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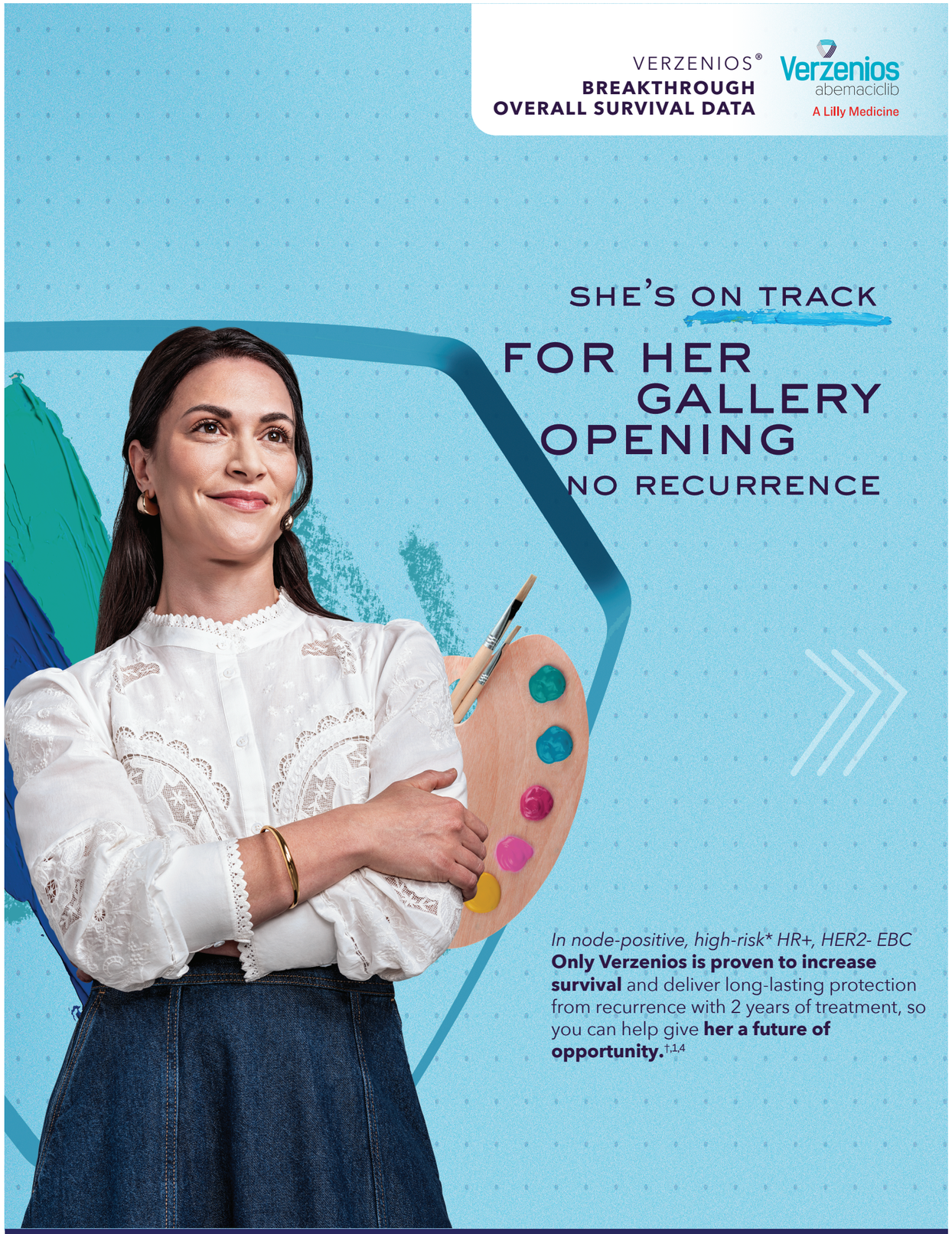


Indication[5]

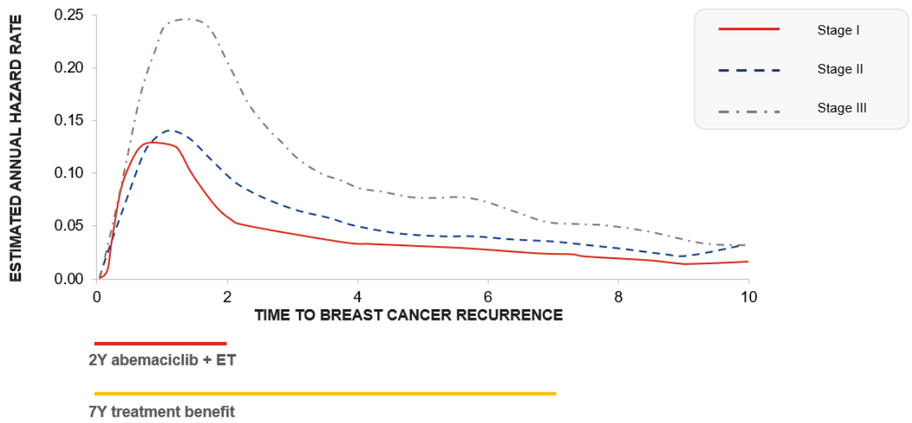
Verzenios® is a CDK4/6 inhibitor indicated for:

- **The adjuvant treatment of HR+, HER2–, node-positive early breast cancer at high risk* of relapse based on lymph node status, primary tumour size and tumour grade.**
- Verzenios® in combination with **endocrine therapy** (tamoxifen or an aromatase inhibitor) in adult female patients at **high risk of recurrence***
- In pre- or perimenopausal women, aromatase inhibitor endocrine therapy should be combined with an LHRH agonist

- **The treatment of HR+, HER2- locally advanced or metastatic breast cancer**
- Verzenios® in combination with an aromatase inhibitor as primary ET or in combination with fulvestrant in patients who have previously under-gone ET
- The tratment of postmenopausal HR+, HER2- locally advanced or metastatic breast cancer as monotherapy following disease progression after endocrine therapy and one or two chemotherapy regimens in the metastatic setting, when chemotherapy is not suitable
- In pre- or perimenopausal women, endocrine therapy should be combined with an LHRH agonist

Risk of recurrence in EBC[1]

Risk of Recurrence by Stage



In patients with HR+, HER2- EBC

Patients with 1 to 3 positive nodes and high-risk features[§] have nearly as high a risk of recurrence as those with 4+ positive nodes[7]

5-year risk of recurrence by nodal involvement[7]

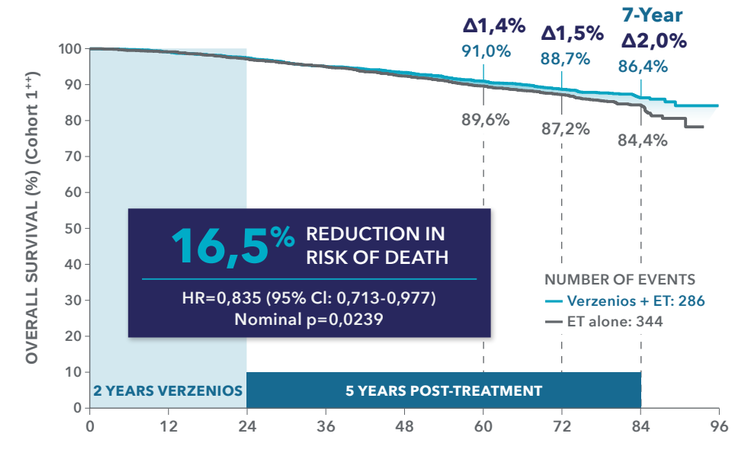
	Group	Risk of Recurrence
Node-Positive High-risk Population	1-3 nodes with high-risk features[§]	26%
	4-9 nodes	34%
	≥10 nodes	35%
	Node-negative or 1-3 nodes without high-risk features	9%

Source: U.S. Flatiron Health EBC database (study period: 2011-2020). This real-world evidence study used the U.S. nationwide Flatiron Health electronic health record (EHR)-derived de-identified database. The de-identified data originated from approximately 280 cancer clinics (~800 sites of care), with the majority of patients originating from community oncology settings. This dataset included >15,000 patients diagnosed with HR+, HER2- EBC from 01 January 2011 through 29 February 2024.[7,8] Median follow-up: 43 months.[7] Hazard ratios with 95% confidence interval were estimated by Cox proportional hazards regression models. Adjustment factors included age, race, menopausal status, resection status, histology, progesterone receptor status, BRCA status, ECOG PS, and Oncotype DX Breast Recurrence Score. Adjusted hazard ratio describes the increase in recurrence risk in each of the node-positive groups versus the group without these high-risk features over the course of follow-up. Risk of recurrence in the bar chart is the chance of having an event (that is, recurrence or death) and is expressed as 100% minus 5-year IDFS rate. Results are based on a post hoc subgroup analysis following the methodology used by Sheffield et al (2022) with a population of patients diagnosed between 2011-2020. This analysis was exploratory and did not test a hypothesis.[7,8]

Breakthrough overall survival data: Verzenios in combination with AI or tamoxifen increases survival[†,1]

Efficacy (Cohort 1**)| Overall survival benefit at 7 years[1]

Verzenios is the only CDK4/6 inhibitor with a proven overall survival benefit in the curative setting and 2 years of treatment[†,4]



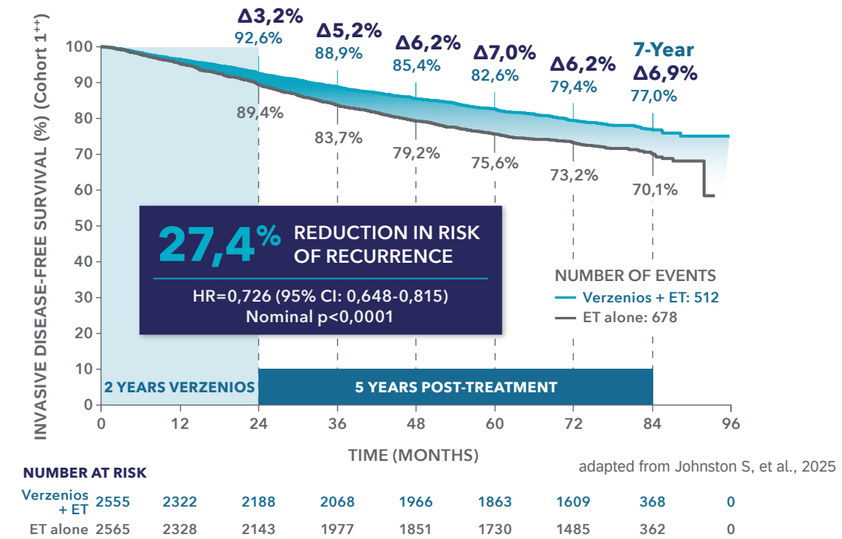
adapted from Johnston S, et al., 2025

NUMBER AT RISK

Verzenios + ET	2555	2381	2290	2186	2123	2030	1798	423	0
ET alone	2565	2416	2305	2211	2117	2005	1753	431	0

Efficacy (Cohort 1**)| IDFS benefit at 7 years[1]

Verzenios delivers 7 years of sustained IDFS benefit with 2 years of treatment[2]



adapted from Johnston S, et al., 2025

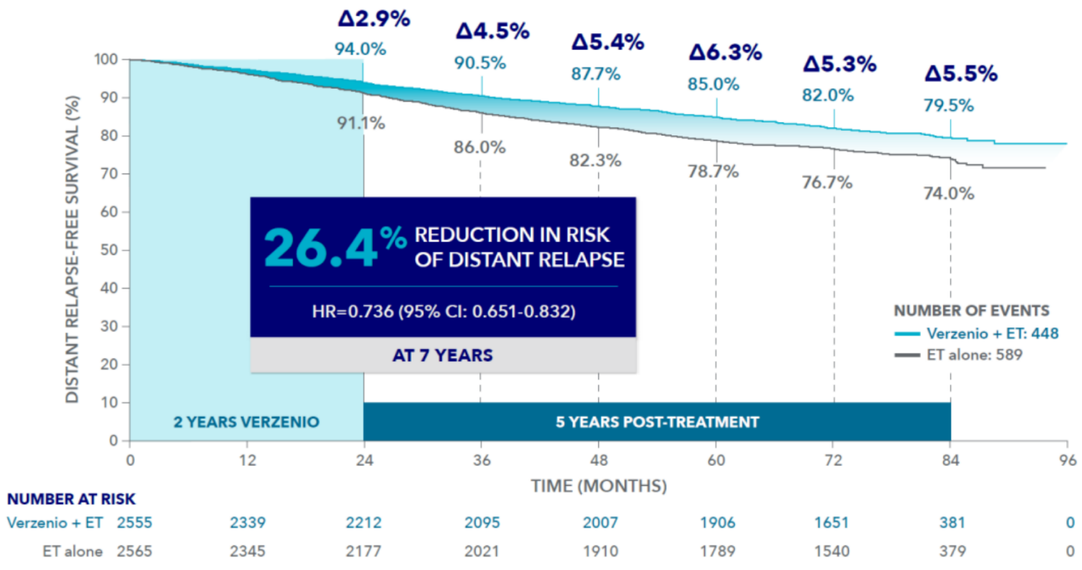
NUMBER AT RISK

Verzenios + ET	2555	2322	2188	2068	1966	1863	1609	368	0
ET alone	2565	2328	2143	1977	1851	1730	1485	362	0

Proven long-lasting protection: Verzenios has the longest follow-up ever reported for a CDK4/6 inhibitor in EBC[1]

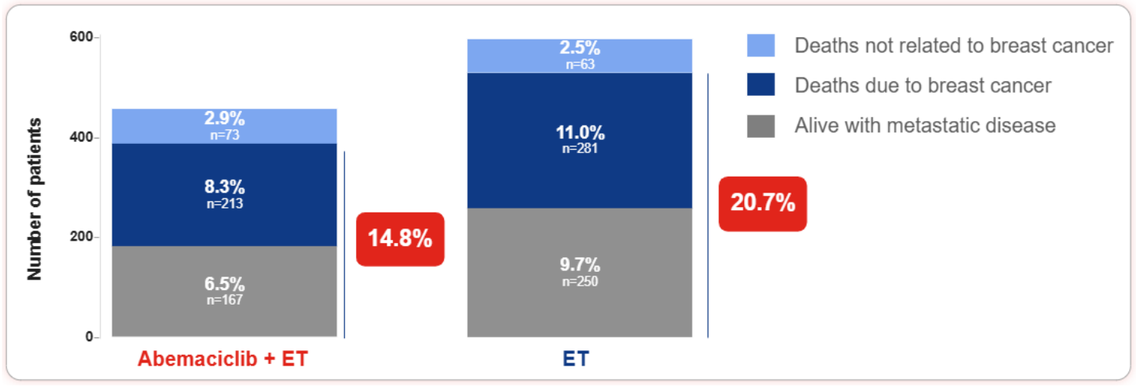
Verzenios delivers long-lasting protection – reducing the risk of recurrence to incurable metastatic disease[1,*]

DRFS benefit sustained at 7 years[1]



adapted from Johnston S, et al., 2025

~30% Fewer Patients in the Abemaciclib Arm Developed and Are Living With Metastatic Disease (Cohort 1**)[1] *



adapted from Johnston S, et al., 2025

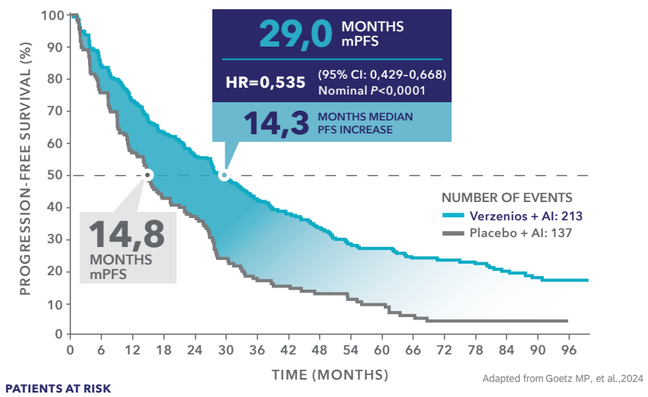


MONARCH 3: Included endocrine-sensitive patients who need greater disease control[#,11]
53% of patients had visceral disease [10]

Progression-free survival | in combination with AI[12]

mPFS in the ITT population at 8,1-year median follow-up[12]

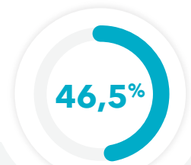
Verzenios + AI showed sustained control of disease progression at the 8-year follow-up[12]



Adapted from Goetz MP, et al.,2024

PATIENTS AT RISK

Verzenios + AI	328	251	209	173	143	121	99	86	76	61	54	45	41	39	31	25	10
Placebo + AI	165	114	84	61	51	31	21	19	15	13	11	7	5	5	5	3	0



At the 8-year follow-up, Verzenios showed sustained control of disease progression[12]

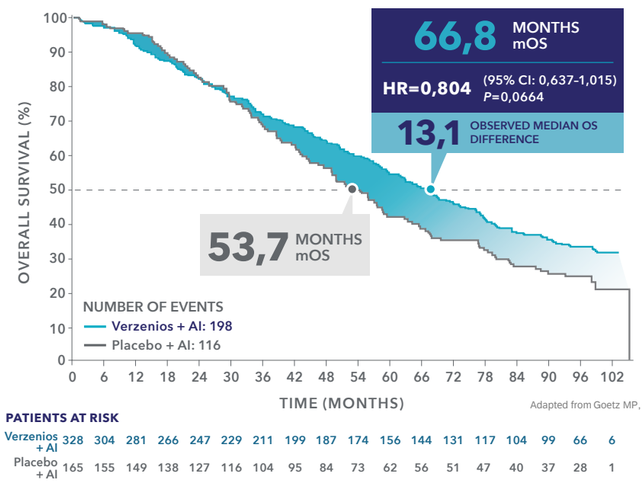
- 46,5% reduction in risk of progression or death

Statistical significance was achieved for PFS at the preplanned interim analysis with 1,5-year median follow-up[**,10]

Overall survival | in combination with AI[12]

mOS in the ITT population at 8,1-year median follow-up[12]

Verzenios has the longest mOS reported for a CDK4/6i in combination with an AI in MBC[††,12-14]



Adapted from Goetz MP, et al.,2024

PATIENTS AT RISK

Verzenios + AI	328	304	281	266	247	229	211	199	187	174	156	144	131	117	104	99	66	6
Placebo + AI	165	155	149	138	127	116	104	95	84	73	62	56	51	47	40	37	28	1

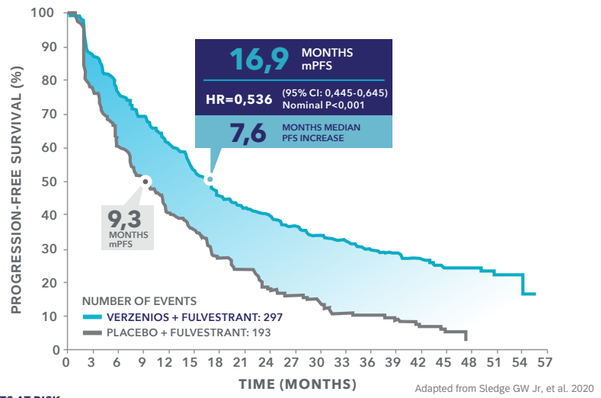
Absolute improvement in mOS was clinically meaningful. mOS in the ITT population was not statistically significant[12]

MONARCH 2: Included endocrine-resistant patients who need greater disease control[15]
- **100%** of patients were endocrine resistant
- **56%** of patients had visceral disease (373/669)

Progression-free survival | in combination with fulvestrant[16]

mPFS in the ITT population at 4,0-year median follow-up[16]

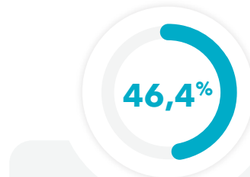
Verzenios + fulvestrant helps control disease progression with over 7 months of mPFS improvement vs placebo + fulvestrant[16]



Adapted from Sledge GW Jr, et al. 2020

PATIENTS AT RISK

Verzenios + fulvestrant	446	335	312	280	242	208	176	158	147	132	121	114	104	97	78	53	28	18	4	0
Placebo + fulvestrant	223	165	124	103	81	72	54	47	36	31	26	18	17	14	9	7	0	0	0	0



Sustained disease control through long-term follow-up[16,17]

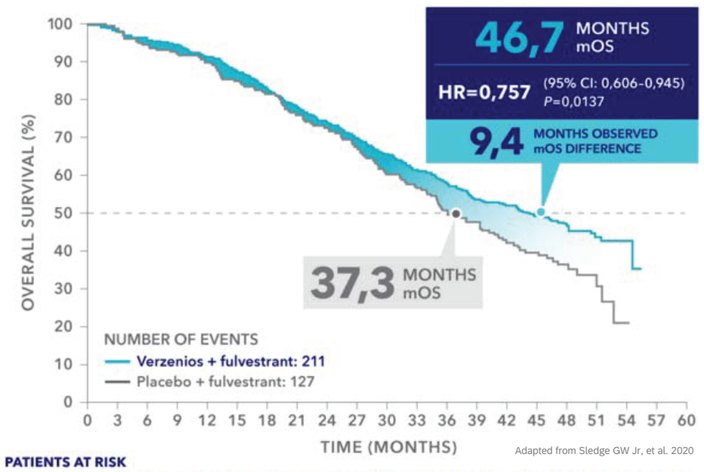
- 46,4% reduction in risk of progression or death[16]

Statistical significance was achieved at the primary analysis with 1,5-year median follow-up[15]

Overall survival | in combination with fulvestrant[16]

mOS in the ITT population at 4,0-year median follow-up[16]

Verzenios + fulvestrant: statistically significant 46,7-month mOS in endocrine-resistant patients[16]



Adapted from Sledge GW Jr, et al. 2020

PATIENTS AT RISK

Verzenios + fulvestrant	446	422	410	397	384	364	339	321	302	284	265	246	234	214	202	157	101	58	23	0	0
Placebo + fulvestrant	223	214	201	195	191	178	170	158	148	135	122	115	99	92	82	62	42	15	3	0	0

Statistically significant survival benefit: 9,4-month improvement shown after progression on prior endocrine therapy[16]

Sustained effect through long-term follow-up[17]

The **well-established** safety profile of Verzenios was **consistent** across MONARCH trials

1

AEs were generally reversible with comedication, dose adjustments, and/or dose hold.[18,19]

2

Mature PRO findings support a tolerable safety profile for Verzenios.[20-23]

3

Adjusting the dose early in treatment, as needed, supports adherence without compromising efficacy.[5,18,19]

4

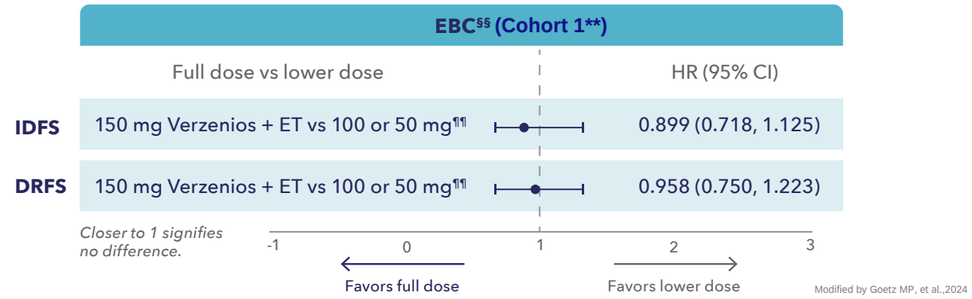
Verzenios is associated with an overall lower number of drug interactions compared to other CDK4/6 inhibitors.[24]

There were low discontinuation rates due to AEs across MONARCH trials[10,15,26]

monarchE[18]	**Verzenios + ET**	**18.5%**
MONARCH 3[10]	**Verzenios + AI**	**19.6%**
MONARCH 2[15]	**Verzenios + fulvestrant**	**15.9%**

Verzenios **dose reductions effectively managed AEs,** when necessary, and **helped retain more patients on treatment‡‡,18,19**

Adjusting the dose early in treatment, as needed, can help patients stay on Verzenios - without compromising efficacy[18,19]



Dose reductions were common in monarchE (44% of patients) and in a real-world study## (51% of patients)[26,27]

In the real-world study

93% **of patients who received dose reductions stayed on treatment through the study period‖‖,27**

2 months **median time to dose reduction[27]**

The Flatiron Health database is a longitudinal, EHR-derived, de-identified database comprising patient-level structured and unstructured data curated via technology-enabled abstraction. Additional data abstraction was conducted to supplement the existing database. The data presented here in originated from approximately 280 cancer clinics (~800 sites of care) from across the U.S., with 80% of patients from community practices and 20% from academic research hospitals.[28,29]

Verzenios offers flexible dosing options with 3 dose strengths (50, 100, 150 mg) to help with managing adverse events[5]

Choose Verzenios to help patients with HR+, HER2– node-positive, high-risk* EBC or MBC stay on track for their future of opportunities[5]

PROVEN EFFICACY ACROSS THREE PHASE 3 TRIALS

monarchE[1]	MONARCH 3[12]	MONARCH 2[16]
Node-positive, high-risk* EBC	Endocrine-sensitive MBC	Endocrine-resistant MBC

MULTIPLE ET OPTIONS

Tamoxifen (EBC)[3]	AI (EBC/MBC)[3,12]	Fulvestrant (MBC)[16]

LONG-TERM SAFETY DATA

AEs were generally reversible, with the ability to dose reduce without compromising efficacy[18,19]



†A statistically significant OS benefit was seen in the ITT population. Following regulatory consultation at the primary IDFS analysis, the OS analysis plan was amended to increase final events from 390 to 650 to ensure ≥5 years' follow-up. Verzenios is approved for Cohort 1 (91% of ITT); OS analysis in this subpopulation was not powered or alpha-controlled.[1-3]

‡Defined as "reduction in risk of recurrence over time".[2,3]

§¶Not an actual patient.

* High-risk features are defined as ≥4 positive lymph nodes or 1 to 3 positive lymph nodes with ≥1 of the following: Grade 3 disease, tumor size ≥5 cm. Patients without these high-risk features had stage I-III EBC that did not meet these criteria (node-negative, or node-positive with 1 to 3 positive nodes and tumor size <5 cm, and histological Grade <3).7

#Disease characteristics that were studied in the clinical trial and could confer a worse prognosis included liver metastases, PgR−status, and high tumor grade in primary tumor. Exploratory subgroup analyses of PFS were performed for patients with these characteristics and for patients with TFI <36 months.[11,16]

‖MONARCH 3 enrolled an endocrine-sensitive population.[11]

**Preplanned interim analysis: HR=0.54 (95% CI: 0.41-0.72; P<0.0001).[10]

††OS was a preplanned secondary endpoint.[10,25]

‡‡The analyses results were from time- dependent Cox proportional hazards model that compared the efficacy of staying at full dose level with being reduced to a lower dose level in monarchE, MONARCH 2, and MONARCH 3.[18,19]

§Data presented are for monarchE Cohort 1 (91% of ITT).[3,19]

¶¶Up to 2 Verzenios dose reductions (100 or 50 mg) were permitted prior to discontinuation.[19]

##The data presented includes 350 patients, comprising a subset of 60 patients who were node-positive, but their high-risk status could not be determined. This information is provided solely to highlight persistence and discontinuation rates and does not imply efficacy claims.

‖‖Persistence rate in the study was assessed at 3 months.[27]

++In Cohort 1 0.6 % of patients were male. Male population is excluded for the Swiss approval.

1L=first-line; AE=adverse event; AI=aromatase inhibitor; BRCA=Breast Cancer gene; CDK4/6=cyclin-dependent kinase 4 and 6; CDK4/6i=cyclin-dependent kinase 4 and 6 inhibitor; CI=confidence interval; DRFS=distant relapse-free survival; EBC=early breast cancer; ECOG PS=Eastern Cooperative Oncology Group performance status; EHR=Electronic Health Record; ET=endocrine therapy; HER2−=human epidermal growth factor receptor 2-negative; HR=hazard ratio; HR+=hormone receptor-positive; IDFS=invasive disease-free survival; ITT=intent-to-treat; LHRH=luteinizing hormone-releasing hormone; mOS=median overall survival; mPFS=median progression-free survival; OS=overall survival; PFS=progression-free survival; PgR=progesterone receptor; PRO=patient-reported outcome; RWE=real-world evidence; TFI=treatment-free interval; U.S.=United States.

Healthcare professionals can request the references from the company at any time.

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Verzenios® (abemaciclib) film-coated tablets

I: Temporarily authorized indication: Adjuvant treatment in combination with endocrine therapy (ET) of adult women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive early breast cancer at high risk of relapse based on lymph node status, primary tumour size and tumour grade. In pre- or perimenopausal women, aromatase inhibitor endocrine therapy should be combined with a LHRH agonist. Permanent Indication: Treatment of postmenopausal women with HR+, HER2- locally advanced or metastatic breast cancer: in combination with an aromatase inhibitor as initial endocrine-based therapy or in combination with fulvestrant in women who have received prior endocrine therapy. As monotherapy following disease progression after endocrine therapy and one or two chemotherapy regimens in the metastatic setting, when chemotherapy is not suitable. In pre- or perimenopausal women combined with a LHRH-agonist. P: The recommended dose is 150 mg twice daily when used in combination with endocrine therapy and as a single agent 200 mg twice daily.CI: Hypersensitivity. W/P: For women who have not received any (neo-) adjuvant chemotherapy before, the available data is limited, because only 2% of women in the monarchE study were included. No statistically significant overall survival benefit from abemaciclib was shown at temporary approval. Its impact on survival compared to later relapse treatment, or on subsequent advanced cancer therapies, remains unassessed. Neutropenia, infections, Interstitial Lung Disease (ILD)/Pneumonitis, diarrhoea, increased aminotransferases, venous thromboembolism and arterial thromboembolic events occurred. Contains lactose. Verzenios can have an influence on the ability to drive and use machines. IA: Abemaciclib and its circulating active metabolites resulted in a down-regulation of CYPs' mRNA, including CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2D6, and CYP3A4 in vitro. In a clinical drug interaction study in women with cancer, multiple doses of abemaciclib did not result in clinically meaningful changes in the pharmacokinetics of CYP1A2 (caffeine), CYP2C9 (S-warfarin), CYP2D6 (dextromethorphane) and CYP3A4 substrates (midazolam). The clinical effects of CYP2C8 and CYP2B6 down regulation are unknown. Abemaciclib is a substrate of CYP3A4, time dependent changes in pharmacokinetics of abemaciclib as a result of autoinhibition of its metabolism were not observed. When strong CYP3A4 inhibitors such as for example clarithromycin, itraconazole, ketoconazole, lopinavir/ritonavir, posaconazole or voriconazole need to be co-administered, the dose of abemaciclib should be reduced. Caution and monitoring of toxicity is recommended during concomitant treatment with sensitive substrates of P-gp or BCRP that have a narrow therapeutic index, such as digoxin and dabigatran. Sensitive substrates of P-gp or BCRP that do not have a narrow therapeutic index such as pitavastatin, pravastatin and rosuvastatin may be used with caution. Abemaciclib and its major active metabolites inhibit the renal transporters OCT2, MATE1, and MATE2-K at concentrations achievable at the approved recommended dosage. Pr/L: There are no data from the use of abemaciclib in pregnant women. Animal studies have shown reproduction toxicity. Therefore, Verzenios should not be used during pregnancy and in women of childbearing potential without use of contraception, unless this is absolutely necessary. If Verzenios is used during pregnancy or if a patient gets pregnant during therapy, the patient should be advised of the potential risk for the fetus. It is unknown whether abemaciclib is excreted in human milk. A risk to newborns/infants cannot be excluded. Women should not breast-feed during treatment with abemaciclib and for at least up to 3 weeks after last administration of abemaciclib. ADR: Very common: Infections, neutropenia, anemia, leukopenia, thrombocytopenia, decreased appetite, dysgeusia, dizziness, diarrhoea, nausea, abdominal pain, vomiting, stomatitis, alopecia, rash, pruritus, fatigue, pyrexia, increased ASAT/ALAT. Common: Lacrimation increase, venous thromboembolism, lymphopenia, Interstitial lung disease/pneumonitis, dry mouth, dry skin, muscular weakness. P: 50 mg, 100 mg, 150 mg, 200 mg: 28 and 56 film-coated tablets. Dispensing category A.. Consult www.swissmedicinfo.ch for further information. Eli Lilly (Suisse) SA, ch. des Coquelicots 16, CP 580, 1214 Vernier (GE). V12-2023

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