MONJUVI®
tafasitamab-cxix | 200 mg
for injection, for intravenous use

INDICATIONS & USAGE

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).

SECURE RESPONSE IN SECOND LINE[1]

MONJUVI is the first and only FDA-approved treatment for adult patients with DLBCL who have received at least 1 prior therapy, in combination with lenalidomide[1]

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) recommend
tafasitamab-cxix (MONJUVI) in combination with lenalidomide as a second-line or subsequent therapy option for DLBCL in patients who are not candidates for transplant.[2*]

DLBCL=diffuse large B-cell lymphoma; NCCN=National Comprehensive Cancer Network.

*It is unclear if tafasitamab will have a negative impact on the efficacy of subsequent anti-CD19 CAR T-cell therapy.

NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

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 chills, 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.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information.

Patients with R/R DLBCL have a poor prognosis, and may need alternate treatment options that do not reutilize CD20 as a target[2-5]

After previous treatment with CD20-based therapy, poor response rates have been reported by re-challenging with CD20-targeted therapy[6-9]*

- After first-line treatment, CD20 expression can be reduced, which may compromise the effects of CD20-based therapy[10-13]

CD19 is broadly and homogeneously expressed across different B-cell malignancies, including DLBCL, and amplifies B-cell receptor signaling and tumor cell proliferation[14]

- CD19 mediates signaling essential for B-cell proliferation and survival, making it an attractive target[15]
- CD19 is expressed in patients with CD20 downregulation associated with prior anti-CD20 antibody therapy for first-line DLBCL[12,16]

CD19 is an effective target antigen in B-cell malignancies, including R/R DLBCL[1,15,16]

R/R=relapsed/refractory.

*Based on evidence from the Collaborative Trial in Relapsed Aggressive Lymphoma (CORAL) study of 396 adult patients with R/R CD20+ DLBCL; an open-label, single-arm, multicenter, phase 2 trial of 81 adult patients with R/R DLBCL who were ineligible for or had progressed following ASCT; and the GAUGUIN trial, an open-label, multicenter, randomized, phase 2 study of 40 adult patients with R/R CD20+ DLBCL or mantle-cell lymphoma.[7-9]

IMPORTANT SAFETY INFORMATION

Warnings and Precautions (cont'd)

Myelosuppression

MONJUVI can cause serious 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.

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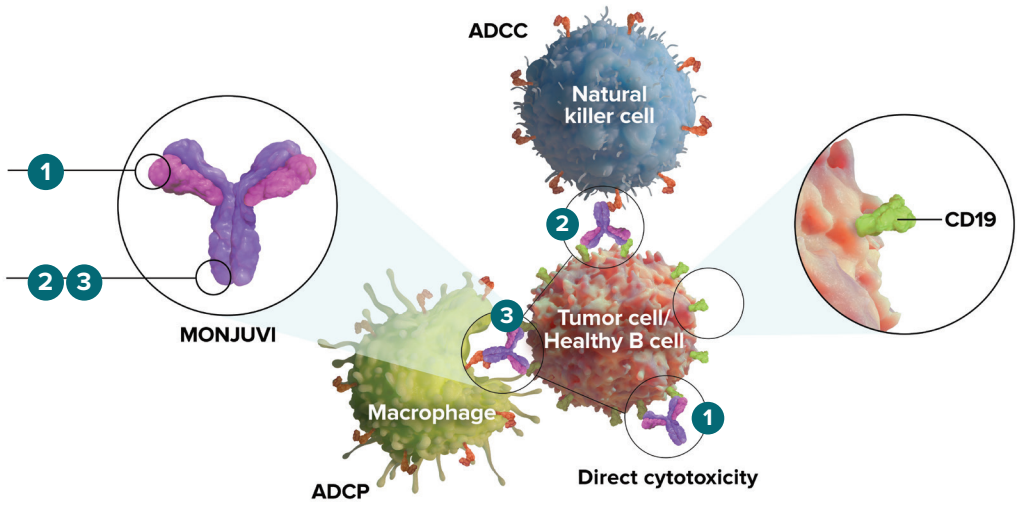
MONJUVI is a monoclonal antibody that effectively targets CD19[1]

- MONJUVI (tafasitamab-cxix) is an Fc-modified monoclonal antibody that binds to the CD19 antigen expressed on the surface of pre-B and mature B lymphocytes and in several B-cell malignancies, including DLBCL

A distinct 3-pronged mechanism of action[1]



Upon binding to CD19, tafasitamab-cxix mediates B-cell lysis through:

1. Apoptosis
2. Antibody-dependent cellular cytotoxicity (ADCC)
3. Antibody-dependent cellular phagocytosis (ADCP)

Fc=fragment crystallizable.

In studies conducted in vitro in DLBCL tumor cells, tafasitamab-cxix, in combination with lenalidomide, resulted in increased ADCC activity compared to tafasitamab-cxix or lenalidomide alone[1]

IMPORTANT SAFETY INFORMATION

Warnings and Precautions (cont'd)

Myelosuppression (cont'd)

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.

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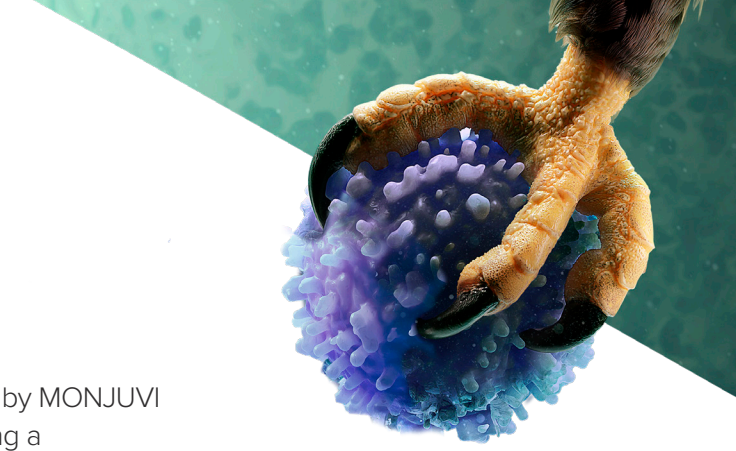
L-MIND: An open-label, multicenter, single-arm, phase 2 study[1,17]



L-MIND study design[1]

- L-MIND evaluated the efficacy and safety of MONJUVI in combination with lenalidomide followed by MONJUVI monotherapy in adult patients with R/R DLBCL after 1 to 3 prior systemic DLBCL therapies, including a CD20-containing therapy
- Enrolled patients at the time of the trial were not eligible for or refused ASCT
- Efficacy was established in 71 patients with DLBCL (confirmed by central laboratory) based on best ORR (defined as the proportion of complete and partial responders) and DoR, as assessed by an Independent Review Committee using the International Working Group Response Criteria (Cheson 2007)
- Patients received MONJUVI 12 mg/kg intravenously in combination with lenalidomide (25 mg orally on days 1 to 21 of each 28-day cycle) for a maximum of 12 cycles, followed by MONJUVI as monotherapy until disease progression or unacceptable toxicity

ASCT=autologous stem cell transplant; ORR=overall response rate; DoR=duration of response.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions (cont'd)

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.

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Select baseline characteristics (N=71)[1,18]

Median age (range)		71 years (41–86 years)
Time between first DLBCL diagnosis and first documented relapse or progression	≤12 months	17 (23.9%)
	>12 months	53 (74.6%
	Unknown	1 (1.4%)
IPI score at screening	0–2 (low and low-intermediate risk)	34 (47.9%)
	3–5 (intermediate-high and high risk)	37 (52.1%)
Prior therapies	Primary refractory disease	14 (19.7%)
	Refractory to last prior therapy	32 (45%)
	Refractory to rituximab	30 (42%)
Prior CD20-containing therapy		100%
Median number of prior therapies		2
Prior lines of therapy	1	49%
	2 to 4	51%
Prior ASCT		9 (13%)
Race*	White	95%
	Asian	3%
Sex, male		55%
ECOG performance status	0	26 (36.6%)
	1	38 (53.5%)
	2	7 (9.9%)
Primary reasons patients were not candidates for ASCT	Age	47%
	Refractory to salvage chemotherapy	27%
	Comorbidities	13%
	Refusal of high-dose chemotherapy/ASCT	13%

IPI=International Prognostic Index; ECOG=Eastern Cooperative Oncology Group.
*Race was collected in 92% of the 71 patients.

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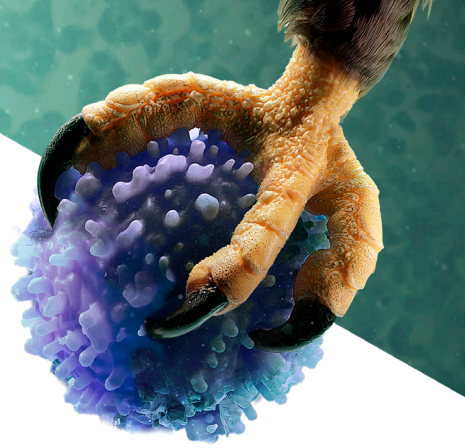
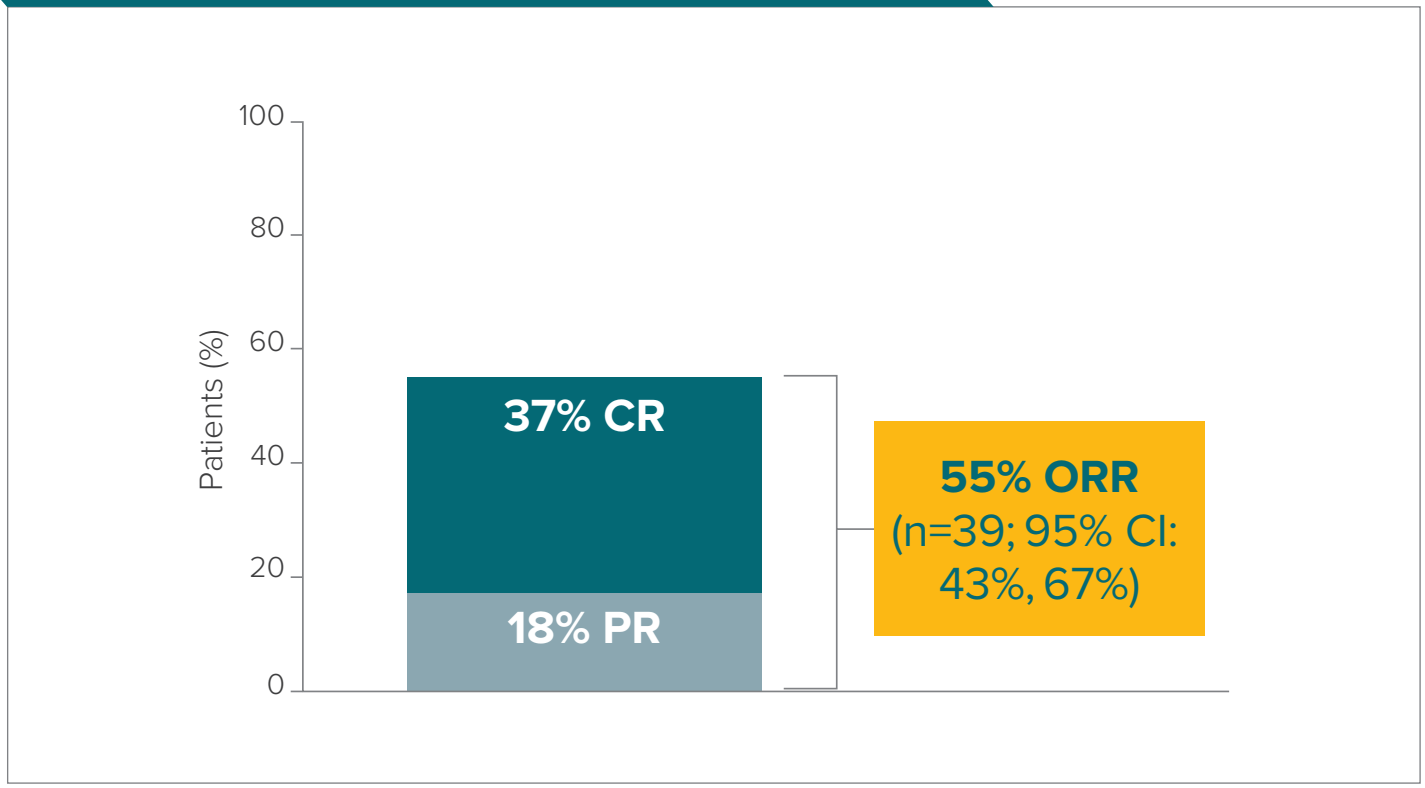
High ORR reached, with a majority of responders achieving CR[1]



Best overall response rate in patients with R/R DLBCL (N=71)[1]*



CR=complete response rate; PR=partial response rate; CI=confidence interval.
*Assessed by an Independent Review Committee.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions (cont'd)

Embryo-Fetal Toxicity

Based on its mechanism of action, MONJUVI may cause fetal B-cell depletion 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.

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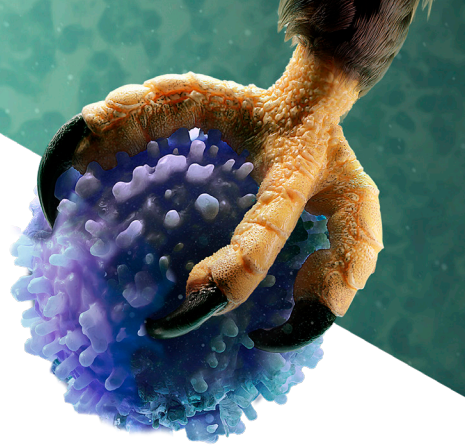
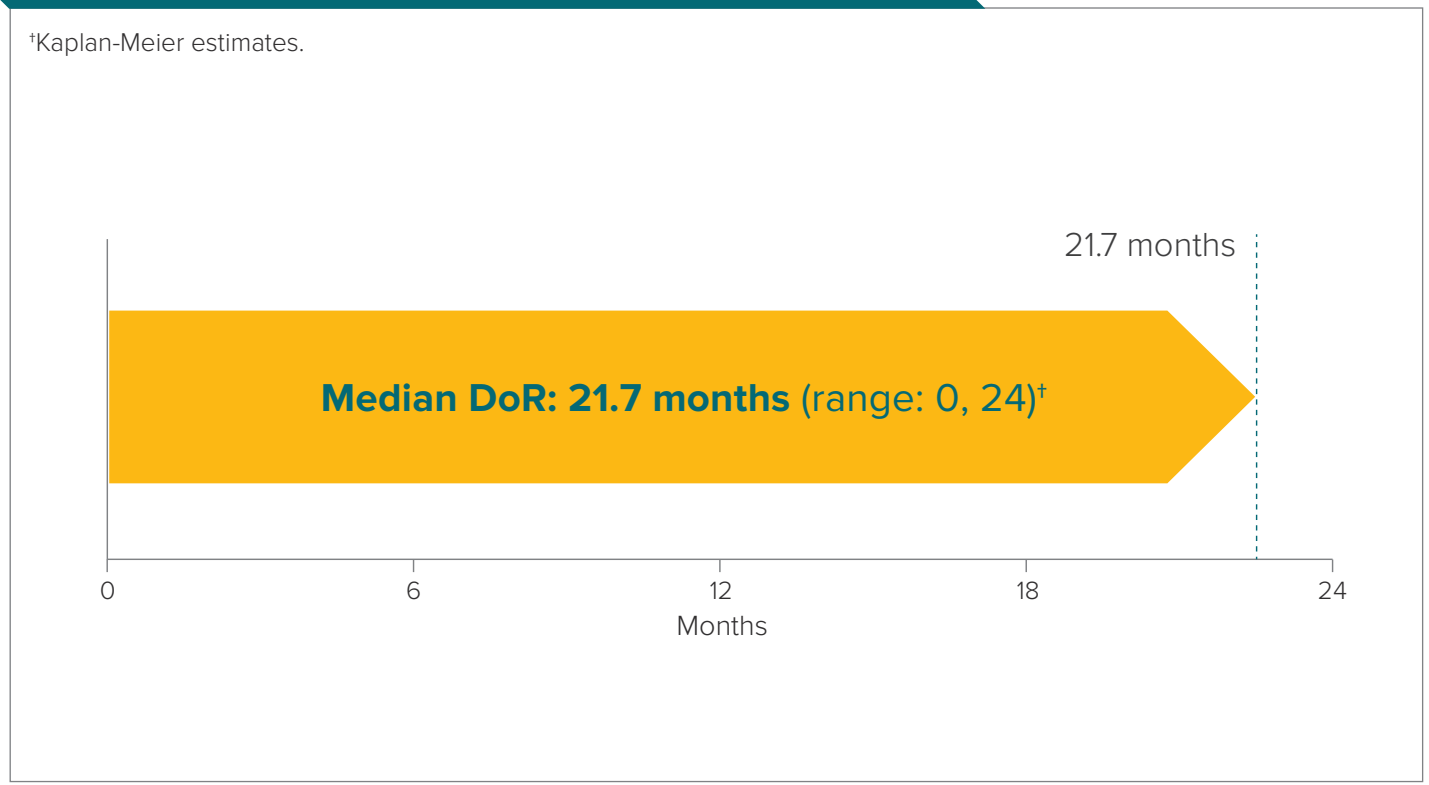
Response sustained beyond 18 months[1]



Duration of response in patients with R/R DLBCL (n=71)[1]*

†Kaplan-Meier estimates.



*Assessed by an Independent Review Committee.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions (cont'd)

Embryo-Fetal Toxicity (cont'd)

MONJUVI is initially administered in combination with lenalidomide. The combination of MONJUVI with lenalidomide is contraindicated in pregnant women because lenalidomide can cause birth defects and death of the unborn child. Refer to the lenalidomide prescribing information on use during pregnancy.

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L-MIND exploratory analysis: ORR by subgroup[1,19]

Subgroup	Characteristics	Number of patients	ORR (%) and 95% CI
All patients (efficacy analysis)		71	55
Age	>70 years ≤70 years	39 32	51 59
IPI	Low risk and low-intermediate risk Intermediate-high and high risk	34 37	62 49
Cell of origin, phenotype	Non-GCB GCB Missing	21 38 12	67 47 58
Ann Arbor stage at baseline	I-II III-IV	16 55	50 56
Elevated LDH	Yes No	40 31	53 58
Rituximab refractory	Yes No	30 40	50 58
Refractory to last line	Yes No	32 39	53 56
Number of prior lines	1 ≥2	35 36	63 47
Prior autologous stem cell transplantation	Yes No	9 62	78 52
Sex	Female Male	32 39	50 59

This analysis is exploratory in nature, and L-MIND was not designed or powered to evaluate and compare multiple subgroups. These results should be interpreted with caution given the small sample size which may lead to estimates that are unstable.

GCB=germinal center B-cell; LDH=lactate dehydrogenase.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions (cont'd)

Adverse Reactions

The most common adverse reactions (≥20%) were neutropenia (51%), fatigue (38%), anemia (36%), diarrhea (36%), thrombocytopenia (31%), cough (26%), pyrexia (24%), peripheral edema (24%), respiratory tract infection (24%), and decreased appetite (22%).

You may report side effects to the FDA at (800) FDA-1088 or www.fda.gov/medwatch.
You may also report side effects to MORPHOSYS US INC. at (844) 667-1992.
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Safety and tolerability[1]

- Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in other clinical trials of another drug and may not reflect the rates observed in practice
- Serious adverse reactions occurred in 52% of patients who received MONJUVI
  - Serious adverse reactions in ≥6% 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 65%
  - 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%), diarrhea (36%), thrombocytopenia (31%), cough (26%), pyrexia (24%), peripheral edema (24%), respiratory tract infection (24%), and decreased appetite (22%)

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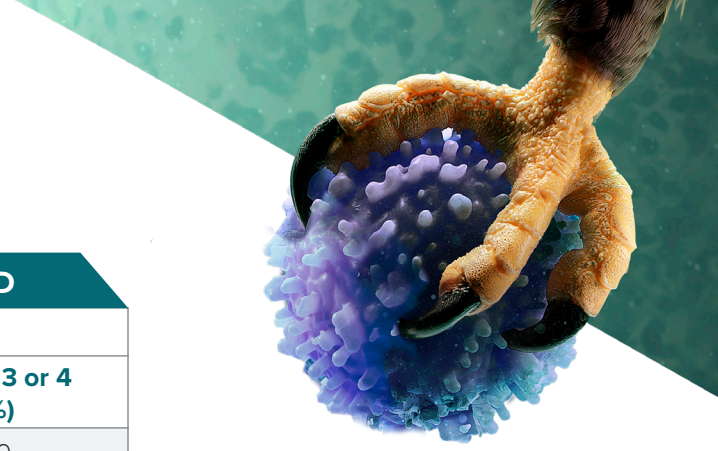
L-MIND: Adverse reactions[1]



Adverse reactions (≥10%) in patients with R/R DLBCL who received MONJUVI in L-MIND

Adverse Reaction		MONJUVI (N=81)	
		All Grades (%)	Grade 3 or 4 (%)
Blood and lymphatic system disorders	Neutropenia	51	49
	Anemia	36	7
	Thrombocytopenia	31	17
	Febrile neutropenia	12	12
General disorders and administration site conditions	Fatigue*	38	3.7
	Pyrexia	24	1.2
	Peripheral edema	24	0
Gastrointestinal disorders	Diarrhea	36	1.2
	Constipation	17	0
	Nausea	15	0
	Vomiting	15	0
Respiratory, thoracic, and mediastinal disorders	Cough	26	1.2
	Dyspnea	12	1.2
Infections	Respiratory tract infection†	24	4.9
	Urinary tract infection‡	17	4.9
	Bronchitis	16	1.2
Metabolism and nutrition disorders	Decreased appetite	22	0
	Hypokalemia	19	6
Musculoskeletal and connective tissue disorders	Back pain	19	2.5
	Muscle spasms	15	0

*Fatigue includes asthenia and fatigue.

†Respiratory tract infection includes: lower respiratory tract infection, upper respiratory tract infection, respiratory tract infection.

‡Urinary tract infection includes: urinary tract infection, Escherichia urinary tract infection, urinary tract infection bacterial, urinary tract infection enterococcal.

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Safety and tolerability (cont'd)[1]

- Clinically relevant adverse reactions in <10% of patients in L-MIND were:
  - Blood and lymphatic system disorders: lymphopenia (6%)
  - General disorders and administration site conditions: IRR (6%)
  - Infections: sepsis (4.9%)
  - Investigations: weight decreased (4.9%)
  - Musculoskeletal and connective tissue disorders: arthralgia (9%), pain in extremity (9%), musculoskeletal pain (2.5%)
  - Neoplasms benign, malignant, and unspecified: basal cell carcinoma (1.2%)
  - Nervous system disorders: headache (9%), paresthesia (7%), dysgeusia (6%)
  - Respiratory, thoracic, and mediastinal disorders: nasal congestion (4.9%), exacerbation of chronic obstructive pulmonary disease (1.2%)
  - Skin and subcutaneous tissue disorders: erythema (4.9%), alopecia (2.5%), hyperhidrosis (2.5%)

IRR=infusion-related reaction.

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L-MIND: Laboratory abnormalities[1]

Select laboratory abnormalities (>20%) worsening from baseline in patients with R/R DLBCL who received MONJUVI in L-MIND

Laboratory Abnormality		MONJUVI*	
		All Grades (%)	Grade 3 or 4 (%)
Chemistry	Glucose increased	49	5
	Calcium decreased	47	1.4
	Gamma glutamyl transferase increased	34	5
	Albumin decreased	26	0
	Magnesium decreased	22	0
	Urate increased	20	7
	Phosphate decreased	20	5
	Creatinine increased	20	1.4
	Aspartate aminotransferase increased	20	0
Coagulation	Activated partial thromboplastin time increased	46	4.1

*The denominator used to calculate the rate was 74 based on the number of patients with a baseline value and at least one post-treatment value.

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Dosage and administration of MONJUVI + lenalidomide

- MONJUVI should be administered by a healthcare professional with immediate access to emergency equipment and appropriate medical support to manage IRRs[1]
- The recommended dose of MONJUVI is 12 mg/kg based on actual body weight administered as an intravenous infusion according to the dosage schedule on the following page[1]
- Administer MONJUVI in combination with lenalidomide 25 mg orally on days 1 to 21 of each 28-day cycle for a maximum of 12 cycles, then continue MONJUVI as monotherapy until disease progression or unacceptable toxicity[1]
- Refer to the lenalidomide prescribing information for lenalidomide dosage recommendations[1]
- Administer MONJUVI as an intravenous infusion[1]
  - For the first infusion, use an infusion rate of 70 mL/h for the first 30 minutes, then increase the rate so that the infusion is administered within 1.5 to 2.5 hours[1]
    - —In the L-MIND study, after the first 30 minutes, the rate of infusion was increased to 125 mL/h over a 2-hour period[14]
  - Administer all subsequent infusions within 1.5 to 2 hours[1]
  - In the L-MIND study, vital signs were measured immediately prior to infusion, at 15 minutes (+/- 5 minutes), 30 minutes (+/- 10 minutes), every 60 minutes (+/- 15 minutes), and at the end of the infusion (+/- 20 minutes)[14]

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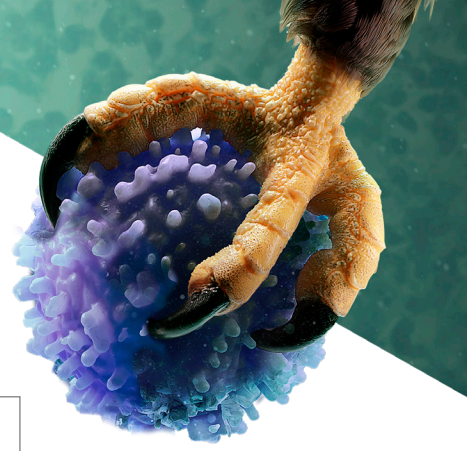
Dosage and administration of MONJUVI + lenalidomide (cont'd)



The cycle length for MONJUVI is 28 days[1]

Cycle 1

DAYS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
MONJUVI 12 mg/kg	■			■				■							■							■						
Lenalidomide 25 mg daily	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●							

Cycles 2 and 3

DAYS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
MONJUVI 12 mg/kg	■							■							■							■						
Lenalidomide 25 mg daily	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●							

Cycles 4 to 12

DAYS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
MONJUVI 12 mg/kg	■														■													
Lenalidomide 25 mg daily	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●							

After 12 cycles, continue MONJUVI monotherapy until disease progression or unacceptable toxicity

DAYS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
MONJUVI 12 mg/kg	■														■													

- 45.7% of patients (37/81) had at least one dose reduction of lenalidomide[20]
- 77.5% of patients (62/81) were able to receive a lenalidomide dose of ≥20 mg/day over the duration of their treatment[20]

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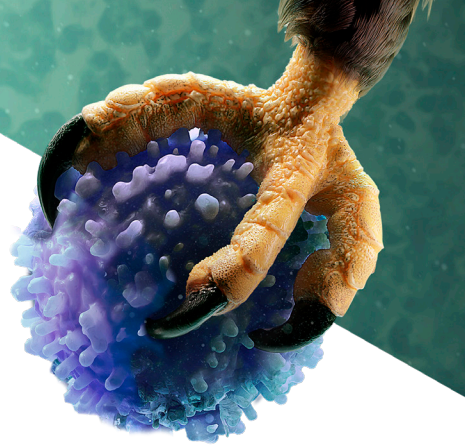
Recommended premedications[1]



Administer premedications 30 minutes to 2 hours prior to starting MONJUVI infusion to minimize IRRs. Premedications may include acetaminophen, histamine H_1 receptor antagonists, histamine H_2 receptor antagonists, and/or glucocorticosteroids.

For patients not experiencing IRRs during the first 3 infusions, premedication is optional for subsequent infusions.

If a patient experiences an IRR, administer premedications before each subsequent infusion.

For details on dosage modifications and management of adverse reactions for IRRs and myelosuppression, please refer to the full Prescribing Information.

For more information about the storage and handling of MONJUVI and how MONJUVI is supplied, please refer to the full Prescribing Information.

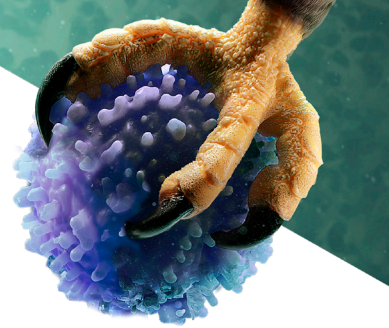
MONJUVI is the only CD19-targeted therapy administered in your office or clinic[1]

REFERENCES: 1. MONJUVI Prescribing Information. Boston, MA: MorphoSys. **2.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for B-Cell Lymphomas V.4.2020. © National Comprehensive Cancer Network, Inc. 2020. All rights reserved. Accessed August 24, 2020. To view the most recent and complete version of the guideline, go online to NCCN.org. **3.** Rovira J, Valera A, Colomo L, et al. Prognosis of patients with diffuse large B cell lymphoma not reaching complete response or relapsing after frontline chemotherapy or immunochemotherapy. *Ann Hematol*. 2015;94:803-812. **4.** Morrison VA, Shou Y, Bell JA, et al. Evaluation of treatment patterns and survival among patients with diffuse large B-cell lymphoma in the USA. *Future Oncol*. 2019;15(9):1021-1034. **5.** Crump M, Neelapu SS, Farooq U, et al. Outcomes in refractory diffuse large B-cell lymphoma: results from the international SCHOLAR-1 study. *Blood*. 2017;130(16):1800-1808. **6.** Friedberg JW. Relapsed/refractory diffuse large B-cell lymphoma. *Hematology Am Soc Hematol Educ Program*. 2011;2011:498-505. **7.** Gisselbrecht C, Glass B, Mounier N, et al. Salvage regimens with autologous transplantation for relapsed large B-cell lymphoma in the rituximab era. *J Clin Oncol*. 2010;28:4184-4190. **8.** Coiffier B, Radford J, Bosly A, et al. A multicentre, phase II trial of ofatumumab monotherapy in relapsed/progressive diffuse large B-cell lymphoma. *Br J Haematol*. 2013;163:334-342. **9.** Morschhauser FA, Cartron G, Thieblemont C, et al. Obinutuzumab (GA101) monotherapy in relapsed/refractory diffuse large B-cell lymphoma or mantle-cell lymphoma: results from the phase II GAUGUIN Study. *J Clin Oncol*. 2013;31:2912-2919. **10.** Hiraga J, Tomita A, Sugimoto T, et al. Down-regulation of CD20 expression in B-cell lymphoma cells after treatment with rituximab-containing combination chemotherapies: its prevalence and clinical significance. *Blood*. 2009;113(20):4885-4893. **11.** Katchi T, Liu D. Diagnosis and treatment of CD20 negative B cell lymphomas. *Biomark Res*. 2017;5(5). doi:/10.1186/s40364-017-0088-5. **12.** Davis TA, Czerwinski DK, Levy R. Therapy of B-cell lymphoma with anti-CD20 antibodies can result in the loss of CD20 antigen expression. *Clin Cancer Res*. 1999;5(3):611-615. **13.** Johnson NA, Boyle M, Bashashati A, et al. Diffuse large B-cell lymphoma: reduced CD20 expression is associated with an inferior survival. *Blood*. 2009;113(16):3773-3780. **14.** Salles G, Duell J, González Barca E, et al. Tafasitamab plus lenalidomide in relapsed or refractory diffuse large B-cell lymphoma (L-MIND): a multicentre, prospective, single-arm, phase 2 study. *Lancet Oncol*. 2020;21(7):978-988. doi:/10.1016/S1470-2045(20)30225-4. **15.** Raufi A, Ebrahim AS, Al-Katib A. Targeting CD19 in B-cell lymphoma: emerging role of SAR3419. *Cancer Manag Res*. 2013;5:225-233. **16.** Hammer O. CD19 as an attractive target for antibody-based therapy. *mAbs*. 2012;4(5):571-577. **17.** ClinicalTrials.gov. A study to evaluate the safety and efficacy of lenalidomide with MOR00208 in patients with R-R DLBCL (L-MIND). https://clinicaltrials.gov/ct2/show/NCT02399085?term=l-mind&draw=2&rank=1. Accessed April 24, 2020. **18.** Data on file. Primary analysis ad hoc tables. MorphoSys. Boston, MA. **19.** Data on file. Ad hoc analysis. MorphoSys. Boston, MA. **20.** Data on file. CSR. MorphoSys. Boston, MA.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information.

MONJUVI®
tafasitamab-cxix | 200 mg
for injection, for intravenous use

SECURE RESPONSE IN SECOND LINE[1]



MONJUVI is the first and only FDA-approved treatment for adult patients with DLBCL who have received at least 1 prior therapy, in combination with lenalidomide[1]

INDICATIONS & USAGE

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).

OVERALL RESPONSE

(N=71)*

- **55% ORR**
  (n=39; 95% CI: 43%, 67%)
- **37% achieved a CR**
- **18% achieved a PR**

DURATION OF RESPONSE

(N=71)*

- Median DoR: **21.7 months**
  (range: 0, 24)†

ACCESSIBILITY

- MONJUVI is administered **in your office or clinic** as a 1.5- to 2-hour infusion
- For the first infusion, use an infusion rate of 70 mL/h for the first 30 minutes, then, increase the rate so that the infusion is administered within 1.5 to 2.5 hours

SELECT SAFETY INFORMATION

MONJUVI can cause serious adverse reactions including:

- **Infusion-Related Reactions:** Monitor patients frequently during infusion. Interrupt or discontinue infusion based on severity
- **Myelosuppression:** Monitor complete blood counts. Manage using dose modifications and growth factor support. Interrupt or discontinue MONJUVI based on severity
- **Infections:** Bacterial, fungal, and viral infections can occur during and following MONJUVI. Monitor patients for infections
- **Embryo-Fetal Toxicity:** May cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and use of effective contraception

Please see related and other Important Safety Information discussed throughout this brochure.

L-MIND: An open-label, multicenter, single-arm study in adult patients with R/R DLBCL.

*Assessed by an Independent Review Committee.

†Kaplan-Meier estimates.

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) recommend
tafasitamab-cxix (MONJUVI) in combination with lenalidomide as a second-line or subsequent therapy option for DLBCL in patients who are not candidates for transplant.[2‡]

‡It is unclear if tafasitamab will have a negative impact on the efficacy of subsequent anti-CD19 CAR T-cell therapy.

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▶ To learn more, visit MonjuviHCP.com

▶ For information about patient assistance, visit MyMissionSupport.com

Please see the full Prescribing Information for additional Important Safety Information.

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tafasitamab-cxix | 200 mg
for injection, for intravenous use