Lilly to showcase oncology portfolio across tumor types and treatment modalities at the 2026 American Society of Clinical Oncology Annual Meeting

May 21, 2026

Phase 3 LIBRETTO-432 study evaluating Retevmo (selpercatinib) as adjuvant therapy in RET fusion-positive NSCLC to be featured in the Plenary Session and ASCO press program

Investigator-initiated study of Verzenio (abemaciclib) in patients with advanced dedifferentiated liposarcoma also selected for the Plenary Session

Kelonia Therapeutics, which Lilly has agreed to acquire, will present updated data for its BCMA-targeted in vivo CAR-T therapy in patients with relapsed and refractory multiple myeloma

Additional Lilly presentations include the first clinical results for an investigational ADC targeting Nectin-4 in patients with advanced urothelial carcinoma and data from programs across lung, breast and blood cancers

INDIANAPOLIS, May 21, 2026 /PRNewswire/ -- Eli Lilly and Company (NYSE: LLY) today announced the details of presentations from across its oncology portfolio at the American Society of Clinical Oncology (ASCO) Annual Meeting, taking place May 29 - June 2 in Chicago, Illinois.

Data at ASCO include two Plenary Session presentations, featuring primary event-free survival results from the Phase 3 LIBRETTO-432 study of adjuvant Retevmo (selpercatinib) in *rearranged during transfection (RET)* fusion-positive non-small cell lung cancer (NSCLC) and an investigator-initiated Phase 3 study, SARC041, evaluating Verzenio (abemaciclib) in patients with advanced dedifferentiated liposarcoma. Additional data include an oral presentation of initial results of an investigational antibody drug conjugate (ADC) targeting Nectin-4 in patients with advanced or metastatic urothelial carcinoma, and data from programs in lung, breast and blood cancers. Updated data from Kelonia Therapeutics' Phase 1 inMMyCAR study of an anti-B-cell maturation antigen (BCMA) targeted in vivo CAR-T therapy in patients with relapsed and refractory multiple myeloma will also be presented in an oral session. Lilly's proposed acquisition of Kelonia Therapeutics was previously announced and is pending transaction close.

"We continue to grow the breadth and depth of the Lilly Oncology portfolio, with clinical programs in nearly every subspeciality of oncology, utilizing a diverse array of technologies to address patients' disease," said Jacob Van Naarden, executive vice president and president of Lilly Oncology. "Our presence at this year's ASCO reflects a snapshot of our most recent meaningful advances, including data for both Retevmo and Verzenio that will be presented in the Plenary Session. These data are complemented by initial proof of concept results for our next antibody drug conjugate and new data from the Kelonia in vivo CAR-T program. Collectively, these findings reflect the expanding reach of our pipeline and our commitment to delivering in ways that matter for patients."

Lilly Presentation Highlights:

- **Retevmo (selpercatinib; RET kinase inhibitor):** In a late-breaking presentation in the Plenary Session, Lilly will share primary event-free survival results from the Phase 3 LIBRETTO-432 study of adjuvant selpercatinib in patients with stage IB-IIIA *RET* fusion-positive NSCLC. Lilly previously announced that selpercatinib met the primary endpoint, demonstrating a highly significant and clinically meaningful improvement in investigator-assessed event free survival. These results were also selected to be highlighted in the ASCO Annual Meeting press program session on May 30.
- **Verzenio (abemaciclib; CDK4/6 Inhibitor):** In a Plenary Session presentation, results will be shared from the Phase 3 investigator-initiated SARC041 study, evaluating abemaciclib in patients with advanced dedifferentiated liposarcoma.
- **LY4052031 (investigational ADC targeting Nectin-4):** In an oral presentation, initial results will be shared from the Phase 1 NEXUS-01 study evaluating LY4052031, an ADC targeting Nectin-4, in patients with advanced or metastatic urothelial carcinoma.

Kelonia Therapeutics Presentation:

- **KLN-1010 (investigational in vivo CAR-T therapy):** In a rapid oral presentation, updated results will be shared from the Phase 1 inMMyCAR study of KLN-1010 in patients with relapsed and refractory multiple myeloma.

A full list of abstract titles and viewing details are listed below:

Abstract Title	**Author**	**Presentation Type/#**	**Session Title**	**Session Date/Time (CDT)**
Retevmo (selpercatinib; RET kinase inhibitor)				
Event-free survival with adjuvant selpercatinib in Stage IB-IIIA *RET* fusion-positive NSCLC: Primary results of the Phase 3 LIBRETTO-432 trial	Jonathan Goldman	Oral Presentation (LBA3)	Plenary Session	**Session Date**: Sunday, May 31 **Presentation Time**: 1:00 p.m. – 4:00 p.m.

LY4052031 (investigational ADC targeting Nectin-4)				
Initial results from NEXUS-01, a Phase 1 study of LY4052031, an antibody-drug conjugate targeting Nectin-4, in participants with advanced or metastatic urothelial carcinoma	Gopa Iyer	Oral Presentation #4508	Genitourinary Cancer—Kidney and Bladder	**Session Date**: Friday, May 29 **Presentation Time**: 2:45 p.m. – 5:45 p.m.
LY4101174 (investigational ADC targeting Nectin-4)				
Initial results from EXCEED, a Phase 1 study of LY4101174, an antibody-drug conjugate targeting Nectin-4, in participants with advanced or metastatic urothelial carcinoma	Xin Gao	Rapid Oral Presentation #4517	Genitourinary Cancer—Kidney and Bladder	**Session Date**: Monday, June 1 **Presentation Time**: 8:00 a.m. – 9:30 a.m.
Verzenio (abemaciclib; CDK4/6 inhibitor) [Investigator-Initiated]				
SARC041: A Phase 3 randomized double-blind study of abemaciclib versus placebo in patients with advanced dedifferentiated liposarcoma	Mark Dickson	Oral Presentation	Plenary Session	**Session Date**: Sunday, May 31 **Presentation Time**: 1:00 p.m. – 4:00 p.m.
Olomorasib (investigational KRAS G12C inhibitor)				
First-line (1L) olomorasib + pembrolizumab in patients with KRAS G12C-mutant advanced NSCLC, and PD-L1 expression 0-49%, from the dose optimization cohorts of LOXO-RAS-20001 and SUNRAY-01	Bryan A. Chan	Poster Board #418	Lung Cancer—Non-Small Cell Metastatic	**Session Date**: Sunday, May 31 **Presentation Time**: 9:00 a.m. – 12:00 p.m.
1L olomorasib plus pembrolizumab +/- chemotherapy in KRAS G12C-Mutant NSCLC patients +/- a prior cycle of SOC: Results from LOXO-RAS 20001 and SUNRAY-01	Timothy Burns	Poster Board #360	Lung Cancer—Non-Small Cell Metastatic	**Session Date**: Sunday, May 31 **Presentation Time**: 9:00 a.m. – 12:00 p.m.
Jaypirca (pirtobrutinib; non-covalent BTK inhibitor)				
Pirtobrutinib in treatment-naïve patients with CLL/SLL: Pooled results from BRUIN CLL-313 and BRUIN CLL-314	William G. Wierda	Poster Board #542	Hematologic Malignancies—Lymphoma and Chronic Lymphocytic Leukemia	**Session Date**: Monday, June 1 **Presentation Time**: 9:00 a.m. – 12:00 p.m.
Tersolisib (investigational pan-mutant selective PI3Kα inhibitor)				
A Phase 1/2 trial of tersolisib (LY4064809/STX-478), a pan-mutant-selective PI3Kα inhibitor (PI3Kαi), in PIK3CA-mutant advanced solid tumors: Updated results from PIKALO-1	Komal Jhaveri	Poster Board #186	Breast Cancer—Metastatic	**Session Date**: Monday, June 1 **Presentation Time**: 1:30 p.m. – 4:30 p.m.
KLN-1010 (Kelonia Therapeutics' investigational in vivo CAR-T therapy)				
Updated results from inMMyCAR, the ongoing first-in-human Phase 1 study of KLN-1010 in patients with relapsed and refractory multiple myeloma (RRMM)	Phoebe Joy Ho	Rapid Oral Presentation #7509	Hematologic Malignancies—Plasma Cell Dyscrasia	**Session Date**: Sunday, May 31 **Presentation Time**: 9:45 a.m. – 11:15 a.m.

For more information on Lilly's oncology pipeline click here.

*Lilly and Kelonia Therapeutics, Inc. remain two separate, independent companies prior to closing. The transaction is subject to customary closing conditions, including customary regulatory approvals, and is expected to close in the second half of 2026.

About Retevmo
Retevmo (selpercatinib, formerly known as LOXO-292) (pronounced reh-TEHV-moh) is a highly selective and potent RET kinase inhibitor with central nervous system (CNS) activity. Retevmo may affect both tumor cells and healthy cells, which can result in side effects. *RET*-driver alterations are predominantly mutually exclusive from other oncogenic drivers. Retevmo is a U.S. FDA-approved oral prescription medicine, 120 mg or 160 mg dependent on weight (<50 kg or ≥50 kg, respectively), taken twice daily until disease progression or unacceptable toxicity.[1]

INDICATIONS FOR RETEVMO (selpercatinib)
RETEVMO is a kinase inhibitor indicated for the treatment of:

- Adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with a rearranged during transfection (RET) gene fusion, as detected by an FDA-approved test

IMPORTANT SAFETY INFORMATION FOR RETEVMO (selpercatinib)

Hepatotoxicity: Serious hepatic adverse reactions occurred in 3% of patients treated with Retevmo. Increased aspartate aminotransferase (AST)

occurred in 59% of patients, including Grade 3 or 4 events in 11% and increased alanine aminotransferase (ALT) occurred in 55% of patients, including Grade 3 or 4 events in 12%. Monitor ALT and AST prior to initiating Retevmo, every 2 weeks during the first 3 months, then monthly thereafter and as clinically indicated. Withhold, reduce dose, or permanently discontinue Retevmo based on severity.

Severe, life-threatening, and fatal **interstitial lung disease (ILD)/pneumonitis** can occur in patients treated with Retevmo. ILD/pneumonitis occurred in 1.8% of patients who received Retevmo, including 0.3% with Grade 3 or 4 events, and 0.3% with fatal reactions. Monitor for pulmonary symptoms indicative of ILD/pneumonitis. Withhold Retevmo and promptly investigate for ILD in any patient who presents with acute or worsening of respiratory symptoms which may be indicative of ILD (e.g., dyspnea, cough, and fever). Withhold, reduce dose, or permanently discontinue Retevmo based on severity of confirmed ILD.

Hypertension occurred in 41% of patients, including Grade 3 hypertension in 20% and Grade 4 in one (0.1%) patient. Overall, 6.3% had their dose interrupted and 1.3% had their dose reduced for hypertension. Treatment-emergent hypertension was most commonly managed with anti-hypertension medications. Do not initiate Retevmo in patients with uncontrolled hypertension. Optimize blood pressure prior to initiating Retevmo. Monitor blood pressure after 1 week, at least monthly thereafter, and as clinically indicated. Initiate or adjust anti-hypertensive therapy as appropriate. Withhold, reduce dose, or permanently discontinue Retevmo based on severity.

Retevmo can cause concentration-dependent **QT interval prolongation**. An increase in QTcF interval to >500 ms was measured in 7% of patients and an increase in the QTcF interval of at least 60 ms over baseline was measured in 20% of patients. Retevmo has not been studied in patients with clinically significant active cardiovascular disease or recent myocardial infarction. Monitor patients who are at significant risk of developing QTc prolongation, including patients with known long QT syndromes, clinically significant bradyarrhythmias, and severe or uncontrolled heart failure. Assess QT interval, electrolytes, and thyroid-stimulating hormone (TSH) at baseline and periodically during treatment, adjusting frequency based upon risk factors including diarrhea. Correct hypokalemia, hypomagnesemia, and hypocalcemia prior to initiating Retevmo and during treatment. Monitor the QT interval more frequently when Retevmo is concomitantly administered with strong and moderate CYP3A inhibitors or drugs known to prolong QTc interval. Withhold and dose reduce or permanently discontinue Retevmo based on the severity.

Serious, including fatal, **hemorrhagic events** can occur with Retevmo. Grade ≥3 hemorrhagic events occurred in 3.1% of patients treated with Retevmo including 4 (0.5%) patients with fatal hemorrhagic events, including cerebral hemorrhage (n=2), tracheostomy site hemorrhage (n=1), and hemoptysis (n=1). Permanently discontinue Retevmo in patients with severe or life-threatening hemorrhage.

Retevmo can cause **hypersensitivity**, including severe skin reactions such as Stevens-Johnson Syndrome. All grade hypersensitivity occurred in 6% of patients receiving Retevmo, including Grade 3 in 1.9%. The median time to onset was 1.9 weeks (range: 5 days to 2 years). Signs and symptoms of hypersensitivity included fever, rash and arthralgias or myalgias with concurrent decreased platelets or transaminitis. Stevens-Johnson Syndrome has been observed in the post-marketing setting. Discontinue Retevmo in patients with Stevens-Johnson Syndrome. If hypersensitivity occurs, withhold Retevmo and begin corticosteroids at a dose of 1 mg/kg prednisone (or equivalent). Upon resolution of the event, resume Retevmo at a reduced dose and increase the dose of Retevmo by 1 dose level each week as tolerated until reaching the dose taken prior to onset of hypersensitivity. Continue steroids until patient reaches target dose and then taper. Permanently discontinue Retevmo for recurrent hypersensitivity.

Tumor lysis syndrome (TLS) occurred in 0.6% of patients with medullary thyroid carcinoma receiving Retevmo. Patients may be at risk of TLS if they have rapidly growing tumors, a high tumor burden, renal dysfunction, or dehydration. Closely monitor patients at risk, consider appropriate prophylaxis including hydration, and treat as clinically indicated.

Impaired wound healing can occur in patients who receive drugs that inhibit the vascular endothelial growth factor (VEGF) signaling pathway. Therefore, Retevmo has the potential to adversely affect wound healing. Withhold Retevmo for at least 7 days prior to elective surgery. Do not administer for at least 2 weeks following major surgery and until adequate wound healing. The safety of resumption of Retevmo after resolution of wound healing complications has not been established.

Retevmo can cause **hypothyroidism**. Hypothyroidism occurred in 13% of patients treated with Retevmo; all reactions were Grade 1 or 2. Hypothyroidism occurred in 13% of patients (50/373) with thyroid cancer and 13% of patients (53/423) with other solid tumors including NSCLC. Monitor thyroid function before treatment with Retevmo and periodically during treatment. Treat with thyroid hormone replacement as clinically indicated. Withhold Retevmo until clinically stable or permanently discontinue Retevmo based on severity.

Based on data from animal reproduction studies and its mechanism of action, Retevmo can cause **fetal harm** when administered to a pregnant woman. Administration of selpercatinib to pregnant rats during organogenesis at maternal exposures that were approximately equal to those observed at the recommended human dose of 160 mg twice daily resulted in embryolethality and malformations. Advise pregnant women and females of reproductive potential of the potential risk to a fetus. Advise females of reproductive potential and males with female partners of reproductive potential to use effective contraception during treatment with Retevmo and for 1 week after the last dose. There are no data on the presence of selpercatinib or its metabolites in human milk or on their 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 Retevmo and for 1 week after the last dose.

Severe adverse reactions (Grade 3-4) occurring in ≥20% of patients who received Retevmo in LIBRETTO-001, were hypertension (20%), diarrhea (5%), prolonged QT interval (4.8%), dyspnea (3.1%), fatigue (3.1%), hemorrhage (2.6%), abdominal pain (2.5%), vomiting (1.8%), headache (1.4%), nausea (1.1%), constipation (0.8%), edema (0.8%), rash (0.6%), and arthralgia (0.3%).

Severe adverse reactions (Grade 3-4) occurring in ≥15% of patients who received Retevmo or chemotherapy with or without pembrolizumab in LIBRETTO-431 were hypertension (20% vs 3.1%), electrocardiogram QT prolonged (9% vs 0%), fatigue (3.2% vs 5%), edema (2.5% vs 0%), rash (1.9% vs 1.0%), diarrhea (1.3% vs 2.0%), abdominal pain (0.6% vs 2.0%), pyrexia (0.6% vs 0%), COVID19 infection (0.6% vs 0%), constipation (0% vs 1.0%), nausea (0% vs 1.0%), vomiting (0% vs 1.0%), and decreased appetite (0% vs 2.0%).

Serious adverse reactions occurred in 44% of patients who received Retevmo in LIBRETTO-001. The most frequently reported serious adverse reactions (in ≥2% of patients) were pneumonia, pleural effusion, abdominal pain, hemorrhage, hypersensitivity, dyspnea, and hyponatremia. **Fatal adverse reactions occurred in 3% of patients in LIBRETTO-001**; fatal adverse reactions included sepsis (n=6), respiratory failure (n=5), hemorrhage (n=4), pneumonia (n=3), pneumonitis (n=2), cardiac arrest (n=2), sudden death (n=1), and cardiac failure (n=1).

Serious adverse reactions occurred in 35% of patients who received Retevmo in LIBRETTO-431. The most frequently reported serious adverse reactions (≥2% of patients) were pleural effusion and abnormal hepatic function. **Fatal adverse reactions occurred in 4.4% of patients who**

received Retevmo in LIBRETTO-431; fatal adverse reactions included myocardial infarction (n=2), respiratory failure (n=2), cardiac arrest, malnutrition, and sudden death (n=1 each).

Common adverse reactions (all grades) occurring in ≥20% of patients who received Retevmo in LIBRETTO-001, were edema (49%), diarrhea (47%), fatigue (46%), dry mouth (43%), hypertension (41%), abdominal pain (34%), rash (33%), constipation (33%), nausea (31%), headache (28%), cough (24%), vomiting (22%), dyspnea (22%), hemorrhage (22%), arthralgia (21%), and prolonged QT interval (21%).

Common adverse reactions (all grades) occurring in ≥15% of patients who received Retevmo or chemotherapy with or without pembrolizumab in LIBRETTO-431 were hypertension (48% vs 7%), diarrhea (44% vs 24%), edema (41% vs 28%), dry mouth (39% vs 6%), rash (33% vs 30%), fatigue (32% vs 50%), abdominal pain (25% vs 19%), musculoskeletal pain (25% vs 28%), constipation (22% vs 40%), electrocardiogram QT prolonged (20% vs 1.0%), COVID19 infection (19% vs 18%), stomatitis (18% vs 16%), decreased appetite (17% vs 34%), nausea (13% vs 44%), vomiting (13% vs 23%), and pyrexia (13% vs 23%).

Laboratory abnormalities (all grades ≥20%; Grade 3-4) worsening from baseline in patients who received Retevmo in LIBRETTO-001, were increased AST (59%; 11%), decreased calcium (59%; 5.7%), increased ALT (56%; 12%), decreased albumin (56%; 2.3%), increased glucose (53%; 2.8%), decreased lymphocytes (52%; 20%), increased creatinine (47%; 2.4%), decreased sodium (42%; 11%), increased alkaline phosphatase (40%; 3.4%), decreased platelets (37%; 3.2%), increased total cholesterol (35%; 1.7%), increased potassium (34%; 2.7%), decreased glucose (34%; 1.0%), decreased magnesium (33%; 0.6%), increased bilirubin (30%; 2.8%), decreased hemoglobin (28%; 3.5%), and decreased neutrophils (25%; 3.2%).

Laboratory abnormalities (all grades ≥20%; Grade 3-4) worsening from baseline in patients who received Retevmo or chemotherapy with or without pembrolizumab in LIBRETTO-431 were increased ALT (81%; 21% vs 63%; 4.1%), increased AST (77%; 10% vs 46%; 0%), decreased calcium (53%; 1.9% vs 24%; 1.0%), decreased platelets (53%; 3.2% vs 39%; 5%), decreased lymphocytes (53%; 8% vs 64%; 15%), decreased neutrophils (53%; 2.0% vs 58%; 11%), increased bilirubin (52%; 1.3% vs 9%; 0%), increased alkaline phosphatase (35%; 1.3% vs 22%; 0%), decreased sodium (31%; 3.2% vs 41%; 2.1%), decreased albumin (25%; 0% vs 5%; 0%), increased blood creatinine (23%; 0% vs 21%; 0%), decreased hemoglobin (21%; 0% vs 91%; 5%), decreased potassium (17%; 1.3% vs 15%; 1.0%), and decreased magnesium (16%; 0.6% vs 8%; 0%).

Concomitant use of **acid-reducing agents** decreases selpercatinib plasma concentrations which may reduce Retevmo anti-tumor activity. Avoid concomitant use of proton-pump inhibitors (PPIs), histamine-2 (H2) receptor antagonists, and locally acting antacids with Retevmo. If coadministration cannot be avoided, take Retevmo with food (with a PPI) or modify its administration time (with a H2 receptor antagonist or a locally acting antacid).

Concomitant use of **strong and moderate CYP3A inhibitors** increases selpercatinib plasma concentrations which may increase the risk of Retevmo adverse reactions including QTc interval prolongation. Avoid concomitant use of strong and moderate CYP3A inhibitors with Retevmo. If concomitant use of a strong or moderate CYP3A inhibitor cannot be avoided, reduce the Retevmo dosage as recommended and monitor the QT interval with ECGs more frequently.

Concomitant use of **strong and moderate CYP3A inducers** decreases selpercatinib plasma concentrations which may reduce Retevmo anti-tumor activity. Avoid coadministration of Retevmo with strong and moderate CYP3A inducers.

Concomitant use of Retevmo with **CYP2C8 and CYP3A substrates** increases their plasma concentrations which may increase the risk of adverse reactions related to these substrates. Avoid coadministration of Retevmo with CYP2C8 and CYP3A substrates where minimal concentration changes may lead to increased adverse reactions. If coadministration cannot be avoided, follow recommendations for CYP2C8 and CYP3A substrates provided in their approved product labeling.

Retevmo is a P-glycoprotein (P-gp) and BCRP inhibitor. Concomitant use of Retevmo with **P-gp or BCRP substrates** increases their plasma concentrations, which may increase the risk of adverse reactions related to these substrates. Avoid coadministration of Retevmo with P-gp or BCRP substrates where minimal concentration changes may lead to increased adverse reactions. If coadministration cannot be avoided, follow recommendations for P-gp and BCRP substrates provided in their approved product labeling.

No dosage modification is recommended for patients with **mild to severe renal impairment** (estimated Glomerular Filtration Rate [eGFR] ≥15 to 89 mL/min, estimated by Modification of Diet in Renal Disease [MDRD] equation). A recommended dosage has not been established for patients with end-stage renal disease.

Reduce the dose when administering Retevmo to patients with **severe hepatic impairment** (total bilirubin greater than 3 to 10 times upper limit of normal [ULN] and any AST). No dosage modification is recommended for patients with mild or moderate hepatic impairment. Monitor for Retevmo-related adverse reactions in patients with hepatic impairment.

Retevmo (selpercatinib) is available as 40 mg and 80 mg capsules, and 40 mg, 80 mg, 120 mg, and 160 mg tablets.

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Please see full Prescribing Information, including Instructions for Use, for Retevmo.

About LY4052031

LY4052031 is an investigational, next-generation anti-Nectin-4 antibody-drug conjugate (ADC) targeting Nectin-4, a protein overexpressed in several solid tumor types including urothelial, breast, cervix, lung, and ovarian cancers.[2] LY4052031 is composed of a fully human IgG1 Fc-silent monoclonal antibody linked to a novel camptothecin (topoisomerase I inhibitor) payload via a cleavable linker with a homogeneous drug-antibody ratio (DAR) of 8:1, and has demonstrated antitumor activity across a range of Nectin-4 expression levels in preclinical models, including in a Nectin-4 MMAE ADC-resistant model.[2,3] LY4052031 is currently being studied in a global, open-label, multicenter, Phase 1a/1b study in patients with advanced or metastatic urothelial carcinoma and other select solid tumors, NCT06465069.

About LY4101174

LY4101174 is an investigational, next-generation anti-Nectin-4 antibody-drug conjugate (ADC) targeting Nectin-4, a protein overexpressed in several solid tumor types including urothelial, breast, cervix, lung, and ovarian cancers.[2] LY4101174 is comprised of a humanized IgG1 Fc-silent monoclonal antibody linked to the topoisomerase I inhibitor exatecan via a polysarcosine linker with a homogeneous drug-antibody ratio (DAR) of 8:1, and has demonstrated antitumor activity across a range of Nectin-4 expression levels in preclinical models, including in a Nectin-4 MMAE ADC-resistant

model.[2,3] LY4101174 is currently being studied in a global, open-label, multicenter, Phase 1a/1b study in patients with advanced or metastatic urothelial carcinoma and select solid tumors, NCT06238479.

About Verzenio (abemaciclib)
Verzenio (abemaciclib) is approved to treat people with certain HR+, HER2- breast cancers in the adjuvant and advanced or metastatic setting. Verzenio is the first CDK4/6 inhibitor approved to treat node-positive, high-risk early breast cancer (EBC) patients.[4] For HR+, HER2- breast cancer, The National Comprehensive Cancer Network® (NCCN®) recommends consideration of two years of abemaciclib (Verzenio) added to endocrine therapy as a Category 1 treatment option in the adjuvant setting.[5] NCCN® also includes Verzenio plus endocrine therapy as a preferred treatment option for HR+, HER2- metastatic breast cancer.[5]

The collective results of Lilly's clinical development program continue to differentiate Verzenio as a CDK4/6 inhibitor. In high-risk EBC, Verzenio has shown a persistent and deepening benefit beyond the two-year treatment period in the monarchE trial, an adjuvant study designed specifically to investigate a CDK4/6 inhibitor in a node-positive, high-risk EBC population.[6] In metastatic breast cancer, Verzenio has demonstrated statistically significant OS in the Phase 3 MONARCH 2 study.[7] Verzenio has shown a consistent and generally manageable safety profile across clinical trials.

Verzenio is an oral tablet taken twice daily and available in strengths of 50 mg, 100 mg, 150 mg, and 200 mg. Discovered and developed by Lilly researchers, Verzenio was first approved in 2017 and is currently authorized for use in more than 90 countries around the world. For full details on indicated uses of Verzenio in HR+, HER2- breast cancer, please see full Prescribing Information, available at www.Verzenio.com.

INDICATIONS FOR VERZENIO
VERZENIO is a kinase inhibitor indicated:

- in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for the adjuvant treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence.
- in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.
- in combination with fulvestrant for the treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy.
- as monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting.

IMPORTANT SAFETY INFORMATION FOR VERZENIO (abemaciclib)
Severe **diarrhea** associated with dehydration and infection occurred in patients treated with Verzenio. Across four clinical trials in 3691 patients, diarrhea occurred in 81 to 90% of patients who received Verzenio. Grade 3 diarrhea occurred in 8 to 20% of patients receiving Verzenio. Most patients experienced diarrhea during the first month of Verzenio treatment. The median time to onset of the first diarrhea event ranged from 6 to 8 days; and the median duration of Grade 2 and Grade 3 diarrhea ranged from 6 to 11 days and 5 to 8 days, respectively. Across trials, 19 to 26% of patients with diarrhea required a Verzenio dose interruption and 13 to 23% required a dose reduction.

Instruct patients to start antidiarrheal therapy, such as loperamide, at the first sign of loose stools, increase oral fluids, and notify their healthcare provider for further instructions and appropriate follow-up. For Grade 3 or 4 diarrhea, or diarrhea that requires hospitalization, discontinue Verzenio until toxicity resolves to ≤Grade 1, and then resume Verzenio at the next lower dose.

Neutropenia, including febrile neutropenia and fatal neutropenic sepsis, occurred in patients treated with Verzenio. Across four clinical trials in 3691 patients, neutropenia occurred in 37 to 46% of patients receiving Verzenio. A Grade ≥3 decrease in neutrophil count (based on laboratory findings) occurred in 19 to 32% of patients receiving Verzenio. Across trials, the median time to first episode of Grade ≥3 neutropenia ranged from 29 to 33 days, and the median duration of Grade ≥3 neutropenia ranged from 11 to 16 days. Febrile neutropenia has been reported in <1% of patients exposed to Verzenio across trials. Two deaths due to neutropenic sepsis were observed in MONARCH 2. Inform patients to promptly report any episodes of fever to their healthcare provider.

Monitor complete blood counts prior to the start of Verzenio therapy, every 2 weeks for the first 2 months, monthly for the next 2 months, and as clinically indicated. Dose interruption, dose reduction, or delay in starting treatment cycles is recommended for patients who develop Grade 3 or 4 neutropenia.

Severe, life-threatening, or **fatal interstitial lung disease (ILD) or pneumonitis** can occur in patients treated with Verzenio and other CDK4/6 inhibitors. In Verzenio-treated patients in EBC (monarchE), 3% of patients experienced ILD or pneumonitis of any grade: 0.4% were Grade 3 or 4 and there was one fatality (0.1%). In Verzenio-treated patients in MBC (MONARCH 1, MONARCH 2, MONARCH 3), 3.3% of Verzenio-treated patients had ILD or pneumonitis of any grade: 0.6% had Grade 3 or 4, and 0.4% had fatal outcomes. Additional cases of ILD or pneumonitis have been observed in the postmarketing setting, with fatalities reported.

Monitor patients for pulmonary symptoms indicative of ILD or pneumonitis. Symptoms may include hypoxia, cough, dyspnea, or interstitial infiltrates on radiologic exams. Infectious, neoplastic, and other causes for such symptoms should be excluded by means of appropriate investigations. Dose interruption or dose reduction is recommended in patients who develop persistent or recurrent Grade 2 ILD or pneumonitis. Permanently discontinue Verzenio in all patients with Grade 3 or 4 ILD or pneumonitis.

Grade ≥3 increases in alanine aminotransferase (ALT) (2 to 6%) and **aspartate aminotransferase (AST)** (2 to 3%) were reported in patients receiving Verzenio. Across three clinical trials in 3559 patients (monarchE, MONARCH 2, MONARCH 3), the median time to onset of Grade ≥3 ALT increases ranged from 57 to 87 days and the median time to resolution to Grade <3 was 13 to 14 days. The median time to onset of Grade ≥3 AST increases ranged from 71 to 185 days and the median time to resolution to Grade <3 ranged from 11 to 15 days.

Monitor liver function tests (LFTs) prior to the start of Verzenio therapy, every 2 weeks for the first 2 months, monthly for the next 2 months, and as clinically indicated. Dose interruption, dose reduction, dose discontinuation, or delay in starting treatment cycles is recommended for patients who develop persistent or recurrent Grade 2, or any Grade 3 or 4 hepatic transaminase elevation.

Venous thromboembolic events (VTE) were reported in 2 to 5% of patients across three clinical trials in 3559 patients treated with Verzenio (monarchE, MONARCH 2, MONARCH 3). VTE included deep vein thrombosis, pulmonary embolism, pelvic venous thrombosis, cerebral venous sinus thrombosis, subclavian and axillary vein thrombosis, and inferior vena cava thrombosis. In clinical trials, deaths due to VTE have been reported in patients treated with Verzenio.

Verzenio has not been studied in patients with early breast cancer who had a history of VTE. Monitor patients for signs and symptoms of venous thrombosis and pulmonary embolism and treat as medically appropriate. Dose interruption is recommended for EBC patients with any grade VTE and for MBC patients with a Grade 3 or 4 VTE.

Verzenio can cause **fetal harm** when administered to a pregnant woman, based on findings from animal studies and the mechanism of action. In animal reproduction studies, administration of abemaciclib to pregnant rats during the period of organogenesis caused teratogenicity and decreased fetal weight at maternal exposures that were similar to the human clinical exposure based on area under the curve (AUC) at the maximum recommended human dose. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with Verzenio and for 3 weeks after the last dose. Based on findings in animals, Verzenio may impair fertility in males of reproductive potential. There are no data on the presence of Verzenio in human milk or its effects on the breastfed child or on milk production. Advise lactating women not to breastfeed during Verzenio treatment and for at least 3 weeks after the last dose because of the potential for serious adverse reactions in breastfed infants.

The most **common adverse reactions (all grades, ≥10%)** observed in **monarchE for Verzenio plus tamoxifen or an aromatase inhibitor vs tamoxifen or an aromatase inhibitor, with a difference between arms of ≥2%,** were diarrhea (84% vs 9%), infections (51% vs 39%), neutropenia (46% vs 6%), fatigue (41% vs 18%), leukopenia (38% vs 7%), nausea (30% vs 9%), anemia (24% vs 4%), headache (20% vs 15%), vomiting (18% vs 4.6%), stomatitis (14% vs 5%), lymphopenia (14% vs 3%), thrombocytopenia (13% vs 2%), decreased appetite (12% vs 2.4%), ALT increased (12% vs 6%), AST increased (12% vs 5%), dizziness (11% vs 7%), rash (11% vs 4.5%), and alopecia (11% vs 2.7%).

The **most frequently reported ≥5% Grade 3 or 4 adverse reaction** that occurred in the Verzenio arm vs the tamoxifen or an aromatase inhibitor arm of monarchE were neutropenia (19.6% vs 1%), leukopenia (11% vs <1%), diarrhea (8% vs 0.2%), and lymphopenia (5% vs <1%).

Lab abnormalities (all grades; Grade 3 or 4) for **monarchE in ≥10% for Verzenio plus tamoxifen or an aromatase inhibitor with a difference between arms of ≥2%** were increased serum creatinine (99% vs 91%; 0.5% vs <0.1%), decreased white blood cells (89% vs 28%; 19.1% vs 1.1%), decreased neutrophil count (84% vs 23%; 18.7% vs 1.9%), anemia (68% vs 17%; 1% vs .1%), decreased lymphocyte count (59% vs 24%; 13.2 % vs 2.5%), decreased platelet count (37% vs 10%; .9% vs .2%), increased ALT (37% vs 24%; 2.6% vs 1.2%), increased AST (31% vs 18%; 1.6% vs .9%), and hypokalemia (11% vs 3.8%; 1.3% vs 0.2%).

The **most common adverse reactions (all grades, ≥10%)** observed in **MONARCH 3 for Verzenio plus anastrozole or letrozole vs anastrozole or letrozole, with a difference between arms of ≥2%,** were diarrhea (81% vs 30%), fatigue (40% vs 32%), neutropenia (41% vs 2%), infections (39% vs 29%), nausea (39% vs 20%), abdominal pain (29% vs 12%), vomiting (28% vs 12%), anemia (28% vs 5%), alopecia (27% vs 11%), decreased appetite (24% vs 9%), leukopenia (21% vs 2%), creatinine increased (19% vs 4%), constipation (16% vs 12%), ALT increased (16% vs 7%), AST increased (15% vs 7%), rash (14% vs 5%), pruritus (13% vs 9%), cough (13% vs 9%), dyspnea (12% vs 6%), dizziness (11% vs 9%), weight decreased (10% vs 3.1%), influenza-like illness (10% vs 8%), and thrombocytopenia (10% vs 2%).

The **most frequently reported ≥5% Grade 3 or 4 adverse reactions** that occurred in the Verzenio arm vs the placebo arm of **MONARCH 3** were neutropenia (22% vs 1%), diarrhea (9% vs 1.2%), leukopenia (7% vs <1%), increased ALT (6% vs 2%), and anemia (6% vs 1%).

Lab abnormalities (all grades; Grade 3 or 4) for **MONARCH 3 in ≥10% for Verzenio plus anastrozole or letrozole with a difference between arms of ≥2%** were increased serum creatinine (98% vs 84%; 2.2% vs 0%), decreased white blood cells (82% vs 27%; 13% vs 0.6%), anemia (82% vs 28%; 1.6% vs 0%), decreased neutrophil count (80% vs 21%; 21.9% vs 2.6%), decreased lymphocyte count (53% vs 26%; 7.6% vs 1.9%), decreased platelet count (36% vs 12%; 1.9% vs 0.6%), increased ALT (48% vs 25%; 6.6% vs 1.9%), and increased AST (37% vs 23%; 3.8% vs 0.6%).

The **most common adverse reactions (all grades, ≥10%)** observed in **MONARCH 2 for Verzenio plus fulvestrant vs fulvestrant, with a difference between arms of ≥2%,** were diarrhea (86% vs 25%), neutropenia (46% vs 4%), fatigue (46% vs 32%), nausea (45% vs 23%), infections (43% vs 25%), abdominal pain (35% vs 16%), anemia (29% vs 4%), leukopenia (28% vs 2%), decreased appetite (27% vs 12%), vomiting (26% vs 10%), headache (20% vs 15%), dysgeusia (18% vs 2.7%), thrombocytopenia (16% vs 3%), alopecia (16% vs 1.8%), stomatitis (15% vs 10%), ALT increased (13% vs 5%), pruritus (13% vs 6%), cough (13% vs 11%), dizziness (12% vs 6%), AST increased (12% vs 7%), peripheral edema (12% vs 7%), creatinine increased (12% vs <1%), rash (11% vs 4.5%), pyrexia (11% vs 6%), and weight decreased (10% vs 2.2%).

The **most frequently reported ≥5% Grade 3 or 4 adverse reactions** that occurred in the Verzenio arm vs the placebo arm of **MONARCH 2** were neutropenia (25% vs 1%), diarrhea (13% vs 0.4%), leukopenia (9% vs 0%), anemia (7% vs 1%), and infections (5.7% vs 3.5%).

Lab abnormalities (all grades; Grade 3 or 4) for **MONARCH 2 in ≥10% for Verzenio plus fulvestrant with a difference between arms of ≥2%** were increased serum creatinine (98% vs 74%; 1.2% vs 0%), decreased white blood cells (90% vs 33%; 23.7% vs .9%), decreased neutrophil count (87% vs 30%; 32.5% vs 4.2%), anemia (84% vs 34%; 2.6% vs .5%), decreased lymphocyte count (63% vs 32%; 12.2% vs 1.8%), decreased platelet count (53% vs 15%; 2.1% vs 0%), increased ALT (41% vs 32%; 4.6% vs 1.4%), and increased AST (37% vs 25%; 3.9% vs 4.2%).

The **most common adverse reactions (all grades, ≥10%)** observed in **MONARCH 1** with Verzenio were diarrhea (90%), fatigue (65%), nausea (64%), decreased appetite (45%), abdominal pain (39%), neutropenia (37%), vomiting (35%), infections (31%), anemia (25%), thrombocytopenia (20%), headache (20%), cough (19%), constipation (17%), leukopenia (17%), arthralgia (15%), dry mouth (14%), weight decreased (14%), stomatitis (14%), creatinine increased (13%), alopecia (12%), dysgeusia (12%), pyrexia (11%), dizziness (11%), and dehydration (10%).

The **most frequently reported ≥5% Grade 3 or 4 adverse reactions** from **MONARCH 1** with Verzenio were diarrhea (20%), neutropenia (24%), fatigue (13%), and leukopenia (5%).

Lab abnormalities (all grades; Grade 3 or 4) for MONARCH 1 with Verzenio were increased serum creatinine (99%; .8%), decreased white blood cells (91%; 28%), decreased neutrophil count (88%; 26.6%), anemia (69%; 0%), decreased lymphocyte count (42%; 13.8%), decreased platelet count (41%; 2.3%), increased ALT (31%; 3.1%), and increased AST (30%; 3.8%).

Strong and moderate CYP3A inhibitors increased the exposure of abemaciclib plus its active metabolites to a clinically meaningful extent and may lead to increased toxicity. Avoid concomitant use of ketoconazole. Ketoconazole is predicted to increase the AUC of abemaciclib by up to 16-fold. In patients with recommended starting doses of 200 mg twice daily or 150 mg twice daily, reduce the Verzenio dose to 100 mg twice daily with concomitant use of strong CYP3A inhibitors other than ketoconazole. In patients who have had a dose reduction to 100 mg twice daily due to adverse reactions, further reduce the Verzenio dose to 50 mg twice daily with concomitant use of strong CYP3A inhibitors. If a patient taking Verzenio discontinues a strong CYP3A inhibitor, increase the Verzenio dose (after 3 to 5 half-lives of the inhibitor) to the dose that was used before starting the inhibitor. With concomitant use of moderate CYP3A inhibitors, monitor for adverse reactions and consider reducing the Verzenio dose in 50 mg decrements. Patients should avoid grapefruit products.

Avoid concomitant use of strong or moderate CYP3A inducers and consider alternative agents. Coadministration of strong or moderate CYP3A inducers decreased the plasma concentrations of abemaciclib plus its active metabolites and may lead to reduced activity.

With severe hepatic impairment (Child-Pugh C), reduce the Verzenio dosing frequency to once daily. The pharmacokinetics of Verzenio in patients with **severe renal impairment** (CLcr <30 mL/min), end stage renal disease, or in patients on dialysis is unknown. No dosage adjustments are necessary in patients with mild or moderate hepatic (Child-Pugh A or B) and/or renal impairment (CLcr ≥30-89 mL/min).

Please see full Prescribing Information and Patient Information for Verzenio.

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About Olomorasib
Olomorasib (LY3537982) is an investigational, oral, potent, and highly selective second-generation inhibitor of the KRAS G12C protein. KRAS is the most common oncogene across all tumor types, and KRAS G12C mutations occur in 13% of patients with non-small cell lung cancer (NSCLC), and 1-3% of patients with other solid tumors.[8] Olomorasib is a highly potent covalent inhibitor with potential for greater than 90% target occupancy, which may allow for safer combinations with less toxicity.[9]

Olomorasib is currently being studied in KRAS G12C-mutated cancers in combination with pembrolizumab with or without chemotherapy for first-line treatment of advanced NSCLC, in combination with immunotherapy for the treatment of resected and unresectable NSCLC, and as monotherapy and in combinations in other advanced solid tumors, including: NCT06119581, NCT06890598, and NCT04956640.

About Jaypirca (pirtobrutinib)
Jaypirca (pirtobrutinib) (pronounced jay-pihr-kaa) is a highly selective (300 times more selective for BTK versus 98% of other kinases tested in preclinical studies), non-covalent inhibitor of the enzyme BTK.[10] BTK is a validated molecular target found across numerous B-cell leukemias and lymphomas including mantle cell lymphoma (MCL) and chronic lymphocytic leukemia (CLL).[11,12] Jaypirca is a U.S. FDA-approved oral prescription medicine, 100 mg or 50 mg tablets taken as a once-daily 200 mg dose with or without food until disease progression or unacceptable toxicity.

INDICATIONS FOR JAYPIRCA (pirtobrutinib)
Jaypirca is indicated for the treatment of

- Adult patients with relapsed or refractory chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL) who have previously been treated with a covalent BTK inhibitor.
- Adult patients with relapsed or refractory (R/R) mantle cell lymphoma (MCL) after at least two lines of systemic therapy, including a BTK inhibitor. This indication is approved under accelerated approval based on response rate. Continued approval for this indication may be contingent upon verification and description of clinical trial benefit in a confirmatory trial.

IMPORTANT SAFETY INFORMATION FOR JAYPIRCA (pirtobrutinib)

Infections: Fatal and serious infections (including bacterial, viral, fungal) and opportunistic infections occurred in Jaypirca-treated patients. Across clinical trials, Grade ≥3 infections occurred (25%), most commonly pneumonia (20%); fatal infections (5%), sepsis (6%), and febrile neutropenia (3.8%) occurred. In patients with CLL/SLL, Grade ≥3 infections occurred (32%), with fatal infections occurring in 8%. Opportunistic infections included *Pneumocystis jirovecii* pneumonia and fungal infection. Consider prophylaxis, including vaccinations and antimicrobial prophylaxis, in patients at increased risk for infection, including opportunistic infections. Monitor for signs and symptoms, evaluate, and treat. Based on severity, reduce dose, temporarily withhold, or permanently discontinue Jaypirca.

Hemorrhage: Fatal and serious hemorrhage has occurred with Jaypirca. Across clinical trials, major hemorrhage (Grade ≥3 bleeding or any central nervous system bleeding) occurred (2.6%), including gastrointestinal hemorrhage; fatal hemorrhage occurred (0.3%). Bleeding of any grade, excluding bruising and petechiae, occurred (16%). Major hemorrhage occurred when taking Jaypirca with (2.0%) and without (0.6%) antithrombotic agents. Consider risks/benefits of co-administering antithrombotic agents with Jaypirca. Monitor for signs of bleeding. Based on severity, reduce dose, temporarily withhold, or permanently discontinue Jaypirca. Consider withholding Jaypirca 3-7 days pre- and post-surgery based on surgery type and bleeding risk.

Cytopenias: Jaypirca can cause cytopenias, including neutropenia, thrombocytopenia, and anemia. Across clinical trials, Grade 3 or 4 cytopenias, including decreased neutrophils (27%), decreased platelets (13%), and decreased hemoglobin (11%), developed. Grade 4 decreased neutrophils (15%) and Grade 4 decreased platelets (6%) developed. Monitor complete blood counts regularly. Based on severity, reduce dose, temporarily withhold, or permanently discontinue Jaypirca.

Cardiac Arrhythmias: Cardiac arrhythmias occurred in patients taking Jaypirca. Across clinical trials, atrial fibrillation or flutter were reported in 3.4% of Jaypirca treated patients, with Grade 3 or 4 atrial fibrillation or flutter in 1.6%. Other serious cardiac arrhythmias such as supraventricular

tachycardia and cardiac arrest occurred (0.4%). Cardiac risk factors such as hypertension or previous arrhythmias may increase risk. Monitor and manage signs and symptoms of arrhythmias (e.g., palpitations, dizziness, syncope, dyspnea). Based on severity, reduce dose, temporarily withhold, or permanently discontinue Jaypirca.

Second Primary Malignancies: Across clinical trials, second primary malignancies, including non-skin carcinomas, developed in 9% of Jaypirca-treated patients, most frequently non-melanoma skin cancer (4.4%). Other second primary malignancies included solid tumors (including genitourinary and breast cancers) and melanoma. Advise patients to use sun protection and monitor for development of second primary malignancies.

Hepatotoxicity, Including Drug-Induced Liver Injury (DILI): Hepatotoxicity, including severe, life-threatening, and potentially fatal cases of DILI, has occurred in patients treated with BTK inhibitors, including Jaypirca. Evaluate bilirubin and transaminases at baseline and throughout Jaypirca treatment. For patients who develop abnormal liver tests after Jaypirca, monitor more frequently for liver test abnormalities and clinical signs and symptoms of hepatic toxicity. If DILI is suspected, withhold Jaypirca. If DILI is confirmed, discontinue Jaypirca.

Embryo-Fetal Toxicity: Jaypirca can cause fetal harm. Administration of pirtobrutinib to pregnant rats caused embryo-fetal toxicity, including embryo-fetal mortality and malformations at maternal exposures (AUC) approximately 3-times the recommended 200 mg/day dose. Advise pregnant women of fetal risk and females of reproductive potential to use effective contraception during treatment and for one week after last dose.

Adverse Reactions (ARs) in Patients Who Received Jaypirca

The most common (≥30%) ARs in the pooled safety population of patients with hematologic malignancies (n=704) were decreased neutrophil count (54%), decreased hemoglobin (43%), decreased leukocytes (32%), fatigue (31%), decreased platelets (31%), decreased lymphocyte count (31%), calcium decreased (30%).

Mantle Cell Lymphoma

Serious ARs occurred in 38% of patients, with pneumonia (14%), COVID-19 (4.7%), musculoskeletal pain (3.9%), hemorrhage (2.3%), pleural effusion (2.3%), and sepsis (2.3%) occurring in ≥2% of patients. **Fatal ARs** within 28 days of last dose occurred in 7% of patients, most commonly due to infections (4.7%), including COVID-19 (3.1% of all patients).

Dose Modifications and Discontinuations Due to ARs: Dose reductions in 4.7%, treatment interruption in 32%, and permanent discontinuation of Jaypirca in 9% of patients. Permanent discontinuation in >1% of patients included pneumonia.

Most common ARs (≥15%) and Select Laboratory Abnormalities (≥10%) (all Grades %; Grade 3-4 %): hemoglobin decreased (42; 9), platelet count decreased (39; 14), neutrophil count decreased (36; 16), lymphocyte count decreased (32; 15), creatinine increased (30; 1.6), fatigue (29; 1.6), musculoskeletal pain (27; 3.9), calcium decreased (19; 1.6), diarrhea (19; -), edema (18; 0.8), dyspnea (17; 2.3), AST increased (17; 1.6), pneumonia (16; 14), bruising (16; -), potassium decreased (13; 1.6), sodium decreased (13; -), lipase increased (12; 4.4), ALT increased (11; 1.6), potassium increased (11; 0.8), alkaline phosphatase increased (11; -). Grade 4 laboratory abnormalities in >5% of patients included neutrophils decreased (10), platelets decreased (7), lymphocytes decreased (6).

Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma from Single-Arm and Randomized Controlled Clinical Trials

Serious ARs occurred in 47-56% of patients across clinical trials. Serious ARs in ≥5% of patients in the single-arm trial were pneumonia (18%), COVID-19 (9%), sepsis (7%), febrile neutropenia (7%). Serious ARs in ≥3% of patients in the randomized controlled trial were pneumonia (21%), COVID-19 (5%), sepsis (3.4%). **Fatal ARs** within 28-30 days of last Jaypirca dose occurred in 8-11% of patients, most commonly due to infections (7-10%), including sepsis (5%), COVID-19 (2.7-5%), and pneumonia (3.4%).

Dose Modifications and Discontinuations Due to ARs: Dose reductions in 3.6-10%, treatment interruption in 42-51%, and permanent discontinuation of Jaypirca in 9-17% of patients. Permanent discontinuation in >1% of patients included second primary malignancy, pneumonia, COVID-19, neutropenia, sepsis, anemia, and cardiac arrythmias.

Most common ARs and Select Laboratory Abnormalities (≥20%) (all Grades %, Grade 3-4 %)--in a randomized controlled trial: neutrophil count decreased (54; 26), hemoglobin decreased (45; 10), platelet count decreased (37; 17), pneumonia (28; 16), ALT increased (25; 1.8), creatinine increased (25; -), calcium decreased (23; 0.9), sodium decreased (22; 0.9), bilirubin increased (21; 0.9), upper respiratory tract infections (21; 0.9); **in a single-arm trial:** neutrophil count decreased (63; 45), hemoglobin decreased (48; 19), calcium decreased (40; 2.8), fatigue (36; 2.7), bruising (36; -), cough (33; -), musculoskeletal pain (32; 0.9), platelet count decreased (30; 15), sodium decreased (30; -), COVID-19 (28; 7), pneumonia (27; 16), diarrhea (26; -), abdominal pain (25; 2.7), lymphocyte count decreased (23; 8), ALT increased (23; 2.8), AST increased (23; 1.9), creatinine increased (23; -), dyspnea (22; 2.7), hemorrhage (22; 2.7), lipase increased (21; 7), alkaline phosphatase increased (21; -), edema (21; -), nausea (21; -), pyrexia (20; 2.7), headache (20; 0.9). Grade 4 laboratory abnormalities in >5% of patients included neutrophils decreased (23).

Drug Interactions

Strong CYP3A Inhibitors: Concomitant use increased pirtobrutinib systemic exposure, which may increase risk of Jaypirca ARs. Avoid using strong CYP3A inhibitors with Jaypirca. If concomitant use is unavoidable, reduce Jaypirca dose according to approved labeling.

Strong or Moderate CYP3A Inducers: Concomitant use decreased pirtobrutinib systemic exposure, which may reduce Jaypirca efficacy. Avoid using Jaypirca with strong or moderate CYP3A inducers. If concomitant use with moderate CYP3A inducers is unavoidable, increase Jaypirca dose according to approved labeling.

Sensitive CYP2C8, CYP2C19, CYP3A, P-gp, or BCRP Substrates: Use with Jaypirca increased their plasma concentrations, which may increase risk of ARs related to these substrates for drugs sensitive to minimal concentration changes. Follow recommendations for these sensitive substrates in their approved labeling.

Use in Specific Populations

Pregnancy and Lactation: Due to potential for Jaypirca to cause fetal harm, verify pregnancy status in females of reproductive potential prior to starting Jaypirca. Presence of pirtobrutinib in human milk is unknown. Advise women to use effective contraception and to not breastfeed while taking

Jaypirca and for one week after last dose.

Geriatric Use: In the pooled safety population of patients with hematologic malignancies, patients aged ≥65 years experienced higher rates of Grade ≥3 ARs and serious ARs compared to patients <65 years of age.

Renal Impairment: Because severe renal impairment increases pirtobrutinib exposure, reduce Jaypirca dose in these patients according to approved labeling.

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Please see Prescribing Information and Patient Information for Jaypirca.

About Tersolisib
Tersolisib (LY4064809/STX-478) is an investigational, oral, next-generation phosphoinositide 3-kinase alpha (PI3Kα) inhibitor designed to selectively target tumors with *PIK3CA* mutations while sparing wild-type PI3Kα. Activating mutations in the *PIK3CA* gene (which encodes PI3Kα enzyme) are oncogenic drivers present in approximately 40% of hormone receptor positive (HR+)/HER2- breast cancers and occur at lower frequencies in many other cancers.[13,14] Tersolisib is currently being studied in patients with HR+ breast cancer and other solid tumors with *PIK3CA* mutations in the Phase 1/2 PIKALO-1 study (NCT05768139) and is currently being studied in the Phase 3 PIKALO-2 trial (NCT07174336) in patients with HR+/HER2-advanced breast cancer with a *PIK3CA* mutation.

About Lilly
Lilly is a medicine company turning science into healing to make life better for people around the world. We've been pioneering life-changing discoveries for nearly 150 years, and today our medicines help tens of millions of people across the globe. Harnessing the power of biotechnology, chemistry and genetic medicine, our scientists are urgently advancing new discoveries to solve some of the world's most significant health challenges: redefining diabetes care; treating obesity and curtailing its most devastating long-term effects; advancing the fight against Alzheimer's disease; providing solutions to some of the most debilitating immune system disorders; and transforming the most difficult-to-treat cancers into manageable diseases. With each step toward a healthier world, we're motivated by one thing: making life better for millions more people. That includes delivering innovative clinical trials that reflect the diversity of our world and working to ensure our medicines are accessible and affordable. To learn more, visit Lilly.com and Lilly.com/news, or follow us on Facebook, Instagram, and LinkedIn. P-LLY

Cautionary Statement Regarding Forward-Looking Statements
This press release contains forward-looking statements (as that term is defined in the Private Securities Litigation Reform Act of 1995) about olomorasib as a potential treatment for certain *KRAS* G12C-mutant advanced solid tumors, Retevmo as a potential treatment for rearranged during transfection (RET) fusion-positive stage IB-IIIA NSCLC following completion of definitive radiotherapy or surgery with curative intent, and other adjuvant therapy if indicated, and preclinical data for an antibody-drug conjugate targeting Nectin-4 and reflects Lilly's current beliefs and expectations. However, as with any pharmaceutical product, there are substantial risks and uncertainties in the process of drug research, development, and commercialization. Among other things, there is no guarantee that planned or ongoing studies will be completed as planned, that future study results will be consistent with study results to date, that any of these therapies will prove to be a safe and effective treatment or receive regulatory approval, or that Lilly will execute its strategy as expected. For further discussion of these and other risks and uncertainties that could cause actual results to differ from Lilly's expectations, see Lilly's Form 10-K and Form 10-Q filings with the United States Securities and Exchange Commission. Except as required by law, Lilly undertakes no duty to update forward-looking statements to reflect events after the date of this release.

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