Press release

For media and investors only

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Positive RUBY phase III data show potential for *Jemperli* (dostarlimab-gxly) combinations in more patients with primary advanced or recurrent endometrial cancer

- Dostarlimab-gxly plus chemotherapy is the only immuno-oncology combination to show statistically significant and clinically meaningful overall survival (OS) in the overall population

- 31% reduction in risk of death and 16.4-month improvement in median OS observed with dostarlimab-gxly plus chemotherapy versus chemotherapy in the overall population

- 37% reduction in risk of disease progression or death and 6-month improvement in median progression-free survival observed with the addition of *Zejula* (niraparib) to dostarlimab-gxly maintenance following dostarlimab-gxly plus chemotherapy versus chemotherapy in MMRp/MSS population where treatment options are still needed

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GSK plc (LSE/NYSE: GSK) today announced statistically significant and clinically meaningful overall survival (OS) results from Part 1 and progression-free survival (PFS) results from Part 2 of the RUBY/ENGOT-EN6/GOG3031/NSGO phase III trial in adult patients with primary advanced or recurrent endometrial cancer. These data were presented today in a late-breaking plenary session at the Society of Gynecologic Oncology 2024 Annual Meeting on Women's Cancer (March 16-18).

The goal of the RUBY phase III trial program is to evaluate which patients with primary advanced or recurrent endometrial cancer could potentially benefit from treatment with *Jemperli* (dostarlimab-gxly) plus chemotherapy, with or without the addition of *Zejula* (niraparib) maintenance. Part 1 of the RUBY phase III trial is investigating dostarlimab-gxly plus standard-of-care chemotherapy (carboplatin-paclitaxel) followed by dostarlimab-gxly compared to chemotherapy plus placebo followed by placebo. Part 2 of the RUBY phase III trial is evaluating dostarlimab-gxly plus standard-of-care chemotherapy, followed by dostarlimab-gxly plus niraparib as maintenance therapy compared to chemotherapy plus placebo followed by placebo. The safety and tolerability profiles of dostarlimab-gxly plus carboplatin-paclitaxel and dostarlimab-gxly plus carboplatin-paclitaxel followed by dostarlimab-glxy plus niraparib were generally consistent with the known safety profiles of the individual medicines.
Previous data showed a statistically significant and clinically meaningful improvement in PFS with *Jemperli* plus chemotherapy versus chemotherapy alone in frontline mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H) primary advanced or recurrent endometrial cancer. These data led to regulatory approvals for this patient population in the US, EU and certain other countries. Data presented today show additional potential benefit of dostarlimab-gxly plus chemotherapy, with or without the addition of niraparib, in the overall population of patients with primary advanced or recurrent endometrial cancer, including patients with mismatch repair proficient (MMRp)/microsatellite stable (MSS) tumors, for which there are currently no approved immuno-therapy-based regimens.
Hesham Abdullah, Senior Vice President, Global Head Oncology, R&D, GSK said: "The positive data presented today further show how dostarlimab-gxly-based regimens could benefit a broader set of patients with endometrial

cancer. The results we've seen to date comprise the growing body of evidence supporting the role of dostarlimab-gxly as the backbone of our immuno-oncology development program. Our goal is to continue to identify ways to use dostarlimab-gxly alone and in combination with other therapies to help improve outcomes for patients with limited treatment options."

RUBY Part 1: a statistically significant and clinically meaningful improvement in OS was observed for dostarlimab-gxly plus chemotherapy versus placebo plus chemotherapy, meeting a primary endpoint of the study.
Dostarlimab-gxly plus chemotherapy versus chemotherapy alone showed:

In the overall population:
- a statistically significant reduction in the risk of death by 31% (Hazard Ratio [HR]: 0.69; [95% CI: 0.539–0.890])
- a clinically meaningful improvement of 16.4 months in median OS (44.6 months vs 28.2 months)

In a prespecified exploratory analysis of the MMRp/MSS population:
- a clinically meaningful trend in reduced risk of death by 21% (HR: 0.79; [95% CI: 0.602–1.044])
- a clinically meaningful improvement of seven months in median OS (34.0 months vs 27.0 months)

Full OS summaries are shown below.

	dostarlimab-gxly + carboplatin-paclitaxel	placebo + carboplatin-paclitaxel
Overall population, Number (N)	245	249
OS, HR (95% CI)	0.69 (0.539–0.890)	
P-value[1]	0.002	
OS, median (95% CI), mo.	44.6 (32.6–NR)	28.2 (22.1–35.6)
dMMR/MSI-H population[2], N	53	65
OS, HR (95% CI)	0.32 (0.166–0.629)	
OS, median[3] (95% CI), mo.	NR (NR–NR)	31.4 (20.3–NR)
MMRp/MSS[2], N	192	184
OS, HR (95% CI)	0.79 (0.602–1.044)	
OS, median (95% CI), mo.	34.0 (28.6–NR)	27.0 (21.5–35.6)

[1] One-sided p-value based on stratified log-rank test.
[2] Exploratory analyses of OS in dMMR/MSI-H and OS in MMRp/MSS populations were pre-specified with no planned hypothesis testing.
[3] Although the median OS was not reached, at 30 months the estimated reduction in the risk of death was 82.8% for patients who received dostarlimab plus chemotherapy vs. 54.1% for patients who received chemotherapy alone.

Matthew Powell, MD, Division of Gynecologic Oncology, Washington University School of Medicine, and US principal investigator of the RUBY trial said: "RUBY Part 1 is the first clinical trial to show a statistically significant and clinically meaningful improvement in overall survival for an immuno-oncology therapy in combination with chemotherapy in the overall population of patients with primary advanced or recurrent endometrial cancer. As a clinician, I celebrate the results of the RUBY Part 1 trial presented today, which show how dostarlimab-gxly added to chemotherapy could potentially benefit a broader set of patients with this type of cancer."

In RUBY Part 1, grade 3 or higher and serious treatment-emergent adverse events (AEs) were approximately 12% higher in the dostarlimab-gxly plus carboplatin-paclitaxel arm (treatment arm) compared with the placebo plus carboplatin-paclitaxel arm (control arm). The nature and types of immune-related AEs in the dostarlimab-gxly plus chemotherapy safety profile were consistent with the mechanism of action of dostarlimab-gxly and similar to those reported for other PD-(L)1 inhibitors. In the trial, 40.7% of participants in the treatment arm and 16.3% of participants in the control arm had immune-related AEs assessed by the investigator as related to dostarlimab-gxly or placebo, respectively. Discontinuation of dostarlimab-gxly or placebo due to a treatment-emergent AE occurred in 19.1% of patients in the treatment arm and 8.1% of patients in the control arm.

GSK expects US Food and Drug Administration regulatory submission acceptance based on RUBY Part 1 data for an expanded indication in the overall population in the first half of this year.

RUBY Part 2: addition of niraparib to dostarlimab-gxly in maintenance setting significantly improved PFS in first-line primary advanced or recurrent endometrial cancer compared to chemotherapy alone, meeting the primary endpoint of the trial.

Dostarlimab-gxly plus chemotherapy followed by dostarlimab-gxly plus niraparib compared to placebo plus chemotherapy followed by placebo showed:

In the overall population:

- a statistically significant reduction in the risk of disease progression or death by 40% (HR: 0.60 [95% CI: 0.43–0.82])
- a clinically meaningful improvement of 6.2 months in median PFS (14.5 months vs 8.3 months)

In the MMRp/MSS population:

- a statistically significant reduction in the risk of disease progression or death by 37% (HR: 0.63 [95% CI: 0.44–0.91])
- a clinically meaningful improvement of 6.0 months in median PFS (14.3 months vs 8.3 months)

Dr Mansoor Raza Mirza, Chief Oncologist, Copenhagen University Hospital, Denmark, and RUBY principal investigator said: “In RUBY Part 2, we observed that the use of dostarlimab-gxly in combination with niraparib in the maintenance therapy setting further improved progression-free survival versus placebo for patients with primary advanced or recurrent endometrial cancer. These findings are particularly important for patients who have MMRp/MSS tumors as the data help build on the initial benefit observed with an immuno-oncology plus chemotherapy regimen, reflecting the potential for the addition of niraparib maintenance to address unmet medical need for these patients.”

In RUBY Part 2, grade 3 or higher and serious treatment-emergent AEs were approximately 36% and 24% higher, respectively, in the dostarlimab-gxly plus chemotherapy followed by dostarlimab-gxly plus niraparib arm (treatment arm) compared with the placebo plus chemotherapy followed by placebo arm (control arm). In the trial, 36.6% of participants in the treatment arm and 6.3% of participants in the control arm had immune-related AEs assessed by the investigator as related to dostarlimab-gxly or placebo, respectively. No cases of myelodysplastic syndrome/acute myeloid leukemia were reported; other secondary primary malignancies occurred in 1 patient each in both treatment arms. Discontinuation of dostarlimab-gxly or placebo due to a TEAE occurred in 24.1% of patients in the treatment arm and 5.2% of patients in the control arm. Discontinuation of niraparib or placebo due to a treatment-emergent AE occurred in 15.7% of patients in the treatment arm and 4.2% of patients in the control arm.

About endometrial cancer

Endometrial cancer is found in the inner lining of the uterus, known as the endometrium. Endometrial cancer is the most common gynecologic cancer in developed countries, with approximately 417,000 new cases reported each year worldwide[1], and incidence rates are expected to rise by almost 40% between 2020 and 2040.[2,3] Approximately 15-20% of patients with endometrial cancer will be diagnosed with advanced disease at the time of diagnosis.[4]

About RUBY

RUBY is a two-part global, randomized, double-blind, multicenter phase III trial of patients with primary advanced or

recurrent endometrial cancer. Part 1 is evaluating dostarlimab-gxly plus carboplatin-paclitaxel followed by dostarlimab-gxly versus carboplatin-paclitaxel plus placebo followed by placebo. Part 2 is evaluating dostarlimab-gxly plus carboplatin-paclitaxel followed by dostarlimab-gxly plus niraparib versus placebo plus carboplatin-paclitaxel followed by placebo.

In Part 1, the dual-primary endpoints are investigator-assessed PFS based on the Response Evaluation Criteria in Solid Tumors v1.1 and OS. The statistical analysis plan included pre-specified analyses of PFS in the dMMR/MSI-H and overall populations and OS in the overall population. Pre-specified exploratory analyses of PFS and OS in the MMRp/MSS population and OS in the dMMR/MSI-H populations were also performed. RUBY Part 1 included a broad population, including histologies often excluded from clinical trials and had approximately 10% of patients with carcinosarcoma and 20% with serous carcinoma.

In Part 2, the primary endpoint is investigator-assessed PFS in the overall population, followed by PFS in the MMRp/MSS population, and OS in the overall population is a key secondary endpoint. Additional secondary endpoints in Part 1 and Part 2 include PFS per blinded independent central review, PFS2, overall response rate, duration of response, disease control rate, patient-reported outcomes, and safety and tolerability.

RUBY is part of an international collaboration between the European Network of Gynaecological Oncological Trial groups (ENGOT), a research network of the European Society of Gynaecological Oncology (ESGO) that consists of 22 trial groups from 31 European countries that perform cooperative clinical trials, and the GOG Foundation, a non-profit organization dedicated to transforming the standard of care in gynecologic oncology.

About *Jemperli* (dostarlimab-gxly)
Jemperli is a programmed death receptor-1 (PD-1)-blocking antibody that binds to the PD-1 receptor and blocks its interaction with the PD-1 ligands PD-L1 and PD-L2.[5]

Jemperli was discovered by AnaptysBio, Inc. and licensed to TESARO, Inc., under a collaboration and exclusive license agreement signed in March 2014. Under this agreement, GSK is responsible for the ongoing research, development, commercialization, and manufacturing of *Jemperli*, and cobolimab (GSK4069889), a TIM-3 antagonist.

Indications and Important Safety Information for JEMPERLI (dostarlimab-gxly)

- JEMPERLI, in combination with carboplatin and paclitaxel, followed by JEMPERLI as a single agent, is indicated for the treatment of adult patients with primary advanced or recurrent endometrial cancer (EC) that is mismatch repair deficient (dMMR), as determined by an FDA-approved test, or microsatellite instability-high (MSI-H).
- JEMPERLI, as a single agent, is indicated for the treatment of adult patients with dMMR recurrent or advanced:
    - EC, as determined by an FDA-approved test, that has progressed on or following prior treatment with a platinum-containing regimen in any setting and are not candidates for curative surgery or radiation, or
    - solid tumors, as determined by an FDA-approved test, that have progressed on or following prior treatment and who have no satisfactory alternative treatment options. This indication is approved under accelerated approval based on tumor 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(s).

Important Safety Information

Severe and Fatal Immune-Mediated Adverse Reactions

- Immune-mediated adverse reactions, which can be severe or fatal, can occur in any organ system or tissue and can occur at any time during or after treatment with a PD-1/PD-L1–blocking antibody, including JEMPERLI.
- Monitor closely for signs and symptoms of immune-mediated adverse reactions. Evaluate liver enzymes, creatinine, and thyroid function tests at baseline and periodically during treatment. For suspected immune-mediated adverse reactions, initiate appropriate workup to exclude alternative etiologies, including infection. Institute medical management promptly, including specialty consultation as appropriate.

- Based on the severity of the adverse reaction, withhold or permanently discontinue JEMPERLI. In general, if JEMPERLI requires interruption or discontinuation, administer systemic corticosteroids (1 to 2 mg/kg/day prednisone or equivalent) until improvement to ≤Grade 1. Upon improvement to ≤Grade 1, initiate corticosteroid taper and continue to taper over at least 1 month. Consider administration of other systemic immunosuppressants in patients whose immune-mediated adverse reaction is not controlled with corticosteroids.

Immune-Mediated Pneumonitis

- JEMPERLI can cause immune-mediated pneumonitis, which can be fatal. In patients treated with other PD-1/PD-L1–blocking antibodies, the incidence of pneumonitis is higher in patients who have received prior thoracic radiation. Pneumonitis occurred in 2.3% (14/605) of patients, including Grade 2 (1.3%), Grade 3 (0.8%), and Grade 4 (0.2%) pneumonitis.

Immune-Mediated Colitis

- Colitis occurred in 1.3% (8/605) of patients, including Grade 2 (0.7%) and Grade 3 (0.7%) adverse reactions. Cytomegalovirus infection/reactivation have occurred in patients with corticosteroid-refractory immune-mediated colitis. In such cases, consider repeating infectious workup to exclude alternative etiologies.

Immune-Mediated Hepatitis

- JEMPERLI can cause immune-mediated hepatitis, which can be fatal. Grade 3 hepatitis occurred in 0.5% (3/605) of patients.

Immune-Mediated Endocrinopathies

- Adrenal Insufficiency
  - Adrenal insufficiency occurred in 1.2% (7/605) of patients, including Grade 2 (0.5%) and Grade 3 (0.7%). For Grade 2 or higher adrenal insufficiency, initiate symptomatic treatment per institutional guidelines, including hormone replacement as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.
- Hypophysitis
  - JEMPERLI can cause immune-mediated hypophysitis. Grade 3 hypophysitis occurred in 0.4% (1/241) of patients receiving JEMPERLI in combination with carboplatin and paclitaxel. Grade 2 hypophysitis occurred in 0.2% (1/605) of patients receiving JEMPERLI as a single agent. Initiate hormone replacement as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.
- Thyroid Disorders
  - Grade 2 thyroiditis occurred in 0.5% (3/605) of patients. Grade 2 hypothyroidism occurred in 12% (28/241) of patients receiving JEMPERLI in combination with carboplatin and paclitaxel. Grade 2 hypothyroidism occurred in 8% (46/605) of patients receiving JEMPERLI as a single agent. Hyperthyroidism occurred in 3.3% (8/241) of patients receiving JEMPERLI in combination with carboplatin and paclitaxel, including Grade 2 (2.9%) and Grade 3 (0.4%). Hyperthyroidism occurred in 2.3% (14/605) of patients receiving JEMPERLI as a single agent, including Grade 2 (2.1%) and Grade 3 (0.2%). Initiate thyroid hormone replacement or medical management of hyperthyroidism as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.
- Type 1 Diabetes Mellitus, Which Can Present with Diabetic Ketoacidosis
  - JEMPERLI can cause type 1 diabetes mellitus, which can present with diabetic ketoacidosis. Grade 3 type 1 diabetes mellitus occurred in 0.4% (1/241) of patients receiving JEMPERLI in combination with carboplatin and paclitaxel. Grade 3 type 1 diabetes mellitus occurred in 0.2% (1/605) of patients receiving JEMPERLI as a single agent. Monitor patients for hyperglycemia or other signs and symptoms of diabetes. Initiate treatment with insulin as clinically indicated. Withhold or permanently discontinue JEMPERLI depending on severity.

Immune-Mediated Nephritis with Renal Dysfunction

- JEMPERLI can cause immune-mediated nephritis, which can be fatal. Grade 2 nephritis, including tubulointerstitial nephritis, occurred in 0.5% (3/605) of patients.

Immune-Mediated Dermatologic Adverse Reactions

- JEMPERLI can cause immune-mediated rash or dermatitis. Bullous and exfoliative dermatitis, including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug rash with eosinophilia and systemic symptoms (DRESS), have occurred with PD-1/PD-L1–blocking antibodies. Topical emollients and/or topical corticosteroids may be adequate to treat mild to moderate non-bullous/exfoliative rashes. Withhold or permanently discontinue JEMPERLI depending on severity.

Other Immune-Mediated Adverse Reactions

- The following clinically significant immune-mediated adverse reactions occurred in <1% of the 605 patients treated with JEMPERLI or were reported with the use of other PD-1/PD-L1–blocking antibodies. Severe or fatal cases have been reported for some of these adverse reactions.
    - *Nervous System:* Meningitis, encephalitis, myelitis and demyelination, myasthenic syndrome/myasthenia gravis, Guillain-Barré syndrome, nerve paresis, autoimmune neuropathy
    - *Cardiac/Vascular:* Myocarditis, pericarditis, vasculitis
    - *Ocular:* Uveitis, iritis, other ocular inflammatory toxicities. Some cases can be associated with retinal detachment. Various grades of visual impairment to include blindness can occur
    - *Gastrointestinal:* Pancreatitis, including increases in serum amylase and lipase levels, gastritis, duodenitis
    - *Musculoskeletal and Connective Tissue:* Myositis/polymyositis, rhabdomyolysis and associated sequelae including renal failure, arthritis, polymyalgia rheumatica
    - *Endocrine:* Hypoparathyroidism
    - *Other (Hematologic/Immune):* Autoimmune hemolytic anemia, aplastic anemia, hemophagocytic lymphohistiocytosis, systemic inflammatory response syndrome, histiocytic necrotizing lymphadenitis (Kikuchi lymphadenitis), sarcoidosis, immune thrombocytopenia, solid organ transplant rejection, other transplant (including corneal graft) rejection

Infusion-Related Reactions

- Severe or life-threatening infusion-related reactions have been reported with PD-1/PD-L1–blocking antibodies. Severe infusion-related reactions (Grade 3) occurred in 0.2% (1/605) of patients receiving JEMPERLI. Monitor patients for signs and symptoms of infusion-related reactions. Interrupt or slow the rate of infusion or permanently discontinue JEMPERLI based on severity of reaction.

Complications of Allogeneic HSCT

- Fatal and other serious complications can occur in patients who receive allogeneic hematopoietic stem cell transplantation (HSCT) before or after treatment with a PD-1/PD-L1–blocking antibody, which may occur despite intervening therapy. Monitor patients closely for transplant-related complications and intervene promptly.

Embryo-Fetal Toxicity and Lactation

- Based on its mechanism of action, JEMPERLI can cause fetal harm. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with JEMPERLI and for 4 months after their last dose. Because of the potential for serious adverse reactions from JEMPERLI in a breastfed child, advise women not to breastfeed during treatment with JEMPERLI and for 4 months after their last dose.

Common Adverse Reactions

The most common adverse reactions (≥20%) in patients with dMMR/MSI-H EC who received JEMPERLI in combination with carboplatin and paclitaxel were rash, diarrhea, hypothyroidism, and hypertension. The most common Grade 3 or 4 laboratory abnormalities (≥10%) were decreased neutrophils, decreased hemoglobin, decreased white blood cell count, decreased lymphocytes, increased glucose, decreased sodium, and decreased platelets.

The most common adverse reactions (≥20%) in patients with dMMR EC who received JEMPERLI as a single agent were fatigue/asthenia, anemia, nausea, diarrhea, constipation, vomiting, and rash. The most common Grade 3 or 4 laboratory abnormalities (>2%) were decreased lymphocytes, decreased sodium, increased alanine aminotransferase, increased creatinine, decreased neutrophils, decreased albumin, and increased alkaline phosphatase.
The most common adverse reactions (≥20%) in patients with dMMR solid tumors who received JEMPERLI as a single agent were fatigue/asthenia, anemia, diarrhea, and nausea. The most common Grade 3 or 4 laboratory abnormalities (≥2%) were decreased lymphocytes, decreased sodium, increased alkaline phosphatase, and decreased albumin.

Please see the full US Prescribing Information for JEMPERLI.

About *Zejula* (niraparib)
Zejula is an oral, once-daily poly(ADP-ribose) polymerase (PARP) inhibitor.

Indication and Important Safety Information for ZEJULA (niraparib)

ZEJULA (niraparib) tablets 100 mg/200 mg/300 mg are indicated:

- for first-line maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to first-line platinum-based chemotherapy
- for the maintenance treatment of adult patients with deleterious or suspected deleterious germline *BRCA*-mutated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for ZEJULA

Important Safety Information

Myelodysplastic syndrome/acute myeloid leukemia (MDS/AML), including cases with a fatal outcome, have been reported in patients who received ZEJULA. In PRIMA, MDS/AML occurred in 6 out of 484 (1.2%) patients treated with ZEJULA, and in 3 out of 244 (1.2%) patients treated with placebo. The duration of therapy with ZEJULA in patients who developed secondary MDS/cancer therapy-related AML varied from 3.7 months to 2.5 years. In NOVA, of patients within the g*BRCA*mut cohort, MDS/AML occurred in 10 out of 136 (7%) patients treated with ZEJULA and in 2 out of 65 (3%) patients treated with placebo. The duration of therapy with ZEJULA in patients who developed secondary MDS/cancer therapy-related AML varied from 3.6 months to 5.9 years. All patients who developed secondary MDS/cancer therapy-related AML had received previous chemotherapy with platinum agents and/or other DNA-damaging agents, including radiotherapy. For suspected MDS/AML or prolonged hematological toxicities, refer the patient to a hematologist for further evaluation. Discontinue ZEJULA if MDS/AML is confirmed.

Hematologic adverse reactions (thrombocytopenia, anemia, neutropenia, and/or pancytopenia) have been reported in patients receiving ZEJULA. The overall incidence of Grade ≥3 thrombocytopenia, anemia, and neutropenia were reported, respectively, in 39%, 31%, and 21% of patients receiving ZEJULA in PRIMA and 29%, 25%, and 20% of patients receiving ZEJULA in NOVA. Discontinuation due to thrombocytopenia, anemia, and neutropenia occurred, respectively, in 4%, 2%, and 2% of patients in PRIMA and 3%, 1%, and 2% of patients in NOVA. In patients who were administered a starting dose of ZEJULA based on baseline weight or platelet count in PRIMA, Grade ≥3 thrombocytopenia, anemia, and neutropenia were reported, respectively, in 22%, 23%, and 15% of patients receiving ZEJULA. Discontinuation due to thrombocytopenia, anemia, and neutropenia occurred, respectively, in 3%, 3%, and 2% of patients. Do not start ZEJULA until patients have recovered from hematological toxicity caused by prior chemotherapy (≤Grade 1). Monitor complete blood counts weekly for the first month, monthly for the next 11 months, and periodically thereafter. If hematological toxicities do not resolve within 28 days following interruption, discontinue ZEJULA, and refer the patient to a hematologist for further investigations.

Hypertension and hypertensive crisis have been reported in patients receiving ZEJULA. Grade 3-4 hypertension occurred in 6% of patients receiving ZEJULA vs 1% of patients receiving placebo in PRIMA, with no reported discontinuations. Grade 3-4 hypertension occurred in 9% of patients receiving ZEJULA vs 2% of patients receiving placebo in NOVA, with discontinuation occurring in <1% of patients. Monitor blood pressure and heart rate at least weekly for the first two months, then monthly for the first year, and periodically thereafter during treatment with ZEJULA. Closely monitor patients with cardiovascular disorders, especially coronary insufficiency, cardiac arrhythmias, and hypertension. Manage hypertension with antihypertensive medications and adjustment of the ZEJULA dose if necessary.

Posterior reversible encephalopathy syndrome (PRES) occurred in 0.1% of 2,165 patients treated with ZEJULA in clinical trials and has also been described in postmarketing reports. Monitor all patients for signs and symptoms of PRES, which include seizure, headache, altered mental status, visual disturbance, or cortical blindness, with or without associated hypertension. Diagnosis requires confirmation by brain imaging. If suspected, promptly discontinue ZEJULA and administer appropriate treatment. The safety of reinitiating ZEJULA is unknown.

Embryo-fetal toxicity and lactation: Based on its mechanism of action, ZEJULA can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effective contraception during treatment and for 6 months after receiving their final dose of ZEJULA. Because of the potential for serious adverse reactions from ZEJULA in breastfed infants, advise lactating women not to breastfeed during treatment with ZEJULA and for 1 month after receiving the last dose.

First-line Maintenance Advanced Ovarian Cancer

Most common adverse reactions (Grades 1-4) in ≥10% of all patients who received ZEJULA in PRIMA were thrombocytopenia (66%), anemia (64%), nausea (57%), fatigue (51%), neutropenia (42%), constipation (40%), musculoskeletal pain (39%), leukopenia (28%), headache (26%), insomnia (25%), vomiting (22%), dyspnea (22%), decreased appetite (19%), dizziness (19%), cough (18%), hypertension (18%), AST/ALT elevation (14%), and acute kidney injury (12%).

Common lab abnormalities (Grades 1-4) in ≥25% of all patients who received ZEJULA in PRIMA included: decreased hemoglobin (87%), decreased platelets (74%), decreased leukocytes (71%), increased glucose (66%), decreased neutrophils (66%), decreased lymphocytes (51%), increased alkaline phosphatase (46%), increased creatinine (40%), decreased magnesium (36%), increased AST (35%), and increased ALT (29%).

Maintenance Recurrent Germline *BRCA*-mutated Ovarian Cancer

Most common adverse reactions (Grades 1-4) in ≥10% of patients who received ZEJULA in NOVA g*BRCA*mut Cohort were nausea (77%), thrombocytopenia (71%), fatigue (61%), anemia (52%), vomiting (40%), constipation (38%), headache (35%), neutropenia (31%), decreased appetite (22%), hypertension (21%), insomnia (18%), dizziness (18%), dyspnea (17%), dyspepsia (17%), back pain (16%), cough (16%), nasopharyngitis (13%), dry mouth (13%), dysgeusia (13%), urinary tract infection (11%), rash (10%), and anxiety (10%).

Common lab abnormalities (Grades 1-4) in ≥25% of patients who received ZEJULA in NOVA g*BRCA*mut Cohort included: decrease in hemoglobin (85%), decrease in platelet count (81%), decrease in white blood cell count (71%), decrease in absolute neutrophil count (56%), increase in AST (35%), and increase in ALT (25%).

Please see the US Prescribing Information for ZEJULA tablets.

GSK in oncology
Oncology is an emerging therapeutic area for GSK where we are committed to maximizing patient survival with a current focus on hematologic malignancies, gynecologic cancers and other solid tumors through breakthroughs in immuno-oncology and tumor-cell targeting therapies.

About GSK
GSK is a global biopharma company with a purpose to unite science, technology, and talent to get ahead of disease together. Find out more at us.gsk.com.

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Cautionary statement regarding forward-looking statements
GSK cautions investors that any forward-looking statements or projections made by GSK, including those made in this announcement, are subject to risks and uncertainties that may cause actual results to differ materially from those projected. Such factors include, but are not limited to, those described under Item 3.D “Risk factors” in the company's Annual Report on Form 20-F for 2023.

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References

1. Faizan U, Muppidi V. Uterine Cancer. [Updated 2022 Sep 5]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available at: www.ncbi.nlm.nih.gov/books/NBK562313/.
2. Braun MM, et al. Am Fam Physician. 2016;93(6):468-474.
3. International Research on Cancer. Global Cancer Observatory. Cancer Tomorrow. gco.iarc.fr/tomorrow/en/dataviz/. Accessed 13 July 2022.
4. CMP: CancerMPact® Patient Metrics Mar-2023, Cerner Enviza. Available at www.cancermpact.com. Accessed 29 Feb 2024.
5. Laken H, Kehry M, Mcneeley P, et al. Identification and characterization of TSR-042, a novel anti-human PD-1 therapeutic antibody. European Journal of Cancer. 2016;69, S102. doi:10.1016/s0959-8049(16)32902-1.