

ICLUSIG is indicated in adult patients with: Chronic phase, accelerated phase, or blast phase chronic myeloid leukaemia (CML) who are resistant to dasatinib or nilotinib; who are intolerant to dasatinib or nilotinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation. Philadelphia chromosome positive acute lymphoblastic leukaemia (Ph+ ALL) who are resistant to dasatinib; who are intolerant to dasatinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation.¹

ICLUSIG® (PONATINIB) COMBINES EXPERIENCE AND DATA THAT MAY HELP IMPROVE PATIENT FUTURES^{2,3}

BECAUSE TOMORROW MATTERS



WE'VE COME A LONG WAY IN CML TREATMENT, BUT WE STILL HAVE WORK TO DO



We know that treatment failure in CML can be devastating for the 1 in 3 patients who experience failure in the 1L setting (on imatinib or a 2G TKI).^{4,5}



Failure of the first 2G TKI is still a problem today: 30–40% of patients experience 2G TKI failure by 5 years in the 1L setting, and there is a low likelihood of response to an alternative 2G TKI (regardless of treatment line).⁶

Read on to learn more about why you should consider switching to ICLUSIG after one 2G TKI, for eligible patients.



ICLUSIG HAS BEEN WITH YOU SINCE 2013!

TOGETHER, WE'VE BUILT EXPERIENCE AND CONFIDENCE WITH ICLUSIG IN PATIENTS WITH CML¹⁻³

Over the last decade, ICLUSIG has proudly demonstrated responses that are:



Fast

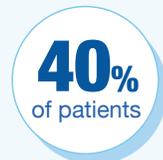
Median time to MCyR in CP-CML patients who achieved MCyR in PACE: **2.8 months** (range: 1.6 to 11.3 months)¹

Median time to MMR in CP-CML patients who achieved MMR in PACE: **5.5 months** (range: 1.8 to 55.5 months)¹



Deep

MMR rate in CP-CML patients in PACE at **5-year follow-up**:²



Durable

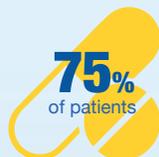
Among CP-CML patients in PACE, at **5 years**: **59%** of patients who achieved MMR at any time maintained their response² **82%** of patients who achieved MCyR by 12 months maintained their response (Kaplan-Meier estimates)²

For patients with CP-CML, the probability of overall survival from PACE is estimated at:¹



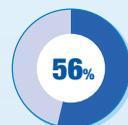
Data from the OPTIC trial affirmed efficacy outcomes, demonstrating clinical benefit in patients with CP-CML

The **primary endpoint** ($\leq 1\%$ BCR::ABL1^{IS} at 12 months) was achieved by **44.1%** of patients.³ Data shown below were secondary endpoints of the OPTIC trial:



with a response-based dose-reduction from 45 mg or 30 mg to 15 mg **maintained response**.^{3*}

MR2 ($\leq 1\%$ BCR::ABL1^{IS}) by 24 months:³



45 mg → 15 mg regimen

Estimated 24-month OS³



45 mg → 15 mg regimen

Estimated 24-month PFS³



45 mg → 15 mg regimen



The OPTIC trial now provides clear evidence to induce, reduce and maintain ICLUSIG dose to manage your patients with CP-CML³



Induce

with 45 mg orally, once daily



Reduce

to 15 mg orally, once daily, upon achievement of $\leq 1\%$ BCR::ABL1^{IS*}

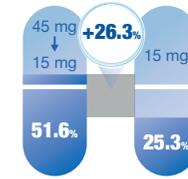


Maintain

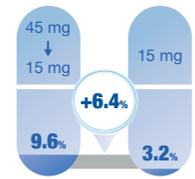
with 15 mg dose*

The results from the OPTIC trial support an ICLUSIG regimen of a starting dose of 45 mg reduced to 15 mg upon response, to maximise response while minimising toxicity³

Improvement in response rate (by 12 months)



AOE rate (by 12 months)

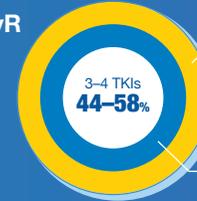


UNDERSTANDING OF HOW TO OPTIMISE USE OF CURRENT TKIs TO IMPROVE PATIENT OUTCOMES CONTINUES TO GROW

Early use of ICLUSIG leads to the deepest responses¹

The deepest response with ICLUSIG was achieved when used after 1 or 2 TKIs compared to after 3 or 4.¹

MCyR



1 TKI
75%

2 TKIs
68%

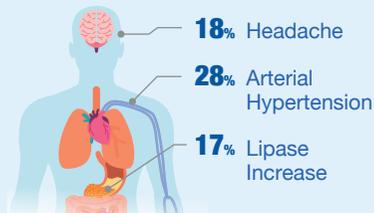
In the PACE trial, patients with CP-CML who received fewer prior TKIs attained higher cytogenetic, haematological and molecular responses.¹



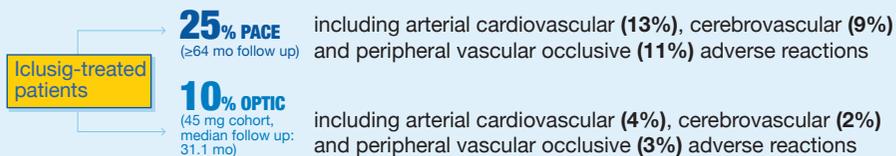
With a decade of ICLUSIG experience, the safety profile is well characterised and tolerability is manageable¹

ICLUSIG had a manageable safety profile in the OPTIC trial, with no new safety signals³

The most common non-haematological TEAEs for all cohorts combined in the OPTIC trial were:³



AOEs have occurred in:¹



Common AEs

- AEs occurring in $\geq 10\%$ of CML and Ph+ ALL patients in PACE:¹

Upper respiratory tract infection, anaemia, platelet count decreased, neutrophil count decreased, decreased appetite, insomnia, headache, dizziness, hypertension, dyspnoea, cough, abdominal pain, diarrhoea, vomiting, constipation, nausea, lipase increased, alanine aminotransferase increased, aspartate aminotransferase increased, rash, dry skin, pruritus, bone pain, arthralgia, myalgia, pain in extremity, back pain, muscle spasm, fatigue, asthenia, oedema peripheral, pyrexia, pain.

- A full list of ADRs can be found in the SmPC¹

ICLUSIG combines experience and data to improve patients' futures – consider early switch to ICLUSIG after just one 2G TKI



A decade of building patients' futures



The recommended starting dose of ICLUSIG is 45 mg once daily. The ICLUSIG (Denmark) abbreviated product information can be found [here](#).

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*Patients with loss of response can re-escalate the dose of ICLUSIG to a previously tolerated dosage of 30 mg or 45 mg orally once daily. Continue ICLUSIG until loss of response at the re-escalated dose or unacceptable toxicity. Consider discontinuing ICLUSIG if a complete haematological response has not occurred by 3 months.¹

1L, first-line; 2G, second-generation; ADR, adverse drug reaction; AE, adverse event; AOE, arterial occlusive event; CML, chronic myeloid leukaemia; CP, chronic phase; IS, International Scale; MCyR, major cytogenetic response; MMR, major molecular response; mo, months; MR, molecular response; OPTIC, Optimizing Ponatinib Treatment In CP-CML; OS, overall survival; PACE, Ponatinib Ph+ ALL and CML Evaluation; PFS, progression-free survival; Ph+ ALL, Philadelphia chromosome-positive acute lymphoblastic leukaemia; SmPC, Summary of Product Characteristics; TEAE, treatment-emergent adverse event; TKI, tyrosine kinase inhibitor.

1. ICLUSIG® (ponatinib). Summary of Product Characteristics. Incyte Biosciences Distribution B.V. 2022; 2. Cortes JE, et al. *Blood*. 2018;132:393-404; 3. Cortes JE, et al. *Blood*. 2021;138:2042-50; 4. Miller GD, et al. *Biologics*. 2014;8:243-54; 5. Borghi L, et al. *Front Psychol*. 2019;10:329; 6. Cortes J, Lang F. *J Hematol Oncol*. 2021;14:44.