RYBREVANT®▼ + LAZCLUZE®▼

(amivantamab)
Injection for IV Use
Injection for SC Use

(lazertinib)
Tablets | 240 mg/80 mg

1L c*EGFR*m ADVANCED NSCLC[1,2]

3 GROUNDBREAKING* REASONS TO REDEFINE 1L CARE



▼This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions.[1,2]

RYBREVANT® subcutaneous formulation is indicated in combination with LAZCLUZE® for the first-line treatment of adult patients with advanced non-small cell lung cancer (NSCLC) with *EGFR* Exon 19 deletions or Exon 21 L858R substitution mutations.[1,2]

1L, first-line; c*EGFR*m, common *EGFR* mutation, EGFR, epidermal growth factor receptor; NSCLC, non-small cell lung cancer.

Extended footnotes

RYBREVANT®▼ (amivantamab)
Injection for IV Use
Injection for SC Use

+

LAZCLUZE®▼ (lazertinib)
Tablets | 240 mg/80 mg

1L c*EGFR*m ADVANCED NSCLC[1,2]

3 GROUNDBREAKING* REASONS TO REDEFINE 1L CARE



▼ **This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions.[1,2]**

Extended footnotes

Primary endpoint achieved with superior mPFS for RYB+LAZ vs. OSI, HR=0.70 (95% CI: 0.58–0.85; *p*=0.0002) assessed by BICR at median follow-up of 22.0 months.[1–3]
*Proven durable survival: OS data, HR=0.75 (95% CI: 0.61–0.92); *p*=0.0048.[4] Designed to change the disease biology: inhibits *EGFR* and addresses *MET*-based resistance mechanisms alongside immune cell-directing activity.[1–3,5] Patient-centred care: in the PALOMA-3 study, RYBREVANT® SC demonstrated non-inferior pharmacokinetic exposure to IV dosing.[6]

BICR, blinded independent central review; CI, confidence interval; EGFR, epidermal growth factor receptor; HR, hazard ratio; IV, intravenous; LAZ, LAZCLUZE®; mPFS, median progression-free survival; OS, overall survival; OSI, osimertinib; PFS, progression-free survival; RYB, RYBREVANT®; SC, subcutaneous.

WILL COMBINED THERAPIES REDEFINE 1L CARE?

In 2025, two Phase III trials demonstrated superior OS with combination therapy compared to osimertinib monotherapy*[4,7]



WHY CHANGE IS NEEDED

- Evidence indicates **patients may live longer** when treated with combination regimens vs. monotherapy*[4,7]
- **50% of osimertinib resistance** cases are linked to ***MET*** **amplification** and ***EGFR*-independent genomic alterations**[8,9]

73% OF PATIENTS PREFERRED A CHEMO-FREE APPROACH

WITH OSI MONOTHERAPY OVER OSI + CHEMOTHERAPY†[10]

*MARIPOSA is a Phase III study evaluating RYB+LAZ (n=429) compared with OSI monotherapy (n=429) in patients with c*EGFR*m advanced NSCLC. At 3 years, the mOS was NE (42.9–NE) with RYB+LAZ vs. 36.7 months (33.4–41.0) with OSI; HR=0.75 (95% CI: 0.61–0.92; *p*=0.0048).[4] FLAURA2 is a Phase III study evaluating OSI + chemotherapy (n=279) compared with OSI monotherapy (n=278) in patients with c*EGFR*m advanced NSCLC. The mOS was 47.5 months (95% CI: 41.0–NE) with OSI + platinum–pemetrexed and 37.6 months (95% CI: 33.2–43.2) with OSI monotherapy; HR=0.77 (95% CI: 0.61–0.96; *p*=0.02).[7] †The Chinese Thoracic Oncology Group performed a survey in China in which 363 patients with lung cancer and their family members and 584 physicians participated. The participants were asked whether they had a preference for OSI monotherapy or OSI + chemotherapy. 73% of the patients selected the monotherapy although they had been told that combination therapy could delay recurrence by 9 months.[10]

1L, first-line; c*EGFR*m, common *EGFR* mutation; CI, confidence interval; EGFR, epidermal growth factor receptor; *EGFR*m, *EGFR* mutation; HR, hazard ratio; LAZ, LAZCLUZE®; mOS, median overall survival; NE, not estimable; NSCLC, non-small cell lung cancer; OS, overall survival; OSI, osimertinib; RYB, RYBREVANT®.

HOW IS CHEMOTHERAPY PERCEIVED BY PATIENTS?

"Since my [chemotherapy] treatment, I have not been able to do most anything physical.... Fatigue and weakness have made it difficult to participate in activities and go anywhere by myself."

Illustrative quote from an oncology patient about the burden of chemotherapy – taken from Epstein *et al.* 2021.[11]



FOR MANY PATIENTS, THE REALITY OF CHEMOTHERAPY IS SHAPED BY DIFFICULT EXPERIENCES SUCH AS:

- **Prolonged time spent in the clinic*[12]**
- **Stigma surrounding the treatment and the belief that it represents a "last resort"[13,14]**
- **Irreversible side effects that may persist beyond treatment[15]**

*The daily average waiting time from check-in time to medication administration time was 2 hours and 27 minutes.[12]

FROM NON-TARGETED CARE TO PRECISION-DRIVEN BREAKTHROUGH[1,16]

2024 MARIPOSA

~2015 3RD GEN EGFR-TKI

Osimertinib addressed key mutations, but **C797S mutation and *MET*-driven resistance** persisted[17,19]

~2013 2ND GEN EGFR-TKI

Improved outcomes but **T790M resistance remained**[17,18]

~2003 1ST GEN EGFR-TKI

Clinical benefit achieved, but **resistance emerged** via the T790M mutation[17,18]

PRE 2000 NON-TARGETED TREATMENTS

Chemotherapy was the SoC, offering **modest survival** and dose-limiting toxicities[16]



RYBREVANT® (amivantamab) + LAZCLUZE® (lazertinib)

PRECISION-DRIVEN, MULTI-TARGETED COMBINATION[1]

ESMO-MCBS 4 SCORE

SUBSTANTIAL BENEFIT ACHIEVED*[20]

Learn more

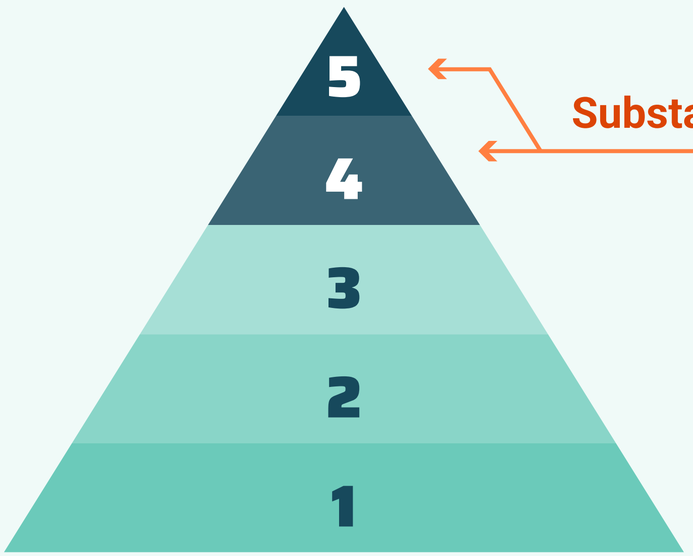
*Data taken from the ESMO Living Guidelines for patients with c*EGFR*m advanced NSCLC.[20]
C797S, C797 substitution; c*EGFR*m, common *EGFR* mutation; EGFR, epidermal growth factor receptor; ESMO-MCBS, European Society for Medical Oncology Magnitude of Clinical Benefit Scale; NSCLC, non-small cell lung cancer; SoC, standard of care; T790M, T790 mutation; TKI, tyrosine kinase inhibitor.

ESMO-MCBS EVALUATION OF RYBREVANT® + LAZCLUZE®

RYB+LAZ was evaluated based on OS outcome* (Form 2a of ESMO-MCBS v2.0) meeting the criterion of mOS with standard treatment ≥36 months or not reached with ≥36 months of follow-up[†4,21,22]

In the non-curative setting, Grade 4 and 5 indicate substantial benefit[21]

Evaluation scale for non-curative treatments



Which criteria does RYB+LAZ meet to obtain the score of 4?

- **Lower CI limit of HR ≤0.70** AND **OS gain ≥12 months**[21] ☑
  - **OS HR – 0.75** (95% CI: **0.61**–0.92)[‡21]
  - **OS gain – 12.23 months** (estimated based on PE HR 0.75)[§21]
- **HR ≤0.65** AND **time pre-specified OS gain ≥10%**[21] ☐
  (if the control arm median is not yet reached)
- **Increase in 7-year survival ≥10%**[21] ☐
  (if ≥20% of patients on experimental arm have reached 7-year OS)

RYB+LAZ achieved a score of 4, demonstrating substantial clinical benefit and statistical significance in OS data, with a survival benefit projected to exceed 12 months[4,20]

*mOS: NE RYB+LAZ vs. 36.7 months OSI; HR=0.75 (95% CI: 0.61–0.92); *p*=0.0048.[1] [†]Assessment based on primary endpoint of PFS and a secondary endpoint of OS with mature data showing a significant OS benefit versus the control arm of the trial.[21] [‡]Per ESMO-MCBS v2.0 instructions, the lower bound of the 95% CI (not the PE) is used to determine eligibility. Since 0.61 is ≤0.70, this satisfies the statistical threshold.[21] [§]Under ESMO Guidelines, the estimated median survival gain is calculated by dividing the control arm's median survival by the PE of the HR.[21]

CI, confidence interval; ESMO-MCBS, European Society for Medical Oncology Magnitude of Clinical Benefit Scale; HR, hazard ratio; LAZ, LAZCLUZE®; mOS, median overall survival; NE, not estimable; OS, overall survival; OSI, osimertinib; PE, point estimate; PFS, progression-free survival; RYB, RYBREVANT®.



3 GROUNDBREAKING REASONS

TO REDEFINE 1L CARE
WITH **RYBREVANT® + LAZCLUZE®**

1 **PROVEN DURABLE SURVIVAL[1,4]**

2 **DESIGNED TO CHANGE DISEASE BIOLOGY*[1–3,5,23]**

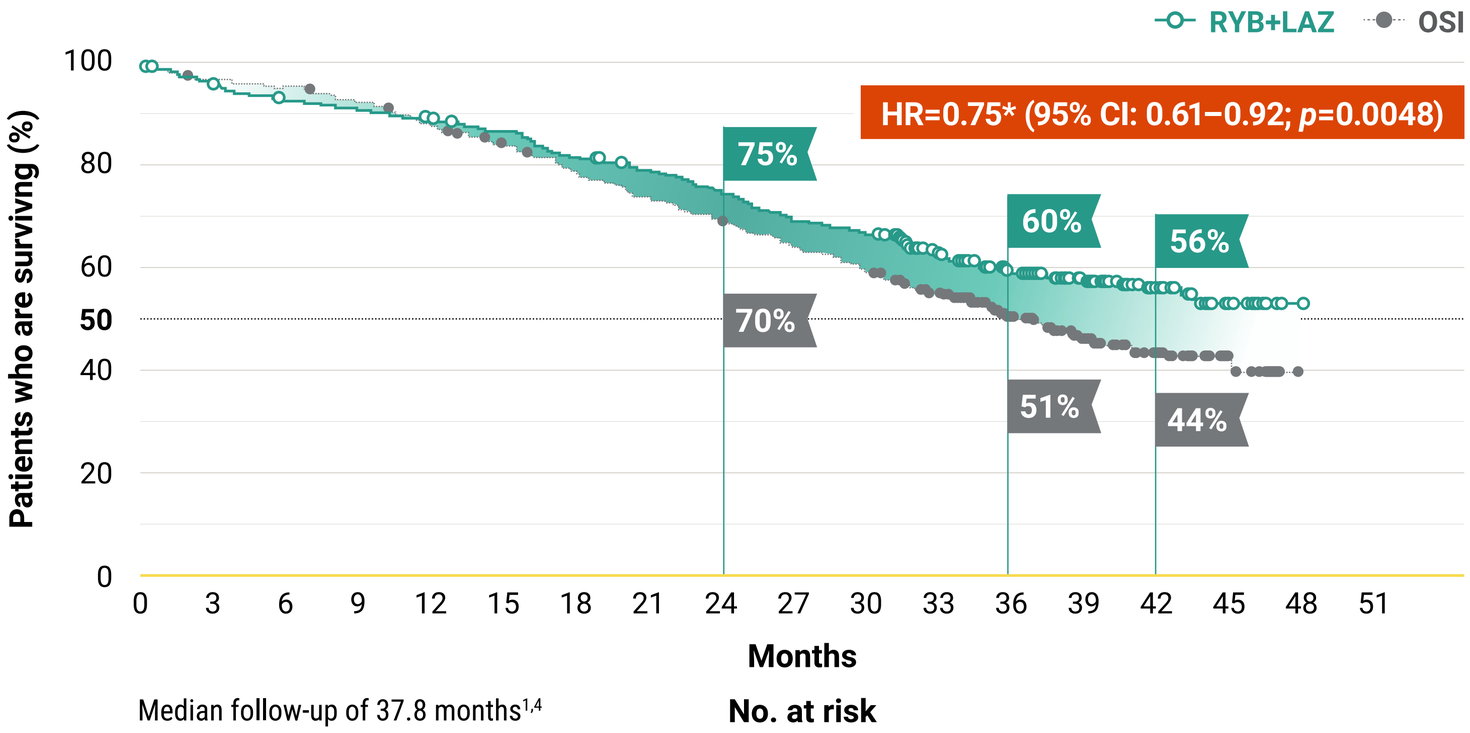
3 **PATIENT-CENTRED CARE†[6]**

*Inhibits *EGFR* and addresses *MET*-based resistance mechanisms alongside immune cell-directing activity.[1–3,5] †Without compromising efficacy; in the PALOMA-3 study, RYBREVANT® SC demonstrated non-inferior pharmacokinetic exposure to IV dosing.[6]

1L, first-line; EGFR, epidermal growth factor receptor; IV, intravenous; SC, subcutaneous.

1 PROVEN DURABLE SURVIVAL

Substantially extending patient life compared with osimertinib at clinical landmarks[4,24]



Median follow-up of 37.8 months[1,4]

No. at risk

RYB+LAZ	429	404	390	383	375	363	343	328	310	287	277	232	168	111	61	18	1	0
OSI	429	416	409	396	374	354	333	311	291	270	251	201	132	87	49	15	0	0

PROGRESSIVE WIDENING OF THE CURVES

when comparing RYB+LAZ vs. OSI[4]

mOS not reached and projected to exceed 4 YEARS

mOS was NE with RYB+LAZ vs. 36.7 months with OSI[4]

+ mOS by subgroup

Primary endpoint achieved: mPFS was 23.7 months (95% CI: 19.1–27.7) with RYB+LAZ vs. 16.6 months (95% CI: 14.8–18.5) with OSI[1–3]
HR=0.70 (95% CI: 0.58–0.85; *p*=0.0002)
*Hazard ratio reflects the OS benefit observed at 3 years for RYB+LAZ vs. OSI; HR was calculated from a stratified Cox regression model.[4,24]
CI, confidence interval; HR, hazard ratio; LAZ, LAZCLUZE®; mOS, median overall survival; mPFS, median progression-free survival; NE, not estimable; OS, overall survival; OSI, osimertinib; PFS, progression-free survival; RYB, RYBREVANT®.

OVERALL SURVIVAL IN PREDEFINED SUBGROUPS

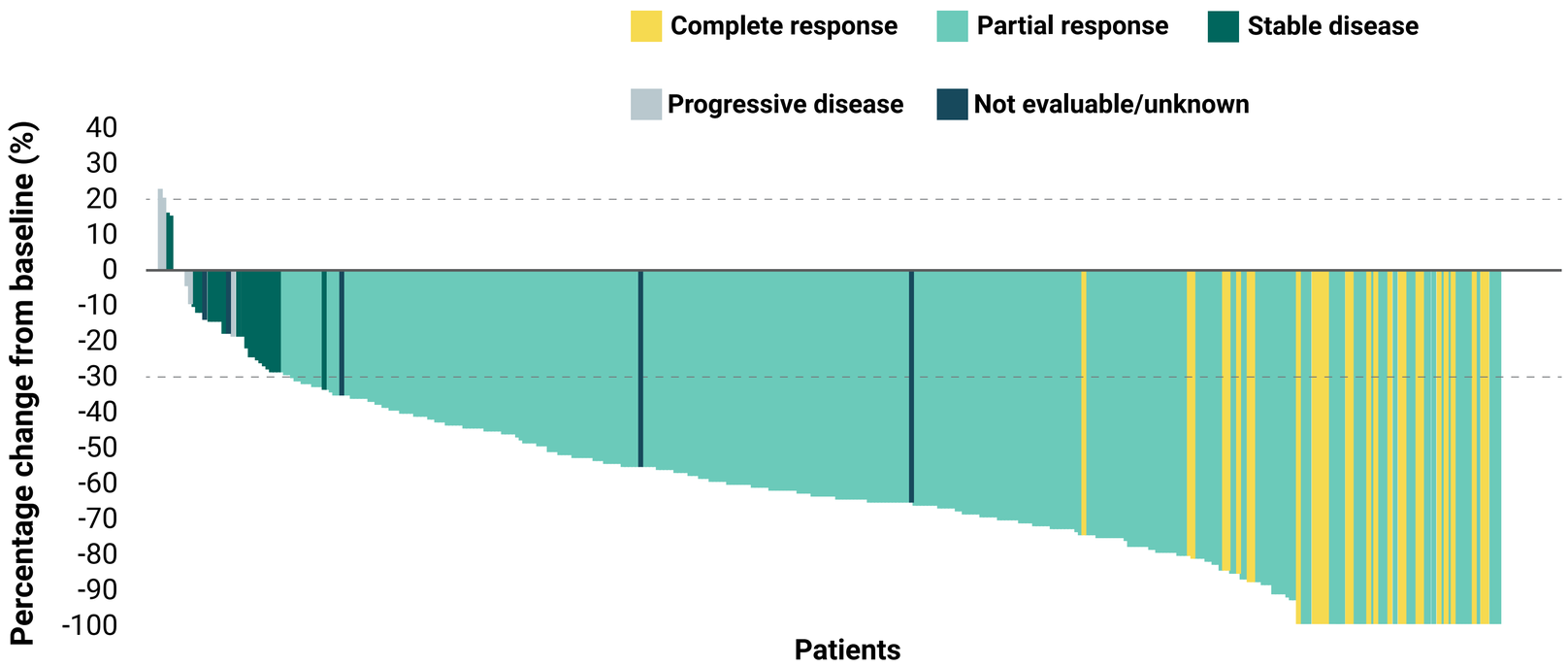
A consistent OS benefit was observed across predefined groups for RYB+LAZ vs. OSI[4]

	Hazard ratio (95% CI)	RYBREVANT® + LAZCLUZE®	Osimertinib
All randomised patients	0.75 (0.61–0.92)	429	429
Age category			
<65 years	0.53 (0.40–0.70)	235	237
≥65 years	1.11 (0.84–1.48)	194	192
<75 years	0.75 (0.60–0.93)	378	376
≥75 years	0.79 (0.47–1.33)	51	53
Sex			
Male	0.73 (0.56–0.95)	275	251
Female	0.81 (0.60–1.09)	154	178
Race			
Asian	0.75 (0.58–0.98)	250	251
Non-Asian	0.74 (0.54–1.00)	177	177
Weight category			
<80 kg	0.78 (0.63–0.97)	376	368
ECOG Performance Status			
0	0.88 (0.61–1.28)	141	149
1	0.70 (0.55–0.89)	288	280
History of smoking			
Yes	0.78 (0.55–1.10)	130	134
No	0.64 (0.58–0.95)	299	295
History of brain metastases			
Yes	0.67 (0.50–0.90)	178	173
No	0.82 (0.62–1.08)	251	256
EGFR mutations			
Ex19del	0.66 (0.50–0.86)	257	257
L858R	0.90 (0.67–1.21)	171	172



CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; EGFR, epidermal growth factor receptor; Ex19del, Exon 19 deletion; L858R, L858R point mutation; LAZ, LAZCLUZE®; OS, overall survival; OSI, osimertinib; RYB, RYBREVANT®.

CHANGE FROM BASELINE IN TARGET LESIONS*[3]



7%

COMPLETE RESPONDERS†[3]

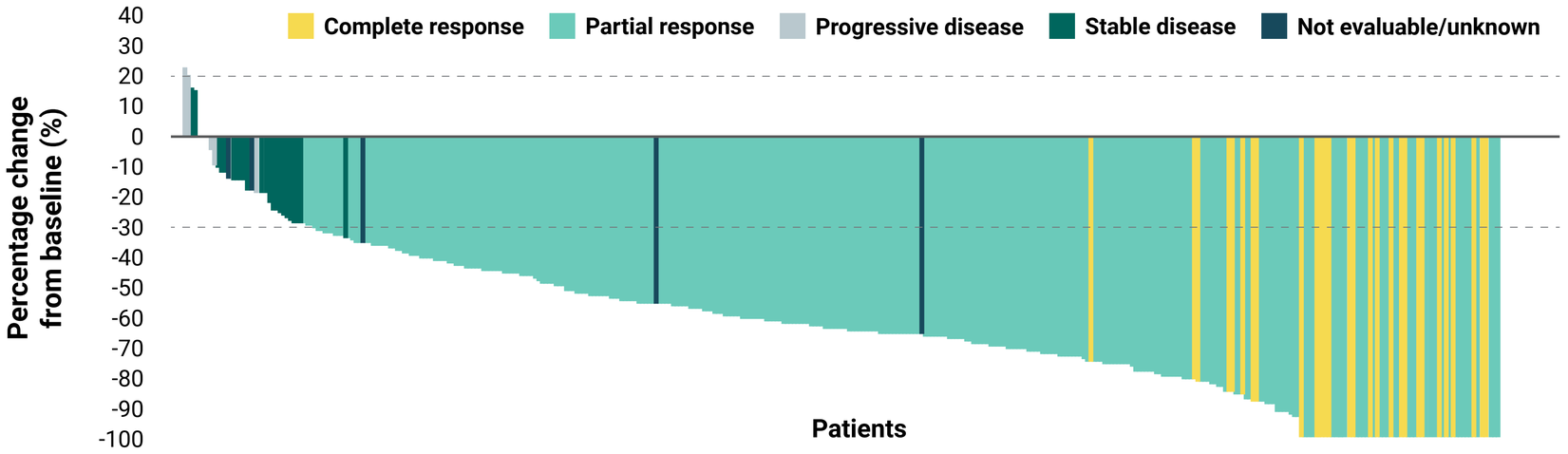
+ RYB+LAZ vs. OSI response comparison

*The number of patients with measurable disease at baseline was n=421 in the RYB+LAZ group and n=414 in the OSI group, as determined by BICR. Target lesions were measured as the sum of the diameters.[3] †RYB+LAZ (n=29) and OSI (n=15); includes all responders.[3]

BICR, blinded independent central review; LAZ, LAZCLUZE®; OSI, osimertinib; RYB, RYBREVANT®.

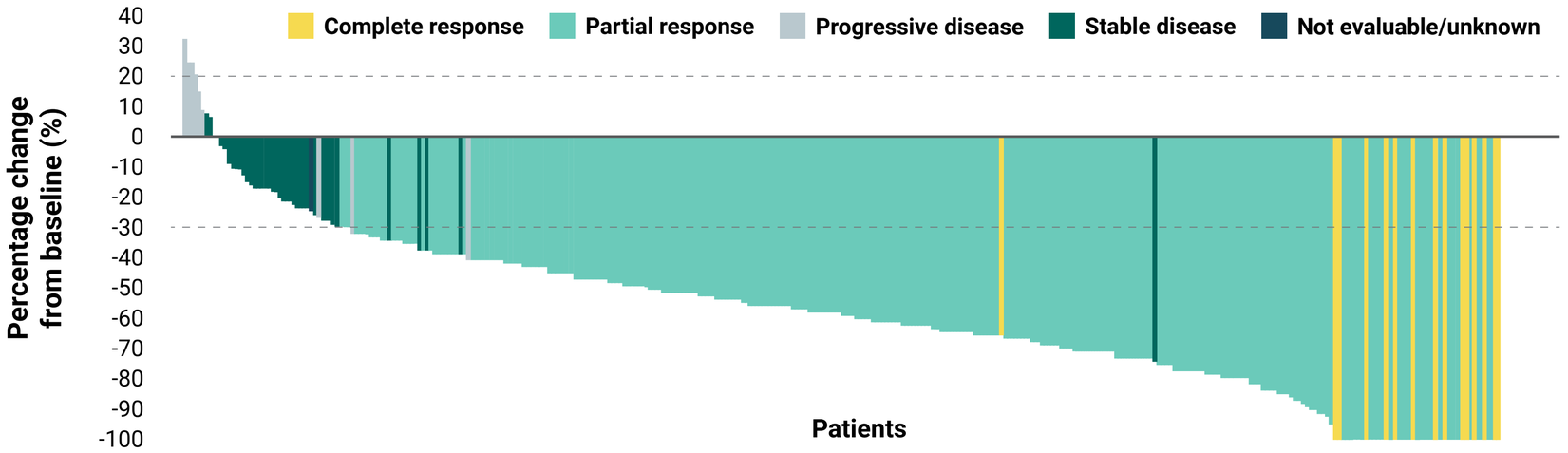
CHANGE FROM BASELINE IN TARGET LESIONS*[3]

RYBREVANT® + LAZCLUZE® group[3]



7%
COMPLETE RESPONDERS†[3]

Osimertinib group[3]



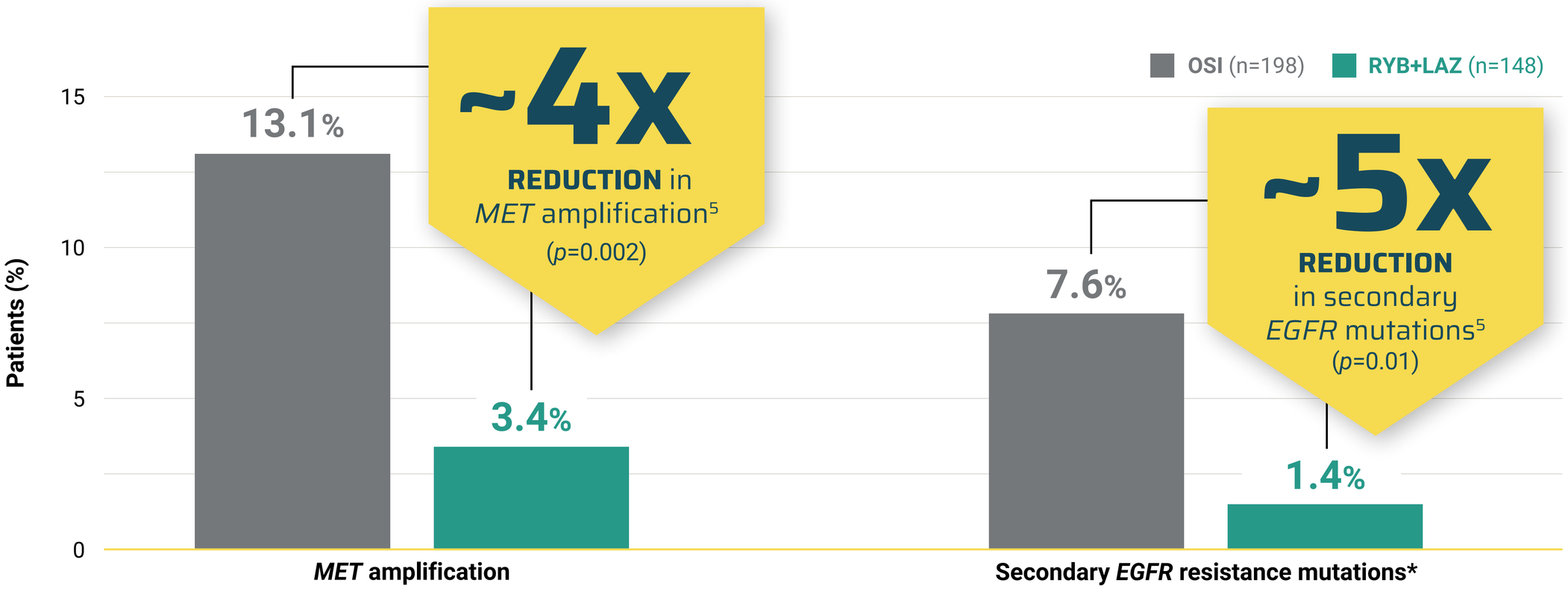
4%
COMPLETE RESPONDERS†[3]

*The number of patients with measurable disease at baseline was n=421 in the RYB+LAZ group and n=414 in the OSI group, as determined by BICR. Target lesions were measured as the sum of the diameters.[3] †RYB+LAZ (n=29) and OSI (n=15); includes all responders. ORR was 86% (95% CI: 83–89) for RYB+LAZ and 85% (95% CI: 81–88) for OSI. DOR was 24.0 months (95% CI: 18.5–NE) for RYB+LAZ and 14.9 months (95% CI: 12.9–17.5) for OSI.[3]

BICR, blinded independent central review; CI, confidence interval; LAZ, LAZCLUZE®; NE, not estimable; OSI, osimertinib; RYB, RYBREVANT®.

2 DESIGNED TO CHANGE THE DISEASE BIOLOGY[1-3,5,23]

When compared to osimertinib monotherapy, RYBREVANT® + LAZCLUZE® patients saw a significant reduction in key resistance mechanisms that lead to complex, hard-to-treat disease[5]



74% of patients were **able** and **willing** to receive **subsequent** lines of **therapy**[4]

+ Mechanisms of resistance by pathway

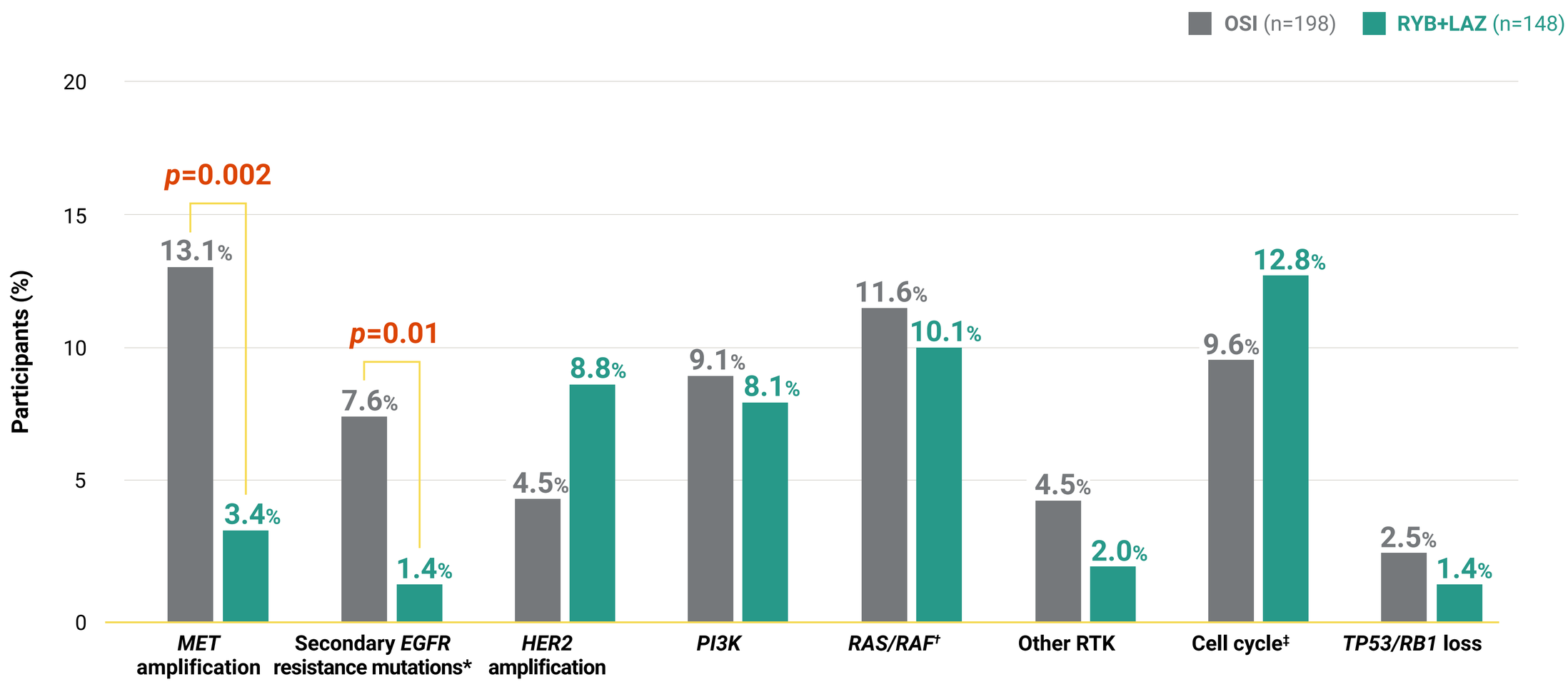
+ Mechanism of action

*C797S, L718X, G724X.[5]

C797S, C797 substitution; EGFR, epidermal growth factor receptor; G724X, G724 deletion; L718X, L718 deletion; LAZ, LAZCLUZE®; OSI, osimertinib; RYB, RYBREVANT®.

MECHANISMS OF RESISTANCE BY PATHWAY[5]

No meaningful increases in other molecular escape pathways were observed with RYBREVANT® + LAZCLUZE®[5]



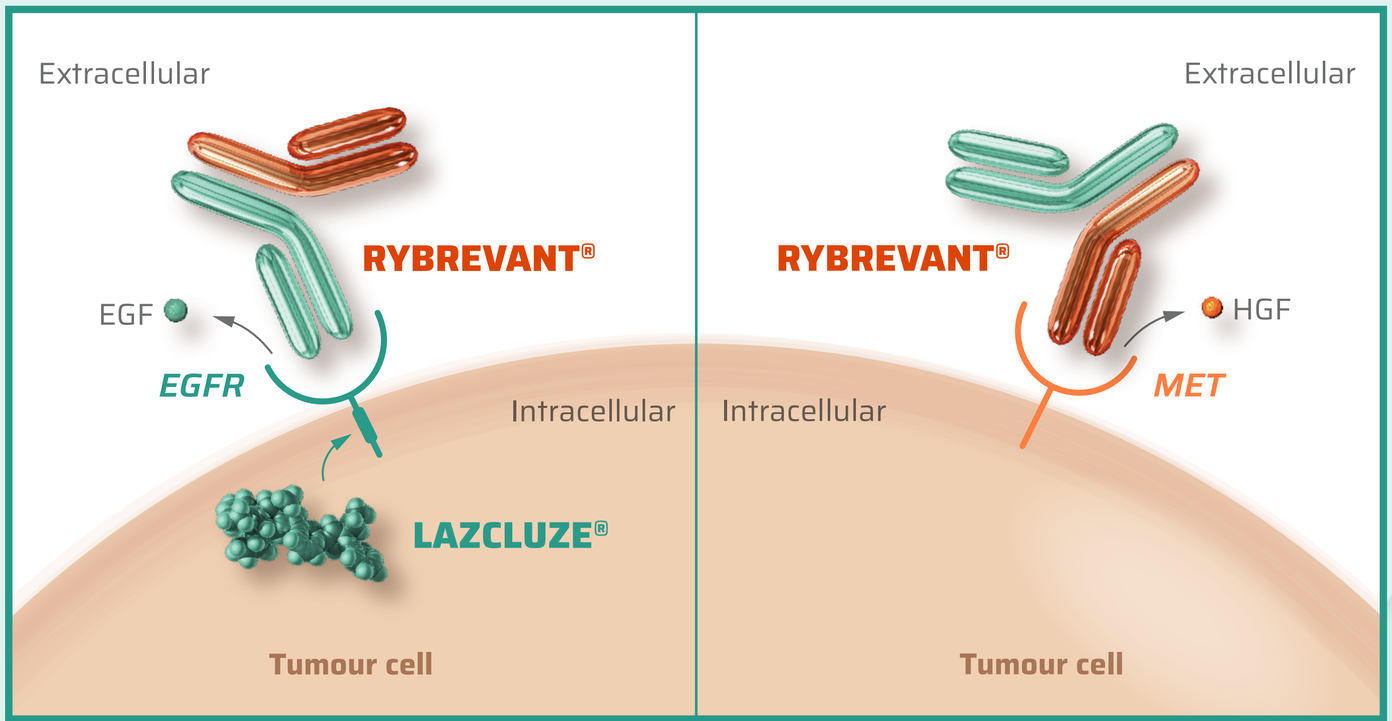
Note: Differences between other pathways were not statistically significant.[5]

*Includes C797S, L718X, G724X.[5] †Includes BRAF, KRAS, NRAS, PTPN11, and RAF1.[5] ‡Includes CCNE1, CDK4, CDKN2A, CCND2, CDK6, and CCND1.[5]

BRAF, B-Raf proto-oncogene, serine/threonine kinase; C797S, C797 substitution; CCND1 cyclin D1; CCND2; cyclin D2; CCNE1, cyclin E1; CDK4, cyclin-dependent kinase 4; CDK6, cyclin-dependent kinase 6; CDKN2A, cyclin-dependent kinase inhibitor 2A; EGFR, epidermal growth factor receptor; G724X, G724 deletion; HER2, human epidermal growth factor receptor 2; KRAS, kirsten rat sarcoma viral oncogene homolog; LAZ, LAZCLUZE®; L718X, L718 deletion; NRAS, neuroblastoma RAS viral oncogene homolog; OSI, osimertinib; PI3K, phosphoinositide 3-kinase; PTPN11, protein tyrosine phosphatase non-receptor type 11; RAF, rapidly accelerated fibrosarcoma kinase (includes ARAF, BRAF, CRAF); RAS, rat sarcoma viral oncogene family (includes KRAS, NRAS, HRAS); RTK receptor tyrosine kinase; RYB, RYBREVANT®.

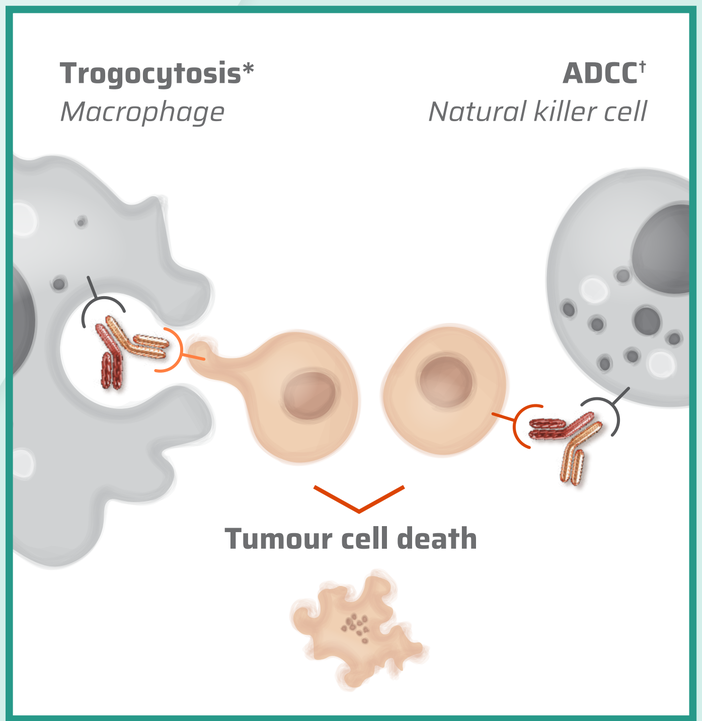
WITH INNOVATIVE TRIPLE-ACTION MECHANISM[1,2,25]

RYBREVANT® + LAZCLUZE® is intentionally designed to suppress the driver mutations and block the escape of the disease[3,26]



SUPPRESS THE DRIVER
EGFR mutations

BLOCK ESCAPE
MET amplification



ENGAGE IMMUNITY for potential long-term containment

*Trogocytosis is a process in which one cell, in this case a macrophage, physically extracts and ingests cellular material of another cell.[1,26] †ADCC involves the release of cytotoxic granules that cause tumour cell death.[1,26]
ADCC, antibody-dependent cellular cytotoxicity; EGF, epidermal growth factor; EGFR, epidermal growth factor receptor; HGF, hepatocyte growth factor.

3 PATIENT-CENTRED CARE
INFORMED BY EVIDENCE, DESIGNED FOR PRACTICE[6,27]

RYBREVANT® (amivantamab)

~5 MIN
SC administration[1]



+

LAZCLUZE® (lazertinib)

1 pill daily[2]



VTE

RETURNED TO BASELINE RISK*[28]
with 4 months of prophylactic anticoagulation†[6]

ARRs

80% RELATIVE REDUCTION
with subcutaneous administration + premedication‡[6]



Patients prefer chemotherapy-free regimens¶[10]

PALOMA-3 is a Phase III, international, randomised trial assessing the noninferiority of PK, efficacy, and safety of RYBREVANT® SC (n=206) vs. RYBREVANT® IV (n=212), both in combination with LAZCLUZE® in patients with *EGFR*-mutated advanced NSCLC after disease progression on OSI and platinum-based chemotherapy.[1,6]

*Baseline risk based on VTE incidence rates for patients with advanced NSCLC treated with first-line ICI-based, chemo-based, or ICI+chemo regimens (17.8 cases per 100 patient-years [95% CI: 16.0–19.5]).[28] †In the PALOMA-3 study, VTEs were 7% with prophylactic anticoagulation vs. 17% without.[6] ‡ARRs occurred in 13% of patients on RYBREVANT® SC vs. 66% of patients on RYBREVANT® IV.[6] ¶The Chinese Thoracic Oncology Group performed a survey in China in which 363 patients with lung cancer and their family members and 584 physicians participated. The participants were asked whether they had a preference for OSI monotherapy or OSI + chemotherapy. 73% of the patients selected the monotherapy although they had been told that combination therapy could delay recurrence by 9 months.[10]

AE, adverse event; ARR, administration-related reaction; BID, twice daily; CI, confidence interval; DM, dermatologic management; EGFR, epidermal growth factor receptor; ICI, immune checkpoint inhibitor; IV, intravenous; NSCLC, non-small cell lung cancer; OR, odds ratio; OSI, osimertinib; PK, pharmacokinetic; QD, once daily; SC, subcutaneous; SoC, standard of care; VTE, venous thromboembolim.

VTE RATES SIMILAR TO BASELINE RISK* WITH 4 MONTHS OF ANTICOAGULATION[6,28]

17.8 CASES
PER 100 PATIENT-YEARS

baseline VTE risk*[28]
with 1L treatment of advanced NSCLC

7%

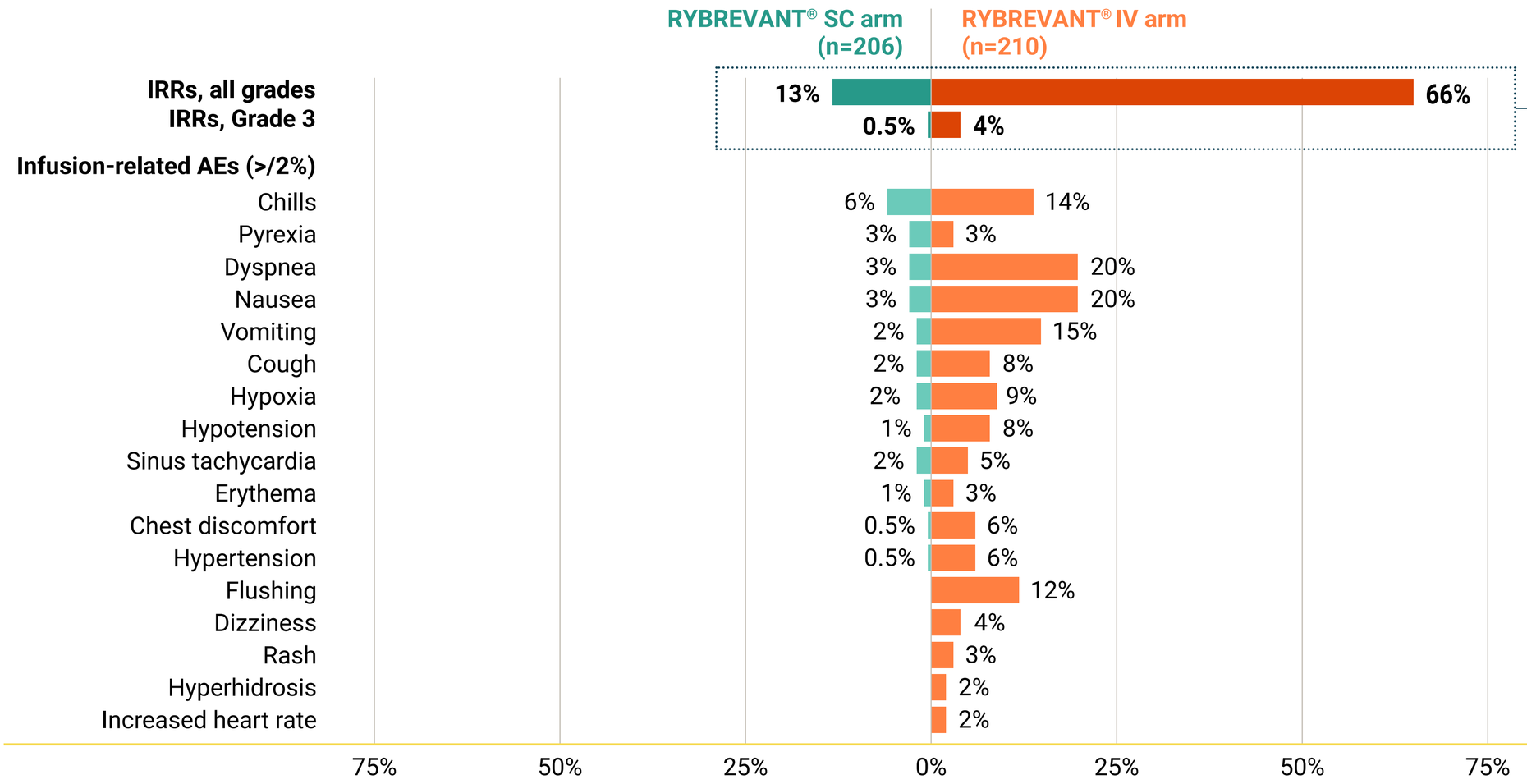
VTE incidence†[6]
with subcutaneous RYBREVANT® + oral LAZCLUZE® and prophylactic anticoagulant (n=164)

*Baseline risk based on VTE incidence rates for patients with advanced NSCLC treated with 1L ICI-based, chemo-based, or ICI+chemo regimens (17.8 cases per 100 patient-years [95% CI: 16.0–19.5]).[28] †80% (n=164) of patients on RYBREVANT® SC received prophylactic anticoagulation.[6]

1L, first-line; CI, confidence interval; ICI, immune checkpoint inhibitor; NSCLC, non-small cell lung cancer; SC, subcutaneous; VTE, venous thromboembolism.

RELATIVE REDUCTION IN ARRs*[6]

PALOMA-3

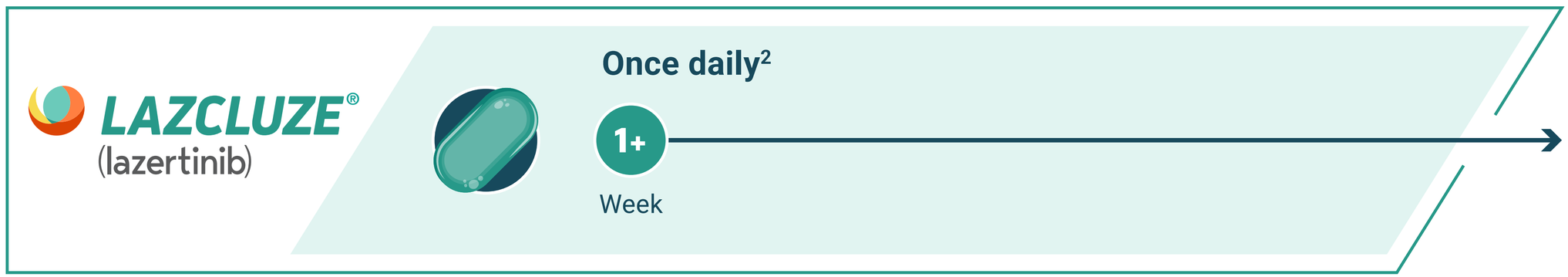


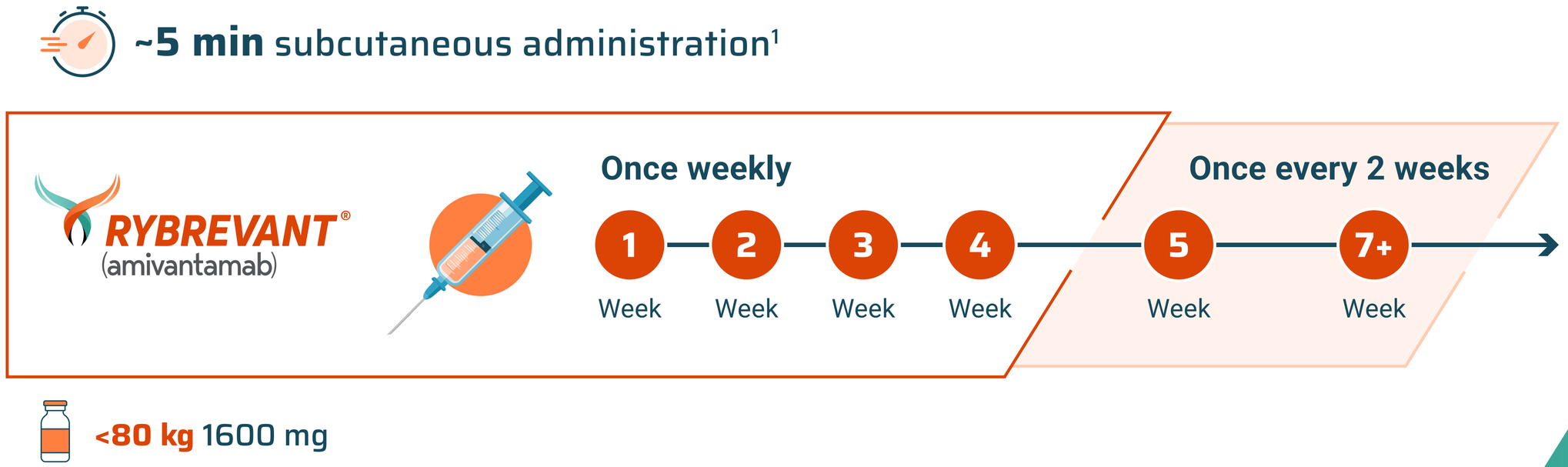
80%
RELATIVE REDUCTION in ARRs[6]

There were no Grade 4 or Grade 5 IRRs[6]

*The safety population included all patients who received ≥1 dose of any treatment.[6]
AE, adverse event; ARR, administration-related reaction; IRR, infusion-related reaction; IV, intravenous, SC, subcutaneous.

STRAIGHTFORWARD ADMINISTRATION*†[1,2]





*When given in combination on the same day, it is recommended to administer RYBREVANT® any time after LAZCLUZE®.[1,2] †Dose adjustments are not required for subsequent body weight changes.[1]
Refer to the RYBREVANT® and LAZCLUZE® Summary of Product Characteristics for detailed dosing and administration information.
SC, subcutaneous.

RYBREVANT® STORAGE AND PREPARATION[1]

STEP 1
REMOVE FROM REFRIGERATOR



Remove the RYBREVANT® vial(s) from refrigerated storage (2–8°C)
- During preparation and prior to injection, **check the vial label** to ensure the drug is RYBREVANT® SC and not RYBREVANT® IV
- **Do not substitute RYBREVANT® SC with RYBREVANT® IV**

STEP 2
BRING TO ROOM TEMPERATURE



Wait at least **15 minutes** to allow the vial(s) to **reach room temperature (15–30°C)**
- Do not warm any other way
- Do not shake or dilute

STEP 3
INSPECT VISUALLY



Once the vial is at room temperature, **visually inspect** for particulate matter and discolouration
- **RYBREVANT® is a colourless to pale yellow solution**
- Do not use if the solution is discoloured or cloudy, or if foreign particles are present

STEP 4
WITHDRAW DOSE



Withdraw the required injection volume from the vial(s) into a(the) syringe(s) using a transfer needle*
- RYBREVANT® is compatible with stainless steel injection needles, PP and PC syringes and PE, PU and PVC SC infusion sets
- **Administer using a 21–23G needle or infusion set** to ensure ease of injection†
- A sodium chloride 9 mg/mL (0.9%) solution may also be used to flush the remaining medication through the infusion set, if needed

Vial storage

- Store RYBREVANT® vials in a refrigerator in the carton to protect from light
- Do not freeze or shake

Syringe storage

- RYBREVANT® does not contain an antimicrobial preservative. The prepared syringes should be administered immediately
- If immediate administration is not possible, replace the transfer needle with a syringe closing cap for transport and store the prepared syringes of RYBREVANT® refrigerated at 2–8°C for up to 24 hours, and then at room temperature of 15–30°C for up to 24 hours
- Discard the prepared syringe(s) if stored for >24 hours in the refrigerator or at room temperature
- If stored in the refrigerator, allow the solution to come to room temperature before administration

*Vials are for single use.[1]
†Decreasing the outer diameter of a needle may help reduce the frequency of insertion pain and bleeding.[3]
IV, intravenous; PC, polycarbonate; PE, polyethylene; PP, polypropylene; PU, polyurethane; PVC, polyvinylchloride; SC, subcutaneous.

RYBREVANT® PREMEDICATIONS FOR ARR MANAGEMENT[1]

PREMEDICATION	DOSING	ADMINISTRATION			TIMING
GLUCOCORTICOID*	Dexamethasone 20 mg or equivalent	**IV** 45–60 minutes prior	OR	**Oral** ≥60 minutes prior	W1D1 or at the next subsequent dose in the event of an ARR
GLUCOCORTICOID*	Dexamethasone 10 mg or equivalent	**IV** 45–60 minutes prior	OR	**Oral** 60–90 minutes prior	Optional for subsequent doses
ANTIHISTAMINE	Diphenhydramine 25–50 mg or equivalent	**IV** 15–30 minutes prior	OR	**Oral** 30–60 minutes prior	All doses
ANTIPYRETIC	Paracetamol/acetaminophen 650–1,000 mg or equivalent	**IV** 15–30 minutes prior	OR	**Oral** 30–60 minutes prior	All doses
ANTIEMETIC	Antiemetics should be administered as needed				

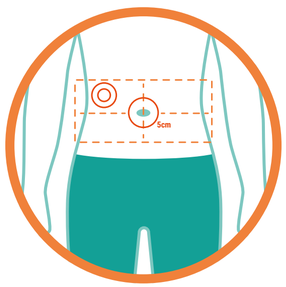
RYBREVANT® ADMINISTRATION[1]

Administer premedications before each RYBREVANT® administration as recommended to help reduce the risk of ARRs

RYBREVANT® injections are for SC administration only

Once the syringe(s) is (are) ready, prepare to administer the injection.
RYBREVANT® injections must be administered by a healthcare professional

Do not inject into tattoos, scars or areas where the skin is red, bruised, tender, hard or not intact, making sure to avoid 5 cm around the periumbilical area



Inject the required volume of RYBREVANT® into the SC tissue of the abdomen over **approximately 5 minutes**.
If the patient experiences pain, **pause or slow the injection**

If the pain is not alleviated, administer the rest of t he dose in a second injection site on the opposite side of the abdomen

For administration with a SC infusion set, ensure the full dose is delivered. A 0.9% sodium chloride solution may be used to flush the remaining medication through the line

*Glucocorticoids should be reinitiated after prolonged dose interruptions.[1]
ARR, administration-related reaction; IV, intravenous; SC, subcutaneous; W1D1, Week 1 Day 1.

SAFETY PROFILE*[1]

The most common† AEs of any grade were:

Rash‡	87%	Oedema‡	42%	Dry skin‡	25%
Nail toxicity‡	67%	Fatigue‡	35%	Decreased appetite	24%
Hypoalbuminaemia‡	48%	Paraesthesia‡§	29%	Nausea	24%
Hepatotoxicity‡	43%	Constipation	26%	Pruritus	23%
Stomatitis‡	43%	Diarrhoea	26%	ARR¶#	14%
				VTE‡#	11%

The safety data in MARIPOSA was achieved prior to incorporating optimal **therapy management strategies**[29–31]

*The safety data is based on exposure to RYBREVANT® (either IV or SC formulation) in combination with LAZCLUZE® in 752 patients with locally advanced or metastatic NSCLC, including 421 patients in MARIPOSA, 125 patients in PALOMA-2 cohorts 1 and 6, and 206 patients in PALOMA-3 subcutaneous arm.[1] †Occurring in ≥1/10 of patients.[1] ‡Grouped terms.[1] §Applicable only to lazertinib.[1] ¶Administration-related reactions are systemic signs and symptoms associated with administration of amivantamab subcutaneous.[1] #Frequency based on amivantamab subcutaneous studies only (PALOMA-2 cohorts 1 and 6 [N=125] and PALOMA-3 subcutaneous arm [N=206]).[1] For full list of AEs, please refer to the RYBREVANT® and LAZCLUZE® Summary of Product Characteristics.

AE, adverse event; ARR, administration-related reaction; IV, intravenous; NSCLC, non-small cell lung cancer; SC, subcutaneous; VTE, venous thromboembolism.

3 GROUNDBREAKING REASONS:
TO REDEFINE 1L CARE WITH RYBREVANT® + LAZCLUZE®



PROVEN DURABLE SURVIVAL[1,4]

- **Progressive widening of the curves** and mOS projected to exceed 4 years*[1,4]

CHANGING THE DISEASE BIOLOGY [1-3,5,23]

- **Reducing complexity of resistance mechanism:**
  - **~4x reduction** in *MET* amplifications vs. OSI†[5]
  - **~5x reduction** in secondary *EGFR* mutations vs. OSI†[5]
- **74% of patients** were able and willing to receive subsequent lines of therapy[4]

PATIENT-CENTRED CARE[6]

- **~5 min** SC administration[1]
- **With proven treatment protocols** to optimise patient outcomes[6,27,29]
- **Patients prefer** chemotherapy-free regimens‡[10]

Primary endpoint achieved with superior mPFS for RYB+LAZ vs. OSI, HR=0.70 (95% CI: 0.58–0.85; *p*=0.0002) assessed by BICR at median follow-up of 22.0 months.[1–3]

*The mOS was NE with RYB+LAZ vs. 36.7 months with OSI; HR=0.75 (95% CI: 0.61–0.92; *p*=0.0048).[4] †*MET* amplification was 3.4% with RYB+LAZ vs. 13.1% with OSI; *p*=0.002; secondary *EGFR* resistance mutations was 1.4% with RYB+LAZ vs. 7.6% with OSI; *p*=0.01.[5] ‡The Chinese Thoracic Oncology Group performed a survey in China in which 363 patients with lung cancer and their family members and 584 physicians participated. The participants were asked whether they had a preference for OSI monotherapy or OSI + chemotherapy. 73% of the patients selected the monotherapy although they had been told that combination therapy could delay recurrence by 9 months.[10]

1L, first-line; BICR, blinded independent central review; CI, confidence interval; EGFR, epidermal growth factor receptor; HR, hazard ratio; LAZ, LAZCLUZE®; mOS, median overall survival; mPFS, median progression-free survival; NE, not estimable; OS, overall survival; OSI, osimertinib; PFS, progression-free survival; RYB, RYBREVANT®; SC, subcutaneous.

REFERENCES

1. RYBREVANT® Saudi Summary of Product Characteristics April 2025.
2. LAZCLUZE® Saudi Summary of Product Characteristics November 2024.
3. Cho BC *et al. N Engl J Med.* 2024;391(16):1486–1498. (Supplement. DOI: 10.1056/NEJMoa2403614).
4. Yang JC *et al. N Engl J Med.* 2025 (ePub ahead of print). doi: 10.1056/NEJMoa2503001. (Supplement. DOI: 10.1056/NEJMoa2503001).
5. Hayashi *et al.* Presented at: World Conference on Lung Cancer. (WCLC) 2025. Abstract #PT1.03.06.
6. Leighl NB *et al. J Clin Oncol.* 2024;42(30):3593–3605.
7. Jänne PA *et al. N Engl J Med.* 2025. (ePub ahead of print) doi: 10.1056/NEJMoa2510308.
8. Angelopoulos PA *et al. Genes.* 2025;16:772.
9. Leonetti A *et al. British Journal of Cancer.* 2019;121:725–737.
10. Wu YL *et al. N Engl J Med.* 2023;389(21):2005–2007.
11. Epstein RS *et al.* Patient Preference and Adherence. 2021;15:453–465.
12. Alzahrani *et al. Global Journal on Quality and Safety in Healthcare.* 2023;6:81–88.
13. Knapp S *et al. Health Psychology Open.* 2014;1:1–10.
14. Puts MTE *et al. Support Care Cancer.* 2017;25:879–886.
15. Herington *et al. Human Journals.* 2021;20:242–258.
16. Schiller JH *et al. N Engl J Med*. 2002;2:92–98.
17. Sha C and Lee PC. *J. Clin. Med.* 2024;13:6391.
18. Hsieh PC *et al. Frontiers in Oncology.* 2022;12:869390.
19. Oxnard GR *et al. JAMA Oncol.* 2018;4:1527–1534.
20. European Society for Medical Oncology (ESMO). ESMO-MCBS scorecards for solid tumours. Available from: https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-for-solid-tumours/esmo_mcbs-scorecards?scorecard=464. Accessed: October 2025.
21. Cherny NI *et al. Annals of Oncology.* 2025;35:886–908.
22. European Society for Medical Oncology (ESMO). Form 2a of ESMO-MCBS v2.0. Available from: https://dam.esmo.org/image/upload/v1747410020/Form_2a_36months_-_ESMO-MCBS_v2.0_dxvoqr.pdf. Accessed: October 2025.
23. Besse B *et al. Ann Oncol.* 2024;35:S1245–S1246.
24. Yang JC *et al.* Presented at: European Lung Cancer Congress (ELCC) 2025. Abstract #40.
25. Yun J *et al. Clin Cancer Res*. 2019;25:2575–2587.
26. Vijayaraghavan *et al. A. Mol Cancer Ther*. 2020;19(10):2044–2056.
27. Alexander M *et al. European Journal of Cancer.* 2025;227:115624.
28. Khorana AA *et al. J Immunother Cancer.* 2023;11(1):e006072.
29. Cho BC *et al. J Thorac Oncol.* 2025;20:1517–1530.
30. Spira AI *et al. J Thorac Oncol.* 2025;20(6):809–816 (and supplementary material).

SCAN QR CODE to ACCESS
Rybrevant® KSA SmPC

SCAN QR CODE to ACCESS
Lazcluze® KSA SmPC

Johnson&Johnson

Johnson & Johnson Trading Limited.
3074 Prince Muhammed Bin Abdulaziz Rd, Al Olaya District,
Tower B Olaya Towers, Level 30.
PO. Box 65305, Riyadh 11556.
Kingdom of Saudi Arabia.
Tel: +966 (11) 4339133.
Fax: +966 (11) 4339140.

For any Medical Information Inquiries,
Please Contact us at: Email: ra-medinfoemmarkets@its.jnj.com.
To report Adverse Events /Products Complaints,
Please Contact us at: Email: GCC-PV2@its.jnj.com,
PV Hotline: 00966540015811.
CP-582253
Date of preparation: April 2026
Date of expiry: April 2028