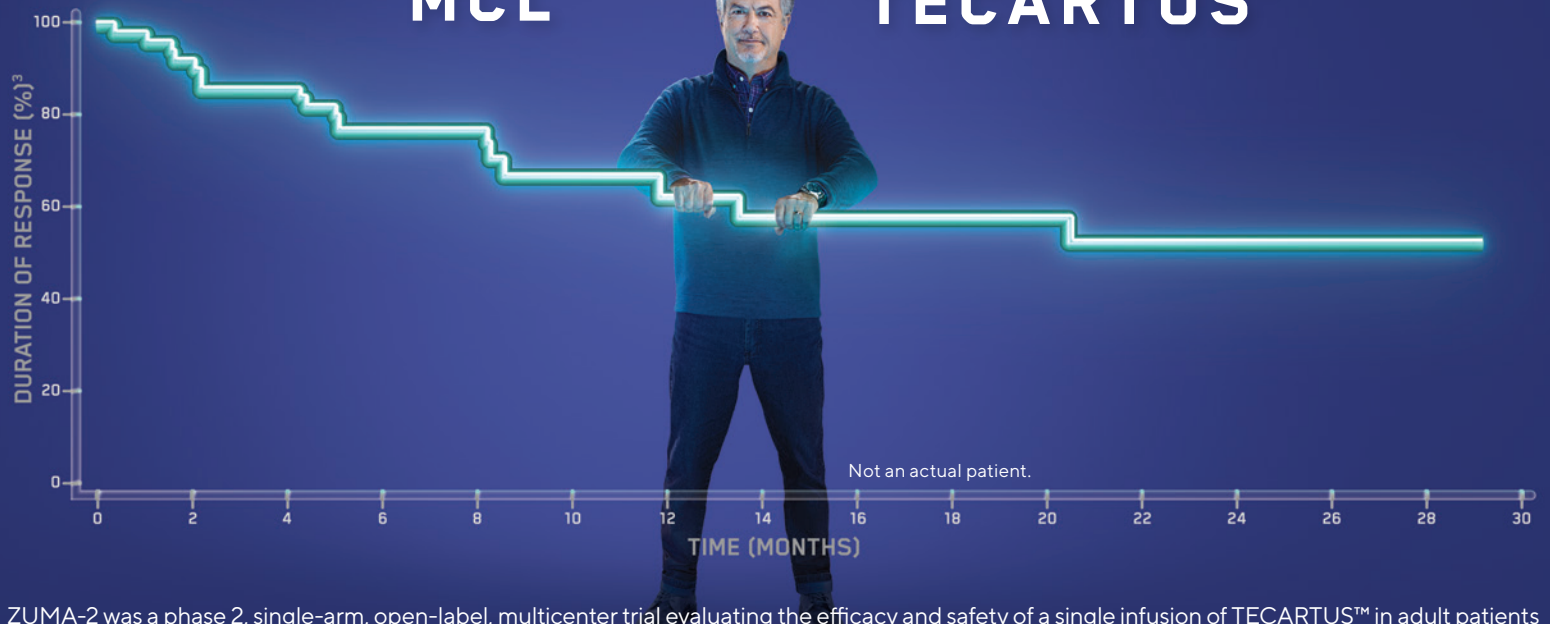
NOW APPROVED WITH FDA BREAKTHROUGH THERAPY DESIGNATION[1]

The first and only **FDA-approved CAR T-cell therapy for adult patients with R/R MCL**[1,2]

IN RELAPSED/ REFRACTORY MCL

AN INCREDIBLE RESPONSE WITH TECARTUS[2]



87% ORR (n=52/60)[2]

DEEP

CR: 62% (n=37/60)[2]

DURABLE

The median duration of response was not reached at a median study follow-up of 12.3 months[4]

RAPID

1 month median time to response (range: 0.8–3.1 months)[2]

ZUMA-2 was a phase 2, single-arm, open-label, multicenter trial evaluating the efficacy and safety of a single infusion of TECARTUS™ in adult patients with relapsed or refractory mantle cell lymphoma who had previously received anthracycline- or bendamustine-containing chemotherapy, an anti-CD20 antibody, and a BTKi (ibrutinib or acalabrutinib). In total, 68 patients were treated with TECARTUS, and 60 patients were evaluable for efficacy. Primary efficacy endpoint was ORR; selected secondary endpoints included DOR, PFS, and safety.[2,5]

INDICATION

TECARTUS is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL).

This indication is approved under accelerated approval based on overall response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

IMPORTANT SAFETY INFORMATION

BOXED WARNING: CYTOKINE RELEASE SYNDROME and NEUROLOGIC TOXICITIES

- **Cytokine Release Syndrome (CRS), including life-threatening reactions, occurred in patients receiving TECARTUS. Do not administer TECARTUS to patients with active infection or inflammatory disorders. Treat severe or life-threatening CRS with tocilizumab or tocilizumab and corticosteroids.**
- **Neurologic toxicities, including life-threatening reactions, occurred in patients receiving TECARTUS, including concurrently with CRS or after CRS resolution. Monitor for neurologic toxicities after treatment with TECARTUS. Provide supportive care and/or corticosteroids as needed.**
- **TECARTUS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the YESCARTA and TECARTUS REMS Program.**

BTKi=Bruton's tyrosine kinase inhibitor; CAR=chimeric antigen receptor; CR=complete response; DOR=duration of response; ORR=objective response rate; PFS=progression-free survival; R/R=relapsed or refractory.

Please see additional Important Safety Information throughout this brochure.

TECARTUS™ (brexucabtagene autoleucel) Suspension for IV infusion

In patients with R/R MCL

ZUMA-2 was a phase 2, multicenter, international, single-arm, open-label study of patients with R/R MCL[2,5]

TECARTUS™ (brexucabtagene autoleucel) Suspension for IV infusion

74 previously treated patients with R/R MCL enrolled and leukapheresed[2]

Conditioning treatment of fludarabine and cyclophosphamide (n=69)[5,6*]

One IV infusion of autologous CAR T-cell therapy (n=68)[2†]

Primary efficacy endpoint: **ORR[2]**

Selected secondary endpoints: **DOR, PFS, safety[5]**

- 60 of the 68 patients who were infused were followed for at least 6 months after their first objective disease response and were evaluable in the efficacy analysis[2‡]
- Bridging therapy between leukapheresis and lymphodepleting chemotherapy was permitted to control disease burden[2,5]

Key inclusion criteria[5,6]

- One to 5 prior regimens for MCL. Prior therapy must have included all of the following:
  - Anthracycline- or bendamustine-containing chemotherapy
  - Anti-CD20 monoclonal antibody therapy
  - BTKi (ibrutinib or acalabrutinib)
- At least 1 measurable lesion
- Age ≥18 years
- ECOG PS 0 or 1
- Adequate bone marrow, renal, hepatic, pulmonary, and cardiac functions
- ALC ≥100 cells/mm^3

Key exclusion criteria[2,6]

- Previously received allogeneic HSCT, CD19-targeted therapy, or CAR T-cell therapy
- History of HIV infection or acute or chronic active hepatitis B or C infection. Patients with a history of hepatitis infection must have cleared their infection as determined by standard serological and genetic testing
- History or presence of CNS disorder, such as seizure disorder, cerebrovascular ischemia/hemorrhage, dementia, cerebellar disease, cerebral edema, posterior reversible encephalopathy syndrome, or any autoimmune disease with CNS involvement
- Presence of fungal, bacterial, viral, or other infection that was uncontrolled or required IV antimicrobials for management

*Consisted of cyclophosphamide 500 mg/m^2 intravenously and fludarabine 30 mg/m^2 intravenously, both given on the fifth, fourth, and third day before TECARTUS™.[2]
†TECARTUS was administered to patients as a single intravenous infusion at a dose of 2 × 10^6 anti-CD19 CAR T cells/kg (maximum permitted dose: 2 × 10^8 cells).[2]
‡Among the 60 efficacy-evaluable patients, 2 × 10^6 CAR-positive viable T cells/kg were administered to 54 (90%). The remaining 6 (10%) patients received doses of 1.0, 1.6, 1.8, 1.8, 1.9, and 1.9 × 10^6 CAR-positive viable T cells/kg.[2]

IMPORTANT SAFETY INFORMATION (continued)

Cytokine Release Syndrome (CRS), including life-threatening reactions, occurred following treatment with TECARTUS. In ZUMA-2, CRS occurred in 91% (75/82) of patients receiving TECARTUS, including ≥ Grade 3 CRS in 18% of patients. Among the patients who died after receiving TECARTUS, one had a fatal CRS event. The median time to onset of CRS was three days (range: 1 to 13 days) and the median duration of CRS was ten days (range: 1 to 50 days). Among patients with CRS, key manifestations (>10%) included fever (99%), hypotension (60%), hypoxia (37%), chills (33%), tachycardia (37%), headache (24%), fatigue (19%), nausea (13%), alanine aminotransferase increased (13%), aspartate aminotransferase increased (12%), and diarrhea (11%). Serious events associated with CRS included hypotension, fever, hypoxia, acute kidney injury, and tachycardia.

Ensure that a minimum of two doses of tocilizumab are available for each patient prior to infusion of TECARTUS. Following infusion, monitor patients for signs and symptoms of CRS daily for at least seven days at the certified healthcare facility, and for four weeks thereafter. Counsel patients to seek immediate medical attention should signs or symptoms of CRS occur at any time. At the first sign of CRS, institute treatment with supportive care, tocilizumab, or tocilizumab and corticosteroids as indicated.

TECARTUS was studied in a range of patients with R/R MCL—a historically difficult-to-treat population[2,7,8*]

Baseline patient characteristics in all treated patients (n=68)[5,6*]

Age, median (range), years	65 (38-79)	**Number of prior therapies, median (range)**	3 (range: 1-5)
Male	84%	**Prior BTKi therapy**	100%
ECOG PS		Ibrutinib	85%
0	65%	Acalabrutinib	24%
1	35%	Both	9%
Patients with extranodal disease	56%	**Relapsed/refractory subgroup**	
Patients with bone marrow involvement	54%	Relapsed after autologous SCT	43%
Intermediate/high-risk simplified MIPI	56%	Refractory to last prior therapy	40%
Patients with high-risk characteristics		Relapsed after last prior therapy	18%
Blastoid/pleomorphic MCL morphology	31%	**BTKi relapsed/refractory status**	
TP53 mutation	17% (n=6/36)	Refractory to BTKi	62%
Ki-67 proliferation index ≥30%	82% (n=40/49)	Relapsed on BTKi	26%
Prior autologous SCT	43%	Relapsed after BTKi	7%
Positive CD19 status	92% (n=47/51)	Intolerant to BTKi	4%

*These data are based on all treated patients (n=68); USPI reports patient characteristics in efficacy-evaluable patients (n=60).[2,5]

Patients with high-risk characteristics were enrolled in the registration trial, including patients with blastoid morphology, *TP53* mutation, or Ki-67 index ≥30%[5]

ALC=absolute lymphocyte count; BTKi=Bruton's tyrosine kinase inhibitor; CAR=chimeric antigen receptor; CNS=central nervous system; DOR=duration of response; ECOG=European Cooperative Oncology Group; HIV=human immunodeficiency virus; HSCT=hematopoietic stem cell transplant; IV=intravenous; MCL=mantle cell lymphoma; MIPI=Mantle Cell Lymphoma International Prognostic Index; ORR=objective response rate; PFS=progression-free survival; PS=performance status; R/R=relapsed or refractory; SCT=stem cell transplant; USPI=US Prescribing Information.

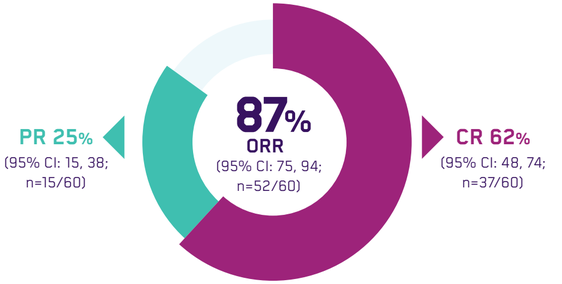
Please see additional Important Safety Information throughout this brochure.

In patients with R/R MCL

Deep and rapid responses were demonstrated in ZUMA-2[2]

TECARTUS™ (brexucabtagene autoleucel) Suspension for IV infusion

Nearly all patients achieved a response (n=52/60) and 62% of patients achieved CR with TECARTUS™ at a median study follow-up of 12.3 months[2,4]



Responses were rapid—the median time to initial response was 1 month (range: 0.8-3.1 months)[2,3]

- **Median time to complete response was 3 months (range: 1.0-9.3 months)**

Many responses deepened over time[3]

- 76% (n=28/37) of patients who achieved CR converted from PR or stable disease
  - Of the 76% of patients who converted to CR, most (n=25/28) converted from PR
  - Conversions occurred as late as 8.3 months postinfusion

Patients experienced deep responses—62% of patients achieved a CR with TECARTUS[2]

IMPORTANT SAFETY INFORMATION (continued)

Neurologic Toxicities, including those that were life-threatening, occurred following treatment with TECARTUS. In ZUMA-2, neurologic events occurred in 81% of patients, 37% of whom experienced Grade ≥3 adverse reactions. The median time to onset for neurologic events was six days (range: 1 to 32 days). Neurologic events resolved for 52 out of 66 (79%) patients with a median duration of 21 days (range: 2 to 454 days). Three patients had ongoing neurologic events at the time of death, including one patient with serious encephalopathy. The remaining unresolved neurologic events were either Grade 1 or Grade 2. Fifty-four (66%) patients experienced CRS by the onset of neurological events. Five (6%) patients did not experience CRS with neurologic events and eight patients (10%) developed neurological events after the resolution of CRS. 85% of all treated patients experienced the first CRS or neurological event within the first seven days after TECARTUS infusion.

The most common neurologic events (>10%) included encephalopathy (51%), headache (35%), tremor (38%), aphasia (23%), and delirium (16%). Serious events including encephalopathy, aphasia, and seizures occurred.

Monitor patients daily for at least seven days at the certified healthcare facility and for four weeks following infusion for signs and symptoms of neurologic toxicities and treat promptly.

Consistent response rates and duration of response demonstrated across efficacy analyses[2]

Response rates and duration of response in ZUMA-2

	Efficacy-Evaluable Patients (n=60)	All Leukapheresed Patients (ITT) (N=74)
Response Rate % (n) [95% CI]		
Objective Response Rate*	87% (52) [75, 94]	80% (59) [69, 88]
Complete Remission Rate	62% (37) [48, 74]	55% (41) [43, 67]
Partial Remission Rate	25% (15) [15, 38]	24% (18) [15, 36]
Duration of Response (DOR)		
Median in months [95% CI] Range† in months	NR [8.6, NE] 0+, 29.2+	NR [8.6, NE] 0+, 29.2+
DOR, if best response is CR, median in months [95% CI] Range† in months	NR [13.6, NE] 1.9+, 29.2+	NR [13.6, NE] 0+, 29.2+
DOR, if best response is PR, median in months [95% CI] Range† in months	2.2 [1.5, 5.1] 0+, 22.1+	2.2 [1.5, 5.1] 0+, 22.1+

*Among all responders. DOR is measured from the date of first objective response to the date of progression or death.
†A + sign indicates censored value.
CI=confidence interval; CR=complete response; ITT=intent-to-treat; MCL=mantle cell lymphoma; NE=not estimable; NR=not reached; ORR=objective response rate; PR=partial response; R/R=relapsed or refractory.

IMPORTANT SAFETY INFORMATION (continued)

REMS Program: Because of the risk of CRS and neurologic toxicities, TECARTUS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the YESCARTA and TECARTUS REMS Program which requires that:

- Healthcare facilities that dispense and administer TECARTUS must be enrolled and comply with the REMS requirements. Certified healthcare facilities must have on-site, immediate access to tocilizumab, and ensure that a minimum of two doses of tocilizumab are available for each patient for infusion within two hours after TECARTUS infusion, if needed for treatment of CRS.
- Certified healthcare facilities must ensure that healthcare providers who prescribe, dispense, or administer TECARTUS are trained in the management of CRS and neurologic toxicities. Further information is available at www.YescartaTecartusREMS.com or 1-844-454-KITE (5483).

Please see additional Important Safety Information throughout this brochure.

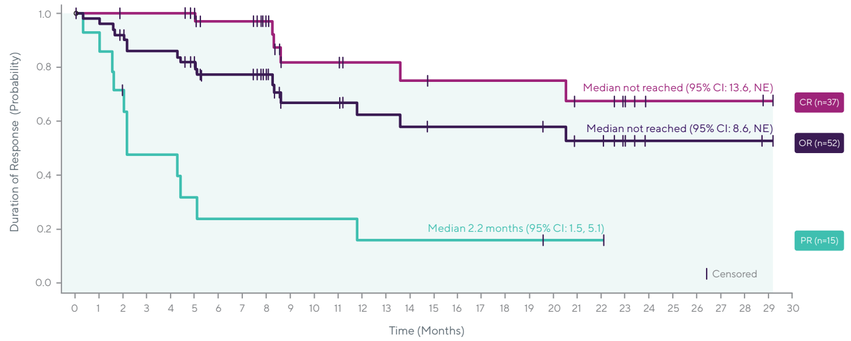
In patients with R/R MCL

TECARTUS™ delivered compelling DOR and PFS at a median study follow-up of 12.3 months[2,3]

TECARTUS™ (brexucabtagene autoleucel) Suspension for IV infusion

With TECARTUS, median duration of response was not reached at a median study follow-up of 12.3 months[2-4*]

- DOR was a secondary endpoint of the ZUMA-2 phase 2, single-arm, open-label study
- DOR data below are descriptive and should be carefully interpreted in light of the single-arm design



- **62%** (n=32/52) of all patients who responded and **81%** (n=30/37) of patients with a CR **remained in remission** at the time of analysis[2,3]
  - Median duration of follow-up for DOR in all responders was 8.6 months (range: 7.9-20.9 months) and in patients with a CR was 8.5 months (range: 7.8-20.9 months)

Long-term follow-up

- In the patients with ≥2 years follow-up, 43% (n=12/28) had an ongoing response[3]

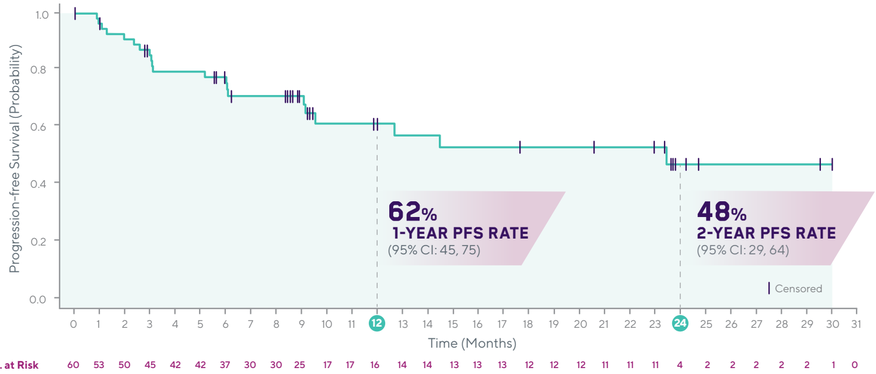
*Kaplan-Meier estimate based on the 52 patients with a response.[3]

CI=confidence interval; CR=complete response; DOR=duration of response; MCL=mantle cell lymphoma; NE=not estimable; OR=objective response; PFS=progression-free survival; PR=partial response; R/R=relapsed or refractory.

Responses were durable—more than half of all patients (62%; n=32/52) were still responding at the time of analysis[3]

62% estimated 1-year PFS rate (95% CI: 45, 75)[3]

- PFS was a secondary endpoint of the ZUMA-2 phase 2, single-arm, open-label study
- PFS data are not included in the USPI. PFS data are descriptive and should be carefully interpreted in light of the single-arm design



It is estimated that at 1 year postinfusion, approximately 82% of patients with a CR will be progression free[3]

IMPORTANT SAFETY INFORMATION (continued)

Hypersensitivity Reactions: Serious hypersensitivity reactions, including anaphylaxis, may occur due to dimethyl sulfoxide (DMSO) or residual gentamicin in TECARTUS.

Severe Infections: Severe or life-threatening infections occurred in patients after TECARTUS infusion. In ZUMA-2, infections (all grades) occurred in 56% of patients. Grade 3 or higher infections, including bacterial, viral, and fungal infections, occurred in 30% of patients. TECARTUS should not be administered to patients with clinically significant active systemic infections. Monitor patients for signs and symptoms of infection before and after infusion and treat appropriately. Administer prophylactic antimicrobials according to local guidelines. **(continued on page 9)**

Please see additional Important Safety Information throughout this brochure.

ADDITIONAL EFFICACY DATA

TECARTUS™ has a well-characterized safety profile[2]

TECARTUS™ (brexucabtagene autoleucel) Suspension for IV infusion

Summary of adverse reactions observed in ≥10% of patients treated with TECARTUS in ZUMA-2 (N=82)[2]

Adverse Reactions	Any Grade (%)	Grade ≥3 (%)
Blood and Lymphatic System Disorders		
Coagulopathy	10	2
Cardiac Disorders		
Tachycardias	45	0
Bradycardias	10	0
Non-ventricular arrhythmias	10	4
Gastrointestinal Disorders		
Nausea	35	1
Constipation	29	0
Diarrhea	28	5
Abdominal pain	17	0
Oral pain	16	0
Vomiting	13	0
Dysphagia	10	2
General Disorders and Administration Site Conditions		
Pyrexia (fever)	94	15
Fatigue	48	1
Chills	41	0
Edema	35	2
Pain	17	2
Immune System Disorders		
Cytokine release syndrome	91	18
Hypogammaglobulinemia	16	1
Infections and Infestations		
Infections (pathogen unspecified)	43	24
Viral infections	18	4
Bacterial infections	13	6
Metabolism and Nutrition Disorders		
Decreased appetite	26	0

Adverse Reactions	Any Grade (%)	Grade ≥3 (%)
Musculoskeletal and Connective Tissue Disorders		
Musculoskeletal pain	37	2
Motor dysfunction	17	4
Nervous System Disorders		
Encephalopathy	51	24
Tremor	38	2
Headache	35	1
Aphasia	20	7
Dizziness	18	6
Neuropathy	13	2
Psychiatric Disorders		
Insomnia	21	0
Delirium	18	5
Anxiety	16	0
Renal and Urinary Disorders		
Renal insufficiency	18	9
Urine output decreased	11	1
Respiratory, Thoracic, and Mediastinal Disorders		
Hypoxia	40	20
Cough	38	0
Dyspnea	24	6
Pleural effusion	21	5
Skin and Subcutaneous Tissue Disorders		
Rash	22	4
Vascular Disorders		
Hypotension	57	27
Hypertension	18	11
Thrombosis	17	4

There were no Grade 5 neurologic events and there was one Grade 5 CRS in ZUMA-2[2]

Grade 3 or 4 laboratory abnormalities occurring in ≥10% of patients in ZUMA-2 following TECARTUS infusion (N=82)[2]

	Grade 3 or 4 (%)		Grade 3 or 4 (%)
Leukopenia	95	Hypocalcemia	21
Neutropenia	95	Blood uric acid increased	17
Lymphopenia	86	Hyponatremia	16
Thrombocytopenia	63	Aspartate aminotransferase increased	15
Anemia	55	Alanine aminotransferase increased	15
Hypophosphatemia	30	Hypokalemia	10

Prolonged cytopenias have occurred following treatment with TECARTUS[2]

- Patients may exhibit cytopenias for several weeks following lymphodepleting chemotherapy and TECARTUS infusion
- At Day 30, 55% of patients had unresolved Grade 3 or higher cytopenias
  - 38% with thrombocytopenia
  - 37% with neutropenia
  - 17% with anemia

Monitor blood counts after TECARTUS infusion[2]

CRS=cytokine release syndrome; MCL=mantle cell lymphoma; R/R=relapsed or refractory.

IMPORTANT SAFETY INFORMATION (continued)

Severe Infections: (continued)

Febrile neutropenia was observed in 6% of patients after TECARTUS infusion and may be concurrent with CRS. In the event of febrile neutropenia, evaluate for infection and manage with broad spectrum antibiotics, fluids, and other supportive care as medically indicated.

Viral Reactivation

Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, can occur in patients treated with drugs directed against B cells. Perform screening for HBV, HCV, and HIV in accordance with clinical guidelines before collection of cells for manufacturing.

Please see additional Important Safety Information throughout this brochure.

Guidance has been established for the management of CAR T-related adverse reactions[2]

TECARTUS™ (brexucabtagene autoleucel) Suspension for IV infusion

18% of patients experienced Grade 3 or higher CRS and 37% experienced Grade 3 or higher neurologic events[2]

Summary of CRS and neurologic events[2,9]

	Median Time to Onset	Median Duration
CRS		
91% of patients (n=75/82) experienced CRS	3 days (range: 1-13)	10 days (range: 1-50)
• Key manifestations of CRS include fever (99%), hypotension (60%), hypoxia (37%), chills (33%), tachycardia (37%), headache (24%), fatigue (19%), nausea (13%), alanine aminotransferase increased (13%), aspartate aminotransferase increased (12%), and diarrhea (11%)		
• 61% (n=50/82) of patients received tocilizumab, 21% (n=17/82) received vasopressors, and 24% (n=20/82) received steroids for management of CRS		
• There was one Grade 5 CRS event		
Neurologic events	6 days (range: 1-32)	21 days (range: 2-454)
81% of patients (n=66/82) experienced neurologic events		
• The most common neurologic events included encephalopathy (51%), headache (35%), tremor (38%), aphasia (23%), and delirium (18%)		
• 23% (n=19/82) of patients received tocilizumab and 40% (n=33/82) received steroids for management of neurologic events		
• There were no Grade 5 neurologic events		

- Most CRS or neurologic events occurred early[2]
  - 85% of all treated patients experienced the first CRS or neurological event within the first 7 days after TECARTUS™ infusion[2]
- In ZUMA-2, 99% of CRS events (n=74/75) and 79% of neurologic events (n=52/66) resolved[2,10]
  - 66% (n=54/82) of patients experienced CRS before neurologic events started
  - 6% (n=5/82) of patients who developed neurologic events did not have CRS
  - 10% (n=8/82) developed neurologic events after the resolution of CRS

Most CRS and neurologic events in ZUMA-2 occurred early, were generally reversible, and were managed medically per established guidance[2,5]

Guidance for monitoring and management of CAR T-related adverse reactions (CRS and neurologic events)[2]

Ensure that **2 doses of tocilizumab** are available for each patient prior to infusion. For more information on CRS and neurologic events management, please see the full Prescribing Information for TECARTUS

Monitor patients **at least daily for 7 days** postinfusion at the Authorized Treatment Center for signs and symptoms of CRS and neurologic events

Continue to monitor patients for signs or symptoms of these adverse reactions for **4 weeks** postinfusion

Counsel patients to **seek immediate medical attention** should signs or symptoms of CRS or neurologic events occur at any time

In the ZUMA-2 trial[11]

- Patients with Grade >1 treatment-related CRS or neurologic events remained hospitalized until the adverse reaction resolved
- Post-discharge monitoring occurred at Weeks 2, 4, 8, and 12, then every 3 months through Month 18

CAR=chimeric antigen receptor; CRS=cytokine release syndrome; MCL=mantle cell lymphoma; R/R=relapsed or refractory.

IMPORTANT SAFETY INFORMATION (continued)

Prolonged Cytopenias: Patients may exhibit cytopenias for several weeks following lymphodepleting chemotherapy and TECARTUS infusion. In ZUMA-2, Grade ≥3 cytopenias not resolved by Day 30 following TECARTUS infusion occurred in 55% of patients and included thrombocytopenia (38%), neutropenia (37%), and anemia (17%). Monitor blood counts after infusion.

Hypogammaglobulinemia and B-cell aplasia can occur in patients receiving treatment with TECARTUS. In ZUMA-2, hypogammaglobulinemia occurred in 16% of patients. Monitor immunoglobulin levels after treatment with TECARTUS and manage using infection precautions, antibiotic prophylaxis, and immunoglobulin replacement. The safety of immunization with live viral vaccines during or following TECARTUS treatment has not been studied. Vaccination with live virus vaccines is not recommended for at least six weeks prior to the start of lymphodepleting chemotherapy, during treatment, and until immune recovery following treatment with TECARTUS.

Please see additional Important Safety Information throughout this brochure.

CAR T-RELATED ARs

A dependable, established treatment process, from leukapheresis to product delivery[2,11]

TECARTUS™ (brexucabtagene autoleucel) Suspension for IV infusion

In ZUMA-2, TECARTUS™ was provided as a single-dose, one-time infusion manufactured within a median of 15 days from leukapheresis to product delivery, with a 96% manufacturing success rate[2]*

The XLP™ cell manufacturing process
To create a suspension of CAR-positive T cells in approximately 68 mL
Median time from leukapheresis to delivery: 15 days (range: 11-28 days)[2]

The TECARTUS treatment process

Referral to ATC

Leukapheresis
To obtain ~5-10x10⁹ mononuclear cells for shipping to manufacturing facility[11,12]

Day -5 to Day -3

Pretreatment
Lymphodepleting regimen of fludarabine and cyclophosphamide[2]

Day 0

Premedication
Acetaminophen and diphenhydramine, or another H1-antihistamine, administered 30 minutes to 1 hour prior to infusion[2]

Infusion
2x10⁶ anti-CD19 CAR T cells/kg, with a max dose of 2x10⁸ for patients >100 kg[2]

Day 0 to Day 7

On-site monitoring
Monitor for signs and symptoms of neurologic events, and other adverse reactions at ATC[2]

Day 8 to Day 28

Post-discharge monitoring
Instruct patients to remain within proximity of the ATC[2]

Long-term follow-up
Patient returns to referring office for routine monitoring[11]

TECARTUS manufacturing, which includes the XLP™ process, allows for rapid and reliable production[2]

To locate the most convenient Authorized Treatment Center for your patients, visit TECARTUS.com

Personalized support from Kite Konnect®
Kite Konnect® supports patients receiving TECARTUS
To learn more, call 1-844-454-KITE, Monday-Friday, 5 AM-6 PM PT or visit **KITEKONNECT.com**

Kite Konnect® supports patients and provides information to healthcare teams throughout the CAR T treatment journey.

*In the ZUMA-2 trial, 3 patients did not receive TECARTUS due to manufacturing failure.[2]
XLP is a trademark of Kite Pharma, Inc.

ATC=Authorized Treatment Center; CAR=chimeric antigen receptor; MCL=mantle cell lymphoma; R/R=relapsed or refractory.

IMPORTANT SAFETY INFORMATION (continued)

Secondary Malignancies may develop. Monitor life-long for secondary malignancies. In the event that it occurs, contact Kite at 1-844-454-KITE (5483) to obtain instructions on patient samples to collect for testing.

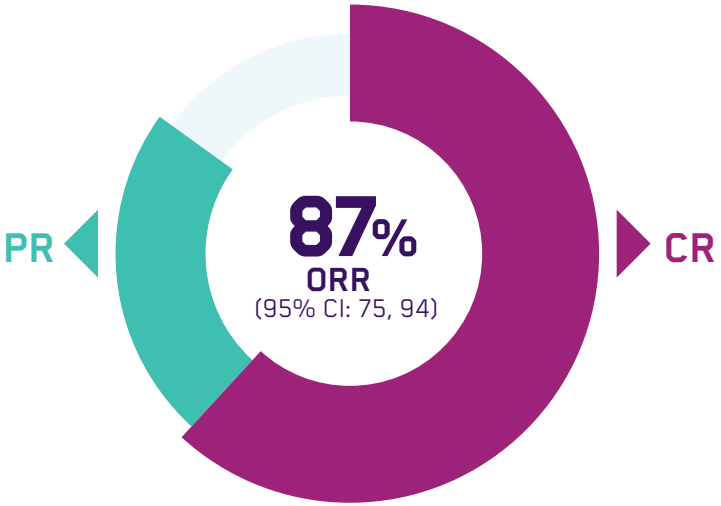
Effects on Ability to Drive and Use Machines: Due to the potential for neurologic events, including altered mental status or seizures, patients are at risk for altered or decreased consciousness or coordination in the 8 weeks following TECARTUS infusion. Advise patients to refrain from driving and engaging in hazardous activities, such as operating heavy or potentially dangerous machinery, during this period.

References: 1. Kite, a Gilead Company [press release]. U.S. FDA approves Kite's TECARTUS™, the first and only CAR T treatment for relapsed or refractory mantle cell lymphoma. Published July 24, 2020. https://www.businesswire.com/news/home/20200724005428/en/U.S.-FDA-Approves-Kite%E2%80%99s-Tecartus%E2%84%A2-CAR-Treatment. Accessed July 24, 2020. **2.** TECARTUS™ (brexucabtagene autoleucel). Prescribing information. Kite Pharma, Inc; 2020. **3.** Data on file [1]. Kite Pharma, Inc; 2020. **4.** Data on file [2]. Kite Pharma, Inc; 2020. **5.** Wang M, Munoz J, Goy A, et al. KTE-X19 CAR T-cell therapy in relapsed or refractory mantle cell lymphoma. *N Engl J Med*. 2020;382(14):1331-1342. **6.** Wang M, Munoz J, Goy A, et al. KTE-X19 CAR T-cell therapy in relapsed or refractory mantle cell lymphoma—supplementary appendix. *N Engl J Med*. 2020;1-33. **7.** Martin P, Maddocks K, Leonard JP, et al. Postibrutinib outcomes in patients with mantle cell lymphoma. *Blood*. 2016;127(12):1559-1563. **8.** Dreyling M, Klapper W, Rule S. Blastoid and pleomorphic mantle cell lymphoma: still a diagnostic and therapeutic challenge! *Blood*. 2018;132(26):2722-2729. **9.** Data on file [3]. Kite Pharma, Inc; 2020. **10.** Data on file [4]. Kite Pharma, Inc; 2020. **11.** Wang M, Munoz J, Goy A, et al. KTE-X19 CAR T-cell therapy in relapsed or refractory mantle cell lymphoma – study protocol. *N Engl J Med*. 2020;1-47. **12.** Data on file [5]. Kite Pharma, Inc; 2020.

Please see additional Important Safety Information throughout this brochure.

In patients with R/R MCL

TECARTUS™ delivered deep, durable, and rapid efficacy[2]



DEEP

CR: 62% (n=37/60)[2]

DURABLE

Median DOR not reached (95% CI: 8.6 months, NE) and **62% estimated 1-year PFS rate** (95% CI: 45, 75) at a median study follow-up of 12.3 months[2-4]

RAPID

1 month median time to response (range: 0.8–3.1)[2]

Data from a phase 2 single-arm, open-label, multicenter trial of TECARTUS in adult patients with R/R MCL. Primary endpoint was ORR; selected secondary endpoints included DOR, PFS, and safety.[2,5] PFS data are not included in the USPI. PFS data are descriptive and should be carefully interpreted in light of the single-arm design.

Well-characterized safety profile[2,5]

- Most CRS and neurologic events in ZUMA-2 occurred early, were generally reversible, and were managed medically per established guidance[2,5]
- 18% of patients experienced Grade 3 or higher CRS and 37% experienced Grade 3 or higher neurologic events[2]
- There were no Grade 5 neurologic events and there was one Grade 5 CRS in ZUMA-2[2]

Rapid and reliable manufacturing[2]

- Median 15 days from leukapheresis to delivery
- 96% manufacturing success rate
- Provided as a single-dose, one-time infusion

Choose TECARTUS, the first and only FDA-approved CAR T-cell therapy delivering deep, durable, and rapid efficacy in R/R MCL.[1,2] Learn more at www.TECARTUS.com

CAR=chimeric antigen receptor; CI=confidence interval; CR=complete response; CRS=cytokine release syndrome; DOR=duration of response; MCL=mantle cell lymphoma; NE=not estimable; ORR=objective response rate; PFS=progression-free survival; PR=partial response; R/R=relapsed or refractory; USPI=US Prescribing Information.

IMPORTANT SAFETY INFORMATION (continued)

Adverse Reactions: The most common adverse reactions (incidence ≥ 20%) were pyrexia, CRS, hypotension, encephalopathy, fatigue, tachycardia, arrhythmia, infection – pathogen unspecified, chills, hypoxia, cough, tremor, musculoskeletal pain, headache, nausea, edema, motor dysfunction, constipation, diarrhea, decreased appetite, dyspnea, rash, insomnia, pleural effusion, and aphasia. Serious adverse reactions occurred in 66% of patients. The most common serious adverse reactions (> 2%) were encephalopathy, pyrexia, infection – pathogen unspecified, CRS, hypoxia, aphasia, renal insufficiency, pleural effusion, respiratory failure, bacterial infections, dyspnea, fatigue, arrhythmia, tachycardia, and viral infections.

Please see additional Important Safety Information throughout, and full Prescribing Information, including **BOXED WARNING** and Medication Guide.

Kite
A GILEAD Company

TECARTUS™
(brexucabtagene autoleucel) Suspension for IV infusion