

Press Release

Astellas Presents New Data that Explores Potential of its Cancer Therapies at 2025 ASCO Annual Meeting

16 abstracts, including two oral presentations, feature new clinical data from Astellas' oncology portfolio

TOKYO, May 19, 2025 – Astellas Pharma Inc. (TSE: 4503, President and CEO: Naoki Okamura, “Astellas”) will present 16 abstracts featuring new data across its approved cancer therapies at the 2025 American Society of Clinical Oncology (ASCO) Annual Meeting (May 30 - June 3). The research underscores Astellas' dedication as a pioneer in oncology and focus on clinical outcomes that matter to patients.

The abstracts include new post hoc analyses of long-term overall survival (OS) data for XTANDI (enzalutamide) and two analyses for PADCEV (enfortumab vedotin), which demonstrate how these standard-of-care medicines can continue to treat patients in metastatic, non-metastatic, castration-resistant, or hormone-sensitive prostate cancer patients and unresectable, locally advanced or metastatic urothelial cancer patients, respectively.

Moitreyee Chatterjee-Kishore, Ph.D., M.B.A., Head of Oncology Development, Astellas

“At Astellas, we are dedicated to transforming cancer care through innovative treatment approaches. The data we will present at ASCO this year, including new long-term follow-up data for advanced prostate and bladder cancers, reflect the pioneering role we continue to play in delivering outcomes that matter to patients. We continue to push the boundaries of cancer treatment with our growing pipeline, using novel modalities and precision medicine approaches, to benefit all eligible patients now and in the future.”

Highlights from Astellas at the 2025 ASCO Annual Meeting will include a strong focus on Overall Survival (OS) data updates, confirming the value that these therapies bring to patients:

Enzalutamide:

- The ARCHES five-year follow-up OS analysis of enzalutamide plus androgen-deprivation therapy (ADT) in patients with metastatic hormone-sensitive prostate cancer (mHSPC) will be featured in an oral presentation

In addition to the ARCHES five-year follow-up presentation, Astellas is supporting investigator-sponsored studies. Eight-year data assessing outcomes of enzalutamide vs non-steroidal anti-androgen (NSAA) in mHSPC will be presented from an independent, investigator-sponsored trial (ENZAMET) led by the Australian and New Zealand Urogenital and Prostate Cancer Trials Group (ANZUP).

Enfortumab vedotin

Urothelial carcinoma

- Two analyses of the phase 3 EV-302 study of enfortumab vedotin in combination with pembrolizumab vs chemotherapy in previously untreated locally advanced or metastatic urothelial carcinoma (la/mUC)
 - Exploratory analysis of responders will be presented in an oral presentation
 - Poster presentation featuring long-term subgroup analysis

Bladder cancer

- A systematic review and meta-analysis of surrogate endpoints in muscle-invasive bladder cancer trials will be featured in a poster presentation.

Shontelle Dodson, Executive Vice President, Head of Medical Affairs, Astellas

“Long-term overall survival is the gold standard endpoint in cancer research. New post hoc analysis data from the ARCHES enzalutamide trial demonstrates our mission to help patients live longer, healthier lives. We are committed to maximizing the impact of our therapies as we continue to pioneer the oncology medicines of tomorrow.”

Astellas Presentations at 2025 ASCO Annual Meeting

Enzalutamide

Presentation Title	Lead Author	Presentation Details
ARCHES 5-year follow-up overall survival analysis of enzalutamide plus androgen deprivation therapy in patients with metastatic hormone-sensitive prostate cancer	A. Armstrong	Type: Oral Presentation Abstract Number: 5005 Date: June 3, 2025, 9:45am – 12:45pm CDT
Cardiovascular event risk in patients with metastatic castration-resistant prostate cancer treated with enzalutamide or abiraterone acetate in the United States	A. Bryce	Type: Poster Presentation Abstract Number: 5041 Date: June 2, 2025, 9:00am – 12:00pm CDT
Secondary outcomes by prior definitive treatment in patients with high-risk biochemically recurrent prostate cancer treated with enzalutamide monotherapy: EMBARK post hoc analysis	S. Freedland	Type: Poster Presentation Abstract Number: 5103 Date: June 2, 2025, 9:00am – 12:00pm CDT

How low do you need to go? Association between various prostate-specific antigen response measures and clinical outcomes in metastatic castration-sensitive prostate cancer in the Veteran Health Administration data	S. Freedland	Type: Poster Presentation Abstract Number: 5092 Date: June 2, 2025, 9:00am – 12:00pm CDT
Abiraterone acetate is associated with shorter overall survival than enzalutamide in patients with chemotherapy naïve metastatic castration-resistant prostate cancer: Real world data from the Flatiron electronic health records database	D. George	Type: E-Publication Only Abstract Number for Publication: e17033
Secondary outcomes by prior definitive treatment in patients with high-risk biochemically recurrent prostate cancer (treated with enzalutamide plus leuprolide (combo): EMBARK post hoc analysis	N. Shore	Type: E-Publication Only Abstract Number for Publication: e17127
Corticosteroid Use and Risk of Adverse Events in Patients Treated for Metastatic Hormone-Sensitive Prostate Cancer	U. Swami	Type: E-Publication Only Abstract Number for Publication: e17097

Enfortumab vedotin

Presentation Title	Lead Author	Presentation Details
EV-302: Long-term subgroup analysis from the phase 3 global study of enfortumab vedotin in combination with pembrolizumab vs chemotherapy in previously untreated locally advanced or metastatic urothelial carcinoma	J. Bedke	Type: Poster Presentation Abstract Number: 4571 Date: June 2, 2025, 9:00am – 12:00pm CDT
Exploratory analysis of responders from the phase 3 EV-302 trial of enfortumab vedotin plus pembrolizumab vs chemotherapy (chemo) in previously untreated	S. Gupta	Type: Oral Presentation Abstract Number: 4502

locally advanced or metastatic urothelial carcinoma		Date: June 1, 2025, 9:45am – 12:45pm CDT
Evaluation of surrogate endpoints in muscle-invasive bladder cancer: A systematic review and meta-analysis	M. Galsky	Type: Poster Presentation Abstract Number: 4580 Date: June 2, 2025, 9:00am – 12:00pm CDT
Study EV-103 Cohort H: Neoadjuvant treatment with enfortumab vedotin monotherapy in cisplatin-ineligible patients with muscle-invasive bladder cancer: 3-year efficacy results	N. Mar	Type: Poster Presentation Abstract Number: 4583 Date: June 2, 2025, 9:00am – 12:00pm CDT
Recent trends in US real-world first-line treatment patterns for patients with locally advanced or metastatic urothelial carcinoma	G. Sonpavde	Type: E-Publication Only Abstract Number for Publication: e16556
Patient and clinician expert perspectives on the impactful symptoms of head and neck squamous cell carcinoma and its treatment	E. Theodorou	Type: E-Publication Only Abstract Number for Publication: e18001

Zolbetuximab

Presentation Title	Lead Author	Presentation Details
A real-world study on epidemiology, biomarker test results, clinical characteristics, and treatment patterns of unresectable locally advanced or metastatic gastric and gastroesophageal junction adenocarcinoma in China	Y. Chen	Type: E-Publication Only Abstract Number for Publication: e16013

Gilteritinib

Presentation Title	Lead Author	Presentation Details
Real-world adherence and tolerability of FLT3 inhibitors s post-allogeneic transplant maintenance therapy in	V. Kennedy	Type: E-Publication Only

older adults with AML: A Medicare claims cohort study		Abstract Number: e18505
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Pipeline

Presentation Title	Lead Author	Presentation Details
Trial in progress: Phase 1 study of the selective protein degrader ASP4396 in patients with locally advanced or metastatic solid tumors with KRAS G12D mutation	Shiraj Sen	Type: Poster Presentation Abstract Number: TPS3178 Date: June 2, 2025, 1:30 – 4:30pm CDT

About Astellas

Astellas is a global life sciences company committed to turning innovative science into VALUE for patients. We provide transformative therapies in disease areas that include oncology, ophthalmology, urology, immunology and women's health. Through our research and development programs, we are pioneering new healthcare solutions for diseases with high unmet medical need. Learn more at www.astellas.com.

About PADCEV and the Astellas, Pfizer and Merck Collaboration

Astellas and Pfizer have a clinical collaboration agreement with Merck to evaluate the combination of Astellas' and Pfizer's PADCEV (enfortumab vedotin) and Merck's KEYTRUDA (pembrolizumab) in patients with previously untreated metastatic urothelial cancer. KEYTRUDA is a registered trademark of Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Rahway, NJ, USA (known as MSD outside of the United States and Canada).

About XTANDI and the Pfizer/Astellas Collaboration

In October 2009, Medivation, Inc., which is now part of Pfizer (NYSE:PFE), and Astellas (TSE: 4503) entered into a commercial agreement to jointly develop and commercialize XTANDI® (enzalutamide) in the United States, while Astellas has responsibility for manufacturing and all additional regulatory filings globally, as well as commercializing the product outside the United States. Pfizer receives alliance revenues as a share of U.S. profits and receives royalties on sales outside the U.S.

XTANDI Important Safety Information

Warnings and Precautions

Seizure occurred in 0.6% of patients receiving XTANDI in eight randomized clinical trials. In a study of patients with predisposing factors for seizure, 2.2% of XTANDI-treated patients experienced a seizure. It is unknown whether anti-epileptic medications will prevent seizures with XTANDI. Patients in the study had one or more of the following predisposing factors: use of medications that may lower the seizure threshold, history of traumatic brain or head injury, history of cerebrovascular accident or transient ischemic attack, and Alzheimer's disease, meningioma, or leptomeningeal disease from prostate cancer, unexplained loss of consciousness within the last 12 months, history of seizure, presence of a space occupying lesion of the brain, history of arteriovenous malformation, or history of brain infection. Advise patients of the risk of developing a seizure while taking XTANDI and of engaging in any activity where

sudden loss of consciousness could cause serious harm to themselves or others. Permanently discontinue XTANDI in patients who develop a seizure during treatment.

Posterior Reversible Encephalopathy Syndrome (PRES) There have been reports of PRES in patients receiving XTANDI. PRES is a neurological disorder that can present with rapidly evolving symptoms including seizure, headache, lethargy, confusion, blindness, and other visual and neurological disturbances, with or without associated hypertension. A diagnosis of PRES requires confirmation by brain imaging, preferably MRI. Discontinue XTANDI in patients who develop PRES.

Hypersensitivity reactions, including edema of the face (0.5%), tongue (0.1%), or lip (0.1%) have been observed with XTANDI in eight randomized clinical trials. Pharyngeal edema has been reported in post-marketing cases. Advise patients who experience any symptoms of hypersensitivity to temporarily discontinue XTANDI and promptly seek medical care. Permanently discontinue XTANDI for serious hypersensitivity reactions.

Ischemic Heart Disease In the combined data of five randomized, placebo-controlled clinical studies, ischemic heart disease occurred more commonly in patients on the XTANDI arm compared to patients on the placebo arm (3.5% vs 2%). Grade 3-4 ischemic events occurred in 1.8% of patients on XTANDI versus 1.1% on placebo. Ischemic events led to death in 0.4% of patients on XTANDI compared to 0.1% on placebo. Monitor for signs and symptoms of ischemic heart disease. Optimize management of cardiovascular risk factors, such as hypertension, diabetes, or dyslipidemia. Discontinue XTANDI for Grade 3-4 ischemic heart disease.

Falls and Fractures occurred in patients receiving XTANDI. Evaluate patients for fracture and fall risk. Monitor and manage patients at risk for fractures according to established treatment guidelines and consider use of bone-targeted agents. In the combined data of five randomized, placebo-controlled clinical studies, falls occurred in 12% of patients treated with XTANDI compared to 6% of patients treated with placebo. Fractures occurred in 13% of patients treated with XTANDI and in 6% of patients treated with placebo.

Embryo-Fetal Toxicity The safety and efficacy of XTANDI have not been established in females. XTANDI can cause fetal harm and loss of pregnancy when administered to a pregnant female. Advise males with female partners of reproductive potential to use effective contraception during treatment with XTANDI and for 3 months after the last dose of XTANDI.

Dysphagia or Choking Severe dysphagia or choking, including events that could be life-threatening requiring medical intervention or fatal, can occur due to XTANDI product size. Advise patients to take each capsule or tablet whole with a sufficient amount of water to ensure that all medication is successfully swallowed. Consider use of a smaller tablet size of XTANDI in patients who have difficulty swallowing. Discontinue XTANDI for patients who cannot swallow capsules or tablets.

Adverse Reactions (ARs)

In the data from the five randomized placebo-controlled trials, the most common ARs ($\geq 10\%$) that occurred more frequently ($\geq 2\%$ over placebo) in XTANDI-treated patients were musculoskeletal pain, fatigue, hot flush, constipation, decreased appetite, diarrhea, hypertension, hemorrhage, fall, fracture, and headache. In the bicalutamide-controlled study, the most common ARs ($\geq 10\%$) reported in XTANDI-treated patients were asthenia/fatigue, back pain, musculoskeletal pain, hot flush, hypertension, nausea, constipation, diarrhea, upper respiratory tract infection, and weight loss.

In AFFIRM, the placebo-controlled study of metastatic CRPC (mCRPC) patients who previously received docetaxel, Grade 3 and higher ARs were reported among 47% of XTANDI-treated patients.

Discontinuations due to ARs were reported for 16% of XTANDI-treated patients. In PREVAIL, the placebo-controlled study of chemotherapy-naïve mCRPC patients, Grade 3-4 ARs were reported in 44% of XTANDI patients and 37% of placebo patients. Discontinuations due to ARs were reported for 6% of XTANDI-treated patients. In TERRAIN, the bicalutamide-controlled study of chemotherapy-naïve mCRPC patients, Grade 3-4 ARs were reported in 39% of XTANDI patients and 38% of bicalutamide patients. Discontinuations with an AR as the primary reason were reported for 8% of XTANDI patients and 6% of bicalutamide patients.

In PROSPER, the placebo-controlled study of nonmetastatic CRPC (nmCRPC) patients, Grade 3 or higher ARs were reported in 31% of XTANDI patients and 23% of placebo patients.

Discontinuations with an AR as the primary reason were reported for 9% of XTANDI patients and 6% of placebo patients.

In ARCHES, the placebo-controlled study of metastatic CSPC (mCSPC) patients, Grade 3 or higher ARs were reported in 24% of XTANDI-treated patients. Permanent discontinuation due to ARs as the primary reason was reported in 5% of XTANDI patients and 4% of placebo patients.

In EMBARK, the placebo-controlled study of nonmetastatic CSPC (nmCSPC) with high-risk biochemical recurrence (BCR) patients, Grade 3 or higher adverse reactions during the total duration of treatment were reported in 46% of patients treated with XTANDI plus leuprolide, 50% of patients receiving XTANDI as a single agent, and 43% of patients receiving placebo plus leuprolide. Permanent treatment discontinuation due to adverse reactions during the total duration of treatment as the primary reason was reported in 21% of patients treated with XTANDI plus leuprolide, 18% of patients receiving XTANDI as a single agent, and 10% of patients receiving placebo plus leuprolide.

Lab Abnormalities: Lab abnormalities that occurred in $\geq 5\%$ of patients, and more frequently ($> 2\%$) in the XTANDI arm compared to placebo in the pooled, randomized, placebo-controlled studies are hemoglobin decrease, neutrophil count decreased, white blood cell decreased, hyperglycemia, hypermagnesemia, hyponatremia, hypophosphatemia, and hypercalcemia.

Hypertension: In the combined data from five randomized placebo-controlled clinical trials, hypertension was reported in 14% of XTANDI patients and 7% of placebo patients. Hypertension led to study discontinuation in $< 1\%$ of patients in each arm.

Drug Interactions

Effect of Other Drugs on XTANDI Avoid coadministration with strong CYP2C8 inhibitors. If coadministration cannot be avoided, reduce the dosage of XTANDI.

Avoid coadministration with strong CYP3A4 inducers. If coadministration cannot be avoided, increase the dosage of XTANDI.

Effect of XTANDI on Other Drugs Avoid coadministration with certain CYP3A4, CYP2C9, and CYP2C19 substrates for which minimal decrease in concentration may lead to therapeutic failure of the substrate. If coadministration cannot be avoided, increase the dosage of these substrates in accordance with their Prescribing Information. In cases where active metabolites are formed, there may be increased exposure to the active metabolites.

Full Prescribing Information

PADCEV Important Safety Information

Warnings and Precautions

Skin reactions Severe cutaneous adverse reactions, including fatal cases of SJS or TEN occurred in patients treated with PADCEV. SJS and TEN occurred predominantly during the first cycle of treatment but may occur later. Skin reactions occurred in 70% (all grades) of the 564 patients treated with PADCEV in combination with pembrolizumab in clinical trials. When PADCEV was given in combination with pembrolizumab, the incidence of skin reactions, including severe events, occurred at a higher rate compared to PADCEV as a single agent. The majority of the skin reactions that occurred with combination therapy included maculo-papular rash, macular rash and papular rash. Grade 3-4 skin reactions occurred in 17% of patients (Grade 3: 16%, Grade 4: 1%), including maculo-papular rash, bullous dermatitis, dermatitis, exfoliative dermatitis, pemphigoid, rash, erythematous rash, macular rash, and papular rash. A fatal reaction of bullous dermatitis occurred in one patient (0.2%). The median time to onset of severe skin reactions was 1.7 months (range: 0.1 to 17.2 months). Skin reactions led to discontinuation of PADCEV in 6% of patients.

Skin reactions occurred in 58% (all grades) of the 720 patients treated with PADCEV as a single agent in clinical trials. Twenty-three percent (23%) of patients had maculo-papular rash and 34% had pruritus. Grade 3-4 skin reactions occurred in 14% of patients, including maculo-papular rash, erythematous rash,

rash or drug eruption, symmetrical drug-related intertriginous and flexural exanthema (SDRIFE), bullous dermatitis, exfoliative dermatitis, and palmar-plantar erythrodysesthesia. The median time to onset of severe skin reactions was 0.6 months (range: 0.1 to 8 months). Among patients experiencing a skin reaction leading to dose interruption who then restarted PADCEV (n=75), 24% of patients restarting at the same dose and 24% of patients restarting at a reduced dose experienced recurrent severe skin reactions. Skin reactions led to discontinuation of PADCEV in 3.1% of patients.

Monitor patients closely throughout treatment for skin reactions. Consider topical corticosteroids and antihistamines, as clinically indicated. For persistent or recurrent Grade 2 skin reactions, consider withholding PADCEV until Grade ≤ 1 . Withhold PADCEV and refer for specialized care for suspected SJS, TEN or for Grade 3 skin reactions. Permanently discontinue PADCEV in patients with confirmed SJS or TEN; or Grade 4 or recurrent Grade 3 skin reactions.

Hyperglycemia and diabetic ketoacidosis (DKA), including fatal events, occurred in patients with and without pre-existing diabetes mellitus, treated with PADCEV. Patients with baseline hemoglobin A1C $\geq 8\%$ were excluded from clinical trials. In clinical trials of PADCEV as a single agent, 17% of the 720 patients treated with PADCEV developed hyperglycemia of any grade; 7% of patients developed Grade 3-4 hyperglycemia (Grade 3: 6.5%, Grade 4: 0.6%). Fatal events of hyperglycemia and DKA occurred in one patient each (0.1%). The incidence of Grade 3-4 hyperglycemia increased consistently in patients with higher body mass index and in patients with higher baseline A1C. The median time to onset of hyperglycemia was 0.5 months (range: 0 to 20 months). Hyperglycemia led to discontinuation of PADCEV in 0.7% of patients. Five percent (5%) of patients required initiation of insulin therapy for treatment of hyperglycemia. Of the patients who initiated insulin therapy for treatment of hyperglycemia, 66% (23/35) discontinued insulin at the time of last evaluation. Closely monitor blood glucose levels in patients with, or at risk for, diabetes mellitus or hyperglycemia. If blood glucose is elevated (>250 mg/dL), withhold PADCEV.

Pneumonitis/Interstitial Lung Disease (ILD) Severe, life-threatening or fatal pneumonitis/ILD occurred in patients treated with PADCEV. When PADCEV was given in combination with pembrolizumab, 10% of the 564 patients treated with combination therapy had pneumonitis/ILD of any grade and 4% had Grade 3-4. A fatal event of pneumonitis/ILD occurred in two patients (0.4%). The incidence of pneumonitis/ILD, including severe events, occurred at a higher rate when PADCEV was given in combination with pembrolizumab compared to PADCEV as a single agent. The median time to onset of any grade pneumonitis/ILD was 4 months (range: 0.3 to 26 months).

In clinical trials of PADCEV as a single agent, 3% of the 720 patients treated with PADCEV had pneumonitis/ILD of any grade and 0.8% had Grade 3-4. The median time to onset of any grade pneumonitis/ILD was 2.9 months (range: 0.6 to 6 months).

Monitor patients for signs and symptoms indicative of pneumonitis/ILD such as hypoxia, cough, dyspnea or interstitial infiltrates on radiologic exams. Evaluate and exclude infectious, neoplastic and other causes for such signs and symptoms through appropriate investigations. Withhold PADCEV for patients who develop Grade 2 pneumonitis/ILD and consider dose reduction. Permanently discontinue PADCEV in all patients with Grade 3 or 4 pneumonitis/ILD.

Peripheral neuropathy (PN) When PADCEV was given in combination with pembrolizumab, 67% of the 564 patients treated with combination therapy had PN of any grade, 36% had Grade 2 neuropathy, and 7% had Grade 3 neuropathy. The incidence of PN occurred at a higher rate when PADCEV was given in combination with pembrolizumab compared to PADCEV as a single agent. The median time to onset of Grade ≥ 2 PN was 6 months (range: 0.3 to 25 months).

PN occurred in 53% of the 720 patients treated with PADCEV as a single agent in clinical trials including 38% with sensory neuropathy, 8% with muscular weakness and 7% with motor neuropathy. Thirty percent of patients experienced Grade 2 reactions and 5% experienced Grade 3-4 reactions. PN occurred in patients treated with PADCEV with or without preexisting PN. The median time to onset of Grade ≥ 2 PN was 4.9 months (range: 0.1 to 20 months). Neuropathy led to treatment discontinuation in 6% of patients. Monitor patients for symptoms of new or worsening PN and consider dose interruption or dose reduction of PADCEV when PN occurs. Permanently discontinue PADCEV in patients who develop Grade ≥ 3 PN.

Ocular disorders were reported in 40% of the 384 patients treated with PADCEV as a single agent in clinical trials in which ophthalmologic exams were scheduled. The majority of these events involved the cornea and included events associated with dry eye such as keratitis, blurred vision, increased lacrimation, conjunctivitis, limbal stem cell deficiency, and keratopathy. Dry eye symptoms occurred in 30% of patients, and blurred vision occurred in 10% of patients, during treatment with PADCEV. The median time to onset to symptomatic ocular disorder was 1.7 months (range: 0 to 30.6 months). Monitor patients for ocular disorders. Consider artificial tears for prophylaxis of dry eyes and ophthalmologic evaluation if ocular symptoms occur or do not resolve. Consider treatment with ophthalmic topical steroids, if indicated after an ophthalmic exam. Consider dose interruption or dose reduction of PADCEV for symptomatic ocular disorders.

Infusion site extravasation Skin and soft tissue reactions secondary to extravasation have been observed after administration of PADCEV. Of the 720 patients treated with PADCEV as a single agent in clinical trials, 1% of patients experienced skin and soft tissue reactions, including 0.3% who experienced Grade 3-4 reactions. Reactions may be delayed. Erythema, swelling, increased temperature, and pain worsened until 2-7 days after extravasation and resolved within 1-4 weeks of peak. Two patients (0.3%) developed extravasation reactions with secondary cellulitis, bullae, or exfoliation. Ensure adequate venous access prior to starting PADCEV and monitor for possible extravasation during administration. If extravasation occurs, stop the infusion and monitor for adverse reactions.

Embryo-fetal toxicity PADCEV can cause fetal harm when administered to a pregnant woman. Advise patients of the potential risk to the fetus. Advise female patients of reproductive potential to use effective contraception during PADCEV treatment and for 2 months after the last dose. Advise male patients with female partners of reproductive potential to use effective contraception during treatment with PADCEV and for 4 months after the last dose.

ADVERSE REACTIONS

Most common adverse reactions, including laboratory abnormalities (≥20%) (PADCEV in combination with pembrolizumab)

Increased aspartate aminotransferase (AST), increased creatinine, rash, increased glucose, PN, increased lipase, decreased lymphocytes, increased alanine aminotransferase (ALT), decreased hemoglobin, fatigue, decreased sodium, decreased phosphate, decreased albumin, pruritus, diarrhea, alopecia, decreased weight, decreased appetite, increased urate, decreased neutrophils, decreased potassium, dry eye, nausea, constipation, increased potassium, dysgeusia, urinary tract infection and decreased platelets.

Most common adverse reactions, including laboratory abnormalities (≥20%) (PADCEV monotherapy)

Increased glucose, increased AST, decreased lymphocytes, increased creatinine, rash, fatigue, PN, decreased albumin, decreased hemoglobin, alopecia, decreased appetite, decreased neutrophils, decreased sodium, increased ALT, decreased phosphate, diarrhea, nausea, pruritus, increased urate, dry eye, dysgeusia, constipation, increased lipase, decreased weight, decreased platelets, abdominal pain, dry skin.

EV-302 Study: 440 patients with previously untreated la/mUC (PADCEV in combination with pembrolizumab)

Serious adverse reactions occurred in 50% of patients treated with PADCEV in combination with pembrolizumab. The most common serious adverse reactions (≥2%) were rash (6%), acute kidney injury (5%), pneumonitis/ILD (4.5%), urinary tract infection (3.6%), diarrhea (3.2%), pneumonia (2.3%), pyrexia (2%), and hyperglycemia (2%). **Fatal adverse reactions** occurred in 3.9% of patients treated with PADCEV in combination with pembrolizumab including acute respiratory failure (0.7%), pneumonia (0.5%), and pneumonitis/ILD (0.2%).

Adverse reactions leading to discontinuation of PADCEV occurred in 35% of patients. **The most common adverse reactions (≥2%) leading to discontinuation** of PADCEV were PN (15%), rash (4.1%) and pneumonitis/ILD (2.3%). Adverse reactions leading to dose interruption of PADCEV occurred in 73% of patients. **The most common adverse reactions (≥2%) leading to dose interruption** of PADCEV were

PN (22%), rash (16%), COVID-19 (10%), diarrhea (5%), pneumonitis/ILD (4.8%), fatigue (3.9%), hyperglycemia (3.6%), increased ALT (3%) and pruritus (2.5%). Adverse reactions leading to dose reduction of PADCEV occurred in 42% of patients. **The most common adverse reactions (≥2%) leading to dose reduction** of PADCEV were rash (16%), PN (13%) and fatigue (2.7%).

EV-103 Study: 121 patients with previously untreated la/mUC who were not eligible for cisplatin-containing chemotherapy (PADCEV in combination with pembrolizumab)

Serious adverse reactions occurred in 50% of patients treated with PADCEV in combination with pembrolizumab; the most common (≥2%) were acute kidney injury (7%), urinary tract infection (7%), urosepsis (5%), sepsis (3.3%), pneumonia (3.3%), hematuria (3.3%), pneumonitis/ILD (3.3%), urinary retention (2.5%), diarrhea (2.5%), myasthenia gravis (2.5%), myositis (2.5%), anemia (2.5%), and hypotension (2.5%). **Fatal adverse reactions** occurred in 5% of patients treated with PADCEV in combination with pembrolizumab, including sepsis (1.6%), bullous dermatitis (0.8%), myasthenia gravis (0.8%), and pneumonitis/ILD (0.8%). **Adverse reactions leading to discontinuation** of PADCEV occurred in 36% of patients; the most common (≥2%) were PN (20%) and rash (6%). **Adverse reactions leading to dose interruption** of PADCEV occurred in 69% of patients; the most common (≥2%) were PN (18%), rash (12%), increased lipase (6%), pneumonitis/ILD (6%), diarrhea (4.1%), acute kidney injury (3.3%), increased ALT (3.3%), fatigue (3.3%), neutropenia (3.3%), urinary tract infection (3.3%), increased amylase (2.5%), anemia (2.5%), COVID-19 (2.5%), hyperglycemia (2.5%), and hypotension (2.5%). **Adverse reactions leading to dose reduction** of PADCEV occurred in 45% of patients; the most common (≥2%) were PN (17%), rash (12%), fatigue (5%), neutropenia (5%), and diarrhea (4.1%).

EV-301 Study: 296 patients previously treated with a PD-1/L1 inhibitor and platinum-based chemotherapy (PADCEV monotherapy)

Serious adverse reactions occurred in 47% of patients treated with PADCEV; the most common (≥2%) were urinary tract infection, acute kidney injury (7% each), and pneumonia (5%). **Fatal adverse reactions** occurred in 3% of patients, including multiorgan dysfunction (1%), hepatic dysfunction, septic shock, hyperglycemia, pneumonitis/ILD, and pelvic abscess (0.3% each). **Adverse reactions leading to discontinuation** occurred in 17% of patients; the most common (≥2%) were PN (5%) and rash (4%). **Adverse reactions leading to dose interruption** occurred in 61% of patients; the most common (≥4%) were PN (23%), rash (11%), and fatigue (9%). **Adverse reactions leading to dose reduction** occurred in 34% of patients; the most common (≥2%) were PN (10%), rash (8%), decreased appetite, and fatigue (3% each).

EV-201, Cohort 2 Study: 89 patients previously treated with a PD-1/L1 inhibitor and not eligible for cisplatin-based chemotherapy (PADCEV monotherapy)

Serious adverse reactions occurred in 39% of patients treated with PADCEV; the most common (≥3%) were pneumonia, sepsis, and diarrhea (5% each). **Fatal adverse reactions** occurred in 8% of patients, including acute kidney injury (2.2%), metabolic acidosis, sepsis, multiorgan dysfunction, pneumonia, and pneumonitis/ILD (1.1% each). **Adverse reactions leading to discontinuation** occurred in 20% of patients; the most common (≥2%) was PN (7%). **Adverse reactions leading to dose interruption** occurred in 60% of patients; the most common (≥3%) were PN (19%), rash (9%), fatigue (8%), diarrhea (5%), increased AST, and hyperglycemia (3% each). **Adverse reactions leading to dose reduction** occurred in 49% of patients; the most common (≥3%) were PN (19%), rash (11%), and fatigue (7%).

DRUG INTERACTIONS

Effects of other drugs on PADCEV (Dual P-gp and Strong CYP3A4 Inhibitors)

Concomitant use with dual P-gp and strong CYP3A4 inhibitors may increase unconjugated monomethyl auristatin E exposure, which may increase the incidence or severity of PADCEV toxicities. Closely monitor patients for signs of toxicity when PADCEV is given concomitantly with dual P-gp and strong CYP3A4 inhibitors.

SPECIFIC POPULATIONS

Lactation Advise lactating women not to breastfeed during treatment with PADCEV and for 3 weeks after the last dose.

Hepatic impairment Avoid the use of PADCEV in patients with moderate or severe hepatic impairment.

Full Prescribing Information

VYLOY Important Safety Information

Warnings and Precautions

Hypersensitivity reactions, including serious anaphylaxis reactions, and serious and fatal infusion-related reactions (IRR) have been reported in clinical studies when VYLOY has been administered. **Any grade hypersensitivity reactions**, including anaphylactic reactions, occurring with VYLOY in combination with mFOLFOX6 or CAPOX was 18%. **Severe (Grade 3 or 4) hypersensitivity reactions**, including anaphylactic reactions, occurred in 2% of patients. Seven patients (1.3%) permanently discontinued VYLOY for hypersensitivity reactions, including two patients (0.4%) who permanently discontinued VYLOY due to anaphylactic reactions. Seventeen (3.2%) patients required dose interruption, and three patients (0.6%) required infusion rate reduction due to hypersensitivity reactions. **All grade IRRs** occurred in 3.2% in patients administered VYLOY in combination with mFOLFOX6 or CAPOX. Severe (Grade 3) IRRs occurred in 2 (0.4%) patients who received VYLOY. An IRR led to permanent discontinuation of VYLOY in 2 (0.4%) patients and dose interruption in 7 (1.3%) patients. The infusion rate was reduced for VYLOY for 2 (0.4%) patients due to an IRR. Monitor patients during infusion with VYLOY and for 2 hours after completion of infusion or longer if clinically indicated, for hypersensitivity reactions with symptoms and signs that are highly suggestive of anaphylaxis (urticaria, repetitive cough, wheeze and throat tightness/change in voice). Monitor patients for signs and symptoms of IRRs including nausea, vomiting, abdominal pain, salivary hypersecretion, pyrexia, chest discomfort, chills, back pain, cough and hypertension. If a severe or life-threatening hypersensitivity or IRR reaction occurs, discontinue VYLOY permanently, treat symptoms according to standard medical care, and monitor until symptoms resolve. For any Grade 2 hypersensitivity or IRR, interrupt the VYLOY infusion until Grade ≤ 1 , then resume at a reduced infusion rate for the remaining infusion. Follow Grade 2 management for Grade 3 infusion-related nausea and vomiting. Premedicate the patient with antihistamines for the subsequent infusions, and closely monitor the patient for symptoms and signs of a hypersensitivity reaction. The infusion rate may be gradually increased as tolerated.

Severe Nausea and Vomiting. VYLOY is emetogenic. Nausea and vomiting occurred more often during the first cycle of treatment. **All grade nausea and vomiting** occurred in 82% and 67% respectively of patients treated with VYLOY in combination with mFOLFOX6 and 69% and 66% in combination with CAPOX, respectively. **Severe (Grade 3) nausea** occurred in 16% and 9% of patients treated with VYLOY in combination with mFOLFOX6 or CAPOX respectively. **Severe (Grade 3) vomiting** occurred in 16% and 12% of patients treated with VYLOY in combination with mFOLFOX6 or CAPOX. Nausea led to permanent discontinuation of VYLOY in combination with mFOLFOX6 or CAPOX in 18 (3.4%) patients and dose interruption in 147 (28%) patients. Vomiting led to permanent discontinuation of VYLOY in combination with mFOLFOX6 or CAPOX in 20 (3.8%) patients and dose interruption in 150 (28%) patients. Pretreat with antiemetics prior to each infusion of VYLOY. Manage patients during and after infusion with antiemetics or fluid replacement. Interrupt the infusion, or permanently discontinue VYLOY based on severity.

ADVERSE REACTIONS

Most common adverse reactions ($\geq 15\%$): Nausea, vomiting, fatigue, decreased appetite, diarrhea, peripheral sensory neuropathy, abdominal pain, constipation, decreased weight, hypersensitivity reactions, and pyrexia.

Most common laboratory abnormalities ($\geq 15\%$): Decreased neutrophil count, decreased leucocyte count, decreased albumin, increased creatinine, decreased hemoglobin, increased glucose, decreased lymphocyte count, increased aspartate aminotransferase, decreased platelets, increased alkaline phosphatase, increased alanine aminotransferase, decreased glucose, decreased sodium, increased phosphate, decreased potassium, and decreased magnesium.

SPOTLIGHT Study: 279 patients with locally advanced unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma whose tumors were CLDN18.2 positive who received at least one dose of VYLOY in combination with mFOLFOX6

Serious adverse reactions occurred in 45% of patients treated with VYLOY in combination with mFOLFOX6; the **most common serious adverse reactions** ($\geq 2\%$) were vomiting (8%), nausea (7%), neutropenia (2.9%), febrile neutropenia (2.9%), diarrhea (2.9%), intestinal obstruction (3.2%), pyrexia (2.5%), pneumonia (2.5%), respiratory failure (2.2%), pulmonary embolism (2.2%), decreased appetite (2.1%) and sepsis (2.0%). **Fatal adverse reactions** occurred in 5% of patients who received VYLOY in combination with mFOLFOX6 including sepsis (1.4%), pneumonia (1.1%), respiratory failure (1.1%), intestinal obstruction (0.7%), acute hepatic failure (0.4%), acute myocardial infarction (0.4%), death (0.4%), disseminated intravascular coagulation (0.4%), encephalopathy (0.4%), and upper gastrointestinal hemorrhage (0.4%). Permanent discontinuation of VYLOY due to an adverse reaction occurred in 20% of patients; the **most common adverse reactions leading to discontinuation** ($\geq 2\%$) were nausea and vomiting. Dosage interruptions of VYLOY due to an adverse reaction occurred in 75% of patients; the **most common adverse reactions leading to dose interruption** ($\geq 5\%$) were nausea, vomiting, neutropenia, abdominal pain, fatigue, and hypertension.

GLOW Study: 254 patients with locally advanced unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma whose tumors were CLDN18.2 positive who received at least one dose of VYLOY in combination with CAPOX

Serious adverse reactions occurred in 47% of patients treated with VYLOY in combination with CAPOX; the **most common serious adverse reactions** ($\geq 2\%$) were vomiting (6%), nausea (4.3%), decreased appetite (3.9%), decreased platelet count (3.1%), upper gastrointestinal hemorrhage (2.8%), diarrhea (2.8%), pneumonia (2.4%), pulmonary embolism (2.3%), and pyrexia (2.0%). **Fatal adverse reactions** occurred in 8% of patients who received VYLOY in combination with CAPOX including sepsis (1.2%), pneumonia (0.4%), death (0.8%), upper gastrointestinal hemorrhage (0.8%), cerebral hemorrhage (0.8%), abdominal infection (0.4%), acute respiratory distress syndrome (0.4%), cardio-respiratory arrest (0.4%), decreased platelet count (0.4%), disseminated intravascular coagulation (0.4%), dyspnea (0.4%), gastric perforation (0.4%), hemorrhagic ascites (0.4%), procedural complication (0.4%), sudden death (0.4%), and syncope (0.4%). Permanent discontinuation of VYLOY due to an adverse reaction occurred in 19% of patients; the **most common adverse reaction leading to discontinuation** ($\geq 2\%$) was vomiting. Dosage interruption of VYLOY due to an adverse reaction occurred in 55% of patients; the **most common adverse reactions leading to dose interruption** ($\geq 2\%$) were nausea, vomiting, neutropenia, thrombocytopenia, anemia, fatigue, infusion-related reaction, and abdominal pain.

SPECIFIC POPULATIONS

Lactation Advise lactating women not to breastfeed during treatment with VYLOY and for 8 months after the last dose.

Full Prescribing Information

XOSPATA Important Safety Information

Contraindications

XOSPATA is contraindicated in patients with hypersensitivity to gilteritinib or any of the excipients. Anaphylactic reactions have been observed in clinical trials.

Warnings and Precautions

Differentiation Syndrome (See BOXED WARNING) 3% of 319 patients treated with XOSPATA in the clinical trials experienced differentiation syndrome. Differentiation syndrome is associated with rapid proliferation and differentiation of myeloid cells and may be life-threatening or fatal if not treated. Symptoms and other clinical findings of differentiation syndrome in patients treated with XOSPATA included fever, dyspnea, pleural effusion, pericardial effusion, pulmonary edema, hypotension, rapid weight gain, peripheral edema, rash, and renal dysfunction. Some cases had concomitant acute febrile neutrophilic dermatosis. Differentiation syndrome occurred as early as 1 day and up to 82 days after

XOSPATA initiation and has been observed with or without concomitant leukocytosis. If differentiation syndrome is suspected, initiate dexamethasone 10 mg IV every 12 hours (or an equivalent dose of an alternative oral or IV corticosteroid) and hemodynamic monitoring until improvement. Taper corticosteroids after resolution of symptoms and administer corticosteroids for a minimum of 3 days. Symptoms of differentiation syndrome may recur with premature discontinuation of corticosteroid treatment. If severe signs and/or symptoms persist for more than 48 hours after initiation of corticosteroids, interrupt XOSPATA until signs and symptoms are no longer severe.

Posterior Reversible Encephalopathy Syndrome (PRES) 1% of 319 patients treated with XOSPATA in the clinical trials experienced posterior reversible encephalopathy syndrome (PRES) with symptoms including seizure and altered mental status. Symptoms have resolved after discontinuation of XOSPATA. A diagnosis of PRES requires confirmation by brain imaging, preferably magnetic resonance imaging (MRI). Discontinue XOSPATA in patients who develop PRES.

Prolonged QT Interval XOSPATA has been associated with prolonged cardiac ventricular repolarization (QT interval). 1% of the 317 patients with a post-baseline QTc measurement on treatment with XOSPATA in the clinical trial were found to have a QTc interval greater than 500 msec and 7% of patients had an increase from baseline QTc greater than 60 msec. Perform electrocardiogram (ECG) prior to initiation of treatment with XOSPATA, on days 8 and 15 of cycle 1, and prior to the start of the next two subsequent cycles. Interrupt and reduce XOSPATA dosage in patients who have a QTcF >500 msec. Hypokalemia or hypomagnesemia may increase the QT prolongation risk. Correct hypokalemia or hypomagnesemia prior to and during XOSPATA administration.

Pancreatitis 4% of 319 patients treated with XOSPATA in the clinical trials experienced pancreatitis. Evaluate patients who develop signs and symptoms of pancreatitis. Interrupt and reduce the dose of XOSPATA in patients who develop pancreatitis.

Embryo-Fetal Toxicity XOSPATA can cause embryo-fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment with XOSPATA and for 6 months after the last dose of XOSPATA. Advise males with female partners of reproductive potential to use effective contraception during treatment with XOSPATA and for 4 months after the last dose of XOSPATA. Pregnant women, patients becoming pregnant while receiving XOSPATA or male patients with pregnant female partners should be apprised of the potential risk to the fetus.

Adverse Reactions

Fatal adverse reactions occurred in 2% of patients receiving XOSPATA. These were cardiac arrest (1%) and one case each of differentiation syndrome and pancreatitis. The most frequent (≥5%) nonhematological serious adverse reactions reported in patients were fever (13%), dyspnea (9%), renal impairment (8%), transaminase increased (6%) and noninfectious diarrhea (5%).

7% discontinued XOSPATA treatment permanently due to an adverse reaction. The most common (>1%) adverse reactions leading to discontinuation were aspartate aminotransferase increased (2%) and alanine aminotransferase increased (2%).

The most frequent (≥5%) grade ≥3 nonhematological adverse reactions reported in patients were transaminase increased (21%), dyspnea (12%), hypotension (7%), mucositis (7%), myalgia/arthralgia (7%), and fatigue/malaise (6%).

Other clinically significant adverse reactions occurring in ≤10% of patients included: electrocardiogram QT prolonged (9%), hypersensitivity (8%), pancreatitis (5%), cardiac failure (4%), pericardial effusion (4%), acute febrile neutrophilic dermatosis (3%), differentiation syndrome (3%), pericarditis/myocarditis (2%), large intestine perforation (1%), and posterior reversible encephalopathy syndrome (1%).

Lab Abnormalities Shifts to grades 3-4 nonhematologic laboratory abnormalities in XOSPATA treated patients included phosphate decreased (14%), alanine aminotransferase increased (13%), sodium decreased (12%), aspartate aminotransferase increased (10%), calcium decreased (6%), creatine kinase increased (6%), triglycerides increased (6%), creatinine increased (3%), and alkaline phosphatase increased (2%).

Drug Interactions

Combined P-gp and Strong CYP3A Inducers Concomitant use of XOSPATA with a combined P-gp and strong CYP3A inducer decreases XOSPATA exposure which may decrease XOSPATA efficacy. Avoid concomitant use of XOSPATA with combined P-gp and strong CYP3A inducers.

Strong CYP3A inhibitors Concomitant use of XOSPATA with a strong CYP3A inhibitor increases XOSPATA exposure. Consider alternative therapies that are not strong CYP3A inhibitors. If the concomitant use of these inhibitors is considered essential for the care of the patient, monitor patient more frequently for XOSPATA adverse reactions. Interrupt and reduce XOSPATA dosage in patients with serious or life-threatening toxicity.

Drugs that Target 5HT2B Receptor or Sigma Nonspecific Receptor Concomitant use of XOSPATA may reduce the effects of drugs that target the 5HT2B receptor or the sigma nonspecific receptor (e.g., escitalopram, fluoxetine, sertraline). Avoid concomitant use of these drugs with XOSPATA unless their use is considered essential for the care of the patient.

P-gp, BCRP, and OCT1 Substrates Based on *in vitro* data, gilteritinib is a P-gp, breast cancer resistant protein (BCRP), and organic cation transporter 1 (OCT1) inhibitor. Coadministration of gilteritinib may increase the exposure of P-gp, BCRP, and OCT1 substrates, which may increase the incidence and severity of adverse reactions of these substrates. For P-gp, BCRP, or OCT1 substrates where small concentration changes may lead to serious adverse reactions, decrease the dose or modify the dosing frequency of such substrate and monitor for adverse reactions as recommended in the respective prescribing information.

Specific Populations

Lactation Advise women not to breastfeed during treatment with XOSPATA and for 2 months after the last dose.

Full Prescribing Information

Cautionary Notes

In this press release, statements made with respect to current plans, estimates, strategies and beliefs and other statements that are not historical facts are forward-looking statements about the future performance of Astellas. These statements are based on management's current assumptions and beliefs in light of the information currently available to it and involve known and unknown risks and uncertainties. A number of factors could cause actual results to differ materially from those discussed in the forward-looking statements. Such factors include, but are not limited to: (i) changes in general economic conditions and in laws and regulations, relating to pharmaceutical markets, (ii) currency exchange rate fluctuations, (iii) delays in new product launches, (iv) the inability of Astellas to market existing and new products effectively, (v) the inability of Astellas to continue to effectively research and develop products accepted by customers in highly competitive markets, and (vi) infringements of Astellas' intellectual property rights by third parties. Information about pharmaceutical products (including products currently in development) which is included in this press release is not intended to constitute an advertisement or medical advice.

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