexed (n=303) every 3 weeks. Patients with EGFR or ALK genomic tumor aberrations; autoimmune disease that required systemic therapy within 2 years of treatment; a medical condition that required immunosuppression; or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible.

The median duration of exposure to KEYTRUDA was 5.6 months (range: 1 day to 27.3 months). Forty-eight percent of patients in the KEYTRUDA arm were exposed to KEYTRUDA 200 mg for  $\geq 6$  months.

The study population characteristics were: median age of 63 years (range: 25 to 90), 45% age 65 or older; 71% male; and 64% White, 30% Asian, and 2% Black. Nineteen percent were Hispanic or Latino. Eighty-seven percent had metastatic disease (stage IV), 13% had stage III disease (2% stage IIIA and 11% stage IIIB), and 5% had treated brain metastases at baseline.

KEYTRUDA was discontinued for adverse reactions in 19% of patients. The most common adverse reactions resulting in permanent discontinuation of KEYTRUDA were pneumonitis (3.0%), death due to unknown cause (1.6%), and pneumonia (1.4%). Adverse reactions leading to interruption of KEYTRUDA occurred in 33% of patients; the most common adverse reactions or laboratory abnormalities leading to interruption of KEYTRUDA ( $\geq 2\%$ ) were pneumonitis (3.1%), pneumonia (3.0%), hypothyroidism (2.2%), and increased ALT (2.0%). The most frequent ( $\geq 2\%$ ) serious adverse reactions were pneumonia (7%), pneumonitis (3.9%), pulmonary embolism (2.4%), and pleural effusion (2.2%).

Tables 10 and 11 summarize the adverse reactions and laboratory abnormalities, respectively, in patients treated with KEYTRUDA in KEYNOTE-042.

**Table 10: Adverse Reactions Occurring in  $\geq 10\%$  of Patients in KEYNOTE-042**

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks n=636		Chemotherapy n=615	
	All Grades* (%)	Grades 3-5 (%)	All Grades (%)	Grades 3-5 (%)
<b>General</b>				
Fatigue <sup>†</sup>	25	3.1	33	3.9
Pyrexia	10	0.3	8	0
<b>Metabolism and Nutrition</b>				
Decreased appetite	17	1.7	21	1.5
<b>Respiratory, Thoracic and Mediastinal</b>				
Dyspnea	17	2.0	11	0.8
Cough	16	0.2	11	0.3
<b>Skin and Subcutaneous Tissue</b>				
Rash <sup>‡</sup>	15	1.3	8	0.2
<b>Gastrointestinal</b>				
Constipation	12	0	21	0.2
Diarrhea	12	0.8	12	0.5
Nausea	12	0.5	32	1.1
<b>Endocrine</b>				
Hypothyroidism	12	0.2	1.5	0
<b>Infections</b>				
Pneumonia	12	7	9	6
<b>Investigations</b>				
Weight loss	10	0.9	7	0.2

\* Graded per NCI CTCAE v4.03

<sup>†</sup> Includes fatigue and asthenia

<sup>‡</sup> Includes rash, rash generalized, rash macular, rash maculo-papular, rash papular, rash pruritic, and rash pustular.

**Table 11: Laboratory Abnormalities Worsened from Baseline in ≥20% of Patients in KEYNOTE-042**

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks		Chemotherapy	
	All Grades <sup>†</sup> %	Grades 3-4 %	All Grades %	Grades 3-4 %
<b>Chemistry</b>				
Hyperglycemia	52	4.7	51	5
Increased ALT	33	4.8	34	2.9
Hypoalbuminemia	33	2.2	29	1.0
Increased AST	31	3.6	32	1.7
Hyponatremia	31	9	32	8
Increased alkaline phosphatase	29	2.3	29	0.3
Hypocalcemia	25	2.5	19	0.7
Hyperkalemia	23	3.0	20	2.2
Increased prothrombin INR	21	2.0	15	2.9
<b>Hematology</b>				
Anemia	43	4.4	79	19
Lymphopenia	30	7	41	13

\* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 598 to 610 patients) and chemotherapy (range: 588 to 597 patients); increased prothrombin INR: KEYTRUDA n=203 and chemotherapy n=173.

† Graded per NCI CTCAE v4.03

### Previously Treated NSCLC

The safety of KEYTRUDA was investigated in KEYNOTE-010, a multicenter, open-label, randomized (1:1:1), active-controlled trial, in patients with advanced NSCLC who had documented disease progression following treatment with platinum-based chemotherapy and, if positive for EGFR or ALK genetic aberrations, appropriate therapy for these aberrations [see *Clinical Studies (14.2)*]. A total of 991 patients received KEYTRUDA 2 mg/kg (n=339) or 10 mg/kg (n=343) every 3 weeks or docetaxel (n=309) at 75 mg/m<sup>2</sup> every 3 weeks. Patients with autoimmune disease, medical conditions that required systemic corticosteroids or other immunosuppressive medication, or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible.

The median duration of exposure to KEYTRUDA 2 mg/kg every 3 weeks was 3.5 months (range: 1 day to 22.4 months) and to KEYTRUDA 10 mg/kg every 3 weeks was 3.5 months (range 1 day to 20.8 months). The data described below reflect exposure to KEYTRUDA 2 mg/kg in 31% of patients exposed to KEYTRUDA for ≥6 months. In the KEYTRUDA 10 mg/kg arm, 34% of patients were exposed to KEYTRUDA for ≥6 months.

The study population characteristics were: median age of 63 years (range: 20 to 88), 42% age 65 or older; 61% male; 72% White and 21% Asian; and 8% with advanced localized disease, 91% with metastatic disease, and 15% with history of brain metastases. Twenty-nine percent received two or more prior systemic treatments for advanced or metastatic disease.

In KEYNOTE-010, the adverse reaction profile was similar for the 2 mg/kg and 10 mg/kg dose, therefore summary safety results are provided in a pooled analysis (n=682). Treatment was discontinued for adverse reactions in 8% of patients receiving KEYTRUDA. The most common adverse events resulting in permanent discontinuation of KEYTRUDA was pneumonitis (1.8%). Adverse reactions leading to interruption of KEYTRUDA occurred in 23% of patients; the most common (≥1%) were diarrhea (1%), fatigue (1.3%), pneumonia (1%), liver enzyme elevation (1.2%), decreased appetite (1.3%), and pneumonitis (1%). Tables 12 and 13 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-010.



**Table 12: Selected\* Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-010**

Adverse Reaction	KEYTRUDA 2 or 10 mg/kg every 3 weeks n=682		Docetaxel 75 mg/m <sup>2</sup> every 3 weeks n=309	
	All Grades <sup>†</sup> (%)	Grades 3-4 (%)	All Grades <sup>†</sup> (%)	Grades 3-4 (%)
<b>Metabolism and Nutrition</b>				
Decreased appetite	25	1.5	23	2.6
<b>Respiratory, Thoracic and Mediastinal</b>				
Dyspnea	23	3.7	20	2.6
Cough	19	0.6	14	0
<b>Gastrointestinal</b>				
Nausea	20	1.3	18	0.6
Constipation	15	0.6	12	0.6
Vomiting	13	0.9	10	0.6
<b>Skin and Subcutaneous Tissue</b>				
Rash <sup>‡</sup>	17	0.4	8	0
Pruritus	11	0	3	0.3
<b>Musculoskeletal and Connective Tissue</b>				
Arthralgia	11	1.0	9	0.3
Back pain	11	1.5	8	0.3

\* Adverse reactions occurring at same or higher incidence than in docetaxel arm

† Graded per NCI CTCAE v4.0

‡ Includes rash, rash erythematous, rash macular, rash maculo-papular, rash papular, and rash pruritic

Other clinically important adverse reactions occurring in patients receiving KEYTRUDA were fatigue (25%), diarrhea (14%), asthenia (11%) and pyrexia (11%).

**Table 13: Selected\* Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of NSCLC Patients Receiving KEYTRUDA in KEYNOTE-010**

Laboratory Test <sup>†</sup>	KEYTRUDA 2 or 10 mg/kg every 3 weeks		Docetaxel 75 mg/m <sup>2</sup> every 3 weeks	
	All Grades <sup>‡</sup> %	Grades 3-4 %	All Grades <sup>‡</sup> %	Grades 3-4 %
<b>Chemistry</b>				
Hyponatremia	32	8	27	2.9
Increased alkaline phosphatase	28	3.0	16	0.7
Increased AST	26	1.6	12	0.7
Increased ALT	22	2.7	9	0.4

\* Laboratory abnormalities occurring at same or higher incidence than in docetaxel arm.

† Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 631 to 638 patients) and docetaxel (range: 274 to 277 patients).

‡ Graded per NCI CTCAE v4.0

Other laboratory abnormalities occurring in ≥20% of patients receiving KEYTRUDA were hyperglycemia (44% all Grades; 4.1% Grades 3-4), anemia (37% all Grades; 3.8% Grades 3-4), hypertriglyceridemia (36% all Grades; 1.8% Grades 3-4), lymphopenia (35% all Grades; 9% Grades 3-4), hypoalbuminemia (34% all Grades; 1.6% Grades 3-4), and hypercholesterolemia (20% all Grades; 0.7% Grades 3-4).

### SCLC

Among the 131 patients with previously treated SCLC who received KEYTRUDA in KEYNOTE-158 Cohort G (n=107) and KEYNOTE-028 Cohort C1 (n=24) [see *Clinical Studies (14.3)*], the median duration of exposure to KEYTRUDA was 2 months (range: 1 day to 2.25 years). Patients with autoimmune disease that required systemic therapy within 2 years of treatment or a medical condition that required

immunosuppression were ineligible. Adverse reactions occurring in patients with SCLC were similar to those occurring in patients with other solid tumors who received KEYTRUDA as a single agent.

## HNSCC

### *First-line treatment of metastatic or unresectable, recurrent HNSCC*

The safety of KEYTRUDA, as a single agent and in combination with platinum (cisplatin or carboplatin) and FU chemotherapy, was investigated in KEYNOTE-048, a multicenter, open-label, randomized (1:1:1), active-controlled trial in patients with previously untreated, recurrent or metastatic HNSCC [see *Clinical Studies (14.4)*]. Patients with autoimmune disease that required systemic therapy within 2 years of treatment or a medical condition that required immunosuppression were ineligible. A total of 576 patients received KEYTRUDA 200 mg every 3 weeks either as a single agent (n=300) or in combination with platinum and FU (n=276) every 3 weeks for 6 cycles followed by KEYTRUDA, compared to 287 patients who received cetuximab weekly in combination with platinum and FU every 3 weeks for 6 cycles followed by cetuximab.

The median duration of exposure to KEYTRUDA was 3.5 months (range: 1 day to 24.2 months) in the KEYTRUDA single agent arm and was 5.8 months (range: 3 days to 24.2 months) in the combination arm. Seventeen percent of patients in the KEYTRUDA single agent arm and 18% of patients in the combination arm were exposed to KEYTRUDA for  $\geq 12$  months. Fifty-seven percent of patients receiving KEYTRUDA in combination with chemotherapy started treatment with carboplatin.

KEYTRUDA was discontinued for adverse reactions in 12% of patients in the KEYTRUDA single agent arm. The most common adverse reactions resulting in permanent discontinuation of KEYTRUDA were sepsis (1.7%) and pneumonia (1.3%). Adverse reactions leading to the interruption of KEYTRUDA occurred in 31% of patients; the most common adverse reactions leading to interruption of KEYTRUDA ( $\geq 2\%$ ) were pneumonia (2.3%), pneumonitis (2.3%), and hyponatremia (2%).

KEYTRUDA was discontinued for adverse reactions in 16% of patients in the combination arm. The most common adverse reactions resulting in permanent discontinuation of KEYTRUDA were pneumonia (2.5%), pneumonitis (1.8%), and septic shock (1.4%). Adverse reactions leading to the interruption of KEYTRUDA occurred in 45% of patients; the most common adverse reactions leading to interruption of KEYTRUDA ( $\geq 2\%$ ) were neutropenia (14%), thrombocytopenia (10%), anemia (6%), pneumonia (4.7%), and febrile neutropenia (2.9%).

Tables 14 and 15 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-048.

**Table 14: Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-048**

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks n=300		KEYTRUDA 200 mg every 3 weeks Platinum FU n=276		Cetuximab Platinum FU n=287	
	All Grades* (%)	Grades 3-4 (%)	All Grades* (%)	Grades 3-4 (%)	All Grades* (%)	Grades 3-4 (%)
<b>General</b>						
Fatigue†	33	4	49	11	48	8
Pyrexia	13	0.7	16	0.7	12	0
Mucosal inflammation	4.3	1.3	31	10	28	5
<b>Gastrointestinal</b>						
Constipation	20	0.3	37	0	33	1.4
Nausea	17	0	51	6	51	6
Diarrhea‡	16	0.7	29	3.3	35	3.1
Vomiting	11	0.3	32	3.6	28	2.8
Dysphagia	8	2.3	12	2.9	10	2.1
Stomatitis	3	0	26	8	28	3.5
<b>Skin</b>						
Rash§	20	2.3	17	0.7	70	8
Pruritus	11	0	8	0	10	0.3
<b>Respiratory, Thoracic and Mediastinal</b>						
Cough¶	18	0.3	22	0	15	0
Dyspnea#	14	2.0	10	1.8	8	1.0
<b>Endocrine</b>						
Hypothyroidism	18	0	15	0	6	0
<b>Metabolism and Nutrition</b>						
Decreased appetite	15	1.0	29	4.7	30	3.5
Weight loss	15	2	16	2.9	21	1.4
<b>Infections</b>						
Pneumonia <sup>Ⓟ</sup>	12	7	19	11	13	6
<b>Nervous System</b>						
Headache	12	0.3	11	0.7	8	0.3
Dizziness	5	0.3	10	0.4	13	0.3
Peripheral sensory neuropathy <sup>Ⓟ</sup>	1	0	14	1.1	7	1
<b>Musculoskeletal</b>						
Myalgia <sup>ⓐ</sup>	12	1.0	13	0.4	11	0.3
Neck pain	6	0.7	10	1.1	7	0.7
<b>Psychiatric</b>						
Insomnia	7	0.7	10	0	8	0

\* Graded per NCI CTCAE v4.0

† Includes fatigue, asthenia

‡ Includes diarrhea, colitis, hemorrhagic diarrhea, microscopic colitis

§ Includes dermatitis, dermatitis acneiform, dermatitis allergic, dermatitis bullous, dermatitis contact, dermatitis exfoliative, drug eruption, erythema, erythema multiforme, rash, erythematous rash, generalized rash, macular rash, maculo-papular rash, pruritic rash, seborrheic dermatitis

¶ Includes cough, productive cough

# Includes dyspnea, exertional dyspnea

Ⓟ Includes pneumonia, atypical pneumonia, bacterial pneumonia, staphylococcal pneumonia, aspiration pneumonia, lower respiratory tract infection, lung infection, lung infection pseudomonal

Ⓟ Includes peripheral sensory neuropathy, peripheral neuropathy, hypoesthesia, dysesthesia

ⓐ Includes back pain, musculoskeletal chest pain, musculoskeletal pain, myalgia

**Table 15: Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Patients Receiving KEYTRUDA in KEYNOTE-048**

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks		KEYTRUDA 200 mg every 3 weeks Platinum FU		Cetuximab Platinum FU	
	All Grades† (%)	Grades 3- 4 (%)	All Grades† (%)	Grades 3- 4 (%)	All Grades† (%)	Grades 3-4 (%)
<b>Hematology</b>						
Lymphopenia	54	25	69	35	74	45
Anemia	52	7	89	28	78	19
Thrombocytopenia	12	3.8	73	18	76	18
Neutropenia	7	1.4	67	35	71	42
<b>Chemistry</b>						
Hyperglycemia	47	3.8	55	6	66	4.7
Hyponatremia	46	17	56	20	59	20
Hypoalbuminemia	44	3.2	47	4.0	49	1.1
Increased AST	28	3.1	24	2.0	37	3.6
Increased ALT	25	2.1	22	1.6	38	1.8
Increased alkaline phosphatase	25	2.1	27	1.2	33	1.1
Hypercalcemia	22	4.6	16	4.3	13	2.6
Hypocalcemia	22	1.1	32	4	58	7
Hyperkalemia	21	2.8	27	4.3	29	4.3
Hypophosphatemia	20	5	35	12	48	19
Hypokalemia	19	5	34	12	47	15
Increased creatinine	18	1.1	36	2.3	27	2.2
Hypomagnesemia	16	0.4	42	1.7	76	6

\* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA/chemotherapy (range: 235 to 266 patients), KEYTRUDA (range: 241 to 288 patients), cetuximab/chemotherapy (range: 249 to 282 patients).

† Graded per NCI CTCAE v4.0

#### *Previously treated recurrent or metastatic HNSCC*

Among the 192 patients with HNSCC enrolled in KEYNOTE-012 [see *Clinical Studies (14.4)*], the median duration of exposure to KEYTRUDA was 3.3 months (range: 1 day to 27.9 months). Patients with autoimmune disease or a medical condition that required immunosuppression were ineligible for KEYNOTE-012.

The study population characteristics were: median age of 60 years (range: 20 to 84), 35% age 65 or older; 83% male; and 77% White, 15% Asian, and 5% Black. Sixty-one percent of patients had two or more lines of therapy in the recurrent or metastatic setting, and 95% had prior radiation therapy. Baseline ECOG PS was 0 (30%) or 1 (70%) and 86% had M1 disease.

KEYTRUDA was discontinued due to adverse reactions in 17% of patients. Serious adverse reactions occurred in 45% of patients receiving KEYTRUDA. The most frequent serious adverse reactions reported in at least 2% of patients were pneumonia, dyspnea, confusional state, vomiting, pleural effusion, and respiratory failure. The incidence of adverse reactions, including serious adverse reactions, was similar between dosage regimens (10 mg/kg every 2 weeks or 200 mg every 3 weeks); therefore, summary safety results are provided in a pooled analysis. The most common adverse reactions (occurring in ≥20% of patients) were fatigue, decreased appetite, and dyspnea. Adverse reactions occurring in patients with HNSCC were generally similar to those occurring in patients with melanoma or NSCLC, with the exception of increased incidences of facial edema (10% all Grades; 2.1% Grades 3-4) and new or worsening hypothyroidism [see *Warnings and Precautions (5.4)*].

#### cHL

Among the 210 patients with cHL enrolled in KEYNOTE-087 [see *Clinical Studies (14.5)*], the median duration of exposure to KEYTRUDA was 8.4 months (range: 1 day to 15.2 months). KEYTRUDA was discontinued due to adverse reactions in 5% of patients, and treatment was interrupted due to adverse reactions in 26%. Fifteen percent (15%) of patients had an adverse reaction requiring systemic

corticosteroid therapy. Serious adverse reactions occurred in 16% of patients. The most frequent serious adverse reactions ( $\geq 1\%$ ) included pneumonia, pneumonitis, pyrexia, dyspnea, graft versus host disease and herpes zoster. Two patients died from causes other than disease progression; one from GVHD after subsequent allogeneic HSCT and one from septic shock. Tables 16 and 17 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-087.

**Table 16: Adverse Reactions in  $\geq 10\%$  of Patients with cHL in KEYNOTE-087**

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks N=210	
	All Grades* (%)	Grade 3 (%)
<b>General</b>		
Fatigue <sup>†</sup>	26	1.0
Pyrexia	24	1.0
<b>Respiratory, Thoracic and Mediastinal</b>		
Cough <sup>‡</sup>	24	0.5
Dyspnea <sup>§</sup>	11	1.0
<b>Musculoskeletal and Connective Tissue</b>		
Musculoskeletal pain <sup>¶</sup>	21	1.0
Arthralgia	10	0.5
<b>Gastrointestinal</b>		
Diarrhea <sup>#</sup>	20	1.4
Vomiting	15	0
Nausea	13	0
<b>Skin and Subcutaneous Tissue</b>		
Rash <sup>▷</sup>	20	0.5
Pruritus	11	0
<b>Endocrine</b>		
Hypothyroidism	14	0.5
<b>Infections</b>		
Upper respiratory tract infection	13	0
<b>Nervous System</b>		
Headache	11	0.5
Peripheral neuropathy <sup>β</sup>	10	0

\* Graded per NCI CTCAE v4.0

† Includes fatigue, asthenia

‡ Includes cough, productive cough

§ Includes dyspnea, dyspnea exertional, wheezing

¶ Includes back pain, myalgia, bone pain, musculoskeletal pain, pain in extremity, musculoskeletal chest pain, musculoskeletal discomfort, neck pain

# Includes diarrhea, gastroenteritis, colitis, enterocolitis

▷ Includes rash, rash maculo-papular, drug eruption, eczema, eczema asteatotic, dermatitis, dermatitis acneiform, dermatitis contact, rash erythematous, rash macular, rash papular, rash pruritic, seborrhoeic dermatitis, dermatitis psoriasiform

β Includes neuropathy peripheral, peripheral sensory neuropathy, hypoesthesia, paresthesia, dysesthesia, polyneuropathy

Other clinically important adverse reactions that occurred in less than 10% of patients on KEYNOTE-087 included infusion reactions (9%), hyperthyroidism (3%), pneumonitis (3%), uveitis and myositis (1% each), and myelitis and myocarditis (0.5% each).

**Table 17: Selected Laboratory Abnormalities Worsened from Baseline Occurring in ≥15% of cHL Patients Receiving KEYTRUDA in KEYNOTE-087**

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks	
	All Grades† (%)	Grades 3-4 (%)
<b>Chemistry</b>		
Hypertransaminasemia‡	34	2
Increased alkaline phosphatase	17	0
Increased creatinine	15	0.5
<b>Hematology</b>		
Anemia	30	6
Thrombocytopenia	27	4
Neutropenia	24	7

\* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA (range: 208 to 209 patients)

† Graded per NCI CTCAE v4.0

‡ Includes elevation of AST or ALT

Hyperbilirubinemia occurred in less than 15% of patients on KEYNOTE-087 (10% all Grades, 2.4% Grade 3-4).

#### PMBCL

Among the 53 patients with PMBCL treated in KEYNOTE-170 [see *Clinical Studies (14.6)*], the median duration of exposure to KEYTRUDA was 3.5 months (range: 1 day to 22.8 months).

KEYTRUDA was discontinued due to adverse reactions in 8% of patients, and treatment was interrupted due to adverse reactions in 15%. Twenty-five percent of patients had an adverse reaction requiring systemic corticosteroid therapy. Serious adverse reactions occurred in 26% of patients, and included arrhythmia (4%), cardiac tamponade (2%), myocardial infarction (2%), pericardial effusion (2%), and pericarditis (2%). Six (11%) patients died within 30 days of start of treatment. Tables 18 and 19 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-170.

















































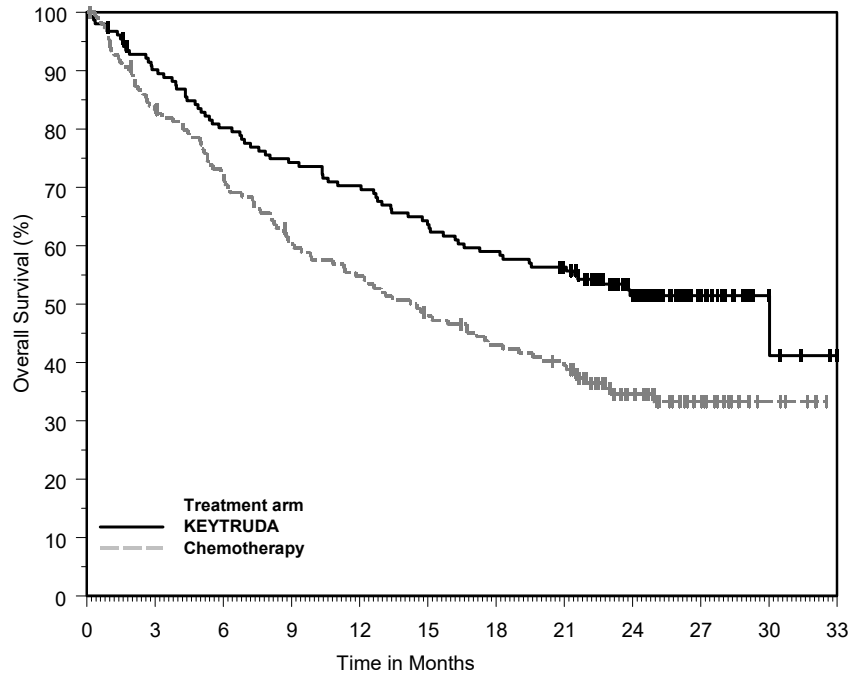








**Figure 7: Kaplan-Meier Curve for Overall Survival in KEYNOTE-024\***



Number at Risk		Time in Months											
		0	3	6	9	12	15	18	21	24	27	30	33
KEYTRUDA:	154	136	121	112	106	96	89	83	52	22	5	0	
Chemotherapy:	151	123	107	88	80	70	61	55	31	16	5	0	

\*Based on the protocol-specified final OS analysis conducted at 169 events, which occurred 14 months after the interim analysis.

### Previously treated NSCLC

The efficacy of KEYTRUDA was investigated in KEYNOTE-010 (NCT01905657), a randomized, multicenter, open-label, active-controlled trial conducted in 1033 patients with metastatic NSCLC that had progressed following platinum-containing chemotherapy, and if appropriate, targeted therapy for EGFR or ALK genomic tumor aberrations. Eligible patients had PD-L1 expression TPS of 1% or greater by an immunohistochemistry assay using the PD-L1 IHC 22C3 pharmDx kit. Patients with autoimmune disease; a medical condition that required immunosuppression; or who had received more than 30 Gy of thoracic radiation within the prior 26 weeks were ineligible. Randomization was stratified by tumor PD-L1 expression (PD-L1 expression TPS  $\geq 50\%$  vs. PD-L1 expression TPS=1-49%), ECOG PS (0 vs. 1), and geographic region (East Asia vs. non-East Asia). Patients were randomized (1:1:1) to receive KEYTRUDA 2 mg/kg intravenously every 3 weeks, KEYTRUDA 10 mg/kg intravenously every 3 weeks or docetaxel intravenously 75 mg/m<sup>2</sup> every 3 weeks until unacceptable toxicity or disease progression. Patients randomized to KEYTRUDA were permitted to continue until disease progression that was symptomatic, rapidly progressive, required urgent intervention, occurred with a decline in performance status, or confirmation of progression at 4 to 6 weeks with repeat imaging or for up to 24 months without disease progression. Assessment of tumor status was performed every 9 weeks. The main efficacy outcome measures were OS and PFS as assessed by BICR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, in the subgroup of patients with TPS  $\geq 50\%$  and the overall population with TPS  $\geq 1\%$ . Additional efficacy outcome measures were ORR and response duration in the subgroup of patients with TPS  $\geq 50\%$  and the overall population with TPS  $\geq 1\%$ .

The study population characteristics were: median age of 63 years (range: 20 to 88), 42% age 65 or older; 61% male; 72% White and 21% Asian; 66% ECOG PS of 1; 43% with high PD-L1 tumor expression; 21% with squamous, 70% with nonsquamous, and 8% with mixed, other or unknown histology; 91% metastatic (M1) disease; 15% with history of brain metastases; and 8% and 1% with



EGFR and ALK genomic aberrations, respectively. All patients had received prior therapy with a platinum-doublet regimen, 29% received two or more prior therapies for their metastatic disease.

Tables 34 and 35 and Figure 8 summarize efficacy results in the subgroup with TPS  $\geq 50\%$  population and in all patients, respectively.

**Table 34: Efficacy Results of the Subgroup of Patients with TPS  $\geq 50\%$  in KEYNOTE-010**

Endpoint	KEYTRUDA 2 mg/kg every 3 weeks n=139	KEYTRUDA 10 mg/kg every 3 weeks n=151	Docetaxel 75 mg/m <sup>2</sup> every 3 weeks n=152
<b>OS</b>			
Deaths (%)	58 (42%)	60 (40%)	86 (57%)
Median in months (95% CI)	14.9 (10.4, NR)	17.3 (11.8, NR)	8.2 (6.4, 10.7)
Hazard ratio* (95% CI)	0.54 (0.38, 0.77)	0.50 (0.36, 0.70)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
<b>PFS</b>			
Events (%)	89 (64%)	97 (64%)	118 (78%)
Median in months (95% CI)	5.2 (4.0, 6.5)	5.2 (4.1, 8.1)	4.1 (3.6, 4.3)
Hazard ratio* (95% CI)	0.58 (0.43, 0.77)	0.59 (0.45, 0.78)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
<b>Objective Response Rate</b>			
ORR <sup>†</sup> (95% CI)	30% (23, 39)	29% (22, 37)	8% (4, 13)
p-Value (Miettinen-Nurminen)	<0.001	<0.001	---
Median duration of response in months (range)	NR (0.7+, 16.8+)	NR (2.1+, 17.8+)	8.1 (2.1+, 8.8+)

\* Hazard ratio (KEYTRUDA compared to docetaxel) based on the stratified Cox proportional hazard model

† All responses were partial responses

NR = not reached

**Table 35: Efficacy Results of All Randomized Patients (TPS  $\geq 1\%$ ) in KEYNOTE-010**

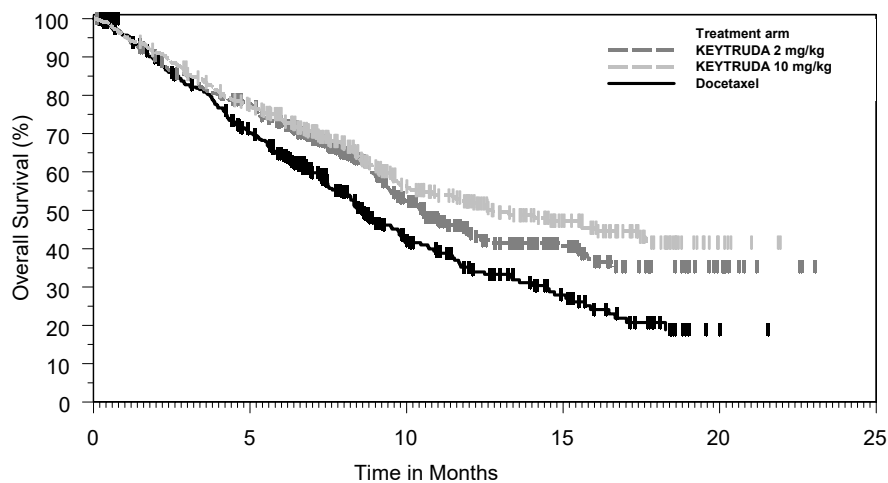
Endpoint	KEYTRUDA 2 mg/kg every 3 weeks n=344	KEYTRUDA 10 mg/kg every 3 weeks n=346	Docetaxel 75 mg/m <sup>2</sup> every 3 weeks n=343
<b>OS</b>			
Deaths (%)	172 (50%)	156 (45%)	193 (56%)
Median in months (95% CI)	10.4 (9.4, 11.9)	12.7 (10.0, 17.3)	8.5 (7.5, 9.8)
Hazard ratio* (95% CI)	0.71 (0.58, 0.88)	0.61 (0.49, 0.75)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
<b>PFS</b>			
Events (%)	266 (77%)	255 (74%)	257 (75%)
Median in months (95% CI)	3.9 (3.1, 4.1)	4.0 (2.6, 4.3)	4.0 (3.1, 4.2)
Hazard ratio* (95% CI)	0.88 (0.73, 1.04)	0.79 (0.66, 0.94)	---
p-Value (stratified log-rank)	0.068	0.005	---
<b>Objective Response Rate</b>			
ORR <sup>†</sup> (95% CI)	18% (14, 23)	19% (15, 23)	9% (7, 13)
p-Value (Miettinen-Nurminen)	<0.001	<0.001	---
Median duration of response in months (range)	NR (0.7+, 20.1+)	NR (2.1+, 17.8+)	6.2 (1.4+, 8.8+)

\* Hazard ratio (KEYTRUDA compared to docetaxel) based on the stratified Cox proportional hazard model

† All responses were partial responses

NR = not reached

**Figure 8: Kaplan-Meier Curve for Overall Survival in all Randomized Patients in KEYNOTE-010 (TPS  $\geq$ 1%)**



Number at Risk		Time in Months					
	0	5	10	15	20	25	
KEYTRUDA 2 mg/kg:	344	259	115	49	12	0	
KEYTRUDA 10 mg/kg:	346	255	124	56	6	0	
Docetaxel:	343	212	79	33	1	0	

### 14.3 Small Cell Lung Cancer

The efficacy of KEYTRUDA was investigated in 83 patients with SCLC who had disease progression on or after platinum-based chemotherapy and at least one other prior line of therapy enrolled in one of two multicenter, multi-cohort, non-randomized, open label trials: KEYNOTE-028 (NCT02054806), Cohort C1, or KEYNOTE-158 (NCT02628067), Cohort G. The trials excluded patients with autoimmune disease or a medical condition that required immunosuppression.

Patients received either KEYTRUDA 200 mg intravenously every 3 weeks (n=64) or 10 mg/kg intravenously every 2 weeks (n=19). Treatment with KEYTRUDA continued until documented disease progression, unacceptable toxicity, or a maximum of 24 months. Patients with initial radiographic disease progression could receive additional doses of KEYTRUDA during confirmation of progression unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, or occurred with a decline in performance status.

Assessment of tumor status was performed every 8 weeks for the first 6 months in KEYNOTE-028, every 9 weeks for the first 12 months in KEYNOTE-158, and every 12 weeks thereafter for both studies. The major efficacy outcome measures were ORR and DoR as assessed by BICR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ.

The study population characteristics were: median age of 62 years (range: 24 to 84); 40% age 65 or older; 64% male; 63% White, 25% Asian, and 2% Black; 30% ECOG PS of 0 and 69% ECOG PS of 1; 7% had M0 disease and 93% had M1 disease; and 16% had a history of brain metastases. Sixty-four percent received two prior lines of therapy and 36% received three or more lines of therapy; 60% received prior thoracic radiation therapy; 51% received prior radiation therapy to the brain.

Efficacy results are summarized in Table 36.

**Table 36: Efficacy Results in Patients with Small Cell Lung Cancer**

Endpoint	KEYTRUDA n=83
<b>Objective Response Rate</b>	
ORR (95% CI)	19% (11, 29)
Complete response rate	2%
Partial response rate	17%
<b>Duration of Response</b>	n=16
Range (months)	4.1, 35.8+
% with duration ≥6 months	94%
% with duration ≥12 months	63%
% with duration ≥18 months	56%

+ Denotes ongoing response

#### 14.4 Head and Neck Squamous Cell Cancer

##### First-line treatment of metastatic or unresectable, recurrent HNSCC

The efficacy of KEYTRUDA was investigated in KEYNOTE-048 (NCT02358031), a randomized, multicenter, open-label, active-controlled trial conducted in 882 patients with metastatic HNSCC who had not previously received systemic therapy for metastatic disease or with recurrent disease who were considered incurable by local therapies. Patients with active autoimmune disease that required systemic therapy within two years of treatment or a medical condition that required immunosuppression were ineligible. Randomization was stratified by tumor PD-L1 expression (TPS ≥50% or <50%) according to the PD-L1 IHC 22C3 pharmDx kit, HPV status according to p16 IHC (positive or negative), and ECOG PS (0 vs. 1). Patients were randomized 1:1:1 to one of the following treatment arms:

- KEYTRUDA 200 mg intravenously every 3 weeks
- KEYTRUDA 200 mg intravenously every 3 weeks, carboplatin AUC 5 mg/mL/min intravenously every 3 weeks or cisplatin 100 mg/m<sup>2</sup> intravenously every 3 weeks, and FU 1000 mg/m<sup>2</sup>/day as a continuous intravenous infusion over 96 hours every 3 weeks (maximum of 6 cycles of platinum and FU)
- Cetuximab 400 mg/m<sup>2</sup> intravenously as the initial dose then 250 mg/m<sup>2</sup> intravenously once weekly, carboplatin AUC 5 mg/mL/min intravenously every 3 weeks or cisplatin 100 mg/m<sup>2</sup> intravenously every 3 weeks, and FU 1000 mg/m<sup>2</sup>/day as a continuous intravenous infusion over 96 hours every 3 weeks (maximum of 6 cycles of platinum and FU)

Treatment with KEYTRUDA continued until RECIST v1.1-defined progression of disease as determined by the investigator, unacceptable toxicity, or a maximum of 24 months. Administration of KEYTRUDA was permitted beyond RECIST-defined disease progression if the patient was clinically stable and considered to be deriving clinical benefit by the investigator. Assessment of tumor status was performed at Week 9 and then every 6 weeks for the first year, followed by every 9 weeks through 24 months. A retrospective re-classification of patients' tumor PD-L1 status according to CPS using the PD-L1 IHC 22C3 pharmDx kit was conducted using the tumor specimens used for randomization.

The main efficacy outcome measures were OS and PFS as assessed by BICR according to RECIST v1.1 (modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ) sequentially tested in the subgroup of patients with CPS ≥20, the subgroup of patients with CPS ≥1, and the overall population.

The study population characteristics were: median age of 61 years (range: 20 to 94), 36% age 65 or older; 83% male; 73% White, 20% Asian and 2.4% Black; 61% had ECOG PS of 1; and 79% were former/current smokers. Twenty-two percent of patients' tumors were HPV-positive, 23% had PD-L1 TPS ≥50%, and 95% had Stage IV disease (Stage IVA 19%, Stage IVB 6%, and Stage IVC 70%). Eighty-five percent of patients' tumors had PD-L1 expression of CPS ≥1 and 43% had CPS ≥20.

The trial demonstrated a statistically significant improvement in OS for patients randomized to KEYTRUDA in combination with chemotherapy compared to those randomized to cetuximab in combination with chemotherapy at a pre-specified interim analysis in the overall population. The trial also demonstrated a statistically significant improvement in OS for the subgroup of patients with PD-L1 CPS  $\geq$ 1 randomized to KEYTRUDA as a single agent compared to those randomized to cetuximab in combination with chemotherapy. At the time of the interim analysis, there was no significant difference in OS between the KEYTRUDA single agent arm and the control arm for the overall population. Table 37 and Figure 9 summarize efficacy results for KEYTRUDA in combination with chemotherapy.

**Table 37: Efficacy Results for KEYTRUDA plus Platinum/Fluorouracil in KEYNOTE-048**

Endpoint	KEYTRUDA 200 mg every 3 weeks Platinum FU n=281	Cetuximab Platinum FU n=278
<b>OS</b>		
Number (%) of patients with event	197 (70%)	223 (80%)
Median in months (95% CI)	13.0 (10.9, 14.7)	10.7 (9.3, 11.7)
Hazard ratio* (95% CI)	0.77 (0.63, 0.93)	
p-Value <sup>†</sup>	0.0067	
<b>PFS</b>		
Number of patients with event (%)	244 (87%)	253 (91%)
Median in months (95% CI)	4.9 (4.7, 6.0)	5.1 (4.9, 6.0)
Hazard ratio* (95% CI)	0.92 (0.77, 1.10)	
p-Value <sup>†</sup>	0.3394	
<b>Objective Response Rate</b>		
ORR <sup>‡</sup> (95% CI)	36% (30.0, 41.5)	36% (30.7, 42.3)
Complete response rate	6%	3%
Partial response rate	30%	33%
<b>Duration of Response</b>		
Median in months (range)	6.7 (1.6+, 30.4+)	4.3 (1.2+, 27.9+)

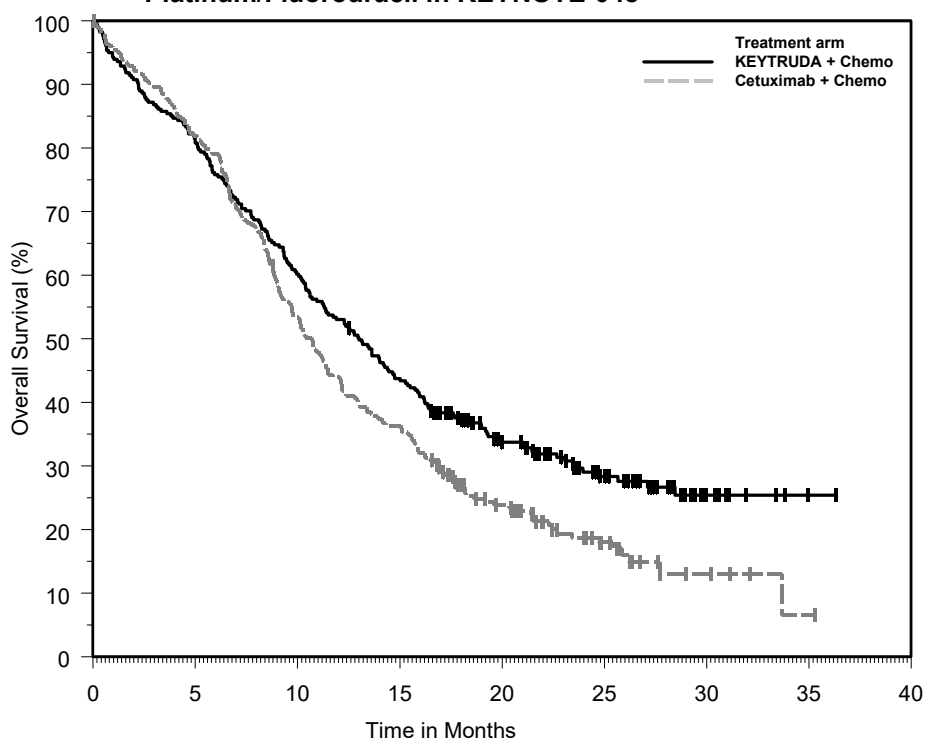
\* Based on the stratified Cox proportional hazard model

<sup>†</sup> Based on stratified log-rank test

<sup>‡</sup> Response: Best objective response as confirmed complete response or partial response

In KEYNOTE-048, OS HRs for patients randomized to KEYTRUDA in combination with chemotherapy, compared with cetuximab in combination with chemotherapy, were similar for all populations regardless of PD-L1 expression in a pre-specified interim analysis: ITT (HR 0.77, 95% CI: 0.63, 0.93), CPS  $\geq$ 1 (HR 0.71, 95% CI: 0.57, 0.88), CPS  $\geq$ 20 (HR 0.69, 95% CI: 0.51, 0.94).

**Figure 9: Kaplan-Meier Curve for Overall Survival for KEYTRUDA plus Platinum/Fluorouracil in KEYNOTE-048**



Number at Risk		0	5	10	15	20	25	30	35
KEYTRUDA + Chemo:	281	227	169	122	75	40	10	1	0
Cetuximab + Chemo:	278	227	147	100	51	20	5	1	0

Table 38 summarizes efficacy results for KEYTRUDA as a single agent in the subgroups of patients with CPS  $\geq 1$  HNSCC and CPS  $\geq 20$  HNSCC. Figure 10 summarizes the OS results in the subgroup of patients with CPS  $\geq 1$  HNSCC.

**Table 38: Efficacy Results for KEYTRUDA as a Single Agent in KEYNOTE-048 (CPS ≥1 and CPS ≥20)**

Endpoint	CPS ≥1		CPS ≥20	
	KEYTRUDA 200 mg every 3 weeks n=257	Cetuximab Platinum FU n=255	KEYTRUDA 200 mg every 3 weeks n=133	Cetuximab Platinum FU n=122
<b>OS</b>				
Number of events (%)	177 (69%)	206 (81%)	82 (62%)	95 (78%)
Median in months (95% CI)	12.3 (10.8, 14.9)	10.3 (9.0, 11.5)	14.9 (11.6, 21.5)	10.7 (8.8, 12.8)
Hazard ratio* (95% CI)	0.78 (0.64, 0.96)		0.61 (0.45, 0.83)	
p-Value†	0.0171		0.0015	
<b>PFS</b>				
Number of events (%)	225 (88%)	231 (91%)	113 (85%)	111 (91%)
Median in months (95% CI)	3.2 (2.2, 3.4)	5.0 (4.8, 5.8)	3.4 (3.2, 3.8)	5.0 (4.8, 6.2)
Hazard ratio* (95% CI)	1.15(0.95, 1.38)		0.99 (0.75, 1.29)	
<b>Objective Response Rate</b>				
ORR‡ (95% CI)	19% (14.5, 24.4)	35% (29.1, 41.1)	23% (16.4, 31.4)	36% (27.6, 45.3)
Complete response rate	5%	3%	8%	3%
Partial response rate	14%	32%	16%	33%
<b>Duration of Response</b>				
Median in months (range)	20.9 (1.5+, 34.8+)	4.5 (1.2+, 28.6+)	20.9 (2.7, 34.8+)	4.2 (1.2+, 22.3+)

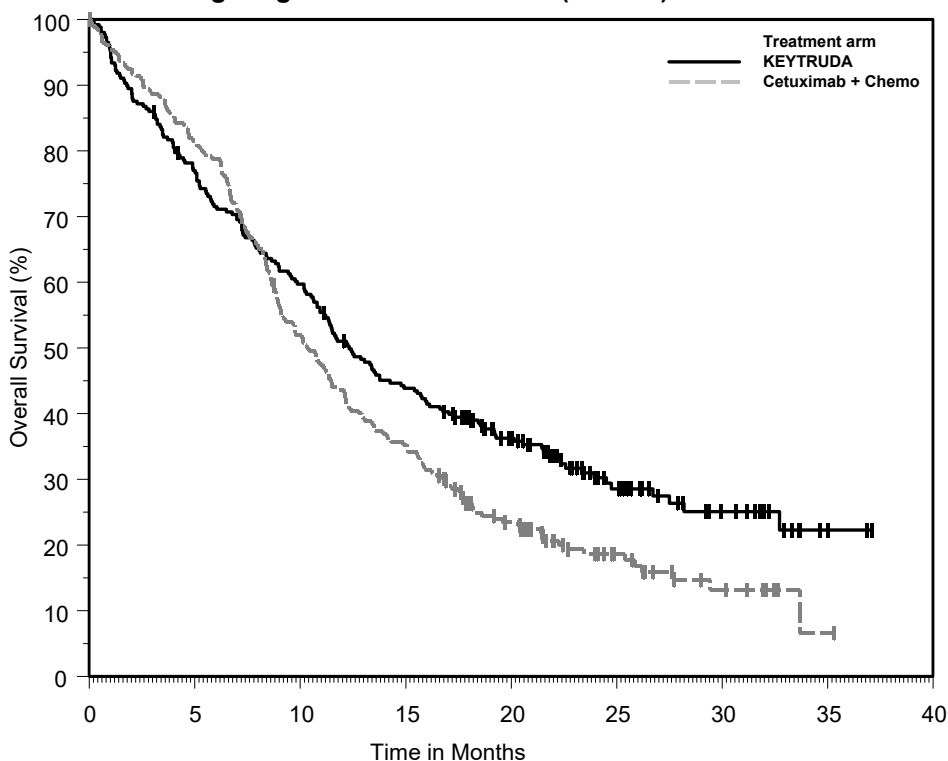
\* Based on the stratified Cox proportional hazard model

† Based on a stratified log-rank test

‡ Response: Best objective response as confirmed complete response or partial response

In an exploratory subgroup analysis for patients with CPS 1-19 HNSCC, the median OS was 10.8 months (95% CI: 9.0, 12.6) for KEYTRUDA as a single agent and 10.1 months (95% CI: 8.7, 12.1) for cetuximab in combination with chemotherapy, with an HR of 0.90 (95% CI: 0.68, 1.18).

**Figure 10: Kaplan-Meier Curve for Overall Survival for KEYTRUDA as a Single Agent in KEYNOTE-048 (CPS ≥1)**



Number at Risk	0	5	10	15	20	25	30	35	40
KEYTRUDA:	257	196	152	110	74	34	17	2	0
Cetuximab + Chemo:	255	207	131	89	47	21	9	1	0

### Previously treated recurrent or metastatic HNSCC

The efficacy of KEYTRUDA was investigated in KEYNOTE-012 (NCT01848834), a multicenter, non-randomized, open-label, multi-cohort study that enrolled 174 patients with recurrent or metastatic HNSCC who had disease progression on or after platinum-containing chemotherapy administered for recurrent or metastatic HNSCC or following platinum-containing chemotherapy administered as part of induction, concurrent, or adjuvant therapy. Patients with active autoimmune disease, a medical condition that required immunosuppression, evidence of interstitial lung disease, or ECOG PS ≥2 were ineligible.

Patients received KEYTRUDA 10 mg/kg every 2 weeks (n=53) or 200 mg every 3 weeks (n=121) until unacceptable toxicity or disease progression that was symptomatic, was rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at least 4 weeks later with repeat imaging. Patients without disease progression were treated for up to 24 months. Treatment with pembrolizumab could be reinitiated for subsequent disease progression and administered for up to 1 additional year. Assessment of tumor status was performed every 8 weeks. The major efficacy outcome measures were ORR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, as assessed by BICR, and DoR.

The study population characteristics were median age of 60 years, 32% age 65 or older; 82% male; 75% White, 16% Asian, and 6% Black; 87% had M1 disease; 33% had HPV positive tumors; 63% had prior cetuximab; 29% had an ECOG PS of 0 and 71% had an ECOG PS of 1; and the median number of prior lines of therapy administered for the treatment of HNSCC was 2.

The ORR was 16% (95% CI: 11, 22) with a complete response rate of 5%. The median follow-up time was 8.9 months. Among the 28 responding patients, the median DoR had not been reached (range: 2.4+ to 27.7+ months), with 23 patients having responses of 6 months or longer. The ORR and DoR were similar irrespective of dosage regimen (10 mg/kg every 2 weeks or 200 mg every 3 weeks) or HPV status.

## 14.5 Classical Hodgkin Lymphoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-087 (NCT02453594), a multicenter, non-randomized, open-label trial in 210 patients with relapsed or refractory cHL. Patients with active, non-infectious pneumonitis, an allogeneic HSCT within the past 5 years (or > 5 years but with symptoms of GVHD), active autoimmune disease, a medical condition that required immunosuppression, or an active infection requiring systemic therapy were ineligible for the trial. Patients received KEYTRUDA 200 mg intravenously every 3 weeks until unacceptable toxicity or documented disease progression, or for up to 24 months in patients who did not progress. Disease assessment was performed every 12 weeks. The major efficacy outcome measures (ORR, Complete Response Rate, and DoR) were assessed by BICR according to the 2007 revised International Working Group (IWG) criteria.

The study population characteristics were: median age of 35 years (range: 18 to 76), 9% age 65 or older; 54% male; 88% White; and 49% ECOG PS of 0 and 51% ECOG PS of 1. The median number of prior lines of therapy administered for the treatment of cHL was 4 (range: 1 to 12). Fifty-eight percent were refractory to the last prior therapy, including 35% with primary refractory disease and 14% whose disease was chemo-refractory to all prior regimens. Sixty-one percent of patients had undergone prior auto-HSCT, 83% had received prior brentuximab vedotin and 36% of patients had prior radiation therapy.

Efficacy results for KEYNOTE-087 are summarized in Table 39.

**Table 39: Efficacy Results in KEYNOTE-087**

Endpoint	KEYTRUDA 200 mg every 3 weeks n=210*
<b>Objective Response Rate</b>	
ORR (95% CI)	69% (62, 75)
Complete response rate	22%
Partial response rate	47%
<b>Duration of Response</b>	
Median in months (range)	11.1 (0.0+, 11.1)†

\* Median follow-up time of 9.4 months

† Based on patients (n=145) with a response by independent review

## 14.6 Primary Mediastinal Large B-Cell Lymphoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-170 (NCT02576990), a multicenter, open-label, single-arm trial in 53 patients with relapsed or refractory PMBCL. Patients were not eligible if they had active non-infectious pneumonitis, allogeneic HSCT within the past 5 years (or >5 years but with symptoms of GVHD), active autoimmune disease, a medical condition that required immunosuppression, or an active infection requiring systemic therapy. Patients were treated with KEYTRUDA 200 mg intravenously every 3 weeks until unacceptable toxicity or documented disease progression, or for up to 24 months for patients who did not progress. Disease assessments were performed every 12 weeks and assessed by BICR according to the 2007 revised IWG criteria. The efficacy outcome measures were ORR and DoR.

The study population characteristics were: median age of 33 years (range: 20 to 61 years); 43% male; 92% White; and 43% ECOG PS of 0 and 57% ECOG PS of 1. The median number of prior lines of therapy administered for the treatment of PMBCL was 3 (range 2 to 8). Thirty-six percent had primary refractory disease, 49% had relapsed disease refractory to the last prior therapy, and 15% had untreated relapse. Twenty-six percent of patients had undergone prior autologous HSCT, and 32% of patients had prior radiation therapy. All patients had received rituximab as part of a prior line of therapy.

For the 24 responders, the median time to first objective response (complete or partial response) was 2.8 months (range 2.1 to 8.5 months). Efficacy results for KEYNOTE-170 are summarized in Table 40.



**Table 40: Efficacy Results in KEYNOTE-170**

Endpoint	KEYTRUDA 200 mg every 3 weeks n=53*
<b>Objective Response Rate</b>	
ORR (95% CI)	45% (32, 60)
Complete response rate	11%
Partial response rate	34%
<b>Duration of Response</b>	
Median in months (range)	NR (1.1+, 19.2+) <sup>†</sup>

\* Median follow-up time of 9.7 months

<sup>†</sup> Based on patients (n=24) with a response by independent review

NR = not reached

## 14.7 Urothelial Carcinoma

### Cisplatin Ineligible Patients with Urothelial Carcinoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-052 (NCT02335424), a multicenter, open-label, single-arm trial in 370 patients with locally advanced or metastatic urothelial carcinoma who were not eligible for cisplatin-containing chemotherapy. The trial excluded patients with autoimmune disease or a medical condition that required immunosuppression. Patients received KEYTRUDA 200 mg every 3 weeks until unacceptable toxicity or disease progression. Patients with initial radiographic disease progression could receive additional doses of treatment during confirmation of progression unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, or occurred with a decline in performance status. Patients without disease progression could be treated for up to 24 months. Tumor response assessments were performed at 9 weeks after the first dose, then every 6 weeks for the first year, and then every 12 weeks thereafter. The major efficacy outcome measures were ORR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, as assessed by independent radiology review, and DoR.

The study population characteristics were: median age of 74 years; 77% male; and 89% White. Eighty-seven percent had M1 disease, and 13% had M0 disease. Eighty-one percent had a primary tumor in the lower tract, and 19% of patients had a primary tumor in the upper tract. Eighty-five percent of patients had visceral metastases, including 21% with liver metastases. Reasons for cisplatin ineligibility included: 50% with baseline creatinine clearance of <60 mL/min, 32% with ECOG PS of 2, 9% with ECOG PS of 2 and baseline creatinine clearance of <60 mL/min, and 9% with other reasons (Class III heart failure, Grade 2 or greater peripheral neuropathy, and Grade 2 or greater hearing loss). Ninety percent of patients were treatment naïve, and 10% received prior adjuvant or neoadjuvant platinum-based chemotherapy.

Among the 370 patients, 30% (n = 110) had tumors that expressed PD-L1 with a CPS ≥10. PD-L1 status was determined using the PD-L1 IHC 22C3 pharmDx kit. The study population characteristics of these 110 patients were: median age of 73 years, 68% male, and 87% White. Eighty-two percent had M1 disease, and 18% had M0 disease. Eighty-one percent had a primary tumor in the lower tract, and 18% of patients had a primary tumor in the upper tract. Seventy-six percent of patients had visceral metastases, including 11% with liver metastases. Reasons for cisplatin ineligibility included: 45% with baseline creatinine clearance of <60 mL/min, 37% with ECOG PS of 2, 10% with ECOG PS of 2 and baseline creatinine clearance of <60 mL/min, and 8% with other reasons (Class III heart failure, Grade 2 or greater peripheral neuropathy, and Grade 2 or greater hearing loss). Ninety percent of patients were treatment naïve, and 10% received prior adjuvant or neoadjuvant platinum-based chemotherapy.

The median follow-up time for 370 patients treated with KEYTRUDA was 7.8 months (range 0.1 to 20 months). Efficacy results are summarized in Table 41.

**Table 41: Efficacy Results in KEYNOTE-052**

Endpoint	KEYTRUDA 200 mg every 3 weeks		
	All Subjects n=370	PD-L1 CPS <10 n=260*	PD-L1 CPS ≥10 n=110
<b>Objective Response Rate</b>			
ORR (95% CI)	29% (24, 34)	21% (16, 26)	47% (38, 57)
Complete response rate	7%	3%	15%
Partial response rate	22%	18%	32%
<b>Duration of Response</b>			
Median in months (range)	NR (1.4+, 17.8+)	NR (1.4+, 16.3+)	NR (1.4+, 17.8+)

\* Includes 9 subjects with unknown PD-L1 status

+ Denotes ongoing

NR = not reached

### Previously Untreated Urothelial Carcinoma

KEYNOTE-361 (NCT02853305) is an ongoing, multicenter, randomized study in previously untreated patients with metastatic urothelial carcinoma who are eligible for platinum-containing chemotherapy. The study compares KEYTRUDA with or without platinum-based chemotherapy (i.e., cisplatin or carboplatin with gemcitabine) to platinum-based chemotherapy alone. The trial also enrolled a third arm of monotherapy with KEYTRUDA to compare to platinum-based chemotherapy alone. The independent Data Monitoring Committee (iDMC) for the study conducted a review of early data and found that in patients classified as having low PD-L1 expression (CPS <10), those treated with KEYTRUDA monotherapy had decreased survival compared to those who received platinum-based chemotherapy. The iDMC recommended to stop further accrual of patients with low PD-L1 expression in the monotherapy arm, however, no other changes were recommended, including any change of therapy for patients who had already been randomized to and were receiving treatment in the monotherapy arm.

### Previously Treated Urothelial Carcinoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-045 (NCT02256436), a multicenter, randomized (1:1), active-controlled trial in 542 patients with locally advanced or metastatic urothelial carcinoma with disease progression on or after platinum-containing chemotherapy. The trial excluded patients with autoimmune disease or a medical condition that required immunosuppression.

Patients were randomized to receive either KEYTRUDA 200 mg every 3 weeks (n=270) or investigator's choice of any of the following chemotherapy regimens all given intravenously every 3 weeks (n=272): paclitaxel 175 mg/m<sup>2</sup> (n=90), docetaxel 75 mg/m<sup>2</sup> (n=92), or vinflunine 320 mg/m<sup>2</sup> (n=90). Treatment continued until unacceptable toxicity or disease progression. Patients with initial radiographic disease progression could receive additional doses of treatment during confirmation of progression unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, or occurred with a decline in performance status. Patients without disease progression could be treated for up to 24 months. Assessment of tumor status was performed at 9 weeks after randomization, then every 6 weeks through the first year, followed by every 12 weeks thereafter. The major efficacy outcomes were OS and PFS as assessed by BICR per RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ. Additional efficacy outcome measures were ORR as assessed by BICR per RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, and DoR.

The study population characteristics were: median age of 66 years (range: 26 to 88), 58% age 65 or older; 74% male; 72% White and 23% Asian; 42% ECOG PS of 0 and 56% ECOG PS of 1; and 96% M1 disease and 4% M0 disease. Eighty-seven percent of patients had visceral metastases, including 34% with liver metastases. Eighty-six percent had a primary tumor in the lower tract and 14% had a primary tumor in the upper tract. Fifteen percent of patients had disease progression following prior platinum-containing neoadjuvant or adjuvant chemotherapy. Twenty-one percent had received 2 or more prior systemic regimens in the metastatic setting. Seventy-six percent of patients received prior cisplatin, 23% had prior carboplatin, and 1% were treated with other platinum-based regimens.

The study demonstrated statistically significant improvements in OS and ORR for patients randomized to KEYTRUDA as compared to chemotherapy. There was no statistically significant difference between KEYTRUDA and chemotherapy with respect to PFS. The median follow-up time for this trial was 9.0 months (range: 0.2 to 20.8 months). Table 42 and Figure 11 summarize the efficacy results for KEYNOTE-045.

**Table 42: Efficacy Results in KEYNOTE-045**

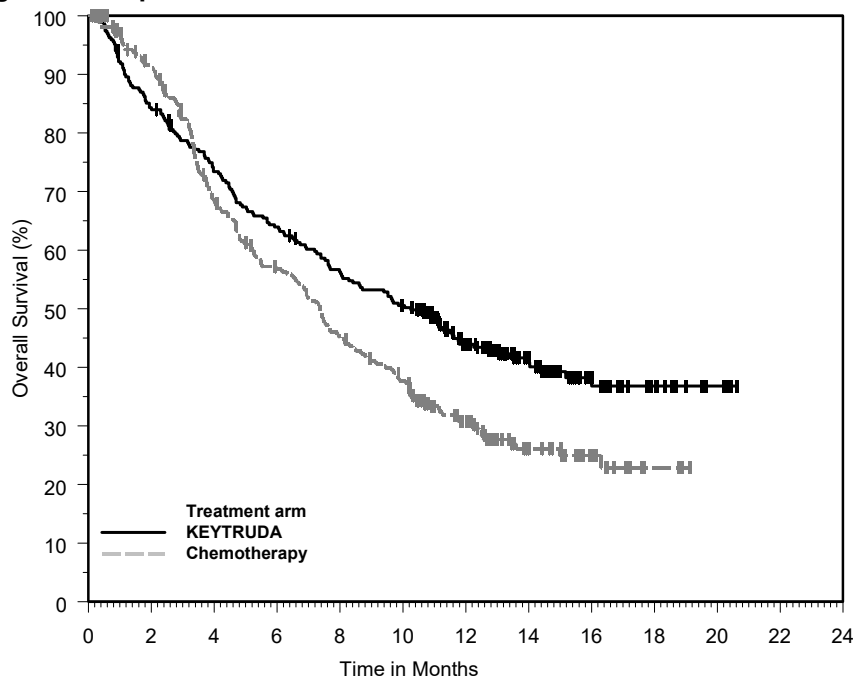
	<b>KEYTRUDA 200 mg every 3 weeks n=270</b>	<b>Chemotherapy n=272</b>
<b>OS</b>		
Deaths (%)	155 (57%)	179 (66%)
Median in months (95% CI)	10.3 (8.0, 11.8)	7.4 (6.1, 8.3)
Hazard ratio* (95% CI)	0.73 (0.59, 0.91)	
p-Value (stratified log-rank)	0.004	
<b>PFS by BICR</b>		
Events (%)	218 (81%)	219 (81%)
Median in months (95% CI)	2.1 (2.0, 2.2)	3.3 (2.3, 3.5)
Hazard ratio* (95% CI)	0.98 (0.81, 1.19)	
p-Value (stratified log-rank)	0.833	
<b>Objective Response Rate</b>		
ORR (95% CI)	21% (16, 27)	11% (8, 16)
Complete response rate	7%	3%
Partial response rate	14%	8%
p-Value (Miettinen-Nurminen)	0.002	
Median duration of response in months (range)	NR (1.6+, 15.6+)	4.3 (1.4+, 15.4+)

\* Hazard ratio (KEYTRUDA compared to chemotherapy) based on the stratified Cox proportional hazard model

+ Denotes ongoing

NR = not reached

**Figure 11: Kaplan-Meier Curve for Overall Survival in KEYNOTE-045**



Number at Risk	0	2	4	6	8	10	12	14	16	18	20	24
KEYTRUDA:	270	226	194	169	147	131	87	54	27	13	4	0
Chemotherapy:	272	232	171	138	109	89	55	27	14	3	0	0

## 14.8 Microsatellite Instability-High Cancer

The efficacy of KEYTRUDA was investigated in patients with MSI-H or mismatch repair deficient (dMMR), solid tumors enrolled in one of five uncontrolled, open-label, multi-cohort, multi-center, single-arm trials. Patients with active autoimmune disease or a medical condition that required immunosuppression were ineligible across the five trials. Patients received either KEYTRUDA 200 mg every 3 weeks or KEYTRUDA 10 mg/kg every 2 weeks. Treatment continued until unacceptable toxicity or disease progression that was either symptomatic, rapidly progressive, required urgent intervention, or occurred with a decline in performance status. A maximum of 24 months of treatment with KEYTRUDA was administered. For the purpose of assessment of anti-tumor activity across these 5 trials, the major efficacy outcome measures were ORR as assessed by BICR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, and DoR.

**Table 43: MSI-H Trials**

Study	Design and Patient Population	Number of Patients	MSI-H/dMMR Testing	Dosage	Prior Therapy
<b>KEYNOTE-016</b> NCT01876511	<ul style="list-style-type: none"> <li>prospective, investigator-initiated</li> <li>6 sites</li> <li>patients with CRC and other tumors</li> </ul>	28 CRC 30 non-CRC	local PCR or IHC	10 mg/kg every 2 weeks	<ul style="list-style-type: none"> <li>CRC: ≥ 2 prior regimens</li> <li>Non-CRC: ≥ 1 prior regimen</li> </ul>
<b>KEYNOTE-164</b> NCT02460198	<ul style="list-style-type: none"> <li>prospective international multi-center</li> <li>CRC</li> </ul>	61	local PCR or IHC	200 mg every 3 weeks	Prior fluoropyrimidine, oxaliplatin, and irinotecan +/- anti-VEGF/EGFR mAb
<b>KEYNOTE-012</b> NCT01848834	<ul style="list-style-type: none"> <li>retrospectively identified patients with PD-L1-positive gastric, bladder, or triple-negative breast cancer</li> </ul>	6	central PCR	10 mg/kg every 2 weeks	≥ 1 prior regimen
<b>KEYNOTE-028</b> NCT02054806	<ul style="list-style-type: none"> <li>retrospectively identified patients with PD-L1-positive esophageal, biliary, breast, endometrial, or CRC</li> </ul>	5	central PCR	10 mg/kg every 2 weeks	≥ 1 prior regimen
<b>KEYNOTE-158</b> NCT02628067	<ul style="list-style-type: none"> <li>prospective international multi-center enrollment of patients with MSI-H/dMMR non-CRC</li> <li>retrospectively identified patients who were enrolled in specific rare tumor non-CRC cohorts</li> </ul>	19	local PCR or IHC (central PCR for patients in rare tumor non-CRC cohorts)	200 mg every 3 weeks	≥ 1 prior regimen
<b>Total</b>		<b>149</b>			

CRC = colorectal cancer

PCR = polymerase chain reaction

IHC = immunohistochemistry

A total of 149 patients with MSI-H or dMMR cancers were identified across the five trials. Among these 149 patients, the baseline characteristics were: median age of 55 years, 36% age 65 or older; 56% male; 77% White, 19% Asian, and 2% Black; and 36% ECOG PS of 0 and 64% ECOG PS of 1. Ninety-eight percent of patients had metastatic disease and 2% had locally advanced, unresectable disease. The median number of prior therapies for metastatic or unresectable disease was two. Eighty-four percent of patients with metastatic CRC and 53% of patients with other solid tumors received two or more prior lines of therapy.

The identification of MSI-H or dMMR tumor status for the majority of patients (135/149) was prospectively determined using local laboratory-developed, polymerase chain reaction (PCR) tests for MSI-H status or immunohistochemistry (IHC) tests for dMMR. Fourteen of the 149 patients were retrospectively identified as MSI-H by testing tumor samples from a total of 415 patients using a central laboratory developed PCR test. Forty-seven patients had dMMR cancer identified by IHC, 60 had MSI-H identified by PCR, and 42 were identified using both tests.

Efficacy results are summarized in Tables 44 and 45.

**Table 44: Efficacy Results for Patients with MSI-H/dMMR Cancer**

Endpoint	KEYTRUDA n=149
<b>Objective Response Rate</b>	
ORR (95% CI)	39.6% (31.7, 47.9)
Complete response rate	7.4%
Partial response rate	32.2%
<b>Duration of Response</b>	
Median in months (range)	NR (1.6+, 22.7+)
% with duration ≥6 months	78%

NR = not reached

**Table 45: Response by Tumor Type**

	N	Objective response rate n (%)	95% CI	DOR range (months)
<b>CRC</b>	90	32 (36%)	(26%, 46%)	(1.6+, 22.7+)
<b>Non-CRC</b>	59	27 (46%)	(33%, 59%)	(1.9+, 22.1+)
Endometrial cancer	14	5 (36%)	(13%, 65%)	(4.2+, 17.3+)
Biliary cancer	11	3 (27%)	(6%, 61%)	(11.6+, 19.6+)
Gastric or GE junction cancer	9	5 (56%)	(21%, 86%)	(5.8+, 22.1+)
Pancreatic cancer	6	5 (83%)	(36%, 100%)	(2.6+, 9.2+)
Small intestinal cancer	8	3 (38%)	(9%, 76%)	(1.9+, 9.1+)
Breast cancer	2	PR, PR		(7.6, 15.9)
Prostate cancer	2	PR, SD		9.8+
Bladder cancer	1	NE		
Esophageal cancer	1	PR		18.2+
Sarcoma	1	PD		
Thyroid cancer	1	NE		
Retroperitoneal adenocarcinoma	1	PR		7.5+
Small cell lung cancer	1	CR		8.9+
Renal cell cancer	1	PD		

CR = complete response  
 PR = partial response  
 SD = stable disease  
 PD = progressive disease  
 NE = not evaluable

## 14.9 Gastric Cancer

The efficacy of KEYTRUDA was investigated in KEYNOTE-059 (NCT02335411), a multicenter, non-randomized, open-label multi-cohort trial that enrolled 259 patients with gastric or gastroesophageal junction (GEJ) adenocarcinoma who progressed on at least 2 prior systemic treatments for advanced disease. Previous treatment must have included a fluoropyrimidine and platinum doublet. HER2/neu positive patients must have previously received treatment with approved HER2/neu-targeted therapy. Patients with active autoimmune disease or a medical condition that required immunosuppression or with clinical evidence of ascites by physical exam were ineligible. Patients received KEYTRUDA 200 mg every 3 weeks until unacceptable toxicity or disease progression that was symptomatic, rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at least 4 weeks later with repeat imaging. Patients without disease progression were treated for up to 24 months. Assessment of tumor status was performed every 6 to 9 weeks. The major efficacy outcome measures were ORR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, as assessed by BICR, and DoR.

Among the 259 patients, 55% (n = 143) had tumors that expressed PD-L1 with a CPS ≥1 and microsatellite stable (MSS) tumor status or undetermined MSI or MMR status. PD-L1 status was determined using the PD-L1 IHC 22C3 pharmDx kit. The baseline characteristics of these 143 patients were: median age of 64 years, 47% age 65 or older; 77% male; 82% White and 11% Asian; and 43% ECOG PS of 0 and 57% ECOG PS of 1. Eighty-five percent had M1 disease and 7% had M0 disease. Fifty-one percent had two and 49% had three or more prior lines of therapy in the recurrent or metastatic setting.

For the 143 patients, the ORR was 13.3% (95% CI: 8.2, 20.0); 1.4% had a complete response and 11.9% had a partial response. Among the 19 responding patients, the DoR ranged from 2.8+ to 19.4+ months, with 11 patients (58%) having responses of 6 months or longer and 5 patients (26%) having responses of 12 months or longer.

Among the 259 patients enrolled in KEYNOTE-059, 7 (3%) had tumors that were determined to be MSI-H. An objective response was observed in 4 patients, including 1 complete response. The DoR ranged from 5.3+ to 14.1+ months.

#### 14.10 Cervical Cancer

The efficacy of KEYTRUDA was investigated in 98 patients with recurrent or metastatic cervical cancer enrolled in a single cohort (Cohort E) in KEYNOTE-158 (NCT02628067), a multicenter, non-randomized, open-label, multi-cohort trial. The trial excluded patients with autoimmune disease or a medical condition that required immunosuppression. Patients received KEYTRUDA 200 mg intravenously every 3 weeks until unacceptable toxicity or documented disease progression. Patients with initial radiographic disease progression could receive additional doses of treatment during confirmation of progression unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, or occurred with a decline in performance status. Patients without disease progression could be treated for up to 24 months. Assessment of tumor status was performed every 9 weeks for the first 12 months, and every 12 weeks thereafter. The major efficacy outcome measures were ORR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, as assessed by BICR, and DoR.

Among the 98 patients in Cohort E, 77 (79%) had tumors that expressed PD-L1 with a CPS  $\geq$  1 and received at least one line of chemotherapy in the metastatic setting. PD-L1 status was determined using the IHC 22C3 pharmDx kit. The baseline characteristics of these 77 patients were: median age of 45 years (range: 27 to 75); 81% White, 14% Asian, and 3% Black; 32% ECOG PS of 0 and 68% ECOG PS of 1; 92% had squamous cell carcinoma, 6% adenocarcinoma, and 1% adenosquamous histology; 95% had M1 disease and 5% had recurrent disease; and 35% had one and 65% had two or more prior lines of therapy in the recurrent or metastatic setting.

No responses were observed in patients whose tumors did not have PD-L1 expression (CPS <1). Efficacy results are summarized in Table 46 for patients with PD-L1 expression (CPS  $\geq$ 1).

**Table 46: Efficacy Results in Patients with Recurrent or Metastatic Cervical Cancer (CPS  $\geq$ 1) in KEYNOTE-158**

Endpoint	KEYTRUDA 200 mg every 3 weeks n=77*
<b>Objective Response Rate</b>	
ORR (95% CI)	14.3% (7.4, 24.1)
Complete response rate	2.6%
Partial response rate	11.7%
<b>Duration of Response</b>	
Median in months (range)	NR (4.1, 18.6+) <sup>†</sup>
% with duration $\geq$ 6 months	91%

\* Median follow-up time of 11.7 months (range 0.6 to 22.7 months)

<sup>†</sup> Based on patients (n=11) with a response by independent review

+ Denotes ongoing

NR = not reached

#### 14.11 Hepatocellular Carcinoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-224 (NCT02702414), a single-arm, multicenter trial in 104 patients with HCC who had disease progression on or after sorafenib or were intolerant to sorafenib; had measurable disease; and Child-Pugh class A liver impairment. Patients with active autoimmune disease, greater than one etiology of hepatitis, a medical condition that required immunosuppression, or clinical evidence of ascites by physical exam were ineligible for the trial. Patients received KEYTRUDA 200 mg intravenously every 3 weeks until unacceptable toxicity, investigator-assessed confirmed disease progression (based on repeat scan at least 4 weeks from the initial scan

showing progression), or completion of 24 months of KEYTRUDA. Assessment of tumor status was performed every 9 weeks. The major efficacy outcome measures were ORR and DoR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, as assessed by BICR.

The study population characteristics were: median age of 68 years, 67% age 65 or older; 83% male; 81% White and 14% Asian; and 61% ECOG PS of 0 and 39% ECOG PS of 1. Child-Pugh class and score were A5 for 72%, A6 for 22%, B7 for 5%, and B8 for 1% of patients. Twenty-one percent of the patients were HBV seropositive and 25% HCV seropositive. There were 9 patients (9%) who were seropositive for both HBV and HCV. For these 9 patients, all of the HBV cases and three of the HCV cases were inactive. Sixty-four percent (64%) of patients had extrahepatic disease, 17% had vascular invasion, and 9% had both. Thirty-eight percent (38%) of patients had alpha-fetoprotein (AFP) levels  $\geq 400$  mcg/L. All patients received prior sorafenib; of whom 20% were unable to tolerate sorafenib. No patient received more than one prior systemic therapy (sorafenib).

Efficacy results are summarized in Table 47.

**Table 47: Efficacy Results in KEYNOTE-224**

Endpoint	KEYTRUDA 200 mg every 3 weeks n=104
<b>BICR-Assessed Objective Response Rate (RECIST v1.1)</b>	
ORR (95% CI)*	17% (11, 26)
Complete response rate	1%
Partial response rate	16%
<b>BICR-Assessed Response Duration</b>	
% with duration $\geq 6$ months	89%
% with duration $\geq 12$ months	56%

\* Based on patients (n=18) with a confirmed response by independent review

#### 14.12 Merkel Cell Carcinoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-017 (NCT02267603), a multicenter, non-randomized, open-label trial that enrolled 50 patients with recurrent locally advanced or metastatic MCC who had not received prior systemic therapy for their advanced disease. Patients with active autoimmune disease or a medical condition that required immunosuppression were ineligible.

Patients received KEYTRUDA 2 mg/kg every 3 weeks until unacceptable toxicity or disease progression that was symptomatic, rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at least 4 weeks later with repeat imaging. Patients without disease progression were treated for up to 24 months. Assessment of tumor status was performed at 13 weeks followed by every 9 weeks for the first year and every 12 weeks thereafter. The major efficacy outcome measures were ORR and DoR as assessed by BICR per RECIST v1.1.

The study population characteristics were: median age of 71 years (range: 46 to 91), 80% age 65 or older; 68% male; 90% White; and 48% ECOG PS of 0 and 52% ECOG PS of 1. Fourteen percent had stage IIIB disease and 86% had stage IV. Eighty-four percent of patients had prior surgery and 70% had prior radiation therapy.

Efficacy results are summarized in Table 48.

**Table 48: Efficacy Results in KEYNOTE-017**

Endpoint	KEYTRUDA 2 mg/kg every 3 weeks n=50
<b>Objective Response Rate</b>	
ORR (95% CI)	56% (41, 70)
Complete response rate (95% CI)	24% (13, 38)
Partial response rate (95% CI)	32% (20, 47)
<b>Duration of Response</b>	
Range in months*	5.9-34.5+
Patients with duration ≥6 months, n (%)	27 (96%)
Patients with duration ≥12 months, n (%)	15 (54%)

\* The median duration of response was not reached.

### 14.13 Renal Cell Carcinoma

The efficacy of KEYTRUDA in combination with axitinib was investigated in KEYNOTE-426 (NCT02853331), a randomized, multicenter, open-label trial conducted in 861 patients who had not received systemic therapy for advanced RCC. Patients were enrolled regardless of PD-L1 tumor expression status. Patients with active autoimmune disease requiring systemic immunosuppression within the last 2 years were ineligible. Randomization was stratified by International Metastatic RCC Database Consortium (IMDC) risk categories (favorable versus intermediate versus poor) and geographic region (North America versus Western Europe versus “Rest of the World”).

Patients were randomized (1:1) to one of the following treatment arms:

- KEYTRUDA 200 mg intravenously every 3 weeks up to 24 months in combination with axitinib 5 mg orally, twice daily. Patients who tolerated axitinib 5 mg twice daily for 2 consecutive cycles (6 weeks) could increase to 7 mg and then subsequently to 10 mg twice daily. Axitinib could be interrupted or reduced to 3 mg twice daily and subsequently to 2 mg twice daily to manage toxicity.
- Sunitinib 50 mg orally, once daily for 4 weeks and then off treatment for 2 weeks.

Treatment with KEYTRUDA and axitinib continued until RECIST v1.1-defined progression of disease or unacceptable toxicity. Administration of KEYTRUDA and axitinib was permitted beyond RECIST-defined disease progression if the patient was clinically stable and considered to be deriving clinical benefit by the investigator. Assessment of tumor status was performed at baseline, after randomization at Week 12, then every 6 weeks thereafter until Week 54, and then every 12 weeks thereafter.

The study population characteristics were: median age of 62 years (range: 26 to 90); 38% age 65 or older; 73% male; 79% White and 16% Asian; 19% and 80% of patients had a baseline KPS of 70 to 80 and 90 to 100, respectively; and patient distribution by IMDC risk categories was 31% favorable, 56% intermediate and 13% poor.

The main efficacy outcome measures were OS and PFS as assessed by BICR according to RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ. Additional efficacy outcome measures included ORR, as assessed by BICR. A statistically significant improvement in OS was demonstrated at the pre-specified interim analysis in patients randomized to KEYTRUDA in combination with axitinib compared with sunitinib. The trial also demonstrated statistically significant improvements in PFS and ORR. Table 49 and Figure 12 summarize the efficacy results for KEYNOTE-426. The median follow-up time was 12.8 months (range 0.1 to 22.0 months). Consistent results were observed across pre-specified subgroups, IMDC risk categories and PD-L1 tumor expression status.



**Table 49: Efficacy Results in KEYNOTE-426**

Endpoint	KEYTRUDA 200 mg every 3 weeks and Axitinib n=432	Sunitinib  n=429
<b>OS</b>		
Number of patients with event (%)	59 (14%)	97 (23%)
Median in months (95% CI)	NR (NR, NR)	NR (NR, NR)
Hazard ratio* (95% CI)	0.53 (0.38, 0.74)	
p-Value <sup>†</sup>	<0.0001 <sup>‡</sup>	
12-month OS rate	90% (86, 92)	78% (74, 82)
<b>PFS</b>		
Number of patients with event (%)	183 (42%)	212 (49%)
Median in months (95% CI)	15.1 (12.6, 17.7)	11.1 (8.7, 12.5)
Hazard ratio* (95% CI)	0.69 (0.57, 0.84)	
p-Value <sup>†</sup>	0.0001 <sup>§</sup>	
<b>ORR</b>		
Overall confirmed response rate (95% CI)	59% (54, 64)	36% (31, 40)
Complete response rate	6%	2%
Partial response rate	53%	34%
p-Value <sup>¶</sup>	<0.0001	

\* Based on the stratified Cox proportional hazard model

<sup>†</sup> Based on stratified log-rank test

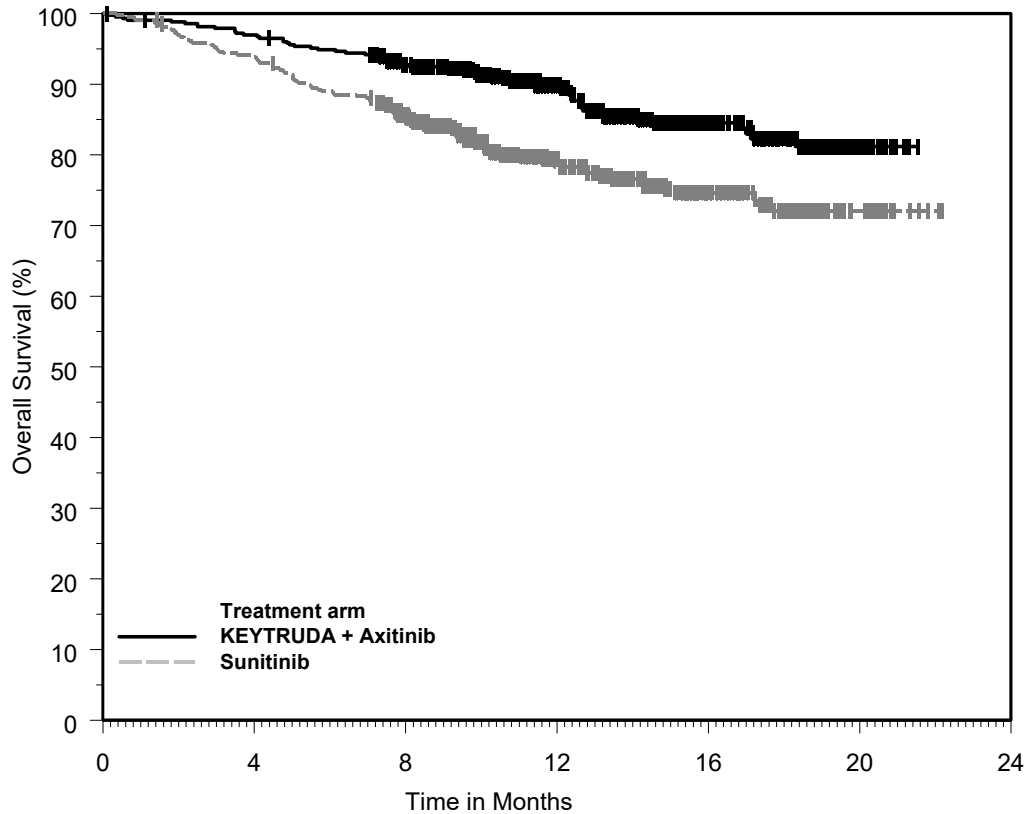
<sup>‡</sup> p-Value (one-sided) is compared with the allocated alpha of 0.0001 for this interim analysis (with 39% of the planned number of events for final analysis).

<sup>§</sup> p-Value (one-sided) is compared with the allocated alpha of 0.0013 for this interim analysis (with 81% of the planned number of events for final analysis).

<sup>¶</sup> Based on Miettinen and Nurminen method stratified by IMDC risk group and geographic region

NR = not reached

**Figure 12: Kaplan-Meier Curve for Overall Survival in KEYNOTE-426**



Number at Risk		Time in Months					
	0	4	8	12	16	20	24
KEYTRUDA + Axitinib:	432	417	378	256	136	18	0
Sunitinib:	429	401	341	211	110	20	0

## 16 HOW SUPPLIED/STORAGE AND HANDLING

KEYTRUDA for injection (white to off-white lyophilized powder):

Carton containing one 50 mg single-dose vial (NDC 0006-3029-02)  
Store vials under refrigeration at 2°C to 8°C (36°F to 46°F).

KEYTRUDA injection (clear to slightly opalescent, colorless to slightly yellow solution):

Carton containing one 100 mg/4 mL (25 mg/mL), single-dose vial (NDC 0006-3026-02)  
Carton containing two 100 mg/4 mL (25 mg/mL), single-dose vials (NDC 0006-3026-04)  
Store vials under refrigeration at 2°C to 8°C (36°F to 46°F) in original carton to protect from light. Do not freeze. Do not shake.

## 17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide).

### Immune-Mediated Adverse Reactions

- Inform patients of the risk of immune-mediated adverse reactions that may be severe or fatal, may occur after discontinuation of treatment, and may require corticosteroid treatment and interruption or discontinuation of KEYTRUDA. These reactions may include:
  - Pneumonitis: Advise patients to contact their healthcare provider immediately for new or worsening cough, chest pain, or shortness of breath [see *Warnings and Precautions* (5.1)].

- Colitis: Advise patients to contact their healthcare provider immediately for diarrhea or severe abdominal pain [see *Warnings and Precautions* (5.2)].
- Hepatitis: Advise patients to contact their healthcare provider immediately for jaundice, severe nausea or vomiting, or easy bruising or bleeding [see *Warnings and Precautions* (5.3)].
- Hypophysitis: Advise patients to contact their healthcare provider immediately for persistent or unusual headache, extreme weakness, dizziness or fainting, or vision changes [see *Warnings and Precautions* (5.4)].
- Hyperthyroidism and Hypothyroidism: Advise patients to contact their healthcare provider immediately for signs or symptoms of hyperthyroidism and hypothyroidism [see *Warnings and Precautions* (5.4)].
- Type 1 Diabetes Mellitus: Advise patients to contact their healthcare provider immediately for signs or symptoms of type 1 diabetes [see *Warnings and Precautions* (5.4)].
- Nephritis: Advise patients to contact their healthcare provider immediately for signs or symptoms of nephritis [see *Warnings and Precautions* (5.5)].
- Severe skin reactions: Advise patients to contact their healthcare provider immediately for any signs or symptoms of severe skin reactions, SJS or TEN [see *Warnings and Precautions* (5.6)].
- Other immune-mediated adverse reactions:
  - Advise patients that immune-mediated adverse reactions can occur and may involve any organ system, and to contact their healthcare provider immediately for any new signs or symptoms [see *Warnings and Precautions* (5.7)].
  - Advise patients of the risk of solid organ transplant rejection and to contact their healthcare provider immediately for signs or symptoms of organ transplant rejection [see *Warnings and Precautions* (5.7)].

#### Infusion-Related Reactions

- Advise patients to contact their healthcare provider immediately for signs or symptoms of infusion-related reactions [see *Warnings and Precautions* (5.8)].

#### Complications of Allogeneic HSC T

- Advise patients of the risk of post-allogeneic hematopoietic stem cell transplantation complications [see *Warnings and Precautions* (5.9)].

#### Embryo-Fetal Toxicity

- Advise females of reproductive potential of the potential risk to a fetus and to inform their healthcare provider of a known or suspected pregnancy [see *Warnings and Precautions* (5.11), *Use in Specific Populations* (8.1, 8.3)].
- Advise females of reproductive potential to use effective contraception during treatment with KEYTRUDA and for 4 months after the last dose [see *Warnings and Precautions* (5.11), *Use in Specific Populations* (8.1, 8.3)].

#### Lactation

- Advise women not to breastfeed during treatment with KEYTRUDA and for 4 months after the final dose [see *Use in Specific Populations* (8.2)].

#### Laboratory Tests

- Advise patients of the importance of keeping scheduled appointments for blood work or other laboratory tests [see *Warnings and Precautions* (5.3, 5.4, 5.5)].

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 **MERCK & CO., INC.**, Whitehouse Station, NJ 08889, USA

U.S. License No. 0002

For KEYTRUDA for injection, at:  
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County Cork, Ireland

For KEYTRUDA injection, at:  
MSD Ireland (Carlow)  
County Carlow, Ireland

For patent information: [www.merck.com/product/patent/home.html](http://www.merck.com/product/patent/home.html)

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## MEDICATION GUIDE

**KEYTRUDA® (key-true-duh)  
(pembrolizumab)  
for injection**

**KEYTRUDA® (key-true-duh)  
(pembrolizumab)  
injection**

### **What is the most important information I should know about KEYTRUDA?**

KEYTRUDA is a medicine that may treat certain cancers by working with your immune system. KEYTRUDA can cause your immune system to attack normal organs and tissues in any area of your body and can affect the way they work. These problems can sometimes become severe or life-threatening and can lead to death. These problems may happen anytime during treatment or even after your treatment has ended.

**Call or see your doctor right away if you develop any symptoms of the following problems or these symptoms get worse:**

**Lung problems (pneumonitis).** Symptoms of pneumonitis may include:

- shortness of breath
- chest pain
- new or worse cough

**Intestinal problems (colitis) that can lead to tears or holes in your intestine.** Signs and symptoms of colitis may include:

- diarrhea or more bowel movements than usual
- stools that are black, tarry, sticky, or have blood or mucus
- severe stomach-area (abdomen) pain or tenderness

**Liver problems, including hepatitis.** Signs and symptoms of liver problems may include:

- yellowing of your skin or the whites of your eyes
- nausea or vomiting
- pain on the right side of your stomach area (abdomen)
- dark urine
- bleeding or bruising more easily than normal

**Hormone gland problems (especially the thyroid, pituitary, adrenal glands, and pancreas).** Signs and symptoms that your hormone glands are not working properly may include:

- rapid heart beat
- weight loss or weight gain
- increased sweating
- feeling more hungry or thirsty
- urinating more often than usual
- hair loss
- feeling cold
- constipation
- your voice gets deeper
- muscle aches
- dizziness or fainting
- headaches that will not go away or unusual headache

**Kidney problems, including nephritis and kidney failure.** Signs of kidney problems may include:

- change in the amount or color of your urine

**Skin problems.** Signs of skin problems may include:

- rash
- itching
- blisters, peeling or skin sores
- painful sores or ulcers in your mouth or in your nose, throat, or genital area

**Problems in other organs.** Signs and symptoms of these problems may include:

- changes in eyesight
- severe or persistent muscle or joint pains
- severe muscle weakness
- low red blood cells (anemia)
- swollen lymph nodes, rash or tender lumps on skin, cough, shortness of breath, vision changes, or eye pain (sarcoidosis)

- confusion, fever, muscle weakness, balance problems, nausea, vomiting, stiff neck, memory problems, or seizures (encephalitis)
- shortness of breath, irregular heartbeat, feeling tired, or chest pain (myocarditis)

**Infusion (IV) reactions that can sometimes be severe and life-threatening.** Signs and symptoms of infusion reactions may include:

- chills or shaking
- shortness of breath or wheezing
- itching or rash
- flushing
- dizziness
- fever
- feeling like passing out

**Rejection of a transplanted organ.** People who have had an organ transplant may have an increased risk of organ transplant rejection. Your doctor should tell you what signs and symptoms you should report and monitor you, depending on the type of organ transplant that you have had.

**Complications, including graft-versus-host-disease (GVHD), in people who have received a bone marrow (stem cell) transplant that uses donor stem cells (allogeneic).** These complications can be severe and can lead to death. These complications may happen if you underwent transplantation either before or after being treated with KEYTRUDA. Your doctor will monitor you for the following signs and symptoms: skin rash, liver inflammation, stomach-area (abdominal) pain, and diarrhea.

**Getting medical treatment right away may help keep these problems from becoming more serious.**

Your doctor will check you for these problems during treatment with KEYTRUDA. Your doctor may treat you with corticosteroid or hormone replacement medicines. Your doctor may also need to delay or completely stop treatment with KEYTRUDA, if you have severe side effects.

### **What is KEYTRUDA?**

KEYTRUDA is a prescription medicine used to treat:

- a kind of skin cancer called melanoma. KEYTRUDA may be used:
  - when your melanoma has spread or cannot be removed by surgery (advanced melanoma), **or**
  - to help prevent melanoma from coming back after it and lymph nodes that contain cancer have been removed by surgery.
- a kind of lung cancer called non-small cell lung cancer (NSCLC).
  - KEYTRUDA may be used with the chemotherapy medicines pemetrexed and a platinum as your first treatment when your lung cancer:
    - has spread (advanced NSCLC), **and**
    - is a type called “nonsquamous”, **and**
    - your tumor does not have an abnormal “EGFR” or “ALK” gene.
  - KEYTRUDA may be used with the chemotherapy medicines carboplatin and either paclitaxel or paclitaxel protein-bound as your first treatment when your lung cancer:
    - has spread (advanced NSCLC), **and**
    - is a type called “squamous”.
  - KEYTRUDA may be used alone as your first treatment when your lung cancer:
    - has not spread outside your chest (stage III) and you cannot have surgery or chemotherapy with radiation **or**
    - your NSCLC has spread to other areas of your body (advanced NSCLC), **and**
    - your tumor tests positive for “PD-L1”, **and**
    - does not have an abnormal “EGFR” or “ALK” gene.
  - KEYTRUDA may also be used alone when:
    - you have received chemotherapy that contains platinum to treat your advanced NSCLC, and it did not work or it is no longer working, **and**
    - your tumor tests positive for “PD-L1”, **and**
    - if your tumor has an abnormal “EGFR” or “ALK” gene, you have also received an EGFR or ALK inhibitor medicine and it did not work or is no longer working.
- a kind of lung cancer called small cell lung cancer (SCLC). KEYTRUDA may be used when your lung cancer:
  - has spread (advanced SCLC), **and**

- you have received 2 or more types of chemotherapy, including one that contains platinum, and it did not work or is no longer working.
- a kind of cancer called head and neck squamous cell cancer (HNSCC).
  - KEYTRUDA may be used with the chemotherapy medicines fluorouracil and a platinum as your first treatment when your head and neck cancer has spread or returned and cannot be removed by surgery.
  - KEYTRUDA may be used alone as your first treatment when your head and neck cancer:
    - has spread or returned and cannot be removed by surgery, **and**
    - your tumor tests positive for “PD-L1”.
  - KEYTRUDA may be used alone when your head and neck cancer:
    - has spread or returned, **and**
    - you have received chemotherapy that contains platinum and it did not work or is no longer working.
- a kind of cancer called classical Hodgkin lymphoma (cHL) in adults and children when:
  - you have tried a treatment and it did not work **or**
  - your cHL has returned after you received 3 or more types of treatment.
- a kind of cancer called primary mediastinal B-cell lymphoma (PMBCL) in adults and children when:
  - you have tried a treatment and it did not work **or**
  - your PMBCL has returned after you received 2 or more types of treatment.
- a kind of bladder and urinary tract cancer called urothelial carcinoma. KEYTRUDA may be used when your bladder or urinary tract cancer:
  - has spread or cannot be removed by surgery (advanced urothelial cancer) **and**,
  - you are not able to receive chemotherapy that contains a medicine called cisplatin, and your tumor tests positive for “PD-L1”, **or**
  - you are not able to receive a medicine called cisplatin or carboplatin, **or**
  - you have received chemotherapy that contains platinum, and it did not work or is no longer working.
- a kind of cancer that is shown by a laboratory test to be a microsatellite instability-high (MSI-H) or a mismatch repair deficient (dMMR) solid tumor. KEYTRUDA may be used in adults and children to treat:
  - cancer that has spread or cannot be removed by surgery (advanced cancer), **and**
  - has progressed following treatment, and you have no satisfactory treatment options, **or**
  - you have colon or rectal cancer, and you have received chemotherapy with fluoropyrimidine, oxaliplatin, and irinotecan but it did not work or is no longer working.

It is not known if KEYTRUDA is safe and effective in children with MSI-H cancers of the brain or spinal cord (central nervous system cancers).
- a kind of stomach cancer called gastric or gastroesophageal junction (GEJ) adenocarcinoma that tests positive for “PD-L1.” KEYTRUDA may be used when your stomach cancer:
  - has returned or spread (advanced gastric cancer), **and**
  - you have received 2 or more types of chemotherapy including fluoropyrimidine and chemotherapy that contains platinum, and it did not work or is no longer working, **and**
  - if your tumor has an abnormal “HER2/neu” gene, you also received a HER2/neu-targeted medicine and it did not work or is no longer working.
- a kind of cancer called cervical cancer that tests positive for “PD-L1.” KEYTRUDA may be used when your cervical cancer:
  - has returned, or has spread or cannot be removed by surgery (advanced cervical cancer), **and**
  - you have received chemotherapy, and it did not work or is no longer working.
- a kind of liver cancer called hepatocellular carcinoma, after you have received the medicine sorafenib.
- a kind of skin cancer called Merkel cell carcinoma (MCC) in adults and children. KEYTRUDA may be used to treat your skin cancer when it has spread or returned.
- a kind of kidney cancer called renal cell carcinoma (RCC). KEYTRUDA may be used with the medicine axitinib as your first treatment when your kidney cancer has spread or cannot be removed by surgery (advanced RCC).

### **What should I tell my doctor before receiving KEYTRUDA?**

#### **Before you receive KEYTRUDA, tell your doctor if you:**

- have immune system problems such as Crohn’s disease, ulcerative colitis, or lupus
- have received an organ transplant, such as a kidney or liver
- have received or plan to receive a stem cell transplant that uses donor stem cells (allogeneic)
- have lung or breathing problems
- have liver problems
- have any other medical problems
- are pregnant or plan to become pregnant
  - KEYTRUDA can harm your unborn baby.

#### **Females who are able to become pregnant:**

- Your doctor will give you a pregnancy test before you start treatment with KEYTRUDA.

- You should use an effective method of birth control during and for at least 4 months after the final dose of KEYTRUDA. Talk to your doctor about birth control methods that you can use during this time.
- Tell your doctor right away if you think you may be pregnant or if you become pregnant during treatment with KEYTRUDA.
- are breastfeeding or plan to breastfeed.
  - It is not known if KEYTRUDA passes into your breast milk.
  - Do not breastfeed during treatment with KEYTRUDA and for 4 months after your final dose of KEYTRUDA.

**Tell your doctor about all the medicines you take**, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

Know the medicines you take. Keep a list of them to show your doctor and pharmacist when you get a new medicine.

#### How will I receive KEYTRUDA?

- Your doctor will give you KEYTRUDA into your vein through an intravenous (IV) line over 30 minutes.
- KEYTRUDA is usually given every 3 weeks.
- Your doctor will decide how many treatments you need.
- Your doctor will do blood tests to check you for side effects.
- If you miss any appointments, call your doctor as soon as possible to reschedule your appointment.

#### What are the possible side effects of KEYTRUDA?

**KEYTRUDA can cause serious side effects. See “What is the most important information I should know about KEYTRUDA?”**

**Common side effects of KEYTRUDA when used alone include:** feeling tired, pain, including pain in muscles, bones or joints and stomach-area (abdominal) pain, decreased appetite, itching, diarrhea, nausea, rash, fever, cough, shortness of breath, and constipation.

**Common side effects of KEYTRUDA when given with certain chemotherapy medicines include:** feeling tired or weak, nausea, constipation, diarrhea, decreased appetite, rash, vomiting, cough, trouble breathing, fever, hair loss, inflammation of the nerves that may cause pain, weakness, and paralysis in the arms and legs, swelling of the lining of the mouth, nose, eyes, throat, intestines, or vagina, and mouth sores.

**Common side effects of KEYTRUDA when given with axitinib include:** diarrhea, feeling tired or weak, high blood pressure, liver problems, low levels of thyroid hormone, decreased appetite, blisters or rash on the palms of your hands and soles of your feet, nausea, mouth sores or swelling of the lining of the mouth, nose, eyes, throat, intestines, or vagina, hoarseness, rash, cough, and constipation.

In children, feeling tired, vomiting and stomach-area (abdominal) pain, and increased levels of liver enzymes and decreased levels of salt (sodium) in the blood are more common than in adults.

These are not all the possible side effects of KEYTRUDA. For more information, ask your doctor or pharmacist.

Tell your doctor if you have any side effect that bothers you or that does not go away.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

#### General information about the safe and effective use of KEYTRUDA

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. If you would like more information about KEYTRUDA, talk with your doctor. You can ask your doctor or nurse for information about KEYTRUDA that is written for healthcare professionals. For more information, go to [www.keytruda.com](http://www.keytruda.com).

#### What are the ingredients in KEYTRUDA?

**Active ingredient:** pembrolizumab

**Inactive ingredients:**

KEYTRUDA for injection: L-histidine, polysorbate 80, and sucrose. May contain hydrochloric acid/sodium hydroxide.

KEYTRUDA injection: L-histidine, polysorbate 80, sucrose, and Water for Injection, USP.



Manufactured by: Merck Sharp & Dohme Corp., a subsidiary of  
**MERCK & CO., INC.**, Whitehouse Station, NJ 08889, USA

For KEYTRUDA for injection, at:  
MSD International GmbH, County Cork, Ireland

For KEYTRUDA injection, at:  
MSD Ireland (Carlow), County Carlow, Ireland  
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