You are cordially invited to attend an In-person program entitled:

Real-World Case Discussion: When to Intervene With Jakafi® (ruxolitinib) in Adults With Polycythemia Vera Who Have an Inadequate Response to Hydroxyurea & MONJUVI (tafasitamab-cxix) in combination with lenalidomide: A 2L Targeted Outpatient Immunotherapy for Adult Patients with R/R DLBCL Who Are Not Eligible for Transplant

Presented By:
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Indianapolis, IN

Thursday, September 21, 2023
6:00 PM
Eastern Standard Time

The program will begin at 6:00 PM - 8:00 PM. Please plan to arrive or log in 15 minutes early.

Due to a change in Policy, Incyte will no longer provide or pay for alcohol at Speaker Programs.

Appropriate attendees include licensed HCPs with a direct role in patient care.

Registration
Online http://sphase.info/inc10561

You may also register by contacting your Incyte representative(s) Joann Fawaz at (302) 438-9314 or jfawaz@incyte.com and/or Thomas Storti at (810) 280-0486, or tsorti@incyte.com with the following information: name, title/degree, state(s) and state license number(s), affiliation, address, phone, and email.

Prior to registering, please review the program title and speaker to ensure you have not attended this program before.

Please familiarize yourself with local COVID guidelines prior to attending the program.

Please note this program is intended for US healthcare professionals who practice in a specialty relevant to the program’s FDA-approved indication or disease state. This program is sponsored by Incyte Corporation and is not eligible for CE credits.

This is an educational event intended only for appropriate healthcare professionals. Spouses, guests, and other individuals who are not the intended audience of this educational program are not permitted to attend. Healthcare professionals who are subject to federal, state, or local laws or government ethics restrictions may not attend this event. Incyte will report the cost of any meals provided at this event as required by federal, state, or local laws.

INDICATIONS & USAGE
Jakafi® (ruxolitinib) is indicated for treatment of polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea.

Jakafi is indicated for treatment of intermediate or high-risk myelofibrosis (MF), including primary MF, post-polycythemia vera MF and post-essential thrombocythemia MF in adults.

MONJUVI (tafasitamab-cxix), in combination with lenalidomide, is indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma, and who are not eligible for autologous stem cell transplant (ASCT).

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

Please see Important Safety Information for Jakafi and Monjuvi on back cover and each Full Prescribing Information.
MONJUVI Important Safety Information

Contraindications
- None

Warnings and Precautions
- Infusion-Related Reactions: MONJUVI can cause infusion-related reactions (IRRs). In L-MIND, infusion-related reactions occurred in 6% of the 81 patients. Eighty percent of infusion-related reactions occurred during cycle 1 or 2. Signs and symptoms included fever, chills, rash, flushing, dyspnea, and hypertension. These reactions were managed with temporary interruption of the infusion and/or with supportive medication. Premedicate patients prior to starting MONJUVI infusion. Monitor patients frequently during infusion. Based on the severity of the infusion-related reaction, interrupt or discontinue MONJUVI. Institute appropriate medical management.
- Myelosuppression: MONJUVI can cause severe or severe myelosuppression, including neutropenia, thrombocytopenia, and anemia. In L-MIND, Grade 3 neutropenia occurred in 25% of patients, thrombocytopenia in 12%, and anemia in 7%. Grade 4 neutropenia occurred in 25% and thrombocytopenia in 6%. Neutropenia led to treatment discontinuation in 3.7% of patients. Monitor complete blood counts (CBC) prior to administration of each treatment cycle and throughout treatment. Monitor patients with neutropenia for signs of infection. Consider granulocyte colony-stimulating factor (G-CSF) administration. Withhold MONJUVI based on the severity of the adverse reaction. Refer to the lenalidomide prescribing information for dosage modifications.
- Infections: Fatal and serious infections, including opportunistic infections, occurred in patients during treatment with MONJUVI and following the last dose. In L-MIND, 73% of the 81 patients developed an infection. The most frequent infections were respiratory tract infection (24%), urinary tract infection (17%), bronchitis (16%), nasopharyngitis (10%) and pneumonia (10%). Grade 3 or higher infection occurred in 30% of the 81 patients. The most frequent grade 3 or higher infection was pneumonia (7%). Infection-related deaths were reported in 2.5% of the 81 patients. Monitor patients for signs and symptoms of infection and manage infections as appropriate.
- Embryo-Fetal Toxicity: Based on its mechanism of action, MONJUVI may cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise women of reproductive potential to use effective contraception during treatment with MONJUVI and for at least 3 months after the last dose.
- MONJUVI is initially administered in combination with lenalidomide. The combination of MONJUVI with lenalidomide is contraindicated in pregnant women because lenalidomide has been shown to cause birth defects and death of the unborn child. Refer to the lenalidomide prescribing information on use during pregnancy.

Adverse Reactions
- Serious adverse reactions occurred in 52% of patients who received MONJUVI. Serious adverse reactions in ≥5% of patients included infections (26%), including pneumonia (7%), and febrile neutropenia (6%). Fatal adverse reactions occurred in 5% of patients who received MONJUVI, including cerebrovascular accident (1.2%), respiratory failure (1.2%), progressive multifocal leukoencephalopathy (1.2%) and sudden death (1.2%).
- Permanent discontinuation of MONJUVI or lenalidomide due to an adverse reaction occurred in 25% of patients and permanent discontinuation of MONJUVI due to an adverse reaction occurred in 15%. The most frequent adverse reactions which resulted in permanent discontinuation of MONJUVI were infections (5%), nervous system disorders (2.5%), respiratory, thoracic and mediastinal disorders (2.5%).
- Dosage interruptions of MONJUVI or lenalidomide due to an adverse reaction occurred in 69% of patients and dosage interruption of MONJUVI due to an adverse reaction occurred in 62%. The most frequent adverse reactions which required a dosage interruption of MONJUVI were blood and lymphatic system disorders (41%), and infections (27%).
- The most common adverse reactions ≥20% were neutropenia (51%), fatigue (38%), anemia (36%), diarhoea (36%), thrombocytopenia (31%), cough (28%), pyrexia (24%), peripheral oedema (24%), respiratory tract infection (24%), and decreased appetite (22%).

Please see each of the accompanying full Prescribing Information.