Dimensions: 6" x 9"

Derived from US-RCC-00436: p6A

PI: p11A,B

SSI 1α

PI: p6I

SSI W

PI: p82H; p83A

PI: p6I

PI: p82B
Rini, 2019: p1117I

PI: p82B-H; p83A
Rini, 2019: p1117I,M,N

PI: p82B-F

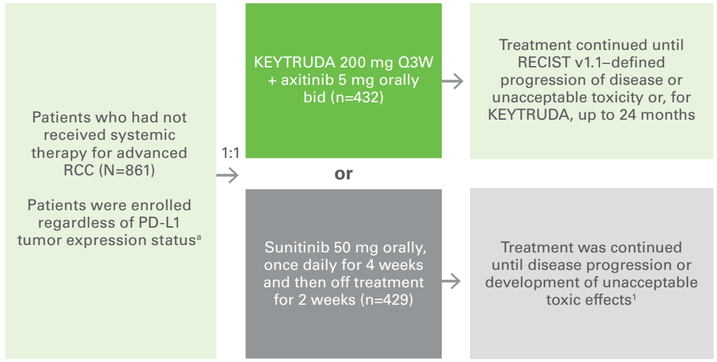
Derived from
US-RCC-00436: p34A; p35A

PI: p11E,F

SSI 2

KEYTRUDA + axitinib in first-line treatment of aRCC

KEYNOTE-426: PHASE 3, MULTICENTER, OPEN-LABEL, RANDOMIZED TRIAL vs SUNITINIB[1]



- Main efficacy outcome measures: overall survival (OS) and progression-free survival (PFS) as assessed by BICR according to modified RECIST v1.1.
- Additional efficacy outcome measure: objective response rate (ORR) as assessed by BICR.
- The median follow-up time was 12.8 months (range: 0.1 to 22.0 months).

[a]Randomization was stratified by IMDC risk categories (favorable vs intermediate vs poor) and geographic region (North America vs Western Europe vs rest of the world).

- Patients with active autoimmune disease requiring systemic immunosuppression within the last 2 years were ineligible.
- Administration of KEYTRUDA and axitinib was permitted beyond RECIST-defined disease progression if the patient was clinically stable and considered to be deriving clinical benefit by the investigator.
- Assessment of tumor status was performed at baseline, after randomization at week 12, then every 6 weeks thereafter until week 54, and then every 12 weeks thereafter.
- Patients who tolerated axitinib 5 mg twice daily for 2 consecutive cycles (6 weeks) could increase to 7 mg and then subsequently to 10 mg twice daily.
- Axitinib could be interrupted or reduced to 3 mg twice daily and subsequently to 2 mg twice daily to manage toxicity.

bid = twice daily; BICR = blinded independent central review; IMDC = International Metastatic RCC Database Consortium; PD-L1 = programmed death ligand 1; Q3W = every 3 weeks; RECIST v1.1 = Response Evaluation Criteria In Solid Tumors v1.1.

SELECTED SAFETY INFORMATION (*continued*)

Immune-Mediated Colitis

- KEYTRUDA can cause immune-mediated colitis. Colitis occurred in 1.7% (48/2799) of patients receiving KEYTRUDA, including Grade 2 (0.4%), 3 (1.1%), and 4 (<0.1%). Monitor patients for signs and symptoms of colitis. Administer corticosteroids for Grade 2 or greater colitis. Withhold KEYTRUDA for Grade 2 or 3; permanently discontinue KEYTRUDA for Grade 4 colitis.

SELECTED SAFETY INFORMATION (*continued*)

Immune-Mediated Hepatitis (KEYTRUDA) and Hepatotoxicity (KEYTRUDA in Combination With Axitinib)

Immune-Mediated Hepatitis

- KEYTRUDA can cause immune-mediated hepatitis. Hepatitis occurred in 0.7% (19/2799) of patients receiving KEYTRUDA, including Grade 2 (0.1%), 3 (0.4%), and 4 (<0.1%). Monitor patients for changes in liver function. Administer corticosteroids for Grade 2 or greater hepatitis and, based on severity of liver enzyme elevations, withhold or discontinue KEYTRUDA.

Hepatotoxicity in Combination With Axitinib

- KEYTRUDA in combination with axitinib can cause hepatic toxicity with higher than expected frequencies of Grades 3 and 4 ALT and AST elevations compared to KEYTRUDA alone. With the combination of KEYTRUDA and axitinib, Grades 3 and 4 increased ALT (20%) and increased AST (13%) were seen. Monitor liver enzymes before initiation of and periodically throughout treatment. Consider more frequent monitoring of liver enzymes as compared to when the drugs are administered as single agents. For elevated liver enzymes, interrupt KEYTRUDA and axitinib, and consider administering corticosteroids as needed.

Immune-Mediated Endocrinopathies

- KEYTRUDA can cause adrenal insufficiency (primary and secondary), hypophysitis, thyroid disorders, and type 1 diabetes mellitus. Adrenal insufficiency occurred in 0.8% (22/2799) of patients, including Grade 2 (0.3%), 3 (0.3%), and 4 (<0.1%). Hypophysitis occurred in 0.6% (17/2799) of patients, including Grade 2 (0.2%), 3 (0.3%), and 4 (<0.1%). Hypothyroidism occurred in 8.5% (237/2799) of patients, including Grade 2 (6.2%) and 3 (0.1%). Hyperthyroidism occurred in 3.4% (96/2799) of patients, including Grade 2 (0.8%) and 3 (0.1%), and thyroiditis occurred in 0.6% (16/2799) of patients, including Grade 2 (0.3%). Type 1 diabetes mellitus, including diabetic ketoacidosis, occurred in 0.2% (6/2799) of patients.
- Monitor patients for signs and symptoms of adrenal insufficiency, hypophysitis (including hypopituitarism), thyroid function (prior to and periodically during treatment), and hyperglycemia. For adrenal insufficiency or hypophysitis, administer corticosteroids and hormone replacement as clinically indicated. Withhold KEYTRUDA for Grade 2 adrenal insufficiency or hypophysitis and withhold or discontinue KEYTRUDA for Grade 3 or Grade 4 adrenal insufficiency or hypophysitis. Administer hormone replacement for hypothyroidism and manage hyperthyroidism with thionamides and beta-blockers as appropriate. Withhold or discontinue KEYTRUDA for Grade 3 or 4 hyperthyroidism. Administer insulin for type 1 diabetes, and withhold KEYTRUDA and administer antihyperglycemics in patients with severe hyperglycemia.

ALT = alanine aminotransferase; AST = aspartate aminotransferase.

PI: p11G; p12A-D

SSI 3b

PI: p12E,F,H,I; p13A-F

SSI 4

PI: p12E,H; p13B,F

SSI 5

Before prescribing KEYTRUDA, please read the additional Selected Safety Information on the following pages and the accompanying Prescribing Information.

KEYTRUDA® (pembrolizumab) Injection 100 mg

PI: p6I

PI: p82H; p83A; p84A
Calc (risk reduction: (1 - 0.53) x 100 = 47%
Rini, 2019: p1121A

Derived from US-RCC-00436: p6A

PI: p13G,H

SSI 6

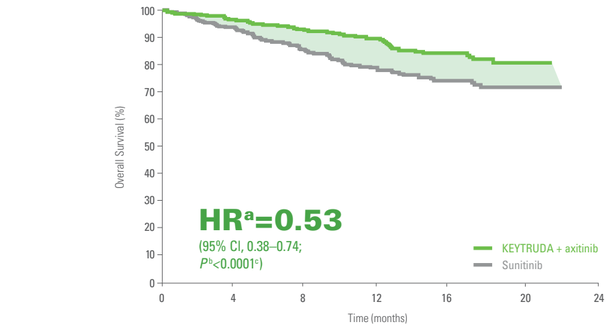
PI: p6I

KEYTRUDA + axitinib in first-line treatment of aRCC

INITIAL ANALYSIS — SUPERIOR OS: REDUCED RISK OF DEATH BY NEARLY HALF vs SUNITINIB

Median patient follow-up was 12.8 months

Kaplan-Meier Estimates of OS in KEYNOTE-426[1]



From *The New England Journal of Medicine*, Rini BI, Plimack ER, Stus V, et al; for the KEYNOTE-426 Investigators. Pembrolizumab plus axitinib versus sunitinib for advanced renal-cell carcinoma, 2019;380:1116–1127. Copyright © 2019 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

[a]Based on the stratified Cox proportional hazard model.
[b]Based on stratified log-rank test.
[c]*P* value (one-sided) is compared with the allocated alpha of 0.0001 for this interim analysis (with 39% of the planned number of events for final analysis).

- Events observed: 59/432 (14%) with KEYTRUDA + axitinib vs 97/429 (23%) with sunitinib
- Median OS not reached (NR) with KEYTRUDA + axitinib or with sunitinib

SELECTED SAFETY INFORMATION (*continued*)

Immune-Mediated Nephritis and Renal Dysfunction

- KEYTRUDA can cause immune-mediated nephritis. Nephritis occurred in 0.3% (9/2799) of patients receiving KEYTRUDA, including Grade 2 (0.1%), 3 (0.1%), and 4 (<0.1%) nephritis. Monitor patients for changes in renal function. Administer corticosteroids for Grade 2 or greater nephritis. Withhold KEYTRUDA for Grade 2; permanently discontinue for Grade 3 or 4 nephritis.

Make KEYTRUDA + axitinib your first move.

PI: p6I

PI: p82H; p83A
Opdivo PI: p3I; p81A,B,E,F; p82A,C

KEYTRUDA + axitinib in first-line treatment of aRCC

INITIAL ANALYSIS: THE ONLY 1L COMBINATION TO ACHIEVE SUPERIORITY ACROSS THESE 3 END POINTS vs SUNITINIB[2]

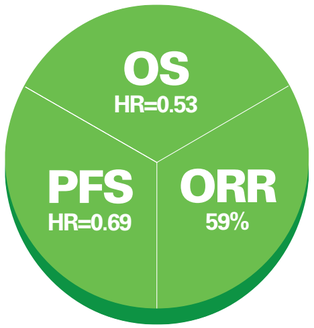
Reduced risk of death by nearly half vs sunitinib

HR[a]=0.53; 95% CI, 0.38–0.74; *P*[b]<0.0001[c]

- Events observed: 59/432 (14%) with KEYTRUDA + axitinib vs 97/429 (23%) with sunitinib

PFS: HR[a]=0.69
(95% CI, 0.56–0.84; *P*[b]=0.0001[d])

- Events observed: 183/432 (42%) with KEYTRUDA + axitinib vs 213/429 (50%) with sunitinib
- Median PFS: 15.1 months (95% CI,12.6–17.7) with KEYTRUDA + axitinib vs 11.0 months (95% CI, 8.7–12.5) with sunitinib



ORR[e]: 59%
(95% CI, 54–64) vs 36% ORR with sunitinib (95% CI, 31–40; *P*[f]<0.0001)

- 6% CR and 53% PR for KEYTRUDA + axitinib vs 2% CR and 34% PR for sunitinib

- Consistent results were observed across prespecified subgroups, IMDC risk categories, and PD-L1 tumor expression status.

[a]Based on the stratified Cox proportional hazard model.
[b]Based on stratified log-rank test.
[c]*P* value (one-sided) is compared with the allocated alpha of 0.0001 for this interim analysis (with 39% of the planned number of events for final analysis).
[d]*P* value (one-sided) is compared with the allocated alpha of 0.0013 for this interim analysis (with 81% of the planned number of events for final analysis).
[e]Best objective response as confirmed complete response or partial response.
[f]Based on Miettinen and Nurminen method stratified by IMDC risk group and geographic region.

1L = first line; CR = complete response; PR = partial response.

SELECTED SAFETY INFORMATION (*continued*)

Immune-Mediated Skin Reactions

- Immune-mediated rashes, including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) (some cases with fatal outcome), exfoliative dermatitis, and bullous pemphigoid, can occur. Monitor patients for suspected severe skin reactions and based on the severity of the adverse reaction, withhold or permanently discontinue KEYTRUDA and administer corticosteroids. For signs or symptoms of SJS or TEN, withhold KEYTRUDA and refer the patient for specialized care for assessment and treatment. If SJS or TEN is confirmed, permanently discontinue KEYTRUDA.

Before prescribing KEYTRUDA, please read the additional Selected Safety Information on the following pages and the accompanying Prescribing Information.

KEYTRUDA® (pembrolizumab) Injection 100 mg

PI: p6I

PI: p82G,H; p83A
Calc (risk reduction: (1 - 0.53) x 100 = 47%)

Derived from US-RCC-00436: p9A

PI: p14A

SSI 7

PI: p6I

Data Available Pack
US-RCC-00474: p5E; p6A

Data Available Pack
US-RCC-00474: p5E

Derived from
US-RCC-00436: p16A

PI: p83A
Data Available Pack
US-RCC-00474: p6A

PI: p83A

Data Available Pack
US-RCC-00474: p6B

Data Available Pack
US-RCC-00474: p5F

PI: p14B,C

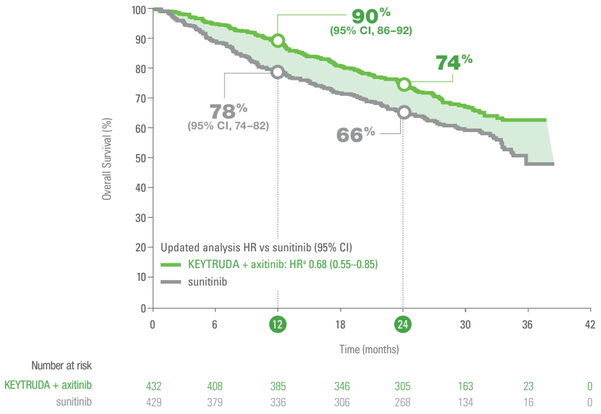
SSI 8

KEYTRUDA + axitinib in first-line treatment of aRCC

UPDATED ANALYSIS: OVERALL SURVIVAL vs SUNITINIB[3]

Median patient follow-up was 27 months[3]

Kaplan-Meier Estimates of OS in KEYNOTE-426[3]



[a]HR based on the stratified Cox proportional hazard model.

- Median overall survival for KEYTRUDA + axitinib was not reached vs 35.7 months for sunitinib (95% CI, 33.3–NR).[3]

LIMITATIONS:

This protocol-specified analysis occurred after an interim analysis that demonstrated the superiority of KEYTRUDA + axitinib in overall survival, progression-free survival, and overall response rate compared to sunitinib alone. No formal statistical testing was performed for the updated analysis, and, therefore, no conclusions can be drawn.[3]

SELECTED SAFETY INFORMATION (*continued*)

Other Immune-Mediated Adverse Reactions

- Immune-mediated adverse reactions, which may be severe or fatal, can occur in any organ system or tissue in patients receiving KEYTRUDA and may also occur after discontinuation of treatment. For suspected immune-mediated adverse reactions, ensure adequate evaluation to confirm etiology or exclude other causes. Based on the severity of the adverse reaction, withhold KEYTRUDA and administer corticosteroids. Upon improvement to Grade 1 or less, initiate corticosteroid taper and continue to taper over at least 1 month. Based on limited data from clinical studies in patients whose immune-related adverse reactions could not be controlled with corticosteroid use, administration of other systemic immunosuppressants can be considered. Resume KEYTRUDA when the adverse reaction remains at Grade 1 or less following corticosteroid taper. Permanently discontinue KEYTRUDA for any Grade 3 immune-mediated adverse reaction that recurs and for any life-threatening immune-mediated adverse reaction.

OS, PFS, AND ORR FROM AN UPDATED ANALYSIS[3]

Data Available Pack
US-RCC-00474: p5E; p6A-D

Median patient follow-up was 27 months[3]

	KEYTRUDA + axitinib (n=432)	Sunitinib (n=429)
Overall Survival		
OS (95% CI)	HR[b]=0.68 (0.55–0.85)	
Events observed	142/432 (33%)	178/429 (42%)
Progression-free Survival		
PFS (95% CI)	HR=0.71 (0.60–0.84)	
Events observed	264/432 (61%)	281/429 (66%)
Median PFS (95% CI)	15.4 months (12.7–18.9)	11.1 months (9.1–12.5)
Objective Response Rate		
ORR	60% (55.4–64.8)	40% (35.2–44.7)
CR	9%	3%
PR	51%	37%

[b]Based on the stratified Cox proportional hazard model.

Data Available Pack
US-RCC-00474: p5E; p6A-D
Calc (% Events Observed with KEYTRUDA + axitinib): 142 / 432 =0.33 x 100 = 33%
Calc (Events Observed with Sunitinib): 178 / 429 = 0.42 x 100 = 42%

PI: p83A

Data Available Pack
US-RCC-00474: p5F

LIMITATIONS:

This protocol-specified analysis occurred after an interim analysis that demonstrated the superiority of KEYTRUDA + axitinib in overall survival, progression-free survival, and overall response rate compared to sunitinib alone. No formal statistical testing was performed for the updated analysis, and, therefore, no conclusions can be drawn.[3]

SELECTED SAFETY INFORMATION (*continued*)

Other Immune-Mediated Adverse Reactions (*continued*)

- The following clinically significant immune-mediated adverse reactions occurred in less than 1% (unless otherwise indicated) of 2799 patients: arthritis (1.5%), uveitis, myositis, Guillain-Barré syndrome, myasthenia gravis, vasculitis, pancreatitis, hemolytic anemia, sarcoidosis, and encephalitis. In addition, myelitis and myocarditis were reported in other clinical trials, including classical Hodgkin lymphoma, and postmarketing use.
- Treatment with KEYTRUDA may increase the risk of rejection in solid organ transplant recipients. Consider the benefit of treatment vs the risk of possible organ rejection in these patients.

PI: p14D

SSI 9

PI: p14E

SSI 10

Before prescribing KEYTRUDA, please read the additional Selected Safety Information on the following pages and the accompanying Prescribing Information.

KEYTRUDA® (pembrolizumab) Injection 100 mg

PI: p6I

PI: p82H; p83A
Data Available Pack
US-RCC-00474: p6D

PI: p83A
Data Available Pack
US-RCC-00474: p6D
Calc (KEYTRUDA PR Long-term Analysis): KEYTRUDA + axitinib: 60% - 9% = 51%; sunitinib: 40% - 3% = 37%

PI: p83A

Data Available Pack
US-RCC-00474: p5F

Derived from
US-RCC-00436: p20A

PI: p14F

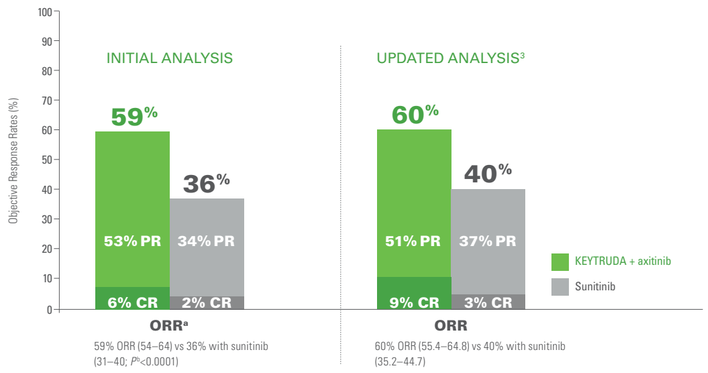
SSI 11

PI: p14G

SSI 12

KEYTRUDA + axitinib in first-line treatment of aRCC

ORR WITH KEYTRUDA + AXITINIB vs SUNITINIB AT INITIAL ANALYSIS AND UPDATED ANALYSIS[3]



[a]Best objective response as confirmed complete response or partial response.
[b]Based on Miettinen and Nurminen method stratified by IMDC risk group and geographic region.

LIMITATIONS:

This protocol-specified analysis occurred after an interim analysis that demonstrated the superiority of KEYTRUDA + axitinib in overall survival, progression-free survival, and overall response rate compared to sunitinib alone. No formal statistical testing was performed for the updated analysis, and, therefore, no conclusions can be drawn.[3]

SELECTED SAFETY INFORMATION (*continued*)

Infusion-Related Reactions

- KEYTRUDA can cause severe or life-threatening infusion-related reactions, including hypersensitivity and anaphylaxis, which have been reported in 0.2% (6/2799) of patients. Monitor patients for signs and symptoms of infusion-related reactions. For Grade 3 or 4 reactions, stop infusion and permanently discontinue KEYTRUDA.

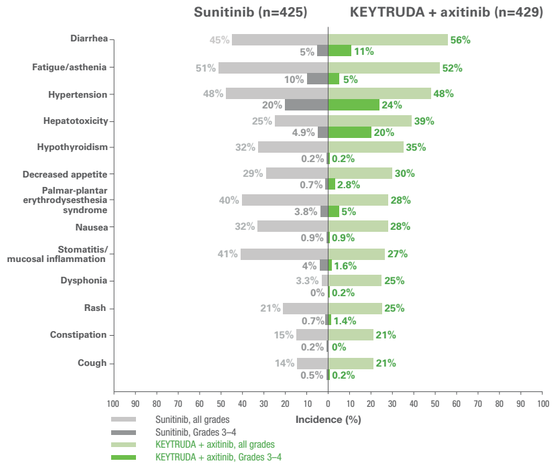
Complications of Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

- Immune-mediated complications, including fatal events, occurred in patients who underwent allogeneic HSCT after treatment with KEYTRUDA. Follow patients closely for early evidence of transplant-related complications such as hyperacute graft-versus-host disease (GVHD), Grade 3 to 4 acute GVHD, steroid-requiring febrile syndrome, hepatic veno-occlusive disease (VOD), and other immune-mediated adverse reactions.

SAFETY DATA FROM KEYNOTE-426

PI: p40B-D; p41A

Adverse Reactions Occurring in ≥20% of Patients Receiving KEYTRUDA + axitinib



– In KEYNOTE-426, when KEYTRUDA was administered in combination with axitinib, fatal adverse reactions occurred in 3.3% of 429 patients. Serious adverse reactions occurred in 40% of patients, the most frequent (≥1%) were hepatotoxicity (7%), diarrhea (4.2%), acute kidney injury (2.3%), dehydration (1%), and pneumonitis (1%).

– Permanent discontinuation due to an adverse reaction occurred in 31% of patients; KEYTRUDA only (13%), axitinib only (13%), and the combination (8%); the most common were hepatotoxicity (13%), diarrhea/colitis (1.9%), acute kidney injury (1.6%), and cerebrovascular accident (1.2%).

Derived from
US-RCC-00436: p29A

SELECTED SAFETY INFORMATION (*continued*)

Complications of Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) (*continued*)

- In patients with a history of allogeneic HSCT, acute GVHD (including fatal GVHD) has been reported after treatment with KEYTRUDA. Patients who experienced GVHD after their transplant procedure may be at increased risk for GVHD after KEYTRUDA. Consider the benefit of KEYTRUDA vs the risk of GVHD in these patients.

PI: p15A

SSI 13

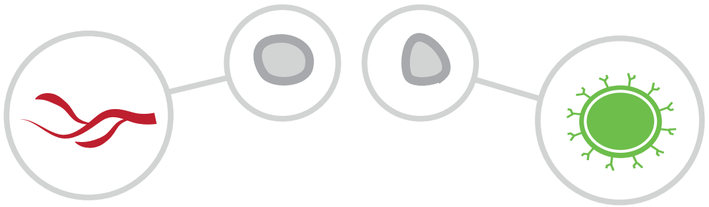
Before prescribing KEYTRUDA, please read the additional Selected Safety Information on the following pages and the accompanying Prescribing Information.

KEYTRUDA® (pembrolizumab) Injection 100 mg

KEYTRUDA and axitinib:

INHIBITS 2 DISTINCT DISEASE PATHWAYS IN aRCC[4]

TUMOR CELLS



Axitinib: VEGF inhibition

- Axitinib has been shown to inhibit receptor tyrosine kinases including vascular endothelial growth factor receptors (VEGFR)-1, VEGFR-2, and VEGFR-3 at therapeutic plasma concentrations.[4]
- These receptors are implicated in pathologic angiogenesis, tumor growth, and cancer progression.[4]

KEYTRUDA: PD-1 receptor blockade

- KEYTRUDA binds to the PD-1 receptor and blocks its interaction with PD-L1 and PD-L2, which helps restore the immune response.
- While having an effect on the tumor, this could also affect normal, healthy cells.

VEGF = vascular endothelial growth factor; PD-1 = programmed death receptor-1; PD-L2 = programmed death ligand 2.

PI: p6I; p47I
Inlyta PI: p22G

Verbatim from US-RCC-00436: p23A

SELECTED SAFETY INFORMATION (*continued*)

Increased Mortality in Patients With Multiple Myeloma

- In trials in patients with multiple myeloma, the addition of KEYTRUDA to a thalidomide analogue plus dexamethasone resulted in increased mortality. Treatment of these patients with a PD-1 or PD-L1 blocking antibody in this combination is not recommended outside of controlled trials.

Embryofetal Toxicity

- Based on its mechanism of action, KEYTRUDA can cause fetal harm when administered to a pregnant woman. Advise women of this potential risk. In females of reproductive potential, verify pregnancy status prior to initiating KEYTRUDA and advise them to use effective contraception during treatment and for 4 months after the last dose.

PI: p15B

SSI 14

PI: p15C; p46F,G

SSI 15

KEYTRUDA, IN COMBINATION WITH AXITINIB, IS INDICATED FOR THE FIRST-LINE TREATMENT OF PATIENTS WITH ADVANCED RENAL CELL CARCINOMA (RCC)

PI: p6I

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Kidney Cancer

PEMBROLIZUMAB (KEYTRUDA) + AXITINIB: THE ONLY PREFERRED FIRST-LINE TREATMENT OPTION RECOMMENDED ACROSS ALL 3 IMDC RISK GROUPS IN ADVANCED CLEAR-CELL RCC[5]

	Favorable risk	Intermediate/ poor risk
Pembrolizumab (KEYTRUDA) + axitinib	Preferred (Category 2A)	Preferred (Category 1)

NCCN Guidelines Kidney Cancer v1.2021: pKID-C 1 of 2A,D

Category 1 = Based upon high-level evidence, there is uniform National Comprehensive Cancer Network® (NCCN®) consensus that the intervention is appropriate.[5]
Category 2A = Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.[5]
Preferred intervention = Intervention that is based on superior efficacy, safety, and evidence; and, when appropriate, affordability.[5]
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.

NCCN Guidelines Kidney Cancer v1.2021: pCAT-1A,B

Verbatim from US-RCC-00436: p36A

SELECTED SAFETY INFORMATION (*continued*)

Adverse Reactions

- In KEYNOTE-426, when KEYTRUDA was administered in combination with axitinib, fatal adverse reactions occurred in 3.3% of 429 patients. Serious adverse reactions occurred in 40% of patients, the most frequent (≥1%) were hepatotoxicity (7%), diarrhea (4.2%), acute kidney injury (2.3%), dehydration (1%), and pneumonitis (1%). Permanent discontinuation due to an adverse reaction occurred in 31% of patients; KEYTRUDA only (13%), axitinib only (13%), and the combination (8%); the most common were hepatotoxicity (13%), diarrhea/colitis (1.9%), acute kidney injury (1.6%), and cerebrovascular accident (1.2%). The most common adverse reactions (≥20%) were diarrhea (56%), fatigue/asthenia (52%), hypertension (48%), hepatotoxicity (39%), hypothyroidism (35%), decreased appetite (30%), palmar-plantar erythrodysesthesia (28%), nausea (28%), stomatitis/mucosal inflammation (27%), dysphonia (25%), rash (25%), cough (21%), and constipation (21%).

PI: p39E; p40B-D,F; p41A

SSI 40

Lactation

- Because of the potential for serious adverse reactions in breastfed children, advise women not to breastfeed during treatment and for 4 months after the final dose.

PI: p46E

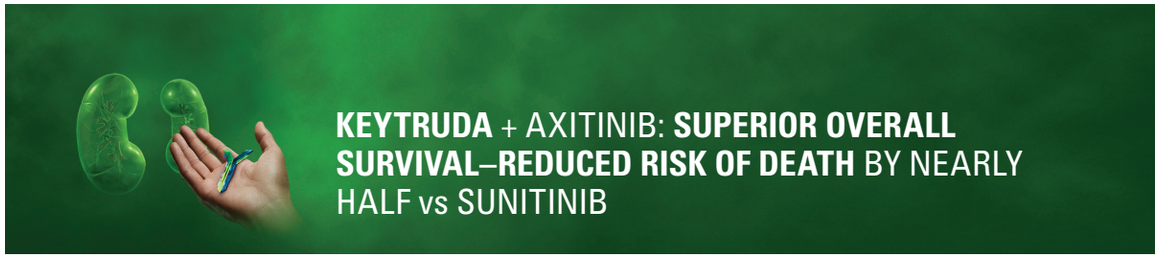
SSI 46

Before prescribing KEYTRUDA, please read the additional Selected Safety Information on the following page and the accompanying Prescribing Information.

KEYTRUDA® (pembrolizumab) Injection 100 mg

PI: p82G,H; p83A
Calc (risk reduction:
(1 - 0.53) x 100 = 47%

Verbatim from
US-RCC-00436: p32A



PI: p6I

SSI W

ADVANCED RENAL CELL CARCINOMA (aRCC): KEYTRUDA, in combination with axitinib, is indicated for the first-line treatment of patients with advanced renal cell carcinoma (RCC).

PI: p82G,H; p83A

Verbatim from
US-RCC-00436: p32A

Superiority across these 3 end points vs sunitinib (Initial Analysis)

- ✓ **OS**
  - **HR[a]=0.53** (95% CI, 0.38–0.74: *P*[b]<0.0001[c])
- ✓ **PFS**
  - **HR[a]=0.69** (95% CI, 0.56–0.84; *P*[b]=0.0001[d])
  - Median PFS: 15.1 months (95% CI, 12.6–17.7) with KEYTRUDA + axitinib vs 11.0 months (95% CI, 8.7–12.5) with sunitinib
- ✓ **ORR[e]**
  - **59%** (95% CI, 54–64; *P*[f]<0.0001) vs 36% ORR with sunitinib (95% CI, 31–40)
  - 6% CR and 53% PR for KEYTRUDA + axitinib vs 2% CR and 34% PR for sunitinib

Approved for use across all 3 IMDC risk groups and regardless of PD-L1 status

- ✓ **FAVORABLE**
- ✓ **INTERMEDIATE**
- ✓ **POOR**

[a]Based on the stratified Cox proportional hazard model.
[b]Based on stratified log-rank test.
[c]*P* value (one-sided) is compared with the allocated alpha of 0.0001 for this interim analysis (with 39% of the planned number of events for final analysis).
[d]*P* value (one-sided) is compared with the allocated alpha of 0.0013 for this interim analysis (with 81% of the planned number of events for final analysis).
[e]Best objective response as confirmed complete response or partial response.
[f]Based on Miettinen and Nurminen method stratified by IMDC risk group and geographic region.

PI: p11A,E,G; p12A,E,H; p13B,F,G; p14A-C,E,G; p15A

SSI 48α

SELECTED SAFETY INFORMATION (*continued*)

Summary of Immune-Mediated Reactions

- Immune-mediated adverse reactions, which may be severe or fatal, can occur with KEYTRUDA, including pneumonitis, colitis, hepatitis, endocrinopathies, nephritis, severe skin reactions, solid organ transplant rejection, and complications of allogeneic HSCT. Based on the severity of the adverse reaction, KEYTRUDA should be withheld or discontinued and corticosteroids administered if appropriate. For more information regarding immune-mediated adverse reactions, please read the additional Selected Safety Information on pages 1–11.

Before prescribing KEYTRUDA, please read the accompanying Prescribing Information. The Medication Guide also is available. For additional copies of the Prescribing Information, please call 800-672-6372, visit keytrudahcp.com, or contact your Merck representative.

References: 1. Rini BI, Plimack ER, Stus V, et al; for the KEYNOTE-426 investigators. Pembrolizumab plus axitinib versus sunitinib for advanced renal-cell carcinoma. *N Engl J Med.* 2019;380(12):1116–1127. **2.** *Opdivo* [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; 2020. **3.** Data available on request from Merck, Professional Services-DAP, WP1-27, PO Box 4, West Point, PA 19486-0004. Please specify information package US-RCC-00474. **4.** *Inlyta* [package insert]. New York, NY: Pfizer Inc; 2020. **5.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Kidney Cancer V.1.2021. © National Comprehensive Cancer Network, Inc. 2020. All rights reserved. Accessed July 16, 2020. To view the most recent and complete version of the guidelines, go online to NCCN.org.

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KEYTRUDA® (pembrolizumab) Injection 100 mg