

For **TKI-naïve** adult patients with locally advanced or metastatic ROS1+ NSCLC¹

POWERFUL

AGAINST ROS1+ NSCLC¹

IBTROZI delivered a **strong and sustained** response in TKI-naïve patients^{1,2}

TRUST-I (n=103)

**90%
ORR**
(95% CI: 83–95)

mDOR NR
(95% CI: 30.4–NR;
range: 1.1 to 46.9+ months)*

TRUST-II (n=54)

**85%
ORR**
(95% CI: 73–93)

mDOR NR
(95% CI: 20.6–NR;
range: 1.4+ to 30.4+ months)*

mDOR for TRUST-II is not reported in the PI due to shorter duration of follow-up and is subject to change.

The efficacy of IBTROZI was evaluated in 270 TKI-naïve or TKI-pretreated patients with ROS1+ NSCLC who received IBTROZI 600 mg once daily, enrolled in 2 multicenter, single-arm, open-label clinical trials. Patients were required to have histologically confirmed, locally advanced or metastatic, ROS1+ NSCLC with an ECOG PS ≤1, and measurable disease per RECIST v1.1. The primary and key secondary endpoints were confirmed ORR and DOR according to RECIST v1.1, as assessed by BICR. All patients were either chemotherapy naïve or had received prior chemotherapy for locally advanced disease.¹

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Recommended³

Taletrectinib (IBTROZI™) is included as an NCCN **Category 2A, preferred first-line treatment option** for patients with advanced or metastatic ROS1+ NSCLC

Taletrectinib is also recommended for subsequent therapy, including as a preferred option for patients with symptomatic brain metastases and as an option for resistant mutations, such as ROS1 G2032R

*"+" indicates an ongoing response.

BICR=blinded independent central review; CI=confidence interval; DOR=duration of response; ECOG=Eastern Cooperative Oncology Group; mDOR=median duration of response; NCCN=National Comprehensive Cancer Network® (NCCN®); NR=not reached; NSCLC=non-small cell lung cancer; ORR=overall response rate; PI=prescribing information; PS=performance status; RECIST=Response Evaluation Criteria in Solid Tumors; ROS1=ROS proto-oncogene 1; TKI=tyrosine kinase inhibitor.

INDICATION

IBTROZI™ (taletrectinib) is indicated for the treatment of adult patients with locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC).

SELECT SAFETY INFORMATION

Serious adverse and sometimes fatal reactions occurred with IBTROZI treatment. Warnings and precautions include hepatotoxicity, interstitial lung disease/pneumonitis, QTc interval prolongation, hyperuricemia, myalgia with creatine phosphokinase (CPK) elevation, skeletal fractures, and embryo-fetal toxicity.

Please see complete **Important Safety Information** on pages 14-17 and accompanying full **Prescribing Information**.

IBTROZI™
taletrectinib 200 mg capsules

IBTROZI: evaluated in a large population across 2 pivotal trials

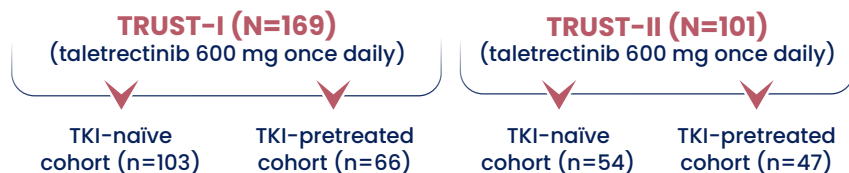
More than 300 patients were enrolled in 2 multicenter, single-arm, open-label phase 2 pivotal studies (TRUST-I and TRUST-II) to evaluate the safety and efficacy of IBTROZI, a selective, brain-penetrant TKI. The results were generated in TKI-naïve and TKI-pretreated patients with ROS1+ NSCLC.^{1,4}

PIVOTAL PHASE 2 TRUST TRIALS^{1,4-6}

Key eligibility criteria in TRUST-I and TRUST-II

- Inclusion**
- Locally advanced or metastatic NSCLC with confirmed ROS1 fusion
 - ≥1 measurable lesion per RECIST v1.1
 - ECOG PS 0-1
 - Stable CNS involvement was allowed
 - ROS1 TKI treatment naïve or received 1 prior ROS1 TKI

- Exclusion**
- Active infection (including active hepatitis B or C)
 - Antitumor drugs ≤14 days
 - Radiotherapy ≤14 days
 - Major surgery ≤4 weeks
 - History of ILD or drug-induced pneumonitis



Endpoints in TRUST-I and TRUST-II

- Primary endpoint**
- BICR-confirmed ORR per RECIST v1.1
- Secondary endpoints**
- DOR, IC-ORR per modified RECIST v1.1, PFS, safety

- The **efficacy-evaluable population (N=270)** included patients with ROS1+ NSCLC with ≥1 measurable lesion at baseline per RECIST v1.1 by BICR and who received ≥1 dose of taletrectinib
- The **TRUST-I/TRUST-II safety population (N=337)** included patients who were exposed to IBTROZI as a single agent dosed at 600 mg orally once daily until disease progression or unacceptable toxicity
- A **pooled safety population (N=352)**, described in the Warnings and Precautions section of the Prescribing Information, included 337 patients with ROS1+ NSCLC and 15 patients with solid tumors who received IBTROZI 600 mg once daily

CNS=central nervous system; IC-ORR=intracranial overall response rate; ILD=interstitial lung disease; PFS=progression-free survival.

SELECT SAFETY INFORMATION (cont'd)

Hepatotoxicity: Hepatotoxicity, including drug-induced liver injury and fatal adverse reactions, can occur. 88% of patients experienced increased AST, including 10% Grade 3/4. 85% of patients experienced increased ALT, including 13% Grade 3/4. Fatal liver events occurred in 0.6% of patients.

PATIENT CHARACTERISTICS FOR TRUST-I AND TRUST-II¹

PATIENT POPULATION	TRUST-I		TRUST-II	
	TKI-NAÏVE (n=103)	TKI-PRETREATED (n=66)	TKI-NAÏVE (n=54)	TKI-PRETREATED (n=47)
Median age, years (range)	56 (26-78)	51 (31-77)	57 (27-82)	55 (27-79)
Male/female	45%/55%	39%/61%	44%/56%	43%/57%
ECOG PS 1	81%	71%	61%	55%
Asian	100%	100%	65%	47%
White	0%	0%	22%	34%
Black or African American	0%	0%	1.9%	2.1%
Unknown or other races	0%	0%	11%	17%
Hispanic or Latino	NA	NA	1.9%	2.1%
Never smoked	73%	74%	50%	62%
Adenocarcinoma histology	96%	92%	98%	98%
Prior platinum-based chemotherapy	19%	35%	19%	40%
Prior crizotinib	NA	100%	NA	79%
Prior entrectinib	NA	0%	NA	21%
Metastatic disease at baseline	91%	97%	91%	98%
CNS metastases at baseline	17%	42%	35%	57%

NA=not applicable.

SELECT SAFETY INFORMATION (cont'd)

Hepatotoxicity (cont'd): Increased AST or ALT each led to dose interruption in 7% of patients and dose reduction in 5% and 9% of patients, respectively. Permanent discontinuation was caused by increased AST, ALT, or bilirubin each in 0.3% and by hepatotoxicity in 0.6% of patients.

Monitor liver function tests prior to treatment, every 2 weeks during the first 2 months, then monthly thereafter as clinically indicated. Test more frequently if transaminase elevations occur. Based on severity and resolution, withhold, then resume at a reduced dose or permanently discontinue.

Please see complete **Important Safety Information** on pages 14-17.

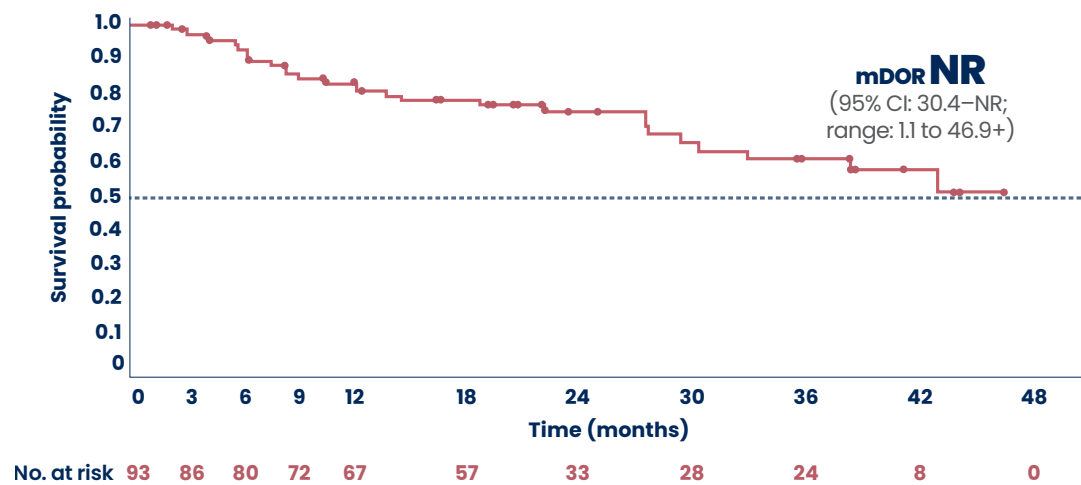


IBTROZI delivered a strong and sustained response in TKI-naïve patients^{1,2}

TRUST-I (n=103)

90% ORR (95% CI: 83–95) 85% PR, 5% CR

Median follow-up time for response: 40 months (range: 19.9 to 48.7)



TRUST-I and TRUST-II are ongoing and DOR results are subject to change as the data mature.

- 72% of responders had an observed DOR of ≥12 months
- In responding patients, the longest DOR observed was 46.9 months, with response ongoing (range: 1.1 to 46.9+)

CR=complete response; PR=partial response.

SELECT SAFETY INFORMATION (cont'd)

Interstitial Lung Disease (ILD)/Pneumonitis: Severe, life-threatening, or fatal ILD or pneumonitis can occur. ILD/pneumonitis occurred in 2.3% of patients, including 1.1% Grade 3/4. One fatal ILD case occurred at the 400 mg daily dose.

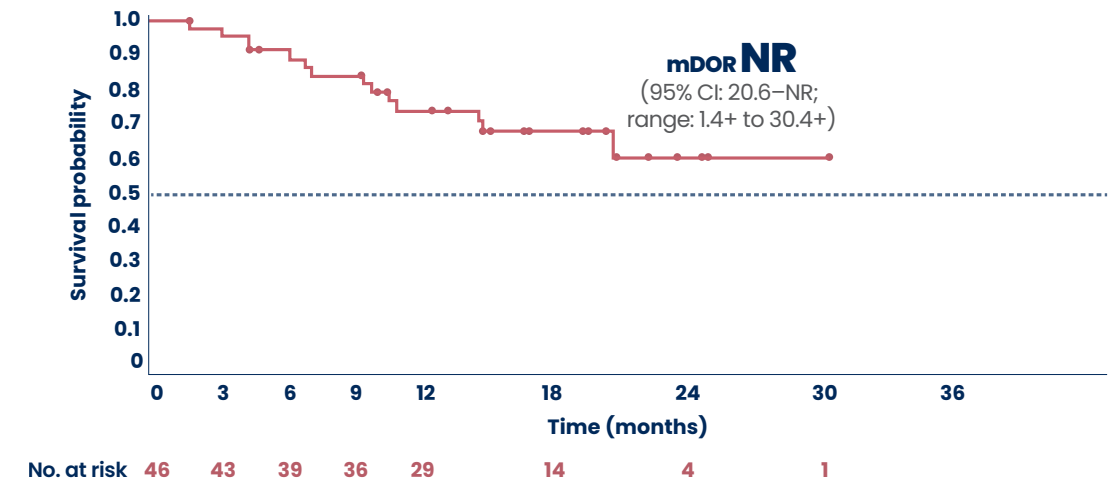
ILD/pneumonitis led to dose interruption in 1.1% of patients, dose reduction in 0.6% of patients, and permanent discontinuation in 0.6% of patients. Monitor patients for new or worsening pulmonary symptoms. If ILD/pneumonitis is suspected, immediately withhold; based on severity and resolution, resume at same or reduced dose, or permanently discontinue.

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TRUST-II (n=54)

85% ORR (95% CI: 73–93) 78% PR, 7% CR

Median follow-up time for response: 19 months (range: 10.6 to 33.1)



TRUST-I and TRUST-II are ongoing and DOR results are subject to change as the data mature. mDOR for TRUST-II is not reported in the PI due to shorter duration of follow-up.

- 63% of responders had an observed DOR of ≥12 months
- In responding patients, the longest DOR observed was 30.4 months, with response ongoing (range: 1.4+ to 30.4+)

Clinically meaningful CNS response in TKI-naïve patients¹



73% (n=11/15) of patients with CNS metastases saw an intracranial response

Please see complete **Important Safety Information** on pages 14–17.



Additional data in TKI-naïve patients

Noncomparative mPFS^{2,7}

Single-arm studies, which lack a comparator arm, may be inadequate to sufficiently evaluate time-to-event endpoints, such as mPFS. The clinical significance of these mPFS data is not known and the observed effect may be attributable to IBTROZI or to other factors.

TRUST-I (n=103)

44.6
months

(95% CI: 30.72–NR;
range: 0.0 to 48.3+ months)

Median follow-up time:

41 months (range: 22.0 to 50.1)

TRUST-II (n=54)

NR

(95% CI: 15.87–NR;
range: 0.5 to 31.6+ months)

Median follow-up time:

21 months (range: 8.3 to 34.5)

mPFS=median progression-free survival.

SELECT SAFETY INFORMATION (cont'd)

QTc Interval Prolongation: QTc interval prolongation can occur, which can increase the risk for ventricular tachyarrhythmias (e.g., torsades de pointes) or sudden death. In patients who received IBTROZI and underwent at least one postbaseline ECG, QTcF increase of >60 msec compared to baseline and QTcF >500 msec occurred in 13% and 2.6% of patients, respectively. 3.4% of patients experienced Grade ≥3. Dose interruption and dose reduction each occurred in 2.8% of patients.

Monitor ECGs and electrolytes prior to start of therapy, and then periodically thereafter as clinically indicated. Adjust frequency based on risk factors. Based on severity and resolution, withhold, then resume at same or reduced dose, or permanently discontinue.

Significant QTc interval prolongation may occur when IBTROZI is taken with food, strong and moderate CYP3A inhibitors, and/or drugs with a known potential to prolong QTc. Administer IBTROZI on an empty stomach. Avoid concomitant use with strong and moderate CYP3A inhibitors and/or drugs with a known potential to prolong QTc.

IBTROZI delivered notable response in patients who received prior TKI treatment^{1,2}

TRUST-I AND TRUST-II

TRUST-I (n=66)

Median follow-up time for response: 33 months (range: 20.2 to 46.0)

52% ORR
(95% CI: 39–64)
52% PR, 0% CR

13.2 months
mDOR

(95% CI: 7.7–24.9; range:
1.4 to 38.7+ months)

- 74% of responders had an observed DOR of ≥6 months
- 44% of responders had an observed DOR of ≥12 months

TRUST-II (n=47)

Median follow-up time for response: 19 months (range: 8.0 to 32.2)

62% ORR
(95% CI: 46–75)
51% PR, 11% CR

19.4 months
mDOR

(95% CI: 10.7–NR; range:
1.7+ to 30.4+ months)

- 83% of responders had an observed DOR of ≥6 months
- 45% of responders had an observed DOR of ≥12 months

TRUST-I and TRUST-II are ongoing and DOR results are subject to change as the data mature. mDOR for TRUST-II is not reported in the PI due to shorter duration of follow-up.

Tumor responses were observed in patients with CNS metastases and resistance mutations who received prior TKI treatment^{1,2,4}



63% (n=15/24) of patients with CNS metastases saw an intracranial response¹



53% (n=8/15) of patients with acquired resistance mutations saw a response¹

- Responses observed in **62% (8/13) patients with G2032R resistance mutations²**
- Solvent front mutation G2032R is the most common on-target resistance mutation in crizotinib-treated patients^{1,4}

Please see complete [Important Safety Information](#) on pages 14–17.

IBTROZITM
taletrectinib 200mg capsules

IBTROZI safety profile

ADVERSE REACTIONS (≥15%) IN PATIENTS WITH ROS1+ NSCLC WHO RECEIVED IBTROZI IN TRUST-I AND TRUST-II^{1,2}

ADVERSE REACTIONS*	IBTROZI (N=337)			
	GRADE 1 (%)	GRADE 2 (%)	GRADE 3 OR 4 (%)	ALL GRADES (%)
GASTROINTESTINAL DISORDERS				
Diarrhea [†]	50	11	2.1	64
Nausea	37	9	1.5	47
Vomiting	34	8	1.5	43
Constipation	18	3	0	21
NERVOUS SYSTEM DISORDERS				
Dizziness [‡]	20	2.1	0.3	22
Peripheral neuropathy [§]	13	3.6	0.3	17
Dysgeusia	13	2.1	0	15
SKIN AND SUBCUTANEOUS TISSUE				
Rash [¶]	13	8	1.8	22
GENERAL DISORDERS				
Fatigue [#]	15	4.5	0.9	20
CARDIAC				
Electrocardiogram QT prolonged	13	2.7	3.6	19
METABOLISM AND NUTRITIONAL				
Decreased appetite	11	4.2	0.3	16
RESPIRATORY, THORACIC, AND MEDIASTINAL DISORDERS				
Cough ^{**}	12	4.7	0	16

*Based on NCI CTCAE version 5.0.¹

[†]Includes enterocolitis.¹

[‡]Includes vertigo and vertigo positional.¹

[§]Includes dysesthesia, hypoesthesia, neuralgia, paresthesia, and peripheral sensory neuropathy.¹

^{||}Includes ageusia.¹

[¶]Includes dermatitis, dermatitis acneiform, drug eruption, eczema, eyelid rash, palmar-plantar erythrodysesthesia syndrome, rash maculo-papular, rash papular, skin exfoliation, and drug reaction with eosinophilia and systemic symptoms (DRESS).¹

[#]Includes asthenia.¹

^{**}Includes productive cough.¹

AR=adverse reaction; CTCAE=Common Terminology Criteria for Adverse Events; NCI=National Cancer Institute.

Serious adverse reactions¹

- Serious ARs occurred in 31% of patients who received IBTROZI. Serious ARs in ≥2% of patients included pneumonia (7%), pleural effusion (4.7%), and hepatotoxicity (2.4%)
- Fatal ARs occurred in 18 (5%) patients who received IBTROZI, including pneumonia (2.4%), multiple organ dysfunction syndrome (0.6%), hepatotoxicity (0.6%), cardiac arrest (0.6%), cardiac failure (0.3%), cardiopulmonary failure (0.3%), respiratory failure (0.3%), and death not otherwise specified (0.3%)

Laboratory abnormalities

LABORATORY ABNORMALITIES^{††} (≥20%) IN PATIENTS WITH ROS1+ NSCLC WHO RECEIVED IBTROZI IN TRUST-I AND TRUST-II^{1,2}

LABORATORY ABNORMALITY*	IBTROZI ^{††}			
	GRADE 1 (%)	GRADE 2 (%)	GRADE 3 OR 4 (%)	ALL GRADES (%)
HEMATOLOGY				
Hemoglobin decreased	31	14	3.6	48
Lymphocytes decreased	14	19	4.8	38
Neutrophils decreased	11	8	5	25
CHEMISTRY				
AST increased	57	20	10	87
ALT increased	51	21	13	85
Creatine phosphokinase increased	37	11	5	53
Cholesterol increased	32	9	0	41
Triglycerides increased	30	8	2.5	41
Creatinine increased	21	18	0.3	39
Uric acid increased	38	0	0	38
Gamma glutamyl transferase increased	28	6	1.8	36
Alkaline phosphatase increased	28	2	0	30
Calcium decreased	21	5	1.8	28
Albumin decreased	19	6	0.9	25
Bilirubin increased	18	4.5	0.6	24
Potassium increased	13	7	1.2	21
Sodium increased	16	2.4	0.9	20

^{††}Laboratory abnormalities that worsened from baseline.¹

^{†††}The denominator used to calculate the rate varied from 149 to 336 based on the number of patients with a baseline value and at least 1 post-treatment value.¹

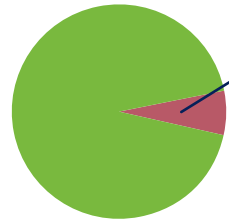
ALT=alanine aminotransferase; AST=aspartate aminotransferase.

Please see complete **Important Safety Information** on pages 14–17.



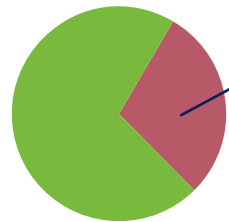
Dose modification rates

Majority of patients were able to remain on treatment¹



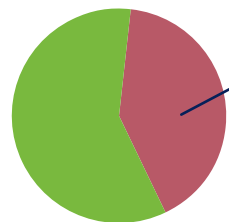
7% of patients discontinued treatment due to ARs

- The ARs resulting in permanent discontinuation of IBTROZI in ≥ 2 patients were pneumonia, ILD, and hepatotoxicity



29% of patients required a dose reduction due to ARs

- ARs that required dosage reductions in $\geq 5\%$ of patients included increased ALT and increased AST



41% of patients required a dose interruption due to ARs

- ARs that required dosage interruption in $\geq 5\%$ of patients included increased AST and increased ALT

IBTROZI has specific dose modifications for hepatotoxicity, ILD/pneumonitis, QTc interval prolongation, hyperuricemia, creatine phosphokinase elevation, and other ARs. See dose modifications for more information.

Explore the full safety profile for IBTROZI

[IBTROZIhcp.com/safety](https://ibtrozihcp.com/safety)



QTc=corrected QT interval.

Simple, once-daily dosing¹



IBTROZI 600 mg should be taken orally daily and continued until disease progression or unacceptable toxicity



Take **three 200 mg IBTROZI capsules** at approximately the **same time** each day. Swallow IBTROZI capsules whole. **Do not open, chew, crush, or dissolve** the capsule prior to swallowing



Take IBTROZI on an empty stomach (**no food intake at least 2 hours before and 2 hours after** taking IBTROZI)

Avoid food or drink containing grapefruit during treatment with IBTROZI.

Minimize sun exposure and use sun protection, including broad-spectrum sunscreen, during treatment with IBTROZI and for at least 5 days after discontinuation.

If a dose is missed, take the next dose at its scheduled time on the following day. If vomiting occurs at any time after taking a dose, take the next dose at its scheduled time on the following day.

Before initiating IBTROZI, evaluate liver function tests (including ALT, AST, and bilirubin), electrolytes, ECG, and uric acid.

ECG=electrocardiogram.

SELECT SAFETY INFORMATION (cont'd)

Hyperuricemia: Hyperuricemia can occur and was reported in 14% of patients, with 16% of these requiring urate-lowering medication without pre-existing gout or hyperuricemia. 0.3% of patients experienced Grade ≥ 3 . Dose interruption occurred in 0.3% of patients.

Monitor serum uric acid levels prior to initiating and periodically during treatment. Initiate urate-lowering medications as clinically indicated. Based upon severity and resolution, withhold, then resume at same or reduced dose, or permanently discontinue.

Please see complete **Important Safety Information** on pages 14–17.



Recommended dose reductions for adverse reactions¹

RECOMMENDED DOSE REDUCTIONS

DOSAGE	RECOMMENDED DOSAGE
First dose reduction	400 mg once daily
Second dose reduction	200 mg once daily

Permanently discontinue IBTROZI capsules in patients unable to tolerate 200 mg once daily

Scan to learn more about managing therapy with IBTROZI
IBTROZIhcp.com/dosing



SELECT SAFETY INFORMATION (cont'd)

Myalgia with Creatine Phosphokinase (CPK) Elevation: Myalgia with or without CPK elevation can occur. Myalgia occurred in 10% of patients. Concurrent myalgia with increased CPK within a 7-day time period occurred in 0.9% of patients. Dose interruption occurred in 0.3% of patients with myalgia and concurrent CPK elevation.

Monitor serum CPK levels during treatment every 2 weeks during the first month, and then as clinically indicated in patients reporting unexplained muscle pain, tenderness, or weakness. Based on severity, withhold, then resume at same or reduced dose upon improvement.



Connection throughout the treatment journey

NuvationConnect is a comprehensive program that offers patients financial, educational, and emotional support.

How we can help*

Benefit Investigation & Access Support

For you and your practice to determine and understand coverage, access, and cost share for IBTROZI

Quick Start Program

Quick start of IBTROZI for certain payer-related coverage delays

Copay Assistance

Eligible commercially insured patients may pay as little as \$0 per month for IBTROZI

Bridge Program

Helps your patients stay on IBTROZI if their insurance coverage changes

Free Trial Offer

Free 30-day supply of IBTROZI with a prescription to determine if treatment is right for your patient

Patient Assistance Program (PAP)

PAP may provide IBTROZI at no cost for your patients that have inadequate insurance coverage or are uninsured

Questions? We're here to help.

1-877-NUV-CON1 (1-877-688-2661)
 Monday-Friday, 8 AM-8 PM EST

Visit us at
NuvationConnect.com

*Terms, conditions, and eligibility criteria apply.

Please see complete **Important Safety Information** on pages 14-17.





IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hepatotoxicity: Hepatotoxicity, including drug-induced liver injury and fatal adverse reactions, can occur. 88% of patients experienced increased AST, including 10% Grade 3/4. 85% of patients experienced increased ALT, including 13% Grade 3/4. Fatal liver events occurred in 0.6% of patients. Median time to first onset of AST or ALT elevation was 15 days (range: 3 days to 20.8 months).

Increased AST or ALT each led to dose interruption in 7% of patients and dose reduction in 5% and 9% of patients, respectively. Permanent discontinuation was caused by increased AST, ALT, or bilirubin each in 0.3% and by hepatotoxicity in 0.6% of patients.

Concurrent elevations in AST or ALT ≥ 3 times the ULN and total bilirubin ≥ 2 times the ULN, with normal alkaline phosphatase, occurred in 0.6% of patients.

Monitor liver function tests (AST, ALT, and bilirubin) prior to treatment, every 2 weeks during the first 2 months, and then monthly thereafter as clinically indicated. Test more frequently if transaminase elevations occur. Advise patients to immediately report symptoms of hepatotoxicity. Based on severity and resolution, withhold, then resume at a reduced dose or permanently discontinue.

Interstitial Lung Disease (ILD)/Pneumonitis: Severe, life-threatening, or fatal ILD or pneumonitis can occur. ILD/pneumonitis occurred in 2.3% of patients, including 1.1% Grade 3/4. One fatal ILD case occurred at the 400 mg daily dose. Median time to first onset of ILD/pneumonitis was 3.8 months (range: 12 days to 11.8 months).

ILD/pneumonitis led to dose interruption in 1.1% of patients, dose reduction in 0.6% of patients, and permanent discontinuation in 0.6% of patients.

Monitor patients for new or worsening pulmonary symptoms. Advise patients to report symptoms. If ILD/pneumonitis is suspected, immediately withhold; based on severity and resolution, resume at same or reduced dose, or permanently discontinue.

QTc Interval Prolongation: QTc interval prolongation can occur, which can increase the risk for ventricular tachyarrhythmias (e.g., torsades de pointes) or sudden death. IBTROZI prolongs the QTc interval in a concentration-dependent manner.

In patients who received IBTROZI and underwent at least one post baseline ECG, QTcF increase of >60 msec compared to baseline and QTcF >500 msec occurred in 13% and 2.6% of patients, respectively. 3.4% of patients experienced Grade ≥ 3 . Median time from first dose of IBTROZI to onset of ECG QT prolongation was 22 days (range: 1 day to 38.7 months). Dose interruption and dose reduction each occurred in 2.8% of patients.

Monitor ECGs and electrolytes prior to start of therapy, and then periodically thereafter as clinically indicated. Adjust frequency based on risk factors such as known long QT syndromes, clinically significant bradyarrhythmias, severe or uncontrolled heart failure, and concomitant medications.

Significant QTc interval prolongation may occur when IBTROZI is taken with food, strong and moderate CYP3A inhibitors, and/or drugs with a known potential to prolong QTc. Administer IBTROZI on an empty stomach. Avoid concomitant use with strong and moderate CYP3A inhibitors and/or drugs with a known potential to prolong QTc.

Advise patients to immediately report any symptoms of QT interval prolongation. Based on severity and resolution, withhold, then resume at same or reduced dose, or permanently discontinue.

Hyperuricemia: Hyperuricemia can occur and was reported in 14% of patients, with 16% of these requiring urate-lowering medication without pre-existing gout or hyperuricemia. 0.3% of patients experienced Grade ≥ 3 . Median time to first onset was 2.1 months (range: 7 days to 35.8 months). Dose interruption occurred in 0.3% of patients.

Monitor serum uric acid levels prior to initiating and periodically during treatment. Initiate urate-lowering medications as clinically indicated. Advise patients to report symptoms. Based upon severity and resolution, withhold, then resume at same or reduced dose, or permanently discontinue.

Myalgia with Creatine Phosphokinase (CPK) Elevation: Myalgia with or without CPK elevation can occur. Myalgia occurred in 10% of patients. Median time to first onset was 11 days (range: 2 days to 10 months).

Concurrent myalgia with increased CPK within a 7-day time period occurred in 0.9% of patients. Dose interruption occurred in 0.3% of patients with myalgia and concurrent CPK elevation.

Advise patients to report any unexplained muscle pain, tenderness, or weakness. Monitor serum CPK levels during treatment every 2 weeks during the first month, and then as clinically indicated. Based on severity, withhold, then resume at same or reduced dose upon improvement.

Skeletal Fractures: IBTROZI can increase the risk of fractures. ROS1 inhibitors as a class have been associated with skeletal fractures. 3.4% of patients experienced fractures, including 1.4% Grade 3. Some fractures occurred in the setting of a fall or other predisposing factors such as osteoporosis, bone metastasis, and age-related degenerative conditions. Median time to first onset of fracture was 10.7 months (range: 26 days to 29.1 months). Dose interruption occurred in 0.3% of patients.

Advise patients to immediately report symptoms. Promptly evaluate patients with signs or symptoms (e.g., pain, changes in mobility, deformity) of fractures.

There are no data on the effects of IBTROZI on healing of known fractures and risk of future fractures.



IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Embryo-Fetal Toxicity: Based on literature, animal studies, and its mechanism of action, IBTROZI can cause fetal harm when administered to a pregnant woman. Verify the pregnancy status of females of reproductive potential prior to initiating IBTROZI. Advise females to inform their healthcare provider of a known or suspected pregnancy.

Advise pregnant women and females of reproductive potential of the potential risk to a fetus. Advise females of reproductive potential and male patients with female partners of reproductive potential to use effective contraception during treatment and for 3 weeks following the last dose.

ADVERSE REACTIONS

Among patients who received IBTROZI, the most frequently reported adverse reactions ($\geq 20\%$) were diarrhea (64%), nausea (47%), vomiting (43%), dizziness (22%), rash (22%), constipation (21%), and fatigue (20%).

The most frequently reported Grade 3/4 laboratory abnormalities ($\geq 5\%$) were increased ALT (13%), increased AST (10%), decreased neutrophils (5%), and increased creatine phosphokinase (5%).

DRUG INTERACTIONS

- **Strong and Moderate CYP3A Inhibitors:** Avoid concomitant use.
- **Strong and Moderate CYP3A Inducers:** Avoid concomitant use.
- **Gastric Acid Reducing Agents:** Avoid concomitant use with PPIs and H₂ receptor antagonists. If an acid-reducing agent cannot be avoided, administer locally acting antacids at least 2 hours before or 2 hours after taking IBTROZI.
- **Drugs that Prolong the QTc Interval:** Avoid concomitant use. If concomitant use cannot be avoided, adjust the frequency of monitoring as recommended. Withhold IBTROZI if the QTc interval is >500 msec or the change from baseline is >60 msec.

OTHER CONSIDERATIONS

- **Pregnancy:** Please see important information in Warnings and Precautions under Embryo-Fetal Toxicity.
- **Lactation:** Advise women not to breastfeed during treatment and for 3 weeks after the last dose.
- **Effect on Fertility:** Based on findings in animals, IBTROZI may impair fertility in males and females. The effects on animal fertility were reversible.
- **Pediatric Use:** The safety and effectiveness of IBTROZI in pediatric patients has not been established.
- **Photosensitivity:** IBTROZI can cause photosensitivity. Advise patients to minimize sun exposure and to use sun protection, including broad-spectrum sunscreen, during treatment and for at least 5 days after discontinuation.

References

References: 1. IBTROZI™ (taletrectinib). Prescribing Information. Nuvation Bio Inc.; 2025. 2. Data on file. Nuvation Bio Inc. 3. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Non-Small Cell Lung Cancer V.8.2025. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed September 25, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way. 4. Pérol M, Li W, Pennell NA, et al. *J Clin Oncol.* 2025;JCO2500275:1-10. 5. A study of AB-106 in subjects with advanced NSCLC harboring ROS1 fusion gene. ClinicalTrials.gov identifier: NCT04395677. Updated October 30, 2023. Accessed April 22, 2025. <https://clinicaltrials.gov/study/NCT04395677> 6. Taltrectinib phase 2 global study in ROS1 positive NSCLC (TRUST-II). ClinicalTrials.gov identifier: NCT04919811. Updated November 21, 2024. Accessed April 22, 2025. <https://clinicaltrials.gov/study/NCT04919811> 7. US Food and Drug Administration. Clinical trial endpoints for the approval of cancer drugs and biologics. Guidance for industry. Updated May 7, 2020. Accessed May 8, 2025. <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/clinical-trial-endpoints-approval-cancer-drugs-and-biologics>

IBTROZI: a powerful, next-generation, brain-penetrant TKI^{1,4}



Strong and sustained responses in TKI-naïve patients^{1,2}

TRUST-I (n=103)

90%_{ORR}

(95% CI: 83–95)

- mDOR not yet reached (95% CI: 30.4–NR; range: 1.1 to 46.9+ months)
- Median follow-up time for response: 40 months

TRUST-II (n=54)

85%_{ORR}

(95% CI: 73–93)

- mDOR not yet reached (95% CI: 20.6–NR; range: 1.4+ to 30.4+ months)
- Median follow-up time for response: 19 months

TRUST-I and TRUST-II are ongoing and DOR results are subject to change as the data mature. mDOR for TRUST-II is not reported in the PI due to shorter duration of follow-up.

Noncomparative mPFS was 44.6 months (95% CI: 30.72–NR) in TRUST-I and NR (95% CI: 15.87–NR) in TRUST-II. Single-arm studies, which lack a comparator arm, may be inadequate to sufficiently evaluate time-to-event endpoints, such as mPFS. The clinical significance of these mPFS data is not known and the observed effect may be attributable to IBTROZI or to other factors.^{2,7}

Established safety profile¹

- 7% of patients discontinued treatment due to ARs

SELECT SAFETY INFORMATION

- **Serious adverse reactions** occurred in 31% of patients who received IBTROZI. Serious adverse reactions in $\geq 2\%$ of patients included pneumonia (7%), pleural effusion (4.7%), and hepatotoxicity (2.4%).
- **Warnings and precautions** associated with IBTROZI treatment include hepatotoxicity, interstitial lung disease/pneumonitis, QTc interval prolongation, hyperuricemia, myalgia with creatine phosphokinase (CPK) elevation, skeletal fractures, and embryo-fetal toxicity.

Choose IBTROZI to take on ROS1+ NSCLC



Please see complete [Important Safety Information](#) on pages 14–17 and accompanying full [Prescribing Information](#).



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