HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use KEYTRUDA safely and effectively. See full prescribing information for KEYTRUDA.

KEYTRUDA® (pembrolizumab) for injection, for intravenous use
KEYTRUDA® (pembrolizumab) injection, for intravenous use
Initial U.S. Approval: 2014

----------RECENT MAJOR CHANGES----------

Indications and Usage (1)	07/2019
Dosage and Administration (2)	07/2019
Warnings and Precautions (5)	06/2019

----------INDICATIONS AND USAGE----------

KEYTRUDA is a programmed death receptor-1 (PD-1)-blocking antibody indicated:

Melanoma
- for the treatment of patients with unresectable or metastatic melanoma. (1.1)
- for the adjuvant treatment of patients with melanoma with involvement of lymph node(s) following complete resection. (1.1)

Non-Small Cell Lung Cancer (NSCLC)
- in combination with pemetrexed and platinum chemotherapy, as first-line treatment of patients with metastatic nonsquamous NSCLC, with no EGFR or ALK genomic tumor aberrations. (1.2)
- in combination with carboplatin and either paclitaxel or paclitaxel protein-bound, as first-line treatment of patients with metastatic squamous NSCLC. (1.2)
- as a single agent for the first-line treatment of patients with NSCLC expressing PD-L1 [Tumor Proportion Score (TPS) ≥1%] as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations, and is:
  - stage III where patients are not candidates for surgical resection or definitive chemoradiation, or
  - metastatic. (1.2, 2.1)
- as a single agent for the treatment of patients with metastatic NSCLC whose tumors express PD-L1 (TPS ≥1%) as determined by an FDA-approved test, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving KEYTRUDA. (1.2, 2.1)

Small Cell Lung Cancer (SCLC)
- for the treatment of patients with metastatic SCLC with disease progression on or after platinum-based chemotherapy and at least one other prior line of therapy.[1] (1.3)

Head and Neck Squamous Cell Cancer (HNSCC)
- in combination with platinum and FU for the first-line treatment of patients with metastatic or with unresectable, recurrent HNSCC. (1.4)
- as a single agent for the first-line treatment of patients with metastatic or with unresectable, recurrent HNSCC whose tumors express PD-L1 [Combined Positive Score (CPS) ≥1] as determined by an FDA-approved test. (1.4, 2.1)
- as a single agent for the treatment of patients with recurrent or metastatic HNSCC with disease progression on or after platinum-containing chemotherapy. (1.4)

Classical Hodgkin Lymphoma (cHL)
- for the treatment of adult and pediatric patients with refractory cHL, or who have relapsed after 3 or more prior lines of therapy.[1] (1.5)

Primary Mediastinal Large B-Cell Lymphoma (PMBCL)
- for the treatment of adult and pediatric patients with refractory PMBCL, or who have relapsed after 2 or more prior lines of therapy.[1] (1.6)
- Limitations of Use: KEYTRUDA is not recommended for treatment of patients with PMBCL who require urgent cytoreductive therapy.

Urothelial Carcinoma
- for the treatment of patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy and whose tumors express PD-L1 [Combined Positive Score (CPS) ≥10] as determined by an FDA-approved test, or in patients who are not eligible for any platinum-containing chemotherapy regardless of PD-L1 status.[1] (1.7, 2.1)
- for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. (1.7)

Microsatellite Instability-High Cancer
- for the treatment of adult and pediatric patients with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient
  - solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options,[1] or
  - colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.[1] (1.8)
- Limitations of Use: The safety and effectiveness of KEYTRUDA in pediatric patients with MSI-H central nervous system cancers have not been established. (1.8)

Gastric Cancer
- for the treatment of patients with recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 [Combined Positive Score (CPS) ≥1] as determined by an FDA-approved test, with disease progression on or after 2 or more prior lines of therapy including fluoropyrimidine- and platinum-containing chemotherapy and if appropriate, HER2/neu-targeted therapy.[1] (1.9, 2.1)

Esophageal Cancer
- for the treatment of patients with recurrent locally advanced or metastatic squamous cell carcinoma of the esophagus whose tumors express PD-L1 [Combined Positive Score (CPS) ≥10] as determined by an FDA-approved test, with disease progression after one or more prior lines of systemic therapy. (1.10, 2.1)

Cervical Cancer
- for the treatment of patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy whose tumors express PD-L1 [Combined Positive Score (CPS) ≥1] as determined by an FDA-approved test.[1] (1.11, 2.1)

Hepatocellular Carcinoma (HCC)
- for the treatment of patients with HCC who have been previously treated with sorafenib.[1] (1.12)

Merkel Cell Carcinoma (MCC)
- for the treatment of adult and pediatric patients with recurrent locally advanced or metastatic Merkel cell carcinoma.[1] (1.13)

Renal Cell Carcinoma (RCC)
- in combination with axitinib, for the first-line treatment of patients with advanced RCC. (1.14)

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

----------DOSAGE AND ADMINISTRATION----------

- Melanoma: 200 mg every 3 weeks. (2.2)
- NSCLC: 200 mg every 3 weeks. (2.3)
- SCLC: 200 mg every 3 weeks (2.4)
- HNSCC: 200 mg every 3 weeks. (2.5)
- cHL or PMBCL: 200 mg every 3 weeks for adults; 2 mg/kg (up to 200 mg) every 3 weeks for pediatrics. (2.6, 2.7)
- Urothelial Carcinoma: 200 mg every 3 weeks. (2.8)
- MSI-H Cancer: 200 mg every 3 weeks for adults and 2 mg/kg (up to 200 mg) every 3 weeks for pediatrics. (2.9)
- Gastric Cancer: 200 mg every 3 weeks. (2.10)
- Esophageal Cancer: 200 mg every 3 weeks. (2.11)
- Cervical Cancer: 200 mg every 3 weeks. (2.12)
- HCC: 200 mg every 3 weeks. (2.13)
- MCC: 200 mg every 3 weeks for adults; 2 mg/kg (up to 200 mg) every 3 weeks for pediatrics. (2.14)
- RCC: 200 mg every 3 weeks with axitinib 5 mg orally twice daily. (2.15)

Administer KEYTRUDA as an intravenous infusion over 30 minutes.

----------DOSAGE FORMS AND STRENGTHS----------

- For injection: 50 mg lyophilized powder in single-dose vial for reconstitution (3)
- Injection: 100 mg/4 mL (25 mg/mL) solution in a single-dose vial (3)

----------CONTRAINDICATIONS----------

None. (4)

----------WARNINGS AND PRECAUTIONS----------

- Immune-mediated pneumonitis: Withhold for moderate, and permanently discontinue for severe, life-threatening or recurrent moderate pneumonitis. (5.1)
- Immune-mediated colitis: Withhold for moderate or severe, and permanently discontinue for life-threatening colitis. (5.2)
- Immune-mediated hepatitis (KEYTRUDA) and hepatotoxicity (KEYTRUDA in combination with axitinib): Monitor for changes in hepatic function. Based on severity of liver enzyme elevations, withhold or discontinue KEYTRUDA, axitinib, or KEYTRUDA and axitinib. Consider corticosteroid therapy. (2.16, 5.3)
- Immune-mediated endocrinopathies (5.4):
  - Hypophysitis: Withhold for moderate and withhold or permanently discontinue for severe or life-threatening hypophysitis.
  - Thyroid disorders: Monitor for changes in thyroid function. Withhold or permanently discontinue for severe or life-threatening hyperthyroidism.
  - Type 1 diabetes mellitus: Monitor for hyperglycemia. Withhold KEYTRUDA in cases of severe hyperglycemia.
- Immune-mediated nephritis: Monitor for changes in renal function. Withhold for moderate, and permanently discontinue for severe or life-threatening nephritis. (5.5)
- Immune-mediated skin adverse reactions including, Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN): Withhold for severe and permanently discontinue for life-threatening skin reactions. (5.6)
- Other immune-mediated adverse reactions: In organ transplant recipients, consider the benefit of treatment with KEYTRUDA versus the risk of possible organ rejection. (5.7)
- Infusion-related reactions: Stop infusion and permanently discontinue KEYTRUDA for severe or life-threatening infusion reactions. (5.8)
- Complications of allogeneic HSCT (5.9):
  - Allogeneic HSCT after treatment with KEYTRUDA: Monitor for hepatic veno-occlusive disease, grade 3-4 acute GVHD including hyperacute GVHD, steroid-requiring febrile syndrome, and other immune-mediated adverse reactions. Transplant-related mortality has occurred.
  - Allogeneic HSCT prior to treatment with KEYTRUDA: In patients with a history of allogeneic HSCT, consider the benefit of treatment with KEYTRUDA versus the risk of GVHD.
- Treatment of patients with multiple myeloma with a PD-1 or PD-L1 blocking antibody in combination with a thalidomide analogue plus dexamethasone is not recommended outside of controlled clinical trials. (5.10)
- Embryo-Fetal toxicity: Can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective method of contraception. (5.11, 8.1, 8.3)

----------ADVERSE REACTIONS----------

Most common adverse reactions (reported in ≥20% of patients) were:

- KEYTRUDA as a single agent: fatigue, musculoskeletal pain, decreased appetite, pruritus, diarrhea, nausea, rash, pyrexia, cough, dyspnea, constipation, pain, and abdominal pain. (6.1)
- KEYTRUDA in combination with chemotherapy: fatigue/asthenia, nausea, constipation, diarrhea, decreased appetite, rash, vomiting, cough, dyspnea, pyrexia, alopecia, peripheral neuropathy, mucosal inflammation, and stomatitis. (6.1)
- KEYTRUDA in combination with axitinib: diarrhea, fatigue/asthenia, hypertension, hepatotoxicity, hypothyroidism, decreased appetite, palmar-plantar erythrodysesthesia, nausea, stomatitis/mucosal inflammation, dysphonia, rash, cough, and constipation. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., at 1-877-888-4231 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----------USE IN SPECIFIC POPULATIONS----------

Lactation: Advise not to breastfeed. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 07/2019

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Melanoma

KEYTRUDA® (pembrolizumab) is indicated for the treatment of patients with unresectable or metastatic melanoma.

KEYTRUDA is indicated for the adjuvant treatment of patients with melanoma with involvement of lymph node(s) following complete resection.

1.2 Non-Small Cell Lung Cancer

KEYTRUDA, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of patients with metastatic nonsquamous non-small cell lung cancer (NSCLC), with no EGFR or ALK genomic tumor aberrations.

KEYTRUDA, in combination with carboplatin and either paclitaxel or paclitaxel protein-bound, is indicated for the first-line treatment of patients with metastatic squamous NSCLC.

KEYTRUDA, as a single agent, is indicated for the first-line treatment of patients with NSCLC expressing PD-L1 [Tumor Proportion Score (TPS) ≥1%] as determined by an FDA-approved test *[see Dosage and Administration (2.1)]*, with no EGFR or ALK genomic tumor aberrations, and is:

- stage III where patients are not candidates for surgical resection or definitive chemoradiation, or
- metastatic.

KEYTRUDA, as a single agent, is indicated for the treatment of patients with metastatic NSCLC whose tumors express PD-L1 (TPS ≥1%) as determined by an FDA-approved test *[see Dosage and Administration (2.1)]*, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving KEYTRUDA.

1.3 Small Cell Lung Cancer

KEYTRUDA is indicated for the treatment of patients with metastatic small cell lung cancer (SCLC) with disease progression on or after platinum-based chemotherapy and at least one other prior line of therapy.

This indication is approved under accelerated approval based on tumor response rate and durability of response *[see Clinical Studies (14.3)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

1.4 Head and Neck Squamous Cell Cancer

KEYTRUDA, in combination with platinum and fluorouracil (FU), is indicated for the first-line treatment of patients with metastatic or with unresectable, recurrent head and neck squamous cell carcinoma (HNSCC).

KEYTRUDA, as a single agent, is indicated for the first-line treatment of patients with metastatic or with unresectable, recurrent HNSCC whose tumors express PD-L1 [Combined Positive Score (CPS) ≥1] as determined by an FDA-approved test *[see Dosage and Administration (2.1)]*.

KEYTRUDA, as a single agent, is indicated for the treatment of patients with recurrent or metastatic HNSCC with disease progression on or after platinum-containing chemotherapy.

1.5 Classical Hodgkin Lymphoma

KEYTRUDA is indicated for the treatment of adult and pediatric patients with refractory classical Hodgkin lymphoma (cHL), or who have relapsed after 3 or more prior lines of therapy.

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This indication is approved under accelerated approval based on tumor response rate and durability of response *[see Clinical Studies (14.5)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

1.6 Primary Mediastinal Large B-Cell Lymphoma

KEYTRUDA is indicated for the treatment of adult and pediatric patients with refractory primary mediastinal large B-cell lymphoma (PMBCL), or who have relapsed after 2 or more prior lines of therapy.

This indication is approved under accelerated approval based on tumor response rate and durability of response *[see Clinical Studies (14.6)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Limitations of Use: KEYTRUDA is not recommended for treatment of patients with PMBCL who require urgent cytoreductive therapy.

1.7 Urothelial Carcinoma

KEYTRUDA is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy and whose tumors express PD-L1 (CPS ≥10) as determined by an FDA-approved test *[see Dosage and Administration (2.1)]*, or in patients who are not eligible for any platinum-containing chemotherapy regardless of PD-L1 status.

This indication is approved under accelerated approval based on tumor response rate and duration of response *[see Clinical Studies (14.7)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

KEYTRUDA is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

1.8 Microsatellite Instability-High Cancer

KEYTRUDA is indicated for the treatment of adult and pediatric patients with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient

- solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options, or
- colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.

This indication is approved under accelerated approval based on tumor response rate and durability of response *[see Clinical Studies (14.8)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

Limitations of Use: The safety and effectiveness of KEYTRUDA in pediatric patients with MSI-H central nervous system cancers have not been established.

1.9 Gastric Cancer

KEYTRUDA is indicated for the treatment of patients with recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 (CPS ≥1) as determined by an FDA-approved test *[see Dosage and Administration (2.1)]*, with disease progression on or after 2 or more prior lines of therapy including fluoropyrimidine- and platinum-containing chemotherapy and if appropriate, HER2/neu-targeted therapy.

This indication is approved under accelerated approval based on tumor response rate and durability of response *[see Clinical Studies (14.9)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

1.10 Esophageal Cancer

KEYTRUDA is indicated for the treatment of patients with recurrent locally advanced or metastatic squamous cell carcinoma of the esophagus whose tumors express PD-L1 (CPS ≥10) as determined by

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an FDA-approved test *[see Dosage and Administration (2.1)]*, with disease progression after one or more prior lines of systemic therapy.

1.11 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 ≥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 (14.11)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

1.12 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 (14.12)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

1.13 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 (14.13)]*. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.

1.14 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, Esophageal 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.
- metastatic esophageal cancer *[see Clinical Studies (14.10)]*.
- recurrent or metastatic cervical cancer *[see Clinical Studies (14.11)]*.

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.

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2.3 Recommended Dosage for NSCLC

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

When administering KEYTRUDA in combination with chemotherapy, administer KEYTRUDA prior to chemotherapy when given on the same day. Refer to the Prescribing Information for the chemotherapy agents administered in combination with KEYTRUDA for recommended dosing information, as appropriate.

2.4 Recommended Dosage for SCLC

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

2.5 Recommended Dosage for HNSCC

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

When administering KEYTRUDA in combination with chemotherapy, administer KEYTRUDA prior to chemotherapy when given on the same day. Refer to the Prescribing Information for the chemotherapy agents administered in combination with KEYTRUDA for recommended dosing information, as appropriate.

2.6 Recommended Dosage for cHL

The recommended dose of KEYTRUDA in adults is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

The recommended dose of KEYTRUDA in pediatric patients is 2 mg/kg (up to a maximum of 200 mg), administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

2.7 Recommended Dosage for PMBCL

The recommended dose of KEYTRUDA in adults is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

The recommended dose of KEYTRUDA in pediatric patients is 2 mg/kg (up to a maximum of 200 mg), administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

2.8 Recommended Dosage for Urothelial Carcinoma

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

2.9 Recommended Dosage for MSI-H Cancer

The recommended dose of KEYTRUDA in adults is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

The recommended dose of KEYTRUDA in pediatric patients is 2 mg/kg (up to a maximum of 200 mg), administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

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2.10 Recommended Dosage for Gastric Cancer

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

2.11 Recommended Dosage for Esophageal Cancer

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

2.12 Recommended Dosage for Cervical Cancer

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

2.13 Recommended Dosage for HCC

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

2.14 Recommended Dosage for MCC

The recommended dose of KEYTRUDA in adults is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression.

The recommended dose of KEYTRUDA in pediatric patients is 2 mg/kg (up to a maximum of 200 mg), administered as an intravenous infusion over 30 minutes every 3 weeks until disease progression or unacceptable toxicity, or up to 24 months in patients without disease progression.

2.15 Recommended Dosage for RCC

The recommended dose of KEYTRUDA is 200 mg administered as an intravenous infusion over 30 minutes every 3 weeks in combination with 5 mg axitinib orally twice daily until disease progression, unacceptable toxicity, or for KEYTRUDA, up to 24 months in patients without disease progression. When axitinib is used in combination with KEYTRUDA, dose escalation of axitinib above the initial 5 mg dose may be considered at intervals of six weeks or longer. See also the Prescribing Information for recommended axitinib dosing information.

2.16 Dose Modifications

No dose reductions of KEYTRUDA are recommended. Withhold or discontinue KEYTRUDA to manage adverse reactions as described in Table 1.

Table 1: Recommended Dose Modifications for Adverse Reactions
[see Warnings and Precautions (5.1-5.9)]

Adverse Reaction	Severity*	Dose Modification for KEYTRUDA
Immune-mediated pneumonitis	Grade 2	Withhold†
	Grades 3 or 4 or recurrent Grade 2	Permanently discontinue
Immune-mediated colitis	Grades 2 or 3	Withhold†

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Adverse Reaction	Severity*	Dose Modification for KEYTRUDA
	Grade 4	Permanently discontinue
Immune-mediated hepatitis in patients with HCC	Aspartate aminotransferase (AST) or alanine aminotransferase (ALT) greater than or equal to 5 times upper limit of normal (ULN) if baseline less than 2 times ULN; AST or ALT greater than 3 times baseline if baseline greater than or equal to 2 times ULN Total bilirubin greater than 2.0 mg/dL if baseline less than 1.5 mg/dL; or Total bilirubin greater than 3.0 mg/dL, regardless of baseline levels	Withhold‡
	ALT or AST greater than 10 times ULN; or Child-Pugh score greater than or equal to 9 points; Gastrointestinal bleeding suggestive of portal hypertension; or New onset of clinically detectable ascites; or encephalopathy	Permanently discontinue
Immune-mediated hepatitis in patients without HCC For liver enzyme elevations in RCC patients treated with combination therapy, see dosing guidelines following this table.	AST or ALT greater than 3 but no more than 5 times the ULN or total bilirubin greater than 1.5 but no more than 3 times the ULN	Withhold†
	In patients without liver metastases, AST or ALT greater than 5 times ULN or total bilirubin greater than 3 times ULN In patients with liver metastasis and Grade 2 AST or ALT at baseline, with an increase in AST or ALT of 50% or more relative to baseline that persists for at least 1 week	Permanently discontinue
Immune-mediated endocrinopathies	Grades 3 or 4	Withhold until clinically stable
Immune-mediated nephritis	Grade 2	Withhold†
	Grades 3 or 4	Permanently discontinue
Immune-mediated skin adverse reactions	Grade 3 or suspected Stevens-Johnson Syndrome (SJS) or toxic epidermal necrolysis (TEN)	Withhold
	Grade 4 or confirmed SJS or TEN	Permanently discontinue
Hematologic toxicity in patients with cHL or PMBCL	Grade 4	Withhold until resolution to Grades 0 or 1
Other immune-mediated adverse reactions	Grades 2 or 3 based on the severity and type of reaction	Withhold†
	Grade 3 based on the severity and type of reaction or Grade 4	Permanently discontinue
Recurrent immune-mediated adverse reactions	Recurrent Grade 2 pneumonitis Recurrent Grades 3 or 4	Permanently discontinue
Inability to taper corticosteroid	Requirement for 10 mg per day or greater prednisone or equivalent for more than 12 weeks after last dose of KEYTRUDA	Permanently discontinue
Persistent Grade 2 or 3 adverse reaction (excluding endocrinopathy)	Grades 2 or 3 adverse reactions lasting 12 weeks or longer after last dose of KEYTRUDA	Permanently discontinue
Infusion-related reactions	Grades 1 or 2	Interrupt or slow the rate of infusion

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Adverse Reaction	Severity*	Dose Modification for KEYTRUDA
	Grades 3 or 4	Permanently discontinue

* Toxicity was graded per National Cancer Institute Common Terminology Criteria for Adverse Events. Version 4.0 (NCI CTCAE v4)
† Resume in patients with complete or partial resolution (Grades 0 to 1) after corticosteroid taper.
‡ Resume in HCC patients when AST or ALT and total bilirubin recover to Grades 0-1 or to baseline.

In patients with RCC being treated with KEYTRUDA in combination with axitinib:

- If ALT or AST ≥3 times ULN but <10 times ULN without concurrent total bilirubin ≥2 times ULN, withhold both KEYTRUDA and axitinib until these adverse reactions recover to Grades 0-1. Consider corticosteroid therapy. Consider rechallenge with a single drug or sequential rechallenge with both drugs after recovery. If rechallenging with axitinib, consider dose reduction as per the axitinib Prescribing Information.
- If ALT or AST ≥10 times ULN or >3 times ULN with concurrent total bilirubin ≥2 times ULN, permanently discontinue both KEYTRUDA and axitinib and consider corticosteroid therapy.

2.17 Preparation and Administration

Reconstitution of KEYTRUDA for Injection (Lyophilized Powder)

- Add 2.3 mL of Sterile Water for Injection, USP by injecting the water along the walls of the vial and not directly on the lyophilized powder (resulting concentration 25 mg/mL).
- Slowly swirl the vial. Allow up to 5 minutes for the bubbles to clear. Do not shake the vial.

Preparation for Intravenous Infusion

- Visually inspect the solution for particulate matter and discoloration. The solution is clear to slightly opalescent, colorless to slightly yellow. Discard the vial if visible particles are observed.
- Dilute KEYTRUDA injection (solution) or reconstituted lyophilized powder prior to intravenous administration.
- Withdraw the required volume from the vial(s) of KEYTRUDA and transfer into an intravenous (IV) bag containing 0.9% Sodium Chloride Injection, USP or 5% Dextrose Injection, USP. Mix diluted solution by gentle inversion. The final concentration of the diluted solution should be between 1 mg/mL to 10 mg/mL.
- Discard any unused portion left in the vial.

Storage of Reconstituted and Diluted Solutions

The product does not contain a preservative.
Store the reconstituted and diluted solution from the KEYTRUDA 50 mg vial either:

- At room temperature for no more than 6 hours from the time of reconstitution. This includes room temperature storage of reconstituted vials, storage of the diluted solution, and the duration of infusion.
- Under refrigeration at 2°C to 8°C (36°F to 46°F) for no more than 24 hours from the time of reconstitution. If refrigerated, allow the diluted solution to come to room temperature prior to administration.

Store the diluted solution from the KEYTRUDA 100 mg/4 mL vial either:

- At room temperature for no more than 6 hours from the time of dilution. This includes room temperature storage of the diluted solution, and the duration of infusion.
- Under refrigeration at 2°C to 8°C (36°F to 46°F) for no more than 24 hours from the time of dilution. If refrigerated, allow the diluted solution to come to room temperature prior to administration.

Discard after 6 hours at room temperature or after 24 hours under refrigeration.

Do not freeze.

Administration

- Administer diluted solution intravenously over 30 minutes through an intravenous line containing a sterile, non-pyrogenic, low-protein binding 0.2 micron to 5 micron in-line or add-on filter.

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- Do not co-administer other drugs through the same infusion line.

3 DOSAGE FORMS AND STRENGTHS

- For injection: 50 mg white to off-white lyophilized powder in a single-dose vial for reconstitution
- Injection: 100 mg/4 mL (25 mg/mL) clear to slightly opalescent, colorless to slightly yellow solution in a single-dose vial

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Immune-Mediated Pneumonitis

KEYTRUDA can cause immune-mediated pneumonitis, including fatal cases. Monitor patients for signs and symptoms of pneumonitis. Evaluate patients with suspected pneumonitis with radiographic imaging and administer corticosteroids (initial dose of 1 to 2 mg/kg/day prednisone or equivalent followed by a taper) for Grade 2 or greater pneumonitis. Withhold KEYTRUDA for moderate (Grade 2) pneumonitis, and permanently discontinue KEYTRUDA for severe (Grade 3), life-threatening (Grade 4), or recurrent moderate (Grade 2) pneumonitis *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)].*

In clinical studies enrolling 2799 patients with various cancers who received KEYTRUDA as a single agent, pneumonitis occurred in 94 (3.4%) patients, including Grade 1 (0.8%), Grade 2 (1.3%), Grade 3 (0.9%), Grade 4 (0.3%), and Grade 5 (0.1%) pneumonitis. The median time to onset was 3.3 months (range: 2 days to 19.3 months), and the median duration was 1.5 months (range: 1 day to 17.2+ months). Sixty-three (67%) of the 94 patients received systemic corticosteroids, with 50 of the 63 receiving high-dose corticosteroids for a median duration of 8 days (range: 1 day to 10.1 months) followed by a corticosteroid taper. Pneumonitis occurred more frequently in patients with a history of prior thoracic radiation (6.9%) than in patients who did not receive prior thoracic radiation (2.9%). Pneumonitis led to discontinuation of KEYTRUDA in 36 (1.3%) patients. Pneumonitis resolved in 55 (59%) of the 94 patients.

In clinical studies enrolling 790 patients with NSCLC who received KEYTRUDA as a single agent as first-line therapy for advanced disease, pneumonitis occurred in 65 (8.2%) patients, including Grades 3-4 in 3.2% of patients. Forty-eight of the 65 patients received high-dose corticosteroids for a median duration of 5 days (range: 1 to 26 days). Pneumonitis occurred in 17% of patients with a history of prior thoracic radiation and 7.7% of patients who did not receive prior thoracic radiation. Pneumonitis led to discontinuation of KEYTRUDA in 29 (3.7%) patients. Pneumonitis resolved in 51% of the patients.

In KEYNOTE-048 enrolling 300 patients with HNSCC who received KEYTRUDA as a single agent pneumonitis occurred in 18 (6%) patients, including Grade 3 (1.3%), Grade 4 (0%), and Grade 5 (0.3%). Eight of the 18 patients received high-dose corticosteroids for a median duration of 14 days (range: 1 to 77 days). Pneumonitis led to discontinuation of KEYTRUDA in 2 (0.7%) patients. Pneumonitis resolved in 12 (66%) of the patients. Pneumonitis occurred in 15 (5.4%) patients of 276 patients with HNSCC receiving KEYTRUDA in combination with platinum and FU as first-line therapy for advanced disease, including Grade 3 (1.1%), Grade 4 (0%), and Grade 5 (0.4%) pneumonitis. Four of the 15 patients received high-dose corticosteroids for a median duration of 16 days (range: 2 to 32 days). Pneumonitis led to discontinuation of KEYTRUDA in 5 (1.8%) patients. Pneumonitis resolved in 12 (80%) of the patients.

5.2 Immune-Mediated Colitis

KEYTRUDA can cause immune-mediated colitis. Monitor patients for signs and symptoms of colitis. Administer corticosteroids (initial dose of 1 to 2 mg/kg/day prednisone or equivalent followed by a taper) for Grade 2 or greater colitis. Withhold KEYTRUDA for moderate (Grade 2) or severe (Grade 3) colitis, and permanently discontinue KEYTRUDA for life-threatening (Grade 4) colitis *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)].*

Colitis occurred in 48 (1.7%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.4%), Grade 3 (1.1%), and Grade 4 (<0.1%) colitis. The median time to onset was 3.5 months (range: 10 days to

16.2 months), and the median duration was 1.3 months (range: 1 day to 8.7+ months). Thirty-three (69%) of the 48 patients received systemic corticosteroids, with 27 of the 33 requiring high-dose corticosteroids for a median duration of 7 days (range: 1 day to 5.3 months) followed by a corticosteroid taper. Colitis led to discontinuation of KEYTRUDA in 15 (0.5%) patients. Colitis resolved in 41 (85%) of the 48 patients.

5.3 Immune-Mediated Hepatitis (KEYTRUDA) and Hepatotoxicity (KEYTRUDA in Combination with Axitinib)

Immune-Mediated Hepatitis

KEYTRUDA can cause immune-mediated hepatitis. Monitor patients for changes in liver function. Administer corticosteroids (initial dose of 0.5 to 1 mg/kg/day [for Grade 2 hepatitis] and 1 to 2 mg/kg/day [for Grade 3 or greater hepatitis] prednisone or equivalent followed by a taper) and, based on severity of liver enzyme elevations, withhold or discontinue KEYTRUDA *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)].*

Hepatitis occurred in 19 (0.7%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.1%), Grade 3 (0.4%), and Grade 4 (<0.1%) hepatitis. The median time to onset was 1.3 months (range: 8 days to 21.4 months), and the median duration was 1.8 months (range: 8 days to 20.9+ months). Thirteen (68%) of the 19 patients received systemic corticosteroids, with 12 of the 13 receiving high-dose corticosteroids for a median duration of 5 days (range: 1 to 26 days) followed by a corticosteroid taper. Hepatitis led to discontinuation of KEYTRUDA in 6 (0.2%) patients. Hepatitis resolved in 15 (79%) of the 19 patients.

Hepatotoxicity in Combination with Axitinib

KEYTRUDA in combination with axitinib can cause hepatic toxicity with higher than expected frequencies of Grades 3 and 4 ALT and AST elevations compared to KEYTRUDA alone. Monitor liver enzymes before initiation of and periodically throughout treatment. Consider more frequent monitoring of liver enzymes as compared to when the drugs are administered as single agents. For elevated liver enzymes, interrupt KEYTRUDA and axitinib and consider administering corticosteroids as needed *[see Dosage and Administration (2.16)]*.

With the combination of KEYTRUDA and axitinib, Grades 3 and 4 increased ALT (20%) and increased AST (13%) were seen. The median time to onset of increased ALT was 2.3 months (range: 7 days to 19.8 months). Sixty-one percent of the patients with increased ALT received systemic corticosteroids. In patients with ALT ≥3 times ULN (Grades 2-4, n=116), ALT resolved to Grades 0-1 in 94%. Among the 92 patients who were rechallenged with either KEYTRUDA (3%) or axitinib (31%) administered as a single agent or with both (50%), 55% had no recurrence of ALT >3 times ULN.

5.4 Immune-Mediated Endocrinopathies

Hypophysitis

KEYTRUDA can cause hypophysitis. Monitor for signs and symptoms of hypophysitis (including hypopituitarism and adrenal insufficiency). Administer corticosteroids and hormone replacement as clinically indicated. Withhold KEYTRUDA for moderate (Grade 2) hypophysitis and withhold or discontinue KEYTRUDA for severe (Grade 3) or life-threatening (Grade 4) hypophysitis *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)].*

Hypophysitis occurred in 17 (0.6%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.2%), Grade 3 (0.3%), and Grade 4 (<0.1%) hypophysitis. The median time to onset was 3.7 months (range: 1 day to 11.9 months), and the median duration was 4.7 months (range: 8+ days to 12.7+ months). Sixteen (94%) of the 17 patients received systemic corticosteroids, with 6 of the 16 receiving high-dose corticosteroids. Hypophysitis led to discontinuation of KEYTRUDA in 4 (0.1%) patients. Hypophysitis resolved in 7 (41%) of the 17 patients.

Thyroid Disorders

KEYTRUDA can cause thyroid disorders, including hyperthyroidism, hypothyroidism and thyroiditis. Monitor patients for changes in thyroid function (at the start of treatment, periodically during treatment,

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and as indicated based on clinical evaluation) and for clinical signs and symptoms of thyroid disorders. Administer replacement hormones for hypothyroidism and manage hyperthyroidism with thionamides and beta-blockers as appropriate. Withhold or discontinue KEYTRUDA for severe (Grade 3) or life-threatening (Grade 4) hyperthyroidism *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)].*

Hyperthyroidism occurred in 96 (3.4%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.8%) and Grade 3 (0.1%) hyperthyroidism. The median time to onset was 1.4 months (range: 1 day to 21.9 months), and the median duration was 2.1 months (range: 3 days to 15.0+ months). Hyperthyroidism led to discontinuation of KEYTRUDA in 2 (<0.1%) patients. Hyperthyroidism resolved in 71 (74%) of the 96 patients.

Hypothyroidism occurred in 237 (8.5%) of 2799 patients receiving KEYTRUDA, including Grade 2 (6.2%) and Grade 3 (0.1%) hypothyroidism. The median time to onset was 3.5 months (range: 1 day to 18.9 months), and the median duration was not reached (range: 2 days to 27.7+ months). Hypothyroidism led to discontinuation of KEYTRUDA in 1 (<0.1%) patient. Hypothyroidism resolved in 48 (20%) of the 237 patients. The incidence of new or worsening hypothyroidism was higher in 1185 patients with HNSCC (16%) receiving KEYTRUDA as a single agent or in combination with platinum and FU, including Grade 3 (0.3%) hypothyroidism.

Thyroiditis occurred in 16 (0.6%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.3%) thyroiditis. The median time of onset was 1.2 months (range: 0.5 to 3.5 months).

Type 1 Diabetes mellitus

KEYTRUDA can cause type 1 diabetes mellitus, including diabetic ketoacidosis, which have been reported in 6 (0.2%) of 2799 patients receiving KEYTRUDA. Monitor patients for hyperglycemia or other signs and symptoms of diabetes. Administer insulin for type 1 diabetes and withhold KEYTRUDA and administer anti-hyperglycemics in patients with severe hyperglycemia *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)]*.

5.5 Immune-Mediated Nephritis and Renal Dysfunction

KEYTRUDA can cause immune-mediated nephritis. Monitor patients for changes in renal function. Administer corticosteroids (initial dose of 1 to 2 mg/kg/day prednisone or equivalent followed by a taper) for Grade 2 or greater nephritis. Withhold KEYTRUDA for moderate (Grade 2), and permanently discontinue KEYTRUDA for severe (Grade 3) or life-threatening (Grade 4) nephritis *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)].*

Nephritis occurred in 9 (0.3%) of 2799 patients receiving KEYTRUDA, including Grade 2 (0.1%), Grade 3 (0.1%), and Grade 4 (<0.1%) nephritis. The median time to onset was 5.1 months (range: 12 days to 12.8 months), and the median duration was 3.3 months (range: 12 days to 8.9+ months). Eight (89%) of the 9 patients received systemic corticosteroids, with 7 of the 8 receiving high-dose corticosteroids for a median duration of 15 days (range: 3 days to 4.0 months) followed by a corticosteroid taper. Nephritis led to discontinuation of KEYTRUDA in 3 (0.1%) patients. Nephritis resolved in 5 (56%) of the 9 patients. Nephritis occurred in 1.7% of 405 patients receiving KEYTRUDA in combination with pemetrexed and platinum in the KEYNOTE-189 study, including Grade 3 (1%) and Grade 4 (0.5%) nephritis. The median time to onset was 3.2 months (range: 16 days to 11.1 months) and the duration ranged from 1.6 to 16.8+ months. Six (86%) of the 7 patients received systemic corticosteroids, with all 6 receiving high-dose corticosteroids for a median duration of 3 days (range: 1 to 17 days) followed by a corticosteroid taper. Nephritis led to discontinuation of KEYTRUDA in 5 (1.2%) patients. Nephritis resolved in 2 (29%) of the 7 patients.

5.6 Immune-Mediated Skin Adverse Reactions

Immune-mediated rashes, including SJS, TEN (some cases with fatal outcome), exfoliative dermatitis, and bullous pemphigoid, can occur. Monitor patients for suspected severe skin reactions and exclude other causes. Based on the severity of the adverse reaction, withhold or permanently discontinue KEYTRUDA and administer corticosteroids. For signs or symptoms of SJS or TEN, withhold KEYTRUDA and refer the patient for specialized care for assessment and treatment. If SJS or TEN is confirmed, permanently discontinue KEYTRUDA *[see Dosage and Administration (2.16)].*

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5.7 Other Immune-Mediated Adverse Reactions

Immune-mediated adverse reactions, which may be severe or fatal, can occur in any organ system or tissue in patients receiving KEYTRUDA. While immune-mediated adverse reactions usually occur during treatment with PD-1/PD-L1 blocking antibodies, they may occur after discontinuation of treatment.

For suspected immune-mediated adverse reactions, ensure adequate evaluation to confirm etiology or exclude other causes. Based on the severity of the adverse reaction, withhold KEYTRUDA and administer corticosteroids. Upon improvement to Grade 1 or less, initiate corticosteroid taper and continue to taper over at least 1 month. Based on limited data from clinical studies in patients whose immune-related adverse reactions could not be controlled with corticosteroid use, administration of other systemic immunosuppressants can be considered. Resume KEYTRUDA when the immune-mediated adverse reaction remains at Grade 1 or less following corticosteroid taper. Permanently discontinue KEYTRUDA for any Grade 3 immune-mediated adverse reaction that recurs and for any life-threatening immune-mediated adverse reaction *[see Dosage and Administration (2.16) and Adverse Reactions (6.1)].*

The following clinically significant, immune-mediated adverse reactions occurred in less than 1% (unless otherwise indicated) of 2799 patients treated with KEYTRUDA: arthritis (1.5%), uveitis, myositis, Guillain-Barré syndrome, myasthenia gravis, vasculitis, pancreatitis, hemolytic anemia, sarcoidosis, and encephalitis. In addition, myelitis and myocarditis were reported in other trials, including cHL, and post-marketing use.

Solid organ transplant rejection has been reported in the post-marketing setting in patients treated with KEYTRUDA. Treatment with KEYTRUDA may increase the risk of rejection in solid organ transplant recipients. Consider the benefit of treatment with KEYTRUDA versus the risk of possible organ rejection in these patients.

5.8 Infusion-Related Reactions

KEYTRUDA can cause severe or life-threatening infusion-related reactions, including hypersensitivity and anaphylaxis, which have been reported in 6 (0.2%) of 2799 patients receiving KEYTRUDA. Monitor patients for signs and symptoms of infusion-related reactions including rigors, chills, wheezing, pruritus, flushing, rash, hypotension, hypoxemia, and fever. For severe (Grade 3) or life-threatening (Grade 4) infusion-related reactions, stop infusion and permanently discontinue KEYTRUDA *[see Dosage and Administration (2.16)]*.

5.9 Complications of Allogeneic HSCT

<u>Allogeneic HSCT after treatment with KEYTRUDA</u>

Immune-mediated complications, including fatal events, occurred in patients who underwent allogeneic hematopoietic stem cell transplantation (HSCT) after being treated with KEYTRUDA. Of 23 patients with cHL who proceeded to allogeneic HSCT after treatment with KEYTRUDA on any trial, 6 patients (26%) developed graft-versus-host-disease (GVHD), one of which was fatal, and 2 patients (9%) developed severe hepatic veno-occlusive disease (VOD) after reduced-intensity conditioning, one of which was fatal. Cases of fatal hyperacute GVHD after allogeneic HSCT have also been reported in patients with lymphoma who received a PD-1 receptor blocking antibody before transplantation. These complications may occur despite intervening therapy between PD-1 blockade and allogeneic HSCT. Follow patients closely for early evidence of transplant-related complications such as hyperacute GVHD, severe (Grade 3 to 4) acute GVHD, steroid-requiring febrile syndrome, hepatic VOD, and other immune-mediated adverse reactions, and intervene promptly.

<u>Allogeneic HSCT prior to treatment with KEYTRUDA</u>

In patients with a history of allogeneic HSCT, acute GVHD, including fatal GVHD, has been reported after treatment with KEYTRUDA. Patients who experienced GVHD after their transplant procedure may be at increased risk for GVHD after treatment with KEYTRUDA. Consider the benefit of treatment with KEYTRUDA versus the risk of possible GVHD in patients with a history of allogeneic HSCT.

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5.10 Increased Mortality in Patients with Multiple Myeloma when KEYTRUDA is Added to a Thalidomide Analogue and Dexamethasone

In two randomized trials in patients with multiple myeloma, the addition of KEYTRUDA to a thalidomide analogue plus dexamethasone, a use for which no PD-1 or PD-L1 blocking antibody is indicated, resulted in increased mortality. Treatment of patients with multiple myeloma with a PD-1 or PD-L1 blocking antibody in combination with a thalidomide analogue plus dexamethasone is not recommended outside of controlled trials.

5.11 Embryo-Fetal Toxicity

Based on its mechanism of action, KEYTRUDA can cause fetal harm when administered to a pregnant woman. Animal models link the PD-1/PD-L1 signaling pathway with maintenance of pregnancy through induction of maternal immune tolerance to fetal tissue. Advise women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with KEYTRUDA and for 4 months after the last dose *[see Use in Specific Populations (8.1, 8.3)].*

6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling.

- Immune-mediated pneumonitis *[see Warnings and Precautions (5.1)]*.
- Immune-mediated colitis *[see Warnings and Precautions (5.2)]*.
- Immune-mediated hepatitis (KEYTRUDA) and hepatotoxicity (KEYTRUDA in combination with axitinib) *[see Warnings and Precautions (5.3)]*.
- Immune-mediated endocrinopathies *[see Warnings and Precautions (5.4)]*.
- Immune-mediated nephritis and renal dysfunction *[see Warnings and Precautions (5.5)]*.
- Immune-mediated skin adverse reactions *[see Warnings and Precautions (5.6)]*.
- Other immune-mediated adverse reactions *[see Warnings and Precautions (5.7)]*.
- Infusion-related reactions *[see Warnings and Precautions (5.8)].*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The data described in the WARNINGS AND PRECAUTIONS reflect exposure to KEYTRUDA as a single agent in 2799 patients in three randomized, open-label, active-controlled trials (KEYNOTE-002, KEYNOTE-006, and KEYNOTE-010), which enrolled 912 patients with melanoma and 682 patients with NSCLC, and one single-arm trial (KEYNOTE-001), which enrolled 655 patients with melanoma and 550 patients with NSCLC. In addition to the 2799 patients, certain subsections in the WARNINGS AND PRECAUTIONS describe adverse reactions observed with exposure to KEYTRUDA as a single agent in two randomized, open-label, active-controlled clinical trials (KEYNOTE-042 and KEYNOTE-024), which enrolled 790 patients with NSCLC; in a non-randomized, open-label, multi-cohort trial (KEYNOTE-012), a non-randomized, open-label, single-cohort trial (KEYNOTE-055), and two randomized, open-label, active-controlled trials (KEYNOTE-040 and KEYNOTE-048 single agent arms), which enrolled 909 patients with HNSCC; in two non-randomized, open-label trials (KEYNOTE-013 and KEYNOTE-087), which enrolled 241 patients with cHL; in combination with chemotherapy in a randomized, active-controlled trial (KEYNOTE-189), which enrolled 405 patients with nonsquamous NSCLC; in a randomized, open-label, active-controlled trial (KEYNOTE-048 combination arm), which enrolled 276 patients with HNSCC; in combination with axitinib in a randomized, active-controlled trial (KEYNOTE 426), which enrolled 429 patients with RCC; and in post-marketing use. Across all trials, KEYTRUDA was administered at doses of 2 mg/kg intravenously every 3 weeks, 10 mg/kg intravenously every 2 weeks, 10 mg/kg intravenously every 3 weeks, or 200 mg intravenously every 3 weeks. Among the 2799 patients, 41% were exposed for 6 months or more and 21% were exposed for 12 months or more.

The data described in this section were obtained in ten randomized, controlled trials (KEYNOTE-002, KEYNOTE-006, KEYNOTE-010, KEYNOTE-042, KEYNOTE-045, KEYNOTE-048, KEYNOTE-189, KEYNOTE-407, KEYNOTE-181, and KEYNOTE-426) and nine non-randomized, open-label trials

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(KEYNOTE-028, KEYNOTE-012, KEYNOTE-087, KEYNOTE-170, KEYNOTE-052, KEYNOTE-059, KEYNOTE-158, KEYNOTE-224, and KEYNOTE-017). The data described in this section also included a single randomized, double-blind, placebo-controlled trial (KEYNOTE-054) in which KEYTRUDA was administered for the adjuvant treatment of 509 patients with melanoma with involvement of lymph node(s) following complete surgical resection. In these trials, KEYTRUDA was administered at 2 mg/kg every 3 weeks, 200 mg every 3 weeks, or 10 mg/kg every 2 or 3 weeks.

Melanoma

Ipilimumab-Naive Melanoma

The safety of KEYTRUDA for the treatment of patients with unresectable or metastatic melanoma who had not received prior ipilimumab and who had received no more than one prior systemic therapy was investigated in KEYNOTE-006. KEYNOTE-006 was a multicenter, open-label, active-controlled trial where patients were randomized (1:1:1) and received KEYTRUDA 10 mg/kg every 2 weeks (n=278) or KEYTRUDA 10 mg/kg every 3 weeks (n=277) until disease progression or unacceptable toxicity or ipilimumab 3 mg/kg every 3 weeks for 4 doses unless discontinued earlier for disease progression or unacceptable toxicity (n=256) *[see Clinical Studies (14.1)]*. Patients with autoimmune disease, a medical condition that required systemic corticosteroids or other immunosuppressive medication; a history of interstitial lung disease; or active infection requiring therapy, including HIV or hepatitis B or C, were ineligible.

The median duration of exposure was 5.6 months (range: 1 day to 11.0 months) for KEYTRUDA and similar in both treatment arms. Fifty-one and 46% of patients received KEYTRUDA 10 mg/kg every 2 or 3 weeks, respectively, for ≥6 months. No patients in either arm received treatment for more than one year.

The study population characteristics were: median age of 62 years (range: 18 to 89); 60% male; 98% White; 32% had an elevated lactate dehydrogenase (LDH) value at baseline; 65% had M1c stage disease; 9% with history of brain metastasis; and approximately 36% had been previously treated with systemic therapy which included a BRAF inhibitor (15%), chemotherapy (13%), and immunotherapy (6%).

In KEYNOTE-006, the adverse reaction profile was similar for the every 2 week and every 3 week schedule, therefore summary safety results are provided in a pooled analysis (n=555) of both KEYTRUDA arms. Adverse reactions leading to permanent discontinuation of KEYTRUDA occurred in 9% of patients. Adverse reactions leading to discontinuation of KEYTRUDA in more than one patient were colitis (1.4%), autoimmune hepatitis (0.7%), allergic reaction (0.4%), polyneuropathy (0.4%), and cardiac failure (0.4%). Adverse reactions leading to interruption of KEYTRUDA occurred in 21% of patients; the most common (≥1%) was diarrhea (2.5%). Tables 2 and 3 summarize selected adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-006.

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Table 2: Selected* Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-006

Adverse Reaction	KEYTRUDA 10 mg/kg every 2 or 3 weeks n=555		Ipilimumab n=256	
	All Grades† (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
General				
Fatigue	28	0.9	28	3.1
Skin and Subcutaneous Tissue				
Rash‡	24	0.2	23	1.2
Vitiligo§	13	0	2	0
Musculoskeletal and Connective Tissue				
Arthralgia	18	0.4	10	1.2
Back pain	12	0.9	7	0.8
Respiratory, Thoracic and Mediastinal				
Cough	17	0	7	0.4
Dyspnea	11	0.9	7	0.8
Metabolism and Nutrition				
Decreased appetite	16	0.5	14	0.8
Nervous System				
Headache	14	0.2	14	0.8

* Adverse reactions occurring at same or higher incidence than in the ipilimumab arm
† Graded per NCI CTCAE v4.0
‡ Includes rash, rash erythematous, rash follicular, rash generalized, rash macular, rash maculo-papular, rash papular, rash pruritic, and exfoliative rash.
§ Includes skin hypopigmentation

Other clinically important adverse reactions occurring in ≥10% of patients receiving KEYTRUDA were diarrhea (26%), nausea (21%), and pruritus (17%).

Table 3: Selected* Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Melanoma Patients Receiving KEYTRUDA in KEYNOTE-006

Laboratory Test†	KEYTRUDA 10 mg/kg every 2 or 3 weeks		Ipilimumab	
	All Grades‡ %	Grades 3-4 %	All Grades %	Grades 3-4 %
Chemistry				
Hyperglycemia	45	4.2	45	3.8
Hypertriglyceridemia	43	2.6	31	1.1
Hyponatremia	28	4.6	26	7
Increased AST	27	2.6	25	2.5
Hypercholesterolemia	20	1.2	13	0
Hematology				
Anemia	35	3.8	33	4.0
Lymphopenia	33	7	25	6

* Laboratory abnormalities occurring at same or higher incidence than in ipilimumab 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 (520 to 546 patients) and ipilimumab (237 to 247 patients); hypertriglyceridemia: KEYTRUDA n=429 and ipilimumab n=183; hypercholesterolemia: KEYTRUDA n=484 and ipilimumab n=205.
‡ Graded per NCI CTCAE v4.0

Other laboratory abnormalities occurring in ≥20% of patients receiving KEYTRUDA were increased hypoalbuminemia (27% all Grades; 2.4% Grades 3-4), increased ALT (23% all Grades; 3.1% Grades 3-4), and increased alkaline phosphatase (21% all Grades, 2% Grades 3-4).

Ipilimumab-Refractory Melanoma

The safety of KEYTRUDA in patients with unresectable or metastatic melanoma with disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor, was investigated in KEYNOTE-002. KEYNOTE-002 was a multicenter, partially blinded (KEYTRUDA dose), randomized (1:1:1), active-controlled trial in which 528 patients received KEYTRUDA 2 mg/kg (n=178) or 10 mg/kg

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(n=179) every 3 weeks or investigator's choice of chemotherapy (n=171), consisting of dacarbazine (26%), temozolomide (25%), paclitaxel and carboplatin (25%), paclitaxel (16%), or carboplatin (8%) *[see Clinical Studies (14.1)]*. Patients with autoimmune disease, severe immune-related toxicity related to ipilimumab, defined as any Grade 4 toxicity or Grade 3 toxicity requiring corticosteroid treatment (greater than 10 mg/day prednisone or equivalent dose) for greater than 12 weeks; medical conditions that required systemic corticosteroids or other immunosuppressive medication; a history of interstitial lung disease; or an active infection requiring therapy, including HIV or hepatitis B or C, were ineligible.

The median duration of exposure to KEYTRUDA 2 mg/kg every 3 weeks was 3.7 months (range: 1 day to 16.6 months) and to KEYTRUDA 10 mg/kg every 3 weeks was 4.8 months (range: 1 day to 16.8 months). In the KEYTRUDA 2 mg/kg arm, 36% of patients were exposed to KEYTRUDA for ≥6 months and 4% were exposed for ≥12 months. In the KEYTRUDA 10 mg/kg arm, 41% of patients were exposed to KEYTRUDA for ≥6 months and 6% of patients were exposed to KEYTRUDA for ≥12 months.

The study population characteristics were: median age of 62 years (range: 15 to 89); 61% male; 98% White; 41% had an elevated LDH value at baseline; 83% had M1c stage disease; 73% received two or more prior therapies for advanced or metastatic disease (100% received ipilimumab and 25% a BRAF inhibitor); and 15% with history of brain metastasis.

In KEYNOTE-002, the adverse reaction profile was similar for the 2 mg/kg dose and 10 mg/kg dose, therefore summary safety results are provided in a pooled analysis (n=357) of both KEYTRUDA arms. Adverse reactions resulting in permanent discontinuation occurred in 12% of patients receiving KEYTRUDA; the most common (≥1%) were general physical health deterioration (1%), asthenia (1%), dyspnea (1%), pneumonitis (1%), and generalized edema (1%). Adverse reactions leading to interruption of KEYTRUDA occurred in 14% of patients; the most common (≥1%) were dyspnea (1%), diarrhea (1%), and maculo-papular rash (1%). Tables 4 and 5 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-002.

Table 4: Selected* Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-002

Adverse Reaction	KEYTRUDA 2 mg/kg or 10 mg/kg every 3 weeks n=357		Chemotherapy† n=171	
	All Grades‡ (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Skin and Subcutaneous Tissue				
Pruritus	28	0	8	0
Rash§	24	0.6	8	0
Gastrointestinal				
Constipation	22	0.3	20	2.3
Diarrhea	20	0.8	20	2.3
Abdominal pain	13	1.7	8	1.2
Respiratory, Thoracic and Mediastinal				
Cough	18	0	16	0
General				
Pyrexia	14	0.3	9	0.6
Asthenia	10	2.0	9	1.8
Musculoskeletal and Connective Tissue				
Arthralgia	14	0.6	10	1.2

* Adverse reactions occurring at same or higher incidence than in chemotherapy arm
† Chemotherapy: dacarbazine, temozolomide, carboplatin plus paclitaxel, paclitaxel, or carboplatin
‡ Graded per NCI CTCAE v4.0
§ Includes rash, rash erythematous, rash generalized, rash macular, rash maculo-papular, rash papular, and rash pruritic

Other clinically important adverse reactions occurring in patients receiving KEYTRUDA were fatigue (43%), nausea (22%), decreased appetite (20%), vomiting (13%), and peripheral neuropathy (1.7%).

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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 %
Chemistry				
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.

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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† (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Gastrointestinal				
Diarrhea	28	1.2	26	1.2
Nausea	17	0.2	15	0
Skin and Subcutaneous Tissue				
Pruritus	19	0	12	0
Rash	13	0.2	9	0
Musculoskeletal and Connective Tissue				
Arthralgia	16	1.2	14	0
Endocrine				
Hypothyroidism	15	0	2.8	0
Hyperthyroidism	10	0.2	1.2	0
Respiratory, Thoracic and Mediastinal				
Cough	14	0	11	0
General				
Asthenia	11	0.2	8	0
Influenza like illness	11	0	8	0
Investigations				
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†	KEYTRUDA 200 mg every 3 weeks		Placebo	
	All Grades‡ %	Grades 3-4 %	All Grades %	Grades 3-4 %
Chemistry				
Increased ALT	27	2.4	16	0.2
Increased AST	24	1.8	15	0.4
Hematology				
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 (≥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 ≥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 (%)
Gastrointestinal				
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
General				
Fatigue†	56	12	58	6
Pyrexia	20	0.2	15	0
Metabolism and Nutrition				
Decreased appetite	28	1.5	30	0.5
Skin and Subcutaneous Tissue				
Rash‡	25	2.0	17	2.5
Respiratory, Thoracic and Mediastinal				
Cough	21	0	28	0
Dyspnea	21	3.7	26	5

* Graded per NCI CTCAE v4.03
† Includes asthenia and fatigue
‡ Includes genital rash, rash, rash generalized, rash macular, rash maculo-papular, rash papular, rash pruritic, and rash pustular.

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Table 9: Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Patients in KEYNOTE-189

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks Pemetrexed Platinum Chemotherapy		Placebo Pemetrexed Platinum Chemotherapy	
	All Grades† %	Grades 3-4 %	All Grades %	Grades 3-4 %
Hematology				
Anemia	85	17	81	18
Lymphopenia	64	22	64	25
Neutropenia	48	20	41	19
Thrombocytopenia	30	12	29	8
Chemistry				
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 ≥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 (≥2%) were thrombocytopenia (20%), neutropenia (11%), anemia (6%), asthenia (2%), and diarrhea (2%). The most frequent (≥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.

Reference ID: 4470211

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 ≥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 (≥2%) were pneumonitis (3.1%), pneumonia (3.0%), hypothyroidism (2.2%), and increased ALT (2.0%). The most frequent (≥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 ≥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 (%)
General				
Fatigue†	25	3.1	33	3.9
Pyrexia	10	0.3	8	0
Metabolism and Nutrition				
Decreased appetite	17	1.7	21	1.5
Respiratory, Thoracic and Mediastinal				
Dyspnea	17	2.0	11	0.8
Cough	16	0.2	11	0.3
Skin and Subcutaneous Tissue				
Rash‡	15	1.3	8	0.2
Gastrointestinal				
Constipation	12	0	21	0.2
Diarrhea	12	0.8	12	0.5
Nausea	12	0.5	32	1.1
Endocrine				
Hypothyroidism	12	0.2	1.5	0
Infections				
Pneumonia	12	7	9	6
Investigations				
Weight loss	10	0.9	7	0.2

* Graded per NCI CTCAE v4.03
† Includes fatigue and asthenia
‡ Includes rash, rash generalized, rash macular, rash maculo-papular, rash papular, rash pruritic, and rash pustular.

Reference ID: 4470211

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† %	Grades 3-4 %	All Grades %	Grades 3-4 %
Chemistry				
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
Hematology				
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^2 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.

Reference ID: 4470211

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

Reference ID: 4470211

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 (%)
General						
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
Gastrointestinal						
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
Skin						
Rash[§]	20	2.3	17	0.7	70	8
Pruritus	11	0	8	0	10	0.3
Respiratory, Thoracic and Mediastinal						
Cough[¶]	18	0.3	22	0	15	0
Dyspnea[#]	14	2.0	10	1.8	8	1.0
Endocrine						
Hypothyroidism	18	0	15	0	6	0
Metabolism and Nutrition						
Decreased appetite	15	1.0	29	4.7	30	3.5
Weight loss	15	2	16	2.9	21	1.4
Infections						
Pneumonia[Þ]	12	7	19	11	13	6
Nervous System						
Headache	12	0.3	11	0.7	8	0.3
Dizziness	5	0.3	10	0.4	13	0.3
Peripheral sensory neuropathy[β]	1	0	14	1.1	7	1
Musculoskeletal						
Myalgia[à]	12	1.0	13	0.4	11	0.3
Neck pain	6	0.7	10	1.1	7	0.7
Psychiatric						
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
Þ Includes pneumonia, atypical pneumonia, bacterial pneumonia, staphylococcal pneumonia, aspiration pneumonia, lower respiratory tract infection, lung infection, lung infection pseudomonal
β Includes peripheral sensory neuropathy, peripheral neuropathy, hypoesthesia, dysesthesia
à Includes back pain, musculoskeletal chest pain, musculoskeletal pain, myalgia

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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 (%)
Hematology						
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
Chemistry						
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 2799 patients with melanoma or NSCLC treated with KEYTRUDA as a single agent, 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

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corticosteroid therapy. Serious adverse reactions occurred in 16% of patients. The most frequent serious adverse reactions (≥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 ≥10% of Patients with cHL in KEYNOTE-087

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

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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 (%)
Chemistry		
Hypertransaminasemia‡	34	2
Increased alkaline phosphatase	17	0
Increased creatinine	15	0.5
Hematology		
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.

Table 18: Adverse Reactions in ≥10% of Patients with PMBCL in KEYNOTE-170

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks N=53	
	All Grades* (%)	Grades 3-4 (%)
Musculoskeletal and Connective Tissue		
Musculoskeletal pain†	30	0
Infections		
Upper respiratory tract infection‡	28	0
General		
Pyrexia	28	0
Fatigue§	23	2
Respiratory, Thoracic and Mediastinal		
Cough¶	26	2
Dyspnea	21	11
Gastrointestinal		
Diarrhea#	13	2
Abdominal pain Þ	13	0
Nausea	11	0
Cardiac		
Arrhythmia β	11	4
Nervous System		
Headache	11	0

* Graded per NCI CTCAE v4.0
† Includes arthralgia, back pain, myalgia, musculoskeletal pain, pain in extremity, musculoskeletal chest pain, bone pain, neck pain, non-cardiac chest pain
‡ Includes nasopharyngitis, pharyngitis, rhinorrhea, rhinitis, sinusitis, upper respiratory tract infection
§ Includes fatigue, asthenia
¶ Includes allergic cough, cough, productive cough
\# Includes diarrhea, gastroenteritis
Þ Includes abdominal pain, abdominal pain upper
β Includes atrial fibrillation, sinus tachycardia, supraventricular tachycardia, tachycardia

Other clinically important adverse reactions that occurred in less than 10% of patients in KEYNOTE-170 included hypothyroidism (8%), hyperthyroidism and pericarditis (4% each), and thyroiditis, pericardial effusion, pneumonitis, arthritis and acute kidney injury (2% each).

Table 19: Laboratory Abnormalities Worsened from Baseline Occurring in ≥15% of PMBCL Patients Receiving KEYTRUDA in KEYNOTE-170

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks	
	All Grades† (%)	Grades 3-4 (%)
Hematology		
Anemia	47	0
Leukopenia	35	9
Lymphopenia	32	18
Neutropenia	30	11
Chemistry		
Hyperglycemia	38	4
Hypophosphatemia	29	10
Hypertransaminasemia‡	27	4
Hypoglycemia	19	0
Increased alkaline phosphatase	17	0
Increased creatinine	17	0
Hypocalcemia	15	4
Hypokalemia	15	4

* 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: 44 to 48 patients)
† Graded per NCI CTCAE v4.0
‡ Includes elevation of AST or ALT

Urothelial Carcinoma

Cisplatin Ineligible Patients with Urothelial Carcinoma

The safety of KEYTRUDA was investigated in KEYNOTE-052, a single-arm trial that enrolled 370 patients with locally advanced or metastatic urothelial carcinoma who were not eligible for cisplatin-containing chemotherapy. Patients with autoimmune disease or medical conditions that required systemic corticosteroids or other immunosuppressive medications were ineligible *[see Clinical Studies (14.7)]*. Patients received KEYTRUDA 200 mg every 3 weeks until unacceptable toxicity or either radiographic or clinical disease progression.

The median duration of exposure to KEYTRUDA was 2.8 months (range: 1 day to 15.8 months).

KEYTRUDA was discontinued due to adverse reactions in 11% of patients. Eighteen patients (5%) died from causes other than disease progression. Five patients (1.4%) who were treated with KEYTRUDA experienced sepsis which led to death, and three patients (0.8%) experienced pneumonia which led to death. Adverse reactions leading to interruption of KEYTRUDA occurred in 22% of patients; the most common (≥1%) were liver enzyme increase, diarrhea, urinary tract infection, acute kidney injury, fatigue, joint pain, and pneumonia. Serious adverse reactions occurred in 42% of patients. The most frequent serious adverse reactions (≥2%) were urinary tract infection, hematuria, acute kidney injury, pneumonia, and urosepsis.

Immune-related adverse reactions that required systemic glucocorticoids occurred in 8% of patients, use of hormonal supplementation due to an immune-related adverse reaction occurred in 8% of patients, and 5% of patients required at least one steroid dose ≥40 mg oral prednisone equivalent.

Table 20 summarizes adverse reactions in patients on KEYTRUDA in KEYNOTE-052.

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Table 20: Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-052

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks N=370	
	All Grades* (%)	Grades 3–4 (%)
General		
Fatigue[†¶]	38	6
Pyrexia	11	0.5
Weight loss	10	0
Musculoskeletal and Connective Tissue		
Musculoskeletal pain[‡]	24	4.9
Arthralgia	10	1.1
Metabolism and Nutrition		
Decreased appetite	22	1.6
Hyponatremia	10	4.1
Gastrointestinal		
Constipation	21	1.1
Diarrhea[§]	20	2.4
Nausea	18	1.1
Abdominal pain[¶]	18	2.7
Elevated LFTs[#]	13	3.5
Vomiting	12	0
Skin and Subcutaneous Tissue		
Rash[Þ]	21	0.5
Pruritus	19	0.3
Edema peripheral	14	1.1
Infections		
Urinary tract infection	19	9
Blood and Lymphatic System		
Anemia	17	7
Respiratory, Thoracic, and Mediastinal		
Cough	14	0
Dyspnea	11	0.5
Renal and Urinary		
Increased blood creatinine	11	1.1
Hematuria	13	3.0

* Graded per NCI CTCAE v4.0
† Includes fatigue, asthenia
‡ Includes back pain, bone pain, musculoskeletal chest pain, musculoskeletal pain, myalgia, neck pain, pain in extremity, spinal pain
§ Includes diarrhea, colitis, enterocolitis, gastroenteritis, frequent bowel movements
¶ Includes abdominal pain, pelvic pain, flank pain, abdominal pain lower, tumor pain, bladder pain, hepatic pain, suprapubic pain, abdominal discomfort, abdominal pain upper
\# Includes autoimmune hepatitis, hepatitis, hepatitis toxic, liver injury, increased transaminases, hyperbilirubinemia, increased blood bilirubin, increased alanine aminotransferase, increased aspartate aminotransferase, increased hepatic enzymes, increased liver function tests
Þ Includes dermatitis, dermatitis bullous, eczema, erythema, rash, rash macular, rash maculo-papular, rash pruritic, rash pustular, skin reaction, dermatitis acneiform, seborrheic dermatitis, palmar-plantar erythrodysesthesia syndrome, rash generalized

Previously Treated Urothelial Carcinoma

The safety of KEYTRUDA for the treatment of patients with locally advanced or metastatic urothelial carcinoma with disease progression following platinum-containing chemotherapy was investigated in KEYNOTE-045. KEYNOTE-045 was a multicenter, open-label, randomized (1:1), active-controlled trial in which 266 patients received KEYTRUDA 200 mg every 3 weeks or investigator's choice of chemotherapy (n=255), consisting of paclitaxel (n=84), docetaxel (n=84) or vinflunine (n=87) *[see Clinical Studies (14.7)]*. Patients with autoimmune disease or a medical condition that required systemic corticosteroids or other immunosuppressive medications were ineligible.

The median duration of exposure was 3.5 months (range: 1 day to 20 months) in patients who received KEYTRUDA and 1.5 months (range: 1 day to 14 months) in patients who received chemotherapy.

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KEYTRUDA was discontinued due to adverse reactions in 8% of patients. The most common adverse reaction resulting in permanent discontinuation of KEYTRUDA was pneumonitis (1.9%). Adverse reactions leading to interruption of KEYTRUDA occurred in 20% of patients; the most common (≥1%) were urinary tract infection (1.5%), diarrhea (1.5%), and colitis (1.1%). Serious adverse reactions occurred in 39% of KEYTRUDA-treated patients. The most frequent serious adverse reactions (≥2%) in KEYTRUDA-treated patients were urinary tract infection, pneumonia, anemia, and pneumonitis.
Tables 21 and 22 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-045.

Table 21: Adverse Reactions Occurring in ≥10% of Patients Receiving KEYTRUDA in KEYNOTE-045

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks n=266		Chemotherapy* n=255	
	All Grades† (%)	Grades 3-4 (%)	All Grades† (%)	Grades 3-4 (%)
General				
Fatigue‡	38	4.5	56	11
Pyrexia	14	0.8	13	1.2
Musculoskeletal and Connective Tissue				
Musculoskeletal pain§	32	3.0	27	2.0
Skin and Subcutaneous Tissue				
Pruritus	23	0	6	0.4
Rash¶	20	0.4	13	0.4
Gastrointestinal				
Nausea	21	1.1	29	1.6
Constipation	19	1.1	32	3.1
Diarrhea#	18	2.3	19	1.6
Vomiting	15	0.4	13	0.4
Abdominal pain	13	1.1	13	2.7
Metabolism and Nutrition				
Decreased appetite	21	3.8	21	1.2
Infections				
Urinary tract infection	15	4.9	14	4.3
Respiratory, Thoracic and Mediastinal				
Cough Þ	15	0.4	9	0
Dyspnea ß	14	1.9	12	1.2
Renal and Urinary				
Hematuria à	12	2.3	8	1.6

* Chemotherapy: paclitaxel, docetaxel, or vinflunine
† Graded per NCI CTCAE v4.0
‡ Includes asthenia, fatigue, malaise, lethargy
§ Includes back pain, myalgia, bone pain, musculoskeletal pain, pain in extremity, musculoskeletal chest pain, musculoskeletal discomfort, neck pain
¶ Includes rash maculo-papular, rash, genital rash, rash erythematous, rash papular, rash pruritic, rash pustular, erythema, drug eruption, eczema, eczema asteatotic, dermatitis contact, dermatitis acneiform, dermatitis, seborrheic keratosis, lichenoid keratosis
\# Includes diarrhea, gastroenteritis, colitis, enterocolitis
Þ Includes cough, productive cough
ß Includes dyspnea, dyspnea exertional, wheezing
à Includes blood urine present, hematuria, chromaturia

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Table 22: Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Urothelial Carcinoma Patients Receiving KEYTRUDA in KEYNOTE-045

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks		Chemotherapy	
	All Grades† %	Grades 3-4 %	All Grades† %	Grades 3-4 %
Chemistry				
Hyperglycemia	52	8	60	7
Anemia	52	13	68	18
Lymphopenia	45	15	53	25
Hypoalbuminemia	43	1.7	50	3.8
Hyponatremia	37	9	47	13
Increased alkaline phosphatase	37	7	33	4.9
Increased creatinine	35	4.4	28	2.9
Hypophosphatemia	29	8	34	14
Increased AST	28	4.1	20	2.5
Hyperkalemia	28	0.8	27	6
Hypocalcemia	26	1.6	34	2.1

* 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: 240 to 248 patients) and chemotherapy (range: 238 to 244 patients); phosphate decreased: KEYTRUDA n=232 and chemotherapy n=222.

† Graded per NCI CTCAE v4.0

Gastric Cancer

Among the 259 patients with gastric cancer enrolled in KEYNOTE-059 *[see Clinical Studies (14.9)]*, the median duration of exposure to KEYTRUDA was 2.1 months (range: 1 day to 21.4 months). Patients with autoimmune disease or a medical condition that required immunosuppression or with clinical evidence of ascites by physical exam were ineligible. Adverse reactions occurring in patients with gastric cancer were similar to those occurring in 2799 patients with melanoma or NSCLC treated with KEYTRUDA as a single agent.

Esophageal Cancer

Among the 314 patients with esophageal cancer enrolled in KEYNOTE-181 *[see Clinical Studies (14.10)]* treated with KEYTRUDA, the median duration of exposure to KEYTRUDA was 2.1 months (range: 1 day to 24.4 months). Patients with autoimmune disease or a medical condition that required immunosuppression were ineligible. Adverse reactions occurring in patients with esophageal cancer were similar to those occurring in 2799 patients with melanoma or NSCLC treated with KEYTRUDA as a single agent.

Cervical Cancer

Among the 98 patients with cervical cancer enrolled in Cohort E of KEYNOTE-158 *[see Clinical Studies (14.11)]*, the median duration of exposure to KEYTRUDA was 2.9 months (range: 1 day to 22.1 months). Patients with autoimmune disease or a medical condition that required immunosuppression were ineligible.

KEYTRUDA was discontinued due to adverse reactions in 8% of patients. Serious adverse reactions occurred in 39% of patients receiving KEYTRUDA. The most frequent serious adverse reactions reported included anemia (7%), fistula (4.1%), hemorrhage (4.1%), and infections [except UTIs] (4.1%). Tables 23 and 24 summarize adverse reactions and laboratory abnormalities, respectively, in patients on KEYTRUDA in KEYNOTE-158.

Table 23: Adverse Reactions Occurring in ≥10% of Patients with Cervical Cancer in KEYNOTE-158

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks N=98	
	All Grades* (%)	Grades 3–4 (%)
General		
Fatigue†	43	5
Pain‡	22	2.0
Pyrexia	19	1.0
Edema peripheral§	15	2.0
Musculoskeletal and Connective Tissue		
Musculoskeletal pain¶	27	5
Gastrointestinal		
Diarrhea#	23	2.0
Abdominal painÞ	22	3.1
Nausea	19	0
Vomiting	19	1.0
Constipation	14	0
Metabolism and Nutrition		
Decreased appetite	21	0
Vascular		
Hemorrhageß	19	5
Infections		
UTIà	18	6
Infection (except UTI)è	16	4.1
Skin and Subcutaneous Tissue		
Rashð	17	2.0
Endocrine		
Hypothyroidism	11	0
Nervous System		
Headache	11	2.0
Respiratory, Thoracic and Mediastinal		
Dyspnea	10	1.0

* Graded per NCI CTCAE v4.0

† Includes asthenia, fatigue, lethargy, malaise

‡ Includes breast pain, cancer pain, dysesthesia, dysuria, ear pain, gingival pain, groin pain, lymph node pain, oropharyngeal pain, pain, pain of skin, pelvic pain, radicular pain, stoma site pain, toothache

§ Includes edema peripheral, peripheral swelling

¶ Includes arthralgia, back pain, musculoskeletal chest pain, musculoskeletal pain, myalgia, myositis, neck pain, non-cardiac chest pain, pain in extremity

\# Includes colitis, diarrhea, gastroenteritis

Þ Includes abdominal discomfort, abdominal distension, abdominal pain, abdominal pain lower, abdominal pain upper

ß Includes epistaxis, hematuria, hemoptysis, metrorrhagia, rectal hemorrhage, uterine hemorrhage, vaginal hemorrhage

à Includes bacterial pyelonephritis, pyelonephritis acute, urinary tract infection, urinary tract infection bacterial, urinary tract infection pseudomonal, urosepsis

è Includes cellulitis, clostridium difficile infection, device-related infection, empyema, erysipelas, herpes virus infection, infected neoplasm, infection, influenza, lower respiratory tract congestion, lung infection, oral candidiasis, oral fungal infection, osteomyelitis, pseudomonas infection, respiratory tract infection, tooth abscess, upper respiratory tract infection, uterine abscess, vulvovaginal candidiasis

ð Includes dermatitis, drug eruption, eczema, erythema, palmar-plantar erythrodysesthesia syndrome, rash, rash generalized, rash maculo-papular

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Table 24: Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Patients with Cervical Cancer in KEYNOTE-158

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks	
	All Grades† (%)	Grades 3-4 (%)
Hematology		
Anemia	54	24
Lymphopenia	47	9
Chemistry		
Hypoalbuminemia	44	5
Increased alkaline phosphatase	42	2.6
Hyponatremia	38	13
Hyperglycemia	38	1.3
Increased AST	34	3.9
Increased creatinine	32	5
Hypocalcemia	27	0
Increased ALT	21	3.9
Hypokalemia	20	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 (range: 76 to 79 patients)

† Graded per NCI CTCAE v4.0

Other laboratory abnormalities occurring in ≥10% of patients receiving KEYTRUDA were hypophosphatemia (19% all Grades; 6% Grades 3-4), increased INR (19% all Grades; 0% Grades 3-4), hypercalcemia (14% all Grades; 2.6% Grades 3-4), platelet count decreased (14% all Grades; 1.3% Grades 3-4), activated partial thromboplastin time prolonged (14% all Grades; 0% Grades 3-4), hypoglycemia (13% all Grades; 1.3% Grades 3-4), white blood cell decreased (13% all Grades; 2.6% Grades 3-4), and hyperkalemia (13% all Grades; 1.3% Grades 3-4).

HCC

Among the 104 patients with HCC who received KEYTRUDA in KEYNOTE-224 *[see Clinical Studies (14.12)]*, the median duration of exposure to KEYTRUDA was 4.2 months (range: 1 day to 1.5 years). Adverse reactions occurring in patients with HCC were generally similar to those in 2799 patients with melanoma or NSCLC treated with KEYTRUDA as a single agent, with the exception of increased incidences of ascites (8% Grades 3-4) and immune-mediated hepatitis (2.9%). Laboratory abnormalities (Grades 3-4) that occurred at a higher incidence were elevated AST (20%), ALT (9%), and hyperbilirubinemia (10%).

MCC

Among the 50 patients with MCC enrolled in KEYNOTE-017 *[see Clinical Studies (14.13)]*, the median duration of exposure to KEYTRUDA was 6.6 months (range 1 day to 23.6 months). Patients with autoimmune disease or a medical condition that required immunosuppression were ineligible. Adverse reactions occurring in patients with MCC were similar to those occurring in 2799 patients with melanoma or NSCLC treated with KEYTRUDA as a single agent. Laboratory abnormalities (Grades 3-4) that occurred at a higher incidence were elevated AST (11%) and hyperglycemia (19%).

RCC

The safety of KEYTRUDA in combination with axitinib was investigated in KEYNOTE-426 *[see Clinical Studies (14.14)]*. Patients with medical conditions that required systemic corticosteroids or other immunosuppressive medications or had a history of severe autoimmune disease other than type 1 diabetes, vitiligo, Sjogren's syndrome, and hypothyroidism stable on hormone replacement were ineligible. Patients received KEYTRUDA 200 mg intravenously every 3 weeks and axitinib 5 mg orally twice daily, or sunitinib 50 mg once daily for 4 weeks and then off treatment for 2 weeks. The median duration of exposure to the combination therapy of KEYTRUDA and axitinib was 10.4 months (range: 1 day to 21.2 months).

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The study population characteristics were: median age of 62 years (range: 30 to 89), 40% age 65 or older; 71% male; 80% White; and 80% Karnofsky Performance Status (KPS) of 90-100 and 20% KPS of 70-80.

Fatal adverse reactions occurred in 3.3% of patients receiving KEYTRUDA in combination with axitinib. These included 3 cases of cardiac arrest, 2 cases of pulmonary embolism and 1 case each of cardiac failure, death due to unknown cause, myasthenia gravis, myocarditis, Fournier's gangrene, plasma cell myeloma, pleural effusion, pneumonitis, and respiratory failure.

Serious adverse reactions occurred in 40% of patients receiving KEYTRUDA in combination with axitinib. Serious adverse reactions in ≥1% of patients receiving KEYTRUDA in combination with axitinib included hepatotoxicity (7%), diarrhea (4.2%), acute kidney injury (2.3%), dehydration (1%), and pneumonitis (1%).

Permanent discontinuation due to an adverse reaction of either KEYTRUDA or axitinib occurred in 31% of patients; 13% KEYTRUDA only, 13% axitinib only, and 8% both drugs. The most common adverse reaction (>1%) resulting in permanent discontinuation of KEYTRUDA, axitinib, or the combination was hepatotoxicity (13%), diarrhea/colitis (1.9%), acute kidney injury (1.6%), and cerebrovascular accident (1.2%).

Dose interruptions or reductions due to an adverse reaction, excluding temporary interruptions of KEYTRUDA infusions due to infusion-related reactions, occurred in 76% of patients receiving KEYTRUDA in combination with axitinib. This includes interruption of KEYTRUDA in 50% of patients. Axitinib was interrupted in 64% of patients and dose reduced in 22% of patients. The most common adverse reactions (>10%) resulting in interruption of KEYTRUDA were hepatotoxicity (14%) and diarrhea (11%), and the most common adverse reactions (>10%) resulting in either interruption or reduction of axitinib were hepatotoxicity (21%), diarrhea (19%), and hypertension (18%).

The most common adverse reactions (≥20%) in patients receiving KEYTRUDA and axitinib were diarrhea, fatigue/asthenia, hypertension, hypothyroidism, decreased appetite, hepatotoxicity, palmar-plantar erythrodysesthesia, nausea, stomatitis/mucosal inflammation, dysphonia, rash, cough, and constipation.

Twenty-seven percent (27%) of patients treated with KEYTRUDA in combination with axitinib received an oral prednisone dose equivalent to ≥40 mg daily for an immune-mediated adverse reaction.

Tables 25 and 26 summarize the adverse reactions and laboratory abnormalities, respectively, that occurred in at least 20% of patients treated with KEYTRUDA and axitinib in KEYNOTE-426.

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Table 25: Adverse Reactions Occurring in ≥20% of Patients Receiving KEYTRUDA with Axitinib in KEYNOTE-426

Adverse Reaction	KEYTRUDA 200 mg every 3 weeks and Axitinib n=429		Sunitinib n=425	
	All Grades* (%)	Grades 3-4 (%)	All Grades (%)	Grades 3-4 (%)
Gastrointestinal				
Diarrhea†	56	11	45	5
Nausea	28	0.9	32	0.9
Constipation	21	0	15	0.2
General				
Fatigue/Asthenia	52	5	51	10
Vascular				
Hypertension‡	48	24	48	20
Hepatobiliary				
Hepatotoxicity§	39	20	25	4.9
Endocrine				
Hypothyroidism	35	0.2	32	0.2
Metabolism and Nutrition				
Decreased appetite	30	2.8	29	0.7
Skin and Subcutaneous Tissue				
Palmar-plantar erythrodysaesthesia syndrome	28	5	40	3.8
Stomatitis/Mucosal inflammation	27	1.6	41	4
Rash¶	25	1.4	21	0.7
Respiratory, Thoracic and Mediastinal				
Dysphonia	25	0.2	3.3	0
Cough	21	0.2	14	0.5

* Graded per NCI CTCAE v4.03

† Includes diarrhea, colitis, enterocolitis, gastroenteritis, enteritis, enterocolitis hemorrhagic

‡ Includes hypertension, blood pressure increased, hypertensive crisis, labile hypertension

§ Includes ALT increased, AST increased, autoimmune hepatitis, blood bilirubin increased, drug-induced liver injury, hepatic enzyme increased, hepatic function abnormal, hepatitis, hepatitis fulminant, hepatocellular injury, hepatotoxicity, hyperbilirubinemia, immune-mediated hepatitis, liver function test increased, liver injury, transaminases increased

¶ Includes rash, butterfly rash, dermatitis, dermatitis acneform, dermatitis atopic, dermatitis bullous, dermatitis contact, exfoliative rash, genital rash, rash erythematous, rash generalized, rash macular, rash maculopapular, rash papular, rash pruritic, seborrhoeric dermatitis, skin discoloration, skin exfoliation, perineal rash

Reference ID: 4470211

Table 26: Laboratory Abnormalities Worsened from Baseline Occurring in ≥20% of Patients Receiving KEYTRUDA with Axitinib in KEYNOTE-426

Laboratory Test*	KEYTRUDA 200 mg every 3 weeks and Axitinib		Sunitinib	
	All Grades† %	Grades 3-4 %	All Grades %	Grades 3-4 %
Chemistry				
Hyperglycemia	62	9	54	3.2
Increased ALT	60	20	44	5
Increased AST	57	13	56	5
Increased creatinine	43	4.3	40	2.4
Hyponatremia	35	8	29	8
Hyperkalemia	34	6	22	1.7
Hypoalbuminemia	32	0.5	34	1.7
Hypercalcemia	27	0.7	15	1.9
Hypophosphatemia	26	6	49	17
Increased alkaline phosphatase	26	1.7	30	2.7
Hypocalcemia‡	22	0.2	29	0.7
Blood bilirubin increased	22	2.1	21	1.9
Activated partial thromboplastin time prolonged§	22	1.2	14	0
Hematology				
Lymphopenia	33	11	46	8
Anemia	29	2.1	65	8
Thrombocytopenia	27	1.4	78	14

* Each test incidence is based on the number of patients who had both baseline and at least one on-study laboratory measurement available: KEYTRUDA/axitinib (range: 342 to 425 patients) and sunitinib (range: 345 to 422 patients).

† Graded per NCI CTCAE v4.03

‡ Corrected for albumin

§ Two patients with a Grade 3 elevated activated partial thromboplastin time prolonged (aPTT) were also reported as having an adverse reaction of hepatotoxicity.

6.2 Immunogenicity

As with all therapeutic proteins, there is the potential for immunogenicity. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors, including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of incidence of antibodies to pembrolizumab in the studies described below with the incidences of antibodies in other studies or to other products may be misleading.

Trough levels of pembrolizumab interfere with the electrochemiluminescent (ECL) assay results; therefore, a subset analysis was performed in the patients with a concentration of pembrolizumab below the drug tolerance level of the anti-product antibody assay. In clinical studies in patients treated with pembrolizumab at a dose of 2 mg/kg every 3 weeks, 200 mg every 3 weeks, or 10 mg/kg every 2 or 3 weeks, 27 (2.1%) of 1289 evaluable patients tested positive for treatment-emergent anti-pembrolizumab antibodies of whom six (0.5%) patients had neutralizing antibodies against pembrolizumab. There was no evidence of an altered pharmacokinetic profile or increased infusion reactions with anti-pembrolizumab binding antibody development.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Based on its mechanism of action, KEYTRUDA can cause fetal harm when administered to a pregnant woman. There are no available human data informing the risk of embryo-fetal toxicity. In animal models, the PD-1/PD-L1 signaling pathway is important in the maintenance of pregnancy through induction of maternal immune tolerance to fetal tissue *(see Data)*. Human IgG4 (immunoglobulins) are known to cross

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the placenta; therefore, pembrolizumab has the potential to be transmitted from the mother to the developing fetus. Advise pregnant women of the potential risk to a fetus.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Data

Animal Data

Animal reproduction studies have not been conducted with KEYTRUDA to evaluate its effect on reproduction and fetal development. A literature-based assessment of the effects of the PD-1 pathway on reproduction demonstrated that a central function of the PD-1/PD-L1 pathway is to preserve pregnancy by maintaining maternal immune tolerance to the fetus. Blockade of PD-L1 signaling has been shown in murine models of pregnancy to disrupt tolerance to the fetus and to result in an increase in fetal loss; therefore, potential risks of administering KEYTRUDA during pregnancy include increased rates of abortion or stillbirth. As reported in the literature, there were no malformations related to the blockade of PD-1 signaling in the offspring of these animals; however, immune-mediated disorders occurred in PD-1 knockout mice. Based on its mechanism of action, fetal exposure to pembrolizumab may increase the risk of developing immune-mediated disorders or of altering the normal immune response.

8.2 Lactation

Risk Summary

There are no data on the presence of pembrolizumab in either animal or human milk or its effects on the breastfed child or on milk production. Because of the potential for serious adverse reactions in breastfed children, advise women not to breastfeed during treatment with KEYTRUDA and for 4 months after the final dose.

8.3 Females and Males of Reproductive Potential

Pregnancy Testing

Verify pregnancy status in females of reproductive potential prior to initiating KEYTRUDA *[see Use in Specific Populations (8.1)].*

Contraception

KEYTRUDA can cause fetal harm when administered to a pregnant woman *[see Warnings and Precautions (5.11), Use in Specific Populations (8.1)].* Advise females of reproductive potential to use effective contraception during treatment with KEYTRUDA and for at least 4 months following the final dose.

8.4 Pediatric Use

The safety and effectiveness of KEYTRUDA have been established in pediatric patients with cHL, PMBCL, and MSI-H cancer. Use of KEYTRUDA in pediatric patients with cHL, PMBCL, and MSI-H cancers is supported by evidence from adequate and well-controlled studies of KEYTRUDA in adults with additional pharmacokinetic and safety data in pediatric patients *[see Adverse Reactions (6.1), Clinical Studies (14.5, 14.6, 14.8), Clinical Pharmacology (12.3)]*.

There is limited experience with KEYTRUDA in pediatric patients. In a trial (NCT02332668), 40 pediatric patients (16 children ages 2 years to less than 12 years and 24 adolescents ages 12 years to 18 years) with various cancers, including unapproved usages, were administered KEYTRUDA 2 mg/kg every 3 weeks. Patients received KEYTRUDA for a median of 3 doses (range: 1-17 doses), with 34 patients (85%) receiving KEYTRUDA for 2 doses or more.

The safety profile in these pediatric patients was similar to that seen in adults; adverse reactions that occurred at a higher rate (≥15% difference) in pediatric patients when compared to adults <65 years of age were fatigue (45%), vomiting (38%), abdominal pain (28%), increased transaminases (28%) and hyponatremia (18%).

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The concentrations of pembrolizumab in pediatric patients were comparable to those observed in adult patients at the same dose regimen of 2 mg/kg every 3 weeks.

The safety and effectiveness of KEYTRUDA in pediatric patients have not been established in the other approved indications *[see Indications and Usage (1)]*.

8.5 Geriatric Use

Of 3991 patients with melanoma, NSCLC, HNSCC, cHL or urothelial carcinoma who were treated with KEYTRUDA in clinical studies, 46% were 65 years and over and 16% were 75 years and over. No overall differences in safety or effectiveness were observed between elderly patients and younger patients.

11 DESCRIPTION

Pembrolizumab is a programmed death receptor-1 (PD 1)-blocking antibody. Pembrolizumab is a humanized monoclonal IgG4 kappa antibody with an approximate molecular weight of 149 kDa. Pembrolizumab is produced in recombinant Chinese hamster ovary (CHO) cells.

KEYTRUDA (pembrolizumab) for injection is a sterile, preservative-free, white to off-white lyophilized powder in single-dose vials for intravenous use. Each 2 mL of reconstituted solution contains 50 mg of pembrolizumab and is formulated in L-histidine (3.1 mg), polysorbate 80 (0.4 mg), and sucrose (140 mg). May contain hydrochloric acid/sodium hydroxide to adjust pH to 5.5.

KEYTRUDA (pembrolizumab) injection is a sterile, preservative-free, clear to slightly opalescent, colorless to slightly yellow solution for intravenous use. Each vial contains 100 mg of pembrolizumab in 4 mL of solution. Each 1 mL of solution contains 25 mg of pembrolizumab and is formulated in: L-histidine (1.55 mg), polysorbate 80 (0.2 mg), sucrose (70 mg), and Water for Injection, USP.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Binding of the PD-1 ligands, PD-L1 and PD-L2, to the PD-1 receptor found on T cells, inhibits T cell proliferation and cytokine production. Upregulation of PD-1 ligands occurs in some tumors and signaling through this pathway can contribute to inhibition of active T-cell immune surveillance of tumors. Pembrolizumab is a monoclonal antibody that binds to the PD-1 receptor and blocks its interaction with PD-L1 and PD-L2, releasing PD-1 pathway-mediated inhibition of the immune response, including the anti-tumor immune response. In syngeneic mouse tumor models, blocking PD-1 activity resulted in decreased tumor growth.

12.2 Pharmacodynamics

Based on dose/exposure efficacy and safety relationships, there are no clinically significant differences in efficacy and safety between pembrolizumab doses of 200 mg or 2 mg/kg every 3 weeks in patients with melanoma or NSCLC.

12.3 Pharmacokinetics

The pharmacokinetics (PK) of pembrolizumab was characterized using a population PK analysis with concentration data collected from 2993 patients with various cancers who received pembrolizumab doses of 1 to 10 mg/kg every 2 weeks, 2 to 10 mg/kg every 3 weeks, or 200 mg every 3 weeks.

Steady-state concentrations of pembrolizumab were reached by 16 weeks of repeated dosing with an every 3-week regimen and the systemic accumulation was 2.1-fold. The peak concentration (C_{max}), trough concentration (C_{min}), and area under the plasma concentration versus time curve at steady state (AUC_{ss}) of pembrolizumab increased dose proportionally in the dose range of 2 to 10 mg/kg every 3 weeks.

<u>Distribution</u>

The geometric mean value (CV%) for volume of distribution at steady state is 6.0 L (20%).

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Elimination

Pembrolizumab clearance (CV%) is approximately 23% lower [geometric mean, 195 mL/day (40%)] at steady state than that after the first dose [252 mL/day (37%)]; this decrease in clearance with time is not considered clinically important. The terminal half-life ($t_{1/2}$) is 22 days (32%).

Specific Populations

The following factors had no clinically important effect on the CL of pembrolizumab: age (range: 15 to 94 years), sex, race (89% White), renal impairment (eGFR ≥ 15 mL/min/1.73 m^2), mild hepatic impairment (total bilirubin ≤ upper limit of normal (ULN) and AST > ULN or total bilirubin between 1 and 1.5 times ULN and any AST), or tumor burden. The impact of moderate or severe hepatic impairment on the pharmacokinetics of pembrolizumab is unknown.

Pediatric Patients: Pembrolizumab concentrations with weight-based dosing at 2 mg/kg every 3 weeks in pediatric patients (2 to 17 years) are comparable to those of adults at the same dose.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

No studies have been performed to test the potential of pembrolizumab for carcinogenicity or genotoxicity.

Fertility studies have not been conducted with pembrolizumab. In 1-month and 6-month repeat-dose toxicology studies in monkeys, there were no notable effects in the male and female reproductive organs; however, most animals in these studies were not sexually mature.

13.2 Animal Toxicology and/or Pharmacology

In animal models, inhibition of PD-1 signaling resulted in an increased severity of some infections and enhanced inflammatory responses. M. tuberculosis-infected PD-1 knockout mice exhibit markedly decreased survival compared with wild-type controls, which correlated with increased bacterial proliferation and inflammatory responses in these animals. PD-1 knockout mice have also shown decreased survival following infection with lymphocytic choriomeningitis virus (LCMV). Administration of pembrolizumab in chimpanzees with naturally occurring chronic hepatitis B infection resulted in two out of four animals with significantly increased levels of serum ALT, AST, and GGT, which persisted for at least 1 month after discontinuation of pembrolizumab.

14 CLINICAL STUDIES

14.1 Melanoma

Ipilimumab-Naive Melanoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-006 (NCT01866319), a randomized (1:1:1), open-label, multicenter, active-controlled trial in 834 patients. Patients were randomized to receive KEYTRUDA at a dose of 10 mg/kg intravenously every 2 weeks or 10 mg/kg intravenously every 3 weeks until disease progression or unacceptable toxicity or to ipilimumab 3 mg/kg intravenously every 3 weeks for 4 doses unless discontinued earlier for disease progression or unacceptable toxicity. Patients with disease progression could receive additional doses of treatment unless disease progression was symptomatic, was rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at 4 to 6 weeks with repeat imaging. Randomization was stratified by line of therapy (0 vs. 1), ECOG PS (0 vs. 1), and PD-L1 expression (≥1% of tumor cells [positive] vs. <1% of tumor cells [negative]) according to an investigational use only (IUO) assay. Key eligibility criteria were unresectable or metastatic melanoma; no prior ipilimumab; and no more than one prior systemic treatment for metastatic melanoma. Patients with BRAF V600E mutation-positive melanoma were not required to have received prior BRAF inhibitor therapy. Patients with autoimmune disease; a medical condition that required immunosuppression; previous severe hypersensitivity to other monoclonal antibodies; and HIV, hepatitis B or hepatitis C infection, were ineligible. Assessment of tumor status was performed at 12 weeks, then every 6 weeks through Week 48, followed by every 12 weeks thereafter. The major efficacy outcome measures were overall survival (OS) and progression-free survival (PFS; as assessed by blinded independent central review [BICR] using Response Evaluation Criteria in Solid

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Tumors [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 objective response rate (ORR) and duration of response (DoR).

The study population characteristics were: median age of 62 years (range: 18 to 89); 60% male; 98% White; 66% had no prior systemic therapy for metastatic disease; 69% ECOG PS of 0; 80% had PD-L1 positive melanoma, 18% had PD-L1 negative melanoma, and 2% had unknown PD-L1 status using the IUO assay; 65% had M1c stage disease; 68% with normal LDH; 36% with reported BRAF mutation-positive melanoma; and 9% with a history of brain metastases. Among patients with BRAF mutation-positive melanoma, 139 (46%) were previously treated with a BRAF inhibitor.

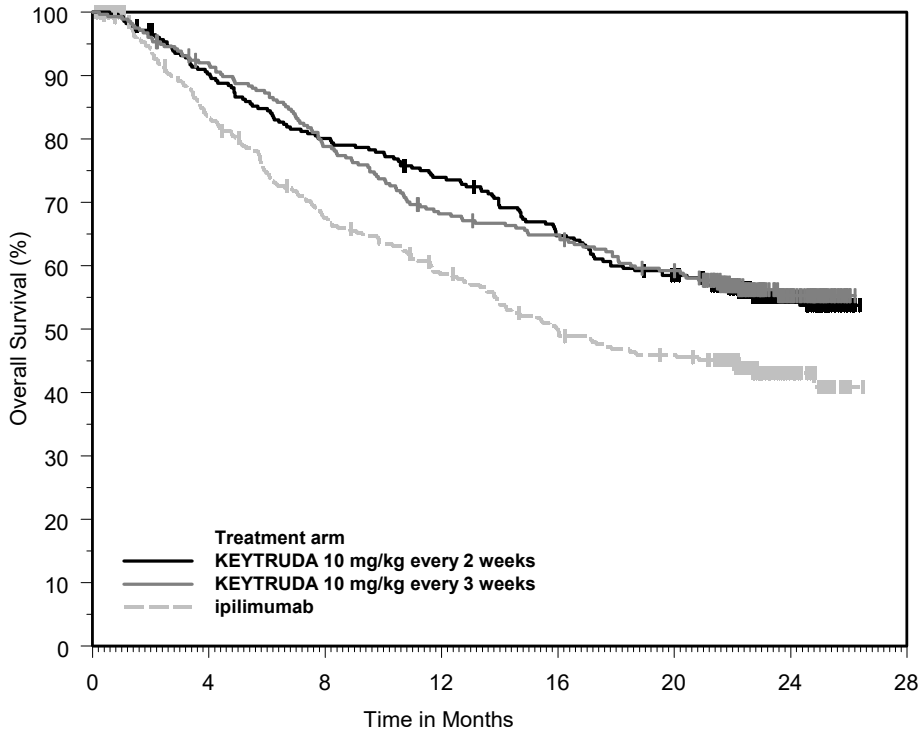
The study demonstrated statistically significant improvements in OS and PFS for patients randomized to KEYTRUDA as compared to ipilimumab. Among the 91 patients randomized to KEYTRUDA 10 mg/kg every 3 weeks with an objective response, response durations ranged from 1.4+ to 8.1+ months. Among the 94 patients randomized to KEYTRUDA 10 mg/kg every 2 weeks with an objective response, response durations ranged from 1.4+ to 8.2 months. Efficacy results are summarized in Table 27 and Figure 1.

Table 27: Efficacy Results in KEYNOTE-006

Endpoint	**KEYTRUDA 10 mg/kg every 3 weeks n=277**	**KEYTRUDA 10 mg/kg every 2 weeks n=279**	**Ipilimumab 3 mg/kg every 3 weeks n=278**
OS			
Deaths (%)	92 (33%)	85 (30%)	112 (40%)
Hazard ratio* (95% CI)	0.69 (0.52, 0.90)	0.63 (0.47, 0.83)	---
p-Value (stratified log-rank)	0.004	<0.001	---
PFS by BICR			
Events (%)	157 (57%)	157 (56%)	188 (68%)
Median in months (95% CI)	4.1 (2.9, 6.9)	5.5 (3.4, 6.9)	2.8 (2.8, 2.9)
Hazard ratio* (95% CI)	0.58 (0.47, 0.72)	0.58 (0.46, 0.72)	---
p-Value (stratified log-rank)	<0.001	<0.001	---
Best objective response by BICR			
ORR (95% CI)	33% (27, 39)	34% (28, 40)	12% (8, 16)
Complete response rate	6%	5%	1%
Partial response rate	27%	29%	10%

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

Figure 1: Kaplan-Meier Curve for Overall Survival in KEYNOTE-006*



Number at Risk								
KEYTRUDA 10 mg/kg every 2 weeks:	279	249	221	202	176	156	44	0
KEYTRUDA 10 mg/kg every 3 weeks:	277	251	215	184	174	156	43	0
ipilimumab:	278	213	170	145	122	110	28	0

**based on the final analysis with an additional follow-up of 9 months (total of 383 deaths as pre-specified in the protocol)*

Ipilimumab-Refractory Melanoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-002 (NCT01704287), a multicenter, randomized (1:1:1), active-controlled trial in 540 patients randomized to receive one of two doses of KEYTRUDA in a blinded fashion or investigator's choice chemotherapy. The treatment arms consisted of KEYTRUDA 2 mg/kg or 10 mg/kg intravenously every 3 weeks or investigator's choice of any of the following chemotherapy regimens: dacarbazine 1000 mg/m^2 intravenously every 3 weeks (26%), temozolomide 200 mg/m^2 orally once daily for 5 days every 28 days (25%), carboplatin AUC 6 mg/mL/min intravenously plus paclitaxel 225 mg/m^2 intravenously every 3 weeks for four cycles then carboplatin AUC of 5 mg/mL/min plus paclitaxel 175 mg/m^2 every 3 weeks (25%), paclitaxel 175 mg/m^2 intravenously every 3 weeks (16%), or carboplatin AUC 5 or 6 mg/mL/min intravenously every 3 weeks (8%). Randomization was stratified by ECOG PS (0 vs. 1), LDH levels (normal vs. elevated [≥110% ULN]) and BRAF V600 mutation status (wild-type [WT] or V600E). The trial included patients with unresectable or metastatic melanoma with progression of disease; refractory to two or more doses of ipilimumab (3 mg/kg or higher) and, if BRAF V600 mutation-positive, a BRAF or MEK inhibitor; and disease progression within 24 weeks following the last dose of ipilimumab. The trial excluded patients with uveal melanoma and active brain metastasis. Patients received KEYTRUDA until unacceptable toxicity; disease progression that was symptomatic, was rapidly progressive, required urgent intervention, occurred with a decline in performance status, or was confirmed at 4 to 6 weeks with repeat imaging; withdrawal of consent; or physician's decision to stop therapy for the patient. Assessment of tumor status was performed at 12 weeks after randomization, then every 6 weeks through week 48, followed by every 12 weeks thereafter. Patients on chemotherapy who experienced progression of disease were offered KEYTRUDA. The major efficacy outcomes were 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, and OS. Additional efficacy outcome measures were confirmed 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 62 years (range: 15 to 89), 43% age 65 or older; 61% male; 98% White; and 55% ECOG PS of 0 and 45% ECOG PS of 1. Twenty-three percent of patients were BRAF V600 mutation positive, 40% had elevated LDH at baseline, 82% had M1c disease, and 73% had two or more prior therapies for advanced or metastatic disease.

The study demonstrated a statistically significant improvement in PFS for patients randomized to KEYTRUDA as compared to control arm. There was no statistically significant difference between KEYTRUDA 2 mg/kg and chemotherapy or between KEYTRUDA 10 mg/kg and chemotherapy in the OS analysis in which 55% of the patients who had been randomized to receive chemotherapy had crossed over to receive KEYTRUDA. Among the 38 patients randomized to KEYTRUDA 2 mg/kg with an objective response, response durations ranged from 1.3+ to 11.5+ months. Among the 46 patients randomized to KEYTRUDA 10 mg/kg with an objective response, response durations ranged from 1.1+ to 11.1+ months. Efficacy results are summarized in Table 28.

Table 28: Efficacy Results in KEYNOTE-002

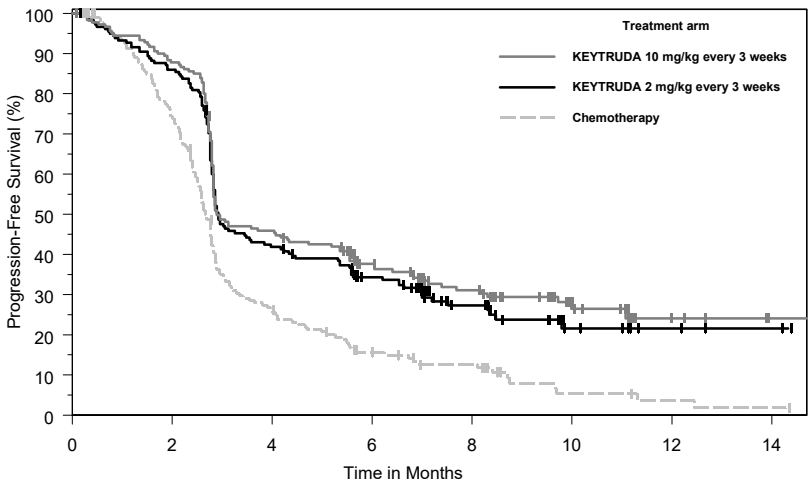
Endpoint	KEYTRUDA 2 mg/kg every 3 weeks n=180	KEYTRUDA 10 mg/kg every 3 weeks n=181	Chemotherapy n=179
PFS			
Number of Events, n (%)	129 (72%)	126 (70%)	155 (87%)
Progression, n (%)	105 (58%)	107 (59%)	134 (75%)
Death, n (%)	24 (13%)	19 (10%)	21 (12%)
Median in months (95% CI)	2.9 (2.8, 3.8)	2.9 (2.8, 4.7)	2.7 (2.5, 2.8)
p-Value (stratified log-rank)	<0.001	<0.001	---
Hazard ratio* (95% CI)	0.57 (0.45, 0.73)	0.50 (0.39, 0.64)	---
OS†			
Deaths (%)	123 (68%)	117 (65%)	128 (72%)
Hazard ratio* (95% CI)	0.86 (0.67, 1.10)	0.74 (0.57, 0.96)	---
p-Value (stratified log-rank)	0.117	0.011‡	---
Median in months (95% CI)	13.4 (11.0, 16.4)	14.7 (11.3, 19.5)	11.0 (8.9, 13.8)
Objective Response Rate			
ORR (95% CI)	21% (15, 28)	25% (19, 32)	4% (2, 9)
Complete response rate	2%	3%	0%
Partial response rate	19%	23%	4%

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

† With additional follow-up of 18 months after the PFS analysis

‡ Not statistically significant compared to multiplicity adjusted significance level of 0.01

Figure 2: Kaplan-Meier Curve for Progression-Free Survival in KEYNOTE-002



Number at Risk

KEYTRUDA 10 mg/kg:	181	158	82	55	39	15	5	1
KEYTRUDA 2 mg/kg:	180	153	74	53	26	9	4	2
Chemotherapy:	179	128	43	22	15	4	2	1

Adjuvant Treatment of Resected Melanoma

The efficacy of KEYTRUDA was investigated in KEYNOTE-054 (NCT02362594), a multicenter, randomized (1:1), double-blind, placebo-controlled trial in patients with completely resected stage IIIA (>1 mm lymph node metastasis), IIIB or IIIC melanoma. Patients were randomized to KEYTRUDA 200 mg intravenously every three weeks or placebo for up to one year until disease recurrence or unacceptable toxicity. Randomization was stratified by American Joint Committee on Cancer 7th edition (AJCC) stage (IIIA vs. IIIB vs. IIIC 1-3 positive lymph nodes vs. IIIC ≥4 positive lymph nodes) and geographic region (North America, European countries, Australia, and other countries as designated). Patients must have undergone lymph node dissection and, if indicated, radiotherapy within 13 weeks prior to starting treatment. The major efficacy outcome measure was investigator-assessed recurrence-free survival (RFS) in the whole population and in the population with PD-L1 positive tumors where RFS was defined as the time between the date of randomization and the date of first recurrence (local, regional, or distant metastasis) or death, whichever occurs first. Patients underwent imaging every 12 weeks after the first dose of KEYTRUDA for the first two years, then every 6 months from year 3 to 5, and then annually.

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); 50% were BRAF V600 mutation positive and 44% were BRAF wild-type; and 84% had PD-L1 positive melanoma with TPS ≥1% according to an IUO assay.

The trial demonstrated a statistically significant improvement in RFS for patients randomized to the KEYTRUDA arm compared with placebo. Efficacy results are summarized in Table 29 and Figure 3.

Table 29: Efficacy Results in KEYNOTE-054

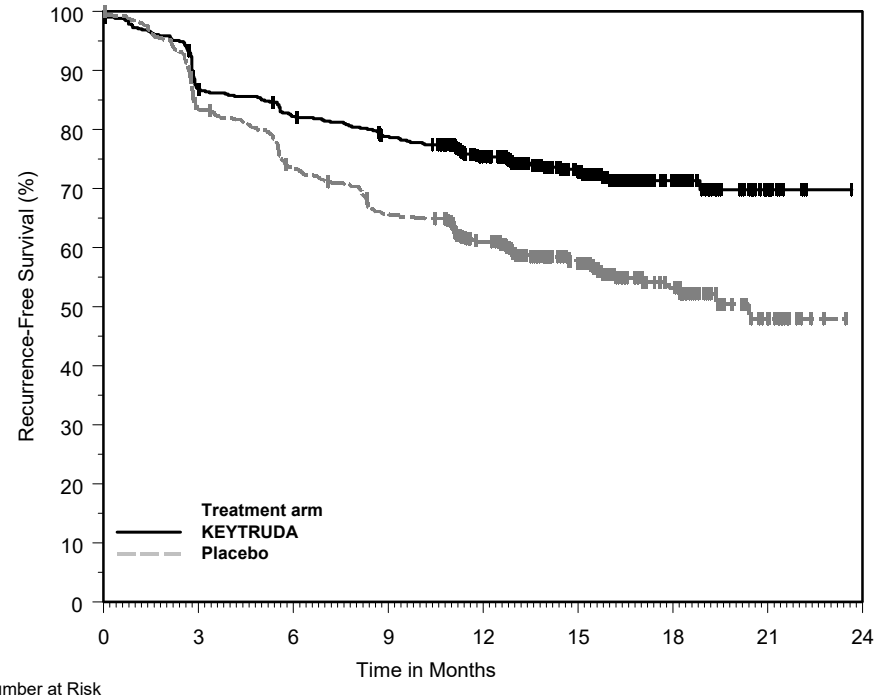
Endpoint	**KEYTRUDA 200 mg every 3 weeks n=514**	**Placebo n=505**
RFS		
Number (%) of patients with event	135 (26%)	216 (43%)
Median in months (95% CI)	NR	20.4 (16.2, NR)
Hazard ratio*† (95% CI)	0.57 (0.46, 0.70)	
p-Value† (log-rank)	<0.001±	

* Based on the stratified Cox proportional hazard model
† Stratified by American Joint Committee on Cancer 7th edition (AJCC) stage
± p-Value is compared with 0.008 of the allocated alpha for this interim analysis.
NR = not reached

For patients with PD-L1 positive tumors, the HR was 0.54 (95% CI: 0.42, 0.69); p<0.001. The RFS benefit for KEYTRUDA compared to placebo was observed regardless of tumor PD-L1 expression.

Reference ID: 4470211

Figure 3: Kaplan-Meier Curve for Recurrence-Free Survival in KEYNOTE-054



Number at Risk									
KEYTRUDA:	514	438	413	392	313	182	73	15	0
Placebo:	505	415	363	323	264	157	60	15	0

14.2 Non-Small Cell Lung Cancer

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

The efficacy of KEYTRUDA in combination with pemetrexed and platinum chemotherapy was investigated in KEYNOTE-189 (NCT02578680), a randomized, multicenter, double-blind, active-controlled trial conducted in 616 patients with metastatic nonsquamous NSCLC, regardless of PD-L1 tumor expression status, who had not previously received systemic therapy for metastatic disease and in whom there were no EGFR or ALK genomic tumor aberrations. 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. Randomization was stratified by smoking status (never vs. former/current), choice of platinum (cisplatin vs. carboplatin), and tumor PD-L1 status (TPS <1% [negative] vs. TPS ≥1%). Patients were randomized (2:1) to one of the following treatment arms:

- KEYTRUDA 200 mg, pemetrexed 500 mg/m^2, and investigator's choice of cisplatin 75 mg/m^2 or carboplatin AUC 5 mg/mL/min intravenously on Day 1 of each 21-day cycle for 4 cycles followed by KEYTRUDA 200 mg and pemetrexed 500 mg/m^2 intravenously every 3 weeks. KEYTRUDA was administered prior to chemotherapy on Day 1.
- Placebo, pemetrexed 500 mg/m^2, and investigator's choice of cisplatin 75 mg/m^2 or carboplatin AUC 5 mg/mL/min intravenously on Day 1 of each 21-day cycle for 4 cycles followed by placebo and pemetrexed 500 mg/m^2 intravenously every 3 weeks.

Treatment with KEYTRUDA continued until RECIST v1.1 (modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ)-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. Patients randomized to placebo and chemotherapy were offered KEYTRUDA as a single agent at the time of disease progression. Assessment of tumor status

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was performed at Week 6, Week 12, and then every 9 weeks thereafter. 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 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 64 years (range: 34 to 84), 49% age 65 or older; 59% male; 94% White and 3% Asian; 56% ECOG PS of 1; and 18% with history of brain metastases. Thirty-one percent had tumor PD-L1 expression TPS <1% [negative]. Seventy-two percent received carboplatin and 12% were never smokers. A total of 85 patients in the placebo and chemotherapy arm received an anti-PD-1/PD-L1 monoclonal antibody at the time of disease progression.

The trial demonstrated a statistically significant improvement in OS and PFS for patients randomized to KEYTRUDA in combination with pemetrexed and platinum chemotherapy compared with placebo, pemetrexed, and platinum chemotherapy. Table 30 and Figure 4 summarize the efficacy results for KEYNOTE-189.

Table 30: Efficacy Results in KEYNOTE-189

Endpoint	**KEYTRUDA 200 mg every 3 weeks Pemetrexed Platinum Chemotherapy n=410**	**Placebo Pemetrexed Platinum Chemotherapy n=206**
OS		
Number (%) of patients with event	127 (31%)	108 (52%)
Median in months (95% CI)	NR (NR, NR)	11.3 (8.7, 15.1)
Hazard ratio* (95% CI)	0.49 (0.38, 0.64)	
p-Value†	<0.0001	
PFS		
Number of patients with event (%)	244 (60%)	166 (81%)
Median in months (95% CI)	8.8 (7.6, 9.2)	4.9 (4.7, 5.5)
Hazard ratio* (95% CI)	0.52 (0.43, 0.64)	
p-Value†	<0.0001	
Objective Response Rate		
ORR‡ (95% CI)	48% (43, 53)	19% (14, 25)
Complete response	0.5%	0.5%
Partial response	47%	18%
p-Value§	<0.0001	
Duration of Response		
Median in months (range)	11.2 (1.1+, 18.0+)	7.8 (2.1+, 16.4+)

* Based on the stratified Cox proportional hazard model
† Based on stratified log-rank test.
‡ Response: Best objective response as confirmed complete response or partial response
§ Based on Miettinen and Nurminen method stratified by PD-L1 status, platinum chemotherapy and smoking status
NR = not reached

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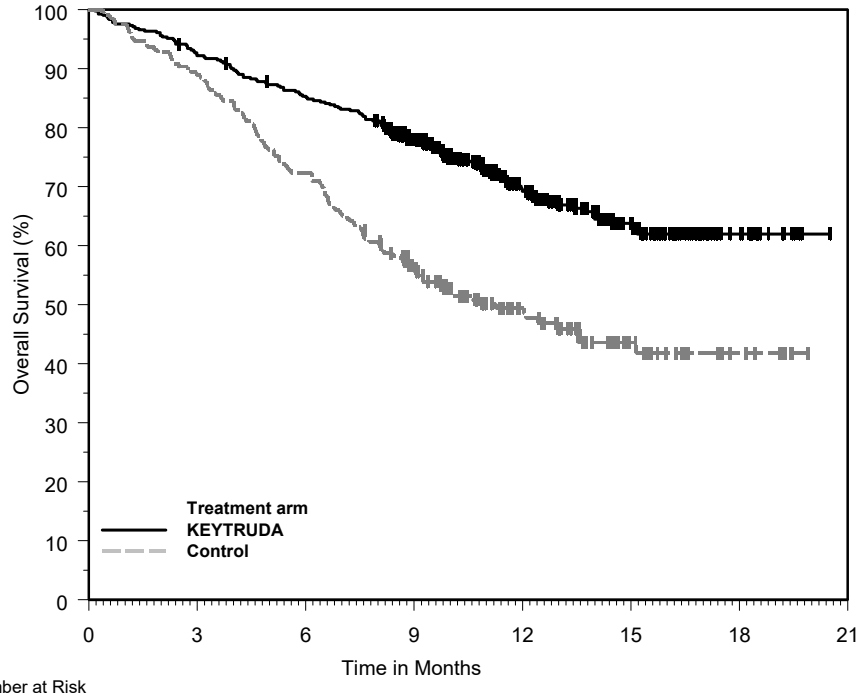
Figure 4: Kaplan-Meier Curve for Overall Survival in KEYNOTE-189



Number at Risk								
KEYTRUDA:	410	377	347	278	163	71	18	0
Control:	206	183	149	104	59	25	8	0

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

The efficacy of KEYTRUDA in combination with carboplatin and investigator's choice of either paclitaxel or paclitaxel protein-bound was investigated in KEYNOTE-407 (NCT02775435), a randomized, multi-center, double-blind, placebo-controlled trial conducted in 559 patients with metastatic squamous NSCLC, regardless of PD-L1 tumor expression status, who had not previously received systemic therapy for metastatic disease. 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. Randomization was stratified by tumor PD-L1 status (TPS <1% [negative] vs. TPS ≥1%), choice of paclitaxel or paclitaxel protein-bound, and geographic region (East Asia vs. non-East Asia). Patients were randomized (1:1) to one of the following treatment arms; all study medications were administered via intravenous infusion:

- KEYTRUDA 200 mg and carboplatin AUC 6 mg/mL/min on Day 1 of each 21-day cycle for 4 cycles, and paclitaxel 200 mg/m^2 on Day 1 of each 21-day cycle for 4 cycles or paclitaxel protein-bound 100 mg/m^2 on Days 1, 8 and 15 of each 21-day cycle for 4 cycles, followed by KEYTRUDA 200 mg every 3 weeks. KEYTRUDA was administered prior to chemotherapy on Day 1.
- Placebo and carboplatin AUC 6 mg/mL/min on Day 1 of each 21-day cycle for 4 cycles and paclitaxel 200 mg/m^2 on Day 1 of each 21-day cycle for 4 cycles or paclitaxel protein-bound 100 mg/m^2 on Days 1, 8 and 15 of each 21-day cycle for 4 cycles, followed by placebo every 3 weeks.

Treatment with KEYTRUDA and chemotherapy or placebo and chemotherapy continued until RECIST v1.1 (modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ)-defined progression of disease as determined by BICR, 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 deriving clinical benefit as determined by the investigator. Patients randomized to the placebo and chemotherapy arm were offered KEYTRUDA as a single agent at the time of disease progression. Assessment of tumor status was performed every 6 weeks through Week 18,

every 9 weeks through Week 45 and every 12 weeks thereafter. The main efficacy outcome measures were PFS and ORR as assessed by BICR using RECIST v1.1, modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ, and OS. An additional efficacy outcome measure was 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 65 years (range: 29 to 88), 55% age 65 or older; 81% male; 77% White; 71% ECOG PS of 1; and 8% with a history of brain metastases. Thirty-five percent had tumor PD-L1 expression TPS <1%; 19% were from the East Asian region; and 60% received paclitaxel.

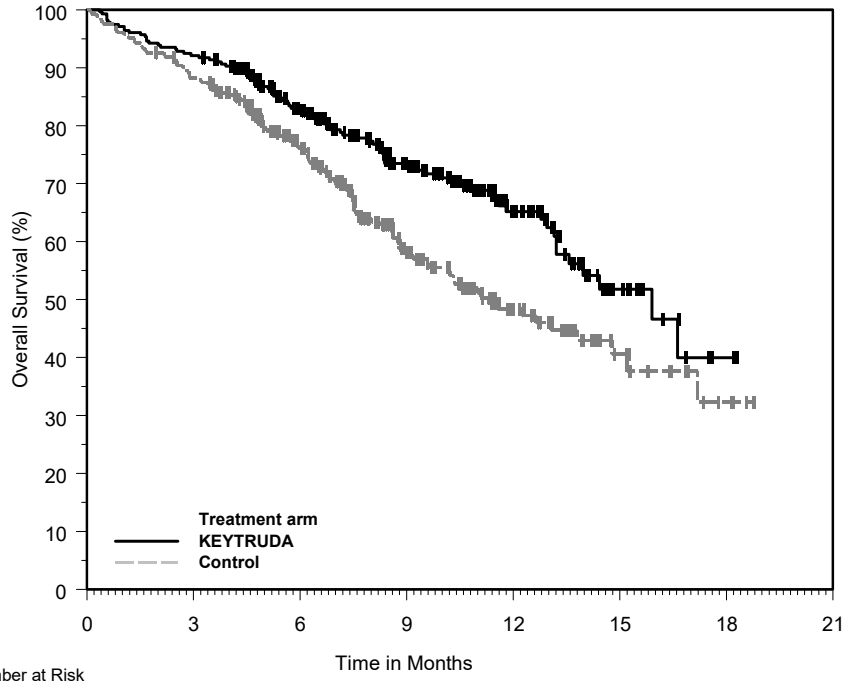
The trial demonstrated a statistically significant improvement in OS, PFS and ORR in patients randomized to KEYTRUDA in combination with carboplatin and either paclitaxel or paclitaxel protein-bound chemotherapy compared with patients randomized to placebo with carboplatin and either paclitaxel or paclitaxel protein-bound chemotherapy. Table 31 and Figure 5 summarize the efficacy results for KEYNOTE-407.

Table 31: Efficacy Results in KEYNOTE-407

Endpoint	**KEYTRUDA 200 mg every 3 weeks Carboplatin Paclitaxel/Paclitaxel protein-bound n=278**	**Placebo Carboplatin Paclitaxel/Paclitaxel protein-bound n=281**
OS		
Number of events (%)	85 (31%)	120 (43%)
Median in months (95% CI)	15.9 (13.2, NE)	11.3 (9.5, 14.8)
Hazard ratio* (95% CI)	0.64 (0.49, 0.85)	
p-Value†	0.0017	
PFS		
Number of events (%)	152 (55%)	197 (70%)
Median in months (95% CI)	6.4 (6.2, 8.3)	4.8 (4.3, 5.7)
Hazard ratio* (95% CI)	0.56 (0.45, 0.70)	
p-Value†	<0.0001	
	n=101	**n=103**
Objective Response Rate‡		
ORR (95% CI)	58% (48, 68)	35% (26, 45)
Difference (95% CI)	23.6% (9.9, 36.4)	
p-Value§	0.0008	
Duration of Response‡		
Median duration of response in months (range)	7.2 (2.4, 12.4+)	4.9 (2.0, 12.4+)

* Based on the stratified Cox proportional hazard model
† Based on a stratified log-rank test
‡ ORR primary analysis and DoR analysis were conducted with the first 204 patients enrolled.
§ Based on a stratified Miettinen-Nurminen test
NE = not estimable

Figure 5: Kaplan-Meier Curve for Overall Survival in KEYNOTE-407



Number at Risk								
KEYTRUDA:	278	256	188	124	62	17	2	0
Control:	281	246	175	93	45	16	4	0

First-line treatment of metastatic NSCLC as a single agent

KEYNOTE-042

The efficacy of KEYTRUDA was investigated in KEYNOTE-042 (NCT02220894), a randomized, multicenter, open-label, active-controlled trial conducted in 1274 patients with stage III NSCLC who were not candidates for surgical resection or definitive chemoradiation, or patients with metastatic NSCLC. Only patients whose tumors expressed PD-L1 (TPS ≥1%) by an immunohistochemistry assay using the PD-L1 IHC 22C3 pharmDx kit and who had not received prior systemic treatment for metastatic NSCLC were eligible. 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 radiation in the thoracic region within the prior 26 weeks of initiation of study were ineligible. Randomization was stratified by ECOG PS (0 vs. 1), histology (squamous vs. nonsquamous), geographic region (East Asia vs. non-East Asia), and PD-L1 expression (TPS ≥50% vs. TPS 1 to 49%). Patients were randomized (1:1) to receive KEYTRUDA 200 mg intravenously every 3 weeks or investigator's choice of either of the following platinum-containing chemotherapy regimens:

- Pemetrexed 500 mg/m^2 every 3 weeks and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for a maximum of 6 cycles followed by optional pemetrexed 500 mg/m^2 every 3 weeks for patients with nonsquamous histologies;
- Paclitaxel 200 mg/m^2 every 3 weeks and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for a maximum of 6 cycles followed by optional pemetrexed 500 mg/m^2 every 3 weeks for patients with nonsquamous histologies.

Treatment with KEYTRUDA continued until RECIST v1.1 (modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ)-defined progression of disease, 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 deriving clinical benefit as determined by the investigator. Treatment with KEYTRUDA could be reinitiated at the time of subsequent disease

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progression and administered for up to 12 months. Assessment of tumor status was performed every 9 weeks. The main efficacy outcome measure was OS in the subgroup of patients with TPS ≥50% NSCLC, the subgroup of patients with TPS ≥20% NSCLC, and the overall population with TPS ≥1% NSCLC. Additional efficacy outcome measures were PFS and ORR in the subgroup of patients with TPS ≥50% NSCLC, the subgroup of patients with TPS ≥20% NSCLC, and the overall population with TPS ≥1% NSCLC 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 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. Sixty-nine percent had ECOG PS of 1; 39% with squamous and 61% with nonsquamous histology; 87% had M1 disease and 13% had Stage IIIA (2%) or Stage IIIB (11%) and who were not candidates for surgical resection or definitive chemoradiation per investigator assessment; and 5% with treated brain metastases at baseline. Forty-seven percent of patients had TPS ≥50% NSCLC and 53% had TPS 1 to 49% NSCLC.

The trial demonstrated a statistically significant improvement in OS for patients (PD-L1 TPS ≥50%, TPS ≥20%, TPS ≥1%) randomized to KEYTRUDA as compared with chemotherapy. Table 32 and Figure 6 summarize the efficacy results in the subgroup of patients with TPS ≥50% and in all randomized patients with TPS ≥1%.

Table 32: Efficacy Results of All Randomized Patients (TPS ≥1% and TPS ≥50%) in KEYNOTE-042

	TPS ≥1%		**TPS ≥50%**	
Endpoint	**KEYTRUDA 200 mg every 3 weeks n=637**	**Chemotherapy n=637**	**KEYTRUDA 200 mg every 3 weeks n=299**	**Chemotherapy n=300**
OS				
Number of events (%)	371 (58%)	438 (69%)	157 (53%)	199 (66%)
Median in months (95% CI)	16.7 (13.9, 19.7)	12.1 (11.3, 13.3)	20.0 (15.4, 24.9)	12.2 (10.4, 14.2)
Hazard ratio* (95% CI)	0.81 (0.71, 0.93)		0.69 (0.56, 0.85)	
p-Value†	0.0036		0.0006	
PFS				
Number of events (%)	507 (80%)	506 (79%)	221 (74%)	233 (78%)
Median in months (95% CI)	5.4 (4.3, 6.2)	6.5 (6.3, 7.0)	7.1 (5.9, 9.0)	6.4 (6.1, 6.9)
Hazard ratio*,‡ (95% CI)	1.07 (0.94, 1.21)		0.81 (0.67, 0.99)	
p-Value†	-‡		NS§	
Objective Response Rate				
ORR‡ (95% CI)	27% (24, 31)	27% (23, 30)	39% (33.9, 45.3)	32% (26.8, 37.6)
Complete response rate	0.5%	0.5%	0.7%	0.3%
Partial response rate	27%	26%	39%	32%
Duration of Response				
% with duration ≥12 months¶	47%	16%	42%	17%
% with duration ≥18 months¶	26%	6%	25%	5%

* Based on the stratified Cox proportional hazard model
† Based on a stratified log-rank test; compared to a p-Value boundary of 0.0291
‡ Not evaluated for statistical significance as a result of the sequential testing procedure for the secondary endpoints
§ Not significant compared to a p-Value boundary of 0.0291
¶ Based on observed duration of response

The results of all efficacy outcome measures in the subgroup of patients with PD-L1 TPS ≥20% NSCLC were intermediate between the results of those with PD-L1 TPS ≥1% and those with PD-L1 TPS ≥50%. In a pre-specified exploratory subgroup analysis for patients with TPS 1-49% NSCLC, the median OS was 13.4 months (95% CI: 10.7, 18.2) for the pembrolizumab group and 12.1 months (95% CI: 11.0, 14.0) in the chemotherapy group, with an HR of 0.92 (95% CI: 0.77, 1.11).

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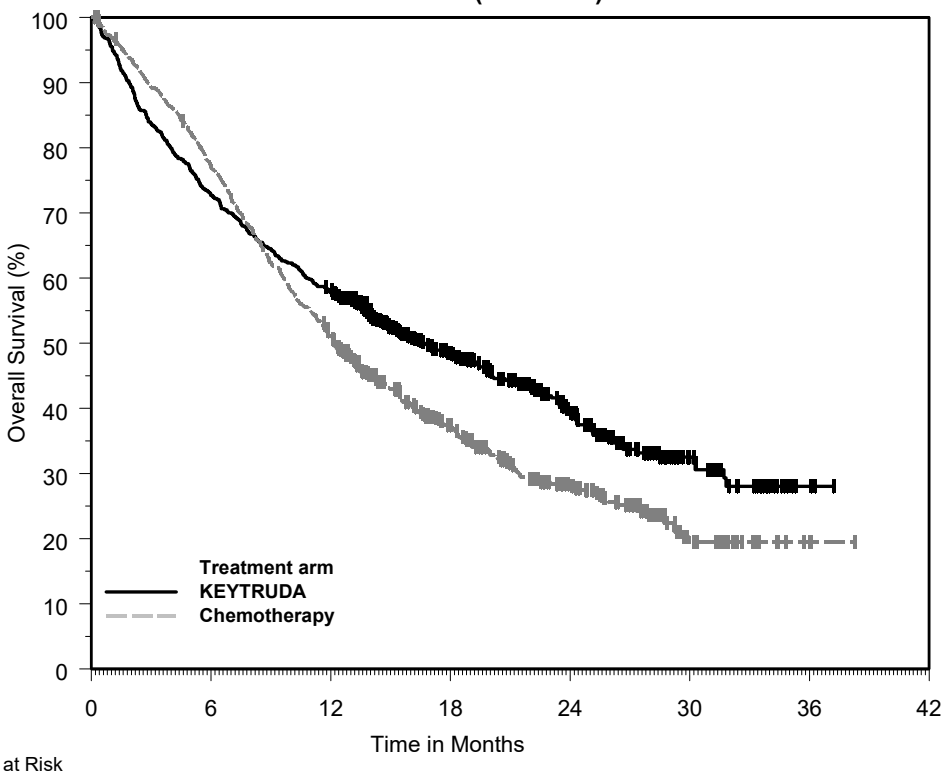
Figure 6: Kaplan-Meier Curve for Overall Survival in all Randomized Patients in KEYNOTE-042 (TPS ≥1%)



Number at Risk								
KEYTRUDA:	637	463	365	214	112	35	2	0
Chemotherapy:	637	485	316	166	88	24	1	0

KEYNOTE-024

The efficacy of KEYTRUDA was also investigated in KEYNOTE-024 (NCT02142738), a randomized, multicenter, open-label, active-controlled trial in 305 previously untreated patients with metastatic NSCLC. The study design was similar to that of KEYNOTE-042, except that only patients whose tumors had high PD-L1 expression (TPS of 50% or greater) by an immunohistochemistry assay using the PD-L1 IHC 22C3 pharmDx kit were eligible. Patients were randomized (1:1) to receive KEYTRUDA 200 mg intravenously every 3 weeks or investigator's choice of any of the following platinum-containing chemotherapy regimens:

- Pemetrexed 500 mg/m^2 every 3 weeks and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for 4 to 6 cycles followed by optional pemetrexed 500 mg/m^2 every 3 weeks for patients with nonsquamous histologies;
- Pemetrexed 500 mg/m^2 every 3 weeks and cisplatin 75 mg/m^2 every 3 weeks on Day 1 for 4 to 6 cycles followed by optional pemetrexed 500 mg/m^2 every 3 weeks for patients with nonsquamous histologies;
- Gemcitabine 1250 mg/m^2 on days 1 and 8 and cisplatin 75 mg/m^2 every 3 weeks on Day 1 for 4 to 6 cycles;
- Gemcitabine 1250 mg/m^2 on Days 1 and 8 and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for 4 to 6 cycles;
- Paclitaxel 200 mg/m^2 every 3 weeks and carboplatin AUC 5 to 6 mg/mL/min every 3 weeks on Day 1 for 4 to 6 cycles followed by optional pemetrexed maintenance (for nonsquamous histologies).

Patients randomized to chemotherapy were offered KEYTRUDA at the time of disease progression.

The main efficacy outcome measure was 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 were OS and 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.

The study population characteristics were: median age of 65 years (range: 33 to 90), 54% age 65 or older; 61% male; 82% White and 15% Asian; 65% with ECOG PS of 1; 18% with squamous and 82% with nonsquamous histology and 9% with history of brain metastases. A total of 66 patients in the chemotherapy arm received KEYTRUDA at the time of disease progression.

The trial demonstrated a statistically significant improvement in both PFS and OS for patients randomized to KEYTRUDA as compared with chemotherapy. Table 33 and Figure 7 summarize the efficacy results for KEYNOTE-024.

Table 33: Efficacy Results in KEYNOTE-024

Endpoint	**KEYTRUDA 200 mg every 3 weeks n=154**	**Chemotherapy n=151**
PFS		
Number (%) of patients with event	73 (47%)	116 (77%)
Median in months (95% CI)	10.3 (6.7, NR)	6.0 (4.2, 6.2)
Hazard ratio* (95% CI)	0.50 (0.37, 0.68)	
p-Value (stratified log-rank)	<0.001	
OS		
Number (%) of patients with event	44 (29%)	64 (42%)
Median in months (95% CI)†	30.0 (18.3, NR)	14.2 (9.8, 19.0)
Hazard ratio* (95% CI)	0.60 (0.41, 0.89)	
p-Value (stratified log-rank)	0.005‡	
Objective Response Rate		
ORR (95% CI)	45% (37, 53)	28% (21, 36)
Complete response rate	4%	1%
Partial response rate	41%	27%
p-Value (Miettinen-Nurminen)	0.001	
Median duration of response in months (range)	NR (1.9+, 14.5+)	6.3 (2.1+, 12.6+)

* Based on the stratified Cox proportional hazard model for the interim analysis

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

‡ p-Value is compared with 0.0118 of the allocated alpha for the interim analysis

NR = not reached

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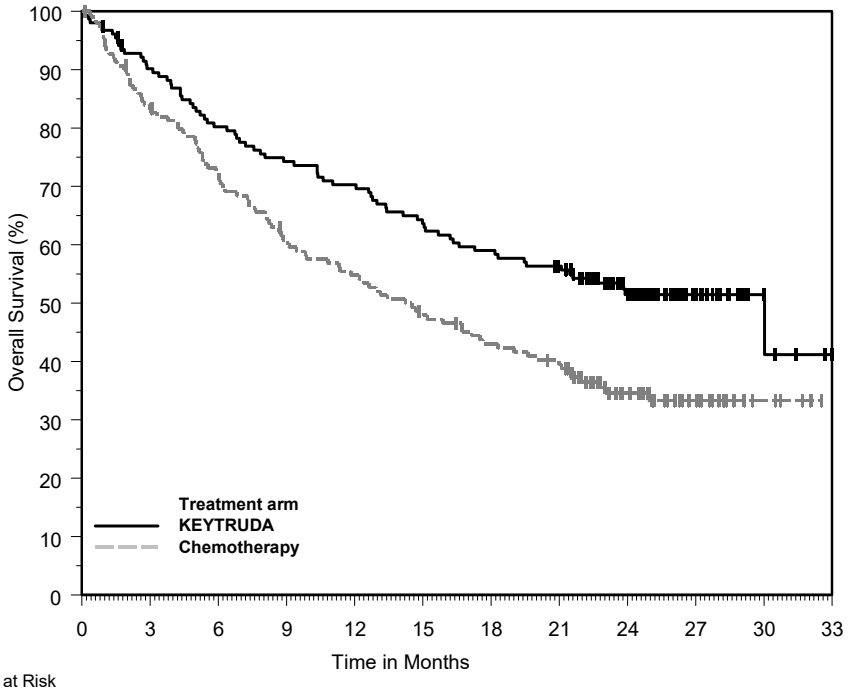
Figure 7: Kaplan-Meier Curve for Overall Survival in KEYNOTE-024*



Number at Risk												
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 ≥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^2 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 ≥50% and the overall population with TPS ≥1%. Additional efficacy outcome measures were ORR and DoR in the subgroup of patients with TPS ≥50% and the overall population with TPS ≥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.

Reference ID: 4470211

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

Table 34: Efficacy Results of the Subgroup of Patients with TPS ≥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^2 every 3 weeks n=152
OS			
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	---
PFS			
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	---
Objective Response Rate			
ORR† (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 ≥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^2 every 3 weeks n=343
OS			
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	---
PFS			
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	---
Objective Response Rate			
ORR† (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+)

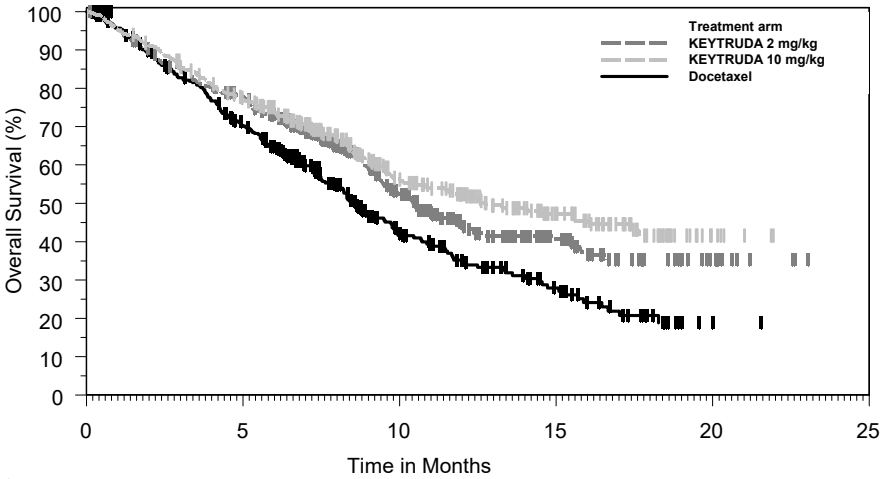
* Hazard ratio (KEYTRUDA compared to docetaxel) based on the stratified Cox proportional hazard model

† All responses were partial responses

NR = not reached

Reference ID: 4470211

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



Number at Risk						
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.

Reference ID: 4470211

Efficacy results are summarized in Table 36.

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

Endpoint	KEYTRUDA n=83
Objective Response Rate	
ORR (95% CI)	19% (11, 29)
Complete response rate	2%
Partial response rate	17%
Duration of Response	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^2 intravenously every 3 weeks, and FU 1000 mg/m^2/day as a continuous intravenous infusion over 96 hours every 3 weeks (maximum of 6 cycles of platinum and FU)
- Cetuximab 400 mg/m^2 intravenously as the initial dose then 250 mg/m^2 intravenously once weekly, carboplatin AUC 5 mg/mL/min intravenously every 3 weeks or cisplatin 100 mg/m^2 intravenously every 3 weeks, and FU 1000 mg/m^2/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 ≥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

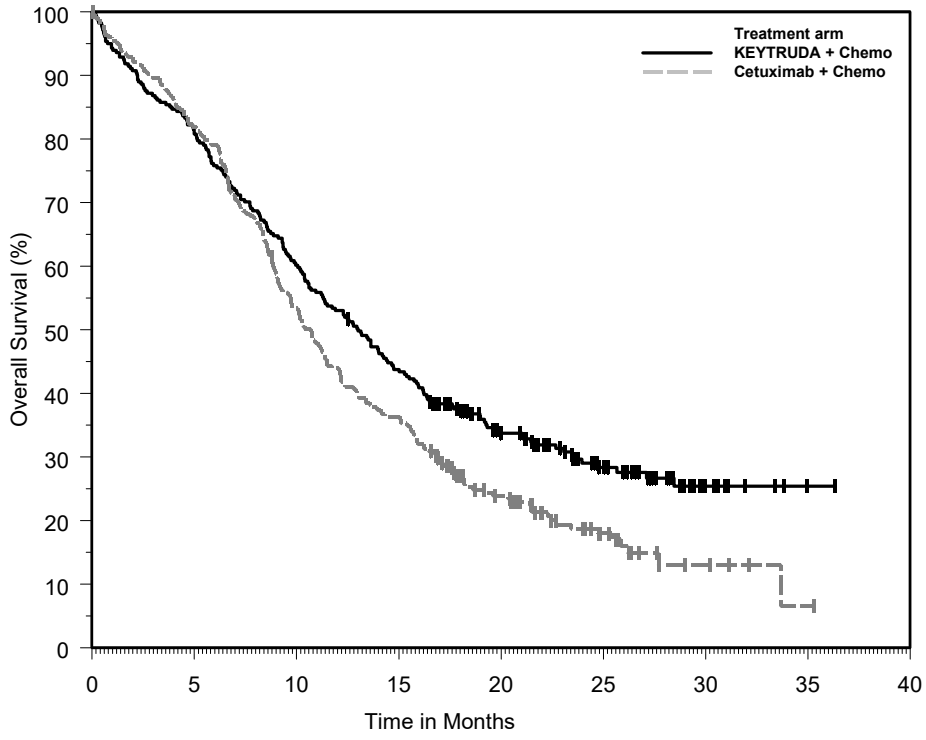
Endpoint	**KEYTRUDA 200 mg every 3 weeks Platinum FU n=281**	**Cetuximab Platinum FU n=278**
OS		
Number (%) of patients with event	197 (70%)	223 (80%)
Median in months (95% CI)	13.0 (10.9, 14.7)	10.7 (9.3, 11.7)
Hazard ratio* (95% CI)	0.77 (0.63, 0.93)	
p-Value†	0.0067	
PFS		
Number of patients with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

* Based on the stratified Cox proportional hazard model
† Based on stratified log-rank test
‡ 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 ≥1 (HR 0.71, 95% CI: 0.57, 0.88), CPS ≥20 (HR 0.69, 95% CI:0.51, 0.94).

Reference ID: 4470211

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



Number at Risk									
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 ≥1 HNSCC and CPS ≥20 HNSCC. Figure 10 summarizes the OS results in the subgroup of patients with CPS ≥1 HNSCC.

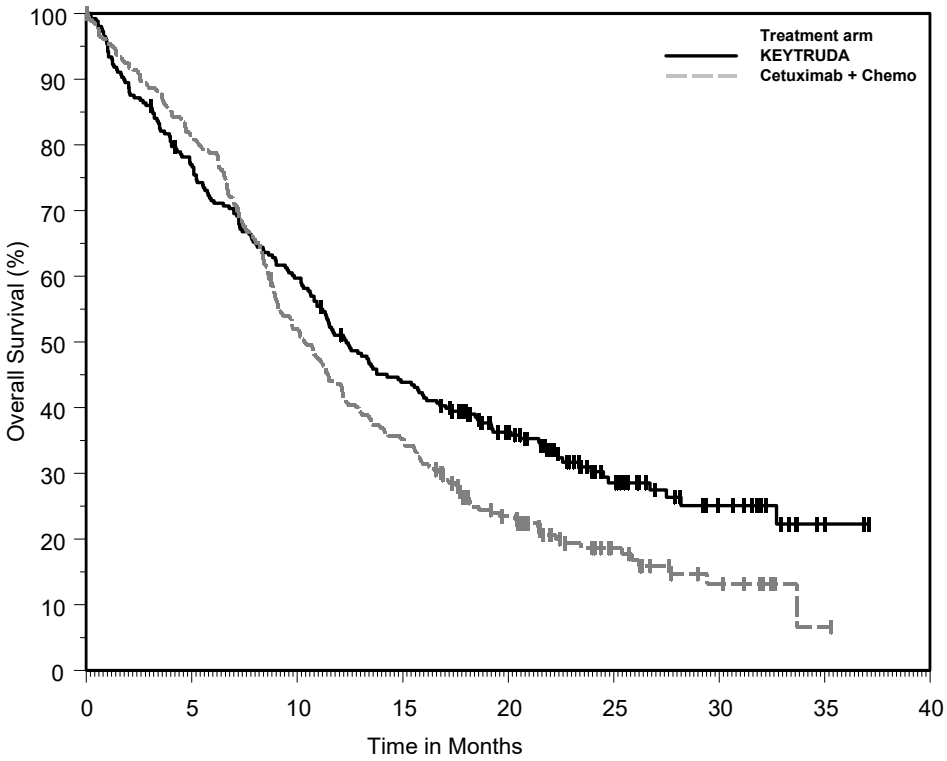
Table 38: Efficacy Results for KEYTRUDA as a Single Agent in KEYNOTE-048 (CPS ≥1 and CPS ≥20)

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
OS				
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	
PFS				
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)	
Objective Response Rate				
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%
Duration of Response				
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									
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.

Reference ID: 4470211

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*
Objective Response Rate	
ORR (95% CI)	69% (62, 75)
Complete response rate	22%
Partial response rate	47%
Duration of Response	
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*
Objective Response Rate	
ORR (95% CI)	45% (32, 60)
Complete response rate	11%
Partial response rate	34%
Duration of Response	
Median in months (range)	NR (1.1+, 19.2+)†

* Median follow-up time of 9.7 months
† 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.

Reference ID: 4470211

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**
Objective Response Rate			
ORR (95% CI)	29% (24, 34)	21% (16, 26)	47% (38, 57)
Complete response rate	7%	3%	15%
Partial response rate	22%	18%	32%
Duration of Response			
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^2 (n=90), docetaxel 75 mg/m^2 (n=92), or vinflunine 320 mg/m^2 (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.

Reference ID: 4470211

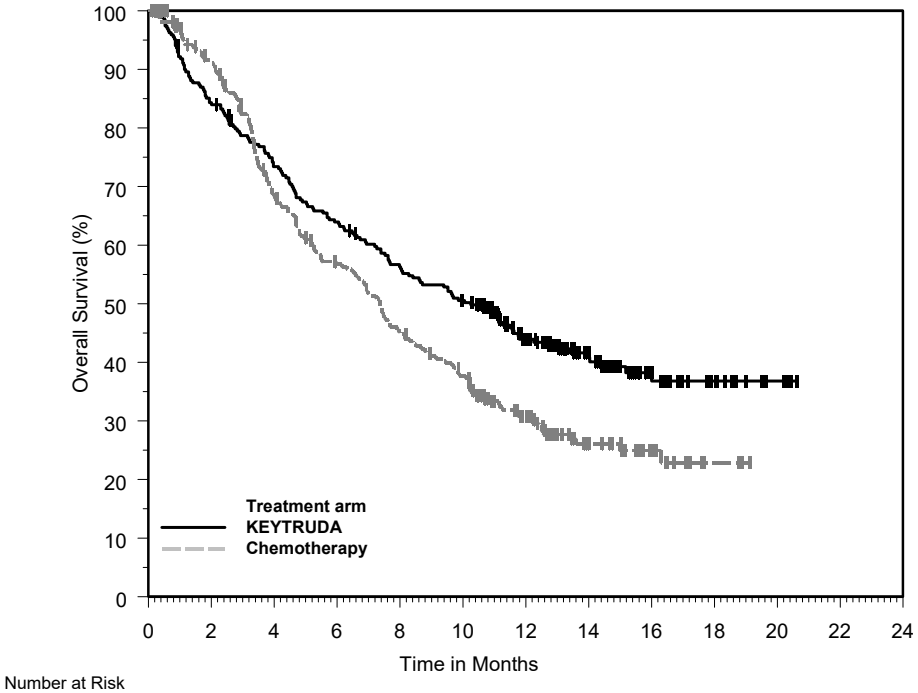
The study demonstrated statistically significant improvements in OS and ORR for patients randomized to KEYTRUDA as compared to chemotherapy. There was no statistically significant difference between KEYTRUDA and chemotherapy with respect to PFS. The median follow-up time for this trial was 9.0 months (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

	KEYTRUDA 200 mg every 3 weeks n=270	**Chemotherapy n=272**
OS		
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	
PFS by BICR		
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	
Objective Response Rate		
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

KEYTRUDA:	270	226	194	169	147	131	87	54	27	13	4	0	0
Chemotherapy:	272	232	171	138	109	89	55	27	14	3	0	0	0

Reference ID: 4470211

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
KEYNOTE-016 NCT01876511	• prospective, investigator-initiated • 6 sites • patients with CRC and other tumors	28 CRC 30 non-CRC	local PCR or IHC	10 mg/kg every 2 weeks	• CRC: ≥ 2 prior regimens • Non-CRC: ≥1 prior regimen
KEYNOTE-164 NCT02460198	• prospective international multi-center • CRC	61	local PCR or IHC	200 mg every 3 weeks	Prior fluoropyrimidine, oxaliplatin, and irinotecan +/- anti-VEGF/EGFR mAb
KEYNOTE-012 NCT01848834	• retrospectively identified patients with PD-L1-positive gastric, bladder, or triple-negative breast cancer	6	central PCR	10 mg/kg every 2 weeks	≥1 prior regimen
KEYNOTE-028 NCT02054806	• retrospectively identified patients with PD-L1-positive esophageal, biliary, breast, endometrial, or CRC	5	central PCR	10 mg/kg every 2 weeks	≥1 prior regimen
KEYNOTE-158 NCT02628067	• prospective international multi-center enrollment of patients with MSI-H/dMMR non-CRC • retrospectively identified patients who were enrolled in specific rare tumor non-CRC cohorts	19	local PCR or IHC (central PCR for patients in rare tumor non-CRC cohorts)	200 mg every 3 weeks	≥1 prior regimen
Total		**149**			

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.

Reference ID: 4470211

Efficacy results are summarized in Tables 44 and 45.

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

Endpoint	KEYTRUDA n=149
Objective Response Rate	
ORR (95% CI)	39.6% (31.7, 47.9)
Complete response rate	7.4%
Partial response rate	32.2%
Duration of Response	
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)
CRC	90	32 (36%)	(26%, 46%)	(1.6+, 22.7+)
Non-CRC	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 Esophageal Cancer

KEYNOTE-181

The efficacy of KEYTRUDA was investigated in KEYNOTE-181 (NCT02564263), a multicenter, randomized, open-label, active-controlled trial that enrolled 628 patients with recurrent locally advanced or metastatic esophageal cancer who progressed on or after one prior line of systemic treatment for advanced disease. Patients with HER2/neu positive esophageal cancer were required to have received treatment with approved HER2/neu targeted therapy. All patients were required to have tumor specimens for PD-L1 testing at a central laboratory; PD L1 status was determined using the PD L1 IHC 22C3 pharmDx kit. Patients with a history of non-infectious pneumonitis that required steroids or current pneumonitis, active autoimmune disease, or a medical condition that required immunosuppression were ineligible.

Patients were randomized (1:1) to receive either KEYTRUDA 200 mg every 3 weeks or investigator's choice of any of the following chemotherapy regimens, all given intravenously: paclitaxel 80-100 mg/m^2 on Days 1, 8, and 15 of every 4-week cycle, docetaxel 75 mg/m^2 every 3 weeks, or irinotecan 180 mg/m^2 every 2 weeks. Randomization was stratified by tumor histology (esophageal squamous cell carcinoma [ESCC] vs. esophageal adenocarcinoma [EAC]/Siewert type I EAC of the gastroesophageal junction [GEJ]), and geographic region (Asia vs. ex-Asia). Treatment with KEYTRUDA or chemotherapy continued until unacceptable toxicity or disease progression. Patients randomized to KEYTRUDA were permitted to continue beyond the first RECIST v1.1 (modified to follow a maximum of 10 target lesions and a maximum of 5 target lesions per organ)-defined disease progression if clinically stable until the first radiographic evidence of disease progression was confirmed at least 4 weeks later with repeat imaging. Patients treated with KEYTRUDA without disease progression could be treated for up to 24 months. Assessment of tumor status was performed every 9 weeks. The major efficacy outcome measure was OS evaluated in the following co-primary populations: patients with ESCC, patients with tumors expressing PD-L1 CPS ≥10, and all randomized patients. Additional efficacy outcome measures were PFS, 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.

A total of 628 patients were enrolled and randomized to KEYTRUDA (n=314) or investigator's treatment of choice (n=314). Of these 628 patients, 167 (27%) had ESCC that expressed PD-L1 with a CPS ≥10. Of these 167 patients, 85 patients were randomized to KEYTRUDA and 82 patients to investigator's treatment of choice [paclitaxel (n=50), docetaxel (n=19), or irinotecan (n=13)]. The baseline characteristics of these 167 patients were: median age of 65 years (range: 33 to 80), 51% age 65 or older; 84% male; 32% White and 68% Asian; 38% had an ECOG PS of 0 and 62% had an ECOG PS of 1. Ninety percent had M1 disease and 10% had M0 disease. Prior to enrollment, 99% of patients had received platinum-based treatment and 84% had also received treatment with a fluoropyrimidine. Thirty-three percent of patients received prior treatment with a taxane.

The observed OS hazard ratio was 0.77 (95% CI: 0.63, 0.96) in patients with ESCC, 0.70 (95% CI: 0.52, 0.94) in patients with tumors expressing PD-L1 CPS ≥10, and 0.89 (95% CI: 0.75, 1.05) in all randomized patients. On further examination in patients whose ESCC tumors expressed PD-L1 (CPS ≥10), an improvement in OS was observed among patients randomized to KEYTRUDA as compared with chemotherapy. Table 46 and Figure 12 summarize the key efficacy measures for KEYNOTE-181 for patients with ESCC CPS ≥10.

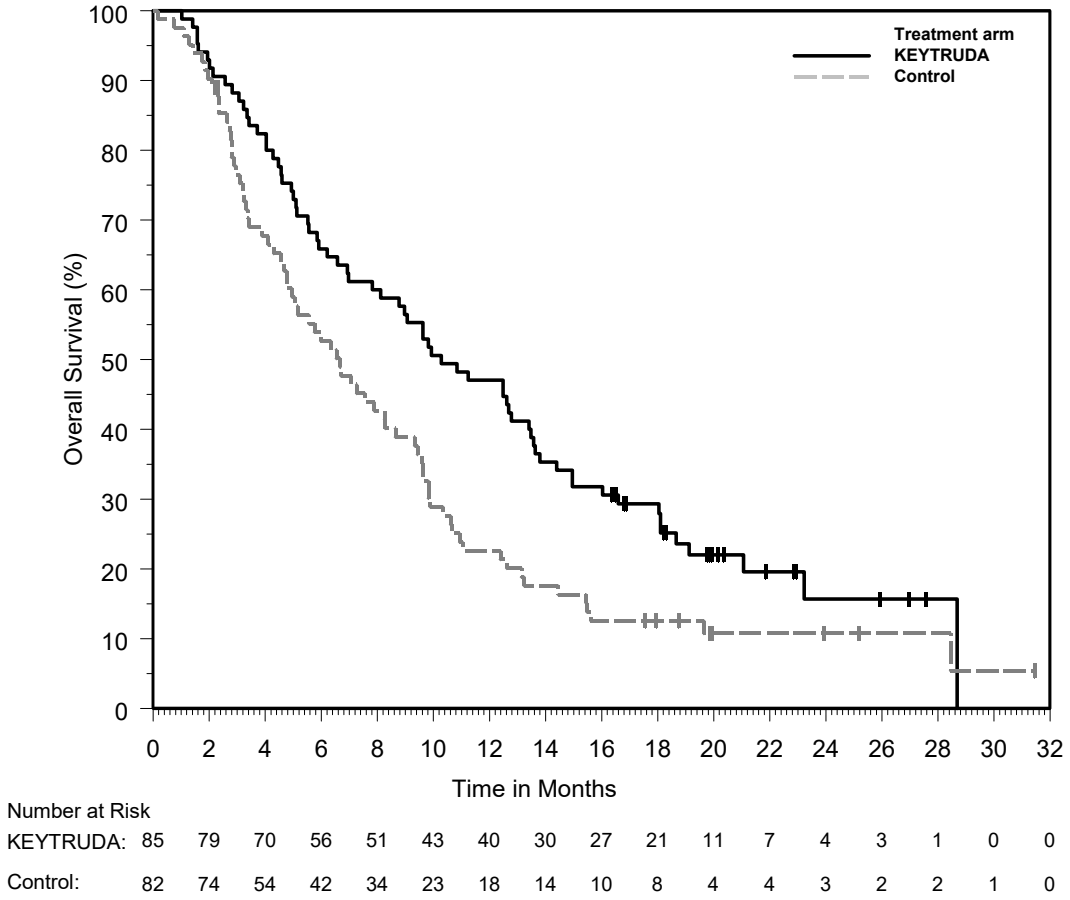
Reference ID: 4470211

Table 46: Efficacy Results in Patients with Recurrent or Metastatic ESCC (CPS ≥10) in KEYNOTE-181

Endpoint	KEYTRUDA 200 mg every 3 weeks n=85	Chemotherapy n=82
OS		
Number (%) of patients with event	68 (80%)	72 (88%)
Median in months (95% CI)	10.3 (7.0, 13.5)	6.7 (4.8, 8.6)
Hazard ratio* (95% CI)	0.64 (0.46, 0.90)	
PFS		
Number (%) of patients with event	76 (89%)	76 (93%)
Median in months (95% CI)	3.2 (2.1, 4.4)	2.3 (2.1, 3.4)
Hazard ratio* (95% CI)	0.66 (0.48, 0.92)	
Objective Response Rate		
ORR (95% CI)	22 (14, 33)	7 (3, 15)
Number (%) of complete responses	4 (5)	1 (1)
Number (%) of partial responses	15 (18)	5 (6)
Median duration of response in months (range)	9.3 (2.1+, 18.8+)	7.7 (4.3, 16.8+)

* Based on the Cox regression model stratified by geographic region (Asia vs. ex-Asia)

Figure 12: Kaplan-Meier Curve for Overall Survival in KEYNOTE-181 (ESCC CPS ≥10)



KEYNOTE-180

The efficacy of KEYTRUDA was investigated in KEYNOTE-180 (NCT02559687), a multicenter, non-randomized, open-label trial that enrolled 121 patients with locally advanced or metastatic esophageal cancer who progressed on or after at least 2 prior systemic treatments for advanced disease. With the

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exception of the number of prior lines of treatment, the eligibility criteria were similar to and the dosage regimen identical to KEYNOTE-181.

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.

Among the 121 patients enrolled, 29% (n=35) had ESCC that expressed PD-L1 CPS ≥10. The baseline characteristics of these 35 patients were: median age of 65 years (range: 47 to 81), 51% age 65 or older; 71% male; 26% White and 69% Asian; 40% had an ECOG PS of 0 and 60% had an ECOG PS of 1. One hundred percent had M1 disease.

The ORR in the 35 patients with ESCC expressing PD-L1 was 20% (95% CI: 8, 37). Among the 7 responding patients, the DoR ranged from 4.2 to 25.1+ months, with 5 patients (71%) having responses of 6 months or longer and 3 patients (57%) having responses of 12 months or longer.

14.11 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 ≥ 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 47 for patients with PD-L1 expression (CPS ≥1).

Table 47: Efficacy Results in Patients with Recurrent or Metastatic Cervical Cancer (CPS ≥1) in KEYNOTE-158

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

* Median follow-up time of 11.7 months (range 0.6 to 22.7 months)
† Based on patients (n=11) with a response by independent review
\+ Denotes ongoing
NR = not reached

14.12 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 ≥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 48.

Table 48: Efficacy Results in KEYNOTE-224

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

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

14.13 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.

Reference ID: 4470211

Efficacy results are summarized in Table 49.

Table 49: Efficacy Results in KEYNOTE-017

Endpoint	KEYTRUDA 2 mg/kg every 3 weeks n=50
Objective Response Rate	
ORR (95% CI)	56% (41, 70)
Complete response rate (95% CI)	24% (13, 38)
Partial response rate (95% CI)	32% (20, 47)
Duration of Response	
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.

14.14 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 50 and Figure 13 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.

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Table 50: Efficacy Results in KEYNOTE-426

Endpoint	KEYTRUDA 200 mg every 3 weeks and Axitinib n=432	Sunitinib n=429
OS		
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†	<0.0001‡	
12-month OS rate	90% (86, 92)	78% (74, 82)
PFS		
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†	0.0001§	
ORR		
Overall confirmed response rate (95% CI)	59% (54, 64)	36% (31, 40)
Complete response rate	6%	2%
Partial response rate	53%	34%
p-Value¶	<0.0001	

* Based on the stratified Cox proportional hazard model

† Based on stratified log-rank test

‡ 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).

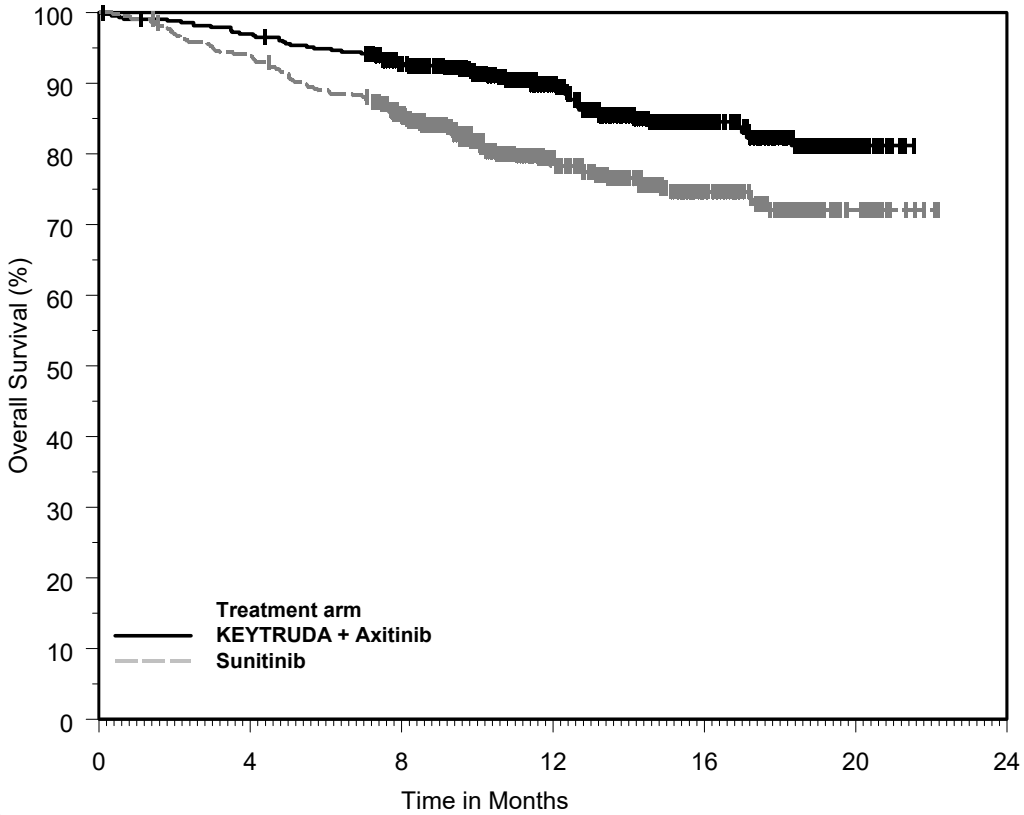
§ p-Value (one-sided) is compared with the allocated alpha of 0.0013 for this interim analysis (with 81% of the planned number of events for final analysis).

¶ Based on Miettinen and Nurminen method stratified by IMDC risk group and geographic region

NR = not reached

Reference ID: 4470211

Figure 13: Kaplan-Meier Curve for Overall Survival in KEYNOTE-426



Number at Risk							
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).

<u>Immune-Mediated Adverse Reactions</u>

- 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)]*.

<u>Infusion-Related Reactions</u>

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

<u>Complications of Allogeneic HSCT</u>

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

<u>Embryo-Fetal Toxicity</u>

- 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)]*.

<u>Lactation</u>

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

<u>Laboratory Tests</u>

- 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)]*.

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

Reference ID: 4470211

U.S. License No. 0002

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

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

For patent information: www.merck.com/product/patent/home.html

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Reference ID: 4470211

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 squamous cell carcinoma of the esophagus. KEYTRUDA may be used when:
    - your cancer has returned or spread (advanced esophageal cancer), **and**
    - your tumor tests positive for "PD-L1" and you have received one or more types of treatment 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.

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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