TECVAYLI®
(teclistamab-cqyv) Injection for subcutaneous use
10 mg/mL and 90 mg/mL

A Guide to TECVAYLI® for Clinical Pharmacists

What you need to know about the first BCMA x CD3 T-cell engager given as an off-the-shelf subcutaneous injection for adult patients with RRMM who have received at least four prior lines of therapy, including a PI, an immunomodulatory agent, and an anti-CD38 monoclonal antibody.[1,2]

INDICATION AND USAGE

TECVAYLI® (teclistamab-cqyv) is a bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody.

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

IMPORTANT SAFETY INFORMATION

WARNING: CYTOKINE RELEASE SYNDROME and NEUROLOGIC TOXICITY including IMMUNE EFFECTOR CELL-ASSOCIATED NEUROTOXICITY SYNDROME

Cytokine release syndrome (CRS), including life-threatening or fatal reactions, can occur in patients receiving TECVAYLI®. Initiate treatment with TECVAYLI® step-up dosing schedule to reduce risk of CRS. Withhold TECVAYLI® until CRS resolves or permanently discontinue based on severity.

Neurologic toxicity, including Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) and serious, life-threatening or fatal reactions, can occur in patients receiving TECVAYLI®. Monitor patients for signs or symptoms of neurologic toxicity, including ICANS, during treatment. Withhold TECVAYLI® until neurologic toxicity resolves or permanently discontinue based on severity.

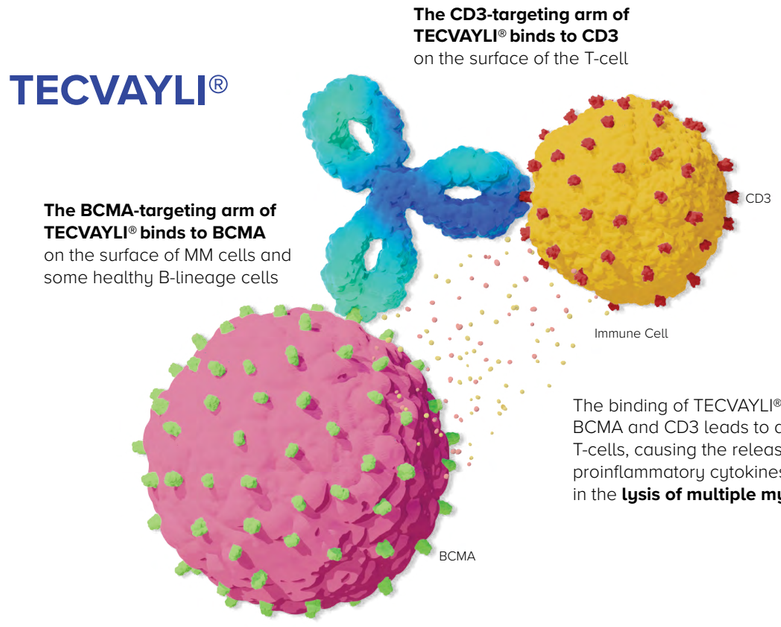
TECVAYLI® is available only through a restricted program called the TECVAYLI® and TALVEY® Risk Evaluation and Mitigation Strategy (REMS).

CD3, cluster of differentiation 3; CD38 cluster of differentiation 38; PI, proteasome inhibitor; RRMM, relapsed or refractory multiple myeloma.

Please read full Important Safety Information on pages 6-7, and full Prescribing Information, including Boxed WARNING, for TECVAYLI®.

TECVAYLI® is the first bispecific BCMA × CD3 T-cell engager[1,2]

TECVAYLI® is a bispecific antibody that uses innovative science to target BCMA and engage T-cells to activate the immune system[1]



The binding of TECVAYLI® to both BCMA and CD3 leads to activation of T-cells, causing the release of various proinflammatory cytokines and resulting in the **lysis of multiple myeloma cells**

BCMA, bispecific B-cell maturation antigen; CD3, cluster of differentiation 3; MM, multiple myeloma.

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS

Cytokine Release Syndrome - TECVAYLI® can cause cytokine release syndrome (CRS), including life-threatening or fatal reactions. In the clinical trial, CRS occurred in 72% of patients who received TECVAYLI® at the recommended dose, with Grade 1 CRS occurring in 50% of patients, Grade 2 in 21%, and Grade 3 in 0.6%. Recurrent CRS occurred in 33% of patients. Most patients experienced CRS following step-up dose 1 (42%), step-up dose 2 (35%), or the initial treatment dose (24%). Less than 3% of patients developed first occurrence of CRS following subsequent doses of TECVAYLI®. The median time to onset of CRS was 2 (range: 1 to 6) days after the most recent dose with a median duration of 2 (range: 1 to 9) days. Clinical signs and symptoms of CRS included, but were not limited to, fever, hypoxia, chills, hypotension, sinus tachycardia, headache, and elevated liver enzymes (aspartate aminotransferase and alanine aminotransferase elevation).

TECVAYLI®, the first bispecific BCMA x CD3 T-cell engager, was evaluated in the MajesTEC-1 Trial[1,2]

The efficacy of TECVAYLI® was evaluated in 110 patients with relapsed or refractory multiple myeloma in the single arm, open-label, multi-center, phase 1/2 MajesTEC-1 trial. Patients had received at least 3 therapies, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody.[1]

Primary Endpoint: ORR[3]
Key Secondary Endpoints: DOR, TTR[3]

Patients with a range of characteristics, including those who were heavily pretreated, were studied in MajesTEC-1[1]

- Median prior lines of therapy: 5 (range 2-14)
- 78% of patients had received ≥4 prior lines of therapy
- 100% of patients had received prior therapy with a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody
- 76% of patients were triple-class refractory (refractory to a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody)
- 81% of patients received prior stem cell transplantation

Patient Characteristics[1]	N=110
Age (median)	66 years (range: 33 to 82)
≥75 years of age	16%
Male	56%
White	91%
Black or African American	5%
Asian	3%
ISS Stage I	50%
ISS Stage II	38%
ISS Stage III	12%
High-risk cytogenetics (presence of del[17p], t[4;14], and t[14;16])	25%
Extramedullary plasmacytomas	17%

BCMA, B-cell maturation antigen; CD3, cluster of differentiation 3; CD38, cluster of differentiation 38; del, deletion; DOR, duration of response; ISS, International Staging System; ORR, overall response rate; t, translocation; TTR, time to response.

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

Cytokine Release Syndrome (continued) - Initiate therapy according to TECVAYLI® step-up dosing schedule to reduce risk of CRS. Administer pretreatment medications to reduce risk of CRS and monitor patients following administration of TECVAYLI® accordingly. At the first sign of CRS, immediately evaluate patient for hospitalization. Administer supportive care based on severity and consider further management per current practice guidelines. Withhold or permanently discontinue TECVAYLI® based on severity.

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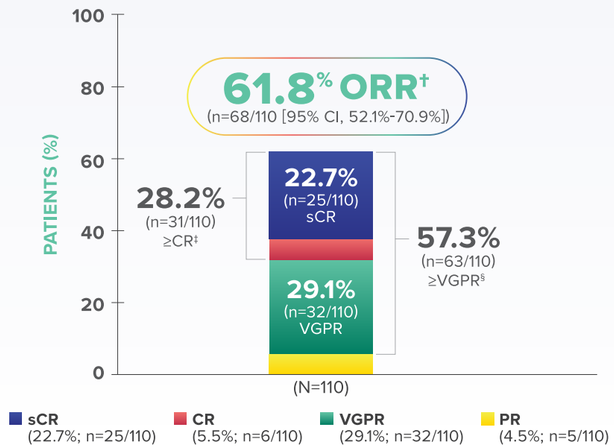
TECVAYLI® provided clinically meaningful efficacy at a median follow-up of 7 months[1,4]

In the MajesTEC-1 primary analysis, TECVAYLI® delivered an ORR of 61.8%, with 57.3% of patients achieving a deep response of VGPR or better[1,4*]



28.2%
of patients
experienced ≥CR‡ with TECVAYLI® in the MajesTEC-1 trial[1]

TECVAYLI® provided a median time to first response of

1.2 months[1] (range: 0.2-5.5 months)

Median DOR not reached[1]
(95% CI, 9.0-NE)

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

Neurologic Toxicity including ICANS - TECVAYLI® can cause, serious life-threatening or fatal neurologic toxicity, including Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS).

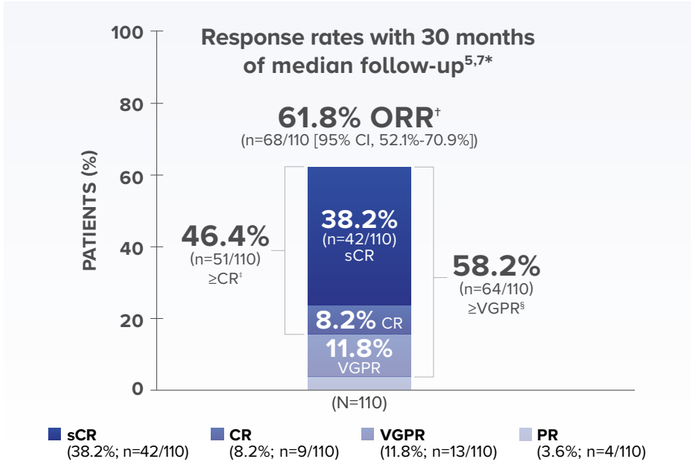
In the clinical trial, neurologic toxicity occurred in 57% of patients who received TECVAYLI® at the recommended dose, with Grade 3 or 4 neurologic toxicity occurring in 2.4% of patients. The most frequent neurologic toxicities were headache (25%), motor dysfunction (16%), sensory neuropathy (15%), and encephalopathy (13%). With longer follow-up, Grade 4 seizure and fatal Guillain-Barré syndrome (one patient each) occurred in patients who received TECVAYLI®.

In the clinical trial, ICANS was reported in 6% of patients who received TECVAYLI® at the recommended dose. Recurrent ICANS occurred in 1.8% of patients. Most patients experienced ICANS following step-up dose 1 (1.2%), step-up dose 2 (0.6%), or the initial treatment dose (1.8%). Less than 3% of patients developed first occurrence of ICANS following subsequent doses of TECVAYLI®. The median time to onset of ICANS was 4 (range: 2 to 8) days after the most recent dose with a median duration of 3 (range: 1 to 20) days. The most frequent clinical manifestations of ICANS reported were confusional state and dysgraphia. The onset of ICANS can be concurrent with CRS, following resolution of CRS, or in the absence of CRS.

MajesTEC-1 final analysis at a median follow-up of 30 months[5‖]

You are now viewing a subsequent follow-up analysis of the MajesTEC-1 trial. This information is not included in the current full Prescribing Information.

At the time of the follow-up report, 25/110 (22.7%) of subjects were still on treatment.[6]



46.4%
of patients
experienced ≥CR‡ with TECVAYLI® in the MajesTEC-1 trial[5]

Patients achieved ≥CR‡ at a median time of

6.0 months[7] (range: 1.7-18.5 months)

*Results were based on ORR as determined by the Independent Review Committee (IRC) assessment using International Myeloma Working Group (IMWG) 2016 criteria.
†ORR: sCR+CR+VGPR+PR.
‡≥CR: sCR+CR.
§≥VGPR: sCR+CR+VGPR.
‖Based on a median duration of follow-up of 29.9 months.[7]
CI, confidence interval; CR, complete response; DOR, duration of response; ORR, overall response rate; PR, partial response; sCR, stringent complete response; VGPR, very good partial response.

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

Neurologic Toxicity Including ICANS (continued) - Monitor patients for signs and symptoms of neurologic toxicity during treatment. At the first sign of neurologic toxicity, including ICANS, immediately evaluate patient and provide supportive therapy based on severity. Withhold or permanently discontinue TECVAYLI® based on severity per recommendations and consider further management per current practice guidelines.

Due to the potential for neurologic toxicity, patients are at risk of depressed level of consciousness. Advise patients to refrain from driving or operating heavy or potentially dangerous machinery during and for 48 hours after completion of TECVAYLI® step-up dosing schedule and in the event of new onset of any neurologic toxicity symptoms until neurologic toxicity resolves.

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WARNINGS AND PRECAUTIONS (continued)

Neurologic Toxicity including ICANS (continued) - Due to the potential for neurologic toxicity, patients are at risk of depressed level of consciousness. Advise patients to refrain from driving or operating heavy or potentially dangerous machinery during and for 48 hours after completion of TECVAYLI® step-up dosing schedule and in the event of new onset of any neurologic toxicity symptoms until neurologic toxicity resolves.

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TECVAYLI® and TALVEY® REMS - TECVAYLI® is available only through a restricted program under a REMS called the TECVAYLI® and TALVEY® REMS because of the risks of CRS and neurologic toxicity, including ICANS.

Hepatotoxicity - TECVAYLI® can cause hepatotoxicity, including fatalities. In patients who received TECVAYLI® at the recommended dose in the clinical trial, there was one fatal case of hepatic failure. Elevated aspartate aminotransferase (AST) occurred in 34% of patients, with Grade 3 or 4 elevations in 1.2%. Elevated alanine aminotransferase (ALT) occurred in 28% of patients, with Grade 3 or 4 elevations in 1.8%. Elevated total bilirubin occurred in 6% of patients with Grade 3 or 4 elevations in 0.6%. Liver enzyme elevation can occur with or without concurrent CRS.
Monitor liver enzymes and bilirubin at baseline and during treatment as clinically indicated. Withhold TECVAYLI® or consider permanent discontinuation of TECVAYLI® based on severity.

Infections - TECVAYLI® can cause severe, life-threatening, or fatal infections. In patients who received TECVAYLI® at the recommended dose in the clinical trial, serious infections, including opportunistic infections, occurred in 30% of patients, with Grade 3 or 4 infections in 35%, and fatal infections in 4.2%. Monitor patients for signs and symptoms of infection prior to and during treatment with TECVAYLI® and treat appropriately. Administer prophylactic antimicrobials according to guidelines. Withhold TECVAYLI® or consider permanent discontinuation of TECVAYLI® based on severity.
Monitor immunoglobulin levels during treatment with TECVAYLI® and treat according to guidelines, including infection precautions and antibiotic or antiviral prophylaxis.

Neutropenia - TECVAYLI® can cause neutropenia and febrile neutropenia. In patients who received TECVAYLI® at the recommended dose in the clinical trial, decreased neutrophils occurred in 84% of patients, with Grade 3 or 4 decreased neutrophils in 56%. Febrile neutropenia occurred in 3% of patients. Monitor complete blood cell counts at baseline and periodically during treatment and provide supportive care per local institutional guidelines. Monitor patients with neutropenia for signs of infection. Withhold TECVAYLI® based on severity.

Hypersensitivity and Other Administration Reactions - TECVAYLI® can cause both systemic administration-related and local injection-site reactions. Systemic Reactions - In patients who received TECVAYLI® at the recommended dose in the clinical trial, 1.2% of patients experienced systemic-administration reactions, which included Grade 1 recurrent pyrexia and Grade 1 swollen tongue. Local Reactions - In patients who received TECVAYLI® at the recommended dose in the clinical trial, injection-site reactions occurred in 35% of patients, with Grade 1 injection-site reactions in 30% and Grade 2 in 4.8%. Withhold TECVAYLI® or consider permanent discontinuation of TECVAYLI® based on severity.

Embryo-Fetal Toxicity - Based on its mechanism of action, TECVAYLI® may cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to the fetus. Advise females of reproductive potential to use effective contraception during treatment with TECVAYLI® and for 5 months after the last dose.

ADVERSE REACTIONS

The most common adverse reactions (≥20%) were pyrexia, CRS, musculoskeletal pain, injection site reaction, fatigue, upper respiratory tract infection, nausea, headache, pneumonia, and diarrhea.
The most common Grade 3 to 4 laboratory abnormalities (≥20%) were decreased lymphocytes, decreased neutrophils, decreased white blood cells, decreased hemoglobin, and decreased platelets.

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Safety from the MajesTEC-1 primary analysis[1]

Among patients who received TECVAYLI®, 47% were exposed for 6 months or longer and 7% were exposed for one year or longer.

Serious adverse reactions occurred in 54% of patients who received TECVAYLI®. Serious adverse reactions in >2% of patients included pneumonia (15%), cytokine release syndrome (8%), sepsis (6%), general physical health deterioration (6%), COVID-19 (6%), acute kidney injury (4.8%), pyrexia (4.8%), musculoskeletal pain (2.4%), and encephalopathy (2.4%).

Fatal adverse reactions occurred in 5% of patients who received TECVAYLI®, including COVID-19 (1.8%), pneumonia (1.8%), septic shock (0.6%), acute renal failure (0.6%), and hemoperitoneum (0.6%).

Permanent discontinuation of TECVAYLI® due to adverse reactions occurred in 1.2% of patients. Adverse reactions which required dosage interruption in >5% of patients included neutropenia, pneumonia, pyrexia, cytokine release syndrome, upper respiratory tract infection, and COVID-19.

Clinically adverse reactions in <10% of patients who received TECVAYLI® included febrile neutropenia, sepsis, ICANS, seizure, Guillain-Barré syndrome, hepatic failure, and new onset or reactivated viral infections (including adenovirus, hepatitis B virus [HBV], cytomegalovirus [CMV], varicella zoster virus [VZV], herpes simplex virus [HSV], and progressive multifocal leukoencephalopathy [PML]).

Please refer to Table 10 in the full Prescribing Information to see a complete list of adverse reactions (≥10%) in patients with multiple myeloma who received TECVAYLI® in MajesTEC-1.

Please see Table 11 in the full Prescribing Information for a summary of select laboratory abnormalities (≥30%) that worsened from baseline in patients with multiple myeloma who received TECVAYLI® in MajesTEC-1.

Dose reductions are not recommended with TECVAYLI®

Dose interruptions of TECVAYLI® due to adverse reactions occurred in 73% of patients, and the most frequent (>5%) leading to dose interruptions were:

- Neutropenia
- Pneumonia
- Pyrexia
- CRS
- Upper respiratory tract infection
- COVID-19

Dosage delays may be required to manage toxicities related to TECVAYLI®.

CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome.

MajesTEC-1 final safety analysis at a median follow-up of 30.4 months[1,5,7]

You are now viewing a subsequent follow-up analysis of the MajesTEC-1 trial. This information is not included in the current full Prescribing Information.

At the time of the follow-up report, 38/165 (23%) of subjects were still on treatment.

Reported since end of primary analysis:
- One patient experienced 2 recurrent CRS events after a treatment delay
- No additional events of ICANS

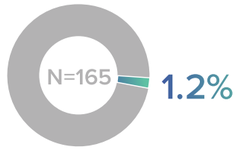
Reported since study initiation:
- Eight treatment-related deaths occurred (4 due to COVID-19)
- Permanent discontinuation due to adverse reactions occurred in 5.5% of patients

Treatment-emergent adverse events in ≥20% at a median follow-up of 30.4 months

Adverse Reactions	(N=165)	
	Any Grade (%)	Grade 3 or 4 (%)
Any TEAE	100.0	94.5
Hematologic		
Neutropenia	71.5	65.5
Anemia	55.2	37.6
Thrombocytopenia	41.8	23.0
Lymphopenia	36.4	34.5
Leukopenia	20.0	9.1
Nonhematologic		
Infections	78.8	55.2
COVID-19	29.1	21.2
Cytokine release syndrome	72.1	0.6
Diarrhea	34.5	3.6
Pyrexia	30.9	0.6
Fatigue	30.3	2.4
Cough	27.9	0
Nausea	27.3	0.6
Injection site erythema	26.7	0
Arthralgia	25.5	1.2
Headache	24.2	0.6
Constipation	22.4	0
Hypogammaglobulinemia	21.8	1.8
Back pain	20.0	2.4

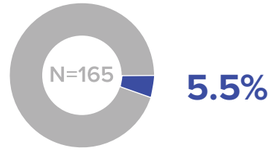
Discontinuation rates due to adverse reactions in MajesTEC-1[1,4,5]

Primary analysis



Adverse reactions resulting in permanent discontinuation of TECVAYLI® were pneumonia (adenoviral and pneumocystis jirovecii pneumonia in the same patient) and hypercalcemia.

Final analysis



Adverse reactions resulting in permanent discontinuation of TECVAYLI® were COVID-19 in 2 patients; progressive multifocal leukoencephalopathy, sepsis, arthralgia, arthritis, and brain neoplasm in 1 patient each; and events of pneumocystis jirovecii pneumonia and pneumonia adenoviral in the same patient, and hypercalcemia.

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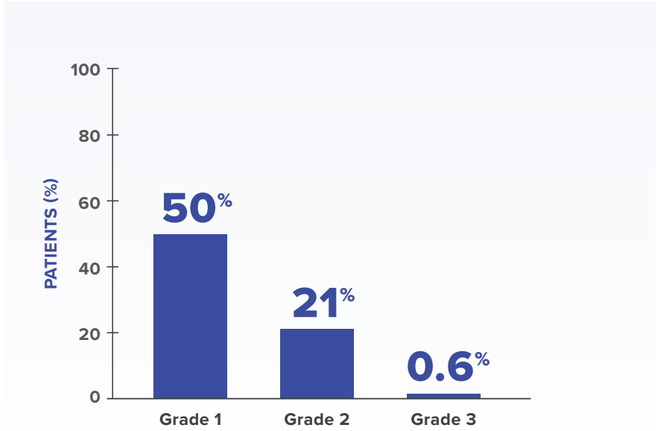
CRS, including life-threatening or fatal reactions, may occur in patients receiving TECVAYLI®[1]

MajesTEC-1 Primary Safety Analysis

Incidence of cytokine release syndrome (CRS)

- CRS of any grade was reported in 72% of patients receiving TECVAYLI®



Median time to onset

2 DAYS

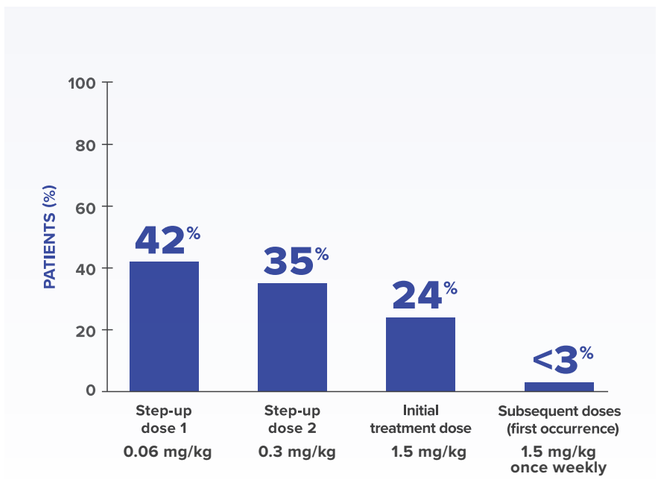
After most recent dose (range: 1-6 days)

Median duration

2 DAYS

(range: 1-9 days)

CRS experienced after specific dose of TECVAYLI®



Recurrent CRS occurred in 33% of patients

If not already hospitalized, at the first sign of CRS, immediately evaluate patient for hospitalization. Administer supportive care based on severity and consider further management per current practice guidelines. Withhold or permanently discontinue TECVAYLI® based on severity.

TECVAYLI® is available only through a restricted program under a REMS.

Signs and symptoms of CRS may include:

- Fever
- Hypoxia
- Chills
- Hypotension
- Sinus tachycardia
- Headache
- Elevated liver enzymes (aspartate aminotransferase and alanine aminotransferase elevation)

Advise patients to immediately contact their healthcare provider if they experience any signs or symptoms of CRS. Advise patients that they will be hospitalized for 48 hours after administration of all doses within the TECVAYLI® step-up dosing schedule.

Manage CRS according to the recommendations in Table 3 in the full Prescribing Information and consider further management per current practice

CRS, cytokine release syndrome; REMS, risk evaluation and mitigation strategy.

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

TECVAYLI® and TALVEY® REMS - TECVAYLI® is available only through a restricted program under a REMS called the TECVAYLI® and TALVEY® REMS because of the risks of CRS and neurologic toxicity, including ICANS.

Hepatoxicity - TECVAYLI® can cause hepatotoxicity, including fatalities. In patients who received TECVAYLI® at the recommended dose in the clinical trial, there was one fatal case of hepatic failure. Elevated aspartate aminotransferase (AST) occurred in 34% of patients, with Grade 3 or 4 elevations in 1.2%. Elevated alanine aminotransferase (ALT) occurred in 28% of patients, with Grade 3 or 4 elevations in 1.8%. Elevated total bilirubin occurred in 6% of patients with Grade 3 or 4 elevations in 0.6%. Liver enzyme elevation can occur with or without concurrent CRS.

Monitor liver enzymes and bilirubin at baseline and during treatment as clinically indicated. Withhold TECVAYLI® or consider permanent discontinuation of TECVAYLI® based on severity.

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Serious, life-threatening or fatal neurologic toxicities, including ICANS, may occur following treatment with TECVAYLI®[1]

MajesTEC-1 Primary Safety Analysis

Incidence of neurologic toxicities

In the primary analysis, neurologic toxicities were reported in 57% of patients receiving TECVAYLI® at the recommended dose.

- The most frequent neurologic toxicities were headache (25%), motor dysfunction (16%), sensory neuropathy (15%), and encephalopathy (13%)
- With longer follow-up, 1 patient experienced Grade 4 seizure and 1 patient experienced fatal Guillain-Barré syndrome
- Grade 3 and Grade 4 neurologic toxicity events (2.4%) have been observed in patients treated with TECVAYLI®

Signs and symptoms associated with neurologic toxicity, including ICANS

- Headache
- Motor dysfunction
- Confusion
- Neuropathy
- Dysgraphia
- Encephalopathy

Monitor patients for signs and symptoms of neurologic toxicity during treatment. At first sign of neurologic toxicity, including ICANS, immediately evaluate patient and provide supportive therapy based on severity.

Advise patients to immediately contact their healthcare provider if they experience any signs or symptoms of neurologic toxicity.

Manage neurotoxicity (excluding ICANS) according to the recommendations in Table 4 in the full Prescribing Information and consider further management per current practice

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

Infections - TECVAYLI® can cause severe, life-threatening, or fatal infections. In patients who received TECVAYLI® at the recommended dose in the clinical trial, serious infections, including opportunistic infections, occurred in 30% of patients, with Grade 3 or 4 infections in 35%, and fatal infections in 4.2%. Monitor patients for signs and symptoms of infection prior to and during treatment with TECVAYLI® and treat appropriately. Administer prophylactic antimicrobials according to guidelines. Withhold TECVAYLI® or consider permanent discontinuation of TECVAYLI® based on severity.

Monitor immunoglobulin levels during treatment with TECVAYLI® and treat according to guidelines, including infection precautions and antibiotic or antiviral prophylaxis.

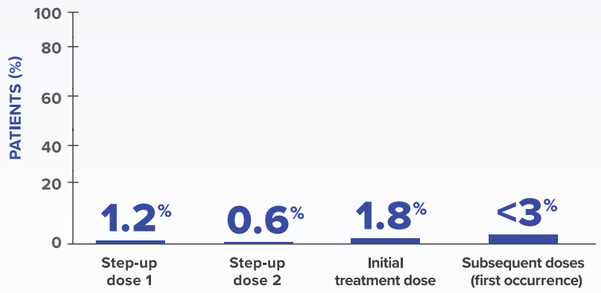
MajesTEC-1 Primary Safety Analysis

Immune effector cell-associated neurotoxicity syndrome (ICANS)

In the primary analysis, ICANS was reported in 6% of patients receiving TECVAYLI® at the recommended dose.

- Recurrent ICANS occurred in 1.8% of patients
- The most frequent clinical manifestations of ICANS reported were confusional state and dysgraphia
- Due to the potential for neurologic toxicity, patients receiving TECVAYLI® are at risk of depressed level of consciousness
- Advise patients to refrain from driving or operating heavy or potentially dangerous machinery during and for 48 hours after completion of receiving TECVAYLI® step-up dosing schedule and in the event of new onset of any neurologic toxicity symptoms until neurologic toxicity resolves

ICANS experienced after specific dose of TECVAYLI®



Median time to onset

4 DAYS

After most recent dose (range: 2-8 days)

Median duration

3 DAYS

(range: 1-20 days)

The onset of ICANS can be concurrent with CRS, following resolution of CRS, or in the absence of CRS.

Manage ICANS according to the recommendations in Table 5 in the full Prescribing Information and consider further management per current practice guidelines.

Please read full Important Safety Information on pages 6-7, and full Prescribing Information, including Boxed WARNING, for TECVAYLI®.

TECVAYLI® (teclistamab-cqyv) Injection for subcutaneous use 10 mg/mL and 90 mg/mL

A subcutaneous injection with an adaptive step-up dosing and personalized weight-based dosing[1]

Step-up doses

- **Step-up dose 2** may be given between **2 to 4 days after step-up dose 1** and may be given **up to 7 days after step-up dose 1** to allow for resolution of adverse reactions
- **First treatment dose** may be given between **2 to 4 days after step-up dose 2** and may be given **up to 7 days after step-up dose 2** to allow for resolution of adverse reactions

Due to the risk of CRS and neurologic toxicity, including ICANS, patients should be hospitalized for 48 hours after administration of all doses within the TECVAYLI® step-up dosing schedule.

Ongoing dosing with TECVAYLI®

After step-up dosing, patients will receive weekly treatment doses with the option of switching to biweekly dosing if they achieve and maintain ≥CR* for a minimum of 6 months

- **Weekly Dosing:** Once-weekly dosing until disease progression or unacceptable toxicity
- **Biweekly Dosing Option:** Extended dosing interval beyond 6 months. The dosing frequency may be decreased to once every 2 weeks after ≥6 months of achieving and maintaining ≥CR* during treatment until disease progression or unacceptable toxicity

Remember: Dose is personalized to each patient's actual body weight. Please refer to Tables 7-9 in the full Prescribing Information to determine the dosage based on predetermined weight ranges. Dose reductions are not recommended, and dose delays may be required to manage toxicities.

TECVAYLI® is administered by a healthcare provider according to the step-up dosing schedule to reduce the incidence and severity of CRS.

*≥CR: sCR+CR.
CR, complete response; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; kg, kilogram; mg, milligram; sCR, stringent complete response.

Pretreatment medications[1]

Prior to starting treatment with TECVAYLI®

Consider initiation of antiviral prophylaxis to prevent herpes zoster reactivation per local institutional guidelines.

1 to 3 hours before dose

Administer the following pretreatment medications of the TECVAYLI® step-up dosing schedule to reduce the risk of CRS.

- Corticosteroid (oral or intravenous dexamethasone 16 mg)
- Histamine-1 (H1) receptor antagonist (oral or intravenous diphenhydramine 50 mg or equivalent)
- Antipyretics (oral or intravenous acetaminophen 650 mg to 1,000 mg or equivalent)

Prior to administration of weekly doses

Administration of pretreatment medications may be required prior to administration of subsequent doses of TECVAYLI® in the following patients:

- Patients who repeat doses within the step-up dosing schedule following a dose delay
- Patients who experienced CRS following the prior dose of TECVAYLI®

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

Neutropenia - TECVAYLI® can cause neutropenia and febrile neutropenia. In patients who received TECVAYLI® at the recommended dose in the clinical trial, decreased neutrophils occurred in 84% of patients, with Grade 3 or 4 decreased neutrophils in 56%. Febrile neutropenia occurred in 3% of patients. Monitor complete blood cell counts at baseline and periodically during treatment and provide supportive care per local institutional guidelines. Monitor patients with neutropenia for signs of infection. Withhold TECVAYLI® based on severity.

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TECVAYLI® (teclistamab-cqyv) Injection for subcutaneous use
10 mg/mL and 90 mg/mL

Preparation and administration[1]

- TECVAYLI® is intended for subcutaneous use by a healthcare provider only
- TECVAYLI® should be administered by a healthcare provider with adequate medical personnel and appropriate medical equipment to manage severe reactions, including CRS and ICANS
- Do not combine TECVAYLI® vials of different concentrations to achieve treatment dose
- Use aseptic technique to prepare and administer TECVAYLI®

Preparation of TECVAYLI®

1. Remove the appropriate strength TECVAYLI® vial from refrigerated storage [2°C to 8°C (36°F to 46°F)].
2. Once removed from refrigerated storage, equilibrate TECVAYLI® to ambient temperature [15°C to 30°C (59°F to 86°F)] for at least 15 minutes. Do not warm TECVAYLI® in any other way.
3. Once equilibrated, gently swirl the vial for approximately 10 seconds to mix. Do not shake.
4. Withdraw the required injection volume of TECVAYLI® from the vial(s) into an appropriately sized syringe using a transfer needle.
5. Replace the transfer needle with an appropriately sized needle for injection.

Each injection volume should not exceed 2 mL. Divide doses requiring greater than 2 mL equally into multiple syringes.

TECVAYLI® is compatible with stainless steel injection needles and polypropylene or polycarbonate syringe material.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. Do not use if the solution is discolored, or cloudy, or if foreign particles are present.

Administration of TECVAYLI®

- Inject the required volume of TECVAYLI® into the subcutaneous tissue of the abdomen (preferred injection site). Alternatively, TECVAYLI® may be injected into the subcutaneous tissue at other sites (eg, thigh). If multiple injections are required, TECVAYLI® injections should be at least 2 cm apart
- Do not inject into tattoos or scars or areas where the skin is red, bruised, tender, hard or not intact
- Any unused product or waste material should be disposed in accordance with local requirements

cm, centimeter; mL, milliliter.

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

Embryo-Fetal Toxicity - Based on its mechanism of action, TECVAYLI® may cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment with TECVAYLI® and for 5 months after the last dose.

Additional considerations[1]

TECVAYLI® dosage strengths

TECVAYLI® injection is a sterile, preservative-free, clear to slightly opalescent, colorless to light yellow solution supplied as follows:

One 30 mg/3 mL (10 mg/mL) single-dose vial in a carton (NDC: 57894-449-01)

One 153 mg/1.7 mL (90 mg/mL) single-dose vial in a carton (NDC: 57894-450-01)

TECVAYLI® supply, storage, and handling

If the prepared dosing syringe(s) of TECVAYLI® is not used immediately, store syringe(s) at 2°C to 8°C (36°F to 46°F) or at ambient temperature 15°C to 30°C (59°F to 86°F) for a maximum of 20 hours. Discard syringe(s) after 20 hours, if not used.

Store refrigerated at 2°C to 8°C (36°F to 46°F) in the original carton to protect from light. Do not freeze.

mg, milligram; mL, milliliter.

IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS (continued)

Hypersensitivity and Other Administration Reactions - TECVAYLI® can cause both systemic administration-related and local injection-site reactions. Systemic Reactions - In patients who received TECVAYLI® at the recommended dose in the clinical trial, 1.2% of patients experienced systemic-administration reactions, which included Grade 1 recurrent pyrexia and Grade 1 swollen tongue. Local Reactions - In patients who received TECVAYLI® at the recommended dose in the clinical trial, injection-site reactions occurred in 35% of patients, with Grade 1 injection-site reactions in 30% and Grade 2 in 4.8%. Withhold TECVAYLI® or consider permanent discontinuation of TECVAYLI® based on severity.

ADVERSE REACTIONS

The most common adverse reactions (≥20%) were pyrexia, CRS, musculoskeletal pain, injection site reaction, fatigue, upper respiratory tract infection, nausea, headache, pneumonia, and diarrhea. The most common Grade 3 to 4 laboratory abnormalities (≥20%) were decreased lymphocytes, decreased neutrophils, decreased white blood cells, decreased hemoglobin, and decreased platelets.

References: 1. TECVAYLI® (teclistamab-cqyv) Prescribing Information. Horsham, PA: Janssen Biotech, Inc. **2.** U.S. Food & Drug Administration. FDA approves teclistamab-cqyv for relapsed or refractory multiple myeloma. Accessed April 3, 2024. https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-teclistamab-cqyv-relapsed-or-refractory-multiple-myeloma **3.** Moreau P, Garfall AL, van de Donk NWCJ, et al. Teclistamab in relapsed or refractory multiple myeloma. *N Engl J Med*. 2022;387(6):495-505. **4.** Data on file. Janssen Biotech, Inc. **5.** Garfall AL, Nooka AK, Niels WCJ van de Donk, et al. Long-term follow-up from the phase 1/2 MajesTEC-1 trial of teclistamab in patients with relapsed/refractory multiple myeloma. Poster. Presented at the 2024 American Society of Clinical Oncology (ASCO) Annual Meeting: May 31-June 4, 2024; Chicago, IL. **6.** Data on file. Janssen Biotech, Inc. **7.** Data on file. Janssen Biotech, Inc.

Please read full Important Safety Information on pages 6-7, and full Prescribing Information, including Boxed WARNING, for TECVAYLI®.

TECVAYLI® (teclistamab-cqyv) Injection for subcutaneous use
10 mg/mL and 90 mg/mL

The following section provides information and considerations based on various sources and the experiences of various professionals and is intended to help you achieve RRMM bispecific operational readiness in your organization.

This information, sample milestones, and suggestions to help you achieve operational readiness in your facility are recommendations but they are not mandatory items for operationalizing bispecific treatment for RRMM. It is recommended that you review this information and adapt based on your own facility.

RRMM, relapsed or refractory multiple myeloma

Three states of readiness can help establish a framework for the journey to operationalize a bispecifics treatment program

Ensuring operational readiness for each of 3 stakeholder groups—facility, provider and care team, and patient and care partner—are key to your RRMM bispecific treatment program.

Facility Readiness

Operational considerations, including identification of an operational champion, facilitating multidisciplinary engagement, SOP development, REMS certification, and financial considerations.

Provider & Care Team Readiness

Staff education, dosing considerations, organizational and provider preparation for care transitions, site of care coordination, and adverse reaction screening, monitoring, and management.

Patient & Care Partner Readiness

Logistical preparedness including travel and transportation and access and affordability, care partner support, and education and expectations for treatment.

REMS, risk evaluation and mitigation strategy; RRMM, relapsed or refractory multiple myeloma; SOP, standard operating procedure.

Bispecific RRMM therapies require a dedicated operational framework[1]

A designated operational champion can facilitate key activities for a multidisciplinary team[2]

The operational champion is a volunteer or appointed healthcare provider who can orchestrate multidisciplinary coordination and facilitate implementation of a bispecific treatment program.

The responsibilities of the operational champion often coincide with the responsibilities of pharmacy staff members.

Some key responsibilities of the operational champion may include:

- Team coordination
- Ownership of the REMS process
- Oversight of SOP development and staff training curriculum
- Design of approaches to transitions of care
- Operationalization of the dosing strategy

The operational champion should be supported by a multidisciplinary team to successfully operationalize a bispecific therapy

Multidisciplinary coordination is required for a multi-phase treatment journey

Core bispecific therapy stakeholders[3,4]

- ✓ Hematologists
- ✓ Medical oncologists
- ✓ APPs
- ✓ Nurses
- ✓ Pharmacists

Ancillary support[3,5]

- ✓ Care coordinators/navigators
- ✓ Emergency department
- ✓ Critical care
- ✓ Infectious disease
- ✓ Neurologists
- ✓ Social workers
- ✓ Psychologists
- ✓ Hospitalists

Mandatory REMS requirements for a bispecific therapy require staff training and provider and pharmacy certification[1,4,6]

- Prescribers must be REMS-certified to prescribe
- Both pharmacies and healthcare settings must be certified in REMS to dispense to patients

One additional thing to consider is understanding what may be required of your organization during a REMS audit. **Establishing standardized documentation processes which align with those requirements can help ensure preparedness for a potential audit.**

APP, advanced practice provider; REMS, risk evaluation and mitigation strategy; RRMM, relapsed or refractory multiple myeloma; SOP, standard operating procedures.

Bispecific RRMM therapies require a dedicated operational framework (cont'd)[1]

SOPs and treatment protocols can help facilitate consistency of care[1,3-5]

Consider establishing SOPs for bispecific therapy. Below are several examples of components.

Education and training plans

- Relevant stakeholders
- Training frequency
- Curriculum refresh

Transition of care coordination, roles, and responsibilities

- Internal collaboration
- Treatment initiation partnerships
- Memorandum of understanding

Adverse reaction (AR) management

- AR signs and symptoms
  - CRS/ICANS, infections, drug-specific ARs, etc.
- Management algorithms
- Additional drug-specific AR protocols*
- Drug availability for supportive care
- Reaction notification protocol
- Admission criteria
- Hospitalization procedure
- Local AR management team†

A memorandum of understanding (MOU) may be used to create a shared agreement between different sites of care[7]

Publically available MOU templates may be found online for reference

Key business considerations when onboarding a bispecific therapy

- **Clinical & Economic**
- **Coverage**
- **Coding**

Informational resources may be available from the bispecific therapy manufacturers to help address questions related to these financial considerations.

*May include infectious disease prophylaxes and management of immune deficiencies.
†Emergency department, critical care, infectious disease, hospitalist teams, nursing, pharmacy, neurology, etc.

AR, adverse reaction; CRS, cytokine release syndrome; ICANS, immune effector cell-associated neurotoxicity syndrome; RRMM, relapsed or refractory multiple myeloma; SOP, standard operating procedure.

HCP and care team readiness for RRMM treatment with a bispecific therapy[4,5]

Staff education is a key component of the operational plan. Potential educational topics include[4]:

Clinical
Efficacy and safety of the therapy, its preparation, dosing, and administration, infection prophylaxis and AR pretreatment, and clinical pearls.

Operational
SOPs and treatment protocols, including AR management, and transitions of care and care coordination.

Ensure organizational and provider preparation for care transitions that may occur as part of the multi-phase bispecific treatment journey[5]

	Diagnosis & treatment choice	Step-up dosing	Treatment dosing
1 center	1 care center for diagnosis, step-up dosing, and treatment dosing		
2 centers	Local oncologist refers patient for step-up dosing (T)	(T)	Patient returns for treatment dosing
Multi-center	Local oncologist refers patient for step-up dosing (T)	(T)	Patient goes to another center for treatment dosing

(T) =transition site of care.

Assess your organization's current infrastructure and ability to support patients through step-up and/or treatment dosing, then consider which model to operationalize.

Site of care coordination between departments and institutions:

- **Ensure site of care preparation:** REMS certification, service line training, treatment and AR management protocols.[4]
- **Align processes and define responsibilities for each care center.**[4,5]
- **Coordinate information transfer approaches:** Determine what information needs to be transferred, who is responsible for transferring the information, how receipt of information will be confirmed, EHR system compatibility, and how information will be shared if not compatible.[4]

AR, adverse reaction; EHR, electronic health record; HCP, healthcare professional; REMS, risk evaluation and mitigation strategy; RRMM, relapsed or refractory multiple myeloma; SOP, standard operating procedure.

HCP and care team readiness for RRMM treatment with a bispecific therapy[4,5] (cont'd)

The following are the roles/responsibilities of the care centers[4,5]:

- Conduct BI/PA
- Develop treatment plan
- Inform patient of estimated costs
- Review patient care plan*
- Schedule patient
- Connect patient with a care navigator
- Follow-up care/ rehospitalization
- Provide patient wallet cards
- Provide social work support
- Care partner support and education

*Ensure patient understands potential toxicities and complications of treatment.

Select adverse reaction screening, monitoring, and management is a key factor in operationalizing an RRMM bispecific treatment[5]

Bispecific therapies may be associated with a distinct adverse reaction profile, including a risk of developing[5]:

CRS
(cytokine release syndrome)

Neurologic toxicity, including ICANS
(immune effector cell-associated neurotoxicity syndrome)

Considerations in the management of CRS and neurologic toxicity, including ICANS

- Establish on-call physician to help manage CRS and neurotoxicity, including ICANS
- Ensure ED/hospitalists are aware of on-call physician
- Deploy training program to all stakeholders
- Develop centralized repository of treatment protocols and algorithms for toxicity management

Management

Please consult current practice guidelines and the protocols of your own institution for further information about managing ARs, including CRS and neurologic toxicities, including ICANS.

AR, adverse reaction; BI, benefits investigation; ED, emergency department; HCP, healthcare professional; PA, prior authorization; RRMM, relapsed or refractory multiple myeloma.

Enabling patient and care partner readiness for their RRMM bispecific therapy

Logistical preparedness can help patients prepare for their bispecific treatment journey

Travel and transportation[4,5]

- Patients may need help considering all aspects of travel and transportation over the course of therapy (as needed). This can include transportation to and from the center, food, lodging, frequency of visits, and length of visits
- If care is being transitioned, determine whether there is a treatment center that is more convenient for the patient. Geographic convenience can also factor into patient expenses

Access and Affordability[4,8]

- Provide patients with estimates for the cost of therapy, taking insurance coverage into consideration
- Provide estimates of additional costs, including care partner support, visiting nurse services, loss of work

Education for care partners is critical to ensure the ability to confidently care for a patient on bispecific therapy

Considerations for a committed care partner[5]

- Awareness of the commitment and availability for the duration of the treatment
- Familiarity with the signs and symptoms of ARs and ability to monitor for them
- Planning times of absence (home visiting nurse)
- Training on monitoring devices
- Knowing what to do and who to call in the event of an emergency

Patients and care partners should be educated on expectations for treatment[1,4,5]

- Patients and care partners should know how the therapy works and its clinical results, the differences between the discrete phases of treatment, potential side effects, the unique dosing schedule, and the overall patient care plan
- Consider developing an informational package for patients and care partners

AR, adverse reaction

Additional resources are available to assist with the 3 states of readiness

Facility Readiness

EHR Order Set Guides
- EHR System-Agnostic
- Epic®
- iKnowMed®
- OncoEMR®

Access and Reimbursement Guide

Billing and Coding Flashcard

Provider & Care Team Readiness

Transition of Care Checklist for Initiating Treatment Centers

Transition of Care Checklist for Ongoing Treatment Centers

Roundtable Program

Treatment Locator Tool on HCP website

Patient & Care Partner Readiness

Starting Treatment Guide

Patient Starter Kit English/Spanish

Patient Brochure English/Spanish

Caregiver Brochure English/Spanish

Scan the QR code to connect with a local Johnson & Johnson representative for more information and to learn more about these resources.

References: 1. Peters B. Annual Indy Hematology Review™. March 17, 2023. Accessed May 6, 2024. https://www.indyhematologyreview.com/wp-content/uploads/2023/03/Peters.Brooke-Operational-Protocol-and-Standard-Operating-Procedures.pdf **2.** Santos WJ, et al. *Implement Sci Commun.* 2022;3:80. **3.** Birhiray R. Annual Indy Hematology Review™. March 17, 2023. Accessed May 6, 2024. https://www.indyhematologyreview.com/wp-content/uploads/2023/03/CONCERT-NETWORK-TALK-Managing-Toxicities-of-T-Cell-Directed-Therapies-used-in-Hematologic-Therapies.pdf **4.** ACCC. Bispecific Antibodies Checklist for Community Providers. Accessed May 6, 2024. https://www.accc-cancer.org/docs/projects/bispecific-antibodies/checklist-for-bispecific-antibodies-jan-2022.pdf **5.** ACCC. Best Practices in Expanding Access to Bispecific Antibodies and Adverse Event Management. Accessed May 6, 2024. https://www.accc-cancer.org/docs/projects/bispecific-antibodies/bispecific-antibodies-brief.pdf **6.** FDA. Risk Evaluation and Mitigation Strategies. Accessed May 6, 2024. https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems **7.** Centers for Disease Control and Prevention. Accessed May 16, 2024. **8.** Weidner S. Annual Indy Hematology Review™. Accessed May 6, 2024. https://www.indyhematologyreview.com/wp-content/uploads/2023/03/Weidner.Susan-Financial-Considerations-for-Cellular-Therapy-in-Community-Oncology.pdf